Paper ref:	TB (04/22) 007

NHS
Sandwell and West Birmingham
NHS Trust

Report Title:	Board Level Metrics (Patient strategic objective)		
Sponsoring Executive:	Richard Beeken, Chief Executive		
Report Authors:	Dr David Carruthers, Medical Director Mel Roberts, Chief Nurse Liam Kennedy, Chief Operating Officer Dinah McLannahan, Chief Finance Officer		
Meeting:	Trust Board (Public)	**Date**	6th April 2022

1.	**Suggested discussion points** *[two or three issues you consider the Trust Board should focus on]*
Each member of the Executive Team has personally provided their own commentary to the area for which they are the lead within the Patients Strategic Objective. This adds a further strengthening the ownership and accountability where improvements are required in the main IQPR Report.	

2.	**Alignment to our Vision** *[indicate with an **'X'** which Strategic Objective 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		To work seamlessly with our partners to improve lives		

3.	**Previous consideration** *[where has this paper been previously discussed?]*
N/a	

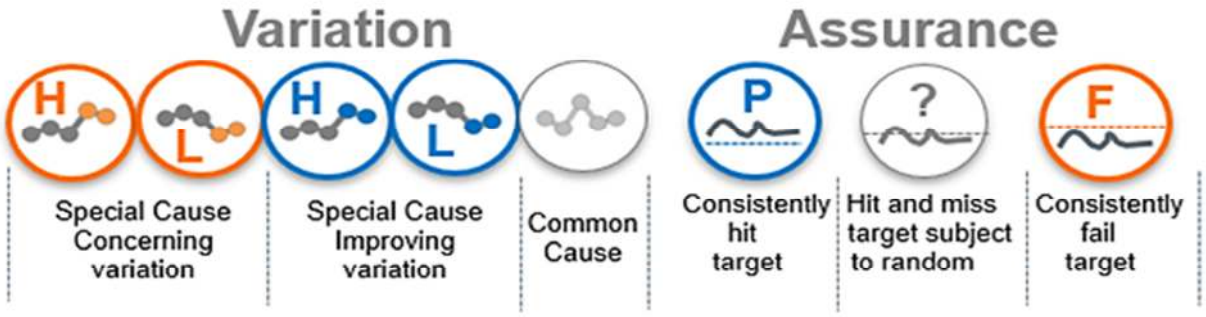
4.	**Recommendation(s)**
The Trust Board is asked to:	
a.	**RECEIVE:** and note the report for assurance
b.	

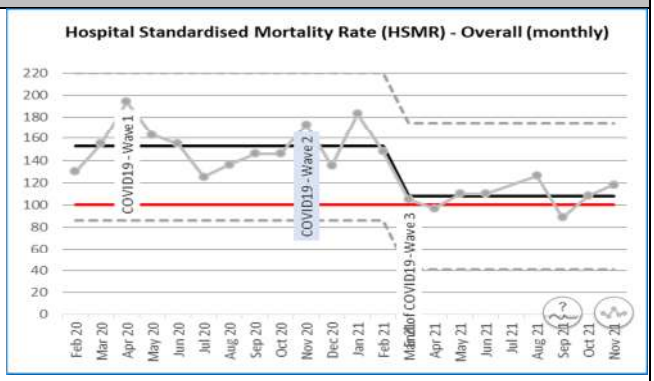
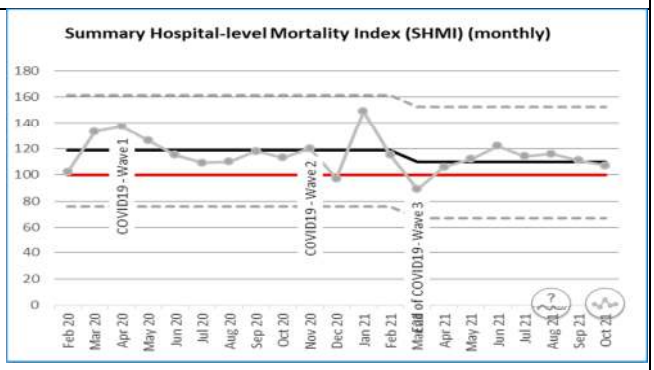
5.	**Impact** *[indicate with an **'X'** which governance initiatives this matter relates to and where shown elaborate]*							
Trust Risk Register								
Board Assurance Framework	X	New BAF risks for this strategic objective are under construction for presentation at April 2022 Trust Board						
Equality 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		

