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	Nov	Dec	Qtr. 3
Referral to Treatment - Admitted	NHSI	90%	69.11%	63.41%	65.33%	65.89%	64.00%	63.75%						
Referral to Treatment - Non Admitted	NHSI	95%	76.06%	77.71%	74.97%	76.20%	75.88%	73.59%						
Referral to Treatment - Incomplete	NHSI	92% (local 82.7%)	73.51%	74.77%	75.26%	75.26%	75.32%	77.22%						
Incompletes 52+ week waiters	NHSI	0	100	87	92	92	211	225						
Diagnostic Waiting Times	NHSI	1%	6.57%	2.57%	1.65%	1.65%	2.13%	2.84%						
A&E: 4 hour waits (all types)	NHSI	95% (local 89%)	83.94%	86.25%	85.05%	85.12%	84.11%	81.16%						
A&E: Total 12 hour waits from arrival (incls non DTA pts)	L	0	361	254	266	881	263	404						
A&E: ambulance handover delays > 60 mins	L	0	51	77	56	184	97	139						
A&E: 12 hour trolley waits	NHSI	0	11	4	2	17	0	1						
Cancer Two Week Wait Standard	NHSI	93%	88.60%	93.80%	95.10%	92.60%	94.70%	NYA		94.70%				
Breast Symptom Two Week Wait	NHSI	93%	97.80%	94.80%	98.80%	97.30%	98.40%	NYA		98.40%				
31 Day Standard	NHSI	96%	100.00%	97.30%	99.10%	98.90%	98.40%	NYA		98.40%				
31 Day Subsequent Drug Standard	NHSI	98%	97.90%	97.60%	99.00%	98.30%	100.00%	NYA		100.00%				
31 Day Subsequent Surgery	NHSI	94%	95.70%	95.50%	100.00%	96.60%	91.30%	NYA		91.30%				
62 Day Standard	NHSI	85%	78.10%	77.20%	81.10%	78.80%	74.50%	NYA		74.50%				
62 Day Screening Standard	NHSI	90%	75.00%	66.00%	62.00%	67.90%	73.00%	NYA		73.00%				
Cancer 104 day waits	NHSI	0	8.5	7.0	5.5	21.0	11.0	NYA		11.0				
Cancelled operations (last minute non clinical reason)	NHSI	0	28	27	41	96	35	47						
Number of patients not treated within 28 days of last minute	NHSI	0	7	2	3	12	2	8						
Delayed Transfers of Care	NHSI	<3.5%	5.9%	6.7%	6.9%	6.5%	7.0%	7.7%						

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 Actual

Description

National standard = 92%

Local Trajectory or local standard = 72.35%

Actual performance = 75.12%

In additional to the 18-week standard the Trust has a target of 0 x 52-week waiters by March 17

Root Cause - key issues

1) The total volume of patients waiting over 52W as of the 16 September is 223, this has doubled following the PUS/PUR validation completion.

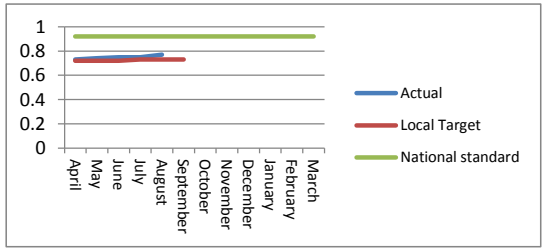
2) Theatre 3 at PRH reopened on 15 September, following the completion of work on the plant and ventilation system. The closure of theatre 3 was for a period of 7-weeks, which required the shared loss of theatre capacity across all specialities.

3) DD on call cover at PRH requires a confirmed start time, to enable a greater shift in higher acuity activity on this site.

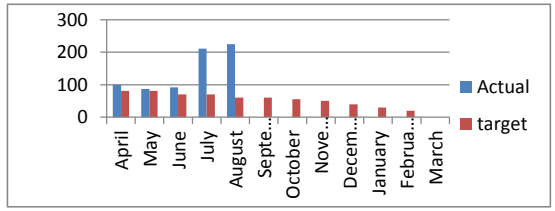
4) Revised RTT trajectories currently being undertaken for completion and submission to NHSI & the CCG's by 23 September.

