

RSM Tenon

2011
Cross client
thematic review

Reporting quality in the acute sector
The disparity of KPI reporting

Foreword

The provision of a high quality service to its patients is both the primary purpose of the NHS and the fundamental expectation of patients. However, a number of recent and well publicised failings have called into question the premise of this expectation.

The NHS has not been slow in identifying and reacting to these concerns. It has seen a number of initiatives to rebalance the focus of Boards to a position where quality should be the predominant issue. These initiatives include the introduction of Quality Accounts, which whilst still relatively embryonic, have introduced the need to publicly report on the quality of services provided.

Monitor's publication, 'Quality Governance Framework' (July 2010), defined quality governance as the following:

“the combination of structures and processes at and below Board level to lead on Trust-wide quality performance including:

- Ensuring standards are achieved
- Investigating and taking action on sub standard performance
- Planning and driving continuous improvement
- Identifying, sharing and ensuring delivery of best practice
- Identifying and managing risks to quality of care”

Monitor's publication, was followed up in March 2011 by the publication by the National Quality Board of 'Quality Governance in the NHS - A guide for provider Boards' which reiterated the important role Boards play in ensuring the delivery of quality services.

One key element of ensuring quality services are being delivered and a continuous improvement culture exists, is the area of 'Measurement' and the importance of monitoring the delivery of quality. Ensuring that these aims are being delivered is an integral element of the overall governance process so we have undertaken a review of the data produced by 25 Acute Trusts in an attempt to show the range of data that is currently provided to enable Boards to fulfil one of their key roles.

We hope you find this report useful in your continued drive for the delivery of quality healthcare to your patients.



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Introduction

Performance monitoring and reporting is an important and integral part of a Trust's operational activities. The performance management process needs to be embedded within the Trust so that robust and accurate assurances, positive or negative, are routinely provided to Trust Board members in order that informed and appropriate decisions and actions may ensue.

Following several high profile cases of serious concerns relating to quality related matters within the NHS the overall profile and importance of reporting on quality and safety issues has never been higher. In our experience all of our clients have increased the range of quality, safety and patient experience indicators and also improved the depth of reporting on such matters. However as this report demonstrates, there are wide inconsistencies in relation to what is reported and how it is reported to Trust Boards.

It is our considered view that any range of indicators covering a particular topic area - financial, HR or quality - should include assurances relating to:

1. **Strategic objectives:** any quality objectives set as part of the Trust's quality accounts or strategic plan;
2. **Mandated targets:** nationally defined areas for improvement such as MRSA, C. diff, stroke etc; and
3. **Operational issues:** bottom up, locally identified concerns emanating from Trust specific intelligence such as incident reporting, complaints, SIRIs, Dr Foster alerts etc.

Through our existing client base and working with Trust Boards more generally, it is clear that many Trusts are preoccupied with, and focus on, the nationally mandated targets. This is at the expense of Trust-specific strategic or operational quality related KPIs which is far more sporadic in nature.

RSM Tenon, as the largest private provider of internal audit services to the NHS, has undertaken this benchmark report in response to these emerging concerns, using its access to a statistically sound and representative sample of Acute Trusts.

Our sample size is 25 English Acute Trusts (out of the 168 Acute Trusts in England) and range from small specialist Trusts (c£19m t/o) through District General Hospitals to large tertiary centres (c£700m t/o) which we feel provides a statistically sound and broad range of Trusts although we would not expect size and complexity to significantly influence the range and number of KPIs being routinely reported.

Ultimately, by publishing this report, our aim is to help improve patient safety, quality and experience. We hope that readers find this report of considerable interest and that it stimulates debate at Trust Board and committee level regarding what quality, safety and experience related indicators should be being reported, how frequently and the format by which they should be being reported.

What are Boards receiving: A summary of our review

The good news is that it is clear that Boards are taking quality performance management increasingly seriously. This can be seen by the development and evolution of performance management processes within operational areas and clinical systems which ultimately will present performance data to the Board.

We have reviewed the performance reports, and separate quality related reports where necessary, that are presented routinely (monthly) to Boards of a range of Acute Trusts, both FTs and non-FTs, to establish the range of indicators reported.

This benchmark report is intended to help Board members understand what is being routinely reported in other Trusts. Often during our work with Trusts, Board members will express a desire to understand what other Boards see as part of their performance management processes and therefore whether their processes and reports are fit for purpose. This report will provide an overview of the KPIs that are routinely reported across our sample and will highlight to individual Trusts the range of indicators other Trusts have identified as being key and pertinent to their Boards. Clearly, the range and content of indicators will, and should, change to some degree across each Trust as they seek to focus on their own strategic objectives and local issues as well as the nationally mandated 'must do's'.

Figure one on page five summarises the results of our review and identifies the number of KPIs that are routinely presented to the Board at each client. ¹ In developing this report, we considered presenting the data based on different peer groupings, such as District General Hospitals, Specialist Trusts, FTs and non-FT, turnover, geographic location or SHA. However we found that these factors appear not to influence the range and depth of indicators currently being reported; indeed the Trust that appears to report the broadest range of indicators is a small rural District General Hospital.

Across the cohort a total of 33 different quality indicators are reported, enabling Trusts to monitor Patient Safety, Patient Experience, Clinical Quality and Maternity. Many Trusts routinely report far fewer indicators than others.

Trust Boards appear to pay more attention to nationally driven indicators. While there is a growing national steer on quality related KPIs via the NHS Outcomes Framework 2011-12 and therefore a likelihood that Trusts will follow this national steer-it cannot and should not be at the expense of locally identified, and bottom-up quality indicators. All Trusts will explicitly say that safety, quality and a good patient experience are at the heart of what they do, yet our review identifies that unless certain quality related targets are nationally mandated. Trusts will not necessarily focus on such matters.

