

**Performance assessment 2009/10****Indicators for acute and specialist trusts**

The Care Quality Commission has published the first and second phases of the 2009/10 periodic review indicator constructions, which have now been formally approved. The remaining indicator constructions will be published as soon as they are approved.

Each indicator includes details of why it is included (the 'rationale'), the data source, the period of time assessed by the indicator (the 'data period'), and the technical specification (the 'indicator').

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Indicator name	Existing commitment	National priority
<a href="#">Waiting times for Rapid Access Chest Pain Clinic</a>	✓	

**Performance assessment 2009/10****18 week referral to treatment times****Rationale**

The NHS Improvement Plan (June 2004) set out the requirement that, by December 2008, there would be a maximum acceptable waiting time of 18 weeks from referral to start of hospital treatment. In 2009/10 trusts will be expected to maintain a maximum waiting time of 18 weeks from referral to start of treatment for 90% of admitted patients and 95% of non-admitted patients.

Trusts will be assessed on having maintained this performance during each quarter of the assessment year (April 2009 to March 2010) and in each of the treatment functions over the year. The treatment functions have been defined by the Department of Health and are specified in the data collection. Trusts will also be assessed against an 18 week maximum wait for direct access audiology patients, which will be included in the overall assessment. These are patients referred into audiology services without a consultant, and who are outside the scope of the 18 week target but are included as a supporting measure in the 'Vital Signs', as set out in the 2009/10 NHS Operating Framework.

A data quality test using the Department of Health's data completeness methodologies for both the Referral to Treatment Times collection and the Direct Access Audiology collection will be applied prior to use of the data, assessed over the whole year. Failure of the data quality test for either admitted or non-admitted patients (including direct access audiology) will result in the relevant part (indicators 1 to 4 and 9 or 5 to 9) being validated as 'Data not returned' and is likely to lead to failure of the overall indicator.

**Numerator 1**

The number of patients who were admitted in April to June 2009 who waited 18 weeks or less, reported in the referral to treatment times data collection.

**Denominator 1**

The total number of patients who were admitted in April to June 2009, reported in the referral to treatment times data collection.

**Indicator 1**

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

**Numerator 2**

The number of patients who were admitted in July to September 2009 who waited 18 weeks or less, reported in the referral to treatment times data collection.

**Denominator 2**

The total number of patients who were admitted in July to September 2009, reported in the referral to treatment times data collection.

**Indicator 2**

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

**Numerator 3**

The number of patients who were admitted in October to December 2009 who waited 18 weeks or less, reported in the referral to treatment times data collection.

**Denominator 3**

The total number of patients who were admitted in October to December 2009, reported

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in the referral to treatment times data collection.

**Indicator 3**

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

**Numerator 4**

The number of patients who were admitted in January to March 2010 who waited 18 weeks or less, reported in the referral to treatment times data collection.

**Denominator 4**

The total number of patients who were admitted in January to March 2010, reported in the referral to treatment times data collection.

**Indicator 4**

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

**Numerator 5**

The number of non-admitted patients with completed pathways in April to June 2009 who waited 18 weeks or less, reported in the referral to treatment times data collection plus the number of direct access audiology patients with completed pathways in April to June 2009 who waited 18 weeks or less, reported in the direct access audiology waiting times collection.

**Denominator 5**

The total number of non-admitted patients with completed pathways in April to June 2009, reported in the referral to treatment times data collection, plus the total number of direct access audiology patients with completed pathways in April to June 2009, reported in the direct access audiology waiting times collection.

**Indicator 5**

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

**Numerator 6**

The number of non-admitted patients with completed pathways in July to September 2009 who waited 18 weeks or less, reported in the referral to treatment times data collection plus the number of direct access audiology patients with completed pathways in July to September 2009 who waited 18 weeks or less, reported in the direct access audiology waiting times collection.

**Denominator 6**

The total number of non-admitted patients with completed pathways in July to September 2009, reported in the referral to treatment times data collection, plus the total number of direct access audiology patients with completed pathways in July to September 2009, reported in the direct access audiology waiting times collection.

**Indicator 6**

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

**Numerator 7**

The number of non-admitted patients with completed pathways in October to December 2009 who waited 18 weeks or less, reported in the referral to treatment times data collection plus the number of direct access audiology patients with completed pathways in October to December 2009 who waited 18 weeks or less, reported in the direct access audiology waiting times collection.

**Performance assessment 2009/10****Denominator 7**

The total number of non-admitted patients with completed pathways in October to December 2009, reported in the referral to treatment times data collection, plus the total number of direct access audiology patients with completed pathways in October to December 2009, reported in the direct access audiology waiting times collection.

**Indicator 7**

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

**Numerator 8**

The number of non-admitted patients with completed pathways in January to March 2010 who waited 18 weeks or less, reported in the referral to treatment times data collection plus the number of direct access audiology patients with completed pathways in January to March 2010 who waited 18 weeks or less, reported in the direct access audiology waiting times collection.

**Denominator 8**

The total number of non-admitted patients with completed pathways in January to March 2010, reported in the referral to treatment times data collection, plus the total number of direct access audiology patients with completed pathways in January to March 2010, reported in the direct access audiology waiting times collection.

**Indicator 8**

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

**Numerator 9**

The number of treatment functions achieving the 90% standard for admitted patients plus the number of treatment functions achieving the 95% standard for non-admitted and direct access audiology patients during the year, reported on the referral to treatment times collection and the direct access audiology waiting times collection.

**Denominator 9**

The total number of treatment functions for admitted patients plus the total number of treatment functions for non-admitted and direct access audiology, reported on the referral to treatment times collection and the direct access audiology waiting times collection.

**Indicator 9**

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

**Overall Indicator**

The results will be combined in a matrix to determine an overall level of performance.