Trend Graph actual V target

18 weeks standard



52 Week waiters



Action	Description	SRO	By when
Dashboard to be produced to provide a robust tracking vehicle to track and date 52-week breaching patients and to prevent further patients tipping into this backlog	Clinical review completed on the DD current 52-week waiters, OPD, internal and external theatre capacity (Nuffield) being explored to tackle and reduce this position	SC	16/09/2016
Plan to be reviewed with Perioperative Directorate, on possible reprovision of dropped activity		SC	30/09/2016
DD consultant on-call rota to cover PRH site (start date November)	DD on-call rota in place from an agreed date, to potentially provide a higher acuity provision of surgery at PRH with the appropriate senior clinical cover. Benefits - greater option to reduce the current >52-week provision and releasing bed capacity at the RSCH site	SC	TBC
Revised RRT trajectories by Directorate	We are currently undertaking RTT trajectory revison for each directorate, to establish aggregate RTT compliance. This is specifically aimed at non-admitted and admitted elective activity and will include stretch targets, internal efficiencies and external capacity, linked to internal challenge to maximise realistic RTT delivery		23-Sep

Responsive

1b. Exception report : A&E 4 hour performance

Target description and Actual

Description

National standard = 95%

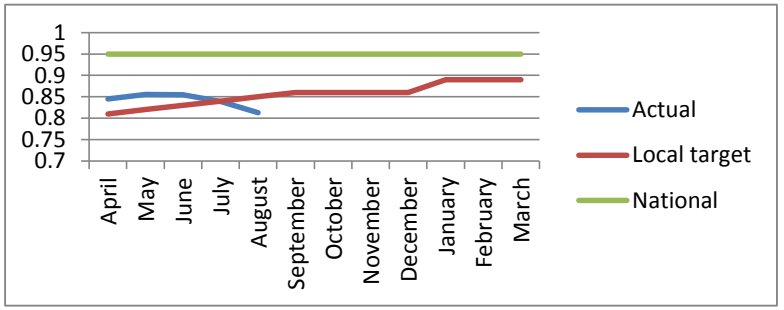
Local Trajectory or local standard = 85%

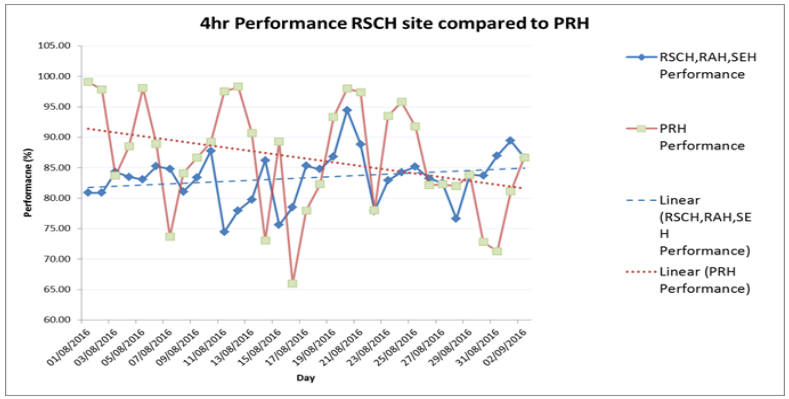
Actual performance = 81%

Root Cause - key issues

1. Timing of flow through hospital mismatched to patient presentation through A&E
2. Deterioration of PRH performance
3. Assessment areas occupied by longer stay patients
4. 7% Delayed Transfers of Care limiting bed turnover
5. High numbers of 'stranded' patients in beds

