South Reading
Clinical Commissioning Group

Governing body meeting in Public – Paper 0613-4 A

REPORT OF THE SOUTH READING CCG BOARD 19.06.13	
Title	Quality Scorecard Exception report
Sponsoring Director	Debbie Daly
Author(s)	Nick Carter-Meadows (Quality Lead, CSCSU)
Purpose	To highlight quality performance of commissioned local providers and provide assurance of actions being taken on areas of poor performance
Previously considered by	Berkshire West CCG Federation Quality Committee
Risk and Assurance	Provides assurance of issues and appropriate actions
Links to the Board Assurance Framework	As above
Legal implications/regulatory requirements	Monitoring of quality to minimise litigation
Public Sector Equality Duty	High quality equitable services
Links to the NHS Constitution (relevant patient/staff rights) *All NHS organisations are required by law to take account of the NHS Constitution in performing their NHS functions*	Demonstration of quality monitoring and improvement assurance of commissioned providers
Consultation, public engagement & partnership working implications/impact	Public assurance of quality issues

Executive Summary
This exception report supports the quality scorecard which accompanies this paper. The scorecard provides an overview of the quality performance of local providers Royal Berkshire FT, Berkshire Healthcare FT, Heatherwood and Wexham park FT and Frimley FT (the latter two trusts provide a benchmark of RBFT performance).
The areas covered in this except report are cancer waits, and cancellation of operations where performance has declined at RBFT in recent months. Admission of patients to the stroke unit within 4 hours has seen performance increase in March.

Recommendation:

This paper is for information and to support CCG Board assurance of quality and support the Boards request for further information on actions being taken to improve areas of quality concern related to the services provided by commissioned healthcare providers.

Performance Report - Exception Reporting Template

Royal Berkshire Hospital NHS FT

Area of concern	Patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	Gap to target / Current performance	Target 85% - March performance 76.7%
What has happened to cause the performance gap?	November 2013 RBFT reported 85.1 % of patients were receiving their first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer. Performance by the trust has decreased since that time (Dec, 82.7%; Jan 82.4%; Feb 76.2%; March 76.7%). This issue was raised at the recent RBFT quality review board meeting and further information to understand the cause of this decrease and actions being taken by the trust were requested.		
Do we understand the true root cause?		Do we need to investigate further to really understand the problem?	
Do we need to take any short term action?			
What needs to be done to correct the problem and prevent this happening again?			
Action 1 - Provider	The figures published in the Quality Schedule are invalidated figures and not those that were submitted to the national data system. The Trust will ensure that figures published in the 2013/14 Quality Scheduled are labelled as validated / unvalidated and the correct position updated each month.		
Action 2 - Provider	The Trust is preparing a Remedial Action Plan to address the failed performance indicator outlining the specific actions that will be taken to by the Trust to ensure performance is meeting the standards. This is due to be sent to CCGs, as agreed in the CQRG, by 16th May 2013.		
Recommendation	Microsoft Word 97 - 2003 Document *See appendix 1*		
Will these actions completely resolve the problem or do we need to do additional things?			
Who will take responsibility for completing the actions?		Does the owner need support?	
Is it a priority?		What is the deadline for completion?	
What are the intermediate milestones?			
How is progress going to be monitored?			
When will performance be on track?		Predicted Year End Position	
Name of person completing template		Date Completed	

Royal Berkshire Hospital NHS FT

Area of concern	Provider cancellation of Elective Care operation for non-clinical reasons either before or after Patient admission	Gap to target / Current performance	0 Breaches
What has happened to cause the performance gap?	Throughout 2012/13 RBFT has reported a rate for cancelled elective care operations at quarterly average of (Q1 0.33%, Q2 0.76%, Q3 0.6%) during March the trust reported a rate of 2.45%.		
Do we understand the true root cause?	This issue was raised at the RBFT quality review board meeting. RBFT reported that this was as a result of a high number of non-elective admissions leading to capacity challenges at the Trust.	Do we need to investigate further to really understand the problem?	
Do we need to take any short term action?			
What needs to be done to correct the problem and prevent this happening again?			
Action 1 - Provider	The Trust was asked to provide assurance that the patients were rebooked within the contractual 28 days. The Trust can confirm that this is the case and that a monthly report is sent to Commissioners as part of the data pack indicating all patients rebooked for this performance indicator. The March report was sent on 23/04/13 @ 09:04.		
Action 2			
Action 3			
Recommendation			
Will these actions completely resolve the problem or do we need to do additional things?			
Who will take responsibility for completing the actions?		Does the owner need support?	
Is it a priority?		What is the deadline for completion?	
What are the intermediate milestones?			
How is progress going to be monitored?			
When will performance be on track?		Predicted Year End Position	
Name of person completing template		Date Completed	

