**NHS Digital**

**Indicator Supporting Documentation**

**IAP00338 Proportion of adults in contact with secondary mental health services in employment**

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| --- | --- |
| IAP Code | IAP00338 |
| Title | Percentage of adults in contact with secondary mental health services in paid employment |
| Published by | NHS Digital |
| Reporting period | Annual |
| Geographical Coverage | England |
| Reporting level(s) | CCG |
| Based on data from | Mental Health Minimum Dataset |
| Contact Author Name | NHS Digital Clinical Indicators team |
| Contact Author Email | Clinical.indicators@nhs.net |
| Rating | Assured |
| Assurance date | 16/01/2014 |
| Review date | 16/01/2015 |
| Indicator set | CCG Outcome Indicator Set |
| Brief Description | This indicator provides an indication of the impact of long-term mental illness on employment among working age adults. The indicator is intended to measure improved employment outcomes for adults with mental health problems, reducing their risk of social exclusion and discrimination. |
| Purpose | This indicator forms part of Domain 3 - Helping people to recover from episodes of ill health or following injury and is intended to measure improved employment outcomes for adults with mental health problems, reducing their risk of social exclusion and discrimination. Employment outcomes demonstrate quality of life and are indicative that health and social care support are personalised. Employment is a wider determinate of health and social care inequalities.  ‘In employment’ refers to either an employee, self-employed, on Government employed and training programmes, or an unpaid family worker (in a family owned business), in accordance with the Labour Organization Definition of basic economic activity. This indicator does not include voluntary work in its numerator, although it is recognised that this form of employment may be beneficial to the recovery of people with mental health issues.  Using results from this indicator, CCGs could work with local authorities through health and well-being boards and other organisations to improve the opportunities for people with long-term mental health conditions to find suitable employment. This indicator could also help inform CCGs about the type, level, intensity and quantity of mental health services they need to commission.  There is strong evidence that re-employment leads to improved self-esteem, improved general and mental health, and reduced psychological distress and minor psychiatric morbidity. The magnitude of this improvement is comparable to the adverse effects of job loss. |
| Definition | This indicator shows the percentage of adults receiving secondary mental health services in paid employment at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting.    This indicator measures the proportion of adults receiving NHS funded community mental health, learning disabilities or autism services who are in employment, expressed as a percentage, split by CCG and Mental health care super cluster.    The proportion of working age adults (aged 18 to 69), who have an open referral to NHS funded community mental health, learning disabilities or autism services at the end of the reporting period, whose record of employment associated with their most recent assessment, formal review, or other multi-disciplinary care planning meeting in the previous 12 months indicated that they were employed, expressed as a percentage with 95% confidence intervals (CI), split by CCG and Mental health care super cluster (for 2014/15 only). |
| Data Source | MHMDS, v4.1 (HSCIC).  <http://www.hscic.gov.uk/media/10688/MHMDSv41UserGuidance/pdf/MHMDS_v4.1_User_Guidance.pdf>  From April 2014, this will be superseded by the Mental Health and Learning Disabilities Dataset (MHLDDS), v1.0. |
| Numerator | Numerator (X): Of people in the denominator, the number recorded as being in employment. The most recent record of employment status for the person during the financial year is used. |
| Denominator | Denominator (Y): CCG level count of the number of working age adults aged 18 to 69 who have received secondary mental health services at any point during the financial year. |
| Calculation | Calculated as a percentage at CCG level.  [ X / Y ] x 100 = The percentage of adults receiving secondary mental health services in paid employment, given by CCG.  Denominator (Y): The number of working age adults aged 18 to 69 who have received secondary mental health services at any point during the financial year.  Age range consistent with PHOF indicator 1.08iii 1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate, and ASCOF (1F) Proportion of adults in contact with secondary mental health services in paid employment  Numerator (X): Of people in the denominator, the number recorded as being in employment. The most recent record of employment status for the person during the financial year is used. |
| Interpretation Guidelines | This indicator may be influenced by the willingness of people with long-term mental health conditions to work. This is likely to be affected by changes to financial incentives (including those implicit in the benefit system).  The ability of people with long-term mental health conditions to find employment will be greatly influenced by the general level of employment in their local area. It is not currently possible to produce general employment statistics at CCG level however, so it is not possible to provide this as a direct comparison.  The indicator doesn’t take into consideration severity of mental health condition  The assignment of a CCG to a patient will be based on GP or practice code where possible and if not, then on the patient’s home postcode. Where the patient’s practice and postcode are both unavailable, the responsible CCG is derived from the location of the hospital or trust. As the numerator is a subset of the denominator, the same method will be used for any particular patient. |
| Caveats | 1. This indicator requires careful interpretation and should not be used in isolation. It should be taken in conjunction with other indicators and information from other sources that together form a holistic view of CCG outcomes and a fuller overview of how CCG processes are impacting on outcomes. For example, a low rate for this indicator may be less significant in an area with high levels unemployment. 2. There are known local variations in data quality, particularly in terms of completion of employment status. 3. Severity of mental illness is not accounted for in the indicator; it may be that less severely ill patients are managed in primary care and therefore not counted in this indicator. This may vary by CCG as different policies are applied. 4. Local variation in service provision between CCGs may have an impact on the indicator. 5. Data quality is currently poor and comparison at CCG level would not be possible however it is hoped that the indicator will drive this up. A data quality improvement plan is to be put in place at the time of renewal. |

