Appendix 6: Using local information and data in the job planning process

Case study 1: Leeds Teaching Hospitals NHS Trust – Appraisal & job planning dataset

Introduction
A consultant job planning and appraisal information pack, including an individualised dataset, has been developed, in recognition of the overlap of documentation between the two interlinked processes.

Each consultant receives:

i. a guide to the appraisal and job planning process and the relevant forms for completion

ii. a series of statistical reports on their performance relative to other consultants in their specialty, and on the specialty’s performance relative to other teaching hospitals – see below for more detail

iii. information for themselves only on complaints and incidents, R&D activity, student feedback on teaching, and clinic and inpatient capacity

iv. access to a support service for further analysis and for advice on interpretation and data quality.

Each appraiser/job plan reviewer receives, in addition to the above:

i. specialty/service-level information on complaints and incidents.

The dataset
The aggregate data is largely based on the patient level information recorded on the hospital Patient Administration System, but will also include data from other departmental systems, principally pathology, radiology, complaints and risk management.

The data is presented to consultants in the form of tables and charts, showing the values and rates for each named consultant within a specialty or ‘specialist grouping’. Careful interpretation is required as many factors can influence consultant rates, not least case mix, preferred clinical practice and the size of clinical teams.

The summaries below outline the reports used by the Trust, including notes for the compilation and use of data.

Report 1.1 – Inpatient activity summary
Summary: Inpatient and day case activity for the last two financial years is presented for each consultant. Data is shown in both tabular and graphical format.

Notes: The standard measurement used to summarise this type of activity is the Finished Consultant Episode (FCE). Since an FCE captures each element of a patient’s stay in hospital, (in terms of the various consultants who may be responsible for their care) it differs from the volume of admissions and discharges. An admission considers the first episode in a hospital stay, while a discharge considers the final episode of the stay.

Other information on the table shows the proportion of day cases as well as the proportions of emergencies, which includes transfers from other hospitals. For those specialties with significant numbers of ‘regular day attenders’, the volumes for this category are shown.

Report 2.1 – Clinical information about procedures and Report 2.2 – Clinical information about diagnoses
Summary: Activity information analysed by clinical code. For every FCE there must be a primary diagnosis; there may also be secondary diagnoses. For episodes where an operation or intervention has taken place, there will be a primary procedure; there may also be secondary procedures. These reports show the number of FCEs analysed by primary procedure and/or primary diagnosis.
Notes: The quality of clinical coding reflects not only on the quality of the source documentation and the skill of the coder, but also on the quality of the administrative processes. Patient level information can be supplied if you wish to audit any of these cases.

Report 3 – Inpatient/day case waiting list shapes
Summary: The number of patients admitted by length of time waited, by consultant, for the past 2 years.
Notes: It does not take into account any periods of suspension so therefore does not correspond to the monthly waiting list targets.

Report 4 – Actual compared to expected length of stay
Summary: The overall average length of stay (LOS) for each consultant is shown compared to what would be expected for that consultant given his/her mix of cases.
Notes: Patients with a ‘0’ day LOS are excluded as are patients whose LOS was longer than 49 days. The expected length of stay is the length of stay for consultants at peer hospitals with a similar case mix. An indication of complexity is provided with this measure. If consultant A has an expected length of stay which is longer than consultant B’s expected length of stay, then it suggests that consultant A has the more complex case mix.

Report 5 – Average length of stay by day of week
Summary: Split by elective and non-elective cases, it shows the actual LOS for each consultant by episode start day.
Notes: It allows for easy comparison of the variation in LOS depending on day of admission or consultant transfer.

Report 6 – Clinical indicator - emergency readmission rates
Summary: DH and the Healthcare Commission have reported this indicator nationally on a named Trust basis for the past 6 years as part of the Performance Assessment Framework and more recently the star ratings. It shows the number of emergency readmissions within 28 days of discharge. Data is presented in both tabular and graphical format.
The table shows the raw data (readmissions and discharges) and the readmission rate for the last financial year.
Notes: Continuous refinements to the definition (recently excluding cancer patients and day cases) mean that the rates cannot be easily compared year on year.

Where numbers allow, a funnel chart is included to show variability in performance. Values are plotted on a chart with a mean line and upper and lower control limits. These limits are calculated as - average process value +/- (3 x standard deviation). These charts distinguish between two types of variation which are called ‘common cause’ and ‘special cause.’
• Common cause variation is indicated by the values falling within the control limits
• Special cause variation is indicated by values falling outside the limits.

Essentially, common-cause variation is due to the normal statistical fluctuation inherent in all processes. This can also be described as controlled variation and shows that the system is stable, or in control. Special cause variation, on the other hand, is due to something over and above the routine variation. It is extrinsic to the process. This can also be described as uncontrolled variation.
Factors contributing to special cause variation may be data, case mix, resources or processes of care. The advantage of presenting this type of information in the form of a control chart is that it makes explicit the random variation, which inevitably exists. This avoids the meaningless ranking associated with the league table approach.
It must be noted that this indicator cannot be used to judge clinical performance. Effective use of an indicator entails the recognition that indicators can help pose questions but do not by themselves provide the answers.
Report 7 – Clinical indicator - deaths in hospital within 30 days of surgery

Summary: DH and the Healthcare Commission have reported this indicator nationally on a named Trust basis for the past 6 years as part of the Performance Assessment Framework and more recently the star ratings. It shows the number of deaths in hospital within 30 days of a surgical procedure. Data is presented in both tabular and graphical format. The table shows the raw data (deaths and discharges) and the mortality rate for the last financial year.

