

Board of Directors: 10.05.2018
Agenda Item: Bo.5.18.8

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 March 2018 is attached for the consideration by the Board of Directors.	To discuss and note

Executive Summary:
The Integrated Dashboard for March 2018 is attached for the consideration by the Board of Directors.

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?
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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

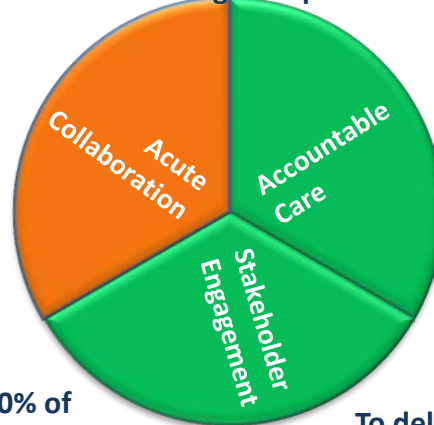
31st March 2018

31st March 2018

To provide outstanding care for our patients



To collaborate effectively with local and regional partners



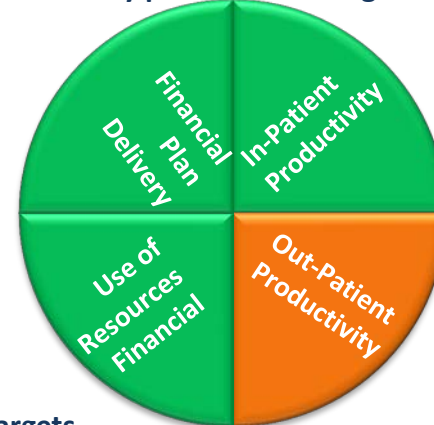
To be a continually learning organisation



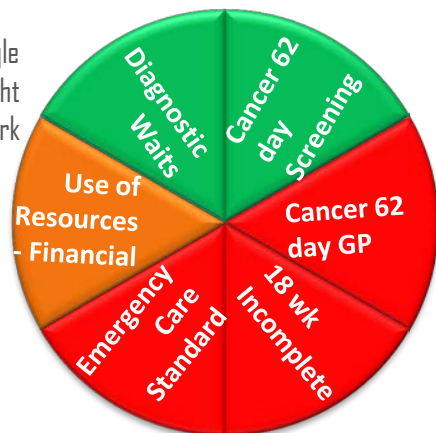
To be in the top 20% of employers in the NHS



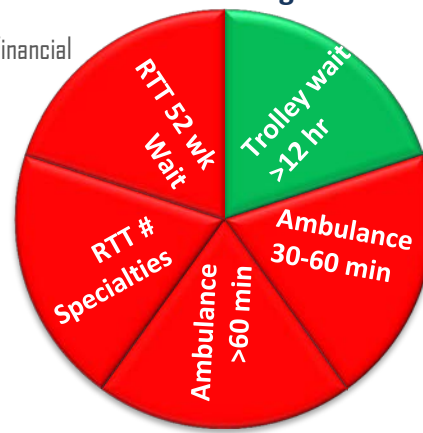
To deliver our financial plan and key performance targets



Single Oversight Framework

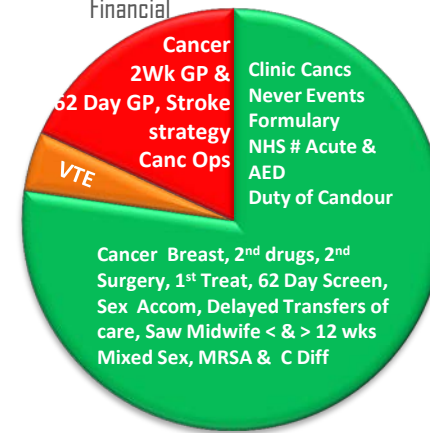


Non-Financial



National targets

Financial



Headlines

Year end financial position has met the Control Total target – The unaudited Month 12 position suggests the Trust has exceeded its pre-STF control total for 2017/18 and has therefore met the financial target allocated by NHS Improvement (NHSI). The pre-STF position net of impairments is a deficit of £7.1m against a £7.8m control total deficit, resulting in a favourable variance of £0.7m. This position includes STF funding for meeting financial targets in all four quarters and AED targets in quarters 2 & 3 amounting to £7.7m. A further £0.7m of STF incentive cash can be recognised due to exceeding the pre-STF control total. This means a total of £8.4m STF is recognised in the bottom line position. The post-STF control total position is therefore a surplus of £1.3m against a post-STF control total target surplus of £2m. The £0.7m adverse variance at this level is explained by the loss of £2.1m STF relating to AED targets in quarters 1 & 4 being partially offset by the favourable £0.7m pre-STF variance and the £0.7m bonus STF. The recovery of the Trust's pre-STF performance due to the deployment of non-recurrent measures in Quarter 4 has resulted in the overall year end UoR risk rating of 2 being now on line with plan. Cash balance is £25.6m which is lower than plan by £10.5m and the liquidity position is 4.9 days which 5.8 days higher than planned.

High attendances and bed occupancy has continued – The Trust has continued to struggle with high bed occupancy, running above 96% most days. Targeted work continues to reduce avoidable discharge delays and reduce the number of patients waiting for social care support. We are seeing a sustainable increase in the number of discharges before 1 PM which is aiding in managing the high occupancy level.

The Emergency Care Standard remains a challenge and improvements are being made - A number of factors are contributing to this position. However improvements are being seen as a result of focussed improvement work. This work includes expansion of the initial streaming and triage capacity to prevent ambulance handover delays and safe patient flow management to avoid long bed waits. In addition, Transformation Team support is being given to undertake value stream mapping and staff observations to identify where delays are occurring in the patient journey.

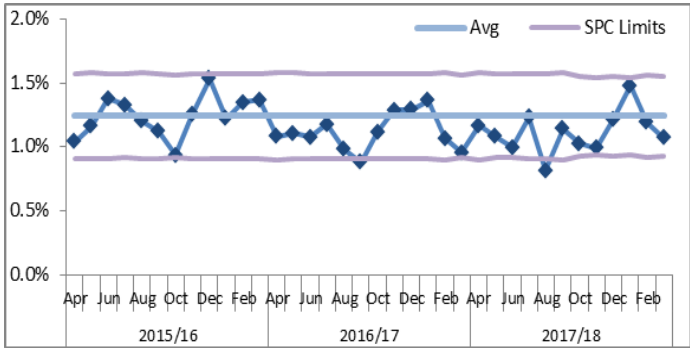
Cancer targets partially met – Detailed recovery work continues. The Trust did not meet the 62 day GP and 2 week wait targets. There is strong focus on improving these positions through the recovery plan with particular focus on reducing the 62 day backlog. Clinical harm reviews are undertaken on all patients treated past 62 days.

Elective Wait List & RTT continues to be high – The Trust is working towards reducing the wait list and improving the RTT performance, post the introduction of the Electronic Patient Record which impacted on productivity. Demand and capacity modelling work is being used to inform the recovery plans. A validation of the waiting list is also being undertaken to remove all data quality errors. This will be a lengthy process. The Trust reported 4 incomplete 52 week breaches in March and will report in 6 in April. The main risks are in ENT, General Surgery, Vascular and Trauma & Orthopaedics. Additional activity is being undertaken to reduce overall waiting times beginning in April.

Workforce – There has been little change in the Trust's workforce metrics since February. Turnover and staff in post rates have remained stable within month, sickness rates having improved now in both February and March. The downward trend has ceased for appraisal completion with the emphasis now on improving performance in targeted areas.

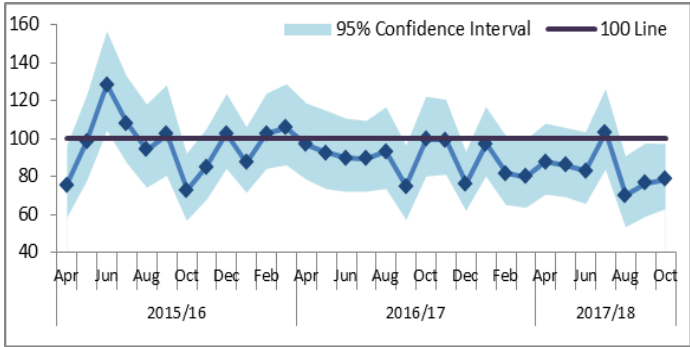
To provide outstanding care for patients

Trend	Challenges & Successes	Comparison	Exec Lead
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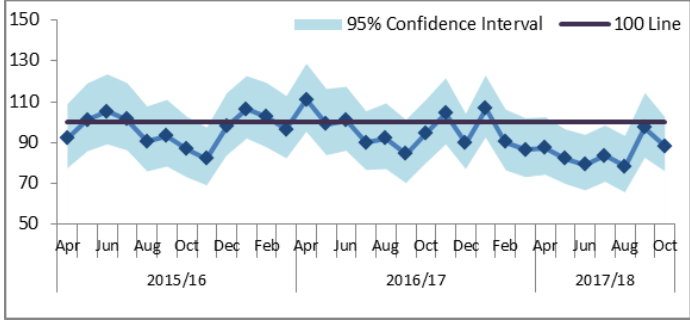
Crude death rate has remained constant throughout the last 18 months. There is no benchmarking data for this measure. Improving learning from mortality is one of the Trust's key quality improvement priorities. There is a comprehensive structure surrounding mortality at the Trust, which is outlined in the Trust's 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 Hospital Standardised Mortality Ratio (HSMR) continues to be relatively low. Over the past 12 months we are statistically better than expected compared to other Trusts.

Medical Director



Our Summary Hospital-level Mortality Indicator (SHMI) continues to be relatively low. Over the past 12 months we are statistically better than expected compared to other Trusts.

Medical Director



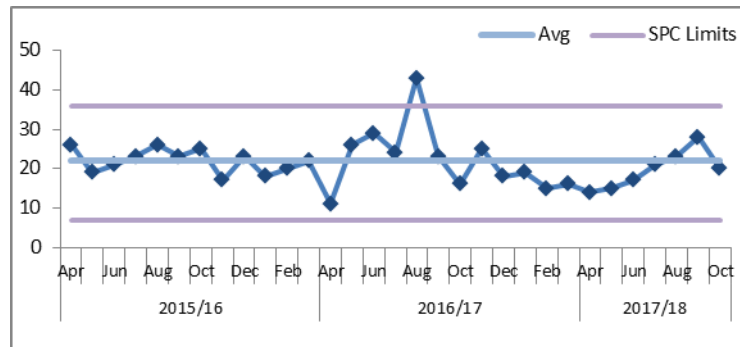
To provide outstanding care for patients

Trend

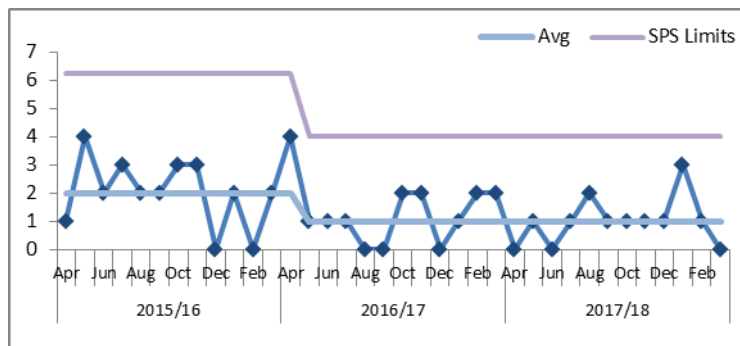
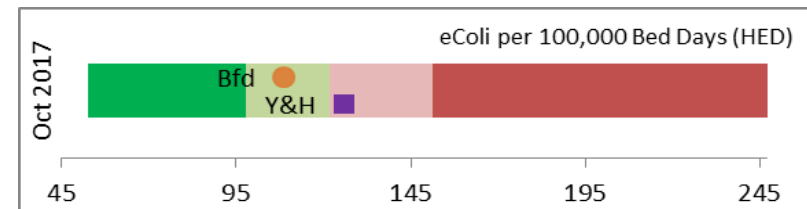
Challenges & Successes

Comparison

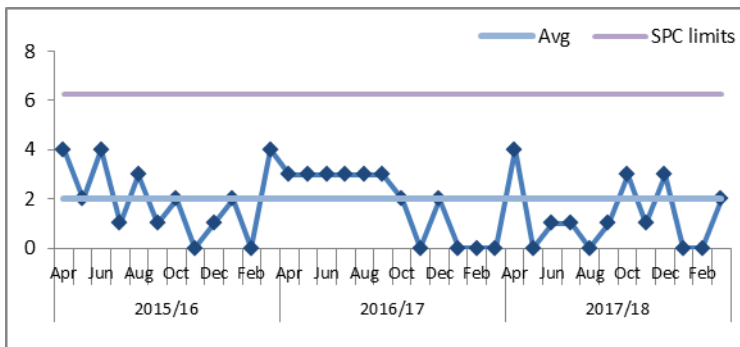
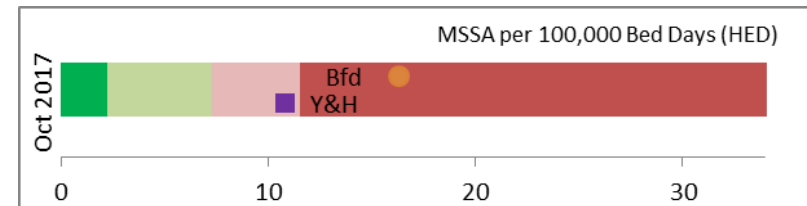
Exec Lead



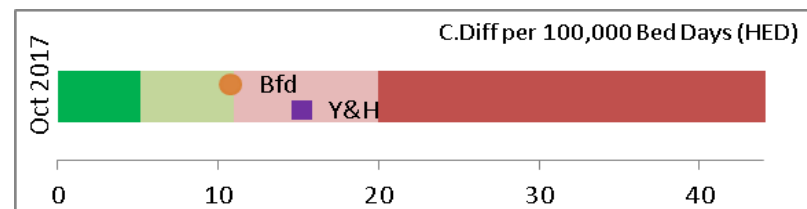
As part of the 18/19 work plan we will focussing on all Chief Nurse bacteraemias. We have seen a reduction of 26% on the previous 12 months (NHS Improvement).



