Bradford Teaching Hospitals
NHS Foundation Trust

Integrated Dashboard
Board of Directors

30th September 2018

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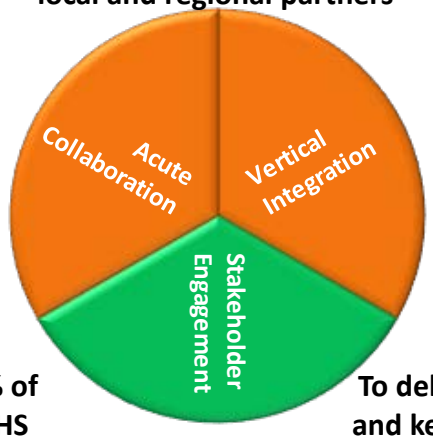
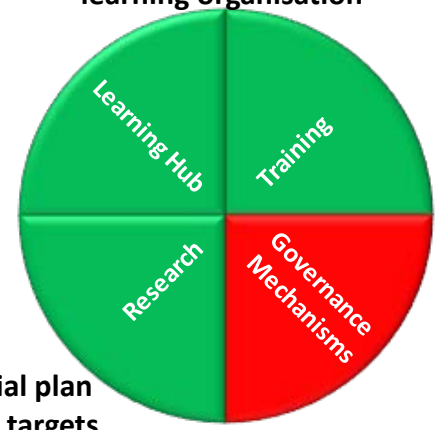
To provide outstanding care for our patients

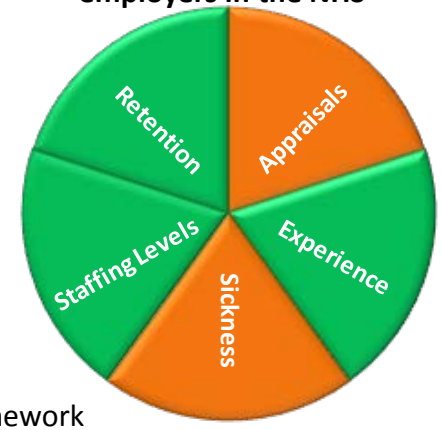
To collaborate effectively with local and regional partners



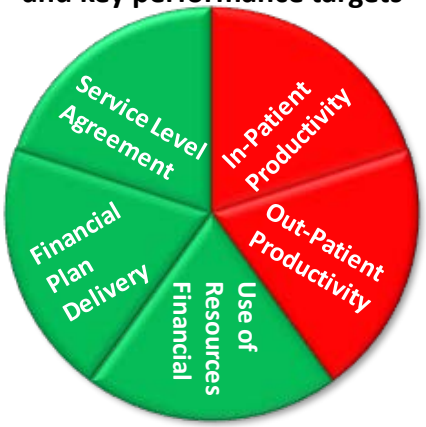
To be a continually learning organisation



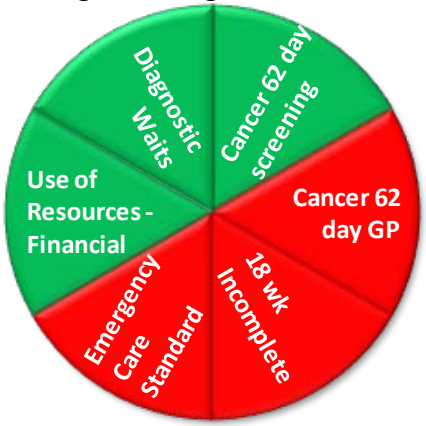
To be in the top 20% of employers in the NHS



To deliver out financial plan and key performance targets



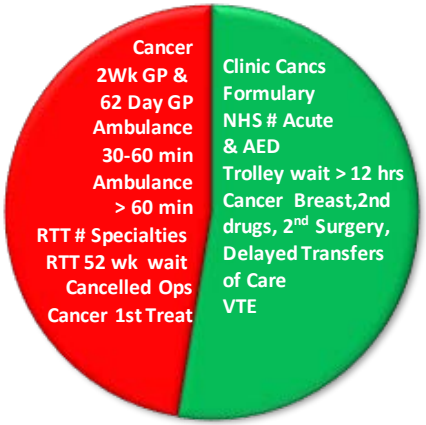
Single Oversight Framework



National targets

Financial

Non-Financial



Headlines

Partnership - The West Yorkshire and Harrogate Health and Care Partnership's Memorandum of Understanding was approved by the Trust's Board of Directors in September 2018. A compromise solution has been proposed and accepted regarding the membership of the Partnership's System Oversight and Assurance Group (SOAG) to ensure both sectors and places are represented. SOAG is the primary governance forum to oversee the Partnership's mutual accountability arrangements.

Delivery of Financial Control Total - Current projections suggest that without a material step change in Income & Expenditure run rates the Trust will fail to deliver its control total in 2018/19. The projected run rate could additionally result in significant cash flow problems before the end of the financial year.

Emergency Care Standard performance was 81.5%, which is behind the plan of 90.0%. The Trust has dropped to 115 of 134 providers. Attendances remain consistently high with increased admissions and high bed occupancy. The correlation between attendances and performance is weak but capacity modelling undertaken by NHS Improvement has identified a significant gap in daytime decision makers in comparison to demand and the physical space modelling shows a gap of Majors cubicles. Tactical solutions ahead of winter are progressing with increased staffing, expansion of minors capacity and a focus on ambulatory pathways. Transformational work around enabling systems is underway to introduction the Command Centre next year and recovery to plan by year end.

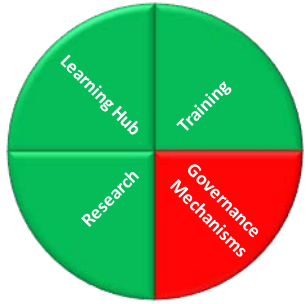
Strong performance has been maintained on a number quality indicators including VTE, Clostridium difficile, HSMR and MRSA.

The progress report for the Maternity Be the Best programme was presented by the Chief Operating Officer to the October 2018 Quality Committee meeting. The Committee recognised the further work that had been addressed to date and recognised the longer term ambitions. In particular the high appraisal and mandatary training rates were noted.

Quality Dashboard
30th September 2018

To provide outstanding care for our patients

To be a continually learning organisation



The progress report for the Maternity Be the Best programme was presented by the Chief Operating Officer to the October 2018 Quality Committee meeting. The Committee recognised the further work that had been addressed to date and recognised the longer term ambitions. In particular the high appraisal and mandatary training rates were noted.

There has been significant improvement on the sepsis indicators following the improvement programme, noting the positive impact of the EPR and the appointment of the sepsis nurse.

The readmission rates, linked to data from EPR, continues to show a higher level than baseline. The Chief Operating Officer is investigating the data prior to consideration of any further action or review of potential harm.

Strong performance has been maintained on a number indicators including VTE, Clostridium difficile, HSMR and MRSA.

Patient Experience Strategy - The Committee was consulted on their views for the forthcoming Patient Experience Strategy. Overall support for - the spirit of kindness.

Two Never Events were discussed: Retained swab. Extended learning from this will be incorporated into the Maternity be the Best Programme. Wrong route medication was deemed not to meet the definition of a never event remains a SUI.

Workforce Dashboard
30th September 2018

Non-Medical Appraisal rates continue to improve with robust monitoring and support in place at divisional and department level to enable us to meet the Trust's target of 95% by end of December 2018.

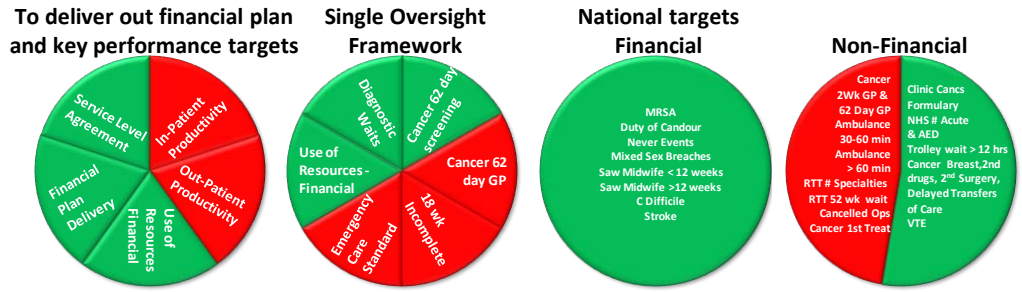
Year to date sickness absence rates continue to show a slight month-on-month deterioration. The Health, Well-being and Attendance Management Policy has been renewed and additional interventions and support put in place where we are seeing the biggest increases. An exception report will be provided to Workforce Committee in November whereby we will assess the achievability of hitting our 4% target.

Nursing Shifts/Care Shifts continue to maintain the average nursing numbers of previous months. Over the last month there has been a decrease in the number of incidents raised in relation to nurse staffing.

Agency use has reduced in September 2018 and we remain below our target spend. Agency HEA usage has decreased significantly due to improved bank recruitment and fill rates.

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

Finance & Performance Dashboard 30th September 2018



Emergency Care Standard performance was 81.5%, which is behind the plan of 90.0%. The Trust has dropped to 115 of 134 providers. Attendances remain consistently high with increased admissions and high bed occupancy. The correlation between attendances and performance is weak but capacity modelling undertaken by NHS Improvement has identified a significant gap in daytime decision makers in comparison to demand and the physical space modelling shows a gap of Majors cubicles. Tactical solutions ahead of winter are progressing with increased staffing, expansion of minors capacity and a focus on ambulatory pathways. Transformational work around enabling systems is underway to introduction the Command Centre next year and recovery to plan by year end.

RTT performance was 75.1%, behind a plan to be at 80.5%. The Trust is in the bottom 5 nationally. The total waiting list size has reduced by over 1,000 for the second consecutive month and performance has been consistent all year suggesting capacity and demand are in balance. The work to manage the longest waits has resulted in the number over 40 week waiters reducing significantly. Backlog clearance plans are being reviewed for each specialty in a series of RTT deep dives which will confirm the additional activity needed and how this will be delivered. Recovery to plan by year end carries additional financial cost.

Cancer 2 week wait performance in August 2018 was 59.7% which remains behind plan and is a deterioration on previous months. The Trust is now ranked bottom nationally following a sustained period of increased referrals. The introduction of a weekly 2WW dashboard is supporting the monitoring of specialty level recovery. It is anticipated that the increased capacity planned for Dermatology and Urology (who together contribute 69% of breaches) will mean visible improvement from November 2018 and a return to trajectory in the final quarter of the year.

Cancer 62 day treatment performance was 62.5% in August which remains behind plan. The deterioration is linked to growth in demand and lost productivity post-EPR. Lung and Endoscopy improvements are expected next month. Urology represents 63% of the breaches. Following regional pathway audit, additional funding have been allocated for diagnostic and surgical capacity. A regional solution is being agreed for clinical oncology capacity; a major contributor to delays.

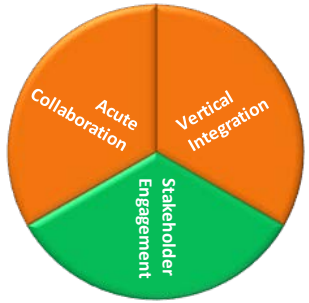
The Trust has delivered its pre-Provider Sustainability Funding (PSF) control total deficit of £8.4m at the end of Quarter 2. Liquidity is 1.4 days which is 0.2 days below plan. Cash balances are £6.6m below plan. The overall Use of Resources Risk Rating is 3 which is in line with plan.

The current Income & Expenditure (I&E) run rate and projected delivery of efficiencies via the Bradford Improvement Programme suggest the Trust is unlikely to deliver its 2018/19 control total at the end of the financial year. There are a number of key variables which remain unresolved and could adversely impact the 2018/19 I&E forecast by material amounts. These variables are unlikely to be fully resolved in Quarter 3 and at present make it impossible to present an accurate year end forecast.

The current best case forecast is a pre-PSF deficit of £12.5m, which is £5m below the £7.5m deficit control total. The worst case forecast is a deficit of £29.1m. The mid-case forecasts is a deficit of £17.5m which is £10m below the control total. Under all of these scenarios, the Trust would suffer significant cash flow problems and risks running out of cash at the end of 2018/19 or in early 2019/20. Actions to reduce planned capital and revenue expenditure and improve working capital management must be considered to protect the Trust's cash position to prevent reliance on external support.

Partnership Dashboard
30th September 2018

To collaborate effectively with local and regional partners



Vertical Integration - The Committee noted the ongoing work to draft a Partnering Agreement between partners in Bradford and agreed to continue to support this work. A common approach had been agreed with Airedale, Wharfedale and Craven and the two Partnership Boards would now work together on consistent agreements to be signed by the end of March 2019. The Committee reflected upon the need to ensure the arrangement will link to the work being done around governance with the West Yorkshire and Harrogate Health and Care Partnership and that all partners needed to clarify what the anticipated end point for the work will be. The committee acknowledged the positive work that was being undertaken to redesign the diabetes pathway, improve intermediate care and develop Community Partnerships across Bradford.

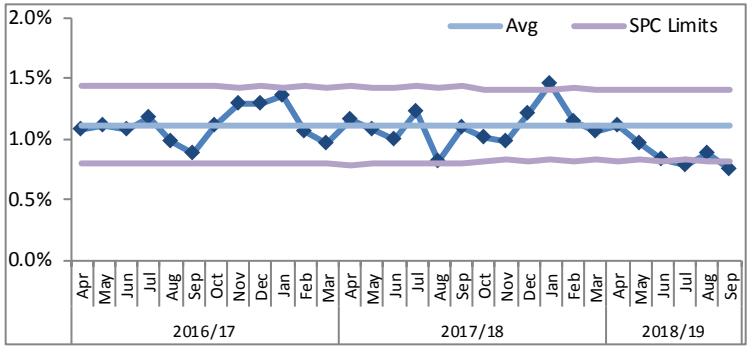
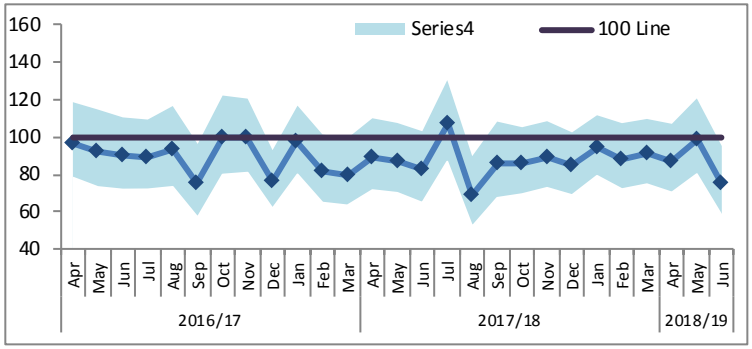
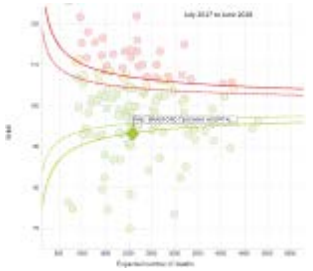
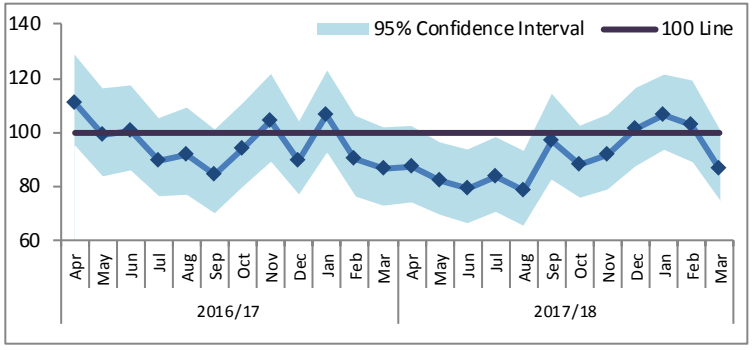
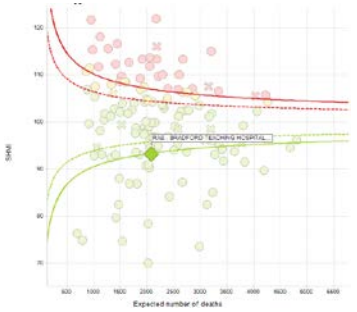
Airedale Collaboration - The Committee noted further positive progress in this area, with both Trusts agreeing they would like to proceed using a "whole service approach" to collaboration. The committee discussed the recent meeting between senior representatives from AFT, BTHFT and NHSE/I, and how the two Trusts are working together on the next steps following this meeting. The committee acknowledged that the current close alignment between the Trusts on the strategic goal to work together, and that BTHFT must look to ensure that this alignment continues.

Horizontal Integration - The Committee noted that the Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership was taken to the Trust's September 2018 Board of Directors meeting for approval. A compromise solution regarding the representation of places and sectors at the System Oversight and Assurance Group has been proposed, following feedback from the Trust's Board of Directors. The Committee noted that the Memorandum of Understanding will be signed at the next System Leadership meeting in November 2018. The Committee noted that the decision regarding the location of an arterial centre is still in the process of being approved by NHS England and that a formal decision is expected this year.

Stakeholder Engagement - The Committee recognised the excellent work that has gone into putting the infrastructure in place, identifying account managers and monitoring relationships. The challenge now is to make sure these processes add value, genuinely improve stakeholder relations, and enable us to identify quickly when a relationship is deteriorating and take action.

