

The new NHS Modern and Dependable: A National Framework for Assessing Performance

Consultation Document

Purpose of this document

INFORMATION

This document is for information

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The new NHS
Modern and Dependable:
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Executive Summary

This consultation document:

- sets out the reasons why the approach to assessing and managing the performance of the NHS needs to change;
- describes a new National Framework to drive improvements in NHS performance;
- illustrates how the framework can be used by a range of different people and organisations;
- considers the development of indicators of NHS performance for the new framework;
- puts forward proposals for an initial small set of high-level indicators to provide an overview of Health Authority performance across the areas of the new framework;
- invites views on the proposals by 20 March 1998 to inform decisions on next steps.

Introduction - the rationale for adopting a new approach to assessing NHS performance

1. “The New NHS” White Paper provides six important principles which underlie the changes being proposed:
 - first, to renew the NHS as a genuinely national service. Patients will get fair access to consistently high quality, prompt and accessible services right across the country;
 - second, to make the delivery of healthcare against these new national standards a matter of local responsibility. Local doctors and nurses who are in the best position to know what patients need will be in the driving seat in shaping services;
 - third, to get the NHS to work in partnership. By breaking down organisational barriers and forging stronger links with Local Authorities, the needs of the patient will be put at the centre of the care process;
 - fourth, to drive efficiency through a more rigorous approach to performance and by cutting bureaucracy, so that every pound in the NHS is spent to maximise the care for patients;
 - fifth, to shift the focus onto quality of care so that excellence is guaranteed to all patients, and quality becomes the driving force for decision-making at every level of the service; and
 - sixth, to rebuild public confidence in the NHS as a public service, accountable to patients, open to the public and shaped by their views.

2. The White Paper outlines the way in which these principles will run through the new NHS arrangements and sets out a system based on partnership and driven by performance. The new approach aims to improve standards of performance across the NHS, and in doing so to tackle the unacceptable variations that currently exist. The way to achieve this is by comparing performance and sharing best practice - not by financial competition between different parts of the service. The White Paper acknowledges that the way in which performance is measured directly affects how the NHS acts - and that the approach to assessing and managing the performance of the NHS needs to be properly aligned with the overall goals and objectives of the service. The new approach will therefore demonstrate how the pursuit of quality and efficiency must go together if the NHS is to deliver the best for patients.

3. The development of a new health strategy and the forthcoming Green Paper “Our Healthier Nation” will also have implications for the way in which the performance of the NHS is assessed and managed. It will require an NHS focused on its contribution to improving health and on taking forward the wider health agenda.
4. “The New NHS” recognises the importance of collaborative working across Health Authorities, local authorities, voluntary organisations and the private sector. Assessment of performance in the NHS needs to take account of the contribution made in improving health by successful partnerships involving the NHS as an advocate for health, as well as the direct health care provided by the NHS.
5. The White Paper makes clear the Government’s objective of an NHS which delivers fairer provision of services, higher quality, improved value for money, greater responsiveness and thereby better health. The way the performance of the NHS is assessed and managed needs to support these goals. However in recent years the focus of NHS performance monitoring has been primarily on activity and financial efficiency. Clearly real efficiency will remain important in the NHS. But the old approach gave Health Authorities and Trusts an incentive to focus more on counting the number of patients treated, rather than on what that treatment meant for the health and wellbeing of patients. The Purchaser Efficiency Index simply failed to reflect the breadth of what is important in the NHS and created perverse incentives which ran counter to the real priorities for the health service. The balance needs to be shifted, so that due weight is given to the things that really matter to patients and the public - the cost and quality of care the NHS delivers and the benefit patients get from their treatment.

A new framework for assessing and managing NHS performance

6. The Government therefore intends to change the way in which NHS performance is assessed by adopting a new National Performance Framework which will support the broader-based goals set out in the White Paper. This new approach is designed to focus on the results achieved by the NHS in a way which is meaningful to the public and patients, to health care professionals and to NHS managers. It is also designed to be used both locally and nationally.
7. “The New NHS” briefly sets out the six areas of the proposed new performance framework. Taken together, the areas give a clear signal of what matters in the new NHS. They provide a comprehensive approach to assessing the performance of the NHS and will provide a way of making a rounded assessment of whether the new NHS is performing in line with the expectations set in the White Paper. The six areas, with a brief explanation of what they cover, are:

I Health Improvement

- to reflect the overarching aim of improving the general health of the population, which is influenced by many factors, reaching well beyond the NHS

II Fair access

- to recognise that the NHS's contribution must begin by offering fair access to health services in relation to people's needs, irrespective of geography, socio-economic group, ethnicity, age or sex

III Effective delivery of appropriate healthcare

- to recognise that fair access must be to care that is effective, appropriate and timely, and complies with agreed standards

IV Efficiency

- the way in which the NHS uses its resources to achieve value for money

V Patient/carer experience

- the way in which patients and their carers view the quality of the treatment and care that they receive, ensuring the NHS is sensitive to individual needs

VI Health outcomes of NHS care

- and finally, through assessing the direct contribution of NHS care to improvements in overall health, completing the circle back to the overarching goal of improved health

8. Table 1 sets out the six areas and aspects of each which might be assessed to provide a rounded picture of performance.

Table 1 The new National Performance Framework

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| Areas | Aspects of performance |
|--|---|
| I Health improvement | The overall health of populations, reflecting social and environmental factors and individual behaviour as well as care provided by the NHS and other agencies |
| II Fair access | The fairness of the provision of services in relation to need on various dimensions: <ul style="list-style-type: none"> - geographical - socio-economic - demographic (age, ethnicity, sex) - care groups (eg. people with learning difficulties) |
| III Effective delivery of appropriate healthcare | The extent to which services are: <ul style="list-style-type: none"> - clinically effective (interventions or care packages are evidence-based) - appropriate to need - timely - in line with agreed standards - provided according to best practice service organisation - delivered by appropriately trained and educated staff |
| IV Efficiency | The extent to which the NHS provides efficient services, including: <ul style="list-style-type: none"> - cost per unit of care/outcome - productivity of capital estate - labour productivity |
| V Patient/carer experience | The patient/carer perceptions on the delivery of services including: <ul style="list-style-type: none"> - responsiveness to individual needs and preferences - the skill, care and continuity of service provision - patient involvement, good information and choice - waiting times and accessibility - the physical environment; the organisation and courtesy of administrative arrangements |
| VI Health outcomes of NHS care | NHS success in using its resources to: <ul style="list-style-type: none"> - reduce levels of risk factors - reduce levels of disease, impairment and complications of treatment - improve quality of life for patients and carers - reduce premature deaths |

Using the new framework

9. The new Performance Framework marks the start of a process which will lead, over time, to a comprehensive assessment of those aspects of performance which really matter. It will encourage greater benchmarking of performance in different areas, and the publication of comparative information will allow people to compare performance and share best practice. The framework will be used to show how NHS resources support a systematic drive to ensure that the quality of local health services and the health of local people are getting demonstrably better every year. Targets for progress against the six areas of the performance framework will therefore be built into the accountability arrangements that will run through all aspects of the way the new NHS is managed.

10. The proposed framework has been designed so that it can be used to look at NHS performance along various dimensions, for example:
 - **by population group** , for example the elderly or children
 - **by disease area** , for example breast cancer or asthma and chronic respiratory disease
 - **by Health Authority, Primary Care Group or NHS Trust**
 - **by service or service sector** , for example orthopaedics, primary care or mental health

11. As more information becomes available to look at the different areas of performance, the framework should be increasingly useful to:
 - **the public, patients and organisations representing them or acting on their behalf**
 - in assessing the performance of the NHS locally and in making informed decisions about their own health and health care
 - **Health Authorities, Primary Care Groups, NHS Trusts and other service providers**
 - in helping managers and clinicians to work together to review the performance and improve the quality, effectiveness, efficiency and outcomes of the services they provide
 - in the long-term agreements between Health Authorities, Primary Care Groups and NHS Trusts
 - in local Health Authority-wide Health Improvement Programmes
 - **Ministers and the NHS Executive**
 - in the performance agreements between the NHS Executive's Regional Offices and Health Authorities

- in providing a means to assess progress - for example with the development priorities in the Planning and Priorities Guidance - across a broader range of areas of performance
- in replacing the Purchaser Efficiency Index from 1 April 1999 with demanding and better measures of efficiency as part of the new performance framework
- in ensuring public accountability for the use of NHS resources

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- 12.** To illustrate how the framework might be used, table 2 looks at aspects of the performance of the NHS in relation to the health and health care of elderly people, across each of the areas of the framework. The table also provides examples of the types of questions which might be raised by looking at performance in this way.

