**NHS Digital**

**Indicator Supporting Documentation**

**IAP0053 Access to NHS dental services**

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| FIELD | CONTENTS |
| IAP Code | IAP00053 |
| Title | Access to NHS Dental Services |
| Published by | NHS Outcomes Framework |
| Reporting period | Quarterly |
| Geographical Coverage | England |
| Reporting level(s) | National |
| Based on data from | GP Patients Survey |
| Contact Author Name | PEPP, NHS North West |
| Contact Author Email | Janet.butterworth@northwest.nhs.uk |
| Rating | Assured |
| Assurance date | 05/10/11 |
| Review date | 05/10/14 |
| Indicator set | NHS Outcomes Framework 2011/12 |
| Brief Description  | 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 | The indicator is based on a patient experience of NHS dental access and is derived from responses to two questions in the GP Patient Survey. Although two questions are asked, the indicator is more fitting as a single measure rather than a composite. The first question is used to ascertain how many of the people answering the questionnaire should be included in our access measure (i.e. how many have actually tried to get an NHS dental appointment in the last two years). Those who do, go on to answer the second question about access (success in getting an appointment). The indicator questions were originally included in the GP Patient Survey in January to March 2010, with the aim for the results to be used to measure dental access at a national level, as well as PCT level in order to give a robust estimate of access at a local level. |
| Definition | The indicator is based on public experience of accessing NHS dentistry and takes into account the demand (how many are trying to get an appointment). The previous dental access indicator (patients seen in 24 months and as a percentage of the population) did not take into account the fact that a proportion of the population are private dental patients and do not visit an NHS dentist. |
| Data Source | GP Patient Survey carried out by Ipsos MORI on behalf of the Department of Health. The Department carries out additional analysis to derive the dental access results from the questionnaire responses. |
| Numerator | All relevant cases are counted. The only exclusions are for data related reasons: \* Respondents who selected (e) or (f) for Q42 are excluded. These respondents have not tried to get an NHS dental appointment so should not be included in the calculation. \* Those that only answered one of the two questions are excluded. \* Respondents who selected (c) ‘can’t remember’ for Q44 are excluded to obtain a ‘pure access’ percentage. |
| Denominator | The average weighted number of respondents to at least one of the 20 questions. |
| Calculation | [𝑁𝑢𝑚𝑒𝑟𝑎𝑡𝑜𝑟𝑖𝐷𝑒𝑛𝑜𝑚𝑖𝑛𝑎𝑡𝑜𝑟𝑖]×100Individual 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 indicator will be used to give an accurate picture of the success in getting an NHS dental appointment (dental access). Known limitations include: \* Non-response to the GP Patient survey, which may produce skewed results \* The survey only collects information from adults, so does not look at access for children and young people \* The survey is only distributed to people who are registered at a GP Practice. |
| Caveats |  |
| Primary category | Dental services |

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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 **(IAP00053)** |
| **The NHS Outcomes Framework 2011/12****Domain 4 – Ensuring that people have a positive experience of care****4.4 - Improving access to NHS dental services** |  |

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| **Section A – Summary Application Details** |

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| 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 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 academics experts in this field from Oxford University.This indicator is part of Domain 4, which reflects the importance of improving access to primary care services, particularly dental services.**IS A *COMPOSITE MEASURE* OR *SINGLE MEASURE* USED? (select one)** |

|  |  |
| --- | --- |
| Composite measure | [ ]  |
| Single measure | [x]  |

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| The indicator is based on a patient experience of NHS dental access and is derived from responses to two questions in the GP Patient Survey. Although two questions are asked, the indicator is more fitting as a single measure rather than a composite. The first question is used to ascertain how many of the people answering the questionnaire should be included in our access measure (i.e. how many have actually tried to get an NHS dental appointment in the last two years). Those that go on to answer the second question about access (success in getting an appointment). The indicator questions were originally included in the GP Patient Survey in January to March 2010, with the aim for the results to be used to measure dental access at a national level, as well as PCT level (to give a robust estimate of access at a local level).Although technical guidance on the NHS Outcomes Framework favours a composite approach, this is not appropriate due to the limited number of questions which relate to dental access in the GP survey. **QUESTION(S):**1. **When did you last try to get an NHS dental appointment for yourself?** a) In the last 3 monthsb) between 3 and 6 months agoc) between 6 months and a year agod) between 1 and 2 years agoe) more than 2 years agof) I have never tried to get an NHS dental appointmentThose who answered a-d above go on to answer the question on access (below):1. **Were you successful in getting an NHS dental appointment?**