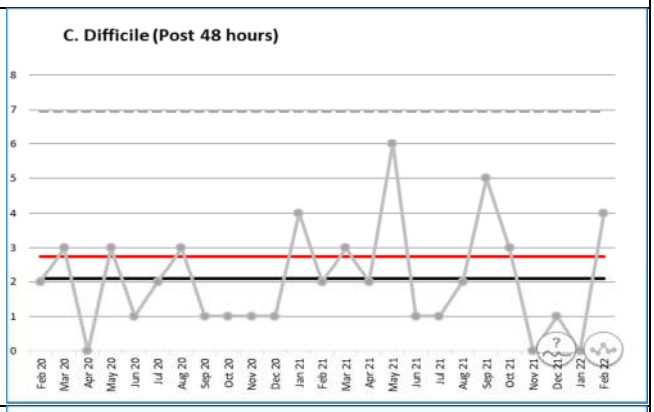
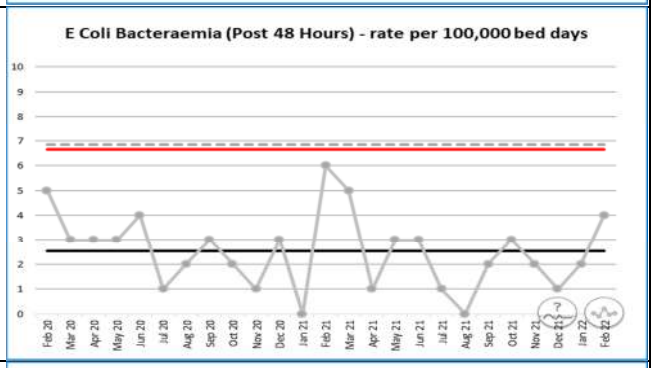
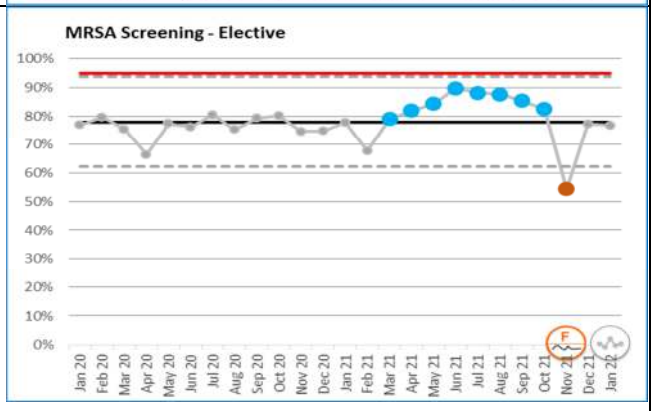
SANDWELL AND WEST BIRMINGHAM NHS TRUST

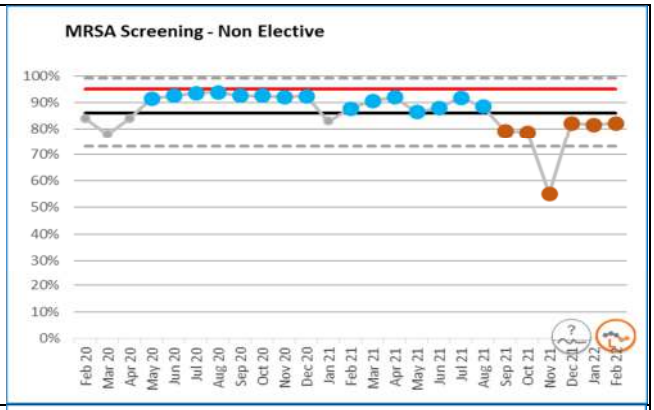
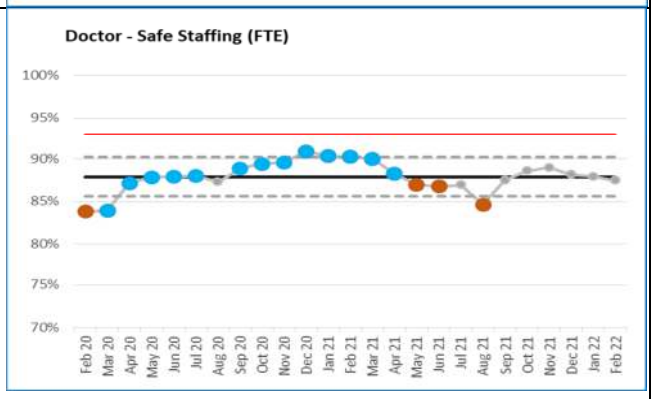
Report to the Public Trust Board: 2nd March 2022

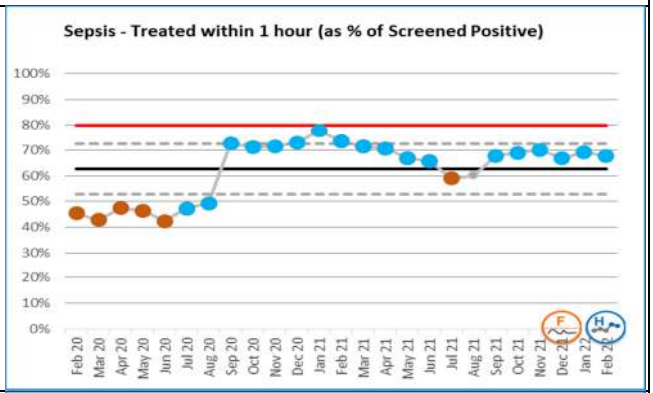
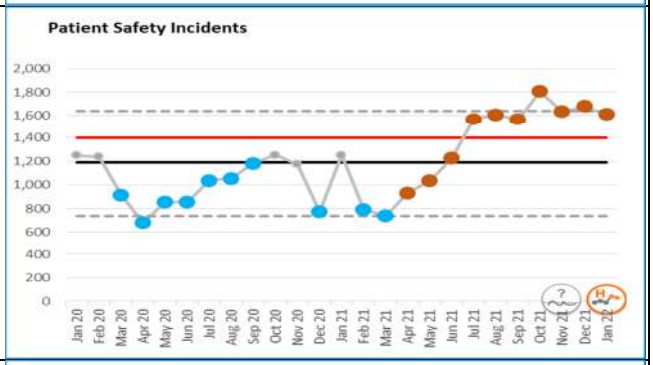
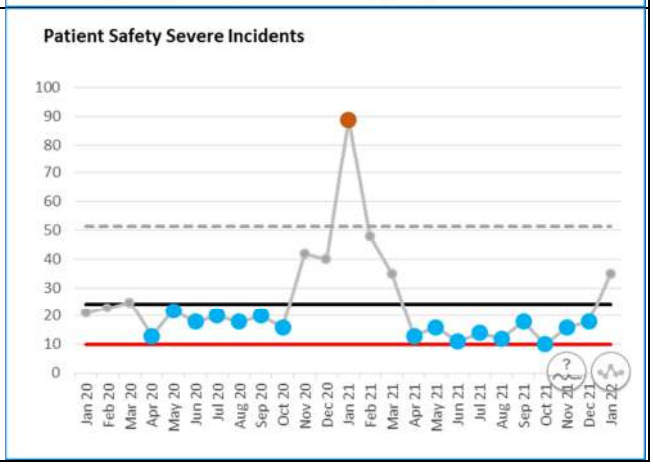
Board Level Metrics for Patients

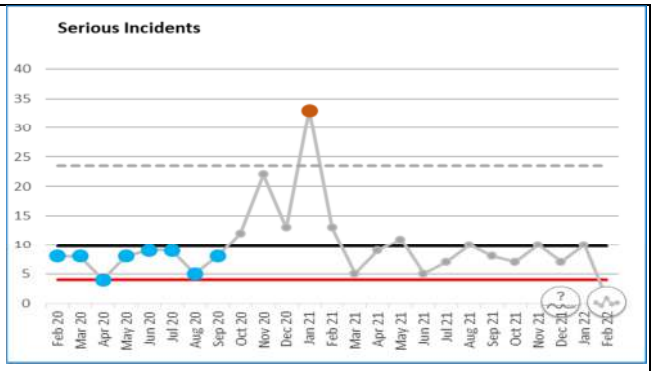
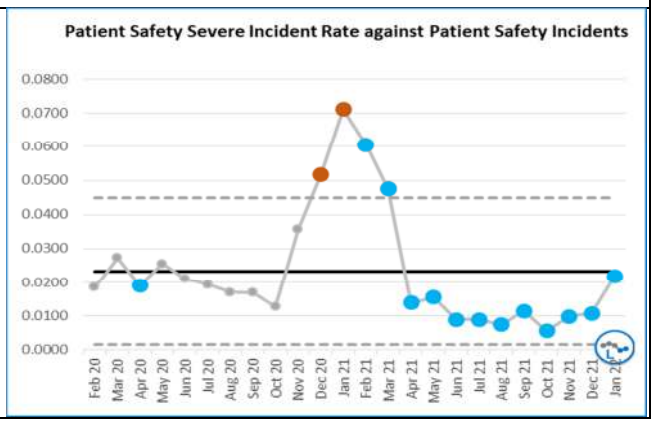


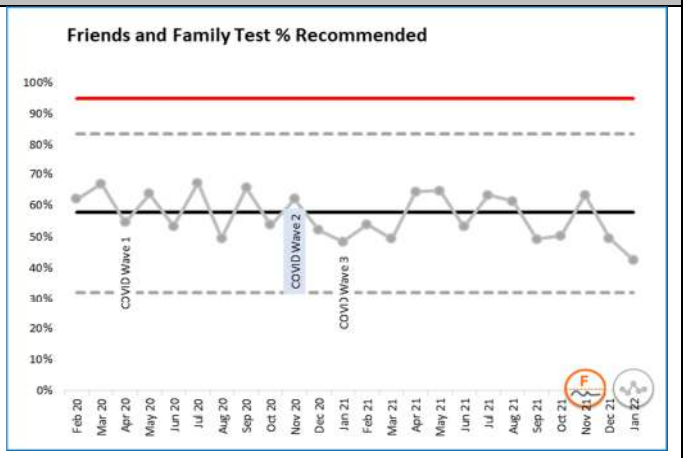
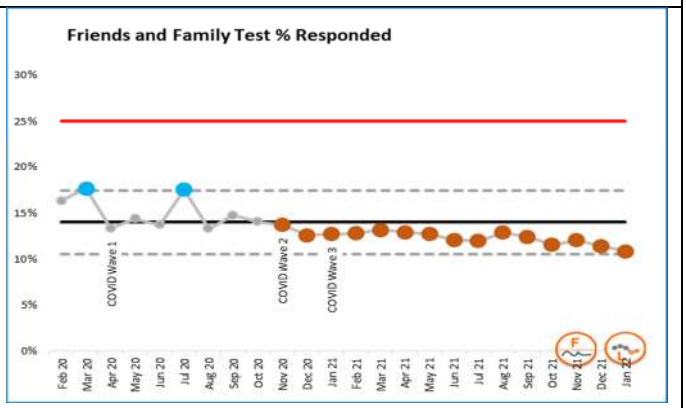
CQC Domain	**Safe**
Trust Strategic Objective	**Our patients**
Executive Lead(s): Medical Director & Chief Nurse	Statistical Process Control (SPC) Trend Charts
Hospital Standardised Mortality Rate (HSMR) - Overall (monthly) Overall downward trend continues in monthly and annualised HSMR (now 122 to December 2021 and lowest since peak in March 2021). Work on documentation, finished consultant episodes and at the elbow support continues. Depth of coding (documentation) for non-elective deaths is steadily increasing.	
Summary Hospital-level Mortality Index (SHMI) (monthly) Cumulative SHMI falling to 113 for 12 month period to November 2021. Some closure of weekday v weekend SHMI rate in last month. Highest rates at Leasowes and now Rowley in view of palliative care cases where documentation and palliative coding is a major focus. Sepsis rapid improvement week based in ED at both sites starts 28th March to focus of institution of sepsis 6 for all patient s where indicated. Overall there is a downward trend in12 month SHMI since	

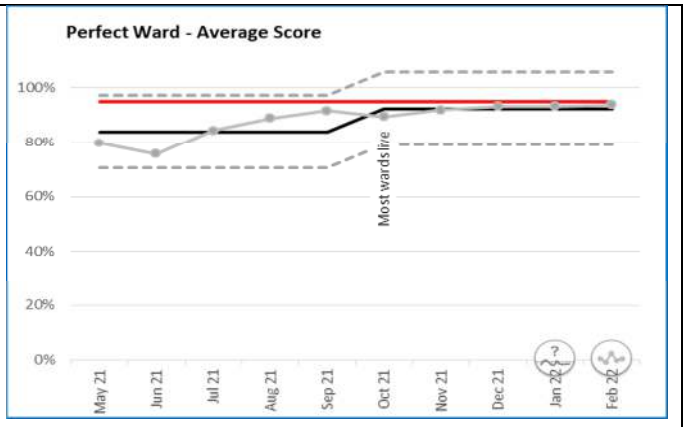
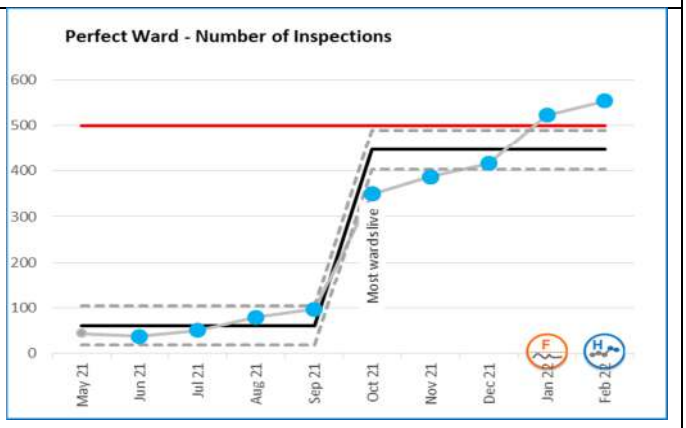
February 2021 but sepsis week work important to maintain this progress. Pneumonia SHMI deaths stable in the trust as mouth care matter and work from pneumonia task force become embedded across all wards.	
C.Difficile (Post 48 hours) Trajectory is 33 (contractual target) post 48 case are 25.This is representative of February data. There are 7 cases of C.diffile that fulfil the criteria for 4 weeks healthcare exposure. All cases have a Post infection and antibiotic review completed. A themed review will be submitted to the infection control operational meeting in May.	
E Coli Bacteraemia (Post 48 Hours) 80 threshold in numbers, the Trust is below trajectory and reporting 21 YTD for February. All cases are reviewed and a themed review will be represented to May's Operational IPC committee.	
MRSA– Elective We have noted that there is a discrepancy with the MRSA data. Historical data downloaded from Trust reports did not match the IPC data reported. This is being investigated by the informatics team and the IPC data analyst. An audit that will cross reference results is being carried out. It should be noted that the data source has been in place since 2004 and requires a refresh but we need to validate the screening following completion of the audit. Soft intelligence informs us that the pre-admission clinics are screening all patients and we have very few inquiries about out of date MRSA screens for elective cases.	

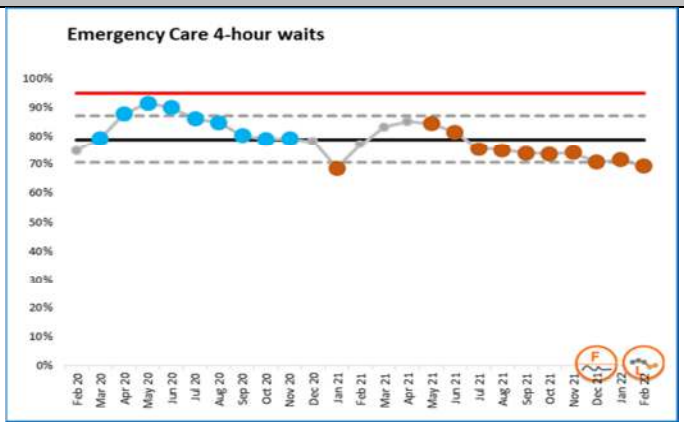
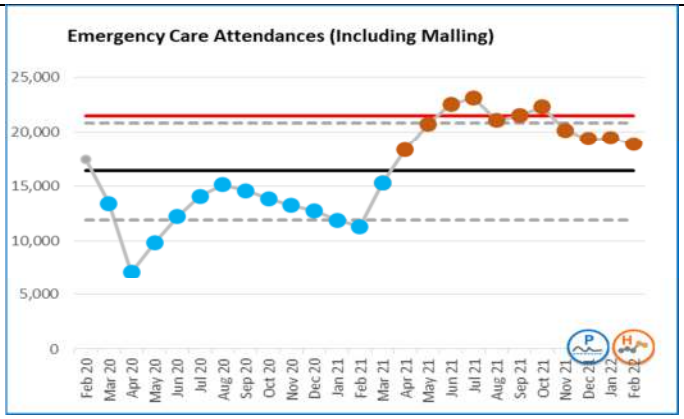
MRSA– Non Elective Information as above – all patients that have a DTA are screened for MRSA in ED, part of the audit will confirm that this is taking place. Again soft intelligence indicates that the screens are taking place.	
Doctor – Safe Staffing (FTE) 110 medical staff posts unfilled. 35 at consultant level (some new posts for MMUH workforce model, some out for advert or JD with colleges for approval. Increase number of appointment committees set up). 75 at JSD, fellow or training post vacancy of which 37 have been filled awaiting start dates. Unfilled posts either out for (re) advert or in process.	
Nursing – Safe Staffing The process for collating nurse staffing levels on the wards 3 times per day has been agreed and developed. This data collection will commence next month and should be in the board metrics in May 2022 Allocate has now been chosen as the preferred provider and procurement has commenced. Throughout April Oceans Blue who are our current provider are working with groups to cleanse the nursing data to ensure when we transfer data to allocate it is accurate roster data Staffing has improved within inpatient areas Medicine and Emergency care has produced a business case to increase staffing in their inpatient areas which we are just discussing with them following their establishment reviews. There is still further work to be undertaken with ward managers and matrons across the areas regarding perceptions in relation to safe staffing and what this is. Areas that are currently hotspots are Theatres, Health Visiting and District Nursing. A theatre staffing meeting has been held and	**UNDER DEVLOPMENT**

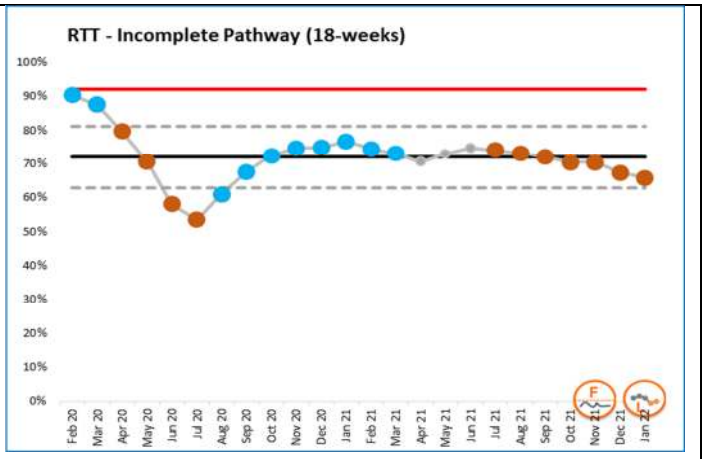
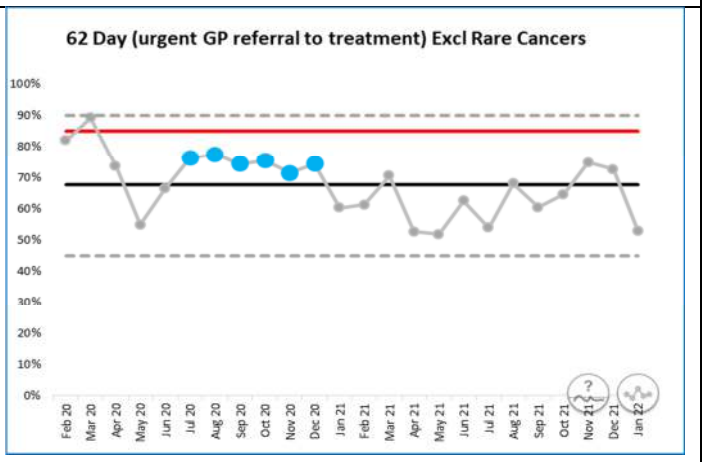
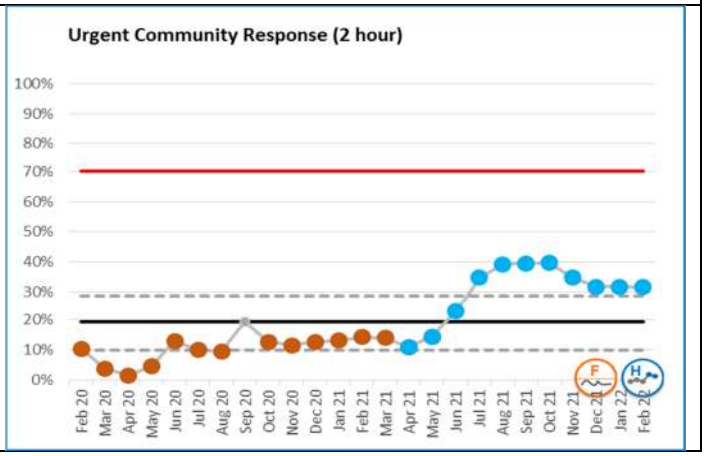
a plan is in place to support over the next 3-6 months including recruiting internationally. Health visiting will be discussed at risk management and again we are working with international partners for both health visiting and district nursing	
HCA – Safe Staffing As above we continue to recruit to HCA posts across the organisation with Indeed or external partners. HCA data will be collected above in line with qualified nurse staffing	**UNDER DEVLOPMENT**
Sepsis – Treated within 1 hour (as % of Screened Positive) No change in data but visibility of data on wards in new dashboard and safety improvement week at end of March to focus on delivery of sepsis 6	
Patient Safety Incidents Number of incidents reported stays stable reflecting good practice from staff to report incidents	
Patient Safety Severe Incidents Some rise in severe incidents in January reflecting a rise in covid related outbreaks in the Trust and long waits in ED secondary to the pressures on capacity	

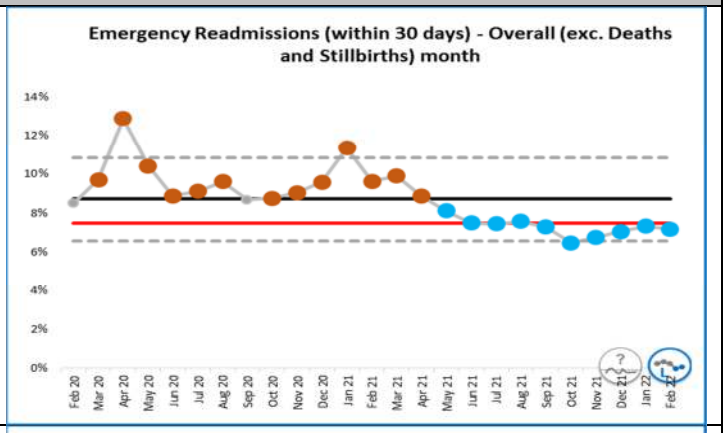
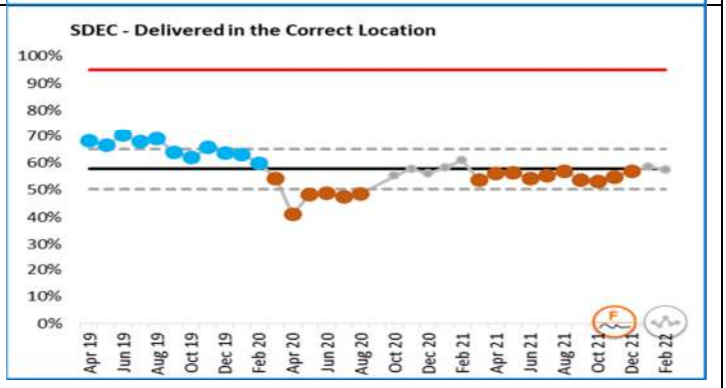
Serious Incidents Severe incidents with moderate harm are reviewed at the harm review meeting and put forward for an SI where system learning or significant harm to patient where wider corporate review is needed. Root cause and actions are confirmed at SI review meeting before sign off. Renewed focus on monitoring of actions in process as well as presentations to EQC for wider learning from the specific cases	
Patient Safety Severe Incident Rate against Patient Safety Incidents Slight rise in this ratio reflecting the increase in severe incidents this month but stable overall incident reporting. Peak in Jan 21 reflective of Covid peak and HACQ covid reporting	

CQC Domain	Caring
Trust Strategic Objective	**Our patients**
Executive Lead(s): Chief Nurse	Statistical Process Control (SPC) Trend Charts
FFT Recommended % Recommended In February 2022, 84% of FFT participants provided a positive experience rating. Actions from the 2021 CQC national maternity survey are being worked through. Further work is being taken forward related to specific patient reported experience measures for CYP care. Patient experience and engagement projects are being scoped in BMEC and around interpreting services. Work has also started to enhance entrance areas, for example with wheelchair provision. Benchmarking to national assessment tools and data sources (CQC national patient surveys and FFT) is near completion and will be presented shortly. This will include a working action plan to implement a Trust framework for patient experience drawing on all data sources and implementation of further patient experience methodology. The plan will include detail of reporting and governance arrangements.	
FFT Recommended % Responded There were 5,704 participants in January FFT across modalities of care where data were statistically valid (inpatient, outpatient, ante-natal/birth and emergency department). Discussion with Performance colleagues has led to review of appropriate FFT measures and quality markers for scrutiny and assurance. Discussions with the Trust FFT provider are taking place regarding the platform commissioned to house FFT data and making this fit for purpose for FFT and potentially, further patient reported experience measures in line with the Fundamentals of Care programme.	

Perfect Ward The GDONs are developing a peer review process to start to validate results. The proposed process is due to be presented to the Deputy Chief Nurse March 2022. We are working with the company to explore their accreditation programmes and how this could further support the Fundamentals of Care improvement programme.	
Perfect Ward – Number of Inspections Currently 57 areas across the organisation are completing the audits monthly, with a total of 540 registered users across the Trust which continues to increase. A small number of areas have yet to commence the audit process; however, work is ongoing to finalise question sets by the end of February 2022 and commence the training for the users within these areas**.** The groups have also identified additional areas they where they would like to implement complete audits. The number of additional areas is approximately 16. The groups are working on drafting question sets based ones currently in use. These will be discussed and signed off with the Deputy Chief Nurse by the end of April 2022. The Deputy Chief Nurse is also working with the company to explore potential flexibility in number of areas and QR codes to support bringing these additional areas on board.	

CQC Domain	Responsive
Trust Strategic Objective	**Our patients**
Executive Lead(s): Chief Operating Officer	Statistical Process Control (SPC) Trend Charts
Emergency Care 4-Hour Waits Our EAS (Emergency Access Standard) performance has deteriorated continually over the last few months; however we still remain in the upper half nationally. This is before we include our UTC data, which will be included in our "all types" EAS performance going forward and will show a 3% increase in performance and allow us to be comparable to others. In March we have reset our bed establishment to support non-Covid flow, to date in March we are achieving 78% performance, which will put is in the top quarter nationally. This is a combination linked to the UTC collection and changed bed flow. The board will see a step change in mean delivery from March going forward.	
Attendances (including Malling) We have seen a continual decrease in attendances since October and February saw a further decline. The board should be aware that as we include UTC data this will increase again and will look like special cause variation, but will just need to re-adjust our SPC charts. The Board should consider how the attendances at ED should be perceived. Reduction should demonstrate an improved system response, resulting in fewer attendances.	

RTT – Incomplete Pathway (18 weeks) Although we have seen a further reduction in our 104 week waiters and our 90+ week waiters our RTT position has continued to decline month on month, but not yet to the point of special cause variation. Demand and Capacity work across all groups is being conducted as we look to reset for 22/23 with the surgical group being the main contributor to the declining performance. The Surgical bed base has been returned and activity levels in April will reflect more pre-pandemic levels. Our current forecasting suggests that improvement in RTT will not be seen until June and that compliance will not be delivered until late summer / autumn 2023.	
62 Day (urgent GP Referral to Treatment) Excluding Rare Cancers We saw a drop of in the 62 day Standard in January, seen nearly every January with patient choice over the festive period, having a significant impact. This was first highlighted in the December 2ww position, which has ultimately led into the 62 day pathway. February has recovered well and outturn will be above 70% in line with a previous increasing trend and will continue to improve. The pathology turnaround time is still a significant concern as is the delays in tertiary centres surgical backlogs.	
Urgent Community Response (2 hour) After a detailed session with the team we have changed the measures against this metric to accurately reflect the position. As of May the Board will see that we are delivering over 70% as per the national request. We are still working with teams to improve this further.	

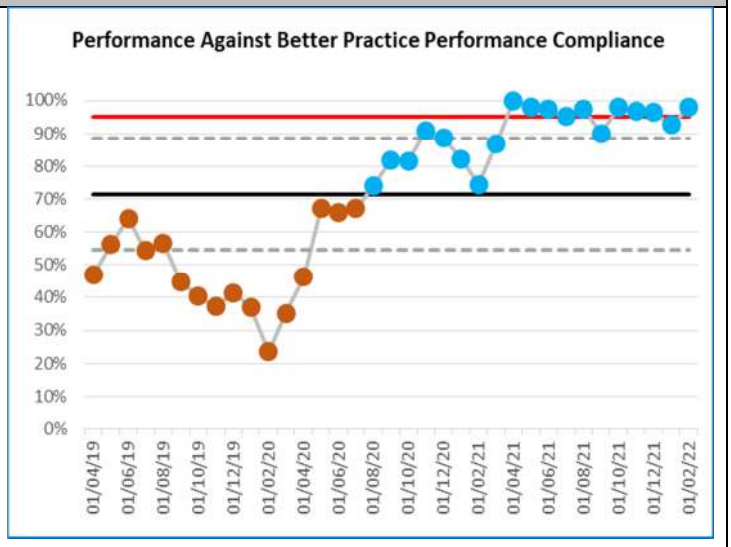
CQC Domain	Effective
Trust Strategic Objective	**Our patients**
Executive Lead(s): Chief Operating Officer	Statistical Process Control (SPC) Trend Charts
Emergency Readmissions (within 30 Days) – Overall (exc. Deaths and Stillbirths) Month Our re-admissions remain below the national standard and we aim to continue to deliver this. No cause for concern.	
SDEC Delivered in correct location We are still not improving this standard as required. In the middle of February we recruited consultant leads into both SDEC facilities to aid a “pull” model and a stepped improvement. The recent NHSI audit supported our understanding of missed opportunities and we know we need to switch to a process driven approach rather than pathway. An intensive program of work is underway to change to a process delivered SDEC as per the national best practice. There is a cultural change in the way we delivery that will take time, but the improvement is fundamental to the delivery of our acute care Model in MMUH as well as key to delivering fewer potentially harmful patient waits in EDs.	

CQC Domain	Use of Resources
Trust Strategic Objective	**Our patients**
Executive Lead(s): Chief Finance Officer	Statistical Process Control (SPC) Trend Charts

Performance Against Better Practice Performance Compliance

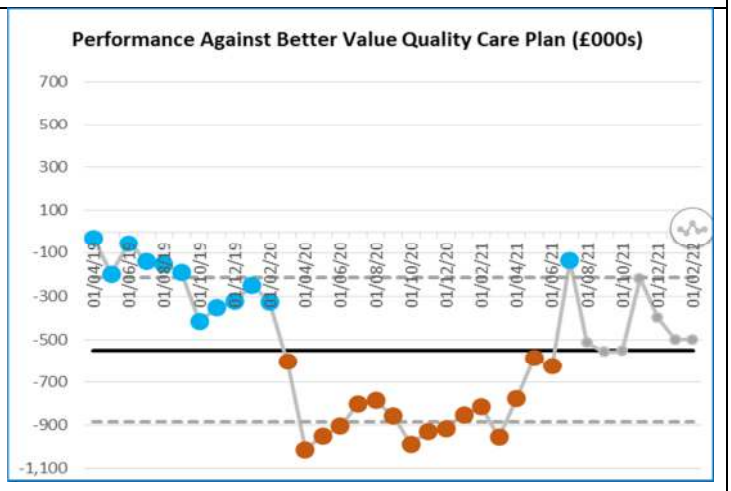
The Trust has implemented a number of key actions to deliver the 95% target for both value and volume and these continue to deliver as shown in the SPC chart on a consistent basis. There has been a positive trend for all of 21/22. Further actions to consolidate this performance include

- Increasing the number of BACS processing runs each week
- Planned Trust wide communications to encourage timely receipting and dispute resolution
- Implementing a Supplier Portal enabling Suppliers to upload invoices directly and allow them to see and assist in progress on invoice approval and payment
- Working with Oracle to identify Invoice hold information in specific circumstances which allows us to exclude the invoice from our performance measure

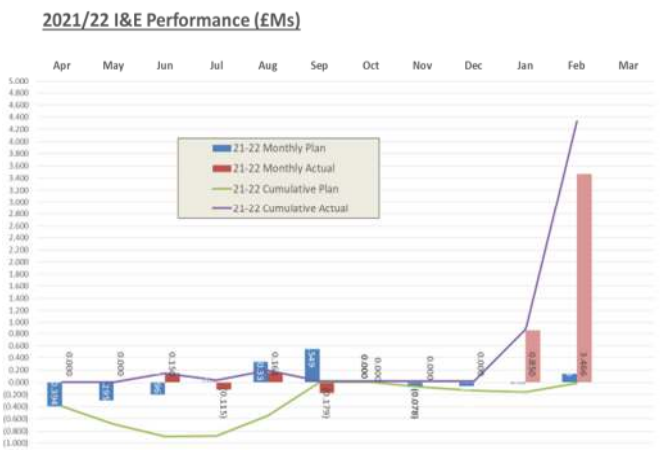


Performance Against Better Value Quality Care Plan (£000's)

The SPC chart for BVQC shows the monthly performance against the SWB stretching, £13.2m CIP plan for 2021/22. This target is more than double the nationally driven target reflecting the cost pressures/developments the Trust supported during the planning process and alignment to the MMUH LTFM . Despite the Trust reporting £6.6m ytd savings and £8.3m forecast for 21/22 we have been consistently below the



monthly target, reflecting the stretching nature of the target	

2021/22 I&E Performance (£M's)
The I&E position is not suitable for a SPC chart, a revised option is presented.
• The blue bars are the monthly plan with the green line being the cumulative plan
• The orange bar is the actual performance with the purple line being the cumulative position
The key points to note are:
• The Trust has consistently delivered against the monthly plan with the gap between the 21/22 plan and 21/22 actuals consistently being favourable
• There are risks and mitigations to deliver the H2 plan which are described in the more detailed d finance paper. It is pleasing to note the Trust has secured £8.9m from the ICS risk reserve to support H2 ERF and the increased energy costs
• M11 (to Feb) was a surplus, £3.466m in month, maintaining the cumulative position of a £4.467m favourable variance
• The Trust is forecasting a surplus in excess of £5.1m. This is driven by:
  ○ Additional income received from the ICS, and
  ○ Performance against funded expenditure streams such as TIF funding, Winter Plans and Elective recovery spending less than plan
	

Underlying Deficit (£M's)

This metric is a subjective and strategic measurement not updated any more frequently than annually due to complex work required and impact of strategic external factors. As such the trend for 21/22 is flat. That said,

- The Trust has reported a £24m underlying deficit to CLE, FIC, Trust Board and the ICS. It is reflected in budgets and the Trust maintained a route to breakeven.
- Work ongoing at system level to determine underlying system deficit position, of which SWBH would have a share (basis to be determined) – expected to be completed by end 2021/22 financial year
- It is recommended as part of the 22/23 planning process the underlying position is reviewed and formally reported through CLE, to FIPC and the Board