Brighton and Sussex University Hospitals NHS Trust

BSUH INTEGRATED PERFORMANCE REPORT

1) Responsive Domain
2) Safe Domain
3) Effective Domain
4) Caring Domain
5) Well Led Domain

RESPONSIVE DOMAIN

Metric	Defined by	Standard	Apr-16	May-16	Jun-16	16/17 Q1	Jul-16	Aug-16	Sep-16	16/17 Q2	Oct-16	Nov-16	Dec-16	16/17 Q3	Jan-17	Feb-17	Mar-17	16/17 Q4
Referral to Treatment - Admitted	NHSI	90%	69.11%	63.41%	65.33%	65.89%	64.00%	63.75%	64.53%	64.09%	65.39%	67.90%	70.73%	68.01%	67.61%			67.61%
Referral to Treatment - Non Admitted	NHSI	95%	76.06%	77.71%	74.97%	76.20%	75.88%	75.24%	76.24%	75.79%	77.58%	77.08%	80.26%	78.31%	81.39%			81.39%
Referral to Treatment - Incomplete	NHSI	92% (local 82.7%)	73.51%	74.77%	75.26%	75.26%	75.32%	75.10%	76.83%	76.83%	77.83%	80.06%	79.60%	79.60%	81.42%			81.42%
Incompletes 52+ week waiters	NHSI	0	100	87	92	92	211	226	184	184	185	161	150	150	152			152
Diagnostic Waiting Times	NHSI	1%	6.57%	2.57%	1.65%	1.65%	2.13%	2.84%	0.99%	0.99%	1.93%	1.06%	1.40%	1.40%	0.77%			0.77%
A&E: 4 hour waits (all types)	NHSI	95% (local 89%)	83.94%	86.25%	85.05%	85.12%	84.11%	81.16%	83.75%	83.03%	82.64%	82.13%	80.44%	81.76%	77.11%			77.11%
A&E: Total 12 hour waits from arrival (incls non DTA pts)	L	0	361	254	266	881	263	403	389	1055	439	506	529	1474	709			709
A&E: ambulance handover delays > 60 mins	L	0	51	77	56	184	97	139	96	332	175	170	197	543	302			302
A&E: 12 hour trolley waits	NHSI	0	11	4	2	17	0	1	1	2	1	1	6	8	28			28
Cancer Two Week Wait Standard	NHSI	93%	88.60%	93.80%	95.10%	92.60%	94.70%	94.10%	94.50%	94.40%	95.12%	94.10%	93.93%	94.39%	NYA			
Breast Symptom Two Week Wait	NHSI	93%	97.80%	94.80%	98.80%	97.30%	98.40%	96.60%	97.40%	97.30%	99.38%	98.91%	97.66%	98.65%	NYA			
31 Day Standard	NHSI	96%	100.00%	97.30%	99.10%	98.90%	98.40%	98.60%	98.20%	98.40%	98.59%	97.27%	97.18%	97.68%	NYA			
31 Day Subsequent Drug Standard	NHSI	98%	97.90%	97.60%	99.00%	98.30%	100.00%	100.00%	98.70%	99.50%	100.00%	98.20%	100.00%	99.50%	NYA			
31 Day Subsequent Surgery	NHSI	94%	95.70%	95.50%	100.00%	96.60%	91.30%	97.80%	97.80%	96.50%	92.10%	89.70%	96.60%	92.70%	NYA			
62 Day Standard	NHSI	85%	78.10%	77.20%	81.10%	78.80%	74.50%	74.70%	85.90%	78.20%	77.90%	76.50%	66.70%	73.90%	NYA			
62 Day Screening Standard	NHSI	90%	75.00%	66.00%	62.00%	67.90%	73.00%	87.50%	74.20%	78.00%	75.00%	96.60%	84.20%	85.30%	NYA			
Cancer 104 day waits	NHSI	0	8.5	7.0	5.5	21.0	11.0	10.5	8.5	30.0	11.0	7.0	6.0	24.0	NYA			
Cancelled operations (last minute non clinical reason)	NHSI	0	28	27	41	96	35	47	34	116	68	70	56	195	56			56
Number of patients not treated within 28 days of last minute	NHSI	0	7	2	3	12	2	8	2	12	8	2	5	15	8			8
Delayed Transfers of Care	NHSI	<3.5%	5.9%	6.7%	6.9%	6.5%	6.8%	7.4%	9.6%	7.9%	8.90%	9.51%	8.66%	9.02%	9.78%			9.78%

