Welcome to Knowledge Matters

By Samantha Riley

In this issue, Bumper takes on new meaning – there is so much to tell you about that (along with the help of others) this fun but informative issue is 16 pages!

I am delighted to announce that NHS South East Coast and the Information for Health and Social Care will be hosting the third Analytical Fair on 14th July. This event will take place in London and will focus on World Class Commissioning. For further details see page 10. I would encourage as many of you as possible to attend – this is a great opportunity to learn about nationally available tools and leading edge work which is going on across the country to support effective commissioning.

I am currently in the process of developing a new structure for the team here at the SHA which will include two additional analysts. Well aware of the issues experienced by the local NHS when trying to recruit analysts, I adapted the person specification slightly by making NHS experience desirable rather than essential. In addition, I also modified the advertisement to appeal to non-NHS applicants. We had 16 applications, very few of whom has NHS experience. Nine candidates were shortlisted and I am pleased to announce that two successful appointments were made – both candidates with the skills and qualities to do the job, but without the NHS experience that we generally require. One candidate that we interviewed commented that he has wanted to work for the NHS for years, but every single person specification that he has seen (apart from mine) required 3 years experience working in the NHS – a real chicken and egg situation.

There have been a number of enhancements to the website since the last issue. There is a new Jargon Buster section which has been developed as a result of feedback regarding the amount of jargon we use in the NHS. Currently over 330 acronyms and other terms are contained in the database, a small number have descriptions attached to them – please help us out by filling in the gaps for your specialist areas. The team has developed an impressive system to enable the forthcoming privacy and dignity assessment to be undertaken on line. A user guide for this system is in development. A next key task is to develop online dashboards driven by a data warehouse.

A few last things to mention before I go….I would like to welcome Romilly Hibling who joined us recently for a three month placement (see more on page 7), for those of you working for PCTs the data pack developed by McKinsey’s has now been published and is available on-line for download. Please contact your Directors of Commissioning to obtain details of website addresses and log on details. Finally, I would encourage as many analysts as possible to sign up for the Data Dictionary and Model Taster Day being held on 15th July - these national events are extremely popular and always oversubscribed.

See you again in August!

Fascinating Fact

In our 2007 Christmas quiz we asked which members of our team went to Southampton University. 45% were right that Kiran went there, and 38% knew Kate went there too. However Rebecca and Andrew were also alumni of this institution and only 17% and 10% respectively worked this out!
Congratulations to…..

Clinical Coders at East Kent Hospitals Trust who have recently won the prestigious Data Quality (England) award from CHKS.

The award recognises excellence in clinical coding which plays an essential role in improving the quality of care provided to patients. This award is a great achievement and an endorsement of the critically important work that coders undertake. At East Kent Hospitals in the past year around 127,000 procedures have been coded, that’s nearly 350 for every day of the year. Accurate coding ensures that the Trust gets paid for the work that it undertakes and is of course critical to ensuring that patients receive the best quality of care.

James Coles, Director Research, CHKS, comments on the award: “This is a great achievement for East Kent Hospitals Trust. While often seen as an administrative burden, complete and accurate clinical coding is an essential part of delivering high quality care. We are delighted to recognise the commitment of staff and the important contribution they make to improving patient outcomes.”

Robin Gammon, Deputy Director of Information, at East Kent Hospitals explains a bit more about the approach to coding at the Trust:

“This award has proven that the hard work that is undertaken by our coders is now recognised. In the past, they were the unsung heroes but have now come to the forefront in generating income for Trusts with the quality of their data capture. In order to support this vital function clinical coding staff need to be sufficiently trained and supported by their Trust. Here at East Kent Hospitals NHS Trust, we have started to put in place a structure to enable coders to undertake Foundation Training and Refresher training so they are kept abreast of changes in clinical coding.

We are committed to realising the full potential of our staff and encouraging coders to sit for the recognised clinical coding qualification: Accredited Clinical Coder. The first person in the Trust to acquire this qualification is Terri Hancock, Clinical Coding Supervisor at the Kent and Canterbury Hospital. She now hopes to carry this forward to become a qualified trainer and auditor”.

Terri Hancock, explains what the award has meant for the team:

“We were really surprised to be nominated for the award as we had not heard anything before the nominations were announced. Our Clinical Director went up to London not knowing that he may come back with something so it was a complete surprise to him to be asked to accept the award.

We feel we have come a long way as the staffing levels over the last two years have been lower than we would like. It really gives us a boost that despite this, we have managed to keep the quality of our data to a good standard. We knew all along we were good and this just proves it.

Everyone around the sites has now heard of our fame and we are hoping we get put forward for a Trust award.”

Congratulations and well done to the whole team!

Clinical coders at KCH
Clinical coders at QEQM
Clinical coders at WHH
Hi everyone

Now that Andrew has retired, I will be hosting coding corner. Having worked with NHS data for many years and having previously worked in an acute Trust, I am well aware of the critical role that clinical coders play in the provision of high quality care for services. The publication of the NHS Operating Framework for 2008/9 brings additional focus on the requirement for timely data which is accurately coded. ‘What's Adam talking about now?’ some of you may be asking - if you are, you need to turn to page 4.

