Bradford Teaching Hospitals
NHS Foundation Trust

Integrated Dashboard
Board of Directors

31st July 2018

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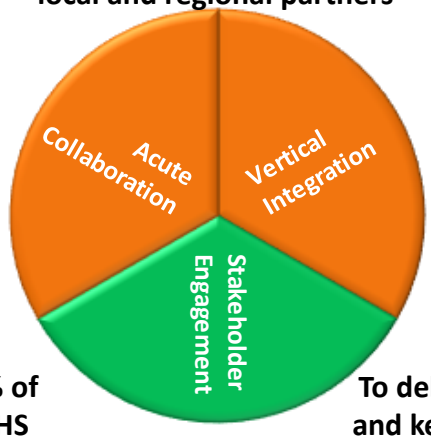
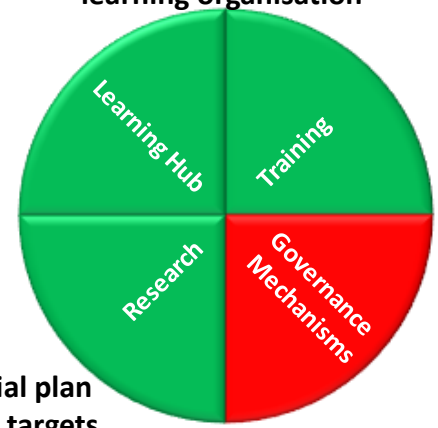
To provide outstanding care for our patients

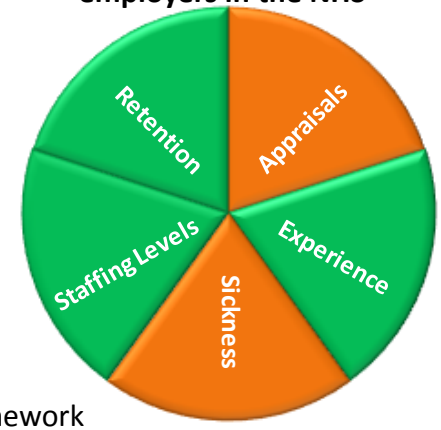
To collaborate effectively with local and regional partners



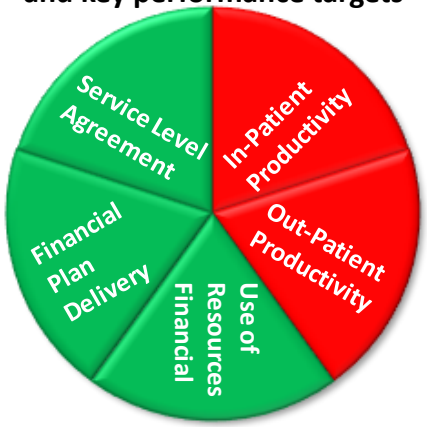
To be a continually learning organisation



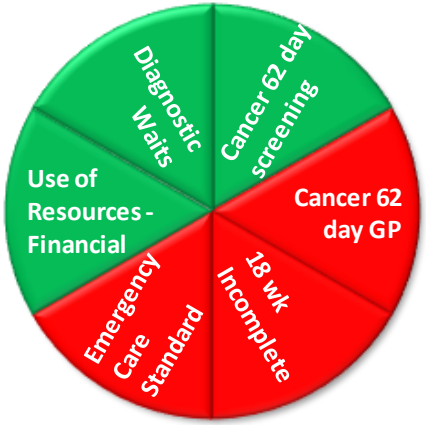
To be in the top 20% of employers in the NHS



To deliver out financial plan and key performance targets



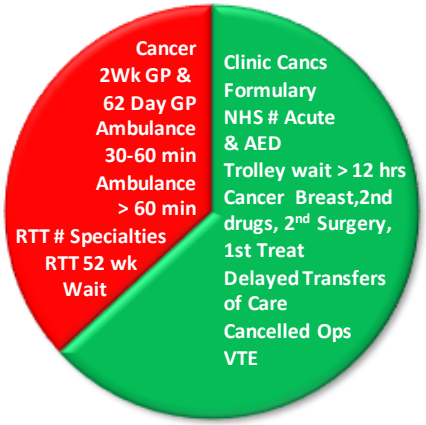
Single Oversight Framework



National targets

Financial

Non-Financial



Headlines

The key headlines for the Board Integrated Dashboard this month are as follows:

The Emergency Care Standard was not achieved this past month. The improvement plan work continues and improvement is expected. A&E Department attendances in the month were exceptionally high with the third highest number of attendances out of the last 100 months and higher than July 2017 by +3.8%.

The Trust's income and expenditure position is in line with the control total at the end of Month 4, however it is forecasted that without increased delivery of efficiencies the year end position will be below the pre-Provider Sustainability Fund control total by a considerable margin (£3m - £8m). This would result in year end cash balances being £14m - £22m lower than planned and would have an impact on both the capital programme and the Trust's ability to pay suppliers in a timely manner. The capital programme would need to be curtailed in this scenario. Data quality issues mean there is a significant risk that the Trust may not be able to accurately substantiate its income position for the Commissioners and as a consequence may not receive payment for the level of income assumed in the year to date or forecast positions. This may result in a material deterioration in the forecast financial position for 2018/19 in excess of the shortfall highlighted above.

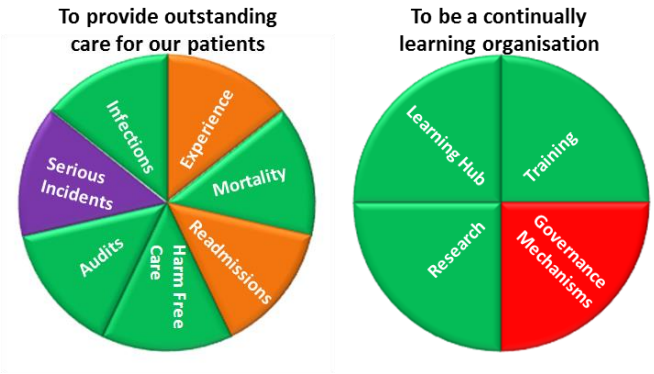
A formal presentation on the stroke service was given at the July 2018 Committee meeting from the Stroke team. The SSNAP results have demonstrated an improvement from Category E to Category C. A formal paper on the service is scheduled for the September 2018 Board of Directors meeting.

The Maternity "Be the Best" Improvement Programme (MIP) was reviewed in detail in the July 2018 Quality Committee meeting. This review included positive progress on action plans. The indicators on the Regional Maternity Dashboard continue to show good performance in most areas against peers. Avoidable still births have shown year on year reductions. Learning from never events is becoming embedded with the World Health Organisation checklist procedures in place with additional audit and monitoring. An external senior clinician has agreed to work with the team to be a critical friend and mentor starting in October 2018.

A higher incidence of puerperal sepsis triggered an alert from the Care Quality Commission. Early indications from the case note review would suggest an over recording of sepsis in labour has led to an increased coding of sepsis.

The Care Quality Commission have requested a formal update on progress against the compliance actions as well as any other improvements; submitted on the 31 August 2018.

Quality Dashboard
31st July 2018



Maternity Services – The Maternity "Be the Best" Improvement Programme (MIP) was covered in detail at the July 2018 Committee meeting. Highlights included all actions on track to deliver within planned timescales. A Regional dashboard continues to show good performance in most areas against peers. Avoidable still births have shown year on year reductions. Learning from never events is becoming embedded with the World Health Organisation (WHO) checklist for procedures in place with additional audit and monitoring. An external senior clinician has agreed to work with the team to be a critical friend and mentor; planning to start in October 2018.
A higher incidence of puerperal sepsis triggered an alert from the Care Quality Commission (CQC). Early indications from the case note review would suggest there has been an over recording of sepsis in labour that has led to an increased coding of sepsis.
The CQC have requested a formal update on progress against the compliance actions as well as any other improvements. A formal response was submitted on 31 August 2018.
See maternity report under Agenda item Bo.9.18.12.

Stroke Services – There was a formal presentation at the July 2018 meeting from the Stroke team, providing strong assurance that improvement was in place and becoming business as usual. The SSNAP results (April – June 2018) demonstrated a rise from category E to category C; formal paper on September 2018 Board agenda. Notification of the first Joint Stroke Board meeting to be held on the 3 September 2018.
See report under Agenda item Bo.9.18.15.

Inpatient Survey - Survey results were disappointing with slight improvement on last year but still requiring improvement in a number of areas. It was agreed at the Committee meeting that there would be a strong focus on experience going forward, including the development of the Patient Experience Strategy to be presented at the November 2018 Committee meeting.

Patient Experience (Including Complaints) – The Quarter 1 patient experience report was reviewed by the Committee with a strong focus on complaints and the timeliness of responses. There has been positive improvement relating to the number of outstanding complaints and complaints waiting longer than 6 months.

Strong performance on a number indicators including was noted including VTE, Clostridium difficile, HSMR, Grade 3 and 2 Pressure Ulcers, and MRSA.

Workforce Dashboard
30th June 2018

Appraisals – There was a detailed discussion by the Committee concerning performance as this had dropped below 75%. Measures and additional interventions in place to support increasing appraisal rates around reporting, training, communications and additional support being provided to managers. Link between appraisal and pay progression discussed as well as the element of re-earnable pay for band 8cs and above. Agreed that if sustainable improvement not seen by end of September 2018 further actions would need to be considered.

Equality indicators - It was noted that our overall Black, Asian & Minority Ethnicity (BAME) workforce was growing and the Trust was ahead of the agreed trajectory. Progress in relation to Band 8a+ was noted however the Trust is behind trajectory and the Committee discussed current actions and what else could be done to close the gap. A 'closing the gap' action plan was being developed and would be specifically monitored.

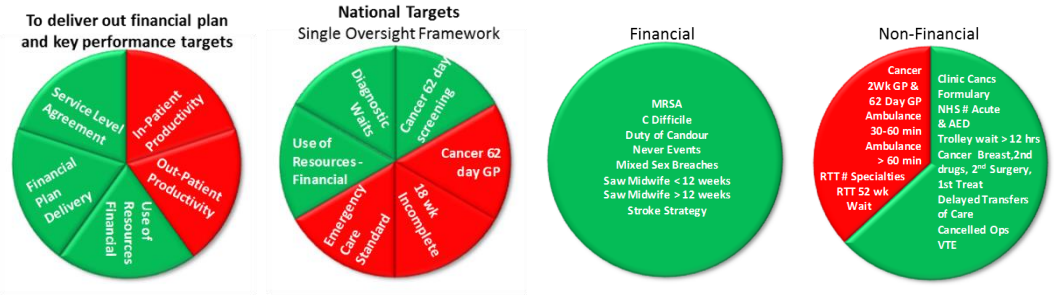
Nurse vacancies/nurse fill rates - The committee noted the detail around current vacancies, recruitment interventions and fill rates, but did not feel this gave them sufficient assurance on how the Trust was performing against peers, whether any element of safe staffing needed to be escalated to the Board, and how we compared to this time last year. It was agreed that a separate nursing recruitment and retention report be provided for the next meeting looking at comparative data for the last year, mitigation and risks ,so the Committee could take an informed view.

Turnover/staff in post – Turnover and Staff in Post were reported as stable.

Sickness absence - The Committee noted the increase in year to date and in month sickness in June 2018, which was on both long term and short term sickness. Health and well being interventions particularly around men's mental health and the role of the occupational therapist on tackling stress and resilience was discussed

Note: Integrated Board Dashboard presents most current data and Committee Dashboard presents Dashboard from the last Committee meeting.

Finance & Performance Dashboard 31st July 2018



Year to Date Income & Expenditure Position vs Control Total – The month 4 2018/19 position is a pre-Provider Sustainability Fund (PSF) deficit of £5.9m which is in line with the planned deficit of £5.9m. The year to date position includes £1.8m of Provider Sustainability Fund income and this results in a post-Provider Sustainability Fund (PSF) deficit of £4.1m which is £0.5m behind plan. See report under Agenda item Bo.9.18.19

Year End Forecast Income & Expenditure Position vs Control Total – The year end forecast presented to NHS Improvement remains full delivery of the financial plan. However, there is now a serious risk that the Trust will fall behind its financial plan after Quarter 3 2018/19. If remedial actions to increase BIP delivery are unsuccessful, the Trust will fail to deliver its pre-PSF control total in 2018/19 by a significant margin (£3m - £8m).

Cash & Capital Programme – The Trust's cash balance is below plan by £6.1m at the end of July. Unless the income and expenditure forecast can be improved via increased delivery of BIP efficiencies, cash is forecast to be below plan by between £14m - £22m at the end of the financial year. In this scenario, the Trust will be unable to implement its capital programme in full. As a consequence, the capital programme may need to be re-prioritised.

Data Quality Risks to Recovery of Income from Commissioners – The coded income and activity datasets produced by the Trust's information systems are impacted by a range of data quality issues which mean the Trust has been unable to accurately substantiate its income position to the satisfaction of Commissioners. There is a data quality action plan in place to address this, however if this plan is unsuccessful the Trust may recover a lower income figure than currently forecast. This may result in a material deterioration in the forecast financial position for 2018/19 in excess of the £3m - £8m pre-PSF shortfall highlighted above.

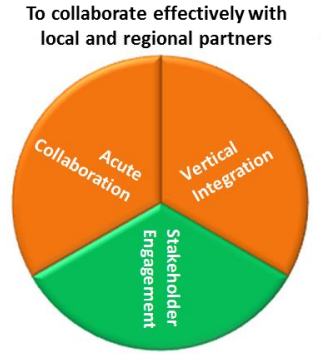
Emergency Care Standard – July 2018 performance for Type 1 & 3 reported at 83.12% and for Type 1, 2 & 3 85.43%, both a deterioration from the previous month. Attendances in July 2018 were exceptionally high with the third highest number of attendances out of the last 100 months.

Cancer – Failures were reported to the Committee against the 2-Week Wait, and 31-Day First and 62-Day First Treatment targets for June 2018; a deterioration of the 31-Day and 62-Day First Treatment targets compared to previous months. Improvement was noted for the 2-Week Wait, however the Skin and Urology positions remain a concern. A programme to review capacity and demand across all sites will commence in September 2018, with timescales for completion to be confirmed. Optimal pathways are being introduced across several of the pressured sites.

Referral to Treatment – July 2018 performance was 74.17%. A slight reduction in waiting list size was noted for three months and a new approach to validation was discussed, providing full validation in the longer term. Activity tracking and recovery planners are in use with those furthest off plan discussed at the RTT delivery and turnaround meetings. There were eight patients reported as waiting over 52 weeks with further deterioration to 13 breaches expected in August 2018 all of whom will be treated in September 2018 with one exception. Improvement is predicted from September 2018 and daily reviews of all waits over 46 weeks will continue. See report under Agenda item Bo.9.18.8

Diagnostics – Excluding Endoscopy and Neurophysiology the target was achieved .

Partnership Dashboard
31st July 2018



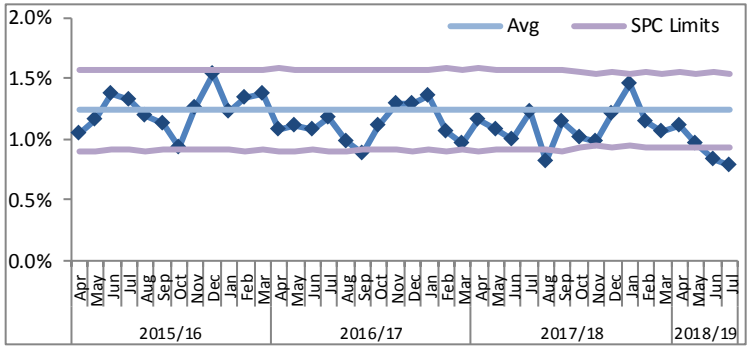
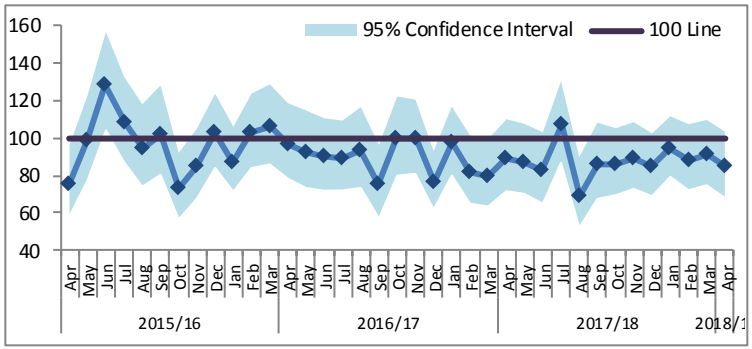
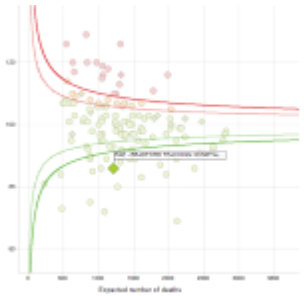
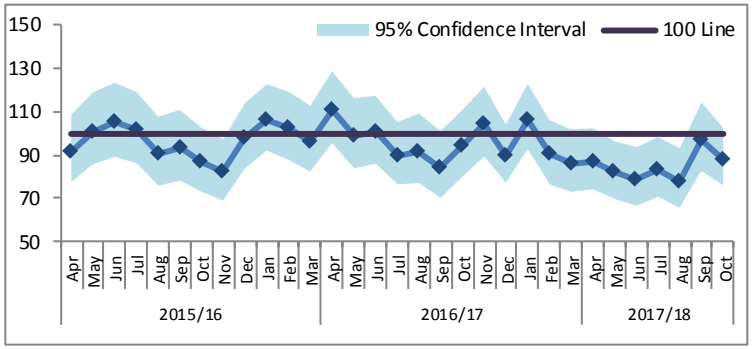
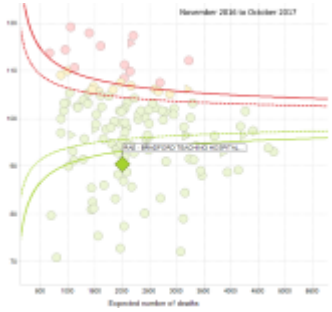
Vertical Integration - The Committee discussed the progress being made to develop a Partnership Operating Framework (POF). This will "articulate partnership functions and governance arrangements" for the Bradford Health and Care Partnership (BHCP). Following on from this document, a legally binding Partnering Agreement (this was formerly known as a Partnership Agreement), will be agreed between the members of the BHCP. This is intended to be signed off by 29 March 2019. The committee acknowledged that more work needs to be done to ensure the POF and Partnering Agreement are not duplicative with the West Yorkshire and Harrogate Health and Care Partnership's (WYHHCP) Memorandum of Understanding.

