



Bradford Teaching Hospitals
NHS Foundation Trust

Integrated Dashboard Board of Directors

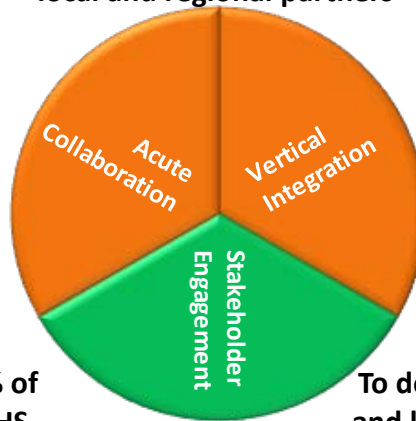
31st March 2019

31st March 2019

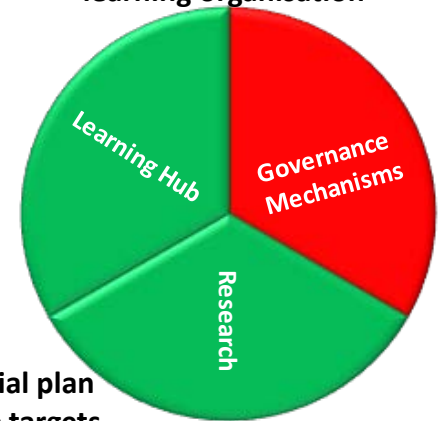
To provide outstanding care for our patients



To collaborate effectively with local and regional partners



To be a continually learning organisation



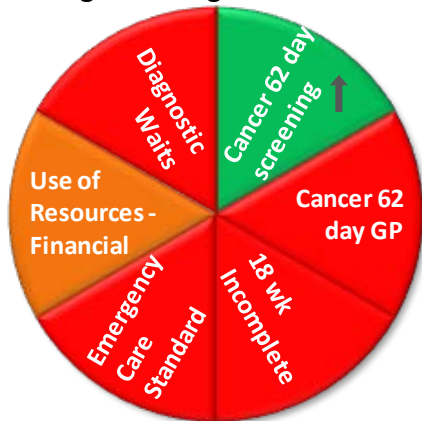
To be in the top 20% of employers in the NHS



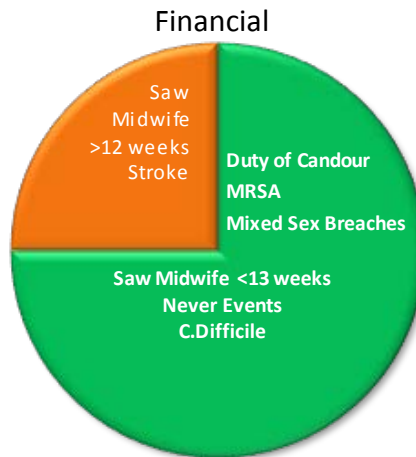
To deliver out financial plan and key performance targets



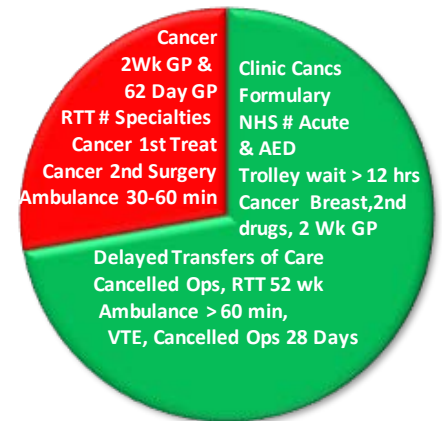
Single Oversight Framework



National targets



Non-Financial



Headlines

Delivery of the **Emergency Care Standard** performance remains a challenge with daily attendances increasing further throughout Quarter 4. The Emergency Care Improvement Programme continues with focus on expansion in the use of the Green Zone, effective streaming, clinical co-ordination and increasing same day emergency care.

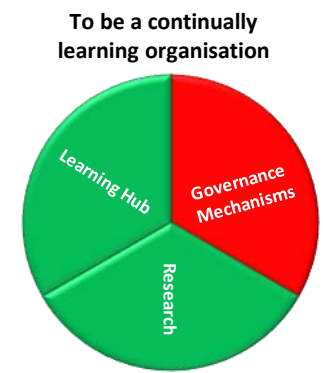
The **Cancer Improvement Plan** is ongoing and the 2 Week Wait performance remains above the 93% target. The 62 Day First Treatment standard is improving and the backlog of over 62 Days people waiting has reduced to 21 people from a high of 151 people in September 2018. Treatment capacity has been significantly improved and the 31 Day treatment standards are forecasted to meet their targets in April 2019. Improvements in the diagnostic phases and the reduced backlog means that the 62 Day performance is forecasted to achieve the 85% target in May 2019.

Referral to Treatment (RTT) performance continues to improve with the tenth successive monthly reduction in the total size of the Waiting List, which has reduced by 10,254 (29.9%) since April 2018. There have been no 52 Week breaches since October 2018 and reported incomplete RTT performance was 84.99% in March 2019.

In the draft, unaudited accounts, the **Trust is reporting successful delivery of the £7.5m deficit control total** excluding Provider Sustainability Funding (PSF). As a result of delivering the pre-PSF control total, the Trust has received £7.2m of core PSF allocation and a further £6.7m of bonus PSF cash. This total £13.9m PSF results in a control total position including PSF of £6.4m surplus, which is £3.6m better than the £2.8m post-PSF control total. These are the unaudited figures and are potentially subject to amendment before the accounts are finalised.

Quality Dashboard

31st March 2019



The annual review of quality measures demonstrates:

Continuous improvement in a number of areas, including mortality rates, infection rates, VTE, core training, consistent over-recruitment to target for research studies, WHO safer procedures checking process and low night-time transfers.

Stable performance continues in a number of areas - pressure ulcers, falls with harm and urinary infections, timely antibiotics for suspected sepsis. The quality improvement programme continues to work with collaborative wards to drive improvement

The Quality Committee is actively reviewing the suite of metrics to drive our improvement journey.

Workforce Dashboard

31st March 2019

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



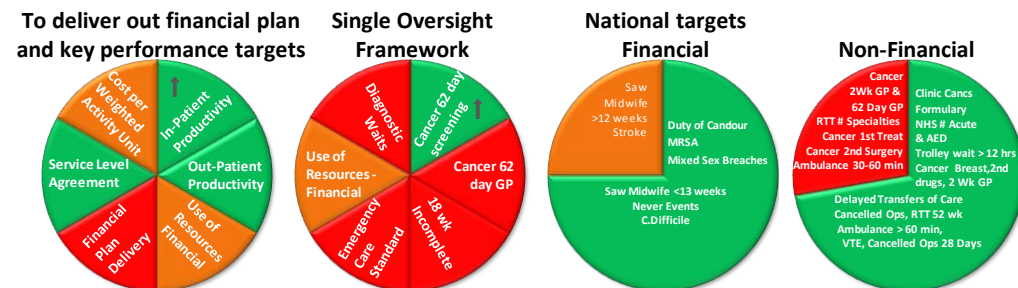
There is **improved Staff Friends and Family Survey Results** in Quarter 4 with improvement seen in both the treatment and place to work questions. This has built on the improved engagement scores seen via the staff survey in Quarter 3.

Staff turnover continues to reduce with agency usage stable in March 2019 enabling us to meet our NHSI agency ceiling for 2018/19.

Continued focus on appraisals is required as managers have not been able to keep up with overdue appraisals in February and March 2019.

Finance & Performance Dashboard

31st March 2019



The **Emergency Care Standard performance for Type 1, 2 & 3 attendances was 75.91% for March 2019 and 83.13% for the full year 2018/19**. Average daily attendances for 2018/19 were 381 compared to 369 in 2017/18; an increase of 3.25% (12 patients per day). Average daily Type 1 & 3 attendances were 389 and Type 2 attendances 74 in March 2019. The Emergency Care Improvement Programme continues with focus on expansion in the use of green zone, effective streaming, clinical co-ordination and increasing same day emergency care.

Cancer 2 Week Wait (2WW) performance for February 2019 was 95.43% and is currently projected at 95.06% for March 2019 with only the Breast specialty not forecasted to meet the 93% target due to a 25% increase in referrals in Quarter 4 (19 extra referrals per week). April 2019 is currently projected to perform below the target at 89.40% due to the deterioration in the Breast position.

Cancer 62 Day First Treatment performance for February 2019 was 63.89% and is currently projected at 74.44% for March 2019 with a further improvement predicted for April 2019 at 79.10%. Recovery to the 85% target is expected from May 2019 with the 62 Day backlog now reduced to 21 patients which represents a reduction of 136 patients waiting since September 2018.

For **March 2019 Referral to Treatment (RTT) Incomplete performance was reported as 84.99%** with the total waiting list reducing by 1,722 patients, which is the tenth successive reduction since April 2018 and part of a total reduction of 10,254 (29.9%) in this period. There were no patients waiting more than 52 Weeks at the end of March 2019 and the same is anticipated at the end of April 2019.

The unaudited, draft Income and Expenditure (I&E) position for 2018/19 is a deficit of £12.7m. This position includes an impairment of £19m relating to the revaluation of assets which NHS Improvement (NHSI) does not include in assessments of control total delivery. On an NHS Improvement control total basis (i.e., excluding this Impairment) the draft I&E position for 2018/19 is a pre-Provider Sustainability Fund (PSF) deficit of £7.5m which is in line with the pre-PSF control total. As the pre-PSF control total has been delivered in this draft position, core PSF income of £7.2m can be recovered and the Trust has been allocated a further £6.7m of bonus PSF, which means the reported position including PSF but excluding the impairment is a post-PSF surplus of £6.4m. This is £3.6m ahead of the £2.8m post-PSF surplus control total.

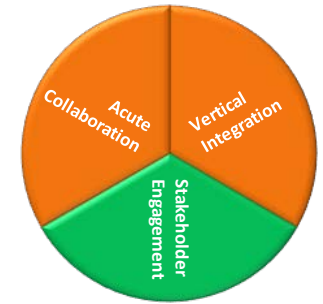
The Trust's cash balance at the end of March 2019 was £21.2m. This is £7.2m below the planned £28.4m balance. The shortfall is largely explained by the under-delivery of the BIP efficiency programme and consequent reliance on non-recurrent, non-cash releasing measures to meet the I&E control total.

These are the unaudited figures and are potentially subject to amendment before the accounts are finalised.

Partnership Dashboard

31st March 2019

To collaborate effectively with
local and regional partners



Positive progress has been made on the Airedale collaboration. The clinical summit went ahead on 8 April 2019 to formally launch the programme and was well attended. The next stage will be work through which specialties should be prioritised for the most support through the programme.

A revised version of **the hybrid theatre capital bid is being drafted** for the construction of a hybrid theatre at Bradford Royal Infirmary.

The Trust's Acting Chief Executive **has signed the Strategic Partnering Agreement** between partners from Bradford District and Craven. A total of 52 stakeholders have now been self-assessed by account managers.

Appendix

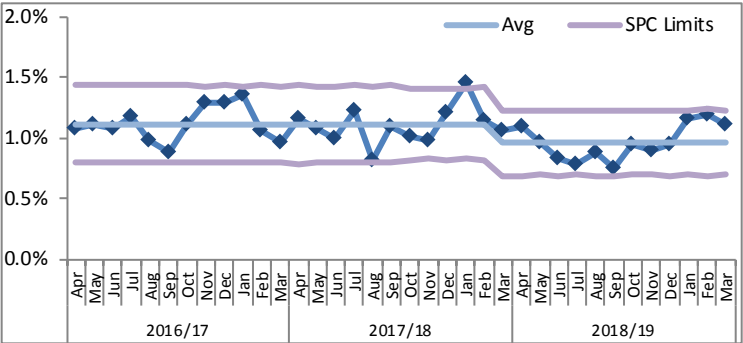
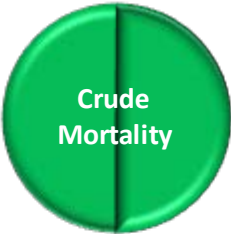
To provide outstanding care for patients

Trend

Challenges and Successes

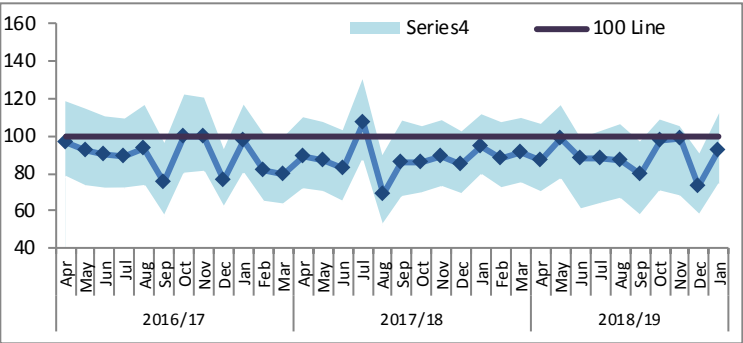
Comparison

Exec Lead



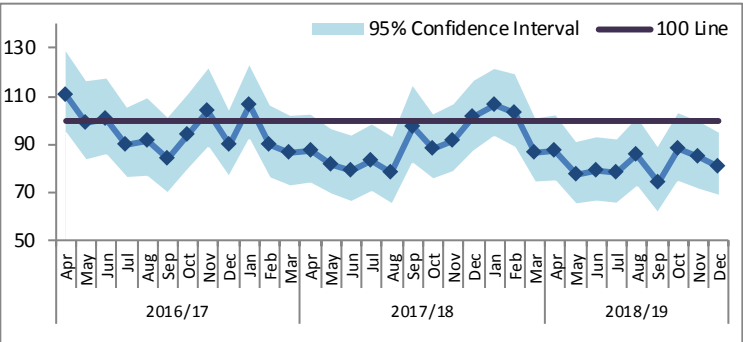
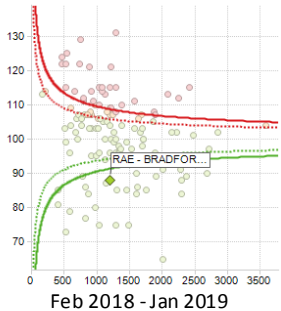
Crude death rate has remained constant throughout the last eighteen months. There is no regional or national benchmarking data for this measure. Improving learning from mortality is now delivered through the 'learning from deaths' process. Reporting on progress to the Quality Committee is via the quarterly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

Chief Medical Officer



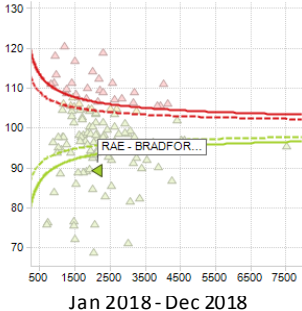
Our Hospital Standardised Mortality Ratio (HSMR) continues to demonstrate a 'better than expected' rate.

Chief Medical Officer



The Summary Hospital-level Mortality Indicator (SHMI) continues to demonstrate a 'better than expected' rate.

Chief Medical Officer



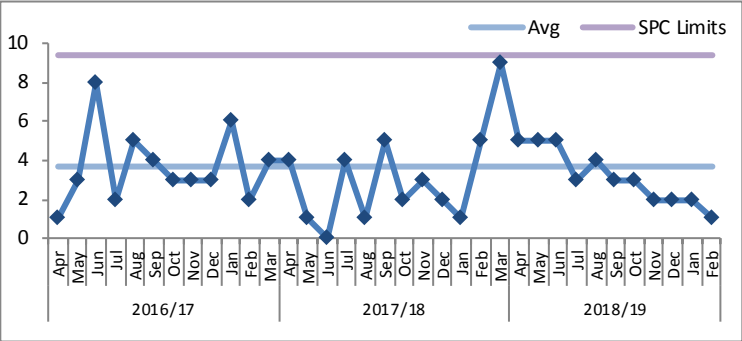
To provide outstanding care for patients

Trend

Challenges and Successes

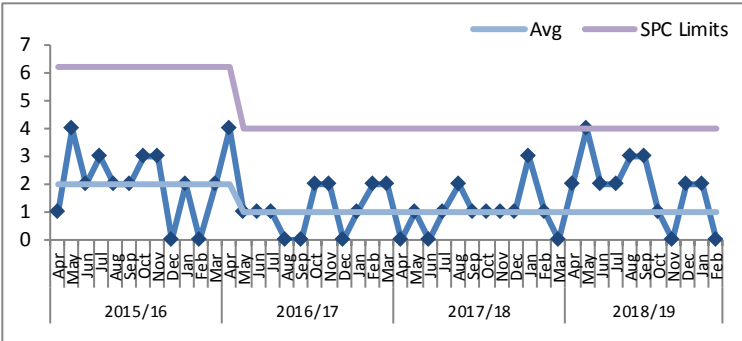
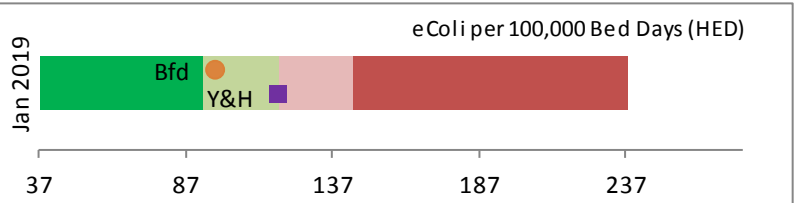
Comparison

Exec Lead



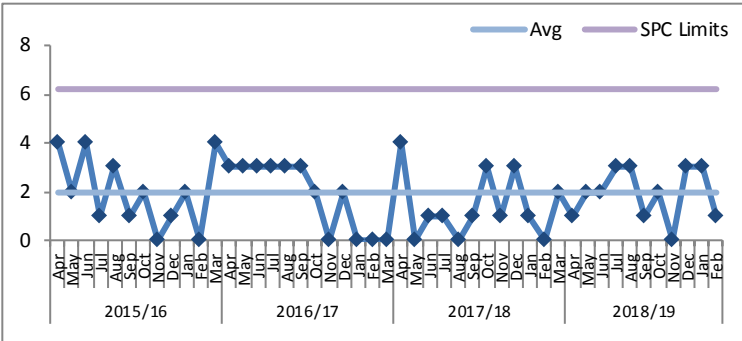
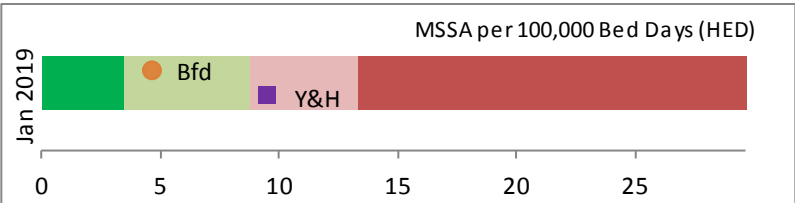
As part of the 2018/19 work plan we will focussing on all bacteraemias. We have seen a reduction of 26% on the previous twelve months (NHS Improvement). This information now only includes hospital acquired Escherichia coli (E. coli) infection data, in line with the other infection metrics.

