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| FIELD | CONTENTS |
| IAP Code | IAP00047 |
| Title | Patient Experience of A&E Services |
| Published by | NHS Outcomes Framework |
| Reporting period | Quarterly |
| Geographical Coverage | England |
| Reporting level(s) | National |
| Based on data from | National Patient Experience Survey architecture |
| Contact Author Name | PEPP team, NHS North West |
| Contact Author Email | PEPP team, NHS North West |
| Rating | Assured |
| Assurance date | 06/10/11 |
| Review date | 06/10/14 |
| Indicator set | NHS Outcomes Framework 2011/12 |
| Brief Description  [This appears as a blurb in search results] | The indicator is driven by policy priorities and is assured by the Patient Experience Policy Programme (PEPP) prior to entering the Indicator Governance Board Assurance process. The PEPP is a collaboration between the Department of Health, Patient and Public Engagement and Experience Division and NHS North West and seeks to produce an Excellence Framework for Patient Experience by March 2012.  This will include strategic options for the future of the national patient experience survey architecture and information for Department of Health Policy Leads on best practice in the development of indicators for patient experience. |
| Purpose | This indicator has been selected as part of a set of indicators – developed through a consultation process – that will be used to hold NHS England to account.  The indicator is part of domain 4, which 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.  This information 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. This information will help drive improvements in the quality of service design and delivery. |
| Definition | This indicator forms part of the NHS Outcomes Framework which is designed to provide national level accountability for the outcomes the NHS delivers plus act as a catalyst for driving transparency, quality improvement and outcome measurement throughout the NHS.  The development of this indicator was driven by key aspects of patient experience in accident and emergency services. |
| Data Source | CQC’s Emergency Department Survey. NHS Survey website <http://www.nhssurveys.org/results>.  The 2009 survey involved 163 acute and specialist NHS trusts. Responses were received from more than 72,000 patients. The response rate was 53%. |
| Numerator | The mean of the scores for each question is calculated for each Trust to provide the Trust indicator score. The mean of the trust scores is calculated to give the national indicator score. |
| 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 | The NHS Outcomes Framework sets out the national outcome goals that the Secretary of State will use to monitor the progress of the NHS England. It does not set out how these outcomes should be delivered. It will be for the NHS England to determine how best to deliver improvements by working with clinical commissioning consortia and making use of various tools and levers at their disposal. |
| Caveats |  |
| Primary category | Patient care |

