

<b>REPORT TITLE:</b>	Board Level Metrics		
<b>SPONSORING EXECUTIVE:</b>	David Baker (Chief Strategy Officer)		
<b>REPORT AUTHOR:</b>	Matthew Maguire (Associate Director Performance/Strategic Insight)		
<b>MEETING:</b>	Public Trust Board	<b>DATE:</b>	6 <sup>th</sup> July 2022

<b>1. Suggested discussion points</b> <i>[two or three issues you consider the Trust Board should focus on in discussion]</i>
<p>The Board level metrics sets out key points for each Committee. Key points for the Trust Board are:</p> <ul style="list-style-type: none"> <li>• DM01 performance - the increase in both the size and duration of waiting times for Imaging patients.</li> <li>• Intelligent Conveyancing - the effect this is having on our Accident and Emergency department.</li> <li>• Occupied Bed Days - current beds usage. We are moving away from the Midland Metropolitan University Hospital bed allocation; how do we recover this?</li> <li>• Summary Hospital Mortality Index (SHMI) – we have seen slow steady performance improvement from 108<sup>th</sup> in August 2021 to 102<sup>nd</sup> in January 2022 as reported in PublicView.</li> </ul>

<b>2. Alignment to our Vision</b> <i>[indicate with an 'X' which Strategic Objective[s] this paper supports]</i>												
<table border="1"> <thead> <tr> <th>OUR PATIENTS</th> <th></th> <th>OUR PEOPLE</th> <th></th> <th>OUR POPULATION</th> <th></th> </tr> </thead> <tbody> <tr> <td>To be good or outstanding in everything that we do</td> <td>X</td> <td>To cultivate and sustain happy, productive and engaged staff</td> <td>X</td> <td>To work seamlessly with our partners to improve lives</td> <td>X</td> </tr> </tbody> </table>	OUR PATIENTS		OUR PEOPLE		OUR POPULATION		To be good or outstanding in everything that we do	X	To cultivate and sustain happy, productive and engaged staff	X	To work seamlessly with our partners to improve lives	X
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<b>3. Previous consideration</b> <i>[at which meeting[s] has this paper/matter been previously discussed?]</i>
All Board Committee's in June 2022

<b>4. Recommendation(s)</b>
The Public Trust Board is asked to:
a. <b>NOTE</b> the performance
b. <b>DISCUSS</b> areas highlighted

<b>5. Impact</b> <i>[indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]</i>						
Board Assurance Framework Risk 01	X	Deliver safe, high-quality care.				
Board Assurance Framework Risk 02	X	Make best strategic use of its resources				
Board Assurance Framework Risk 03	X	Deliver the MMUH benefits case				
Board Assurance Framework Risk 04	X	Recruit, retain, train, and develop an engaged and effective workforce				
Board Assurance Framework Risk 05	X	Deliver on its ambitions as an integrated care organisation				
Corporate Risk Register <small>[Safeguard Risk Nos]</small>						
Equality Impact Assessment	Is this required?	Y		N		If 'Y' date completed
Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed

# SANDWELL AND WEST BIRMINGHAM NHS TRUST

## Report to the Public Trust Board on 6<sup>th</sup> July 2022

### Board Level Metrics

#### 1. Introduction or background

- 1.1 The Board Level Metrics were introduced in August 2021. We continue to develop those metrics that are not complete and refine those that are so that we use the best possible graphs and use the most appropriate targets.

#### 2. Developments

- 2.1 The Chief Nurse Officer has requested that the HCA indicator be removed as inconsistencies in the data from electronic staff record (ESR) system is showing an incorrect position. The indicator was only recently agreed as a stop gap until the Allocate data became available.

- 2.2 We have included the West Midland Ambulance Service (WMAS) ambulance hand overs taking more than 30 minutes.

- 2.3 We are trying to obtain the longer-term historic data from West Midland Ambulance Service (WMAS) concerning intelligent conveyances. We have managed to obtain the WMAS Intelligent Conveyances data for May 2022 data which shows:

- 2.3.1 We requested that 23 ambulances be sent to other hospitals whereas we received **333** ambulances which were intelligently conveyed to us from other hospitals.

- 2.3.2 Sandwell and West Birmingham took **41%** of all Intelligent conveyancing within the West Midlands with a net figure of **310**.

