

Consultation on potential COF indicators

Consultation dates: 1 February to 29 February 2012

This document provides an introduction to the Commissioning Outcomes Framework (COF) and the indicator development process. It includes:

- Information about the COF
- Information about the indicator consultation process
- Indicators in the consultation
- A brief rationale for each indicator
- A list of further indicators being considered for future development
- A consultation proforma through which stakeholders are invited to submit comments on potential COF indicators to NICE.

About the Commissioning Outcomes Framework (COF)

What is the COF?

The Commissioning Outcomes Framework is an accountability framework for clinical commissioning groups (CCGs). The COF will allow the NHS Commissioning Board to identify the contribution of CCGs to achieving the priorities for health improvement in the NHS Outcomes Framework. The COF will contain a number of indicators developed from NICE evidence-based quality standards. Indicators are also sourced from the NHS Outcomes Framework and existing indicator collections.

The NICE COF Indicator Programme

NICE's role is to manage the process of developing health outcome and quality of care indicators for the COF. This involves reviewing NICE quality standards to develop indicators for consideration by the COF Advisory Committee.

The Advisory Committee will then recommend which indicators, based on an agreed selection criteria (see NICE website), should go forward for further development, including indicator testing and public consultation.

The NICE process, including public consultation, will also assess potential indicators for the COF from the NHS Outcomes Framework and existing indicator collections.

Development Stages

The COF will become operational from April 2013. Key stages in the development process are:

- Draft indicators are developed from NICE quality standards and are reviewed by a topic-specific review group. Indicators considered as

clear and valid are then presented to the COF advisory Committee, which selects indicators for further development and testing.

- NICE works with the NHS Information Centre (NHS IC) to further develop and test indicators. Indicator development and testing includes the following:
 - Extraction of data, development of detailed indicator methods including any required risk adjustment
 - qualitative assessments of indicator specifications via a web survey;
 - review of detailed indicator methods with selected internal external stakeholders
 - quantitative testing of indicator data with selected stakeholders in a live NHS environment
 - public consultation
- The COF advisory Committee meets for a second time to review the results of indicator development including the results of consultation, and recommends a set of indicators for consideration by the NHS Commissioning Board and publication on the NICE website.
- Indicators from other sources, including those derived from the NHS Outcomes Framework that can be measured at CCG level are included in the indicator development process including the public consultation. These indicators will also be reviewed by the COF advisory Committee.
- NICE publishes the recommended indicators alongside supporting information.
- The NHS Commissioning Board decides which indicators should be included in the COF.

Consultation on potential COF indicators

We encourage stakeholders to comment on the potential COF indicators that are now out for consultation.

In relation to the COF indicator set as a whole, stakeholders are asked to consider the questions below. Appendix 3 highlights a number of further indicators that have been identified for potential inclusion in the COF but require further development and will not be ready for April 2013. Stakeholders may wish to consider these additional indicators in response to these questions:

- What are your views on the scope of the COF? Do you think that there is sufficient breadth of topics covered in this consultation, if not, can you suggest other topics that may be appropriate for COF indicator development?

For indicators that have *not* been derived from the NHS Outcomes Framework, stakeholders are asked to consider the following questions:

- Which of the care processes or health outcomes measured by the indicators do you consider have the greatest potential to improve the quality of care in the five domains described in the [NHS Outcomes Framework](#)?
- To what extent do you think the care processes or health outcomes measured by the indicators may be influenced by the actions of clinical commissioning groups¹?
- To what extent do you think the care processes or health outcomes measured by the indicators reflect areas where there are current unacceptable variations?

¹ For example through decisions on which services to commission, the setting of contracts and the monitoring of the quality of services commissioned from providers

- What, if any, are the barriers to implementing the care processes measured by any of these indicators?
- What, if any, are the potential unintended consequences resulting from the use of these indicators in the COF?
- Do you think there is potential for any of care processes measured by the indicators to impact differently on any particular groups in respect of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation? If so, please state whether this difference is adverse or positive and for which group.
- If you think any of the care processes measured by the indicators may have an adverse impact on any particular groups in the community, can you suggest how the indicators could be changed in order to reduce health inequalities?

Indicators derived from the NHS Outcomes Framework have already been through a consultation process. Therefore, stakeholders are asked to consider the following two questions which relate to the appropriateness of their inclusion in the COF:

- To what extent do you think the indicators may be influenced by the commissioning activities of clinical commissioning groups?
- What, if any, are the potential unintended consequences resulting from these indicators applied at clinical commissioning group population level?

The wording of the indicators presented in this document is subject to change following indicator testing and public consultation. At times it has been necessary to develop permutations of an indicator for the purpose of indicator testing.

Some indicators included in this consultation are similar to those included in the recent Quality and Outcomes Framework (QOF) consultation.

Stakeholders who have commented on these indicators during the QOF consultation may refer to their responses to the QOF consultation. However, stakeholders should also consider the different focus of the COF.

How to submit your comments

If you would like to comment on any of the indicators in this consultation please use the comments proforma provided in appendix 2 and forward this to cof@nice.org.uk by 29 February 2012. For more information see the [NICE COF web site](#).

Indicators for consultation

The list of potential COF indicators for consultation is presented in terms of the five domains of the NHS Outcomes Framework. Within each domain there are potential COF indicators derived from NICE quality standards, directly from the NHS Outcomes Framework and indicators from other sources.

There is a reference number alongside each indicator. The reference numbers are not always sequential: numbers may appear to be missing from the sequence where the associated indicators are not part of the current consultation on potential indicators for the 2013/14 COF.

The wording of indicators is subject to further development.

Domain 1: Preventing people from dying prematurely
Domain 1: Indicators derived from NHS Outcomes Framework
1b Life expectancy at 75: i Males ii Females 1.1 Under 75 mortality rate from cardiovascular disease 1.2 Under 75 mortality rate from respiratory disease 1.3 Under 75 mortality rate from liver disease 1.4 Cancer: ii Five-year survival from colorectal cancer iv Five-year survival from breast cancer vi Five-year survival from lung cancer vii Under 75 mortality rate from cancer 1.6 Reducing deaths in babies and young children: i Infant mortality ii Neonatal mortality and stillbirths
Domain 1: Indicators derived from quality standards and existing collections
Coronary Heart Disease
1.16 Timely intervention: ambulance response times following suspected myocardial infarction
1.17 Timely intervention: thrombolysis following suspected myocardial infarction
Dementia
1.23 People with dementia prescribed anti-psychotic medication
Diabetes
1.24 Myocardial infarction, stroke and end stage kidney disease in people with diabetes
Maternity
1.25 Antenatal assessments <13 weeks
1.26 Maternal smoking in pregnancy
1.27 Maternal smoking at delivery
1.28 Breast feeding initiation
1.29 Breast feeding prevalence at 6-8 weeks
Mental Health
1.30 People with severe mental illness who have received complete list of physical checks
1.31 Duration of untreated psychosis
1.32 The number of those with first onset psychosis taken on by early intervention (EI) services as a proportion of local incidence
Stroke
1.34 Mortality within 30 days of hospital admission for stroke

Domain 2: Enhancing quality of life for people with long term conditions
Domain 2: Indicators derived from NHS Outcomes Framework
2 Health-related quality of life for people with long-term conditions
2.1 Proportion of people feeling supported to manage their condition
2.2 Employment of people with long-term conditions
2.3.
i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
2.5 Employment of people with mental illness
Domain 2: Indicators derived from quality standards and existing collections
Generic
2.7 Unplanned hospitalisation for chronic ambulatory care sensitive conditions
2.8 Patterns of care (person-based hospitalisation over 12 months: generic or composite covering asthma, COPD, diabetes, heart failure, mental health)
Asthma
2.10 Emergency attendance at A&E: asthma
Chronic Obstructive Pulmonary Disease
2.23 People with COPD who are functionally disabled, usually MRC grade 3 and above referred to a pulmonary rehabilitation programme
2.28 Emergency attendance at A&E: COPD
Chronic Kidney Disease
2.32 People with CKD on long term dialysis who start on home dialysis [Peritoneal dialysis (PD) or home haemodialysis (HD)] or self-care
2.33 People with stage 5 CKD who receive a pre-emptive kidney transplant before they receive dialysis in the last 12 months
2.34 People starting haemodialysis (HD) treatment who start dialysis with a functioning arteriovenous fistula
2.35 People on Peritoneal dialysis (PD) who are on automated peritoneal dialysis
2.36 Transplantation within last 12 months (living / cadaveric) in people with CKD 5
Coronary Heart Disease
2.42 Cardiac rehabilitation
Depression
2.51 People with depression referred for psychological therapy receiving it