a) yesb) noc) can’t rememberThose who respond with the answer c) to the second question are not included in the access indicator calculation.To note: Although we have 5 quarters worth of data on this indicator the methodology of the survey going forward may change and therefore it may not be possible to compare data from previous surveys with future surveys. Ipsos MORI and the DH GP Team have been looking into this, but we do not know yet if the changes will affect our ability to compare the old and new version of the Survey. **MEASUREMENT UNITS (how will the question(s) be scored?** It will be a percentage. Of those who tried to get an NHS dental appointment in the last 2 years (who answered with response a-d in question one above), what proportion succeeded (of those who answered question two above with response a and b, what percentage answered with a). **GEOGRAPHICAL RANGE (England/UK):**England (but broken down and published at SHA and PCT level)**AGE:** The survey is distributed to adult patients, aged 18 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. |

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| The following strands are covered in the survey used to measure this indicator: |

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| Religion or belief | [x]  |
| Gender | [x]  |
| Disability | [x]  |
| Sexual orientation | [x]  |
| Socio-economic group (NS-SEC) | [ ]  |
| Deprivation (via postcode or area) | [x]  |
| Age | [x]  |
| Ethnicity | [x]  |

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| For a number of the strands that are covered, desegregation 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:18-2425-3435-4445-5455-6465-7475-8485+ Note that for the dental access results published by the Department of Health, the last two age groups are grouped together (75+) because the sample size for 85+ is too small. |

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| 3.Does this indicator measure a | [ ]  process | [x]  outcome including process as proxy |
| 4.This measure is… | [ ] …compared against a national average | [ ] …compared against an optimum value |
| [ ] ...a comparison against an absolute evidence based standard | [x] ...compared against self / baseline over time | [ ] …not compared against any other values |

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| 5.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 24-month patient seen data has previously been used as an indicator of dental access. This data is still collected and is published by the NHS Information Centre but was limited in giving an overall picture of NHS dental access. For example, it showed that Kensington and Chelsea PCT had one of the lowest 24-month patient seen figures (as a proportion of the population), which implies they need to improve dental access. However, the figure does not show that this particular PCT has a large proportion of its population who prefer private dentistry, and therefore the access to NHS dentistry is not an issue for this PCT. The CQC used this as an indicator in the past but this is no longer the case. |
| 6.What value does the proposed indicator offer over existing indicators?  |
| The indicator is based on public experience of accessing NHS dentistry and takes into account the demand (how many are trying to get an appointment). The previous dental access indicator (patients seen in 24 months and as a percentage of the population), did not take into account the fact that a proportion of the population are private dental patients and do not visit an NHS dentist. .  |
| 7.How is the indicator to be derived from its source data? |

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| 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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| 8.Is this indicator linked to another that has been submitted to pipeline?  |
| 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 services4.4 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 lives4.7 Improving experience of healthcare for people with mental illness 4.8 Improving children and young people’s experience of healthcareTwo indicators are being developed as part of 4.4:The indicator relating to dental services (as detailed in this form), and the indicator relating to GP services. |
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| **Section B – Application contact details (please note all contact details will be treated confidentially)** |

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| 1. Applicant Name
 |  PEPP team | 1. Applicant Role / Job Title
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| --- | --- | --- |
| 1. Applicant Organisation
 |  PEPP, NHS North West | Applicant Email |
| 1. Applicant Telephone
 | 0161 625 7344 |  Janet.Butterworth@northwest.nhs.uk |

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| 1. Sponsor name
 | Tara Guinnessy | 1. Sponsor Role / Job Title
 | Senior Statistical Officer, Department of Health |

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| 1. Sponsor Organisation
 | Department of Health, Patient Experience Policy Team | 1. Acknowledgements
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| 1. Please list any other stakeholder groups
 | Ipsos MORI (Survey Provider) |  |

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| **Section C – Users of the Proposed Indicator** |

