Public Health England

NHS

Key performance indicator and pathway standards data submission process 1 April 2017 to 31 March 2018

Diabetic eye screening programme
Abdominal aortic aneurysm screening programme

Updated March 2017

Public Health England leads the NHS Screening Programmes

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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About PHE Screening

Screening identifies apparently healthy people who may be at increased risk of a disease or condition, enabling earlier treatment or better informed decisions. National population screening programmes are implemented in the NHS on the advice of the UK National Screening Committee (UK NSC), which makes independent, evidence-based recommendations to ministers in the four UK countries. The Screening Quality Assurance Service ensures programmes are safe and effective by checking that national standards are met. PHE leads the NHS Screening Programmes and hosts the UK NSC secretariat.

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Contents

Background

Screening key performance indicators (KPIs) were introduced in 2011 for NDESP and 2014 for NAAASP. The KPI measures are selected to define consistent performance measures for a selection of public health priorities. They aim to give a high level overview of the quality of screening services but are not, in themselves, sufficient to quality assure or performance manage screening services.

Pathway standards were established in 2007 for Diabetic Eye Screening (DES) and 2009 for Abdominal Aortic Aneurysm screening (AAA). These standards were developed by the screening programmes and latterly PHE to ensure that the local screening services are delivering high quality services for their local populations and achieving the programme objectives.

The full roll out of the AAA programme across the country and the use of a common software solution ensures that the burden of producing data, for KPIs and pathway standards, is minimal for local screening services. Data will be extracted and compiled centrally by the AAA programme with local screening services having the opportunity to sense check and validate the data before publication.

Movement to a common pathway for DES and the production of a standard performance report has also allowed for a reduction in the burden of producing data for KPIs and pathway standards. Due to different software solutions in use, local screening services will continue to submit data but only once for multiple outputs and data will be collated, processed and analysed centrally.

This document describes the procedures for the submission of data necessary for the production of DES and AAA KPIs and pathway standards reports.

This guidance should be using in conjunction with the national KPI definitions and data submission document (https://www.gov.uk/government/collections/nhs-screening-programmes-national-data-reporting).

Abdominal aortic aneurysm screening

Key performance indicators

KPI	Description	Data source	Responsible for submission
AA2	Coverage of initial screen	National AAA system	AAA programme
AA3	Coverage of annual surveillance screen	National AAA system	AAA programme
AA4	Coverage of quarterly surveillance screen	National AAA system	AAA programme

Timescales for the key performance indicators

Timescales for submitting data are the same as the other national KPIs

Reporting period	Time for sense checking and sign off	Publication date
Q1 (1 April to 30 June)	1 September to 30 September	15 November 2017
Q2 (1 July to 30 September)	1 December to 31 December	14 February 2018
Q3 (1 October to 31 December)	1 March to 31 March	16 May 2018
Q4 (1 January to 31 March)	1 June to 30 June	15 August 2018

KPI submission

The AAA programme will be responsible for extracting the KPI data from SMaRT (Screening Management and Referral Tracking, national IT system).

1.1 The KPI numerator, denominator and percentage will be emailed to each programme co-ordinator/manager to review and sign off as correct and will be copied to the Screening Quality Assurance Service (SQAS) regions for information. **If the local screening service does not raise any concerns regarding the data by the end of the submission window it will be taken that the data is accurate**.

1.2 Concerns regarding data quality should be addressed to the AAA programme at phe.adultscreeningdata@nhs.net. These concerns will be resolved between software supplier, local screening service, SQAS (regions) and the AAA programme as appropriate. Data quality issues could be due to incorrect information entered onto SMaRT, an error with the query or the KPI figure is much higher or lower than previous quarters.

1.3 Once any data quality issues are resolved the data will be amended in the national submission by the AAA programme.

1.4 The data will then be emailed by the AAA programme to the national KPI screening data and information manager for inclusion in the provisional tables at the close of the submission window. Local screening services should share their KPI data with commissioners and screening and immunisation team as soon as it has been signed off.

