Technical Guidance for the 2011/12 Operating Framework

20 January 2011

Technical Guidance for 2011/12 Operating Framework

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning /	Finance
Clinical	Social Care / Partnership Working

Document Purpose	For Information
Gateway Reference	15476
Title	Technical Guidance for the 2011/12 Operating Framework
Author	Knowledge & Intelligence Branch
Publication Date	20 Jan 2011
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs
Circulation List	
Description	The purpose of this Technical Guidance is to list all the indicators against which the NHS will be held accountable nationally during 2011/12.
Cross Ref	The NHS Operating Framework for 2011/12
Superseded Docs	Technical Descriptions for Plans Updated for 2010/11 Refresh
Action Required	N/A
Timing	N/A
Contact Details	Julia Bowman Knowledge & Intelligence Branch Room 4E40, Quarry House, Quarry Hill Leeds LS2 7UE 0113 2545215
For Recipient's Use	

Technical Guidance for the 2011/12 Operating Framework

Prepared by Knowledge & Intelligence Branch

Contents

Executive summary

The purpose of this Technical Guidance is to describe the indicators in the Integrated Performance Measures in the NHS Operating Framework for 2011/12, and to set out for each measure:

- Definitions
- Monitoring Arrangements
- Accountability Expectations
- Planning Requirements, if applicable
- Further Information

HQU01: HCAI measure (MRSA)

DEFINITIONS

Detailed Descriptor:

Number of Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia, as defined below.

Lines within Indicator (Units):

Infections (positive samples).

Data Definition:

An MRSA bacteraemia is defined as a positive blood sample test for MRSA on a patient. Reports of MRSA cases must include all MRSA positive blood cultures detected in the laboratories, whether clinically significant or not, whether treated or not, whether acquired in the Trust or elsewhere. Positive results on the same patient more than 14 days apart should be reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where they were taken.

In constructing the objective, use was made of rates based on both population sizes and numbers of occupied bed days. Sources and definitions used are:

For PCOs: The Office for National Statistics mid-year population estimates for 2008 for residents (all ages).

For acute trusts: The number of occupied bed days in the year derived from DH return KH03 – 2009-10 financial year.

Basis for Accountability:

The national objective for MRSA bacteraemia is for acute trusts and PCOs to achieve a reduction in each year to 2012-13 based on the median and best quartile rate of the 12-month period October to September of the preceding year. For primary care organisations (PCOs comprising primary care trusts and care trusts), the basis of the assessment is the number of positive MRSA blood samples (more than 14 days apart) in patients for whom the PCO has responsibility (see data definition below).

Cases will be attributed to responsible PCOs via the NHS Connecting for Health's Demographics Batch Service (DBS) using the NHS number and date of birth or, where this is not possible, attributed to the *lead* PCO (sometimes called the *coordinating* PCO) for the trust reporting the case.

For acute trusts the basis of the assessment is the number of positive MRSA blood specimens (more than 14 days apart) taken from inpatients, excluding specimens taken on the day of admission or on the day following the day of admission. In addition, specimens from admitted patients where an admission date has not been recorded, or where it cannot be determined if the patient was admitted, are also

attributed to the acute trust.

For example:

admission day
admission day + 1
admission day + 2 -   specimens taken on this day or later are trust apportioned

---

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

HPA HCAI Data Capture System

ACCOUNTABILITY

What success looks like, direction, milestones

The objective aims to deliver a continuing reduction in the number of MRSA bacteraemia in acute and non-acute settings by requiring acute trusts and PCOs to improve their performance to the level of the top performers, as judged by the bed day or population rates.

Appropriate objective figures for 2011-12 have been calculated centrally for each PCO and acute trust, based on their performance in the 12 months October 2009 to September 2010. For the best performers (those in the best quartile, based on their population or bed day rates) no central objective will be set, but it is expected that these organisations will negotiate local objectives that at least maintain their current performance.

The objectives were calculated as:

- Organisations with baseline rates above the median rate: reduce to the median rate, or by 20%, whichever results in the larger reduction.

- Organisations between the median and best quartile rates: reduce rates by 20% or to the "best" (lowest) quartile whichever results in the smaller reduction. This is to ensure no trust or PCO is required to achieve a rate better than the current best quartile.

- Organisations currently in the best quartile: no objective will be set centrally. SHAs and PCOs will negotiate objectives locally and it is expected that organisations will aim to at least maintain current performance. These organisations will advise the Department of the objectives they have set locally.

- PCOs will be expected to set locally agreed objectives for their non-acute

providers to ensure they achieve their overarching objective as appropriate.

- Where the objective calculation results in a fractional objective number, the number will be rounded to the nearest whole number, unless this would result in an objective of zero in which case it will be rounded up to 1.

- If, as a result of a fractional rounding, the objective number does not require an organisation to reduce its numbers of MRSA bacteraemia then no objective will be set centrally. In these cases, the objective will be negotiated locally and it is expected that organisations will aim to at least maintain current performance. These organisations will need to advise the Department of the objectives that they have set locally.

- If, as a result of worsening performance between 2008-09 and 2009-10, the calculated objective for an organisation is higher than their plan for 2010-11, the objective for 2011-12 will be set ("capped") at the 2010-11 plan.

The baseline median and best quartile rates were:

	Median	Best quartile
PCOs (cases per *million* population)	33.04	24.09
Acute trusts (trust apportioned cases per *million* bed days)	20.02	11.69

Timeframe/Baseline:

For each financial year the objective for each trust or PCO will be based on the performance in the 12 months to the end of September of the previous year. So objectives for 2011-12 will be based on performance in the period October 2009 to September 2010.

Timeframe Until:

The original intention was that the objective would continue until 2012-13, but it will be reviewed in Autumn 2011.

Rationale:

Reduction in healthcare associated infection has been a priority for the NHS, and has been reiterated by the new administration in the White Paper "Equity and excellence: Liberating the NHS". The Department recognises that it may not be possible to achieve zero infections as there are some infections that cannot be prevented. The ultimate aim is for zero *preventable* infections.

MRSA is still a significant patient safety issue with over 1,700 bacteraemias in the 12 months to September 2010 in England. Along with other healthcare associated infections, it can cause illness and, sometimes, death. It can be very distressing for patients who acquire an infection, for their family and friends and for staff who treat them. It is also a continuing key issue for public confidence in the NHS. Reducing MRSA bacteraemia will lead to significantly improved patient outcomes as well as

cost savings for the NHS.

Organisations need to take necessary action to ensure progress in reducing MRSA while at the same time as maintaining or improving performance on *Clostridium difficile* infection (CDI) - an infection also of key concern to the public.

SHA Envelopes:

Envelopes have not been independently calculated for the SHAs, however their performance will be monitored based on the sum of their constituent PCOs.

PLANNING REQUIREMENTS
Are Plans Required?:

Yes, provider and commissioner plans

Planning Frequency:

Monthly for 2011/12

Criteria for Plan Sign-off:

Organisation's plans for 2011-12 need to at least meet the objective calculated centrally. These are detailed for each organisation in the tables attached to this guidance.

Where the objective is to be locally agreed the plan should at least maintain the performance achieved in the 12 month period October 2009 to September 2010.

FURTHER INFORMATION
Further Information:

Further information on the objective is available on Unify at:
http://nww.unify2.dh.nhs.uk/InstantForum414/Topic10033833-10004211-1.aspx

and from the HPA at https://nww.hcai.nhs.uk/MRSA/download.htm.

If you have any queries please contact MRSA_Objective_Queries@dh.gsi.gov.uk

Changes from 2010/11 Planning Round:

The formal methodology is unchanged from 2010-11 except that no organisation has been set an objective that is higher than 2010-11 plan.

HQU02: HCAI measure (CDI)

DEFINITIONS
Detailed Descriptor:

Incidence of Clostridium difficile-

Number of *Clostridium difficile* infections (CDIs), as defined below, for patients aged 2 or more.

Lines within Indicator (Units):

Infections (positive samples).

Data Definition:

A CDI is defined as a case where the patient shows clinical symptoms of *C. difficile* infection, and has a positive laboratory test result for CDI recognised as a case according to the Trust's diagnostic algorithm. Positive results on the same patient more than 28 days apart should be reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where they were taken.

In constructing the objectives, use was made of rates based on both population sizes and numbers of occupied bed days. Sources and definitions used are:

For PCOs: The Office for national Statistics (ONS) population estimates for 2008 for residents aged 2 and over.

For acute trusts: The sum of episode durations for episodes finishing in 2009-10 where the patient was aged 2 or over at the end of the episode from Hospital Episode Statistics (HES).
.

Basis for Accountability:

PCOs (PCTs and Care Trusts) are accountable for all cases of CDI occurring in their responsible populations.

Cases will be attributed to responsible PCOs via the NHS Connecting for Health's Demographics Batch Service (DBS) using the NHS number and date of birth or, where this is not possible, attributed to the *lead* PCO (sometimes called the *coordinating* PCO) for the trust reporting the case.

Acute provider trusts are accountable for all CDI cases for which the trust is deemed responsible. This is defined as a case where the sample was taken on the fourth day or later of an admission to that trust (where the day of admission is day one).

For example:
admission day

admission day + 1

admission day + 2

admission day + 3 - specimens taken on this day or later are trust apportioned

MONITORING
Monitoring Frequency:

Monthly

Monitoring Data Source:

HPA HCAI Data Capture System

ACCOUNTABILITY
What success looks like, direction, milestones

The indicator should decrease. Organisations with higher baseline rates will be required to deliver larger reductions.

Appropriate objective figures have been calculated centrally for each PCO and each acute trust based on a formula which, if the objectives are met, will deliver a further national reduction in cases of 29% whilst also reducing the variation in population and bed day rates between organisations.

See the Further Information section below for links to detailed documents with explanations of the formula used and the rationale behind it.

Timeframe/Baseline:

The baseline period is the 12 months October 2009 to September 2010. This means that objectives have been set according to performance in this period.

Timeframe Until:

The initial period for the indicator will be the financial year 2011-12, although it may continue for further years. The indicator will be reviewed in Autumn 2011.

Rationale:

Reduction in healthcare associated infection has been a priority for the NHS, and has been reiterated by the new administration in the White Paper "Equity and excellence: Liberating the NHS".

CDI is a significant patient safety issue with over 24,000 cases in the baseline 12 month period (October 2009 to September 2010) in England. Along with other healthcare associated infections, it can cause illness and, sometimes, death. It is distressing for patients who acquire an infection, for their family and friends and for staff who treat them.

Although significant progress has been made over the last few years, particularly in terms of narrowing the gap between the best and poorest performers, there is still considerable room for further improvement. Reducing CDI will lead to significantly improved patient outcomes as well as cost savings for the NHS.

Organisations need to take necessary action to ensure progress in reducing CDI while at the same time as maintaining or improving performance on MRSA - an infection also of key concern to the public.

SHA Envelopes:

Envelopes have not been independently calculated for the SHAs, however their performance will be monitored based on the sum of their constituent PCOs.

PLANNING REQUIREMENTS

Are Plans Required?:

Yes, provider and commissioner plans

Planning Frequency:

Monthly for 2011/12

Criteria for Plan Sign-off:

Organisation's plans for 2011-12 need to at least meet the objective calculated centrally. These are detailed for each organisation in the tables attached to this guidance.

FURTHER INFORMATION

Further Information:

Further information on the objective is available on Unify at:

http://nww.unify2.dh.nhs.uk/InstantForum414/Topic10033833-10004211-1.aspx

and from the HPA at https://nww.hcai.nhs.uk/MRSA/download.htm.

If you have any queries please contact CDIObjectivequeries@dh.gsi.gov.uk

Changes from 2010/11 Planning Round:

Whilst the monitoring and reporting arrangements have not changed, a new level of ambition has been set for the service following the achievement of the previous CDI objective.

HQU03: Ambulance Quality (Cat A Response Times)

HQU03_01: Ambulance Clinical Quality- Category A 8 Minute Response Time

DEFINITIONS

Detailed Descriptor:

Improved health outcomes from ensuring a defibrillator and timely response to immediately life-threatening ambulance calls

Lines within Indicator (Units):

Numerator:
The total number of Category A incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes.

Denominator:
The total number of Category A incidents, which resulted in an emergency response arriving at the scene.

Data Definition:

Numerator:
The total number of Category A incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes. A response within eight minutes means eight minutes zero seconds or less. (KA34 Line 03 Category A)

Denominator:
The total number of Category A incidents, which resulted in an emergency response arriving at the scene. If there have been multiple calls to a single incident, only one incident should be recorded. (KA34 Line 02 Category A)

Category A incidents: presenting conditions, which may be immediately life threatening and should receive an emergency response within 8 minutes irrespective of location in 75% of cases. The "clock stops" when the first emergency response vehicle arrives at the scene of the incident. A legitimate clock stop position can include the vehicle arriving at a pre-arrival rendezvous point when one has been determined as appropriate for the safety of ambulance staff in agreement with the control room.

Basis for Accountability:

This data will be reported for all Ambulance Trusts at a Trust-wide level

MONITORING
Monitoring Frequency:
Annual for official monitoring of the Category A 8 minute response time standard. Weekly ambulances sitrep return. Monthly for inclusion in the clinical quality indicators for the ambulance service
Monitoring Data Source:
Ambulance Computer Aided Dispatch system Data submitted via form KA34 to the NHS Information Centre for Health and Social Care

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Faster response times improve health outcomes and experience for patients with immediately life-threatening conditions. Category A incidents: presenting conditions, which may be immediately life threatening and should receive an emergency response within 8 minutes irrespective of location in 75% of cases.
Timeframe/Baseline:
Timeframe Until:
Ongoing
Rationale:
Faster response times improve health outcomes and experience for patients with immediately life-threatening conditions.
SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:

Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
The KA34 guidance published by the Information Centre for Health and Social Care sets out the definitive definition for this indicator and expands upon the definitional information provided here. Further information and guidance on the Ambulance Clinical Quality Indicators will be released early in 2011 by the Ambulance Service, the Department, and the NHS Information Centre for Health and Social Care.
Changes from 2010/11 Planning Round:
This is a new indicator

HQU03_02: Ambulance Clinical Quality- Category A 19 Minute Transportation Time

DEFINITIONS
Detailed Descriptor:

Patient outcomes can be improved by ensuring patients with immediately life-threatening conditions receive a response at the scene which is able to transport the patient in a clinically safe manner, if they require such a response.

Lines within Indicator (Units):

Numerator: The total number of calls resulting in an ambulance arriving at the scene of the incident within 19 minutes.

Denominator: The total number of Category A incidents with ambulance response arriving

Data Definition:

Numerator: The total number of Category A incidents, which resulted in a fully equipped ambulance vehicle (car or ambulance) able to transport the patient in a clinically safe manner arriving at the scene within 19 minutes of the request being made (KA34 Line 06 Category A)

Denominator: The total number of Category A calls resulting in an ambulance able to transport the patient arriving at the scene of the incident (KA34 Line 05 Category A)

Category A incidents: presenting conditions, which may be immediately life threatening and should receive an ambulance response at the scene within 19 minutes irrespective of location in 95% of cases.

The "clock stops" when the first emergency response vehicle arrives at the scene of the incident. A legitimate clock stop position can include the vehicle arriving at a pre-arrival rendezvous point when one has been determined as appropriate for the safety of ambulance staff in agreement with the control room.

Basis for Accountability:

This data will be reported for all Ambulance Trusts at a Trust-wide level

MONITORING
Monitoring Frequency:

Annual for official monitoring of the Category A 19 minute response time standard

Monitoring Data Source:
Ambulance Computer Aided Dispatch system
Data submitted via form KA34 to the NHS Information Centre for Health and Social Care

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Faster response times improve health outcomes and experience for patients with immediately life-threatening conditions.
Category A incidents: presenting conditions, which may be immediately life threatening and should receive an ambulance response at the scene within 19 minutes irrespective of location in 95% of cases.

Timeframe/Baseline:
Ambulance services should aim for continuous improvement on these indicators and monitor as long a time series as possible (24 continuous months is preferable). In addition to comparing current performance with performance in the immediately preceding periods, services may also find it helpful to compare current performance against a baseline of activity in the same period in the previous year. This will allow services to place current performance in context, and stimulate discussion on how to continuously improve.
When comparing current performance with historical performance care should be taken to assess how much of the observed change in activity or performance is affected by changes in the coverage and quality of the data"

Timeframe Until:
Ongoing

Rationale:
Patient outcomes can be improved by ensuring patients with immediately life-threatening conditions receive a response at the scene which is able to transport the patient in a clinically safe manner, if they require such a response.

SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No

Planning Frequency:

Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
The KA34 guidance published by the Information Centre for Health and Social Care sets out the definitive definition for this indicator and expands upon the definitional information provided here.
Changes from 2010/11 Planning Round:
This is a new indicator

HQU04: Patient Experience Survey
DEFINITIONS
Detailed Descriptor:

Improving Patient Experience: ensuring people have a positive experience of care

Patients' experiences of NHS inpatient care.
The template below covers the annual adult inpatient survey, which is one of a suite of surveys which make up the NHS National Patient Survey Programme. The technical guidance set out here applies to this specific survey only.

Other patient experience surveys
 In 2011-12, a range of additional surveys will be also be conducted – covering primary care and dental services, outpatient services, and community mental health services. Collectively, these surveys make up domain 4 of the NHS Outcomes Framework ("ensuring people have a positive experience of care"). While these surveys will yield data in 2011-12, further work is required on developing the data definition and a full technical specification for constructing the final indicator. Further details on these indicators are available on the DH website (see below), and final details will be published in due course:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944

Lines within Indicator (Units):

The data source for this measure is the adult inpatient survey, part of the NHS National Patient Survey Programme. The survey is conducted using a postal self-completion survey approach, and is conducted among a sample of recent patients who have spent at least one night in hospital. The survey covers both elective and emergency care patients, but does not include maternity, mental health patients or patients under the age of 18.

Published National Statistics summarise the survey into a set of five domain scores (out of 100) and an overall score calculated as the average of the five domains:

- Access & waiting

- Safe, high quality co-ordinated care

- Better information more choice

- Building closer relationships

- Clean comfortable friendly place to be

- Overall score.

Each domain score is calculated using a subset of questions from the survey. Only the overall score is being proposed to be used as the high level outcome measure. However, performance can be disaggregated by each of the domains, and then again at the level of each individual survey question that makes up the indicator – at

a national, regional and provider trust level.

Data Definition:

See above. Also, further details of the methodology used to construct the indicator are available on the DH website.
http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/Nationalsurveyof NHSpatients/DH_087516

Further details about this nationally coordinated survey are available on the websites of the NHS national patient survey coordination centre and Care Quality Commission:
http://www.nhssurveys.org/
http://www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patients urveys.cfm

Basis for Accountability:

Surveys are conducted by acute trusts in line with standardised guidance and methodologies. Results can be aggregated to form regional and national scores. A series of support tools are available on the DH website to assist organisations understand their current performance, and to identify priority areas for improvement (see link below for further details):
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAn dGuidance/DH_091660

MONITORING
Monitoring Frequency:

This nationally coordinated survey is conducted on an annual basis, and time-series comparisons for the indicator are available going back over several years. This survey and indicator provide a robust snapshot of performance. Trusts may wish to also develop a more regular or continuous view of performance, which can be achieved by putting in place appropriate mechanisms for ensuring comparable in-year assessments – for example, by either locally replicating the national survey, or through the use of other patient feedback arrangements (such as through "real-time" approaches). A localised support package is available from the NHS patient survey coordination centre for local organisations to support them in developing such approaches (further details are available via the link below)
http://www.nhssurveys.org/localsurveys

Monitoring Data Source:

Details provided above.

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Success if defined as improved patient experience ratings, calculated in line with the methodology set out above. Additionally, as part of the NHS Performance

Framework, levels of trust performance are also assessed against the indicator – with trusts rated as "performing", "under review" or "underperforming". Further details are available via the DH website:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_115035

Timeframe/Baseline:

This survey is conducted annually. Survey fieldwork typically takes place between October – January each year (with patients sampled on the basis of having an inpatient stay in July-August of the same year). The complete set of local and national results are published by the Care Quality Commission each spring, although it is important to note that each NHS trust will have access to their own local data well in advance of this date (usually in January, made available from their survey contractor or in-house survey team).

Timeframe Until:

N/A

Rationale:

Patient centred care, and improving patient experience, are priorities for the coalition government – as is evident from the 2011-12 NHS Operating Framework. In addition, these priorities feature very strongly in the White Paper, and a number of the related consultations (including the NHS Outcomes Framework).

SHA Envelopes:

N/A

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Details set out above
Changes from 2010/11 Planning Round:
None

HQU05-07: Referral to Treatment waits (95th percentile measures)

DEFINITIONS

Detailed Descriptor:

RTT waits (3 measures- admitted 95th centile, non-admitted 95th centile, incomplete 95th centile)-

The 95th percentile time waited for admitted and non-admitted patients completing an RTT pathway, and for incomplete pathways

Lines within Indicator (Units):

HQU05 - the 95th percentile time waited for admitted patients whose clocks stopped during the period on an adjusted basis

HQU06 - the 95th percentile time waited for non-admitted patients whose clocks stopped during the period

HQU07 - the 95th percentile time waited for patients on incomplete pathways at the end of the period.

Data Definition:

A calculation of the 95th percentile time waited for completed admitted and non-admitted, and incomplete referral to treatment pathways based on referral to treatment data provided by NHS and independent sector organisations and signed off by NHS commissioners.

Basis for Accountability:

Commissioner.

MONITORING

Monitoring Frequency:

Monthly.

Monitoring Data Source:

Referral to Treatment Consultant-led Waiting Times data collection (National Statistics).

ACCOUNTABILITY
What success looks like, Direction, Milestones:
95th percentile time waited for completed admitted and non-admitted, and incomplete referral to treatment pathways should not deteriorate and where possible improve during 2011/12. Performance will also be judged against the following thresholds • Admitted : 23 weeks • Non-admitted : 18.3 weeks • Incomplete : 28 weeks Performance will also be assessed alongside other data including referrals, activity and finance.
Timeframe/Baseline:
N/A
Timeframe Until:
Ongoing.
Rationale:
As set out in the Operating framework for 20011/12, patients' rights to access services within maximum waiting times under the NHS Constitution continue and commissioners should ensure that performance does not deteriorate and where possible improves during 2011/12. With that in mind, providers should be expected to offer information on maximum waiting times to patients.
SHA Envelopes:
N/A

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
N/A
Criteria for Plan Sign-off:
N/A

FURTHER INFORMATION
Further Information:
Data and full guidance can be found here http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/ReferraltoTreatmentstatistics/index.htm
Changes from 2010/11 Planning Round:
The approach to monitoring referral to treatment waits has changed <u>from</u> monitoring the percentage of patients whose referral to treatment time was less than 18 weeks <u>to</u> monitoring the 95th percentile time waited for completed admitted and non-admitted, and incomplete referral to treatment pathways.

HQU08: MSA Breaches

DEFINITIONS
Detailed Descriptor:

Patient Experience: Breaches of Same Sex Accommodation-

All providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient, in accordance with the definitions set out in the Professional Letter CNO/2010/3.

From April 2011, all providers of NHS funded care must routinely report breaches of sleeping accommodation, as set out in national guidance, and will attract contract sanctions in respect of each patient affected.

Each year, on or by 1 April, all such organisations must declare that they are compliant with the national definition or face financial penalties. PCTs should report to SHAs, on an exception basis, those organisations that have had financial sanctions applied, or those whose compliance status has changed.

Lines within Indicator (Units):

This data set supports the collection of consistently defined data on breaches of DH guidance on Mixed-Sex Accommodation. (NB: The policy commitment relates to gender, not sex, but to ensure a better public understanding it is referred to as Mixed-Sex Accommodation {MSA}).

The focus of the indicator and the associated central reporting, is on MSA breaches in respect of sleeping accommodation only - even though the NHS is required to monitor locally all justified mixing in sleeping accommodation, all mixed-sex sharing of bathroom/toilet facilities (including passing through accommodation or toilet/bathroom facilities used by the opposite gender). Locally, it will also monitor lack of provision of women-only day areas in mental health units.

A breach of the policy occurs each time an admitted patient is placed in MSA, outside the terms of the policy.

From 1 December 2010, the collection of NHS organisations' MSA breaches in relation to sleeping accommodation will commence, with routine reporting to begin in January 2011.

NHS organisations must submit aggregated data to the Unify2 data collection system, detailing the hospital site where the breach occurred and the patient's commissioning organisation.

For performance monitoring of MSA, it will be the MSA breach rate (MSA breaches per 1,000 FCEs), as well as the number of breaches, that will need to be monitored.

MSA Breach Rate Indicator Definition:
The number of breaches of mixed-sex accommodation (MSA) sleeping

accommodation, per 1,000 Finished Consultant Episodes.

Formula:
MSA Breach Rate = Numerator/Denominator x 1,000

Numerator:
The number of MSA breaches for the reporting month in question.
Data Source: MSA Unify2 data collection

Denominator:
The number of Finished Consultant Episodes (FCEs) that finished in the month, regardless of when they started.
Data source: Inpatient HES

For more information on the MSA breach rate indicator, please refer to the methodology paper on the MSA publication website. This can be located via:

http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/index.htm

Data Definition:

Providers are required to report all breaches of sleeping accommodation* - i.e. for each patient affected, via the Unify2 system. Detailed definition of what constitutes a breach of same sex guidance is provided in Professional Letter CNO/2010/3.

"Sleeping accommodation" includes areas where patients are admitted and cared for on beds or trolleys, even where they do not stay overnight. It therefore includes all admissions and assessment units (including clinical decision units), plus day surgery and endoscopy units. It does not include areas where patients have not been admitted, such as accident and emergency cubicles.

An Information Standards Notice (ISN) has been published for the MSA data collection (Ref: ISB 1573). This can be found at:
http://www.isb.nhs.uk/library/standard/226

New NHS Data Dictionary standards have been published for the MSA data collection. These can be found at:
http://www.isb.nhs.uk/documents/isb-1573/amd-168-2010/cr1207.pdf

Basis for Accountability:

Overall accountability rests with the provider organisation which will;
- report breaches in line with the arrangements specified above
- pursue the broader, improvement-based activities as would reasonably be associated with the level of breaches being published.

It is the local commissioner's responsibility to jointly sign-off the monthly data. Where breaches have occurred, commissioners and providers must meet to discuss sanctions.

Data will be made public from January 2011.

MONITORING
Monitoring Frequency:
Monitoring is based on a monthly data collection. Mandatory collection of data for non-FTs to begin in December 2010. Voluntary collection for FTs until April 2011, at which point this too becomes mandatory. Monthly publication is expected to take place on the third Thursday of every month.
Monitoring Data Source:
UNIFY {2} Performance monitoring arrangements. NB: Published data can be revised and amended within two months of publication. This will allow the outcome of meetings between providers and commissioners regarding breaches to be incorporated into the data.

ACCOUNTABILITY
What success looks like, Direction, Milestones:
All providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient. Ability to deliver this requirement is the key indicator of success.
Timeframe/Baseline:
N/A.
Timeframe Until:
Ongoing
Rationale:
Patients have told us that mixed sex accommodation is distressing to patients at a time when they feel at their most vulnerable. The above focus means that organisations will be held to account for managing beds and facilities to eliminate MSA. It also better facilitates commissioners' application of sanctions to NHS organisations that breach the guidance. Publication of the associated breach data means that patients and the public will be better informed about an organisation's progress in eliminating mixed sex accommodation.
SHA Envelopes:
N/A

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
National policy: Elizabeth.jones@dh.gsi.gov.uk and Roger.wallis@dh.gsi.gov.uk

Performance management: Gillian.donachie@dh.gsi.gov.uk |
| **Changes from 2010/11 Planning Round:** |
| The O.F.s (original and revised) for 2010/11 both set out requirements relating to MSA. However, the 2011/12 O.F. is the first to require a central data collection. |

HQU09-13: A&E Quality Indicators (5 measures)

HQU09: A&E Clinical Quality- Unplanned Re-attendance Rate

DEFINITIONS

Detailed Descriptor:

Unplanned re-attendance at A&E within 7 days of original attendance (including if referred back by another health professional)

Lines within Indicator (Units):

Numerator
Number of unplanned follow-up attendances within 7 days of discharge from A&E for the original attendance

Denominator
Number of attendances at A&E

Data Definition:

Numerator
Number of unplanned follow-up attendances within 7 days of discharge from A&E for the original attendance

Denominator
Number of attendances at A&E

Exclusions
Planned follow-up attendances should be excluded from both the numerator and denominator.

Attendances where the A&E CDS Attendance Category of the patient is unknown should be excluded. However, if the proportion of attendances where the attendance category is unknown is greater than 5% of all attendances, A&E sites must note this in the data quality section of the narrative for this indicator (see Further Information).

A patient may re-attend for the same condition even though the presenting symptoms and clinical coding of the A&E episode differ to the original attendance. Therefore, where possible all re-attendances for a patient should be recorded and investigated.

Further notes
Where possible, trusts should attempt to include re-attendances that occur at A&E sites that differ to the A&E of the original (index) attendance.

This indicator can be improved, where possible, by looking at re-attendance rates for specific conditions.

Basis for Accountability:
Provider-basis, all A&E sites Data should be presented in a way that is most meaningful for the patient and which facilitates targeted local interventions to improve the quality of A&E services. Data should therefore be reported for providers at the level of five character provider codes (i.e. organisation code + site code), rather than three character provider codes (i.e. trust level). To appropriately reflect the patient's journey and modern co-located models that provide urgent and primary care facilities on the same site, where there is more than one type of A&E on the same campus, data should be reported for the whole campus, not for separate facilities, even if the service is provided by different organisations.

MONITORING
Monitoring Frequency:
Monthly
Monitoring Data Source:
Secondary Uses Services (SUS) data, A&E Commissioning Data Set (CDS)   – [A&E Attendance category] - to exclude planned follow-up attendances, exclude unknown Attendance Categories, and identify unplanned follow-up attendances

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Management of the indicator The unplanned re-attendance rate has been included as a headline measure in the Operating Framework for the NHS in England in 2011/12, to assess organisational and system health. The unplanned re-attendance rate should be minimal; a rate above 5% may trigger intervention. These headline measures will be performance managed but against a minimum threshold that delineates poor and potentially unsafe care, and by understanding whether particular sites are outliers because of innovative care or because of poor quality care. Commissioners and the SHA (as the local headquarters of the NHS) will therefore need to consider whether improvement action is necessary (and timescales) where performance levels are below nationally set minima. It is important to note that these minimum thresholds denote potentially unsafe care and are not the levels sites should aim to or be commissioned to operate at; there is no prescribed level which sites should be content to remain at, and sites should aim for continuous improvements in performance across all elements of the A&E clinical quality indicators. The aim is for these indicators to stimulate debate and discussion of A&E performance - which should always be considered across the set of all eight A&E clinical quality indicators.

What good looks like
Patients should be correctly diagnosed, treated and advised on their first visit. Some complications will occur after acute illness or injury but these can be minimised by best care on the first visit. These unplanned re-attendances are to be reviewed by a senior clinician where appropriate.

Those with chronic conditions may have multiple re-attendances because of the nature of their disease but evidence suggests that most can have the number of acute episodes reduced by good case management in primary care.

Nationally, at present, unplanned follow-up attendances account for 2.1% of all attendances, with different sites reporting rates of between 0 and 22%.

International literature on re-attendance reports very variable rates and also measures re-attendance over a varying length of time and with varying definitions. Most reports report 2-3% in 72 hours with studies at one week varying from 2-13%. These are also from a variety of health systems. The only UK study specifying entry criteria demonstrated a rate of 3% in one month but limited it to cases with associated symptoms. Expert opinion suggests that levels should be below 5% but that levels less than 1% may reflect a risk averse approach to care.

This indicator will reflect the care delivered by the A&E department, but will also be affected by the provision and use of other emergency and urgent care services, and the incidence, casemix and severity of presenting conditions in the local population. These factors should be noted before comparisons are made across different A&E departments. It may therefore be appropriate to benchmark against units with similar case mix (there is no easy measure of case mix but admission rates, proportion brought by ambulance, age distribution may be useful indicators).

Key messages
- The re-attendance rate can reflect quality of care on the initial attendance but does not demonstrate the cause of any problems. Good practice is for a re-attending patient to be seen by a different and more senior clinician.
- Rates above 5% are likely to reflect poor quality care but rates below 1% may reflect excessive risk aversion.
- A rate above 5% may trigger intervention as this is one of the five A&E quality indicators included as a headline measure under national oversight to assess organisational and system health in the NHS Operating Framework for 2011/12.

Timeframe/Baseline:

Timeframe Until:
Ongoing

Rationale:
The aim of this indicator is to reduce avoidable re-attendances at A&E by improving

the care and communication delivered during the original attendance.

Patients may re-attend A&E because of the wrong initial diagnosis, wrong treatment or poor explanation by clinicians. A subset of re-attendances at A&E may be due to chronic re-attendance for conditions such as mental health problems and substance abuse. Effective case management and ensuring patients receive the right care first time can improve patient experience and health outcomes. If re-attendances within 48 hours are monitored this may miss many cases, whereas 2/3 will be detected by looking at re-attendances within seven days.

The optimum re-attendance is not zero. Patients may be expected to re-attend if their conditions unavoidably worsen, or if they re-attend for unrelated conditions; discharging patients on consideration of the clinical risk, with appropriate safety-netting advice can be good care; and a low re-attendance rate may also reflect unnecessarily high admission rates and longer stays in hospital. For these reasons, only avoidable re-attendances should be reduced, and the re-attendance rate should be balanced by investigating admission rates and lengths of stay where appropriate to ensure that these are not increasing at the expense of a low re-attendance. It is suggested that when change occurs in re-attendance rates then commissioners should study these countermeasures and understand how reductions in re-attendance have been achieved to ensure this reflects good practice.

SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:

Further information on the definitions, management and publication of the A&E clinical quality indicators is published on the Department of Health website. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122868

In developing these clinical quality indicators we have suggested amendments to the current NHS data dictionary definitions for the A&E CDS (particularly around the Follow-up Accident And Emergency Attendance – unplanned Attendance Category), in order to increase the clinical relevance of these definitions or timestamps. A summary of these changes is set out in Annex A to the data definitions document for these indicators (published on the Department of Health website), and trusts should

endeavour to collect data in line with these requirements to ensure that these A&E indicator data are as clinically meaningful as possible.
Changes from 2010/11 Planning Round:
This is a new indicator

HQU10: A&E Clinical Quality- Total Time in the A&E Department

DEFINITIONS

Detailed Descriptor:

The median, 95th percentile and single longest total time spent by patients in the A&E department, for admitted and non-admitted patients

Lines within Indicator (Units):

Median time spent from arrival at A&E to admission, transfer or discharge (i.e. the time below which 50% of attendances were admitted, transferred or discharged).

95th percentile of times from arrival at A&E to admission, transfer or discharge (i.e. the time below which 95% of attendances within the month were admitted, transferred or discharged).

Single longest time recorded from arrival at A&E to admission, transfer or discharge

These measures should be reported separately for admitted and non-admitted patients to reflect the differing processes of care these groups require.

Data Definition:

Planned follow-up attendances should be excluded.

Attendances where the time to departure from A&E is unknown should be excluded. However, if the proportion of attendances where the time to departure from A&E is unknown is greater than 5% of all attendances, A&E sites must note this in the data quality section of the narrative for this indicator.

The time of arrival in A&E should be recorded by the clinician carrying out the initial triage/assessment or A&E reception whichever is earlier. For ambulance cases, arrival time is when hand over occurs or 15 minutes after the ambulance arrives at A&E, whichever is earlier. In other words if the ambulance crew have been unable to hand over 15 minutes after arrival, that patient is nevertheless deemed to have arrived at A&E and the time clock has started.

The total time in the A&E department ends when the patient is admitted, transferred, or discharged home.

Admission is defined as an emergency admission via A&E under admission code 21. Time of admission is defined as the time when such a patient leaves the department to go to:
(i) An operating theatre;
(ii) A bed in a ward;
(iii) An x-ray or diagnostic test or other treatment directly en route to a bed in a ward or operating theatre. However leaving A&E for a diagnostic test or other treatment does not count as time of admission if the patient then returns to A&E to continue waiting for a bed.

Transfer is defined as transfer to the care of another NHS organisation or other public/private sector agency (for example social services). However, to reflect the patient's perspective, and modern co-located models that provide urgent and primary care facilities on the same site or campus as type 1 A&E departments, the time in A&E should not stop or be restarted when patients are moved from between A&E departments on the same site or campus. A&E facilities on the same site or campus should be treated as one department for the purposes of the A&E clinical quality indicators even where they are operated by different provider organisations. Time of transfer is defined as when the patient leaves the department.

Time of **discharge** home is defined as when the patient's clinical episode is finished (including death of the patient), unless they are waiting for hospital arranged transport or social care / social service support. In the latter case the time of departure is the time the patient actually leaves the department. Patients awaiting family or 'private' transport or who wish to make their own arrangements should be considered discharged once the clinical episode is complete whether or not they have actually left the department.

Basis for Accountability:

Provider-basis, all A&E sites

Data should be presented in a way that is most meaningful for the patient and which facilitates targeted local interventions to improve the quality of A&E services. Data should therefore be reported for providers at the level of five character provider codes (i.e. organisation code + site code), rather than three character provider codes (i.e. trust level). To appropriately reflect the patient's journey and modern co-located models that provide urgent and primary care facilities on the same site, where there is more than one type of A&E on the same campus, data should be reported for the whole campus, not for separate facilities, even if the service is provided by different organisations.

MONITORING
Monitoring Frequency:

Monthly

Monitoring Data Source:

Secondary Uses Services (SUS) data, A&E Commissioning Data Set (CDS)
– [A&E Attendance category] - to exclude planned follow-up attendances
– [A&E Arrival time] and [A&E Departure time] - to determine time spent in A&E (please see Annex A in the data definitions document referred to in the "Further Information" section below for further details), and exclude attendances where time to departure is unknown.

ACCOUNTABILITY
What success looks like, Direction, Milestones:

Management of the indicator
The total time in A&E has been included as a headline measure in the Operating Framework for the NHS in England in 2011/12, to assess organisational and system health. The total time in A&E should not be investigated in isolation, and should be monitored in conjunction with the other seven A&E clinical quality indicators. Timeliness of care should not deteriorate from that achieved in the last few years. **A 95th percentile wait above four hours, for admitted and non-admitted patients, may trigger intervention.**

All remaining elements of the indicator, for example the median and single longest wait, are included as supporting measures.

These headline measures will be performance managed but against a minimum threshold that delineates poor and potentially unsafe care, and by understanding whether particular sites are outliers because of innovative care or because of poor quality care. Commissioners and the SHA (as the local headquarters of the NHS) will therefore need to consider whether improvement action is necessary (and timescales) where performance levels are below nationally set minima. It is important to note that these minimum thresholds denote potentially unsafe care and are not the levels sites should aim to or be commissioned to operate at; there is no prescribed level which sites should be content to remain at, and sites should aim for continuous improvements in performance across all elements of the A&E clinical quality indicators. The aim is for these indicators to stimulate debate and discussion of A&E performance - which should always be considered across the set of all eight A&E clinical quality indicators.

What good looks like
Total time in A&E has been measured for several years. The way it is reported under this indicator differs from the previous approach and this allows a more clinically orientated focus. However, overall time should not deteriorate from existing levels. International literature suggests increases in adverse outcomes for patients who have been in the ED for more than 4-6 hours.

Excessive total time in the A&E is linked to poor outcomes and patient delays should be minimised (but care should not be hurried or rushed). Changes in the practice of emergency medicine in some departments also means that more is being done for patients in the A&E, which may take longer but is for the benefit of the patient. A decreased admission rate may be evidence of more productive care in A&E that might justify a longer total time.

Benchmarking should also be undertaken across all emergency care providers, split between admitted and non-admitted patients, to better understand how processes can be improved with A&E departments for these patients; however, commissioners need to understand the model of care before deciding who to benchmark against.

Key messages
- Timeliness of care should not deteriorate from that achieved in the last few years.

- The total time in A&E should not be investigated in isolation, and should be monitored in conjunction with the other A&E clinical quality indicators
- Clinical advice suggests that a 95th percentile wait above 4 hours for admitted patients and with the same threshold for non-admitted patients is not good practice.
- The single longest wait should be no more than 6 hours.
- A 95th percentile wait above four hours may trigger intervention as this is one of the five A&E quality indicators included as a headline measure under national oversight to assess organisational and system health under national oversight in the NHS Operating Framework for 2011/12.

Timeframe/Baseline:

Timeframe Until:

Ongoing

Rationale:

Longer lengths of stay in the emergency department are associated with poorer health outcomes and patient experience as well as transport delays, treatment delays, ambulance diversion, patients leaving without being seen, and financial effects . It is critical that patients receive the care they need in a timely fashion, so that patients who require admission are placed in a bed as soon as possible, patients who need to be transferred to other healthcare providers receive transport with minimal delays, and patients who are fit to go home are discharged safely and rapidly.

Monitoring the median, 95th percentile and longest time spent by patients in A&E departments will allow departments to understand the entire distribution of waiting times of the patients they care for. This will prevent patients being ignored as they spend more time in A&E, and will give sites more flexibility in providing care to patients as they need it, rather than attempting to see all patients within the same time period irrespective of the severity or requirements of the patients' conditions. There is professional agreement that some patients need prolonged times in A&E. However, these exceptions are rare and unlikely to account for more than 5% of attendances.

SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Further information on the definitions, management and publication of the A&E clinical quality indicators is published on the Department of Health website. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122868   In developing these clinical quality indicators we have suggested amendments to the current NHS data dictionary definitions for the A&E CDS (particularly around the clock start and clock stop positions for this indicator), in order to increase the clinical relevance of these definitions or timestamps. A summary of these changes is set out in Annex A to the data definitions document for these indicators (published on the Department of Health website), and trusts should endeavour to collect data in line with these requirements to ensure that these A&E indicator data are as clinically meaningful as possible.
Changes from 2010/11 Planning Round:
This is a new indicator

HQU11: A&E Clinical Quality- Left Without Being Seen Rate

DEFINITIONS
Detailed Descriptor:

The percentage of people who leave the A&E without being seen

Lines within Indicator (Units):

Numerator
Number of attendances where the patient left without being seen (LWBS) by a clinical decision maker

Denominator
Number of attendances at A&E

Data Definition:

Numerator
Number of attendances where "Left before treatment" was recorded in the A&E Commissioning Data Set field for "Attendance Disposal".

Once a patient has seen a clinical decision-maker they are not considered as having left without being seen, but this must have been a meaningful assessment and the patient should be making an informed decision about leaving i.e. patients who leave after receiving a non-meaningful clinical assessment should be regarded as having left without being seen. Attendances should be excluded from the numerator where the patient left after receiving a meaningful assessment by a clinical decision-maker, but before treatment commenced.

Denominator
Number of attendances at A&E

Exclusions
Attendances should be excluded from the numerator and denominator where the A&E CDS Attendance Disposal Category was unknown. However, if the proportion of attendances where the attendance disposal category is unknown is greater than 5% of all attendances, A&E sites must note this in the data quality section of the narrative for this indicator (see Further Information).

Planned follow-up attendances should be excluded from both the numerator and denominator.

Basis for Accountability:

Provider-basis, all A&E sites

Data should be presented in a way that is most meaningful for the patient and which facilitates targeted local interventions to improve the quality of A&E services. Data should therefore be reported for providers at the level of five character provider

codes (i.e. organisation code + site code), rather than three character provider codes (i.e. trust level). To appropriately reflect the patient's journey and modern co-located models that provide urgent and primary care facilities on the same site, where there is more than one type of A&E on the same campus, data should be reported for the whole campus, not for separate facilities, even if the service is provided by different organisations.

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

Secondary Uses Services (SUS) data, A&E Commissioning Data Set (CDS)
  – [A&E Attendance category] - to exclude planned follow-up attendances
  – [A&E Attendance disposal] - to determine number of patients leaving A&E before treatment (please see Annex A in the data definitions document referred to in the "Further Information" section below for further details), and exclude attendances where the attendance disposal is unknown

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Management of the indicator
The Left Without Being Seen rate has been included as a headline measure in the Operating Framework for the NHS in England in 2011/12, to assess organisational and system health. The left without being seen rate should be minimal and best practice would be to have a rate below 5%; **a rate at or above 5% may trigger intervention.**

These headline measures will be performance managed but against a minimum threshold that delineates poor and potentially unsafe care, and by understanding whether particular sites are outliers because of innovative care or because of poor quality care. Commissioners and the SHA (as the local headquarters of the NHS) will therefore need to consider whether improvement action is necessary (and timescales) where performance levels are below nationally set minima. It is important to note that these minimum thresholds denote potentially unsafe care and are not the levels sites should aim to or be commissioned to operate at; there is no prescribed level which sites should be content to remain at, and sites should aim for continuous improvements in performance across all elements of the A&E clinical quality indicators. The aim is for these indicators to stimulate debate and discussion of A&E performance - which should always be considered across the set of all eight A&E clinical quality indicators.

What good looks like
If a patient leaves A&E, it should be because they have made an informed decision not because they are dissatisfied. Ideally patients should only leave after they have had a meaningful clinical assessment. Inevitably some patients will leave without

being seen.

At present 3.6% of patients leave without being seen, but individual A&E sites range from 0-22% using current A&E HES data (this may currently overestimate due to data quality and poor coding, e.g., planned re-attendances to clinics).

The published literature mostly shows rates under 9% with a few outliers. Expert opinion suggests that the LWBS rate should be below 5% in good UK practice

Key messages
- LWBS reflects the satisfaction of patients with the initial management and experience they receive in A&E.
- The left without being seen rate should be minimal and best practice would be to have level below 5%.
- A rate at or above 5% may trigger intervention as this is one of the five A&E quality indicators included as a headline measure under national oversight to assess organisational and system health in the NHS Operating Framework for 2011/12.

Timeframe/Baseline:

Timeframe Until:
Ongoing

Rationale:
The aim of this indicator is to improve patient experience and reduce the clinical risk to patients who leave A&E before receiving the care they need. Patients who decide to leave A&E after they have been initially received, but before being seen by a clinical decision maker, may have health conditions that will deteriorate without treatment. Patients who leave without being seen are also likely to have recurrent LWBS episodes in A&E. A recent international literature review has shown that LWBS is linked with some patient characteristics as well as hospital characteristics. It also demonstrated that up to 49% needed subsequent urgent treatment, and national data for England indicate that over 14% of unplanned follow-up attendances result in admission to hospital . High rates of leaving before being seen by a clinical decision maker are associated with perceptions of excessive waiting times in A&E and overcrowding and poorer patient experience. Although patients may unexpectedly leave A&E for a variety of reasons, as a matter of good practice A&E sites should have arrangements in place to regularly check that patients listed as waiting are still waiting and offer information about why they are waiting and the expected treatment time.

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Further information on the definitions, management and publication of the A&E clinical quality indicators is published on the Department of Health website. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122868   In developing these clinical quality indicators we have suggested amendments to the current NHS data dictionary definitions for the A&E CDS (particularly around the Left Before Treatment Attendance Disposal Category), in order to increase the clinical relevance of these definitions or timestamps. A summary of these changes is set out in Annex A to the data definitions document for these indicators (published on the Department of Health website), and trusts should endeavour to collect data in line with these requirements to ensure that these A&E indicator data are as clinically meaningful as possible.
Changes from 2010/11 Planning Round:
This is a new indicator

HQU12: A&E Clinical Quality- Time to Initial Assessment

DEFINITIONS

Detailed Descriptor:

Time from arrival to start of full initial assessment, which includes a brief history, pain and early warning scores (including vital signs), for all patients arriving by emergency ambulance.

Lines within Indicator (Units):

Median time spent from arrival at A&E to initial assessment for patients brought in by emergency ambulance (i.e. the time below which 50% of attendances within the month were assessed).

95th percentile of times from arrival at A&E to full initial assessment for patients brought in by emergency ambulance (i.e. the time below which 95% of attendances within the month were assessed).

Single longest time recorded from arrival at A&E to full initial assessment for patients brought in by emergency ambulance

Data Definition:

Planned follow-up attendances should be excluded.

Attendances where the time to initial assessment or mode of arrival is unknown should be excluded. However, if the proportion of attendances where the time to assessment is unknown is greater than 5% of all attendances, A&E sites must note this in the data quality section of the narrative for this indicator.

Time to initial assessment is the time from arrival at A&E to the time when a patient is assessed by an emergency care medical or nursing professional to determine priority for treatment. This assessment would be expected to include a brief history, pain and early warning scores (including vital signs).

As there is no commonly accepted and consistent definition of major cases at present, the indicator will apply to cases arriving by emergency ambulance. It is recognised that some major patients may not arrive by emergency ambulance and some attendances brought in by ambulance may not be majors within A&E. Best practice is to also undertake full initial assessment for those who self-present with major conditions, where this does not place unnecessary additional steps in the care pathways of minors patients.

The time of arrival in A&E should be recorded by the clinician carrying out the initial triage/assessment or A&E reception whichever is earlier. For ambulance cases, arrival time is when hand over occurs or 15 minutes after the ambulance arrives at A&E, whichever is earlier. In other words if the ambulance crew have been unable to hand over 15 minutes after arrival, that patient is nevertheless deemed to have arrived at A&E and the time clock has started. If the hand over process includes a

full initial assessment as set out in this document then the clock stops for this indicator at the point of hand over.

Basis for Accountability:

Provider-basis, all A&E sites

Data should be presented in a way that is most meaningful for the patient and which facilitates targeted local interventions to improve the quality of A&E services. Data should therefore be reported for providers at the level of five character provider codes (i.e. organisation code + site code), rather than three character provider codes (i.e. trust level). To appropriately reflect the patient's journey and modern co-located models that provide urgent and primary care facilities on the same site, where there is more than one type of A&E on the same campus, data should be reported for the whole campus, not for separate facilities, even if the service is provided by different organisations.

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

Secondary Uses Services (SUS) data, A&E Commissioning Data Set (CDS)
  – [A&E Attendance category] - to exclude planned follow-up attendances
  – [A&E Arrival mode] – to determine whether a patient is brought to A&E by emergency ambulance, and exclude attendances where arrival mode is unknown
  – [A&E Arrival time] and [A&E Initial Assessment time] - to determine time spent in A&E prior to assessment (please see Annex A for further details), and exclude attendances where time to assessment is unknown.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Management of the indicator
The time to initial assessment has been included as a headline measure in the Operating Framework for the NHS in England in 2011/12, to assess organisational and system health. Patients should be assessed as soon as possible; good practice would be to have all patients assessed within 20 minutes of arrival, **and a 95th percentile time to assessment above 15 minutes may trigger intervention.**

All remaining elements of the indicator, for example the median and single longest wait, are included as supporting measures.

These headline measures will be performance managed but against a minimum threshold that delineates poor and potentially unsafe care, and by understanding whether particular sites are outliers because of innovative care or because of poor

quality care. Commissioners and the SHA (as the local headquarters of the NHS) will therefore need to consider whether improvement action is necessary (and timescales) where performance levels are below nationally set minima. It is important to note that these minimum thresholds denote potentially unsafe care and are not the levels sites should aim to or be commissioned to operate at; there is no prescribed level which sites should be content to remain at, and sites should aim for continuous improvements in performance across all elements of the A&E clinical quality indicators. The aim is for these indicators to stimulate debate and discussion of A&E performance - which should always be considered across the set of all eight A&E clinical quality indicators.

What good looks like
The time to initial assessment should be minimised. Most international systems state that the initial assessment should be undertaken immediately or as soon as possible but do not define a time scale. In Canada it is expected that a rapid initial assessment is undertaken within 10 minutes of arrival.

Expert opinion suggests that the time to initial assessment should be less than 20 minutes from arrival time.

Benchmarking should be able to be undertaken across all emergency care providers as best care will be the same everywhere.

Key messages
- The delay in the A&E department in assessing and then accepting care of the patient should be minimised but that assessment must be meaningful and add value for the patient:
- Patients should be assessed as soon as possible; good practice would be to have all patients assessed within 20 minutes of arrival.
- A 95th percentile time to assessment above 15 minutes may trigger intervention as this is one of the five A&E quality indicators included as a headline measure under national oversight to assess organisational and system health in the NHS Operating Framework for 2011/12.

Timeframe/Baseline:

Timeframe Until:
Ongoing

Rationale:
The aim of this indicator is to reduce the clinical risk associated with the time the patient spends unassessed in A&E Many urgent and emergency conditions are time-sensitive, and the period before a patient is seen by a health professional represents clinical risk. In the past, many serious untoward incidents have related to patients who deteriorate rapidly before being assessed. Full assessments of major cases that include a brief history, pain and early warning

scores (including vital signs) are a marker of higher quality patient care. This initial assessment should be able to detect those who need emergency intervention. Reducing delays in assessment can improve health outcomes and patient experience, and the focus on major cases has been made to make sure patients with the greatest clinical risk are given the attention they need. We also want to avoid placing unnecessary additional steps in the care pathways of minors patients where see and treat without initial assessment may be more appropriate.

As there is no commonly accepted and consistent definition of major cases at present, the indicator will apply to cases arriving by ambulance but best practice is to also undertake full initial assessment for those who self present with major conditions.

SHA Envelopes:

PLANNING REQUIREMENTS

Are Plans Required?:

No

Planning Frequency:

Criteria for Plan Sign-off:

FURTHER INFORMATION

Further Information:

Further information on the definitions, management and publication of the A&E clinical quality indicators is published on the Department of Health website. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122868

In developing these clinical quality indicators we have suggested amendments to the current NHS data dictionary definitions for the A&E CDS (particularly around the clock start and clock stop positions for this indicator), in order to increase the clinical relevance of these definitions or timestamps. A summary of these changes is set out in Annex A to the data definitions document for these indicators (published on the Department of Health website), and trusts should endeavour to collect data in line with these requirements to ensure that these A&E indicator data are as clinically meaningful as possible.

Changes from 2010/11 Planning Round:

This is a new indicator

HQU13: A&E Clinical Quality- Time to Treatment

Detailed Descriptor:

Time from arrival to start of definitive treatment from a decision-making clinician (someone who can define the management plan and discharge the patient)

Lines within Indicator (Units):

Median time spent from arrival at A&E to treatment (i.e. the time below which 50% of attendances within the month were treated).

95th percentile of times from arrival at A&E to treatment (i.e. the time below which 95% of attendances within the month were treated).

Single longest time recorded from arrival at A&E to treatment

Data Definition:

Planned follow-up attendances should be excluded.

Attendances where the time to treatment is unknown should be excluded. However, if the proportion of attendances where the time to treatment is unknown is greater than 5% of all attendances, A&E sites must note in the data quality section of the narrative for this indicator.

Time to treatment is the time from arrival at A&E to the time when a patient is seen by a decision-making clinician (someone who can define the management plan and discharge the patient) to diagnose the problem and arrange or start definitive treatment as necessary.

The time of arrival in A&E should be recorded by the clinician carrying out the initial triage/assessment or A&E reception whichever is earlier. For ambulance cases, arrival time is when hand over occurs or 15 minutes after the ambulance arrives at A&E, whichever is earlier. In other words if the ambulance crew have been unable to hand over 15 minutes after arrival, that patient is nevertheless deemed to have arrived at A&E and the time clock has started.

Basis for Accountability:

Provider-basis, all A&E sites

Data should be presented in a way that is most meaningful for the patient and which facilitates targeted local interventions to improve the quality of A&E services. Data should therefore be reported for providers at the level of five character provider codes (i.e. organisation code + site code), rather than three character provider codes (i.e. trust level). To appropriately reflect the patient's journey and modern co-located models that provide urgent and primary care facilities on the same site, where there is more than one type of A&E on the same campus, data should be reported for the whole campus, not for separate facilities, even if the service is provided by different organisations.

MONITORING
Monitoring Frequency:
Monthly

Monitoring Data Source:

Secondary Uses Services (SUS) data, A&E Commissioning Data Set (CDS)
  – [A&E Attendance category] - to exclude planned follow-up attendances
  – [A&E Arrival time] and [A&E time seen for treatment] - to determine time spent in A&E prior to start of treatment (please see Annex A for further details), and exclude attendances where time to treatment is unknown.

ACCOUNTABILITY
What success looks like, Direction, Milestones:

Management of the indicator

The time to treatment has been included as a headline measure in the Operating Framework for the NHS in England in 2011/12, to assess organisational and system health. Time to the start of treatment should be minimised but not at the expense of other A&E Clinical Quality Indicators. Expert clinical opinion suggests that patients should be seen by a decision-maker within 60 minutes of arrival, but this may be too long for the more serious cases. The earlier the correct management plan is made the better for the patient; a wait of over 30 minutes is excessive for certain presentations, e.g., sepsis, stroke, myocardial infarction, respiratory distress. **A median above 60 minutes from arrival to seeing a decision-making clinician across all patients may trigger intervention.**

All remaining elements of the indicator, for example the 95th percentile and single longest wait, are included as supporting measures.

These headline measures will be performance managed but against a minimum threshold that delineates poor and potentially unsafe care, and by understanding whether particular sites are outliers because of innovative care or because of poor quality care. Commissioners and the SHA (as the local headquarters of the NHS) will therefore need to consider whether improvement action is necessary (and timescales) where performance levels are below nationally set minima. It is important to note that these minimum thresholds denote potentially unsafe care and are not the levels sites should aim to or be commissioned to operate at; there is no prescribed level which sites should be content to remain at, and sites should aim for continuous improvements in performance across all elements of the A&E clinical quality indicators. The aim is for these indicators to stimulate debate and discussion of A&E performance - which should always be considered across the set of all eight A&E clinical quality indicators.

What good looks like

There are many conditions where the outcome is improved by earlier care. Outcomes are improved if the management plan for the patient is decided earlier and time critical interventions are therefore undertaken as early as possible in the

patients care.

In England the median time to start of treatment is 57 minutes; however, over 100 A&E sites report median times to treatment in excess of 60 minutes. Data quality issues mean that we do not currently have an accurate picture of 95th percentile time to treatment. Expert opinion suggest that patients should be seen by a decision maker within 60 minutes of arrival but that this may be too long for the more serious cases.

Benchmarking should be able to be undertaken across all emergency care providers as best care will be the same everywhere.

Key messages
- Time to the start of treatment should be minimised but not at the expense of other A&E Clinical Quality Indicators.
- Expert clinical opinion suggests that patients should be seen by a decision-maker within 60 minutes of arrival, but this may be too long for the more serious cases.
- The earlier the correct management plan is made the better for the patient; a wait of over 30 minutes is excessive for certain presentations, e.g., sepsis, stroke, myocardial infarction, respiratory distress.
- A median above 60 minutes from arrival to seeing a decision-making clinician across all patients may trigger intervention as this is one of the five A&E quality indicators included as a headline measure under national oversight to assess organisational and system health in the NHS Operating Framework for 2011/12.

Timeframe/Baseline:
Timeframe Until:
Ongoing
Rationale:
The aim of this indicator is to reduce the clinical risk and discomfort associated with the time the patient spends before their treatment begins in A&E
The period before a patient is seen by a health professional to make a provisional diagnosis and a care management plan represents clinical risk and anxiety . Patients may deteriorate prior to the commencement of treatment, and reducing delays in delivering definitive treatment can improve health outcomes and patient experience. The decision-maker should be someone who can define the management plan and has the ability to discharge the patient.
SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Further information on the definitions, management and publication of the A&E clinical quality indicators is published on the Department of Health website. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122868

In developing these clinical quality indicators we have suggested amendments to the current NHS data dictionary definitions for the A&E CDS (particularly around the clock start and clock stop positions for this indicator), in order to increase the clinical relevance of these definitions or timestamps. A summary of these changes is set out in Annex A to the data definitions document for these indicators (published on the Department of Health website), and trusts should endeavour to collect data in line with these requirements to ensure that these A&E indicator data are as clinically meaningful as possible. |
| **Changes from 2010/11 Planning Round:** |
| This is a new indicator |

HQU14: Cancer 2 week (aggregate measure)

DEFINITIONS
Detailed Descriptor:

2 week wait services (including cancer)-

Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer (Part A) and percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected (Part B).

Lines within Indicator (Units):

Part A: All Cancer Two Week Wait

Denominator: All patients urgently referred with suspected cancer by their GP who are first seen within the period

Numerator: Patients urgently referred with suspected cancer by their GP who are first seen within 14 calendar days within the period

Part B: Two Week Wait for Breast Symptoms (where cancer was not initially suspected)

Denominator: All patients urgently referred for evaluation/investigation of "breast symptoms" by a primary or secondary care professional within a period, excluding those referred urgently for suspected breast cancer who are first seen within the period.

Numerator: Patients urgently referred for evaluation/investigation of "breast symptoms" by a primary or secondary care professional during a period (excluding those referred urgently for suspected breast cancer) who are first seen within 14 calendar days during the period.

All referrals to a breast clinical team, excluding those for suspected cancer, and those to family history clinics should be included within the dataset supplied for this indicator.

Data Definition:

Numerator and Denominator details are defined above.

All data are to be returned to the Cancer Waiting Times Database (CWT-Db) as per the definitions and mandates specified to the NHS in Dataset Set Change Notice (DSCN) 20/2008.   A copy of this DSCN can be accessed at: http://www.isb.nhs.uk/documents/dscn/dscn2008/dataset/202008.pdf

Basis for Accountability:
Provider (NHS Trusts, NHS Foundation Trusts and PCT Providers) and Commissioner

MONITORING
Monitoring Frequency:
Monthly and Quarterly
Monitoring Data Source:
Data are sourced from the CWT-Db on a monthly and quarterly basis.

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Part A: All Cancer Two Week Wait Performance is to be sustained at or above the published operational standard Part B: Two Week Wait for Breast Symptoms (where cancer was not initially suspected) Performance is to be sustained at or above the published operational standard Details of current operational standards are available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleague letters/DH_103436
Timeframe/Baseline:
Not Applicable
Timeframe Until:
Not applicable
Rationale:
These two week wait services are a vital component of the patient pathway, they ensure fast access to diagnostic tests, supporting the provision of an earlier diagnosis and therefore assist in improving survival rates for cancer. It remains important for patients with cancer or its symptoms, to be seen by the right person, with appropriate expertise, within two weeks to ensure that the receive the best possible survival probability and a lower level of anxiety than if they were waiting for a routine appointment. Part A of this indicator also relates to a patient's right to be seen in two weeks as expressed in the NHS Constitution. Details of this are available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/doc uments/digitalasset/dh_113644.pdf

SHA Envelopes:
No

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:

The All Cancer Two Week Wait was introduced by the NHS Cancer Plan (2000), a copy of which is available at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009609

The Two Week Wait for Breast Symptoms (where cancer was not initially suspected) was introduced by the Cancer Reform Strategy (2007), a copy of which is available at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081006

Improving Outcomes: a Strategy for Cancer along with the recent Review of Waiting Times Standards is available at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123371

Full guidance on the monitoring of these services and supporting information on the scope and patient pathways are available at:
http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation

Help and further support for monitoring these standards is available via e-mail at:
cancer-waits@dh.gsi.gov.uk

Changes from 2010/11 Planning Round:

For 2011/12 this indicator has been restructured to include two indicators previously identified separately (EXC05 and VSA08). The restriction on Part B which incorrectly specified only referral from primary care has also been removed. The breast symptom two week wait definitions also allow referrals from relevant secondary care services such as NHS Screening Services and secondary care clinicians in other sectors.

HQU15: Cancer 62 Day Waits (aggregate measure)

DEFINITIONS
Detailed Descriptor:

Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer (Part A), and percentage of patients receiving first definitive treatment for cancer within 62-days of referral from and NHS Cancer Screening Service (Part B).

Lines within Indicator (Units):

Part A: All Cancer Two Month Urgent Referral to Treatment Wait

Denominator: Total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

Numerator: Number of patients receiving first definitive treatment for cancer within 62-days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

Part B: 62-Day Wait for First Treatment Following Referral from an NHS Cancer Screening Service

Denominator: Total number of patients receiving first definitive treatment for cancer following referral from an NHS Cancer Screening Service within a given period (covers any cancer ICD-10 C00 to C97 and D05)

Numerator: Number of patients receiving first definitive treatment for cancer within 62-days following referral from an NHS Cancer Screening Service during a given period(covers any cancer ICD-10 C00 to C97 and D05)

Part C: 62-Day Wait for First Treatment For Cancer Following a Consultants Decision to Upgrade The Patient Priority

Denominator: Total number of patients receiving first definitive treatment for cancer following a consultant decision to upgrade their priority status within a given period

Numerator: Number of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.

Scope: Patients included in this indicator will not have been referred urgently for suspected cancer by their GP or referred from an NHS Cancer Screening Service with suspected cancer.

Data Definition:
Numerator and Denominator details are defined above.

All data are to be returned to the Cancer Waiting Times Database (CWT-Db) as per the definitions and mandates specified to the NHS in Dataset Set Change Notice (DSCN) 20/2008.   A copy of this DSCN can be accessed at: http://www.isb.nhs.uk/documents/dscn/dscn2008/dataset/202008.pdf |

Basis for Accountability:
Provider (NHS Trusts, NHS Foundation Trusts and PCT Providers) and Commissioner

MONITORING
Monitoring Frequency:
Monthly and Quarterly

Monitoring Data Source:
Data are sourced from the CWT-Db on a monthly and quarterly basis.

ACCOUNTABILITY
What success looks like, Direction, Milestones:
<u>Part A, B & C</u>

Performance is to be sustained at or above the published operational standard

Details of current operational standards are available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleague letters/DH_103436 |

Timeframe/Baseline:
Not Applicable

Timeframe Until:
Ongoing

Rationale:
Maintaining these standards will ensure that a cancer patient will move along their pathway of care at a clinically appropriate pace, thus providing a better patient experience, with a service focussed on a patients wishes, whilst improving survival and mortality rates.

SHA Envelopes:
No

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:

The All Cancer Two Month Standard was introduced by the NHS Cancer Plan (2000), a copy of which is available at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009609

The 62-day wait for first treatment following referral from an NHS Screening Service was introduced by the Cancer Reform Strategy (2007), a copy of which is available at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081006

The 62-day standard was extended to include those patients whose priority is upgraded by the consultant responsible for their care in the same document.

Improving Outcomes: a Strategy for Cancer along with the recent Review of Waiting Times Standards is available at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123371

Full guidance on the monitoring of these services and supporting information on the scope and patient pathways are available at:
http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation

Help and further support for monitoring these standards is available via e-mail at:
cancer-waits@dh.gsi.gov.uk

Changes from 2010/11 Planning Round:

In 2010/11 this indicator was expressed as two separate requirements. Part A (All Cancer 62-Day Referral to Treatment Wait) was covered by EXC07 and Part B (62-Day Wait for First Treatment Following Referral from an NHS Cancer Screening Service) by VSA13B. Part C was previously displayed as one half of VSA13.