¹ See Appendix A for a detailed narrative in relation to each of the KPIs.

Trusts should not wait to be told what the issues are or what they should focus on: they should make better use of their local intelligence and governance systems to inform their Boards about the quality of services within their Trust.

In summary our review concluded:

- Overall, there is an inconsistent approach to the reporting of quality KPIs across Trusts
- The range of indicators being monitored at Board level is dominated by nationally mandated targets with few Trust-specific, local issue indicators being reported
- Some Trust Boards must find it difficult to be assured of the quality of service provision with their indicators and KPI reporting practices
- Where a target is nationally mandated, there is more of a uniform and consistent approach to its reporting
- Neither the size, complexity, FT status or specialist nature of a Trust appear to influence the range and depth of indicators being routinely reported
- The reporting of quality KPIs can be discursive in nature and not action centred. Around half of the KPIs have targets attached, and of them, only around half are rated in relation to performance against the target
- Nursing care and ward level indicators are not routinely presented at Board level

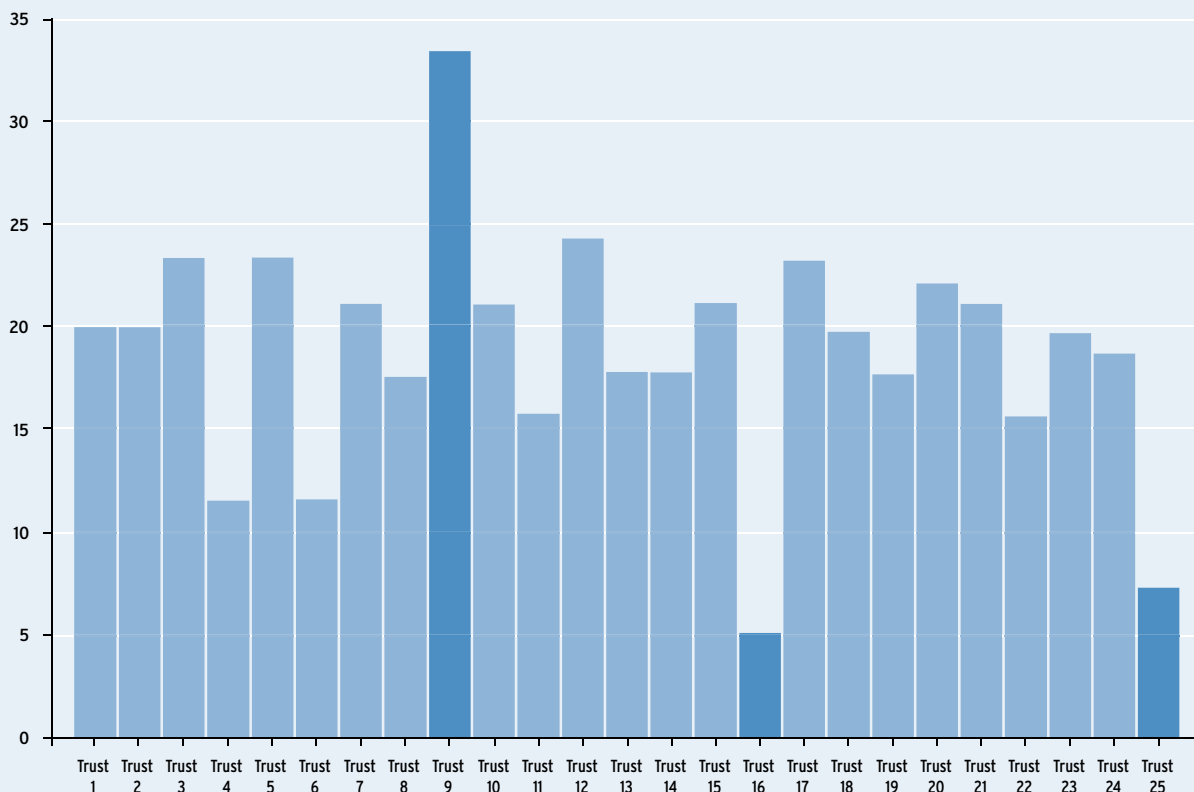
Figure one shows the range of the number of quality indicators being routinely reported by Trusts. Although there is no nationally defined standard set of quality indicators and each Trust has its own set of issues/challenges in addition to the nationally mandated indicators, it is surprising that the number of quality indicators reported monthly to Trust Boards ranges from five to 33 with the majority appearing to report around 15 to 20 quality indicators at each Board meeting.

Trusts 9, 16 and 25 appear as outliers.

- We checked across a wider reporting period for Trust 9 and confirmed that the 33 quality indicators do form part of the monthly reporting of quality to their Trust Board
- We have identified Trusts 16 and 25 as outliers, as whilst the Board does receive a separate quality related performance report, it is provided to the Board on a less than monthly basis. Our review of the benchmark data concentrates on those indicators that are being reported monthly to Boards in line with best practice.

In some cases, we have identified that aspects of quality performance reporting may be discursive in nature and therefore do not include clear targets and/or performance against which Board members and users of the report can ascertain whether the performance of the Trust is on track or not. For the purposes of this report, we have excluded these. In our opinion these offer little value to Board members when attempting to hold the organisation to account for its performance.

