Sandwell and West Birmingham Hospitals NHS Trust

Board Level Metrics & IQPR Exceptions

INTEGRATED PERFORMANCE REPORTING – SEPTEMBER 2021

Contents

Board Level Metrics Development Update

Domain	Finalised	In Development	To Amend	No Target Set
Safe Medical Director	HSMR & SHMI C-diff E-coli Patient safety incidents Moderate harm < incidents Serious incidents	**Safe Staffing.** This is a technically challenging chart to build thus taking longer. Need a different extract from the supplier to support this development. Nursing has been split into Nurses and HCA. Looking to build nurse bank and agency fill rate. Have also created Clinicians post verse clinicians in post.	**MRSA Bacteraemia.** This event is too rare (2 in 2 years) to be meaningfully displayed in an SPC chart as a count. This measure should be removed and reported as an exception. ***MRSA screening is suggested as an alternative.*** **Serious incidents.** Amend to incident date rather than date reported to STEIS, audit data quality – agreed with Governance, Governance are working towards completing by October 2021 available in the November / December.	Patient safety incidents, NRLS Patient Safety Incidents Moderate Harm & Above, Safe Staffing
Caring Chief Nurse	Friends & Family Test (FFT) Recommended% and Responded%	**Perfect Ward.** This is still being rolled out across the organisation, and in the process of gaining access to the source data from Perfect Ward. This is proving difficult and may not be able to report for several months. Need Informatics support to connect data between servers.		Perfect Ward
Responsive Chief Operating Officer	ED – 4 hour target and Attendances. Cancer 62 Day. RTT 92% target	**2 hour Community Response.** This is a new national measure recently announced in the System Oversight Framework, requiring definitions and build. Awaiting definition from PCCT. Not expected before December.		2 hour community response
Effective Chief Operating Officer	Readmissions within 30 Days Rate per 1000 Bed Days **SDEC**	PREMS to be re-evaluated. SEPSIS has been built	**PREMs.** What is the plan to record this, as others being explored. Deaths in hospital verses a place of death recorded.	PREMs
Well-Led Chief People Officer & Director of Governance	Days lost to sickness Turnover monthly Risk Mitigation	**Pulse Survey.** The results have not been distributed for this quarter. We will look at what chart is appropriate when available.		Risk Mitigations
Use of Resources Chief Finance Officer	Better Practice Performance Compliance	**Return on Capital Employed.** In development by finance, expected next month.	**Income & Expenditure Against Plan, Better Value Quality Care Plan** To return as cumulative line charts vs plan.	

Board Level Metrics: How to Interpret SPC Charts

An SPC chart is a time series graph with three reference lines - the mean, upper and lower control limits. The limits help us understand the variability of the data. We use them to distinguish between natural variation **(common cause)** in performance and unusual patterns **(special cause)** in data which are unlikely to have occurred due to chance and require investigation. They can also **provide assurance on whether a target or plan will reliably be met or whether the process is incapable of meeting the target** without a change.

Special Cause Variation is statistically significant patterns in data which may require investigation, including:

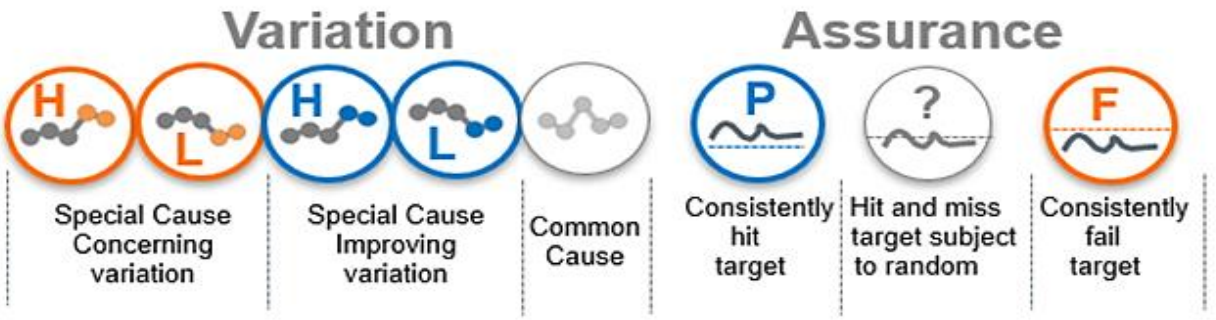
- Trend: 6 or more consecutive points trending upwards or downwards
- Shift: 7 or more consecutive points above or below the mean
- Outside control limits: One or more data points are beyond the upper or lower control limits

Orange indicates a decline in performance; Blue indicates an improvement in performance.

The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://improvement.nhs.uk/resources/making-data-count

	Variation Icons The icon which represents the last data point on an SPC chart is displayed.						Assurance Icons If there is a target or expectation set, the icon displays on the chart based on the whole visible data range.		
ICON									
DEFINITION	Common Cause Variation	Special Cause Variation where neither High nor Low is good	Special Cause Concern where Low is good	Special Cause Concern where High is good	Special Cause Improvement where High is good	Special Cause Improvement where Low is good	Target Indicator – Pass/Fail	Target Indicator – Fail	Target Indicator – Pass
PLAIN ENGLISH	Nothing to see here!	Something's going on!	Your aim is low numbers but you have some high numbers.	Your aim is high numbers but you have some low numbers	Your aim is high numbers and you have some.	Your aim is low numbers and you have some.	The system will randomly meet and not meet the target/expectation due to common cause variation.	The system will consistently fail to meet the target/expectation.	The system will consistently achieve the target/expectation.
ACTION REQUIRED	Consider if the level/range of variation is acceptable.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and whether you need to change something.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Investigate to find out what is happening/ happened; what you can learn and celebrate the improvement or success.	Consider whether this is acceptable and if not, you will need to change something in the system or process.	Change something in the system or process if you want to meet the target.	Understand whether this is by design (!) and consider whether the target is still appropriate, should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Board Level Metrics



The matrix below shows how each metric is performing:

