Bradford Teaching Hospitals
NHS Foundation Trust

Integrated Dashboard
Board of Directors

30th November 2018

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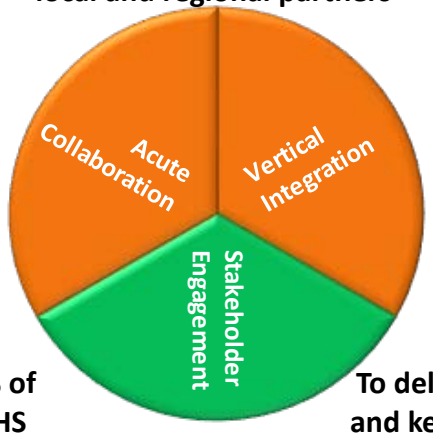
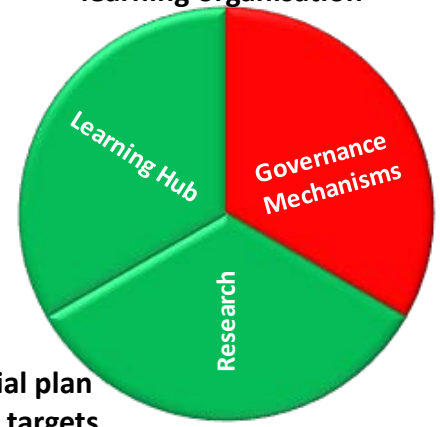
To provide outstanding care for our patients

To collaborate effectively with local and regional partners

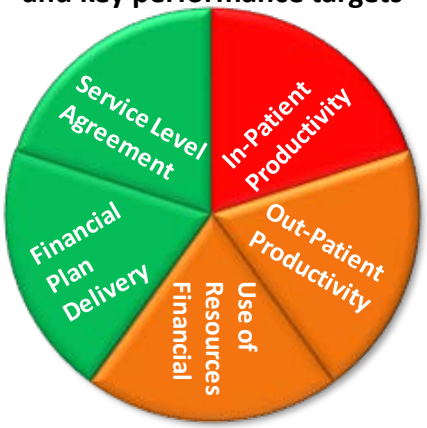


To be a continually learning organisation

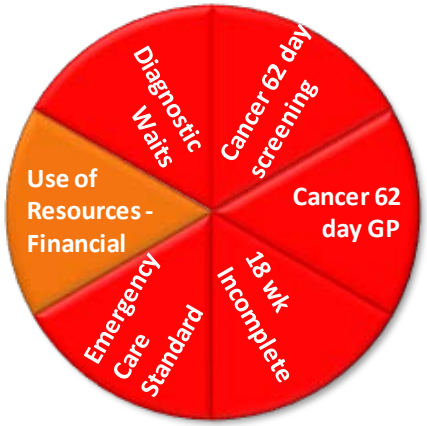


To be in the top 20% of employers in the NHS

To deliver out financial plan and key performance targets

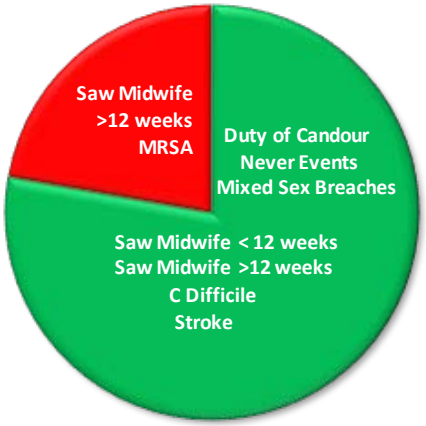


Single Oversight Framework

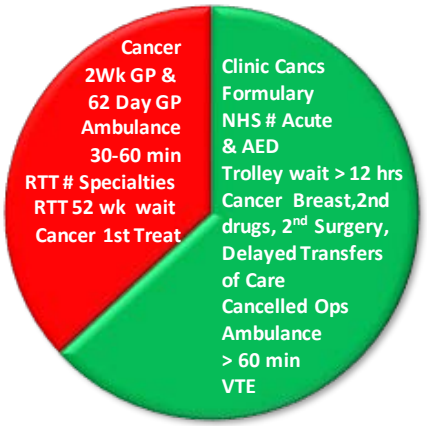


National targets

Financial



Non-Financial



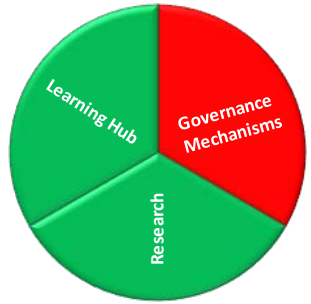
Headlines

The Trust continues to make significant progress in reducing patients on the waiting list and has seen a sustained improvement in the Referral to Treatment (RTT) 18 Week Incomplete indicator (slide 37).
All mortality indicators remain in a positive position.
Emergency attendances continue to be high. The Trust did not meet the Emergency Care Standard (ECS, slide 38) in November 2018/19 with the position off plan. Additional leadership support and control processes have been introduced. The Emergency Care Improvement Programme work continues with additional measures scheduled to be introduced including a General Practitioner (GP) advice line, an assess to admit model via the Ambulatory Care Unit (ACU), expansion of integrated minor illness and injury unit and direct streaming to assessment units. Although there has been continued high bed occupancy there has been complementary positive improvements in admissions before 1 PM.
Staff appraisal rates have improved substantially with the Trust continuing to track well to the plan to have 95% of all non-medical staff appraisals completed by the end of December 2018/19 (slide 20).
The Cancer Improvement Plan continues with a focus on urgent cancer treatment. A number of measures have been taken that are increasing the capacity to treat patients particularly in two challenged specialties where the volumes of patients are greatest.
The Trust's Month 8 position excluding Provider Sustainability Funding (PSF) is a deficit of £6.7m, which is in line with the year to date control total. Delivery of the 2018/19 control total at year end is contingent on recovery of the planned benefits from the Alternative Delivery Model (ADM) for Estates and Facilities, recovery of an appropriate element of the estimated contract income overtrade and delivery in full of the 2018/19 Financial Recovery Plan. The Financial Recovery Plan shared with NHS Improvement targets £11.7m of run rate improvements to deliver the control total – these plans include £5.3m of technical measures and £6.4m of run rate improvements. There remains a significant degree of risk to full delivery of the Financial Recovery Plan, however efforts are being made to identify additional options to mitigate this risk.

Quality Dashboard
30th November 2018

To provide outstanding care for our patients

To be a continually learning organisation



A working group is being set up to review all of the Quality Committee key performance indicators (KPI's) in line with the emerging quality strategy, this will be reported via Quality Committee and effective from 2019/20.
All mortality indicators remain better than expected. However, caution as the Summary Hospital-level Mortality Indicator (SHMI, slide 9) is being reviewed nationally and the data may change.
We continue to have strong performance with the infection control measures, with the exception of Catheter Associated Urinary Tract Infection (CAUTI, slide 12) – Infection Control committee is currently reviewing..
Venous thromboembolism (VTE, slide 11) performance remains strong. However, we intend to start reporting hospital acquired thrombosis from April 2019/20.
The majority of falls with harm (slide 11) are low harm, we intend to revise this indicator to provide greater clarity on the actual levels of harm.
Night time transfers (slide 13) remain low. However, we intend to start reporting night time discharges by exception.

Workforce Dashboard
30th November 2018

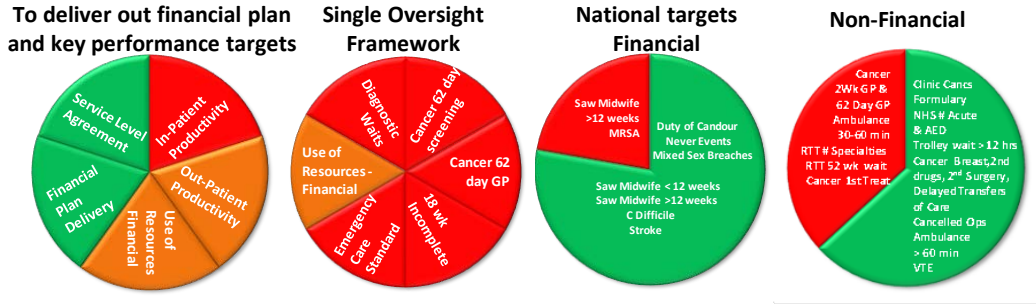
To be in the top 20% of employers in the NHS

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 2018/19 (slide 20).
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 reviewed and additional interventions and support put in place where we are seeing the biggest increases. An exception report was provided to Workforce Committee in November 2018/19 which detailed the actions in place. We will not achieve our 4% target at the end of March 2019 (slide 22).
Nursing / 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. Karen Dawber (Chief Nurse) to check (slide 23).
Agency use has continued to reduce and we remain below our target spend (slide 24).
The Black, Asian and Minority Ethnic (BAME) workforce, from our most recent data, shows us making good progress with us being ahead of trajectory on our overall workforce, and a slight closing of the gap on senior staff. A new recruitment process is now in place for senior appointments (slide 20).

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

Finance & Performance Dashboard

30th November 2018



Emergency Care Standard (slide 38) performance (type 1 and 3) for November 2018/19 reported 75.2% with a very high daily average of 396 type 1 & 3 attendances. Additional leadership support and a command and control process has been introduced to support recovery. An Emergency Care Improvement Programme is in place and key areas of focus include the introduction of a General Practitioner (GP) advice line, implementation of an assess to admit model via the Ambulatory Care Unit (ACU), expansion of integrated minor illness and minor injury unit in January 2019, and introduction of direct streaming to assessment units.

RTT Incomplete performance (slide 37) for November 2018/19 was 79.01% which is an improvement on October 2018/19 but remains behind the original improvement trajectory in the annual plan. Detailed recovery plans have been developed with all specialties as part of the Planned Care Recovery Programme. Activity has increased in line with these plans which will support delivery of 88-89% performance by March 2019.

Cancer 2 Week Wait (slide 42) reported performance for October 2018/19 was 55.78% which remains below target but recovery plans enacted during November have significantly improved performance with December close to 90% and recovery to trajectory in Quarter 4 a realistic goal.

Cancer 62 Day Treatment (slide 38) reported performance position for October 2018/19 is 62.31%. Urology contributes the majority of breaches. Site specific capacity and demand has been reviewed and pathways streamlined to remove bottle necks and duplicated process. Short term recovery is being managed through additional diagnostic and treatment capacity with 62 day backlogs reducing significantly in recent weeks.

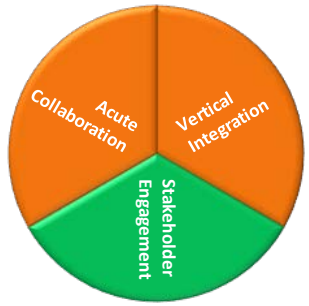
The Trust has delivered its pre-Provider Sustainability Fund (PSF) control total deficit of £6.7m at the end of Month 8. Liquidity is 2.6 days which is 0.2 days below plan. Cash balances are £16.1m below plan. The overall Use of Resources (UoR) Risk Rating is 3 which is in line with plan (slides 32-33).

Delivery of the 2018/19 control total at year end is contingent on recovery of the planned benefits from the Alternative Delivery Model (ADM) for Estates and Facilities, recovery of an appropriate element of the estimated contract income overtrade and delivery in full of the 2018/19 Financial Recovery Plan. The Recovery Plan shared with NHS Improvement targets £11.7m of run rate improvements to deliver the control total – these plans include £5.3m of technical measures and £6.4m of run rate improvements. There remains a significant degree of risk to full delivery of the Financial Recovery Plan.

The current forecast pre-Provider Sustainability Fund (PSF) year end position ranges from successful delivery of the £7.5m control total deficit target to delivery of a deficit of £12.2m which would be £4.7m below the control total. Should the Alternative Delivery Model (ADM) benefits not be realised in 2018/19, this position would deteriorate by a further £7m. The Trust continues to investigate alternative measures to add to the Financial Recovery Plan to mitigate these risks.

Partnership Dashboard
30th November 2018

To collaborate effectively with local and regional partners



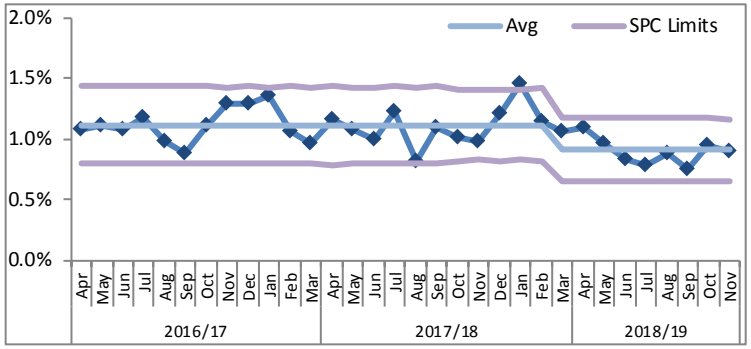
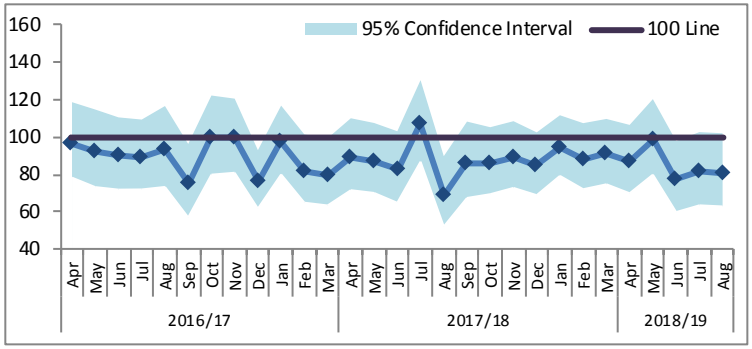
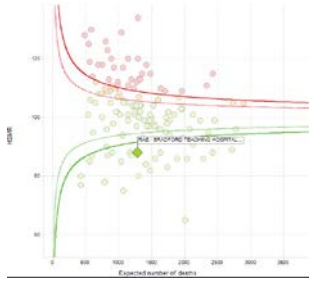
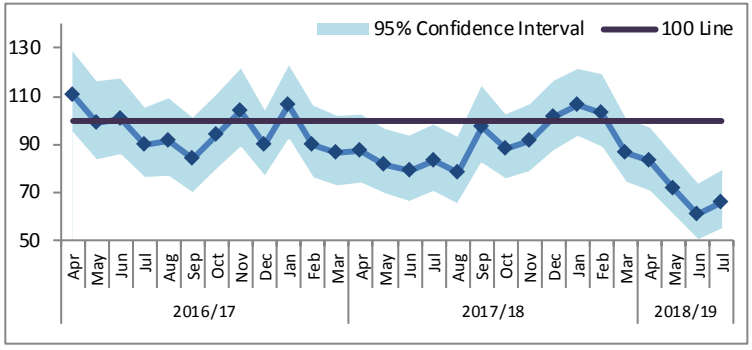
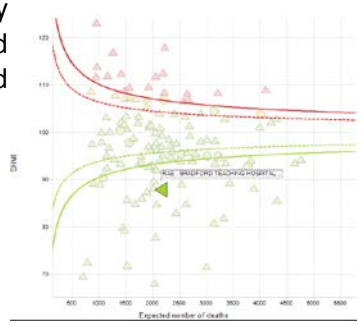
Vertical Integration – There is ongoing work to draft a Strategic Partnering Agreement (SPA) between local partners within the Bradford and District Health and Care Partnership Board. This will create a framework for financial, governance and contractual working between the partner organisations, and the Partnership Committee has agreed the trust should continue to support this work. A common approach has been agreed with Airedale, Wharfedale and Craven Partnership Board, and the two Partnership Boards are now working towards signing off a consistent set agreements by the end of March 2019. The Committee has seen the latest draft of the SPA document to feed through comments for the trust to use in discussions with partners in the coming weeks. The most significant of those discussion will be the two Partnership Boards having a joint discussion at the end of January 2019. (slide 18)

Stakeholder Engagement - The Committee has previously 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. There has been work completed recently to do this, with self-assessments by Account Managers of stakeholder relationships and the closing of the latest stakeholder engagement survey. The results of these will be discussed at a future board development session.

Acute collaboration – The Committee has previously noted the progress of the collaboration with Airedale foundation Trust. This progress is now gaining pace with plans to formally launch the programme of work across all the relevant specialties at both organisations through a Clinical Summit at the end of the financial year. The programme has also appointed an executive lead who will also be in post at the end of the financial year. Work is ongoing to establish the necessary resource and governance for the programme ahead of its launch. In acute collaboration more broadly, the committee has previously noted the progress of the approval of the West Yorkshire Association of Acute Trusts (WYAAT) vascular recommendation – NHS England have approved this decision and is looking for that to be ratified at the next West Yorkshire Health and Overview Scrutiny Committee.