Table 2 Using the framework to look at aspects of performance in relation to the health and healthcare of elderly people

| | |
|------------------------|--|
| Area I | Health improvement |
| Title | Death rates amongst the elderly |
| | |
| Indicator | Standardised all-cause mortality ratio (65-74), 1985-95 |
| Explanation | A downward trend in death rates indicates rising life expectancy. Coupled with reduced illness/disability it suggests health improvement |
| Illustrative Qs | <p>What are the reasons for the differing mortality rates?</p> <p>What factors might explain the trends?</p> |

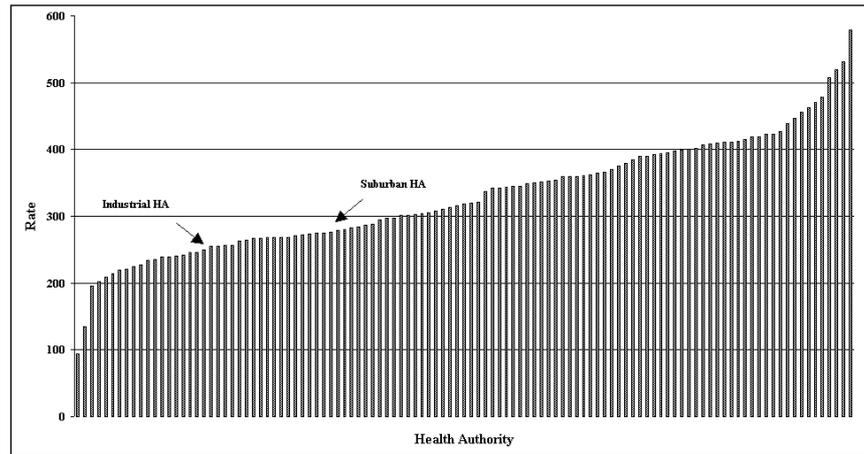
| | |
|------------------------|--|
| Area II | Fair access |
| Title | Availability of district nurse services for over 75s |
| | |
| Indicator | Number of district nurse contacts for those 75 and over per 1000 population, 1996/7 |
| Explanation | Similar levels of district nurse visits may indicate fairness in the provision of services to the elderly in different parts of the country, depending on other factors |
| Illustrative Qs | <p>Do the variations suggest that older people's access to community services is unequal, or are there other factors? For example, do the number of over 30 minute visits reveal any possible reason for the variations?</p> |

Area III

Effective delivery of appropriate healthcare

Title

Meeting the need for hip replacements for over 65s



Indicator

Age standardised rate for hip replacement for those 65 and over, 1994/5

Explanation

A high number of appropriate hip replacements may suggest that HAs are meeting needs for surgery in reducing disability in the elderly and restoring their independence

Illustrative Qs

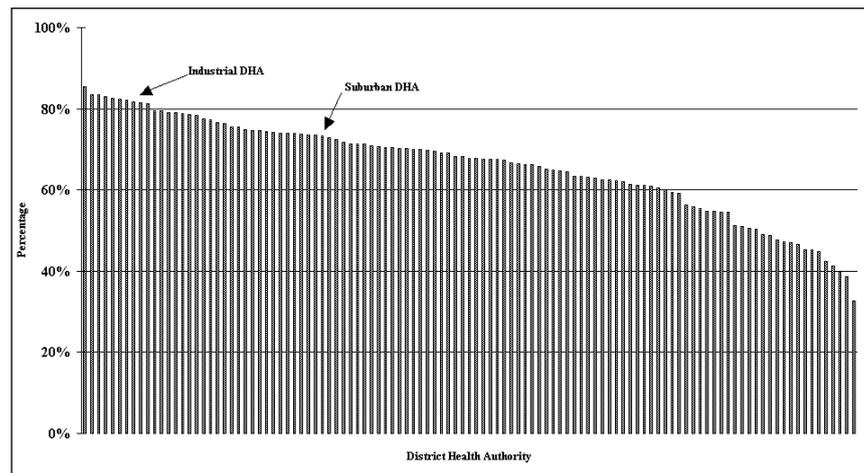
Does a low rate of hip replacements indicate unmet need? What is the relationship between the rate of hip replacements and the time patients have to wait for their operation?

Area IV

Efficiency

Title

Length of stay for patients with fractured neck of femur (top of thigh)



Indicator

Rate of discharge home within 56 days of admission with a fractured neck of femur

Explanation

It is more efficient (and effective) for many patients to receive long-term care in the community with appropriate community health and social care support rather than staying in acute hospitals for a long time

Illustrative Qs

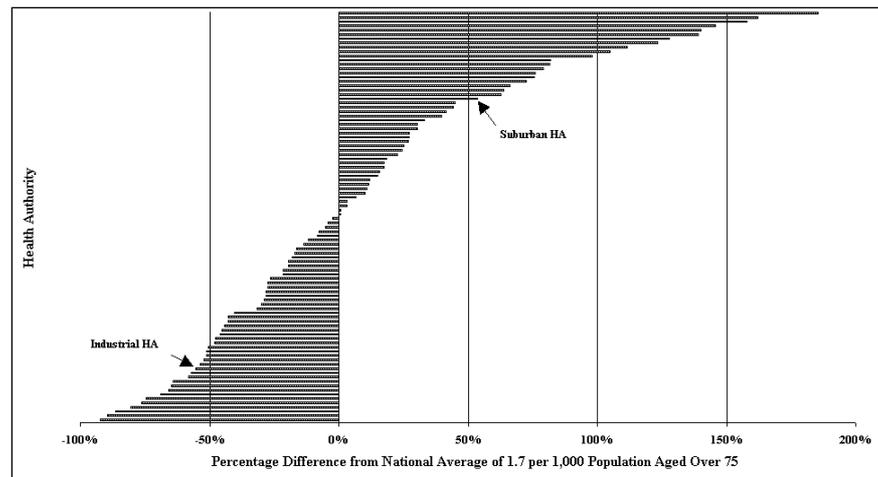
How can best practice be shared across the NHS?

Area V

Patient/carer experience

Title

Number of patients aged over 75 whose discharge from hospital is delayed



Indicator

Number of delayed discharges for those 75 and over, 1996/7

Explanation

A low level of delayed discharges is likely to improve the patient and carer's experience of the service

Illustrative Qs

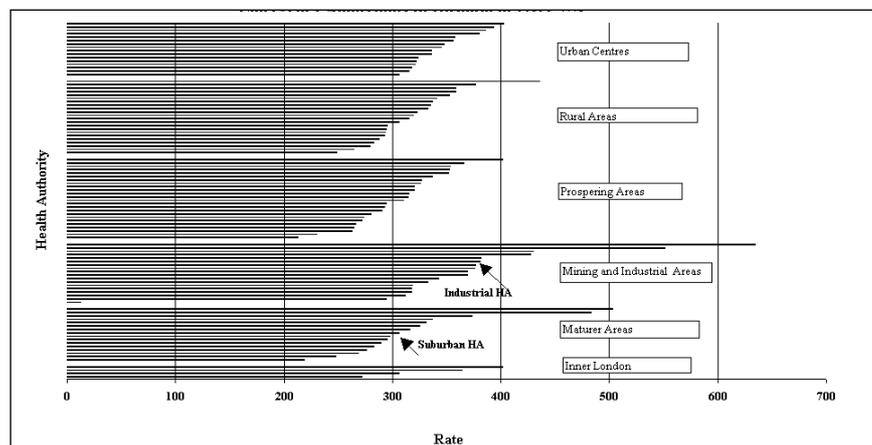
How can communication and co-ordination between acute, continuing and community NHS services and local authorities be improved to give a better service to patients and their carers?

Area VI

Health outcomes of NHS care

Title

Success of the support given to over 75s in the community



Indicator

Emergency admissions to hospital (episodes of care) for those 75 and over per 1000 population, 1996/7

Explanation

A low level of emergency admissions may indicate more effective management of the health of over 75 year olds in the community

Illustrative Qs

Do the variations in emergency admissions rates suggest a need to strengthen discharge arrangements, rehabilitation and recovery or the arrangements for community care? Do the differences between Health Authorities reflect the effectiveness of joint working between health and social services teams?