Lead : Chief Operating Officer - where forecast in red , significant risk of hitting year end standard and senior intervention involved (please see exception report for action)

Responsive

1a. Exception report : 18 weeks incompletes standard & 52 week waiters

Target description and performance

1. National standard = 92%

Local Trajectory or standard = 82.53% (5,856) by the end of February 2017

Actual performance = 81.25% (5,677) as of 9-2-17

2. Local standard of 0 x 52-week waiters by the end of March 2017

key issues

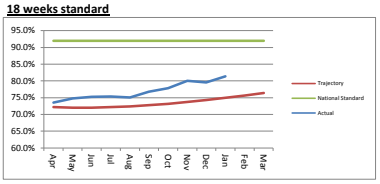
1. The trust is not achieving the national standard on RTT, but is on trajectory with it's recovery plan. We have an ongoing programme of work underway to ensure our reporting method for RTT follows national best practice, which includes a recalculation of the size of our waiting list. Following a significant increase in our backlog in August 2016, an extensive validation exercise has not identified any further significant problems. Validation will continue until April 2017.

2. We will not achieve the standard of zero 52+ week waits by 31 March 2017. At the end of January there were 150 patients waiting over 52 weeks, mainly in Digestive Diseases (DD). A trust level revised 52-week trajectory has been agreed with NHSi. There is a plan to treat the majority of the backlog of 37 Neurosurgery patients by 31st March. One Neurosurgery patient is currently booked into April, and we are searching for an alternative provider for 2 x Scoliosis patients due to a Consultant Surgeon resignation. The DD Directorate has a plan to tackle its backlog of 113 patients over 52 weeks by October 2017. The Directorate has agreed a start date in mid March 2017 for the additional capacity. Harm reviews for all patients treated after 52 weeks have been consistently implemented, and to date in 2016/17 15 cases needed detailed review, and some harm was found in three cases. From February harm reviews will be delivered for all patients at the

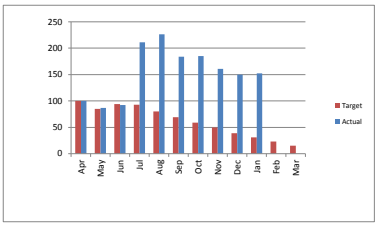
Action	Description	SRO	By when
Directorate level RTT trajectories have been reviewed to minimise premium rate clinical activity, and we are still projecting we will achieve our trajectory of 83.8% by the end of March 2017.	Specialty level activity and Patient Treatment Lists (PTLs) are reviewed at weekly performance meetings. Any deviation from plan is monitored and additional scrutiny, support and capacity identified as appropriate.	Shaun Carr	Weekly - ongoing
Review of RTT reporting to ensure we follow the national best practice methodology.	We aim to move to an 'open clock' method of reporting wait times, and validation is underway to ensure we have an accurate record of all patients on the waiting list. The validation exercise checks open clocks that are likely to be errors, before closing these clocks, and ultimately moving to a new and improved reporting process that makes PTLs accessible in real time.	Shaun Carr	The validation process is due to be completed by end of April 2017.