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 Summary Hospital-level Mortality Indicator (SHMI) has remained unchanged and demonstrates good performance.		Chief Medical Officer

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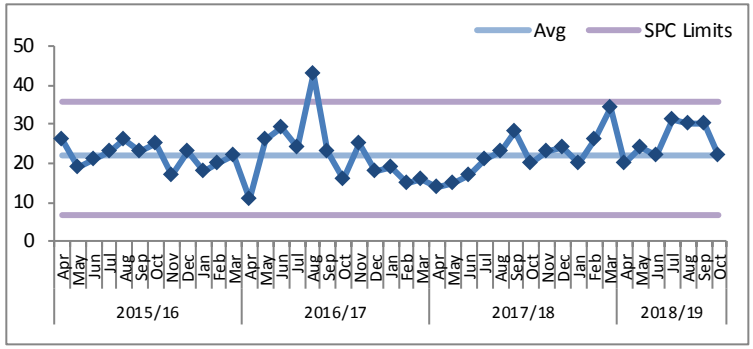
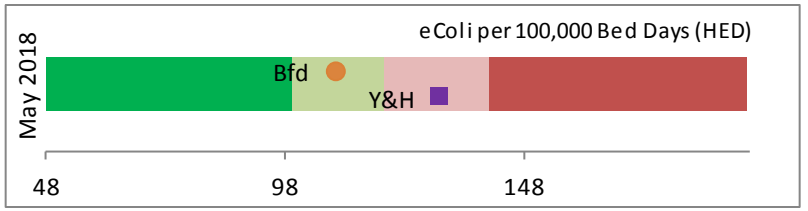
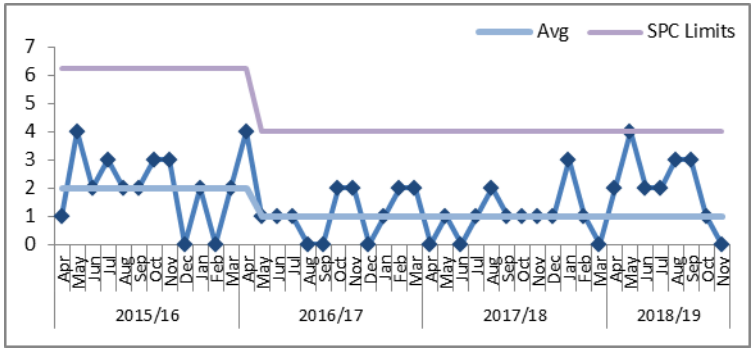
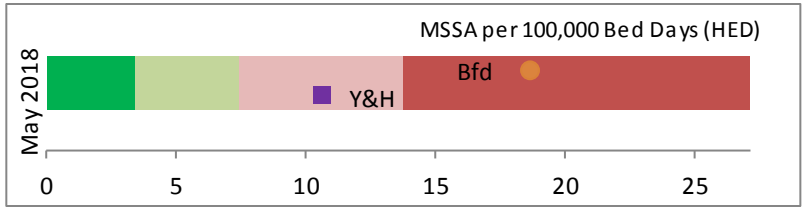
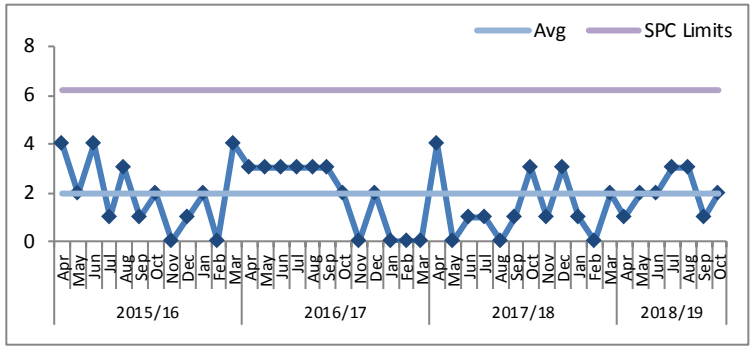
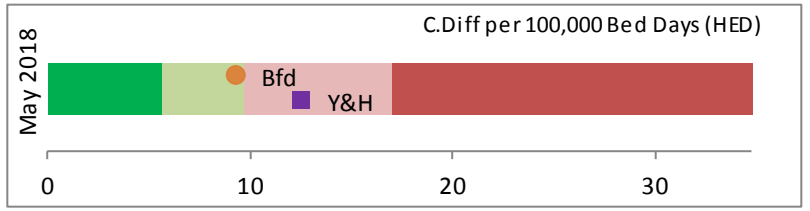
	Trend	Challenges and Successes	Comparison	Exec Lead
eColi		As part of the 2018/19 work plan we will focussing on all bacteraemias. We have seen a reduction of 26% on the previous 12 months (NHS Improvement).		Chief Nurse
MSSA		Part of national improvement collaborative for Infection Prevention and Control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

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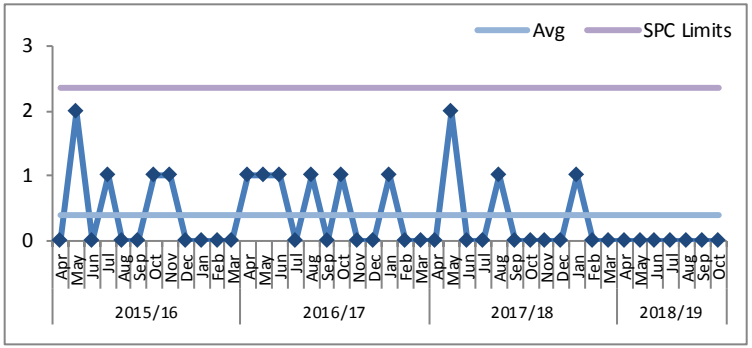
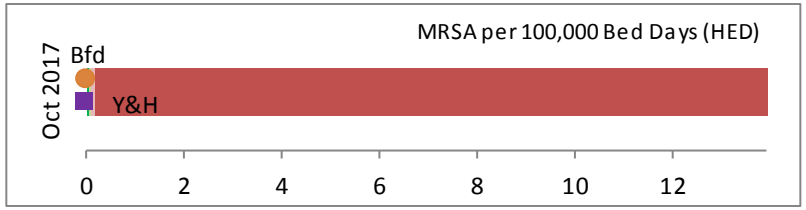
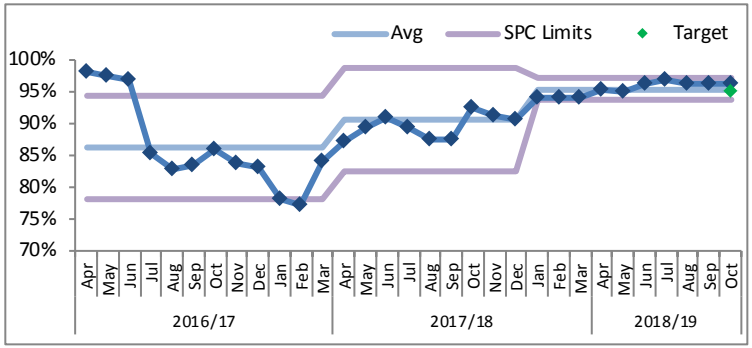
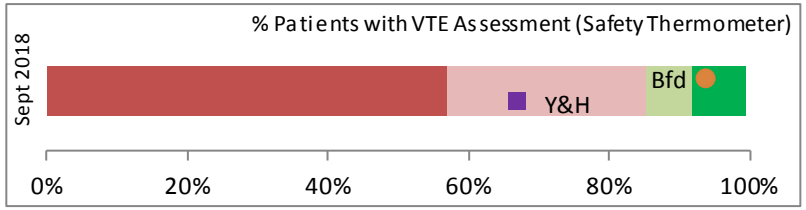
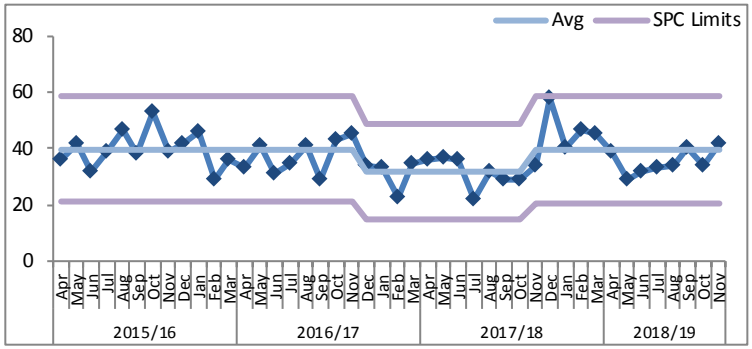
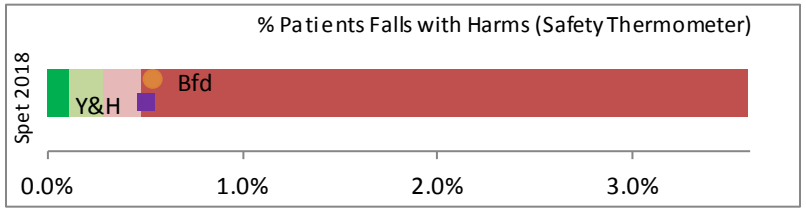
	Trend	Challenges and Successes	Comparison	Exec Lead
MRSA		Zero Methicillin-resistant Staphylococcus aureus (MRSA) year to date.		Chief Nurse
VTE Assessment		The Venous Thromboembolism (VTE) assessment shows sustained compliance with the standard.		Chief Medical Officer
Falls with Harm		For the month of November there were 42 falls with harm. Of these: 37 were low harm, 4 were moderate harm, and 1 was severe harm.		Chief Nurse

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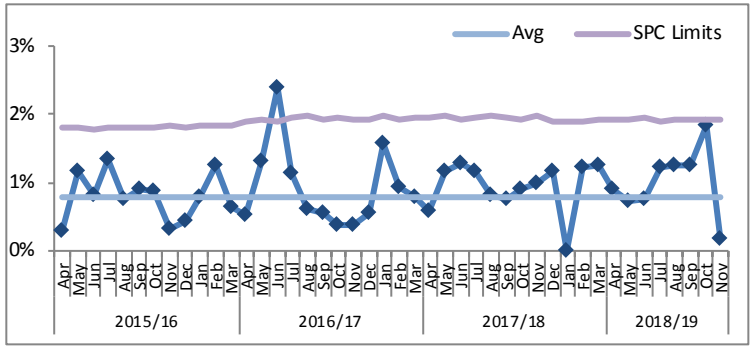
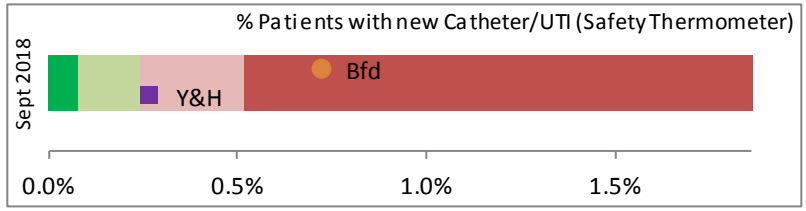
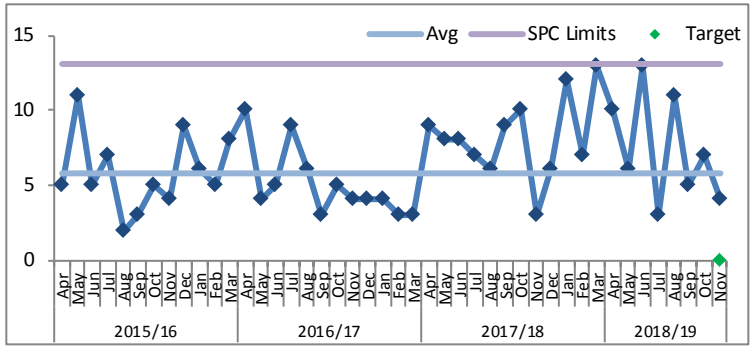
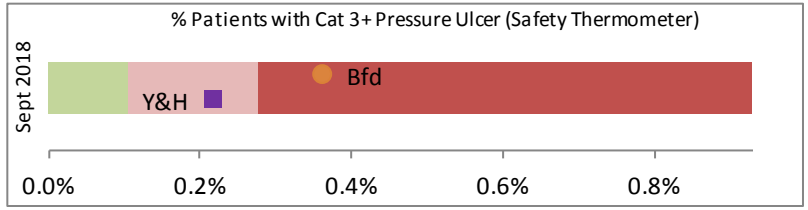
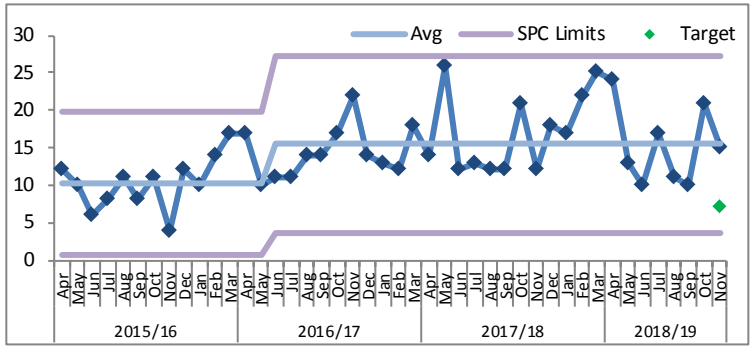
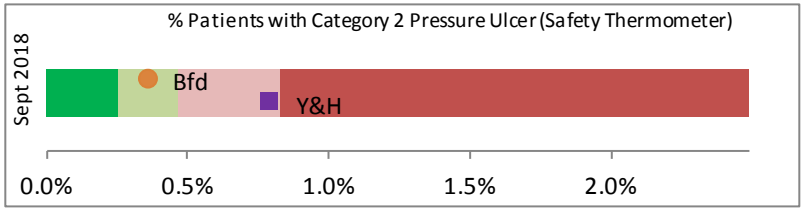
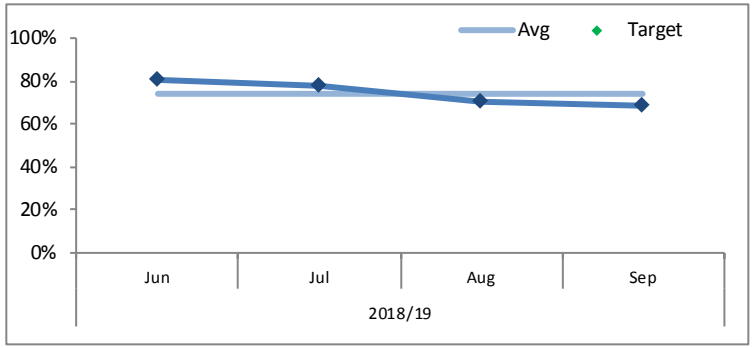
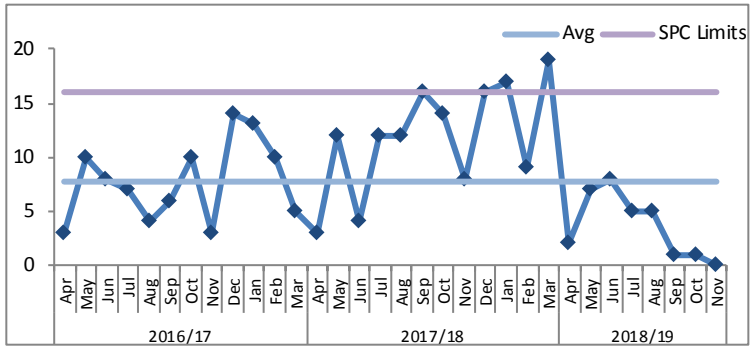
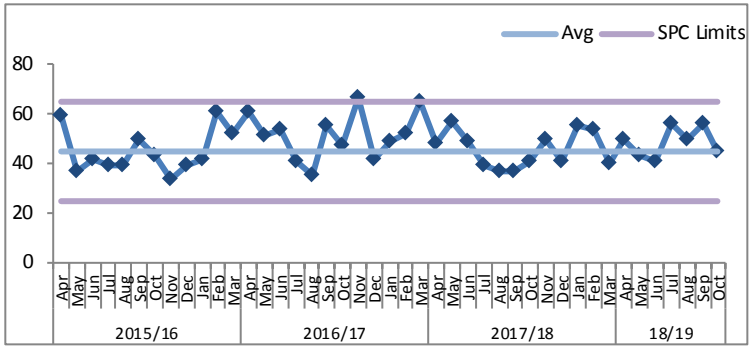
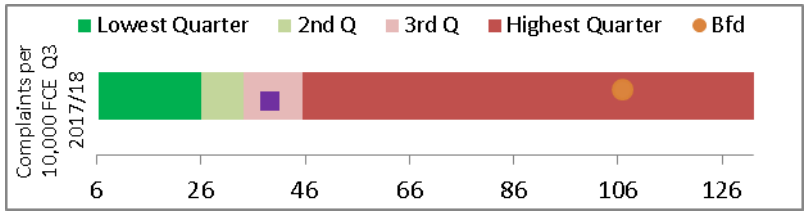
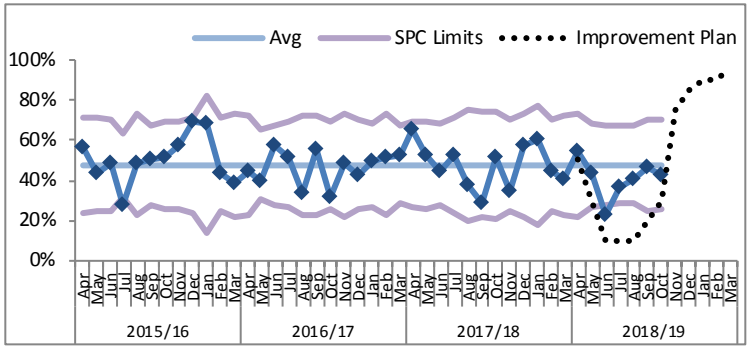
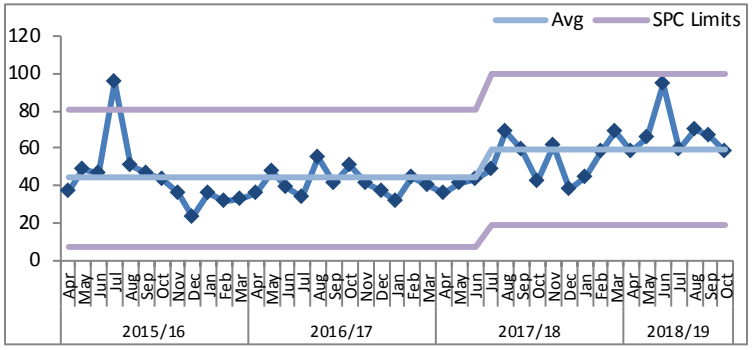
	Trend	Challenges and Successes	Comparison	Exec Lead
Catheters & UTIs		The infection control team is reviewing the data submission relating to Catheters and Urinary Tract Infections (CAUTI), including a review of the indicator.		Chief Nurse
Pressure Ulcers Cat 3+		Further work is being planned with the Chief Nurse to introduce new standards relating to pressure ulcers and the impact on how we record and document		Chief Nurse

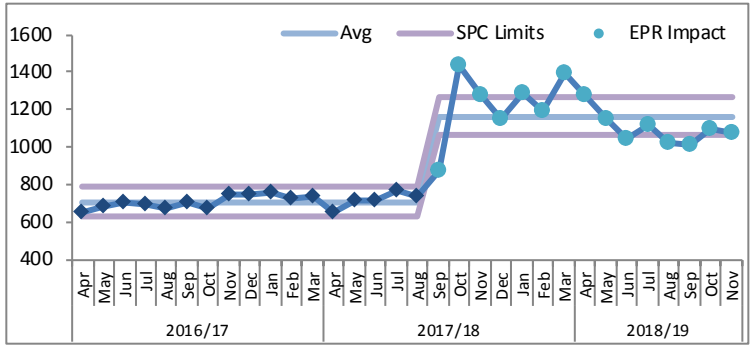
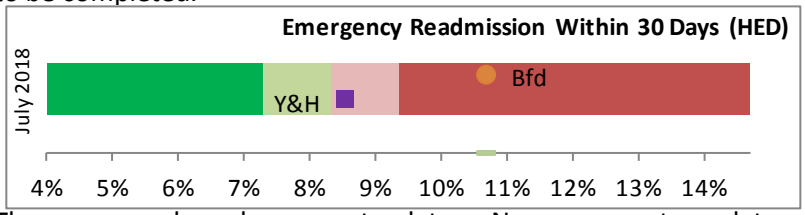
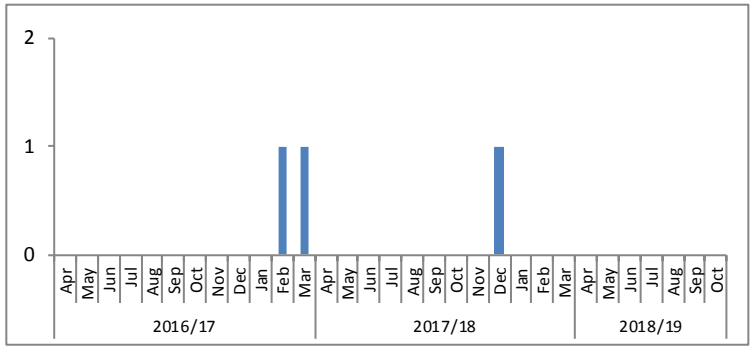
To provide outstanding care for patients

	Trend	Challenges and Successes	Comparison	Exec Lead
Pressure Ulcers Cat 2		Further work is being planned with the Chief Nurse to introduce new standards relating to pressure ulcers and the impact on how we record and document.		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. We have introduced (November 2018/19) the capability to measure on a weekly basis to enable targeted intervention.		Chief Nurse
Night-time Transfers		There were no transfers for non-clinical reasons during November 2018/19.		Chief Operating Officer

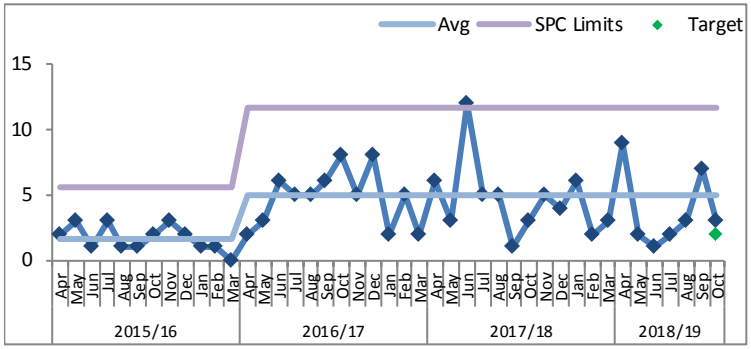
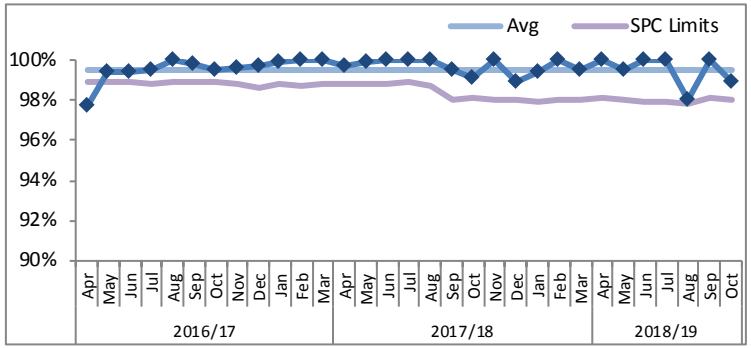
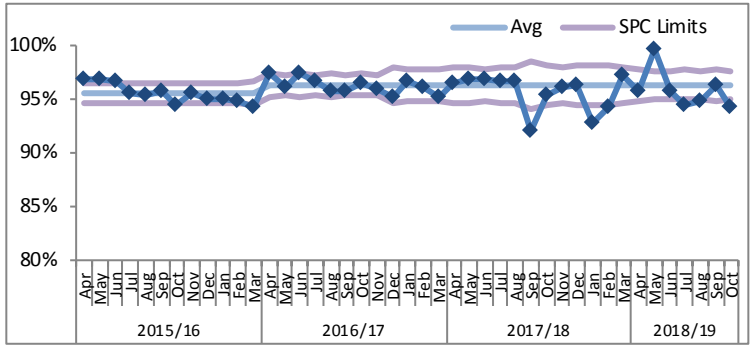
To provide outstanding care for patients

	Trend	Challenges and Successes	Comparison	Exec Lead
Complaints		Remain static and with variation.		Chief Nurse
Complaints Closed		Backlog is reducing with total number of complaints reducing by over one third.		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

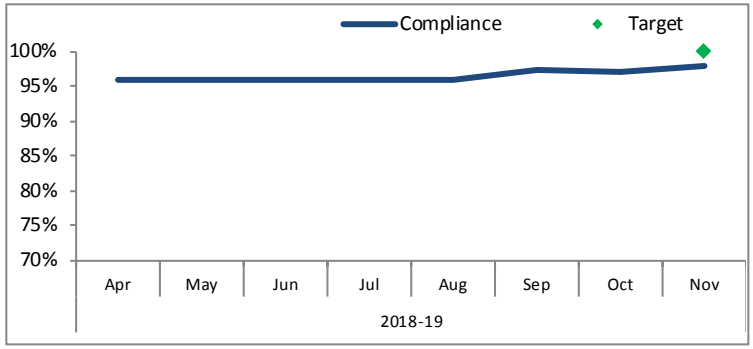
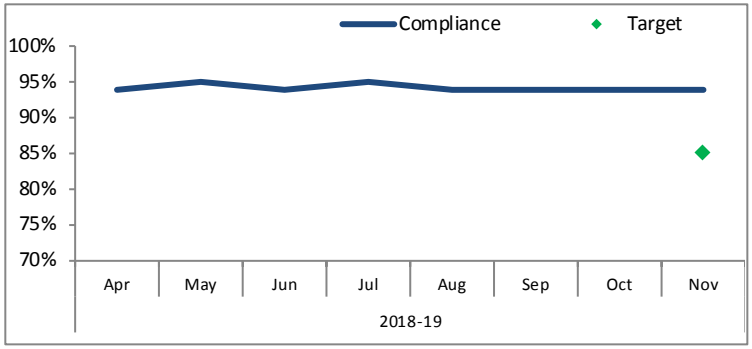
To provide outstanding care for patients

	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. 		Chief Operating Officer
Information Governance Breaches		There are no breaches year to date (YTD) 2018/19. Awareness remains high.	No comparator data is published.	Chief Digital and Information Officer

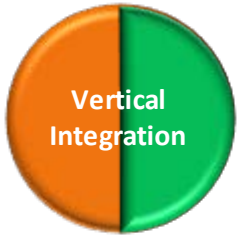
To provide outstanding care for patients

	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		There is a small degree of variation (99-100%) in achieving 100% compliance. Data by theatre block is shared directly with staff to drive improvements and feeds into the theatre improvement work.	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

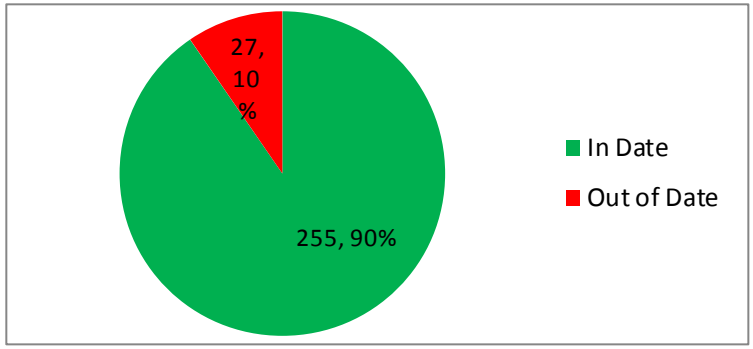
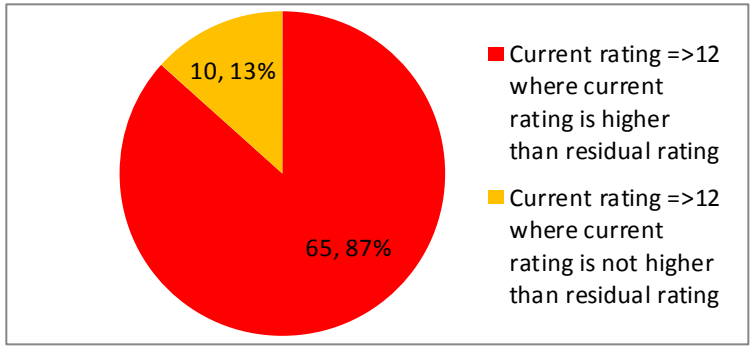
To be a continually learning organisation

	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

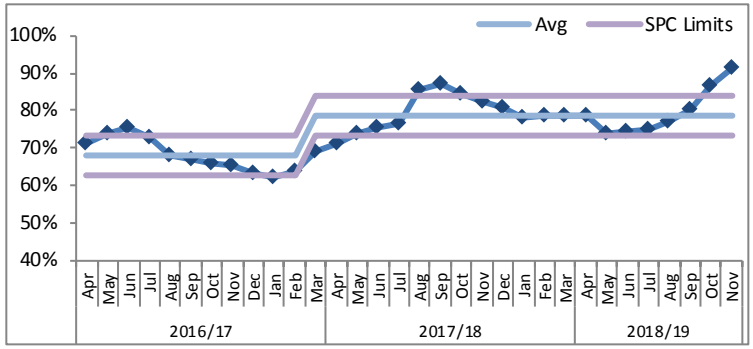
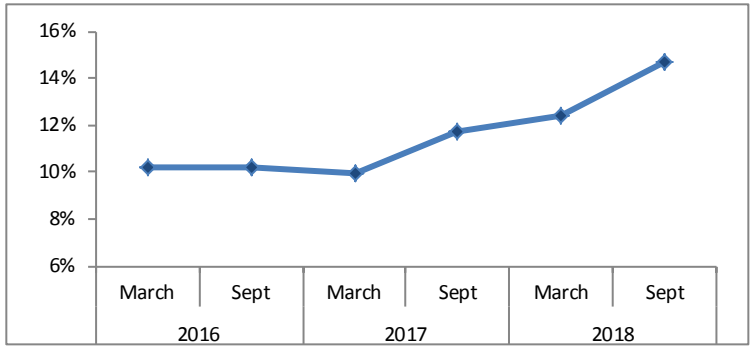
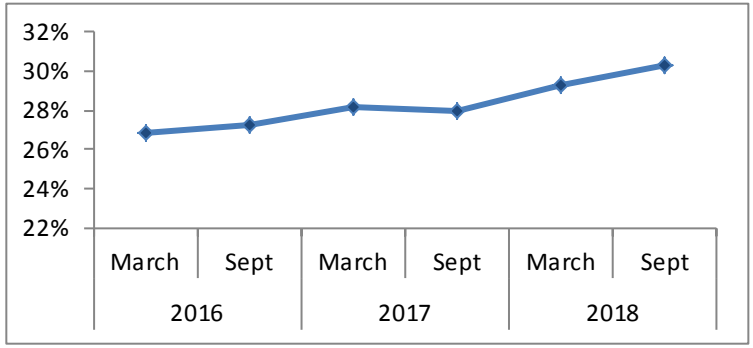
To collaborate effectively with local and regional partners

	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 Partnership 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 Partnership 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 variation, address workforce shortages, achieve efficiencies etc. However the collaboration 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 - however our positions with individual acute trusts continually shifts . The Partnership Committee has advised that progress/red, amber, green (RAG) rating should be based on a subjective assessment, in the absence of a meaningful hard metric. There is an action to assess whether broader information or objective processes can be fed into in directorate judgment as to whether key performance indicators (KPI's) are being attained. There is also an action to ensure specific risks related to this objective are discussed in Partnership committee updates.			Director of Strategy & Integration

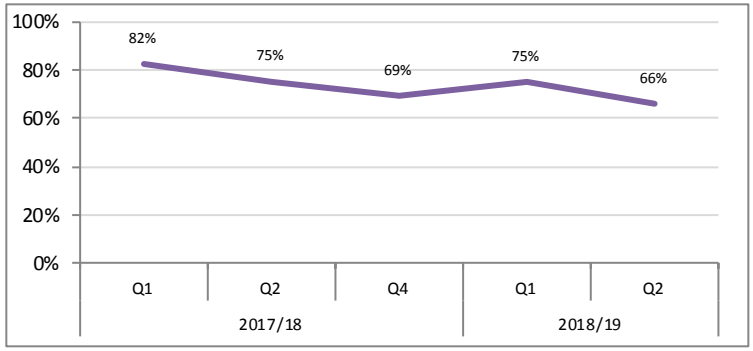
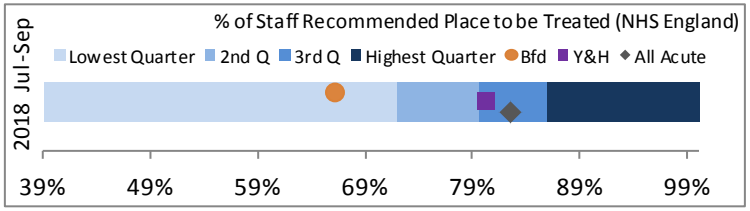
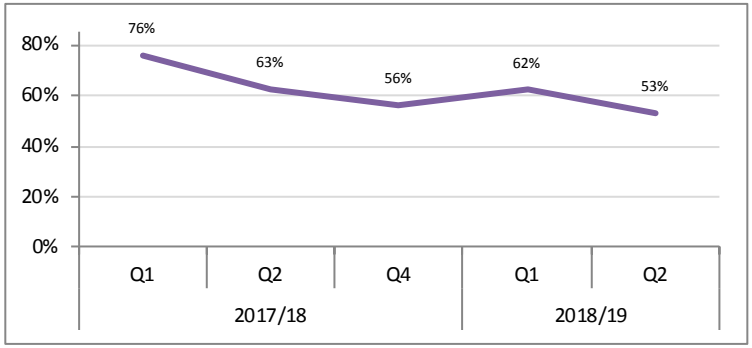
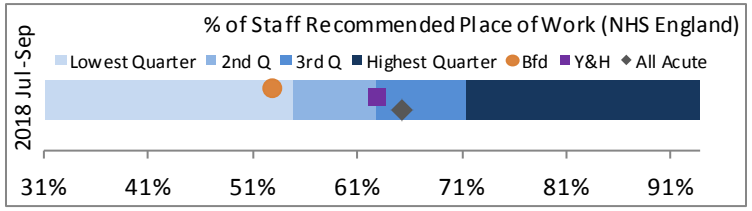
To be a continually learning organisation

	Trend	Challenges and Successes	Comparison	Exec Lead
		A focussed programme of work commenced in Quarter 3 2018/19 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 Strategy & Integration
		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 Strategy & Integration

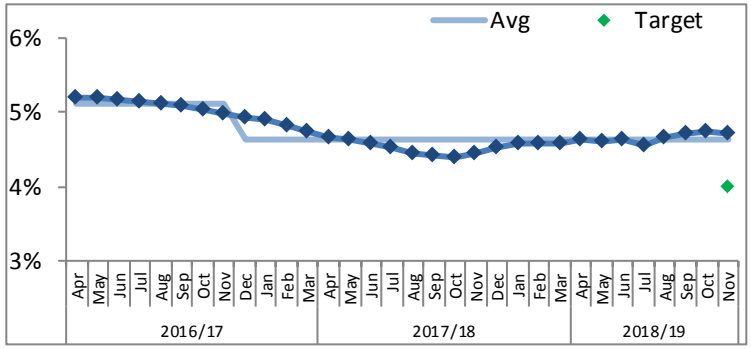
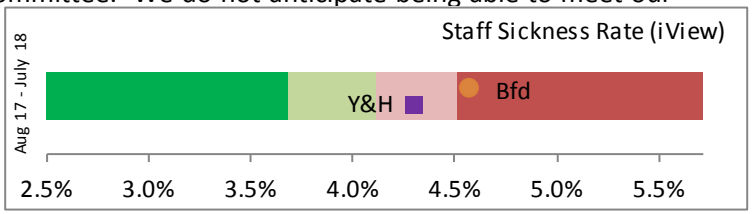
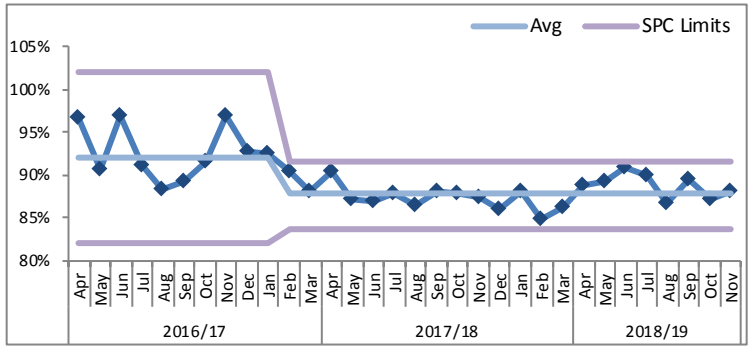
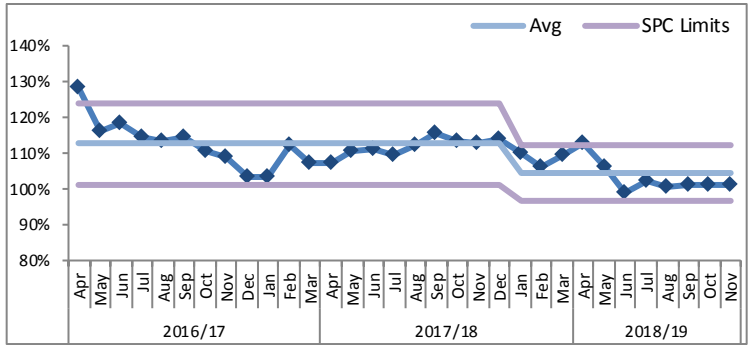
To be in the top 20% of employers in the NHS

	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 80.16% in September to 86.68% in October 2018/19. All three divisions showed an increase: Division of Women and Children increased from 91.59% to 93.32%; Division of Anaesthesia, Diagnostics and Surgery increased from 79.01% to 86.97% and Division of Medicine and Integrated Care from 77.51% to 86.55%. Work continues to focus on targeted support for managers in 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 increased 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 10%. This has reduced from 13%. No comparator data is available. Senior BAME staff are now involved in recruitment for Band 8+9 posts, with the aim of accelerating progress on this target.		Director of Human Resources
BAME % Workforce		Good progress is being made. We are 6% ahead of our trajectory to have a workforce reflective of the local ethnic population by 2025.		Director of Human Resources

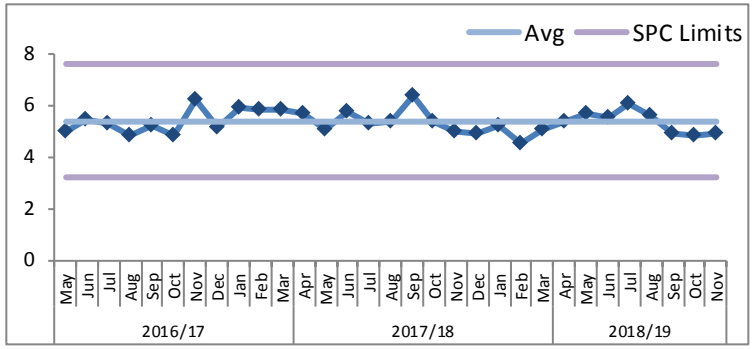
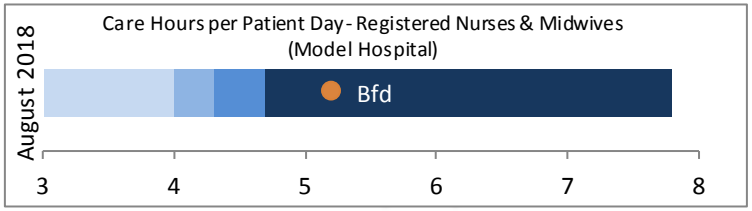
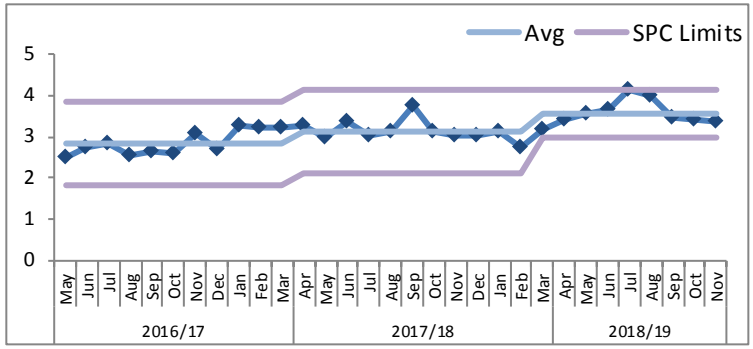
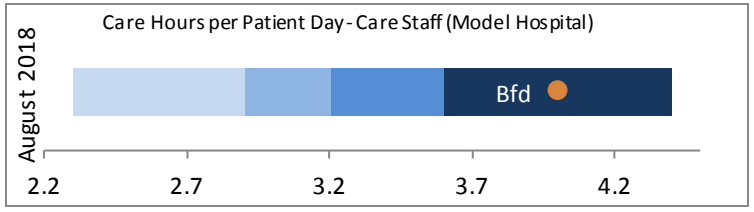
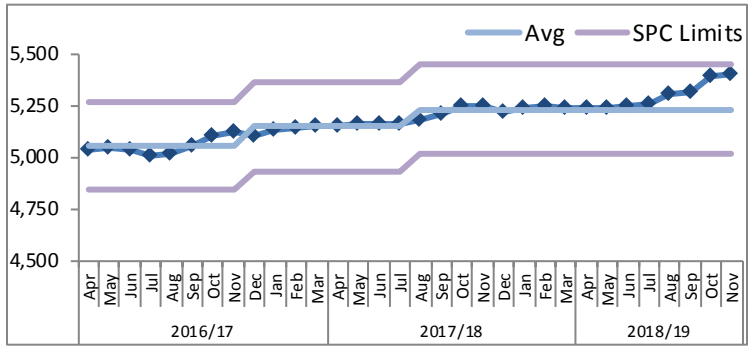
To be in the top 20% of employers in the NHS

	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 2018/19. 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

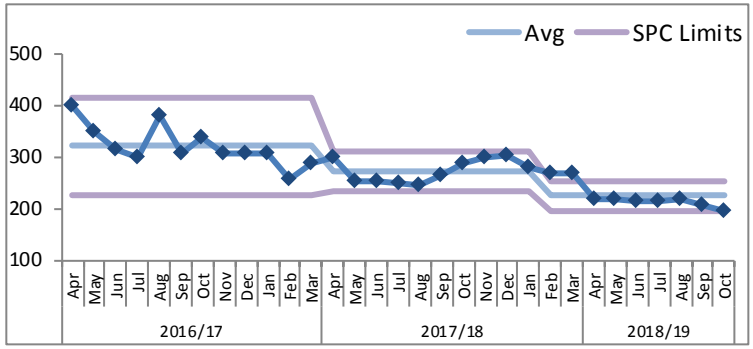
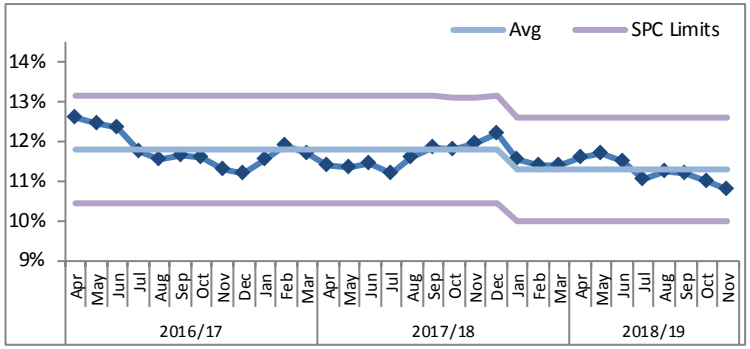
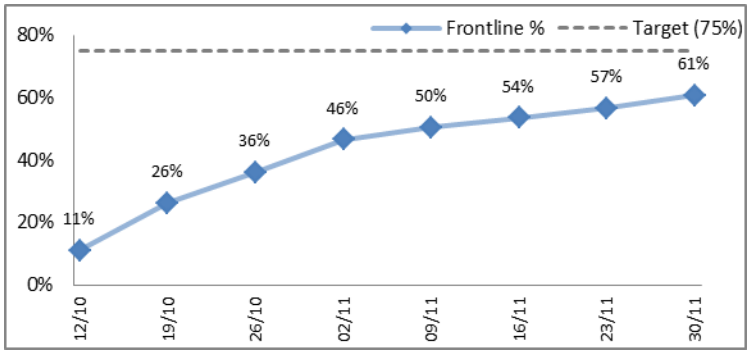
To be in the top 20% of employers in the NHS

	Trend	Challenges and Successes	Comparison	Exec Lead
Sickness		The rolling 12 month sickness absence rate as at the end of October 2018/19 was 4.75% a slight increase on the previous month. Sickness absence is increasing in Estates, Women's and Children and Core Central Services. Pharmacy's absence had been increasing since February until September 2018/19 but reduced in October 2018/19 by 0.20%. A detailed exception report is being presented to Workforce Committee. We do not anticipate being able to meet our target of 4%.		Director of Human Resources
Nursing Shifts Filled		Fill rates for Registered Nurses 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		Fill rates are now consistently 100% and are as expected.		Chief Nurse

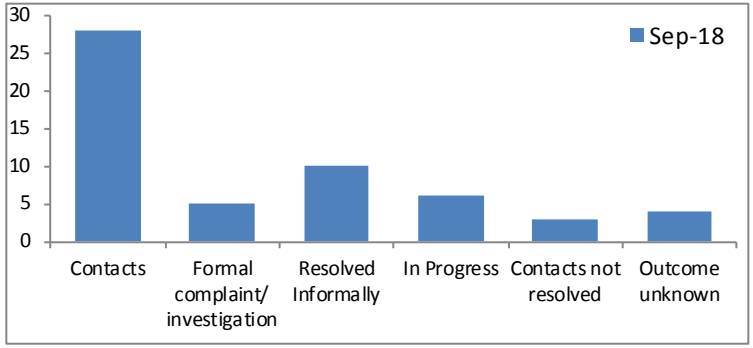
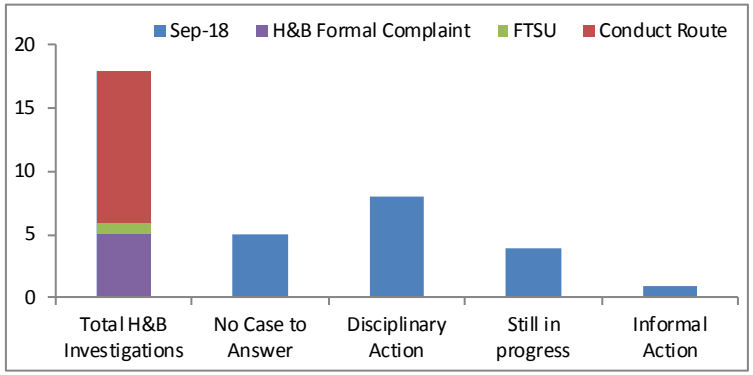
To be in the top 20% of employers in the NHS

	Trend	Challenges and Successes	Comparison	Exec Lead
Nursing Care Hours		Rate remains stable and benchmarks appropriately with model hospital data. 		Chief Nurse
Care Staff Care Hours		The carer workforce has stabilised in line with our workforce plans, benchmarks appropriately with model hospital. 		Chief Nurse
Staff in Post		Staffing numbers have increased in October 2018/19. The increases related to the recruitment of Newly Qualified Nurses and Midwives.		Director of Human Resources.

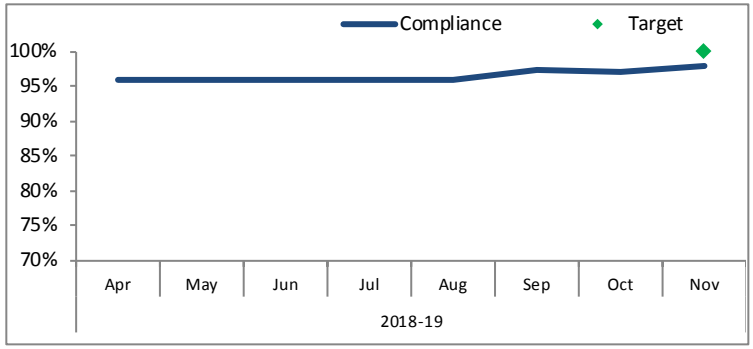
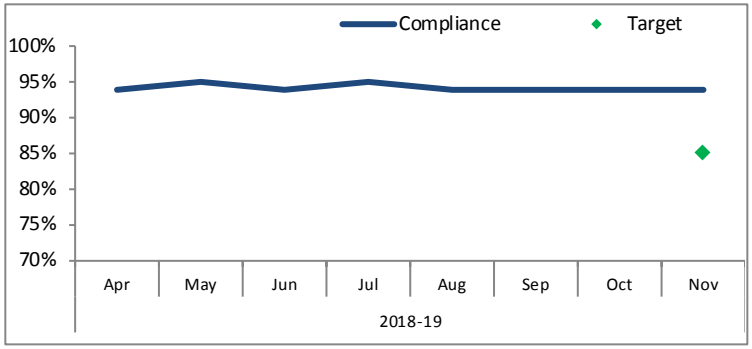
To be in the top 20% of employers in the NHS

	Trend	Challenges and Successes	Comparison	Exec Lead
Use of Agency (WTE)		The reduction in use of agency Healthcare Assistants (HCAs) in the Additional Clinical Services Group has reduced further with the average weekly bank fill rate being over 90%. This month a further 70 Healthcare Assistants were offered bank posts. Surgery and Medicine Divisions have stopped using agency Healthcare Assistants unless approved by their Head of Nursing. October 2018/19 saw 81% of all Medical and Dental shift requests being filled, 53% of those by internal bank. Agency use in the Allied Health Professionals (AHP's) has remained static. Administrative and Clerical has seen a decrease in agency use due to successful substantive recruitment.		Director of Human Resources
Turnover		Turnover continues to show a slight reduction at Trust level and in October 2018/19 was 11.01% compared to 11.20% in September 2018/19.		Director of Human Resources
Frontline Staff Flu Vaccination		Communication to promote the flu campaign continues via global email, articles in 'Let's Talk', the Trust tannoy system and social media. All NHS Trusts this year are charged with reporting the figures for staff not wishing to receive the flu vaccine, and a letter has been sent from the Trust endorsed by the Board and Trade Unions which is to capture the reasons anonymously for any member of staff who declines vaccination. The number of staff who have undertaken training to become a peer vaccinator is now 25 who are able to offer colleagues flu vaccination at different sites within our hospitals. The Commissioning for Quality and Innovation (CQUIN) target to be reached by 28th February 2019 is 75% of frontline staff receiving the flu vaccine.		Director of Human Resources

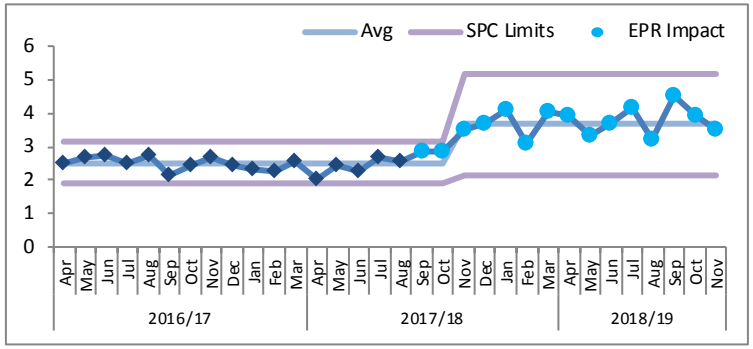
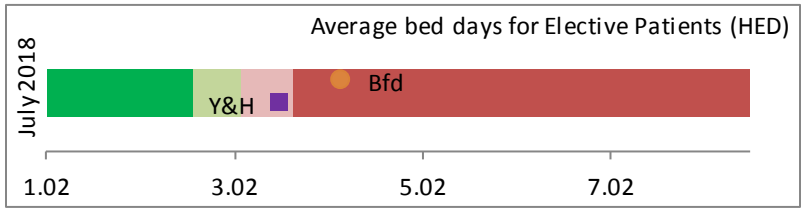
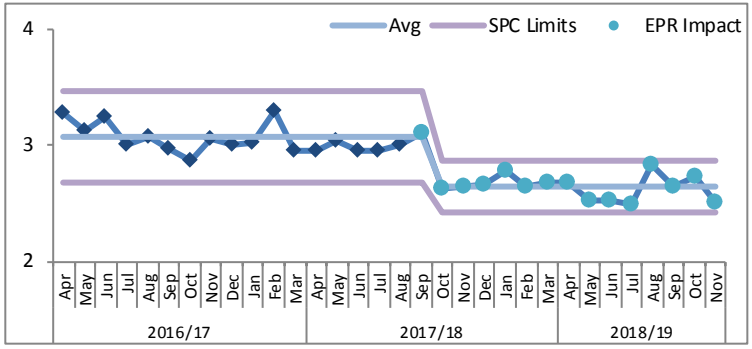
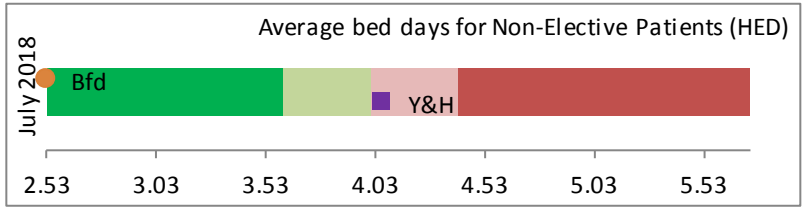
To be in the top 20% of employers in the NHS

