

Board of Directors: 11.1.18

Agenda Item: Bo.1.18.8

Integrated Dashboard

Presented by:	Clive Kay, Chief Executive	Author:	Cindy Fedell, Director of Informatics
Previously considered by:	Committees		

Key points	Purpose:
1. The Integrated Dashboard for November 2017 is attached for the consideration by the Board of Directors.	To discuss and note

Executive Summary:
<p>The Integrated Dashboard for November 2017 is attached for the consideration by the Board of Directors.</p>

Board of Directors: 11.1.18
Agenda Item: Bo.1.18.8

Financial implications:
No

Regulatory relevance:

Monitor:	
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Equality Impact / Implications:	Is there likely to be any impact on any of the protected characteristics? (Age, Disability, Gender, Gender Reassignment, Pregnancy and Maternity, Race, Religion or Belief, Sexual Orientation, Health Inequalities, Human Rights)
	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
	If yes, what is the mitigation against this?

Other:	
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Strategic Objective: <i>Reference to Strategic Objective(s) this paper relates to</i>	To provide outstanding care for patients
	To deliver our financial plan and key performance targets
	To be in the top 20% of NHS employers
	To be a continually learning organisation
	To collaborate effectively with local and regional partners



Bradford Teaching Hospitals
NHS Foundation Trust

Integrated Dashboard Board of Directors

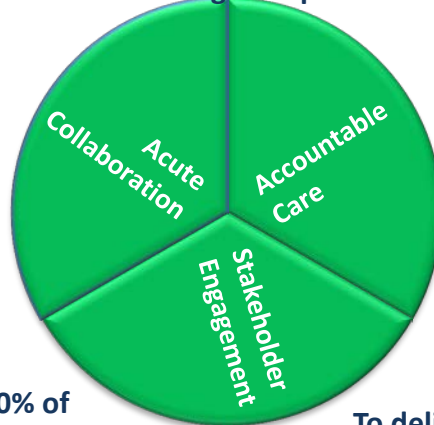
30th November 2017

30th November 2017

To provide outstanding care for our patients



To collaborate effectively with local and regional partners



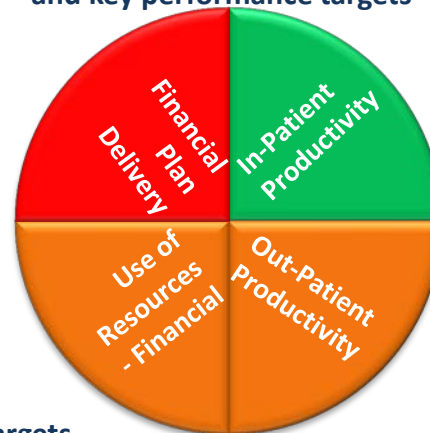
To be a continually learning organisation



To be in the top 20% of employers in the NHS

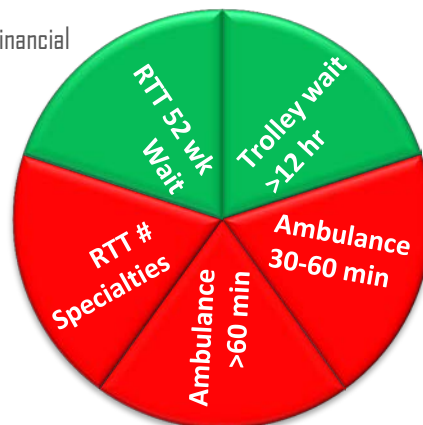


To deliver our financial plan and key performance targets

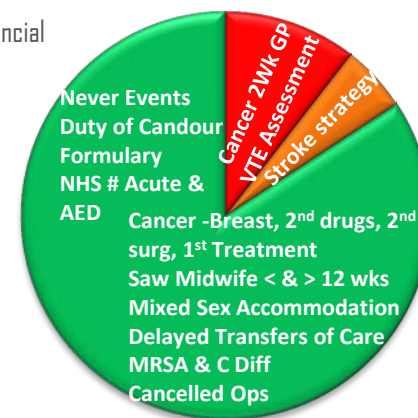


National targets

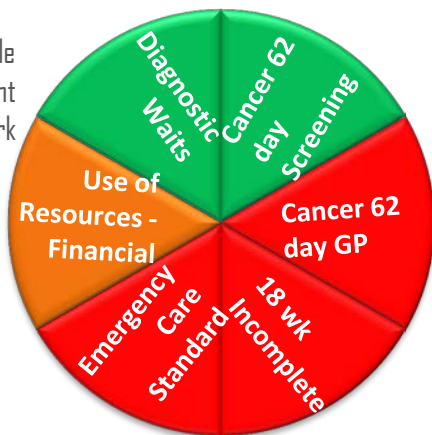
Non-Financial



Financial



Single Oversight Framework



Headlines

Emergency Care – A recovery plan is in place for the Emergency Care Standard and Ambulance Handovers. Recent improvements include the opening of the Clinical Decision Unit and the commencement of the Paediatric ACE project, an admission avoidance scheme. General Practitioners' streaming in AED has also commenced. The Trust is seeing the impact of winter pressures which is affecting performance against the standard.

Workforce - Workforce indicators are in a relatively good position. The number of staff in post has continually increased throughout the year. The sickness rate has also been improving throughout the year. However it is unlikely that the Trust's target will be reached by the end of the year. Agency and bank usage has increased with approval processes having been further strengthened for non-clinical posts. Appraisal rates had improved significantly throughout the year but the position is deteriorating and concerted action and support is continuing with Divisions to ensure that performance does not deteriorate further.

National Targets - Recovery plans have been developed for all national access standards. Further work is required to quantify the impact of winter pressures on the Trust's ability to improve performance. The diagnostic DMO1 standard was met for all modalities reported but does not currently include endoscopy and neurophysiology due to the availability of the report from EPR.

Cancer – The 62 day target for cancer continues to be a challenge. Improvement actions are focused on the early diagnosis pathways in urology and colorectal. The 2 Week Wait target has been impacted by capacity issues in dermatology and endoscopy. Recovery plans are in place.

Elective Wait List & RTT - An update on RTT and non-RTT position was given to the Finance & Performance Committee on 20 December 2017. Overall the incomplete waiting list has increased due to data quality issues and planned reduction in activity following the EPR implementation.

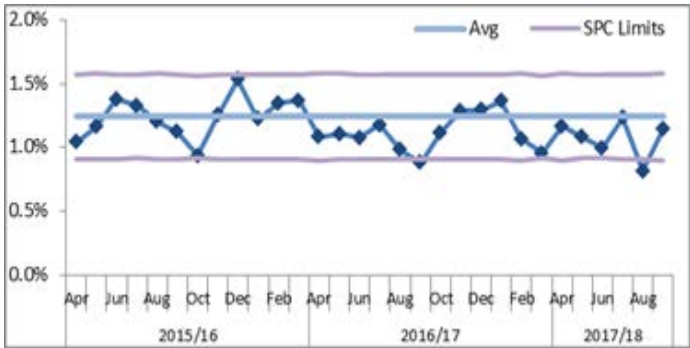
Pressure Ulcers and Falls – Improvement is showing in both pressure ulcers and falls in keeping with the Back to Basics programme work.

VTE - The Trust has struggled with hitting the national and internal improvement targets for VTE assessment due to a number of factors. The reporting data from the new EPR became available for the first time at the end of November. This has enabled targeted communication and engagement with all poorly performing clinical areas. The change to EPR has also identified a number of transition issues including staff responsibilities and rules used in the report that may not be correct. These weekly reports are now being using on all wards and for the individual ward improvement plans in place, along with corrections to the report and clarity of responsibilities.

Finances - The Trust reported a pre-STF deficit of £7.5m at the end of Month 8 which is £3.3m behind the pre-STF control total. The Improvement Plan forecasts a pre-STF deficit of £6.2m at Month 8, meaning financial recovery is £1.3m behind plan. The Month 8 bottom line post-STF position is a deficit of £4.3m against a planned £1.2m surplus, meaning the Trust is £5.5m behind the post-STF control total. The currently agreed Improvement Plan measures result in a forecasted shortfall of £4.7m against the year-end pre-STF control total. Although work is ongoing to mitigate this, there remains a significant risk that the control total will not be delivered in 2017/18.

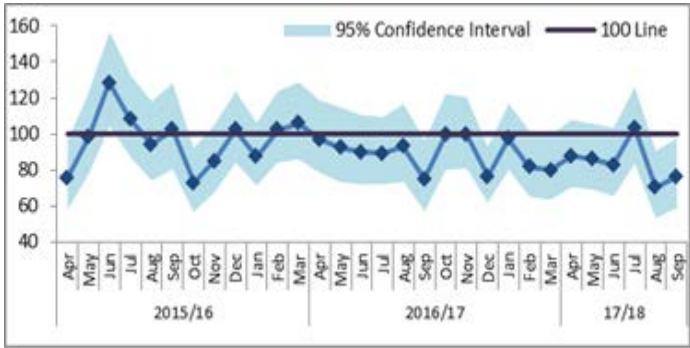
To provide outstanding care for patients

Trend	Challenges & Successes	Comparison	Exec Lead
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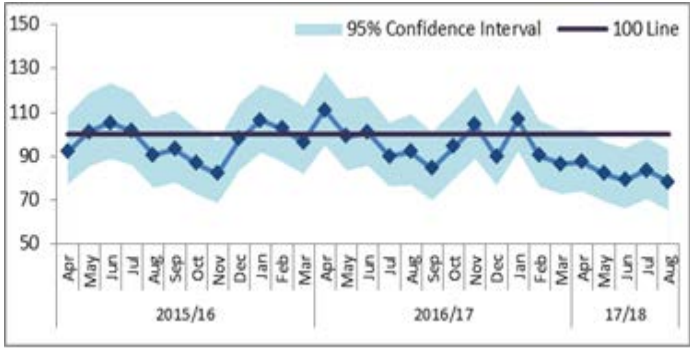
Crude death rate has remained constant throughout the last 18 months. There is no benchmarking data for this measure. Improving learning from mortality is one of the Trust's key quality improvement priorities. There is a comprehensive structure surrounding mortality at the Trust, which is outlined in the Trust's newly published Learning from Deaths policy. The Trust has for a number of years worked toward implementing a Structured Judgement Review process to ensure learning from deaths. In addition a mortality dashboard is produced each month for the Mortality Sub-Committee which provides an overview of data on mortality including specific diagnosis group standardised mortality ratios. Data for August and September is currently going through data quality checking due to a change in the underlying reporting system.

Medical Director



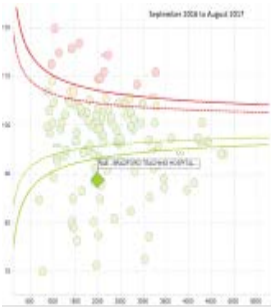
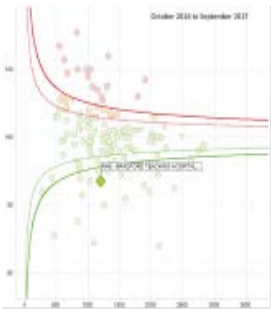
Our HSMR continues to be relatively low. Over the past 12 months we are statistically low compared to other Trusts. Our SHMI continues to be relatively low at 83.9 compared to 88.1 in April. Over the past 12 months we are statistically low compared to other Trusts.

Medical Director



Improving learning from mortality is one of the Trust's key quality improvement priorities. There is a comprehensive structure surrounding mortality at the Trust, which is outlined in the Trust's newly published Learning from Deaths policy. The Trust has for a number of years worked toward implementing a Structured Judgement Review process to ensure learning from deaths. In addition a mortality dashboard is produced each month for the Mortality Sub-Committee which provides an overview of data on mortality including specific diagnosis group standardised mortality ratios.

Medical Director



To provide outstanding care for patients

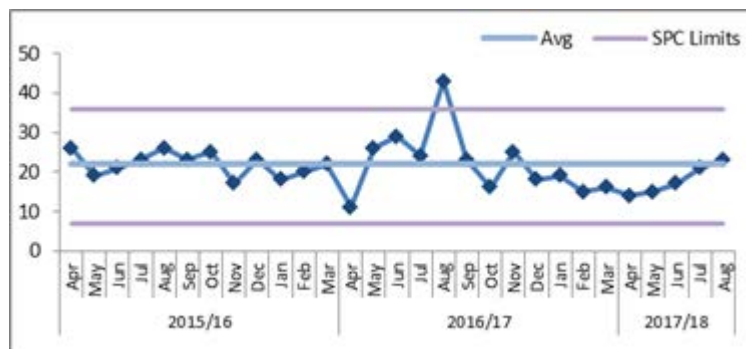
Trend

Challenges & Successes

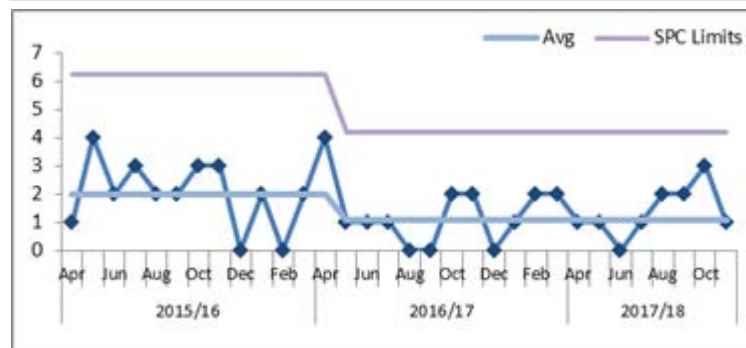
Comparison

Exec Lead

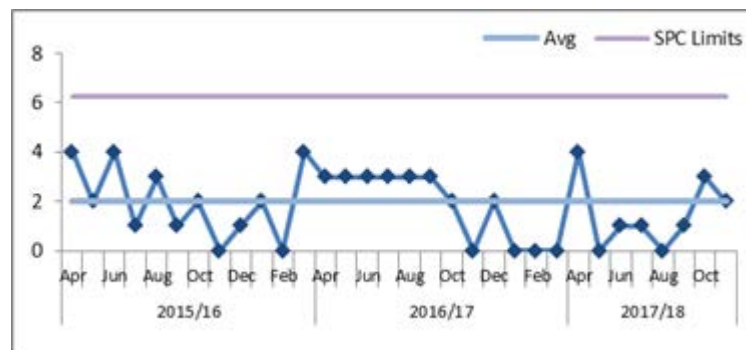
eColi



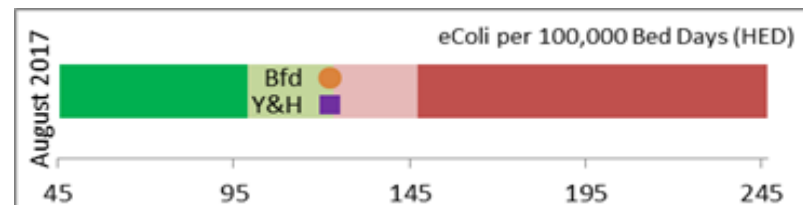
MSSA



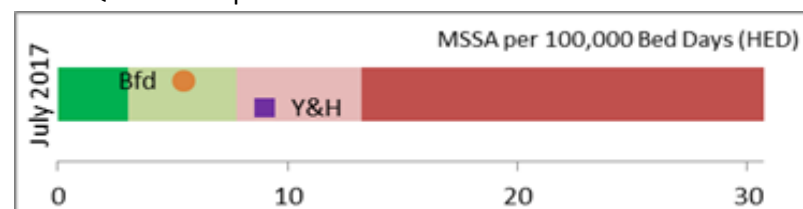
C Difficile



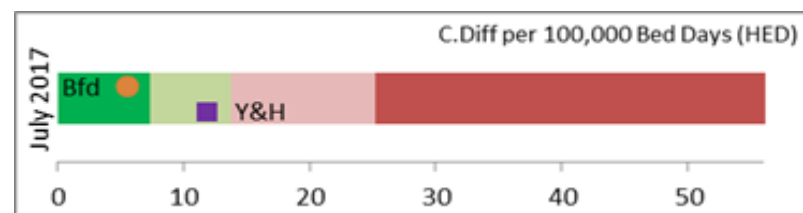
PIR process established this year for E.coli to identify learning and inform improvements Chief Nurse



