**NHS Digital**

**Indicator Supporting Documentation**

**IAP00036 Responsiveness to inpatient’s personal needs**

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| FIELD | CONTENTS |
| IAP Code | IAP00036 |
| Title | Improving Hospitals’ Responsiveness to Inpatients Personal Needs |
| Published by | NHS Outcomes Framework |
| Reporting period | Quarterly |
| Geographical Coverage | England |
| Reporting level(s) | National |
| Based on data from | Adult inpatient survey |
| Contact Author Name | Department of Health |
| Contact Author Email | Dawn.fagence@dh.gsi.gov.uk |
| Rating | Assured |
| Assurance date | 06/10/11 |
| Review date | 06/10/14 |
| Indicator set | NHS Outcomes Framework 2011/12 |
| Brief Description | The Care Quality Commission’s Adult Inpatient Survey (from the CQC nationally coordinated patient survey programme) is conducted annually amongst patients who have had at least one overnight stay in hospital as an inpatient between June-August. |
| Purpose | Consultation feedback indicated that personalisation and service responsiveness are important issues for inpatients. Improving hospitals’ responsiveness to personal needs has therefore been selected as part of the set of NHS Outcome indicators.  The indicator is part of domain 4 of the set; this domain reflects the importance of providing a positive experience of care for patients, service users and carers. It is now standard practice in healthcare systems worldwide to ask people to provide direct feedback on the quality of their experience, treatment and care.  It will be used alongside additional information sources to provide local clinicians and managers with intelligence on the quality of local services from the patients’ and service users’ point of view. Ultimately the indicator will play a role in driving improvements in the quality of service design and delivery. |
| Definition | The survey is conducted annually, among patients who have had at least one overnight stay in hospital as an inpatient between June-August. A postal self-completion survey  method is used and fieldwork takes place between September–January. The survey covers both elective and emergency care patients but does not include maternity, mental health patients or patients under the age of 18 (see survey guidance via link above for further details, including sample inclusion and exclusion criteria).  The annual survey typically achieves responses from around 70,000 patients across England for a total response rate of around 50%. The latest available results in the public domain are for the 2009 adult inpatient survey, published in May 2010 by CQC (via weblink below). The 2010 survey has been completed, and CQC are planning to publish results in spring 2011.  [www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patientsurveys/inpatientservices.cfm](http://www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patientsurveys/inpatientservices.cfm) |
| Data Source | The Care Quality Commission’s Adult Inpatient Survey - from the CQC nationally coordinated patient survey programme. All materials (including guidance documents) are available on the NHS national patient survey coordination centre website <http://www.nhssurveys.org/> |
| Numerator | Overall score of five separate domain (with questions within each), data is standardised by age, gender and emergency/elective split. For each trust, an average weighted score is calculated (weighted by age/gender) for each of the relevant questions. Missing values are ignored. These scores are aggregated into the domains using a simple weighted average. National domain scores are calculated by a simple average of the Trust scores. |
| Denominator | The average weighted number of respondents to at least one of the 20 questions. |
| Calculation | [𝑁𝑢𝑚𝑒𝑟𝑎𝑡𝑜𝑟𝑖𝐷𝑒𝑛𝑜𝑚𝑖𝑛𝑎𝑡𝑜𝑟𝑖]×100  Individual questions are scored according to a pre-defined scoring regime that awards scores between 0 and 100. Therefore, this indicator will take values between 0 and 100, where 0 is the worst score and 100 is the best score. |
| Interpretation Guidelines | There is a theoretical case for adjusting scores for different rates of non-response in different age and gender groups as well as for sizes of Trusts. Such a change would add further complexity to the methodology though analysis suggested that the impact of such a change would be small. The MRG recommended that analysis should be included in this quality statement.  An impact of Trust size has been considered to illustrate and quantify the impact of different calculation methods. This has been done on the Patient Experience Overall scores: Adult inpatient survey results. The age-gender-admission method weighting currently used has been retained, but instead of taking a crude average of trust scores a volume weight has been applied calculated purely from total count of FCEs.  Results show that the weighting does alter the results with scores generally being a touch lower. However, there is no discernible impact on the trend. |
| Caveats |  |
| Primary Category | Patient care |

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| **Indicator Title** | **IAP Code (IAP00036)** |
| Improving hospitals’ responsiveness to personal needs |  |