Figure one - Number of quality KPIs routinely presented to Trust Boards

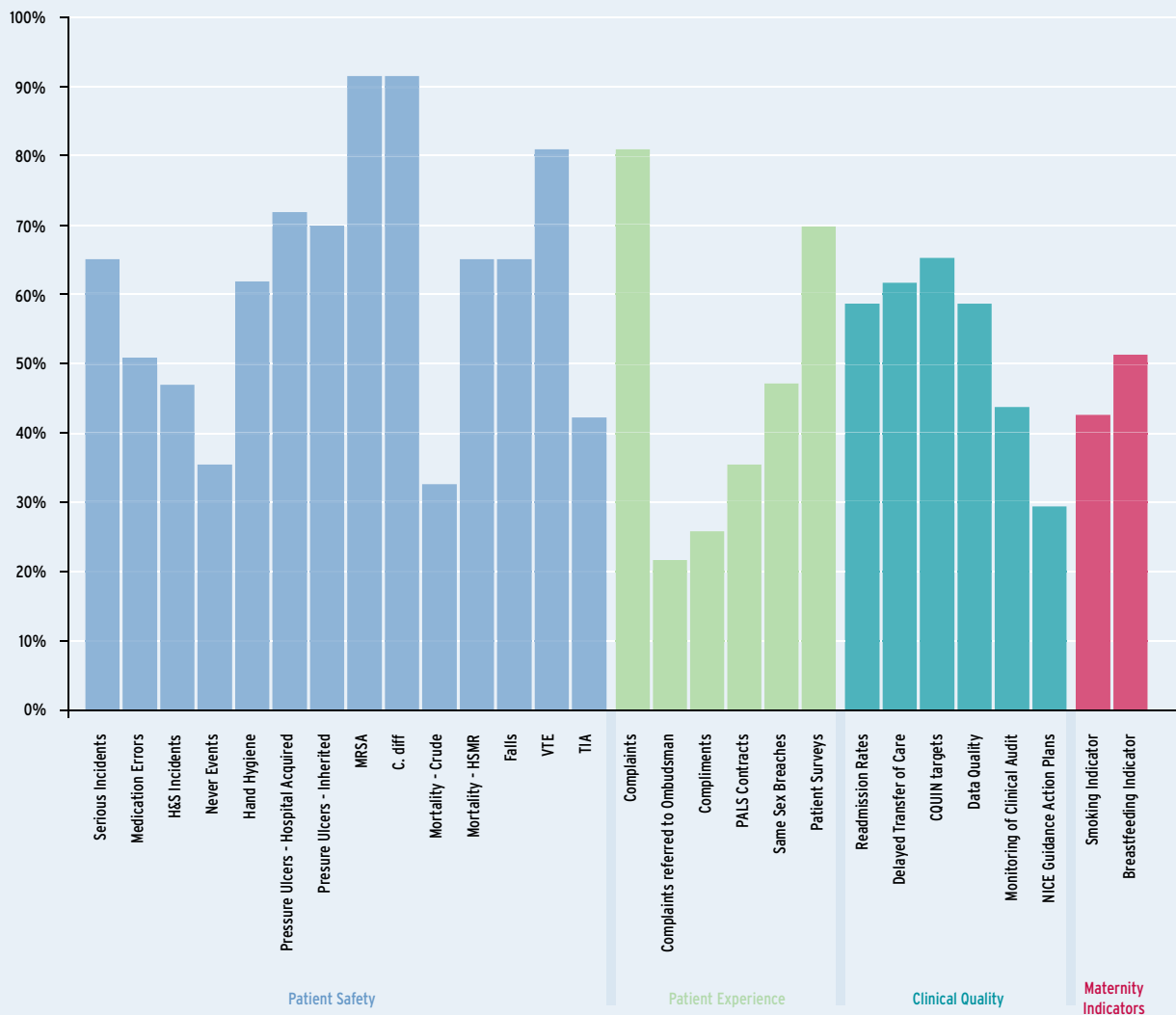


Source: RSM Tenon research

- The number of quality indicators routinely reported to Trust Boards varies from 5 to 33
- There is no clear rationale as to why Trusts report a higher or lower number
- There are too few local indicators with many Trusts merely reporting nationally mandated targets
- Nursing care indicators and ward based outcome measures do not feature highly despite the relatively recent, well documented, national profile failures within the NHS
- It remains unclear how Boards assure themselves regarding the quality of services across the breadth of services being provided
- Where outcomes cannot be captured electronically (and therefore more easily) there is an absence of indicators in many Trusts

To expand on Figure one, we revisited the data and considered the occurrence of each specific indicator across the cohort. As Figure two on page six shows only 54% of the quality indicators are presented to more than 60% of the Boards sampled, whilst some indicators are only present in around 30% of Trusts.

Figure two - The prevalence of reporting of individual quality KPIs



Source: RSM Tenon research

There does not seem to be a common set of indicators presented in each report, apart from the nationally mandated indicators for MRSA and C. diff.

Every Trust has included these two indicators within the quality performance data routinely presented to the Board.

Why is it that 52% of Trusts view the reporting of medication errors at Trust Board level appropriate yet 48% of Trusts do not?

Hospital acquired pressure ulcers, which can indicate more general concerns regarding a ward level or nursing care, a notoriously difficult area on which to report, are only reported at 74% of Trusts.

The remaining 46% of the indicators (i.e. less than 60% reportable) do not seem to be consistently reported across the cohort of Trusts. This is a surprise and perhaps a reflection of the nascent nature of quality reporting. Given the national media focus surrounding the reporting of quality during 2010/11, we expected to see a greater degree of consistency.