Chief Nurse



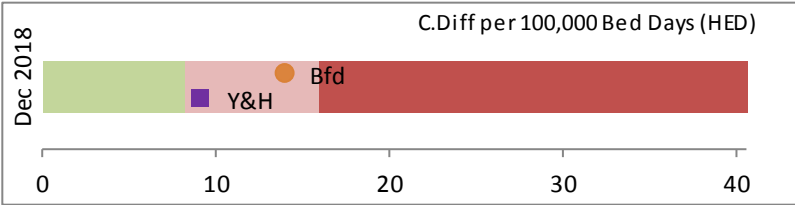
Part of national improvement collaborative for Infection Prevention and Control (IPC). Ongoing improvements are overseen by Infection Prevention and Control and reviewed on a quarterly basis.

Chief Nurse



Continues as per previous years, and is within expected range.

Chief Nurse



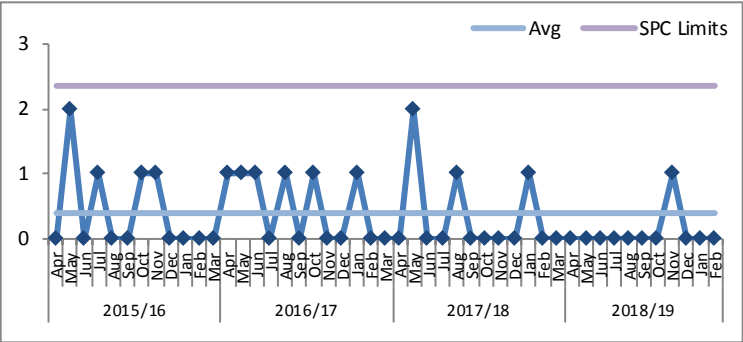
To provide outstanding care for patients

Trend

Challenges and Successes

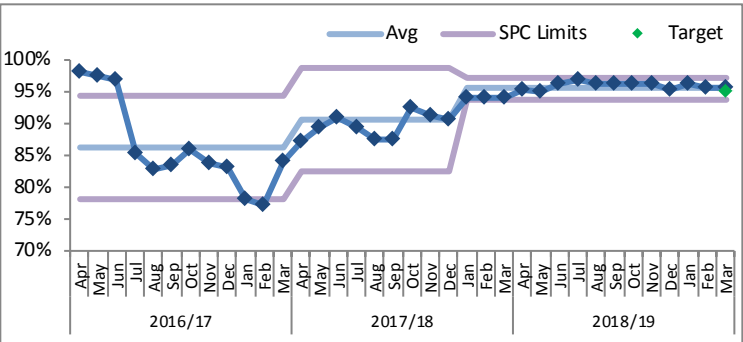
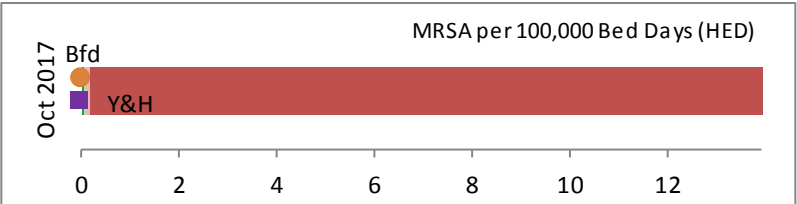
Comparison

Exec Lead



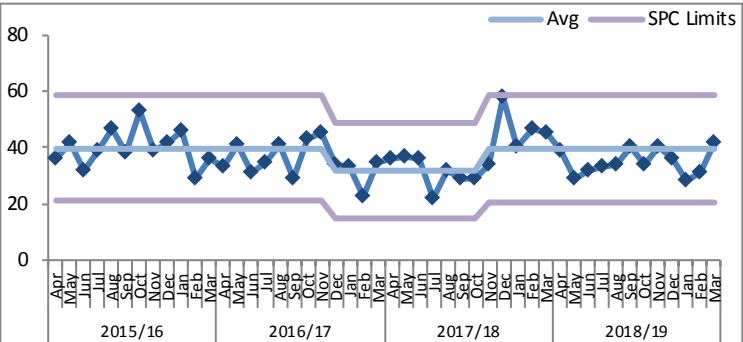
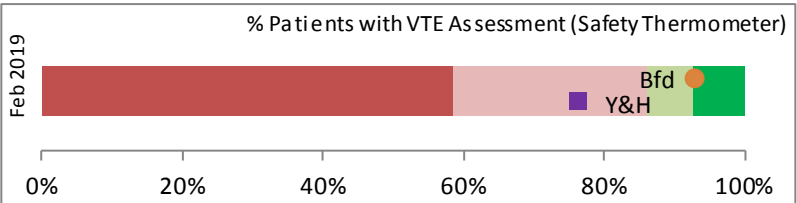
One case in November 2018, no deficits in care.

Chief Nurse



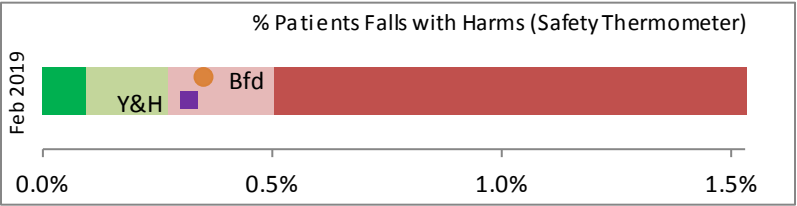
The Venous Thromboembolism (VTE) assessment shows sustained compliance with the standard.

Chief Medical Officer



Falls remain on an improved trajectory.

Chief Nurse



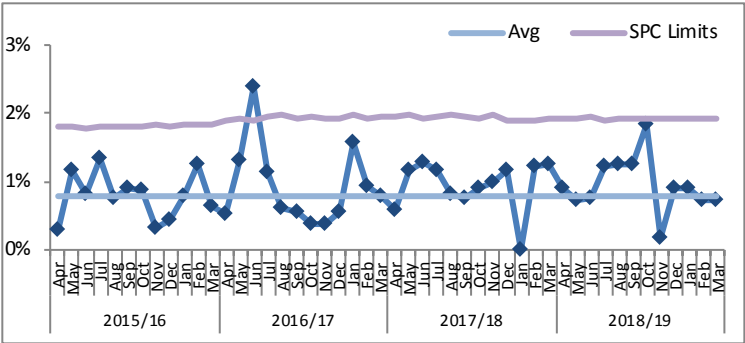
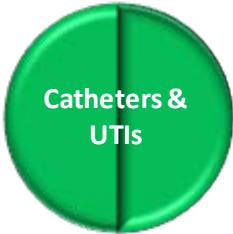
To provide outstanding care for patients

Trend

Challenges and Successes

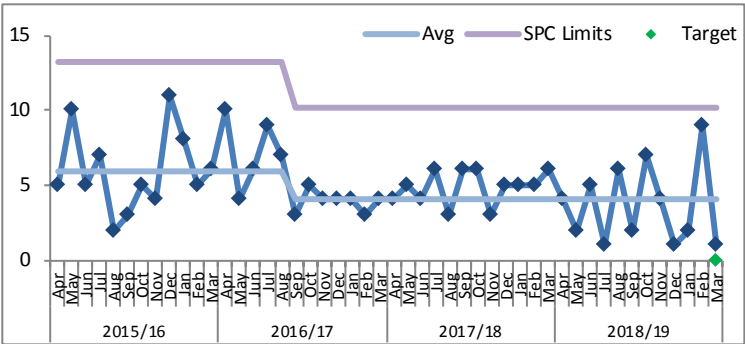
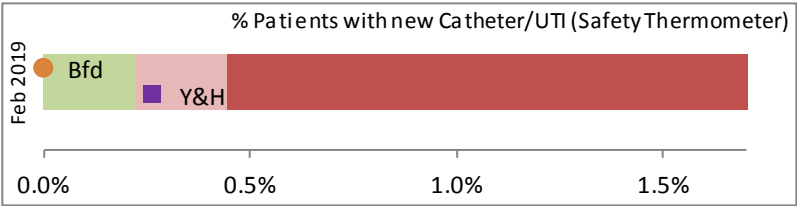
Comparison

Exec Lead



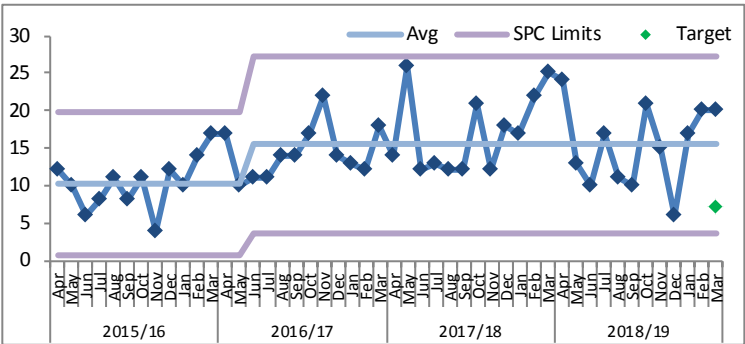
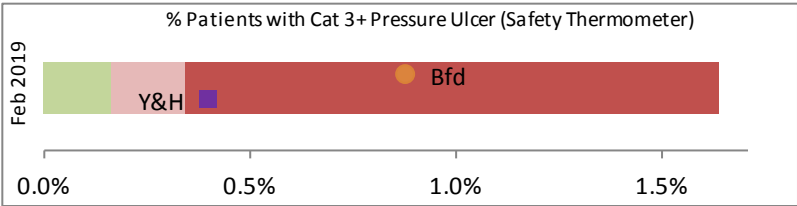
The Infection Control team is reviewing the data submission relating to Catheters and Urinary Tract Infections (CAUTI), including a review of the indicator. Further detail is included within the Infection Control report.

Chief Nurse



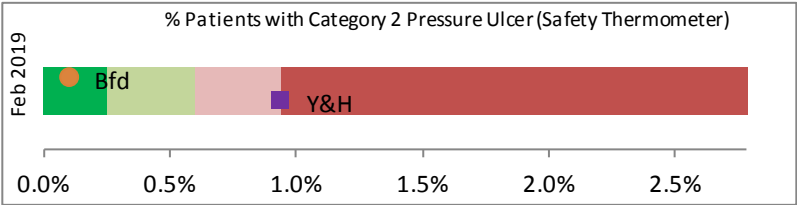
All systems relating to pressure ulcers have been reviewed in line with the revised NHS England Guidance. This data now excludes unstageable and deep tissue injuries (DTIs).

Chief Nurse



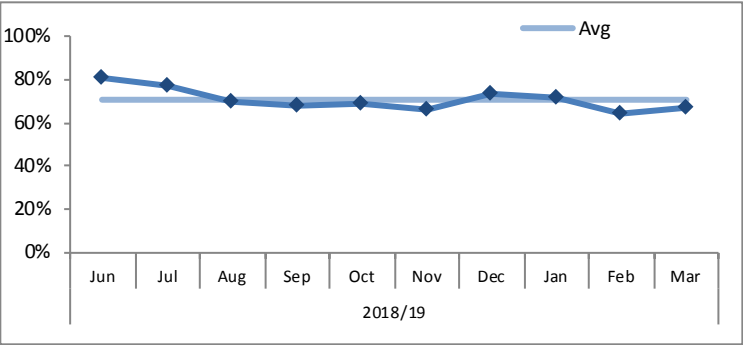
All systems relating to pressure ulcers have been reviewed in line with the revised NHS England Guidance.

Chief Nurse



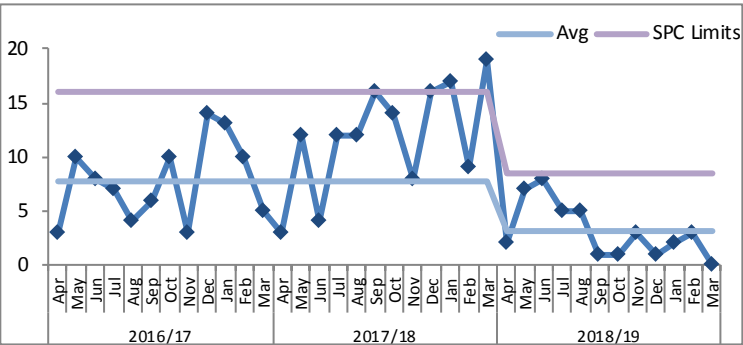
To provide outstanding care for patients

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



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) the capability to measure on a weekly basis to enable targeted intervention.

Chief Nurse



There were no night time transfers in March 2019.

Chief
Operating
Officer

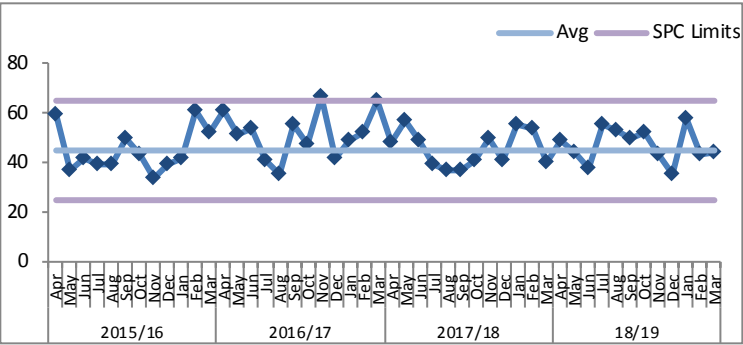
To provide outstanding care for patients

Trend

Challenges and Successes

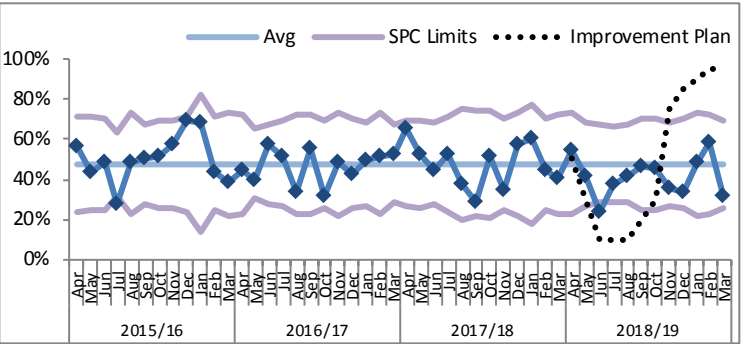
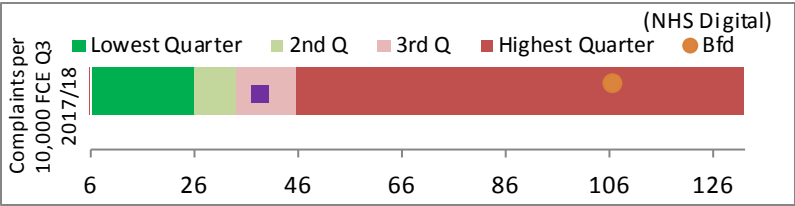
Comparison

Exec Lead



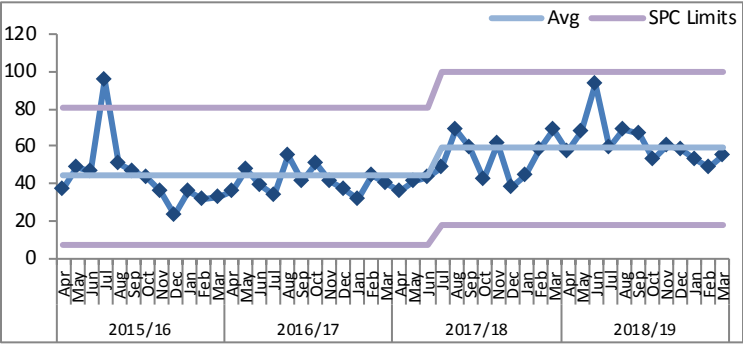
The trajectories are now beyond the improvement period set and need to be revised as part of the 2019/20 metrics.

Chief Nurse



The trajectories are now beyond the improvement period set and need to be revised as part of the 2019/20 metrics.

Chief Nurse



The trajectories are now beyond the improvement period set and need to be revised as part of the 2019/20 metrics.