Diabetes
2.52 Single marker of all nine basic care processes performed
2.53 People with newly diagnosed diabetes who are offered structured education within 3 months of diagnosis
2.54 People with established diabetes who are offered structured education
2.55 People with newly diagnosed diabetes who start structured education
2.56 People with established diabetes who start structured education
2.57 People with newly diagnosed diabetes who complete structured education
2.58 People with established diabetes who complete structured education
2.59 People with established diabetes whose structured education has been reviewed and reinforced within the last 15 months
2.60 Readmission rates of people admitted with diabetic ketoacidosis within 12 months following discharge
2.61 Rates of complications associated with diabetes
2.62 Rates of lower limb amputation
2.63 Emergency admissions: diabetic ketoacidosis in people with diabetes
2.64 Emergency admissions: hypoglycaemia in people with diabetes
Glaucoma
2.71 Age-stratified incidence of certification of visual impairment (at each level of registration) with chronic open angle glaucoma (COAG) as the primary cause
Liver Disease
2.77 Emergency admissions: Liver disease
Mental Health
2.79 People on Care Programme Approach (CPA) followed-up within 7 days of discharge from psychiatric inpatient stay
2.80 Number of Home Treatment episodes carried by Crisis Resolution / Home Treatment Teams
2.81 Percentage of inpatient admissions that were gatekept by Crisis Resolution / Home Treatment Teams
Stroke
2.85 People who have had a stroke who have been free from vascular events for 6 months following initial (index) admission for stroke (case-mix adjusted)
2.87 Joint health and social care plans on discharge of patients with stroke from hospital
2.88 Psychological support for mood, behaviour and cognitive disturbance by 6 months after stroke
2.89 People with stroke reviewed 6 months after leaving hospital
2.90 People with stroke supported by a stroke skilled early supported discharge (ESD) team

Domain 3: Helping people to recover from episodes of ill health or following injury
Domain 3: Indicators derived from NHS Outcomes Framework
3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospital
3.1 Patient Reported Outcomes Measures (PROMs) for elective procedures
i Hip replacement
ii Knee replacement
iii Groin hernia
iv Varicose veins
3.2 Emergency admissions for children with lower respiratory tract infections (LRTI)
Domain 3: Indicators derived from quality standards and existing collections
Chronic Obstructive Pulmonary Disease
3.7 People admitted to hospital with an exacerbation of COPD who are under the care of a respiratory consultant within 48hrs of admission until discharge
3.8 Emergency readmissions: people who have been admitted following an exacerbation of COPD
3.10 Emergency readmissions: COPD
3.11 Emergency readmissions: oxygen toxicity
Coronary Heart Disease
3.14 Hospital procedures: repeat percutaneous transluminal coronary angioplasty (PTCA)
3.15 Hospital procedures: repeat coronary artery bypass graft (CABG)
Depression
3.18 People with new presentation of severity depression who receive appropriate treatment
Diabetes
3.22 People with diabetes with a new diagnosis of foot ulceration requiring urgent medical attention who are seen by the MDT foot care team within 24 hours of referral
Liver disease
3.23 Emergency readmissions: liver disease
Mental Health
3.24 Movement towards recovery following treatment for depression by secondary mental health services
3.25 The proportion of those receiving talking therapies aged >65
3.26 Recovery following talking therapies all ages and aged > 65
3.27 Length of stay: Severe Mental Illness
3.28 Delayed discharge from psychiatric inpatient ward
Out of Hours Care
3.29 Total time: time from the start of the original call or arrival at the urgent care or out-of-hours base (where the patient does not phone beforehand) until discharge, admission or transfer to another service
3.30 Unplanned re-contact rate:
a) Re-contact following discharge of care by clinical telephone advice within 7 days of a previous call
b) Unplanned re-contact within 7 days of attendance at an urgent care or out-of-hours base
Stroke

3.31 For those people assessed as having a stroke and seen by ambulance services, the proportion who are taken to a hospital with a acute stroke unit within 1 hour of arrival at the emergency
3.32 People who have had an acute stroke who have brain imaging within one hour of arrival at the hospital
3.33 People who have had an acute stroke who receive thrombolysis
3.34 Patients with stroke admitted to an acute stroke unit within 4 hours of arrival to hospital
3.35 People who have had an acute stroke whose swallowing is screened by a specially trained healthcare professional within 4 hours of admission to hospital
Urgent and Emergency Care
3.41 Unplanned re-attendance at A&E within 7 days of original attendance

Domain 4: Ensuring that people have a positive experience of care
Domain 4: Indicators derived from NHS Outcomes Framework
4a Patient experience of GP Out of Hours services 4b Patient experience of hospital care 4.1 Patient experience of outpatient services 4.2 Responsiveness to in-patients' personal needs 4.3 Patient experience of A&E services 4.5 Women's experience of maternity services 4.7 Patient experience of community mental health services
Domain 4: Indicators derived from quality standards and existing collections
Cancers
4.10 Deaths at home: all cancers
Diabetes
4.18 Patient experience of diabetes services
Mental Health
4.19 Patient experience of IAPT (improved access to psychological therapies) services 4.20 Access to community mental health services by BME (black and minority ethnic) groups 4.21 Access to IAPT services by BME groups
Urgent and Emergency Care
4.22 Attenders leaving without being seen 4.23 High risk re-attenders reviewed by consultant before being discharged

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm
Domain 5: Indicators derived from NHS Outcomes Framework
5a Patient safety incidents reported 5b Safety incidents involving severe harm or death 5.2 Incidence of healthcare associated infection (HCAI): i MRSA ii C. difficile 5.4 Incidence of medication errors causing serious harm 5.5 Admission of full-term babies to neonatal care 5.6 Incidence of harm to children due to 'failure to monitor'
Domain 5: Indicators derived from quality standards and existing collections
Mental Health
5.7 Hospital admissions: self-harm 5.8 Absence without leave for patients detained under the Mental Health Act
Venous Thromboembolism (VTE)
5.9 Adult patients who have had a VTE risk assessment on admission to hospital, using the clinical criteria of the national tool 5.10 Emergency readmissions: VTE

Appendix 1: Brief rationale for indicators out for consultation

Domain 1: Preventing people from dying prematurely

Domain 1: Indicators derived from NHS Outcomes Framework

Indicator area	Indicator
Overarching	1b Life expectancy at 75: i Males ii Females

This indicator is included in the 2012/13 NHS Outcomes Framework and is a pure outcome indicator. Full details on this indicator can be found in the NHS Outcomes Framework 2012/13 Technical Appendix document, available [here](#).

Indicator area	Indicator
Improvement	1.1 Under 75 mortality rate from cardiovascular disease 1.2 Under 75 mortality rate from respiratory disease 1.3 Under 75 mortality rate from liver disease 1.4 ii Five-year survival from colorectal cancer iv Five-year survival from breast cancer vi Five-year survival from lung cancer vii Under 75 mortality rate from cancer 1.6 Reducing deaths in babies and young children: i Infant mortality ii Neonatal mortality and stillbirths

These indicators are included in the 2012/13 NHS Outcomes Framework and are pure outcome indicators. Full details on these indicators can be found in the NHS Outcomes Framework 2012/13 Technical Appendix document, available [here](#).

