Prioritisation of metrics from National Clinical Audits and Clinical Outcome Review Programmes

Maximising the use and accessibility of National Clinical Audit and Clinical Outcome Review Programme data to optimise the CQC regulatory process and to support quality improvement measures at Trust level

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Contents

Purpose of this document: what it covers

The purpose of this document is to provide a rationale for the prioritisation of metrics from National Clinical Audits (NCAs) and Clinical Outcome Review Programmes – within the National Clinical Audit and Patient Outcomes Programme (NCAPOP) – and a framework to allow transparent selection thereof.

The ultimate aim of this process is to drive improvements in healthcare quality through optimisation of the use of NCA data by regulators of health care and to facilitate targeted quality improvement measures by audit participants.

Audience: who this document is intended for

This document is intended primarily for audit and programme providers but it is envisaged that the information contained within will also be of interest to audit participants (e.g. to assess performance against national benchmarks and to help direct specific quality improvement measures), regulators (e.g. to assist in the process of judging healthcare quality) and commissioners (e.g. to assess effectiveness of resource use)

Background: why this document is needed

The Healthcare Quality Improvement Partnership (HQIP) has a central role in facilitating nationwide improvements in healthcare delivery through its role as commissioner of approximately 30 NCAs and four Clinical Outcome Review Programmes within the current NCAPOP. The expansion of NCAPOP has occurred concurrently with landmark reviews of provision within the National Health Service (NHS) which identified the importance of measuring healthcare-related metrics in order to demonstrate improvement, effectiveness and safety (Darzi, 2008). This has been followed by executive-level directives to increase transparency and openness within the NHS – in part through increased reporting of healthcare-related metrics (Lansley, 2010).

As such, results of NCAs are currently disseminated through a variety of avenues including hard-copy and web-based publication of reports, individualised feedback directly to audit participants and to regulators of healthcare such as the Care Quality Commission (CQC).

The CQC regulates health and social care in England and utilises a wide variety of different data sources to monitor providers (and thus to direct inspections) and also to inform inspectors during the inspection process. It is known that a substantial amount of NCA data is already made available to CQC (Phekoo et al., 2014). However, it is also acknowledged that the CQC's use of this data has grown opportunistically rather than systematically over the years and consequently requires optimisation.

Specific issues with the current status quo include the large number of metrics collected by some NCAs, the lack of a clear link between referenced national guidelines and some specific process metrics, presentational aspects of reporting and contemporaneousness of data flow, all of which can hinder meaningful interpretation by CQC inspectors who may not possess audit-specific specialty expertise. It is of particular note that similar concerns with NCA data relating to data burden, standards mapping and presentational format have also been voiced by audit participants (Allwood, 2014).

HQIP and CQC have therefore agreed to collaborate on a project to improve the utility of metrics from NCAs and Clinical Outcome Review Programmes within the NCAPOP as aligned with the CQC inspection process. In keeping with the current prioritisation of outcomes reporting in the NHS, metrics which demonstrate the effectiveness of care are of particular interest. Transparently selecting and appropriately presenting a basket of ‘key’ metrics from NCA and Clinical Outcome Review datasets to the CQC could empower inspectors to form more accurate and holistic opinions about the quality of services and would thus improve the assessment process. Ultimately, by reducing the immediate data burden, it is also hoped that audit participants would be better placed to direct specific quality improvement measures.

Planning: where this document has come from

Oversight for the collaboration between HQIP and CQC (and thus for the creation of this document) has been provided by members of a Steering Group comprised of representatives from HQIP, the Care Quality Commission, the National Advisory Group on Clinical Audit and Enquiries (NAGCAE), NCA clinical and methodological leadership, Trust Audit Departments and Service User Networks. The details of individual Steering Group membership are listed in Appendix 1.

This guidance has been formulated in a manner analogous to the HQIP document "HQIP Principles of Quality in National Clinical Audit" (Healthcare Quality Improvement Partnership, 2011) and is intended to complement other HQIP guidance on delivery of high quality national clinical audit. It is recognised that the majority of published literature is focused on local rather than national clinical audit. Consequently, although peer-reviewed evidence is cited to support specific principles where applicable, the document is primarily based on HQIP's professional opinion, judgement and experience gained through commissioning NCAs and Clinical Outcome Review Programmes within the NCAPOP.