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 Post Chief Nurse Infection Review process in place.



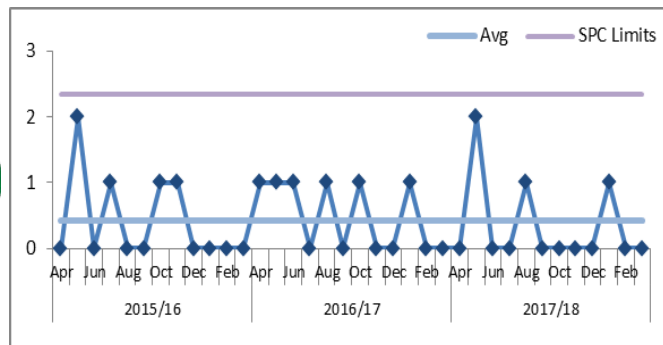
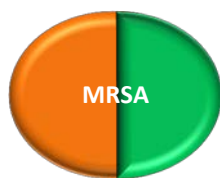
To provide outstanding care for patients

Trend

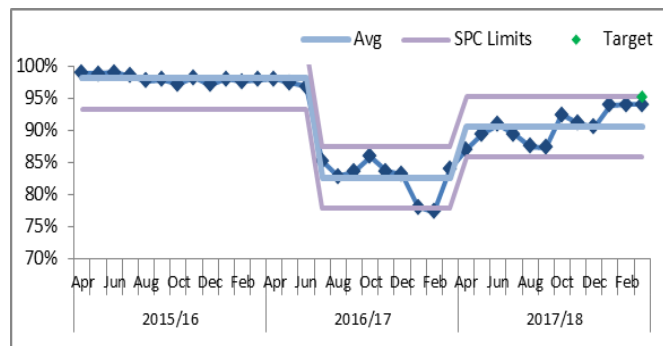
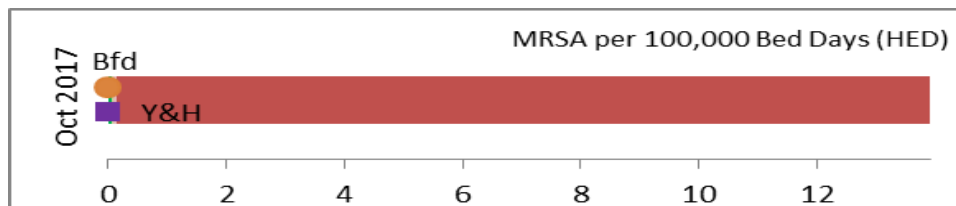
Challenges & Successes

Comparison

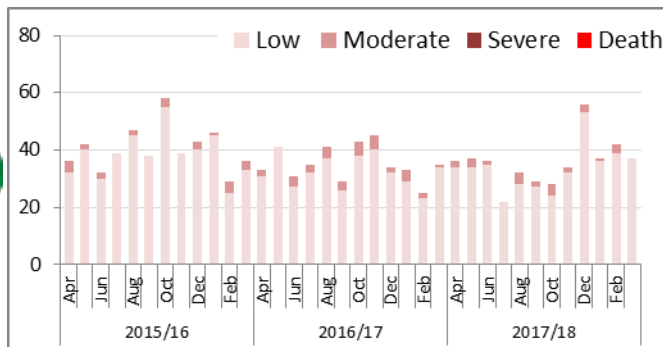
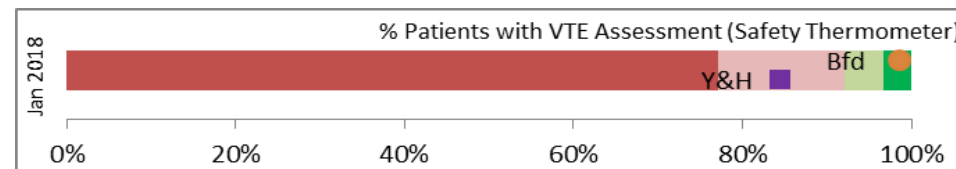
Exec Lead



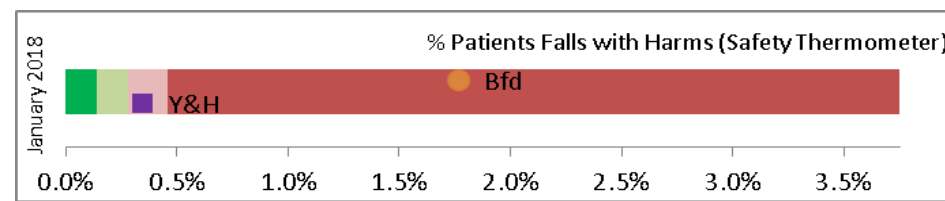
1 occurrence of MRSA bacteraemia, awaiting Post Infection Review, no common themes, not statistically significant, performance has improved on 16/17. Chief Nurse



The performance for the month of March 93.9%. Current performance in April is Medical 94.86%. Work continues through the Medical Director's Office to work with Director areas where improvements can be made.



Number of falls has reduced over the last month, Quality Improvement work continues with top 10 wards Chief Nurse



To provide outstanding care for patients

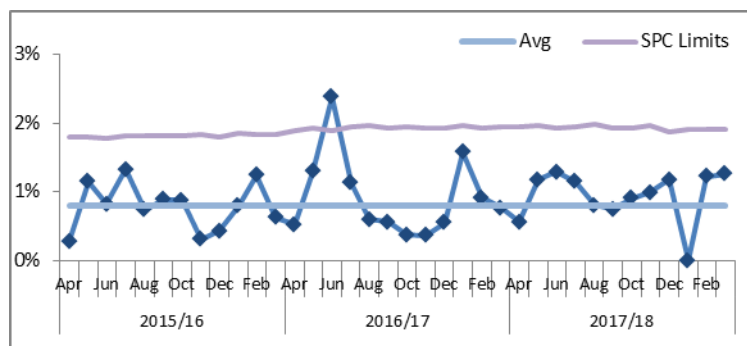
Trend

Challenges & Successes

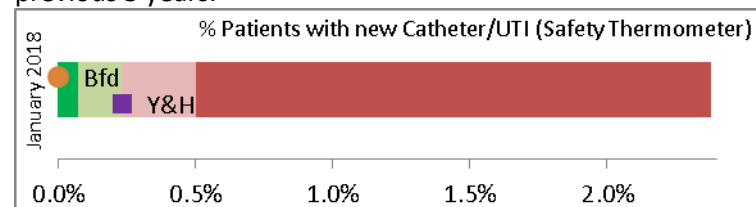
Comparison

Exec Lead

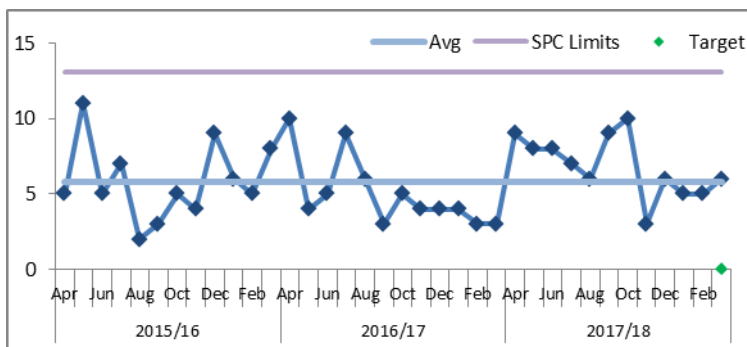
Catheters & UTIs



Plans in place to undertake work (overseen by the IPC) to reduce the point prevalence of catheter urinary tract infections (CAUTI). Opportunity to use the EPR to audit care and support improvement being explored with chief nurse team. The trend continues to mirror previous 3 years.

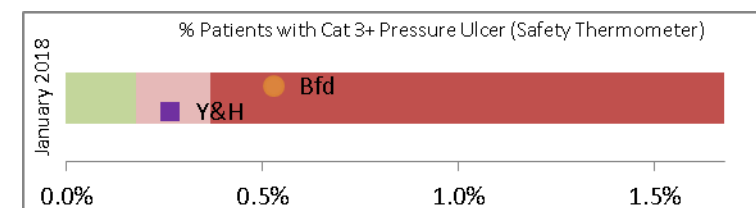


Pressure Ulcers Cat 3+

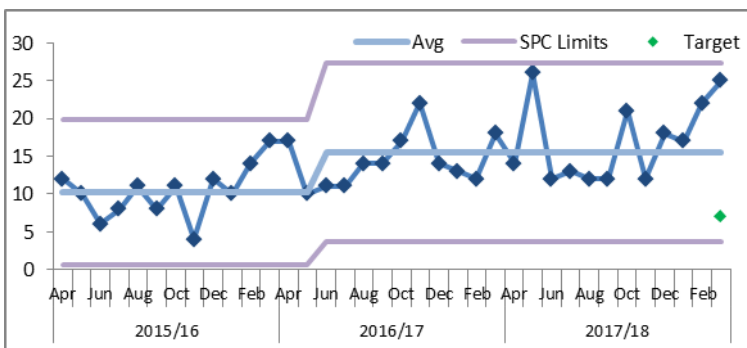


Now showing a sustained improvement since introduction of EPR and improvement work

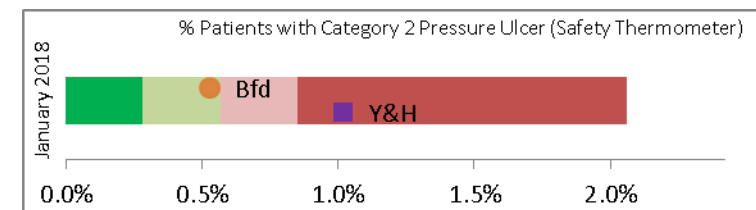
Chief Nurse



Pressure Ulcers Cat 2



Whilst the stabilisation of grade 3 is pleasing it may be that this Chief Nurse reduction is reflected in the increase of grade 2's. Further work planned in 18/19 to review change in avoidable / unavoidable



To provide outstanding care for patients

Trend

Challenges & Successes

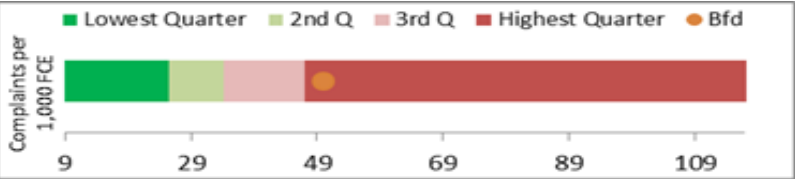
Comparison

Exec Lead



We are seeing the Q4 increase in numbers of complaints, a similar pattern of the last few years. Our complaints data shows an overall decrease over time with an increase in PALS contacts

Chief Nurse



The Friends and Family Test has recovered back to normal baseline after a drop in September 2017. Further detailed work to improve number of returns has started.

Chief Nurse


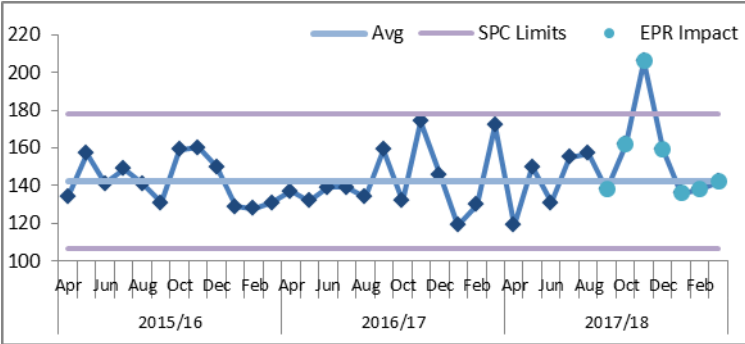
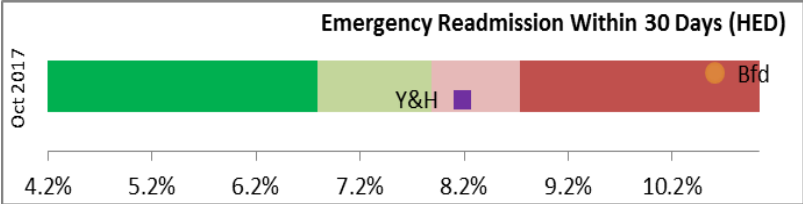
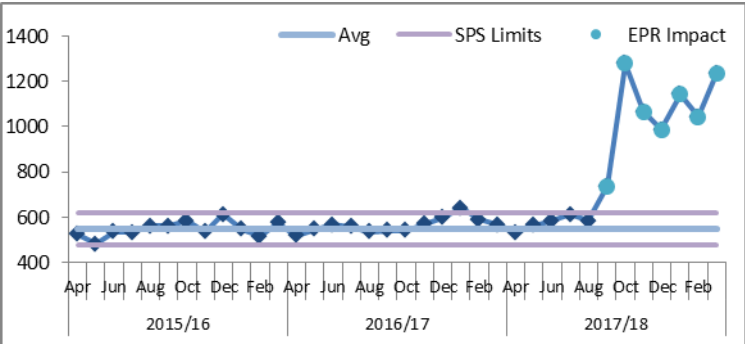

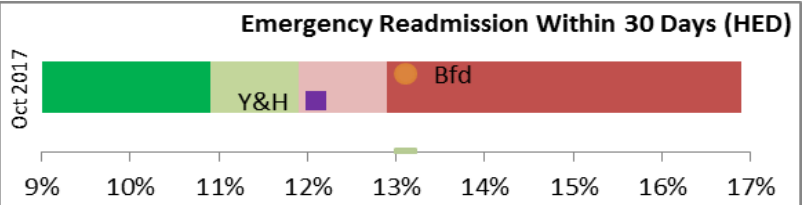

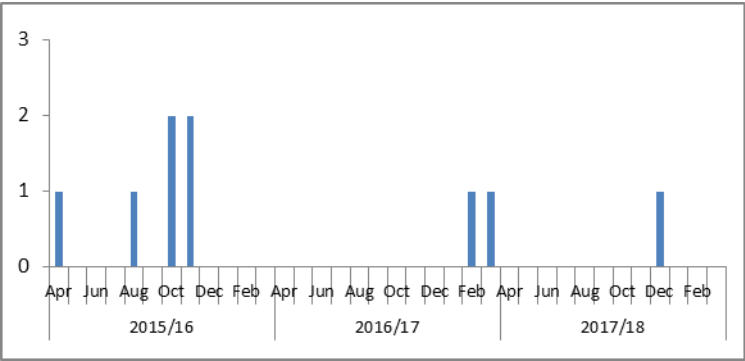


Daily review of night time transfers continues. In summary there were 19 night time patient transfers which occurred on 8 nights in the month. In all cases the moves were clinically necessary in order to create either a side room for patients requiring isolation or to create a specific specialty bed due to manage acute demand. Work has continued to reduce outliers with reductions achieved at end of March which should improve the night time transfers from April. Trend analysis will continue undertaken on a monthly basis.

