**NHS Digital**

**Indicator Supporting Documentation**

**IAP00084 Rates of complications associated with diabetes**

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| FIELD | CONTENTS |
| IAP Code | IAP00084 |
| Title | Rates of Complications associated with diabetes |
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| Reporting period | Annually |
| Geographical Coverage |  |
| Reporting level(s) |  |
| Based on data from | HES, National Diabetes Audit (NDA) and GP Population Data |
| Contact Author Name | Primary Medical Care Branch, DH |
| Contact Author Email |  |
| Rating | Assured |
| Assurance date | 18/01/13 |
| Review date | 18/01/16 |
| Indicator set | CCGOIS 2.8 & COF 2.61 |
| Brief Description  [This appears as a blurb in search results] | The indicator is based on a NICE Quality Standard and has been identified by the NICE COF Advisory Committee for use in the Commissioning Outcomes Framework.  This indicator is considered useful in measuring the quality of commissioning for people with diabetes. |
| Purpose | Rates of complications associated with diabetes.  NDA complication types are diagnoses or procedures as follow:  \* Ketoacidosis  \* Angina  \* Myocardial Infarction  \* Cardiac Failure  \* Stroke  \* Diabetic Retinopathy treatments  \* Renal Failure  \* Amputation minor  \* Amputation major  ICD-10 and OPCS-4 codes are provided Indicator will be reported annually (April to March). |
| Definition | This NDA complications indicator, which provides NDA analysis pertaining to incidence and prevalence of complications amongst the NDA diabetes population, was developed to assess the complication rates in the diabetic population. The indicator was requested and developed in conjunction with the NDA clinical lead, Bob Young and expert clinical coders. These indicators are collected nationally as part of the NDA. |
| Data Source | National Diabetes Audit, HES/PEDW |
| Numerator | Number of people identified by NDA in the denominator with a HES record of NDA complications using ICD-10 primary or secondary diagnosis codes, or primary and secondary OPCS codes. |
| Denominator | Number of people with diabetes identified by the NDA who were alive at the start of the follow-up period. |
| Calculation | Indicator will be constructed as follows:  Cohort: Patients in the 2009/10 NDA alive on 31st March 2010  Numerator: Number of patients with one or more of the complications during follow up period 1st April  2010 to 31st March 2011  Denominator: Number of patients in cohort  This removes the survivor bias we were seeing in the indicator – restricted pre-published numbers will  be discussed at the meeting. |
| Interpretation Guidelines | None |
| Caveats | None |

Indicator Assurance Pipeline Process

**Methodology Review Group**

**Applications for consideration**

**26th October 2012**

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**0. Document Control**

## Version History

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| **Version** | **Date** | **Changed By** | **Summary of Changes** |
| V 0.1 | 19/10/2012 |  | Initial Draft |
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## Approvals

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## Distribution

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# Introduction

Indicators to discuss:

COF Patient Safety Indicators

* COF: 5a Patient Safety Incidents Reported
* COF: 5.2ii incidents of healthcare associated infection – c.difficile
* COF: 5.9 Adult patients who have had a VTE risk assessment on admission to hospital

***(New for MRG)***

* NHSOF: 5.5 Admission of full-term babies to neonatal care

***(Update for MRG)***

* NHSOF/COF 1a – Potential Years of Life Lost (PYLL) from causes considered amenable to health care

***(New for MRG)***

* NHSOF 3.6 - The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services

***(Update for MRG)***

COF Diabetes Indicators

* COF 2.61 **(IAP00084) CCGOIS 2.8** – Rates of complications associated with diabetes
* COF 1.24 Myocardial infarction, stroke and end stage kidney disease in people with diabetes

***(Update for MRG)***

COF Maternity Indicators (Previously circulated for comment)

* COF: 1.25 Antenatal assessments <13 weeks
* COF: 1.27 Maternal smoking at delivery
* COF: 1.29 Breast feeding prevalence at 6-8 weeks

***(Review of comments received )***

# Indicators for Consideration

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**Commissioning Outcomes Framework (COF) - Patient Safety Indicators**

The following three indicators use provider-level data that are not directly attributable to a GP practice and so are not directly reportable at CCG level:

* 5a - Patient Safety Incidents Reported
* 5.2ii – Incidents of healthcare associated infection - C. Difficile
* 5.9 – Adult patients who have had a VTE risk assessment on admission to hospital

The approach outlined below is the best available tool to indicate where activity takes place at CCG level. It is intended to provide estimates for CCGs on levels of Patient Safety incidents.

**Attribution Method**

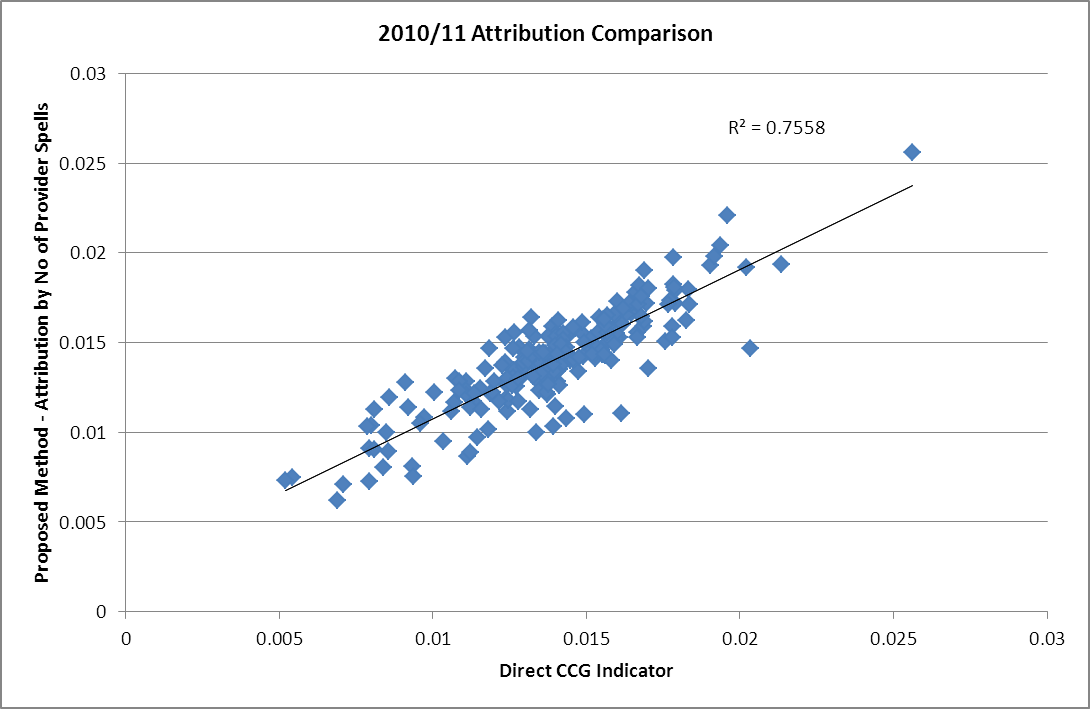
The attribution method apportions a number of incidents to a CCG based upon the overall inpatient activity at a provider (2010-11 HES data) that has been commissioned by the CCG.

The method has been tested using a dummy indicator on known HES data, where a comparison can be made, as the provider can be accurately matched to a CCG via the GP Practice code in HES. When tested using this known data, there was a correlation of 0.75, i.e. in 75 out of 100 cases the activity will be correctly matched to the commissioning CCG. Based on initial analysis by the Clinical Indicators team, there is evidence that use of this attribution method is inappropriate where there are fewer than 300 results, as the correlation dwindles.

The graph below shows the correlation between the direct provider-to-CCG volumes (available in HES) and the attributed volumes. The dummy indicator used is a crude mortality rate indicator, summarised below;

Denominator: The number of provider spells in financial year 2010/11.

Numerator: The number of provider spells that end in a discharge coded as death in financial year 2010/11.



The examples used in the MRG reports use a CCG based in the North of England with full year 2010-11 figures for the incidents relevant to the indicator at provider-level.

**Attribution Method Potential Issues**

Using the attribution method assumes a correlation between provider-to-CCG activity and the number of Patient Safety/HCAI/VTE issues, which may or may not be valid.

Use of this attribution method could mask statistically significant variation at CCG-level by inappropriately allocating each CCG a proportion of cases based purely upon the number of patients sent to the provider in question. It would therefore be inappropriate to use this method to hold CCGs to account. The results should be viewed in the context of the provider and not as an individual figure in isolation.

It is recommended the word ‘Estimated’ be included in the indicator title.

Indicators constructed using this proxy attribution method should not be used in the allocation of payments or quality premium.

This method was presented to the NICE COF Advisory Committee in September and they did not support the use of these indicators.