Royal Berkshire Hospital NHS FT

Area of concern	Direct admission of patients to the Hyper-acute Stroke Unit / Acute Stroke Unit within 4 hours of arrival	Gap to target / Current performance	March performance was 59% against a target of 95%
What has happened to cause the performance gap?	Although the trust has achieved the target for stroke patients spending at least 90% of their time on a Stroke unit, the trust has during 2012/13 not met the 95% target for the direct admission of patients to the stroke unit within 4 hours of arrival. The first three Quarters of 2012/13 reported rates of (Q1 62.6%; Q2 49.6%; Q3 60.3%; Q4 65.3%) March performance was 59%.		
Do we understand the true root cause?	The underperformance of this target was as a result of significant capacity pressures within the Hospital	Do we need to investigate further to really understand the problem?	
Do we need to take any short term action?			
What needs to be done to correct the problem and prevent this happening again?			
Action 1 – Provider/Commissioner	Clinical meeting to discuss and agree any remedial actions is scheduled for 11:00 on 15th May 2013. The CQRG agreed this meeting was required and that Debbie New would update the attendees of the CQRG after the meeting on the outcome of the meeting.		
Action 2			
Action 3			
Recommendation			
Will these actions completely resolve the problem or do we need to do additional things?			
Who will take responsibility for completing the actions?		Does the owner need support?	
Is it a priority?		What is the deadline for completion?	
What are the intermediate milestones?			
How is progress going to be monitored?			
When will performance be on track?		Predicted Year End Position	
Name of person completing template		Date Completed	

Royal Berkshire Hospital NHS FT

Area of concern	Caesarean Section Rate	Gap to target / Current performance	Current performance (March) 27% against a Target of 23%
What has happened to cause the performance gap?	The C-section rate has continued to be above the target for February (28%) and March (27%). The January rate has reduced to 23% for the first time in 2012/13. The increase has been due to a rise in emergency C-sections from 12% in January to 16% in February and 15% in March.		
Do we understand the true root cause?	At the RBFT quality review meeting the cause of the increase in C-sections was reported to be a result of capacity issues resulting in delivery delays and as a consequence an increase in emergency C-Sections.	Do we need to investigate further to really understand the problem?	No
Do we need to take any short term action?	Increasing use of Rushey MLU for low-risk women to minimise the risk of intervention in this group of women.		
What needs to be done to correct the problem and prevent this happening again?			
Action 1	Create capacity by developing a 4 bed high dependency area in Delivery Suite. This will reduce delays and postponements affecting women in labour and those being induced. By expediting the efficient progress of labour the emergency caesarean section rate will reduce		
Action 2	Commission the introduction of automated “intelligent” electronic fetal monitoring system (Guardian) to enable safer supervision of high-risk women in labour thereby reducing inappropriate intervention (including caesaraen section) yet avoiding slow or inappropriate responses to fetal distress in labour		
Action 3	Increase consultant presence and supervision on delivery suite – requires funding and recruitment of additional personnel.		
Recommendation	*To continue to review the C-section rates for the trust and progress the trust is making toward reducing these to meet target.*		
Will these actions completely resolve the problem or do we need to do additional things?			
Who will take responsibility for completing the actions?		Does the owner need support?	
Is it a priority?		What is the deadline for completion?	
What are the intermediate milestones?	Reduced delays and diversions		
How is progress going to be monitored?	Maternity Dashboard		
When will performance be on track?	When the changes are funded and implemented	Predicted Year End Position	
Name of person completing template		Date Completed	