Chief Operating Officer



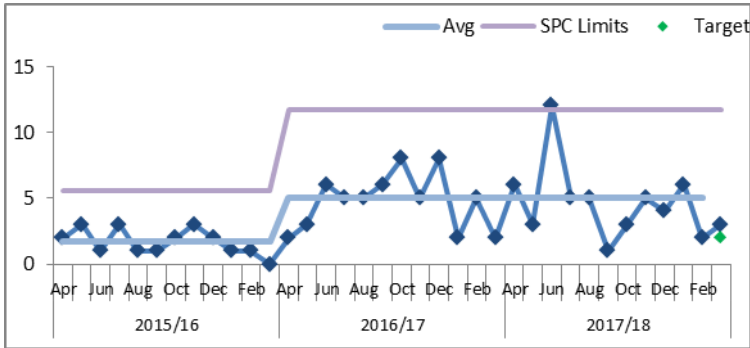
To provide outstanding care for patients

Trend		Challenges & Successes	Comparison	Exec Lead
		This is impacted on by DQ issues following EPR implementation and forms part of the DQ recovery programme.		Chief Operating Officer
				
		This is impacted on by DQ issues following EPR implementation and forms part of the DQ recovery programme.		Chief Operating Officer
		There has been one breach in December 2018 and one in total in the financial year. Awareness remains high as training was incorporated into EPR training.	No comparator data is published.	Director of Informatics

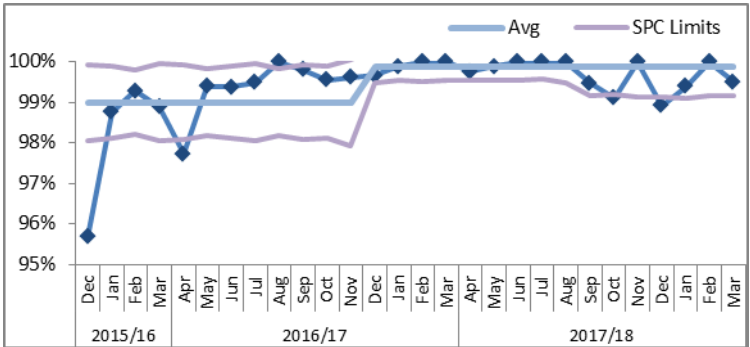
To provide outstanding care for patients

Trend	Challenges & Successes	Comparison	Exec Lead
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Serious Incidents






Audit of WHO Checklist



Every incident that meets the criteria for the declaration of a serious incident is reported on the Strategic Executive Information System (StEIS) and a root cause investigation is commissioned. They are reported to the Quality Committee. All recommendations made following an investigation are subject to action planning to minimise the risk of reoccurrence. There is a detailed process of assurance to assess the effectiveness of the action planning	No comparator data is available.	Director of Governance & Corporate Affairs
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

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 are initially focused 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>			Director of Strategy & Integration
	<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 developed a model for diabetes; in time, the ambition is for a broader range of "out of hospital" care to be managed in this way. The trust continues to monitor, input and support the processes that supports these areas, but acknowledge the lack of pace towards quantifiable improvement.</p>			Director of Strategy & Integration
	<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. As such the collaboration picture is extremely complex, with progress and risk difficult to quantify at both a trust and system level.</p>			Director of Strategy & Integration

To be a continually learning organisation

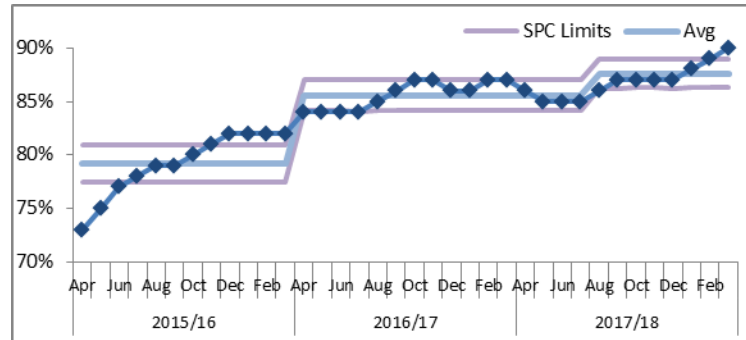
Trend

Challenges & Successes

Comparison

Exec Lead

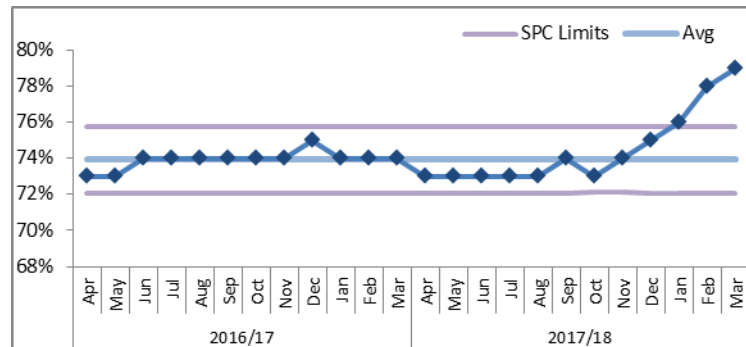
Core Training



Compliance rates have continued to improve following a focused programme of work with the education team and divisional teams. Comparator data not available.

Medical Director

High Priority Training



Compliance rates have continued to improve following a focused programme of work with the education team and divisional teams. Comparator data not available.

Medical Director

Learning Hub

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 & Corporate Affairs

To be a continually learning organisation

Trend	Challenges & Successes	Comparison	Exec Lead
<div data-bbox="10 321 217 492"> <p>Out of date policies</p> </div>	<p>A focussed programme of work continued through out Q4 with regular reports to Executive Directors and the Trust Operational Group. The position remains a concern and further initiatives are required in order to improve the Trust position in relation to Trust-wide policies and their management. There is confidence about the approach to managing locally-developed guidance within Divisions, however performance has deteriorated during quarter 4.</p>	<p>Comparator data not available.</p>	<p>Director of Governance & Operations</p>
<div data-bbox="10 656 217 828"> <p>Risks not mitigated</p> </div>	<p>A clear work programme is ongoing to improve the risk assessment process, with a key focus on the assuring the effectiveness of mitigation strategies used. Skilled risk staff have been devolved to the divisions and they continue to support and sustain this work. The approach to risk assessing proactively, for instance in relation to the outcome of clinical audits is now a key focus of the work of the divisional facilitator staff and the effectiveness team</p>	<p>Comparator data not available.</p>	<p>Director of Governance & Operations</p>
<div data-bbox="10 1006 217 1178"> <p>Research patients recruited</p> </div>	<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>

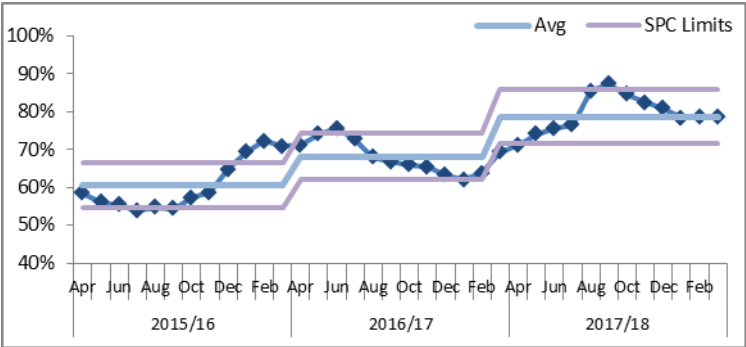
To be in the top 20% of employers in the NHS

Trend

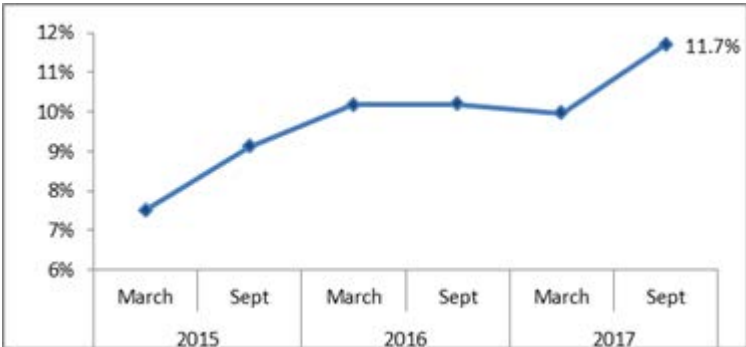
Challenges & Successes

Comparison

Exec Lead

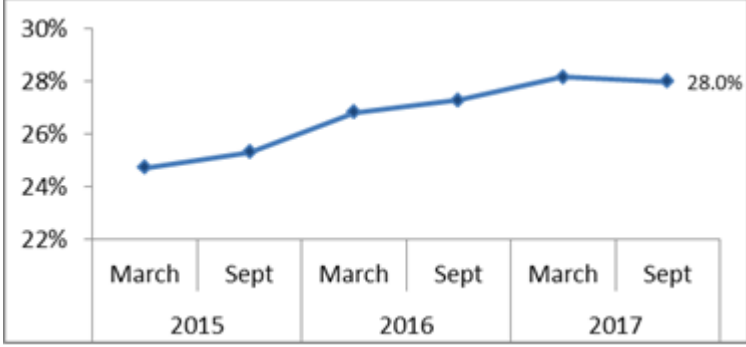


The target for non-medical appraisal is that 100% of eligible employees are appraised; as of the end of March, appraisal rates were 78.53%. Although for the last three months the downward trend has stopped, rates have not yet shown an increase at Trust level. The divisions continue to be supported by the OD Team to ensure that appraisal remains high priority. A range of development workshops focusing on appraisals continue to be delivered and a series of Let's Talk newsletter articles are being run throughout May promoting and sharing examples of good practice across the Trust.



Next update July 2018

No comparator data is available. Director of Human Resources



Next update July 2018

No comparator data is available. Director of Human Resources

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

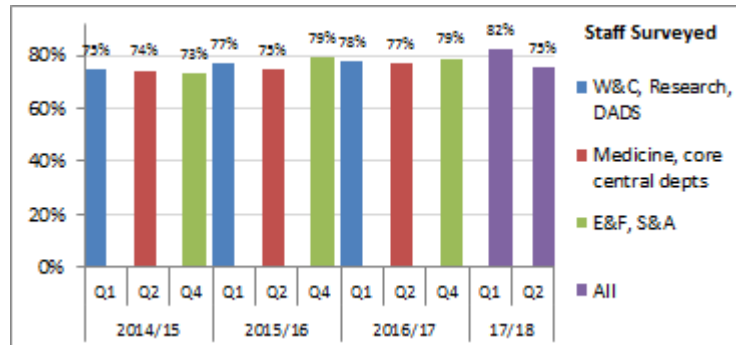
Trend

Challenges & Successes

Comparison

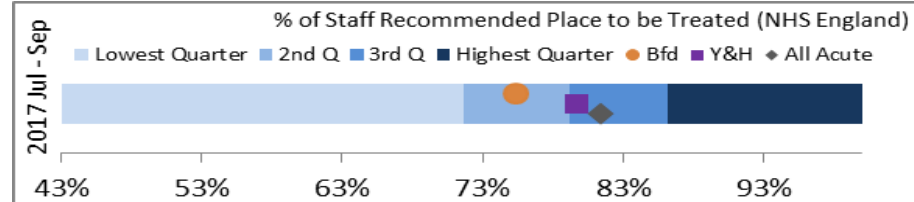
Exec Lead

Staff FFT
Treatment

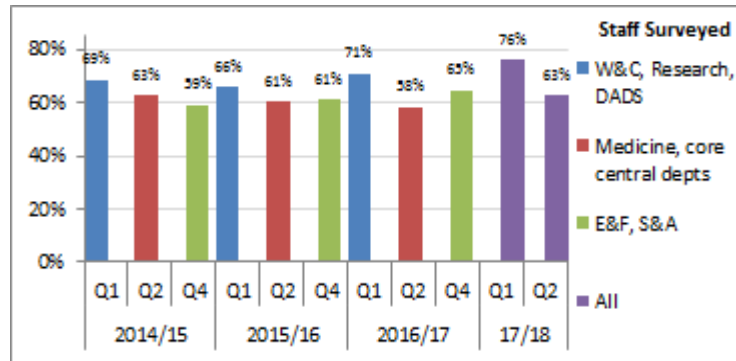


BTHFT is currently below the Yorkshire and Humber average, and also below average for all acutes. The Trust target is to be agreed in line with the NHS Quest Employment Brand Standards and Criteria.
Q4 update reported May 2018

Director of
Human
Resources



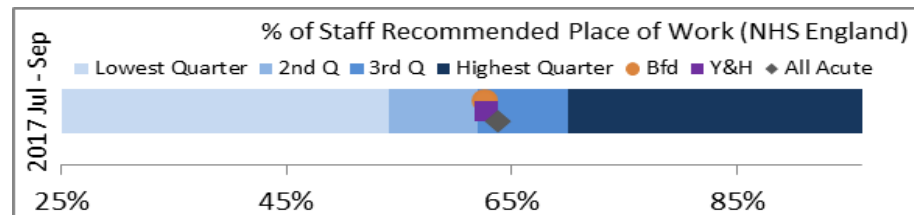
Staff FFT
Work



The Target is to be agreed in line with NHS Quest Employment Brand Standards and Criteria. Significant work is ongoing to improve the employee 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. We are currently on par with Yorkshire and Humber and Acute Trusts.