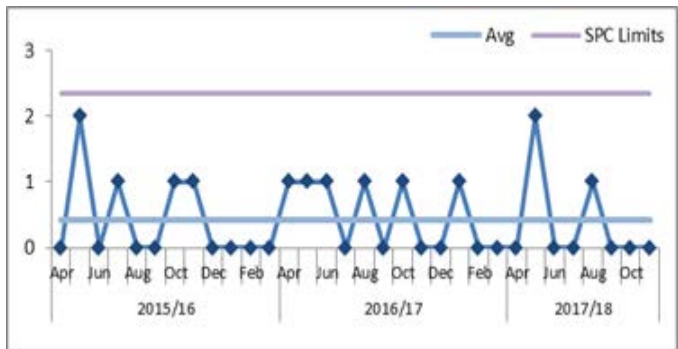
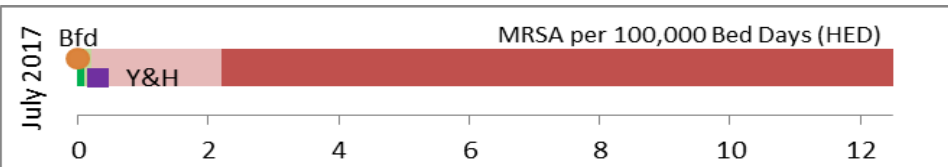
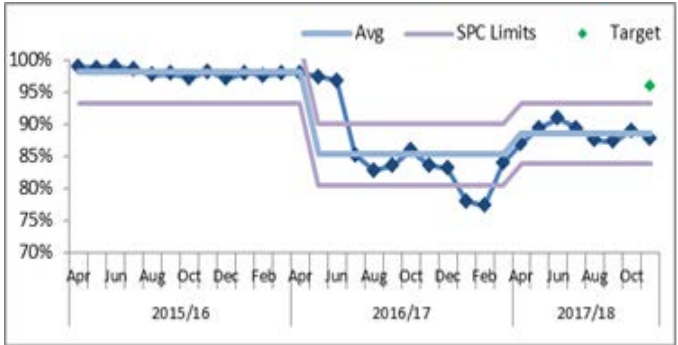
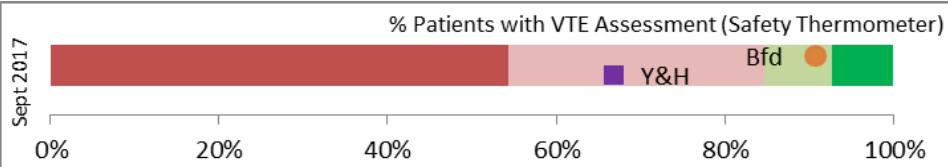
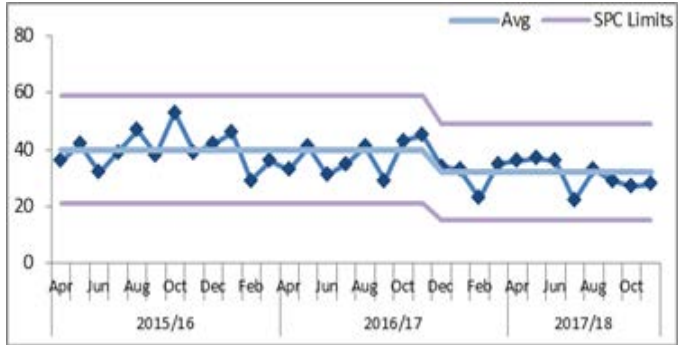
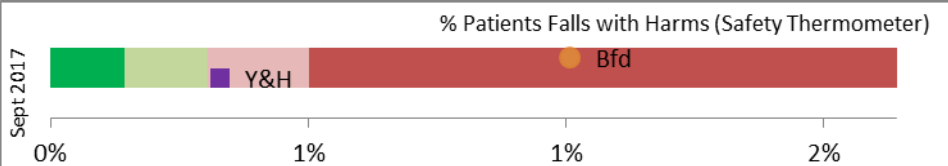
Ongoing challenges with consistency of MRSA/MSSA. Part of Chief Nurse national improvement collaborative for Infection Prevention & Control (IPC). Ongoing improvements overseen by IPC and reviewed in the Quarter 2 report.



Sustained reduction in C.difficile has been achieved. Robust PIR Chief Nurse process in place.



To provide outstanding care for patients

Trend	Challenges & Successes	Comparison	Exec Lead
	<p>Ongoing challenges with consistency of MRSA/MSSA .Part of national Chief Nurse improvement collaborative for Infection Prevention & Control (IPC). Ongoing improvements overseen by IPC and reviewed in the Quarter 2 report.</p>		
			
			

To provide outstanding care for patients

	Trend	Challenges & Successes	Comparison	Exec Lead
<div>Catheters & UTIs</div>		<p>Plans in place to undertake work (overseen by the IPC) to reduce the point prevalence of CAUTI. Opportunity to use the EPR to audit care and support improvement being explored.</p>		<p>Chief Nurse</p>
<div>Pressure Ulcers Cat 3+</div>		<p>Although this would appear a large deterioration in the position the TVN team believe that new documentation in EPR has led to some community acquired incidences being classed as hospital acquired. The November position is 3 grade 3's and 12 grade 2's – suggesting that the EPR documentation theory is correct. Targeted work has been commenced with Ward 31, who remain an outlier.</p>		<p>Chief Nurse</p>
<div>Pressure Ulcers Cat 2</div>				

To provide outstanding care for patients

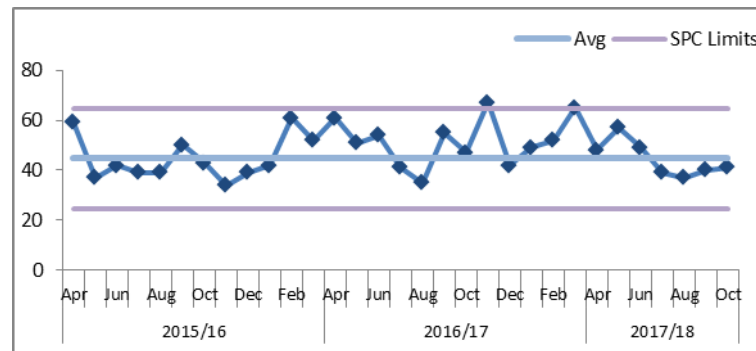
Trend

Challenges & Successes

Comparison

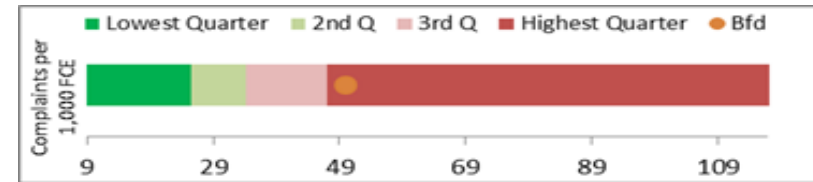
Exec Lead

Complaints

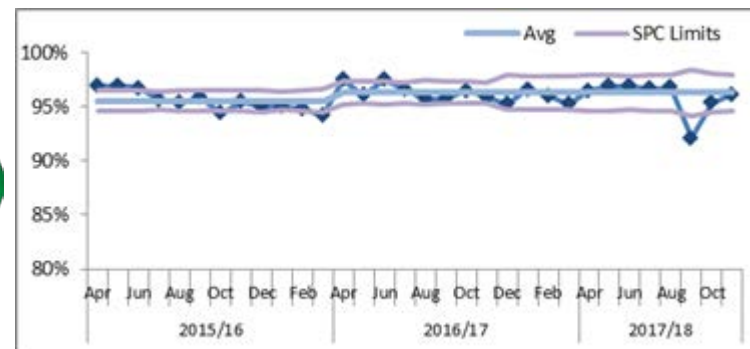


Complaints continue to reduce since a spike in March 2017.

Chief Nurse



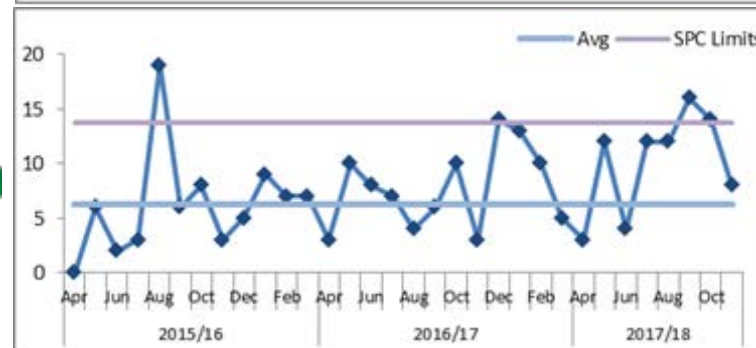
Friends and Family Test



The Friends and Family Test has recovered back to normal baseline after a drop in September 2017.

Chief Nurse

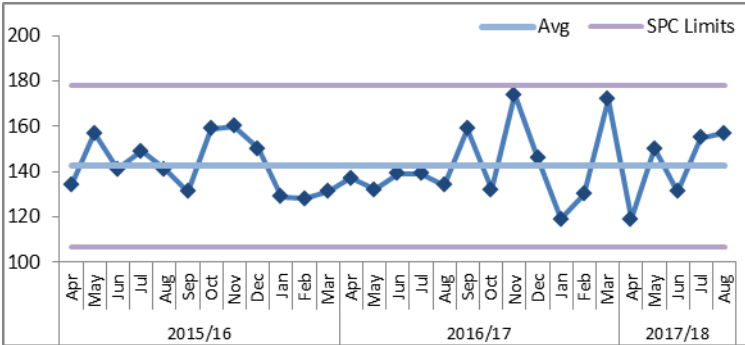
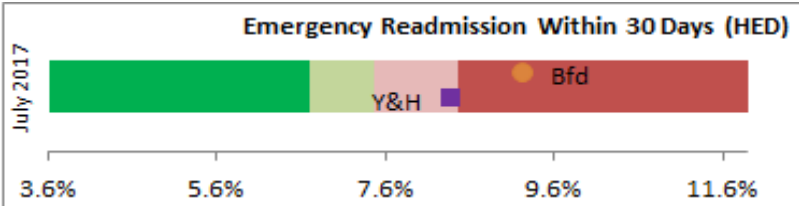
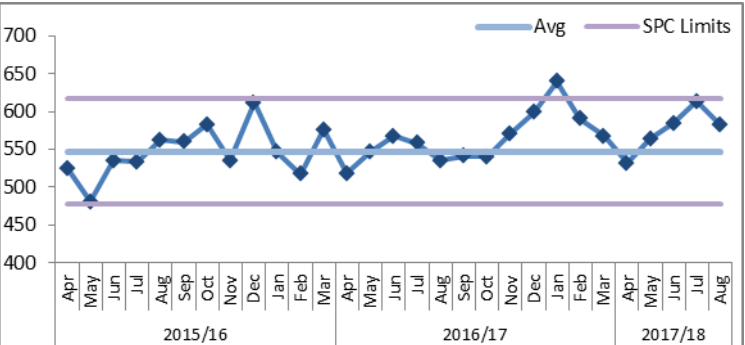
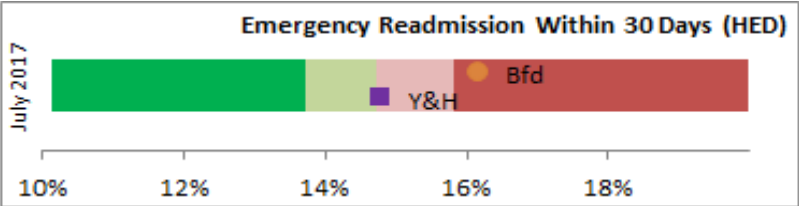
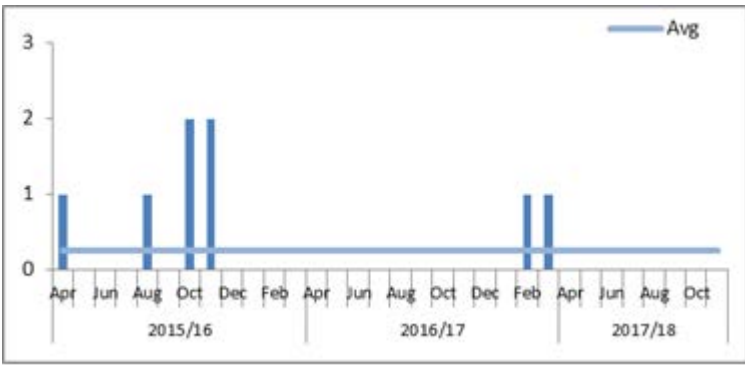
Night-time Transfers



There is a renewed focus on avoiding night-time transfers after 10 PM. Improvement is being enabled by the patient flow work.

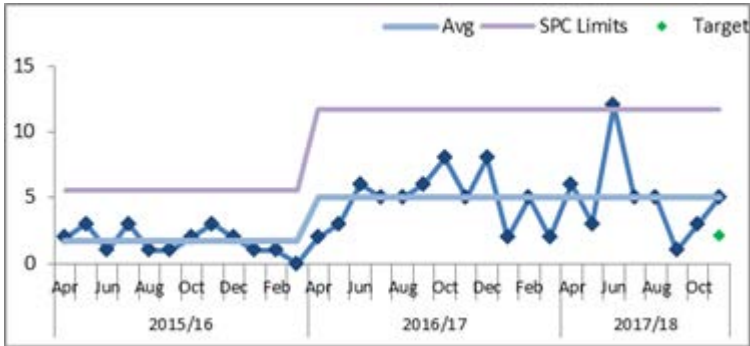
Director of Governance & Operations

To provide outstanding care for patients

	Trend	Challenges & Successes	Comparison	Exec Lead
<div>Readmissions from Elective</div>				Director of Governance & Operations
<div>Readmissions from Non-Elective</div>		Following review of the trend data, the clinical effectiveness team have been asked to look into the readmissions rates. Any key findings will be escalated.		Director of Governance & Operations
<div>Information Governance Breaches</div>		There have been no reportable Information Governance incidents this financial year to date. Awareness remains high as training was incorporated into EPR training.	No comparator data is published.	Director of Informatics

To provide outstanding care for patients

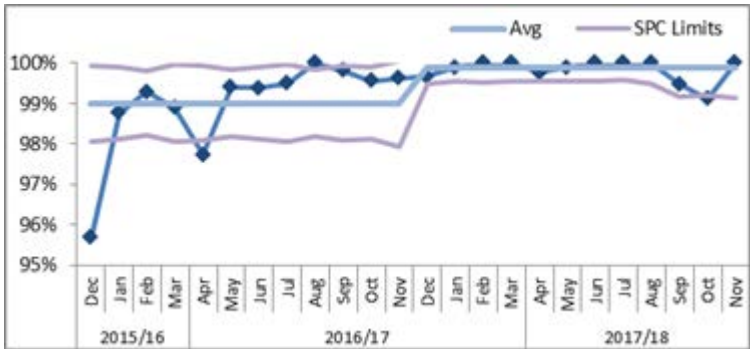
Trend	Challenges & Successes	Comparison	Exec Lead
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Each serious incident is investigated and reported to the Quality Committee.