Chief Nurse

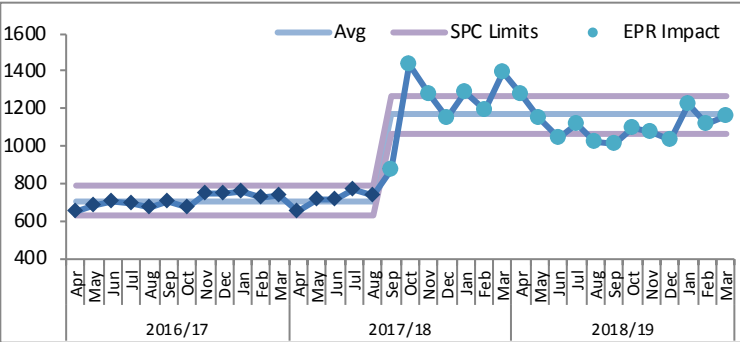
To provide outstanding care for patients

Trend

Challenges and Successes

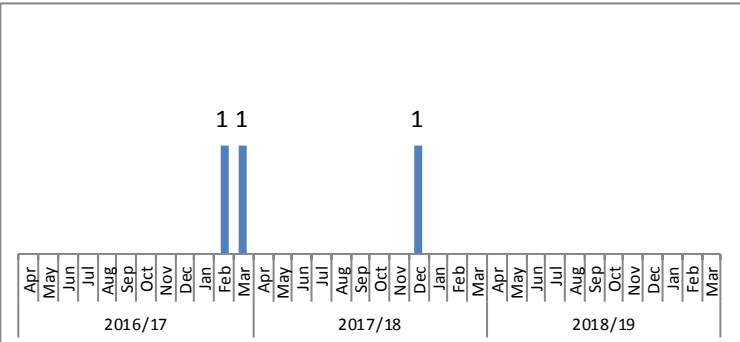
Comparison

Exec Lead



Readmissions increased significantly post EPR implementation. A review of readmission reporting to an agreed action plan is underway. The increase predominantly reflects a change in the recording of assessments and the inclusion of paediatric assessments as non-elective admissions.

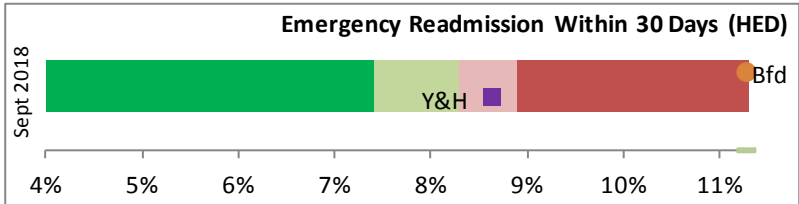
Chief Operating Officer




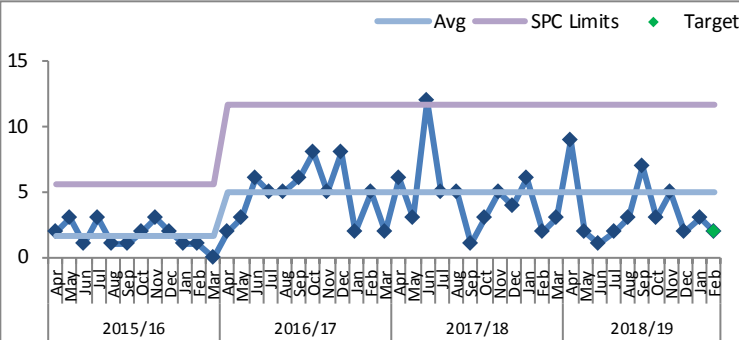

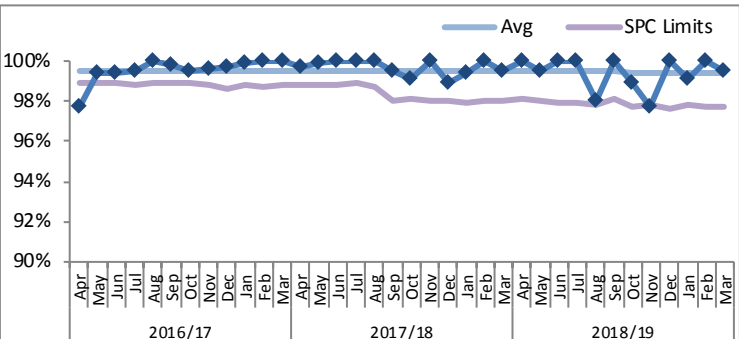

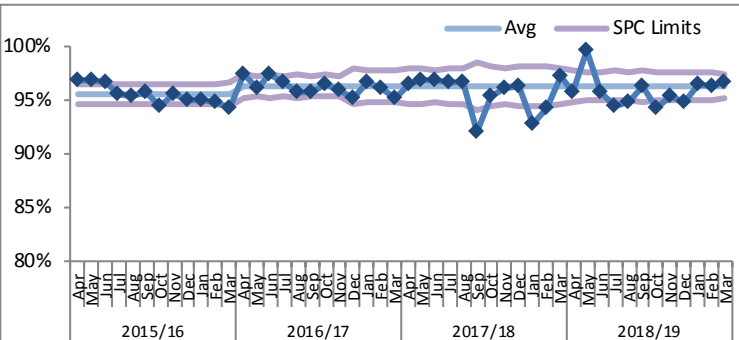
There are no breaches year to date 2018/19. Awareness remains high.

No comparator data is published.


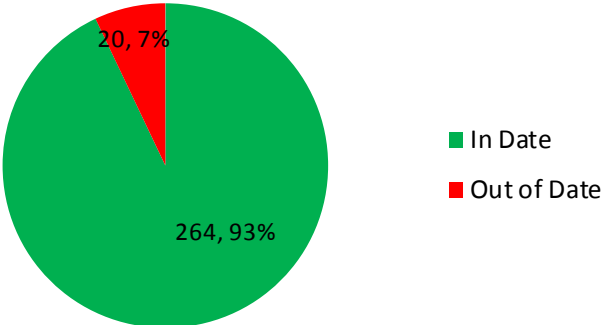

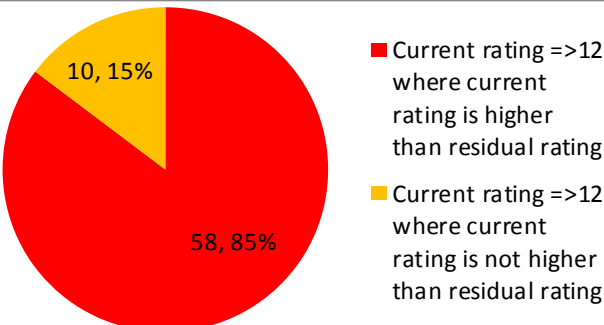
Chief Digital and Information Officer



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 Serious Incidents (SI's) are anticipated and the Quality Oversight System is in place to ensure identified themes or trends are acted upon.		Director of Strategy and Integration
		Compliance has sustained at or above 98% compliance with many months at 100%. Data by theatre block is shared directly with leaders to help drive this sustained improvement.	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. Further detailed work to improve number of returns has started.		Chief Nurse

To be a continually learning organisation

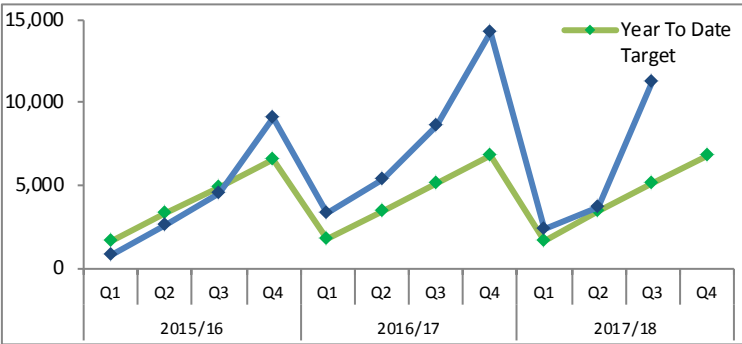
	Trend	Challenges and Successes	Comparison	Exec Lead
		<p>A focussed programme of work continues in order to improve the Trust position in relation to Trust-wide policies and their management. There is significant confidence about the approach to managing locally-developed guidance within Divisions.</p>		Director of Strategy and Integration
		<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>		Director of Strategy and Integration

To be a continually learning organisation

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

The Learning Hub continues to work to generate and assimilate learning from precursor events across the Trust, and now routinely incorporating learning from external events, for instance through the sharing of Serious Incident learning from other organisations, Healthcare Safety Investigation Branch (HSIB) and the National Reporting and Learning System (NRLS). The first monthly learning award, which has been developed with the support of the family of a child whose death in our hospital was the catalyst for significant system wide learning, will be awarded at the end of Quarter 1 2019/20.

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 Partnerships 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. A total of 52 stakeholders have now been self-assessed by account managers.

Director of
Strategy &
Integration



Vertical Integration

Partnerships 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. The Trust is represented on Bradford's ten Community Partnerships, which are an important aspect of the NHS Long Term Plan (in which they are referred to as Primary Care Networks). A "Strategic Partnering Agreement", has been drafted between the partners, this has now been signed by the Trust's acting chief executive at the end of March 2019. Due to the local elections, it is anticipated that this will not be signed by all of the partners until June 2019.

Director of
Strategy &
Integration



Acute Collaboration

Partnerships 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. The Trust is actively working on a revised bid for capital funding for the hybrid theatre at Bradford Royal Infirmary, which is needed for the arterial centre. Our work with Airedale Foundation Trust was formally launched at a clinical summit on 8 April. This was well attended and well received by clinicians and senior staff from both Trusts. The programme will now consider the output from the summit and which specialties should be prioritised.

Director of
Strategy &
Integration

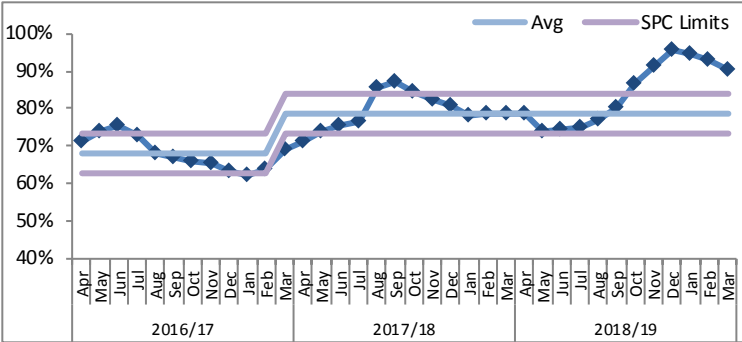
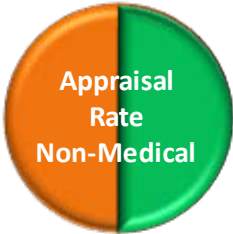
To be in the top 20% of employers in the NHS

Trend

Challenges and Successes

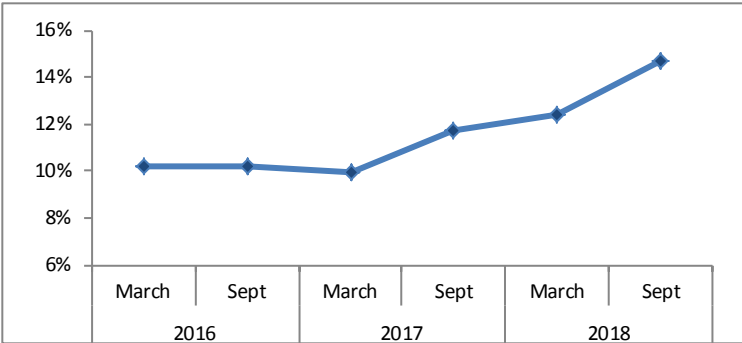
Comparison

Exec Lead



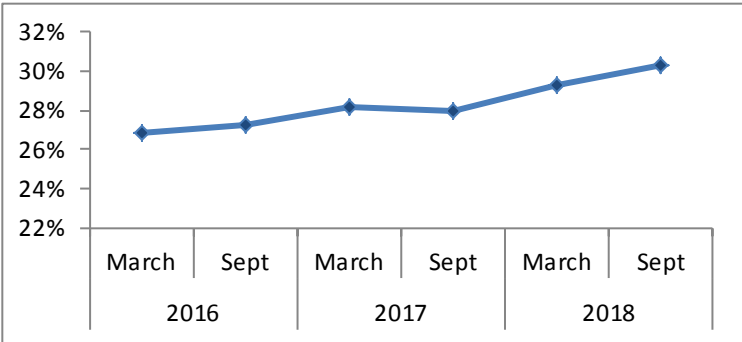
Our completion rate for March 2019 was 90.54%, decreasing from 92.68% in February 2019, a downward trend since December 2018. Work continues targeting areas where there are overdue appraisals, particularly in the divisions; making sure recording and reporting appraisals continues using the Electronic Staff Record (ESR) during the transition to the new Clinical Business Units and making sure protected time is allocated for appraisals that are due using e-roster where appropriate.

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 April 2019.

Director of Human Resources

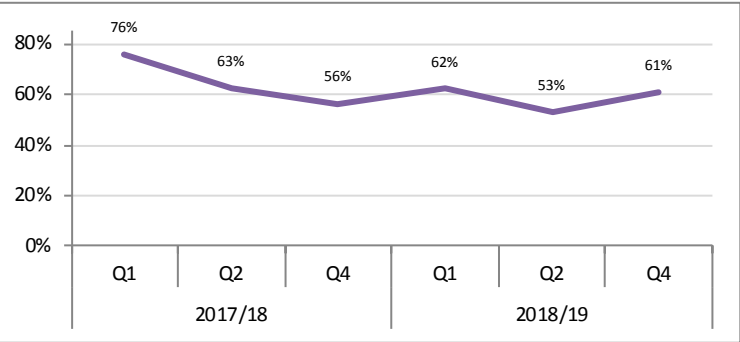
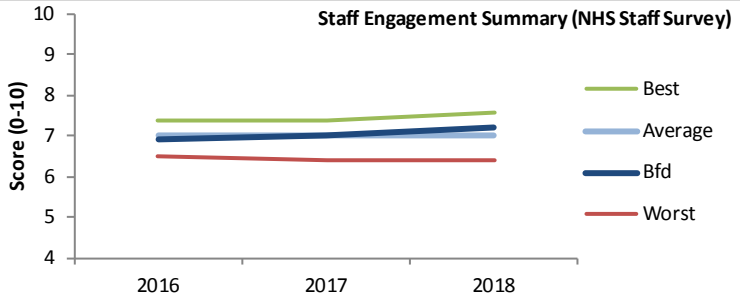
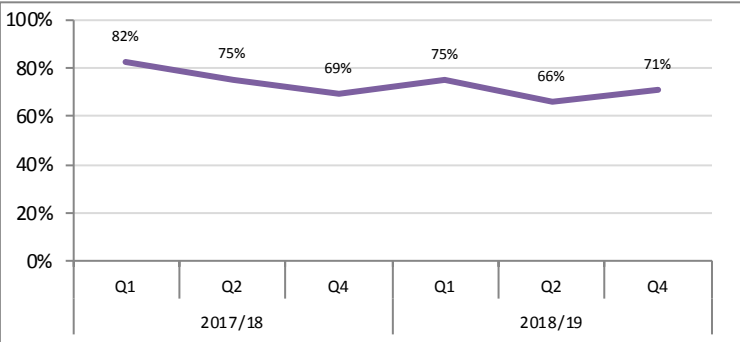


Good progress is being made. We are 6% ahead of our trajectory to have a workforce reflective of the local ethnic population by 2025. Next update April 2019.

Director of Human Resources

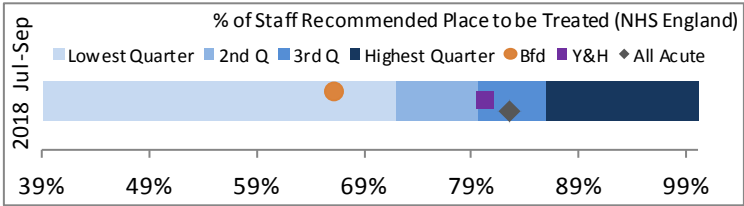
To be in the top 20% of employers in the NHS

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



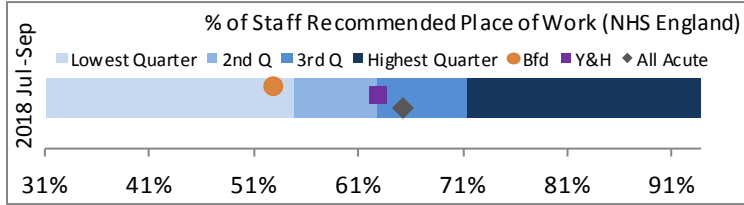
The results of the Staff Friends and Family Test (SFFT) for Q4 2018/19 show 71% of staff would recommend our Trust as a place to receive treatment or care, which compares to 66% in the Q2 test and 68% in the NHS Staff Survey 2018. 336 staff took part in the Q4 SFFT compared to 204 in Q2 which represents a 65% increase in uptake and work continues to make sure more staff take part in the test going forward.

Director of Human Resources



The Q4 2018/19 SFFT shows 61% of staff would recommend us as a place to work compared to 53% in the Q2 test and 64.6% in the NHS Staff Survey 2018. of staff would recommend our Trust as a place to work. The SFFT questions contribute towards the overall Staff engagement score in the NHS Staff Survey and engagement remains a priority in our Staff Survey action plan this year; organisational development and engagement work will focus on making sure staff feel proud to work here, feel it is a great place to work and receive treatment or care.