Director of
Human
Resources

Q4 update reported May 2018



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

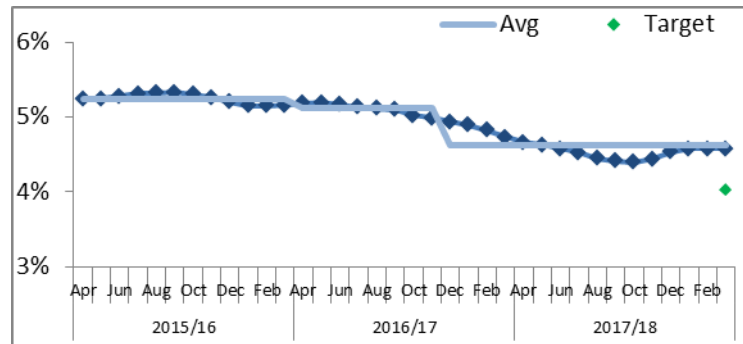
Trend

Challenges & Successes

Comparison

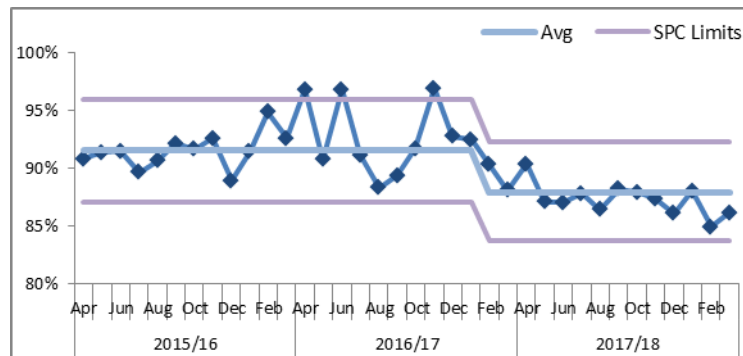
Exec Lead

Sickness



The actual Trust sickness figure for March 2018 is 4.48%. This represents a decrease from February 2018 which was 4.79%. This shows that the trend is continuing in the right direction. The March rolling figure stands at 4.61%. The sickness absence target for the Trust for 2018-19 will remain at 4%. The Divisional targets will also remain the same as for 2017-18 and the Divisions have been informed of this accordingly.

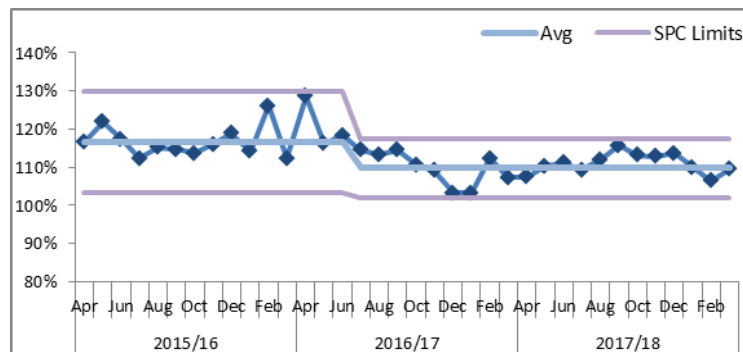
Nursing Shifts Filled



Standing item on the agenda regarding nurse fill rate and staffing levels. No areas have been unsafe or have had less than 2 qualified staff on duty.

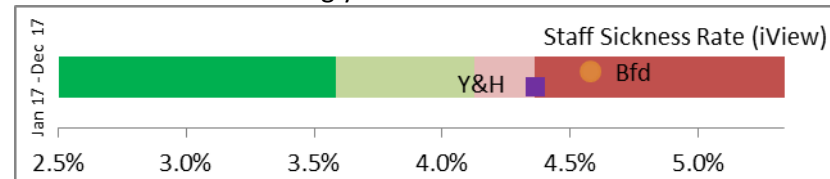
See Nurse Staffing Report for more details.

Care Staff Shifts Filled



The fill rates for care staff has been consistently over the planned, but this reflects the fact that care staff are used to backfill gaps in registered nurses and as part of ongoing reconfiguration.

See Nurse Staffing Report for more details.



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

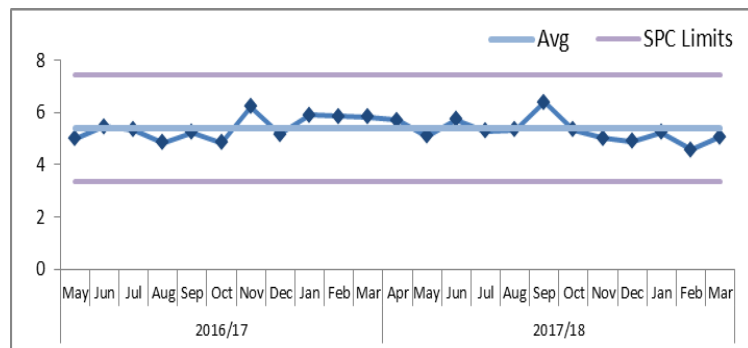
Trend

Challenges & Successes

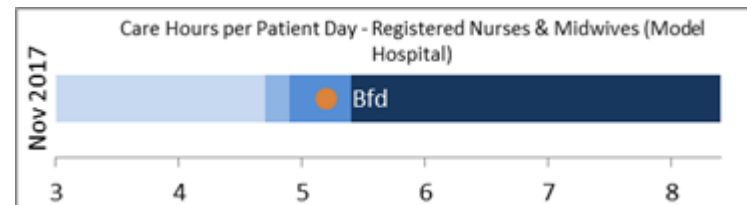
Comparison

Exec Lead

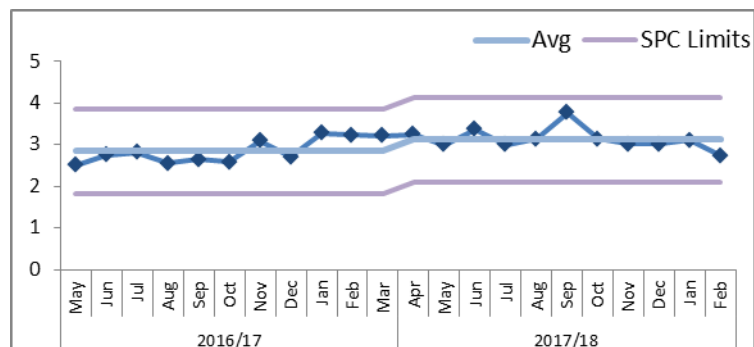
Nursing
Care
Hours



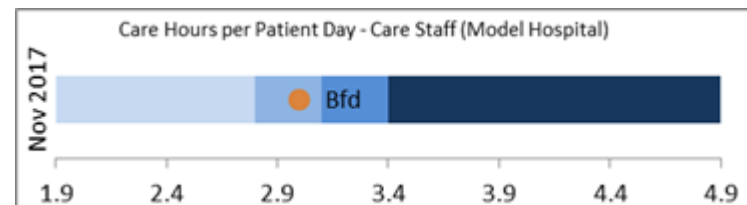
Full details included in the staffing reports we continue to be Chief Nurse average when compared to other Trusts



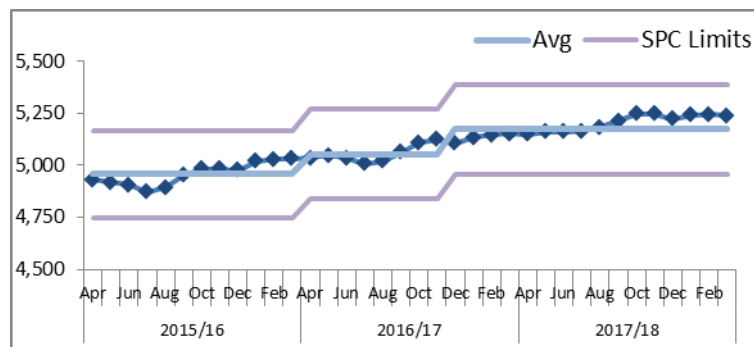
Care Staff
Care
Hours



Full details included in the staffing reports we continue to be Chief Nurse average when compared to other Trusts



Staff in
Post



Little change in staff in post numbers.

Director of
Human
Resources.

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

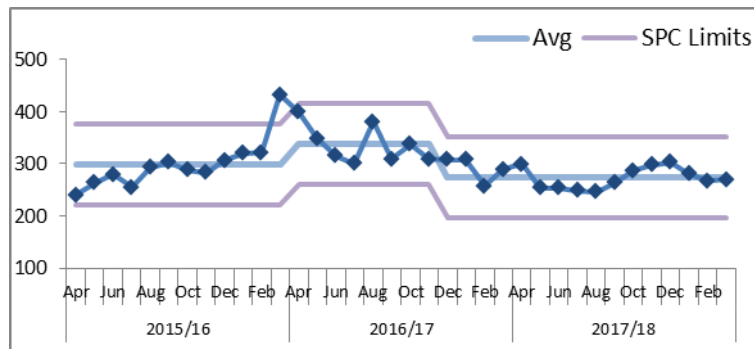
Trend

Challenges & Successes

Comparison

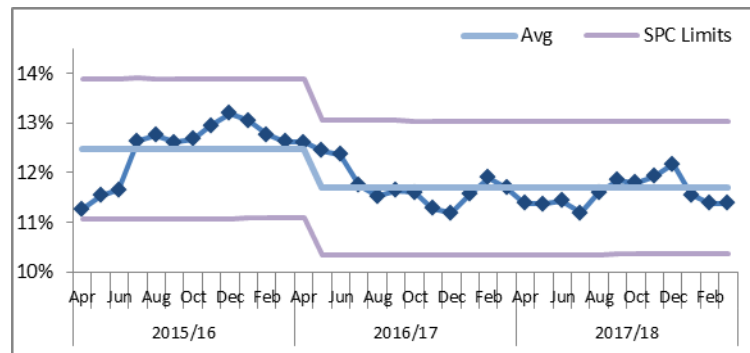
Exec Lead

Use of
Agency
(WTE)



Use of Agency continues to be monitored closely and is subject to Director of robust approval mechanisms. Agency cover for vacant clinical posts remains the primary reason for usage. Use of Agency AHP's has Resources reduced due to substantive recruitment in the divisions.

Turnover



Turnover remains stable at Trust level over the last 3 months.

Director of
Human
Resources

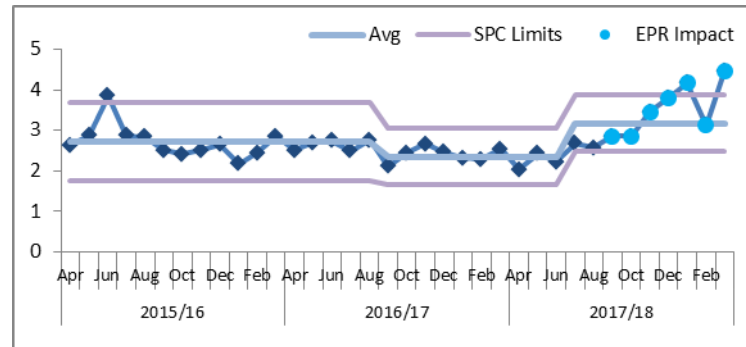
To deliver our financial plan and key performance targets

Trend

Challenges & Successes

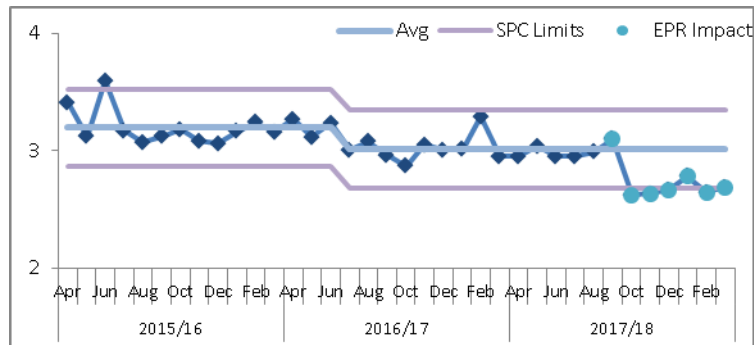
Comparison

Exec Lead



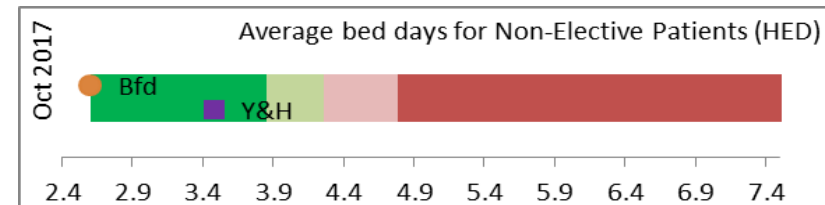
The residual data quality issues following EPR implementation continue. Work is ongoing to resolve the position and should show a more accurate length of stay in future months.

Chief Operating Officer



The same data quality issue as the previous indicator with elective, assessment and ward attender patients being incorrectly admitted as non-elective. These very short length of stay spells will reduce the overall length of stay for non elective admissions. This will improve in future months as the data quality issues are resolved.

Chief Operating Officer



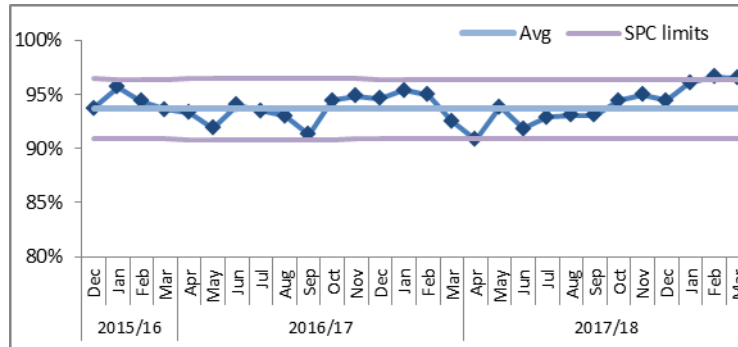
To deliver our financial plan and key performance targets

Trend

Challenges & Successes

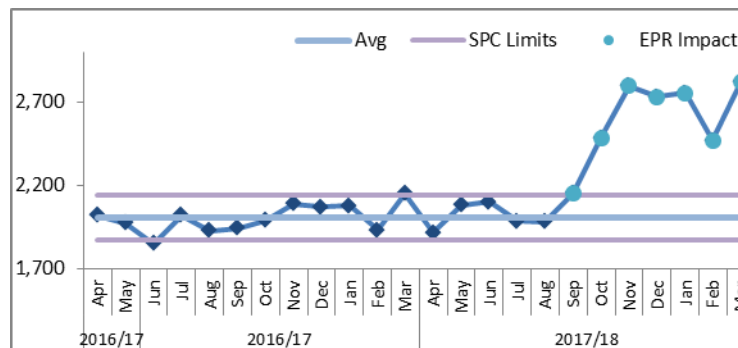
Comparison

Exec Lead



Bed occupancy has remained high throughout March due to ongoing acute demand as consequence of winter pressures. Key actions previously reported continue with plan to close all escalation beds by middle of April. Daily proactive management of discharges is in place with further actions planned as part of the Trust wide "Working as One" week scheduled in May.