1.5 Only complete data is published. KPI data is shared with NHS England analytics team with responsibility for screening, one week prior to publication, to perform data analysis to support commissioning, and to SQAS (regions) to support quality assurance (https://www.gov.uk/government/collections/nhs-screening-programmes-national-data-reporting).

1.6 The KPI data will be made publically available on GOV.uk on the publication dates stated above (https://www.gov.uk/government/collections/nhs-screening-programmes-national-data-reporting).

Please note that only complete data will be published. No data will be released if it impinges on data confidentiality and no data will be released if a KPI numerator is less than 5 for an individual quarter. In such cases, the data will be aggregated and published annually.

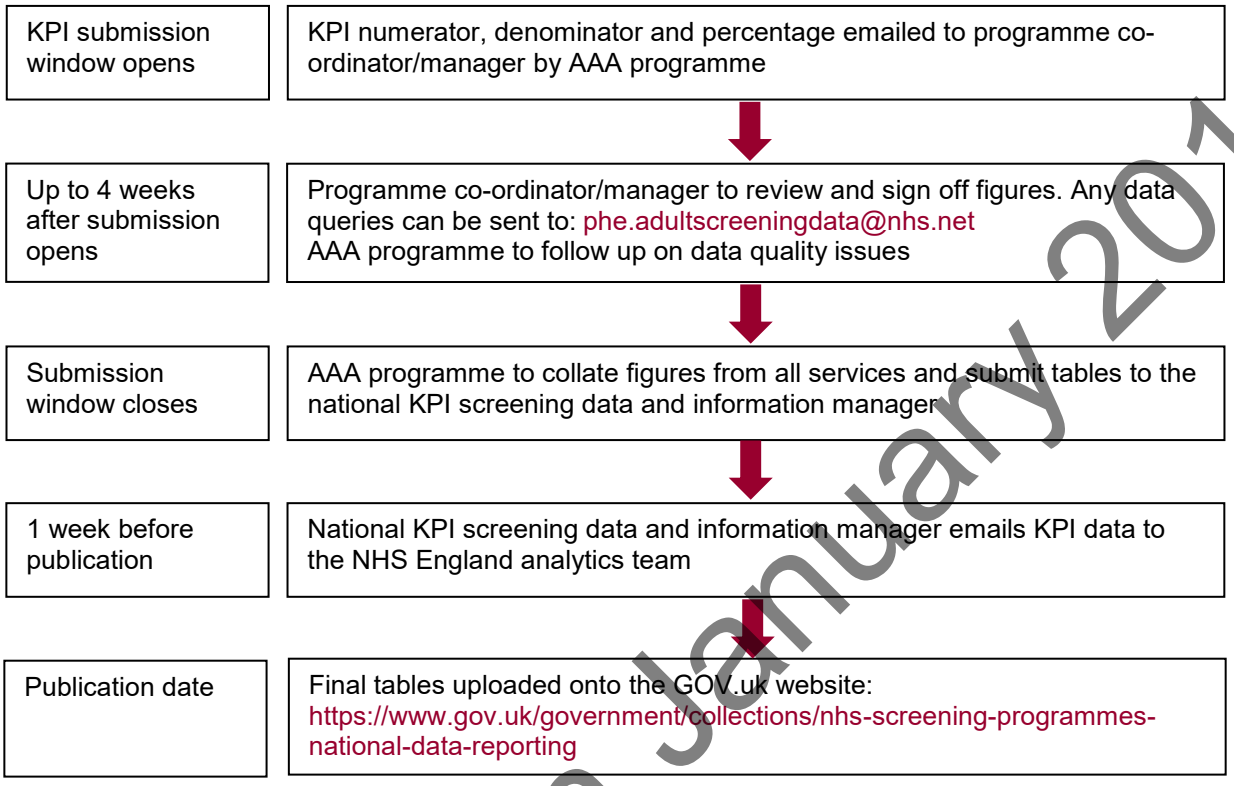
Validating the KPI data

Guidance for checking AA2 (standard 2a) can be found in the guidance for validating the pathway standards (https://www.gov.uk/government/publications/aaa-screening-validate-annual-pathway-standards).