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| Indicator Definition, including calculation, measurement units, geographical range, age and gender |
| The indicator is a composite, calculated as the average of 5 survey questions.  Each question describes a different element of the overarching theme,  “*responsiveness to patients’ personal needs”.*  **•** Were you involved as much as you wanted to be in decisions about your  care and treatment?  **•** Did you find someone on the hospital staff to talk to about your worries and  fears?  **•** Were you given enough privacy when discussing your condition or  treatment?  **•** Did a member of staff tell you about medication side effects to watch for  when you went home?  **•** Did hospital staff tell you who to contact if you were worried about your  condition or treatment after you left hospital?  Individual questions are scored according to a pre-defined scoring regime that  awards scores between 0-100. Therefore, this indicator will also take values  between 0-100.  In terms of disaggregation, we require indicators to be disaggregated by the equality and inequality strands as appropriate set out in the outcome framework for national level data document where this is feasible. We also require disaggregation by age **[DN bandings to be decided].**  **DN. NEED TO BEAR IN MIND THAT NOT ALL EQUALITIES STRANDS ARE COVERED IN THE SURVEYS. FOR THOSE THAT ARE AVAILABLE, THIS CAN ONLY BE DONE NATIONALLY – SAMPLE SIZES MEAN THAT RESULTS AT TRUST LEVEL WILL NOT BE RELIABLE. SOME WORK HAS BEEN DONE ON THIS IN THE PAST - IE**  DH – BME GROUPS:  http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH\_100467  BY CHI/HC – ACROSS DIFFERENT DEMOGRAPHICS  Can’t find on their website – so will need to request  **This is an England-only based survey.** |
| Indicator Data Source(s) |
| Details of data sources, if known. Please note if this data is collected currently, or if it will require some sort of development  *The data source is ready.*  The Care Quality Commission’s Adult Inpatient Survey - from the CQC nationally  coordinated patient survey programme. All materials (including guidance documents) are available on the NHS national patient survey coordination centre website (see link below):  http://www.nhssurveys.org/  The survey is conducted annually, among patients who have had at least one overnight stay in hospital as an inpatient between June-August. A postal self-completion survey method is used, and fieldwork takes place between September – January. The survey covers both elective and emergency care patients, but does  not include maternity, mental health patients or patients under the age of 18 (see survey guidance via link above for further details, including for sample inclusion and exclusion criteria).  The annual survey typically achieves responses from around 70,000 patients across England (a total response rate of around 50%). The latest available results in the public domain are for the 2009 adult inpatient survey, published in May 2010 by CQC (via weblink below). The 2010 survey has been completed, and CQC are planning to publish results in spring 2011.  [www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patientsurveys/inpatientservices.cfm](http://www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patientsurveys/inpatientservices.cfm).  The national data for this indicator are published annually on the DH website in  accordance with national statistics guidelines (see the first link below). DH also publishes a detailed diagnostic tool on its website, which aims to assist NHS organisations identify areas of underperformance in the subset of questions that make uyp this indicator.  <http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/DH_087516>  http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\_091660  Detailed results for each provider, presented question by question, are also published on  the CQC website (see second link below).  [www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patientsurveys.cfm](http://www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patientsurveys.cfm)  Guidance material for this survey (covering inclusion and exclusion criteria for  compiling the sample frame) is available on the NHS national patient survey  coordination centre website: www.nhssurveys.org. |
| Indicator Data Source Availability |
| Is data publicly available (eg National Statistic), or is it only available as a bespoke dataset upon request. Comment on availability of raw data to customers outside the NHS/Public Sector  The data is publicly available from the DH website (see links above).  CQC provide detailed report for each organisation taking part in each survey, covering the full range of survey questions. These are available on the CQC website at http://www.cqc.org.uk/publications.cfm?fde\_id=15551 . |
| **Indicator Overlap** |
| List the indicator sets you have checked for overlap or if you have searched the IC Indicator library |
| For example, NHS Choices, IQI / MQI, Better Care, Better Value, NCHOD, NHS Comparators  During the consultation process for the NHS Outcomes Framework there was wide checking of other indicator sets for overlap. This indicator was selected as being fit for the purpose of the NHS outcomes indicators  The NHS Consultation document set out a range of options for the future iterations of the the Framework, which requires development of the underlying feedback/survey architecture to ensure that they are fit for purpose. These options were strongly supported in the consultation, and the Government response made a committed to initiate this work. Work on the survey architecture is now being planned – details will be set out in Ministerial submission that will go up in early March. |
| List any indicators which overlap with the proposed indicator |
| *Data are not currently published.*  Patient experience indicators in IQI (individual headline scores published).  This indicator was developed as part of a national CQUIN goal for acute  providers in 2009/10. Further information is available on the website of the  Department of Health and the NHS Institute for Innovation and Improvement  (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAnd  Guidance/DH\_091443).  Please include, where known, any indicator code or unique reference, as well as the title of the indicator |
| What value does the proposed indicator offers over existing indicators |
| Highlight any gaps left by any current indicators  N/A – this indicator was selected as part of the NHS Outcome indicator set. It needs to be developed as part of the set for consistency and coherence. |

**Indicator Use**

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| Does this indicator measure a | process |  | outcome |  |

This measure is…

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| …compared against absolute evidence based standard |  | …compared against national average |  | …compared against optimum value |  |
| …comparison against self over time |  | … not compared against any other values |  |  |  |

Indicator Title/ Definition Review **(IC use only)**

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| --- | --- | --- | --- |
| *Indicator meets criteria for :*  Indicator definition self explanatory  Indicator definition in plain English, suitable for publishing to all audiences  Indicator definition with clear measurement units  Indicator definition with clear scope (geog, age, sex)  Data source available  Data source suitable  Indicator is unique  Face validity of concept and indicator use  **Information complete - proceed** |  | *Requires revision for following reasons:*  Title not confined to concept only  Use of acronyms  Definition needs more detail on:  - calculations  - data sources  - geographical coverage  - patient/population groups  Insufficient information about data source  Insufficient exploration of overlap  Insufficient information about indicator use |  |

Notes:

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| **Application contact details** (please note all contact details will be treated confidentially) |  |
| Applicant Name | Dawn Fagence |
| Applicant Role | Co-ordinating analyst for NHS outcomes indicators in domains 3 & 4 framework |
| Applicant Organisation | DH |
| Applicant Telephone | 0207 972 5724 |
| Applicant Email | dawn.fagence@dh.gsi.gov.uk |
| Indicator Set Name | NHS Outcomes Framework |
| Sponsor Name | DH – Quality Framework & QIPP teams |
| Sponsor Role | Delivery of NHS Outcome Indicators for SoS to use to hold NHS Commissioning Board to account. |
| Sponsor Organisation | DH |
| Acknowledgements |  |
| Other Stakeholder Name | CQC |
| Other Stakeholder Role | Collector/supplier of survey data for this indicator |
| Other Stakeholder Organisation | None |
| Please list any additional Stakeholder(s) | None |

**Users of the Proposed Indicator**

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| --- | --- | --- | --- |
|  | Primary User | Secondary User | Not intended for |
| Boards (national, local) |  |  |  |
| Provider Managers |  |  |  |
| Commissioning mangers |  |  |  |
| Regulators |  |  |  |
| Clinicians |  |  |  |
| Patients |  |  |  |
| Public |  |  |  |
| Other (please specify) |  |  |  |
| Other (please specify) |  |  |  |