HQU16: Emergency Readmissions

DEFINITIONS
Detailed Descriptor:
Emergency Readmissions = All readmissions that are an emergency that occur within 30 days of any previous discharge
Lines within Indicator (Units):
Indicator is the proportion of admissions which are emergency readmissions Numerator: Emergency Readmissions in the period Denominator: Total Admissions in the period
Data Definition:
Emergency Readmissions = All readmissions that are an emergency (admission method codes 21 to 28) that occur within 30 days of any previous discharge, including previous admissions/ discharges at different providers. Total Admissions = All admissions for the provider It is planned to test this aggregate measure during 2011/12. It may prove necessary to refine it, for example by excluding some groups of admissions.
Basis for Accountability:
Commissioner

MONITORING
Monitoring Frequency:
Monthly
Monitoring Data Source:
Secondary Uses Service (SUS) extracts and reports

ACCOUNTABILITY
What success looks like, Direction, Milestones:
The emergency readmission rates should decrease over time
Timeframe/Baseline:
2010/11

Timeframe Until:
March 2012

Rationale:
Paragraph 5.33 from Operating Framework 2011/12 In 2011/12 hospitals will not be reimbursed for emergency readmissions within 30 days of discharge following an elective admission, and all other readmissions within 30 days of discharge will be subject to locally agreed thresholds, set to deliver a 25% reduction, where possible. This is to ensure that, wherever possible, hospitals have good discharge arrangements in place to avoid readmissions. PCTs should work with providers, GPs and local authorities to manage the savings arising from non-payment of emergency readmissions to fund reablement and post discharge support.

SHA Envelopes:
Not applicable

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Not applicable
Criteria for Plan Sign-off:
Not applicable

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
This is a new indicator.

HRS01: Financial forecast outturn & performance against plan

Financial forecast outturn performance against plan at organisational and regional level. In addition, no PCT forecast deficits are expected and no provider should plan for a forecast deficit unless part of an agreed recovery plan.

Plan required: Yes

HRS02: Financial performance score for NHS Trusts

Quarterly provider performance ratings to be given based on financial performance and position. Information received quarterly to feed into calculation of the ratings.

Plan required: No

HRS03: Delivery of running cost targets

Actual running costs to be compared to target running costs at regional level. Definition of running costs to form part of planning guidance.

The financial planning guidance will allocate the running costs reductions by region and it will be for SHAs to determine how the target reduction is managed across the region.

Plan required: Yes

HRS04: Progress on delivery of QIPP savings

QIPP delivery (savings and re-investment) in 2011/12 and QIPP for 2012/13 to 2014/15.

Monitoring of efficiencies to focus on key area's, including those savings which are driven by changes in demand, and those which are cash releasing.

Further guidance, including the format of monitoring will be included in the planning guidance issued in January 2011.

Plan required: Yes

HRS05: Acute Bed Capacity

DEFINITIONS
Detailed Descriptor:

General and Acute bed numbers

Lines within Indicator (Units):

HRS05_01 - the average number of available day only beds (general and acute)

HRS05_02 - the average number of available beds open overnight (general and acute)

HRS05_03 - the total number of available general and acute beds

Note: Line 01 + Line 02 = Line 03.

Data Definition:

Includes consultant-led general and acute beds in units managed by the provider, but excludes mental illness, learning disabilities and maternity beds.

Also excludes beds commissioned from other providers, beds designated solely for the use of well babies, and residential care beds.

Basis for Accountability:

Provider.

MONITORING
Monitoring Frequency:

Quarterly.

Monitoring Data Source:

KHO3 return.

ACCOUNTABILITY
What success looks like, Direction, Milestones:

That bed numbers will continue to reduce, reflecting the move of activity into other primary care and community settings.

Timeframe/Baseline:
Q1 & Q2 2010/11

Timeframe Until:
March 2015

Rationale:
To be used as a proxy indicator of care moving into primary care and the community.

SHA Envelopes:
No

PLANNING REQUIREMENTS

Are Plans Required?:
Yes, provider forecast with SHA assurance of PCT sign off

Planning Frequency:
Firm quarterly forecasts for 2011/12, and outline annual forecasts for 2012/13, 2013/14, 2014/15.

Criteria for Plan Sign-off:
None. Forecasts will be assessed for consistency with the forecasts for referrals, activity, length of stay, finance, and waiting times.

FURTHER INFORMATION

Further Information:
The data submitted should be consistent with the revised KH03 guidance that has applied from Q1 2010/11. Guidance available here: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Beds/DH_083781 Data available here: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Beds/DH_083781 http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Beds/DH_077449

Changes from 2010/11 Planning Round:
This is a new indicator.

HRS06: Non-elective FFCEs

DEFINITIONS
Detailed Descriptor:
Total number of non-elective FFCEs in general & acute (G&A) specialties in a month

Lines within Indicator (Units):
Number of G&A non-elective FFCEs in the period

Data Definition:
Non-Elective FFCEs data are derived from the Monthly Activity Return, which is collected from the NHS. It is collected from providers (both NHS and IS) who provide the data broken down by Commissioner.

Number of first finished consultant episodes (FFCEs) for the G&A specialties (see below) relating to hospital provider spells for which:
- patient classification = ordinary admission;
- admission method = emergency admission, maternity admission, other admission (codes 21-83);
- episode number = 1.

Exclude "well babies". These are defined as having admission method = other and neonatal level of care = normal care.

General & Acute specialties
- include: 100-192, 300-460, 502, 800-831, 900 and 901
- exclude: 501, 700-715

http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/adm/admitted_patient_total_non-elective_admissions_de.asp?query=elective%20admissions&rank=75&shownav=1 |

Basis for Accountability:
Commissioner

MONITORING
Monitoring Frequency:
Monthly

Monitoring Data Source:
Monthly Activity Returns (MAR)

ACCOUNTABILITY
What success looks like, Direction, Milestones:
There should be a reduction in the growth of the number of non-elective FFCEs
Timeframe/Baseline:
2010/11
Timeframe Until:
March 2015
Rationale:
To reduce inappropriate use of expensive emergency care, and improve use of other services where appropriate.
SHA Envelopes:
Not applicable

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, forecasts are required - provider forecast with SHA assurance of PCT sign off; and commissioner forecast
Planning Frequency:
Firm monthly forecasts for 2011/12, and outline annual forecasts for 2012/13, 2013/14, 2014/15.
Criteria for Plan Sign-off:
None. Forecasts will be assessed: - to ensure that they are based on robust demand assumptions that support delivery of QIPP over four years;   - and for consistency with the forecasts for beds, length of stay, elective activity and finance.

FURTHER INFORMATION
Further Information:
http://www.connectingforhealth.nhs.uk/systemsandservices/data/nhsdmds/faqs
Changes from 2010/11 Planning Round:
None

HRS07: Numbers Waiting on an Incomplete Referral to Treatment Pathway

DEFINITIONS
Detailed Descriptor:
The total number of incomplete Referral to Treatment pathways at the end of the period
Lines within Indicator (Units):
The total number of incomplete Referral to Treatment pathways at the end of the period
Data Definition:
The number of incomplete Referral to Treatment pathways at the end of the period based on referral to treatment data provided by NHS and independent sector organisations and signed off by NHS commissioners
Basis for Accountability:
Commissioners.

MONITORING
Monitoring Frequency:
Monthly.
Monitoring Data Source:
Referral to Treatment Consultant-led Waiting Times data collection via Unify2 (National Statistics).

ACCOUNTABILITY
What success looks like, Direction, Milestones:
This will be assessed alongside other data, including referrals, activity, finance, and referral to treatment data - including for consistency with sustaining 95th percentile and median waiting times.
Timeframe/Baseline:
2010/11
Timeframe Until:
March 2015

Rationale:
As set out in the Operating framework for 20011/12, patients' rights to access services within maximum waiting times under the NHS Constitution continue and commissioners should ensure that performance does not deteriorate and where possible improves during 2011/12. With that in mind, providers should be expected to offer information on maximum waiting times to patients.
SHA Envelopes:
N/A.

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, commissioner forecasts.
Planning Frequency:
Firm monthly forecasts for 2011/12, and outline annual forecasts for 2012/13, 2013/14, 2014/15.
Criteria for Plan Sign-off:
None. Forecasts will be assessed for consistency with the forecasts for referrals, activity, finance and completed referral to treatment 95th percentile and median waits.

FURTHER INFORMATION
Further Information:
Data and full guidance can be found here http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/ReferraltoTreatmentstatistics/index.htm
Changes from 2010/11 Planning Round:
None. This information has been routinely reported and monitored since 2007.

HRS08: Health Visitor Numbers

DEFINITIONS
Detailed Descriptor:
Number of health visitors (headcount - to be confirmed)
Lines within Indicator (Units):
Health visitor numbers as a subset of the all Hospital and Community Health Services (HCHS) workforce by Headcount using data from the Electronic Staff Record (ESR) The figures do not include data for GPs and practice staff.
Data Definition:
High-level NHS HCHS Workforce statistics at a National and SHA level for health visitors
Basis for Accountability:
All trusts aggregated to national and SHA level

MONITORING
Monitoring Frequency:
Monthly (ESR) or Annually (Annual Census)
Monitoring Data Source:
ESR data. For Moorfields and Chesterfields FT, the actual census data as at 30 September 2009

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Delivery of extra 4200 health visitors by 2015.
Timeframe/Baseline:
September 2010
Timeframe Until:
2015

The Coalition Agreement contained a commitment to delivering an extra 4,200 health visitors to ensure families have a positive start, working in partnership with other health services, GPs, Sure Start Children's Centres and other early years services. The Departmental Business Plan stipulates that this commitment must be implemented by 2015.

PLANNING REQUIREMENTS

Are Plans Required?:

Yes, by provider

Planning Frequency:

Monthly

Criteria for Plan Sign-off:

- Plans to demonstrate increase in HV headcount numbers during 2011-12 and progress in all areas in growing the workforce, including training commissions, towards the additional 4,200 extra HVs by 2015, taking account of the indicative SHA workforce growth envelopes circulated with the NHS management letter.

- Plans to demonstrate extended coverage of local delivery of the HCP during 2011-12.

- Confirmation that plans have been shared with LA children's services.

FURTHER INFORMATION

Further Information:

Changes from 2010/11 Planning Round:

This is a new indicator.

HRS09: Workforce Productivity

DEFINITIONS
Detailed Descriptor:

Workforce productivity measure

Lines within Indicator (Units):

1. Cost-weighted secondary care activity
2. Earnings weighted staff capacity
3. Workforce productivity =

$$\frac{(1+ \% \text{ change in secondary activity})}{(1+ \% \text{ change in staff capacity})} - 1$$

Data Definition:

Cost-weighted secondary activity:
Weighted sum of non-elective FFCEs, elective FFCEs, first out-patient attendances, follow-up outpatient appointments (based on a ratio of first:follow-up attendances) and A&E attendances.
Weights are equal to the weighted average reference cost for each activity.

Earnings weighted staff capacity:
Weighted sum of number of staff in each staff group, with weights being average earnings of each staff group

Basis for Accountability:

Commissioner, aggregated to SHAs

MONITORING
Monitoring Frequency:

Monthly

Monitoring Data Source:

Non-elective FFCEs: Monthly Activity returns
Elective FFCEs: Monthly Activity returns
First out-patient attendances: Monthly Activity returns
Follow-up outpatient appointments (based on a ratio of first:follow-up attendances)
A&E attendances: Weekly Sitreps
Staff numbers: iView data
Staff earnings: ESR data

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Workforce productivity should show an increase on previous year
Timeframe/Baseline:
2010-11
Timeframe Until:
End of planning period
Rationale:
Productivity is a measure of outputs over inputs. This indicator takes the output of the NHS as a measure of secondary care activity, and the input as staff capacity. As efficiencies are put in place, then it would be expected that for the same level of staff capacity, there would in an increase in activity.
SHA Envelopes:
N/A

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
This is a new indicator

HRF04: Establishment of PCT clusters

This measure is being designed to measure progress on creating PCT clusters as part of the transition to the new commissioning architecture. The measure is not appropriate for planning purposes but will be used in-year to judge progress. The definitions are currently being developed and will be shared (with SHAs) when this work is complete.

SQU01: VTE Risk Assessment

DEFINITIONS
Detailed Descriptor:
VTE risk assessment for inpatient admissions- % of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool
Lines within Indicator (Units): % performance calculated from:
Numerator: Number of adult inpatient admissions reported as having had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool (including those risk assessed using a cohort approach in line with published guidance). Denominator: Number of adults who were admitted as inpatients (includes day cases, maternity and transfers; both elective and non-elective admissions)
Basis for Accountability:

MONITORING
Monitoring Frequency:
Monthly
Monitoring Data Source:
Providers submit a mandatory monthly census data return through UNIFY2 – Department of Health

ACCOUNTABILITY
What success looks like, Direction, Milestones:
All providers of acute services should be delivering and sustaining improvements in performance towards the level specified by the national CQUIN goal in 2010/11 and 2011/12 (i.e. 90% of all adult inpatients risk assessed for VTE on admission to acute care providers).
Timeframe/Baseline:
1-31 March 2011
Timeframe Until:
Ongoing

Rationale:
VTE is a condition in which a blood clot (thrombus) forms in a vein. Blood flow through the affected vain can be limited by the clot, and may cause swelling and pain. Venous thrombosis occurs most commonly in the deep veins of the leg or pelvis; this is known as a deep vein thrombosis (DVT). An embolism occurs if all or part of the clot breaks off from the site where it forms and travels through the venous system.   If the clot lodges in the lung a potentially serious and sometimes fatal condition, pulmonary embolism (PE) occurs.   DVT and PE are the commonest manifestations of venous thrombosis.   The term VTE embraces both the acute conditions of DVT and PE, and also the chronic conditions which may arise after acute VTE such as post thrombotic syndrome and pulmonary hypertension, both problems being associated with significant ill-health and disability.   VTE is a significant cause of mortality, long-term disability and chronic ill health. It was estimated by a Health Committee Report in 2005 that there were around 25,000 deaths from VTE each year in hospitals in England and many these death were avoidable. VTE is now recognised as a clinical priority for the NHS by the National Quality Board and the NHS Leadership Team and the Three Professions (Academy of Medical Royal Colleges, Royal College of Nursing and Royal College of Pharmacists).   Providers using the NHS Standard Acute Contract who achieve 90% against this indicator will be financially rewarded through the Commissioning for Quality and Innovation (CQUIN) payment framework in 2011/12, as in 2010/11. However the indicator is also included as a performance measure for national oversight in 2011/12 in order to ensure that all providers are improving their overall performance, even if they do not achieve the threshold required to receive a CQUIN payment.

SHA Envelopes:
Not applicable

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Department of Health National VTE Risk Assessment Tool http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088215

NICE guidelines – The NICE clinical guideline 92, 'Venous thromboembolism – reducing the risk', (http://guidance.nice.org.uk/CG92

NICE Quality Standard: -
 http://www.nice.org.uk/aboutnice/qualitystandards/vteprevention

National NHS VTE Exemplar Centre Network:
http://www.kingsthrombosiscentre.org.uk/cgi-bin/kings/exemplarcentres.pl

Map of Medicine VTE Prevention Pathway:
http://healthguides.mapofmedicine.com/choices/map/index.html

A Guide for Delivering the CQUIN Goal on VTE Risk Assessment:
http://www.kingsthrombosiscentre.org.uk/kings/Delivering%20the%20CQUIN%20Goal_2ndEdition_LR.pdf

VTE Risk Assessment data collection: July-September 2010
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_122283

Changes from 2010/11 Planning Round:

This is a new indicator.

SQU02: % Deaths at Home (inc Care Homes)

DEFINITIONS
Detailed Descriptor:

Percentage of deaths in usual place of residence.
Usual place of residence is defined as: home, care homes (NHS and non-NHS) and religious establishments

Lines within Indicator (Units):

Numerator: number of deaths in usual place of residence registered in the respective quarter

Denominator: number of total deaths (less exclusions) registered in the respective quarter

Data Definition:

Usual place of residence is defined as: home, care homes (NHS and non-NHS) and religious establishments
'Home' means the deceased's own private residence (ONS place of death code H).
'Care home' means a nursing home or residential home (ONS CE type codes 02, 04, 07, 10, 14, 20-22, 32, 33) or (ONS CE type codes 03, 99 and NHSind 2).
Religious establishments are also included (ONS CE type codes 52, 64).
These definitions will be updated following revision of the ONS place of death classification.

Inclusions/exclusions
All ages will be included.
Deaths from external causes (underlying cause=ICD-10 codes V01-Y98) will be excluded, as (i) these deaths cannot be planned for, and (ii) their registration may be delayed by referral to a coroner.
Deaths of non-residents will be excluded.

Basis for Accountability:

Commissioner

MONITORING
Monitoring Frequency:

Quarterly for England and SHAs.
Quarterly on a rolling 12 month basis for PCTs, i.e. each quarter's figures will update the previous figures by adding the most recent quarter and dropping the oldest. The quarterly figures published will also include raw data for the most recent quarter. All figures will be by date of registration. To allow quarterly reporting, provisional ONS data will be used.

Delivery will be within 3 months of each period end. There will be an additional annual publication of figures based on final ONS data, to be followed in each case by any revisions to the preceding quarterly figures following annual quality assurance processes.

Monitoring Data Source:

ONS. A spreadsheet is available on Unify2 which contains more information about the mortality data from the ONS official quarterly datasets. This may be helpful when compiling returns.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Good performance is represented by an increasing proportion of deaths occurring in usual place of residence.

Timeframe/Baseline:

2009

Timeframe Until:

Ongoing

Rationale:

To improve end of life care allowing more patients the choice of dying at home.
For many people "home" will be a care home. The End of Life Care Strategy sets out the direction of travel to provide all adults nearing the end of life, regardless of diagnosis, access to high quality palliative care, giving more people the choice to die at home, including in a care home. This requires effective care pathways to meet the health and social care needs and preferences at the end of life.

SHA Envelopes:

N/A

PLANNING REQUIREMENTS

Are Plans Required?:

Yes, commissioner plans

Planning Frequency:

Quarterly for 2011/12

The proportion of patients supported to remain in their usual place of residence until the end of their life should show an increase in 2011/12 over the baseline at both PCT and SHA level. This will be assessed by taking the average proportion over the planning period and comparing it to the baseline figure. Note that the baseline used relates to the 2009 calendar year as this is the latest full year for which final ONS data is available.

FURTHER INFORMATION

Further Information:

Changes from 2010/11 Planning Round:

The previous Vital Sign covered only deaths at home. The original intent was to include care homes as soon as we could be confident that definitions and data were sufficiently robust. This has also been wanted by the field. The new Indicator therefore includes home and care homes and also covers the small number of deaths in religious establishments.

SQU03: Ambulance Quality Indicators (all other measures)

SQU03_01: Ambulance Clinical Quality- Call Abandonment Rate

Detailed Descriptor:
The percentage of calls abandoned before answered
Lines within Indicator (Units):
Numerator: Number of calls abandoned before call answered **Denominator**: Total number of 999 ambulance calls presented to switchboard
Data Definition:
Numerator: Number of calls abandoned before being answered **Denominator**: Total number of 999 calls presented to switchboard (KA34 Line 01)
Basis for Accountability:
This data will be reported for all Ambulance Trusts at a Trust-wide level

MONITORING
Monitoring Frequency:
Monthly
Monitoring Data Source:
Ambulance telephony system Data submitted via form KA34 to the NHS Information Centre for Health and Social Care

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Lower rates of call abandonment are a marker of better patient care and experience. The lowest possible abandonment rate is the aim but zero will never be achieved. For example, there are some good reasons for call being abandoned, such as patients realising that their condition is not serious.
Timeframe/Baseline:

Timeframe Until:
Ongoing

Rationale:
The call abandoned rate is a marker of patient experience. Patients may hang up because they are unhappy about the delay in answering the call. A high call abandoned rate is not safe and may reflect a high level of clinical risk for patients, as patients who hang up before being assessed by a clinical decision maker may have health conditions that will exacerbate without treatment.

SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Further information and guidance on the Ambulance Clinical Quality Indicators will be released early in 2011 by the Ambulance Service, the Department, and the NHS Information Centre for Health and Social Care.
Changes from 2010/11 Planning Round:
This is a new indicator.

SQU03_02: Ambulance Clinical Quality- Re-Contact Rate Following Discharge of Care

Detailed Descriptor:
Unplanned re-contact with the ambulance service within 24 hours of discharge of care (discharge by clinical telephone advice, or following treatment at the scene)

Lines within Indicator (Units):
(a) Re-contact rate following discharge of care by telephone   **Numerator**: Calls closed with telephone advice where re-contact occurs within 24 hours   **Denominator**: Call closed with telephone advice   **(b) Re-contact, following discharge of care from treatment at the scene**   **Numerator**: Patients treated and discharged on scene where re-contact occurs within 24 hours   **Denominator :** Patients treated and discharged on scene   **(c) Proportion of calls from patients for whom a locally agreed frequent caller procedure is in place**   **Numerator**: Call from patients for whom a locally agreed frequent caller procedure is in place   **Denominator :** Total number of emergency calls

Data Definition:
(a) Re-contact rate following discharge of care by telephone   **Numerator**: Calls closed with telephone advice where re-contact with the ambulance service via 999 occurs from the same address or phone number for the same patient within 24 hours of time of discharge   **Denominator**: Number of successfully completed calls that have been resolved (i.e. where advice has been given with any appropriate action agreed with the patient), with no resource arrived at the scene of the incident, by   – a designated healthcare professional accountable to the Trust providing telephone advice only, or;   – calls dealt with by a healthcare professional accountable to the Trust, or;   – call dealt with through decisions supported by clinical decision support software, or;   – calls passed to another organisation working with the Trust through an agreed contract or Service Level Agreement

(b) Re-contact, following discharge of care from treatment at the scene

Numerator: Patients treated and discharged on scene where re-contact with the ambulance service via 999 occurs from the same address or phone number for the same patient within 24 hours of time of discharge

Denominator: Number of patients treated at the scene only (KA34 Line 10)

Exclusions (for components 'a)' and 'b)' of this indicator)
This indicator measures patients re-contacting 999 within 24 hours of original call; the following calls should be excluded from the numerator:
- Re-contact for different patient
- Patients transported after first contact

Re-contact rates are based on telephone number or address information, rather than patient level information. Therefore it should be noted that data may not be available for:
 - patients calling from public places;
- patients calling from locations not in their own home for first contact;

(c) Proportion of calls from patients for whom a locally agreed frequent caller procedure is in place

Numerator: Call from patients for whom a locally agreed frequent caller procedure is in place

Calls from patients for whom a frequent caller procedure is in place should be reported, and the narrative explanation of performance for this component of the indicator should refer to what actions the trust is taking to manage and provide an appropriate clinical service to these frequent callers.

Denominator : Total number of 999 calls presented to switchboard (KA34 Line 01)

The following calls should be excluded from the numerator and denominator of this indicator:
- Duplicate or multiple calls to an incident where a response has already been activated;
- Hang-ups before coding is complete
- Caller not with patient and unable to give details
- Caller refuses to give details
- Hoax calls where response not activated
Response cancelled before coding is complete (e.g. patient recovers)

Basis for Accountability:

This data will be reported for all Ambulance Trusts at a Trust-wide level

MONITORING
Monitoring Frequency:
Monthly

Monitoring Data Source:
Ambulance Computer Aided Dispatch system
Data submitted via form KA34 to the NHS Information Centre for Health and Social Care

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Lower re-contact rates are desirable. However, the optimum re-contact is *not zero*. Patients may be expected to re-contact if their conditions unavoidably worsen, or if they re-contact for separate conditions. Discharging patients on consideration of the clinical risk with appropriate safety-netting advice can also be good care.

Timeframe/Baseline:

Timeframe Until:
Ongoing

Rationale:
Patients may re-contact the ambulance service because of the incorrect initial telephone diagnosis or poor explanation by clinical staff.
Unplanned re-contact is a marker of the accuracy of initial telephone or face to face assessment in identifying those patients requiring an escalation of care or likely to experience deterioration.

SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No

Planning Frequency:

85

FURTHER INFORMATION
Further Information:
Further information and guidance on the Ambulance Clinical Quality Indicators will be released early in 2011 by the Ambulance Service, the Department, and the NHS Information Centre for Health and Social Care.
Changes from 2010/11 Planning Round:
This is a new indicator.

SQU03_03: Ambulance Clinical Quality- Outcome from Cardiac Arrest – Return of Spontaneous Circulation

Detailed Descriptor:

Outcome from cardiac arrest, measured by return of spontaneous circulation (ROSC) at point of handover of the patient to hospital. Recording of ROSC at hospital indicates the outcome of the pre-hospital response and intervention.

Lines within Indicator (Units):

(a) ROSC at time of arrival at hospital (Overall)

Numerator: Of the patients included in the denominator, the number of patients who had return of spontaneous circulation on arrival at hospital.

Time of arrival refers to the point at which clinical responsibility for the patient is handed over from the ambulance service to the receiving hospital.

Denominator: All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest .

(b) ROSC at time of arrival at hospital (Utstein Comparator Group)

Numerator: Of the patients included in the denominator, the number of patients who had return of spontaneous circulation on arrival at hospital.

Time of arrival refers to the point at which clinical responsibility for the patient is handed over from the ambulance service to the receiving hospital.

Denominator: All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander or Emergency Medical Service witnessed and the initial rhythm was VF or VT.

Data Definition:

(a) ROSC at time of arrival at hospital (Overall)

Numerator: Of the patients included in the denominator, the number of patients who had return of spontaneous circulation on arrival at hospital.

Time of arrival refers to the point at which clinical responsibility for the patient is handed over from the ambulance service to the receiving hospital.

Denominator: All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest.

(b) ROSC at time of arrival at hospital (Utstein Comparator Group)

Numerator: Of the patients included in the denominator, the number of patients who had return of spontaneous circulation on arrival at hospital.

Time of arrival refers to the point at which clinical responsibility for the patient is handed over from the ambulance service to the receiving hospital.

Denominator: All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander or Emergency Medical Service witnessed and the initial rhythm was VF or VT.

Basis for Accountability:

This data will be reported for all Ambulance Trusts at a Trust-wide level

MONITORING

Monitoring Frequency:

Quarterly – commencing from April 2011

Monitoring Data Source:

Ambulance Trust data (including clinical and computer-aided dispatch (CAD) data) collected as per Ambulance Clinical Performance Indicators guidelines and definitions

ACCOUNTABILITY

What success looks like, Direction, Milestones:

The higher the ROSC rate the better.

Timeframe/Baseline:

Timeframe Until:

Ongoing

Rationale:

The aim of this indicator is to reduce the proportion of patients who die from out of hospital cardiac arrest.

The return of spontaneous circulation is calculated for two patient groups: The overall rate measures the overall effectiveness of the urgent and emergency care system in managing care for all out of hospital cardiac arrest patients; the rate for the Utstein comparator group applies to a subset of all cardiac arrest patients and

provides a more comparable measure of management of cardiac arrest for patients where timely and effective clinical care can particularly improve survival.

SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Further information and guidance on the Ambulance Clinical Quality Indicators will be released early in 2011 by the Ambulance Service, the Department, and the NHS Information Centre for Health and Social Care.
Changes from 2010/11 Planning Round:
This is a new indicator

SQU03_04: Ambulance Clinical Quality- Service Experience

Detailed Descriptor:

Narrative on how the experience of users of the ambulance service is captured, what the results were, and what has been done to improve the design and delivery of services in light of the results

Lines within Indicator (Units):

Not applicable

Data Definition:

There is no one definitive data source or method for understanding the experience of service users. Ambulance services have therefore been given the flexibility to develop and commission the methods they feel are most appropriate for understanding and assessing the experience of their users.

However this indicator should include a qualitative understanding and description of user experience, and should not be restricted to reporting quantitative measures of user satisfaction from questionnaires. This indicator aims to ensure that the health needs and issues which matter most to patients (in all call categories), such as timeliness and being treated with dignity, are being effectively met.

Providers are expected to provide a narrative which sets out:

(1) What work they have undertaken to understand and assess the experience of a wide and representative range of patients, carers and staff, reflecting the 24 hour nature of the service, over the whole of the previous quarter
(2) What the results of these assessments were
(3) What has been done to improve services in light of these results
(4) What the outcome has been in terms of improved user experience

It is important that all four components of the narrative are completed. For example, it is not enough to note that user have been asked "Were you treated with dignity and respect?" or that discovery interviews have been conducted (Component 1); or to report the percentage of users reporting dissatisfaction on this measure, or anonymised narrative information summarising the interviews (Component 2); providers should also say what they have done to improve services (Component 3), and what the outcome was in terms of users reporting an improvement on this particular aspect of their care (Component 4)

Basis for Accountability:

This data will be reported for all Ambulance Trusts at a Trust-wide level

MONITORING
Monitoring Frequency:
Quarterly
Monitoring Data Source:
Please see data definitions section

ACCOUNTABILITY
What success looks like, Direction, Milestones:
A good ambulance service will undertake frequent research into what its users think of its service and act on this feedback. There is no one definitive way of undertaking this. High volume surveys with simple questions can be useful in finding out certain information but tend to measure satisfaction rather than explore areas of improvement; more detailed but lower volume interviews will bring different issues to light and allow more exploration of what can be improved. A high performing Ambulance service will be able to demonstrate that it has made changes to the way it provides services because of user feedback and that subsequent feedback has shown these changes to enhance user experience.
Timeframe/Baseline:
Timeframe Until:
Ongoing
Rationale:
User experience is a marker of the quality of care received and can be influenced by user expectations, the approach of staff and the information and clinical care they provide, and the delays in receiving the timely care they need. Listening to and addressing the views of users can guide providers in raising the quality of the services they provide.
SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:

FURTHER INFORMATION
Further Information:
Further information and guidance on the Ambulance Clinical Quality Indicators will be released early in 2011 by the Ambulance Service, the Department, and the NHS Information Centre for Health and Social Care.
Changes from 2010/11 Planning Round:
This is a new indicator.

SQU03_05: Ambulance Clinical Quality- Outcome from acute ST-elevation myocardial infarction (STEMI)

Detailed Descriptor:

This indicator has three components:

(a) The percentage of patients suffering a ST-elevation myocardial infarction (STEMI) receiving thrombolysis within 60 minutes of call.

(b) The percentage of patients suffering a STEMI who are directly transferred to a centre capable of delivering primary percutaneous coronary intervention (PPCI) and receive angioplasty within 150 minutes of call.

(c) The percentage of patients suffering a STEMI who receive an appropriate care bundle.

Lines within Indicator (Units):

(a) The percentage of patients suffering a STEMI receiving thrombolysis within 60 minutes of call

Numerator: Patients with initial diagnosis of 'definite myocardial infarction' (in accordance with Myocardial Ischaemia National Audit Project (MINAP) guidance) receiving thrombolysis within 60 minutes of call connected to ambulance service, where first diagnostic Electrocardiogram (ECG) performed is by ambulance personnel

Denominator: Patients with initial diagnosis of 'definite myocardial infarction' receiving thrombolysis, where first diagnostic ECG performed is by ambulance personnel

(b) The percentage of patients suffering a STEMI and who, following direct transfer to a PPCI centre , primary angioplasty commences within 150 minutes of call

Numerator: Patients with initial diagnosis of 'definite myocardial infarction' for whom primary angioplasty commenced within 150 minutes of call connected to ambulance service, where first diagnostic Electrocardiogram (ECG) performed is by ambulance personnel and patient was directly transferred to a designated PPCI centre as locally agreed

Denominator: Patients with initial diagnosis of 'definite myocardial infarction' who received primary angioplasty, where first diagnostic ECG performed is by ambulance personnel and patient was directly transferred to a designated PPCI centre as locally agreed

(c) The percentage of patients suffering a STEMI who receive an appropriate care bundle

Numerator: Patients with a pre-hospital diagnosis of suspected ST elevation myocardial infarction confirmed on ECG who received an appropriate care bundle

Denominator: Patients with a pre-hospital diagnosis of suspected ST elevation myocardial infarction confirmed on ECG

Data Definition:

(a) The percentage of patients suffering a STEMI receiving thrombolysis within 60 minutes of call

Numerator: Patients with initial diagnosis of 'definite myocardial infarction' receiving thrombolysis within 60 minutes of call connected to ambulance service, where first diagnostic Electrocardiogram (ECG) performed is by ambulance personnel

Denominator: Patients with initial diagnosis of 'definite myocardial infarction' receiving thrombolysis, where first diagnostic ECG performed is by ambulance personnel

Exceptions include (As per Myocardial Ischaemia National Audit Project (MINAP) guidance [Data Collection for the Myocardial Ischaemia National Audit Project Application NotesV6 2009]):

1. Sustained hypertension,
2. Clinical concern about recent cerebro-vascular event or recent surgery,
3. Delay obtaining consent,
4. Cardiac arrest,
5. Ambulance procedural delay (This includes any pre-hospital delay outside the control of the ambulance service, eg incorrect address, difficulty finding address, unable to gain entry to patient's house, patient reasons eg initial refusal to go to hospital or extended domestic arrangements, adverse weather conditions, stabilising the patient, crew had to wait for boat, helicopter delay, wait for police to gain entry, failure to cannulate.)
6. Other exclusions on clinical grounds which have been formally approved in discussions with MINAP

(b) The percentage of patients suffering a STEMI and who, following direct transfer to a PPCI centre receive primary angioplasty within 150 minutes of call

Numerator: Patients with initial diagnosis of 'definite myocardial infarction' for whom primary angioplasty commenced within 150 minutes of call connected to ambulance service, where first diagnostic Electrocardiogram (ECG) performed is by ambulance personnel and patient was directly transferred to a designated PPCI centre as locally agreed

Denominator: Patients with initial diagnosis of 'definite myocardial infarction' who received primary angioplasty, where first diagnostic ECG performed is by ambulance personnel and patient was directly transferred to a designated PPCI centre as locally agreed

Exceptions include

1. Secondary transfers to PPCI from non-PPCI capable hospitals
2. Delay obtaining consent,
3. Cardiac arrest,
4. Ambulance procedural delay (This includes any pre-hospital delay outside the control of the ambulance service, eg incorrect address, difficulty finding address, unable to gain entry to patient's house, patient reasons eg initial refusal to go to hospital or extended domestic arrangements, adverse weather conditions, stabilising the patient, crew had to wait for boat, helicopter delay, wait for police to gain entry, failure to cannulate.)
5. Sustained hypertension,
6. Clinical concern about recent cerebro-vascular event or recent surgery,
7. Other exclusions on clinical grounds which have been formally approved in discussions with MINAP

(c) The percentage of patients suffering a STEMI who receive an appropriate care bundle

Numerator: Patients with a pre-hospital diagnosis of suspected ST elevation myocardial infarction confirmed on ECG receiving the STEMI care bundle

Denominator: Patients with a pre-hospital diagnosis of suspected ST elevation myocardial infarction confirmed on ECG

Notes
1. Components of the care bundle for STEMI patients, in line with Ambulance Clinical Performance indicator guidelines, are presented below, with their exceptions in parenthesis..
   a. Aspirin given (Patient refusal, contraindication to drug)
   b. Glyceryl trinitrate - GTN given (Patient refusal, contraindication to drug)
   c. Two pain scores recorded (Patient refusal/Patient unable/Patient unconscious)
   d. Analgesia - Morphine and/or Entonox - given (Patient refusal/Patient not in pain/Contraindication to drug(s))

If **one** element of the care bundle is not administered due to one of its specified exceptions, but the remainder of the care bundle is administered then the care bundle is complete. However, if more than one component of the care bundle is not administered then the care bundle is not complete and the patient episode should not be included in the numerator.