If providers are required ‘to deliver initially coded datasets weekly to support achievement of the 18-week target, and comprehensively coded datasets monthly’ - what's the impact on clinical coding staff? Although I’m not an expert, I would imagine that a key impact is the requirement to have enough clinical coders who are adequately trained.

So, how much training is required to become a coder? Well, my investigations have shown that a significant amount of training is required indeed. The NHS Classifications Service develop and issue the national coding training resource materials that ensure clinical coders in the NHS are trained to a required standard that delivers accurate data quality. This ensures clinical coding training is consistently delivered across the NHS using the same source materials so giving confidence that the quality of coded clinical data is also consistent.

To start with, there is the Clinical Coding Foundation Course. The course aims to provide the novice coder with a thorough grounding in the theory of classifications as well as opportunities to develop practical skills in clinical coding. The course runs over 18 days and costs £3004. In addition, each delegate must supply their own reference books for use during the course. After the foundation course, coders are continually supported and trained by their Managers for at least another year in order to gain competency across many specialties. This means that it is often two years before many coders are up to the required level of expertise. In addition to this there are a wide range of courses - refresher courses, train the trainer courses, specialist coding courses and clinical coding audit workshops to name a few. Attendance at these training sessions is critical if clinical coders are to maintain the highest standards of coding as recently proven by East Kent Hospitals.

Once staff are trained, Trusts need to keep up the investment in staff as DH programmes such as PbR and 18 weeks put further pressure on coders to increase complexity and accuracy in their work. This will only increase as version 4 of HRGs is introduced as this entails coding to be done in much finer detail than ever before.

For more information on this area, a good starting place is the training and accreditation section of the NHS Classifications Service website http://www.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/trainingaccred

Along with details of training courses, there are a range of e-learning materials along with a range of Clinical Codings Toolboxes with training materials, newsletters, links to other useful websites and a wealth of other useful information such as how to log a query with the Clinical Coding Helpdesk. If you are interested in the area of coding, I would encourage you to have a look at this site.

One final thought - do commissioners have adequate knowledge and understanding of the Clinical Coding function and its relationship with Healthcare Resource Groups (HRGs)? The NHS Classifications Service is now running local workshops across the country aimed at commissioners and helping them understand this area. We are in the process of finalising a workshop for NHS South East Coast for later in the year (likely to be October or November).

If you would like further details, please do keep an eye on our website or get in touch with me.

If there is a particular topic you would like me to focus on next time, please do let me know.

Is there something that you wish you knew more about? To suggest future topics for knowledge matters contact the team
The NHS Operating Framework 2008/9
By Samantha Riley

How many of you are aware that Information is named as one of the key enabling strategies within the Department of Health Operating Framework for 2008/9, Section 3.35 on page 35 of the document describes key priorities and expectations related to information. The relevant section on information reads as follows: -

• From April 2008, we expect providers to deliver initially coded datasets weekly to support achievement of the 18-week target, and comprehensively coded datasets monthly. These are expected to be through the Secondary Uses Service (SUS), as soon as each provider can make the necessary technical changes. This is in preparation for April 2009, when the NHS should use SUS as the standard repository for activity for performance monitoring, reconciliation and payments;
• From April 2008, the data warehouse fed from the Electronic Staff Record will increasingly be used for strategic workforce planning and monitoring purposes. Trusts should focus on workforce data quality;
• Formal data-quality audits will be developed and introduced, possibly by the Audit Commission, in the same way as for financial accounts. We are discussing the way forward for foundation trusts with Monitor;
• All NHS organisations will need to focus on the capture, coding and submission process to ensure that data used via data warehouses is as reliable as the data currently used and manually returned to the Department. This focus on quality will be offset by reduced information requests to trusts as data warehouses are use;
• Trusts should continue to ensure that patient identifiable data is safeguarded, and there should be rigorous processes, administration and technology controls to ensure that it is used appropriately.

How equipped is your organisation to deliver on these priorities? Do you have concerns about some of these requirements?

An area which I know many of you have concerns about is SUS. For some time now, a local group (previously the SUS user group and recently renamed as the South East Coast Data Flows and Standards Group) has met to consider the implications of the move to SUS, share local knowledge and agree the best approach to solve problems. There is also now a national SUS User Group which has met on a number of occasions. We have two South East Coast representatives on the national group whose role it is to both raise awareness of local issues and communicate national developments locally. The next meeting of the South East Coast Data Flows and Standards Group is on 9th July between 2pm and 4pm at York House in Horley. If you are interested in attending, please contact me directly (samantha.riley@southeastcoast.nhs.uk). All papers from both the National and local groups are available to download from our website once you are registered as a user (www.sec.nhs.uk/knowledge)

Free Data Model and Dictionary event 15th July 2008

The NHS Data Model and Dictionary Service will be holding an open day for NHS South East Coast to discuss the latest developments and proposed changes to the NHS Data Model and Dictionary. This is a fantastic opportunity for NHS staff and Service Providers to raise ideas and any concerns they have for the NHS Data Model and Dictionary and proposed changes. The event will be taking place on: -

Tuesday 15th July 2008 at K2 Leisure Centre, Crawley 9.30am - 3pm

Topics covered will include:

• NHS Data Model and Dictionary Service Products;
• How to navigate the NHS Data Model and Dictionary;
• Commissioning Data Set Version 6;
• Measuring 18 weeks;
• Secondary Uses Service 18 Week Processing and Reporting;

Registration is via the Connecting for Health events website link http://etdevents.connectingforhealth.nhs.uk/1774 If you experience any problems with booking, please contact Samantha Riley (Samantha.riley@southeastcoast.nhs.uk)
A3: ASK AN ANALYST

If you have a question for the team please e-mail: Knowledge.management@southeastcoast.nhs.uk

Q - In the recent trajectory setting for the Vital Signs C-Diff lines, the number of cases reported at each Trust was apportioned out between acute and community to arrive at an acute baseline. I can't understand how the apportioning was carried out - can you please help?