Indicator Applicant Review **(IC use only)**

|  |  |  |  |
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| *Indicator meets criteria for :*  **Information complete - proceed** |  | *Requires revision for following reasons:*  Applicant information not complete  User information not complete |  |

Notes:

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| **Rationale for indicators** |
| **Please list any relevant policies, strategies or programmes** |

High level subject area

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| Preventing people from dying prematurely |  | Enhancing quality of life for people with long term conditions |  | Helping people recover from episodes of ill health or following an injury |  |
| Ensuring people have positive experiences of care |  | Treating and caring for people in a safe environment and protecting them from avoidable harm |  | Other |  |

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| Evidence base for the indicator |
| Provide a paragraph summarising the evidence, noting quality of evidence where appropriate. Do not list the relevant docs here, please extract saliant messages.  Indicator has been selected as part of the set of NHS Outcome indicators – evidence produced and considered for the set. The indicator is part of domain 4 of the set – this domain reflects the importance of providing a positive experience of care for patients, service users and carers. It is now standard practice in healthcare systems worldwide to ask people to provide direct feedback on the quality of their experience, treatment and care. It will be used alongside additional information sources to provide local clinicians and managers with intelligence on the quality of local services from the patients’ and service users’ point of view. Ultimately to play a role in driving improvements in the quality of service design and delivery.  Improving hospitals’ responsiveness to personal needs has been selected as consultation feedback indicated that personalisation and service responsiveness are important issues for inpatients. |
| References |
| Extensive consultation – see transparency in outcomes – a framework for the NHS, The NHS Outcomes Framework 2011-12 |
| Clinical advice |
| Provide details of any clinical adivice or support already given in development or preparation of indicator. |

Indicator Rationale Review **(IC use only)**

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| Priority level linked to policy, strategy or programme  Quality of evidence  - clinical trial / cohort studies/ meta-analysis  - non-analytical studies  - best practice (clinical)  - good practice for patient experience  **Information complete - proceed** |  | *Requires revision for following reasons:*  Policy, strategy, programme information not complete  Evidence information not complete |  |

Notes:

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| **Indicator Methodology – information sources** |
| Numerator definition Word description of the data source |
| The indicator is a composite, calculated as the average of 5 survey questions.  Each question describes a different element of the overarching theme,  “*responsiveness to patients’ personal needs”.*  **•** Were you involved as much as you wanted to be in decisions about your  care and treatment?  **•** Did you find someone on the hospital staff to talk to about your worries and  fears?  **•** Were you given enough privacy when discussing your condition or  treatment?  **•** Did a member of staff tell you about medication side effects to watch for  when you went home?  **•** Did hospital staff tell you who to contact if you were worried about your  condition or treatment after you left hospital?  Individual questions are scored according to a pre-defined scoring regime that  awards scores between 0-100. Therefore, this indicator will also take values  between 0-100.  This indicator was developed as part of a national CQUIN goal for acute  providers in 2009/10. Further information is available on the website of the  Department of Health and the NHS Institute for Innovation and Improvement  (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAnd  Guidance/DH\_091443). |
| Numerator source Organisation and data collection |
| Adult inpatient survey, CQC |
| Numerator construction Which data fields (specify) and values (specify codes) are combined to arrive at the count. Include any special rules. |
| Overall score of five separate domain (with questions within each), data is standardised by age, gender and emergency/elective split. For each trust an average weighted score is calculated (weighted by age/gender) for each of the relevant questions. Missing values are ignored. These scores are aggregated into the domains using a simple weighted average. National domain scores are calculated by a simple average of the Trust scores. |
| Numerator acertainment Any known exclusions, shortfalls or collection issues which will effect the total amount of data collected. |
| Survey is collected for approximately 70,000 people (around 50% response rate) for around 50 questions. |
| Numerator quality of data Issues with accuracy or known variability of recording. For example coding by untrained staff. |
| No known quality issues, response rate is fairly good. Sample sizes provide reliable results at organisation level, though there are variations that may need to be borne in mind in some cases. Missing values are excluded from analysis |
| Numerator access to data Is data publicly available / published. Is it available only upon request, or even only to 'trusted' groups of people? |
| Indicator results are published on DH website. Full survey results are published on the CQC website at http://www.cqc.org.uk/publications.cfm?fde\_id=15551 |
| Numerator timeliness Frequency and timeliness of data. State how the publication/release of data relates to indicator production timescales. |
| The survey is conducted annually between October and January for patients who had an inpatient episode between June-August. The latest Adult Inpatient Survey (2009) was published in May 2010; result for 2010 will be available in spring 2011. |
| Denominator definition Word description of the data source |
| **Denominator** |
| Denominator source Organisation and data collection |
| See above for numerator |
| Denominator construction Which data fields (specify) and values (specify codes) are combined to arrive at the count. Include any special rules. |
|  |
| Denominator acertainment Any known exclusions, shortfalls or collection issues which will effect the total amount of data collected. |
|  |
| Denominator quality of data Issues with accuracy or known variability of recording. For example coding by untrained staff. |
|  |
| Denominator access to data Is data publicly available / published. Is it available only upon request, or even only to 'trusted' groups of people? |
|  |
| Denominator timeliness Frequency and timeliness of data. State how the publication/release of data relates to indicator production timescales. |

Indicator Applicant Review **(IC use only)**

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| Are raw data universally available for others to recreate indicator?  Are data available in a suitable timeframe and frequency?  Are data quality issues well documented and acknowledged?  Are data robust enough to support indicator and derivations?  Are data consistent over the required time?  Are construction of numerator and denominator robust and comparable with other sources  **Information complete - proceed** |  | *Requires revision for following reasons:*  Numerator info not complete  Denominator info not complete |  |

Notes:

