



**Bradford Teaching Hospitals**  
NHS Foundation Trust

# Integrated Dashboard Board of Directors

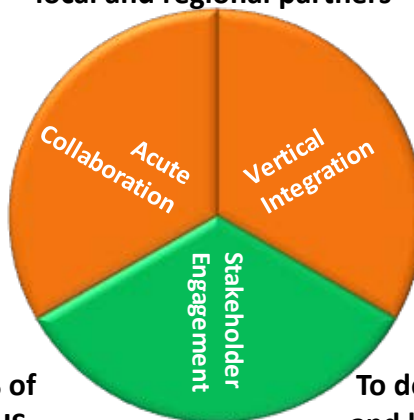
31<sup>st</sup> January 2019

31st January 2019

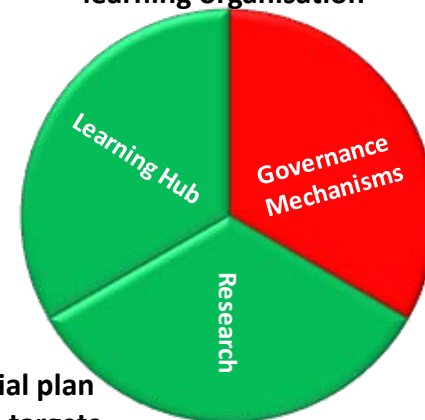
To provide outstanding care for our patients



To collaborate effectively with local and regional partners



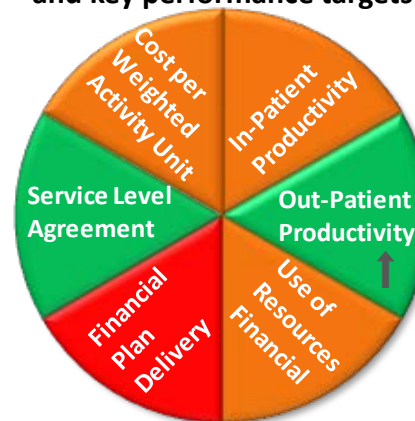
To be a continually learning organisation



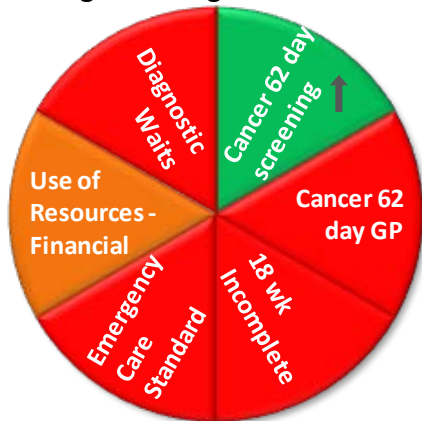
To be in the top 20% of employers in the NHS



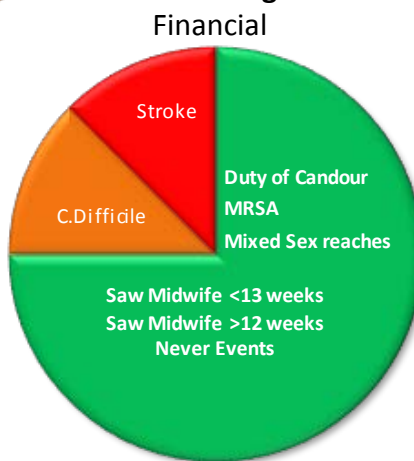
To deliver out financial plan and key performance targets



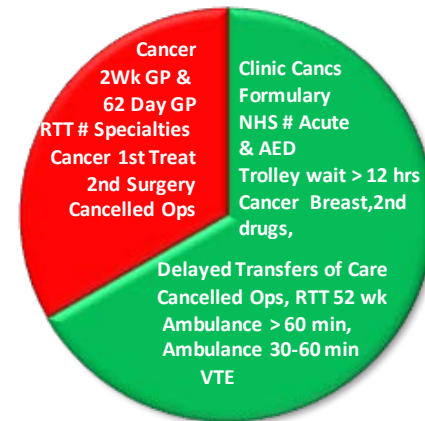
Single Oversight Framework



National targets



Non-Financial



# Headlines

**Delivery of the Emergency Care Standard performance** remains a challenge with high attendances continuing. Improvement work is progressing well and the Trust is continuing to work closely with Elective Care Intensive Support Team (ECIST) who are providing on site support during February and March 2019 with a particular focus on ambulance handover and management of long length of stay patients. The Green Zone opened within the Emergency Department in late January 2019, which is anticipated to support improved management of patients with minor illness in collaboration with Primary Care practitioners

The **Cancer Improvement Plan** is ongoing and the 2 Week Wait performance has recovered to above 90% with an expectation that February 2019 will meet the 93% standard. The 62 Day First Treatment standard improvement is expected in April 2019 whilst the focus in February and March 2019 is on clearing long wait backlogs through additional diagnostic and treatment capacity.

**Referral to Treatment (RTT)** performance continues to improve with the eighth successive monthly reduction in the total size of the Waiting List and zero 52 week breaches in January 2019. There is continued improvement in the RTT Incomplete indicator.

The Trust has achieved the **staff flu vaccination** target and the **staff appraisal** target.

**Partnerships** Committee has noted strong progress on the Airedale Collaboration with the programme governance and funding being agreed and a clinical summit planned for April 2019. The drafting of the Strategic Partnering Agreement, between partners from Bradford District and Craven, continues and is planned to be signed by the end of March 2019. The Trust is working with the West Yorkshire Association of Acute Trusts (WYAAT) to gain final approval from NHS England for the Arterial Centre. WYAAT is considering the next steps for the funding for the Hybrid Theatre (which is needed for the Arterial Centre), following the unsuccessful conclusion of the bid for national funding.

Delivery of the **2018/19 Control Total** at year end is contingent on recovery of the planned benefits from the Wholly Owned Subsidiary (WOS) for Estates & Facilities and delivery in full of the 2018/19 Financial Recovery Plan. The Recovery Plan shared with NHS Improvement targets £21.8m of run rate improvements to deliver the Control Total. These plans have been updated and now include £17m of technical measures and £4.7m of run rate improvements. There remains a significant degree of risk to full delivery of the Financial Recovery Plan.

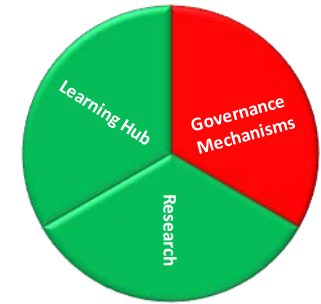
# Quality Dashboard

## 31<sup>st</sup> January 2019

To provide outstanding care for our patients



To be a continually learning organisation



**Strong performance** in mortality, infection prevention, VTE and safe care in theatres and reduction in significant harms.

Although **complaints** show an improving trend, it is not at the anticipated rate due to resource constraints. Revised trajectories are in development as part of formal review of the 2019/20 Dashboard.

Identification and management of **sepsis** is improving (Quality Committee February 2019). The Dashboard metric will be enhanced to reflect the improvement.

**Night time transfers** continue to be low indicating strong patient flow management.

# Workforce Dashboard

## 31<sup>st</sup> January 2019

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



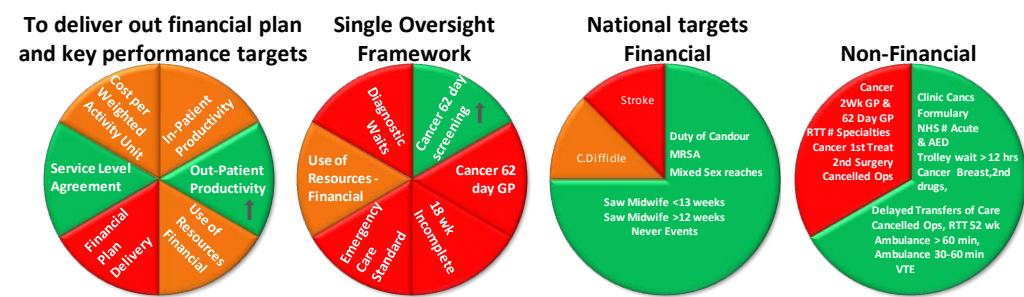
Frontline **staff flu vaccination** rate has been achieved at 76.3%.

The Trust achieved our target of 95% **staff appraised** at the end of December 2018. Appraisal rates fell slightly in January 2019 to 94.57%, highlighting the need for there to be a continued focus until the end of March 2019.

The **nurse staffing** metrics report a constant and good performance. However it should be noted that within the overall positive picture there are a couple of areas of concern, particularly Ward 6 (stroke) where additional mitigation is in place to maintain safe staffing levels.

# Finance & Performance Dashboard

## 31<sup>st</sup> January 2019



**Emergency Care Standard performance** for Type 1, 2 & 3 attendances is reported at 79.93% for January 2019 and 84.13% year to date. Average daily type 1 & 3 attendances in January 2019 were 372 which has increased to 392 for February 2019 to date. Type 2 attendances have remained high at an average of 72 per day in this period. The Elective Care Intensive Support Team (ECIST) is providing ongoing support to the Trust's improvement programme and the Command Centre transformation programme continues with excellent progress made across the enabling schemes.

**Cancer 2 Week Wait (2WW) performance** for December 2018 was reported at 91.05% and is currently projected at 91.32% for January 2019 with only Urology, Lower GI and Upper GI not forecast to meet the 93% target. Increased referrals, particularly for Breast, are putting pressure on this standard but ongoing improvement actions and plans for additional ad hoc clinics will mitigate this risk.

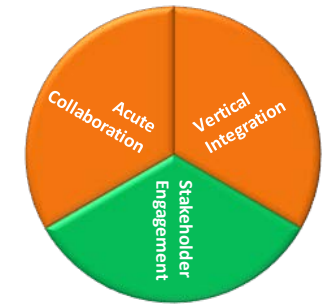
**Cancer 62 Day First Treatment performance** for December 2018 was reported at 70.34% and is currently projected at 72.50% for January 2019. Trust recovery to the 85% target is expected from April 2019. The backlog for Urology and Lower GI poses a risk to compliance for these two tumour groups, although additional diagnostic and treatment capacity is now in place which will help clear this backlog and treat patients within the 62 days

In January 2019 **Referral to Treatment (RTT) Incomplete performance** was reported as 81.45% with the total Waiting List reduced by 826 patients, which is the eighth successive month of improvement. There were no patients waiting more than 52 weeks at the end of January 2019 and the same is anticipated at the end of February 2019. Confirmed plans will support improvement to 85%, but it is anticipated that additional actions currently being implemented will support recovery to 87.8% by March 2019.

The Trust has delivered its **Pre-Provider Sustainability Funding (PSF) Control Total** deficit of £7.1m at the end of Month 10. Liquidity is a negative 2.6 days, which is 6.5 days below the plan. Cash balances are £13.2m below the plan. The overall Use of Resources Risk Rating is 3 which is in line with plan.

Delivery of the **2018/19 Control Total** at year end is contingent on recovery of the planned benefits from the Wholly Owned Subsidiary (WOS) for Estates & Facilities and delivery in full of the 2018/19 Financial Recovery Plan. The Recovery Plan shared with NHS Improvement targets £21.8m of run rate improvements to deliver the Control Total. These plans have been updated and now include £17m of technical measures and £4.7m of run rate improvements. There remains a significant degree of risk to full delivery of the Financial Recovery Plan.

The current forecast **Pre-PSF Control Total 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 WOS 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

## 31<sup>st</sup> January 2019

**Horizontal integration** - The Trust is working with West Yorkshire Association of Acute Trusts (WYAAT) to ensure the arterial centre gains NHS England approval, as a part of this process, approval will be needed from the West Yorkshire Health Overview and Scrutiny Committee. WYAAT was not successful in securing national capital funding for the hybrid theatre required for the arterial centre. The trust is involved in discussions to ensure the hybrid theatre is maintained as a high priority in future capital funding bids by the Sustainability and Transformation Plan (STP). The WYAAT programme to establish a single pathology network potentially impacts on the joint venture the Trust has with Airedale Hospital Foundation Trust (AHFT). However, this risk has been mitigated by the Trust working through the different WYAAT forums to ensure the single network outline case reflects the needs of the joint venture.

**Airedale collaboration** - The programme governance for the collaboration with Airedale has been agreed. Following discussions between the Trust, AHFT and the Clinical Commissioning Groups (CCGs). It has been agreed that the funding for the programme management office and executive lead will be split equally between the three parties. A joint clinical summit is planned to launch the programme with clinicians. This will take place in April 2019.

**Vertical integration** - The Trust is actively involved in the drafting of a Strategic Partnering Agreement, which will set out how collaboration and decision making will work in Bradford District and Craven. This will include the provision for the health and care partnership boards to decide how commissioning money is spent in the future. It is planned that this document will be signed and agreed by the partners by the end of March 2019. The Trust is working with a multi-disciplinary team of clinicians and commissioners to develop a new model of care for diabetes. A phased implementation of the new model is planned to commence on 1 April 2019 and it will take two years to fully implement.

**Links between the Trust and Bradford's economy** – The Committee considered an item outlining the contribution the Trust makes to the local Bradford economy. The contribution and links includes the Trust's role as a large local employer, its involvement in innovation and research and the concept of NHS Trust's as "anchor institutions" which add social value to local communities.

# Appendix



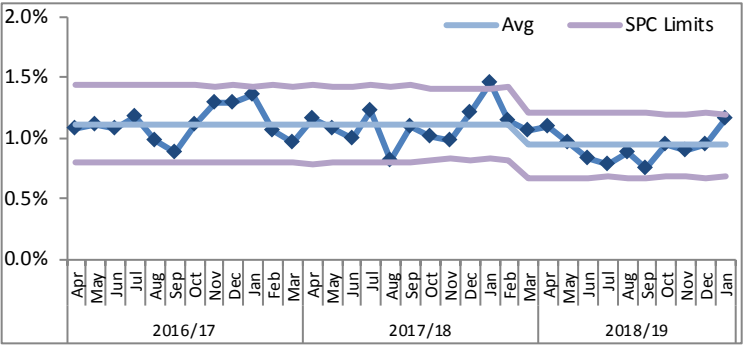
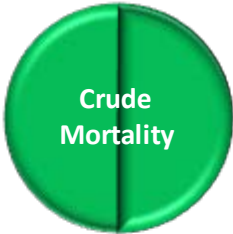
# To provide outstanding care for patients

Trend
-------

Challenges and Successes
--------------------------

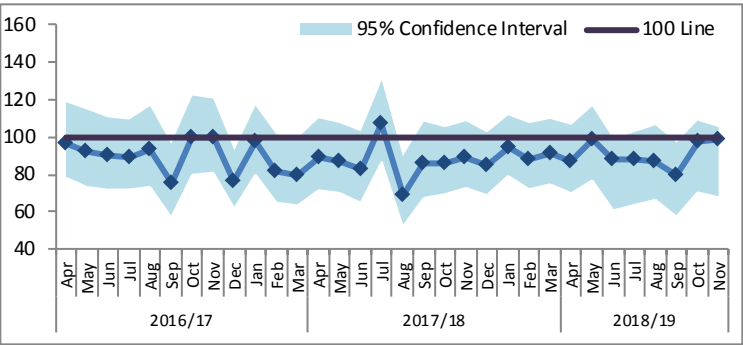
Comparison
------------

Exec Lead
-----------



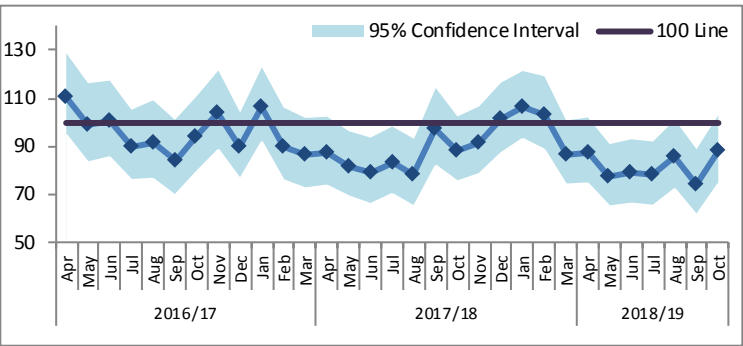
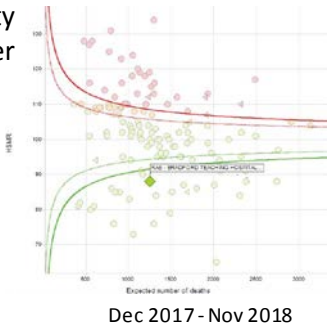
Crude death rate has remained constant throughout the last 18 months. There is no regional or national benchmarking data for this measure. Improving learning from mortality is now delivered though the ‘learning from deaths’ process. Reporting on progress to the Quality Committee is via the quarterly learning from deaths report.

Chief Medical Officer



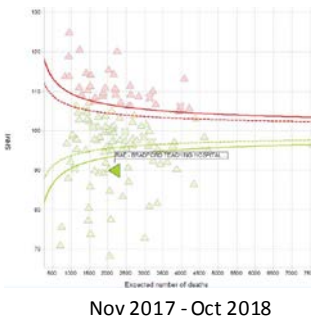
Our Hospital Standardised Mortality Ratio (HSMR) continues to be better than expected.

Chief Medical Officer



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

Chief Medical Officer



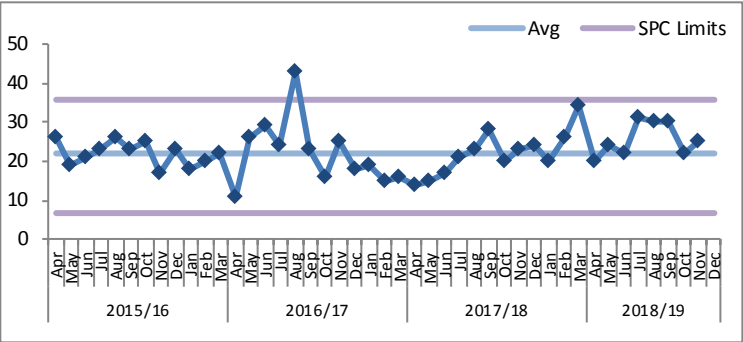
# To provide outstanding care for patients

Trend
-------

Challenges and Successes
--------------------------

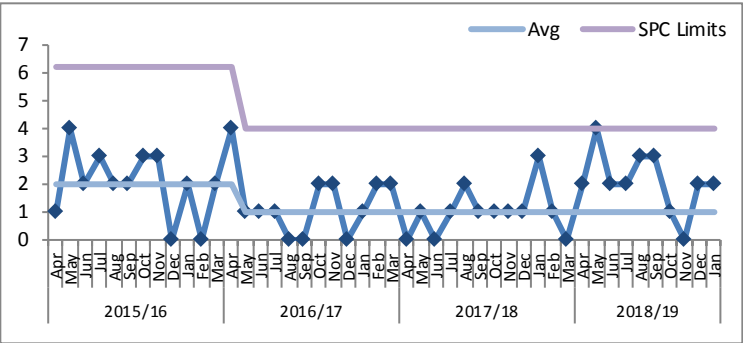
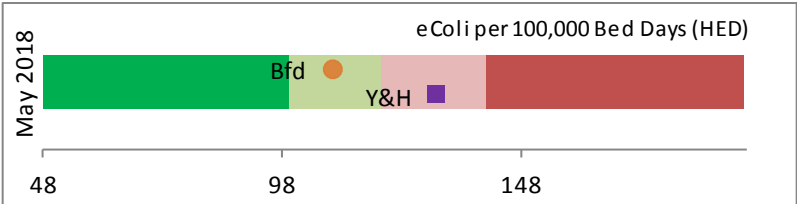
Comparison
------------

Exec Lead
-----------



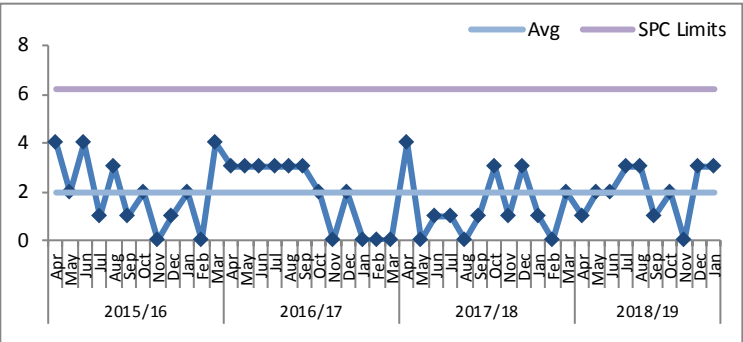
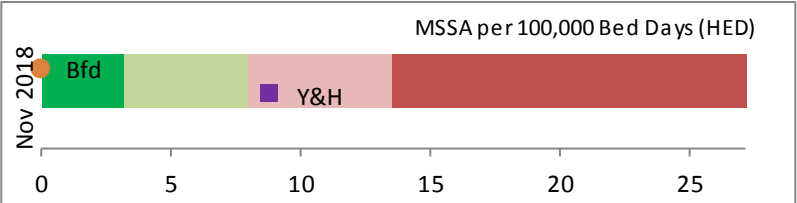
As part of the 2018/19 work plan we will focussing on all bacteraemias. We have seen a reduction of 26% on the previous 12 months (NHS Improvement).