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| **Indicator Title,**  **This is the short title, a concise concept. Do not include details of calculation, geography, time period or population characteristics**  **Application Code (IAP00047)** |
| **The NHS Outcomes Framework 2011/12**  **Domain 4 – Ensuring that people have a positive experience of care**  **4.3 - Improving people’s experiences of Accident and Emergency services** |
| **Section A – Summary Application Details** |
| 1. Indicator Definition, this is the longer description of the indicator. Include a description of the calculation, measurement units, geographical range, and characteristics of the population such as age and gender. |
| **OVERVIEW OF INDICATOR:**  This indicator forms part of the NHS Outcomes Framework, which is designed to provide national level accountability for the outcomes the NHS delivers, and act as a catalyst for driving transparency, quality improvement and outcome measurement throughout the NHS.  The indicator is driven by policy priorities and is assured by the Patient Experience Policy Programme prior to entering the Information Centre Assurance process. The Patient Experience Policy Programme (PEPP) is a collaboration between the Department of Health Patient and Public, Engagement and Experience Division and NHS North West and seeks to produce by March 2012 an Excellence Framework for Patient Experience. This will include strategic options for the future of the national patient experience survey architecture and information for Department of Health Policy Leads on best practice in the development of indicators for patient experience. The Strategic Overview and Recommendations from PEPP are attached in the following draft embedded document ‘Strategic Overview and Recommendations, draft 6May 2011. Indicators developed using data sources from the current national patient experience survey architecture are presented as short term solutions prior to consideration of PEPP recommendations for the future.  Document available on request by email to [indicators@nice.org.uk](mailto:indicators@nice.org.uk)  Quality assurance for the PEPP assurance process for Domain 4 indicator development has been sourced from the NHS North West INSPIRE training and development framework and particularly in the area of analytical and clinical review expertise in developing an understanding of experience data and analysis and creating a shared understanding of service experience values, language and terminology. In addition, the development of indicators for Domain 4 will be included in the quality assurance process for PEPP which has been commissioned from academic’s experts in this field from Oxford University.  This indicator is part of Domain 4, which reflects the importance of providing a positive experience of care for patients, service users and carers in outpatient services.. The development of this indicator was, therefore, driven by the key aspects of patient experience in outpatient services.  **IS A COMPOSITE MEASURE OR SINGLE MEASURE USED?**  Composite measure  Single measure  **QUESTION(S):**  Q12. While you were in the Emergency department, did a doctor or nurse explain your treatment in a way you could understand?  Q15. Did you have confidence and trust in the doctors and nurses examining and treating you?  Q21. Were you involved as much as you wanted to be in decisions about your care and treatment?  Q27. Do you think the hospital staff did everything they could to help control your pain?  Q39. Overall, did you feel you were treated with respect and dignity while you were in the Emergency Department?  **MEASUREMENT UNITS**  The questions are answered on a 3 point scale, although some have a 'not applicable' option. The pre-defined scoring regime then awards scores between 0-100 to each scale point. Therefore, this indicator will also take values between 0-100.  **GEOGRAPHICAL RANGE:**  England  **AGE**  The questionnaire is for patients aged 16 and over.  **DISAGGREGATION:**  The Department of Health has made tackling health inequalities a priority. It is also under a legal obligation to promote equality across the equality strands protected in the Equality Act 2010. There is, therefore, a legal requirement and a principle that the design and introduction of the NHS Outcomes Framework will not cause any group to be disadvantaged.   Where possible, all indicators in Domain 4 should be disaggregated by the equality and inequality strands. It should be noted that not all strands are covered in the surveys.  The following strands are covered in the survey used to measure this indicator  Religion or belief  Gender  Disability  Sexual orientation  Socio-economic group (NS-SEC)  Deprivation (via postcode or area)  Age  Ethnicity  For those strands that are covered, disaggregation is only possible at a national level. Disaggregation at trust level is unreliable due to sample size.  Disaggregation is also required by age, using the following age bandings:  16-35  36-50  51-65  >65 |
| 1. Does this indicator measure a   process  outcome including process as proxy |
| 1. This measure is…   …compared against a national average  …compared against an optimum value |
| ...a comparison against an absolute evidence based standard  ...compared against self / baseline over time  …not compared against any other values |
| 1. List any indicators which overlap with the proposed indicator Are there other similar indicators currently in use? The IC will provide a library of existing indicators as a later part of this project development. For now, please list any indicator sources you have checked. |
| During the consultation process for the NHS Outcomes Framework, wide checks were undertaken to identify overlaps with other indicators. This indicator was selected as being fit for the purpose of the NHS outcomes indicators.  It is recognised that there is some overlap between the NHS Outcomes Framework, the Public Health Outcomes Framework and the Adult Social Care Framework. Further work, including a consultation process, is currently being undertaken in this area.  The A&E clinical quality indicators include an indicator on service experience. Instead of requiring all service providers to conduct a survey in a centrally prescribed manner, it requires them to set out a qualitative description of what has been done locally to assess the experience of patients, carers and staff, what the results were and what has been done to improve services in light of the results. As such it does not duplicate the Outcomes Framework indicator; rather it is hoped that the Outcomes Framework indicator will act as a starting point to help identify issues which need to be probed further. |
| 1. What value does the proposed indicator offer over existing indicators? |
