

2006/2007 annual health check performance rating frequently asked questions



This document is designed to support our annual health check performance rating scoring information, which was published in February 2007 and provides further detail concerning many of the questions raised below –

http://www.healthcarecommission.org.uk/_db/_documents/0607_annual_health_check_performance_rating_scoring_rules_200702284632.pdf

http://www.healthcarecommission.org.uk/_db/_documents/0607_annual_health_check_components_scoring_methodologies.pdf

This is the second version of our frequently asked questions document (version 1 was published on 28 February 2007), and includes additional questions 27 to 34.

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Q1. What changes have been made for the 2006/2007 annual health check?

A1. 2005/2006 was the first year of the Healthcare Commission's annual health check. For 2006/2007, we have broadly retained the same system.

As for last year, each NHS trust is given an annual performance rating based on two parts: use of resources and quality of services. The latter part is based on an organisation's performance across three components of the annual health check, namely core standards, existing national targets and new national targets. Unlike in 2005/2006, service reviews (the new name for improvement reviews and the acute hospital portfolio) do not contribute to an organisation's quality of services score. They will be scored separately and the results will be presented on our website.

The scoring rules that govern both parts of the annual performance rating, as well as the three underlying components, have remained largely unchanged from 2005/2006. In February 2007, we published comprehensive scoring information, which describes each step of how we come to an overall annual performance rating for each organisation.

The Healthcare Commission's annual health check includes lots of other work that doesn't form part of an organisation's annual performance rating. Along with our service reviews, we are also undertaking national studies and a pilot assessment of developmental standards.

Q2. What are the main scoring rules that you use to come to an overall score for quality of services?

A2. There are three components that combine to form an NHS organisation's quality of services score. Core standards and existing national targets both measure performance against existing requirements or targets that are required of NHS organisations. New national targets set out the priorities for the service, and are typically set to be delivered by 2008 or 2010. Our assessment against these measures progress made towards their ultimate delivery.

Our core standards assessment looks at trusts' performance against the standards that all healthcare organisations in England should be achieving as set out in *Standards for better health* published by the Department of Health in July 2004.

Our existing national targets assessment looks at the targets that were set during the Department of Health's 2003-2006 planning round.

Our new national targets assessment looks at the national targets as outlined in *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/2006 – 2007/2008*.

The Healthcare Commission gives one of four component level scores. For core standards and existing national targets, these are 'fully met' (the highest available score), 'almost met', 'partly met' and 'not met' (the lowest available score). For new national targets, these are 'excellent' (the highest available score), 'good', 'fair' and 'weak' (the lowest available score). The score that an NHS organisation is given reflects its performance for that component as a whole.

An NHS organisation's component level scores are then combined to form the overall score for quality of services. The rules to determine the quality of services score are designed to ensure that an organisation must demonstrate consistently strong performance across the board to gain the two highest scores. Therefore, in order to be 'good' for quality of services, an organisation must be at least 'almost met' for core standards and existing national targets, as well as being at least 'good' for new national targets. And in order to be 'excellent' for quality of services, an organisation must receive the highest available score for each of the three components.

Because core standards and existing national targets both measure existing requirements or targets that NHS organisations should maintain performance against, these components alone hold additional weight within the scoring rules. If an organisation is 'not met' for either core standards or existing national targets (please note that there is one exception to this rule, which concerns mental health trusts' existing national targets assessment), it is automatically given a score of 'weak' for quality of services. This is the only way in which an NHS organisation can end up with a score of 'weak'.

If an organisation does not fulfil the criteria to be 'excellent', 'good' or 'weak', then a score of 'fair' for quality of services is given.

Quality of services is one part of our annual health check performance rating, with use of resources being the other.

Q3. Don't your scoring rules penalise an NHS organisation that performs very well in all but one component? Shouldn't you use an average of an NHS organisation's whole performance?

A3. Taking an average, or mean, score across the components would allow for poor performance to be masked by good performance elsewhere. An organisation would potentially be able to perform very well in one component, whilst also performing very poorly in another and still receive a high overall score. In addition, this situation could well have associated resource and priority implications that would adversely impact the provision of high quality care across an organisation's full spectrum of responsibility. For example, an organisation may not be incentivized to put additional effort into achieving the more challenging standards or targets if our scoring system enabled them to do well by focussing attention on a narrower range of requirements. Therefore, our scoring rules reflect the need for consistently strong performance.