**Note**

The Department of Health's 18 weeks performance sharing methodology will be applied to referral to treatment times data, which enables breaches of patients who have been referred on from one provider to another to be shared equally between the reporting provider and the previous provider on the patient pathway.

**Data source and period**

National Direct Access Audiology Waiting Times Dataset (financial year 2009/10)  
National referral to treatment time data collection (financial year 2009/10)

**Performance assessment 2009/10****Access to GUM clinics****Rationale**

Annual numbers of sexually transmitted diseases diagnosed in genito-urinary medicine (GUM) clinics in England rose by 43% between 1996 and 2002, with an overall increase in clinic workload of 79% for the same period. The white paper, 'Choosing health: making healthier choices easier' (Department of Health, 2004), included a number of commitments, including improved access to GUM clinics, and efficient and convenient screening services.

The good practice guide, 'Genitourinary Medicine 48-hour Access: Getting to target and staying there' (Department of Health, 2008) included recommendations to support clinics to reach the GUM 48 hour access target by March 2008 and maintain their levels of access.

Guaranteed access to a genito-urinary medicine clinic within 48 hours of contacting a service remains an existing commitment in the 2009/10 NHS Operating Framework.

**Numerator**

The actual total number of first attendances at a GUM service who were offered an appointment to be seen within 48 hours of contacting a service.

**Denominator**

The actual total number of first attendances at the GUM service.

**Indicator**

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

**Note**

This indicator relates to the offer of an appointment for the patient to be seen within 48 hours of contacting the service rather than an offer of an appointment that is made within 48 hours of contacting the service but to be seen at a later date.

Contact is any request to be seen by the GUM service, whether by GP referral, self-referral in person, by letter or by phone.

**Data source and period**

Department of Health GUM clinics waiting times collection (financial year 2009/10 (quarters 1 to 4))

**Performance assessment 2009/10****Access to healthcare for people with a learning disability****Rationale**

Equality in access to healthcare is central to the delivery of healthcare. The Independent Inquiry into Access to Healthcare for People with learning Disabilities, led by Sir Jonathan Michael, published its findings 'Healthcare for all' on 29<sup>th</sup> July 2008.

The inquiry was ordered following Mencap's 'Death by indifference' report, which told the stories of six people with a learning disability who died while in NHS care. The Inquiry sought to identify the action needed to ensure adults and children with learning disabilities receive appropriate treatment in acute and primary healthcare in England.

Central to the development of these performance indicators is adherence to the Human Rights Act 1998 and the Disability Discrimination Act 1995, to ensure equality of access and equity for all people with learning disabilities and that a human rights approach is adopted by the NHS and that 'reasonable adjustments' are made in the delivery of services to reduce health inequalities.

This indicator will seek to respond to the recommendations made in the Inquiry report for providers, specifically around the collection of data and information necessary to allow people with a learning disability to be identified and the arrangements trusts have in place to ensure the views and interests of people with learning disabilities and their carers are included in the planning and development of services.

**Indicator****NOTE**

This indicator will not be included in the scored assessment for 2009/10. However, trusts will be expected to collect the requisite information and report on it separately and we will publish this along side the results of the review to ensure visibility.

Trusts will be assessed on their responses to the following six questions, based on the recommendations set out in 'Healthcare for all' (2008) – the Independent Inquiry into Access to Healthcare for People with learning Disabilities. For each question, a response of 1 to 4 is required depending upon the extent to which plans and protocols are in place and are fully implemented for all aspects of each question.

The scoring guide for all questions (except question 2) is as follows:

- (1) = Protocols/mechanisms are not in place.
- (2) = Protocols/mechanisms are in place but have not yet been implemented.
- (3) = Protocols/mechanisms are in place but are only partially implemented.
- (4) = Protocols/mechanisms are in place and are fully implemented.

1. Does the trust have a mechanism in place to identify and flag patients with learning disabilities\* and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? (1-4)

2. In accordance with the Disability Equality Duty of the Disability Discrimination Act (2005), does the trust provide readily available and comprehensible information\*\*

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(jointly designed and agreed with people with learning disabilities, representative local bodies and/or local advocacy organisations) to patients with learning disabilities about the following criteria:

- treatment options (including health promotion)
- complaints procedures, and
- appointments

Scoring:

1. Accessible information not provided
2. Accessible information provided for one of the criteria
3. Accessible information provided for two of the criteria
4. Accessible information provided for all three of the criteria.

3. Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities, including the provision of information regarding learning disabilities, relevant legislation\*\*\* and carers' rights? (1-4)

4. Does the trust have protocols in place to routinely include training on learning disability awareness, relevant legislation\*\*\*, human rights, communication techniques for working with people with learning disabilities and person centred approaches in their staff development and/or induction programmes for all staff? (1-4)

5. Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers within Trust Boards, local groups and other relevant forums, which seek to incorporate their views and interests in the planning and development of health services? (1-4)

6. Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? (1-4)

\* Learning disabilities (Valuing People, 2001) include the presence of:

1. A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
2. A reduced ability to cope independently (impaired social functioning);
3. which started before adulthood, with a lasting effect on development.

\*\*As described in the Mental Capacity Act (2007), organisations should take 'all practicable steps' to present information in a way that is appropriate to the person's circumstances.

\*\*\*To include the Mental Capacity Act (2007), the Disability Discrimination Act (1995) and the Carers Act (1995)

**Data source and period**

Care Quality Commission special data collection (as at 31st March 2010)

**Performance assessment 2009/10****All cancers: one month diagnosis (decision to treat) to treatment including new cancer strategy commitment****Rationale**

The NHS Cancer Plan set the ultimate goal that no patient should wait longer than one month (31 days) from diagnosis of cancer to the beginning of treatment, except for good clinical reasons.