No comparator data is available.

Director of Governance & Operations



Audited data has shown high compliance, however, recent observation work has identified that there is still work needed to continue to develop the culture of safety in theatres.




No comparator data is available.

Medical Director


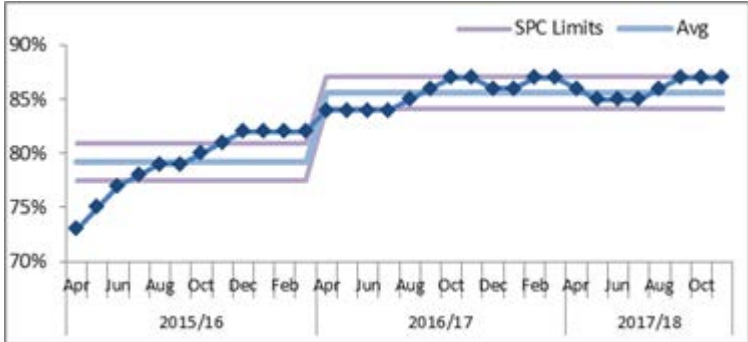

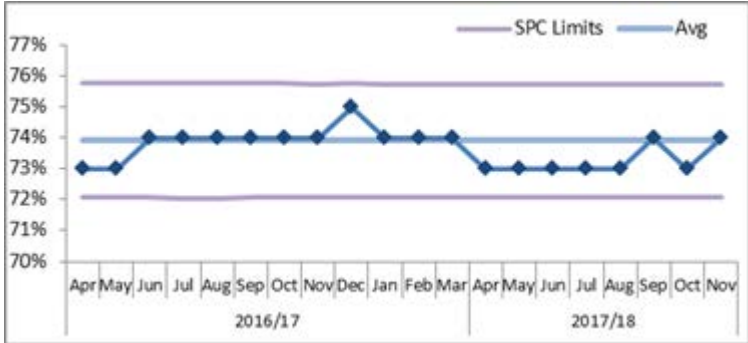

Serious Incidents

Audit of WHO Checklist

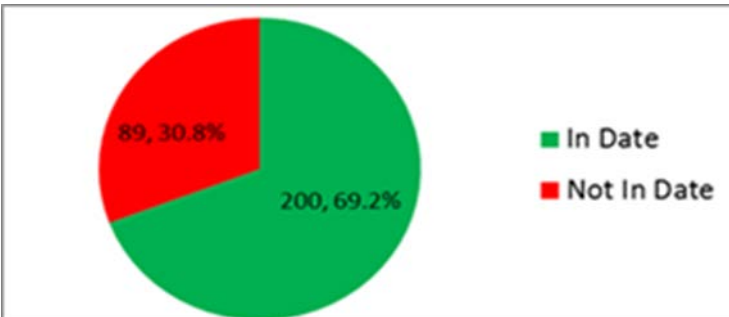
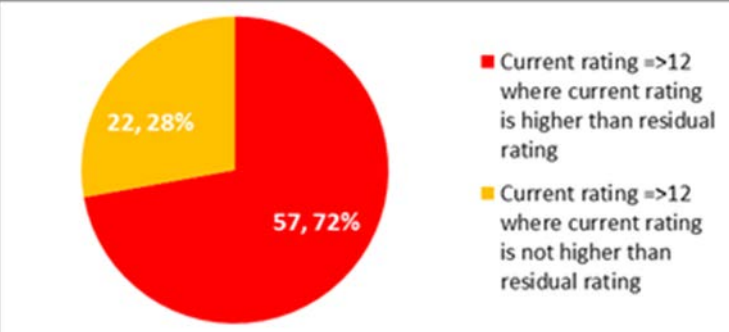
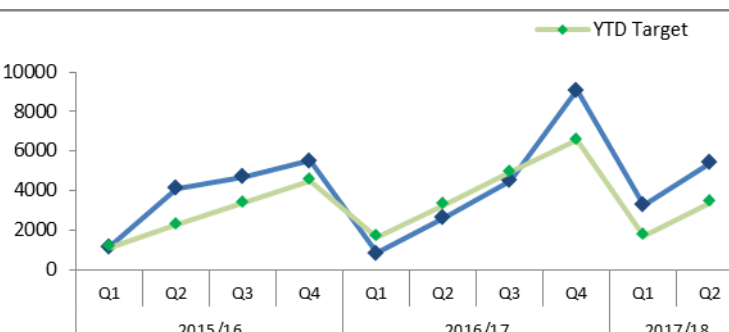
To collaborate effectively with local and regional partners

Trend	Challenges & Successes	Comparison	Exec Lead
	<p>BTHFT's systematic approach to stakeholder management identifies key external partners, and for each an executive sponsor and an account manager has been identified, with responsibility for maintaining/improving the health of the relationship. To establish the baseline an initial survey has been sent out by account managers to a cohort of the various stakeholder organisations (we are phasing the introduction to test the approach). The findings will help us determine whether an action plan is required to improve any of the individual relationships (to be measured on a "maturity index"). KPIs for this programme of work will focus initially on the achievement of basic inputs/milestones, and in time will evolve into evidence based measures of the extent of improvement based on stakeholder surveys.</p>		<p>Director of Strategy & Integration</p>
	<p>Our clinical strategy commits us to "work with local partners and contribute to the formal establishment of a responsive, integrated care system", in which Bradford service providers will work together to develop models of care which best meet the needs of service users, manage demand and achieve optimal vfm. This will be achieved by improving information and education, supporting self-care, and enhancing primary and community care arrangements. The aim is that attendance at the acute hospital is only for those patients that require care which cannot be provided elsewhere. Initially, CCGs have asked providers to develop a model for diabetes; in time, the ambition is for a broader range of "out of hospital" care to be managed in this way. KPIs for this programme of work will focus initially on the achievement of basic inputs/milestones, and in time will evolve into evidence based measures of growth in range and value of services covered.</p>		<p>Director of Strategy & Integration</p>
	<p>The Trust is committed to work with other acute providers to ensure resilient services, reduce outcome variation, address workforce shortages, achieve efficiencies, meet national activity volume standards, etc. However the collaboration environment is difficult – Trusts are funded and regulated separately, with individual financial and performance targets. With no prospect of legislative change, radical developments involve risk, and are undertaken against a historic backdrop of competition. KPIs for this work programme initially focus on the achievement of basic inputs/milestones, and in time will evolve into evidence based measures of growth in range and value of services covered.</p>		<p>Director of Strategy & Integration</p>

To be a continually learning organisation

	Trend	Challenges & Successes	Comparison	Exec Lead
		Core (mandatory) training compliance is relatively stable	Comparator data not available.	Medical Director
		High Priority training compliance has been stable for several months.	Comparator data not available.	Medical Director
	The Learning Hub is becoming well established within the Trust and is meeting expectations in relation to delivery of the agreed learning outputs, for example, Learning Matters. A full review is planned for Q1 2018/19.			Director of Governance & Operations

To be a continually learning organisation

Trend	Challenges & Successes	Comparison	Exec Lead
 <p>Out of date policies</p>	<p>A focussed programme of work commenced in Quarter 3 in order to improve the Trust position in relation to Trust-wide policies and their management. There is significant confidence about the approach to managing locally-developed guidance within Divisions</p>	<p>Comparator data not available.</p>	<p>Director of Governance & Operations</p>
 <p>Risks not mitigated</p>	<p>There is a clear work programme to improve the risk assessments and plans by the end of Quarter 3. Skilled risk staff have been devolved to the divisions to support and sustain this work. The Integrated Governance and Risk Committee review has commenced. The refreshed Risk Management Strategy has been completed and approved.</p>	<p>Comparator data not available.</p>	<p>Director of Governance & Operations</p>
 <p>Research patients recruited</p>	<p>Number of participants recruited to National Institute for Health Research Portfolio Studies since 2015, including commercial and non-commercial studies, remains strong and in line with expectation.</p>	<p>Comparator data not available.</p>	<p>Medical Director</p>

To be in the top 20% of employers in the NHS

Trend

Challenges & Successes

Comparison

Exec Lead

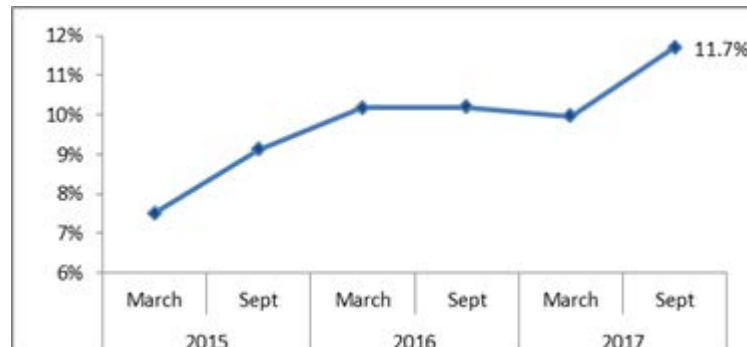
Appraisal
Rate Non-
Medical



The target for non-medical appraisal is that 100% of eligible employees are appraised as of the end of November 2017 appraisal rates were at 82.4%. The divisions continue to be supported by the OD Team to ensure that appraisal remains high priority and that performance does not deteriorate.

Director of
Human
Resources

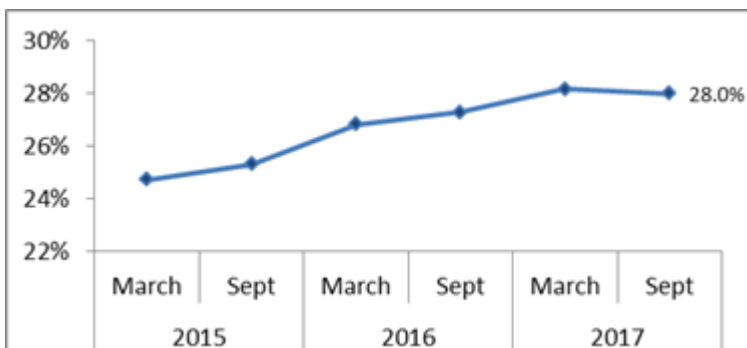
BAME %
Senior Leaders



We have made a significant increase in the number of BAME staff at Bands 8 & 9 over the past six months. However, based on the current trajectory, we would miss our employment target to have a senior workforce reflective of the local population by 2025 by around 14%.

Director of
Human
Resources

BAME %
Workforce



Good progress is being made. We are ahead of our trajectory to have a workforce reflective of the local ethnic local population by 2025.

Director of
Human
Resources

To be in the top 20% of employers in the NHS

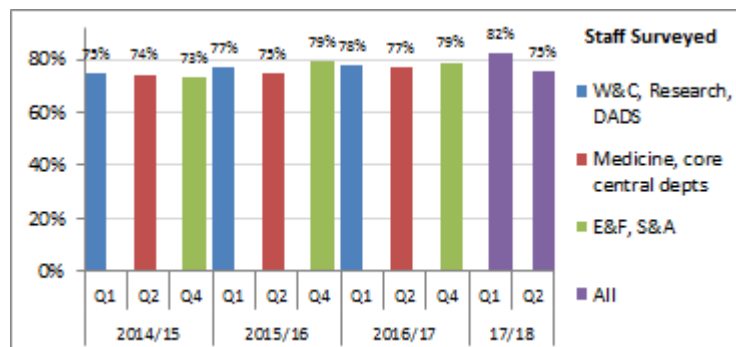
Trend

Challenges & Successes

Comparison

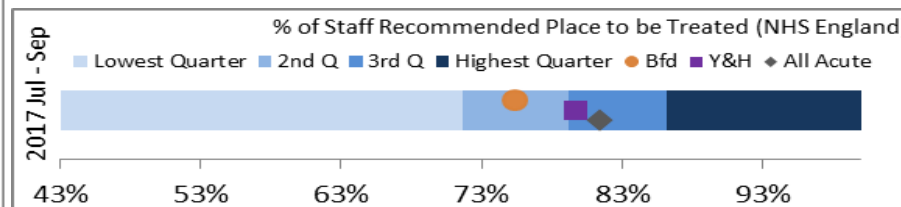
Exec Lead

Staff FFT Treatment

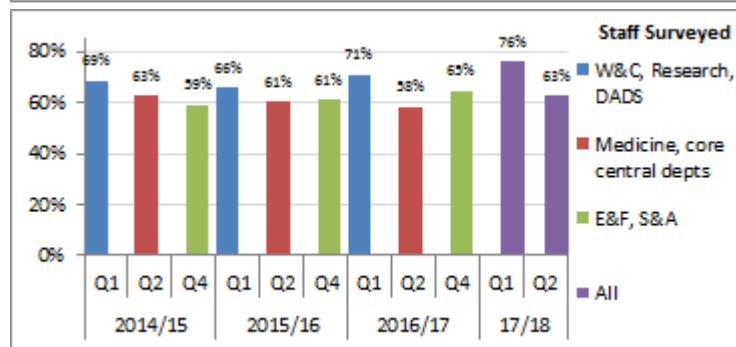


BTHFT is currently below the Yorkshire and Humber average and slightly below average for all acutes. The Trust target is to be agreed in line with the NHS Quest Employment Brand Standards and Criteria.