Airedale Collaboration - The Committee discussed the positive progress in this area. Highlights include a meeting to discuss "developing clinical models across Airedale and Bradford" scheduled in August 2018 between the two acute Trusts' Chief Executives/Chairs, local NHS England/Improvement representatives and the CCGs' Chief Executive, and that the independent review of current service interdependencies between the two Trusts was underway. The Committee recognised that it might be difficult for Bradford Teaching Hospitals Foundation Trust (BTHFT to commit fully to the West Yorkshire Association of Acute Trust's strategy work and the whole service approach with the Airedale Hospitals Foundation Trust, although it was noted that BTHFT must attempt to do both.

Horizontal Integration - The Committee reflected upon and discussed two positive pieces of news. The decision to award vascular services to BTHFT is expected to be ratified by NHS England, with a final decision expected in November 2018. The West Yorkshire and Harrogate Health and Care Partnership (WYHHCP) have also prioritised the hybrid theatre required at BTHFT in its bid for capital funding. The WYHHCP's clinical strategy development was discussed. This is in its early stages and the committee noted that there was some debate over whether it was taking heed of existing place based arrangements and queried whether it would give a strong enough steer on acute strategic decisions.

Appendix

To provide outstanding care for patients

	Trend	Challenges and Successes	Comparison	Exec Lead
Crude Mortality		Crude death rate has remained constant throughout the last 18 months. There is no regional or national 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
Hospital Standardised Mortality Ratio		Our Hospital Standardised Mortality Ratio (HSMR) continues to be better than expected.		Medical Director
Summary Hospital-level Mortality Indicator		The national time delay in reporting Summary Hospital-level Mortality Indicator (SHMI) and implementation of EPR means that the most up to date data available shows the trust in the 'better than expected' range. It is anticipated that this metric will be updated next month.		Medical Director

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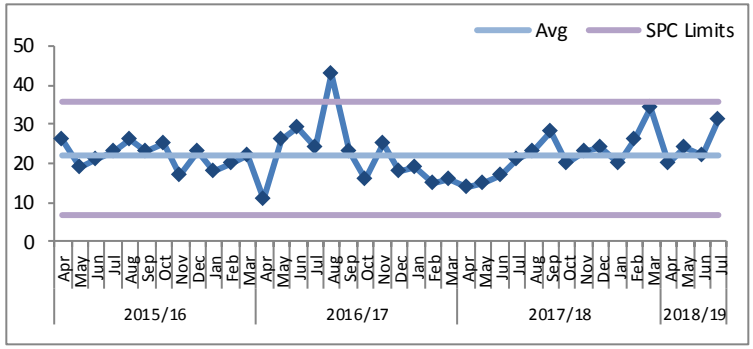
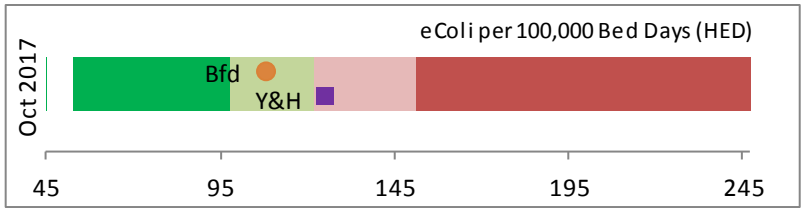
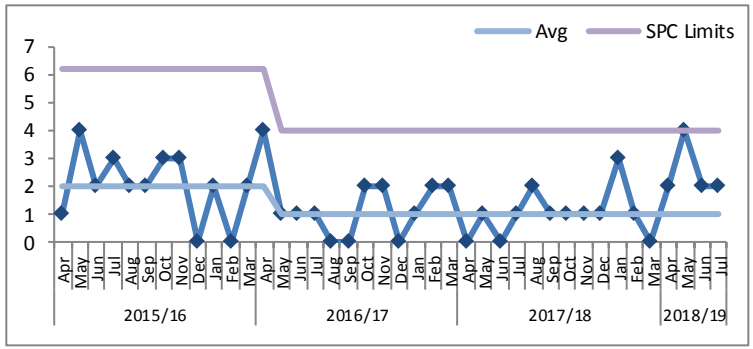
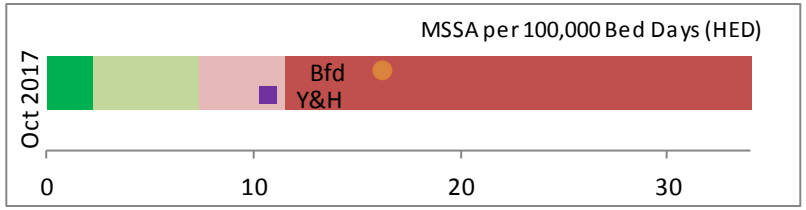
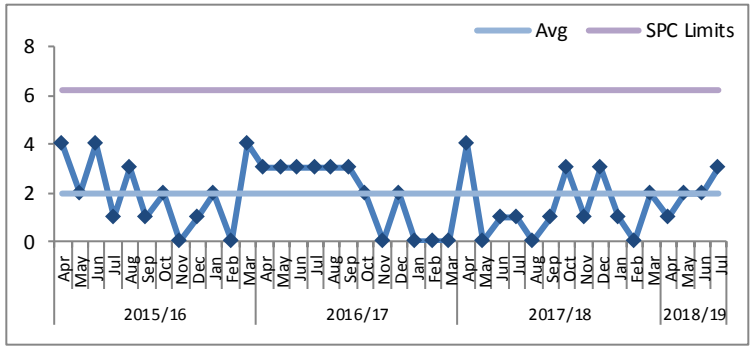
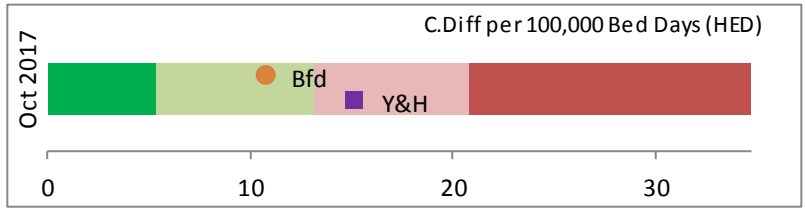
	Trend	Challenges and Successes	Comparison	Exec Lead
eColi		As part of the 2018/19 work plan we will focussing on all bacteraemias. We have seen a reduction of 26% on the previous 12 months (NHS Improvement).		Chief Nurse
MSSA		Part of national improvement collaborative for Infection Prevention and Control (IPC). Ongoing improvements are overseen by Infection Prevention and Control and reviewed on a quarterly basis.		Chief Nurse
C. Difficile		Sustained reduction in Clostridium Difficile (C. Diff) has been achieved. A robust Post Infection Review (PIR) process is in place.		Chief Nurse

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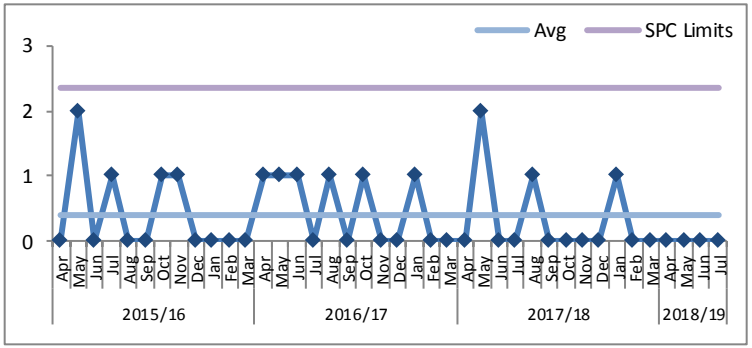
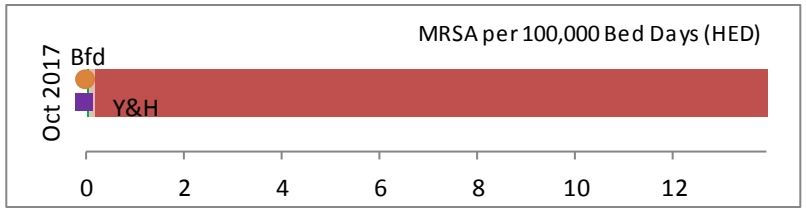
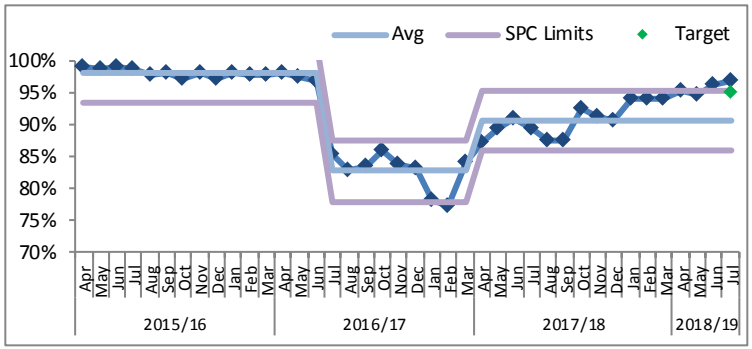
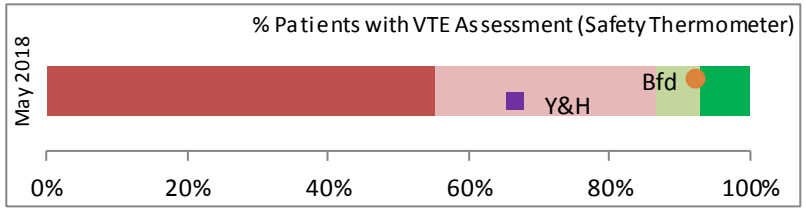
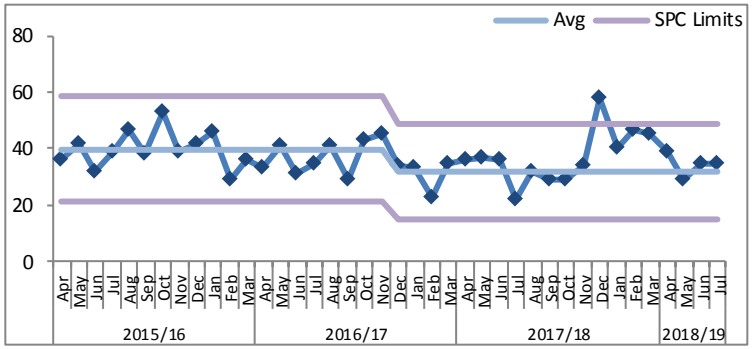
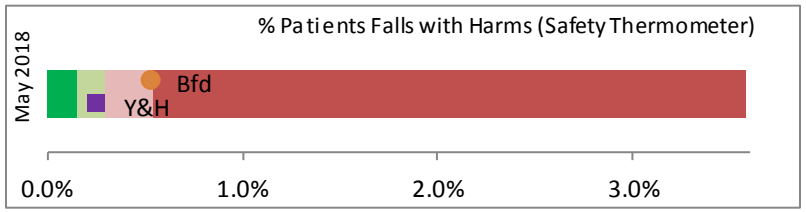
MRSA		Zero Methicillin-resistant Staphylococcus aureus (MRSA) year to date.		Chief Nurse
VTE Assessment		Significant progress has been made in Venous Thromboembolism (VTE) assessments with the average for the past 4 months achieving the standard of > 95%.		Medical Director
Falls with Harm		Collaborative work is having a positive impact on the number of falls with harm, further reduction back to previous baseline.		Chief Nurse

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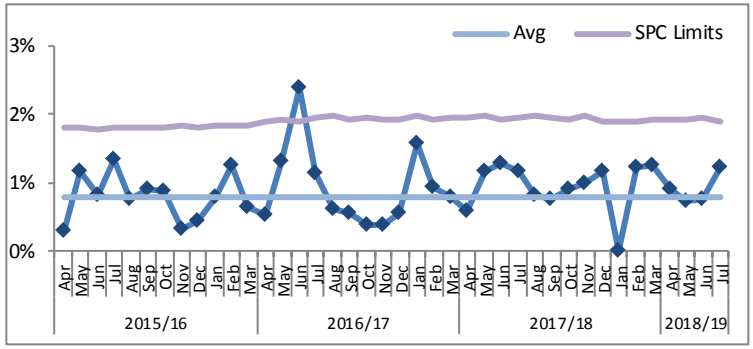
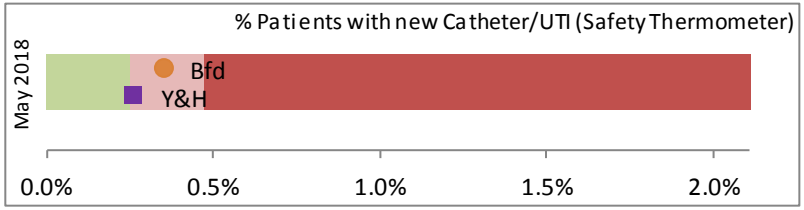
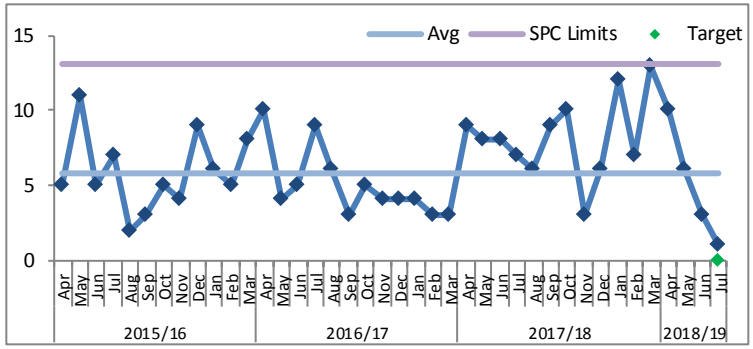
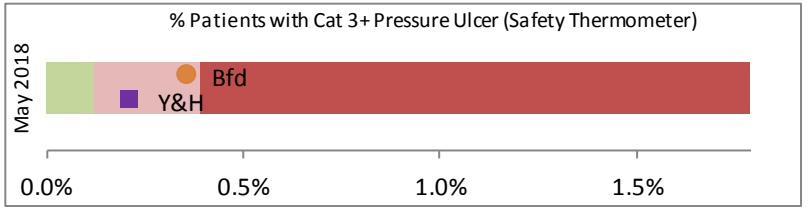
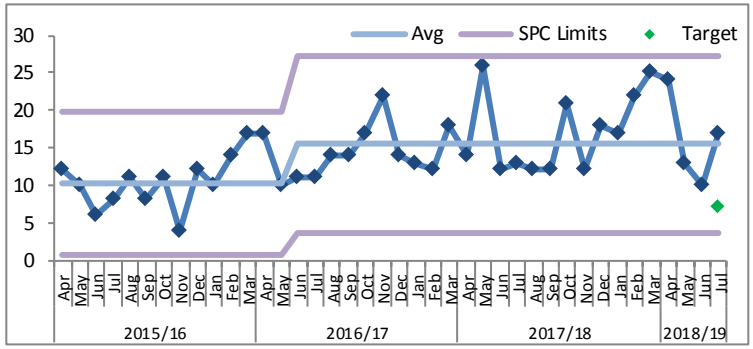
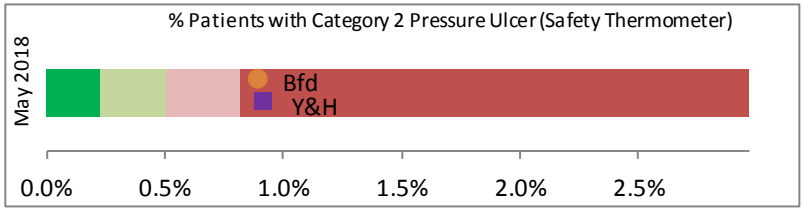
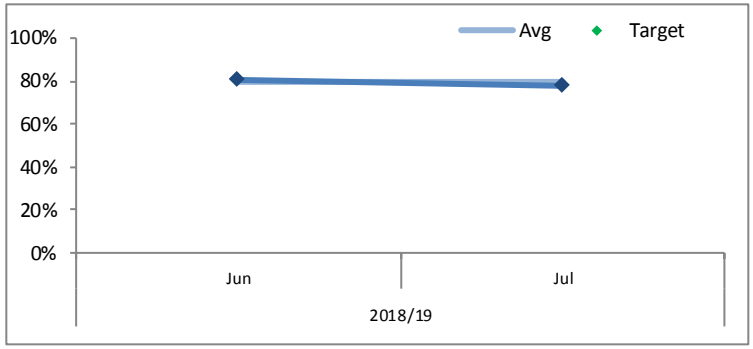
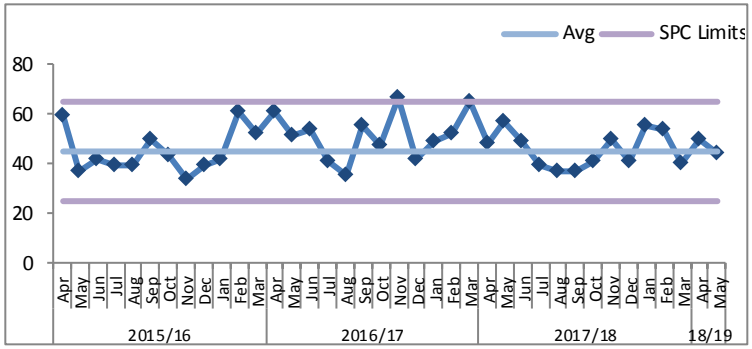
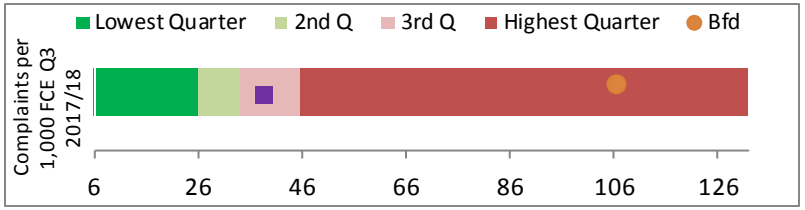
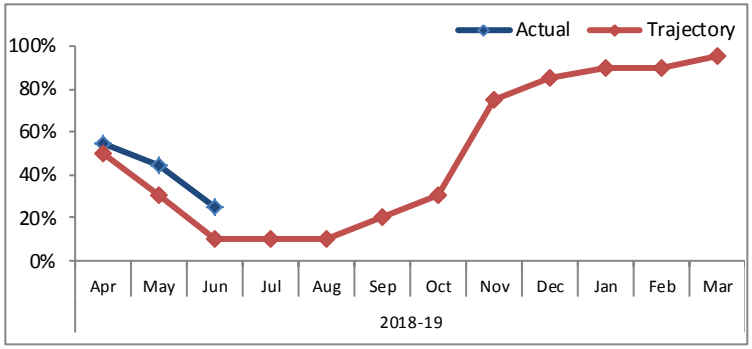
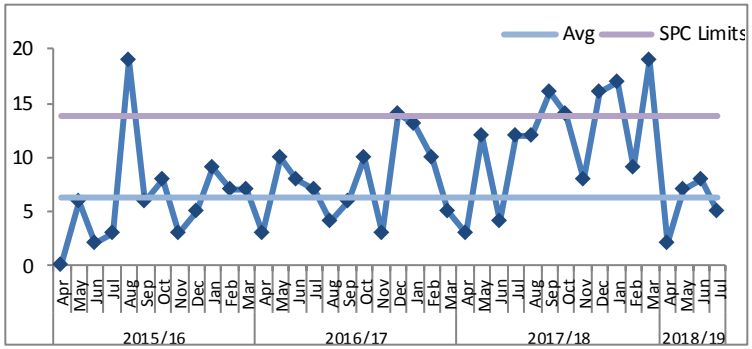
	Trend	Challenges and Successes	Comparison	Exec Lead
Catheters & UTIs		Plans in place to undertake work (overseen by Infection Prevention and Control Team) to reduce the point prevalence of Catheter Associated Urinary Tract Infections (CAUTI). Opportunity to use the EPR to audit care and support improvement being explored with chief nurse team. The trend continues to mirror the previous 3 years. 		Chief Nurse
Pressure Ulcers Cat 3+		Focussed work continues with the Tissue Viability Nursing team and recent participation in the national collaborative is raising awareness of documentation, assessment and care planning. 		Chief Nurse