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| **Indicator:** | **5a – Patient Safety Incidents Reported** |
| **Rationale** | “Patient safety incidents are an unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS-funded healthcare.”  (<http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/healthcare-staff-reporting/>)  It is impossible to eliminate entirely adverse events in healthcare but the need to learn from the events is understood. Work is on-going to improve data collection to support the reduction in these incidents.  This is based upon the NHS Outcomes Framework indicator of the same number and name. It seeks an improved readiness of the NHS to report harm and to learn from it.  The IC was asked by DH to provide an attribution method to allocate provider-level data to CCGs. |
| **Data Source** | Organisation Patient Safety Incident workbook, attributed to CCGs via a proxy attribution method.  These data have historically been reported to the National Patient Safety Agency (NPSA) by the National Reporting and Learning System (NRLS). However, this this is in transition to Imperial College, London to which NRLS will transfer following the abolition of the NPSA.  <http://www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports/directory/> |
| **Construction and data source** | The indicator is a raw count of the number of reported Patient Safety incidents attributed to CCGs via the proxy attribution method, explained previously.  The example below uses a CCG based in the North of England with full year 2010-11 figures for Patient Safety incidents at provider-level. The top 6 providers make up 99% of the overall CCG activity, with a further 90 providers making up the remaining 1%.  In the example, Provider 1 has had 6716 incidents during the time period and 18.46% of its total activity is commissioned by the CCG, so 1240 incidents are attributed to the CCG (6716 x 18.46%).  CCG 1 – North of England  The case below is a Mental Health provider which has 4073 admissions recorded in HES but which reported 11391 Patient Safety incidents for 2010-11. This highlights an issue with the attribution method as incidents can happen in any setting but the attribution method only uses inpatient activity). Other types of activity would need to be sourced from other collections e.g. MHMDS. It also highlights the issue that the attribution method assumes a correlation between provider-to-CCG inpatient activity and the number of Patient Safety incidents, which may or may not be valid.  **Reporting period:** Currently reported bi-annually (six monthly).  **Reporting type:** Raw count of the number of incidents.  **Standardisation:** Risk adjustment is not necessary for this indicator.  **Available at CCG reporting level:** Yes, via the proxy attribution method. |
| **Ref Docs** | Reference: [Consultation](http://www.nice.org.uk/aboutnice/cof/ConsultationOnCOFIndicators.jsp?domedia=1&mid=2F5CB0D2-19B9-E0B5-D44BE3ECD0B4AB42) on potential COF indicators, NICE.  HSCIC feedback report to NICE for COF indicator 5a. |
| **Potential issues** | * It is only mandatory for providers to report incidents with a *severe degree of harm or death;* the reporting of patient safety incidents in general is voluntary and under-reporting is known to be common. There are major concerns regarding the level of completeness in the National Reporting and Learning System (NRLS) dataset currently available, particularly because NRLS has traditionally focussed upon learning from patient safety incidents and was never intended to be a reporting or data collection mechanism. The data in NRLS is not a complete count of all cases where a patient is harmed during contact with the NHS. * Secondary care submissions from providers is currently the only data used in the indicator, as the attribution method is based on inpatient provider spells only. PCT-level data is available but we are unsure as to whether the attribution method should be applied. * Patient Safety incidents occurring in acute trusts could happen in a number of different settings, including admitted patients (who *are* reported on HES), outpatients, pharmacy, diagnostic tests and administration. The published data does not specify the location or service, only the degree of harm and category of incident. * Frequency of reporting will need further consideration, as the provider-level data is currently reported every six months. The attribution method currently uses annual inpatient admission data, which is provider spell-based and not person-based. * Potential issues relating to the attribution method issues explained previously. |
| **Additional Information** | DH would prefer a single figure to be reported, however our recommendation to the NICE Committee was that this would be inappropriate, as these are attributed figures. |
| **Indicator:** | **5.2ii – Incidents of healthcare associated infection C. Difficile** |
| **Rationale** | Healthcare Associated Infections can result in longer hospital stays and, in severe cases, prolonged illness or death. High standards of infection control can limit the incidence of such infections. Reductions are linked to better patient outcomes (or a lack of harmful outcome).  This is based upon the NHS Outcomes Framework indicator of the same number and name. It seeks a reduction in the incidence of Healthcare Associated Infection (HCAI).  The IC was asked by DH to provide an attribution method to allocate provider-level data to CCGs. |
| **Data Source** | The data are taken from published Health Protection Agency data (Table 6a: Financial year annual counts and rates of C. difficile). This reports a crude count of all cases of Clostridium difficile (C. difficile) in patients aged 2 and over reported to the Health Protection Agency. It is mandatory for providers to report HCAIs.  <http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1179746015058> |
| **Construction and data source** | The indicator is the raw count of the number of reported cases of C. Difficile infections in patients aged 2 years and over, attributed to CCGs via a proxy attribution method.  The example below uses a CCG based in the North of England with full year 2010-11 figures for healthcare associated infections at provider-level (these are ‘trust apportioned’ from the total number of infections detected – see the caveats in the Additional Information). The top 6 providers make up 99% of the overall CCG activity, with a further 85 providers making up the remaining 1%.  In the example, Provider 1 has had 70 trust-apportioned infections during the time period and 18.46% of its total activity is commissioned by the CCG, so 13 incidents are attributed to the CCG (70 x 18.46%).  CCG 1 – North of England  **Reporting period:** Data are reported annually.  **Reporting type:** Raw count of the number of healthcare associated infections.  **Standardisation:** Risk adjustment is not necessary for this indicator.  **Available at CCG reporting level:** Yes, via the proxy attribution method. |
| **Ref Docs** | Reference: [Consultation](http://www.nice.org.uk/aboutnice/cof/ConsultationOnCOFIndicators.jsp?domedia=1&mid=2F5CB0D2-19B9-E0B5-D44BE3ECD0B4AB42) on potential COF indicators, NICE.  HSCIC feedback report to NICE for COF indicator 5.2 ii. |
| **Potential issues** | Small numbers of HCAI incidence are a potential problem.  Among the ‘caveats’ stated by HPA relating to the data files are:  What this data does not provide:   * A basis for decisions on the clinical effectiveness of infection control interventions in individual Trusts: further investigations considering potential confounders would need to be undertaken before this could be done. Variations in the patient populations being treated and seasonality can also cause large variation in counts. * A basis for comparisons between Trusts. Rate information, using rate calculations as currently defined, is not appropriate for comparison between Trusts. The counts of infections have not been adjusted to give a standardised rate considering factors such as the hospital demographics or case mix. Rate information is of use for comparison of an individual Trust over time.   In the data, ‘all reported cases’ refers to all toxin positive results for C. Difficile infections that are detected by the trust whose laboratory processes the specimen. This does not necessarily imply that the infection was acquired there.  The number of C. Difficile infections are apportioned to trusts providing the following rules are met:   * The location where the specimen was taken is given as ‘acute trust’ or is not known; * The patient was either an ‘inpatient,’ ‘day patient,’ in ‘emergency assessment’ or is not known; * The patient’s specimen date is on or after the fourth day of the admission (or admission date is null), where day of admission is day 1.   The data provided by HPA are already ‘trust apportioned’ so further attributing these to CCGs takes us further away from the actual reported incidents and may not be particularly helpful to CCGs.  Currently, data is only available for NHS secondary care organisations (i.e. PCT’s and private providers are excluded).  Potential issues relating to the attribution method issues explained previously. |
| **Additional Information** | DH have informed us that Public Health England will hold information on numbers of C. difficile infections by Trust and CCG from April13. The HPA have undertaken a mapping exercise and DH may wish to substitute their method. |

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| **Indicator:** | **5.9 – Adult patients who have had a VTE risk assessment on admission to hospital** |
| **Rationale** | 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.  The IC was asked by DH to provide an attribution method to allocate provider-level data to CCGs. |
| **Data Source** | The data are reported at Acute Trust level and are provided by UNIFY2. All providers of NHS-funded acute care are required to return data; the collection has been mandatory since June 2010.  <http://transparency.dh.gov.uk/category/statistics/vte/> |
| **Construction and data source** | **Denominator:** Number of adults (aged 18 years and over) who were admitted as inpatients (including day cases, maternity and transfers; both elective and non-elective admissions).  **Numerator:** Number of adult inpatient admissions reported as having had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool (including those risk assessed using a cohort approach in line with published guidance.  <http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117030.pdf>  The example below uses a CCG based in the North of England with Q4 2010-11 figures (full-year data is unavailable as the collection only commenced mid-way through 2010-11) for VTE Risk Assessment at provider-level. The top 5 providers make up 99% of the overall CCG activity, with a further 81 providers making up the remaining 1%.  In the example, Provider 1 has had 30,650 VTE assessments (from 33,069 admissions) during the time period and 18.46% of its total activity is commissioned by the CCG, so 5,659 VTE assessments are attributed to the CCG (30,650 x 18.46%). Attributed admissions are calculated in the same way.  CCG 1 – North of England  **Reporting period:** Reported quarterly, with monthly data aggregated to a quarter.  **Reporting type:** Percentage.  **Standardisation:** Risk adjustment is not necessary for this indicator.  **Available at CCG reporting level:** Yes, via the proxy attribution method. |
| **Ref Docs** | Reference: [Consultation](http://www.nice.org.uk/aboutnice/cof/ConsultationOnCOFIndicators.jsp?domedia=1&mid=2F5CB0D2-19B9-E0B5-D44BE3ECD0B4AB42) on potential COF indicators, NICE.  HSCIC feedback report to NICE for COF indicator 5.9. |
| **Potential issues** | Data is currently only available for NHS trusts and a small amount of private/independent providers.  Due to the linear nature of the attribution method, apportioning both the numerator and denominator to a CCG will result in the same indicator percentage calculation as the actual provider figures. It may be more accurate to simply inform the CCGs of the overall VTE assessment performance for their main providers.  Potential issues relating to the attribution method issues explained previously. |

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| **Indicator** | **5.5 Admission of full-term babies to neonatal care**  ***(Original Application)*** |
| **Rationale** | 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 (e.g. failure to recognise risk of preterm birth, a safety issue if inappropriate place of birth was chosen.) * Quality of antenatal care (e.g. 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 (e.g. 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. |
| **Construction and data source** | **Data source**: Hospital Episode Statistics  Proportion of full term babies (gestation 37 weeks) admitted to hospital  **Denominator:** Collected from birth notification records  **Numerator**: Where length of gestation >= 37 weeks, Episode type = 3,6, Episode Status = 3, Episode order = 1, Neonatal care = 1,2,3, |

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Proposed change tabled 25th May

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| **Indicator** | **5.5 Admission of full-term babies to neonatal care**  *(discussed 25/5/12)* |
| **Construction and data source** | *Original Denominator:*The number births where gestation period is greater than 36 weeks. Data source HES  **Proposed Revised Denominator:** The number of births where gestation period is greater than 36 weeks. **Data source ONS.**  **Numerator** The number of admissions to neonatal care where gestation period is greater than 36 weeks (full term). Data source HES. |
| **Rationale for Change** | HES does not capture all births in England. It has been proposed that ONS data is used as the denominator to increase the coverage. ONS link birth registrations to birth notifications an analyse births by gestational age and ethnicity. |
| **Potential issues** | * The ONS linkage rate is very high, 99.9% for England and Wales from 2007 to 2009 (most recently available data). * Gestation period coverage is not as complete in HES as in the ONS data. |

HES data:

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| Year | Total births | Gestation period not recorded | % not recorded |
| 2010/11 | 668,195 | 107,120 | 16.03% |
| 2009/10 | 632,714 | 110,626 | 17.48% |
| 2008/09 | 652,638 | 192,605 | 29.51% |
| 2007/08 | 649,837 | 319,690 | 49.20% |
| 2006/07 | 629,207 | 336,078 | 53.41% |

For 2009, 1.0% of ONS linked records did not have gestation period recorded.

* The ONS data is not as timely as HES. ONS data for 2010 will be available in autumn 2012. Finalised HES data for 2011/12 will be available close to this time.

It has not been decided whether calendar or financial years will be used for this indicator.