Q4. Can an NHS organisation miss out on being 'excellent' if they fail only one target or standard?

A4. Our points and rules based scoring system does potentially mean that a trust can be prevented from scoring a higher quality of services score based on performance against a single performance indicator, target or standard. For example, in order to be 'fully met' for existing national targets, an ambulance trust must achieve all the applicable targets (typically this will mean achieving four targets). However, an acute trust that is assessed against 12 existing national targets can fail one, or underachieve three, of these and still be 'fully met' for the component. The tolerance we allow reflects a number of factors, including the scope and range of a set of targets.

As we assess every NHS organisation, and give them all one of four overall quality of services scores, there is a high likelihood that there will be instances where a trust or multiple trusts come narrowly close to achieving a higher overall score. This is a natural product of a tiered scoring system.

In designing our scoring rules, we have tried to make them clear and simple for patients and the public. In February 2007, we published comprehensive scoring information, which describes each step of how we come to an overall annual performance rating for each organisation.

Q5. You mention a 'tiered scoring system' – what does this actually mean?

A5. There are three components that combine to form an NHS organisation's quality of services score. The structure of the existing national targets and new national targets component is very similar and is a good example of a tiered scoring system.

Each type of trust has a defined number of targets that apply to it. For example, a maximum of 12 existing national targets apply to an acute trust. In order to assess each target, we use a number of performance indicators. Often this will be a one-to-one relationship (in other words, the target is measured by use of one performance indicator), but sometimes we will use more than one indicator in order to more fully assess performance against a particular target – this is most common in our assessment of primary care trusts against the new national targets. To use our assessment of acute trusts against the existing national targets as an example, 11 of the 12 targets are underpinned by a single performance indicator, with one target being underpinned by two performance indicators.

We first assess how an organisation has done against each of the performance indicators. This is the first tier of scoring. For each indicator, we use thresholds of performance to decide whether an organisation has 'achieved', 'underachieved' or 'failed' that indicator.

We next assess how an organisation has done against each of the targets that apply to them. This is the second tier of scoring. Where there is only one indicator supporting a target, the performance against that indicator is directly carried across to form the performance against the target. In other words, if an organisation 'underachieved' the one performance indicator, then they will have automatically 'underachieved' the target as well. Where there is more than one indicator supporting a target, we combine the indicator level scores to come up with an overall score at target level. As at indicator level, we score an organisation as either 'achieving', 'underachieving' or 'failing' the target. We award three points for achieving a target, two points for underachieving a target, and zero points for failing a target.

We then assess how an organisation has done against the existing or new national targets component as a whole. This is the third tier of scoring. Based on the number of points scored out of the total number of points available, we use allocation tables to decide which component level score each organisation is given – for both targets components, we give one of four component level scores. For existing national targets, the scores are 'fully met', 'almost met', 'partly met' or 'not met'. For new national targets, the scores are 'excellent', 'good', 'fair' and 'weak'. The different language used reflects our different expectations in relation to the two targets components. Broadly speaking, we expect trusts to be meeting the existing national targets, whilst also demonstrating that they are making progress towards meeting the new national targets. Our allocation tables reflect a number of factors, including the scope and range of a set of targets. For example, in order to be 'fully met' for existing national targets, an ambulance trust must achieve all the applicable targets (typically this will mean achieving four targets). However, an acute trust that is assessed against 12 existing national targets can fail one, or underachieve three, of these and still be 'fully met' for the component.

Finally we assess how an organisation has done for the quality of services part of the annual performance rating. This is the fourth and final tier of scoring. We take the scores for each of

the three components that feed into quality of services, and combine them using a few straightforward rules. This results in each trust being given an overall score of either 'excellent', 'good', 'fair' or 'weak'.

All of the above is covered in more detail in our 2006/2007 annual health check performance rating scoring information that was published in February 2007.

Q6. What are the main scoring rules that you use to come to an overall score for use of resources?

