Information from CQC on NHS Bedfordshire Performance – detail on Indicators.

1. This note provides more detail on each of the indicators that are not achieved or compliant. The information below is taken from the CQC website.

2. The following is provided for each indicator:

   - NHS Bedfordshire's performance, in relation to other similar trusts
   - The rationale for each indicator, set by the Department of Health

   It should be noted that NHS Bedfordshire is assessed both on services it delivers and on services that it commissions.

Existing Commitments Performance – Commissioning

3. **Category A calls meeting 8 minute standard**

   - **Rating** Under achieved
   - **Indicator value** 74.60%

3.1. Methodology: The following thresholds were applied when determining the score for this indicator:

Achieved:	Greater than or equal to 75%
Under achieved:	Greater than or equal to 70%
Failed:	Less than 70%

3.2. How similar trusts performed

Similar Trusts	Rating
57.2%	Achieved
30.3%	Under achieved
12.5%	Failed

3.3. Rationale

This indicator measures performance in response to category A calls. The Department of Health's requirement is that a minimum of seventy five per cent of category A calls (defined as "immediately life-threatening") should receive an emergency response at the scene of the incident within eight minutes.

All PCTs will be aware that from 1 April 2008 the "clock" for measuring the response times standards starts from the connection of the call to the ambulance control room, a change which formed one of the recommendations of the report 'Taking Healthcare to the Patient'.
This will ensure that the measurement of the response time is aligned with the caller's experience and lead to greater consistency between trusts in how the standards are measured. The change will make the response time standards more difficult to achieve, and the impact will be greatest for the category A 8 minute measure. It is expected that PCTs and ambulance trusts will have been working together and will have jointly agreed their strategy for achieving this.

3.4. Numerator

The number of category A calls resulting in an emergency response arriving at the scene of the incident within eight minutes (as defined in the 2008/09 Information Centre KA34 guidance).

3.5. Denominator

The number of category A calls resulting in an emergency response arriving at the scene of the incident (as defined in the 2008/09 Information Centre KA34 guidance).

3.6. Indicator

The indicator is the numerator divided by the denominator, expressed as a percentage. Performance of ambulance trusts will be mapped to PCTs.

3.7. Data source and period

KA34 ambulance services (financial year 2008/09)

4. Category B calls meeting national 19 minute standard

- **Rating** Under achieved
- **Indicator value** 93.29%

4.1. Methodology: The following thresholds were applied when determining the score for this indicator:

Achieved:	Greater than or equal to 95%
Under achieved:	Greater than or equal to 85%
Failed:	Less than 85%

4.2. How similar trusts performed

Similar Trusts	Rating
27.0%	Achieved
52.6%	Under achieved
20.4%	Failed

4.3. Rationale

This indicator measures performance in response to category B calls. The Department of Health's requirement is that a minimum of ninety five per cent of all category B calls (defined as "serious but not immediately life-threatening") should receive an emergency response at the scene of the incident within 19 minutes. All PCTs will be aware that from 1 April 2008 the "clock" for measuring the response times standards starts from the connection of the call to the ambulance control room, a change which formed one of the recommendations of the report 'Taking Healthcare to the Patient'. The change will make the response time targets more difficult to achieve, but the change in relation to the category B 19 minute target will have a considerably lesser impact than for the category A 8 minute measure, and therefore should not result in a significant change in reported levels of performance.

4.4. Numerator

The number of category B calls resulting in an ambulance vehicle able to transport the patient arriving at the scene of the incident within 19 minutes (as defined in the 2008/09 Information Centre KA34 guidance).

4.5. Denominator

The number of category B calls resulting in an ambulance vehicle able to transport the patient arriving at the scene of the incident (as defined in the 2008/09 Information Centre KA34 guidance).

4.6. Indicator

The indicator is the numerator divided by the denominator, expressed as a percentage. Performance of ambulance trusts will be mapped to PCTs.

4.7. Data source and period

KA34 ambulance services (financial year 2008/09)

5. Patients waiting longer than three months (13 weeks) for revascularisation

- **Rating** Failed
- **Indicator value** 1.06%

5.1. Methodology: The following thresholds were applied when determining the score for this indicator:

Achieved:	Less than or equal to 0.5%
Under achieved:	Less than or equal to 1%
Failed:	Greater than 1%

If any organisations incur only one breach, they are considered to have 'Achieved' this indicator.