For the AA3 and AA4 data, screening services will be provided with a line list of surveillance appointments due, to aid the validation. Men who are not conclusively tested within the relevant time frames should be reported using the AAA exception report, which will be provided to services via email.

It is recommended that local screening services check the data as soon as possible after it is sent as the data will change on a daily basis. This will minimise differences due to the day on which the queries are run.

Flowchart



Quarterly pathway standards report

Timescales

Reporting period	Run date	Sign off deadline
Q1 (1 April to 30 June)	11 July 2017	1 August 2017
Q2 (1 July to 30 September)	10 October 2017	31 October 2017
Q3 (1 October to 31 December)	9 January 2018	30 January 2018
Q4 (1 January to 31 March)	10 April 2018	1 May 2018

These reports will be produced for each local screening service on a quarterly basis. Due to the long timescales for some of the standards the data extracted and presented will be cumulative across the year. The AAA programme will be responsible for extracting the pathway standards data from SMaRT in the form of a report.

1.1 The pathway standards reports will be uploaded onto SMaRT for local screening services to review in the second week after the end of the reporting quarter. Please note that local screening services will only be able to see their own and national level data due to data sharing restrictions. **If the programme co-ordinator/manager does not raise any concerns within three weeks then it will be taken that the data is accurate**. It is recommended that local screening services check the data as soon as possible after it is sent as the data will change on a daily basis. This will minimise differences due to the day on which the queries are run. A copy of the initial reports will be sent to SQAS (regions).

1.2 Concerns regarding data quality should be addressed to the AAA programme at phe.adultscreeningdata@nhs.net. These concerns will be resolved between software supplier, local screening service, SQAS (regions) and the AAA programme as appropriate.

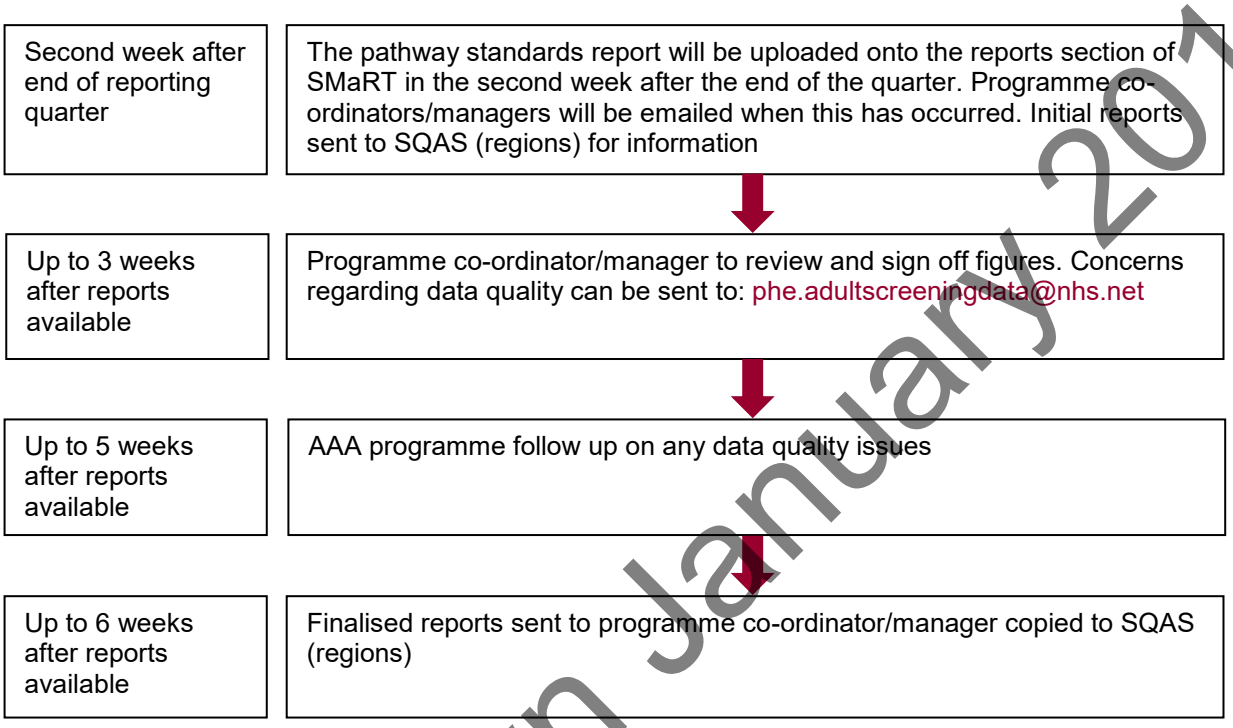
1.3 As SMaRT is a live system it will not be possible to extract the data for the report again, as there may have been significant changes to the underlying data in each programme. However, updated figures will be available in the subsequent reports.