A6. The use of resources score is derived from the work of other regulators. For non-foundation trusts, the work is done by the Audit Commission and the local auditors responsible for evaluating trusts' performance. For foundation trusts, the work is done by Monitor. We use this information to then give a use of resources score on our four point scale of 'excellent' (the highest available score), 'good', 'fair' and 'weak' (the lowest available score).

Use of resources is one part of our annual health check performance rating, with quality of services being the other.

Q7. What is the difference between a foundation and non-foundation trust, and why do you assess them differently for use of resources?

A7. NHS foundation trusts are a new type of organisation, created under the Health and Social Care (Community Health and Standards) Act 2003.

There are statutory differences between foundation trusts and non-foundation trusts. NHS foundation trusts have been set up under a different financial regime to other NHS organisations and, as a result, have different responsibilities and different financial requirements. Importantly, NHS foundation trusts are not required to break even in year or comply with the statutory three-year break-even duty.

Given these differences between the two types of bodies, it is not appropriate to assess them on the same basis. The assessment methods do however have the same purpose, namely to provide a view of the use of resources at each organisation whilst acknowledging their different statutory financial responsibilities.

It is a trust's status at the end of the financial year (for this year, 31st March 2007) that determines which assessment method is undertaken.

Q8. Where can I find out more about the work of the Audit Commission and Monitor?

A8. Information about the assessment of non-foundation trusts can be found on the Audit Commission's website at:

www.audit-commission.gov.uk/subject.asp?CategoryID=ENGLISH^574^SUBJECT^30

Information about Monitor's annual financial risk rating, as used for the assessment of foundation trusts, can be found at:

http://www.monitor-nhsft.gov.uk/ratings_description.php

Q9. What is the impact of breakeven on an organisation's use of resources score?

A9. The achievement of in-year breakeven is a key requirement for non-foundation trusts. The Department of Health is clear that addressing financial balance is vital for the NHS and we agree that financial balance is fundamental to any organisation. This is reflected within the scoring rules. A failure to achieve breakeven in-year would lead to a score of 1 for the "financial standing" theme of a trust's assessment, which would result in an overall score of 'weak' for use of resources.

We will continue to apply zero tolerance to the achievement of in-year breakeven.

Non-foundation trusts also have a statutory three-year breakeven target. This is also assessed as part of the "financial standing" theme of the auditors local evaluation.

Foundation trusts operate under a different financial regime and they do not have an in-year breakeven requirement. It is therefore possible for a foundation trust to have a year-end deficit but not be rated as 'weak', providing they are performing adequately compared to their financial plan and are demonstrating that they are on course to meet reductions in their deficit position.

Q10. What are the core standards?

A10. The core standards are described in 'National Standards, Local Action' (Annex A) published by the Department of Health in July 2004. This document can be viewed at

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4086057&chk=yFwOL

The core standards form one component of the quality of services part of the annual health check performance rating.

Q11. What are the main scoring rules that you use to come to a score for core standards?

A11. Our scoring rules for the assessment of core standards are designed to reflect the proportion of core standards for which there is compliance. The score for each trust is calculated in two steps. Step 1 considers the level of compliance across the entire year to calculate the maximum score that a trust can achieve. Step 2 considers the level of compliance at the end of the year to calculate the actual score achieved. We have published two sets of thresholds: one set is used to determine the maximum score a trust can achieve (step 1), and the other set of thresholds is used to determine the actual score a trust can achieve (step 2).

The scores are determined using information from trusts' declarations and from the findings of our inspections of trusts. An inspection may result in the Healthcare Commission qualifying a trust's declaration. Qualifications will apply where we conclude that a trust's declaration of 'compliant' for one or more standards is not supported by the evidence presented. For each of the affected standard(s), the inspection will also record whether the evidence supports a more limited statement of compliance – that is, the evidence demonstrates the standard had been met by March 31st 2007. For each affected standard, a trust will receive two penalty points, which will be used in the calculation of its score. Any trust that has its declaration qualified will be limited to a maximum score of 'almost met'.

All of the above is covered in more detail in our 2006/2007 annual health check performance rating scoring information that was published in February 2007.

Q12. What are the existing and new national targets?