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| **Indicator methodology - statistical methods** |
| Statistical support |
| Summarise involvement of statistician involvement in developing indicator so far, and ongoing support for indicator when rolled out.  Statisticians in CQC and DH have led the process for developing the indicators so far and would be available for support when it is rolled out. |
| Risk adjustment variables |
|  |
| Statistical methods |
| Type of analysis (any methods used), risk adjustment (predictive power of model), special techniques (dealing with dispersion, constant risk), statistical process control  Composite indicator calculated as the average of five survey questions, each describing a different element of the overarching theme. For each trust an average weighted score is calculated (weighted by age/gender) for each of the relevant questions. Missing values are ignored. These scores are aggregated using a simple weighted average. National domain scores are calculated by a simple average of the Trust scores. |
| Quality assurance processes |
| Detail the quality assurance processes in place to check data, identify anomalies, and explore these further with providers.  See CQC report at http://www.cqc.org.uk/publications.cfm?fde\_id=15552 |
| Test data or sample data |

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| During course of pipeline application, test or sample data will be required to give proof of concept. Insert table of raw data.  **Q1 Was your most recent hospital stay planned in advance or an emergency?** |

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| Survey Year | 2002 | 2005 | 2006 | 2007 | 2008 | 2009 | Significant change between 08 and 09 | Significant change between 02 and 09 |
| Emergency or urgent | 52% | 53% | 54% | 54% | 55% | 55% |  | ↑ |
| Waiting list or planned in advance | 48% | 44% | 44% | 43% | 42% | 42% |  | ↓ |
| Something else | - | 3% | 3% | 3% | 3% | 3% |  |  |
| Number of respondents | 89815 | 77840 | 77665 | 73355 | 70020 | 66946 |  |  |

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| Interpretation |
| Describe how this indicator is planned to be used and what questions the indicator is planned to answer, and any known limitation  Indicator has been selected as part of the set of NHS Outcome indicators – See ‘The NHS Outcomes Framework 2011-12’ document. The indicator is part of domain 4 of the set – this domain reflects the importance of providing a positive experience of care for patients, service users and carers. It is now standard practice in healthcare systems worldwide to ask people to provide direct feedback on the quality of their experience, treatment and care. It will be used alongside additional information sources to provide local clinicians and managers with intelligence on the quality of local services from the patients’ and service users’ point of view. Ultimately to play a role in driving improvements in the quality of service design and delivery. |
| Format of presentation |
| Describe published format, such as interactive website, csv file, etc. Provide table or screenshot (or mock version) of how the final presentation of data will appear. Include any interpretative text as well as figures  CSV file to DH |

Indicator Methodology Review **(IC use only)**

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| Transparency / reproducibility  Anomaly investigation and action  Valid and appropriate methods used  Can play of chance be assessed  Identification and action on outliers  Presentation suitable for audience  Construct validity  Interpretation  **Information complete - proceed** |  | *Requires revision for following reasons:*  Statistical methods information not complete  Test data not complete  Interpretation not complete  Presentation not complete |  |

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| Notes:  Potential bias and confounding  Suitability of risk adjustment (if used)  Predictive capability of model (if used) |
|  |
| **Indicator production and management** |
| Commissioner of indicator (this may be the same as the stakeholder) |
| DH |
| Producer of indicator (this may be the same as the proposer) |
| CQC/NHS IC |
| Expected ‘improvement actions’ as a result of this indicator |
| State where responsibility will lie, and what actions will be expected as the result of a 'poor' rating of this indicator.  The NHS Outcomes Framework sets out the national outcome goals that the SoS will use to monitor the progress of the NHS Commissioning Board. It does not set out how these outcomes should be delivered, it will be for the NHS Commissioning Board to determine how best to deliver improvements by working with GP commissioning consortia to make use of the tools at their disposal. |

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| Have costs of collection, construction, dissemination and presentation been fully identified? See NHS Outcomes Framework impact assessment |  |

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| Funding status |
| Secured / being saught / not identifield  Please add comments |
| What timescales do you envisage for developing / producing this indicator |
| Give specific dates for key stages or publication or development of indicator  To be ready/ published April 2011 |
| Risks, assumptions and impact of producing indicator |
|  |
| Risk of perverse incentive and gaming by healthcare providers |
| To what extent can organisations influence the value of the indicator in ways which may not benefit patients?  This is very unlikely given that this is a survey based indicator, therefore healthcare providers have little chance to influence the indicator value. |
| Risks, assumptions and impact of not producing indicator |
| This is not an option as there has been a public commitment made to doing so. This indicator is part of the NHS Outcome Framework 2011-12 indicator set. |

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| Indicator Production Review **(IC use only)** |  |  |  |
| Action-ability  Funding capacity identified  Risks sufficiently explored  **Information complete - proceed** |  | *Requires revision for following reasons:*  Commissioner information not complete  Producer information not complete  Improvement actions not complete  Funding status not complete  Timescale info not complete  Risk assessment not complete |  |
| Notes:  Timescales – comment on the appropriate priority level for assuring this indicator  Risks – comment on any significant risks |  |  |  |

Indicator Assurance Pipeline Process

**Methodology Review Group**

**Applications for consideration**

**8 September 2011**

|  |  |
| --- | --- |
| **Document Author:** | *Peter Knighton* |
| **Document Owner:** | *Peter Knighton* |
| **Created Date:** | *16/09/2011* |
| **Current Issue Date:** | *16/09/2011* |
| **Responses expected by:** | *n/a* |
| **Version Number:** | *V 0.2* |

# Document Control

## Version History

|  |  |  |  |
| --- | --- | --- | --- |
| **Version** | **Date** | **Changed By** | **Summary of Changes** |
| V 0.1 | 05/09/2011 | Peter Knighton | Initial Draft |
| V0.2 | 16/09/2011 | Peter Knighton | With recommendations |
|  |  |  |  |
|  |  |  |  |