Notes: The national indicator includes deaths outside hospital. Please refer to Report 6 for a full description of these charts. It must be noted that this indicator cannot be used to judge clinical performance. Effective use of an indicator entails the recognition that indicators can help pose questions but do not by themselves provide the answers.

Report 8 – Overall mortality rates

Summary: A simple count of the number of deaths divided by the number of discharges for each consultant.

Notes: A death is assigned to the consultant who was responsible for the care of the patient at the time of death. It must be noted that this indicator cannot be used to judge clinical performance. Effective use of an indicator entails the recognition that indicators can help pose questions but do not by themselves provide the answers.

Report 9.1 – Outpatient activity summary

Summary: Total attendances in outpatient clinics for all consultant-led clinics. Two indicators are included.

Notes: The first indicator concerns the ratio of ‘new’ to ‘follow-up’ patients. This is provided at aggregate level for all referral sources as well as by type of referral source, i.e. GP or ‘other’. The reason for the breakdown is that there tends to be a higher new:follow-up rate for consultant referrals (included in the ‘other’ category). The second indicator is the DNA (did not attend) rate. The actual number of DNAs is shown as well as the percentage DNA of total attendances. Use graphs to show total attendances by referral source. We suggest that this report be used in conjunction with report 9.2 as variations in rates may be due to the type of clinic.

Report 9.2 – Outpatient activity by clinic

Summary: A tabular report with the same data items as 9.1 but here activity is shown by clinic.

Report 10 – Outpatient waiting list shapes

Summary: The chart shows, by consultant, the length of time (in weeks) that patients have waited before their first appointment, for the past 2 years.

Report 11.1 – Total pathology sets in relation to activity

Summary: This report provides the context for 11.2, the number of pathology sets requested.

Notes: Total inpatient (IP) (including day cases) and outpatient (OP) activity is presented along with the total number of sets for each consultant. Two indicators have been derived namely, ‘IP sets requested per FCE’ and ‘OP sets requested per OP attendance’. While these two indicators allow some degree of comparison between consultants, it is inevitable that case mix differences will explain some of the variation.

Report 11.2 – Requested pathology sets

Summary: This shows for each consultant the number of requested sets by category, for both inpatients (including day cases) and outpatients.
Notes: Sets are either a single test or a group of tests and represent the way tests are requested. For example, a urea and electrolyte set contains between 4 and 6 tests. It should be noted that around 10% of requests received have no identifiable consultant or GP. The figures provided may therefore be somewhat under-reported.

Report 12 – Written complaints received

Summary: Presents both the number of written complaints received by the Trust from a patient under the care of a consultant and the various reasons within those complaints.

Notes: There can be five or six reasons within one complaint relating to varying aspects of a patient’s care. Not all complaint reasons are attributable to the consultant in charge of their care.

Report 13 – Risk management claims

Summary: The number of claims for clinical negligence (CNST) received by the trust from a patient under the care of a consultant.

Notes: This information covers new claims received during the years stated. These claims can relate to treatment provided months/years previously. The claims at this point are for alleged clinical negligence and not all claims are attributable to the consultant in charge of their care.

Report 14 – Radiology exams ordered by Korner category

Summary: The number of exams ordered by ‘Korner’ category, for each consultant.

Notes: The data comprises, inpatients (including day cases), outpatients and Accident & Emergency exams ordered. Further work to break the categories down is currently being carried out. ‘Korner’ is one of many data collection systems used by DH. Korner groups are inflexible and as such each group will contain multiple exam types.

Report 15 – Theatre utilisation

Summary: This is a standard utilisation report shown by specialty and consultant for all theatres.
Case study 2: Devon Partnership NHS Trust – Developing a dataset for use during job plan reviews

Introduction

The project focused on identifying the types of data and information available both within Devon Partnership NHS Trust and within other health and social care organisations that could enhance and inform discussions during job plan reviews.

Aims and objectives

- To identify what information and data is readily available both within the Trust and other health and social care organisations
- To develop formats and data presentations so that information can be presented by:
  - localities
  - teams within localities
  - individual consultants working within teams
- To trial the data available and assess its benefit in a number of job planning meetings.

The majority of work was undertaken with the Associate Director of Performance and Planning with access to data and information relating to performance targets and monitoring requirements.

The following detail was included:

1. unit/department specific
2. complaints / PAS Information
3. Mental Health Act – Section 135 & 136
4. patient contact – by month, type of contact, outcome
5. length of stays – by consultant episode
6. length of time for referrals
7. open episodes
8. number of service users on MHA section
9. population percentage.

The participants in the review completed a simple evaluation form to assess the relevance and presentation of the data.

The feedback showed that the most useful information was:
- data referring to the unit/department specific
- patient contact
- length of stays
- open episodes.

This data aided discussions around targets.

Other data that also proved helpful was:
- clinical outcome data
- service level agreements
- untoward incidents
- workload.

There was also an opportunity for the consultant to match their understanding of their productivity against the recorded data; this is likely to aid data collection in the future. However, there were aspects of the information needing refinement, particularly the presentation.

The evaluation highlighted that the information stimulated discussion about workload and productivity. However limitations of content and presentation were identified, such as completeness of information and the ability to compare individual consultants’ data. Comparison of data would require agreement of each consultant. It was also recognised that the information would need to be identified in advance of the review to enhance discussion in a format suitable to each participant.

The Trust has now decided that the data set agreed from the evaluation will be available for future reviews along with further diary exercises, the data being distributed before the meeting. The caveat being that the information might not always be complete.