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| **Update on recommendations made at MRG 25th May** |
| Rec 2012/79  As there is a disparity between the proposed sources in the data quality of the gestation period it would be appropriate to remove the gestation filter from the numerator. Tests should be run to investigate the impact of this. The data quality may vary between providers causing greater problems at lower geographies.  If this change was made the name of the indicator would need to change. |
| **Update:**  **Data source has been changed** |
| Rec 2012/80  The proposed denominator is data from different sources linked using NHS number. It is therefore possible to link this data to HES aligning the quality of the data sources. This should be investigated as a long term solution. |
| **Update**  **Data source has been changed** |

**UPDATES TO INDICATOR 5.5 ADMISSIONS OF FULL-TERM BABIES TO NEONATAL CARE:** 26th OCTOBER 2012:

Following discussion relating to the completeness of HES data (as outlined above), a new data source is being proposed for the indicator numerator.

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| **Construction and data source** | **Numerator:**  Number of full term babies (gestation 37 weeks) admitted within 28 days of birth  Data source: National Neonatal Research Database for years 2010 onwards.   * Live born term infants, born greater than and equal to 37+0 weeks gestational age, admitted to neonatal units in England (first admission only) * Admitted within 28 days of birth * Level of care of day of first admission is either 1, 2 or 3 only |
| **Rationale for Change** | For 2010 the national neonatal database had 98.3% coverage of admissions to neonatal care in England and in 2011 this figure was 100%. Alongside this, 99.6% of records in the audit have a valid gestational age. This is much improved on the completeness of HES. |
| **Potential issues** | There is a possibility an infant (especially a term infant) will be admitted to a paediatric ward rather than a neonatal unit and may only receive care there, thus never entering the database. |

**INDICATOR 1a *Potential Years of Life Lost (PYLL) from causes considered amenable to health care* for use in Commissioning Outcomes Framework (COF)**

**Previous discussions for NOF (24/7/12):**

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| **Indicator** | **NHSOF 1a – Potential Years of Life Lost (PYLL) from causes considered amenable to health care**  *(Discussed 24/7/12)* |
| **Rationale** | This indicator has been chosen to capture, at a high level, how successfully the NHS is meeting its objective in preventing people from dying prematurely where it can make a difference. This approach requires the definition of amenable mortality to be up to date in terms of the capabilities of current interventions. The recent ONS ‘National Statistics’ definition of amenable mortality comprises a list of causes of death from which “all or most deaths could be avoided through good quality health care”. |
| **Construction and data source** | **Denominator:** Resident population of relevant age group and gender.  Source: ONS  **Numerator:** Number of registered deaths from causes considered amenable to health care (List of ICD-10 code in Appendix 1) Source: ONS Mortality File  Age-specific life expectancy for the relevant age-group and gender.  **Source: ONS**  **Construction**: It is expressed as the PYLL per 100,000 subject population.  European age-standardised  where: *i* is the age group (<1, 1-4, 5-9, 10-14… 70-74, 75-79, 80-84, 85+). *di*is the observed number of deaths in the relevant subject population age group *i*  *ai* is the average residual life expectancy of age group *i*.  *ni* is number of individuals in the subject population in age group *i*.  *wi* is the number, or proportion, of individuals in the standard population in age group *i*.  A methodology for calculating confidence intervals has yet to be proposed. |
| **Potential issues** | 1. The data will not include deaths under 28 days which are not coded by ICD10 classification 2. Risk of perverse incentive that the NHS may give priority to younger patients   ***DH Response:*** *it is not the intention that PYLL for amenable causes be reduced by interfering with clinical prioritisation in the treatment of any specific disease (for example by prioritising younger sufferers), but rather to focus additional effort on diseases within the basket that tend to strike at younger ages. Having life expectancy at 75 as an indicator will also mitigate this.*   1. An assumption is made that people with 'amenable' conditions should expect to live as long as the general population 2. Interpretation of trends - if PYLL changes is this because the number of lives lost has changed or because the background life expectancy has changed? 3. Which is the appropriate life expectancy to use at local level? 4. All other things being equal, if Life expectancy continues to rise the PYLL rate will rise also, so we are 'chasing a moving target'.   ***DH response*** *- Note that in each case there is an underlying tendency for PYLL to rise consequential to the projected rise in life expectancy: thus sustained downtrends must reflect an outweighing of this tendency by sustained improvements in factors driving better outcomes*   1. The European Standard Population might not be the most appropriate population to standardise by. |

**Table** : The definition is in terms of a) the list of causes considered amenable and b) the calculation method (Source: ONS)

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| **ICD–10 codes** | **Condition group and cause** | **Ages included** |
| **Infections** |  |  |
| A15–A19, B90 | Tuberculosis | 0–74 |
| A38–A41, A46, A48.1, B50–B54, G00, G03, J02, L03 | Selected invasive bacterial and protozoal infections | 0–74 |
| B17.1, B18.2 | Hepatitis C | 0-74 |
| B20-B24 | HIV/AIDS | All |
| **Neoplasms** |  |  |
| C18–C21 | Malignant neoplasm of colon and rectum | 0–74 |
| C43 | Malignant melanoma of skin | 0–74 |
| C50 | Malignant neoplasm of breast | 0–74 |
| C53 | Malignant neoplasm of cervix uteri | 0–74 |
| C67 | Malignant neoplasm of bladder | 0–74 |
| C73 | Malignant neoplasm of thyroid gland | 0–74 |
| C81 | Hodgkin’s disease | 0–74 |
| C91, C92.0 | Leukaemia | 0–44 |
| D10–D36 | Benign neoplasms | 0–74 |
| **Nutritional, endocrine and metabolic** |  |  |
| E10–E14 | Diabetes mellitus | 0–49 |
| **Neurological disorders** |  |  |
| G40–G41 | Epilepsy and status epilepticus | 0–74 |
| **Cardiovascular diseases (CVD)** |  |  |
| I01–I09 | Rheumatic and other valvular heart disease | 0–74 |
| I10–I15 | Hypertensive diseases | 0–74 |
| I20–I25 | Ischaemic heart disease | 0–74 |
| I60–I69 | Cerebrovascular diseases | 0–74 |
| **Respiratory diseases** |  |  |
| J09–J11 | Influenza (including swine flu) | 0–74 |
| J12–J18 | Pneumonia | 0–74 |
| J45– J46 | Asthma | 0–74 |
| **Digestive disorders** |  |  |
| K25–K28 | Gastric and duodenal ulcer | 0–74 |
| K35–K38, K40–K46, K80–K83, K85,K86.1-K86.9, K91.5 | Acute abdomen, appendicitis, intestinal obstruction, cholecystitis / lithiasis, pancreatitis, hernia | 0–74 |
| **Genitourinary disorders** |  |  |
| N00–N07, N17–N19, N25-N27 | Nephritis and nephrosis | 0–74 |
| N13, N20–N21, N35, N40, N99.1 | Obstructive uropathy & prostatic hyperplasia | 0–74 |
| **Maternal & infant** |  |  |
| P00–P96, A33 | Complications of perinatal period | All |
| Q00–Q99 | Congenital malformations, deformations and chromosomal anomalies | 0–74 |
| **Injuries** |  |  |
| Y60–Y69, Y83–Y84 | Misadventures to patients during surgical and medical care | All |

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|  | **Recommendations made at MRG 27th July 2012** |
| Rec 2012/133 | MRG suggested publishing contextual information alongside this indictor such as mortality rates and life expectancy changes. |
| Rec 2012/134 | MRG acknowledged *that there may be issues if a local level breakdown of the indicator is produced.* Which life expectancies are most appropriate to use in this case needs to be clarified, particularly if the indicator is ever used for resource allocation purposes. This will be revisited if and when a local breakdown is required. |
| Rec 2012/135 | MRG suggested looking at the methodology for calculating confidence intervals that is used in the Compendium as a starting point for the confidence interval methodology for this indicator. Daniel Eyres also has a lot of experience with this and may be able to offer advice. |
| Rec 2012/136 | MRG noted that long term conditions are not always recorded in death registrations and this might affect the interpretation of the indicator. For example, it is well known that diabetes is under recorded on death certificates. This issue may be particularly problematic if a breakdown of the indicator by condition is produced.  MRG asked for an equivalent table to the one presented in the Table (above) for this indicator but showing causes which are non-amenable to health care. |

**Queries raised by IC colleagues working on Commissioning Outcomes Framework relating to the calculation of this indicator at CCG level:**

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| **Indicator** | **COF 1a – Potential Years of Life Lost (PYLL) from causes considered amenable to health care** |
| Construction Issues | **Denominator:** Resident population of relevant age group and gender.  Source: ONS   * ONS mid-year population estimates has been used for NHSOF. * **CCG registered population** has been used for other indicators which will result in **mismatch** between numerator (based on ONS population estimates) and denominator. An age and sex breakdown is required.   **Numerator:** Number of registered deaths from causes considered amenable to health care (List of ICD-10 code in Appendix 1)  Source: ONS Mortality File   * Annual ONS Avoidable Mortality for England is currently only published at a national level, with certain breakdowns (age, gender condition).   **Age-specific life expectancy for the relevant age-group and gender.**  Source: ONS  This is problematic, as these are currently only available at a national level. Although life expectancy at birth is available at a lower level, **the calculation relies on having a life expectancy for each cohort (<1, 1-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85 +).** *MRG were explicit in saying that subnational breakdowns should not be calculated from the national life expectancies.* |

**Response received from DH setting out a case for using national age-specific Life Expectancies to calculate the disaggregation’s for indicator 1a (see below), for MRG to consider.**

Case for using national age-specific life expectancies as weights to calculate local disaggregation’s of NHS Outcomes Framework indicator 1a – PYLL from causes considered amenable to health care.

The Department of Health proposes using national life expectancies to calculate local disaggregation’s of NHS Outcomes Framework indicator 1a - PYLL from causes considered amenable to health care. The justification for this is as follows:

1. Lower life expectancy in areas with higher PYLL is in part attributable to the higher PYLL itself; use of local life expectancies would thus understate the gain arising from avoiding these deaths - this would tend to understate the gain from reducing inequality in outcomes.
2. Nevertheless, we would need a caveat that the use of national LEs will overstate the life year gains from reduced mortality in deprived areas, because the differences in life expectances are attributable to higher PYLL only in part - differences in non-amenable mortality must also play a part. A more sophisticated measure could be devised but so long as CCG comparisons in PYLL are not being used to imply poorer health care performance cross-sectionally, such sophistication is probably not warranted.
3. There is a precedent in the Years of Life Lost indicators published by the Compendium of Public Health Indicators (NCHOD) on the NHS IC indicator portal – these are published at local level for a variety of causes and use the same fixed weights for all geographies (75 minus age at death).
4. Age-specific Life Expectancies are not currently available at LA or CCG level [awaiting ONS confirmation?]