Heatherwood & Wexham Park Hospital

Area of concern	Direct admission of patients to the Hyper-acute Stroke Unit / Acute Stroke Unit within 4 hours of arrival	Gap to target / Current performance	March performance was 35% against a target of 95%. April performance has increased to 73%
What has happened to cause the performance gap?	The target for stroke patient's direct admission of patients to the Hyper-acute Stroke Unit / Acute Stroke Unit within 4 hours of arrival, the trust has during 2012/13 not met the 95% target for the direct admission of patients to the stroke unit within 4 hours of arrival throughout the year. Performance in January 36%, February 17%, March 35%, April 73%		
Do we understand the true root cause?	The underperformance of this target was as a result of significant capacity pressures within the Hospital	Do we need to investigate further to really understand the problem?	
Do we need to take any short term action?			
What needs to be done to correct the problem and prevent this happening again?			
Action 1 – Provider/Commissioner	The Trust reported that they are maintaining 2 ring-fenced stroke beds most days, and improvement to performance should be demonstrated in coming months.		
Action 2	The Trust are planning a re-launch of their stroke service supported by education of A&E clinicians and induction of junior doctors		
Action 3	The Trust had communicated that there were occasions when the stroke coordinator had been taken off this role for periods of time, due to capacity issues. Sarah Bellars has discussed this with the trust and stressed that this should not happen as this is a patient safety issue. The trust has agreed to protect the stroke coordinators role in future to ensure stroke patient safety.		
Recommendation	To continue to closely monitor performance		
Will these actions completely resolve the problem or do we need to do additional things?			
Who will take responsibility for completing the actions?		Does the owner need support?	
Is it a priority?	Performance in this area appears to be an outcome of the capacity issues the trust has experienced in recent months	What is the deadline for completion?	
What are the intermediate milestones?			
How is progress going to be monitored?			
When will performance be on track?		Predicted Year End Position	
Name of person completing template		Date Completed	

Heatherwood & Wexham Park Hospital

Area of concern	% of patients who spent 90% of their time on Stroke Unit	Gap to target / Current performance	March performance was 50% against a target of 80%
What has happened to cause the performance gap?	The target for stroke patients spending at least 90% of their time on a Stroke unit, the trust has during 2012/13 not met the 95% target for the direct admission of patients to the stroke unit within 4 hours of arrival throughout the year. Performance in January 60%, February 35%, March 50%		
Do we understand the true root cause?	The underperformance of this target was as a result of significant capacity pressures within the Hospital	Do we need to investigate further to really understand the problem?	
Do we need to take any short term action?			
What needs to be done to correct the problem and prevent this happening again?			
Action 1 – Provider/Commissioner	The Trust reported that they are maintaining 2 ring-fenced stroke beds most days, and improvement to performance should be demonstrated in coming months.		
Action 2	The Trust had communicated that there were occasions when the stroke coordinator had been taken off this role for periods of time, due to capacity issues. Sarah Bellars has discussed this with the trust and stressed that this should not happen as this is a patient safety issue. The trust has agreed to protect the stroke coordinators role in future to ensure stroke patient safety.		
Action 3			
Recommendation			
Will these actions completely resolve the problem or do we need to do additional things?			
Who will take responsibility for completing the actions?		Does the owner need support?	
Is it a priority?		What is the deadline for completion?	
What are the intermediate milestones?			
How is progress going to be monitored?			
When will performance be on track?		Predicted Year End Position	
Name of person completing template		Date Completed	

Heatherwood & Wexham Park Hospital

Area of concern	Cancelled of elective operations	Gap to target / Current performance	April performance 4.40% against a target of 3%
What has happened to cause the performance gap?	Capacity issues experienced by trust has impacted upon elective operations		
Do we understand the true root cause?	Process inefficiencies have been identified by the Trust who have commissioned an external company to review its utilisation of theatre space.	Do we need to investigate further to really understand the problem?	
Do we need to take any short term action?			
What needs to be done to correct the problem and prevent this happening again?			
Action 1 – Provider/Commissioner	The Trust has engaged an external company called 'Newton' as part of its Efficiency in Theatre Programme. This programme is looking at how the trust can most effectively utilise its theatre space. Using private sector to reduce 18 week backlog		
Action 2	As a component of the above programme the trust are looking at its management of its theatre list. This involves the identification of 'golden patients' who are now selected in advance and called to theatre at 08:30 regardless of system pressures. This has led to better management of lists and theatre usage.		
Action 3	The trust has also reported that the reduction in its bad capacity pressures has also resulted in the freeing up of space in the surgical assessment unit. Theatre 2 is up and running at Heatherwood Hospital.		
Recommendation	Continue to review trust performance and monitor implementation of trust actions plan developed in collaboration with 'Newton'.		
Will these actions completely resolve the problem or do we need to do additional things?			
Who will take responsibility for completing the actions?	At the recent HWPFT Quality review Group commissioners requested more detail of the trajectory for cancelled operations improvement and development actions	Does the owner need support?	
Is it a priority?		What is the deadline for completion?	
What are the intermediate milestones?			
How is progress going to be monitored?			
When will performance be on track?		Predicted Year End Position	
Name of person completing template		Date Completed	

Appendix 1 :

Remedial Action Plan

The following document sets out a remedial action plan to bring performance back in line with national standards and or contracted targets.

