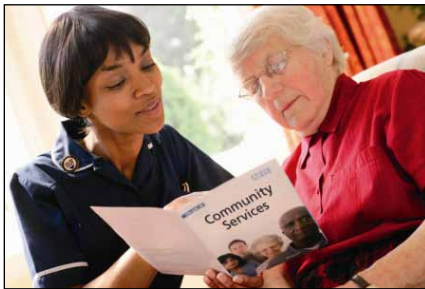


# Transforming Community Services

Demonstrating and Measuring Achievement:  
Community Indicators for Quality Improvement



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**DH INFORMATION READER BOX**

<b>Policy</b> HR/Workforce Management Planning/Performance Clinical	Estates Commissioning IM&T Finance Social Care/Partnership Working
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<b>Author</b>	Transforming Community Services
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<b>Circulation list</b>	PCT Chief Executives, NHS Trust Chief Executives, Care Trust Chief Executives, Foundation Trust Chief Executives, Medical Directors, Directors of Public Health, Directors of Nursing, Directors of Adult Social Services, Allied Health Professionals, GPs, Directors of Children's Social Services, Voluntary Organisations/Non Departmental Public Bodies, Allied Health Professional Bodies
<b>Description</b>	This document introduces 43 indicators for quality improvement for voluntary, local use in a community setting. These carefully chosen quality indicators will assist local service improvement and help to raise the standard of care delivered to patients and communities.
<b>Cross refs</b>	Quality Framework: Guidance for Community Services
<b>Superseded doc</b>	N/A
<b>Action required</b>	N/A
<b>Timing</b>	N/A
<b>Contact details</b>	Transforming Community Services 4N11, Quarry House Leeds, LS2 7UE 01325 45585 Email: <a href="mailto:transformingcommunityservices@dh.gsi.gov.uk">transformingcommunityservices@dh.gsi.gov.uk</a>  <a href="http://www.dh.gov.uk/en/Healthcare/TCS/InformationModelsforcommunityservices/index.htm">www.dh.gov.uk/en/Healthcare/TCS/InformationModelsforcommunityservices/index.htm</a>
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## Introduction

The Transforming Community Services programme has developed 43 indicators for quality improvement. The use of these indicators is voluntary and for local use only. They cover many aspects of community services that interface with GPs, secondary care and social services.

They will be of interest to clinicians, providers and commissioners of community services for inclusion in local quality improvement strategies. Although these indicators are not appropriate for the use of benchmarking against other services, carefully chosen quality indicators, used as part of a local quality improvement strategy, will assist local service improvement and help to raise the standard of care delivered to patients and communities.

Where appropriate, organisations will use these indicators in their Joint Strategic Needs Assessment (JSNA). The statutory duty of JSNA requires primary care trusts and local authorities to assess the current and future health and wellbeing needs of their population. The findings of the JSNA will lead to shared priorities to improve outcomes and reduce health inequalities.

To get the best from the community indicators, it is important to select those that measure what you value and what matters to the people who use your services, and which instigate and inform dialogue about where improvement is needed.

Used in isolation, a single indicator may risk setting too narrow a perspective, focusing attention on only one aspect of quality over other equally important dimensions. Using a balanced approach in the use of quality indicators can help you to get more out of your choice of indicators.

'Bundling' several indicators together will provide a more rounded view of quality improvement. A bundle of indicators enables the different domains of safety, effectiveness and experience to be reflected, and can be used to give a focus to a particular aspect, service or pathway of care. How many indicators to use will depend on local circumstances and the focus on quality improvement.

Involving stakeholders in the selection of the indicators will also provide assurance of a balanced focus. For example:

- What is important to all your patients, including those from excluded and hard to reach groups (such as asylum seekers, gypsies and travellers, and homeless people)?
- What are your commissioners interested in?

These quality indicators will help clinicians and frontline services to measure and monitor quality improvement, by indicating where change is needed and demonstrating what high quality personalised care looks like. However, the indicators are not a definitive list and you may find there are more appropriate indicators that better describe the care your service delivers.



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# Using this guide

This guide is an interactive pdf. You will be able to navigate your way through it, as you would a website, using the navigation and functionality buttons and links.

The page example below is a guide to using the links and buttons on a clinical pathways page.

The list of indicators on the clinical pathway section home page are linked, which means you can click on an indicator to take you directly to the page that you require.

The navigation and functionality buttons enable you to move through this guide and allow you to print the page you are on or exit the guide.

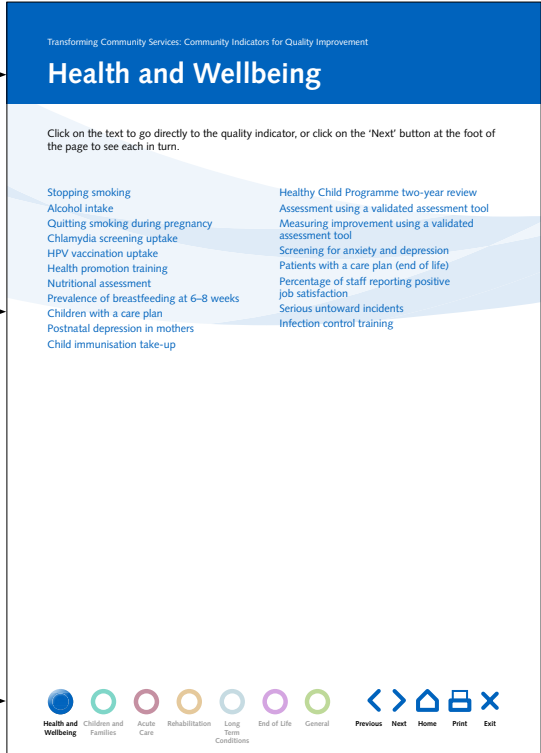
The buttons at the bottom of each page represent the clinical pathways and can be used to navigate to the section home page of the clinical pathway you choose.

If you are on an indicator page, the buttons that show the relevant clinical pathways for that indicator will light up.

This is the title of the clinical pathway that you are in.

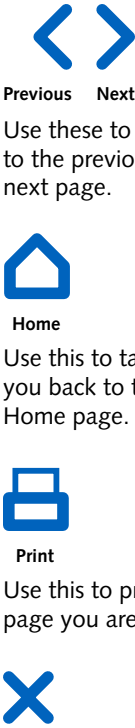
This is a list of indicators that relate to the clinical pathway you are in. Click on the title to link to a particular indicator.

These buttons represent the clinical pathways. They light up if they are relevant to the indicator page you are on. You can also use these buttons to go to the home page of any of the clinical pathways.



The screenshot shows a page titled "Health and Wellbeing" under the heading "Transforming Community Services: Community Indicators for Quality Improvement". Below the title is a list of indicators, including "Stopping smoking", "Alcohol intake", "Quitting smoking during pregnancy", "Chlamydia screening uptake", "HPV vaccination uptake", "Health promotion training", "Nutritional assessment", "Prevalence of breastfeeding at 6-8 weeks", "Children with a care plan", "Postnatal depression in mothers", "Child immunisation take-up", "Healthy Child Programme two-year review", "Assessment using a validated assessment tool", "Measuring improvement using a validated assessment tool", "Screening for anxiety and depression", "Patients with a care plan (end of life)", "Percentage of staff reporting positive job satisfaction", "Serious untoward incidents", and "Infection control training". At the bottom of the page is a navigation bar with icons for "Health and Wellbeing", "Children and Families", "Acute Care", "Rehabilitation", "Long Term Conditions", "End of Life", "General", "Previous", "Next", "Home", "Print", and "Exit".

Navigation and functionality buttons



Use these to move to the previous or next page.

Use this to take you back to the Home page.

Use this to print the page you are on.

Use this to exit the guide.



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# Health and Wellbeing

Click on the text to go directly to the quality indicator, or click on the 'Next' button at the foot of the page to see each in turn.

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[Quitting smoking during pregnancy](#)

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# Health and Wellbeing

## Stopping smoking (tcs 01)

### Description

The percentage of self-reported four-week smoking quitters aged 16 or over.

### Rationale

Stop Smoking Services are a key NHS intervention to reduce smoking across all groups in the community, with particular focus on routine and manual groups. They are part of a programme of action needed to tackle the underlying determinants of ill health and health inequalities, to reduce smoking rates to 21% or less by 2011, with a reduction in prevalence among routine and manual groups to 26% or less.

Four-week smoking quit rates are the local measure to reflect smoking prevalence. They provide a useful performance measure for NHS Stop Smoking Services and a means of tracking service performance against local operating plans.

### Definition

This indicator relates to clients/patients receiving support through NHS Stop Smoking Services. A client is counted as a self-reported four-week quitter if they have been assessed four weeks after the designated quit date and declare that they have not smoked even a single puff on a cigarette in the past two weeks. The indicator is a tally of treatment episodes rather than people: if an individual undergoes two treatment episodes and has quit at four weeks in both cases, they are counted twice.

See DH guidance for detailed definitions (NHS Stop Smoking Services: service and monitoring guidance 2010/11).

