Using the Commissioning for Quality and Innovation (CQUIN) payment framework – Guidance on national goals for 2011/12

This document sets out the detail of two national goals for acute CQUIN schemes in 2011/12. It should be read as an addendum to the guidance published in December 2008 and the summary guide published in December 2010, and in the context of the 2011/12 NHS Operating Framework.

DH INFORMATION READER BOX

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Description	The CQUIN payment framework enables commissioners to reward excellence by linking a proportion of provider income to local quality improvement goals. The NHS Operating Framework 2011/12 announced the continuation of two national goals for acute CQUIN schemes. This document sets out the detail of those goals, with specific changes for 2011/12.
Cross Ref	Using the Commissioning for Quality and Innovation (CQUIN) payment framework (December 2008)
Superseded Docs	Using the Commissioning for Quality and Innovation (CQUIN) payment framework - an addendum to the 2008 policy guidance for 2010/11
Action Required	Commissioners and providers must include the two goals within agreed CQUIN schemes for acute providers in 2011/12.
Timing	**By 2011/12**
Contact Details	cquin.payment.framework@dh.gsi.gov.uk Policy, Strategy and Finance Directorate Department of Health 79 Whitehall London SW1A 2NS
For Recipient's Use	

Using the Commissioning for Quality and Innovation (CQUIN) payment framework – Guidance on national goals for 2011/12

Introduction to the national CQUIN goals

1. The CQUIN framework is a national framework for locally agreed quality improvement schemes. It enables commissioners to reward excellence by paying a quality increment to providers using NHS Standard Contracts if they achieve agreed quality improvement goals.

2. In the challenging financial context, it is important that CQUIN schemes reflect both local priorities and priority areas set out in the NHS Operating Framework. In 2010/11 CQUIN schemes for acute providers also had to include two nationally defined goals, each with a specified indicator:
    I. Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE) (See Annex 1 - page 5)
    II. Improve responsiveness to personal needs of patients (See Annex 2 - page 9)

3. **The NHS Operating Framework 2011/12 confirms that these two goals must again be included within 2011/12 acute CQUIN schemes.**

4. The CQUIN framework remains a national framework for locally agreed schemes, and it is incumbent on commissioners and providers to discuss and agree how to translate these national goals into action at local level. More detailed guidance on using them is provided in annexes 1 and 2. This has been updated for 2011/12 and includes **two specific changes**:

    a. The timing of payment for the VTE goal in year two
    b. The timing of survey data for the patient experience goal

Background to the national goals

5. The CQUIN framework is a national framework for local schemes. In year one, 2009/10, it was important to establish the principles of commissioner-provider dialogue and local clinical engagement to develop and agree CQUIN schemes. These principles remain key to the effective use of the framework.

6. In 2010/11, the NHS Operations Board decided to support local health economies by providing a consistent national approach to delivering improvement in two priority areas. The national CQUIN goals reflected areas where there was widespread need for improvement across the NHS. We wanted to encourage local engagement and capability building but also to share good practice, encourage benchmarking and avoid duplication of effort across the country.

7. **The requirement to include the two national goals for a second year in acute schemes is intended to fully embed VTE risk assessment across all providers following the improvements made in 2010/11, and to support continuous improvements in patient experience.** Local organisations should apply the goals in a way that rewards improvement above and beyond what was achieved in 2010/11. For example, in the second year we are suggesting that

Commissioners split available payment for the VTE indicator into equal monthly amounts, with payment triggered by monthly achievement of the goal to support a thoroughly embedded approach to risk assessment.

8. As in 2010/11, the national goals are intended to complement locally agreed improvement goals, which will continue to make up the majority of local CQUIN schemes.

Using the national goals in 2011/12

9. **As in 2010/11 the two goals should be included within acute CQUIN schemes (including those agreed with Specialised Commissioning Groups). The goals should together account for around a fifth of the value of schemes, 0.3% of the Actual Outturn Value of provider contracts, unless commissioners decide there is negligible room for improvement.** Where the goals are being applied for the first time in 2011/12 (eg. for an independent sector provider who is moving onto the NHS Standard Contract and therefore agreeing a CQUIN scheme for the first time) they must be linked to around a fifth of the value of the scheme.

10. The national goals and indicators should be set out alongside other locally agreed goals within the CQUIN scheme in acute provider contracts. A part-populated version for each of the national goals is provided in the annexes below. These templates can also be accessed in Excel format on the NHS Institute website. It is the responsibility of commissioners and providers locally to determine precisely how much of the overall CQUIN value should be linked to each indicator and, for the national goal on patient experience, to determine the payment thresholds for rewarding provider achievement.

11. Clearly, the national goals and indicators should only be used where they are relevant to provider services. If commissioners agree that one of the national indicators cannot be applied to a provider, they should replace the national indicator with a locally defined indicator. For example, the National Inpatient Survey is only undertaken amongst adult patients, therefore a specialist children's hospital will not be able to use the data source intended for the national measure. They will need to find a different way of measuring improvements in patient experience.

12. Local organisations can consider whether and how they might apply the two national goals to other types of providers if they wish.

Annex 1 – National goal to reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)

1. Introduction and Background

Venous-Thromboembolism (VTE) is a significant cause of mortality, long-term disability and chronic ill health. The goal of the established National VTE Prevention Programme is to reduce avoidable death and long term disability from VTE. In 2005 a Health Select Committee report estimated that there were around 25,000 deaths from VTE each year in hospitals in England[1]. There is strong evidence that many of these deaths are avoidable if a patient is assessed for risk of VTE on admission to hospital, with appropriate prophylaxis then provided based on national guidelines.

VTE prevention is now recognised as a clinical priority for the NHS by the National Quality Board and the NHS Leadership Team, and a national programme of work to reduce incidence is underway across the NHS in England. This National VTE Prevention Programme (as implemented from the recommendations of Chief Medical Officer's VTE Expert Group[2]) is the most comprehensive of any healthcare system; development of national VTE outcome focussed indicators aimed at saving lives is therefore at the cutting edge of VTE prevention. The National Quality Board has published a report and recommendations on System Alignment in VTE Prevention[3]; implementation of these recommendations will be overseen by a newly established Department of Health VTE board.

The National Institute for Health and Clinical Excellence (NICE) published their clinical guideline 92, 'Venous thromboembolism - reducing the risk', (http://guidance.nice.org.uk/CG92) in January 2010, and the national risk assessment template, originally developed by the Department of Health and NICE in 2008, was updated to reflect this clinical guideline. NICE also published a Quality Standard on VTE Prevention in June 2010 (http://www.nice.org.uk/aboutnice/qualitystandards/vteprevention).

During 2010/11, the national CQUIN goal on VTE risk assessment has already made a significant difference to the priority that providers of NHS acute services place on VTE prevention. Including a national goal on VTE prevention for a second year within all acute CQUIN schemes will help commissioners to ensure that the national best practice resources on VTE are effectively used for the benefit of patients at local level. This will build on the good work that has been done during 2010/11, embedding best practice for VTE risk assessment and saving lives as a result.

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[1] *House of Commons Health Committee Report on the Prevention of Venous Thromboembolism in Hospitalised Patients -Second Report of Session 2004-05*
http://www.publications.parliament.uk/pa/cm200405/cmselect/cmhealth/99/99.pdf

[2] *Report of the Independent Expert Working Group on the Prevention of VTE in Hospitalised Patients*
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_073950.pdf

[3] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_121890.pdf

2. How will achievement be measured?

Achievement of this goal will be measured using the quality indicator:

% of all adult inpatients who have had a VTE risk assessment on admission to hospital[4], using the clinical criteria of the national tool[5]

Payment will be triggered by achieving at least 90%.

Compliance with the risk assessment indicator is measured through a nationally mandated monthly Unify2 data collection for all providers of NHS acute services. The collection has been in place since 1st June 2010, and the first publication of data from this collection was on 3 December 2010, relating to data from July-September 2010[6]. Guidance on the data collection is available on the Department of Health website[7], and be will be subject to in-year revision as necessary.

