Sheffield Health and Social Care NHS Foundation Trust

Board of Directors Meeting – Open

Date:	11 November 2020	Item Ref:	17ii

TITLE OF PAPER	**Performance Framework**
TO BE PRESENTED BY	Phillip Easthope, Executive Director
ACTION REQUIRED	Approve Performance Framework

OUTCOME	Performance Framework in place across organisation. It will be further developed in early 2021 (Review and Refine January to March 2021).
TIMETABLE FOR DECISION	Board of Directors meeting – November 2020
LINKS TO OTHER KEY REPORTS / DECISIONS	Finance & Performance Committee development oversight and approval October 2020 Review of team to Board reporting within Clinical Operations – A revised diagram / flow chart will be incorporated into performance framework.
STRATEGIC AIM **STRATEGIC OBJECTIVE** **BAF RISK NUMBER & DESCRIPTION**	All: Deliver Oustanding Care Great place to Work Improve use of Resources
LINKS TO NHS CONSTITUTION /OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	Delivery of Trust Strategy and Operational Plan
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	Framework sets out how performance will be managed including where mitigation is expected, it should enable a clear understanding of expectations and our response where a recovery plan is required.
CONSIDERATION OF LEGAL ISSUES	NA

Author of Report	Phillip Easthope
Designation	Executive Director
Date of Report	November 2020

Proud to care in Sheffield

Performance Management Framework

Proud to care in Sheffield

Title: Trust Performance Management Framework Date: October 2020

Version: 0.4

Author	XXXXX – Performance and Information Manager
Owner	Phillip Easthope, Director of Finance
Client	Richard Mills, Chair of Finance & Performance Committee

Document History

Version	Date	Changes
0.4	October 2020	Updated version to incorporate changes following comments made by Board sub committees and key professional leads (Planning, quality governance and performance) See consultation document for comments and response

Distribution Record

Version	Date	Distributed to:
Draft 0.1	June 2020	PE Director of Finance
Draft 0.2	27 July 2020	Finance & Performance Committee
Draft 0.2	27 July2020	Senior Management Roles, Performance, Quality & Planning
Draft 0.3	Oct 2020	PE Director of Finance
Draft 0.4	26 Oct 2020	Finance & Performance Committee
Draft 0.4	11 Nov 2020	Trust Board
Final 1.0	November 2020	
Draft 2.0	February 2021	Update to Finance & Performance Committee, Quality Assurance Committee, People Committee
Draft 2.1	March 2021	Trust Board

Contents

Appendices

1 Executive Summary

This paper sets out the Performance Management Framework adopted by Sheffield Health and Social Care NHS Foundation Trust.

The purpose of this paper is to demonstrate the Trust's commitment to transparency and accountability to its patients and the wider community, with regard to how the Trust is performing and any measures in place to improve performance.

The Trust's vision is:

> *To improve the mental, physical and social wellbeing of the people in our communities*

This framework sets out the performance management approach that will be adopted to achieve that vision. The performance management system is designed to define clear accountability arrangements and set out the process through which the Trust Board will be provided with assurance. The scope covers the performance management of a range of local and national performance metrics.

The document also sets out the relationship between performance management and Business Planning, as well as the Programme Management Office function, and the connection between operational plans and the overarching Trust Business Plan. In Appendix I a glossary of terms is provided.

Performance Measurement outlines the external metrics and additional internal metrics that need to be achieved to deliver the overall objectives of the organisation. These metrics are then monitored with delivery criteria and thresholds, current performance against target using icons derived by Statistical Process Control (SPC) methodology to assess the statistical significance of movements in performance and the assurance that targets will be achieved.

The **Performance Monitoring** process explains the mechanisms by which Operational services, Senior Management, the Trust Board and its committees all receive information on all relevant metrics.

The **Performance Management** approach adopted is split into two elements. Monthly performance meetings are used to assess performance. Implementation of a recovery plan process, a relevant Committee report and specifically cover sheet will draw the attention of the Committee members to areas where the SPC analysis identified an issue with performance and whether, following consideration by the Committee, a recovery plan should be developed.

The aim of this approach is to avoid duplication of work where specific actions were already taking place to address known problems.

The Recovery Plan process is covered in detail in Section 9.1. The principle of the performance management system is that delivery of metrics and planning of improvements to meet performance metrics is devolved to operational services. Where recovery plans are required, these plans contain trajectories to track the intended improvement in performance and where progress is significantly adrift from trajectory, an exception report is escalated to the Finance & Performance Committee, the Quality Assurance Committee or People Committee, depending upon which of these Committees has the overarching responsibility for the metric (See Appendix II for detail).

In addition to the monthly process focusing on performance metrics each Service Directorate is subject to broader strategic reviews by the Executive Directors twice yearly. The start of

the financial year review will assess the previous year's performance and look forward to considering pressures and objectives. The mid-year Service Directorate strategic review will assess progress in year so far, consider actions for the remainder of the year and look forward to planning issues for the following year that need to be included in the next business plan. Both reviews will have a focus on risks for each Service Directorate. These strategic reviews are scheduled to take place in April / May and October / November each year.

Performance, Finance, Quality and Development are interconnected: the performance framework includes high level reporting against the four dimensions but also recognises the role of specific connected groups in reviewing progress in each area.

2 Introduction and Scope

This paper sets out the Performance Management Framework adopted by Sheffield Health and Social Care NHS Foundation Trust. The focus of this document is the delivery of national and local performance metrics, as well as the recovery and escalation processes that are invoked when performance deviates from plan. This document will reference other areas of performance management, such as finance and the broader quality management agenda; however, these areas fall outside of the scope of this Framework.

The document:

- Sets out the relationship between the organisations objectives and performance metrics.
- Clarifies the external metrics that the organisation is monitored against.
- Defines additional internal metrics set by the organisation.
- Defines the process that will be used to measure, monitor and manage performance.
- Documents the roles of individuals and specific groups in the performance management system.

Each year the performance system is reviewed to ensure that it is appropriate for the changing external performance monitoring requirements. The approach is designed to allow the organisation to adapt its approach as external requirements change, without the need to fundamentally redesign the system.

The Trust includes services that are integrated with the Local Authority. Performance metrics cover health and social care, this includes external metrics (e.g. Self-directed support) and internal metrics (e.g. delivering financial targets). The system is also designed to minimise duplication, so for integrated services, performance reviews are designed to meet the needs of the Trust and Local Authority.

During 2020/21, the arrangements outlined in this document are likely to need to evolve to accommodate closer and different working arrangements across the local health and social care economy. This is with particular reference to the ongoing development of the ACP & ICS performance arrangements and the introduction of the Primary Care Networks.

It is also recognised that the performance framework is introduced at a time of significant change and uncertainty during the COVID 19 epidemic, whilst we may not be being measured against some of the national and local performance targets, the framework is written as if we are, to facilitate improvement to the framework and help facilitate our learning journey and inform future strategy and planning.

3 NHS Environment

3.1 – The Current Environment

There are a number of organisations that set the agenda for both quantitative and qualitative performance metrics, namely:

- NHS England and NHS Improvement
- Care Quality Commission (CQC)
- Clinical Commissioning Groups (CCGs)
- Primary Care Networks (PCNs)
- Local Authority for social care metrics
- Sheffield Accountable Care Partnership (ACP)
- South Yorkshire and Bassetlaw Integrated Care System (SYB ICS)
- Public Health

NHS Improvement remains the primary regulator of providers across the NHS in respect of performance. In 2016 NHS Improvement introduced the Single Oversight Framework, a document that sought to outline the approach to the regulation of NHS providers. The document was updated annually to reflect the latest targets and initiatives. The 2019 update highlighted a strategic change which demonstrates the closer alignment between NHS Improvement and NHS England and a move to a more system-wide approach to performance regulation.

The NHS Long Term Plan was published in January 2019 and sets out key areas where the NHS can develop and achieve an NHS fit for the future.

- A new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting.

- Increase the contribution to prevention of some of the most significant causes of ill health and tackling health inequalities.

- Tackle current workforce pressures and support existing staff making the NHS a better place to work meaning staff stay within the NHS

- Making better use of data and digital technology where patients and their carers can better manage their health and clinicians can access and interact with patient records and care plans wherever they are.

- Getting the NHS back onto a sustainable financial path using the secure and improved funding averaging 3.4% a year over the next 5 years.

PCNs were a key component of the NHS Long Term Plan and during 2019 guidance was published as to the shape and scope of these Networks and their role within the local health systems. PCNs will be geographically based groups of primary care practices, typically covering 30,000 to 50,000 patients. The Networks will provide the structure and funding for services to develop locally to meet the needs of the population they serve. At the time of writing, PCNs had been in existence for a comparatively short space of time and whilst there will clearly be very close working relationships between the PCNs and the Trust, particularly with regard to the role of Neighbourhood Teams, clear performance metrics had not been agreed. It is clear however that PCNs will play a major role in the future NHS environment, both as a provider and a commissioner of services.

To assist those planning services locally, NHS England also publishes comparative

information on outcomes for patients in all CCG and local authority areas. These outcomes benchmarking packs are intended to support the local planning of health and care.

As part of the contracts between the CCGs, the Local Authority and the Trust, there is a further suite of clear performance metrics. These metrics are based on the levels of service commissioned and the patient outcomes that are expected to be delivered from these services. Regarding this, the commissioners, via the Contract Management Board meeting, will become the second level of external performance management for the Trust.

3.2 Accountable Care Partnership (ACP) & Integrated Care Systems (ICSs)

In line with the requirements laid down by the NHS Shared Planning Guidance, the Trust is a partner organisation of Sheffield ACP ('place') and South Yorkshire & Bassetlaw ICS ('system').