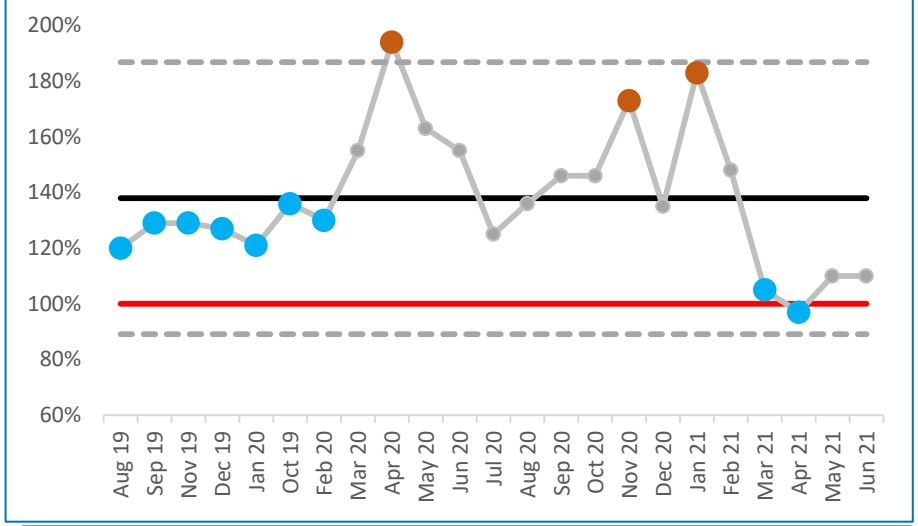
- If there is special or common cause
- Pass, fail or hit and miss its target
- No target set

		Assurance			
		Pass	**Hit & Miss**	**Fail**	**No target**
Variation	**Special Cause: Improvement**		MRSA bacteraemia, Emergency Readmissions,		
	Common Cause		C-difficile, Serious incidents, E-coli, Turnover (monthly)	HSMR, SHMI, FFT % Recommend, ED 4 hour, SDEC	NRLS Patient Safety Incidents Moderate Harm & Above
	Special Cause : Concern	ED Attendances	62 Day Cancer, Days lost to sickness absences	RTT Incomplete Pathways, FFT % Response,	Patient safety incidents, Risk mitigations

Safe

Executive Lead: Medical Director

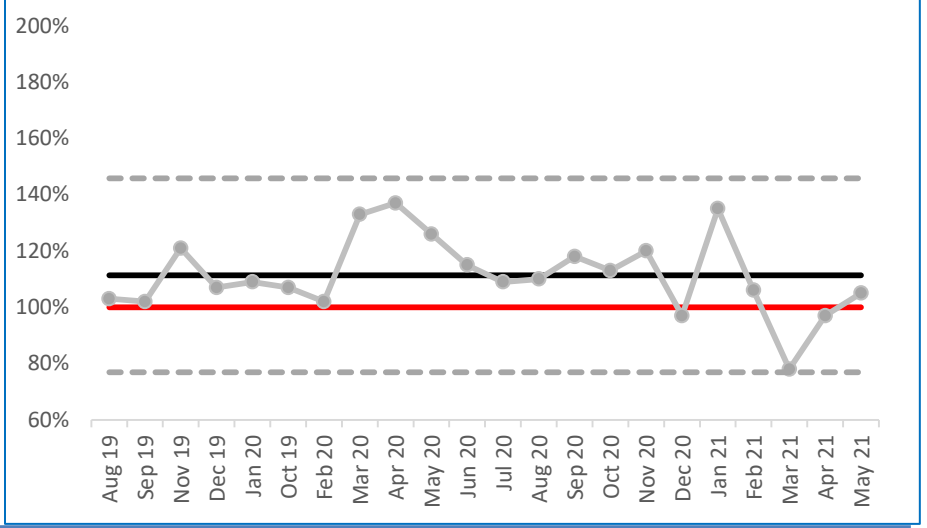
Hospital Standardised Mortality Rate (HSMR) - Overall (monthly)



Commentary

SWB consistently fails HSMR target. Prior to COVID HSMR was elevated above national standard, and has increased demonstrably as shown by special cause variation aligned to COVID peaks. National systems are late in producing more up to date analysis.

Summary Hospital-level Mortality Index (SHMI) (monthly)



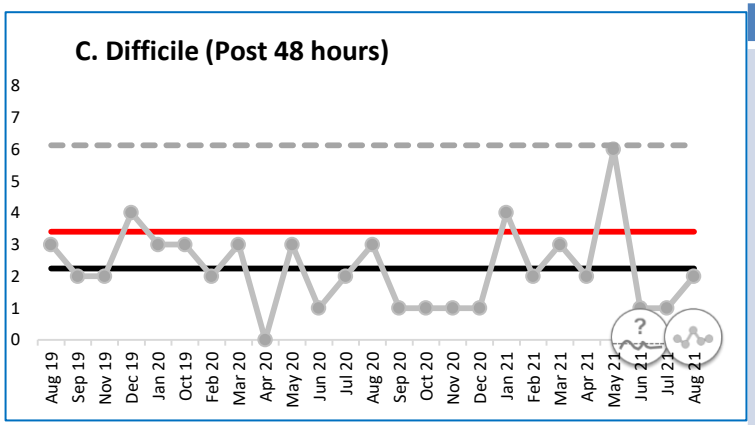
Commentary

SWB fails the SHMI target most of the time. Common cause variation is seen throughout the period indicating a predictable process.
National systems are late in producing more up to date analysis.
We are ranked 108th out of 123 Trusts as of April '21 using 12 month cumulative performance the monthly performance for May 21 would place us 88th.

