NHS BIRMINGHAM EAST AND NORTH 2010/11 CQUIN Indicators

HEART OF ENGLAND NHS FOUNDATION TRUST

Commissioner	NHS Birmingham East and North
Associate Commissioners:	Solihull Care Trust and South Staffordshire PCT
Expected financial value of Scheme	£6,038,858

Goals and Indicators

Goal no.	Description of goal	Quality Domain(s) [6]	Indicator no [7]	Indicator name	National or Regional indicator [8]	Indicator weighting %
1	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety	1	VTE risk assessment	Nationally mandated	10
2	Improve responsiveness to personal needs of patients	Patient experience	2	Composite indicator on responsiveness to personal needs from the Adult Inpatient Survey	Nationally mandated	10
3	Percentage of smokers/tobacco users attending selected* outpatient clinic appointments receiving a brief intervention to reduce tobacco use including being given written advice as per NICE guidance	Effectiveness/ Innovation	3	Smoking – Brief Intervention in Outpatients	Regionally strongly recommended	15
4	To implement best practice care in hospitals in the West Midlands for the care of inpatients with a secondary diagnosis of diabetes and as a consequence reduce associated healthcare costs	Effectiveness	4	Compliance with Think Glucose guidance	Regionally strongly recommended	10
5	To improve nursing practice in the prevention, assessment and management of pressure ulcers.	Safety/ Effectiveness	5	Tissue Viability	Regionally strongly recommended	20
6	Number of admitted patients (identified as at and of life) who had followed the Supportive Care Pathway for (at least) the last 3 days or duration of their admission if less that 3 days.	Experience/ Effectiveness	6	End of Life Care Pathway	Regionally suggested	10

7	Admission to Stroke Unit within 4 hours of arrival at hospital (usually A&E) for suspected stroke patients	Effectiveness/ Safety	7	Stroke -	Regionally suggested	10
8	Reduced failure to administer prescribed medicines as a result of non-availability of the medicine	Effectiveness/ Safety		Delayed and missed doses of medicines for hospital in-patients	Regionally suggested	15

Indicator 1 – VTE risk assessment

Description of indicator	% of all adult inpatients who have had a VTE risk assessment on admission to hospital using the national tool
Numerator	Number of adult inpatient admissions reported as having had a VTE risk assessment on admission to hospital using the national tool
Denominator	Number of adults who were admitted as inpatients (includes day-cases, maternity and transfers; both elective and non-elective admissions)
Rationale for inclusion	VTE is a significant patient safety issue, however outcome data on VTE is poor – post mortem studies suggest that only 1-2 in every 10 fatal pulmonary emboli is diagnosed. Whilst work is underway to improve reliability of outcome data, the process measure of VTE risk assessment will set an effective foundation for appropriate prophylaxis. This gives the potential to save thousands of lives each year.
Data source and frequency of collection	Monthly return through Unify [Insert further details to be provided by DH early in 2010]
Organisation responsible for data collection	Heart of England NHS Foundation Trust
Frequency of reporting to Commissioner	Monthly
Baseline period / date	Quarter 1
Baseline value	To be confirmed end of Quarter 1
Final indicator period / date (on which payment is based)	To be confirmed end of Quarter 1 dependent on baseline
Final indicator value (payment threshold)	90%
Final indicator reporting date	To be confirmed end of Quarter 1 dependent on baseline
Rules for partial achievement of indicator at year-end	N/A
Rules for any agreed in-year milestones that result in payment	N/A
Rules for delayed achievement against final indicator period/date and/or in-year milestones	To be confirmed end of Quarter 1 dependent on baseline