### Methodology

Numerator:	Number of self-reported four-week smoking quitters
Denominator:	Population aged 16 or over
Formula:	Numerator / Denominator x 100
Unit of measure:	Percentage of smokers on caseload who are four-week quitters
Frequency:	Monthly
Source of data:	Local information systems Data published on NHS Information Centre website



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# Health and Wellbeing

## Alcohol intake (tcs 02)

### Description

The percentage of patients on a caseload who have been screened for alcohol intake by community service staff as part of their assessment or personalised care planning.

### Rationale

Alcohol intake is a key determinant of health and wellbeing. By monitoring patterns of alcohol intake, commissioners can understand better where to focus their resources to reduce alcohol-related ill health.

All frontline health and social care workers should have the skills, knowledge and confidence to ask patients or clients about their drinking, reflecting an awareness and sensitivity to cultural and religious attitudes to alcohol.

Screening/assessment tools can be used effectively with a minimal amount of training, enabling spread of skills across different professions.

Inclusion of screening for alcohol intake as part of a patient's assessment on referral to a community service, or as part of a personalised care plan, would substantially improve the knowledge of prevalence and enable early intervention.

### Definition

As part of routine assessment and care planning, the alcohol intake of the patient is recorded using an established screening tool such as those recommended by Alcohol Concern.

**Caseload:** Patients who require active management of their condition, in accordance with a care plan developed with the clinician/service. Active management would entail regular and numerous contacts during a specified period of time.

### Methodology

Numerator:	Number of patients screened for alcohol intake
Denominator:	All patients in an active caseload
Formula:	$\text{Numerator} / \text{Denominator} \times 100$
Unit of measure:	Percentage of patients screened
Frequency:	Monthly
Source of data:	Local information systems



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# Health and Wellbeing

## Quitting smoking during pregnancy (tcs 03)

### Description

The percentage of expectant mothers registered as a smoker when booking a first midwife appointment who, by the time of delivery, have stopped smoking.

### Rationale

Smoking during pregnancy is a key determinant of low birth weight, which is, in turn, the single most important factor in perinatal and infant mortality. With smoking during pregnancy being more prevalent among young mothers and disadvantaged groups, this indicator measures a key issue for tackling health inequalities and improving public health.

### Definition

A booking appointment, or booking-in visit as it is also known, is the first official check-up in pregnancy. The midwife will ask the woman whether or not she smokes. This is recorded in the midwifery notes.

At the time of delivery, the midwife will ask the woman whether or not she smokes. This is also recorded in the midwifery notes.

A smoker is defined as anybody who smokes, regardless of the amount smoked per day, week or month.

### Methodology

Numerator:	Number of expectant mothers who are classified as smokers at their first booking (antenatal) appointment and have stopped smoking by delivery
Denominator:	Total number of expectant mothers who were classified as smokers at their first booking (antenatal) appointment
Formula:	$\text{Numerator} / \text{Denominator} \times 100$
Unit of measure:	Percentage of mothers who have stopped smoking by delivery
Frequency:	Monthly
Source of data:	Local information systems



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# Health and Wellbeing

## Chlamydia screening uptake (tcs 04)

### Description

The percentage of the population aged 15 to 24 accepting a test for chlamydia.

### Rationale

Chlamydia is the most common sexually transmitted infection and there is evidence that up to 1 in 10 young people aged under 25 may be infected. It often has no symptoms, but if left untreated can lead to pelvic inflammatory disease, ectopic pregnancy and infertility. Chlamydia is very easily treated.

The National Chlamydia Screening Programme has a community focus. It concentrates on opportunistic screening of asymptomatic sexually active men and women under the age of 25 who would not normally access, or be offered, a chlamydia test, and focuses on screening in non-traditional sites.

All chlamydia tests undertaken outside of genitourinary medicine (GUM) clinics on 15–24-year-olds count towards calculating screening coverage in residents of each primary care trust (PCT).

### Definition

All tests for *Chlamydia trachomatis* with a confirmed positive and negative test result. Full definitions can be found on the National Chlamydia Screening Programme website.

**Number:** The number of persons resident within a PCT.

**Persons:** Individuals screened or tested.

**Tests and screens:** All chlamydia tests performed outside GUM clinics.

The population should be calculated using mid-year population estimates from the Office for National Statistics (by single year of age and sex, by PCT).

### Methodology

Numerator:	Number of 15–24-year-olds screened or tested for chlamydia
Denominator:	Population aged 15–24 years
Formula:	Numerator / Denominator x 100
Unit of measure:	Percentage screened
Frequency:	Monthly
Source of data:	National Chlamydia Screening Programme returns



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# Health and Wellbeing

## HPV vaccination uptake (tcs 05)

### Description

The percentage of 12/13-year-old girls who receive the human papilloma virus (HPV) vaccination for cervical cancer.

### Rationale

HPV is a known cause of cervical cancer. The national programme to vaccinate girls aged 12/13 has been in place since 2008.

### Definition

As at 31 March each year, the proportion of girls aged 12/13 registered with the PCT who have a record of HPV vaccination in the preceding period 1 April–31 March (unless contraindications or side-effects are recorded) where delivered by community services.

See the NHS Cancer Screening Programme.

### Methodology

Numerator:	Number of 12/13-year-old girls vaccinated
Denominator:	Total PCT-registered population of 12/13-year-old girls
Formula:	Numerator / Denominator x 100
Unit of measure:	Percentage of 12/13-year-old girls vaccinated
Frequency:	Monthly
Source of data:	Local information systems Monthly data available



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# Health and Wellbeing

## Health promotion training (tcs 06)

### Description

The percentage of staff who have received health promotion training (as per local training policy) in the last 12 months.

### Rationale

Promoting healthy lifestyles with those who already have a health concern, or with those wanting to maintain a healthy lifestyle, is an important aspect of healthcare as the policy emphasis moves from *treating* ill health to *preventing* ill health.

Clinicians in community services are ideally placed to provide support for people to take greater responsibility for their health and wellbeing.

For clinicians to be able to fulfil this role, they need to have the appropriate skill base underpinned by relevant and current training programmes.

All community service providers should have clear and focused training and development plans that make explicit what training, knowledge and skill development are required by their workforce, both currently and for future successful health promoting roles. These training plans should focus on supporting provision of strategic business objectives through the delivery of services that both treat patients and prevent disease.

### Definition

Health promotion training provides the means by which eligible staff acquire the knowledge, skills and understanding to support health and wellbeing across all groups in the community. It is recognised that any training undertaken needs to be reinforced by practical experience in order to develop a competent skill base.

### Methodology

Numerator:	Number of staff who have received health promotion training (as per local training policy) in the last 12 months
Denominator:	Total number of staff
Formula:	Numerator / Denominator x 100 expressed on a rolling 12-month basis
Unit of measure:	Percentage of staff
Frequency:	Quarterly
Source of data:	Local information systems



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# Health and Wellbeing

## Nutritional assessment (tcs 07)

### Description

The percentage of patients assessed for nutritional requirements.

### Rationale

The key message of *Choosing a Better Diet: a food and health action plan* is that good nutrition is vital to good health. Malnutrition or undernourishment compromises health and wellbeing, undermining patients' recovery, and increasing dependency and vulnerability to infection. On a patient level, malnutrition is often unrecognised (particularly with older people) and its impact on their health unappreciated.

Nutritional screening is the first step in identifying patients who may be at nutritional risk or potentially at risk of malnutrition. Systematic screening as a part of routine assessment allows care planning with access to appropriate and co-ordinated nutritional advice, sensitive to cultural and religious dietary requirements.

This aligns with *Essence of Care 2010* and the Chief Nursing Officer's High Impact Actions.

### Definition

Malnutrition happens when the food a person eats does not give them the nutrients they need to maintain good health. Malnutrition commonly occurs when someone does not eat enough food (sub-nutrition). It can also occur if a person has a poor diet that gives them the wrong balance of the basic food groups. It is possible for an obese person whose diet consists mainly of fast food to be malnourished because the type of food they eat lacks the nutrients that their body requires.

Patients should be screened for risk of malnutrition or undernourishment using an established screening tool such as the Malnutrition Universal Screening Tool.

**Caseload:** Patients who require active management of their condition, in accordance with a care plan developed with the clinician/service. Active management would entail regular and numerous contacts during a period of time.

### Methodology

Numerator:	Number of patients screened for nutritional requirements using an established screening tool
Denominator:	Number of patients on caseload
Formula:	$\text{Numerator} / \text{Denominator} \times 100$
Unit of measure:	Percentage of patients on caseload
Frequency:	Monthly
Source of data:	Local information systems



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[Children with a care plan](#)

[Postnatal depression in mothers](#)

[Child immunisation take-up](#)

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# Children and Families

## Prevalence of breastfeeding at 6–8 weeks (tcs 08)

### Description

1. The percentage of infants being breastfed at 6–8 weeks.
2. The percentage of infants for whom breastfeeding status is recorded.

