

TRUST-WIDE NON-CLINICAL POLICY DOCUMENT

PERFORMANCE INDICATOR KITE-MARKING

Policy Number:	SA41
Scope of this Document:	All staff involved in producing and reporting performance information to the board of directors. Internal and external audit.
Recommending Committee:	Health records and data quality working group
Approving Committee:	Executive Committee
Date Ratified:	21 November 2019
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Lead Executive Director:	Executive Director of Finance / Deputy Chief Executive
Lead Author(s):	Chief Information Officer

2019 – Version 2.1

Striving for perfect care and a just culture

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PERFORMANCE INDICATOR KITE-MARKING

Further information about this document:

Document name	PERFORMANCE INDICATOR KITE-MARKING (SA41)
Document summary	<p>The purpose of this policy is to provide a system for reporting assurance of key performance indicators (KPIs) to ensure that board information provides an accurate reflection of the trust's performance.</p> <p>This policy document summarises Mersey Care NHS Trust's Performance Indicator Kite-Marking system. It sets out rationale for implementation, description of the system and practical guidance on how the system is to be applied and the standards expected.</p>
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To be read in conjunction with	<p style="text-align: right;">Health records (IT06) Corporate Data Quality (IT11)</p>
This document can be made available in a range of alternative formats including various languages, large print and braille etc	
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Version Control:

Version History:		
Final draft 1.0	Original issue to corporate document review group.	August 2014
Final Version 1.1	Minor revisions to reflect feedback from corporate document review group. Ratified and uploaded to trust website.	August 2014
Version 1.2	Revised version for consideration by policy review group. Amendments made to version 1.1 to ensure adherence to new policy format and to reflect lessons learned during the first year of implementation of the policy.	August 2015
Version 1.3	Amended in line with policy group recommendations. For approval by executive committee in September 2015.	August 2015
Version 1.4	Acquisition Steering Group	June 2016
Version 2.0	Revised in accordance with new approach to kite-marking agreed by Audit Committee in August 2018. For approval by executive committee in November 2018	October 2018

Version History:		
Version 2.1	Revised to reflect agreed scope of performance indicator kite-mark application from 2019/20 as agreed at the Health Records and Data Quality Working Group in September 2019.	November 2019

SUPPORTING STATEMENTS – this document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY’S BUSINESS

All Mersey Care NHS Trust employees have a statutory duty to safeguard and promote the welfare of children and adults, including:

- being alert to the possibility of child / adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child / adult;
- knowing how to deal with a disclosure or allegation of child / adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child / adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust’s safeguarding team;
- participating in multi-agency working to safeguard the child or adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy / maternity and marriage / civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Trust is committed to carrying out its functions and service delivery in line with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

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1 PURPOSE AND RATIONALE

- 1.1 **Purpose** – The purpose of this policy is to provide a system for reporting assurance of key performance indicators (KPIs) to ensure that board information provides an accurate reflection of the trust’s performance.
- 1.2 **Rationale** – This requirement is derived from NHS Improvement’s “Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts “ (KLOE 6, page 33) (June 2017) which requires that “The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses.” Acceptable data quality is crucial to operational and transactional processes and to the reliability of business analytics / business intelligence reporting. High quality information leads to better decision making to improve patient care and patient safety, and there are potentially serious consequences if information is not correct and up to date. Management information produced from patient data is essential for the efficient running of the trust and to maximise utilisation of resources for the benefit of patients and staff. Poor data quality puts organisations at significant risk of: damaging stakeholder trust; weakening frontline service delivery; incurring financial loss; and poor value for money.

2 OUTCOME FOCUSED AIMS AND OBJECTIVES

- 2.1 For this Performance Indicator Kite-marking policy the aims and objectives are as follows.
- a) Performance information considered by the board of directors and its committees will provide an accurate reflection of trust’s performance.

3 SCOPE

- 3.1 This is a trust wide non-clinical policy.
- 3.2 This policy applies to all those involved in producing and reporting performance information to the board of directors.
- 3.3 The policy also provides the elements and criteria to be used by internal and external audit as the basis for providing assurance on the quality of performance information supplied to the board of directors and committees of the board.
- 3.4 The only exception to this will be where external auditors are required to adopt an alternative approach in order to meet the requirements of those commissioning the work.

