

Board of Directors: 12.07.2018
Agenda Item: Bo.7.18.9

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

Executive Summary:
The Integrated Dashboard for May 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

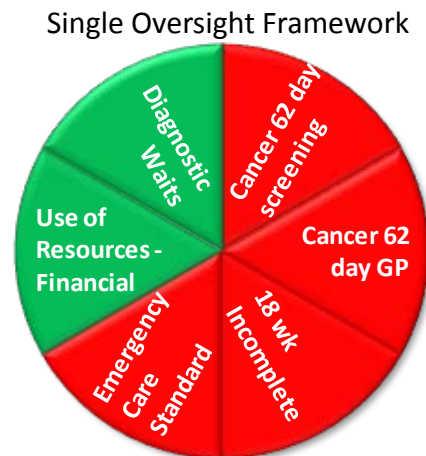
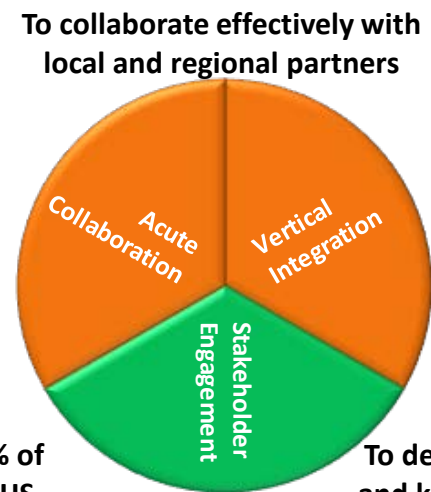


Bradford Teaching Hospitals
NHS Foundation Trust

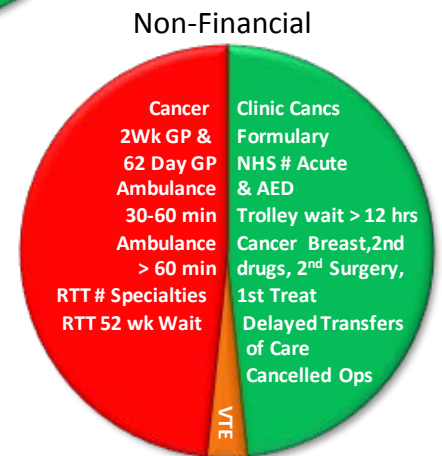
Integrated Dashboard Board of Directors

31st May 2018

31st May 2018



National targets



Headlines

The CQC has published its findings of the Trust’s Unannounced and Well-Led inspections which it undertook in 2017/18 Quarter 4. Whilst they noted improvements since the 2016 inspection, they identified areas of concern in maternity and medical services which required improvement. The CQC issued eight compliance notices. As a result of this and the fact that the 2016 inspection’s ‘Requires Improvement’ services were not re-inspected, the Trust’s overall rating remains- ‘Requires Improvement’. As a result of the Well-Led inspection, the Trust-wide Well-Led domain was rated ‘Good’. The Local Services Review findings have also been released. The report describes many areas that are working well in Bradford and identifies some opportunities for improving how the system works for patients.

Quality Committee

Training compliance is high, as is VTE compliance. The Trust has delivered over 94.5% VTE assessment for the past 4 months. In May the 95% standard was achieved. Improvement work continues to deliver sustainable achievement of the standard. Compliance with training for core and high priority training has increased again this month. Core training has increased to 95% and high priority has increased to 90% against a compliance targets of 85% for both. The response by staff to undertake their training has been very positive and this is reflected by the increased compliance.

There have been two new Serious Incidents reported during May 2018. One incident has been declared as a Never Event. The incident involved the incorrect administration of fluid for bladder irrigation. The incident related to the wrong route of administration of medication. The other incident related to sub-optimal assessment and care which resulted in a patient developing a grade three pressure ulcer.

Workforce Committee

Sickness absence rates and using agency staff have both improved. Turnover rates and number of staff remain relatively stable. Appraisal rates have deteriorated. Their compliance targets and process are being reviewed. Nurse staffing shift fill rates for Bradford Royal Infirmary have improved for two consecutive months.

Finance & Performance Committee

Emergency Care Standard and some Cancer targets are not being met but continue to improve through the Emergency Care Improvement Programme and operational management. There continues to be periods of increased pressure, which is multifactorial, impacting performance. Work continues across the department’s staff groups to continue to recover the performance position. Work includes consistent streaming, operational grip and focus on ambulatory care, and working with specialties to ensure patients are seen in the right place, first time. Issues relating to the underachievement against the two cancer access standards (62 Day and 2 Week Wait) are multifactorial in a number of sites and site-level recovery plans are being strengthened with the Lead Cancer Team and the General Managers. The overarching Cancer Recovery Plan is monitored and updated fortnightly. The Lead Cancer Team and Divisional staff are engaged with the West Yorkshire and Harrogate Cancer Alliance to review high volume pathways and pressure areas to work more collaboratively to improve performance.

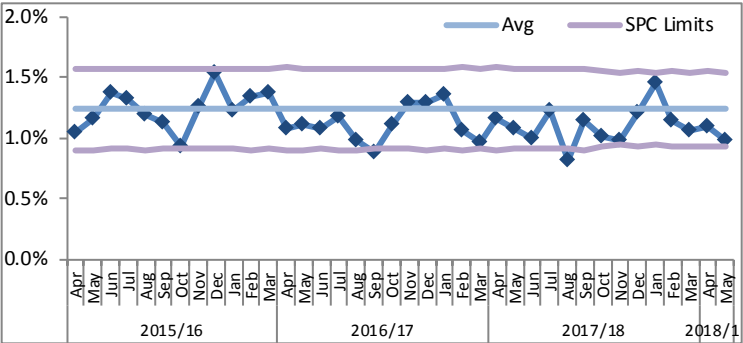
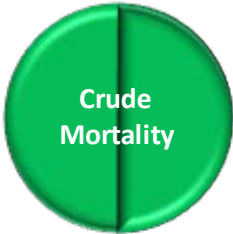
Embedding of the EPR continues with focus on improving consistent use & correct design for data quality, managed through the Data Quality Group launched at Go-Live, focussing on the correct recording of activity. The Group has extended its scope to support wider improvements in EPR use. Cultural change across the teams with a tiered approach to data quality issue/error resolution is being taken and is underpinned by a change in the associated training delivery. EPR design issues are being jointly reviewed with the operational and Informatics teams to ensure correct prioritisation. The use of data quality indicators has been instrumental in the improvements made to date and this will be further embedded across all levels of performance monitoring and improvement.

Partnerships Committee

Collaboration in West Yorkshire & Harrogate has progressed with Shadow Integrated Care System (ICS) designation . This means NHS England has recognised the area as being in a mature state than other areas. Practically the Shadow ICS will take on performance oversight and intervention of some areas while gaining access to funding and national support. Full status is given after completing certain actions; the key action is a signed memorandum of understanding.

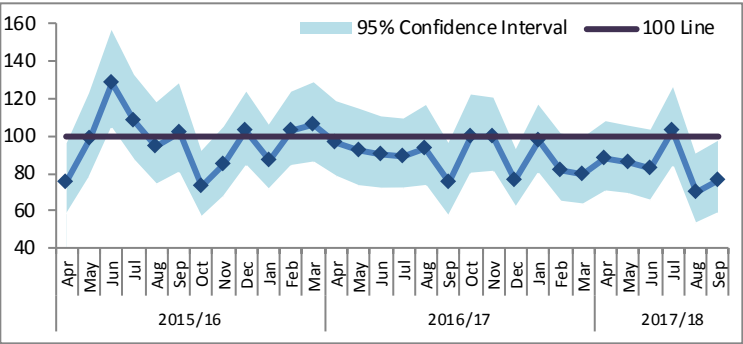
To provide outstanding care for patients

Trend	Challenges and Successes	Comparison	Exec Lead
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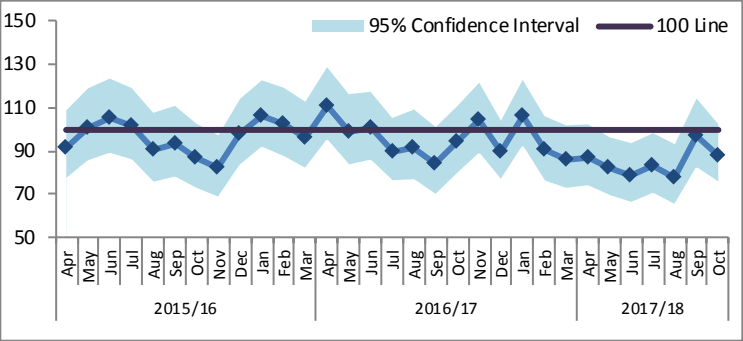
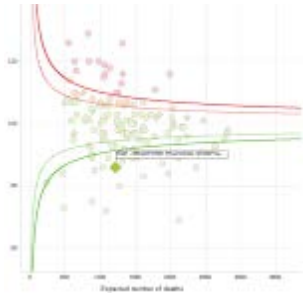
Crude death rate has remained constant throughout the last 18 months. There is no benchmarking data for this measure. Improving learning from mortality is now delivered though the 'learning from deaths' process. Reporting on progress to the Quality Committee is via the quarterly report.

Medical Director



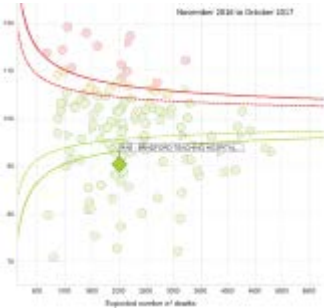
Our Hospital Standardised Mortality Ratio (HSMR) continues to be relatively low. Over the past 12 months presented we are statistically better than expected. We expect to be able to update this metric next month.

Medical Director



Our Summary Hospital-level Mortality Indicator (SHMI) continues to be relatively low. Over the past 12 months presented we are statistically better than expected. We expect to be able to update this metric next month.

Medical Director



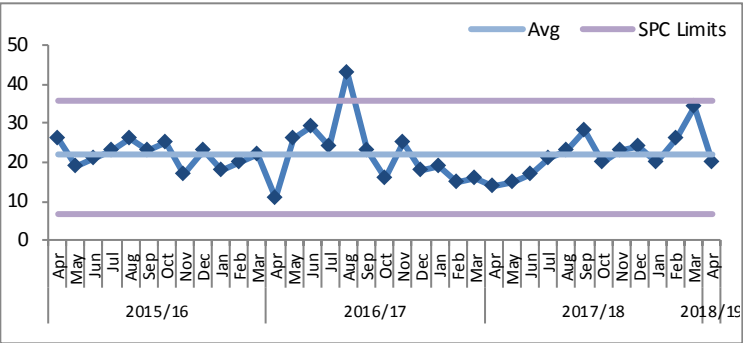
To provide outstanding care for patients

Trend

Challenges and Successes

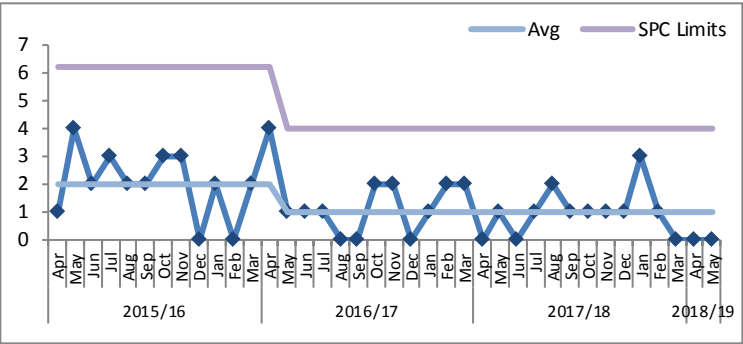
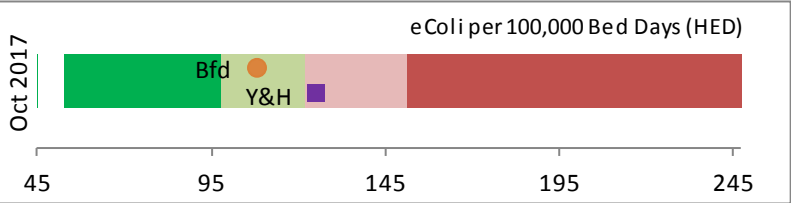
Comparison

Exec Lead



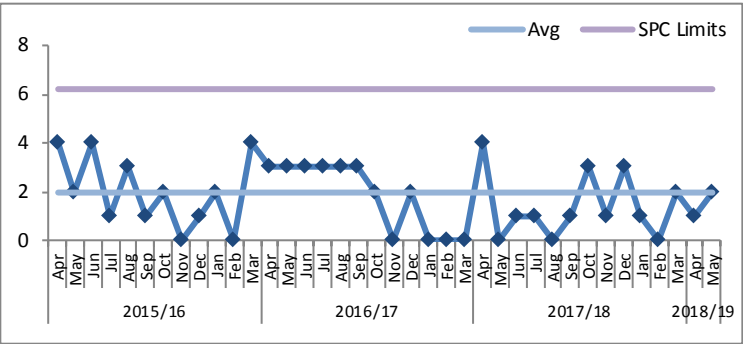
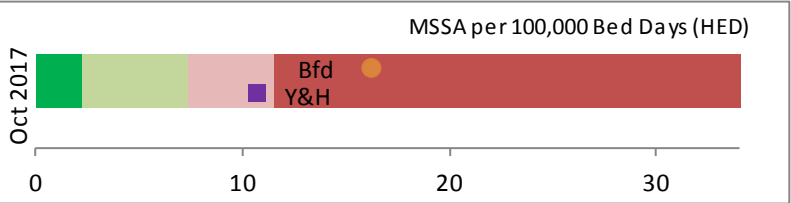
As part of the 2018/19 work plan we will focussing on all bacteraemias. We have seen a reduction of 26% on the previous 12 months (NHS Improvement).

Chief Nurse



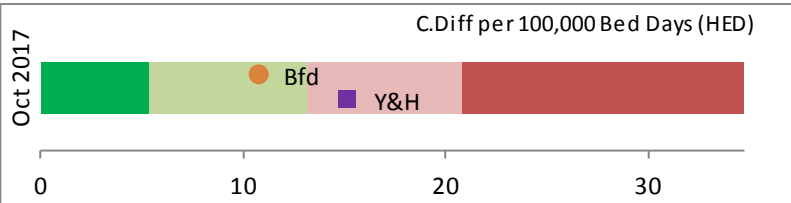
Part of national improvement collaborative for Infection Prevention and Control (IPC). Ongoing improvements are overseen by Infection Prevention & Control and reviewed on a quarterly basis.

