**NHS Digital**

**Indicator Supporting Documentation**

**IAP00028 Employment of people with long term conditions**

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| **Indicator Title** |
| Employment of people with a long-term condition |
| **IAP Code (IAP00028)** |
| Indicator Definition, including calculation, measurement units, geographical range, age and gender |
| Include any relevant detail of the statistic, such as calculation type (eg rate per 100,000 population), gender, age or geography  Proportion of people with a long-term condition who are in employment.  This indicator will be compared with the proportion of the population who are in employment in order to take into account any wider economic factors that may be affecting the employment rate. The two figures will be reported together, and the difference between them will be calculated. For example: “The gap in employment rates between those with an LTC and the total population was 21%. The employment rate for all people in England in the same quarter was 70% and the employment rate for people with an LTC was 49%”  In terms of disaggregation, we require indicators to be disaggregated by the equality and inequality strands set out in the outcome framework for national level data where this is feasible. Sub-national breakdowns may be required if feasible, for use in setting levels of ambition. |
| Indicator Data Source(s) |
| Details of data sources, if known. Please note if this data is collected currently, or if it will require some sort of development  Labour Force Survey  The Labour Force Survey (LFS) is a quarterly sample survey of households living at private addresses in Great Britain. Its purpose is to provide information on the UK labour market that can then be used to develop, manage, evaluate and report on labour market policies. The questionnaire design, sample selection, and interviewing are carried out by the Social and Vital Statistics Division of the Office for National Statistics (ONS) on behalf of the Statistical Outputs Group of the ONS.  In the October-December 2010 data, the achieved sample size was 102,842 individuals. |
| Indicator Data Source Availability |
| Is data publicly available (eg National Statistic), or is it only available as a bespoke dataset upon request. Comment on availability of raw data to customers outside the NHS/Public Sector  Quarterly Labour Force Survey Eurostat datasets are now available from ESDS. Data for October to December was published on 22 February 2011.  http://www.esds.ac.uk/findingData/snDescription.asp?sn=6715  Data is publicly available through ESDS |
| **Indicator Overlap** |
| List the indicator sets you have checked for overlap or if you have searched the IC Indicator library |
| For example, NHS Choices, IQI / MQI, Better Care, Better Value, NCHOD, NHS Comparators  During the consultation process for the NHS Outcomes Framework there was wide checking of other indicator sets for overlap. This indicator was selected as being fit for the purpose of the outcomes indicators. |
| List any indicators which overlap with the proposed indicator |
| Please include, where known, any indicator code or unique reference, as well as the title of the indicator  A similar indicator is being developed for people with mental illness.  The Department for Work and Pensions recently published an indicator for employment rate of those with a limiting long-term health condition for the “Health Work and Well-being: Baseline indicators report”. This considers those people who are both DDA disabled and work-limiting disabled, DDA disabled only, and work limiting disabled only. This will be published on an annual basis, and is compared to a figure for the employment rate for all people (aged 16-64). DDA disabled includes only those who have a long-term disability which substantially limits their day-to-day activities. Work-limiting disabled includes only those who have a long-term disability which affects the kind or amount of work they might do.  The Office for National Statistics publish a quarterly figure for employment rate for the general population (aged 16-64) based on the Labour Force Survey. |
| What value does the proposed indicator offers over existing indicators |
| Highlight any gaps left by any current indicators  This indicator aims to capture employment of all people with a long-term condition. The DWP indicator counts only those respondents who report that their condition limits their day-to-day activities, or the type and amount of work they do and is therefore considered too narrow. |

**Indicator Use**

Does this indicator measure a process or an outcome? **Outcome.**

**This measure is…**

…compared against national average

…comparison against self over time

Indicator Title/ Definition Review **(IC use only)**

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| *Indicator meets criteria for :*  Indicator definition self explanatory  Indicator definition in plain English, suitable for publishing to all audiences  Indicator definition with clear measurement units  Indicator definition with clear scope (geog, age, sex)  Data source available  Data source suitable  Indicator is unique  Face validity of concept and indicator use  **Information complete - proceed** |  | *Requires revision for following reasons:*  Title not confined to concept only  Use of acronyms  Definition needs more detail on:  - calculations  - data sources  - geographical coverage  - patient/population groups  Insufficient information about data source  Insufficient exploration of overlap  Insufficient information about indicator use |  |

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| Applicant Name | Alison Kirby |
| Applicant Role | Analyst for the NHS Outcomes Framework |
| Applicant Organisation | Department of Health |
| Applicant Telephone | 020 797 21160 |
| Applicant Email | [Alison.kirby@dh.gsi.gov.uk](mailto:Alison.kirby@dh.gsi.gov.uk) |
| Indicator Set Name | NHS Outcomes Framework |
| Sponsor Name | DH – Quality Framework and QIPP teams |
| Sponsor Role | Delivery of NHS Outcome Indicators for SofS to use to hold the NHS Commissioning Board to account |
| Sponsor Organisation | DH |
| Acknowledgements |  |
| Other Stakeholder Name | ONS |
| Other Stakeholder Role | Data owners for LFS and population data |
| Other Stakeholder Organisation |  |
| Please list any additional Stakeholder(s) | DWP |

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| **Users of the Proposed Indicator** | Primary User | Secondary User | Not intended for |
| Boards (national, local) |  |  |  |
| Provider Managers |  |  |  |
| Commissioning mangers |  |  |  |
| Regulators |  |  |  |
| Clinicians |  |  |  |
| Patients |  |  |  |
| Public |  |  |  |
| Other (please specify) DH |  |  |  |
| Other (please specify) |  |  |  |