The publication of the Cancer Reform Strategy, in December 2007, set new, more ambitious standards for the NHS. Specifically for the one month wait, the standard was widened to cover all cancer treatments, including second and subsequent treatments and treatment for recurrence of cancer, with achievement of this for all patients receiving surgery or drug treatment required by December 2008.

The expansion of the standard to incorporate radiotherapy treatment is required to be achieved by December 2010, and therefore during 2009/2010 trusts will need to continue to work to ensure that capacity is in place to achieve this.

**Numerator 1**

The number of patients receiving their first definitive treatment within one month (31 days) of a decision to treat (as a proxy for diagnosis) for cancer

**Denominator 1**

The total number of patients receiving their first definitive treatment for cancer

**Indicator 1**

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

**Numerator 2**

The number of patients receiving subsequent treatment (surgery and drug treatment only) within one month (31 days) of a decision to treat

**Denominator 2**

The total number of patients receiving subsequent treatments (surgery and drug treatment only)

**Indicator 2**

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

**Overall Indicator**

These measures will be combined in a matrix to determine a level of performance

**Note**

Four quarterly data submissions are required within the specified deadlines (the 25th working day after the end of each quarter). Data will also be tested to assess whether the relevant activity is covered in the submitted data. Services should be aware that if data are not of sufficient quality they will be penalised. Please note that for subsequent treatments this assessment will cover all treatment modalities including radiotherapy.

**Data source and period**

Cancer waits database (financial year 2009/10)

**Performance assessment 2009/10****All cancers: two month urgent referral to treatment  
(including new cancer strategy commitment)****Rationale**

The NHS Cancer Plan set the ultimate goal that no patient should wait longer than two months (62 days) from a GP urgent referral for suspected cancer to the beginning of treatment, except for good clinical reasons.

The publication of the Cancer Reform Strategy, in December 2007, set new, more ambitious standards for the NHS. Specifically for the two month wait, the standard was widened to cover both referrals from the national screening programmes and from consultants where they request that the patient is managed on the two month pathway. Both these enhancements to the target were due to be met by December 2008. In 2009/2010 trusts will be assessed on maintaining achievement of the new enhancements while continuing to meet the existing commitment on GP urgent referrals.

**Numerator 1**

The number of patients receiving their first definitive treatment for cancer within two months (62 days) of GP or dentist urgent referral for suspected cancer

**Denominator 1**

The total number of patients receiving their first definitive treatment for cancer following an urgent GP or dentist referral for suspected cancer

**Indicator 1**

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

**Numerator 2**

The number of patients receiving their first definitive treatment for cancer within two months (62 days) of urgent referral from the national screening service

**Denominator 2**

The total number of patients receiving their first definitive treatment for cancer following an urgent referral from the national screening service

**Indicator 2**

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

**Numerator 3**

The number of patients receiving their first definitive treatment for cancer within two months (62 days) of urgent referral from a consultant (consultant upgrade) for suspected cancer

**Denominator 3**

The total number of patients receiving their first definitive treatment for cancer following an urgent referral from a consultant (consultant upgrade) for suspected cancer

**Indicator 3**

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

**Overall Indicator**

### **Performance assessment 2009/10**

These measures will be combined in a matrix to determine a level of performance

#### **Note**

Four quarterly data submissions are required within the specified deadlines (the 25th working day after the end of each quarter). Data will also be tested to assess whether the relevant activity is covered in the submitted data. Services should be aware that if data are not of sufficient quality they will be penalised. As in previous years, where a patient has been transferred between more than one provider and treated after the 62 day target has elapsed, the Care Quality Commission will be operating a facility to enable breaches to be reallocated where agreement between all trusts concerned has been reached.

#### **Data source and period**

Cancer waits database (financial year 2009/10)

**Performance assessment 2009/10****All cancers: two week wait****Rationale**

The NHS Cancer Plan set the ultimate goal that by 2008 no patient should wait longer than one month from an urgent referral for suspected cancer to the beginning of treatment except for good clinical reasons. A series of staged milestones and targets were set out between 2000 and 2005 including "a maximum two week wait from an urgent GP referral for suspected cancer to date first seen for suspected cancers by end of 2000".

The publication of the Cancer Reform Strategy, in December 2007, set new, more ambitious standards for the NHS. Specifically for the two week wait, all referrals with breast symptoms, regardless of whether cancer is suspected, will be subject to a maximum two week wait, with full implementation expected by the end of December 2009. Within its scored assessments, the Care Quality Commission will retain its requirement for trusts to maintain the existing commitment on urgent referral to first outpatient appointment.

**Numerator 1**

The number of patients first seen by a specialist within two weeks when urgently referred by their GP or dentist with suspected cancer, April 2009 to March 2010

**Denominator 1**

The total number of patients first seen by a specialist when urgently referred by their GP or dentist with suspected cancer, April 2009 to March 2010

**Indicator 1**

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

**Numerator 2**

The number of patients first seen by a specialist within two weeks when urgently referred by their GP with any breast symptom except suspected cancer, January to March 2010

**Denominator 2**

The number of patients first seen by a specialist when urgently referred by the GP with any breast symptom except suspected cancer, January to March 2010

**Indicator 2**

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

**Overall Indicator**

These measures will be combined in a matrix to determine a level of performance

**Note**

This indicator includes all urgent referrals whether received within 24 hours or not, and whether or not referred using Choose and Book. Services should be aware that if data are not of sufficient quality they will be penalised. Four quarterly data submissions are required within the specified deadlines (the 25th working day after the end of each quarter).

**Data source and period**

Cancer waits database (financial year 2009/10)

**Performance assessment 2009/10****Cancelled operations and those not admitted within 28 days****Rationale**

The NHS Plan (published in July 2000) states that patients will have the right to redress when things go wrong. When a patient's operation is cancelled by the hospital on the day of admission, or later, for non-clinical reasons, the hospital will have to offer another binding date to treat the patient within a maximum of 28 days or fund the patient's treatment at the time and hospital of the patient's choice. This continues to be a standard which should be maintained by the NHS, as set out in the 2009/10 NHS Operating Framework.