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 learning from deaths report.		Chief Medical Officer
Hospital Standardised Mortality Ratio		Our Hospital Standardised Mortality Ratio (HSMR) continues to be better than expected.		Chief Medical Officer
Summary Hospital-level Mortality Indicator		The SHMI has remained unchanged and demonstrates good performance.		Chief Medical Officer

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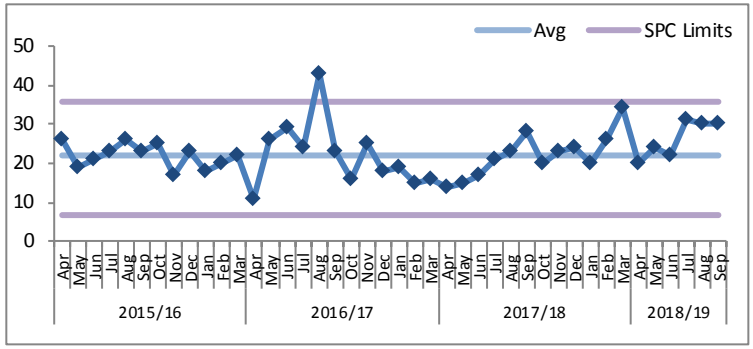
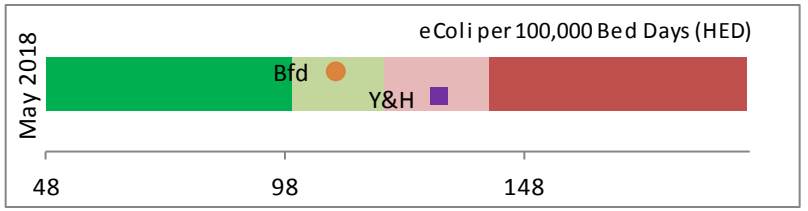
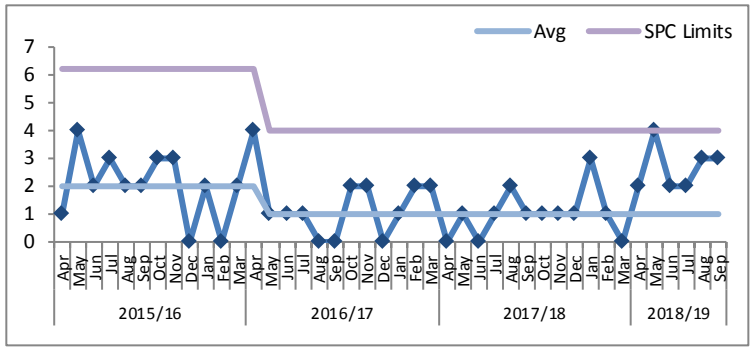
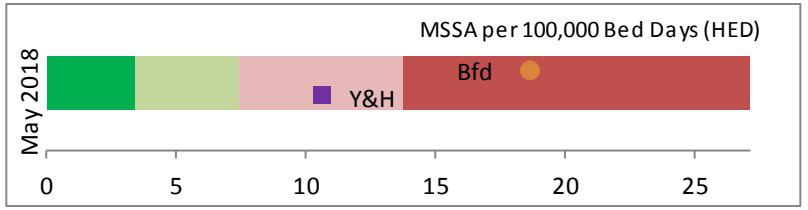
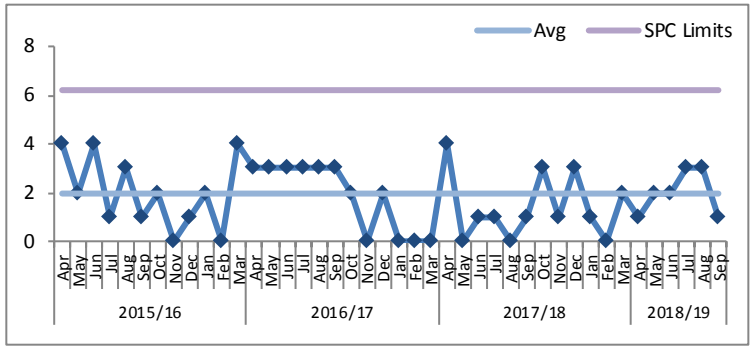
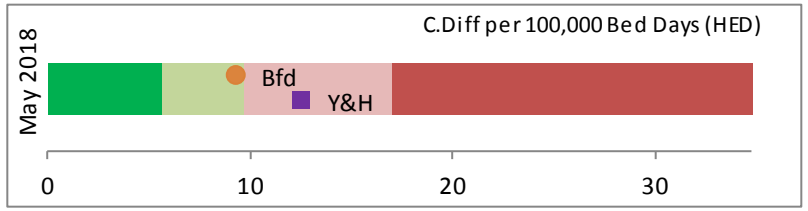
eColi		As part of the 2018/19 work plan we will focussing on all bacteraemias. We have seen a reduction of 26% on the previous 12 months (NHS Improvement).		Chief Nurse
MSSA		Part of national improvement collaborative for Infection Prevention and Control (IPC). Ongoing improvements are overseen by Infection 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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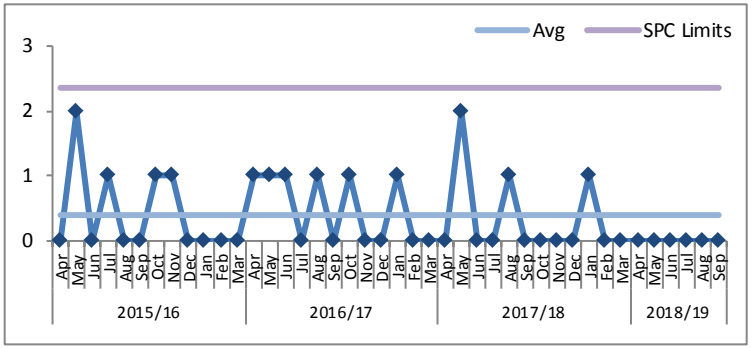
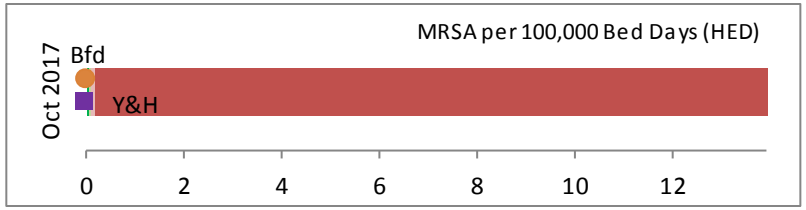
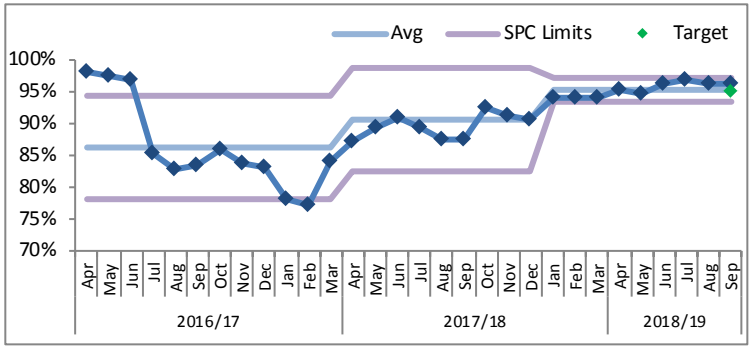
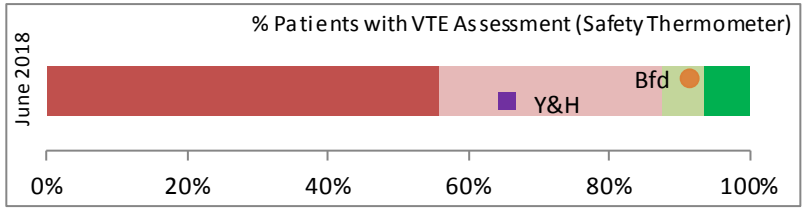
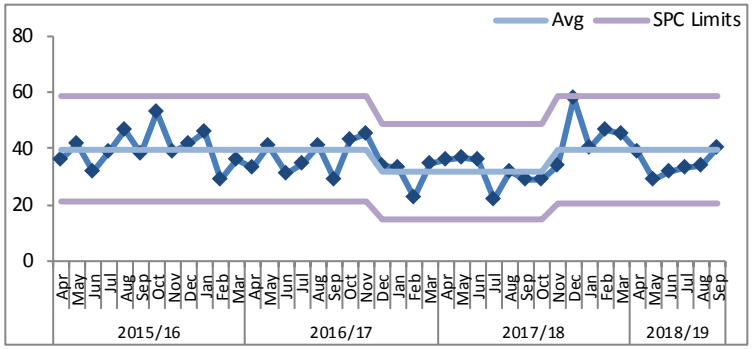
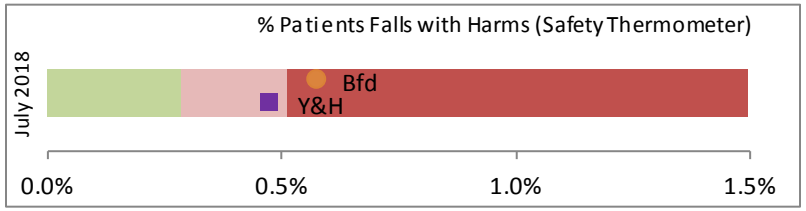
	Trend	Challenges and Successes	Comparison	Exec Lead
MRSA		Zero Methicillin-resistant Staphylococcus aureus (MRSA) year to date.		Chief Nurse
VTE Assessment		The Venous Thromboembolism (VTE) standard has now been sustainably met at > 95% for the past 6 months		Chief Medical Officer
Falls with Harm		Collaborative 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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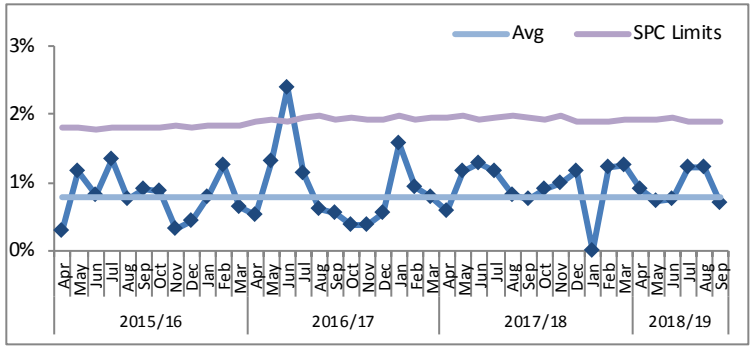
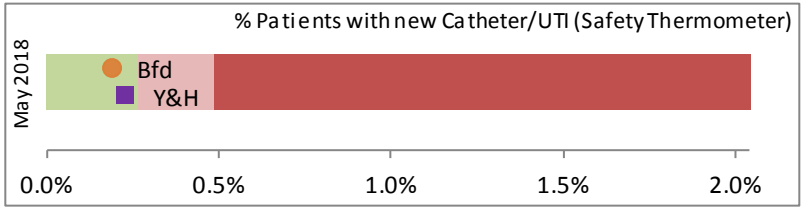
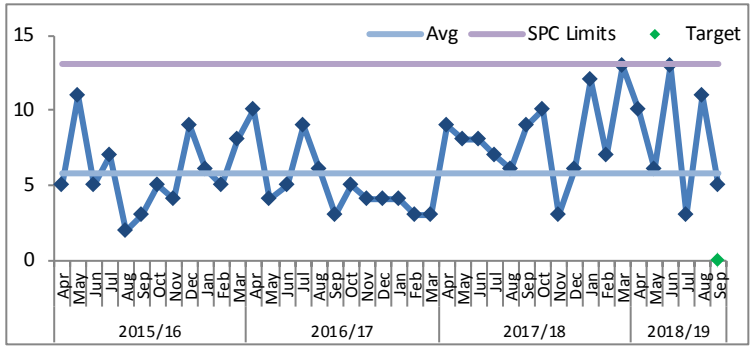
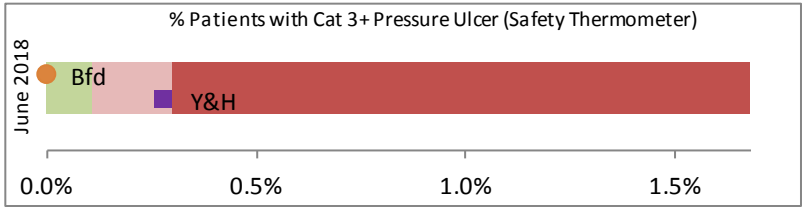
Catheters & UTIs		Plans in place to undertake work (overseen by Infection Prevention and Control Team) to reduce the point prevalence of Catheter Associated Urinary Tract Infections (CAUTI). Opportunity to use the EPR to audit care and support improvement being explored with chief nurse team. The trend 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

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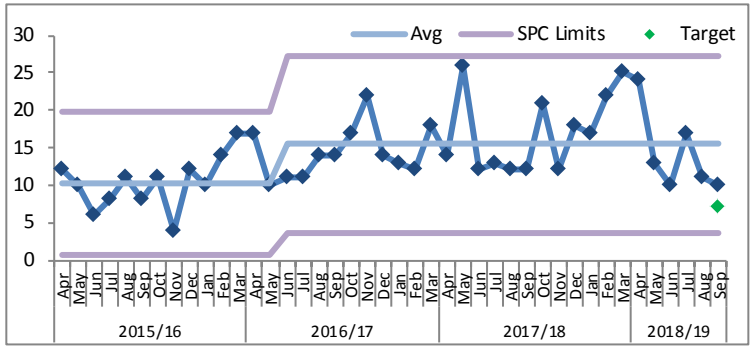
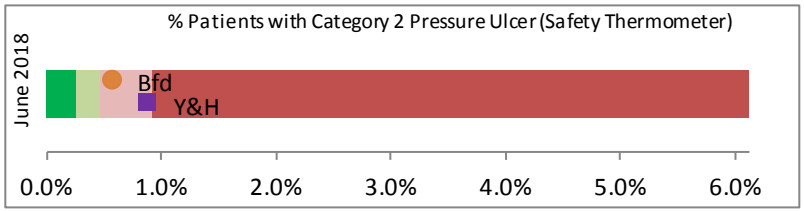
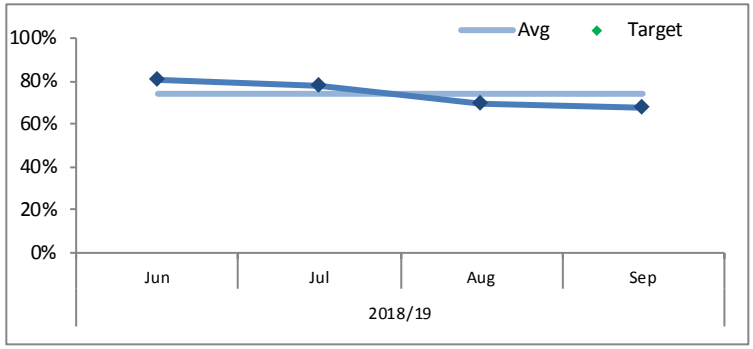
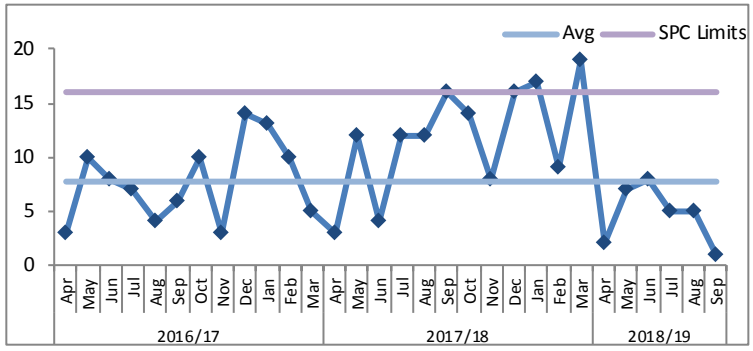
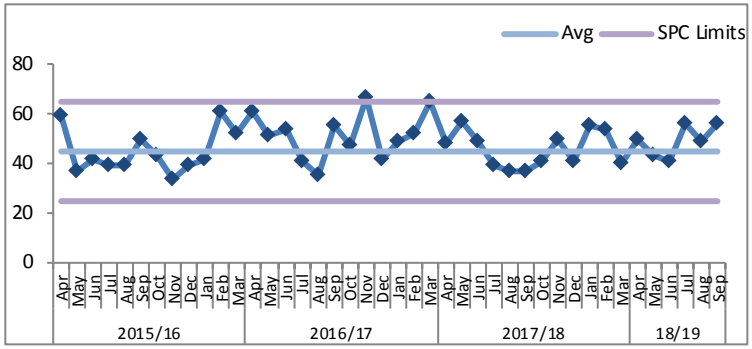
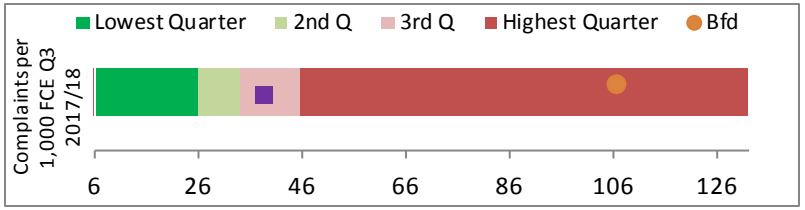
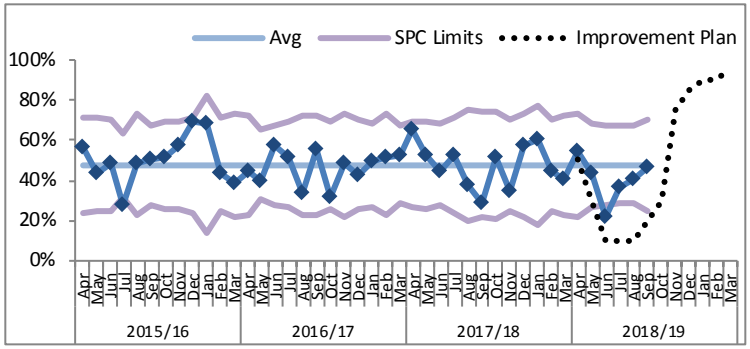
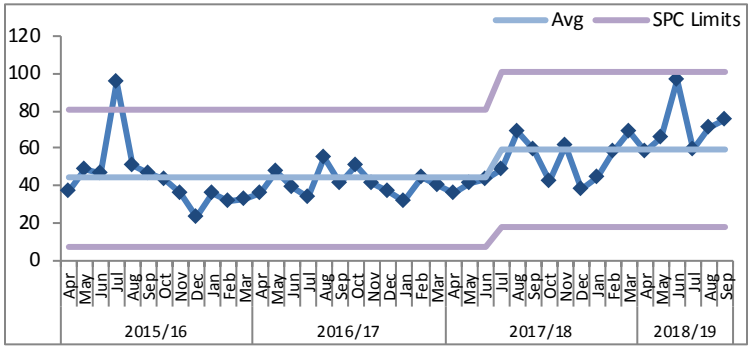
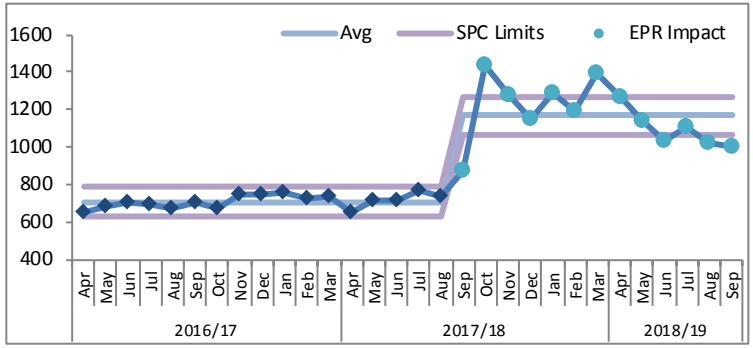
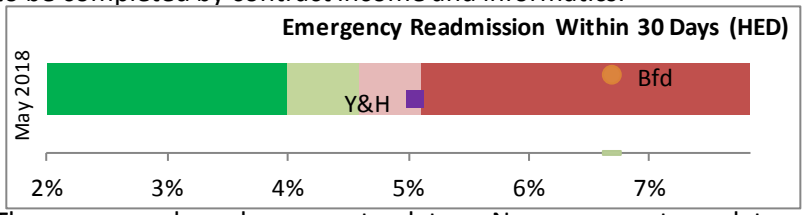
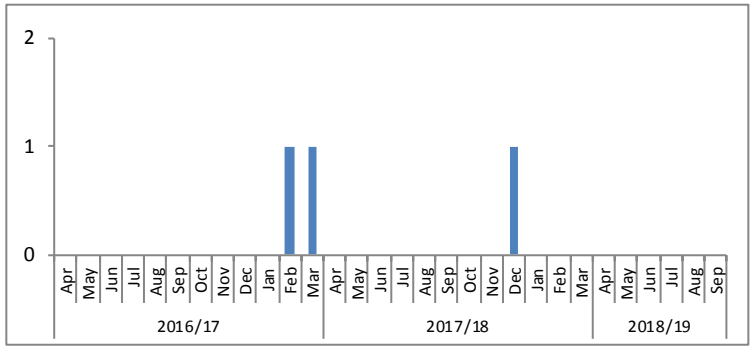
	Trend	Challenges and Successes	Comparison	Exec Lead
Pressure Ulcers Cat 2		Focussed work continues with the Tissue Viability Nursing team and recent participation in the national collaborative is raising awareness of documentation, assessment and care planning.		Chief Nurse
Sepsis patients receive antibiotics 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
Night-time Transfers		Daily review of night time transfers continues with no concerns to be escalated. There was only 1 patient transferred after 10pm in the month of September 2018/19. The reported reason was to create a Coronary Care Unit (CCU) bed for an emergency admission from the Accident and Emergency (A&E) department .		Chief Operating Officer

