Appendix D

Royal Brompton & Harefield NHS
NHS Foundation Trust

Month 12 2015/16 – period ending 31st March 2016

Section 1 – RBHFT Performance 2015/16

Monitor
Independent Regulator of NHS Foundation Trusts

1.1 Monitor; Risk Assessment Framework

Clostridium difficile	M12 0	YTD M12 25	YTD M12 Cases under review 16	YTD M12 Confirmed lapses of care; to count against the threshold 0	Performance Standard Monitor threshold = 12	Variance from Target ▼ -12 YTD	Met
Indicator	Threshold		14/15 Performance M12	15/16 Performance M12	QTD	Variance from Threshold	Q4 Actual
18 weeks RTT Incomplete Pathway	92%		93.49%	88.86%	90.09%[1]	▼ -1.91%	Not Met
Cancer – 14 day Urgent GP Referral	93%		No. of cases Q4 2015/16 = 2; Not Assessed if 5 cases or fewer in the quarter				Not Assessed
Cancer – 31 day 1st treatment	96%		100%	100%	96.64%[2]	▲ +0.64%	Met
Cancer – 31 day subsequent treatment	94%		96.15%	96.43%	95.88%	▲ +1.88%	Met
Cancer - 62 day Urgent GP referral to first definitive treatment	85%		61.90%	75.0%	60.38%	▼ -24.62%	Not Met

CareQuality Commission

1.2 CQC Registration

CQC – Planned Inspection	14th-17th June 2016
CQC Inspection – Royal Brompton Hospital	13th/14th August 2013 – Fully Compliant
CQC Inspection – Harefield Hospital	3rd February 2014 – Fully compliant
Intelligent Monitoring – May 2015	Band 3

[1] Monitor; Risk Assessment Framework (March 2015); 'any failure in one month is considered to be a quarterly failure'. The incomplete RTT Target is not met for M10+M11+M12

[2] 31 day decision to treat to first definitive treatment performance is the average monthly performance in the quarter.

1.3 NHS Standard Contract (NHS England)

Clostridium difficile	M12 0	YTD M12 25	YTD M12 Cases under review 16	YTD M12 Confirmed lapses of care; to count against the threshold 0	Performance Standard Dept. Health Trajectory = 23	YTD M11 Threshold = 23	Variance from Threshold ▼ -23 YTD

Indicator	M12	M12 YTD	M12 Target	Variance from Target	M12 Position
MRSA	0	0	Zero tolerance	◆ 0	**Met**
Mixed Sex Accommodation	0	9	Zero tolerance	▲ +9	**Met**
Urgent operations cancelled for the 2nd time	0	4	Zero tolerance	▲ +4	**Met**
Cancelled Operations; not carried out within 28 days	0	11	Zero tolerance of no readmission within 28 days	▲ +11	**Met**
Cancelled Procedures; (catheter labs and bronchoscopies); not carried out within 28 days	0	38	Zero tolerance of no readmission within 28 days	▲ +38	
52 week breaches	0	5	Zero tolerance	▲ +5	**Met**
18 weeks RTT Incomplete National Specialty Level	See page 15 for details	Not applicable	92%		**Not Met**
Cancer - 62 day Urgent GP referral to first definitive treatment	75.0%	Not applicable	85%	▼ -10.0%	**Not Met**
Cancer – 62 day Consultant Upgrade to first definitive treatment	No. treated 3 / No. treated in time 2.5	No threshold set in NHS Contract		Not applicable	**Not assessed**

Incidents

	15/16 M12	14/15 Total Incidents	14/15 YTD Incidents at M12	15/16 YTD Incidents at M12	Δ
Outbreaks of Infection	0	2	2	2	◆ 0
Serious Incidents	4	27	27	24	▼ -3
Never Events	0	3	3	0	▼ -3
Radiation Safety incident's	0	8	8	7	▼ -1

1.4 Clinical Outcomes

HSMR Ratio	97.18 (1 Year Period : Jan 2015 – Dec 2015)	Slightly below average, but within the expected range published by Dr Foster
Complaints	*The Q3 Complaints Report was reviewed by the Risk and Safety Committee on 22nd February 2016*	

1.5 Workforce Targets (set by the Trust)

	Current Year Target	14/15 YTD Position	15/16 Position	Δ	YTD Variance from Target	M11Position
Staff Sickness	3%	Feb 15 2.54 %	Feb 16 2.64 %	+ 0.1 %	▼ -0.36%	**Met**
Staff Turnover	12%	Mar 15 10.1 %	Mar 16 10.3 %	+ 0.2 %	▼ -1.8%	**Met**

Section 2 – RBHFT planned/implemented improvements

Extract from Quality Priorities 2015-16

1. **Improving the Patient Experience for the cardiac surgery pathway**

What are our aims?

We aim to improve the patient experience by reducing the number of patients whose pathway from initial GP referral to undergoing cardiac surgery exceeds 18 weeks; and by reducing the number of cardiac surgical operations cancelled for non-clinical reasons.

How will we measure this?