5.2. How similar trusts performed

Similar Trusts	Rating
94.1%	Achieved
3.3%	Under achieved
2.6%	Failed

5.3. Rationale

The National Service Framework for Coronary Heart Disease states that there is good evidence that many people with atheromatous plaques and narrowed coronary arteries can have their symptoms relieved and/or their risks of dying reduced by restoring blood flow through blocked coronary arteries - revascularisation. The Government target was to deliver a maximum wait of three months for revascularisation by March 2005. Data are now collected in weekly timebands, and hence 13 weeks is now used in this indicator.

5.4. Numerator

The total number of patients who have been waiting more than 13 weeks for either a coronary artery bypass graft (CABG (OPCS4 codes K40-46)) or percutaneous transluminal coronary angioplasty (PTCA (OPCS4 codes K49, K50.1 and K75)). The value will be made up of the number of patients waiting 13 weeks or over on the monthly returns summed across the months April 2008 to March 2009.

5.5. Denominator

The total number of patients that have received a CABG (OPCS4 codes K40-46) or PTCA (OPCS4 codes K49, K50.1 and K75). This value will be the sum of the number of patients in the CABG and PTCA activity columns for 2008/2009 using the cumulative activity figures reported in the March 2009 Monthly Monitoring Return.

5.6. Indicator

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

5.7. Data source and period

Monthly monitoring return (financial year 2008/09)

6. Time to reperfusion for patients who have had a heart attack

- **Rating** Underachieved
- **Indicator value** 66.07%

6.1. Methodology: The following thresholds were applied when determining the score for this indicator:

Achieved:	Greater than or equal to 68%
Under achieved:	Greater than or equal to 48%
Failed:	Less than 48%

Organisations reporting either a small number of patients (i.e. fewer than 20 in the denominator) or a high proportion of patients (i.e. 75% or more) with primary percutaneous coronary intervention have been given 'Data not available'.

6.2. How similar trusts performed

Similar Trusts	Rating
70.1%	Achieved
25.3%	Under achieved
4.6%	Failed

6.3. Rationale

Cardiovascular disease (CVD) is a preventable disease that kills nearly 198,000 people in the UK every year. Approximately half of all deaths from CVD are from coronary heart disease and more than a quarter are from stroke. The Government is committed to reducing the death rate from coronary heart disease and stroke and related diseases in people under 75 by at least 40% (to 83.8 deaths per 100,000 population) by 2010. There are two treatment strategies for heart attacks, thrombolysis and primary angioplasty. To date the majority of patients have been treated using thrombolysis although this is increasingly changing as a result of a wider use of primary angioplasty to treat heart attack patients. Currently, 22% of all eligible patients are treated using

primary angioplasty. The key to improving outcomes after heart attack is to re-establish coronary artery flow as quickly as possible and limit damage to the heart muscle. Thrombolysis, or treatment with thrombolytic drugs, helps reverse the effects of a heart attack by lysing blood clots blocking the coronary artery and returning blood supply to the affected part of the heart again. Thrombolytic treatment can be given up to twelve hours after the onset of the symptoms of a heart attack but it is most effective when given within the first two hours. The CHD National Service Framework sets a standard to administer thrombolysis to all eligible patients within one hour of calling for professional help (60 minute call to needle).

6.4. Numerator

The number of eligible patients with acute myocardial infarction who received thrombolysis treatment either by injection or by infusion within 60 minutes of calling for professional help.

6.5. Denominator

The number of eligible patients with acute myocardial infarction who received thrombolysis treatment either by injection or by infusion.