Cancelled operations are defined as those which have been cancelled by the trust for non-clinical reasons on the day of admission or later.

**Numerator 1**

The number of patients whose operation was cancelled, by the hospital, for non-clinical reasons, on the day of or after admission.

**Denominator 1**

The total number of general and acute first finished consultant episodes (FFCEs) for elective activity (inpatient ordinary and day case admissions) in 2009/10 using cumulative figures reported in the March 2010 monthly monitoring return.

**Indicator 1**

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

**Numerator 2**

The number of patients whose operation was cancelled, by the hospital, for non-clinical reasons, on the day of or after admission, who were not treated within 28 days.

**Denominator 2**

The number of patients whose operation was cancelled, by the hospital, for non-clinical reasons on the day of or after admission.

**Indicator 2**

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

**Overall Indicator**

The results from both indicators will be combined in a matrix to determine a level of performance. Trusts will be expected to perform well on both parts in order to achieve the overall indicator.

**Data source and period**

Monthly activity return (financial year 2009/10)  
QMCO quarterly monitoring (financial year 2009/10)

**Performance assessment 2009/10****Data quality on ethnic group****Rationale**

In order to monitor the reduction of health inequalities related to ethnic diversity, it is essential that data sources used for this purpose include adequate information on ethnic group. This indicator underpins local and national monitoring of performance against the target. Service planning and delivery must be appropriate for the needs of local communities to reduce barriers to healthcare. Data should be used to monitor if there are unequal outcomes between different ethnic groups, and public authorities have a statutory obligation to promote greater equality and to prevent direct and indirect discrimination. In addition to providing crucial information to support individualised patient care which takes account of the different risks of disease and the cultural appropriateness of services, good quality data on patient ethnicity are essential at a population level for service planning and to monitor progress on health inequalities across ethnic group.

**Numerator**

The number of Finished Consultant Episodes (FCEs) for the trust on Hospital Episode Statistics (HES) data with valid 2001 census coding for ethnic category (excluding 'not stated' and 'not known').

**Denominator**

The number of FCEs for the trust on HES.

**Indicator**

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

**Note**

HES data for the indicator will be sourced from Secondary Uses Service (SUS). We intend to use HES data relating to April to December 2009 which will be available from the month 9 provider submission deadline on 22 January 2010. The Care Quality Commission retains the right to use data from any provider submission deadline from 22 January 2010 and to assess all trusts using data from that provider submission deadline. Provider submission deadlines, including the month 9 deadline, are published by the Information Centre on their website:

<http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=229>

Trusts with insufficient activity in their data for April 2009 to December 2009 will be penalised. The target excludes birth episodes and other birth events (episode types 3 and 6). For further details on the ethnic categories please see the data set change notice (DSCN) 21/2004:

<http://www.connectingforhealth.nhs.uk/dscn/dscn2004/212004.pdf> (opens new window)

**Data source and period**

Hospital Episodes Statistics (April to December 2009)

**Performance assessment 2009/10****Delayed transfers of care****Rationale**

This indicator measures the impact of community-based care in facilitating timely discharge from hospital and the mechanisms in place within the hospital to facilitate timely discharge. People should receive the right care in the right place at the right time and primary care trusts must ensure, with acute trusts and social services partners, that people move on from the acute environment once they are safe to transfer. The Community Care (Delayed Discharges, etc) Act 2003 facilitates joint working with social services and requires partners to identify the causes of delay, and implement the actions required to tackle delays within their local system. Although this is an all-adult indicator the vast majority of those delayed are patients aged over 75 years.

The 2009/10 NHS Operating Framework reiterates that this target should continue to be maintained.

**Numerator**

The number of acute patients (aged 18 and over) whose transfer of care was delayed each week, summed across April to December of 2009/10.

**Denominator**

The number of acute patients (aged 18 and over) who were admitted to the trust each week, summed across April to December of 2009/10.

**Indicator**

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

**Note**

The numerator uses weekly SitReps snapshot data (number of acute patients whose transfer of care is delayed on each Thursday) from April to December 2009 provided by the Department of Health. The denominator uses 2009/10 HES data to calculate the number of admitted acute patients at the point of each weekly SitReps snapshot (i.e. for each week, the number of acute patients admitted any time before, and discharged after, each Thursday snapshot). HES data for the indicator will be sourced from Secondary Uses Service (SUS). We intend to use HES data relating to April to December 2009, which will likely be taken from the month 9 provider submission deadline on 22 January 2010. However, the Care Quality Commission retains the right to use data from any provider submission deadline from 22 January 2010 onwards and to assess all trusts using data from that provider submission deadline. Provider submission deadlines, including the month 9 deadline, are published by the Information Centre on their website:

<http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=229>

**Data source and period**

Department of Health SitReps (April to December 2009)

Hospital Episode Statistics (HES) (April to December 2009)

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# Experience of patients

### **Rationale**

The 2009/10 NHS Operating Framework requires each NHS trust to obtain feedback from patients about their experience of care. The Care Quality Commission will use data from its ongoing programme of patient surveys to calculate this indicator.

### **Indicator**

Selected questions from the inpatient survey will be used to calculate an overall score for this indicator.

### **Data source and period**

Care Quality Commission emergency and elective inpatient survey (fieldwork to be undertaken in autumn 2009)

**Performance assessment 2009/10****Incidence of Clostridium *difficile*****Rationale**

Tackling healthcare-associated infections, such as Clostridium *difficile* (*C. difficile*), continues to be a key patient safety issue and is a priority for the NHS, as set out in the 2009/10 NHS Operating Framework and the 2007 Public Service Agreement 'Ensure better care for all'.