Structure of the document

This methodological component of this document is divided into five parts:

A) A summary of the scope of the project;

B) An overview of the CQC inspection process;

C) An overview of current NCA data flow within the CQC;

D) Eligibility criteria for selection of NCAs and Clinical Outcome Reviews for inclusion in the process;

E) Principles to guide metric selection from NCAs and Clinical Outcome Review Programmes deemed suitable for inclusion.

A) Project scope

The initial phase of this project will be limited to currently active NCAs and Clinical Outcome Review Programmes within the NCAPOP and which have thus passed through a common specification and procurement procedure. Although it is acknowledged that several high quality and much valued NCAs are delivered out with the NCAPOP and it is hoped that future phases of the project might include expansion to include non-NCAPOP NCAs, delivery of the project as an initial "proof of concept" relies on appropriate oversight of ancillary issues such as data flow and end-product ownership. HQIP is thus well positioned to enable delivery given its role in commissioning the NCAPOP.

Balancing the CQC's wider regulatory remit and inspection process with the first phase of this project, metric selection will initially focus on NCAs and Clinical Outcome Review Programmes relevant to acute care and mental health services with particular (although not necessarily exclusive) reference to the effectiveness of healthcare delivery. If successful, the framework could subsequently be expanded to cover other types of healthcare provider.

Selected metrics would be used by CQC as a layered approach to organising data to populate pre-inspection packs (see section C) in a uniform manner across all applicable core services within a hospital or Trust. This would ultimately benefit the inspection process by providing CQC inspectors with a global and balanced view of the "key" standards being achieved at the institution with poor performance followed up on inspection to understand how the hospital is responding to the audit results. Complete data sets would continue to be utilised by CQC to allow inspectors to explore particular core services in greater detail where needed.

In order to promote the ethos of quality improvement, the basket of metrics would also be accessible by hospitals and Trusts in the form of a data repository or dashboard. In keeping with the NHS transparency agenda, the repository would need to be available, in some form, to the public.

The ultimate aim is to maintain a degree of generic applicability to the process to accommodate changing data feeds (such as the commissioning of new NCAs and contemporaneous interest in different metrics). It is envisaged that data flow issues to ensure accuracy and contemporaneousness of data would be managed through HQIP's specification and procurement processes.

B) The CQC inspection process

The CQC regulates health and social care in England. Although its remit extends to both primary, secondary and community care, as well as to paramedical services such as Ambulance Trusts and social care. This phase of the project will concentrate on the inspection process as applied to acute hospitals and mental health services.

Directed by a sophisticated process of data screening to assign Trusts into priority bands for inspection ('Intelligent Monitoring'), CQC utilises national teams of professional hospital inspectors, clinicians and recipients of care ('Experts by Experience') to perform in-depth inspections of hospitals. Inspectors are trained to use their observations of care noted at inspection supported by objective measures (such as NCA data) to assess services within a provider against five 'key questions' (Care Quality Commission, 2015b, Care Quality Commission, 2015d):

- *Safety* - defined as protection from abuse and avoidable harm
- *Effectiveness* - defined as care which achieves good outcomes and is based on the best available evidence
- *Caring* - defined as treatment with compassion, kindness, dignity and respect
- *Responsiveness* - defined as appropriate organisation of services to meet the individual needs of patients
- *Well-led* - defined as organisational leadership, management and governance which assures high quality care, supports learning and innovation and promotes openness and fairness

For each type of provider, CQC defines core services which (if provided) are routinely inspected. These core services have been identified on the basis of presumed risk and patient population coverage:

Table 1: Core services for NHS acute hospitals

Core Services: NHS Acute hospitals
Urgent and emergency services
Medical care (including older people's care)
Surgery
Critical care
Maternity and gynaecology
Services for children and young people
End of life care
Outpatients and diagnostic imaging

Table 2: Core services for Specialist Mental Health services

Core Services: Specialist Mental Health services
Mental health wards
Acute wards for adults of working age and psychiatric intensive care units
Long stay/rehabilitation mental health wards for working age adults
Forensic inpatient/secure wards
Child and adolescent mental health wards
Wards for older people with mental health problems
Wards for people with learning disabilities or autism
Community-based mental health and crisis response services
Community-based mental health services for adults of working age
Mental health crisis services and health-based places of safety
Specialist community mental health services for children and young people
Community-based mental health services for older people
Community mental health services for people with a learning disability or autism