#### 3. Board Level Metrics

- 3.1 Where we have national benchmarking from Public View, we now show which quartile we are in along with a Care Quality Commission (CQC) style rating when using **all** providers. This includes: acute; combined; community only; mental health; ambulance and specialist.

- MRSA is Outstanding
- E-Coli is Good
- C-Difficile is Good
- Emergency Care 4 hour - Good
- RTT incomplete pathways - Requires Improvement
- Day lost to Sickness Absence - Requires Improvement
- 62-day cancer - Requires Improvement
- SHMI mortality ratio - Inadequate
- Friend and Family Test recommended – Inadequate

3.2 If we only considered using Acute and Combined providers, our performance would look as follows:

Indicator	Current (all providers)	Proposed (Acute and Combined providers)	Movement
MRSA	Outstanding	Outstanding	Same
E-Coli (Hospital Onset)	Good	Outstanding	Improved
C-Difficile (Hospital Onset)	Good	Outstanding	Improved
Emergency Care 4 hour	Good	Good	Same
RTT incomplete pathways	Requires Improvement	Good	Improved
Day lost to Sickness Absence	Requires Improvement	Inadequate	Deteriorated
62-day cancer	Requires Improvement	Requires Improvement	Same
SHMI mortality ratio	Inadequate	Inadequate	Same
Friend and Family Test recommended	Inadequate	Inadequate	Same

Whilst it does not make a huge difference it does seem to be a better comparator for us to use. With regards to the overall Hospital Combined Score, this does not affect our position. We remain at 108/123 which is in the bottom quartile.

3.3 As we have now signed the 5-year strategy and received a metrics paper into the Integration Committee the Chief Strategy Officer is carrying out a review to rationalise the original metrics so that we can accommodate the population metrics and some key MMUH metrics.

#### 4. Committees

##### 4.1 Quality and Safety Committee

4.1.1 **Sepsis – treated within 1 hour** – We now require the clinicians to follow the process and mark patients as “not sepsis” following the National Early Warning Score (NEWS) indicating the possibility of sepsis to improve the performance. We are not seeing any evidence of the new process being followed.

4.1.2 **Safer Staffing – Nursing** - The Chief Nurse Officer had proposed that Band 5 vacancies and Health Care Assistants (HCA) vacancies are used as a proxy for safe staffing levels until the new rostering system is in place next year. However due to inconsistencies in the Electronic Staff Record (ESR) system the Chief Nurse is now asking for the HCA indicator to be removed.

4.1.3 **Family and Friends Test (FFT) recommended** – we are using 5 combined FFT scores for Emergency Department, Inpatient, Outpatient, Maternity and Postnatal care. Of the 4 trusts in the Black Country ICS our performance is the lowest in A&E and Inpatients.