**High level subject area: Enhancing quality of life for people with long term conditions**

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| Evidence base for the indicator  Provide a paragraph summarising the evidence, noting quality of evidence where appropriate. Do not list the relevant docs here, please extract saliant messages.  The recent review “Is work good for your health and well-being” concluded that work was generally good for both physical and mental health and well-being. The findings are summarised below:  There is a strong association between worklessness and poor health. This may be partly a health selection effect, but it is also to a large extent cause and effect. There is strong evidence that unemployment is generally harmful to health, including:   * higher mortality; * poorer general health, long-standing illness, limiting longstanding illness; * poorer mental health, psychological distress, minor psychological/psychiatric morbidity; * higher medical consultation, medication consumption and hospital admission rates   The same review finds that, overall:  1. Work is beneficial to health and well-being  2. Lack of work is detrimental to health and well-being.  3. For people without work, re-employment leads to improvement in health and well-being amd further unemployment leads to deterioration.  4. For people who are sick or disabled, placement in work improves health and psychosocial status.  5. The health status of people of all ages who move off welfare benefits improves.  6. These benefits apply equally to people who have mental health problems including those with severe mental health problems. There is no evidence that work is harmful to the mental health of people with severe mental illness.  There is strong evidence that re-employment leads to improved self-esteem, improved general and mental health, and reduced psychological distress and minor psychiatric morbidity. The magnitude of this improvement is more or less comparable to the adverse effects of job loss.  There is a broad consensus across multiple disciplines, disability groups, employers, unions, insurers and all political parties, based on extensive clinical experience and on principles of fairness and social justice. When their health condition permits, sick and disabled people (particularly those with “common health problems”) should be encouraged and supported to remain in or to (re)-enter work as soon as possible because it:   * Is therapeutic; * Helps to promote recovery and rehabilitation; * Leads to better health outcomes; * Minimises the harmful physical, mental and social effects of long-term sickness absence; * Reduces the risk of long-term incapacity; * Promotes full participation in society, independence and human rights; * Reduces poverty;   Improves quality of life and well-being. |
| References |
| List up to six key references or documents  Extensive consultation – see transparency in outcomes – a framework for the NHS, The NHS Outcomes Framework 2011-12 Employment status, employment conditions, and limiting illness: prospective evidence from the British household panel survey 1991–2001 [*http://jech.bmj.com/content/58/6/501.full*](http://jech.bmj.com/content/58/6/501.full)  Is work good for your health and well-being? – Gordon Waddell, A Kim Burton  [*http://www.dwp.gov.uk/docs/hwwb-is-work-good-for-you.pdf*](http://www.dwp.gov.uk/docs/hwwb-is-work-good-for-you.pdf)  Mental Health and work – Royal College of Psychiatrists |
| Clinical advice |
| Provide details of any clinical advice or support already given in development or preparation of indicator. |

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| Priority level linked to policy, strategy or programme  Quality of evidence  - clinical trial / cohort studies/ meta-analysis  - non-analytical studies  - best practice (clinical)  - good practice for patient experience  **Information complete - proceed** |  | *Requires revision for following reasons:*  Policy, strategy, programme information not complete  Evidence information not complete |  |

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| **Indicator Methodology – information sources** |
| Numerator definition Word description of the data source |
| **1. Employment rate of people with a long-term condition**  Number of people with a long-term condition who are in employment (i.e. classed as 1,2,3,4 in INECAC05 field in LFS)  **2. Employment rate of population**  Number of people who are in employment (i.e. classed as 1,2,3,4 in INECAC05 field in LFS) |
| Numerator source Organisation and data collection |
| Labour Force Survey, Office for National Statistics |
| Numerator construction Which data fields (specify) and values (specify codes) are combined to arrive at the count. Include any special rules. |
| For respondents where COUNTRY = 1 (England)  Cases should be weighted by variable *pwt09*  **1. Employment rate of people with a LTC**  Number of people with LTCs in employment –  Those where:  LNGLIM = 1 *(the respondent has a health problem or disabilities that they expect will last for more than a year)*  AND  INECAC05=1,2,3, or 4 *(Respondent is either Employee (1), Self-employed (2), Government employment & training programmes (3), or Unpaid family worker (4) – This is the ILO definition of Basic economic activity)*  AND  MF1664 = 1 (respondent is of working age)  **2. Employment rate of population**  Number of people who are in employment  Those where:  INECAC05 = 1,2,3 or 4 *(Respondent is either Employee (1), Self-employed (2), Government employment & training programmes (3), or Unpaid family worker (4) – This is the ILO definition of Basic economic activity)*  AND  MF1664 = 1 (respondent is of working age) |
| Numerator ascertainment Any known exclusions, shortfalls or collection issues which will affect the total amount of data collected. |
| None. |
| Numerator quality of data Issues with accuracy or known variability of recording. For example coding by untrained staff. |
| No information available |
| Numerator access to data Is data publicly available / published. Is it available only upon request, or even only to 'trusted' groups of people? |
| Data available through ESDS for all those who have athens institution log-in |
| Numerator timeliness Frequency and timeliness of data. State how the publication/release of data relates to indicator production timescales. |
| Quarterly, around 3 months after the end of the quarter. |
| Denominator definition Word description of the data source |
| **1. Employment rate of people with a long-term condition**  Number of people with a long-term condition of working age  **2. Employment rate of population**  Population of people of working age |
| Denominator source Organisation and data collection |
| LFS  ONS Mid-year population estimates |
| Denominator construction Which data fields (specify) and values (specify codes) are combined to arrive at the count. Include any special rules. |
| For respondents where COUNTRY = 1 (England)  Cases should be weighted by variable *pwt09*  **1. Number of people with an LTC of working age**  Those where:  LNGLIM = 1 *(the respondent has a health problem or disabilities that they expect will last for more than a year)*  AND  MF1664 = 1 (respondent is of working age)  **2. Working age population**  MF1664 = 1 (respondent is of working age) |
| Denominator ascertainment Any known exclusions, shortfalls or collection issues which will affect the total amount of data collected. |
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| Denominator quality of data Issues with accuracy or known variability of recording. For example coding by untrained staff. |
|  |
| Denominator access to data Is data publicly available / published. Is it available only upon request, or even only to 'trusted' groups of people? |
| Data available through ESDS for all those who have athens institution log-in |
| Denominator timeliness Frequency and timeliness of data. State how the publication/release of data relates to indicator production timescales. |
| LFS data is quarterly, available around 3 months after the end of the quarter. |