Inspections are focussed through use of standard 'key lines of enquiry' (KLOEs) directly related to the five 'key questions' to ensure consistency of approach. Four sources of evidence are used to answer KLOEs: pre-inspection data gathering (e.g. hospital and key stakeholder feedback), local and national data (e.g. NCAs), on-going local feedback (e.g. complaints data) and on-site inspection findings (e.g. observations of care, interviews with staff and patients) thus enabling a rating to be formed for each 'key question' for each core service. Service-level ratings are subsequently aggregated according to pre-defined principles to derive provider level judgements (Care Quality Commission, 2015a, Care Quality Commission, 2015c). Further detail on the CQC inspection process can be accessed at http://www.cqc.org.uk but the salient feature is that CQC uses evidence from a range of healthcare data sources (including NCAs) to raise questions about the provision and outcomes of care (Care Quality Commission, 2013). The judgements derived are always based on a combination of what is found at inspection (e.g. how Trusts are responding to audit results), what people (e.g. patients, staff and commissioners) tell CQC, analysis of available data and local information from the Trust and other organisations.

The corollary of this is that the prioritisation of 'key' metrics is unlikely to be at the expense of unselected data because the CQC inspection process is multi-faceted and, by default, seeks to examine service provision holistically and in its entirety. CQC would reserve the right to look beyond prioritised metrics and examine entire data sets where it was felt conducive to improving the robustness of an inspection.

C) Current status of NCA data flow within CQC

There is a wide range of evidence which CQC uses as part of the inspection process, and this is considered in three 'tiers' as outlined below:

- *Tier 1* – These are the indicators used for 'Intelligent Monitoring' and comprise a focused set for key indicators for monitoring risks to the quality of care which patients receive. Intelligent Monitoring looks at a range of information including patient experience, staff experience and performance. The indicators relate to the five key questions CQC asks of all services: are they safe, effective, caring, responsive and well-led?
- *Tier 2* – This wider set of indicators includes nationally comparable data such as NCAs and is considered in the planning stage for inspection. Analyses of these indicators feature in the pre-inspection packs that are prepared for each inspection, are often referred to in the inspection reports and help support judgements.
- *Tier 3* - Data which are either not nationally comparable, not routinely available or are otherwise developmental and thus not yet appropriate for inclusion in higher tiers. Although not monitored routinely, they are 'horizon scanned' in conjunction with engagement of specialist societies to identify metrics which may become suitable for elevation to a higher tier in the future.

NCA data are already utilised by the CQC at both Tier 1 and Tier 2 levels underpinned by a complex set of data flows as outlined in Figure 1 in Appendix 2.

NCA metrics designated as Tier 1 indicators for the purposes of Intelligent Monitoring have been chosen primarily on the basis of "key" clinical importance and secondarily on the basis of statistical robustness through internal (the CQC's Intelligence Analytical Group) and external consultation. Final ratification of proposed Tier 1 indicators occurs through the appropriate CQC governance group comprising senior leadership from the CQC's Strategy and Intelligence divisions and the Chief Inspector of Hospitals. The process remains dynamic such that indicators can be added (e.g. where a new key data source becomes available) or removed (e.g. where a data source becomes obsolete).

Importantly, NCA metric rationalisation also occurs at the stage of compiling the pre-inspection packs ('Tier 2') and is constrained by factors such as volume of data and print space. HQIP and CQC's collaboration seeks to optimise this stage of data flow and presentation such that NCA metrics are appropriately (and transparently) prioritised and presented in a layered fashion to maximise their utility to CQC inspectors prior to and during inspections.

The objective of this project is thus illustrated graphically in Figure 2 in Appendix 2.

D) Eligibility criteria for selection of NCAs and Clinical Outcome Review Programmes

Criterion 1: The clinical audit or review programme should be part of the NCAPOP.

Rationale: NCAs and Clinical Outcome Review Programmes within the NCAPOP have undergone a common specification development and procurement process with commissioning oversight provided by HQIP. Delivery of this project as a 'proof of concept' would benefit from restricting the first phase to the NCAPOP to maximise engagement. As a corollary of this, numerous high quality non-NCAPOP NCAs are delivered by other providers and selecting some NCAs over others could adversely affect clinical 'buy-in' for the project as a whole.