Indicator 2 – Improve responsiveness to personal needs of patients

Description of indicator	The indicator will be a composite, calculated from 5 survey questions. Each describes a different element of the overarching theme: "*responsiveness to personal needs* : • Involved in decisions about treatment/care • Hospital staff available to talk about worries/concerns • Privacy when discussing condition/treatment • Informed about medication side effects • 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 and frequency of collection	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.
Organisation responsible for data collection	Heart of England NHS Foundation Trust
Frequency of reporting to Commissioner	Annually: 1) Early local data (mid-January 2011) 2) Published data. (April-May 2011)
Baseline period / date	Adult inpatient survey 2009/10 (based on inpatient episodes between July and August 2009)
Baseline value	To be confirmed end of q1 when published data available
Final indicator period / date (on which payment is based)	Adult inpatient survey 2010/11 (based on inpatient episodes between July and August 2010)
Final indicator value (payment threshold)	To be confirmed end of q1 when published data available
Final indicator reporting date	To be confirmed end of q1 when published data available

Rules for partial achievement of indicator at year-end	To be confirmed end of q1 when published data available
Rules for any agreed in-year milestones that result in payment	N/A
Rules for delayed achievement against final indicator period/date and/or in-year milestones	N/A

Indicator 3: Smoking – Brief Intervention in Outpatients

Description of indicator	Percentage of smokers/tobacco users attending selected* outpatient clinic appointments receiving a brief intervention to reduce tobacco use including being given written advice as per NICE guidance which should at least include: • Ask and record smoking status (at booking and delivery) • Provide Stop Smoking Brief Advice to all smokers** *(or advise to reduce smoking if the patient does not wish to quit).* • Offer referral to the Local Stop Smoking Service and document in patient records. ** cardiology, paediatrics (passive smoking), maternity, respiratory and pre-operative (final set to be agreed)* ***Either Brief or Very Brief Advice as per most current NHS Service and Monitoring Guidance*
Numerator	The number of patients attending *selected** outpatient clinic appointments recorded as smokers/users of tobacco who receive a brief intervention to reduce tobacco use including being given written advice as per NICE guidance. The brief intervention should be at the time of the clinic visit.
Denominator	All patients attending *selected* outpatient clinic appointments who are recorded as smokers/users of tobacco. Patients excluded* from this denominator will include those who do not attend an appointment, those who are mentally incapable of understanding the advice given (e.g. advanced dementia), are at the end of their life (expected to live for <6 months), those who are already engaged in a formal stop smoking programme or those that explicitly decline to discuss their tobacco use.
Rationale for inclusion	Increased numbers of people quitting smoking/reducing tobacco use which leads to reduction in ill health, premature mortality and healthcare need.
Data source and frequency of collection	To be monitored via audit *(sample size, method and frequency to be confirmed by end of Q2 following training and implementation phase)*
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly

Baseline period / date	N/A
Baseline value	N/A
Final indicator period / date (on which payment is based)	Q1 and Q2 for any required training and implementation. Audit to be carried out Q3 and Q4 2010/11
Final indicator value (on which payment is based)	90% of smokers/users of tobacco attending selected outpatient clinics receiving a brief intervention including offer of referral to stop smoking service (as described in description of indicator) to reduce tobacco use.
Final indicator reporting date	End of Quarter 4
Rules for partial achievement of indicator at year-end	90%+ of smokers/users of tobacco attending selected outpatient clinics receive a brief intervention – 0% reduction in overall payment 85-89.9% of smokers/users of tobacco attending selected outpatient clinics receive a brief intervention – 25% reduction in overall payment 80-84.5% of smokers/users of tobacco attending selected outpatient clinics receive a brief intervention – 50% reduction in overall payment <80% of smokers/users of tobacco attending selected outpatient clinics receive a brief intervention – 100% reduction in overall payment
Rules for any agreed in-year milestones that result in payment	None
Rules for delayed achievement against final indicator period/date and/or in-year milestones	None

CQUIN Definitions:

"Scheme" The agreed package of goals and indicators, which in total, if achieved, enables the provider to earn 0.5% of its contract value. Where the provider has multiple contracts, the scheme should be reflected within all contracts, excepting contracts for specialised services (see contract guidance)