In line with good clinical governance, providers are expected to ensure that patients receive appropriate prophylaxis for VTE based on national guidance according to their risk assessment. The NHS Standard Contract for acute services requires reporting of appropriate prophylaxis, and, completion of root cause analysis on all confirmed inpatient cases of pulmonary embolism (PE) or deep vein thrombosis (DVT). Local organisations may choose to agree an additional CQUIN goal to reward improvements in appropriate prophylaxis, and an exemplar CQUIN goal on this is available for local use.[8]

3. What action is required to define and agree this goal in local provider contracts?

The Commissioner and Provider need to complete the template below within the contract, including time periods on which performance is assessed, and ensuring a clear understanding of:

- Numerator and denominator
- Data collection arrangements and timings
- Payment threshold

4. Who do we need to involve in working towards this goal?

Commissioner and provider representatives involved in contract negotiations should consider involving the following key stakeholders to support achievement of the goal during the year:

- Thrombosis Committees
- Risk and Audit Committees, and Clinical Governance / Patient Safety teams

[4] This may include documented risk assessment carried out as part of pre-admission for elective patients. However providers will need to have reassessment protocols in place for such adults admitted to hospital.

[5] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088215.

[6] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_122283

[7] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_116316

[8] http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

- Regional/local patient safety collaboratives, and SHA VTE Prevention leads
- Collaboration for Leadership in Applied Health Research and Care (CLAHRC) partnerships
- Academic Health Science Centres (AHSCs)
- Health and Innovation Education Clusters (HIECs)
- Emerging GP Consortia
- NHS VTE exemplar centres
- NHS Institute

5. What action is required to support achievement of this goal during the financial year?

Providers will want to:

- ensure clinical staff understand the goal and are able to risk assess patients, record the outcome, prescribe and administer appropriate prophylaxis
- plan and organise data collection on risk assessment of all adult inpatients
- use their local data collection to ensure that all patient groups have equal access to VTE risk assessment, rather than focussing on "easy to reach" groups

A range of resources are available to local health economies in tackling VTE:
National VTE Risk Assessment Template:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088215

NICE guideline:
The National Institute for Health and Clinical Excellence (NICE) clinical guideline 92, 'Venous thromboembolism - reducing the risk', (http://guidance.nice.org.uk/CG92)

NICE Quality Standard:
http://www.nice.org.uk/aboutnice/qualitystandards/vteprevention/

National NHS VTE Exemplar Centre Network:
http://www.kingsthrombosiscentre.org.uk/cgi-bin/kings/exemplarcentres.pl

A Guide for Delivering the CQUIN Goal:
http://www.kingsthrombosiscentre.org.uk/kings/Delivering%20the%20CQUIN%20Goal_2ndEdition_LR.pdf

Department of Health Dear Colleague letter providing clarification on the national mandatory data collection on VTE risk assessment, which commenced on 1 June 2010:
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_116317

Map of Medicine VTE Prevention Pathway:
http://healthguides.mapofmedicine.com/choices/map/index.html

E-learning on venous thromboembolism: e-VTE
http://www.e-lfh.org.uk/projects/vte/launch/

Fifteen minute VTE prevention e-Learning module designed for hospital induction training programmes
http://www.kingsthrombosiscentre.org.uk/induction/index.html

Standard template for CQUIN schemes 2011/12 (for inclusion in contract)

Goals and indicator summary

Goal Number	Goal Name	Description of Goal	Goal Weighting (% of CQUIN scheme available)	Expected Financial Value of Goal	Safety	Effectiveness	Patient Experience	Innovation
1	VTE prevention	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	[Insert local weighting]		Yes			

Goal Number	Indicator Number	Indicator Name	Indicator Weighting (% of CQUIN scheme available)	Expected Financial Value of Indicator
1	1	VTE risk assessment	[Insert local weighting]	