Developing indicators of performance for the new framework

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- 13.** The change in emphasis with the new framework will be supported by developments with indicator sets. Existing indicator sets which support the new framework will remain, including the Public Health Common Data Set and the Population Health Outcome Indicators. Others sets of less relevance will be discontinued. This latter category includes those parts of the Health Service Indicators related to inputs and processes, although the more outcome-focused sections will continue to be available as stand alone indicator sets. New indicators are already under development, such as the Clinical Indicators for the NHS (issued for consultation in August 1997 with EL 97/49). In other areas the publication of the framework highlights the fact that there are significant gaps in the information available to assess NHS performance. It will therefore take time to develop a robust, broad-based set of indicators covering all aspects of the framework. However adopting the framework will signal what is important. It will provide a catalyst for the development work - both locally and nationally - needed to fill the gaps and improve the information available. It will be important that the further development of existing indicators, together with work on new indicators, is considered in the light of the new framework to ensure a coherent and complementary approach.
- 14.** In those areas where there is little information currently available to allow assessment of NHS performance, work is starting to fill the gaps. As part of this, the new NHS Charter is likely to include new standards for assessing the quality of treatment and care. "The New NHS" also gave a commitment to introduce a new national survey to provide comparable information on patient and user experiences. The survey will be developed over the coming months in discussion with the NHS, professional and consumer organisations.
- 15.** Annex 1 shows how the indicators already in use and those under development link into the proposed areas of the performance framework. For example, the Population Health Outcome Indicators fit under *Health outcomes of NHS care*. To illustrate how the framework pulls together various different indicators in monitoring the NHS for a specific disease, table 3 shows how breast cancer could be assessed against each of the six areas using national indicators. More detailed information available locally may also allow additional information to be used to provide a fuller picture.

Table 3 Relationship of the new National Performance Framework to indicators for a particular disease: Breast Cancer

| AREAS | BREAST CANCER INDICATORS |
|---|--|
| Health Improvement | <ul style="list-style-type: none"> Standardised Mortality Ratios (available at national and HA level) |
| Fair access* | <ul style="list-style-type: none"> Waiting times (available at national and HA level for some procedures) Variation in take up of services analysed by population demographic characteristics (available at HA level) Calculation of systematic component of variation in service access rates after adjusting for random variation |
| Effective Delivery of Appropriate Healthcare* | |
| - Known to be effective (evidence based) | <ul style="list-style-type: none"> Coverage of breast cancer screening (available at national and HA level) <i>Percentage of patients receiving diagnostic triple assessment in single visit</i> |
| - Appropriate to need | <ul style="list-style-type: none"> Standardised treatment rates by type eg surgery (available at national and HA level) <i>Terminal care</i> |
| - Timely | <ul style="list-style-type: none"> <i>Trends in stage at diagnosis</i> |
| - Compliance with standards | |
| - Service organisation | <ul style="list-style-type: none"> Implementation of Calman/Hine recommendations |
| Efficiency - Cost per unit of care | <ul style="list-style-type: none"> Cost per HRG Cost per case detected by screening |
| Patient/carer experience* | <ul style="list-style-type: none"> Waiting times from diagnosis to operation <i>Waiting times from contact with NHS to diagnosis</i> <i>Patient satisfaction with information provision/choice/involvement in care/outcome</i> <i>Complaints</i> |
| Health Outcomes of NHS Care | |
| - NHS success in reducing level of risk | |
| - NHS success in reducing level of disease, impairment and complications of treatment | <ul style="list-style-type: none"> Cancer registrations (available for 1991 at national and HA level) <i>Cancer registrations plus interval cancers by stage at first diagnosis (available at HA level from some cancer registries)</i> <i>Incidence of avoidable complications - (recurrence, complications of therapy etc)</i> |
| - NHS success in restoring function and improving quality of life of patients /carers | <ul style="list-style-type: none"> <i>Measured using a self-assessment questionnaire (such as EuroQol, EQ-5D) or other appropriate measure</i> |
| - NHS success in reducing premature death | <ul style="list-style-type: none"> 5 year survival (based on 1991 registrations at national and HA level) <i>5 year survival standardised for age and stage (could be developed over 3-4 years)</i> |

Notes: *In these areas, measures of health care structure and process may be used as proxies for outcomes.

Items in normal text could be produced using existing data. *Items in italics*

16. It is proposed that eventually a range of different indicator sets, all linking into the framework, should be available for use by different groups - patients, the public, healthcare professionals, Health Authorities, Primary Care Groups, NHS Trusts, the NHS Executive - both locally and nationally.

Proposals for a small set of high-level performance indicators

17. To support benchmarking of NHS performance locally and the assessment of performance across the NHS nationally, it is proposed that a small set of high-level indicators should be developed. This high-level indicator set will aim to give a balanced view of NHS performance at Health Authority level. The purpose of the indicator set will be to raise questions, highlight areas where further investigation may be required and drive improvements in performance. It is expected that the framework and the indicator set will encourage the development of further measures locally to assess and improve performance.
18. To avoid additional burdens on the NHS from new data collection, and to enable early progress to be made, the indicator set will initially make use of information that is already routinely available at Health Authority level. This will mean, in particular, that some of the high-level indicators are far from ideal, and that some of them will use process measures as a proxy for information that is not yet available on outcomes, effectiveness and quality. The high-level indicator set will be developed over time as better, more outcomes-focused data becomes available. But it is intended that the set will remain small.
19. Attached in Annex 2 is an initial set of high-level indicators together with the [rationale for their selection](#). The indicators consist in the main of either composite indicators (combining several sets of data to give an overall picture) or sentinel indicators (single indicators which reflect performance in a wider area). Where the high-level indicators draw on material currently out for consultation (such as the Clinical Indicators), the results of that consultation may require the high-level indicator set to be further refined.
20. Following the consultation process, it is proposed that NHS Executive Regional Offices will work with Health Authorities in 1998-99 to road-test the framework using a revised set of high-level indicators. The aim of this process will be to look at the suitability and appropriateness of the indicators for use locally and nationally in assessing and improving performance.
21. Over time, the set of high-level indicators will provide an overview of NHS performance to inform the performance management process, encourage national and local improvements in performance and support public accountability. However there will clearly be other issues not captured in the high-level indicator set where there will be a need for effective performance management to achieve improvements in health and health care.

Consultation on the framework

- 22.** The Government is committed to ensuring that the way in which the performance of the NHS is assessed and managed fully reflects the service's overall goals and objectives. The proposed framework provides the starting point for this. The changes required to make progress in improving health and health care across all six areas are not under-estimated. However reaching agreement on the overall approach is an important first step. Views are therefore invited on:
- i.** the new performance framework;
 - ii.** how the framework should be used nationally and locally;
 - iii.** the proposal to have a small set of high-level indicators to give a rounded view of Health Authority performance across all six areas of the new framework and to road-test a set of indicators in 1998-99;
 - iv.** whether the set of high-level indicators put forward in Annex 2 captures the important areas of performance (given the constraints of using available data) or if other indicators would be more valuable.
- 23.** Subject to the outcome of the consultation process, further guidance will be issued in Spring 1998 setting out the next steps on the framework and high-level indicators.
- 24.** Responses to this consultation should be sent to the address below by 20 March 1998 to inform the next steps on the use of the framework and high-level indicator set during 1998-99. Responses should also be copied to the relevant Regional Office contact, who will also be able to provide further background on the framework and deal with any specific regional issues arising as part of the consultation process (see Annex 3 for names and addresses).

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Annex 1

The relationship of the new National Performance Framework to existing indicator sets and those under development

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| Areas | Potential indicators |
|--|---|
| I Health Improvement | Public Health Common Data Set “Our Healthier Nation” Green Paper indicators Standardised Mortality Ratios Health expectancy |
| II Fair access | Variations in the take up of services shown by other indicators give information on equity of access |
| III Effective delivery of appropriate healthcare | Community care Prescribing <i>Clinical indicators</i> <i>Clinical effectiveness indicators</i> <i>Primary care effectiveness indicators</i> <i>Mental health</i> <i>Continuing care</i> |
| IV Efficiency | Unit costs Labour productivity index <i>Capital productivity</i> <i>Costed HRGs</i> |
| V Patient/carer experience | Waiting times Patient’s Charter/ <i>NHS Charter</i> <i>National survey on patient/carer experiences</i> |
| VI Health outcomes of NHS care | Population health outcomes <i>Mental health outcomes</i> |

** those indicators under development are in italics*

Annex 2

The proposed set of high-level performance indicators

The indicators

1. The proposed set of high-level performance indicators are listed in Attachment A under the headings of the six areas of the performance framework. The sub-issues to which the indicators relate are also given.
2. The rationale for each indicator is given in Attachment B, together with information on the client groups to whom the indicators relate and the source and timeliness of the data used. Attachment C then sets out the criteria used in selecting the proposed indicators.

Issues in the selection of indicators

3. The set of indicators is confined to information that is currently available at health authority level, is of acceptable quality (or can be expected to improve rapidly) and will be available nationally in a reasonably up-to-date form by early 1998.
4. The small set of indicators is not intended to be comprehensive in covering all aspects of NHS activities. However so far as data availability allows, the indicators have been chosen to throw light on particularly important health service objectives and activities.
5. The development of a set of high-level indicators across each aspect of the new performance framework draws attention to areas where current information systems are not ideal. In some areas - notably health outcomes of health care - the problems have been recognised for some time and are now being addressed. In other areas - notably equity of access and patient/carer experience - there is a need for further action to develop indicators which are more informative.