| The Outcomes Framework as published requires a simple measure of A&E patient experience which the A&E service experience indicator will not provide. |
| 1. How is the indicator to be derived from its source data? |
| (a)  Re-use of existing data for an indicator, using data that are already aggregated or pre-calculated to answer the indicator question.  (b)  Existing raw data that require further calculation to answer the indicator question.  (c)  New data source will be created or an existing source changed to meet the requirement for this indicator |
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| 1. Is this indicator linked to another that has been submitted to pipeline? Give the name and relationship |
| Yes, this is indicator is part of the Domain 4 indicator set which is being developed as part of The NHS Outcomes Framework 2011/12.  4a Patient experience of primary care  4b Patient experience of hospital care  4.1 Improving people’s experience of outpatient care  4.2 Improving hospitals’ responsiveness to personal needs  4.3 Improving people’s experience of accident and emergency services 4.4 Improving access to primary care services  4.5 Improving women and their families’ experience of maternity services  4.6 Improving the experience of care for people at the end of their lives  4.7 Improving experience of healthcare for people with mental illness  4.8 Improving children and young people’s experience of healthcare |
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| **Section B – Application contact details (please note all contact details will be treated confidentially)** |
| 1. Applicant Name   Name of person who is completing this application.  PEPP team  Applicant Role / Job Title |
| 1. Applicant Organisation   PEPP, NHS North West  Applicant Email |
| 1. Applicant Telephone   0161 625 7344  Janet.Butterworth@northwest.nhs.uk |
| 1. Sponsor name   Name of the person who is paying for the production of the indicator  NB The indicator uses an existing survey so there are no cost implications.  Stephen Anderson   1. Sponsor Role / Job Title   Policy Manager, Urgent and Emergency Care |
| 1. Sponsor Organisation   Department of Health, Patient Experience Policy Team   1. Acknowledgements Please list any contributors to the development of the indicator you wish accredited |
| 1. Please list any other stakeholder groups   Name specific groups of users who may wish to be involved in assurance of this indicator |
| **Section C – Users of the Proposed Indicator** |
| **Primary User Secondary User Not intended for** |
| National Government |
| Local Government |
| Governing Boards (NHS, local government etc) |
| Providing Managers |
| Commissioning Managers |
| Regulators |
| Clinicians |
| Patients |
| Public |
| Other (please specify) Secretary of State for Health |
| Other (please specify) NHS Commissioning Board |
| **Section D – Rationale for Indicator** |
| 1. Relevant policies, strategies or programmes |
| 1. The NHS Outcomes Framework 2011-12 <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944>  2. Patient Experience Policy Programme (PEPP)  3. Excellence Framework for Patient Experience: Strategic Overview and recommendations, PEPP, NHS North West  4. Equity and excellence: Liberating the NHS commits the Government to the development of a coherent 24/7 urgent care service in every area of England. A&E departments will be a key provider of this service. There are five aims related to the commitment, including improved patient experience (‘a greater focus on collecting and acting on patient feedback’). |
| 1. High level subject area |
| 1. Preventing people from dying prematurely  1. Enhancing quality of life for people with long term conditions  1. Helping people recover from episodes of ill health or following injury |
| 1. Ensuring people have positive experiences of care  1. Treating and caring for people in a safe environment and protecting them from avoidable harm  1. Helping people to stay healthy |
| 1. Equitable access to care   Other (specify) |
| 1. Evidence base for the indicator Provide a paragraph summarising the evidence for the rationale, noting quality of evidence where appropriate. Please extract salient messages, list the relevant documents in Question 4. |
| The NHS Outcomes Framework will provide national level accountability for the outcomes the NHS delivers. Its purpose is to:   1. Provide a national level overview of how well the NHS is performing. 2. Provide an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board. 3. Act as a catalyst for driving quality improvement and outcome measurement throughout the NHS.   This indicator has been selected as part of a set of indicators – developed through a consultation process – that will be used to hold the NHS Commissioning Board to account. The set of indicators consists of five domains:   1. Preventing people from dying prematurely 2. Enhancing quality of life for people with long-term conditions 3. Helping people to recover from episodes of ill-health or following injury 4. **Ensuring that people have a positive experience of care** 5. Treating and caring for people in a safe environment and protecting them from avoidable harm   This indicator is part of domain 4, which 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. This information 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. This information will help drive improvements in the quality of service design and delivery.  Improving people’s experience of accident and emergency (A&E) services is a vital outcome and determinant of patient experience. A&E is a crucial gateway into the NHS for individuals. With A&E it is about more than just how quickly people are seen by doctors or nurses but about their experience while in A&E care.  We have chosen a composite indicator because one single question is not available to cover all aspects of patient experience of A&E care that could, at the same time, provide useful information to service providers and commissioners that enable the identification of potential improvements to services.  Work by the King’s Fund and King’s College London and by Inspiration NW has identified that there are two dimensions to patient care, what happens to patients (functional) and how they feel about it (relational). Both are important, but we have focused on the relational aspects in developing the A&E indicator, not least because data on what happens to patients is captured elsewhere, such as in the A&E clinical quality indicator data.  Moreover, focusing on the relational aspect enables assessment of the emotional impact on patients of their care which may highlight issues not captured satisfactorily by data assessing clinical quality or timeliness of care. In particular, there already exists a wealth of data on timeliness of care, in the Quarterly Monitoring of A&E/weekly SitReps and HES collections and it is used systematically to improve patient care. It was therefore decided that it would not be appropriate to use survey questions about access to/timeliness of care in this indicator, even though the original intention of the A&E indicator (as set out in the Outcomes Framework) was linked to access.  