4 DEFINITIONS

4.1 The relevant terms and their definitions (within the context of this policy document) are outlined in Table 1.

Table 1: Definitions

Term	Definition
IT	Information Technology
KLOE	Key Line of Enquiry
KPI	Key performance indicator
KPI owner	The individual (executive director) responsible for setting standards and agreeing reporting methodologies in relation to key performance indicators. The individual holds operations to account for the delivery. The individual responsible for the sign off of “improvement plans” developed in respect of key performance indicators.
Data quality	Data are of high quality “if they are fit for their intended uses in operations, decision making and planning.” Alternatively, data are deemed of high quality if they correctly represent the real-world construct to which they refer. Within an organisation, acceptable data quality is crucial to operational and transactional processes and to the reliability of business analytics / business intelligence reporting. Data quality is affected by the way the data is entered, stored, analysed, managed and reported. (J. M. Juran, 1951)
Accuracy	Data should be sufficiently accurate for its intended purposes and captured as close to the point of activity as possible. (Audit Commission, 2007)
Validity	Data will be recorded and used in compliance with relevant requirements, including the correct application of any rules or definitions. (Audit Commission, 2007)
Reliability	Data will reflect stable and consistent data collection processes across collection points and over time. Managers and stakeholders should be confident that progress toward performance targets reflects real changes rather than variations in data collection methods. (Audit Commission, 2007)
Timeliness	Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of service or management decisions. (Audit Commission, 2007)
Relevance	Data captured will be relevant to the purposes for which it is used, capable of evolving to reflect changing needs. Quality assurance and feedback processes are needed to ensure the quality of such data. (Audit Commission, 2007)
Completeness	Data requirements will be clearly specified and based upon the information needs of the organisation and data collection processes matched to these requirements. (Audit Commission, 2007)

5 DUTIES

- 5.1 **Board of Directors** – the board of directors, through the executive team, is ultimately responsible for ensuring the quality of the performance data received by itself and its committees.
- 5.2 **Board Committees** – the committees of the board of directors provide oversight of the implementation of this policy and procedure and the results of the kite-mark system. The committees of the board can request the application of the kite-mark to any performance indicator reported to the board of directors and / or one of its committees. The performance, investment and finance committee receives a biannual update on the implementation of the kite-mark including a summary of outcomes of any performance indicator testing undertaken. The audit committee is the approving committee for any proposed changes to the kite-mark and receives the outcomes of indicator testing and reviews of the executive performance report undertaken by internal auditors.
- 5.3 **Lead Executive Director** – the lead executive director for this policy (Executive Director of Finance / Deputy Chief Executive) has strategic responsibility for the management of data quality working through the Chief Information Officer on a day to day basis. The lead executive director is responsible for selecting the KPIs on which the trust needs to be assured using the kite-mark and for defining appropriate elements for inclusion in the kite-mark.
- 5.4 **Policy Lead** – the policy lead (Chief Information Officer) has operational responsibility for data quality in the trust. The Chief Information Officer will be responsible, together with their team, for putting measures in place such that the kite-mark can be reliably populated and reported to the board of directors and its committees, where appropriate.
- 5.5 **KPI owners** – KPI owners are responsible for ensuring that indicators are appropriately designed and that actions required to address any non-compliance with the criteria detailed within this document are promptly taken.
- 5.6 **External and internal audit** – to provide independent assurance of the quality of performance information reported to the board in line with the framework and criteria detailed in this policy.

6 PROCESS / PROCEDURE

- 6.1 The kite-mark is designed to appear within the metric glossary of the executive performance report for agreed key performance indicators to provide visual assurance on quality of a performance indicator (see Figure 1). Where an indicator does not require the application of the kite-mark; this will be referenced within the metric glossary as “Not Required”.
- 6.2 The kite-mark will be applied to all NHS England / NHS Improvement oversight framework indicators and prioritised contract and long term quality

improvement indicators that appear within the trust wide executive performance report and divisional versions of this.