Criterion 2: The NCA or Clinical Outcome Review Programmes should be able to produce timely data which is available to HQIP.

Rationale: Evidence submitted to the CQC for inspection purposes must be contemporaneous. Data older than three years at the time of an inspection is unsuitable to support judgements. Consequently, non-iterative 'snap-shot' audits and those audits in the process of being decommissioned are unlikely to be suitable for inclusion in this process.

E) Principles to guide metric selection from NCAs and Clinical Outcome Review Programmes

Principle 1: Metrics should be available from the most recent or current data set collected by the audit.

Rationale: This project does not seek to extract new metrics or to devise composites from currently collected data. Metrics which formed part of historical data sets (e.g. collected by previous iterations of the audit) would be unsuitable for use in the CQC inspection process.

Principle 2: Providers should aim to supply up to five metrics per NCA or Clinical Outcome Review Programmes.

Rationale: It is acknowledged that this number of recommended metrics (five) is relatively arbitrary and that some NCAs with smaller data sets may find the process simpler than their larger counterparts. However, excessive data burden has already been identified as an impediment to both CQC inspections and to hospital level quality improvement measures. This process should be regarded as an opportunity to optimise both by focussing attention on metrics of central importance.

Principle 3: Metrics should be selected on the basis of perceived universal importance (e.g. outcomes) and/or on the basis of known variability.

Rationale: Regulatory efforts should necessarily be focussed on metrics felt to be of greatest importance to patients whilst selection of metrics with minimal inter-provider variability renders them non-discriminatory. Inter-provider variability represents an opportunity to target quality improvement measures (Merkow et al., 2009, Saunders et al., 2012).

Principle 4: Outcome metrics should be prioritised and whether they are crude or risk-adjusted should be explicitly stated.

Rationale: Outcomes are the most visible and easily quantifiable endpoints of care (Sinha et al., 2012). Criticisms about the potential afforded for quality improvement related to the reporting of outcomes have been noted and their use should be context-sensitive (Rubin et al., 2001, Holt et al., 2008). Nonetheless, given the link between clinical outcomes and effectiveness as well as the universal relevance to patients, clinicians, commissioners and regulators, outcomes reporting is a current priority in the NHS (Lansley, 2010, Care Quality Commission, 2013).

Principle 5: Process measures should either have an evidence-based link to outcomes or should themselves be explicitly based on definitive evidence-based guidelines (such as clinical guidelines from bodies such as NICE, SIGN, Royal Colleges or comparable bodies). Where suggested process measures only approximate to guidelines or where they are based on consensus opinion, this should be clearly stated.

Rationale: The purpose of clinical audit is to enable quality improvement by measuring performance against recognised standards. This is consistent with HQP's principles of good practice and quality in audit and complements the CQC's approach to assessing the effectiveness of care (Healthcare Quality Improvement Partnership, 2011, Care Quality Commission, 2013).

Principle 6: Organisational factors (structural measures), patient reported outcome measures (PROMs) and patient reported experience measures (PREMs) are less preferable to outcome and process metrics.

Rationale: The lack of standard terminology for organisational variables represents a significant methodological hurdle in consistently linking structures to outcomes and thus prevents comparisons between Trusts (Pronovost et al., 2009). In particular, organisational data - particularly where collected as binary responses - presents relatively less opportunity for targeted quality improvement compared with process measures. Additionally, quality improvement measures directed at improving process metrics may well exert their effect through infrastructural changes (Hearld et al., 2008). Although HQIP recognises the value of PROMs/PREMs, within the NCAPOP they are currently not reported at Trust or hospital level with sufficient completeness to facilitate their use in this process. Furthermore, the lack of a clear methodology for interpreting PROMs and PREMs for directing quality improvement reflects their de-prioritisation within HQIP's current commissioning framework.

Principle 7: The use of duplicative or highly correlated metrics should be avoided.

Rationale: Measurement of outcomes (such as mortality) at different intervals is undoubtedly important and reflects the differing viewpoints of recipients, providers and commissioners of healthcare but their use for this project would run counter to the principles of reducing data burden and facilitating quality improvement (Daley et al., 2001). A similar rationale applies to presentation of both crude and risk-adjusted outcomes (Fink, 2009). Whilst full presentation of such metrics is necessarily included in NCA reports as they are pertinent to methodology, this process represents an opportunity to improve their utility in quality improvement and assurance.