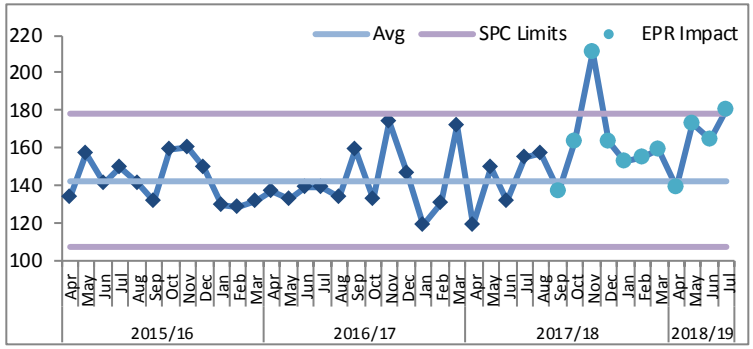
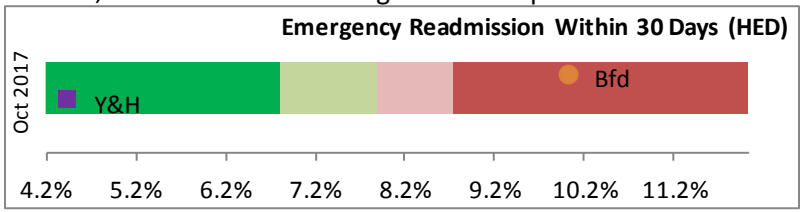
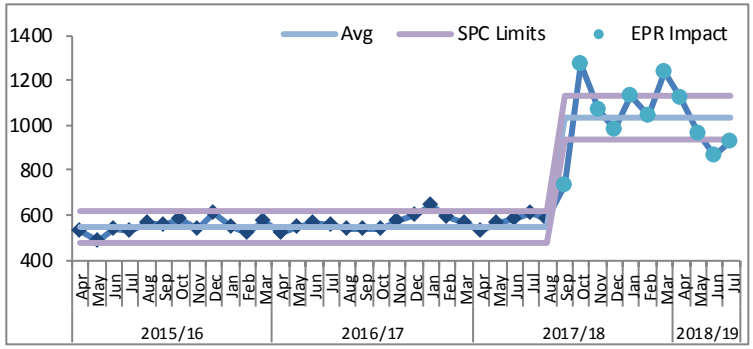
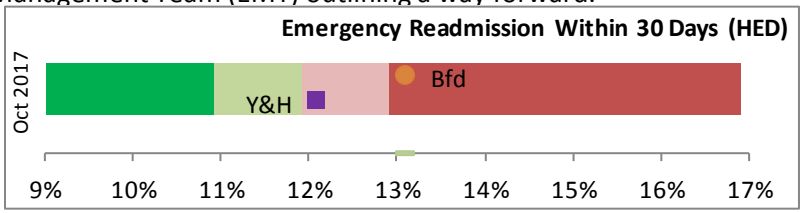
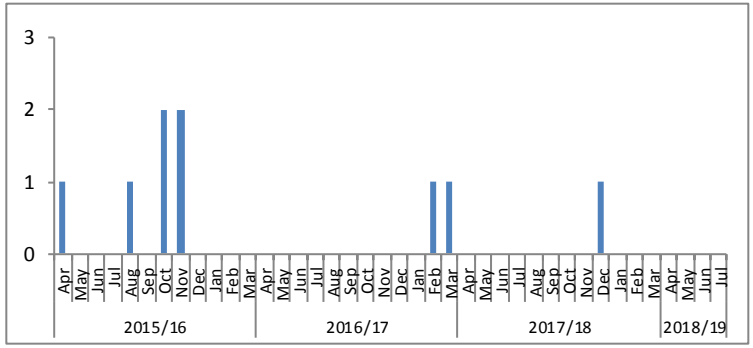
To provide outstanding care for patients

	Trend	Challenges and Successes	Comparison	Exec Lead
Pressure Ulcers Cat 2		Focussed work continues with the Tissue Viability Nursing team and recent participation in the national collaborative is raising awareness of documentation, assessment and care planning.		Chief Nurse
Sepsis patients receive antibiotics within an hour		This is a new indicator being tracked as part of the sepsis Commissioning for Quality and Innovation (CQUIN). A sepsis improvement work stream has been established led by the Nurse Consultant for Infection Prevention and Control, and an improvement programme is being developed as part of this work stream.		Chief Nurse

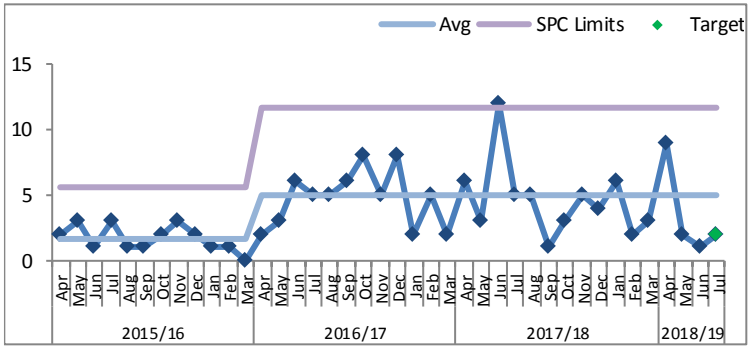
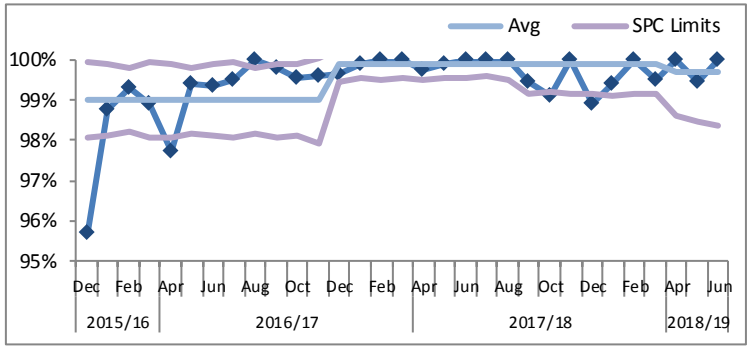
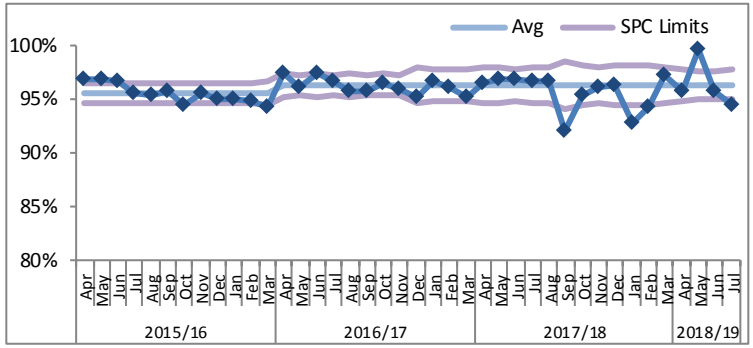
To provide outstanding care for patients

	Trend	Challenges and Successes	Comparison	Exec Lead
Complaints		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
Complaints Closed		We are currently dealing with a backlog in the number of complaints within the system. An improvement trajectory has been set, it is anticipated that the position will deteriorate as the backlog is cleared and then improve over the next 6 months.		Chief Nurse
Night-time Transfers		Daily review of night time transfers continues. There were 5 patient transfers after 10pm which occurred in the month of July 2018/19; 2 to create an ENT bed, 1 to create a side room, 1 to create a Care of the Elderly bed, and 1 to avoid a potential complaint.		Chief Operating Officer

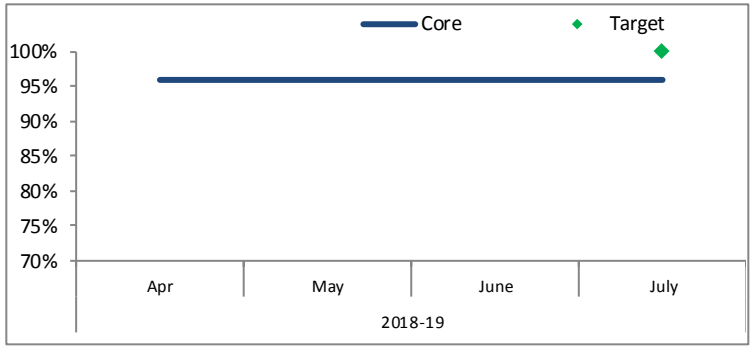
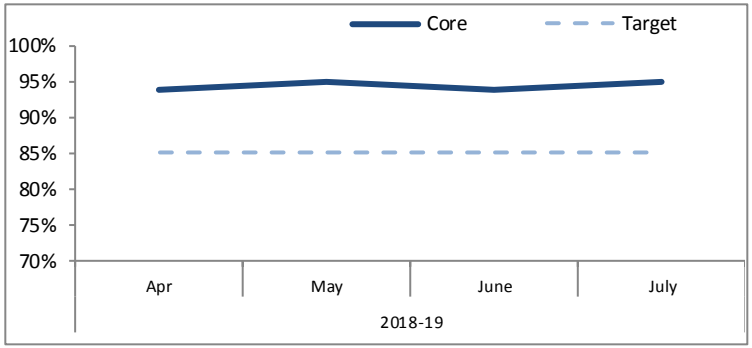
To provide outstanding care for patients

	Trend	Challenges and Successes	Comparison	Exec Lead
Readmissions from Elective		This indicator is impacted by data quality issues following EPR implementation and forms part of the data quality recovery programme. However, national benchmarking from pre-EPR data has identified any outliers and improvement plans have now been agreed for these, to be monitored through divisional performance reviews. 		Chief Operating Officer
Readmissions from Non-Elective		This is impacted by data quality issues following EPR implementation and forms part of the data quality recovery programme. A review of changes in reporting of assessment unit attendances post EPR is in progress and a report will be submitted to the Executive Management Team (EMT) outlining a way forward. 		Chief Operating Officer
Information Governance Breaches		There was one breach in the last financial year and no breaches year to date 2018/19. Awareness remains high as training is above 99%.	No comparator data is published.	Director of Informatics

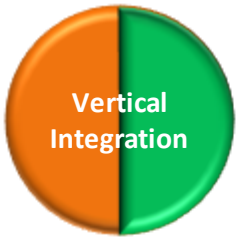
To provide outstanding care for patients

	Trend	Challenges and Successes	Comparison	Exec Lead
Serious Incidents		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 s of the action planning.	No comparator data is available.	Director of Governance & Corporate Affairs
Audit of WHO Checklist		Safer procedures collaborative launched on 16th July 2018 with attendance from all specialities undertaking high risk procedures. Two Never Events in Maternity in April and May 2018/19 targeted improvements with Maternity Team now in place.	No comparator data is available.	Medical Director
Friends and Family Test		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

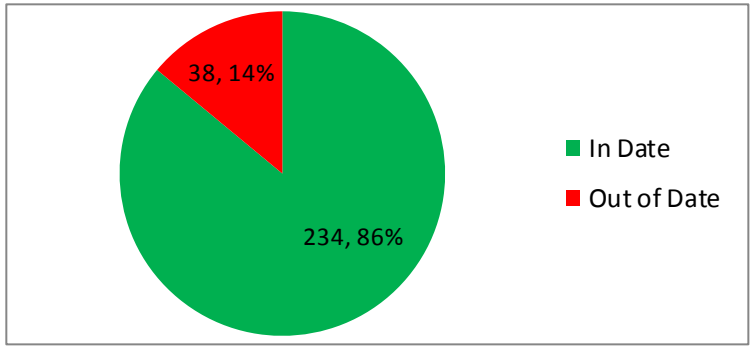
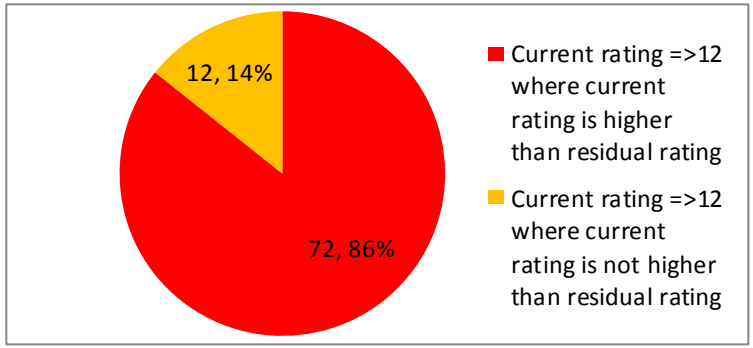
To be a continually learning organisation

	Trend	Challenges and Successes	Comparison	Exec Lead
New Starter Training		The trust changed its approach to reporting core training in April 2018/19 by splitting induction and refresher training. The data demonstrates consistently over 95% performance albeit this is below the target of 100%. Escalation processes are in place to track delivery of performance at an individual level.	Comparator data not available.	Medical Director
Refresher Training		The trust changed its approach to reporting core training in April 2018/19 by splitting induction and refresher training. The trust has consistently exceeded its target refresher training standard since April 2018/19, averaging over 95%.	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 review has been undertaken in relation to the hub and a revised approach to engagement identified.			Director of Governance & Corporate Affairs