6.3 Each indicator will be assessed against three criteria:

- a) Standard operating procedure
- b) Fully automated / manual intervention
- c) Internal / external audit

6.4 The assessment criteria are provided in Table 2.

Figure 1: The kite-mark



Table 2: The kite-mark assessment criteria

Kite-mark element	Description	Rating
Standing Operating Procedure	Does the indicator have an associated Standard Operating Procedure that is within date and meets the expected quality criteria (as defined in section 6.5 and 6.6 of the policy)?	Red – No
		Green - Yes
Automated	Is this indicator produced electronically or is it subject to manual intervention?	Red – Manual intervention
		Green – Fully automated
Audit	Has the indicator been subject to internal / external audit in the last three years *?	Red – No Audit
		Amber – Internal Audit
		Green – External Audit

* External audit is defined as an audit undertaken by an organisation independent of the trust e.g. external auditors or internal auditors. Internal audit is defined as an audit undertaken by Mersey Care NHS Foundation Trust staff.

6.5 The standard operating procedure will be required to cover the following elements:

- a) Rationale for the indicator
- b) Indicator description (including numerator, denominator, frequency of reporting)

- c) Recording process (including any timeliness standards around data input to clinical or business systems)
- d) Reporting process (where is the indicator reported and what is the process for generating and analysing the performance information; including timeliness of reporting)
- e) Validation process
- f) Review date

6.6 The standard operating procedure should reference the extent to which the local definitions and reporting processes are compliant with national guidelines if these exist. Where there is a departure from national guidelines, the rationale for this and any permissions obtained from relevant bodies that support this should be included within the procedure.

6.7 All indicators subject to the kite-mark will be audited at least once every three years as detailed in Table 2. The Chief Information Officer will be responsible for developing an annual audit schedule in line with the prioritisation process detailed in paragraph 6.8.

6.8 The prioritisation process will be as follows:

- a) Priority 1 (High): national indicators
- b) Priority 2 (Medium): contract indicators
- c) Priority 3 (Low): long term quality improvement indicators

6.9 Where an indicator subject to the kite-mark is not identified as requiring audit through the schedule, this will be clearly identified within the audit schedule document and the reason detailed.

6.10 Internal or external audit of key performance indicators subject to the kite-mark will use the elements detailed in Table 3 and the assessment criteria detailed in Table 4.

6.11 The outcomes of audits undertaken by external auditors (as defined in Table 2) will be received by the Audit Committee.

Table 3: Elements to be considered by auditors

Element	Definition
Timeliness	This is the time taken between the end of the data period and when the information can be produced and reviewed. The acceptable data lag will be different for different performance indicators. Data should be captured as quickly as possible after the event or activity and must be available for the intended use within a reasonable time period. Data must be available quickly and frequently enough to support information needs and to influence the appropriate level of

Element	Definition
	service or management decisions.
Monitoring	This is the degree to which the trust can drill down into data in order to review and understand operational performance. The level to which the trust needs to drill down into the data will vary for different performance indicators. Some information should always be available at patient level for performance monitoring purposes. Whereas some information may be sufficient if it is available at specialty level for all specialties or even trust level for performance monitoring purposes.
Completeness	There are two aspects to completeness. This is the extent to which all of the expected attributes of the data are populated but also the extent to which all of the records for the relevant population are provided.
Validation	This is the extent to which the data has been validated to ensure it is accurate and in compliance with relevant requirements. For example, correct application of rules and definitions. The level of validation required will vary from indicator-to-indicator and will depend on the level of data quality risk. Final validation is classified as sufficient where validation has been completed and where the indicator has received final approval from responsible individuals.
Reliability	This is the extent to which the data is generated by a computerised system, with automated IT controls, or a manual process. It also relates to the degree of documentation outlining the data flow, i.e. documented process with controls and data flows mapped. Is the data collected and reported consistently across different parts of the organisation? Where variation exists, is this appropriate given the variation in services delivered and information systems used? Data should reflect stable and consistent data collection processes across collection points and over time, whether using manual or computer based systems or a combination. Managers and stakeholders should be confident that progress toward performance targets reflects real changes rather than variations in data collection approaches or methods.
Relevance	This is the extent to which the data is captured for the purposes for which it is used. This entails periodic review of the selection of key performance indicators to reflect changing needs, such as new strategic objectives. For example, is this indicator the right indicator by which to measure performance against a strategic objective?

Table 4: Audit assessment criteria

Element	Sufficient	Insufficient
Timeliness	Where data is available daily for an indicator, up-to-date data can be produced, reviewed and reported upon the next day.	Where data is available daily for an indicator, there is a data lag of more than one day.