Indicator sheet

Goal number	1
Goal name	VTE prevention
Indicator number	1
Indicator name	VTE risk assessment
Indicator weighting (% of CQUIN scheme available)	[Insert local weighting]
Description of indicator	% of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool
Numerator	Number of adult inpatient admissions reported as having had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool (including those risk assessed using a cohort approach in line with published guidance - http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117030.pdf)
Denominator	Number of adults who were admitted as inpatients (includes daycases, maternity and transfers; both elective and non-elective admissions)
Rationale for inclusion	VTE is a significant cause of mortality, long-term disability and chronic ill health. It was estimated in 2005 there were around 25,000 deaths from VTE each year in hospitals in England and VTE has been recognised as a clinical priority for the NHS by the National Quality Board and the NHS Leadership Team.
Data source	[Insert local data sources which are the basis of monthly data return through Unify2 eg. PAS system]
Frequency of data collection	[Insert local frequency of data collection eg. real time/on admission]
Organisation responsible for data collection	[Insert Provider name]
Frequency of reporting to commissioner	Provider to submit a mandatory monthly data return through Unify2
Baseline period/date	1-31 March 2011
Baseline value	[Insert local baseline value as reported on Unify2 for the period 1-31 March 2011]
Final indicator period/date (on which payment is based)	[Insert final indicator period. For providers adopting the goal for a second year, we suggest using the "in year milestones" option to split the payment into equal monthly amounts for each month where 90% is achieved. For providers adopting the goal for the first time, it may be more appropriate to set a single final indicator period but this must be at least a full quarter.]
Final indicator value (payment threshold)	90%
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	[Insert locally agreed rules. **Note that for this indicator all payments must be based on achievement of at least 90%]
Final indicator reporting date	20 working days after the end of each month (deadline for Unify2 submission)

Annex 2 - National goal to improve responsiveness to the personal needs of patients

1. Introduction and Background

Patients and the public justifiably expect public services which are responsive to their needs and driven by them. It has been estimated that this approach could contribute towards a saving in the NHS of more than £6.9 billion per year[9].

There is a wealth of evidence which informs our understanding of what is important to patients in delivering personalised care[10]. A better patient experience and improved patient satisfaction will go hand in hand with service improvements. To provide national focus, and to complement locally defined CQUIN goals and indicators, we have considered what is important to patients alongside evidence which demonstrates room for improvement. This led to the definition of a national CQUIN goal and indicator on patient experience: "*Improving responsiveness to personal needs of patients*" for inclusion in acute CQUIN schemes in 2010/11.

The nationally defined indicator for this national CQUIN goal uses results from the adult inpatient survey coordinated by the Care Quality Commission (CQC), which is an existing standardised national data source, collected to a common standard and with consistent definitions (see Appendix 1 for further details).

The composite indicator is based on five survey questions, which collectively describe different elements of this overarching service theme: "*Improving responsiveness to personal needs of patients*". The chosen questions reflect service issues that are consistent priorities for patients and the public and are applicable to all/most patients (eg rather than focussing on a particular pathway). The indicator has generally been well-received by organisations in its first year of operation.

Using this indicator provides an opportunity to reward year-on-year improvements and sustained high levels of performance in patient experience. Also, a nationally consistent definition for the indicator allows organisations to benchmark and share good practice across the country. It is important to highlight that commissioners and providers can also continue to use locally defined indicators, in addition to the national indicator described here, to measure improvement across the full range of service and delivery issues that are of importance to local patients and service users. Locally defined indicators could for example include "real-time feedback" initiatives at the point of care.

Commissioners and providers may also wish to extend the general approach to identify patient experience indicators for areas not covered by the inpatient survey, but for which good local baseline measures are or could be established eg ambulance, community, mental health & learning disability services and other specialist services in acute settings such as maternity and paediatrics.

2. How will achievement be measured?

[9] The Human Factor, Harris M and Bunt L, NESTA, 2009
By increasing levels of self-care and patient-focused approaches in health, the NHS could save more than £6.9 billion a year (£20.7 billion by 2014).
[10] Survey Coordination Centre, Publications: Development Work
http://www.nhssurveys.org/publications

A single composite measure *"Improving responsiveness to personal needs of patients"* for each organisation has been defined for inclusion as a CQUIN indicator. This composite measure is made up of the following five survey questions:

- *Were you involved as much as you wanted to be in decisions about your care and treatment?*
- *Did you find someone on the hospital staff to talk to about your worries and fears?*
- *Were you given enough privacy when discussing your condition or treatment?*
- *Did a member of staff tell you about medication side effects to watch for when you went home?*
- *Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?*

In identifying survey questions which explored responsiveness to personal needs, we looked for questions where there was both strong evidence that some Trusts are able to deliver good practice and also evidence of scope for significant improvement across most, if not all acute providers. The data source also needed to have a sufficient number of respondents at each organisation answering each question – so ensuring results give a representative and robust view of performance.

Performance on each of the five survey questions for each organisation will be calculated using the same method as for all previous adult inpatient surveys (i.e. each trust is scored out of 100 and, the higher the score, the more positive the experience). The composite indicator is then defined as the equally weighted average of these 5 questions. See Appendix 2 for further details.

3. What action is required to define and agree the CQUIN goal in local provider contracts?

The 2010/11 adult inpatient survey is currently ongoing. The survey is coordinated by CQC but is conducted by local trusts themselves using standardised instruments and methodologies - some run the surveys in-house, but most do so via a specialist contractor which they directly procure (using an approved list set-up by CQC).

This delivery architecture has implications for when and how data are available to access and use – locally, regionally and nationally. The CQC will not publish these data until April/May. However, to support CQUIN schemes, the national survey coordination centre for NHS Surveys[11] will provide the 'final standardised data' for the five CQUIN questions and the composite indicator in advance of publication. This advanced data will be identical to that published in April/May by CQC[12]. The timetable and related activity for defining and agreeing this goal in local provider contracts is therefore as follows:

- By January 2011 – local survey contractors who conduct the inpatient survey are able to provide NHS Trusts with their own individual initial raw survey results from 2010, however this data is not quality assured by the national survey coordination centre, nor is it standardised by age, gender and admission method. This local 'raw data' is submitted to the national survey coordination centre.
- Mid-February 2011
    - The national survey coordination centre will send each NHS Trust individual survey lead their 'final standardised data' for the five CQUIN

[11] www.nhssurveys.org
[12] In April/May 2011 CQC will publish all of the inpatient survey results including the 5 CQUIN questions.

questions and the composite indicator. This data is standardised by age, gender and admission method and the data will be identical to that published in April/May by CQC.

- DH will also provide to each SHA 'final standardised data', which is password protected for all NHS Trusts in their region. PCT's will obtain access to this data either through the SHA or directly from the NHS Trust.
- Commissioners and Providers will need to use the data to:
  - assess whether the CQUIN goal has been achieved in 2010/11
  - agree payment thresholds for 2011/12 (which may be informed by benchmarked data for similar providers in 2009 and 2010)

4. Who do we need to involve in agreeing and working towards this goal?

Commissioner and provider representatives involved in contract negotiations will wish to consider who in their respective organisations to involve in setting the achievement levels, as the use of this national indicator needs to be fully aligned with other locally defined indicators and initiatives. You may wish to include:

- Local public and patient engagement & experience (PPE) leads
- SHA PPE leads, who can point to available guidance and tools as well as providing assurance

5. How should we go about setting payment thresholds locally?

The five survey questions are used to define a single composite indicator, giving each acute provider a score out of 100. Commissioners and providers need to agree locally:

- What % of the overall CQUIN value will be linked to the national indicator
- What levels of achievement will be required for payment

One option might include splitting payment between a reward for improvement against baseline (measured in points out of 100) and a separate reward for exceeding an absolute value. However, commissioners will wish to take local provider baselines into account when setting a payment threshold to encourage ambition.

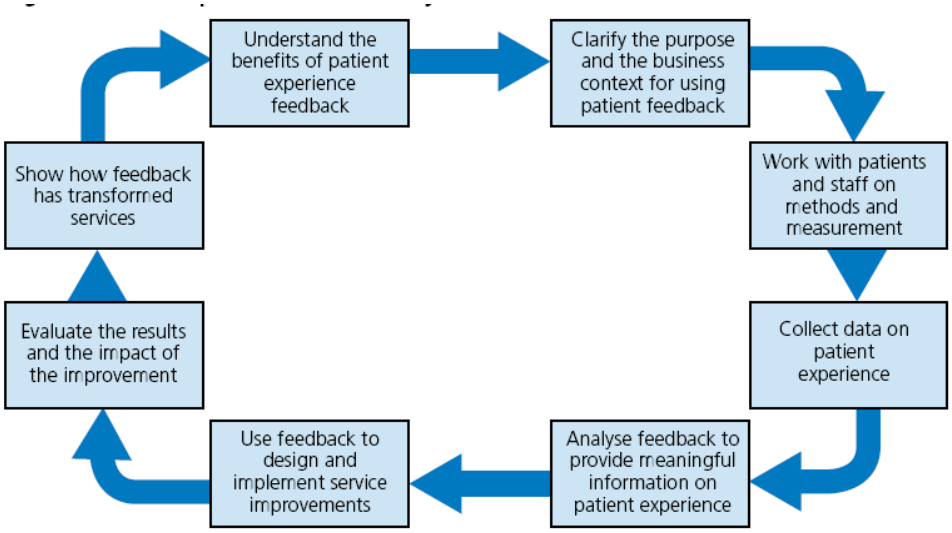
Local organisations will be able to benchmark their performance against comparator organisations in their region, using the 'final standardised data' provided to each SHA by the Department of Health.

6. What action is required to support achievement of this goal during the financial year?

Organisations will wish to consider how the goal fits with their own locally agreed processes for capturing and using patient/user feedback to monitor service quality and inform local improvement activities. This might include the use of other locally defined indicators within CQUIN schemes eg. to focus on improving patient experience for any particular groups who have historically reported poor experience or been under-represented within previous measurement.

The patient experience feedback cycle may be of help at this point[13]:

[13] The patient experience feedback cycle is taken from *"Understanding what matters: A guide to using patient feedback to transform patient care"*, which is available from the Department of Health website: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_099780



Patient experience feedback cycle diagram

A range of support tools and packages are available to help local organisations monitor and improve the experience of their patients' and service users in-year – this covers support on a broad continuum of approaches ranging from realtime feedback, locally defined surveys, and existing national surveys covering a range of settings including:

- A support service for trusts that provides advice and guidance on how to capture patient feedback, conduct surveys, and use the results to inform local improvement activities. This can support more frequent, comparable monitoring if required. Run by the national survey coordination centre, who can be contacted by telephone (01865 208127) or by e-mail (advice@pickereurope.ac.uk). Further information is available from the coordination centre website at http://www.nhssurveys.org/localsurveys

- A series of patient experience data toolkits, aimed at assisting organisations to identify areas where nationally available data suggests they could focus on in their local improvement activities. These tools focus on a wider range of patient experience measures than the 5 CQUIN questions, and are available on the Department of Health website: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091660

- In the past, case studies of best practice have been collected and used locally and regionally. To build on this local work, the Department commissioned the NHS Institute (NHSI) to collate a range of examples/case studies, along with evidence of what works and why. This work will form part of an on-line support network for the sharing of best and effective practice across the NHS. http://www.institute.nhs.uk/share_and_network/pen/add_your_experience_programme_story.html

- The NHSI have also recently delivered a pilot Patient Experience Action Learning Set. This course focused on how to better use patient feedback and self-defined outcomes to develop and meet local patient experience and service improvement goals. Whilst the course has now completed, the NHS Institute are taking requests for future roll-out and can be contacted for further details (patientexperience@institute.nhs.uk). The material from the 2010/11 course is available on the NHS Institute website.

Standard template for CQUIN schemes 2011/12 (for inclusion in contract)

Goals and indicator summary

Goal Number	Goal Name	Description of Goal	Goal Weighting (% of CQUIN scheme available)	Expected Financial Value of Goal	Safety	Effectiveness	Patient Experience	Innovation
2	Patient experience - personal needs	Improve responsiveness to personal needs of patients	[Insert local weighting]				Yes	

Goal Number	Indicator Number	Indicator Name	Indicator Weighting (% of CQUIN scheme available)	Expected Financial Value of Indicator
2	2	Composite indicator on responsiveness to personal needs	[Insert local weighting]	

Indicator sheet

Goal number	2
Goal name	Patient experience - personal needs
Indicator number	2
Indicator name	Composite indicator on responsiveness to personal needs
Indicator weighting (% of CQUIN scheme available)	[Insert local weighting]
Description of indicator	The indicator is a composite, calculated from 5 survey questions. Each describes a different element of the overarching patient experience theme "responsiveness to personal needs of patients". The elements are: 1) Involvement in decisions about treatment/care, 2) Hospital staff being available to talk about worries/concerns, 3) Privacy when discussing condition/treatment, 4) Being informed about side effects of medication, 5) Being informed who to contact if worried about condition after leaving hospital.
Numerator	Index-based score reflecting positive responses to the 5 questions within the composite indicator
Denominator	N/A
Rationale for inclusion	The indicator incorporates questions which are known to be important to patients and where past data indicates significant room for improvement across England.
Data source	Adult inpatient survey, from the CQC nationally coordinated patient survey programme. The survey is conducted annually between October and January for patients who had an inpatient episode between July and August.
Frequency of data collection	Annually
Organisation responsible for data collection	[Insert name of responsible organisation: either the Provider or their appointed contractor]
Frequency of reporting to commissioner	Annually. Provider will supply Commissioner with advance data supplied by the national survey coordination centre in February 2012.
Baseline period/date	Adult inpatient survey 2010/11 (based on inpatient episodes between July and August 2010)
Baseline value	[Insert local baseline value based on advance data from national survey coordination centre in February 2011]
Final indicator period/date (on which payment is based)	Adult inpatient survey 2011/12 (based on inpatient episodes between July and August 2011)
Final indicator value (payment threshold)	[Insert locally agreed final indicator value]
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	[Insert locally agreed rules, eg. payment will be based on demonstration of the provider having achieved the final indicator value through the advance data on the adult inpatient survey 2011/12.]

Annex 2, Appendix 1 – Background on the national patient survey programme

The survey programme is designed to provide robust organisational measures on service quality from the *patients' point of view*, and each questionnaire contains a wide range of questions asking patients detailed questions about different aspects of their treatment/care.

The programme[14] is run on a devolved basis: CQC have responsibility for developing and coordinating the surveys, while acute trusts are responsible for conducting (and paying for) their own local survey using a standardised instrument and methodology and in line with an agreed timetable. While some trusts conduct their survey in-house, most contract out this work to one of several contractors that are approved by CQC[15].

The annual survey follows a specific timetable:

- Autumn: trusts select their sample based on patient records identifying patients who had an inpatient episode between July-August
- October - January: survey fieldwork
- By January – local survey contractors who conduct the inpatient survey are usually able to provide NHS Trusts with their own individual initial raw survey results, however this data is not quality assured by the national survey coordination centre, nor is it standardised by age, gender and admission method. This local 'raw data' is submitted to the national survey coordination centre.
- Mid-February: The national survey coordination centre will send each NHS Trust individual survey lead their 'final standardised data' for the five CQUIN questions and the composite indicator. This data is standardised by age, gender and admission method and the data will be identical to that published in April/May by CQC.
- DH will provide to each SHA 'final standardised data', which is password protected for all NHS Trusts in their region. PCT's will obtain access to this data either through the SHA or directly from the NHS Trust.
- Providers and/or SHAs will provide access to PCTs in order to:
    - support contract discussions
    - identify a baseline position
    - agree payment thresholds, which may be informed by benchmarked data for similar providers
- April-May: CQC publish full survey results. (The date on which CQC will formally publish the results is yet to be decided.)

[14] Further information on the national patient survey programme is available on the CQC website, as well as the national survey coordination centre:
http://www.cqc.org.uk/usingcareservices/healthcare/patientsurveys.cfm
http://www.nhssurveys.org/

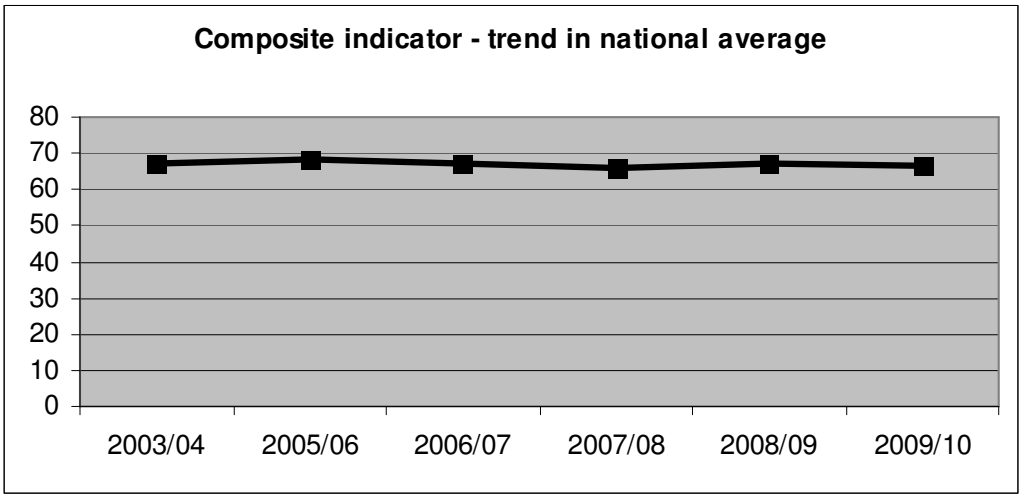
[15] Approved list of contractors can be found on http://www.nhssurveys.org/approvedcontractors

Annex 2, Appendix 2 – An illustration of a composite measures approach

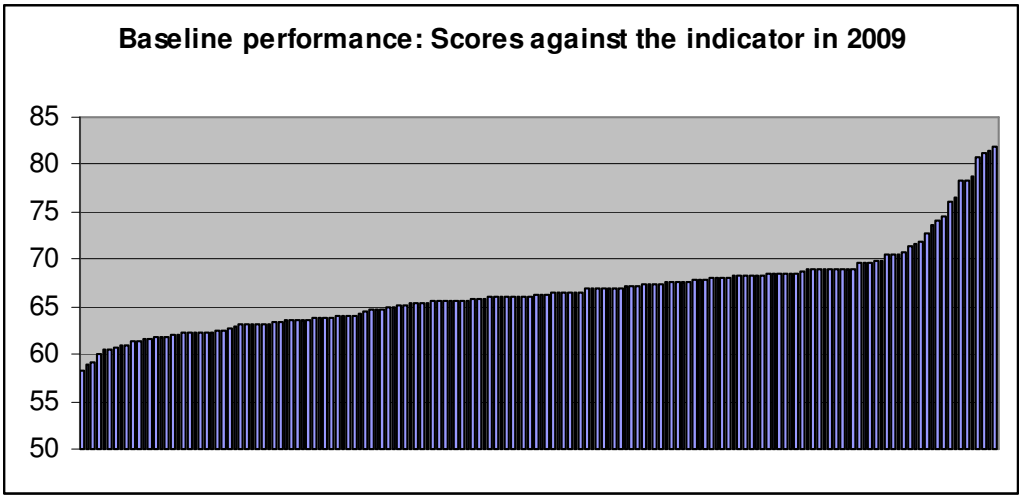
The use of composite indicators is consistent with use of survey data by DH and CQC in the past, and it provides an additional degree of robustness/stability in the data as an improvement measure (eg as in the current User Experience domain of the Performance Framework).

The composite indicator is calculated by taking an equally weighted average across the five questions that make up the indicator. We have produced an illustration of NHS performance on this indicator using data from previous surveys:

- **At national level, performance has been fairly static over a number of years**[16]



- **But trust-level performance differentials for both the composite indicator and the 5 individual questions are wide**[17]:



[16] The national average in the most recent data from the 2009/10 survey is 66.7. This compares to 67.1 in 2008/09; 66.0 in 2007/08; 67.0 in 2006/07; 68.2 in 2004/05; and 67.4 in 2003/04.
[17] In 2009/10, trust-level performance ranges from 58.3 through to 81.9.