Chief Nurse



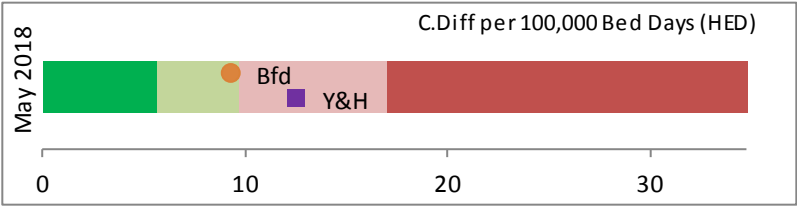
Part of national improvement collaborative for Infection Prevention and Control (IPC). Ongoing improvements are overseen by Infection Prevention and Control and reviewed on a quarterly basis.

Chief Nurse



Continues as per previous years, is within expected range.

Chief Nurse



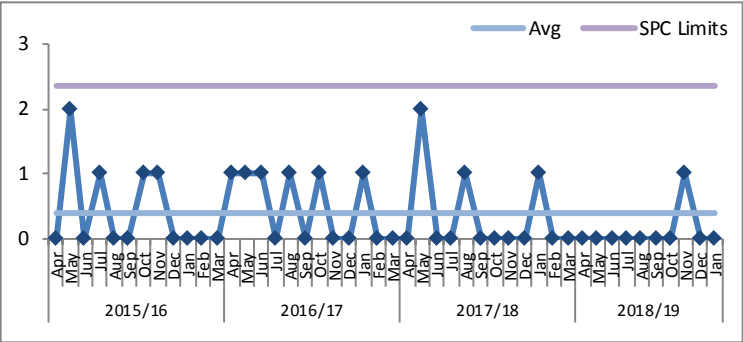
# To provide outstanding care for patients

## Trend

## Challenges and Successes

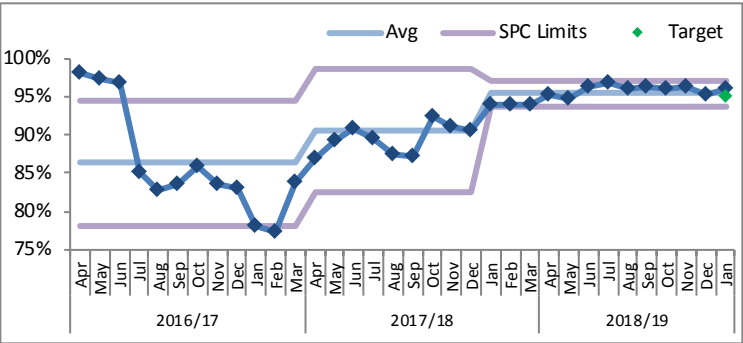
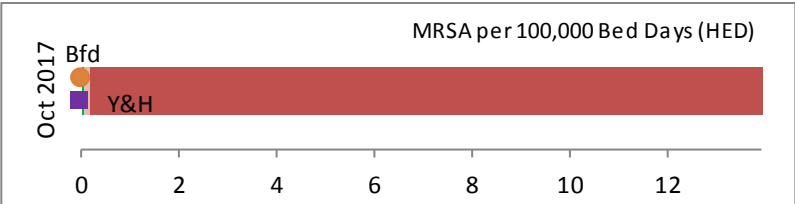
## Comparison

## Exec Lead



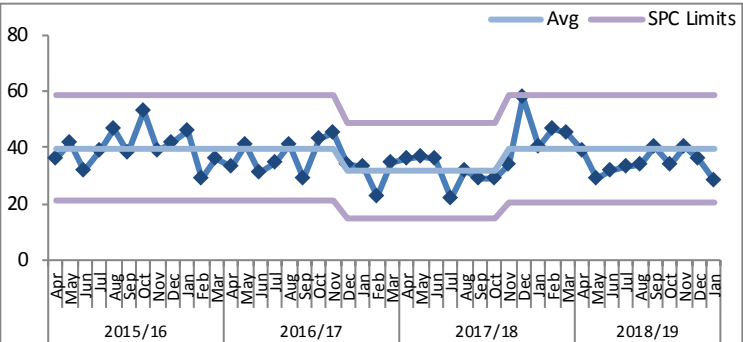
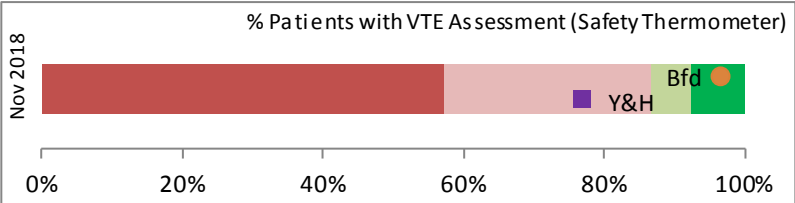
One case in November 2018/19, no deficits in care.

Chief Nurse



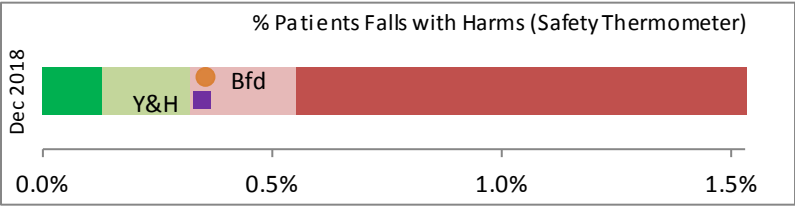
The Venous Thromboembolism (VTE) assessment shows sustained compliance with the standard.

Chief Medical Officer



For the month of January 2018/19 there were 28 falls with harm, of which one was moderate harm and the remaining 27 were of low harm.

Chief Nurse



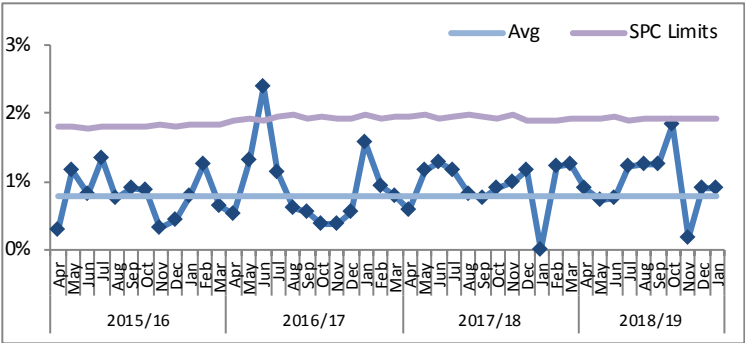
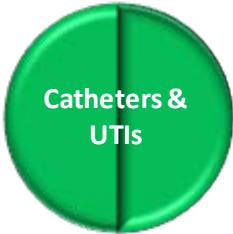
# To provide outstanding care for patients

Trend

Challenges and Successes

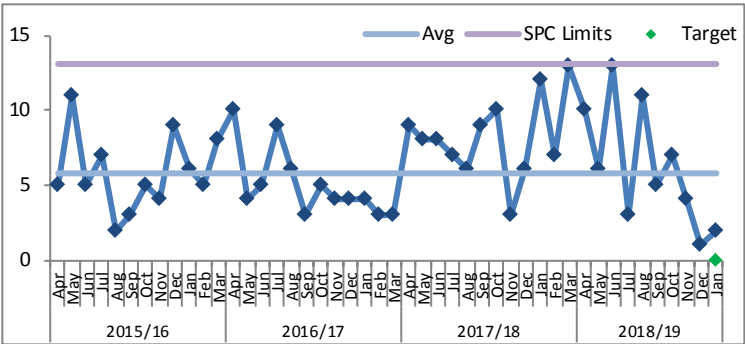
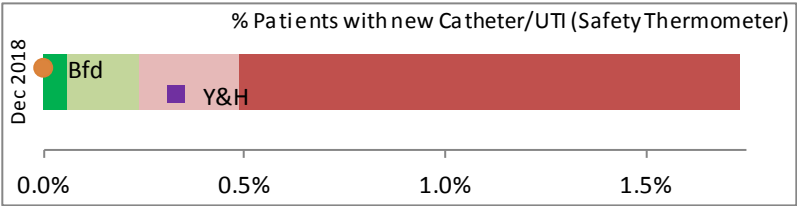
Comparison

Exec Lead



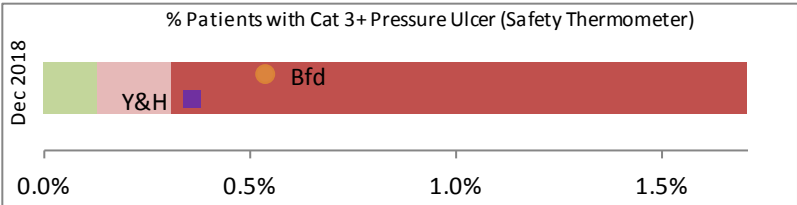
The Infection Control team is reviewing the data submission relating to Catheters and Urinary Tract Infections (CAUTI), including a review of the indicator. Further detail is included within the Infection Control report.

Chief Nurse



All systems relating to pressure ulcers have been reviewed in line with the revised NHS England Guidance.

Chief Nurse



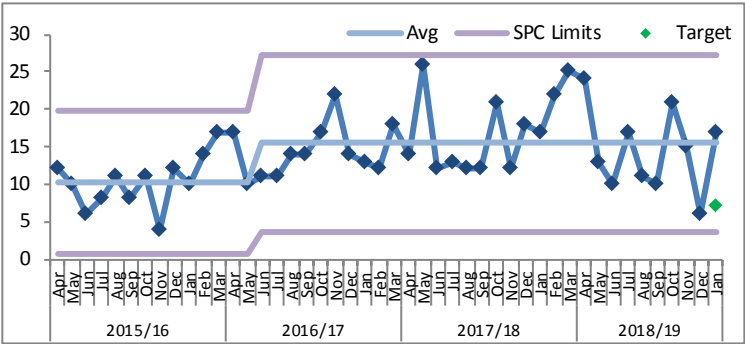
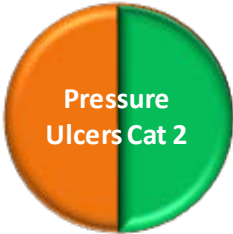
# To provide outstanding care for patients

## Trend

## Challenges and Successes

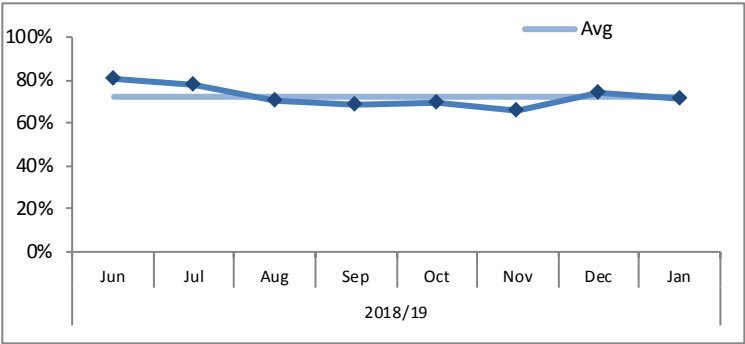
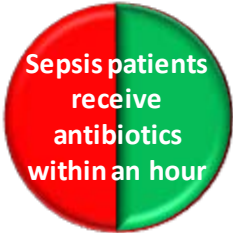
## Comparison

## Exec Lead



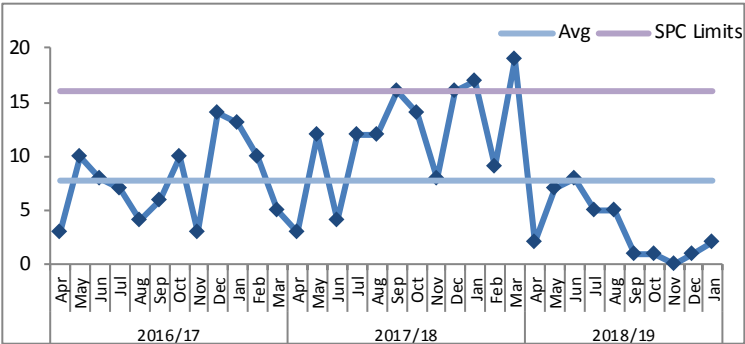
All systems relating to pressure ulcers have been reviewed in line with the revised NHS England Guidance.

Chief Nurse



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



There were two transfers for non-clinical reasons during January 2018/19. Both were on the same occasion and to create a side room which was authorised by the Clinical Site Matron.

Chief Operating Officer

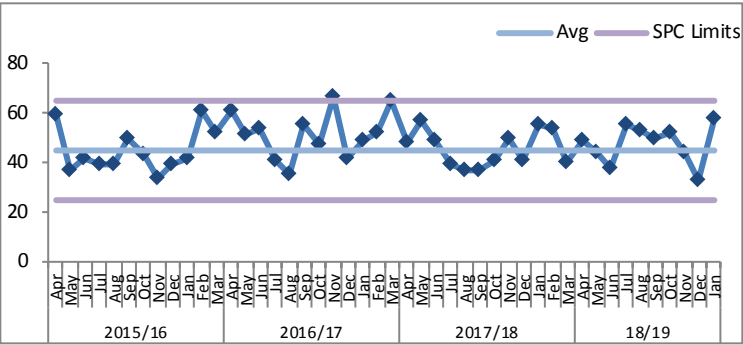
# To provide outstanding care for patients

Trend
-------

Challenges and Successes
--------------------------

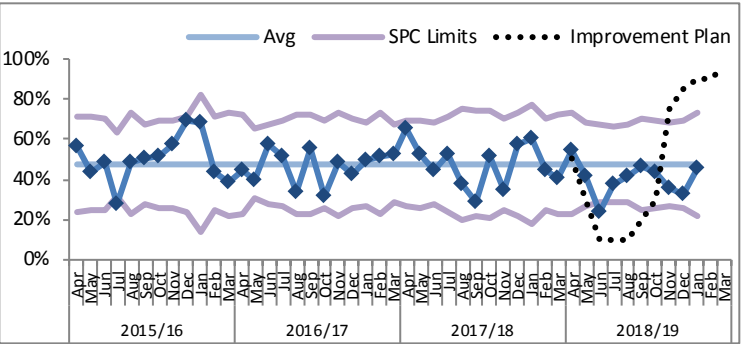
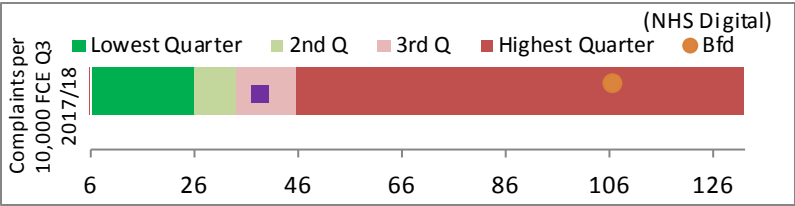
Comparison
------------

Exec Lead
-----------



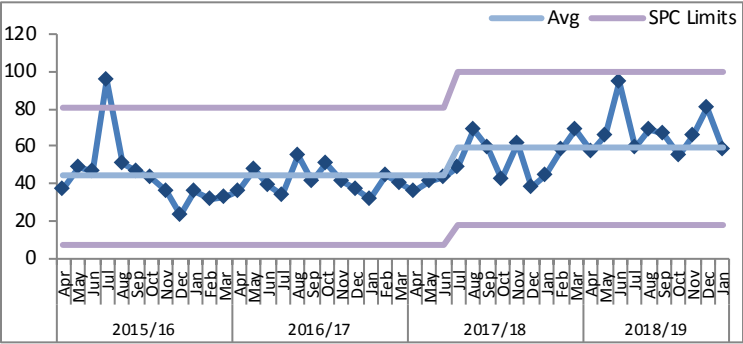
The backlog of complaints and total number of complaints has reduced considerably. The trajectories and metrics need to be reviewed by the Committee, this is included in the Patient Experience report.

Chief Nurse



The backlog of complains and total number of complaints has reduced considerably. The trajectories and metrics need to be reviewed by the Committee, this is included in the Patient Experience report.

Chief Nurse



The backlog of complaints and total number of complaints has reduced considerably. The trajectories and metrics need to be reviewed by the Committee, this is included in the Patient Experience report.

Chief Nurse

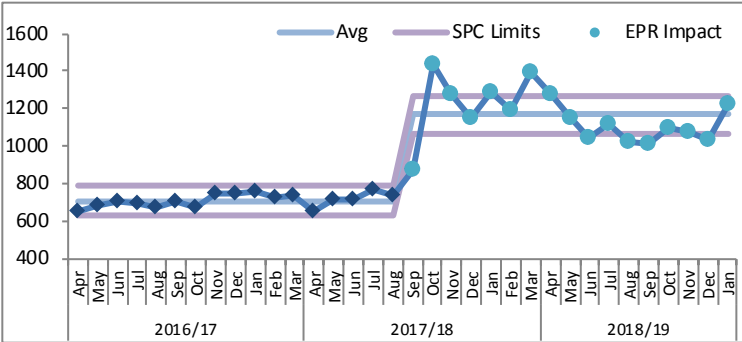
# To provide outstanding care for patients

## Trend

## Challenges and Successes

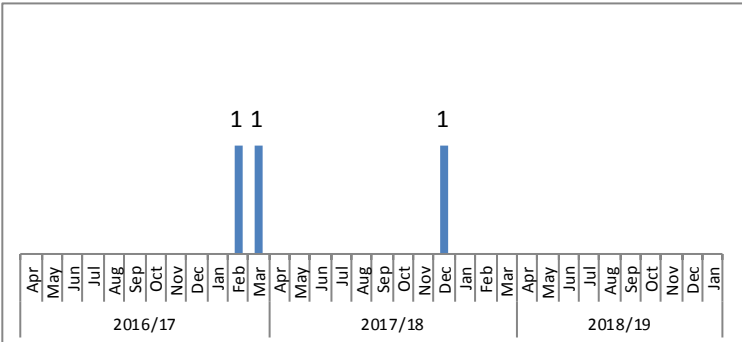
## Comparison

## Exec Lead



Readmissions increased significantly post EPR implementation. A review of readmission reporting and data quality investigated the root cause / impact which is found to predominantly reflect a change in recording of assessments and issues regarding the inclusion of paediatric assessments as non-elective admissions. The Performance and Business Intelligence teams are working together to agree and apply an improved methodology for reporting readmissions from March 2018/19. The slight increase in January 2018/19 is in line with seasonal trends but will be closely monitored during February 2018/19. Further clinical review of genuine readmissions will be undertaken to understand the reasons for readmissions

Chief Operating Officer


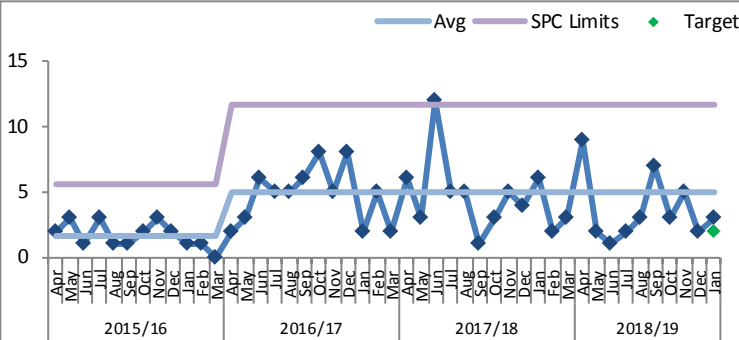

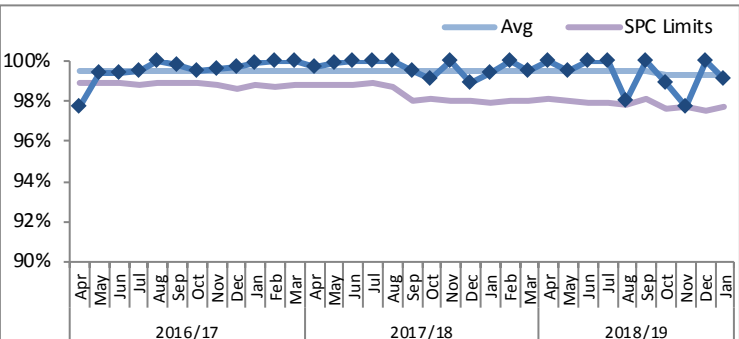

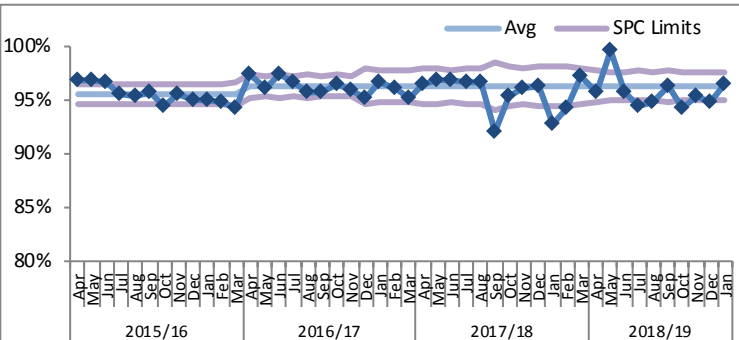


There are no breaches year to date 2018/19. Awareness remains high.