Chief Nurse


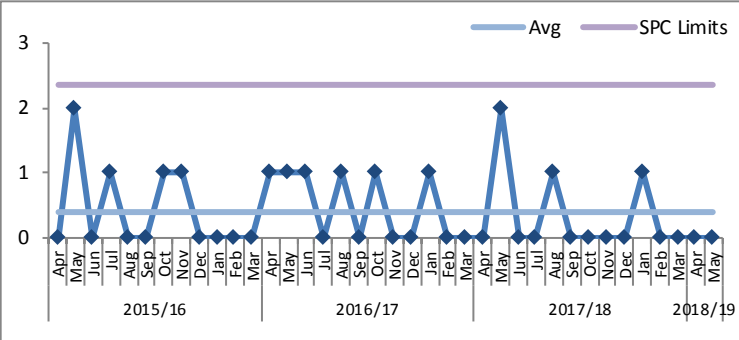

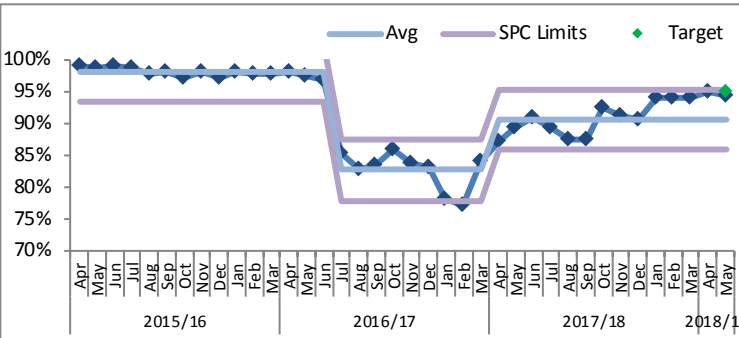

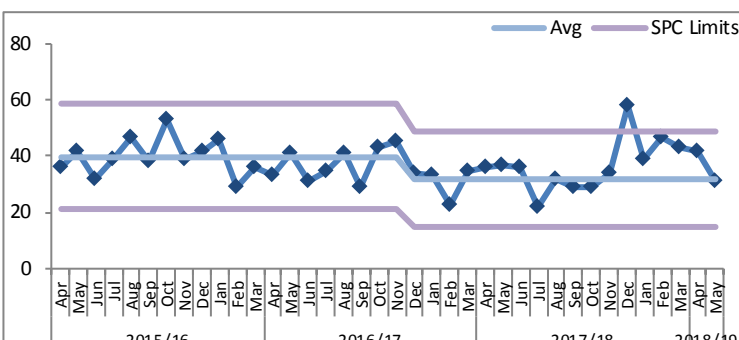


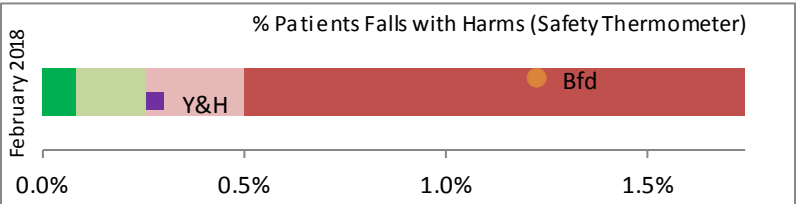
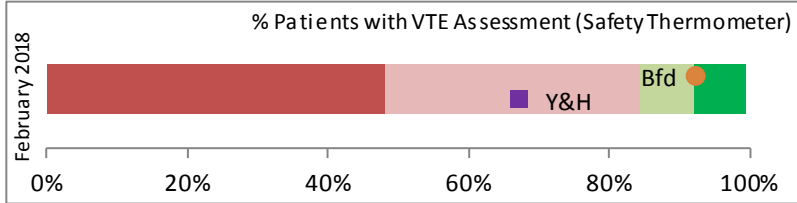
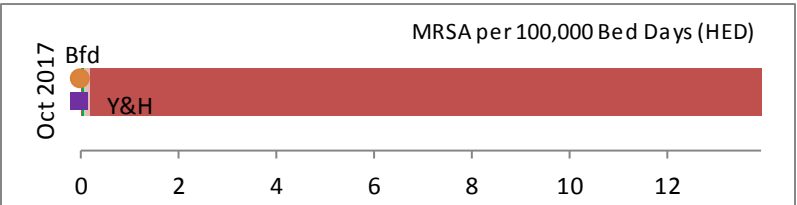
Sustained reduction in Clostridium Difficile has been achieved. A robust Post Infection Review process is in place.

Chief Nurse



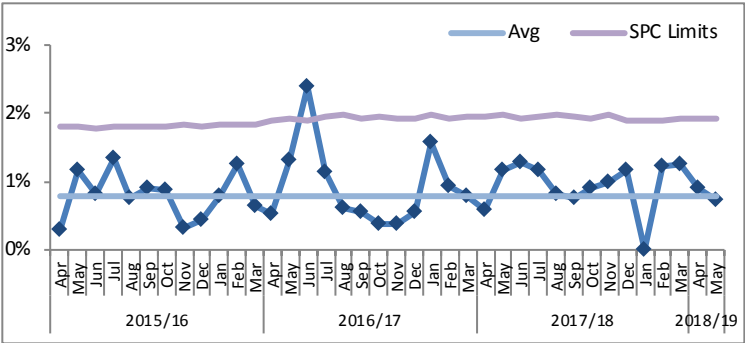
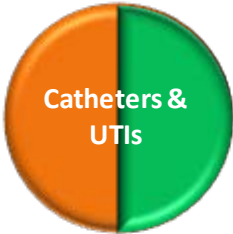
To provide outstanding care for patients

	Trend	Challenges and Successes	Comparison	Exec Lead
		Zero Methicillin-resistant Staphylococcus (MRSA) year to date.		Chief Nurse
		The performance for the past 3 months was an average of 94.7% with April achieving the standard at 95.2%. Work continues through the Medical Director's Office to embed sustainable delivery of the standard. A quarterly update will be provided to the Quality Committee on 27th June 2018/19.		Chief Nurse
		Collaborative work is having a positive impact on the number of falls with harm, further reduction back to previous baseline.		Chief Nurse



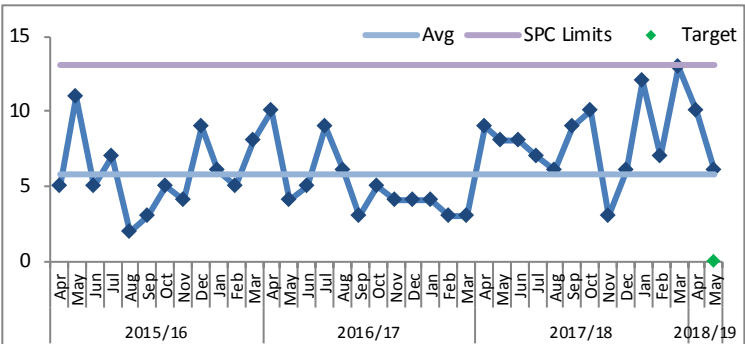
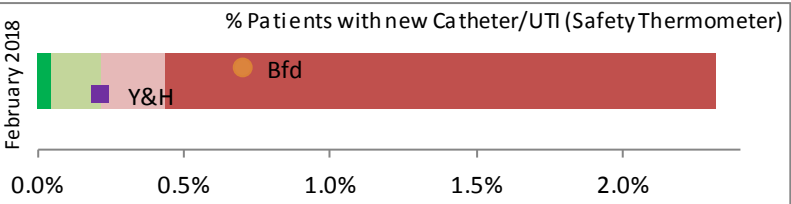
To provide outstanding care for patients

Trend	Challenges and Successes	Comparison	Exec Lead
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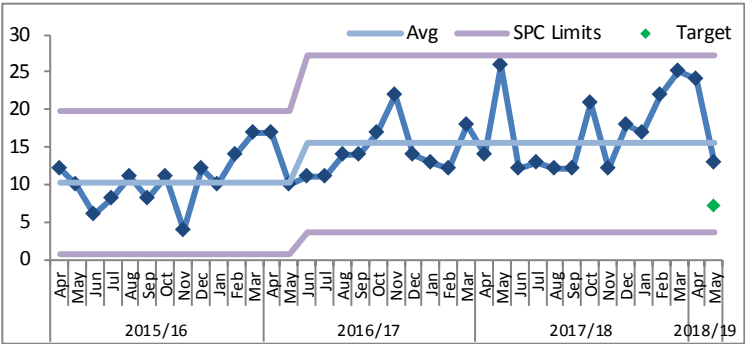
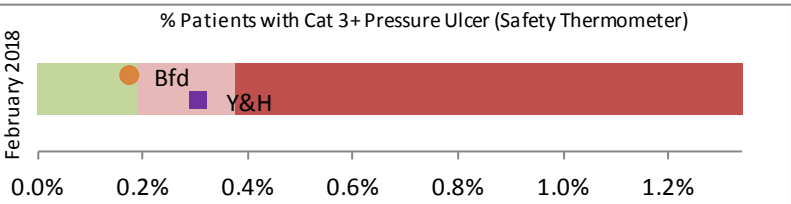
Plans in place to undertake work (overseen by the Infection Prevention and Control) to reduce the point prevalence of Catheter Urinary Tract Infections (CAUTI). Opportunity to use the EPR to audit care and support improvement being explored with chief nurse team. The trend continues to mirror previous 3 years.

Chief Nurse



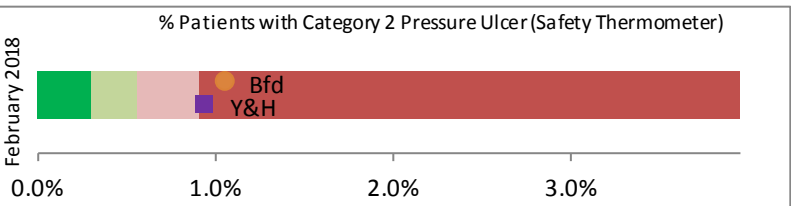
Focussed work continues with the Tissue Viability Nursing team and recent participation in national collaborative is raising awareness of documentation, assessment and care planning.

Chief Nurse



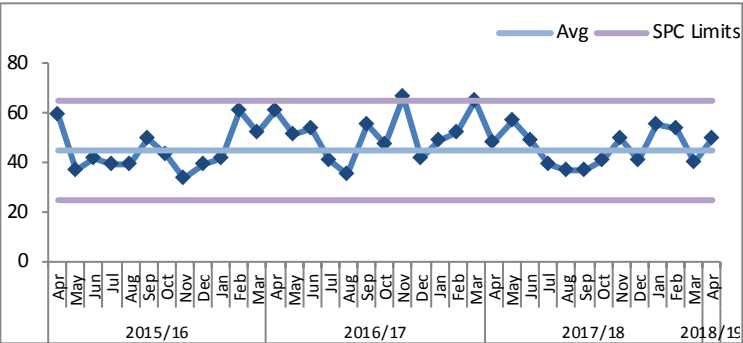
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Chief Nurse



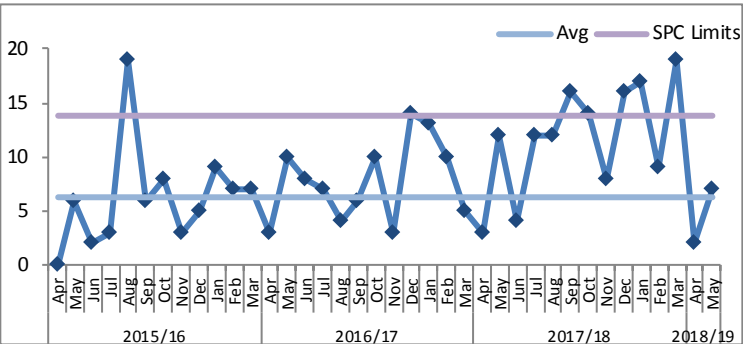
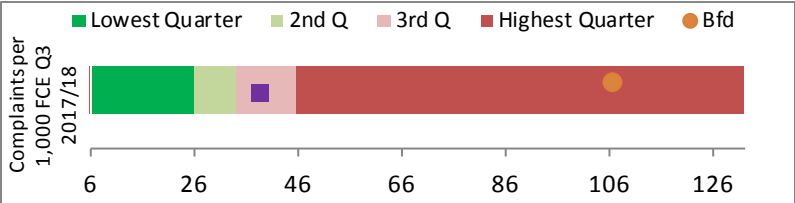
To provide outstanding care for patients

Trend	Challenges and Successes	Comparison	Exec Lead
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We are seeing an increase in numbers of complaints in Quarter 4 2017/18, a similar pattern over the last few years. Our complaints data shows an overall decrease over time with an increase in Patient Advice and Liaison Service (PALS) contacts.

Chief Nurse

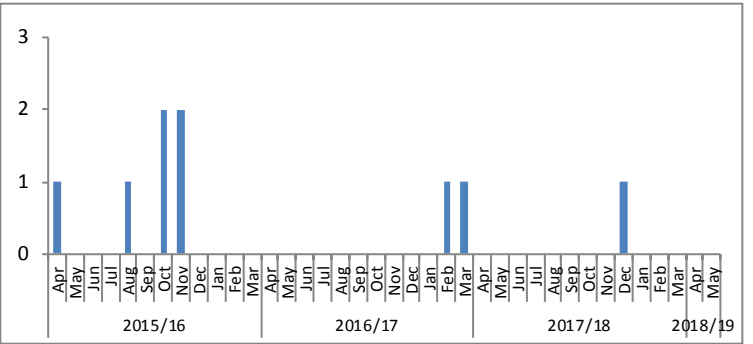
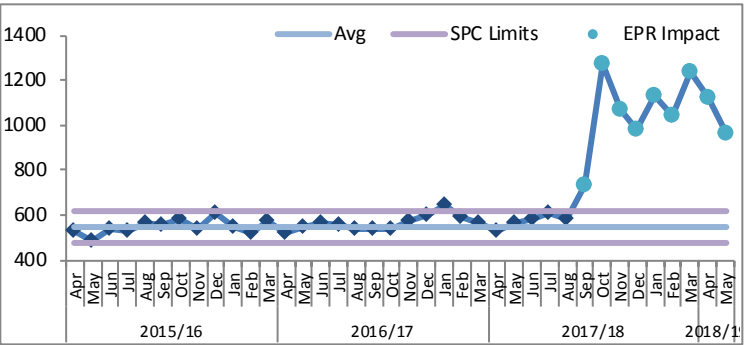
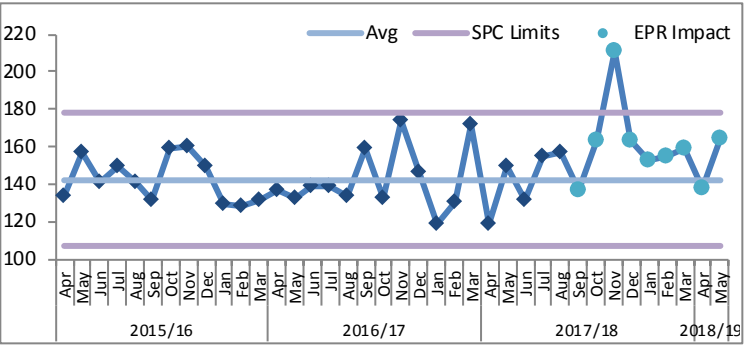


Daily review of night time transfers continues. A significant reduction was seen in April 2018/19 as anticipated which has been maintained in May 2018/19. In summary, there were 7 night time patient transfers which occurred on 5 nights in the month. In all cases the moves were clinically necessary in order to create either a side room for patients requiring isolation or to create a specific specialty bed due to manage acute demand.

Chief Operating Officer

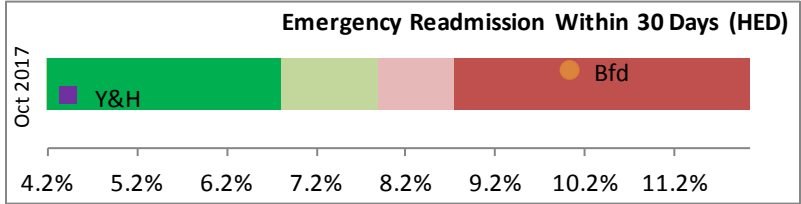
To provide outstanding care for patients

Trend

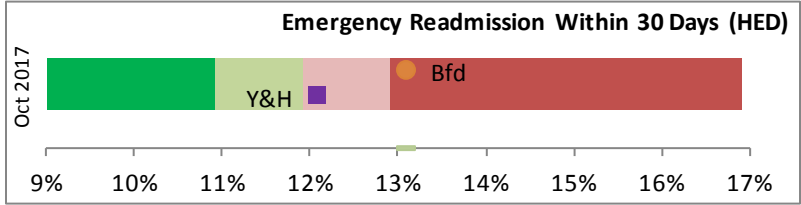


Challenges and Successes

This indicator is impacted on by data quality issues following EPR implementation and forms part of the data quality recovery programme.