A - I’m indebted to Rifat Soyfoo from the Health Protection Agency (HPA) who has shared the following methodology with us.

The data set used to set the baseline was taken directly from the HPA HCAI data capture system.

1. Was patient admitted?

Identify admitted patients from the Patient Category field, as shown below:

<table>
<thead>
<tr>
<th>Patient category</th>
<th>Classify as:</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN_PAT, DAY_PAT, EMERG_ASSES</td>
<td>Admitted</td>
<td>Go to step 3</td>
</tr>
<tr>
<td>OUT_PAT, REG_ATT, A&amp;E_ONLY, OTHER</td>
<td>Not admitted</td>
<td>Record not allocated to trust</td>
</tr>
<tr>
<td>Missing</td>
<td>Missing</td>
<td>Go to step 2</td>
</tr>
</tbody>
</table>

2. Missing Patient Category

If Patient category is missing, regard patient as admitted if the sample was taken in an acute trust:

<table>
<thead>
<tr>
<th>SpecimenLocation</th>
<th>Classify as:</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC_TRUST</td>
<td>Admitted</td>
<td>Go to step 3</td>
</tr>
<tr>
<td>Anything else</td>
<td>Not admitted</td>
<td>Record not allocated to trust</td>
</tr>
</tbody>
</table>

3. For patients known or assumed to have been admitted, is the admission date present?

<table>
<thead>
<tr>
<th>Admission date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present</td>
<td>Go to step 4</td>
</tr>
<tr>
<td>Missing</td>
<td>Allocate to trust</td>
</tr>
</tbody>
</table>

4. Was sample taken within 2 days of admission?

<table>
<thead>
<tr>
<th>Within 2 days of admission?</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes (DateSpecimen - DateAdmitted &lt; 2)</td>
<td>Record not allocated to trust</td>
</tr>
<tr>
<td>No (DateSpecimen - DateAdmitted &gt;= 2)</td>
<td>Allocate to trust</td>
</tr>
</tbody>
</table>

The website of the Health Protection Agency is to here: http://www.hpa.org.uk/

If you have any other queries related to C-diff or MRSA, please get in touch with me and I’ll do my best to help!

Adam Cook

Is there something that you wish you knew more about? To suggest future topics for knowledge matters contact the team
Skills Builder: Chi Squared Distributions....

So far, our skills builder articles focused on statistics have been looking at normal distributions, confidence intervals and other concepts that are applicable largely to certain types of data - namely interval or ratio data, which is measured on a continuous scale, such as height, weight, IQ etc.

However, much NHS data, and certainly a lot of medical research data, is more likely to consist of nominal or ordinal data, which isn’t measured continuously and cannot be subjected to mathematical calculation. For example, we can’t say that amongst the Knowledge Management team the average favourite colour is purple with a standard deviation of blue. We need a different approach if we want to look at differences between populations or groups. A range of statistical tests called nonparametric tests are available for just this purpose and the most commonly employed is called Chi-squared ($\chi^2$).

$$\chi^2 = \Sigma (O - E)^2 / E \quad \text{where } O = \text{observed, } E = \text{expected}$$

In deference to the author’s recent status, the following example (taken from Norman & Streiner, 2003) concerns the association between complications in pregnancy and exposure to VDUs (yes, hi everyone! It’s Kate here! I’m back from maternity leave soon and clearly still contributing to Knowledge Matters!)

In this example, the independent variable is exposure to VDUs and the dependent variable is complications in pregnancy, and our data can be displayed in a 2 x 2 table, as in table 1.

<table>
<thead>
<tr>
<th>VDU exposure</th>
<th>Complications in pregnancy</th>
<th>Normal pregnancy</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>60</td>
<td>50</td>
<td>110</td>
</tr>
<tr>
<td>No</td>
<td>40</td>
<td>150</td>
<td>190</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>200</td>
<td>300</td>
</tr>
</tbody>
</table>

The essence of Chi-square, as indicated by the formula, is to compare what we expect (based on chance) with what we actually observe. So, if there is no effect of VDU exposure on pregnancy, we would expect the proportion of mothers with exposure to VDU to be the same in both the ‘complications’ and ‘normal’ groups. We can make a good estimate of this proportion by taking the total number of exposed (110) and divide by the total number of mothers (300), giving us a proportion of 36.7%. By applying this proportion to each group we end up with an expected number of exposures of 36.7 in the complicated group, and 73.3 in the normal group. Applying the same method, we can calculate the expected values for the non-exposed group as 63.3 for the complicated group, and 126.6 for the normal group.