Within the Patient Safety theme of indicators, there are a number of indicators that are not routinely reported to the Board. A number of Trusts appear to report quality performance by exception when an event occurs as opposed to routinely reporting a nil return for the month for e.g. Never Events. In the absence of a reported nil return a Board member would have to assume that there were no Never Events (for example) as distinct from simply no reports on such matters. This is ambiguous and would require verbal clarification each month.

Best practice guidance:

The indicators reported to the Board should include a combination of not only the high profile, often nationally mandated indicators but also local indicators that are Trust specific. Exception reporting or visual aids should be used to highlight adverse movements in performance and draw attention to the areas that require focus and attention.

Some Trusts choose to report quarterly on a number of key quality indicators. This is too late to draw Board members attention to them should there be adverse variances. Boards need to be clear why certain indicators are deemed appropriate to report on a quarterly basis as opposed to monthly.

In general, those areas that are of national interest and of a higher profile tend to be the areas that are more likely to be reported monthly although this is not uniform across the sample. Part of the reason for this could be due to the extreme use of exception reporting utilised by some Trusts.

Our review of the performance reports used to compile this report has identified a plethora of approaches to formatting the performance reports presented to the Board. These range from a purely narrative report that describes the movement in performance (but not against targets) through to RAG rated tables of indicators with little or no narrative.

Based on our experience, there are certain key considerations of effective performance reporting. While each Trust Board must determine the right approach that works for them, the clear, unambiguous presentation of accurate and timely information is a pre-requisite for effective performance management in any organisation.

Considerations for an effective reporting system:

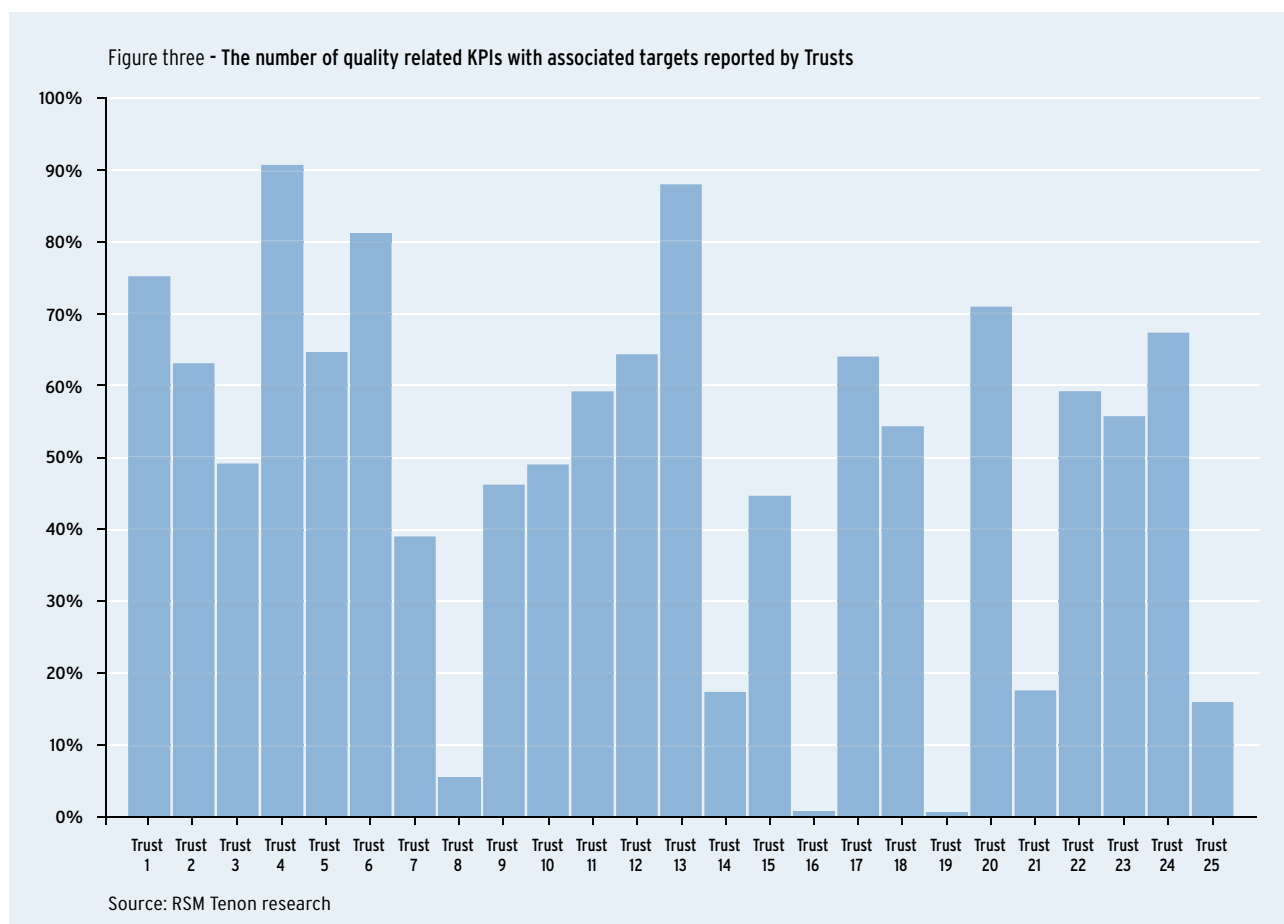
- Align measures with Trust and National aims and objectives
- Allow informed and timely decision making
- Exception reports can highlight areas of poor performance that are outside the scope of routine KPIs
- Executive summary must be capable of standing alone
- Forward looking/trend based wherever appropriate - not 'snapshot' reporting
- Need for succinctness - use of visual aids and action focus
- Trust Board must establish, and own, clear performance parameters
- Ensure performance data is validated prior to reporting
- Allow the reader to hold the 'deliverer' to account - clear accountability assigned to each target
- Action oriented, not discursive in nature
- Layout needs to be flexible to withstand KPI churn
- Agree parameters for Red/Amber/Green ratings
- Where performance is rated Red - show trajectory for improvement for future monitoring
- Consider use of Amber rating (subjective) - when is a fail not a fail?