The questions chosen fit with the key dimensions of care identified by the various research carried out by the King’s Fund and King’s College, Inspiration NW, the Picker Institute and the Institute of Medicine. Communication, confidence/trust, involvement in decision-making, comfort/pain management and respect/dignity are all recurrent themes.  A&E services are not different to other healthcare services in this respect, although there is evidence that some patients faced with an emergency healthcare value involvement in the decision-making process less than patients making choices about elective care, and some very seriously ill patients may not be able to contribute. Nevertheless, the key findings report for the 2008 A&E survey demonstrate that patient involvement is linked to higher satisfaction.  There are also repeated NAO (National Audit Office)and CQC reports that highlight that the areas chosen have great variability. The chosen topics reflect areas of specific concern that are not picked up in the existing A&E clinical quality indicators. As a result, the whole set will provide a more holistic picture of quality.  Bespoke analysis shows that the results from some of the questions discriminate between organisations poorly. However, our focus in creating the indicator is to quality assure the care and support continuous improvement rather than show up variations in care.. The data shows that there is still room for improvement in all questions. Alternative questions were considered but discounted as these were only relevant to a proportion of patients, e.g., patients who had had tests.  Pain management may appear on the surface to be transactional/functional. It is possible to measure by other methods which patients received pain relief, but it is only by asking the patient directly that we discover whether the pain relief provided made them comfortable.  There is no evidence to support weighting, so we have not suggested this. |
| 1. References List up to six key references or documents. If available on the internet, please give the URL |
| 1. ‘What matters to patients?’ Developing the evidence base for measuring and improving patient experience, Kings Fund, March 2011 |
| 1. ‘Analysis of the current patient experience survey architecture’, unpublished research paper, PEPP May 2011 |
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| 1. Clinical Advice Provide details of any clinical advice or support already given in development or preparation of indicator. |
| We have sought advice from Professor Matthew Cooke, National Clinical Director for Urgent and Emergency Care and Nicholas Reeves, Urgent Care Adviser to the Department. |
| **Section E – Management and production of Indicator** |
| 1. Commissioner Organisation This may be the same as the stakeholder in Section B, Question 8   Department of Health   1. Producer of indicator This is the organisation who will publish or provide the indicator and may be the same as the proposer in Section B, Question 3   NHS Information Centre |
| 1. 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. For example, poor performance will lead to letter being sent to Chief Executive of organisation, to stimulate them to take action. |
| The NHS Outcomes Framework sets out the national outcome goals that the Secretary of State 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 clinical commissioning consortia and making use of various tools and levers at their disposal. |
| 1. Have costs of collection, construction, dissemination and presentation been fully identified? Please provide, even if the indicator is not to be produced by the NHS IC. This is a useful measure of how committed the sponsor is to this indicator and helps us prioritise applications through the process. |
| This indicator makes use of an existing survey, so there are no cost implications. |
| 1. Funding status   Secured  Being sought  Not identified  Not applicable |
| 1. What are the timescales you envisage for developing / producing this indicator Give specific dates for key stages or publication or development of indicator |
| The indicator needs to be produced by 31 March 2012 as required for the NHS Outcomes Framework . |
| 1. Risks, assumptions and impact of producing indicator Are there any external factors that need to be understood, such as changes to policy, data collections, finances or political changes.   Having done quite a lot of research into patient experience, we have favoured a broader and less prescriptive approach to service experience in our own A&E clinical quality indicators which aims to support local services to improve. Instead of requiring all service providers to conduct a survey in a centrally prescribed manner, it requires them to set out a qualitative description of what has been done locally to assess the experience of patients, carers and staff, what the results were and what has been done to improve services in light of the results.  However, the Outcomes Framework as published requires a simple measure of A&E patient experience. Given the timescales involved, it is not possible to do anything other than use the existing CQC A&E survey to develop this. However, in the medium term we are likely to want to revisit the methodology for measuring patient experience.  The data source for the indicator is the A&E survey. This currently only includes major A&E departments and excludes single specialty and urgent care departments. The limitations of the survey strengthened the need for a review of methodology for the medium term. |
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| 1. Risks 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? |
| As this is a survey based indicator, healthcare providers have little chance to influence the indicator value. There is, therefore, a low risk of perverse incentive or gaming by healthcare providers. |
| 1. Risks, assumptions and impact of not producing indicator |
| This indicator is part of the NHS Outcome Framework 2011-12 indicator set. A public commitment has been made to developing this set of indicators by April 2012. |
| **Section F – Methodology**  **Please note that the methodology outlined below has been recommended by NHSIC for use across all Domain 4 indicators. If you are proposing an alternative methodology, please describe in detail below.** |
| 1. Select the calculation type |
| Count For example volume of procedures, number of patients  Percentage For example percentage of patients treated  Rate per For example, rate per 100,000 population |