**Application Form**

|  |  |
| --- | --- |
| Title |  |
| Set or domain | CCG OIS 3.17 |
| Topic area |  |
| Definition | This indicator shows the percentage of adults receiving secondary mental health services in paid employment at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting.  This indicator measures the proportion of adults receiving NHS funded community mental health, learning disabilities or autism services who are in employment, expressed as a percentage, split by CCG and Mental health care super cluster.  The proportion of working age adults (aged 18 to 69), who have an open referral to NHS funded community mental health, learning disabilities or autism services at the end of the reporting period, whose record of employment associated with their most recent assessment, formal review, or other multi-disciplinary care planning meeting in the previous 12 months indicated that they were employed, expressed as a percentage with 95% confidence intervals (CI), split by CCG and Mental health care super cluster (for 2014/15 only) |
| Indicator owner & contact details |  |
| Publication status | Currently in publication |
| **Purpose** | The intended audience for the indicator is CCGs, the Department of Health, Provider Managers, Commissioning Managers, Clinicians, Patients and the Public.  This indicator forms part of Domain 3 - Helping people to recover from episodes of ill health or following injury and is intended to measure improved employment outcomes for adults with mental health problems, reducing their risk of social exclusion and discrimination. Employment outcomes demonstrate quality of life and are indicative that health and social care support are personalised. Employment is a wider determinate of health and social care inequalities.  ‘In employment’ refers to either an employee, self-employed, on Government employed and training programmes, or an unpaid family worker (in a family owned business), in accordance with the Labour Organization Definition of basic economic activity. This indicator does not include voluntary work in its numerator, although it is recognised that this form of employment may be beneficial to the recovery of people with mental health issues.  This indicator counts all patients who had an open mental health care spell in the MHSDS, not just those on the Care Programme Approach, which may be used in other frameworks.  The link between employment and positive mental health is an important issue for the NHS, both in terms of supporting service users to recover from mental health conditions and for improving staff productivity. It is estimated that between 10% and 16% of people with a mental health condition (excluding depression) are in employment. However, between 86% and 90% of this group want to work (Work, Recovery and Inclusion: Employment support for people in contact with secondary mental health services – National Mental Health Development Unit, based on 2001 ONS data). Meaningful work is integral to recovery.  There is strong evidence that re-employment leads to improved self-esteem, improved general and mental health, and reduced psychological distress and minor psychiatric morbidity. The magnitude of this improvement is comparable to the adverse effects of job loss.  There is a broad consensus across multiple disciplines, disability groups, employers, unions, insurers and all political parties, based on extensive clinical experience and on principles of fairness and social justice. When their health condition permits, sick and disabled people (particularly those with “common health problems”) should be encouraged and supported to remain in or to (re)-enter work as soon as possible because it:   * is therapeutic; * helps to promote recovery and rehabilitation; * leads to better health outcomes; * minimises the harmful physical, mental and social effects of long-term sickness absence; * reduces the risk of long-term incapacity; * promotes full participation in society, independence and human rights; * reduces poverty; * improves quality of life and well-being.   This indicator provides a good indication of the impact of long-term mental illness on employment among working age adults.  It should be expected that there would be improved functional ability, through employment, in people with mental illness. If people are able to find employment when they want, they will find it easier to maintain a family and social life and contribute to community life, and in doing so, avoid loneliness or isolation.  The indicator is intended to measure improved employment outcomes for adults with mental health problems, reducing their risk of social exclusion and discrimination. Supporting someone with their employment aspirations is a key part of the recovery process.  CCGs could work with local authorities through health and well-being boards and other organisations to improve the opportunities for people with long-term mental health conditions to find suitable employment opportunities.  This indicator could also help inform CCGs about the type, level, intensity and quantity of mental health services they need to commission. |
| **Sponsor** |  |
| **Endorsement** |  |
| **Evidence and Policy base**  Including related national incentives, critical business question, NICE quality standard and set or domain rationale, if appropriate | The 2006 evidence review by Waddell and Burton *Is work good for your health and well-being?* (commissioned by the Department for Work and Pensions) concluded that work was generally good for both physical and mental health and well-being.  The review found a strong association between worklessness and poor health. This may be partly a health selection effect, but it is also to a large extent cause and effect. There is strong evidence that unemployment is generally harmful to health, including:   * higher mortality; * poorer general health, long-standing illness, limiting longstanding illness; * poorer mental health, psychological distress, minor psychological/psychiatric morbidity; * higher medical consultation, medication consumption and hospital admission rates.   The review also found that, overall:   * work is beneficial to health and well-being; * lack of work is detrimental to health and well-being; * for people without work, re-employment leads to improvement in health and well-being and further unemployment leads to deterioration; * for people who are sick or disabled, placement in work improves health and psychosocial status; * the health status of people of all ages who move off welfare benefits improves; * these benefits apply equally to people who have mental health problems, including those with severe mental health problems. There is no evidence that work is harmful to the mental health of people with severe mental illness. |
| **Data source** | Mental Health Services Data Set (MHSDS): <http://content.digital.nhs.uk/mhsds> |
| **Justification of source and others considered** | MHSDS supersedes and replaces the Mental Health and Learning Disabilities Data Set (MHLDDS), which in turn replaced the original source of the indicator, the Mental Health Minimum Data Set (MHMDS). |
| **Data availability** |  |
| **Data quality** | **i) What data quality checks are relevant to this indicator?**  **Coverage**  **Completeness**  **Validity**  **Default**  **Integrity**  **Timeliness**  **Other** |
| **Data quality** | **If you included ‘Other’ as a data quality check, please describe the check, how it will be measured, and its reason for use below:** |
| **Data quality** | **ii) What are the current values for the data quality checks selected?** The period of data the current values are calculated from should be stated. Current values should be recorded as a percentage and calculated as described below.  **Period of data:**  **Coverage: Calculation**  **Completeness: Calculation:**  **Validity: Calculation:**  **Default: Calculation:**  **Integrity: Calculation:**  **Timeliness: Calculation:**  **Other: Calculation:** |
|  | **iii) What are the thresholds for the data quality checks selected?**  **Coverage:**  **Completeness:**  **Validity:**  **Default:**  **Integrity:**  **Timeliness:**  **Other:** |
| **Data quality** | **iv) What is the rationale for the selection of the data quality checks and thresholds selected above?** |
| **Data quality** | **v) Describe how you would plan to improve data quality should it not meet, or subsequently fall below, the thresholds required for this indicator.** |
| **Data quality** | **vi) Who will own the data quality risks and issues for this indicator?**  **Name:**  **Job Title:**  **Role:**  **Email:**  **Telephone:** |
| **Data quality** | **vii) Describe how the data quality risks and issues will be managed for this indicator, including the escalation process.** |
| **Data quality** | **viii) Describe any assumptions you have made about data quality for this indicator.** |
| **Data quality** | **ix) Describe any data quality constraints you are aware of for this indicator.** |
| **Data quality** | **x) Additional data quality information:**  Data quality from the MHSDS is considered to be good, however as a new data set, further investigation of data quality is ongoing. Further information can be found at <http://content.digital.nhs.uk/mhsds>.  The MHSDS, introduced in January 2016, is a new data set that supersedes and replaces the Mental Health and Learning Disabilities Data Set (MHLDDS), introduced in September 2014, which in turn replaced the original source of the indicator, the Mental Health Minimum Data Set (MHMDS). The MHSDS includes those in contact with access to community mental health, learning disabilities and autism services. Releases of data from the different versions of the data set are not directly comparable with each other due to changes in scope. All outputs from the MHSDS are currently classified as experimental statistics until all the relevant aspects of the new data set have been further investigated.  Completeness of the employment status field is poor, for the period 2016/17 in the MHSDS this was 35%. As such, extra caution must be taken when using the indicator or making comparisons. This indicator is presented with the recording level (i.e. the percentage of records where the employment status was complete) for each CCG, which is given as contextual information to assist users to understand the data completeness.  Employment status is a ‘required’ field in the MHSDS; meaning that if a patient’s status is recorded then it must be submitted. Clinical guidance recommends that the check on a patient’s employment status should be carried out annually; hence, the status should be recorded and submitted once per year.  The addition of adult mental health care super cluster in the indictor resulted in a small amount of duplication in the 2014/15 data, the degree of which is reported in the Final Data Quality Report Mental Health and Learning Disabilities Statistics Monthly Report. Due to data quality concerns, Mental health care super cluster was not reported in the July 2015 to June 2016 or October 2015 to September 2016 reporting periods. The duplication has been resolved in the July 2015 to June 2016 data onwards.  The MHSDS is updated monthly and routine reports are available approximately three months following the end of the month in which the activity took place. |
| **Quality assurance** |  |
| **Data linkage** |  |
| **Quality of data linkage** |  |
| **Data fields** | For this indicator the data source is derived from final MHSDS data. Finalised data is usually available approximately three months following the activity date. Numerator and denominator figures are supplied by the NHS Digital Community and Mental Health team.  The data fields that are used to create this indicator are as follows. Details of MHSDS fields and classifications are available in the MHSDS Specification:  <http://content.digital.nhs.uk/mhsds/spec>.   * **UniqMHSDSPersID** – Unique Person identifier * **IC\_Rec\_CCG -** Person's postcode, based on GP practice or Postcode if no GP practice * **Gender** - Gender of person * **AgeRepPeriodEnd** - Age at the end of the reporting period * **AMHCareClustCodeFin** - Adult Mental Health Care Cluster   **Employ Status** - Employment status of patient |

# Data filters

**Denominator**

Working age adults with a valid CCG Code ‘In contact with mental health services’ is defined as people who are in contact with NHS funded community mental health, learning disabilities or autism services.

Working age is defined as 18 to 69.

**Numerator**

Employment status is recorded using the following categories:

|  |  |
| --- | --- |
| 01 | Employed |
| 02 | Unemployed and Seeking Work |
| 03 | Students who are undertaking full (at least 16 hours per week) or part-time (less than 16 hours per week) education or training and who are not working or actively seeking work |
| 04 | Long-term sick or disabled, those who are receiving Incapacity Benefit, Income Support or both; or Employment and Support Allowance |
| 05 | Homemaker looking after the family or home and who are not working or actively seeking work |
| 06 | Not receiving benefits and who are not working or actively seeking work |
| 07 | Unpaid voluntary work who are not working or actively seeking work |
| 08 | Retired |
| ZZ | Not Stated (person asked but declined to provide a response) |

The definition of employment in this indicator is ‘01’. In employment refers to either an employee, self-employed, on Government employed and training programmes, or an unpaid family worker (in a family owned business). This is the International Labour Organization Definition of basic economic activity.

The percentage of records where the Employment Status was completed is presented as the Recording level.

**Data processing**

The data are aggregated by the NHS Digital Community and Mental Health team using GP Practice code where the person is registered (or where the person is resident if registration information is not available).

