



National Audit Office

Measuring Up

How good are the Government's data systems for monitoring performance against Public Service Agreements?

PSA 19: 'Ensure better care for all'

A review of the data systems underpinning the Public Service Agreement led by the Department of Health under the Comprehensive Spending Review 2007

REPORT BY THE NATIONAL AUDIT OFFICE

Validation of the data systems for the PSA19, Spending Review Period 2008-11

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Executive Summary

Introduction

1. This report summarises the results of our examination of the data systems used by the Government in 2008 to monitor and report on progress against PSA 19.

The PSA and the Department

2. PSAs are at the centre of Government's performance measurement system. They are usually three year agreements, set during the spending review process and negotiated between Departments and the Treasury. They set the objectives for the priority areas of Government's work.
3. PSA 19 is led by the Department of Health who are responsible for all 8 indicators underpinning the PSA. Each PSA has a Senior Responsible Officer who is responsible for maintaining a sound system of control across Departmental boundaries that supports the achievement of the PSA. The underlying data systems are an important element in this framework of control.
4. The most recent public statement provided by the Department on progress against this PSA was in the Autumn Performance Report 2008.

The purpose and scope of this review

5. The Government invited the Comptroller and Auditor General to validate the data systems used by Government to monitor and report its performance. During the period September 2008 to February 2009, the National Audit Office (NAO) carried out an examination of the data systems for all the indicators used to report performance against this PSA. This involved a detailed review of the processes and controls governing:
 - The match between the indicators selected to measure performance and the PSA. The indicators should address all key elements of performance referred to in the PSA.
 - The match between indicators and their data systems. The data system should produce data that allows the Department to accurately measure the relevant element of performance.
 - For each indicator, the selection, collection, processing and analysis of data. Control procedures should mitigate all known significant risks to data reliability. In addition, system processes and controls should be adequately documented to support consistent application over time; and
 - The reporting of results. Outturn data should be presented fairly for all key aspects of performance referred to in the target. Any significant limitations should be disclosed and the implications for interpreting progress explained.

6. Our conclusions are summarised in the form of traffic lights (see figure 1). The ratings are based on the extent to which Departments have:
 - (i) put in place and operated internal controls over the data systems that are effective and proportionate to the risks involved;
 - (ii) explained clearly any limitations in the quality of its data systems to Parliament and the public
7. The remaining sections of this report provide an overview of the results of our assessment, followed by a brief description of the findings and conclusions for each individual data system. Our assessment does not provide a conclusion on the accuracy of the outturn figures included in the Department's public performance statements. This is because the existence of sound data systems reduces but does not eliminate the possibility of error in reported data.

Figure 1: Key to traffic light ratings

Rating	Meaning ...
GREEN (fit for purpose)	The data system is fit for the purpose of measuring and reporting performance against the indicator
GREEN (disclosure)	The data system is appropriate for the indicator and the Department has explained fully the implications of limitations that cannot be cost-effectively controlled
AMBER (systems)	Broadly appropriate, but needs strengthening to ensure that remaining risks are adequately controlled
AMBER (disclosure)	Broadly appropriate, but includes limitations that cannot be cost-effectively controlled; the Department should explain the implications of these
RED (systems)	The data system does not permit reliable measurement and reporting against the indicator
RED (not established)	The Department has not yet put in place a system to measure performance against the indicator

Overview

8. The aim of the PSA is to ensure better care for all and is supported by 8 indicators. The indicators have been chosen to measure progress in

aspects of accessibility, quality and speed of treatment, and responsiveness to users' needs. For this PSA, we have concluded that the indicators selected to measure progress are consistent with the scope of the PSA and afford a reasonable view of progress.

9. There is a named officer within the Department responsible for each of these indicators. This officer is supported by a lead analyst and statistical team. Performance and delivery of the PSA is overseen by a PSA Board, led by the Senior Reporting Officer within the Department. A Performance Committee also exists and meets quarterly to oversee governance and reporting of the PSA.