No comparator data is published.


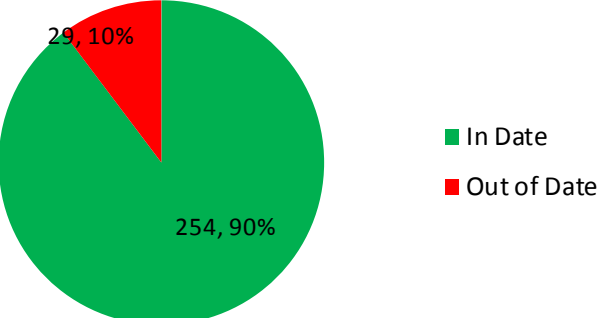
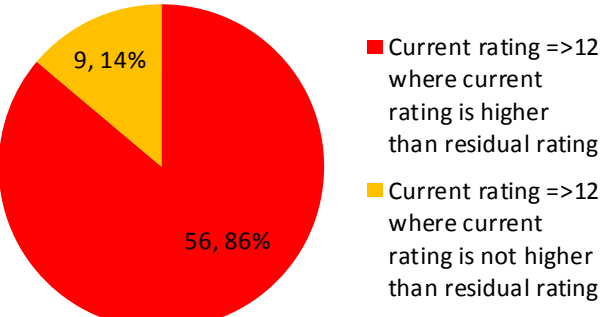

Chief Digital and Information Officer

# To provide outstanding care for patients

	Trend	Challenges and Successes	Comparison	Exec Lead
		Incidents that meet the criteria for the declaration of a serious incident (SI) are 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 are subject to action planning to minimise risk of reoccurrence. There is a detailed process of assurance to assess the effectiveness of action planning. Fluctuations in the number of monthly SI's are anticipated and the Quality Oversight System is in place to ensure identified themes or trends are acted upon.	No comparator data is available.	Director of Strategy and Integration
		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
		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

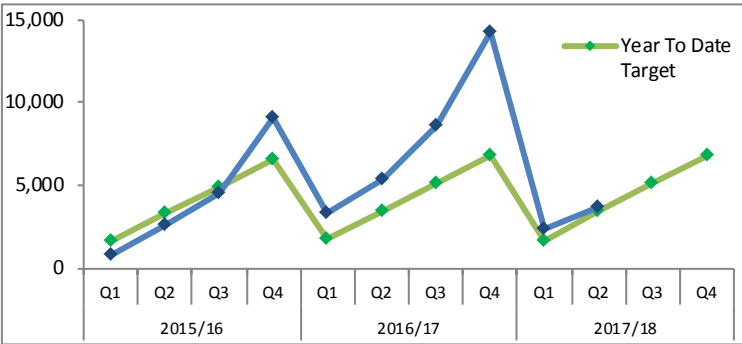
Trend		Challenges and Successes	Comparison	Exec Lead
		<p>A focussed programme of work continues in order to improve the Trust position in relation to Trust-wide policies and their management. There is significant confidence about the approach to managing locally-developed guidance within Divisions</p>		<p>Director of Strategy and Integration</p>
				
		<p>A recent Internal Audit report in relation to the implementation of the risk management strategy resulted in a significant assurance rating. As a result the metrics used to monitor the quality of governance in the Trust are being reviewed.</p>		<p>Director of Strategy and Integration</p>

# To be a continually learning organisation

Trend	Challenges and Successes	Comparison	Exec Lead
-------	--------------------------	------------	-----------

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




Number of participants recruited to National Institute of Health Research Portfolio Studies since 2015/16, including commercial and non-commercial studies, remains strong and in line with expectations.

Chief Medical Officer

# To collaborate effectively with local and regional partners

Trend	Challenges and Successes	Comparison	Exec Lead
-------	--------------------------	------------	-----------



## Stakeholder Engagement

Potential key performance indicators (KPIs) have been discussed at the Partnership Committee but there was no support for a numerical representation, instead the Committee receives periodic qualitative updates. The Trusts' systematic approach to stakeholder management identifies key external partners. For each, an executive sponsor and an account manager has been identified, with responsibility for maintaining/improving the health of the relationship. To establish the baseline, an initial survey was sent out by account managers to a cohort of the various stakeholder organisations. Following a low initial response rate, account managers were also asked to self-assess. The findings helped determine whether an action plan was required to improve any of the relationships. Further meetings with account managers have since been held. The survey was repeated in December 2018/19, with an improved response rate.

Director of  
Strategy &  
Integration



## Vertical Integration

Partnership Committee has advised that the red, amber, green (RAG) rating should be based on a subjective assessment, in the absence of a meaningful, readily understandable hard metric. 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 providers work together to develop models of care which best meet the needs of service users, manage demand and achieve optimal value for money. The focus of work to date is on designing and implementing a new model of care for diabetes, and also rethinking the provision of and managing access to community beds. These are progressing well (although not to the optimistic timescales envisaged by some stakeholders at the outset). There is also a governance question around how the Trust and partners including the Clinical Commissioning Groups (CCG's) commit to share risk and reward: a draft "Strategic Partnering Agreement" intended to cover all participant organisations has been presented to Partnerships Committee, and Board is invited to sign-off on 7<sup>th</sup> March 2018/19.

Director of  
Strategy &  
Integration



## Acute Collaboration

Partnership Committee has advised that the RAG rating should be based on a subjective assessment, in the absence of a meaningful hard metric. The Trust is committed to work with other acute providers to ensure resilient services, reduce variation, address workforce shortages, achieve efficiencies etc. There are multiple developments underway including the emergence of a West Yorkshire and Harrogate integrated care system (ICS), with Trust executives involved in multiple fora. Our work with Airedale Foundation Trust to optimise collaboration in the provision of secondary care is progressing well, and will be formally launched with a clinical summit on 8<sup>th</sup> April 2019/20 involving clinical leaders from both Trusts.

Director of  
Strategy &  
Integration

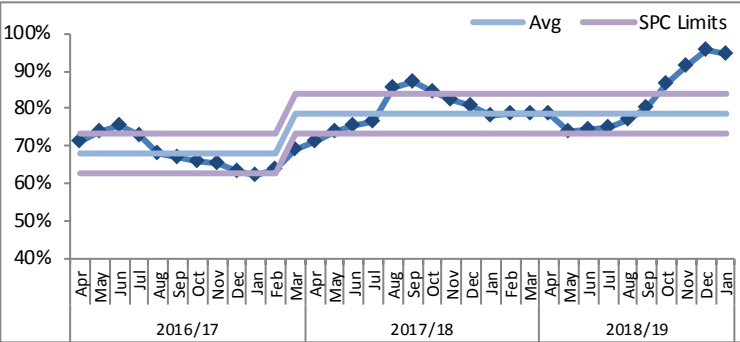
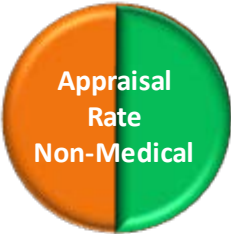
# To be in the top 20% of employers in the NHS

Trend
-------

Challenges and Successes
--------------------------

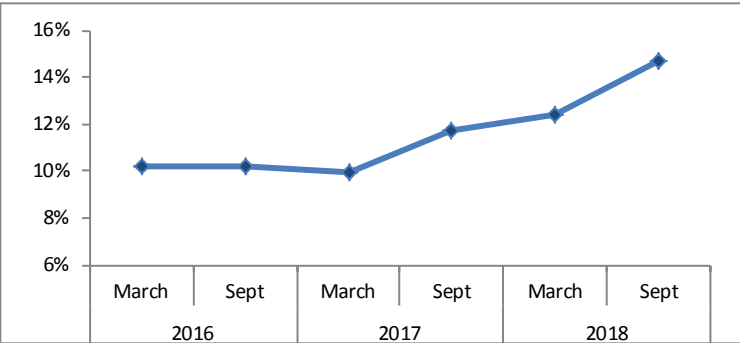
Comparison
------------

Exec Lead
-----------



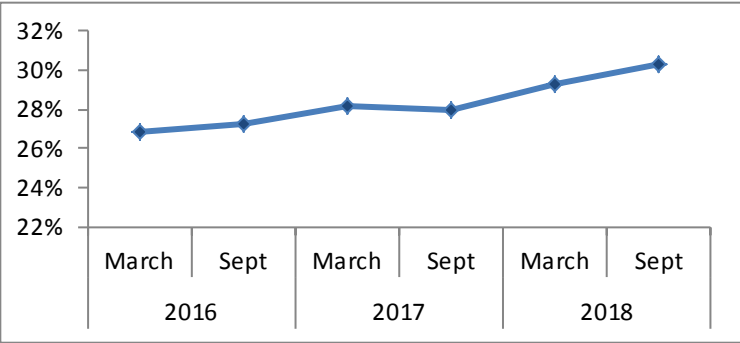
Our completion rate for January 2018/19 was 94.57%, a slight decrease from December 2018. Work continues to make sure our completion rate is 95% at the end of March 2018/19. The work includes continuing to promote the benefits of effective appraisals; developing managers; making sure recording and reporting appraisals is carried out using the Electronic Staff Record (ESR) and making sure protected time is allocated for appraisals that are due.

Director of Human Resources



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 and 9 posts, with the aim of accelerating progress on this target. Next update March 2018/19.

Director of Human Resources

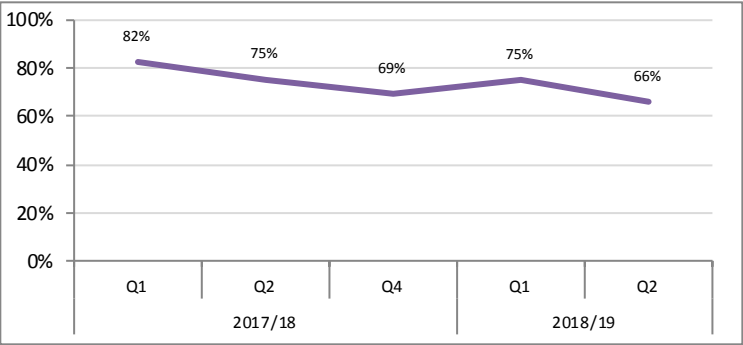


Good progress is being made. We are 6% ahead of our trajectory to have a workforce reflective of the local ethnic population by 2025. Next update March 2018.19.

Director of Human Resources

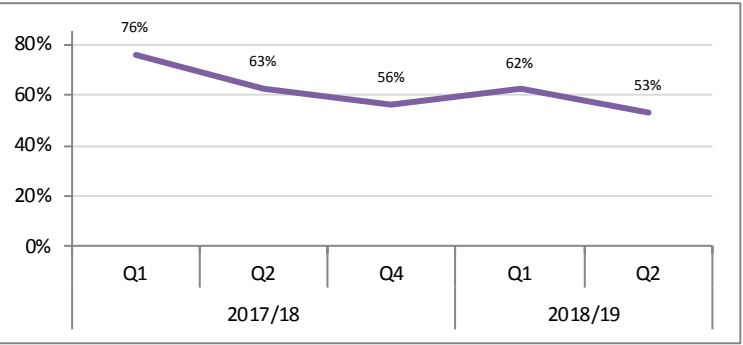
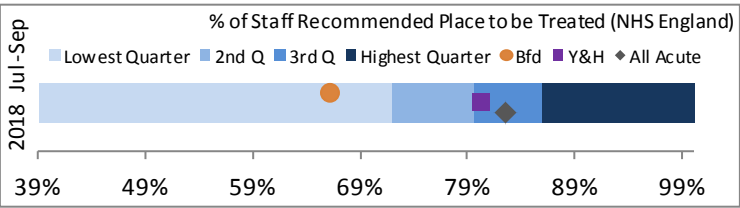
# To be in the top 20% of employers in the NHS

Trend	Challenges and Successes	Comparison	Exec Lead
-------	--------------------------	------------	-----------



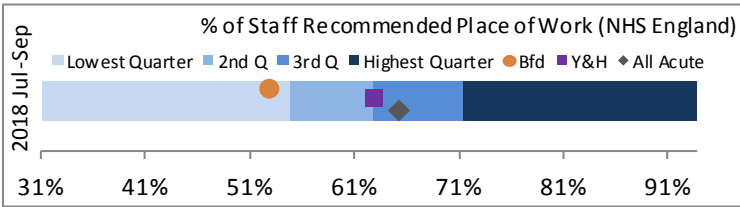
The NHS Staff Survey results are published on 26 February 2018/19 and an action plan will be developed to address priorities; the outcomes will shape annual plans for 2019/20. Preparations are underway for the launch of the Staff Friends and Family Test for Q3, which runs from 11 – 31 March 2018/19. We are looking at a range of ways to engage staff to encourage them to take part and increase our response rate.

Director of Human Resources



The NHS Staff Survey results are published on 26 February 2018/19 and an action plan will be developed to address priorities; the outcomes will shape annual plans for 2019/20. Preparations are underway for the launch of the Staff Friends and Family Test for Q3, which runs from 11 – 31 March 2018/19. We are looking at a range of ways to engage staff to encourage them to take part and increase our response rate.

Director of Human Resources



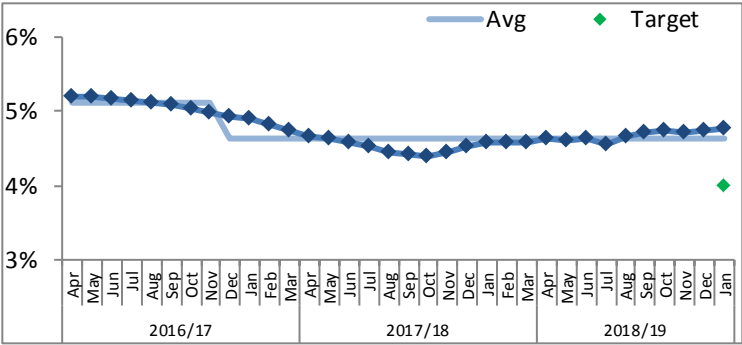
# To be in the top 20% of employers in the NHS

Trend
-------

Challenges and Successes
--------------------------

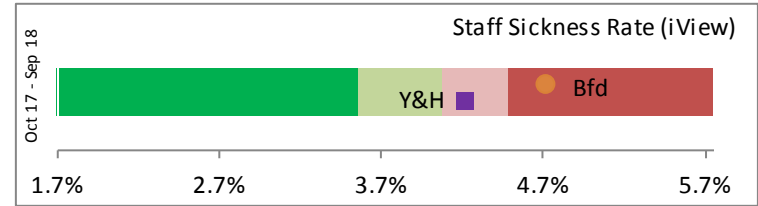
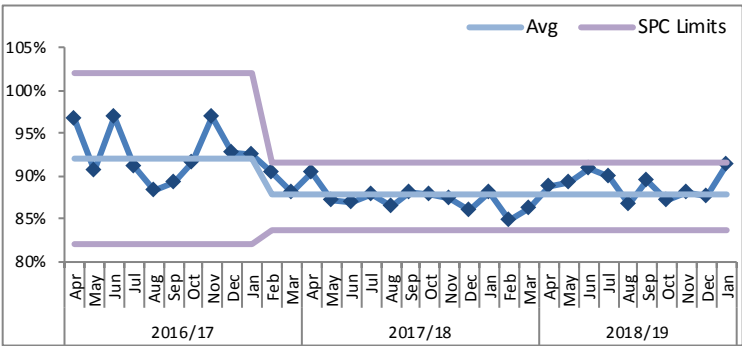
Comparison
------------

Exec Lead
-----------



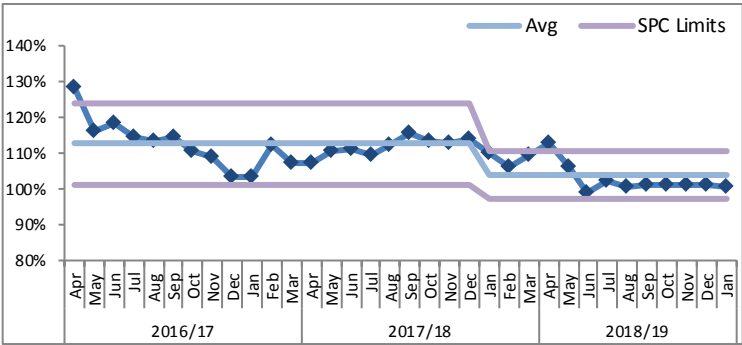
The rolling 12 month sickness absence rate as at the end of January 2018/19 was 4.76% a slight increase from December 2018/19. Sickness absence is increasing in Medicine, Women’s and Children’s and Corporate Services. We will not now meet our target of 4%. Work is ongoing to remodel absence targets for the following 2 years taking into consideration Acute Trusts with similar health deprivation rates as well as regional and national trends.

Director of Human Resources



Fill rates for Registered Nurses remains relatively stable around 90%. See Nurse staffing report for more details.

Chief Nurse



Fill rates are now consistently 100% and are as expected.