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|  | Primary User | Secondary User | Not intended for |
| Governing Boards (NHS, local government etc) | [ ]  | [x]  | [ ]  |
| Commissioning Managers | [x]  | [ ]  | [ ]  |
| Regulators | [ ]  | [x]  | [ ]  |
| Clinicians | [ ]  | [x]  | [ ]  |
| Patients | [ ]  | [x]  | [ ]  |
| Public | [ ]  | [x]  | [ ]  |
| Other (please specify) Secretary of State for Health | [x]  | [ ]  | [ ]  |
| Other (please specify)NHS Commissioning Board | [x]  | [ ]  | [ ]  |

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| **Section D – Rationale for Indicator** |
| 1. Relevant policies, strategies or programmes
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| 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 |
| 1. High level subject area
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| 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
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| 1. [x]  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
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| 1. [x]  Equitable access to care
 | 1. [ ]  Other (specify)
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| 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 access to primary care serviceswas frequently raised in the consultation process as a vital outcome for people in their interaction with the NHS. As part of its primary care responsibilities, the NHS is also responsible for delivering dental services to those who wish to use the NHS for their dental care. The desired outcome for NHS dental services is that everyone who wants to use an NHS dentist is able to do so. An indicator of ‘access to dental services’is therefore included in Domain 4.  |
| 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 by Dr Shaibal Roy, May 2011
 |
| 1. ‘Cognitive Testing Reports’, unpublished reports from Ipsos MORI to DH on the outcomes of all cognitive testing of the 2011-12 GP Patient Survey
 |
| 1. ‘DH Dental Access Technical Report’ unpublished report that give some background to how the dental access questions for the GP Patient Survey were evolved;
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| 1. Clinical Advice Provide details of any clinical advice or support already given in development or preparation of indicator.
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| **Section E – Management and production of Indicator** |

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| 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 |

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| 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 GP 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.

 There is funding for Ipsos MORI to continue the GP Patient Survey until June 2013, additional cost to this is DH resource (analyst in DH to create, QA and publish the dental access tables). |

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| 1. Funding status
 | [x]  Secured | [ ]  Being sought | [ ]  Not identified | [ ]  Not applicable |

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| 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 next GP Patient Survey results will be published in December 2011 (on the GP Patient Survey website) and therefore is also when we will publish the next dental access results will (on the DH website).The GP Patient Survey is carried out by Ipsos MORI and the questionnaire results are published on the GP Patient Survey website (which Ipsos MORI also run), however analysts in the Department of Health published the dental access results, on the same day that Ipsos MORI publish the survey results on the web pages below<http://www.gp-patient.co.uk/results/><http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_127417> |
| 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.
 |
| I have concerns of inaccurate assumptions being made on the dental access results (if the dental lead analysts is not involved or informed of additional analysis that may be carried out with this data). |
| 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 develop this set of indicators by April 2012. |

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| **Section F – Methodology** |
| 1. Select the calculation type
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| [ ]  Count For example volume of procedures, number of patients | [x]  Percentage For example percentage of patients treated | [ ]  Rate per for example, rate per 100,000 population |

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| --- | --- | --- |
| [ ]  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 |       |

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| 1. Select the adjustment or standardisation type used Select all that apply
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| [ ]  No adjustment or standardisation | [ ]  Direct standardisation | [ ]  Indirect standardisation |
| [ ]  Non-response weighting | [ ]  Risk adjustment  | [ ]  Pooled data  |
| [ ]  Rolling averages | [x]  Confidence limits or intervals applied |  |