Director of Human Resources



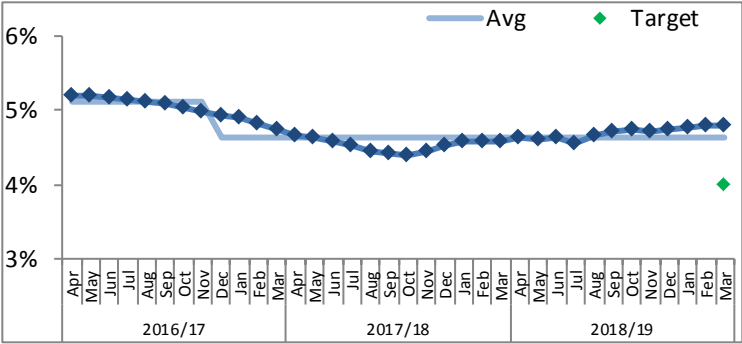
To be in the top 20% of employers in the NHS

Trend

Challenges and Successes

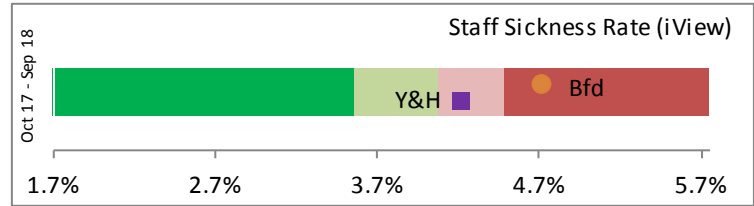
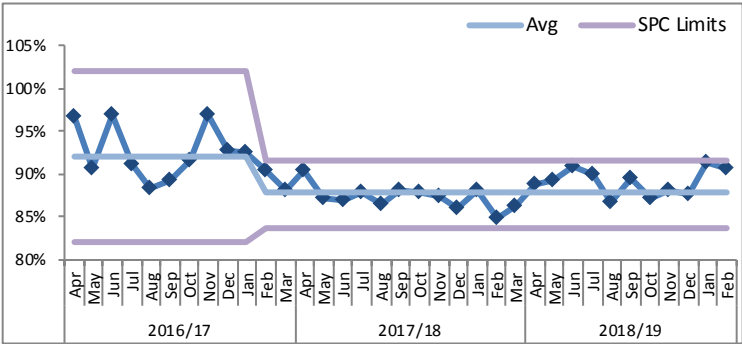
Comparison

Exec Lead



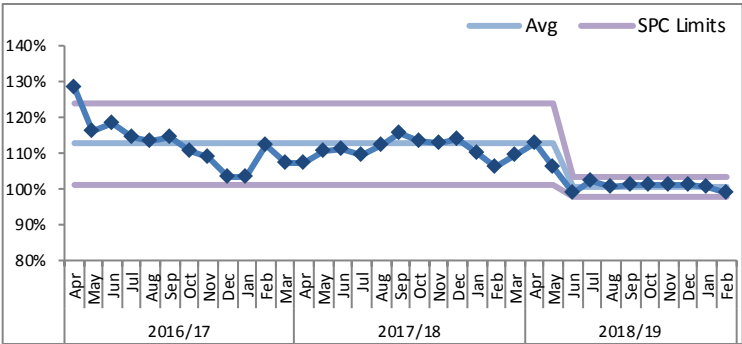
The rolling 12 month sickness absence rate as at the end of March 2019 is 4.79% which remains the same as in February 2019. Sickness absence has reduced in all Divisions apart from Surgery, Women’s & Children’s and Estates & Facilities.

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

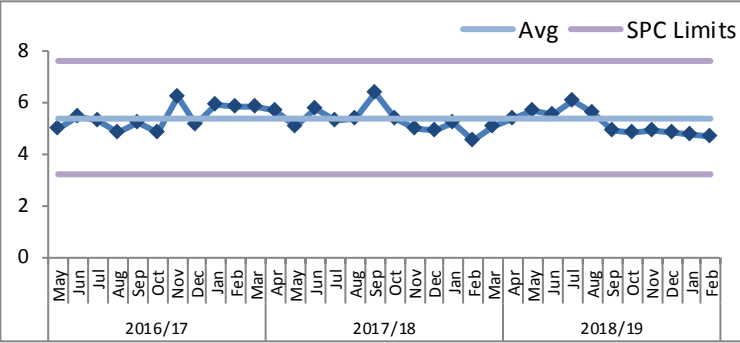
To be in the top 20% of employers in the NHS

Trend

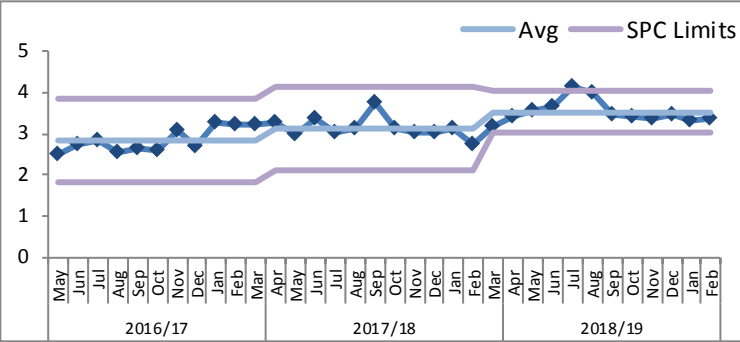
Challenges and Successes

Comparison

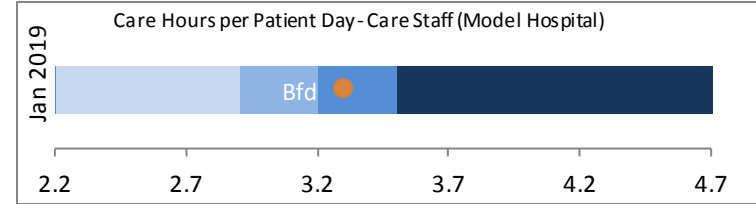
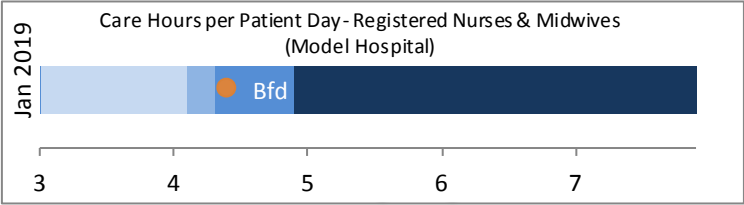
Exec Lead



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

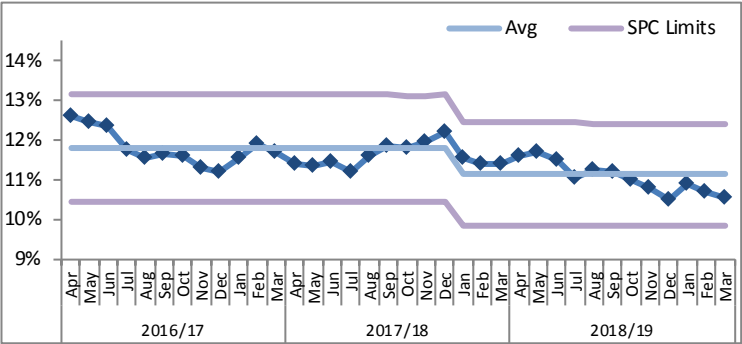
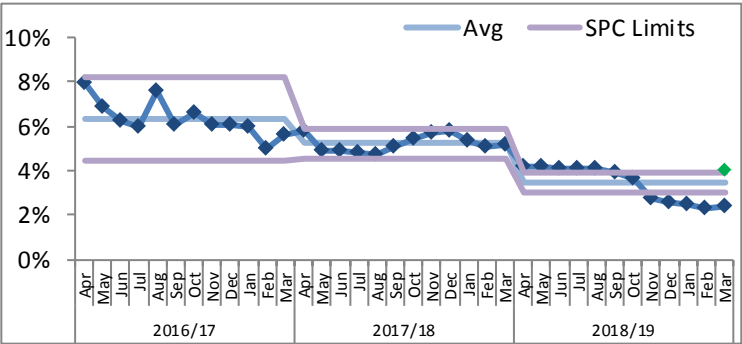


The carer workforce has stabilised in line with our workforce plans, benchmarks appropriately with model hospital. Chief Nurse



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

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



Agency staff as a proportion of Full Time Equivalents (FTE) is stable in March 2019. Agency use continues to decrease although qualified nurse agency has increased from the previous month. Agency use in the Allied Health Professional (AHP's) and Administrative and Clerical staff groups has remained static across the reporting period. Medical and Dental had a slight agency increase due to Referral to Treatment (RTT) recovery plans. The primary need for medical agency staff is due to Consultant vacancies. The numbers of staff in post have reduced slightly in March with the largest reduction in the Admin & Clerical staff group.

Director of Human Resources

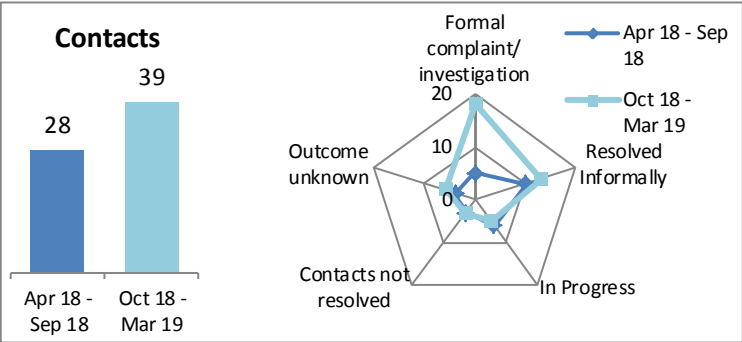
Turnover has continued to slowly decrease at Trust level in March 2019 to 10.54% down from 10.68% in February. Staff Groups that have seen the biggest decrease are Medical and Dental and Administrative and Clerical. Turnover is still low compared to historical levels in the Trust.

Director of Human Resources

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

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

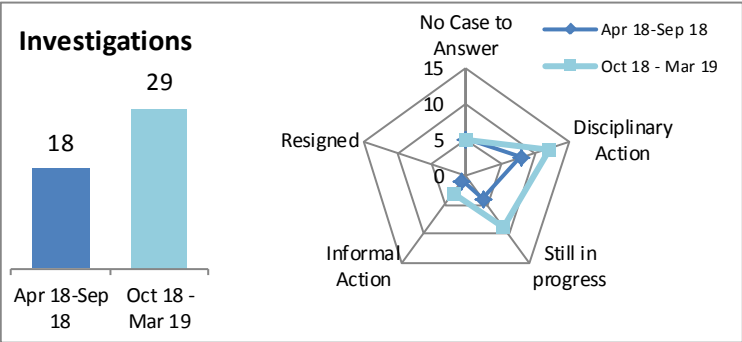
Staff Advocate Service Contacts & Outcomes



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

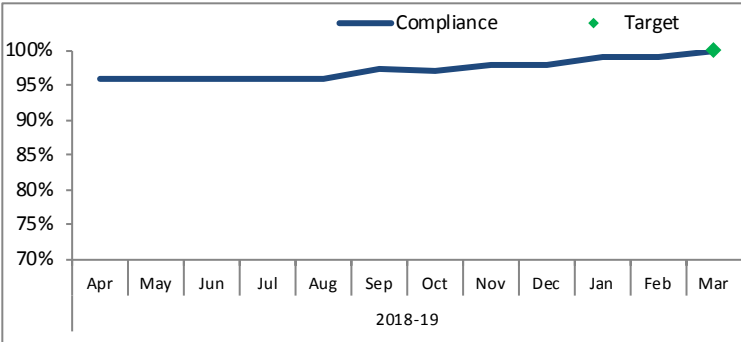
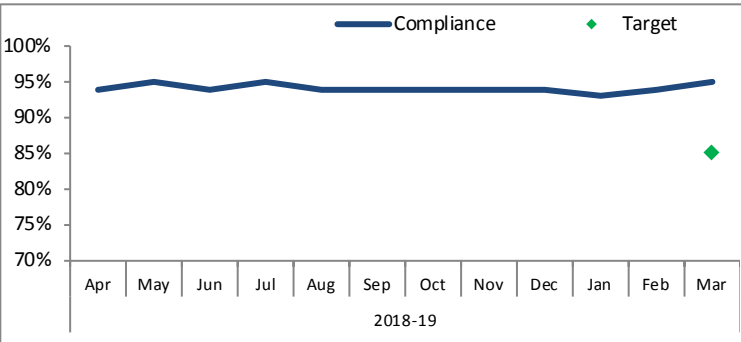
Harassment & Bullying Related Investigations



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 and 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>New Starter Training</div>  <table border="1"><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><tr><td>Feb</td><td>99</td><td>95</td></tr><tr><td>Mar</td><td>99</td><td>95</td></tr></tbody></table>	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	Feb	99	95	Mar	99	95	<p>The data demonstrates consistently over 98% performance with a comprehensive escalation process to track delivery of performance at an individual level.</p>	Comparator data not available.	Chief Medical Officer
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																																								
Feb	99	95																																								
Mar	99	95																																								
<div>Refresher Training</div>  <table border="1"><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>90</td></tr><tr><td>May</td><td>95</td><td>90</td></tr><tr><td>Jun</td><td>94</td><td>90</td></tr><tr><td>Jul</td><td>95</td><td>90</td></tr><tr><td>Aug</td><td>94</td><td>90</td></tr><tr><td>Sep</td><td>94</td><td>90</td></tr><tr><td>Oct</td><td>94</td><td>90</td></tr><tr><td>Nov</td><td>94</td><td>90</td></tr><tr><td>Dec</td><td>94</td><td>90</td></tr><tr><td>Jan</td><td>93</td><td>90</td></tr><tr><td>Feb</td><td>94</td><td>90</td></tr><tr><td>Mar</td><td>95</td><td>90</td></tr></tbody></table>	Month	Compliance (%)	Target (%)	Apr	94	90	May	95	90	Jun	94	90	Jul	95	90	Aug	94	90	Sep	94	90	Oct	94	90	Nov	94	90	Dec	94	90	Jan	93	90	Feb	94	90	Mar	95	90	<p>The Trust has consistently exceeded its target refresher training standard since April 2018, averaging over 95%. Work now focussed on performance at service line level.</p>	Comparator data not available.	Chief Medical Officer
Month	Compliance (%)	Target (%)																																								
Apr	94	90																																								
May	95	90																																								
Jun	94	90																																								
Jul	95	90																																								
Aug	94	90																																								
Sep	94	90																																								
Oct	94	90																																								
Nov	94	90																																								
Dec	94	90																																								
Jan	93	90																																								
Feb	94	90																																								
Mar	95	90																																								

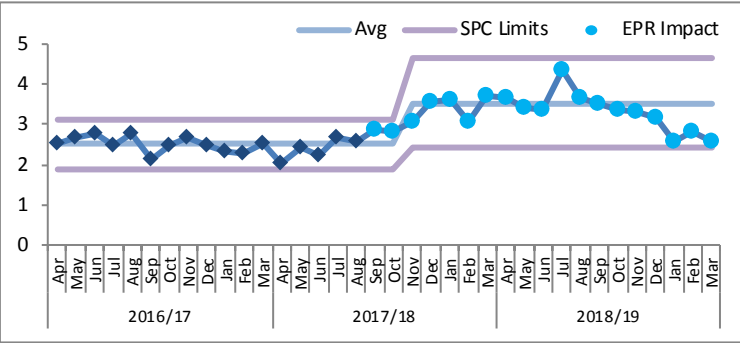
To deliver our financial plan and key performance targets

Trend

Challenges and Successes

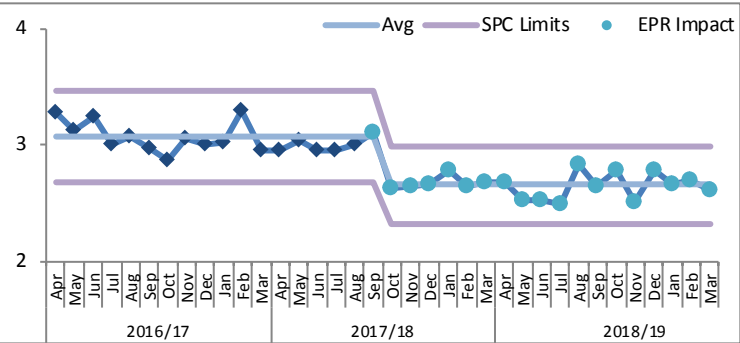
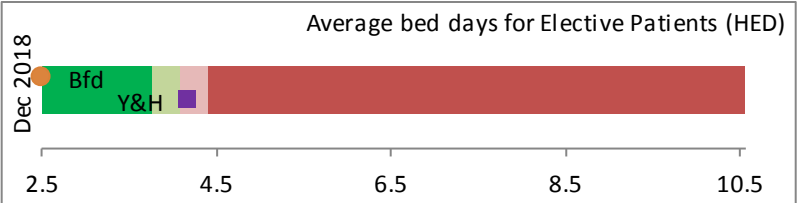
Comparison

Exec Lead



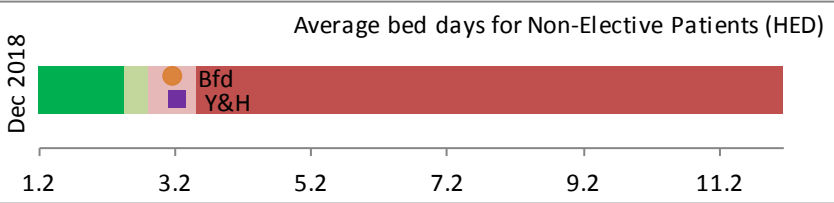
The increase post EPR relates to a movement of 1 day length of stay (included in this average) to day cases (which aren't included). The trend doesn't reflect a deterioration in length of stay and the actual number of stays greater than 2 days is in line with previous volumes. Removal of data quality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

Chief Operating Officer



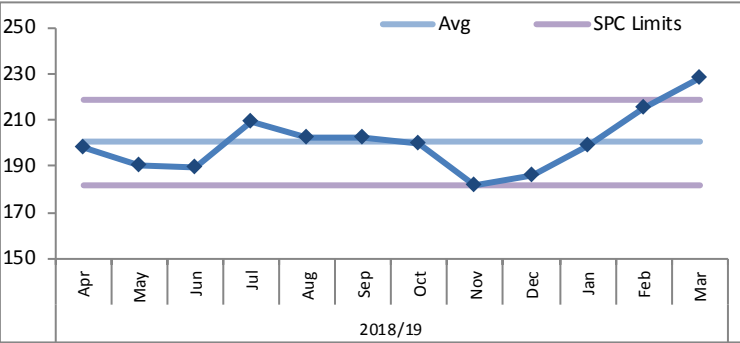
Trends over time show an increase in the number of 0 and 1 day length of stays which is why the average has reduced. This relates to a growth in assessments, particularly within Ambulatory Care which remain high.