## 

## Approvals

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Title** | **Date** | **Version** | **Signature** |
|  |  |  |  |  |

## Distribution

|  |  |  |
| --- | --- | --- |
| **Version** | **Date** | **Distribution List** |
|  | 05/09/11 | NHS Information Centre: John Varlow, Andy Sutherland, Azim Lakhani, Heather Dawe, Alyson Whitmarsh, Simone Chung, Alison Crawford, Sam Widdowfield.  Department of Health: Arun Bhoopal, Dawn Fagence, Candida Ballantyne.  Patient Experience Policy Program: Mandy Wearne, Janet Butterworth |

# Introduction

Matters to discuss include updates on NHS Outcomes Framework recommendations, the first indicator to be submitted by an NHS organisation that provides frontline healthcare and four new indicators for consideration on patient experience in the NHS Outcomes Framework.

# Additional information and feedback from data owners on MRG Recommendations

|  |  |
| --- | --- |
| **Indicator** | **Construction and data source, Rationale, Potential issues** |
| **Recommendation 2011/46** | The possibility of HES data for the denominator should be looked into. Completeness for home births may be an issue. It may be cleaner to use HES for both numerator and denominator. CIT to investigate. |
| **Update 08/09/2011** | Interrogation of the HES birth data has found that when compared to ONS birth notifications, the total number of all live births in England in a 12 month period is broadly similar (ONS 687,007 vs HES 667,580 ). The rate of births reported as having taken place at a domestic address is lower in HES (1.4% of all births) compared to ONS (2.7 in 2009), which may in some part account for the lower total of births. It is suggested that HES birth data are used, as they include the gestational length that other sources lack, with a note in the data quality statement about the under ascertainment of home births.  Within HES it has also been found that it not possible to use the ‘neocare’ variable to identify admissions for neonatal services, as this variable was taken out of service in 2005. Other options include including only cases admitted to a neonatal ICU (Augmented Care Location), or counting all non-delivery admissions where gestation is full term, implying it is a neonatal episode.  Previous meeting we had discussed the removal of duplicate records from the dataset. Investigation has found that in 2009/10, there were no duplicate records (all HESID occurred only once in data) |
| **Recommendation 2011/57** | Data quality statement to quantify data loss between HES and ONS including home birth analysis as described. The data quality statement should also explain that some admissions are unavoidable. Clinical Indicators Team (CIT) to action. |
| **Recommendation 2011/58** | No de-duplication to be carried out. If indicator calculated for historical period description of duplication to be included in quality statement. CIT to action. |
| **Recommendation 2011/59** | There is a possibility that there is disparity between the mother and child records in HES. CIT to investigate. |

**2.3i Unplanned hospitalisation for chronic ambulatory care sensitive conditions**

**3a Emergency admissions for acute conditions that should not usually require hospital admission**

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| **Recommendation 2011/53** | DH need to demonstrate that evidence for the inclusion and exclusion of certain conditions is fit for purpose and could stand up to future scrutiny and challenges on methodology. The bounds of the pipeline process need to be clarified to show what this process has and has not covered. |
| **Update 08/09/2011** | **Evidence provided:**  Discussions held with clinical colleagues around appropriate definitions led to agreement that the most appropriate way forward is to build on the definition of ambulatory care sensitive conditions as used in the NHS Comparators indicator “Emergency admissions for 19 ambulatory care sensitive conditions”, with some additions and removals as deemed appropriate for the purpose of the indicator.  Conditions have been included for two reasons – either the condition itself should be treated in the community/primary care, or management of the condition outside hospital should prevent the condition escalating so that an emergency admission is required.  There has been effort made to ensure consistency with other definitions – namely the conditions set out in the NCHOD indicators “Acute/Chronic conditions usually managed in primary care”, and those set out in the NHS Institute population “Directory of Ambulatory Emergency Care for Adults”. Some conditions may appear in the directory, but not in the definition set out below. This is because ambulatory emergency care needs to be distinguished from the ambulatory care sensitive conditions. The latter refers to conditions in which improved preventative healthcare or improved long-term condition management results in a decreased risk of an acute event occurring. With the Directory of Ambulatory Emergency Care for Adults, the 49 scenarios relate to where the acute event has developed and delivery of that acute care is feasible for a significant proportion of cases without an overnight stay in hospital. Thus, there are overlaps in the conditions mentioned but they represent differing points in the patient journey.  Additional details on the definitions are outlined in the paper *NHS Outcomes Framework indicators: Definition of Ambulatory Care Sensitive conditions*. |

**Is this sufficient evidence? Can these indicators go to IGB?**

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| **Recommendation 2011/60** | Re-circulate acute/chronic paper for group to approve. Be clear to group which documents to read to assess quality of evidence. CIT to action.  The documents referenced need to be in the public domain. Also need to be careful what is referenced e.g. should be NICE for clinical guidelines.  CIT to investigate the use of existing conventions for establishing quality of evidence. |

**3.2: Emergency admissions for children with lower respiratory tract infections**

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| **Recommendation 2011/50** | A verbal update at the meeting stated that ages 0 to 19 are to be used. DH to supply the documentation behind this decision and bring back to MRG |
| **Update 08/09/2011** | **Evidence provided:**   * link to clinical guidelines to support the decision to increase the age to up to 19 years - <http://www.sign.ac.uk/pdf/sign59.pdf> * response received from DH policy team - they consulted their senior clinical advisor who said - 'It makes sense to keep the definition of children and young people consistent. We've used up to 19 since the NSF so I'd stick with that. I doubt increasing from 15 to 19 will make a great difference.' |

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| **Is this sufficient evidence? Can these indicators go to IGB?** |
| **Recommendation 2011/60 also applies to this indicator.** |