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There was one breach in the last financial year and no breaches year to date. Awareness remains high as training is above 99%.

Comparison

No comparator data is published.

Exec Lead

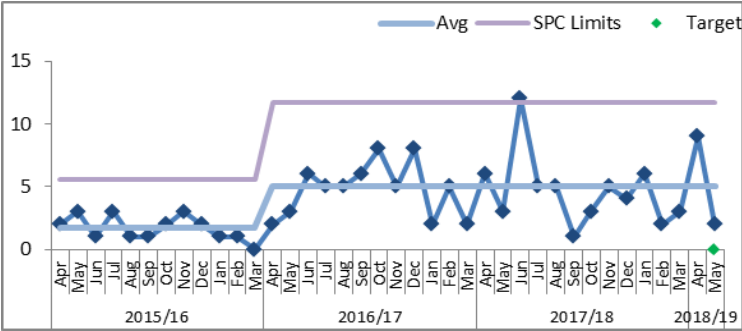
Chief Operating Officer

Chief Operating Officer

Director of Informatics

To provide outstanding care for patients

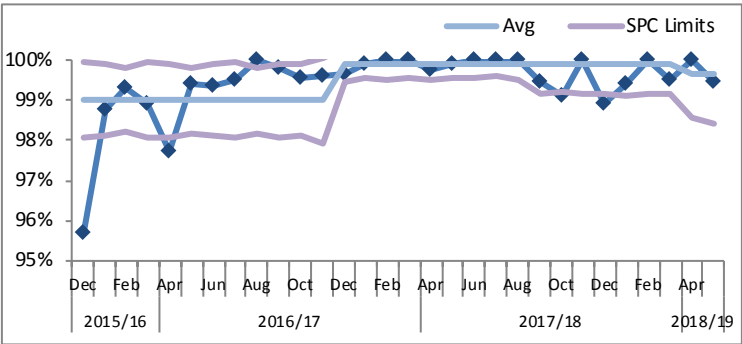
Trend	Challenges and Successes	Comparison	Exec Lead
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Every incident that meets the criteria for the declaration of a serious incident is reported on the Strategic Executive Information System (StEIS) and a root cause investigation is commissioned. They 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.

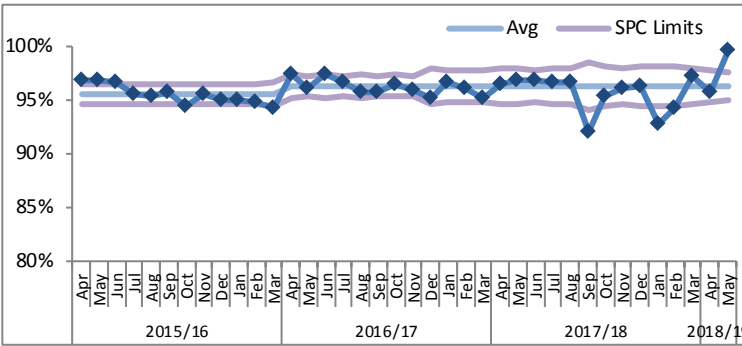
Director of Governance & Corporate Affairs



Audited data in theatres continues to show high compliance. Work now extending to all areas undertaking interventional procedures to meet the National Standards for Invasive Procedures (SIP).

No comparator data is available.


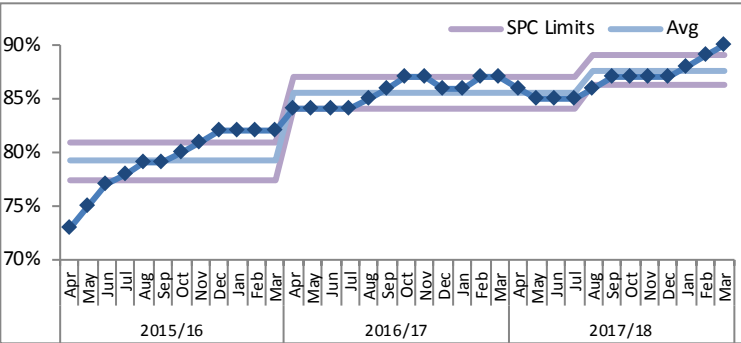

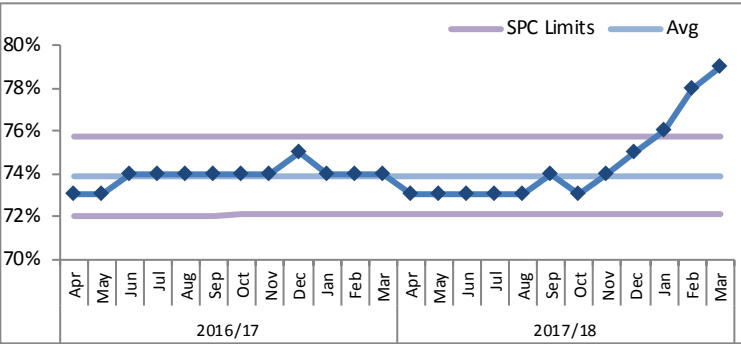

Medical Director



The Friends and Family Test has recovered back to normal baseline after a drop in September 2017/18. Further detailed work to improve number of returns has started.

Chief Nurse

To be a continually learning organisation

	Trend	Challenges and Successes	Comparison	Exec Lead
		Compliance rates have continued to improve following a focused programme of work with the education team and divisional teams. <i>*This metric will be revised in next month's dashboard.</i>	Comparator data not available.	Medical Director
		Compliance rates have continued to improve following a focused programme of work with the education team and divisional teams. <i>*This metric will be revised in next month's dashboard.</i>	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 Quarter 1 2018/19.			Director of Governance & Corporate Affairs

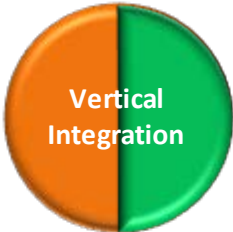
To collaborate effectively with local and regional partners

Trend	Challenges and Successes	Comparison	Exec Lead
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Bradford Teaching Hospital’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 was sent out by account managers to a cohort of the various stakeholder organisations (we are phasing the introduction to test the approach). Given the low initial response rate, account managers were also asked to self-assess. The findings 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 initially focus 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 and self assessment. We are due to discuss and agree this metric with Partnerships Committee (25 May 2018).

Director of
Strategy &
Integration



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 value for money. 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. The Trust continues to monitor, input to and support this work, but acknowledges the lack of pace towards quantifiable improvement. Partnerships Committee has advised that progress/RAG rating should be based on a subjective assessment, in the absence of a meaningful, readily understandable hard metric.


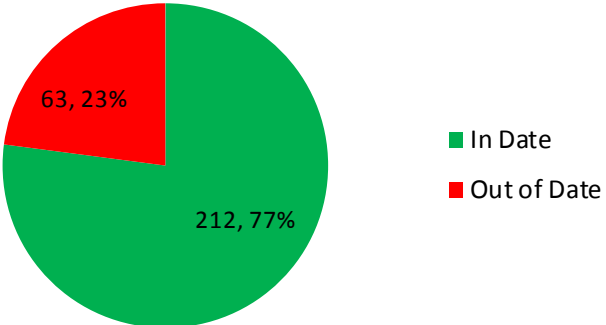
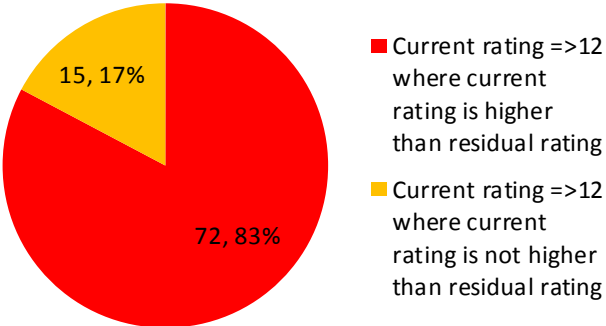

Director of
Strategy &
Integration



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. There are multiple developments underway including the emergence of a West Yorkshire & Harrogate integrated care system (seeking greater autonomy from central control) and bilateral discussions e.g. with Airedale Foundation Trust. Partnerships Committee has advised that progress/RAG rating should be based on a subjective assessment, in the absence of a meaningful, readily understandable hard metric.

Director of
Strategy &
Integration

To be a continually learning organisation

Trend		Challenges and Successes	Comparison	Exec Lead
		<p>A focussed programme of work commenced in Quarter 3 last year 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>Director of Governance & Operations</p>
				
				

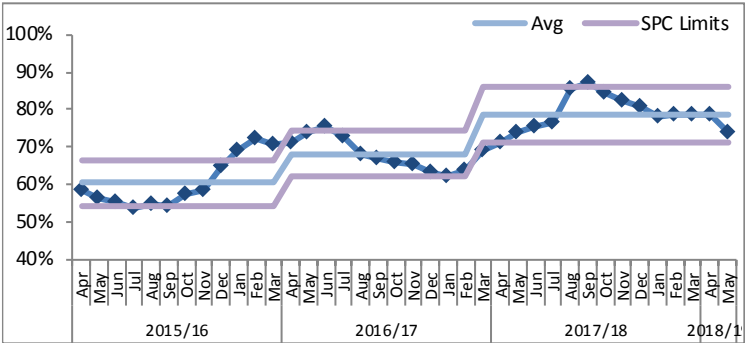
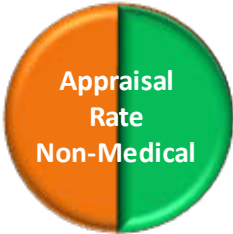
To be in the top 20% of employers in the NHS

Trend

Challenges and Successes

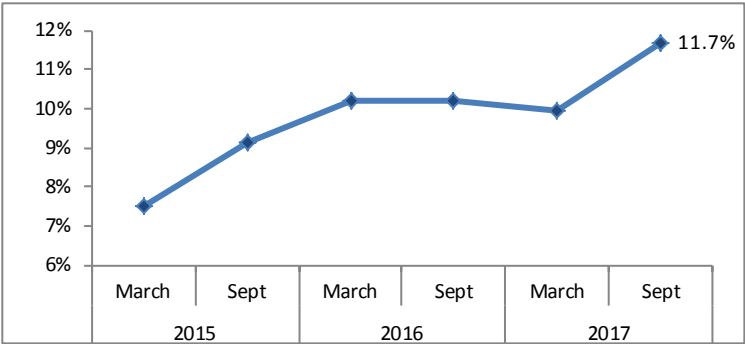
Comparison

Exec Lead



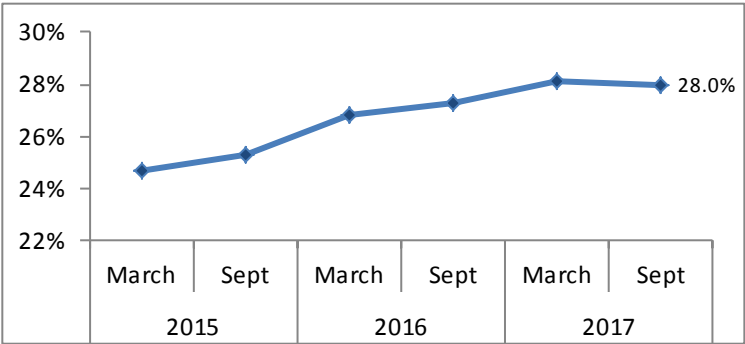
The target for non-medical appraisals is that 100% of eligible employees are appraised. Appraisal rates dropped from 78.41% in April 2018/19 to 74.01% in May 2018/19. Despite continued work aimed at improving performance, including; developing managers, engaging staff, sharing good practice and trajectory plans to meet the completion rate, we are still falling short of our target. A paper is being presented at the Executive Management Team meeting on 3rd July 2018/19 with recommendations of further actions to address this.

Director of Human Resources



We have made a significant increase in the number of Black, Asian, Minority, Ethnic (BAME) staff at bands 8 and 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%. No comparator data is available. We expect to update this metric next month.

Director of Human Resources

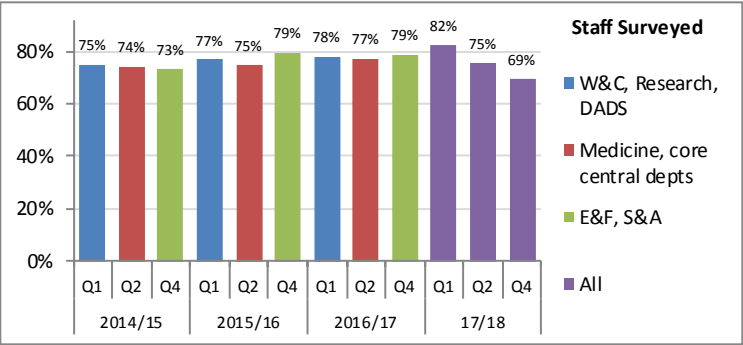


Good progress is being made. We are ahead of our trajectory to have a workforce reflective of the local ethnic local population by 2025. We expect to update this metric next month.

Director of Human Resources

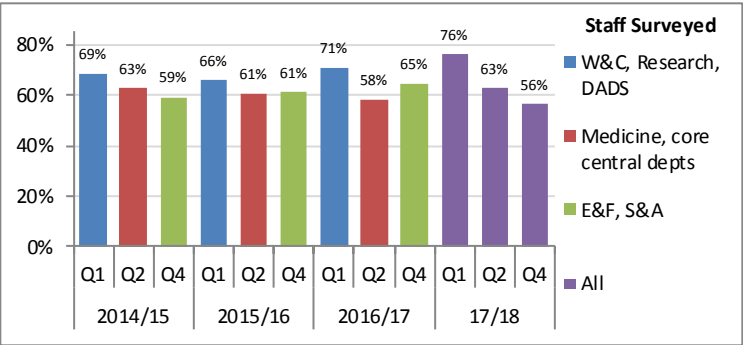
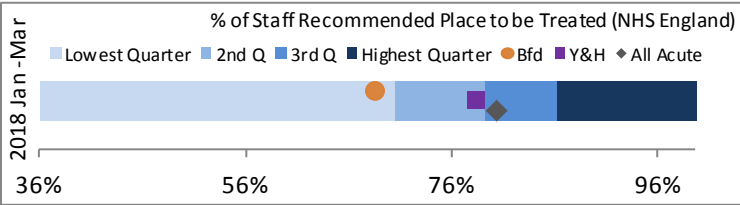
To be in the top 20% of employers in the NHS

Trend	Challenges and Successes	Comparison	Exec Lead
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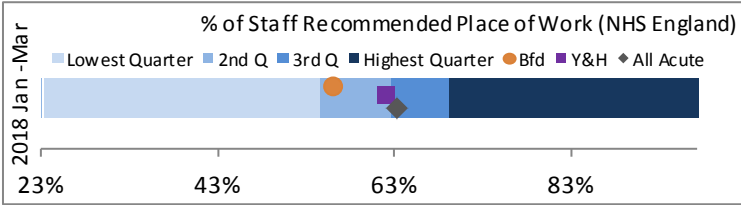
In Quarter 2 2017/18 BTHFT was below the Yorkshire and Humber average, and also below average for all Acute Trusts. In Quarter 4 2017/18 this position remains the same.

Director of Human Resources



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. In Quarter 2 2017/18 we were on par with Yorkshire and Humber and Acute Trusts. In Quarter 4 2017/18 BTHFT has fallen slightly below both the Yorkshire and Humber and Acute Trusts.