10. Figure 2 summarises our assessment of the data systems.

Figure 2: Summary of assessments for indicator data systems

No	Indicator	Rating
1	The self reported experience of patients/users	GREEN (disclosure)
2&3	Percentage of patients seen within 18 weeks for (i) admitted patients and (ii) non-admitted patients	GREEN (disclosure)
4	Access for women to maternity services	AMBER (disclosure)
5	People with long term conditions supported to be independent and in control of their condition	GREEN (disclosure)
6	Patient experience of access to primary care	GREEN (disclosure)
7&8	Health care associated infection rates – (i) MRSA and (ii) Clostridium difficile	GREEN (fit for purpose)

11. The Department has made efforts to integrate the indicators for this PSA into its 'Vital Signs' within the Operating Framework 2008/09 for the NHS, which describes the national priorities for the year. Our review of the Vital Signs framework illustrated that, although Tier 3 indicators provide PCTs with the flexibility to prioritise at a local level, the data for the PSA target still have to be reported using the approved national systems e.g. UNIFY2, HES.

12. The Department undertakes extensive monitoring and analysis in respect of its performance against its PSAs and the underlying indicators. Data

quality is also taken seriously within the Department; where external data are collected, service level agreements are in place detailing management's expectations of data quality and where data are collected at a local level, the Department supplements local level controls with central checks over data quality and completeness.

13. We have carried out a review on business critical IT systems and concluded that the Department has satisfactory processes and controls in place designed to ensure effective operation for the purposes of collecting and reporting of data in respect of the Department's PSAs.

14. Our main conclusions on the PSAs are:

- Although there is some evidence that the Department routinely identifies risks relating to the collection of data and reporting of PSAs, the risk analysis and quality reviews are often not formalised.
- The Department has agreed measurement annexes for all of its PSA indicators, setting out the definition of the indicator and the data sources to be used. It also has written, internal guidance providing further detail as to how the indicator will be calculated. However, it is sometimes unclear which elements of the guidance relate to local reporting and monitoring and which relate to national reporting.
- Where the Department obtains data from external sources, such as outturn data are often published on the website of the external provider. The technical notes do not always make the reader aware of the availability of such information.
- For some of the indicators, it is difficult to understand how success will be measured as this is not always defined in the technical guidance, and in some cases the Department intend to define the success criteria for the measure only after a baseline has been established in a future period. For example the long term condition patient experience for those who are supported to be independent does not include a trajectory for improvement and the technical guidance defines the data set as ' a patient experience measure of the proportion of people with a long term condition who are supported ... '. The use of 'proportion' indicates that greater numbers with a positive experience rather than a better overall experience 'score' for the population as a whole may be the core indicator.

- Where data are collected at a local level, the Department does not always obtain evidence of local level controls and checks on the data. This would be good practice, even though the Department institutes its own centralised controls and checks on the data.

15. We recommend that the Department:

- Formalises risk identification and quality review of data systems underpinning the PSA indicators. This could be in the form of data risk registers related to each indicator, which set out the risks to data quality, how the risks are expected to be mitigated and confirmation that the mitigation remains effective;
- Distinguishes those elements of reporting that are only applicable at a local level from those required to assess progress against the PSA indicator;
- Ensures that all technical guidance details how success will be defined and how progress will be measured at a national level, including details of reporting intervals;
- Includes links in technical guidance to external sources of data reporting; and
- Seeks further evidence to confirm the effective operation of local level controls.

Assessment of indicator set

16. In undertaking the validation we read the documentation associated with the PSA, including the Delivery Agreement and considered whether the indicators selected to measure progress are consistent with the scope of this PSA. We conclude that the indicators selected afford a reasonable view of progress.

FINDINGS AND CONCLUSIONS FOR INDIVIDUAL DATA SYSTEMS

The following sections summarise the results of the NAO's examination of each data system.

Indicator 1 – The self reported experience of patients/users

Conclusion – Green (disclosure)

17. The data system is capable of collecting reliable information on all of the key elements of patient experience over the five 'domains' publicised by the Department. However, due to the nature of surveys, there are some limitations that cannot be easily mitigated or controlled cost effectively. Such limitations have been disclosed alongside the latest survey results on the Department's website, and baseline figures have also been reported in the Autumn Performance Report 2008.

Characteristics of the data system

18. The 'patient experience' element of this target is measured using a rolling programme of patient surveys, administered by the Healthcare Commission¹. These are based on five key dimensions rated by patients as important:

- Access and waiting;
- Safe, high quality, co-ordinated care;
- Building closer relationships;
- A safe, clean, comfortable place to be; and
- Better information and more choice.

Success will be defined through increasingly positive national survey results under each patient dimension.