Domain 1: Indicators derived from quality standards and existing collections

Topic area	Indicator
Coronary Heart Disease	1.16 Timely intervention: ambulance response times following suspected myocardial infarction 1.17 Timely intervention: thrombolysis following suspected myocardial infarction

Indicators 1.16 and 1.17 are quality indicators included in the NHS Operating Framework 2012/13. These indicators aim to address timely intervention following suspected myocardial infarction.

For indicator 1.17, SIGN guideline 36 on antithrombotic therapy states: Patients with acute myocardial infarction should also be considered for thrombolysis as quickly as possible after the onset of symptoms

Topic area	Indicator
Dementia	1.23 People with dementia prescribed anti-psychotic medication

The intent of indicator 1.23 is to measure the proportion of people with dementia who are prescribed anti-psychotic medication. A threshold of close to zero is expected for this indicator.

Topic area	Indicator
Diabetes	1.24 Myocardial infarction, stroke and end stage kidney disease in people with diabetes

The intent of indicator 1.24 is to measure the proportion of people with diabetes who develop long term conditions or complications that may be exacerbated by poor management of diabetes.

Topic area	Indicator
Maternity	1.25 Antenatal assessments <13 weeks 1.26 Maternal smoking in pregnancy 1.27 Maternal smoking at delivery 1.29 Breast feeding initiation 1.29 Breast feeding prevalence at 6-8 weeks

Indicators 1.25 to 1.29 are consistent with high quality care as described in the following NICE clinical guidelines:

Indicator 1.25:

- NICE clinical guideline CG62 on ante-natal care recommendation 1.2.5.2 states: Early in pregnancy, all women should receive appropriate written information about the likely number, timing and content of antenatal appointments associated with different options of care and be given an opportunity to discuss this schedule with their midwife or doctor.

Indicator 1.26 and 1.27:

- NICE clinical guideline CG62 on ante-natal care recommendation 1.3.10.4 states: Monitor smoking status and offer smoking cessation advice, encouragement and support throughout the pregnancy and beyond.

Indicators 1.28 and 1.29:

- NICE clinical guideline CG62 on ante-natal care recommendation 1.1.1.1 states: New antenatal information should be given to pregnant women according to the following schedule. Before or at 36 weeks: breastfeeding information, including technique and good management practices that would help a woman succeed, such as detailed in the UNICEF 'Baby Friendly Initiative'.

Topic area	Indicator
Mental Health	1.30 People with severe mental illness who have received complete list of physical checks 1.31 Duration of untreated psychosis 1.32 The number of those with first onset psychosis taken on by early intervention (EI) services as a proportion of local incidence

Indicators 1.30 to 1.32 are consistent with high quality care as described in the following NICE clinical guidelines:

Indicator 1.30:

- NICE clinical guideline GC82 on schizophrenia recommendation 1.1.4.1 states: Ensure that people with schizophrenia receive a comprehensive multidisciplinary assessment, including a psychiatric, psychological and physical health assessment.

Indicator 1.31:

- NICE clinical guideline GC82 on schizophrenia recommendation 1.2.1.1 states: Urgently refer all people with first presentation of psychotic symptoms in primary care to a local community-based secondary mental health service (for example, crisis resolution and home treatment team, early intervention service, community mental health team). Referral to early intervention services may be from primary or secondary care. The choice of team should be determined by the stage and severity of illness and the local context.

Indicator 1.32:

- NICE clinical guideline GC82 on schizophrenia recommendation 1.2.2.1 states: Offer early intervention services to all people with a first episode or first presentation of psychosis, irrespective of the person's age or the duration of untreated psychosis. Referral to early intervention services may be from primary or secondary care.

Topic area	Indicator
Stroke	1.34 Mortality within 30 days of hospital admission for stroke

This indicator measures a health outcome. It may be regarded as a proxy measure for the acute care of people who have been admitted to hospital with stroke.

Domain 2: Enhancing quality of life for people with long term conditions

Domain 2: Indicators derived from NHS Outcomes Framework

Indicator area	Indicator
Overarching	2 Health-related quality of life for people with long-term conditions

This indicator is included in the 2012/13 NHS Outcomes Framework. Full details on this indicator can be found in the NHS Outcomes Framework 2012/13 Technical Appendix document, available [here](#).

Indicator area	Indicator
Improvement	2.1 Proportion of people feeling supported to manage their condition 2.2 Employment of people with long-term conditions 2.3. i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s 2.5 Employment of people with mental illness

These indicators are included in the 2012/13 NHS Outcomes Framework. Full details on these indicators can be found in the NHS Outcomes Framework 2012/13 Technical Appendix document, available [here](#).

Domain 2: Indicators derived from quality standards and existing collections

Topic area	Indicator
Generic	2.7 Unplanned hospitalisation for chronic ambulatory care sensitive conditions 2.8 Patterns of care (person-based hospitalisation over 12 months: generic or composite covering asthma, COPD, diabetes, heart failure, mental health)

Chronic ambulatory care sensitive (ACS) conditions include congestive heart failure, chronic obstructive pulmonary disease (COPD), diabetes, asthma and hypertension. It is anticipated that actively managing ACS conditions can prevent some acute exacerbations and reduce some of the need for emergency hospital admission. These indicators therefore intend to measure, unplanned hospitalisations and patterns of care in this group as a proxy for overall ACS management. Indicator 2.7 is intended to be measured as a group and by individual conditions such as asthma and COPD.

Topic area	Indicator
Asthma	2.10 Emergency attendance at A&E: asthma

This indicator measures emergency attendances at accident and emergency (A&E) for people with asthma, and is intended to act as a proxy measure for overall asthma management.

Topic area	Indicator
COPD	2.23 People with COPD who are functionally disabled, usually MRC grade 3 and above referred to a pulmonary rehabilitation programme

This has been identified as being a key component of high quality care as defined in the NICE quality standard for COPD in statement 6: People with COPD meeting appropriate criteria are offered an effective, timely and accessible multidisciplinary pulmonary rehabilitation programme.

Topic area	Indicator
COPD	2.28 Emergency attendance at A&E: COPD

This indicator measures emergency attendances at accident and emergency (A&E) for people with COPD, and is intended to act as a proxy measure for overall COPD management.

Topic area	Indicator
Chronic Kidney Disease	2.32 People with CKD on long term dialysis who start on home dialysis [Peritoneal dialysis (PD) or home haemodialysis (HD)] or self-care 2.33 People with stage 5 CKD who receive a pre-emptive kidney transplant before they receive dialysis in the last 12 months 2.34 People starting haemodialysis (HD) treatment who start dialysis with a functioning arteriovenous fistula 2.35 People on peritoneal dialysis (PD) who are on automated peritoneal dialysis 2.36 Transplantation within last 12 months (living / cadaveric) in people with CKD 5

These indicators have been identified as being a key component of high quality care as defined in the NICE quality standard for chronic kidney disease (CKD).

- Statement 14 (for indicator 2.32): People on long-term dialysis receive the best possible therapy, incorporating regular and frequent application of dialysis and ideally home-based or self-care dialysis.
- Statement 11 (for indicators 2.33 and 2.36): People with CKD are supported to receive a pre-emptive kidney transplant before they need dialysis, if they are medically suitable.
- Statement 13 (for indicators 2.34 and 2.35): People with established kidney failure start dialysis with a functioning arteriovenous fistula or peritoneal dialysis catheter in situ.

Topic area	Indicator
Coronary Heart Disease	2.42 Cardiac rehabilitation

Indicator 2.42 is consistent with high quality care as described in NICE clinical guideline CG48 on MI: secondary prevention, recommendations 1.2.1.1 to 1.2.1.4, which state:

- All patients (regardless of their age) should be given advice about and offered a cardiac rehabilitation programme with an exercise component.

- Patients with left ventricular dysfunction who are stable can safely be offered the exercise component of cardiac rehabilitation.

Additionally, NICE clinical guideline CG108 on chronic heart failure, recommendation 1.3.1.1, states: Offer a supervised group exercise-based rehabilitation programme designed for patients with heart failure.

NICE clinical guideline CG 94 on unstable angina and NSTEMI states that people should be given advice and information about cardiac rehabilitation.