Chief Nurse

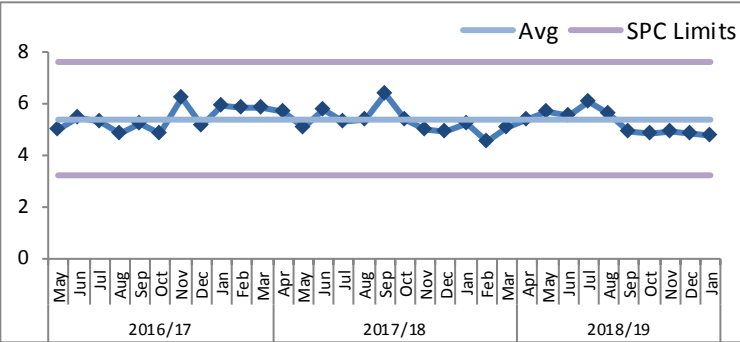
# To be in the top 20% of employers in the NHS

## Trend

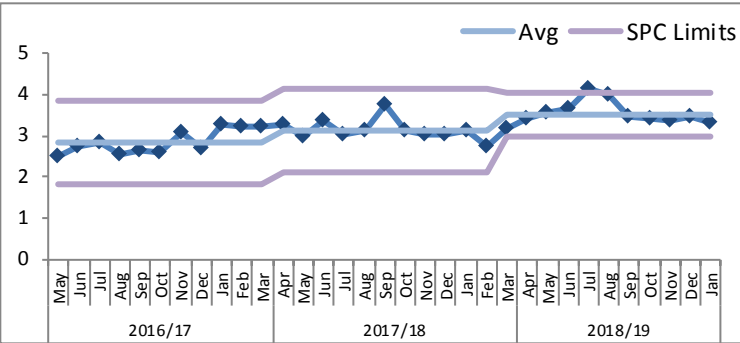
## Challenges and Successes

## Comparison

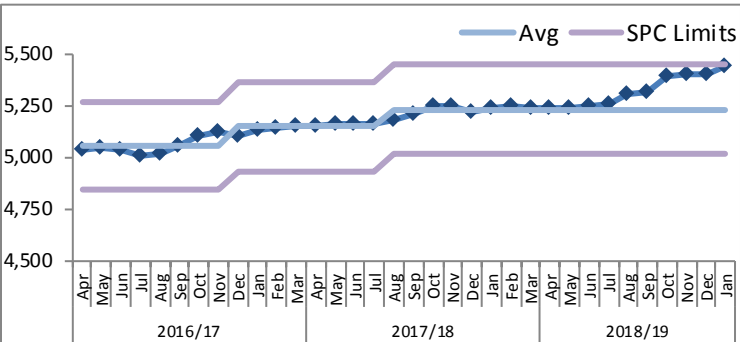
## Exec Lead



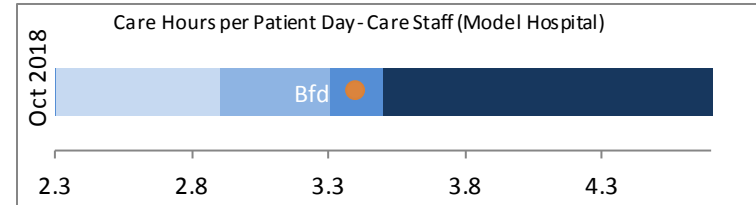
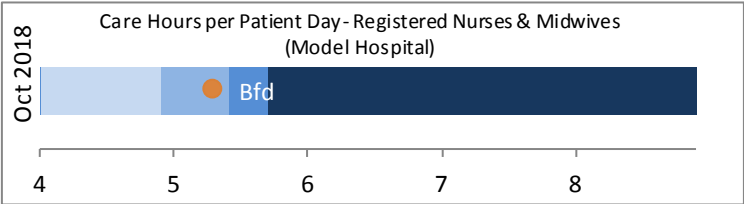
Rate remains stable and benchmarks appropriately with model hospital data. Chief Nurse




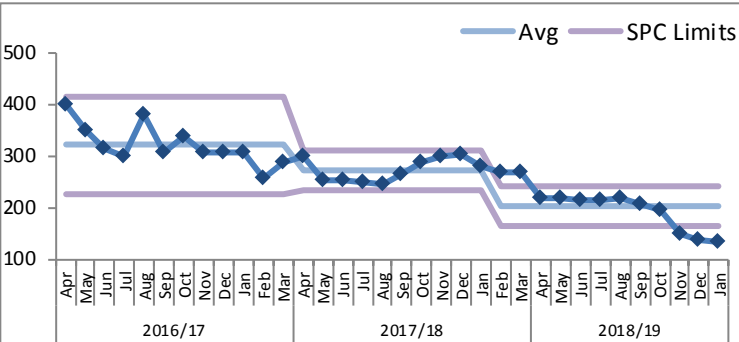

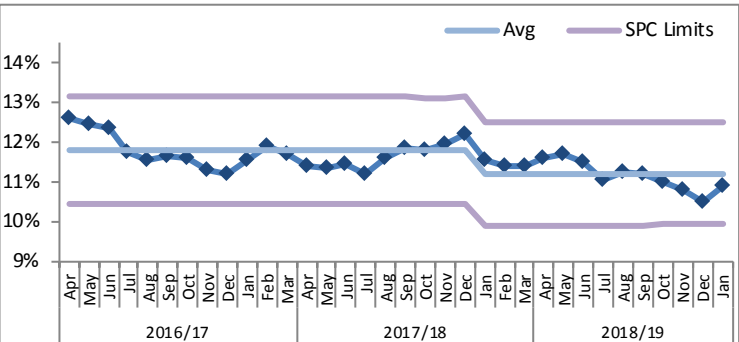

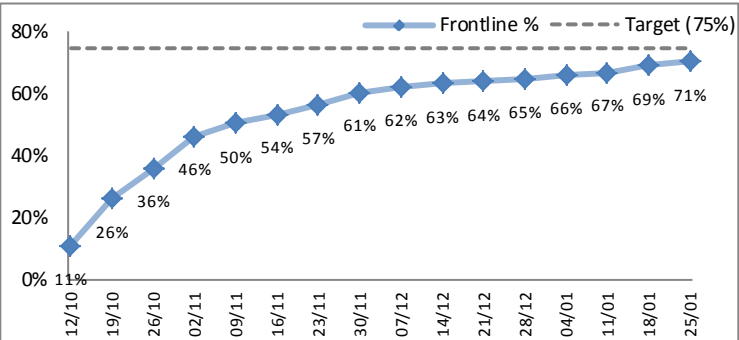
The carer workforce has stabilised in line with our workforce plans, benchmarks appropriately with model hospital. Chief Nurse



Staffing numbers have increased in January 2018/19. The increase relates to the recruitment of Apprentice Operating Department Practitioners (ODP's) and Healthcare Assistants. (HCA's) Director of Human Resources.



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

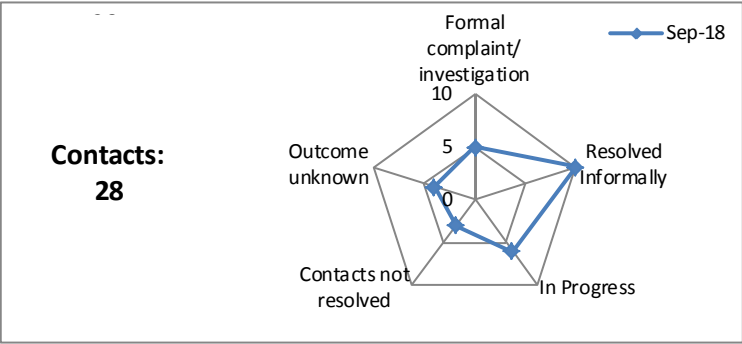
	Trend	Challenges and Successes	Comparison	Exec Lead
		Agency usage has decreased further across the Healthcare Assistants (HCA's) staff group to just 2% of shifts covered by agency as all divisions have stopped using agency HCA's unless escalated to their Head of Nursing. Use of qualified Nurses from agencies has remained around 30% (1255 shifts) in January 2018/19 with an increase in bank cover to 48% (2005 shifts). This has been achieved by substantive appointments and improved rostering of Nurses and HCA's. Agency use in the Allied Health Professional (AHP's) group has remained static across the reporting period. Medical and Dental had a slight agency increase due to recovery plans. The primary need for medical agency staff is due to Consultant vacancies.		Director of Human Resources
		Turnover has increased slightly at Trust Level in January 2018/19 to 10.90% up from 10.40% in December 2018/19. Staff Groups that have seen the biggest increase are Additional Clinical Services which covers clinical staff in bands 1-4 and Registered Nurses & Midwives. Turnover is still low compared to historical levels in the Trust.		Director of Human Resources
		Work with the 2018/2019 'flu campaign continues with more than 600 frontline staff vaccinated compared to the same period last year. There were 3,630 frontline staff who have received their vaccine, 73.2% of all frontline staff. The campaign will end on 28/02/2019 when the Commissioning for Quality & Innovation (CQUIN) target of 75% frontline staff will hopefully be achieved.		Director of Human Resources



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

Trend	Challenges and Successes	Comparison	Exec Lead
-------	--------------------------	------------	-----------

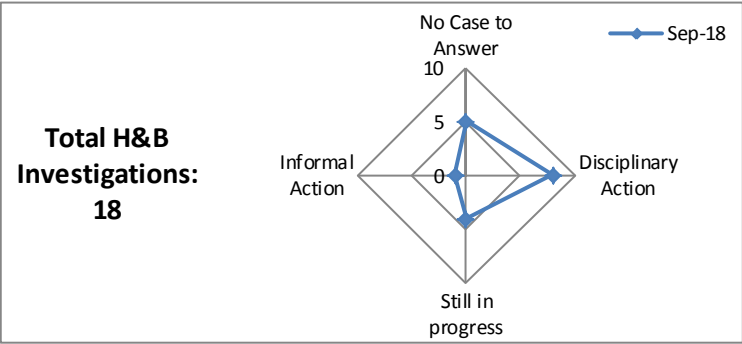
Staff Advocate  
Service Contacts  
& Outcomes



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																														
<div><div>New Starter Training</div><table><caption>New Starter Training Compliance Data (2018-19)</caption><thead><tr><th>Month</th><th>Compliance (%)</th><th>Target (%)</th></tr></thead><tbody><tr><td>Apr</td><td>96</td><td>95</td></tr><tr><td>May</td><td>96</td><td>95</td></tr><tr><td>Jun</td><td>96</td><td>95</td></tr><tr><td>Jul</td><td>96</td><td>95</td></tr><tr><td>Aug</td><td>96</td><td>95</td></tr><tr><td>Sep</td><td>97</td><td>95</td></tr><tr><td>Oct</td><td>97</td><td>95</td></tr><tr><td>Nov</td><td>98</td><td>95</td></tr><tr><td>Dec</td><td>98</td><td>95</td></tr><tr><td>Jan</td><td>99</td><td>95</td></tr></tbody></table></div> <div><p>The data demonstrates consistently over 98% performance with a comprehensive escalation process to track delivery of performance at an individual level.</p></div> <div><div>Comparator available.</div><div>data</div><div>not</div></div> <div>Chief Medical Officer</div>	Month	Compliance (%)	Target (%)	Apr	96	95	May	96	95	Jun	96	95	Jul	96	95	Aug	96	95	Sep	97	95	Oct	97	95	Nov	98	95	Dec	98	95	Jan	99	95
Month	Compliance (%)	Target (%)																															
Apr	96	95																															
May	96	95																															
Jun	96	95																															
Jul	96	95																															
Aug	96	95																															
Sep	97	95																															
Oct	97	95																															
Nov	98	95																															
Dec	98	95																															
Jan	99	95																															
<div><div>Refresher Training</div><table><caption>Refresher Training Compliance Data (2018-19)</caption><thead><tr><th>Month</th><th>Compliance (%)</th><th>Target (%)</th></tr></thead><tbody><tr><td>Apr</td><td>94</td><td>95</td></tr><tr><td>May</td><td>95</td><td>95</td></tr><tr><td>Jun</td><td>94</td><td>95</td></tr><tr><td>Jul</td><td>95</td><td>95</td></tr><tr><td>Aug</td><td>94</td><td>95</td></tr><tr><td>Sep</td><td>94</td><td>95</td></tr><tr><td>Oct</td><td>94</td><td>95</td></tr><tr><td>Nov</td><td>94</td><td>95</td></tr><tr><td>Dec</td><td>94</td><td>95</td></tr><tr><td>Jan</td><td>85</td><td>95</td></tr></tbody></table></div> <div><p>The Trust has consistently exceeded its target refresher training standard since April 2018/19, averaging over 95%.</p></div> <div><div>Comparator available.</div><div>data</div><div>not</div></div> <div>Chief Medical Officer</div>	Month	Compliance (%)	Target (%)	Apr	94	95	May	95	95	Jun	94	95	Jul	95	95	Aug	94	95	Sep	94	95	Oct	94	95	Nov	94	95	Dec	94	95	Jan	85	95
Month	Compliance (%)	Target (%)																															
Apr	94	95																															
May	95	95																															
Jun	94	95																															
Jul	95	95																															
Aug	94	95																															
Sep	94	95																															
Oct	94	95																															
Nov	94	95																															
Dec	94	95																															
Jan	85	95																															

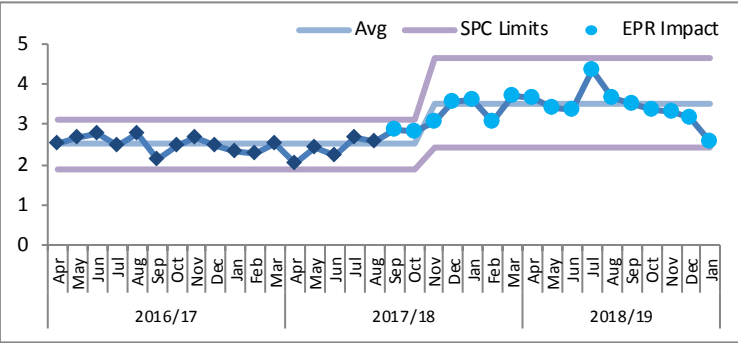
# To deliver our financial plan and key performance targets

Trend
-------

Challenges and Successes
--------------------------

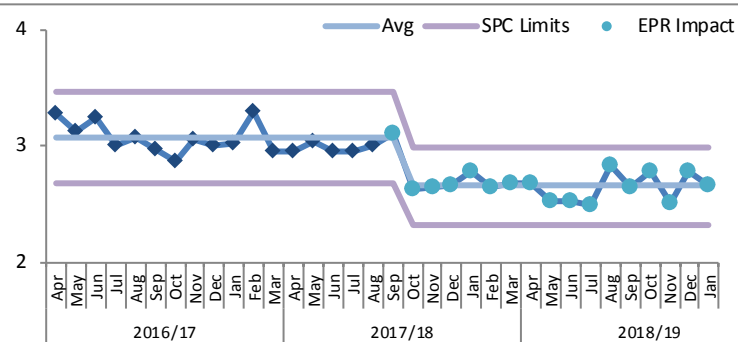
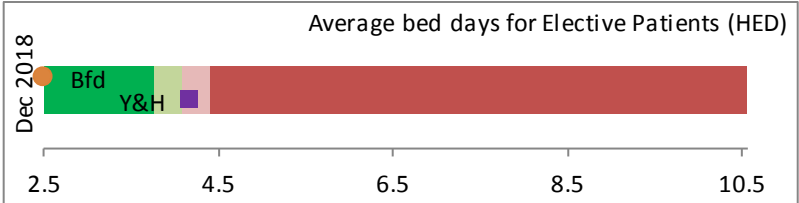
Comparison
------------

Exec Lead
-----------



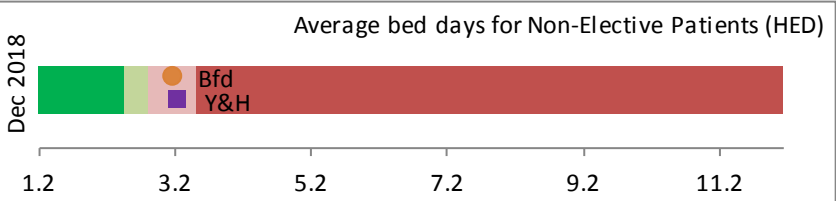
The increase post EPR relates to a movement of 1 day length of stay (included in this average) to day cases (which aren't included). The trend doesn't reflect a deterioration in length of stay and the actual number of stays greater than 2 days is in line with previous volumes. Removal of data quality errors has improved the reported performance which now shows a downward trend in recent months.

Chief Operating Officer



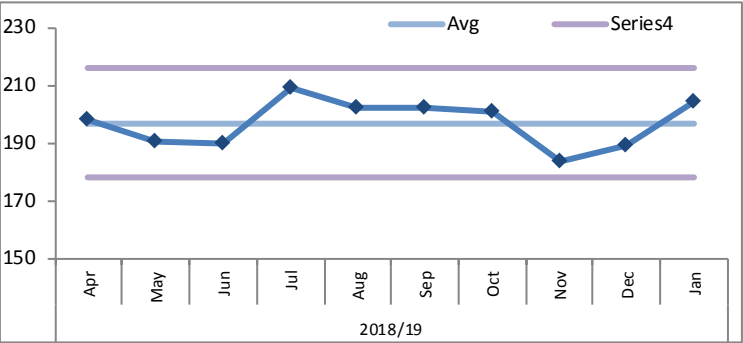
Trends over time show an increase in the number of 0 and 1 day length of stays which is why the average has reduced. This relates to a growth in assessments following the introduction of the Clinical Decision Unit (CDU) and increased Ambulatory Care Unit (ACU) activity.

Chief Operating Officer



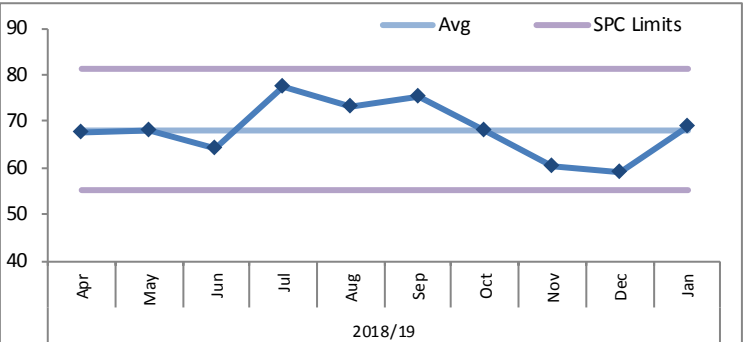
# To deliver our financial plan and key performance targets

Trend	Challenges and Successes	Comparison	Exec Lead
-------	--------------------------	------------	-----------



There is a twice weekly review of stranded patients, including a weekly multi-agency review of over 21 day length of stay and a remote reporting of all stranded patients over 7 days each week. Additional inpatient beds have been opened in support of winter pressures and data quality checks are in place to improve the accuracy of the reported long stay position. The Emergency Care Intensive Support Team (ECIST) reporting tool is now being used to document the outputs from the weekly multidisciplinary team review. This process and information is being refined to enable the publication of a Trust report which can also be provided at ward level. There is a review of the application of estimated date of discharge (EDD) underway which will also link into the development of the tiles required in the Command Centre .

Chief  
Operating  
Officer



Chief  
Operating  
Officer

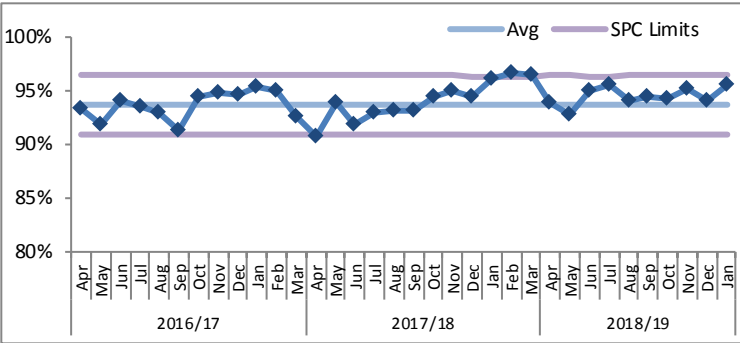
# To deliver our financial plan and key performance targets

Trend
-------

Challenges and Successes
--------------------------

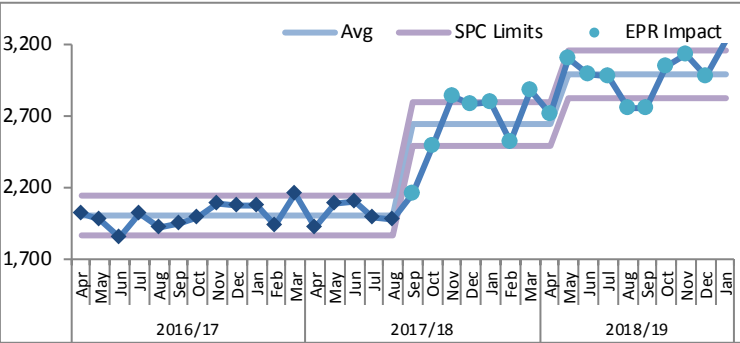
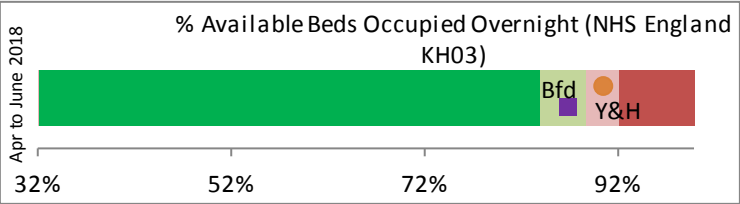
Comparison
------------

Exec Lead
-----------



Bed occupancy has remained slightly above average. The Trust is involved in the national SAFER collaborative, the Emergency Care Intensive Support Team (ECIST) has agreed to support this work stream over the next couple of months.