|  |  |
| --- | --- |
| **Numerator** | Of people in the denominator, the number recorded as being in employment at their most recent assessment, formal review, or other multi-disciplinary care planning meeting.  This is defined in MHSDS as the number of people aged 18 to 69 with an open referral at the end of the reporting period, where the record of employment associated with their most recent contact with mental health services in the previous 12 months indicates that they were employed.  Patients are only counted once even if they have attended more than the practice or CCG in the period. Their referral with a provider of NHS funded community mental health, learning disabilities or autism services is used for the purpose of this analysis, even if the employment record is not the most recent record. |
| **Denominator** | CCG level count of working age adults aged 18 to 69 who have received NHS funded community mental health, learning disabilities or autism services at any point during the year.  Defined in MHSDS as the number of people aged 18 to 69 with an open Adult Mental health care, learning disabilities or autism services referral at the end of the reporting period. |
| **Computation** | This indicator is calculated as a percentage with 95% confidence intervals. |
| **Risk adjustment or standardisation type and methodology** | **None**  *Variables and methodology:* |
| **Justification of risk adjustment type and variables**  or why risk adjustment is not used | The data are not standardised. The most obvious factor to standardise by is a measure of the strength of the local labour market, as measured by local employment rates. However, it is not currently possible to produce employment statistics at CCG level. |
| **Confidence interval / control limit use and methodology** | Confidence Intervals  *Methodology:*  Confidence intervals are calculated using the Wilson Score method, as specified in “Commonly used public health statistics and their confidence intervals” (APHO, March 2008).  The formulae for the 100(1 – *α*)% confidence interval limits for the proportion 𝑝 are:  The formulae for the 100(1 – α)% confidence interval limits for the proportion 𝑝  where:  𝑂 is the observed number of individuals in the sample/population having the specified characteristic (i.e., the numerator);  𝑛 is the total number of individuals in the sample/population (i.e., the denominator);  𝑞 = (1 – 𝑝) is the proportion without the specified characteristic;  𝑧 is the 100(1 – *α*/2)th percentile value from the Standard Normal distribution. For example for a 95% confidence interval, *α* = 0.05, and 𝑧 = 97.5th percentile value from the Standard Normal distribution. |
| **Justification of confidence intervals / control limits used** | The indicator is published with 95% confidence intervals recognising the existence of natural variation between the CCG populations. Local knowledge may be required to distinguish changes in volume between years that reflect changes in service delivery from those that are an artefact of changes in the data. |
| **Presentation of indicator** | The results for this indicator are published in .csv and .xlsx formats.  Data is currently available for the reporting periods:   * 01/04/2016 to 31/03/2017 * 01/01/2016 to 31/12/2016 * 01/10/2015 to 30/09/2016 * 01/07/2015 to 30/06/2016 * 01/04/2014 to 31/03/2015 * 01/04/2013 to 31/03/2014 * 01/04/2012 to 31/03/2013   Data is presented with the following column headings:   * Reporting period * Period of coverage * Breakdown * ONS code * Level * Level description * Mental health care super cluster * Indicator value * CI lower * CI upper * Denominator * Numerator   Recording level |
| **Contextual information provided alongside indicator**  with justification |  |
| **Calculation and data source of contextual information** |  |
| **Use of bandings, benchmarks or targets**  with justification |  |
| **Banding, benchmark or target methodology**  if appropriate |  |
| **Interpretation guidelines** |  |
| **Limitations and potential bias** | 1. This indicator requires careful interpretation and should not be used in isolation. It should be taken in conjunction with other indicators and information from other sources that together form a holistic view of CCG outcomes and a fuller overview of how CCG processes are impacting on outcomes. For example, a low rate for this indicator may be less significant in an area with high levels unemployment. 2. Employment status is a ‘required’ field in the MHSDS; this means that if the patient’s employment status is recorded then it must be submitted. Clinical guidance recommends that the check on a patient’s employment status should be carried out annually; hence the status should be recorded and submitted once per year. 3. There are known local variations in data quality, particularly in terms of completion of employment status: Nationally, the completeness of the employment status field is at 35% for the period 2016/17. From 2008 employment status was measured for patients that were on the Care Programme Approach (CPA), i.e. those patients with more serious illness. Policy direction has moved away from focussing on patients on CPA to all patients in contact with mental health services, for this and other mental health indicators. 4. Severity of mental illness is not accounted for in the indicator; it may be that less severely ill patients are managed in primary care and therefore not counted in this indicator. This may vary by CCG as different policies are applied. 5. Local variation in service provision between CCGs may have an impact on the indicator. 6. Differences in casemix, comorbidities and other potential risk factors also contribute to the variation.   There may be variation in the prevalence of mental health conditions/employment status due to differing levels of deprivation, for other geo-demographic reasons or between patients of different ethnic heritages. |
| **Improvement actions** | It is expected that CCGs can use the indicator to work with organisations in their area to improve the opportunities for people with long-term mental health conditions to find employment |
| **Evidence of variability** |  |
| **Similar existing indicators** | There are no directly comparable indicators currently published in the CCG OIS. A number of indicators relating to employment and mental health are included in other indicator sets, but not measured at CCG level:   * NHS Outcomes Framework (NHS OF), 2.5 Employment of people with mental illness. This indicator shows the difference between the employment rate for those with a long-term mental health condition and the employment rate for the working-age population. * Adult Social Care Outcomes Framework (ASCOF), 1F Proportion of adults in contact with secondary mental health services in paid employment. This indicator shows the employment rate for those with a long-term mental health condition (currently it focusses only on those patients in contact with adult mental health services who are on the Care Programme Approach). * Public Health Outcomes Framework (PHOF), 1.8iii. This indicator shows the difference between the employment rate for adults in contact with secondary mental health services in paid employment and the employment rate of all respondents who are of working age to the Annual Population Survey.   Note that the indicators in the NHS Outcomes Framework and the PHOF are looking at the differences between employment of people with a mental health condition and employment of all people of working age. This is not the case with this CCG OIS indicator (or the ASCOF indicator) as it is not possible to look at employment rates of all people of working age by CCG. Consequently, having a low score on this indicator may be an indication that an area has high unemployment levels in general. |
| **Coherence and comparability** |  |
| **Undesired behaviours and/or gaming** |  |
| **Approach to indicator review** | Comments can be made through various media, including NHS Digital general enquiries by email enquiries@nhsdigital.nhs.uk or by telephone 0300 303 5678.  As well as initially assuring the quality and methodology of this indicator, the NHS Digital’s Indicator Assurance Process will be used on an on-going basis to review any new indicators. User needs and feedback will be taken into consideration during this  assurance process. |
| **Disclosure control** | When publishing data, if the indicator is calculated from a numerator of 0 to 4, the value is suppressed to ensure an individual’s identity is not at risk of being disclosed. If one figure is suppressed in this way and included in a total the second smallest figure is also suppressed. For data prior to 2013/14 suppression was applied if a numerator value was between 1 and 5.  Numerator and denominator figures are rounded to the nearest 5 at CCG level. Rates are calculated from unrounded figures. Numerator and denominator national figures are presented unrounded.  Rates are rounded to the nearest integer at both CCG and national level. |
| **Copyright** | This indicator makes use of an existing data collection, so there are no additional data collection cost implications or burden. |

**Appendix 1 – Filters used for the Denominator and Numerator.**

**Denominator**

Working age adults with a valid CCG Code ‘In contact with mental health services’ is defined

as people who are in contact with NHS funded community mental health, learning disabilities

or autism services.

Working age is defined as 18 to 69.

**Numerator**

Employment status is recorded using the following categories:

|  |  |
| --- | --- |
| 01 | Employed |
| 02 | Unemployed and Seeking Work |
| 03 | Students who are undertaking full (at least 16 hours per week) or part-time (less than 16 hours per week) education or training and who are not working or actively seeking work |
| 04 | Long-term sick or disabled, those who are receiving Incapacity Benefit, Income Support or both; or Employment and Support Allowance |
| 05 | Homemaker looking after the family or home and who are not working or actively seeking work |
| 06 | Not receiving benefits and who are not working or actively seeking work |
| 07 | Unpaid voluntary work who are not working or actively seeking work |
| 08 | Retired |
| ZZ | Not Stated (person asked but declined to provide a response) |

The definition of employment in this indicator is ‘01’. In employment refers to either an employee, self-employed, on Government employed and training programmes, or an unpaid family worker (in a family owned business). This is the International Labour Organization Definition of basic economic activity.

The percentage of records where the Employment Status was completed is presented as the

Recording level.

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| --- | --- |
| **IAS Ref Code** |  |
| **Indicator Title** |  |
| **Indicator Set** |  |

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| --- | --- | --- | --- |
| Version | Date | Changed By | Summary of changes |
| v.01 | 29/08/13 | Chris Wilson | Document Created |
| v.02 | 30/08/13 | Geoff Green | Text inserted from pipeline application |
| V0.3 | 20/09/13 | Geoff Green | Initial amendments made following MRG meeting |
| v.04 | 01/04/14 | Chris Wilson | Document updated in preparation for IGB |
|  |  |  |  |

**Assurance Summary**

|  |  |
| --- | --- |
| **IAS Ref Code** |  |
| **Indicator Title** |  |
| **Indicator Set** |  |

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| --- | --- | --- | --- |
| Assurance Stage |  | Date(s) | Comments |
| Application Received |  |  |  |
| Initial Appraisal Completed |  |  |  |
| Peer Review Appraisal |  | 11/09/13 |  |
| Methodology Review Group Discussion |  | 20/09/13, 18/10/13 |  |
| Indicator Governance Board Discussion |  |  |  |
| Signed-off |  |  |  |

Peer Review

|  |  |
| --- | --- |
| Peer Reviewer(s) / Organisations | *Outcome of Peer Review consideration:* |
|  | 1. **Proposal signed off, with or without caveats** |
|  | 1. **Minor changes recommended** |
|  | 1. **Declined to sign-off** |

Methodology Review Group (MRG)

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| *Outcome of MRG consideration:* |
| 1. **No significant issues identified** |
| 1. **No significant issues on basis of completion of outstanding actions** |
| 1. **Some concerns expressed as caveats or limitations** |
| 1. **Significant reservations** |
| 1. **Unresolved issues** |

Indicator Governance Board (IGB)

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| --- | --- |
| *Final Appraisal Status* | 1. **Assured** |
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**Peer Review** Summary

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| --- | --- |
| Date of Peer Review | 11/09/13 |
| Peer Reviewer(s) / Organisations : | Andrea Johnson  Clinical Indicators, HSCIC |
| Peer Review Comments based on the application form: | * There appears to be conflict between the indicator rationale and what it actually measures. The rationale relates to supporting individuals who have been in contact with mental health services to get back into work, whereas the indicator measures the proportion of those in contact with mental health services who are in work, with no variable relating to care provided included in the indicator. * It is assumed that this indicator is designed to measure improvement in employment outcomes, not clinical care or hospital performance (though this isn’t clearly stated). It does provide a way by which CCGs can measure the number of people with long term mental health conditions who are in paid employment. * However, the indicator makes no adjustment for variables outside control of the organisation. The most likely external variable is the impact of the local job market which would impact on employment opportunities for everyone in the area and therefore affect improvement. Local employment levels could mean that CCGs may not have much influence on outcomes. * Further explanation of known data quality issues should be provided. * A data quality spreadsheet is linked in the application forms but accompanying documents are missing, specifically MHMDS v4.1 User Guidance and Information Standards Notice (ISN) 87/2010. * Within the application form it is stated that ‘It is expected that all relevant cases are included in the MHMDS. A valid code for employment is present for around 92% of records within MHMDS (June 2013)’. It is not explicitly specified if those without a valid employment code are excluded or included in the dataset. Issues of missing data and how it is handled are not explained. * May need to add a definition as to what constitutes a secondary mental health service. * The application notes that ‘A high rate is desirable’. It is assumed from the application that the indicator seeks to improve and will measure changes over time in employment outcomes for adults aged 18-69 who have been in contact with secondary mental health services over the past year, however this is not explicitly stated in the rationale. * Additionally, there is no rigorous procedure outlined for identifying outliers. CCGs may be particularly affected by the external job market which could impact on performance on this indicator. Although whole population local labour force statistics are available at Local Authority level, they are not currently available and are not able to be produced at CCG level. * The applicant proposes to compare this indicator (which is at CCG level) with employment rates of the general working population (which is NOT published at CCG level). The influence of the wider economy and local employment opportunities for everyone, not just those in receipt of secondary mental health services could affect performance on this indicator. A serious area for concern is whether CCG boundaries are co-terminus with LA boundaries as if they are not, or only some are, reliable comparisons cannot be made. * It is noted that willingness to work among the population and changes to the benefits system may also be a confounding variable.      * Training and voluntary work are excluded from the indicator. The evidence base mentions that paid work reduces the risk of social isolation. The same could be argued for voluntary work and training as both get people socially involved and enhance skills necessary for employment. Possible contextual indicators? * There is a risk of a perverse incentive that could encourage providers not to provide secondary care mental health services to those who are unlikely to become involved in paid employment. |
| *Outcome of MRG consideration:* | 1. **Declined to sign-off** |
| Link to Peer Review Appraisal |  |