Does your performance report provide for the above and allow you the opportunity to assure yourself across the full range of required indicators? Where necessary, can you effectively hold the organisation to account?

Putting performance into perspective

As mentioned above, the higher profile indicators relating to MRSA and C. diff are reported at each of the Trusts in our sample. These indicators are most commonly reported against a target to allow a Trust to see how well it is performing against the target. The inclusion of a target provides a context against which actual performance can be assessed. As part of the benchmarking review we have looked at the performance reports for our clients to consider whether activity is reported in isolation or against a 'yard stick'.

As Figure Three shows, only five Trusts routinely report against a target. This can make it difficult for users of the report to determine whether the performance presented to them is good, bad or indifferent.



It seems that a relatively low number of Trusts routinely use targets for the vast majority of their indicators. For a large number of Trusts, performance is reported in isolation without an associated target. This must make it difficult to interpret the data and determine whether the area requires focus by the Trust Board.

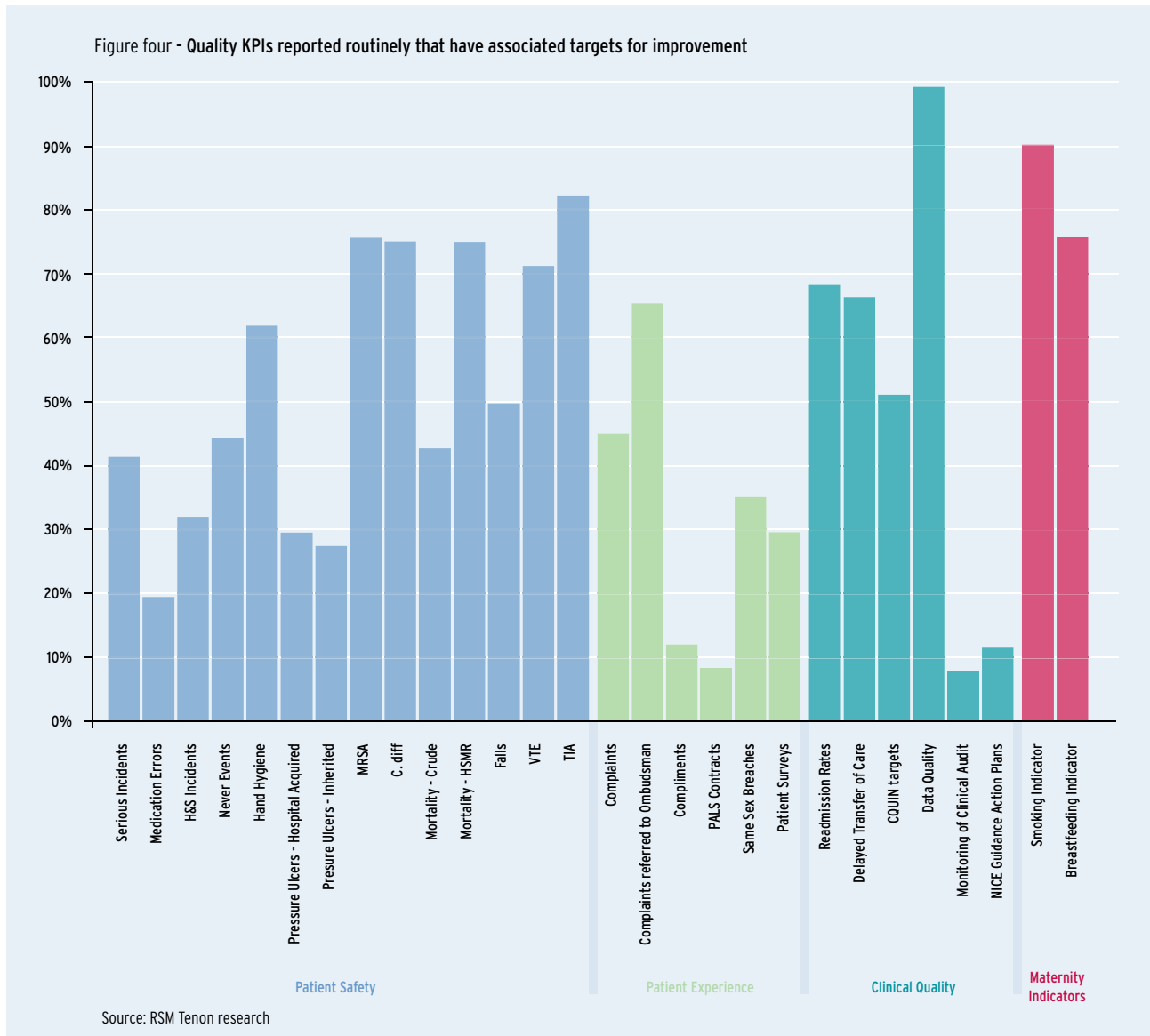
Two Trusts do not provide target data to the Trust Board for any of the indicators they present, and a further three Trusts present just 20% of their indicators with a target. For the remainder there is a mixture of including a target and not including a target with the report.