Cause of variation?	What actions have been completed?	What next?	When will it improve?
Documentation of comorbidities, correct prefix use for diagnosis description, avoidance of R codes and clarification of process for FCE are general factors. Palliative care coding affects HSMR more than SHMI. Number of admitted patient occurrences also influences expected mortality levels, so change in pathways to ambulatory care, covid or diagnosis definitions after 2nd FCE all impact HSMR/SHMI	Information on good documentation, a focus on R codes and prefixes and depth of coding have all been provided to clinical teams. Understanding impact of Same Day Emergency Care (SDEC) and exploration of palliative care codes also needed. QI group has been setup, and a digital fellow as been appointed as a point of reference for clinicians use of Unity, providing support on good documentation standards in Unity.	Review process for recording FCE with current team based approach to patient care, at the elbow support for clinical teams to improve documentation elements, review of deceased care records between M+M leads and coding team. Admin support to identify where FCE can be altered and palliative care recording addressed. SOP approval by executive for M+M meetings with coding team.	Wary of effect that increase in SDEC in MMUH will have on mortality data with reduction in episodes of admitted care, but over next 12 months need to establish process and working practice for the elements outlined earlier

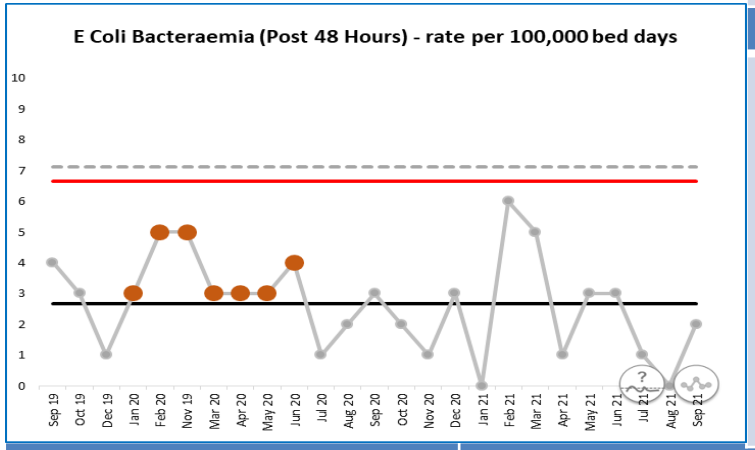
Safe

Executive Lead: Medical Director/Chief Nurse



Commentary

Common cause variation is broadly observed, excluding May 21. This is a largely a predictable process. *SWB was ranked 18rd out of 139 Trusts in June.*



Commentary

Special cause variation of concern can be seen in the first six months of 2020. Performance has been otherwise stable. *SWB was ranked 14th out of 139 Trusts in June.*

Safe Staffing Nursing

Commentary

It is technically challenging to produce this report into an SPC chart due to the way it is collected. Nevertheless this chart is in process and hope to include asap.

Safe Staffing Medical

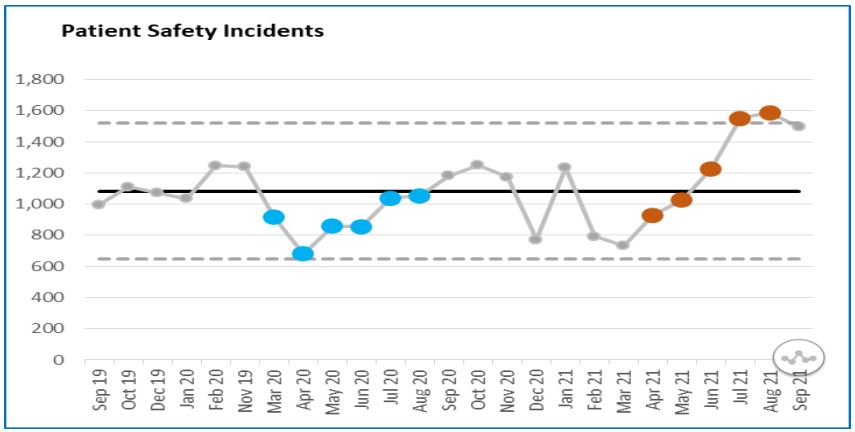
Commentary

This is a difficult measure to define as there is not a safe staffing report like there is for nursing. Discussions are underway with the Medical Director and Medical Staffing team to define.

Cause of variation?	What actions have been completed?	What next?	When will it improve?
C-Diff Variation in May was due to antibiotic usage which was identified following Post Infection Review (PIR) process. **E-coli** No variation of concern within past 12 months.	**C-Diff** PIR reviews completed and antimicrobial prescribing was appropriate and in line with formulary **E-coli** Each E-coli case has a Post Infection Review (PIR) completed with no themes or trends identified. No hot spot areas identified.	**C-Diff** Internal target set at 41 cases 2021/22 – below target to date **E-coli** UTI project under way to review management of UTI this impacts on Blood Stream Infections (BSI), Improvement project around hydration to reduce UTIs and also management of catheters is on-going.	**C-Diff** Robust processes in place with additional work being undertaken to strengthen antimicrobial prescribing and stop dates **E-coli** Current processes to continue with active surveillance and review of cases and learning disseminated to monitor improvement