Director of Human Resources

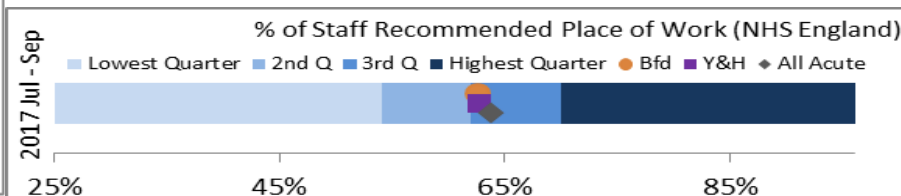


Staff FFT Work

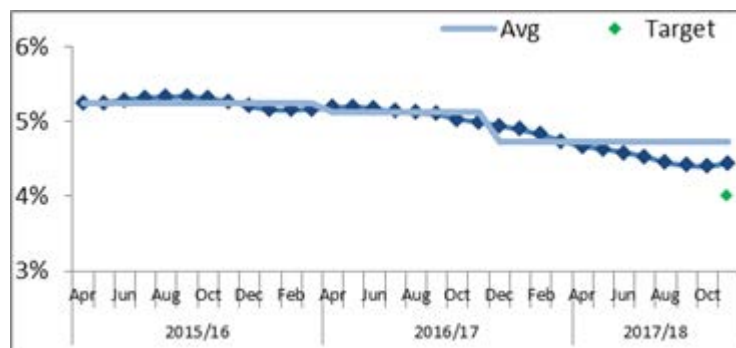


The target is to be agreed in line with NHS Quest Employment Brand Standards and Criteria. The Trust is in line with the region. Significant work is ongoing to improve engagement and experience at work through the actions plans agreed as part of the People Strategy. These action plans are monitored through the Trust Education and Workforce Committee.

Director of Human Resources

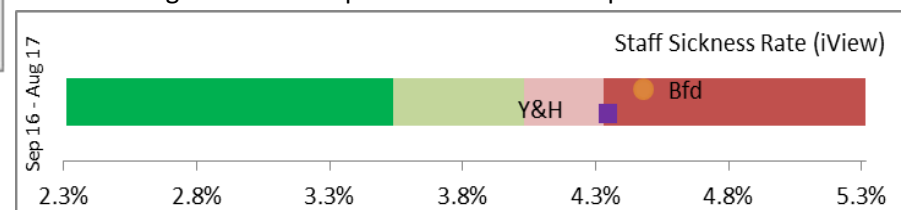


Sickness



Sickness rate reductions are monitored through the Trust Improvement Programme. Sickness rate reductions are part of the two year programme to reduce trust absence to 4% by the end of March 2018. Targets are in place for each Division and corporate department. Monthly reports show progress against the target. The Trust Year to Date absence % rate has increased slightly at the end of November to 4.44%. Sustained effective management of absence must continue during the winter period. The benchmarking data will be updated for the next report.

Director of Human Resources



To be in the top 20% of employers in the NHS

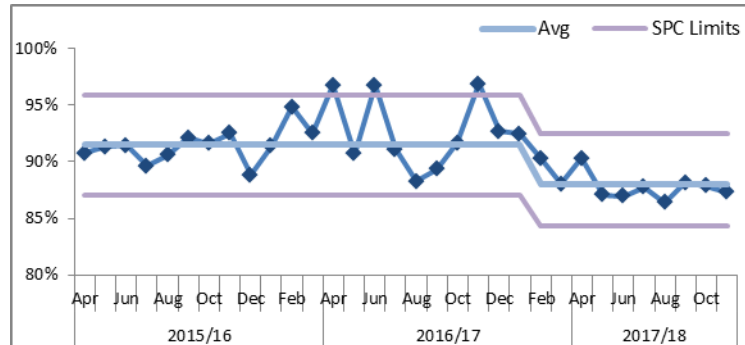
Trend

Challenges & Successes

Comparison

Exec Lead

Nursing
Shifts
Filled



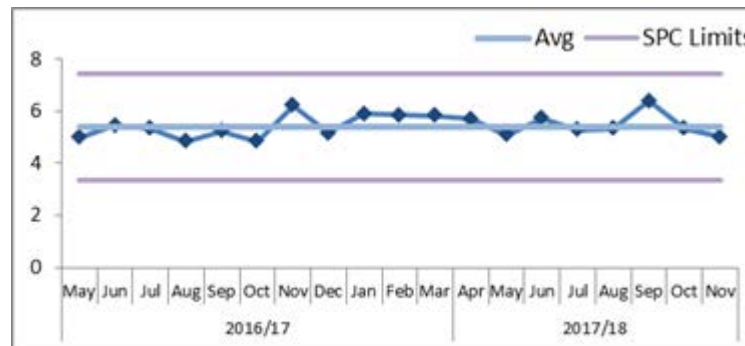
Ongoing challenges with recruitment of registered nurses. Reward and recognition work plan for nursing has been agreed. Comparator data is available from Model Hospital but is dated. Chief Nurse

Care Staff
Shifts
Filled

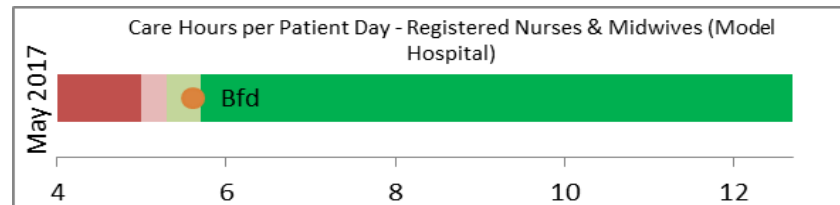


The fill rates for care staff has been consistently over the planned, Chief Nurse but this reflects the fact that care staff are used to backfill gaps in registered nurses to ensure basic care needs can be provided for.

Nursing Care
Hours



Care hours per day is a rough measure that is expected to remain stable. Care hours vary by type of care being given and patient acuity, for example, intensive care. Chief Nurse



To be in the top 20% of employers in the NHS

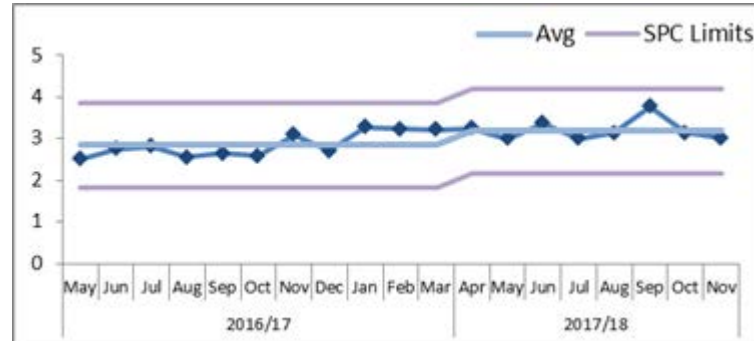
Trend

Challenges & Successes

Comparison

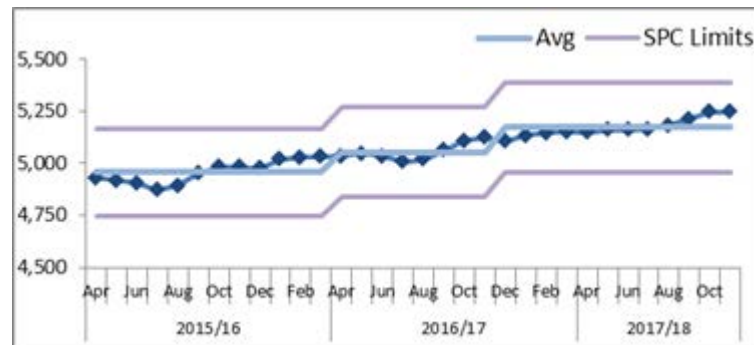
Exec Lead

Care Staff Care Hours



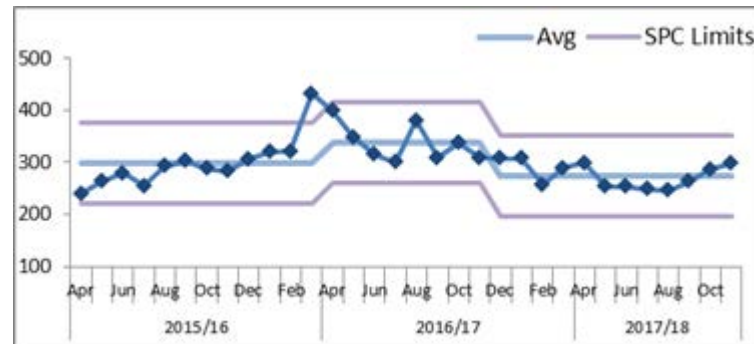
Care hours per day is a rough measure that is expected to remain stable. Care hours vary by type of care being given and patient acuity, for example, intensive care. Chief Nurse

Staff in Post

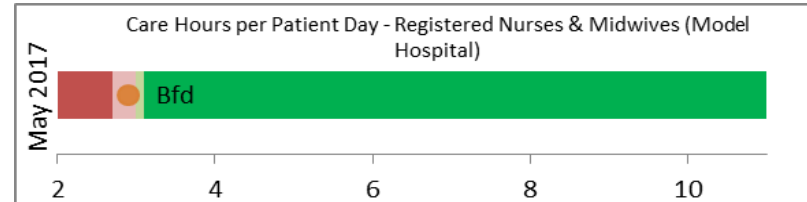


Full time Equivalents at the Trust have slightly increased and are now at 5249. Increases in the last month have been in the AHP and Medical and Dental staff groups. Director of Human Resources

Use of Agency (WTE)



Use of Agency continues to be monitored closely and is subject to robust approval mechanisms. Agency cover for vacant clinical posts remains the primary reason for usage. Director of Human Resources



To be in the top 20% of employers in the NHS

Trend

Challenges & Successes

Comparison

Exec Lead

Turnover



Turnover % rates are reported on to the Trust Workforce Committee and are monitored by trend and exception. Turnover is expected to sit within a range of 10% to 12%. Turnover is benchmarked against West Yorkshire Acute Trusts.

To deliver our financial plan and key performance targets

Trend

Challenges & Successes

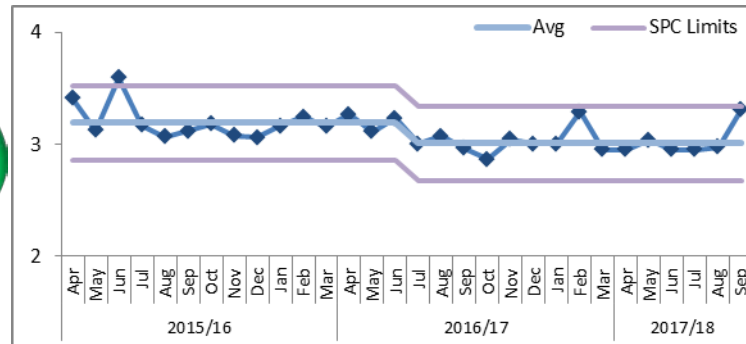
Comparison

Exec Lead

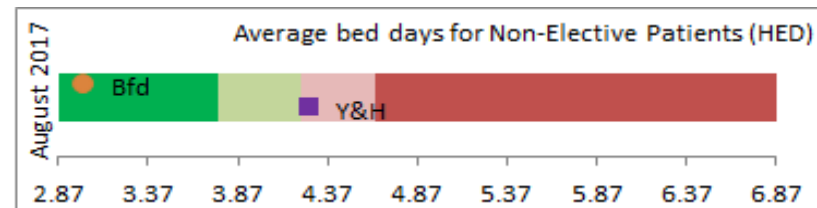
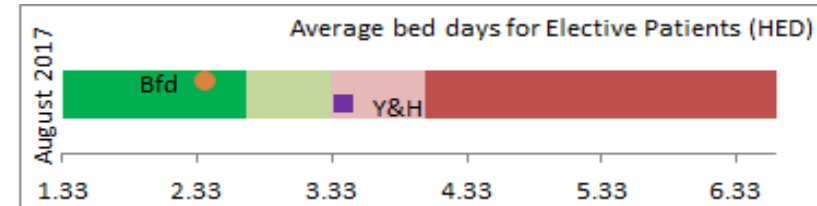
Length of Stay
Elective



Length of Stay
Non-Elective



Length of stay will be updated with a new EPR report.



Director of
Governance
& Operations

Director of
Governance
& Operations

To deliver our financial plan and key performance targets

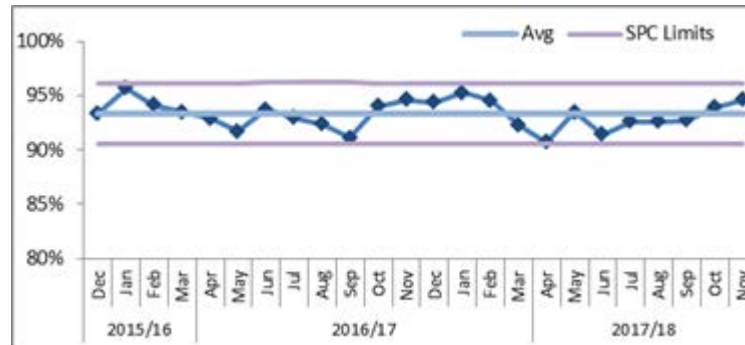
Trend

Challenges & Successes

Comparison

Exec Lead

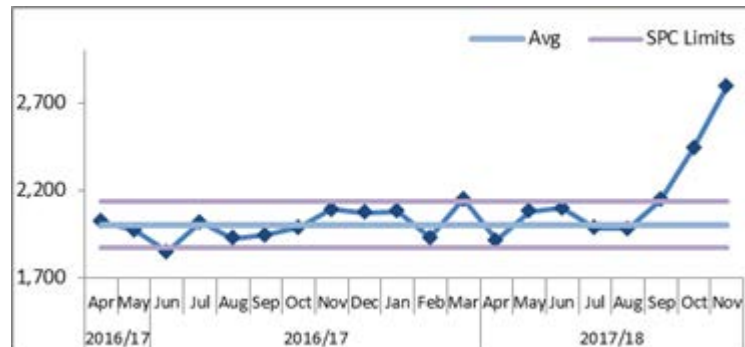
Bed
Occupancy



Bed occupancy continues to remain relatively static. Focussed work continues to ensure careful management of beds.

Director of
Governance
& Operations

Discharges
before 1
PM



Discharges before 1pm appear to be rising as part of quality improvement work.