1.4 The finalised report will be emailed by the AAA programme to SQAS (regions).

The pathway standards report should be used for quarterly programme board meetings and to inform discussions between the local screening services and SQAS (regions). It should be noted that the data in the quarterly pathway standards reports will be provisional and only

contains information that can be extracted from SMaRT. It will be the responsibility of the local screening services to disseminate the report to commissioners and screening and immunisation team. We encourage local screening services to share their report as soon as it is signed off.

Flowchart



Annual pathway standards report

The AAA programme will be responsible for extracting the pathway standards data from SMaRT in the form of a report. The annual pathway standards report will be the finalised data for the screening year. The data will be extracted three months after the end of the last quarter so that outcome data will be captured. Local screening services will receive a quarter 4 report in April and should use the time between this and the extraction of annual data in July to ensure the data for the year is accurate and complete.

1.1 The report will be emailed to the local screening service to review and validate where possible using national guidance and copied to SQAS (regions). Local screening services will have three weeks to respond. If no concerns are raised within three weeks the data will be taken as accurate.

1.2 Concerns regarding data quality should be addressed to the AAA programme at phe.adultscreeningdata@nhs.net. These concerns will be resolved between supplier, local screening service, SQAS (regions) and the AAA programme as appropriate.

1.3 Once data quality issues are resolved the data will be extracted from SMaRT again and the report updated so that the changes are reflected.

Finalised reports will be emailed to the programme co-ordinator/manager and relevant SQAS (regions). It will be the responsibility of the local screening services to disseminate the report to commissioners and screening and immunisation team. We encourage local screening services to share their report as soon as it is signed off. The annual pathway standards reports can be used to support the quality assurance visits and Programme Board meetings.

Waiting times for treatment tracker

Timescales for the trackers

Reporting period	Deadline for updating SMaRT	Date tracker available on SMaRT	Time for validation by services	Time for validation by SQAS (regions)
Q1 (1 April to 30 June)	1 September 2017	5 September 2017	5 to 12 September 2017	12 to 19 September 2017
Q2 (1 July to 30 September)	1 December 2017	5 December 2017	5 to 12 December 2017	12 to 19 December 2017
Q3 (1 October to 31 December)	2 March 2018	6 March 2018	6 to 13 March 2018	13 to 20 March 2018
Q4 (1 January to 31 March)	1 June 2018	5 June 2018	5 to 12 June 2018	12 to 19 June 2018

The trackers are run on the first Tuesday three months after the end of the quarter. This ensures that local screening services have three months to complete information on referrals made each quarter. The reports are run on Tuesdays following a weekly update of the database. The data needs to be entered by close of play on the Friday preceding the running of the reports to ensure that the snapshot of the database includes the most up to date data.

1.1 Local screening services should ensure that records for men referred to surgery are kept as up to date as possible. Delays for attendance at specialist assessments and for surgery should be recorded when the information becomes available to the service. Guidance on the completing the relevant sections of SMaRT is available in the AAA SMaRT user release notes v9.1, which is available in the support section of SMaRT.