The concept was first introduced in 2016 and extensive work has been undertaken with a view to delivering the requirements initially included within the 5 Year Forward View and the triple aim, and subsequently re-affirmed in NHS Long Term Plan (2019) of:

- Improved Health and Well Being
- Transformed Quality of Care Delivery
- Sustainable Finances

The overarching objective was the development of Integrated Care Systems (ICSs). The role of ICSs will be to bring together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. They will have a key role in working with Local Authorities at 'place' level, and through ICSs, commissioners will make shared decisions with providers on population health, service redesign and Long-Term Plan implementation. The objective is to have ICSs established everywhere by April 2021.

The NHS Operational Planning and Contracting Guidance 2020/21 published in January 2020 carries forward many of the concepts introduced by the 2019/20 document, explaining that the NHS Long Term Plan had set out the transformation of services and outcomes the NHS will deliver by 2023/24 by investing the long-term revenue settlement that had been received from Central Government. The NHS and its partners had used this stability to develop local system-wide strategic plans during 2019 that will put the NHS on a sustainable footing whilst expanding and improving services and care provided to patient and the public.

It described the main priorities and performance assessments that need to be undertaken in particular the following;

- Deliver the 2020/21 elements of the NHS Long-Term Plan commitments, which local systems had developed via their strategic plans;
- Improve Urgent and Emergency Care (UEC) performance and expand the capacity to meet URC demand, including reducing bed occupancy levels to 92% through acute bed expansions, increasing community care, investments in primary care and improvements in length of stay and admission avoidance;
- Reduce waiting lists for elective care and eradicate waits of more than 52 weeks;
- Improve performance against the cancer standards, including the 62 day measure and that at least 70% of people get a cancer diagnosis within 28 days;
- Expand primary and community services by increasing investment in primary medical and community services;
- Meet the Mental Health Investment Standard with an additional investment of £1.5bn in mental health services. This will fund the service improvements set out in the mental health implementation plan, including the expansion of access to Improving Access to

Psychological Therapies by over 14% so that nearly 1.5 million people can benefit;
- Continue to improve outcomes and care for people of all ages with a learning disability or autism and delivering against the commitments to reduce the number of adults and children receiving care in an inpatient setting;
- Live within financial trajectories and deliver productivity and efficiency gains by continuing to maximise opportunities identified by schemes such as RightCare, Model Hospital and Getting It Right First Time to reduce unwarranted variation;
- Embed and strengthen the governance of systems as the move towards "system by default" operational model takes place and all system are prepared to become an Integrated Care System by April 2021.

3.3 CQC Role

The CQC monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety, they publish their findings, including performance ratings to help people to choose care.

The CQC awards performance ratings on a four-point scale: outstanding, good, requires improvement, or inadequate. This Trust was reviewed in 2020, the Trust performance rating reduced to Inadequate and placed in special measures by NHS Improvement under its Performance regime (see below)

4 NHS Performance Regime

The basis of the performance reporting, monitoring and management structure of the Trust has always been to recreate the performance frameworks that have been put in place by the various regulatory bodies. This allows all tiers of the organisation to be appraised on their performance in a consistent way and for the Trust to understand any performance ratings that may be made by external agencies.

There remain a number of other external agencies with whom the Trust has performance requirements and any changes to the overall regime from 2019/20 to 2020/21 are mapped out below:

4.1 The NHS Improvement Performance Regime

In April 2016, NHS Improvement took over the responsibilities for the management of NHS Providers from Monitor and the TDA. NHS Improvement aligned with CQC and NHS England to create a single definition of success for providers. In September 2016 NHS Improvement published the Single Oversight Framework, which replaced the Monitor Risk Assessment Framework and the TDA Accountability Framework. The Framework is updated annually, usually in September, to reflect changes to national priorities. The update in 2019 sought to reflect the joint working of NHS Improvement and NHS England including performance for both providers and CCGs in the same document. The Framework was re-named The Oversight Framework. The performance regime of the Trust is updated to reflect these changes.

The purpose of the oversight framework is to identify where providers may benefit from, or require improvement support or access across a range of areas. This will then inform the way NHSI work with each provider. The oversight framework does not set out in detail the improvement support that will be provided in each case as this will as this will be tailored to individual provider needs. NHSI will work across five themes which are contained within the Single Oversight Framework, these themes are as follows:-

Quality of Care (safe, effective, caring, responsive). NHSI will use CQC's most recent assessments of whether a provider's care is **safe, effective, caring and responsive**, in combination with in-year information where available. This will also include delivery of the four priority standards for 7-day hospital services

Finance and use of resources; NHSI will oversee a provider's financial efficiency and progress in meeting its financial control total, reflecting the approach taken in 'Strengthening financial performance and accountability'. NHSI will be co-developing this approach with CQC. One of the most significant changes to the November 2017 updated Framework was the introduction of Use of Resources Assessments. The document outlined how Providers would receive a formal inspection visit to assess their capability against a range of key performance indicators. This would involve a desktop assessment of productivity data that was already available via other sources (Predominantly the Model Hospital) and a formal on-site visit, whereby members of the senior team of the Trust would be interviewed regarding the productivity and efficiency of the organisation. The outcome of this assessment would count towards to overall segmentation of the Trust and would supplement the ongoing management of performance against the published suite of key performance indicators.

Operational Performance: NHSI will support providers in improving and sustaining performance against NHS Constitution standards and other, including A&E waiting times, referral to treatment times, and access to mental health services. These NHS Constitution

standards may relate to one or more facets of quality (ie safe, effective, caring and/or responsive).

Strategic change: working with system partners NHSI will consider how providers are delivering the strategic change set out in the 5 Year Forward View, with a particular focus on their contribution to Integrated Care Systems (ICSs) new care models, and, where relevant, implementation of devolution

Leadership and improvement capability (well-led): building on the joint CQC and NHSI well-led framework, NHSI will develop a shared system view with CQC of what good governance and leadership look like, including organisations' ability to learn and improve.

The Single Oversight Framework includes segmentation, which is designed to help NHSI identify the level, type and frequency of specialist support and scrutiny that organisations might require.

It does not give a performance assessment, nor is it intended to predict the ratings given by CQC. It also does not determine the specifics of the support package needed- this is tailored by teams working with the provider in question. There are four different segments and Trusts are allocated to one of these segments depending on the extent of support needs identified through the oversight process.

The segmentation a provider is placed in will reflect NHSI judgement of the seriousness and complexity of the issue it faces. The decision will be based on:

- Consideration of all available information on providers – both obtained directly and from third parties

- NHSI will make a judgement, based on relationship knowledge and/or the findings of formal or informal investigations, or analysis. Consideration of the scale of the issues faced by a provider and whether it is in breach or suspected breach of licence conditions.

- Identifying providers with a potential support need in one or more themes.

The definitions for each segment are outlined below in table 1:

Table 1 Segments Definitions

Segment	Description
1	**Providers with maximum autonomy** - no potential support needs identified across our five themes - lowest level of oversight and expectation that provider will support providers in other segments
2	**Providers offered targeted support** – potential support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS Trust) and/or forma action is not needed
3	**Providers receiving mandated support for significant concerns** – the provider is in actual/suspected breach of the licence (or equivalent for NHS trusts)
4	**Special Measures** – The Provider is in actual/suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that mean that they are in special measures

In parallel with the development of the framework, NHSI will consider the incentives for providers to be in segment 1. While some conditions are fixed across the sector (e.g. control

totals), others could vary from segment to segment in accordance with the principle of earned autonomy.

Segmentation is reviewed within NHSI on a monthly basis by its Regional Support Group. All decisions are then ratified by a similar forum operating at national level.

4.2 CCG and Local Authority integrated commissioning

As outlined within Section 3 above, CCGs and Local Authority will apply a range of performance metrics that are contained within the Performance, Quality and Outcomes Report / framework. It is the intention that the Trust Performance Report and Commissioning Dashboard will be updated to incorporate any new metrics that are identified as part of this process.

As well as the metrics that will emanate from the contract process, a number of service specifications will be developed with the commissioners that will also contain metrics that will need to be reported on.

4.3 Quality Metrics

The Trust Performance Report includes specific quality metrics. The integrated dashboard presents the Trust's key quality metrics alongside those of finance and performance.