Trend Graph actual V target





Action	Description	SRO	By when
SAFER implementation	Strengthening of Right Care, Right Place, Eact Time Project	MS	End September 2016
Change in portering	Implement revised SOP for portering	MS	In place
Support PRH A&E medical capacity	Increase twilight medical staffing in A&E at PRH	MS	Implemented 12 September 2016
Increase capacity for discharge	Hospital at Home	MS	October to November 2016
Assured assessment capacity	Ring fence ambulatory care unit	MS	In place 24 August 2016
Review of long stay patients	Weekly 'top ten' cross-organisation meetings	MS	In place 24 August 2016

Responsive

1c. Exception report : Delay Transfers of Care

Target description and Actual

Description

National standard = 3.5%

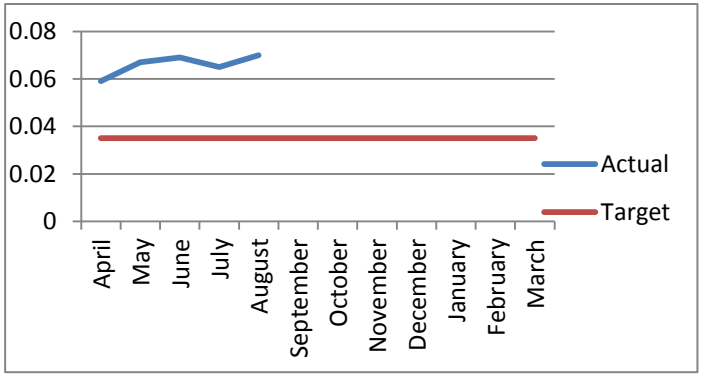
Local Trajectory or local standard = 3.5%

Actual performance = 7%

Root Cause - key issues

1) Insufficient care capacity
2) Assessment processes for community care are complex
3) Lack of flexibility of community admission criteria
4) Reduction in social care capacity
5) BSUH not assessing in timely manner

Trend Graph actual V target



Action	Description	SRO	By when
Assure greater care capacity	CCG proposals for market management and joint working	SRG	Nov-16
Reduce delays in assessment	SRG proposals for 'Trusted Assessor'	SRG	
Flexing admission criteria	Agreement for flex when BSUH in 'Black' escalation	CCG	In place late August 2016

SAFE DOMAIN

Metric	Defined by	Standard	Apr-16	May-16	Jun-16	16/17 Q1	Jul-16	Aug-16	Sep-16	6/17 Q2	Oct	Nov	Dec	Qtr. 3
C Difficile - number of cases	NHSI	46	4	2	2	8	7	3						
MRSA Bacteraemia -	NHSI	0	0	0	0	0	0	0						
Never Events - number of	NHSI	0	0	0	0	0	0	0						
Serious Incidents - number declared	L	Trajectory to be set	8	3	4	15	5	5						
Patient Safety Incidents that are harmful	NHSI	Trajectory to be set	0.24%	0.12%	0.10%	0.15%	0.11%	0.30%						
Medication Errors - causing serious harm per 1000 bed days	NHSI	0	0	0	0	0	0	0						
Medication Errors - number causing serious harm	L	0	0	0	0	0	0	0						
Patient Falls - total number	L	Trajectory to be set	93	83	89	265	83							
Patient falls - Sis	L	Trajectory to be set	3	1	1	5	5	3						
Fire Risk assessments completed	L	100%		69%	73%	73%	100%	100%						
CAS Alerts - overdue alerts	NHSI	0	0	0	0	0	11							
Hand Hygiene compliance	L	98%	93.00%	77.00%	71.00%	80.00%	80.00%	85.00%						
Mean wait of patients in corridor area A&E (mins)	L	TBC					49	55						
Max wait of a patient in corridor A&E (mins)	L	TBC					371	405						
Avoidable Pressure Ulcers (category 3 & 4)	L	0	0	1	0	1	1	1						
Histology reporting turnaround (% within 7 days)		80%	30%	26%	19%	25%	18%	33%						
Emergency C section rate	NHSI	<12%	15.09%	12.11%	12.03%	13.06%	12.50%	12.90%						
VTE Risk Assessment	NHSI	95%	84.52%	85.46%	82.99%	84.32%	NYA	NYA						
% Harm Free Care	NHSI	95%	94.81%	94.90%	95.10%	94.94%	95.46%	95.80%						