Principle 8: The use of non-composite measures is preferred.

Rationale: Composite measures have much value in summating data (often in a weighted manner) and enabling ease of presentation. This quality lends itself well to their use as screening metrics, for example, for Intelligent Monitoring (see section C: Current status of NCA data flow within CQC).

However, composites sacrifice granularity and interpretability for quality improvement and quality assurance purposes (Simms et al., 2013, Jacobs et al., 2005, Reilly and Johnstone, 2000).

Principle 9: The proposed metrics should align themselves with the five keys questions which underpin the CQC inspection process (i.e. are services safe, effective, caring, responsive and well-led?). Metrics which demonstrate effectiveness of care are preferred.

Rationale: The five key questions of the CQC align themselves both with current interpretations of the definition of quality within the NHS as well as the NHS Outcomes Framework (Care Quality Commission, 2013, Darzi, 2008, Department of Health, 2010).

Principle 10: The selected metrics must be available and identifiable at named hospital or Trust level.

Rationale: By necessity, evidence incorporated into the CQC inspection process must be attributable to the hospital or Trust being inspected. Consequently, audits or programmes which either rely on anonymised data submission or for which data sharing frameworks preclude dissemination of identifiable audit participant level data are unlikely to be suitable for inclusion in this process.

Principle 11: Selected metrics should be made available in numerical format along with the historical results (e.g. previous year's result), contemporaneous results (e.g. national average) and the national standard (if applicable) and with guidance on the NCA provider's preferred methodology for defining outlier status (e.g. funnel plots; measured against national average or the national standard). Guidance should either be detailed enough to allow CQC to reproduce graphical output themselves or should be supplied as a completed analysis with graphical output.

Rationale: Outlier analysis details are important to CQC for the purposes of quality assurance. Methodology will, necessarily, be different for different conditions across the different NCAs and thus it crucial that CQC's outlier analyses are identical to those of the provider for any NCA participating in this project. However, presentation of summary graphical data without the underlying numerical values impedes Trust-level quality improvement as data then needs to be manually extracted from the graphical output.

Definitions/Glossary

Audit Participants: Refers to suppliers of data at local level (i.e. hospitals or trusts).

Audit Providers: Refers to organisations who manage the central functions of the audit (i.e. project planning and co-ordination, communications and data analysis).

Clinical Outcome Review Programmes: Programmes formerly known as 'confidential enquiries', which are designed to assess healthcare quality and stimulate improvement by enabling learning from adverse events and other relevant data.

Metric: Measurements of performance related to the delivery of healthcare.

National Clinical Audits (NCAs): In keeping with preceding guidance from HQIP, the term 'National Clinical Audit' is understood to include registries and databases (such as the National Joint Registry and the National Hip Fracture Database) (Healthcare Quality Improvement Partnership, 2011).

National Clinical And Patient Outcomes Programme (NCAPOP): An HQIP commissioned programme comprising of approximately 30 NCAs and four Clinical Outcome Review Programmes.

NICE: National Institute for Health and Care Excellence.

PREMs: Patient reported experience measures.

PROMs: Patient reported outcome measures.

SIGN: Scottish Intercollegiate Guidelines Network.

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Appendix 1 - Steering Group Membership

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Ms Jenny Mooney - Director of Operations NCAPOP

Dr Yvonne Silove - Associate Director for Quality and Development HQIP

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Geraldine Waters - NAGCAE representative

Kat Young - NQICAN representative

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Josceline Miles - Trust Audit Professional King's College Hospital NHS Foundation Trust

Claire Palmer - Trust Audit Professional King's College Hospital NHS Foundation Trust

Professor Mike Dent - Service User Network representative

Dr Sarah Markham - Service User Network representative

Dr Sonia Renwick – Associate Medical Director Royal Free Hospital NHS Foundation Trust