# New indicators to be considered

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| **Indicator** | **Construction and data source** | **Rationale** | **Potential issues** |
| IAPP00046 - 1st time CABG (Coronary Artery Bypass Grafting) - Betablockers prescribed / given to the patients before the surgery should also be given on the day of surgery | Indicator Definition: Percentage of 1st time CABG (Coronary Artery Bypass Grafting) patients who are prescribed / given betablockers before the surgery should also receive it on the day of surgery  Denominator : Number of patients who were admitted to hospital for 1st time CABG and were prescribed or given betablocker before the surgery. We are looking at the finished spells in a specified time period  Numerator : Number of patients who were admitted to hospital for 1st time CABG and were prescribed or given betablocker before the surgery and also given on the day of surgery. We are looking at the finished spells in a specified time period  Data Source – PATS (Local cardiac surgery electronic system) which is used to feed data for UHB into CCAD, PICS (Electronic prescribing system used in UHB)  All persons (Male and Female)  Hospital Level  Frequency – Monthly (could be performed quarterly or annually) | Clinical evidence supports use of BB in 1st time CABG patients. | Data appears to be of good quality, with a robust numerator and denominator.  Risk adjustment is not required and has been considered.  Data presented as simple % for financial cumulative year, updated each month, compared to previous 3 year %.  Outliers will be identified as +/- 3 St Dev from mean  Assumes all orgs that wish to use this indicator collect the same data items in the same way, which is reasonable as some have ISB risk |

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| **Recommendation 2011/61** | Provide the group with the clinical evidence supporting the use of the indicator. Is there a NICE guideline for this? CIT to follow up with applicant. |
| **Recommendation 2011/62** | The indicator wording, both top level definition and descriptions of numerator and denominator need to be clearer. CIT to follow up with applicant. |
| **Recommendation 2011/63** | The following issues require clarification:   * How far before the operation? * Only those who actually have the operation? * What is good? Dependent on standards. * Exact definition of 1st time CABG. E.g. 1st on each vein? What if first failed? * Often done as an emergency or as part of another procedure – are these alternatives included?   CIT to follow up with applicant. |
| **Recommendation 2011/64** | Outliers are an intrinsic part of the indicator and should be presented as part of the indicator construction. |

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| **Indicator** | **Construction** | **Rationale** | **Potential issues** |
| **DOMAIN 4 – Patient experience**  4.3 – Patient experience of Accident and Emergency services. | Data source: CQC’s Emergency Department Survey.  Around 50,000 responses to 2008 survey – response rate of around 40%.  This is a composite indicator averaging scores from five questions. Individual questions are scored according to pre-defined scoring regime that awards scores between 0-100. Therefore the indicator will take values between 0-100. The questions have been selected by the A&E policy team at DH and assured by the Patient Experience Policy Team (PEPP). Full details of the selection and assurance are provided in document entitled ‘AE D4 4.3 PEPP ASSURANCE SIGNED OFF’.  Construction:  Overall score of five separate questions. Data is standardised by age and sex. For each trust, an average weighted score is calculated for each of the relevant questions. Missing values are excluded from analysis. These scores are aggregated into the overall value using a simple weighted average. National domain scores are calculated by a simple average of the Trust scores. | It is now standard practice in healthcare systems worldwide to ask people to provide direct feedback on the quality of their experience, treatment and care. It will be used alongside additional information sources to provide local clinicians and managers with intelligence on the quality of local services from the patients’ and service users’ point of view. Ultimately to play a role in driving improvements in the quality of service design and delivery. | 1. The calculation method is the same as that used for indicators 4b and 4.2. Questions and recommendations regarding this method have been raised by the MRG. The update in section 4 of this paper details the recommendations and responses. This concludes with the acceptance of the method, with alternatives and analysis included in the indicator data quality statement.  2. The future survey architecture may change *which could mean that the survey questions this indicator is based on will change.* |
| **DOMAIN 4 – Patient experience**  4.5 – Improving women and their families’ experience of maternity services | Data source: CQC’s Maternity care survey.  Over 25,000 responses to 2010 survey – response rate of 52%.  This is a composite indicator averaging scores from six questions – two each on antenatal, intrapartum (labour and delivery) and postnatal. Individual questions are scored according to pre-defined scoring regime that awards scores between 0-100. Therefore the indicator will take values between 0-100. The questions have been selected by the Maternity and New Born policy team at DH and assured by the Patient Experience Policy Team (PEPP). Full details of the selection and assurance are provided in document entitled ‘Maternity D4 4.5 PEPP assurance SIGNED OFF’.  Construction:  Overall score of six separate questions. Data is standardised by age. For each trust, an average weighted score is calculated for each of the relevant questions. Missing values are excluded from analysis. These scores are aggregated into the overall value using a simple weighted average. National domain scores are calculated by a simple average of the Trust scores. | It is now standard practice in healthcare systems worldwide to ask people to provide direct feedback on the quality of their experience, treatment and care. It will be used alongside additional information sources to provide local clinicians and managers with intelligence on the quality of local services from the patients’ and service users’ point of view. Ultimately to play a role in driving improvements in the quality of service design and delivery. | 1. Calculation method as stated for indicator 4.3 above.  2. An interim step of the national indicator is to calculate trust level scores. For two of the questions selected for the indicator one particular trust is not solely responsible for the care being provided. No scoring is currently available for these questions. CQC can provide this, but it needs to be made clear that this indicator cannot be reported at Trust level with the questions selected.  3. The future survey architecture may change *which could mean that the survey questions this indicator is based on will change.* |
| **DOMAIN 4 – Patient experience**  4.7 – Patient experience of community mental health services. | Data source: CQC’s Community mental health services survey.  Over 17,000 responses to 2010 survey – response rate of 33%.  This is a composite indicator averaging scores from five questions. Individual questions are scored according to pre-defined scoring regime that awards scores between 0-100. Therefore the indicator will take values between 0-100. The questions have been selected by the Mental Health policy team at DH and assured by the Patient Experience Policy Team (PEPP). Full details of the selection and assurance are provided in document entitled ‘Mental Health D4 4.7 PEPP ASSURANCE SIGNED OFF’.  Construction:  Overall score of five separate questions. Data is standardised by age and sex. For each trust, an average weighted score is calculated for each of the relevant questions. Missing values are excluded from analysis. These scores are aggregated into the overall value using a simple weighted average. National domain scores are calculated by a simple average of the Trust scores. | It is now standard practice in healthcare systems worldwide to ask people to provide direct feedback on the quality of their experience, treatment and care. It will be used alongside additional information sources to provide local clinicians and managers with intelligence on the quality of local services from the patients’ and service users’ point of view. Ultimately to play a role in driving improvements in the quality of service design and delivery. | 1. Calculation method as stated for indicator 4.3 above.  2. The future survey architecture may change *which could mean that the survey questions this indicator is based on will change.* |
| **DOMAIN 4 – Patient experience**  4.1 – Patient experience of outpatient services. | Data source: CQC’s Outpatient services survey.  Over 72,000 responses to 2009 survey – response rate of 53%.  This is a composite indicator averaging scores from five questions- one pre visit, three during visit and one post visit. Individual questions are scored according to pre-defined scoring regime that awards scores between 0-100. Therefore the indicator will take values between 0-100. The questions have been selected and assured by the Patient Experience Policy Team (PEPP). Full details of the selection and assurance are provided in document entitled ‘OP D4 4.1 PEPP ASSURANCE SIGNED OFF’.  Construction:  Overall score of five separate questions. Data is standardised by age and sex. For each trust, an average weighted score is calculated for each of the relevant questions. Missing values are excluded from analysis. These scores are aggregated into the overall value using a simple weighted average. National domain scores are calculated by a simple average of the Trust scores. | It is now standard practice in healthcare systems worldwide to ask people to provide direct feedback on the quality of their experience, treatment and care. It will be used alongside additional information sources to provide local clinicians and managers with intelligence on the quality of local services from the patients’ and service users’ point of view. Ultimately to play a role in driving improvements in the quality of service design and delivery. | 1. Calculation method as stated for indicator 4.3 above.  2. The future survey architecture may change *which could mean that the survey questions this indicator is based on will change.* |