Director of
Governance
& Operations

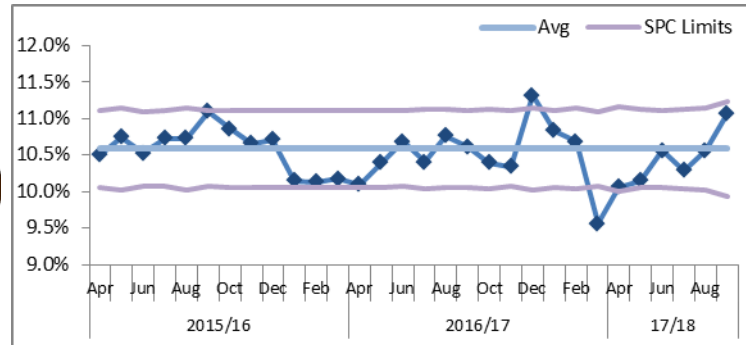
To deliver our financial plan and key performance targets

Trend

Challenges & Successes

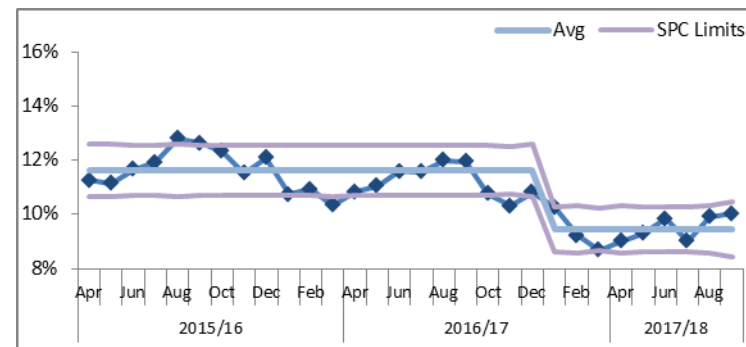
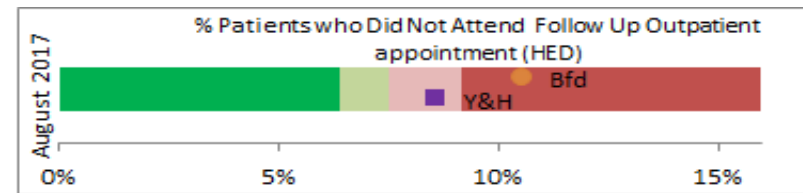
Comparison

Exec Lead



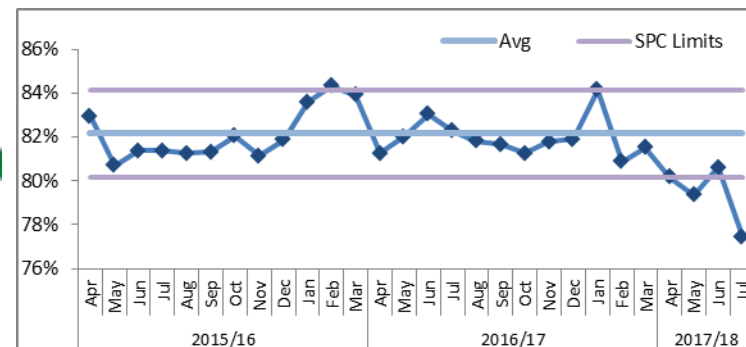
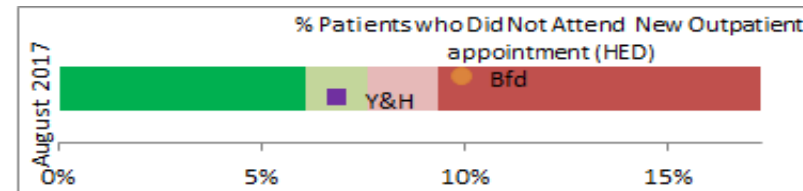
Did Not Attend rates for November 2017 are not yet available due to the introduction of EPR. Did Not Attend rates are being reviewed within the Out Patient Improvement Programme.

Director of Governance & Operations



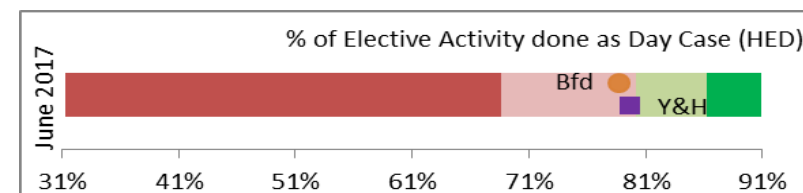
DNA rates for new appointments increased for the last 2 months, and are comparatively high vs Acute trusts. this is being reviewed within the Out Patient Improvement Programme.

Director of Governance & Operations



Benchmark well for day case activity but some specialties need further review. Updated data, post EPR introduction will be available next month.

Director of Governance & Operation.



To deliver our financial plan and key performance targets

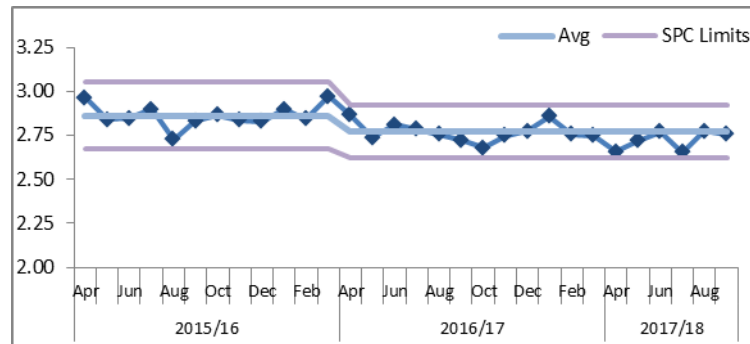
Trend

Challenges & Successes

Comparison

Exec Lead

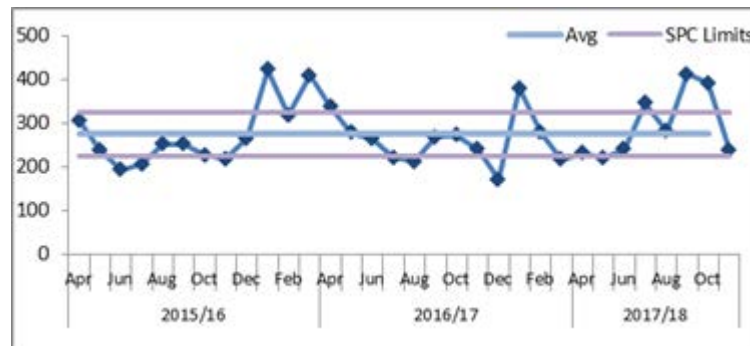
New to Follow-up Ratio



This metric is being reviewed as part of the Out Patient Improvement Programme. Updated data will be available next month due to introduction of EPR.

Director of Governance & Operations

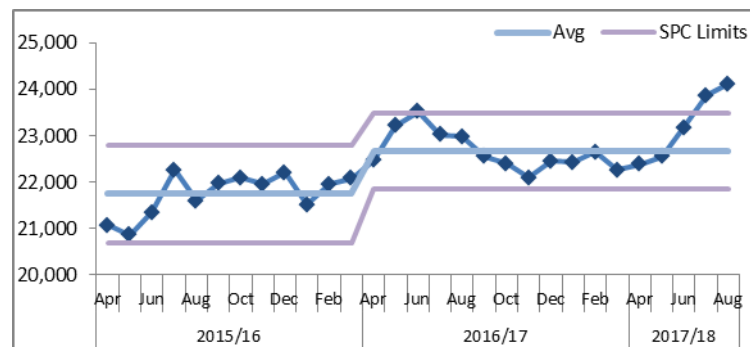
Short notice Clinic Cancellations



Three key specialties have been reviewed and root causes identified. The divisions are now implementing remedial action to bring performance into compliance. Further specialties are now under review.

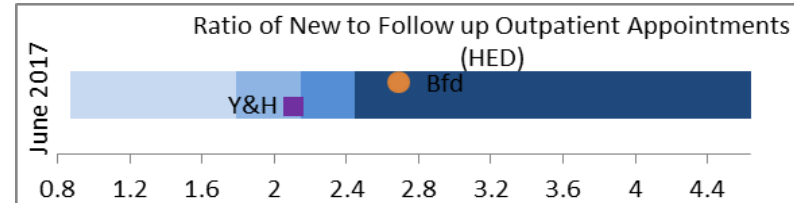
Director of Governance & Operations

Elective Wait List



The aggregate data is not available due to report availability from EPR. The wait lists are being managed proactively through the weekly planned care access group.

Director of Governance & Operations

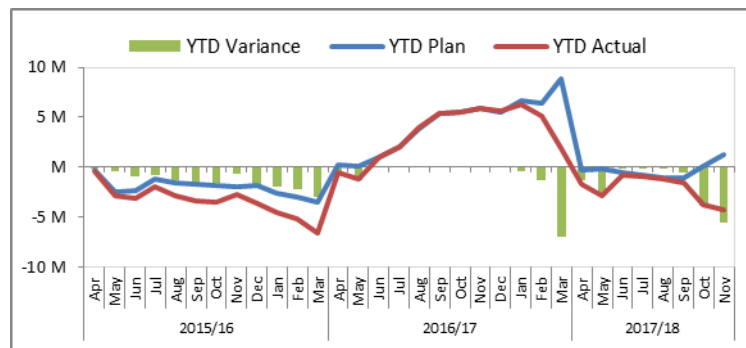


To deliver our financial plan and key performance targets

Trend

Challenges & Successes

Exec Lead



The Trust reported a pre-STF deficit of £7.5m at the end of month 8 Director of Finance which is £3.3m behind the pre-STF control total. None of the £2m STF can be recovered for Month 7 and 8. Including STF recovered for Q1 & Q2, the YTD post-STF position is a deficit of £4.3m against a planned £1.2m surplus, meaning the Trust is £5.5m behind the cumulative post-STF control total. The in-month position is an adverse pre-STF variance of £1.0m. A surplus of £0.4m was forecast in the Improvement Plan, which means the Trust is £1.4m behind the Improvement Plan trajectory shared with NHSI. The FYE forecast presented is full delivery of the Improvement Plan and pre-STF control total, although there remain unmitigated risks to this forecast.

NHSI Use of Resources	Plan	Actual	Last
Risk Rating (UoR)	YTD	YTD	Month
As at 30.11.17			
Capital Servicing Capacity	2	4	3
Liquidity	1	1	1
I & E Margin	3	4	4
Variance from plan (I & E Margin)	1	4	3
Agency Spend	2	2	2
Combined UoR (after triggers)	2	3	2

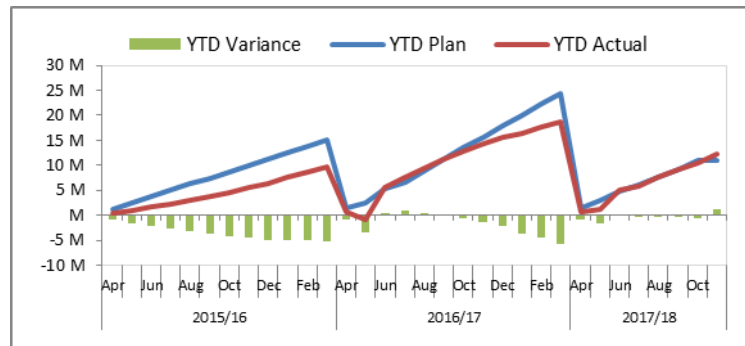
The deterioration in the financial position in October and November Director of Finance 2017 has impacted on the 'UoR' rating which overall is reporting a Finance rating of 3. The two metrics deteriorating in month are 'I&E Margin' and 'Variance from Control Total'. The annual plan was to deliver an overall rating of 2 by the end of the year. Delivery of the improvement plan will secure the planned 'UoR' rating.

To deliver our financial plan and key performance targets

Trend

Challenges & Successes

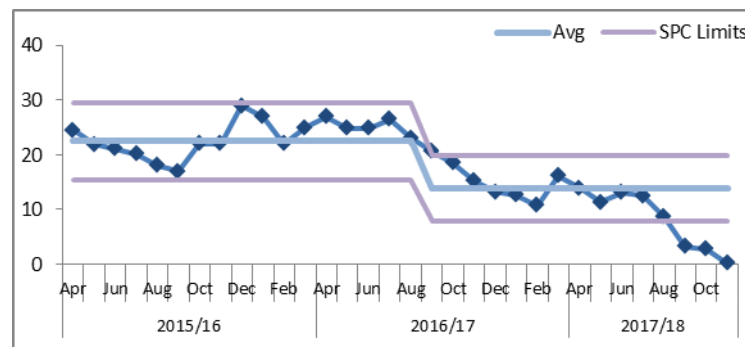
Exec Lead



Cumulative CIP delivery at the end of November was £12.2m against a YTD target of £11.1m. Although £1.1m ahead of plan, this reflects the rephasing of the improvement plan due to under-delivery in the early part of the year, with a substantial increased requirement in Q4.

The forecast delivery from the original CIP programmes have been amalgamated with the £12.2m Improvement Plan requirement to arrive at a projected combined efficiency requirement of £25.8m in 2017/18.

This target reflects deteriorations in the income and expenditure run rate in recent months and additional unplanned cost pressures arising in the year, as well as the reliance on non-recurrent measures to deliver the control total in Quarters 1 & 2.



Liquidity is 2.2 days below plan at the end of November, reflecting the use of non-recurrent measures to offset improvement plan shortfalls, lower than planned levels of clinical income and delays with STF payments.

Delivery of the improvement plan will ensure the planned level of liquidity for the year will be delivered. Any shortfall in delivery of the improvement plan/Pre STF control total will have a material impact on the planned liquidity position given the value of the STF funding available in Q3 and Q4.

Cost Improvement Plan

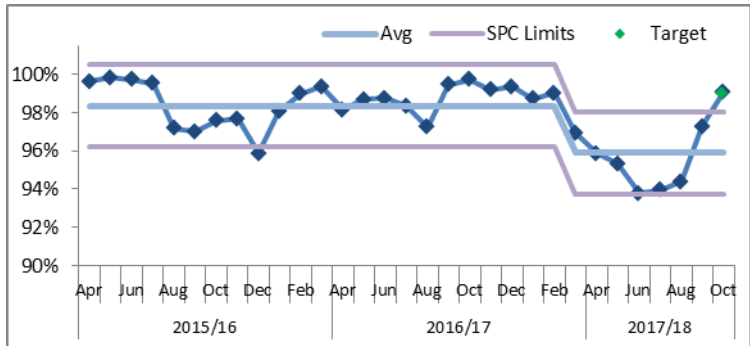
Liquidity rating

National Indicators

Single Oversight Framework

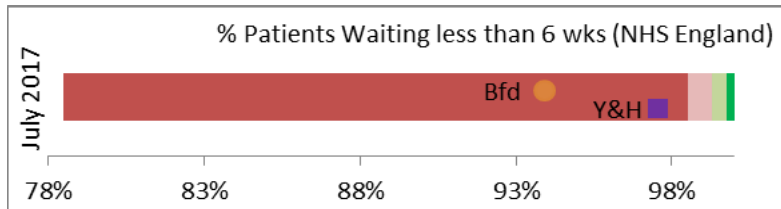
Trend	Challenges & Successes	Comparison	Exec Lead
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Diagnostic Waits



Waits for CT Scans have continued to improve. October 2017 now meeting target at 99.1%.

Director of Governance & Operations



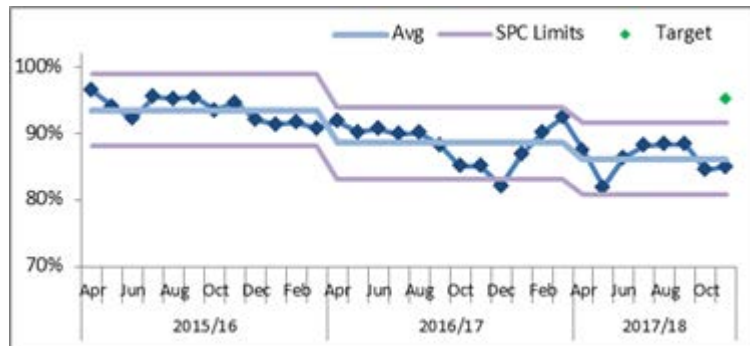
Use of Resources - Financial

NHSI Use of Resources	Plan YTD	Actual YTD	Last Month
Risk Rating (UoR)			
As at 30.11.17			
Capital Servicing Capacity	2	4	3
Liquidity	1	1	1
I & E Margin	3	4	4
Variance from plan (I & E Margin)	1	4	3
Agency Spend	2	2	2
Combined UoR (after triggers)	2	3	2

The deterioration in the financial position in October and November 2017 has impacted on the 'UoR' rating which overall is reporting a rating of 3. The two metrics deteriorating in these months are 'I&E Margin' and 'Variance from Control Total'. The annual plan was to deliver an overall rating of 2 by the end of the year. Delivery of the improvement plan will secure the planned 'UoR' rating.