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| **Indicator** | **NOF 3.6 - The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services**  *(discussed 21/9/12)* |
| **Rationale** | The indicator is part of domain 3 of the set of NHS Outcome indicators. This domain reflects the importance of helping people to recover from episodes of ill health or following injury. This can be seen as two complementary objectives: preventing conditions from becoming more serious (wherever possible) and helping people to recover effectively.  This indicator measures people who are recovering effectively. It measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services. The aim is to provide an indication of the number of older people offered reablement and of them how many were still at home 91 days after discharge as an approximation of a successful outcome.  Previously, the indicator focussed on the success of the reablement service only. The indicator is now a two-part measure to reflect both the effectiveness of rehabilitation and the coverage of the service. This will avoid past situations where an area scores well on the measure having offered reablement to only a very small number of people. The two parts of the indicator are:  i) the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services and,  ii) the proportion of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital.  The first part of the measure refers to the proportion of people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting) who are at home (or in extra care housing or an adult placement scheme setting) three months after the date of their discharge from hospital.  The second part refers to the proportion of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital. This measure will take the denominator from part i) as its numerator (the number of older people offered rehabilitation services). The new denominator will be the total number of older people discharged from acute or community hospitals based on Hospital Episode Statistics (HES). |
| **Data Source** | Denominator:   1. Adult Social Care Combined Activity Return (ASC-CAR) table I1 2. Hospital Episode Statistics   Numerator: Adult Social Care Combined Activity Return (ASC-CAR) table I1 |
| **Construction and data source** | The indicator is a two-part measure.  **Part 1: The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services.**  Denominator: Number of older people discharged from acute or community hospitals   * to their own home or * to a residential or nursing care home or extra care housing for rehabilitation,   with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting).  Numerator: Number of older people discharged from acute or community hospitals   * to their own home or * to a residential or nursing care home or extra care housing for rehabilitation,   with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital.  This should only include the outcome for those cases referred to in the denominator.  Those who are in hospital or in a registered care home (other than for a brief episode of respite care from which they are expected to return home) at the three month date and those who have died within the three months are not reported in the numerator.  **Part 2: The proportion of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital**  Denominator: Total number of people, aged 65 and over, discharged alive from hospitals in England between 1 October 2011 and 31 December 2011. This includes all specialities and zero-length stays. Data for geographical areas is based on usual residence of patient.  Numerator: (as Denominator Part 1) Number of older people discharged from acute or community hospitals   * to their own home or * to a residential or nursing care home or extra care housing for rehabilitation,   with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting).  Data for both numerators have been published by the HSCIC. This was previously NI125 in CLG’s National Indicator List and the latest data (along with historical data) are available at http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/social-care-and-mental-health-indicators-from-the-national-indicator-set--2010-11-final-release. It will continue to be available annually  Reporting period – Annual  Reporting type – No adjustment or standardisation  Indicator format: Percentage (numerator/denominator)  See ‘Additional information’ for worked examples of calculating both parts of the indicator. |
| **Potential issues** | The indicator includes older people who had received a joint multi-disciplinary assessment prior to or following their discharge from hospital before going on to receive a rehabilitation service and people who had received reablement services through ASC only. It does not include people who receive reablement from NHS services only because these people are not captured by the LA data collection. |
| **Additional information** | Calculating the indicator: A worked example  Part 1:  Suppose the number of people aged 65+ on discharge and who were discharged and benefited from intermediate care/ rehabilitation still living at home 3 months after discharge = 217.  And if the number of people discharged from hospital aged 65+ and entering into joint ‘intermediate care’ or a ‘rehabilitation service’ = 306.  Therefore, the percentage achieving independence = (217 /306) x 100 = 70.9%  Part 2:  If the number of people discharged from hospital aged 65+ and entering into joint ‘intermediate care’ or a ‘rehabilitation service’ = 306 (using same figure as above)  And if the total number of people aged 65+ discharged from hospital = 6,857  Then, the proportion offered reablement services = (306/6,857) x 100 = 4.5%  Definitions: Rehabilitation/re-enablement services  People should be included in the table of return I1 if they have been provided, on discharge from a hospital, with a rehabilitation/re-enablement service AND who;   * Would otherwise face an unnecessarily prolonged stay in acute in-patient/community hospital care, or be permanently admitted to long term residential or nursing home care, or potentially use continuing NHS inpatient care; and * Have a planned outcome of maximising independence and enabling them to resume living at home; and * Are provided with care services on the basis of either a joint assessment from NHS and social care services or an assessment from social care services only, resulting in * an individual support plan that involves active therapy, treatment or opportunity for recovery. * Are to receive short-term rehabilitative interventions, typically lasting no longer than 6 weeks, and frequently as little as 1-2 weeks or less.   Therefore, on the basis of a joint, multi-disciplinary assessment or an assessment from social care services only prior or following their hospital discharge, the patient will subsequently have received services specifically aimed at rehabilitation/re-enablement and the patient’s return to living at home. It requires inputs commissioned/provided by the NHS and/or the CASSR to re-enable or rehabilitate the patient so that they can continue to live at home, with or without the on-going need for support by formal care staff.  Rehabilitation/re-enablement should not solely comprise of the provision of, for example, an item of equipment, wound nursing or provision of meals on wheels or getting up / putting to bed services, nor simply restarting of service(s) already in place at the time of admission to hospital unless the service(s) were specifically intended to provide rehabilitative/reenablement support.  The data collection covers both residential and non-residential 'rehabilitation/re-enablement services'.  ASCOF publication on the Indicator Portal; September 2012 |

**UPDATES TO INDICATOR 3.6 - The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services:** 26th OCTOBER 2012:

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| **Indicator** | **NOF 3.6 - The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services** |
| Rec 2012/254 | MRG recommended that deaths should be excluded from the denominator as well as the numerator in part one of the indicator |
|  | **Update**  DH comment:  We do not agree with this. An indication of a successful reablement is that the individual has not died within 91 days of discharge into reablement. For this reason, we include all people offered reablement (including people who died during the 91 day period) in the denominator but do not include them in the numerator (as we measure success of reablement services). |
| Rec 2012/255 | MRG also seeks clarification on the exclusions and their extent – e.g. people residing out of areas, not knowns. |
|  | **Update**  DH comment:  People included are older people aged 65+ on discharge from hospital who:  - Would otherwise face an unnecessarily prolonged stay in acute in-patient care, or be permanently admitted to long term residential or nursing home care, or potentially use continuing NHS in-patient care;  - Have a planned outcome of maximising independence and enabling them to resume living at home;  - Are provided with care services on the basis of a multi-disciplinary assessment or an assessment from social care services only resulting in an individual support plan that involves active therapy, treatment or opportunity for recovery (with contributions from both health and social care, or social care only);  - Are to receive short-term interventions, typically lasting no longer than 6 weeks, and frequently as little as 1-2 weeks or less.  **People excluded:**  - Rehabilitation/re-enablement services following hospital discharge which are provided solely by health with social care consideration of needs in the assessment/care planning process. (PCTs may wish to collate evidence on such activity and its outcomes for local consideration)  - continuing care services provided solely by health  - palliative / end of life care  A hospital discharge is defined as an individual who has been formally admitted to hospital (not simply an attendance at A and E or outpatients) and then discharged. The length of time between admission and discharge will vary from a few hours (e.g. in a clinical decision unit) to days or weeks.  If an individual has had more than one discharge to rehabilitation/re-enablement services during the reporting period, then each discharge is included. If they also have multiple reviews then the correct review is also attached to each discharge.  The number of discharges is collected during the period 1 October to 31 December. These people are then contacted during the period 1 January to 31 March to see if they are still living at home. This could be done via a formal process such as a review or could be done informally, e.g. via a telephone call to the service user.  Discharges of those aged 65 and over from both acute and community hospitals should be included (discharges from psychiatric units and EMI units should be excluded). Councils and NHS partners may, however, want to extend the local reporting process to cover these discharges and / or instances where a joint rehabilitation plan is arranged to avoid admission to hospital.  Living at home is defined as those people living in their own home in the community, including in extra care housing or an adult placement scheme setting. Those people who are in hospital (other than for a brief episode of care from which they are expected to return home) or are in a registered care home (other than for a brief period of respite care from which they are expected to return home) are not considered to be living at home.  If there are discharges where social services have no details of the person 91 days after discharge, e.g. the person is not listed on the social care records or on the books to receive social care services, then social services have to use a variety of methods to trace these cases.  For example:  - social care records  - patient registrations from Primary Care Trusts  - address details from GPs  - benefits data from housing team  - details of deaths from local Registrars  For discharges where the person cannot be traced after 91 days, **they should be included in the denominator, but not in the numerator.**  Information is from IC 2012 guidance on ASC Combined Activity Returns (ASC-CAR)  http://www.ic.nhs.uk/webfiles/Services/Social\_care/Collections\_201112/ASC-CAR/ASC\_CAR\_Guidance\_2011\_12\_v1.0.pdf |
| Rec 2012/256 | Feedback is to be sought from HES/Social Care/Policy teams as to whether the denominator can be better defined to make it more related to population covered in part one of the indicator. |
|  | **Update**  DH comment:  We agree in theory but in practice this is not possible due to lack of data. We already tried to do this!  The original indicator was only part 1 of the current indicator and therefore did not provide any information on coverage. It did not tell us whether there was sufficient capacity locally to support all who could benefit from rehabilitation/reablement; e.g. Hertfordshire’s below average ‘success rate’ of 78.4% represents 3,330 individuals regaining independence, while York’s 100 per cent ‘success rate’ only benefitted 10 people.  To mitigate this, we incorporated the extent to which local councils offer reablement services. The ideal measure would be the number of people still at home after 91 days out of the total number who should have entered reablement. However, this is not possible from existing data sources.  Several alternative proposals were investigated and adding a separate indicator that measures the proportion of older people offered reablement services following discharges from hospital during the same period was considered the best. Creating this additional indicator to be used alongside the original indicator could **contextualise** the success rate of the reablement services relative to the capacity of the councils in offering these services. There was never the intention to achieve 100% in this additional sub-indicator as we acknowledge that not all hospital discharges need reablement. |