Best practice guidance:

Targets can help contextualise performance and assist report users to determine whether the performance being measured is good or poor.

On average, only 50% of indicators reported to the Board are linked to a target.

Figure four explores the data by indicator. Whilst we acknowledge that there are a number of KPIs that do not necessarily lend themselves to having a target, such as the PALS Contacts indicator, there are many KPIs where targets are meaningful and easy to ascertain and yet these are not being routinely reported.



Best practice tip:

Where targets are not an appropriate way to provide context for indicators it may be possible to compare performance against previous periods such as the preceding month or year. This enables report users to spot trends or understand the impact of new initiatives and investments.

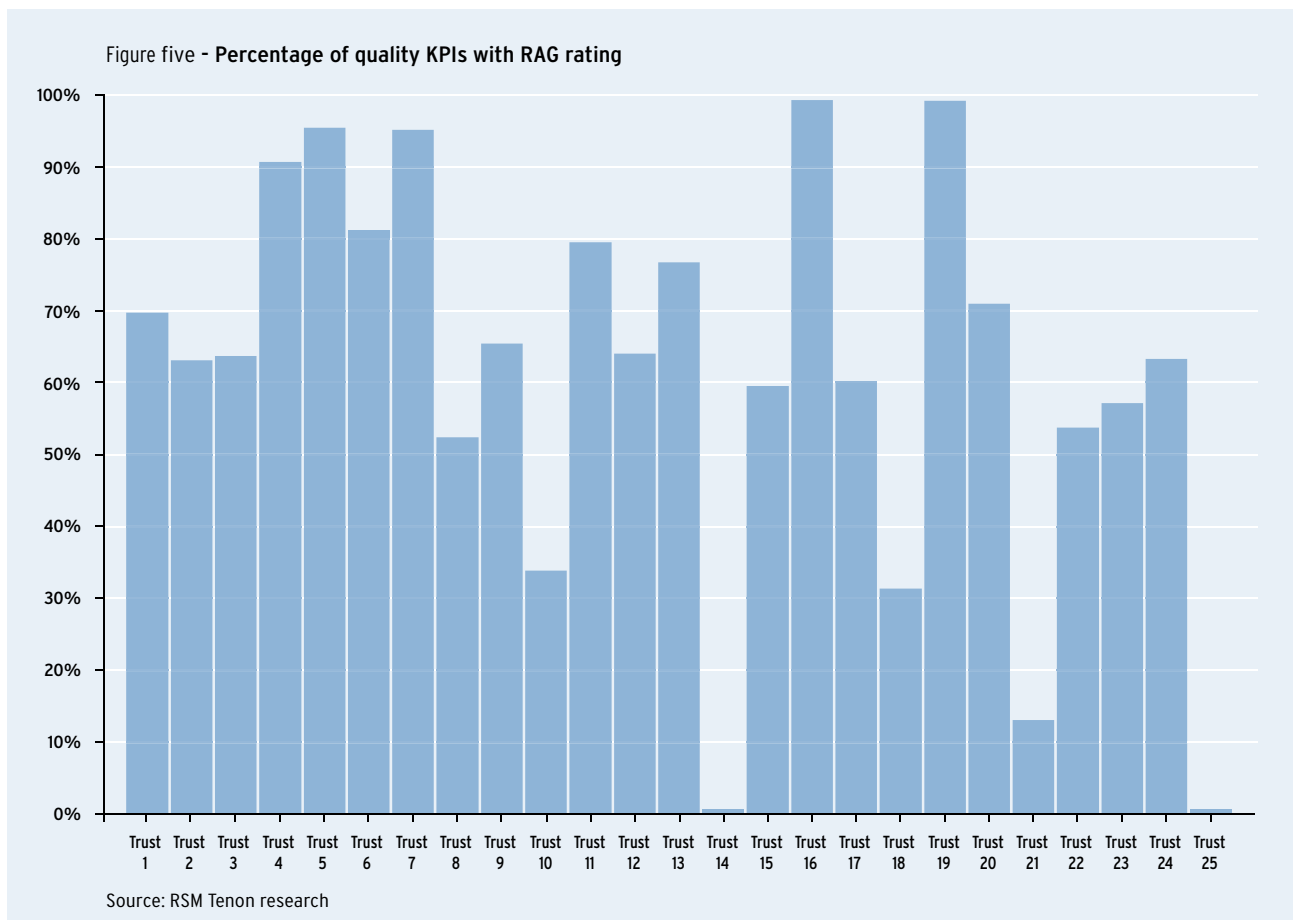
How quality KPIs are reported

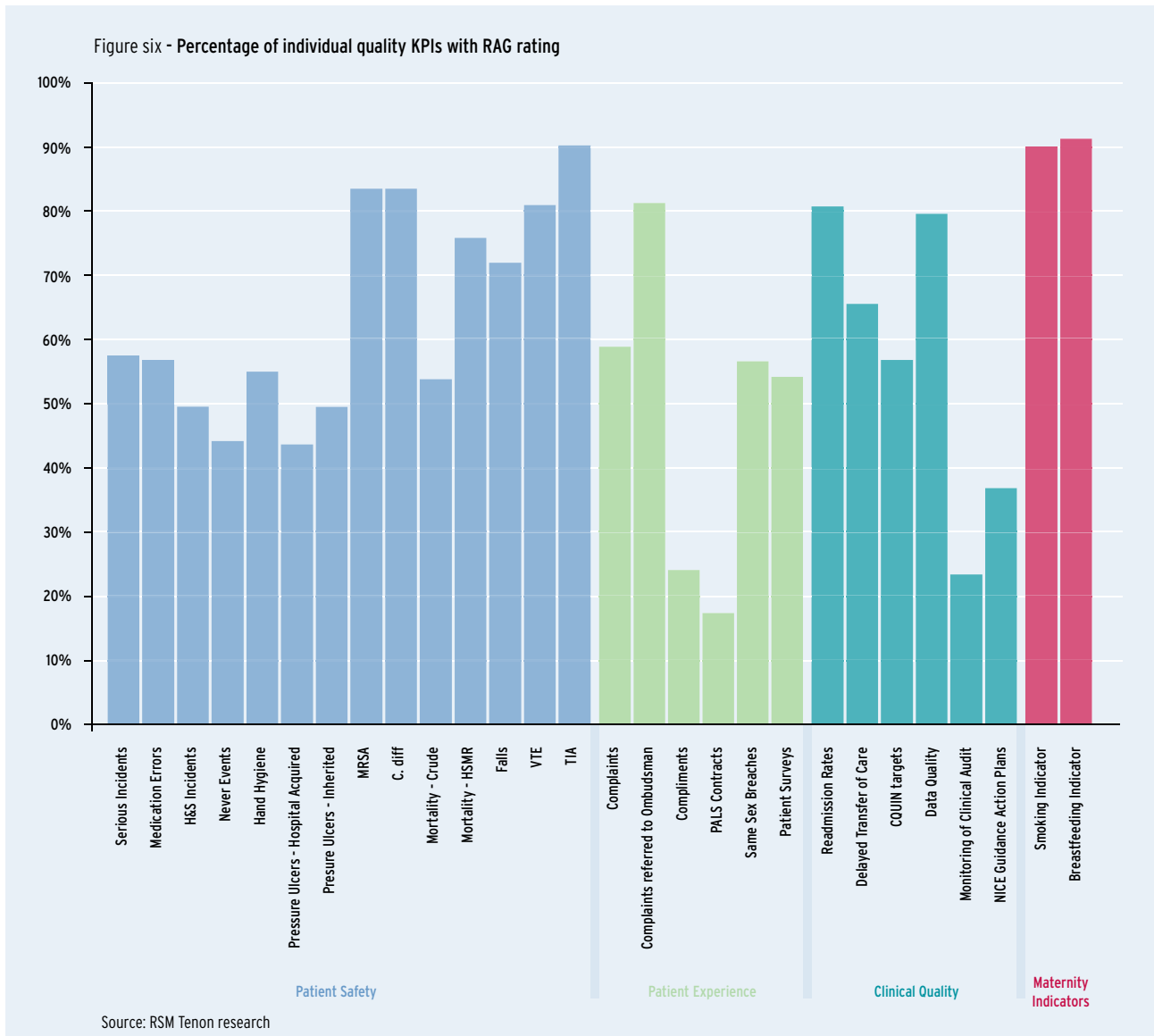
To allow Boards and committees to focus on quality, performance management systems need to simplify results reporting to allow report users and Board members to quickly understand the areas of adverse performance and those that require attention. The most commonly used mechanism to report performance is the use of Red, Amber, and Green (RAG) ratings which visually draws the reader towards areas of poor performance.

About half of the Trusts in our sample consistently use a RAG rating approach to focus attention on the indicator for discussion (see Figure five) and quickly identify areas of concern.

Of the Trusts where a target has been identified (see Section 2) we would expect RAG rating to be used almost uniformly across the cohort as it is easy to understand and an established method for reporting performance.

However, as the Figure below shows, this is not the case. Some Trusts report performance against a target, but then do not expressly state whether this is at an acceptable level.





The nationally mandated targets tend to be the indicators that are currently being reported with a RAG rating. This may be due to the fact that often a national target is prescribed and therefore comparison of actual and target is well defined and can be easily RAG rated.

This principle should extend beyond the nationally mandated targets as there are a high number of indicators within the cohort that lend themselves to the use of RAG ratings against easily defined targets. It appears that Trusts are somewhat reluctant to define local targets and RAG rate performance accordingly for non-mandated targets.