19. The rolling surveys do not include all surveyed services each year, thus while the Adult Inpatient survey is carried out annually, other surveys are carried out at intervals of 2-5 years. This programme is designed to be cost-effective, as well as reducing the burden on local organisations.

¹ The Health Care Commission was replaced by the Care Quality Commission from 1 April 2009

20. The 'patient involvement' and 'choice of provider' elements of the target are also being measured through these patient surveys and ask the extent to which patients feel involved about their treatment/care and whether they consider they were offered a choice of provider following referral.

Findings

21. The surveys were overseen and regulated by the Healthcare Commission, through contracts with the Picker Institute and the National Centre for Social Research which act as advice and co-ordination centres for NHS Trusts and Primary Care Trusts.

22. The system has been well specified; a wide range of in-house and external specialists were consulted in the design of the system, the surveys are administered by an independent body and there is a list of approved contractors to carry out the surveys. The co-ordination centres were procured using competitive tendering exercises and contracts are in place between them and the Healthcare Commission, which include specifications providing assurance over data quality.

23. A small number of trusts conduct the surveys in-house, although this practice is reducing year on year. Where this occurs, the trusts must follow the guidance set out by the Picker Institute and are subject to the same checks and controls as those trusts using independent contractors.

24. The Patient Experience PSA Scores were classed as a National Statistic in April 2008, and thus are subject to quality review and are produced in accordance with the National Statistics Code of Practice protocols. However, we still consider there to be some minor risks to data collection. Although samples are selected which are representative of the general population of patients, this is no guarantee that a representative sample of responses will be received.

25. The Healthcare Commission identified low response rates from males, younger patients and black and ethnic minority groups. In light of this, in 2006 the Department and Healthcare Commission conducted a joint review of the methodological issues in the survey, which considered among other things whether to weight results due to the different response rates from different groups. The review decided against

introducing weighting as it added to the complexity of the methodology and seemed to have only a small impact on results.

26. The Department is still attempting to increase responses from these low-response groups and a number of review projects have since been undertaken exploring options designed to enhance response rates amongst these groups. These were brought in during the piloting period of the 2007 inpatient survey; however, none of the methods piloted resulted in significant improvement to the response rate and therefore have not been introduced. A new survey method enabling respondents to complete the questionnaires via the internet is being piloted during the 2009 inpatient survey. An evaluation report will be published in due course, considering the impact on response rates.
27. The Department has published baseline results relating to patient experience PSA scores for the most recently available survey results. Reporting is clear and transparent and is accompanied by suitable disclosures to explain where certain results are not comparable across settings or previous years.
28. As noted above, different aspects of service are surveyed at different times and thus the Department will need to disclose limitations to the data alongside its reporting of progress.

Indicator 2 and Indicator 3 – Percentage of patients seen within 18 weeks for admitted patients and non-admitted patients

Conclusion – Green (disclosure)

29. The system in place to collect data on the 18 week referral to treatment target is appropriate for the indicator and the Department have explained the implications of limitations that cannot be cost-effectively controlled. The system does not measure data according to the exact wording of the PSA as published - the reported results reflect the percentage of all patients treated within 18 weeks, not only those patients for whom it was clinically appropriate and chose to start their treatment in 18 weeks.

Characteristics of the data system

30. The data system has been designed to measure the time from initial GP referral through to the start of hospital treatment or other clinically appropriate outcome. The target aims to ensure that by December 2008 this interval is no longer than 18 weeks for all patients who choose, and for whom it is clinically appropriate, to start treatment within this timeframe.

31. The system in place does not capture the reason for a patient not meeting the 18 week target, and thus operational standards have been set to take into account patient-initiated delays or clinical exceptions.

32. The operational standards set adjusted tolerance levels, based on research to determine an estimate of cases where 18 weeks is inappropriate. These state that 90% of admitted and 95% of non-admitted patients should start treatment within 18 weeks of referral. Overall success is defined by both providers and commissioners delivering against the target.

33. All NHS organisations that provide services falling within the scope of the 18 weeks target must collate referral to treatment patient pathway data via their local patient administration systems (PAS). Data are then entered onto a monthly return and submitted to the Department through the UNIFY2 data collection tool. In-built functionality within UNIFY2 will aggregate the provider data and produce a commissioner return

which primary care trusts (PCTs) must check, update for any missing data, and submit to the Department, again through UNIFY2. It is the commissioner based data that forms the basis of the PSA reported figures.