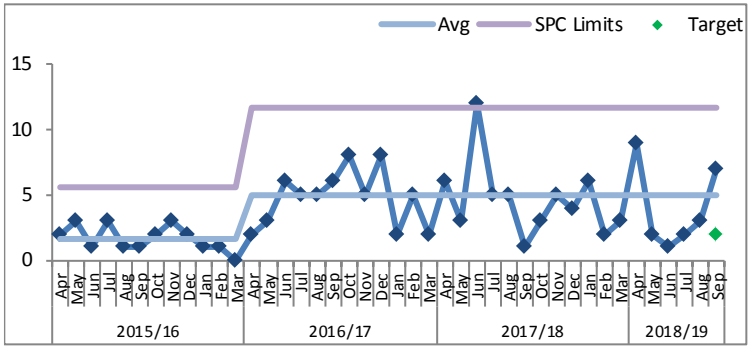
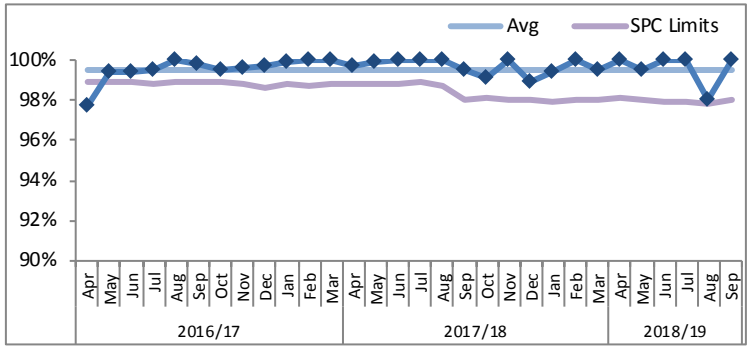
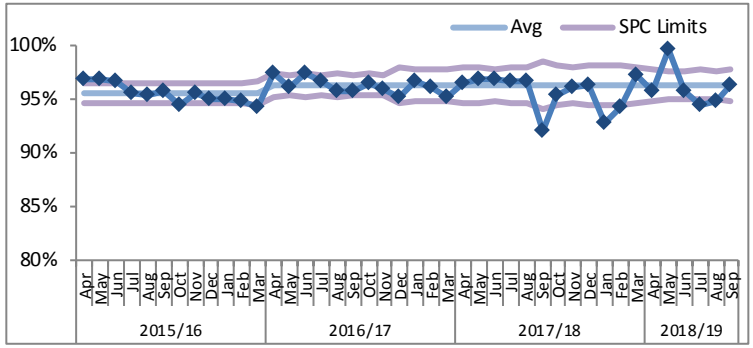
To provide outstanding care for patients

	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
Complaints Working Days Turnaround Time		The turnaround time for complaints is 30 days unless an alternative timeframe has been agreed with the complainant. The progress of each complaint is reviewed on a weekly basis. Although the backlog is being reduced, further work is required to eliminate it.		Chief Nurse

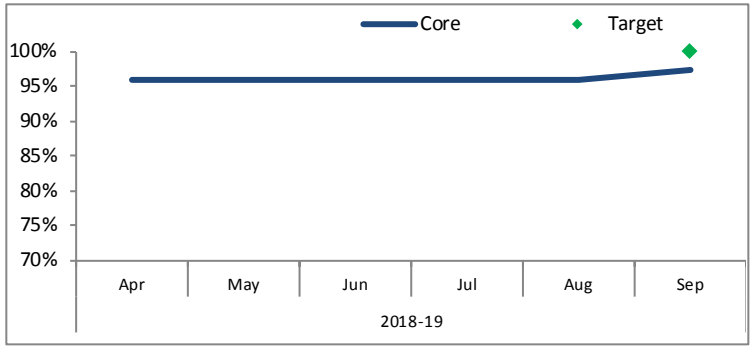
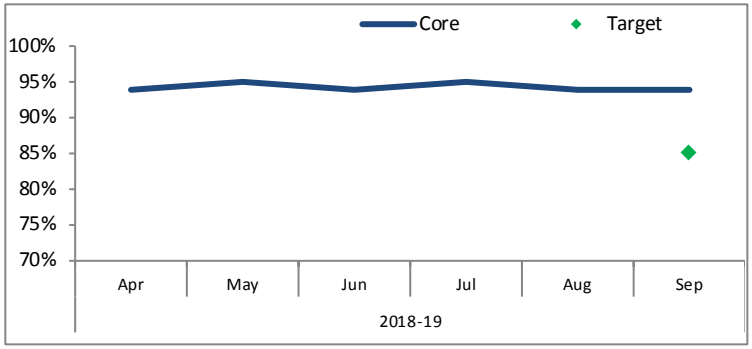
To provide outstanding care for patients

	Trend	Challenges and Successes	Comparison	Exec Lead
Readmissions		Readmissions and the readmission rate increases significantly post EPR. This relates directly to a change in reporting. Operational teams confirm that both emergency admissions and readmissions have increased but would expect no material change to readmission rate. A number of data quality improvements have been made which has reduced the trend this financial year but the inclusion of paediatric assessments as non-elective admissions and changes within the other admission and assessment units will continue to show an increase on what was previously reported. A full assessment of this change is still to be completed by contract income and informatics. 		Chief Operating Officer
Information Governance Breaches		There are no breaches year to date 2018/19. Awareness remains high.	No comparator data is published.	Chief Digital and Information Officer

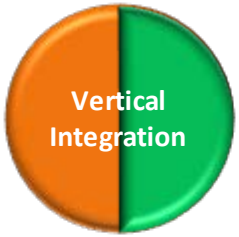
To provide outstanding care for patients

	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 of the action planning.	No comparator data is available.	Director of Strategy and Integration
Audit of WHO Checklist		Following previous months dip in performance, agreed actions implemented and performance this month has returned to previous levels.	No comparator data is available.	Chief Medical Officer
Friends and Family Test		The Friends and Family Test (FFT) 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

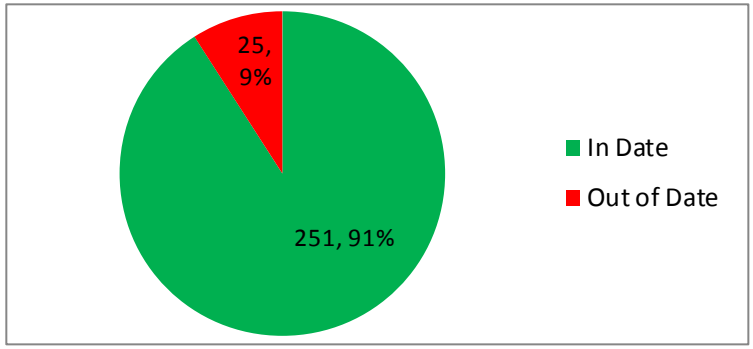
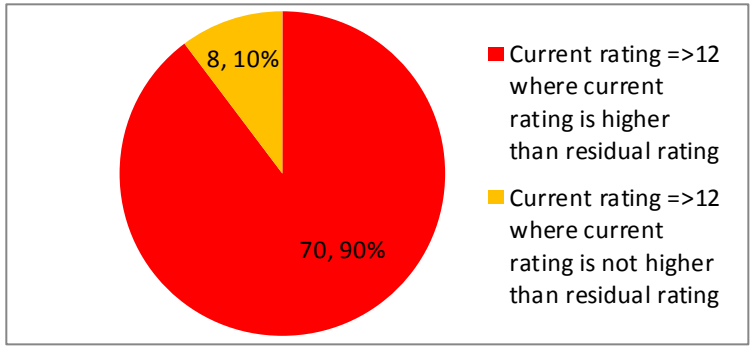
To be a continually learning organisation

	Trend	Challenges and Successes	Comparison	Exec Lead
New Starter Training		The 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.	Chief Medical Officer
Refresher Training		The trust has consistently exceeded its target refresher training standard since April 2018/19, averaging over 95%.	Comparator data not available.	Chief Medical Officer
Learning Hub		The Learning Hub is becoming well established within the Trust and is meeting expectations in relation to delivery of the agreed learning outputs, for example, Learning Matters. A full review was undertaken during Quarter 1 2018/19 and a plan to improve the approach with a key focus on engagement identified. During Quarter 4 2018/19 we will be launching a monthly 'learning award'.		Director of Strategy and Integration

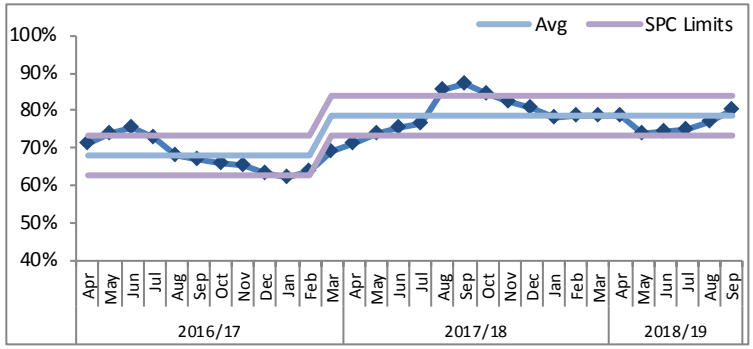
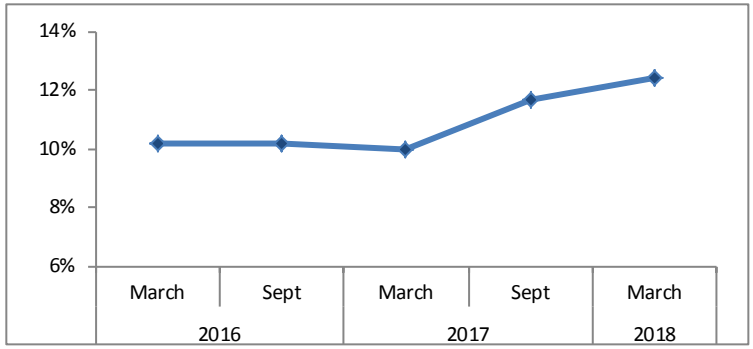
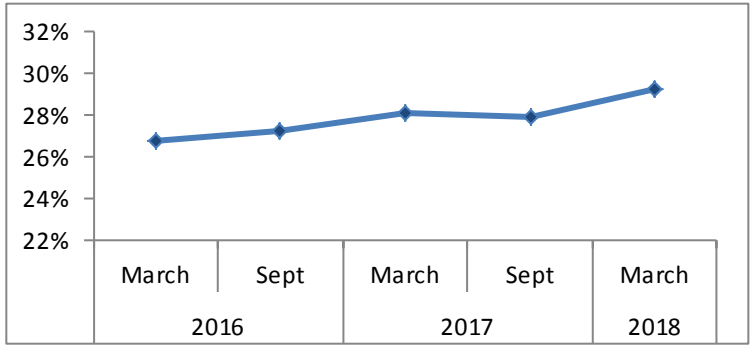
To collaborate effectively with local and regional partners

	Trend	Challenges and Successes	Comparison	Exec Lead
	Bradford Teaching Hospital's systematic approach to stakeholder management identifies key external partners. For each key external partner 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 key performance indicators (KPI's) for this programme were discussed at the Partnerships Committee (25th May 2018/19) 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/red, amber, green (RAG) rating should be based on a subjective assessment, in the absence of a meaningful, readily understandable hard metric. "There is an action to assess whether broader information or objective processes can be fed into in directorate judgment as to whether KPIs are being attained. There is also an action to ensure specific risks and milestones related to this objective are discussed in Partnership committee updates.			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. 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 and Harrogate integrated care system (seeking greater autonomy from central control) and bilateral discussions e.g. with Airedale Foundation Trust. The Partnerships Committee has advised that progress/red, amber, green (RAG) rating should be based on a subjective assessment, in the absence of a meaningful, readily understandable hard metric. There is an action to assess whether broader information or objective processes can be fed into in directorate judgment as to whether KPIs are being attained. There is also an action to ensure specific risks and milestones related to this objective are discussed in Partnership committee updates.			Director of Strategy & Integration

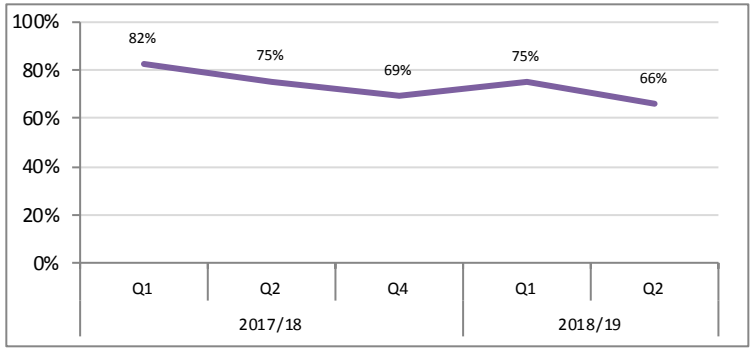
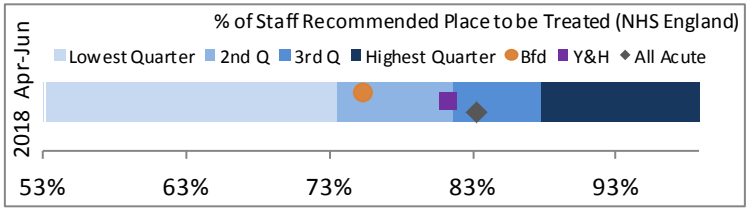
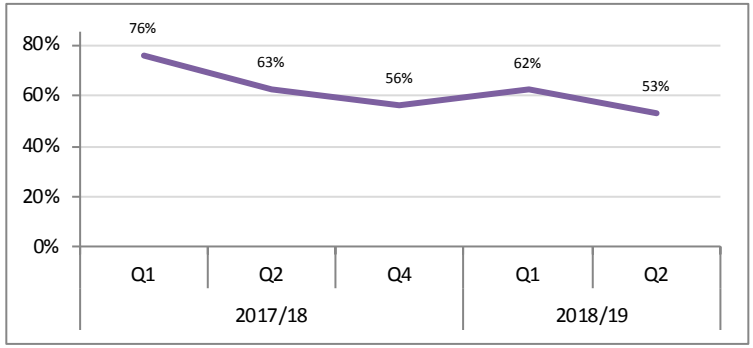
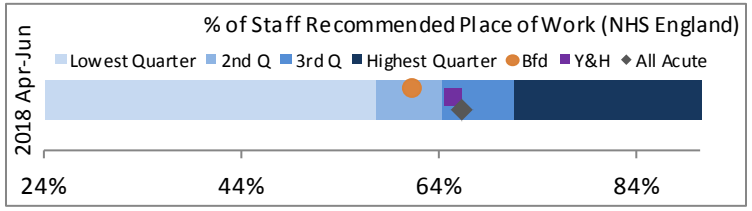
To be a continually learning organisation