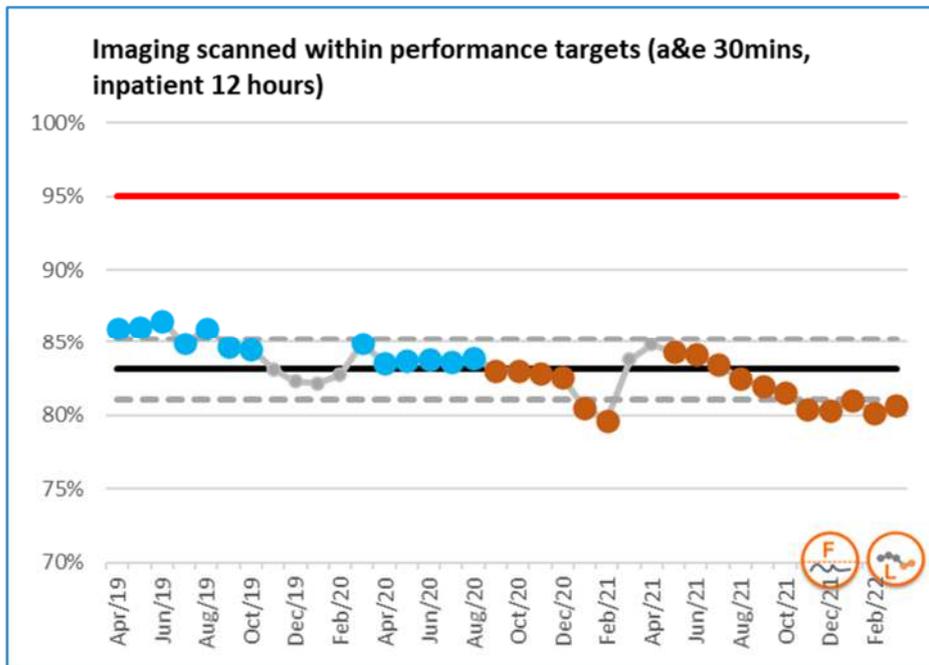
- 4.1.4 **Emergency Readmissions** – we continue to see good performance against the target since April 2021.
- 4.1.5 **Same Day Emergency Care** – we are seeing a small improvement in the provision of activity in the correct location and away from the Emergency Department (ED). If we see this improvement continue for another 2 months, we will move into special cause improvement.
- 4.1.6 **MRSA Screening** – Infection control has increased the number of exclusions and so performance has slightly improved.
- 4.1.7 **C. Difficile** – Trust performance continues to be good.
- 4.1.8 **E. Coli** – Has seen an astronomical data point in May 22. We will see if this is replicated next month.
- 4.1.9 **Summary Hospital-Level Mortality Index (monthly)** – we have a prolonged period now of common cause variation. Based on a rolling 12month data set our publicview ranking has improved from 108<sup>th</sup> to 102<sup>nd</sup> in January 2022.
- 4.1.10 **Hospital Standardised Mortality Rate (HSMR)** – since the last wave of Covid19 we have seen a reduction in our HSMR below the mean but still higher than expected. If the Covid19 time period was removed, we believe this would show common cause variation.
- 4.1.11 **Serious Incidents** – we have seen two astronomical data points where we have three times the number of serious incidents to the average (mean), this is caused by Hospital acquired covid (nosocomial) infections.
- 4.1.12 **Patient Safety (Moderate harm or above)** - we have twice as many incidents as normally reported, again this was due to nosocomial infections.
- 4.1.13 **DMO1** – we are now reporting 27,872 patients waiting for diagnostic tests with 12,426 waiting over 6 weeks. Most of our waiting is in MRI – 5543 (city scanner is not working), Non obstetric ultrasound – 16634, CT – 1464. The Group Director of Operations for imaging also reported issues with other equipment such the DEXA scanner as equipment is either past or coming to end of life. Current Imaging demand and capacity work is suggesting that we will end 2022/23 with more patients waiting for MRI/CT and ultrasound than are waiting now.
- 4.2 Finance, Investment & Performance Committee
  - 4.2.1 **Cancer performance** (April 22) – we met the performance target for breast symptomatic 2 week wait; we failed the Cancer 2 week wait target (by 0.5%), Cancer 31-day Target (0.5%) and Cancer 62-day target (by over 20%).
  - 4.2.2 **SitRep late cancellations** – Last month we reported a reduction to 30 late cancellations, this has increased again to 47 against a target of 20 per month.

- 4.2.3 **28 Day Breaches** – We have 1 x 28-day breach in May 2022 (where we cancel a patient and then do not get them back into surgery within this national guarantee) with 9 x 28-day breaches in the previous month of April 2022.
- 4.2.4 **RTT** – Although we have seen the number of patients waiting over 104 weeks reduce, the total number of people waiting for treatment has increased again by over 2000 this month to 58,905. Our backlog (which is over 18 weeks) continues to grow and has gone up ~1000 to 20,565.
- 4.2.5 **Underlying Deficit** –the trust has agreed a £31million underlying deficit plan. This will create a different financial environment to work within. Our deficit in May is £4.4m against a planned deficit of £3.3m. This excludes any potential Elective Recovery Fund (ERF) clawback.
- 4.2.6 **DM01** – we are now reporting 27,872 patients waiting for diagnostic tests with 12,426 waiting over 6 weeks. Most of our waiting is in MRI – 5543 (city scanner is not working), Non obstetric ultrasound – 16634, CT – 1464. The Group Director of Operations for imaging also reported issues with other equipment such the DEXA scanner as equipment is either past or coming to end of life. Current Imaging demand and capacity work is suggesting that we will end 2022/23 with more patients waiting for MRI/CT and ultrasound than are waiting now.
- 4.2.7 **Emergency Care indicators** – these now include activity from Virgin Healthcare (as from April 2022) from its Summerfield location (West Birmingham). Now that we have increased the volume of attendances we seek permission to increase the target in line with these new attendances.
- 4.3 People and Organisational Development Committee
- 4.3.1 **Sickness Absence** – This remains above 4.5% target (6.23%) and is impacting our ability to deliver services particularly in Surgery
- 4.3.2 **Nurse Turnover** – The target is 10.7% and we have been reporting over 11% for 11 consecutive months, April 2022 at 13.1%.
- 4.3.3 **Staff Survey** – The radar diagram shows we have deteriorated from our baseline position. Staff Survey includes national survey and pulse surveys for the 9 specific questions.
- 4.4 Integration Committee
- 4.4.1 **Covid – Virtual Ward** - it measures the number of patients who we monitor at home rather than admitting them into hospital (admission avoidance).
- 4.4.2 **Hospital at Home** – these are patient we are positively managing in their own homes avoiding a hospital admission.
- 4.4.3 **Urgent Community Response** – we need to increase the number of patients who access this service to reduce emergency admissions.