Director of Human Resources



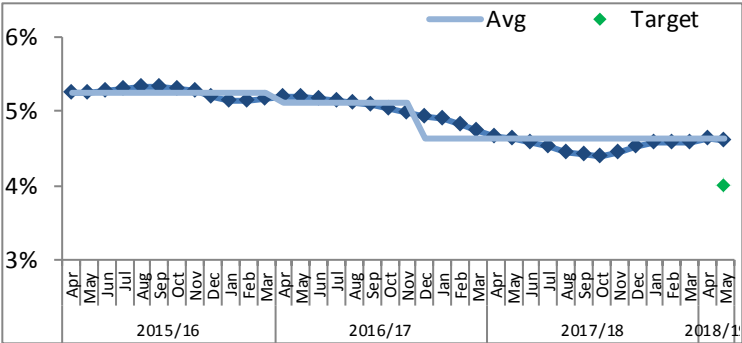
To be in the top 20% of employers in the NHS

Trend

Challenges and Successes

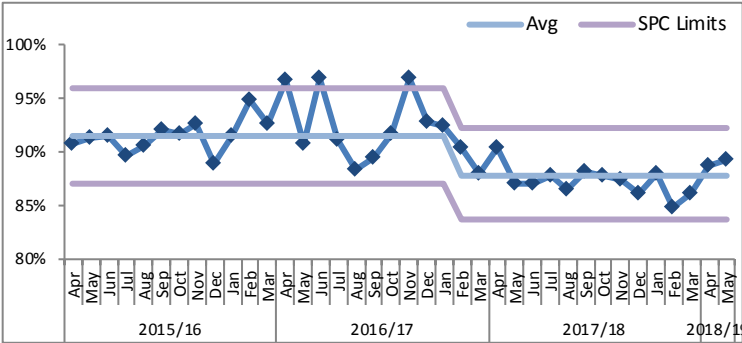
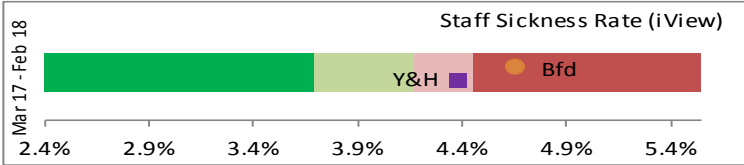
Comparison

Exec Lead



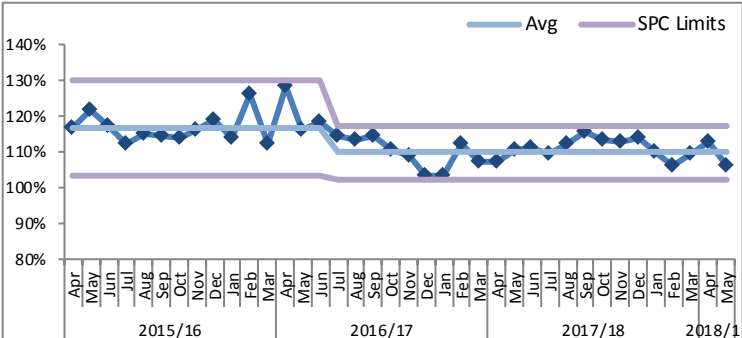
The actual Trust sickness figure for May 2018/19 is 4.18%. This has remained the same as April 2018/19. The May 2018/19 rolling figure stands at 4.60% and represents a reduction from April 2018/19 when it was 4.62%. The sickness absence target for the Trust for 2018/19 will remain at 4%. The Divisional targets will also remain the same as for 2017/18 and the Divisions have been informed of this accordingly.

Director of Human Resources



Continued improvement with closure of additional beds and improved roster management.

Chief Nurse



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.

Chief Nurse

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

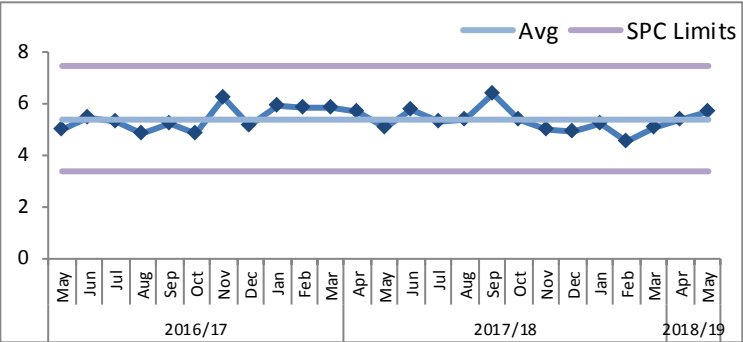
Trend

Challenges and Successes

Comparison

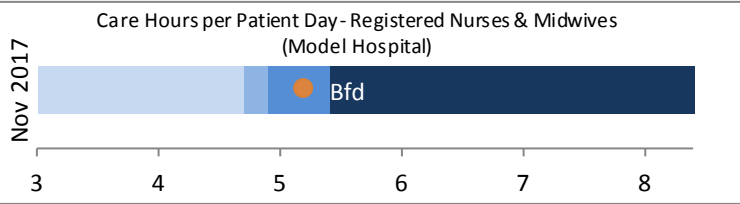
Exec Lead

Nursing Care Hours

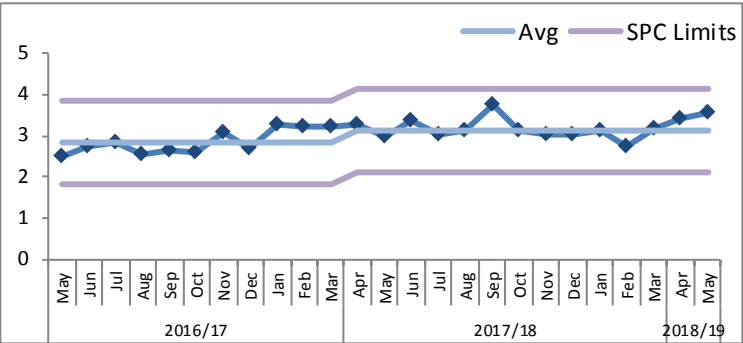


Continued improvement with closure of additional beds and improved roster management.

Chief Nurse

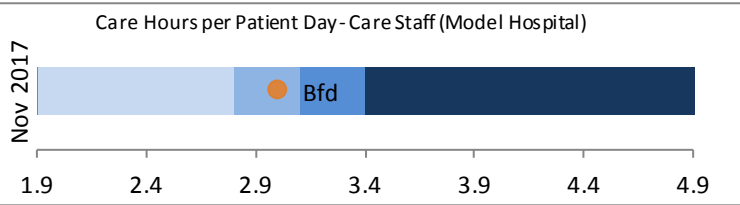


Care Staff Care Hours

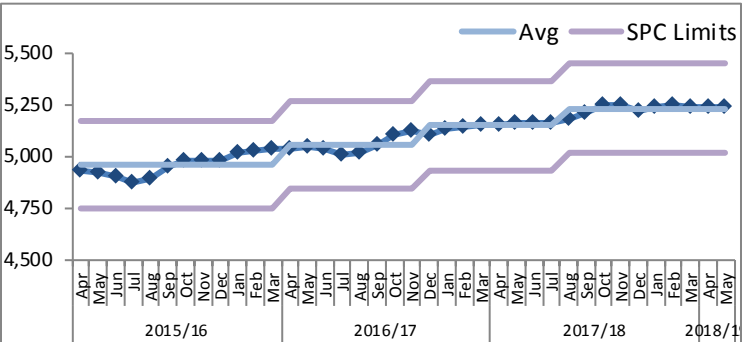


Full details included in the staffing reports show we continue to be average when compared to other Trusts.

Chief Nurse



Staff in Post



There continues to be little change in staff in post numbers.

Director of Human Resources.

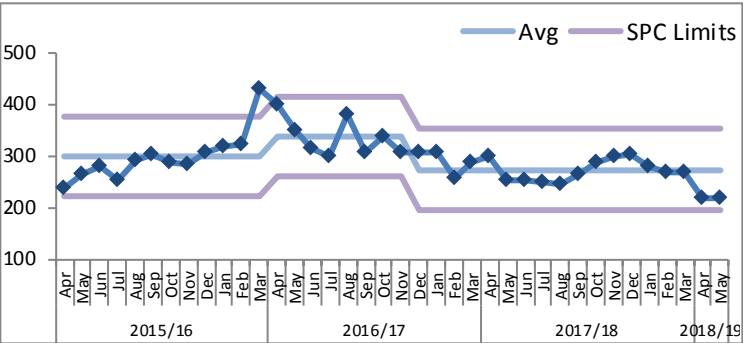
To be in the top 20% of employers in the NHS

Trend

Challenges and Successes

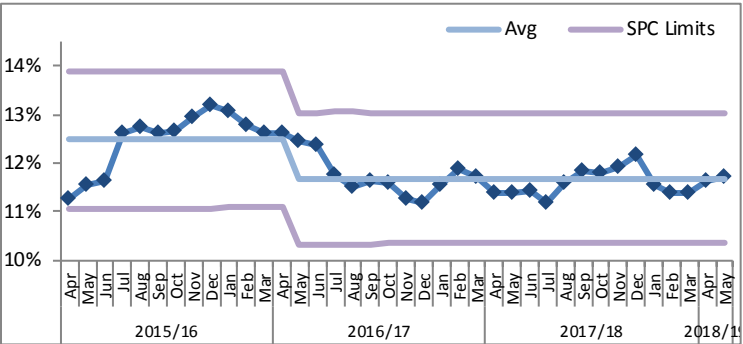
Comparison

Exec Lead



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. There was an increase in the use of bank and agency Nurses and Healthcare Assistants (HCA's) in May 2018/19.

Director of Human Resources



Turnover continues to remain stable at Trust level.

Director of Human Resources

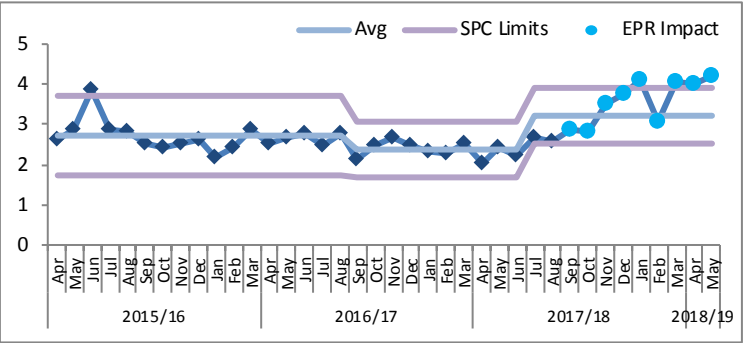
To deliver our financial plan and key performance targets

Trend

Challenges and Successes

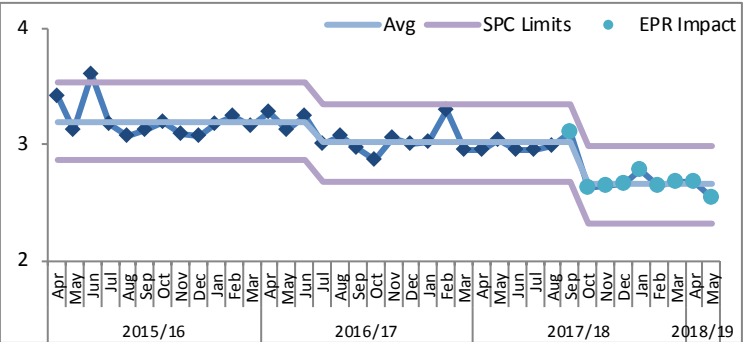
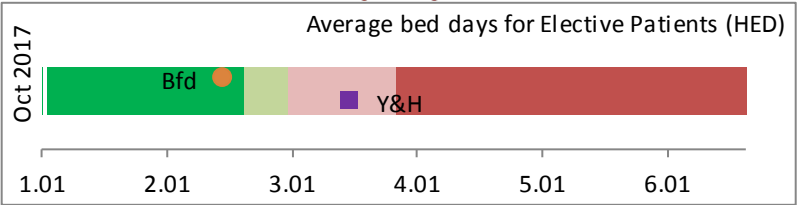
Comparison

Exec Lead



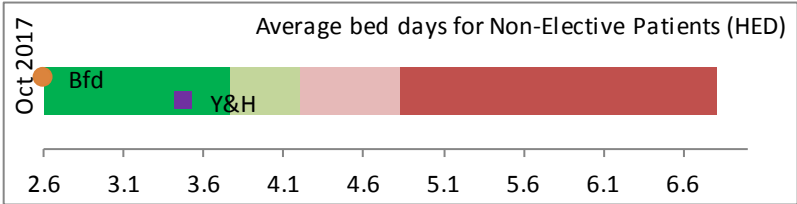
The trend continues to indicate an increase in elective length of stay (LOS), however this is still related to the ongoing data quality issues following EPR implementation. Work is ongoing to resolve the position and enable a more accurate length of stay in future months.

Chief Operating Officer


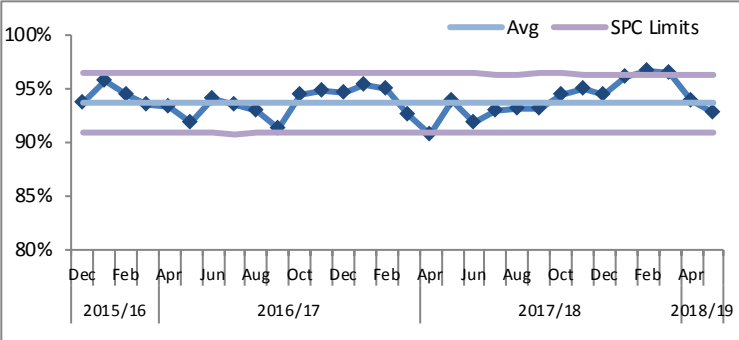

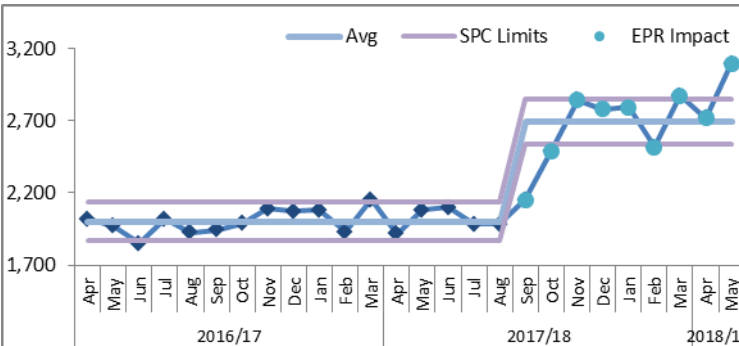

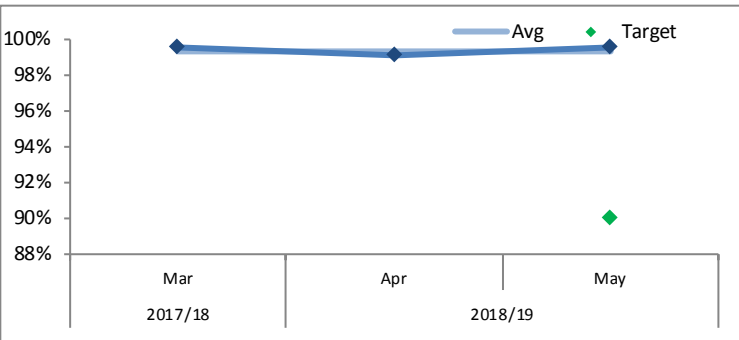


The same data quality issues as the previous indicator exist with elective, assessment and ward attender patients being incorrectly admitted as non-elective. These very short length of stay spells will reduce the overall length of stay for non-elective admissions. The Data Quality team are focusing on a resolution for non-elective admissions to correct this position.