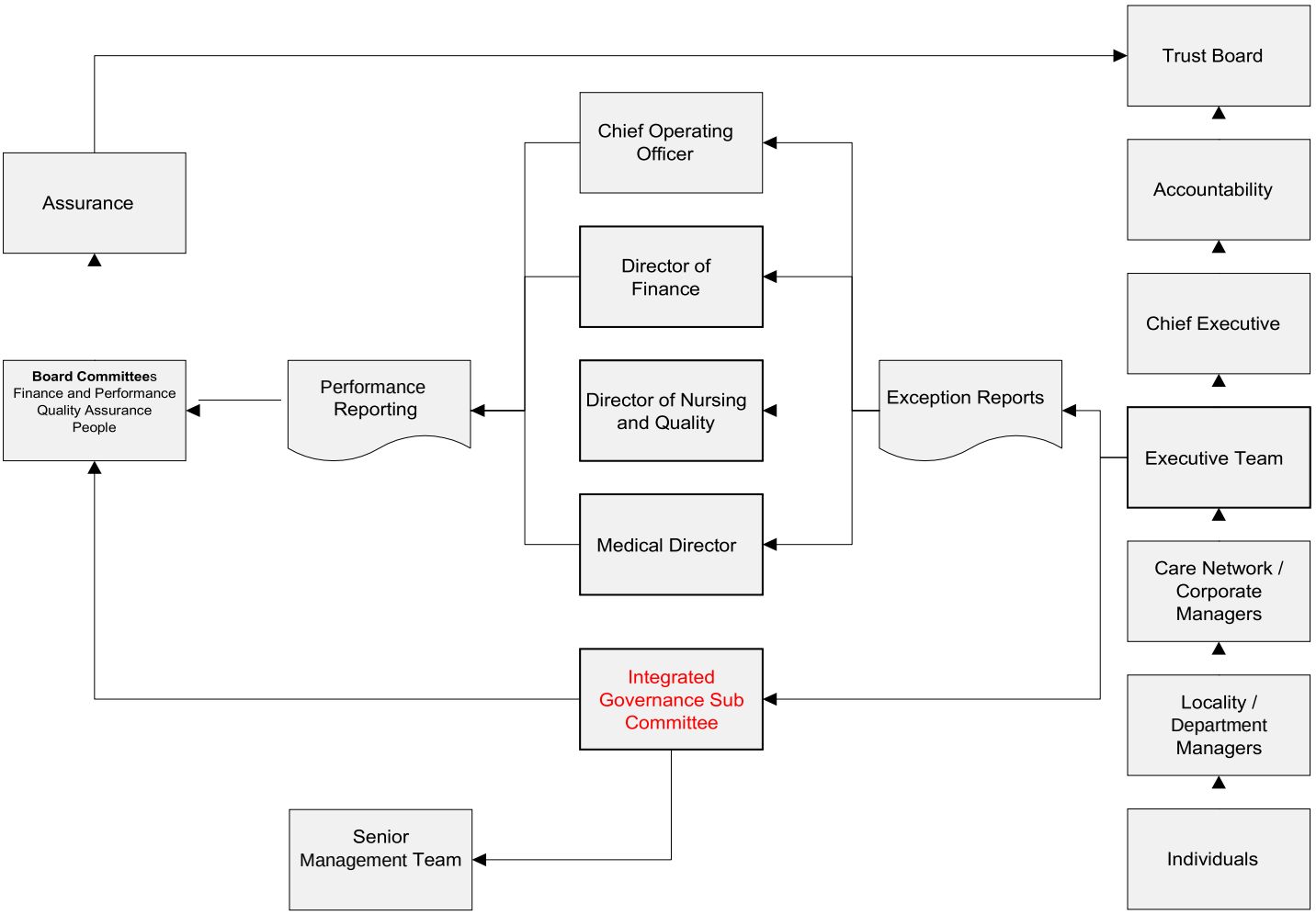
5 Accountability and Assurance

The Trust Board is ultimately responsible for the performance of the Trust.

The Board needs to be assured that the organisation is achieving the objectives that have been set out; to achieve this, a number of Board Committees have been established. The committees that have a role in performance management are set out in figure 1.

Accountability for the delivery of objectives is achieved through the management structure which is also shown in the diagram.

Figure 1 Monthly Accountability and Assurance



The Trust also has a Transformation Board (TB) who are responsible for coordinating projects to achieve the Trust's strategic objectives. TB has overview and accountability for delivery of any transformational Cost Improvement Programmes, strategic projects and new business opportunities for the Trust.

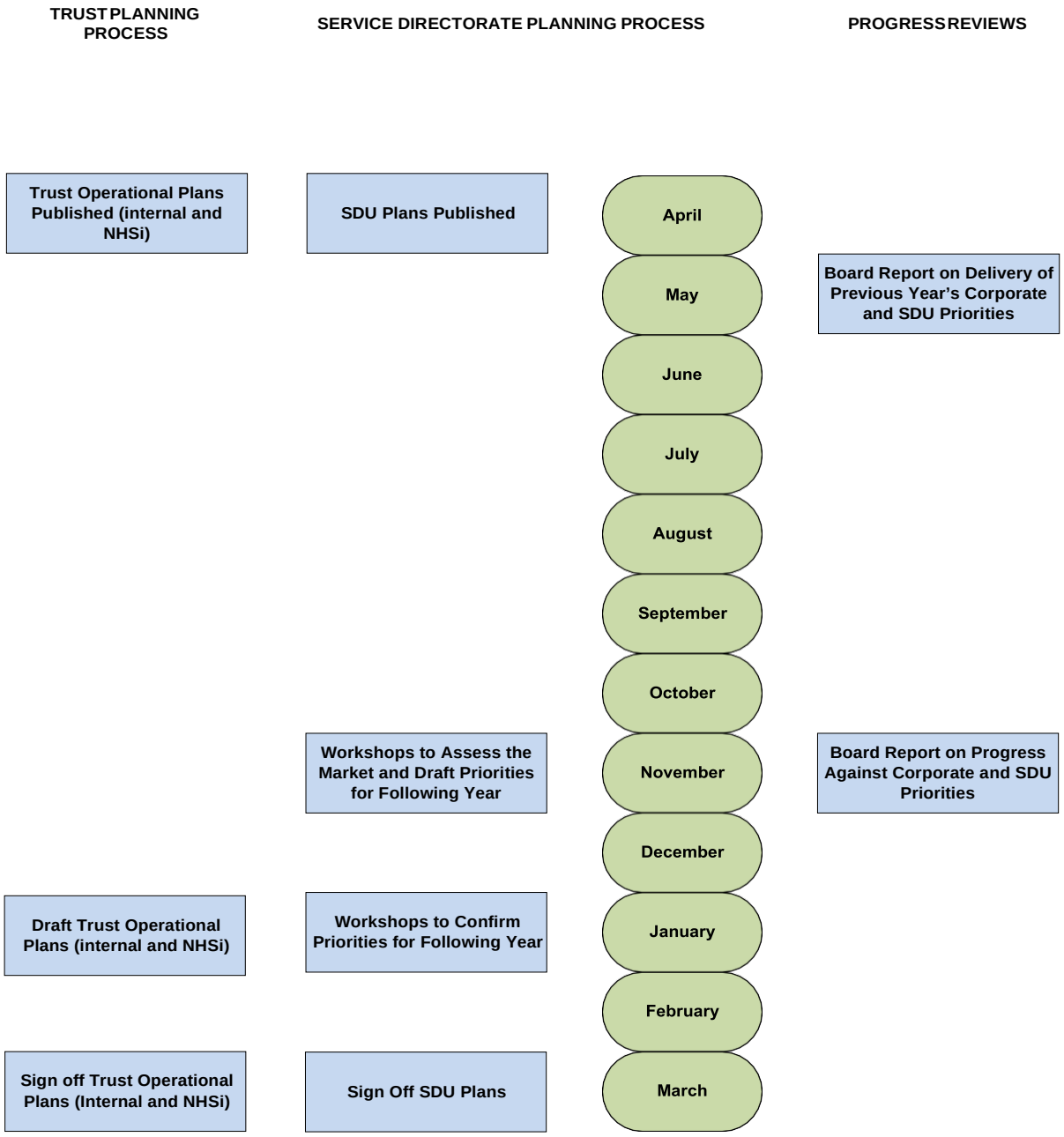
The relationship between Assurance and Accountability will be managed. If there are significant variations from defined metrics or business plan objectives these will be reported through Service Delivery Units to the relevant Board committees.

6 Business Planning

A key element of Performance Management is the development of a Trust Operational Plan. The Trust publishes an annual operational plan in April each year, which draws on the plans developed by each of the part of the organisation. To achieve this, performance reviews include a high level summary of the anticipated objectives from each part of the Trust.

The diagram illustrates the process for developing the annual operational plan and highlights the critical relationship between the Service Directorate operational plan and corporate department plans and the overarching Trust Operational Plan.

Figure 2 Business Planning Process



7 Performance Measurement

7.1 Trust Objectives

Sheffield Health and Social Care NHS Foundation Trust have worked with staff, patients and stakeholders to agree what kind of organisation we would like to be.

The Trust has undertaken a refresh of its strategy for 20/21 with a full review encompassing wide engagement will be undertaken in 21/21.

Our vision: What we aspire to:

To improve the mental, physical and social wellbeing of the people in our communities

Values: What we believe in and how we will behave:

- **Respect** — We listen to others, valuing their view and contributions
- **Compassion** — We show empathy and kindness to others so they feel supported, understood and safe
- **Partnership** — We engage with others on the basis of equality and collaboration
- **Accountability** — We are open and transparent, acting with honesty and integrity, accepting responsibility for outcomes
- **Fairness** — We ensure equal access to care for all people
- **Ambition** — We are committed to making a difference and helping to fulfil aspirations and hopes of our service users and staff

Strategic aims: how we will achieve our vision

- Deliver outstanding care and experiences for our service users and carers;
- Create a great place to work where colleagues can deliver high quality care;
- Improve our use of resources

Strategic priorities: what we want our organisation to achieve

- Covid, getting through safely;
- CQC, getting back to good;
- Transformation, changing things that will make a difference

The key themes that will drive our plans to improve services are:

- Care will be Safe.
- Access to services will be timely.
- Our approach will be Person centered and coproduced with the individual.
- We will make a positive difference, delivering the right outcomes for the individual and

their carers.

These will be achieved by a number of 'enablers' which are:

- Quality Improvement and assurance
- Service user carer engagement
- People
- Organisational Development
- Communication and engagement plan
- Estates
- Digital
- Research
- Sustainable development

Quality Improvement

In 2019/20, the Trust reviewed its Quality Objectives as defined within the Quality Improvement and Assurance Strategy 2016-21 refresh Jan 19.

The Trust's quality objectives for 19/20 are:

- **Quality Objective 1** Improving access to services and treatment

- **Quality Objective 2** Improving service user and carer experience, involvement and engagement

- **Quality Objective 3** Improving physical and social wellbeing outcomes for all service users.

The Trust's Quality Improvement and Assurance Strategy focusses on delivering continuous quality improvements, recognising that each team will develop plans to improve quality and that the Trust will have a number of Trust-wide improvement priorities and a smaller number of Transformation Programmes. The strategy aligns with the Trust's values: delivering care in partnership with staff and service users in a respectful and compassionate culture, and ensuring we are all accountable for delivering excellent care as a learning organisation.

Our aim is to create a culture of continuous quality improvement, where safeguarding and improving care is everyone's responsibility.