	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

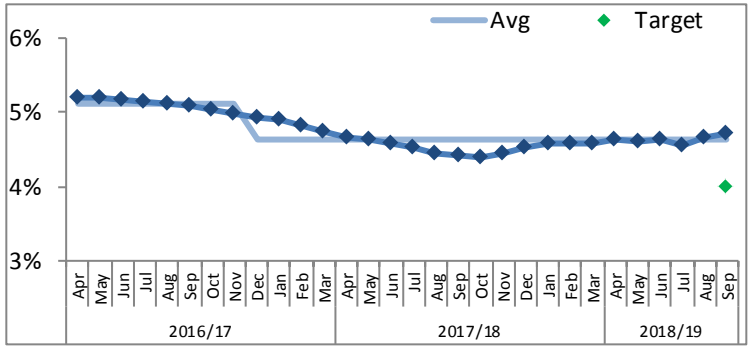
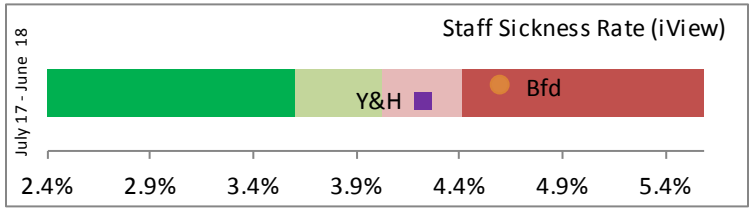
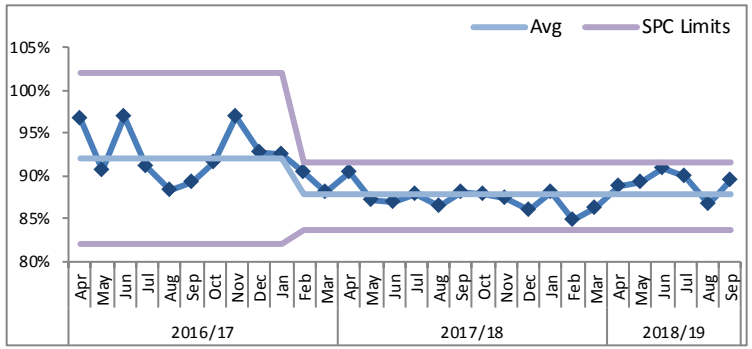
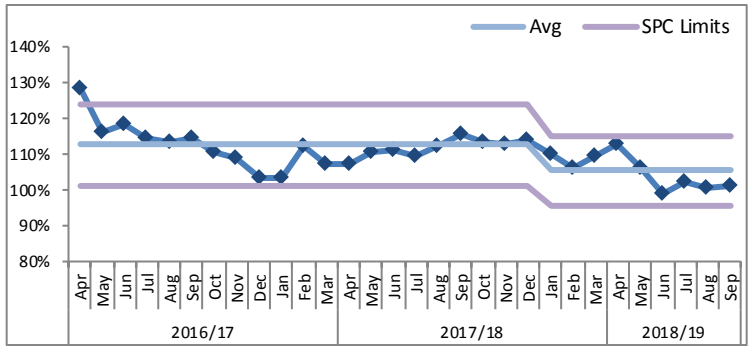
To be in the top 20% of employers in the NHS

	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 2018/19. The appraisals completion rate has increased from 77.08 in August to 80.16% in September 2018/19. Division of Women and Children increased to 91.59% (+8.72%) and Division of Anaesthesia, Diagnostics and Surgery increased to 79.01 (+7.42). Division of Medicine and Integrated Care has decreased from 80.21% to 77.51%. Work continues to make sure staff have an effective appraisal and we meet the December target. The focus is on targeted support for identified areas; recording and reporting appraisals using the Electronic Staff Record (ESR); developing managers and making sure protected time is allocated.		Director of Human Resources
BAME % Senior Leaders		We have made a significant increase in the number of Black, Asian, Minority and 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. The next 6 monthly data will be reported to Workforce Committee in November 2018/19.		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. The next 6 monthly data will be reported to Workforce Committee in November 2018/19.		Director of Human Resources

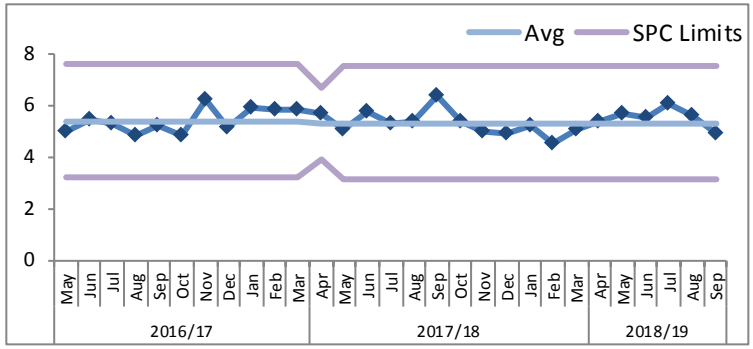
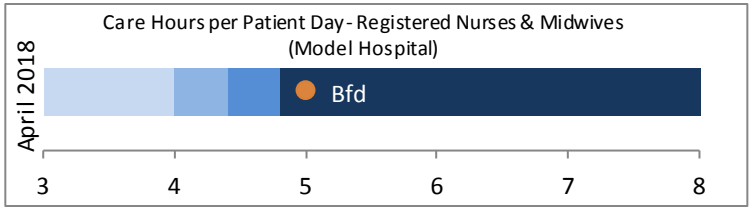
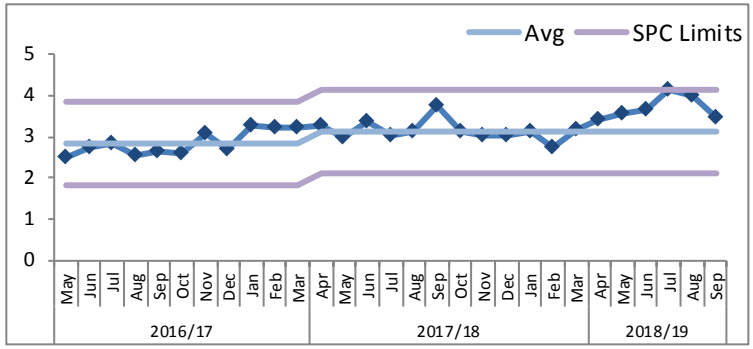
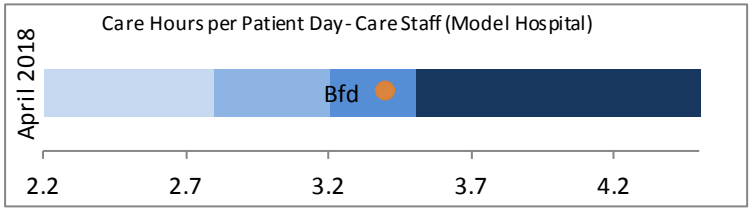
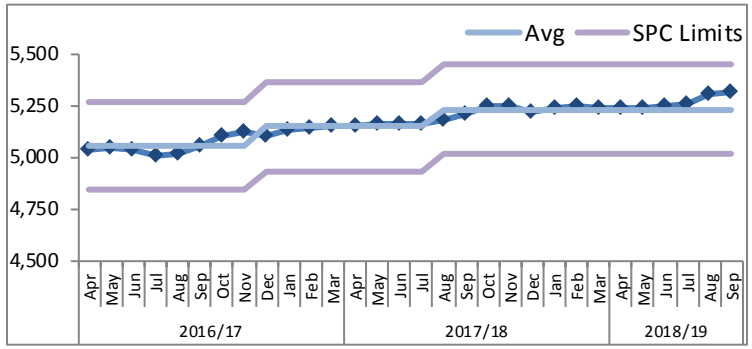
To be in the top 20% of employers in the NHS

	Trend	Challenges and Successes	Comparison	Exec Lead
Staff FFT Treatment		Results for Quarter 2 showed 66% of staff were likely to recommend the Trust as a place to receive care or treatment, compared to 75% in Quarter 1 (-9%). NHS England comparison data for Quarter 2 will be available on 22 November 2018. Comparison data for Quarter 1 2018/19 showed we were below the average for acute trusts (83%) and below the Yorkshire and Humber average (81%).		Director of Human Resources
Staff FFT Work		In Quarter 2, 53% of staff were likely to recommend the Trust as a place to work, compared to 62% in Quarter 1 (-9%). NHS England comparison data for Quarter 2 will be available on 22 November 2018/19. Quarter 1 showed we were below average compared to other acute trusts (67%) and below the Yorkshire and Humber average (66%). Work continues to address areas of improvement through the Staff Survey action plan. This year's NHS Staff Survey launched on 13th September and closes on 30 November 2018/19.		Director of Human Resources

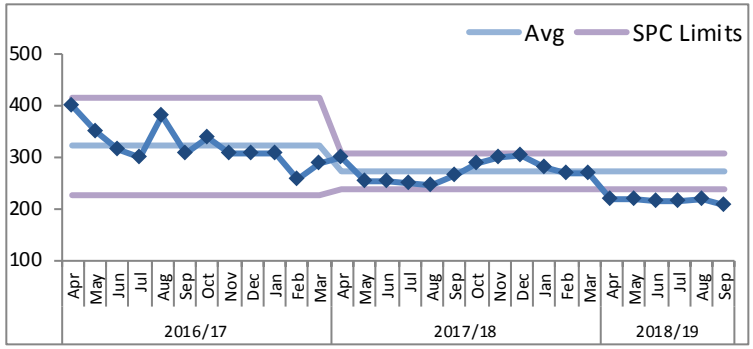
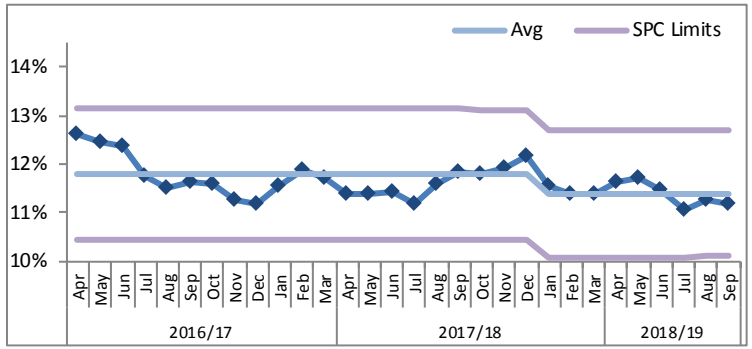
To be in the top 20% of employers in the NHS

	Trend	Challenges and Successes	Comparison	Exec Lead
Sickness		The rolling 12 month sickness rate is currently 4.72% which is an increase. Sickness absence has been increasing in Estates and Facilities, Pharmacy, Surgery and Anaesthesia. An exception report will be provided to Novembers Workforce Committee.		Director of Human Resources
Nursing Shifts Filled		Fill rates for RNs remains relatively stable around 90%. See nurse staffing report for more details. Slight downturn in August 2018/19, as expected.		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

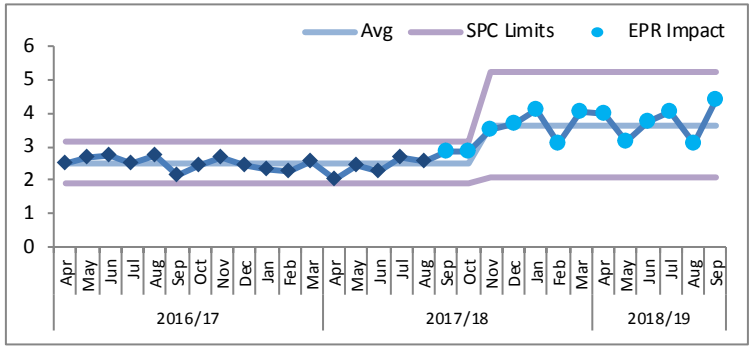
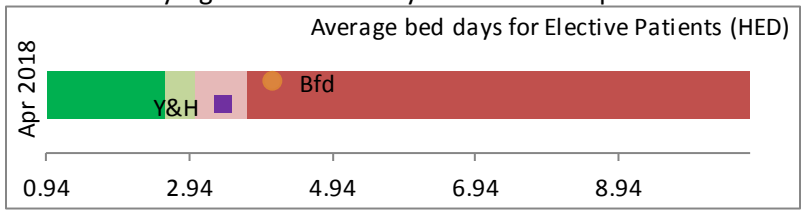
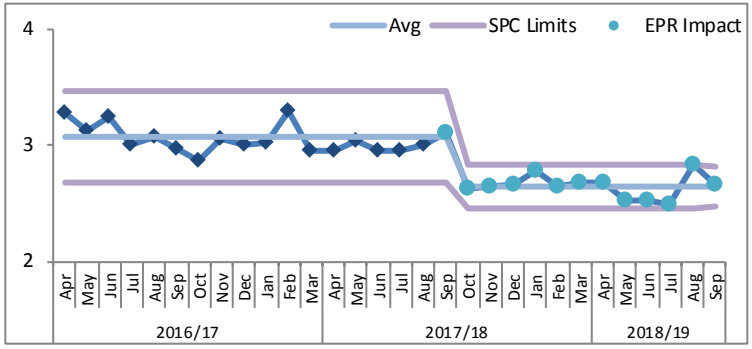
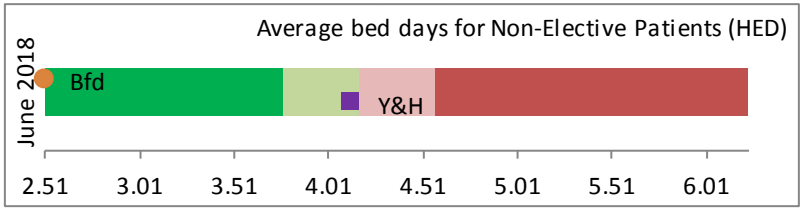
To be in the top 20% of employers in the NHS

	Trend	Challenges and Successes	Comparison	Exec Lead
Nursing Care Hours		Rate remains stable.		Chief Nurse
Care Staff Care Hours		The figure shows a slight decrease but remains largely stable.		Chief Nurse
Staff in Post		Staffing numbers increased slightly in September. Increases were seen relating to the recruitment of a Cohort Physician Associates		Director of Human Resources.

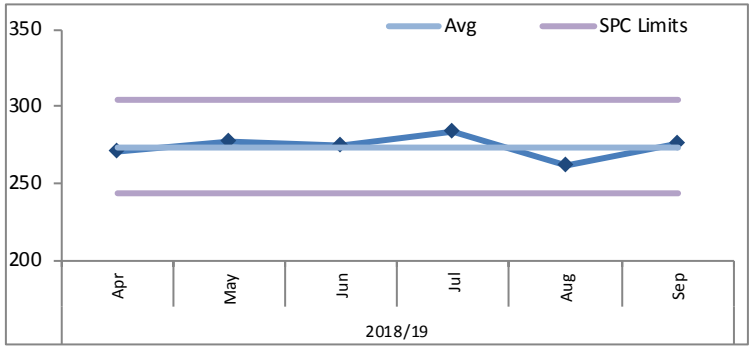
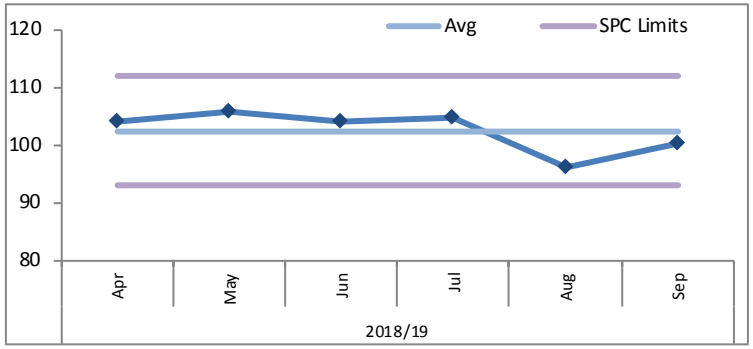
To be in the top 20% of employers in the NHS

	Trend	Challenges and Successes	Comparison	Exec Lead
Use of Agency (WTE)		The reduction in use of agency Healthcare Assistants in the Additional Clinical Services Group has reduced further with the average weekly bank fill rate reaching 85%. This month a further 70 HCAs were offered bank posts. This will mean a further decrease in the use of agency Healthcare Assistants. September saw 79% of all Medical & Dental shift requests being filled, 52% of those by internal bank. The shift to filling gaps with bank Doctors rather than agency has remained. Agency use in the Allied Health Professionals (AHP's) and Admin & Clerical staff groups has remained static across the reporting period.		Director of Human Resources
Turnover		Turnover has reduced slightly at Trust level to 11.20% from 11.27% in July 2018/19.		Director of Human Resources