**Commissioning Outcomes Framework (COF)**

**Diabetes Indicators**

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| **Indicator** | **COF 2.61 (IAP00084) – Rates of complications associated with diabetes**  *(discussed 9/8/12)* |
| **Construction and data source** | **Data source:** HES, National Diabetes Audit (NDA) and GP Population Data  **Indicator definition**: Rates of complications associated with diabetes  NDA complication types are diagnoses or procedures as follow:   * Ketoacidosis * Angina * Myocardial Infarction * Cardiac Failure * Stroke * Diabetic Retinopathy treatments * Renal Failure * Amputation minor * Amputation major   ICD-10 and OPCS-4 codes are provided  Indicator will be reported annually (April to March). This indicator will be a rate.  **Denominator:** Number of people with diabetes collected by the NDA from Primary and / or Secondary Care  **Numerator:** Number of people identified by NDA in the denominator with a HES record of NDA complications using (a) ICD-10 primary or secondary diagnosis codes (see below) or (b) OPCS-4 procedure codes |
| **Rationale** | The indicator is based on a NICE Quality Standard (refer to section 3, Evidence Base) and has been identified by the NICE COF Advisory Committee for use in the Commissioning Outcomes Framework.  NDA reports on complications prevalence in the NDA diabetes population annually, this is available publicly via the HSCIC website.  This indicator is considered useful in measuring the quality of commissioning for people with diabetes. |
| **Potential issues** | 1. Complication    1. prevalence is defined as the number of people who have had one or more records of a specific complication over the defined time period    2. incidence is defined as the total number of times a specific complication has occurred within the defined time period   Clarify whether to count people with complications irrespective of number, or count of incidents (which theoretically could return a higher numerator than denominator)   1. Complications incidence cannot be provided for renal failure, cardiac failure and angina. |

**Recommendations Update COF 2.61 (IAP00084)**

Rec 2012/40

Further investigation of death rates connected to myocardial infarction is required to confirm this is not impacting on results.

**Update**

Indicator will be constructed as follows

Cohort: Patients in the 2009/10 NDA alive on 31st March 2010

Numerator: Number of patients with one or more of the complications during follow up period 1st April 2010 to 31st March 2011

Denominator: Number of patients in cohort

This removes the survivor bias we were seeing in the indicator – restricted pre-published numbers will be discussed at the meeting.

Rec 2012/41

MRG recommended that an exercise take place to verify the number of instances where NDA/HES items don’t match, e.g. where missing NHS number

Update

NDA has NHS Number as a mandatory item; complete NHS numbers are verified and validated through Open Exeter as well formed and belonging to the individual.

Rec 2012/42

MRG recommended that a review of whether there is a necessity for age standardisation take place, for instance is the complication connected to age profile, with a risk model built as appropriate.The NDA team have indirectly standardised these rates for publication as these complications are strongly associated with age, as is diabetes.

For the calculation of COF indicators, we propose to apply Direct Standardisation for Age and Sex, in line with the decision for other COF indicators.

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| **Indicator** | **COF 1.24 Myocardial infarction, stroke and end stage kidney disease in people with diabetes**  *(discussed 21/9/12)* |
| **Rationale** | The indicator supports the NHS Outcomes Framework and has been identified by the NICE COF Advisory Committee for use in the Commissioning Outcomes Framework.  “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.”  This indicator is considered useful in measuring the quality of commissioning for people with diabetes.  The NDA MI, stroke and end stage kidney disease complications indicator was developed to assess the complication rates in the diabetic population. |
| **Data Source** | NDA and HES |
| **Construction and data source** | **Definition: See 2.61**  Indicator will be reported annually for the audit period.  This indicator will be a rate.  **Denominator**: Number of people with diabetes identified by the NDA.  **Numerator**: Number of people collected by the NDA who have a HES primary or secondary diagnosis during the reporting period of MI, stroke or end stage kidney disease.  A list of NHS numbers of patients with diabetes will be provided by NDA and matched to HES data. Anyone with a primary or secondary diagnosis on the list below is identified. |
| **Potential issues** | 1. See 1.24 2. For primary care, participation in the NDA is voluntary. The NDA 2010-2011 achieved 82.8% participation rate for 6,774 GP Practices in England and reported on 2,150,634 patients. For secondary care, participation in the audit is mandatory under the NHS Standard Contract. In the NDA 2010-2011, 75 secondary care units submitted data. |
| **Additional Information** | ICD-10 Codes  Myocardial infarction   * 1. - I21.0 Acute transmural myocardial infarction of anterior wall   2. - I21.1 Acute transmural myocardial infarction of inferior wall   3. - I21.2 Acute transmural myocardial infarction of other sites   4. - I21.3 Acute transmural myocardial infarction of unspecified site   5. - I21.4 Acute subendocardial myocardial infarction   6. - I21.9 Acute myocardial infarction, unspecified   7. - I22.0 Subsequent myocardial infarction of anterior wall   8. - I22.1 Subsequent myocardial infarction of inferior wall   9. - I22.8 Subsequent myocardial infarction of other sites   10. - I22.9 Subsequent myocardial infarction of unspecified site   Stroke   * 1. - I61.0 Intracerebral haemorrhage in hemisphere, subcortical   2. - I61.1 Intracerebral haemorrhage in hemisphere, cortical   3. - I61.2 Intracerebral haemorrhage in hemisphere, unspecified   4. - I61.3 Intracerebral haemorrhage in brain stem   5. - I61.4 Intracerebral haemorrhage in cerebellum   6. - I61.5 Intracerebral haemorrhage, intraventricular   7. - I61.6 Intracerebral haemorrhage, multiple localized   8. - I61.8 Other intracerebral haemorrhage   9. - I61.9 Intracerebral haemorrhage, unspecified   10. - I63.0 Cerebral infarct due to thrombosis of precerebral arteries   11. - I63.1 Cerebral infarction due to embolism of precerebral arteries   12. - I63.2 Cereb infarct due unsp occlusion or stenos precerebrl arts   13. - I63.3 Cerebral infarction due to thrombosis of cerebral arteries   14. - I63.4 Cerebral infarction due to embolism of cerebral arteries   15. - I63.5 Cerebrl infarct due unspec occlusion or stenos cerebrl arts   16. - I63.6 Cereb infarct due cerebral venous thrombosis, nonpyogenic   17. - I63.8 Other cerebral infarction   18. - I63.9 Cerebral infarction, unspecified   19. - I64.X Stroke, not specified as haemorrhage or infarction   20. - I67.9 Cerebrovascular disease, unspecified   Renal failure   * 1. - N18.0 End-stage renal disease   2. - Z49.0 Preparatory care for dialysis   3. - Z49.1 Extracorporeal dialysis   4. - Z49.2 Other dialysis   5. - Z99.2 Dependence on renal dialysis   6. - M01.1 Autotransplantation of kidney   7. - M01.2 Allotransplantation of kidney from live donor   8. - M01.3 Allotransplantation of kidney from cadaver NEC   9. - M01.4 Allotransplantation of kidney from cadaver heart-beating   10. - M01.5 Allotransplantation of kidney from cadaver non-heart-beating   11. - M01.8 Transplantation of kidney, Other specified   12. - M01.9 Unspecified transplantation of kidney |
| **Sample data** | NOTE: This provisional NDA analysis suggests that the data can support the construction of this indicator. |

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| **Recommendations Update COF 1.24 – Myocardial infarction, stroke and stage 5 chronic kidney disease in people with diabetes** |
| Rec 2012/  MRG noted that this indicator overlapped with COF 2.61 – Complications associated with diabetes as it had earlier been agreed that 2.61 would be a composite indicator covering multiple conditions, rather than a separate indicator for each complication. MRG recommended that it be reviewed whether or not both indicators needed to be included. MRG suggested providing a breakdown by condition of the composite indicator 2.61 as contextual information should be investigated. |
| **Update:**  The method for this indicator is the same as that for indicator 2.61, however this indicator is more likely to have small number issues as it only looks at 3 types of complications. |

**Commissioning Outcomes Framework (COF)**

**Maternity Indicators**

Distributed for comment 10/10/12

**General Information:**

* Where calculated, the indicators presented in the paper are calculated within the collection systems as the numerator and denominator are entered by the PCT; they are being included in the COF and as such we are being asked to provide the mechanism to forward the data on to the CQRS system as part of the package of COF data.
* Two of the indicators are also in the Public Health Outcomes Framework, items 1.27 and 1.29
* The definition of 'maternities' used in these indicators is
* "the number of women in the relevant population who give birth to one or more live of still born babies of at least 24 weeks gestation where the baby is delivered by either midwife of a doctor and the place of delivery is either at home or in an NHS hospital (including GP units). Exclude all maternities that occur in either psychiatric or private beds/ hospitals." (Source: Vital Signs Monitoring Return)
* Since the last MRG meeting (10th October) DH have informed us that item 1.28 Breast Feeding Initiation is no longer in scope for inclusion in the COF, hence it has been removed from this paper

**Comments received from MRG members via correspondence (MRG 10th Oct 2012):**

*COF 1.25 Antenatal assessments <13 weeks*

* I assume that a denominator is collected relevant to this, and this needs to be defined (it appears in the table).
* Greater clarity is required around the treatment of incomplete pregnancies – maternal deaths, stillbirths, abortions etc.
* Greater clarity is required around the treatment of those who did not see anyone until giving birth.
* Greater clarity is required around the precise time periods covered – I can see that, in a quarter, if someone has been seen for assessment one can determine whether this is within 12 weeks and 6 days (subject to the uncertainties already mentioned), but this needs to be set in the context of a denominator, and it is not clear what that denominator is and what time period it relates to or should relate to.

*COF 1.27 Maternal smoking at delivery*

*COF 1.29 Breast feeding prevalence at 6-8 weeks*

* I don’t think we should be signing off something which is a ratio of forecasts unless we have seen and approved the forecast methodology (or is the reference to forecasts in ‘additional information’ only intended as contextual information for us, rather than underpinning a calculation?).
* **Update:** The reference to forecasts is contextual information as to what the PCT is required to submit; only the actual figures are used in calculation of the indicators.