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| **Recommendation 2011/65** | Is there bias in the profile of respondents and, if so, how is this handled in the indicator calculation? CIT to provide details. |
| **Recommendation 2011/66** | The individual questions that constitute the indicator, and their scores, should be displayed alongside the indicator itself. CIT to investigate. |
| **Recommendation 2011/67** | Has user engagement been sought and accounted for in the selection of questions? PEPP to follow up. |
| **Recommendation 2011/68** | Indicators to proceed to IGB. CIT to action. |

# Recommendations update

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| **Indicator** | **Construction** | **Rationale** | **Potential issues** |
| **DOMAIN 4 – Patient experience**  4b Patient experience of hospital care | Data source: CQC’s Adult Inpatient Survey. Annual survey of patients with and inpatient episode between June and August. Covers elective and emergency care patients with at least one night in hospital. Doesn’t include maternity, mental health patients or patients under 18. Is an existing National Statistic published by DH and CQC.  Around 70,000 responses annually – response rate of around 50%.  This is a composite indicator averaging scores in five domains. Individual questions are scored according to pre-defined scoring regime that awards scores between 0-100. Therefore the indicator will take values between 0-100.  Construction:  Overall score of five separate domains (with questions within each), data is standardised by age-sex, and pathway (emergency or elective). For each trust, an average weighted score is calculated for each of the relevant questions. Missing values are excluded from analysis. These scores are aggregated into the domains using a simple weighted average. National domain scores are calculated by a simple average of the Trust scores. Full methodology is available. | It is now standard practice in healthcare systems worldwide to ask people to provide direct feedback on the quality of their experience, treatment and care. It will be used alongside additional information sources to provide local clinicians and managers with intelligence on the quality of local services from the patients’ and service users’ point of view. Ultimately to play a role in driving improvements in the quality of service design and delivery. | 1. Title not specific to inpatients  2. Comparison both over time and against an optimum value are highlighted as requirements. Detail of optimum value requirements to be worked through.  3. The future survey architecture may change *which could mean that the survey questions this indicator is based on will change.*  4. It is expected that both NHS/DH boards will be users and the public. |
| 4.2 **(IAP00036)** Responsiveness to inpatients’ personal needs | Data source: CQC’s Adult Inpatient Survey. Annual survey of patients with and inpatient episode between June and August. Covers elective and emergency care patients with at least one night in hospital. Doesn’t include maternity, mental health patients or patients under 18. Underlying data source is currently published and scores for this indicator are shared with the NHS but no national level indicator is currently published.  Around 70,000 responses annually – response rate of around 50%.  This will be a composite indicator averaging scores in five domains. Individual questions are scored according to pre-defined scoring regime that awards scores between 0-100. Therefore the indicator will take values between 0-100.  Construction:  Overall score of five separate domains (with questions within each), data is standardised by age-sex, and pathway (emergency or elective). For each trust, an average weighted score is calculated for each of the relevant questions. Missing values are excluded from analysis. These scores are aggregated into the domains using a simple weighted average. National domain scores are calculated by a simple average of the Trust scores. | Indicator was developed as part of a national CQIN goal for acute providers.  It is now standard practice in healthcare systems worldwide to ask people to provide direct feedback on the quality of their experience, treatment and care. It will be used alongside additional information sources to provide local clinicians and managers with intelligence on the quality of local services from the patients’ and service users’ point of view. Ultimately to play a role in driving improvements in the quality of service design and delivery. | 1. Assume national indicator would be created in same way as current national indicator for 4b.  2. Comparison both over time and against an optimum value are highlighted as requirements. Detail of optimum value requirements to be worked through.  3. The future survey architecture may change *which could mean that the survey questions this indicator is based on will change.*  4. It is expected that both NHS/DH boards will be users and the public. |