Chief Operating Officer



There has been an improvement in the % of discharges before 1pm in March. Discharge targets by ward have been developed which will be piloted in April and monitored on a daily basis.

Chief Operating Officer

To deliver our financial plan and key performance targets

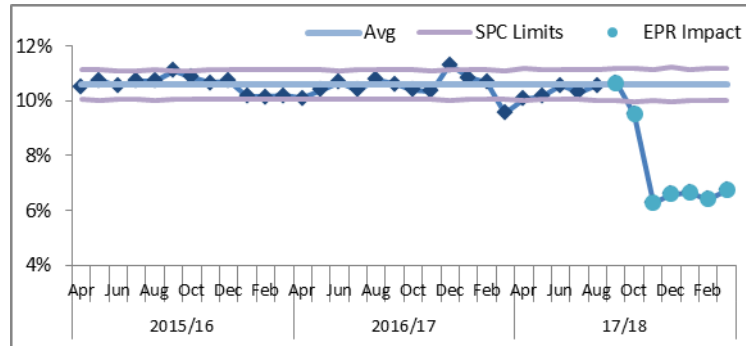
Trend

Challenges & Successes

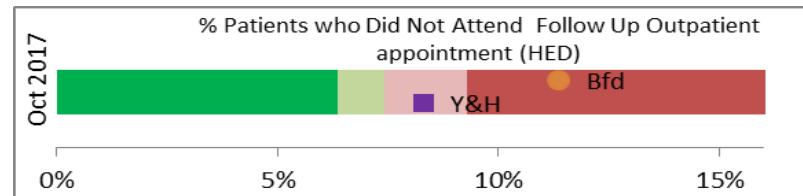
Comparison

Exec Lead

Did Not Attend Follow-Ups



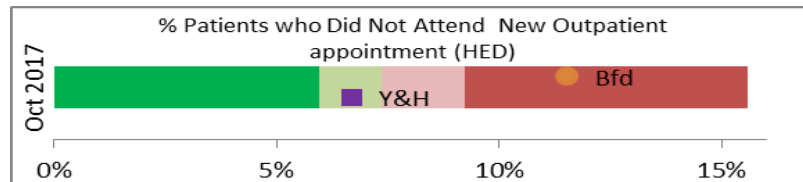
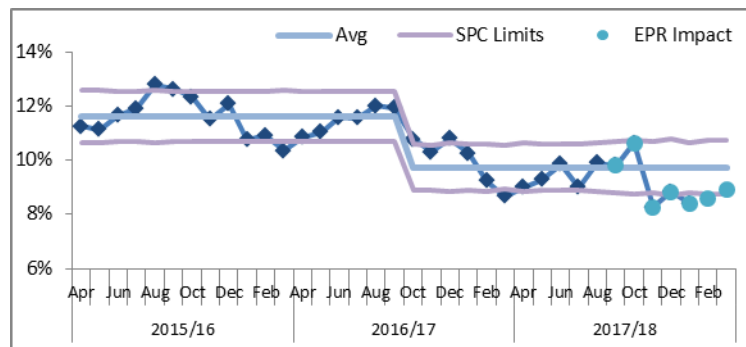
Did Not Attend rates have improved since implementation of two Chief Operating Officer way texting in some specialties. However, the significant change in Officer trend is being investigated by the performance team to confirm the continuity of methodology pre and post EPR.



Same as above

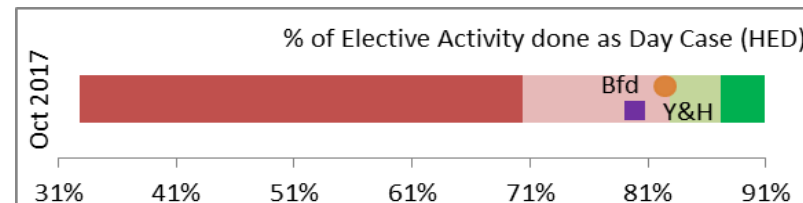
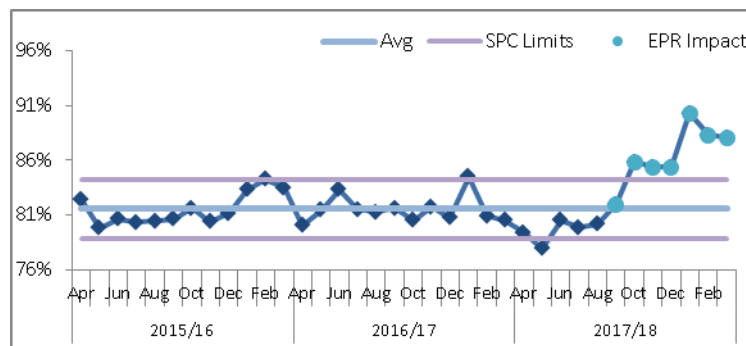
Chief Operating Officer

Did not Attend New



'Getting It Right First Time' (GIRFT) data has been provided to Chief Operating specialties to identify areas for focused work. This is affected by Officer the non-elective / elective admission data quality issue and should also improve as DQ issues are resolved.

Elective Day Case Rate



To deliver our financial plan and key performance targets

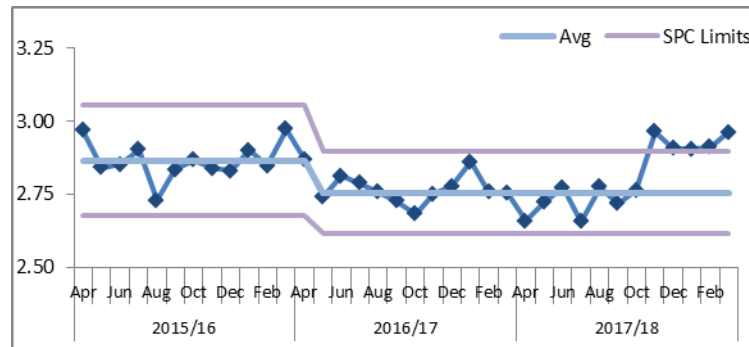
Trend

Challenges & Successes

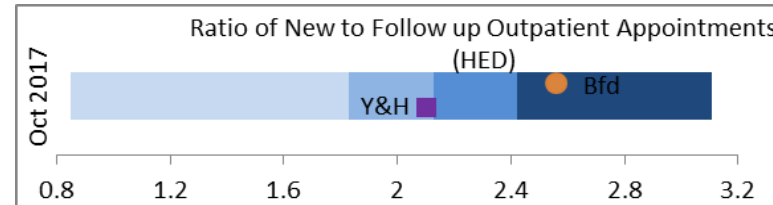
Comparison

Exec Lead

New to Follow-up Ratio

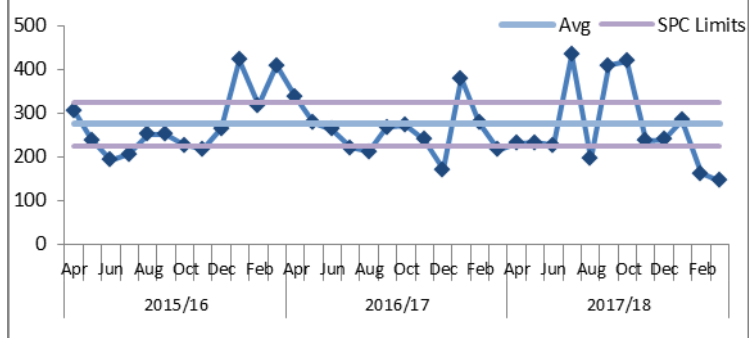


This metric is a continued focus within the Outpatient Chief Operating Improvement Programme. Each division is working on two main Officer specialties where opportunities for improvement have been identified. Progress is monitored on monthly basis

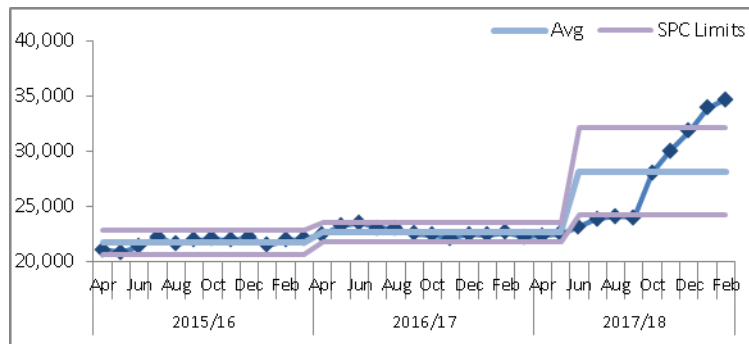


The improvement in short notice cancellations has continued in a positive direction. Chief Operating Officer

Short notice Clinic Cancellations



Elective Wait List



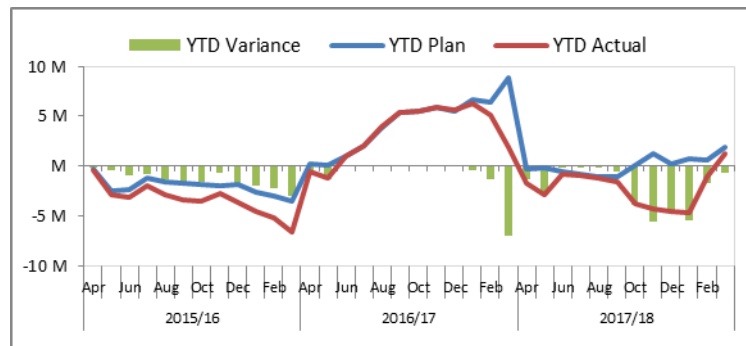
Waiting Lists and waiting times have increased as a result of the Chief Operating planned reduction in elective activity during EPR implementation Officer and during winter pressures. In addition data quality issues have had an impact on the overall waiting list size. The waiting list size has shown a small decrease in March

To deliver our financial plan and key performance targets

Trend

Challenges & Successes

Exec Lead



The unaudited Month 12 position suggests the Trust has exceeded its pre-STF control total for 2017/18 and has therefore met the financial target allocated by NHS Improvement (NHSI). The pre-STF position net of impairments is a deficit of £7.1m against a £7.8m control total deficit, resulting in a favourable variance of £0.7m. This position includes STF funding for meeting financial targets in all four quarters and AED targets in quarters 2 & 3 amounting to £7.7m.

A further £0.7m of STF incentive cash can be recognised due to exceeding the pre-STF control total. This means a total of £8.4m STF is recognised in the bottom line position.

The post-STF control total position is therefore a surplus of £1.3m against a post-STF control total target surplus of £2m. The £0.7m adverse variance at this level is explained by the loss of £2.1m STF relating to AED targets in quarters 1 & 4 being partially offset by the favourable £0.7m pre-STF variance and the £0.7m bonus STF.

The recovery of the Trust's pre-STF performance due to the deployment of non-recurrent measures in Quarter 4 has resulted in the overall year end Use of Resources risk rating of 2 being now on line with plan.

NHSI Use of Resources Risk Rating (UoR) As at 31.3.18	Plan YTD	Actual YTD	Last Month	RAG
Capital Servicing Capacity	2	2	3	
Liquidity	2	2	2	
I & E Margin	2	2	3	
Variance from plan (I & E Margin)	1	2	2	
Agency Spend	2	2	2	
Combined UoR (after triggers)	2	2	2	

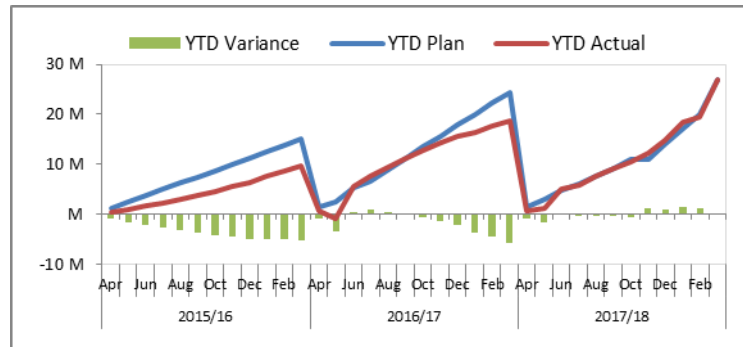
* For 'Delivery of financial plan' and 'Use of Resources – Financial' above the right hand side of the indicator relates to Financial Year 2018/19.

To deliver our financial plan and key performance targets

Trend

Challenges & Successes

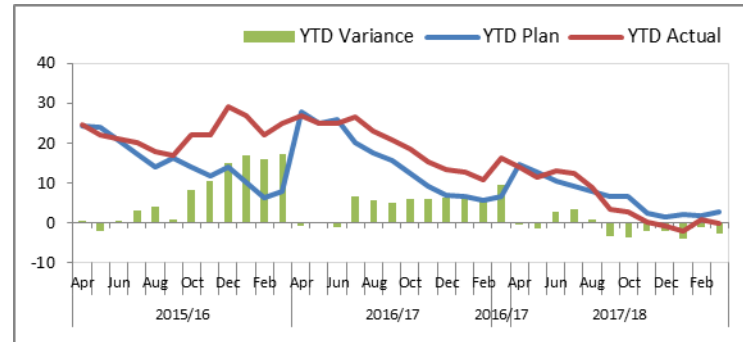
Exec Lead



The Trust has delivered efficiencies of £26.8m in 2017/18. This was sufficient to meet the pre-STF control total target. Director of Finance

Delivery in 2017/18 has relied overwhelmingly on non-recurrent support and this is a key factor driving the very challenging efficiency target in 2018/19.

The Trust can no longer rely on non-recurrent measures to deliver its efficiency requirements and must deliver sustainable productivities from early in 2018/19 if the required financial stability is to be in place to support the corporate strategy and the capital programme.



Liquidity is marginally negative (-0.1 days) and is below the planned 6.6 days liquidity. This shortfall reflects the reliance on non-cash releasing measures to meet the pre-STF control total in 2017/18. Director of Finance

The outlook for 2018/19 is that liquidity will continue to fall unless recurrent efficiency programmes are implemented very early in the financial year.

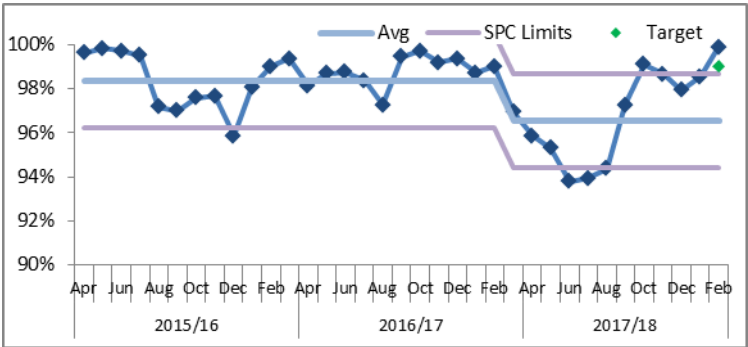
** For 'Cost Improvement Plan' and 'Liquidity' above the right hand side of the indicator relates to Financial Year 2018/19.*

National Indicators

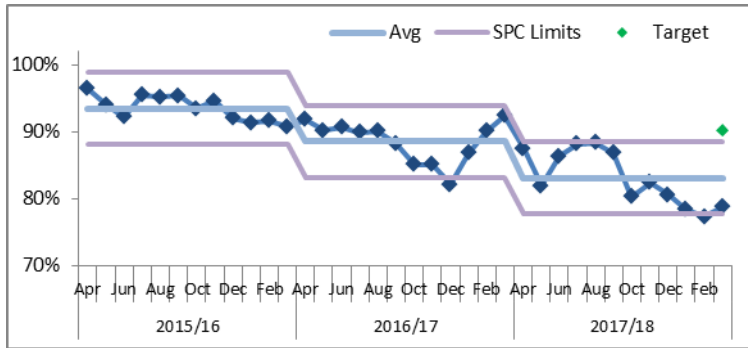
Single Oversight Framework



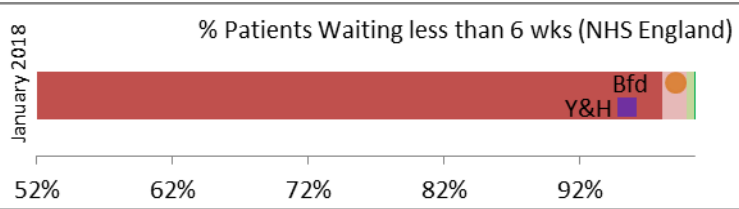
Trend	Challenges & Successes	Comparison	Exec Lead
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NHSI Use of Resources Risk Rating (UoR)	Plan YTD	Actual YTD	Last Month	RAG
As at 31.3.18				
Capital Servicing Capacity	2	2	3	
Liquidity	2	2	2	
I & E Margin	2	2	3	
Variance from plan (I & E Margin)	1	2	2	
Agency Spend	2	2	2	
Combined UoR (after triggers)	2	2	2	



March DM01 is position is 99.9%. (4 breaches). Endoscopy is still Chief Operating excluded and when included will have a significant impact on Officer DM01 performance. A recovery plan is in place.

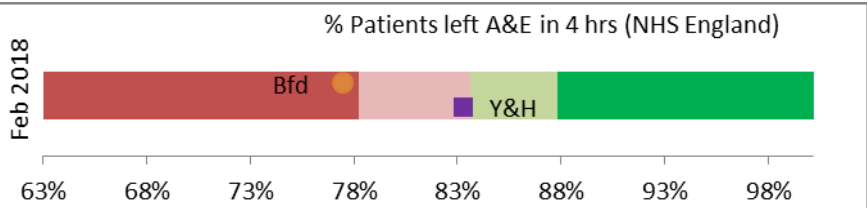


The recovery of the Trust's pre-STF performance due to the Director of deployment of non-recurrent measures in Quarter 4 has resulted Finance in the overall year end Use of Resources risk rating of 2 being now on line with plan.

* The right hand side of the indicator relates to Financial Year 2018/19.

Performance has improved in March compared to February however Chief Operating continued high bed occupancy coupled with late discharges have impacted on emergency flow. Work on the improvement plan continues.

Key actions include: Focus on front door streaming and early assessment and promote use of ambulatory pathways and admission avoidance schemes.

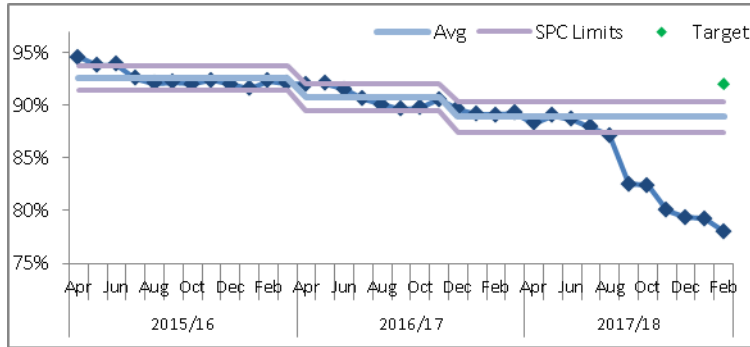


National Indicators

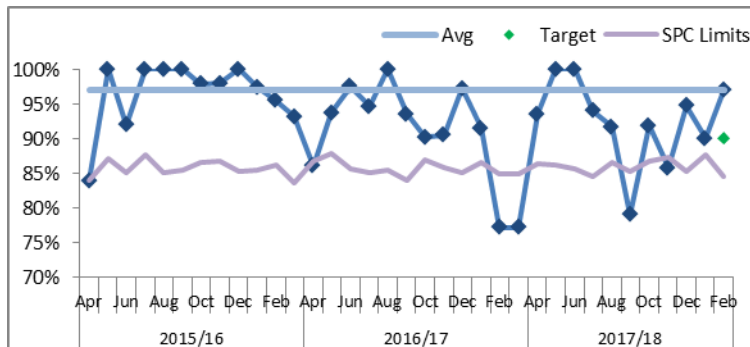
Single Oversight Framework

Trend	Challenges & Successes	Exec Lead
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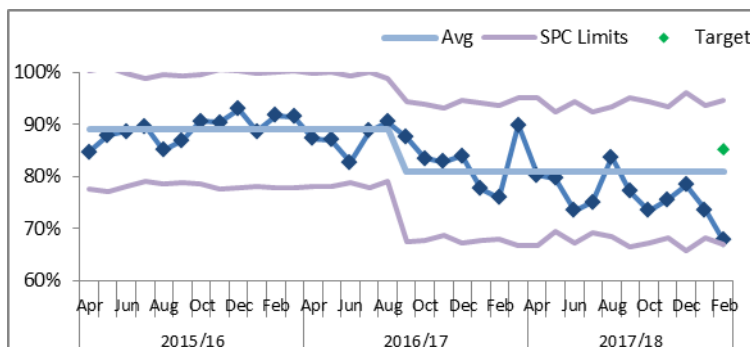
RTT 18 Week Incomplete



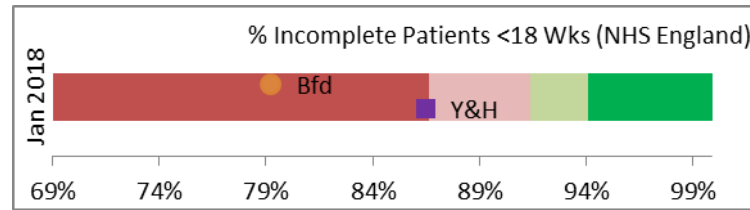
Cancer Urgent 62 Day Screening



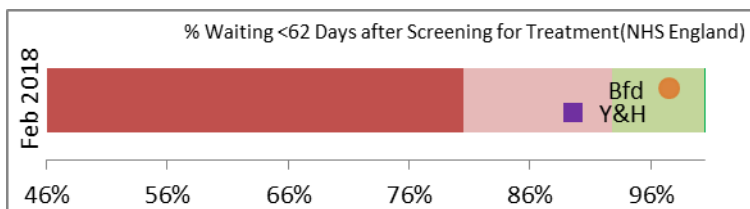
Cancer Urgent 62 Day GP



Incomplete performance for March was 73.94% .Detailed recovery Chief Operating plans are being developed with all specialties to increase activity, Officer reduce overall waiting list sizes and increase compliance with 18 week RTT. These will commence mid April.



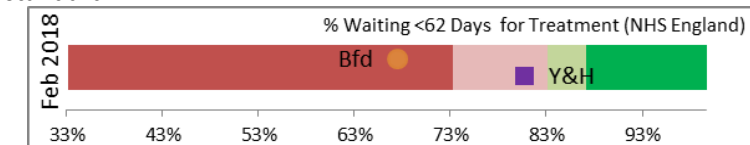
This standard is predicted to achieve for March. Chief Operating Officer



The position continues to be managed via the cancer lead in Chief Operating conjunction with the divisional teams. Speciality level action plans have Officer been agreed and a focus on –

- 1.Reducing 62 day backlog.
- 2.Improved operational grip and close daily tracking of patient lists.
- 3.Demand and capacity analysis

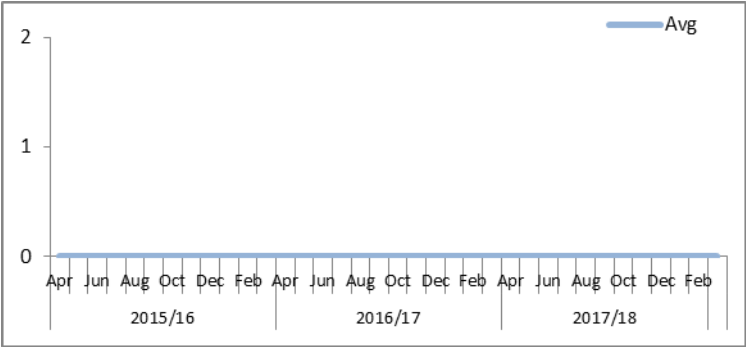
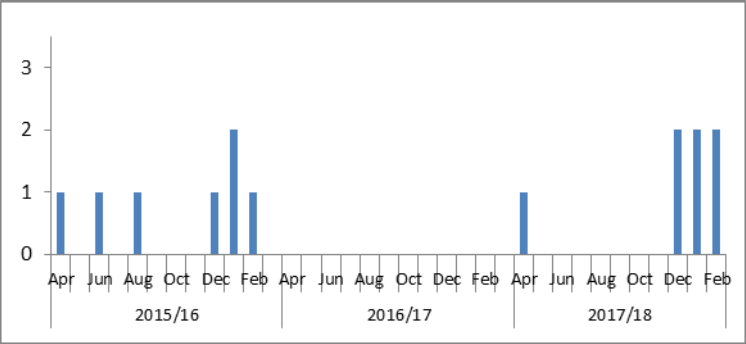
A weekly cancer access group reviews patient by patient all long waiters with Root cause analysis completed for all patients who breach the standard.



National Indicators

National Target Non-Financial

Trend	Challenges & Successes	Exec Lead
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The weekly planned care access group continues to review all long waiting patients on a weekly basis.
The Trust reported 4 incomplete 52 week breaches in March and will report in 6 in April
The main risks are in ENT, General surgery, Vascular and T&O

Chief Operating Officer

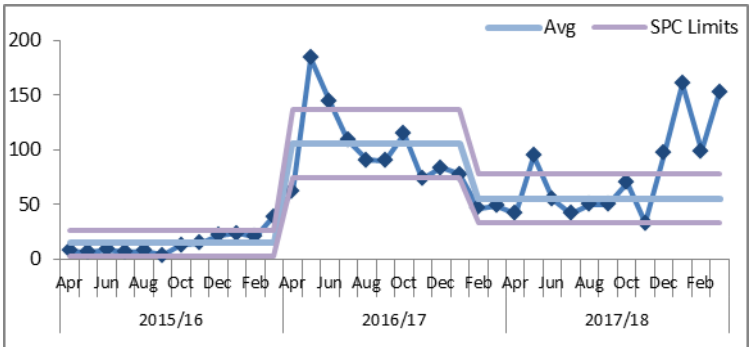
There have been no > 12 hour trolley waits.

Chief Operating Officer

National Indicators

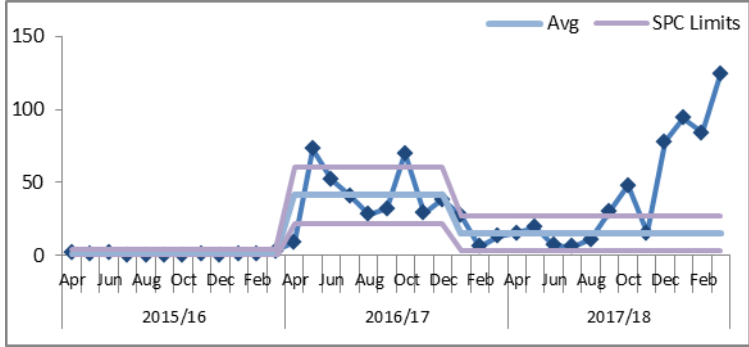
National Target Non-Financial

Trend	Challenges & Successes	Comparison	Exec Lead
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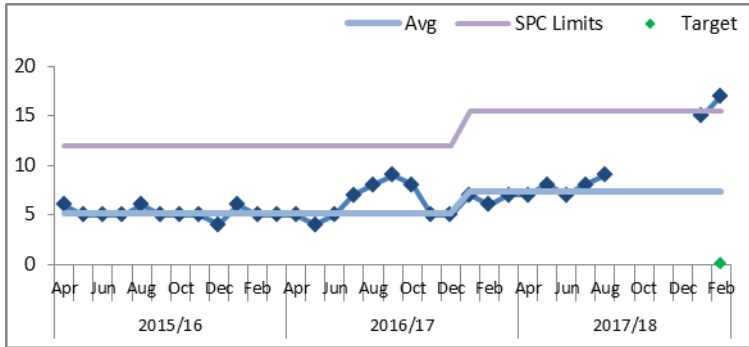
The Trust is not currently meeting the standard for ambulance handover. Plans have been implemented, as part of the AED Improvement Plan to improve this position.