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| **Indicator:** | **COF 1.25 Antenatal assessments <13 weeks** |
| **Rationale** | The indicator has been identified as one which supports the NHS Outcomes Framework for use in the Commissioning Outcomes Framework.  All women should access maternity services for a full health and social care assessment of needs, risks and choices by 12 completed weeks of their pregnancy to give them the full benefit of personalised maternity care and improve outcomes and experience for mother and baby. |
| **Data Source** | DH Unify2 data collection – IPMR. |
| **Construction and data source** | The indicator is established and currently reported as a stand-alone figure at PCT level. As of April 2013, it will be reported at CCG level.  Number of women in the relevant PCT population who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 weeks and 6 days of pregnancy.  **Reporting period:** Quarterly.  **Reporting type:** Number.  **Standardisation:** N/A.  **Available at CCG reporting level:** As of April 2013. |
| **Ref Docs** | Reference: [Consultation](http://www.nice.org.uk/aboutnice/cof/ConsultationOnCOFIndicators.jsp?domedia=1&mid=2F5CB0D2-19B9-E0B5-D44BE3ECD0B4AB42) on potential COF indicators, NICE  HSCIC feedback report to NICE for COF indicator 1.25 |
| **Potential issues** | This indicator is well established at PCT level. It is yet to transition to CCG level, which may impact on completeness of the collection.  We understand from the Commissioning Analysis & Intelligence team at DH that this collection will transition to a CCG level collection from April 2013. |
| **Additional Information** | **Detailed Definitions**  Pregnancy – Pregnancy is defined as all maternities regardless of outcome, excluding those where care is provided outside an NHS setting.  **In the relevant** PCT population **-** This refers to the PCT of the GP the woman is registered with. Where a woman is not registered with a GP, the woman's postcode of residence should be used.  Seen – This means completion of a full assessment; this may occur over multiple sessions but will be measured by the completion of the final session not the initiation of the first.  Midwife – To qualify as a midwife in this definition the person must hold current registration with the nursing and midwifery council and being in active employment as a midwife with the NHS.  Maternity healthcare professional – This is a description which covers obstetricians and general practitioners with current registration with the General Medical Council and working for the NHS providing maternity services.  12 weeks and 6 days – this relates to the measured gestation of the pregnancy and is the cut-off point for measurement against the Indicator. The most valid approach is to use gestational age as calculated by ultrasound assessment, but it is recognised that the ultrasound calculation of gestation is not always available at the time of assessment of needs, risk and choices. The gestational age at completion of assessment may therefore be estimated from the date of completed assessment and the Estimated Date of Delivery (from clinical estimation/LMP or scan).  Health and Social Care assessment of needs, risks and **choices** is defined as an antenatal care “booking visit” where the handheld maternity record is completed. This must include:   * Information provided on the choice of type of antenatal care as in 'Maternity Matters'; * Antenatal information, checks and tests described in the NICE antenatal care guidance of March 2008 including:   - vitamin D supplements  - screening for risk factors of gestational diabetes  - maternal height and weight; body mass index calculated  - screening questions for depression and other mental disorders  - offer of screening for anaemia  - offer of early ultrasound scan for gestational age assessment   * Assessment of incidence of domestic abuse. |

Sample Data**:**

**Number of women who have been seen by a midwife or maternity health professional**

IPMR Access to Midwifery is the collection of data to monitor women seen by a midwife or maternity health professional

January to Mar 2012

Department of Health: Unify2 data collection – IPMR

16th May 2012

[**Maternity : Department of Health - Publications**](http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Integratedperfomancemeasuresmonitoring/DH_112544)



|  |  |
| --- | --- |
| **Indicator** | **COF 1.27 Maternal smoking at delivery** |
| **Rationale** | The indicator has been identified as one which supports the NHS Outcomes Framework for use in the Commissioning Outcomes Framework.  The indicator is linked to rates of Maternal smoking in pregnancy which is due to be collected as part of the Maternity Services Data Set. Enabling comparison to be made on maternities smoking at the start of pregnancy and those not smoking at delivery is mentioned in the NICE clinical guideline: CG62 on ante-natal care; Recommendation 1.3.10.4 “Monitor smoking status and offer smoking cessation advice, encouragement and support throughout the pregnancy and beyond.” |
| **Data Source** | Omnibus. |
| **Construction and data source** | The indicator is established and currently reported at PCT level. As of April 2013, it will be reported at CCG level.  **Denominator:** Number of maternities in the relevant PCT.  **Numerator:** Number of maternities where mother recorded as smoking at delivery.  **Reporting period:** Quarterly.  **Reporting type:** Percentage rate.  **Standardisation:** Not applicable to this indicator.  **Available at CCG reporting level:** Expected as of April 2013. |
| **Ref Docs** | Reference: [Consultation](http://www.nice.org.uk/aboutnice/cof/ConsultationOnCOFIndicators.jsp?domedia=1&mid=2F5CB0D2-19B9-E0B5-D44BE3ECD0B4AB42) on potential COF indicators, NICE  HSCIC feedback report to NICE for COF indicator 1.27 |
| **Potential issues** | This indicator is well established at PCT level. It is yet to transition to CCG level, which may impact on completeness of the collection.  We understand from the Omnibus team that this collection is expected to transition to a CCG level collection from April 2013. DH have informed us that in due course, the data will be collected via the Maternity Services Data Set which is being implemented by the HSCIC. |
| **Additional Information** | Each Primary Care Trust (PCT) is required to submit actual figures for the quarter, year-to-date and forecasts for the year as a whole for the following three items:   * The number of maternities * The number of mothers recorded as smoking at delivery * The number of mothers recorded as not smoking at delivery   **Applied Filters**    **Data Validation**  All three numbers must be submitted as integers. All validation checks must be passed by PCTs/SHAs in order for the data to meet departmental statistical requirements. Where information has not passed these validation checks, this is identified in the tables in this report.  The data is checked against previous year’s data by HSCIC. Maternities figures are sent to the Health Improvement Analytical Team at Department of Health to compare against data that is collected on the number of maternities via the UNIFY system. The DH confirms the data and informs the IC if any PCTs should be followed up for more accurate data. |

Sample Data:

**Smoking status at time of delivery, by Primary Care Trust and Strategic Health Authority, 2012/13 Q1**

April-Jun 2012

Collected via Omnibus data collection system and published on the HSCIC website

30th August 2012

<http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/smoking/statistics-on-womens-smoking-status-at-time-of-delivery-england-quarter-1-2012-13>

**Number of maternities (1)**

**Mothers whose smoking status was not known (3)**

2012/13 Q1

Code

Name

No.

No.

%

95%

confidence

interval

No.

%

GEOGCD

Code

Name

SHA

St HA Name

No.

No.

%

No.

%

GEOGCD

5ND

County Durham PCT

Q30

North East

1,297

254

19.6%

17.5% - 21.8%

0

0.0%

E16000085

5J9

Darlington PCT

Q30

North East

316

70

22.2%

17.9% - 27.0%

1

0.3%

E16000041

5KF

Gateshead PCT

Q30

North East

560

91

16.3%

13.4% - 19.5%

0

0.0%

E16000050

5D9

Hartlepool PCT

Q30

North East

271

55

20.3%

15.9% - 25.5%

1

0.4%

E16000019

5KM

Middlesbrough PCT

Q30

North East

491

131

26.7%

23.0% - 30.8%

0

0.0%

E16000053

5D7

Newcastle PCT

Q30

North East

770

123

16.0%

13.6% - 18.7%

0

0.0%

E16000017

5E1

North Tees PCT

Q30

North East

575

88

15.3%

12.6% - 18.5%

13

2.3%

E16000020

5D8

North Tyneside PCT

Q30

North East

544

87

16.0%

13.2% - 19.3%

1

0.2%

E16000018

TAC

Northumberland Care Trust

Q30

North East

778

161

20.7%

18.0% - 23.7%

3

0.4%

E17000001

5QR

Redcar And Cleveland PCT

Q30

North East

353

80

22.7%

18.6% - 27.3%

0

0.0%

E16000146

5KG

South Tyneside PCT

Q30

North East

409

101

24.7%

20.8% - 29.1%

0

0.0%

E16000051

5KL

Sunderland Teaching PCT

Q30

North East

726

147

20.2%

17.5% - 23.3%

6

0.8%

E16000052

5HG

Ashton, Leigh And Wigan PCT

Q31

North West

829

144

17.4%

14.9% - 20.1%

0

0.0%

E16000032

TAP

Blackburn With Darwen PCT

Q31

North West

534

92

17.2%

14.3% - 20.7%

0

0.0%

E17000006

5HP

Blackpool PCT

Q31

North West

427

118

27.6%

23.6% - 32.1%

5

1.2%

E16000033

5HQ

Bolton PCT

Q31

North West

975

193

19.8%

17.4% - 22.4%

0

0.0%

E16000034

**Smoking at time of delivery (2)**

2012/13 Q1

2012/13 Q1

Population & Lifestyles team at HSCIC publish the data, including the 95% confidence interval on the smoking at time of delivery figure given the numbers of mothers whose smoking status was not known.

|  |  |
| --- | --- |
| **Indicator** | **COF 1.29 Breast feeding prevalence at 6-8 weeks** |
| **Rationale** | The indicator has been identified as one which supports the NHS Outcomes Framework for use in Commissioning Outcomes Framework.  Higher levels of breastfeeding initiation (delivery) and 6-8 week breastfeeding mean that more infants are receiving breast milk at those time periods. Lower drop off rates mean that less mothers are stopping breastfeeding in the period from initiation to the 6-8 week review. |
| **Data Source** | Collected as part of the Vital Sign Monitoring Return (VSMR) via the data collection tool that is part of Unify2. The figures are typically derived by PCTs from information recorded at infants’ 6-8 week check. |
| **Construction and data source** | The indicator is established and currently reported at PCT level. As of April 2013, it is expected that it will be reported at CCG level.  **Denominator:** Number of infants whose breastfeeding status was known at 6-8 weeks.  **Numerator:** Number of infants totally or partially breastfed at 6-8 weeks of age.  **Reporting period:** Quarterly.  **Reporting type:** Percentage.  **Standardisation:** N/A.  **Available at CCG reporting level:** As of April 2013. |
| **Ref Docs** | Reference: [Consultation](http://www.nice.org.uk/aboutnice/cof/ConsultationOnCOFIndicators.jsp?domedia=1&mid=2F5CB0D2-19B9-E0B5-D44BE3ECD0B4AB42) on potential COF indicators, NICE  HSCIC feedback report to NICE for COF indicator 1.28 |
| **Potential issues** | This indicator is well established at PCT level. It is yet to transition to CCG level, which may impact on completeness of the collection.  We understand from the Commissioning Analysis & Intelligence team at DH that this collection will transition to a CCG level collection from April 2013.  In the current collection, there is a high level of PCTs failing validation with less than the required level of coverage (95%) of breastfeeding at 6-8 weeks (QA, YTD or FOT). |
| **Additional Information** | For breastfeeding prevalence, each Primary Care Trust (PCT) is required to submit actual figures for the quarter and the year-to-date and forecasts for the year as a whole for the following four items:   * The number of infants due a 6–8 week check in each quarter. * The number of infants being “totally” breastfed (defined as infants who are exclusively receiving breast milk at 6-8 weeks of age - that is, they are NOT receiving formula milk, any other liquids or food). * The number of infants being “partially” breastfed (defined as infants who are currently receiving breast milk at 6-8 weeks of age and who are also receiving formula milk or any other liquids or food). * The number of infants being “not at all” breastfed (defined as infants who are not currently receiving any breast milk at 6-8 weeks of age).   **Applied Filters**    Where information has not passed these validation checks, this is identified in the tables in this report by highlighting the data. |