Trend Graph actual V target

18 weeks standard



52 Week waiters

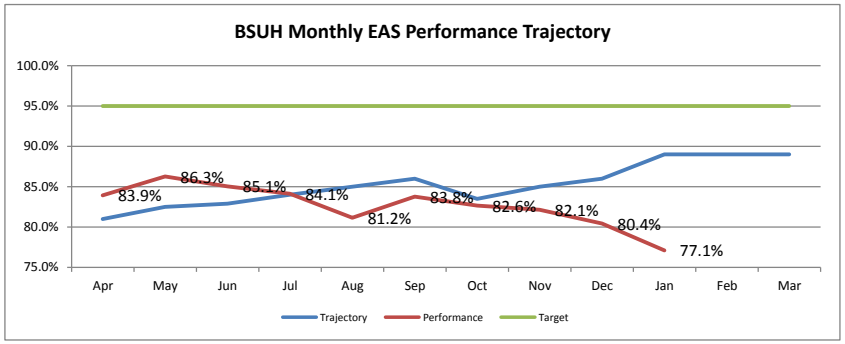


Responsive

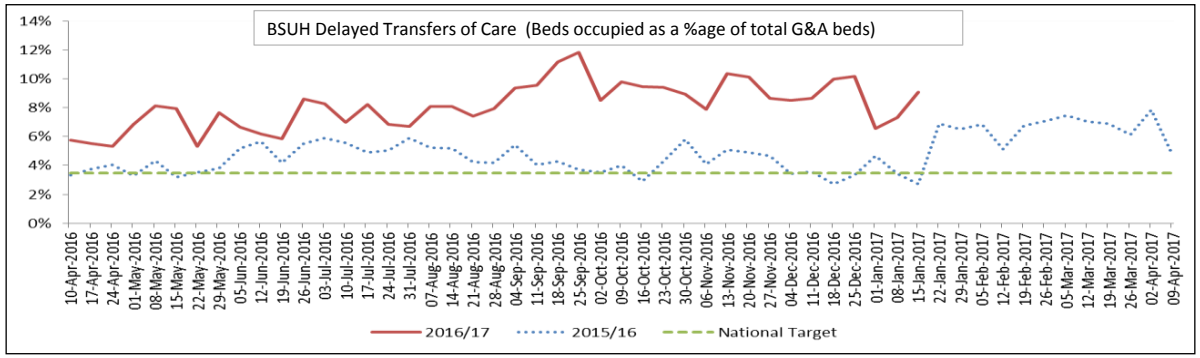
1b. Exception report : Emergency Access Standard

Target description and performance
1. National Emergency Access Standard = 95%
2. Local Trajectory or standard = 89.00% for Jan 2017
Actual performance = 77.11% for Jan-17

key issues
1. and 2. The driver of poor performance on this standard is overcrowding in ED at RSCH, caused by exit block. Exit from ED is blocked due to high bed occupancy - running at an average of 99%+ in January at RSCH. In turn this was caused by high levels of Delayed Transfers of Care (DTOCs). There were 90 DTOCs at the end of January (10.5% of beds occupied). Infrastructure failures in the Barry building exacerbated the problem for several weeks in January and caused 18 out of 28 12hr trolley waits in ED at RSCH. Ambulance handover performance deteriorated in January (276 ambulance handovers >60 mins in January compared with 180 in December 2016).



Action	Description	SRO	By when
Revised handover protocol with SECAMB, protect ambulatory and assessment space	New protocol in development to ensure rapid triage and handover, and avoid handover delays, funding for HALO agreed, Site coordination team to prioritise assessment space.	Mark Angus	End of February 2017
Transfer activity from RSCH to PRH and create ambulatory care space at PRH	At PRH: establish a medical day case unit, discharge lounge, transfer elective general surgery, open additional beds.	RMcE	Mid March 2017 at the latest
Creat bed capacity in the community	Extend the bed base at Newhaven downs from 12 to 20, increase hospital at home from 10 to 20 spaces	RMcE	Mid March 2017 at the latest