	Trend	Challenges and Successes	Comparison	Exec Lead
Staff Advocate Service Contacts and Outcomes		Anticipate the number of contacts with the Staff Advocacy Service to increase following the introduction of the new service. Unfortunately, there will always be a number of unknown outcomes, due to people contacting the service and then ceasing contact or leaving the Trust. A feedback form, better triangulation of data with Human Resources (HR) and regular updates from the staff advocates will help to eliminate some of these unknown outcomes.		Director of Human Resources
Harassment & Bullying Related Investigations		The first column shows the number of investigations relating the Harassment and Bullying and the route which they been received; Freedom to Speak Up (FTSU), Harassment & Bullying (H&B) complaint or conduct investigation – it also shows the outcomes. It is worth noting that one case came through the Freedom to Speak Up route. Outcomes have not been broken down to further detail so as not to identify any individuals.		Director of Human Resources

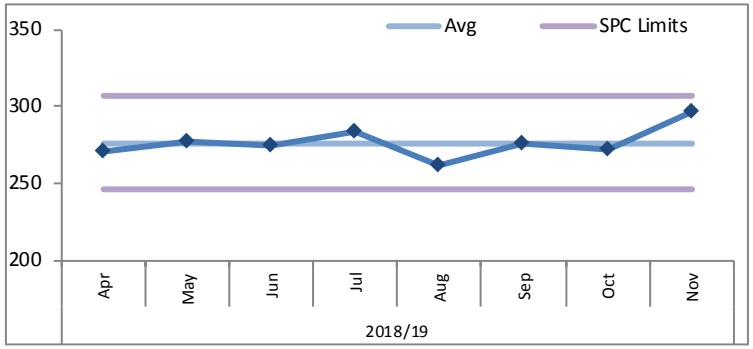
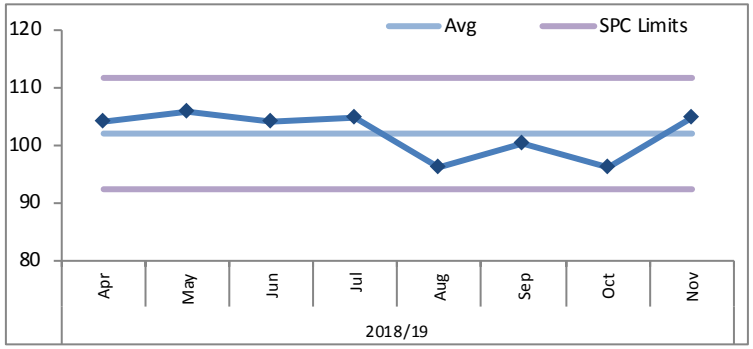
To be in the top 20% of employers in the NHS

	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

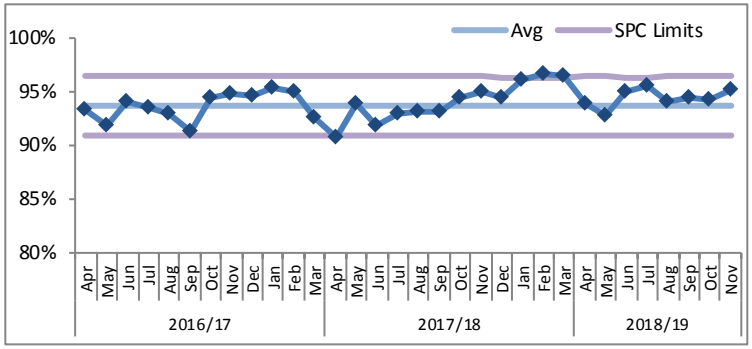
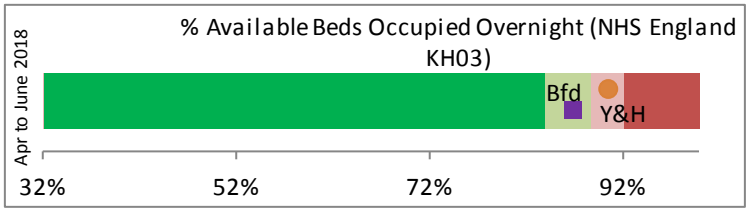
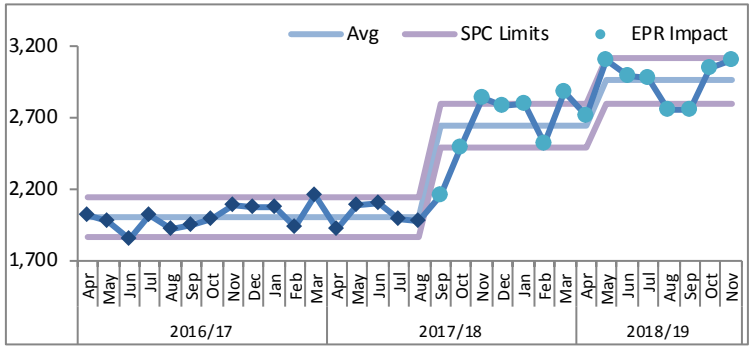
To deliver our financial plan and key performance targets

	Trend	Challenges and Successes	Comparison	Exec Lead
Length of Stay Elective		The increase 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. An investigation into the greater variance post EPR has found a number of outliers that appear to be data quality issues, these are predominately very long length of stays for patients on day case only units and should be excluded in future reports.		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 relates to a growth in assessments following the introduction of the Clinical Decision Unit (CDU) and increased Ambulatory Care Unit (ACU) attendances alongside the incorrect use of non elective workflows for elective patients (which is being proactively targeted by the Data Quality project and is showing significant improvement).		Chief Operating Officer

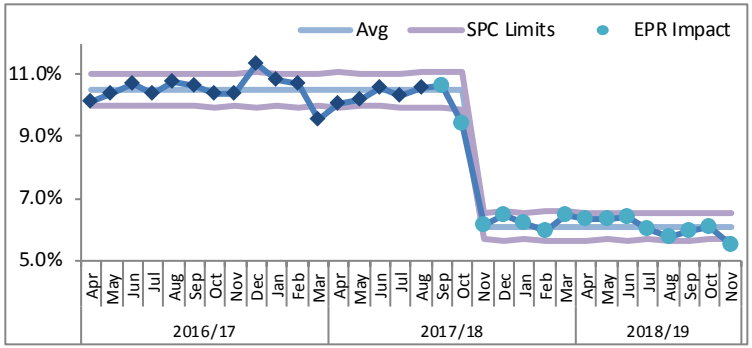
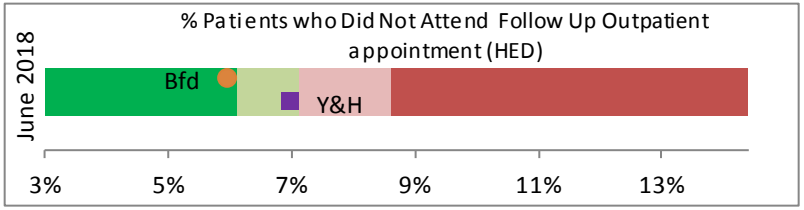
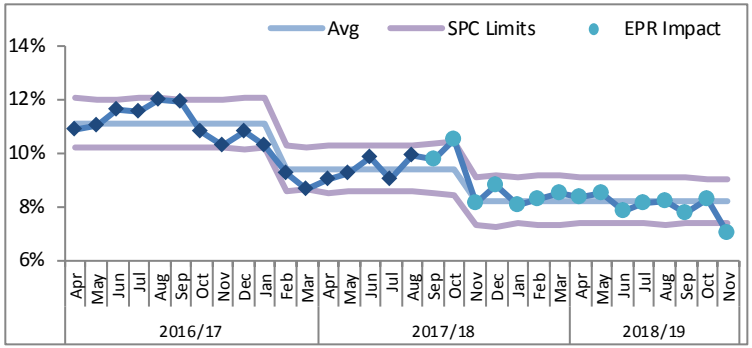
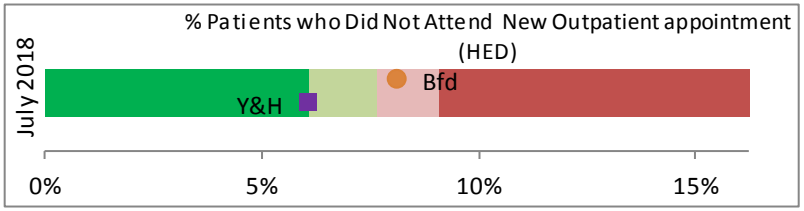
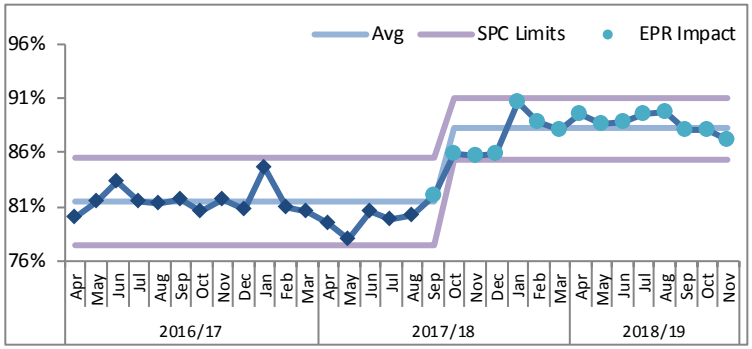
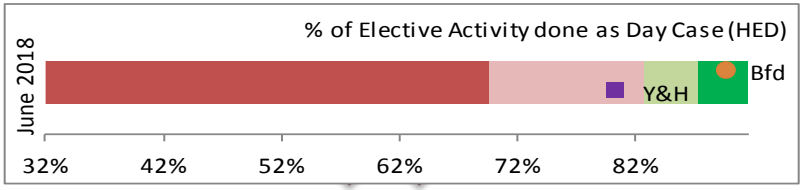
To deliver our financial plan and key performance targets

	Trend	Challenges and Successes	Comparison	Exec Lead
Stranded Patients Length of Stay >= 7 days		Following a Trust-wide day of care audit on 17th October 2018/19 the process for stranded patients has been revised. There is now a weekly multidisciplinary team (MDT) ward round to review all stranded patients. Additional inpatient beds will be opened in support of winter pressures. Performance excluding community beds and removing obvious data quality errors (as reported in the situation report (SIT-REP)) actually improved during November 2018/19.		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. West Yorkshire Accelerator Zone (WYAZ) 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 2018/19. Performance excluding community beds and removing obvious data quality errors (as reported in the situation report (SIT-REP)) actually improved during November 2018/19.		Chief Operating Officer

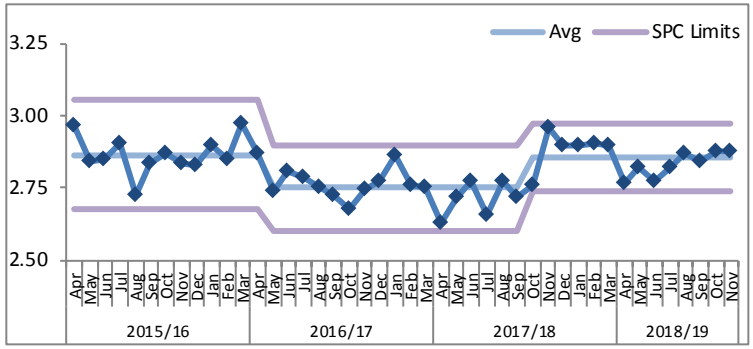
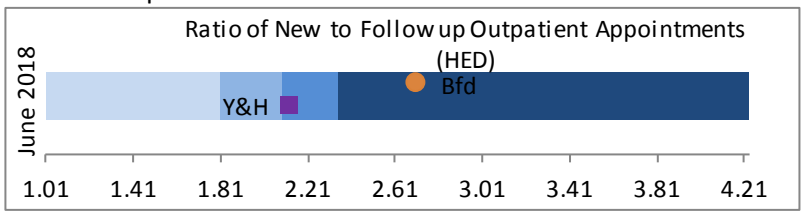
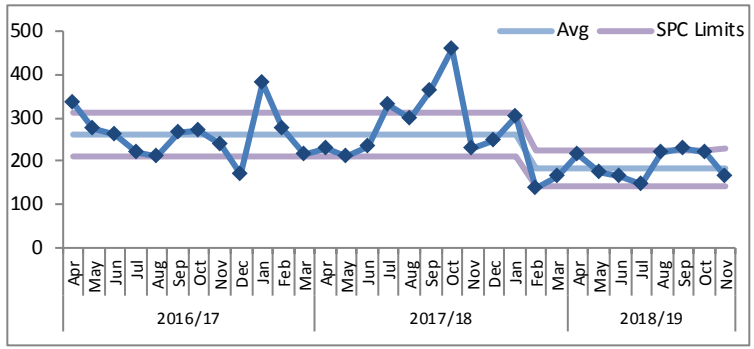
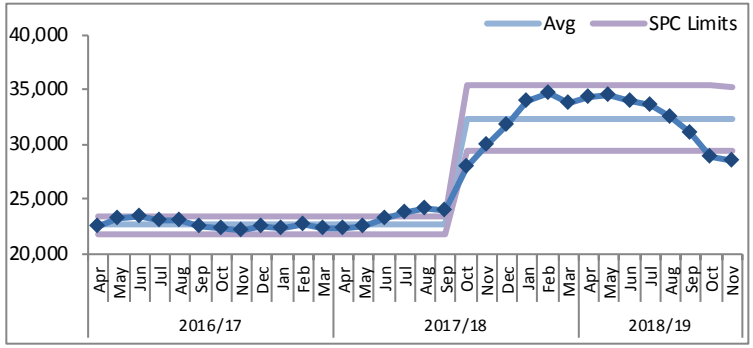
To deliver our financial plan and key performance targets

	Trend	Challenges and Successes	Comparison	Exec Lead
Bed Occupancy		Bed occupancy has remained slightly above average for the last 3 months. Ongoing improvement actions within Accident and Emergency (A&E), admission units, 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 increased in November 2018/19.		Chief Operating Officer

To deliver our financial plan and key performance targets

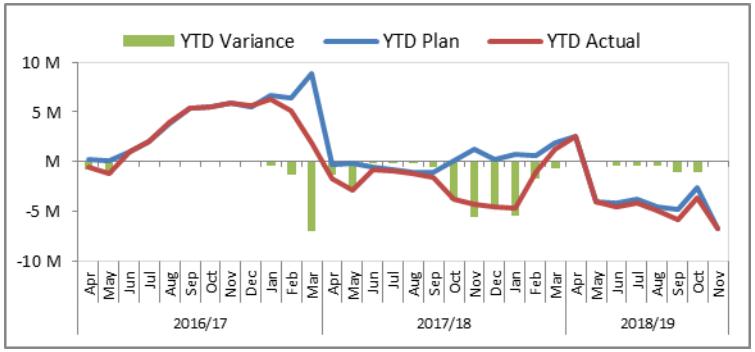
	Trend	Challenges and Successes	Comparison	Exec Lead
Did not Attend Follow-Ups		The position remains unchanged and the majority of this reduction is due to changes in recording/ reporting. Operational teams continue to support the investigation into this change and are cross referencing two weeks manually collected data to the reported position.		Chief Operating Officer
Did not Attend New		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 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 with virtual clinics and earlier discharge practice being introduced wherever possible. Changes to recording / reporting of follow ups are being investigated as follow up numbers appear high for certain specialties. 		Chief Operating Officer
Short notice Clinic Cancellations		Numbers for November 2018/19 were close to average with no concerns raised at the planned care delivery group.		Chief Operating Officer
Elective Wait List		A programme of validation to remove data quality issues is underway and the reported position has been refined to ensure all exclusions are applied. The Planned Care Recovery Programme provides a weekly focus on waiting times, delivery of contracted activity and reduction in overall waiting list sizes. Specialty level Referral to Treatment (RTT) deep dives have identified additional recovery actions to further reduce waiting times and waiting list sizes by March 2019.		Chief Operating Officer

To deliver our financial plan and key performance targets

Trend	Challenges and Successes	Comparison	Exec Lead



The Month 8 position is a pre-Provider Sustainability Fund (PSF) deficit of £6.7m which is in line with the planned deficit. £4.6m of the available £5.7m Provider Sustainability Fund is included in this position. This results in a post-Provider Sustainability Fund deficit of £2.2m which is £1.1m behind plan. The year end forecast submitted to NHS Improvement on 15th December 2018 was full delivery of the £7.5m pre-Provider Sustainability Fund control total deficit for 2018/19. This performance will not be achieved without full delivery of the 2018/19 financial recovery plan in Months 9 - 12. A recovery plan has been developed which targets sufficient cost reductions to deliver the income and expenditure control total in 2018/19. Meeting the control total in 2018/19 is contingent upon i) Recovery of a significant element of the estimated contract income overtrade with local commissioners. There remains a high degree of risk to this assumption and to the estimated income position reported for Month 8. ii) Recovery of the forecast £7m benefits from the Alternative Delivery Model (ADM) for Estates and Facilities. This is contingent on a favourable outcome to the NHS Improvement consultation. iii) Delivery in full of the cost reductions targeted by the Financial Recovery Plan over the final four months of the financial year.

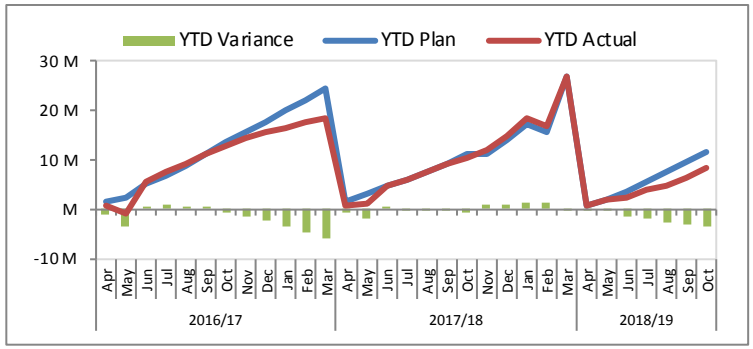
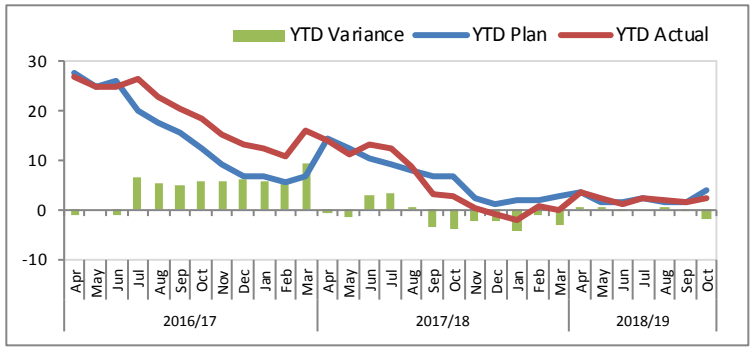
Director of Finance

NHSI Use of Resources Risk Rating (UoR) As at 30.11.18	Plan YTD	Actual YTD	*Last Month*	RAG
Capital Servicing Capacity	3	3	4	
Liquidity	1	1	1	
I & E Margin	3	3	4	
Variance from plan (I & E Margin)	1	2	2	
Agency Spend	2	2	2	
Combined UoR (after triggers)	**3**	**3**	**3**	

The Trust's overall Use of Resources (UoR) rating is in line with plan at the end of Month 8. Complying with this plan is not an indicator 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 pre-Provider Sustainability Fund (PSF) deficit of £6.7m. Delivery of the plan requires significant improvements in the remaining months of the financial year.

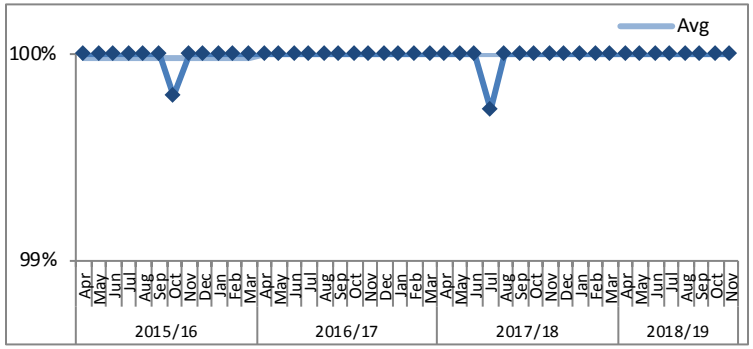
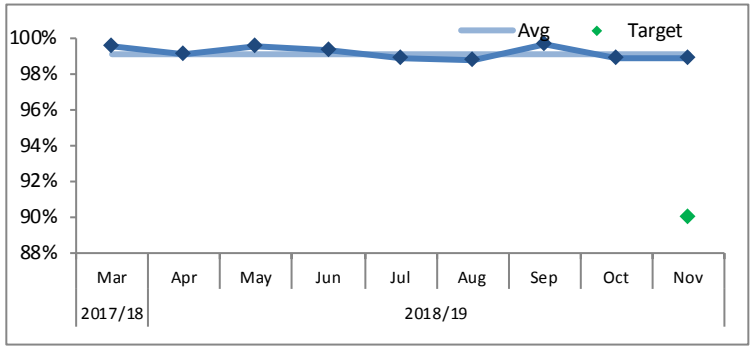
Director of Finance

To deliver our financial plan and key performance targets

	Trend	Challenges and Successes	Comparison	Exec Lead
Bradford Improvement Plan		The Trust has delivered £9.3m of efficiencies at the end of Month 8. This is £4.4m behind the phased plans submitted by the divisions and corporate departments and £7.8m behind an even monthly apportionment of the annual target, which would have required £17.1m of savings to be delivered by Month 8. A total of £0.8m of the year to date efficiencies were delivered via technical non-recurrent adjustments and a further £1.2m relates to accrued benefits from the Alternative Delivery Model (ADM) implementation which are now subject to NHS Improvement consultation. The divisions and corporate departments are currently forecasting delivery of £22.6m efficiencies, which would leave the Trust £3m 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 £17.0m, which would leave the Trust £8.6m short of its target.		Director of Finance
Liquidity rating		Year to date liquidity is 2.6 days which is 0.2 days below plan. Liquidity is forecast at 1.8 days which is slightly above plan. This would see the Use of Resources (UoR) score to remain at the planned level of 1. The forecast assumes full delivery of the Trusts Bradford Improvement Programme (BIP). Should the Trust deliver the recovery plan forecast year end liquidity is -5.7 which would result in the Use of Resources score falling from 1 to 2. If the Trust fails to deliver the recovery plan Liquidity will fall to -16.9 days which would lead to a Use of Resources score of 4.		Director of Finance

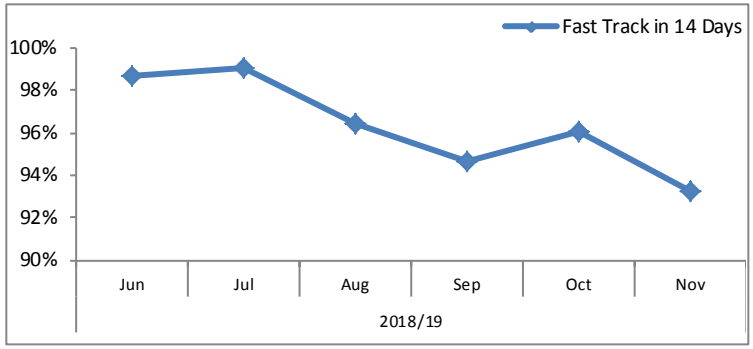
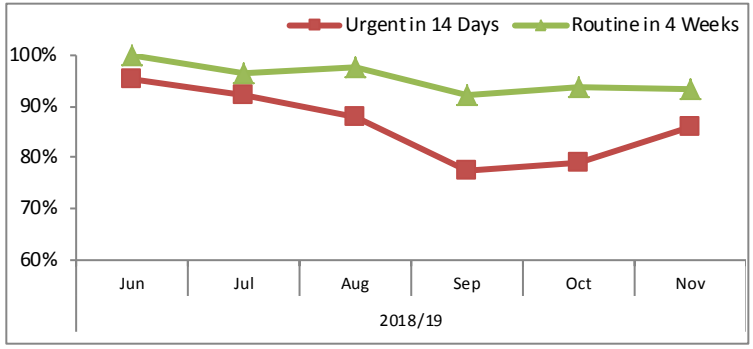
National Indicators

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 8 months since the introduction of this target.		Chief Operating Officer

National Indicators

Service Level Agreements

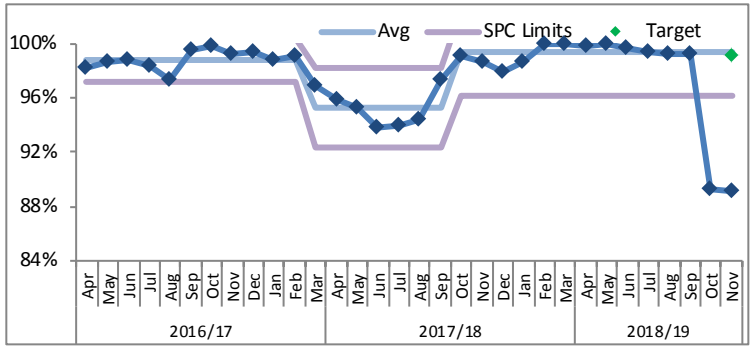
	Trend	Challenges and Successes	Comparison	Exec Lead
Radiology Reporting Turnaround Time Fast Track		There were 65 patients where the report was not completed within the 14 days during November 2018/19. Of these 60 related to Computed Tomography (CT) virtual colonoscopies where capacity was reduced due to sickness at a time when demand for this test continues to be high. This is a small team with limited resilience when a member of team absent, but this will be supported by the additional resource that has been included in a recent business case.		Chief Operating Officer
Radiology Reporting Turnaround Time Outpatients		The same capacity issues impacting fast track (FT) performance in October 2018/19 also impacted on the timeliness of urgent and routine reporting. Although improvement in Magnetic Resonance Imaging (MRI) turnaround times supported an overall improvement against the previous two months.		Chief Operating Officer

National Indicators

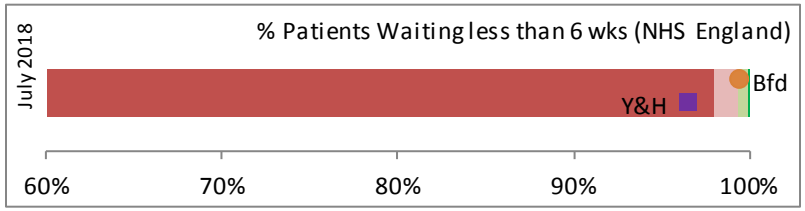
Single Oversight Framework

Trend	Challenges and Successes	Comparison	Exec Lead

Diagnostic Waits



November DM01 (Diagnostic Waiting Times and Activity) reported 89.13% (784 breaches). This position now includes Endoscopy tests which form the bulk of the reported breaches. A recovery plan for Colonoscopy, Flexi Sigmoidoscopy, Cystoscopy and Gastroscopy has been agreed with additional sessions and the use of the independent sector in place. Magnetic Resonance Imaging (MRI) performance is now above the 99% target.



Chief Operating Officer

Use of Resources - Financial

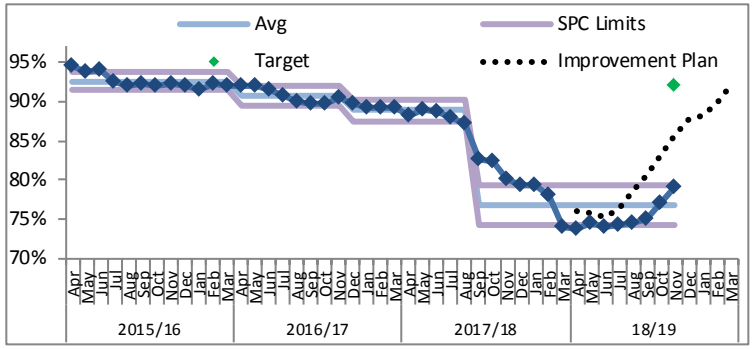
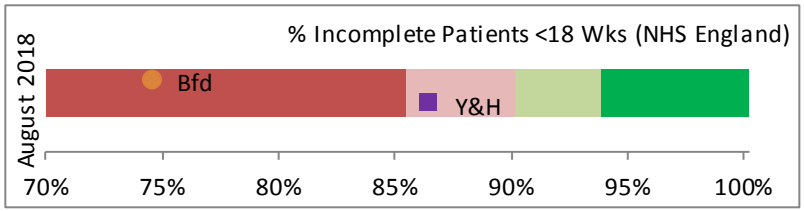
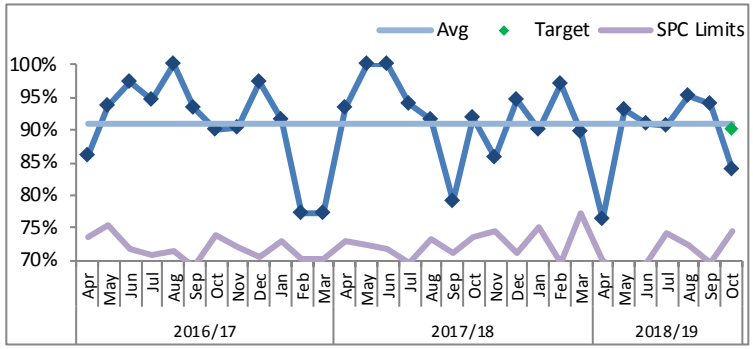
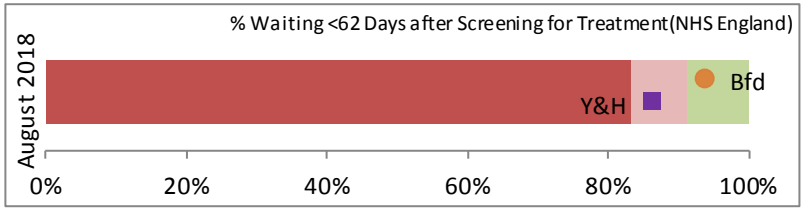
NHSI Use of Resources Risk Rating (UoR) As at 30.11.18	Plan YTD	Actual YTD	*Last Month*	RAG
Capital Servicing Capacity	3	3	4	
Liquidity	1	1	1	
I & E Margin	3	3	4	
Variance from plan (I & E Margin)	1	2	2	
Agency Spend	2	2	2	
Combined UoR (after triggers)	**3**	**3**	**3**	

The Trust's overall Use of Resources (UoR) rating is in line with plan at the end of Month 8. Complying with this plan is not an indicator 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 pre-Provider Sustainability Fund (PSF) deficit of £6.7m. Delivery of the plan requires significant improvements in the remaining months of the financial year.

Director of Finance

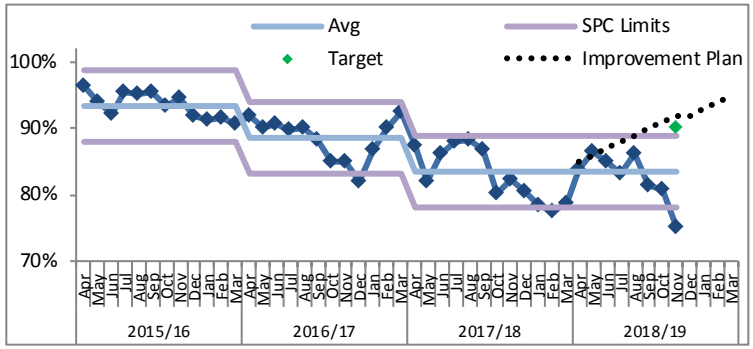
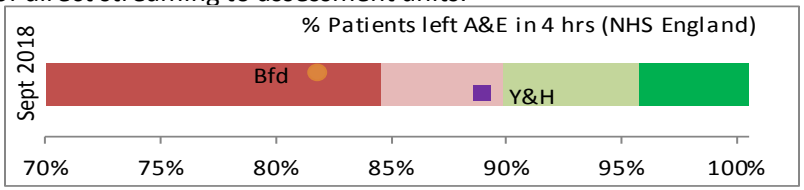
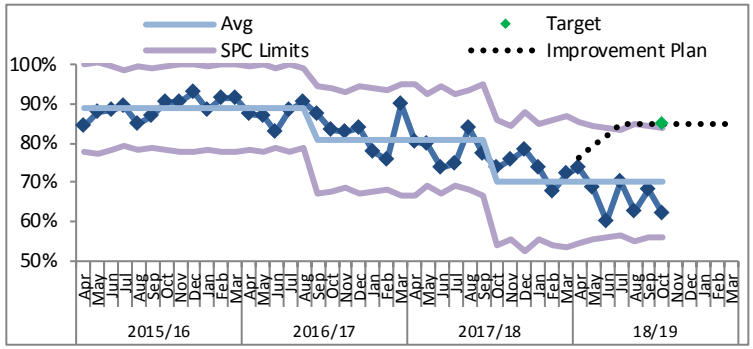
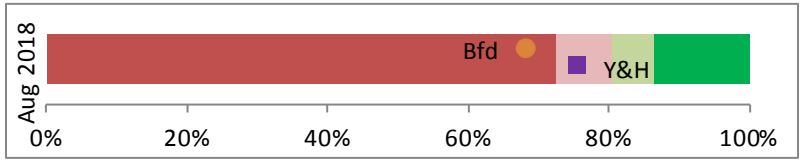
National Indicators

Single Oversight Framework

	Trend	Challenges and Successes	Exec Lead
RTT 18 Week Incomplete		Incomplete performance for November 2018/19 was 79.01% which is an improvement on October 2018/19 but remains behind the original improvement trajectory in the annual plan. Detailed recovery plans have been developed with all specialties as part of the Planned Care Recovery Programme. Activity has increased in line with these plans which will support delivery of 88-89% performance by March 2019. 	Chief Operating Officer
Cancer Urgent 62 Day Screening		This standard was not achieved achieved in November 2018/19 due complex pathways for patients post Breast Screening. A full review of each timeline is underway to support future improvements. 	Chief Operating Officer

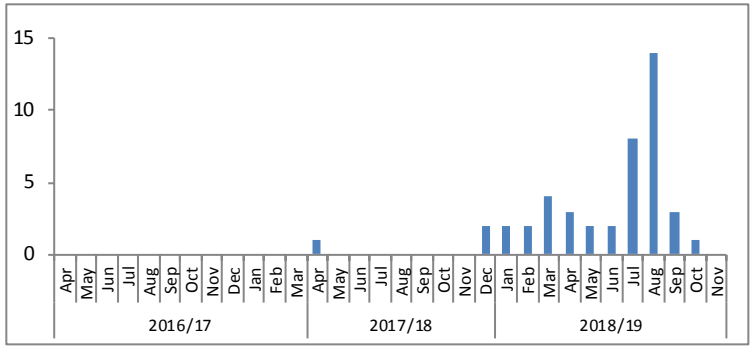
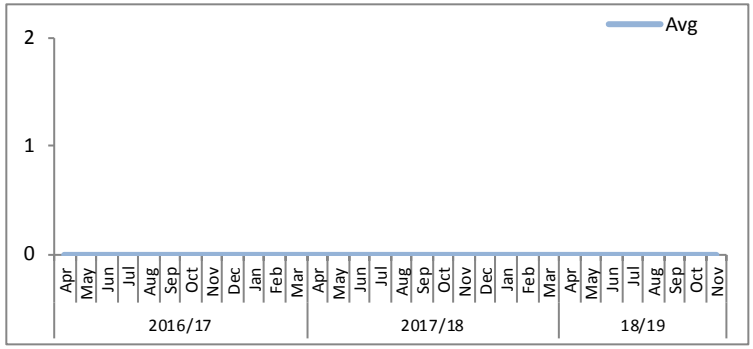
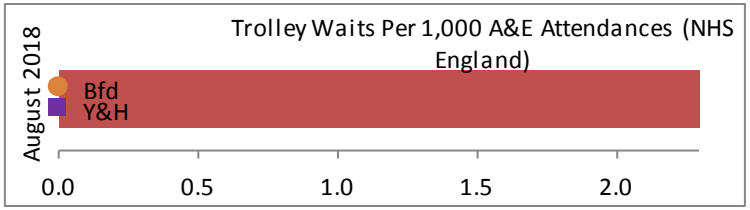
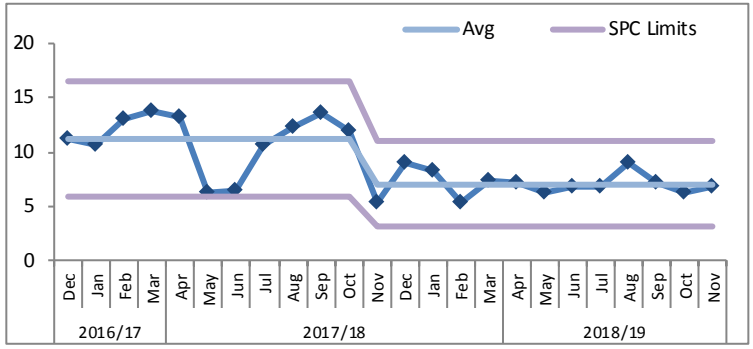
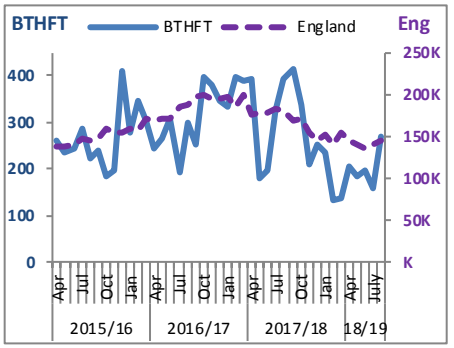
National Indicators

Single Oversight Framework

	Trend	Challenges and Successes	Comparison	Exec Lead
Emergency Care Standard		Emergency Care Standard (ECS) performance (type 1 and 3) for November 2018/19 reported 75.2% with a very high daily average of 396 type 1 and 3 attendances. Additional leadership support and a command and control process has been introduced to support recovery. An Emergency Care Improvement Programme is in place and key areas of focus include the introduction of a General Practitioner (GP) advice line, implementation of an assess to admit model via the Ambulatory Care Unit (ACU), expansion of integrated minor illness and minor injury unit in January 2019, and introduction of direct streaming to assessment units. 	Chief Operating Officer
Cancer Urgent 62 Day GP		The reported position for October 2018/19 is 62.31%. Urology contributes the majority of breaches. Site specific capacity and demand has been reviewed and pathways streamlined to remove bottle necks and duplicated process. Short term recovery is being managed through additional diagnostic and treatment capacity with 62 day backlogs reducing significantly in recent weeks. 	Chief Operating Officer

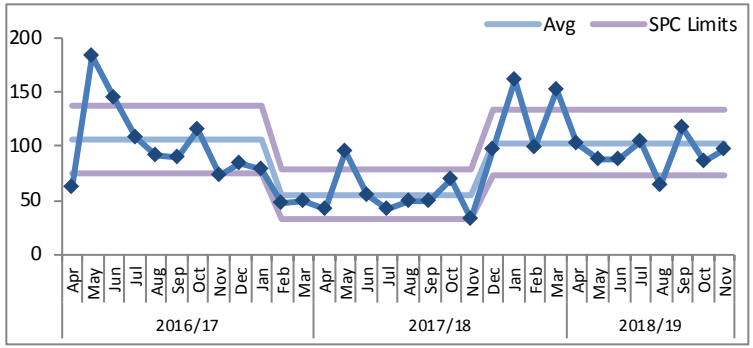
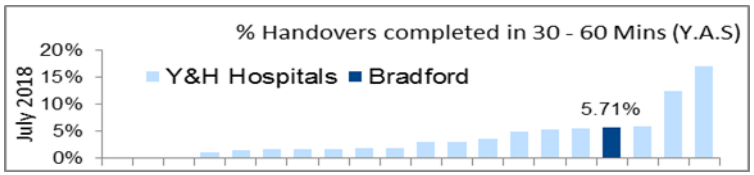
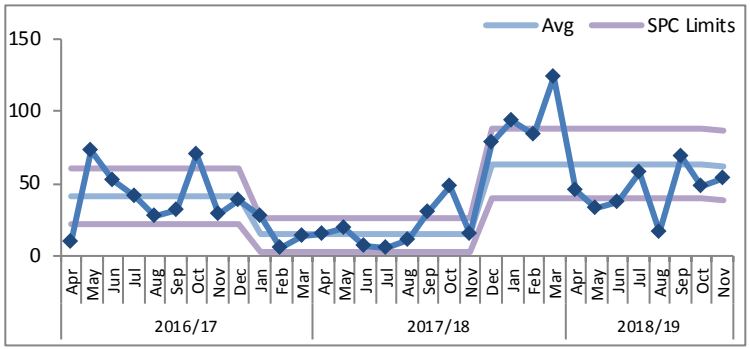
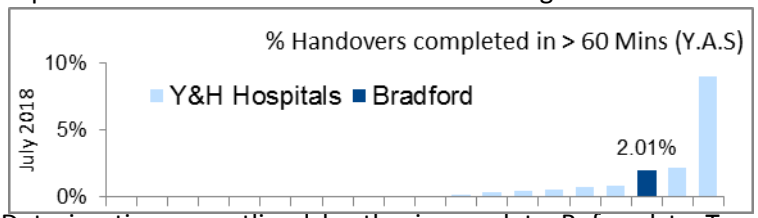
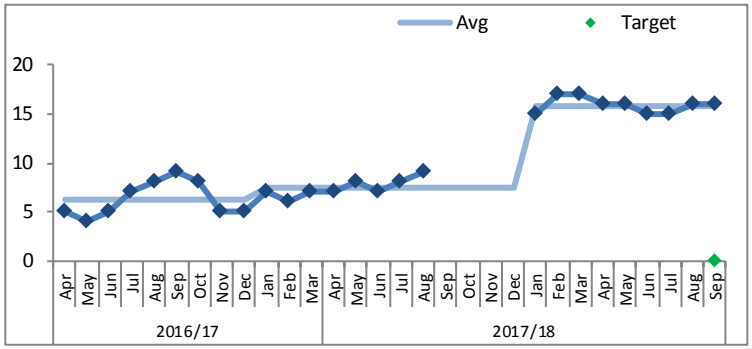
National Indicators

National Target – Non-Financial

	Trend	Challenges and Successes	Exec Lead
RTT 52 Week Wait		The Trust reported 0 incomplete 52 week breach in November 2018/19. A daily review of all management plans for patients waiting over 35 weeks is in place with weekly escalation through the Planned Care Recovery group and updates to the Chief Operating Officer (COO).	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

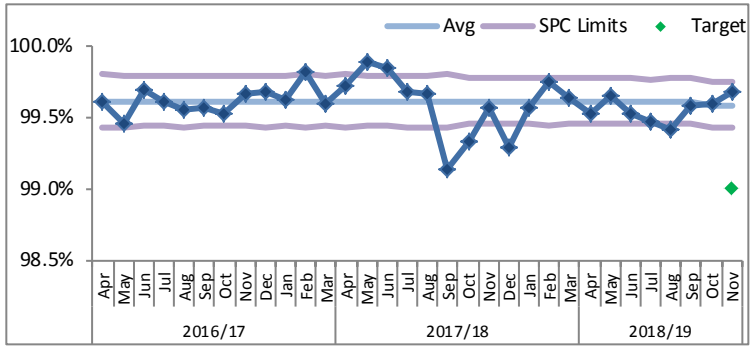
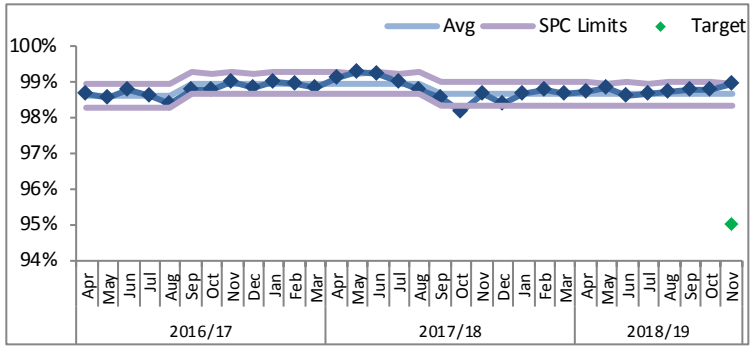
National Indicators

National Target – Non-Financial

	Trend	Challenges and Successes	Comparison	Exec Lead
Ambulance Handover 30-60 mins		97 handovers took between 30-60 minutes in November 2018/19 following delays in process. An improvement work-stream has been established with support from GE Consulting which will focus on joint work between the Trust and the Yorkshire Ambulance Service (YAS) alongside review of our internal processes. 	Chief Operating Officer
Ambulance Handover >60 mins		54 handovers took between 30-60 minutes in November 2018/19 following delays in process. The Emergency Department team have formed strong links with the Yorkshire Ambulance Service (YAS) locality manager for Bradford, as well as the assigned Hospital Ambulance Liaison Officer (HALO). This has created a team approach which is proving effective and we hope to demonstrate considerable improvement in handover times in the coming weeks. 	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 (RTT) deep dive process.		Chief Operating Officer

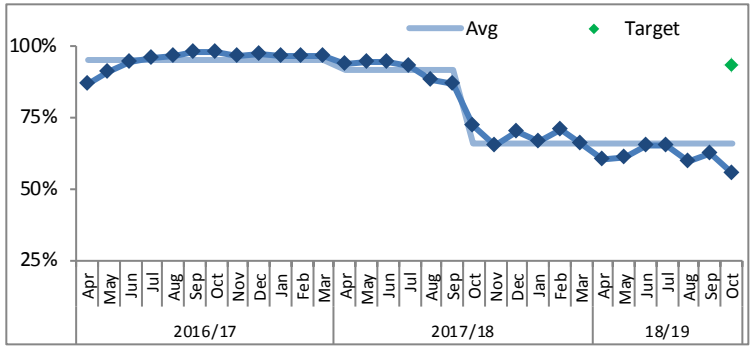
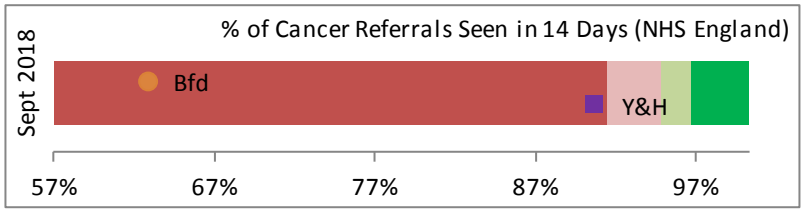
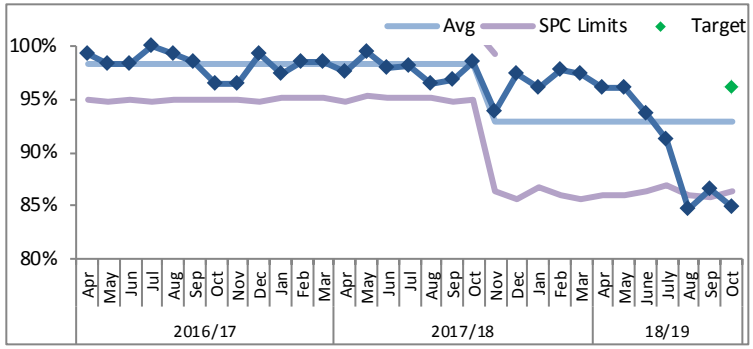
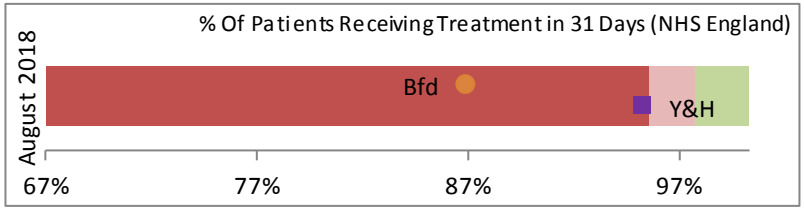
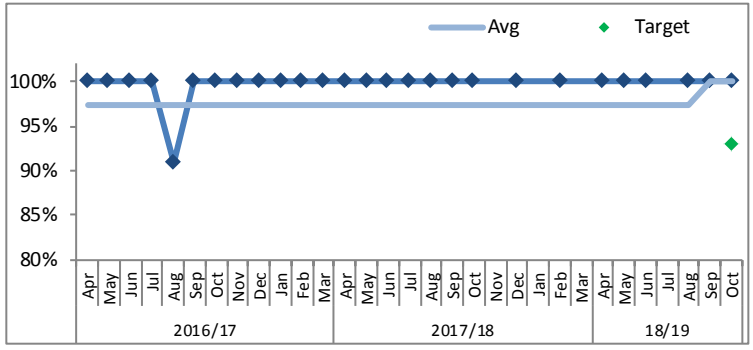
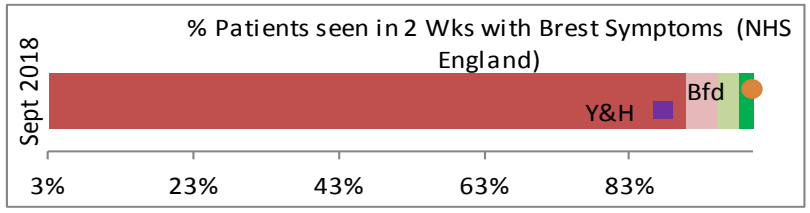
National Indicators

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

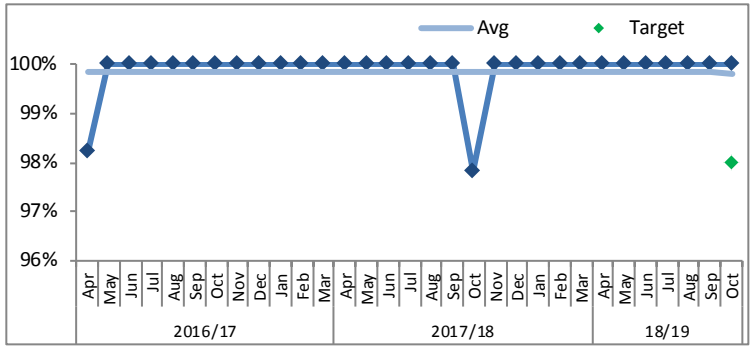
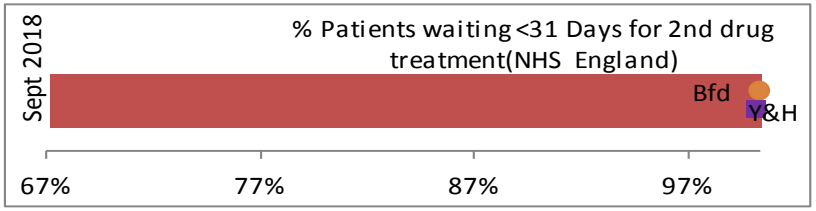
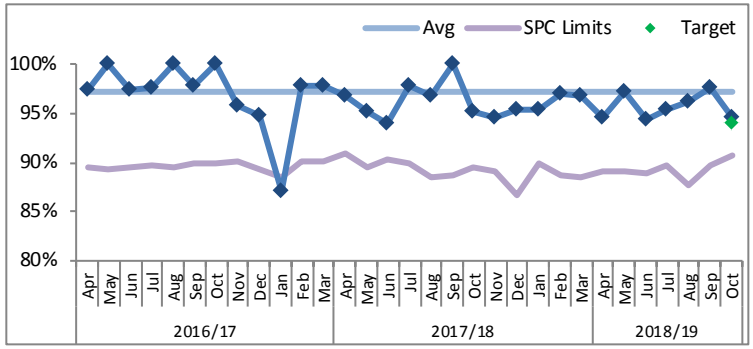
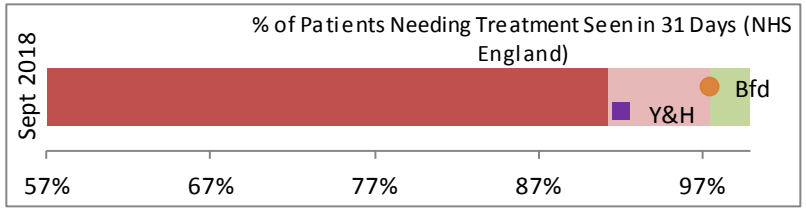
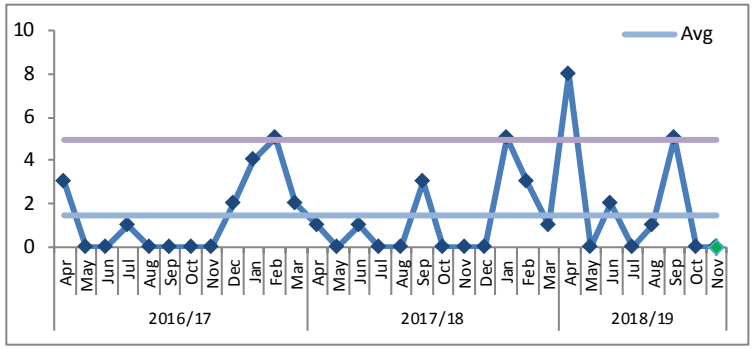
National Indicators