Indicator Applicant Review **(IC use only)**

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| Are raw data universally available for others to recreate indicator?  Are data available in a suitable timeframe and frequency?  Are data quality issues well documented and acknowledged?  Are data robust enough to support indicator and derivations?  Are data consistent over the required time?  Are construction of numerator and denominator robust and comparable with other sources  **Information complete - proceed** |  | *Requires revision for following reasons:*  Numerator info not complete  Denominator info not complete |  |

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| **Indicator methodology - statistical methods** |
| Statistical support |
| Summarise involvement of statistician involvement in developing indicator so far, and ongoing support for indicator when rolled out.  Statisticians have led the process for developing the indicators  Discussion with ONS and DWP to get advice about the methodology used to calculate the indicator. |
| Risk adjustment variables |
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| Statistical methods |
| Type of analysis (any methods used), risk adjustment (predictive power of model), special techniques (dealing with dispersion, constant risk), statistical process control  Survey weighting methods will be required – use variable *pwt09* to weight:  The LFS collects information on a sample of the population. To convert this information to give estimates for the population we must weight the data. Each case is given a weight which can be thought of as the number of people that case represents. This is done because of differential non-response – which means that some people are more likely to be in the sample than others. People with a lower probability of being in the sample should have a higher weight.  The population is split into sub-groups where the number of people in each sub-group is known (based on population estimates). The known population weights are calculated by assigning each case in the sub-group the weight calculated by dividing the population in that subgroup by the number of cases in the sample in the subgroup. This is done in three stages – where each stage corrects for a different cause of non-response. Stage 1 corrects for non-response at a local area level; stage 2 corrects for non-response amongst young people by age and sex; and stage 3 corrects for non-response by region, age and sex.  The weighting field used by ONS in calculating the estimates of employment is “*pwt09*”, which weights to 2009 population estimates. This weighting does not take into account any differences between the general population and the population with an LTC or mental illness. However, asthere are no appropriate estimates of the population size of people with LTCs that can be used for weighting, we should continue to use the *pwt09* weighting.  Some standardisation may need to be considered for the disaggregation |
| Quality assurance processes |
| Detail the quality assurance processes in place to check data, identify anomalies, and explore these further with providers.  QA processes in place in ONS and IC |
| Test data or sample data |
| During course of pipeline application, test or sample data will be required to give proof of concept. Insert table of raw data.  See separate e-mail |
| Interpretation |
| Describe how this indicator is planned to be used and what questions the indicator is planned to answer, and any known limitation  This, along with a suite of other indicators, seeks to capture how successfully the NHS is supporting people with long-term conditions to live as normal a life as possible.  In particular, this indicator looks at functional ability, measuring how well the person is able to live as normal a life as possible, and by looking at employment ties in well with DWP and the Government’s wider policies about getting people back to work. |
| Format of presentation |
| Describe published format, such as interactive website, csv file, etc. Provide table or screenshot (or mock version) of how the final presentation of data will appear. Include any interpretative text as well as figures  .csv file provided to DH  Historical timeseries data will be requested. |

Indicator Methodology Review **(IC use only)**

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| Transparency / reproducibility  Anomaly investigation and action  Valid and appropriate methods used  Can play of chance be assessed  Identification and action on outliers  Presentation suitable for audience  Construct validity  Interpretation  **Information complete - proceed** |  | *Requires revision for following reasons:*  Statistical methods information not complete  Test data not complete  Interpretation not complete  Presentation not complete |  |

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| **Indicator production and management** |
| Commissioner of indicator (this may be the same as the stakeholder) |
| DH |
| Producer of indicator (this may be the same as the proposer) |
| **IC** |
| Expected ‘improvement actions’ as a result of this indicator |
| State where responsibility will lie, and what actions will be expected as the result of a 'poor' rating of this indicator.  The NHS Outcomes Framework sets out the national outcome goals that the SofS will use to monitor the progress of the NHS Commissioning Board. It does not set out how these outcomes should be delivered, it will be for the NHS Commissioning Board to determine how best to deliver improvements by working with GP commissioning consortia to make use of the tools at their disposal. |
| Have costs of collection, construction, dissemination and presentation been fully identified? |
| Funding status |
| Secured / ***being sought*** / not identified  Please add comments  Discussions for funding in 2012/13 are ongoing amongst senior colleagues in the NHS Quality and QIPP teams. |
| What timescales do you envisage for developing / producing this indicator |
| Give specific dates for key stages or publication or development of indicator  Indicator to be published in Autumn 2011 |
| Risks, assumptions and impact of producing indicator |
| There is a risk that the indicator is not sensitive enough to improvements in NHS performance. The employment rate for disabled people has gradually increased since 1998 from 39% to 48% in 2008. (Labour Force Survey 2008, Quarter 2 – quoted in Department for Work and Pensions: Secretary of State Report on Disability Equality, December 2008)  The employment rate of people with long-term conditions will be mapped to the employment rate of the general population in order to allow for the impact of the wider economic situation to be taken into account.  It will be difficult to ascertain the impact of the NHS over and above the impact of other policies (for example, from the Department of Work and Pensions) on this indicator. |
| Risk of perverse incentive and gaming by healthcare providers |
| To what extent can organisations influence the value of the indicator in ways which may not benefit patients? |
| Risks, assumptions and impact of not producing indicator |
| This is not an option as there has been a public commitment made to doing so. This indicator is part of the NHS Outcome Framework 2011-12 indicator set. |
| Indicator Production Review **(IC use only)** |

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| Action-ability  Funding capacity identified  Risks sufficiently explored  **Information complete - proceed** |  | *Requires revision for following reasons:*  Commissioner information not complete  Producer information not complete  Improvement actions not complete  Funding status not complete  Timescale info not complete  Risk assessment not complete |  |

**Pipeline Methodology Review Group**

**Applications for consideration**

**28th June 2011**

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| --- | --- |
| **Document Author:** | *Peter Knighton* |
| **Document Owner:** | *Peter Knighton* |
| **Created Date:** | *23rd June 2011* |
| **Current Issue Date:** | *1st July 2011* |
| **Responses expected by:** | *n/a* |
| **Version Number:** | *V 0.2* |

# Introduction

There are several recommendations from previous MRG meetings that have been investigated and now require further input from the group. In section 2 of this paper the original submissions and recommendations are followed by the new responses to the recommendations.