There are a range of tools, techniques and methodologies to support our improvement work, along with access to colleagues with expertise in using Quality Improvement approaches.

7.2 Targets

The Trust has performance metrics set from a range of external sources. These metrics relate to one or more of the Trusts objectives. In addition, where objectives are not fully addressed through external performance metrics additional internal metrics have been defined.

The key external metrics are set out in Appendix II which shows the organisation that sets the metric, these include:

- NHS Improvement / NHS England performance regime

- Local Authority performance management system
- CCG

Internal metrics are also in place, for example Mandatory Training.

Each year (and potentially in year) new metrics may be set by external organisations. These metrics must be incorporated into the performance management system. External metrics will be identified by the information department and highlighted in the monthly performance report once they are known. Where new metrics are to be introduced a shadow reporting system will be introduced as soon as possible and a minimum of three months prior to the introduction of the metric.

7.3 Relationship between Strategic Objectives and Performance Metrics

The initial schedules of metrics that have been included in the high-level dashboard are based on metrics used by external organisations to assess the Trust.

Internal and External metrics are listed in Appendix II.

8 Performance Monitoring

In order to track progress against metrics a monthly performance report and integrated dashboard will be produced. In addition, Service Delivery Unit specific reports will be available so that performance to a more granular level can be identified. It is important that the Information Team work closely with operational colleagues, finance directorate, human resource directorate and the quality directorate to ensure that reports are fit for purpose and meet the needs of the specific service.

It is important to note that the content of the performance report is flexible and has to be capable of changing as and when new performance metrics are introduced.

From 2019-20 onwards, NHSI has encouraged Trusts to use Statistical Process Control (SPC) methodology in their monthly reporting processes. It is believed that the use of SPC will help Trusts move away from the reliance on RAG for reporting purposes and provide a more statistically meaningful approach to trend analysis. Statistical process control (SPC) is an analytical technique – underpinned by science and statistics – that plots data over time. It helps the Trust understand variation and in so doing guides us to take the most appropriate action.

The application of SPC methodology and analysis will provide specific outputs which allow the Trust to:

- Identify a situation that may be deteriorating
- Identify if a situation is improving
- Assess how capable a system is of delivering a standard or target
- Assess whether a process that we depend on is reliable and in control.

The Trust has used SPC charts in its reporting for a number of years including SPC for some indicators featured in the Oversight Framework that apply to the Trust. This has largely been limited to quality and safety reporting. During 2020 the use of SPC charts will be standardized and embedded within the performance regime and develop our understanding to ensure it is understood by the Board and all Committees.

The reports will make use of SPC Icons, 'The SHSC way' building on the SPSC icons developed by NHSI which are used to articulate the concepts outlined above. A guide to the SPC Icons is provided in Appendix V

The report is structured so that all key performance metrics for the Trust, covering all of the external performance regimes highlighted within Section 3 of this report are reported to the Board. The report seeks to:

- Highlight to the Board or Committee the high-level performance against the metrics contained within the NHS Improvement performance regime. Deviation from plan for any metric contained therein could impact on the Trust Segmentation status;
- Provide an update on the performance of any metrics that have been subject to a recovery plan, and the progress against planned trajectory;
- For ease of use by any audience, group the key performance metrics by Service Delivery Unit;
- At the highest level:
    - Map each metric to an objective of the organisation;
    - Establish the target for each metric;
    - Establish thresholds for both performance and under performance for each metric. Based upon the performance for each metric against this threshold, a "RAG" (Red / Amber / Green) rating will be determined;
    - Show performance for both the current and the previous months;
    - Use SPC to show variation in data alongside the current RAG system – see

Appendix V which provides the guide to SPC Charts Icons.

- Where a metric is new, there is concern regarding performance, there is evidence of excellent performance or it is considered that the Board would benefit from additional information, a drill-down analysis is provided, including the underlying data in detail and a graphical representation of the information.

It is the intention to roll-out SPC based analysis to the Service Directorate level performance reports during the course of 2020/21. This will eradicate the use of "RAG" rating performance and provide a more statistically sound assessment of performance consistently across the organisation.

Information will be aggregated at a number of different levels for different groups to review performance; the main levels are shown in table 2 below:

Table 2: Performance Management Arrangements

Committee	Reporting Documents	Timetable
LEVEL 4: OPERATIONAL MEETINGS		
Integrated Governance Meeting Service Directorate Performance Meetings	• Draft Performance Report to Service Directorate Level • Quality and Safety Reports • Workforce Dashboards • Finance Report • Recovery Plans • Service Improvement Plans • Service and Locality Dashboards	Draft reports available no earlier than 10th working day of the month for meeting on the 3rd Wednesday of month TBC
LEVEL 3: SMT		
Senior Management Team	• Full Performance Report to Service Directorate Level • Other issues by exception	Performance report circulated which has been to FPC Committee in the previous month. This will be available for SMT TBC
LEVEL 2: TRUST BOARD COMMITEES		
Finance and Performance Committee	• Full Performance Report to Service Directorate Level • Integrated Dashboard • Recovery Plans	Report will be circulated on the 3 working days prior to the meeting, usually last Monday of the month.
Quality and Assurance Committee	• Integrated Dashboard • Full Performance Report • Recovery plans	TBC
People Committee	• Workforce Metrics • Workforce Metrics/Deep Dive • Workforce Risk Register • Workforce Policies for Ratification	TBC

LEVEL 1: TRUST BOARD		
Trust Board	• Reports to include the quality and service performance metrics contained within the Single Oversight Framework • Integrated Dashboard	Report available on 1st Wednesday of Month for meeting on the 2nd Wednesday of the month

8.1 Performance Reporting Process

As outlined above, the first cut of the various reports covering performance, quality and safety and workforce metrics will be produced no later than the tenth working day of each month in draft format for consideration by the Integrated Governance meeting. The final version of the Finance and Performance Report and Integrated Dashboard will be available the day after the Integrated Governance meeting. There will be a standard performance report which will be used for each of the corporate meetings and the order and role of these meetings is outlined as follows:

- Integrated Governance Meeting - Chaired by the Chief Operating Officer or their deputy/nominated chair, this group has first sight of the draft performance report, quality and safety report, the workforce dashboard, the finance report and any supporting recovery plans. Concerns around data quality are raised and there is an opportunity to address any issues before the report proceeds to the other corporate meetings. Senior representatives from the Nursing and Quality Directorate(s) (usually the Directors of Nursing and Quality), the Human Resources team and the Finance Team are also present at this meeting. The Service Delivery Unit Leads and their Teams are challenged around the corrective actions that are being taken to address any shortfalls in performance. Areas where performance is below the required standard are discussed, and in accordance with the definitions set out at Section 9.2 of this document, Recovery Plans will be required to be produced.

- Senior Management Team – The full Trust performance report is circulated virtually to the members of the team and an exception report of any issues is presented by the Head of Performance.

- Finance and Performance Committee, Quality Assurance Committee and People Committee – The performance report is subject to review by the members of all the above Committees and the Service Delivery Unit Leads are required to respond to areas where performance is below the expected level. The recovery plans discussed at the Integrated Governance meeting are submitted to the Committees to provide assurance that corrective actions are being taken against a prescribed timescale. Service Delivery Unit Leads will be required to present the Recovery Plans to the Committee and to respond to any questions that arise. In addition, the Committees can request the development of recovery plans for any areas where they require additional information as outlined in section 9.2.3.

  Reports presented to Committees and Board should be identified as being for either Assurance or for Reference. For those reports identified as being for assurance, the Committee will be required so assign an assurance

level, with the levels being drawn from those used by the Internal Audit service for audit reports, namely:

- None - The report highlighted weaknesses in the design or operation of controls that have not only had a significant impact on the delivery of key system objectives; they have also impacted on the delivery of the organisation's strategic objectives. As a result, **no** assurance can be given on the operation of the system's internal controls to prevent risks from impacting on achievement of both system and strategic objectives.

- Limited - The report highlighted some weaknesses in the design or operation of control that have had a serious impact on the delivery of key system objectives, and could also impact on the delivery of some or all of the organisation's strategic objectives. As a result, only **limited** assurance can be given on the operation of the system's internal controls to prevent risks from impacting on achievement of the system's objectives.

- Moderate - The report did not highlight any weaknesses that would in overall terms impact on the achievement of the system's key objectives. However, the audit did identify some control weaknesses that have impacted on the delivery of certain system objectives. As a result, only **moderate** assurance can be given on the design and operation of the system's internal controls to prevent risks from impacting on achievement of the system's objectives.

- Significant - The report did not highlight any weaknesses that would materially impact on the achievement of the system's key objectives. The audit did find some low impact control weaknesses detailed in section four of this report which, if addressed, would improve the overall performance of the system. However, these weaknesses do not affect key controls and are unlikely to impair the achievement of the system's objectives. As a result, **significant** assurance can be given on the design and operation of the system's internal controls to prevent risks from impacting on achievement of the system's objectives.

- Full - The report did not highlight any weaknesses that would impact on the achievement of the system's key objectives. It has therefore been concluded that key controls have been adequately designed and are operating effectively to deliver the key objectives of the system. As a result, **full** assurance can be given on the operation of the system's internal controls to prevent risks from impacting on achievement of the system's objectives.

This approach will be embedded across the Committees April 2020 onwards with the assessment of level of assurance agreed by the Committee recorded within the minutes. Plans will need to be put in place around how the levels of assurance assigned by the Committees can be improved.

- Trust Board – A version of the performance report that covers only quality and service metrics contained with the Single Oversight Framework will be presented to the Board to provide members with assurance on performance issues, to raise any problematic areas and to outline the corrective actions that are being taken. The integrated dashboard will also be presented along with any recovery plans that have required escalation. The Director of Operations also provides context and detail to the Board around specific performance issues that might arise.