Topic area	Indicator
Depression	2.51 People with depression referred for psychological therapy receiving it

Indicator 2.51 is consistent with high quality care as described in NICE clinical guideline CG90 on depression, NICE clinical guideline CG91 on depression with a chronic physical health problem and NICE clinical guideline CG123 on common mental health disorders. These guidelines contain specific recommendations on types of psychological interventions for subgroups of people with depression.

Indicator 2.51 is a quality indicator included in the NHS Operating Framework 2012/13.

Topic area	Indicator
Diabetes	<p>2.52 Single marker of all nine basic care processes performed.</p> <p>2.53 People with newly diagnosed diabetes who are offered structured education within 3 months of diagnosis</p> <p>2.54 People with established diabetes who are offered structured education</p> <p>2.55 People with newly diagnosed diabetes who start structured education</p> <p>2.56 People with established diabetes who start structured education</p> <p>2.57 People with newly diagnosed diabetes who complete structured education</p> <p>2.58 People with established diabetes who complete structured education</p> <p>2.59 People with established diabetes whose structured education has been reviewed and reinforced within the last 15 months</p> <p>2.60 Readmission rates of people admitted with diabetic ketoacidosis within 12 months following discharge</p> <p>2.61 Rates of complications associated with diabetes</p> <p>2.62 Rates of lower limb amputation</p> <p>2.63 Emergency admissions: diabetic ketoacidosis in people with diabetes</p> <p>2.64 Emergency admissions: hypoglycaemia in people with diabetes</p>

For indicator 2.52, the nine basic annual health checks for people with diabetes measured by the indicator are:

- weight and BMI measurements
- blood pressure
- smoking status
- blood test (HbA1c – blood glucose levels)
- urinary albumin test (or protein test to measure the kidney function)
- serum creatinine test (creatinine is an indicator for renal function)
- cholesterol levels
- eye check (retinopathy screening)
- feet check

NICE clinical guidelines CG10 on type 2 diabetes footcare, CG15 on type 1 diabetes and CG87 on type 2 diabetes state that people with diabetes should receive key health checks to monitor and manage the condition, as well as to reduce the risk of complications such as stroke, heart disease and amputations.

Indicators 2.53 to 2.64 have been identified as being a key component of high quality care as defined in the NICE quality standard for diabetes.

- Statement 1 (for indicators 2.53 to 2.59): People with diabetes and/or their carers receive a structured educational programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to ongoing education.
- Statement 12 (for indicators 2.60 and 2.63): People admitted to hospital with diabetic ketoacidosis receive educational and psychological support prior to discharge and are followed up by a specialist diabetes team.
- Statement 8 (for indicator 2.61): People with diabetes receive an annual assessment for the risk and presence of the complications of diabetes, and these are managed appropriately.
- Statement 10 (for indicator 2.62): People with diabetes with or at risk of foot ulceration receive regular review by a foot protection team in accordance with NICE guidance, and those with a foot problem requiring urgent medical attention are referred to and treated by a multidisciplinary foot care team within 24 hours.
- Statement 13 (for indicator 2.64): People with diabetes who have experienced hypoglycaemia requiring medical attention are referred to a specialist diabetes team.

Topic area	Indicator
Glaucoma	2.71 Age-stratified incidence of certification of visual impairment (at each level of registration) with chronic open angle glaucoma (COAG) as the primary cause

This indicator measures an outcome: visual impairment with chronic open angle glaucoma (COAG) as the cause. The indicator may be regarded as a proxy for overall glaucoma management as outlined in the NICE quality standard on glaucoma.

Topic area	Indicator
Liver Disease	2.77 Emergency admissions: Liver disease

Indicator 2.77 is an indicator included in the NHS Operating Framework 2012/13. This indicator measures emergency admissions for people with liver disease, and is intended to act as a proxy measure for overall liver disease management.

Topic area	Indicator
Mental Health	2.79 People on Care Programme Approach (CPA) followed-up within 7 days of discharge from psychiatric inpatient stay 2.80 Number of Home Treatment episodes carried by Crisis Resolution / Home Treatment Teams 2.81 Percent of inpatient admissions that were gatekept by Crisis Resolution / Home Treatment Teams

These indicators are mental health measures on Care Programme Approach (CPA) and crisis resolution / home treatment that are included in the NHS Operating Framework 2012/13.

A number of NICE clinical guidelines make reference to the use of crisis resolution and home treatment teams to manage serious mental health related episodes in the community:

- Depression in adults (CG90) recommendation 1.10.1.3: Use crisis resolution and home treatment teams to manage crises for people with severe depression who present significant risk, and to deliver high-quality acute care. The teams should monitor risk as a high-priority routine activity in a way that allows people to continue their lives without disruption.
- Depression in adults (CG90) recommendation 1.10.2.3: Consider crisis resolution and home treatment teams for people with depression who might benefit from early discharge from hospital after a period of inpatient care.

- Borderline Personality Disorder (CG78) recommendation 1.4.1.1: Before considering admission to an acute psychiatric inpatient unit for a person with borderline personality disorder, first refer them to a crisis resolution and home treatment team or other locally available alternative to admission
- Service user experience in adult mental health (CG136) recommendation 1.5.7: Health and social care providers should ensure that crisis resolution and home treatment teams are accessible 24 hours a day, 7 days a week, and available to service users in crisis regardless of their diagnosis.
- Schizophrenia (CG82) recommendation 1.3.1.2: Crisis resolution and home treatment teams should be used to support people with schizophrenia during an acute episode in the community. Teams should pay particular attention to risk monitoring as a high-priority routine activity.
- Bipolar Disorder (CG38) recommendation 1.3.2.5: Crisis resolution and home treatment teams (which should have prompt access to existing care plans) should be considered for people with bipolar disorder to: manage crises at home or in the community....

Topic area	Indicator
Stroke	2.85 People who have had a stroke who have been free from vascular events for 6 months following initial (index) admission for stroke (case-mix adjusted) 2.87 Joint health and social care plans on discharge of patients with stroke from hospital 2.88 Psychological support for mood, behaviour and cognitive disturbance by 6 months after stroke 2.89 People with stroke reviewed 6 months after leaving hospital 2.90 People with stroke supported by a stroke skilled early supported discharge (ESD) team

Indicator 2.85 measures a health outcome and is a proxy for the management of stroke.

Indicators 2.87 to 2.90 relate to the NHS Stroke Improvement Programme (SIP), set up to support the development of stroke care networks and the implementation of the National Stroke Strategy. More information on SIP is available [here](#).

Domain 3: Helping people to recover from episodes of ill health or following injury

Domain 3: Indicators derived from NHS Outcomes Framework

Indicator area	Indicator
Overarching	3a Emergency admissions for acute conditions that should not usually require hospital admission 3b Emergency readmissions within 30 days of discharge from hospital

These indicators are included in the 2012/13 NHS Outcomes Framework. Full details on these indicators can be found in the NHS Outcomes Framework 2012/13 Technical Appendix document, available [here](#).

Indicator area	Indicator
Improvement	3.1 Patient Reported Outcomes Measures (PROMs) for elective procedures: i Hip replacement ii Knee replacement iii Groin hernia iv Varicose veins 3.2 Emergency admissions for children with lower respiratory tract infection (LRTI)

These indicators are included in the 2012/13 NHS Outcomes Framework and are pure outcome indicators. Full details on these indicators can be found in the NHS Outcomes Framework 2012/13 Technical Appendix document, available [here](#).

Domain 3: Indicators derived from quality standards and existing collections

Topic area	Indicator
COPD	<p>3.7 People admitted to hospital with an exacerbation of COPD who are under the care of a respiratory consultant within 48hrs of admission until discharge</p> <p>3.8 Emergency readmissions: people who have been admitted following an exacerbation of COPD</p> <p>3.10 Emergency readmissions: COPD</p> <p>3.11 Emergency readmissions: oxygen toxicity</p>

Indicator 3.7 has been identified as being a key component of high quality care as defined in the NICE quality standard for COPD, statement 10: People admitted to hospital with an exacerbation of COPD are cared for by a respiratory team, and have access to a specialist early supported-discharge scheme with appropriate community support.