Our review has identified areas of good practice reporting and we commend these to you as a way of improving the reporting of quality matters and hence Boards abilities to respond to what is being provided and make timely, meaningful interactions.

In some cases, when we reviewed the performance reports provided to us we found it difficult to interpret the data, fully understand the performance and easily determine which areas require focus. We have included below examples of poor practice in performance reporting to stimulate debate and discussion at Board level.

Examples of good practice in relation to the reporting of performance include:

- Use of in year and/or previous year trend information so that information is not merely provided as an 'in month' snapshot
- Clear presentation of the parameters of performance that constituted RED, AMBER or GREEN performance
- Clear executive accountabilities identified against each KPI
- Good use of executive summaries which focused on the RED rated performance areas and identified actions, timelines, accountabilities and revised trajectories where appropriate whereby Board members can effectively hold the organisation to account
- Clear visual use of graphs, tables, bullet points and RAG rating for ease of reading and understanding of priority areas

Areas where we felt that Trusts could help improve the readability of the reports, in addition to the good practice points above include:

- Quality performance reporting dominated by the nationally mandated 'must do's' with few, if any, Trust specific indicators reflecting strategic objectives and local issues as identified by the Trust's intelligence and/or governance systems
- Many of the reports encountered were descriptive in nature, neither action focused nor exception based, making it difficult to extract the salient points and identify priority areas
- Few Trusts are reporting a forward looking forecast outturn projection to help steer conversations and demonstrate the impact of actions, etc
- It was unclear what parameters are used to determine if performance is RED, AMBER or GREEN and whether or not those parameters had been signed off by the relevant Board or committee
- There was inconsistent use of the AMBER rating with most Trusts recognising a close failure to achieve a target as warranting an AMBER performance (which is still a fail) as opposed to a marginally achieved target i.e. a narrow success
- Too few indicators had targets associated with them

Appendix A: Common KPIs

Patient Safety

Serious Incidents: Reported as the number of incidents categorised by the Trust as serious.