Appendix 2 – NCA data flows to the CQC

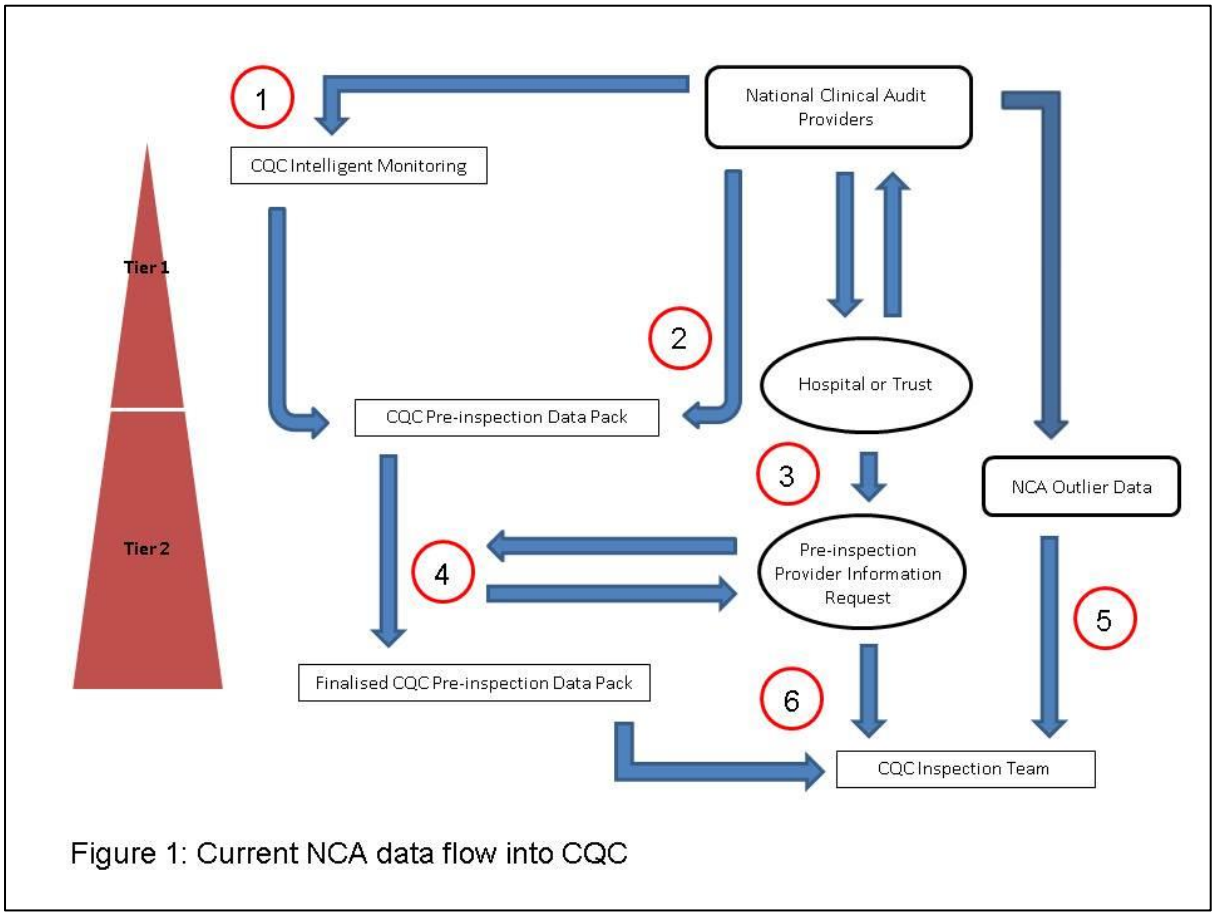

Figure 1: Current NCA data flow into CQC

1) Selected metrics from NCAs used for Intelligent Monitoring on the basis of clinical importance via internal proposals (CQC inspectorate) and through external consultation (audit providers). This data is also included in the pre-inspection pack as provenance.

2) NCA data flows to CQC either actively (i.e. automated audit provider feed directly to CQC) or passively (i.e. CQC retrieves NCA data from publically available repositories e.g. audit reports and websites) to populate Pre-Inspection Packs.

3) CQC requests disclosure of NCA participation by hospital prior to impending inspection ('Pre-inspection Provider Information Request' [PPIR]). This is typically a very detailed document containing hospital-specific results from numerous data sources (i.e. not only NCA data).

4) Further NCA data added to Pre-Inspection Packs by Inspection Analyst Teams through analysis of the data within the PPIR, via liaison with CQC Inspection Team, through analyst team knowledge of hospital activity and after factual accuracy cross-check with hospital leading to finalised data pack.

5) For some NCAs, CQC are informed directly of outlier performance by audit providers and this information is passed to the Inspection Teams. This process is distinct from the CQC Outliers Programme which utilises HES data to monitor mortality.