Indicators 3.8, 3.10 and 3.11 measure emergency readmissions for people with COPD, and may be regarded as a proxy measures for overall COPD management.

Topic area	Indicator
Coronary Heart Disease	<p>3.14 Hospital procedures: repeat percutaneous transluminal coronary angioplasty (PTCA)</p> <p>3.15 Hospital procedures: repeat coronary artery bypass graft (CABG)</p>

Coronary artery bypass graft (CABG) and percutaneous transluminal coronary angioplasty (PTCA) are common procedures recommended by NICE for a number of indications. Indicators 3.14 and 3.15 measure repeat procedures as it is thought that a proportion of these could be avoided.

Topic area	Indicator
Depression	3.18 People with new presentation of depression who receive appropriate treatment

Indicator 3.18 is based on the principles outlined in the NICE quality standard on depression. For this indicator, the intention is to measure that the appropriate level (intensity and duration) of treatment is received for the level of severity of depression.

Topic area	Indicator
Diabetes	3.22 People with diabetes with a new diagnosis of foot ulceration requiring urgent medical attention who are seen by the MDT foot care team within 24 hours of referral

This has been identified as being a key component of high quality care as defined in the NICE quality standard for diabetes in statement 10: People with diabetes with or at risk of foot ulceration receive regular review by a foot protection team in accordance with NICE guidance, and those with a foot problem requiring urgent medical attention are referred to and treated by a multidisciplinary foot care team within 24 hours.

Topic area	Indicator
Liver Disease	3.23 Emergency readmissions: liver disease

Indicator 3.23 measures emergency readmissions for people with liver disease, and is intended to act as a proxy measure for overall liver disease management.

Topic area	Indicator
Mental Health	3.24 Movement towards recovery following treatment for depression by secondary mental health services 3.25 The proportion of those receiving talking therapies aged >65 3.26 Recovery following talking therapies all ages and aged > 65 3.27 Length of stay: Severe Mental Illness 3.28 Delayed discharge from psychiatric inpatient ward

NICE clinical guideline CG90 on depression, NICE clinical guideline CG91 on depression with a chronic physical health problem and NICE clinical guideline CG123 on common mental health disorders contain specific

recommendations on types of psychological interventions for subgroups of people with depression.

The NICE depression quality standard includes a statement on the monitoring of health outcomes for those people who are receiving treatment:

Statement 3: Practitioners delivering pharmacological, psychological or psychosocial interventions for people with depression record health outcomes at each appointment and use the findings to adjust delivery of interventions.

Indicator 3.26 relates to the [mental health outcomes strategy](#) which states that the nationwide roll-out of psychological therapy services for adults who have depression or anxiety disorders, will pay particular attention to ensuring appropriate access for people over 65 years of age. The strategy also states that people who remain healthy into older age are more likely to continue in employment if they wish, and to participate actively in their communities.

Indicators 3.27 and 3.28 are indicators of length of stay and delayed transfers of care included in the NHS Operating Framework 2012/13.

Topic area	Indicator
Out of Hours Care	3.29 Total time: time from the start of the original call or arrival at the urgent care or out-of-hours base (where the patient does not phone beforehand) until discharge, admission or transfer to another service 3.30 Unplanned re-contact rate: a) Re-contact following discharge of care by clinical telephone advice within 7 days of a previous call b) Unplanned re-contact within 7 days of attendance at an urgent care or out-of-hours base

Indicator 3.29 is a measure of the timeliness of out of hours services.

Indicator 3.30 is an ambulance clinical quality indicator included in the NHS Operating Framework 2011/12.

Topic area	Indicator
Stroke	<p>3.31 For those people assessed as having a stroke and seen by ambulance services, the proportion who are taken to a hospital with a acute stroke unit within 1 hour of arrival at the emergency</p> <p>3.32 People who have had an acute stroke who have brain imaging within one hour of arrival at the hospital</p> <p>3.33 People who have had an acute stroke who receive thrombolysis</p> <p>3.34 Patients with stroke admitted to an acute stroke unit within 4 hours of arrival to hospital</p> <p>3.35 People who have had an acute stroke whose swallowing is screened by a specially trained healthcare professional within 4 hours of admission to hospital</p>

These indicators have been identified as being a key component of high quality care as defined in the NICE quality standard for stroke.

- Statement 1 (for 3.31 and 3.34): People seen by ambulance staff outside hospital, who have sudden onset of neurological symptoms, are screened using a validated tool to diagnose stroke or transient ischaemic attack (TIA). Those people with persisting neurological symptoms who screen positive using a validated tool, in whom hypoglycaemia has been excluded, and who have a possible diagnosis of stroke, are transferred to a specialist acute stroke unit within 1 hour.
- Statement 2 (for 3.32): Patients with acute stroke receive brain imaging within 1 hour of arrival at the hospital if they meet any of the indications for immediate imaging.
- Statement 3 (for 3.33): Patients with suspected stroke are admitted directly to a specialist acute stroke unit and assessed for thrombolysis, receiving it if clinically indicated.
- Statement 4 (for 3.35): Patients with acute stroke have their swallowing screened by a specially trained healthcare professional within 4 hours of admission to hospital, before being given any oral food, fluid or medication, and they have an ongoing management plan for the provision of adequate nutrition.

Topic area	Indicator
Urgent and Unplanned Care	3.41 Unplanned re-attendance at A&E within 7 days of original attendance

Indicator 3.41 is an accident and emergency (A&E) clinical quality indicator included in the NHS Operating Framework 2011/12.

Domain 4: Ensuring that people have a positive experience of care

Domain 4: Indicators derived from NHS Outcomes Framework

Indicator area	Indicator
Overarching	4a Patient experience of GP Out of Hours services 4b Patient experience of hospital care

These indicators are included in the 2012/13 NHS Outcomes Framework. Full details on these indicators can be found in the NHS Outcomes Framework 2012/13 Technical Appendix document, available [here](#).

Indicator area	Indicator
Improvement	4.1 Patient experience of outpatient services 4.2 Responsiveness to in-patients' personal needs 4.3 Patient experience of A&E services 4.5 Women's experience of maternity services 4.7 Patient experience of community mental health services

These indicators are included in the 2012/13 NHS Outcomes Framework. Full details on these indicators can be found in the NHS Outcomes Framework 2012/13 Technical Appendix document, available [here](#).

Domain 4: Indicators derived from quality standards and existing collections

Topic area	Indicator
Cancers	4.10 Deaths at home: all cancers

Indicator 4.10 may be regarded as a subset of a 'deaths at home' indicator (to be assessed against plan) in the NHS Operating Framework 2012/13.

Topic area	Indicator
Diabetes	4.18 Patient experience of diabetes services

Good quality patient experience of diabetes services is highlighted in the National Diabetes Audit, which will report on experience of care.

Topic area	Indicator
Mental Health	4.19 Patient experience of IAPT (improved access to psychological therapies) services
	4.20 Access to community mental health services by BME (black and minority ethnic) groups
	4.21 Access to IAPT services by BME groups

Indicator 4.23 is an experience indicator, and attempts to measure the experience of people attending IAPT (improved access to psychological therapies) services.

Indicators 4.24 and 4.25 reflect policy initiatives on access to mental health and IAPT services among black and minority ethnic groups (BME). NICE clinical guideline CG136 on service user experience in adult mental health, recommendation 1.2.5, states: Local mental health services should work with primary care and local third sector, including voluntary, organisations to ensure that:

- all people with mental health problems have equal access to services based on clinical need and irrespective of gender, sexual orientation, socioeconomic status, age, background (including cultural, ethnic and religious background) and any disability
- services are culturally appropriate.

Topic area	Indicator
Urgent and Emergency Care	4.22 Attenders leaving without being seen
	4.23 High risk re-attenders reviewed by consultant before being discharged

Indicators 4.27 is an accident and emergency (A&E) clinical quality indicator included in the NHS Operating Framework 2012/13.