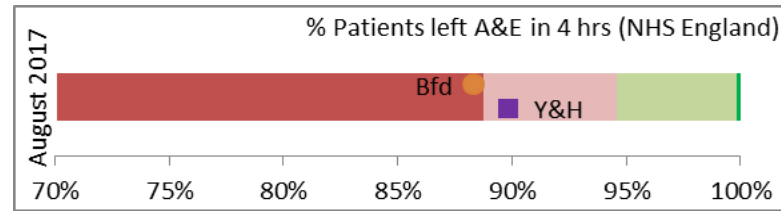
Director of Finance

Emergency Care Standard



Performance continues at a similar rate in November 2017 of patients being discharged within 4 hours from the department. Work on the improvement plan has commenced. Notably the Clinical Decisions Unit has now opened.

Director of Governance and Operations

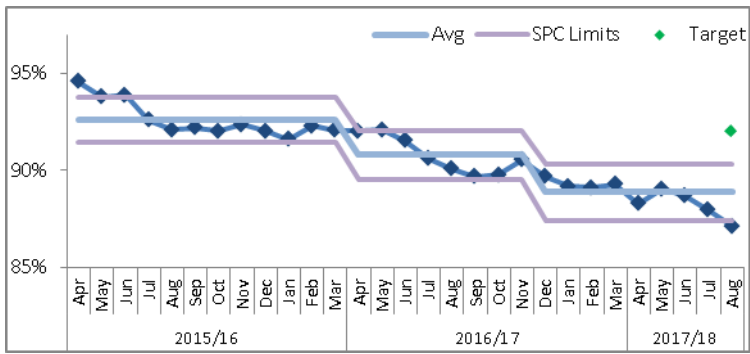


National Indicators

Single Oversight Framework

Trend	Challenges & Successes	Exec Lead
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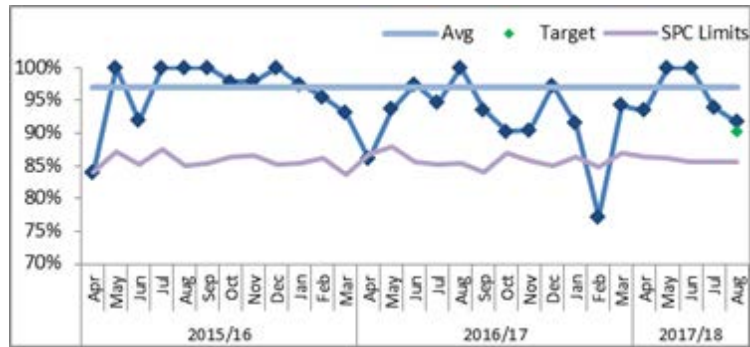
RTT 18 Week Incomplete



The aggregate RTT and Cancer data is not available due to report availability from EPR. The weekly planned care access group continues to challenge the position on a patient-by-patient level with all divisions. RTT 18 week admitted performance is relatively stable, but below the target and the local and National picture.

Director of Governance & Operations

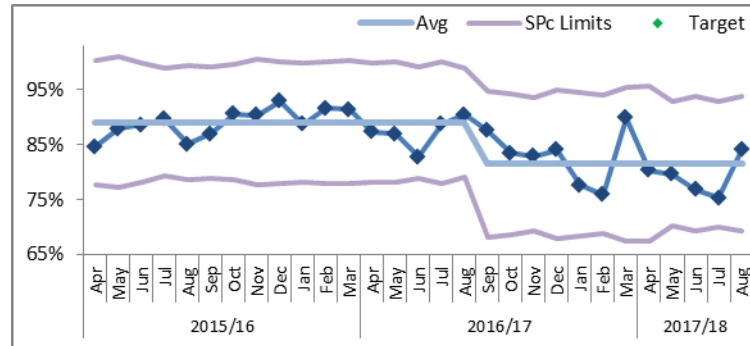
Cancer Urgent 62 Day Screening



The position continues to be managed via the cancer lead in conjunction with the divisional teams. Updated data on cancer will be available in the next report.

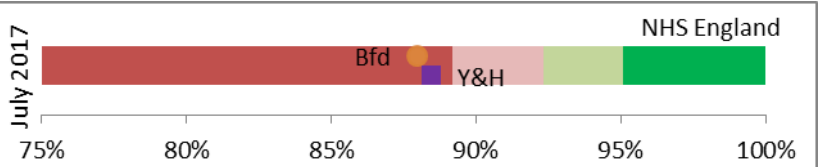
Director of Governance & Operations

Cancer Urgent 62 Day GP



The cancer recovery plan is being implemented with actions monitored through the weekly planned care access group.

Director of Governance & Operations

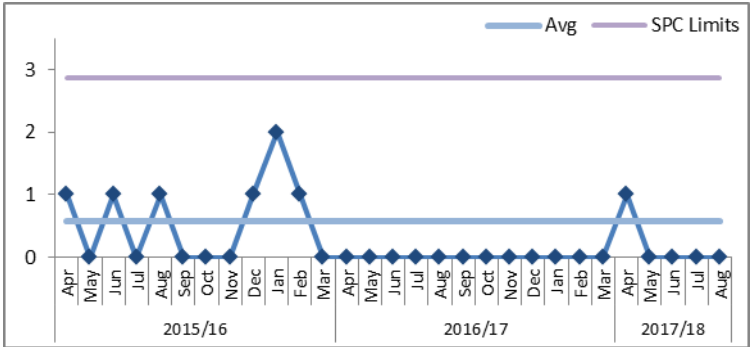


National Indicators

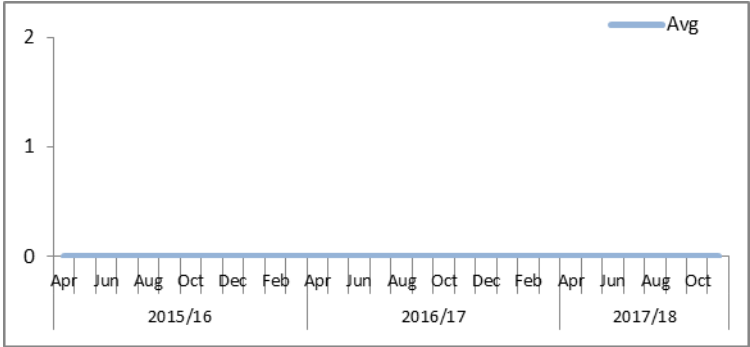
National Target Non-Financial

Trend	Challenges & Successes	Exec Lead
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RTT 52
Week Wait



Trolley Waits
>12 Hours




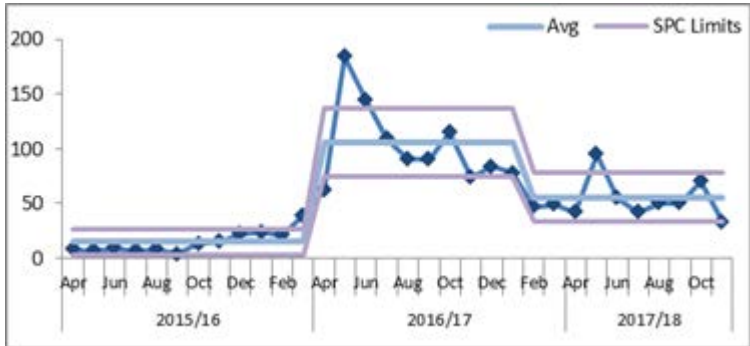
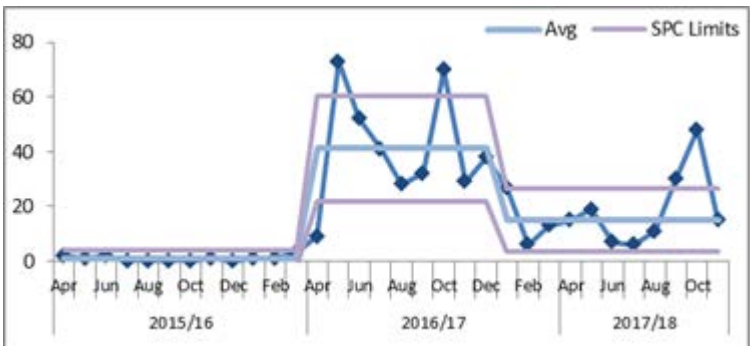
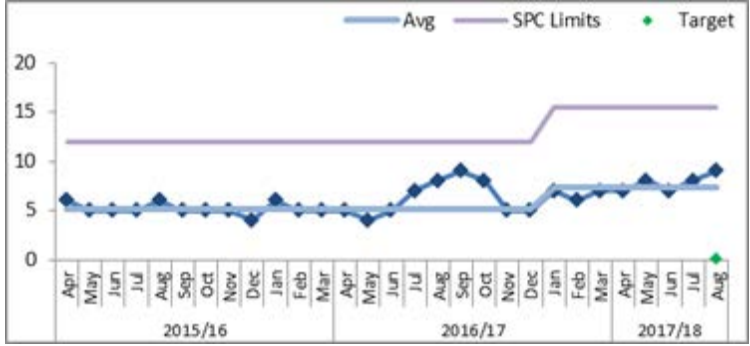
The aggregate data is not available due to report availability from EPR. Director of Governance & Operations

The weekly planned care access group continues to manage on a patient-by-patient level with all divisions. Very good tracking minimises the chance of a 52 week breach.

There have been no > 12 hour trolley waits. Director of Governance & Operations

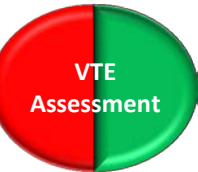
National Indicators

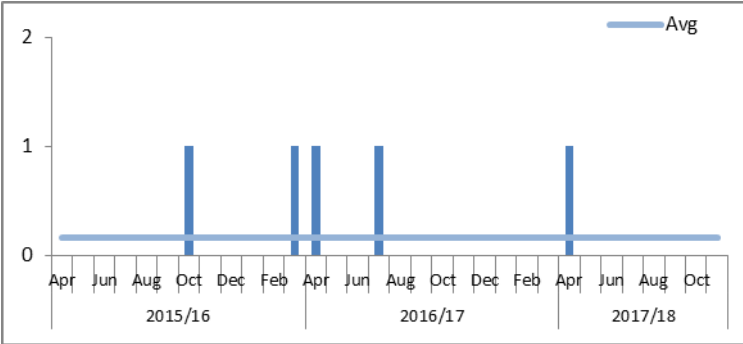
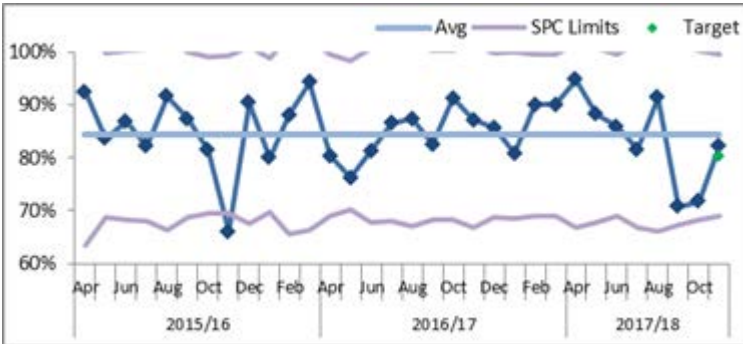

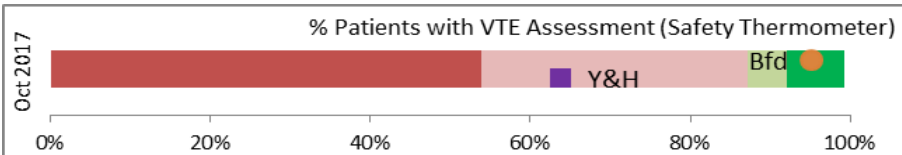
National Target Non-Financial

Trend		Challenges & Successes	Comparison	Exec Lead
 Ambulance Handover 30-60 mins		The Trust is not currently meeting the standard for ambulance handover. Plans are in place , as part of the AED Improvement Plan to improve this position.		Director of Governance & Operations
		The Trust is not currently meeting the standard for ambulance handover. Plans are in place , as part of the AED Improvement Plan to improve this position.		Director of Governance & Operations
		The aggregate data is not available due to report availability from EPR. The weekly planned care access group continues to challenge the position on a patient-by-patient level with all divisions. There are currently nine specialties failing the RTT target. Focussed work is in progress. Up to date data is not available due to EPR implementation. There is local management through the weekly planned access meetings.		Director of Governance & Operations

National Indicators

National Target Financial



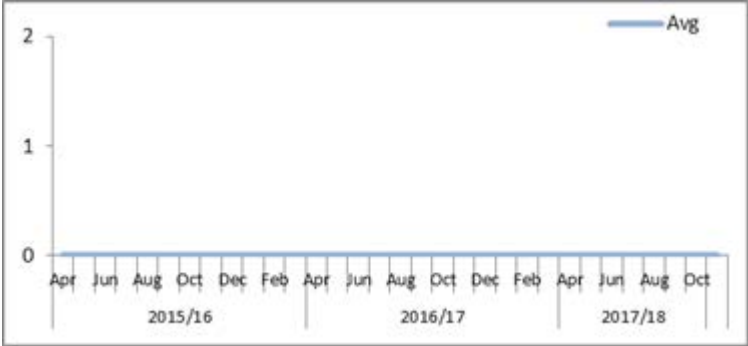
Trend	Challenges & Successes	Comparison	Exec Lead
	No Never Events reported this month.	No comparator data is available.	Director of Governance & Operations
	All breaches of the target continue to be reviewed by the lead		Director of Governance & Operations
	VTE assessments were high historically and suddenly fell in Jul 2016 with a Medical change in the system. Documentation has improved since Mar 2017 and is on track for our trajectory. There is a Prevention of VTE action plan which aims to eliminate the risk of a preventable Venous Thromboembolism through high quality assessment, risk reduction and patient information. A change team is in place to oversee this work led by the Deputy Medical for Patient Safety and Risk. The Prevention of VTE sub-group now meets regularly and is targeting work based upon review of data from the EPR and reviewing and updating the cohorts for this measure.		Medical Director
			

National Indicators

National Target Financial

Trend	Challenges & Successes	Comparison	Exec Lead
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Duty of Candour



There have been no Duty of Candour breaches.

Director of Governance & Operations

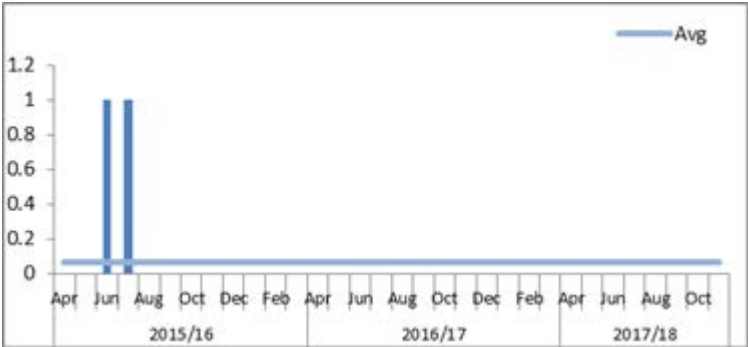
Formulary

The Trust ensures that the Formulary is published on the website

No comparator data is available.