Lead : Medical Director and Chief Nurse

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	Nov	Dec	Qtr. 3
HSMR	NHSI	<100	89.27	87.56	87.56	87.56		NYA	NYA							
HSMR weekends	NHSI	<100	91.79	91.06	91.06	91.06		NYA	NYA							
SHMI	NHSI	<100	93.68	93.68	93.68	93.68		NYA	NYA							
Crude mortality (non elective pts)	NHSI	monitor	3.32%	3.37%	2.81%	3.16%		2.86%	2.69%		2.78%					
Emergency readmissions 30 days	L	10.50%	12.80%	NYA	NYA	12.80%		NYA	NYA							
A&E % patients who began treatment within 60 minutes (SCH)	L	95.00%				49%		50%	49%							
Discaharges before 10.00 AM (SCH)	L	100% (1 per ward)				9%		10%	7%							
Avg LoS Variance from Acute Teaching Hospital	L	Var = 0	0.45	0.41	NYA	0.43		NYA	NYA							
DNA rate	L	<6%	8.22%	8.72%	8.80%	8.59%		8.88%	8.72%							
Theatres Utilisation	L	85%	84.41%	84.89%	84.22%	84.50%		85.78%	82.27%							
% of emergency # neck of femur receiving surgery within 48 hours	L	TBC				NYA		NYA	NYA							
Stroke patients > 90% on a stroke ward	NHSI/ CQC	80%	82.98%	82.46%	86.96%	84.00%		83.33%	57.14%							
Stroke % admitted directly to a stoke ward	NHSI/ CQC	90%	74.47%	64.91%	58.33%	65.79%		68.63%	64.29%							
Stroke patients scanned within 24 hours	NHSI/ CQC	50%	100.00%	100.00%	95.12%	98.32%		97.62%	100.00%							
Stroke % of high risk TIA treated in 24 hours	NHSI/ CQC	60%	100.00%	87.50%	78.95%	87.50%		92.31%	100.00%							
Stroke % of low risk TIA treated within 7 days	NHSI/ CQC	100%	100.00%	92.00%	100.00%	98.06%		100.00%	96.30%							
Lead Chief Nurse and Medical Director and COO																

Brighton and Sussex University Hospitals NHS Trust

CARING DOMAIN

Metric	CIU Notes (Hide Me)	Defined by	Standard	Apr-16	May-16	Jun-16	16/17 Q1		Jul-16	Aug-16	Sep-16	16/17 Q2		Oct	Nov	Dec	Qtr. 3
FFT - Staff - % recommended as place to receive care		NHSI	95%				67.0%		Qtr updte								
FFT - Inpatient - % positive	IP	NHSI	95%	95.9%	97.6%	94.8%	96.1%		96.0%	95.4%		95.7%					
FFT - A&E/WiC/MIIU - % positive	AE	NHSI	95%	87.7%	87.0%	89.9%	88.2%		87.5%	86.6%		87.1%					
FFT - Maternity - % positive	Maternity	NHSI	95%	90.6%	94.9%	94.7%	93.3%		96.8%	97.1%		97.0%					
Complaints responded to < 40 days		NHSI	90%	63.8%	74.4%	67.0%	68.1%		NYA	NYA							
Number of complaints received		L	monitor	105	90	106	301		104	133		237					
Outstanding complaints over 6 months		L	0							28							
Re-opened complaints		L	<10%	11.4%	18.9%	10.4%	13.3%		11.5%	13.5%		12.7%					
Mixed Sex Accommodation breaches		NHSI	0	57	69	76	202		77	113		190					