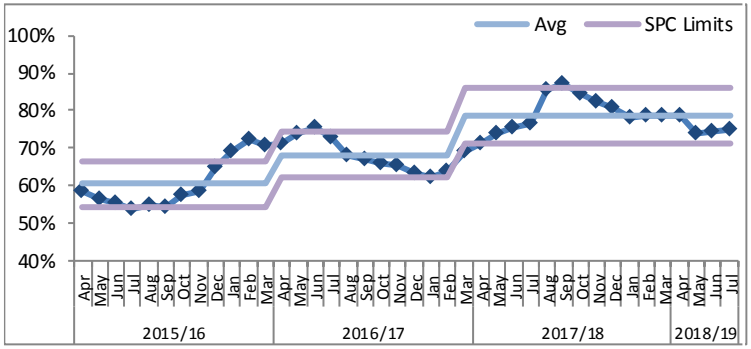
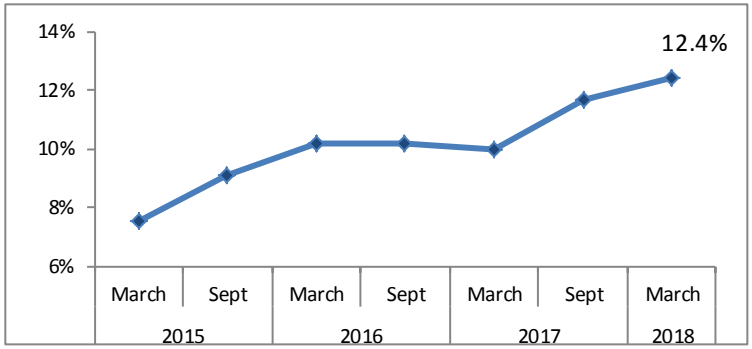
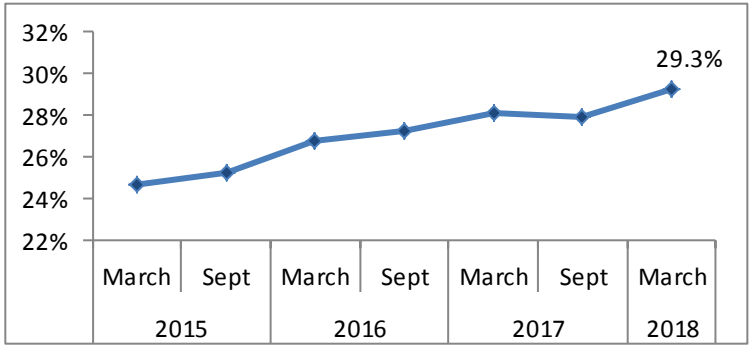
To collaborate effectively with local and regional partners

	Trend	Challenges and Successes	Comparison	Exec Lead
	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 and a second round of meetings with account managers is underway. Potential KPIs for this programme were discussed at Partnerships Committee (25th May 2018) but there was no support for a numerical representation to attempt to show how the strength of relationships improves over time. Instead the Committee will receive periodic qualitative updates.			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 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 and is reliant on the individual actions of autonomous organisations meaning progress and risk is 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

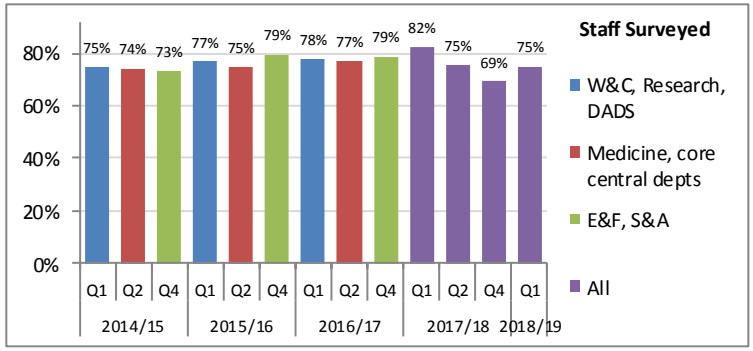
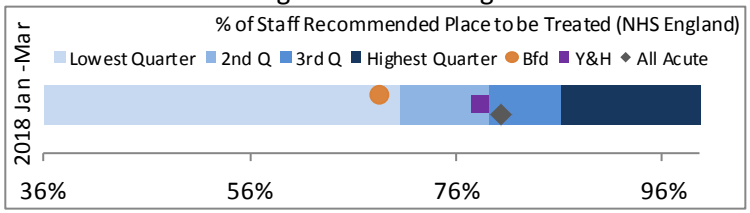
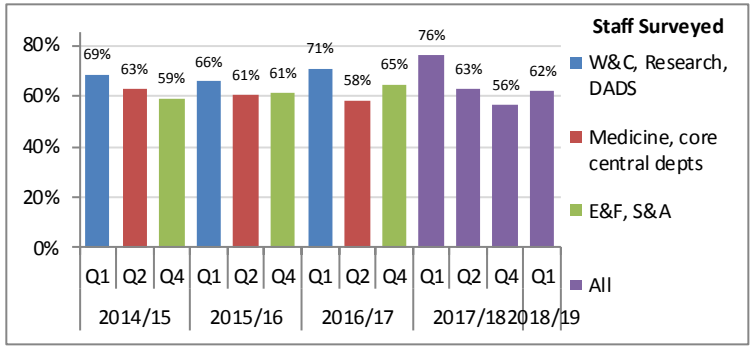
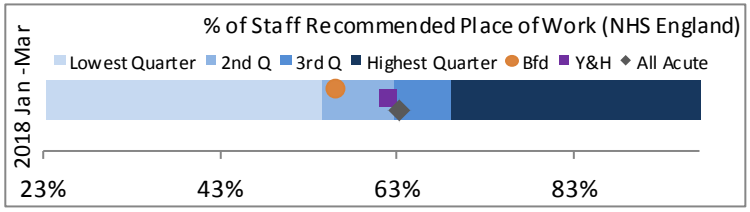
To be a continually learning organisation

	Trend	Challenges and Successes	Comparison	Exec Lead
Out of date Policies		A focussed programme of work commenced in Quarter 3 in order to improve the Trust position in relation to Trust-wide policies and their management. There is significant confidence about the approach to managing locally-developed guidance within Divisions		Director of Governance & Operations
Risks not Mitigated		A clear work programme is ongoing to improve the risk assessments and plans. Skilled risk staff have been devolved to the divisions to support and sustain this work. The Integrated Governance and Risk Committee review is ongoing. The refreshed Risk Management Strategy has been approved and implemented.		Director of Governance & Operations

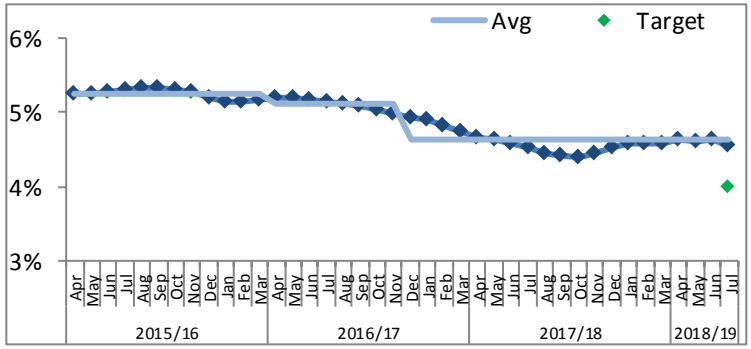
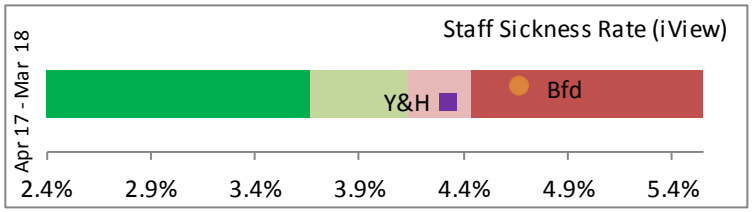
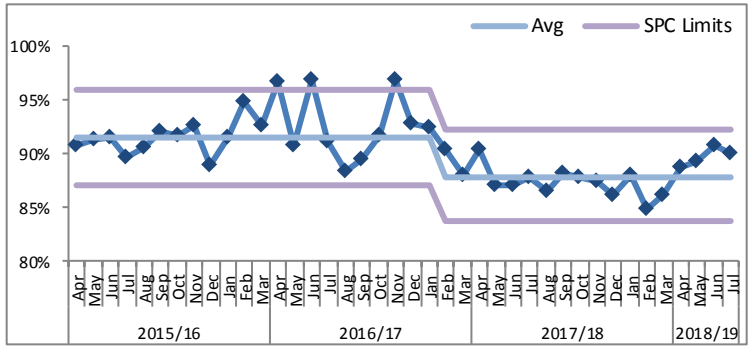
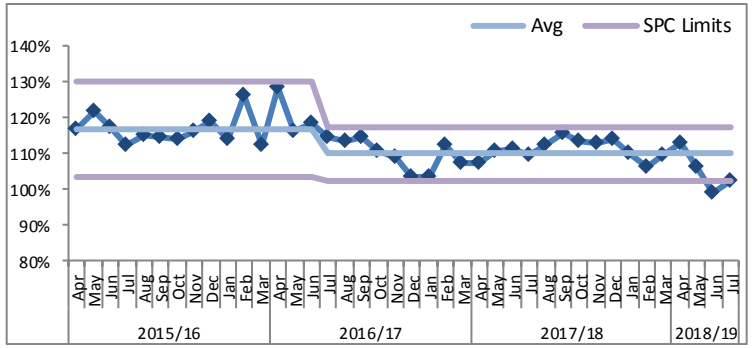
To be in the top 20% of employers in the NHS

	Trend	Challenges and Successes	Comparison	Exec Lead
Appraisal Rate Non-Medical		The target for non-medical appraisals is that 95% of employees are appraised by the end of December. Appraisal rates increased slightly from 74.56 last month to 75.08% at the end of July 2018/19. HR are supporting Divisions and Departments to make sure managers complete appraisals and are communicating the changes to pay and conditions which links appraisals to pay progression.		Director of Human Resources
BAME % Senior Leaders		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 13%. No comparator data is available. We expect to update this metric in October.		Director of Human Resources
BAME % Workforce		Good progress is being made. We are ahead of our trajectory to have a workforce reflective of the local ethnic local population by 2025. We expect to update this metric in October.		Director of Human Resources

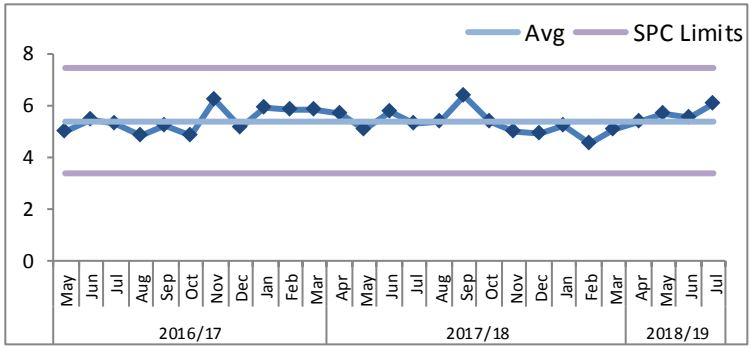
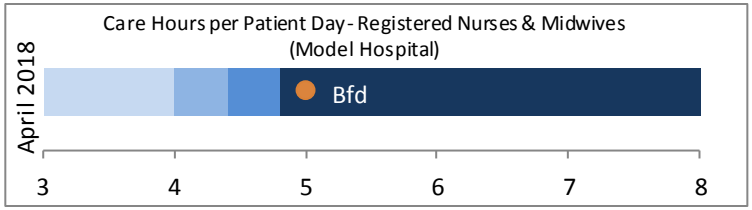
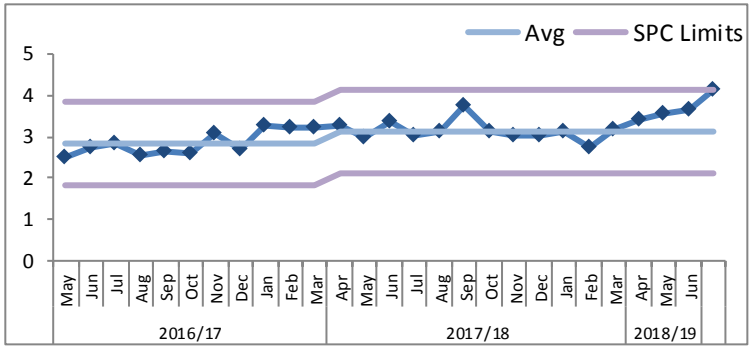
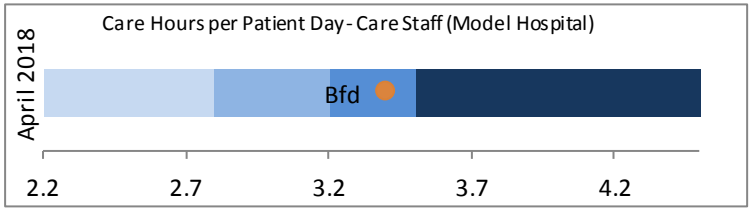
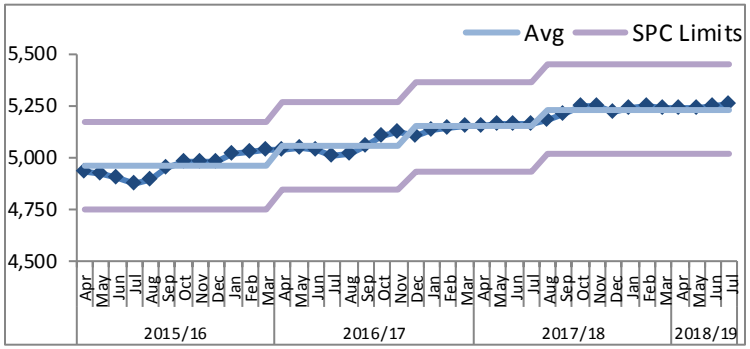
To be in the top 20% of employers in the NHS

	Trend	Challenges and Successes	Comparison	Exec Lead
Staff FFT Treatment		In Quarter 4 2017/18 BTHFT was below the Yorkshire and Humber average, and also below average for all Acute Trusts. In Quarter 1 2018/19 our score for this measure increased from 69% in Q4 2017/18 to 75% (+6%). Comparison data for Quarter 1 2018/19 will be available from NHS England on 23rd August 2018.		Director of Human Resources
Staff FFT Work		In Q4 2017/18 our score for this measure (56%) fell slightly below both the Yorkshire and Humber and Acute Trusts; however, we have seen a 6% increase in Q1 2018/19 with a score of 62%. Comparison data for Q1 2018/19 will be available from NHS England on 23 August 2018. Following analysis of 2017's NHS Staff Survey results, a Trust-wide action plan was agreed for 2018/19 targeting key areas of improvement in relation to employee engagement and experience. Progress in relation to the actions will continue to be monitored and reviewed through the Trust Education and Workforce Committee in line with Staff Friends and Family Test feedback and other People Strategy metrics.		Director of Human Resources

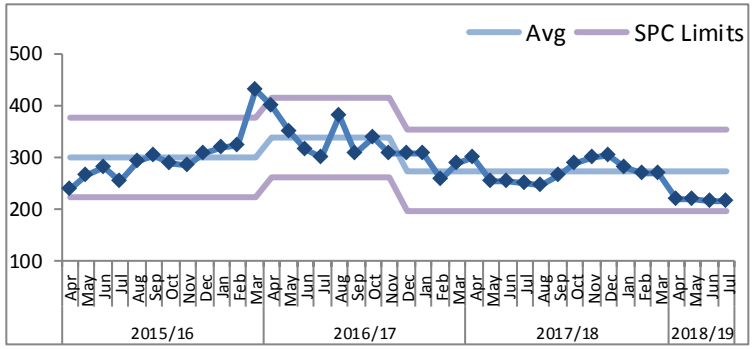
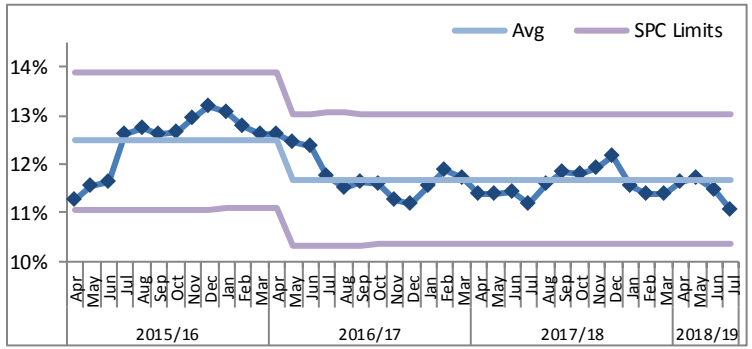
To be in the top 20% of employers in the NHS

	Trend	Challenges and Successes	Comparison	Exec Lead
Sickness		The rolling 12 month sickness rate is currently 4.64%, this is a slight increase on last month. Reductions have been seen in Research and Women & Children's Divisions with increases in all other Divisions.		Director of Human Resources
Nursing Shifts Filled		Fill rates for RNs remains relatively stable around 90%. See nurse staffing report for more details.		Chief Nurse
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.		Chief Nurse

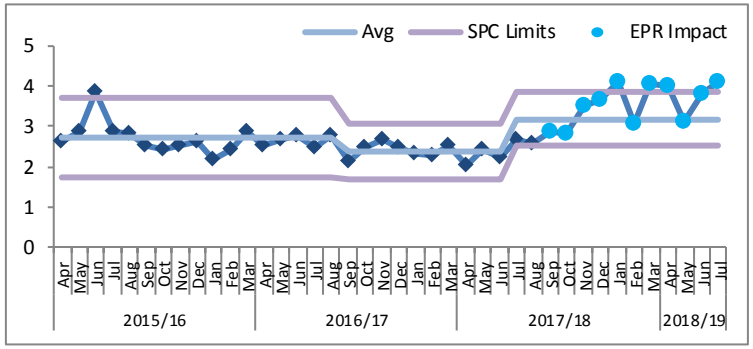
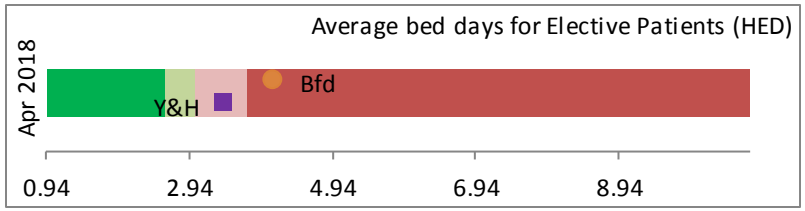
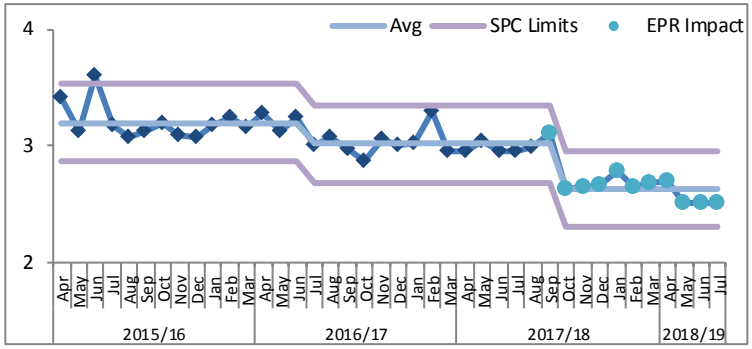
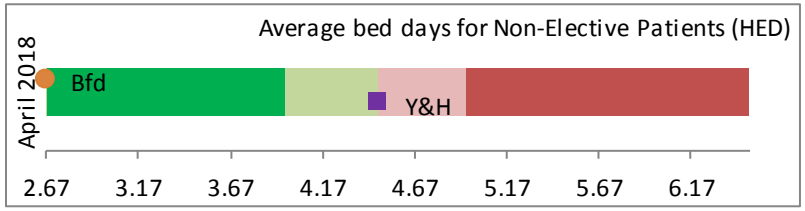
To be in the top 20% of employers in the NHS

	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.