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| 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
 |
| Of those who tried to get an NHS dental Appointment (answered a-d to question 42) and went on to answer the success question (Q44) with either a yes or no, what proportion said yes. |
| 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
 |
| Weighted data is used for the calculations and tables on NHS dental access. The GP Patient Survey is sent out to people based on which GP Practice they are registered with.  The GP Practice a patient is registered with has no relationship to the NHS dentist they may use.  Therefore, we are only interested in NHS Dental results at PCT level and above.  We weight the data differently for NHS Dental questions in order to make the responses representative of the PCT population, rather than the population registered with an individual GP Practice. |
| 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.
 |
| The results are weighted (Ipsos MORI calculate the weightings) |
| 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.
 |
| Ipsos MORI and DH analyst’s quality assure the data prior to publication. We receive the patient level data, PCT level data and the tables Ipsos MORI will be publishing, for us to check and sign off before publication. Our QA process includes comparisons to previous quarters and across PCTS, to identify any anomalies. This is then fed back to Ipsos MORI, if anomalies are found.Prior to analysis perform of the dental access tables by DH, responses provided by respondents who only answered one of the two questions are eliminated. |
| 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 will be used to give an accurate picture of the success in getting an NHS dental appointment (dental access). Known limitations include:* Non-response to the GP Patient survey, which may produce skewed results
* The survey only collects information from adults, so does not look at access for children and young people
* The survey is only distributed to people who are registered at a GP Practice.
 |
| 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 number of respondents to the GP Patient Survey who tried to get an NHS dental appointment in the last 24 months and of those how many succeeded (in getting an appointment). |
| 1. Numerator source Organisation and data collection name
 |
| GP Patient Survey carried out by Ipsos MORI on behalf of the Department of Health. The Department carries out additional analysis to derive the dental access results from the questionnaire responses.  |
| 1. Numerator construction Which data fields (specify) and values (specify codes) are combined to arrive at the count. Include any special rules or filters
 |
| Only those who answered with responses a-d in question 42 go forward to answer question 44. Of question 44 only those who answered a and b are included in the indicator calculation The percentage is calculated by dividing the number who responded with a to question 44 out of all those who responded with a and b in question 44. Respondents need to answer both Q42 and Q44 to be included in analysis. Respondents who only answered Q44 and left the remaining questions blank would not be included |
| 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?
 |
| All relevant cases are counted. The only exclusions are for data related reasons, outlined below: * Respondents who selected (e) or (f) for Q42 are excluded. These respondents have not tried to get an NHS dental appointment so should not be included in the calculation.
* Those that only answered one of the two questions are excluded.
* Respondents who selected (c) ‘can’t remember’ for Q44 are excluded to obtain a ‘pure access’ percentage.
 |
| 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)
 |
| The analysis work carried out by The Department of Health is quality assured to reduce inaccuracies, but some may still occur. |
| 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?

The GP Patient website published the responses to the dental questions at the following location (The data is published weighted or unweighted):<http://www.gp-patient.co.uk/results/>The Department of Health publish the access figures, along with other data at the following link (This is based on the weighted data only):<http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_127417> |
| Is survey data publicly available: |

|  |  |
| --- | --- |
| Yes | [x]  |
| No | [ ]  |
| <http://www.gp-patient.co.uk/results/><http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_127417> |  |

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| 1. Numerator timeliness Frequency and timeliness of data. State how the publication / release of data relates to envisioned indicator productions timescales
 |
| **SURVEY TIMING** (frequency/how quickly is it published?)The data comes through to us from Ipsos MORI approximately a month (4-5 weeks) before it is due to be published. We published the dental access data the same date Ipsos MORI publish the survey results.**Will baseline data be available by March 2012?** |

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| Yes | [x]  |  |
| No | [ ]  | **If No, please state why, and indicate when it will be available** |

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| 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
 |
| 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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| 10.Numerator comments Please detail any caveats not already covered |
|  |
| 11.Denominator definition Word description of the cases or events to be counted.  |
| N/A |
| 12.Denominator source Organisation and data collection name |
| N/A |
| 13.Denominator construction Which data fields (specify) and values (specify codes) are combined to arrive at the count. Include any special rules |
| N/A |
| 14.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 |
| 15.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 |
| 16.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 |
| 17.Denominator timeliness Frequency and timeliness of data. State how the publication / release of data relates to envisioned indicator productions timescales |
| N/A |
| 18.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 |
| 19.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 |
| 20.Denominator comments Please detail any caveats not already covered |
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| Application Checklist – Clinical Indicator Team use only |

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| [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      |

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| Issues for consideration Record all major issues to be considered before indicator can be ‘assured’ |

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| 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

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| 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 |
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Indicator Assurance Pipeline Process

 **Methodology Review Group**

**Applications for consideration**

**27th September 2011**

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| --- | --- |
| **Document Author:** | *Peter Knighton* |
| **Document Owner:** | *Peter Knighton* |
| **Created Date:** | *23/09/2011* |
| **Current Issue Date:** | *05/10/2011* |
| **Responses expected by:** | *n/a* |
| **Version Number:** | *V 0.2* |