Basis for Accountability:

This data will be reported for all Ambulance Trusts at a Trust-wide level

MONITORING

Monitoring Frequency:

Quarterly – commencing from April 2011

(a) The percentage of patients suffering an ST-elevation myocardial infarction (STEMI) receiving thrombolysis within 60 minutes of call.
Myocardial Ischaemia National Audit Project (MINAP) data

Acute trusts are required to work and support ambulance trusts in the provision and timely linking of data to ensure that outcome information is captured as accurately, and for as many patients as possible.

(b) The percentage of patients suffering a STEMI who are directly transferred to a centre capable of delivering primary percutaneous coronary intervention (PPCI) and receive angioplasty within 150 minutes of call.
Myocardial Ischaemia National Audit Project (MINAP) data

Acute trusts are required to work and support ambulance trusts in the provision and timely linking of data to ensure that outcome information is captured as accurately, and for as many patients as possible.

(c) The percentage of patients suffering a STEMI who receive an appropriate care bundle.
Ambulance Trust data (including clinical and computer-aided dispatch (CAD) data) collected as per Ambulance Clinical Performance Indicators guidelines and definitions

ACCOUNTABILITY
What success looks like, Direction, Milestones:
High proportion of patients receiving early reperfusion (timely thrombolysis and primary angioplasty; delivery of care bundle) and all components of assessment and care
Timeframe/Baseline:
Timeframe Until:
Ongoing
Rationale:
Early access to reperfusion and other assessment and care interventions are associated with reductions in STEMI mortality and morbidity.   This is evidenced in both NSF for CHD and National Infarct Angioplasty Project Gateway 9116 (2008) and Mending Hearts and Brains.
SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Further information and guidance on the Ambulance Clinical Quality Indicators will be released early in 2011 by the Ambulance Service, the Department, and the NHS Information Centre for Health and Social Care.
Changes from 2010/11 Planning Round:
This is a new indicator.

SQU03_06: Ambulance Clinical Quality- Outcome from stroke for ambulance patients

Detailed Descriptor:

(a) The percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call.

(b) The percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle.

Lines within Indicator (Units):

(a) The percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call.

Numerator: FAST positive patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines arriving at hospitals with a hyperacute stroke centre within 60 minutes of call connecting to the ambulance service

Denominator: FAST positive patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines

(b) The percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle.

Numerator: The number of suspected stroke patients assessed face to face who received an appropriate care bundle

Denominator: The number of suspected stroke patients assessed face to face

Data Definition:

(a) The percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call.

Numerator: FAST positive patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines arriving at hospitals with a hyperacute stroke centre within 60 minutes of call connecting to the ambulance service

Denominator: FAST positive patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines

Exclusions that may be considered for inclusion in local guidelines
1. Patient refusal

2. Complete resolution of symptoms before arrival at stroke centre [transient ischaemic attack (TIA)]
3. Advance Directive for refusal of treatment (ADRT)
4. Patients who are not clinically safe for bypass to hyperacute stroke centre (i.e. patients with seizures/agitation; Glasgow Coma Scale score below 8; time critical features (airway problem, reduced consciousness)

(b) The percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle.

Numerator: The number of suspected new stroke, or transient ischaemic attack, patients assessed face to face who received an appropriate care bundle

Denominator: The number of suspected stroke positive patients assessed face to face

Notes
1. Components of the care bundle for suspected stroke patients, in line with Ambulance Clinical Performance indicator guidelines, are presented below, with their exceptions in parenthesis:
   a. FAST assessment recorded (Prior neurological deficit/ Patient unconscious/Patient refusal/Patient does not understand/Head trauma/injury)
   b. Blood glucose recorded (Patient refusal/Patient does not understand/Head trauma/injury)
   c. Systolic and diastolic blood pressure recorded (Patient refusal/Time critical features (airway problem, reduced consciousness))

If **one** element of the care bundle is not administered due to one of its specified exceptions, but the remainder of the care bundle is administered then the care bundle is complete. However, if more than one component of the care bundle is not administered then the care bundle is not complete and the patient episode should not be included in the numerator.

Basis for Accountability:
This data will be reported for all Ambulance Trusts at a Trust-wide level

MONITORING
Monitoring Frequency:
Quarterly – commencing from April 2011
Monitoring Data Source:
(a) The percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call. Ambulance Trust data (including clinical and computer-aided dispatch (CAD) data) collected as per Ambulance Clinical Performance Indicators guidelines and

definitions

(b) The percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle.
Ambulance Trust data (including clinical and computer-aided dispatch (CAD) data) collected as per Ambulance Clinical Performance Indicators guidelines and definitions

ACCOUNTABILITY
What success looks like, Direction, Milestones:

The higher the percentage of FAST positive stroke patients arriving at a hyperacute stroke centre within 60 mins the better.

The higher the percentage of suspected stroke patients receiving a care bundle the better.

Timeframe/Baseline:

Timeframe Until:

Ongoing

Rationale:

Patients should be arriving at the hyperacute stroke centre as soon as possible so that they can be rapidly assessed for thrombolysis, delivered following a CT scan in a short but safe time frame; this has been demonstrated to reduce mortality and improve recovery.

Eligibility criteria, particularly in relation to the therapeutic time window, will vary between local services, depending on the availability of local expertise e.g. intra-arterial clot lysis.

This indicator supports the NICE national quality standard that indicates this is an effective measure of the ambulance service's contribution to the stroke pathway

SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:

No

Planning Frequency:

FURTHER INFORMATION
Further Information:
Further information on the detailed definitions, management and publication of the Ambulance clinical quality indicators will be published in early 2011.
Changes from 2010/11 Planning Round:
This is a new indicator

SQU03_07: Ambulance Clinical Quality- Outcome from cardiac arrest – Survival to discharge

Detailed Descriptor:

a. Survival to discharge – Overall survival rate
b. Survival to discharge – Utstein Comparator Group survival rate

This survival to discharge measure reflects the effectiveness of the whole urgent and emergency care system in managing out of hospital cardiac arrest.

Lines within Indicator (Units):

a. **Survival to discharge – Overall survival rate**

Numerator: Of the patients included in the denominator, the number of patients discharged from hospital alive

Denominator: All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest

b. **Survival to discharge – Utstein Comparator Group survival rate**

Numerator: Of the patients included in the denominator, the number of patients discharged from hospital alive

Denominator: All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest of presumed cardiac origin, where the arrest was bystander or Emergency Medical Service witnessed and the initial rhythm was VF or VT.

Data Definition:

a. **Survival to discharge – Overall survival rate**

Numerator: Of the patients included in the denominator, the number of patients discharged from hospital alive

Denominator: All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac arrest

b. **Survival to discharge – Utstein Comparator Group survival rate**

Numerator: Of the patients included in the denominator, the number of patients discharged from hospital alive

Denominator: All patients who had resuscitation (Advanced or Basic Life Support) commenced/continued by ambulance service following an out-of-hospital cardiac

arrest of presumed cardiac origin, where the arrest was bystander or Emergency Medical Service witnessed and the initial rhythm was VF or VT.

Basis for Accountability:

This data will be reported for all Ambulance Trusts at a Trust-wide level

MONITORING

Monitoring Frequency:

Quarterly – commencing from April 2011

Monitoring Data Source:

Survival to discharge information will be obtained from clinical and operational information from ambulance trust records, and data obtained from national databases and hospital sources.

Acute trusts are required to work and support ambulance trusts in the provision and timely linking of data to ensure that outcome information is captured as accurately, and for as many patients as possible.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

The higher survival to discharge rate the better.

Timeframe/Baseline:

Timeframe Until:

Ongoing

Rationale:

Survival to discharge outcome measures reflect the effectiveness of the whole urgent and emergency care system in managing out of hospital cardiac arrest.

The overall survival rate measures the overall effectiveness of the urgent and emergency care system in managing care for all out of hospital cardiac arrest patients; the Utstein survival rate applies to a subset of all cardiac arrest patients and provides a more comparable measure of management of cardiac arrest for patients where timely and effective clinical care can particularly improve survival.

SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Further information and guidance on the Ambulance Clinical Quality Indicators will be released early in 2011 by the Ambulance Service, the Department, and the NHS Information Centre for Health and Social Care.
Changes from 2010/11 Planning Round:
This is a new indicator

SQU03_08: Ambulance Clinical Quality- Time to Answer Call

Detailed Descriptor:
The time to answer calls

Lines within Indicator (Units):
Numerator: Time to answer calls, measured by median, 95th percentile and longest time to answer **Denominator** Not applicable

Data Definition:
Numerator: Time to call answering, measured by: - median time spent between Call Connect and call answer (i.e. the time below which 50% of calls were answered) - 95th percentile of times from Call Connect and call answer (i.e. the time below which 95% of calls were answered) - 99th percentile of times from Call Connect and call answer (i.e. the time below which 99% of calls were answered) Call Connect refers to the time at which the call is presented to the control room telephone switch. Excluding: - Calls abandoned before answer

Basis for Accountability:
This data will be reported for all Ambulance Trusts at a Trust-wide level

MONITORING
Monitoring Frequency:
Monthly

Monitoring Data Source:
Ambulance telephony system Data submitted via form KA34 to the NHS Information Centre for Health and Social Care

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Quicker times to answer calls is a marker of better patient care and experience. The lowest possible waiting times are the aim. As a matter of good practice Ambulance Trusts should have arrangements in place to continually monitor call answering performance and calls waiting.
Timeframe/Baseline:
Timeframe Until:
Ongoing
Rationale:
The time till a call is answered represents a period of clinical risk to the patient prior to assessment from trained ambulance service personnel. Many adverse events are related to initial delays in care and many emergency conditions are time-sensitive, therefore the period before a patient begins treatment represents clinical risk. Reducing delays in treatment can improve health outcomes and patient experience.
SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Further information and guidance on the Ambulance Clinical Quality Indicators will be released early in 2011 by the Ambulance Service, the Department, and the NHS Information Centre for Health and Social Care.
Changes from 2010/11 Planning Round:
This is a new indicator.

SQU03_09: Ambulance Clinical Quality- Time to Treatment

Detailed Descriptor:

Time to arrival of ambulance-dispatched health professional, for immediately life-threatening (Category A) calls

Lines within Indicator (Units):

Numerator: Time to arrival of a qualified health professional dispatched by the ambulance service for immediately life-threatening (Category A) calls, measured by median, 95th percentile and 99th percentile

Denominator : Not applicable

Data Definition:

Time to arrival of a qualified health professional, measured by:
- median time spent to arrival of a qualified health professional (i.e. the time below which 50% of incidents reported the arrival of a qualified health professional)
- 95th percentile of times to arrival of a qualified health professional (i.e. the time below which 95% of incidents reported the arrival of a qualified health professional, for example "95% of incidents reported the arrival of a qualified health professional within [x] minutes")
- 99th percentile of times to arrival of a qualified health professional (i.e. the time below which 99% of incidents reported the arrival of a qualified health professional, for example "99% of incidents reported the arrival of a qualified health professional within [x] minutes")

The clock start for this indicator is the earliest of:
– chief complaint information is obtained
– vehicle assigned
– 60 seconds after Call Connect (i.e. 60 seconds after the time at which the call is presented to the control room telephone switch)

This clock start position reflects this indicator's aim to:
– Ensure the appropriate resource is dispatched to meet the clinical needs of the patient [i.e. chief complaint information is obtained]
– Avoid perverse incentives to dispatch healthcare professionals to all calls regardless of the clinical need of the patient [i.e. clock start of chief complaint, rather than Call Connect/call presented to ambulance control room telephone switch]
– Maintain best practice in timely handling and answering of ambulance calls [i.e. clock start is capped at 60 seconds following presentation of the call to the ambulance control room telephone switch]

Only Category A (immediately life-threatening) calls should be used for analysis

Healthcare professionals include Doctors, Paramedics, Nurse or Ambulance Technicians accountable to, and/or dispatched by, the Ambulance Trust. This

definition of healthcare professionals excludes Emergency Care Support Workers, Emergency Care Assistants, Community First Responders, and static defibrillator sites. Therefore calls that are not closed by healthcare professionals, as defined above, attending the scene should be excluded from this indicator.

Basis for Accountability:

This data will be reported for all Ambulance Trusts at a Trust-wide level

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

Ambulance Computer Aided Dispatch system

Data submitted via form KA34 to the NHS Information Centre for Health and Social Care

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Lower times to treatment by a qualified healthcare professional are a marker of better quality care.

Timeframe/Baseline:

Timeframe Until:

Ongoing

Rationale:

The period before a patient is seen by a health professional represents a period of clinical risk and anxiety for the patient. The current Category A 8 minute response time includes clock-stop positions where calls can be resolved through a defibrillator on scene or a Community First Responder, however, a qualified healthcare professional is needed to provide a more effective clinical response for non-cardiac conditions such as administration of intravenous fluids, pain relief and drug therapy. By encouraging earlier definitive care and reducing delays in treatment this indicator will improve health outcomes and patient experience for all patients with life-threatening conditions.

SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Further information and guidance on the Ambulance Clinical Quality Indicators will be released early in 2011 by the Ambulance Service, the Department, and the NHS Information Centre for Health and Social Care.
Changes from 2010/11 Planning Round:
This is a new indicator.

SQU03_10: Ambulance Clinical Quality- Ambulance calls closed with telephone advice or managed without transport to A&E (where clinically appropriate)

Detailed Descriptor:

Measure the proportion of patients managed appropriately without the need for an ambulance response at the scene, or onward transport to major A&E departments

Lines within Indicator (Units):

Call closed with telephone advice

Numerator: Number of 999 calls that have been resolved by providing telephone advice

Denominator: All emergency 999 calls that receive a telephone or face-to-face response from the ambulance service

Incidents managed without the need for transport to A&E

Numerator: Patient journeys to a destination other than Type 1 and 2 A&E + number of patients discharged after treatment at the scene or onward referral to an alternative care pathway

Denominator: All emergency 999 calls that receive a face-to-face response from the ambulance service

Data Definition:

Call closed with telephone advice

Numerator: Number of successfully completed calls that have been resolved (i.e. where advice has been given with any appropriate action agreed with the patient), with no resource arrived at the scene of the incident, by
– a designated healthcare professional accountable to the Trust providing telephone advice only, or;
– calls dealt with by a healthcare professional accountable to the Trust, or;
– call dealt with through decisions supported by clinical decision support software, or;
– calls passed to another organisation working with the Trust through an agreed contract or Service Level Agreement

Denominator : All emergency 999 calls that receive a telephone or face-to-face response from the ambulance service at the scene of the incident.

Exclusions
The following calls should be excluded from the numerator and denominator of this indicator:
• Duplicate or multiple calls to an incident where a response has already been activated;

109

- Hang-ups before coding is complete
- Caller not with patient and unable to give details
- Caller refuses to give details
- Hoax calls where response not activated
- Response cancelled before coding is complete (e.g. patient recovers)

Incidents managed without the need for transport to A&E (Emergency Department)

Numerator: Patient journeys to a destination other than Type 1 and 2 A&E (KA34 Line 09; all references are to the KA34 2010/11 form) + number of patients treated at the scene only (KA34 Line 10)

Denominator: All emergency 999 calls that receive a face-to-face response from the ambulance service [KA34 line 08 (patient journeys to Type 1 and 2 A&E destinations) + line 09 (Patient journeys to a destination other than Type 1 and 2 A&E) + line 10 (patients treated at the scene only)]

Patient journeys
Each patient conveyed is counted as an individual patient destination. Similarly, each patient who is treated at the scene of an incident without requiring onward conveyance is counted as an individual treatment at the scene. Trusts should include only those patients conveyed as a result of a 999 call made by a member of the public or organisation, or as a result of being categorised as an emergency following a referral by a health care professional.

It should be noted that a single incident may result in more than one patient journey.

Emergency patient journeys to Type 1 and 2 A&E (as defined in the NHS Data Dictionary) – include those emergency patient journeys provided by the Trust where a patient is transported to a Type 1 or Type 2 A&E department only.

Emergency patient journeys to a destination other than Type 1 and 2 A&E – include those emergency patient journeys provided by the Trust where a patient is transported to all other destinations other than Type 1 or 2 A&E departments. An example of this could be conveying a patient to a minor injuries unit or a Walk-in Centre, a specialist stroke or cardiac centre, GP service or any other health or social care service.

Treatment at the scene – include those patients who were treated at the scene by the ambulance service and as a result of that treatment did not require onward transportation for further treatment. If, as part of that treatment, the ambulance trust staff arranged, for example, an appointment for the patient at a GP surgery or a follow-up home visit from a health professional that should also be counted as treatment at the scene. Responses where ambulance trust staff attended an incident and advice was given but no clinical intervention was necessary with no onward transportation required, then that should also be included as treatment at the scene.

Basis for Accountability:
This data will be reported for all Ambulance Trusts at a Trust-wide level

MONITORING
Monitoring Frequency:
Monthly
Monitoring Data Source:
Ambulance Computer Aided Dispatch system Data submitted via form KA34 to the NHS Information Centre for Health and Social Care

ACCOUNTABILITY
What success looks like, Direction, Milestones:
The percentage of patients requiring response or conveyance will vary according to factors within the control of the ambulance service (e.g. clinical skill level) but also due to other factors such as social deprivation, access to alternative care pathways, including in hours and out of hours primary care services, as well as medical factors (e.g. severity and co-existing disease). Good care is achieving as much care in the community as is *clinically appropriate* whilst responding to and conveying those patients who would not be suitable for treatment at the scene or through clinical telephone advice.
Timeframe/Baseline:
Timeframe Until:
Ongoing
Rationale:
Providing effective pre-hospital care for patients allows for better patient care and case management, care delivered closer to home, and a reduction in avoidable emergency patient journeys and admissions to hospital which are costly and expose patients to otherwise avoidable clinical risks such as healthcare-acquired infections. Providing clinically appropriate pre-hospital care through clinical telephone advice and treatment at the scene will result in better outcomes for patients and a more efficient use of ambulance resources. Effective and timely community care and case-management can further reduce the need for emergency care for patients, especially for patients with chronic conditions where effective case management can prevent acute exacerbations, and patients with acute conditions where timely care can prevent further deterioration.

112

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Further information and guidance on the Ambulance Clinical Quality Indicators will be released early in 2011 by the Ambulance Service, the Department, and the NHS Information Centre for Health and Social Care.
Changes from 2010/11 Planning Round:
This is a new indicator.

SQU04: A&E Quality Indicators (all other measures)

SQU04_01: A&E Clinical Quality- Ambulatory Care

DEFINITIONS
Detailed Descriptor:

Please note that this indicator has two separate components. One component measures the proportion of patients attending A&E for cellulitis and DVT who are then admitted (Component A). However, to recognise that not all A&E sites are able to fully clinically code attendances for these two conditions, a broader measure of admission rates per weighted head of population has been included (Component B).

Component A (A&E attendances ending in admission)
Ambulatory care for emergency conditions: the percentage of A&E attendances for cellulitis and DVT that end in admission

Component B (Admissions per head of population)
Ambulatory care sensitive conditions: the number of admissions for cellulitis and deep vein thrombosis (DVT) per head of weighted population

Lines within Indicator (Units):

Component A (A&E attendances ending in admission)
Numerator
i) Number of emergency admissions *via A&E* where the primary diagnosis was for cellulitis
ii) Number of emergency admissions *via A&E* where the primary diagnosis was for DVT

Denominator
i) Number of attendances at A&E where the primary diagnosis was for cellulitis
II) Number of attendances at A&E where the primary diagnosis was for DVT

Component B (Admissions per head of population)

Numerator
i) Number of finished admission episodes classed as emergency admissions, where the primary diagnosis was for cellulitis
ii) Number of finished admission episodes classed as emergency admissions, where the primary diagnosis was for DVT

Denominator
PCT Unified weighted populations

Data Definition:

Component A (A&E attendances ending in admission)

Numerator
  1. Number of emergency admissions via A&E where the primary diagnosis was for cellulitis
  2. Number of emergency admissions via A&E where the primary diagnosis was for DVT

Admission is defined as an emergency admission via A&E under Method of Admission code 21 (*Emergency - via Accident and Emergency (A&E) services, including the casualty department of the provider*)

Denominator
  1. Number of attendances at A&E where the primary diagnosis was for cellulitis
  2. Number of attendances at A&E where the primary diagnosis was for DVT

Data for planned follow-up attendances should be excluded from both the numerator and denominator.

Component B (Admissions per head of population)

Numerator
  1. Number of finished admission episodes classed as emergency admissions, where the primary diagnosis was for cellulitis
  2. Number of finished admission episodes classed as emergency admissions, where the primary diagnosis was for DVT

International classification of disease (ICD) 10 codes for the conditions are specified below:
  • Cellulitis (L030, L031, L032, L033, L038, L039, I891, L028, L029, L088, L089)
  • DVT (I801, I802, I803)

Emergency admissions are defined as admissions that are unpredictable and at short notice because of clinical need. The Method of Admission codes used to identify these episodes are below:

  ● (21) Emergency - via Accident and Emergency (A&E) services, including the casualty department of the provider
  ● (22) Emergency - via General Practitioner (GP)
  ● (23) Emergency - via Bed Bureau, including the Central Bureau
  ● (24) Emergency - via consultant out-patient clinic
  ● (28) Emergency - other means, including patients who arrive via the A&E department of another health care provider

Denominator
PCT Unified weighted populations

Basis for Accountability:

Component A (A&E attendances ending in admission)
● Provider-basis, all A&E sites

Data should be presented in a way that is most meaningful for the patient and which facilitates targeted local interventions to improve the quality of A&E services. Data should therefore be reported for providers at the level of five character provider codes (i.e. organisation code + site code), rather than three character provider codes (i.e. trust level). To appropriately reflect the patient's journey and modern co-located models that provide urgent and primary care facilities on the same site, where there is more than one type of A&E on the same campus, data should be reported for the whole campus, not for separate facilities, even if the service is provided by different organisations.

Component B (Admissions per head of population)
● Commissioner-basis, Primary care trusts (PCTs)

MONITORING

Monitoring Frequency:

Quarterly – April, July, October, January of each year

Monitoring Data Source:

Component A (A&E attendances ending in admission)
● Secondary Uses Services (SUS) data, A&E Commissioning Data Set (CDS)
　－ [A&E Attendance category] - to exclude planned follow-up attendances
　－ [A&E Attendance disposal] - to determine admission from A&E
　－ [A&E Primary Diagnosis] - to determine condition diagnosis for cellulitis and DVT

Component B (Admissions per head of population)
● Hospital Episode Statistics (HES) for inpatients
● PCT Unified weighted populations

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Management of the indicator
Providers should aim for continuous improvement on this indicator.

What good looks like
When it is safe and effective a patient should be treated at home or in settings where the delivery of acute care is feasible without requiring an admission for overnight stays in hospital, reflected in lower admission rates for these two conditions.

It is vital that accepted guidelines are followed to ensure that ambulatory care is only undertaken in clinically safe and indicated cases, and commissioners and providers

should refer to the A&E Clinical Quality Indicators guidance document and information on managing ambulatory care conditions published by the NHS Institute for Innovation and Improvement (see Further Information Section).

Key messages
- Healthcare systems should explore how they can safely treat as many people as possible in the community by exploring existing system-based barriers.
- Benchmarking against systems in other localities will demonstrate the capacity for improvement.
- Evidence suggests there is a high potential for ambulatory care for cellulitis cases (i.e. 60-90% of admissions) and a very high potential for ambulatory care for DVT (i.e. > 90% of admissions)

Timeframe/Baseline:

Timeframe Until:
Ongoing

Rationale:

The aim of this indicator is to reduce avoidable hospital admissions by improving the provision of ambulatory care.

Ambulatory care is clinical care for urgent conditions, which may include diagnosis, observation, treatment and rehabilitation that are not provided within the traditional hospital bed base or within traditional outpatient services; the healthcare setting may vary, but optimal clinical care will often require prompt access to diagnostic support for clinical assessments.

Ambulatory care sensitive conditions, such as chronic obstructive pulmonary disease (COPD), are those where improved preventative healthcare or improved long-term condition management in community care settings can result in decreased risk of an acute event occurring. These can be distinguished from the provision of ambulatory care for emergency conditions, such as cellulitis and DVT, where an acute event has already developed but the delivery of acute care is feasible without requiring an admission for overnight stays in hospital. Patients suffering from those conditions have traditionally been managed in an inpatient environment but many can now be managed without a hospital stay.

Providing effective ambulatory care for conditions such as cellulitis and DVT will allow for better patient care and case management, care delivered closer to home, and a reduction in avoidable emergency admissions which are costly and also expose patients to otherwise avoidable clinical risks such healthcare-acquired infections. These two conditions of cellulitis and DVT have been chosen because we know there is a large variation in admission rates, they are common conditions and they require a whole systems approach.

To better reflect the specific role of A&Es in improving patient care and reducing avoidable admissions to hospital, the preferred measure is the proportion of patients

attending A&E for cellulitis and DVT who are then admitted. However, to recognise that not all A&E sites are able to fully clinically code attendances for these two specific conditions, a broader measure of admission rates per weighted head of registered population has been included. This also supports whole system planning and encourages patient focus.

SHA Envelopes:

PLANNING REQUIREMENTS

Are Plans Required?:

No

Planning Frequency:

Criteria for Plan Sign-off:

FURTHER INFORMATION

Further Information:

Further information on the definitions, management and publication of the A&E clinical quality indicators is published on the Department of Health website.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122868

Guidelines, specific safety issues that local implementation teams should take into consideration (including possible differential diagnoses), and further detailed information on providing ambulatory care for emergency conditions is available in the Directory of Ambulatory Emergency Care for Adults
https://www.institute.nhs.uk/index.php?option=com_content&task=view&id=1530&Itemid=4009

Specific guidelines on the management of cellulitis in adults are available at:
www.gain-ni.org/Guidelines/Management_Cellulitis_Adults.asp

Procedures for the outpatient management of patients with deep venous thrombosis are available at:
www.bcshguidelines.com/pdf/dvt_220506.pdf

Changes from 2010/11 Planning Round:

This is a new indicator.

SQU04_02: A&E Clinical Quality- Consultant Sign-off

DEFINITIONS
Detailed Descriptor:

The percentage of patients presenting at type 1 and 2 (major) A&E sites in certain high-risk patient groups (adults with non-traumatic chest pain, febrile children less than 1 year old and patients making an unscheduled return visit with the same condition within 72 hours of discharge) who are reviewed by an emergency medicine consultant before being discharged.

Lines within Indicator (Units):

Numerator : Number of audited attendances for high-risk patient groups who were reviewed by a consultant in Emergency Medicine before being discharged from A&E

Denominator : Number of audited attendances for high-risk patient groups which concluded in discharge from A&E

Data Definition:

The following high-risk patient groups should be reviewed by a consultant in Emergency Medicine prior to discharge from A&E:
- Adults (over 17 years of age) with non-traumatic chest pain;
- Febrile children less than 1 year old; and
- Patients making an unscheduled return to A&E with the same condition within 72 hours of discharge from A&E.

Junior doctors should have formulated a clear diagnosis or differential diagnosis and documented their proposed care plan prior to seeking consultant sign-off. The consultant's review should normally include the patient being seen and reviewed in person by the consultant. If the consultant is unable to make a contemporaneous note in the patient's record, they should countersign the notes at the next earliest opportunity, making a record of the date and time that this occurs.

Expert clinical opinion suggests that all patients with these high risk conditions should be reviewed by a consultant. If, due to insufficient availability of consultant staff, an emergency medicine consultant is not immediately available on the "shop floor", review may be carried out by a senior trainee in emergency medicine (ST4 or above), or by a staff grade or similar substantive career grade doctor with sufficient experience to be designated to undertake this role by the emergency medicine consultant medical staff, though this should only be done in exceptional circumstances.

Further notes
If only a sample of attendances of high-risk patient groups have been audited over the audit period, the A&E site should separately report the total number of attendances for patients in the high-risk groups (i.e. including those attendances for high-risk patients which were not audited), with some explanation of why these cases were not audited and any further relevant information (for example, significant

demographic or clinical differences in the patients who were and were not audited).

These patient groups have been selected on the basis that they are important presentations with a risk of life-threatening disease that may not be immediately appreciated by less experienced clinical staff. There are many other presentations that carry a high risk, e.g., headache and abdominal pain, and should be included as the next steps. Individual sites will want to ensure that all high risk presentation groups are monitored so that all patients are given appropriate, safe care.

Emergency patients may be referred to admitting speciality teams. It is not intended that A&E consultant staff should review the patients of other teams prior to discharge, however, to take account of the patient's perspective and the clinical risk associated with these conditions, it is recommended that this same standard be applied to patients referred to speciality teams, for example those patients admitted directly to acute medicine or paediatrics from primary care, with consultant review by the inpatient specialist occurring prior to discharge.

Basis for Accountability:

Provider basis: Type 1 and 2 A&E sites

Initially this indicator will only apply to Type 1 and 2 A&E sites, but through further developments of this indicator it is expected that high-risk conditions should receive appropriate senior clinician review regardless of where they present.

Data should be presented in a way that is most meaningful for the patient and which facilitates targeted local interventions to improve the quality of A&E services. Data should therefore be reported for providers at the level of five character provider codes (i.e. organisation code + site code), rather than three character provider codes (i.e. trust level). To appropriately reflect the patient's journey and modern co-located models that provide urgent and primary care facilities on the same site, where there is more than one type of A&E on the same campus, data should be reported for the whole campus, not for separate facilities, even if the service is provided by different organisations.

MONITORING
Monitoring Frequency:

Six Monthly – October and March of each year

Monitoring Data Source:

College of Emergency Medicine (CEM) audit data

ACCOUNTABILITY
What success looks like, Direction, Milestones:

Management of the indicator
Providers should aim for continuous improvement on this indicator.

Key messages
- The more high risk patients seen by a senior clinician the safer and more effective the care. This will depend on appropriate staffing levels and usage of those staff but must be balanced against other patients who also benefit from senior care.
- All patients in these high risk groups being seen by a consultant would currently be good practice, but sites not able to reach this should aim for continuous improvement.

Timeframe/Baseline:

Timeframe Until:

Ongoing

Rationale:

The aim of this indicator is to improve clinical processes and outcomes and reduce the risk patients are exposed to.

Research indicates that the care delivered by senior staff has better clinical outcomes and experience than that by more junior staff working alone. Patients in high risk groups can be managed more safely and effectively by reviewing their condition with a consultant, with an improvement in the delivery of care via more rapid identification of clinical risk and more decisive treatment.

SHA Envelopes:

PLANNING REQUIREMENTS

Are Plans Required?:

No

Planning Frequency:

Criteria for Plan Sign-off:

FURTHER INFORMATION

Further Information:

Further information on the definitions, management and publication of the A&E clinical quality indicators is published on the Department of Health website.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122868

Changes from 2010/11 Planning Round:

This is a new indicator.

SQU04_03: A&E Clinical Quality – Service Experience

DEFINITIONS
Detailed Descriptor:
Narrative description of what has been done to assess the experience of patients using A&E services and their carers, what the results were, and what has been done to improve services in light of the results
Lines within Indicator (Units):
Not applicable
Data Definition:
There is no one definitive data source or method for understanding the experience of patients and their carers., Sites have therefore been given the flexibility to develop and commission the methods they feel are most appropriate for understanding and assessing the experience of their patients. However this indicator should include a qualitative understanding and description of patient experience, and should <u>not</u> be restricted to reporting quantitative measures of patient satisfaction from questionnaires. Providers are expected to provide a narrative which sets out: (5) What work they have undertaken to understand and assess the experience of a wide and representative range of patients, carers and staff, reflecting the 24 hour nature of the service, over the whole of the previous quarter (6) What the results of these assessments were (7) What has been done to improve services in light of these results (8) What the outcome has been in terms of improved patient experience It is important that all four components of the narrative are completed. For example, it is not enough to note that patients have been asked "If you needed attention, were you able to get a member of staff to help you?" or that patient discovery interviews have been conducted (Component 1); or to report the percentage of patients reporting dissatisfaction on this measure, or anonymised narrative information summarising the interviews (Component 2); providers should also say what they have done to improve services (Component 3 – e.g. having a named nurse for each trolley patient, placing call bells in each trolley area), and what the outcome was in terms of patients reporting an improvement on this particular aspect of their care (Component 4)
Basis for Accountability:
Provider-basis, all A&E sites Data should be presented in a way that is most meaningful for the patient and which facilitates targeted local interventions to improve the quality of A&E services. Data

should therefore be reported for providers at the level of five character provider codes (i.e. organisation code + site code), rather than three character provider codes (i.e. trust level). To appropriately reflect the patient's journey and modern co-located models that provide urgent and primary care facilities on the same site, where there is more than one type of A&E on the same campus, data should be reported for the whole campus, not for separate facilities, even if the service is provided by different organisations.