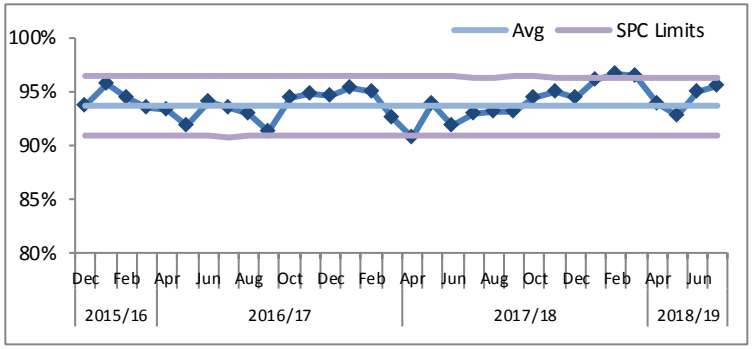
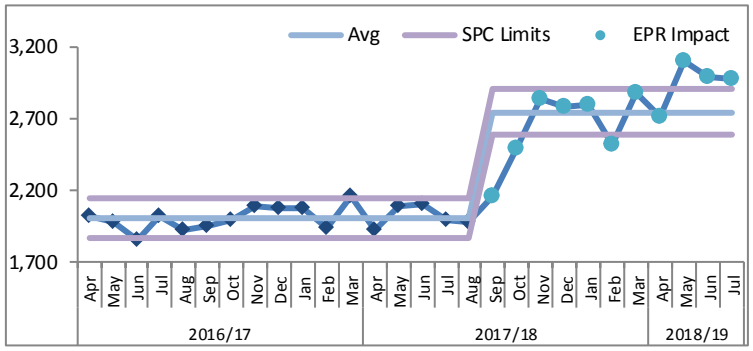
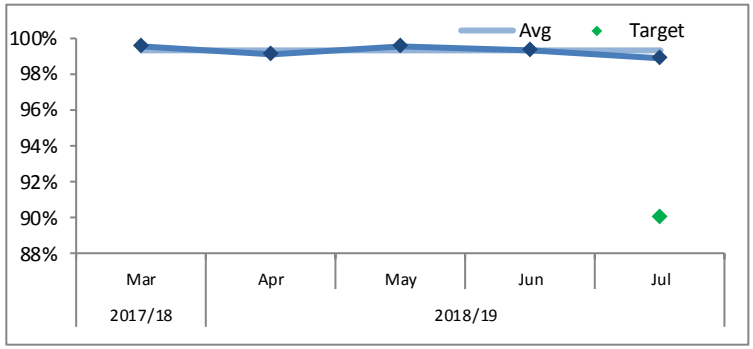
To be in the top 20% of employers in the NHS

	Trend	Challenges and Successes	Comparison	Exec Lead
Use of Agency (WTE)		Use of agency continues to be monitored closely and is subject to robust approval mechanisms. Agency cover for vacant clinical posts remains the primary reason for usage. Bank fill continues to increase with agency spend under our target at the end of month 4.		Director of Human Resources
Turnover		Turnover has reduced at Trust level to 11.05% from 11.48% in June. The largest reduction was in the Nursing & Midwifery Registered staff group (1.10%) and Women & Children's Division (0.9%).		Director of Human Resources

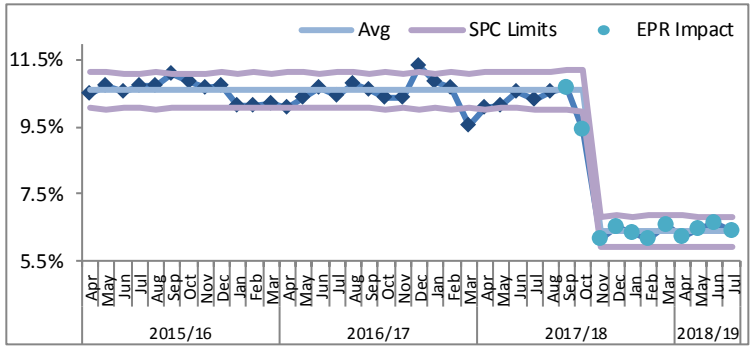
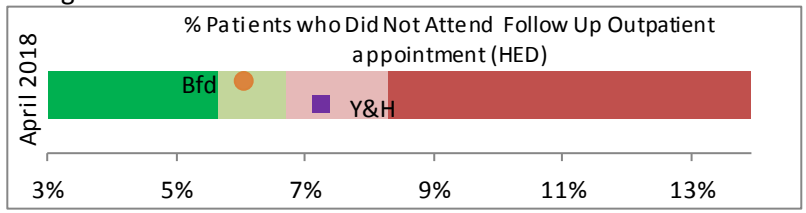
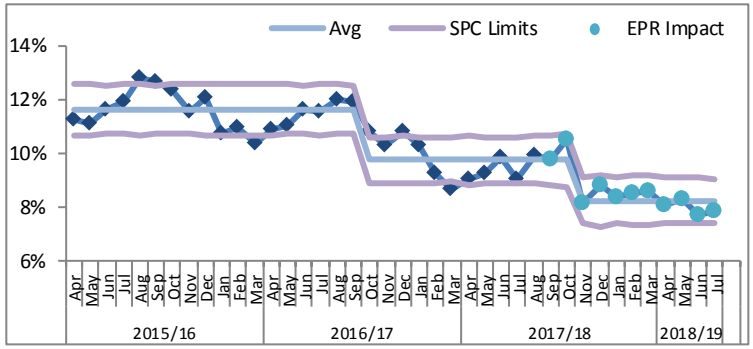
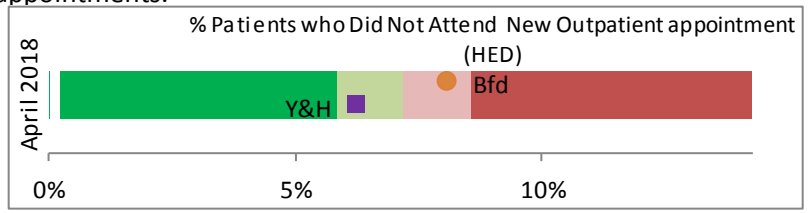
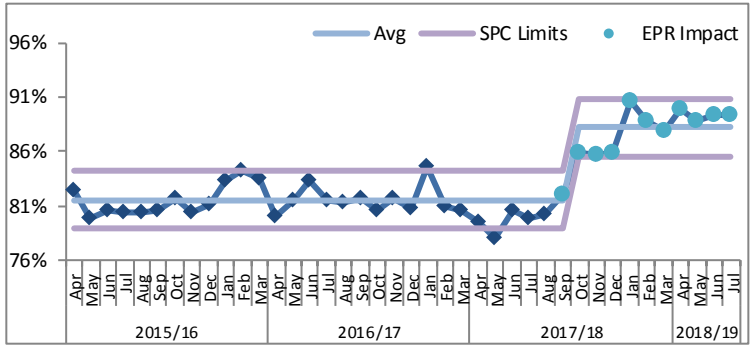
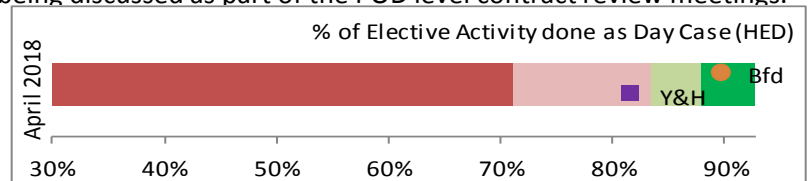
To deliver our financial plan and key performance targets

	Trend	Challenges and Successes	Comparison	Exec Lead
Length of Stay Elective		The trend continues to indicate an increase in elective length of stay (LoS). It is expected that the increased length of stay will correlate to the increased day case rate as this improvement is likely to have reduced the number of 1 day stays included in the data and increases the average. This is a trend that can be observed over time but with continued reductions evident post EPR. 		Chief Operating Officer
Length of Stay Non-Elective & Assessments		This indicator is impacted by data quality issues with elective day cases and ward attender patients being incorrectly recorded as non-elective admissions which will reduce the average length of stay. The Data Quality project team are focusing on a resolution for non-elective admissions to correct this position. Trends over time show a step change in the number of 0 and 1 day length of stays which is why the average has reduced. 		Chief Operating Officer

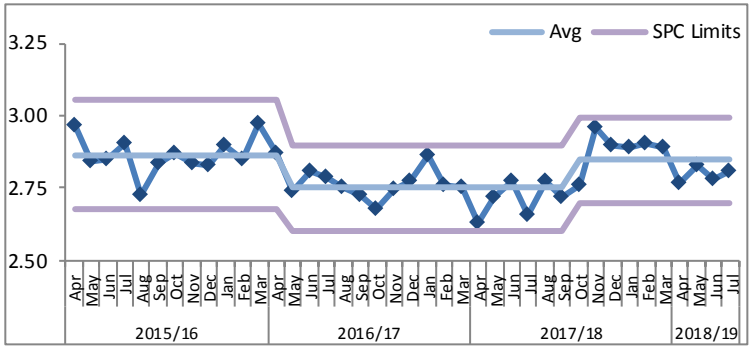
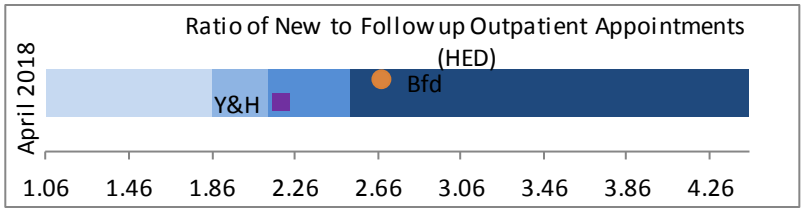
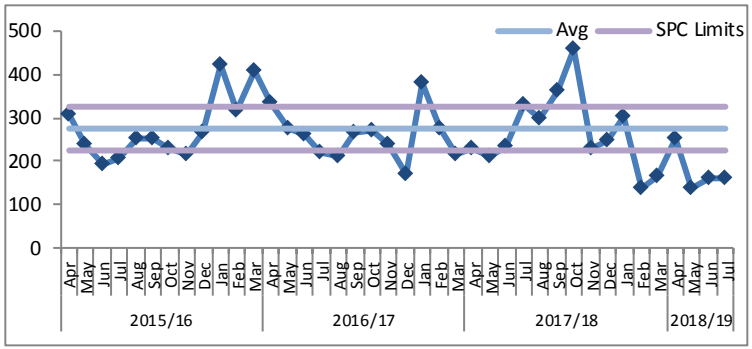
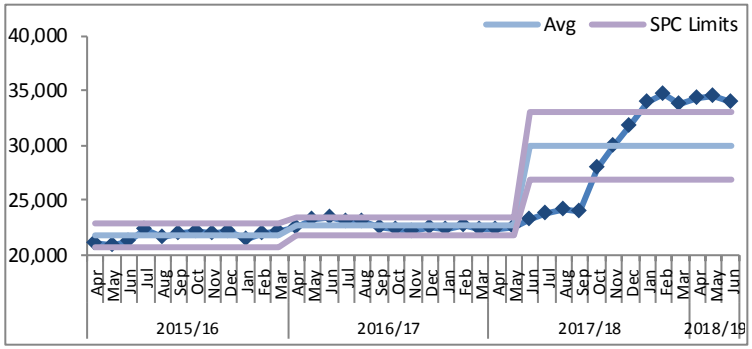
To deliver our financial plan and key performance targets

	Trend	Challenges and Successes	Comparison	Exec Lead
Bed Occupancy		Bed occupancy has been high in June and July 2018/19, particularly when compared to the same period in previous years. Attendances and admissions have also been high suggesting bed occupancy relates to an increase in volume but improving the length of stay (LoS) information would confirm or disprove this.		Chief Operating Officer
Discharges before 1PM		Increases in the proportion of discharges before 1pm were sustained into June 2018/19. Discharge targets by ward have been implemented with daily review.		Chief Operating Officer
Full Blood Count to Wards < 2 Hours		Performance has been achieved for the first 5 months since the introduction of this target.		Chief Operating Officer

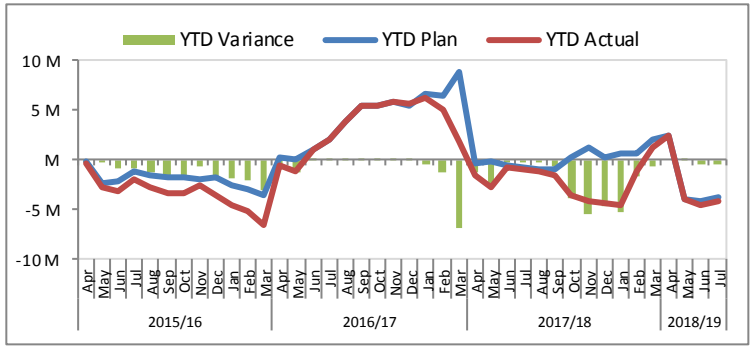
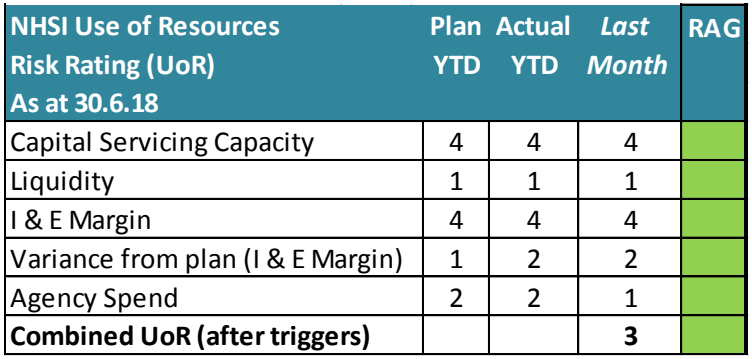
To deliver our financial plan and key performance targets

	Trend	Challenges and Successes	Comparison	Exec Lead
Did not Attend Follow-Ups		Whilst there has been improvement from two way texting in some specialities, the majority of this reduction is due to changes in recording. These are being investigated as potential data quality issues as a number of clinics have had no did not attends (DNAs) since go live.		Chief Operating Officer
Did not Attend New		Did not attend (DNA) rates have improved since implementation of two way texting in some specialties. Further work is to be undertaken by GE Consulting to optimise the benefits of two way texting. Data quality investigations will also extend to new appointments.		Chief Operating Officer
Elective Day Case Rate		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. This is being discussed as part of the POD level contract review meetings.		Chief Operating Officer