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| **Recommendation 2011/18** | The wording for these indicators suggests use outside of the national level. In the first instance the NHS Outcomes Framework requires only a national indicator. The group should ensure it is reviewing at the appropriate level. |
| **Recommendation 2011/19** | National level indicator should be constructed from the lowest level data rather than from combining trust scores. The availability of this data should be investigated. DH to inform IC. Report back to MRG if not possible. |
| **Update** | The following is taken from ‘Methods, reasoning and scope. Statement of methodology for overall patient experience scores (statistics)’  <http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127319.pdf> page 14  Decision 8: How should we aggregate Trust level scores to national level scores (Trust weighting issues)  There are three possible ways to work out national figures:   1. use the whole dataset and ignore distinctions between trusts (i.e. treat the country as one giant trust – the ‘one nation’ method) 2. work out individual Trust level scores and then take a simple average 3. calculate a weighted average of Trust level scores using some measure of trust size   Since the initial sample size for all Trusts is the same (850) the first two methods give similar results, and the second has the advantage of showing a clear and simple relationship between Trust level scores and national scores.  In principle the third method would give a more accurate national picture by giving a higher weight to larger Trusts, but the difference is not large. This approach would introduce an extra layer of complexity to the calculation and would require judgements to be made about the most appropriate measure of size to use for Trusts. Whichever measure of size we selected (beds, admissions, patient episodes etc) this method would require links to other data because there are no direct measures of Trust size within the patient survey datasets. Different measures of size would give results, and this introduces a degree of subjectivity into the methodology that is undesirable. In addition, this approach would tend to make the overall national measure unstable when there is organisational change in the NHS (for example Trust mergers).  It is important to note that because all Trusts have the same sample size, patients at smaller Trusts are disproportionately represented in the national figures, but this provides a sensible balance between transparent and simple methodology and analytical rigour.  This was further elaborated on by DH as follows:  On the technical points we discussed, there was an outstanding issue about demonstrating that two different approaches to national indicators give similar results:  i) working out Trust level indicators first, then averaging  ii) working out a national level measure directly.  As we discussed, there are good qualitative reasons for using method (i), principally that it allows Trusts to relate their own figures very directly to the national overview. We also use the Trust level figures extensively in other indicator systems (for example the performance framework), so it is helpful to have a single coherent mechanism. |

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| **Recommendation 2011/20** | Variation in response rates between trusts should be considered when aggregating to national level. DH to provide information. Report back to MRG if problems arise. |
| **Update** | The following is from a document from the DH from April 2006 when the indicators were first being prepared.  Weighting for differential non-response   1. Standardisation, as described above [referring to paragraphs in the document from which this paragraph was taken], aligns the age and gender mix for each Trust with the age and gender mix of the *returned* questionnaires. This is fine if the returned questionnaires are representative of the whole population, but some patients choose not to respond to patient surveys, and the response rate can vary for different age/ sex groupings. 2. There is a theoretical case for adjusting scores for different rates of non-response in different age and gender groups. Such a change would add further complexity to the methodology, and analysis suggested that the impact of such a change would be small.   The analysis referred to is no longer available. |

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| **Recommendation 2011/41** | The differences between the possible calculation methods should be quantified. If they are small the indicator should proceed with the current method, with the alternatives and this analysis included in the indicator data quality statement. The differences should be checked annually to ensure this is consistent over time. IC Clinical Indicators Team (CIT) to discuss with team at DH that produce these indicators. |
| **Update 08/09/2011** | An impact of trust size has been considered to illustrate and quantify the impact of different calculation methods. This has been done on the Patient Experience Overall scores: Adult inpatient survey results. The age-gender-admission method weighting currently used has been retained, but instead of taking a crude average of trust scores a volume weight has been applied calculated purely from total count of FCEs. Results are shown below (in table). This shows that the weighting does alter the results, with scores generally being a touch lower. However, there is no discernible impact on the trend.  Closed – differences are small, so the indicator can proceed. |

Current national statistics. Source: National Patient Survey Programme

**Patient Experience Overall scores:** Adult Inpatient Survey results

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|  | **2005-06** | **2009-10** | **2010-11** |
| Access & waiting | 84.9 | 85.0 | 84.2 |
| Safe, high quality, coordinated care | 65.1 | 64.4 | 64.6 |
| Better information, more choice | 69.1 | 66.8 | 67.2 |
| Building closer relationships | 83.1 | 82.9 | 83.0 |
| Clean, friendly, comfortable place to be | 78.6 | 79.1 | 79.3 |
| **Overall** | **76.2** | **75.6** | **75.7** |

Weighted by crude volume measure for trusts

**Patient Experience Overall scores:** Adult Inpatient Survey results

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| --- | --- | --- | --- |
|  | **2005-06** | **2009-10** | **2010-11** |
| Access & waiting | 84.7 | 83.6 | 83.8 |
| Safe, high quality, coordinated care | 64.8 | 63.7 | 63.9 |
| Better information, more choice | 68.8 | 66.3 | 66.5 |
| Building closer relationships | 83.0 | 82.4 | 82.7 |
| Clean, friendly, comfortable place to be | 78.2 | 78.8 | 78.9 |
| **Overall** | **75.9** | **75.0** | **75.2** |

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| **Recommendation 2011/42** | The original purpose of the indicators should be checked against the aims within the NHS Outcomes Framework. CIT to follow this up. |
| **Update 08/09/2011** | The primary purpose of the current series is to provide users with data that are comparable over time. This matches the aim that there ‘will be a framework of accountability that focuses squarely on how well services are improving outcomes for people.’  Closed – purposes directly relate to one another |