**Contents**

[0. Document Control 3](#_Toc305569146)

[0.1 Version History 3](#_Toc305569147)

[0.2 Approvals 3](#_Toc305569148)

[0.3 Distribution 3](#_Toc305569149)

[1. Introduction 4](#_Toc305569150)

[2. New indicators to be considered 5](#_Toc305569151)

[2.1 NHS Outcomes Framework – Domain 4: Ensuring that people have a positive experience of care 5](#_Toc305569152)

[2.2 Proposals from University Hospitals Birmingham 12](#_Toc305569153)

[3. Additional information and feedback from data owners on MRG Recommendations 15](#_Toc305569154)

Document Control

## Version History

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| **Version** | **Date** | **Changed By** | **Summary of Changes** |
| V 0.1 | 23/09/2011 | Peter Knighton | Initial Draft |
| V 0.2 | 05/10/2011 | Peter Knighton | With recommendations following meeting. |
| V 0.3 | 27/02/2012 | Chris Wilson | Pg12 – Indicator reference changed to IAPP00050 (from 00047) due to duplication in pipeline process |

## Approvals

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

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| **Version** | **Date** | **Distribution List** |
|  | 23/09/11 | 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 ButterworthUniversity Hospitals Birmingham: Anupama Chawla |

# Introduction

 Matters to discuss include patient experience indicators for the NHS Outcomes Framework and indicators from University Hospitals Birmingham. New indicators to be considered

## NHS Outcomes Framework – Domain 4: Ensuring that people have a positive experience of care

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| **Indicator** | **Construction** | **Rationale** | **Potential issues** |
| **DOMAIN 4 – Patient experience**4a – Patient experience of primary care. i) GP, ii) Dental, iii) Out of hours | Data source: GP Patient Survey. The survey will run twice a year (July to September and January to March) and will survey a total of 2.8 million people (1.4 per wave), with an expected number of returns in the region of 1 million over the two waves (36% approx).The indicator is made up of three new questions from the GP Patient Survey measuring experience of GP Services, NHS Dental Services and Out of Hours services. The indicators will be based on the percentage of people responding Fairly Good or Very Good to each of the following questions:* Overall how would you describe your experience of your GP Surgery?
* Overall how would you describe your experience of out-of-hours GP Services?
* Overall how would you describe your experience of NHS Dental Services?

The possible responses to each question are:* Very good
* Fairly good
* Neither good nor poor
* Fairly poor
* Very poor

These questions will be included in the GP Patient Survey from 2011-12 onwards. | 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. Weighting for non-response bias has been applied in the past. Previously this has been done solely on age and gender. Ipsos MORI are currently looking at other options including ethnicity and deprivation. Both Crude and weighted results from the survey are currently published.
2. The GP patient survey has been redeveloped. As this indicator is made up of three new questions back comparability will not be possible.
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| **Meeting Note** | PEPP welcome a new approach to indicator development and the transparency of using a single question for each area  |
| **Recommendation 2011/69** | Will all survey respondents be included in the denominator, or just those who answered the question? |
| **Recommendation 2011/70** | Please supply further detail of non-response weighting when known. Of particular interest was the handling of geographical factors. |

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| **DOMAIN 4 – Patient experience**4.4 ii) **(IAP00053)** – Access to dental services. | Data source: GP Patient Survey.The indicator will be derived using two questions in the survey:QUESTION(S):1. When did you last try to get an NHS dental appointment for yourself? a) In the last 3 monthsb) between 3 and 6 months agoc) between 6 months and a year agod) between 1 and 2 years agoe) more than 2 years agof) I have never tried to get an NHS dental appointmentThose who answered a-d above go on to answer the question on access below:Were you successful in getting an NHS dental appointment? a) yesb) noc) cant rememberThose who respond with the answer c) to the second question are not included in the access indicator calculation.The indicator result will be a percentage. Of those who tried to get an NHS dental appointment in the last 2 years (who answered with response a-d in question one above), what proportion succeeded. 2 years is used as NICE guidelines state that an individual should go to see a dentist at least once every two years.This indicator is currently produced and published by DH. The results are age and sex standardised at PCT GP patient population level. | 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. Some back data is available, but as the survey structure is changing back comparability may not be possible. Ipsos MORI and the DH GP team are looking into this.
2. The survey only collects information from adults, so does not look at access for children and young people
3. The survey is only distributed to people who are registered at a GP Practice.
4. Standardisation may change in line with Ipsos MORI findings as discussed for indicator 4a above.
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| **Meeting Note** | Very few options for dental in the GP survey for use as a data source for this indicator.PEPP support the single question approach. |
| **Recommendation 2011/71** | A measure of what proportion of the population tried to access dental services should included. I.e. a measure of Q42 next to Q45. |
| **Recommendation 2011/70 also applies to this indicator.** |  |
| **Recommendation 2011/72** | Include scope of survey (i.e. those registered with GP practice) in quality statement. |
| **Recommendation 2011/73** | Report back on backwards comparability. |