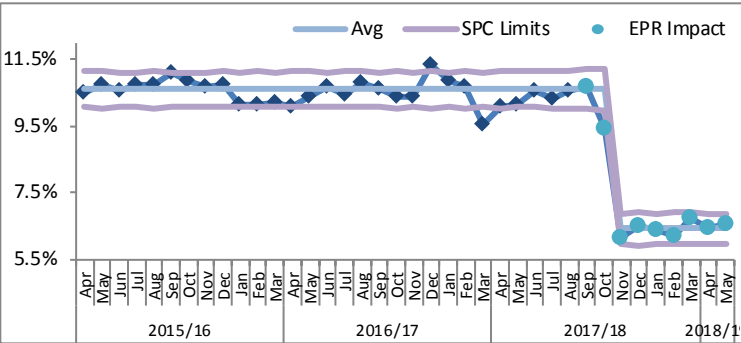
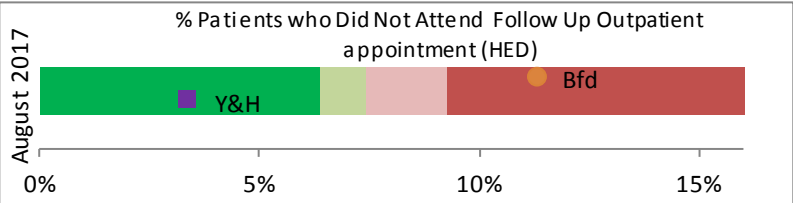
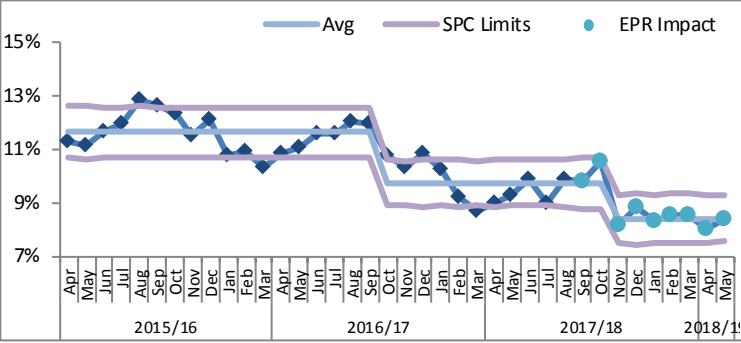
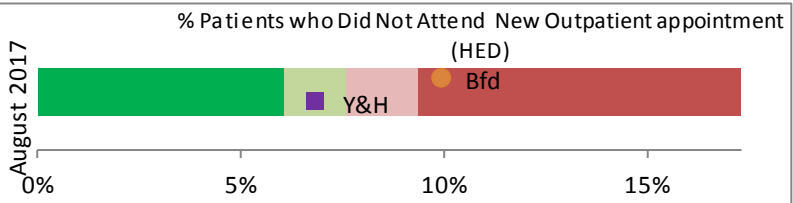
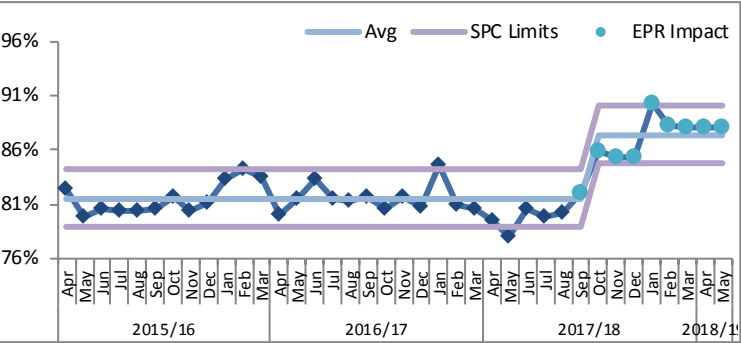
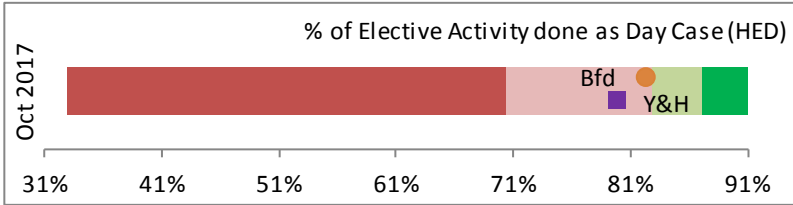
Chief Operating Officer



To deliver our financial plan and key performance targets

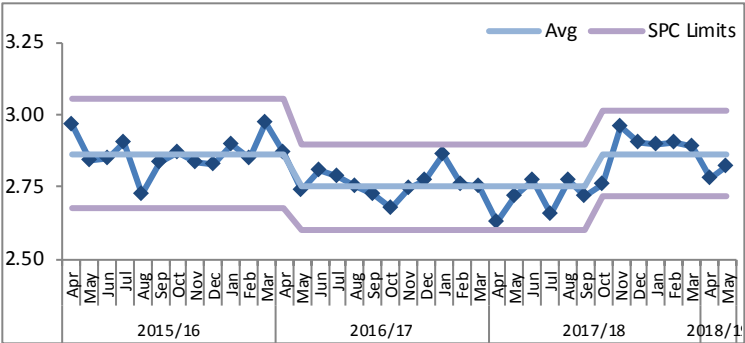
	Trend	Challenges and Successes	Comparison	Exec Lead
		The improvement in bed occupancy has been sustained at an average of 93% in May 2018/19. There is continued focus on patient flow, building on the initiatives commenced during Work As One Week.		Chief Operating Officer
		Significant increases in the proportion of discharges before 1pm during May 2018/19, are attributable in part to the focus on patient flow during Work as One week. Discharge targets by ward have been implemented with daily review.		Chief Operating Officer
		Performance has been achieved for the first 3 months since the introduction of this target.		Chief Operating Officer

To deliver our financial plan and key performance targets

Trend		Challenges and Successes	Comparison	Exec Lead
		Did not attend (DNA) rates have improved since implementation of two way texting in some specialties. Further work is to be undertaken by GE to optimise the benefits of two way texting.		Chief Operating Officer
		Did not attend rates have improved since implementation of two way texting in some specialties. Further work is to be undertaken by GE to optimise the benefits of two way texting.		Chief Operating Officer
		Specialties continue to work on the Getting It Right First Time (GIRFT) data to identify target areas. Initiatives are underway as part of the Elective Care Improvement Programme to maximise day cases. This metric is affected by the non-elective/elective admission data quality issue and once resolved anticipate a more accurate position.		Chief Operating Officer

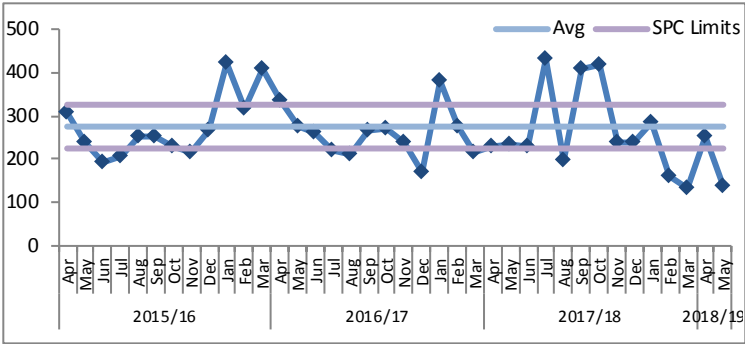
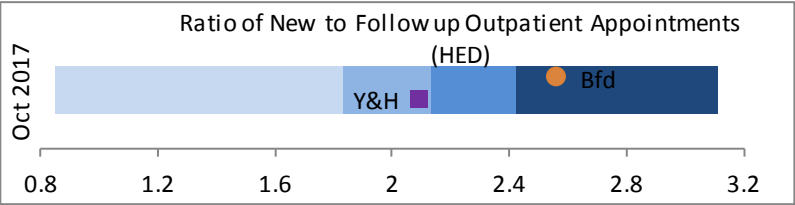
To deliver our financial plan and key performance targets

Trend	Challenges and Successes	Comparison	Exec Lead
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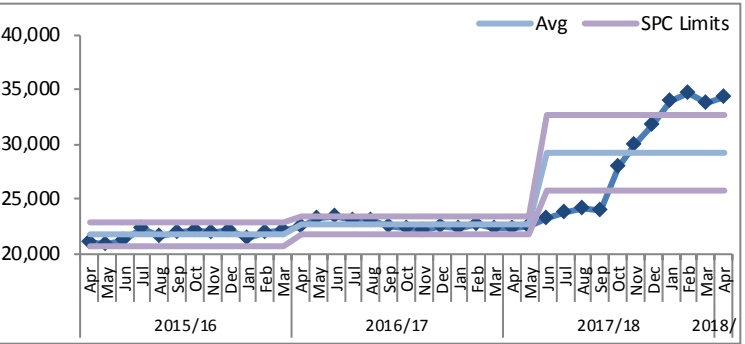
This metric is a continued focus within the Outpatient Improvement Programme. Activity trackers by specialty are now in place with monitoring via the Planned Care Delivery Group.

Chief Operating Officer



Small improvement noted in May 2018/19.

Chief Operating Officer

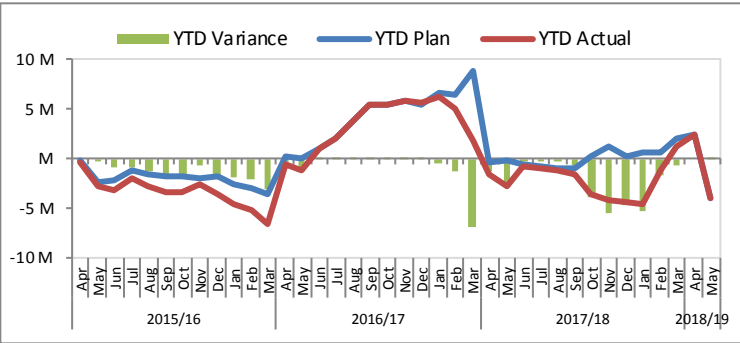


A programme of validation to remove data quality issues has commenced. The Elective Care Recovery Programme has also commenced as part of the Bradford Improvement Programme with weekly focus on waiting times, delivery of contracted activity and reduction in overall waiting list sizes.

Director of Governance & Operations

To deliver our financial plan and key performance targets

Trend	Challenges and Successes	Comparison	Exec Lead
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The month 2 position is a pre-Provider Sustainability Fund deficit of £4m which is in line with the planned deficit of £4m. 100% of the Provider Sustainability Fund available for month 2 has been assumed in the position, equating to £1m. This results in a post-Provider Sustainability Fund deficit of £3m which is in line with plan. The forecast to NHS Improvement on 15th May 2018/19 was full delivery of the financial plan at year end. However, subsequent modelling of the run rate and forecast shortfalls on Bradford Improvement Programme delivery suggests it is now a probability that the Trust will fall behind its financial plan from Month 4 onwards and without urgent action will fail to deliver its control total in 2018/19.

Director of Finance

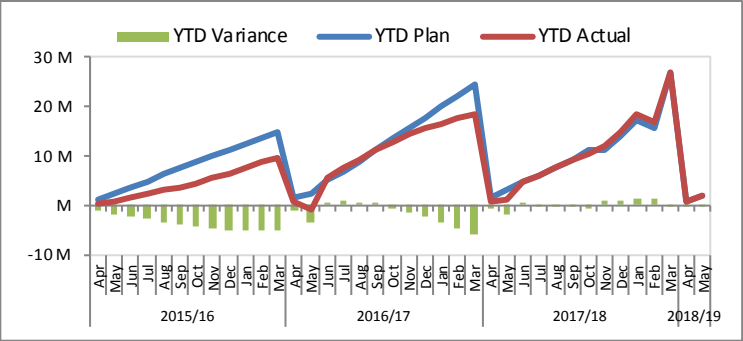
NHSI Use of Resources Risk Rating (UoR) As at 31.5.18	Plan YTD	Actual YTD	Last Month	RAG
Capital Servicing Capacity	4	4	4	
Liquidity	1	1	1	
I & E Margin	4	4	4	
Variance from plan (I & E Margin)	1	2	1	
Agency Spend	2	1	2	
Combined UoR (after triggers)	3	3	3	

Use of Resources ratings are currently in line with plan but will rapidly deteriorate as the financial year progresses if the current run rate continues and projected Bradford Improvement Programme shortfalls materialise as forecast. All metrics with the exception of agency expenditure are dependent on delivery of the Income & Expenditure plan and are impacted by the currently forecast adverse deviation.

Director of Finance

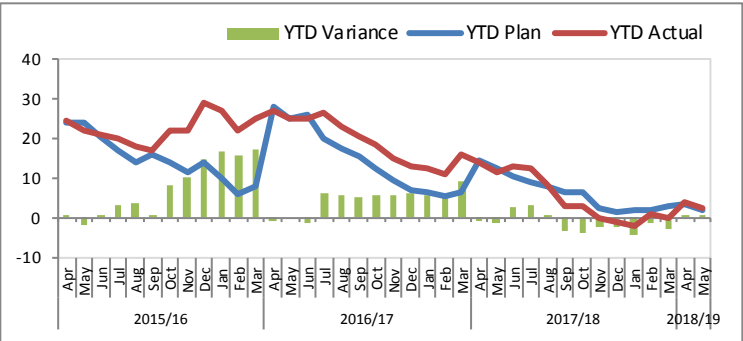
To deliver our financial plan and key performance targets

Trend	Challenges and Successes	Comparison	Exec Lead
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The divisions and corporate departments are currently forecasting delivery of £20.1m efficiencies, which would leave the Trust £5.5m short of the required £25.6m annual savings. A substantial element of these plans requires significant additional work to be implemented, and there is therefore a high degree of risk in this best case scenario forecast. Removing some of the riskier plans from this forecast results in total projected savings of £16.9m, which would leave the Trust £8.7m short of its target.

Director of Finance



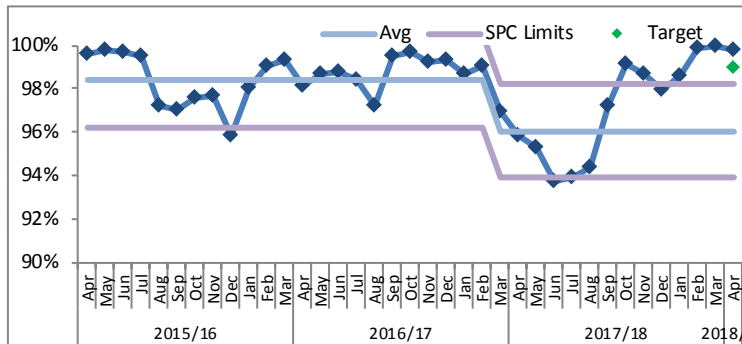
Liquidity is currently in line with plan but will rapidly become negative as the financial year progresses if the current run rate continues and projected Bradford Improvement Programme shortfalls materialise as forecast.