Responsive

3. Exception report : Cancer 62 days

Target description and performance

1. National standard = 85%

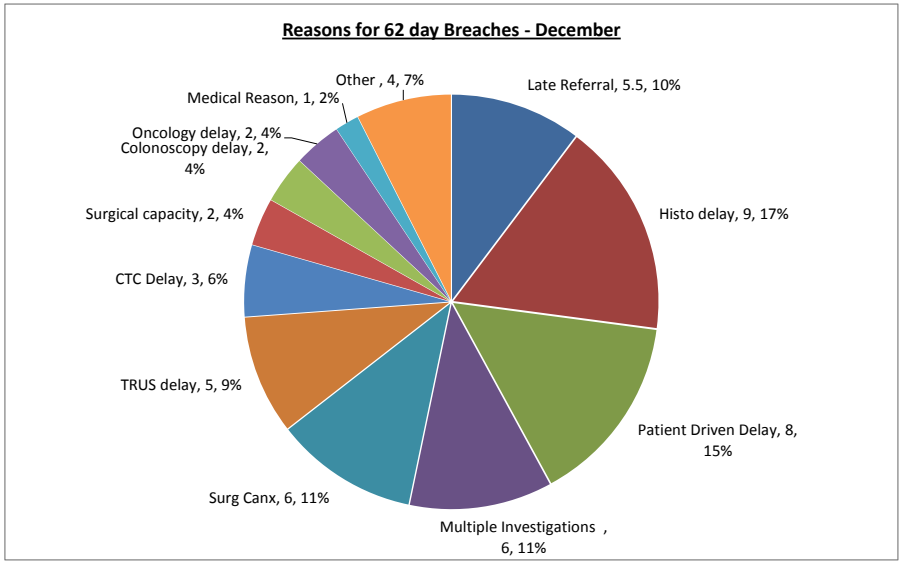
Actual performance = 66.7% in December 2017, and as of 17th February 2017 the January position was 74.4%

key issues

1. The trust is not achieving the national standard on cancer 62 days, but has a plan to deliver from April 2017 onwards. Of 108 patient pathways completed in December, The breaches in Head and Neck were due to surgical capacity and late referrals from East Sussex, In Urology and colorectal the issue was largely diagnostic delays, and in Gynae the issue was 4 late referrals from East Sussex. 5.5 of our December breaches were referred to BSUH after the breach date, and from 1st April 2017 there will be no shared breaches for late referrals. 7 patients waited over 104 days from referral to treatment. Harm reviews and RCAs were or will be

Action	Description	SRO	By when
Weekly cancer preformance meetings.	Specialty level activity and Patient Treatment Lists (PTLs) are reviewed at weekly performance meetings. Any individual patients identified at risk of delay to be expedited as appropriate. Extra capacity has been created to tackle diagnostic delays in TRUS, MRI, and CT colon.	Shaun Carr	Weekly - ongoing
A specific plan has been agreed following a review of the urology pathway to tackle a significant backlog in this specialty, and a trajectory agreed to clear the backlog by April 2017.	An additional 7 sessions per week of MRI for urology was implemented in January as planned, but the proposed increase in TRUS capacity was only possible from 1st February.	Shaun Carr	clearing the Urology backlog will cause us to breach the aggregate standard of 85% in February and March 2017, with compliance from April onwards.

	Total Seen	Number of Breaches	Performance
Brain	0.5	0	100%
Breast	15	0	100%
Gynaecology	6.5	4	38%
Haematology	2.5	1.5	40%
Head and Neck	13	10.5	19%
Colorectal	9.5	5.5	42%
Lung	7.5	2.5	67%
Skin	24.5	0	100%
Upper GI	7.5	2.5	67%
Urology	21.5	9.5	56%
Total	**108**	**36**	**66.7%**