To deliver our financial plan and key performance targets

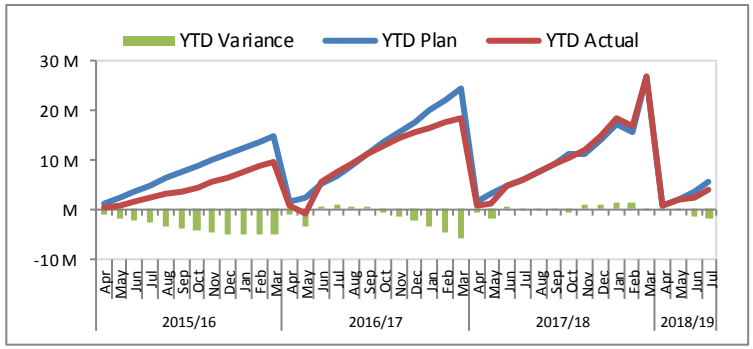
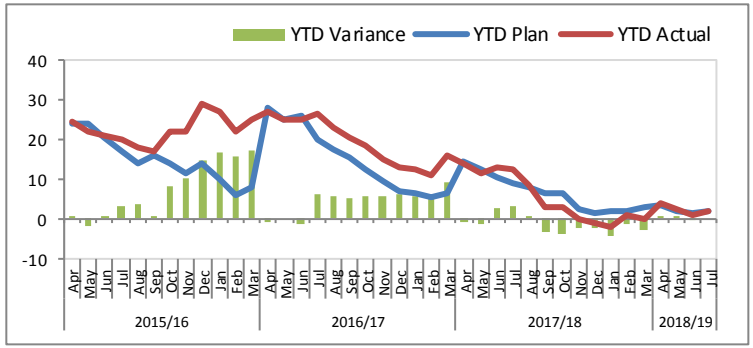
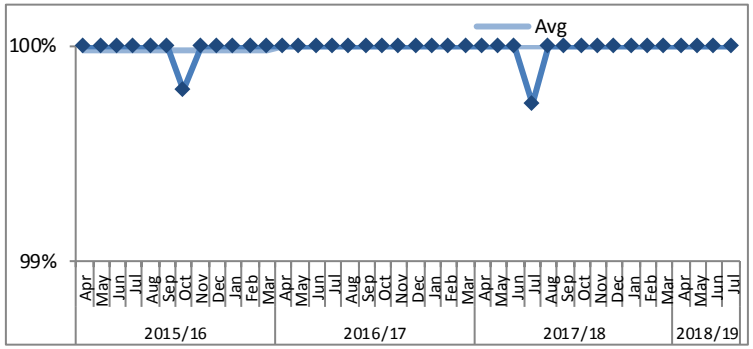
	Trend	Challenges and Successes	Comparison	Exec Lead
New to Follow-up Ratio		This metric is a continued focus within the Outpatient Improvement Programme. Activity trackers by specialty are now in place with monitoring via the Planned Care Delivery Group. 		Chief Operating Officer
Short notice Clinic Cancellations		Stable performance over the last five months below lower Statistical Process Control (SPC) limit.		Chief Operating Officer
Elective Wait List		A programme of validation to remove data quality issues has commenced. The Planned Care Recovery Programme as part of the Bradford Improvement Programme provides a weekly focus on waiting times, delivery of contracted activity and reduction in overall waiting list sizes. The total reported waiting list size has been relatively stable for the last 6 months. NHS Improvement Intensive Support Team (IST) review with positive feedback and recommendation to focus on Patient Tracker List (PTL) development.		Director of Governance & Operations

To deliver our financial plan and key performance targets

	Trend	Challenges and Successes	Comparison	Exec Lead
Delivery of Financial Plan		The month 4 2018/19 position is a pre-Provider Sustainability Fund (PSF) deficit of £5.9m which is in line with the planned deficit of £5.9m. The year to date position includes £1.8m of Provider Sustainability Fund income. This position is made up of 70% of the Quarter 1 2018/19 target (£1.1m) and full recovery of both financial and A&E performance targets in month 4 (£0.7m). This results in a post-Provider Sustainability Fund deficit of £4.1m which is £0.5m behind plan. The year end forecast presented in this table is full delivery of the financial plan and mirrors the forecast submitted to NHS Improvement on 15th August 2018. However internal modelling of the current run rate and forecast BIP delivery suggests it is now probable that the Trust will fall behind its financial plan after Quarter 3 2018/19 and if the proposed remedial actions are unsuccessful will fail to deliver its control total in 2018/19 by a significant margin.		Director of Finance
Use of Resources - Financial		The Trust's overall Use of Resources (UoR) rating is in line with plan at the end of month 4 2018/19. The plan for month 4 2018/19 is relatively unchallenging and the Trust planned to record the second highest risk rating for month 4 2018/19 (Use of Resources rating = 3). Complying with this plan is not an indictor of strong financial performance, as the Trust is showing the highest possible risk ratings for both capital service cover and income and expenditure margin, which is reflective of the year to date post-Provider Sustainability Fund deficit of £4.1m. The plan requires significant improvements in the remaining months of the financial year.		Director of Finance

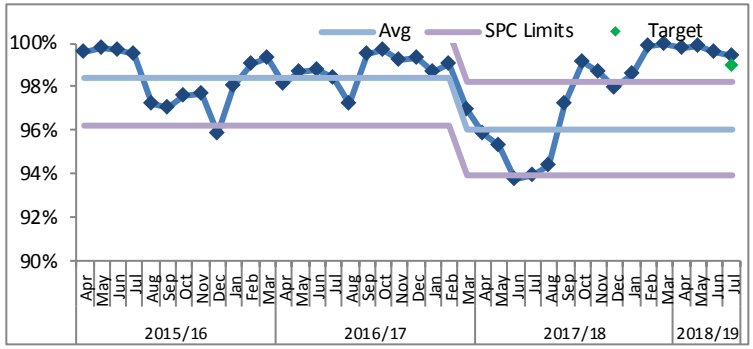
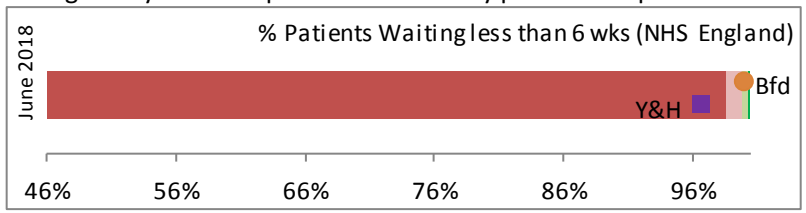
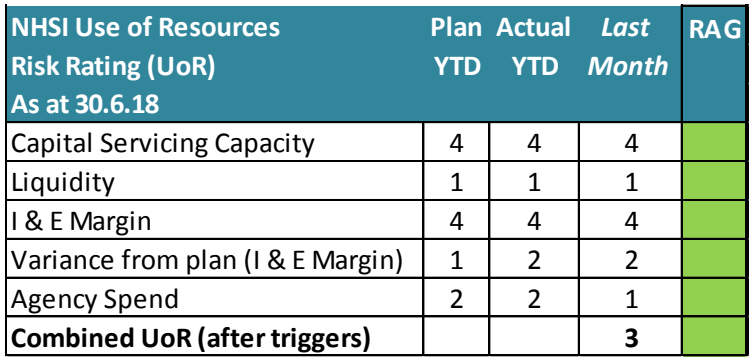
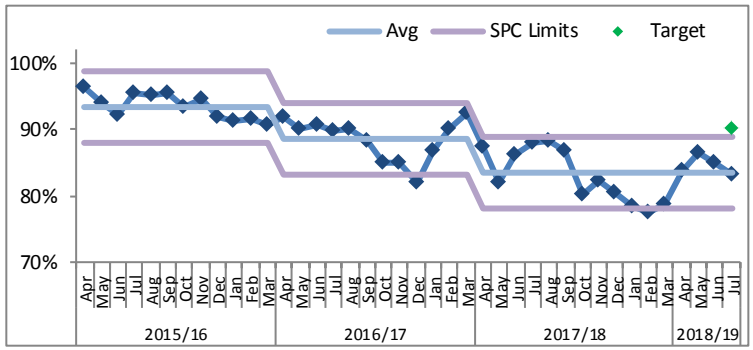
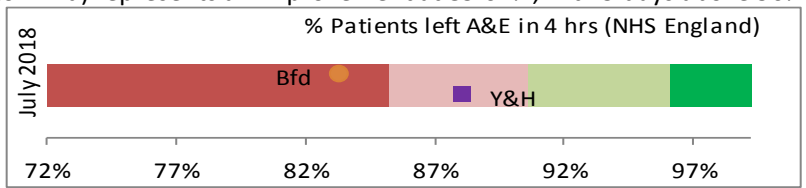
NHSI Use of Resources Risk Rating (UoR) As at 30.6.18	Plan YTD	Actual YTD	*Last Month*	RAG
Capital Servicing Capacity	4	4	4	
Liquidity	1	1	1	
I & E Margin	4	4	4	
Variance from plan (I & E Margin)	1	2	2	
Agency Spend	2	2	1	
Combined UoR (after triggers)			**3**	

To deliver our financial plan and key performance targets

	Trend	Challenges and Successes	Comparison	Exec Lead
Cost Improvement Plan		The Trust delivered £4.0m of efficiencies by the end of month 4 2018/19. This is £1.7m behind phased plans submitted by divisions and corporate departments and £4.5m behind an even monthly apportionment of the annual target, which would have required £8.5m of savings to be delivered by this time. A total of £0.8m of the year to date (YTD) efficiencies were delivered via technical non-recurrent adjustments. Divisions and corporate departments are currently forecasting delivery of £22.5m efficiencies, which would leave the Trust £3.1m short of the required £25.6m annual savings. A substantial element of these divisional plans requires significant additional work or are reliant on commissioners paying in excess of the contract. There is therefore a high degree of risk in this best case scenario forecast. Removing the high risk plans from this forecast results in total projected savings of £17.0m, which would leave the Trust £8.6m short of its target.		Director of Finance
Liquidity rating		Year to date (YTD) liquidity is 2.0 days, 0.2 days below plan. Liquidity is forecast to remain on plan, assuming the full delivery of the Trust's Bradford Improvement Programme (BIP), with an improved position from September 2018/19 onwards as a result of income and expenditure savings. From November 2018/19 liquidity is expected to decline due to capital spend which is largely profiled in Quarter 3 and 4 2018/19. The planned year end position is 1.3 days which is rated as level 1 on the NHS Improvement Use of Resources (UoR) metrics. If the Trust deliver £22m of improvements it will move into negative liquidity in Quarter 3 2018/19 as a result of its lower cash balances. The forecast year end position is liquidity of -7.6 which would result in the Use of Resources (UoR) score falling from 1 (planned) to 3. If the Trust delivers £17m of improvements, liquidity will fall to -15.2 days, leading to a Use of Resources (UoR) score of 4.		Director of Finance
Mission Critical Systems Uptime		The Trust continues to achieve a higher than target uptime for its mission critical systems.		Director of Informatics

National Indicators

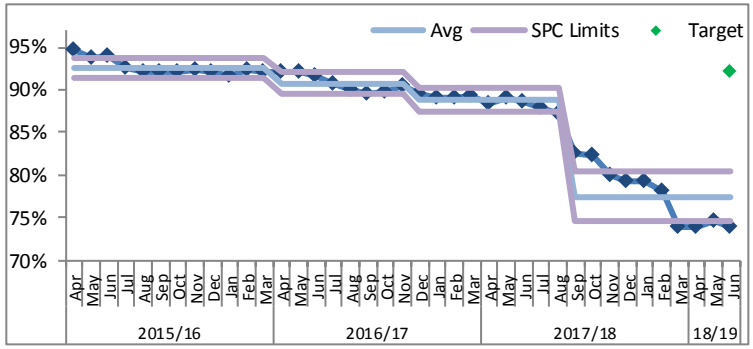
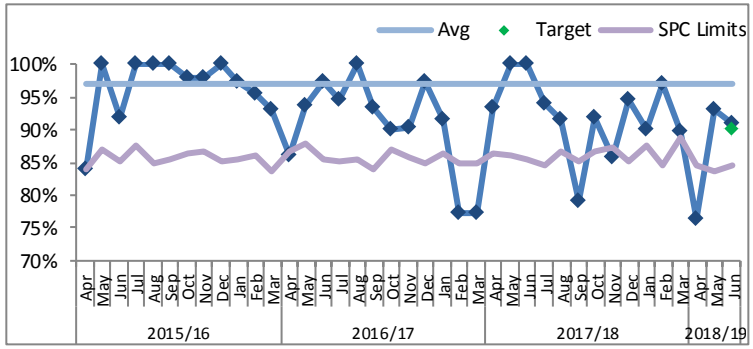
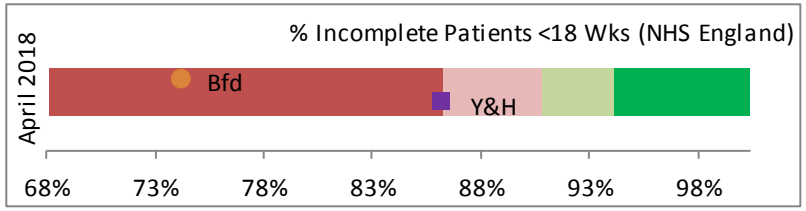
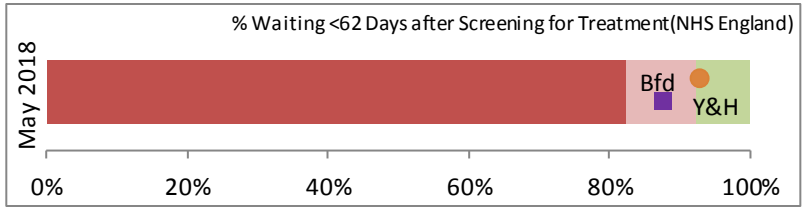
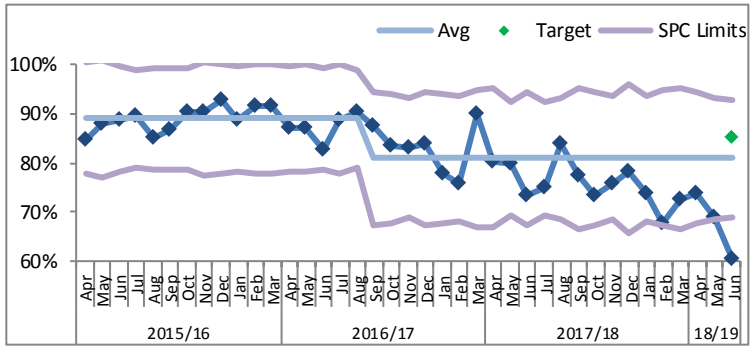
Single Oversight Framework

	Trend	Challenges and Successes	Comparison	Exec Lead
Diagnostic Waits		July DM01 reported 99.43% (28 breaches). This is better than target but excludes Endoscopy and Neurophysiology. Plans in place to improve the reporting for these two areas for inclusion from September 2018/19. Endoscopy position is significantly below target but backlog clearance underway with expected compliance from Quarter 3 2018/19. July breaches in MRI relate to a specific test. Capacity issues and national shortage of dye have impacted but recovery plans are in place.		Chief Operating Officer
Use of Resources - Financial		The Trust's overall Use of Resources (UoR) rating is in line with plan at the end of month 4 2018/19. The plan for month 4 is relatively unchallenging and the Trust planned to record the second highest risk rating for month 4 (Use of Resources rating = 3). Complying with this plan is not an indictor of strong performance, as the Trust is showing the highest possible risk ratings for both capital service cover and income and expenditure margin, which is reflective of the year to date post-Provider Sustainability Fund (PSF) deficit of £4.1m. The plan requires significant improvements in remaining months of the financial year.		Director of Finance
Emergency Care Standard		July 2018/19 performance (Type 1 and 3) was 83.12%. Attendances remained high in July 2018/19, particularly when compared to the same period over the last 10 years. Performance in August 2018/19 to date (up to 22nd) is 87.2% with 5 days at 90% or above. Performance for Type 1, 2 and 3 was 85.43% in July 2018/19, while August 2018/19 to date (up to 22nd) represents an improvement at 89.04%, with 9 days above 90%.		Chief Operating Officer

NHSI Use of Resources Risk Rating (UoR) As at 30.6.18	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	2	
Agency Spend	2	2	1	
Combined UoR (after triggers)			**3**	

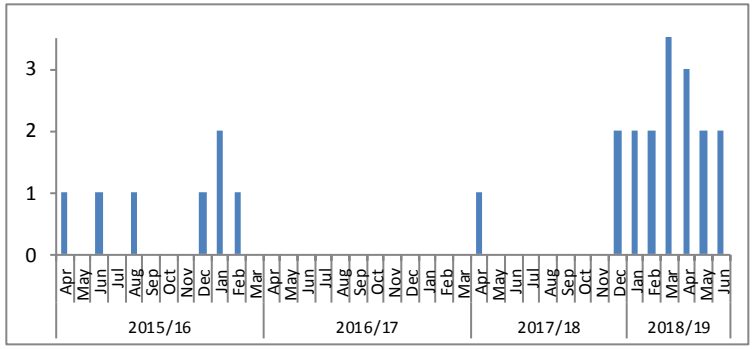
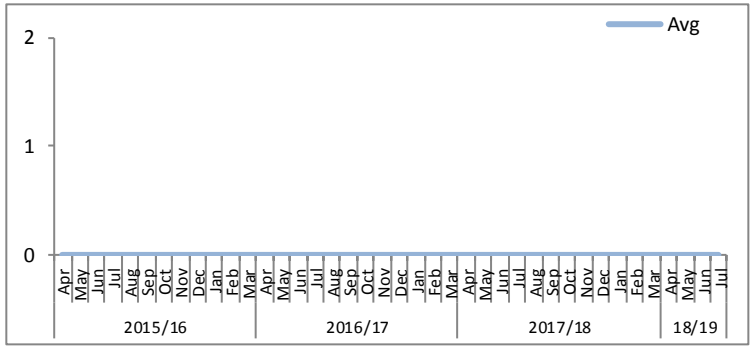
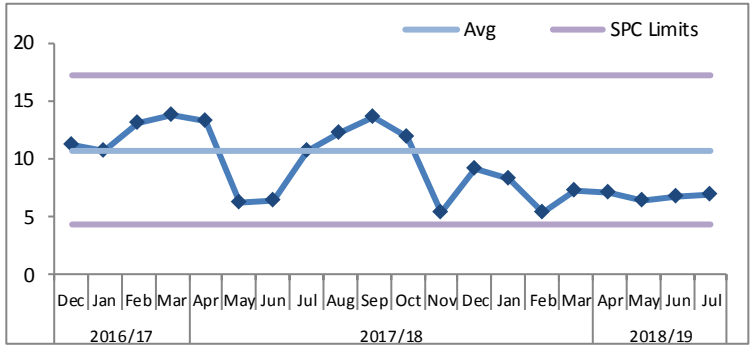
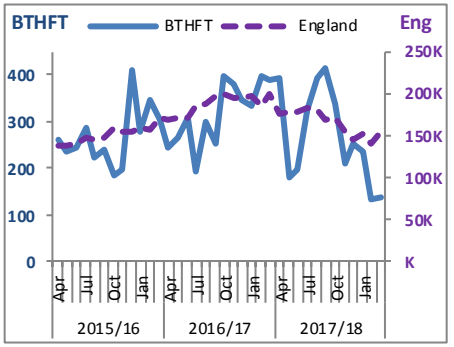
National Indicators