Indicator Methodology for Consideration - **Methodology Review Group**

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| Introduction |
| [Brief background on indicators being considered, especially if they form part of a programme of indicators. Provide any general information such as ; urgency of approval / broad timescales; history and direction of any indicator programmes involved e.g. General news about NHS Outcomes Framework; Level of IC’s involvement, e.g. is it commissioned to produce or surface the data ]  The Clinical Commissioning Group Outcome Indicator Set (CCG OIS) is an integral part of NHS England’s systematic approach to quality improvement. It is intended to provide clear, comparative information for CCGs, patients and the public about the quality of health services commissioned by CCGs and the associated health outcomes. All of the CCG outcomes indicators have been chosen on the basis that they contribute to the overarching aims of the five domains in the NHS Outcomes Framework and it is intended as a tool for CCGs to drive local improvement and set priorities. Reference: CCG OIS, NHS England: http://www.england.nhs.uk/ccg-ois/.  This indicator shows the percentage of adults receiving secondary mental health services in paid employment at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting.  The indicator provides a CCG level figure that complements the following indicators.   * NHS Outcomes Framework, 2.5 (Technical Appendix, pp40-42) – this indicator shows the gap between the employment rate for those with a long-term mental health condition and the employment rate for the working-age population. It uses data from the Labour Force Survey, produced by the Office for National Statistics (ONS). * Public Health Outcomes Framework, 1.8iii (Update to Summary Technical Specifications of Public Health Indicators: Part 2, pp3-6) – this indicator shows the gap between the employment rate for those with a long-term mental health condition and the employment rate for the working-age population. It uses data from the Annual Population Survey (ONS) and the Mental Health Minimum Dataset (MHMDS). * Adult Social Care Outcomes Framework (ASCOF), 1F – this indicator shows the employment rate for adults in contact with secondary mental health services. It uses MHMDS data.   This indicator uses a similar definition to ASCOF indicator 1F; it is produced at CCG level rather than local authority level. All of the above indicators only consider people in paid employment. |

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| Indicator Details - Initial MRG Submission | Date of Initial Discussion: 20/09/13 |
| Rationale / usefulness  Evidence and action ability of indicator [take this directly from the application if possible] | The link between employment and positive mental health is an important issue for the NHS, both in terms of supporting service users to recover from mental health conditions and for improving staff productivity. It is estimated that between 10% and 16% of people with a mental health condition (excluding depression) are in employment. However, between 86% and 90% of this group want to work (Work, Recovery and Inclusion: Employment support for people in contact with secondary mental health services – National Mental Health Development Unit, based on 2001 ONS data). Meaningful work is integral to recovery.  The 2006 evidence review by Waddell and Burton “Is work good for your health and well-being?” (commissioned by the Department for Work and Pensions) concluded that work was generally good for both physical and mental health and well-being.  The review found a strong association between worklessness and poor health. This may be partly a health selection effect, but it is also to a large extent cause and effect. There is strong evidence that unemployment is generally harmful to health, including:   * higher mortality; * poorer general health, long-standing illness, limiting longstanding illness; * poorer mental health, psychological distress, minor psychological/psychiatric morbidity; * higher medical consultation, medication consumption and hospital admission rates.   The review also found that, overall:   * work is beneficial to health and well-being; * lack of work is detrimental to health and well-being; * for people without work, re-employment leads to improvement in health and well-being and further unemployment leads to deterioration; * for people who are sick or disabled, placement in work improves health and psychosocial status; * the health status of people of all ages who move off welfare benefits improves; * these benefits apply equally to people who have mental health problems, including those with severe mental health problems. There is no evidence that work is harmful to the mental health of people with severe mental illness.   There is strong evidence that re-employment leads to improved self-esteem, improved general and mental health, and reduced psychological distress and minor psychiatric morbidity. The magnitude of this improvement is comparable to the adverse effects of job loss.  There is a broad consensus across multiple disciplines, disability groups, employers, unions, insurers and all political parties, based on extensive clinical experience and on principles of fairness and social justice. When their health condition permits, sick and disabled people (particularly those with “common health problems”) should be encouraged and supported to remain in or to (re)-enter work as soon as possible because it:   * is therapeutic; * helps to promote recovery and rehabilitation; * leads to better health outcomes; * minimises the harmful physical, mental and social effects of long-term sickness absence; * reduces the risk of long-term incapacity; * promotes full participation in society, independence and human rights; * reduces poverty; * improves quality of life and well-being.   This indicator provides a good indication of the impact of long-term mental illness on employment among working age adults.  It should be expected that there would be improved functional ability, through employment, in people with mental illness. If people are able to find employment when they want, they will find it easier to maintain a family and social life and contribute to community life, and in doing so, avoid loneliness or isolation.  The indicator is intended to measure improved employment outcomes for adults with mental health problems, reducing their risk of social exclusion and discrimination. Supporting someone with their employment aspirations is a key part of the recovery process.  CCGs could work with local authorities through health and well-being boards and other organisations to improve the opportunities for people with long-term mental health conditions to find suitable employment opportunities.  This indicator could also help inform CCGs about the type, level, intensity and quantity of mental health services they need to commission. |
| Data source | MHMDS, v4.1 (HSCIC).  <http://www.hscic.gov.uk/media/10688/MHMDSv41UserGuidance/pdf/MHMDS_v4.1_User_Guidance.pdf>  From April 2014, this will be superseded by the Mental Health and Learning Disabilities Dataset (MHLDDS), v1.0. |
| Construction | ***Summary description of the calculation:***  The percentage of adults receiving secondary mental health services who are in paid employment, given by CCG. |
| Construction | ***Calculation type:*** Percentage. |
| Construction | ***Denominator:*** The number of working age adults aged 18 to 69 who have received secondary mental health services at any point during the quarter.  Working age is defined as ages 18 to 69. This matches the age range for a measure that has been used historically and therefore maintains a time series.  Secondary mental health services are any mental health services provided in a secondary care setting, including inpatient and outpatient care and care provided by community mental health teams.  ***Numerator:*** Of people in the denominator, the number recorded as being in employment at their most recent assessment, formal review or other multi-disciplinary care planning meeting.  The measure is focused on ‘paid’ employment, to be clear that voluntary work is to be excluded for the purposes of this measure. Employment status is recorded using the following categories:   * 01 Employed * 02 Unemployed and Seeking Work * 03 Students who are undertaking full (at least 16 hours per week) or part-time (less than 16 hours per week) education or training and who are not working or actively seeking work * 04 Long-term sick or disabled, those who are receiving Incapacity Benefit, Income Support or both; or Employment and Support Allowance * 05 Homemaker looking after the family or home and who are not working or actively seeking work * 06 Not receiving benefits and who are not working or actively seeking work * 07 Unpaid voluntary work who are not working or actively seeking work * 08 Retired * ZZ Not Stated (person asked but declined to provide a response)   Paid employment for this indicator is 01. In employment means either an employee, self-employed, on Government employment & training programmes, or an unpaid family worker (in a family owned business) (this is the International Labour Organization definition of basic economic activity). |
| Construction | ***Statistical Methods / Risk adjustment variables:***  The data are not standardised. The most obvious factor to standardise by is a measure of the strength of the local labour market, as measured by local employment rates. However, it is not possible to produce employment statistics at CCG level.  Confidence intervals are calculated using the Wilson Score method, as specified in “Commonly used public health statistics and their confidence intervals” (APHO, March 2008). |
| Construction | ***Other (Quality assurance/interpretation/known limitations):***  Data Quality Measures for MHMDS v4.1, indicating acceptable values that can be input to data collection systems, are highlighted in: <http://www.hscic.gov.uk/media/10994/MHMDS-Appx-3-Data-Quality-Measures/xls/Appendix_3_-_MHMDS_v4.1_Data_Quality_Measures.xls>  A high rate is desirable. The employment rate of adults receiving secondary mental health services could be compared with the employment rate of the general population, in order to see whether the indicator is particularly low, although this is not available at CCG level. In most cases it should be possible to compare with associated local authorities.  This indicator only considers those patients in contact with secondary mental health services. This is not likely to be all people with a long-term mental health condition; for example, people only ever seen in primary care are not included. |
| Potential Issues  Highlight any of the following that apply  -data source(s) do not collect 100% of events  -data source(s) organisation or geographic coverage shortfalls  -codes or filters not matching the policy question  -data source(s) definitions not meeting policy question  -data source(s) quality problems or inconsistency of reporting  -statistical methods not appropriate for test or audience  -risk adjustment not considered  -long term security of the data source(s)  -timing of data availability for use in indicator  presentation of data likely to mislead or give false confidence in findings | The completeness of employment status within MHMDS is around 92% (June 2013). Those with an invalid or missing code for employment status are included in the denominator but not in the numerator.  The assignment of a CCG to a patient will be based on GP or practice code where possible and if not, then on the patient’s home postcode. Where the patient’s practice and postcode are both unavailable, the responsible CCG is derived from the location of the hospital or trust. As the numerator is a subset of the denominator, the same method will be used for any particular patient. A valid practice code is present in more than 98% of records in MHMDS (June 2013).  This indicator may be influenced by the willingness of people with long-term mental health conditions to work. This is likely to be affected by changes to financial incentives (including those implicit in the benefit system). It is not possible to standardise for this variable although its effects are likely to be similar within the general population.  Employment rates for people with long-term mental health conditions will be affected by a number of factors outside the control of the NHS, particularly the general level of employment in the local area. Other factors that could be taken into account when considering CCG influence on employment include the stage or severity of serious mental illness. Changes in severity could result from the quality of care, as this may affect the progress of a disease. However, they may also be caused by changes in the size of the affected population, due to either earlier diagnosis of conditions or people surviving longer.  It is not currently possible to produce employment statistics for the whole population at CCG level, so it is not possible to provide this as a direct comparison. |
| Supporting Documents  Provide links to any additional documentation used to support discussion at MRG | Is work good for your health & well-being? – Gordon Waddell and Kim Burton (2006) <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214326/hwwb-is-work-good-for-you.pdf>  PH22 Promoting mental wellbeing at work – Guidance for employers on promoting mental wellbeing through productive and healthy working conditions (Public health guidance, PH22, November 2009)  <http://www.nice.org.uk/PH22> |

Additional Information / Sample Data - Note that this sample data is for June 2013, although it is proposed to produce the indicator quarterly.