Medication Errors: Reported as the number of medication errors which have occurring in the previous period.

H&S Incidents: The number of health and safety incidents reported within the previous period.

Never Events: Defined by the NPSA as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Hand Hygiene: reported as the development and implementation of the NPSAs and the Clean your hands campaigns guidance.

Pressure Ulcers: Reported as the number of Hospital and Inherited pressure ulcers.

MRSA: reported as the number of reported MRSA incidents. Hospital Acquired MRSA bacteraemia is defined as an infection identified from positive blood cultures taken 48 hours after admission. Positive blood cultures taken within 48 hours of admission are not classified as Hospital Acquired.

C. diff: reported as the number of C. diff positive cases-post 48 hours.

Mortality: reported as the crude mortality rate and the hospital standardised mortality ratio.

Falls: reported as the number of falls per 1000 bed days.

VTE: reported as the National goal to reduce avoidable death, disability and chronic ill health from Venous-Thromboembolism (VTE).

TIA: the percentage of high risk Transient Ischemic Attacks (TIA) patients treated within 24 hours.

Patient Experience

Complaints: the number of complaints received.

Complaints Referred to HSE: the number of complaints reference to HSE.

Compliments: the number of compliments received.

PALS: the number of PALS contacts.

Same Sex Breaches: the number of Same Sex Breaches reported.

Patient Surveys: whether the results of patient experience is reported.

Clinical Quality

Readmission Rates: the rate of readmissions given the number of admissions to the Trust.

Delayed Transfer of Care: The percentage of patients occupying an acute hospital bed whose transfer of care was delayed.

CQUIN Targets: whether any targets set under the CQUIN have been reported.

Data Quality: whether any targets have set and reported in relation to data quality.

Monitoring of Clinical Audit: whether any targets have set and reported in relation to Clinical Audit.

NICE Guidance Action Plans: whether NICE Action Plans have been implemented.

Maternity Indicators

Breastfeeding Initiative: The number of new mothers who initiate breastfeeding.

Smoking During Pregnancy: the number of expectant mothers who smoke during pregnancy.

Glossary

C. diff - Clostridium difficile

DGH - District General Hospital

FTs - Foundation Trusts

MRSA - Methicillin-resistant Staphylococcus aureus

PCTs - Primary Care Trusts

SHA - Strategic Health Authority

PALS - Patient Advice and Liaison Service

HSE - Health and Safety Executive

CQUIN - Commissioning for Quality and Innovation framework

NICE - National Institute for Clinical Excellence

About the author

Mike heads the Healthcare team within RSM Tenon's Business Advisory Services division.

He has over 20 years experience of working within and around NHS, including NHS Finance in the 1990s and consultancy with RSM Tenon between 2001 and 2003.

In December 2003 Mike joined Monitor, Independent Regulator of Foundation Trusts to assist in developing the Foundation Trust assessment process. As Assessment Director he oversaw the first three waves of assessments and, helped lead the national FT diagnostic exercise in 2005 where every Trust in England was assessed in relation to their current state of readiness for FT status. Mike was also the Monitor lead in developing the Mental Health assessment process.

In 2006, Mike became FT Assessment Director within the Department of Health (DH), working with SHAs and aspirant FTs upstream of the Monitor process. There was a high failure rate of applicants in the Monitor phase and Mike was invited to help restructure the DH phase of the FT journey to ensure that aspirants were better equipped to deal with the Monitor phase. He successfully helped raise the first time pass rate at Monitor during that period.

In 2008, Mike rejoined the NHS and joined Mid Staffordshire Hospitals NHS FT as Deputy CEO and Finance Director as the first of the new Board to oversee the required clinical and corporate governance turnaround. Whilst at Mid Staffs, Mike introduced many changes to the governance framework and led the development and delivery of the Trust's Transformation Programme which is the Trust's response to the various recommendations contained within all of the reports thus far published on the Trust. During this period Mike worked closely with both the regulators (Monitor and CQC) to develop the necessary assurance framework through appropriate KPIs.

Since rejoining RSM Tenon, Mike has undertaken several assignments including 'dry run' Quality Governance Framework assessments and aspirant FT support packages for Trusts including Board level working and development.

Following his time at Mid Staffs, Mike is a passionate advocate of patient safety and quality matters. He wishes to raise the profile and significance of such matters at Board level to help ensure that the NHS minimises the risks of similar high profile events happening elsewhere within the NHS and to ensure that patients receive a high quality service.



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About us

RSM Tenon is the largest provider of Governance and Risk Management Services to the Public Sector with over 650 clients across the health, education, housing and local government sectors as well as a large number of government departments and agencies.

Within that, we work with over 80 NHS clients including Foundation Trusts, Acute Trusts, Mental Health Trusts, Community Trusts and Primary Care Trusts.

We are the 7th largest accounting and professional services firm in the UK and the UK member firm of RSM International, the 6th largest global network of independently owned and managed professional services firms.

Acknowledgements

We would like to take this opportunity to thank the Trusts that provided us with their relevant Board reports (dated February 2011) containing their quality related KPIs in order for us to provide this benchmark report, particularly those Trusts where quality KPI reporting is not publicly accessible.

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