Single Oversight Framework

	Trend	Challenges and Successes	Exec Lead
RTT 18 Week Incomplete		Incomplete performance for July 2018/19 was 74.17% which is behind trajectory which was set at 76.20%. Long wait profiles are beginning to stabilise following a period of growth. Detailed recovery plans have been developed with all specialties as part of the Planned Care Recovery Programme with weekly review alongside the activity trackers.	Chief Operating Officer
Cancer Urgent 62 Day Screening		 This standard was achieved in June 2018/19 and projected to be achieved in July 2018/19. 	Chief Operating Officer
Cancer Urgent 62 Day GP		The projection for July 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. The cancer tracking team has been restructured and pathway audits by tumour site have commenced. NHS Improvement Intensive Support Team (IST) have offered support for capacity and demand modelling.	Chief Operating Officer

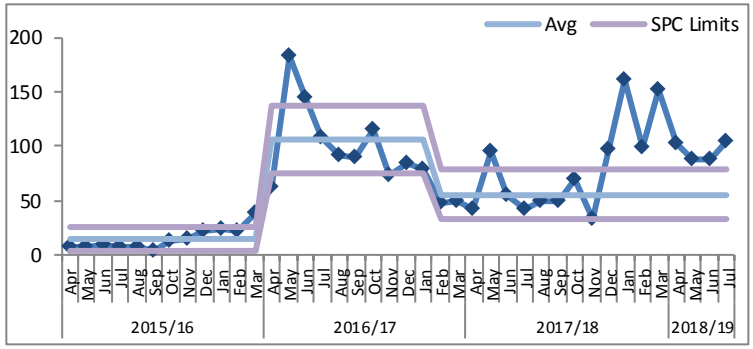
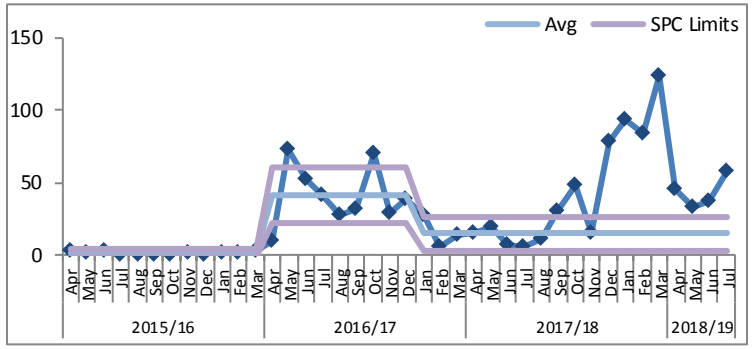
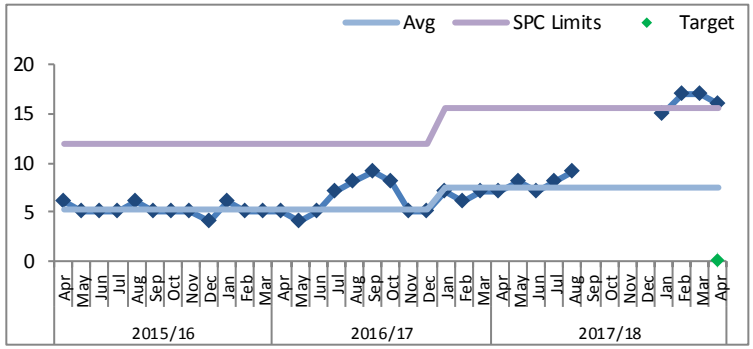
National Indicators

National Target – Non-Financial

	Trend	Challenges and Successes	Exec Lead
RTT 52 Week Wait		The weekly Planned Care Access group continues to review all long waiting patients on a weekly basis. The Trust reported 8 incomplete 52 week breaches in July 2018/19 and the prediction for August is currently 15. The position is expected to improve from September which is supported by the long wait trends but pressures in Vascular and General Surgery will need to be carefully monitored.	Chief Operating Officer
Trolley Waits > 12 Hours		There have been no over 12 hour trolley waits.	Chief Operating Officer
Delayed Transfers of Care		Delayed Transfers Of Care was maintained in July 2018/19 at less than 1% of occupied bed days and positive compared to the national standard of 3.5%. This represents a July 2018/19 average of 6.25 beds occupied per day. 	Chief Operating Officer

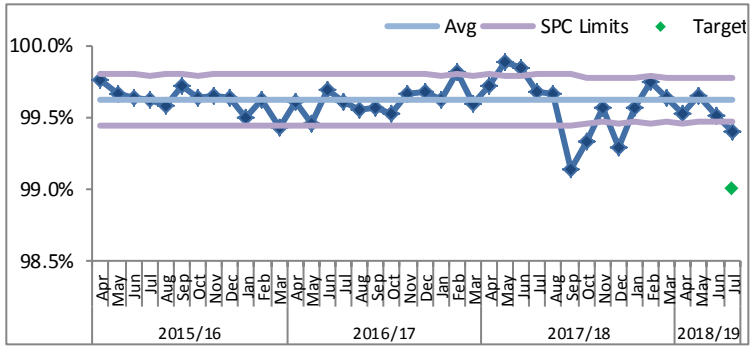
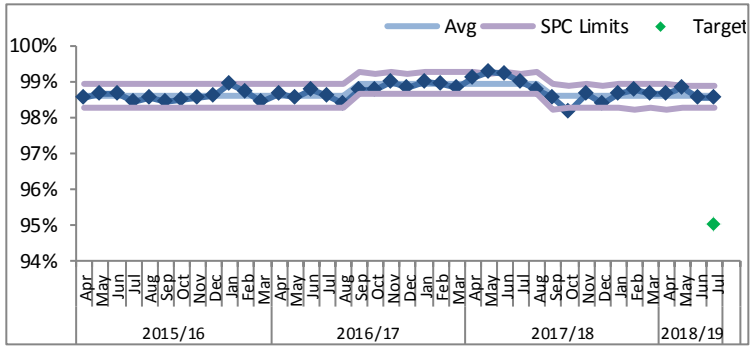
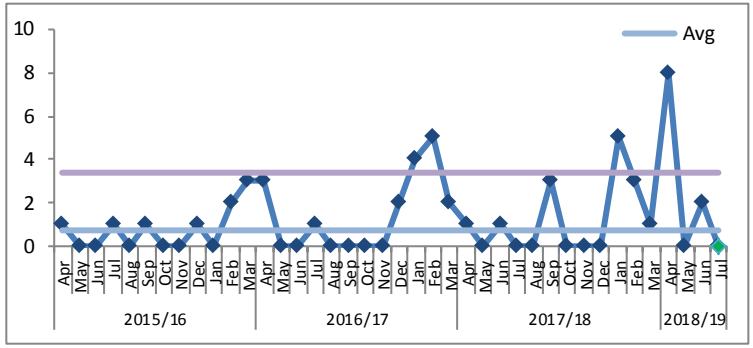
National Indicators

National Target – Non-Financial

	Trend	Challenges and Successes	Comparison	Exec Lead
Ambulance Handover 30-60 mins		The Trust is not currently meeting the standard for ambulance handover with performance in July 2018/19 increasing slightly from the previous month. Plans have been implemented as part of the Emergency Department Improvement Programme to further improve the position but high attendances continue to put pressure on performance.		Chief Operating Officer
Ambulance Handover >60 mins		The Trust is not currently meeting the standard for ambulance handover with performance in July 2018/19 increasing slightly from the previous month.		Chief Operating Officer
RTT Number of Specialties		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

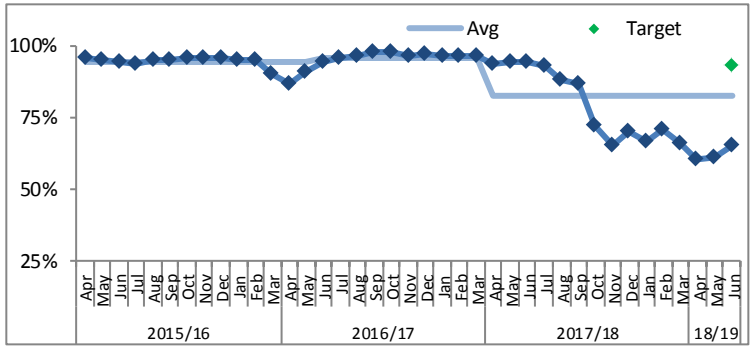
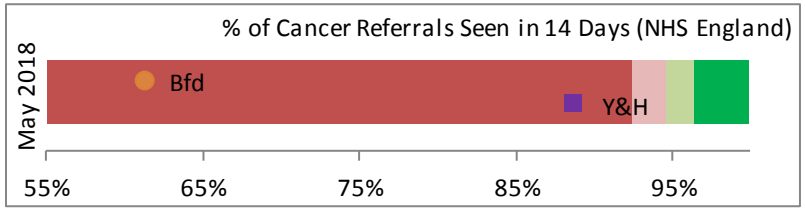
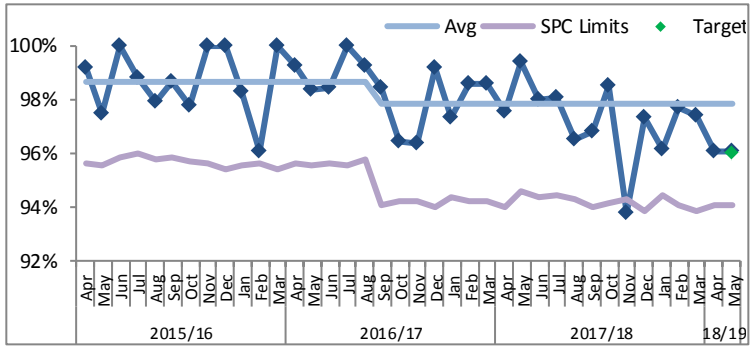
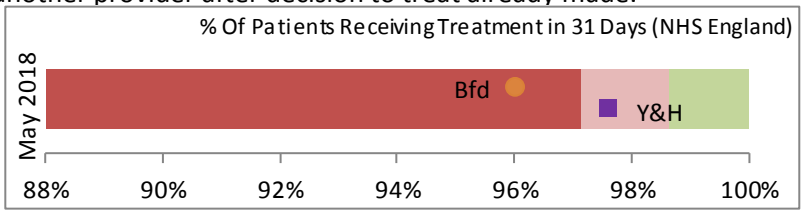
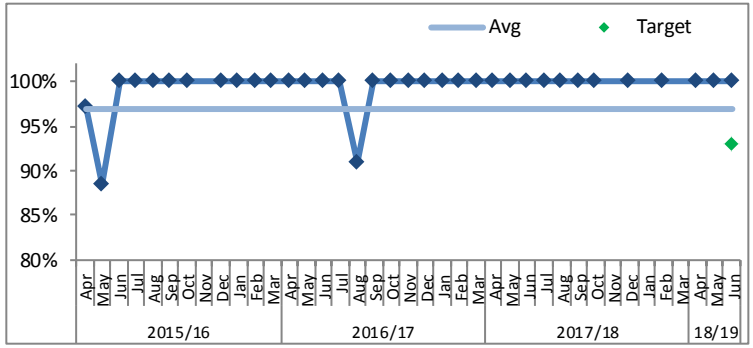
National Indicators

National Target – Non-Financial

	Trend	Challenges and Successes	Comparison	Exec Lead
NHS No's Acute		With the standardisation and integration of the Patient Administration System (PAS) 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
NHS No's A&E		With the standardisation and integration of the Patient Administration System (PAS0 data, as the one source of truth, the Trust compliance to NHS Number use is strong.		Director of Informatics
Cancelled Operations 28 day		There were no breaches of the 28 day standard in July 2018/19. There has however been an increase in the number of reportable same day cancellations and a number of these are expected to breach the 28 day standard in August. The weekly review cycle has been strengthened and now mirrors the Referral To Treatment 40+ process.		Chief Operating Officer

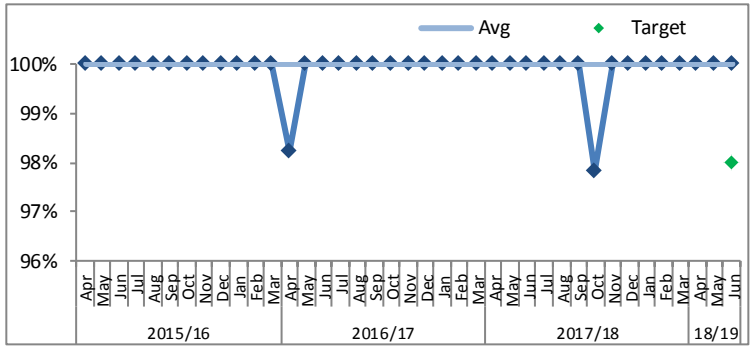
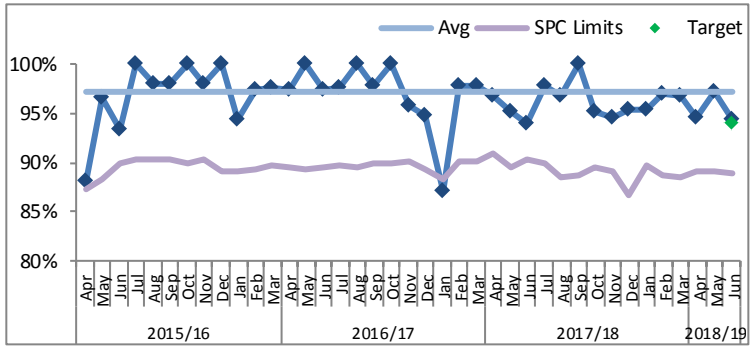
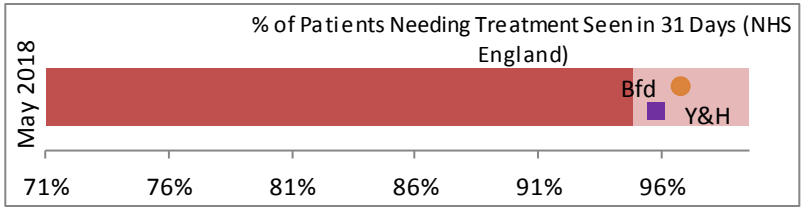
National Indicators

National Target – Non-Financial

	Trend	Challenges and Successes	Comparison	Exec Lead
Cancer 2 Week GP		Performance has not been achieved for June 2018/19 and is not predicted to be achieved for July 2018/19. The main issue remains the impact of Dermatology and Lower Gastrointestinal. Recovery plans are in place for all specialties and a central review of demand and capacity (using the NHS Improvement Intensive Support Team model) for all sites will be prioritised, the output of which will be built into recovery trackers to be used weekly by each management team.		Chief Operating Officer
Cancer 31 Day 1st Treatment		This standard was not achieved in June 2018/19 with 7 breaches mainly due to capacity but a couple relating to timely transfer from another provider after decision to treat already made.		Chief Operating Officer
Cancer 2 Week - Breast		This standard was achieved in June 2018/19 and projected to be achieved in July 2018/19.		Chief Operating Officer

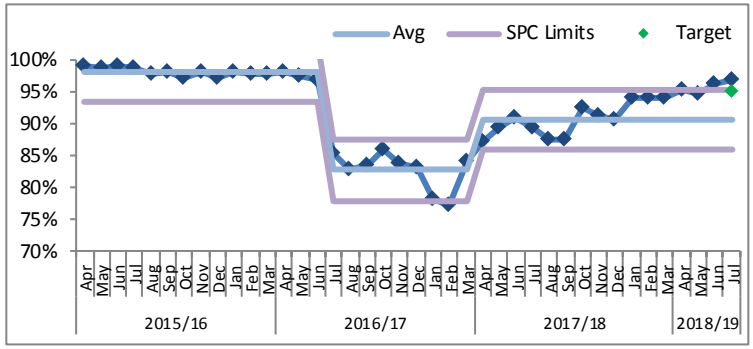
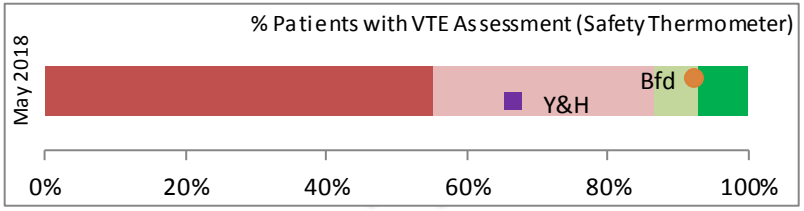
National Indicators