6) Finalised Pre-Inspection Packs made available to CQC Inspection Teams. Due to space constraints, rather than directly populating the Pre-Inspection Pack, some data from the PPIR is shared directly with core-service specific parts of the CQC Inspection Team.

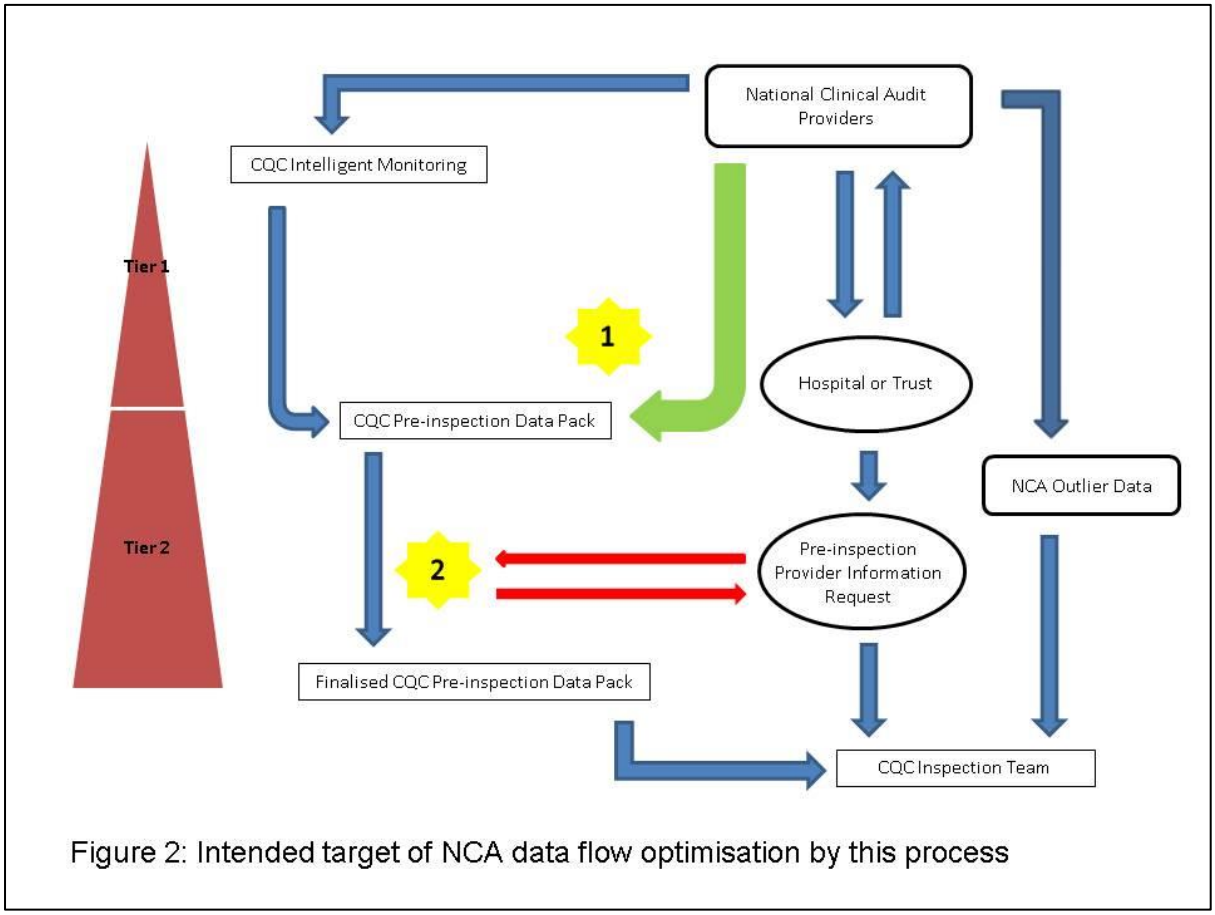

Figure 2: Intended target of NCA data flow optimisation by this process

1) This project aims to maximise and optimise NCA data flow at this level. By selecting 'key' metrics from all NCAPOP NCAs and Clinical Outcome Review Programmes, there would be a '1st layer' of key audit metrics which would be used to populate pre-inspection packs. Full data sets would continue to be used by the CQC where inspection findings deemed this necessary.