Chief Operating Officer



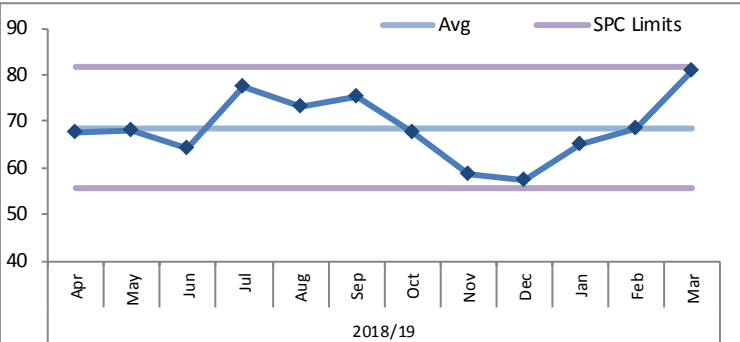
To deliver our financial plan and key performance targets

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



Position for March 2019 has deteriorated due to increased complexity of patients. Going forward weekly multi-agency will include a clinician and review will include all patients over 14 day length of stay. Further review of practice is being carried out with Emergency Care Intensive Support Team (ECIST) to identify additional improvements in the process.

Chief
Operating
Officer



There is a twice weekly review of stranded patients, including a weekly multi-agency review of over 21 day length of stay. Additional inpatient beds have been opened in support of winter pressures and data quality checks are in place to improve 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. Work is in process to standardise and embed the application of estimated date of discharge (EDD) which will also support the development of the command centre tiles .

Chief
Operating
Officer

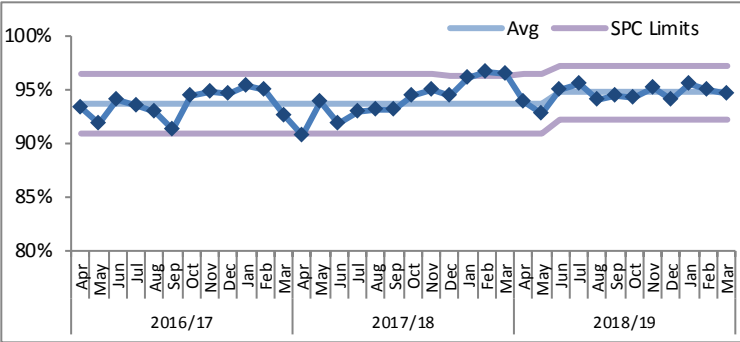
To deliver our financial plan and key performance targets

Trend

Challenges and Successes

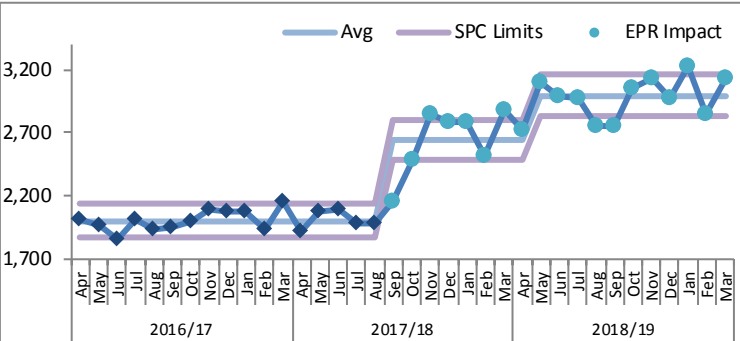
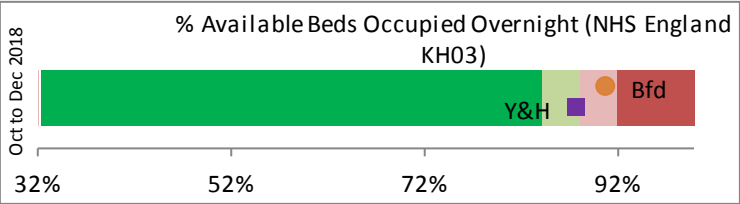
Comparison

Exec Lead



Bed occupancy continues close to the 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 a daily review. The total number of discharges before 1pm remained high.

Chief Operating Officer

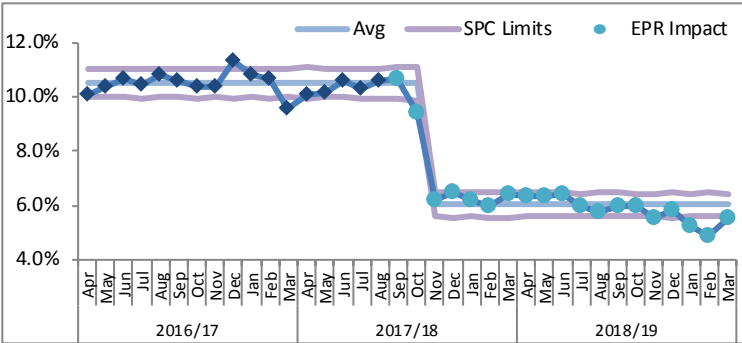
To deliver our financial plan and key performance targets

Trend

Challenges and Successes

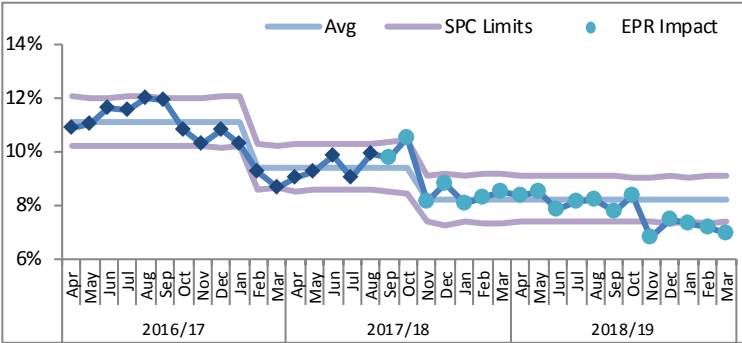
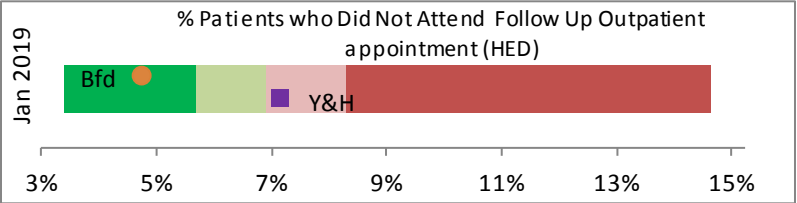
Comparison

Exec Lead



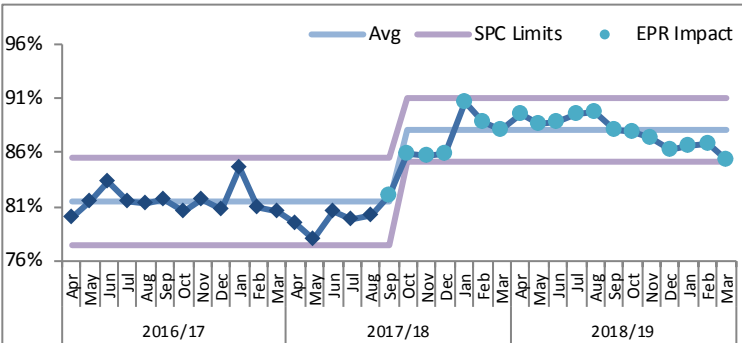
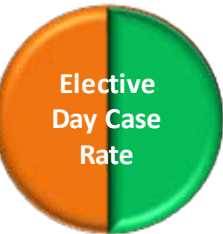
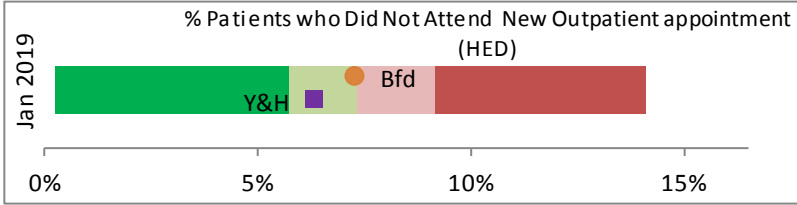
Investigation into data quality issues which may be impacting reporting has found a potential issue with how the number of did not attend (DNAs) and cancellations are reported when the appointment is rescheduled. This predominately impacts follow up attendances and a fix is currently being tested for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

Chief Operating Officer



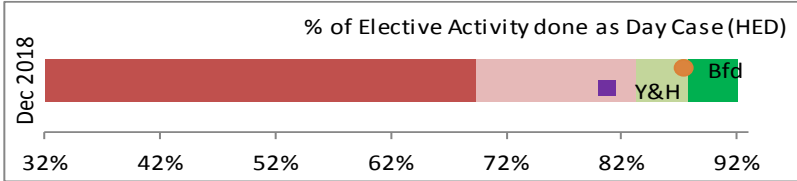
Data quality / reporting investigations also extend to new appointments.

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



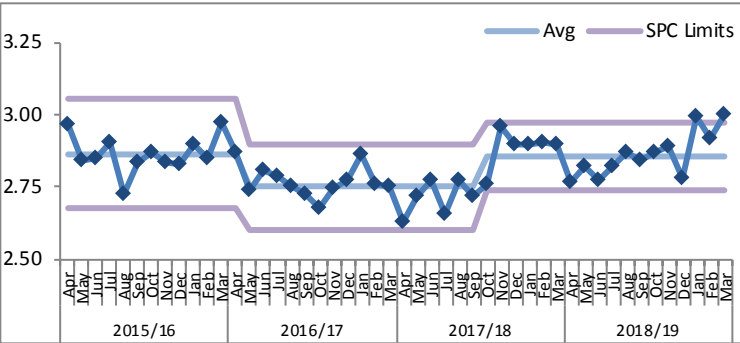
To deliver our financial plan and key performance targets

Trend

Challenges and Successes

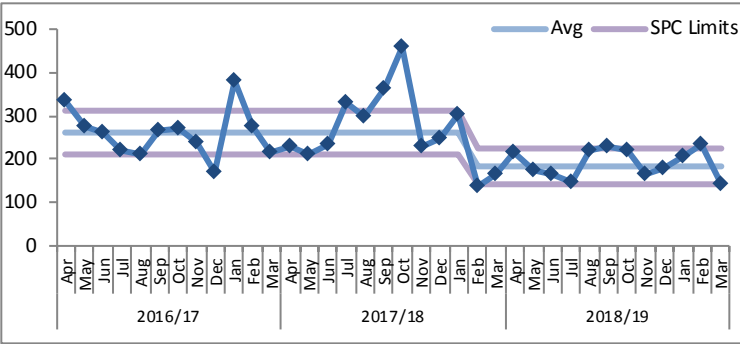
Comparison

Exec Lead



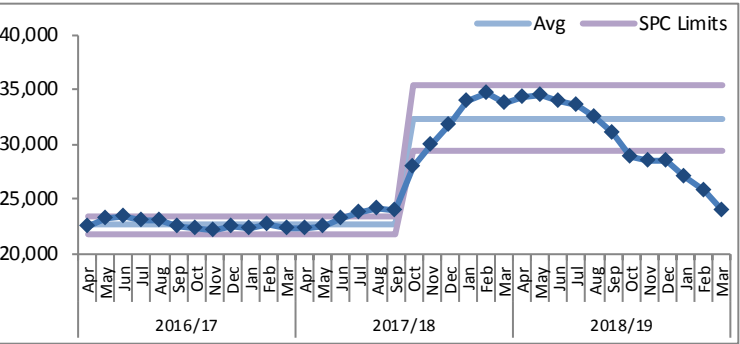
Additional activity being provided in support of referral to treatment (RTT) recovery includes additional follow up attendances which explains the increased ratio since January 2019.

Chief Operating Officer



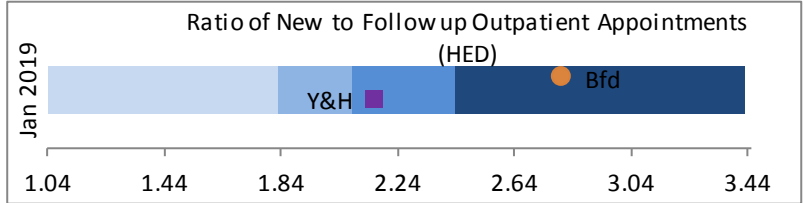
Numbers for March 2019 reduced significantly compared to February 2019.

Chief Operating Officer



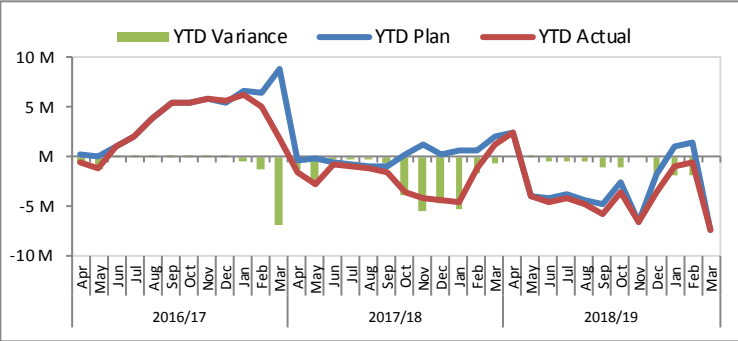
The total waiting list size reduced by 1,100 patients in March 2019 from the reported February 2019 position, which is the tenth successive reduction since April 2018.

Chief Operating Officer



To deliver our financial plan and key performance targets

Trend



Challenges and Successes

Comparison

Exec Lead

The draft Month 12 Income and Expenditure position is a pre-Provider Sustainability Fund (PSF) deficit of £7.5m which is in line with the planned deficit control total for the year. The draft year end position includes £7.2m of PSF income. This results in a draft post-PSF deficit of £0.3m which is £3.1m behind plan. This draft position does not include any assumption of bonus PSF cash which will be notified by NHS Improvement at a later date. These figures reflect the draft unaudited position and may be subject to change.

Director of Finance

NHSI Use of Resources Risk Rating (UoR) As at 28/02/2019	Plan YTD	Actual YTD	Last Month	RAG
Capital Servicing Capacity	2	4	4	Red
Liquidity	1	2	2	Yellow
I & E Margin	2	3	3	Yellow
Variance from plan (I & E Margin)	2	2	2	Yellow
Agency Spend	2	1	1	Green
Combined UoR (after triggers)				

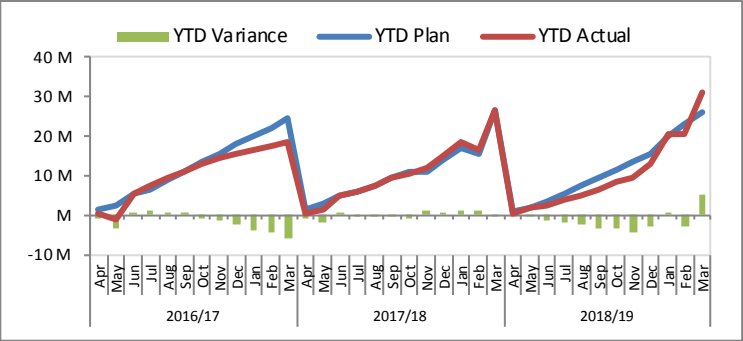
The Trust's overall Use of Resources (UoR) rating is in line with plan at the end of Month 12 (March 2018/19) based on the draft year end position.

Director of Finance



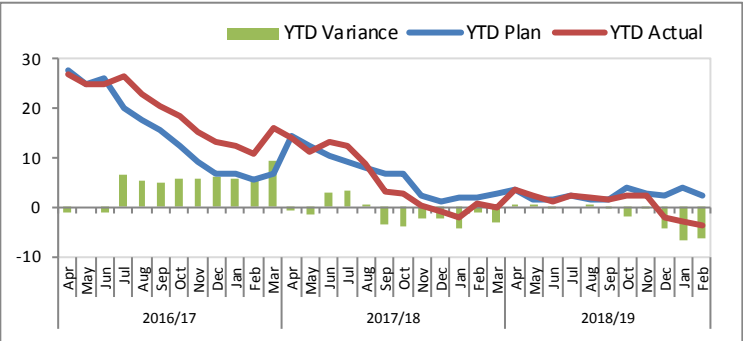
To deliver our financial plan and key performance targets

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



The Trust has delivered £31.2m of efficiencies as at the end of Month 12 (March 2018/19). A total of £18.9m of these efficiencies were delivered non-recurrently, with £12.3m of recurrent efficiencies delivered in 2018/19.

Director of Finance



This information is not available due to the constraints of the year end reporting timetable.