SAFE DOMAIN

Metric	Defined by	Standard	Apr-16	May-16	Jun-16	16/17 Q1	Jul-16	Aug-16	Sep-16	16/17 Q2	Oct-16	Nov-16	Dec-16	16/17 Q3	Jan-17	Feb-17	Mar-17	16/17 Q4
C Difficile - number of cases	NHSI	46	4	2	2	8	7	3	9	19	5	4	4	13	4			4
MRSA Bacteraemia -	NHSI	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0
Never Events - number of	NHSI	0	0	0	0	0	0	0	2	2	0	3	0	3	0			0
Serious Incidents - number declared	L	Trajectory to be set	8	3	4	15	5	6	5	16	5	6	5	16	4			4
Patient Safety Incidents that are harmful	NHSI	Trajectory to be set	0.24%	0.12%	0.20%	0.19%	0.10%	0.10%	0.23%	0.14%	0.22%	0.23%	0.12%	0.15%	0.22%			0.22%
Medication Errors - causing serious harm per 1000 bed days	NHSI	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0
Medication Errors - number causing serious harm	L	0	0	0	0	0	0	0	0	0	0	0	0	0	0			0
Patient Falls - total number	L	Trajectory to be set	93	83	89	265	83	110	100	293	109	104	88	301	96			96
Patient falls - Sis	L	Trajectory to be set	3	1	1	5	5	3	2	10	3	2	0	5	0			0
Fire Risk assessments completed	L	100%		69%	73%	73%	100%	100%	100%	100%	100%	100%	100%	100%				
CAS Alerts - overdue alerts	NHSI	0	0	0	0	0	11	20	11	11	9	20	20	20	10			10
Hand Hygiene compliance	L	98%	93.00%	77.00%	71.00%	80.00%	80.00%	85.00%	64.00%		65%	67%	63%		64%			64%
Mean wait of patients in corridor area A&E (mins)	L	TBC					51	57	51	53	53	61	72	62	74			74
Max wait of a patient in corridor A&E (mins)	L	TBC					810	518	657	810	335	959	658	959	732			732
Avoidable Pressure Ulcers (category 3 & 4)	L	0	0	1	0	1	1	1	1	3	0	1	0	1	2			2
Histology reporting turnaround (% within 7 days)		80%	30%	26%	19%	25%	18%	33%	18%	23%	21.33%	15.36%	15.40%	17.36%	NYA			
Emergency C section rate	NHSI	<12%	15.09%	12.11%	12.03%	13.06%	12.50%	12.90%	13.60%	13.00%	13.0%	14.5%	18.7%	15.4%	20.2%			20.2%
VTE Risk Assessment	NHSI	95%	84.52%	85.46%	82.99%	84.32%	89.98%	88.69%	89.16%	89.29%	92.60%	92.60%	91.80%	92.30%	NYA			
% Harm Free Care	NHSI	95%	94.81%	94.90%	95.10%	94.94%	95.46%	95.78%	95.31%	95.50%	94.51%	94.66%	94.70%	94.58%	95.20%			95.20%