A12. The Government sets targets of expected performance for the NHS and the Healthcare Commission undertakes assessment of performance against those targets. The existing and new national targets are described in 'National Standards, Local Action' (in Appendix 1 and Annex B respectively) published by the Department of Health in July 2004. This document can be viewed at

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4086057&chk=yFwOL

The existing and new national targets form two of the components of the quality of services part of the annual health check performance rating.

Q13. Where can I find out more about the way in which the Healthcare Commission will assess the performance of trusts in relation to the existing and new national targets in 2006/2007?

A13. Information about our assessment of performance relating to the existing and new national targets can be found via the following link

<http://ratings2007.healthcarecommission.org.uk/>

This site includes detailed information regarding the indicators that we will use to assess performance against the targets, descriptions of the targets themselves and how our indicators relate to them, and a summary of our process for assessment.

Q14. What is a 'ratification period'?

A14. The principal objective of a ratification process is for organisations to assure themselves that the Healthcare Commission's assessments of their performance are using data as supplied by the organisation and that no error has been introduced following their data submission. The ratification period is a scheduled period during which organisations have the opportunity to view the data we hold and submit a query if they detect any error has been introduced following their submission to us or to the data collection agencies from whom we source the majority of our data. We have recently published guidance covering ratification for the 2006/2007 annual health check, which is available below:

<http://www.healthcarecommission.org.uk/serviceproviderinformation/annualhealthcheck/ratificationofdata.cfm>

Q15. What are 'extenuating circumstances'?

A15. Where organisations believe that their performance has been adversely affected by unforeseen or emergency circumstances outside of the organisation's control and where the organisation could not reasonably be expected to have contingency in place to mitigate or remove this effect, they may request that this is taken into consideration. Additionally, where organisations believe that their ability to submit accurate, comprehensive data within data collection deadlines was compromised due to unforeseen or emergency circumstances outside of the organisation's control and where the organisation could not reasonably be expected to have contingency in place to mitigate or remove this effect, they may also request that this is taken into consideration. We have recently published guidance covering extenuating circumstances for the 2006/2007 annual health check, which is available below:

<http://www.healthcarecommission.org.uk/serviceproviderinformation/annualhealthcheck/extenuatingcircumstances.cfm>

Q16. What is the difference between ‘targets’, ‘indicators’ and ‘constructions’?

A16. Targets set out Government expectations of the NHS, which are to be achieved by specific dates. Indicators are the measures that the Healthcare Commission uses to assess performance against the targets. And constructions are the detailed information we publish about the indicators, which show the data and the method we will use to calculate the indicator score. This is best demonstrated by an example from the existing national targets –

Target:

Maintain a two week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals.

Construction:

Numerator:

The number of patients first seen by a specialist within two weeks when urgently referred by their GP with suspected cancer, and the referral being received by the NHS trust within 24 hours.

Denominator:

The total number of patients first seen by a specialist when urgently referred by their GP with suspected cancer, and the referral being received by the NHS trust within 24 hours.

Indicator:

The indicator is the numerator divided by the denominator, expressed as a percentage.

Q17. What are ‘thresholds’ and ‘bandings’?

A17. Thresholds determine the required levels of performance for each banding.

For example, if a performance indicator has the following thresholds:

- Threshold for ‘achieved’ is 90%
- Threshold for ‘underachieved’ is 70%

Then the bandings will be as follows:

- ‘Achieved’ – equal to or greater than 90%
- ‘Underachieved’ – greater than or equal to 70% but less than 90%
- ‘Failed’ – less than 70%

At indicator level, we therefore have three bands of performance, governed by two thresholds.

Q18. What is an ‘allocation table’?

A18. All the allocation tables that we will use to assign component level performance for existing and new national targets were published in February 2007, as part of our comprehensive 2006/2007 annual health check performance rating scoring information. These tables were devised in the knowledge that differing numbers of targets would apply to different trusts. A trust with fewer targets applicable to them does potentially have less tolerance within an allocation table than a trust with more targets applicable, reflecting the scope and challenge of achieving all relevant targets. For example, in order to be ‘fully met’ for existing national targets, an ambulance trust must achieve all the applicable targets (typically this will mean achieving four targets). However, an acute trust that is assessed against 12 existing national targets can fail one, or underachieve three, of these and still be ‘fully met’ for the component.