Findings

34. The key data collection tool for this target is the UNIFY2 system. This has been separately assessed by the NAO and we are content that there are appropriate controls over data submitted to and maintained in that system.
35. Initial data collection is undertaken by NHS trusts, which are subject to spot checks by the Audit Commission on behalf of the Healthcare Commission, the responsible body for the annual healthcheck. Data returns must also be signed off by the trust Chief Executive as being complete and accurate. Returns are then further validated by the commissioning PCT and the Department, making use of corroborative data sources and knowledge of historical performance trends. A data completeness assessment is undertaken by the Department against expected completed treatment pathways.
36. The risk of inconsistent application of data definitions has been mitigated by codifying data definitions at national level through a data dictionary. Detailed written guidance has been provided to trusts advising how to apply the 18 weeks 'rules' and support helplines are available to deal with specific queries. Much work has also been carried out with NHS trusts during pilot programmes and roadshows to ensure that organisations are confident in applying the 18 week criteria consistently. The Department has set up an 18 weeks website which gives access to comprehensive application guidance.
37. There is a potential risk to the completeness of data given that this is a new collection, but this is being monitored by the Department and performance indicators relating to data completeness are published alongside referral to treatment figures to aid interpretation of results. E.g. September 2008 indicators show data completeness was 97% for admitted pathways and 93% for non-admitted pathways.
38. The PSA is well defined in the technical note; however the operational standards underpinning the target are not fully disclosed. These are

disclosed in the 2008 Departmental Report, the 2009/10 Operating Framework and other documents on the Department's website, but it would still be useful for the technical note to be updated. It may also aid the user of the referral to treatment data to understand which treatment functions are within the scope of the 18 week pathway – this could be disclosed via a link in the technical note.

39. Results are reported on a monthly basis via the Department's website according to a published timetable. The percentage of patients meeting the 18 week target is set out on an individual provider or commissioner basis rather than an aggregated national position. However, progress against the national position has been reported in statistical press releases on the Department's "18 weeks" website. The technical note does not currently include any links to where reported data can be accessed and it should be updated accordingly.

Indicator 4 – Access for women to maternity services

Conclusion – Amber (disclosure)

40. A revised data system has been formalised and is due to be put in place for the 2008-09 quarter three data collection. The system specification is well defined and relevant to the indicator. There are some limitations that cannot be mitigated or cost effectively controlled and these will have to be explained by the Department when reporting on progress begins. The current system acts as a proxy system in the interim and is broadly appropriate to the indicator.

Characteristics of the data system

41. The indicator aims to measure the percentage of pregnant women who have seen a midwife or maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 weeks and 6 days of pregnancy. The long term intention is that maternity data will be collected by the NHS Information Centre through a Hospital Episodes Statistics (HES) collection. However, that dataset is still awaiting business case approval.

42. A proxy system is in place to be used for the first two years of PSA data collection. This involves primary care trusts (PCTs) submitting quarterly Vital Signs Monitoring Returns, detailing each woman's date of assessment and estimated date of delivery. The denominator is then derived from GP and Child Health Information Systems which extract figures for the number of women in the relevant PCT population who give birth to one or more babies of at least 24 weeks gestation. The data used as the denominator will relate to two quarters after the quarter of collection to ensure that both numerator and denominator relate to broadly the same cohort of women.

Findings

43. This indicator is a new data collection and initial problems were encountered, with only 82% of PCTs being able to submit figures for

2008-09 quarter one. As a result, the Department took the decision to redefine the indicator and provide detailed guidance on how each element of the data stream would be collected. The intention is that this will improve data completeness in 2008-09 quarter three.