Element	Sufficient	Insufficient
	<p>Where data is only available monthly, up-to-date data can be produced, reviewed and reported upon within one month.</p> <p>Where the data is only available quarterly, up-to-date data can be produced, reviewed and reported upon within three months.</p> <p>Where data is only available annually, data being produced, reviewed and reported upon is no more than 12 months old.</p>	<p>Where data is only available monthly, there is a data lag of more than one month.</p> <p>Where data is only available quarterly, there is a data lag of more than one quarter.</p> <p>Where data is only available annually, there is a data lag of more than 12 months.</p>
Monitoring	<p>Where relevant, the trust is able to drill down into the data down to the right level (for example, speciality or patient level) to inform decision making on operational performance.</p> <p>Additionally, where the trust is able to drill down into the data to the right level, the KPI owner is able to provide assurance that this information is reviewed on a regular basis at that level (i.e. board, sub-committees, divisions, service lines, consultants)</p>	<p>The trust is either:</p> <ol style="list-style-type: none"> 1. Not able to drill down into the data down to speciality or patient level where required; or 2. able to drill down into the data but the KPI owner cannot provide assurance that this information is appropriately reviewed at different levels.
Completeness	<p>Fewer than 3% blank or invalid fields in expected data set.</p> <p>This standard applies unless a different standard is explicitly stated for a KPI within commissioner contracts or through national requirements.</p> <p>Additionally, the KPI owner can provide assurance that effective controls are in place to ensure that 100% of records are included in population. In other words, no individual records are omitted from the population due to fraud or error.</p>	<p>More than 3% blank or invalid fields in expected data set</p> <p>Inadequate assurance or no assurance that effective controls are in place to ensure that 100% of records are included within the total population.</p>
Validation	<p>The trust has agreed upon procedures in place for the validation of data for the KPI.</p> <p>A sufficient amount of the data,</p>	<p>Either:</p> <ol style="list-style-type: none"> 1. No validation has taken place; or

Element	Sufficient	Insufficient
	<p>proportionate to the risk, has been validated by the trust to ensure data is:</p> <ul style="list-style-type: none"> • accurate; and • in compliance with relevant rules and definitions for the KPI. <p>The KPI owner is responsible for determining what a 'sufficient' amount of data validation is.</p>	<p>2. an insufficient amount of data has been validated as determined by the KPI owner; or</p> <p>3. Validation has found that the KPI is not accurate or does not comply with relevant rules and definitions.</p> <p>Commentary should be available to indicate which of the above is the case</p>
Reliability	<p>Mostly a computerised system, with IT automated controls, and therefore less prone to human error. Automated controls may include field validation, system interface reconciliations and system configuration.</p> <p>Process is fully documented with controls and data flows mapped.</p> <p>Process is stable and consistent over the last 12 months unless the change in reporting was necessary to reflect a change in operational / statutory requirement.</p> <p>Where data is processed by a third party, the trust has received assurance over the processes and controls in place at the third party to ensure data quality.</p> <p>Where a manual process exists, this is fully documented with controls and validation procedures detailed.</p>	<p>Mostly a manual system, with no IT automated controls, and therefore more prone to human error.</p> <p>Process is not documented and / or, for manual data production, does not adequately detail controls and validation procedures.</p> <p>Process has changed during the last 12 months therefore there is an increased risk that data is not consistent between reporting periods. Any change in reporting methodology cannot be linked back to an operational / statutory requirement.</p> <p>Where data is processed by a third party, the trust has not received assurance over the processes and controls in place at the third party to ensure data quality.</p> <p>Commentary should be available to indicate which of the above is the case.</p>
Relevance	This indicator is relevant to the measurement of performance	This indicator is no longer relevant to the

Element	Sufficient	Insufficient
	against the: <ul style="list-style-type: none"> • Performance area • Performance question • Strategic objective 	measurement of performance against the: <ul style="list-style-type: none"> • Performance area • Performance question • Strategic objective

7 CONSULTATION

- 7.1 Review of the revised kite-mark process that has been in place since November 2018 has been undertaken in conjunction with the members of the health records and data quality working group. This revised policy reflects the outcome of the review.
- 7.2 The completed Equality, Diversity and Human Rights analysis for this policy is included in Appendix A.

8 TRAINING AND SUPPORT

- 8.1 No formal training is required to support the implementation of this policy. Advice on application of the policy will be provided by the Chief Information Officer.