MONITORING

Monitoring Frequency:

Quarterly – April, July, October, January of each year

Monitoring Data Source:

See Data definition section above

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Management of the indicator
Providers should aim for continuous improvement on this indicator.

What good looks like
A good service will respond to the needs of the user as an individual. It will search out and listen to feedback, it will encourage users to suggest improvements and it will discuss this feedback across the whole health economy and will act upon it promptly to deliver measurable improvements.

Because this indicator is reported as narrative, it cannot be benchmarked but there will undoubtedly be learning applicable to many departments.

Key messages
- Quarterly feedback from patients, carers and staff relating to experience is important for improving the service and we need to show how commissioners and service providers have considered and acted upon it.
- Information on the experience of a wide range of patients, carers and staff, reflecting the 24 hour nature of the service, over the whole of the previous quarter, must be collected, analysed and acted upon by providers and commissioners.

Timeframe/Baseline:

Timeframe Until:

Ongoing

Rationale:

The aim of this indicator is to improve the experience of patients who use A&E services, and their carers.

Service experience is a marker of the quality of care received in the A&E department, and can be influenced by service user expectations, the approach of staff, the information and clinical care staff provide, and the delays in receiving the timely care patients need. The three most frequently identified service factors are: interpersonal skills/staff attitudes; provision of information/explanation; and perceived waiting times . Listening to and addressing the views of patients, their carers and staff can guide providers in raising the quality of the services they provide to patients.

More timely and frequent service experience information is required specifically for A&E departments to drive this improvement in services. The focus of this indicator should not be restricted to simply recording and reporting quantitative levels of service satisfaction (e.g. the percentage of patients/carers who reported that they received a good service in A&E); a good A&E department will obtain a deep understanding of what patients think of the service that has been provided and how they believe it can be improved, and will act upon this feedback to improve their service.

SHA Envelopes:

PLANNING REQUIREMENTS

Are Plans Required?:

No

Planning Frequency:

Criteria for Plan Sign-off:

FURTHER INFORMATION

Further Information:

Further information on the definitions, management and publication of the A&E clinical quality indicators is published on the Department of Health website.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122868

Changes from 2010/11 Planning Round:

This is a new indicator.

SQU05 (and HQU14-15): Cancer Waits (all 9 measures)

DEFINITIONS
Detailed Descriptor:

Cancer 31 day waits-

Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat') (Part A)

Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is a Surgery (Part B), an Anti-Cancer Drug Regimen (Part C) or a Radiotherapy Treatment Course (Part D).

Lines within Indicator (Units):

Part A: Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat')

Denominator: Total number of patients receiving first definitive treatment for cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

Numerator: Number of patients receiving first definitive treatment for cancer within 31 days of receiving a diagnosis (decision to treat) within a given period for all cancers (ICD-10 C00 to C97 and D05)

Part B: 31-Day Standard for Subsequent Cancer Treatments-Surgery

Denominator: Total number of patients receiving subsequent surgery within a given period, including patients with recurrent cancer.

Numerator: Number of patients receiving subsequent surgery within a maximum waiting time of 31-days during a given period, including patients with recurrent cancer.

Scope: Those treatments classified as "Surgery" within DSCN 20/2008

Part C: 31-Day Standard for Subsequent Cancer Treatments-Anti Cancer Drug Regimens

Denominator: Total number of patients receiving a subsequent/adjuvant anti-cancer drug regimen within a given period, including patients with recurrent cancer.

Numerator: Number of patients receiving a subsequent/adjuvant anti-cancer drug regimen within a maximum waiting time of 31-days during a given period, including patients with recurrent cancer.

Scope: Using the definitions published in DSCN 20/2008 "Anti Cancer Drug Regimens" might include: Cytotoxic Chemotherapy, Immunotherapy, Hormone Therapy and other and unspecified

drug treatments.

Part D: 31-Day Standard for Subsequent Cancer Treatments-Radiotherapy

Denominator: Total number of patients receiving subsequent/adjuvant radiotherapy treatment within a given period, including patients with recurrent cancer.

Numerator: Number of patients receiving subsequent/adjuvant radiotherapy treatment within a maximum waiting time of 31-days during a given period, including patients with recurrent cancer.

Scope: Using the definitions published in DSCN 20/2008 "Radiotherapy Treatments" might include: Teletherapy (beam radiation), Brachytherapy, Chemoradiotherapy and Proton Therapy.

Data Definition:

Numerator and Denominator details are defined above.

All data are to be returned to the Cancer Waiting Times Database (CWT-Db) as per the definitions and mandates specified to the NHS in Dataset Set Change Notice (DSCN) 20/2008. A copy of this DSCN can be accessed at: http://www.isb.nhs.uk/documents/dscn/dscn2008/dataset/202008.pdf

Basis for Accountability:

Provider (NHS Trusts, NHS Foundation Trusts and PCT Providers) and Commissioner

MONITORING

Monitoring Frequency:

Monthly and Quarterly

Monitoring Data Source:

Data are sourced from the CWT-Db on a monthly and quarterly basis.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Parts A, B, C & D

Performance is to be sustained at or above the published operational standard

Details of current operational standards are available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleague

letters/DH_103436

Timeframe/Baseline:
Not applicable

Timeframe Until:
Not applicable

Rationale:
Maintaining these standards will ensure that cancer patients receive all treatments within their package of care within clinically appropriate timeframes, thus providing a better patient experience, with a service focussed on a patients wishes, whilst improving survival and mortality rates.

SHA Envelopes:
No

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
The All Cancer One-Month Standard was introduced by the NHS Cancer Plan (2000), a copy of which is available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009609

The 31-day subsequent treatment standards (Surgery, Anti-Cancer Drug Regimen and Radiotherapy) were introduced, with different operational timings, by the Cancer Reform Strategy (2007), a copy of which is available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081006

Improving Outcomes: a Strategy for Cancer along with the recent Review of Waiting Times Standards is available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123371 |

Full guidance on the monitoring of these services and supporting information on the scope and patient pathways are available at:
http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation

Help and further support for monitoring these standards is available via e-mail at:
cancer-waits@dh.gsi.gov.uk

Changes from 2010/11 Planning Round:

Part A: No changes to indicator construction
Parts B, C and D: The indicators for 2011/12 show a renumbering and reorganisation to present VSA11A, VSA11B and VSA12 as parts of the same basic standard, though they are still reported as individual lines to reflect the different characteristics of the services.

SQU06: Stroke Indicator

DEFINITIONS
Detailed Descriptor:

Quality stroke care-

People who have had a stroke who spend at least 90% of their time in hospital on a stroke unit (Part 1) and people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours (Part 2).

Lines within Indicator (Units):

Numerator 1: number of people who have had a stroke and spend at least 90% of their time on a stroke unit

Denominator 1: number of people who have a stroke who are admitted to hospital

Numerator 2: number of people referred with a suspected TIA, who are at high risk of stroke, who are assessed and treated within 24 hours

Denominator 2: number of people who are referred with a suspected TIA who are at high risk of stroke.

Data Definition:

Part 1

Stroke unit definition:

The National Sentinel Stroke Audit defines a stroke unit as a discrete ward designated for stroke patients, staffed by a multi-disciplinary team including specialist nursing staff. There are different models of care in-patient care including:

- *Acute stroke units* that accept patients acutely but discharge early (usually within 7 days but in many instances, fewer). This should include an "intensive" model of care, sometimes referred to as a "hyper-acute unit", with continuous monitoring and high levels of nurse staffing.
- *Rehabilitation stroke units* that accept patients after the hyper-acute phase of their stroke and focus on rehabilitation.
- *Combined stroke units* (ie no separation between acute and rehabilitation beds) that accept patients acutely and also provide rehabilitation.

In addition to a multi-disciplinary team including specialist nursing staff based in a discrete ward which has been designated for stroke patients (see above), a stroke unit should have the key characteristics of a good stroke unit as defined by the National Sentinel Stroke Audit which include:

•Consultant physician with responsibility for stroke

- Formal links with patient and carer organisations
- Multidisciplinary meetings at least weekly to plan patient care
- Provision of information to patients about stroke
- Continuing education programmes for staff.

Numerator 1: People who have had a stroke who spend at least 90% of their time in hospital on a stroke unit

Patients with ICD10 codes I61, I63, and I64 (including the various sub-sets of coding for each of these main codes) should be reported against this line.

If a patient has two episodes on a stroke unit each one should be counted separately.

If a patient has two distinct hospital spells on a stroke unit, within the same reporting period, they should be counted twice.

For the definition of a stroke unit, see above.

Denominator 1: people who have had a stroke who are admitted to hospital

Patients with ICD10 codes I61, I63, and I64 (including the various sub-sets of coding for each of these main codes) should be reported against this line.

If a patient has two episodes on a stroke unit each one should be counted separately.

If a patient has two distinct hospital spells on a stroke unit, within the same reporting period, they should be counted twice.

Part 2

Numerator 2: Transient Ischaemic Attack (TIA) cases with a higher risk of stroke who are assessed and treated within 24 hours. Detailed definition:

High risk TIA patients are defined as those with an ABCD2 score of 4 or above.

The ABCD2 score is calculated using the patient's age (A); blood pressure (B); clinical features (C); duration of TIA symptoms (D); and presence of diabetes (2).

Scores are between 0 and 7 points.
- **A**ge (≥60 years, 1 point);
- **B**lood pressure at presentation (≥140/90 mm Hg, 1 point);
- **C**linical features (unilateral weakness, 2 points; speech disturbance without weakness, 1 point);
- **D**uration of TIA symptoms (≥60 minutes, 2 points; 10-59 minutes, 1 point); and
- presence of diabetes (1 point).

Whilst selected patients with high risk TIA - particularly those with 'crescendo' TIAs[1] - will continue to need admission, the majority should not be admitted solely to expedite investigations. The challenge is to enable such investigations to be performed and acted upon in a timely fashion on an out-patient basis.

Patients with higher risk TIA should be counted only if they attended an out-patient appointment at a TIA or neurovascular clinic, or an urgent appointment, on an out-patient basis, at an alternative relevant clinic (eg neurology clinic or by attending a stroke unit directly.) In this context, patients who are admitted to hospital are not counted. A more detailed explanation about this appears in the full VSMR Guidance available on the Unify2 web-site.

Patients with the following ICD10 codes should be reported against this line.
G450 Vertebro-basilar artery syndrome
G451 Carotid artery syndrome (hemispheric)
G452 Multiple and bilateral precerebral artery syndromes
G453 Amaurosis fugax
G458 Other transient cerebral ischaemic attacks and related synd
G459 Transient cerebral ischaemic attack, unspecified

Denominator 2: number of people who are referred with a suspected TIA who are at high risk of stroke.

If a patient has two episodes of TIA, in the period, they should be counted twice.
The same ICD10 codes apply as above.
The following **investigations** for high risk TIA cases should be completed within the 24-hour time window:
- Blood tests (all patients).
- Electrocardiogram (ECG: all patients).
- Brain scan (if vascular territory or pathology uncertain. Diffusion-weighted MRI is preferred, except where contraindicated, when CT should be used).
- Completion of carotid imaging (where indicated), and referral for carotid surgical intervention (where indicated).

The following **treatments** should be commenced for high risk TIA cases within the 24-hour time window:
- Aspirin (where needed or alternative if contraindicated).
- Statin (where needed or alternative if contraindicated).
- Control of blood pressure (where needed unless contraindicated).

Best Practice Tariff (BPT) from April 2011

DH is introducing from April 2011, a mandatory BPT for non-admitted services for suspected TIA. The BPT rewards providers already meeting minimum best practice whilst acting as an incentive for provision of best practice where it does not currently exist. The guidance on the BPT is consistent with this guidance.

NICE Quality Standard

---

[1] As defined in the current NICE Clinical Guideline.

The NICE Quality Standard, launched in July 2010[2], gives a specific, concise statement that acts as a marker of high-quality, clinical and cost-effective patient care. The 11 quality statements in the Standard are consistent both with the Stroke Strategy and with this guidance.

More detailed definitions of what should be counted under the planning round can be found under the VSMR guidance for Stroke & TIA and the associated Frequently Asked Questions on the Unify2 web-site.

Basis for Accountability:

Commissioners (Data are based on PCT of residence)

MONITORING

Monitoring Frequency:

Quarterly throughout 2011/12

Monitoring Data Source:

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Stroke patient outcomes will improve. Significant numbers of TIA patients will not have a stroke. Care in high quality stroke units reduces mortality by 14% and death or institutionalisation by 18% (Stroke Unit Trialist Collaboration 1997: randomised trials of original in-patient stroke care. If all patients with stroke are admitted directly to a stroke unit either via A&E, via brain imaging or directly via ambulance) fewer people will die and fewer people will require institutional care as a result of stroke related disabilities.

Rapid scanning and treatment of people at high risk of stroke who experience a transient ischaemic attack (TIA) reduces their risk of going on to have a full stroke by up to 80%.

Timeframe/Baseline:

All PCT plans for 2010/11 showed that they would achieve the 80% threshold for stroke (Part 1) and the 60% for TIA (Part 2) by March 2011; this level of performance should be maintained in each quarter of 2011/12 and where possible e.g. through service redesign, improved on.

---

[2] The NICE quality standards are available here:
http://www.nice.org.uk/aboutnice/qualitystandards/qualitystandards.jsp

Timeframe Until:
Where PCTs have been unsuccessful in achieving the 2010/11 threshold they should achieve it by Quarter 1 of 2011/12 and the level should be maintained, or exceeded, continuously.
Rationale:
There are approximately 110,000 strokes per year in England, around a third of whom die. Stroke is the largest single cause of adult disability and there are around 300,000 people in England living with moderate to severe disabilities as a result of stroke. Good care on a dedicated stroke unit is the single most effective way to improve outcomes for people with stroke. Good care is described in the NICE Stroke Quality Standard and the National Clinical Guidelines for stroke prepared by the Intercollegiate Stroke Working Party 2008. Early initiation of treatment for Transient Ischaemic Attacks (TIAs) or minor strokes can reduce the number of people who go on to have a major stroke by 80%. People who are at high risk of stroke are defined as those with an ABCD2 score of 4 or above.
SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
Yes
Planning Frequency:
Quarterly
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Ray Szynowski at the DH on ray.szynowski@dh.gsi.gov.uk
Changes from 2010/11 Planning Round:
None

SQU07: Community Services

Indicator to be developed in 2011/12.

SQU08: Carers Breaks

DEFINITIONS
Detailed Descriptor:
Agree and make available to local people policies, plans and budgets to support carers.
Lines within Indicator (Units):
Data Definition:
Basis for Accountability:
PCT

MONITORING
Monitoring Frequency:
Annual
Monitoring Data Source:
Through SHA planning checklist – SHAs will provide assurance to DH that the plans will be developed by PCTs/PCT clusters and made available to local people.

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Policy,plans and budgets for supporting carers agreed with councils and local carers' organisations
Timeframe/Baseline:
Timeframe Until:
March 2012
Rationale:
It has not always been apparent how funding to support carers has been used in each PCT. The Spending Review has made available additional funding in PCT baselines to support the provision of breaks for carers. PCTs should pool budgets with local authorities to provide carers' breaks, as far as possible, via direct

payments or personal health budgets. For 2011/12, PCTs should agree policies, plans and budgets to support carers with local authorities and local carers' organisations, and make them available to local people.

SHA Envelopes:

Not applicable

PLANNING REQUIREMENTS

Are Plans Required?:

Yes- by PCT

Planning Frequency:

Annual

Criteria for Plan Sign-off:

FURTHER INFORMATION

Further Information:

The Government's four priorities for supporting carers are set out in *Recognised, valued and supported: Next steps for the Carers Strategy*

http://www.dh.gov.uk/en/SocialCare/Carers/index.htm

Changes from 2010/11 Planning Round:

This is a new indicator

SQU09: Access to NHS Dentistry

DEFINITIONS
Detailed Descriptor:

PCTs need to ensure access to dental services for anyone who actively seeks it. SHAs have committed to this being delivered by March 2011.

Expressed or active demand is defined as all those who would, if services were available, use primary care dental services commissioned by the PCT.

PCTs estimated in the 2010 dental tool-kit exercise, the number of people who would access NHS dental services if there were no remaining supply issues. All PCTs worked with their SHAs on a refresh of the Vital Signs plan lines relating to Dental Services, and specifically their 2011 demand estimates. These estimates were informed by the first dental access results from the GP Patient Survey. Supply trajectories were produced for the period up to March 2013.

Progress to meeting dental demand will be measured in 2010/11 and in 2011/12 by comparing the number of patients accessing dental services in 24 months with PCTs supply trajectories. This will be the indicator during 2011/12. The new dental patient experience indicator from the GP Patient Survey will continue to be available and will help PCTs in monitoring the improvement in patient perceptions of NHS dental access in their areas.

Lines within Indicator (Units):

Number of patients receiving NHS primary dental services located within the PCT area within a 24 month period.

Data Definition:

This is a count of the number of distinct patient identities (ID) where their most recent course of treatment in the previous 24 months was provided through a contract in the PCT. Patients have been identified by using surname, first initial, gender and date of birth. No other identifiers have been used.

The count of patients includes activity from all types of contract and performer. Hence the figures include patients who have only received orthodontic treatment in the 24-month period, the patients who have been treated by Vocational Dental Practitioners (VDP) and it includes patients treated under any type of contract (GDS, PDS and salaried services).

In the 24 month counts children are defined as patients under 18 on the last day of the 24 month period.

Each unique patient ID is counted against the dentist contract against which the most recent claim was recorded in the 24 month period, with the following exceptions:

• If the most recent claim is for urgent treatment, orthodontic treatment, charge exempt treatment or treatment on referral the ID remains with the previous contract,

if there is one within the 24 month period.

• If the claim for the previous contract occurred before the 24 month period the ID is allocated to the most recent contract.

Although the count of patient IDs is a robust statistical indicator of the overall level of patient involvement with NHS primary dental care, there are circumstances where it will not strictly correspond to the number of different individual patients. It has been necessary to make a pragmatic compromise between undercounting patients with common identifiers and over-counting where there are slight differences in recorded details.

Scenarios which may give rise to deviations from a true count are as follows:

• patients who share the same surname, initial, sex and date of birth,

• patients whose surnames have changed within a 24 month period

• patients whose details have been misrecorded (particularly relevant to long or unusual surnames)

There will also be delays to the reporting of accurate counts where:

• the recording of incorrect patient IDs are spotted and corrected

• delays in the processing of treatment information (late submission , postal delays or long courses of treatment)

None of the above factors is likely to affect the overall count by more than one or two percent, but at a PCT level there may be local demographic factors which make the local total more susceptible - e.g. a high proportion of women of marriageable age, a large ethnic community, a transient patient base. Caution should be taken in drawing comparisons between different areas using patient count as a denominator for indicators.

Basis for Accountability:

Commissioner.

MONITORING

Monitoring Frequency:

Data will be available monthly, a month in arrears.

Monitoring Data Source:

NHS Information Centre for health and social care / Dental Services Division of NHS Business Services Authority 24 month 'patients seen' data. Quarterly data to December 2008 by PCT and SHA is available at :
http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry
(follow the link to specific data)

And information available on the Dental Services section of the NHS Business Services Authority website:
http://www.nhsbsa.nhs.uk/1143.aspx

ACCOUNTABILITY
What success looks like, Direction, Milestones:
This is designed to support performance management of progress on dental access during 10/11 and 11/12. We expect continued improvements in numbers of patients accessing NHS Dentistry, meeting the expected forecast demand in March 2011 and delivering PCTs dental supply plans.
Timeframe/Baseline:
Timeframe Until:
March 2012
Rationale:
 SQU09 measure is the measure for securing access to NHS dentistry for everyone who actively seeks it.
SHA Envelopes:
 SHAs will be held accountable for their PCTs delivery of forecast supply of dental services.

PLANNING REQUIREMENTS
Are Plans Required?:
 No – already collected
Planning Frequency:
 Monthly
Criteria for Plan Sign-off:
 SHAs have access to data (at SHA and PCT level) on: • Current access data (at IC website – see Data Source below) SHAs have agreed plans at PCT level which assess current dental access and levels of need and demand for dental services, identify the steps to address specific local issues and ensure year on year improvements in the numbers of patients accessing NHS dental services. At SHA level the combined PCT plans are expected to collectively achieve the SHA planning assumptions.

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
 None.

SQU10: Staff Engagement

DEFINITIONS
Detailed Descriptor:

NHS staff survey based measure of staff engagement-

The overall Staff Engagement score is calculated from responses to multiple questions in the annual NHS staff survey.

The score is an aggregate measure valued from 1 (low) to 5 (high)

The questions cover three components of engagement: involvement, staff advocacy and motivation. Each of these three components is also given a separate score to sit under the overall engagement score.

The results from the following questions in the survey are used in the calculation of the overall staff engagement score:

- Care of patients/ service users is my trusts top priority
- I would recommend my trust as a place to work
- If a friend or relative needed treatment I would be happy with the standard of care provided by this trust

(These questions are scored from 1-5 with the options Strongly disagree, disagree, Neither agree nor disagree, Agree, Strongly agree)

- I look forward to going to work
- I am enthusiastic about my job
- Time passes quickly when I am at work

(These questions are scored from 1-5 with the options Never, Rarely, Sometimes, Often, Always)

Lines within Indicator (Units):

Staff Engagement Absolute Score value 1-5, where 1 is low and 5 is high.

Data is provided at Trust level:

The results for each trust are calculated and benchmarked against national performance then included in the reports that CQC send to each trust detailing their survey results

Data provided at SHA level:

The scores can then be aggregated up to averages for each SHA and a split also provided to SHAs detailing high and low scores in their area.

Data Definition:
Staff Engagement score calculated from the following questions in the NHS staff survey: • Care of patients/ service users is my trusts top priority • I would recommend my trust as a place to work • If a friend or relative needed treatment I would be happy with the standard of care provided by this trust (These questions are scored from 1-5 with the options Strongly disagree, disagree, Neither agree nor disagree, Agree, Strongly agree) • I look forward to going to work • I am enthusiastic about my job • Time passes quickly when I am at work (These questions are scored from 1-5 with the options Never, Rarely, Sometimes, Often, Always)

Basis for Accountability:
Provider Trusts and PCTs independently. All trusts complete the NHS staff survey and are accountable for their own performance.

MONITORING
Monitoring Frequency:
Annually
Monitoring Data Source:
Care Quality Commission for 2010 survey, organisation to be confirmed for 2011 onwards.

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Staff engagement scores for all trusts should increase year on year, or be sustained for the top 10 per cent of trusts, with bigger increases seen among those scoring lowest previously. Nationally the average score for all trusts should increase year on year.

Timeframe/Baseline:
The baselines for each trust are provided by the 2009 NHS staff survey results.

Timeframe Until:
Ongoing.

Rationale:
Staff Engagement is a workforce indicator that is directly correlated with a wide range of key outcomes in NHS trusts. Patients respond to how their healthcare staff feel. The way that highly engaged staff act at work can influence patient choice, response to treatment and overall health. Patients receive better care when staff feel good about their work. Evidence tells us that highly engaged and empowered staff not only generate better outcomes for patients but there are also clear benefits in terms of clinical quality and additional business benefits, such as lower levels of sickness absence and higher levels of health and well-being among staff. Organisations with high levels of engagement are much more likely to be delivering better patient outcomes and managing their finances better, as measured by CQC. This means that improving levels of engagement can create an environment in which greater financial efficiency and savings can be achieved. ▪ Organisations that create and maintain cultures which demonstrably value their staff will be much more likely to successfully manage financial challenges and evolve into stronger organisations within the new healthcare system. ▪ Where patients are more satisfied they are more likely to have a shorter stay in hospital, freeing up resources. ▪ Where CQC ratings for quality of financial management are high, trusts are more efficient in using resources, meaning patients get better care for less spend. ▪ Where staff are absent from work less, trusts spend less on bank and agency staff and patients should feel a greater continuity of care, meaning they get better quicker. The evidence has also been presented to the francis enquiry on Mid Staffordshire with the conclusion that low levels of engagement can be an indicator that an organisation is at risk of major failings.

SHA Envelopes:
Not Applicable.

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
As an introduction to the concept of staff engagement, the Macleod review of staff engagement in the UK is available from www.bis.gov.uk/files/file52215.pdf This document provides very detailed background information on the benefits of staff engagement and case studies from numerous UK companies and public sector organisations on why engagement matters. Specific to the NHS Further information on how the staff engagement score is created can be found in the document "making sense of your staff survey data", which can be downloaded from www.cqc.org.uk/usingcareservices/healthcare/nhsstaffsurveys.cfm Guidance on developing local staff engagement policies and other useful information on staff engagement has been produced by DH and is available from www.dh.gov.uk/en/Managingyourorganisation/Workforce/NHSStaffExperience/index.htm This site also features regular insight notes detailing emerging evidence for Trust boards to consider. NHS employers also have a specific section on staff engagement on their website, containing briefing, guidance and case studies from within the NHS. www.nhsemployers.org/EmploymentPolicyAndPractice/staff-engagement/Pages/Staff-Engagement-And-Involvement.aspx
Changes from 2010/11 Planning Round:
This is a new indicator.

SQU11: PROMS Scores

DEFINITIONS

Detailed Descriptor:

Average (mean) case-mix adjusted change in health status (EQ-5D), pre- to pos-operatively.

Four indicators calculated and presented separately for NHS-funded elective hip replacements, knee replacements, groin hernia surgeries and varicose vein surgeries.

Lines within Indicator (Units):

Average (mean) case-mix adjusted change in health status as measured by a change in reported EQ-5D scores pre- to post-operatively.

Calculated and presented routinely by the NHS Information Centre using the formula $[(a)*(b)] - (c)$ where:
(a) is the mean ratio of actual to predicted patient level post-op PROMs scores (measured by the EQ-5D) for a given provider, averaged across provider's patients,
(b) is the national average (mean) post-operative PROMs score (EQ-5D),
(c) is the national average (mean) pre-operative PROMs score (EQ-5D).

Data Definition:

Further details of how the case-mix adjusted mean changes in health status are calculated can be seen at: www.chks.co.uk/index.php?id=24 and http://www.northgate-proms.co.uk/documents.html

Basis for Accountability:

Provider

(a similar indicator is also published by the NHS Information Centre and available for the Commissioner perspective)

MONITORING

Monitoring Frequency:

Monthly. [Note:frequency of publication may be subject to review as the published PROMs data are currently classified as "experimental statistics".]

Monitoring Data Source:

Patient Reported Outcome Measures (PROMs) monthly summary, available from HES Online:
http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=1295

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Success would be increasing mean case-mix adjusted change scores over time.
Timeframe/Baseline:
Ongoing. Baselines are provider specific although the national average provides a benchmark for comparison.
Timeframe Until:
Not applicable
Rationale:
The objective of NHS-funded services is to increase the health of recipients.
SHA Envelopes:
Not applicable

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Not applicable
Criteria for Plan Sign-off:
Not applicable

FURTHER INFORMATION
Further Information:
Further information on the PROMs programme can be found at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_092647
Changes from 2010/11 Planning Round:
This is a new indicator.

SQU12: Maternity 12 weeks

DEFINITIONS
Detailed Descriptor:
Early access for women to maternity services-

Increasing early access for women to maternity services – % of women in the relevant PCT population who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 weeks and 6 days of pregnancy.

Lines within Indicator (Units):

Formula: N = Numerator/Denominator x 100

Numerator: Number of women in the relevant PCT population who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 weeks and 6 days of pregnancy (VSMR Line 2001 within the quarter.)

Denominator: The number of women in the relevant PCT population who give birth to one or more live or still-born babies of at least 24 weeks gestation where the baby is delivered by either midwife or a doctor and the place of delivery is either at home or in an NHS hospital (including GP units). Exclude all maternities that occur in either psychiatric or private beds/hospitals. (VSMR Line 7101.)

Note: more than 100% may potentially be achieved if women who are assessed go on to miscarry or terminate, causing them to be captured in the numerator but not the denominator

Calculation of the indicator

The data used as this denominator will relate to two quarters after the quarter of the numerator collection to ensure that both numerator and denominator broadly relate to the same cohort of women. For example, if the quarter of collection is Q3, then assessments in that quarter (the numerator) will be subsequently compared to births (the denominator) in Q1 of the following year.

This relationship between numerator and denominator is to be followed when completing the maternity reporting template on Unify. Q1 of the numerator will be assessed against future Q3 of the denominator; and Q2 nominator versus Q4 denominator and so on.

Data Definition:

The percentage of women in the relevant PCT population who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 weeks and 6 days of pregnancy.

Pregnancy – Pregnancy is defined as all maternities regardless of outcome, excluding those where care is provided outside an NHS setting.
In the relevant PCT population - This refers to the PCT of the GP the woman is registered with. Where a woman is not registered with a GP, the woman's postcode of residence should be used.
Seen – This means completion of a full needs, risk and choices assessment, this may occur over multiple sessions but will be measured by the completion of the final session and the record being included in the maternity notes as part of the individual plan of care.
Midwife – To qualify as a midwife in this definition the person must hold current registration with the nursing and midwifery council and being in active employment as a midwife with the NHS.
Maternity healthcare professional – This is a description which covers obstetricians and general practitioners with current registration with the General Medical Council and working for the NHS providing maternity services.
12 weeks and 6 days – this relates to the measured gestation of the pregnancy and is the cut-off point for measurement against the indicator. The most valid approach is to use gestational age as calculated by ultrasound assessment, but it is recognised that the ultrasound calculation of gestation is not always available at the time of assessment of needs, risk and choices. The gestational age at completion of assessment may therefore be estimated from the date of completed assessment and the Estimated Date of Delivery (from clinical estimation/LMP or scan).
Health and Social Care assessment of needs, risks and choices is defined as an antenatal care "booking visit" where the hand held-maternity notes/record and plan of care is completed. This must include:
Information provided on the choice of type of antenatal care and planning place of birth
Antenatal information, checks and tests described in the NICE antenatal care guidance of 2008 (updated June 2010) including:
- vitamin D supplements
- screening for risk factors of gestational diabetes
- maternal height and weight; body mass index calculated
- screening questions for depression and other mental disorders
- offer of screening for anaemia
- offer of early ultrasound scan for gestational age assessment
Identifying women who may need additional care and support and plan pattern of care for the pregnancy.
Assessment of incidence of domestic abuse

Basis for Accountability:
Commissioner (PCT)

MONITORING
Monitoring Frequency:
Quarterly
Monitoring Data Source:
NHS PCT VSMR collections

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Consistently above 90% - individual services should identify their own threshold based on an audit to identify the percentage of women resident in their area at the beginning of pregnancy less those who enter the UK already pregnant
Timeframe/Baseline:
PCT NHS VSMR return Q4 2010
Timeframe Until:
End of planning round
Rationale:
Women who access maternity care late have poorer outcomes.   Ensures the best health outcomes for mother and baby: All women should access maternity care early for a full health and social care assessment of their needs, risks and choices by 12 completed weeks of pregnancy so that a women's plan of care can be tailored to address any identified needs and ensure women receive the right care at the right time and also help with identifying families who may need ongoing support with parenting so that support can be put in place at an early stage.   Addresses health inequalities: Reducing the percentage of women who access maternity care late through targeted outreach work for vulnerable and socially excluded groups will provide a focus on reducing the health inequalities and improving outcomes for mothers and babies whilst also extending the range of choices available to women and their families.   Promotes choice and personalised care: Early access allows pregnant women and their families to discuss with the maternity team what services are available locally and the choices that are right for them from an early stage in their pregnancy.
SHA Envelopes:
N/A

PLANNING REQUIREMENTS
Are Plans Required?:
Yes

Planning Frequency:
Quarterly

Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Consult NICE guidelines including: Antental Care: routine care for the healthy pregnant women – updated June 2010 the NICE *Antenatal care guideline* (updated) was published. Pregnancy and complex social factors – September 2010 - the guideline *Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors was published.* This describes how access to care can be improved, and contact with antenatal carers can be maintained, through additional support and consultations. The guidance sets out a model of service provision for pregnant women who misuse substances are recent migrants or are under age 20 or who experience domestic abuse.

Changes from 2010/11 Planning Round:
None

SQU13: Mental Health Measure- Early Intervention in Psychosis

DEFINITIONS

Detailed Descriptor:

The number of new cases of psychosis served by early intervention teams

Lines within Indicator (Units):

The number of new patients taken on by Early Intervention teams

Data Definition:

Cases of First Episode Psychosis which have been taken on by Early Intervention teams for treatment and support since 1 April 2011 to 31 March 2012. Include all new cases taken on the caseload of an EI team from 1 April to the end of the latest Quarter.

Patients who are being monitored for a limited period because they are suspected cases should not be included in this count.

Basis for Accountability:

PCT & MH Trust

MONITORING

Monitoring Frequency:

Quarterly

Monitoring Data Source:

UNIFY2

ACCOUNTABILITY

What success looks like, Direction, Milestones:

An early intervention service caseload builds up over a 3 year period. The expectation is that nationally there will be 7,500 new cases yearly and patients will stay engaged over three years. Success is that locally agreed plans are met yearly.

Timeframe/Baseline:

This is a national annual expectation

Timeframe Until:
Ongoing

Rationale:
Psychosis is a debilitating illness with far-reaching implications for the individual and his/her family. It can affect all aspects of life - education and employment, relationships and social functioning, physical and mental wellbeing. Without support and adequate care, psychosis can place a heavy burden on carers, family and society at large. Early treatment is crucial because the first few years of psychosis carry the highest risk of serious physical, social and legal harm.