44. All PCTs must sign off the Vital Signs Monitoring returns as being complete and accurate. An additional validation check, to confirm general data accuracy, is the provision of an alternative denominator that measures the number of women in the relevant PCT population who have seen a midwife or maternity healthcare professional at any time during pregnancy for the quarter of collection. The addition of this denominator, although not as robust as that relating to subsequent live births, allows for a more timely measure of progress and an approximate check of data completeness and quality.
45. There are certain limitations with the data in that the live births denominator will exclude any woman who has had or should have had an assessment within 12 weeks and 6 days of pregnancy, but who then has an abortion or goes on to lose their baby before 24 weeks of gestation. The Department believe the rate of miscarriage after 12 weeks and 6 days to be less than 2% of all pregnancies, and a report by the Royal College of Obstetrics and Gynaecology in 2004 found that 14% of all abortions took place after 13 weeks.
46. This is a pragmatic approach that has been taken by the Department to capturing early assessment rather than having a denominator referring to the population of pregnant women, or women who reach a certain gestational age. These alternative denominators would have implications in terms of data collection burden or require linkage to ONS birth data which would introduce a significant time lag. However, it does mean that it is feasible to achieve an indicator percentage greater than 100% if women who are assessed go on to terminate or miscarry, causing them to be captured in the numerator but not the denominator.
47. There has currently been no reporting of progress against this indicator as it is too early to report results. When the Department does report results it will have to ensure that adequate explanations of the limitations in the data system are disclosed.

Indicator 5 – People with long-term conditions supported to be independent and in control of their condition

Conclusion – Green (disclosure)

48. A reliable data system is in place to measure the percentage of people with long-term conditions supported to be independent and in control of their condition, through a self-reported patient experience survey. However, due to the nature of surveys, there are some limitations that cannot be easily mitigated or controlled cost effectively. The Department has published baseline figures for 2007-08 and further details are available on the Healthcare Commission's website.
49. In 2008-09 a proxy system will be in place to report progress which measures reduction in the emergency bed days used by patients with long term conditions. The NAO assessed the data system for this measure as green in the CSR 2004 period. There have been no changes since then and the rating given reflects the proxy system.

Characteristics of the data system

50. Measurement of the indicator is derived from the results of the Primary Care Trust (PCT) Patient Survey, administered by the Healthcare Commission. It is part of the same rolling programme of surveys used to derive the data for Indicator 1- the self reported experience of patients and users. The survey is therefore subject to the same checks and controls as described in that section.
51. In the 2008 PCT questionnaire-based survey respondents were asked to tick a box stating if they have any of the listed long-term conditions. The questionnaire then goes on to ask the extent to which they have received sufficient support from local services or organisations to manage their long term health condition which is considered to be a close enough map to the indicator wording. The results are then extracted to form a percentage of those respondents who ticked 'yes, definitely' or 'yes, to some extent' from the population of respondents who identified themselves as having a long-term condition.

52. The proxy system relies on data collected as part of hospital episode statistics. These underpin a number of PSA targets and the data is collected and submitted with appropriate robust controls and validation checks applied locally and centrally.

Findings

53. The patient experience survey targets a population of all patients aged 16 or over who are registered with a GP and is therefore not a direct representation of the indicator's target population. This is due to the fact that it is not possible to use the sampling frame to extract patient data according to medical condition.

54. In the 2008 survey only 25% of survey respondents were eligible to answer the long-term conditions question. However, confidence levels and error intervals for the survey as a whole and for the single question on long-term conditions show the resulting data to be statistically reliable for reporting.

55. Other general survey findings are as discussed in reference to Indicator 1 - the self reported experience of patients and users.

56. The Department has reported baseline data (both for the PCT Patient Survey and provisional data for the emergency bed days proxy measure) for the indicator for 2007-08 in its Autumn Performance Report 2008. The Healthcare Commission has also published more detailed 2008 survey results on its website. The technical note could be updated to include a link to where the Healthcare Commission data are publicly available.

Indicator 6 – Patient experience of access to primary care

Conclusion – Green (disclosure)

57. The current system measures the key elements of patient experience of access to primary care as defined in the technical note in a reliable manner. There are some uncontrollable risks that cannot be cost effectively mitigated due to the nature of surveys. Also, there has been no Departmental reporting of progress against the indicator for the current CSR period and so we cannot conclude on this aspect or on whether limitations are adequately disclosed.

Characteristics of the data system

58. The current data system measures patient experience of access to primary care using the average of five key elements covered in the GP Patient Survey. These are:

- Satisfaction with telephone access to GP practice;
- Ability to see GP within 48 hours if wanted;
- Ability to book GP consultation 3+ days ahead if wanted;
- Ability to see a specific GP if wanted; and
- Satisfaction with GP practice opening hours.

59. Management of the survey is contracted out to Ipsos MORI which follows detailed guidance set by the Department. A sample population is extracted for each primary care trust population based on all patients aged 18 or over who are registered with GP practices which are signed up to provide Directed Enhanced Services (this was 99% of GP practices in 2007-08) .