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| **June 2013** | **The number of working age adults aged 18 to 69 who have received secondary mental health services** | **Of people in the denominator, the number recorded as being in employment.** |  |  |  |
| **CCG Code** | **Denominator** | **Numerator** | **%** | **Lower CI** | **Upper CI** |
| **Random selection** |  |  |  |  |  |
| CCG A | 2904 | 441 | 15.2% | 13.9% | 16.5% |
| CCG B | 57930 | 5342 | 9.2% | 9.0% | 9.5% |
| CCG C | 7073 | 509 | 7.2% | 6.6% | 7.8% |
| CCG D | 21282 | 1429 | 6.7% | 6.4% | 7.1% |
| CCG E | 2656 | 339 | 12.8% | 11.5% | 14.1% |
| CCG F | 8181 | 760 | 9.3% | 8.7% | 9.9% |
| CCG G | 1286 | 226 | 17.6% | 15.6% | 19.7% |
| CCG H | 6745 | 544 | 8.1% | 7.4% | 8.7% |
| CCG I | 5794 | 574 | 9.9% | 9.2% | 10.7% |
| CCG J | 7607 | 385 | 5.1% | 4.6% | 5.6% |
| CCG K | 1085 | 81 | 7.5% | 6.0% | 9.2% |
| CCG L | 4963 | 242 | 4.9% | 4.3% | 5.5% |
| CCG M | 12453 | 1528 | 12.3% | 11.7% | 12.9% |
| CCG N | 6658 | 324 | 4.9% | 4.4% | 5.4% |
| CCG O | 5415 | 580 | 10.7% | 9.9% | 11.6% |
| CCG P | 23771 | 2402 | 10.1% | 9.7% | 10.5% |
| CCG Q | 7339 | 511 | 7.0% | 6.4% | 7.6% |
| CCG R | 2558 | 174 | 6.8% | 5.9% | 7.8% |
| CCG S | 9435 | 1353 | 14.3% | 13.6% | 15.1% |
| CCG T | 2926 | 564 | 19.3% | 17.9% | 20.7% |
|  |  |  |  |  |  |
| **Lowest 10** |  |  |  |  |  |
| CCG 001 | 177 | 5 | 2.8% | 1.2% | 6.4% |
| CCG 002 | 8946 | 360 | 4.0% | 3.6% | 4.5% |
| CCG 003 | 15111 | 665 | 4.4% | 4.1% | 4.7% |
| CCG 004 | 36969 | 1640 | 4.4% | 4.2% | 4.7% |
| CCG 005 | 6922 | 314 | 4.5% | 4.1% | 5.1% |
| CCG 006 | 11614 | 547 | 4.7% | 4.3% | 5.1% |
| CCG 007 | 6184 | 293 | 4.7% | 4.2% | 5.3% |
| CCG 008 | 2944 | 142 | 4.8% | 4.1% | 5.7% |
| CCG 009 | 3141 | 152 | 4.8% | 4.1% | 5.6% |
| CCG 010 | 6443 | 312 | 4.8% | 4.3% | 5.4% |
|  |  |  |  |  |  |
| **Highest 10** |  |  |  |  |  |
| CCG 202 | 9070 | 1795 | 19.8% | 19.0% | 20.6% |
| CCG 203 | 4156 | 847 | 20.4% | 19.2% | 21.6% |
| CCG 204 | 1601 | 336 | 21.0% | 19.1% | 23.0% |
| CCG 205 | 6629 | 1467 | 22.1% | 21.1% | 23.1% |
| CCG 206 | 4409 | 1012 | 23.0% | 21.7% | 24.2% |
| CCG 207 | 2219 | 513 | 23.1% | 21.4% | 24.9% |
| CCG 208 | 2891 | 840 | 29.1% | 27.4% | 30.7% |
| CCG 209 | 3373 | 1110 | 32.9% | 31.3% | 34.5% |
| CCG 210 | 1622 | 580 | 35.8% | 33.5% | 38.1% |
| CCG 211 | 1467 | 614 | 41.9% | 39.4% | 44.4% |

MRG Recommendations, Comments & Updates:

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| Summary of Discussion | NHS England have asked for the indicator to be produced. Although similar indicators exist these are not produced at CCG level. The indicator is not standardised, in line with other employment indicators.  It was suggested that in this indicator the title should be changed from ‘Proportion of’ to ‘Percentage of’. This applies to a number of the other indicators presented at this meeting; however, it was also noted that the approach taken in Public Health is to use the description ‘Proportion …, expressed as a percentage’.  MRG queried what would happen if an individual had more than one interaction with mental health services, would they be counted more than once? The applicant replied that individuals were counted so they would be counted once. It was then asked where an individual would be counted if they moved, and so had contact with more than one CCG. The applicant replied that as far as he was aware it would be the last episode that would be counted but this needed checking. It was also asked if MHMDS data tracked an individual in the event that they moved. The applicant replied that it did as it is based on NHS number. MRG requested that it was clarified that it was checked across CCGs to ensure that patients are not duplicated in the data.  A question was raised about differences in the severity of mental illness and how this would be reflected in the indicator. The applicant replied that this is not reflected in the indicator . There was a query about what secondary care actually meant and comment that this covered a wide variation. The applicant explained that this includes people who may have had one outpatient appointment in a quarter or may have been in hospital. It was noted that there may be a difference in approaches with CCGs and how they provide services, e.g. some encouraging outpatient appointments, which could be highlighted by this indicator, therefore It may be of interest to see if there were a difference between CCGs in the effect of severity of illness on the indicator. It was noted that there were different models of care e.g. Tower Hamlets work to move people away from secondary care lists and have them managed by GPs. The less severe patients are therefore managed in primary care and whether or not such approaches are adopted could have an impact on this indicator. Although it was felt that this may call into question some of the data, as this is an indicator of an issue, a caveat could be placed on it rather than disregarding the usefulness of the indicator itself.  MRG queried whether when the applicant describes the indicator as having a ‘similar’ definition to ASCOF, it really meant the same, just the areas were different. It was noted that the methodology described is not the same as the Public Health Outcomes Framework indicator. The PHOF indicator shows the difference between two employment rates at local authority level: adults in contact with secondary mental health services in paid employment, compared to the percentage of all respondents to the Annual Population Survey. The proposed indicator is similar to the first bit of this.  It was also noted that the indicator doesn’t take into account the state of the local background unemployment rate. This indicator is similar to the ASCOF definition but with subtle differences after taking advice from the mental health team at HSCIC, this indicator looks at everyone on the MHMDS whereas ASCOF is (at the moment) restricted to people on the Care Programme Approach.  The number of indicators measuring the subject with different definitions was questioned, alongside if the creation of another was justifiable. If definition is tied to the ASCOF this was considered acceptable however the creation of a fourth definition was not desirable. It was queried as to what extent this indicator added value over the ones already in existence. The applicant replied that the value was that it was produced at CCG level (the other indicators are only available at Local Authority level). These existing indicators are not able to be reproduced at this level. MRG felt that a specific statement should be made to this effect.  A further query was raised about why the focus was only on paid employment and that unpaid employment was excluded, as the rationale points to employment and meaningful activity. The evidence suggests that unpaid employment would be just as beneficial. The coding does give an option for unpaid voluntary work which was suggested as a possible contextual indicator? It was noted that the rationale mentions health benefits. If the rationale were strictly economic then the definition just using paid employment would be appropriate however with the emphasis on health benefits it calls into question some of the other parts of employment particularly voluntary work. It was recognised however that this could potential cause issues relating to not having different definitions across different domains. Further understanding of why other domains use just paid employments would be helpful. The applicant responded that the NHSOF indicator has previously been through MRG, so perhaps those documents could be referred to. The other two indicators have not been through MRG so it was difficult to comment on why that definition was chosen or why other parts were excluded.  Further discussion took place regarding the use of the voluntary work and student/training codes. CCGs wanting to know if their services help people get better presents a strong case for having the voluntary work included. It was suggested to add a contextual indicator for voluntary work alongside the main indicator. It was felt that voluntary work (code 07) was the most appropriate code to include following a discussion on the various codes. The applicant was asked to look into producing a contextual indicator for this and bring it back to MRG. It was agreed that the further discussion would take place only around the contextual indicator on voluntary work rather than going back through the indicator.  MRG members noted that the significant difference between this indicator and others in the NHSOF and PHOF is in not being able to access background employment rates. People looking at this indicator will have to bear in mind that having a high score on this indicator may be an indication that an area has high unemployment levels in general. This point needs to be absolutely clear in the metadata so that those coming to the indicator fresh can see what its limitations might be. |