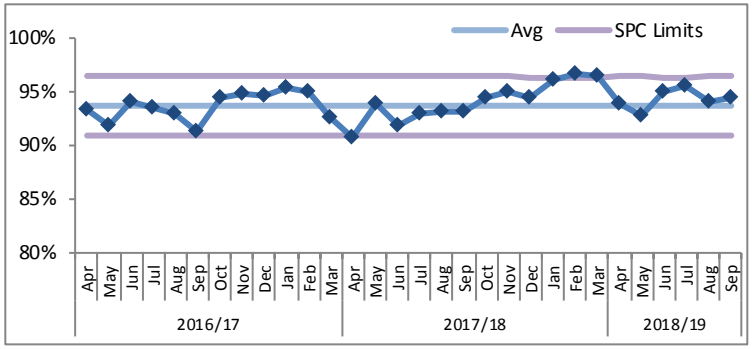
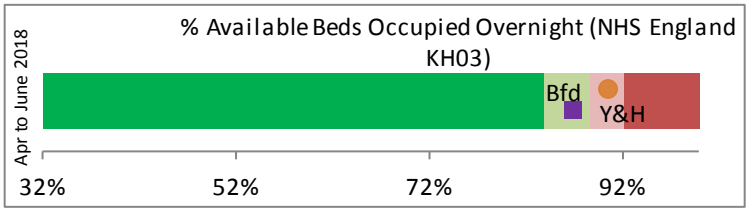
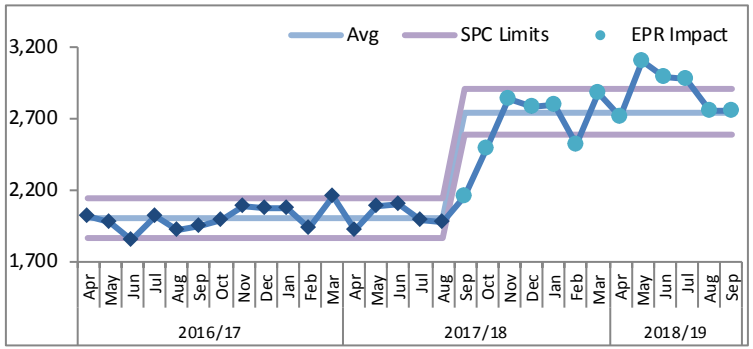
To deliver our financial plan and key performance targets

	Trend	Challenges and Successes	Comparison	Exec Lead
Length of Stay Elective		The trend continues to indicate an increase in elective length of stay (LoS), however, this relates to a movement of 1 day length of stay (included in this average) to day cases (which aren't included). The trend doesn't reflect a deterioration in length of stay and the actual number of stays greater than 2 days is in line with previous volumes. 		Chief Operating Officer
Length of Stay Non-Elective & Assessments		Trends over time show an increase in the number of 0 and 1 day length of stays which is why the average has reduced. This indicator is impacted by data quality issues with elective day cases 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. Growth in assessments following the introduction of the Clinical Decision Unit (CDU) and increased Ambulatory Care Unit (ACU) attendances will also contribute to the reduction. 		Chief Operating Officer

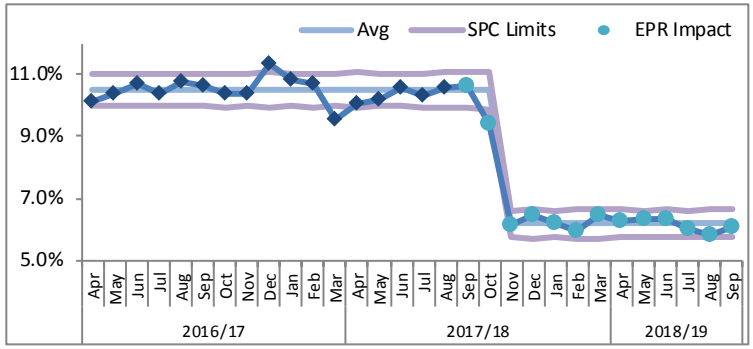
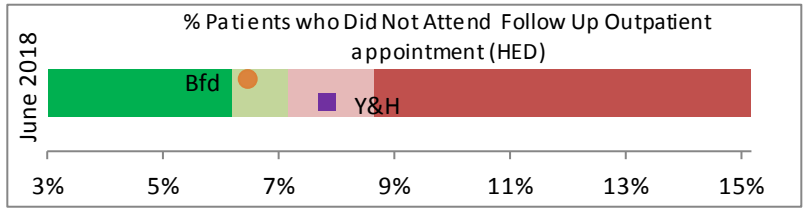
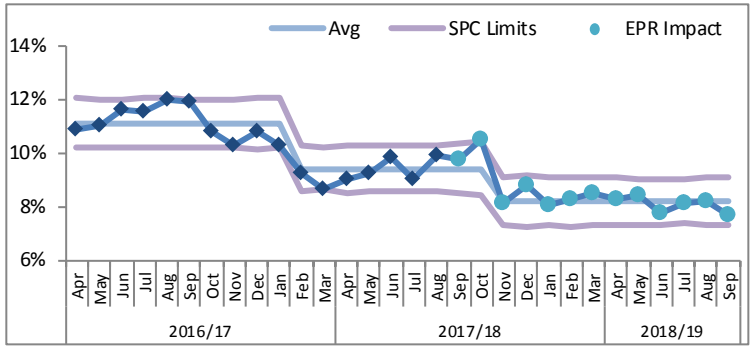
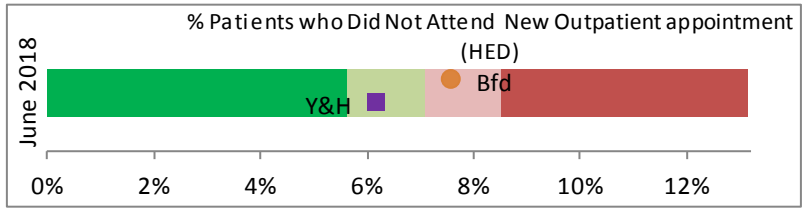
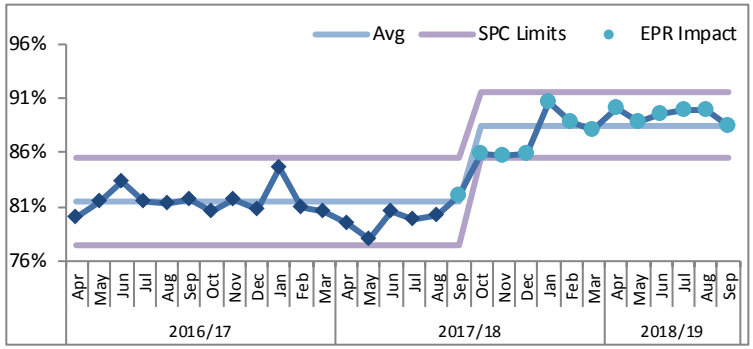
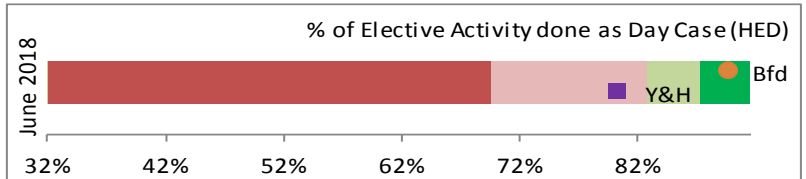
To deliver our financial plan and key performance targets

	Trend	Challenges and Successes	Comparison	Exec Lead
Stranded Patients Length of Stay >= 7 days		There is a twice weekly review of cohort 7-21 days to identify any potential blockages which lead to longer than expected length of stays (LoS). This is completed in conjunction with the multi-agency integrated discharge team. The number has slightly increased in September 2018/19 compared to August, but remains within normal variation. A Trust-wide day of care audit was undertaken on 17th October 2018 which identified opportunities to further improve discharge processes and direct patients to alternative care provision.		Chief Operating Officer
Super Stranded Patients Length of Stay >= 21 days		There is a daily review in place where plans to expedite discharges are agreed together with resolution of any data quality issues. The number has slightly increased in September 2018/19 compared to August, but remains within normal variation. The definition for this indicator has changed within the Sitrep from October 2018 with additional exclusion applied meaning the number will reduce. WYAT winter funding being used on assess to admit and early supported discharge. Led by the Chief Operating Officer a work as one system week is planned for early December 2018.		Chief Operating Officer

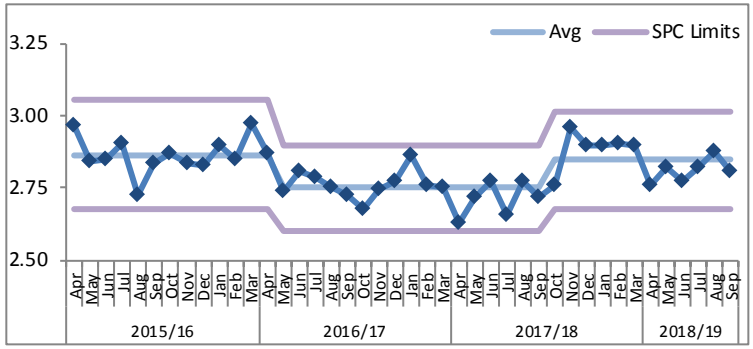
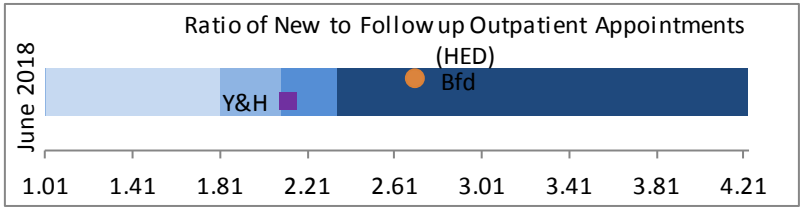
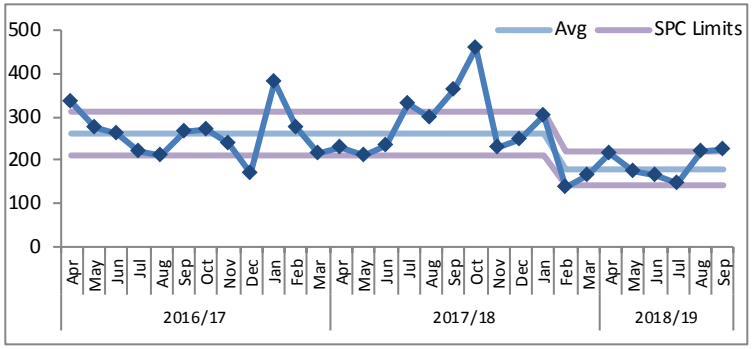
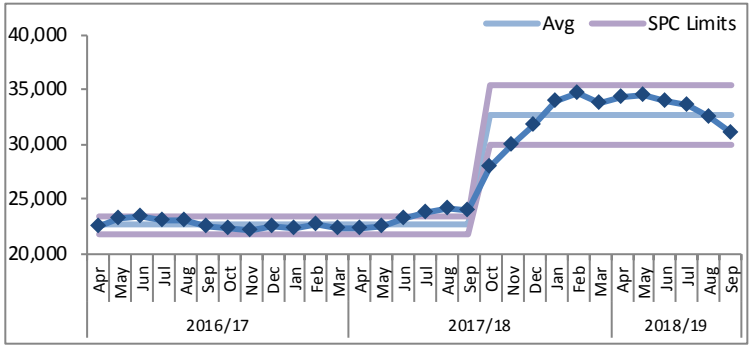
To deliver our financial plan and key performance targets

	Trend	Challenges and Successes	Comparison	Exec Lead
Bed Occupancy		Bed occupancy reduced in August 2018/19 in line with seasonal trend and remained stable in September. Ongoing improvement actions within the Emergency Care Standard (ECS), patient flow and discharge processes will have a positive impact on this indicator.		Chief Operating Officer
Discharges before 1PM		Discharge targets by ward have been implemented with daily review. The total number of discharges before 1pm remained stable in September 2018 but increased by around 3% as a percentage.		Chief Operating Officer

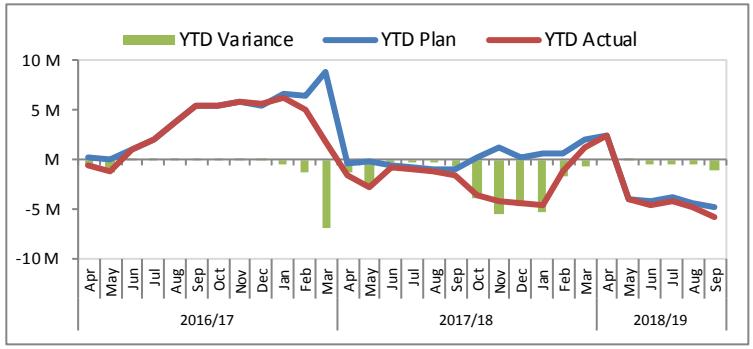
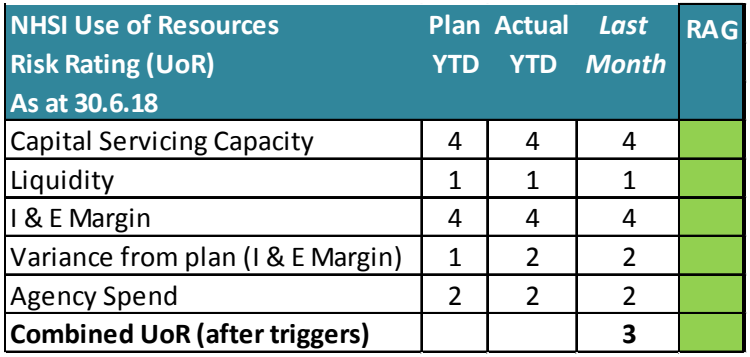
To deliver our financial plan and key performance targets

	Trend	Challenges and Successes	Comparison	Exec Lead
Did not Attend Follow-Ups		The position remains unchanged and the majority of this reduction is due to changes in recording. Operational teams continue to support the investigation into this change.		Chief Operating Officer
Did not Attend New		Did not attend rates have improved since implementation of two way texting in some specialties. Further work is being 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		Initiatives are underway as part of the Elective Care Improvement Programme to maximise day cases. This has been reviewed as part of the specialty level contract review meetings with initial findings suggesting that both practice and recording improvements are evident across the Trust.		Chief Operating Officer

To deliver our financial plan and key performance targets

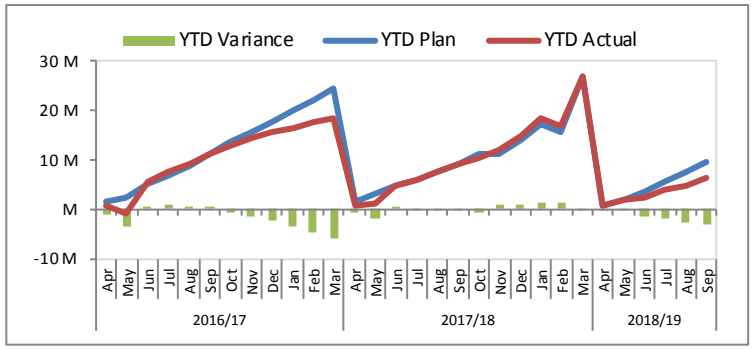
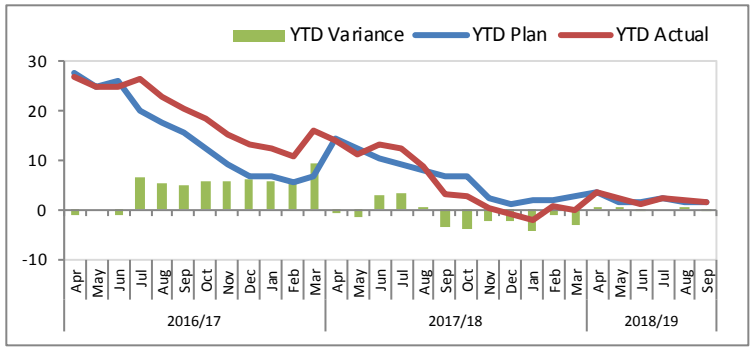
	Trend	Challenges and Successes	Comparison	Exec Lead
New to Follow-up Ratio		This metric is a continued focus within the Outpatient Improvement Programme. Activity trackers by specialty are now in place with monitoring via the Planned Care Delivery Group. Reducing follow ups will be part of referral to treatment (RTT) recovery deep dive process.		Chief Operating Officer
Short notice Clinic Cancellations		The number of short notice cancellations has increased in August and September 2018/19 but remains within normal variation limits. Trends have been reviewed at the weekly planned care recovery group. An increase in short notice annual leave requests was noted in August but significantly improved in September 2018/19. Compassionate leave accounts for the increase this month and an underlying trend in Registrar capacity is being monitored.		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 (BIP) 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 started to reduce in recent months. Patient tracking list (PTL) development is underway following feedback from NHS Improvement. Specialty level referral to treatment deep dives will support additional recovery actions to reduce waiting times and waiting list sizes.		Chief Operating Officer

To deliver our financial plan and key performance targets

	Trend	Challenges and Successes	Comparison	Exec Lead
Delivery of Financial Plan		The Month 6 Income and Expenditure position is a pre-Provider Sustainability Fund (PSF) deficit of £8.4m which is in line with the planned deficit. The year to date position includes £2.5m of Provider Sustainability Fund income. The Provider Sustainability Fund position is made up of 70% of the Quarter 1 and 2 target, with 30% related to Accident and Emergency (A&E) department targets being unrecoverable. This results in a post-Provider Sustainability Fund deficit of £5.9m which is £1.1m behind plan. The year end forecast presented is full delivery of the financial plan and mirrors the forecast submitted to NHS Improvement on 15th October 2018. However, internal modelling of the current run rate and forecast Bradford Improvement Programme delivery suggests it is now probable that the Trust will fall behind its financial plan after Quarter 3 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 6. The plan for Month 6 is relatively unchallenging and the Trust planned to record the second highest risk rating for month 6 (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 £5.9m. Deliver of the plan requires significant improvements in the remaining months of the financial year.		Director of Finance