2) As a corollary, the project aims to minimise the amount of data flow into the Pre-Inspection Pack at this level.

Appendix 3 - Individual Metric Selection Data Sheets

National Clinical Audit:

Method of sampling (total target, random sample, convenience sample, other):

Frequency of data collection:

Name of person completing form:

Contact details of person completing form:

Number of metrics suggested (1-5):

1) Metric 1:

2) Type of metric (outcome, process, organisational, PROMs/PEMs):

3) Rationale for inclusion (importance, variability or other):

4) For outcome measures, please state if crude or risk-adjusted:

5) For process measures or organisational factors, please state if based on national guideline/standard (e.g. NICE), consensus opinion or other:

6) For process measures or organisational factors with a corresponding national guideline -

A) Please state the corresponding national guideline or standard:

B) Please state if process measure maps exactly or approximately to guideline:

7) For the chosen metric, please specify whether outlier status is defined (Y/N):

8) For metrics with defined outlier status, please state how this is –

A) Defined (e.g. against the national standard or against the national average):

B) Presented (e.g. risk-adjusted funnel plots with 99.8% Poisson control limits):

Free Text Comments:

1) Metric 2:

2) Type of metric (outcome, process, organisational, PROMs/PEMs):

3) Rationale for inclusion (importance, variability or other):

4) For outcome measures, please state if crude or risk-adjusted:

5) For process measures or organisational factors, please state if based on national guideline/standard (e.g. NICE), consensus opinion or other:

6) For process measures or organisational factors with a corresponding national guideline -

A) Please state the corresponding national guideline or standard:

B) Please state if process measure maps exactly or approximately to guideline:

7) For the chosen metric, please specify whether outlier status is defined (Y/N):

8) For metrics with defined outlier status, please state how this is –

A) Defined (e.g. against the national standard or against the national average):

B) Presented (e.g. risk-adjusted funnel plots with 99.8% Poisson control limits):

Free Text Comments:

1) Metric 3:

2) Type of metric (outcome, process, organisational, PROMs/PEMs):

3) Rationale for inclusion (importance, variability or other):

4) For outcome measures, please state if crude or risk-adjusted:

5) For process measures or organisational factors, please state if based on national guideline/standard (e.g. NICE), consensus opinion or other:

6) For process measures or organisational factors with a corresponding national guideline -

A) Please state the corresponding national guideline or standard:

B) Please state if process measure maps exactly or approximately to guideline:

7) For the chosen metric, please specify whether outlier status is defined (Y/N):

8) For metrics with defined outlier status, please state how this is –

A) Defined (e.g. against the national standard or against the national average):

B) Presented (e.g. risk-adjusted funnel plots with 99.8% Poisson control limits):

Free Text Comments:

1) Metric 4:

2) Type of metric (outcome, process, organisational, PROMs/PEMs):

3) Rationale for inclusion (importance, variability or other):

4) For outcome measures, please state if crude or risk-adjusted:

5) For process measures or organisational factors, please state if based on national guideline/standard (e.g. NICE), consensus opinion or other:

6) For process measures or organisational factors with a corresponding national guideline -

A) Please state the corresponding national guideline or standard:

B) Please state if process measure maps exactly or approximately to guideline:

7) For the chosen metric, please specify whether outlier status is defined (Y/N):

8) For metrics with defined outlier status, please state how this is –

A) Defined (e.g. against the national standard or against the national average):

B) Presented (e.g. risk-adjusted funnel plots with 99.8% Poisson control limits):

Free Text Comments:

1) Metric 5:

2) Type of metric (outcome, process, organisational, PROMs/PEMs):

3) Rationale for inclusion (importance, variability or other):

4) For outcome measures, please state if crude or risk-adjusted:

5) For process measures or organisational factors, please state if based on national guideline/standard (e.g. NICE), consensus opinion or other:

6) For process measures or organisational factors with a corresponding national guideline -

A) Please state the corresponding national guideline or standard:

B) Please state if process measure maps exactly or approximately to guideline:

7) For the chosen metric, please specify whether outlier status is defined (Y/N):

8) For metrics with defined outlier status, please state how this is –

A) Defined (e.g. against the national standard or against the national average):

B) Presented (e.g. risk-adjusted funnel plots with 99.8% Poisson control limits):

Free Text Comments: