Paper ref:	TB (06/22) 012

PATIENTS PEOPLE POPULATION

NHS
Sandwell and West Birmingham
NHS Trust

REPORT TITLE:	Public View Board Report- Verification against Internal Reporting		
SPONSORING EXECUTIVE:	Chief Strategy Officer		
REPORT AUTHOR:	Berenice Lufton (Head of Operational Insight)		
MEETING:	Public Trust Board	DATE:	8/6/22

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

A review by Public View reported to the Board in February successfully provided assurance as to why the Trust's Hospital Combined Score had fallen significantly during the early stages of the pandemic.

Additionally, the report raised some additional points that required further investigation. To this end the Chief Strategy Officer took away 19 data points to explore in more depth, primarily to look for the rationale behind potential differences in our IQPR reporting and that of Public View. An update on progress, along with the agreed actions is provided in this paper.

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?]*

4. Recommendation(s)

The Public Trust Board is asked to:

a.	**NOTE** the findings and the actions agreed by the Executive Team
b.	**NOTE** the further work to be completed

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		*Make best strategic use of its resources*						
Board Assurance Framework Risk 03		*Deliver the MMUH benefits case*						
Board Assurance Framework Risk 04		*Recruit, retain, train, and develop an engaged and effective workforce*						
Board Assurance Framework Risk 05		*Deliver on its ambitions as an integrated care organisation*						
Corporate Risk Register [Safeguard Risk Nos]								
Equality Impact Assessment		Is this required?	Y		N	N	If 'Y' date completed	
Quality Impact Assessment		Is this required?	Y		N	N	If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM NHS TRUST

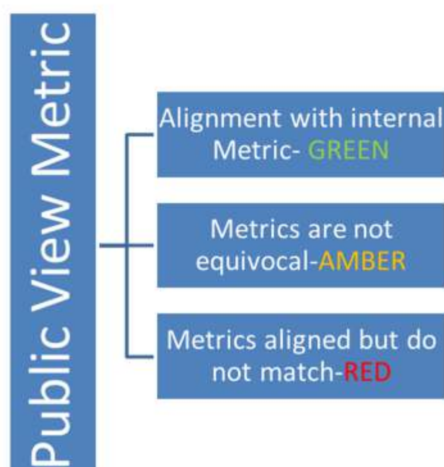
Report to the Board: 8 June 2022

Review of Public View Metrics v Internal Metrics

1. Introduction or background

1.1 Public View produced a report that was presented to the February Board which highlighted the reasons behind the deterioration in what is described as their "Overall Hospital performance combined score" metric. This was accepted by the Board. In addition, the report referenced some other metrics where variation between our internal reporting and that which is in the public domain may exist.

1.2 The Chief Strategy Officer offered to take the report away and work through the metrics via the performance and Insight team to understand differences before reporting back to Board. 19 metrics were identified. An initial assessment of these metrics has placed them into three categories: green; amber and red.



1.3 On initial review:

- 6 metrics were rated Green meaning that they are aligned.
- 8 metrics were rated Amber meaning that they had differences but that we felt these were caused by being slightly different metrics;
- 5 metrics were Red meaning that the metrics were different for no obvious reason.

2. Progress Update

2.1 The table below shows the 19 metrics, along with their colour rating from the initial assessment. The tick in the end column shows whether we have carried out further investigation to date to understand the root cause of the difference and to be in a position to make a recommendation. Those with a cross are work in progress.

No.	Public View Ind	HCPS METRIC	Title	1st Review & Recommendation
1	14	YES	A&E - 4 Hour Standard	×
2	23	YES	Summary Hospital Mortality Indicator	✓
3	17	NO	RTT Incomplete 18 Week Standard	✓
4	146	YES	E.coli (Hospital Onset)	✓
5	150	YES	MSSA (Hospital Onset)	✓
6	19	YES	C.difficile (Hospital Onset)	✓
7	15	YES	Cancer 62 Day Classic	✓
8	46	NO	Cancer 31 Day First Treatment	✓
9	36	YES	Staff Recommend Care	×
10	149	YES	MRSA (Hospital Onset)	✓
11	28	YES	Sickness Absence Rate	✓
12	41	YES	Financials YTD	×
13	34	YES	A&E -DTA	×
14	153	NO	Hopsital Onset Infection Rate	✓
15	232	NO	New to Follow Ratio	✓
16	36	NO	Emergency C Section Rate	×
17	71	NO	Antenatal Booking Appt	✓
18	736	NO	Maternity FFT	✓
19	1	YES	Complaints	×

Green Metrics

2.2 Of the 6 metrics that are green, 5 have no reason for further comment. The remaining one is still worthy of mention:

2.3 The New to Review Ratio: We have an issue where our Patient Administration System (PAS) allows appointments to be administrated as new or review based on user preference. This means we get pathways where there may be multiple new appointments or no new appointments on a referral pathway. Based on this known issue (data quality log) there are data quality reports which highlight these scenarios so that they can be amended. There are thousands of these that are not being actioned, for example, as of 19 May 2022 (for records relating to April) there are 3328 across 4 chosen specialties that should be reviews but are marked as news and 2131 that are marked as reviews but which are actually news. Resolving our data quality issue would worsen our new to follow up ratio which would then show where we truly sit from a benchmarking point of view.

Proposed Action – Operations to action the reviews and the news each month as an interim measure.

Proposed Action – IT and Operations to look into changes to the PAS so that inserting multiple new appointments on the same pathway is removed and so that follow ups must have a new.

Executive Agreed Action – This issue will be prioritised and picked up by the incoming Assistant Director of Operational Transformation who starts in July 2022.

Amber Metrics

2.4 8 Metrics were rated as Amber. These were identified as having no exact match in internal monitoring or the measure was a different calculation. 5 of these 8 metrics relate to Hospital Onset Infection.

2.5 E-Coli (Hospital Onset) -This is one of 5 Hospital Onset (over 48 hours) infection metrics under review. The issue uncovered here relates to the data set which is transmitted nationally to Public Health England. The data set does not allow for both date and time to be submitted, therefore the external calculation of "Hospital Onset" is not accurate. This will be the same for all Trusts. Its effect is to overstate hospital onset infection rates within public information. The ability to submit more complete data should align internal and external measurement. This factor applies to all 5 Hospital Onset Infection metrics and so includes MSSA, CDiff, MRSA and the overall Hospital Onset Infection Rate.

There is a further point, as we work in a more integrated manner for the benefit of our population we may also wish to consider whether our lag measure should be all, rather than Hospital onset, with lead measures (not Board Level metrics) being separated between hospital onset and community onset, or whether we should monitor hospital onset in "patients" and community onset in "population".

Proposed Action – The Performance and Insight team to write to Public Health England (PHE) to request that they improve the submission template for hospital onset infections. If they do nationally reported Hospital Onset infection rates across the Country will decline and our figures will be aligned**. Action agreed by Executive Team with support from CEO if required to influence.**

Note to Board: since the Executive agreed this action, we are no longer certain that we have interpreted this correctly. It is possible that this should be recorded by day rather than by hour. We will look into this further with the Chief Nurse and the Infection control team.

Proposed Action - The Executive to decide how we want to reflect infection rates going forwards in the Board Level metrics. The Performance and Insight team will then action this. **The Executive agreed to maintain the focus on Hospital Onset as the measure.**

2.6 "Staff recommend care", Complaints and Financial YTD are the other three metrics rated as Amber. These will be reviewed and reported back.

Red Metrics

2.7 5 Metrics were rated as Red. Internal reporting does not match Public View and should. These need alignment. Of these 5 metrics 2 have been reviewed.

2.8 Summary Hospital Mortality Indicator: the internal declared figure is not aligned with the Public View published figure. The internal data is manually entered by the clinical effectiveness team. They take this data from the HED reporting system. Within this HED system they have the option to use SHMI data from HES or SHMI data from NHS Digital. In order to align with Public View they should be using the SHMI data from NHS Digital.

Proposed Action – Change in process by the Clinical Effectiveness Team. **Action Agreed by Executive Team**

2.9 Antenatal Booking Appointments within 10 weeks: Internal data is not consistently reported and does not match the data published in Public View. The Public View data is taken from the Maternity Services Data Set, internal data is not. As the Maternity services data set is increasingly being used as a source for published metrics, there is a need to align the transmitted data to the data sources held. This warrants a plan to take this forward.

Proposed Action – Performance and Insight to initiate a project to review the current Maternity Dashboard and reporting from it. **Action Agreed by The Executive**

2.10 A&E standards(4-hour) and (12-hour DTA) and Emergency Caesarean section rate are both Red rated. These are part of our further review, at this stage we do not want to pre-judge the outcome of the review.

3. Next Steps

3.1 Implement the actions agreed at PMC
3.2 Complete the review work
3.3 Bring finalised work to PMC (~8 weeks) and if required Board.

4. Recommendations

4.1 The Board is asked to:

- **NOTE** the findings and the actions agreed by The Executive Team;
- **NOTE** the further work to be completed

Berenice Lufton, Head of Operational Insight

16th May 2022