A postal questionnaire is then sent out to the sample population and Ipsos MORI collate the results. This underpinning data is submitted to the Department, who then calculate the percentage scores based on the survey count figures.

Findings

60. The survey is sampled from a large population and has a high level of statistical accuracy, capable of distinguishing significant change between periods of assessment. However, there are still some data risks that surround all survey based measures such as the respondent population not being representative of the sample population. Sufficient controls and checks are in place to ensure the validity of the data that is returned, although the department could improve disclosure in the technical note by providing links to the detailed guidance and survey methodology.
61. There is a concern that in 2009-10 the survey will move towards a quarterly basis and the indicator will be broadened to include new data on the proportion of people who were satisfied with their overall experience of their GP practice. An exercise will therefore be required to map the old questions against the new ones and comparability of data may be compromised. However, our review has been carried out before such changes have been implemented and as a result we cannot conclude on the proposed changes to data collection.
62. Departmental reporting has not yet taken place with regard to progress made within the current CSR period so we are unable to conclude on this aspect at present.

Indicator 7 and Indicator 8 – Healthcare associated infection rates (MRSA and Clostridium Difficile)

Conclusion – GREEN (fit for purpose)

63. The data collection system is well established and well defined, being a direct measure of the indicator. There is no evidence of any significant uncontrolled risks affecting data quality and any minor risks are adequately disclosed.

Characteristics of the data system

64. If a patient within an NHS Trust is identified as having symptoms that could be related to either MRSA or Clostridium Difficile then blood/stool samples are taken and sent to trust laboratories for testing. If a positive case of either MRSA or Clostridium Difficile is identified, then the laboratory will usually report to the Infection Control team at the trust who will collect the data and record it on their local patient administration system (PAS).

65. Each trust is then required on a monthly basis to report all known cases of MRSA and Clostridium Difficile to the Health Protection Agency (HPA). Trusts access their user accounts on the HPA-managed HCAI Data Capture System and upload their data which is then signed off by the trust Chief Executive as being complete and accurate. The HPA validates and analyses the figures and publishes them on its website on a quarterly basis. The Department uses these figures to measure progress against the PSA target.

66. HPA data quality checks include corroborating returns against voluntary laboratory reporting from trusts (90% of all cases are voluntarily reported). This crosscheck occurs for MRSA cases only.

67. Further corroborative checks are also carried out against Hospital Episode Statistics for both MRSA and Clostridium Difficile cases. (N.B. The Hospital Episode Statistics dataset does not collect community acquired infection data.)

Findings

68. The data collection system is well defined in that it is a direct measure of the healthcare associated infection indicators. It is also well established, having been introduced in 2001 with reporting of MRSA cases having been made mandatory in 2005. Reporting of Clostridium Difficile cases is also mandatory.
69. The HPA administers the data system but there is no current service level agreement in place between the Department and HPA. Whilst there is no evidence that this has compromised data quality in any way, it would be good practice to formalise the respective responsibilities of both organisations.
70. The main risk to data quality is likely to arise from trust errors. In order to mitigate this, detailed guidance is provided in order to ensure that data are collected and reported in a consistent manner. NHS Trust Chief Executive sign-off provides additional assurance over the completeness of data. The HPA then carries out further validation checks based on known trends and parallel laboratory data which further reduce the risk to data quality.
71. Success of the Clostridium Difficile indicator is well defined in the technical note; however, successful performance against the MRSA indicator is not as transparent. Definitions of performance success indicate two alternative measures; the first states the average annual number of MRSA cases over the CSR period should be less than the baseline (half the 2003-04 figure) and the second is that in each of the CSR years, the number of MRSA cases should be less than the baseline. Greater clarity with regard to defining success is required within the technical note.
72. There have been recent changes to the data definitions for collecting and reporting Clostridium Difficile data. However, the Department has issued a Dataset Change Notice to request all trusts to re-submit historical data from April 2007, the start of the baseline period, in accordance with the revised definitions to ensure comparability throughout the CSR period.

73. The Department has reported a clear assessment of progress against the MRSA and Clostridium Difficile indicators within the Autumn Performance Report 2008. Further quarterly statistical data can also be found on the HPA website and links should be included in the technical note to advise readers as to where this is located.