### Rationale

There is evidence indicating that the longer the duration of breastfeeding, the greater the health benefits in later life. In 2005, only 50% of all mothers who initiated breastfeeding were continuing to breastfeed at 6 weeks, and 26% continued some breastfeeding at 6 months. There is clear evidence that adequate support to mothers in the first few weeks is likely to increase the duration of breastfeeding.

Breastfeeding has an important contribution to make towards reducing infant mortality, childhood obesity and health inequalities.

### Definition

- a. The number of infants due for a 6–8 week check.
- b. The number of infants recorded as being totally breastfed at 6–8 weeks.
- c. The number of children recorded as being partially breastfed (receiving both breast milk and infant formula) at 6–8 weeks.
- d. The number of children recorded as not at all breastfed at 6–8 weeks.

Where:

- a. 'Infants due' for a 6–8 week check is defined as those registered with the primary care trust.
- b. 'Totally breastfed' is defined as infants who are exclusively receiving breast milk at 6–8 weeks of age – that is, they are **not** receiving formula milk, any other liquids or food.
- c. 'Partially breastfed' is defined as infants who are currently receiving breast milk at 6–8 weeks of age and who are also receiving formula milk or any other liquids or food.
- d. 'Not at all breastfed' is defined as infants who are not currently receiving any breast milk at 6–8 weeks of age.

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## Prevalence of breastfeeding at 6–8 weeks (continued)

### Methodology

Numerator:	Number of infants recorded as being totally breastfed at 6–8 weeks + Number of infants recorded as being partially breastfed
Denominator:	Total number of infants receiving 6–8 week checks Numerator / Denominator x 100
Formula:	1. Percentage of infants being breastfed at 6–8 weeks (breastfeeding prevalence) $\left( \frac{b + c}{a} \times 100\% \right)$ Where: a = Total number of infants due for 6–8 week checks b = Number of infants recorded as being totally breastfed at 6–8 weeks c = Number of infants recorded as being partially breastfed at 6–8 weeks 2. Percentage of infants for whom breastfeeding status is recorded (breastfeeding coverage) $\left( \frac{b + c + d}{a} \right) \times 100\%$ Where: a = Total number of infants due for 6–8 week checks b = Number of infants recorded as being totally breastfed at 6–8 weeks c = Number of infants recorded as being partially breastfed at 6–8 weeks d = Number of infants recorded as not at all breastfed at 6–8 weeks
Unit of measure:	Percentage of infants receiving 6–8 week checks
Frequency:	Monthly
Source of data:	Primary care trust Child Health Records, which are reported to the Department of Health at quarterly intervals via Vital Signs Monitoring Return using Unify2



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# Children and Families

## Children with a care plan (tcs 09)

### Description

The percentage of children on a caseload who have a care plan.

### Rationale

Care planning is a process whereby the child and their parent or guardian are supported to gain confidence and competence in managing the challenges of living with their condition(s). As they do so, their quality of life and clinical outcomes improve. A care plan is the record of this process.

Children with complex needs, long term conditions or other disabilities should have a care plan.

### Definition

A care plan records the outcome of the care planning discussion between the child, their parent or guardian and their healthcare professional. It should contain all the information needed to support the child, with their parent or guardian, to manage their health effectively. The plan is owned by the child and may be a written document or something that is recorded in the child's health record. It may be complex or simple, depending on the child's health and social care needs. If it is a written document it should be understandable and meaningful to the child and their parent or guardian. A copy of the care plan should be given to the child and their parent or guardian, and stored in their medical records. Copies should be available, or at least accessible, to all health and social care professionals providing direct care to the child, and any other individuals (such as carers) who have been given permission to see the plan.

**Caseload:** Children who require active management of their condition, in accordance with a care plan developed with the clinician/service. Active management would entail regular and numerous contacts during a specified period of time.

### Methodology

Numerator:	Number of children on caseload who have a care plan
Denominator:	Number of children on caseload
Formula:	Numerator / Denominator x 100
Unit of measure:	Percentage of children on caseload
Frequency:	Monthly
Source of data:	Local information systems



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# Children and Families

## Postnatal depression in mothers (tcs 10)

### Description

The percentage of new mothers with an assessment for postnatal depression.

### Rationale

Some 10% to 15% of new mothers experience postnatal depression. It can last for months, or in rare cases even years. By ensuring that new mothers, particularly those in vulnerable and socially excluded groups, immigration detention centres or prisons, are offered an assessment for postnatal depression, it increases the possibility that the condition will be identified and appropriate support and treatment offered, with a referral to a local Improving Access to Psychological Therapies programme.

### Definition

A postnatal depression assessment by a healthcare professional should cover the following:

- Ask the mother about her health and wellbeing and that of her baby. This should include asking the mother about their experience of common physical health problems. Any symptoms reported by the mother or identified through clinical observations should be assessed.
- Take a holistic approach, involving the mother, baby and partner (husband/boyfriend, etc), carer and family.
- Offer consistent information and clear explanations to empower the mother to take care of her own health and that of her baby, and to recognise symptoms that may require discussion.
- Encourage the mother and her family to report any concerns in relation to their physical, social, mental or emotional health, discuss issues and ask questions.
- Document in the care plan status levels and any specific problems, and follow up.

Recommended assessment tools include:

- Edinburgh Postnatal Depression Scale (EPDS)
- Hospital Anxiety and Depression Scale (HADS)
- Patient Health Questionnaire (PHQ-9).

*continued*

## Postnatal depression in mothers (continued)

### Methodology

Numerator:	Number of new mothers with postnatal depression assessment between 6 and 12 weeks following delivery
Denominator:	Total number of new mothers
Formula:	Numerator / Denominator x 100
Unit of measure:	Percentage of new mothers
Frequency:	Monthly
Source of data:	Health visitor records Individual patient care plans Local information systems



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# Children and Families

## Child immunisation take-up (tcs 11)

### Description

The percentage of children having routine immunisation at 12 months, 24 months, 5 years and 18 years of age.

### Rationale

In line with current World Health Organization (WHO) immunisation recommendations, at least 95% of children should receive three primary doses of diphtheria, tetanus, polio and pertussis vaccine in the first year of life; and at least 95% should receive a first dose of a measles, mumps and rubella-containing vaccine by two years of age. At least 90% should receive a booster dose of tetanus, diphtheria and polio vaccine between 13 and 18 years of age.

### Definition

Figures for childhood immunisation uptake at 12 months, 24 months and 5 years are collected by financial year through the Cover of Vaccination Evaluated Rapidly (COVER) data collection for primary care trusts (PCTs). The number of reinforcing doses of diphtheria, tetanus and polio vaccine given by school leaving age in a financial year are collected on an Immunisation Programmes KC50 return from known providers of immunisation services.

COVER data relates to children for whom the PCT is responsible. These are:

- all children registered with a GP whose practice forms part of the PCT, regardless of where the child is resident
- any children not registered with a GP, but who are resident within the PCT's statutory geographical boundary.

Further details of COVER can be accessed through the Health Protection Agency website.

NB: Data excludes the uptake of HPV immunisation for 12/13-year-old girls.

*continued*

## Child immunisation take-up (continued)

### Methodology

Numerator:	Number of children having routine immunisation at 12 months, 24 months, 5 years and 18 years of age.
Denominator:	Total number of eligible children within the age groups
Formula:	Numerator / Denominator x 100
Unit of measure:	Percentage of children having routine immunisation for the following: <ul style="list-style-type: none"><li>• children aged 1 who have completed immunisation for diphtheria, tetanus, polio, pertussis and <i>Haemophilus influenzae</i> type b (Hib)</li><li>• children aged 2 who have completed immunisation for pneumococcal infection</li><li>• children aged 2 who have completed immunisation for <i>Haemophilus influenzae</i> type b (Hib) and meningitis C (MenC)</li><li>• children aged 2 who have completed immunisation for measles, mumps and rubella</li><li>• children aged 5 who have completed immunisation for diphtheria, tetanus, polio and pertussis (DTaP/IPV)</li><li>• children aged 5 who have completed immunisation for measles, mumps and rubella (MMR)</li><li>• children aged 13–18 who have received their booster for tetanus, diphtheria and polio (Td/IPV)</li></ul>
Frequency:	Monthly
Source of data:	COVER Immunisation Programmes KC50 return records information on the immunisation of children aged 13–18 years Local information systems



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# Children and Families

## Reception year child obesity rates (tcs 12)

### Description

The percentage of children in reception year who are obese.

### Rationale

Child obesity is one of the most significant challenges for children and is linked to a number of poor outcomes – physical, social and psychological. Child obesity is one of the top ten priorities identified as a World Class Commissioning indicator by primary care trusts (PCTs). Delivery of messages on nutrition and physical activity for the whole family is a key element of the Healthy Child Programme.

The National Child Measurement Programme (NCMP), part of the government strategy 'Healthy Weight, Healthy Lives', is informed by an annual reporting cycle of obesity rate data from PCTs across the country. The NHS Information Centre collates and validates the data, producing an annual report with detailed analysis at PCT level.

To avoid biased results, a sample must be representative of the entire population from which it was drawn. In the case of the NCMP, this means that every child must have an equal chance of being included in the dataset. The programme aims to achieve an 85% participation rate, and monitoring progress in achieving this can maintain attention on how well services are addressing inequality and equity of provision across all communities.