National Target – Non-Financial

	Trend	Challenges and Successes	Comparison	Exec Lead
Cancer 2 Week GP		Reported performance for October 2018/19 was 55.78% which remains below target but recovery plans enacted during November have significantly improved performance with December close to 90% and recovery to trajectory in Quarter 4 a realistic goal.		Chief Operating Officer
Cancer 31 Day 1st Treatment		This standard was not achieved in October 2018/19 with 22 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 October 2018/19 and projected to be achieved in November 2018/19.		Chief Operating Officer

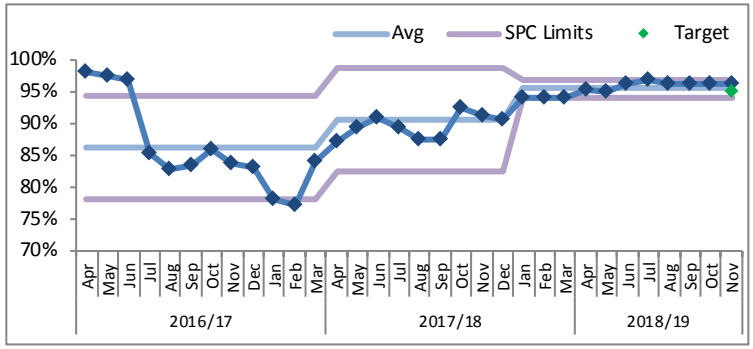
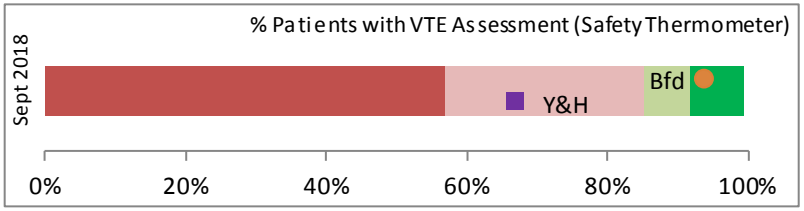
National Indicators

National Target – Non-Financial

	Trend	Challenges and Successes	Comparison	Exec Lead
Cancer 2nd Treatment Drugs		This standard was achieved in October 2018/19 and projected to be achieved in November 2018/19.		Chief Operating Officer
Cancer 2nd Treatment Surgery		This standard was achieved in October 2018/19 and projected to be achieved in November 2018/19.		Chief Operating Officer
Cancelled Operations 28 day		There were 0 breaches of the 28 day standard in November 2018/19. The weekly review cycle has been strengthened and there are no predicted breaches for December 2018/19.		Chief Operating Officer

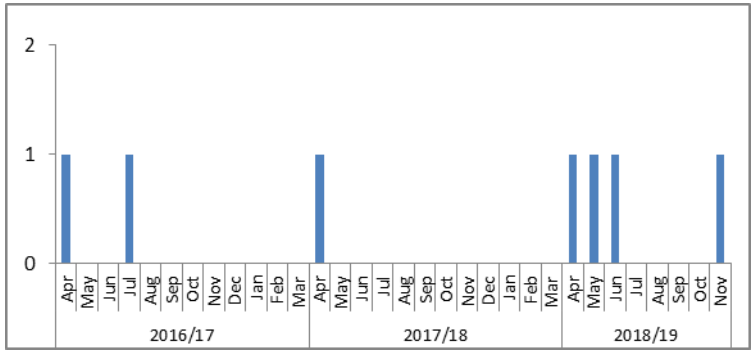
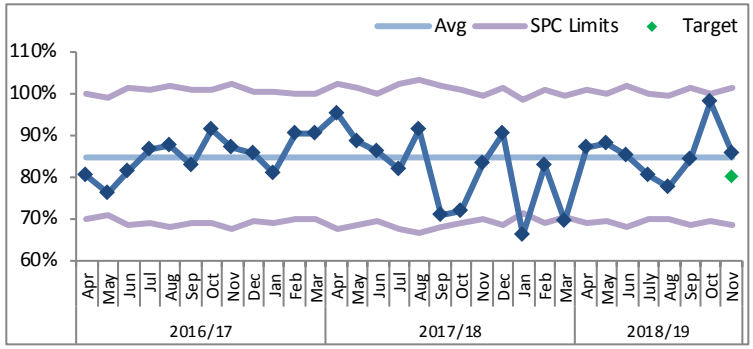
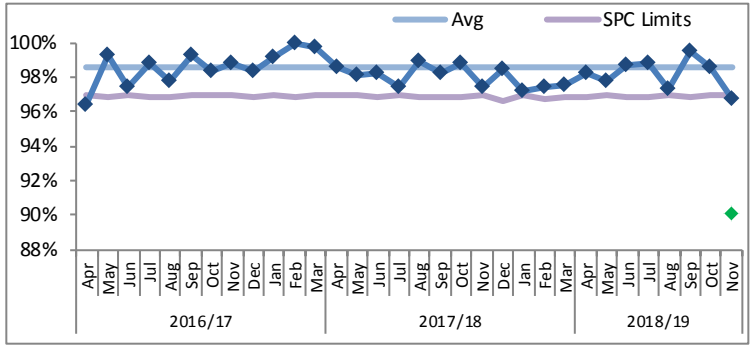
National Indicators

National Target – Non-Financial

	Trend	Challenges and Successes	Comparison	Exec Lead
VTE Assessment		The Venous Thromboembolism (VTE) assessment shows sustained compliance with the standard. 		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

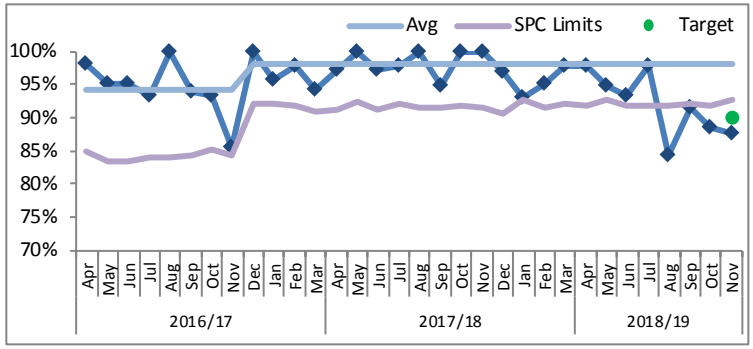
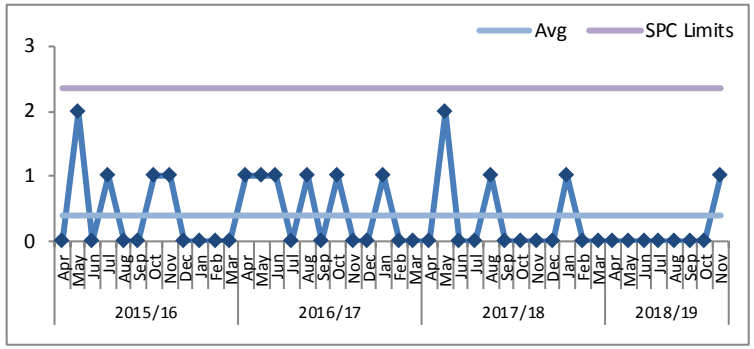
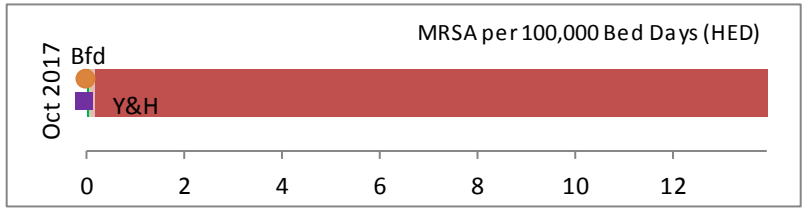
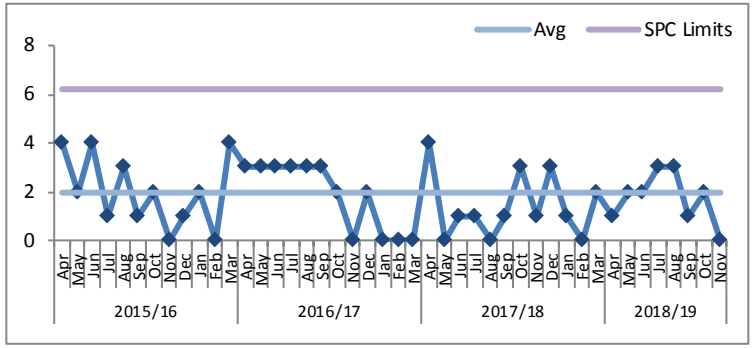
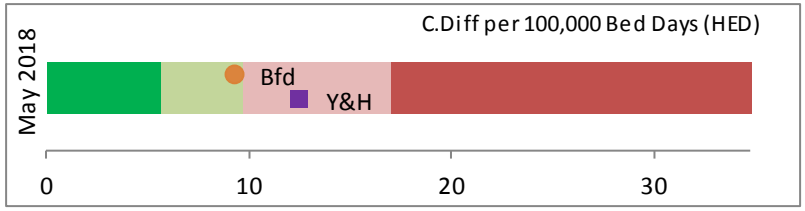
National Indicators

National Target – Financial

	Trend	Challenges and Successes	Comparison	Exec Lead
Never Events		There was 1 never event in November 2018/19 (wrong tooth removed) bringing the total for 2018/19 to 4.	No comparator data is available.	Chief Operating Officer
Stroke Strategy		Performance remained above target in November 2018/19.		Chief Operating Officer
Seen By Midwife <13 Weeks		The threshold continues to be achieved.		Chief Operating Officer

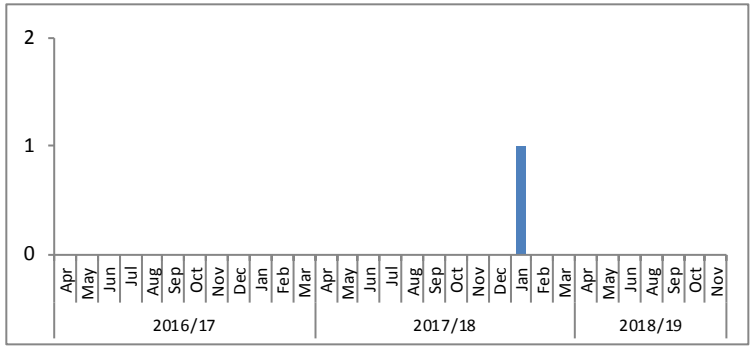
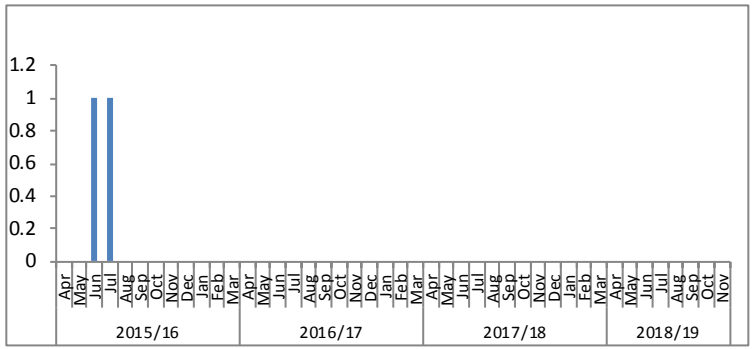
National Indicators

National Target – Financial

	Trend	Challenges and Successes	Comparison	Exec Lead
Seen By Midwife > 12 Weeks		November 2018/19 was 87.7%, only 1 attendance short of the 90% threshold. Capacity were cited as the reason for delays and the process to escalate any potentially breaches of this target to the community midwifery team leads for resource reallocation has been re-circulated to support future improvement.		Chief Operating Officer
MRSA		One case in November 2018/19 has been apportioned to the Trust. The sample was taken on 13/11/2018 on Ward 31 (Elderly Care). The Post Infection Review (PIR) has not identified any deficits in care, however, under Public Health England (PHE) guidelines the case remains attributable to the Trust as the blood culture was taken >48 hours after admission.		Chief Nurse
C. Difficile		No cases recorded in November 2018/19.		Chief Nurse

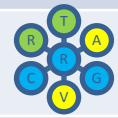
National Indicators

National Target – Financial

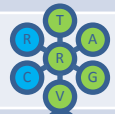
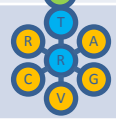
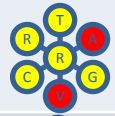
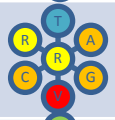
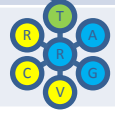
	Trend	Challenges and Successes	Comparison	Exec Lead
Duty of Candour		There were no Duty of Candour breaches in November 2018/19.		Director of Strategy & Integration
Mixed Sex Breaches		There have been no Mixed Sex Breaches.		Chief Operating Officer

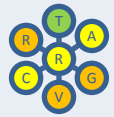
Glossary

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	

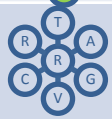
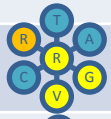
Indicator	Definition	Data Quality Kite-Mark
Harm Free Care		
VTE Assessment	VTE risk assessments completed Red < 90%, Amber >=90% & < 95%, Green >=95%	
Falls with Harm	Patient falls resulting from harm. The benchmarking data comes from the Safety Thermometer prevalence information. Red >= 40, Amber >=25 & < 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	

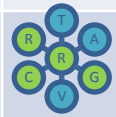
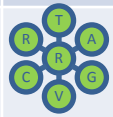
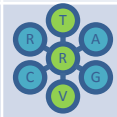
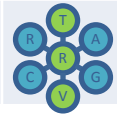
Glossary

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	The number of readmissions within 30 days of discharge from hospital. Red >= 7.8%, Amber >=6.7% & < 7.8%, Green <6.7%	
Information Governance Breaches	The number of reported breaches of the information governance standards Red > 6, Amber <=6 & > 2, Green <=2	

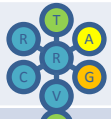
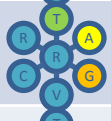
Indicator	Definition	Data Quality Kite-Mark
Audits		
Audit of WHO Checklist	Audit of the World Health Organisation surgical checklist monitoring the number that were complete compared to the number of checklists Red < 90%, Amber >=90% & < 95%, Green >=95%	
Serious incidents	Unexpected or avoidable death, serious harm, never events, service delivery prevention compared to all incidents reported Red > 0, Green = 0	
To collaborate effectively with local and regional partners		
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	

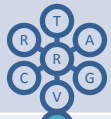
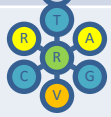
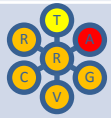
Glossary

Indicator	Definition	Data Quality Kite-Mark
To be a continually learning organisation		
Training		
New Starter Training	% of new staff who are compliant with mandatory training requirements Red < 90%, Amber >=90% & <100%, Green = 100%	
Refresher Training	% of staff who are compliant with mandatory training requirements Red < 75%, Amber >=75% & <85%, Green >= 85%	
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%	

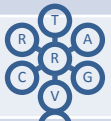
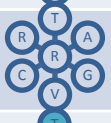
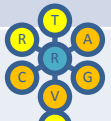
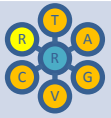
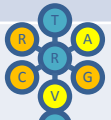
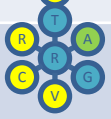
Indicator	Definition	Data Quality Kite-Mark
To be in the top 20% of employers in the NHS		
Appraisals		
Appraisal Rate Non-Medical	% of eligible staff employed at the trusts who have had an appraisal in the last 12 months. Red <75%, Amber >=75% and <95%, Green >=95%	
Experience		
BAME % Senior Leaders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

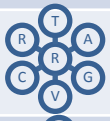
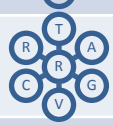
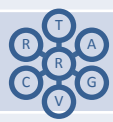
Glossary

Indicator	Definition	Data Quality Kite-Mark
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	
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.	

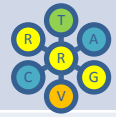
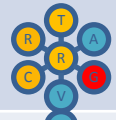
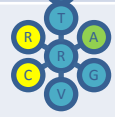
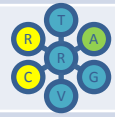
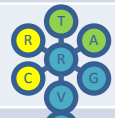
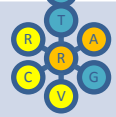
Indicator	Definition	Data Quality Kite-Mark
Retention		
Turnover	Number of employees who have left the organisation in the past 12 months as a % of the average number of employees over the same period Red > 14%, Amber 12% – 14%, Green < 12%	
Frontline Staff Flu Vaccination	Flu vaccine uptake percentage amongst frontline staff Red < 75%, Green >= 75%	
Staff Advocate Service Contacts and Outcomes	Contacts and Outcomes for the Staff Advocate Service	
Harassment & Bullying Related Investigations	Investigations arising from Harassment & Bullying and outcomes	
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%	

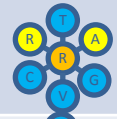
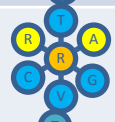
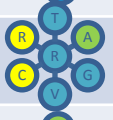
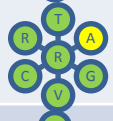
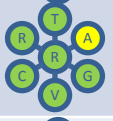
Glossary

Indicator	Definition	Data Quality Kite-Mark
In-Patient Productivity (cont.)		
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	
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	

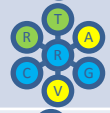
Indicator	Definition	Data Quality Kite-Mark
Finance		
Delivery of financial plan	Delivery of finances against plan.	
Use of Resources - Financial	Use of resources is a calculation on the status of a number of financial measures – Capital Servicing Capacity, Liquidity, I & E Margin, and Agency Spend.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

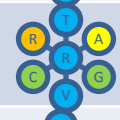
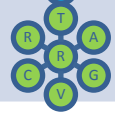
Glossary

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.