1.2 The AAA programme will email the programme coordinator/managers on the date that the tracker reports are available in the report section of SMaRT.

1.3 The programme coordinator/manager will have one week to review the data in the report against local information. If any discrepancies are identified the record in SMaRT should be amended accordingly. The change in SMaRT will be captured for subsequent reports. The programme coordinator/manager should also amend an Excel version of the tracker report and send this amended version to their regional SQAS and the AAA programme (email addresses below). If there are no amendments to be made, the original version of the file should be sent to relevant

SQAS (regions) and AAA programme stating that no changes have been made. Reports should be sent on the last day of the service validation period at the latest.

1.4 Upon receipt of the tracker report SQAS (regions) and the AAA programme will review the figures and liaise with local screening services if there are queries regarding the information provided.

SQAS (regions): phe.northqa@nhs.net
phe.midsandeastqa@nhs.net
phe.southqa@nhs.net
phe.londonqa@nhs.net

Data submissions to the AAA programme: phe.adultscreeningdata@nhs.net

Flowchart

2 weeks before the tracker report available	AAA programme data and information manager sends email to programme co-ordinator/manager with a reminder of the deadline for updating SMaRT
Report available	The tracker report will be uploaded onto the reports section of SMaRT on the first Tuesday three months after the end of the quarter (see timetable). Programme co-ordinators/managers will be emailed when this has occurred
Up to 1 week after report is available	Local screening service reviews and validates tracker report. Upon identification of errors the record on SMaRT should be updated and the Excel version of the tracker report amended The finalised report for every service should be sent to the relevant SQAS (regions) inbox and the AAA programme via phe.adultscreeningdata@nhs.net
Up to 2 weeks after report is available	SQAS (regions) and AAA programme data and information manager to review validated reports and follow up on any queries, for example data quality issues

Diabetic eye screening

Key performance indicators

KPI	Description	Data source	Responsible for submission
DE1	Uptake of routine digital screening encounter	Local screening service	DES programme
DE2	Results issued within three weeks of screening	Local screening service	DES programme
DE3	Timely consultation for R3A screen positive	Local screening service or source from ophthalmology provider trust(s)	DES programme

Timescales for the key performance indicators

Timescales for submitting data will remain the same as the other national KPIs

Reporting period	Time for submission of PPRs and sign off	Publication date
Q1 (1 April to 30 June)	1 September to 30 September	15 November 2017
Q2 (1 July to 30 September)	1 December to 31 December	14 February 2018
Q3 (1 October to 31 December)	1 March to 31 March	16 May 2018
Q4 (1 January to 31 March)	1 June to 30 June	15 August 2018

KPI submission

1.5 When the data submission window opens, the local screening service should run three programme performance reports from their system. One for the reporting period quarter and one for the 12 months ending in the reporting period quarter, for example 1 July to 30 September 2017 and 1 October 2016 to 30 September 2017. The second 12 month report is needed because DE1 is over a rolling 12 month period. The third report is for the previous quarter is required to calculate the routine referral standards for the quarterly report, for example 1 April to 30 June 2017. For local screening services using EMIS software this is the “Programme Performance Report”; for those using HISL software it is the “NDESP

Performance Report" query. **Local screening services are not required to submit any other system specific reports to the DES programme.**

1.6 The programme manager and clinical lead should review the data prior to submission in accordance with any locally agreed arrangements. Note, anonymised versions of trackers can be submitted to support referral standards.

1.7 The reports should be emailed by the local screening service to the DES programme using the following generic address: phe.adultscreeningdata@nhs.net.

1.8 Any non-responders after two weeks of the submission window opening will be followed up by the DES programme.

1.9 The KPI numerators, denominators and percentages will be sent via email from the DES programme to the programme manager and clinical lead to review and sign off their individual figures. Commissioners should be made aware of the figures prior to sign off either by email at programme board. The KPIs will be copied to SQAS (regions) for information.