6.6. Indicator

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

6.7. Notes: General

A 'low numbers' rule will be applied which will withdraw trusts treating a low number of eligible cases from the assessment. An eligible patient is defined as a patient presenting with symptoms suggestive of myocardial infarction with a first electrocardiograph showing typical ST segment elevation or new left bundle branch block. There should be no contraindication to thrombolytic treatment, nor should there be a justifiable delay before treatment. Patients having primary angioplasty, or patients receiving thrombolysis that self present or were already in hospital at the time of their myocardial infarction are excluded from this part of the indicator. Patients receiving pre-hospital thrombolysis are included. Although no further changes have been made to the criteria for 'justifiable delay', in a minority of cases involving long ambulance journeys patients may present a first ECG which is equivocal and the patient is ineligible for pre hospital thrombolysis. Subsequent ECGs may confirm ST elevation and the patient receives thrombolytic treatment with an extended call to needle time. Trusts will have the opportunity to present evidence on a case by case basis as part of the extenuating circumstances process, each of which will be considered by the Healthcare Commission in discussion with clinical experts. Cases upheld will be removed from both the numerator and denominator for the purposes of the assessment. A call for professional help is defined as a call by the patient, relative or attendant. This may be to a GP, NHS Direct, or the ambulance service. The time of the emergency call should be available from the ambulance

service record. The acute trust should know to whom the initial call was made. A call to the ambulance service is defined as the time of the first ring of the telephone call

6.8. Data source and period

Myocardial Ischaemia National Audit (financial year 2008/09)

7. Inpatients waiting longer than the 26 week standard

- **Rating** Underachieved
- **Indicator value** 0.047%

7.1. Methodology: The following thresholds were applied when determining the score for this indicator:

Achieved:	Less than or equal to 0.03%
Under achieved:	Less than or equal to 0.15%
Failed:	Greater than 0.15%

Organisations commissioning treatment for a small number of patients (i.e. fewer than 5,200 in the denominator of the indicator construction) have double the thresholds. In addition, if any organisations commissioning treatment for a small number of patients incur a very small number of breaches (i.e. fewer than 2 inpatient breaches), they are considered to have 'Achieved' this indicator.

7.2. How similar trusts performed

Similar Trusts	Rating
71.1%	Achieved
24.3%	Under achieved
4.6%	Failed

7.3. Rationale

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

7.4. Numerator

The number of patients waiting 26 weeks or more for an elective (inpatient ordinary or daycase) admission. The value will be made up of a count of the number of patients waiting 26 weeks or more at the end of each month summed across the months April 2008 to March 2009.

7.5. Denominator

The total number of general and acute first finished consultant episodes (FFCEs) for elective activity (inpatient ordinary and day case admissions) minus the number of planned elective admissions reported in the monthly activity returns from April 2008 to March 2009.

7.6. Indicator

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

7.7. Notes: General

The numerator applies to patients for whom English PCTs are responsible and awaiting NHS-funded treatment at providers in England. This description applies to provider and commissioner indicators. In DH central returns commissioners are required to report upon all patients waiting for whom they are responsible. For performance assessment purposes commissioners should separately identify patients waiting to be seen by a provider in Wales.

7.8. Data source and period

Monthly activity return (financial year 2008/09)

Monthly monitoring return (financial year 2008/09)

National Priorities – Commissioning Services

8. **Teenage conception rates per 1000 females aged 15-17**

- **Rating** Failed
- **Indicator value** 0.047%

8.1. Methodology: The following thresholds were applied when determining the score for this indicator:

Achieved: Performance consistent with plan

Under achieved: Performance poorer than plan

Failed:	Performance poorer than plan by a clear margin

Organisations commissioning treatment for a small number of patients (i.e. fewer than 5,200 in the denominator of the indicator construction) have double the thresholds. In addition, if any organisations commissioning treatment for a small number of patients incur a very small number of breaches (i.e. fewer than 2 inpatient breaches), they are considered to have 'Achieved' this indicator.

8.2. How similar trusts performed

Similar Trusts	**Rating**
21.8%	Achieved
9.5%	Under achieved
68.7%	Failed

8.3. Rationale

Britain's teenage birth rates are among the highest in Europe[1]. Teenage mothers are more likely to suffer poor health outcomes. The teenage pregnancy strategy seeks to halve the under-18 conception rate by 2010 (from the 1998 baseline) through a wide- ranging programme of coordinated activity, including improved advice and contraceptive services for young people. In addition, local under-18 conception rate targets have been agreed with teenage pregnancy partnership areas, which are coterminous with top tier local authority areas in England. These local targets range between a 40% to 60% reduction by 2010. Each PCT is signed up to the target for their teenage pregnancy partnership area.