There are also two new indicators for consideration in section 3.

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# Additional information and feedback from data owners on MRG Recommendations

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| **Indicator** | **Construction and data source** | **Rationale** | **Potential issues** |
| DOMAIN 2: Enhancing quality of life for people with long-term conditions  2.2 **(IAP00028)** Employment of people with a long-term condition | Data source: Labour Force Survey.  Proportion of people of working age with a long-term condition who are in employment. This indicator will be compared with the proportion of the population of working age who are in employment.  Quarterly achieved sample size approx 100,000. Indicator will be quarterly.  a) Proportion of people with a long-term condition who are in employment:  NUMERATOR:  Number of people with LTCs in employment (the respondent has a health problem or disabilities that they expect will last for more than a year AND respondent is either an employee, self-employed, government training, unpaid family worker (ILO basic economic activity) AND of working age (16-64)).  DENOMINATOR:  Number of people with a long-term condition of working age  b) Proportion of the population who are in employment:  NUMERATOR:  Number of people in employment (respondent is either an employee, self-employed, government training, unpaid family worker (ILO basic economic activity) AND of working age (16-64))  DENOMINATOR:  Number of people of working age | Outcomes seeking to measure: Improved functional ability in people with long term conditions  There is much evidence of a strong association between worklessness and poor health and strong evidence that unemployment is generally harmful to health. | 1. Whether evidence for worklessness is sufficient for an indicator which focuses on employment being better for health. Currently seeking comment on whether employment rather than unemployment is the best indicator.  2. Ability of survey to collect accurate information on those with LTC to be advised by ONS and whether the weighting applied is sufficient when looking at those with LTCs and mental illness.  3. There is some overlap with a DWP indicator: employment rate of those with a limiting long-term health condition which considers people who are DDA disabled, work limiting disabled and both DDA disabled and work limiting disabled. This is considered too narrow a scope for the Outcomes Framework. Uses the same data source.  4. It will be difficult to ascertain the impact of the NHS over and above the impact of other policies on this indicator, particularly perhaps for those identifying LTCs in the survey but not seeking any medical help. |

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| **Recommendation 2011/34** | The Labour Force Survey (LFS) is focussed on labour, with health as a supplementary issue. The emphasis within health is on self diagnosis. Are the questions asked suitable for this indicator? DH to investigate any quality statements or similar documents ONS have published on this. |
| **Update** | The published quality documents do not cover this. However, LFS response is comparable with those from other surveys asking about long term illnesses (General Lifestyle Survey and the Life Opportunities Survey). Feedback is currently being sought from ONS regarding question testing in this area. |
| **Recommendation 2011/37** | The possibility of age standardisation should be looked into. It is understood that ONS carry out some weighting, but this needs to be clarified. DH to investigate. |
| **Update** | The weighting uses 5 year age band breakdowns to standardise the data up to the age of 80. Further details:  <http://www.statistics.gov.uk/downloads/theme_labour/Vol1-Final-2009.pdf> |
| **Recommendation 2011/39** | Proceed to the IGB with this indicator pending response from ONS. Self response element of the source to be included in the Data Quality statement. |

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| **Indicator** | **Construction** | **Rationale** | **Potential issues** |
| DOMAIN 2: Enhancing quality of life for people with long-term conditions  2.5 Employment of people with mental health illness | Data source: Labour Force Survey.  Proportion of people of working age with mental illness who are in employment. This indicator will be compared with the proportion of the population of working age who are in employment.  Quarterly achieved sample size approx 100,000. Indicator will be quarterly.  a) Proportion of people with mental illness who are in employment:  NUMERATOR:  Number of people with mental illness in employment (the respondent has a health problem or disabilities that they expect will last for more than a year AND has depression, bad nerves or anxiety, severe or specific learning difficulties or mental illness or suffer from phobia, panics or other nervous disorders AND respondent is either an employee, self-employed, government training, unpaid family worker (ILO basic economic activity) AND of working age (16-64))  DENOMINATOR:  Number of people with a long-term condition AND has depression, bad nerves or anxiety, severe or specific learning difficulties or mental illness or suffer from phobias, panics or other nervous disorders AND of working age  b) Proportion of the population who are in employment:  NUMERATOR:  Number of people in employment (respondent is either an employee, self-employed, government training, unpaid family worker (ILO basic economic activity) AND of working age (16-64))  DENOMINATOR:  Number of people of working age | Outcomes seeking to measure: Enhancing quality of life for people with mental illness.  There is much evidence of a strong association between worklessness and poor health and strong evidence that unemployment is generally harmful to health. Between 10 and 16% of people with a mental health condition excluding depression are in employment. However between 86 and 90% of this group want to work. | As above |