Mandatory surveillance of *C. difficile* was introduced in England in January 2004 with all acute and specialist NHS trusts in England required to report all diarrhoeal samples (defined as those that take the shape of their container) from people 65 years of age or older who have not been diagnosed with *C. difficile* infection (CDI) during the preceding four weeks. Trusts are required to report all positive results, including those received from people in the community. Since 1 April 2007, trusts were required to expand this reporting to include all positive results in patients aged two years and over.

The national target (a 30% reduction nationally in 2010/11 compared with the 2007/08 baseline figure) requires effective working across health communities to tackle infections in both healthcare settings and the community. Acute and specialist trusts are therefore expected to work effectively with primary care trusts to tackle *C. difficile* infections. As such, acute and specialist trusts are expected to set interim targets each year (between 2008/09 and 2010/11) with their strategic health authorities (SHA) to help achieve the national target overall by 2010/11.

**Construction**

Trusts will be assessed using data from mandatory surveillance of *C. difficile*, comparing numbers of *C. difficile* reports against numbers in the trust trajectories (plans).

**Numerator**

Number of *C. difficile* infections confirmed from samples obtained from admitted patients (aged 2 years and above, and where the sampling interval is greater than 28 days for the same patient) in 2009/10, excluding samples not apportioned to acute trusts as per the data definition in the Department of Health's Vital Signs guidance.

**Denominator**

Trust's total trajectory number of *C. difficile* infections confirmed from samples obtained from admitted patients (aged 2 years and above, and where the sampling interval is greater than 28 days for the same patient) in 2009/10, excluding samples not apportioned to acute trusts as per the data definition in the Department of Health's Vital Signs guidance.

**Indicator**

Numerator divided by the denominator, expressed as a percentage.

Performance banding will be based on statistical methods to identify trusts that have numbers of *C. difficile* infections higher than their 2009/10 trajectory.

**Note**

Detailed advice on the definition and timing of *C. difficile* data returns was issued in a joint letter from the Chief Medical Officer and Chief Nursing Officer in January 2008 (PL/CMO/2008/1; PL/CNO/2008/1). Trusts are expected to submit accurate data by

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agreed deadlines. The Hygiene Code states that trusts have an obligation to comply with mandatory surveillance of healthcare associated infections, which includes *C. difficile*. Trusts which fail to provide good quality data by the specified dates will be penalised and may, as a result, fail this indicator.

**Data source and period**

Health Protection Agency (financial year 2009/10)

Trajectories for *C. difficile* reduction (financial year 2009/10)

**Performance assessment 2009/10****Incidence of MRSA Bacteraemia****Rationale**

Tackling healthcare-associated infections, such as MRSA, continues to be a key patient safety issue and is a priority for the NHS, as set out in the 2009/10 NHS Operating Framework and the 2007 Public Service Agreement 'Ensure better care for all'.

MRSA bloodstream infections are a significant cause of morbidity and can be difficult to treat because of their multiple antibiotic resistance. Infections lengthen hospital stay and increase morbidity and, in some cases, result in death. Reducing the incidence of infection will therefore have significant patient benefits. The aim is that action on MRSA will also help to reduce the incidence of other similar infections, through the implementation of improved infection control measures.

The 2004 national Public Service Agreement (PSA) set out the target of halving the number of MRSA bacteraemias (bloodstream infections) in NHS acute and specialist trusts in England by March 2008. To achieve this target, each acute and specialist trust with more than 12 MRSA bacteraemias in 2003/04 (the baseline year) was expected to achieve either a 60% reduction in the number of bloodstream infections by 2007/08 or a maximum of 12 infections in 2007/08. Trusts with 12 or fewer infections in 2003/04 were expected to maintain or reduce these levels. The 2009/10 NHS Operating Framework and the 2007 Public Service Agreement 'Ensure better care for all' sets out the target of maintaining the national annual number of MRSA bloodstream infections at less than half the national number in 2003/04. As such, trusts are required in 2009/10 to ensure that their agreed 'ceilings' are not exceeded so that, collectively, the level of infections nationally is maintained at less than half the number in 2003/04.

**Indicator**

Trusts will be assessed using data from mandatory surveillance of MRSA bacteraemia, comparing numbers of MRSA bacteraemia reports against trusts' agreed 'ceiling' for MRSA bacteraemia reports. Part 1 of the indicator will be applied to trusts with more than 12 MRSA bacteraemias reported in 2009/10, part 2 to trusts with 12 or fewer MRSA bacteraemias reported in 2009/10.

**Part 1****Numerator 1**

Number of MRSA bacteraemias (an absolute number) reported by the trust in 2009/10, minus agreed exclusions from the trust's count (see guidance below\*).

**Denominator 1**

The trust's agreed 'ceiling' for number of MRSA bacteraemias for 2009/10.

**Indicator 1**

Numerator divided by the denominator, expressed as a percentage.

Performance banding will be based on statistical methods to identify trusts that have numbers of MRSA bacteraemias higher than their 2009/10 'ceilings'. Trusts that are within one standard deviation above their 'ceiling' will underachieve the indicator. Trusts that are more than one standard deviation above their 'ceiling' will fail the indicator.

**Performance assessment 2009/10****Part 2**

Trusts with 12 or fewer MRSA bacteraemias in 2003/04 were set a target of maintaining or reducing this number. Trust 'ceilings' of 0 for 2009/10 will be taken as 1 for assessment purposes so that all trusts will be allowed some tolerance above the trajectory value.

**Numerator 2**

Number of MRSA bacteraemias (an absolute number) reported by the trust in 2009/10, minus agreed exclusions from the trust's count (see guidance below\*).

**Denominator 2**

The trust's agreed 'ceiling' for number of MRSA bacteraemias for 2009/10.

**Indicator 2**

Numerator divided by the denominator, expressed as a percentage.