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| **DOMAIN 4 – Patient experience**4.4 i) – Access to GP services | Data source: GP Patient Survey.The survey will run twice a year (July to September and January to March) and will survey a total of 2.8 million people (1.4 per wave), with an expected number of returns in the region of 1 million over the two waves (36% approx).The indicator will be based on the following question from the survey (question 18 in the survey),Overall, how would you describe your experience of making an appointment?* Very good
* Fairly good
* Neither good nor poor
* Fairly poor
* Very poor

This is the final question in a section of the survey on making an appointment. Regression analysis on the other questions in this section will be carried out to see which 4-5 questions are the key drivers for this question. These will be presented alongside the results of question 18. The regression will be carried out each time the indicator is calculated (and can be done at sub-national level). | 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. Ministerial advice was sought by the GP team at DH as to whether a single question or composite indicator should be used. Awaiting approval of this method.
2. The practicalities of how, and whether, the regression can be carried out are yet to be finalised.
3. General issues on the GP survey raised above also apply here.
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| **Recommendation 2011/74** | The group requests further details of regression for consideration. Suggested that this was kept as simple as practical. |
| **Recommendation 2011/75** | Members of the Group felt that, presented in this way, this was not really an indicator, more of a research project. Suggested that this kept separate from the indicator as complementary work. |
| **Recommendation 2011/70 also applies to this indicator.** |  |

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| **DOMAIN 4 – Patient experience**4.6 – Improving the experience of care for people at the end of their lives. | Data source: New national VOICES survey of bereaved relatives. This version has been piloted in two PCT areas with the conclusion that it will perform well as a national survey.Survey sample size: 49,000Response rate: approximately 40%The Indicator proposed here uses the summary question from VOICES: Overall, and taking all services into account, how would you rate his care in the last three months of life?Tick one only: Outstanding Excellent Good Fair Poor Don't knowThe number of responses in each category will form the numerator while the denominator will be the total number of responses, allowing us to report (for example) “75% of people experienced outstanding care in the final three months of life, as reported by their bereaved relatives. For the remaining 25%, respondents did not know.” | 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. This is a survey of bereaved relatives and so is a proxy to the experience of the patient.
* End of Life (EOL) DH team response: This is currently the only way to capture the experiences of all adults who die. While it is possible to ask questions directly of some patient groups – principally those with cancer, whose prognosis is comparatively easy – other diseases have very much less predictable trajectories. Organ failure, for example, typically involves a series of exacerbations and it is very difficult to predict which will lead to death. Many older people also die either with or from dementia and once they have lost capacity it is not possible to survey them in this way.
1. The question selected has not been cognitively tested.

EOL team response: The summary question was designed by the academic team who ran the pilot study. It uses the same form of words already within the national survey for the overarching questions for the various sections within the survey. These were all subject to cognitive testing. The views of a wider group of survey researchers were sought on the development of the single summary question, and it was drafted in line with this advice.1. This survey has not run before, so response rate is based on pilot.
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| **Meeting Note** | PEPP raised concerns about breadth of research used by EOL team. |
| **Recommendation 2011/76** | The NHS Outcomes Framework is to measure the performance of the NHS. Does this question cover more than just NHS care? If so, accountability for this indicator will not solely lie with the NHS Commissioning Board and this will need to be made clear in the production and presentation of the indicator. |
| **Recommendation 2011/77** | What is the rationale for selecting the last three months of life (as opposed to say one or six months)? |
| **Recommendation 2011/78** | How was the scale of answers selected? |
| **Recommendation 2011/79** | What is the coverage of the survey? How are the recipients selected? Are there any dangers in selection, such as sending questionnaire to estranged spouse? What is the evidence of the relationship between a relative and the patients view? How does any non-response affect the results? |
| **Recommendation 2011/80** | If this question is to be used it should be cognitively tested. |
| **Recommendation 2011/81** | Less general, but better defined questions should be considered for this indicator to allow for drill down into what could be improved. |