- Partnership Boards – There are two levels of governance to support the Alliance Boards; The strategic level – ICS Board and the operational level, Place delivery boards. KPI monitoring is in place at a basic level across the system and place aligned to key national KPI, as this develops the Trust performance framework will need to be

developed further.

- During the course of the year as PCNs mature, there will need to be development of performance dashboards to articulate the contribution that the Neighbourhood Teams and wider Trust services are contributing towards the care of the local communities.

- More detailed dashboards and performance packs are provided at Service Delivery Unit level for use at the Team meetings. A number of dashboards are now set up for staff to view in shared folders on the Trust IT network. This information is at a more granular level to facilitate local decision making about specific components of the service. The Performance Team aim to have these available before the Service Directorate monthly performance meetings.

8.2 Rating Methodology

As previously outlined, SPC analysis is in place to support in the rating of performance for a number of key indicators. NHSI have developed a range of icons that can be used to provide an illustration of:

- A metric that may be deteriorating
- A metric that is improving
- The capability of a system to meet a standard or target
- The level of assurance that can be afforded to system to determine whether it is reliable and in control.

Whilst the SPC approach and the supporting icons will support the performance management system in gaining a better understanding of the statistical significance of our data and the underlying trends, there will continue to be a requirement to measure absolute performance against key targets. One of the main advantages of SPC based analysis is that it allows for normal variation within a system over time. Historically, the Trust has tracked performance on a month on month basis, and movements in performance, however small may have been interpreted as improvement or deterioration, SPC analysis will indicate where such movements are within the parameters of normal variation and will support a greater understanding of the data.

The method used is based on numerical triggers; there are no indicators where a subjective assessment is used to determine the rating. The Performance metrics are rated based on variations from a defined performance level, the relevant Board committees agree the triggers and therefore the point at which intervention is planned. There are three types of target:

8.2.1 Externally monitored metrics.

These are targets that an external body will use to assess the performance of the Trust by adding weightings against each indicator. For example, NHSI Single Oversight Framework stated that 95% of CPAs have to be reviewed within 12 months. For targets of this nature any drop below 95% results is a red metric.

The Trust will not allocate more challenging thresholds internally. This approach has the advantage of ensuring clarity across the organisation but also means there is no margin for drop off against the metrics being monitored in the dashboards.

8.2.2 Externally benchmarked metrics.

These are metrics that the Trust may be measured against but not in a formal capacity, ie they do not form part of an assessment. For these metrics the Trust will identify performance

thresholds based on a combination of benchmarking and an assessment of risk.

Metrics included within documents such as “Everyone Counts: Planning for Patients 2014/15” or “Towards High Quality, Sustainable Services” would be included in this section.

Historically, RAG ratings have been used for these metrics; however, during the course of 2020/21, the performance regime will move to the utilisation of SPC analysis to provide a more insightful view of performance. Close work will take place with the management teams to ensure that interpretation of the SPC analysis is consistent and correct. This change in approach will allow a more statistical approach to performance assessment and provide front-line services with assurance around their ability to consistently hit the target, and also identify where achievement of the target is out of reach unless a fundamental system change takes place.

8.2.3 Internal Metrics

These are metrics that have been defined to ensure the delivery of Trust objectives and are not benchmarked against other organisations. As with the externally benchmarked metrics, the plan is to move to SPC analysis, removing the RAG rating system allowing for more meaningful assessment of performance and to provide greater assurance around the ability of the services to achieve the target on a consistent basis.

The dashboards do not identify any ranking of metrics. The objective is to achieve a comprehensive set of consistently achieved indicators on a sustained basis.

The monthly Performance Management Report includes a high-level summary that draws out the key metrics used externally to assess the Trust performance. The framework recognises that although these external metrics are an important element of performance management the more fundamental objective is to ensure strong and effective management against the broad range of organisational objectives.

8.2.4 Data Quality and timeliness

The performance framework is dependent on operational managers having access to accurate information within a reasonable timeframe. It is the responsibility of the information department to ensure information is available, identify data quality concerns and implement action plans to improve data quality. Where there are concerns that data quality or timeliness may impact on the Trusts reported performance this will be highlighted in the monthly performance report.

The Data Quality Improvement Group is a formal Sub Committee of the Audit Committee includes representatives from Quality Directorate, Performance and Information and Clinical Services

The aims are:

- to provide additional in depth assurance regarding data quality
- scrutinise areas of concern
- target areas for improvement and drive delivery
- quantify and monitor improvement in data quality

In conclusion, during 2020/21 the Trust will move away from the RAG rating system towards comprehensive use of SPC analysis to determine an overall picture of performance.

9 Performance Management

Performance management will be organised through two key mechanisms.

- Monthly Performance Assessment and
- Six Monthly Strategic Reviews

The principle of the performance management system is that delivery of performance metrics and planning of improvements to meet the requirements of these metrics is devolved to operational services. Where performance deviates from the required levels, recovery plans may be required. During 2020/21, a different approach to the assessment of whether a recovery plan is required.

Where appropriate, operational services will work together with other partners and service providers to produce recovery plans. The criteria for recovery plans are laid out in detail at Section 9.1 below. These recovery plans are then presented to either the Finance & Performance Committee, Quality Assurance Committee or the People Committee. The Committee with responsibility for the oversight and scrutiny of the recovery plan is clearly identified at the point where the plan is initiated. Appendix II references the Committee that has responsibility for each metric. Appendix III references the Trust Board Committees and provides an indication of how the Performance Management Framework connects to each.

9.1 Monthly Performance Assessment

Monthly Performance Dashboards will be published showing the status of all relevant metrics.

When a metric is green or the SPC analysis shows that the data is within the parameters of normal variation, the Service Delivery Unit (Team/Ward) does not need to take any specific action. In the event that the SPC analysis identifies four successive points of deterioration, even though the metric RAG rating remains green, an explanation for the downward trend will be required. In the event that seven successive points of deterioration occur, triggering the SPC icon, a formal recovery plan will be required, even though the indicator remains rated as green. A performance recovery plan template is provided in Appendix IV.

When a metric is amber the Service Delivery Unit must consider the current position, review trends. As with the explanation above, should four successive points of deterioration be identified, consideration should be given to the reasons behind such a downturn. No formal recovery plan will be required until the SPC icon is triggered by seven successive points of deterioration. Similarly, if the SPC data suggests that the system has limited chance of achieving the overall target, the Service Directorate will be asked to identify what, if any, actions need to be taken to ensure achievement of the target.

The recovery plan may cover a period greater than one month, where this is the case there must be a forecast position for each interim month. If a metric is Amber detailed actions are reported in the Integrated Governance meeting. Assurance shall also be given to the Finance Performance, Quality and Safety and People Committees that any areas of sustained amber performance are being addressed.

When a metric is Red, the metric will be firstly considered by the Integrated Governance Meeting chaired by Director of Operations. The escalation process for the recovery plan is then determined based on the Level of Metric.

9.1.1 Level 1 Metric – New Recovery Plan

This relates to any national or contractually agreed local metrics. This will cover those metrics

contained within the NHS Improvement performance regime, CCG and NHS England contracts.

All level 1 metrics are covered by SPC based analysis. In the event that an alert is triggered, the Committee with responsibility for the indicator will be asked to consider whether a formal recovery plan is required. This is communicated via the cover sheet of the report to the Committee. It may be that work to improve performance is already taking place via a parallel piece of work, and as such, a recovery plan would be a duplication of work. A current example of this relates to the staff turnover metric and the Aspire programme of work, where a recovery plan would largely be a replication of the Aspire programme plan.

An alert would be triggered by:

- Four consecutive data points showing deterioration even though the target is being achieved;
- A special cause variation, where at least one data point falls outside of the upper or lower control limit;
- Data shows that the metric is consistently not being met;

In the event that the Committee require a recovery plan to be developed:

- This would be communicated to the relevant Service Directorate Lead(s), who would then look to pull together the recovery plan;
- The Head of Performance will review formal recovery plans and where appropriate work with Service Directorate Leads to strengthen the plans;
- The formal recovery plan will then be discussed at the Integrated Governance Meeting on the 3rd Wednesday of the month. This needs to be circulated to members of this meeting at least a week before.
- The Integrated Governance Meeting will discuss the Recovery Plan and sign off or make recommendations on changes that need to be made
- Final signed off versions of the Recovery Plan will need to be available by lunch time on the following day after the Integrated Governance Meeting
- The Recovery Plan will be then sent, as appropriate, to the responsible Committee as outlined within Appendix II.
- An Operational Lead with Responsibility for the Recovery Plan will be required to attend the relevant Committee meeting to present the recovery plan.
- Given the profile of Level 1 Metrics, the issue of the failing metric will be formally raised as part of the Trust Board Performance Report by the Director of Finance and the Director of Operations.
- The board will decide if it is content for the committee to oversee the delivery of the plan during the next 3 months or whether the oversight will be retained by the Trust Board.

9.1.2 Level 2 Metrics – New Recovery Plan

This covers any other metrics on the Performance Report not covered by level 1 Metrics. The recovery plan process for these metrics is by default left at an operational level but could be escalated to the formal mechanism if requested by committee.