Comments

Lead : Chief Nurse

WELL LED DOMAIN

Metric	CIU Notes (Hide Me)	Defined by	Standard	Apr-16	May-16	Jun-16	16/17 Q1	Jul-16	Aug-16	Sep-16	16/17 Q2	Oct	Nov	Dec	Qtr. 3
Temporary staffing spend as a % of paybill		NHSI	<10%	7.18%	7.37%	6.27%	6.94%	6.01%	5.78%		5.89%				
Staff sickness		NHSI	<3%	4.27%	4.27%	4.28%		4.26%	NYA						
Staff turnover		NHSI	<12%	12.81%	12.81%	13.17%		13.58%	12.90%						
FFT - Inpatient - Response rate	IP	NHSI	>35%	15.4%	15.4%	13.5%	14.8%	12.7%	11.3%		12.0%				
FFT - Staff - % recommended as place to work		NHSI	95%				48.00%	Qtr							
% of STAM training		L	>75%		49.00%	55.00%	55.00%	56%	NYA						
% of IG training			95%			50.00%	50.00%	55%	60%						
% of Appraisals		L	100%	69.80%	70.60%	70.20%		70.40%	66.90%						
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%		96.15%				
% of bank staff		CQC	<15%	14.66%	14.88%	14.97%	14.84%	14.32%	14.83%		14.58%				
Pay actual £'000 - (Surplus) / Deficit			334279.132 (July target 27,924)	28,968	28,625	29,027		28,369	28,444						
Non Pay actual £'000 - (Surplus) / Deficit			197197.338 (July target 16,651)	17,389	18,997	17,098		17,764	18,704						
Income actual £'000 - (Surplus) / Deficit			-549636.28 (July target - 45,810)	(44,229)	(44,058)	(51,275)		(43,738)	(46,117)						
I&E Position £'000 - (Surplus) / Deficit			15570.191 (July target 1,608)	4,703	6,386	(2,350)		5,281	4,087						
CIP's			25104 (July target 1,692)	737	645	466		516	699						
% Temporary Staff			TBC	7.40%	7.37%	6.84%	7.20%	6.01%	6.11%						
% of agency Nurse			<1%	2.64%	2.21%	1.65%	2.10%	1.45%	1.99%						
% of Nurse bank			TBC	7.82%	7.31%	8.12%	7.70%	6.50%	3.94%						

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 =

Actual performance = Appraisals = 67%

Root Cause - key issues

1) Data requiring cleansing

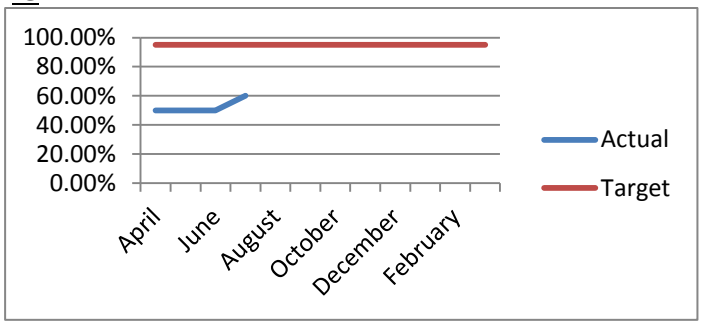
2) Ring fencing time especially when site under pressure

3) Expectation of roles and accountability

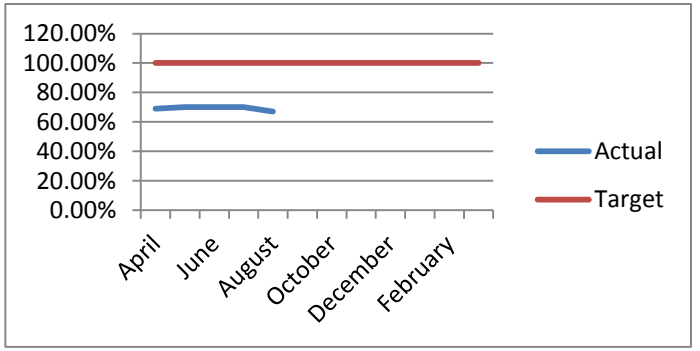
4) Access to Systems for some staff

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