Chief Operating Officer



Discharge targets by ward have been implemented with daily review. The total number of discharges before 1pm remained high in December 2018/19.

Chief Operating Officer

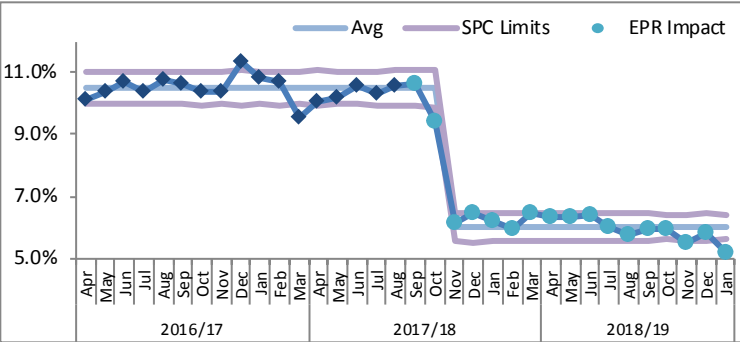
# To deliver our financial plan and key performance targets

Trend
-------

Challenges and Successes
--------------------------

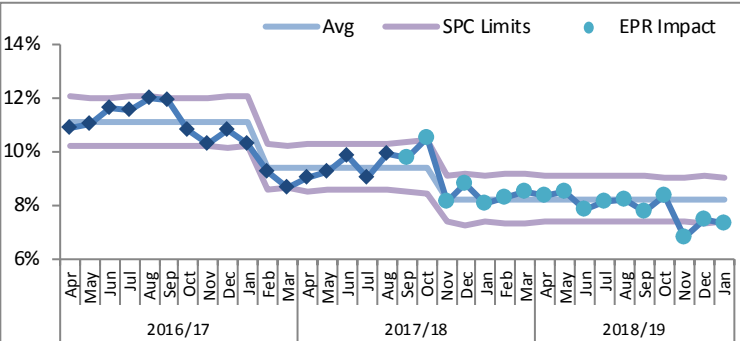
Comparison
------------

Exec Lead
-----------



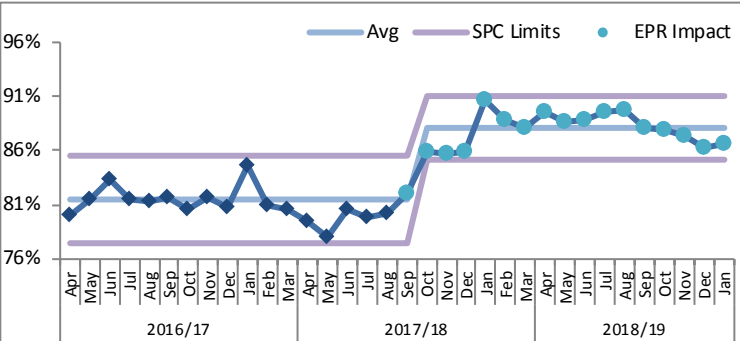
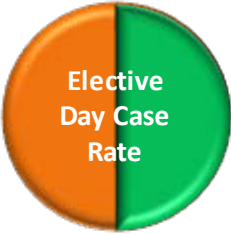
Investigation into data quality issues which may be impacting reporting has found a potential issue with how the number of did not attend (DNA's) and cancellations are reported when the appointment is rescheduled. This predominately impacts follow up attendances and a fix is currently being tested.

Chief Operating Officer



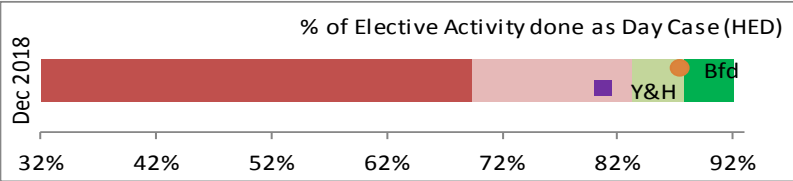
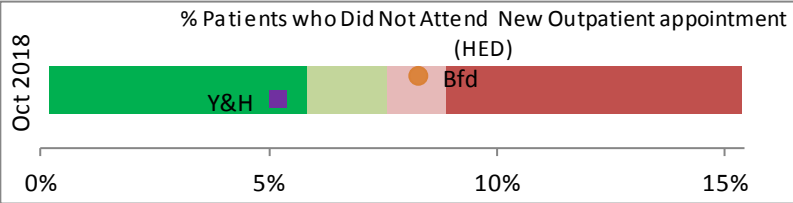
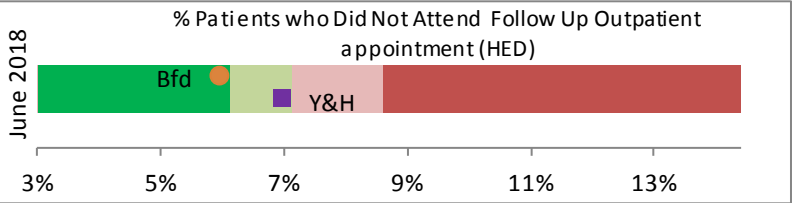
Data quality investigations will also extend to new appointments.

Chief Operating Officer



The recent decline in day case rate relates in the main to a growth in elective inpatient spells which is supporting referral to treatment (RTT) recovery plans.

Chief Operating Officer



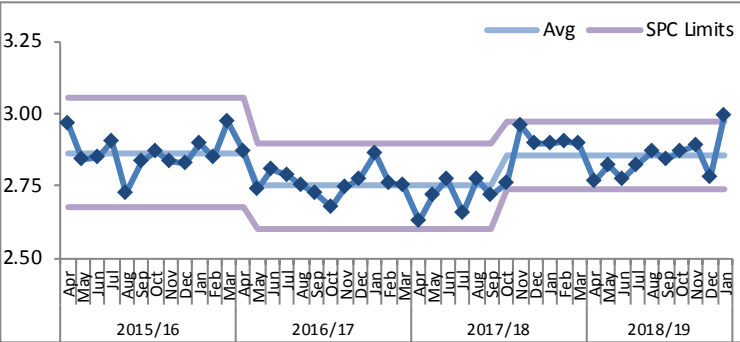
# To deliver our financial plan and key performance targets

Trend
-------

Challenges and Successes
--------------------------

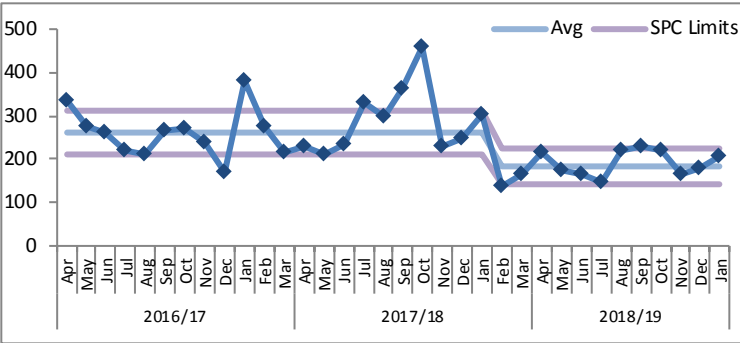
Comparison
------------

Exec Lead
-----------



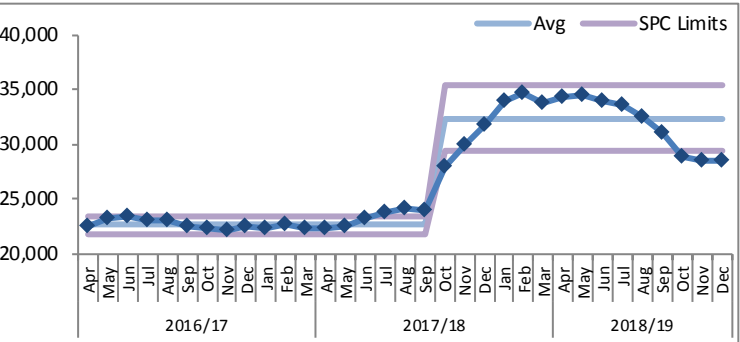
Additional activity being provided in support of referral to treatment (RTT) recovery includes additional follow up attendances which explains the increased ratio for January 2018/19.

Chief Operating Officer



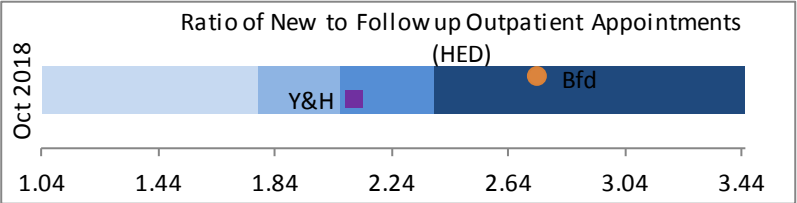
Numbers for January 2018/19 were in line with the average.

Chief Operating Officer



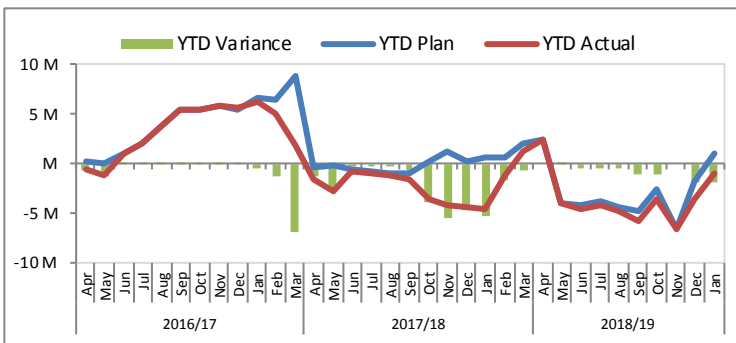
The total waiting list size is projected to reduce by 691 in January 2018/19 from the reported December 2018/19 position, which is the 8th successive reduction since April 2018/19.

Chief Operating Officer



# To deliver our financial plan and key performance targets

Trend	Challenges and Successes	Comparison	Exec Lead
-------	--------------------------	------------	-----------



The Month 10 Income and Expenditure position is a pre-Provider Sustainability Fund (PSF) deficit of £7.1m which is in line with the planned deficit. The year to date position includes £5.9m of PSF income. The PSF position is made up of 70% of the Quarter 1, 2 and 3 target, with 30% related to Accident and Emergency (A&E) department targets being unrecoverable. This results in a post-PSF deficit of £1.2m which is £1.9m behind plan. The year end forecast presented is full delivery of the pre-PSF control total and mirrors the forecast submitted to NHS Improvement on 15th January 2019. The 2018/19 Financial Recovery Plan projections support this forecast, however there remains a risk that the pre-PSF control total will not be delivered. The post-PSF control total will not be delivered due to the loss of A&E related PSF cash.

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	2	4	3	Red
Liquidity	1	2	2	Yellow
I & E Margin	2	3	4	Orange
Variance from plan (I & E Margin)	1	2	2	Yellow
Agency Spend	2	1	1	Green
<b>Combined UoR (after triggers)</b>			<b>3</b>	

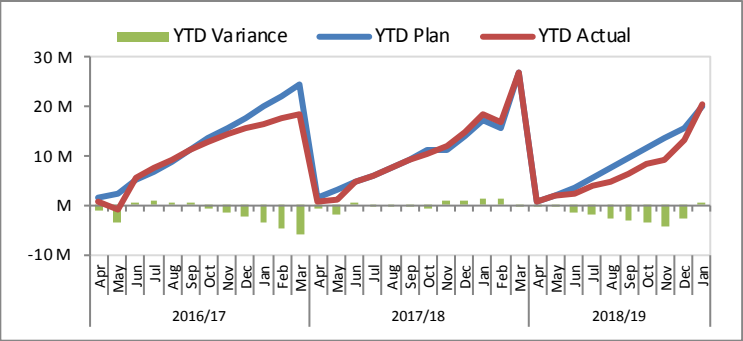
The Trust's overall use of resources (UoR) rating is in line with plan at the end of Month 10. The plan for Month 10 is relatively unchallenging and the Trust planned to record the second highest risk rating for month 10 (UoR rating = 3). Complying with this plan is not an indicator of strong financial performance, as the Trust is showing the highest possible risk ratings for both capital service cover and income and expenditure (I&E) margin, which is reflective of the year to date post-PSF deficit of £1.0m. Delivery of the plan requires full delivery of the recovery plan in the remaining months of the financial year.

Director of Finance



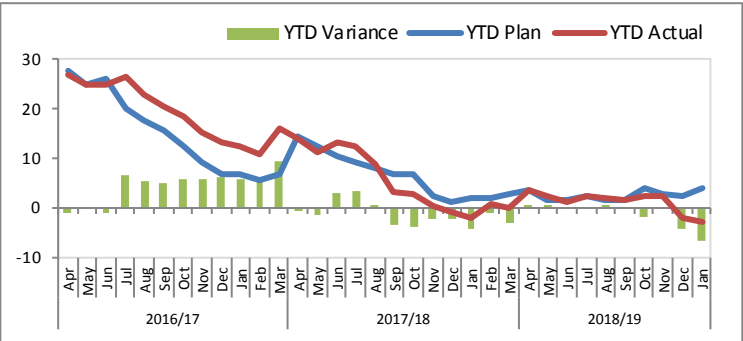
# To deliver our financial plan and key performance targets

Trend	Challenges and Successes	Comparison	Exec Lead
-------	--------------------------	------------	-----------



The Trust has delivered £19.1m of efficiencies at the end of Month 10. This is £4.7m behind the phased plans submitted by the divisions and corporate departments. A total of £4m of the year to date efficiencies were delivered via technical non-recurrent adjustments, Modern Equivalent Asset Valuation (MEAV) of £1.75m, and a further £7m relate to accrued Wholly Owned Subsidiary (WOS) benefits which are subject to NHS Improvement approval of the Trust's business case. Including the Financial Recovery Plan, divisions and corporate departments are currently forecasting delivery of £31.2m efficiencies, which would ensure the Trust delivers its annual savings target. The plan to deliver the £31.2m includes WOS savings of £7.0m, MEAV benefits £3.5m other recovery plans of £11.3m and divisional plans of £9.4m.

Director of Finance



Year to date liquidity is negative 2.6 days which is 6.5 days below plan. The in month movement on liquidity is a reduction of 0.7 days. This is a result of accrued receivable of the Estates WOS being considered non-current and therefore excluded from liquidity. There has also been an increase in deferred income which has contributed to the reduced liquidity metric. Liquidity is forecast at negative 4.2 days which 5.5 days below plan. This would see the use of resources (UoR) score to move to 2 from a planned level of 1. The forecast assumes the Trust will achieve its control total. If the Trust fails to deliver the recovery plan liquidity will fall to -17.8 days which would lead to a UoR score of 4.

Director of Finance

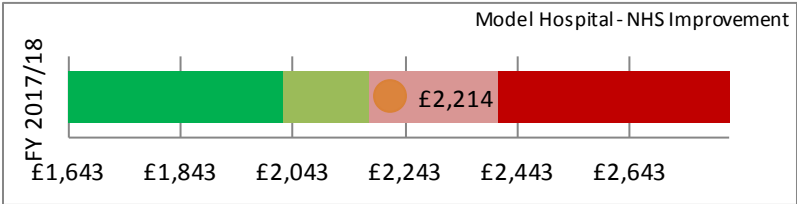
# To deliver our financial plan and key performance targets

Trend	Challenges and Successes	Comparison	Exec Lead
-------	--------------------------	------------	-----------



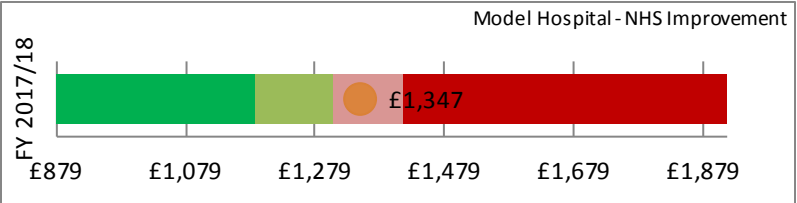
The Model Hospital pay and non-pay costs per weighted average unit (WAU) are the 2017/18 figures based on the 2017/18 Reference Costs and audited accounts. These metrics are updated annually and will next be updated by the Model Hospital with 2018/19's costs and activity in late 2019. For 2017/18's cost base and coded activity, the Trust's pay cost per WAU is £2,214. This places the Trust in the upper-mid quartile for this metric. The lower quartile (best performing) ranges from £1,643 to £2,015 and the lower mid-quartile ranges from £2,026 to £2,180. This high level metric suggests that the Trust spent more on staffing for the volume and casemix of work carried out in 2017/18 than would have been expected based on average expenditure in other NHS Providers in that year. At this high level, the Model Hospital suggests the Trust has the opportunity to reduce pay expenditure by up to £8.1m by replicating upper quartile cost performance for the 2017/18 coded casemix. Work in ongoing to validate the true realisable opportunity for the Trust.

Director of Finance



For 2017/18's cost base and coded activity, the Trust's non-pay cost per WAU is £1,347. This places the Trust in the upper-mid quartile for this metric. The lower quartile (best performing) ranges from £879 to £1,187 and the lower mid-quartile ranges from £1,190 to £1,307. This high level metric suggests that the Trust spent more on non-staffing items (such as drugs, medical consumables and non-clinical supplies and services) for the volume and casemix of work carried out in 2017/18 than would have been expected based on average expenditure in other NHS Providers in that year. The Model Hospital does not present an overall opportunity for improving the Trust's 2017/18 non-pay expenditure per WAU to the national upper quartile performance, however it appears to be substantial. Work in ongoing to validate the true realisable opportunity for the Trust. To improve this metric, the Trust would need to either reduce expenditure on staffing or increase the volume or complexity of coded activity.

Director of Finance



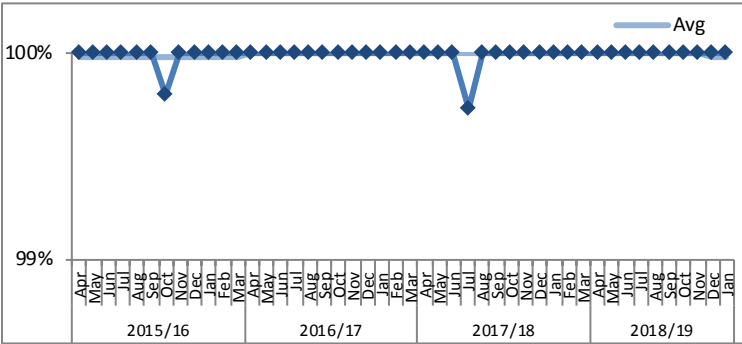
# To deliver our financial plan and key performance targets

Trend
-------

Challenges and Successes
--------------------------

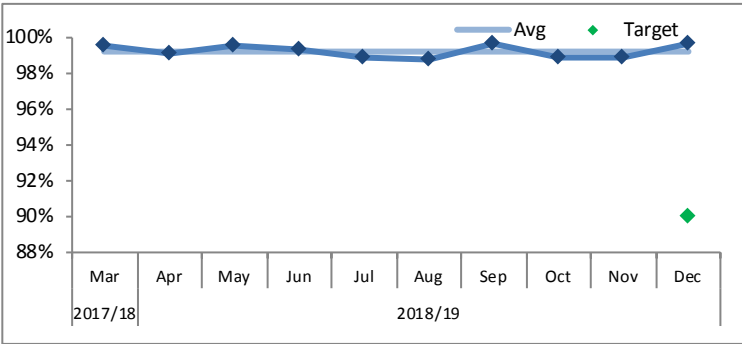
Comparison
------------

Exec Lead
-----------



The Trust continues to achieve a higher than target uptime for its mission critical systems.

Chief Digital and Information Officer

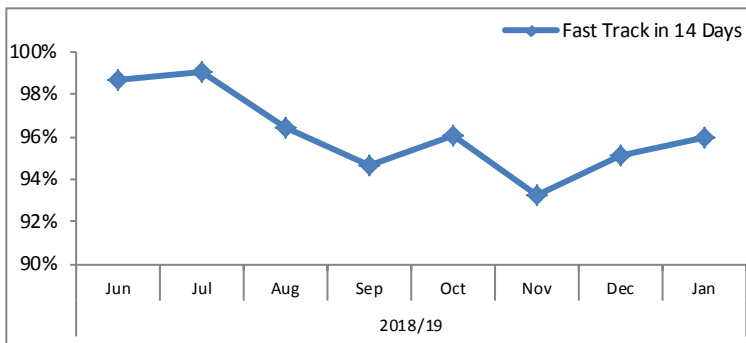


Performance has been achieved for the first 10 months since the introduction of this target.