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|  | **Recommendations 2011/34, 2011/35, 2011/36 and 2011/37 also apply to this indicator.** |
| **Recommendation 2011/38** | Other data sources may be more suitable for this indicator, but comparison issues between indicators may arise if a different source is used. Possible alternative sources suggested were the Mental Health Minimum Data Set (MHMDS) and Adult Psychiatric Morbidity Service. DH and CIT to investigate other sources before the indicator is taken forward. |
| **Update** | The Adult Psychiatric Morbidity Survey does include employment questions, but it is only carried out every seven years. The last survey was for 2007 and was published in 2009.  The MHMDS covers inpatient, outpatient and community activity. Some people within the MHMDS are on the Care Programme Approach (CPA), a system of delivering community care to those with mental illness. A CPA only employment rate indicator is already calculated every quarter from the MHMDS. (It is currently in the pipeline under reference number MH8.) It would be possible to calculate a similar indicator using all people in the dataset, not just CPA.  There are concerns that if we used the MHMDS for this indicator we would not be able to compare this employment rate with the employment rate for the general population, as they would be calculated using two different methods. Also the MHMDS covers people who are in contact with mental health services whereas the LFS captures all, including those with a mental health condition who are not in contact with healthcare services. |
| **Recommendation 2011/40** | Use the LFS as the specific aim of the indicator is to capture not just those people in contact with mental health services. The coverage of the employment status in the MHMDS is not considered to be thorough enough. As this improves the MHMDS could be looked at in the future. Using the LFS will keep consistent the methods between all long term conditions, those for mental health and all national employment. This is to be captured in the data quality statement for this indicator. |

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| **Indicator** | **Construction** | **Rationale** | **Potential issues** |
| **DOMAIN 4 – Patient experience**  4b Patient experience of hospital care | Data source: CQC’s Adult Inpatient Survey. Annual survey of patients with and inpatient episode between June and August. Covers elective and emergency care patients with at least one night in hospital. Doesn’t include maternity, mental health patients or patients under 18. Is an existing National Statistic published by DH and CQC.  Around 70,000 responses annually – response rate of around 50%.  This is a composite indicator averaging scores in five domains. Individual questions are scored according to pre-defined scoring regime that awards scores between 0-100. Therefore the indicator will take values between 0-100.  Construction:  Overall score of five separate domains (with questions within each), data is standardised by age-sex, and pathway (emergency or elective). For each trust, an average weighted score is calculated for each of the relevant questions. Missing values are excluded from analysis. These scores are aggregated into the domains using a simple weighted average. National domain scores are calculated by a simple average of the Trust scores. Full methodology is available. | It is now standard practice in healthcare systems worldwide to ask people to provide direct feedback on the quality of their experience, treatment and care. It will be used alongside additional information sources to provide local clinicians and managers with intelligence on the quality of local services from the patients’ and service users’ point of view. Ultimately to play a role in driving improvements in the quality of service design and delivery. | 1. Title not specific to inpatients  2. Comparison both over time and against an optimum value are highlighted as requirements. Detail of optimum value requirements to be worked through.  3. The future survey architecture may change *which could mean that the survey questions this indicator is based on will change.*  4. It is expected that both NHS/DH boards will be users and the public. |
| 4.2 Responsiveness to inpatients’ personal needs | Data source: CQC’s Adult Inpatient Survey. Annual survey of patients with and inpatient episode between June and August. Covers elective and emergency care patients with at least one night in hospital. Doesn’t include maternity, mental health patients or patients under 18. Underlying data source is currently published and scores for this indicator are shared with the NHS but no national level indicator is currently published.  Around 70,000 responses annually – response rate of around 50%.  This will be a composite indicator averaging scores in five domains. Individual questions are scored according to pre-defined scoring regime that awards scores between 0-100. Therefore the indicator will take values between 0-100.  Construction:  Overall score of five separate domains (with questions within each), data is standardised by age-sex, and pathway (emergency or elective). For each trust, an average weighted score is calculated for each of the relevant questions. Missing values are excluded from analysis. These scores are aggregated into the domains using a simple weighted average. National domain scores are calculated by a simple average of the Trust scores. | Indicator was developed as part of a national CQIN goal for acute providers.  It is now standard practice in healthcare systems worldwide to ask people to provide direct feedback on the quality of their experience, treatment and care. It will be used alongside additional information sources to provide local clinicians and managers with intelligence on the quality of local services from the patients’ and service users’ point of view. Ultimately to play a role in driving improvements in the quality of service design and delivery. | 1. Assume national indicator would be created in same way as current national indicator for 4b.  2. Comparison both over time and against an optimum value are highlighted as requirements. Detail of optimum value requirements to be worked through.  3. The future survey architecture may change *which could mean that the survey questions this indicator is based on will change.*  4. It is expected that both NHS/DH boards will be users and the public. |

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| **Recommendation 2011/18** | The wording for these indicators suggests use outside of the national level. In the first instance the NHS Outcomes Framework requires only a national indicator. The group should ensure it is reviewing at the appropriate level. |
| **Recommendation 2011/19** | National level indicator should be constructed from the lowest level data rather than from combining trust scores. The availability of this data should be investigated. DH to inform IC. Report back to MRG if not possible. |
| **Update** | The following is taken from ‘Methods, reasoning and scope. Statement of methodology for overall patient experience scores (statistics)’  <http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127319.pdf> page 14  Decision 8: How should we aggregate Trust level scores to national level scores (Trust weighting issues)  There are three possible ways to work out national figures:   1. use the whole dataset and ignore distinctions between trusts (i.e. treat the country as one giant trust – the ‘one nation’ method) 2. work out individual Trust level scores and then take a simple average 3. calculate a weighted average of Trust level scores using some measure of trust size   Since the initial sample size for all Trusts is the same (850) the first two methods give similar results, and the second has the advantage of showing a clear and simple relationship between Trust level scores and national scores.  In principle the third method would give a more accurate national picture by giving a higher weight to larger Trusts, but the difference is not large. This approach would introduce an extra layer of complexity to the calculation and would require judgements to be made about the most appropriate measure of size to use for Trusts. Whichever measure of size we selected (beds, admissions, patient episodes etc) this method would require links to other data because there are no direct measures of Trust size within the patient survey datasets. Different measures of size would give results, and this introduces a degree of subjectivity into the methodology that is undesirable. In addition, this approach would tend to make the overall national measure unstable when there is organisational change in the NHS (for example Trust mergers).  It is important to note that because all Trusts have the same sample size, patients at smaller Trusts are disproportionately represented in the national figures, but this provides a sensible balance between transparent and simple methodology and analytical rigour.  This was further elaborated on by DH as follows:  On the technical points we discussed, there was an outstanding issue about demonstrating that two different approaches to national indicators give similar results:  i) working out Trust level indicators first, then averaging  ii) working out a national level measure directly.  As we discussed, there are good qualitative reasons for using method (i), principally that it allows Trusts to relate their own figures very directly to the national overview. We also use the Trust level figures extensively in other indicator systems (for example the performance framework), so it is helpful to have a single coherent mechanism. |
| **Recommendation 2011/20** | Variation in response rates between trusts should be considered when aggregating to national level. DH to provide information. Report back to MRG if problems arise. |
| **Update** | The following is from a document from the DH from April 2006 when the indicators were first being prepared.  Weighting for differential non-response   1. Standardisation, as described above [referring to paragraphs in the document from which this paragraph was taken], aligns the age and gender mix for each Trust with the age and gender mix of the *returned* questionnaires. This is fine if the returned questionnaires are representative of the whole population, but some patients choose not to respond to patient surveys, and the response rate can vary for different age/ sex groupings. 2. There is a theoretical case for adjusting scores for different rates of non-response in different age and gender groups. Such a change would add further complexity to the methodology, and analysis suggested that the impact of such a change would be small.   The analysis referred to is no longer available. |
| **Recommendation 2011/41** | The differences between the possible calculation methods should be quantified. If they are small the indicator should proceed with the current method, with the alternatives and this analysis included in the indicator data quality statement. The differences should be checked annually to ensure this is consistent over time. IC Clinical Indicators Team (CIT) to discuss with team at DH that produce these indicators. |
| **Recommendation 2011/42** | The original purpose of the indicators should be checked against the aims within the NHS Outcomes Framework. CIT to follow this up. |

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| **Title** | **Status** | **Numerator construction** | **Numerator notes** | **Denominator** |
| 5.2i Incidence of healthcare associated infections - MRSA | Currently published on HPA website as counts on a monthly, quarterly and annual basis for all acute and primary care organisations. | Count of all MRSA infections identified two days after admission, where the patient specimen location is ‘acute’ (or null), and patient location is ‘In-patient’, ‘Day patient’, ‘Emergency assessment’ (or is *null*) | These data should not be used as the basis for decisions on the clinical effectiveness of interventions in individual NHS organisations without further investigations | Patient bed day denominators are calculated using the average daily ‘Total (occupied)’ bed data from the KH03 dataset. Figures are now submitted quarterly on form KH03 by each NHS provider and provide a summary across all hospital sites within the Trust or PCT. Patients requiring critical care are excluded as they are captured in a bi-annual census. Occupation of beds by well babies are also excluded. |
| 5.2ii Incidence of healthcare associated infections – *C difficile* | Currently published on HPA website as counts on a monthly, quarterly and annual basis for all acute and primary care organisations. | Count of all C difficile infections identified three days after admission, where the patient specimen location is ‘acute’ (or null), and patient location is ‘In-patient’, ‘Day patient’, ‘Emergency assessment’ (or is *null*) | These data should not be used as the basis for decisions on the clinical effectiveness of interventions in individual NHS organisations without further investigations | Patient bed day denominators are calculated using the average daily ‘Total (occupied)’ bed data from the KH03 dataset. Figures are now submitted quarterly on form KH03 by each NHS provider and provide a summary across all hospital sites within the Trust or PCT. Patients requiring critical care are excluded as they are captured in a bi-annual census. Occupation of beds by well babies are also excluded. |

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| **Recommendation 15** | Review use of bed days as denominator and ability of KH03 to provide this (aggregate return?).  Investigate suitability of SPC based on numbers or rates to see variation from expected. Report back to MRG and QIC. |
| **Update** | HPA has provided two spreadsheets of MRSA and C diff of total cases by population (they have provided the calculated data), which underlie a chart which is published quarterly in a bulletin. However the customer has requested the DH HCAI team are involved in these discussions, as they monitor trust rates based on bed days. |
| **Recommendation 2011/43** | DH HCAI team should be included in discussion. The HPA and DH approaches should be reviewed together. CIT to follow this up. |
| **Recommendation 2011/44** | Any mismatch between the numerator and denominator on the exclusion of patients requiring critical care should be investigated. This is to be considered in the review in recommendation 2011/43. |

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| **Indicator** | **Construction and data source** | **Rationale** | **Potential issues** |
| 5.5 Admission of full-term babies to neonatal care | Proportion of full term babies (gestation 37 weeks) admitted to hospital  Numerator  Where length of gestation >= 37 weeks, Episode type = 3,6, Episode Status = 3, Episode order = 1, Neonatal care = 1,2,3,  Denominator  Collected from birth notification records | This outcome will help drive improvements in the quality of maternity services throughout the maternity care pathway (antenatal, intrapartum, postpartum).  Babies may be admitted to neonatal care for a variety of reasons. Some may be unavoidable but others will reflect standards and quality of care and decision making resulting in failure to plan safe care. Confidential enquiries (CEMD and CESDI) have consistently found 50% of deaths associated with substandard care.  Unexpected admission of a term baby to neonatal care may result from failure at many stages of the maternity pathway:   * Antenatal booking and plan of care (eg failure to recognise risk of preterm birth, a safety issue if inappropriate place of birth was chosen.) * Quality of antenatal care (eg failure to detect intrauterine growth restriction, a safety issue if resulting in failure to investigate or intervene or inadequate monitoring in labour) * Safety of care in labour (eg competent fetal heart monitoring including interpretation of CTG, safe and appropriate use of Syntocinon to augment labour and avoid fetal hypoxia) * Inappropriate planning of elective caesarean section before 39 weeks (increasing the risk of respiratory distress)   Failure to ensure safe care through the presence of an experienced midwife (shift co-ordinator) for each shift on the labour ward and to ensure there is a sufficiently experienced obstetrician immediately available to attend all complicated births and increase the safety for mother and baby. | Pending further discussion with HES and DH statistician, this indicator seems straightforward to produce.  As stated in the rationale, the indicator will include admissions which were not avoidable or as a result of poor care.  This measure will be used to measure orgs/areas against themselves over time, which will show where the proportion of admissions changes from the baseline time period, but does not set a mechanism to help identify orgs / areas that require improvement in this area of patient care. |