This data has operational value for local quality improvement to inform where local initiatives aimed at children and families should be targeted to best effect.

### Definition

Measurements of children's heights and weights, without shoes and coats and in normal, light, indoor clothing, are used to calculate their body mass index (BMI) percentile, allowing recording of the proportion found to be obese. For population monitoring purposes, children are defined as obese if their BMI falls above the 95th percentile of the reference curve for their age and sex according to the UK National BMI percentile classification (Cole TJ, Freeman JV and Preece MA (1995) 'Body mass index reference curves for the UK, 1990.' *Archives of Disease in Childhood* 73(1):25–29).

*continued*

## Reception year child obesity rates (continued)

### Methodology

Numerator:	Number of children in reception year who are obese
Denominator:	Number of children measured in reception year
Formula:	$\text{Numerator} / \text{Denominator} \times 100$
Unit of measure:	Percentage of children in reception year
Frequency:	Annually
Source of data:	Validated results are published by the NHS Information Centre The data is supplied by PCTs, allowing monitoring of participation rates at an operational level



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# Children and Families

## Year 6 child obesity rates (tcs 13)

### Description

The percentage of children in year 6 who are obese.

### Rationale

Child obesity is one of the most significant challenges for children and is linked to a number of poor outcomes – physical, social and psychological. Child obesity is one of the top ten priorities identified as a World Class Commissioning indicator by primary care trusts (PCTs). Delivery of messages on nutrition and physical activity for the whole family is a key element of the Healthy Child Programme.

The National Child Measurement Programme (NCMP), part of the government strategy 'Healthy Weight, Healthy Lives', is informed by an annual reporting cycle of obesity rate data from PCTs across the country. The NHS Information Centre collates and validates the data, producing an annual report with detailed analysis at PCT level.

To avoid biased results, a sample must be representative of the entire population from which it was drawn. In the case of the NCMP, this means that every child must have an equal chance of being included in the dataset. The programme aims to achieve an 85% participation rate, and monitoring progress in achieving this can maintain attention on how well services are addressing inequality and equity of provision across all communities.

This data has operational value for local quality improvement to inform where local initiatives aimed at children and families should be targeted to best effect.

### Definition

Measurements of children's heights and weights, without shoes and coats and in normal, light, indoor clothing, are used to calculate their body mass index (BMI) percentile, allowing recording of the proportion found to be obese. For population monitoring purposes, children are defined as obese if their BMI falls above the 95th percentile of the reference curve for their age and sex according to the UK National BMI percentile classification (Cole TJ, Freeman JV and Preece MA (1995) 'Body mass index reference curves for the UK, 1990.' *Archives of Disease in Childhood* 73(1):25–29).

*continued*



## Year 6 child obesity rates (continued)

### Methodology

Numerator:	Number of children in year 6 who are obese
Denominator:	Number of children measured in year 6
Formula:	Numerator / Denominator x 100
Unit of measure:	Percentage of children in year 6
Frequency:	Annually
Source of data:	Validated results are published by the NHS Information Centre The data is supplied by PCTs, allowing monitoring of participation rates at an operational level



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# Children and Families

## Healthy Child Programme two-year review (tcs 14)

### Description

The percentage of children who have had a two-year review by 32 months of age.

### Rationale

The Healthy Child Programme is the universal public health programme for all children and families. It consists of a schedule of reviews, immunisations, health promotion, parenting support and screening tests that promote and protect the health and wellbeing of children from pregnancy through to adulthood.

The review at two years of age is one of the key reviews recommended in the Healthy Child Programme. It needs to reach all two-year-olds in the area and be carried out in a timely fashion. 100% of children need to have been seen by 32 months (the recommended age for this review is 24–30 months). In the case of the Healthy Child Programme two-year review, every child must have an equal chance of being included in the dataset, i.e. there is a progressive universal approach to targeting those most in need.

Priority topics for the two-year review are:

- nutrition, active play and obesity prevention
- immunisation
- personal, social and emotional development
- speech, language and communication
- injury prevention.

The Healthy Child Programme (including the two-year review) should be underpinned by a systematic assessment of population needs that provides the basis for configuring services and allocating resources to address the topics listed above.

This data has operational value for local quality improvement to inform where local initiatives aimed at children and families should be targeted to best effect.

### Definition

The number of all children with recorded two-year reviews.

*continued*

## Healthy Child Programme two-year review (continued)

### Methodology

Numerator:	All children with recorded completed two-year reviews
Denominator:	Number of children in age group
Formula:	Numerator / Denominator x 100
Unit of measure:	Percentage of children in age group
Frequency:	Annually
Source of data:	The data is collected by the Healthy Child Programme team led by the health visitor Local information systems



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# Children and Families

## Health assessments for children who are looked after (tcs 15)

### Description

The percentage of children for whom you are commissioned to provide a service who, on becoming looked after, have received health assessment in line with the requirements in the national statutory guidance on promoting the health and wellbeing of looked after children.

### Rationale

Looked after children (as defined by the Children and Young Persons Act 2008) and young people share many of the same health risks and problems as their peers, but often to a greater degree. They often enter care with a worse level of health than their peers, due in part to the impact of poverty, abuse and neglect.

The NHS contributes to meeting the health needs of looked after children by:

- the commissioning of effective services in line with the national statutory guidance on promoting the health and wellbeing of looked after children
- delivery through a provider organisation with clinicians offering co-ordinated care for each child and young person to meet their health needs.

### Definition

A looked after child is defined as:

- being looked after by the council as at 30 September, and
- having been looked after continuously from and including 1 October of the previous calendar year, or earlier.

Do not include children who had been looked after at any point during that time under an agreed series of short-term breaks (under the provisions of Reg. 13 of the Arrangements for Placement of Children (General) Regulations 1991). They are classed as SSDA 903 legal status code V3 or V4.

Health assessments must be carried out twice a year for those under five years of age. Two assessments must have been carried out in order for the annual assessment requirement to be satisfied for under-fives. The assessment should be carried out once in every six-month period before the child's fifth birthday. For those aged five or over, a single annual assessment fulfils the requirement.

*continued*

## Health assessments for children who are looked after (continued)

### Methodology

Numerator:	Number of children receiving annual health assessment according to national statutory guidance on promoting the health and wellbeing of looked after children
Denominator:	Total number of looked after children for whom you are commissioned to provide a service
Formula:	$\text{Numerator} / \text{Denominator} \times 100$
Unit of measure:	Percentage of looked after children
Frequency:	Monthly
Source of data:	Local information systems



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# Children and Families

## Safeguarding children training (tcs 16)

### Description

The percentage of staff who have completed mandatory training in child protection in the last 12 months.

### Rationale

Mandatory training underpins the safety of children, their patients or guardians, and staff. All community service providers should have clear and focused mandatory training plans that make explicit what training, knowledge and skill development are required by their workforce, both currently and for future modernisation of roles. These training plans should focus on supporting provision of strategic business objectives on child welfare through the delivery of safe and high quality care.

### Definition

Mandatory training is described as training that the organisation deems necessary in order for staff to undertake their work in a safe and effective manner.

It is recognised that any training undertaken needs to be reinforced by practical experience in order to develop a competent skill base.

### Methodology

Numerator:	Number of staff who have received mandatory child protection training (as per local training policy) in the last 12 months
Denominator:	Total number of staff
Formula:	Numerator / Denominator x 100 expressed on a rolling 12-month basis
Unit of measure:	Percentage of staff
Frequency:	Quarterly
Source of data:	Local information systems



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# Acute Care

## Incidence of pressure ulcer (tcs 17)

### Description

The percentage of patients on a caseload with a pressure ulcer of grade 2 or higher.

### Rationale

Pressure ulcers are a substantial cause of morbidity. Their treatment can require significant use of NHS resources, including acute hospital admissions. Pressure ulcer incidence is a good indicator of the quality of care provided by health professionals and preventive care strategies. Pressure sores can also result from improper wheelchair or seating provision, and thus this should be monitored accordingly. In a community setting, pressure ulcers are often identified following discharge from hospital.

### Definition

A pressure ulcer is an area of localised damage to the skin and underlying tissue caused by pressure, shear, friction and/or a combination of these.

The European Pressure Ulcer Advisory Panel classifications when assessing a pressure ulcer are as follows:

**Grade 1:** Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema and hardness may also be used as indicators, particularly on individuals with darker skin.

**Grade 2:** Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion or blister.

**Grade 3:** Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia.

**Grade 4:** Extensive destruction, tissue necrosis, or damage to muscle, bone or supporting structures, with or without full thickness skin loss.

**Caseload:** Patients who require active management of their condition, in accordance with a care plan developed with the clinician/service. Active management would entail regular and numerous contacts during a specified period of time.