Performance banding will be based on statistical methods to identify trusts that have numbers of MRSA bacteraemias higher than their 2009/10 'ceilings'. Different statistical criteria will be used for parts 1 and 2 of the indicator construction. Trusts with 12 or fewer reported MRSA bacteraemias in 2009/10 will not be assessed as failing the indicator, regardless of the trust's agreed 'ceiling'. They will, however, be assessed as underachieved if reported bacteraemias are more than one standard deviation above their 'ceiling'.

**Note**

Detailed advice on the definition and timing of MRSA bacteraemia data returns was issued in a joint letter from the Chief Medical Officer and Chief Nursing Officer in June 2005 (PL/CMO/2005/4; PL/CNO/2005/4). Trusts are expected to submit accurate data by agreed deadlines. It is part of the Hygiene Code that trusts have an obligation to comply with mandatory surveillance of healthcare associated infections, which include MRSA. Trusts which fail to provide good quality data by the specified dates will be penalised and may, as a result, fail this indicator.

\* Guidelines (and an application form) for considering whether a MRSA bacteraemia record may be excluded from counting against a trust's trajectory are available on the Health Protection Agency's website: <http://nww.hpanw.nhs.uk/MRSA/download.htm>.

**Data source and period**

Trajectories for MRSA reduction (financial year 2009/10)  
Health Protection Agency (financial year 2009/10)

**Performance assessment 2009/10****Infant health & inequalities: smoking during pregnancy and breastfeeding initiation****Rationale**

There has been significant evidence showing the benefit of breastfeeding including lowering the risks of breast and ovarian cancer for the mother and gastro-intestinal and respiratory infections for the infant. Infants who are not breastfed are also five times more likely to be admitted to hospital with infections in their first year of life.

Smoking during pregnancy is a key determinant of low birth weight, which is in turn the single most important factor in perinatal and infant mortality. With smoking during pregnancy being more prevalent among young mothers and disadvantaged groups, these indicators measure a key issue for tackling health inequalities and public health.

**Numerator 1**

The actual number of women known to be smokers at the time of delivery (2009/10)

**Denominator 1**

The actual number of maternities (2009/10)\*

**Indicator 1**

The indicator is the numerator divided by the denominator, expressed as a percentage. (2009/10)

**Numerator 2**

The actual number of women known to be smokers at the time of delivery (2008/09)

**Denominator 2**

The actual number of maternities (2008/09)\*

**Indicator 2**

The indicator is the numerator divided by the denominator, expressed as a percentage. (2008/09)

**Numerator 3**

The actual number of mothers known to initiate breastfeeding (2009/10)\*\*

**Denominator 3**

The actual number of maternities (2009/10)\*

**Indicator 3**

The indicator is the numerator divided by the denominator, expressed as a percentage. (2009/10)

**Numerator 4**

The actual number of mothers known to initiate breastfeeding (2008/09)\*\*

**Denominator 4**

The actual number of maternities (2008/09)\*

**Indicator 4**

**Performance assessment 2009/10**

The indicator is the numerator divided by the denominator, expressed as a percentage. (2008/09)

**Overall indicator**

This will be calculated as indicator 1 divided by indicator 2 and indicator 3 divided by indicator 4, expressed as a percentage. These two measures will be combined in a matrix to determine a level of performance.

**Note**

In line with previous years, trusts should note that a high percentage of maternities with breastfeeding and/or smoking status not known will impact upon performance against this indicator. Trusts reporting more than 5% of status not known for 2009/10 data submission will fail this validation and will be categorised as 'data not returned' for indicator 1 and indicator 3 accordingly. This may result in a fail for the overall indicator.

\*The number of women who gave birth to one or more live or still born babies of at least 24 weeks gestation where the baby was delivered by either a midwife or a doctor and the place of delivery was an NHS hospital within the trust. Exclude all maternities that occurred in either psychiatric or private beds.

\*\*The mother is defined as having initiated breastfeeding if, within the first 48 hours of birth, either she puts the baby to the breast or the baby is given any of the mother's breast milk.

**Data source and period**

Care Quality Commission special data collection (financial year 2009/10)

**Performance assessment 2009/10****Inpatients waiting longer than the 26 week standard****Rationale**

Public consultation prior to the production of the NHS Plan indicated that the public wanted to see reduced waiting times in the NHS. The NHS Plan (July 2000) set out the goal that from December 2005 the maximum wait for inpatient treatment is 26 weeks. Urgent cases would continue to be treated in accordance with clinical need. The maintenance of the 18-week referral to treatment target has subsequently become the most important waiting time priority for the NHS, however, this indicator remains as an existing commitment to be maintained as set out in the 2009/10 NHS Operating Framework.

**Numerator**

The number of patients waiting 26 weeks or more for an elective (inpatient ordinary or daycase) admission. The value will be made up of a count of the number of patients waiting 26 weeks or more at the end of each month summed across the months April 2009 to March 2010.

**Denominator**

The total number of general and acute first finished consultant episodes (FFCEs) for elective activity (inpatient ordinary and day case admissions) minus the number of planned elective admissions reported in the monthly activity returns from April 2009 to March 2010.

**Indicator**

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

**Note**

The numerator applies to patients for whom English PCTs are responsible and awaiting NHS-funded treatment at providers in England. This description applies to provider and commissioner indicators. In DH central returns, providers are required to report upon all patients waiting. For performance assessment purposes, providers should then separately identify any patients for whom no English commissioner is responsible.

**Data source and period**

Monthly activity return (financial year 2009/10)

Monthly monitoring return (financial year 2009/10)

**Performance assessment 2009/10****Maternity Hospital Episodes Statistics: data quality indicator****Rationale**

The 2009/10 Operating Framework identified maternity as a key priority for the NHS. For acute trusts, this means going beyond the vital sign to ensure improved access as part of the wider Maternity Matters Strategy to deliver safe, high-quality care for all women, their partners and their babies. In July 2005, the Healthcare Commission's investigation report 'Review of maternity services provided by North West London Hospitals NHS Trust' highlighted the importance of good information systems within maternity units. The report included a national recommendation on the development and implementation of a national dataset for maternity services.