1.10 **Local screening services will have two weeks to review and sign off the figures and raise any issues regarding the accuracy of the data. If no response is received within two weeks the data will be accepted as accurate**.

1.11 Concerns regarding data quality should be addressed to the DES programme at phe.adultscreeningdata@nhs.net. These concerns will be resolved between supplier, local screening service, SQAS (regions) and the DES programme as appropriate. Data quality issues could include two successive KPIs from one service having the same numerator and denominator; the KPI figure is much higher or lower than previous quarters; no data is submitted or file received contains no data.

1.12 Once data quality issues are resolved, local screening services will run the performance reports again and send to the DES programme so that the changes are reflected in the extracted data.

1.13 The data will be processed again by the DES programme and signed off with the programme manager and clinical lead. The DES programme will then send the final figures to the national KPI screening data and information manager on the last day of the submission window.

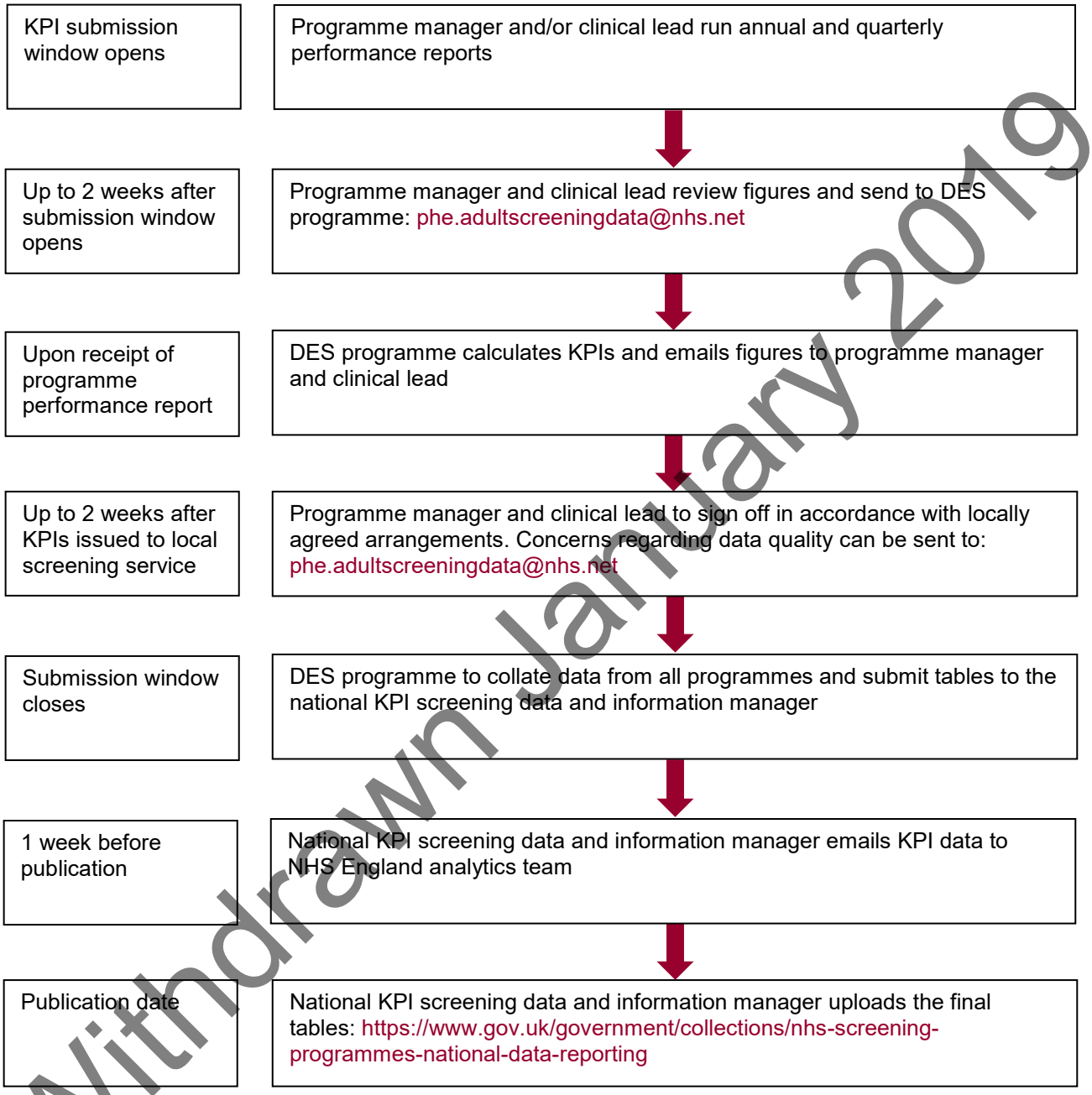
1.14 Only complete data is published. KPI data is shared with NHS England analytics team with responsibility for screening, one week prior to publication, to perform