We will measure this by comparing the number of operations cancelled for non-clinical reasons in 2014/15 with the number cancelled in 2015/16; and, subject to the volume of activity commissioned by NHS England, by comparing the no. and proportion patients on the waiting-list for cardiac surgery on 31st March 2015 with those waiting on 31st March 2016.

Progress and Outcomes

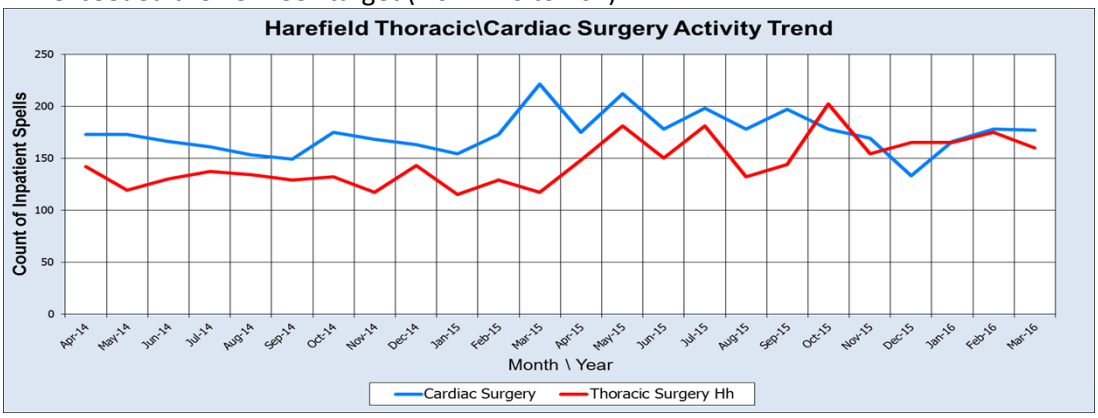
At Royal Brompton Hospital:

- between April 2015 and February 2016 there were 48 cancellations of cardiac surgical operations (for non-clinical reasons) compared to 94 in the same period 2014/15, a 49% reduction. This improvement is a result of focused effort and education to the clinical teams on the need to improve patient experience, productivity and efficiency. The daily theatre schedule is scrutinised to ensure every effort is made to avoid cancellations, with a weekly review meeting of any cancellations and related issues.
- For patients on the 18-week cardiac surgical pathway, there has been a slight (6%) increase in the number of patients exceeding the 18-week target when compared to 2014/15 (from 174 to 184 patients). This was a consequence of reduced theatre capacity for redevelopment works for part of 2015.

Lawrence Mack; General Manager, Heart Division, Royal Brompton

At Harefield Hospital:

- between April 2015 and February 2016 there was a significant (43%) increase in cancellations of cardiac surgery for non-clinical reasons, 294 in 2015/16 compared to 205 in 2014/15. The main cause of the increase was additional pressure on ward-beds (i.e. hospital admissions being cancelled) as a consequence of growing thoracic surgical activity as we strive to admit cancer patients promptly for surgery (see chart below), thus restricting the no. of beds available for cardiac surgery. In response to these pressures, a regular cancellations review meeting has been initiated and the team are aiming to increase the number of 'day-of-surgery' admissions in order to reduce length of stay and where possible.
- There was a small (5%) reduction in 2015/16 in the number of patients whose pathway exceeded the 18-week target (from 276 to 261).



Peter Doyle; Interim General Manager, Heart Division, Harefield

2. Improving the management of patients with Cancer

What are the aims?

We will continue to focus on improving overall waiting-times for patients on the 62-day cancer pathway. In addition, we want to ensure that cancer patients receive the best possible experience whilst in our care, receiving the appropriate interventions and information at the right time.

How will we measure this?

We will utilise a number of indicators to establish our effectiveness against this priority, including the contracted performance measures and feedback on patient and carer experience.

Progress and Outcomes

A 2015/6 Performance Overview report was completed by the Cancer Manager in March 2016 in order to provide an update on quality priority 4 – "Improving the management of patients with cancer". The report concluded that, whilst the cancer waiting-time target is a challenge, we need to continue to work with our network of referring hospitals to assist in improving the lung cancer referral pathway for all patients. The external Cancer Service Review (being undertaken by Dr Pallav Shah (RB&H) and Dr Sanjay Popat (Royal Marsden) as a follow-up to their 2014 review) will be available by the end of April 2016. It will focus on the parts of the lung cancer pathway that can be improved so that patients can be seen and diagnosed earlier, and then referred promptly for treatment, thus reducing overall waiting-times.

In addition to waiting-time performance, there are various clinical and patient experience indicators that are considered part of the overall quality and safety of the service. For example, in terms of lung cancer resections alone, the Trust is in the top four performing hospitals in the country, with a better-than-average in-hospital mortality rate, as well as a better-than-England-average rate for 30- and 90-day post-operative mortality for first time primary lung cancer resections. It is therefore important that these indicators are also monitored on a regular basis and form part of the overall assessment of the lung cancer service going forward.

John Pearcey; Cancer Manager and Assistant General Manager, Lung Division