The use of composite indicators

6. Presentation of all the proposed indicators in the framework individually would lead to the dataset becoming large and unwieldy. Therefore it is proposed that a number of indicators in the high-level set will be presented in aggregate, or composite, form.
7. Compositing will allow the set of indicators to remain relatively small in number whilst still encompassing a wide range of aspects of NHS performance. This approach is analogous to measures such as the Retail Prices Index where price movements of numerous different items are weighted and summarised in a single high level measure. Such an approach provides an additional, summary, level of information for particular areas for use within the high level framework whilst the individual constituent indicators, within a composite measure, are available from their original sources to enable more in-depth analysis as appropriate.

Explaining variations in the indicators

8. When using the performance framework, it is important to understand what may be driving the indicators and what factors may cause variations between Health Authorities. It is reasonable to suppose that differences between Health Authorities may in part be driven by differences in performance, but there may also be other factors, beyond the control of Health Authorities, which lead to variations and confound comparisons between one Health Authority and another.

9. The most obvious factors to consider when making comparisons are differences in the age and sex distribution in Health Authorities. Where appropriate, it is proposed that indicators be age and sex standardised to control for these differences, but there may be other factors, such as differing levels of 'need' for health services, which ought to be controlled for in some way. Further work is in hand to attempt to identify other such factors.

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Attachment A

Summary of the Proposed set of High Level Performance Indicators

| Areas, and categories covered | High level indicators at HA level (page numbers refer to details in attachment B) |
|---|---|
| I Health improvement | |
| The overall health status of populations, reflecting social and environmental factors and individual behaviour as well as care provided by the NHS and other agencies | <ul style="list-style-type: none"> i. Deaths from all causes (for people aged 15-64)(<i>page 20</i>) ii. Deaths from all causes (for people aged 65-74)(<i>page 20</i>) iii. Cancer registrations (<i>page 21</i>) |
| II Fair access | |
| Access to elective surgery | i. Surgery rates (<i>page 22</i>) |
| Access to family planning services | ii. Conceptions rate for girls aged 13-15 (<i>page 23</i>) |
| Access to dentists | iii. People registered with an NHS dentist (<i>page 24</i>) |
| Access to health promotion | iv. Early detection of cancer (<i>page 25</i>) |
| Access to community services | v. District nurse contacts (<i>page 26</i>) |
| III Effective delivery of appropriate healthcare | |
| Health promotion/ disease prevention | <ul style="list-style-type: none"> i. Disease prevention and health promotion (<i>page 27</i>) ii. Early detection of cancer (<i>page 28</i>) |
| Appropriateness of surgery | <ul style="list-style-type: none"> iii. Inappropriately used surgery (<i>page 29</i>) iv. Surgery rates (<i>page 30</i>) |
| Primary care management | <ul style="list-style-type: none"> v. Acute care management (<i>page 31</i>) vi. Chronic care management (<i>page 32</i>) vii. Mental health in primary care (<i>page 33</i>) viii. Cost-effective prescribing (<i>page 34</i>) |
| Compliance with standards | ix. Discharge from hospital (<i>page 35</i>) |
| IV Efficiency | |
| Maximising use of resources | <ul style="list-style-type: none"> i. Day case rate (<i>page 36</i>) ii. Length of stay in hospital (<i>page 36</i>) iii. Unit costs (<i>page 37</i>) iv. Generic prescribing (<i>page 38</i>) |

Summary of indicators (cont):

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| Areas, and categories covered | High level indicators at HA level (page numbers refer to details in attachment B) |
|--|--|
| V Patient/carer experience of the NHS | |
| Accessibility | i. Patients who wait more than 2 hours for emergency admission (<i>page 38</i>) ii. Patients with operations cancelled for non-medical reasons on the day of, or after, admission (<i>page 39</i>) |
| Co-ordination and communication | iii. Delayed discharge from hospital for people aged over 75 (<i>page 40</i>) iv. First outpatient appointments for which patient did not attend (<i>page 40</i>) |
| Waiting times | v. Outpatients seen within 13 weeks of written GP referral (<i>page 41</i>) vi. Inpatients admitted within 3 months of a decision to admit (<i>page 41</i>) |
| VI Health outcomes of NHS care | |
| NHS success in reducing level of risk | i. Conceptions rate for girls aged 13-15 (<i>page 42</i>) |
| NHS success in reducing level of disease, impairment and complication of treatment | ii. Decayed, missing and filled teeth in 5 year olds (<i>page 43</i>) iii. Avoidable diseases (<i>page 44</i>) iv. Adverse events/complications of treatment (<i>page 45</i>) |
| NHS success in optimising function and improving quality of life for patients and carers | v. Emergency admission to hospital for people aged over 75 (<i>page 46</i>) vi. Emergency psychiatric readmission rate (<i>page 47</i>) |
| NHS success in reducing premature death | vii. Infant deaths (<i>page 48</i>) viii. Survival rates for breast and cervical cancer (<i>page 49</i>) ix. Avoidable deaths (<i>page 50</i>) x. In-hospital premature deaths (<i>page 52</i>) |

Attachment B

Proposed set of High Level Performance Indicators

Health Improvement

| | |
|----------------------|---|
| Indicator(s): | (i) Deaths from all causes (for people aged 15-64). (ii) Deaths from all causes (for people aged 65-74). |
| Area | The wider health status of the population. |
| Rationale: | All cause mortality ratios can be used as broad guides to the relative health status of Health Authority populations in the context of wider influences on health. Two age bands have been used to reflect the differences in the types of factors and conditions which may contribute to mortality in adults (15-64) and older people. These indicators are likely to show a strong relationship with socio-economic factors outside the influence of the NHS, and this will need to be borne in mind when making comparisons across Health Authorities on these indicators. |
| Data | Primary source for this data is the Office for National Statistics. The indicators are defined as the indirectly age and sex standardised mortality ratio for all persons (15-64 or 65-74) resident in an area. By March 1998, data relating to the calendar year 1996 will be available. |
| Client groups | All age groups. |
| Comments | All cause mortality ratios are currently analysed as part of the Public Health Common Data Set - indicator CDS-C3A. |

Health Improvement (cont.):

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- Indicator(s):** (iii) Cancer registrations - the summation of age and sex standardised rates for the following cancers:
- malignant neoplasm of the stomach;
 - malignant neoplasm of small intestine, colon, rectum, rectosigmoid junction and anus;
 - malignant neoplasm of trachea, bronchus and lung;
 - malignant melanoma of the skin;
 - other malignant neoplasm of the skin;
 - malignant neoplasm of female breast;
 - malignant neoplasm of cervix uteri.

Area: The wider health status of the population.

Rationale: These cancers have been chosen because the NHS has a part to play in their prevention, mostly through its general role as an advocate for health. The incidence of these cancers will largely reflect the wider health status and lifestyles of the population.

Data: Data on cancer registrations is collected by the Office for National Statistics. There is a long time lag before the data becomes available because registrations are coded retrospectively. It is hoped that by March 1998, data relating to 1992 will be available.

Client groups: All ages.

Comments: Standardised registration ratios for these cancers are already presented as part of the Public Health Common Data Set - indicator CDS-D1. Reduction of the incidence of cervical cancer and skin cancer, and the reduction of deaths from breast cancer are currently Health of the Nation targets. Cancer has been identified as a priority for the Government.

Stage data will be available shortly for breast and cervical cancer. This will allow Health Authorities to assess whether they are improving the timely detection of these cancers. However, the usefulness of these data, and of cancer registrations in general, will depend on whether more timely data can be made available.

Fair Access

- Indicator(s):**
- (i) Surgery rates - a composite indicator of elective surgery rates, consisting of age and sex standardised:
 - CABG and PTCA rates;
 - hip replacement rates (for those aged 65 and over);
 - knee replacement rates (for those aged 65 and over);
 - cataract replacement rates.

Area: Access to elective surgery.

Rationale: This composite indicator groups together surgical rates for a number of important interventions to provide an overview of access to elective surgery. The interventions are effective when used appropriately and low and variable rates may suggest poor performance and unmet need.

The same measure is used as indicator (iv) under Effective Delivery of Appropriate Healthcare to provide information on unmet surgical need.

Coronary artery bypass grafts (CABGs) and **percutaneous transluminal coronary angioplasty (PTCA)** are effective interventions shown to reduce morbidity and mortality.

Hip and knee replacements increase mobility and alleviate discomfort caused by arthropathies of the hip joint. Used appropriately, they are effective procedures.

Early removal and replacement of one or more clouded lens of the eye (**cataract replacement**) restores vision and increases independence. If left untreated, this condition can lead to blindness.

A lack of progress on this indicator may reflect inadequate commissioning plans or restricted capacity due to unexpected increases in emergency admissions.

Data: Source of data is HES. By March 1998, provisional data for 1996/97 will be available.

Client groups: Adults and the older people (by nature of the current indicators available), but the indicator is intended to be representative of access for all ages.

Comments: Some of these indicators form part of the forthcoming Clinical Effectiveness Indicators set. Rates of surgery for inguinal hernia were considered for inclusion in the composite indicator. It is not currently included to ensure consistency with indicator (iv) under Effective Delivery of Appropriate Healthcare.

Fair Access (cont.):

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Indicator(s): (ii) Conceptions below age 16 (rate, girls aged 13-15).

Area: Access to family planning services.

Consultation Document

Rationale: This indicator reflects the access which teenagers have to family planning services. A lower rate of conceptions will reflect how well services are advertised, whether confidentiality is assured, and how easy it is for young people to access them. The indicator could be representative of young people's access to all health services.

The same measure is used as indicator (i) under Health Outcomes of NHS Care to provide information on NHS success in reducing the levels of risk.

Data: Primary source for the data is the Office for National Statistics and relates to calendar years. In March 1998, the latest data will relate to 1995.

Client groups: Teenagers.

Comments: This indicator is currently used as a Health of the Nation Indicator (HON-D3) and as part of the Population Health Outcome Indicators (PHOI A1.4).

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Fair Access (cont.):

Indicator(s): (iii) People registered with an NHS dentist - percentage of population registered

Area: Access to dentists.

Rationale: This indicator will provide a way of evaluating geographical inequities in accessing primary care services.

The indicator will be most valuable when used to look at the results of one Health Authority over time, rather than to directly compare Health Authorities. Changes over time will reflect the work done by individual health authorities to improve access to NHS dentists.

This measure does not include private patients.

Data: Registrations collected by Dental Practice Board are used in conjunction with Department of Health population data. By March 1998, data relating to the calendar year 1997 will be available.

Client groups: All ages.

Comments: A measure of access to GPs would be appropriate within this section. However, it has not been possible to identify a suitable measure. Percentage of population registered with a GP or length of lists could be misleading because they may not accurately reflect accessibility in practice e.g. how long a patient has to wait for an appointment with their GP.

An indicator measuring access to therapy services is also being considered, as is a measure of access to General Ophthalmic Services.

Fair Access (cont.):

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- Indicator(s):** (iv) Early detection of cancer - a composite indicator, consisting of:
- % of target population screened for breast cancer;
 - % of target population screened for cervical cancer.

Area Access to health promotion.

Rationale: This composite measure provides a combined view of the coverage of breast and cervical screening programmes.

The same measure is used as indicator (ii) under Effective Delivery of Appropriate Healthcare to provide information on health promotion/disease prevention.

This indicator can be used to assess the access of different socioeconomic groups to disease prevention services, by comparing specific groups of Health Authorities, eg inner city HAs against rural HAs.

The Forrest working group concluded that **screening by mammography** amongst women aged 50-64 could reduce deaths from breast cancer. This conclusion was reinforced by the report of the NHS Breast Screening Programme. The indicator is intended to measure the impact of health promotion interventions funded by Health Authorities.

Cervical cancer is readily diagnosed and there is successful treatment for early stage disease. Studies suggest that screening is effective if coverage is high. The target population for screening is women aged between 20 and 64, and they should be screened at least once every 5 years.

Data Source data on screening is collected by the Department of Health. Data relating to 1996/7 will be available by March 1998.

Client groups Women in the relevant target populations, but the indicator is intended to be representative of access to health promotion generally.

Comments: Percentage of target population screened for these cancers was included in the last set of NHS Performance Tables. They are also presented in the forthcoming Clinical Effectiveness Indicators set and in the Primary Care Effectiveness Indicators.

AIDS/HIV rates were considered as a possible additional indicator of access to health promotion or of NHS success in reducing the level of risk. However, such an indicator will have a natural geographical bias against London and so has not been selected.

Fair Access (cont.):

- Indicator(s):** (v) District nurse contacts - a composite indicator looking at access to community services, consisting of:
- district nurse contacts for those aged 75 and over;
 - district nurse contacts over 30 mins for those aged 75 and over;
 - assisted district nurse contacts for those aged 75 and over.

Area: Access to community services.

Rationale: As a proportion of contacts for all ages, this set of indicators should demonstrate whether older people have equal access to community services. A composite indicator is proposed, which measures different types of contacts to provide information about both the volume and the intensity of health services in the community.

Data: Collected as part of the Common Information Core. By March 1998, data up to December 97 will be available.

Client groups: Older people.

Effective Delivery of Appropriate Healthcare

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- Indicator(s):**
- (i) Disease prevention and health promotion - a composite indicator consisting of:
- % of target population vaccinated;
 - % of all orchidopexies below age 5.

Area: Health promotion/disease prevention.

Rationale: A composite indicator is proposed as both these measures are largely attributable to primary care.

Part of this composite indicator measures **vaccinations** for all infections currently listed in the Statement of Fees and Allowances (diphtheria, tetanus, polio, pertussis, measles, mumps, rubella and hib meningitis). The aim is that by age 2 children should have been immunised against the infections listed. The vaccination rate should be near to 100%, and is achieved in a number of Health Authorities.

The purpose of the **orchidopexies** indicator is to reflect the consensus that undescended testes over age 5 is thought to be indicative of a failure of detection in primary and community care and hence of timely surgical treatment to avoid future complications. A high value on this indicator suggests good detection and timely intervention.

Data: Source data on vaccinations is collected on returns by the Department of Health and the orchidopexies information is collected via HES. Provisional data for 1996/7 will be available by March 1998.

Client groups: Children.

Comments: Vaccinations and orchidopexies are also included in the Population Health Outcome Indicators and the Primary Care Effectiveness Indicators.

Percentage of children vaccinated was also included in the last set of NHS Performance Tables.

Effective Delivery of Appropriate Healthcare (cont.):

- Indicator(s):** (ii) Early detection of cancer - a composite indicator consisting of:
- % of target population screened for breast cancer;
 - % of target population screened for cervical cancer.

Area: Health promotion/disease prevention.

Rationale: This composite measure provides a combined view of the coverage of breast and cervical screening programmes.

The same measure is used as indicator (iv) under Fair Access to provide information on access to health promotion.

The Forrest working group concluded that **screening by mammography** amongst women aged 50-64 could reduce deaths from breast cancer. This conclusion was reinforced by the report of the NHS Breast Screening Programme. The indicator is intended to measure the impact of health promotion interventions funded by health authorities.

Cervical cancer is readily diagnosed and there is successful treatment for early stage disease. Studies suggest that screening is effective if coverage is high. The target population for screening is women aged between 20 and 64, and they should be screened at least once every 5 years.

Data: Source data on screening is collected by the Department of Health. Data relating to 1996/7 will be available by March 1998.

Client groups: Women in the relevant target groups.

Comments: Percentage of target population screened for these cancers was included in the last set of NHS Performance Tables. They are also presented in the forthcoming Clinical Effectiveness Indicator set and in the Primary Care Effectiveness Indicators.

Effective Delivery of Appropriate Healthcare (cont.):

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- Indicator(s):** (iii) Inappropriately used surgery - a composite indicator consisting of age and sex standardised:
- rates of D&Cs performed in women under 40
 - surgical intervention rates for glue ear (grommet surgery).

Area: Appropriateness of surgery.

Rationale: Both of these indicators relate to procedures where a significant amount of activity is thought to be inappropriate.

Research has demonstrated that **dilation and curettage (D&C)** is an ineffective diagnostic technique for women presenting with menorrhagia and therefore the number performed should be reduced.

Evidence suggests limitations on the clinical effectiveness of **grommet surgery** and indicates that a significant proportion of children receive unnecessary surgery. High rates may be the result of inappropriate clinical practice.

Data: Source of data is HES. By March 1998, provisional data for 1996/97 will be available.

Client groups: As it stands the indicator relates specifically to women and children, but it is intended to be indicative of the appropriateness of surgery generally and not just for these groups.

Comments: These indicators form part of the forthcoming Clinical Effectiveness Indicators set. Rates of D&C in women under 40 are also part of the Clinical Indicators.

Effective Delivery of Appropriate Healthcare (cont.):

- Indicator(s):** (iv) Surgery rates - a composite indicator of elective surgery rates, consisting of age and sex standardised:
- CABG and PTCA rates;
 - hip replacement rates (for those aged 65 and over);
 - knee replacement rates (for those aged 65 and over);
 - cataract replacement rates.

Area Appropriateness of surgery/unmet surgical need.

Rationale: This composite indicator groups together surgical rates for a number of important interventions to provide an overview of access to elective surgery. The interventions are effective when used appropriately and low and variable rates may suggest poor performance and unmet need.

The same measure is used as indicator (i) under Fair Access to provide information on access to elective surgery.

Coronary artery bypass grafts (CABGs) and **percutaneous transluminal coronary angioplasty (PTCA)** are effective interventions shown to reduce morbidity and mortality.

Hip and knee replacements increase mobility and alleviate discomfort caused by arthropathies of the hip joint. Used appropriately, they are effective procedures.

Early removal and replacement of one or more clouded lens of the eye (**cataract replacement**) restores vision and increases independence. If left untreated, this condition can lead to blindness.

Data Source of data is HES. By March 1998, provisional data for 1996/97 will be available.

Client groups Adults and older people (by nature of the current indicators available), but it should be indicative of the appropriateness of surgery generally and not just for these groups.

Comments Some of these indicators form part of the forthcoming Clinical Effectiveness Indicators set. Hip replacement rates are part of the Population Health Outcome Indicators (PHO-B7).

Renal replacement rates were also considered for inclusion, but were rejected partly due to data difficulties and also because there is evidence that the incidence of end-stage renal failure has a strong ethnic bias, which would be difficult to standardise for.

Effective Delivery of Appropriate Healthcare (cont.):

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Indicator(s): (v) Acute care management - a composite indicator consisting of age and sex standardised admission rates for:

- severe ENT infection;
- kidney/urinary tract infection;
- heart failure.

Area: Primary care management.

Rationale: These indicators provide a measure of the level of potentially “avoidable hospitalisations” as a result of conditions which should, at least in part, be treatable in primary care.

Data: Source of data is HES. By March 1998, provisional data for 1996/97 will be available.

Client groups: All ages.

Comments: This indicator is taken from the Primary Care Effectiveness Indicators.

Effective Delivery of Appropriate Healthcare (cont.):

| | |
|----------------------|--|
| Indicator(s): | (vi) Chronic care management - a composite indicator consisting of age and sex standardised admission rates for: <ul style="list-style-type: none">• asthma;• diabetes;• epilepsy. |
| Area | Primary care management. |
| Rationale: | These three chronic conditions are largely managed in a primary care setting. High hospital admission rates for these conditions may indicate poor management of these conditions in primary care. |
| Data | Source of data is HES. By March 1998, provisional data for 1996/97 will be available. |
| Client groups | All ages. |
| Comments | This indicator is taken from the Primary Care Effectiveness Indicators. |

Effective Delivery of Appropriate Healthcare (cont.):

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| | |
|-----------------------|--|
| Indicator(s): | (vii) Mental health in primary care - a composite indicator consisting of: <ul style="list-style-type: none">• volume of benzodiazepines;• ratio of antidepressants to benzodiazepines prescribed. |
| Area: | Primary care management. |
| Rationale: | <p>These indicators attempt to measure the level of detection of, and appropriate prescribing for, mental health conditions in primary care.</p> <p>There is a broad consensus that prescribing of benzodiazepines should be kept to a minimum. Good detection and treatment of depression should point to a high ratio of antidepressants to benzodiazepines.</p> |
| Data: | Indicators are derived from PACT data. By March 1998, data relating to the calendar year 1997 will be available. |
| Client groups: | Mentally ill. |
| Comments: | These indicators are taken from the Primary Care Effectiveness Indicators and are also Prescribing Indicators. |

Effective Delivery of Appropriate Healthcare (cont.):

- Indicator(s):** (viii) Cost effective prescribing - a composite measure consisting of:
- cost/ASTRO-PU of combination products;
 - cost/ASTRO-PU of modified release products;
 - cost/ASTRO-PU of drugs of limited clinical value;
 - cost/DDD of inhaled corticosteroids.

(ASTRO-PU - the number of prescriptions/head weighted according to geographic and demographic variations)
(DDD - "Defined Daily Dose" - the assumed average dose per day for a drug used for its main indication in adults)

Area: Primary care management - cost effective prescribing.

Rationale: These indicators are broadly a measure of cost-effective prescribing. They cover areas where there is often over-prescribing of expensive drugs, or of any drug, when clinical need can be met by a cheaper alternative.

Data: Most of these indicators are derived from PACT data. By March 1998, data relating to the calendar year 1997 will be available.

Client groups: All ages.

Comments: These indicators are taken from the Primary Care Effectiveness Indicators and are also Prescribing Indicators.

Consideration should be given to identifying prescribing indicators where high levels of prescribing are desirable. Months of hormone replacement therapy prescribed to women in the relevant age band is a possibility.

Effective Delivery of Appropriate Healthcare (cont.):

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- Indicator(s):** (ix) Discharge from hospital - a composite indicator consisting of:
- rate of discharge home within 56 days of emergency admission from home with a stroke;
 - rate of discharge home within 56 days of admission with a fractured neck of femur.

Area: Compliance with standards.

Rationale: There are no particular standards for the appropriate length of stay following admission to hospital for stroke or for a fractured neck of femur. However, evidence suggests that acute hospitals may not be the most appropriate long term care setting for patients with these conditions.

There is a clear link between these indicators and the availability of community health services, social care and family support. These indicators can, at least in part, be taken as a reflection of the level of co-ordination between hospital and community health services.

Data: Source of data is HES. By March 1998, provisional data for 1996/97 will be available.

Client groups: Adults and older people (by nature of the current indicators available).

Comments: These indicators form part of the Clinical Indicators set and are currently the subject of a consultation exercise. Their inclusion in this set of indicators will be influenced by the outcome of that consultation.

The absence of more appropriate indicators in this section highlights the lack of national monitoring of clinical standards.

Efficiency

Indicator(s):

- (i) day case rate.
- (ii) length of stay in hospital (casemix adjusted).

Area:

Maximising resource use

Rationale:

Day case rates and average length of stay are measures of resource use per hospital inpatient. Casemix adjustment takes account of variation which can be attributed to differences in the patients being treated, eg the diagnosis and the age of the patient. These indicators are relevant to both Health Authorities and Trusts.

Data:

Day case rates by Health Authority are available from the Quarterly Monitoring returns. By March 1998, data up to December 1997 will be available.

Casemix adjusted average length of stay is only available from HES. By March 1998, provisional data for 1996/97 will be available.

Client groups:

Hospital patients, all ages.

Comments:

Day case rates and length of stay have been calculated on the basis of consultant episodes. Current investigations may lead to a change to inpatient spells. Current development of a database of HRG unit costs may offer an alternative measure in the future.

Efficiency (cont.):

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Indicator(s): (iii) Unit costs (HCHS).

Area: Maximising resource use

Consultation Document

Rationale: The Hospital and Community Health Service (HCHS) unit cost is an aggregate measure of cost per patient treatment. It allows comparisons both cross-sectionally and over time, and can be disaggregated as appropriate.

Data: Health Authority data are available from the Quarterly Monitoring returns. By March 1998, data up to December 1997 will be available.

Client groups: All ages.

Comments: Current development of a database of HRG unit costs may offer an alternative measure in the future.

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Efficiency (cont.):

Indicator(s): (iv) Generic prescribing (percentage measure).

Consultation Document

Area: Maximising resource use

Rationale: Considerable cost savings have been achieved by promoting the prescribing of generic products, as some branded products can cost the NHS substantially more than the generic version. Also, prescribing a drug by its generic name is recognised as good prescribing practice. Generic manufacturers must satisfy the Medicines Control Agency that their products are of a similar quality to branded products before a license is granted.

There are wide variations in the extent of generic prescribing throughout England. Further increases in the level of generic prescribing would still result in substantial cost savings without compromising patient care.

Data: All items prescribed by GPs in England are recorded by the Prescription Pricing Authority and reported as PACT data. By March 1998, data relating to the calendar year 1997 will be available.

Client groups: All patients receiving prescriptions.

Patient/Carer Experience Of The NHS

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- Indicator(s):**
- (i) Patients who wait more than 2 hours for emergency admission (admitted through A&E).
 - (ii) Patients with operations cancelled for non-medical reasons on the day of, or after, admission.

Area: Accessibility.

Rationale: The ability to access services where and when they are needed is a key aspect both of direct patient experience and of wider service quality. **Waiting times for emergency admission through A&E** is a high-profile indicator of emergency access to hospital beds and a proxy measure of the patient's experience. The intention is to reduce the number of long trolley waits and ensure that patients to be admitted are dealt with rapidly and appropriately.

The last minute **cancellation of operations** is distressing and inconvenient for patients. This indicator measures the number of patients who are not readmitted promptly following such an experience.

Data: Data collected from the Patient's Charter return. By March 1998, data relating to the calendar year 1997 will be available.

Client groups: Emergency admissions and those waiting for treatment.

Comments: These indicators are consistent with current Patient's Charter standards.

Ambulance response times were considered for inclusion under this heading, but data are not available by Health Authority so the indicator has not been selected.

Patient/Carer Experience Of The NHS (cont.):

| | |
|-----------------------|--|
| Indicator(s): | (iii) Delayed discharge from hospital for people aged over 75 (per 1,000 75 year olds not in hospital). (iv) First outpatient appointments for which patient did not attend (percentage measure). |
| Area: | Co-ordination and communication. |
| Rationale: | <p>Most episodes of care involve several members of NHS staff. Treatment or care over time often includes different NHS organisations and other agencies. The ways in which staff and organisations communicate and co-ordinate within and among themselves are important components of the patient experience.</p> <p>Hospital discharge marks the boundary between the responsibility of the acute, continuing and community health services of the NHS and Local Authorities. Delayed discharge may be the result of poor communication between the relevant care organisations.</p> <p>Outpatient “did not attends” (DNAs) are expensive for the NHS and mean that patients miss out on care. Outpatient DNA rates vary widely and there is evidence that they can be significantly reduced by reviewing appointment and other procedures from the perspective of the patients. Reducing DNA rates may also have an impact on the length of waiting lists and waiting times.</p> |
| Data: | Delayed discharge is collected as part of the Common Information Core. By March 1998, data relating to the calendar year 1997 will be available. |
| Client groups: | Delayed discharge relates to older people. Outpatients DNAs relate to all ages. |
| Comments: | Good information on patient experience of co-ordination and communication requires asking them directly. A national feedback survey is under development. |

Patient/Carer Experience Of The NHS (cont.):

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- Indicator(s):**
- (v) Outpatients seen within 13 weeks of GP referral (percentage measure).
 - (vi) Inpatients admitted within 3 months of a decision to admit (percentage measure).

Area Waiting times.

Rationale: Waiting times act as a proxy measure of the patient experience: the longer the waiting time, the poorer the experience. In addition, some interventions are most effective when carried out at the earliest opportunity, and a shorter waiting time may translate into a better health outcome.

Data The outpatients measure is collected through Waiting Times returns. By March 1998, data relating to the calendar year 1997 will be available. The inpatient measure is collected through HES. By March 1998, provisional data relating to 1996/97 will be available.

Client groups Those waiting for treatment.

Comments: Outpatients seen within 13 weeks of referral is consistent with current Patient's Charter standards.

The Patient's Charter guarantees that 100% of inpatient admissions are within 18 months.

Health Outcomes of NHS Care

Consultation Document

Indicator(s): (i) Conceptions below age 16 (rate, girls aged 13-15).

Area: NHS success in reducing the level of risk.

Rationale: Improved health and sex education programmes and improved contraceptive services should reduce the number of conceptions in young girls. Health Authorities need to ensure that the provision of family planning services through GPs, clinics and hospitals is appropriate, accessible and comprehensive. There is some evidence to suggest that rates of teenage conceptions are correlated with levels of deprivation.

The same measure is used as indicator (ii) under Fair Access to provide information on access to family planning services.

Data: Primary source for the data is the Office for National Statistics and relates to calendar years. In March 1998, the latest data will relate to 1995.

Client groups: Teenagers.

Comments: This indicator is currently used as a Health of the Nation Indicator (HON-D3) and as part of the Population Health Outcome Indicators (PHOI A1.4).

Indicators measuring smoking rates, obesity and alcohol consumption, as currently monitored through the Health of the Nation, were also considered for inclusion in this section. However, data are not currently available at Health Authority level for these indicators and so they have not been included.

Health Outcomes of NHS Care (cont.):

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Indicator(s): (ii) Decayed, missing and filled teeth in five year olds.

Area: NHS success in reducing the level of disease, impairment and complication of treatment.

Consultation Document

Rationale: Dental decay is a common childhood disease which affects both deciduous (milk) and permanent teeth. Its sequelae can last throughout life and require ongoing care to maintain functional dentition. Tooth loss in children is almost entirely a consequence of dental decay and early tooth loss is a significant cause of adult periodontal disease. Water fluoridation or the use of fluoride dietary supplements reduce the level of dental decay. The NHS can reduce the level of dental decay through promoting good oral hygiene, and reducing the amount and frequency of intake of sugar-containing foods.

Data: The source for this data is the Dental Epidemiological Survey Programme co-ordinated by the British Association for the Study of Community Dentistry for the UK Departments of Health. Surveys are conducted every second year for 5 olds and give the average number of decayed, missing and filled teeth. Data is also available for 12 and 14 year olds, but these surveys are completed only once every four years. 1996/7 data will be available during 1998.

Client groups: Children.

Comments: This indicator is already presented as part of the Public Health Common Data Set - indicator OHI A1.4.

Health Outcomes of NHS Care (cont.):

Indicator(s): (iii) Avoidable diseases - a composite indicator of avoidable diseases and impairments, consisting of age and sex standardised:

- notification rates for pertussis in children;
- notification rates for measles;
- episode rates for fracture of proximal femur (in those aged 65 and over);
- notification rates for TB.

Area NHS success in reducing the level of disease, impairment and complication of treatment.

Rationale: This composite indicator combines a range of diseases/conditions where the NHS has significant impact in reducing rates through good quality health promotion and prevention.

Immunisation with ***pertussis and measles*** vaccines reduces incidence and mortality from these infections. High notification rates may signify poor accessibility to services provided by GPs and HAs, a need for public education programmes and a lack of coordination.

Many ***fractures of the proximal femur*** are associated with osteoporosis. Primary prevention may be effective in reducing osteoporosis through, for example, hormone replacement therapy, encouraging regular exercise, encouraging the reduction of smoking and increasing the dietary intake of calcium.

BCG vaccinations provide effective cover against ***tuberculosis*** infection, but there are variations among Health Authorities in vaccination policies and coverage.

Data Primary source for data for notifications of pertussis, measles and TB is the Office for National Statistics. The latest available data by March 1998 would relate to 1996. Episode rates for fracture of the proximal femur are from HES and by March 1998, provisional data relating to 1996/97 will be available.

Client groups Children (mainly) - one indicator relevant to older people.

Comments These indicators are currently presented as part of the Population Health outcome Indicators - notification rates for pertussis (PHOI A2.1), measles (PHOI A2.2), TB (PHOI B8.2) and episode rates for fracture of proximal femur (PHOI B6.1).

Health Outcomes of NHS Care (cont.):

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- Indicator(s):** (iv) Adverse events/complications of treatment - a composite indicator consisting of age standardised:
- 28 day emergency readmission rates;
 - rates of surgery for hernia recurrence.

Area: NHS success in reducing the level of disease, impairment and complication of treatment.

Rationale: It is proposed to composite these indicators because they are both measuring episodes which are potentially avoidable. High rates may raise questions about quality of care which could be investigated further.

Emergency readmission rates are being used as a proxy for potentially avoidable readmissions which were not part of the originally planned treatment. High readmission rates could, for example, reflect poor physician care, poor nursing care and inadequate discharge arrangements. They could also be due to a lack of community care.

Surgery for **hernia recurrence** should be largely avoidable.

Data: Source of data is HES. By March 1998, provisional data for 1996/97 will be available.

Client groups: All ages.

Comments: These indicators form part of the Clinical Indicators set and are currently the subject of a consultation exercise. Their inclusion in this set of indicators will be influenced by the outcome of that consultation.

Given the number of events, hernia recurrence is going to be largely overshadowed by readmissions. There is also a time lag involved in hernia recurrence.

Health Outcomes of NHS Care (cont.):

| | |
|----------------------|---|
| Indicator(s): | (v) Emergency admissions to hospital for people aged over 75 (per 1,000 75 year olds). |
| Area | NHS success in optimising function and improving quality of life for patients and carers. |
| Rationale: | The emergency admission rate is an important measure of the effectiveness of hospital discharge and community care arrangements for elderly people. As these arrangements must be jointly agreed between health and social services departments, it is also an indicator of how well these agencies are working together. There is considerable anecdotal evidence that pressure for early discharge, inadequate rehabilitation and recovery, poor discharge arrangements or inadequate arrangements for community care lead to unnecessary emergency admissions. |
| Data | Collected as part of the Common Information Core. By March 1998, data up to December 1997 will be available. |
| Client groups | Older people. |
| Comments | Not all emergency episodes of care are considered potentially avoidable. Some will be for valid reasons e.g. following a stroke or for fracture of neck of femur. |

Health Outcomes of NHS Care (cont.):

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Indicator(s): (vi) Emergency psychiatric readmission rate

Area: NHS success in optimising function and improving quality of life for patients and carers.