Lead : Medical Director and Chief Nurse

EFFECTIVENESS DOMAIN

Brighton and Sussex University Hospitals NHS Trust

EFFECTIVNESS DOMAIN

Metric	Defined by	Standard	Apr-16	May-16	Jun-16	16/17 Q1	Jul-16	Aug-16	Sep-16	16/17 Q2	Oct-16	Nov-16	Dec-16	16/17 Q3	Jan-17	Feb-17	Mar-17	16/17 Q4
HSMR (All)	NHSI	<100	89.17	88.42	89.98	89.98	91.16	90.78	89.85	89.85	92.51	91.82	NYA	91.82	NYA			
HSMR (Weekends)	NHSI	<100	91.51	92.05	95.89	95.89	98.84	99.22	97.51	97.51	99.91	99.72	NYA	99.72	NYA			
SHMI	NHSI	<100	95.18	93.63	93.78	93.78	94.05	93.82	94.55	94.55	94.87	NYA	NYA	94.87	NYA			
Crude mortality (non elective pts)	NHSI	monitor	3.32%	3.37%	2.81%	3.16%	2.85%	2.72%	2.68%	2.75%	3.73%	3.57%	4.39%	3.90%	4.75%			4.75%
Emergency readmissions 30 days	L	10.50%	13.47%	14.34%	13.81%	13.88%	13.87%	13.35%	12.74%	13.33%	13.34%	NYA	NYA	13.34%	NYA			
A&E % patients who began treatment within 60 minutes (RSCH)	L	95.00%	48.6%	48.1%	49.8%	48.8%	48.1%	49.4%	51.6%	49.7%	49.5%	47.9%	51.8%	49.7%	49.7%			49.7%
Discharges before 10.00 AM (RSCH)	L	100% (1 per ward)				9%	8%	8%	11%		16%	14%	9%		NYA			
Avg LoS Variance from Acute Teaching Hospital	L	Var = 0	0.5	0.39	0.28	0.38	0.23	0.38	0.37	0.34	0.56	0.41	NYA	0.49	NYA			
DNA rate	L	<6%	8.22%	8.72%	8.80%	8.59%	8.80%	8.53%	8.72%	8.68%	7.98%	7.80%	8.02%	7.93%	8.05%			8.05%
Theatres Utilisation	L	85%	84.41%	84.89%	84.22%	84.50%	85.62%	83.65%	81.67%	83.59%	81.25%	83.49%	81.32%	82.08%	80.54%			80.54%
% of emergency # neck of femur receiving surgery within 48 hours	L	TBC	85.71%	87.50%	88.33%	87.26%	88.68%	80.85%	94.23%	88.16%	90.32%	NYA	NYA	90.32%	NYA			
Stroke patients > 90% on a stroke ward	NHSI/ CQC	80%	82.98%	82.46%	86.96%	84.00%	83.82%	86.44%	94.00%	87.57%	84.75%	92.16%	77.50%	85.33%	NYA			
Stroke % admitted directly to a stoke ward	NHSI/ CQC	90%	74.47%	64.91%	58.33%	65.79%	72.06%	77.97%	70.00%	73.45%	55.93%	64.71%	57.50%	59.33%	NYA			
Stroke patients scanned within 24 hours	NHSI/ CQC	50%	100.00%	100.00%	95.12%	98.32%	97.96%	100.00%	100.00%	99.31%	100.00%	97.67%	100.00%	99.18%	NYA			
Stroke % of high risk TIA treated in 24 hours	NHSI/ CQC	60%	100.00%	87.50%	78.95%	87.50%	85.71%	100.00%	77.78%	83.67%	94.74%	75.00%	88.24%	85.00%	88.46%			88.46%
Stroke % of low risk TIA treated within 7 days	NHSI/ CQC	100%	100.00%	92.00%	100.00%	98.06%	100.00%	96.55%	100.00%	98.78%	100.00%	92.00%	100.00%	96.97%	100.00%			100.00%
Lead Chief Nurse and Medical Director and COO																		