Director of Finance

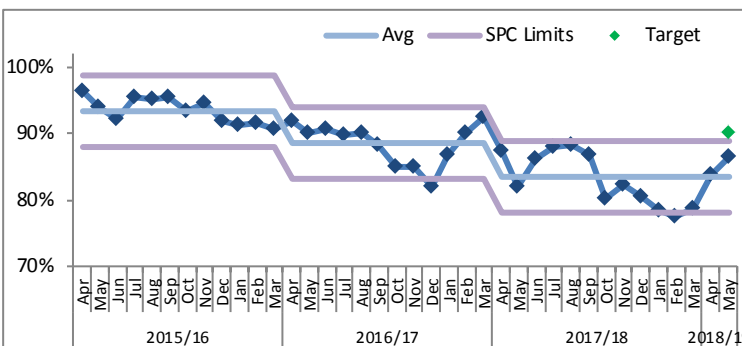
National Indicators

Single Oversight Framework

Trend

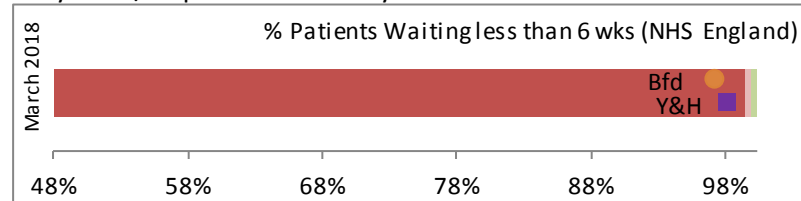


NHSI Use of Resources Risk Rating (UoR) As at 31.5.18	Plan YTD	Actual YTD	Last Month	RAG
Capital Servicing Capacity	4	4	4	
Liquidity	1	1	1	
I & E Margin	4	4	4	
Variance from plan (I & E Margin)	1	2	1	
Agency Spend	2	1	2	
Combined UoR (after triggers)	3	3	3	



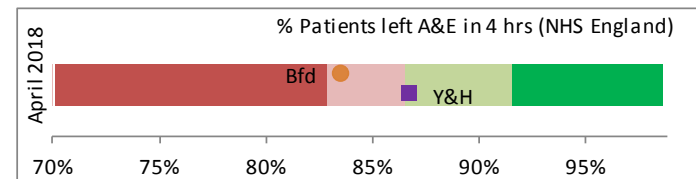
Challenges and Successes

April 2018/19 DM01 position is 99.9% (13 breaches). The submission now includes Neurophysiology for the first time since EPR implementation. Endoscopy is still excluded, a detailed validation of the total waiting list is progressing. When Endoscopy is included this will have a significant impact on our performance. The May 2018/19 position has not yet been confirmed.



Use of Resources ratings are currently in line with plan but will rapidly deteriorate as the financial year progresses if the current run rate continues and projected Bradford Improvement Programme shortfalls materialise as forecast. All metrics with the exception of agency expenditure are dependent on delivery of the Income & Expenditure plan and are impacted by the currently forecast adverse deviation.* *The right hand side of the indicator relates to Financial Year 2018/19.*

Performance for May 2018/19 is 86.55%, a 2.8% improvement from April 2018/19 and achieved the trajectory submitted to NHS England. Compared to May 2017/18 Emergency Care Standard performance improved by 4.7%. 229 more patients were treated in the Emergency Department and 759 more treated within 4 hours (7.7% increase). Improved performance has continued into June 2018/19 with 9 out of 18 days over 90%.



Exec Lead


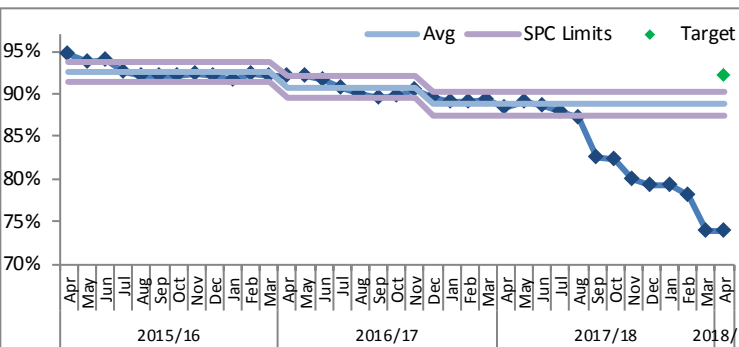
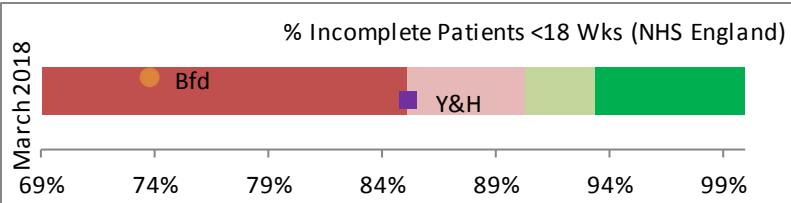
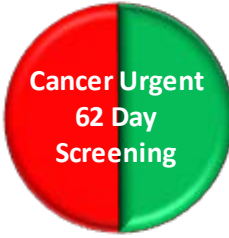
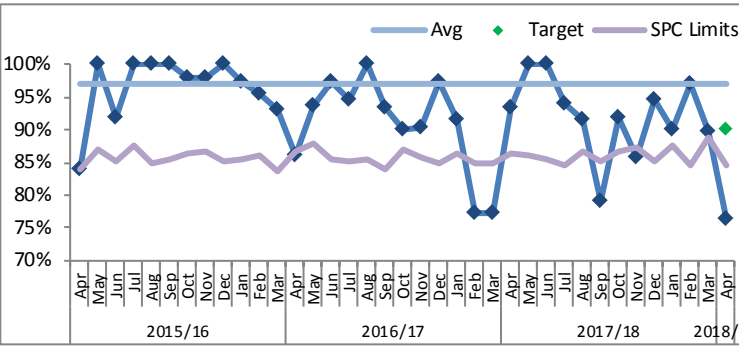
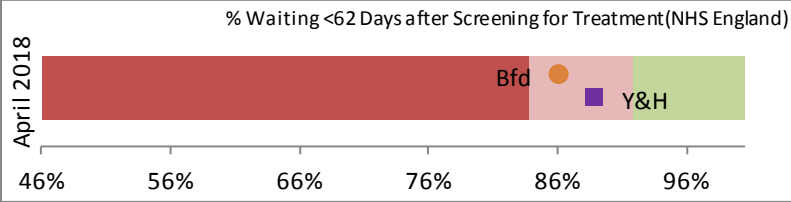

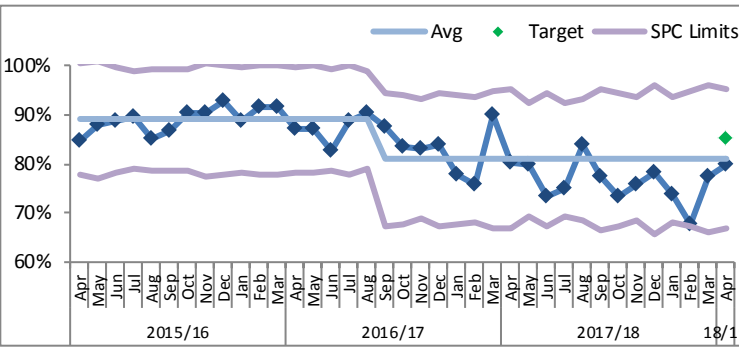
Chief Operating Officer

Director of Finance

Chief Operating Officer

National Indicators

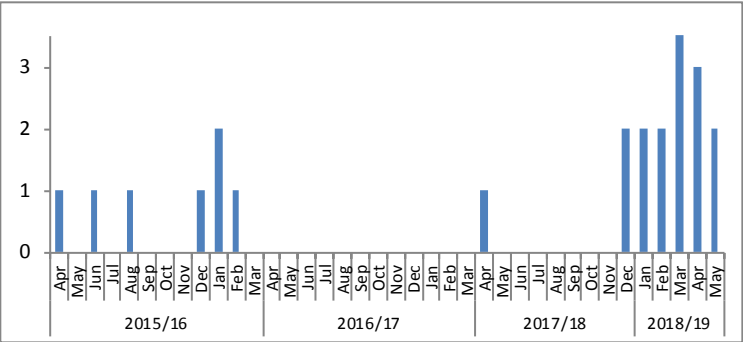
Single Oversight Framework

	Trend	Challenges and Successes	Exec Lead
		<p>Incomplete performance for May 2018/19 was 74.61% which is an improvement of 0.76% compared to April 2018/19. Detailed recovery plans have been developed with all specialties as part of the Elective Care Recovery Programme.</p> 	Chief Operating Officer
		<p>This standard was not achieved for April 2018/19, with 1 breach over standard. The projection for May 2018/19 is for the threshold to be achieved.</p> 	Chief Operating Officer
		<p>The projection for May 2018/19 is that the threshold will not be achieved. The position continues to be managed via the cancer lead in conjunction with the divisional teams. Speciality level action plans are in place with a continued focus on: 1. Reducing 62 day backlog, 2. Improved operational grip and close daily tracking of patient lists, and 3. Demand and capacity analysis. A weekly cancer access group reviews all long waiters, patient by patient, with root cause analysis completed for all patients who breach the standard.</p>	Chief Operating Officer

National Indicators

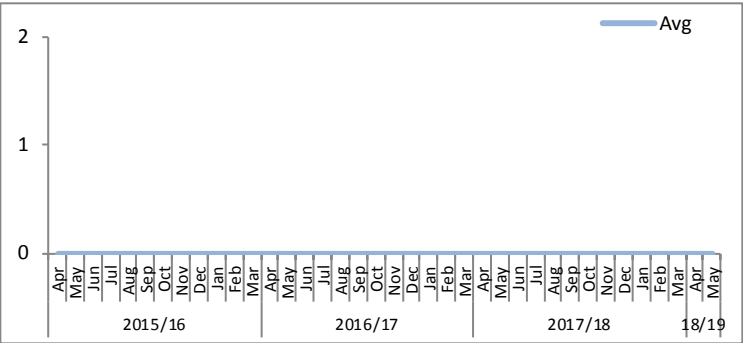
National Target – Non-Financial

Trend	Challenges and Successes	Exec Lead
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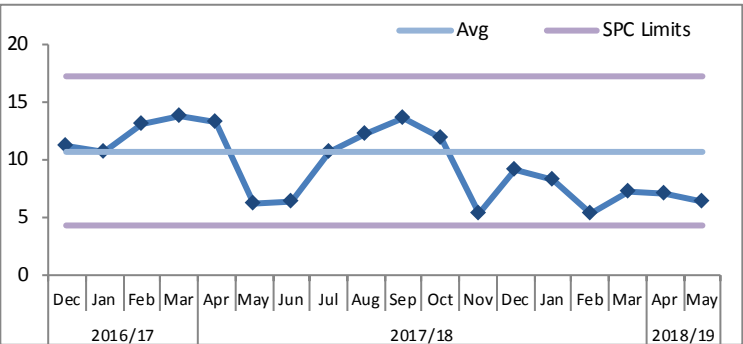
The weekly Planned Care Access group continues to review all long waiting patients on a weekly basis. The Trust reported 2 incomplete 52 week breaches in May 2018/19 (1 in Ear, Nose and Throat and 1 in Vascular). The main risks continue in Ear, Nose and Throat, General Surgery and Vascular.

Chief Operating Officer



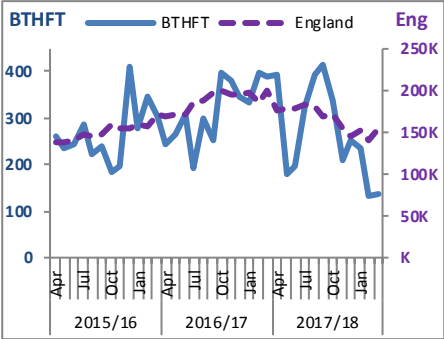
There have been no over 12 hour trolley waits.

Chief Operating Officer



Delayed Transfers Of Care was maintained in May 2018/19 at less than 1% of occupied bed days and positive compared to the national standard of 3.5%. This represents a May 2018/19 average of 6.25 beds occupied per day.

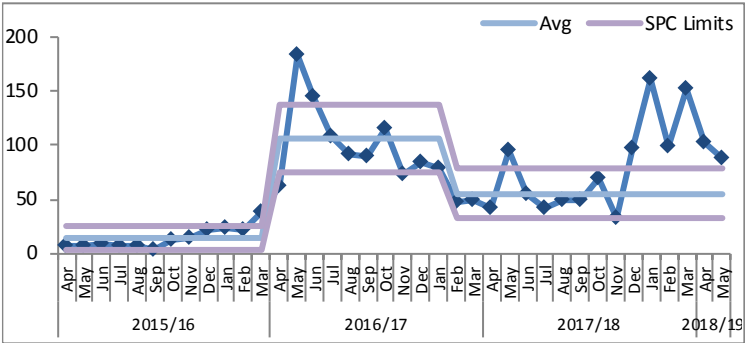
Chief Operating Officer



National Indicators

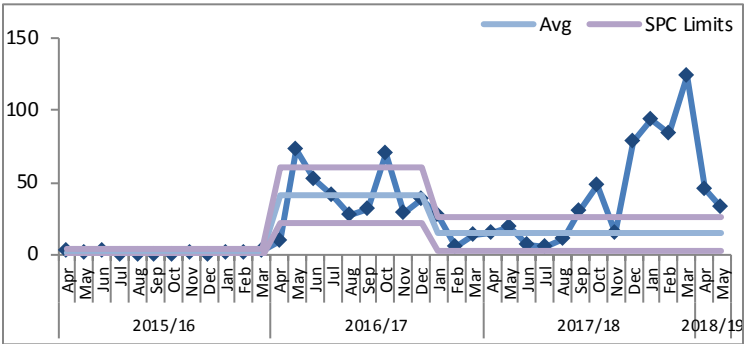
National Target – Non-Financial

Trend	Challenges and Successes	Comparison	Exec Lead
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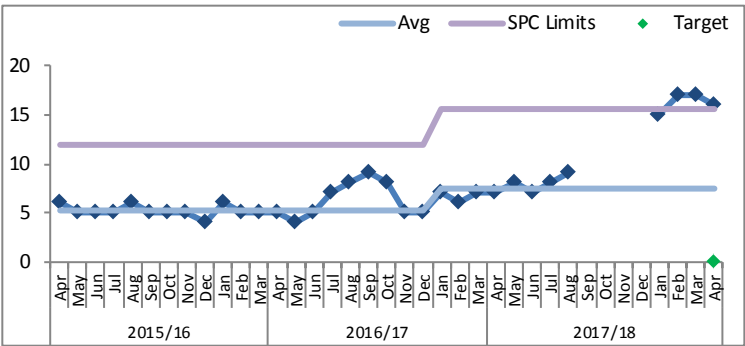
The Trust is not currently meeting the standard for ambulance handover but has continued to improve in May 2018/19. Plans have been implemented as part of the Emergency Department Improvement Programme to sustain this improvement.

Chief Operating Officer



The Trust is not currently meeting the standard for ambulance handover but has maintained the improvement seen in April into May 2018/19.