| Ratio For example observed deaths to expected deaths  Score For example score from suite of survey questions, or score against predicted or estimated value  Index score |
| Mean This is the sum of all values divided by the number of values, or common ‘average’.  Median This is the middle value observed  Mode This is the most common value observed |
| Interquartile range  Other Please use this if you are proposing a complex indicator which cannot be described in simple terms, such as Standardised Hospital Mortality Rates |
| 1. Select the adjustment or standardisation type used Select all that apply |
| No adjustment or standardisation  Direct standardisation  Indirect standardisation |
| Non-response weighting  Risk adjustment  Pooled data |
| Rolling averages  Confidence limits or intervals applied |
| 1. Descriptions of the calculation Describe the calculation required in words. Where this is insufficient, please submit a document with formulae in addition to this application |
| **Cleaning and scoring**   * All questions responses are converted to scores using the scoring scheme given. * Missing values for age and gender are replaced with values from the sample file where available. * Records without a valid age or gender or admission type are removed from the file. * Records without any valid question responses are removed from the file. * Ages are grouped into bands: 16 to 35, 36 to 50, 51 to 64, 65 plus. * Survey filters are followed and inappropriate routing corrected (e.g. respondent answers Q42, which then says, ‘go to Q46’, but respondent has also answered Q43-45. In this example, the answers to Q43-45 would be removed).   **Standardisation by age and gender**  Each individual is assigned to a group based on their age-band and gender. Totals for each such group (or strata) are calculated for each NHS Trust, and also nationally. A weight is then calculated for each individual as follows:  Where n is the number of valid records at Trust or national level in the same strata as patient i.  Weight = ∑ntrust,i  ∑ntnational,i  **Question scores at trust level**  A mean score is then worked out for each of the relevant questions, within each trust. The Trust level mean score for question j and Trust k is given by:  Here, the xijk represent the question scores from each individual patient and the Wi represents the weight for that individual.  Note at this point how the method handles missing values. The relevant xijk would be ‘missing’ and therefore excluded from the numerator. To compensate, the Wi for those individuals is set to zero, so they do not contribute to the denominator either. Thus, the question score is a weighted mean of responses received, regardless of how many responses there were.  **Using question scores to calculate trust and national indicator scores**  The mean of the scores for each question is calculated for each trust to give the trust indicator score. The mean of the trust scores is calculated to give the national indicator score. |
| 1. Statistical Methods Type of analysis (any methods used), risk adjustment (predictive power of model), special techniques (dealing with dispersion, constant risk), statistical process control |
| See above |
| 1. Risk adjustment variables The purpose of risk adjustment is to remove the effect of aspects beyond the direct control of the organisation or group monitored. Where risk adjustment is used, summarise the application of risk adjustment and selection of relevant variables. If not used, state why. |
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| 1. Quality assurance process Detail the quality assurance processes in place to check data, identify anomalies. Note any processes or arrangements in place to discuss issues with the suppliers of the raw data if required. |
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| 1. Test or sample data Test or sample data are required as proof of concept. Please submit a document or spreadsheet with this application |
| 1. Interpretation Describe how this indicator is planned to be used, what questions the indicator is planned to answer, and any known limitation(s) |
| The indicator forms part of the NHS Outcomes Framework, which is designed to provide national level accountability for the outcomes the NHS delivers, and act as a catalyst for driving quality improvement and outcome measurement throughout the NHS.  Having done quite a lot of research into patient experience, we have favoured a broader and less prescriptive approach to service experience in our own A&E clinical quality indicators which aims to support local services to improve. Instead of requiring all service providers to conduct a survey in a centrally prescribed manner, it requires them to set out a qualitative description of what has been done locally to assess the experience of patients, carers and staff, what the results were and what has been done to improve services in light of the results. It is hoped that the Outcome Framework indicator will act as a starting point to help identify issues which need to be probed further. |
| 1. Format of presentation Describe the final published format, such as interactive website, csv file etc. Please submit a document with an example or screenshot (or mock version) of how the final presentation of the data will appear. Include any interpretive text as well as figures |
| Department of Health have requested that the data be provided in CSV format. |
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| **Section G – Data sources** |
| If you answered (a) in [Section A](#Section_A) Question 6, please complete only the numerator part of this section. If you answered (b) or (c) and the indicator is based on more than one data source answer both numerator and denominator parts. |
| 1. Numerator definition Word description of the cases or events to be counted. The numerator should be a subset of the denominator |
| The indicator is a composite, calculated as the average of 5 survey questions. Each question describes a different element of the overarching theme: Improving people’s experiences of Accident and Emergency services.  Q12. While you were in the Emergency department, did a doctor or nurse explain your treatment in a way you could understand?  Q15. Did you have confidence and trust in the doctors and nurses examining and treating you?  Q21. Were you involved as much as you wanted to be in decisions about your care and treatment?  Q27. Do you think the hospital staff did everything they could to help control your pain?  Q39. Overall, did you feel you were treated with respect and dignity while you were in the Emergency Department?  **Scoring**  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). |
| 1. Numerator source Organisation and data collection name |
| Emergency Department Questionnaire (part of the National Survey Programme) |