Brighton and Sussex University Hospitals NHS Trust

CARING DOMAIN

Metric	Defined by	Standard	Apr-16	May-16	Jun-16	16/17 Q1	Jul-16	Aug-16	Sep-16	16/17 Q2	Oct-16	Nov-16	Dec-16	16/17 Q3	Jan-17	Feb-17	Mar-17	16/17 Q4
FFT - Staff - % recommended as place to receive care	NHSI	95%				67.0%				63.0%	Quarterly - Q2 Latest Available				NYA			
FFT - Inpatient - % positive	NHSI	95%	95.9%	97.6%	94.8%	96.1%	96.0%	95.4%	95.9%	95.8%	95.3%	93.8%	94.0%	94.4%	95.9%			95.9%
FFT - A&E/WiC/MIIU - % positive	NHSI	95%	87.7%	87.0%	89.9%	88.2%	87.5%	86.6%	86.8%	87.1%	86.1%	88.1%	87.5%	87.2%	88.2%			88.2%
FFT - Maternity - % positive	NHSI	95%	90.6%	94.9%	94.7%	93.3%	96.8%	97.1%	91.3%	94.9%	92.0%	94.5%	94.5%	93.6%	94.7%			94.7%
Complaints responded to < 40 days	NHSI	90%	63.8%	74.4%	67.0%	68.1%	51.92%	45.86%	46.09%	47.67%	46.61%	72.22%	NYA	57.69%	NYA			
Number of complaints received	L	monitor	105	90	106	301	104	133	128	365	118	90	108	316	112			112
Outstanding complaints over 6 months	L	0						28	28	28	24	25	24	24	29			29
Re-opened complaints	L	<10%	11.4%	18.9%	10.4%	13.3%	11.5%	13.5%	6.3%	10.4%	7.6%	7.8%	10.20%	7.7%	7.1%			7.1%
Mixed Sex Accommodation breaches	NHSI	0	57	69	76	202	77	113	80	270	41	137	72	250	61			61

Comments

Lead : Chief Nurse

WELL LED DOMAIN

Metric	Defined by	Standard	Apr-16	May-16	Jun-16	16/17 Q1	Jul-16	Aug-16	Sep-16	16/17 Q2	Oct-16	Nov-16	Dec-16	16/17 Q3	Jan-17	Feb-17	Mar-17	16/17 Q4
Temporary staffing spend as a % of paybill	NHSI	<10%	7.18%	7.37%	6.27%	6.94%	6.01%	5.78%	7.01%	6.27%	9.22%	7.35%	7.25%	9.04%	8.13%			8.13%
Staff sickness	NHSI	<3%	4.27%	4.27%	4.28%		4.26%	4.24%	4.22%		4.25%	4.26%	4.26%		NYA			
Staff turnover	NHSI	<12%	12.81%	12.81%	13.17%		13.58%	12.90%	13.30%		13.40%	13.58%	14.00%		14.20%			
FFT - Inpatient - Response rate	NHSI	>35%	15.4%	15.4%	13.5%	14.8%	12.7%	11.3%	12.3%	12.0%	14.4%	11.6%	10.5%	12.2%	13.1%			13.1%
FFT - Staff - % recommended as place to work	NHSI	95%				48.00%				44.00%	Quarterly - Q2 Latest Available				NYA			
% of STAM training	L	>75%		49.00%	55.00%	55.00%	71%	61%	60%		60%	64%	64%					
% of IG training		95%			50.00%	50.00%	68%	67%	82%		86%	86%	86%					
% of Appraisals	L	100%	69.80%	70.60%	70.20%		70.40%	66.90%	71.90%		73.40%	75.70%	77.20%		79.20%			
6 week notice rostas			*Automated Reporting system to be estabilised*															
Safe staffing fill	NHSI	95%	96.84%	98.35%	98.23%	97.81%	96.20%	96.10%	94.77%	95.70%	95.31%	97.11%	95.54%	95.98%	98.17%			98.17%
% of bank staff	CQC	<15%	14.66%	14.88%	14.97%	14.84%	14.32%	14.83%	15.04%	14.73%	15.17%	13.41%	13.90%	14.16%	14.16%			14.16%
Pay actual £'000 - (Surplus) / Deficit		334,279 (Oct target 27,365)	28,968	28,625	29,027	86,620	28,369	28,444	29,130	85,943	29,179	29,260	28,790	87,229	28,817			28,817
Non Pay actual £'000 - (Surplus) / Deficit		197,197 (Oct target 16,166)	17,389	18,997	17,098	53,484	17,764	18,704	18,750	55,218	18,199	19,177	18,973	56,349	18,428			18,428
Income actual £'000 - (Surplus) / Deficit		-549,636 (Oct target - 45,829)	(44,229)	(44,058)	(51,275)	(139,562)	(43,738)	(46,117)	(45,332)	(135,187)	(46,019)	(46,926)	(46,027)	(138,972)	(45,969)			(45,969)
I&E Position £'000 - (Surplus) / Deficit		15,570 (Oct target 536)	4,703	6,386	(2,350)	8,739	5,281	4,087	5,585	14,953	3,860	4,007	4,557	12,424	4,077			4,077
CIP's		25,110 (Oct target 2,886)	1912	1304	1880	1,849	1694	1545	2,219	3,175	1,656	1,670	1,562	4,888	1,579			1,579
% Temporary Staff		TBC	7.40%	7.37%	6.84%	7.20%	6.01%	5.76%	7.09%	6.29%	9.22%	7.35%	7.21%	8.29%	8.37%			8.37%
% of agency Nurse		<1%	2.64%	2.21%	1.65%	2.17%	1.45%	1.59%	1.95%	1.66%	2.28%	2.09%	1.58%	2.19%	2.26%			2.26%
% of Nurse bank		TBC	7.82%	7.31%	8.12%	7.75%	6.50%	6.37%	8.85%	7.24%	12.49%	7.84%	7.59%	10.17%	9.61%			9.61%