Chief Operating Officer



The Trust is not currently meeting the standard for ambulance handover with a deterioration noted in March. Plans have been implemented, as part of the AED Improvement Plan to improve this position.

Chief Operating Officer



The Trust is now reporting RTT but performance is affected by data quality issues and a growth in waiting times due to reduced productivity. The weekly planned care access group continues to challenge the position on a patient-by-patient level with all divisions.

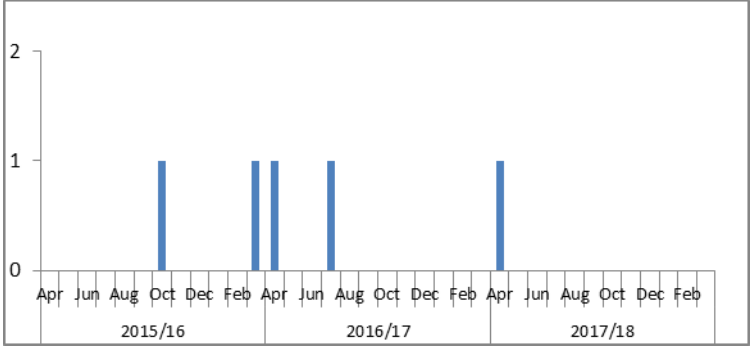
Chief Operating Officer

National Indicators

National Target Financial



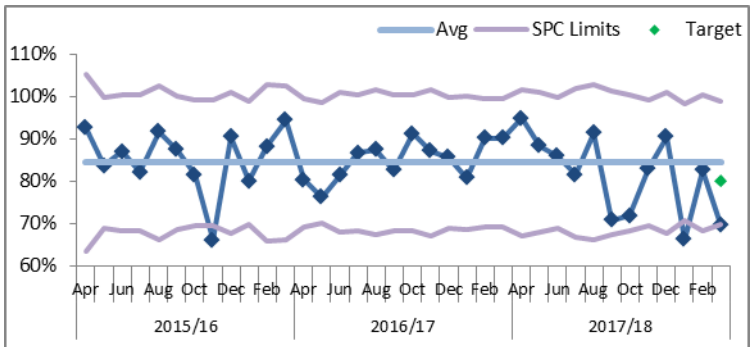
Trend	Challenges & Successes	Comparison	Exec Lead
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No Never Events reported this month.

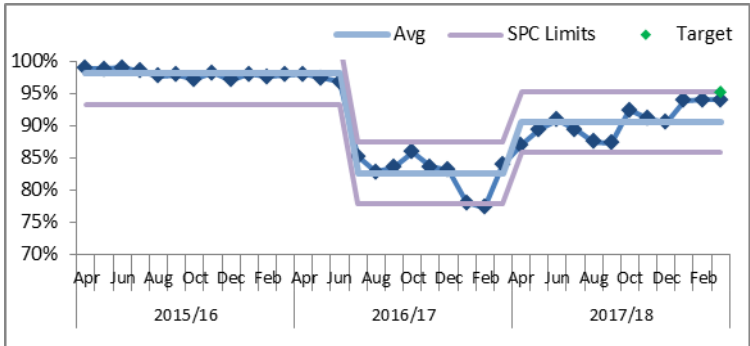
No comparator data is available.

Chief Operating Officer



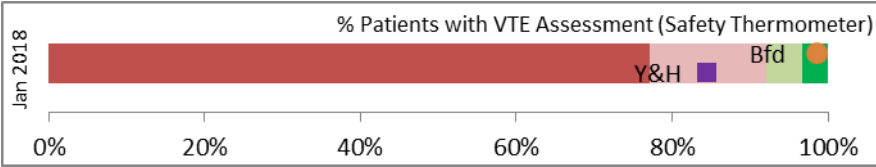
This indicator has deteriorated in March with 19 breaches of the target, Chief however the number of patients treated within target was consistent with previous months . All breaches of the target continue to be reviewed by the lead clinician. The service is currently undertaking a service review with development of a support plan.

Chief Operating Officer



VTE assessment performance has improved to 93.9% by the end of March 2018. Work continues through the Medical Director’s Office to work with areas where further improvements can be made. A update report on progress and trajectory was discussed at the Quality committee in March 2018.

Medical Director



National Indicators

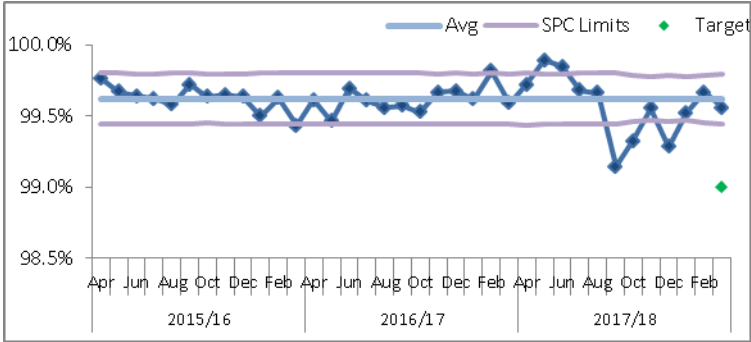
National Target Financial

	Trend	Challenges & Successes	Comparison	Exec Lead																																						
<div>Duty of Candour</div>	<table border="1"><thead><tr><th>Month</th><th>Breaches</th></tr></thead><tbody><tr><td>Apr 2015</td><td>0</td></tr><tr><td>Jun 2015</td><td>0</td></tr><tr><td>Aug 2015</td><td>0</td></tr><tr><td>Oct 2015</td><td>0</td></tr><tr><td>Dec 2015</td><td>0</td></tr><tr><td>Feb 2016</td><td>0</td></tr><tr><td>Apr 2016</td><td>0</td></tr><tr><td>Jun 2016</td><td>0</td></tr><tr><td>Aug 2016</td><td>0</td></tr><tr><td>Oct 2016</td><td>0</td></tr><tr><td>Dec 2016</td><td>0</td></tr><tr><td>Feb 2017</td><td>0</td></tr><tr><td>Apr 2017</td><td>0</td></tr><tr><td>Jun 2017</td><td>0</td></tr><tr><td>Aug 2017</td><td>0</td></tr><tr><td>Oct 2017</td><td>0</td></tr><tr><td>Dec 2017</td><td>0</td></tr><tr><td>Feb 2018</td><td>1</td></tr></tbody></table>	Month	Breaches	Apr 2015	0	Jun 2015	0	Aug 2015	0	Oct 2015	0	Dec 2015	0	Feb 2016	0	Apr 2016	0	Jun 2016	0	Aug 2016	0	Oct 2016	0	Dec 2016	0	Feb 2017	0	Apr 2017	0	Jun 2017	0	Aug 2017	0	Oct 2017	0	Dec 2017	0	Feb 2018	1	There were no Duty of Candour breaches in March		Director of Governance & Corporate Affairs
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<div>Formulary</div>	The Trust ensures that the Formulary is published on the website		No comparator data is available.	Director of Informatics																																						
<div>Mixed Sex Breaches</div>	<table border="1"><thead><tr><th>Month</th><th>Breaches</th></tr></thead><tbody><tr><td>Apr 2015</td><td>0</td></tr><tr><td>Jun 2015</td><td>1.0</td></tr><tr><td>Aug 2015</td><td>1.0</td></tr><tr><td>Oct 2015</td><td>0</td></tr><tr><td>Dec 2015</td><td>0</td></tr><tr><td>Feb 2016</td><td>0</td></tr><tr><td>Apr 2016</td><td>0</td></tr><tr><td>Jun 2016</td><td>0</td></tr><tr><td>Aug 2016</td><td>0</td></tr><tr><td>Oct 2016</td><td>0</td></tr><tr><td>Dec 2016</td><td>0</td></tr><tr><td>Feb 2017</td><td>0</td></tr><tr><td>Apr 2017</td><td>0</td></tr><tr><td>Jun 2017</td><td>0</td></tr><tr><td>Aug 2017</td><td>0</td></tr><tr><td>Oct 2017</td><td>0</td></tr><tr><td>Dec 2017</td><td>0</td></tr><tr><td>Feb 2018</td><td>0</td></tr></tbody></table>	Month	Breaches	Apr 2015	0	Jun 2015	1.0	Aug 2015	1.0	Oct 2015	0	Dec 2015	0	Feb 2016	0	Apr 2016	0	Jun 2016	0	Aug 2016	0	Oct 2016	0	Dec 2016	0	Feb 2017	0	Apr 2017	0	Jun 2017	0	Aug 2017	0	Oct 2017	0	Dec 2017	0	Feb 2018	0	There have been no Mixed Sex Breaches.		Chief Operating Officer
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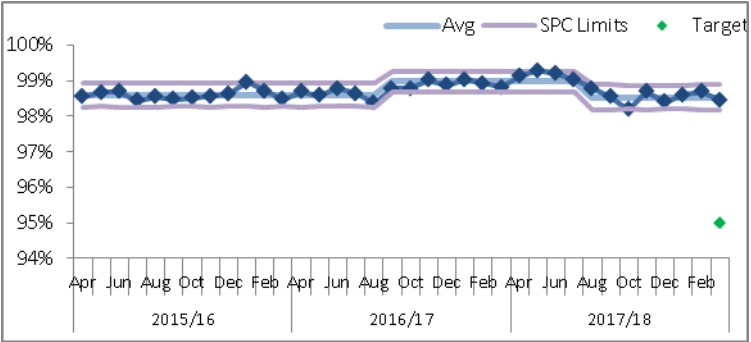
National Indicators

National Target Financial

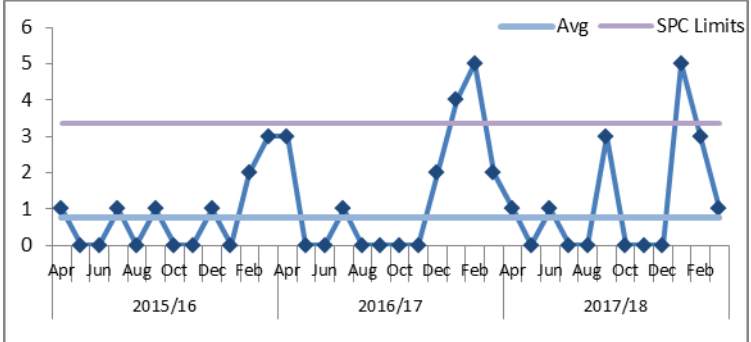
Trend	Challenges & Successes	Exec Lead
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With the standardisation and integration of the patient Director of administration system data, as the one source of truth, the Informatics Trust compliance to NHS Number use is strong. Issues in related to EPR embedding and will improve.



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.

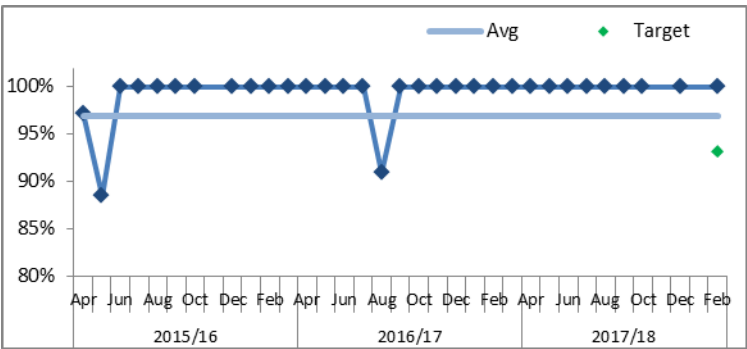
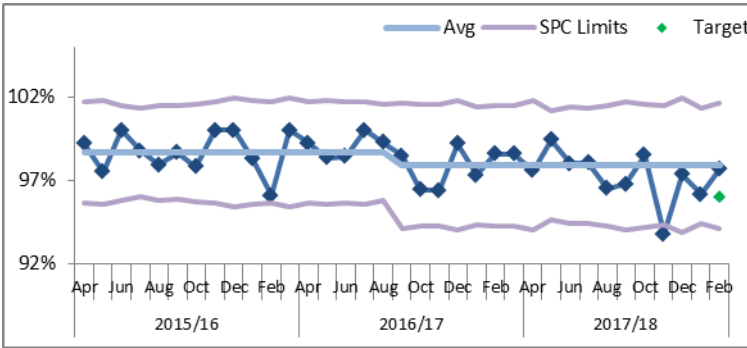
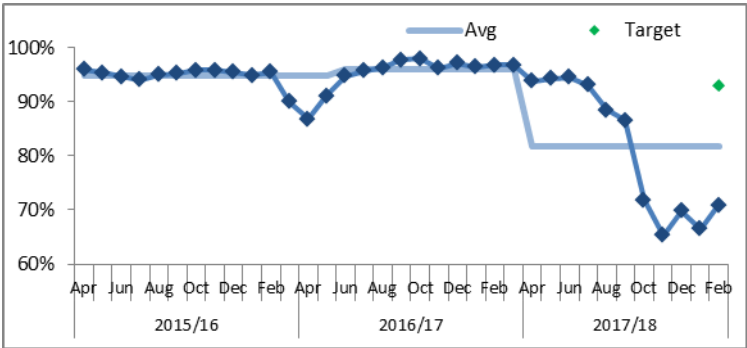


There was one 28 day breach for March in Ophthalmology. Chief Operating Officer

To note due to adverse weather conditions experienced in March which resulted in 53 same day cancellations it is projected that a further 8 cases will breach the 28 day standard in April.

