Paper ref:	TB (09/22) 004b Appendix 2

PATIENTS PEOPLE POPULATION

NHS
Sandwell and West Birmingham
NHS Trust

REPORT TITLE:	Board Level Metrics Review		
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REPORT AUTHOR:	Meggan Jarvis, Head of Innovation		
MEETING:	Public Trust Board	**DATE:**	7th September 2022

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on in discussion]*

The Board Level Metrics were introduced in August 2021 and were aligned to our Patients strategic objective. The philosophy of their introduction aligned with several areas of best practice including:

- The Institute of Healthcare Improvements (IHI) research that we should be able to run a healthcare organisation on 12-24 metrics;
- The introduction of Statistical Process Control (SPC) charts in line with NHSE/I "Making Data Count" approach.

It was always our intention to review the Board Level metrics once our Trust strategy was signed off and metrics had been identified within the Place Based Partnership.

This paper follows several forums where the metrics were rationalised. The paper has been amended to reflect some changes following discussion:

- Complaints is suggested as a rate per 1000 Whole Time Equivalent (WTE). This is the national benchmark standard which a) creates equitable comparisons between larger and smaller Trusts b) WTE is universal across all care provision (in/outpatient, community, primary care) whereas other methods such as bed days or episodes are inpatient only.
- Discharge to Assess will show pathways 1-4, and pathway 0 when data quality has improved.
- Beds delivered in Community has been rephrased to 'referrals to avoid admission' and will include the Frailty Intervention Team (FIT) as a further admission avoidance mechanism.

2. Alignment to our Vision *[indicate with an 'X' which Strategic Objective[s] this paper supports]*

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

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

July - Executive Group, Performance Management Group, Clinical Leadership Executive

4. Recommendation(s)

The Public Trust Board is asked to:

a. **AGREE** the proposed set of Board Level Metrics

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]*

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 [Safeguard Risk Nos]								
Equality Impact Assessment	Is this required?		Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?		Y		N	X	If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board on 7th September 2022

Rationalised Board Level Metrics

1. Background

1.1 The Board Level Metrics were introduced in August 2021 and were aligned to our Patients strategic objective. Since its adoption, the number of Board metrics has increased, now totalling 47 (including the 8 Midland Metropolitan University Hospital (MMUH) metrics). This does not include a considered set of metrics within Population, whereby 62 Place metrics developed by the Sandwell place were discussed at April Integration Committee.

1.2 Following approval of our strategy, we are undergoing a strategic portfolio review to prioritise change initiatives that will have the biggest impact in achieving our objectives and pre MMUH priorities. It is therefore timely that we review the Board Level Metrics to rationalise the set back down to a focused amount within best practice guidelines (12 to 24). By agreeing a rationalised set of board level metrics, we can prioritise the portfolio against these metrics.

1.3 A paper was discussed at June Performance Management Committee (PMC) stimulating a review of the current set. A Strategic Executive Group was held on Tuesday 12th July which reached a broad consensus on the set of Board Level Metrics.

2. Best Practice

2.1 Whilst there may be many worthy metrics for consideration, a good metric at Board level should be:

2.1.1 A big ticket, outcome metric (not lead / driver / process metric). The focused few are the reasons we exist as an organisation and the ultimate end goals;

2.1.2 Sensitive to national and reputational impacts as these are what the public see;

2.1.3 Measurable month to month and where we will see a difference;

2.1.4 Totalling 12-24, to stimulate focused and meaningful accountability. We still run our lengthy Integrated Quality and Performance Report (IQPR), so this creates room to elevate any exceptions that need recognition.

3. Review

3.1 In this review we considered a long list of metrics and sources including:

3.1.1 Our pre and post MMUH priorities as identified in the strategy

3.1.2 The CQC Key Lines of Enquiry (KLOEs)

3.1.3 Public View's "Hospital Combined Performance Score"

3.1.4 NHSE "Use of Resources" metrics

3.1.5 Sandwell Place Based Partnership – Outcome and Operational Measures (See April Integration Committee Papers)

3.2 Concluding strategic Executive Group, the following 28 metrics were proposed for Board level:

Patients (13)	People (6)	Population / MMUH (9)
-SHMI ≥Moderate Harm & Patient Safety -Incidents (run chart with 2 measures or 2 SPC charts) -Doctor vacancies -Band 5 Nurse vacancies	-Staff Survey / People - Pulse - Overall engagement score and radar diagram of the 9 national questions -Pulse – experience of Digital Technology and Environment as Trust agreed questions (2) (go live in Jan 23) -Sickness -Turnover	-2 hr Community Response -Referrals to avoid admission (Epicentre, virtual ward, Hospital@Home, Frailty Intervention Team) -Discharge2Assess (D2A) Length of Time to Discharge pathways 1-4 and 0 -Contacts to Care Navigation Centre -Readmissions within 30 days -Days exceeded Target Discharge Date *MMUH* *-Bed Occupancy* *-Geriatric Bed Days* *-Cardiology Bed Days*
-FFT score -Complaints per 1000 WTE		
-ED 4 hour (Average Wait when national target confirmed) -Ambulance handover 30 min -RTT -62 day Cancer		
-Capital vs plan -Cash vs plan -Income & Expenditure vs plan		

3.3 The following Patient metrics were agreed for removal / downgrade:

Patients – Downgraded (13)	People	MMUH – Downgraded (4)
HSMR Patient safety incidents (now on 1 chart with ≥Moderate harm) Serious Incidents Sepsis treated within 1hr MRSA screening – Elective & Non Elective (2) Hospital Acquired E-Coli and C-difficile (2) Perfect Ward Average Score Perfect Ward Inspections ED Attendances Same Day Emergency Care (SDEC) Risk Mitigations	N/A	Theatre Productivity Imaging Investigations Incomplete Inpatient RTT Community Contacts

4. Rationale

4.1 *Patients*

4.1.1 Previously a much larger set of metrics, Patients has been distilled down to its essence. Within safety, there are one to two metrics against the key areas in the CQC KLOE: mortality, harm, and safe staffing. These are the ultimate outcome metrics for safety; pushing other metrics which are subsets of these into broader IQPR, committee level or other reporting routes. As the Fundamentals of Care plan is developed so too will a set of metrics which will monitor progress at the plan level. By running the IQPR simultaneously,

we will continue to elevate any outliers of concern as part of the Board Level Metrics report. Safe staffing is currently reflected through vacancies as a proxy measure until the implementation of e-rostering. In the future this will reflect staffing levels on shift.

4.1.2 Within Caring, Perfect Ward (Tenable) has been removed in favour of complaints. Public View benchmarking data indicates that we are a significant outlier for complaints. There are several ways in which to measure complaints, and the complaints measure within Public View's Hospital Combined Score (CQC predictor) is count of complaints per 1000 WTE. This metric therefore contextualises the volume of complaints against staffing. Perfect Ward (Tenable) will continue to be monitored within the Fundamentals of Care plan.

4.1.3 Responsive remains largely the same, removing ED attendances as it is a contextual measure. Of note, if average wait within ED is confirmed as a national target we will consider replacing the four hour target with it.

4.1.4 The only Well-Led metric that was not related to People was Risk Mitigations (open actions against red and amber risks). Given the other risk management and governance frameworks at senior level it was deemed that this metric could be removed.

4.1.5 Use of Resources has been reframed in line with the agreed Finance metrics paper taken to Financial Improvement and Performance Committee in June. Better Value, Quality Care was deemed to be a driver of the financial position rather than an outcome.

4.1.6 The Effective domain and MMUH have been moved into Population. The CQC KLOE for Effective is centred upon personalised care and partnership working, thus lending more to Population focus. MMUH is centred upon demand management and flow, which also lends to Population.

4.2 *People*

4.2.1 The People related metrics previously listed under 'Well Led' have been extracted to a new heading, People, to appropriately reflect our 3 P's strategy. The metrics are largely the same, retaining aggregated engagement score (9 nationally standardised questions including radar breakdown) and turnover. Sickness will be amended to reflect a percentage following a data quality review. Reflecting our strategy, 2 additional Pulse questions will be added to measure how staff feel about digital and technology in the Trust as well as their physical environment. These questions will not affect the national engagement score.

4.3 *Population & MMUH*

4.3.1 The existing metrics for Population have been amended and expanded upon. Two hour community response remains the same, whilst 'Beds Delivered in the Community' aggregates two existing metrics (Virtual Ward and Hospital@Home) with Epicentre into a single metric that reflects Community avoiding admission or stepping down care earlier. Contacts to Care Navigation Centre has been added as a metric of demand redirection.

4.3.2 D2A Length of Time to Discharge and Days Exceeded Target Discharge Date have been added as length of stay metrics. Days Exceeded Target Discharge Date is the best metric to capture delayed discharge, rather than Length of Stay which is less reliable as the variation within an average can distort the true picture. Furthermore, as we expect to increase our

zero day length of stay, it will not always be clear if a change is an improvement in Length of Stay.

4.3.3 Days Exceeded Target Discharge Date is a clinically driven metric, which accounts for differences in acuity rather than a blanket length of stay approach. The metric will also be counter measured in the IQPR to track how many times a target date has been 1) changed and 2) met too early, to mitigate a metric being 'gamed' by setting a too generous target or repeated changing of the target. The commentary will also include a thematic commentary as to why a delay has occurred. Readmissions has been moved from the Patient objective into Population as it is a counter measure to safe discharge.

4.3.4 MMUH metrics are included at Board Level in recognition of their strategic importance at this time. The three most impactful metrics have been chosen: bed occupancy, patients aged 65 and over bed days, and Cardiology bed days. The other metrics previously at Board level have been shifted to be sit at MMUH programme level for assurance. Although Over 65s and Cardiology are process measures to the outcome measure of occupancy, their importance at this time has elevated them to board level on a temporary basis until we are assured of MMUH fit.

5. Strategic Portfolio and Breakthrough Objectives

5.1 The strategic Executive Group also discussed the strategic portfolio development and the route to prioritising change initiatives into a one page strategic summary. An example is shown below from University Hospitals Sussex which follows the golden thread from strategic objective, current target (key Board Level Metric), breakthrough target, and strategic and corporate change programmes.

5.2

University Hospitals Sussex NHS Foundation Trust

North Mid True North Output

Strategic Theme	Strategic Goal	Current Target	Current Breakthrough Objective	Strategic Initiatives	Corporate Projects
Patient	We have the highest % of patients recommending us as a place to be treated in London (FFT)	95% of our patients recommend us as a place to be treated by the end 2025/26 (FFT)	Increase our response rate for FFT to 90%	PFIS Rollout Programme Clinical Strategy Green Plan Cultural Improvement Programme ICS Estates Strategy/Master Plan Royal Free & Provider Alliance	Productivity THEATRES CQC Going for Good eRostering Digital NorthMid Violence & Aggression Scheme Cultural Improvement Programme RESPECTFUL RESOLUTION Cultural Improvement Programme VALUES INTO ACTION
Sustainability	To ensure we are able to deliver patient services without spending more than we earn each year	To reduce the gap between what we spend and what we are given to spend each year by the following percentages: 2021-2022 = 20% 2022-2023 = 40% 2023-2024 = 40%	To develop and fully deliver a recurrent efficiency programme as defined by the Trust's annual financial plan.		
People	To be the best Acute Trust in London for staff who feel they are respected, included and work in a safe environment	Above average by end 2025/26 (All London Acute Trusts) for staff reporting they feel respected and included (Equality, Diversity & Inclusion) Above average by end 2025/26 (All London Acute Trusts) for staff reporting they work in a Safe Environment	Significantly increase the percentage of staff who report that NMUH act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age Significantly decrease the percentage of staff reporting how many times they have personally experienced harassment, bullying or abuse at work from managers		
Outstanding Care	There are no moderate/severe/death harms in our care Our patients are treated within 4 hours in A&E 100% of the time	50% reduction in incidents of moderate/severe/death harms Consistently achieve 80% of patients admitted from A&E within 4 hours	Improve average discharge time by 4 hours		
Partnerships	Reduction in prevalence of top 5 risk factors that contribute to years lived in poor health	25% reduction in prevalence of smoking across Enfield & Haringey	Within 12 months all patients and staff are provided with evidence-based advice on stopping smoking where a tobacco dependence is identified		

5.3 To achieve our strategic objectives, we need to work together on a few key levers that will turn the dials on our most important metrics. A 'breakthrough objective' is a driver metric that will contribute the biggest impact in improving the current target metric. In the example above, 'Outstanding Care' has a current target 'to achieve 80% patients seen in ED

within 4 hours'. The corresponding 'breakthrough objective' is to 'improve average discharge time by 4 hours' as this is a key driver of timely admission.

5.4 Through the strategic portfolio work, we will be exploring what are the four to five key levers we can pull in the organisation to turn the dials on our performance. Whilst further work is required to agree the breakthrough objectives, initial discussion suggested that Patients and Population would work together on the same current target of Bed Occupancy, as this is a key target for MMUH fit. The current target for People was suggested to be the combined Pulse Engagement score. Leadership culture was discussed as a high level breakthrough area, but further work was needed to define measurement.

5.5 A visual example is shown below, though the detail is not confirmed. When the Strategic Summary is fully developed and confirmed, it is suggested that the current targets are agenda items at CLE, so that they are projects we all work on together.

Strategic Objective		Current Target *(key Board Level Metric)*	Breakthrough Objective *(driver metric)*	Strategic Initiatives
Patients	**To be good or outstanding at everything we do**	Reduce Bed Occupancy ≥65s Bed Days Cardiology Bed Days	Days exceeded Target Discharge Date	Flow project
Population	**To work seamlessly with partners to improve lives**		Reduce discharge time by 4 hours	Development of Town Teams & Care Navigation Centres
People	**To cultivate and sustain happy, productive, and engaged staff**	Staff engagement score (Pulse)	Leadership trained vs target	Clinical Leadership Development

5.6

5.7 Agreeing a rationalised set of Board Level Metrics also acknowledges the need to develop Committee and Group level metrics to ensure that the same golden thread runs through the organisation as has been established at the top. Work has commenced in POD committee to agree metrics in the first instance, but the development of an organisational wide accountability system will take time.

6. Recommendations

6.1 The Public Trust Board is asked to:

a. **AGREE** the proposed set of Board Level Metrics

Meggan Jarvis, Head of Innovation
22nd July 2022