Q19. I've had a look at last year's results, and I see that most trusts do get a score of either 'achieved', 'underachieved' or 'failed' for each performance indicator and target, however there are also categories of 'not applicable', 'data not available' and 'data not returned' – what do these mean?

A19. Along with the most commonly used scores of 'achieved', 'underachieved' and 'failed', we do also use an additional three categories to take account of all eventualities.

The category 'not applicable' is used when an indicator or target does not apply to an organisation, and as a result we don't assess that organisation against it. An example of this is the total time in accident and emergency (A&E) existing national target. If an acute trust does not have an A&E unit, we deem them to be 'not applicable'.

The category 'data not available' is used when the relevant data were not available to assess an organisation against an indicator or target through no fault of the organisation, and as a result we don't assess that organisation against it. An example of this is the thrombolysis existing national target. If an acute trust administers thrombolysis to fewer than 20 patients, we deem them to be 'data not available', in recognition that there is an insufficient sample size upon which to make a valid and meaningful assessment.

The final category that we use is 'data not returned'. This is when the relevant data were either not returned or were of insufficient quality to assess an organisation against an indicator or target, and as a result, we give an organisation the lowest score for this indicator or target. Receiving 'data not returned' is therefore equivalent to a score of 'failed'.

Q20. Why are you assessing provider trusts (for example, acute trusts) against the new national targets? Surely these are only relevant to primary care trusts?

A20. The new national targets should be viewed in the context of overall improvements in the health of the population. Many of the targets have relevance to the whole of the NHS - the entire healthcare community has responsibilities in relation to progress towards, and ultimate achievement of, these targets.

The targets themselves were agreed between the Department of Health and Treasury and published in July 2004. The role of the Healthcare Commission is to construct indicator measures to address the various targets. Our indicators are tailored to the particular roles that different types of NHS organisations play in the healthcare community. In constructing these indicators, we take advice from national policy, data and clinical leads to ensure that they are reasonable and proportionate to the type and level of contribution expected from each service provider type.

Q21. How and why do you assess acute trusts against the new national target concerned with reducing teenage pregnancies?

A21. We do not directly assess acute trusts on reducing teenage pregnancies. Acute trusts are assessed on a key action required of them in helping the NHS to hit the broader target, which is concerned with improving sexual health, specifically on providing access within 48 hours to genito-urinary medicine (GUM) services.

Q22. How and why do you assess acute trusts against the new national target concerned with reducing suicide rates?

A22. We do not directly assess acute trusts on reducing suicides. Acute trusts are assessed on the key actions required of them in helping the NHS to hit this target, specifically, on ensuring appropriate systems are in place to care for people who have self-harmed and who may, therefore, present a higher risk of suicide if such care is not provided. This is a valuable input into achieving the broader target.

Q23. How and why do you assess acute trusts against the new national target concerned with reducing adult smoking rates?

A23. We hold acute trusts to account for their performance towards the smoking target by assessing smoke free status preparations and additional arrangements for in-patients to support smoking cessation. Smoking is a national service priority, as highlighted in 'Choosing health' (DH 2004), which stated 'NHS organisations should take action to eliminate second-hand smoke from all their buildings and provide comprehensive support for smokers who want to give up'. The white paper also set a commitment for the NHS to become smoke-free by the end of 2006.

Acute trusts should be able to determine levels of smoking within their adult patient populations and should have plans that support the reduction of smoking prevalence amongst patients and staff, including the provision of smoking cessation advice and services to all their staff. In addition to disease prevention or reduction, stopping smoking reduces the risks of surgical complications for smokers and increases the availability of hospital beds. It is therefore important that hospitals should actively encourage and help smokers to stop.

Q24. Having read your smoke-free NHS performance indicators, I'm still not sure about what is meant by 'smoke-free'?

A24. 'Smoke-free' means that smoking is not permitted anywhere within hospital buildings. No exceptions will be made for staff or visitors. For long stay mental health patients in an acute psychiatric state or for terminally ill patients, exceptions may be made on a case-by-case basis. However, no blanket exceptions will be allowed for particular categories of patients.