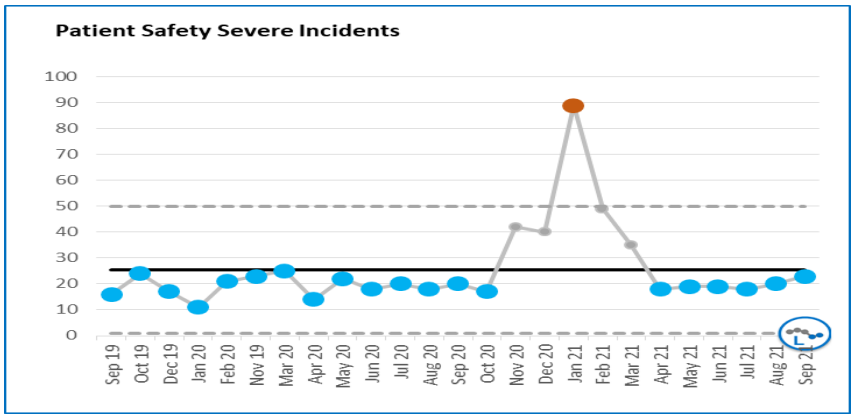
Safe

Executive Lead: Medical Director



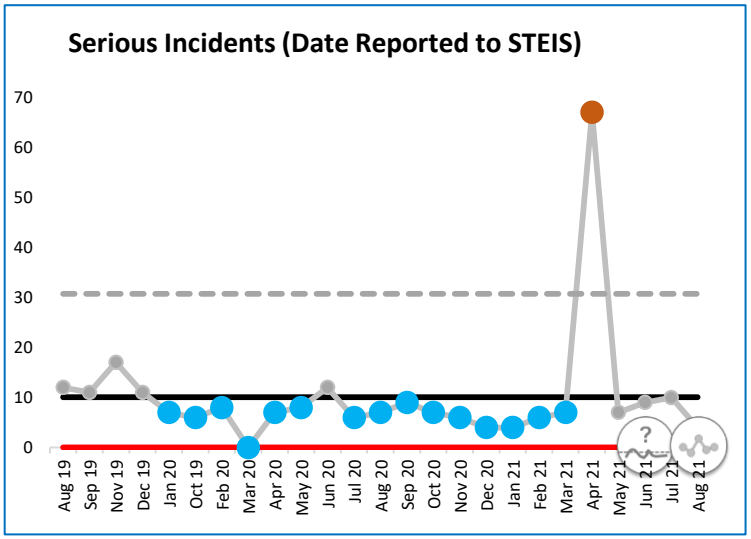
Commentary

The chart is now showing special cause for concern and needs further investigation.



Commentary

A peak can be observed during Winter 2020-21 with an astronomical data point in Jan '21. This peak lifts the mean and obscures what appears to be common cause variation prior and following this period.



Commentary

SWB consistently fails the zero serious incidents target. The chart shows when serious incidents were reported, rather than the incident date. This explains why there is an astronomical data point in April '21 related to change in STEIS reporting requirements related to COVID (see below), and an appearance of improvement during Oct '20 to March '21. In addition this gives the appearance that the target was met in March '20 which is unlikely. Special cause variation of concern can also be seen in Nov 19. It is recommended that this measure is amended to incident date rather than date reported to STEIS and reviewed for quality of data process.

Cause of variation?

Patient safety incidents
Increase in reporting is an indicator of a good reporting culture. Challenges in ED in admitting patients and seeing them in the outlined timeframes has generated a significant number of incidents.

Moderate and above harm
In November 2020, Trusts were asked to report Hospital Acquired COVID 19 infections and deaths. These are what has caused the rise in moderate harm and above incidents.

Serious incidents
The April rise relates to the Hospital Acquired Covid cases being reported nationally as this is when the information was provided.

What actions have been completed?

Patient safety incidents
Groups and Directorates are aware of some of the challenges which have seen a rise in incidents and have plans in place. Tissue viability team has been working with specific wards to improve pressure ulcers..

Moderate and above harm
No specific actions have been carried out. We have moderate harm review process. An action plan for falls has been put in place and we are now below the national average.

Serious incidents
All cases are reported on an ongoing basis moving forward. Action plan identified for Blood transfusion

What next?

Patient safety incidents
Continue to encourage reporting, more importantly encourage robust feedback on incidents raised.

Moderate and above harm
Review of the process for assigning harm level and presentation of the incident.

Serious incidents
Provide training to improve number of people able to investigate Sis to improve timeliness of investigations.

When will it improve?

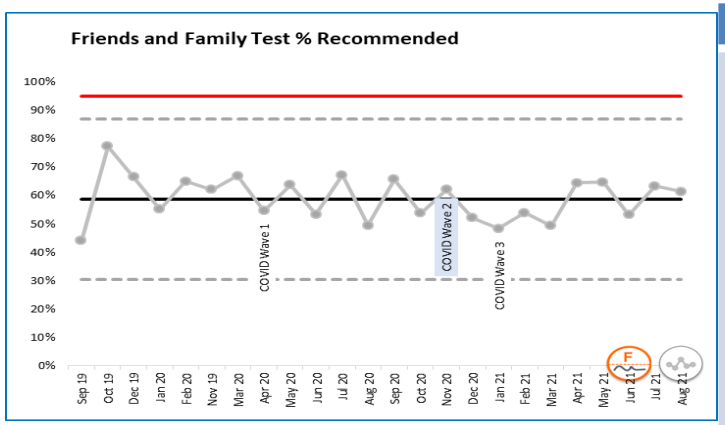
Patient safety incidents
Increasing numbers of incidents is not necessarily a negative. Groups and Directorates need to be aware of their trends and address where possible.

Moderate and above harm
Aiming for quarter 3, 2021/22

Serious incidents
Looking to provide a training session in October 2021.

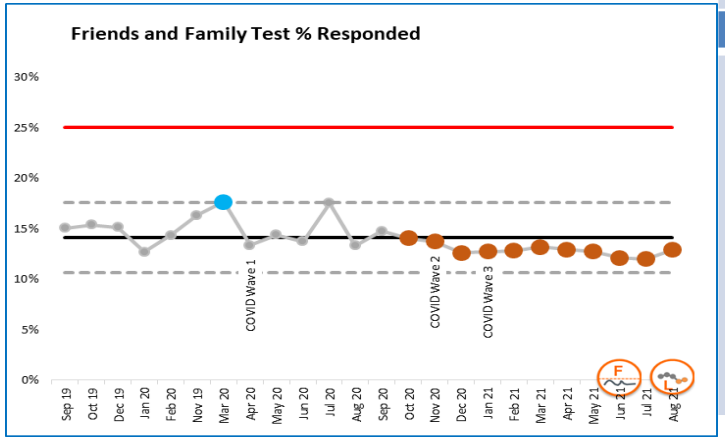
Caring

Executive Lead: Chief Nurse



Commentary

SWB is consistently failing the 95% friends and family test score. Common cause variation can be seen throughout indicating a predictable performance. *SWB ranked 127th out of 137 Trusts for the Inpatient score in July 21.*



Commentary

Special cause variation (improvement) can be seen in March and Jul '20. However, since September '20 special cause variation indicating a decline in performance can be seen.