9 MONITORING

- 9.1 The Chief Information Officer should review the effectiveness of the kite-marking system and this policy on a biannual basis. This may involve internal audit periodically to provide independent assurance.
- 9.2 The Audit Committee receives a biannual update on the implementation of the kite-mark including a summary of outcomes of any performance indicator testing undertaken.

10 SUPPORTING DOCUMENTS AND REFERENCES

- 10.1 Table 5 provides details of the supporting documents that should be considered alongside of this policy.

Table 5: List of supporting documents

Reference	Name
IT06	Health records
IT11	Corporate Data Quality

10.2 Table 6 provides details of the reference documents and bibliography used in the development of this policy.

Table 6: List of references and bibliography

Name
Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts, NHS Improvement, London, June 2017
Improving Information to Support Decision Making: Standards for Better Data Quality, the Audit Commission, Audit Commission Publishing Team, 2007
Quality Control Handbook, J M Juran, New York, NY: McGraw-Hill, 1951

Equality and Human Rights Analysis

Equality and Human Rights Analysis

Title: Performance Indicator Kite-marking Policy

Area covered: The purpose of this policy is to provide a system for reporting assurance on the of key performance indicators (KPIs) to ensure that board information provides an accurate reflection of the trust's performance.

What are the intended outcomes of this work?

REVIEW AUGUST JULY 2019

To ensure that board information provides an accurate reflection of the trust's performance.

Who will be affected?

Board members and those responsible for applying the kite-mark to the executive performance report.

Evidence

What evidence have you considered?

Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts, NHS Improvement, London, June 2017

Improving Information to Support Decision Making: Standards for Better Data Quality, the Audit Commission, Audit Commission Publishing Team, 2007

Quality Control Handbook, J M Juran, New York, NY: McGraw-Hill, 1951

Outcome of a review of the policy by equality analysis group.

Disability including learning disability

Nil - Reviewed 2019

Sex

Nil- Reviewed 2019

Race

Nil- Reviewed 2019

Age

Nil- Reviewed 2019

Gender reassignment (including transgender) Nil- Reviewed 2019
Sexual orientation Nil- Reviewed 2019
Religion or belief Nil- Reviewed 2019
Pregnancy and maternity Nil- Reviewed 2019
Carers Nil- Reviewed 2019
Other identified groups Nil- Reviewed 2019

Human Rights	Is there an impact? How this right could be protected?
Right to life (Article 2)	No - Reviewed 2019
Right of freedom from inhuman and degrading treatment (Article 3)	No - Reviewed 2019
Right to liberty (Article 5)	No - Reviewed 2019
Right to a fair trial (Article 6)	No - Reviewed 2019
Right to private and family life (Article 8)	No - Reviewed 2019
Right of freedom of religion or belief (Article 9)	No - Reviewed 2019
Right to freedom of expression Note: this does not include insulting language such as racism (Article 10)	No - Reviewed 2019
Right to freedom from discrimination (Article 14)	No - Reviewed 2019

<p>Engagement and involvement External advice sought including a presentation to trust officers. Circulation of the presentation to key individuals including non-executive directors Sharing of proposed attributes with the performance and investment committee</p>
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<p>Summary of analysis - Reviewed 2019 No specific equality or human rights significant within this policy</p>
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Eliminate discrimination, harassment and victimisation

The improvement of data quality and scrutiny will support the Trust to identify and indicate relevant action to support the elimination of discrimination, harassment and victimisation.

Advance equality of opportunity

The improvement of data quality and scrutiny will support the Trust to identify and indicate relevant action to support the advancement of opportunity

Promote good relations between groups

The improvement of data quality and scrutiny will support the Trust to identify and indicate relevant action to support the promotion of good relations between groups.

What is the overall impact?

Nil

Addressing the impact on equalities

No issues identified

Action planning for improvement

No issues identified for action

For the record**Name of persons who carried out this assessment:**

Wendy Copeland-Blair (Chair) (August 2014, Review August 2018 & Review July 2019)

Joyce Williamson (August 2014)

Kate Greenwood (August 2014)

Meryl Cuzak (August 2015)

Kate Greenwood (August 2015)

Date assessment completed:

11 August 2014 / Reviewed 10 August 2015 / Reviewed 8 August 2018 / Reviewed 25 July 2019

Name of responsible Director/Director General:

Neil Smith, Executive Director of Finance / Deputy Chief Executive

Date assessment was signed:

11 August 2014 / 10 August 2015 / 8 August 2018 / 25 July 2019