Chief Operating Officer


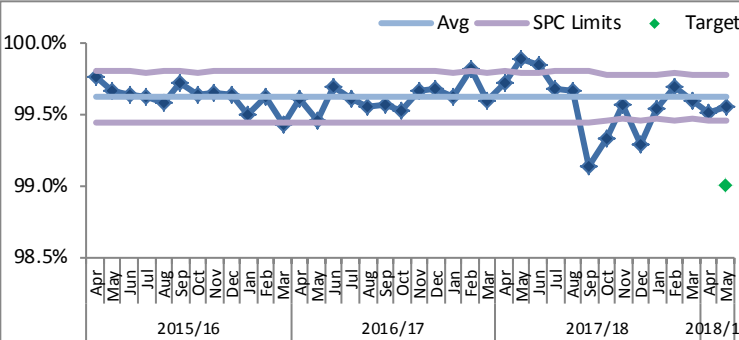

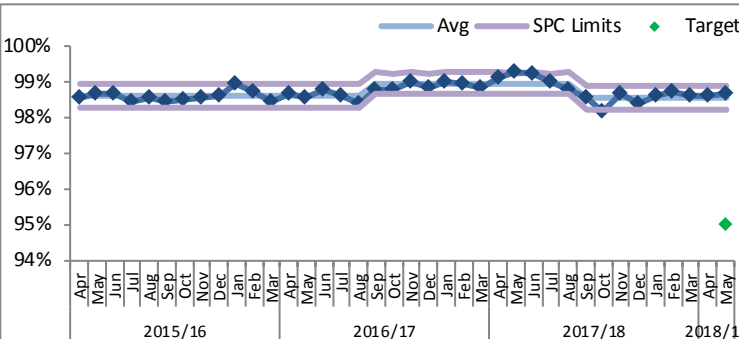

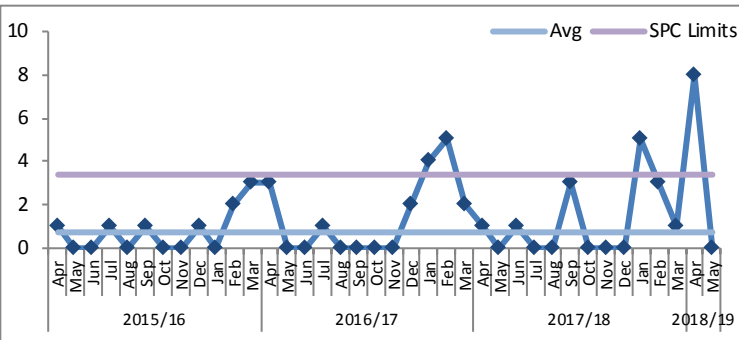


The Trust is now reporting referral to treatment (RTT) but performance remains below standard. Recovery plans in place as part of the Elective Performance Improvement Programme.

Chief Operating Officer

National Indicators

National Target – Non-Financial

	Trend	Challenges and Successes	Comparison	Exec Lead
		With the standardisation and integration of the Patient Administration System data, as the one source of truth, the Trust compliance to NHS Number use is strong. Issues in related to EPR embedding and will improve.		Director of Informatics
		With the standardisation and integration of the Patient Administration System data, as the one source of truth, the Trust compliance to NHS Number use is strong.		Director of Informatics
		There were zero breaches of the 28 day standard in May 2018/19.		Chief Operating Officer

National Indicators

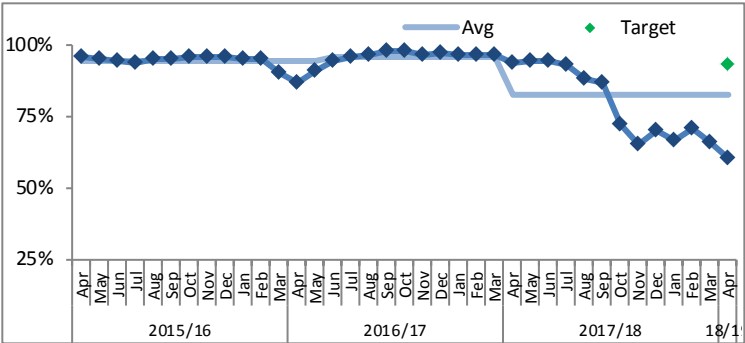
National Target – Non-Financial

Trend

Challenges and Successes

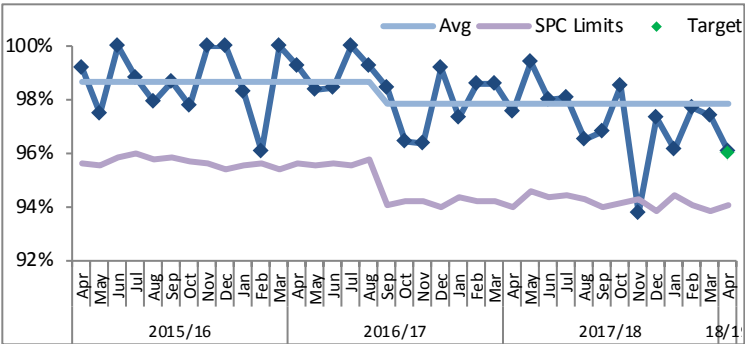
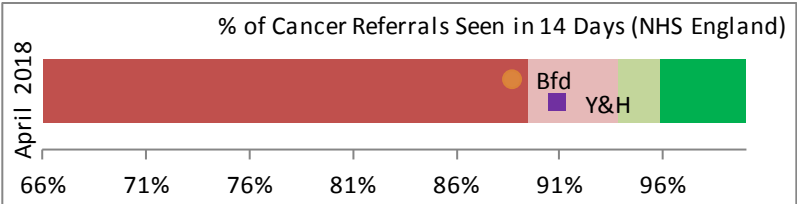
Comparison

Exec Lead



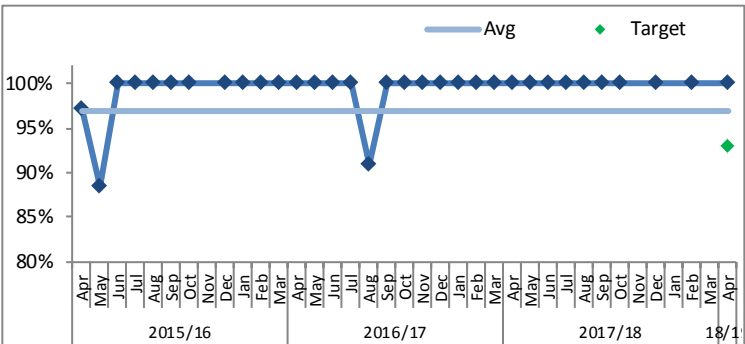
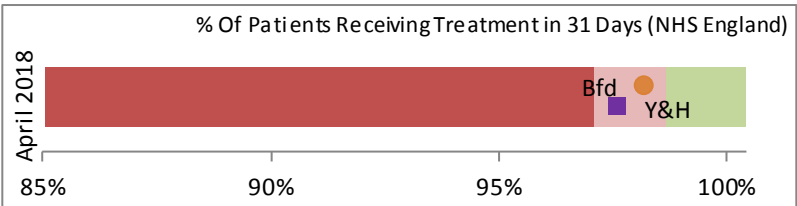
Performance has not been achieved for April 2018/19 and is not predicted to be achieved for May 2018/19. The main issue remains the impact of Dermatology and Lower Gastrointestinal. Recovery plans are in place for all specialties.

Chief Operating Officer



This standard was achieved in March 207/18 and projected to be achieved in May 2018/19.

Chief Operating Officer



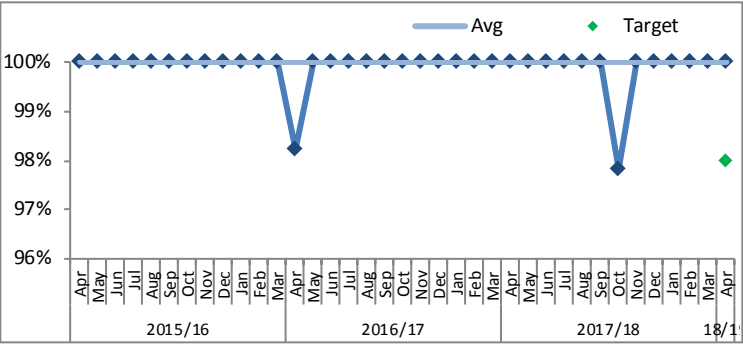
This standard was achieved in March 2017/18 and projected to be achieved in May 2018/19.

Chief Operating Officer

National Indicators

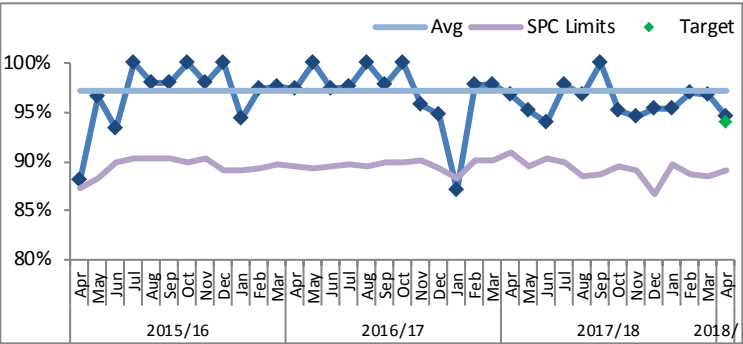
National Target – Non-Financial

Trend	Challenges and Successes	Comparison	Exec Lead
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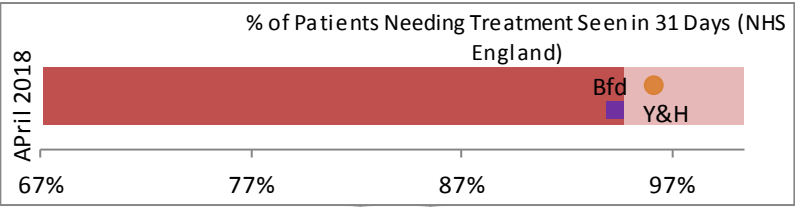
This standard was achieved in March 2017/18 and projected to be achieved in May 2018/19.

Chief Operating Officer



This standard was achieved in March 2017/18 and projected to be achieved in May 2018/19.

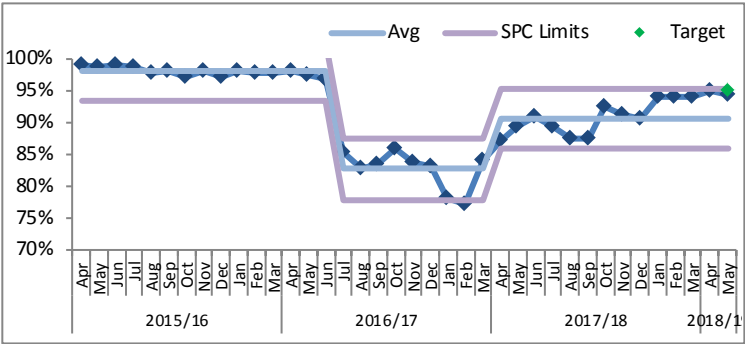
Chief Operating Officer



National Indicators

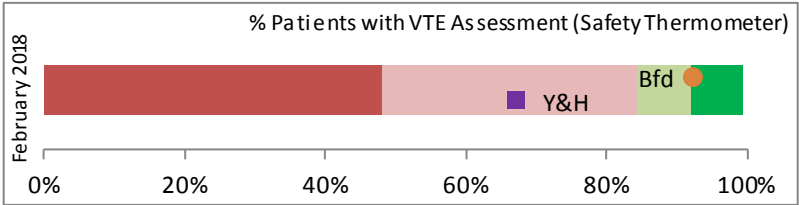
National Target – Non-Financial

Trend	Challenges and Successes	Comparison	Exec Lead
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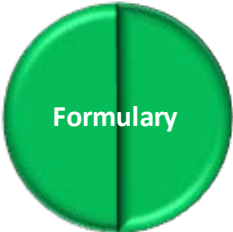
The performance for the past 3 months was an average of 94.7% with April 2018/19 achieving the standard at 95.2%. Work continues through the Medical Director’s Office to embed sustainable delivery of the standard. A quarterly update will be provided to Quality Committee on 27th June 2018/19.

Medical Director



No comparator data is available.

Director of Informatics

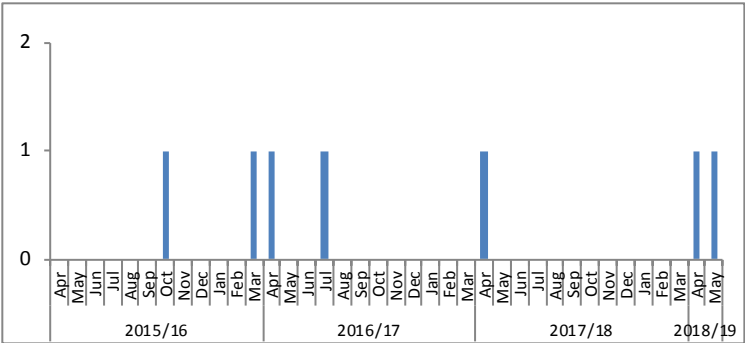


The Trust ensures that the Formulary is published on the website.

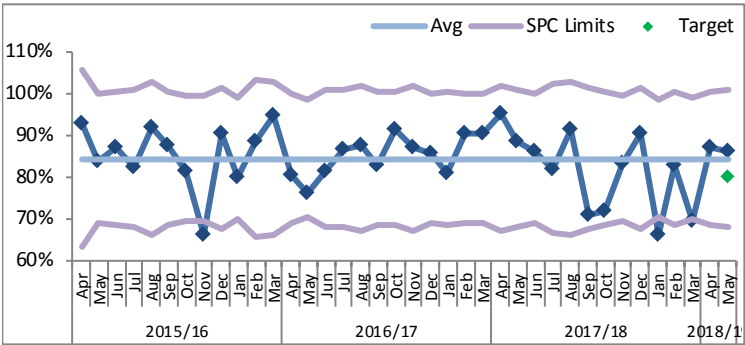
National Indicators

National Target – Financial

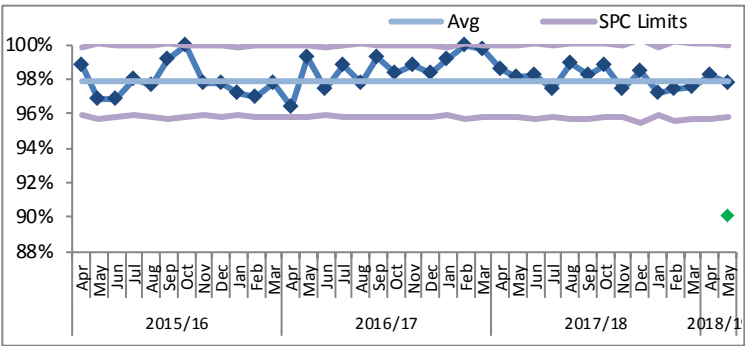
Trend	Challenges and Successes	Comparison	Exec Lead
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A never event was reported in May 2018/19. No comparator data is available. Chief Operating Officer



This indicator was achieved in May 2018/19 as 86% of eligible patients spent 90% of their time on a designated stroke ward demonstrating a sustained level of care. The improvement plan continues to be implemented and weekly meetings with the Medical Director and stroke service continue. Chief Operating Officer

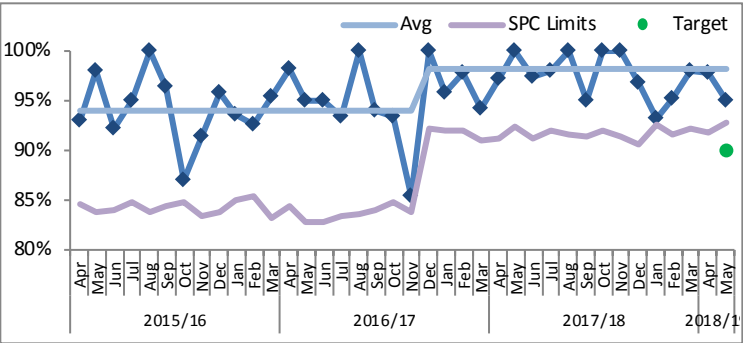


The threshold has been achieved in all previous months of the last financial year. Chief Operating Officer