## Proposals from University Hospitals Birmingham

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| **Indicator** | **Construction and data source** | **Rationale** | **Potential issues** |
| IAPP00050 – a)1st time CABG - Patients discharged on ACE-Inhibitorsb)1st time CABG - Patients discharged on Antiplatelet therapyc)1st time CABG - Patients discharged on Statins**Three separate but similar indicators** | Indicator Definition: Percentage of 1st time CABG (Coronary Artery Bypass Grafting) patients who were discharged on ACE-Inhibitors, Antiplatelet therapy or StatinsNumerator : Number of patients who were admitted to hospital for 1st time CABG and were discharged on a)ACE-inhibitorsb)Antiplatelet therapyc)StatinsDenominator : Number of patients who were admitted to hospital for 1st time CABG, finished spells in a specified time periodPrimary procedure = 1st time CABG (recorded as Isolated CABG on PATS)Operation = 1st Operation (There is a field in PATS for first/redo operation)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)**Ace Inhibitors medication used =**Perindopril, Ramipril, Lisinopril, Enalapril, Captopril, Trandolapril, Quinapril, Fosinopril, Imidapril, Candesartan, Losartan, Irbesartan**Antiplatelets therapy medication used =** Aspirin, Clopidogrel, Dipyridamole**Statins medication used** =simvastatin, atorvastatin, nystatin, pravastatin, rosuvastatin, fluvastatin, Cerivastatin, Sandostatin,Imipenem/cilastatin | A number of studies have shown that in the long term using angiotensin converting enzyme inhibitors (ACE inhibitors or other similar drugs) in first-time, isolated CABG patients can prolong the life of both patients and grafts.Anti-platelet drug therapy improves graft function through the prevention of clot formation for patients who have had a first-time, isolated CABG. It also helps prevent further cardiac problems.Statins are used in patients following first-time, isolated CABG to reduce the risk of further cardiac problems, though not all patients can tolerate them. | As per IAPP00046(see below). Supporting information These indicators relate to standards developed by The Society of Thoracic Surgeons established a Quality MeasurementTask Force, based in the US. <http://ats.ctsnetjournals.org/cgi/content/full/83/4_Supplement/S3>**MRG are asked to review this paper** and consider if this evidence is appropriate in this context  |

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| **Clarifications given during meeting** | A score between 90% and 95% is the target. It is not 100% as for some patients there may be specific reasons why they were not discharged on the specified drugs. |
| **Recommendation 2011/82** | Check that no NICE standards are being developed which may look at the same topic in a slightly different way. |
| **Recommendation 2011/83** | Relevant elements of recommendations relating to application IAPP00046 (Proportion of patients undergoing 1st time CABG who are on betablockers before surgery who receive betablocker on the day of surgery) should also be considered here. |
| **Recommendation 2011/84** | Evidence should be supplied showing that taking these drugs after discharge is beneficial. |

# Additional information and feedback from data owners on MRG Recommendations

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| **Recommendation ref** | **Response** |
| **Recommendation 2011/59****NHS OF – 5.5 Full-term neonatal admissions** | There is a possibility that there is disparity between the mother and child records in HES. CIT to investigate. |
| **Update 27/9/11** | Records used in analyses limited to babies only by selecting where Age = 0-28 days, and Gestation length =37 weeks or more. The data items used in the indicator relate only to the baby, so cannot be verified by comparison with the associated maternal record.  |

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| **Meeting Note**  | HES data quality statements are published every month, so the data shortcomings are known. Recommendation 2011/59 closed. |

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| **Recommendation 2011/62**Proportion of patients undergoing 1st time CABG who are on betablockers before surgery who receive betablocker on the day of surgery | The indicator wording, both top level definition and descriptions of numerator and denominator need to be clearer. CIT to follow up with applicant. |
| **Update 27/9/11** | Proposed text - Proportion of patients undergoing 1st time CABG who are on betablockers before surgery who receive betablocker on the day of surgery |