Chief Operating Officer

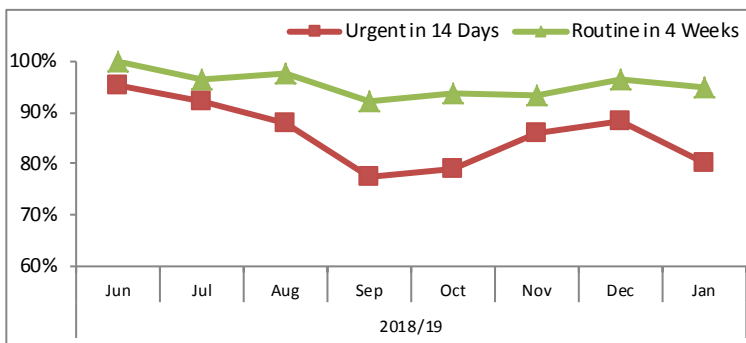
# To deliver our financial plan and key performance targets

Trend	Challenges and Successes	Comparison	Exec Lead
-------	--------------------------	------------	-----------



We achieved 96% for Fast Track in January 2018/19 against our local Key Performance Indicator (KPI). There were 45 patients where the report was not completed within 14 days and 35 of these related to Computed Tomography (CT) where the main pressure for Fast Track reporting continues to be CT virtual colonoscopies. Recovery actions to clear a reporting backlog for this test have seen month on month improvements since November 2018/19. Monitoring of turnaround times against a 7 day standard is now being reviewed, for January 2018/19 we achieved 86% with 157 reports not completed within 7 days.

Chief Operating Officer



Scanning capacity was sustained in January 2018/19 but we were not able to re-provide the equivalent CT reporting capacity and this has particularly impacted on the timeliness of urgent reporting. Turnaround times for routine patients has remained at a similar performance level to the previous month, this was supported by sending general MRI scans to an outsourcing company for reporting.

Chief Operating Officer

# National Indicators

## Single Oversight Framework

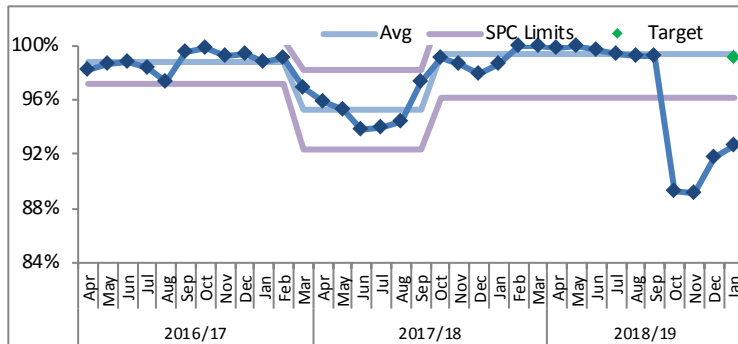
Trend

Challenges and Successes

Comparison

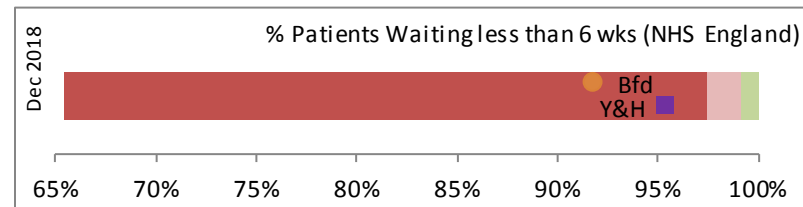
Exec Lead

Diagnostic  
Waits



A recovery plan for Colonoscopy, Flexi Sigmoidoscopy, Cystoscopy and Gastroscopy is in place with waiting list validation, additional sessions and the use of the independent sector providing recovery by March 2018/19. January 2018/19 reported performance of 92.62% which is the 2nd consecutive improvement but slightly behind the trajectory set for March 2018/19 compliance. Further validation was required this month as additional waits were included in the reported position following patient tracking list (PTL) development.

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	2	4	3	Red
Liquidity	1	2	2	Yellow
I & E Margin	2	3	4	Orange
Variance from plan (I & E Margin)	1	2	2	Yellow
Agency Spend	2	1	1	Green
<b>Combined UoR (after triggers)</b>			<b>3</b>	

The Trust's overall use of resources (UoR) rating is in line with plan at the end of Month 10. The plan for Month 10 is relatively unchallenging and the Trust planned to record the second highest risk rating for month 10 (UoR rating = 3). 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 (I&E) margin, which is reflective of the year to date post-Provider Sustainability Fund (PSF) deficit of £1.0m. Delivery of the plan requires full delivery of the recovery plan in the remaining months of the financial year.

Director of  
Finance

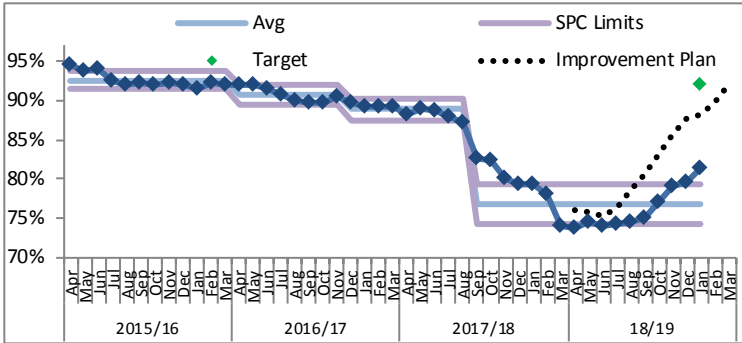
# National Indicators

## Single Oversight Framework

Trend

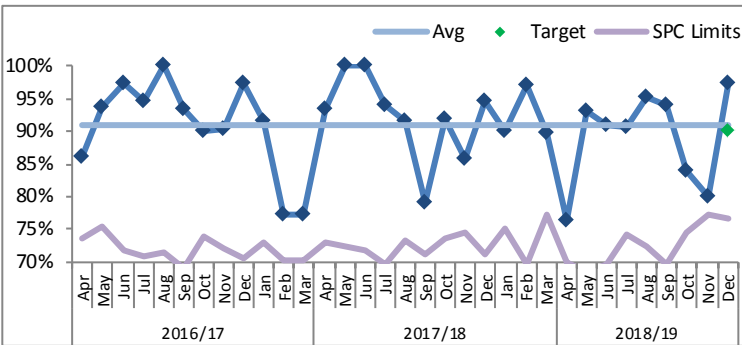
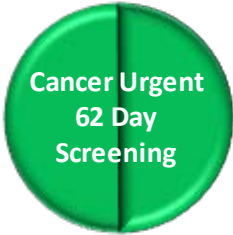
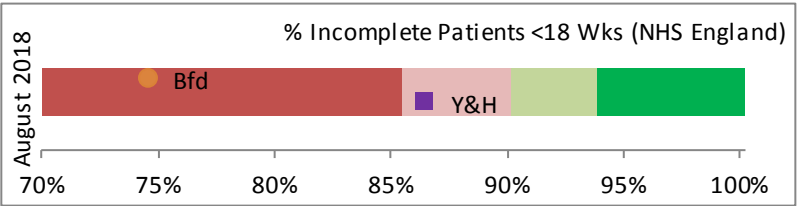
Challenges and Successes

Exec Lead



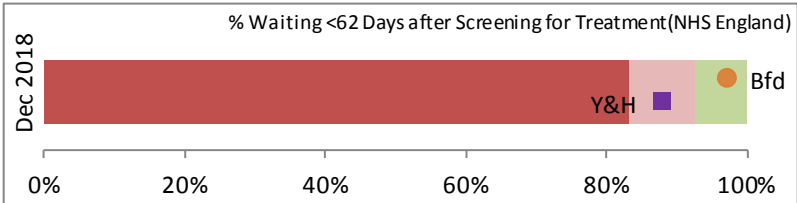
Incomplete performance for January 2018/19 was 81.45% which is an improvement on December 2018/19 but slightly behind (-1.8%) the recovery trajectory agreed in October 2018/19. Additional activity is being delivered through increased internal capacity and the use of the independent sector. Confirmed plans support recovery to 85% with additional schemes being prioritised in Ear, Nose and Throat (ENT), General Surgery and Vascular Surgery which would increase this to 87.8% if successful.

Chief Operating Officer



Performance was above target for December 2018/19.

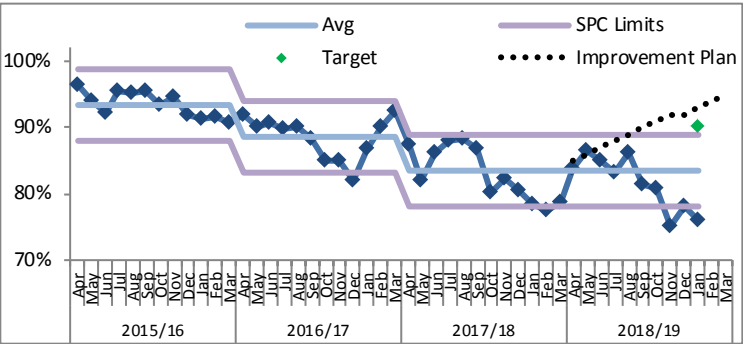
Chief Operating Officer



# National Indicators

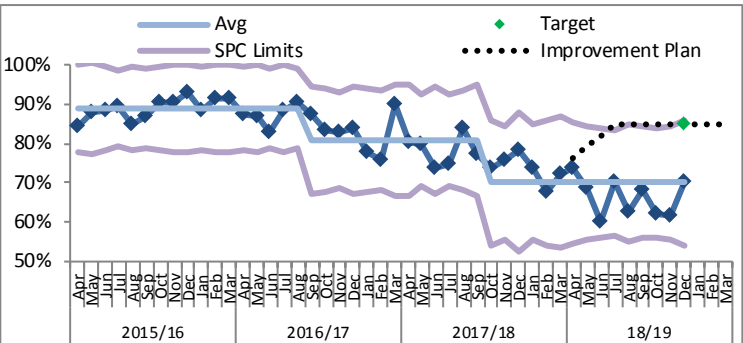
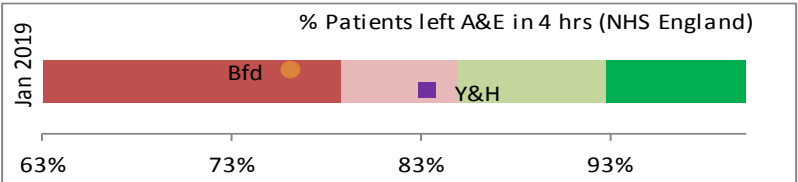
## Single Oversight Framework

Trend	Challenges and Successes	Comparison	Exec Lead
-------	--------------------------	------------	-----------



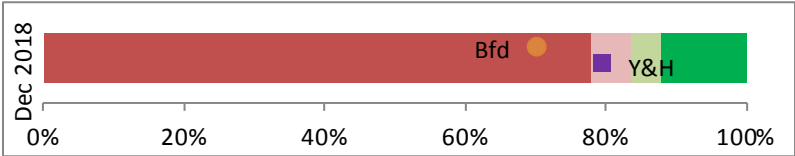
Emergency Care Standard (ECS) performance (type 1 and 3) was 76.03% in January 2018/19 and year to date performance is now 81.56%. The Emergency Care Improvement Programme continues with focus on streaming and ambulance handover, expansion in the use of Green Zone and increasing same day emergency care. A work as one system week in January 2018/19 with positive engagement and feedback from all health and social care partners.

Chief Operating Officer



January 2018/19 pre-validated performance against the 62-day cancer standard is projected to be 72.20%. Trust recovery to the 85% target is expected from April 2019/20. Weekly treatment numbers have increased and the 62 day backlog will be reduced to a sustainable position by March 2018/19. The 62 day backlog for Urology and Lower Gastrointestinal poses a risk to compliance for these two tumour groups, although additional diagnostic and treatment capacity is now in place which will help clear this backlog and treat patients less than 62 days.

Chief Operating Officer



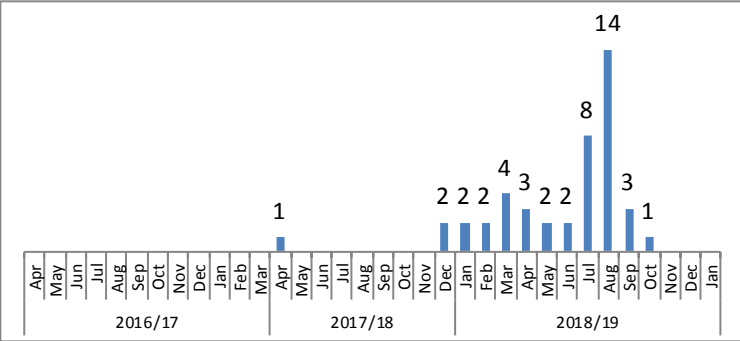
# National Indicators

## National Target – Non-Financial

Trend
-------

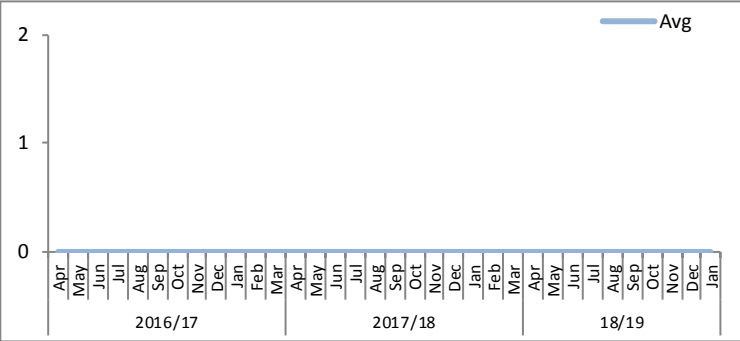
Challenges and Successes
--------------------------

Exec Lead
-----------



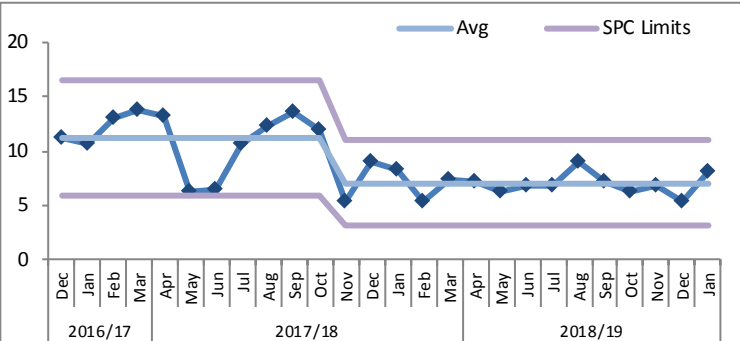
The Trust reported 0 incomplete 52 week incomplete waits in January 2018/19, which is the 3<sup>rd</sup> consecutive month with no breaches. A daily review of all management plans for patients waiting over 35 weeks is in place with weekly escalation through the Planned Care Recovery group and updates to the Chief Operating Officer (COO).

Chief Operating Officer



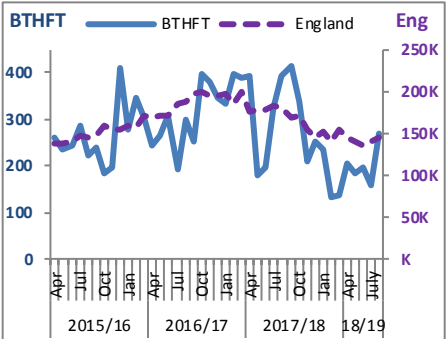
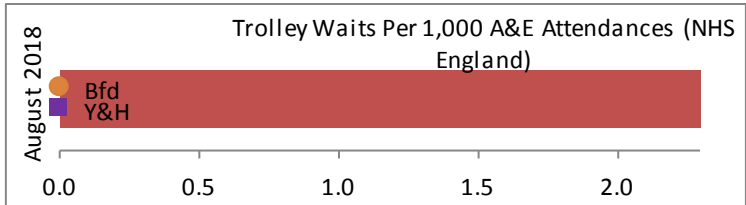
There have been no over 12 hour trolley waits.

Chief Operating Officer



Performance remains within statistical process control (SPC) limits for the Trust and better than the national standard.

Chief Operating Officer





# National Indicators

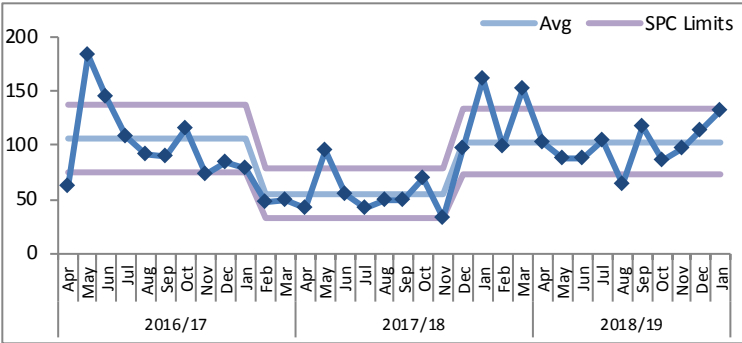
## National Target – Non-Financial

Trend
-------

Challenges and Successes
--------------------------

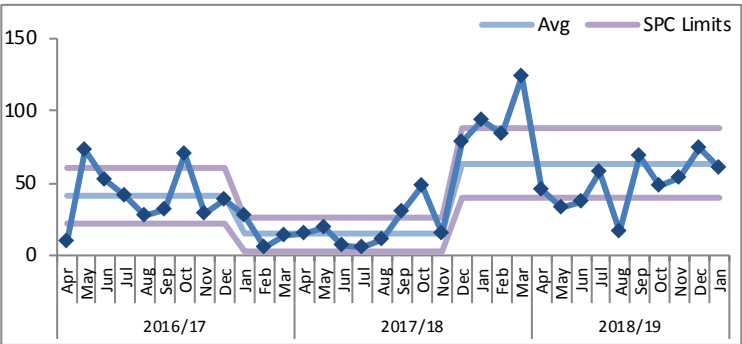
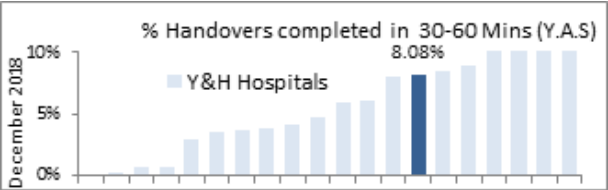
Comparison
------------

Exec Lead
-----------



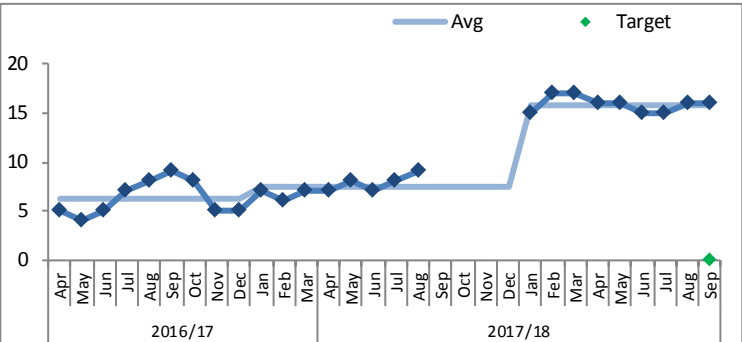
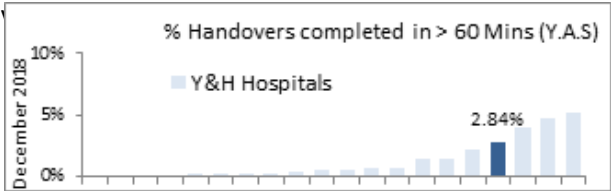
132 handovers took between 30-60 minutes in January 2018/19. Dedicated handover coordination was cited as a key factor in the improved performance seen during the work as one week. Consistent provision of this role is part of the improvement plan. There are also strong links with the Yorkshire Ambulance Service (YAS) and the assigned Hospital Ambulance Liaison Officer (HALO).

Chief Operating Officer



60 handovers took over 60 minutes in January 2018/19. This is a slight improvement on the previous month. 57% of these occurred over 4 days which highlights that performance is generally good but is

Chief Operating Officer



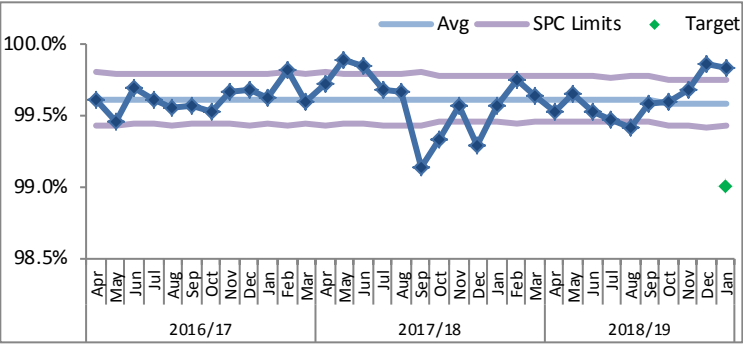
Recovery plans are in place for all specialties.

Chief Operating Officer

# National Indicators

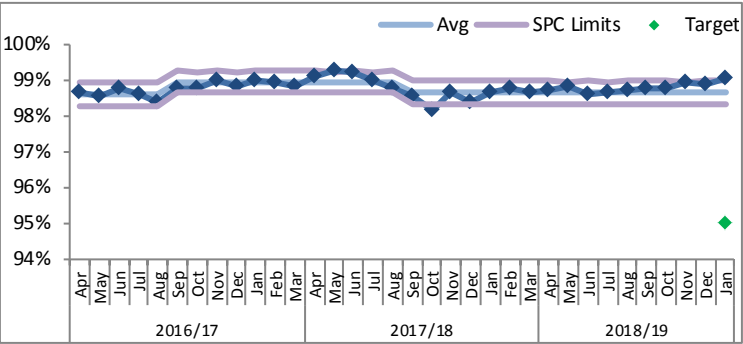
## National Target – Non-Financial

Trend	Challenges and Successes	Comparison	Exec Lead
-------	--------------------------	------------	-----------



With the standardisation and integration of the patient administration system (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



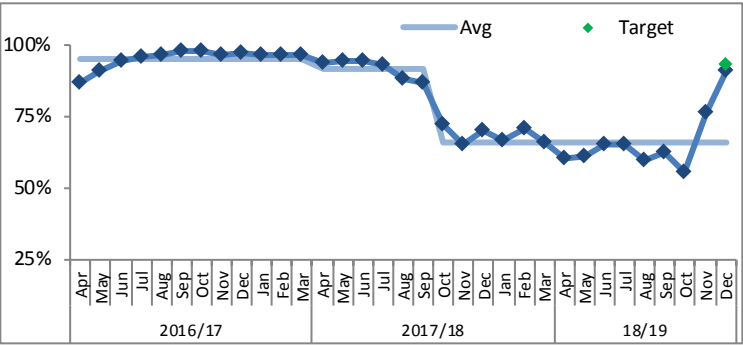
With the standardisation and integration of the patient administration system (PAS) data, as the one source of truth, the Trust compliance to NHS Number use is strong.

Chief Digital and Information Officer

# National Indicators

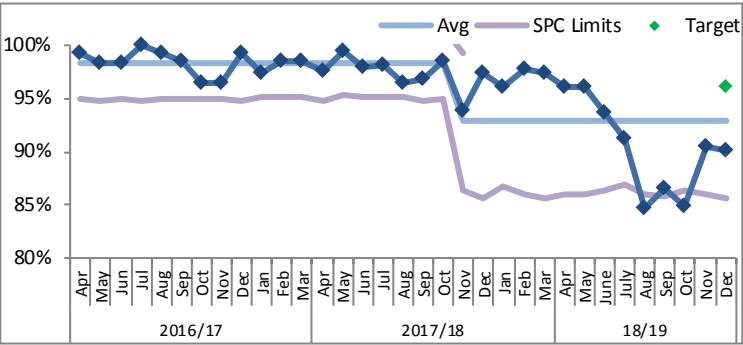
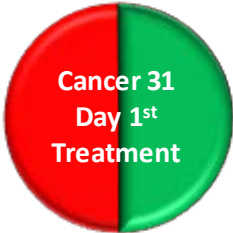
## National Target – Non-Financial

Trend	Challenges and Successes	Comparison	Exec Lead
-------	--------------------------	------------	-----------



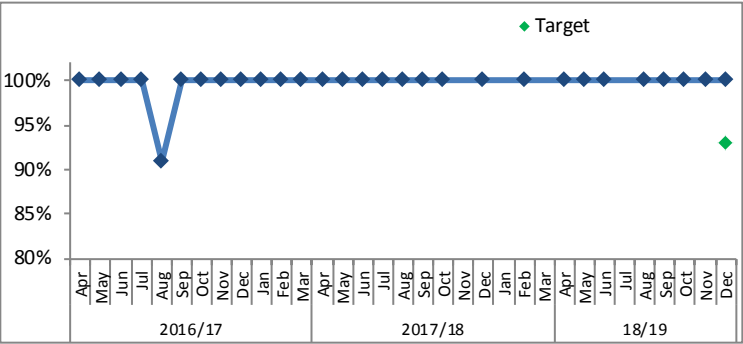
January 2018/19 pre-validated performance against the 2 week-wait cancer standard is projected to be 91.30% with only Urology, Lower Gastrointestinal and Upper Gastrointestinal not meeting the 93% target. Trust compliance is expected from March 2018/19.

Chief Operating Officer



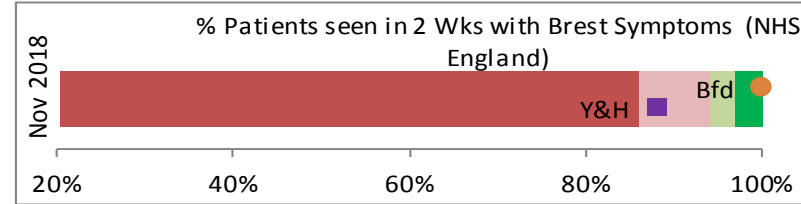
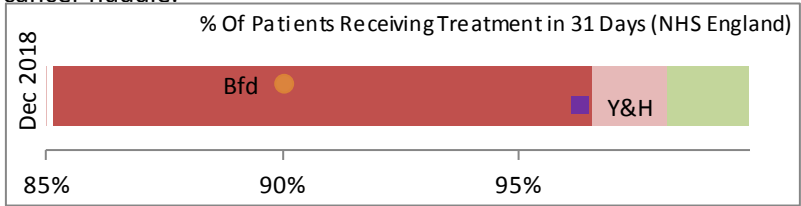
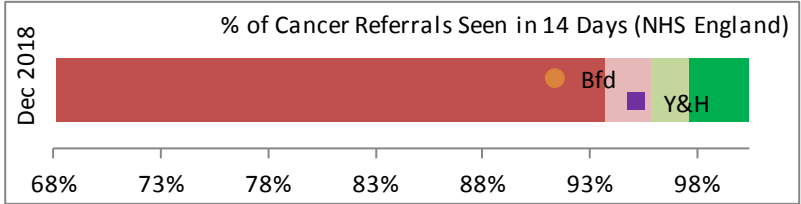
This standard was not achieved due to Urology surgical capacity issues. 62 day improvement actions for this specialty will also help this indicator. These patients are reviewed daily at the Urology cancer huddle.

Chief Operating Officer



This standard was achieved in December 2018/19 and projected to be achieved in January 2018/19.

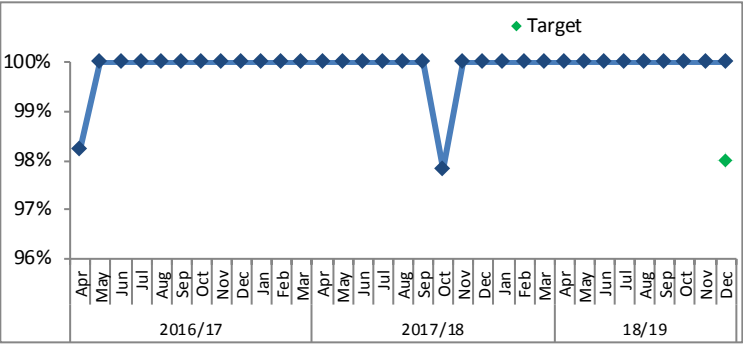
Chief Operating Officer



# National Indicators

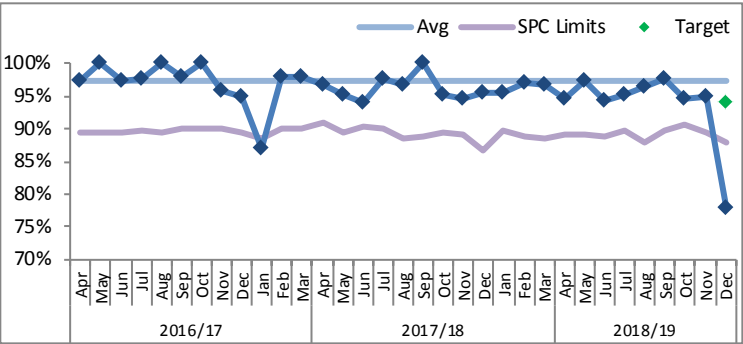
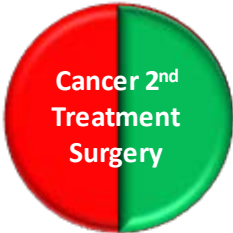
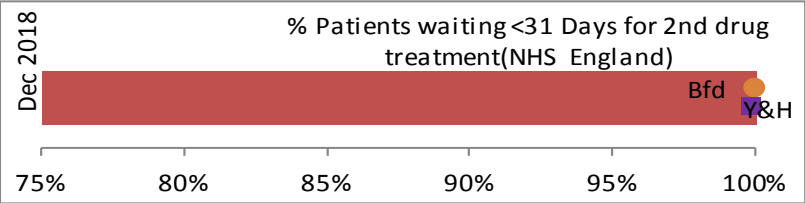
## National Target – Non-Financial

Trend	Challenges and Successes	Comparison	Exec Lead
-------	--------------------------	------------	-----------



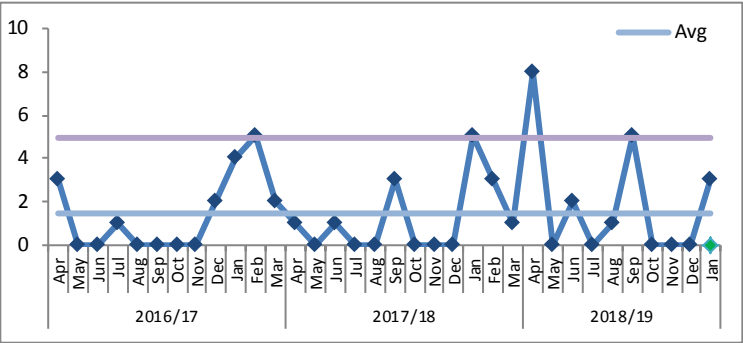
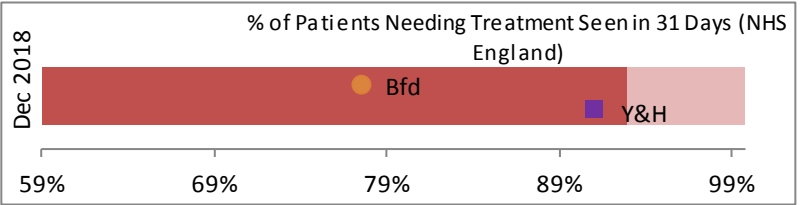
This standard was achieved in December 2018/19 and projected to be achieved in January 2018/19.

Chief Operating Officer



This standard was not achieved due to Urology surgical capacity issues. 62 day improvement actions for this specialty will also help this indicator. These patients are reviewed daily at the Urology Cancer huddle.

Chief Operating Officer



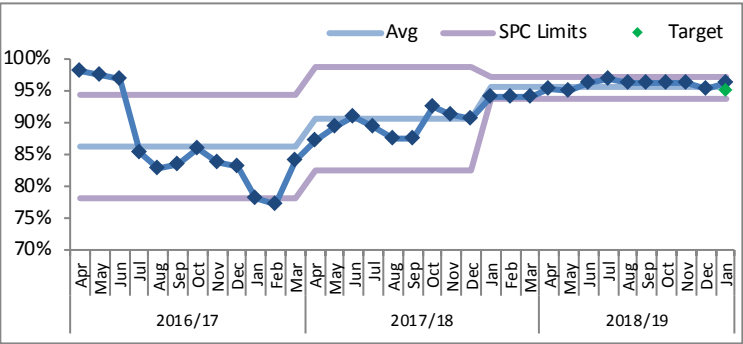
There were 3 breaches of the 28 day standard in January 2018/19. The failure to rebook in time was due to admin errors. New starter training and retraining of existing staff has been undertaken and the escalation processes reiterated to prevent future breaches.

Chief Operating Officer

# National Indicators

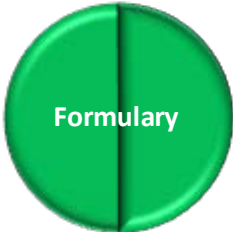
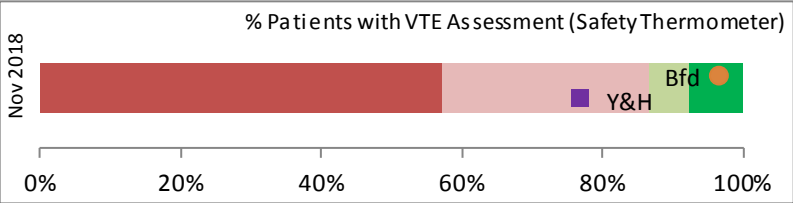
## National Target – Non-Financial

Trend	Challenges and Successes	Comparison	Exec Lead
-------	--------------------------	------------	-----------



The Venous Thromboembolism (VTE) assessment shows sustained compliance with the standard.

Chief Medical Officer



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

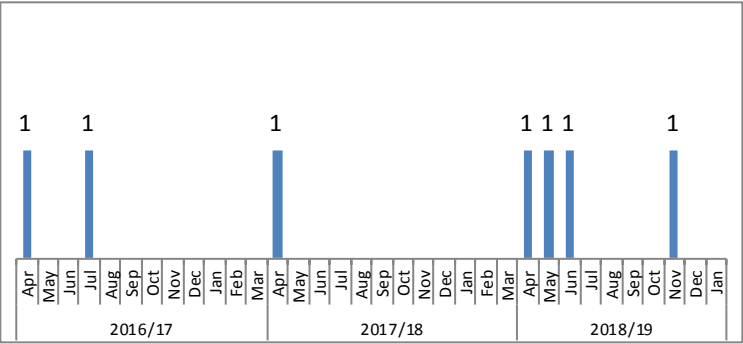
No comparator data is available.

Chief Digital and Information Officer

# National Indicators

## National Target – Financial

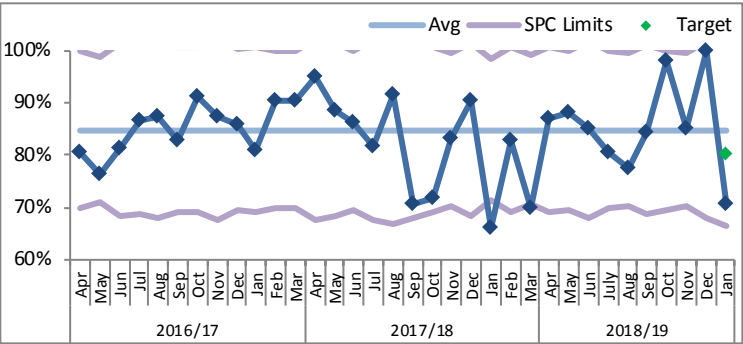
Trend	Challenges and Successes	Comparison	Exec Lead
-------	--------------------------	------------	-----------



There were no never events in January 2018/19.

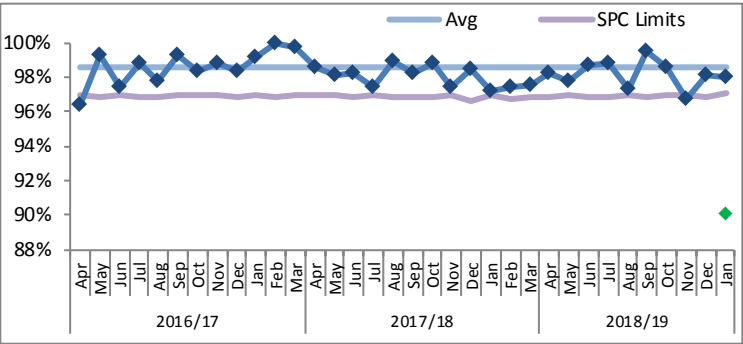
No comparator data is available.

Chief Operating Officer



Performance dropped below target in January 2018/19, although delays in coding could mean performance improves as additional episodes are included. The improvement plan continues to be implemented with oversight from the Medical Director.

Chief Operating Officer



The threshold continues to be achieved.

Chief Operating Officer

# National Indicators

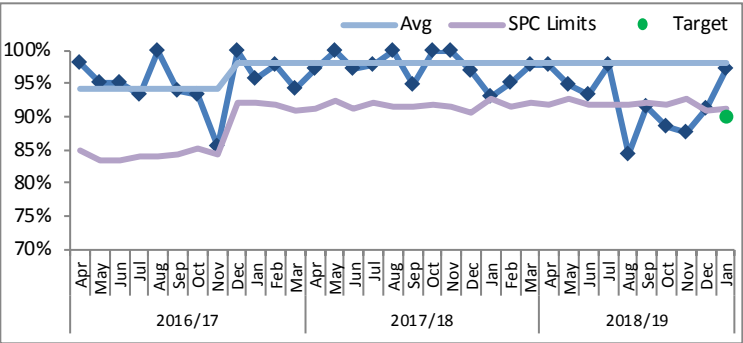
## National Target – Financial

Trend
-------

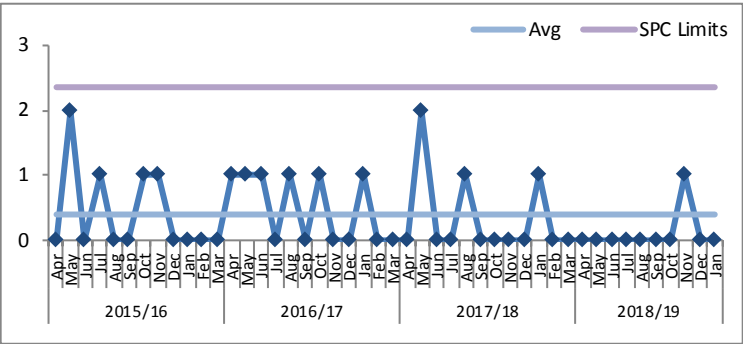
Challenges and Successes
--------------------------

Comparison
------------

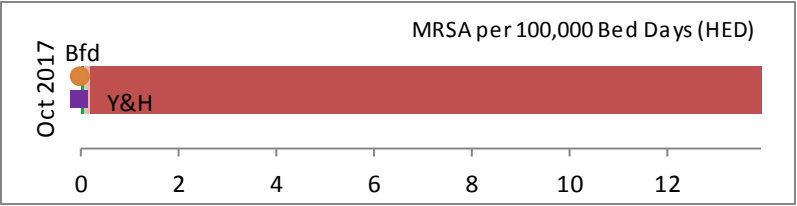
Exec Lead
-----------



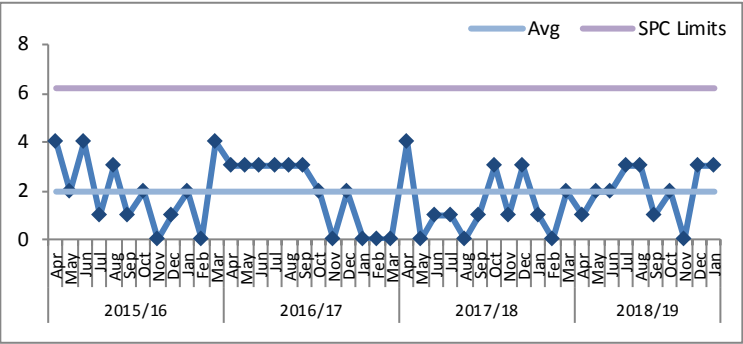
Capacity remains a risk for delays but a process to escalate any Chief  
potential breaches of this target to the community midwifery team Operating  
leads for resource reallocation is in place and supporting delivery Officer  
above target.