Just by looking at these expected values we can see that there is a big difference from what has actually been recorded. We can now put all these expected and observed values into the formula to create what is called the chi-squared statistic. The larger this number is, the more figures in the table differ from what we would expect if there were no association between the two variables. In this example, the overall calculation would look like this:

$$36.7^2 + 73.3^2 + 63.3^2 + 126.7^2 = 35.17$$
A statistic of 35.17 is quite high. We can use a table from a ‘big bumper book of stats’ to see if this is statistically significant (which it is, to the 99% level), although this won’t tell us the direction of the association (ie does VDU exposure increase or decrease incidence of complications?). By looking at the observed and expected values we can see that exposure to VDUs appears to increase the incidence of complications, as we have a higher than expected number in the exposed/complications cell in the table, and a lower than expected number in the exposed/normal cell, potentially causing thousands of mothers to pick up the phone to their lawyers (not recommended, this data is made up!).

<table>
<thead>
<tr>
<th>Degrees of Freedom</th>
<th>0.25</th>
<th>0.2</th>
<th>0.15</th>
<th>0.1</th>
<th>0.05</th>
<th>0.025</th>
<th>0.02</th>
<th>0.01</th>
<th>0.005</th>
<th>0.0025</th>
<th>0.001</th>
<th>0.0005</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.32</td>
<td>1.64</td>
<td>2.07</td>
<td>2.71</td>
<td>3.84</td>
<td>5.02</td>
<td>5.41</td>
<td>6.63</td>
<td>7.88</td>
<td>9.14</td>
<td>10.83</td>
<td>12.12</td>
</tr>
<tr>
<td>2</td>
<td>2.77</td>
<td>3.22</td>
<td>3.79</td>
<td>4.61</td>
<td>5.99</td>
<td>7.38</td>
<td>7.82</td>
<td>9.21</td>
<td>10.6</td>
<td>11.98</td>
<td>13.82</td>
<td>15.2</td>
</tr>
<tr>
<td>3</td>
<td>4.11</td>
<td>4.64</td>
<td>5.32</td>
<td>6.25</td>
<td>7.81</td>
<td>9.35</td>
<td>9.84</td>
<td>11.34</td>
<td>12.84</td>
<td>14.32</td>
<td>16.27</td>
<td>17.73</td>
</tr>
<tr>
<td>6</td>
<td>7.84</td>
<td>8.56</td>
<td>9.45</td>
<td>10.64</td>
<td>12.53</td>
<td>14.45</td>
<td>15.03</td>
<td>16.81</td>
<td>18.55</td>
<td>20.25</td>
<td>22.46</td>
<td>24.1</td>
</tr>
<tr>
<td>7</td>
<td>9.04</td>
<td>9.8</td>
<td>10.75</td>
<td>12.02</td>
<td>14.07</td>
<td>16.01</td>
<td>16.62</td>
<td>18.48</td>
<td>20.28</td>
<td>22.04</td>
<td>24.32</td>
<td>26.02</td>
</tr>
<tr>
<td>8</td>
<td>10.22</td>
<td>11.03</td>
<td>12.03</td>
<td>13.36</td>
<td>15.51</td>
<td>17.53</td>
<td>18.17</td>
<td>20.09</td>
<td>21.95</td>
<td>23.77</td>
<td>26.12</td>
<td>27.87</td>
</tr>
</tbody>
</table>

Chi-square does have limitations, the most notable of which is that it will not work if any cell in the table has a small number in it, conventionally 5 or less. There are alternatives in the form of Fisher’s exact test or the binomial test. In addition to this, it is worth noting that Chi-square treats all variables as nominal variables, which means if you have ordinal data (that is a categorical variable with some semblance of order such as pain rating, stage of disease etc.) you could be excluding important information. Non-parametric tests such as Mann-Whitney U or Kruskal Wallis can be used in this instance.


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**Welcome to ……**

Romilly Hibling who is a 2nd year Undergraduate studying Information Studies at Sheffield University.

Romilly joined the team on 23rd June and will be spending three months with the SHA Knowledge Management Team.

“I was so excited to be considered for this work placement as it ties in so nicely with my choice of degree at Sheffield University. I am very keen to see how my studies of knowledge management actually apply in ‘the real world’ and in such an interesting area of the NHS. I very much look forward to my three months here with the SEC Knowledge Management Team and I know that the skills I learn and the understanding I gain will be invaluable!”

Romilly will be supporting the team in a range of activities and in particular supporting arrangements for the forthcoming analytical fair - she looks forward to meeting as many of you as possible on the day!

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**...and congratulations to**

Mehmet Bakkaloglu and Nia Naibheman who have recently been appointed as Performance Analysts within the Knowledge Management Team.

Nia is an Economics graduate with knowledge of econometrics. Mehmet has a wealth of database experience (he is a qualified IBM database administrator) and recently returned from spending two years with the VSO (Voluntary Services Organisation) in Ghana and Ethiopia supporting the implementation of databases and production of analyses.

We hope that Nia and Mehmet will join the team in July. Primarily they will be supporting Rebecca with the the monitoring of performance (including Vital Signs), providing analysis to support priority programmes and of course future planning process.

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Is there something that you wish you knew more about? To suggest future topics for knowledge matters contact the team.
What's in Andrew's favourites?

Top Tips from the SHA’s ex- Business Intelligence and Information Advisor

Hello! I bet you thought that you had seen the back of me. Well, luckily I had so many useful websites in my favourites that I’m likely to be around for a few issues yet. If you’re interested in knowing about my experience post NHS, do turn to the back page… This issue I’m sharing my favourites related to Finance and Public Health Information resources for the NHS and Social Care - I hope you find them useful!

Index of Multiple Deprivation

http://www.communities.gov.uk/archived/publications/communities/indicesdeprivation

Free downloadable version of The English Indices of Deprivation 2004: Summary (revised)
“The new Index of Multiple Deprivation 2004 (IMD 2004) is a Super Output Area (SOA) level measure of multiple deprivation and is made up of seven SOA level Domain Indices.”

Community Care Service Statistics


A veritable cornucopia of information from the covering a wide range of historical community activity including ambulance services, chiropody services, Occupational Therapy, and much, much more!

Population Statistics


“2006-based long term Subnational population Projections for England (SNPP) were published on 12 June 2008. They give an indication of future trends in population for the period 2006-2031.”

Resource Allocation Papers -

http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Allocations/DH_4108515

“Catalogue of the major research papers (RARPs) and working papers (RAWPs) commissioned by ACRA and its predecessor body.”
Papers covering a variety of resource allocation issues such as Market Forces Factor, Prescribing Allocations, NHS Needs Formula, etc.

Programme Budgetting

http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/index.htm

“The Programme Budgetting project provides a retrospective appraisal of NHS resources broken down into ‘programmes’, with a view to influencing and tracking future expenditure in those same programmes to achieve the greatest health improvement per £ spent in the NHS.”

I also highly recommend the first annual population value review which was undertaken in 2007 by the NHS Knowledge Service - this really does explain to commissioners how to fully utilise programme budget information to inform optimal levels of spending for their local population

http://www.nks.nhs.uk/annualpopulation.ASP
Workforce Profiling – Equality and Diversity?

Kiran Cheema, Workforce Analyst

In the last issue we announced the release of the South East Coast workforce profiling tool. The tool contains three groups of measures related to age, gender, disability, ethnicity and pay scales.

This issue we thought it might be useful to have a look at how we might be able to use some of this information to answer a few age old questions around equality and diversity.

Q: Does the Ethnic mix within the workforce represent that of the population it serves?

It has been suggested that the ethnic mix of the workforce should be representative of the population it serves. Anecdotal evidence has suggested that the workforce is not representative of the local population with minorities being under represented. So can we assess if there is truth in this?

Well the first thing to do would be to find out what the population across the South East Coast looks like. Using ONS Census information (mid 2005 Population estimates) we can create a representation of this (figure 1), From this we can see that the largest ethnic group in the local population is “White” making up approx 94% while the other ethnic groups make up 6% of the population. Of this 6%, the 2 largest groups are those categorised as “other” and “Indian” making up approx 4% of the population.

Now let’s take a look at the workforce using information contained within the ESR DW (data warehouse). When we look at the Staff Employed within SEC Organisations (all staff groups/Sept 2007) we can see a slightly different pattern emerging. In the workforce information there are two things of note: the first is that there are a number of not givens (approx 9%) and the second is that while the largest ethnic group is also recorded as “White” this makes up between 77-86% of the workforce with the other ethnic groups making up 14-23%. Of these the 2 largest groups are those categorised as “other” (7%) and “Indian” (4%). Within the Groups we can also identify that the “White” Group has the largest gender variance with under 20% of this group being male in the other groups the gender split is roughly 50/50.

So in answer to our question, we can see that the workforce is not representative of the local population, there is actually an over representation of minority groups when compared with the population being served and an under representation males within the “white” group. This may be the result of historical overseas recruitment processes or possibly the due to differences in culture or opinions of NHS Careers in different groups and genders.

However we are looking at the whole workforce. This pattern may not be repeated in all staff groups or in individual organisations or geographical areas, with further investigations needed to highlight variances between different staff groups or job roles.

Next time … Evidencing a Glass Ceiling? Is it possible and what metrics and measures are available?
World Class Commissioning Analytical Fair 14th July

On the 14th of July at the New Connaught Rooms, London, another of the regular series of Analytical Fairs will take place - this time the focus will be World Class Commissioning. The vision of ‘Adding years to life and life to years’ will only be achieved if commissioners have world class information and knowledge and knowledge management is one of the key competencies.

This FREE event will offer a real opportunity for commissioners of NHS funded care to share their successes, experiences and challenges related to using data and information to inform decision making and achieve world class commissioning.

What else does this event have to offer?

- An insight into the latest thinking and national policy in world class commissioning;
- To give a greater understanding of how clinicians engage with world class commissioning;
- To learn how the competencies needed for world class commissioning are supported by world class information and knowledge management tools;
- And to share examples of local work and to discuss this with colleagues from other parts of the country in the ‘modelling marketplace’ - one aspect of previous events which delegates have found of great value.

Contributors to the day include:

- Mark Britnall, Director General of Commissioning and System Management, Department of Health;
- Professor Sir Bruce Keogh, Medical Director and Interim IT Director General, Department of Health;
- Candy Morris, Chief Executive, NHS South East Coast;
- Sandra Hills, Director of Commissioning, The NHS Information Centre;
- Robert Lake, Director of Social Care, The NHS Information Centre;
- A range of speakers from the local NHS across the country.

In addition to formal presentations, there will be a wide range of exhibitors at the Modelling Marketplace - a great chance for you to network with colleagues from across the country and see demonstrations of a wide range of tools and models.

How to book?

There are two ways to book your free place at this free event:
Call on 0845 300 6016
Or e-mail to enquiries@ic.nhs.uk

There are still places available at this FREE event - so get registering now!

Hope to see you there!
Making Links – Healthcare Commission

Chris Mason (Delivery lead) & Emma Steel (Development lead), Indicators and Measurement team

The Healthcare Commission exists to promote improvements in the quality of healthcare and public health in England and Wales. Our task is to inspect, inform and improve. We achieve this through the following:

- Assessing the performance of the NHS using standards set out by the Department of Health and the best available evidence
- Registering and inspecting individuals and organisations that provide independent healthcare services
- Publishing an annual report on the state of healthcare in England and Wales, which we present to Parliament
- Providing the best possible information on the performance of healthcare organisations so that they can make informed decisions about their healthcare
- Informing patients, carers, the public, providers of healthcare and the Government about the standard and quality of healthcare services
- Assessing the performance of providers of healthcare by reference to standards which promote improvement
- Carrying out independent reviews of complaints
- Carrying out investigations into allegations of serious service failings, particularly when there are concerns for the safety of patients

The annual health check is how we deliver our statutory duty of producing an annual rating for each NHS trust in England. It is one of our highest profile products and covers a broad range of assessments including standards and indicators based assessments (which together form the annual rating) and reviews and studies, which provide a broader picture of performance. More information about the annual health check can be found at [http://www.healthcarecommission.org.uk/serviceproviderinformation/annualhealthcheck.cfm](http://www.healthcarecommission.org.uk/serviceproviderinformation/annualhealthcheck.cfm)

Our investigations work is also high profile and we are currently conducting investigations into two organisations: West London Mental Health Trust and Mid Staffordshire NHS Foundation Trust. Where the Healthcare Commission has serious concerns about the provision of healthcare it will consider whether it needs to conduct an investigation. Triggers that might alert the Healthcare Commission to the potential need for an investigation include:

- direct contact from patients, the public, NHS staff, other inspectorates, the Secretary of State or the media
- issues brought to light during Healthcare Commission’s screening processes, reviews or visits
- trends or issues highlighted in the monitoring of complaints which reach the independent stage

More information about our investigations can be found at [http://www.healthcarecommission.org.uk/healthcareproviders/serviceproviderinformation/investigations/investigationscriteria.cfm](http://www.healthcarecommission.org.uk/healthcareproviders/serviceproviderinformation/investigations/investigationscriteria.cfm)

We inspect and regulate independent health care providers as well as the NHS, this includes cosmetic surgery and IVF amongst many other services. This has led us to become involved with a joint agency working group with the Department of Health and the Information Centre to align information across the NHS and independent healthcare sectors. We assess all registered services annually, through a self-assessment process, to ensure that they are meeting the national minimum standards (Department of Health, 2002). Where we identify risks of standards not being adhered to we may undertake an inspection to look at this in more detail. We inspect all services at least once every five years.

We work closely with the Commission for Social Care Inspection and the Mental Health Act Commission in a number of areas, such as inspecting services for older people and looking at safeguarding children. In 2008/2009 we are conducting a joint assessment of commissioning services for people with a learning disability. Subject to the passing of legislation, the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection will merge by 2010, as part of a wider review of regulation in health and social care, to form the Care Quality Commission (CQC).

The role of the CQC is, in part, outlined in the recent DH publication: Developing the NHS Performance Regime. This can be downloaded via the following link:

The indicators and measurement team is a team of 15 specialists who develop and deliver performance indicators for the annual rating and comparative purposes. If you have any queries, we can be contacted via the following email address: performance.indicators@healthcarecommission.org.uk

Is there something that you wish you knew more about? To suggest future topics for knowledge matters contact the team.
Kent and Medway HIS – HIS business intelligence (HISbi)

By Paul Bolton, Head of Information (Operational) & Peter Gough, HIS Business Intelligence Centre Manager

For a number of years Kent and Medway Health Informatics Service have been developing a business intelligence system for use by its customers. HISbi (pronounced HIS bee eye) was formerly known as Vital Signs – a timely change of name as the DH took a fancy to that one. The HIS Business Intelligence Centre, managed by Peter Gough, has a team of 7 staff who warehouse the data and develop the business intelligence reports.

HISbi uses the latest version of Cognos (version 8.3) and links to our data warehouse - the most comprehensive store of NHS data in Kent and Medway. Since upgrading to Cognos 8 there has been a surge of intense interest in HISbi because it has full dashboard and performance management functionality. Some of the exciting projects we have been working on include:

Acute Contracting Team
We have developed a suite of reports that allow ACT to monitor the whole Kent and Medway commissioning budget, activity and expenditure. The rules governing the costing of activity are automated and the reporting is available through the web interface. By allowing trusts access to the same reports and data the activity and costings can be reconciled quickly and easily. The system allows secure drill through to record level for checking.