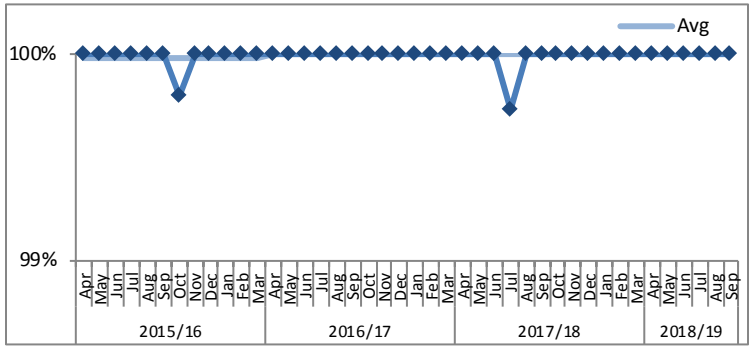
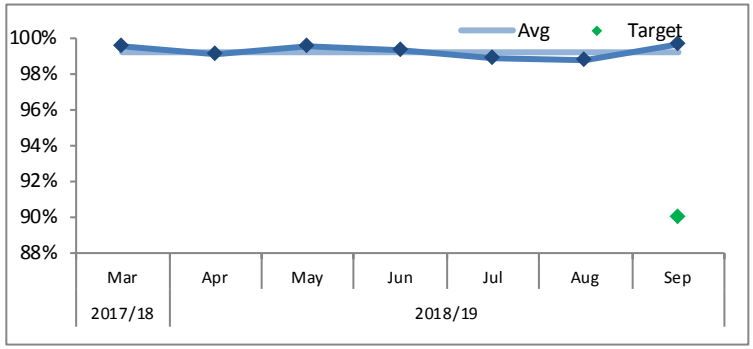
NHSI Use of Resources Risk Rating (UoR) As at 30.6.18	Plan YTD	Actual YTD	*Last Month*	RAG
Capital Servicing Capacity	4	4	4	
Liquidity	1	1	1	
I & E Margin	4	4	4	
Variance from plan (I & E Margin)	1	2	2	
Agency Spend	2	2	2	
Combined UoR (after triggers)			**3**	

To deliver our financial plan and key performance targets

	Trend	Challenges and Successes	Comparison	Exec Lead
Bradford Improvement Plan		The Trust has delivered £6.4m of efficiencies at the end of Month 6. This is £3.1m behind the phased plans submitted by the divisions and corporate departments and £6.4m behind an even monthly apportionment of the annual target, which would have required £12.8m of savings to be delivered by Month 6. A total of £0.8m of the year to date efficiencies were delivered via technical non-recurrent adjustments and a further £0.7m relate to accrued Alternative Delivery Model (ADM) benefits which are now at risk. The divisions and corporate departments are currently forecasting delivery of £22.8m efficiencies, which would leave the Trust £2.8m short of the required £25.6m annual savings. A very substantial element of these divisional plans requires significant additional work to be implemented, and there is therefore a high degree of risk in this best case scenario forecast. Removing some of the riskier plans from this forecast results in total projected savings of £17.7m, which would leave the Trust £8.6m short of its target.		Director of Finance
Liquidity rating		Year to date liquidity is 1.4 days which is 0.2 days below plan. Liquidity is forecast to fall to -3.4 days by year end which would see the Use of Resources score declining from 1 (planned) to a 2. The forecast assumes full delivery of the Trusts Bradford Improvement Programme however the majority of accrued benefits from establishing an Estates subsidiary being received over a number of years and therefore being considered non liquid leading to a lower than planned year end position. It is expected that the Trust will enter negative liquidity in Quarter 3. Should the Trust deliver £22.8m of Bradford Improvement Programme forecast year end liquidity is -11.5 which would result in the use of resources score falling from 2 to 3. If the Trust delivers £17.8m of BIP liquidity will fall to -19 days which would lead to a Use of Resources score of 4.		Director of Finance

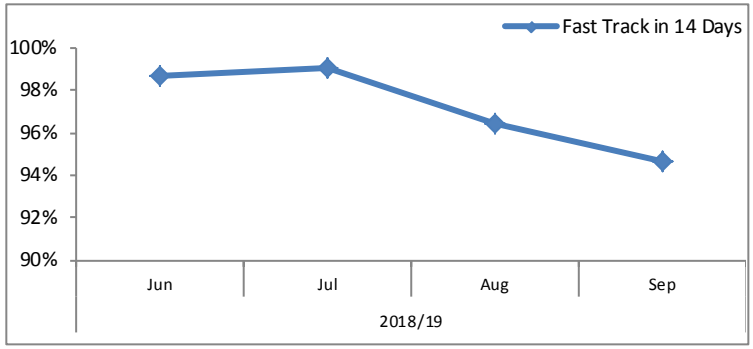
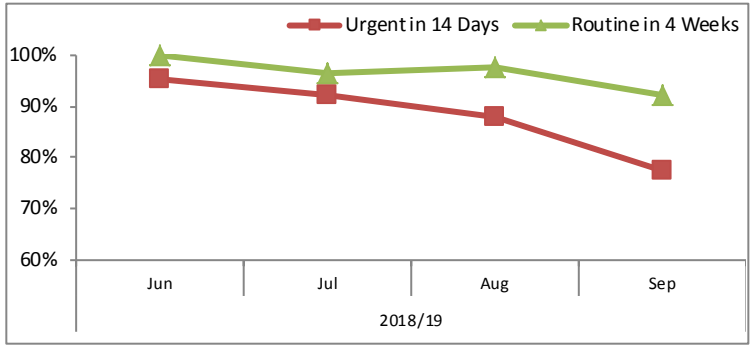
National Indicators

Service Level Agreements

	Trend	Challenges and Successes	Comparison	Exec Lead
Mission Critical Systems Uptime		The Trust continues to achieve a higher than target uptime for its mission critical systems.		Chief Digital and Information Officer
Full Blood Count to Wards < 2 Hours		Performance has been achieved for the first 7 months since the introduction of this target.		Chief Operating Officer

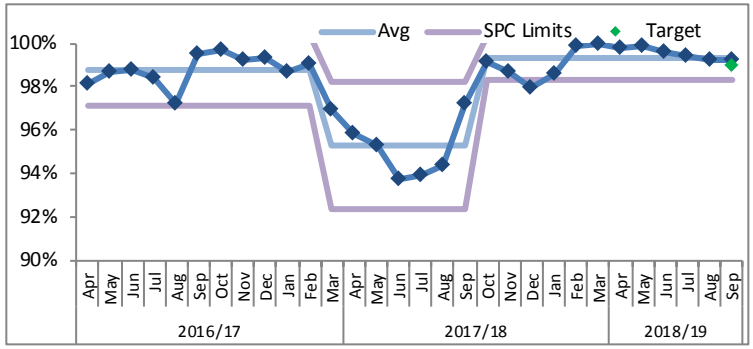
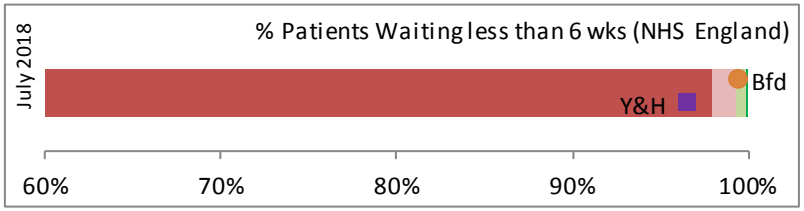
National Indicators

Service Level Agreements

	Trend	Challenges and Successes	Comparison	Exec Lead
Radiology Reporting Turnaround Time Fast Track		There were 52 patients where the report was not completed within the 14 days during September 2018/19. Most of these were Cardiac Computerised Tomography (CT) where capacity reduced due to compassionate leave whilst demand for this test remains extremely high.		Chief Operating Officer
Radiology Reporting Turnaround Time Outpatients		The same capacity issues impacting fast track (FT) performance in September 2018/19 also impacted on the timeliness of urgent and routine reporting. There was also a Whole Time Equivalent (WTE) gap in Magnetic Resonance Imaging (MRI) for 5 weeks between one Consultant leaving and another starting which mainly impacted on the Urgent standard.		Chief Operating Officer

National Indicators

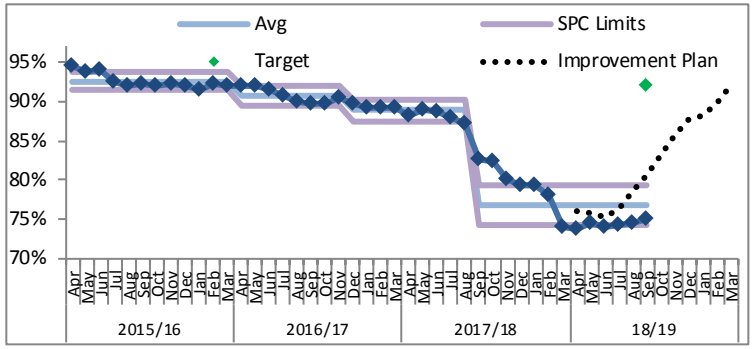
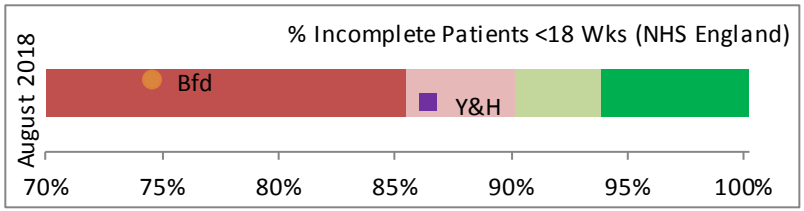
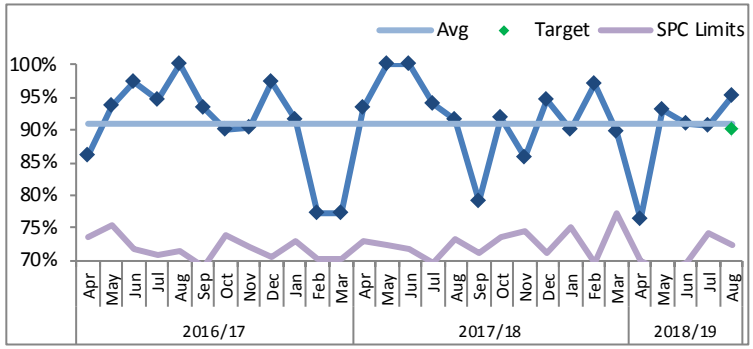
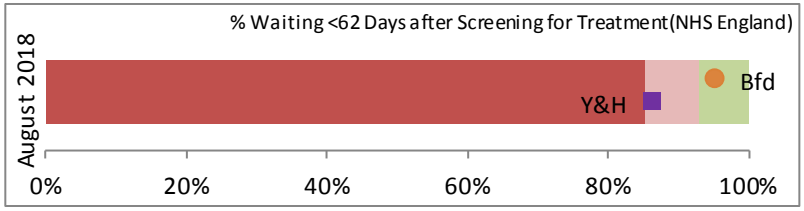
Single Oversight Framework

	Trend	Challenges and Successes	Comparison	Exec Lead
Diagnostic Waits		September DM01 (Monthly Diagnostics Waiting Times and Activity report) reported 99.20% (44 breaches). This is better than target but excludes Endoscopy as work continues to produce an accurate Patient Tracking List (PTL) within acceptable data quality limits ahead of planned submission of Octobers position. The Magnetic Resonance Imaging (MRI) backlog for shoulder arthrograms contributed most of these breaches but an alternative product has been approved and clearance commenced. 		Chief Operating Officer
Use of Resources - Financial		The Trust's overall Use of Resources rating is in line with plan at the end of Month 6. The plan for Month 6 is relatively unchallenging and the Trust planned to record the second highest risk rating for Month 6 (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 £5.9m. Deliver of 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	2	
Combined UoR (after triggers)			**3**	

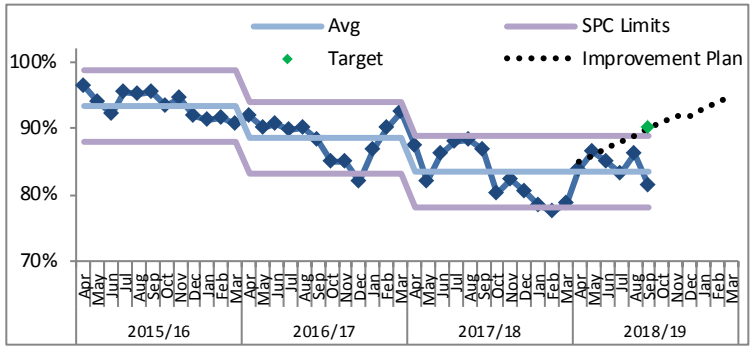
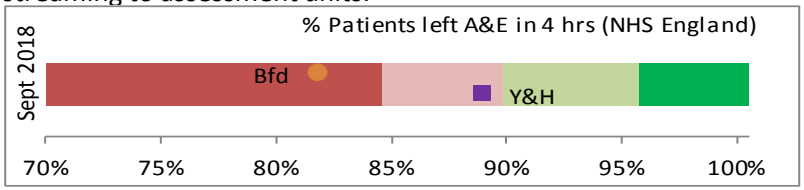
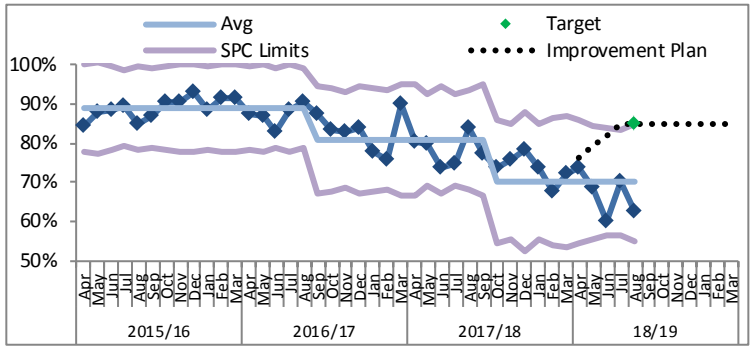
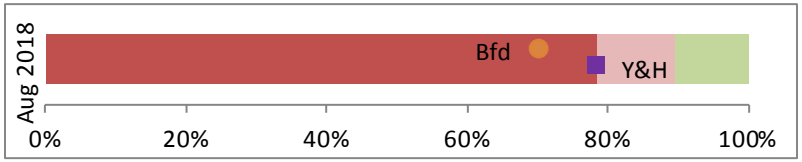
National Indicators

Single Oversight Framework

	Trend	Challenges and Successes	Exec Lead
RTT 18 Week Incomplete		Incomplete performance for September 2018 was 75.09% which is a slight improvement on August 2018 but remains behind trajectory. Long wait profiles are beginning to reduce 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. Over the last month all recovery trajectories and plans have been reviewed and specialty level deep dives will help inform additional recovery actions. 	Chief Operating Officer
Cancer Urgent 62 Day Screening		This standard was achieved in August 2018 and projected to be achieved in September 2018. 	Chief Operating Officer

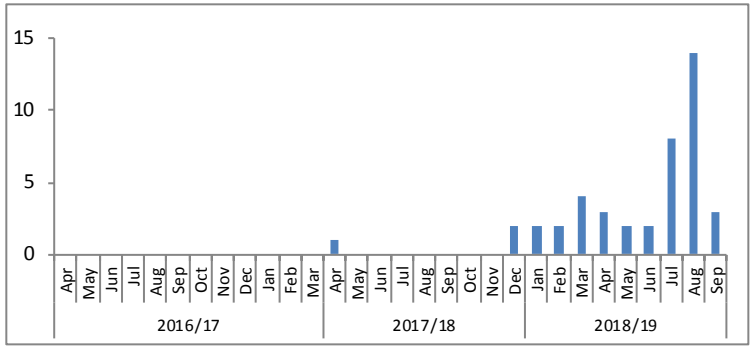
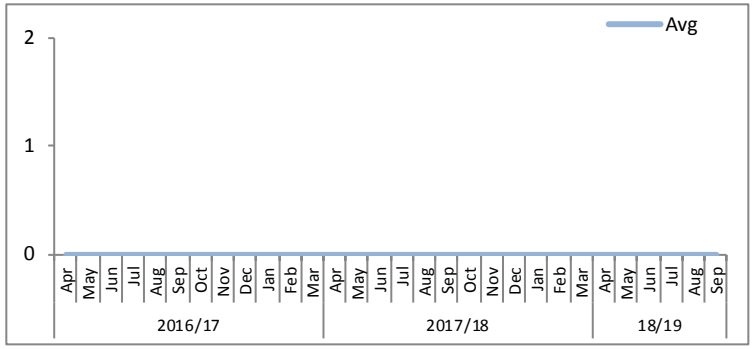
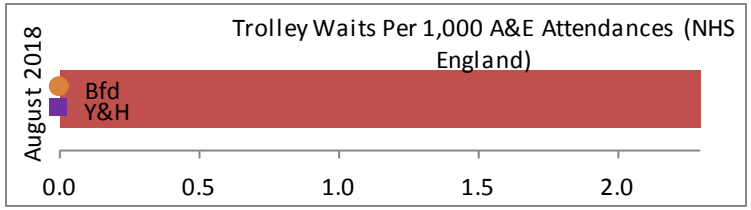
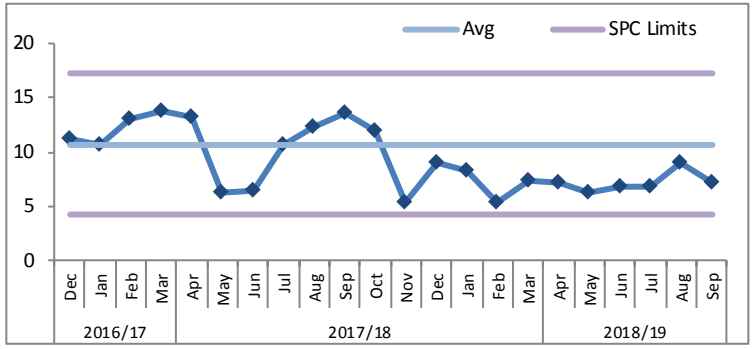
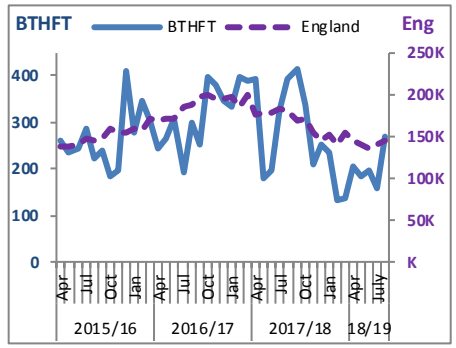
National Indicators