If a metric is a level 2 Metric, the process for 3 consecutive months red (Or given the move to SPC analysis, the criteria outlined above for level1 metrics) is as follows: -

- On receipt of the Integrated Governance Meeting Papers on the second Thursday of the month, Service Directorate to review their performance against their metrics.
- If the Service Directorate have a level 2 Metric that is now showing red for a third consecutive month, a detailed recovery plan plans will be drafted by the Service

Directorate Operational Lead

- The Recovery Plan needs to set trajectories that are achievable and outlines a set of detailed actions.
- The Associate Director of Contracting, Information and Performance will review recovery plan and where appropriate work with Service Delivery Unit Leads to strengthen the plans. The draft recovery plan will then be discussed at the Integrated Governance Meeting on the 3rd Wednesday of the month. This will need to be circulated to members of this meeting at least a day before.
- Integrated Governance Meeting will discuss the Recovery Plan and sign off or make recommendations on changes that need to be made

It should be noted that the Chair of either the Finance and Performance Committee, Quality Assurance Committee or People Committee can request a Level 2 metric in order that the metric receives additional scrutiny by the Committee; however, it is unlikely that a metric with a lower profile would be escalated to Board level unless it was deemed necessary that Board input and / or the allocation of additional resources would be required to return performance back to the required level.

9.1.3 Chair's Prerogative (Members, via the Chair)

Notwithstanding the processes outlined above, the Chair of the Board, the Finance and Performance Committee, Quality Assurance Committee, People Committee and the members of any of these forums can request additional information around the performance of a metric or request that a recovery plan be constituted. The management of these plans will be in line with the requirements outlined for Level 1 and Level 2 metrics.

9.1.4 Monthly Monitoring of Recovery Plans

The monitoring of recovery plans on a month by month basis will be undertaken by the Integrated Governance Meeting. Similar detailed scrutiny will take place at the Service Directorate specific performance meetings.

The Finance & Performance Committee, Quality Assurance Committee and People Committee will receive the initial copies of the recovery plans and subsequent updates at appropriate times in accordance with the specific trajectories contained within the plans. Monthly progress against the trajectory for all recovery plans is routinely included within the performance report. Service Delivery Unit Leads and corporate directorates will be required to outline the remedial actions that are included within the plans. Additionally, commissioners can request to have sight of the recovery plans to assess the remedial action that is being taken. In the event that recovery plans are failing to deliver to the trajectory outlined within the plan, an updated version will be required to be produced.

It is recognised that performance metrics cannot cover every aspect of the organisation; similarly, the assessment of the organisation against metrics presents risks in itself as not every aspect of the organisation is subject to performance metrics. The principle that has been adopted is that for every Trust objective there will be several metrics that provide some insight into how the organisation is performing against the overarching objective. In developing recovery plans it will be essential to consider the overarching objective not just the detail of the metric.

9.1.5 Risk management

It may be appropriate to record issues that are the subject of recovery plans on the appropriate risk register. The team producing the recovery plan should consider the guidance on registering risks at the time the recovery plan is developed.

9.2 Six Monthly Strategic Reviews

9.2.1 Purpose of 6 Month Strategic Reviews

Strategic reviews represent an important element of the Trust accountability framework. The process is essential to ensure that the executive team is able to discharge their duties in terms of highlighting potential risks to the Trust Board and assuring the Trust Board that progress is being made against agreed objectives.

The six monthly strategic reviews aim to consider the Service Directorate in the round during which the Service Directorate Team are invited to provide an insight into successes and challenges experienced in the 6 month period since the last review against the broad headings of Finance, Quality (Including Workforce) and Performance. This allows for specific areas to be identified and a focussed dialogue to take place.

Appendix I Glossary of Terms

ACP	Accountable Care Partnership
AWOL	Absent without Leave
CCG	Clinical Commissioning Group
CIP	Cost Improvement Plan
CQC	Care Quality Commission
CPA	Care Programme Approach
CRHT	Crisis Resolution Home Treatment
DNA	Did Not Attend
EI	Early Intervention
FRR	Financial Risk Rating
FT	Foundation Trust
HCAI	Healthcare Associated Infections
HoNOS	Health of the Nation Outcome Scales
ICSs	Integrated Care Systems
KPI	Key Performance Indicator
MHMDS	Mental Health Minimum Dataset
MIU	Minor Injuries Unit
NHSE	NHS England
NHSI	NHS Improvement
OAPs	Out of Area Placements
PBR	Payment By Results
PDR	Personal Development Review
RAF	Risk Assessment Framework
RTT	Referral to Treatment
SMT	Senior Management Team
SPC	Statistical Process Control

Appendix II Monitoring Targets

(below is an example KPI list under development)

Level 1 Reporting Trust Board						
Metrics	*NHS Improvement*	*NHS England*	*Local Authority*	*Clinical Commissioning Groups*	*Local*	*Responsible Committee*
People with a first episode of psychosis begin treatment with a NICE recommended package of care with 2 weeks of referral	*Y*			*Y*		FPC
Patients on Care Programme Approach Discharged from MH Inpatient Care who are Followed-Up within 7 Days	*Y*			*Y*		FPC
Number of admissions to Adult Mental Health Facilities for patients aged under 16	*Y*			*Y*		FPC
MIU - < 4 hours from arrival to admission/transfer/discharge	*Y*			*Y*		FPC
• Data Quality Maturity Index (DQMI) – MHSDS dataset score	*Y*			*Y*		FPC
IAPT – The proportion of people who have depression and/or anxiety disorders who complete treatment and who move to recovery	*Y*			*Y*		FPC
IAPT -Waiting Times to begin treatment • Within 6 weeks • Within 18 weeks	*Y*			*Y*		FPC
IAPT – Access Rates – Patients receiving Psychological Therapies	*Y*			*Y*		FPC
Ensure that Cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas • Inpatient Wards • Early Intervention in Psychosis Services • Community Mental Health Services (people on CPA)	*Y*					FPC
Maximum time of 18 weeks from point of referral to treatment in aggregate - non admitted – Patients on an incomplete pathway	*Y*			*Y*		FPC
RTT Over 52 weeks waiters				*Y*	*Y*	FPC
Proportion of Adults on Care Programme Approach receiving Secondary MH Services in Settled Accommodation	*Y*			Y		FPC
Proportion of Adults on Care Programme Approach receiving Secondary MH Services in Employment	*Y*			Y		FPC
Patient on CPA who had a CPA Review within the last 12 months				Y	*Y*	*FPC*
Inappropriate out-of-area placements for Adult Mental Health Services (Total Number of Bed Days	*Y*				*Y*	*FPC*
Mental Health Delayed Transfers of Care - Consultant Beds and NHS Responsible Delays			*Y*	Y	*Y*	*FPC*
Community Hospitals Delays Transfers of Care – Consultant Beds and NHS Responsible Delays	*Y*		*Y*	Y		*FPC*
Mental Health Clustering				Y	*Y*	*FPC*
Mental Health Clustering Reviews				Y	*Y*	*FPC*
Proportion of Temporary Staff	*Y*					*FPC*
Aggressive Cost Reductions plans	*Y*					*FPC*
Financial Risk - Liquidity Rating	*Y*					*FPC*
Financial Risk -Capital Servicing Capacity Metric	*Y*					*FPC*
Financial Risk -I&E Margin Rating	*Y*					*FPC*
Financial Risk-Distance from Plan Rating	*Y*					*FPC*
Financial Risk -Agency Metric	*Y*					*FPC*
Financial Risk -Use of Resource Rating	*Y*					*FPC*
Financial Risk – Capital Servicing Score	*Y*					*FPC*
Clostridium Difficile –Variance from Plan	*Y*			Y		*Q&S*
Clostridium Difficile –Incidence Rate (Monthly Trajectory)	Y			Y		Q&S
Incidence of MRSA	Y			Y		Q&S

Level 1 Reporting Trust Board							
Metrics	*NHS Improvement*	*NHS England*	*Local Authority*	*Clinical Commissioning Groups*	*Local*	*Responsible Committee*
Never Event Count	Y			Y		Q&S
VTE Risk Assessment	Y			Y		Q&S
Inpatient Score from Family and Friends Test - % Positive	Y					Q&S
FFT – Minor Injury	Y					Q&S
FFT – Mental Health	Y					Q&S
FFT - Community	Y					Q&S
Mixed Sex Accommodation Breaches (number)	Y					Q&S
Safety Thermometer - % of patients free from Harm	*Y*					*Q&S*
% of Incidents in categorised as resulting in moderate harm, severe harm or death	*Y*			*Y*		*Q&S*
Number of admissions to Adult Mental Health Facilities for patients aged under 16	*Y*			*Y*		*Q&S*
Number of avoidable grade 3&4 pressure ulcers	*Y*			*Y*		*Q&S*
Number of Prone Restraints	*Y*					*Q&S*
Staff FT response rate	*Y*			*Y*	*Y*	*Q&S*
Number of Complaints upheld by the Ombudsman	*Y*					*Q&S*
Number of Complaints	*Y*			*Y*		*Q&S*
Staff FFT Percentage Recommended - Care	*Y*					*WF*
Staff FFT Percentage Recommended - Work	*Y*					*WF*
Trust Turnover Rate (monthly)	*y*					*WF*
Trust Vacancy Rate					*Y*	*WF*
Trust Level Total Sickness rate	*Y*					*WF*
Executive Team Turnover					*Y*	*WF*
Workforce WTE					*Y*	*WF*
% Uptake of Mandatory Training over previous 12 months					*Y*	*WF*
% staff with completed appraisals over previous 12 months					*Y*	*WF*

Level 2 and 3 Reporting Trust Board Committees and SMT	***Includes all Level 1 metrics and the following metrics***						
Metrics	*NHS Improvement*	*NHS England*	*Local Authority*	*Clinical Commissioning Groups*	*Local*	*Responsible Committee*
18 Week Waiting Times Community Care Therapy and Nursing Services				Y	y	FPC
18 Week Waiting Times Children's Services			Y		Y	FPC
Mental Health Waiting Times				Y	Y	*FPC*
Completion of a valid NHS Number field in MIU Commissioning data sets submitted via SUS.			Y	Y	Y	FPC
18 Weeks - Consultant Led Dental Waiting Times		Y			Y	FPC
Community Hospital Delay Transfers of Care – All Delays				Y	Y	FPC
OAMH Delay Transfer of Care -All Delays				Y	Y	FPC
Adult Mental Health Delay Transfers of Care – All Delays				Y	Y	FPC
Enhanced Care Response Times within 4 hours				Y	Y	FPC
Infection Control E. coli				Y	Y	FPC
OAMH Consultant Led Outpatient DNA Rates					Y	FPC
Community Hospital Consultant Led Outpatient DNA Rates					Y	FPC