"Goal" A description of the intended objective which is being incentivised by the CQUIN scheme eg. "to improve patient satisfaction within maternity clinics", or "to improve the health of the population by delivering effective stop smoking advice to smokers and ensuring

	referral pathways to the local NHS Stop Smoking Services" . A goal may be measured using several indicators (see below).
"Indicator"	A measure which determines whether the goal or an element of the goal has been achieved, and on the basis of which payment is made. The achievement of one indicator should not be dependent on the achievement of a separate indicator within the scheme. It may be appropriate to agree rules for payment against a) partial achievement of the indicator and/or b) in-year milestones. However any locally agreed rules should comply with the national policy on rewarding measurement through CQUIN schemes; it is proposed that mandatory CQUIN schemes should only be able to reward measurement in their first year, hence any payments for in-year milestones should reward real improvements only after the first year of a scheme.

Indicator 4: Compliance with Think Glucose Guidance

Description of indicator	Compliance with Think Glucose guidance To implement best practice care in hospitals in the West Midlands for the care of inpatients with a secondary diagnosis of diabetes and as a consequence reduce associated healthcare costs.
Numerator	Compliance with Think Glucose guidance – compliance guidance to be finalised and achieve clinical sign off by end February.
Denominator	N/A
Rationale for inclusion	Potential benefits identified in NHS Institute 'Think Glucose' pilots sites include: • Reduction in Insulin Drug Errors • Reduction in inappropriate referrals to the Specialist Diabetes Team • Reduction in length of stay by an average of 2 days for these patients. The financial value of this 2 day LOS reduction for a typical district general hospital is estimated by the NHS Institute as being about £1m per annum. The NHS Institute has a tested improvement methodology for Think Glucose and a range of toolkits and resources to support organisations in the following areas: • Assessment of the current baseline position in relation to care for this group of patients. • Improvement techniques • Monitoring and measurement tools • Protocols to support the effective use of insulin • Measurement of patient experience of care • Best practice on coding to ensure that the right patients are identified • Training materials for staff There is a commitment from the NHS Institute to support the region-wide rollout of the approach in every hospital. Within the QIPP Programme, the SHA is establishing a region-wide, clinically-led steering group to oversee this work.
Data source and frequency of collection	TBC - Likely to be locally based audit approach to monitoring. (SHA confirmation expected by end of quarter 1)
Organisation responsible for data collection	TBC (SHA confirmation expected by end of quarter 1)

Frequency of reporting to Commissioners	TBC (SHA confirmation expected by end of quarter 1)
Baseline period / date	TBC (SHA confirmation expected by end of quarter 1)
Baseline value	TBC (SHA confirmation expected by end of quarter 1)
Final indicator period / date (on which payment is based)	TBC (SHA confirmation expected by end of quarter 1)
Final indicator value (payment threshold)	TBC (SHA confirmation expected by end of quarter 1)
Final indicator reporting date	TBC (SHA confirmation expected by end of quarter 1)
Rules for partial achievement of indicator at year-end	TBC (SHA confirmation expected by end of quarter 1)
Rules for any agreed in-year milestones that result in payment	TBC (SHA confirmation expected by end of quarter 1)
Rules for delayed achievement against final indicator period/date and/or in-year milestones	TBC (SHA confirmation expected by end of quarter 1)

Indicator 5: Tissue Viability

Goal no.	Indicator name	Quality Domain	Indicator number	Description of goal	*Indicator weighting (within goal)**
5	Tissue Viability	Safety Effectiveness	5a	All patients on admission (and within a minimum of six hours) should be assessed by a suitable competent and experienced Registered Nurse for their risk of developing a pressure ulceration using a recognised evidence based tool. Exclusions are paediatrics, day cases, maternity	*10%*
			5b	Inpatients assessed to be at risk of ulceration or who currently have a pressure ulcer will have preventative actions taken and documented in their care plan.	*20%*
			5c	% Decrease** on numbers of acute hospital acquired grade 2, 3 and 4*** ulcerations demonstrated by Q4 against baseline level established in Q1	*50%*
			5d	All hospital acquired ulcerations of grade 2, 3 or 4*** will be recorded as a TV patient safety incident on the appropriate system and a Route Cause Analysis undertaken within 5 working days. The Director of Nursing will be accountable for the RCA, action, patient care to improve and safeguard the patient and reporting to the Board . The RCA and subsequent action taken will be reported to the PCT contemporaneously	*10%*
			5e	All ulcerations which show a deterioration from grade 2 to 3 or 3 to 4*** will be recorded as TV patient safety incident on the appropriate system and the Director of Nursing requested to brief the PCT on action(s) being taken to safeguard the patient and challenge / improve nursing	*10%*

				practice.	

Clearly the goal and indicator numbers may be different in every contract – the numbers used here are purely for ease of reference.

** The indicator weighting refers to the relative value for each of the indicators within the overall tissue viability goal value (not the overall value of CQUIN). These are suggested and may be varied by local commissioners dependent on current provider performance and local prioritisation. Once incorporated in the overall CQUIN scheme the weightings would need to be adjusted to show weighting within overall scheme.*

*** For indicator 1c the SHA recommended reduction is 10%, but this if for local commissioner determination and negotiation with providers dependent on baseline position.*

**** As referred to in the High Impact Actions for Nursing and Midwifery. If alternative grading systems are in use, then the equivalent grades should be used.*

Detail of Indicator

Description of indicator	**Indicator 1a** All patients on admission (and within a minimum of six hours) should be assessed by a suitable competent and experienced Registered Nurse for their risk of developing a pressure ulceration using a recognised evidence based tool. Exclusions are paediatrics, day cases, maternity. Target should allow for other patients where this may not be appropriate (e.g. those where death is expected within 24 hours).
Numerator	Number of patients with documented assessment of their risk of developing a pressure ulceration using a recognised evidence based tool
Denominator	Number of patients admitted (other than paediatrics, maternity and day cases)
Rationale for inclusion	Pressure ulcers represent a major burden of sickness and quality of life for patients and their carers and are costly to the NHS Treatment costs vary greatly depending on the grade of ulcer. New pressure ulcers are estimated to occur in 4 – 10% of patients, admitted to acute hospitals in the UK. It is also estimated that up to 30% of patients may suffer in the community and 20% in nursing and residential homes may be affected. Pressure ulcers can occur in any patient but are more likely in high risk groups such as the obese, elderly, malnourished and those with certain underlying conditions. The presence has been associated with an increased risk of secondary infection and a two to four fold risk of death in older people in intensive care units.
Data source and frequency of collection	Bi –annual audit of patient records – sample size will need to be sufficient to allow for a 95% confidence rate in results against standards. A report by the Nurse Director on both point prevalence and incidence will be provided to each CQR.
Organisation responsible for data collection	Provider to carry out audit according to criteria set by Commissioner.
Frequency of reporting to commissioner	Quarterly
Baseline period / date	Baseline to be established by end of quarter 1
Baseline value	To be confirmed by end of quarter 1
Final indicator period / date (on which payment is based)	To be confirmed

Final indicator value (on which payment is based)	99%
Final indicator reporting date	Q4 - March 2011
Rules for partial achievement of indicator at year-end	10% of goal value for X% of inpatients (other than paediatrics, maternity and day cases) who are assessed by a suitable competent and experienced Registered Nurse for their risk of developing a pressure ulceration using a recognised evidence based tool. Achievement Payment (% of goal value) 99% 10% 98% 8% 97% 5%
Rules for any agreed in-year milestones that result in payment	To be confirmed by end of quarter 1 following establishment of baseline
Rules for delayed achievement against final indicator period/date and/or in-year milestones	To be confirmed by end of quarter 1 following establishment of baseline

Description of indicator	**Indicator 1b** Patients assessed to be at risk of ulceration, or who have an ulcer, will have appropriate preventative / treatment actions documented in their care plan. 100% of patients who are identified as being at risk of ulceration or who currently have a pressure ulcer will have preventative actions documented in their care plan. For reference on appropriate care plans see http://www.nice.org.uk/nicemedia/pdf/CG029fullguideline.pdf
Numerator	Number of patients with action plan to prevent ulceration or treat current ulcer in their care plan
Denominator	Number of patients identified as at risk following assessment
Rationale for inclusion	Pressure ulcers represent a major burden of sickness and quality of life for patients and their carers and are costly to the NHS. Treatment costs vary depending on the grade of ulcer. New pressure ulcers are estimated to occur in 4 – 10% of patients, admitted to acute hospitals in the UK. It is also estimated that up to 30% of patients may suffer in the community and 20% in nursing

	and residential homes may be affected. Pressure ulcers can occur in any patient but are more likely in high risk groups such as the obese, elderly, malnourished and those with certain underlying conditions. The presence has been associated with an increased risk of secondary infection and a two to four fold risk of death in older people in intensive care units.
Data source and frequency of collection	Bi –annual audit of patient records – sample size will be sufficient to allow for a 95% confidence rate in results against standards.
Organisation responsible for data collection	Provider to carry out audit according to criteria set by Commissioner.
Frequency of reporting to commissioner	Quarterly
Baseline period / date	Baseline to be established by end of quarter 1
Baseline value	To be determined by end of quarter 1
Final indicator period / date (on which payment is based)	To be determined
Final indicator value (on which payment is based)	100%
Final indicator reporting date	March 2011
Rules for partial achievement of indicator at year-end	20% of goal value for 100% of admitted patients (other than exclusions – see 1a above) who are identified as being at risk of ulceration or who currently have a pressure ulcer who have preventative actions documented in their care plan Achievement Payment (% of goal value) 100% 20% 99% 10% 98% 5%
Rules for any agreed in-year milestones that result in payment	To be confirmed
Rules for delayed achievement against final indicator period/date and/or in-year milestones	To be confirmed by end of quarter 1 dependent on baseline

Description of indicator	**Indicator 1c** % Decrease* on numbers of acute hospital acquired grade 2, 3 and 4** ulcerations demonstrated by Q4 against baseline level established in Q1
Numerator	Number of patients with grade 2, 3 and 4 pressure ulcerations in Q4
Denominator	Number of patients with grade 2, 3 and 4 pressure ulcerations at baseline established in Q1
Rationale for inclusion	Pressure ulcers represent a major burden of sickness and quality of life for patients and their carers and are costly to the NHS. Treatment costs vary depending on the grade of ulcer. New pressure ulcers are estimated to occur in 4 – 10% of patients, admitted to acute hospitals in the UK. It is also estimated that up to 30% of patients may suffer in the community and 20% in nursing and residential homes may be affected. Pressure ulcers can occur in any patient but are more likely in high risk groups such as the obese, elderly, malnourished and those with certain underlying conditions. The presence has been associated with an increased risk of secondary infection and a two to four fold risk of death in older people in intensive care units.
Data source and frequency of collection	Bi-annual audit of patient records– sample size will be sufficient to allow for a 95% confidence rate in results against standards Or Quarterly Incident reports
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Audit information to be presented to commissioner as agreed locally Quarterly report on incidents
Baseline period / date	Quarter 1
Baseline value	To be confirmed by end of quarter 1
Final indicator period / date (on which payment is based)	Quarter 4
Final indicator value (on which payment is based)	10% reduction on baseline
Final indicator reporting date	End of March 2011 – Q4
Rules for partial achievement of indicator at	To be confirmed by end of quarter 1 following establishment of

year-end	baseline
Rules for any agreed in-year milestones that result in payment	To be confirmed following establishment of baseline
Rules for delayed achievement against final indicator period/date and/or in-year milestones	To be confirmed following establishment of baseline