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| **Meeting Note** | MRG happy with new title. Recommendation 2011/62 closed. |

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| **Recommendation 2011/63**Proportion of patients undergoing 1st time CABG who are on betablockers before surgery who receive betablocker on the day of surgery | 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. |
| **Update 27/9/11** | 1st time CABG patients are recorded in the CARDIAC SURGERY electronic system as primary procedure. It can be identified from the national dataset using the following The number of continuous inpatient spells where there was at least one Coronary Artery Bypass Graft (CABG) procedure (OPCS 4 codes K40-K46) in any operation field in the spell, except where the CABG occurred after a Percutaneous Transluminal Coronary Angioplasty (PTCA) procedure (OPCS 4 codes K49-K50 other than K50.2 and K50.3) and/or alongside a heart valve procedure (OPCS 4 codes K25-K38). A spell may include more than one operative procedure: K40.- Saphenous vein graft replacement of coronary artery K41.- Other autograft replacement of coronary artery K42.- Allograft replacement of coronary artery K43.- Prosthetic replacement of coronary artery K44.- Other replacement of coronary artery K45.- Connection of thoracic artery to coronary artery K46.- Other bypass of coronary artery (reproduced from Information centre – Clinical and Health outcomes knowledge base. Link : [http://www.nchod.nhs.uk/NCHOD/compendium.nsf/361d5bea85d84b7c802573a30020fcd5/49f00edf565e5be0652570d1001cb7ba!OpenDocument](http://www.nchod.nhs.uk/NCHOD/compendium.nsf/361d5bea85d84b7c802573a30020fcd5/49f00edf565e5be0652570d1001cb7ba%21OpenDocument) )  They didn’t have any cardiac procedure done before and have coronary artery bypass graft for the first time.             If a patient had two separate single by-pass procedures on different vessels would, the first operation would be classed as 1st time CABG If the 1st time CABG procedure has failed, it is still counted in the data as we have another indicator for counting the redo operation numbers.Emergency and Elective procedures included. If CABG is carried out in addition to other procedures during the same operation, is CABG still identified?  - No, all patients with 1st time CABG only are counted for this indicatorAll patients who have been prescribed betablocker before the surgery are included no matter how many days.All the finished spells are used to calculate this indicator |
| **Clarifications given during meeting** | * The indicator is concerned with patients who have a live prescription of betablockers on admission to hospital.
* Only those who have the procedure are included.
* A score between 90% and 95% is the target. It is not 100% as for some patients there may be specific reasons why they do not receive betablockers.
* Emergency cases are excluded, only those patients with an elective admission are included in the indicator.
* Only patients who are included as 1st time CABG only procedure are included
* Only finished spells are to be included.

Concerns were raised by the MRG that the NCHOD selection criteria may not be appropriate. UHB have a flag in their system to assess 1st time CABG with closely matching criteria. Clinical Indicators Team (CIT) and UHB should work to clarify definition. |
| **Recommendation 2011/85** | CIT and UHB to work to clarify definition of 1st time CABG. |
| **Recommendation 2011/64**Proportion of patients undergoing 1st time CABG who are on betablockers before surgery who receive betablocker on the day of surgery | Outliers are an intrinsic part of the indicator and should be presented as part of the indicator construction. |
| **Update 27/9/11** | Internally, spc is used to identify outliers. The control charts are shewart charts for the proportion defective, the control limits are plus or minus 3 standard deviations (for both fixed and variable sample size)The runs test is used to test for that the process is out of control. The R package qcc,  <http://cran.r-project.org/web/packages/qcc/index.html> is used to generate the chartsWe use the SPC for internal purposes of QuORU to check the variation. It is displayed as rolling 3 years and rolling 12 months for the Trust’s external website.On the internal QuORU dashboard, indicator data is displayed as monthly bar chart for latest 6 months, last year’s figure and latest year to date figure on a dial with access to patient level information for numerator, denominator and not in numerator. This data gets updated on daily/ monthly/ quarterly/ annually basis depending on the indicator.  |
| **Clarification given during meeting** | The SPC is an internal UHB mechanism that is not proposed as part of the indicator.  |
| **Recommendation 2011/86** | SPC and outliers should not be presented as part of the indicator format should follow that on UHB’s public facing site. |