Sample Data:

**Breastfeeding initiation and prevalence at 6 to 8 weeks, 2012/13 Q1**

April-Jun 2012

Collected as part of the Vital Sign Monitoring Return (VSMR) via the data collection tool that is part of Unify2

30th August 2012

<http://transparency.dh.gov.uk/2012/06/26/breastfeeding-data-downloads/>



**Indicator Governance Board Meeting – 18th January 2012**

**Indicators for Appraisal**

**Batch 1 – CCGOIS Diabetes Indicators**

**Record of Assurance provided by Indicator Governance Board**

|  |  |
| --- | --- |
| **Indicator Title** | **2.4** *(COF2.52)* **Number of people with diabetes with a single marker of all nine basic care processes performed** |
| IAS Ref Code: | AP00125 |
| Construction Summary | *Denominator:* *Number of people with diabetes collected by the NDA, including registration from primary and secondary care as follows: - Registrations from primary care - diabetes patients with a GP record in the selected data. - Registrations from secondary care - diabetes patients with a secondary care record in the selected data but not a GP record.*  *Numerator: Number of people with diabetes collected by the NDA who have received all of the nine care processes listed below within the audit year as follows.*  *Risk factors:*  *1.Blood pressure (Systolic and diastolic)*  *2.Blood test (HbA1c – blood glucose levels)*  *3.Cholesterol levels*  *4.BMI and weight*  *5.Smoking review*  *Tests for early complications*  *6.Foot exam*  *7.Eye screening (retinopathy screening)*  *8.Urinary albumin test (or protein test to measure the kidney function)*  *9.Blood creatinine (indicator for renal function)*  *Results for care processes are taken from both primary and secondary care records..*  Note: Any patient under 12 only has to have had their HbA1c measured annually. Everyone aged 12 or over should have all nine care processes annually. For example, an 11 year old will only be required to have their HbA1C value tested and if this is done they will have achieved the “all care process” element. An adult aged 25 will have to have received all nine different care processes to have achieved the “all care processes” element. |
| Initial IGB discussion | 18/01/13 |

**Strategic Considerations & Implications**

|  |  |
| --- | --- |
| Applicant / Sponsor Organisation | Primary Medical Care Branch, DH  \*Costing for assurance appraisal included in development cost - YES  Assurance process funded? - NO |
| Indicator rationale | The National Service Framework for Diabetes defines nine key care processes for diabetes care; five are risk factors and four tests for early complications. These are to be monitored annually. |
| Basis for rationale  [Details of quality statement, policy etc] | The indicator is based on a NICE Quality Standard and has been identified by the NICE COF Advisory Committee for use in the CCG Outcomes Indicator Set. |
| Risks & assumptions | The National Diabetes Audit (NDA) is the only source for some of the data elements required to construct many diabetes related indicators although GPES may be able to provide much of the required information given the correct data extraction business rules. |
| IG Considerations [e.g. release of under-lying data, intermediaries’ access to data, data ownership impact on production] | *Data Source:* *National Diabetes Audit* NDA is collected by the HSCIC by automated and manual data extraction from GP Practices, using various clinical systems (Apollo, TPP SystmOne, Informatica and Miquest) via Open Exeter |
| Potential impacts on other business areas [inc outstanding generic issues] | None Identified |
| Implementation Method  [inc production funding] | Costs for the production of the CCG indicators are being included in the COF/CQRS project business case. The requirements for publication of the indicators by HSCIC is yet to be agreed with DH and the NHS Commissioning Board. |

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| **Record of MRG Discussion** |  |
| Discussion dates: | 09/08/12 |
| By: | John Varlow, Andy Sutherland, Azim Lakhani, Jonathan Hope |
| Summary of MRG discussions: | * MRG recommended that the title of the indicator should be changed to better describe the indicator, for example “Single marker of all nine basic care processes performed for patients with diabetes”. * Based on recommendations made at MRG the SDS team has confirmed the following information has been addressed in the quality statement / specification:   + documentation on why all nine processes should be performed within each year included for completeness.   + the time periods for inclusion in both the numerator and denominator made clear.   Non-response reported in the quality statement e.g. participation in the audit at CCG level. MRG also noted that further work may need to be carried out in the future on weighting the indicator to account for non-response bias |

|  |  |
| --- | --- |
| *Outcome of MRG consideration:* | 1. No significant issues identified |
| MRG statement of recommendation: | Indicator approved for escalation to Indicator Governance Board on the basis that supporting documentation is included with the quality statement to aid interpretation. |
| **Additional Assurance Details** |  |
| Peer Reviewers: | No peer review currently undertaken |
| Peer Review summary: | n/a |
| Range of input  [Have relevant business areas contributed e.g. clinical assurance?] | This indicator was developed as part of the National Diabetes Audit primary care data collection to determine the percentage of patients with diabetes who are referred to diabetes education programmes. The indicator was requested and developed in conjunction with the NDA clinical lead, Bob Young and expert clinical coders. This indicator is collected nationally as part of the NDA. |

IGB – Additional Recommendations:

[Add new section as necessary]

Review:

|  |  |
| --- | --- |
| Review Timescale | **3 years** |
| Rationale | [Issues to consider – Changes to process, policy data source, coding defintions HES definitions ]  In light of no significant issues being identified with the methodology or anticipated changes to process or data source it is recommended that the indicator be reviewed in 3 years, unless there are any changes to data collection methodologies (e.g. use of GPES). |

Record of Assurance provided by **Indicator Governance Board**

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| **Indicator Title** | **2.5** *(COF 2.53)* **People with diabetes, who have been diagnosed for less than 1 year with a structured education referral recorded.** |
| IAS Ref Code: | IAP00075 |
| Indicator Set |  |
| Construction Summary | *Denominator:* Number of patients with diabetes collected by the NDA who have been diagnosed for less than 1 year.  *Numerator:* Number of patients with diabetes collected by the National Diabetes Audit (NDA) who have been diagnosed for less than 1 year with a structured education referral recorded. |
| Initial IGB discussion | 18/01/13 |
| Further discussed | None |
|  |  |
|  |  |

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| --- | --- |
| **Strategic Considerations & Implications** |  |
| Applicant / Sponsor Organisation | Primary Medical Care Branch, DH  \*Costing for assurance appraisal included in development cost |
| Assurance process funded? | Yes |
| Indicator rationale | This has been based on the NICE Quality Standard for Diabetes.  “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 on-going education.” |
| Basis for rationale  [Details of quality statement, policy etc] | The indicator is based on a NICE Quality Standard and has been identified by the NICE COF Advisory Committee for use in the Commissioning Outcomes Framework. |
| Risks & assumptions | The National Diabetes Audit (NDA) is the only source for some of the data elements required to construct many diabetes related indicators although GPES may be able to provide much of the required information given the correct data extraction business rules. |
| IG Considerations [e.g. release of under-lying data, intermediaries’ access to data, data ownership impact on production] | *Data Source:* *National Diabetes Audit* NDA is collected by the HSCIC by automated and manual data extraction from GP Practices, using various clinical systems (Apollo, TPP SystmOne, Informatica and Miquest) via Open Exeter |
| Potential impacts on other business areas [inc outstanding generic issues] | None Identified |
| Implementation Method  [inc production funding] | Funding being sought.   * Costs for the production of the CCG indicators are being included in the COF/CQRS project business case. The requirements for publication of the indicators by HSCIC is yet to be agreed with DH and the NHS Commissioning Board. |
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| --- | --- |
| **Record of MRG Discussion** |  |
| Discussion dates: | 14/3/12, 09/08/12 |
| By: | John Varlow, Andy Sutherland, Azim Lakhani, Jonathan Hope |
| Summary of MRG discussions: | * MRG recommended indicator re-defined, which was done following the NICE COF Advisory Committee May 2012*. Originally - People with newly diagnosed diabetes who are offered structured education within 3 months of diagnosis* * Reported to MRG that although data more readily support this re-defined indicator, structured education is poorly recorded in primary care to the extent that NDA does not report figures. * It is suggested that the poor completion is due to the fact that there are no QOF points associated with the recording of this measure – for example, 90-95% of diabetes patients have a record of their blood sugar level because there is an incentive to record this information * Possibility that where a newly diagnosed patient has no record of referral but has a code of “did not attend” or “refused” structured education, it could be inferred that the education was offered, meaning these patients could be included in the numerator which has been identified in the quality statement by the SDS team. * Additionally, the SDS team has included the following in the quality statement based on MRG recommendations:   + note that low values for the indicator could be due to poor performance or poor data quality.   + that the time periods for inclusion in both the numerator and denominator should be made clear. |
| *Outcome of MRG consideration:* | **c. Some concerns expressed as caveats or limitations** |
| MRG statement of recommendation: | Indicator approved for escalation to Indicator Governance Board on the basis that limitations relating to data completeness are made available. |
| **Additional Assurance Details** |  |
| Peer Reviewers: | No peer review currently undertaken |
| Peer Review summary: | n/a |
| Range of input  [Have relevant business areas contributed e.g. clinical assurance?] | This indicator was developed as part of the National Diabetes Audit primary care data collection to determine the percentage of patients with diabetes who are referred to diabetes education programmes. The indicator was requested and developed in conjunction with the NDA clinical lead, Bob Young and expert clinical coders. This indicator is collected nationally as part of the NDA. |
|  |  |

Review: Review Timescale: Other

The introduction of a new treatment function code for structured eduction may enable calculation from CDS from 2015 which will need to be investigated. The outcome of this may present a need to review methodologies at this time.