Director of Informatics

Mixed Sex Breaches



There have been no Mixed Sex Breaches.

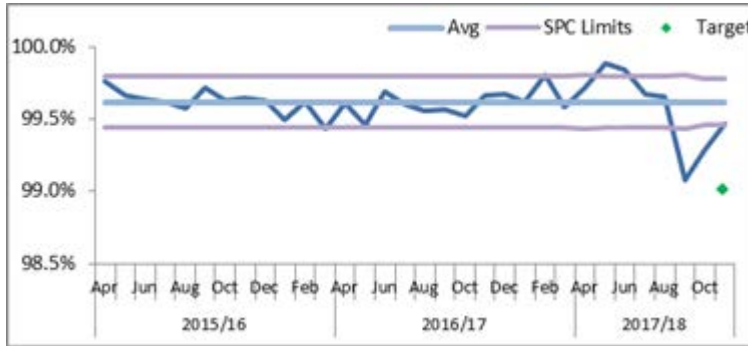
Director of Governance & Operations

National Indicators

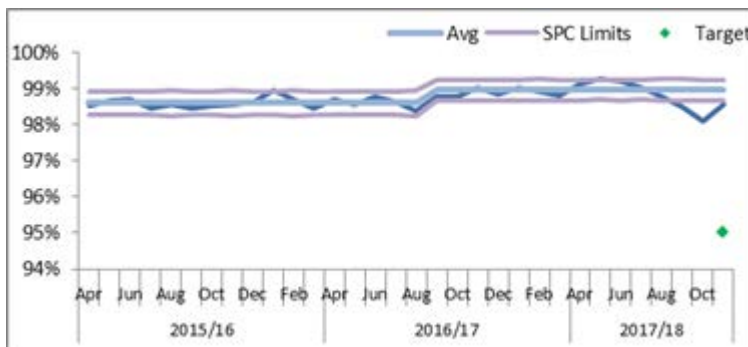
National Target Financial

Trend	Challenges & Successes	Exec Lead
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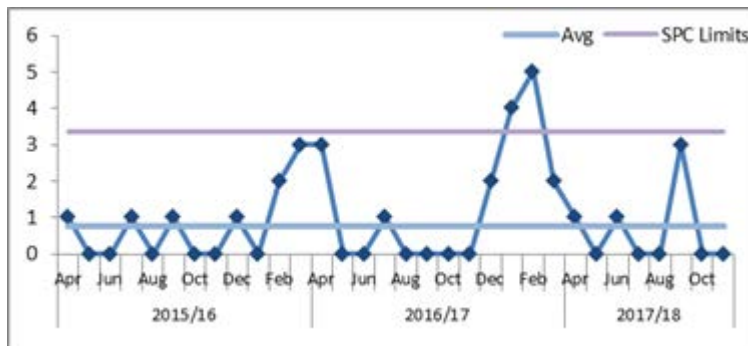
NHS No's
Acute



NHS No's
A&E



Cancelled
Operations 28
day



With the standardisation and integration of the patient Director of administration system data, as the one source of truth, the Informatics Trust compliance to NHS Number use is strong.

With the standardisation and integration of the patient Director of administration system data, as the one source of truth, the Informatics Trust compliance to NHS Number use is strong.

All cases have been reviewed for September 2017 and there Director of was no systematic root cause. No cases in October and Governance & November 2017. Operations

National Indicators

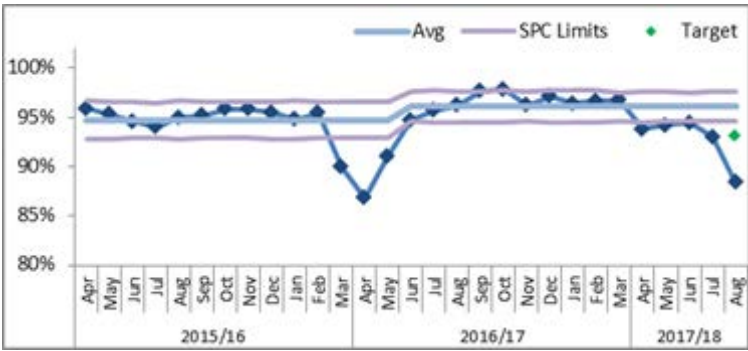
National Target Financial

Cancer 2 Week GP

Cancer 1st Treatment

Cancer 2 Week - Breast

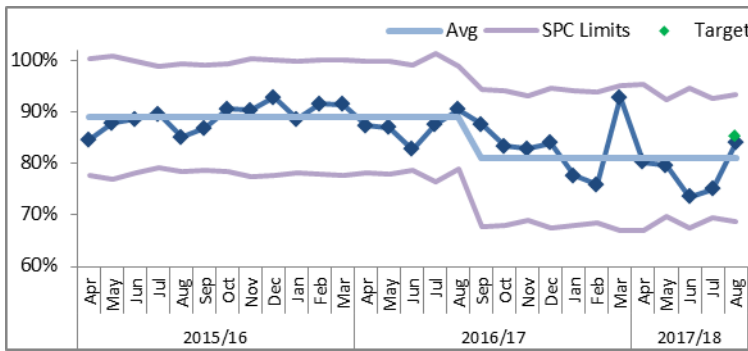
Trend	Challenges & Successes	Exec Lead
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The aggregate data is not available due to report availability from EPR, which is now in place. Data will be available next month.

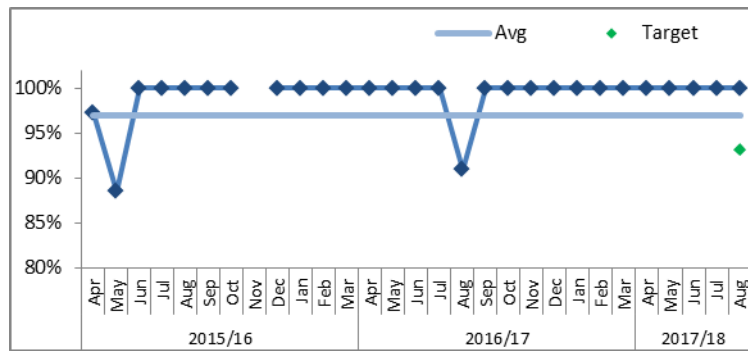
Cancer patients are carefully being managed patient-by-patient and reported through the access meetings.

Director of Governance & Operations



Cancer patients are carefully being managed patient-by-patient and reported through the access meetings.

Director of Governance & Operations



Cancer patients are carefully being managed patient-by-patient and reported through the access meetings.

Director of Governance & Operations

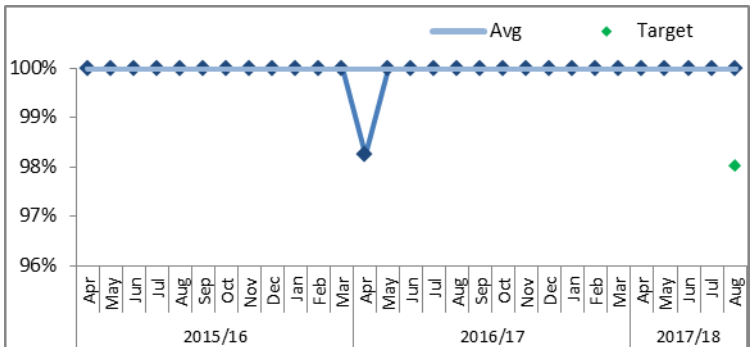
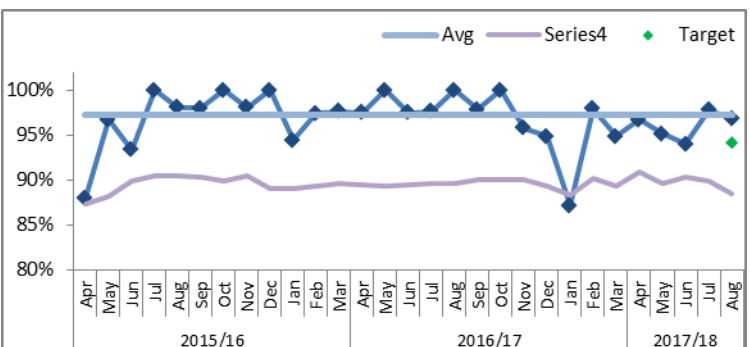
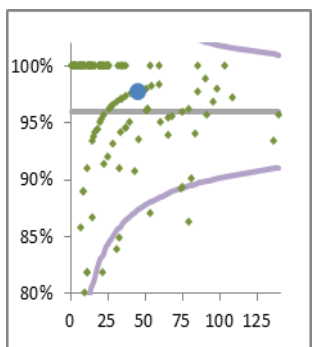
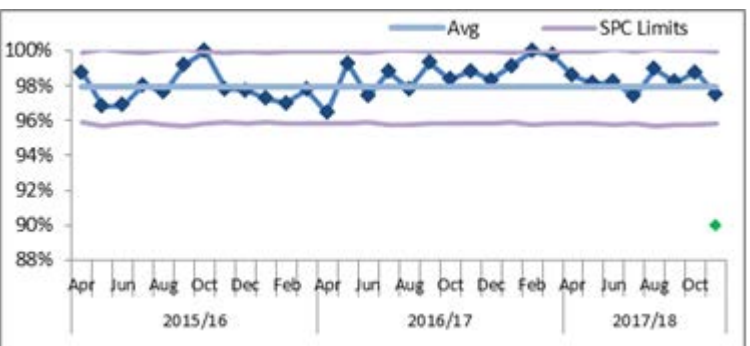
National Indicators

National Target Financial

Cancer 2nd Treatment Drugs

Cancer 2nd Treatment Surgery

Seen By Midwife <13 Weeks

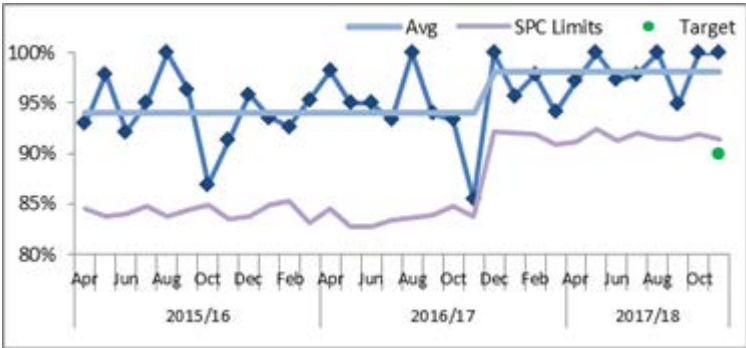
Trend	Challenges & Successes	Comparison	Exec Lead
 <p>The chart displays the average performance (Avg) and target (Target) for Cancer 2nd Treatment Drugs from April 2015 to August 2017. The y-axis represents the percentage of patients, ranging from 96% to 100%. The x-axis shows months from April 2015 to August 2017. The average performance is consistently at 100% until March 2016, where it drops to approximately 98.2% in April 2016, then returns to 100% by May 2016 and remains there until August 2017. The target is set at 100% throughout the period.</p>	<p>The aggregate data is not available due to report availability from EPR.</p> <p>Cancer patients are carefully being managed patient-by-patient and reported through the access meetings.</p>		Director of Governance & Operations
 <p>The chart displays the average performance (Avg), Series4, and target (Target) for Cancer 2nd Treatment Surgery from April 2015 to August 2017. The y-axis represents the percentage of patients, ranging from 80% to 100%. The x-axis shows months from April 2015 to August 2017. The average performance (Avg) fluctuates between 95% and 100%, with a notable dip to approximately 87% in January 2017. The target (Target) is set at 100% throughout the period. Series4 is a purple line that remains relatively stable around 90%.</p>	<p>Cancer patients are carefully being managed patient-by-patient and reported through the access meetings.</p>	 <p>The scatter plot shows individual data points (green diamonds) and trend lines for Cancer 2nd Treatment Surgery. The y-axis represents the percentage of patients, ranging from 80% to 100%. The x-axis represents a numerical scale from 0 to 125. The data points are clustered between 85% and 100%, with a general upward trend as the x-axis value increases.</p>	Director of Governance & Operations
 <p>The chart displays the average performance (Avg) and SPC Limits for Seen By Midwife <13 Weeks from April 2015 to October 2017. The y-axis represents the percentage of patients, ranging from 88% to 100%. The x-axis shows months from April 2015 to October 2017. The average performance (Avg) fluctuates between 96% and 99%, with a notable dip to approximately 96% in February 2016. The SPC Limits are represented by two horizontal lines at approximately 96% and 99%.</p>	<p>The target for women being seen by a midwife within the timeframe is currently being met.</p>		Director of Governance & Operations

National Indicators

National Target Financial

Trend	Challenges & Successes	Comparison	Exec Lead

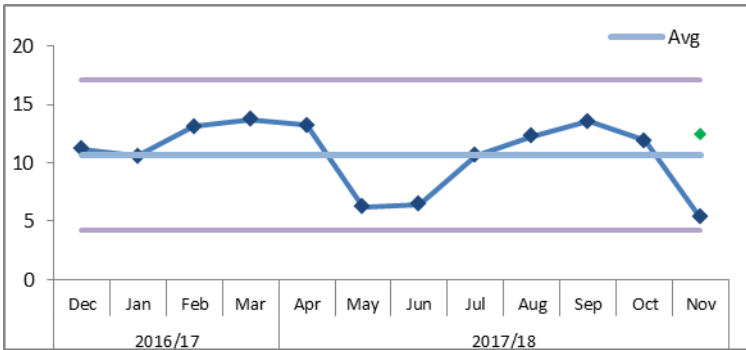
Seen By
Midwife > 12
Weeks



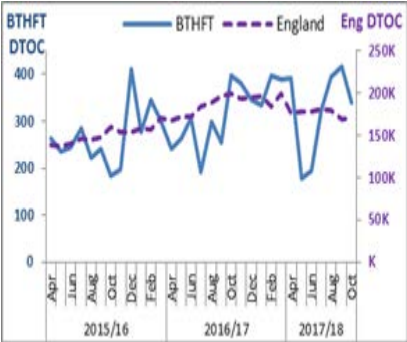
The target for women being seen by a midwife within the timeframe is currently being met.

Director of Governance & Operations

Delayed
Transfers of
Care per Day



Delayed Transfers Of Care increased to 4.0% in September. Since October 2016 there have regularly been higher than the 2015/16 baseline. Work is on going within the MAIDT. This includes the introduction of a 7-day service. Patient/family choice. Responsibilities of the clinical teams and the adult social care teams.