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| Ref code  **IAP00338-01**  Made: 20/09/13 | It was recommended to review the title to describe that the indicator is being expressed as a percentage |
| Update:  Made: 20/09/13 | The title has been amended, as recommended by MRG.  Note that both the ASCOF and NHS OF indicators refer to proportions. The proposed CCG OIS indicator attempts to be similar to the ASCOF indicator and it was from here that the title was taken. |
| Further Rec:  Made: xx/xx/xx |  |
| Update:  Made: xx/xx/xx |  |
| Rec Status: |  |

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| Ref code  **IAP00338-02**  Made: 20/09/13 | The applicant is to check regarding what would happen if a patient moved CCGs during the year and whether or not patients are tracked across CCGs via NHS number. |
| Update:  Made: 20/09/13 | Patients are tracked such that only the CCG of the most recent contact is counted. Patients are only counted once in this indicator even if they have more than one practice or CCG in the period. |
| Further Rec:  Made: xx/xx/xx |  |
| Update:  Made: xx/xx/xx |  |
| Rec Status: |  |

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| Ref code  **IAP00338-04**  Made: 20/09/13 | A number of caveats to be identified in the supporting metadata were identified including:   * The possible impact of different approaches to service provision should be noted as a caveat for the indicator * Identifying that there are similar indicator in other outcome frameworks, but these cannot be produced at CCG level. * That it isn’t possible to incorporate local labour force survey information is a limitation of the indicator. * In interpreting results the user should be aware that a high score may be an indication that an area has high unemployment levels in general. |
| Update:  Made: 20/09/13 | The first point is relevant to the quality statement for this indicator and can be included within that. As with almost any service, how it is delivered could vary and this could impact on the resulting indicator.  The second point was noted in the ‘introduction’ to the original MRG application. It will be repeated in the quality statement for this indicator.  The third point was covered in both the ‘construction: statistical methods’ and ‘potential issues’ sections of the original MRG application. It will be repeated in the quality statement for this indicator.  Similarly, the fourth point was covered in the ‘construction: other (interpretation)’ section of the original MRG application. It will be repeated in the quality statement for this indicator. Note that this indicator is about people in employment, so a high rate is desirable. A low rate may not be such an issue if an area has high unemployment levels (and low employment levels) in general. |
| Further Rec:  Made: xx/xx/xx |  |
| Update:  Made: xx/xx/xx |  |
| Rec Status: |  |

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| Ref code  **IAP00338-04**  Made: 20/09/13 | The applicant is to look into producing a contextual indicator for code 07 – voluntary work and bring this back to MRG. |
| Update:  Made: 20/09/13 | The number of people doing unpaid voluntary work who are not working or actively seeking work (code 07) is 0 for 36 CCGs (17.1%) in June 2013 and 0% to one decimal place for more than a quarter of CCGs (53 CCGs, 25.1%).  In 206 CCGs (97.6%) the percentage of people doing unpaid voluntary work who are not working or actively seeking work is less than 3% of the number of adults who have received secondary mental health services. In only 4 CCGs is the percentage more than 10%. All 4 of these CCGs are in the same county, suggesting either a different policy is in use by the mental health care provider or the local authority. The data are shown below.  One reason for the low percentage in most CCGs would be the definition of the code 07, which excludes anybody doing unpaid voluntary work but who is actively seeking work. Therefore, we do not consider this to be useful. |
| Further Rec:  Made: xx/xx/xx |  |
| Update:  Made: xx/xx/xx |  |
| Rec Status: |  |

**Denominator: The number of working age adults aged 18 to 69 who have received secondary mental health services**

**Numerator: Unpaid voluntary work who are not working or actively seeking work (07)**

**95% Confidence Interval calculated using Wilson Score  
method.**

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| **CCG Code** | **Denominator** | **Numerator** | **%** | **Lower CI** | **Upper CI** |
| **Highest 10** |  |  |  |  |  |
| CCG 211 | 1306 | 271 | 20.8% | 18.6% | 23.0% |
| CCG 210 | 1345 | 199 | 14.8% | 13.0% | 16.8% |
| CCG 209 | 2237 | 310 | 13.9% | 12.5% | 15.4% |
| CCG 208 | 1639 | 177 | 10.8% | 9.4% | 12.4% |
| CCG 207 | 1956 | 129 | 6.6% | 5.6% | 7.8% |
| CCG 206 | 6263 | 174 | 2.8% | 2.4% | 3.2% |
| CCG 205 | 7303 | 200 | 2.7% | 2.4% | 3.1% |
| CCG 204 | 8181 | 224 | 2.7% | 2.4% | 3.1% |
| CCG 203 | 1561 | 41 | 2.6% | 1.9% | 3.5% |
| CCG 202 | 8751 | 220 | 2.5% | 2.2% | 2.9% |
|  |  |  |  |  |  |
| **Random selection** |  |  |  |  |  |
| CCG A | 8564 | 73 | 0.9% | 0.7% | 1.1% |
| CCG B | 4748 | 4 | 0.1% | 0.0% | 0.2% |
| CCG C | 3883 | 57 | 1.5% | 1.1% | 1.9% |
| CCG D | 2097 | 9 | 0.4% | 0.2% | 0.8% |
| CCG E | 10051 | 7 | 0.1% | 0.0% | 0.1% |
| CCG F | 6443 | 1 | 0.0% | 0.0% | 0.1% |
| CCG G | 3321 | 1 | 0.0% | 0.0% | 0.2% |
| CCG H | 9583 | 214 | 2.2% | 2.0% | 2.5% |
| CCG I | 4670 |  | 0.0% | 0.0% | 0.1% |
| CCG J | 12100 | 120 | 1.0% | 0.8% | 1.2% |
| CCG K | 3974 |  | 0.0% | 0.0% | 0.1% |
| CCG L | 7219 |  | 0.0% | 0.0% | 0.1% |
| CCG M | 235 |  | 0.0% | 0.0% | 1.6% |
| CCG N | 9214 | 72 | 0.8% | 0.6% | 1.0% |
| CCG O | 8918 | 2 | 0.0% | 0.0% | 0.1% |
| CCG P | 6089 | 68 | 1.1% | 0.9% | 1.4% |
| CCG Q | 5297 | 3 | 0.1% | 0.0% | 0.2% |
| CCG R | 37879 | 60 | 0.2% | 0.1% | 0.2% |
| CCG S | 2466 | 10 | 0.4% | 0.2% | 0.7% |
| CCG T | 4872 | 30 | 0.6% | 0.4% | 0.9% |

MRG Recommendations, Comments & Updates:

Summary of Discussion 18/10/13

The indicator was introduced by explaining the modifications that had been made regarding the recommendations that were made last time the indicator came to MRG.

Please see individual indicator record of assurance for details.

MRG felt that voluntary work was beneficial to recovery for people with mental health issues, however felt that the indicator outcome matches the title. It was felt that in the quality statement, it should specify that voluntary work is not included although it was appreciated that this may have the same benefits as paid work.

|  |  |
| --- | --- |
| Ref code  **IAP00338-01**  Made: 18/10/13 | **Update the quality statement to say that voluntary work was not included, although this may be beneficial to recovery.** |
| Update:  Made: 20/09/13 |  |
| Further Rec:  Made: xx/xx/xx |  |
| Update:  Made: xx/xx/xx |  |
| Rec Status: |  |

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| **Item 8.2:** **Decision** |
| **This indicator was recommended for discussion by IGB on completion of the above recommendations.** |

Revision – 21/02/2014

**Correction to an application previously assured by MRG.**

This paper concerns the CCGOIS indicator number 3.17 Proportion of adults in contact with secondary mental health services in paid employment. (Indicator Assurance reference IAP00338)

The indicator was presented to MRG on 20th September and 18th October 2013 when it was recommended to progress to IGB. Before presentation to IGB, an error came to light in the explanation of data quality. As a result, IGB requested that the indicator return to MRG for the specific issue of data quality to be re-considered.

1. **Background**

This section contains extracts from the original MRG papers as context:

1.1 Extract from the rationale for the indicator

“The indicator is intended to measure improved employment outcomes for adults with mental health problems, reducing their risk of social exclusion and discrimination. Supporting someone with their employment aspirations is a key part of the recovery process.

CCGs could work with local authorities through health and well-being boards and other organisations to improve the opportunities for people with long-term mental health conditions to find suitable employment opportunities. This indicator could also help inform CCGs about the type, level, intensity and quantity of mental health services they need to commission.”

1.2 Construction

“Denominator: The number of working age adults aged 18 to 69 who have received secondary mental health services at any point during the quarter.

Working age is defined as ages 18 to 69. This matches the age range for a measure that has been used historically and therefore maintains a time series.

Secondary mental health services are any mental health services provided in a secondary care setting, including inpatient and outpatient care and care provided by community mental health teams.

Numerator: Of people in the denominator, the number recorded as being in employment at their most recent assessment, formal review or other multi-disciplinary care planning meeting.