| 1. Numerator construction Which data fields (specify) and values (specify codes) are combined to arrive at the count. Include any special rules or filters |
| **Using question scores to calculate trust and national indicator scores**  The mean of the scores for each question is calculated for each trust to give the trust indicator score. The mean of the trust scores is calculated to give the national indicator score. |
| 1. Numerator completeness Are all relevant cases/ events counted. List any known exclusions, shortfalls or collection issues which will affect the required count. How do counts compare with other sources? |
| **SURVEY SAMPLE SIZE:**  The 2009 survey involved 163 acute and specialist NHS trusts. Responses were received from more than 72,000 patients.  **RESPONSE RATE:**  The response rate was 53%.  **COLLECTION ISSUES**  Results are slightly skewed towards females and the older population.  Females (57%) Males (43%)  66 and older (46%), 51-65 (29%), 36-50 (16%), 35 and younger (9%) |
| 1. Numerator quality of data Issues with accuracy or known variability of recording. For example, coding by untrained staff. Please list any indicators of data quality available (by field or whole numerator) |
|  |
| 1. Numerator data availability Are the data publicly available / published? Are they available only upon request, or only to groups of people meeting specific criteria / conditions? |
| Is survey data publicly available:  Yes  If Yes, please state where available, and in what format  (If the data is published in multiple locations, please include  all known locations, including URLs)  No  • NHS Information Centre (available upon request in various formats)  • NHS Survey website <http://www.nhssurveys.org/results>  • Care Quality Commission <http://www.cqc.org.uk/_db/_documents/Outpatient_09_MaydayHealthcareNHSTrust_RJ6.pdf> |
| 1. Numerator timeliness Frequency and timeliness of data. State how the publication / release of data relates to envisioned indicator productions timescales |
| **SURVEY TIMING**  The A&E survey is currently collected on a rolling basis, i.e. each is collected once every three years. This surveys will continue on this basis, with levels of ambition set for the relevant outcomes for a three-year period. The A&E Survey is next due to run in 2012.  **Will baseline data be available by March 2012?**  Yes **☒**  No **☐** |
| 1. Numerator ISB compliance Some data items used across the NHS and social care have been approved as an Information Standard by the Information Standard Board for health and social care and is a measure of quality and consistency. Please give the Information Standard number and release version where appropriate |
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| 1. Numerator ROCR approval Data collected by NHS and social care staff other than that required for day-to-day treatment of patients must be approved by the Review of Central Returns. Please give the ROCR Reference number and date for review where appropriate. |
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| 1. Numerator comments Please detail any caveats not already covered |
|  |
| 1. Denominator definition Word description of the cases or events to be counted. |
| N/A |
| 1. Denominator source Organisation and data collection name |
| N/A |
| 1. Denominator construction Which data fields (specify) and values (specify codes) are combined to arrive at the count. Include any special rules |
| N/A |
| 1. Denominator completeness Are all relevant cases/ events counted. List any known exclusions, shortfalls or collection issues which will affect the required count. How do counts compare with other sources? |
| N/A |
| 1. Denominator quality of data Issues with accuracy or known variability of recording. For example, coding by untrained staff. Please list any indicators of data quality available (by field or whole numerator) |
| N/A |
| 1. Denominator data availability Are the data publicly available / published? Are they available only upon request, or only to groups of people meeting specific criteria / conditions? |
| N/A |
| 1. Denominator timeliness Frequency and timeliness of data. State how the publication / release of data relates to envisioned indicator productions timescales |
| N/A |
| 1. Denominator ISB compliance Some data items used across the NHS and social care have been approved as an Information Standard by the Information Standard Board for health and social care and is a measure of quality and consistency. Please give the Information Standard number and release version where appropriate |
| N/A |
| 1. Denominator ROCR approval Data collected by NHS and social care staff other than that required for day-to-day treatment of patients must be approved by the Review of Central Returns. Please give the ROCR Reference number and date for review where appropriate. |
| N/A |
| 1. Denominator comments Please detail any caveats not already covered |
| N/A |
| Application Checklist – Clinical Indicator Team use only |
| [Section A](#Section_A) – Summary Application Details  Requires additional information  Satisfactory  Comments include all issues, even minor ones to be resolved outside the major meetings |
| [Section B](#Section_B) – Application contact details  Requires additional information  Satisfactory  Comments include all issues, even minor ones to be resolved outside the major meetings |
| [Section C](#Section_C) – Users of the Proposed Indicator  Requires additional information  Satisfactory  Comments include all issues, even minor ones to be resolved outside the major meetings |
| [Section D](#Section_D) – Rationale for Indicator  Requires additional information  Satisfactory  Comments include all issues, even minor ones to be resolved outside the major meetings |
| [Section E](#Section_E) – Management and production of Indicator  Requires additional information  Satisfactory  Comments include all issues, even minor ones to be resolved outside the major meetings |
| [Section F](#Section_F) – Methodology  Requires additional information  Satisfactory  Comments include all issues, even minor ones to be resolved outside the major meetings |
| [Section G](#Section_G) – Data sources  Requires additional information  Satisfactory  Comments include all issues, even minor ones to be resolved outside the major meetings |
| Issues for consideration Record all major issues to be considered before indicator can be ‘assured’ |
| Area where issue resides  Group to discuss  Summary of issue  Actioned / resolved |
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| Record of meetings Choose meeting type and add hyperlink to the meeting minutes |
| Meeting type  Date  Issues discussed  Minutes please insert the hyperlink to the minutes of the meeting |
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| Caveats to apply to indicator |