National Indicators

National Target Financial



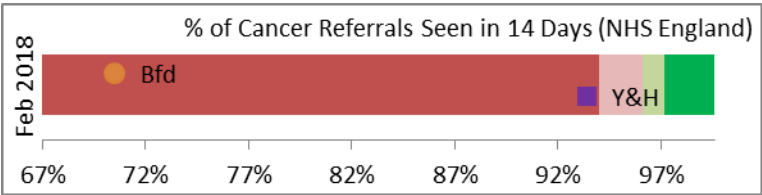
Trend

Challenges & Successes

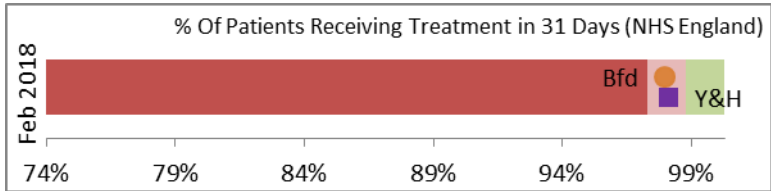
Comparison

Exec Lead

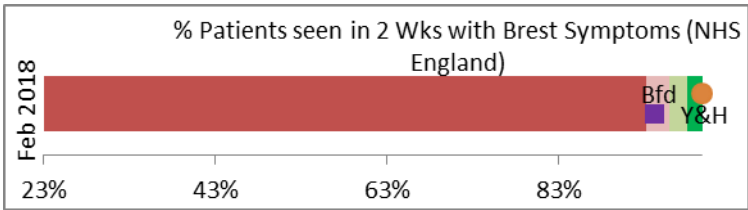
2 week wait performance has not been achieved for March. The Chief main issue remains the impact of Dermatology, however Breast, Operating Haematology and Lower GI services are also contributing to the Officer position . Recovery plans are in place for all specialties.



This standard was achieved in March.



This standard was achieved in March.



Chief
Operating
Officer

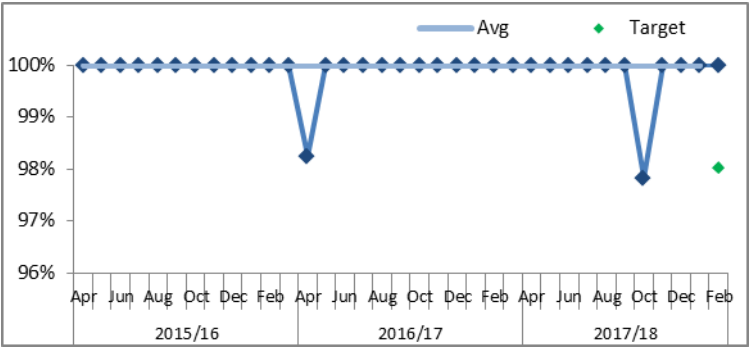
Chief
Operating
Officer

National Indicators

National Target Financial

Trend	Challenges & Successes	Comparison	Exec Lead
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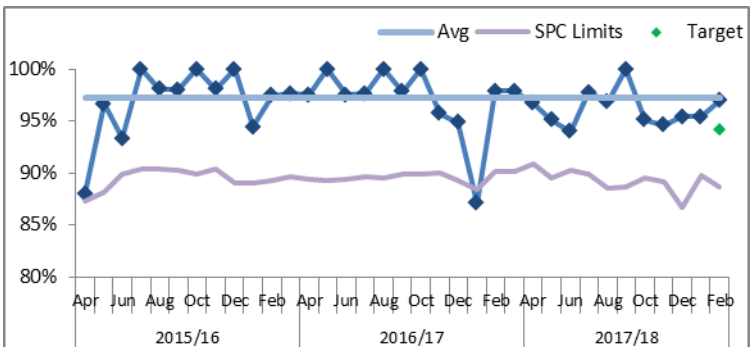
Cancer 2nd Treatment Drugs



This standard was achieved in March.

Chief Operating Officer

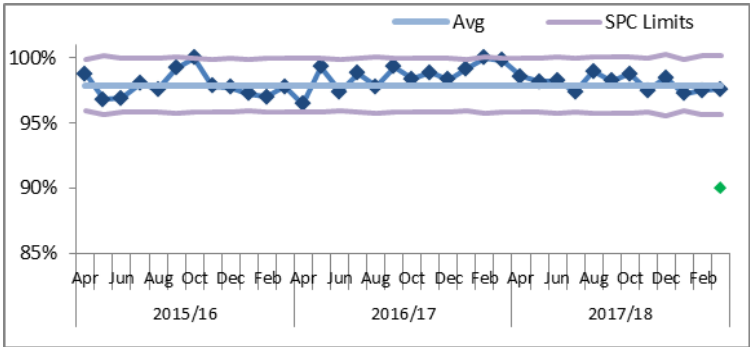
Cancer 2nd Treatment Surgery



This standard was achieved in March.

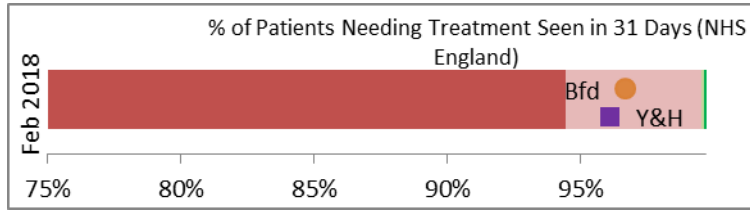
Chief Operating Officer

Seen By Midwife <13 Weeks



The local contract target has been met in March and each month this year.

Chief Operating Officer

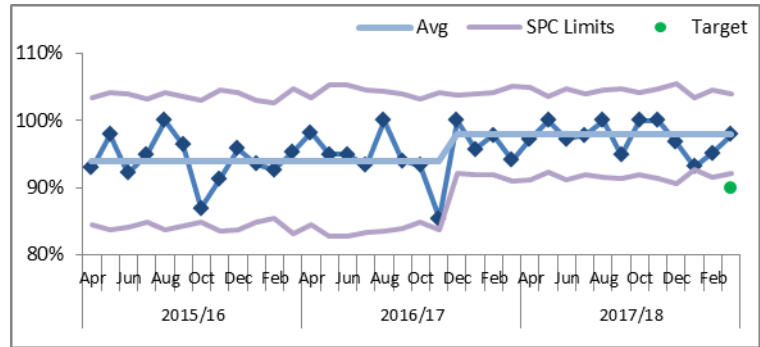


National Indicators

National Target Financial

Trend	Challenges & Successes	Comparison	Exec Lead
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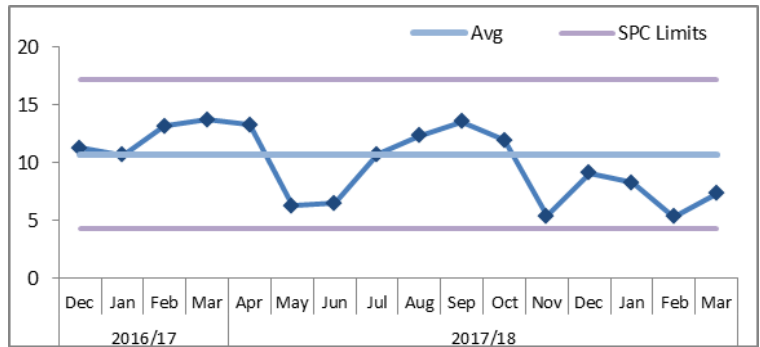
Seen By
Midwife > 12
Weeks



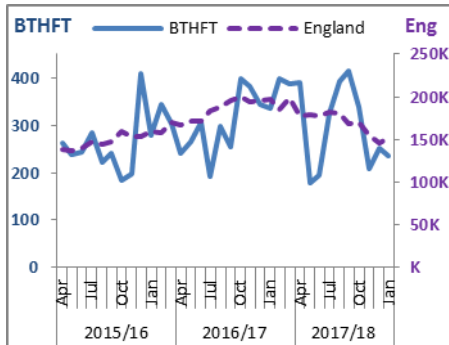
The local contract target has been met in March and each month this year.

Chief
Operating
Officer

Delayed
Transfers of
Care



Delayed Transfers Of Care have increased during March as a consequence of continued high admissions for Elderly patients, however performance remains good with continued close working with Social Services to focus on timely discharges

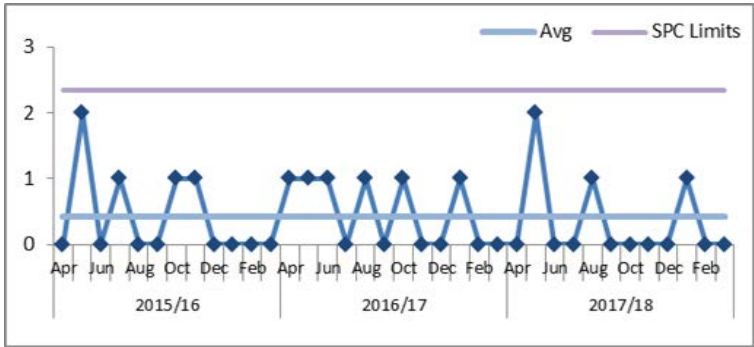


Chief
Operating
Officer

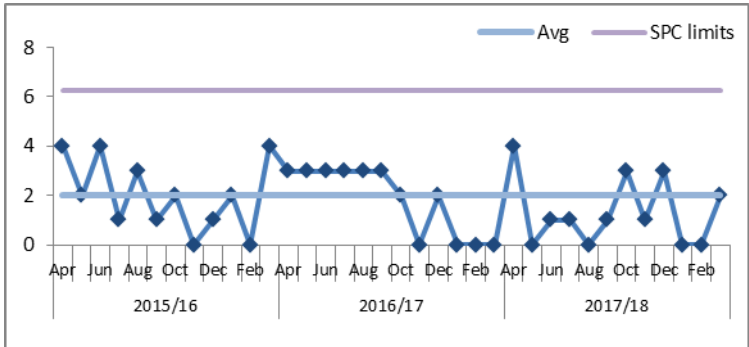
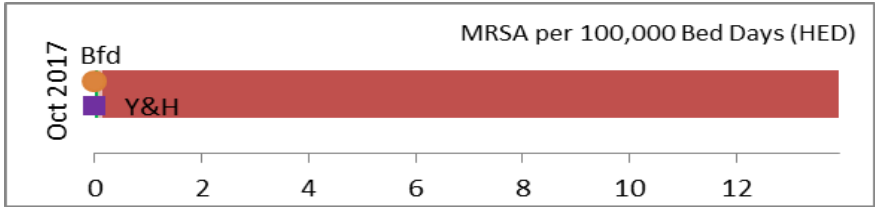
National Indicators

National Target Financial

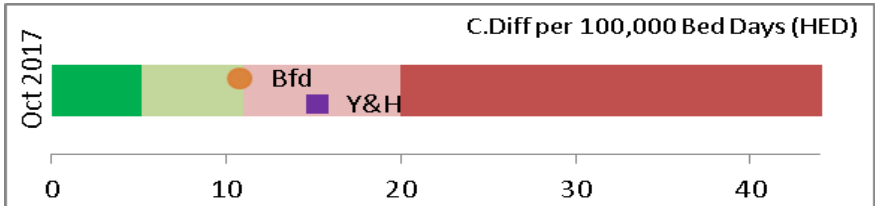
Trend	Challenges & Successes	Comparison	Exec Lead
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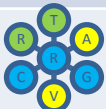











Remain on track to improve on 16/17 but remain higher than zero Chief Nurse tolerance. 18/19 work plan for ICC focusses on reduction of bacteraemia



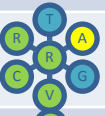





Sustained reduction in C. Difficile has been achieved. Robust PIR process. Chief Nurse Below trajectory





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.		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.		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.	
C Difficile	The number of cases either attributable or pending review.				
eColi	Counts of patients with Escherichia coli (eColi).				
MRSA	Counts of patients with Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia				
MSSA	Counts of patients with Meticillin Sensitive Staphylococcus aureus (MSSA) 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	
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.	
Information Governance Breaches	The number of reported breaches of the information governance standards	

Indicator	Definition	Data Quality Kite-Mark
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	

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.	


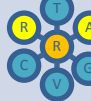






Glossary

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. Red < 99%, Amber , Green >= 99%	
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. Red < 90%, Amber , Green >= 90%	
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. Red < 96%, Amber , Green >= 96%	
Cancer Urgent 62 Day GP	Proportion of patients receiving treatment for cancer within 62 days of an urgent GP referral for suspected cancer. Red < 85%, Amber , Green >= 85%	
Non-Financial		
RTT 52 Week Wait	Number of patients waiting more than 52 weeks. Red > 0, Amber , Green = 0	
Trolley Waits >12 hours	Trolley waits of > 12 hours. Red > 0, Amber , Green = 0	

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. Red > Same Month LY, Amber , Green >=Same Month LY	
Ambulance Handover >60 mins	Ambulance handover taking longer than 60 minutes to handover. Red > Same Month LY, Amber , Green >=Same Month LY	
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. Red > 0, Amber , Green = 0	
Stroke Strategy	Implementation of the Stroke Strategy – patients who spend at least 90% of their time on a stroke unit. Red < 80%, Amber , Green >= 80%	
VTE Assessments	VTE risk assessments completed. Red < 90%, Amber >= 90% & < 95%, Green >= 95%	
Duty of Candour	Patient informed duty of candour. Red > 0, Amber , Green = 0	
Formulary published	Hospital formulary is published on the Trust's external website. Red Not published, Amber , Green Published	

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. Red > 0, Amber , Green = 0		Cancer 2 nd Treatment Surgery	Patients that require further surgery following initial treatment should receive treatment within 31 days . Red < 94%, Amber , Green >= 94%	
NHS # field completion acute	Completion of valid NHS # field in acute commissioning data sets submitted via SUS Red < 99%, Amber , Green >= 99%		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 AED	Completion of valid NHS # field in AED commissioning data sets submitted via SUS. Red < 95%, Amber , Green >= 95%		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	Number of patients who were cancelled on day of surgery and subsequently not been treated. Red > 0, Amber , Green = 0		Delayed Transfers of Care	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 Red < 93%, Amber , Green >= 93%		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. Red < 94%, Amber , Green >= 94%		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. Red < 93%, Amber , Green >= 93%				
Cancer 2 nd Treatment Drugs	Proportion of patients waiting no more than 31 days for second or subsequent drug treatments. Red < 98%, Amber , Green >= 98%				

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.