The measure is focused on ‘paid’ employment, to be clear that voluntary work is to be excluded for the purposes of this measure. Employment status is recorded using the following categories:

* 01 Employed
* 02 Unemployed and Seeking Work
* 03 Students who are undertaking full (at least 16 hours per week) or part-time (less than 16 hours per week) education or training and who are not working or actively seeking work
* 04 Long-term sick or disabled, those who are receiving Incapacity Benefit, Income Support or both; or Employment and Support Allowance
* 05 Homemaker looking after the family or home and who are not working or actively seeking work
* 06 Not receiving benefits and who are not working or actively seeking work
* 07 Unpaid voluntary work who are not working or actively seeking work
* 08 Retired
* ZZ Not Stated (person asked but declined to provide a response)

Paid employment for this indicator is 01. In employment means either an employee, self-employed, on Government employment & training programmes, or an unpaid family worker (in a family owned business) (this is the International Labour Organization definition of basic economic activity).

The indicator is not standardised.”

1. **Issue for correction**

2.1 In the application presented to MRG it was stated that “*The completeness of employment status within MHMDS is around 92% (June 2013)”.* This has been found to be incorrect. The figure of 92% relates to the percentage of valid employment codes, where submitted by the Mental Health Provider. This is different from the overall data completeness for this field which was 38% for the twelve months to the end of July 2013.

2.2 Employment status is a ‘required’ field in the MHMDS; this means that if the patient’s employment status is recorded then it must be submitted. Clinical guidance recommends that the check on a patient’s employment status should be carried out annually; hence the status should be recorded and submitted once per year.

2.3 SDS and the Mental Health team have undertaken some additional work in this area as part of an external commitment to provide data focussed on people with serious mental illness (SMI). By investigating the numbers of people with SMI who are in paid employment it has highlighted that the completeness of the employment status field increases to 54% for those with SMI. This is a reflection of policy direction from 2008 which has measured the employment status for patients that were on the Care Programme Approach (CPA), i.e. those patients with more serious illness. Policy direction has moved away from focussing on patients on CPA to all patients in contact with mental health services, for this and other MH indicators.

Table 1: Data to show the comparison between all MHMDS patients and those with SMI is shown below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Number of spells1 | Number with employment recorded2 | Percent with employment recorded | Number in employment3 | Percent in employment |
| All patients | 610,048 | 229,823 | 37.67% | 37,330 | 6.12% |
| Patients with SMI | 226,237 | 124,192 | 54.89% | 12,773 | 5.65% |

1 Number of people aged 18-69 with an open Adult Mental Health Care Spell (spell) at the end of the month

2 Number of people aged 18-69 with an open spell at the end of the month who had Employment Status recorded in the previous 12 months

3 Number of people aged 18-69 with an open spell at the end of the month whose most recent record of Employment Status in the previous 12 months showed they were employed.

Data source: Mental Health Minimum Dataset (MHMDS) YTD File July 2013

2.4 This correction to the data quality does not affect the indicator output figures previously presented to MRG but for completion we have provided CCG level data for the indicator is provided in Annex 1 which uses the same data source as Table 1 above. This shows that the proportion of adults in contact with secondary mental health services in paid employment ranges from 0% to 16.1% at CCG level. This is comparable to the ASCOF measure at Local Authority level for 2012/13 for which the range was 1.3% to 22% (with the caveat that the ASCOF measure uses data for patients on CPA and therefore has better completeness than the CCGOIS measure for all patients).

2.5 MRG members may be interested to note that development work is being carried out by the Royal College of Psychiatrists and HSCIC to improve the completeness of the recording of employment status via development of a Commissioning for Quality and Innovation (CQUIN) payment for this area.

1. **Action proposed to be taken by the developer**

We will highlight this data completeness issue as a caveat in the Indicator Quality Statement. We will also include information on the work being carried out to develop the CQUIN and promote improvements in recording of this particular piece of information.

**ANNEX 1**

Data for indicator 3.17; source MHMDS year to date July 2013

Sample data for indicator 3.17

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

|  |  |
| --- | --- |
| **Indicator Title** | Percentage of adults in contact with secondary mental health services in paid employment |
| Indicator Set | CCG Outcome Indicator Set |
| IAS Ref Code: | IAP00338 |
| Description | This indicator shows the percentage of adults receiving secondary mental health services in paid employment at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. |

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| Initial IGB discussion | 16/01/14 | Further discussed |  |

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|  | **Strategic Considerations & Implications** |
| Applicant / Sponsor Organisation | NHS England  \*Costing for assurance appraisal included in development cost |
| Assurance process funded? | Yes |
| Indicator rationale | This indicator provides an indication of the impact of long-term mental illness on employment among working age adults. The indicator is intended to measure improved employment outcomes for adults with mental health problems, reducing their risk of social exclusion and discrimination.  Using results from this indicator, CCGs could work with local authorities through health and well-being boards and other organisations to improve the opportunities for people with long-term mental health conditions to find suitable employment. This indicator could also help inform CCGs about the type, level, intensity and quantity of mental health services they need to commission. |
| Basis for rationale  [Details of quality statement, policy etc.] | It is estimated that between 10% and 16% of people with a mental health condition (excluding depression) are in employment. However, between 86% and 90% of people with a mental health condition want to work *(Work, Recovery and Inclusion: Employment support for people in contact with secondary mental health services – National Mental Health Development Unit, based on 2001 ONS data).*  The 2006 evidence review by Waddell and Burton “Is work good for your health and well-being?” *(commissioned by the Department for Work and Pensions)* concluded that work was generally good for both physical and mental health and well-being. The review found a strong association between worklessness and poor health. This may be partly a health selection effect, but it is also to a large extent cause and effect. There is strong evidence that unemployment is generally harmful to health, including:   * higher mortality; * poorer general health, long-standing illness, limiting longstanding illness; * poorer mental health, psychological distress, minor psychological/psychiatric morbidity; * higher medical consultation, medication consumption and hospital admission rates.   There is strong evidence that re-employment leads to improved self-esteem, improved general and mental health, and reduced psychological distress and minor psychiatric morbidity. The magnitude of this improvement is comparable to the adverse effects of job loss.  The CCG Outcome Indicator Set (CCG OIS) is an integral part of NHS England’s systematic approach to quality improvement. It is intended to provide clear, comparative information for CCGs, patients and the public about the quality of health services commissioned by CCGs and the associated health outcomes. All of the CCG outcomes indicators have been chosen on the basis that they contribute to the overarching aims of the five domains in the NHS Outcomes Framework and it is intended as a tool for CCGs to drive local improvement and set priorities. Reference: CCG OIS, NHS England. <http://www.england.nhs.uk/ccg-ois/> |
| Calculation Summary | Calculated as a percentage at CCG level.  [ X / Y ] x 100 = The percentage of adults receiving secondary mental health services in paid employment, given by CCG.  **Denominator** (Y): The number of working age adults aged 18 to 69 who have received secondary mental health services at any point during the financial year.  *\* age range consistent with PHOF indicator 1.08iii 1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate, and ASCOF (1F) Proportion of adults in contact with secondary mental health services in paid employment*  **Numerator** (X): Of people in the denominator, the number recorded as being in employment. The most recent record of employment status for the person during the financial year is used.  *\*the MHMDS definition of [01] Employed states:*   * *Employed refers to those who are employed by a company and have their National Insurance paid for directly from their wages.* * *It also includes those who are self-employed (i.e. those who work for themselves and generally pay their National Insurance themselves); those who are in supported employment; and those who are in permitted work (i.e. those who are in paid work and who are also receiving Incapacity Benefit). It should also include those who are unpaid family workers (i.e. those who do unpaid work for a business they own or work for a business a relative owns).* |
| Risks & assumptions | This indicator may be influenced by the willingness of people with long-term mental health conditions to work. This is likely to be affected by changes to financial incentives (including those implicit in the benefit system).  The ability of people with long-term mental health conditions to find employment will be greatly influenced by the general level of employment in their local area. It is not currently possible to produce general employment statistics at CCG level however, so it is not possible to provide this as a direct comparison.  The indicator doesn’t take into consideration severity of mental health condition  The assignment of a CCG to a patient will be based on GP or practice code where possible and if not, then on the patient’s home postcode. Where the patient’s practice and postcode are both unavailable, the responsible CCG is derived from the location of the hospital or trust. As the numerator is a subset of the denominator, the same method will be used for any particular patient. |
| IG Considerations [e.g. release of under-lying data, intermediaries’ access to data, data ownership impact on production] | *Data Source:* MHMDS, v4.1 (HSCIC).  <http://www.hscic.gov.uk/media/10688/MHMDSv41UserGuidance/pdf/MHMDS_v4.1_User_Guidance.pdf>  From April 2014, this will be superseded by the Mental Health and Learning Disabilities Dataset (MHLDDS), v1.0. |
| IG Considerations [e.g. release of under-lying data, intermediaries’ access to data, data ownership impact on production] | The underlying individual level data are held by the HSCIC and are made available to customers via several mechanisms depending on their requirements. HSCIC publishes quarterly summaries of MHMDS data. There is also a chargeable extract service that covers both bespoke and routine extracts.  MHMDS (version 4.1, release Amd 25/2012) is approved by ISB ref ISB 0011.  MHMDS has been approved by ROCR license number ROCR/OR/0017/FT6/002MAND. |
| Potential impacts on other business areas [inc outstanding generic issues] | There are a number of similar indicators existing :  However;   * None of these indicators are produced at Clinical Commissioning Group (CCG) level. * The proposed indicator looks at everyone on the MHMDS whereas ASCOF is (at the moment) restricted to people on the Care Programme Approach. This was based on advice from the mental health team at HSCIC.   NHS Outcomes Framework (NHSOF), 2.5 *Employment of people with mental illness*  This indicator shows the gap between the employment rate for those with a long-term mental health condition and the employment rate for the working-age population.  Adult Social Care Outcomes Framework (ASCOF), 1F *Proportion of adults in contact with secondary mental health services in paid employment*  This indicator shows the employment rate for those with a long-term mental health condition.  Public Health Outcomes Framework (PHOF), 1.8iii  This indicator shows the difference between two employment rates at local authority level: adults in contact with secondary mental health services in paid employment, compared to the percentage of all respondents to the Annual Population Survey. The proposed indicator is similar to the first part of this. |
| Implementation Method  [inc production funding] | NHS England has commissioned HSCIC to produce and disseminate the CCG OIS indicators; this is funded via the Grant In Aid funding to HSCIC.  Collection of the data for the CCG OIS is via existing data collections, in this case by the Mental Health Minimum Dataset (MHMDS). Testing and specification of this indicator was carried out by the Specification Development Service. The construction of the indicators will be carried out by Clinical Indicators via the CI Platform at HSCIC.  Dissemination and presentation of the CCG OIS will be via a number of routes:   * The indicators and their underlying data will be made publicly available via the HSCIC website and the Indicator Portal. * The data will also be provided to NHS England for use in their internal Intelligence Tool.   Subject to confirmation by NHS England, the calculated indicator, numerator and denominator for CCGs will be supplied by messaging to the Calculating Quality Reporting Service (CQRS) for use by CCGs as part of their management information. |