West Kent PCT
We have worked with the PCT to develop a set of Practice based Commissioning reports that will be available to all 104 of the PCTs practices. These reports contain a 2 year rolling trend of outpatient and inpatient activity including referrals and waiting lists and practices can check the data by drilling through to record level. There is also an age standardised comparison of the practices that can be looked at by specialty. The next phase of this project is to include financial information for practices that will automate the reports they currently get on spreadsheet. This will be the foundation of very comprehensive PbC reporting.

Medway PCT
We are undertaking three key areas of work with the PCT:

1. Developing a set of reports and dashboards for provider services. Initial trials with stroke services have proved successful and this will be followed by all the main provider services. We are linking this to the SHA clinical metrics programme for stroke;
2. Providing reporting on care pathways for stroke services where data from primary care, acute and community data will be linked by NHS number to better understand patient pathways;
3. Practice based Commissioning. A suite of reports PbC reports are also being developed for West Kent but with local requirements and these will be rolled out to their practices after an initial trial period.

We are really pleased that the local NHS is working with us to embrace and develop business intelligence systems such as this. We are hopeful that by the end of 2008, the majority of Kent and Medway PCTs, Trusts and GP practices will be using HISbi as an integral part of everyday business. If you would like to learn more, we would be delighted to hear from you!

Contact either peter.gough@ekht.nhs.uk or paul.bolton@nhs.net

Do you have something you would like to contribute to Knowledge Matters? Please contact us!
Clinical Metrics – Dementia

Adam Cook, Development Analyst

In the last issue, Simon wrote about the progress that has been made in the development of stroke metrics. I am leading on a similar programme of work for dementia metrics. The aims are the same as for stroke i.e. the development of metrics that are relevant and meaningful to clinicians and practitioners within both primary and secondary care using existing data flows. Work on the development of metrics to describe dementia services across South East Coast has been underway since the autumn of 2007.

Analyses undertaken so far include:

- Admissions and length of stay information for stays in acute non-mental health Trusts for patients with a diagnosis of dementia;
- By GP practice, predicted prevalence compared to the number of patients on dementia registers;
- Analysis of QOF data relevant to dementia;
- Programme budget spend on dementia;
- Spend on dementia drugs;

The prevalence information is particularly interesting as this provides a detailed picture of the number of patients on dementia registers at each practice compared to the number of expected dementia cases based on local demography. Mirroring national research, most practices have significantly fewer patients on dementia registers than expected - this could present a real issue for commissioners. If patients are not on dementia registers, can we be confident that they are receiving appropriate care? What would the financial implications be if PCTs had 100% of expected patients on dementia registers? These are the kind of questions that we are hoping that this type of information prompts. As often is the case, much of this analyses poses more questions that it provides answers…..

Further work is nearly finalised to combine different data sets together to test out whether there are clear relationships between indicators. In addition, a radar plot (see left) is being populated for each PCT within South East Coast - this will provide a very visual representation to enable comparison between PCTs. Already it is interesting to see the range of shapes for different PCTs. I can certainly see a variation, however it is clinicians from the local areas affected that can provide the local context and initiate local discussion - that’s what this programme of work is all about.

There are of course challenges associated with this project. In particular, there is an absence of existing data sets to describe this pathway of care. There are also issues relating to the quality of data recorded.

The draft national dementia strategy has been developed and is currently out to consultation. We are linking with the team working on the strategy and will be meeting them soon to update on progress to date, challenges that we have experienced and measures that we have discovered are meaningful.

If you would like to learn more or would like to be involved you can give me a call (01293 778846), e-mail me or log on to our website (www.sec.nhs.uk/knowledge). If you register as a user and go to the ‘downloads’ section you can download all of the meeting minutes and analysis undertaken so far.

Is there something that you wish you knew more about? To suggest future topics for knowledge matters contact the team.
Health Inequalities Gap Measurement Tool
By Dr Robert Kyffin, Senior Public Health Intelligence Officer

The objective of reducing health inequalities lies at the very heart of Department of Health policy and is a key NHS objective. Yet information on the nature and extent of local health inequalities is often limited. To try and address this information gap, the South East Public Health Group (the Department of Health’s presence in the region based in the Government Office for the South East) have produced a ‘Health Inequalities Gap Measurement Tool’ which aims to increase understanding in the NHS and Local Authorities of their health inequalities gap.

Nationally, the gap between the Government’s priority health areas - the Spearhead PCTs - and the England average is increasing. The relative gap in female life expectancy in England, for example, was 11% wider in 2004-6 than at the 1995-7 baseline. While the South East has no Spearhead PCTs, the gap in life expectancy between the quintiles of Local Authorities with the lowest and highest mortality rates is increasing.

The South East Gap Measurement Tool aims to provide a standardised approach to measuring these local inequalities based on cause-specific mortality rates for 2002-6 for deprivation score derived quintiles of super output areas (SOAs).

Using the tool
The Gap Measurement Tool has been developed using Microsoft Excel and can be obtained directly from the Public Health Group or downloaded from the SEPHO website.

After opening the tool, the first step is to select the geographic area (plus optional comparator) and cause of death to be reviewed. Users can choose between the South East region, two SHAs, 17 PCTs and 19 Unitary Authorities and County Councils, and 17 cause of death categories from drop-down menus. Mortality rates for persons, males or females can be selected, and the confidence limits adjusted or switched off. The final step is to select the deprivation quintiles to be compared and the display format to be used from a range of chart and data table options.

Most of the display formats - such as the line chart shown below - show the age-specific mortality rates for the area(s), quintile(s) and cause of death selected. Different display formats can be selected - such as logarithmic charts - to help clarify the age-specific nature of the inequalities gap between areas. For example, for diseases of the circulatory system, the tool makes clear that there is a statistically significant mortality gap between the most deprived quintile of SOAs in South East Coast SHA and the South East average from age 30 onwards.

This gap can also be displayed using the ‘relative gaps’ chart option.

As well as comparing different areas, the numbers of deaths and the populations for each deprivation quintile can be displayed, as can the overall mortality profile for each area. Maps showing the location of the least and most deprived SOA quintiles are also provided, as are full methodological and data source notes.

The Gap Measurement Tool can be used alongside the recently updated APHO Health Inequalities Intervention Tool - an interactive tool which allows users to model the impact of different interventions on their gap - to provide a comprehensive picture of the causes of death, age and sex groups and geographic areas driving the health inequalities gap in their local area.

Further information
The Gap Measurement Tool can be downloaded from the SEPHO website at http://tinyurl.com/69gy9j and further information on the tool can be obtained from Robert Kyffin in the South East Public Health Group (robert.kyffin@dh.gsi.gov.uk, 01483 882 264).

References
• Association of Public Health Observatories. Health Inequalities Intervention Tool. http://tinyurl.com/ysx72a
**News**

**South East Coast Hospitals Win Awards**

CHKS have named 5 Trusts within South East Coast as being within the Top 40 Hospital Trusts. Winners are chosen from the CHKS client base and are judged on the evaluation of 20 key performance indicators covering clinical effectiveness, health outcomes, efficiency, patient experience and quality of care. The prize winners are:

- Dartford and Gravesham Hospital
- Frimley Park Hospital
- Royal Surrey County
- Royal West Sussex NHS Trust
- Worthing and Southlands NHS Trust

**BCBV Indicators update**

Quarter 3 data is now published and available to download from [www.productivity.nhs.uk](http://www.productivity.nhs.uk)

The productivity website also provides access to the web based tool called NHS Indicator Explorer which facilitates a further drill down into the data beneath the published indicators. Access to this tool is now provided free to Trusts and PCTs by the NHS Institute. For further details and to register to use the tool please go to [http://www.nhsindicatorexplorer.productivity.nhs.uk/render/controler/dhnpi/](http://www.nhsindicatorexplorer.productivity.nhs.uk/render/controler/dhnpi/)

**South East Coast Commissioning Rules**

Following the recent Independent Review of the Commissioning Rules Programme, it has been agreed that the Commissioning Rules Panel will be replaced by a Consistency and Controls Panel. Terms of reference are currently being developed for this new group. For further details, contact Samantha Riley.

**World Class Commissioning Knowledge Management within SEC**

A sub group has been formed to support this critical area with representation from South East Coast Commissioners, library services, SEPHO, and the SHA. Key work streams are as:

1. Identification and mapping of tools and resources to each element of the commissioning cycle;
2. Production of commissioning guides signposting tools/resources to support PCTs;
3. Analyst recruitment, retention and career structure;
4. Skills development for Information Specialists;
5. Developing the intelligent user;
6. Information systems, data warehousing and reporting tools.

For further information of to get involved with one of the work streams, please either contact your Director of Commissioning or Samantha Riley. All documents

**Vital Signs**

Thanks to Trusts and PCTs for sending in their trajectories for the Vital Signs refresh. A further refresh of stroke and midwifery plans is likely in September - guidance on monitoring the stroke plans should be available shortly.

**Unify2**

SHAs are currently compiling lists of any issues that their organisations are experiencing with Unify to pass onto the Unify2 steering group for resolution. Please forward any issues to Rebecca Owen.

**18 Weeks**

The new ready reckoners, as calculated in the recent data completeness exercise, are now in use. These were applied to the monthly return for March data and have been used on the weekly PTL reports for data week ending 6th June onwards.

**2008/09 Annual Health Check**

Guidance and Performance Indicators for the 2008/09 annual health check is now available on the Healthcare Commission website - [www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk).

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**NHS South East Coast**

There's a suburban town called Horley
Noted for charity shops,
Where the HQ of the health authority,
Is just down the road from the cops.

In two magnificent buildings,
Namely York House & the Gables,
People are hunched over computers,
And having grand meetings round tables.

Eight PCTs and thirteen acutes,
(Three of which are foundations.)
Three Mental Health and an ambulance Trust,
All providing care to our patients.

The role of the SHA is threefold,
First leadership of a strategic variety,
Then developing NHS organisations,
Finally effective delivery is a priority.

Working jointly with all organisations
To provide the best of the NHS,
And holding PCTs accountable,
As they traverse the road to success.

Answerable direct to the Department,
Ensuring we all play our part,
Following government policy,
And keeping patients close to our heart.
Knowledge matters is the newsletter of NHS South East Coast’s Knowledge Management Team, to discuss any items raised in this publication, for further information or to be added to our distribution list, please contact:

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Do you have something you would like to contribute to Knowledge Matters? Please contact us!