### Methodology

Numerator:	Patients on caseload with a pressure ulcer of grade 2 or higher
Denominator:	Patients on caseload
Formula:	Numerator / Denominator x 100
Unit of measure:	Percentage of patients with a pressure ulcer of grade 2 or higher
Frequency:	Monthly
Source of data:	Local information systems



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# Acute Care

## Leg ulcer wounds (tcs 18)

### Description

The percentage of venous leg ulcer wounds that have healed within 12 to 24 weeks from start of treatment.

### Rationale

Venous leg ulcer wounds constitute a significant proportion of community activity. Royal College of Nursing guidelines provide an established evidence base supporting a reasonable expectation that well managed care should result in healing within 12 to 24 weeks.

### Definition

Start of treatment is defined as when the initial assessment is conducted and a treatment plan agreed.

The assessment and clinical investigation of patients with a leg ulcer should be undertaken by health professionals trained in leg ulcer management.

### Methodology

Numerator:	Number of wounds healed within 12 to 24 weeks from start of treatment
Denominator:	Total number of wounds at initial assessment
Formula:	Numerator / Denominator x 100
Unit of measure:	Percentage of wounds that heal within 12 weeks of referral for treatment Percentage of wounds that heal within 24 weeks of referral for treatment
Frequency:	Monthly
Source of data:	Local information systems



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# Acute Care

## Unplanned admissions with short stay (tcs 19)

### Description

The percentage of patients from an agreed cohort who have an unplanned admission where the length of stay was less than two days.

### Rationale

Providing care closer to home and avoidance of hospital admissions by effective and personalised services is a core function of community services.

A short unplanned stay may indicate that the patient's condition did not require substantial hospital care or that admission was precautionary. It may reflect a breakdown of care planning or point to opportunities where further support provided by the community team could prevent future admissions.

Monitoring of unplanned admissions with a short length of stay should act as a catalyst for root-cause analysis by frontline services to review practice and consider quality improvements.

### Definition

Admission could be to an acute or community hospital. For patients on an End of Life care pathway, services may also want to monitor unplanned admissions to a hospice.

**Agreed cohort:** The commissioner and the provider should agree on how to identify patients of whom the community provider can reasonably be expected to have ownership. Possible options to base this on may include a defined range of conditions, identifiable by diagnostic coding, or a caseload of patients referred to the community provider.

**Caseload:** Patients who require active management of their condition, in accordance with a care plan developed with the clinician/service. Active management would entail regular and numerous contacts during a specified period of time.

**Short stay:** Length of stay is less than or equal to two nights.

### Methodology

Numerator:	Patients in agreed cohort who have an unplanned admission with a short stay
Denominator:	Patients in agreed cohort
Formula:	$\text{Numerator} / \text{Denominator} \times 100$
Unit of measure:	Percentage of patients in agreed cohort
Frequency:	Monthly
Source of data:	Local information systems



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# Acute Care

## Bed days lost due to delayed discharge or transfer from hospital (tcs 20)

### Description

The number of bed days lost due to patients whose discharge or transfer from community hospital is delayed, as a percentage of the total bed days available.

### Rationale

High quality community services should avoid delays to discharge or transfer from hospital through effective joint working between professionals, teams and organisations. This is important as delays represent poor patient experience, increase risk of infections and waste resources. Monitoring of bed days lost should act as a catalyst to understanding the causes of delays and developing solutions.

### Definition

**Patients whose discharge or transfer is delayed:** Any patient who is not discharged or transferred from hospital on the same calendar day as they are approved by a clinician as being fit and ready for discharge or transfer. This can apply to an acute or community hospital.

**Days lost due to delayed discharge:** The difference in days between the date when a patient is approved by a clinician as ready to be discharged from hospital and the date when they leave.

**Total bed days available:** The number of beds occupied in the community hospital multiplied by the defined time period, normally a calendar month.

### Methodology

Numerator:	Bed days lost
Denominator:	Total bed days occupied
Formula:	Numerator / Denominator x 100
Unit of measure:	Percentage of total bed days
Frequency:	Monthly
Source of data:	Local information systems Situation reports



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# Acute Care

## Percentage of patients whose discharge or transfer from hospital is delayed (tcs 21)

### Description

The percentage of patients whose discharge or transfer from hospital is delayed.

### Rationale

High quality community services should avoid delays to discharge or transfer from hospital through effective joint working between professionals, teams and organisations. This is important as delays represent poor patient experience, increase risk of infections and waste resources. Monitoring of patients whose discharge was delayed should act as a catalyst to understanding the causes of delays and developing solutions.

### Definition

**Patients whose discharge or transfer is delayed:** Any patient who experiences a delay in discharge or transfer from hospital on the same calendar day as they are approved by a clinician as being fit and ready for discharge or transfer. Community hospitals should be included within the scope of this indicator.

### Methodology

Numerator:	Number of patients whose discharge or transfer is delayed
Denominator:	Total number of patients whose discharge or transfer has been approved during defined time period
Formula:	$\text{Numerator} / \text{Denominator} \times 100$
Unit of measure:	Percentage of patients whose discharge or transfer has been approved
Frequency:	Monthly
Source of data:	Local information systems



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# Acute Care

## Falls in a community setting (tcs 22)

### Description

The number of falls in a community setting as a percentage of the total number of patients on a caseload.

### Rationale

Falls are a major cause of disability and the leading cause of mortality due to injury in people aged over 75. By introducing integrated falls services, falls and their consequences can be reduced. This should contribute to improved outcomes for older people and promote their independence, as well as reducing pressure on the NHS and social care services. Although most falls do not result in serious injury, the consequences for an individual of falling or of not being able to get up after a fall can include:

- psychological problems, for example a fear of falling and a loss of confidence in being able to move about safely
- loss of mobility, leading to social isolation and depression
- an increase in dependency and disability
- hypothermia
- pressure-related injury
- infection.

The prevention and management of falls in older people is outlined in the National Service Framework for Older People, standard 6.

The focus on falls as a percentage of the number of patients on a caseload keeps attention on the effectiveness of falls prevention assessments and interventions.

*continued*

## Falls in a community setting (continued)

### Definition

The falls should be categorised and counted according to the severity of the harm resulting from the fall, according to the National Patient Safety Agency (NPSA) definition. The NPSA defines harm as injury, suffering, disability or death, and categorises the severity of harm as follows:

**None:** A situation where no harm occurred: either a prevented patient safety incident or a no harm patient safety incident.

**Low:** Any unexpected or unintended incident which required extra observation or minor treatment and caused minimal harm, to one or more persons.

**Moderate:** Any unexpected or unintended incident which resulted in further treatment, possible surgical intervention, cancelling of treatment or transfer to another area, and which caused short-term harm, to one or more persons.

**Severe:** Any unexpected or unintended incident which caused permanent or long-term harm, to one or more persons.

**Death:** Any unexpected or unintended incident which caused the death of one or more persons.

**Caseload:** Patients who require active management of their condition, in accordance with a care plan developed with the clinician/service. Active management would entail regular and numerous contacts during a specified period of time.

### Methodology

Numerator:	Number of falls in a community setting, categorised by the NPSA definition of harm (additional stratification may include by setting)
Denominator:	Number of patients on caseload
Formula:	Numerator / Denominator x 100
Unit of measure:	Number of falls
Frequency:	Monthly
Source of data:	Local information systems



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# Rehabilitation

## Assessment using a validated assessment tool (tcs 23)

### Description

The percentage of patients on a caseload assessed using a validated assessment tool appropriate to the scope of the practice.

### Rationale

Good clinical practice will involve audit and peer review. Adoption of this indicator will make this more systematic and outward facing, contributing to a wider and more outcome-focused understanding of service performance.

There is a broad range of established validated assessment tools used by clinicians of all professions. Many are specific to individual professions, but some can be utilised in a multi-disciplinary context.

For example, the British Society of Rehabilitation Medicine has produced a 'Basket of approved measures' which may help to narrow down the range of validation assessment tools. For indicators that could be used in the area of neurological rehabilitation, the 'validated assessment measure' could include at least one of the following:

- the Barthel Index
- the Functional Independence Measure (FIM) or the UK FIM + Functional Assessment Measure (FAM)
- Goal Attainment Scaling (rated on a 5-point scale of -2 to +2).

Recommended rating manuals and computerised software for all of these instruments are available through the National Dataset for Specialist Neurorehabilitation Services, UK Rehabilitation Outcomes Collaborative.

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## Assessment using a validated assessment tool (continued)

### Definition

Definition of the cohort of patients should take into account the variability of patient conditions. Not all patients can be expected to demonstrate improvement, but continued intervention can still be appropriate.

The clinician should be able to identify an anticipated outcome at the onset of a period of care. It is suggested that three broad bandings are used:

**Positive change/improvement:** Curative treatment.

**Advisory/maintenance:** Anticipating likely needs/problems, intervention is aimed at enabling the patient to be self-managing, or at preventive action.

**Support:** In cases where the patient's condition is expected to decline and the intervention is intended to improve the patient's experience as much as possible; this includes palliative care.

From these three bandings, an identifiable cohort of patients, for whom improvement is expected, should be possible.

Selection of an appropriate validated assessment tool must have professional support. It should be a tool that is considered effective in routine patient care. It should not be imposed on a clinical team in addition to or in place of an existing tool that is used with confidence.