Single Oversight Framework

	Trend	Challenges and Successes	Comparison	Exec Lead
Emergency Care Standard		Performance (type 1 and 3) for September 2018/19 reported 81.27%. This represents -4.97% deterioration compared to August 2018/19. September 2018/19 attendances have been higher than September 2017/18 (+3.6%) and significantly increased compared to August 2018/19 (+4.0%). Emergency Care Improvement Programme in place. Key areas of focus include implementation of assess to admit model via Ambulatory Care Unit (ACU), expansion of integrated minor illness and minor injury unit by end of November 2018/19, implementation of additional ambulatory pathways, and introduction of direct streaming to assessment units. 	Chief Operating Officer
Cancer Urgent 62 Day GP		The reported position for August 2018/19 is 62.5%, a -7.7% deterioration on July 2018/19. but higher than June 2018/19 (+2.3%). The position continues to be managed via the cancer lead in conjunction with divisional teams and supported by a secondment into the role of cancer improvement manager. Urology contributes the majority of breaches. The regional review of the prostate pathway is complete and identified delays due to diagnostic and clinical oncology capacity gaps. A bid for money from the NHS England via the Cancer Alliance to support these gaps and increase consultant capacity has been made. 	Chief Operating Officer

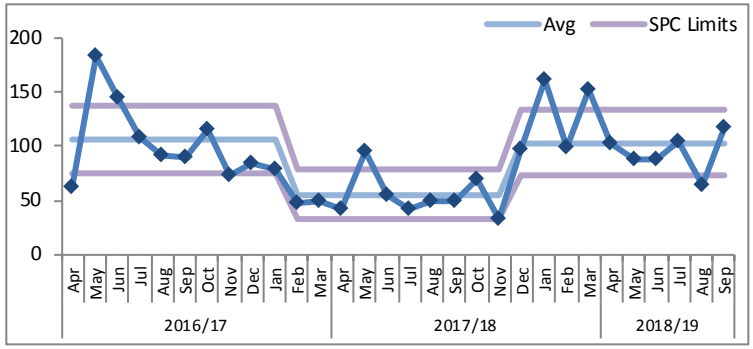
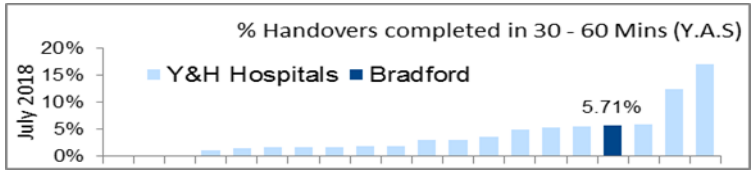
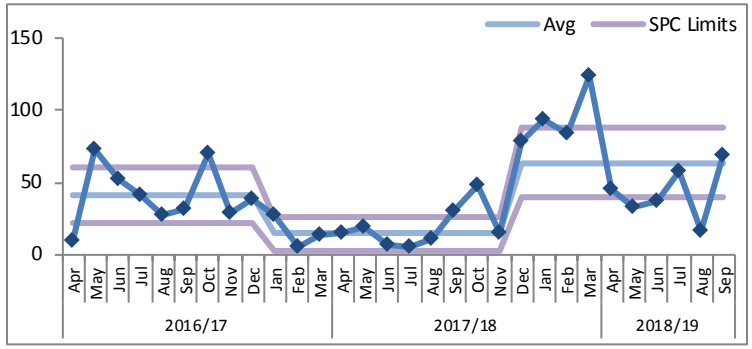
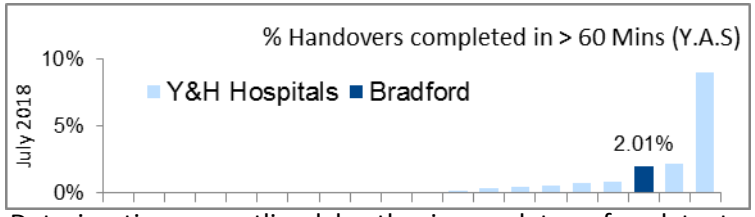
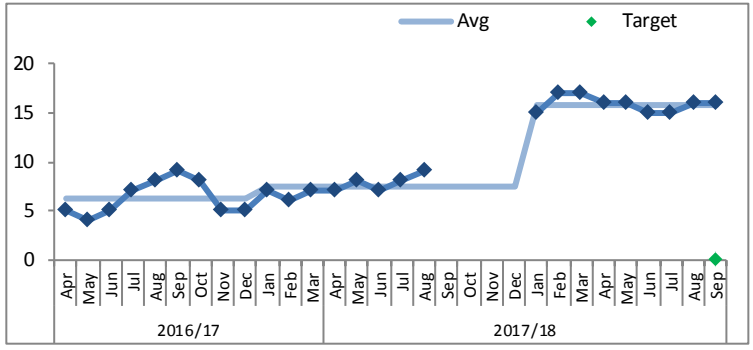
National Indicators

National Target – Non-Financial

	Trend	Challenges and Successes	Exec Lead
RTT 52 Week Wait		The Trust reported 3 incomplete 52 week breaches in September 2018/19 which represents a significant improvement on August 2018/19. This is a result of the various actions that were implemented last month including a daily review of all patients waiting over 46 weeks to ensure a management plan is in place to treat within target. Based on existing plans only one patient is expected to be waiting 52 weeks at the end of October 2018.	Chief Operating Officer
Trolley Waits > 12 Hours		There have been no over 12 hour trolley waits. 	Chief Operating Officer
Delayed Transfers of Care		The number of delayed transfers of care is back to normal levels following a slight increase in August 2018/19. Performance remains below average for the Trust and better than the national standard. 	Chief Operating Officer

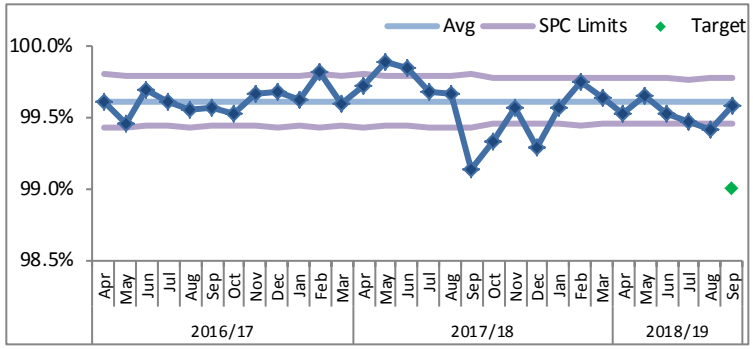
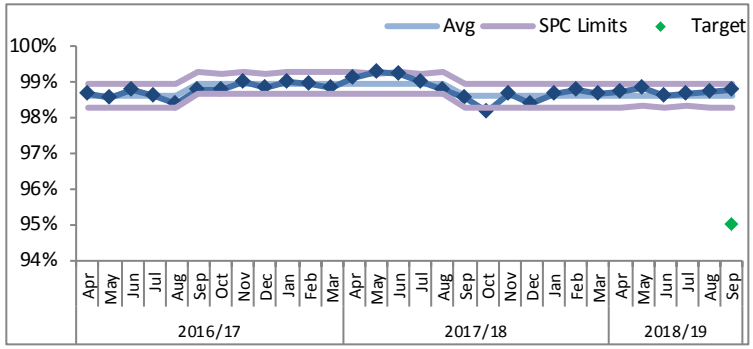
National Indicators

National Target – Non-Financial

	Trend	Challenges and Successes	Comparison	Exec Lead
Ambulance Handover 30-60 mins		Ambulance handovers for September 2018/19 reported as 118, 30-60 minute breaches. This represents deterioration compared to August 2018/19 however the number of these that were validated also dropped. A Hospital Ambulance Liaison Officer (HALO) is on site and GE Consulting supported improvement work-stream in place. 	Chief Operating Officer
Ambulance Handover >60 mins		Ambulance handovers for August 2018/19 reported as 69, 60+ minute breaches. This represents deterioration compared to August 2018/19. Improvement work as part of the Emergency Care Improvement Programme and additional validation of potential breaches are ongoing. 	Chief Operating Officer
RTT Number of Specialties		Deterioration as outlined by the incomplete referral to treatment (RTT) performance figure is spread across multiple specialties and recovery plans in place for each and managed by the Planned Care Recovery Programme. All specialties will be supported through the referral to treatment deep dive process.		Chief Operating Officer

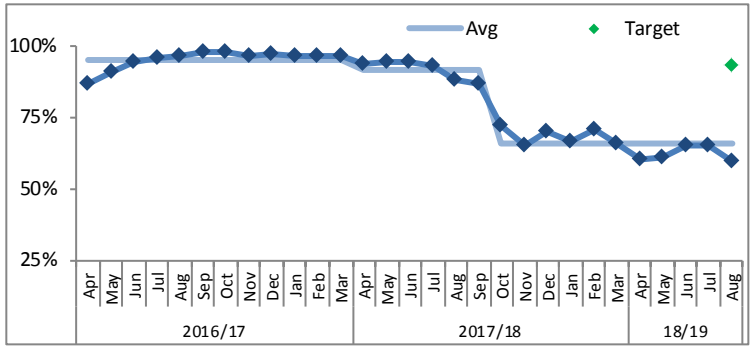
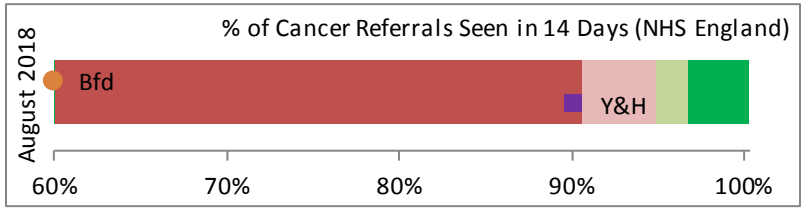
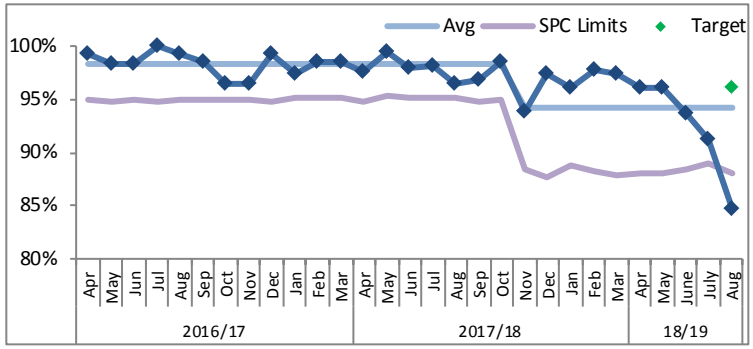
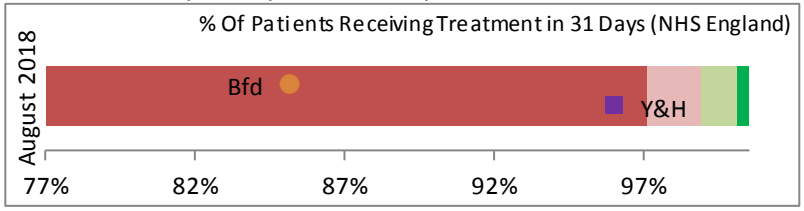
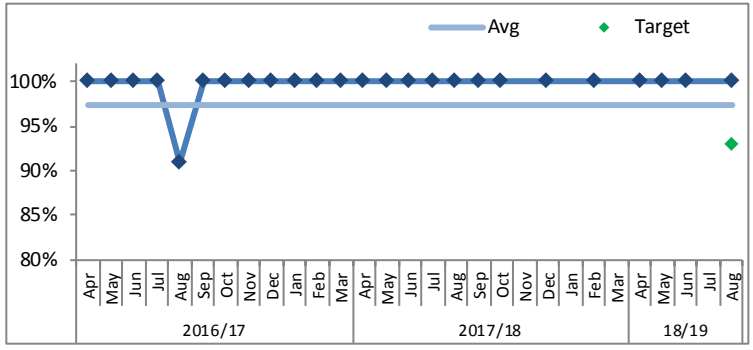
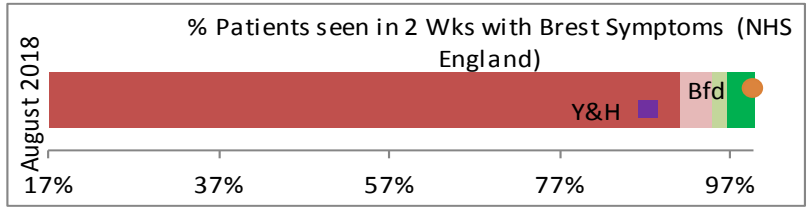
National Indicators

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 are related to EPR embedding and will improve.		Chief Digital and Information Officer
NHS No's A&E		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.		Chief Digital and Information Officer

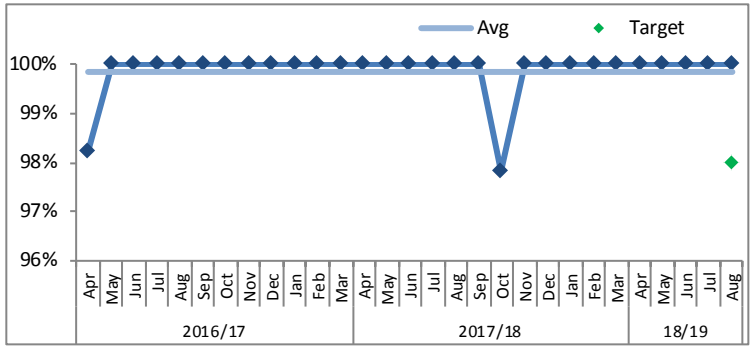
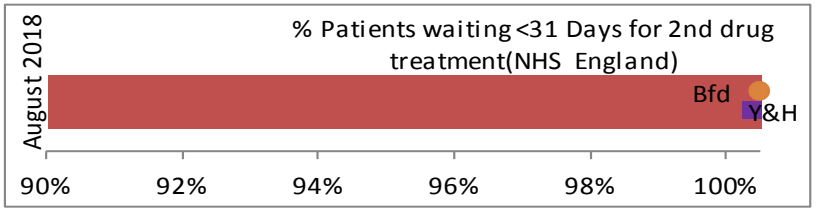
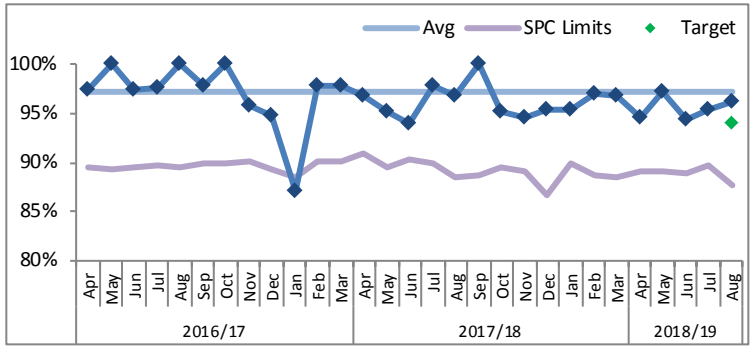
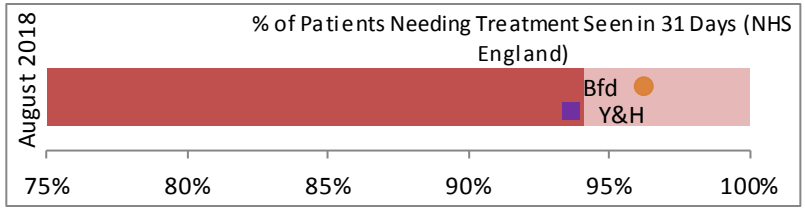
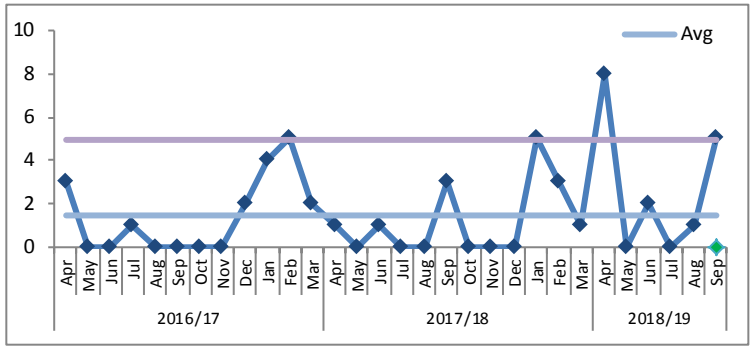
National Indicators

National Target – Non-Financial

	Trend	Challenges and Successes	Comparison	Exec Lead
Cancer 2 Week GP		Reported performance for August 2018/19 was 59.7% which remains below target. The main contributing specialties are Dermatology, Lower Gastrointestinal and Urology. Urology fast track (FT) capacity has increased above predicted demand levels to support backlog clearance. Dermatology pathway changes, in conjunction with the clinical commissioning group (CCG), have commenced which will allow us to increase fast track capacity for this site. Improvement should be noticeable from November with recovery to trajectory in Quarter 4.		Chief Operating Officer
Cancer 31 Day 1st Treatment		This standard was not achieved in August 2018/19 with 19 breaches mainly due to Urology surgical capacity issues. 62 day improvement actions for this specialty will also help this indicator.		Chief Operating Officer
Cancer 2 Week - Breast		This standard was achieved in August 2018/19 and projected to be achieved in September 2018/19.		Chief Operating Officer