National Indicators

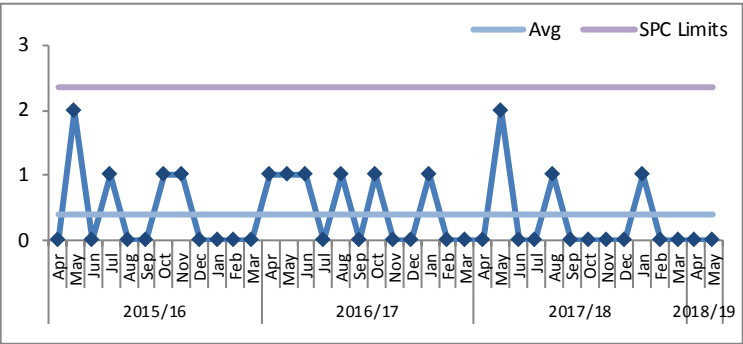
National Target – Financial

Trend	Challenges and Successes	Comparison	Exec Lead
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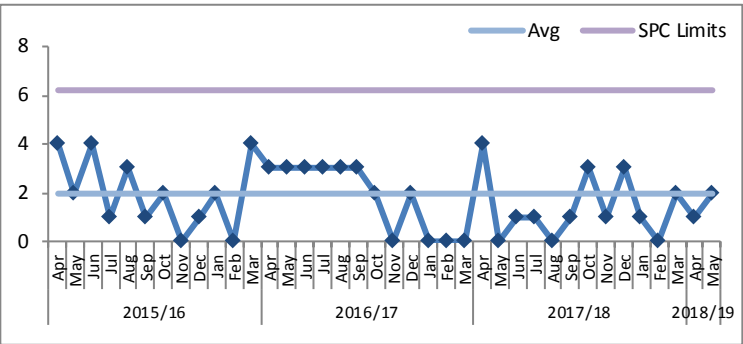
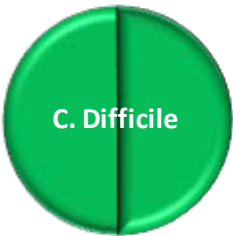
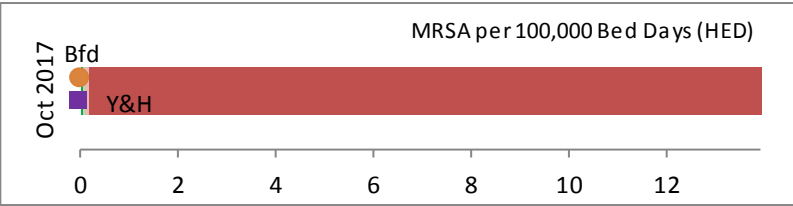


The threshold has been achieved in all previous months of the last financial year.

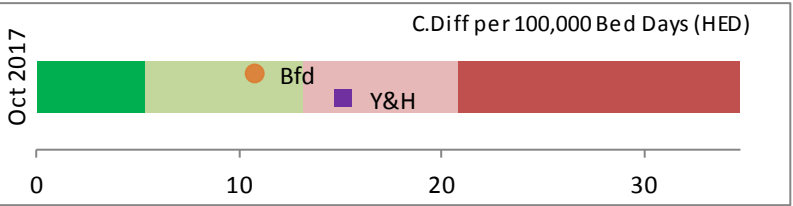
Chief
Operating
Officer



The Methicillin-resistant Staphylococcus Aureus (MRSA) rate in May 2018/19 is community acquired and not attributed to BTHFT.



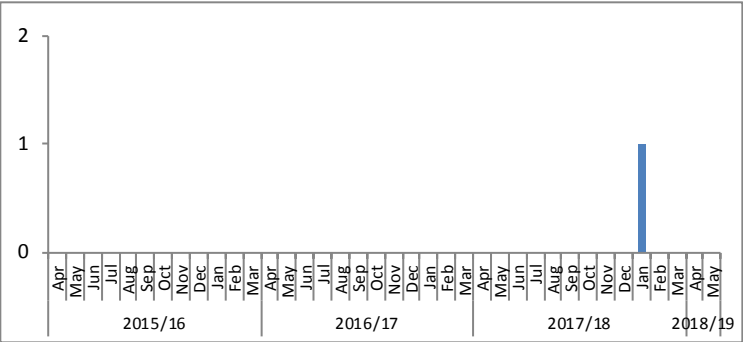
Sustained reduction in Clostridium Difficile has been achieved. A robust Post Infection Review process is in place. Below trajectory.



National Indicators

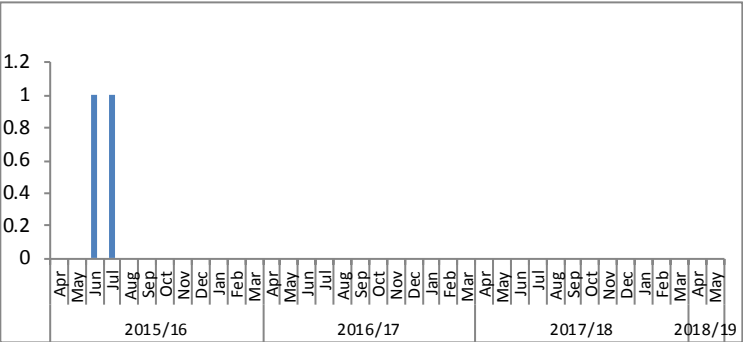
National Target – Financial

Trend	Challenges and Successes	Comparison	Exec Lead
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There were no Duty of Candour breaches in May 2018/19.

Director of Governance & Corporate Affairs



There have been no Mixed Sex Breaches.

Chief Operating Officer

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 Red < 90%, Amber >=90% & < 95%, Green >=95%	
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. Red >= 40, Amber >=25 & < 40, Green <25	
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. Red > 1.5%, Amber 1%-1.5%, Green < 1%	
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. Red >= 6, Amber 5, Green < 5	
Infections			Pressure Ulcers Cat 2+	Number of reported hospital acquired category 2 pressure ulcers. The benchmarking data comes from the Safety Thermometer prevalence information. Red >= 20, Amber 15-19, Green < 15	
C Difficile	The number of cases either attributable or pending review. Red >= 3, Amber = 2, Green <=1				
eColi	Counts of patients with Escherichia coli (eColi). Red >=30 Amber >=20 and <30, Green <20				
MRSA	Counts of patients with Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia Per month: Red >= 1, Green 0				
MSSA	Counts of patients with Meticillin Sensitive Staphylococcus aureus (MSSA) bacteraemia Per month: Red >= 3, Amber 2, Green <= 1 Per year: Red >= 30, Amber 20-29, Green < 20				

Glossary

Indicator	Definition	Data Quality Kite-Mark	Indicator	Definition	Data Quality Kite-Mark
Patient Experience			Audits		
Complaints	Number of complaints. Red >= 50, Amber 40-49, Green < 40		Audit of WHO Checklist	Audit of the World Health Organisation surgical checklist monitoring the number that were complete compared to the number of checklists Red < 90%, Amber >=90% & < 95%, Green >=95%	
Friends and Family Test	The % of patients who Strongly Recommend the Trust.		Serious incidents	Unexpected or avoidable death, serious harm, never events, service delivery prevention compared to all incidents reported Red > 0, Green = 0	
Night-time Transfers	The number of non-clinical bed moves out of hours Red > 0, Green = 0		Stakeholder Engagement	The Hospital'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.	
Readmissions from Elective	The number of non-elective readmissions within 30 days of discharge from hospital. This is from discharges originally from elective admissions. Red >= 7.8%, Amber >=6.7% & < 7.8%, Green <6.7%		Vertical Integration	Working with local partners and contribute to the formal establishment of a responsive, integrated care system. RAG rating subjectively agreed by the committee	
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. Red >= 12%, Amber >=11% & < 12%, Green <11%		Acute Collaboration	Working with other acute providers to ensure resilient services, reduce outcome variation, address workforce shortages, achieve efficiencies, and meet national activity volume standards. RAG rating subjectively agreed by the committee	
Information Governance Breaches	The number of reported breaches of the information governance standards Red < 6, Amber >=6 & < 2, Green >=2				

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 Red < 80%, Amber >=80% & < 85%, Green >=85%	
High Priority Training	% of staff who are compliant with high priority training requirements Red < 65%, Amber >=65% & < 75%, Green >=75%	
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. Red < 95%, Amber >=95% & <100%, Green = 100%	
Risks not mitigated	Risks 12 and above whose current rating is above the target (residual) rating. Red > 15%, Amber >5% and <=15%, Green <=5%	
Research		
Research patients recruited	Number of patients recruited to studies against the planned recruitment. Red <60%, Amber >=60% & <80%, Green >=80%	

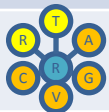



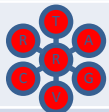

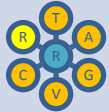

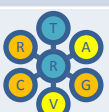
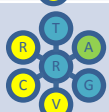
Indicator	Definition	Data Quality Kite-Mark
To be in the top 20% of employers in the NHS		
Appraisals		
Appraisal Rate Non-Medical	% of eligible staff employed at the trusts who have had an appraisal in the last 12 months. Red <75%, Amber >=75% and <95%, Green >=95%	
Experience		
BAME % Senior Leaders	% of staff employed in Band 8+ Senior Manager roles at the trust who are of Black, Asian or Minority Ethnic background Red >=2% below Trajectory Target, Amber >2% of Target, Green >= Target	
BAME % Workforce	% of staff employed at the trust who are of Black, Asian or Minority Ethnic background. Red >=2% below Trajectory Target, Amber >2% of Target, Green >= Target	
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%) Red >1% point above Target, Amber within 1% point above Target, Green <= Target	

Glossary


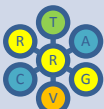



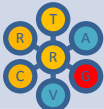





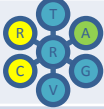

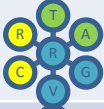
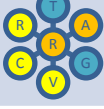
Indicator	Definition	Data Quality Kite-Mark
Staffing Levels		
Nursing Staff Fill Rate	% of time nursing staff staffing hours filled as planned Red < 80%, Amber 80% – 95%, Green > 95%	
Care Staff Fill Rate	% of time care staff staffing hours filled as planned Red < 80%, Amber 80% – 95%, Green > 95%	
Nursing 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. Red >=3, Amber >=2.6 & <3, Green <2.6	
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. Red >=4.2, Amber >=3.8 & <4.2, Green <3.8	
Bed Occupancy	Average % of available beds which were occupied overnight. Red >=95%, Amber 85-95%, Green <85%	
Discharges before 1 pm	Number of discharges from hospital which happened before 1 pm.	
Service Level Agreements		
Full Blood Count Acute Wards within 2 Hours	The time taken for the laboratory to process Full Blood Counts samples from all Acute Wards and validated results are available on the Laboratory Information Management System (LIMS). The time measured is from the sample being booked on to the LIMS and results being validated on the LIMS and available to requestors Red <85%, Amber >=85% & < 90%, Green >=90%	

Glossary

Indicator	Definition	Data Quality Kite-Mark	Indicator	Definition	Data Quality Kite-Mark
Out-Patient Productivity			Finance		
Did Not Attend Follow-Up	This is the % of Follow-up Outpatient appointments where the patient does not attend. Red >=7.6%, Amber >=6.1% & <7.6% , Green <6.1%		Delivery of financial plan	Delivery of finances against plan.	
Did Not Attend New	This is the % of New Outpatient appointments where the patient does not attend. Red >=7.4%, Amber >=6.4% & <7.4% , Green <6.4%		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.	
Elective Day Case Rate	The number of patients admitted for planned procedure and leave same day as a % of all procedures. Red < 83%, Amber <87% & >=83% , Green >= 87%		Cost Improvement Plan	Cost Improvement Plan progress against target.	
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. Red >=2.1, Amber >=1.8 & <2.1 , Green <1.8		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.	
Short Notice Clinic Cancellations	Clinics cancelled within the 6 week timeframe. Red 5% higher 17/18 avg, Amber within 5% of 17/18 avg, Green 5% less 17/18 avg				
Elective Wait List	Wait list of patients on an elective pathway.				

Glossary

Indicator	Definition	Data Quality Kite-Mark	Indicator	Definition	Data Quality Kite-Mark
National Indicators			Non-Financial continued		
Single Oversight Framework			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. Red > 12.44, Green <= 12.44	
Diagnostic waits	% of patients who have waited less than 6 weeks for a diagnostic test. Red < 99%, Green >= 99%		Ambulance Handover 30-60 mins	Ambulance handover taking longer than 30 – 60 minutes to handover. Red > Same Month LY, Green <=Same Month LY	
User of Resources	Calculation on the status of a number of financial measures – Capital Servicing Capacity, Liquidity, I & E Margin, and Agency Spend.		Ambulance Handover >60 mins	Ambulance handover taking longer than 60 minutes to handover. Red > Same Month LY, Green <=Same Month LY	
Emergency Care Standard	% patients seen in A&E within 4 hours. Red < 90%, Green >= 90%		RTT # Specialties	Number of specialties not achieving RTT incomplete. Red > 0, Green = 0	
RTT 18 Week Incomplete	Percentage of patients waiting within 18 weeks on an incomplete pathway. Red < 92%, Green >= 92%		NHS # field completion acute	Completion of valid NHS # field in acute commissioning data sets submitted via SUS Red < 99%, Green >= 99%	
Cancer Urgent 62 day Screening	Proportion of patients receiving treatment for cancer within 62 days of an NHS Cancer Screening service. Red < 96%, Green >= 96%		NHS # field completion AED	Completion of valid NHS # field in AED commissioning data sets submitted via SUS. Red < 95%, Green >= 95%	
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%, Green >= 85%		Cancelled Operations 28 Days	Number of patients who were cancelled on day of surgery and subsequently not been treated. Red > 0, Green = 0	
Non-Financial					
RTT 52 Week Wait	Number of patients waiting more than 52 weeks. Red > 0, Green = 0				
Trolley Waits >12 hours	Trolley waits of > 12 hours. Red > 0, Green = 0				

Glossary

Indicator	Definition	Data Quality Kite-Mark	Indicator	Definition	Data Quality Kite-Mark
Non-Financial continued			Financial		
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%, Green >= 93%		Never Events	The number of serious incidents that occur despite there being defined processes and procedures to prevent them. Red > 0, Green = 0	
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%, Green >= 94%		Stroke Strategy	Implementation of the Stroke Strategy – patients who spend at least 90% of their time on a stroke unit. Red < 80%, Green >= 80%	
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%, Green >= 93%		Seen by 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. Red < 85 %, Amber >= 85% & < 90 %, Green >= 90%	
Cancer 2 nd Treatment Drugs	Proportion of patients waiting no more than 31 days for second or subsequent drug treatments. Red < 98%, Green >= 98%		Seen by Midwife > 12 wks	Percentage of women who presented after 12 weeks 6 days who have seen a midwife within 2 weeks. Red < 85 %, Amber >= 85% & < 90 %, Green >= 90%	
Cancer 2 nd Treatment Surgery	Patients that require further surgery following initial treatment should receive treatment within 31 days . Red < 94%, Green >= 94%		MRSA	Counts of patients with Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia. Red > 0, Green = 0	
VTE Assessments	VTE risk assessments completed. Red < 90%, Amber >= 90% & < 95%, Green >= 95%		C Difficile	Number of cases either attributable or pending review. Red > 4, Amber 3, Green < 3	
Formulary published	Hospital formulary is published on the Trust's external website. Red Not published, Green Published		Duty of Candour	Patient informed duty of candour. Red > 0, Green = 0	
			Mixed Sex Accommodation	Number of occurrences of unjustified mixing in relation to sleeping accommodation. Red > 0, Green = 0	

Glossary

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.