The smoke-free indicators are based on the guidance issued by the Health Development Agency in 2005, which can be viewed at <http://www.nice.org.uk/page.aspx?o=502903>

For the smoke-free indicator that applies to mental health trusts, it is also helpful to refer to a letter from Louis Appleby, National Clinical Director for Mental Health, written on 1st February 2005. The letter updated mental health trusts on the Government's plans for how smoke-free legislation will affect mental health units. The letter can be downloaded via

http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/DearColleagueLetters/DearColleagueLettersArticle/fs/en?CONTENT_ID=4142561&chk=Pct7At

Q25. You assess acute trusts against the number of MRSA bacteraemias, but do you take into account that some trusts are starting from a lower baseline than others?

A25. Our indicator assesses performance of trusts against the target set by the Department of Health. The Department of Health target states "each acute and specialist trust with more than 12 MRSA bacteraemias (infections) in 2003/2004 will be expected to achieve either a 60% reduction in the number of infections by 2007/2008 or a maximum of 12 infections in 2007/2008". Each trust has produced a plan outlining how they will meet the target, and we assess them on progress against this plan. Trusts are not required to reduce their level of infections below 12. For example, a trust with a 2003/2004 baseline of 14 is expected to reduce this to a maximum of 12 infections, rather than achieve the greater reductions required of trusts with high baselines. As the target is based on reducing infections, trusts with higher numbers of infections are required to achieve greater absolute reductions than trusts with lower numbers of infections.

Q26. Why are you assessing inpatient and outpatient waiting times as part of both the existing national targets (26 and 13 weeks) as well as the new national targets (20 week and 11 week milestones)?

A26. The existing targets on inpatient and outpatient waiting times have been in place for some years and represent standards that the government expects all trusts now to be meeting. Within the new national targets, the government announced a target that by the end of 2008 there would be a maximum 18 week wait from referral to treatment, and in order for the NHS to meet this target, interim milestones have been set for the end of the financial years 2005/2006, 2006/2007 and 2007/2008 for the separate 'stages of treatment' (including inpatients and outpatients).

The Healthcare Commission's assessment of the existing national targets on inpatient and outpatient waits in 2006/2007 require achievement of the maximum 26 week and 13 week waiting times over the whole year, while our assessment of the new national target milestones assess performance at the end of the financial year. It remains important for trusts to have met the existing targets even if they do not meet the new national target milestones in this area. Therefore it will be possible for trusts to meet the existing targets and not meet the more exacting new national targets although trusts in this position will obviously score less highly overall in the new national targets component.

Q27. What do your scores of 'fully met', 'almost met', 'partly met' and 'not met' mean?

A27. When scoring the core standards and existing national targets components, we use a four point scale of 'fully met' (the highest available score), 'almost met', 'partly met' and 'not met' (the lowest available score). A score of 'fully met' is awarded where an organisation has performed consistently well for the assessment in question, while a score of 'almost met' is awarded where an organisation has performed well for many aspects of the assessment. A score of 'partly met' is awarded where an organisation has performed poorly for some aspects of the assessment, with a score of 'not met' denoting that the organisation has performed poorly for the assessment in general.

Q28. In terms of the quality of services score, is an 'excellent' PCT the same as an 'excellent' mental health trust?

A28. The overall quality of services scores are not directly comparable across different organisation types, due mainly to the differing number of existing and new national targets that apply to each type. For example, a primary care trust is assessed against a far wider range of requirements than a mental health trust. This is because a primary care organisation's responsibilities encompass far more of the national priorities set by the Department of Health. For a primary care organisation to receive an overall quality of services score of 'excellent', they will have been assessed against almost all of the existing and new national targets, including being assessed on how well the services that they have commissioned on behalf of their populations have performed. Primary care organisations are therefore assessed upon how they are running their own organisations, as well as how they are commissioning services from provider organisations.

We would therefore advise that direct comparisons of overall quality of services scores are only valid within an individual organisation type.

Q29. I see that there are far fewer NHS organisations for you to assess this year than there were last year. As several mergers took place mid-year, how are you going to assess these new organisations?