Indicator 4.28 is an accident and emergency (A&E) clinical quality indicator included in the NHS Operating Framework 2011/12.

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Domain 5: Indicators derived from NHS Outcomes Framework

Indicator area	Indicator
Overarching	5a Patient safety incidents reported 5b Safety incidents involving severe harm or death

These indicators are included in the 2012/13 NHS Outcomes Framework. Full details on these indicators can be found in the NHS Outcomes Framework 2012/13 Technical Appendix document, available [here](#).

Indicator area	Indicator
Improvement	5.2 Incidence of healthcare associated infection (HCAI): i MRSA ii C. difficile 5.4 Incidence of medication errors causing serious harm 5.5 Admission of full-term babies to neonatal care 5.6 Incidence of harm to children due to 'failure to monitor'

These indicators are included in the 2012/13 NHS Outcomes Framework. Full details on these indicators can be found in the NHS Outcomes Framework 2012/13 Technical Appendix document, available [here](#).

Domain 5: Indicators derived from quality standards and existing collections

Topic area	Indicator
Mental Health	5.7 Hospital admissions: self-harm 5.8 Absence without leave for patients detained under the Mental Health Act

Indicator 5.7 also relates to the [mental health outcomes strategy](#) which states that, for those people admitted for a mental health problem, seven day follow from inpatient care is critical in helping to prevent suicide and self harm.

Indicator 5.7 may therefore be regarded as a proxy outcome indicator.

Response to self-harm has been identified as a key component of high quality care as defined in the NICE clinical guideline CG16 on self-harm, recommendation 1.1.1.9, which states: People who have self-harmed should be offered treatment for the physical consequences of self-harm, regardless of their willingness to accept psychosocial assessment or psychiatric treatment.

For indicator 5.8, information on absence without leave is included in the Mental Health Minimum Dataset. This indicator provides a measure of people who are detained who are at risk of harm as a result of being absent without leave.

Topic area	Indicator
Venous Thromboembolism (VTE)	5.9 Adult patients who have had a VTE risk assessment on admission to hospital, using the clinical criteria of the national tool 5.10 Emergency readmissions: VTE

Indicator 5.9 has been identified as being a key component of high quality care as defined in the NICE quality standard for venous thromboembolism (VTE) prevention in statement 1: All patients, on admission, receive an assessment of VTE and bleeding risk using the clinical risk assessment criteria described in the national tool.

Indicator 5.9 is also an indicator included in the NHS Operating Framework 2012/13.

Indicator 5.10 measures emergency readmissions for people venous thromboembolism (VTE) and is intended to act as a proxy measure for the management of VTE risk.

Appendix 2: Consultation proforma

National Institute for Health and Clinical Excellence

Potential indicators for COF

Consultation dates: 1 February to 29 February 2012

Stakeholders are asked to submit comments for any indicators of interest or relevance based on the following set of questions.

In relation to the COF indicator set as a whole, stakeholders are asked to consider the questions below. Appendix 3 in the main consultation document highlights a number of further indicators that have been identified for potential inclusion in the COF but require further development and will not be ready for April 2013. Stakeholders may wish to consider these additional indicators in response to these questions:

- What are your views on the scope of the COF? Do you think that there is sufficient breadth of topics covered in this consultation, if not, can you suggest other topics that may be appropriate for COF indicator development?

For indicators that have *not* been derived from the NHS Outcomes Framework, stakeholders are asked to consider the following questions:

- Which of the care processes or health outcomes measured by the indicators do you consider have the greatest potential to improve the quality of care in the five domains described in the [NHS Outcomes Framework](#)?

- To what extent do you think the care processes or health outcomes measured by the indicators may be influenced by the actions of clinical commissioning groups (CCGs)²?
- To what extent do you think the care processes or health outcomes measured by the indicators reflect areas where there are unacceptable variations?
- What, if any, are the barriers to implementing the care processes measured by any of these indicators?
- What, if any, are the potential unintended consequences resulting from the implementation of these indicators?
- Do you think there is potential for any of care processes measured by the indicators to impact differently on any particular groups in respect of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation? If so, please state whether this difference is adverse or positive and for which group.
- If you think any of the care processes measured by the indicators may have an adverse impact on any particular groups in the community, can you suggest how delivery of the indicators could be changed in order to reduce health inequalities?

Indicators derived from the NHS Outcomes Framework have already been through a consultation process. Therefore, stakeholders are asked to consider the following two questions which relate to the appropriateness of their inclusion in the COF:

- To what extent do you think the indicators may be influenced by the commissioning activities of clinical commissioning groups?

² For example through decisions on which services to commission, the setting of contracts and the monitoring of the quality of services commissioned from providers

- What, if any, are the potential unintended consequences resulting from these indicators applied at clinical commissioning group population level?

How to submit your comments

If you would like to comment on any of the indicators out for consultation please use the comments proforma and forward to Liane Marsh at cof@nice.org.uk by 29 February 2012.

COMMENTS PROFORMA	
Consultee name:	
Indicator	Consultee Comment
<p>Scope of the COF</p> <p>NB stakeholders should also see appendix 3 in the main consultation document for further indicators identified for potential inclusion in the COF but require further development and will not be ready for April 2013.</p>	
Domain 1: Preventing people from dying prematurely	
Domain 1: Indicators derived from NHS Outcomes Framework	
<p>1b Life expectancy at 75:</p> <p>i Males</p> <p>ii Females</p> <p>1.1 Under 75 mortality rate from cardiovascular disease</p> <p>1.2 Under 75 mortality rate from respiratory disease</p> <p>1.3 Under 75 mortality rate from liver disease</p> <p>1.4 Cancer:</p> <p>ii Five-year survival from colorectal cancer</p> <p>iv Five-year survival from breast cancer</p> <p>vi Five-year survival from lung cancer</p> <p>vii Under 75 mortality rate from cancer</p>	

1.6 Reducing deaths in babies and young children: i Infant mortality ii Neonatal mortality and stillbirths	
Domain 1: Indicators derived from quality standards and existing collections	
Coronary Heart Disease	
1.16 Timely intervention: ambulance response times following suspected myocardial infarction 1.17 Timely intervention: thrombolysis following suspected myocardial infarction	
Dementia	
1.23 People with dementia prescribed anti-psychotic medication	
Diabetes	
1.24 Myocardial infarction, stroke and end stage kidney disease in people with diabetes	
Maternity	
1.25 Antenatal assessments <13 weeks 1.26 Maternal smoking in pregnancy 1.27 Maternal smoking at delivery 1.28 Breast feeding initiation 1.29 Breast feeding prevalence at 6-8 weeks	
Mental Health	
1.30 People with severe mental illness who have received complete list of physical checks 1.31 Duration of untreated psychosis 1.32 The number of those with first onset psychosis taken on by early intervention (EI) services as a proportion of local incidence	
Stroke	
1.34 Mortality within 30 days of hospital admission for stroke	
Domain 2: Enhancing quality of life for people with long term conditions	
Domain 2: Indicators derived from NHS Outcomes Framework	
2 Health-related quality of life for people with long-term conditions	

2.1 Proportion of people feeling supported to manage their condition 2.2 Employment of people with long-term conditions 2.3. i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s 2.5 Employment of people with mental illness	
Domain 2: Indicators derived from quality standards and existing collections	
Generic	
2.7 Unplanned hospitalisation for chronic ambulatory care sensitive conditions 2.8 Patterns of care (person-based hospitalisation over 12 months: generic or composite covering asthma, COPD, diabetes, heart failure, mental health)	
Asthma	
2.10 Emergency attendance at A&E: asthma	
Chronic Obstructive Pulmonary Disease	
2.23 People with COPD who are functionally disabled, usually MRC grade 3 and above referred to a pulmonary rehabilitation programme	
2.28 Emergency attendance at A&E: COPD	
Chronic Kidney Disease	
2.32 People with CKD on long term dialysis who start on home dialysis [peritoneal dialysis (PD) or home haemodialysis (HD)] or self-care 2.33 People with stage 5 CKD who receive a pre-emptive kidney transplant before they receive dialysis in the last 12 months 2.34 People starting haemodialysis (HD) treatment who start dialysis with a functioning arteriovenous fistula 2.35 People on peritoneal dialysis (PD) who are on automated peritoneal dialysis 2.36 Transplantation within last 12 months (living / cadaveric) in people with CKD 5	