*** As referred to in the High Impact Actions for Nursing and Midwifery. If alternative grading systems are in use, then the equivalent grades should be used.*Description of indicator	**Indicator 1d** All hospital acquired ulcerations of grade 2, 3 or 4* will be recorded as TV patient safety incident on the Appropriate system
Numerator	Number of TV patient safety incidents recorded on Appropriate system and a Route Cause Analysis undertaken within 5 working days.
Denominator	Number of patients recorded as having a hospital acquired grade 2, 3 or 4 ulceration in records
Rationale for inclusion	Pressure ulcers represent a major burden of sickness and quality of life for patients and their carers and are costly to the NHS. Treatment costs vary depending on the grade of ulcer. New pressure ulcers are estimated to occur in 4 – 10% of patients, admitted to acute hospitals in the UK. It is also estimated that up to 30% of patients may suffer in the community and 20% in nursing and residential homes may be affected. Pressure ulcers can occur in any patient but are more likely in high risk groups such as the obese, elderly, malnourished and those with certain underlying conditions. The presence has been associated with an increased risk of secondary infection and a two to four fold risk of death in older people in intensive care units.
Data source and frequency of collection	Bi-annual audit of patient records– sample size will be sufficient to allow for a 95% confidence rate in results against standards Against incident reports
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Q3 October 2010 and Q4 March 2011 Audit information to be presented to commissioner Quarterly report on incidents

Baseline period / date	N/A
Baseline value	N/A
Final indicator period / date (on which payment is based)	Q3 and Q4
Final indicator value (on which payment is based)	100%
Final indicator reporting date	Q3 and Q4
Rules for partial achievement of indicator at year-end	10% of goal value for 100% ulcerations of grade 2, 3 or 4 recorded as an incident on the appropriate system Achievement Payment (% of goal value) 100% 10% 99% 8% 98% 5%
Rules for any agreed in-year milestones that result in payment	To be confirmed at end Q1
Rules for delayed achievement against final indicator period/date and/or in-year milestones	To be confirmed at end Q1

* *As referred to in the High Impact Actions for Nursing and Midwifery. If alternative grading systems are in use, then the equivalent grades should be used.Description of indicator*	**Indicator 1e** All ulcerations which show a deterioration from grade 2 to 3 or 3 to 4* will be recorded as an incident on the Appropriate system
Numerator	Number of incidents of deterioration recorded on appropriate system
Denominator	Number of patients whose records show a deterioration in ulcer grade
Rationale for inclusion	Pressure ulcers represent a major burden of sickness and quality of life for patients and their carers and are costly to the NHS. Treatment costs vary depending on the grade of ulcer. New pressure ulcers are estimated to occur in 4 – 10% of patients, admitted to acute hospitals in the UK. It is also estimated that up to 30% of patients may suffer in the community and 20% in nursing and residential homes may be affected.

	Pressure ulcers can occur in any patient but are more likely in high risk groups such as the obese, elderly, malnourished and those with certain underlying conditions. The presence has been associated with an increased risk of secondary infection and a two to four fold risk of death in older people in intensive care units.
Data source and frequency of collection	Bi-annual audit of patient records– sample size will be sufficient to allow for a 95% confidence rate in results against standards Against incident reports
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Audit to be completed in Q3 October 2010 and Q4 March 2011 Audit information to be presented to commissioner Quarterly report on incidents
Baseline period / date	N/A
Baseline value	N/A
Final indicator period / date (on which payment is based)	Q3 and Q4
Final indicator value (on which payment is based)	100%
Final indicator reporting date	Q4
Rules for partial achievement of indicator at year-end	10% of goal value for 100% which show a deterioration from grade 2 to 3 or 3 to 4* recorded as an incident on the appropriate system Achievement Payment (% of goal value) 100% 10% 99% 8% 98% 5%
Rules for any agreed in-year milestones that result in payment	To be confirmed
Rules for delayed achievement against final indicator period/date and/or in-year milestones	To be confirmed

** As referred to in the High Impact Actions for Nursing and Midwifery. If alternative grading systems are in use, then the equivalent grades should be used.*

Indicator 6: End of Life Care Pathway

Description of indicator	End of Life Care Pathway
Numerator	Number of admitted patients (identified as at end of life) who had followed the Supportive Care pathway or Liverpool End of Life Care Pathway for (at least) the last 3 days or duration of their admission if less than 3 days.
Denominator	Number of admitted patients (identified as at end of life)
Rationale for inclusion	Supports the delivery of the strategic priority focusing on end of life care.
Data source and frequency of collection	Provider trust data audit
Organisation responsible for data collection	Provider trust
Frequency of reporting to Commissioners	Quarterly audit undertaken by the Provider Trust.
Baseline period / date	Quarter 1
Baseline value	To be confirmed by end quarter 1
Final indicator period / date (on which payment is based)	Quarter 4
Final indicator value (payment threshold)	25% improvement depending on baseline
Final indicator reporting date	Quarter 4
Rules for partial achievement of indicator at year-end	To be confirmed (depending on baseline – to be established at end quarter 1)
Rules for any agreed in-year milestones that result in payment	To be confirmed (depending on baseline – to be established at end quarter 1)
Rules for delayed achievement against final indicator period/date and/or in-year milestones	To be confirmed (depending on baseline – to be established at end quarter 1)

Indicator 7: Admission to Stroke Unit within 4 hours

Description of indicator	Stroke - Admission to Stroke Unit within 4 hours of arrival at hospital (usually A&E) for suspected stroke patients
Numerator	Number of suspected stroke patients admitted to Stroke Unit within 4 hours of arrival at hospital
Denominator	Number of suspected stroke patients arriving at hospital
Rationale for inclusion	Current practice shows a large number of patients going to a variety of different areas after arrival at hospital. The evidence shows that best practice is for patients to immediately be admitted to the acute stroke unit.
Data source and frequency of collection	Provider data collection – monthly
Organisation responsible for data collection	Provider
Frequency of reporting to Commissioners	Monthly
Baseline period / date	Quarter 4 of 2009/10
Baseline value	To be confirmed at end of baseline period (To be reported via local Stroke Networks)
Final indicator period / date (on which payment is based)	Quarter 4 of 2010/11
Final indicator value (payment threshold)	Baseline + 20%
Final indicator reporting date	Locally determined
Rules for partial achievement of indicator at year-end	Baseline + 15% = 75% of indicator value Baseline + 10% = 50% of indicator value Baseline + 5% = 25% of indicator value Under Baseline + 5% = no payment
Rules for any agreed in-year milestones that result in payment	N/A
Rules for delayed achievement against final indicator period/date and/or in-year milestones	N/A

Indicator 8: Delayed and missed doses of medicines for hospital in-patients

Description of indicator	Failure to administer all prescribed medicines as a result of non-availability of the medicine
Numerator	The number of in-patients who have missed doses due to a medicine not being available for more than 24 hours
Denominator	Number of in-patients with regular medicines prescribed
Rationale for inclusion	The omission of critical medicines has the potential to result in fatalities or severe harm to patients. Non-availability of medicines is one of the causes of missed doses. NPSA national priority.
Data source and frequency of collection	Baseline audit at 2 months (May 2010) First re-audit at 6 months (Sept 2010) Second re-audit at 10 months (Jan 2011)
Organisation responsible for data collection	Provider
Frequency of reporting to provider	Report at 4 months (July 2010) Report at 8 months (Nov 2010) Report at 12 months (Mar 2011)
Baseline period / date	May 2010
Baseline value	To be established
Final indicator period / date on which payment is based	Jan 2011
Final indicator value (payment threshold)	Baseline plus % improvement on baseline (to be confirmed following confirmation of baseline – due end of May 2010)

Final indicator reporting date	March 2011
Rules for partial achievement of indicator at year-end	Baseline plus % improvement on baseline (to be confirmed following confirmation of baseline – due end of May 2010)
Rules for any agreed in-year milestones that result in payment	Baseline plus % improvement on baseline (to be confirmed following confirmation of baseline – due end of May 2010)
Rules for delayed achievement against final indicator period/date and/or in-year milestones	To be confirmed following confirmation of baseline – due end of May 2010)