A29. In October 2007, we will give an annual performance rating to 394 NHS trusts, based on their performance during the 2006/2007 financial year (i.e. 1 April 2006 to 31 March 2007). As you note, the significant fall in the number of organisations assessed, down from 570 in 2005/2006, is due to the large scale service reconfigurations that occurred during the 2006/2007 financial year, which resulted in several ambulance and primary care trust mergers.

As in previous years, we will assess organisations as they exist at the end of the assessment year in question – for this year, that will be as at the 31st of March 2007. Guidance provided to the NHS through the statutory instruments concerning in-year mergers explicitly stated: "Anything done before 1st October 2006 by, or in relation to, the old trust or the old PCT shall be treated on and after that date as if done by, or in relation to, the new trust or PCT". More information can be found via

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4139565

We therefore intend to directly map activity to the new organisations, and hold the new organisations fully accountable for all activity and planning that they have inherited.

Where this is not possible or would require unjustifiable resource to accurately complete, we will take a pragmatic approach and rely on the most recently available data that can be accurately mapped to the new organisation. In the case of PCTs which have split, we will use the percentage splits which have been calculated and approved by SHAs and PCTs for the purposes of updating local delivery plans. Further information regarding this is available via the link below

http://ratings2007.healthcarecommission.org.uk/Indicators_2007/more_information.asp

Q30. Given the penalty that it carries (i.e. equivalent to a 'fail'), what sort of things do you consider before giving a score of 'data not returned'?

A30. It is the responsibility of every healthcare organisation to ensure that they submit all necessary data for our assessment purposes by the deadline date for each data collection. If an organisation has any questions or queries, they must liaise directly with the data collection agency prior to the submission deadline, giving reasonable and appropriate time for the agency to answer.

In the case of data collections administered directly by us, we are happy to be contacted for further advice, although the above provisos still apply i.e. any questions or queries must be received prior to the submission deadline, giving reasonable and appropriate time for an answer to be supplied.

Failure to submit data, late submission of data or submission of inadequate data will all be penalised by 'data not returned'.

Q31. What are the use of resources scores for foundation trusts based on for 2006/07?

A31. The financial risk rating, as awarded by Monitor, forms the basis of the use of resources scores for foundation trusts. As agreed with Monitor, foundation trusts scores for the annual health check in 2005/2006 were based on the annual financial risk rating as at the start of 2006/2007.

However, following publication of the 2005/2006 performance ratings, a number of trusts, and the Foundation Trust Network, queried the appropriateness of using this forward looking rating. Given these comments, and following discussion with Monitor, we have revised the basis of the use of resources scores for 2006/2007. We will be using the financial risk rating as at the end of quarter four 2006/2007, rather than at the start of 2007/2008, as this will more accurately reflect a trust's performance in its management of its financial resources for that year.

Please note this is a clarification of the scoring rules and does not require any action from trusts. Furthermore, the use of resources scores for 2005/2006 will not be affected by this revision.

Q32. I've had a look at the thresholds used by Monitor and the Healthcare Commission, and I see that they are not always the same, despite them measuring performance against the same targets – why is this?

A32. Monitor and the Healthcare Commission perform different functions and this is reflected in the approach we take to monitoring and assessing performance. Where our respective roles and objectives allow, we aim to ensure that there is consistency. Where they do not, full alignment is not possible. Monitor requires regular self-reporting from foundation trusts, usually on a quarterly basis, concerning compliance with targets, whilst the Healthcare Commission assesses performance at the end of the financial year. This difference, between ongoing, in-year assessment, and retrospective, year-end assessment, can result in different thresholds being applied. The Healthcare Commission and Monitor continue to maintain close contact and on-going dialogue to ensure that thresholds are aligned as much as possible.

Q33. Why doesn't the Healthcare Commission weight targets in the same way Monitor does?

A33. The Healthcare Commission assesses actual performance at the end of the financial year and considers all targets to have equal weighting. Monitor seeks to identify areas of risk in-year to indicate where further review and potential intervention may be necessary. To achieve this, Monitor measures targets in line with the Department of Health's priorities and weights them in line with the potential risk level anticipated.

Q34. When will the 2006/2007 annual health check performance ratings be made available to the public?

A34. The 2006/2007 annual health check performance ratings will be published on Thursday 18 October. All results and supporting information will be available via our website.