#### 4.5 MMUH Opening Committee

- 4.5.1 Occupied Bed Days** – This is showing a relatively small increase in our bed usage however this is hiding the variability in our different bed types.
- 4.5.2 Geriatric Bed Days** - We are building 3 wards of 32 beds which will be allocated to Geriatric Beds in the MMUH building. Whilst we have reduced the number of Over 65 Medical admissions and reduced the number of medical admissions with a zero length of stay, our bed usage of geriatric beds has gone up from ~3600 bed days per month in 2019 (which would need 133 beds @ 90% occupancy) to ~5000 bed days per month in 2022 (which would need 179 beds @ 90% occupancy), which is an increase of ~46 beds at a time when we would have hoped that Same Day Emergency Care (SDEC) and Frailty Intervention Team (FIT) would have reduced the bed day situation. This is having an impact on additional wards being opened and patients having to outlie into surgical wards. From an MMUH perspective this a bed gap of 85 beds or a 47% reduction.
- 4.5.3 Cardiology Bed Days** - We have 42 beds allocated for Cardiology. We have been tracking much higher but have dropped down to the target level in May 2022.
- 4.5.4 Inpatient RTT Incomplete Pathways** - The number of patients waiting for an inpatient admission for treatment is more than double our normal historic levels (~4000), whilst we try to increase our activity to reduce our backlog of patients waiting and to meet the requirements of the Elective Recovery Fund (ERF), this will increase our demand on beds.
- 4.5.5 Community Contacts** - We have met with the Group Director of Operations for Primary Care, Community Contacts to discuss setting a target for this indicator. Whilst discussing the setting of the target we discussed whether this was the correct indicator to be monitored. We agreed that we should be presenting an indicator showing the number of patients who are going through the new community processes with admission avoidance at the core. Eg Hospital at home, patients on virtual wards, patients processed through the frailty intervention team etc. as community contacts may be considered too large an aggregation as some activities need to reduce and some increase, we may not be able to differentiate. This will be reconsidered in the review of Board Level Metrics.
- 4.5.6 Imaging Investigations** - We are recommending a new Target for the Imaging Investigations based on the MMUH modelling done by the Service Improvement team. It takes the activity undertaken in 2021/22 and applies the expected levels of increase between now and the projected opening of MMUH. The recommended monthly target is 33289 which is a range from 1% to 7% increase per year based on modality.

At the same time for discussion, would a better indicator be the % of scans that are performed within the allocated time frame, as MMUH is predominantly A&E, SDEC, UTC and Inpatient activity we should only monitor these imaging activities, below is an example of the chart with a 95% target set.



This informs us that we are not currently achieving the scanning targets of < 30 mins in A&E and 12 hours for inpatient requests. This will have an impact on patient flow within the new building.

#### 4.5.7 Theatre Productivity – BADS

Whilst we have a steady state in the percentage of day cases that are being undertaken, we have not seen any real improvement, even though we are trying to improve the number of operations undertaken to achieve our ERF. If we do not see an improvement in our performance, we will have additional pressure on the beds at MMUH.

4.5.8 **Same Day Emergency Care (SDEC)** - We have observed slow progress in this indicator, however the performance is for the last 4 months has been above the mean and is now in common cause variation.

### 5. Recommendations

5.1 The Public Board is asked to:

- a. **NOTE** the performance.
- b. **DISCUSS** the areas highlighted

Matthew Maguire  
Associate Director of Performance and Strategic Insight

21/06/2022

**Annex 1: Board\_Level\_Metrics\_May\_2022\_v4.pptx**