8.4. Numerator 1

The actual number of conceptions to 15 to 17 year olds in calendar year 2007

8.5. Denominator 1

The actual number of females aged 15 to 17 years in calender year 2007

8.6. Indicator 1

The indicator is the numerator divided by the denominator, expressed as a rate per 1000 females

[1] ***Source:*** ***(rcog.org.uk/resources/public/pdf/RCOGTeenagePregnancySummaryReview.pdf***

8.7. Numerator 2

The planned number of conceptions to 15 to 17 year olds in calender year 2007

8.8. Denominator 2

The planned number of females aged 15 to 17 years in calender year 2007

8.9. Indicator 2

The indicator is the numerator divided by the denominator, expressed as a rate per 1000 females

8.10. Overall Indicator

This indicator will be indicator 1 divided by indicator 2, expressed as a percentage

8.11. Notes: General

The under-18 conception rate is the number of conceptions to under-18 year olds per thousand females aged 15-17. It is calculated on a calender year basis and is available by local authority area. PCTs are mapped to top-tier local authority areas. Conception Statistics are derived from birth registrations (Form 309 and Form 308), abortion notifications (HSA4), and latest available ONS mid year population estimates. Note that a three-year age group only (15-17) is used as the denominator in the calculation. The reason for this is that the vast majority of conceptions to under-18 year olds occur in this age group. Only about 5% of under-18 conceptions are to girls aged 14 or under and to include younger age groups in the base population would produce misleading results. The 15-17 group is effectively treated as the 'population at risk'.

8.12 Data source and period

Local delivery plan (calendar year 2007)

Office for National Statistics (calendar year 2007)

9. **Chlamydia screening**

- **Rating** Under Achieved
- **Indicator value** 95.32%

9.1. Methodology: The following thresholds were applied when determining the score for this indicator:

Achieved: Greater than or equal to 14 out of 16 points based on answers to four questions

Under achieved:	Greater than or equal to 12 out of 16 points based on answers to four questions
Failed:	Less than 12 out of 16 points based on answers to four questions

Four points are awarded for each part of the indicator achieved resulting in 16 points available.

9.2. How similar trusts performed

Similar Trusts	Rating
45.3%	Achieved
33.6%	Under achieved
21.1%	Failed

9.3. Rationale

Chlamydia is the most common sexually transmitted infection (STI) and there is evidence that up to one in 10 young people aged under 25 may be infected. It often has no symptoms, but if left untreated can lead to pelvic inflammatory disease, ectopic pregnancy and infertility. Chlamydia is very easily treated. The national chlamydia screening programme (NCSP) has a community focus and concentrates on opportunistic screening of asymptomatic sexually active men and women under the age of 25 who would not normally access, or be offered a chlamydia test, and focuses on screening in non-traditional sites. In 2008/09, all chlamydia tests undertaken outside of genitourinary medicine clinics (GUM) on 15-24 year olds will count towards calculating screening coverage in residents of each Primary Care Trust (PCT). It is the responsibility of each PCT to ensure that the data submitted reflects the activity within their community.

9.4. Numerator 1

The actual number of 15-24 year old persons tested for chlamydia (excluding tests at GUM clinics)

9.5. Denominator 1

PCT Population aged 15-24 years

9.6. Indicator 1

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

9.7. Numerator 2

The planned number of 15-24 year old persons tested for chlamydia (excluding tests at GUM clinics)

9.8. Denominator 2

PCT Population aged 15-24 years

9.9. Indicator 2

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

9.10. Overall Indicator

This indicator will be indicator 1 divided by indicator 2, expressed as a percentage.

9.11. Notes: General

PCTs are responsible for ensuring that all chlamydia tests carried out in their primary care trust (excluding tests at GUM clinics) are reported to the NCSP as noted in the guidance document[2]. Only chlamydia tests that are reported to the NCSP[3] will be counted towards the assessment.

9.12 Data source and period

Chlamydia screening programme returns (financial year 2008/09)

Vital Signs plans (financial year 2008/09)

10. Commissioning a comprehensive child and adolescent mental health service

- **Rating** Under Achieved
- **Indicator value** -

10.1. Methodology: The following thresholds were applied when determining the score for this indicator:

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[2] Guidance Document is entitled NHS Chlamydia 'Vital Signs' Indicator 2008/09, Gateway reference 9952

[3] For further information regarding the NCSP Programme, can be found via www.chlamydiascreening.nhs.uk

Achieved:	Performance poorer than plan by a clear margin
Under achieved:	Actual performance greater than or equal to 100% of planned performance
Failed:	Actual performance greater than or equal to 75% of planned performance

Actual performance less than 75% of planned performance. A percentage greater than 100% indicates that an organisation's actual performance exceeded its planned performance.