data analysis to support commissioning, and to SQAS (regions) to support quality assurance (https://www.gov.uk/government/collections/nhs-screening-programmes-national-data-reporting).

1.15 The KPI data will be made publically available on GOV.uk on the publication dates stated above (https://www.gov.uk/government/collections/nhs-screening-programmes-national-data-reporting). Please note that DE3 will continue to be collected quarterly but only published annually.

Please note that only complete data will be published. No data will be released if it impinges on data confidentiality and no data will be released if a KPI numerator is less than 5 for an individual quarter. In such cases, the data will be aggregated and published annually.

Flowchart



Process for producing quarterly pathway standards reports

These reports will be produced for each local screening services for quarters 1 to 4 using the performance reports submitted for the KPIs and an additional report for the previous quarter to cover the routine referrals, which have a longer time frame for consultation and treatment.

The data is extracted for the relevant time periods as per steps 1.1 to 1.4 above. However, the programme manager and clinical lead may wish to review the additional data fields contained in the Programme Performance Report that will be used to calculate the pathway standards.

1.5 Individual quarterly pathway standards reports, for each local screening service, will be produced from the performance reports supplied for the KPIs.

1.6 The quarterly pathway standard report will be sent along with the KPIs to each programme manager and clinical lead to sign off and copied to SQAS (regions) for information. Concerns regarding data quality should be sent to: phe.adultscreeningdata@nhs.net. **If no concerns are raised within three weeks it will be accepted that the data is accurate.** Please note that the screening to treatment timeline tracker can be used to validate the referral information and tracker figures used if they are more accurate.