### Methodology

Numerator:	Patients within defined cohort(s) assessed using validated assessment tool
Denominator:	Patients within defined cohort(s)
Formula:	$\text{Numerator} / \text{Denominator} \times 100$
Unit of measure:	Percentage of patients within defined cohort(s)
Frequency:	Monthly
Source of data:	Local information systems



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# Rehabilitation

## Measuring improvement using a validated assessment tool (tcs 24)

### Description

The percentage of patients on a caseload achieving improvement as measured using a validated assessment tool appropriate to the scope of the practice.

### Rationale

Good clinical practice will involve audit and peer review. Adoption of this indicator will make this more systematic and outward facing, contributing to a wider and more outcome-focused understanding of service performance.

There is a broad range of established validated assessment tools used by clinicians of all professions. Many are specific to individual professions, but some can be utilised in a multi-disciplinary context.

For example, the British Society of Rehabilitation Medicine has produced a 'Basket of approved measures' which may help to narrow down the range of validation assessment tools. For indicators that could be used in the area of neurological rehabilitation, the 'validated assessment measure' could include at least one of the following:

- the Barthel Index
- the Functional Independence Measure (FIM) or UK FIM + Functional Assessment Measure (FAM)
- Goal Attainment Scaling (rated on a 5-point scale of -2 to +2).

Recommended rating manuals and computerised software for all of these instruments are available through the National Dataset for Specialist Neurorehabilitation Services, UK Rehabilitation Outcomes Collaborative.

*continued*

## Measuring improvement using a validated assessment tool (continued)

### Definition

Definition of the cohort of patients should take into account the variability of patient conditions. Not all patients can be expected to demonstrate improvement, but continued intervention can still be appropriate.

The clinician should be able to identify an anticipated outcome at the onset of a period of care. It is suggested that three broad bandings are used:

**Positive change/improvement:** Curative treatment.

**Advisory/maintenance:** Anticipating likely needs/problems, intervention is aimed at enabling the patient to be self-managing, or at preventive action.

**Support:** In cases where the patient's condition is expected to decline and the intervention is intended to improve the patient's experience as much as possible; this includes palliative care.

From these three bandings, an identifiable cohort of patients, for whom improvement is expected, should be possible.

Selection of an appropriate validated assessment tool must have professional support. It should be a tool that is considered effective in routine patient care. It should not be imposed on a clinical team in addition to or in place of an existing tool that is used with confidence.

### Methodology

Numerator:	Patients within defined cohort(s) who have improved, measured using validated assessment tool
Denominator:	Patients within defined cohort(s)
Formula:	$\text{Numerator} / \text{Denominator} \times 100$
Unit of measure:	Percentage of patients within defined cohort(s) who have improved
Frequency:	Monthly
Source of data:	Local information systems



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# Rehabilitation

## Supporting independence with community services (tcs 25)

### Description

The percentage of patients on a caseload who have not been admitted to hospital by day 90 following referral.

### Rationale

Supporting people to be independent in their own home and avoiding hospital admissions through effective and personalised services is a core function of community services. This measure identifies the effectiveness of community interventions by monitoring whether or not they have been successful in enabling patients to continue to live at home.

Admission could be to an acute or community hospital. For patients on an End of Life care pathway, services may also want to monitor unplanned admissions to a hospice.

This focuses explicitly on the patients who have been referred to community services either by a GP or following discharge from hospital, and who require a period of interventions – hence considered to be on the active caseload.

### Definition

**Caseload:** Patients who require active management of their condition, in accordance with a care plan developed with the clinician/service. Active management would entail regular and numerous contacts during a specified period of time.

*continued*

## Supporting independence with community services (continued)

### Methodology

Numerator:	Patients on caseload without an admission to hospital
Denominator:	Patients on caseload
Formula:	$\text{Numerator} / \text{Denominator} \times 100$
Unit of measure:	Percentage of patients on caseload
Frequency:	Monthly
Source of data:	Local information systems



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# Long Term Conditions

For further background and context, see also:

[Your Health, Your Way](#)

[Generic Choice Model for Long Term Conditions](#)

Click on the text to go directly to the quality indicator, or click on the 'Next' button at the foot of the page to see each in turn.

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# Long Term Conditions

## Screening for anxiety and depression (tcs 26)

### Description

The percentage of patients on a caseload who have been screened for anxiety and depression.

### Rationale

Policy for patients with a long term condition (LTC) sets out the commitment for personalised care planning and supporting self-managed care. *The Generic Choice Model for Long Term Conditions* highlights how the care planning process feeds into the commissioning of more personalised services for people with LTC. The model highlights a number of specific elements that should be considered during the care planning discussion:

- self-care and self-management
- clinical support
- supporting independence
- psychological support
- other relevant social factors.

Routine inclusion of screening for anxiety and depression as part of the care planning process represents good practice and may be part of a commissioning specification, contributing to the planning of appropriate psychological support.

### Definition

The current caseload denotes patients who are actively receiving an intervention or treatment following referral. Community staff will be working with the patient, ensuring that they have a personalised care plan.

The definition of an LTC will be based on the locally agreed definition.

Effective screening tools include:

- Patient Health Questionnaire (PHQ-9)
- Hospital and Anxiety Depression Scale (HADS)
- Beck Depression Inventory, 2nd edition (BDI-II).

**Caseload:** Patients who require active management of their condition, in accordance with a care plan developed with the clinician/service. Active management would entail regular and numerous contacts during a specified period of time.

*continued*

## Screening for anxiety and depression (continued)

### Methodology

Numerator:	Patients on caseload who have been screened for anxiety and depression
Denominator:	Total number of patients on caseload
Formula:	$\text{Numerator} / \text{Denominator} \times 100$
Unit of measure:	Percentage of patients on caseload
Frequency:	Monthly
Source of data:	Local information systems



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# Long Term Conditions

## Assessment using the Caregiver Strain Index (tcs 27)

### Description

The percentage of carers who have been assessed using the Caregiver Strain Index.

### Rationale

Since the launch of the Carers Strategy in 1999, the vital role played by carers in the society has been a focus of government support. The Caregiver Strain Index is an established tool which measures the strain related to providing care, using the domains of:

- employment
- financial
- physical
- social
- time.

Use of the Caregiver Strain Index should be considered when a carer is identified as part of a patient's care planning process.

Good clinical practice will involve audit and peer review. Adoption of this indicator will make this more systematic and outward facing, contributing to a wider and more outcome-focused understanding of service performance.

### Definition

*Carers at the heart of 21st-century families and communities* provides the following definition of a carer:

'A carer spends a significant proportion of their life providing unpaid support to family or potentially friends. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.'

**Caseload:** Patients who require active management of their condition, in accordance with a care plan developed with the clinician/service. Active management would entail regular and numerous contacts during a specified period of time.

*continued*

## Assessment using the Caregiver Strain Index (continued)

### Methodology

Numerator:	Carers assessed using Caregiver Strain Index
Denominator:	Carers of patients on caseload
Formula:	$\text{Numerator} / \text{Denominator} \times 100$
Unit of measure:	Percentage of patients within defined cohort(s)
Frequency:	Monthly
Source of data:	Local information systems



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# End of Life

For further background and context, see also:

[End of Life Care Strategy](#)

[End of Life Care Strategy: Quality markers and measures for end of life care](#)

Click on the text to go directly to the quality indicator, or click on the 'Next' button at the foot of the page to see each in turn.

[Patients with a care plan \(end of life\)](#)  
[Patients on an End of Life care pathway](#)  
[Preferred place of care](#)  
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# End of Life

## Patients with a care plan (end of life) (tcs 28)

### Description

The percentage of patients on an End of Life care pathway who have a personalised care plan.

### Rationale

A personalised care plan supports patients as they enter the End of Life care pathway, helping to ensure that they and their carers feel their care is being co-ordinated and provided around their needs.

**Policy link:** *End of Life Care Strategy.*

### Definition

An End of Life care pathway is defined as a pathway with a series of interventions and expectations of care that are evidence based, such as the Gold Standard Framework, the Liverpool Care Pathway and, for children, the Transition Care Pathway.

The *End of Life Care Strategy: Quality markers and measures for end of life care* defines a care plan as:

'A written document jointly agreed by the patient and professional. It is the tangible record of the process of care planning. It should allow a holistic approach to care, empowering individuals to bring all relevant areas of their life to the discussion. It can also help in the audit of service delivery.'

A care plan records the outcome of the care planning discussion between an individual and their healthcare professional. The plan is owned by the individual and may be a written document or something that is recorded in the person's health record. It may be complex or simple, depending on the individual's health and social care needs. If it is a written document, a copy of the care plan should be given to the individual and stored in their medical records. Copies should be available, or at least accessible, to all health and social care professionals providing direct care to the individual, and any other individuals (such as carers) who have been given permission to see the plan.

### Methodology

Numerator:	Patients with a care plan
Denominator:	Patients on an End of Life care pathway
Formula:	Numerator / Denominator x 100
Unit of measure:	Percentage of patients on an End of Life care pathway
Frequency:	Monthly
Source of data:	Local information systems

# End of Life

## Patients on an End of Life care pathway (tcs 29)

### Description

The percentage of patients who died on an End of Life care pathway.