10.2. How similar trusts performed

Similar Trusts	Rating
54.0%	Achieved
41.4%	Under achieved
4.6%	Failed

10.3. Rationale

Mental health problems in children are associated with educational failure, family disruption, disability, offending and antisocial behaviour, placing demands on social services, schools and the youth justice system. Untreated mental health problems create distress not only in the children and young people but also for their families and carers, continuing into adult life and affecting the next generation. The National Service Framework for Children, Young People and Maternity Services set out the standards and milestones for improvement in child and adolescent mental health services, including year on year improvements in access. The 2008/2009 NHS Operating Framework and the 2007 Public Service Agreement 'Improve the health and wellbeing of children and young people' describe four proxy measures for a truly comprehensive child and adolescent mental health service:

- 24 hour/seven days a week cover to meet the urgent mental health needs of children and young people
- a full range of CAMHS for children and young people who also have a learning disability
- a full range of CAMHS for 16 and 17 years olds, appropriate to their age and level of maturity
- a full range of early intervention support services jointly commissioned by the Local Authority and PCT in partnership

Indicator

10.4. This is a four part indicator, assessing PCTs on their commissioning of a comprehensive child and adolescent mental health service. Data for this indicator will be taken from the quarter 3 2008/09 (December 2008) Vital Signs return.

10.5. Indicator 1

As at 31 December 2008, has a full range of CAMH services for children and young people with learning disabilities been commissioned?

10.6. Indicator 2

As at 31 December 2008, do 16 and 17 year olds who require mental health services have access to services and accommodation appropriate to their age and level of maturity?

10.7. Indicator 3

As at 31 December 2008, are arrangements in place to ensure that 24 hour cover is available to meet urgent mental health needs of children and young people and for a specialist mental health assessment to be undertaken within 24 hours or the next working day where indicated?

10.8. Indicator 4

As at 31 December 2008 are a full range of early intervention support services delivered in universal settings and through targeted services for children experiencing mental health problems commissioned by the Local Authority and PCT in partnership?

10.9. Notes: General

PCTs are asked to rate the service under each part of the indicator on a scale of 1 to 4 where 1 is for no protocols or services in place and 4 is for a full range of services and full implementation. For detailed definitions of each part of this indicator and guidelines for rating each part of this indicator, please see the guidance posted by the Department of Health on UNIFY2/Forums/LDPR/Guidance and information/Vital signs monitoring returns guidance and schedule 2008/09 - 2010/11.

10.10. Data source and period

Vital Signs returns (as at 31 December 2008)

11. **Proportion of individuals who complete immunisation by recommended ages**

- **Rating** Under Achieved

- **Indicator value** -

11.1. Methodology: The following thresholds were applied when determining the score for this indicator:

Achieved:	Actual performance greater than or equal to 100% of planned performance (greater than or equal to 15 points out of 18)
Under achieved:	Actual performance greater than or equal to 75% of planned performance (greater than or equal to 12 points out of 18)
Failed:	Actual performance less than 75% of planned performance (less than 12 points out of 18)

Three points are awarded for each part of the indicator achieved and 2 points for each part of the indicator underachieved. This results in a maximum of 18 points available. A maximum of 3 underachieves against plan or 1 fail against plan is allowed, with all other parts being achieved i.e. 15 points out of a maximum of 18 points.

11.2. How similar trusts performed

Similar Trusts	Rating
35.5%	Achieved
55.3%	Under achieved
9.2%	Failed

11.3. Rationale

This indicator highlights an area of national and international concern to end the transmission of preventable life-threatening infectious diseases. Vaccines prevent infectious disease and can dramatically reduce disease and complications in early childhood, as well as mortality rates. Pre-school immunisation for the under 5 year olds in England enables the control of diseases such as diphtheria, tetanus, polio, pertussis, measles, rubella, Haemophilus influenzae type b (Hib), pneumococcal infection and meningitis C. Although the coverage is relatively high for majority of the vaccines when England averages are considered, it is variable across trusts with some areas reporting particularly low immunisation rates. In addition, current World Health Organisation (WHO) immunisation recommendations states that at least 95% of children should receive three primary doses of diphtheria, tetanus, polio and pertussis in the first year of life and a first dose of measles, mumps and rubella containing vaccine by 2 years of age.