Perfect Ward

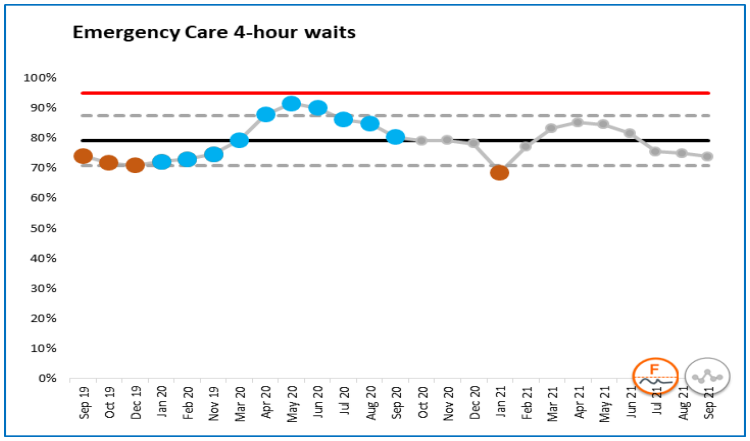
Commentary

P&I are trying to gain access to Perfect Ward data. However, there are significant organisational technical barriers from Perfect Ward. It is unlikely we can get this data for several months.

Cause of variation?	What actions have been completed?	What next?	When will it improve?
FFT Recommended & Responded During the pandemic FFT was paused nationally before recommencing January 2021. The Trust lacks a wider patient experience / involvement strategy and framework which FFT would be a part of, hence performance has remained stagnant.	**FFT Recommended & Responded** The Head of Patients involvement and Insights has now been recruited too and commences in post in January 2022 FFT has also been discussed with ward managers and matrons to promote feedback via this route	**FFT Recommended & Responded** Once the lead post holder commences in post the Trust will complete a benchmarking exercise against the NHSE/I improving patient experience standards, and agree the associated action plan to address the identified gaps. A Trust strategy for patient experience and involvement needs to be developed to support taking this important agenda forward. The FFT process needs to be reviewed and reinvigorated as part of this wider work.	**FFT Recommended & Responder** Given the level of the lead post, there will be approximately a 3 month lead in time from interview to commencing in post. It is unlikely that the post holder will commence before January 2022. Considering the work required surrounding this agenda, and the systems and processes that need to be developed, it is envisaged that improvements will be seen over a 12-24month period.

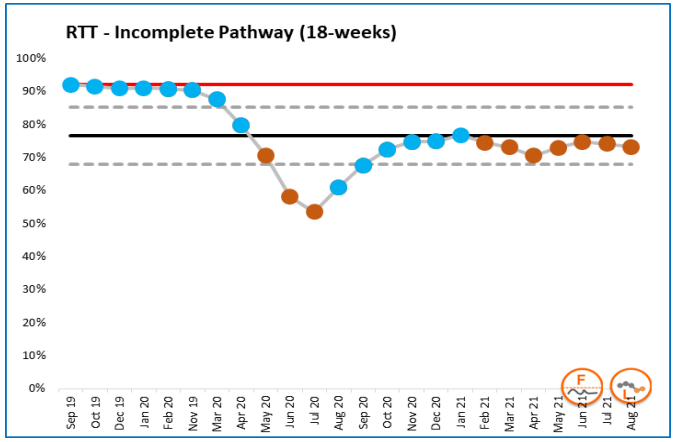
Responsive

Executive Lead: Chief Operating Officer



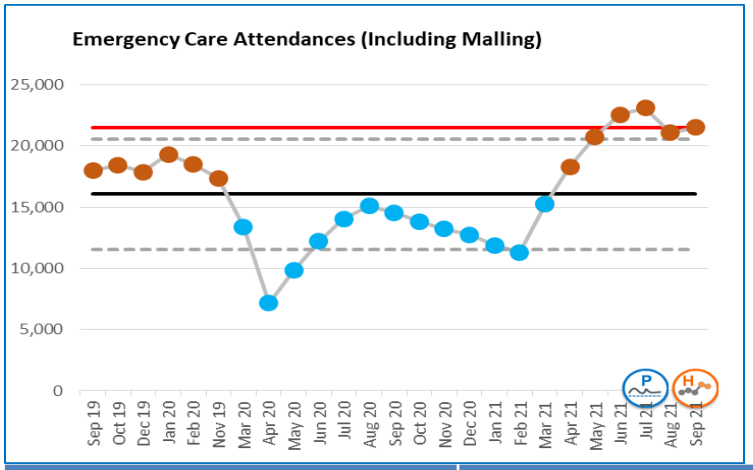
Commentary

The blue special cause variation observed from Dec '19 to May '20 shows a upward trend, followed by a downward trend. This correlates with seasonal variation and attendance figures.
SWB was ranked 83rd out of 134 Trusts in August.



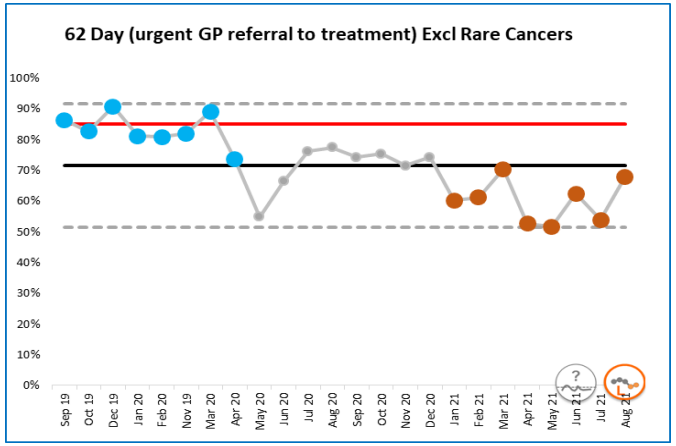
Commentary

Special cause variation (6 points above mean) can be seen from March to September '20. However, the astronomical data point in Jun '21 pulls down the mean in an otherwise stable process.
SWB was ranked 81st out of 172 Trusts in July.