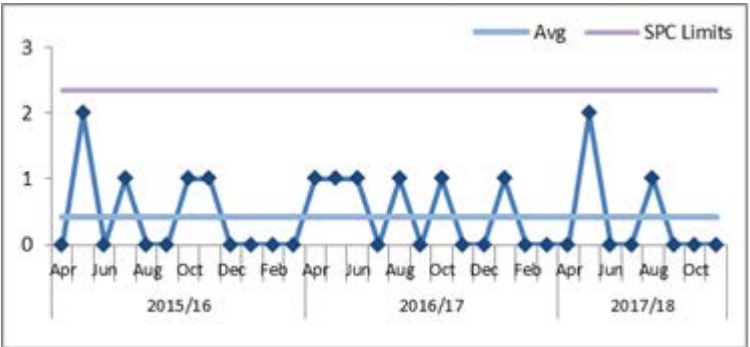
Director of Governance & Operations

National Indicators

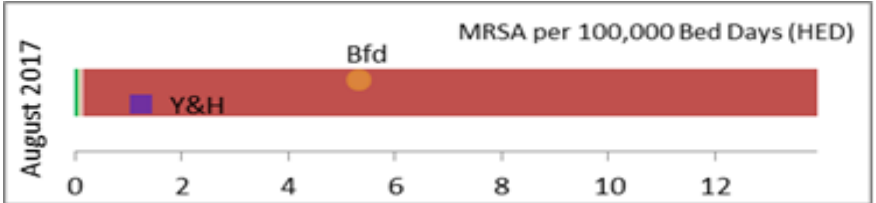
National Target Financial

Trend	Challenges & Successes	Comparison	Exec Lead
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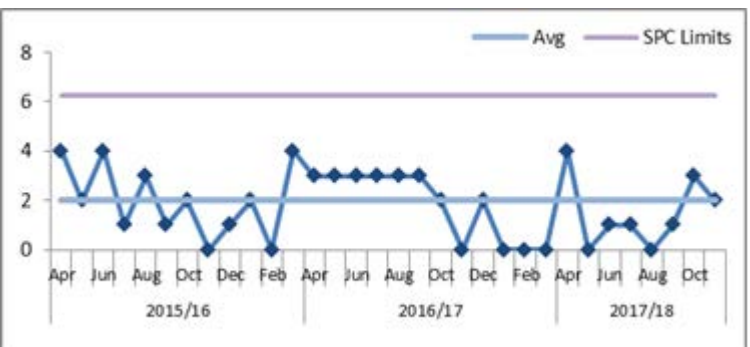
MRSA



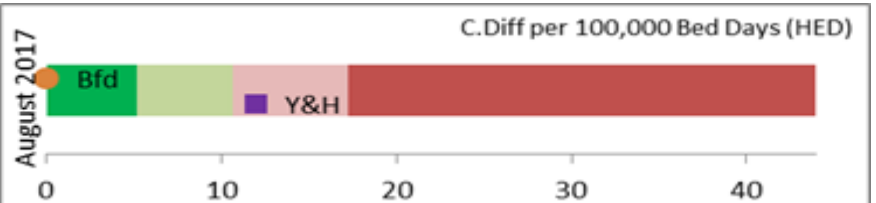
Ongoing challenges with consistency of MRSA/MSSA. Part of national Chief Nurse improvement collaborative for IPC. Ongoing improvements overseen by IPC.















C Difficile



Sustained reduction in C.difficile has been achieved. Robust PIR process. Chief Nurse



Glossary

Indicator	Definition	Data Quality Kite-Mark	Indicator	Definition	Data Quality Kite-Mark
To provide outstanding care for our patients			Harm Free Care		
Mortality			VTE Assessment	VTE risk assessments completed	
Crude Mortality	Crude Mortality rates, i.e., per admissions.		Falls with Harm	Patient falls resulting from harm. The benchmarking data comes from the Safety Thermometer prevalence information.	
Hospital Standardised Mortality Ratio	The mortality indicator is evaluated from a standardised mortality ratio (SMR). The formula for the ratio is observed deaths divided by expected deaths, multiplied by 100. This is calculated for each provider within the data. HSMR is made up of 56 diagnosis groups which account for around 80% of deaths and includes only those patients who die whilst in hospital.		Catheters & UTIs	Urinary tract infections in patients with a catheter. The benchmarking data comes from the Safety Thermometer prevalence information.	
SHMI	The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. SHMI includes patients who die in hospital and up to 30 days following discharge.		Pressure Ulcers Cat 3+	Number of reported hospital acquired category 3 and 4 pressure ulcers. The benchmarking data comes from the Safety Thermometer prevalence information.	
Infections			Pressure Ulcers Cat 2+	Number of reported hospital acquired category 2 pressure ulcers. The benchmarking data comes from the Safety Thermometer prevalence information.	
eColi	Counts of patients with Escherichia coli (eColi).				
MSSA	Counts of patients with Meticillin Sensitive Staphylococcus aureus (MSSA) bacteraemia				
C Difficile	The number of cases either attributable or pending review.				
MRSA	Counts of patients with Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia				

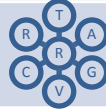





Glossary

Indicator	Definition	Data Quality Kite-Mark
Patient Experience		
Complaints	Number of complaints.	
Friends and Family Test	The % of patients who Strongly Recommend the Trust.	
Night-time Transfers	The number of non-clinical bed moves out of hours	
Information Governance Breaches	The number of reported breaches of the information governance standards	
Audits		
Audit of WHO Checklist	Audit of the World Health Organisation surgical checklist monitoring the number that were complete compared to the number of checklists	
Serious incidents	Unexpected or avoidable death, serious harm, never events, service delivery prevention compared to all incidents reported	

Indicator	Definition	Data Quality Kite-Mark
Readmissions		
Readmissions from Elective	The number of non-elective readmissions within 30 days of discharge from hospital. This is from discharges originally from elective admissions.	
Readmissions from Non-Elective	The number of non-elective readmissions within 30 days of discharge from hospital. This is from discharges originally from non-elective admissions.	

Glossary

Indicator	Definition	Data Quality Kite-Mark
To be a continually learning organisation		
Training		
Core Training	% of staff who are compliant with mandatory training requirements	
High Priority Training	% of staff who are compliant with high priority training requirements	
Progress on embedding the Learning Hub	Progress on embedding the Learning Hub in the Trust against the plan.	
Governance Mechanisms		
Out of date policies	% of policies that are currently out of and within date.	
Risks not mitigated	Risks 12 and above whose current rating is above the target (residual) rating.	
Research		
Research patients recruited	Number of patients recruited to studies against the planned recruitment.	







Indicator	Definition	Data Quality Kite-Mark
To be in the top 20% of employers in the NHS		
Appraisals		
Appraisal Rate Non-Medical	% of eligible staff employed at the trusts who have had an appraisal in the last 12 months.	
Experience		
BAME % Senior Leaders	% of staff employed in Band 8+ Senior Manger roles at the trust who are of Black, Asian or Minority Ethnic background	
BAME % Workforce	% of staff employed at the trust who are of Black, Asian or Minority Ethnic background.	
Staff FFT Treatment	% of staff recommending the trust as a place to receive care or treatment.	
Staff FFT Work	% of staff recommending the trust as a place to work.	
Sickness		
Sickness	% of time lost due to sickness in a given period (the reported month, year to date is the previous 12 months rolling average for which Trust target is 4.00%)	





Glossary

Indicator	Definition	Data Quality Kite-Mark
Staffing Levels		
Nursing Staff Fill Rate	% of time nursing staff staffing hours filled as planned	
Care Staff Fill Rate	% of time care staff staffing hours filled as planned	
Nursing Care Hours	Total of the actual number of RN /RM hours for the month divided by the total number of patients who were an inpatient at midnight for each day of that month.	
Care Staff Care Hours	Total of the actual number Care Staff hours for the month divided by the total number of patients who were an inpatient at midnight for each day of that month.	
Staff in post	Number of FTE's employed at the trust.	
Use of Agency	Use of agency workers in all areas.	
Retention		
Turnover	Number of employees who have left the organisation in the past 12 months as a % of the average number of employees over the same period	

Indicator	Definition	Data Quality Kite-Mark
To deliver our financial plan and key performance targets		
In-Patient Productivity		
Length of Stay Elective	The average length of stay for elective patients, in days. The benchmark data is for Acute trusts for June 2017 from HED, which has a subtly different calculation, which can result in very small differences in numbers.	
Length of Stay Non-Elective	The average length of stay for non-elective patients, in days. The benchmark data is for Acute trusts for June 2017 from HED, which has a subtly different calculation, which can result in very small differences in numbers.	
Bed Occupancy	Average % of available beds which were occupied overnight.	
Discharges before 1 pm	Number of discharges from hospital which happened before 1 pm.	

Glossary

Indicator	Definition	Data Quality Kite-Mark
Out-Patient Productivity		
Did Not Attend Follow-Up	This is the % of Follow-up Outpatient appointments where the patient does not attend.	
Did Not Attend New	This is the % of New Outpatient appointments where the patient does not attend.	
Elective Day Case Rate	The number of patients admitted for planned procedure and leave same day as a % of all procedures.	
New to Follow-Up ratio	The ratio between New and Follow Up Outpatient appointments. Benchmarking data is from HED, which has a subtly different calculation, which can result in very small differences in numbers.	
Short Notice Clinic Cancellations	Clinics cancelled within the 6 week timeframe.	
Elective Wait List	Wait list of patients on an elective pathway.	





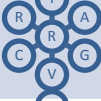
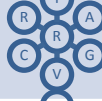






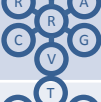

Indicator	Definition	Data Quality Kite-Mark
Finance		
Delivery of financial plan	Delivery of finances against plan.	
Use of Resources - Financial	Use of resources is a calculation on the status of a number of financial measures – Capital Servicing Capacity, Liquidity, I & E Margin, and Agency Spend.	
Cost Improvement Plan	Cost Improvement Plan progress against target.	
Liquidity	A measure of how many days an organisation can continue to fund its operations based on the level of net current assets and available borrowing.	

Glossary

Indicator	Definition	Data Quality Kite-Mark
National Indicators		
Single Oversight Framework		
Diagnostic waits	% of patients who have waited less than 6 weeks for a diagnostic test.	
User of Resources	Calculation on the status of a number of financial measures – Capital Servicing Capacity, Liquidity, I & E Margin, and Agency Spend.	
Emergency Care Standard	% patients seen in A&E within 4 hours.	
RTT 18 Week Incomplete	Percentage of patients waiting within 18 weeks on an incomplete pathway.	
Cancer Urgent 62 day Screening	Proportion of patients receiving treatment for cancer within 62 days of an NHS Cancer Screening service.	
Cancer Urgent 62 Day GP	Proportion of patients receiving treatment for cancer within 62 days of an urgent GP referral for suspected cancer.	
Non-Financial		
RTT 52 Week Wait	Number of patients waiting more than 52 weeks.	
Trolley Waits >12 hours	Trolley waits of > 12 hours.	

Indicator	Definition	Data Quality Kite-Mark
Non-Financial Cont'd..		
Ambulance Handover 30-60 mins	Ambulance handover taking longer than 30 – 60 minutes to handover.	
Ambulance Handover >60 mins	Ambulance handover taking longer than 60 minutes to handover.	
RTT # Specialties	Number of specialties not achieving RTT incomplete.	
Financial		
Never Events	The number of serious incidents that occur despite there being defined processes and procedures to prevent them.	
Stroke Strategy	Implementation of the Stroke Strategy – patients who spend at least 90% of their time on a stroke unit.	
VTE Assessments	VTE risk assessments completed.	
Duty of Candour	Patient informed duty of candour.	
Formulary published	Hospital formulary is published on the Trust's external website.	

Glossary

Indicator	Definition	Data Quality Kite-Mark	Indicator	Definition	Data Quality Kite-Mark
National Indicators			National Indicators		
Financial Cont'd			Financial Cont'd		
Mixed Sex Accommodation	Number of occurrences of unjustified mixing in relation to sleeping accommodation.		Cancer 2 nd Treatment Surgery	Patients that require further surgery following initial treatment should receive treatment within 31 days .	
NHS # field completion acute	Completion of valid NHS # field in acute commissioning data sets submitted via SUS		Saw Midwife < 13 wks	Percentage of women who presented before 12 weeks 6 days who have seen a midwife within 12 weeks and 6 days of pregnancy.	
NHS # field completion A&E	Completion of valid NHS # field in AED commissioning data sets submitted via SUS.		Saw Midwife > 12 wks	Percentage of women who presented after 12 weeks 6 days who have seen a midwife within 2 weeks.	
Cancelled Operations 28 Days	% of patients who have their operation cancelled on the day for non-clinical reasons		Delayed Transfers of Care per Day	Average number of patients per day who had a delayed transfer; when an adult inpatient is ready to go home or move to a less acute stage of care but is prevented from doing so.	
Cancer 2 Week GP	% patients who have waited a maximum of 2 weeks to see a specialist for all patients referred with suspected cancer symptoms		MRSA	Counts of patients with Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia.	
Cancer 1 st Treatment	Patients that have a decision to treat them surgically for a cancer diagnosis should have a date for their treatment within 31 days of the decision to treat.		C Difficile	Number of cases either attributable or pending review.	
Cancer 2 Week Breast	Proportion of patients with breast symptoms where cancer not initially suspected referred to a specialist who are seen within 2 weeks of referral.				
Cancer 2 nd Treatment Drugs	Proportion of patients waiting no more than 31 days for second or subsequent drug treatments.				

Status

Colour-coding:

- Red = 2 or more Red Indicators from within the Domain (represented by a circle) or a Composite Indicator. For a single indicator - Off target
- Amber = 0 Red and half or more Amber Indicators from within the Domain, For a single indicator – On target, but at risk
- Green = 0 Red and less than half Amber; or All Green Composite Indicators. For a single indicator - On target

Indicator:

- Left-hand side of Indicator is Current Status
- Right-hand side of Indicator is Planned Status

Statistical Process Control (SPC) Chart

The information is generally presented using “control limits” to determine whether any one month is statistically high or low. The average is calculated over the first 12 months, and after this time if there is a period of 8 months in a row which are all above (or below) the average, a new average and control limits are calculated from this point.

Benchmarking

The majority of benchmarking charts show information for the most recently available period. The range of other Acute Trusts values are split into 4 quartiles, showing the range of the bottom 25% of Trust values, 25-50% of Trust values etc. The value for Bradford Teaching Hospitals is shown alongside a single value looking at the average of Acute trusts in Yorkshire and Humber.

Data Quality Kite-Mark

RAG status of assurance of the data quality of the information being presented. The DQ Kite-Mark is currently being piloted and will be updated with feedback.

Score/ Rating	Summary
1	Insufficient systems, processes or documentation are available to provide any assurance on the asset (data set). A narrative response on actions being taken to manage the asset is required.
2	Limited systems, processes and documentation are available therefore the assurance on the data set is also limited. A narrative response on actions being taken to manage the asset is required.
3	Systems, processes and documentation are available and the asset has been locally verified with assurance provided. A narrative response on actions being taken to manage the asset is not required.
4	Full systems, processes and documentation are available and the asset has been locally verified with assurance provided.
5	Full systems, processes and documentation are available and the asset has been independently verified with full assurance provided.