11.5. Numerator 1

Actual immunisation rate for children aged 1 who have completed immunisation for for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenzae type b (Hib) / (DTaP/IPV/Hib)

11.6. Denominator 1

Planned immunisation rate for children aged 1 who have completed immunisation for for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenzae type b (Hib) / (DTaP/IPV/Hib)

11.7. Indicator 1

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

11.8. Numerator 2

Actual immunisation rate for children aged 2 who have completed immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)

11.9. Denominator 2

Planned immunisation rate for children aged 2 who have completed immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)

11.10. Indicator 2

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

11.11. Numerator 3

Actual immunisation rate for children aged 2 who have completed immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster)/ (Hib/MenC booster)

11.12. Denominator 3

Planned immunisation rate for children aged 2 who have completed immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) / (Hib/MenC booster)

11.13. Indicator 3

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

11.14. Numerator 4

Actual immunisation rate for children aged 5 who have completed immunisation for Diphtheria, Tetanus, Polio, Pertussis (i.e. 4 doses) - (DTaP/IPV)

11.15. Denominator 4

Planned immunisation rate for children aged 5 who have completed immunisation for Diphtheria, Tetanus, Polio, Pertussis (i.e. 4 doses) - (DTaP/IPV)

11.16. Indicator 4

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

11.17. Numerator 5

Actual immunisation rate for children aged 2 who have completed immunisation for measles, mumps and rubella (MMR)

11.18. Denominator 5

Planned immunisation rate for children aged 2 who have completed immunisation for measles, mumps and rubella (MMR)

11.19. Indicator 5

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

11.20. Numerator 6

Actual immunisation rate for children aged 5 who have completed immunisation for measles, mumps and rubella (MMR) (i.e 2 doses)

11.21. Denominator 6

Planned immunisation rate for children aged 5 who have completed immunisation for measles, mumps and rubella (MMR) (i.e 2 doses)

11.22. Indicator 6

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

11.23. Overall Indicator

Points will be allocated for each indicator based on performance levels. The aggregated scores for indicators 1 to 4 and the aggregated scores for indicator 5 and 6 will be combined in a matrix to determine the level of performance.

11.24. Notes: General
Completed immunisation is defined as having received all the vaccinations of the type defined, that have to be received by that age as set out in the childhood immunisation scheme[4]. The data relates to children for whom the PCT is responsible. They include all children registered with a GP whose practice forms part of the PCT, regardless of where the child is resident, plus any children not registered with a GP who are resident within the PCT's statutory geographical boundary.

11.25. Data source and period

Vital Signs plans (financial year 2008/09)

Cover of Vaccination Evaluated Rapidly (COVER) programme (financial year 2008/09)

12. Stroke care

- **Rating** Failed
- **Indicator value** 21.43%

12.1. Methodology: The following thresholds were applied when determining the score for this indicator:

Achieved:	Greater than or equal to 50%
Under achieved:	Greater than or equal to 30%
Failed:	Less than 30%

12.2. How similar trusts performed

[4] Further information on the immunisation programme and vaccine recommendations can be found in Immunisation Against Infectious Disease (the 'Green book') available at www.dh.gov.uk/greenbook and at www.immunisation.nhs.uk.

Similar Trusts	Rating
46.7%	Achieved
35.5%	Under achieved
17.8%	Failed

12.3. Rationale

Cardiovascular disease (CVD) is a preventable disease that kills nearly 198,000 people in the UK every year. More than a quarter of these deaths from stroke (British Heart Foundation, 2008). A stroke is caused by a disturbance to the flow of blood to the brain by one of two main means, either as a result of a clot that narrows or blocks blood vessels or where blood vessels burst causing bleeding into the brain. The National Stroke Strategy, 2007, sets out a quality framework and identifies examples of excellent care to help local services make improvements to stroke services. These examples include the treatment of stroke patients within specialist stroke units and the provision of rapid access to services for people who have had a minor stroke or transient ischemic attack (TIA).