Commentary

Pre COVID attendances were around 18k, dropping to 12k during COVID/Summer '20, now increasing on pre COVID levels exceeding 22k.
Nb. We took on Sandwell UCC – Apr 21



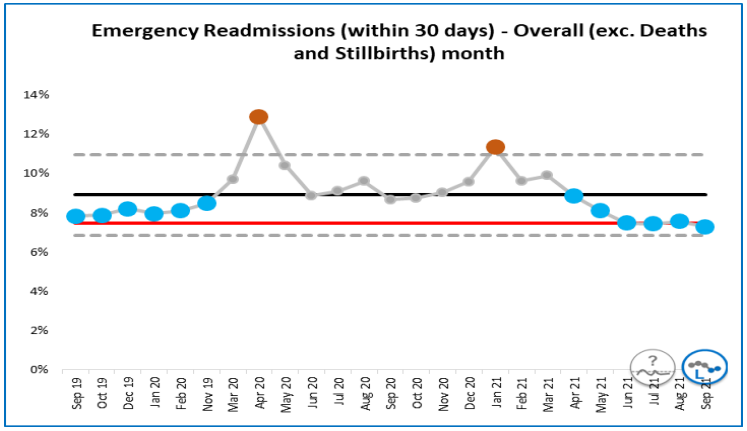
Commentary

Special cause concern and improvement can be seen. The vast change in performance obscures reliable control limits even when re baselined as shown.
SWB was ranked 127st out of 135 in July.

Cause of variation?	What actions have been completed?	What next?	When will it improve?
Emergency Care – the variation is caused by Covid. During Wave 1 we saw a reduction in attendances (graph 2) which improved performance in wave 2 and 3 we have seen an increase in attendances and a mix of attendances between Covid and non Covid **62 Day Cancer –** linked to Covid **RTT –** linked to Covid	**Emergency Care –** Split ED between red and amber, live dashboard in creation to monitor variance in real time. Although it is below expected standard it is above the national median and from a quantity perspective it is the 21st busiest in the country and 56th in performance. (agreed target of 20,000 target) **62 Day Cancer –** as we are working through backlog this adversely affecting our in month performance. **RTT –** prioritising P2 breach patients which can negatively impact on performance, we have almost eliminated our 104 week patients.	**Emergency Care-** better streaming criteria, live dashboard, improved SDEC infrastructure **62 Day Cancer –** more of the same **RTT –** more of the same, and we are working down towards our 90+ weeks patients.	**Emergency Care –** recovery trajectory showing incremental improvements with 90% delivery by March 2022 **62 Day Cancer –** aiming to recover the 62 day position by December 2021 **RTT –** aiming to be back compliant by Aug 2022

Effective

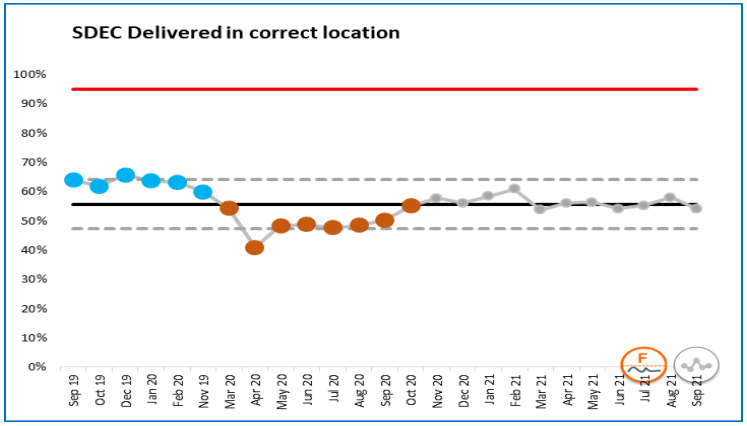
Executive Lead: Chief Operating Officer



Commentary

Pre COVID performance appears as special cause improvement relative to drop in performance thereafter. Common cause variation is mostly observed excluding astronomical data points correlating with COVID peaks.

Commentary



Commentary

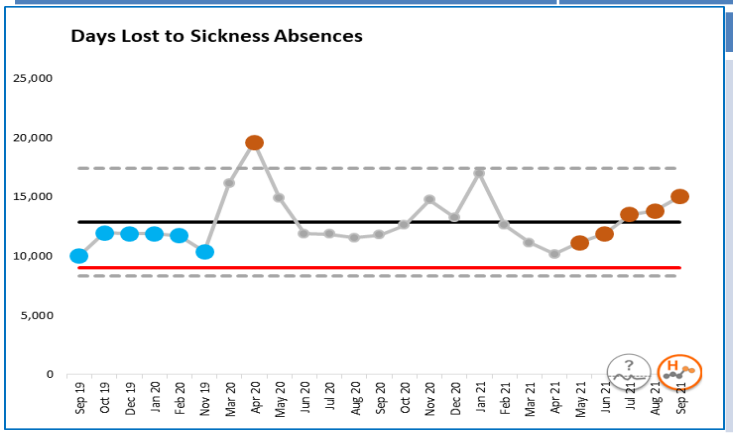
This measures the count of patients in medical and surgical ambulatory units (numerator) over the total count of patients eligible for SDEC based on the 55 national pathways within opening hours. Suggested target is 92%. Improvement may not increase prior to MMUH.

Commentary

Cause of variation?	What actions have been completed?	What next?	When will it improve?
Readmissions – Covid19 have reduced our admissions and so those that are coming back as a percentage of admissions has reduced. **SDEC –** need greater geographical locations at both sites. Need more pathways being implement by screening navigators	**Readmissions –** review of speciality specific re-attendances (not completed). Agreed target of 7.46% , which is Model Hospital median) **SDEC –** scoped a better geographical location for SDEC, completed winter funding models. Scoped ED front door navigator role for streaming. Agreed target of 95%)	**Readmissions –** review of speciality specific re-attendances not completed and now overdue. Review top 10 specialities or conditions and understand why we are seeing re-admissions in those areas **SDEC –** Empowerment of navigators to implement pathway changes. Increase in geographical footprint.	**Readmissions –** it is now better than the national median within model hospital. **SDEC –** February 2022 when pathways are being utilised fully.

Well-Led

Executive Lead: Chief People Officer & Director of Governance



Commentary

Post COVID common cause variation is mostly observed apart from two astronomical data points associated with COVID peaks. On average days lost has increased by 1.5k days /month since COVID.

The sickness absence rate was 141st out of 215 Trusts in April..