The Information Centre publishes annual data quality reports which examine the coverage of data submitted by NHS trusts to the Hospital Episode Statistics (HES). There are mandatory fields on HES relating to maternities and births. The Information Centre's annual reports have routinely found that completeness of these fields is, for many NHS trusts, inadequate.

The absence of adequate information on HES restricts the ability to monitor the clinical effectiveness and safety of maternity services across the country and increases the consequent administrative burden on trust staff of frequent data requests. One of the findings of the Healthcare Commission's maternity service review, published in 2008, was that completeness of the parts of the HES records ('tails') relating to maternities and births continued to be poor.

**Numerator**

Number of mandatory fields not complete within all Maternity Finished Consultant Episodes (FCEs), April to December 2009.

**Denominator**

Number of mandatory fields within all Maternity Finished Consultant Episodes (FCEs) April to December 2009.

**Indicator**

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

**Note**

Mandatory fields in HES are detailed here:

[http://www.datadictionary.nhs.uk/web\\_site\\_content/cds\\_supporting\\_information/hospital\\_episode\\_statistics/hes - cds data items cross referenced by hes name - table 1 fr.asp?shownav=1](http://www.datadictionary.nhs.uk/web_site_content/cds_supporting_information/hospital_episode_statistics/hes_-_cds_data_items_cross_referenced_by_hes_name_-_table_1_fr.asp?shownav=1)

'Not complete' is defined as invalid or containing the default value.

HES data for the indicator will be sourced from Secondary Uses Service (SUS). We intend to use HES data relating to April to December 2009 which will be available from the month 9 provider submission deadline on 22 January 2010. The Care Quality Commission retains the right to use data from any provider submission deadline from 22 January 2010 and to assess all trusts using data from that provider submission deadline.

### **Performance assessment 2009/10**

Provider submission deadlines, including the month 9 deadline, are published by the Information Centre on their website:

<http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=229>

#### **Data source and period**

Hospital Episodes Statistics (April to December 2009)

**Performance assessment 2009/10****NHS staff satisfaction****Rationale**

Improving staff satisfaction is one of the five key areas of the 2009/10 NHS Operating Framework. The NHS Staff Survey has been carried out annually since 2003 and changes in the reported levels of NHS staff job satisfaction can be compared year on year from this time. This provides a survey-based measure of job satisfaction for NHS staff. A more satisfied workforce is likely to be more sustainable and provide better patient care, with motivated and involved staff being better placed to know what is working well and how to improve services for the benefit of patients and the public. The 2009/10 NHS Operating Framework set out the expectation that NHS organisations help staff understand their role in delivering a better NHS and encouraging staff to participate in the NHS Staff Survey and act on the findings.

**Indicator**

Selected questions from the NHS Staff Survey will be used to calculate a job satisfaction key score, which will be used to score this indicator overall.

**Data source and period**

National NHS staff survey (fieldwork to be undertaken in autumn 2009)

**Performance assessment 2009/10****Outpatients waiting longer than the 13 week standard****Rationale**

Public consultation prior to the production of the NHS Plan indicated that the public wanted to see reduced waiting times in the NHS. The NHS Plan (July 2000) sets out the goal that from December 2005 the maximum wait for an outpatient appointment is 13 weeks. Urgent cases would continue to be treated in accordance with clinical need.

The implementation of the 18-week referral to treatment target has subsequently become the most important waiting time priority for the NHS, however this indicator remains as an existing commitment to be maintained as set out in the 2009/10 NHS Operating Framework.

**Numerator**

The number of patients waiting 13 weeks or more for a first outpatient appointment following a GP written referral. The value will be made up of a count of the number of patients waiting 13 weeks or more at the end of each month between April 2009 and March 2010.

**Denominator**

The total number of patients seen following a GP written referral request for a first outpatient appointment reported in the monthly activity returns from April 2009 to March 2010.

**Indicator**

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

**Note**

The numerator applies to patients for whom English PCTs are responsible and awaiting NHS-funded treatment at providers in England. This description applies to provider and commissioner indicators. In DH central returns, providers are required to report upon all patients waiting. For performance assessment purposes, providers should then separately identify any patients for whom no English commissioner is responsible.

**Data source and period**

Monthly activity return (financial year 2009/10)

Monthly monitoring return (financial year 2009/10)

**Performance assessment 2009/10****Patients waiting longer than three months (13 weeks) for revascularisation****Rationale**

The National Service Framework for Coronary Heart Disease states that there is good evidence that many people with atheromatous plaques and narrowed coronary arteries can have their symptoms relieved and/or their risks of dying reduced by restoring blood flow through blocked coronary arteries - revascularisation. The Government existing commitment was to deliver a maximum wait of three months for revascularisation by March 2005, this re-iterated in the 2009/10 NHS Operating Framework as an existing commitment.

Data are now collected in weekly timebands, and hence 13 weeks is now used in this indicator.

**Numerator**

The total number of patients who have been waiting more than 13 weeks for either a coronary artery bypass graft (CABG (OPCS4 codes K40-46)) or percutaneous transluminal coronary angioplasty (PTCA (OPCS4 codes K49, K50.1 and K75)). The value will be made up of the number of patients waiting 13 weeks or over on the monthly returns summed across the months April 2009 to March 2010.

**Denominator**

The total number of patients that have received a CABG (OPCS4 codes K40-46) or PTCA (OPCS4 codes K49, K50.1 and K75). This value will be the sum of the number of patients in the CABG and PTCA activity columns for 2009/10 using the cumulative activity figures reported in the March 2010 Monthly Monitoring Return.