12.4. Numerator

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

12.5. Denominator

Number of people who were admitted to hospital following a stroke

12.6. Indicator

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

12.7. Data source and period

Vital Signs returns (quarter four 2008/09)

13. 18 Week referral to treatment times

- **Rating** Failed
- **Indicator value** -

13.1. Methodology: The following thresholds were applied when determining the score for this indicator:

Achieved:	Achieved the 18 week standard for both admitted and non admitted patients and good data quality in every month since the standard took effect and performed well for direct access audiology including data quality (the standard is that 90% of admitted and 95% of non admitted and direct access audiology patients must start treatment within 18 weeks of their referral)
Under achieved:	Good data quality and no failure of the 18 week standard in any month and no more than one failure for direct access audiology (failure of the standard is defined as more than 10% points below the standard e.g. less than 80% of admitted patients starting treatment within 18 weeks)
Failed:	Poor data quality or failure of the 18 week standard in any month or two or more failures for direct access audiology (failure of the standard is defined as more than 10% points below the standard e.g. less than 80% of admitted patients starting treatment within 18 weeks)

For admitted and non admitted patients, where fewer than 20 patients comprise the denominator, that part of the indicator is not assessed. For direct access audiology, where the expected number of patients is less than 20, that part of the indicator is not assessed. Good data quality refers to >=80% and <=120% average data completeness over the quarter for both admitted and non-admitted patients and >=80% and <=120% on direct access audiology data completeness. Poor data quality refers to either <80% or >120% average over the quarter for either admitted or non-admitted patients and either <70% or >130% on direct access audiology data completeness.

13.2. How similar trusts performed

Similar Trusts	Rating
83.5%	Achieved
9.9%	Under achieved
6.6%	Failed

13.3. Rationale

The NHS Improvement Plan (June 2004) set out the requirement that, by December 2008, there would be a maximum acceptable waiting time of 18 weeks from referral to start of hospital treatment. Providing fast, convenient access will reduce pain and anxiety for patients and ensure that waiting times for treatment are no longer a major issue for patients and the public. In 2008/2009 trusts will be expected to have achieved, by December 2008, a maximum waiting time of 18 weeks from referral to start of treatment for 90% of admitted patients and 95% of non-admitted patients. Trusts will be assessed on having maintained this performance during the final quarter of the financial year (January to March 2009). Trusts will also be assessed against an 18 week maximum wait for direct access audiology patients. These are patients referred into audiology services without a consultant, and who are outside the scope of the 18 week target but are included as a supporting measure in the 'Vital Signs', published in January 2008.

For parts 1 and 2 of the indicator (referral to treatment times), a data quality test using the Department of Health's data completeness methodology will be applied prior to use of the data, assessed over the whole quarter. Failure of the data quality test for either admitted or non-admitted patients will result in that part being validated as ‘Data not returned' and is likely to lead to failure of the entire indicator.

For part 3 (the measure of direct access audiology), data completeness will be measured as part of the indicator, using the Department of Health methodology for direct access audiology data completeness for January, February and March. Again it is likely that failure on data completeness will lead to overall failure of the entire indicator[5].

13.4. Indicator 1: admitted patients[6]

For each of the months January, February and March 2009

13.5. Numerator 1

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

13.6. Denominator 1

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

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[5] Further information on data completeness for direct access audiology is available on the 18 weeks website via the following links:**Direct Access Audiology Waiting Times and PTL collections** and **News: Reporting audiology activity and waiting times**

[6] Indicator 1 - The indicator is the numerator divided by the denominator, expressed as a percentage. Trusts will be expected to achieve the target (90% of admitted patients seen within 18 weeks) in each of the three months.

13.7. Indicator 2: non-admitted patients[7]

For each of the months January, February and March 2009

13.8. Numerator 2

The number of non-admitted patients with completed pathways in the month who waited 18 weeks or less, reported in the referral to treatment times data collection.

13.9. Denominator 2

The total number of non-admitted patients with completed pathways in the month, reported in the referral to treatment times data collection.