Service / Performance Area	62 day (2ww) Cancer Waits Target
Executive Sponsor Royal Berkshire NHS Foundation Trust	Peter Malone
Project Lead Royal Berkshire NHS Foundation Trust	Steve Green
Completion Date	

Issue	Action Required	Specific Milestone	Responsible	Due Date
Performance for 62 day (classic) below national standard of 85%	Increase Endoscopy capacity	Endoscopy capacity at Dunedin	Steve Green	TBC
		Endoscopy capacity at WBCH on Saturdays	Wendy Riddle and Donna Rowell	May 2013
		Endoscopy capacity in dropped theatre lists – requires more nursing support at WBCH	Wendy Riddle and Donna Rowell	May 2013
		Changing recovery room to be a 4th room at RBH for procedures	Margaret Myszor / Clare Gardiner	TBC
		Mixed lists at WBCH – if surgeon is light on a light, fill end of list with colonoscopies	Wendy Riddle and Donna Rowell	May 2013
		Pathway meeting to reduce delays in referral management	Chris Lowrie	May 2013
		Agreed to rebook failed investigations within a	Margaret Myszor, Clare Gardiner and Chris Lowrie	May 2013

		week		
	Increase EUS availability	List per week as opposed to fortnightly	Chris Lowrie	May 2013 **Complete**
	Lower GI	Locum consultant recruited Staff grade in LGI surgery appointed – 4-6 weeks Pathway meeting with Colorectal team to improve referral management (e.g. rapid staging to allow for rapid MDT)	Wendy Riddle Wendy Riddle Chris Lowrie	May 2013 **Complete** July 2013 May 2013
	Breast staff grade	Recruited, starts in 3 weeks	Wendy Riddle	June 2013
	UGI speciality doctor	Recruited, starts in 4-6 weeks	Wendy Riddle	June 2013
	Gynaecology	Approval for a specialty doctor. Consultants deciding job plan Recruitment of locum to the agreed job plan Purchase of an US machine to aid hysteroscopy	Alan Crystal / Wendy Riddle Wendy Riddle Wendy Riddle	May 2013 May 2013 May 2013
	Cancer patient clinic letters	Agreed that 48 hour turnaround of suspected cancer patients should be the norm	Chris Lowrie	May 2013
	Radiology	Staff consultation to open CT longer (10pm 4 days a week) Extra CT capacity @	Tom Mills, Mandy Claridge and Julie Cameron Steve Green	May 2013 May 2013

		Dunedin Full utilisation of empty slots in the GP direct access CT clinic Renew MRI equipment to meet current demand Replace mobile MRI with mobile CT to solve short term CT issues – dependant upon MRI renewal	 Tom Mills, Mandy Claridge and Julie Cameron Tom Mills, Mandy Claridge and Julie Cameron Tom Mills, Mandy Claridge and Julie Cameron	 May 2013 Dec 2013 Dec 2013
	Diagnostic waiting times	Highlight any patient unbooked or booked beyond 7 days to move their appts forward and expedite the pathway	Chris Lowrie, Steve Green, Mandy Claridge, Mark Robson	May 2013 – started
	Dermatology	Adjust OP clinic locations to meet growing choice for appts at WBCH and Woosehill	Alison Gowdy	May 2013 **Completed**
	Lung	Increase EBUS capacity at Guys & St. Thomas Provide EBUS at RBFT	Chris Lowrie Andy Zurek	June 2013 Dec 2013
	Cross pathway referrals	Reduce delays in referrals from Skin and H&N to the Plastics team	Chris Lowrie	May 2013
	Communication with Oxford	Provide all information automatically on a proforma for OUH to expedite 62 day patients	Chris Lowrie	April 2013 **Completed**
	Achieve operating standard of 85%.	Compliance with NHS Constitution and Acute Contract	Steve Green	Quarter 1 2013/14 Reported 1st week in August 2013.