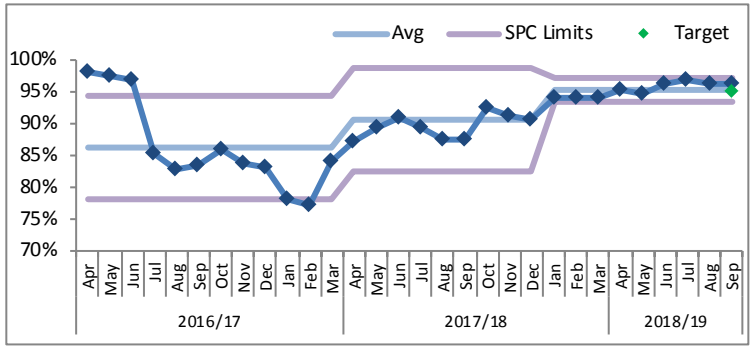
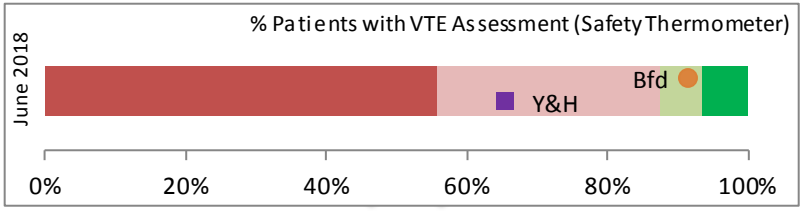
National Indicators

National Target – Non-Financial

	Trend	Challenges and Successes	Comparison	Exec Lead
Cancer 2nd Treatment Drugs		This standard was achieved in August 2018/19 and projected to be achieved in September 2018/19.		Chief Operating Officer
Cancer 2nd Treatment Surgery		This standard was achieved in August 2018/19 and projected to be achieved in September 2018/19.		Chief Operating Officer
Cancelled Operations 28 day		There was 5 breaches (3 in Ophthalmology, 1 in General Surgery and 1 in Urology) of the 28 day standard in September 2018/19 following a higher than average number of reportable same day cancellations at the end of July due to session over runs. The weekly review cycle has been strengthened and now mirrors the referral to treatment (RTT) 40+ process. There are no predicted breaches for October 2018.		Chief Operating Officer

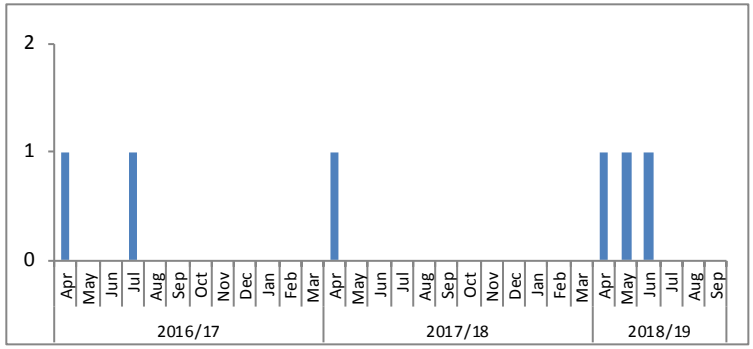
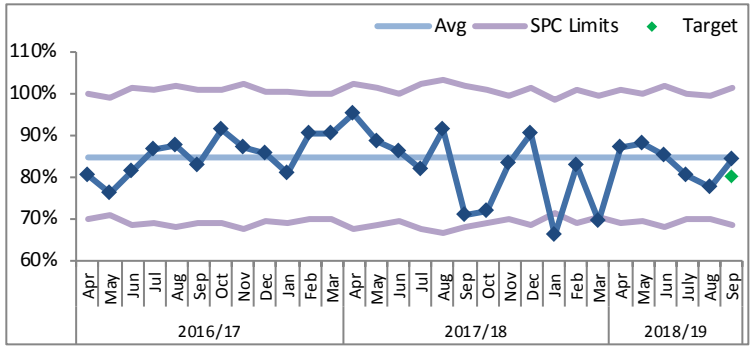
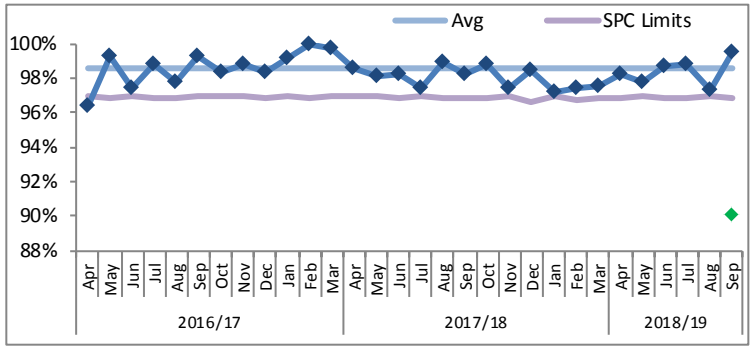
National Indicators

National Target – Non-Financial

	Trend	Challenges and Successes	Comparison	Exec Lead
VTE Assessment		The trust has sustained delivery of > 95% for this standard for the past 5 months. 		Chief Medical Officer
Formulary	The Trust ensures that the Formulary is published on the website		No comparator data is available.	Chief Digital and Information Officer

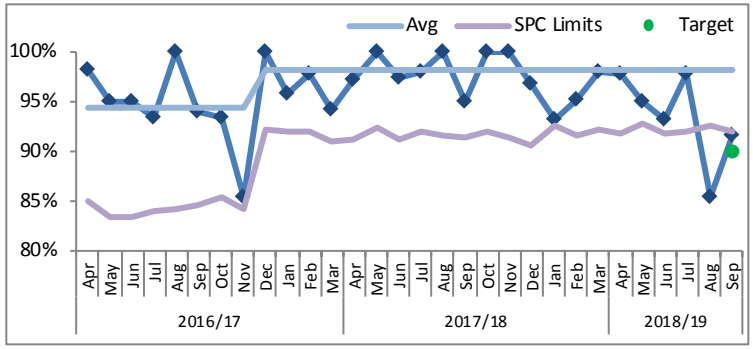
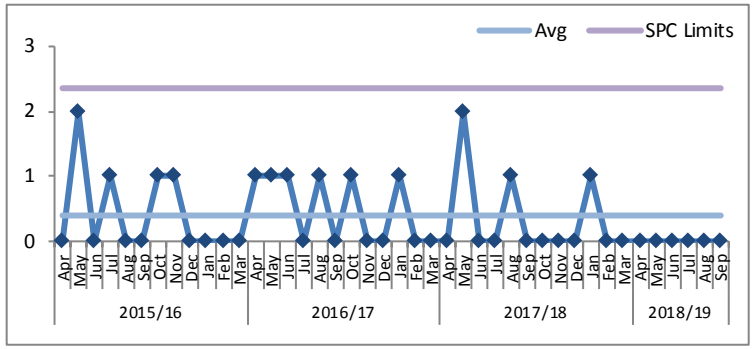
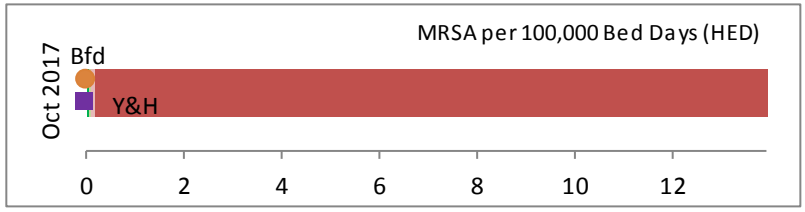
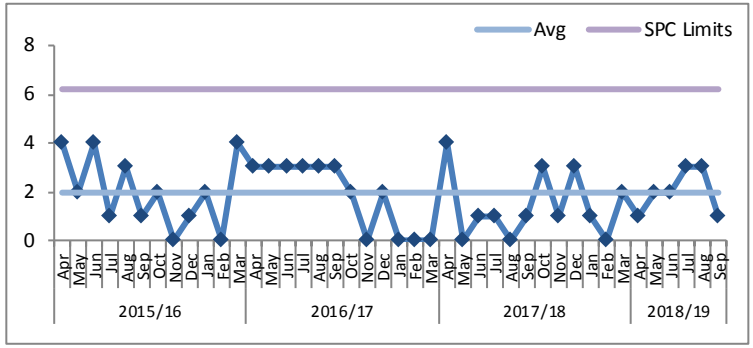
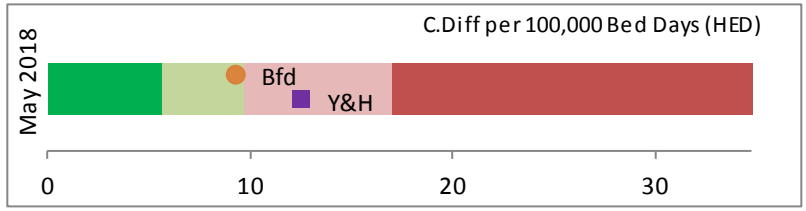
National Indicators

National Target – Financial

	Trend	Challenges and Successes	Comparison	Exec Lead
Never Events		There were no never events for September 2018/19.	No comparator data is available.	Chief Operating Officer
Stroke Strategy		For September 2018/19 84.1% of eligible patients spent 90% of their time on a designated stroke ward, which is above the 80% target. The improvement plan continues to be implemented with oversight from the Chief Medical Officer.		Chief Operating Officer
Seen By Midwife <13 Weeks		The threshold continues to be achieved.		Chief Operating Officer

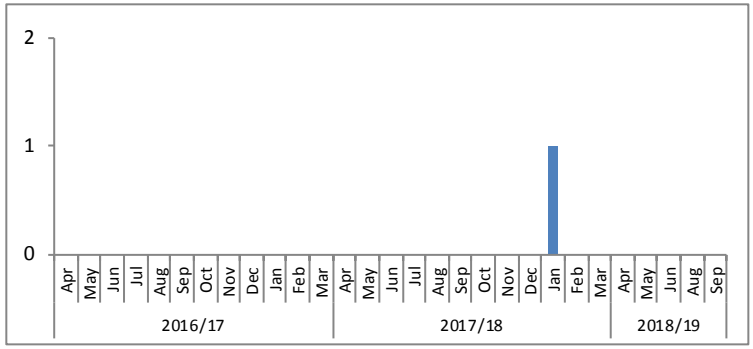
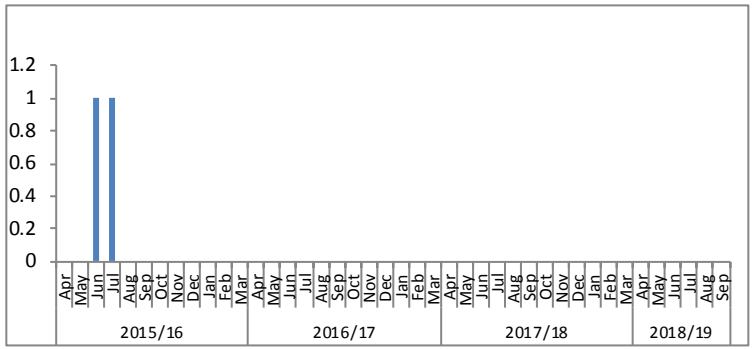
National Indicators

National Target – Financial

	Trend	Challenges and Successes	Comparison	Exec Lead
Seen By Midwife > 12 Weeks		The position was recovered above target in September 2018/19 following failure of the standard last month. The community and antenatal care managers are reviewing the cases which failed the standard in August 2018/19 to identify the root cause and a remedial action plan has been developed from the findings.		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 (PIR) process is in place. Below trajectory.		Chief Nurse

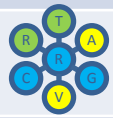
National Indicators

National Target – Financial

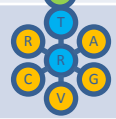
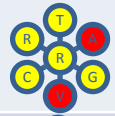
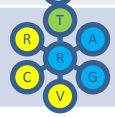
	Trend	Challenges and Successes	Comparison	Exec Lead
Duty of Candour		There were no Duty of Candour breaches in August 2018/19.		Director of Strategy and Integration
Mixed Sex Breaches		There have been no Mixed Sex Breaches.		Chief Operating Officer

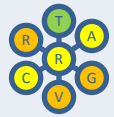
Glossary

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	

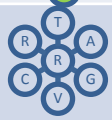
Indicator	Definition	Data Quality Kite-Mark
Harm Free Care		
VTE Assessment	VTE risk assessments completed Red < 90%, Amber >=90% & < 95%, Green >=95%	
Falls with Harm	Patient falls resulting from harm. The benchmarking data comes from the Safety Thermometer prevalence information. Red >= 40, Amber >=25 & < 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	
Sepsis patients receive antibiotics within an hour	Percentage of patients who were found to have sepsis during the screening process and received IV antibiotics within 1 hour	

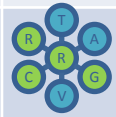
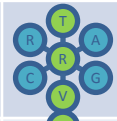
Glossary

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	

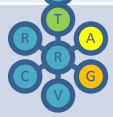
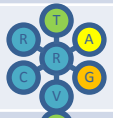
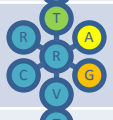
Indicator	Definition	Data Quality Kite-Mark
Audits		
Audit of WHO Checklist	Audit of the World Health Organisation surgical checklist monitoring the number that were complete compared to the number of checklists Red < 90%, Amber >=90% & < 95%, Green >=95%	
Serious incidents	Unexpected or avoidable death, 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	

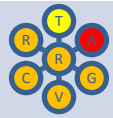
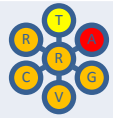
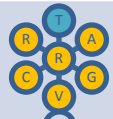
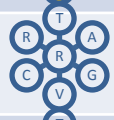
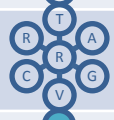
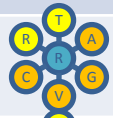
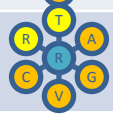
Glossary

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%	

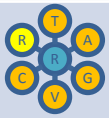
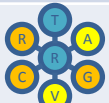
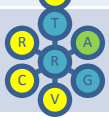
Indicator	Definition	Data Quality Kite-Mark
To be in the top 20% of employers in the NHS		
Appraisals		
Appraisal Rate Non-Medical	% of eligible staff employed at the trusts who have had an appraisal in the last 12 months. Red <75%, Amber >=75% and <95%, Green >=95%	
Experience		
BAME % Senior Leaders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

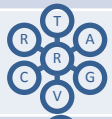
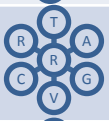
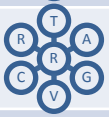
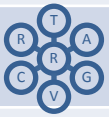
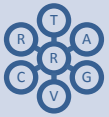
Glossary

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	

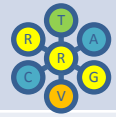
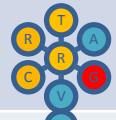
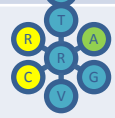
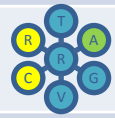
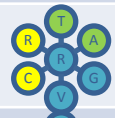
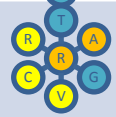
Indicator	Definition	Data Quality Kite-Mark
To deliver our financial plan and key performance targets		
In-Patient Productivity		
Length of Stay Elective	The average length of stay for elective patients, in days. The benchmark data is for Acute trusts for June 2017 from HED, which has a subtly different calculation, which can result in very small differences in numbers. Red < 50th Percentile England, Amber 50 – 25th Percentile ,Green Upper Quartile England	
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 < 50th Percentile England, Amber 50 – 25th Percentile, Green Upper Quartile England	
Bed Occupancy	Average % of available beds which were occupied overnight. Red >=95%, Amber 85-95%, Green <85%	
Stranded Patients LoS >= 7 days	The average number of patients (excluding Maternity) who have been in hospital 7 days or more.	
Super Stranded Patients LoS >= 21 days	The average number of patients (excluding Maternity) who have been in hospital 21 days or more.	
Discharges before 1 pm	Number of discharges from hospital which happened before 1 pm. Red < 50th Percentile England, Amber 50 – 25th Percentile, Green Upper Quartile England	
Out-Patient Productivity		
Did Not Attend Follow-Up	This is the % of Follow-up Outpatient appointments where the patient does not attend. Red < 50th Percentile England, Amber 50 – 25th Percentile, Green Upper Quartile England	
Did Not Attend New	This is the % of New Outpatient appointments where the patient does not attend. Red < 50th Percentile England, Amber 50 – 25th Percentile, Green Upper Quartile England	

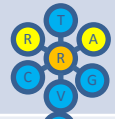
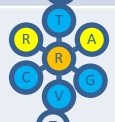
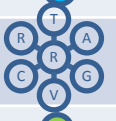
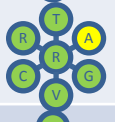
Glossary

Indicator	Definition	Data Quality Kite-Mark
Out-Patient Productivity		
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 < 50th Percentile England, Amber 50 – 25th Percentile, Green Upper Quartile England	
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. Red Greater than last month, Amber , Green Less than last month	

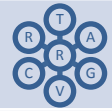
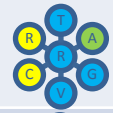
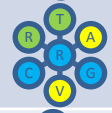
Indicator	Definition	Data Quality Kite-Mark
Finance		
Delivery of financial plan	Delivery of finances against plan.	
Use of Resources - Financial	Use of resources is a calculation on the status of a number of financial measures – Capital Servicing Capacity, Liquidity, I & E Margin, and Agency Spend.	
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.	
Service Level Agreements		
Mission Critical Systems	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%	
Radiology Turnaround Time Fast Track	Radiology Turnaround Time for Fast Track Scan to Report. Percentage reported within 14 days.	
Radiology Turnaround Time Outpatients	Radiology Turnaround Time for Outpatient Scan to Report. Percentage reported within 14 days for Urgent and within 4 weeks for Routine.	

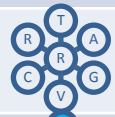
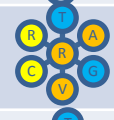
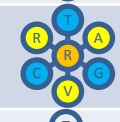
Glossary

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.