Dental DNA Rates					Y	FPC
Community Hospital Bed Occupancy Rates				Y	Y	FPC
Inpatient - Admissions and Discharges			Y	Y	Y	FPC
AMH & OAMH – Service Users with a Direct Payment (snapshot)			Y			FPC
AMH & OAMH – Safe Records dataset (Missing Data)			Y			FPC
AMH & OAMH – Uncompleted Episodes over 3 months			Y			FPC
AMH & OAMH – Carers Assessments and Reviews			Y			FPC
AMH & OMAH - % of clients in Service for 12 months or more and reviewed in last 12 months			Y			FPC
Percentage of social care clients with services for a year or more reviewed in the last 15 months (Overdue reviews)			Y			FPC
ASCOF 2B Performance – Proportion of Older People 65+ still at home 91 days after completing reablement/rehabilitation services following a hospital discharges			Y			FPC
Breast Feeding at 6-8 weeks Prevalence and Coverage			Y			FPC
Percentage of Births that receive a New Birth Visit within 14 days by a HV			Y			FPC
Percentage of face to face New Birth Visits by a HV – no result			Y			FPC
Percentage of Children who received a 12 month review by the time the turned 12 months			Y			FPC
Percentage of Children who received a 2-2.5 year review			Y			FPC
AWP Vasectomy Waiting Times for Counselling and Procedures			Y			FPC
Sexual Health - GUM Clinic Patient Seen within 48 Hours of Initial Contact (YTD)			Y			FPC
Percentage of all under 25 yr olds seen/screened for Chlamydia			Y			FPC
Percentage of people offered an appointment or offered the opportunity to attend a walk in session, within 48 hours of contacting level 3 provider			Y			FPC
Level 2 and 3 Reporting Trust Board Committees and SMT	***Includes all Level 1 metrics and the following metrics***					
Metrics	*NHS Improvement*	*NHS England*	*Local Authority*	*Clinical Commissioning Groups*	*Local*	*Responsible Committee*
Percentage of users experiencing waiting times in walk-in clinics of >2 hours			Y			FPC
Percentage of clients waiting longer than 30 mins attending booked clinics level2/3 services within specialised services			Y			FPC
Number of Episodes of Absence without leave (AWOL) for patients detained under the Mental Health Act 1983			Y		Y	FPC
The number of admissions to the Trust's acute Mental Health wards that are gate kept by the crisis resolution home treatment team	Y			Y	Y	FPC
Patients on a new Care Programme Approach who have had a HoNOS assessment in the last 12 months				Y	Y	FPC
Average Length of Stay - Inpatients			Y	Y	Y	FPC
Percentage of Patients with a valid Ethnic Code				Y	Y	FPC
Infection Control – E.coli				Y	Y	Q&S
Total Number of Grade 2 Pressure Ulcers acquired in our Care				Y	Y	Q&S
% of Falls incidents categorised as resulting in moderate harm, severe harm or death					Y	Q&S
% medication errors categorised as resulting in moderate harm, severe harm or death					Y	Q&S
Ulysses - % Incidents completed within 20 days					Y	Q&S

Clinical Audits that are running to plan					Y	Q&S
Number of serious incidents in month					Y	Q&S
Serious Incidents investigations opened for > 60 days				Y	Y	Q&S
Number of Complaints in Month re-opened					Y	Q&S
Numbers of Complaints received relating to staff attitude or behaviour					Y	Q&S
Number of Compliments in Month					Y	Q&S
Rolling 12 Month Sickness Absence Rate (Monthly)				Y		Q&S
Infection Control Training Update – All Staff Groups				Y		WF

Level 4 Reporting Operational Meetings	***Includes all Level 1, 2 and 3 metrics and the following additional metrics/dashboards***						
Metrics		*NHS Improvement*	*NHS England*	*Local Authority*	*Clinical Commissioning Groups*	*Local*	*Responsible Committee*
Crisis and Emergency Service Directorate dashboard						*Y*	*FPC*
Scheduled and Planned Service Directorate dashboard						*Y*	*FPC*

Appendix III Trust Board Committees

There are seven formal committees of the Board their role is described below along with an indication of how the Performance Management Framework connects to each.

Committee	Role	Relationship with Performance Management Framework
Finance and Performance	The Finance and Performance Committee is a committee of the Sheffield Health and Social Care NHS Foundation Trust Board. The Committee is constituted in line with the Standing Orders of the Trust and will operate in strict accordance therewith. To report to and provide the Board with the assurance that: • The Trust's financial strategies and plans are being implemented • the Trust is financially resilient and sustainable • The Trust's performance, as identified through an agreed set of Key Performance Indicators, is being monitored and managed.	Receives Performance Indicator Schedule showing status for each Business unit and the Trust overall position. Receives Recovery Plans where metrics have been red for three consecutive months Agrees performance targets Relating to specific objectives • Deliver financial breakdown • Deliver agreed activity levels • Maximize efficiency of workforce. • Effective management of clinics • Effective management of care pathways • Information complete Agrees summary report to be submitted to Trust Board.
Audit & Risk Committee	The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.	Agreement that Performance Management Framework delivers appropriate controls. Audit effectiveness of Performance Management Framework. Scrutinise Data Quality
Quality Assurance Committee	The Quality Assurance Committee is a committee of the Board of Sheffield Health and Social Care NHS Foundation Trust (the Trust). The Committee is constituted in line with the Standing Orders of the Trust and will operate in strict accordance therewith. The Quality Assurance Committee's prime responsibility is to ensure that governance requirements, other than those for which the Audit Committee is responsible, are complied with and delivered. The Quality Assurance Committee is a key component of the Trust's integrated governance arrangements and will liaise with the Audit Committee. The committee will also act as a conduit for ensuring all elements of quality and safety are considered	Receives Performance Indicators relating to quality Agrees performance targets relating to quality. Monitors objectives relating to quality
People	The People Committee is a committee of the Board of Sheffield Health and Social Care NHS Foundation Trust (the Trust). The Committee is constituted in line with the Standing Orders of the Trust and will operate in strict accordance therewith.	Receives Performance Indicators relating to workforce metrics Receives Recovery Plans where metrics have been red for three consecutive months

Committee	Role	Relationship with Performance Management Framework
	The committee will act as a conduit for ensuring all matters regarding our workforce are duly considered. The committee's prime responsibility is to ensure that all workforce governance requirements are complied with and delivered. The People Committee is a key component of the Trust's integrated governance arrangements and will liaise with the Audit, Finance and Performance and Quality Assurance Committees as required.	
Mental Health Legislation Committee	Mental Health Legislation Committee is responsible for providing assurance to Trust Board that we are acting lawfully and appropriately relating to our usage of the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards. They monitor trends and themes arising from these Acts and consider data relating to complaints, incidents, claims and triangulate with other sources of data. The Committee also includes our Associate Hospital Managers who discharge the powers of the Hospital Managers on behalf of the Trust relating to the Mental Health Act. The Committee meets 4 times a year.	No direct role
Remuneration	To manage the appointment of the Chief Executive and oversee arrangements for the appointment of Executive Board members. [(Note: The appointment of the Chief Executive and Executive Directors of the Trust shall be in accordance with 1.3.2.5 of the Scheme of Delegation (Derived from the Codes of Conduct and Accountability)]	No direct role

Appendix IV – Recovery Plan Template

Service Delivery Unit		Aims & Objectives relating to this indicator	
Reportable Committee		Finance and Performance, Quality and Safety or People Committee	

Indicator	Month	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
	Trajectory												
	Actual												
Description of Issue													

Date		Version		Written by		Agreed by	

Actions	Responsible	Date	Update	Date

Appendix V – A Guide to Using SPC Charts and SPC Icons

SPC charts (Statistical Process Control Charts) are used to measure changes in data over time. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes worth investigating (Extreme values) from normal variations.
The charts consist of;

- A line graph showing the data across a time series. The data can be in months, weeks, or days- but it is always best to ensure there are at least 15 data points in order to ensure the accurate identification of patterns, trends, anomalies (causes for concern) and random variations.

- A horizontal line showing the Mean. This is the sum of the outcomes, divided by the amount of values. This is used in determining if there is a statistically significant trend or pattern.

- Two horizontal lines either side of the Mean- called the upper and lower control limits. Any data points on the line graph outside these limits, are 'extreme values' and is not within the expected 'normal variation'.

- A horizontal line showing the Target. In order for this target to be achievable, it should sit within the control limits. Any target set that is not within the control limits will not be reached without dramatic changes to the process involved in reaching the outcomes. Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies. Identifying patterns

- Normal variation- (common cause) fluctuations in data points that sit between the upper and lower control limits that do not reach the criteria for a Trend.

- Extreme values- (special cause) any value on the line graph that falls outside the control limits. These are very unlikely to occur- and where they do, there is likely a reason or handful of reasons outside the control of the process behind the extreme value.

- A Shift- a trend may be identified where there are 7 consecutive points in either a pattern that could be; a downward trend, and upward trend, or string of data points that are all above, or all below the mean. A shift would indicate that there has been a change in process resulting in a change in outcome. E.g., on an SPC chart showing patient waiting times; there may be a run of 7 points below the mean. This indicates that there has been a change in the process- such as there are more appointment slots available than what there was previously (this would reduce the waiting times). This could be down to something like there has been a new member of staff recruited (increasing the potential appointments available), or appointment times have been shortened (meaning that more appointments can be booked in the same period). Icons are used throughout this report either complementing or as a substitute for SPC charts.