**Indicator**

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

**Data source and period**

Monthly monitoring return (financial year 2009/10)

**Performance assessment 2009/10****Stroke care****Rationale**

A stroke is caused by a disturbance to the flow of blood to the brain by one of two main means, either as a result of a clot that narrows or blocks blood vessels or where blood vessels burst causing bleeding into the brain.

Driving up standards of care to reduce mortality and morbidity through implementation of the National Stroke Strategy continues to be an important activity for PCTs, supported by their local stroke care networks (Operating Framework for the NHS in England 2009/10).

Every year 110,000 people have a stroke, 20% - 30% of whom die within 1 month. 11% of all deaths in England occur as a result of a stroke, making it the third largest cause of death in the country, and 300,000 people live with a moderate to severe disability as a result of a stroke making it the largest cause of adult disability in England. The 2005 National Audit Office report found that, compared to other countries, England has a higher rate of mortality and disability caused by strokes, despite stroke care being among the most expensive internationally.

The National Stroke Strategy, 2007, sets out 20 quality markers which define excellent care at different stages in the pathway, to help local services make improvements to stroke services. These definitions include the treatment of stroke patients within specialist stroke units and the provision of rapid access to services for people who have had a minor stroke or transient ischaemic attack (TIA).

**Numerator 1**

Number of patients who spend at least 90% of their time on a stroke unit

**Denominator 1**

Number of patients who were admitted to hospital following a stroke

**Indicator 1**

Percentage of patients that have spent more than 90% or more of their stay in hospital on a stroke unit.

**Numerator 2**

Number of transient ischaemic attack (TIA) cases with a higher risk of stroke who are treated within 24 hours

**Denominator 2**

Number of people who have had a transient ischaemic attack (TIA) who are at higher risk of stroke

**Indicator 2**

Percentage of high risk transient ischaemic attack (TIA) patients who are treated within 24 hours.

**Overall Indicator**

These measures will be combined in a matrix to determine a level of performance.

### **Performance assessment 2009/10**

#### **Note**

Data definitions for this indicator are the same as for PCTs' vital signs monitoring return (VSMR). Please see the following link for further guidance:

<http://www.unify2.dh.nhs.uk/InstantForumSetup/Topic10008041-10000502-1.aspx>

#### **Data source and period**

Care Quality Commission special data collection (financial year 2009/10)

**Performance assessment 2009/10****Total time in A&E: four hours or less****Rationale**

The NHS targets for 2003-2005 set out in the Priorities and Planning Framework for 2003/04 to 2005/06 required that trusts ensure that, from January 2005 onwards, at least 98% of patients spend four hours or less in any type of A&E from arrival to admission, transfer or discharge. The NHS Operating Framework for 2009/10 reiterates that this standard should continue to be maintained and notes that the regulator would continue to assess trusts' performance.

With an increasing number of PCTs commissioning Walk-In Centres and minor injuries units from the independent sector the indicator now includes performance in these centres where appropriate. Commuter Walk-In Centres are not included as they are commissioned directly by the Department of Health.

Concerns have emerged that in some trusts guidelines relating to the start time of the clock for the four-hour measure may not be being strictly adhered to, particularly where queues of ambulances outside A&E are occurring. The Care Quality Commission operates a principle of maintaining the highest data quality and where it is found that this is not the case the standard penalties will be invoked.

**Numerator**

The number of patients spending four hours or less in an A&E department. This includes attendances at all types of A&E department run by the trust, any partner PCT or independent sector provider contracted by the NHS. 'Partner' PCT means any PCT that provides local A&E services and is designated by the strategic health authority as a 'partner' of an acute trust. PCT services will normally be partnered with the nearest acute trust with a major A&E department.

**Denominator**

The total number of patients attending at an A&E department. This includes attendances at all types of A&E department run by the trust and any attendances at 'partner' PCT services including those run by the independent sector.

**Indicator**

The indicator is the numerator divided by the denominator, expressed as a percentage for the financial year 2009/10. This includes attendances at all types of A&E department run by the trust or 'partner' PCT.

**Data source and period**

QMAE quarterly return (financial year 2009/10)

**Performance assessment 2009/10****Waiting times for rapid access chest pain clinic****Rationale**

The Government target is that all patients referred by their GP to a rapid access chest pain clinic should be seen within two weeks. This indicator only applies to those patients whose referral was received by the clinic within 24 hours of the GP deciding to refer.

Rapid access chest pain clinics should work under protocols set up by a cardiologist or general physician with a special interest in cardiology, and staff should be able to call on a cardiologist / general physician with a special interest in cardiology although the consultant does not have to be present at all times.

As set out in the 2009/10 NHS Operating Framework there is an existing commitment to maintain a maximum two-week standard for rapid access chest pain clinics.

**Numerator**

Number of patients with recent onset chest pain (i.e. pain in the last month) thought to be angina (i.e. the GP has made a clinical decision that symptoms are indicative of angina and are worthy of further investigation) seen in a facility supervised by a cardiologist or general physician with a special interest in cardiology for the assessment of patients with recent onset chest pain (rapid access chest pain clinic) within 14 days of the GP deciding to refer. This only applies to those patients whose referral is received by the clinic within 24 hours of the GP deciding to refer.

**Denominator**

Number of patients with recent onset chest pain (i.e. pain in the last month) thought to be angina (i.e. the GP has made a clinical decision that symptoms are indicative of angina and are worthy of further investigation) referred to a facility supervised by a cardiologist or general physician with a special interest in cardiology for the assessment of patients with recent onset chest pain (rapid access chest pain clinic). This only applies to those patients whose referral is received by the clinic within 24 hours of the GP deciding to refer.

**Indicator**

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

**Data source and period**

Vital Signs returns (financial year 2009/10)