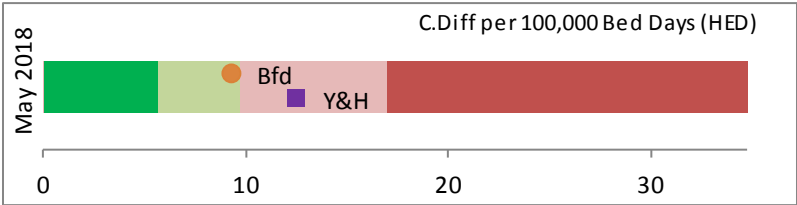
One case in November 2018/19 has been apportioned to the Trust. Chief Nurse  
The sample was taken on 13<sup>th</sup> November 2018 on Ward 31 (Elderly  
Care). The Post Infection Review (PIR) has not identified any deficits in  
care, however, under Public Health England (PHE) guidelines the case  
remains attributable to the Trust as the blood culture was taken >48  
hours after admission.



Chief Nurse



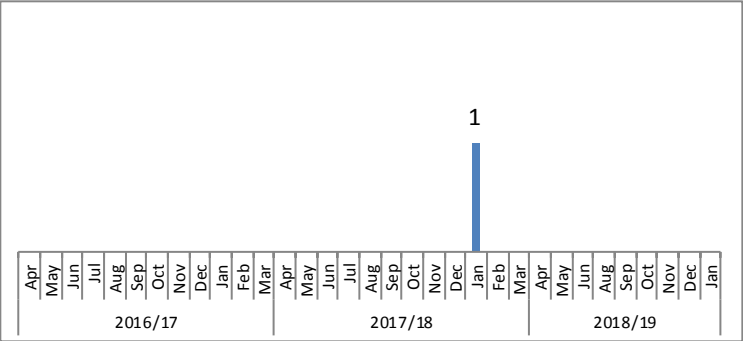
Continues as per previous years and is within expected range.



# National Indicators

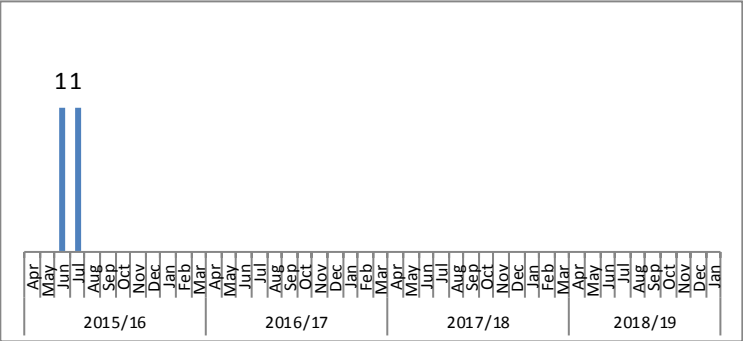
## National Target – Financial

Trend	Challenges and Successes	Comparison	Exec Lead
-------	--------------------------	------------	-----------



There were no Duty of Candour breaches to date in 2018/19.

Director of Strategy and Integration

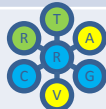









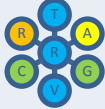




There have been no Mixed Sex Breaches.

Chief Operating Officer



# Glossary

Indicator	Definition	Data Quality Kite-Mark	Indicator	Definition	Data Quality Kite-Mark
<b>To provide outstanding care for our patients</b>			<b>Harm Free Care</b>		
<b>Mortality</b>			VTE Assessment	VTE risk assessments completed <b>Red</b> < 90%, <b>Amber</b> >=90% & < 95%, <b>Green</b> >=95%	
Crude Mortality	Crude Mortality rates, i.e., per admissions.		Falls with Harm	Patient falls resulting from harm. The benchmarking data comes from the Safety Thermometer prevalence information. <b>Red</b> >= 40, <b>Amber</b> >=25 & < 40, <b>Green</b> <25	
Hospital Standardised Mortality Ratio	The mortality indicator is evaluated from a standardised mortality ratio (SMR). The formula for the ratio is observed deaths divided by expected deaths, multiplied by 100. This is calculated for each provider within the data.		Catheters & UTIs	Urinary tract infections in patients with a catheter. The benchmarking data comes from the Safety Thermometer prevalence information. <b>Red</b> > 1.5%, <b>Amber</b> 1%-1.5%, <b>Green</b> < 1%	
SHMI	The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.		Pressure Ulcers Cat 3+	Number of reported hospital acquired category 3 and 4 pressure ulcers. The benchmarking data comes from the Safety Thermometer prevalence information. <b>Red</b> >= 6, <b>Amber</b> 5, <b>Green</b> < 5	
<b>Infections</b>			Pressure Ulcers Cat 2+	Number of reported hospital acquired category 2 pressure ulcers. The benchmarking data comes from the Safety Thermometer prevalence information. <b>Red</b> >= 20, <b>Amber</b> 15-19, <b>Green</b> < 15	
C Difficile	The number of cases either attributable or pending review. <b>Red</b> >= 3, <b>Amber</b> = 2, <b>Green</b> <=1		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	
eColi	Counts of patients with Escherichia coli (eColi). <b>Red</b> >=30 <b>Amber</b> >=20 and <30, <b>Green</b> <20				
MRSA	Counts of patients with Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia Per month: <b>Red</b> >= 1, <b>Green</b> 0				
MSSA	Counts of patients with Meticillin Sensitive Staphylococcus aureus (MSSA) bacteraemia Per month: <b>Red</b> >= 3, <b>Amber</b> 2, <b>Green</b> <= 1 Per year: <b>Red</b> >= 30, <b>Amber</b> 20-29, <b>Green</b> < 20				

# Glossary

Indicator	Definition	Data Quality Kite-Mark
<b>Patient Experience</b>		
Complaints	Number of complaints. Red >= 50, Amber 40-49, Green < 40	
Complaints Closed	Percentage of complaints closed within agreed timescales Red < 95%, Green >=95%	
Complaints Turnaround Time	The average number of working days between Date Received and Date Replied for complaints.	
Friends and Family Test	The % of patients who Strongly Recommend the Trust.	
Night-time Transfers	The number of non-clinical bed moves out of hours Red > 0, Green = 0	
Information Governance Breaches	The number of reported breaches of the information governance standards Red > 6, Amber <=6 & > 2, Green <=2	
<b>Readmissions</b>		
Readmissions	The number of readmissions within 30 days of discharge from hospital. Red >= 7.8%, Amber >=6.7% & < 7.8%, Green <6.7%	

Indicator	Definition	Data Quality Kite-Mark
<b>Audits</b>		
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 > 5, Amber 3-5, Green <=2	
<b>To be a continually learning organisation</b>		
<b>Learning Hub</b>		
Progress on embedding the Learning Hub	Progress on embedding the Learning Hub in the Trust against the plan.	
<b>Research</b>		
Research patients recruited	Number of patients recruited to studies against the planned recruitment. Red <60%, Amber >=60% & <80%, Green >=80%	

# Glossary

Indicator	Definition	Data Quality Kite-Mark
<b>To be a continually learning organisation</b>		
<b>Training</b>		
New Starter Training	% of new staff who are compliant with mandatory training requirements <b>Red</b> < 90%, <b>Amber</b> >=90% & <100%, <b>Green</b> = 100%	
Refresher Training	% of staff who are compliant with mandatory training requirements <b>Red</b> < 75%, <b>Amber</b> >=75% & <85%, <b>Green</b> >= 85%	
<b>Governance Mechanisms</b>		
Out of date policies	% of policies that are currently out of and within date. <b>Red</b> < 95%, <b>Amber</b> >=95% & <100%, <b>Green</b> = 100%	
Risks not mitigated	Risks 12 and above whose current rating is above the target (residual) rating. <b>Red</b> > 15%, <b>Amber</b> >5% and <=15%, <b>Green</b> <=5%	
<b>To collaborate effectively with local and regional partners</b>		
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	

Indicator	Definition	Data Quality Kite-Mark
<b>To be in the top 20% of employers in the NHS</b>		
<b>Appraisals</b>		
Appraisal Rate Non-Medical	% of eligible staff employed at the trusts who have had an appraisal in the last 12 months. <b>Red</b> <75%, <b>Amber</b> >=75% and <95%, <b>Green</b> >=95%	
<b>Experience</b>		
BAME % Senior Leaders	% of staff employed in Band 8+ Senior Manger roles at the trust who are of Black, Asian or Minority Ethnic background <b>Red</b> >=2% below Trajectory Target, <b>Amber</b> >2% of Target, <b>Green</b> >= Target	
BAME % Workforce	% of staff employed at the trust who are of Black, Asian or Minority Ethnic background. <b>Red</b> >=2% below Trajectory Target, <b>Amber</b> >2% of Target, <b>Green</b> >= Target	
Staff FFT Treatment	% of staff recommending the trust as a place to receive care or treatment. <b>Red</b> <Yorkshire &Humber, <b>Green</b> >Yorkshire &Humber	
Staff FFT Work	% of staff recommending the trust as a place to work. <b>Red</b> <Yorkshire &Humber, <b>Green</b> >Yorkshire &Humber	

# Glossary

Indicator	Definition	Data Quality Kite-Mark
<b>Sickness</b>		
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%) <b>Red</b> >1% point above Target, <b>Amber</b> within 1% point above Target, <b>Green</b> <= Target	
<b>Staffing Levels</b>		
Nursing Staff Fill Rate	% of time nursing staff staffing hours filled as planned <b>Red</b> < 80%, <b>Amber</b> 80% – 95%, <b>Green</b> > 95%	
Care Staff Fill Rate	% of time care staff staffing hours filled as planned <b>Red</b> < 80%, <b>Amber</b> 80% – 95%, <b>Green</b> > 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
<b>Retention</b>		
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 <b>Red</b> > 14%, <b>Amber</b> 12% – 14%, <b>Green</b> < 12%	
<b>Additional Workforce metrics</b>		
Frontline Staff Flu Vaccination	Flu vaccine uptake percentage amongst frontline staff <b>Red</b> < 75%, <b>Green</b> >= 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	
<b>To deliver our financial plan and key performance targets</b>		
<b>In-Patient Productivity</b>		
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. <b>Red</b> < 50 <sup>th</sup> Percentile England, <b>Amber</b> 50 – 25 <sup>th</sup> Percentile, <b>Green</b> 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. <b>Red</b> < 50 <sup>th</sup> Percentile England, <b>Amber</b> 50 – 25 <sup>th</sup> Percentile, <b>Green</b> Upper Quartile England	
Bed Occupancy	Average % of available beds which were occupied overnight. <b>Red</b> >=95%, <b>Amber</b> 85-95%, <b>Green</b> <85%	
















# Glossary

Indicator	Definition	Data Quality Kite-Mark	Indicator	Definition	Data Quality Kite-Mark
<b>In-Patient Productivity (cont.)</b>			<b>Finance</b>		
Stranded Patients LoS >= 7 days	The average number of patients (excluding Maternity) who have been in hospital 7 days or more.		Delivery of financial plan	Delivery of finances against plan.	
Super Stranded Patients LoS >= 21 days	The average number of patients (excluding Maternity) who have been in hospital 21 days or more. <b>Red</b> >= 62, <b>Amber</b> 56-61, <b>Green</b> <= 55 (Based on the baseline of 72)		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.	
Discharges before 1 pm	Number of discharges from hospital which happened before 1 pm. <b>Red</b> < 50 <sup>th</sup> Percentile England, <b>Amber</b> 50 – 25 <sup>th</sup> Percentile, <b>Green</b> Upper Quartile England		Cost Improvement Plan	Cost Improvement Plan progress against target.	
<b>Out-Patient Productivity</b>			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.	
Did Not Attend Follow-Up	This is the % of Follow-up Outpatient appointments where the patient does not attend. <b>Red</b> < 50 <sup>th</sup> Percentile England, <b>Amber</b> 50 – 25 <sup>th</sup> Percentile, <b>Green</b> Upper Quartile England		<b>Cost Per Weighted Activity Unit</b>		
Did Not Attend New	This is the % of New Outpatient appointments where the patient does not attend. <b>Red</b> < 50 <sup>th</sup> Percentile England, <b>Amber</b> 50 – 25 <sup>th</sup> Percentile, <b>Green</b> Upper Quartile England		Total Pay Cost Per WAU	A WAU (Weighted Activity Unit) represents the average amount of clinical activity of any type that can be produced in an average hospital for £3,500 (calculated by the Model Hospital). The Pay Cost per WAU metric shows the amount the trust spends on pay (ie staffing) per WAU across all areas of NHS clinical activity. <b>Red</b> – 4 <sup>th</sup> quartile, <b>Amber</b> – 2 <sup>nd</sup> /3 <sup>rd</sup> quartiles, <b>Green</b> – 1 <sup>st</sup> quartile	
Elective Day Case Rate	The number of patients admitted for planned procedure and leave same day as a % of all procedures. <b>Red</b> < 83%, <b>Amber</b> <87% & >=83%, <b>Green</b> >= 87%		Total Non-Pay Cost Per WAU	The Non-Pay Cost per WAU metric shows the amount the trust spends on non-pay (ie expenditure other than on staffing) per WAU across all areas of NHS clinical activity. <b>Red</b> – 4 <sup>th</sup> quartile, <b>Amber</b> – 2 <sup>nd</sup> /3 <sup>rd</sup> quartiles, <b>Green</b> – 1 <sup>st</sup> quartile	
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. <b>Red</b> < 50 <sup>th</sup> Percentile England, <b>Amber</b> 50 – 25 <sup>th</sup> Percentile, <b>Green</b> Upper Quartile England		<b>Service Level Agreements</b>		
Short Notice Clinic Cancellations	Clinics cancelled within the 6 week timeframe. <b>Red</b> 5% higher 17/18 avg, <b>Amber</b> within 5% of 17/18 avg, <b>Green</b> 5% less 17/18 avg		Mission Critical Systems	Percentage of time all Mission Critical Systems were up and running <b>Red</b> <99.7%, <b>Amber</b> >=99.7% & < 99.9%, <b>Green</b> >=99.9%	
Elective Wait List	Wait list of patients on an elective pathway. <b>Red</b> Greater than last month, <b>Amber</b> , <b>Green</b> Less than last month		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 <b>Red</b> <85%, <b>Amber</b> >=85% & < 90%, <b>Green</b> >=90%	

# Glossary

Indicator	Definition	Data Quality Kite-Mark	Indicator	Definition	Data Quality Kite-Mark
<b>Service Level Agreements - continued</b>			<b>Non-Financial</b>		
Radiology Turnaround Time Fast Track	Radiology Turnaround Time for Fast Track Scan to Report. Percentage reported within 14 days. <b>Red</b> <95%, <b>Amber</b> >=95% & < 98%, <b>Green</b> >=98%		RTT 52 Week Wait	Number of patients waiting more than 52 weeks. <b>Red</b> > 0, <b>Green</b> = 0	
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. <b>Red</b> <95%, <b>Amber</b> >=95% & < 98%, <b>Green</b> >=98%		Trolley Waits >12 hours	Trolley waits of > 12 hours. <b>Red</b> > 0, <b>Green</b> = 0	
<b>National Indicators</b>			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. <b>Red</b> > 12.44, <b>Green</b> <= 12.44	
<b>Single Oversight Framework</b>			Ambulance Handover 30-60 mins	Ambulance handover taking longer than 30 – 60 minutes to handover. <b>Red</b> > Same Month LY, <b>Green</b> <=Same Month LY	
Diagnostic waits	% of patients who have waited less than 6 weeks for a diagnostic test. <b>Red</b> < 99%, <b>Green</b> >= 99%		Ambulance Handover >60 mins	Ambulance handover taking longer than 60 minutes to handover. <b>Red</b> > Same Month LY, <b>Green</b> <=Same Month LY	
User of Resources	Calculation on the status of a number of financial measures – Capital Servicing Capacity, Liquidity, I & E Margin, and Agency Spend.		RTT # Specialties	Number of specialties not achieving RTT incomplete. <b>Red</b> > 0, <b>Green</b> = 0	
Emergency Care Standard	% patients seen in A&E within 4 hours. <b>Red</b> < 90%, <b>Green</b> >= 90%		NHS # field completion acute	Completion of valid NHS # field in acute commissioning data sets submitted via SUS. <b>Red</b> < 99%, <b>Green</b> >= 99%	
RTT 18 Week Incomplete	Percentage of patients waiting within 18 weeks on an incomplete pathway. <b>Red</b> < 92%, <b>Green</b> >= 92%		NHS # field completion AED	Completion of valid NHS # field in AED commissioning data sets submitted via SUS. <b>Red</b> < 95%, <b>Green</b> >= 95%	
Cancer Urgent 62 day Screening	Proportion of patients receiving treatment for cancer within 62 days of an NHS Cancer Screening service. <b>Red</b> < 96%, <b>Green</b> >= 96%		Cancelled Operations 28 Days	Number of patients who were cancelled on day of surgery and subsequently not been treated. <b>Red</b> > 0, <b>Green</b> = 0	
Cancer Urgent 62 Day GP	Proportion of patients receiving treatment for cancer within 62 days of an urgent GP referral for suspected cancer. <b>Red</b> < 85%, <b>Green</b> >= 85%				

# Glossary

Indicator	Definition	Data Quality Kite-Mark	Indicator	Definition	Data Quality Kite-Mark
<b>Non-Financial continued</b>			<b>Financial</b>		
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 <b>Red</b> < 93%, <b>Green</b> >= 93%		Never Events	The number of serious incidents that occur despite there being defined processes and procedures to prevent them. <b>Red</b> > 0, <b>Green</b> = 0	
Cancer 1 <sup>st</sup> 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. <b>Red</b> < 94%, <b>Green</b> >= 94%		Stroke Strategy	Implementation of the Stroke Strategy – patients who spend at least 90% of their time on a stroke unit. <b>Red</b> < 80%, <b>Green</b> >= 80%	
Cancer 2 Week Breast	Proportion of patients with breast symptoms where cancer not initially suspected referred to a specialist who are seen within 2 weeks of referral. <b>Red</b> < 93%, <b>Green</b> >= 93%		Seen by Midwife < 13 wks	Percentage of women who presented before 12 weeks 6 days who have seen a midwife within 12 weeks and 6 days of pregnancy. <b>Red</b> < 85 %, <b>Amber</b> >= 85% & < 90 %, <b>Green</b> >= 90%	
Cancer 2 <sup>nd</sup> Treatment Drugs	Proportion of patients waiting no more than 31 days for second or subsequent drug treatments. <b>Red</b> < 98%, <b>Green</b> >= 98%		Seen by Midwife > 12 wks	Percentage of women who presented after 12 weeks 6 days who have seen a midwife within 2 weeks. <b>Red</b> < 85 %, <b>Amber</b> >= 85% & < 90 %, <b>Green</b> >= 90%	
Cancer 2 <sup>nd</sup> Treatment Surgery	Patients that require further surgery following initial treatment should receive treatment within 31 days . <b>Red</b> < 94%, <b>Green</b> >= 94%		MRSA	Counts of patients with Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia. <b>Red</b> > 0, <b>Green</b> = 0	
VTE Assessments	VTE risk assessments completed. <b>Red</b> < 90%, <b>Amber</b> >= 90% & < 95%, <b>Green</b> >= 95%		C Difficile	Number of cases either attributable or pending review. <b>Red</b> > 4, <b>Amber</b> 3, <b>Green</b> < 3	
Formulary published	Hospital formulary is published on the Trust's external website. <b>Red</b> Not published, <b>Green</b> Published		Duty of Candour	Patient informed duty of candour. <b>Red</b> > 0, <b>Green</b> = 0	
			Mixed Sex Accommodation	Number of occurrences of unjustified mixing in relation to sleeping accommodation. <b>Red</b> > 0, <b>Green</b> = 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

Arrows (applies to strategic objective and Single Oversight Framework pie-slices):

- An upward arrow indicates the RAG of a particular pie-slice has improved from the previous month
- A downward arrow indicates the RAG of a particular pie-slice has deteriorated from the previous month
- No arrow indicates no change from the previous month

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 (DQ) Kite-Mark

RAG status of assurance of the data quality of the information being presented. The Data Quality 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.