Indicator Assurance Pipeline Process

**Methodology Review Group**

**Applications for consideration**

**8 September 2011**

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| --- | --- |
| **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 |

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# Document Control

## Version History

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| --- | --- | --- | --- |
| **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 |
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## Approvals

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

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| **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

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| **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. |

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| **2.3i Unplanned hospitalisation for chronic ambulatory care sensitive conditions** |
| **3a Emergency admissions for acute conditions that should not usually require hospital admission** |
| **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?** |
| **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** |
| **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.' |
| **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 **(IAP00047)** – 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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| **DOMAIN 4 – Patient experience**  4b Patient experience of hospital care  **Construction**  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.  **Rationale**  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.  **Potential issues**  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.  **Indicator**  4.2 Responsiveness to inpatients’ personal needs  **Construction**  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.  **Rationale**  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.  **Potential issues**  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. |
| **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. |
| **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. |
| **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. 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.  **CURRENT NATIONAL STATISTICS**    **Patient Experience Overall scores**: Adult Inpatient Survey results  **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    Source: National Patient Survey Programme      **WEIGHTED BY CRUDE VOLUME MEASURE FOR TRUSTS**    Patient Experience Overall scores: Adult Inpatient Survey results  **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    Source: National Patient Survey Programme  Closed – differences are small, so the indicator can proceed. |
| **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. |