The guidance below describes the meaning behind each icon.

SPC Explained

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

	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.

Development of Performance Framework – First Draft
Consultation Comments

Finance & Performance Committee – July 2020
Quality Assurance Committee – September 2020
People Committee – September 2020

From	Comment	Action	Complete
1)	Generally – this process - which is definitely necessary – implies a significant shift to the primary emphasis of FPC being on performance, and is a decisive shift away from its earlier Finance and Investment function. It also moves us into a central performance management role rather than the previous one of considering and approving (or not) papers (I know I'm caricaturing a bit here). The proposed KPI has FPC routinely monitoring 66 performance measures which are heavily focused on NHSi and CCG targets.	Ensure FPC role is clear a) Responsible for ensuring Performance framework is in place, assurance role to board re system and process b) Oversee Financial performance KPIs and other KPI relevant for committee if applicable (Estates, IT strategy) Review KPI list and ensure 66 KPIs reflects intention – once finalised	Complete
2)	Our ToR, agendas and membership will need review in this light. I'd also want clarity on how we manage and agree monthly performance indicators if we don't meet monthly – which we have said we don't necessarily want to do.	KPI agreement will be annual process, through committee onto Board. Oversight of those can be flexed if assurance is high. i.e. Committee may not need to meet monthly if everything is highly assured but may increase frequency Check process is clear in performance framework	FPC agree Complete
3)	P5 – strategic review – when do committees and Board set these The care networks should be defined in the guidance	Executive led, (formally service reviews) ? consider feeding through for assurance, is the request this is board led? Could create annex, wanted to avoid too many links to other corporate docs to minimise version updates but can see benefit here.	

		Further discussion with execs on service reviews (cum strategic review)	
4)	P13 – fig 1 – there are lines missing from Board committees to assurance, and on the far right boxes - Should the Transformation Board be on this chart - IG sub committee – what is it a sub committee of?	Word version is complete. Checked PDF for FPC and this does look odd. Could add to show assurance route on transformation.	Complete
5)	P19 – would QAC also have full performance report to Care Network level	Need to develop team to Board and exception reporting including hotspots Not the current intention but open for discussion	Complete
6)	P20 – could we have a flow chart for the monthly cycle IG meeting – committees – Board	Diagram on pg 13intends to reflect flow etc, is it something more specific i.e dates etc or is current diagram not achieving desired impact. (Also p4 14) Can incorporate simpler diagram on team to Board.	FPC to confirm Complete
7)	P21 - as previously stated, I understand the use of the assurance terms, but find them hard to relate to, with an apparent focus entirely on 'controls'. Is there wording or methodology here that could be more widely used Who puts plans in place around levels of assurance Is there clarity on cycles and timing – if Board and FPC review the same data, does FPC always do it first (back to my monthly meeting issues)	Consider Board development frame here (Red arrows) this is that Cycles will be reviewed as part of well led. It needs to function FPC - BoD	Complete
8)	P34 - How does FPC agree summary report to go to Board	Think this process will develop over time. Hard to see now given lack of current assurance and additional detail required for board. Initially FPC will agree any revised summary format. i.e assure process Monthly FPC review, like with significant issues report FPC can sign off Key issues for escalation etc to be included in report.	FPC to Confirm Complete

		Expectation ratify and refine what is provided	
9)	Page 13 structure chart - I don`t quite understand what the function of the Integrated Governance sub committee is - who would sit on it and exactly what its function is. You have a track note about its relationship with directorate management, but not regarding its relationship with FIPC and QAC.	I see this as an executive leg group that oversee the performance of the organisation at operational level. Execs discharge their responsibilities and confirm challenge content etc. Prior to any output to committees Also discussion forum for issues and future direction / development Need to consider new Clinical floor to Board and proposed Clinical Services review meeting, is this duplication? Corporate area?	
10)	Same page (text) what is the PMB?	Error changed	Compete
11)	The rest of my observations are really around the overall Governance review. Appendix II shows some developing KPIs where FIPC (as an example) would monitor some KPIs that presently are way outside FIPC`remit (eg waiting times/discharge rates etc) So are these just examples, or do we envisage the Committee roles fundamentally changing in some cases? This then would link to table on page 33 - some of these "purposes" would presumably need to be changed. However, that said, against FIPC 2nd bullet point re presenting true and fair view to Board - that would never be FIPC. It's actually ARC, but only annual via annual reports. So suggest this bullet point removed. True and fair view is an accounting term so I suggest omit.	Example is for illustration we do need to develop and continue to refine Some changes yes, its not unusual for some KPI that are seen as non-quality KPI being under the remit of performance and Finance committees, aligned to activity conversations which should be at FPC. They would still add value to QAC re full picture for safety but a key conversation for commissioners re demand management. T&F views – This is not meant in the context of annual accounts. But in the monthly financials represent an accurate picture. I'm happy to look at appropriate wording Review wording in FPC ToR and align	Changed wording to reflect financial resilience and assurance
12)	To add to this, it would help if you could walk us through some examples. One part I don't understand how it would work is the Integrated Governance sub committee. I just don't really understand what this	See 9) Discussed as a potential additional group when feeding into well led review work	Duplicate

	would do, who would be on it etc. I was also going to ask how this fits with the work being done by Charis consulting. Overall, happy that this is being developed.		
13)	Performance Management We have different styles, but it read better to me if we say 'sets out how we will manage our performance' … 'measuring our performance'… 'monitoring our performance' … managing our performance' etc.. makes it's a bit more about us and our actions? Do we want some messages re performance = delivering quality? Suggest switch in language from delivery of metrics to delivering standards of care etc	Will leave this for later re future development, I think this preferred narrative talks to Trusts current culture, but lets test in future re wider feedback. Could add Strategic objectives in under vision and create clearer link to that. (links to section 7.1) want to ensure we have quantified metrics	FPC to confirm Complete
14)	Page 4 final para No previous intro re a monthly process or description??	? under Performance management 3 paras up.	Complete
15)	Page 5 first para confirm that appropriate and necessary arrangements are in place to deliver the agreed objectives for the rest of the new financial year. Do you see this as kick starting April 2021?	TBC re covid 2nd wave and timing Narrative stands for framework	Complete
16)	Page 6 first para reference other areas of pm Why?? Personally, I don't think it is helpful to have 'performance' framed as something different to the quality, workforce, finance agendas etc? A fair bit of the rest of the doc. Covers quality and references finance etc??	Its trying to acknowledge scope, it covers key financial performance indicators, but doesn't go near SFIs etc. It covers quality KPI but not safe nursing practice etc The KPI list will define scope	Complete

17)	Page 6 – clarify external metrics Rather than external would 'national' be better? Clarifies the national standards that are set and apply to the services and care we deliver?	National doesn't cover, System and Place (Director of travel) in current arrangements doesn't cover CCG or LA commissioned metric See 24) below	Complete
18)	Page 7 PCNs Do they? Would move CQC up the list? Add Sheffield ACP??	PCS influential in prevention agenda, voice through CCG and in place. Its talking to agenda not just set KPIs. Added ACP & ICS, moved CQC up	Complete
19)	Page 7 care metrics Also SMS?	My view is implied in LA and social care (i.e. commissioned through LA	Complete
20)	Page 7 Public Health Were you thinking PHE or LA Public Health function?	Happy to leave off E to cover both but mainly PHE	
21)	Page 10 5th para final sentence ????	24/7 covers gp services (access at evenings and weekends) Also 7ds is viewed as been a system issue A key link is liaison 24/7 But acknowledge its primarily and Acute hospital agenda Delete if causing additional complexity or confusion	FPC to confirm Complete
22)	Page 11 3rd para "introduces the concept" Been around since 2016 as referenced above?	Segmentation in its current form hasn't but agree 'introduces the concept' is superfluous Changed wording	Complete
23)	Page 15 Quality Improvement Maybe move this bit to the end of this section so it flows as vision, values, strategic aims/ priorities, enablers and then this section re QI and the assurance strategy etc	Understand reasoning, moved	Complete
24)	Page 16 2nd para "shows the audience"	Changed to - shows the organisations that sets the metric	Complete

	Suggest… shows the range of national and local standards that relate to the services and care we provide and the body that we report to.		
25)	Page 24 9.1 Monthly Performance Assessment This section felt really complicated and found it hard to follow. What are you wanting to cover? How we assess performance each month, in which forums etc, who is reporting into who?? The triggers that will give something due attention The processes for triggering a recovery plan? Re the triggers, it was complicated re Red/Amber/ Green and then 4 or 7 points even if green What makes something amber?? (this maybe elsewhere, apols) What may work better is a simple table with one columns listing the triggers … green, green with 4 points, green with 7 points, SPV and then a column with the responses??	Next para Appendix for SPC simplifies, needs some refinement	
26)	Page 25 “An alert would be triggered by:” Alert is triggered Then there is the usual report to the committee Assume in the usual report there is discussion around the alert, views, work in hand and expectations etc? Would the report propose a recovery plan, recommend one is developed, or be silent and see what the		

	committee conclude and ask from the briefing provided??		
27)	Page 25 “In the event that the Committee require a recovery plan to be developed” (2nd bullet point) reference to Care Network Leads - Earlier you were saying service delivery units? Is that networks etc?	No Team/ Service	Complete
28)	Page 27 9.1.6 Relationship with the Local Authority And same for CCG?	Check and confirm requirements here deleted	Complete
29)	Page 27 9.2.2 Integrated Services Is this re delegated responsibilities etc?? I may be wrong, but I don’t think we have any re OA of LDS? Yes, we have some services that are commissioned in these areas by council but not any different to CCG commissioned stuff??	Agree deleted	Complete
30)	Just to say you’ve got some slight inconsistency in the box re Quality Assurance Committee on line it refers to Quality and Safety Committee.	Errors corrected	Complete