Director of Finance

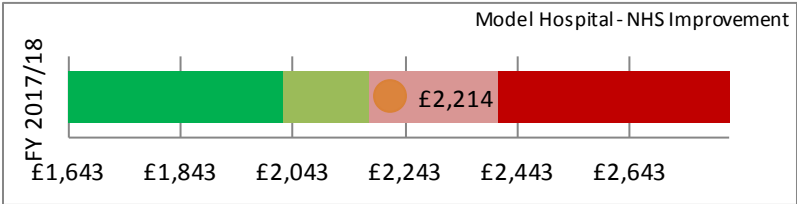
To deliver our financial plan and key performance targets

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



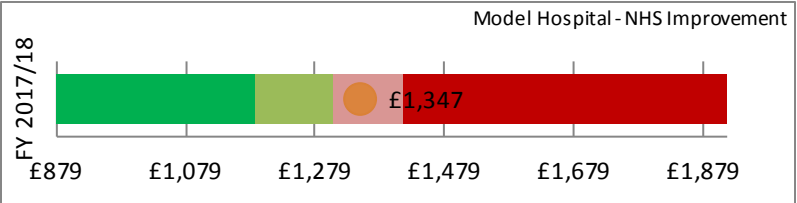
The Model Hospital pay and non-pay costs per weighted average unit (WAU) are the 2017/18 figures based on the 2017/18 Reference Costs and audited accounts. These metrics are updated annually and will next be updated by the Model Hospital with 2018/19's costs and activity in late 2019. For 2017/18's cost 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

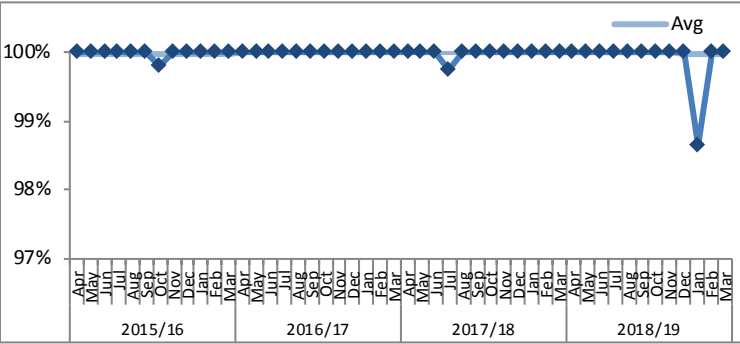
Trend

Challenges and Successes

Comparison

Exec Lead

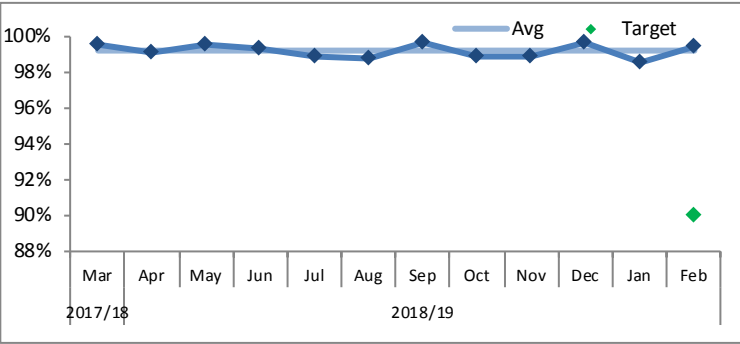
Mission Critical Systems Uptime



The Trust is maintaining a high level of uptime.

Chief Digital and Information Officer

Full Blood Count to Wards < 2 Hours

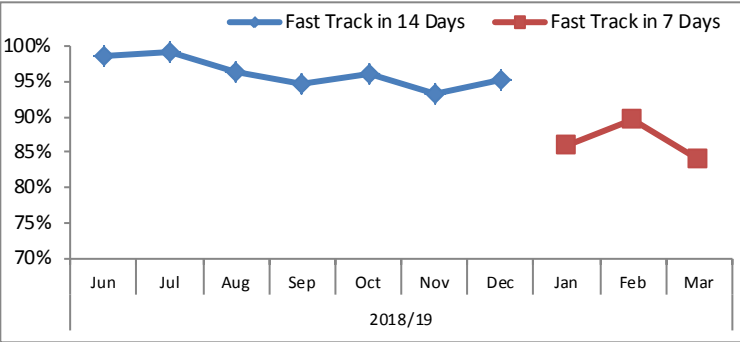


Performance continues to achieve compliance since the introduction of this target.

Chief Operating Officer

To deliver our financial plan and key performance targets

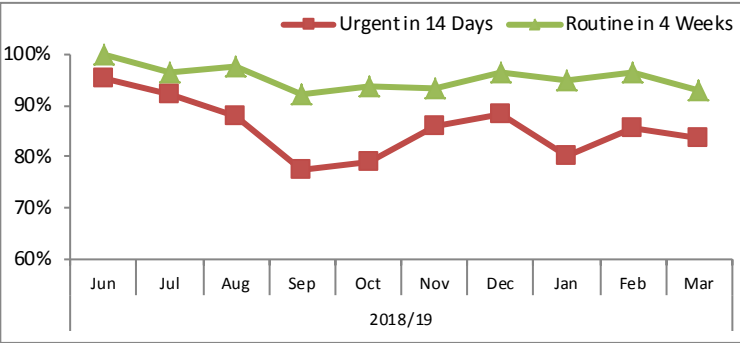
Trend	Challenges and Successes	Comparison	Exec Lead
-------	--------------------------	------------	-----------



Monitoring of turnaround times against a 7-day standard is now in place (previous Key Performance Indicator (KPI) was 14 days)) as this better aligns to improving cancer performance.

Chief Operating Officer

Performance against the 7-day target in March 2019 was 84%, there were 167 patients where the report was not completed within 7 days. Of these, 154 related to Computed Tomography (CT). Despite a focus on CT virtual colonoscopies which has been our main pressure, this position is a deterioration on last month's performance of 89% as during the last two weeks of March 2019 we have seen a reduction in uptake in additional consultant reporting sessions for CT and Magnetic Resonance Imaging (MRI).



Turnaround times for urgent and routine patients has slightly deteriorated from the previous month. Again this is because there has been a reduction in uptake in additional consultant reporting sessions despite sending general CT and MRI scans to an outsourcing company for reporting.

Chief Operating Officer

National Indicators

Single Oversight Framework

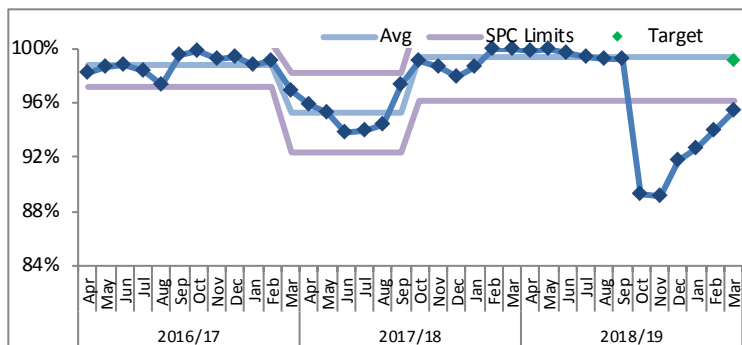
Trend

Challenges and Successes

Comparison

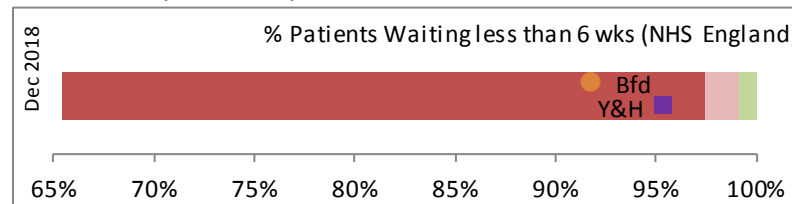
Exec Lead

Diagnostic
Waits



Performance for March 2019 shows continued improvement however current performance is still behind plan due to the inclusion of additional waits in the reportable position. Activity from the independent sector continues and total endoscopy activity has increased to support recovery to trajectory. Additional opportunities to further increase capacity are being explored. The cystoscopy position remains behind plan, however a reduction has been seen in waiting list size and number of breaches. Validation of the full waiting list is currently underway.

Chief
Operating
Officer



Use of
Resources -
Financial

NHSI Use of Resources Risk Rating (UoR) As at 28/02/2019	Plan YTD	Actual YTD	Last Month	RAG
Capital Servicing Capacity	2	4	4	Red
Liquidity	1	2	2	Yellow
I & E Margin	2	3	3	Yellow
Variance from plan (I & E Margin)	2	2	2	Yellow
Agency Spend	2	1	1	Green
Combined UoR (after triggers)				

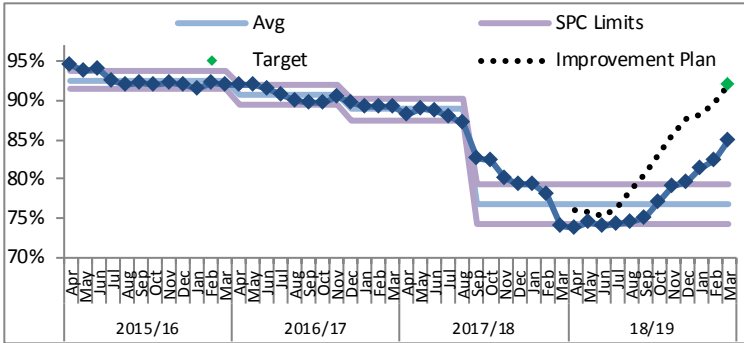
The Trust's overall Use of Resources (UoR) rating is in line with plan at the end of Month 12 (March 2018/19) based on the draft year end position.

Director of
Finance

National Indicators

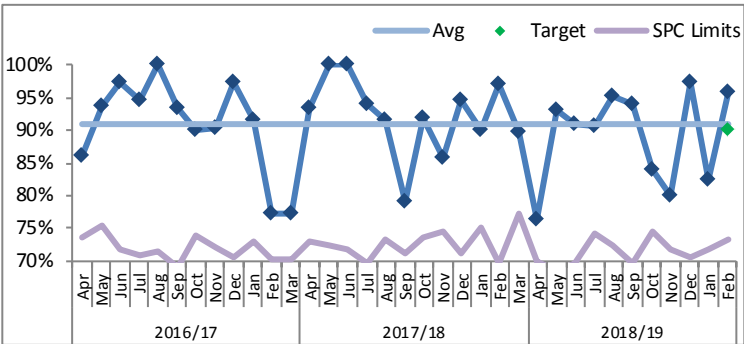
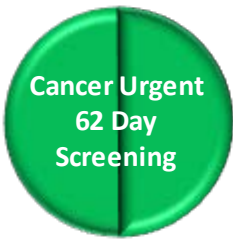
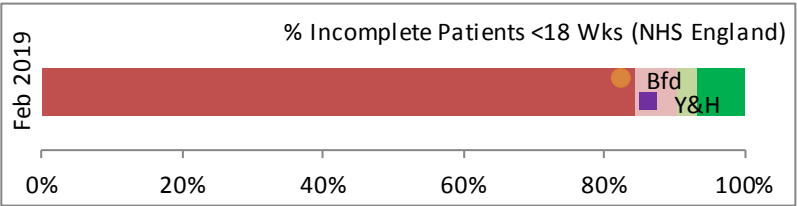
Single Oversight Framework

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



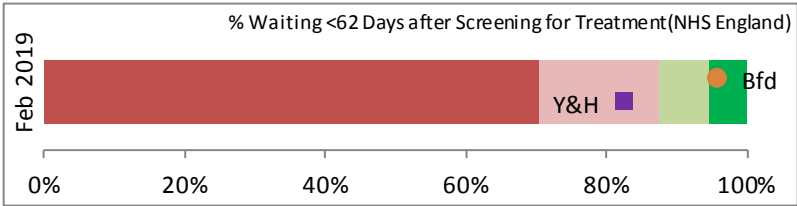
Incomplete performance for March 2019 is 84.99% which represents an improvement on February 2019 but slightly behind the recovery trajectory agreed in October 2018. Additional activity is being delivered through increased internal capacity and the use of the independent sector. A new trajectory has been submitted with recovery to the 92% target planned for September 2019.

Chief Operating Officer



Performance in February 2019 has been recovered above the 90% threshold. March 2019 Performance is also predicted to achieve the standard.

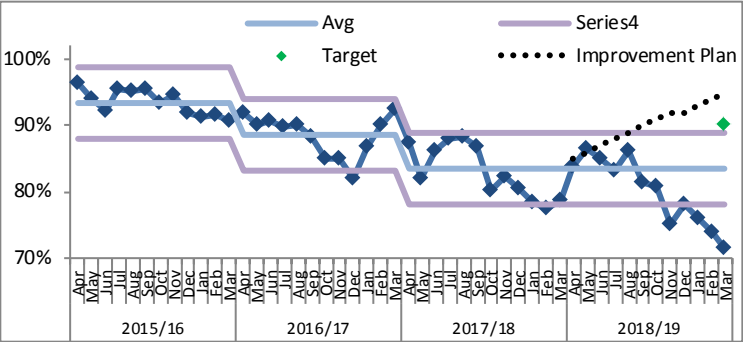
Chief Operating Officer



National Indicators

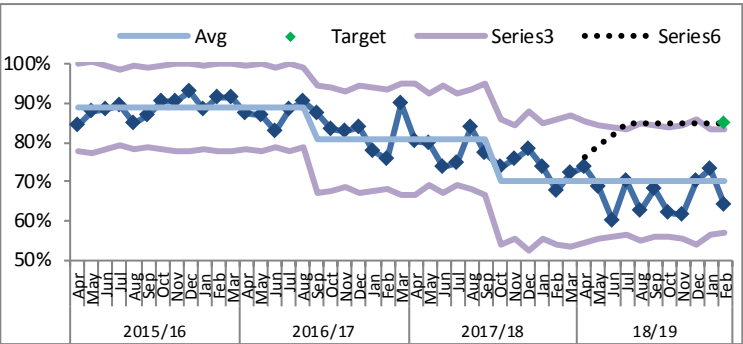
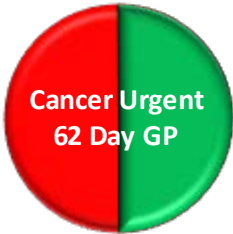
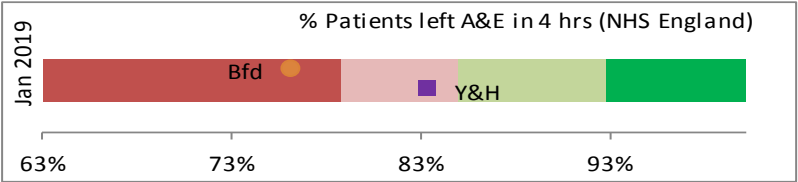
Single Oversight Framework

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



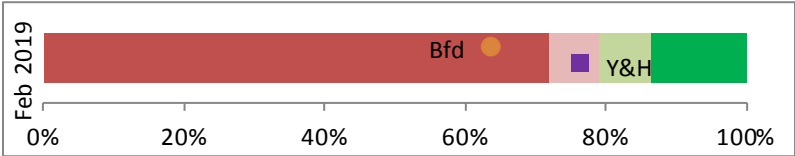
Emergency Care Standard (ECS) performance (type 1 and 3) was 71.36% in March 2019 and full year position for 2018/19 is 80.07%. The Emergency Care Improvement Programme continues with focus on streaming and ambulance handover, expansion in the use of Green Zone and increasing same day emergency care.

Chief Operating Officer



February 2019 performance against the 62-day cancer standard was 63.89%. Performance for March and April 2019 are predicted to show improvements, on previous months with a significant reduction in the number of patients on the 62 day backlog. Weekly diagnostic and treatment numbers remain high and the 62 day backlog has been significantly reduced in support of this timescale.

Chief Operating Officer



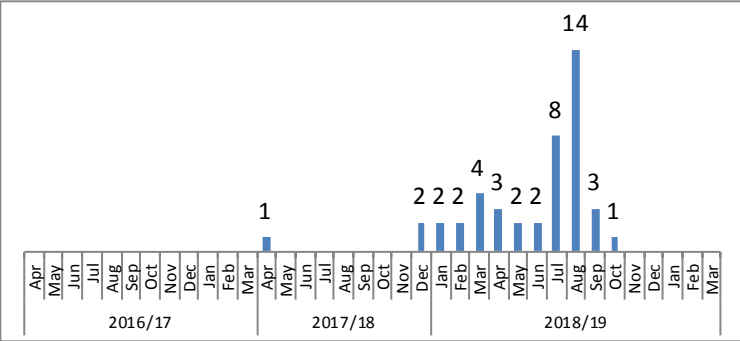
National Indicators

National Target – Non-Financial

Trend

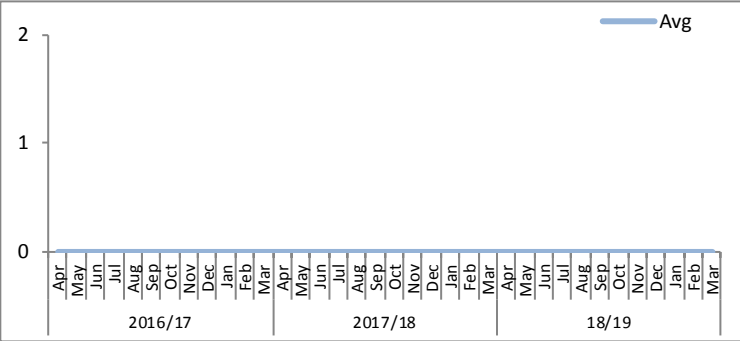
Challenges and Successes

Exec Lead



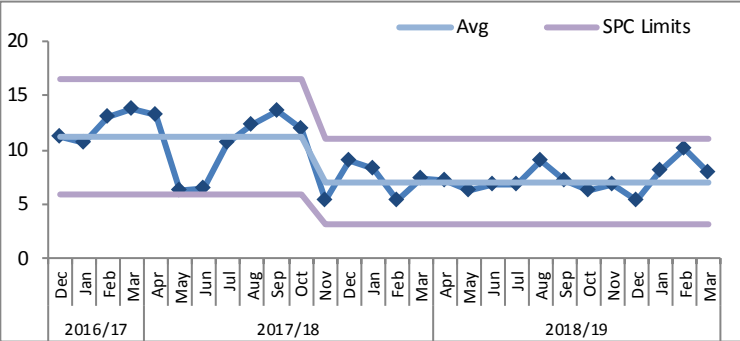
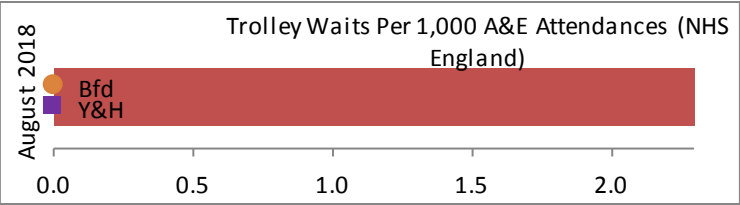
The Trust reported 0 incomplete 52 week waits in March 2019, which is the fifth consecutive month with no breaches. Daily review of all management plans for patients waiting over 35 weeks continues, with weekly escalation through the Planned Care Recovery group and updates to the Chief Operating Officer (COO).