Q2 21/22 People Pulse Staff Engagement Score

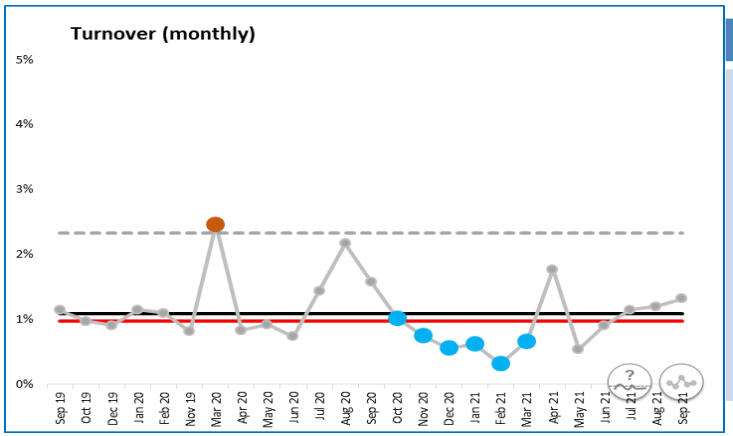
Sub-scale	Score out of 10
Motivation	6.52
Ability to Contribute to Improvements	6.31
Recommendation of the Organisation	6.51
Overall	**6.45**

	Highest	Lowest
Directorate	People & OD 7.43	Maternity & Perinatal 5.26
Staff Group	Healthcare Scientists 7.27	Estates & Ancillary 5.84

Commentary

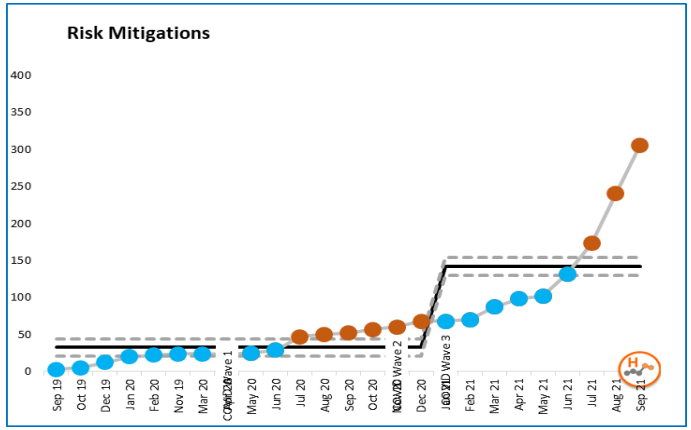
Overall Staff Engagement is measured as an average across three subscales, consisting of 3 questions each.

1,549 responses were received.



Commentary

Special cause signalling improvement can be seen from October '20 to March '21. Since April 21 we have common cause variation.



Commentary

The chart demonstrates the count of overdue risk actions growing beyond control limits consistently over time. This makes it difficult to plot on an SPC chart.

Cause of variation?

Sickness
We have experienced increases in sickness absence due to Covid sickness and also stress and anxiety

Turnover
Increase in rates related to TUPE transfers, end of fixed term training contracts of doctors on training and students who were recruited as additional capacity during Covid19.

Risk Mitigations
Likely to be changes in personnel and non review of risks

What actions have been completed?

Sickness
Corporate focus on health and wellbeing; Well-being hubs; Group focus on Restoration and Recovery; Training for managers to support staff suffering from stress and anxiety.

Turnover
Revised PDR process ; Stay conversations guidance issued; Exit interview guidance developed ; Integrated Workforce; Analysis Tool developed to identify hot spot areas

Staff Engagement
New Pulse quarterly survey shows a decline in all questions from the 2020 staff survey. This has been shared with all group and corporate leads.

Risk Mitigations
The Board Metric was discussed at Risk Management Committee in September and in conjunction with discussions around risks and actions by Groups and Corporate Directorates, work to address the overdue reviews has started happening. The risk team are supporting areas to address the overdue risk actions and due to the timing of pulling the information does not reflect some of the work that is known to have been done.

What next?

Sickness
Maintain focus on Heath and well Being; Groups to ensure trigger meetings take place; Staff engagement work in relation to priority areas identified from staff survey results

Turnover
Revised Recruitment & On-boarding process ; Nurse retention focus groups ; Support for retaining colleagues in later career ; Revised strategy for Flexible working ; High Impact action plan for Equality , Diversity and Inclusion to be developed in conjunction with ICS

Staff Engagement
HR business partners are looking for any variation in professional groups and directorates.. Quarterly listening events in November.

Risk Mitigations
Will assist staff to review all open actions and look at providing more targeted information to individuals and Groups/Directorates

When will it improve?

Sickness
Revised sickness trajectory forecast sickness rate set at 4.51%

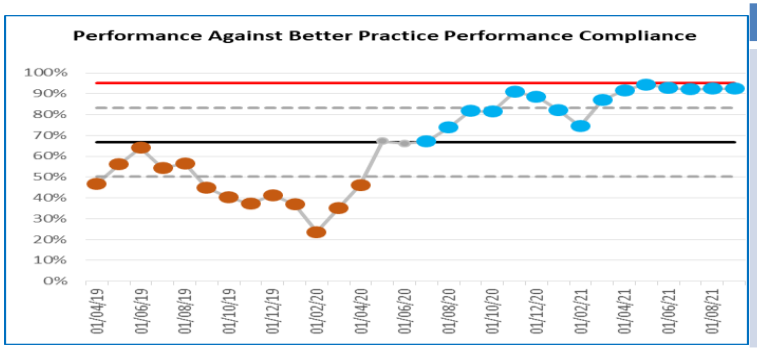
Turnover
When excluding Tupe transfers, doctors in training , end of fixed term contracts the turnover rate is 9.57%

Staff Engagement

Risk Mitigations
By the end of this Financial year these will have been resolved and better monitoring in place corporately and by teams.