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Rationale: High emergency psychiatric readmission rates may suggest that the level of mental health support provided in the community is inadequate.

Data: Collected as part of the Common Information Core. By March 1998, data relating to the calendar year 1997 will be available.

Client groups: Mentally ill.

Health Outcomes of NHS Care (cont.):

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Indicator(s): (vii) Infant deaths - a composite indicator consisting of:

- stillbirth rates;
- infant mortality rates.

Area: NHS success in reducing premature deaths.

Rationale: Equitable access to a full range of services in the preconception, antenatal, intrapartum, and neonatal periods will help to reduce infant morbidity and mortality. Services aimed at improving general health, education and nutrition and reducing the prevalence of risk factors such as smoking and drinking in pregnancy are also important.

Data: Primary source for this data is the Office for National Statistics. By March 1998, data relating to the calendar year 1996 will be available.

Client groups: Babies

Comments: These indicators are currently presented in the Population Health Outcome Indicators (PHOI A5.1 and A5.3).

Health Outcomes of NHS Care (cont.):

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Indicator(s): (viii) Survival rates for breast and cervical cancer - a composite indicator of 5 year survival rates consisting of age and sex standardised:

- survival rates from breast cancer (ages 50-69);
- survival rates from cervical cancer (ages 15-74).

Area: NHS success in reducing premature deaths.

Rationale: Survival rates for these cancers will reflect the underlying effectiveness of treatment for them by the NHS. They reflect a different dimension of NHS performance from simply looking at cancer registration rates alone.

Data: Cancer registrations data are collated by the Office for National Statistics and can be combined with mortality data to estimate survival rates. The first data, relating to survival rates from cancers registered in 1990, should be available by March 1998.

Client groups: Those registered as having cancer.

Comments: It is proposed to include 5 year survival rates for these cancers in the Public Health Common Data Set and mortality from breast cancer is currently a Health of the Nation indicator. Cancer has been identified as a key priority for the Government.

Health Outcomes of NHS Care (cont.):

Indicator(s):

- (ix) Avoidable deaths - a composite indicator of potentially avoidable deaths consisting of (with age and sex standardisation where possible):
- mortality from peptic ulcer (ages 25-74);
 - mortality rate from fracture of skull and intracranial injury (ages 1+);
 - maternal mortality (ages 15-44);
 - mortality from tuberculosis (ages 5-64);
 - mortality from Hodgkin's disease (ages 5-64);
 - mortality from chronic rheumatic heart disease (ages 5-44);
 - mortality from hypertensive and cerebrovascular disease (ages 35-64);
 - mortality from asthma (ages 5-44);
 - mortality from appendicitis, abdominal hernia, cholelithiasis and cholecystitis (ages 5-64);
 - mortality from CHD in persons under 65.

Area

NHS success in reducing premature deaths.

Rationale:

These indicators have been selected because they measure causes of mortality which are amenable to health service intervention, either preventive or curative. A number of them were developed at St. Thomas' hospital. Whilst it may not be possible to prevent every death measured by these indicators, they are indicators where a substantial proportion of deaths, in the stated age bands, could be expected to be prevented. With this in mind, they are probably best thought of as "potentially avoidable deaths".

Health services can be effective in reducing mortality associated with **peptic ulcer** through early diagnosis, referral and appropriate therapy before life threatening conditions occur.

Many **trauma deaths** can be prevented by good management of seriously injured patients e.g. early emergency care, prevention and treatment of secondary complications, and effective care at the scene of accident and during transfer to hospital.

Maternal mortality appears to be more sensitive to the quality of obstetric care than to the socio-economic circumstances of the mother. A recent report of the Confidential Enquiry into Maternal Death noted some degree of substandard care in 40% of maternal deaths.

Tuberculosis is both preventable and treatable through health service intervention. Variations in mortality rates may reflect the quality of services for surveillance, early detection and effective treatment.

Health Outcomes of NHS Care (cont.):

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Mortality from **Hodgkin's disease** is considered to be potentially avoidable and may be a measure of the quality of available radiotherapy and oncology services.

Rheumatic heart disease is thought to be preventable through prompt treatment of streptococcal throat infections and prophylactic treatment in those with a history of rheumatic fever. The manifestations of chronic rheumatic heart disease can be managed effectively by medical and surgical cardiac services e.g. heart valve surgery.

Deaths from stroke (**cerebrovascular disease**) in the under 65s are considered to be potentially avoidable as the main risk factor is hypertension, which is readily identifiable and treatable. Other risk factors (e.g. smoking and alcohol) may be influenced by health education programs.

Asthma mortality has been shown through audits to be influenced by the management of chronic asthma and in the acute treatment of severe attacks.

Deaths from **appendicitis, abdominal hernia, cholelithiasis and cholecystitis** are considered to be avoidable and may reflect the quality of surgical services locally. Mortality is influenced by delayed diagnosis and inadequacies in pre-operative, operative and post-operative management and treatment.

The NHS may be able to influence **mortality from CHD** in a number of ways, including the appropriate use of lipid lowering drugs, revascularisation surgery and through reducing ambulance response times following MI. There is also evidence that timely use of thrombolytic drugs can reduce mortality.

Data: Source of the data for these indicators is the Office for National Statistics. By March 1998, data relating to the calendar year 1996 will be available.

Client groups: Adults and children aged over 5 (mostly).

Comments: All these indicators are currently presented as part of the Population Health Outcome Indicators, except mortality from CHD (under 65s) which is a Health of the Nation indicator (HON A1).

Numbers of deaths will vary from condition to condition and large numbers for some conditions, e.g. stroke, may overshadow small numbers for other conditions e.g. TB.

Health Outcomes of NHS Care (cont.):

Indicator(s): (x) In-hospital premature deaths - a composite indicator consisting of age and sex standardised:

- 30 day perioperative mortality rate;
- 30 day mortality rates following myocardial infarction (MI).

Area: NHS success in reducing premature deaths.

Rationale: The rationale for combining these two indicators is that they are both measuring potentially avoidable deaths, which could be directly influenced by aspects of clinical care.

Confidential enquiries into **perioperative deaths** highlight a range of “avoidable” factors which could reduce mortality rates e.g. improved collaboration among anaesthetists, surgeons and physicians, improved surgical management and continuity of care after operations.

The NHS may be able to influence **mortality from CHD** in a number of ways, including the appropriate use of lipid lowering drugs, revascularisation surgery and through reducing ambulance response times following MI. The use of aspirin, beta-blockers or ACE inhibitors can also contribute to better outcomes. There is also evidence that timely use of thrombolytic drugs can reduce mortality.

Data: Source of data is HES. By March 1998, provisional data for 1996/7 will be available.

Client groups: All ages.

Comments: These indicators form part of the Clinical Indicators set and are currently the subject of a consultation exercise. Their inclusion in this set of indicators will be influenced by the outcome of that consultation.

Attachment C

THE DEVELOPMENT OF HIGH-LEVEL INDICATORS

Criteria for assessing indicators

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Six broad criteria have been used in assessing possible indicators. They are not presented in any particular order of importance as all can be seen as key attributes of suitable indicators for performance management. They are summarised as:

- **attributable** - indicators should reflect health and social outcomes which are substantially attributable to the NHS through its roles as service provider, advocate for health and inter-agency partner.
- **important** - the indicators should cover an outcome which is relevant and important to policy makers, health professionals and managers (and which resonates with the concerns of the public).
- **avoid perverse incentives** - an indicator should be presented in such a way that managers can act upon it without introducing perverse incentives. There should be no incentive to shift problems onto other organisations. Where this is the case, a counterbalancing indicator should be considered alongside.
- **robust** - measurement of the indicator should be reliable and coverage of the outcome measured should be high, although sampling may be appropriate for some indicators. In particular, data should be robust at the level at which performance monitoring is undertaken. For example, if monitoring of Health Authority (HA) performance is the aim, the indicator should be measuring sufficient numbers of events so that HA values are not unduly subject to large random variations. In other words, the indicator should be reliable for the purpose for which it is used.
- **responsive** - an indicator should be responsive to change and change should be measurable. It should not be an indicator where change will be so small that monitoring trends becomes difficult. Consideration should be given to whether the rate at which change can be expected to occur makes the indicator relevant for performance monitoring purposes.
- **useability and timeliness** - data should be readily available within a reasonable timescale.

ANNEX 3

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