Chief Operating Officer



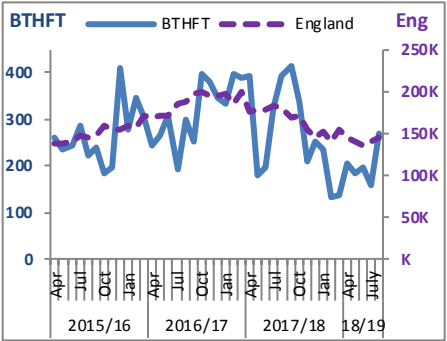
There have been no over 12 hour trolley waits.

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

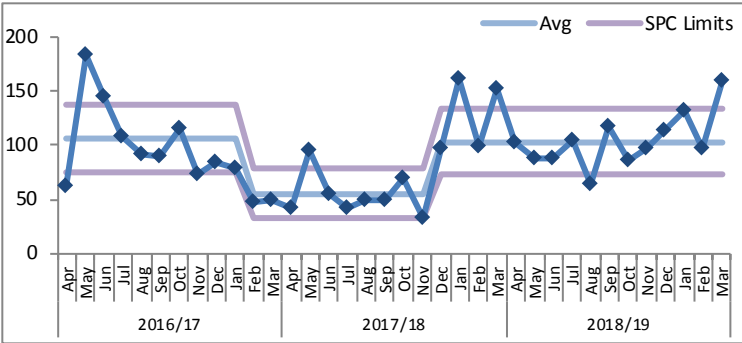
National Target – Non-Financial

Trend

Challenges and Successes

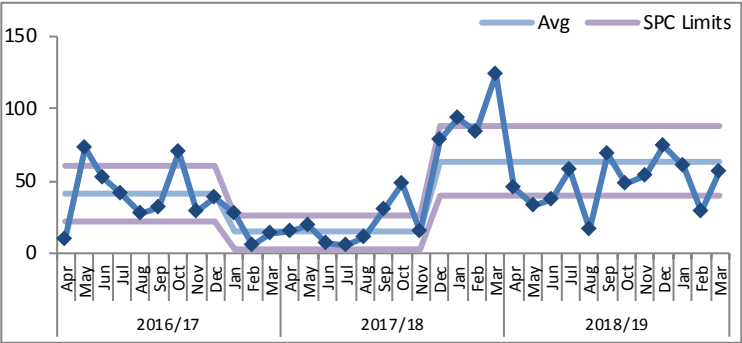
Comparison

Exec Lead



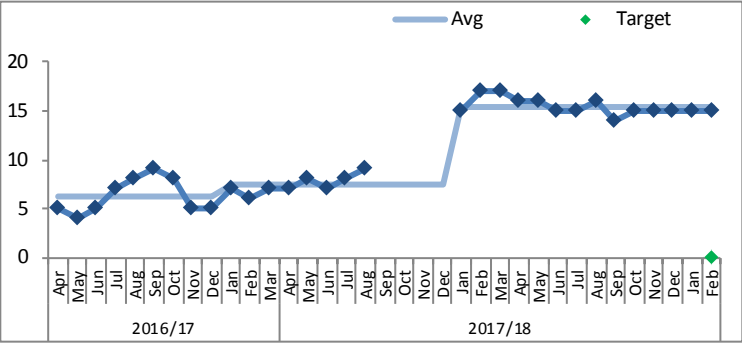
In March 2019 the number of ambulance handovers delays attributable to the Trust taking 30-60 minute was 159. Further work is being carried out to validate this position. Improvement work alongside colleagues from Yorkshire Ambulance Service (YAS) continues, fit to sit has been implemented and the improvement work-stream is being supported by Emergency Care Intensive Support Team (ECIST). Administrative support is to be introduced in Ambulance assessment area to reduce delays in registering patients. Consistent provision of dedicated handover coordination is part of the improvement plan.

Chief Operating Officer



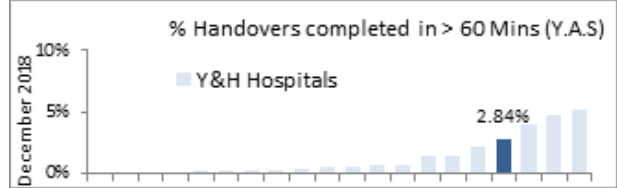
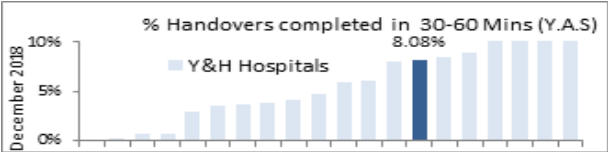
In March 2019 the number of ambulance handovers delays attributable to the Trust taking over 60 minutes was 57. This position is within Statistical process control (SPC) and below annual average. Further work is being carried out to validate this position.

Chief Operating Officer



Recovery plans are in place for all specialties.

Chief Operating Officer



National Indicators

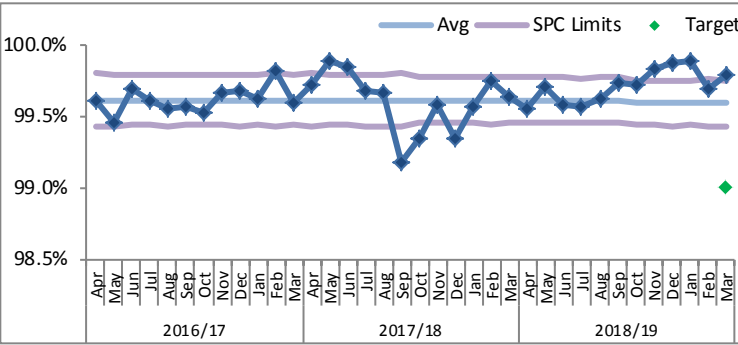
National Target – Non-Financial

Trend

Challenges and Successes

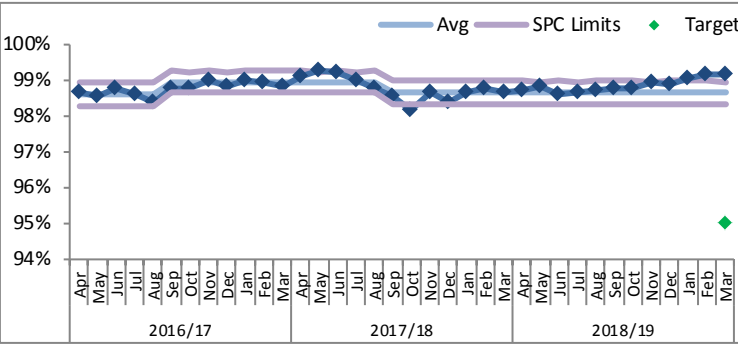
Comparison

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



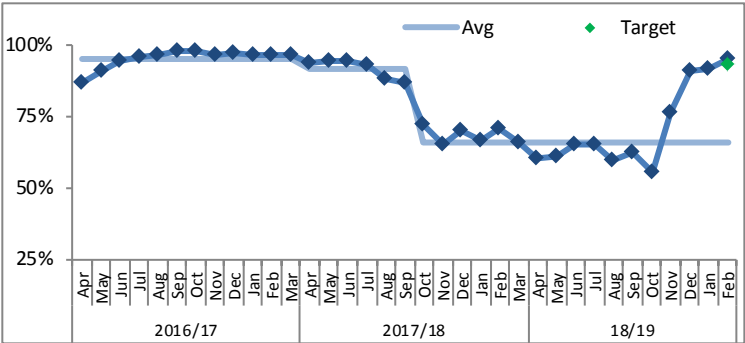
With the standardisation and integration of the patient administration system (PAS) data, as the one source of truth, the Trust compliance to NHS Number use is strong.

Chief Digital and Information Officer

National Indicators

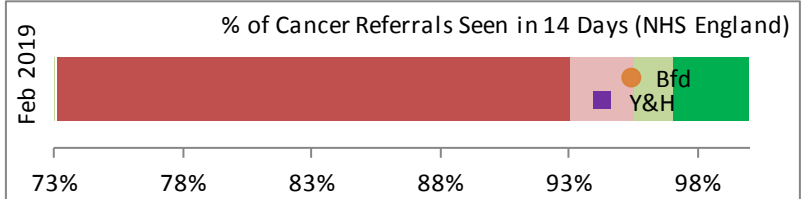
National Target – Non-Financial

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



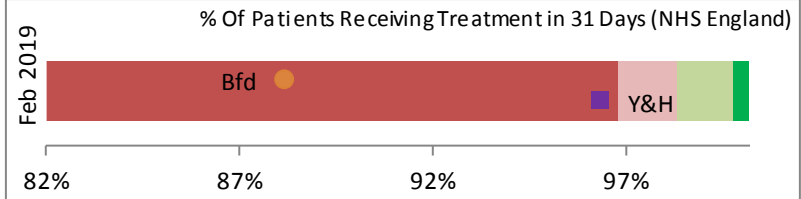
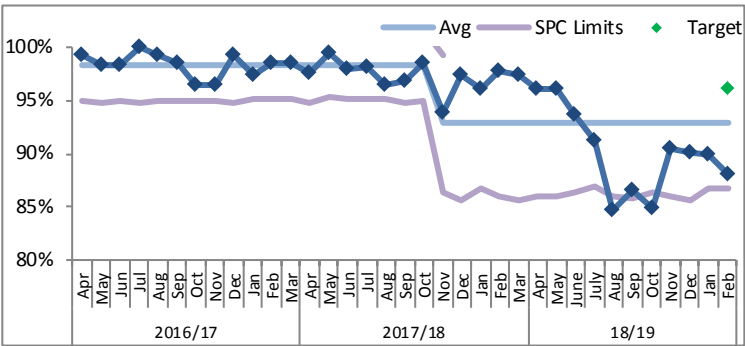
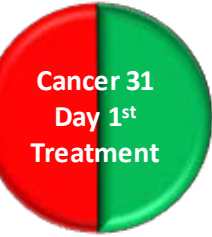
February 2019 performance against the 2 week-wait cancer standard was reported above the 93% target for the first time since July 2017 at 95.43%. March 2019 performance is predicted to remain above the threshold for all specialties except for Breast. There has been a 25% increase in suspected breast cancer referrals in the last 3 months.

Chief Operating Officer



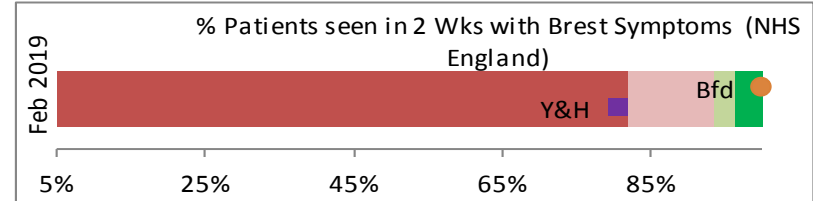
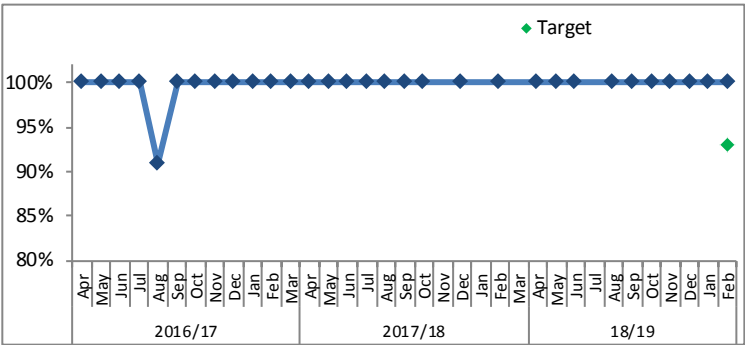
This standard was not achieved due to Urology surgical capacity issues. These patients are reviewed daily at the Urology cancer huddle. The standard is predicted to fail in March 2019 but recovery above the 96% target is expected in April 2019.

Chief Operating Officer



This standard was achieved in February 2019 and projected to be remain above the 90% target in March 2019.

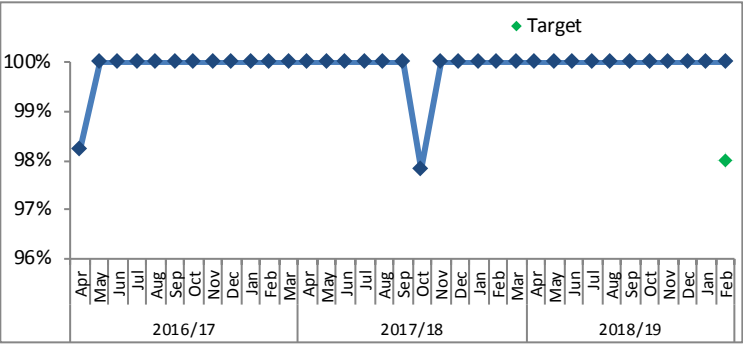
Chief Operating Officer



National Indicators

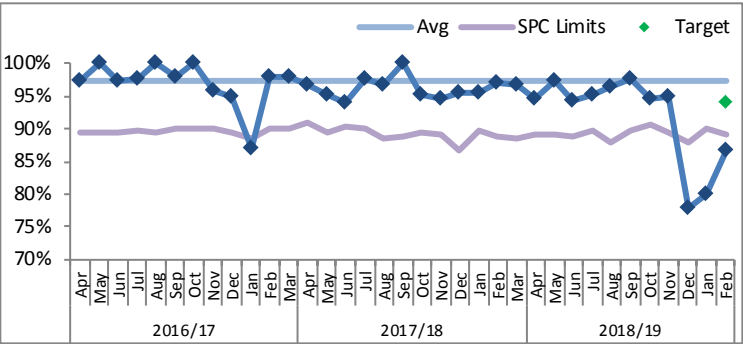
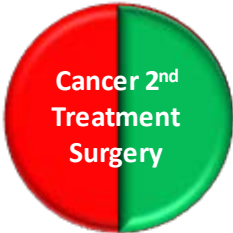
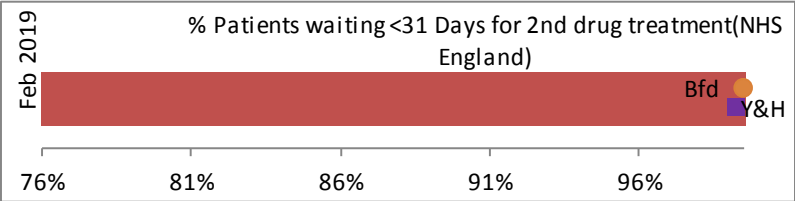
National Target – Non-Financial

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



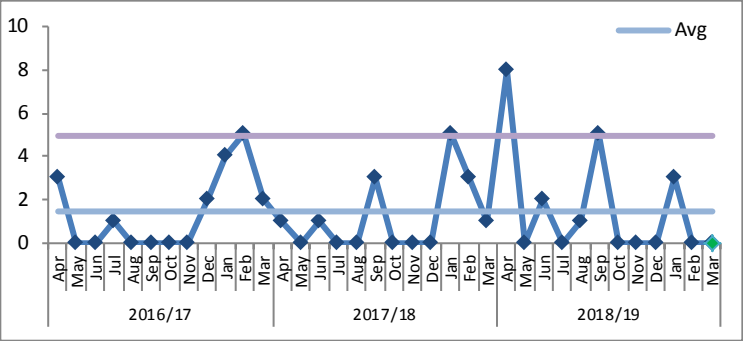
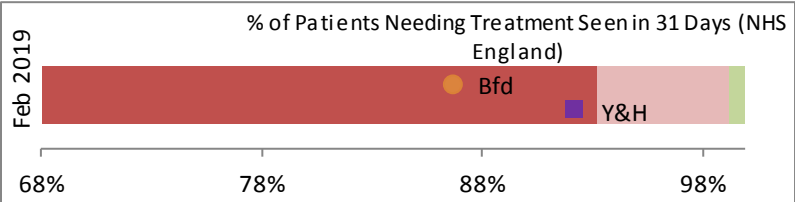
This standard was achieved in February 2019 and projected to be achieved in March 2019.

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. The standard is predicted to fail in March 2019 but recovery above the 94% target is expected in April 2019.