Lead : Chief Nurse/ HR director/ COO

Well Led

2a. Exception report : Statuary and Mandatory Training

Target description and Actual

Description

National standard = 98% IG and 100% Appraisals
Local Trajectory or local standard = 80% Appraisals
Actual performance = Appraisals = 75.7% / IG = 86%

Root Cause - key issues

1) Data requiring cleansing

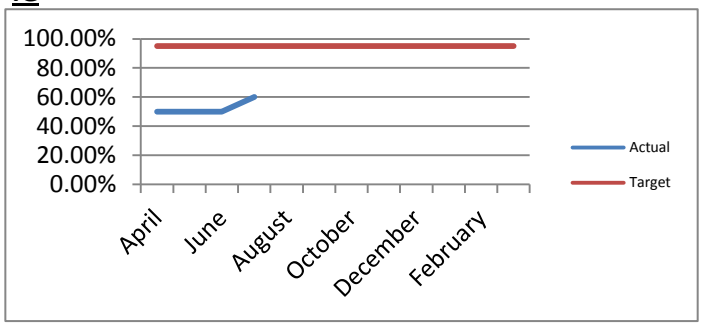
2) Ring fencing time especially when site under pressure

3) Expectation of roles and accountability

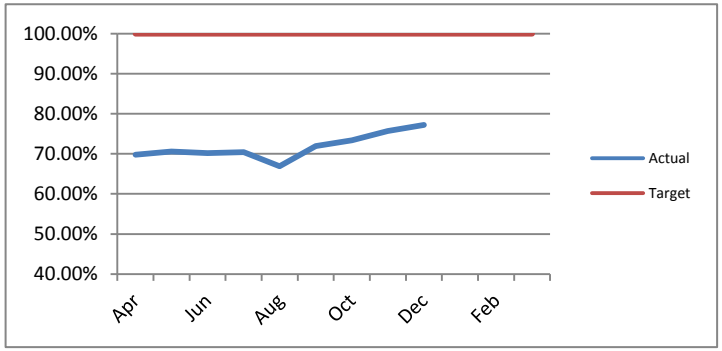
4) Access to Systems for some staff

Trend Graph actual V target

IG



Appraisals



Action	Description	SRO	By when
Data	Large data cleansing exercise underway during August /Sept	HW	September
Time ring fenced	Staff all given ring fenced time for training and appraisals	ALL	On going
Accountability	Reports at department level issued so clear who has not done training or undertaken appraisals. Performance management of this	All	On going
System	Staff to provide HR business partners any systems issues so these can be manually updated	ALL	On going