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|  | **Development Advice / Peer Review (undertaken as part of assurance process)** |
| Range of input during development | HSCIC Mental Health team have advised on the use of MHMDS data. |
| Assurance Service  Peer Reviewers: | Andrea Johnson, Clinical Indicators, HSCIC |
| Peer Review summary: | Comments received from peer review are summarised below. All were subsequently discussed at MRG.    The peer reviewer noted that:   * Although whole population local labour force statistics are available at Local Authority level, they are not currently available and are not able to be produced at CCG level. Where CCG boundaries are not co-terminus with LA boundaries, reliable comparisons cannot be made. * The wider economy and general local employment opportunities (i.e. not just those in receipt of secondary mental health services) could affect performance on this indicator. * The original application did not explicitly specify if those without a valid employment code are excluded or included in the dataset. Issues of missing data and how it is handled are not explained. This was subsequently covered in the MRG discussion regarding the update on data completeness. * Training and voluntary work are excluded from the indicator. The evidence base mentions that paid work reduces the risk of social isolation. The same could be argued for voluntary work and training as both get people socially involved and enhance skills necessary for employment. This was tested at the MRG stage. |

Record of MRG discussions:

Discussion dates: 20/09/13 18/10/13 & 28/02/14

|  |  |  |
| --- | --- | --- |
| Heather Dawe | HSCIC | Programme Manager, Clinical Indicators |
| Paul Fryers | Public Health England | Deputy Director, East Midlands Knowledge and Intelligence Team |
| Alyson Whitmarsh | HSCIC | Programme Manager, Clinical Audit |
| Irena Begaj | UHB | Statistical Intelligence Analyst |
| Chris Dew | HSCIC | Section Head, Clinical Indicators |
| Andy Sutherland | HSCIC | Statistics Head of Profession |
| Daniel Sutcliffe | NICE | Programme Manager |
| Paul Iggulden | HSCIC | Interim Head of Clinical Analysis Research & Development |
| Julie Stroud | HSCIC | Programme Head, Population Health |
| Gerry Firkins | HSCIC | NHS Sec Management Domain Lead |
| John Sharp | HSCIC | Head of Data Quality |

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| Summary of MRG discussions: | * The number of indicators measuring the subject with different definitions was questioned, and whether the creation of another was justifiable. MRG concluded that if the definition is tied to the ASCOF approach this was acceptable, however the creation of a fourth definition was not desirable. It was queried as to what extent this indicator added value over the ones already in existence. * The applicant has identified that there are similar indicators in other outcome frameworks, but these cannot be produced at CCG level in the indicator quality statement * The title was amended. from ‘Proportion of’ to ‘Percentage of’ * MRG queried what would happen if an individual had more than one interaction with mental health services. * The applicant updated the group that as it is the last episode counted, individuals would be counted once. MHMDS data tracks an individual in the event that they move as it is based on NHS number. Patients are tracked such that only the CCG of the most recent contact is counted and are only counted once in this indicator even if they have more than one practice or CCG in the period. * MRG noted that the severity of mental illness is not reflected in the indicator and it may be of interest to see if there were a difference between CCGs in the effect of severity of illness on the indicator. It was also noted that there were different models of care e.g. Tower Hamlets work to move people away from secondary care lists and have them managed by GPs. The less severe patients are therefore managed in primary care. MRG concluded that although it was felt that this may call into question some of the data, a caveat could be placed on it rather than disregarding the usefulness of the indicator itself. * A query was raised about why the focus was only on paid employment and that unpaid employment was excluded, as the rationale points to employment and meaningful activity. The coding does give an option for unpaid voluntary work which was suggested as a possible contextual indicator. * Further discussion took place regarding the use of the voluntary work and student/training codes. CCGs wanting to know if their services help people get better presents a strong case for having the voluntary work included. It was suggested to add a contextual indicator for voluntary work alongside the main indicator. * Subsequent research was undertaken into producing a contextual indicator using code 07 – voluntary work. This revealed that in 206 CCGs (97.6%) the percentage of people doing unpaid voluntary work who are not working or actively seeking work is less than 3% of the number of adults who have received secondary mental health services. In only 4 CCGs (in the same county) is the percentage more than 10%. One reason for the low percentage in most CCGs would be the definition of the code 07, which excludes anybody doing unpaid voluntary work but who is actively seeking work. Therefore, it was not considered to be useful. * MRG concluded that although there was a view that voluntary work was beneficial to recovery for people with mental health issues, in this case the indicator outcome matches the title. It was felt that in the quality statement, it should specify that voluntary work is not included although it was appreciated that this may have the same benefits as paid work. * MRG members noted that the significant difference between this indicator and others in the NHSOF and PHOF is in not being able to access background employment rates, therefore having a high score on this indicator may be an indication that an area has high unemployment levels in general. This point needs to be absolutely clear in the metadata. * The fact that it isn’t possible to incorporate local labour force survey information is included in the indicator quality statement as a limitation of the indicator. The statement will also identify that when interpreting results, the user should be aware that a high score may be an indication that an area has high unemployment levels in general.   Subsequent to the indicator being presented to MRG on 18th October 2013 (when it was recommended to progress to IGB), the applicant highlighted an error in the explanation of data quality. As a result, the indicator returned to MRG for re-consideration with regards to the specific issue of data quality:   * In the original application it was stated that “The completeness of employment status within MHMDS is around 92% (June 2013)”. However, this figure relates to the percentage of valid employment codes, where submitted by the Mental Health Provider. This is different from the overall data completeness for this field which was 38% for the twelve months to the end of July 2013. * Employment status is a ‘required’ field in the MHMDS; this means that if the patient’s employment status is recorded then it must be submitted. Clinical guidance recommends that the check on a patient’s employment status should be carried out annually; hence the status should be recorded and submitted once per year. * SDS and the Mental Health team have undertaken some additional work in this area as part of an external commitment to provide data focussed on people with serious mental illness (SMI). By investigating the numbers of people with SMI who are in paid employment it has highlighted that the completeness of the employment status field increases to 54% for those with SMI. This is a reflection of policy direction from 2008 which has measured the employment status for patients that were on the Care Programme Approach (CPA), i.e. those patients with more serious illness. Policy direction has moved away from focussing on patients on CPA to all patients in contact with mental health services, for this and other MH indicators.      * It was highlighted by the applicant that the MHMDS data is already in use for the equivalent ASCOF indicator and is the only data source that will support CCG level analysis. * Output figures show that the proportion of adults in contact with secondary mental health services in paid employment ranges from 0% to 16.1% at CCG level. This is comparable to the ASCOF measure at Local Authority level for 2012/13 for which the range was 1.3% to 22% (with the caveat that the ASCOF measure uses data for patients on CPA and therefore has better completeness than the CCGOIS measure for all patients). * The applicant updated MRG members that development work is being carried out by the Royal College of Psychiatrists and HSCIC to improve the completeness of the recording of employment status via development of a Commissioning for Quality and Innovation (CQUIN) payment for this area. * A caveat highlighting data completeness is included in the Indicator Quality Statement, alongside information on the work being carried out to develop the CQUIN and promote improvements in recording of this particular piece of information. * It was suggested that the recording level by CCG is reported alongside the indicator as contextual information. This will be done on production of the indicator later in 14/15, and has been added to the output in the Spec. |
| *Outcome of MRG consideration:* | **Some concerns expressed as caveats or limitations** |
| MRG statement of recommendation: | The consensus among MRG members is that the data quality is currently at a poor level and comparison at CCG level would not be possible. However, it is hoped that the indicator will drive up data quality and in light of this MRG members have queried whether it is possible to attach a “provisional” status to both the indicator and /or assurance.  This indicator is recommended for discussion by IGB on the basis that relevant data quality warnings are highlighted, and it is further recommended that a data quality improvement plan is put in place which can be revisited when the indicator is reviewed. This is to ensure there has been sufficient commitment to improve data quality, and improvements have been made. |

Review:

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| Review Timescale | Other |
| Rationale | Issues to consider – Changes to process, policy data source, coding definitions HES definitions ]  It is proposed to review the indicator after the first year of data to re-visit the issues raised at MRG and review data completeness. |

IGB Sign-off Indicator Assurance Process Output

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| *Final Appraisal Status* | **Assured** |
| Basis of Sign-off  [Detail caveats and limitations ] | The indicator methodology was signed off as assured for inclusion in the indicator library with a review date of 1 year. |
| Sign-off Date | June 2014 |

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