13.10. Indicator 3: direct access audiology[8]

For each of the months January, February and March 2009

13.11. Numerator 3

The number of direct access audiology patients with completed pathways in the month who waited 18 weeks or less, reported in the audiology waiting times collection.

13.12. Denominator 3

The total number of direct access audiology patients with completed pathways in the month, reported in the audiology waiting times collection.

13.13. General Note

Data quality tests will be applied to each part.

13.14. Data source and period

National referral to treatment time data collection (January to March 2009);

National Direct Access Audiology Waiting Times Dataset (January to March 2009)

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

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[7] Indicator 2- The indicator is the numerator divided by the denominator, expressed as a percentage. Trusts will be expected to achieve the target (95% of non-admitted patients seen within 18 weeks) in each of the three months.

[8] Indicator 3 - The indicator is the numerator divided by the denominator, expressed as a percentage. Trusts will be expected to achieve 95% in each of the three months.

14. **NHS staff satisfaction**

- **Rating** Poor
- **Indicator value** 95.32%

14.1. Methodology: The following thresholds were applied when determining the score for this indicator:

Satisfactory:	Performance consistent with or better than average
Below average:	Performance poorer than average
Poor:	Performance poorer than average by a clear margin

14.2. How similar trusts performed

Similar Trusts	Rating
84.9%	Achieved
7.2%	Under achieved
7.9%	Failed

14.3. Rationale

Improving staff satisfaction is one of the five key areas of the 2008/09 NHS Operating Framework. The NHS Staff Survey has been carried out annually since 2003 and changes in the reported levels of NHS staff job satisfaction can be compared year on year from this time. This provides a survey-based measure of job satisfaction for NHS staff. A more satisfied workforce is likely to be more sustainable and provide better patient care, with motivated and involved staff being better placed to know what is working well and how to improve services for the benefit of patients and the public. The 2008/09 NHS Operating Framework set out the expectation that NHS organisations help staff understand their role in delivering a better NHS and encouraging staff to participate in the NHS Staff Survey and act on the findings.

14.4. Indicator

Selected questions from the NHS Staff Survey will be used to calculate a job satisfaction key score, which will be used to score this indicator overall[9].

[9] Further technical information is available from the **NHS Staff satisfaction technical document.**

14.5. General Note

The staff satisfaction indicator will not be applied more than once to any trust. This means that hybrid PCTs will be assessed against staff satisfaction as part of the commissioning national priorities indicator set only.

14.6. Data source and period

National NHS staff survey (fieldwork to be undertaken in autumn 2008)

Standards Performance: Providing Safety

14. **C04b - Safe use of Medical Devices**

- **Rating** Insufficient assurance
- **Indicator value** -

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all risks associated with the acquisition and use of medical devices are minimised.

14.1. How similar trusts performed

Similar Trusts	Rating
84.4%	Achieved
6.1%	Under achieved
9.5%	Failed

14.2. How this organisation plans to comply with the standard C04b

Start date	01 April 2008
Finish date	31 March 2009

14.3. Issue

The register of devices and continuous training lapsed in the early part of the year. Procurement was compliant through the NHS supply chain and Procurement Hub, guided by an expert reference group.

14.4. Action

A specialist medical devices agency was commissioned to help us deliver MHRA guidelines. During the year the Medical Devices Policy has been updated and ratified; the register of equipment has been updated; equipment has been inspected and asset labelled; Department Equipment Controllers

have been identified and training rolled out; a Medical Devices Group has been established; and risk management processes for CAS alerts have been reviewed and publicised.

15. **C04c - decontamination**

- **Rating** Not met
- **Indicator value** -

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.

15.1. How similar trusts performed

Similar Trusts	Rating
88.4%	Achieved
4.1%	Under achieved
7.5%	Failed

15.2. How this organisation plans to comply with the standard C04c

Start date	01 January 2009
Finish date	31 May 2009

15.3. Issue

This was an issue within dental services only. Audit of decontamination of dental instruments showed inconsistent results across the services. This was shown to be primarily a problem with interpretation of the different categories (damage, corrosion, debris etc).

15.4. Action

Training has been undertaken; categories were clarified, and further re-audits are being undertaken, with significantly improved results. Standards are now being reviewed against the full publication of HTM 01-05.