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| **Recommendation 2011/22** | HES data has been proposed for use although other sources have been suggested. Duplicates are potentially a problem with HES. An alternative source suggested is that used by Imperial College London which is apparently better on duplicates. Information Governance clarification will be needed on alternate sources. IC to investigate and update MRG on possibilities if necessary. |
| **Recommendation 2011/23** | The denominator needs to be more specific, e.g. full term births. The source needs clarifying: HES won’t cover all births and other sources will have their limitations. DH to advise on definition. |
| **Recommendation 2011/24** | This indicator is currently a crude rate. Standardisation by deprivation would be appropriate if possible. The possibility should be investigated. DH invited to comment. Report back to MRG. |
| **Recommendation 2011/25** | Some admissions may be unavoidable, so their inclusion in an indicator measuring NHS performance would be inappropriate. The possibility of accounting for this should be investigated. DH invited to comment. Report back to MRG. |
| **Update** | Discussions with HES suggest that the rate of duplication is fairly low, and they have offered support to deduplicate the data which they have said is possible. Source of data for denominator has been suggested as the Birth Notification Data Set, which is held by CfH however, have not been able to find out how to request access to these data as there are no contact details and a trawl of contacts has not yielded anything.  Require further advice from DH on standardisation by deprivation, inclusion of unavoidable admissions |
| **Recommendation 2011/45** | Additional suggestions for CfH contacts should be pursued by CIT. |
| **Recommendation 2011/46** | The possibility of HES data for the denominator should be looked into. Completeness for home births may be an issue. It may be cleaner to use HES for both numerator and denominator. CIT to investigate. |
| **Recommendation 2011/47** | Standardisation for deprivation may remove the very element of NHS quality that should be of concern. An alternative is to present the national indicator in deprivation quintiles, to help with interpretation and action, without standardisation. How to handle deprivation should be considered for this indicator. |

# New indicators to be considered

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| **Indicator** | **Construction and data source** | **Rationale** | **Potential issues** |
| DOMAIN 3:  Helping people to recover from episodes of ill health or following injury  3a Emergency admissions for acute conditions that should not usually require hospital admission | Data source: Hospital Episode Statistics (The NHS IC) and ONS population statistics  Proportion of persons with acute conditions (ear/nose/throat infections, kidney/urinary tract infections, heart failure) admitted to hospital as an emergency admission in the respective quarter of the financial year.  Indicator will be quarterly.  NUMERATOR:  The number of finished and unfinished continuous inpatient (CIP) spells, excluding transfers, for patients with an emergency method of admission and with the primary diagnoses (DIAG\_01in the 1st episode of the spell, ICD 10 codes) listed in annex A in the respective quarter of the financial year.  DENOMINATOR:  Resident population for the respective organisation. | Outcomes seeking to measure:  Progress in preventing conditions from becoming more serious will be measured using this indicator. It looks at conditions that should usually be managed without the patient having to be admitted to hospital. Where an individual has been admitted for one of these conditions, it may indicate that they have deteriorated more than should have been allowed by the adequate provision of healthcare in primary care or as an outpatient in hospital. | 1. Indicator is based on a NCHOD indicator. The NCHOD indicator is produced using a 10 year linked file whereas this indicator will be not produced in this way due to the quarterly outputs required. |

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| **Recommendation 2011/48** | The clinical codes for this indicator differ from those used for similar indicators for Comparators and NCHOD. DH to supply Further evidence for the selection. |
| **Recommendation 2011/49** | Following on from recommendation 2011/48 CIT should look at the NCHOD and Comparators indicators with relation to this. |
|  | **Recommendation 2011/17 applies to this indicator in the selection of the most appropriate source of HES data.** |
| **Recommendation 2011/17** | Consistency across framework is important. Indicators based on admissions should use finished and unfinished spells. Indicators based on outcome and follow up of spells should use finished spells only. |

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| DOMAIN 3:  Helping people to recover from episodes of ill health or following injury  3.2 Emergency admissions for children with lower respiratory tract infections | Data source: Hospital Episode Statistics (The NHS IC) and ONS population statistics  Proportion of children aged **[DN confirm age cut-off]** admitted to hospital as an emergency admission for LRTIs in the respective quarter of the financial year.  Indicator will be quarterly.  NUMERATOR:  The number of finished and unfinished continuous inpatient (CIP) spells, excluding transfers, for patients aged **[DN insert when confirmed]** with an emergency method of admission and with any of the following primary diagnoses (DIAG\_01 in the 1st episode of the spell, ICD 10 codes) in the respective quarter of the financial year:  Bronchiolitis, bronchopneumonia and pneumonia**:**   * J10.0 Influenza with pneumonia virus identified; * J11.0 Influenza with pneumonia, virus not identified; * J11.1 Influenza with other respiratory manifestations, virus not identified (bronchiolitis with influenza); * J12.- Viral pneumonia nec; * J13 Pneumonia due to Streptococcus pneumoniae; * J14 Pneumonia due to Haemophilus influenzae; * J15.- Bacterial pneumonia nec; * J16.- Pneumonia due to other infectious organisms nec; * J18.0 Bronchopneumonia, unspecified; * J18.1 Lobar pneumonia; * J18.9 Pneumonia unspecified; * J21.- Acute bronchiolitis.   DENOMINATOR:  Resident population for the respective organisation. | Outcomes seeking to measure:  LRTIs in children leads to a high number of emergency bed days and is included here to attempt to address the problem. The aim is that in the future, these will be more successfully treated in primary care rather than secondary care.  Respiratory infections form one of the most common reasons for hospital admission in childhood, especially in infants. Between 1 and 3% of all babies experience an admission with bronchiolitis and about 2.5% of all child admissions are for pneumonia. Emergency admission rates in children, especially under the age of 5 years for lower respiratory infections - bronchiolitis, bronchopneumonia and pneumonia - reflect a variety of influences. Rates vary across the country but are increased in areas of socio-economic deprivation. Previous analyses have shown that they also vary between health authorities, even when social deprivation is taken into account, probably reflecting variation in access to, and expectation of, health services and also clinical practice. Lower rates are linked to higher breast feeding rates and reduction of exposure to tobacco smoke - preventive measures that reduce both incidence and severity of infections. | As above |