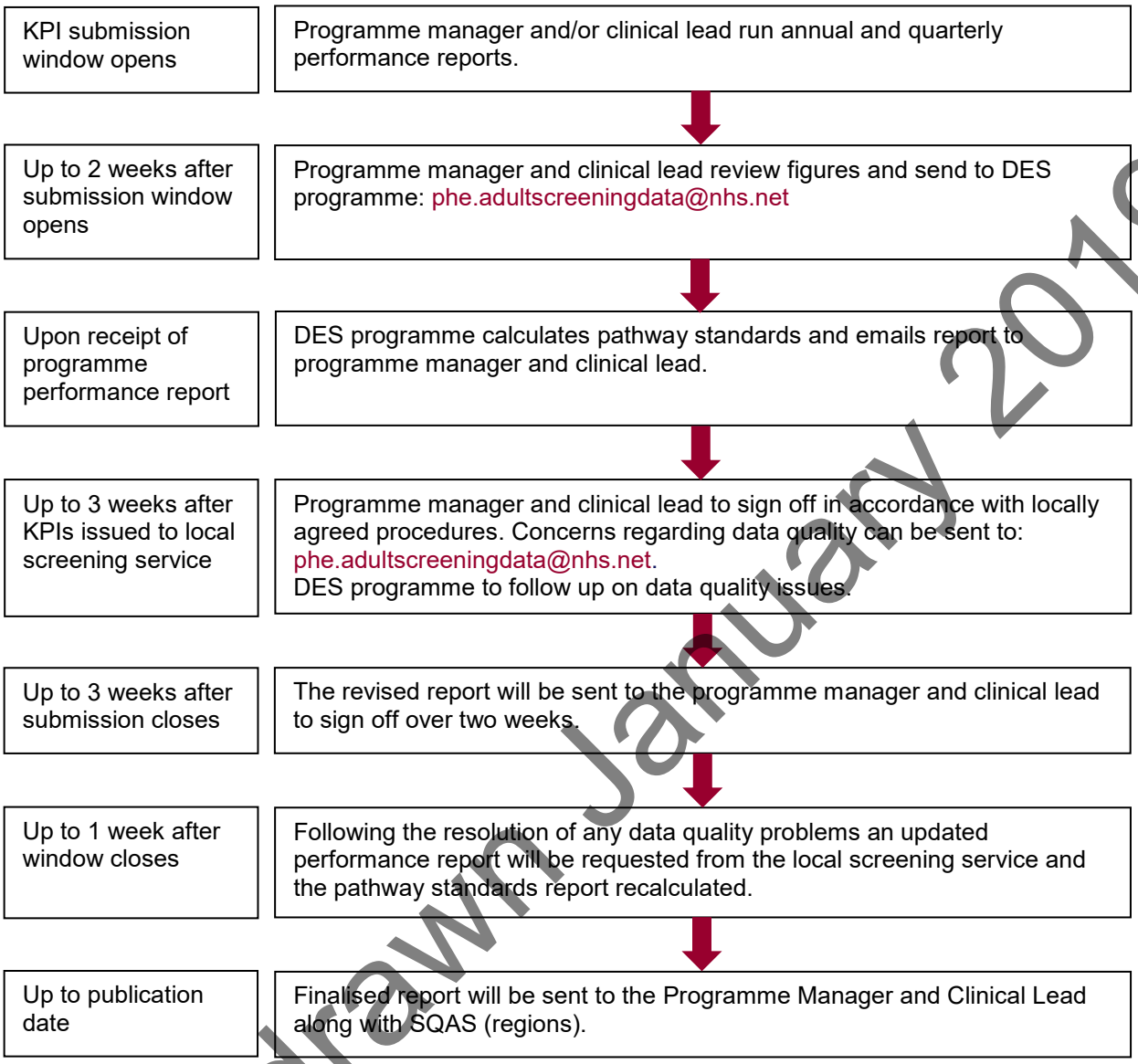
1.7 Concerns regarding data quality will be resolved between supplier, local screening service, SQAS (regions) and the DES programme as appropriate.

1.8 Once data quality issues are resolved, the local screening service will run the performance reports again and send to the DES programme so that any changes are reflected.

1.9 The finalised pathway standards report will be sent to programme managers and the relevant SQAS (regions) by the KPI publication date.

The report can then be used for quarterly programme board meetings and to inform discussions between the local screening services and SQAS (regions). It should be noted that the data in the quarterly pathway standards reports will be provisional and that only standards that can be reported on quarterly will be included. It will be the responsibility of the local screening services to disseminate the report to commissioners and screening and immunisation team. We encourage local screening services to share their report as soon as it is provided.

Flowchart



Process for producing annual pathway standards reports

These reports will be produced for each local screening service on an annual basis to cover the screening year and will include information on all standards.

Local screening services will be required to submit one Programme Performance Report or NDESP Performance Report by 31 October for the preceding financial year to allow for non-attendances and the longest recommended times between diagnosis and treatment. This will be in addition to the quarterly reports extracted in September and December.

Data will be produced as per steps 1.1 to 1.8 for the quarterly pathway standards.

The finalised report will be emailed to the programme manager and relevant SQAS (regions) by 31 December.

It will be the responsibility of the local screening services to disseminate the report to commissioners and screening and immunisation team. We encourage local screening services to share their report as soon as it is signed off. The report can be used to support the assessment of local screening service at their quality assurance visits.