IGB Sign-off: Not completed

Record of Assurance provided by **Indicator Governance Board**

|  |  |
| --- | --- |
| **Indicator Title** | **2.8** *(COF 2.61)* **Rates of complications associated with diabetes** |
| IAS Ref Code: | **IAP00084** |
| Construction Summary | *Denominator:* *Number of people with diabetes identified by the NDA who were alive at the start of the follow-up period*  *Numerator: Number of people identified by NDA in the denominator with a HES record of NDA complications using ICD-10 primary or secondary diagnosis codes, or primary and secondary OPCS codes.* |
| Initial IGB discussion | 18/01/13 |
| Further discussed |  |
|  |  |

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| --- | --- |
| **Strategic Considerations & Implications** |  |
| Applicant / Sponsor Organisation | Primary Medical Care Branch, DH  \*Costing for assurance appraisal included in development cost |
| Assurance process funded? | Yes |
| Indicator rationale | The indicator is based on a NICE Quality Standard and has been identified by the NICE COF Advisory Committee for use in the Commissioning Outcomes Framework.  This indicator is considered useful in measuring the quality of commissioning for people with diabetes. |
| Basis for rationale  [Details of quality statement, policy etc] | The NDA currently covers four ‘core care’ components of the National Service Framework (NSF) for Diabetes. These include:   * Registrations: * Care Processes: * Treatment Targets:   **Complications:** For people with registered diabetes what are the rates of acute and long term complications (disease outcomes)? The complications are ketoacidosis, angina, myocardial infarction, cardiac failure, stroke, end stage kidney disease treatment, diabetic retinopathy treatments, minor amputations, major amputations |
| Risks & assumptions | None Identified |
| IG Considerations [e.g. release of under-lying data, intermediaries’ access to data, data ownership impact on production] | *Data Source:* *National Diabetes Audit,* *HES/PEDW*  NDA is collected by the HSCIC by automated and manual data extraction from GP Practices, using various clinical systems (Apollo, TPP SystmOne, Informatica and Miquest) via Open Exeter.  Complications are recorded in HES/PEDW using ICD10 and OPCS-4 codes. |
|  |  |
| Potential impacts on other business areas [inc outstanding generic issues] | None Identified |
| Implementation Method  [inc production funding] | Funding being sought.   * Costs for the production of the CCG indicators are being included in the COF/CQRS project business case. The requirements for publication of the indicators by HSCIC is yet to be agreed with DH and the NHS Commissioning Board. |

|  |  |
| --- | --- |
| **Record of MRG Discussion** |  |
| Discussion dates: | 14/3/12, 09/08/12, 26/10/12 |
| By: | HSCIC - Alyson Whitmarsh, Andy Sutherland, Azim Lakhani, John Varlow, Jonathan Hope  NICE – Daniel Sutcliffe  UHB – Daniel Ray, Irena Begaj  ISB – Neil McCrirrick |
| Summary of MRG discussions: | * Exercise to verify the number of instances where NDA/HES items don’t match, e.g. where missing NHS number recommended. Reported back that NDA has NHS Number as a mandatory item; complete NHS numbers are verified and validated through Open Exeter as well formed and belonging to the individual. * MRG recommended a review of the necessity for age standardisation with a risk model built as appropriate. Final recommendation to use indirect standardisation accepted by MRG * Possibility of splitting indicator to report separately for each complication discussed but was reported that NICE had rejected this proposal. Since it is not appropriate to report incidence for chronic conditions such as angina, MRG recommended that prevalence should be reported. * Recommendation that patients with multiple complications or more than one incident of a single complication should only be counted once in the numerator, avoiding possibility of the numerator being higher than the denominator. Quality statement to make clear what is not being captured by the indicator e.g. multiple incidents of ketoacidosis, patients with multiple complications. * NDA currently audits only those patients alive at the end of the audit period, which presents a potential issue in terms of reporting complications with high mortality rates such as myocardial infarction. Recommendation that further work should be carried out to see if it is possible to identify those patients who exist in the previous audit period but not the current audit and then link to ONS death records so that those patients who die from complications e.g. myocardial infarction can be included. Noted that the IG permissions needed for this data linkage are already in place. Commented that patients with chronic conditions, such as angina, should be included in the numerator for as long as they are alive, even if they do not appear in HES with further work to be carried out to see if this is possible. * Noted that because of differences in scale of the complications, large variations where the numbers are small (e.g. major amputations) could be masked by small changes where the number of occurrences is greater (e.g. angina). This to be explained in the quality statement, along with other limitations of the indicator. * It was recommended that the denominator be changed to better reflect the period of risk. This would mean that someone alive for half the numerator time period (1 year) would be counted as 0.5, rather than 1. However, the NDA team subsequently reported that using the above methodology would lead to a disparity between the production of the indicator and that used to analyse the audit data as NDA only use ‘years at risk’ in the mortality standardisation. * Quality Statement to refer the reader / user to contextual information showing the disaggregation of rates at CCG levels by complication. This information will be available in the annual report. |
| *Outcome of MRG consideration:* | **No significant issues on basis of completion of outstanding actions** |
| MRG statement of recommendation: | * Indicator approved for escalation to Indicator Governance Board on the basis that limitations described above are outlined in the quality statement and that further analysis work in relation to the list of inclusions of chronic conditions is continued. |
| **Additional Assurance Details** |  |
| Peer Reviewers: | No peer review currently undertaken |
| Peer Review summary: | n/a |
| Range of input  [Have relevant business areas contributed e.g. clinical assurance?] |  |
|  | This NDA complications indicator, which provides NDA analysis pertaining to incidence and prevalence of complications amongst the NDA diabetes population, was developed to assess the complication rates in the diabetic population. The indicator was requested and developed in conjunction with the NDA clinical lead, Bob Young and expert clinical coders. These indicators are collected nationally as part of the NDA. |

IGB – Additional Recommendations: None

[Add new section as necessary]

Review:

3 years

In light of no significant issues being identified with the methodology or anticipated changes to process or data source it is recommended that the indicator be reviewed in 3 years, unless there are any changes to data collection methodologies (e.g. use of GPES).

IGB Sign-off:

Record of Assurance provided by **Indicator Governance Board**

|  |  |
| --- | --- |
| **Indicator Title** | **1.4** *(COF 1.24)* **Myocardial infarction, stroke and end stage kidney disease in people with diabetes** |
| IAS Ref Code: | IAP00126 |
| Indicator Set |  |
| Construction Summary | *Denominator:* Number of people with diabetes identified by the NDA.  *Numerator:* Number of people collected by the NDA who have a HES primary or secondary diagnosis during the reporting period of MI, stroke or end stage kidney disease. |
| Initial IGB discussion | 18/01/13 |
| Further discussed |  |

|  |  |
| --- | --- |
| **Strategic Considerations & Implications** |  |
| Applicant / Sponsor Organisation | Primary Medical Care Branch, DH  \*Costing for assurance appraisal included in development cost |
| Assurance process funded? | Yes |
| Indicator rationale | The indicator is based on a NICE Quality Standard and has been identified by the NICE COF Advisory Committee for use in the Commissioning Outcomes Framework. |
| Basis for rationale  [Details of quality statement, policy etc] | This indicator is considered useful in measuring the quality of commissioning for people with diabetes. |
| Risks & assumptions | * For primary care, participation in the NDA is voluntary. The NDA 2010-2011 achieved 82.8% participation rate for 6,774 GP Practices in England and reported on 2,150,634 patients. * For secondary care, participation in the audit is mandatory under the NHS Standard Contract. In the NDA 2010-2011, 75 secondary care units submitted data. * The method for this indicator is the same as that for indicator 2.8, however this indicator is more likely to have small number issues as it only looks at 3 types of complications. |
| IG Considerations [e.g. release of under-lying data, intermediaries’ access to data, data ownership impact on production] | NDA is collected by the HSCIC by automated and manual data extraction from GP Practices, using various clinical systems (Apollo, TPP SystmOne, Informatica and Miquest) via Open Exeter |
| Potential impacts on other business areas [inc outstanding generic issues] | None Identified |
| Implementation Method  [inc production funding] | Funding being sought.  Costs for the production of the CCG indicators are being included in the COF/CQRS project business case. The requirements for publication of the indicators by HSCIC is yet to be agreed with DH and the NHS Commissioning Board. |

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| **Record of MRG Discussion** |  |
| Discussion dates: | 09/08/12, 26/10/12 |
| By: | HSCIC - Alyson Whitmarsh, Andy Sutherland, Azim Lakhani, John Varlow, Jonathan Hope  NICE – Daniel Sutcliffe  UHB – Daniel Ray, Irena Begaj  ISB – Neil McCrirrick |
| Summary of MRG discussions: |  |
| *Outcome of MRG consideration:* | * MRG noted that this indicator overlapped with CCGOIS *2.8 – Complications associated with diabetes*, as it had earlier been agreed that 2.8 would be a composite indicator covering multiple conditions, rather than a separate indicator for each complication. * MRG recommended that it be reviewed whether or not both indicators needed to be included, however this approach rejected by DH.   See also 2.8 - Rates of complications associated with diabetes (IAP0084)   * Reported back that NDA has NHS Number as a mandatory item; complete NHS numbers are verified and validated through Open Exeter. * Final recommendation to use indirect standardisation accepted by MRG * Further work should be carried out to see if it is possible to identify those patients who exist in the previous audit period but not the current audit and then link to ONS death records * It was recommended that the denominator be changed to better reflect the period of risk. This would mean that someone alive for half the numerator time period (1 year) would be counted as 0.5, rather than 1. However, the NDA team subsequently reported that using the above methodology would lead to a disparity between the production of the indicator and that used to analyse the audit data as NDA only use ‘years at risk’ in the mortality standardisation. |
|  | **No significant issues on basis of completion of outstanding actions** |
| MRG statement of recommendation: | * Indicator approved for escalation to Indicator Governance Board |
| **Additional Assurance Details** |  |
| Peer Reviewers: | No peer review currently undertaken |
| Peer Review summary: |  |
| Range of input  [Have relevant business areas contributed e.g. clinical assurance?] | n/a |
|  | This indicator was developed as part of the National Diabetes Audit primary care data collection to determine the percentage of patients with diabetes who are referred to diabetes education programmes. The indicator was requested and developed in conjunction with the NDA clinical lead, Bob Young and expert clinical coders. This indicator is collected nationally as part of the NDA. |

Review: 3 years

In light of no significant issues being identified with the methodology or anticipated changes to process or data source it is recommended that the indicator be reviewed in 3 years, unless there are any changes to data collection methodologies (e.g. use of GPES).