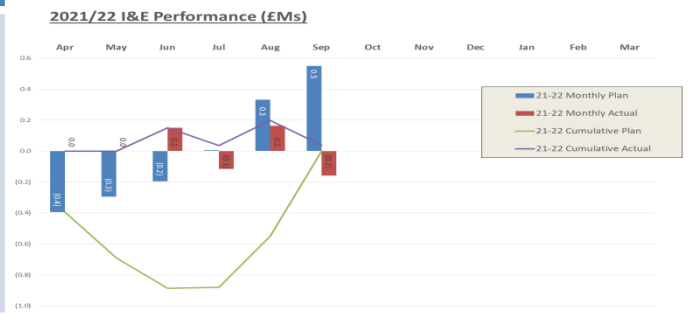
Use of Resources

Executive Lead: Chief Finance Officer



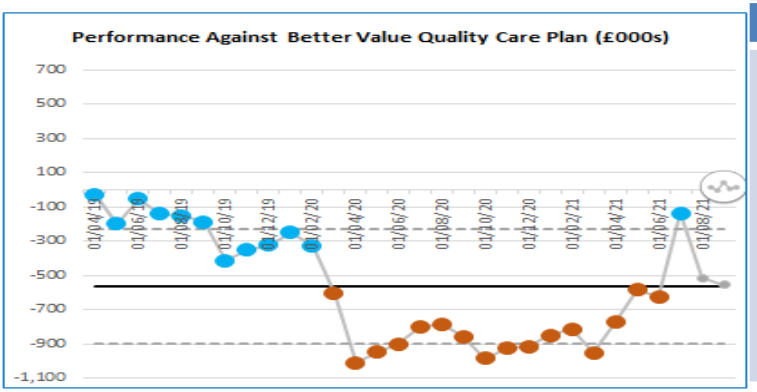
Commentary

Special cause concern following be special cause improvement can be observed during the period. The organisation has consistently failed this target, however performance is improving and is now just below the target between 90% and 94%.



Commentary

Finance noted that SPC was not an appropriate format to monitor this measure, but have provided an alternative chart showing in month and cumulative performance



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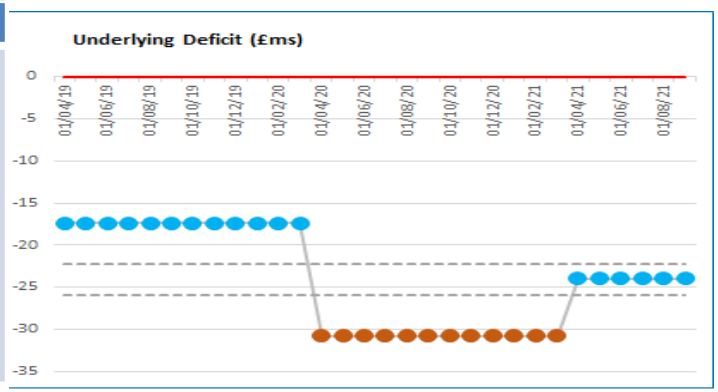

Commentary

Finance noted that SPC was not an appropriate format to monitor this measure as it is reported annually, but have provided an example to illustrate.

BPPC

SPC works well for this measure

- Action plan to deliver 95% for both value and volume of invoices has been agreed for 21/22 and progress will be monitored via the Finance Directorate Board
- Prompt authorisation of invoices by budget holders, raising of accurate purchase orders and timely receipting all assist with prompt payment, as does clear identification of disputed invoices as these can be excluded from performance measurement
- ·Actions already completed include more regular payment runs – poor performance previously was reflective of the trust regularly just missing the deadline by a few days rather than process issues – the Trust tries not to pay "early" as the more cash we have in our bank for longer, the lower our PDC dividend charges and the higher our interest earned. The Trust will be aiming to pay local suppliers early and work is underway on this
- 2021 performance was also impacted by the Covid arrangements to clear all old NHS provider to provider debt – when an invoice is paid it hits the metric – so as lots of old debts were paid, our performance dropped

BVQC

An SPC chart creates an interesting conversation about performance for this metric but arguably there are better charts that will explain the Trust's performance against the target. The value is in month, not cumulative, although if you add them all up they do equal the annual performance against plan

Issues include;

- Phasing of target – if a back ended "hockey stick" rather than equal values, performance against the plan will be affected
- Performance against the plan is the Trust's plan, which doesn't necessarily equate to national efficiency requirements, so for example in 2021, although we were well below Trust plan, our performance in comparison to others was strong, and we delivered above national requirements. Despite this, we can't "bank" this over performance due to current financial arrangements.
- Actions to improve – CIP achieved for 2122 (FYE) is likely to be more than nationally is required of us – we must ensure we are able to bank any over-performance – this is a risk if blocks continue and 2223 "resets" – timing of delivery into 2223 may therefore be advisable
- CLE BVQC focus at future meeting, including SLR and costing information, model hospital opportunity, agreement of 2223 framework and areas of focus

Income & Expenditure

· The I&E position isn't really suitable for a SPC chart. The chart above is an alternative option

- 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:

- A monthly profile moving from a deficit position in month to a monthly surplus for August an d September
- Cumulative position is a breakeven plan for H1
- Actuals are showing a small surplus year to date reflecting in a favourable position to the plan
- The focus is now on securing H2 income through the ICS and then cost management during October to March 22.

Underlying Deficit

Subjective, strategic measurement not updated any more frequently than annually due to complex work required and impact of strategic external factors, therefore not suitable for SPC

- Any deficit driven by income received which since 1st April 2020 to present is enough to cover costs – if this is recurrent – there is no deficit
- Trust should aim to over-deliver against national efficiency targets to fund investment and improvement and/or mitigate the risk of income shortfall against costs which would create an underlying deficit
- 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

IQPR Exceptions

Many indicators have started showing recovery during September but with some notable exceptions.

- **ED** (September) attendances at 21,505; 5645 patients breaching the 4hr wait. Using national benchmarking with Septembers performance we would rank 62nd out of 109 trusts for our ED 4 hour wait down from 58th in May we were ranked 41st. We still show long median times to treat at 250 mins and
- **Cancer** (August) performance has started to see an up turn in performance across the board although we are still not meeting national performance targets. Cancer 2 week wait is at 88.3% (target 93%); whilst breast asymptomatic has shown an improvement (~5%) to 81.7% (target 93%). The Cancer pathways performance will remain low whilst the backlog is being prioritised and so individual specialty plans may not perform to the planned date.
- **Mixed Sex Accommodation** was due to recommence national reporting in June. However, the Trust has not yet reported. Operational lead has committed to reporting the September data which will report October/November 2021.