Coronary Heart Disease	
2.42 Cardiac rehabilitation	
Depression	
2.51 People with depression referred for psychological therapy receiving it	
Diabetes	
2.52 Single marker of all nine basic care processes performed	
2.53 People with newly diagnosed diabetes who are offered structured education within 3 months of diagnosis	
2.54 People with established diabetes who are offered structured education	
2.55 People with newly diagnosed diabetes who start structured education	
2.56 People with established diabetes who start structured education	
2.57 People with newly diagnosed diabetes who complete structured education	
2.58 People with established diabetes who complete structured education	
2.59 People with established diabetes whose structured education has been reviewed and reinforced within the last 15 months	
2.60 Readmission rates of people admitted with diabetic ketoacidosis within 12 months following discharge	
2.61 Rates of complications associated with diabetes	
2.62 Rates of lower limb amputation	
2.63 Emergency admissions: diabetic ketoacidosis in people with diabetes	
2.64 Emergency admissions: hypoglycaemia in people with diabetes	
Glaucoma	
2.71 Age-stratified incidence of certification of visual impairment (at each level of registration) with chronic open angle glaucoma (COAG) as the primary cause	
Liver Disease	
2.77 Emergency admissions: Liver disease	
Mental Health	
2.79 People on CPA followed-up within 7 days of discharge from psychiatric inpatient stay	
2.80 Number of Home Treatment episodes carried by Crisis Resolution / Home	

Treatment Teams 2.81 Percentage of inpatient admissions that were gatekept by Crisis Resolution / Home Treatment Teams	
Stroke	
2.85 People who have had a stroke who have been free from vascular events for 6 months following initial (index) admission for stroke (case-mix adjusted) 2.87 Joint health and social care plans on discharge of patients with stroke from hospital 2.88 Psychological support for mood, behaviour and cognitive disturbance by 6 months after stroke 2.89 People with stroke reviewed 6 months after leaving hospital 2.90 People with stroke supported by a stroke skilled early supported discharge (ESD) team	
Domain 3: Helping people to recover from episodes of ill health or following injury	
Domain 3: Indicators derived from NHS Outcomes Framework	
3a Emergency admissions for acute conditions that should not usually require hospital admission 3b Emergency readmissions within 30 days of discharge from hospital 3.1 Patient Reported Outcomes Measures (PROMs) for elective procedures i Hip replacement ii Knee replacement iii Groin hernia iv Varicose veins 3.2 Emergency admissions for children with lower respiratory tract infections (LRTI)	
Domain 3: Indicators derived from quality standards and existing collections	
Chronic Obstructive Pulmonary Disease	
3.7 People admitted to hospital with an exacerbation of COPD who are under the	

care of a respiratory consultant within 48hrs of admission until discharge 3.8 Emergency readmissions: people who have been admitted following an exacerbation of COPD 3.10 Emergency readmissions: COPD 3.11 Emergency readmissions: oxygen toxicity	
Coronary Heart Disease	
3.14 Hospital procedures: repeat percutaneous transluminal coronary angioplasty (PTCA) 3.15 Hospital procedures: repeat coronary artery bypass graft (CABG)	
Depression	
3.18 People with new presentation of severity depression who receive appropriate treatment	
Diabetes	
3.22 People with diabetes with a new diagnosis of foot ulceration requiring urgent medical attention who are seen by the MDT foot care team within 24 hours of referral	
Liver disease	
3.23 Emergency readmissions: liver disease	
Mental Health	
3.24 Movement towards recovery following treatment for depression by secondary mental health services 3.25 The proportion of those receiving talking therapies aged >65 3.26 Recovery following talking therapies all ages and aged > 65 3.27 Length of stay: Severe Mental Illness 3.28 Delayed discharge from psychiatric inpatient ward	
Out of Hours Care	
3.29 Total time: time from the start of the original call or arrival at the urgent care or out-of-hours base (where the patient does not phone beforehand) until discharge, admission or transfer to another service 3.30 Unplanned re-contact rate: a) Re-contact following discharge of care by clinical telephone advice within 7	

days of a previous call b) Unplanned re-contact within 7 days of attendance at an urgent care or out-of-hours base	
Stroke	
3.31 For those people assessed as having a stroke and seen by ambulance services, the proportion who are taken to a hospital with a acute stroke unit within 1 hour of arrival at the emergency 3.32 People who have had an acute stroke who have brain imaging within one hour of arrival at the hospital 3.33 People who have had an acute stroke who receive thrombolysis 3.34 Patients with stroke admitted to an acute stroke unit within 4 hours of arrival to hospital 3.35 People who have had an acute stroke whose swallowing is screened by a specially trained healthcare professional within 4 hours of admission to hospital	
Urgent and Emergency Care	
3.41 Unplanned re-attendance at A&E within 7 days of original attendance	
Domain 4: Ensuring that people have a positive experience of care	
Domain 4: Indicators derived from NHS Outcomes Framework	
4a Patient experience of GP Out of Hours services 4b Patient experience of hospital care 4.1 Patient experience of outpatient services 4.2 Responsiveness to in-patients' personal needs 4.3 Patient experience of A&E services 4.5 Women's experience of maternity services 4.7 Patient experience of community mental health services	
Domain 4: Indicators derived from quality standards and existing collections	
Cancers	
4.10 Deaths at home: all cancers	
Diabetes	
4.18 Patient experience of diabetes services	

Mental Health	
4.19 Patient experience of IAPT (improved access to psychological therapies) services 4.20 Access to community mental health services by BME (black and minority ethnic) groups 4.21 Access to IAPT services by BME groups	
Urgent and Emergency Care	
4.27 Attenders leaving without being seen 4.28 High risk re-attenders reviewed by consultant before being discharged	
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	
Domain 5: Indicators derived from NHS Outcomes Framework	
5a Patient safety incidents reported 5b Safety incidents involving severe harm or death 5.2 Incidence of healthcare associated infection (HCAI) i MRSA ii C. difficile 5.4 Incidence of medication errors causing serious harm 5.5 Admission of full-term babies to neonatal care 5.6 Incidence of harm to children due to 'failure to monitor'	
Domain 5: Indicators derived from quality standards and existing collections	
Mental Health	
5.7 Hospital admissions: self-harm 5.8 Absence without leave for patients detained under the Mental Health Act	
Venous Thromboembolism (VTE)	
5.9 Adult patients who have had a VTE risk assessment on admission to hospital, using the clinical criteria of the national tool 5.10 Emergency readmissions: VTE	

Appendix 3: Potential indicators for future development

In addition to the indicators that are out for consultation, further indicators have been outlined for potential inclusion in the COF, pending development or identification of suitable indicators. A list of these indicators is presented here:

Domain 1: Preventing people from dying prematurely
Domain 1: Indicators derived from NHS Outcomes Framework
1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
1.4 Cancer:
i One-year survival from colorectal cancer
iii One-year survival from breast cancer
v One-year survival from lung cancer
1.5 Excess under 75 mortality rate in adults with serious mental illness
1.7 Reducing premature death in people with learning disabilities: an indicator needs to be developed
Domain 1: Further indicators by topic
Asthma
1.8 Asthma deaths systematically investigated
Cancer
1.9 Cancers diagnosed via emergency routes
1.10 Cancers stage at diagnosis
1.11 Cancers detected at stage 1 or 2
COPD
1.12 People with COPD who smoke and who are not smoking in a sustained way at 12 months from the agreed quit date
1.13 Stage at diagnosis of COPD
1.14 Referral, timely assessment and treatment of patients with COPD
1.15 Progression (stage) of COPD
Coronary Heart Disease
1.18 Outcome of cardiac arrest – ambulance journey
1.19 Outcome of cardiac arrest – survival to discharge
1.20 Outcome from acute ST elevation MI – timely thrombolysis
1.21 Outcome from acute ST elevation MI – timely angioplasty
1.22 Outcome from acute ST elevation MI – timely appropriate care bundle
Mental Health
1.33 Smoking rates in people with SMI
Stroke
1.35 Stroke patients eligible for thrombolysis – timely transfer to stroke centre
1.36 Stroke patients who receive a timely appropriate care bundle
1.37 Early detection and treatment of atrial fibrillation
Urgent and Emergency Care