SHA Envelopes:
SHA envelopes are contained in the Quarterly Reports in the Unify Report Library: http://nww.unify2.dh.nhs.uk/UNIFY/reporting/library.aspx

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, for non-FT MH Trusts
Planning Frequency:
Quarterly for 2011/12
Criteria for Plan Sign-off:
None

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
This is a new indicator

SQU14: Mental Health Measure- Crisis Resolution Home Treatment

DEFINITIONS
Detailed Descriptor:

The number of Home Treatment Episodes

Lines within Indicator (Units):

The number of Home Treatment episodes carried by Crisis Resolution/Home Treatment teams.

Data Definition:

Before an episode of home treatment commences, a patient will have been assessed by the team and a decision made that home treatment is appropriate. An episode of home treatment starts on the first day on which care is delivered to the patient at home or alternative community setting (home means the current place of residence which could include, for example, hostel accommodation) and ends with discharge from the CR/HT team's care. If an assessment is made at the patient's home and a decision made to provide home treatment, this may start during the same visit. However, it can only be judged to have started if *a firm decision to provide home treatment was made* at the time of assessment *and this is followed by treatment related action or discussion* during the same visit.

This measure is a count of the total number of treatment episodes and not the number of patients who received an episode of care during the year. This means that if a single patient received two or more separate episodes of care during the year each episode can be counted separately. However a separate episode is only counted if the patient has been discharged from the previous episode (noting that the discharge date is the formal end date for an episode). In addition, for two episodes involving the same patient to count as separate episodes, there must be a minimum interval of 14 days between the **last home visit** in the first episode and the **first home visit** in the second episode. Either an assessment visit or a treatment visit counts as a first home visit.

Basis for Accountability:

PCTs, MH Trusts and SHAs in the context of SHA envelopes.

MONITORING
Monitoring Frequency:

Quarterly

Monitoring Data Source:

NHS Information Centre Omnibus Survey

ACCOUNTABILITY
What success looks like, Direction, Milestones:
The returns for an individual PCT should show a progressive increase from Quarter to Quarter. 100,000 home treatment episodes yearly to people who would otherwise require hospital treatment
Timeframe/Baseline:
This is a national yearly target
Timeframe Until:
Ongoing
Rationale:
A crisis resolution home treatment team provides intensive support for people in mental health crises in their own home: they stay involved until the problem is resolved. It is designed to provide prompt and effective home treatment, including medication, in order to prevent hospital admissions and give support to informal carers.
SHA Envelopes:
SHA envelopes are contained in the Quarterly Reports in the Unify Report Library: http://nww.unify2.dh.nhs.uk/UNIFY/reporting/library.aspx

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Please see NHS Information Centre Omnibus Survey website for further information Community Activity Mental Health Collection 2010-2011 Specific Guidance
Changes from 2010/11 Planning Round:
This is a new indicator

SQU15: Mental Health Measure- Care Programme Approach (CPA)

DEFINITIONS
Detailed Descriptor:

Care Programme Approach (CPA) 7 day follow up-

The proportion of those patients on Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days

Lines within Indicator (Units):

The indicator is the numerator divided by the denominator, expressed as a percentage

Numerator : The number of people under adult mental illness specialties on CPA who were followed up (either by face to face contact or by phone discussion) within 7 days of discharge from psychiatric in-patient care.

Denominator : The total number of people under adult mental illness specialties on CPA who were discharged from psychiatric in-patient care. All patients discharged from a psychiatric in-patient wards are regarded as being on CPA.

Data Definition:

All patients discharge to their place of residence, care home, residential accommodation, or to non psychiatric care must be followed up within 7 days of discharge. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team.

Exemption: Patients who die within 7 days of discharge may be excluded.
Where legal precedence has forced the removal of a patient from the country.
Patients transferred to NHS psychiatric inpatient ward.
CAMHS (child and adolescent mental health services) are not included.

The 7 day period should be measured in days not hours and should start on the day after the discharge.

Basis for Accountability:

PCT & MH Trust

MONITORING
Monitoring Frequency:

Quarterly

Monitoring Data Source:
UNIFY2

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Achieving at least 95% rate of patients followed up after discharge each quarter
Timeframe/Baseline:
Ongoing
Timeframe Until:
Ongoing
Rationale:
Reduction in the overall rate of death by suicide will be supported by arrangement for securing provision by PCTs of appropriate care for all those with mental ill health. To reduce risk and social exclusion and improve care pathways to Patients on CPA discharged from a spell of in-patient care.
SHA Envelopes:
N/A

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
This is a new indicator

SQU16: Mental Health Measure- Improved access to psychological services

DEFINITIONS
Detailed Descriptor:

The primary purpose of this indicator is to measure improved access to psychological therapies (IAPT) for people with depression and/or anxiety disorders. This is done using two indicators :
1. The proportion of people that enter treatment against the level of need in the general population (the level of prevalence addressed or 'captured' by referral routes); and
2. The proportion of those referred that enter treatment (indicating the effectiveness and efficiency of services in processing referrals and forming a basis for addressing inequities in the system).

Lines within Indicator (Units):

Indicator 1: The proportion of people that enter treatment against the level of need in the general population ie the proportion of people who have depression and/or anxiety disorders who receive psychological therapies (SQU16_04)
Numerator: the number of people who receive psychological therapies (SQU16_01)
Denominator: the number of people who have depression and/or anxiety disorders (local estimate based on Psychiatric Morbidity Survey) (SQU16_02)

Indicator 2: The proportion of those referred that enter treatment ie the proportion of people who are referred for psychological therapies who receive psychological therapies (SQU16_05)
Numerator: the number of people who receive psychological therapies (SQU16_01)
Denominator: the number of people who are referred for psychological therapies (SQU16_03)

Data Definition:

Relevant IAPT data items and the permissible values for each data item are defined in the IAPT minimum data set (MDS)

Psychological therapy: NICE recommended treatment from a qualified psychological therapist (low or high intensity).

Definition of a 'case': a patient suffering from depression and/or anxiety disorders, as determined by scores on the Patient Health Questionnaire (PHQ9) for depression and/or the Patient Health Questionnaire (GAD7) for anxiety disorders, or other anxiety disorder specific measure as appropriate for the patient's diagnosis.

For the denominator of indicator 1, the expectation is NOT that PCTs carry out a survey of their own, but that they extrapolate local prevalence from the national Psychiatric Morbidity Survey as part of their needs assessment

Although data units are sourced from providers, completion and submission of data returns are the responsibility of the Commissioner.

Services referred to are those complying with IAPT programme quality standards, that includes the delivery of NICE compliant (stepped care) therapies, and routine patient reported outcome measures.

The reporting lines cited in this guidance can be compiled using data compliant with the IAPT minimum data set (MDS).

MONITORING

Monitoring Frequency:

Quarterly

Monitoring Data Source:

Information Centre, Omnibus returns

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Ongoing improvement is anticipated.

Progress will be measured by looking at the increase in the proportion of people with anxiety disorders and depression by demographic group, who access evidence-based psychological therapies. Services able to collect and report against the lines indicated will have baseline data to assist them in complying with their statutory duties for equalities monitoring (which should be undertaken in conjunction with Equality Impact Assessment(s)), which will enable them to target improvements in service provision to improve access.

Timeframe/Baseline:

Quarter 2 2010/11

Timeframe Until:

March 2012.

Rationale:

This indicator focuses on improved access to psychological therapies, in order to address the enduring unmet need. Around one in six adults in England suffer from a common mental health problem, such as depression or an anxiety disorder. Collecting this indicator will demonstrate the extent to which this need is being met.

SHA Envelopes:
Not applicable.

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, commissioner plans
Planning Frequency:
Quarterly for 2010/11
Criteria for Plan Sign-off:
• The proportion of people who have depression and/or anxiety disorders who receive psychological therapies in line with NICE guidelines in each quarter of 2011/12 should be higher than the proportion in previous quarter. • The proportion of people who are referred for psychological therapies who receive psychological therapies in line with NICE guidelines in each quarter of 2011/12 should be higher than the proportion in previous quarter. NB: Plans for Q1 2011/12 will need to show improvement over Q2 2010/11 as this is the latest data currently available.

FURTHER INFORMATION
Further Information:
The IAPT Data Handbook which explains the function of effective data collection and reporting in IAPT is available from http://www.iapt.nhs.uk/services/measuring-outcomes. Detailed guidance on use of the IAPT data set in compiling reports referred to here is contained in the appendices. The IAPT Equality Impact Assessment Guidance for Commissioners details an approach for applying primary data to measuring and reducing inequalities. It can be downloaded from http://www.iapt.nhs.uk/services/equalities/
Changes from 2010/11 Planning Round:
IAPT report lines are now focussed on improving equitable access for all sections of the community. Guidance for services in data collection and reporting has been much improved following publication of the IAPT Data Handbook (August 2010), and the IAPT Equality Impact Assessment Guidance for Commissioners (October 2010). In the previous planning round the first indicator (proportion of people who receive psychological therapies of those who have depression and/or anxiety disorders) used the number of people referred to IAPT services as the numerator.

157

SQU17: Low Value Procedures

DEFINITIONS
Detailed Descriptor:
Activity levels of identified low value procedures-   Number of identified low value procedures carried out
Lines within Indicator (Units):
Data Definition:
This indicator is currently under development
Basis for Accountability:

MONITORING
Monitoring Frequency:
Monthly
Monitoring Data Source:
HES

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Timeframe/Baseline:
Timeframe Until:
Rationale:
SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Not applicable
Criteria for Plan Sign-off:
Not applicable

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
This is a new indicator

SQU18: Smoking Quitters

DEFINITIONS
Detailed Descriptor:

Number of clients of NHS Stop Smoking Services who report that they are not smoking four weeks after setting a quit date.

Lines within Indicator (Units):

Line 1: Number of 4-week smoking quitters that have attended NHS Stop Smoking Services

Data Definition:

The definitions are in line with the Russell Clinical guidelines (Thorax 1997). For details, see "NHS Stop Smoking Services: service and monitoring guidance 2010/11" at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109696

Basis for Accountability:

Commissioner

MONITORING
Monitoring Frequency:

Quarterly

Monitoring Data Source:

The data are collected from / submitted by PCTs to the NHS Information Centre using a web-based tool – all are currently part of the mandatory data return and are reported quarterly.

The results are published by the IC in their "Statistics on NHS Stop Smoking Services" series at:
http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services

ACCOUNTABILITY
What success looks like, Direction, Milestones:

The number of 4 week smoking quitters should continue to increase over time.

In order to fully measure success of the 4 week smoking quitters indicator, organisations may wish to observe the following two markers of good practice in the delivery of smoking cessation:

Percentage of those clients setting a quit date who report that they are not smoking four weeks after that date.
Percentage of those clients reporting that they are not smoking four weeks after setting a quit date whose smoking status at four weeks is confirmed by the results from a carbon monoxide (CO) test.

These two markers plus the main 4 week smoking quitters indicators should continue to increase over time.
It is best practice for the percentage of clients reporting a quit date at 4 weeks to be not less than 25% (this is the natural quit rate at 4 weeks) and should range from 35-70%. Reports outside of this range should trigger an exception reporting procedure at SHA level.
A best practice aspiration for commissioners for monitoring CO validation testing should be to achieve 85%. These two sets of data are already collected as part of the NHS Information Centre return, so commissioners can observe them alongside the data collected on the number of 4 week smoking quitters.

Timeframe/Baseline:

2009/10

Timeframe Until:

Measured quarterly and annually until end of planning period.

Rationale:

These data provide important clinical indicators of the quality and efficacy of services provided to the population. The additional two markers of success are a best practice guide to help support a more clear observation of how the 4 week smoking quitters indicator is being delivered. Biochemical validation (co or cotinine) is important as it provides a more accurate outcome measure than self report, and this allows for modelling of the impact of service provision on local and national prevalence. Given the planned transition to prevalence, these data will act as translational to the new outcomes framework and will support commissioners to link quality and efficacy of services to both the quality, cost effective (QIPP) and prevalence reduction agendas.

SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:

Yes, commissioner plans

Planning Frequency:
Quarterly for 2011/12

Criteria for Plan Sign-off:
The number of four-week quitters in each quarter of 2011/12 should be higher than the number in the corresponding quarter of 2009/10. For example, Q1 2011/12 should be higher than Q1 2009/10.

FURTHER INFORMATION
Further Information:
NHS Stop Smoking Services: service and monitoring guidance 2010/11: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicy

Statistics on NHS Stop Smoking Services: http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services |
| **Changes from 2010/11 Planning Round:** |
| The indicator for 2011/12 has changed from number of quitters per 100,000 population to just the number of quitters to avoid problems caused by alternative population estimates and projections. In addition, we are recommending that commissioners will wish to observe two additional markers of success stated below, in order to observe performance in the round and to help graduate towards smoking prevalence in future years.

Percentage of those clients setting a quit date who report that they are not smoking four weeks after that date.
Percentage of those clients reporting that they are not smoking four weeks after setting a quit date whose smoking status at four weeks is confirmed by the results from a carbon monoxide (CO) test. |

SQU19: Breastfeeding at 6-8 Weeks

DEFINITIONS
Detailed Descriptor:

Prevalence of breastfeeding 6-8 weeks after birth.

Lines within Indicator (Units):

1. The number of infants due a 6–8 week check during the quarter.

2. The number of infants recorded as being totally breastfed at 6-8 week check during the quarter.

3. The number of infants recorded as being partially breastfed (receiving both breast milk and infant formula) at 6-8 week check during the quarter.

4. The number of infants being recorded as not at all breastfed at 6–8 week check during the quarter.

5. Prevalence is calculated as follows ((Line 2 + Line 3) / Line 1)) * 100%

6. Coverage is calculated as follows ((Line 2 + Line 3 + Line 4) / Line 1)) * 100%

Data Definition:

Infants due a 6–8 week check are defined as those registered with a GP that is managed by the PCT.
Totally breastfed is defined as infants who are exclusively receiving breast milk at 6-8 weeks of age - that is, they are NOT receiving formula milk, any other liquids or food.
Partially breastfed is defined as infants who are currently receiving breast milk at 6-8 weeks of age and who are also receiving formula milk or any other liquids or food.
Not at all breastfed is defined as infants who are not currently receiving any breast milk at 6-8 weeks of age.

Prevalence = Numerator/Denominator x 100%
Numerator is Line 2 + Line 3 = Number of infants recorded as being totally breastfed at 6-8 weeks + number of infants recorded as being partially breastfed
Denominator is Line 1 = Total number of infants due for 6-8 weeks check.
Details of how to calculate the number of infants due a check can be found on the DH webpage.
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Children/Maternity/Maternalandinfantnutrition/Breastfeedinginfantfeeding/DH_085657

Number of infants due a 6-8 week check

MUST BE LESS THAN

Maximum National Statistics (ONS) reported number of live births for the last 5 years +20.0%

And

MUST BE GREATER THAN

Minimum National Statistics (ONS) reported number of live births for the last 5 years - 10.0%

Basis for Accountability:

Commissioner

MONITORING
Monitoring Frequency:

Quarterly

Monitoring Data Source:

Primary Care Trust (PCT) Child Health Information records, which are reported to the Department of Health at quarterly intervals via Unify2

ACCOUNTABILITY
What success looks like, Direction, Milestones:

Good performance is typified by an increase in prevalence each quarter during the planning year when compared to the most recently reported figure for the same quarter. For example, planned prevalence in Q1 2011/12 must be greater than the actual figure for Q1 2010/11.

Good performance is also typified by achievement of the required data quality standard. Coverage of at least 95% is required for DH to publish and use the information, where coverage is defined as ((Line 2 + Line 3 + Line 4) / Line 1)) * 100%.

Timeframe/Baseline:

The Department of Health routinely publishes reports showing PCTs' performance for 6-8 week breastfeeding and these can be found at the following webpage

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_116060

The prevalence figures for Q1 2010/11, Q2 2010/11, Q3 2009/10 and Q4 2009/10 from these reports have been used as the baselines for quarters Q1 to Q4 2011/12 respectively.

Where a PCT's figure for one of these quarters did not pass the validation checks, the figure for the most recent quarter that passes validation has been used as the baseline instead. For example, if the figure for Q3 2009/10 did not pass validation, but the figure for Q2 2010/11 did, then the latter has been used as the baseline for Q3 2011/12.

Timeframe Until:

Not applicable

Rationale:

There is a clear case for investing in services to support breastfeeding as part of a local child health strategy. This is particularly important for mothers from low income groups, as it is known that they are less likely to breastfeed. Breastfeeding protects the health of babies and mothers, and reduces the risk of illness.

Breast milk is the best form of nutrition for infants, and exclusive breastfeeding is recommended for the first six months (26 weeks) of an infant's life. Thereafter, breastfeeding should continue for as long as the mother and baby wish, while gradually introducing the baby to a more varied diet.

In recent years, research has shown that infants who are not breastfed are more likely to have infections in the short-term such as gastroenteritis, respiratory and ear infections, and particularly infections requiring hospitalisation. In the longer term, evidence suggests that infants who are not breastfed are more likely to become obese in later childhood, which means they are more likely to develop type 2 diabetes, and tend to have slightly higher levels of blood pressure and blood cholesterol in adulthood. For mothers, breastfeeding is associated with a reduction in the risk of breast and ovarian cancers. A recent study also suggests a positive association between breastfeeding and parenting capability, particularly among single and low-income mothers.

The UK Infant Feeding Survey 2005 (Bolling et al. 2007) showed that 78% of women in England breastfed their babies after birth. However, a third of these women had stopped soon after so that only 50% of all new mothers were breastfeeding by week 6 and 26% by 6 months.

SHA Envelopes:

N/A

PLANNING REQUIREMENTS

Are Plans Required?:

Yes, commissioner plans

Planning Frequency:

Quarterly for 2011/12

Criteria for Plan Sign-off:

- 95% coverage across all four quarters

- Planned 6 to 8 week prevalence must show a year on year increase as follows

  Q1 2011/12 plan > Q1 2010/11 actual
  Q2 2011/12 plan > Q2 2010/11 actual
  Q3 2011/12 plan > Q3 2009/10 actual
  Q4 2011/13 plan > Q4 2009/10 actual

  Where a PCT's figure for one of these quarters did not pass the validation checks, the figure for the most recent quarter that passes validation has been used as the baseline instead. For example, if the figure for Q3 2009/10 did not pass validation, but the figure for Q2 2010/11 did, then the latter has been used as the baseline for Q3 2011/12.

FURTHER INFORMATION
Further Information:

DH quarterly reports including validation criteria and guidance can be found at the following webpages:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_116060
&
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/Children/Maternity/Maternalandinfantnutrition/Breastfeedinginfantfeeding/DH_085657

Changes from 2010/11 Planning Round:

None

SQU20: Breast Screening

DEFINITIONS

Detailed Descriptor:

Extension of NHS breast screening programme to women aged 47-49 and 71-73-

Percentage of women aged 47-49 and 71-73 invited for breast screening

Lines within Indicator (Units):

Numerator: The number of women aged 47-49 and 71-73 invited for breast screening (this should be cumulative over the year).

Denominator: A third of the number of women aged 47-49 and 71-73 in the PCT population. [1]

[1] Standard population data will be used to populate these lines within Unify. DH will use 2006 based ONS projections for 2010/11

Data Definition:

Patient scope: Include all eligible women aged 47-49 and 71-73

Basis for Accountability:

Commissioner

MONITORING

Monitoring Frequency:

Quarterly

Monitoring Data Source:

NHS Cancer Screening Programmes from NHAIS System

ACCOUNTABILITY

What success looks like, Direction, Milestones:

All 81 local breast screening programmes are inviting women aged 47-49 or 71-73 a part of the randomisation project, whilst maintaining current standards and fully converting to direct digital mammography

Timeframe/Baseline:

As per NHS Operating Framework 2010/11, all local screening units should be inviting either women aged 47-49 or 71-73 depending on the randomisation project protocol

Timeframe Until:
Randomisation project to run to 2015/16 (ie two screening rounds), after which the programme will routinely invite women aged 47 to 73

Rationale:
In February 2006, a report from the Advisory Committee on Breast Cancer Screening (Screening for Breast Cancer in England: Past and Future, NHSBSP Publication No 61) estimated that the breast screening programme in England is saving 1,400 lives per year.

The International Agency for Research on Cancer (IARC) of the World Health Organisation (WHO) evaluated the evidence on breast cancer screening in March 2002. IARC concluded that trials have provided sufficient evidence for the efficacy of mammography screening of women between 50 and 70 years, and that the reduction in mortality from breast cancer among women who choose to participate in screening programmes was estimated to be about 35%.

At present, women are invited for screening seven times at three yearly intervals between 50 and 70 years. In 2007/2008, over 1.7 million women were screened for breast cancer in England, and over 14,000 cancers were detected.

The Cancer Reform Strategy (CRS - December 2007) stated the programme will be extended to nine screening rounds between 47 and 73 years with a guarantee that women will have their first invitation for screening before the age of 50 (previously some women waited until nearly their 53rd birthday before they received their first invitation). There is also increasing evidence of the clinical and cost-effectiveness of screening women up to age 73.

The CRS stated that the extension of the breast screening programme would be managed by NHS Cancer Screening Programmes in partnership with local health services.

The necessary phasing in of this expansion has been carefully considered to ensure that the most useful epidemiological data can be gathered to inform future decisions about the programme. Five local screening programmes piloted a randomisation project, with batches randomised into screening either 47-49 or 71-73 year-old women. Researchers at the University of Oxford produced a proposal to randomise the extension, with the extension beginning with half the 47-49 year-old women and half the 71-73 year-old women. This will give directly comparable mortality data on the effectiveness of screening to address concerns in the literature from a minority of experts that breast screening does not work, and would be internationally important. Ethical approval was granted for a pilot in spring 2009, and based on the success of the pilot sites full ethics approval was granted in early 2010.

Advice to the NHS issued in January 2009 (Gateway ref: 11119) stated: "As capacity does not allow for full immediate roll out of 9 rounds [of screening] across the whole of England, the age extension will need to be phased-in, firstly with 8 screening invitation rounds being offered, then with full implementation of the 9 invitation rounds."

Until local ethical approval is received, the default is that local programmes begin the extension by inviting women aged 47-49 as women aged over 70 can already self-refer for screening. Programmes have been and will continue to be immediately

transferred on to the randomisation project once local ethical approval is granted.

Some local programmes will not be able to enter the randomise for technical reasons, and these programmes should begin the age extension by inviting women aged 47-49.

All local screening programmes were expected to begin one extra three year screening round (the 8th) in 2010-11. Commissioners whose local programmes did not start the extension should ensure they do so as soon as possible.

On the advice of the Advisory Committee on Breast Cancer Screening, the randomisation project will now run for two three-year screening rounds in order to increase the power of the results.

As per the guidance issued in January 2009, funding from NHS Cancer Screening Programmes will only be released if three other NHS Breast Screening Programme standards are being met. These are:

- screen to assessment of 3 weeks
- film readers reading a minimum of 5,000 mammograms every year
- technical call/recall rates of no more than 3%

Good progress has been made on achieving the 36 month round length standard for the existing 50-70 age range, apart from in a few notable areas where recovery plans are in place. The 36 month round length should be sustained throughout the roll-out period of the age extension and thereafter.

In addition, the Cancer Reform Strategy stated that all local screening programmes should have at least one full-field direct digital mammography (DDM) machine in place by 2010. This is particularly important as DDM is more effective than analogue mammography in pre-menopausal women (i.e. for age extension purposes those aged 47-49) as their breasts are denser. National framework agreements for DDM x-ray equipment and trailers have been put in place through the NHS Supply Chain - the best prices have been negotiated nationally. Good progress has been made in DDM, and commissioners should be looking to full conversion where this has not already taken place.

SHA Envelopes:

No

PLANNING REQUIREMENTS

Are Plans Required?:

No

Planning Frequency:

Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
NHS Cancer Screening Programmes: 0114 2711060 www.cancerscreening.nhs.co.uk
Changes from 2010/11 Planning Round:
Randomisation project will now run for two three yearly screening rounds rather than one

SQU21: Bowel screening

DEFINITIONS
Detailed Descriptor:
Extension of NHS bowel cancer screening programme to men and women aged 70 up to 75th birthday (75)- Percentage of adult population aged 70-75 invited for bowel cancer screening

Lines within Indicator (Units):	
Numerator:	The number of men and women aged 70-75 invited for bowel cancer screening (this should be cumulative over the year).
Denominator:	The number of men and women aged 70-75 in the PCT population.

Data Definition:	
Patient scope:	Include all eligible men and women aged 70 to 75.

Basis for Accountability:
Commissioner

MONITORING
Monitoring Frequency:
Quarterly

Monitoring Data Source:
NHS Cancer Screening Programmes from NHAIS System

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Inviting men and women aged 70 to their 75th birthday two years after completion of original two year screening round to men and women aged 60 to 69

Timeframe/Baseline:
Completion of first two year screening round

Timeframe Until:
Continual once implemented

Rationale:
Evidence suggests that implementation of a national screening programme should reduce bowel cancer mortality by around 16% and contribute to the Coalition Government's ambition to deliver cancer survival rates amongst the best in the world. Evidence suggests efficacy of screening up to age 75, and 61% of bowel cancers occur in those aged 70 and over. National roll-out of the NHS Bowel Cancer Screening Programme for men and women aged 60 to 69 began in 2006. Coverage of the original programme to all PCTs in England was completed in August 2010. Every PCT that has completed the original two-year screening round for 60-69 year olds was expected to commence the 70-75 roll-out from 2010/11. All other PCTs should commence roll-out on completion of their first two-year screening round. Local planning for roll-out of the 70-75 age extension should concentrate in particular on ensuring adequate capacity for endoscopy services. Programmes should begin the expansion by inviting men and women to be screened who were previously invited when aged 68 and 69 at ages 70 and 71, those aged 70-74 who had previously "opted in" two years after their previous screening episode and those previously uninvited and newly turned 74 year-olds. This has been built into the Bowel Cancer Screening IT system. **DH will be using data collected from the NHAIS system in year to performance manage progress against the trajectories.** Commissioners should work with NHS Cancer Screening Programmes to ensure extension to 70-75 year-olds begins as planned from 2010, or on immediate completion of the original two-year screening plan.

SHA Envelopes:
No

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
NHS Cancer Screening Programmes: 0114 2711060   www.cancerscreening.nhs.co.uk
Changes from 2010/11 Planning Round:
None

SQU22: Cervical Screening Test Results

DEFINITIONS
Detailed Descriptor:

All women to receive results of cervical screening tests within two weeks-

Percentage of women with an expected date of delivery for their cervical screening test result within 14 days of the test being taken

Lines within Indicator (Units):

% performance calculated from:

Numerator:	The number of eligible women with an expected date of delivery of screening test result within 14 days.
Denominator:	The number of eligible women (25-64) having a cervical screening test.

Data Definition:

Day 0 will be date of test

Target date will be date of expected delivery of results by post

Monitoring will be based on a calendar week, not working days

Basis for Accountability:

Commissioner

MONITORING
Monitoring Frequency:

Quarterly

Monitoring Data Source:

NHS Cancer Screening Programmes through NHAIS System

ACCOUNTABILITY
What success looks like, Direction, Milestones:

All women should have been receiving the results of their cervical screening tests within 14 days by the end of 2010. Annual data will be available when the 2011/12 ONS/NHS IC statistical bulletin is published in autumn 2012.

Timeframe/Baseline:

By December 2010

Timeframe Until:

Ongoing

Rationale:

In May 2004, the International Agency for Research on Cancer (IARC), part of the World Health Organisation, concluded that organised and quality controlled cervical screening can achieve an 80% reduction in the mortality of cervical cancer.

In July 2004, Professor Julian Peto and colleagues published a paper in The Lancet, *The cervical cancer epidemic that screening has prevented in the UK.* The paper concluded that cervical screening has prevented an epidemic that would have killed about one in 65 of all British women born since 1950 and culminated in about 6,000 deaths per year in this country. 80% or more of these deaths, up to 5,000 per year, are likely to be prevented by screening. This means that about 100,000 women will have been saved from premature death by the cervical screening programme by 2030.

In 2009-10, 78.9% of eligible women had a test result in the last 5 years and 3.3 million women were screened.

In 2009-10, only 44.6% of test results were sent by PCOs to women within two weeks of the sample being taken, a substantial increase from 21.4% in 2008-09. However, over 13% of women had to wait over 6 weeks for their result. Waiting so long for results, especially for a test for abnormalities which may lead to cancer, causes anxiety in women. It may also deter women from being screened next time they are invited.

That is why the Cancer Reform Strategy (December 2007) said that all women should receive cervical screening test result within 14 days. The strategy noted that achieving a 14 day turnaround time (TAT) from sample taking to the woman having her result would be a challenge for many parts of the country, involving all partners in the screening pathway, not just laboratories or Trusts. NHS Improvement: Cancer are providing focused service improvement resources across the cervical screening pathway to support the delivery of faster turnaround times.

Commissioners with local screening failing to achieve the 14 day TAT are strongly advised to access *Cytology improvement guide – achieving a 14 day turnaround time in cytology* (November 2009) and Continuous Improvement in Cytology: sustaining and accelerating improvement (October 2010):

http://www.improvement.nhs.uk/diagnostics/CytologyNewsandEvents/tabid/99/Default.aspx

DH will be using data collected from the NHAIS system in year to performance manage progress against the trajectories.

SHA Envelopes:

No

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
NHS Cancer Screening Programmes: 0114 2711060   www.cancerscreening.nhs.co.uk
Changes from 2010/11 Planning Round:
None

SQU23: Diabetic Retinopathy Screening

DEFINITIONS

Detailed Descriptor:

Percentage of eligible people offered screening for the early detection (and treatment if needed) of diabetic retinopathy in the previous twelve months

Lines within Indicator (Units):

1. Number of people offered screening for the early detection (and treatment if needed) of diabetic retinopathy
2. Number of people receiving screening for the early detection (and treatment if needed) of diabetic retinopathy
3. Number of people with diabetes suspended from diabetic retinopathy screening
4. Number of people with diabetes identified by diabetic retinopathy screening programmes in the PCT

Indicator construction is Line 1 divided by (Line 4 minus Line 3)

Data Definition:

Count of the number of people who have been offered screening for diabetic retinopathy as part of a systematic programme that meets national standards, during the last 12 months where the following conditions are met:

- Test is digital photography only (slit lamp bio-microscopy or direct ophthalmoscopy does not count).
- Appropriately trained screening and grading staff.
- Clearly identified clinical lead and programme manager.
- Appropriate follow-up of positive screening tests.
- Appropriate systems to ensure that the PCT population of people with diabetes on GP registers are notified to relevant screening programmes, lists are regularly updated, and risks of missing people or losing people to follow up are minimised.
- Annual screening interval
- Minimum programme size of 12,000 people with diabetes.
- Programme management based on a single, comprehensive, managed list of those people with diabetes covered by the programme, including the ability to take account of groups such as those under the care of hospital eye clinics, and track those excluded for any reason.
- Call and recall managed from a single point for the programme, based on the list above..
- Participation in quality assurance, including:
  - o grading of screening outcome by use of national minimum dataset, and quality assurance of grading,
  - o regular monitoring, and reporting of achievement against national quality standards with action to achieve at least minimum levels.
- Procurement and installation of cameras and specialised programme

management software. All software must support the Diabetic Retinopathy Screening Dataset, available from

- http://www.connectingforhealth.nhs.uk/dscn/dscn2007/DSCN19-2007.pdf.

- All imagesets per patient must have been full disease graded before being counted as a screen. Photography alone is not a screen.

Basis for Accountability:

PCTs

MONITORING

Monitoring Frequency:

Quarterly

Monitoring Data Source:

VSMR

ACCOUNTABILITY

What success looks like, Direction, Milestones:

An offered screening rate of over 95% (when taking account of exclusions) would be a minimum level of achievement

Timeframe/Baseline:

Not applicable

Timeframe Until:

Ongoing

Rationale:

Diabetic retinopathy is the most common cause of blindness in working age people in England. If untreated, 50% of those who develop proliferative diabetic retinopathy will lose their sight within two years, and some of these within 12 months. Early detection of sight threatening diabetic retinopathy and treatment (usually with laser therapy) halves the risk of blindness.

SHA Envelopes:

Not applicable

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Full guidance available on unify2 at following link http://nww.unify2.dh.nhs.uk/InstantForum414/Topic10008041-10000502-1.aspx
Changes from 2010/11 Planning Round:
This is a new indicator

SQU24-26: Referral to Treatment Waits (Median Wait Measures)

DEFINITIONS
Detailed Descriptor:
RTT waits (3 measures- admitted median, non-admitted median, incomplete median)-
The median time waited for admitted and non-admitted patients completing an RTT pathway, and for incomplete pathways.
Lines within Indicator (Units):
SQU24 - the median time waited for admitted patients whose clocks stopped during the period on an adjusted basis
SQU25 - the median time waited for non-admitted patients whose clocks stopped during the period
SQU26 - the median time waited for patients on incomplete pathways at the end of the period.
Data Definition:
A calculation of the median time waited for completed admitted and non-admitted, and incomplete referral to treatment pathways based on referral to treatment data provided by NHS and independent sector organisations and signed off by NHS commissioners.
Basis for Accountability:
Commissioner.

MONITORING
Monitoring Frequency:
Monthly.
Monitoring Data Source:
Referral to Treatment Consultant-led Waiting Times data collection via Unify2 (National Statistics).

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Median time waited for completed admitted and non-admitted, and incomplete

referral to treatment pathways should not deteriorate and where possible improve during 2011/12. This information will be assessed alongside other data including referrals, activity, finance and waiting times.

Timeframe/Baseline:

2010/11

Timeframe Until:

Ongoing.

Rationale:

Patients' rights to access services within maximum waiting times under the NHS Constitution continue and commissioners should ensure that performance does not deteriorate and where possible improves during 2011/12. With that in mind, providers should be expected to offer information on maximum waiting times to patients; and there should be monitoring of compliance with this and of the 95th percentile of waiting time.

SHA Envelopes:

N/A

PLANNING REQUIREMENTS

Are Plans Required?:

No

Planning Frequency:

N/a

Criteria for Plan Sign-off:

N/a

FURTHER INFORMATION

Further Information:

Data and full guidance can be found here
http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/ReferraltoTreatmentstatistics/index.htm

Changes from 2010/11 Planning Round:

The approach to monitoring referral to treatment waits has changed <u>from</u> monitoring the percentage of patients whose referral to treatment time was less than 18 weeks <u>to</u> monitoring the median time waited for completed admitted and non-admitted, and incomplete referral to treatment pathways.

SQU27: Coverage of NHS Health Checks

DEFINITIONS
Detailed Descriptor:

Please calculate:

1. the percentage of people eligible for the NHS Health Check programme who have been <u>offered</u> an NHS Health Check *and*
2. the percentage of people eligible for the programme who have <u>received</u> a NHS Health Check.

The NHS Health Check programme is a systematic prevention programme that assesses an individual's risk of heart disease, stroke, diabetes and kidney disease. It is for people aged 40-74 who have not been previously diagnosed with one of these conditions (including hypertension) and consists of a face to face individual risk assessment followed by risk management advice (the risk assessment element of the check) and interventions (the risk management element of the check). For those at low risk, the risk management might be no more than general advice on how best to stay healthy. Others may be assisted to join a weight management programme or a stop smoking service. Those at the highest risk might also require preventive medication with statins or blood pressure treatment.

The NHS Health Check: Vascular Risk Assessment and Management Best Practice Guide was published in April 2009 and this clearly explains the core tests and measures in the risk assessment element of the NHS Health Check, along with similar information about risk management interventions. It describes what every person should receive as the national offer of an NHS Health Check.

PCTs will be collecting this data as part of monitoring their LES or contracts with providers of this service.

Lines within Indicator (Units):

1. Number of eligible people who have been offered an NHS Health Check in 2011/12.

2. Number of eligible people who have received an NHS Health check

3. Number of people aged 40-74 eligible for an NHS Health Check in 2011/12

4. Percentage of eligible people who have been offered an NHS Health Check in 2011/12

5. Percentage of eligible people that have received an NHS Health Check in 2011/12

Data Definition:

Determine the number of people aged 40-74 eligible for a NHS Health in 2011/12.

This data is to be drawn from that held at the Office for National Statistics collection.

We recommend that PCTs use ONS's 2008- resident based population projections for 2011 to calculate their population aged 40-74 eligible for an NHS Heath Check (published 27 May 2010 – see link). Best practice would be to determine the eligible population at the start of the year to aid planning. This population would remain unchanged for the rest of the year, but acts as a baseline for individuals to be offered NHS Health Checks. Any fluctuations in the populations in year should be relatively small and not affect the rates to a great extent.
http://www.statistics.gov.uk/statbase/product.asp?vlnk=997

This should be adjusted to exclude people who have been diagnosed with:- ,
- heart disease,
- stroke,
- diabetes
- kidney disease (stages 3 to 5)
- hypertension
- Atrial Fibrillation
- Transient Ischaemic Attack (TIA)
- Familial Hypercholesterolaemia
- Heart failure
- Peripheral Arterial Disease (PAD)

Read codes to assist in determining the exclusions have been identified and a list will be made available shortly.

- *Count the number of eligible people who have been offered a NHS Health Check during 2010/11.*

PCTs should offer NHS Health Checks to those eligible people aged 40-74 without an existing diagnosed vascular disease.   The data we are seeking is the number of **people** who have been offered an NHS Health Check not the number of offers that have been made. Every person who receives an NHS Health Check will have been offered one and so this should be recorded. The offer can be anything from a formal invitation through to opportunistically asking whether the person would be interested in having a check e.g. in a pharmacy. It is important to record the number of people who have been offered an NHS Health Check so that take up rates can be calculated which can then be used to give an indication of the accessibility of the programme. **People should only be counted once even if they have had several offers of a check.**

- *Count the number of eligible people who have received a NHS Health Check during 2011/12.*

The NHS Health Check should be compliant with the Best Practice Guidance published in April 2009. A completed vascular risk assessment as part of an NHS Health Check is:-

- risk assessment undertaken,
- communication of risk given to the individual,
- individual lifestyle advice given to the person, and
- referral, as appropriate, to a lifestyle intervention or for further medical investigation.

The Best Practice Guide (see link) describes what every person should receive as the national offer of a NHS Health Check.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098410.pdf

Basis for Accountability:

Commissioner.

MONITORING

Monitoring Frequency:

Quarterly, to see progress through the year on the number of NHS Health Checks offered, and the percentage take up within each PCT.

Monitoring Data Source:

VSMR commissioner return via Unify2

ACCOUNTABILITY

What success looks like, Direction, Milestones:

The number of NHS Health Checks offered and undertaken should increase until 2012 to reflect phased implementation of the programme. Thereafter, there should be a fairly stable number of checks being offered and conducted every year (nationally around 3m offered and we estimate about 2.2m conducted).

Timeframe/Baseline:

1 April 2011

Timeframe Until:

31 March 2012

Rationale:

Collectively, vascular disease – heart disease, stroke, diabetes and kidney disease – affect the lives of more than four million people and kill 170,000 every year. They also account for more than half the mortality gap between rich and poor. Modelling work undertaken by the Department of Health has found that offering NHS Health Checks to all people between 40 and 74, and recalling them every five years would be clinically and cost effective.

The NHS Health Check programme will assess people's risk of heart disease, stroke, chronic kidney disease and diabetes and be based on straightforward questions and measurements such as age, sex, family history, height, weight and blood pressure. A simple blood test will also be carried out to measure cholesterol.

Everyone will receive a personal assessment, setting out the person's level of risk and exactly what they can do to reduce it. For those at low risk, this might be no more than general advice on how best to stay healthy. Others may be assisted to join a weight management programme or a stop smoking service. Those at the highest risk might also require preventive medication with statins or blood pressure treatment.

Phased implementation of the programme began in 2009/10. The NHS Health Check: Vascular Risk Assessment and Management Best Practice Guide was published in April 2009 and this clearly explains the core tests and measures in the risk assessment element of the NHS Health Check, along with similar information about risk management interventions. It describes what every person should receive as the national offer of a NHS Health Check.

SHA Envelopes:

PLANNING REQUIREMENTS

Are Plans Required?:

Yes, for commissioners

Planning Frequency:

Quarterly for 2011/12

Criteria for Plan Sign-off:

PCTs began phased implementation of the NHS Health Check programme from April 2009 for which funding has been provided. Funding in PCTs baseline for 2011/12 is available to deliver 90% towards full roll out of the programme. Plans for 2011/12 should therefore reflect this. Full roll out of the programme will be reached when PCTs are inviting at least a fifth of their eligible population every year as part of a 5 year rolling programme. Therefore, we would expect PCT plans for 2011/12 to for a programme which will enable 90% of a fifth (18%) of their eligible cohort to have an NHS Health Check . Eg. if a PCT has an eligible cohort of 100,000, for a five year programme, we would expect PCTs to divide that cohort by 5 and invite 20,000 people each year for NHS Health Check. Phased rollout at 90% would therefore equate to 18,000 people (i.e. 90% of 20,000).

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
The indicator for the NHS Health Check programme remains unchanged from 2010/11 Operating Framework.

SQU28: People with long-term conditions feeling independent and in control of their condition

DEFINITIONS

Detailed Descriptor:

People with a long-term condition feeling independent and in control of their condition-

This is a patient experience measure of the proportion of people with a long-term condition who are "supported by people providing health and social care services to manage their condition".

Lines within Indicator (Units):

The GP patient survey identifies people with one or more long-term conditions using survey question "Do you have any long-standing health problem, disability or infirmity? Please include anything that has troubled you over a period of time or that is likely to affect you over a period of time."

Percentage:

Denominator is the number of people in the survey who define themselves as having a long-term condition as defined using the question above and who respond to the question "In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? (Please think about all services and organisations, not just health services)". The denominator includes those saying "yes, definitely" and "yes, to some extent" or "no" to this question. The denominator excludes those who reply "don't know" or "I have not needed such support".

Numerator is the number of people in the survey with a long-term condition as defined above that said they "had enough support from local services or organisations to help manage their long-term health condition(s)" (those saying "yes, definitely" and "yes, to some extent").

Data Definition:

The proportion of people with a long-term condition who are "supported by people providing health and social care services to manage their condition", with numerator and denominator as defined above

Basis for Accountability:

Commissioner

MONITORING
Monitoring Frequency:
Currently data are collected quarterly in 2010/11, though data will only available every six months in the 2011-12 surveys (i.e. for Q2 2011/12, and Q4 2011/12)
Monitoring Data Source:
Currently GP patient survey

ACCOUNTABILITY
What success looks like, Direction, Milestones:
An increase in this indicator is desirable
Timeframe/Baseline:
2010-11 figures will be published in June 2011.
Timeframe Until:
Ongoing
Rationale:
This indicator focuses attention on patient experience against exact national policy aims for people with long-term conditions. People with long-term conditions want greater control of their lives, to be treated sooner before their condition causes more serious problems and to enjoy a good quality of life. This means transforming the lives of people with long-term conditions to move away from the reactive care based in acute settings toward a more systematic patient-centred approach, where care is rooted in primary and community settings and underpinned by strong partnerships across the whole health and social care spectrum.
SHA Envelopes:
N/A

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, commissioner forecasts
Planning Frequency:
Firm forecasts for Q2 and Q4 2011/12 and outline forecasts for 2012/13 2013/14 2014/15
Criteria for Plan Sign-off:
None

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
This was previously an indicator (VSC11) in the Vital Signs indicator set and NI124 in the local area agreement indicator set.

SQU29: Emergency Admissions for Long Term Conditions

DEFINITIONS
Detailed Descriptor:

Emergency admissions for people with long term conditions-

Number of emergency admissions to hospital for Long-Term Conditions diagnoses each month

Lines within Indicator (Units):

Number of emergency admissions to hospital for Long-Term Conditions diagnoses

Data Definition:

Emergency Admissions are derived from the monthly HES extract, and are calculated in the following way:
Admission method is emergency (21, 22, 23, 24, 28)
Patient classification is inpatient (1, 5, 8 & 9)
Episode end date is in the time period specified

Primary diagnosis is not:
A00 – B99: relating to infectious and viral diseases.
O00 – Q99: relating to abortion and complications and abnormalities arising in labour, delivery and the neonatal and perinatal periods.

External Cause Code is not::
V01 – V99: relating to vehicular accidents.

Basis for Accountability:

Commissioner, aggregate to SHA

MONITORING
Monitoring Frequency:

Monthly

Monitoring Data Source:

HES

ACCOUNTABILITY
What success looks like, Direction, Milestones:
There should be a reduction in the growth in the number of emergency admissions for people with long-term conditions.
Timeframe/Baseline:
Baseline of 2010-11
Timeframe Until:
March 2014
Rationale:
Improved use of other services for people with LTCs, will reduce use of expensive emergency care if not appropriate.
SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
This is a new indicator

SQU30: Safeguarding

Indicator to be developed in 2011/12.

SRS01: Total Pay Costs

Total costs of staff (to include cost of staff within provider contracts)

Performance will be measured against plan and in comparison to workforce

Plan required: Yes

SRS02: Total Workforce (WTEs)

DEFINITIONS
Detailed Descriptor:
NHS Workforce

Lines within Indicator (Units):
All Hospital and Community Health Services (HCHS) workforce by FTE using data from the Electronic Staff Record (ESR) The figures do not include data for GPs and practice staff.

Data Definition:
High-level NHS HCHS Workforce statistics at a National and SHA level for Hospital Doctors and Non Medical Staff by major staff groups. Tables of headcount, FTE, role and turnover counts also available

Basis for Accountability:
All trusts aggregated to national and SHA level

MONITORING
Monitoring Frequency:
Monthly

Monitoring Data Source:
ESR data
For Moorfields and Chesterfields FT, the actual census data as at 30 September 2009

ACCOUNTABILITY
What success looks like, Direction, Milestones:

Timeframe/Baseline:
2010-11

Timeframe Until:
Ongoing

The NHS must make up to £20bn of efficiency savings by 2014 by reducing bureaucracy and doing things differently.

Efficiency gains will allow the NHS to reinvest in support for front line services and improving quality

PLANNING REQUIREMENTS

Are Plans Required?:

Yes, forecasts are required from SHA.

Planning Frequency:

Criteria for Plan Sign-off:

FURTHER INFORMATION

Further Information:

Changes from 2010/11 Planning Round:

NHS Information Centre now publish HCHS workforce data on a monthly basis drawn from the Electronic Staff Record

SRS03: Year to date financial position

In year cumulative surplus/(deficit) position of PCTs and Trusts will be assessed against plan, and in particular, how it relates to the reported forecast financial outturn

Plan required: Yes

SRS04: NHS Trusts Breakeven duty

NHS Trusts three year rolling break even duty

Plan required: Yes

SRS05: Delivery of 2% recurrent headroom

All PCTs required to ensure that 2% of their recurrent funding is only ever committed non-recurrently. The 2% to be held by SHAs with PCTs accessing the funding through business case submissions

Plan required: tbc

SRS06: PCT legacy debt position

PCTs with legacy debt issues (that arose prior to 2011/12) to be dealt with by the end of 2012/13. PCTs to work with developing GP consortia to ensure no new deficits in 2011/12 to 2012/13

Plan required: Yes

SRS07: Underlying financial position of PCTs and NHS Trusts

Recurrent position of PCTs and Trusts as reported in FIMs.

Plan required: Yes

SRS08: Length of Stay (Acute & MH)

DEFINITIONS
Detailed Descriptor:

This indicator gives the average length of stay for hospital spells, for acute spells and for mental health spells.

Lines within Indicator (Units):

SRS08_01 Average spell duration for non-same day acute discharges
SRS08_02 Average spell duration for non-same day MH discharges

Data Definition:

These are sourced by the NHS IC HES Analysis Team from the Hospital Episodes Statistics (HES) data warehouse as national and SHA totals.

This indicator is calculated using the following formula:

Average length of stay (days) = [Total Speldur] / [Non-same day discharges]

SRS08_01 – Non-same data acute discharges does not include those spells which were for maternity or mental health specialties, and therefore excludes the following specialties (HES field name = Mainspecialty):
501 – obstetrics
560 – midwifery
null – other maternity events
700 – learning disability
710 – adult mental illness
711 – child and adolescent psychiatry
712 – forensic psychiatry
713 – psychotherapy
715 – old age psychiatry

In addition, it excludes well-babies - i.e. excludes those spells with Patient Set Well-baby check flag set to Y.

SRS08_02 – Non-same data acute discharges for Mental health include only those spells which were under following specialties (HES field name = Mainspecialty):
700 – learning disability
710 – adult mental illness
711 – child and adolescent psychiatry
712 – forensic psychiatry
713 – psychotherapy
715 – old age psychiatry

The length of stay for Mental Health patients will vary due to the casemix within

each trust, and it is important that this is considered when calculating and monitoring this measure. It is therefore suggested that it is good practice to disaggregate the indicator by primary diagnosis using the ICD-10 codes under "Mental and behavioural disorders" (high-level single numerical digit F codes). This will help explain any variation in length of stay.

Basis for Accountability:

Provider

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

HES

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Reducing the length of stay would show improved productivity and a reduced cost of care.

Timeframe/Baseline:

Baseline of 2010-11

Timeframe Until:

March 2015

Rationale:

Reducing the length of stay would show improved productivity and a reduced cost of care.

SHA Envelopes:

Not applicable.

PLANNING REQUIREMENTS

Are Plans Required?:

Yes, provider forecast with SHA assurance of PCT sign off

Planning Frequency:
Firm monthly forecasts for 2011/12, and outline annual forecasts for 2012/13, 2013/14, 2014/15.

Criteria for Plan Sign-off:
None. Forecasts will be assessed: • to ensure that they are based on robust demand assumptions that support delivery of QIPP over four years; • and for consistency with the forecasts for beds, activity, referrals and finance.

FURTHER INFORMATION
Further Information:
Definition of spell duration and discharges can be found at the HES Online data dictionary: http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=571 Some data on average length of stay is published as headline figures on the HES Online website: http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=193

Changes from 2010/11 Planning Round:
This is a new indicator

SRS09: Daycase Rate

DEFINITIONS
Detailed Descriptor:

This is calculated as the number of elective General and Acute daycase FFCEs expressed as a proportion (%) of the total General and Acute elective FFCEs.

Lines within Indicator (Units):

Line 1: Numerator = Number of elective General and Acute daycase FFCEs
Line 2: Denominator = Total General and Acute elective FFCEs
Line 3: Proportion (%) = Line 1 /Line 2

Data Definition:

These data are derived from the Monthly Activity Return, which is collected from the NHS. The return provides aggregate data of in-patient and out-patient activity flows. It is collected from providers (both NHS and IS).

The number of elective general and acute daycase FFCEs expressed as a proportion of all elective general and acute FFCEs.

Number of first finished consultant episodes (FFCEs) for the G&A specialties (see below) relating to hospital provider spells for which:

- patient classification = daycase admission;
- admission method = elective admission (includes waiting list, booked and planned);
- episode number = 1;

General & Acute specialties

- include: 100-192, 300-460, 502, 800-831, 900 and 901
- exclude: 501, 700-715

Exclude "well babies". These are defined as having admission method = other and neonatal level of care = normal care

Number of first finished consultant episodes (FFCEs) for the G&A specialties (see below) relating to hospital provider spells for which:

- patient classification = day case or ordinary;
- admission method = elective admission (includes waiting list, booked and planned);
- episode number =1;

General & Acute specialties

- include: 100-192, 300-460, 502, 800-831, 900 and 901
- exclude: 501, 700-715

Exclude "well babies". These are defined as having admission method = other and

neonatal level of care = normal care
http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/adm/admitted_patient_elective_admissions_de.asp?query=elective%20admissions&rank=75&shownav=1
http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/adm/admitted_patient_elective_admissions_(day_case)_de.asp?query=elective%20admissions&rank=75&shownav=1

Basis for Accountability:
Provider

MONITORING
Monitoring Frequency:
Monthly

Monitoring Data Source:
Monthly Activity Returns (MAR)

ACCOUNTABILITY
What success looks like, Direction, Milestones:
There should be an increase in the daycase rate over the planning period where this is clinically appropriate. However, shifts of care from daycase into outpatient settings may decrease the daycase rate.

Timeframe/Baseline:
Baseline of 2010-11

Timeframe Until:
March 2015

Rationale:
Where clinically appropriate, this indicator should reflect a shift in activity from ordinary admissions to daycase admissions, which will result in an increase in the daycase rate. An increase in the daycase rate will therefore reflect a reduction in the use of hospital beds, a reduction in the clinical risk patients are exposed to during long inpatient stay (for example, healthcare-acquired infections) and increasingly efficient use of NHS resources.
An increase in the daycase rate is not the goal in itself, and in best practice commissioners should also put provisions in place to move activity to outpatient

clinics and to provide ambulatory emergency care in A&E departments where clinically appropriate, to deliver care closer to the patient.

Care that is delivered closer to home and which avoids the need for unnecessary hospital stays will result in more effective patient care, improved patient experience and a more efficient use of NHS resources.

SHA Envelopes:
None

PLANNING REQUIREMENTS
Are Plans Required?:
No, will derive from forecasts for SRS15.
Planning Frequency:
See SRS15 for details
Criteria for Plan Sign-off:
None. Forecasts will be assessed: • to ensure that they are based on robust demand assumptions that support delivery of QIPP over four years; • and for consistency with the forecasts for beds, length of stay and finance.

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
This is a new indicator

SRS10: Delayed Transfers of Care – Acute & MH

DEFINITIONS

Detailed Descriptor:

The number of Delayed Transfers of Care per 100,000 population (all adults – aged 18 plus)

Lines within Indicator (Units):

Delayed Transfers of Care:
- Commissioner measure is number of delayed transfer of care of acute and non-acute adult patients (aged 18+) per 100,000 population
- Provider measure is number of delayed transfers of care of acute and non-acute adult patients (aged 18+) as a proportion of the number of occupied beds.

Reporting

Provider quarterly totals will be reported by type of provider (acute, MH, other). Commissioner quarterly subtotals will be reported for:
- Acute
- Non-acute

Data Definition:

Commissioner numerator_01: Number of Delayed Transfers of Care of acute and non-acute adult patients (aged 18+ years)

Commissioner denominator _02: Current ONS resident population projection for the relevant year aged 18 years or more

Provider numerator_03: Number of patients (acute and non-acute, aged 18 and over) whose transfer of care was delayed, averaged over the quarter. The average of the three monthly sitrep figures is used as the numerator.

Provider denominator_04: Average number of occupied beds

A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.
A patient is ready for transfer when:
[a] a clinical decision has been made that the patient is ready for transfer **AND**
[b] a multi-disciplinary team decision has been made that the patient is ready for transfer **AND**
[c] the patient is safe to discharge/transfer.

To be effective, the measure must apply to acute beds, and to non-acute and mental health beds. If one category of beds is excluded, the risk is that patients will be re-located to one of the 'excluded' beds rather than be discharged.

Basis for Accountability:
Commissioner (data are based on area of residence)

MONITORING
Monitoring Frequency:
Commissioner: quarterly Provider: quarterly
Monitoring Data Source:
Commissioner numerator: quarterly VSMR data collected via Unify2 Provider numerator: monthly sitrep data collected via Unify2 Commissioner denominator: ONS population projections for resident population aged 18 years or more. Provider denominator: KHO3 return

ACCOUNTABILITY
What success looks like, Direction, Milestones:
The ambition is to maintain the lowest possible rate of delayed transfers of care. *Good* performance is demonstrated by a consistently low rate over time, and/or by a decreasing rate. *Poor* performance is characterised by a high rate, and/or by an increase in the rate.
Timeframe/Baseline:
2010/11
Timeframe Until:
March 2012
Rationale:
This indicator measures the impact of hospital services and community-based care in achieving timely and appropriate discharge from all hospitals for all adults. This therefore measures the ability of the whole system to ensure appropriate discharge for the whole population passing through hospital and is an indicator of the (a) effectiveness of the interfaces within and between health and social care services, and (b) the efficient use of NHS resources (i.e. hospital beds).
SHA Envelopes:
N/A

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
N/A
Criteria for Plan Sign-off:
N/A

FURTHER INFORMATION
Further Information:
Definitions and guidance on the monthly delayed transfer of care SitRep data collection can be found here: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AcuteandNon-AcuteDelayedTransfersofCare/index.htm Guidance on the quarterly Monitoring Return, including delayed transfers of care, can be found on the Forum on Unify. http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Vitalsignsmonitoring/DH_112546 http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AcuteandNon-AcuteDelayedTransfersofCare/index.htm
Changes from 2010/11 Planning Round:
No change to commissioner measure. Provider measures are new. Monitoring remains unchanged.

SRS11: GP Written Referrals to Hospital

DEFINITIONS
Detailed Descriptor:

GP written referrals from GPs for a first outpatient appointment in G&A specialities-

Number of written referrals from GPs for a first outpatient appointment in general & acute specialties.

Lines within Indicator (Units):

Number of GP written referrals in the period

Data Definition:

The total number of GP written Referral Requests for a first Consultant Outpatient Episode in the period.

An electronic message should be counted as written, as should a verbal request which is subsequently confirmed by a written request.

It is the total number of GP written referrals where:
Referral Request Type = National Code 01 'GP referral request'
Written Referral Request Indicator = classification 'Yes'

General & Acute specialties

Include: 100-192, 300-460, 502, 800-831, 900, 901

Exclude: 501, 700-715

http://www.datadictionary.nhs.uk/data_dictionary/messages/central_return_data_sets/data_sets/out-patient_flows_data_set_fr.asp?shownav=1

Basis for Accountability:

Commissioner

MONITORING
Monitoring Frequency:

Monthly

Monitoring Data Source:

Monthly Activity Return (MAR)

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Timeframe/Baseline:
2010/11
Timeframe Until:
March 2015
Rationale:
Commissioners need to show that their plans for referrals and activity are realistic, and consistent with sustaining 95th percentile and median waiting times.
SHA Envelopes:
Not applicable

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, forecasts are required - provider forecast with SHA assurance of PCT sign off; and commissioner forecast
Planning Frequency:
Firm monthly forecasts for 2011/12, and outline annual forecasts for 2012/13, 2013/14, 2014/15.
Criteria for Plan Sign-off:
None. Forecasts will be assessed: • to ensure that they are based on robust demand assumptions; • and for consistency with the forecasts for activity and finance.

FURTHER INFORMATION
Further Information:
Connecting for Health website: http://www.connectingforhealth.nhs.uk/systemsandservices/data/datamodeldictionary/help/faqs-07/index_html
Changes from 2010/11 Planning Round:
None.

SRS12: Other Referrals For a First Outpatient Appointment

DEFINITIONS

Detailed Descriptor:

Other referrals for a first outpatient appointment in general & acute specialities-

Referrals other than from a GP for a first outpatient appointment in general & acute specialties.

Lines within Indicator (Units):

Number of referrals in the period.

Data Definition:

The total number of other (non-GP) referral requests (written or verbal or electronic) for a first consultant outpatient episode in the period.

The total number of other Referral Requests (written or verbal) for a first Consultant Out-Patient Episode in the period. All referral requests to a Consultant whether directed to a specific consultant or not, should be recorded, regardless of whether they result in an outpatient attendance.

The referral request received date of the referral request should be used to identify referrals to be included in the return.

It is the total number of referrals requests excluding:
a. GP written referrals; these are where the REFERRAL REQUEST TYPE of the REFERRAL REQUEST is National Code 01 'GP referral request' and the WRITTEN REFERRAL REQUEST INDICATOR of the REFERRAL REQUEST is classification 'Yes'

 b. Self-referrals; these are where the REFERRAL REQUEST TYPE of the REFERRAL REQUEST is National Code 04 'Patient self-referral request'

 c. Initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode referrals; these are where the SOURCE OF REFERRAL FOR OUT-PATIENTS of the REFERRAL REQUEST is National Code 01 'following an emergency admission' or 02 'following a domiciliary visit' or 10 'following an Accident And Emergency Attendance' or 11 'other'

 d. Referrals initiated by attendance at drop-in clinic without prior appointment; these are where the OUT-PATIENT CLINIC REFERRING INDICATOR of the REFERRAL REQUEST is classification 'Attended referring Out-Patient Clinic without prior appointment'

General & acute specialties

Include: 100-192, 300-460, 502, 800-831, 900, 901

Exclude: 501, 700-715

http://www.datadictionary.nhs.uk/data_dictionary/messages/central_return_data_sets/data_sets/out-patient_flows_data_set_fr.asp?shownav=1

Basis for Accountability:

Commissioner

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

Monthly Activity Return (MAR)

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Timeframe/Baseline:

2010/11

Timeframe Until:

March 2015

Rationale:

Commissioners need to show that their plans for referrals and activity are realistic, and are consistent with sustaining 95th percentile and median waiting times.

SHA Envelopes:

Not applicable

PLANNING REQUIREMENTS

Are Plans Required?:

Yes, forecasts are required - provider forecast with SHA assurance of PCT sign off; and commissioner forecast

Firm monthly forecasts for 2011/12, and outline annual forecasts for 2012/13, 2013/14, 2014/15.

None.

Forecasts will be assessed:
- to ensure that they are based on robust demand assumptions;
- and for consistency with the forecasts for activity and finance.

FURTHER INFORMATION

Further Information:

Connecting for Health website:
http://www.connectingforhealth.nhs.uk/systemsandservices/data/datamodeldictionary/help/faqs-07/index_html

Changes from 2010/11 Planning Round:

None.

SRS13: First Outpatient Attendances following GP Referral

DEFINITIONS

Detailed Descriptor:

First outpatient attendances (consultant-led) following GP referral in general and acute specialties-

[This line is a sub-total of all first outpatient attendances (consultant-led) in general and acute specialties, SRS14.]

Lines within Indicator (Units):

Number of attendances in the period.

Data Definition:

A count of all first outpatient attendances taking place within the period, whether taking place within a consultant clinic session or outside a session.

The patient must have been seen by a consultant, or a clinician acting for the consultant, for examination or treatment.

Specifically, the number of consultant outpatient attendances in general & acute specialties for which:

- Referral Request Type = National Code 01 'GP referral request';

- Written Referral Request Indicator = classification 'Yes';

- First Attendance of the Out-Patient Attendance Consultant Care Contact = National Code 1 'First attendance face to face' or 3 'First telephone or telemedicine consultation'.

General & Acute specialties: include: 100-192, 300-460, 502, 800-831, 900, 901 but exclude: 501, 700-715

http://www.datadictionary.nhs.uk/data_dictionary/messages/central_return_data_sets/data_sets/out-patient_flows_data_set_fr.asp?shownav=1

Basis for Accountability:

Commissioner (data to be based on responsible commissioner).

MONITORING

Monitoring Frequency:

Monthly.

Monitoring Data Source:
Monthly Activity Return (MAR).

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Timeframe/Baseline:
2010/11
Timeframe Until:
Until March 2015
Rationale:
Commissioners need to show the activity required to sustain 95th percentile and median waiting times.
SHA Envelopes:
No.

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, forecasts are required - provider forecast with SHA assurance of PCT sign off; and commissioner forecast
Planning Frequency:
Firm monthly forecasts for 2011/12, and outline annual forecasts for 2012/13, 2013/14, 2014/15.
Criteria for Plan Sign-off:
None. Forecasts will be assessed: • to ensure that they are consistent with sustaining 95th percentile and median waiting times; • and for consistency with the forecasts for referrals, activity and finance.

FURTHER INFORMATION
Further Information:
Connecting for Health website: http://www.connectingforhealth.nhs.uk/systemsandservices/data/datamodeldictionary/help/faqs-07/index_html
Changes from 2010/11 Planning Round:
None.

SRS14: All First Outpatient Attendances

DEFINITIONS
Detailed Descriptor:

All first outpatient attendances (consultant-led) in general and acute specialties.

Lines within Indicator (Units):

Number of attendances in the period.

Data Definition:

A count of all outpatient attendances taking place within the period, whether taking place within a consultant clinic session or outside a session.

The patient must have been seen by a consultant, or a clinician acting for the consultant, for examination or treatment.

Specifically, the number of consultant outpatient attendances in general & acute specialties for which:

- first attendance = yes;

- attended or did not attend = attended (and was seen);

- First Attendance of the Out-Patient Attendance Consultant Care Contact = National Code 1 'First attendance face to face' or 3 'First telephone or telemedicine consultation'.
This includes first outpatient attendance for all consultant outpatient episodes for all sources of referral.

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

General & Acute specialties: include: 100-192, 300-460, 502, 800-831, 900, 901 but exclude: 501,700-715

http://www.datadictionary.nhs.uk/data_dictionary/messages/central_return_data_sets/data_sets/out-patient_flows_data_set_fr.asp?shownav=1

Basis for Accountability:

Commissioner (data to be based on responsible commissioner).

MONITORING
Monitoring Frequency:

Monthly.

Monitoring Data Source:
Monthly Activity Return (MAR).

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Timeframe/Baseline:
2010/11
Timeframe Until:
March 2015
Rationale:
Commissioners need to show the activity required to sustain 95th percentile and median waiting times.
SHA Envelopes:
No.

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, forecasts are required - provider forecast with SHA assurance of PCT sign off; and commissioner forecast
Planning Frequency:
Firm monthly forecasts for 2011/12, and outline annual forecasts for 2012/13, 2013/14, 2014/15.
Criteria for Plan Sign-off:
None.

Forecasts will be assessed:
- to ensure that they are consistent with sustaining 95th percentile and median waiting times;
- and for consistency with the forecasts for referrals, activity and finance.

FURTHER INFORMATION
Further Information:
Connecting for Health website: http://www.connectingforhealth.nhs.uk/systemsandservices/data/datamodeldictionary/help/faqs-07/index_html
Changes from 2010/11 Planning Round:
None

SRS15: Elective FFCEs

DEFINITIONS

Detailed Descriptor:

Number of general & acute (G&A) elective admissions Finished First Consultant Episodes (FFCEs)

Lines within Indicator (Units):

Line 1: number of G&A elective ordinary admission FFCEs in the period

Line 2: number of G&A daycase FFCEs in the period

Line 3: total number of G&A elective FFCEs in the period

Note: Line 1 + Line 2 = Line 3

Data Definition:

Number of finished first consultant episodes (FFCEs) for the G&A specialties (see below) relating to hospital provider spells for which:

- patient classification = ordinary admission (1) Daycase admission (2);
- admission method = elective admission (admission method 11, 12, 13);

Exclude "well babies". These are defined as having admission method = other and neonatal level of care = normal care.

- episode number = 1

General & Acute specialties

include:100-192, 300-460, 502, 800-831, 900, 901

exclude: 501, 700-715

http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/adm/admitted_patient_elective_admissions_(ordinary)_de.asp?query=elective%20admissions&rank=75&shownav=1
http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/adm/admitted_patient_elective_admissions_(day_case)_de.asp?query=elective%20admissions&rank=75&shownav=1

Basis for Accountability:

Commissioner

MONITORING
Monitoring Frequency:
Monthly

Monitoring Data Source:
Monthly Activity Return (MAR)

ACCOUNTABILITY
What success looks like, Direction, Milestones:
That elective activity will reflect future demand and the move of activity into other primary care and community settings.

Timeframe/Baseline:
2010/11

Timeframe Until:
March 2015

Rationale:
Commissioners need to show that their plans for referrals and activity are realistic, and are consistent with sustaining 95th percentile and median waiting times.

SHA Envelopes:
Not applicable.

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, forecasts are required - provider forecast with SHA assurance of PCT sign off; and commissioner forecast

Planning Frequency:
Firm monthly forecasts for 2011/12, and outline annual forecasts for 2012/13, 2013/14, 2014/15.

Criteria for Plan Sign-off:
None.   Forecasts will be assessed: • to ensure that they are consistent with sustaining 95th percentile and median

> waiting times;
> - and for consistency with the forecasts for beds, length of stay, outpatient activity and finance.
>
> Please note that these forecasts of elective admissions will also be assessed using the criteria shown above for Daycase Rate (SRS09).

FURTHER INFORMATION
Further Information:
Connecting for Health website: http://www.connectingforhealth.nhs.uk/systemsandservices/data/datamodeldictionary/help/faqs-07/index_html
Changes from 2010/11 Planning Round:
None.

SRS16: A&E Attendances

DEFINITIONS
Detailed Descriptor: Number of attendances at A&E departments in a quarter
Lines within Indicator (Units): SRS16_01 Number of attendances at Type 1 A&E Departments SRS16_02 Total Number of attendances at all A&E Departments Note: Line 01 is subset of Line 02
Data Definition: A&E Attendance figures are sourced from weekly SitRep data provided to the Department of Health by Trusts – this is a weekly total taken from a reporting period of 00.01 Monday to 24.00 Sunday. 'Total A&E attendances' is defined as the total of type 1, type 2 and type 3 attendances. This is automatically calculated on the SitRep submission form. Data from the forms are collated from Trusts into monthly totals by the DH and then aggregated into Strategic Health Authority and national totals by the NHS IC.
Basis for Accountability: Provider level

MONITORING
Monitoring Frequency: Quarterly - aggregated from weekly
Monitoring Data Source: Weekly Sitrep data

ACCOUNTABILITY
What success looks like, Direction, Milestones: There should be a reduction in the growth of the number of A&E attendances
Timeframe/Baseline: Baseline of 2010-11

Timeframe Until:
March 2015

Rationale:
This workstream aims to ensure that patients requiring urgent and emergency care get the right care by the right person at the right place and time. There are large numbers of people presenting to accident and emergency departments because they either do not know how, or are unable, to access the care they feel they need when they want it. A reduction in the growth of the number of A&E attendances would indicate a reduction in inappropriate use of expensive emergency care, and improve use of other services where appropriate.

SHA Envelopes:
Not applicable

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, provider forecast with SHA assurance of PCT sign off
Planning Frequency:
Firm quarterly forecasts for 2011/12, and outline annual forecasts for 2012/13, 2013/14, 2014/15
Criteria for Plan Sign-off:
None.   Forecasts will be assessed to ensure that they are based on robust demand assumptions that support delivery of QIPP over four years.

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
This is a new indicator

SRS17: Ambulance Urgent & Emergency Journeys

DEFINITIONS
Detailed Descriptor:
Number of urgent and emergency journeys via ambulance, quarterly
Lines within Indicator (Units):
Number of urgent and emergency journeys via ambulance, quarterly
Data Definition:
The number of urgent and emergency journeys taking place each quarter
Basis for Accountability:
Ambulance Trust

MONITORING
Monitoring Frequency:
Quarterly - aggregated from weekly
Monitoring Data Source:
Weekly Ambulance Sitrep data

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Reduction in the growth in the number of ambulance journeys
Timeframe/Baseline:
Baseline of 2010-11
Timeframe Until:
March 2015
Rationale:
More joined up services should mean transfers of activity away from A&E and ambulance services into primary and community based care. Increasing the volume of "hear and treat" (clinical advice over the telephone) and "see and treat" (treatment at the scene of the incident) will also result in the proportion of patients conveyed by ambulance.

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, provider (ambulance trust) forecast with SHA assurance of PCT sign off
Planning Frequency:
Firm quarterly forecasts for 2011/12, and outline annual forecasts for 2012/13, 2013/14, 2014/15.
Criteria for Plan Sign-off:
None. Forecasts will be assessed to ensure that they are based on robust demand assumptions that support delivery of QIPP over four years.

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
This is a new indicator.

SRS18: Community Activity

Indicator to be developed in 2011/12.

SRS19: Staff Absences

DEFINITIONS
Detailed Descriptor:
Monthly sickness absence rate
Lines within Indicator (Units):
Line 1: Numerator = WTE Number of days sick Line 2: Denominator = WTE number of days available Line 3: Rate = Line 1/Line 2
Data Definition:
A monthly extract is downloaded from ESR detailing the contracted full-time equivalent for a member of staff and the number of days of sickness absence, adjusted for the contracted full-time equivalent, over said month for all NHS staff in England. Rates have been calculated by dividing the "Whole Time Equivalent (Wte) Number of Days Sick" by the "Wte Number of Days Available" on the ESR.
Basis for Accountability:
SHA

MONITORING
Monitoring Frequency:
Monthly
Monitoring Data Source:
ESR

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Reduction in the sickness absence rate.
Timeframe/Baseline:
Baseline of 2009-10
Timeframe Until:
March 2014

Lower sickness absence rate should suggest improved productivity and reduced costs due to absence

PLANNING REQUIREMENTS

Are Plans Required?:

Yes, forecasts are required from SHA.

Planning Frequency:

Quarterly

Criteria for Plan Sign-off:

Planned 12-month average to March 2014 needs to be no more than 3.0% for London, South Central, South East Coast, East of England and South West SHAs; and no more than 3.4% for North East, North West, Yorkshire & Humber, East Midlands and West Midlands SHAs. If not, plan needs to be agreed by the national NHS Workforce Leadership Group.

FURTHER INFORMATION

Further Information:

The 12-month average statistics used will be the average of those published quarterly by the Information Centre for Health & Social Care.

Changes from 2010/11 Planning Round:

This is a new indicator

SRS20: Temporary Staffing Costs

DEFINITIONS

Detailed Descriptor:

Temporary Staffing Costs

Lines within Indicator (Units):

Temporary Staffing Costs

Data Definition:

Basis for Accountability:

Provider.
Monitoring only covers non-FTs.

MONITORING

Monitoring Frequency:

Quarterly

Monitoring Data Source:

FIMS

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Expected to reduce

Timeframe/Baseline:

2010/11

Timeframe Until:

March 2012

Rationale:

SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Not applicable
Criteria for Plan Sign-off:
Not applicable

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
This is a new indicator

SRS21: Clinical staff numbers

DEFINITIONS
Detailed Descriptor:

Clinical staff numbers

Lines within Indicator (Units):

Clinical staff numbers as a subset of the all Hospital and Community Health Services (HCHS) workforce by FTE using data from the Electronic Staff Record (ESR) The figures do not include data for GPs and practice staff.

Data Definition:

High-level NHS HCHS Workforce statistics at a National and SHA level for clinical staff
- Medical & dental
- Qualified nursing
- ST&Ts
- Ambulance staff
- Clinical support

Basis for Accountability:

All trusts aggregated to national and SHA level

MONITORING
Monitoring Frequency:

Monthly

Monitoring Data Source:

ESR data
For Moorfields and Chesterfields FT, the actual census data as at 30 September 2009

ACCOUNTABILITY
What success looks like, Direction, Milestones:

Published data maps SHA workforce QIPP Trajectories

Timeframe/Baseline:

2010-11

Timeframe Until:
End of planning period

Rationale:
The NHS must make up to £20bn of efficiency savings by 2014 by reducing bureaucracy and doing things differently. Efficiency gains will allow the NHS to reinvest in support for front line services and improving quality

SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, forecasts are required from SHA.
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
NHS Information Centre now publish HCHS data on a monthly basis

SRS22: Management Numbers

DEFINITIONS
Detailed Descriptor:

Management
Numbers of HCHS FTE in the categories below
  • Admin & estates
  • Managers & senior managers

Lines within Indicator (Units):
Managers, senior managers and admin and estates numbers as a subset of the all Hospital and Community Health Services (HCHS) workforce by FTE using data from the Electronic Staff Record (ESR) The figures do not include data for GPs and practice staff.
Data Definition:
High-level NHS HCHS Workforce statistics at a National and SHA level for managers, senior managers, admin and estates
Basis for Accountability:
All trusts aggregated to national and SHA level

MONITORING
Monitoring Frequency:
Monthly
Monitoring Data Source:
ESR data For Moorfields and Chesterfields FT, the actual census data as at 30 September 2009
ACCOUNTABILITY
What success looks like, Direction, Milestones:
Published data maps SHA workforce QIPP Trajectories broken down to show managers and senior managers numbers plus admin and estates numbers
Timeframe/Baseline:
2010-11

Timeframe Until:
End of planning period

Rationale:
The NHS must make up to £20bn of efficiency savings by 2014 by reducing bureaucracy and doing things differently. The requirement to cut management costs and protect the front-line will mean reduced numbers of administrative posts.

SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, forecasts are required from SHA.
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
NHS Information Centre now publish HCHS data on a monthly basis

SRS23: Redundancy Numbers

DEFINITIONS
Detailed Descriptor:
Compulsory redundancy of NHS staff within NHS organisations apart from Moorfield FT and Chesterfield FT
Lines within Indicator (Units):
Data drawn from the Electronic Staff Record
Data Definition:
Clinical compulsory redundancy at national level Non clinical compulsory redundancy at national level
Basis for Accountability:
All trusts aggregated at national level apart from Moorfield FT and Chesterfield FT

MONITORING
Monitoring Frequency:
Quarterly - under review
Monitoring Data Source:
ESR data via the DH (with plans to move over this collection to the NHS IC) The data excludes Moorfield FT and Chesterfield FT There is no plan to capture their data

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Compulsory redundancies are minimised wherever possible
Timeframe/Baseline:
Timeframe Until:
Rationale:
Redundancy is a waste of our significant investment in time; training and education which we have undertaken to provide a first class safe healthcare service for our patients. It is a last resort.

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:

SRF01: % of Organisations Progressing Along Pipeline to Milestones Agreed Between SHA, trust and DH

DEFINITIONS
Detailed Descriptor:
Progression of trusts along the FT pipeline- Percentage of Non – FTs within the SHA's region which are on track against their agreed milestones within the tripartite formal agreements between DH, the SHA and the Trust (to be agreed)
Lines within Indicator (Units):
Number of non-FTs on track / total number of non-FTs in the region (in the pipeline)
Data Definition:
Basis for Accountability:
SHA

MONITORING
Monitoring Frequency:
Quarterly (starting at end of 1st quarter 2011/12)
Monitoring Data Source:
SHA derived measure from SHA monitoring of trust performance

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Success is 100%. This may change depending on the position of Trusts following further analysis of Trust returns in January.
Timeframe/Baseline:
1 April 2011
Timeframe Until:
31 March 2014

To assess progress against agreed milestones for the pipeline.

Not applicable

PLANNING REQUIREMENTS
Are Plans Required?:
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
This is a new indicator.

SRF02: % of Organisations Behind Expected Position Along the FT Pipeline by Over 3 Months

DEFINITIONS
Detailed Descriptor:
Assessment of risk to successful delivery of pipeline-   Percentage of non-FTs behind their expected position against the milestones within the tripartite formal agreements between SHA, Department and the Trust (to be agreed) by over 3 months.
Lines within Indicator (Units):
Number non-FTs that are more than 3 months behind their expected position / total number of non-FTs in the region
Data Definition:
Basis for Accountability:
SHA

MONITORING
Monitoring Frequency:
Quarterly
Monitoring Data Source:
SHA derived measure from SHA monitoring of trust performance

ACCOUNTABILITY
What success looks like, Direction, Milestones:
As low a % as possible
Timeframe/Baseline:
1 April 2011
Timeframe Until:
31 March 2014
Rationale:
Provides an indicator of risk to pipeline delivery and facilitates the identification of issues.

SHA Envelopes:
Not applicable

PLANNING REQUIREMENTS
Are Plans Required?:
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
This is a new indicator.

SRF03: % of Organisations Behind Expected Position Along the FT Pipeline by Over 3 Months That Are in the Unsustainable Providers Classification

DEFINITIONS

Detailed Descriptor:

Assessment of progress along the pipeline of trusts in category 4 (unsustainable provider classification)-

Percentage of non-FTs in Category 4 behind their expected position against the milestones within the tripartite formal agreements between the SHA, Department and the Trust (to be agreed) by over 3 months.

Lines within Indicator (Units):

Number of non-FTs in Category 4 that are more than 3 months behind their expected position / total number of non-FTs in the region (in the pipeline)

Data Definition:

Basis for Accountability:

SHA

MONITORING

Monitoring Frequency:

Quarterly

Monitoring Data Source:

SHA derived measure from SHA monitoring of trust performance

ACCOUNTABILITY

What success looks like, Direction, Milestones:

As low a % as possible

Timeframe/Baseline:

1 April 2011

Timeframe Until:

31 March 2014

Rationale:
Provides an indicator of progress within Trusts where the organisational solution is particularly challenging. A high % in this area poses a very high risk to delivery of the pipeline.

SHA Envelopes:
Not applicable

PLANNING REQUIREMENTS
Are Plans Required?:
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
This is a new indicator

SRF04: Uptake Community Services Right to Request Scheme and Forecast Uptake in Right to Provide

DEFINITIONS
Detailed Descriptor:
% of autonomous organisations established through right to provide following approval of expression of interest.
Lines within Indicator (Units):
Number of autonomous organisations established within the SHA's region/ Total number of expressions of interest within the SHA's region
Data Definition:
Basis for Accountability:
SHA

MONITORING
Monitoring Frequency:
Quarterly (starting from 1st quarter of 2011/12)
Monitoring Data Source:
SHA return to DH

ACCOUNTABILITY
What success looks like, Direction, Milestones:
An increasing % over time.
Timeframe/Baseline:
1 April 2011 onwards
Timeframe Until:
31 March 2014
Rationale:
This indicator measures successful progression along right to provide assurance

framework following approval of expression of interest. Uptake of right to provide in each SHA region as part of development of new provider landscape, and in line with cross-government initiative.

SHA Envelopes:
Not applicable

PLANNING REQUIREMENTS
Are Plans Required?:
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
This is a new indicator.

SRF05: % (Value) of Community and Mental Health Services by PCT Subject to Any Willing Provider

DEFINITIONS
Detailed Descriptor:
% (value) of elective, community and mental health services by PCT subject to Any Willing Provider We will break this down into individual service types, the service categories are tbc by Ministers. Plans relating to the introduction of AWP will be published as guidance to the NHS in Spring 2011; this will outline which services AWP will apply to for 2011-12.
Lines within Indicator (Units):
The amount of community services that are commissioned using the AWP template or as an AWP process on S2H – expressed as a % of total commissioning budget allocated to community services We will be more specific about which community services this will be subject to in guidance to be published in Spring 2011 (as above). The amount of MH services that are commissioned using the AWP template as an AWP process on S2H – expressed as a % of total commissioning budget allocated to MH services
Data Definition:
£ of commissioning spend
Basis for Accountability:
Commissioner.

MONITORING
Monitoring Frequency:
Monthly
Monitoring Data Source:
Supply 2 health

ACCOUNTABILITY
What success looks like, Direction, Milestones:
We expect a gradual start from April 2011, in line with the direction signalled in the NHS Operating Framework 2011-12. Following publication of forthcoming AWP guidance, which will set out the expectations for community services AWP – we would expect the rate of uptake to increase. Success would be that all of the

commissioning spend for a particular range of community services is commissioned through an AWP model.

Timeframe/Baseline:
April 2011 – but is not accountable until October 2011

Timeframe Until:
Until April 2012 and than annual thereafter on a monthly basis

Rationale:
The Government's aim is to 'free up provision of healthcare, so that in most sectors of care, **any willing provider** can provide services, giving patients greater choice and ensuring effective competition stimulates innovation and improvements, and increases productivity within a social market. There should be a presumption that everyone should have choice and control over their care and treatment, and choice of any willing provider, wherever relevant. We expect this to become the reality in the majority of NHS-funded services by no later than 2013/14.' (Paragraph 1.2 *Liberating the NHS: Greater Choice & Control Consultation*, DH October 2010) The White Paper has expressed the requirement to have a "phased approach to community services" subject to AWP, with the majority of services commissioned under AWP by 2012/3.

SHA Envelopes:
N/A

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Guidance will be issued by the AWP team in Spring 2011 regarding the approach to AWP and which services we expect to be subject to AWP by October 2011.
Changes from 2010/11 Planning Round:
This is a new indicator.

SRF06: Extent of Completion of TCS Programme- Separation and Divestment of Provider Services

DEFINITIONS
Detailed Descriptor:
Percentage of PCTs within the SHA region which have divested all of their directly provided services as per the OF 2010/11 milestones
Lines within Indicator (Units):
Number of PCTs fully divested/total number of PCTs in the region
Data Definition:
By Divestment we mean that by April 2011 we expect: • any transfers to other NHS organisations to have been completed • any transfers to Local Authorities to have been completed • previous proposals for continued direct provision to have been reviewed and alternative options developed which have secured separation • all aspirant 'first' and 'second' wave CFTs to have achieved NHS Trust status or to meet NHS Transactions Board timescales for NHS Trust status. • 'first wave' social enterprises to be fully operational • Wave 2 and wave 3 R2R applications to have achieved assurance milestone 1 [paragraph 3.1 of the R2R assurance guidance] made significant progress towards milestone 2, be established as a legal entity and have a senior leadership team capable of contracting with PCTs for the 2011/12 contract round. To achieve this we would expect PCT Boards to have made an assessment of progress against a set minimum criteria (to be published shortly) by the end of March 2011 • All Wave 2 and 3 Social Enterprises to be fully operational by 30 September 2011. • All PCTs to have achieved separation from April 1 in line with 'DH guidance on internal separation for SHAs to support Business Readiness'
Basis for Accountability:
SHA

MONITORING
Monitoring Frequency:
Quarterly (starting at end of 1st quarter 2011/12). Data collection likely to end at Quarter 3. Vast majority will have achieved milestone by April1.
Monitoring Data Source:
SHA derived measure from SHA monitoring and assurance of PCTs divestment

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Success is 100%. A small number of PCTs have been authorised by Ian Dalton Director of Provider Development to divest later than April 2011, due to specific local circumstances.
Timeframe/Baseline:
1 April 2011
Timeframe Until:
Rationale:
To assess progress against agreed milestones for the pipeline.
SHA Envelopes:
Not applicable

PLANNING REQUIREMENTS
Are Plans Required?:
Plans already in place within all SHAs and PCTs
Planning Frequency:
Criteria for Plan Sign-off:
Nationally agreed TCS assurance and approvals process as set out in 2010/11.

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
This is a new indicator.

SRF07: % of GPs (a) in pathfinder consortia and (b) in pipeline to become pathfinders

These measures are being designed to measure progress on creating the new commissioning architecture, including the NHS Commissioning Board, commissioning support and new GP consortia. They are not appropriate for planning purposes but will be used in-year to judge progress. The definitions are currently being developed and will be shared (with SHAs) when this work is complete.

SRF08: % of PCT commissioning spend delegated to GP practices

These measures are being designed to measure progress on creating the new commissioning architecture, including the NHS Commissioning Board, commissioning support and new GP consortia. They are not appropriate for planning purposes but will be used in-year to judge progress. The definitions are currently being developed and will be shared (with SHAs) when this work is complete.

SRF09: Running costs per head of pop. delegated from PCTs to consortia for start up costs

These measures are being designed to measure progress on creating the new commissioning architecture, including the NHS Commissioning Board, commissioning support and new GP consortia. They are not appropriate for planning purposes but will be used in-year to judge progress. The definitions are currently being developed and will be shared (with SHAs) when this work is complete.

SRF10: Has SHA completed full analysis of current levels of staffing and arrangements for those region-wide (SHA and PCT) functions, which will transfer to the NHS CB?

These measures are being designed to measure progress on creating the new commissioning architecture, including the NHS Commissioning Board, commissioning support and new GP consortia. They are not appropriate for planning purposes but will be used in-year to judge progress. The definitions are currently being developed and will be shared (with SHAs) when this work is complete.

SRF11: Bookings to Services Where Named Consultant Led Team was Available (Even if Not Selected)

DEFINITIONS
Detailed Descriptor:

Bookings to services where named consultant led team was available (even if not selected)

Lines within Indicator (Units):

For all PCTs:
Numerator: Bookings made through Choose and Book (CAB) to services where there was at least one named clinician listed on the system.

Denominator: All bookings to services made through CAB.

Data Definition:

CAB bookings comprise Unique Booking Reference Numbers (UBRNs) that are converted to a booking into an outpatient service.   Re-bookings are excluded but onward referrals to an outpatient service, eg from an assessment service, are included. Qualifying services are those with at least one named clinician listed (not just allocated).

Basis for Accountability:

 Commissioner. (Data are based on PCT of responsibility).

MONITORING
Monitoring Frequency:

Monthly

Monitoring Data Source:

CAB bookings from data extracted from the CAB system – ATOS daily booking extracts compiled into a bookings database. The CAB Directory of Services shows which of these are for first outpatient appointments and the Named clinicians extract shows which services have named consultants listed.

ACCOUNTABILITY
What success looks like, Direction, Milestones:

All patients should have the opportunity to choose a named clinician for first outpatient appointment from April 2011, even if they do not wish to take that opportunity. The first step is for providers to attach named clinicians to services they

list on CAB and the second is for patients to book into those services.

This indicator should be considered in conjunction with the System indicator, "Use of Choose and Book", to judge success. Success would look like a rapidly increasing % of CAB bookings being made to services where a named consultant-led team was available where there is also a high level of utilisation of Choose and Book overall. A high % on this indicator where utilisation of Choose and Book is low overall would only indicate that where services are listed they are listed against named consultant-led teams.

Timeframe/Baseline:
Not applicable.
Timeframe Until:
Not applicable.
Rationale:
The White Paper, *Equity and excellence: Liberating the NHS*, committed to introducing a choice of named consultant-led team by April 2011 where clinically appropriate. The intention is for everyone who needs to see a consultant to be able to make an appointment with a particular team headed by a named consultant.
SHA Envelopes:
Not applicable.

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Not applicable
Criteria for Plan Sign-off:
Not applicable

FURTHER INFORMATION
Further Information:
The information is given in the Month series sheet of the Weekly CAB bookings report available to the NHS via the following link: www.directory-of-services.info/asplogin
Changes from 2010/11 Planning Round:
This is a new indicator.

SRF12: Proportion of GP Referrals to First OP Appointments Booked Using Choose and Book

DEFINITIONS

Detailed Descriptor:

Proportion of GP referrals to first OP appointments booked using Choose and Book.

Lines within Indicator (Units):

For all PCTs:
Numerator: GP referrals to first outpatient services booked using Choose and Book (CAB) in the period.
Denominator: Total referrals made by GPs to first outpatient services in the period.

Data Definition:

CAB bookings comprise Unique Booking Reference Numbers (UBRNs) that are converted to a booking into an outpatient service. Re-bookings are excluded but onward referrals to an outpatient service, eg from an assessment service, are included.

Total GP referrals comprise written referrals from GPs for first consultant outpatient appointment (all specialties), regardless of whether or not they resulted in an outpatient attendance. Written referrals include electronic messages and those made verbally and confirmed in writing.

Basis for Accountability:

 Commissioner. (Data are based on PCT of responsibility).

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

CAB bookings from data extracted from the CAB system – ATOS daily booking extracts compiled into a bookings database.

GP referrals from the DH Monthly Activity Return, adjusted to remove referrals from General Dental Practitioners based on a percentage advised by the PCT and updated on request.

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Success would be a high percentage of GP referrals to first outpatient appointments being made using Choose and Book. Historically, the ambition was to achieve 90% of GP referrals to first outpatient appointments being made using CAB. Although there is no longer a target for CAB utilisation, this figure may serve as a useful guide for judging success. It should be noted that some referrals may remain outside the scope of CAB.
Timeframe/Baseline:
Not applicable.
Timeframe Until:
Not applicable.
Rationale:
Choose and Book is the electronic referral and booking system that supports patient choice by enabling GPs and patients to navigate through the increasing array of services available to them once a decision has been made to refer to a first consultant outpatient appointment. GPs can search for all secondary care services from across the country (provided by NHS and independent providers under a national contract), alongside all primary care services which are commissioned by their PCT. The patient can then book their appointment there and then in the GP practice or later at a more convenient time via the internet or by telephone.
SHA Envelopes:
Not applicable.

PLANNING REQUIREMENTS
Are Plans Required?:
No.
Planning Frequency:
Not applicable.
Criteria for Plan Sign-off:
Not applicable.

FURTHER INFORMATION
Further Information:
The information is given in the Month series sheet of the Weekly CAB bookings report available to the NHS via the following link: www.directory-of-services.info/asplogin
Changes from 2010/11 Planning Round:
This is a new indicator.

SRF13: Trend in Value/Volume of Patients Being Treated at non-NHS Hospitals
DEFINITIONS
Detailed Descriptor:
Trend in volume of NHS-funded patients being treated at independent sector (non-NHS) facilities (Treatment centres and hospitals)
Lines within Indicator (Units):
For all PCTs: **Volume:** Numerator: GP referrals to first outpatient services at non-NHS providers booked using Choose and Book (CAB) in the period. Denominator: All GP referrals to first OP services booked using CAB.
Data Definition:
CAB bookings comprise Unique Booking Reference Numbers (UBRNs) that are converted to a booking into an outpatient service.   Re-bookings are excluded but onward referrals to an outpatient service, eg from an assessment service, are included. Qualifying services are those to any non-NHS provider.
Basis for Accountability:
Commissioner. (Data are based on PCT of responsibility).

MONITORING
Monitoring Frequency:
Monthly
Monitoring Data Source:
CAB bookings from data extracted from the CAB system – ATOS daily booking extracts compiled into a bookings database.

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Patients should have the opportunity to choose a range of providers for their first outpatient appointment, including those in the Independent sector. This indicator shows a percentage of patients who have exercised choice, since it is likely that an alternative NHS provider was also offered to them. An increasing percentage of CAB bookings being made to the IS may be indicative of more choice being offered to patients.

This indicator should be considered in conjunction with the System indicator, "Use of Choose and Book". Relatively high percentages of CAB bookings being made to the IS may not be indicative of what is happening overall if CAB utilisation is low.

Timeframe/Baseline:
Not applicable.

Timeframe Until:
Not applicable.

Rationale:
Use of the independent sector is viewed as a good proxy measure of the take-up of choice as use of the independent sector implies that an NHS alternative was foregone. The measure is indicative and for benchmarking only as the availability of alternative independent sector providers differs across the country.

SHA Envelopes:
Not applicable.

PLANNING REQUIREMENTS
Are Plans Required?:
No

Planning Frequency:
Not applicable

Criteria for Plan Sign-off:
Not applicable

FURTHER INFORMATION
Further Information:
The information is derived from the Weekly CAB bookings report available to the NHS via the following link: www.directory-of-services.info/asplogin

Changes from 2010/11 Planning Round:
This is a new indicator.

SRF14: Percentage of patients with greater control of their care records

DEFINITIONS
Detailed Descriptor:

% of patients with greater control of their care records

This indicator cannot be reported using current data and so a proxy is to be used for 2011-12. The proxy is "the percentage of GP practices where there is the opportunity for patients to begin to have greater control through on-line access to their primary care records". For more information on why this indicator is included for 2011-12 please see the Rationale section at the end of this document. Links to documents are provided in the Further Information section.

Lines within Indicator (Units):

1. Number of general practices within the PCT who have functionality in place to enable patients to view elements of their own primary care records online

2. Number of general practices within the PCT who have enabled functionality to allow patients to view elements of their primary care record online

3. Total number of general practices within the PCT

Data Definition:

General practices: Practices are as reported on the NHS Connecting for Health Tracking Database i.e. branch surgeries are not counted separately.

Functionality in place to enable patients to view elements of their own primary care records online: The following functionality provides patients with access to view elements of their records online:

1. Access to view/request medication
2. Access to test results and letters
3. Access to a summary or subset of the full medical record
4. Access to a full medical record.

Qualifying functionality is that which enables patients to see all or part of their care record online. Access either to (a) **all three** of the elements of the record identified in points 1, 2 & 3 or (b) to the full medical record as identified in point 4 or (for the avoidance of any doubt) to (c) all four of the elements of the record identified in points 1, 2, 3 & 4 will qualify for this indicator.

General practices that have enabled functionality to allow patients to view elements of their primary care record online: Number of practices where this functionality is available for patients **and in use**. Practices qualify if they have started to give patients access, even if patients are not yet regularly accessing their records.

Total number of general practices within the PCT: The total number of practices in

the PCT on the day of the report.

The indicator reported will be "Number of general practices within the PCT which have enabled functionality to allow patients to view elements of their primary care record online" as a percentage of "Total number of general practices within the PCT"

Line 1- "Number of general practices within the PCT who have functionality in place to enable patients to view elements of their own primary care records online" will be used to identify the current capability for patient access to records within each SHA and PCT. It is acknowledged that at present some PCTs may have little if any capability within their area.

Basis for Accountability:

PCT

MONITORING
Monitoring Frequency:

Quarterly. Report dates 31 March 2011, 30 June 2011, 30 September 2011, 31 December 2011 and 31 March 2012.

Monitoring Data Source:

Line 1 from suppliers. PCTs can infer this from reviewing details of deployed system.

Line 2 from suppliers. PCTs are not able to obtain this information directly.

Line 3 From the Tracking Database.

ACCOUNTABILITY
What success looks like, Direction, Milestones:

This indicator will set the baseline for reporting progress in providing on-line *patient access to their GP held care records* during 2011-12 as a step towards patients being able to exercise greater control of the care records held about them from FY 2012-13 onwards. Any increase in capability will be regarded as a success in FY 2011-12 while acknowledging that many general practices have no opportunity for providing this service to patients until their own information system supplier offers the service. The capability will not be uniform across England.

PCTs will be able to report in more detail on general practice progress in providing patients with access and control of their care records through reports to SHAs as part of the planning and assurance process for 2011-12. Practices with many years experience of offering this service are achieving rates of approx 5-10% of their patients accessing their care records. SHAs and PCTs may want to give general practices that are already offering this service opportunity to provide information

about take-up of the service.

We expect that indicator(s) for 2012-13 onwards may more directly monitor numbers of *patients with greater control of their care records* and new indicators and that any associated standards will be based in part on results of this base-lining activity being carried out in 2011-12.

Timeframe/Baseline:

The baseline for this indicator will be taken on 31 March 2011 and reporting will be quarterly. There is an expectation that there will be an increase in capability and usage but no level of expectation has been set.

Timeframe Until:

The final report in this reporting cycle will be 31 March 2012. This indicator will be reviewed and is likely to be amended to more closely monitor the number of patients with control of their care records through taking a baseline at the start of 2012-13 with regular monitoring thereafter. Commissioners and general practices should start planning for this amended indicator during 2011-12 and more information about it will be made available in due course.

Rationale:

Giving patients greater control of their care records is a headline objective within the White Paper *"Equity and Excellence:- Liberating the NHS"* :

"2.11 We will enable patients to have control of their health records. This will start with access to the records held by their GP and over time this will extend to health records held by all providers. The patient will determine who else can access their records and will easily be able to see changes when they are made to their records. We will consult on arrangements, including appropriate confidentiality safeguards, later this year.

"2.12 Our aim is that people should be able to share their records with third parties, such as support groups for patients, who can help patients understand their records and manage their condition better. We will make it simple for a patient to download their record and pass it, in a standard format, to any organisation of their choice."

The department is consulting on arrangements for greater patient/service user control of records through "*Liberating the NHS: An Information Revolution*" (paragraphs 2.3-2.17 on pages 16-21), which closed on 14 January. A response to the consultation and a plan and timetable to deliver greater patient control of records will be published in April 2011 (see the Department of Health Business Plan page 8 section 1.3 as published on the Number 10 website). We must not pre-judge or compromise the results of the consultation in respect of patient control of records. The proposed baseline indicator for on-line access to GP held patient records will signal that the policy of increasing patients' control of their records is a key one that will be measured, but that this is a first step to be built upon.

We are also constrained by the commitments in the White Paper and the Information

Revolution consultation to reducing the burden of data collection. It is not possible to accurately report on the number of patients with access to or control of their records without significantly increasing the burden of administrative data collection and this increased burden cannot be justified.

In respect of the proposed indicator, suppliers of information systems are able to provide PCTs with information about general practices that have the capability for patients to access their care records (Line 1) and about those that have enabled this functionality (Line 2). Suppliers whose systems do not currently provide this functionality will receive a clear signal that the policy of providing patients with access to and control of their care records, initially GP records but increasingly all care records, is a key policy for the government.

PCTs and SHAs will have opportunity to provide more information about progress towards giving patients greater control of their records (beyond simple on-line view access to primary care records) during the integrated planning and assurance process that the DH is running in conjunction with the NHS from the launch of the Operating Framework in December 2010 to the end of FY 2011-12

As mentioned above, the Department's Business Plan commits us to publishing, in April 2011, a plan and timetable to deliver greater patient control of records. This proxy baseline indicator and information gathered about other services which deliver greater patient control of records will support more detailed planning in relation to general practice.

SHA Envelopes:

Not applicable

PLANNING REQUIREMENTS
Are Plans Required?:

Planning Frequency:

Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:

The White Paper can be downloaded from the Department of Health website at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

The consultation *"Liberating the NHS: An Information Revolution"* is also on the same website at
www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/Informationrevolution/index.htm
(see pages 16-21)

The government response will be published early in FY 2011-12

The Department of Health Business Plan is at http://transparency.number10.gov.uk/transparency/srp/view-srp/41 A standard for a Personalised Information Giving Data Set has just been published.
Changes from 2010/11 Planning Round:
This is a new indicator to support new government policy.

SRF15: Secure Leadership Capacity in Critical Posts in PCTs, Clusters and SHAs

These measures are being designed to measure progress on creating the new commissioning architecture, including the NHS Commissioning Board, commissioning support and new GP consortia. They are not appropriate for planning purposes but will be used in-year to judge progress. The definitions are currently being developed and will be shared (with SHAs) when this work is complete.