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| **Recommendation 2011/50** | A verbal update at the meeting stated that ages 0 to 19 are to be used. DH to supply the documentation behind this decision. |
|  | **Recommendation 2011/17 applies to this indicator in the selection of the most appropriate source of HES data.** |
| **Recommendation 2011/17** | Consistency across framework is important. Indicators based on admissions should use finished and unfinished spells. Indicators based on outcome and follow up of spells should use finished spells only. |

**Annex A: Emergency admissions for acute conditions that should not usually require hospital admission – diagnoses**

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| J10 | Influenza due to identified influenza virus |
| J11 | Influenza, virus not identified |
| J13X | Pneumonia due to Streptococcus pneumoniae |
| J14 | Pneumonia due to Haemophilus influenzae |
| J15.3 | Pneumonia due to streptococcus, group B |
| J15.4 | Pneumonia due to other streptococci |
| J15.7 | Pneumonia due to Mycoplasma pneumoniae |
| J15.9 | Bacterial pneumonia, unspecified |
| J16.8 | Pneumonia due to other specified infectious organisms |
| J18.1 | Lobar pneumonia, unspecified |
| J18.8 | Other pneumonia, organism unspecified |
| A36 | Diphtheria |
| A37 | Whooping cough |
| B05 | Measles |
| B06 | Rubella [German measles] |
| B16.1 | Acute hep B with delta-agent (coinfectn) without hep coma |
| B16.9 | Acute hep B without delta-agent and without hepat coma |
| B26 | Mumps |
| M01.4 | Rubella arthritis |
| I24.0 | Coronary thrombosis not resulting in myocardial infarction |
| I24.8 | Other forms of acute ischaemic heart disease |
| I24.9 | Acute ischaemic heart disease, unspecified |
| E86 | Volume depletion |
| K52 | Other noninfective gastroenteritis and colitis |
| A02.0 | Salmonella enteritis |
| A04 | Other bacterial intestinal infections |
| A05.9 | Bacterial foodborne intoxication, unspecified |
| A07.2 | Cryptosporidiosis |
| A08 | Viral and other specified intestinal infections |
| A09 | Diarrhoea and gastroenteritis of presumed infectious origin |
| N10 | Acute tubulo-interstitial nephritis |
| N11 | Chronic tubulo-interstitial nephritis |
| N12 | Tubulo-interstitial nephritis not spec as acute or chronic |
| N13.6 | Pyonephrosis |
| N15.9 | Renal tubulo-interstitial disease, unspecified; |
| N39.0 | Urinary tract infection, site not specified; |
| N30.0 | Acute cystitis |
| N30.8 | Other cystitis |
| N30.9 | Cystitis, unspecified |
| K25.0-K25.2, K25.4-K25.6 | Gastric ulcer |
| K26.0-K26.2, K26.4-K26.6 | Duodenal ulcer |
| K27.0-K27.2, K27.4-K27.6 | Peptic ulcer, site unspecified |
| K28.0-K28.2, K28.4-K28.6 | Gastrojejunal ulcer |
| K20 | Oesophagitis |
| K21 | Gastro-oesophageal reflux disease |
| L03 | Cellulitis |
| L04 | Acute lymphadenitis |
| L08.0 | Pyoderma |
| L08.8 | Other spec local infections of skin and subcutaneous tissue |
| L08.9 | Local infection of skin and subcutaneous tissue, unspecified |
| L88 | Pyoderma gangrenosum |
| L98.0 | Pyogenic granuloma |
| I89.1 | Lymphangitis |
| L01 | Impetigo |
| L02 | Cutaneous abscess, furuncle and carbuncle |
| H66 | Suppurative and unspecified otitis media |
| H67 | Otitis media in diseases classified elsewhere |
| J02 | Acute pharyngitis |
| J03 | Acute tonsillitis |
| J06 | Acute upper respiratory infections multiple and unsp sites |
| J31.2 | Chronic pharyngitis |
| J04.0 | Acute laryngitis |
| A69.0 | Necrotizing ulcerative stomatitis |
| K02 | Dental caries |
| K03 | Other diseases of hard tissues of teeth |
| K04 | Diseases of pulp and periapical tissues |
| K05 | Gingivitis and periodontal diseases |
| K06 | Other disorders of gingiva and edentulous alveolar ridge |
| K08 | Other disorders of teeth and supporting structures |
| K09.8 | Other cysts of oral region, not elsewhere classified |
| K09.9 | Cyst of oral region, unspecified |
| K12 | Stomatitis and related lesions |
| K13 | Other diseases of lip and oral mucosa |
| R56 | Convulsions, not elsewhere classified |
| O15 | Eclampsia |
| G25.3 | Myoclonus |