National Target – Non-Financial

	Trend	Challenges and Successes	Comparison	Exec Lead
Cancer 2nd Treatment Drugs		This standard was achieved in June 2018/19 and projected to be achieved in July 2018/19.		Chief Operating Officer
Cancer 2nd Treatment Surgery		This standard was achieved in June 2018/19 and projected to be achieved in July 2018/19.		Chief Operating Officer

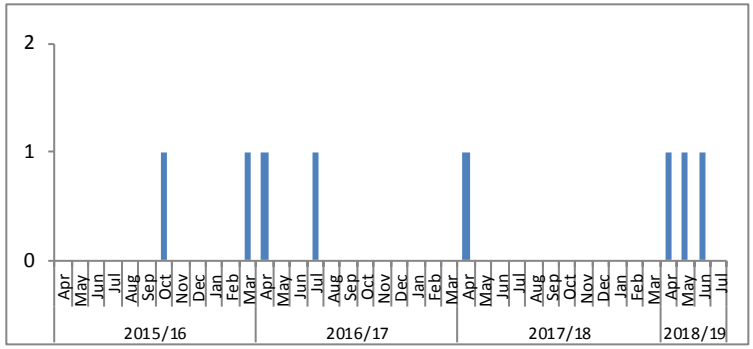
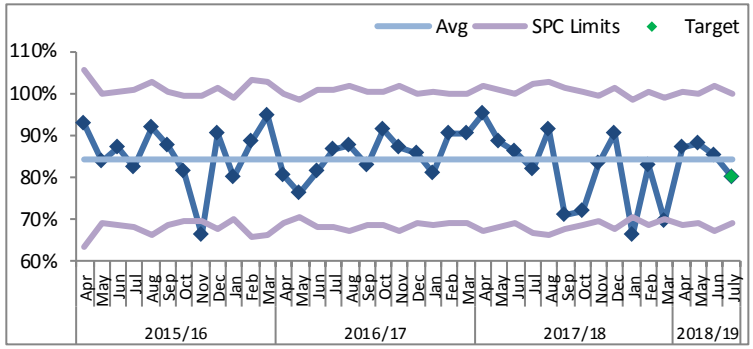
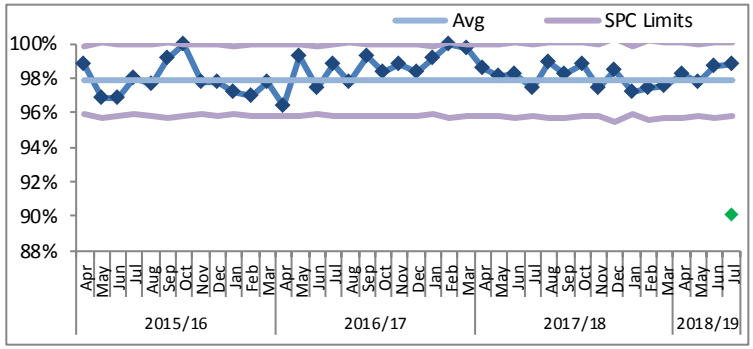
National Indicators

National Target – Non-Financial

	Trend	Challenges and Successes	Comparison	Exec Lead
VTE Assessment		Significant progress has been made in Venous Thromboembolism (VTE) assessments with the average for the past 4 months achieving the standard of > 95%. 		Medical Director
Formulary	The Trust ensures that the Formulary is published on the website		No comparator data is available.	Director of Informatics

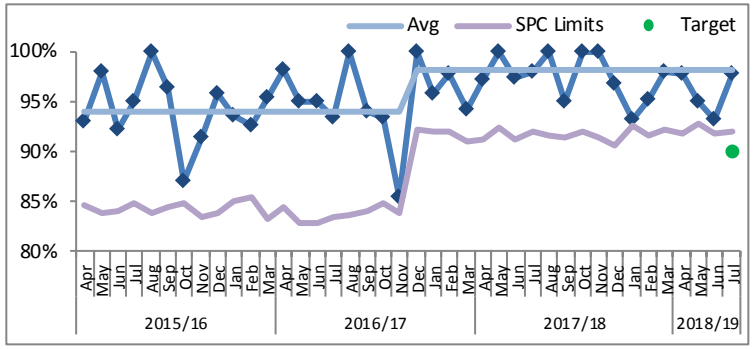
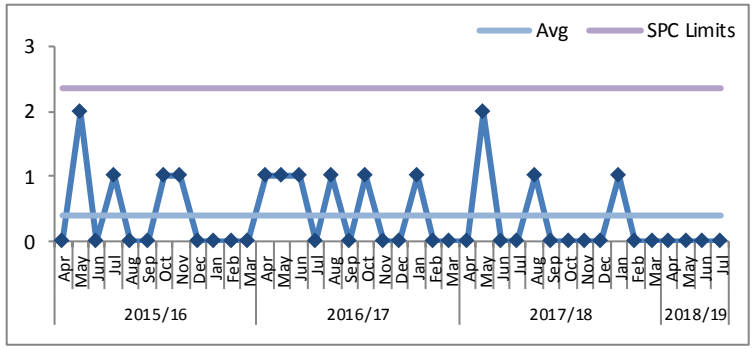
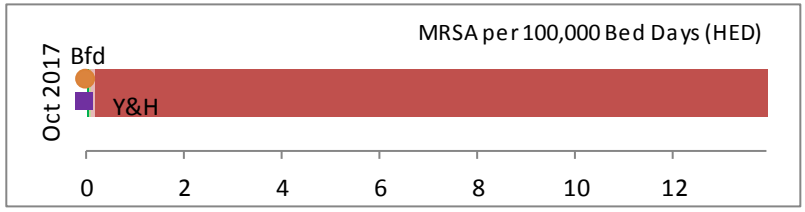
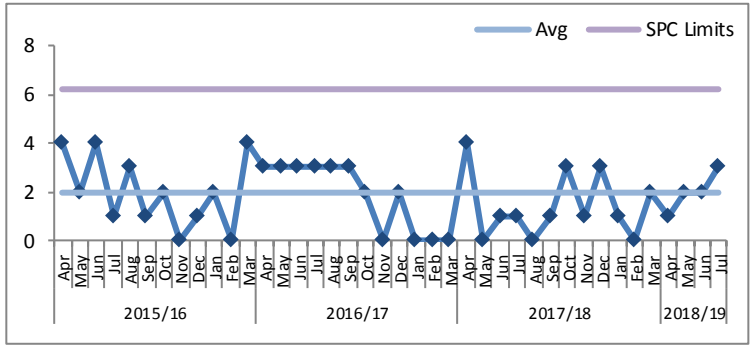
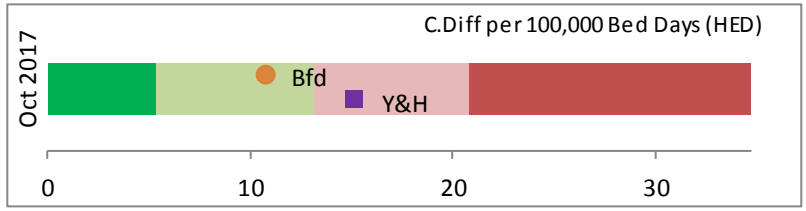
National Indicators

National Target – Financial

	Trend	Challenges and Successes	Comparison	Exec Lead
Never Events		There were no never events for July 2018/19.	No comparator data is available.	Chief Operating Officer
Stroke Strategy		This indicator was achieved in July 2018/19 as 80% 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
Seen By Midwife <13 Weeks		The threshold continues to be achieved.		Chief Operating Officer

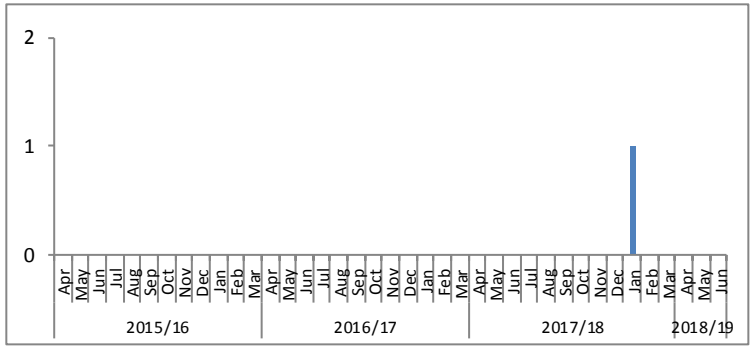
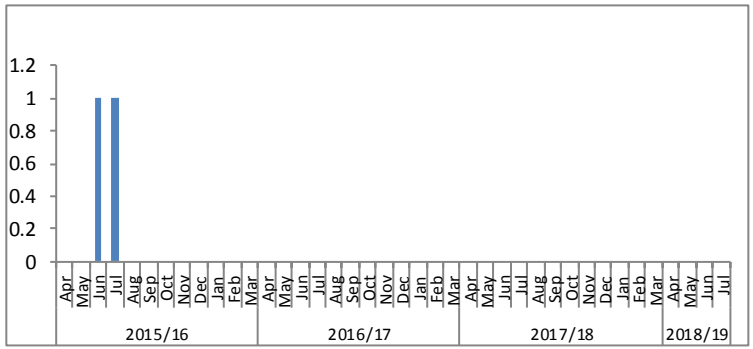
National Indicators

National Target – Financial

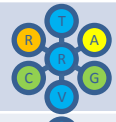
	Trend	Challenges and Successes	Comparison	Exec Lead
Seen By Midwife > 12 Weeks		The threshold continues to be achieved.		Chief Operating Officer
MRSA		Zero year to date (YTD).		Chief Nurse
C. Difficile		Sustained reduction in Clostridium Difficile (C. Diff) has been achieved. A robust Post Infection Review process is in place. Below trajectory.		Chief Nurse

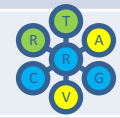
National Indicators

National Target – Financial

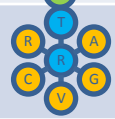
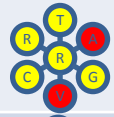
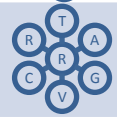
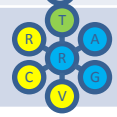
	Trend	Challenges and Successes	Comparison	Exec Lead
Duty of Candour		There were no Duty of Candour breaches in July 2018/19.		Director of Governance & Corporate Affairs
Mixed Sex Breaches		There have been no Mixed Sex Breaches.		Chief Operating Officer

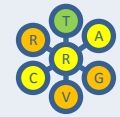
Glossary

Indicator	Definition	Data Quality Kite-Mark
To provide outstanding care for our patients		
Mortality		
Crude Mortality	Crude Mortality rates, i.e., per admissions.	
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.	
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.	
Infections		
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	

Indicator	Definition	Data Quality Kite-Mark
Harm Free Care		
VTE Assessment	VTE risk assessments completed Red < 90%, Amber >=90% & < 95%, Green >=95%	
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	
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%	
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	
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	

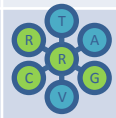
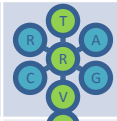
Glossary

Indicator	Definition	Data Quality Kite-Mark
Patient Experience		
Complaints	Number of complaints. Red >= 50, Amber 40-49, Green < 40	
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 Red > 0, Green = 0	
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%	
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%	
Information Governance Breaches	The number of reported breaches of the information governance standards Red > 6, Amber <=6 & > 2, Green <=2	

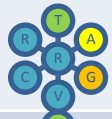
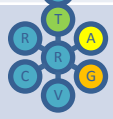
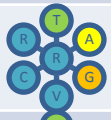
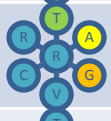
Indicator	Definition	Data Quality Kite-Mark
Audits		
Audit of WHO Checklist	Audit of the World Health Organisation surgical checklist monitoring the number that were complete compared to the number of checklists Red < 90%, Amber >=90% & < 95%, Green >=95%	
Serious incidents	Unexpected or avoidable death, serious harm, never events, service delivery prevention compared to all incidents reported 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.	
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	
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	

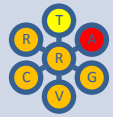
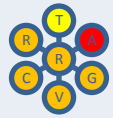
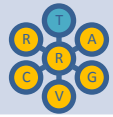
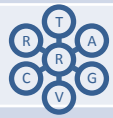
Glossary

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%	

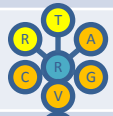
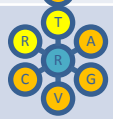
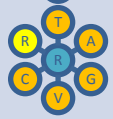
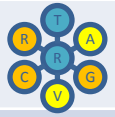
Indicator	Definition	Data Quality Kite-Mark
To be in the top 20% of employers in the NHS		
Appraisals		
Appraisal Rate Non-Medical	% of eligible staff employed at the trusts who have had an appraisal in the last 12 months. Red <75%, Amber >=75% and <95%, Green >=95%	
Experience		
BAME % Senior Leaders	% of staff employed in Band 8+ Senior Manger 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	

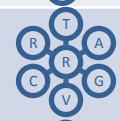
Glossary

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	

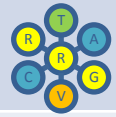
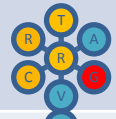
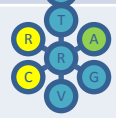
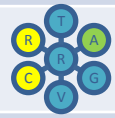
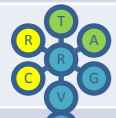
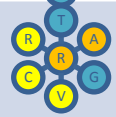
Indicator	Definition	Data Quality Kite-Mark
To deliver our financial plan and key performance targets		
In-Patient Productivity		
Length of Stay Elective	The average length of stay for elective patients, in days. The benchmark data is for Acute trusts for June 2017 from HED, which has a subtly different 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		
Mission Critical Systems Uptime	Percentage of time all Mission Critical Systems were up and running Red <99.7%, Amber >=99.7% & < 99.9%, Green >=99.9%	
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%	

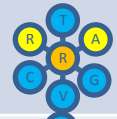
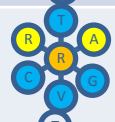
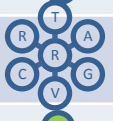
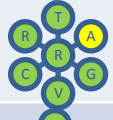
Glossary

Indicator	Definition	Data Quality Kite-Mark
Out-Patient Productivity		
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%	
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%	
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%	
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	
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.	

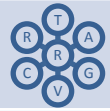
Indicator	Definition	Data Quality Kite-Mark
Finance		
Delivery of financial plan	Delivery of finances against plan.	
Use of Resources - Financial	Use of resources is a calculation on the status of a number of financial measures – Capital Servicing Capacity, Liquidity, I & E Margin, and Agency Spend.	
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.	

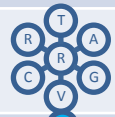
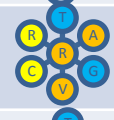
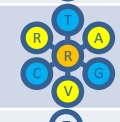
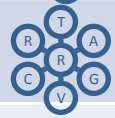
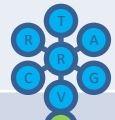
Glossary

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%,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%, Green >= 90%	
RTT 18 Week Incomplete	Percentage of patients waiting within 18 weeks on an incomplete pathway. Red < 92%, Green >= 92%	
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%	
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%	
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	

Indicator	Definition	Data Quality Kite-Mark
Non-Financial continued		
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	
Ambulance Handover 30-60 mins	Ambulance handover taking longer than 30 – 60 minutes to handover. Red > Same Month LY, Green <=Same Month LY	
Ambulance Handover >60 mins	Ambulance handover taking longer than 60 minutes to handover. Red > Same Month LY, Green <=Same Month LY	
RTT # Specialties	Number of specialties not achieving RTT incomplete. Red > 0, Green = 0	
NHS # field completion acute	Completion of valid NHS # field in acute commissioning data sets submitted via SUS Red < 99%, Green >= 99%	
NHS # field completion AED	Completion of valid NHS # field in AED commissioning data sets submitted via SUS. Red < 95%, Green >= 95%	
Cancelled Operations 28 Days	Number of patients who were cancelled on day of surgery and subsequently not been treated. Red > 0, Green = 0	

Glossary

Indicator	Definition	Data Quality Kite-Mark
Non-Financial continued		
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%	
Cancer 1st 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%	
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%	
Cancer 2nd Treatment Drugs	Proportion of patients waiting no more than 31 days for second or subsequent drug treatments. Red < 98%, Green >= 98%	
Cancer 2nd Treatment Surgery	Patients that require further surgery following initial treatment should receive treatment within 31 days . Red < 94%, Green >= 94%	
VTE Assessments	VTE risk assessments completed. Red < 90%, Amber >= 90% & < 95%, Green >= 95%	
Formulary published	Hospital formulary is published on the Trust's external website. Red Not published, Green Published	

Indicator	Definition	Data Quality Kite-Mark
Financial		
Never Events	The number of serious incidents that occur despite there being defined processes and procedures to prevent them. Red > 0, Green = 0	
Stroke Strategy	Implementation of the Stroke Strategy – patients who spend at least 90% of their time on a stroke unit. Red < 80%, Green >= 80%	
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%	
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%	
MRSA	Counts of patients with Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia. Red > 0, Green = 0	
C Difficile	Number of cases either attributable or pending review. Red > 4, Amber 3, Green <3	
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.