### Rationale

Over the past few years a major drive has been under way to ensure that all patients nearing the end of their life, and their relatives and carers, receive a high standard of care in their final days. This indicator monitors the extent to which good practice in end of life care is being consistently applied to patients who are on a defined End of Life care pathway.

### Definition

An End of Life care pathway is defined as a pathway with a series of interventions and expectations of care that are evidence based, such as the Gold Standard Framework, the Liverpool Care Pathway and, for children, the Transition Care Pathway.

The Liverpool Care Pathway was originally developed for the care of cancer patients in the acute environment, but it is applicable to all care settings and conditions, e.g. chronic obstructive pulmonary disease, heart failure and neurological conditions.

### Methodology

Numerator:	Number of patients who have died on an End of Life care pathway in a specified period
Denominator:	Number of patients who died in a specified period
Formula:	Numerator / Denominator x 100
Unit of measure:	Percentage of patients
Frequency:	Monthly
Source of data:	Local information systems



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# End of Life

## Preferred place of care (tcs 30)

### Description

The percentage of patients on an End of Life care pathway who die in their preferred place of care.

### Rationale

Over the past few years a major drive has been under way to ensure that all dying patients, and their relatives and carers, receive a high standard of care in the last days and hours of their lives. Most people would prefer to die in their own home or preferred place of care. This requires patients and carers to be involved in decision making and planning for the end of the patient's life, and for appropriate community-based support and care to be put in place.

### Definition

An End of Life care pathway is defined as a pathway with a series of interventions and expectations of care that are evidence based, such as the Gold Standard Framework, the Liverpool Care Pathway and, for children, the Transition Care Pathway.

Preferred place of care should be recorded as part of the patient's care plan.

### Methodology

Numerator:	Patients on an End of Life care pathway who die in their preferred place of care
Denominator:	Patients on an End of Life care pathway who have died
Formula:	Numerator / Denominator x 100
Unit of measure:	Percentage of patients who die in their preferred place of care
Frequency:	Monthly
Source of data:	Local information systems



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# General

## Readmissions within 28 days (tcs 31)

### Description

The percentage of patients from an agreed cohort with an unplanned readmission to hospital within 28 days following discharge.

### Rationale

Providing care closer to home and avoiding hospital admissions through effective and personalised services is a core function of community services. This measure challenges the effectiveness of discharge arrangements by focusing on readmission within 28 days of patients referred to community services. It should act as a catalyst for root-cause analysis by frontline services to identify possible interventions that may have prevented the readmission.

### Definition

Readmission and discharge can include those to and from an acute or community hospital. Community hospitals do not have a standard definition and many community providers do not have a community hospital.

**Agreed cohort:** The commissioner and the provider should agree on how to identify patients of whom the community provider can reasonably be expected to have ownership. Possible options to base this on may include a defined range of conditions, identifiable by diagnostic coding, or a caseload of patients referred to the community provider.

**Caseload:** Patients who require active management of their condition, in accordance with a care plan developed with the clinician/service. Active management would entail regular and numerous contacts during a specified period of time.

### Methodology

Numerator:	Patients from an agreed cohort who are readmitted to hospital within 28 days
Denominator:	Patients in agreed cohort
Formula:	$\text{Numerator} / \text{Denominator} \times 100$
Unit of measure:	Percentage of patients in agreed cohort
Frequency:	Monthly
Source of data:	Local information systems



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# General

## Rate of non-elective admissions (tcs 32)

### Description

The rate of non-elective admissions to hospital of people diagnosed within a defined set of conditions.

### Rationale

Providing care closer to home and avoiding hospital admissions through effective and personalised services is a core function of community services.

There are a number of conditions where emergency admissions to hospital can sometimes be avoided through effective and proactive management of the condition in the community. Through enabling primary care trusts (PCTs) to compare their non-elective admission rates with those of other PCTs, it will be possible to identify where their comparative rates of emergency admission are high and therefore where there is potential for more effective management of these conditions in the community.

### Definition

A suggested set of conditions is as follows:

Group	ICD-10 codes
Diabetes complications	E10.0–E10.8, E11.0–E11.8, E12.0–E12.8, E13.0–E13.8, E14.0–E14.8
Nutritional deficiencies	E40–E43, E55.0, E64.3
Iron deficiency anaemia	D50.1–D50.9
Hypertension	I10, I11.9
Congestive heart failure	I11.0, I50, J81
Angina	I20, I24.0, I24.8, I24.9
Chronic obstructive pulmonary disease	J41–J44, J47, (J20)
Asthma	J45, J46

Source: Office for National Statistics Mid Year Population Estimates 2007, directly standardised.

### Methodology

Numerator:	Non-elective admissions
Denominator:	Office for National Statistics Mid Year Population Estimates 2007
Formula:	Numerator / Denominator x 1,000
Unit of measure:	Non-elective admissions per 1,000 population
Frequency:	Monthly
Source of data:	Hospital Episode Statistics Office for National Statistics Mid Year Population Estimates 2007



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# General

## Rate of cancelled appointments (tcs 33)

### Description

The percentage of cancellations by provider services of all outpatient specialties, consultant and non-consultant clinics and allied healthcare professional-led contacts in a contracted month (including home visits).

### Rationale

Cancellations by providers incur waste, are frustrating for patients and delay their access to services. This indicator will enable measurement and benchmarking of cancellation rates across providers and primary care trust areas, provoking enquiry and investigation into the causes and the impact on patient care.

### Definition

The provider cancellation rate of consultant and non-consultant outpatient appointments. Contacts would include home visits.

Cancellations of new and review appointments/contacts should be monitored separately.

### Methodology

Numerator:	Number of cancelled appointments or contacts
Denominator:	Total number of booked appointments or contacts
Formula:	$\text{Numerator} / \text{Denominator} \times 100$
Unit of measure:	Percentage of cancelled appointments or contacts
Frequency:	Monthly
Source of data:	Local information systems



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# General

## Rate of 'did not attends' (tcs 34)

### Description

The percentage of appointments that were 'did not attends' (DNAs) in all outpatient specialties, consultant and non-consultant clinics and allied healthcare professional-led contacts in a contracted month (including home visits).

### Rationale

Reducing the number of patients who do not attend appointments potentially enables better use to be made of capacity, improving access for patients overall and improving the efficiency of services. DNAs can be reduced through better communication with patients.

High levels of DNAs can indicate where a service or clinic may be, or is perceived to be, difficult to access. Analysis of DNAs may highlight a higher prevalence in disadvantaged groups in the community, providing a focus for targeted action to address inequalities.

### Definition

The DNA rate of consultant and non-consultant outpatient appointments, and contacts by provider.

A DNA for a contact or home visit would be when the patient is not present at the agreed time.

### Methodology

Numerator:	Number of DNAs
Denominator:	Number of booked appointments or contacts
Formula:	Numerator / Denominator x 100
Unit of measure:	Percentage of DNAs
Frequency:	Monthly
Source of data:	Local information systems



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# General

## Home equipment delivery (tcs 35)

### Description

The percentage of completed referrals for home equipment within seven days.

For wheelchairs:

- 95% of chairs should be provided within eight weeks of referral to service.
- The remaining 5% should be delivered within 18 weeks.
- Simple chairs (no modifications or adaptations) should be delivered on the day of assessment or within five working days.
- Exceptions must be reported with performance data.

For wheelchair repairs:

- Urgently required repairs (where the chair is unusable) should be provided on the same day at the location of the wheelchair user.
- Non-urgent repairs (where the chair is damaged but still safely usable) should be repaired within a maximum of 72 hours.

### Rationale

The timely provision of equipment is important to help people to improve their mobility or perform tasks in their daily living environment. This ensures ongoing independence and wellbeing, so reducing dependence on other health and social care services.

Services may want to consider a shorter standard for patients with urgent needs, for example those on an End of Life care pathway or those with rapidly progressive conditions.

The Transforming Community Equipment Services programme is developing a new model of provision that anticipates a shift to delivery by the voluntary sector and private retailers for many of the commonly required aids.

*continued*

## Home equipment delivery (continued)

### Definition

**Referral:** Request for equipment, which may include more than one item. For wheelchairs: Referral to the wheelchair service.

**Referral start:** The date that assessment is made for equipment. For wheelchairs: The date that referral is made to the wheelchair service.

**Completed referral:** The date that all equipment identified on referral is delivered (including wheelchairs).

**Measurement:** The number of days from the referral being received by the service to the date that home equipment is delivered to the patient.

### Methodology

Numerator:	Number of referrals completed within seven days
Denominator:	Number of referrals made
Formula:	$\text{Numerator} / \text{Denominator} \times 100$
Unit of measure:	Percentage of referrals for home equipment
Frequency:	Monthly
Source of data:	Local information systems



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# General

## Referral to treatment waiting time (tcs 36)

### Description

The percentage of patients whose referral to treatment time is within a locally agreed standard, where they are defined.

### Rationale

This indicator enables the consistent measurement of waiting times for patients accessing community services. Where long waiting times exist, service improvement can be initiated to reduce waiting time, improve access to services and improve patient experience.

### Definition

Referral to treatment waiting time is the length of time from the date that a referral is received by the service until the date that the first definitive treatment is provided.

The definitions to be used should be drawn from the *Allied Health Professional Referral to Treatment Guide*.

### Methodology

Numerator:	Number of first definitive treatments provided
Denominator:	Number of patients on waiting list
Formula:	Numerator / Denominator x 100
Unit of measure:	Percentage of first definitive treatments provided
Frequency:	Monthly
Source of data:	Local information systems



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# General

## Percentage of patients offered a time band for a visit (tcs 37)

### Description

Where care is being delivered in the patient's home, the percentage of patients offered a time band for a visit.

### Rationale

Where care is being delivered in the patient's home, the time of the professional's visit should respect the patient's convenience as much as the convenience of the service.

Patients should be offered choice in when they see health professionals as part of the personalisation of services agenda. Increasing the availability of appointments to suit individual choice is an important principle of delivering a quality service and has the potential to reduce waste in terms of cancelled visits.

Good practice would be to agree with the patient a convenient time band for each visit.

### Definition

This indicator would not apply in outpatient or clinic-based services or in hospital settings.

An example of a time band could be within a two-hour timeframe, but this should be agreed locally.

### Methodology

Numerator:	Number of patients offered a time band
Denominator:	Total number of visits booked for given service
Formula:	Numerator / Denominator x 100
Unit of measure:	Percentage of visits
Frequency:	Monthly
Source of data:	Patient satisfaction surveys Local information systems



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# General

## Percentage of patients offered a choice of appointment time (tcs 38)

### Description

The percentage of appointments booked where the patient has been offered a choice of appointment time.

### Rationale

The Choose and Book service has given patients the opportunity to book the appointment time of their choice for new hospital appointments.

Many services have chosen to broaden the offer of booking services not normally required in the Choose and Book service. Choice of appointment time provides a more personalised and responsive service, an important component of quality.

Ensuring that the patient is seen by a health professional, at a time convenient to them, has the potential to reduce waste in terms of cancelled appointments and 'did not attends'.

### Definition

Choice of appointment should include:

- date of appointment
- time of appointment
- place to attend for appointment.

Community service providers may be able to take advantage of the Choose and Book IT system when offering a choice of appointment time.

### Methodology

Numerator:	Number of appointments booked for a given service where the patient has been offered a choice of appointment time
Denominator:	Total number of appointments booked for given service
Formula:	Numerator / Denominator x 100
Unit of measure:	Percentage of appointments
Frequency:	Monthly
Source of data:	Patient satisfaction surveys Existing booking systems for outpatient appointments Local information systems



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# General

## Percentage of staff reporting positive job satisfaction (tcs 39)

### Description

The percentage of staff reporting positive job satisfaction (based on the NHS Staff Survey scores-based measure of job satisfaction).

### Rationale

Improving staff satisfaction is fundamental to the delivery of high quality community services. Run by the Care Quality Commission, the NHS Staff Survey has been carried out annually since 2003, and changes in the reported levels of NHS staff job satisfaction can be compared year on year from this time.

A more satisfied workforce is likely to be more sustainable and to provide better patient care, with motivated and involved staff being better placed to know what is working well and how to improve services for the benefit of patients and the public.

Analysis by age, gender and ethnic group can point to underlying trends, which should be reviewed as a guard against discrimination.

### Definition

A specific section of the NHS Staff Survey focuses on job satisfaction with eight criteria, which are rated on a five-point scale ranging from 'Very satisfied' to 'Very dissatisfied':

How satisfied are you with each of the following aspects of your job?

- a. The recognition I get for good work.
- b. The support I get from my immediate manager.
- c. The freedom I have to choose my own method of working.
- d. The support I get from my work colleagues.
- e. The amount of responsibility I am given.
- f. The opportunities I have to use my skills.
- g. The extent to which my Trust values my work.
- h. My level of pay.

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## Percentage of staff reporting positive job satisfaction (continued)

### Methodology

Numerator:	Number of respondents reporting 'Very satisfied' or 'Satisfied'
Denominator:	Total number of respondents
Formula:	Numerator / Denominator x 100
Unit of measure:	Percentage of respondents
Frequency:	Annually
Source of data:	NHS Staff Survey



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## Serious Untoward Incidents (tcs 40)

### Description

The number of reported Serious Untoward Incidents (SUIs) where the action plan has not yet been finalised and agreed as per local policy.

### Rationale

SUIs should be investigated promptly and, where necessary, an action plan developed in response to the findings. Action plans should be formally approved through governance mechanisms in accordance with local policy.

Boards should be regularly informed of the number of SUIs and their status.

### Definition

A SUI should be defined in accordance with local policy that has been assessed as being compliant with the NHS Litigation Authority standards or by the local strategic health authority.

Timescales for investigation and response should be agreed with local commissioners and strategic health authorities.

### Methodology

Numerator:	The number of SUIs where investigation is not complete and an associated action plan not approved in accordance with local policy
Denominator:	Total number of SUIs reported to date (contract year)
Formula:	Numerator / Denominator (present as a ratio, not as a percentage)
Unit of measure:	Number of SUIs
Frequency:	Monthly
Source of data:	Local information systems



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## Discharge letters issued according to national guideline standards (tcs 41)

### Description

The percentage of discharge letters issued in accordance with national guideline standards, containing appropriate details on diagnosis, medication and investigations, within 24 hours of a patient's discharge.

### Rationale

Where community provider services are discharging patients, they should comply with the discharge and patient transfer protocols. The NHS Standard Contract for Community Services contains the requirement that, from 1 April 2010, providers must issue a Discharge Summary to the referrer and the patient within 24 hours of a patient's discharge.

### Definition

**Discharge Summary:** A summary of information relevant to each patient discharged. It should be understandable and meaningful to the patient, containing the following information as a minimum:

1. The date of the patient's admission to the provider.
2. The date of the patient's discharge by the provider.
3. Details of any services provided to the patient, including any operation(s) and diagnostic procedures performed and their outcomes.
4. A summary of the key diagnosis made during the patient's admission.
5. Details of any medication prescribed at the time of the patient's discharge.
6. Any adverse reactions or allergies to medications or treatments observed in the patient during admission.
7. The name of the responsible clinician at the time of the patient's discharge.
8. Any immediate post-discharge requirements from the primary healthcare team.
9. Any planned follow-up arrangements.
10. Whether the patient has any relevant infection, for example MRSA.
11. The name and position of the person to whom questions about the content of the Discharge Summary may be addressed, and complete and accurate contact details (including a telephone number) for that person.

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## Discharge letters issued according to national guideline standards (continued)

### Methodology

Numerator:	Total number of compliant Discharge Summaries issued within the specified period
Denominator:	Number of discharges made
Formula:	$\text{Numerator} / \text{Denominator} \times 100$
Unit of measure:	Percentage of discharges
Frequency:	Monthly
Source of data:	Local information systems



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## 'Safeguarding Adults' training (tcs 42)

### Description

The percentage of eligible staff who have completed mandatory training in adult protection in the last 12 months.

### Rationale

Mandatory training underpins the safety of both patients and staff. All community service providers should have clear and focused mandatory training plans that make explicit what training and skill development are required by their workforce, both currently and for the future modernisation of roles. These training plans should focus on supporting provision of strategic business objectives through the delivery of safe and high quality care.

### Definition

Mandatory training is described as training that the organisation deems necessary in order for staff to undertake their work in a safe and effective manner.

It is recognised that any training undertaken needs to be reinforced by practical experience in order to develop a competent skill base.

### Methodology

Numerator:	Number of eligible staff who have received mandatory adult protection training (as per local training policy) in the last 12 months
Denominator:	Total number of eligible staff
Formula:	Numerator / Denominator x 100, expressed on a rolling 12-month basis
Unit of measure:	Percentage of eligible staff
Frequency:	Quarterly
Source of data:	Local information systems



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# General

## Infection control training (tcs 43)

### Description

The percentage of eligible staff who have completed mandatory training in infection control in the last 12 months.

### Rationale

Mandatory training underpins the safety of both patients and staff. All community service providers should have clear and focused mandatory training plans that make explicit what training and skill development are required by their workforce, both currently and for the future modernisation of roles. These training plans should focus on supporting provision of strategic business objectives through the delivery of safe and high quality care.

### Definition

Mandatory training is described as training that the organisation deems necessary in order for staff to undertake their work in a safe and effective manner.

It is recognised that any training undertaken needs to be reinforced by practical experience in order to develop a competent skill base.

### Methodology

Numerator:	Number of eligible staff who have received mandatory infection control training (as per local training policy) in the last 12 months
Denominator:	Total number of eligible staff
Formula:	Numerator / Denominator x 100, expressed on a rolling 12-month basis
Unit of measure:	Percentage of eligible staff
Frequency:	Quarterly
Source of data:	Local information systems



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