Chief Operating Officer



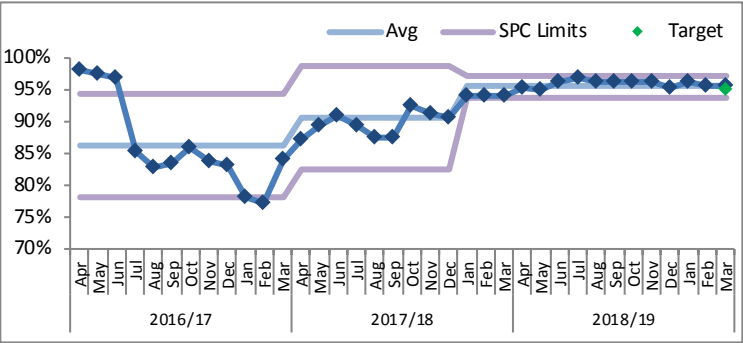
There were 0 breaches of the 28 day standard in March 2019.

Chief Operating Officer

National Indicators

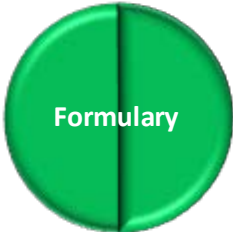
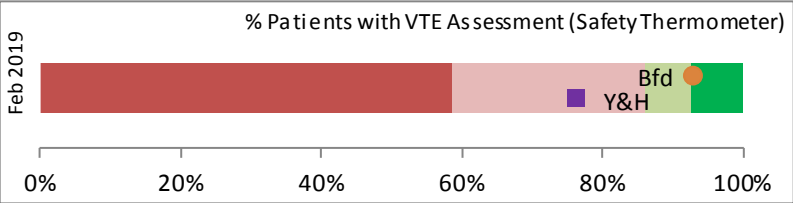
National Target – Non-Financial

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.

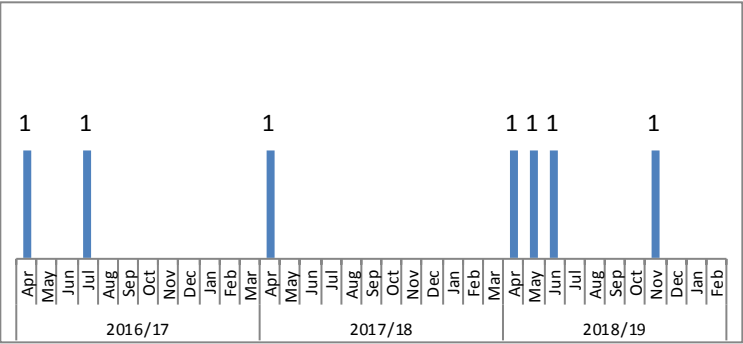
No comparator data is available.

Chief Digital and Information Officer

National Indicators

National Target – Financial

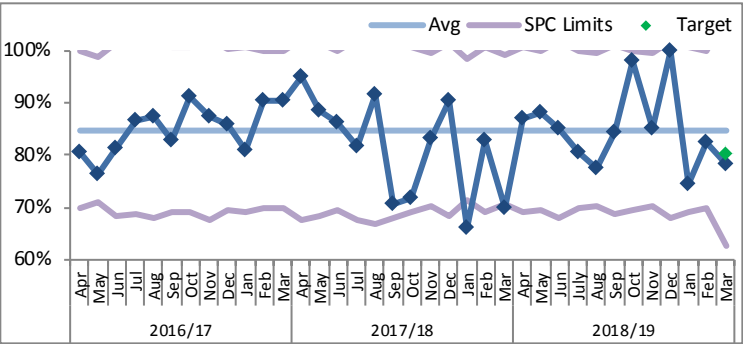
Trend	Challenges and Successes	Comparison	Exec Lead
-------	--------------------------	------------	-----------



There were no never events in March 2019.

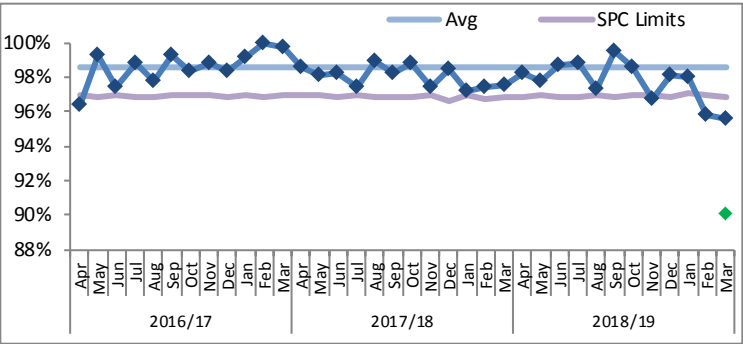
No comparator data is available.

Chief Operating Officer



Performance has deteriorated in March 2019 and overall compliance is below target. The service is experiencing extreme capacity pressures, coupled with high staffing gaps from a medical consultant perspective and high length of stay for stroke patients. Plans continue to be implemented with oversight from the Medical Director.

Chief Operating Officer



The threshold continues to be achieved.

Chief Operating Officer

National Indicators

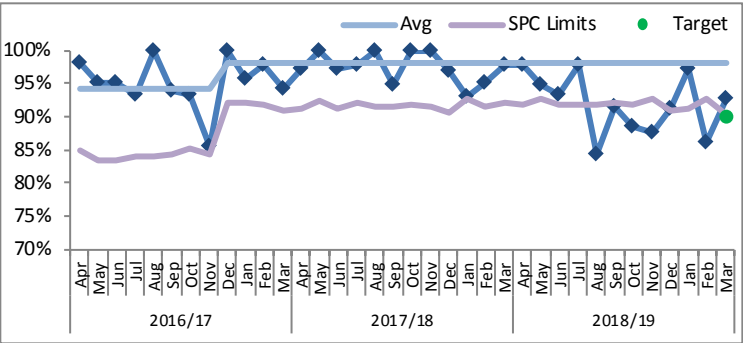
National Target – Financial

Trend

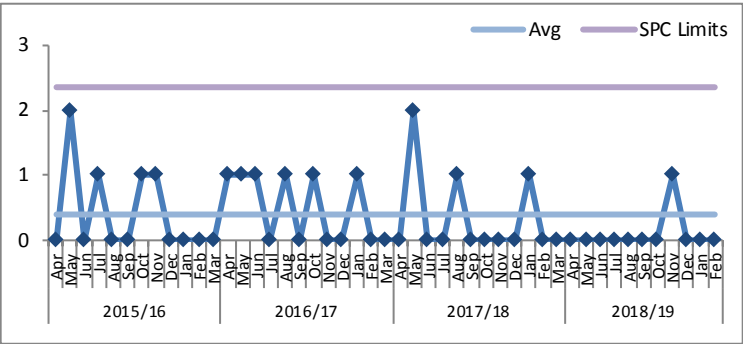
Challenges and Successes

Comparison

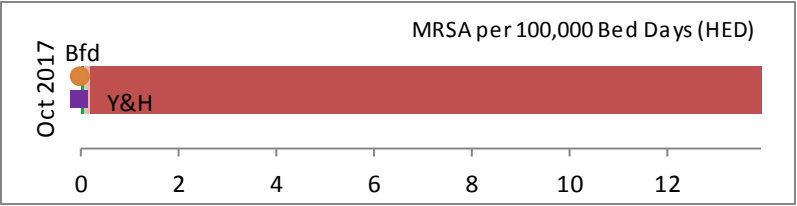
Exec Lead



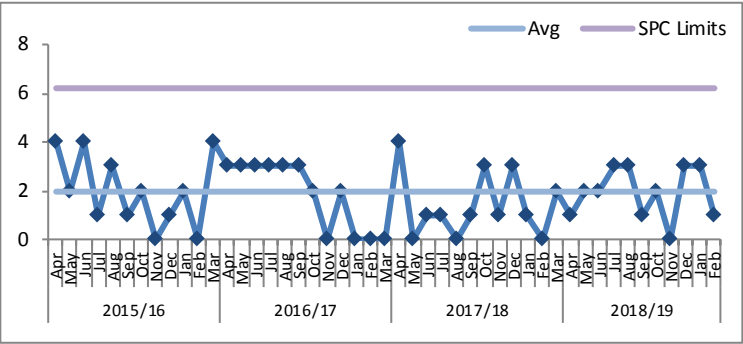
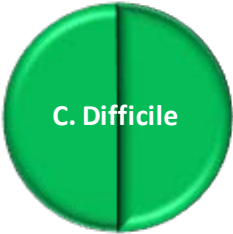
Performance in March 2019 shows an improved position above Chief Operating Officer target.



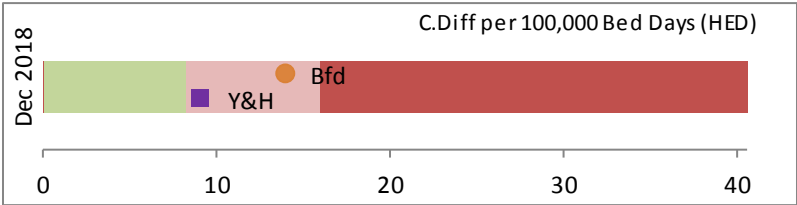
One case in November 2018 has been apportioned to the Trust. The Chief Nurse sample was taken in November 2018 on Ward 31 (Elderly Care). The Post Infection Review (PIR) has not identified any deficits in care, however, under Public Health England (PHE) guidelines the case remains attributable to the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



Chief Nurse



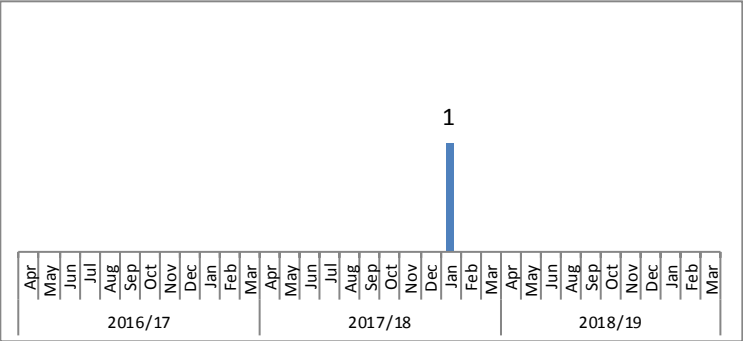
Continues as per previous years and is within expected range.



National Indicators

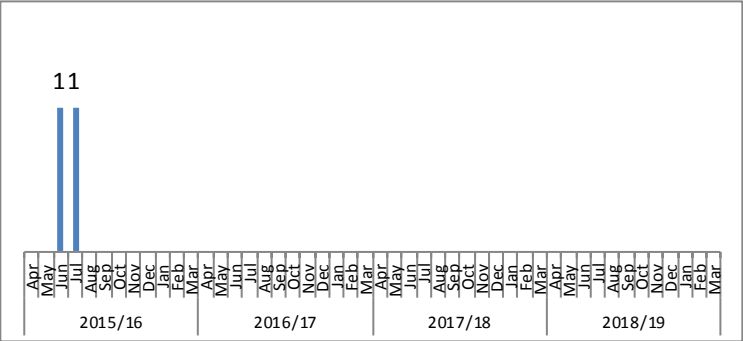
National Target – Financial

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

Glossary

Indicator	Definition	Data Quality Kite-Mark
Patient Experience		
Complaints	Number of complaints. Red ≥ 50 , Amber 40-49, Green < 40	
Complaints Closed	Percentage of complaints closed within agreed timescales Red $< 95\%$, Green $\geq 95\%$	
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 $= 0$	
Night-time Discharges	Discharges out of hospital between 12am and 6am. Excludes transfers to other hospital providers, self-discharges and assessment patients. Red = Outside control limits, Green = Inside control limits	
Information Governance Breaches	The number of reported breaches of the information governance standards Red > 6 , Amber ≤ 6 & > 2 , Green ≤ 2	
Readmissions		
Readmissions	The number of readmissions within 30 days of discharge from hospital. Red $\geq 7.8\%$, Amber $\geq 6.7\%$ & $< 7.8\%$, Green $< 6.7\%$	

Indicator	Definition	Data Quality Kite-Mark
Audits		
Audit of WHO Checklist	Audit of the World Health Organisation surgical checklist monitoring the number that were complete compared to the number of checklists Red < 90%, Amber >=90% & < 95%, Green >=95%	
Serious Incidents	Unexpected or avoidable death, serious harm, never events, service delivery prevention compared to all incidents reported Red > 5, Amber 3-5, Green <=2	
To be a continually learning organisation		
Learning Hub		
Progress on embedding the Learning Hub	Progress on embedding the Learning Hub in the Trust against the plan.	Qualitative Metric
Research		
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
To be a continually learning organisation		
Training		
New Starter Training	% of new staff who are compliant with mandatory training requirements Red < 90%, Amber >=90% & <100%, Green = 100%	
Refresher Training	% of staff who are compliant with mandatory training requirements Red < 75%, Amber >=75% & <85%, Green >= 85%	
Governance Mechanisms		
Out of date policies	% of policies that are currently out of and within date. Red < 95%, Amber >=95% & <100%, Green = 100%	
Risks not mitigated	Risks 12 and above whose current rating is above the target (residual) rating. Red > 15%, Amber >5% and <=15%, Green <=5%	
To collaborate effectively with local and regional partners		
Stakeholder Engagement	The Hospital's systematic approach to stakeholder management identifies key external partners, and for each an executive sponsor and an account manager has been identified, with responsibility for maintaining/improving the health of the relationship.	Qualitative Metric
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	Qualitative Metric
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	Qualitative Metric

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

Glossary

Indicator	Definition	Data Quality Kite-Mark	Indicator	Definition	Data Quality Kite-Mark
Sickness			Retention		
Sickness	% of time lost due to sickness in a given period (the reported month, year to date is the previous 12 months rolling average for which Trust target is 4.00%) Red >1% point above Target, Amber within 1% point above Target, Green <= Target		Turnover	Number of employees who have left the organisation in the past 12 months as a % of the average number of employees over the same period Red > 14%, Amber 12% – 14%, Green < 12%	
Staffing Levels			Additional Workforce metrics		
Nursing Staff Fill Rate	% of time nursing staff staffing hours filled as planned Red < 80%, Amber 80% – 95%, Green > 95%		Staff Advocate Service Contacts and Outcomes	Contacts and Outcomes for the Staff Advocate Service	
Care Staff Fill Rate	% of time care staff staffing hours filled as planned Red < 80%, Amber 80% – 95%, Green > 95%		Harassment & Bullying Related Investigations	Investigations arising from Harassment & Bullying and outcomes	
To deliver our financial plan and key performance targets					
In-Patient Productivity			In-Patient Productivity		
Length of Stay Elective	The average length of stay for elective patients, in days. The benchmark data is for Acute trusts for June 2017 from HED, which has a subtly different calculation, which can result in very small differences in numbers. Red < 50 th Percentile England, Amber 50 – 25 th Percentile, Green Upper Quartile England		Length of Stay Non-Elective	The average length of stay for non-elective patients, in days. The benchmark data is for Acute trusts for June 2017 from HED, which has a subtly different calculation, which can result in very small differences in numbers. Red < 50 th Percentile England, Amber 50 – 25 th Percentile, Green Upper Quartile England	
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. Red = Lower two quartiles, Green = Upper two quartiles		Bed Occupancy	Average % of available beds which were occupied overnight. Red >=95%, Amber 85-95%, Green <85%	
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. Red = Lower two quartiles, Green = Upper two quartiles				
Agency % of FTE	Agency FTEs as a percentage of all FTEs				

Glossary

Indicator	Definition	Data Quality Kite-Mark	Indicator	Definition	Data Quality Kite-Mark
In-Patient Productivity (cont.)			Finance		
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. Red >= 62, Amber 56-61, Green <= 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. Red = Outside control limits, Green = Inside control limits		Cost Improvement Plan	Cost Improvement Plan progress against target.	
Out-Patient Productivity			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. Red < 50 th Percentile England, Amber 50 – 25 th Percentile, Green Upper Quartile England		Cost Per Weighted Activity Unit		
Did Not Attend New	This is the % of New Outpatient appointments where the patient does not attend. Red < 50 th Percentile England, Amber 50 – 25 th Percentile, Green 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. Red – 4 th quartile, Amber – 2 nd /3 rd quartiles, Green – 1 st quartile	
Elective Day Case Rate	The number of patients admitted for planned procedure and leave same day as a % of all procedures. Red < 83%, Amber <87% & >=83% , Green >= 87%		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. Red – 4 th quartile, Amber – 2 nd /3 rd quartiles, Green – 1 st 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. Red < 50 th Percentile England, Amber 50 – 25 th Percentile, Green Upper Quartile England		Service Level Agreements		
Short Notice Clinic Cancellations	Clinics cancelled within the 6 week timeframe. Red 5% higher 17/18 avg, Amber within 5% of 17/18 avg, Green 5% less 17/18 avg		Mission Critical Systems	Percentage of time all Mission Critical Systems were up and running Red <99.7%, Amber >=99.7% & < 99.9%, Green >=99.9%	
Elective Wait List	Wait list of patients on an elective pathway. Red Greater than last month, Amber , Green 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 Red <85%, Amber >=85% & < 90%, Green >=90%	

Glossary

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

Glossary

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

Glossary

Status

Colour-coding:

Red = 2 or more Red Indicators from within the Domain (represented by a circle) or a Composite Indicator. For a single indicator - Off target

Amber = 0 Red and half or more Amber Indicators from within the Domain, For a single indicator – On target, but at risk

Green = 0 Red and less than half Amber; or All Green Composite Indicators. For a single indicator - On target

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.