1.38 Time to answer call
1.39 Time to treatment – life threatening
Venous Thromboembolism Prevention
1.40 VTE mortality

Domain 2: Enhancing quality of life for people with long term conditions
Domain 2: Indicators derived from NHS Outcomes Framework
2.4 Health-related quality of life for carers
2.6 Enhancing quality of life for people with dementia: an indicator needs to be developed
Domain 2 – further indicators by topic
Generic
2.9 People with LTCs who develop a further preventable LTC
Asthma
2.11 Patient Reported Outcomes Measures (PROMs): asthma
2.12 Risk categorisation of asthma
2.13 Assessments based on RCP scores of patients with asthma
2.14 Self-management plans for patients with asthma
2.15 Reviews of patients with asthma
2.16 Use of medicines by patients with asthma
2.17 Days lost from work by patients with asthma
Cancer
2.18 Patient Reported Outcomes Measures (PROMs): cancer
Carers
2.19 Carers identified on practice registers
2.20 Delayed discharge from hospital
2.21 Number of information prescriptions for carers
2.22 Referrals to LAs and the voluntary sector for advice and support
COPD
2.24 People with COPD with oxygen saturation less than or equal to 92% when clinically stable, who are referred to a specialist oxygen service for long term oxygen therapy assessment
2.25 People with COPD with oxygen saturation less than or equal to 92% when clinically stable, who are assessed for LTOT by a specialist oxygen service
2.26 People with COPD referred to a pulmonary rehabilitation programme who complete the programme
2.27 People with COPD who have completed a pulmonary rehabilitation programme who have a clinically significant improvement in health related quality of life from baseline
2.29 Return to normal social function: COPD
2.30 CAT (disability) score: COPD
2.31 Employment rates ages <65: COPD
Chronic Kidney Disease
2.37 People known for >90 days to the renal unit who started chronic dialysis without requiring hospital admission
2.38 People on long-term HD who receive a minimum of three sessions of HD per week of at least 4 hours duration
2.39 People with known CKD stages 4 and 5 CKD (with or without diabetes) who have been referred for specialist assessment
2.40 People with newly diagnosed CKD who are assessed for cardiovascular risk at the time of diagnosis

2.41 People with stages 3b, 4 and 5 CKD with latest recorded haemoglobin less than 10 g/dl
Dementia
2.43 People presenting with suspected dementia who are referred to a memory assessment service
2.44 People presenting with suspected dementia who are referred and seen by memory assessment services within 3 months
2.45 People newly diagnosed with dementia with early stage of dementia (as a proportion of all people newly diagnosed)
2.46 Staff who work with people with dementia who have had dementia care training
2.47 Staff who have a record of appropriate dementia care training within the last 3 years
2.48 Health related quality of life for people with dementia (assessed using DEMQol)
2.49 Carers of people with dementia referred for an assessment of their social needs
2.50 People with suspected dementia or a diagnosis of dementia admitted to hospital, or attending the emergency department, who are referred to a liaison service
Diabetes
2.65 People with diabetes starting insulin therapy that is initiated by an appropriately trained healthcare professional
2.66 In-patients with diabetes who are reviewed by an appropriately trained healthcare professional with access to the specialist diabetes team
2.67 Women with diabetes documented as being of child-bearing potential who have had a documented discussion about contraception, pre-conception care and pregnancy risks in the previous 15 months
2.68 People with diabetes who have a patient-held documented care plan which includes agreed goals and an action plan which has been updated in the previous 15 months
2.69 People with diabetes who have an agreed target for HbA1c
2.70 People with diabetes achieving their HbA1c target
Glaucoma
2.72 People with a new diagnosis of COAG who have a definitive diagnosis made by a consultant ophthalmologist
2.73 People with newly diagnosed COAG who first present at defined stage of COAG (see guideline 3 categories)
2.74 People with suspected COAG or with OHT who are recommended to receive medication whose most recent review was within the specified risk-based monitoring interval (+/-15%) following the last previous review
2.75 People with COAG whose most recent review was within the specified risk-based monitoring interval (+/-15%) following the last previous review
2.76 Patient Reported Outcomes Measures (PROMs): cataract extraction
Liver Disease
2.78 Variation in liver disease admissions/attendances between practices in a CCG
Mental Health
2.82 Improvement after 6 months based on HoNOS for patients with SMI starting a new spell of care
2.83 People with SMI in settled accommodation
2.84 Reported incidents of physical assaults on users of specialised mental health services
Stroke
2.86 Evidence that services provide information and support to carers, commissioned to include a named contact for stroke information and written information about the patient's diagnosis and management plan

Domain 3: Helping people to recover from episodes of ill health or following injury
Domain 3: Indicators derived from NHS Outcomes Framework
3.3 Improving recovery from injuries and trauma: an indicator needs to be developed.
3.4 Improving recovery from stroke: an indicator to be derived based on the proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months
3.5 The proportion of patients recovering to their previous levels of mobility / walking ability at: i 30 days ii 120 days
3.6 Proportion of older people (65 and over) who were: i still at home 91 days after discharge into rehabilitation ii offered rehabilitation following discharge from acute or community hospital
Domain 3: Further indicators by topic
COPD
3.9 People with COPD who have had an exacerbation of COPD who have a written management plan with advice on the management of future exacerbations
3.12 Patients in acidotic respiratory failure who receive NI ventilation (within 1 hour)
3.13 Standby treatment packs with instructions available to patients with COPD
Coronary Heart Disease
3.16 Patient Reported Outcomes Measures (PROMs): PTCA
3.17 Patient Reported Outcomes Measures (PROMs): CABG
Depression
3.19 People who receive treatment from supervised practitioners as defined - at least 1 hour per fortnight
3.20 People with chronic physical ill health and new presentation of severity depression who receive appropriate treatment
3.21 People with new presentation of depression who are assessed as non-case 6 months after the initiation of treatment
Stroke
3.36 Patients who have acute stroke who spend 90% or more of their stay on a stroke unit
3.37 People who have had a stroke who receive a minimum of 45 minutes physiotherapy a day for 70% of their hospital stay
3.38 People who have had a stroke who receive a minimum of 45 minutes occupational therapy a day for 70% of their hospital stay
3.39 People who have had a stroke who receive a minimum of 45 minutes speech and language therapy a day for 70% of their hospital stay
3.40 People who have had a stroke with identified ongoing rehabilitation needs who are seen by the relevant members of the specialist stroke/skills rehabilitation team within 72 hours of discharge from hospital

Domain 4: Ensuring that people have a positive experience of care
Domain 4: Indicators derived from NHS Outcomes Framework
4.6 An indicator to be derived from the survey of bereaved carers
4.8 An indicator to be derived from a Children's Patient Experience Questionnaire
Domain 4: Further indicators by topic
Cancers
4.11 Patient experience of cancer services
Carers
4.12 Involvement of carers: unplanned readmissions with or without care plan
4.13 Involvement of carers: delayed discharge from hospital
Chronic Kidney Disease
4.14 People receiving HD in a renal unit or hospital and who are collected from home within 30 minutes of their pick up time
4.15 People receiving HD in a renal unit or hospital and who are collected within 30 minutes of finishing dialysis
Dementia
4.16 Carers of people with dementia receiving an assessment of their needs for psychological interventions
4.17 Carers of people with dementia assessed as needing psychological interventions who receive psychological interventions
Urgent and Emergency Care
4.24 Patient experience of ambulance services

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm
Domain 5: Indicators derived from NHS Outcomes Framework
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers