Bradford Teaching Hospitals
NHS Foundation Trust

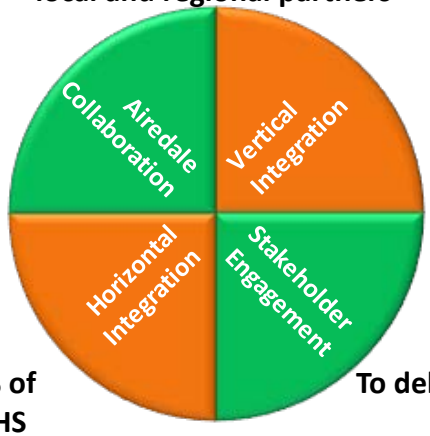
# Integrated Dashboard
# Board of Directors

31st May 2019

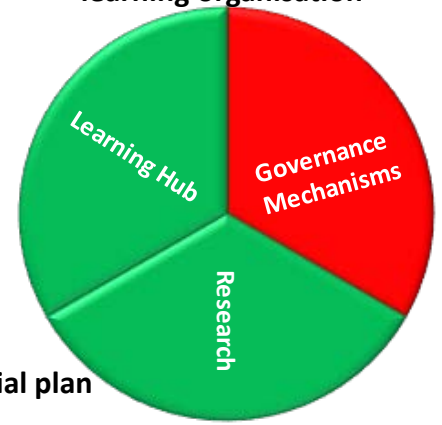
31st May 2019

**To provide outstanding care for our patients**


**To collaborate effectively with local and regional partners**

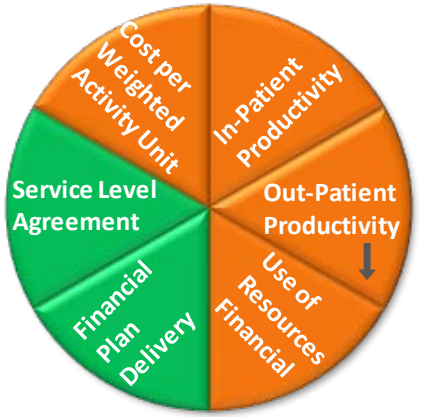



**To be a continually learning organisation**

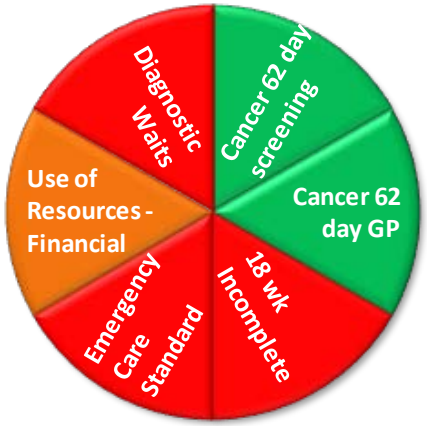



**To be in the top 20% of employers in the NHS**


**To deliver out financial plan**

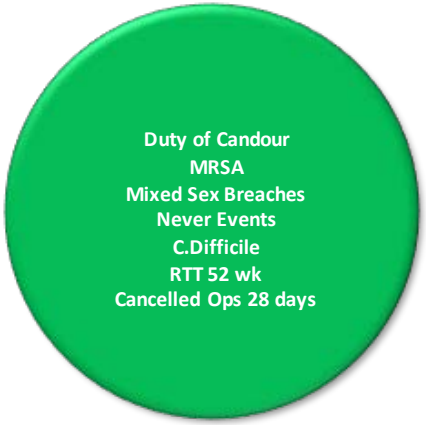



Single Oversight Framework

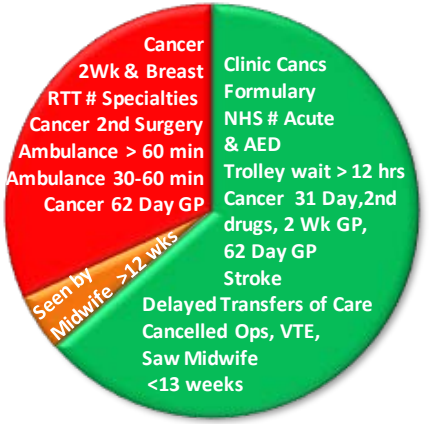



**National targets**

Financial




Non-Financial



# Headlines

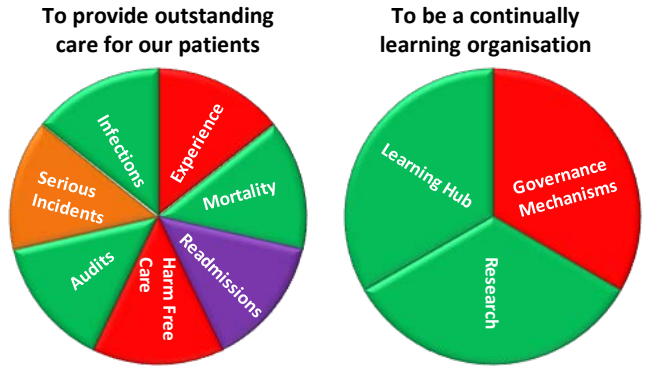
The Month 2 **Income & Expenditure position is in line with the plan with a pre-PSF deficit of £3.1m,** in line with the control total. 100% of the PSF / FRF available for Month 2 has been assumed in the position, equating to £1.25m. This results in a year to date post-PSF deficit of £1.8m which is in line with plan. The year end forecast submitted to NHS Improvement is full delivery of the £12.5m pre-PSF control total deficit and recovery of the full £12.5m PSF / FRF to achieve the breakeven post-PSF control total. However, the current run rate would result in the Trust falling short of its control total by a significant margin. To deliver the control total, a step change in the delivery of financial efficiencies is required. A number of additional steps to mitigate this risk are being introduced.

Delivery of the **Emergency Care Standard (ECS)** remains a challenge. The introduction of navigation and medical coordination roles from May 2019 has supported improved wait times and when consistently utilised result in performance typically exceeding 85% for ECS. The department continue to embed these roles, reduce instances where they are used for tasks other than navigation or coordination, and test further enhancements in how the roles are delivered. Some capacity issues within GP streaming, which have been escalated to the System Urgent Care Operational Group, have reduced the overall impact of these improvements on ECS performance in June 2019.

The **Cancer Improvement Plan** is ongoing with improved performance across each standard compared to the previous year. Increased fast track demand has caused some deterioration in 2 Week Wait performance over recent months but additional clinics have been delivered and performance is expected to meet the standard from next month. The 62 Day First Treatment standard was met in April 2019 but this target remains a challenge due to diagnostic and clinical oncology delays. Improvement plans are in place for this phase with a focus on pathway analysis, capacity and demand tracking, and improved system working.

**Referral to Treatment (RTT)** performance continues to improve with the twelfth successive monthly reduction in the total size of the Waiting List, which has reduced by 12,034 (35.1%) since April 2018. There have been no 52 Week breaches since October 2018 and reported incomplete RTT performance was 86.38% in March 2019.

# Quality Dashboard
# 31st May 2019

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|---|
| The **quality indicators continue to demonstrate positive progress** with very good outcomes in relation to Infection control, mortality, and VTE. |
| As per previous reports we are reviewing the suite of reports and corresponding ratings for the two strategic objectives by Autumn 2019. |
| **Patient Experience continues to have a focus in relation to complaints** and the recent In-patient survey results. The Committee will see additional monthly reports to gain further assurance in relation to Patient experience. |
| The Committee asserts that the Board Assurance Framework rating assessment continues to demonstrate a Green rating. |

# Workforce Dashboard
# 31st May 2019

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


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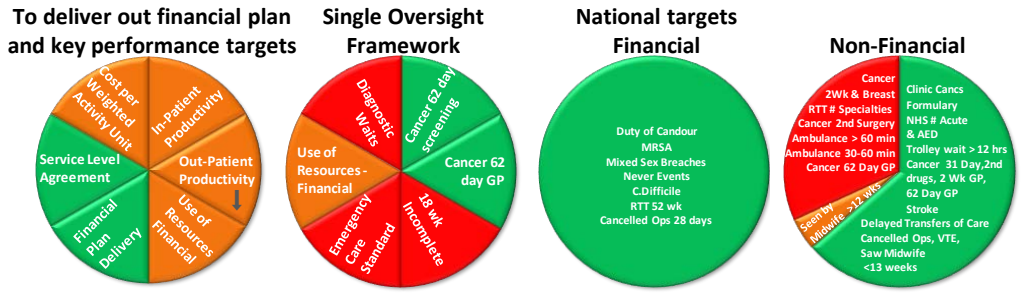
| **Appraisal performance is 90.5%.** A decision has been taken to retain the 95% appraisal completion target at end December 2019 and re-review move to appraisal season in 2020. |
| Staff Friends and Family results are showing a gap closing on 'Place to Work' indicator but not 'Place to receive treatment' indicator when benchmarked against Yorkshire and Humber Trusts. |
| There was a discussion by the Committee regarding sickness absence and relevant Model Hospital comparable data. |
| All other workforce metrics remain stable |

# Finance & Performance Dashboard 31st May 2019




The Month 2 **Income & Expenditure position is in line with plan** with a pre-PSF deficit of £3.1m, in line with the plan and control total. 100% of the PSF / FRF available for Month 2 has been assumed in the position, equating to £1.25m. This results in a year to date post-PSF deficit of £1.8m which is in line with plan. The year end forecast submitted to NHSI is full delivery of the £12.5m pre-PSF control total deficit and recovery of the full £12.5m PSF / FRF to achieve the breakeven post-PSF control total. However, the current run rate would result in the Trust falling short of its control total by a significant margin. To deliver the control total, a step change in the delivery of financial efficiencies is required.

There remain significant unmitigated **risks around the delivery of the full efficiency** / Cost Improvement Programme required to deliver the control total. The Chief Operating Officer and Director of Finance held a series of opportunity scoping meetings and have initiated a weekly monitoring meeting to increase the focus. In addition, a Budgetary Management Framework has been produced to increase grip.

The Bradford Districts and Craven NHS partner organisations have agreed to share their financial risk in 2019/20. £3m of the Trust's efficiency target is being addressed by the local NHS system. A System Finance & Performance Committee reporting into the Health & Care Partnerships Boards has been introduced to oversee the process of delivering system savings.

The Capital Plan for 2019/20 was approved and the Committee was asked to note the reduction in available funding for capital expenditure in subsequent years.

The **Emergency Care Standard performance for Type 1 & 3 attendances improved to 82.32%** for May 2019 and is forecast at 78.01% for June 2019. Average daily attendances for 2019/20 to date are 380 which is in line with 2018/19 and an increase of 3.25% . The Emergency Care Improvement Programme continues with focus on expanding the use of green zone, effective navigation, clinical co-ordination and increasing same day emergency care. The introduction of navigation and coordination roles from May 2019 has improved wait times and when fully utilised the ECS has typically exceeded 85%.

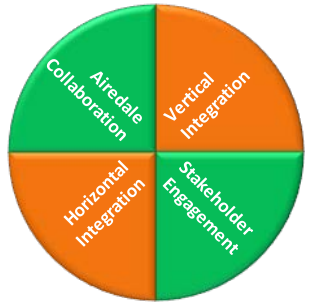
**Cancer 2 Week Wait performance for April 2019 was 88.77%** and is currently projected at 91.57% for May 2019. Increased referrals for Breast and Upper GI increased wait times and created a backlog. Additional capacity is in place and the backlog is being cleared for compliance from July 2019. The growth in referrals for Breast has reduced from +25% to +15% following targeted work with GP practices.

**Cancer 62 Day First Treatment performance for April 2019 was 88.10%** and is currently projected at 80.83% for May 2019. A detailed review identified ongoing issues with the diagnostic phase causing delays for treatment or in transferring to another provider resulting in a higher share of breaches under changed allocation rules, thus the Faster Diagnosis work-stream will be a key priority. Clinical Oncology capacity remains a risk to performance and work is in process through the Cancer Alliance to develop alternative workforce and delivery models.

The **Referral to Treatment (RTT) Incomplete performance was reported as 86.38% for May 2019** with the total waiting list reducing by 708 patients, which is the twelfth successive reduction since April 2018 and part of a total reduction of 12,034 (35.1%) in this period. There were no patients waiting more than 52 weeks at the end of May 2019 and the same is anticipated at the end of June 2019.

# Partnership Dashboard
# 31st May 2019

**To collaborate effectively with local and regional partners**




**Vertical Integration -** The Committee noted that the Strategic Partnering Agreement (SPA), which sets out how collaboration will work in Bradford District and Craven in future, had been signed by all partners, with the exception of Bradford Council, who could not sign until after the local elections. The Committee discussed how well known the SPA was within the Trust, and the discussion concluded that knowledge of the SPA could be further embedded. The Committee was provided with an update on Community Partnerships and how these link to Primary Care Networks.

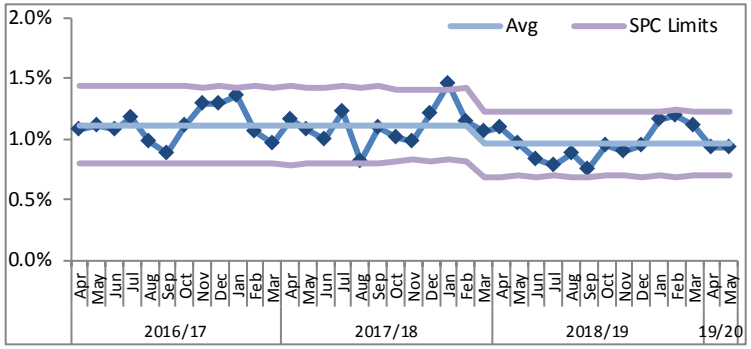
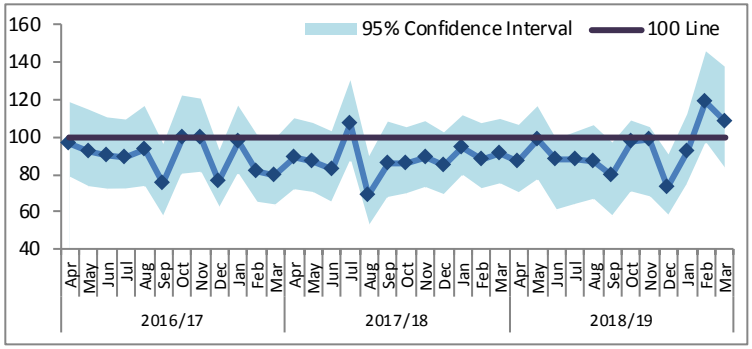
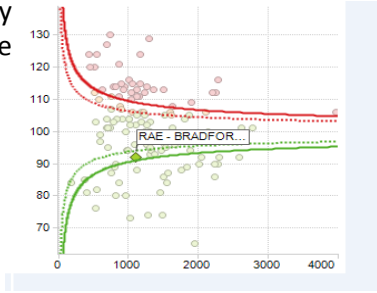
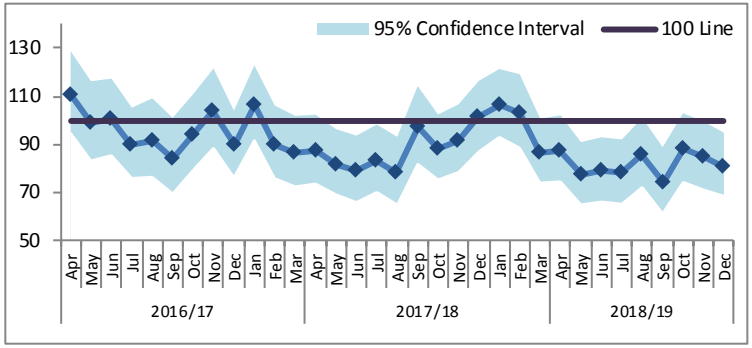
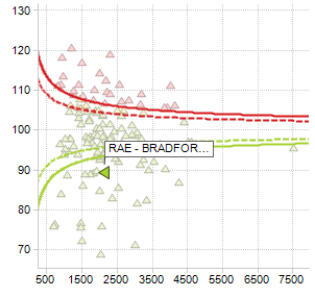
**Airedale Collaboration -** The positive progress made recently regarding the collaboration with Airedale was reviewed, noting a significantly stronger strategic alignment between the two organisations than there had been in the past. It noted that work was underway to prioritise the order specialities would addressed by clinicians and the Project Management Office, and that an initial draft of the strategy that will underpin the work would be drafted for July 2019.

**Stakeholder Engagement -** The regular 6-monthly report on stakeholder engagement was received by the Committee, including a summary of the latest self-assessments carried out by account managers. The Committee confirmed they were assured this was in line with the Clinical Services Strategy and adequately mitigates the identified risk that the Trust fails to engage key partners and misses opportunities for collaboration.

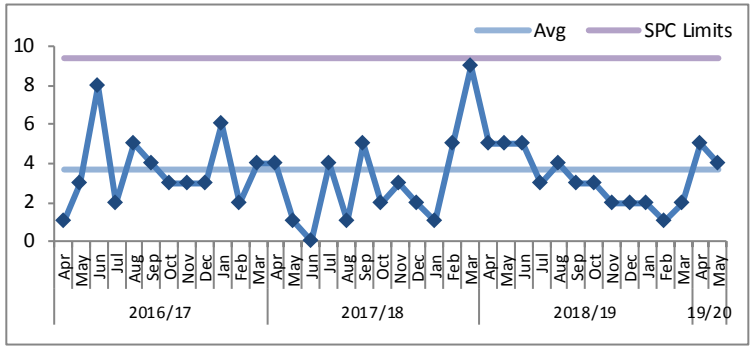
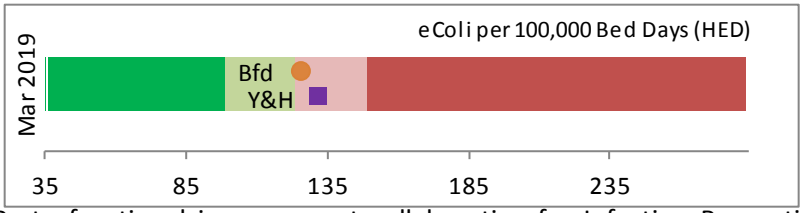
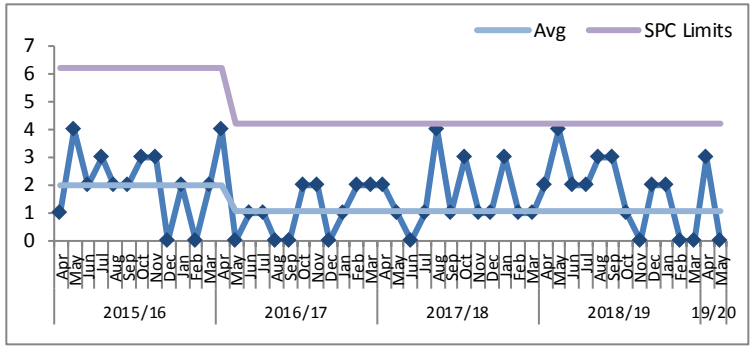
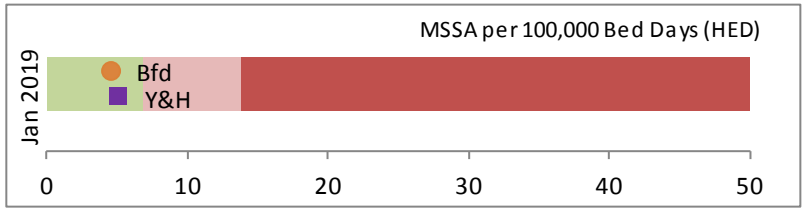
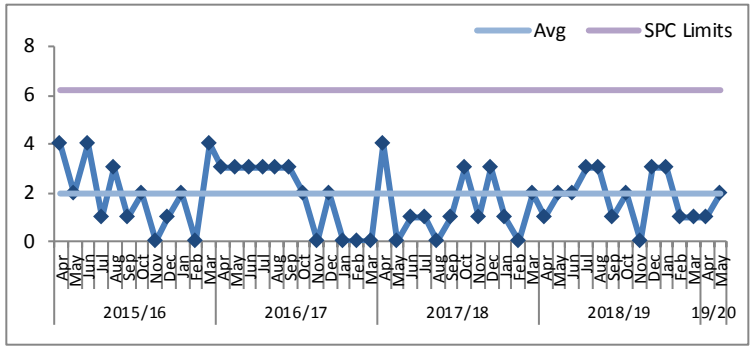
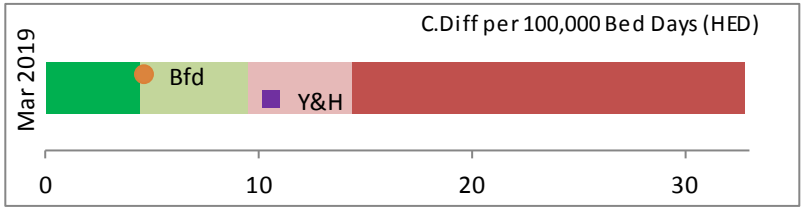
**Horizontal Integration -** The Committee noted the current operational pressures in vascular interventional radiology and the knock on effect this had had on the proposed West Yorkshire Vascular Network. The Committee was updated on the latest position regarding a revised capital bid to access capital funding for a hybrid theatre, to support the establishment as Bradford Royal Infirmary as an arterial centre. The Committee noted the latest position on the WYAAT and Health and Care Partnership programmes and the progress being made to create the new ICS 5 year strategy in response to the requirements set out in the NHS long term plan.

# Appendix

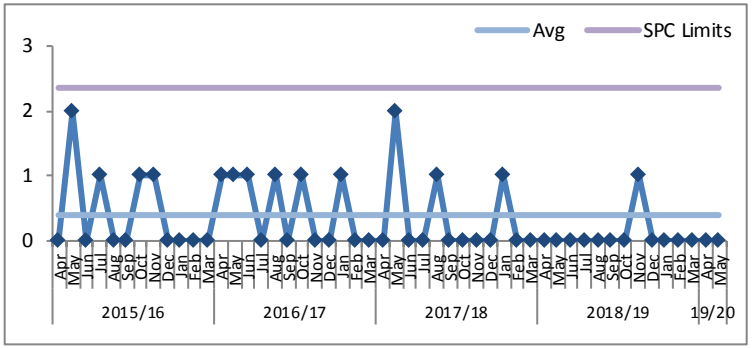
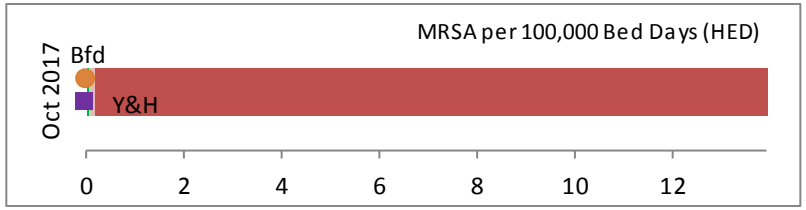
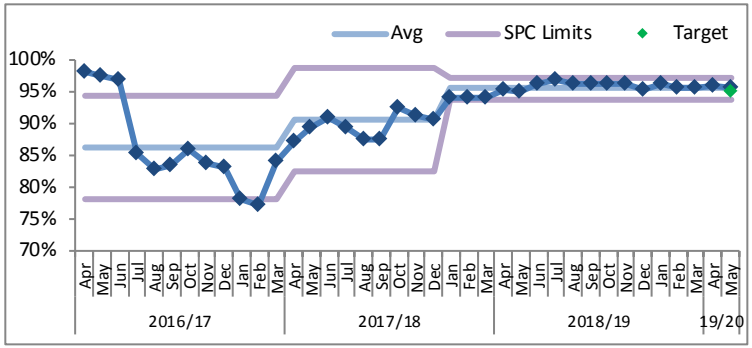
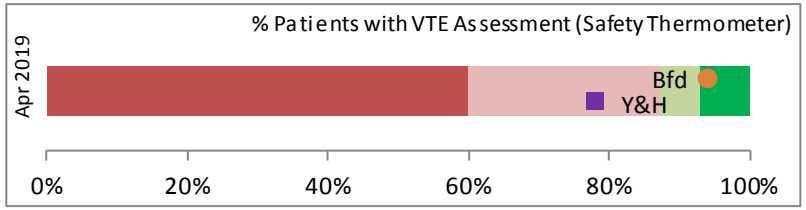
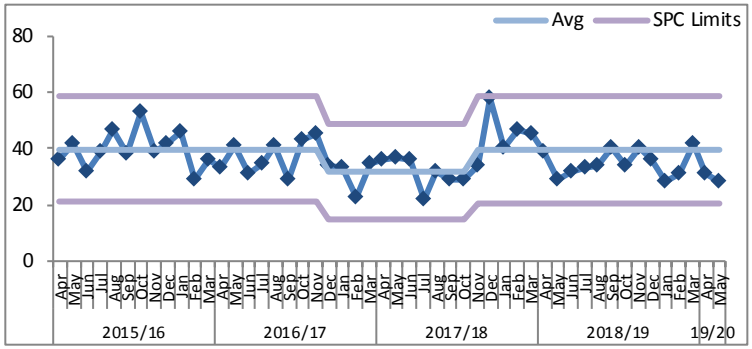
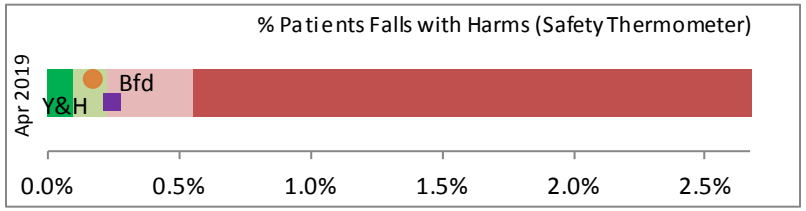
# To provide outstanding care for patients

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Crude Mortality |  | Crude death rate has remained constant throughout the last eighteen months, with expected seasonal variation. There is no regional or national benchmarking data for this measure. Improving learning from mortality is now delivered though the 'learning from deaths' process. Reporting on progress to the Quality Committee is via the quarterly learning from deaths report. | | Chief Medical Officer |
| Hospital Standardised Mortality Ratio |  | Our Hospital Standardised Mortality Ratio (HSMR) continues to demonstrate a 'better than expected' rate. |  Apr 2018 - Mar 2019 | Chief Medical Officer |
| Summary Hospital-level Mortality Indicator |  | The Summary Hospital-level Mortality Indicator (SHMI) continues to demonstrate a 'better than expected' rate. |  Jan 2018 - Dec 2018 | Chief Medical Officer |

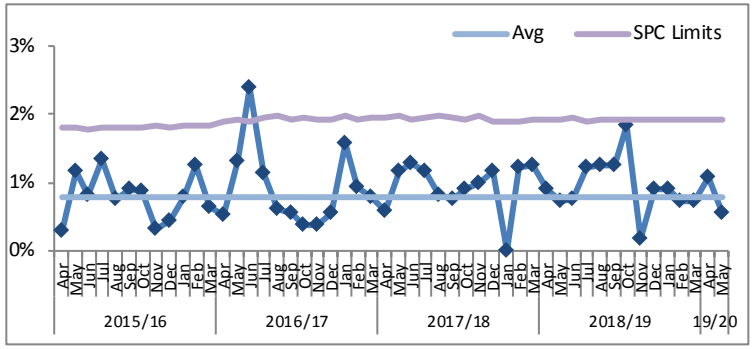
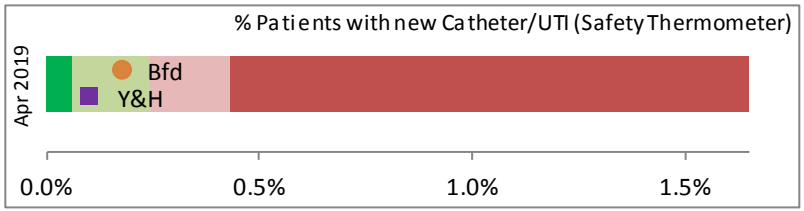
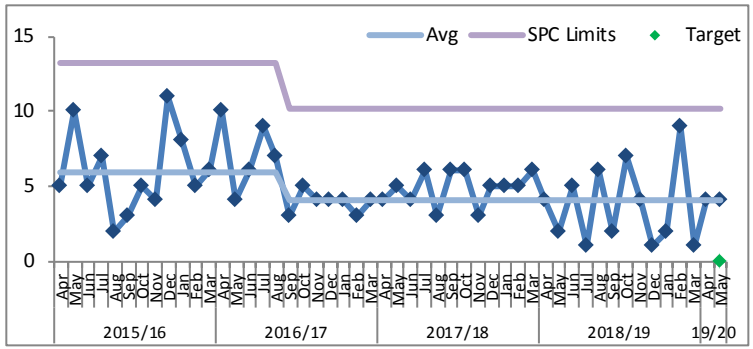
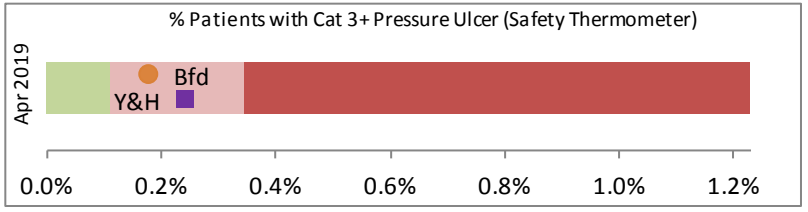
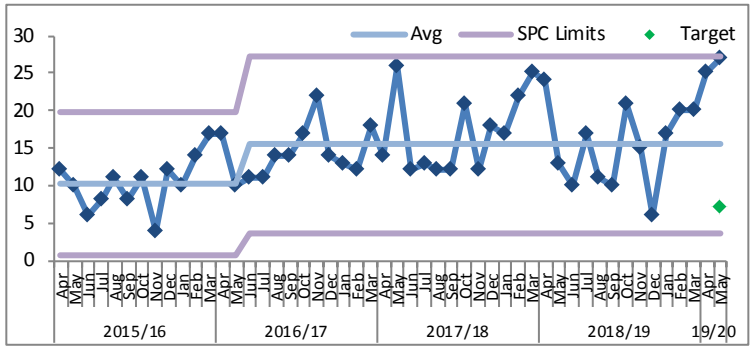
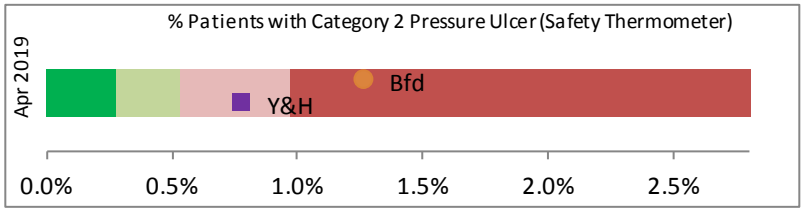
# To provide outstanding care for patients

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| eColi |  | As part of the 2018/19 work plan we will focussing on all bacteraemias. We have seen a reduction of 26% on the previous 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 |
| MSSA |  | Part of national improvement collaborative for Infection Prevention and Control (IPC). Ongoing improvements are overseen by Infection Prevention and Control and reviewed on a quarterly basis. |  | Chief Nurse |
| C. Difficile |  | Continues as per previous years, and is within expected range. It must be noted that the Clostridium difficile (C. diff) objective has been changed for 2019/20, this will result in additional cases being included in the data, Infection Control Committee will be advising on the improvement trajectory following review of the criteria. |  | Chief Nurse |

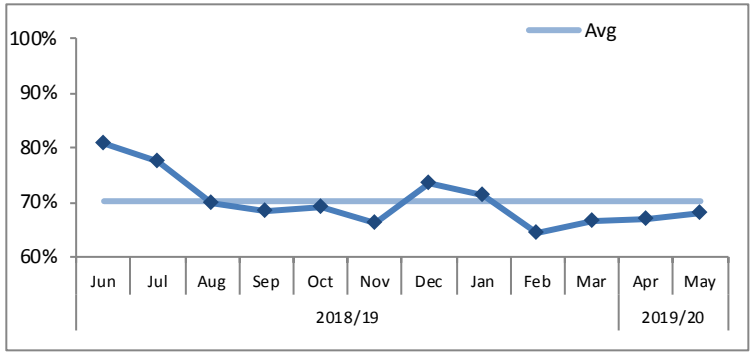
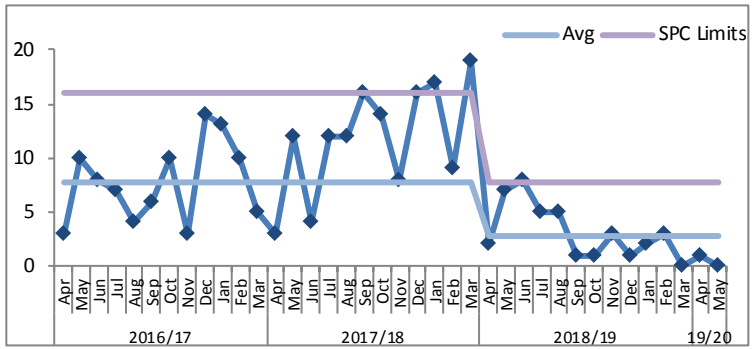
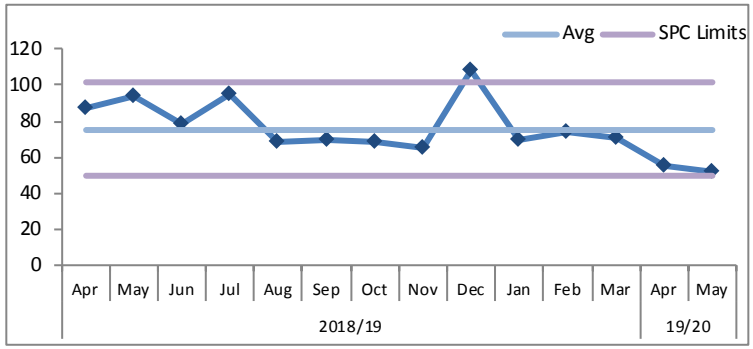
# To provide outstanding care for patients

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| MRSA |  | One case in November 2018, no deficits in care. |  | Chief Nurse |
| VTE Assessment |  | The Venous Thromboembolism (VTE) assessment shows sustained compliance with the standard. |  | Chief Medical Officer |
| Falls with Harm |  | Falls remain on an improved trajectory. |  | Chief Nurse |

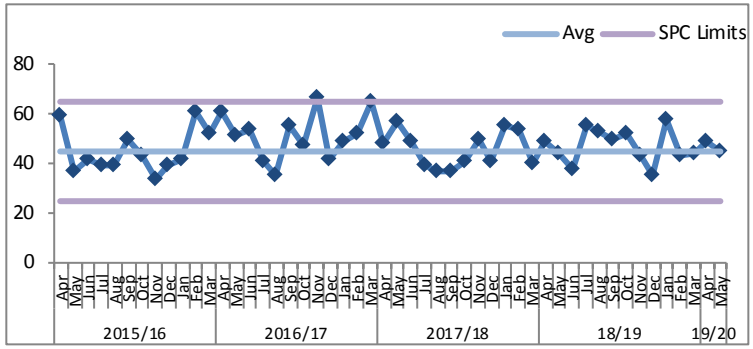
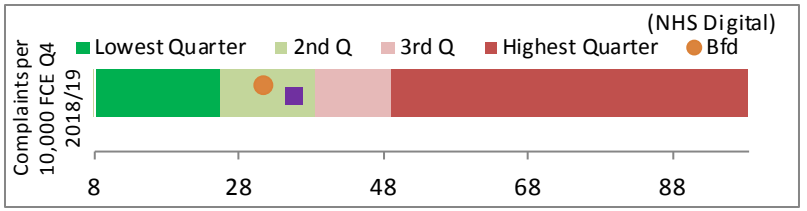
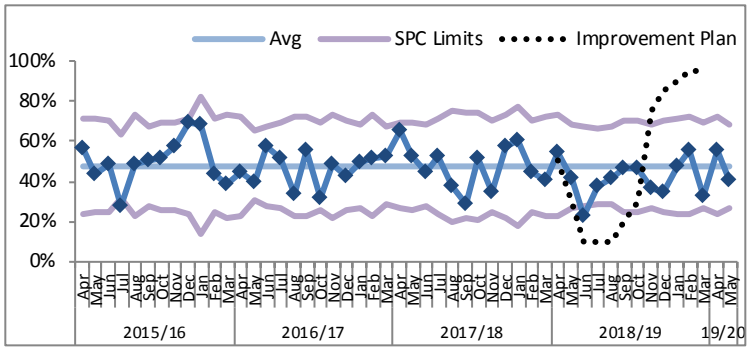
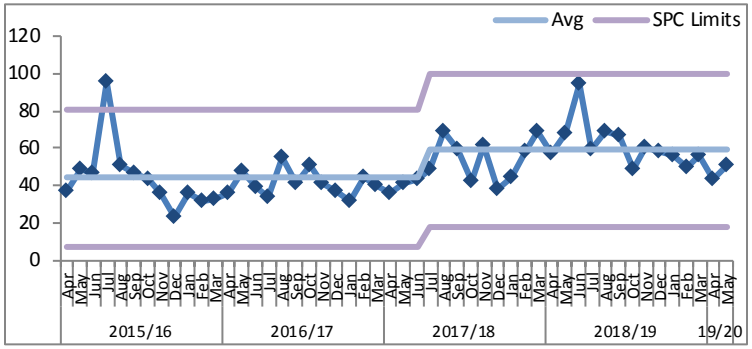
# To provide outstanding care for patients

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Catheters & UTIs |  | The Infection Control team is reviewing the data submission relating to Catheters and Urinary Tract Infections (CAUTI), including a review of the indicator. Further detail is included within the Infection Control report. |  | Chief Nurse |
| Pressure Ulcers Cat 3+ |  | 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 |
| Pressure Ulcers Cat 2 |  | All systems relating to pressure ulcers have been reviewed in line with the revised NHS England Guidance. |  | Chief Nurse |

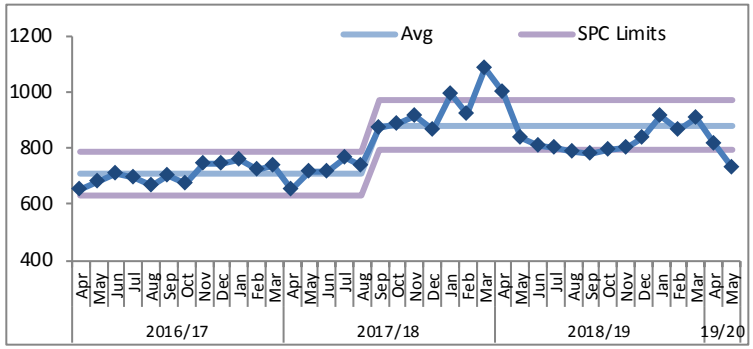
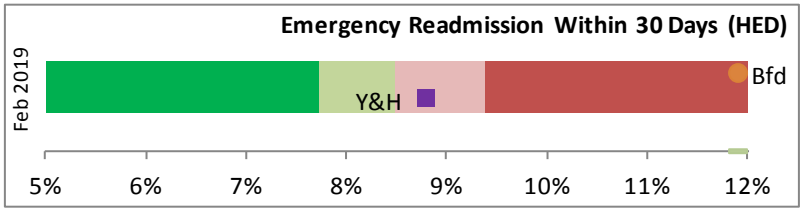
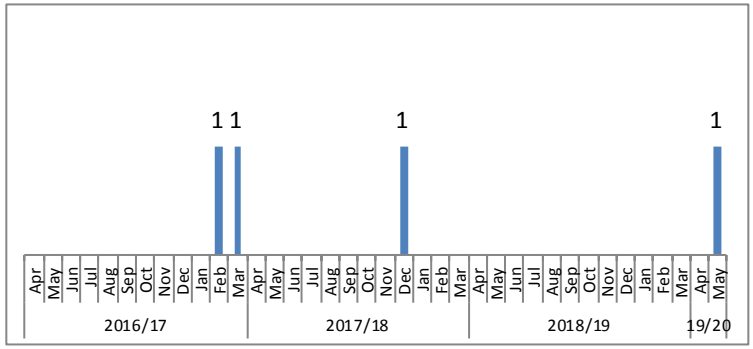
# To provide outstanding care for patients

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Sepsis patients receive antibiotics within an hour |  | This is a new indicator being tracked as part of the Sepsis Commissioning for Quality and Innovation (CQUIN). A Sepsis improvement work stream has been established led by the Nurse Consultant for Infection Prevention and Control, and an improvement programme is being developed as part of this work stream. We have introduced (November 2018/19) the capability to measure on a weekly basis to enable targeted intervention. | | Chief Nurse |
| Night-time Transfers |  | There were no night time transfers in May 2019. | | Chief Operating Officer |
| Night-time Discharges |  | This new (development) metric is starting to look at appropriate timing of discharge for our patients. This is early data and further work will now take place to understand the circumstances around these discharges. | | Chief Nurse |

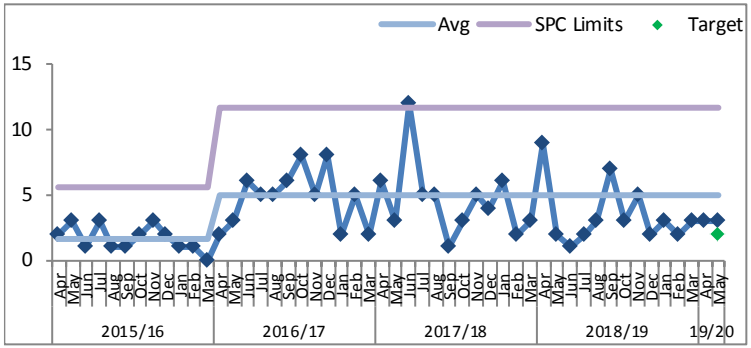
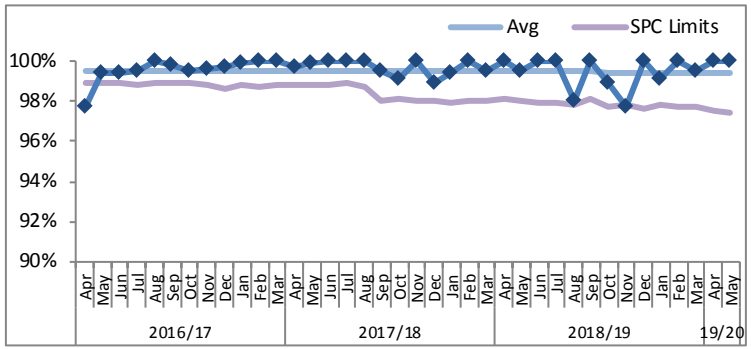
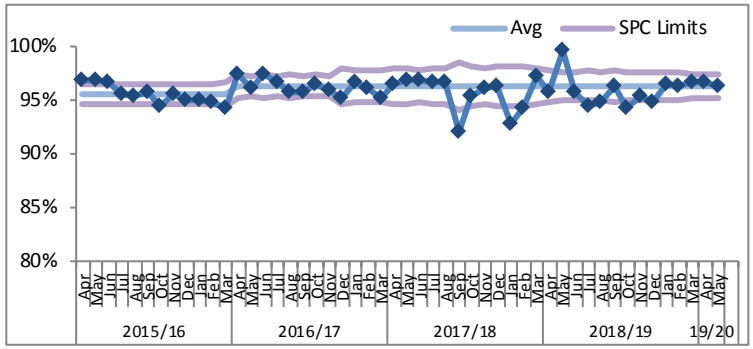
# To provide outstanding care for patients

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Complaints |  | The trajectories are now beyond the improvement period set and need to be revised as part of the 2019/20 metrics. Proposal due from Patient first Committee following analysis of Q4 2018/19. |  | Chief Nurse |
| Complaints Closed |  | The trajectories are now beyond the improvement period set and need to be revised as part of the 2019/20 metrics. Proposal due from Patient first Committee following analysis of Q4 2018/19. | | Chief Nurse |
| Complaints Working Days Turnaround Time |  | The trajectories are now beyond the improvement period set and need to be revised as part of the 2019/20 metrics. Proposal due from Patient first Committee following analysis of Q4 2018/19. | | Chief Nurse |

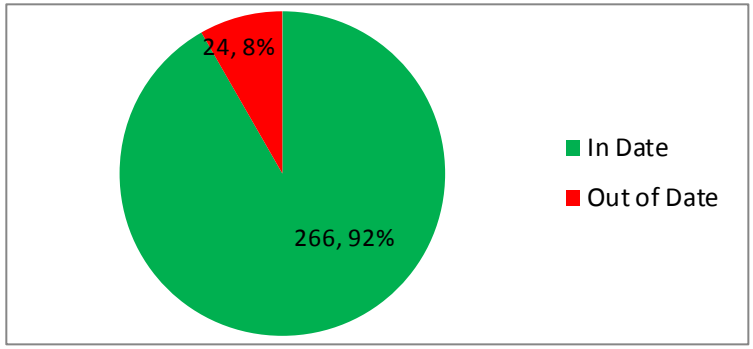
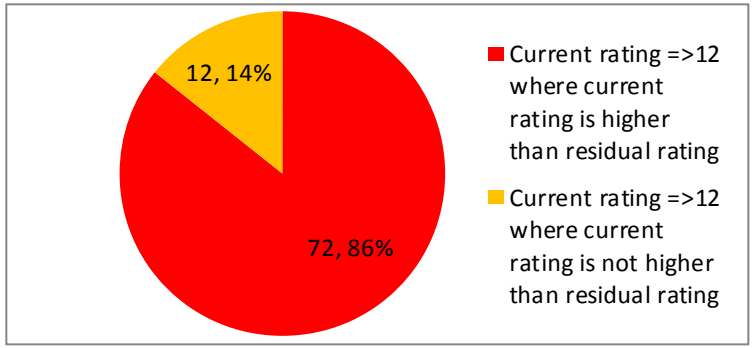
# To provide outstanding care for patients

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Readmissions |  | The readmissions information has been amended in line with an agreed change to internal reporting. The trend shows growth post EPR as previously reported and then a period of stable performance. This needs to be validated but there are no known areas of concern.<br>  | | Chief Operating Officer |
| Information Governance Breaches |  | The Trust has reported an information governance breach to the Information Commissioner's Office. An investigation is underway. | No comparator data is published. | Chief Digital and Information Officer |

# To provide outstanding care for patients

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Serious Incidents |  | 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 |
| Audit of WHO Checklist |  | 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 |
| Friends and Family Test |  | The Friends and Family Test (FFT) has recovered back to normal baseline after a drop in September 2017/18. Further detailed work to improve number of returns has started. | | Chief Nurse |

# To be a continually learning organisation

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Out of date Policies |  | 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. | | Director of Strategy and Integration |
| Risks not Mitigated |  | 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. | | Director of Strategy and Integration |

# To be a continually learning organisation

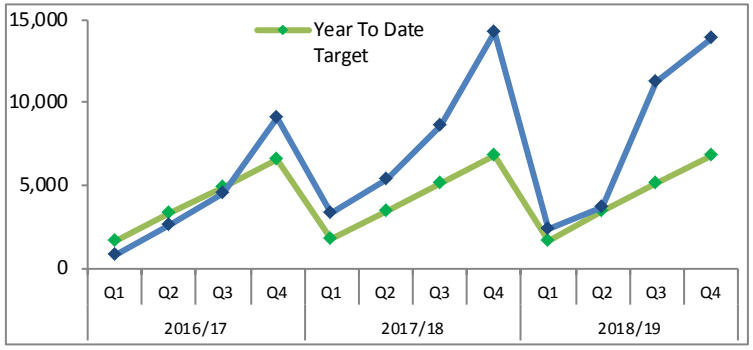
| Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|

**Learning Hub**

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 Q1 2019/20.

Director of Strategy and Integration

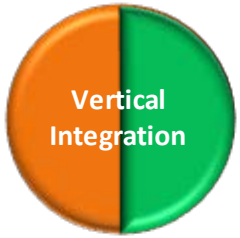
**Research Patients Recruited**



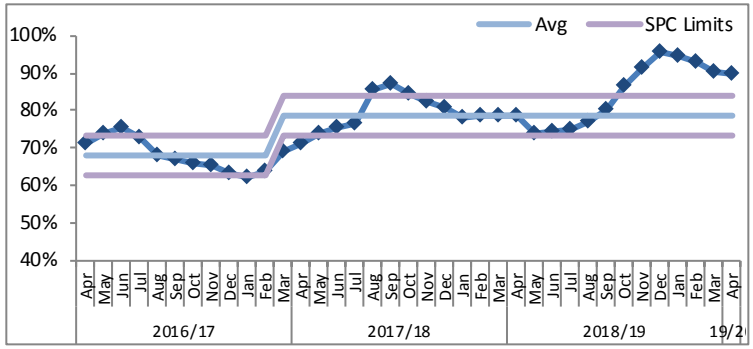
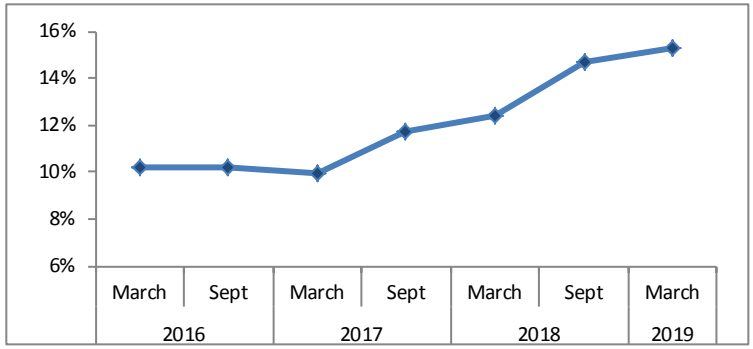
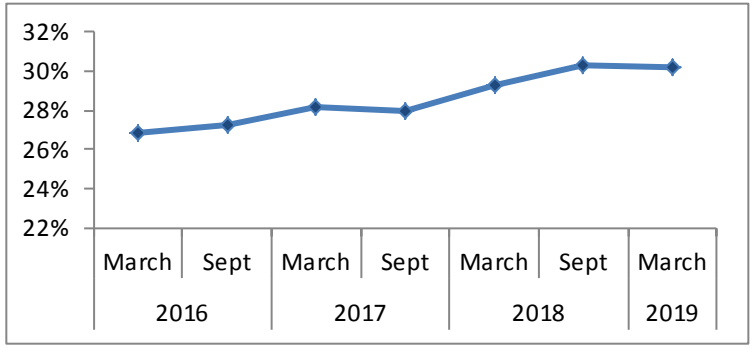

Number of participants recruited to National Institute of Health Research Portfolio Studies since 2015/16, including commercial and non-commercial studies, remains strong and in line with expectations.

Chief Medical Officer

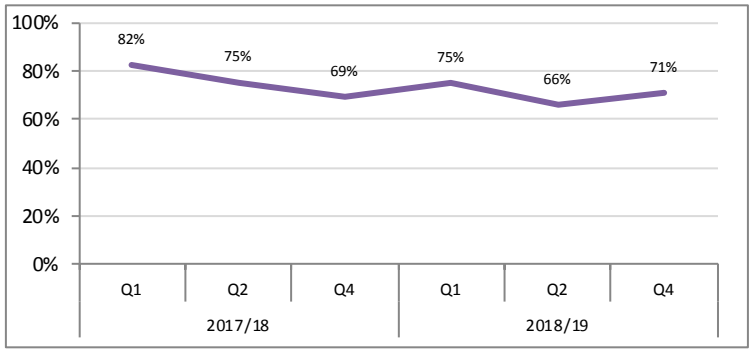
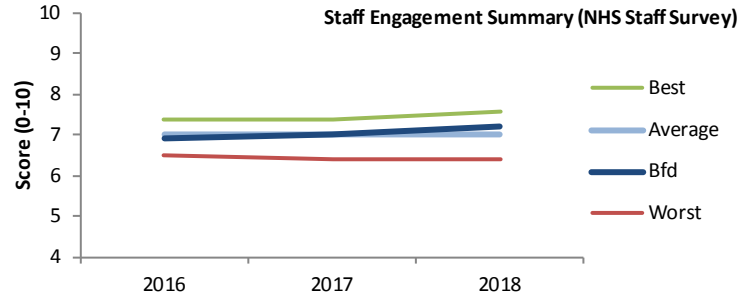
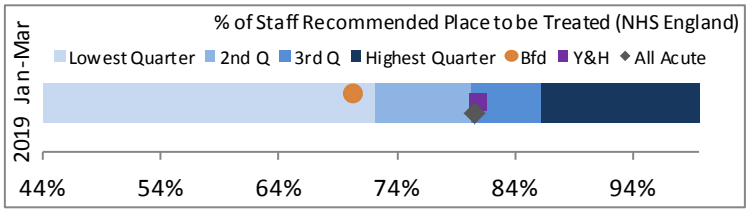
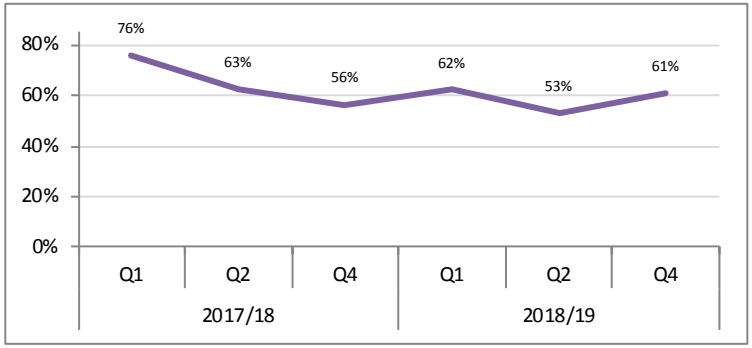
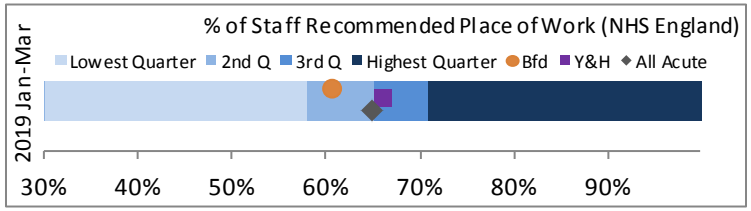
# To collaborate effectively with local and regional partners

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
|   | 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 date, a total of 52 stakeholders have now been self-assessed by account managers. An update on progress was provided to May 2019's Partnerships Committee. | | | Director of Strategy & 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. The Trust is working with its fellow providers in Bradford to work together to develop models of care which best meet the needs of service users and patients. The Trust signed a 'Strategic Partnering Agreement', drafted by the partners in Bradford District and Craven (BDC) at the end of March 2019, and this has been approved by all partners. This sets out how decisions and collaboration will happen at 'place' in the future. A review of the health and care based programmes in BDC is underway. The configuration of Community Partnerships in Bradford has changed as a result of the creation of Primary Care Networks (PCNs). The Trust is working through how to respond to these changes and how to influence the PCNs. | | | Director of Strategy & 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. The Trust is working with its partner organisations in formal governance arrangements and programmes in the West Yorkshire Association of Acute Trusts (WYAAT) the West Yorkshire and Harrogate Health and Care Partnership (WYHCP) Integrated Care System, with Trust executives involved in multiple fora examining both strategic and operational collaboration issues. Recently, the Trust has worked with partners in WYAAT to agree on the future configuration of vascular services in across West Yorkshire, and to manage the service pressures in interventional radiology. | | | Director of Strategy & Integration |
|   | The Airedale Collaboration programme between BTHFT and Airedale NHS Foundation Trust (ANHSFT), formally started with a clinical summit on 8th April 2019. Workshops have been held in some specialties, and the programme governance, incorporating a Strategic Collaboration Board and Steering Group have been established to monitor and oversee the progress of the work. Clinical leads for a small number of specialties, and for the programme as a whole, are largely recruited to. The prioritisation for the programme has been completed and the specialties have been divided into those that will be covered in the first year and those that will be covered in the second year of the programme. It is proposed that it is assessed an whether easily understandable hard metric can be developed to provide the RAG rating for this item. | | | Director of Strategy & Integration |

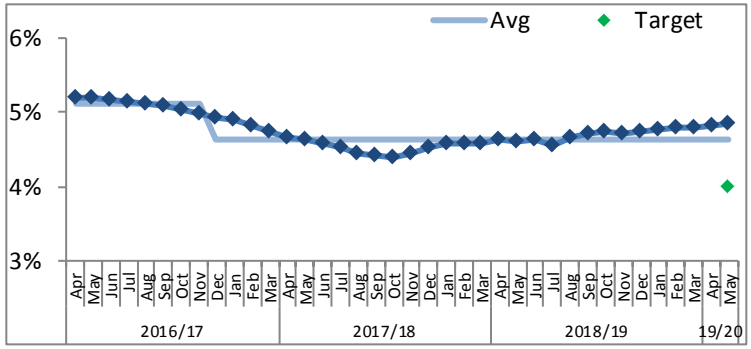
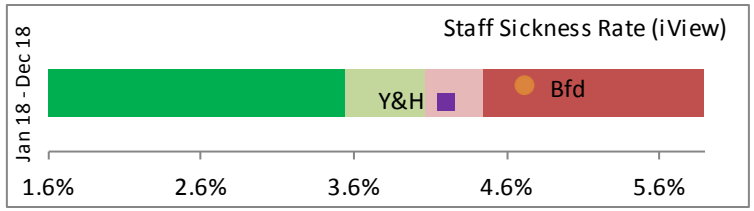
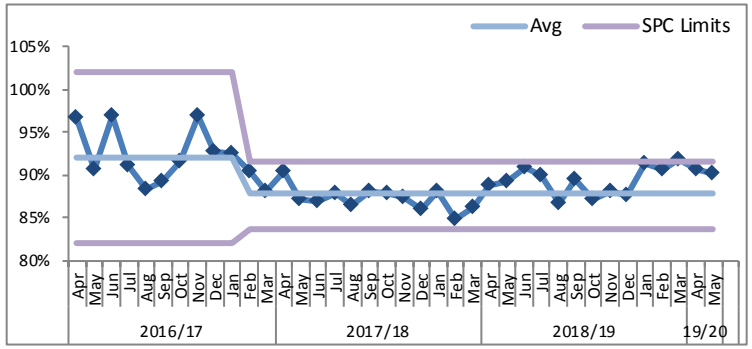
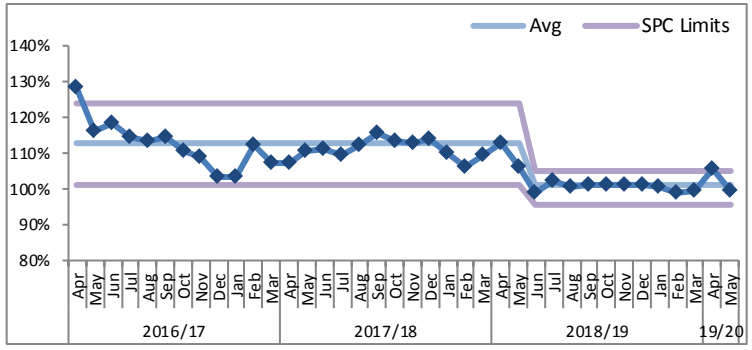
# To be in the top 20% of employers in the NHS

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Appraisal Rate Non-Medical |  | Senior Leadership Team (SLT) to consider if appraisal season is still the best approach. The focus now is making sure all overdue appraisals from 2018/19 are completed so at 31 March 2019 all eligible staff have had an effective appraisal. Planning for the appraisal season is underway, which will include briefings; further development for managers and appraisee guidance. | | Director of Human Resources |
| BAME % Senior Leaders |  | We have increased in the number of Black, Asian, Minority and Ethnic (BAME) staff at bands 8 and 9 over the past six months. However, based on the current trajectory, we would miss our employment target to have a senior workforce reflective of the local population by 2025 by around 9%. This has reduced from 10%. 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 October 2019 (for period ending 31 September 2019). | | Director of Human Resources |
| BAME % Workforce |  | Good progress is being made. We are about 4% ahead of our trajectory to have a workforce reflective of the local ethnic population by 2025. Next update October 2019 (for period ending 31 September 2019). | | Director of Human Resources |

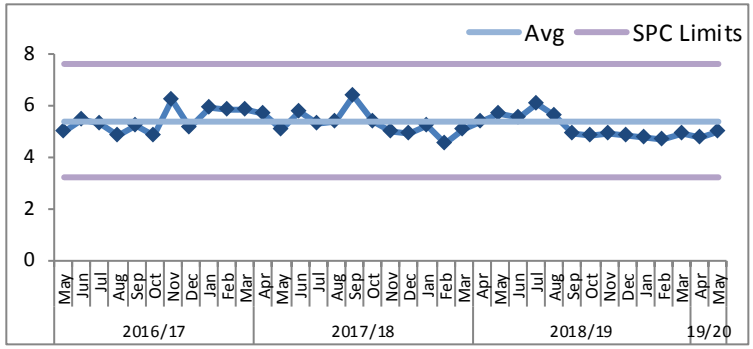
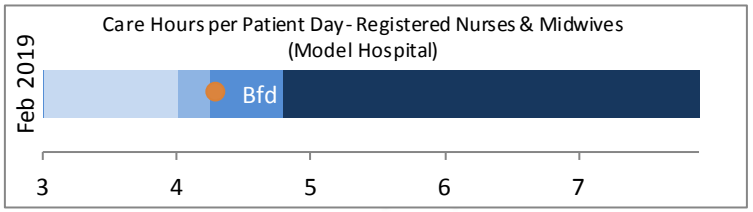
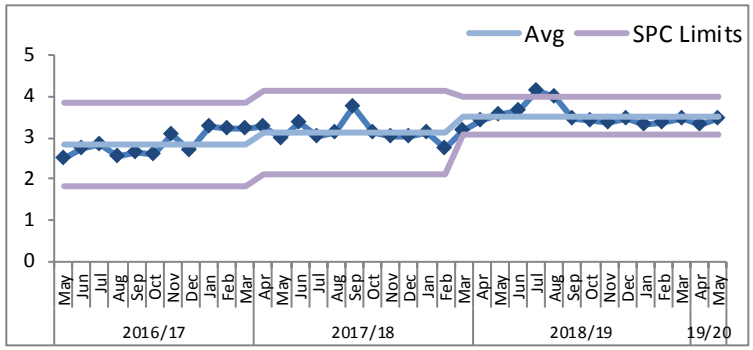
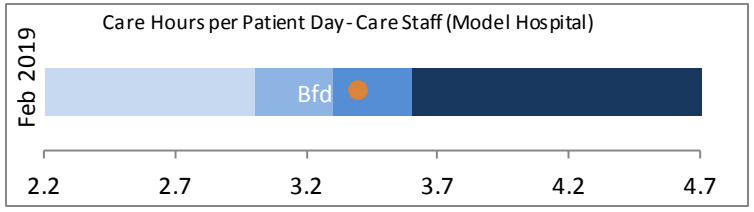
# To be in the top 20% of employers in the NHS

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Staff FFT Treatment |   | Despite improvement in our results in Q4 2018/19 we are still benchmarking lower than other Trusts in Yorkshire and Humber. The national results for the Staff Friends and Family Test (SFFT) will be available on 30 May 2019. Our results 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 2018/19 test and 68% in the NHS Staff Survey 2018. Planning is underway for the Q1 2019/20 SFFT, is currently open to 30 June 2019.  | Director of Human Resources |
| Staff FFT Work |  | Despite improvement in our results in Q4 2018/19 we are still benchmarking lower than other Trusts in Yorkshire and Humber. The national results for the Staff Friends and Family Test (SFFT) will be available on 30 May 2019. Our results for Q4 2018/19 show 61% of staff would recommend us as a place to work compared to 53% in the Q2 2018/19 test and 64.6% in the NHS Staff Survey 2018. Planning is underway for the Q1 2019/20 SFFT, is currently open to 30 June 2019.  | Director of Human Resources |

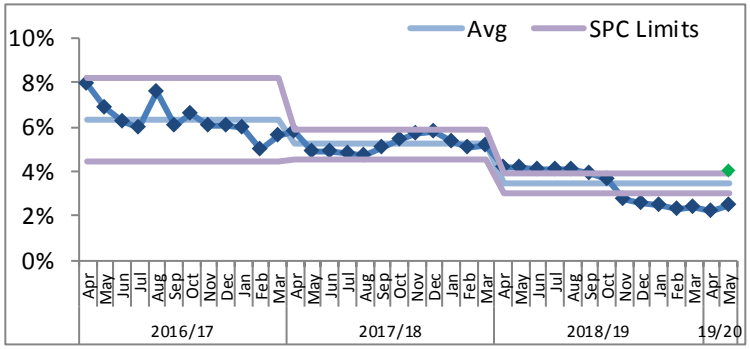
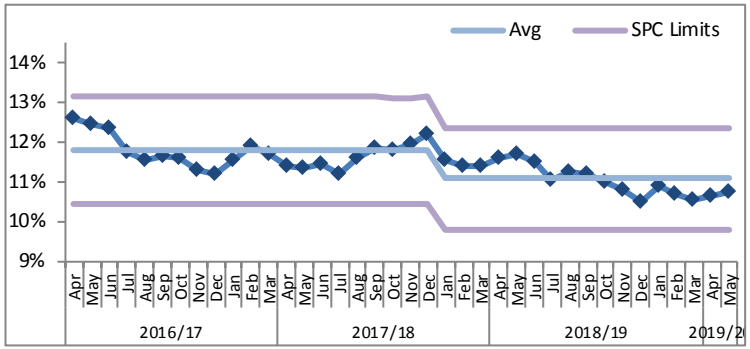
# To be in the top 20% of employers in the NHS

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Sickness |  | The rolling 12 month sickness absence rate at the end of May 2019 is 4.84%. There have been slight increases in Unplanned Care, Pharmacy and Estates and Facilities with reductions seen in the other Care Groups and corporate departments. The Trust target has been set at 4.5% which we will be monitoring Care Groups and corporate departments against.  | | Director of Human Resources |
| Nursing Shifts Filled |  | Fill rates for Registered Nurses remains relatively stable around 90%. See Nurse staffing report for more details. | | Chief Nurse |
| Care Staff Shifts Filled |  | Fill rates are now consistently 100% and are as expected. | | Chief Nurse |

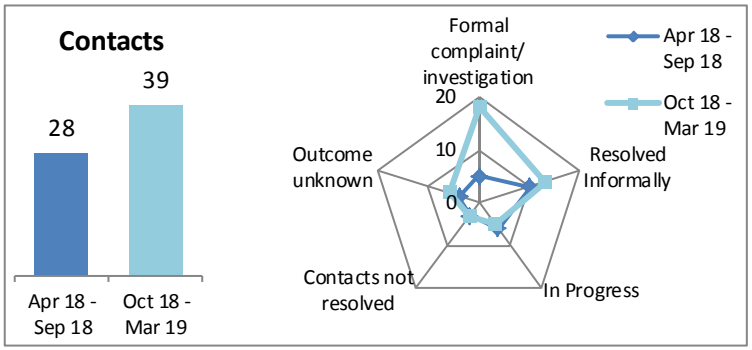
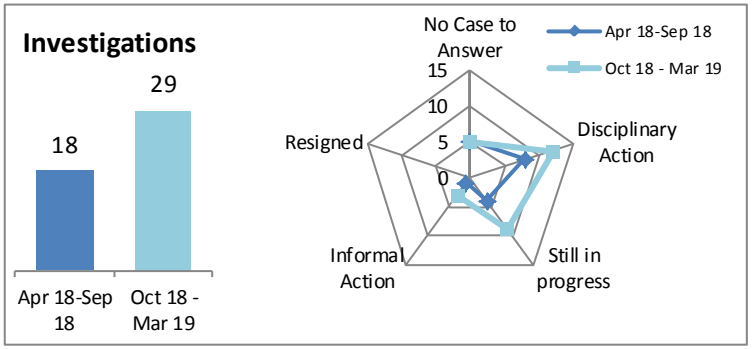
# To be in the top 20% of employers in the NHS

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Nursing Care Hours |  | Rate remains stable and benchmarks appropriately with model hospital data. |  | Chief Nurse |
| Care Staff Care Hours |  | The carer workforce has stabilised in line with our workforce plans, benchmarks appropriately with model hospital data. |  | Chief Nurse |

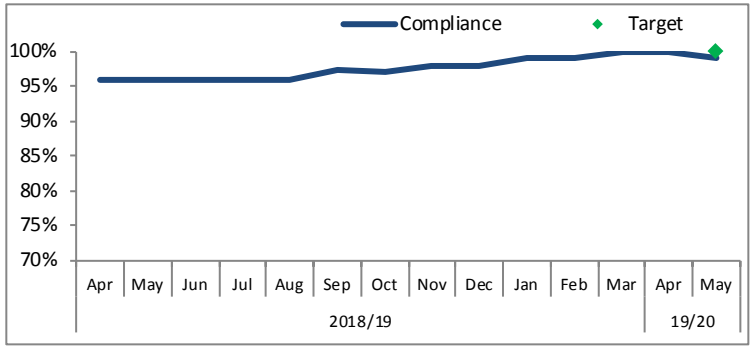
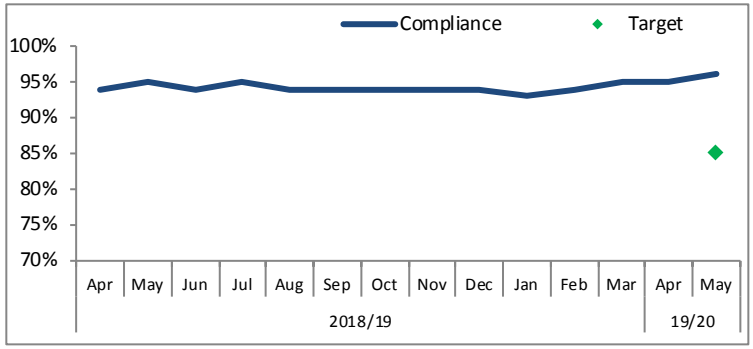
# To be in the top 20% of employers in the NHS

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Agency % of FTE |  | There has been a slight increase in agency qualified Nurse use in the last 2 months. Administrative and Clerical use has reduced to just 6 whole time equivalent (WTE). Medical and Dental has reduced slightly due to the end of additional Consultants brought in due to Referral to Treatment (RTT) recovery plans by the end of March. Agency Allied Health Professional (AHP's) use has remained static across the reporting period. Healthcare Assistants (HCA's) agency use has ceased, unless in exceptional patient safety circumstances. | | Director of Human Resources |
| Turnover |  | Turnover has increased slightly at Trust level in May 2019 to 10.73% from 10.63% in April 2019. Reductions in turnover were in the Planned Care Group and Research. Other areas saw slight increases from last month. Turnover is still low compared to historical levels in the Trust. | | Director of Human Resources |

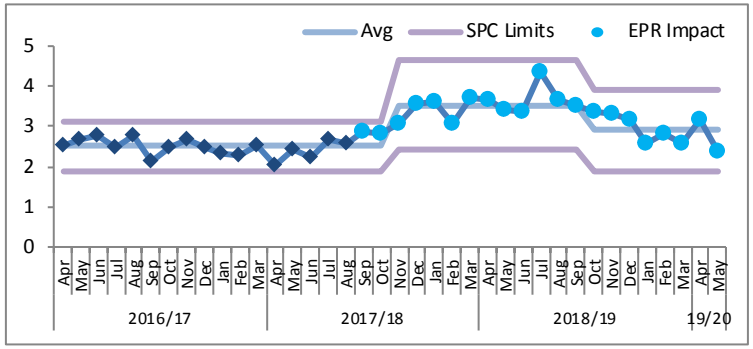
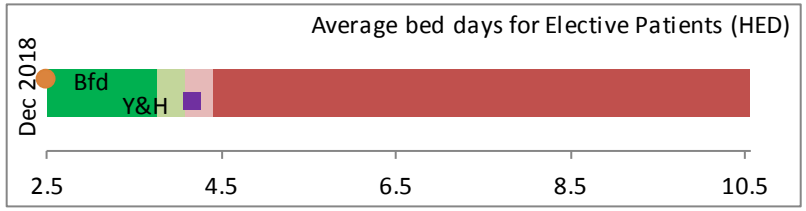
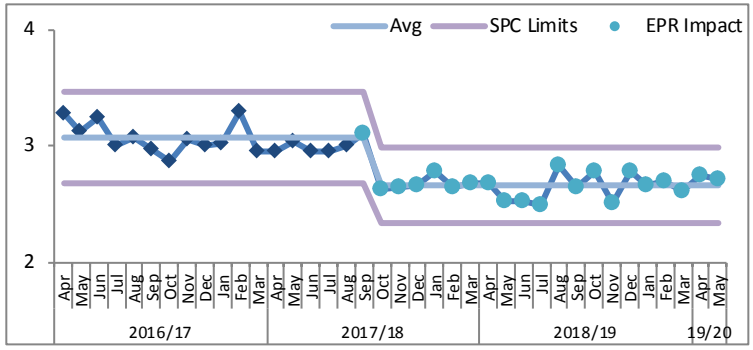
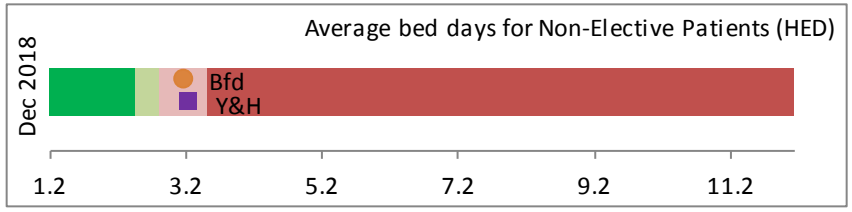
# To be in the top 20% of employers in the NHS

| | 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 |

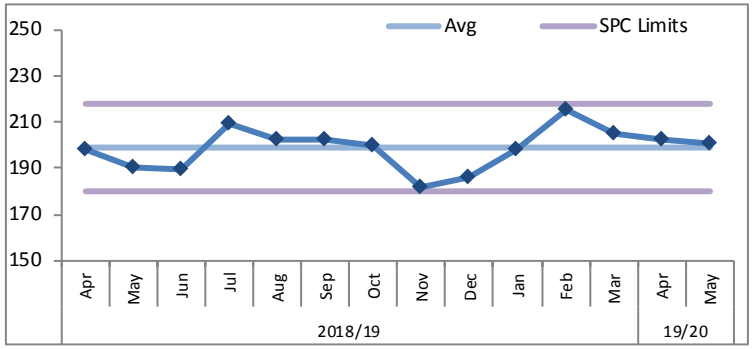
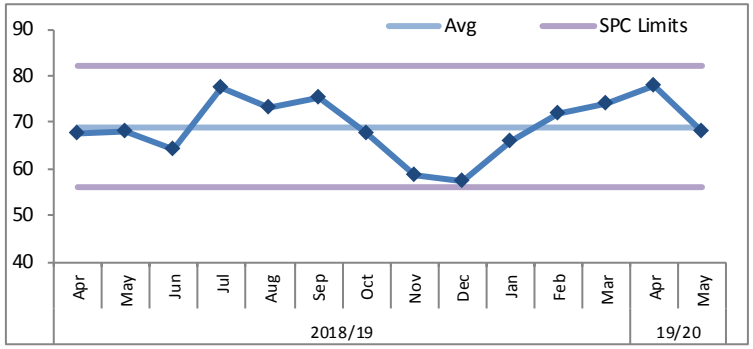
# To be in the top 20% of employers in the NHS

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
|  |  | The data demonstrates consistent performance over 98%. There is a comprehensive escalation process in place to track delivery of performance at an individual level. | Comparator data not available. | Chief Medical Officer |
|  |  | 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. | Comparator data not available. | Chief Medical Officer |

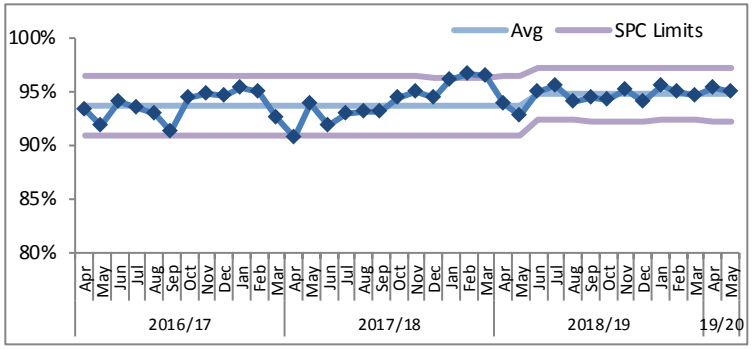
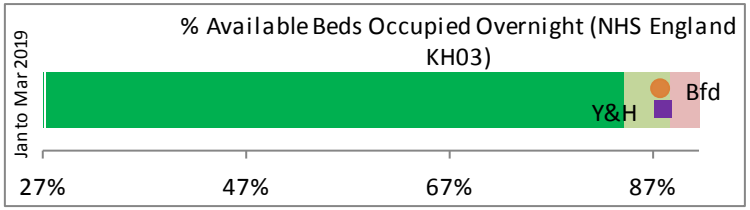
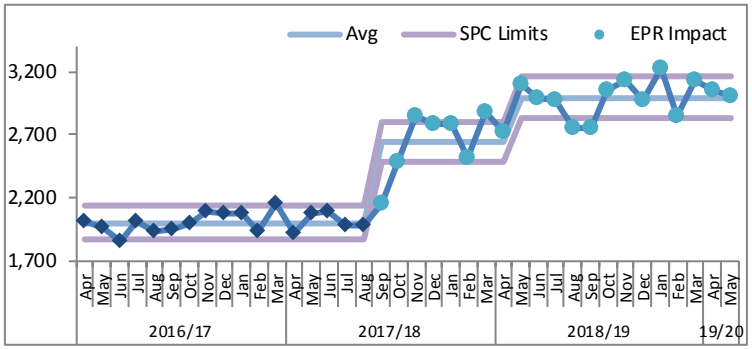
# To deliver our financial plan and key performance targets

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Length of Stay Elective |  | Average length of stay is within confidence intervals and benchmarks positively against the national average and the Yorkshire and Humber region. |  | Chief Operating Officer |
| Length of Stay Non-Elective & Assessments |  | Average length of stay is within confidence intervals and benchmarks positively against the national average and the Yorkshire and Humber region. |  | Chief Operating Officer |

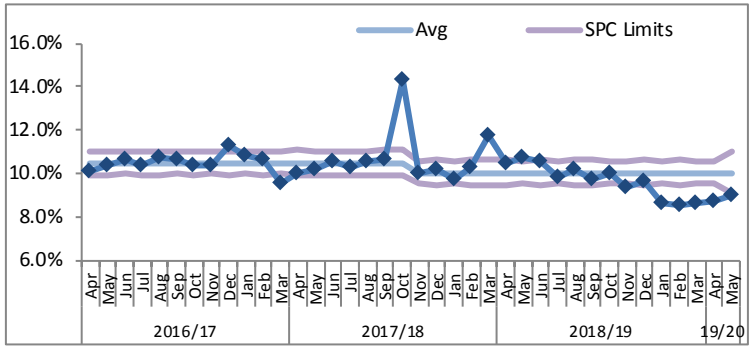
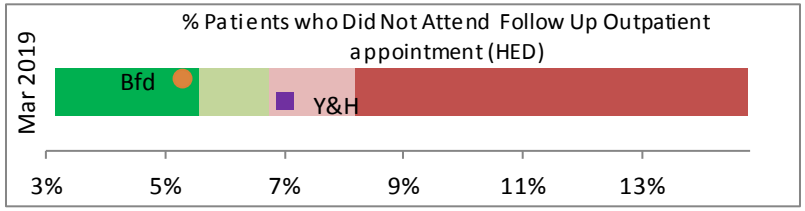
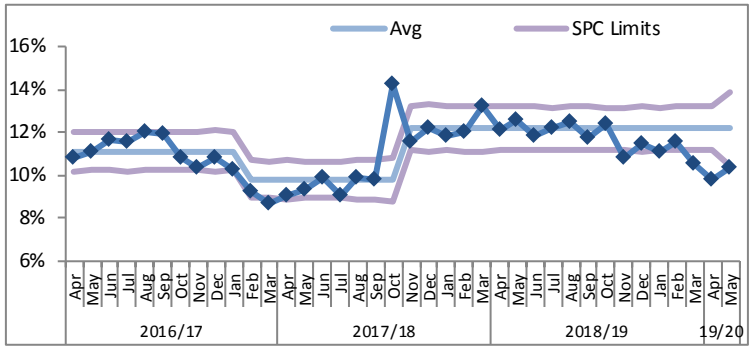
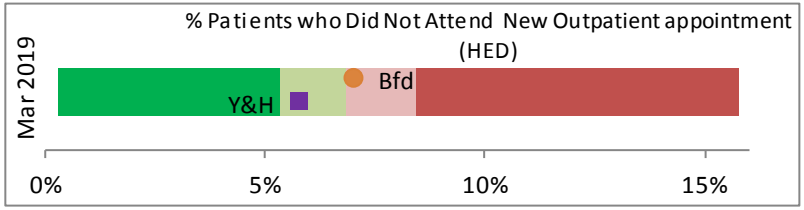
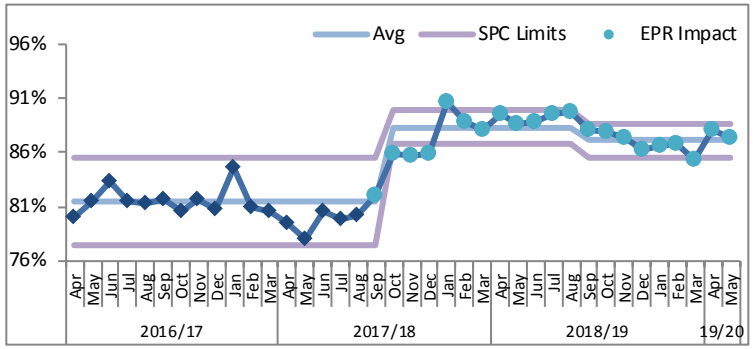
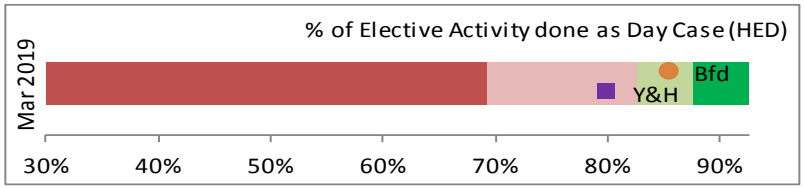
# To deliver our financial plan and key performance targets

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Stranded Patients Length of Stay >= 7 days |  | Weekly multi-disciplinary reviews have included all patients with a length of stay over 14 days which has helped reduce the number of patients with a length of stay greater than 7 days during May 2019. | | Chief Operating Officer |
| Super Stranded Patients Length of Stay >= 21 days |  | Performance deteriorated during April 2019 but was significantly better during May 2019. There remains a twice weekly review of stranded patients, including a weekly multi-disciplinary review of patients with a length of stay over 14 days. The Emergency Care Intensive Support Team (ECIST) reporting tool is being used and the improvement plan for 2019/20 includes improved use of Estimated Discharge Date (EDD), a revised frailty pathway, and further enhancements to Early Supported Discharge. Weekly reporting to NHS Improvement will be in place from July 2019. | | Chief Operating Officer |

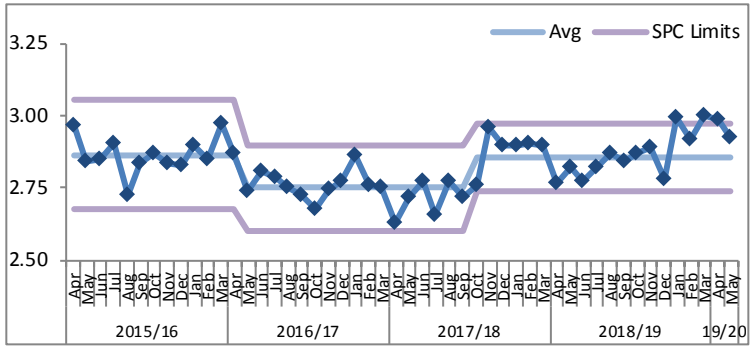
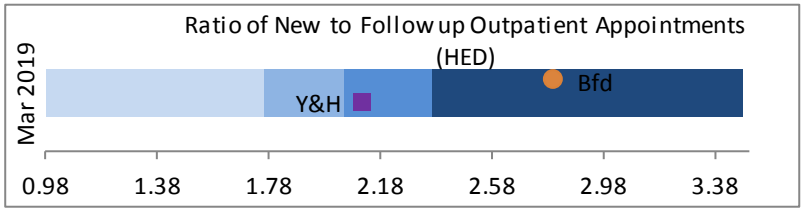
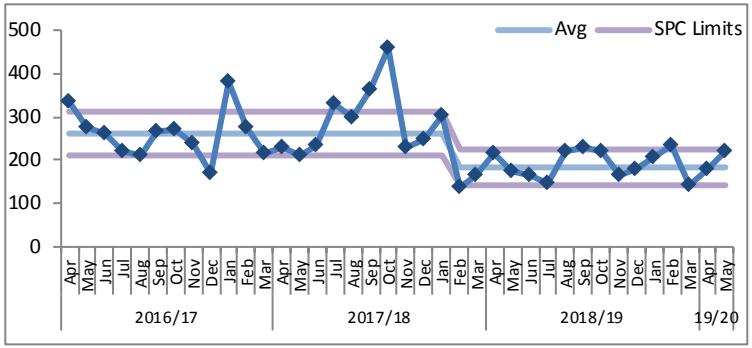
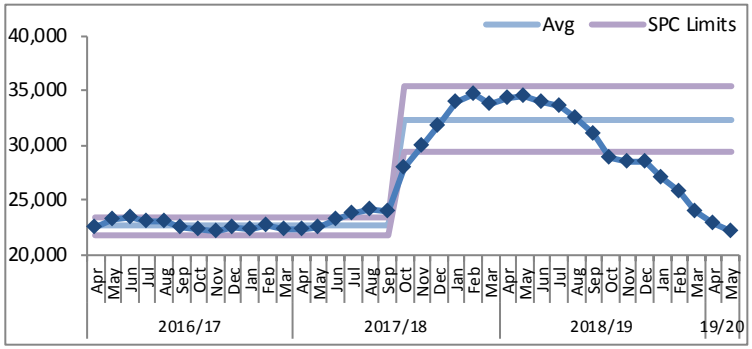
# To deliver our financial plan and key performance targets

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Bed Occupancy |  | Bed occupancy continues close to the average. The Trust is involved in the national SAFER collaborative and there are a number of actions within the Emergency Care Improvement Plan which will reduce admissions, improve timely discharges and support reduced bed occupancy. |  | Chief Operating Officer |
| Discharges before 1PM |  | Discharge targets by ward have been implemented with a daily review in place. The total number of discharges before 1pm remained high in May 2019. | | Chief Operating Officer |

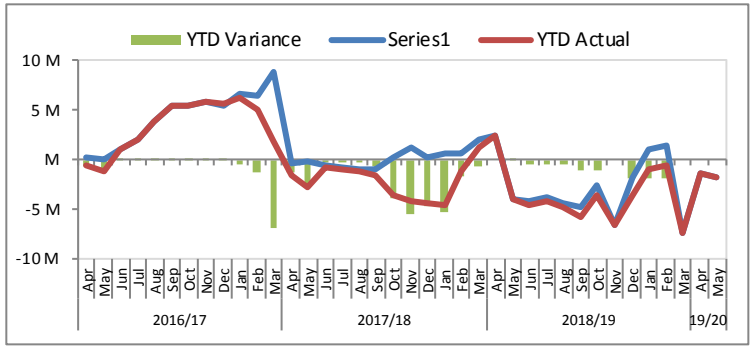
# To deliver our financial plan and key performance targets

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Did not Attend Follow-Ups |  | DNA rates have improved during 2018/19. |  | Chief Operating Officer |
| Did not Attend New |  | DNA rates have improved during 2018/19 following an increase post EPR. |  | Chief Operating Officer |
| Elective Day Case Rate |  | Day case rates continue to be above the national and regional average. |  | Chief Operating Officer |

# To deliver our financial plan and key performance targets

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| New to Follow-up Ratio |  | Follow up activity reduced slightly in May 2019. Reducing this ratio is a key part of the 2019/20 improvement programme for both the Trust and the system.  | | Chief Operating Officer |
| Short notice Clinic Cancellations |  | The number of short notice clinic cancellations remain within control limits. A review by specialty is planned for the June 2019 performance review meetings. | | Chief Operating Officer |
| Elective Wait List |  | The total waiting list size reduced for the 12th consecutive month in May 2019. | | Chief Operating Officer |

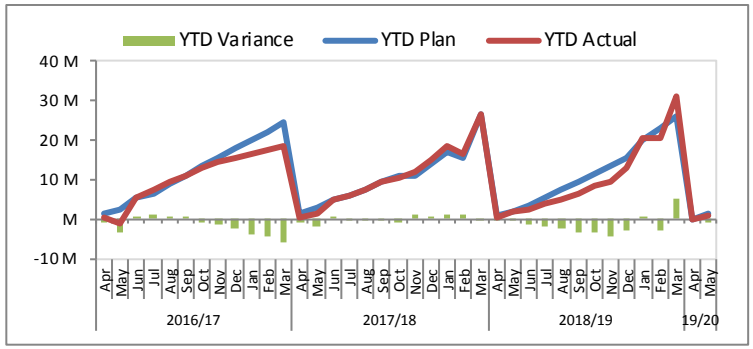
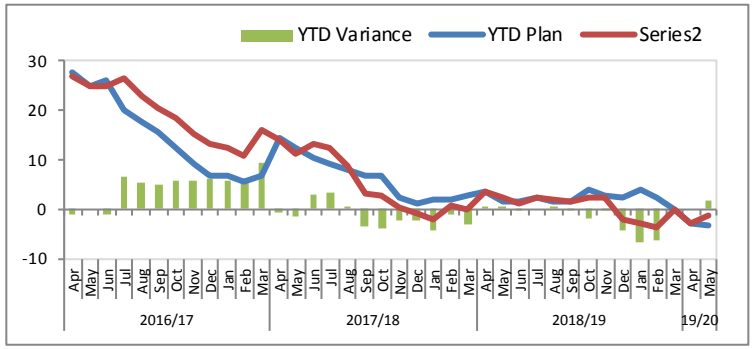
# To deliver our financial plan and key performance targets

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Delivery of Financial Plan |  | The Month 2 Income and Expenditure position is a pre-Provider Sustainability Fund (PSF) deficit of £3.1m which is in line with the planned deficit for month 2. The position includes £1.3m of PSF income. This results in a post-PSF deficit of £1.8m which is on plan. | | Director of Finance |
| Use of Resources - Financial | | The Trust's overall Use of Resources (UoR) rating of 3 is in line with plan at the end of Month 2 (May 2019/20). | | Director of Finance |



| NHSI Use of Resources Risk Rating (UoR) As at 31/05/2019 | Plan YTD | Actual YTD | *Last Month* | RAG |
|---|---|---|---|---|
| Capital Servicing Capacity | **4** | **4** | 4 | |
| Liquidity | **2** | **2** | 2 | |
| I & E Margin | **4** | **4** | 3 | |
| Variance from plan (I & E Margin) | **1** | **1** | 2 | |
| Agency Spend | **1** | **1** | 2 | |
| **Combined UoR (after triggers)** | | | | |

# To deliver our financial plan and key performance targets

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Bradford Improvement Plan |  | The Trust has delivered £0.8m of recurrent efficiencies as at the end of Month 2 (May 2019/20) against a target of £1.7m | | Director of Finance |
| Liquidity rating |  | The Trust's Liquidity rating of 1 is an improvement on the planned rating of 2 at the end of Month 2 (May 2019/20). | | Director of Finance |

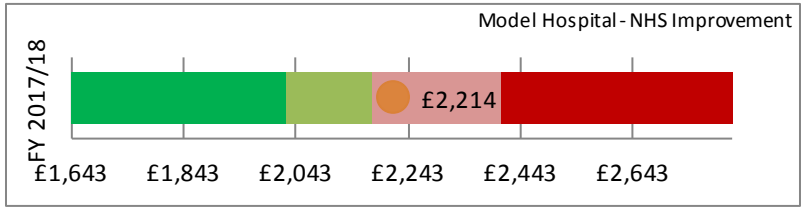
# To deliver our financial plan and key performance targets

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

**Total Pay Cost Per WAU**

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 the 2018/19 costs and activity in late 2019. For the 2017/18 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.

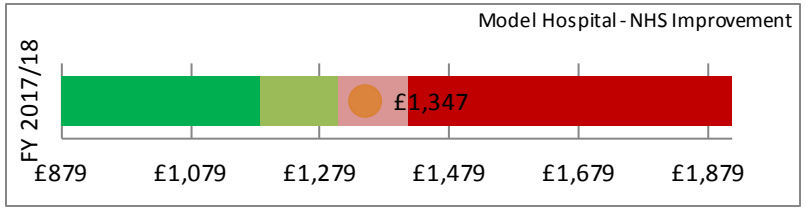
Director of Finance



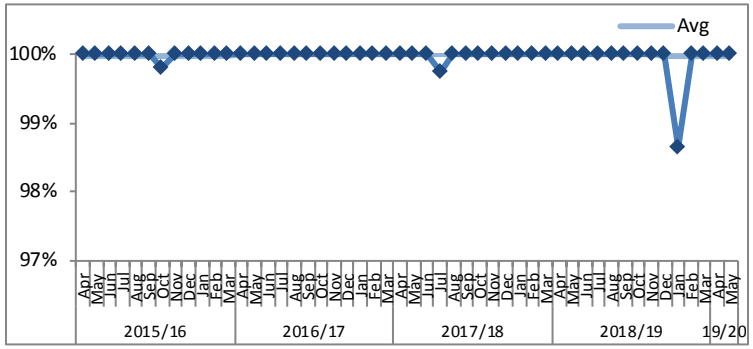
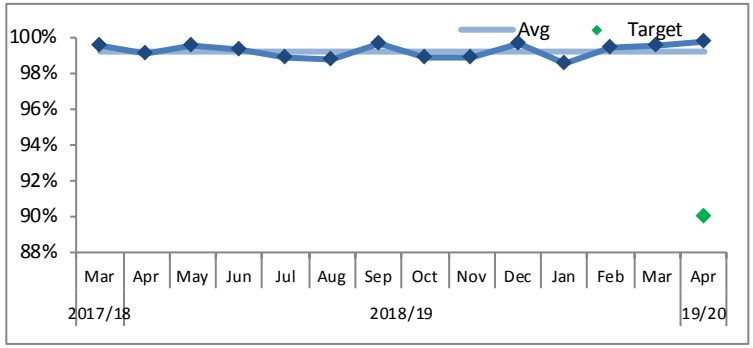

**Total Non-Pay Cost Per WAU**

For the 2017/18 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.

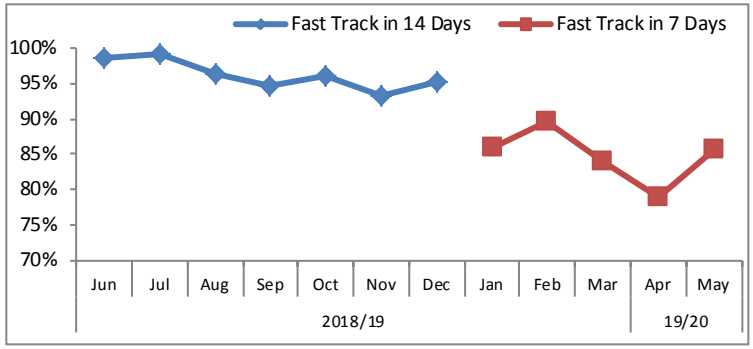
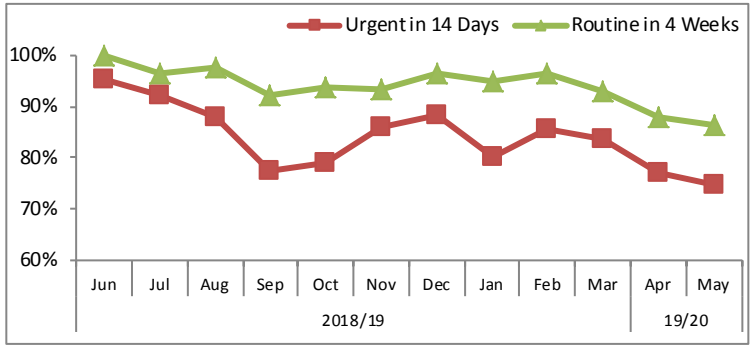
Director of Finance



# To deliver our financial plan and key performance targets

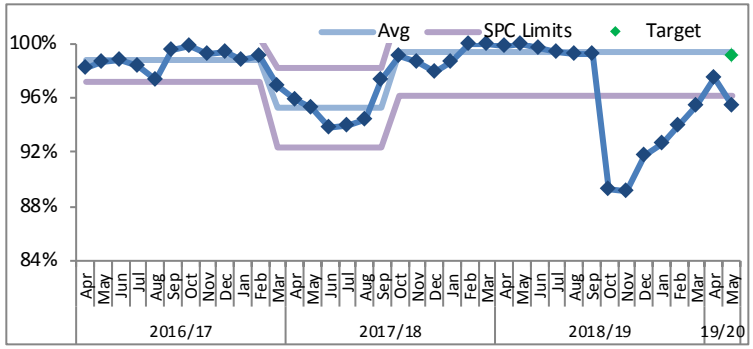
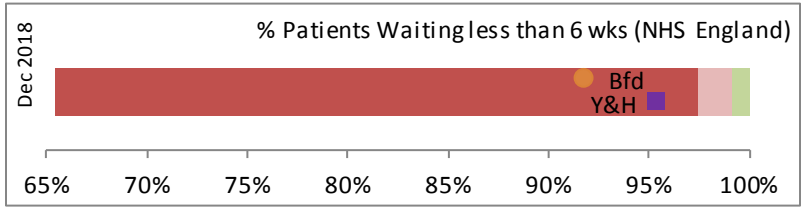
| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Mission Critical Systems Uptime |  | The Trust is maintaining a high level of uptime. | | Chief Digital and Information Officer |
| Full Blood Count to Wards < 2 Hours |  | Performance continues to achieve compliance 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 |
|---|---|---|---|---|
| Radiology Reporting Turnaround Time Fast Track |  | Performance for May 2019 improved to 85.7% following the use of a Locum for 7 days to clear the reporting backlog. In total, there were 173 patients where the report was not completed within 7 days. Of these, 159 related to Computed Tomography (CT). CT virtual colonoscopies continues to be the main pressure and this has been compounded by a reduction in uptake of additional consultant reporting sessions for CT and Magnetic Resonance Imaging (MRI). | | Chief Operating Officer |
| Radiology Reporting Turnaround Time Outpatients |  | Turnaround times for urgent and routine patients have deteriorated from the previous month as there has been a reduction in uptake in additional consultant reporting sessions. To mitigate this reduction the Trust have continued to send 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 May 2019 is a slight deterioration, this is the first time since recovery actions for Endoscopy were agreed that performance has not improved and relates to a change to the Cystoscopy position following full validation of the historic waiting list. Activity for Cystoscopy is up on previous months and further additional sessions are planned in support of backlog clearance. Colonoscopy capacity was impacted by short term sickness and the remainder of Endoscopy maintained previous performance in May 2019.  | | Chief Operating Officer |
| Use of Resources - Financial | | The Trust's overall Use of Resources (UoR) rating of 3 is in line with plan at the end of Month 2 (May 2019/20). | | Director of Finance |

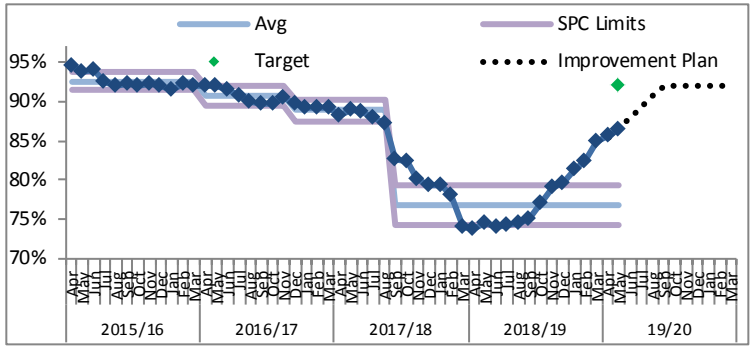
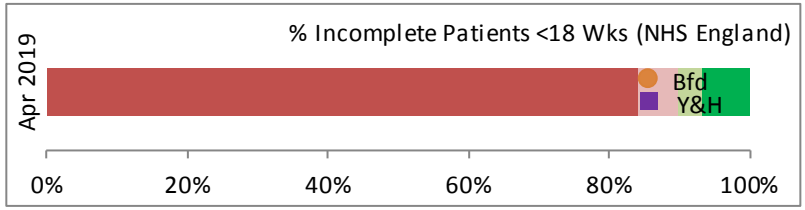
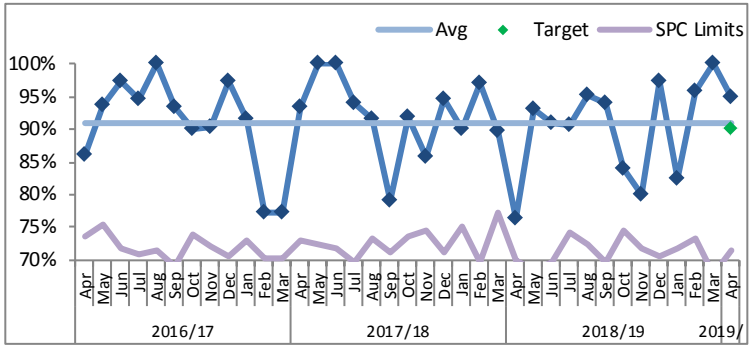
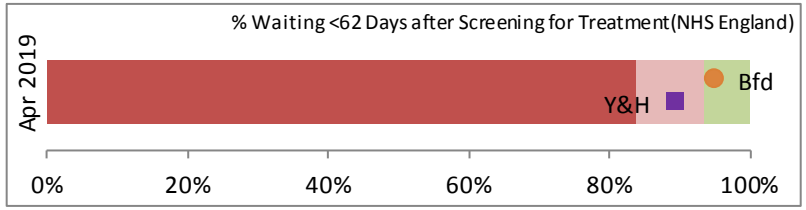




| NHSI Use of Resources Risk Rating (UoR) As at 31/05/2019 | Plan YTD | Actual YTD | *Last Month* | RAG |
|---|---|---|---|---|
| Capital Servicing Capacity | 4 | 4 | 4 | |
| Liquidity | 2 | 2 | 2 | |
| I & E Margin | 4 | 4 | 3 | |
| Variance from plan (I & E Margin) | 1 | 1 | 2 | |
| Agency Spend | 1 | 1 | 2 | |
| **Combined UoR (after triggers)** | | | | |

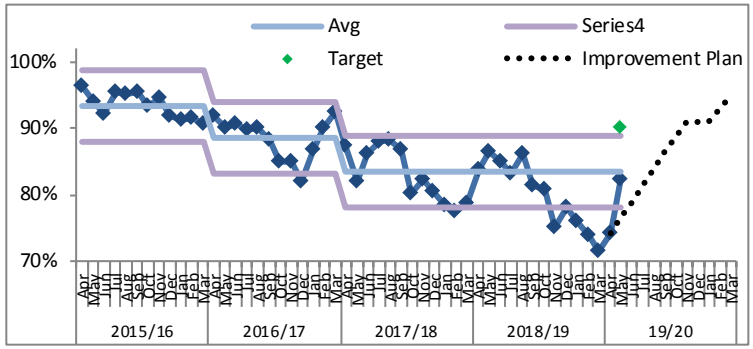
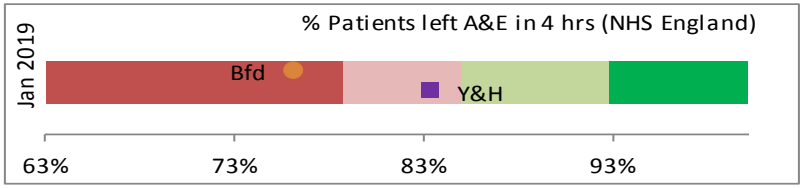
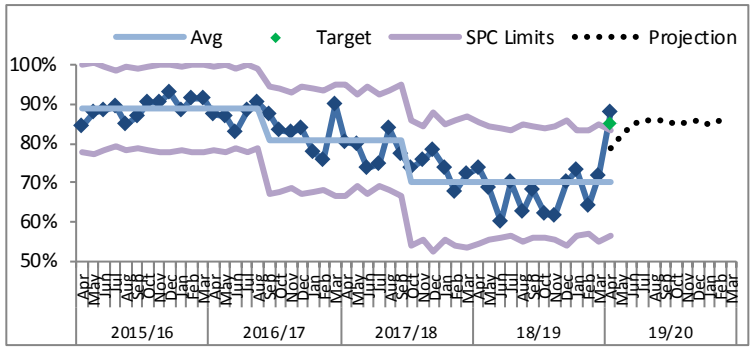
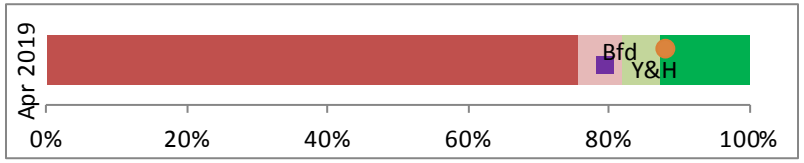
# National Indicators

## Single Oversight Framework

| | Trend | Challenges and Successes | Exec Lead |
|---|---|---|---|
| RTT 18 Week Incomplete |  | Incomplete performance for May 2019 is 86.38% which represents an improvement on April 2019 and remains on track with the recovery trajectory for improvement to 92% by Q2 2019/20. Additional activity is being delivered through increased internal capacity, with a particular focus on productivity and waiting list management.  | Chief Operating Officer |
| Cancer Urgent 62 Day Screening |  | Performance continues to meet the target for this standard.  | Chief Operating Officer |

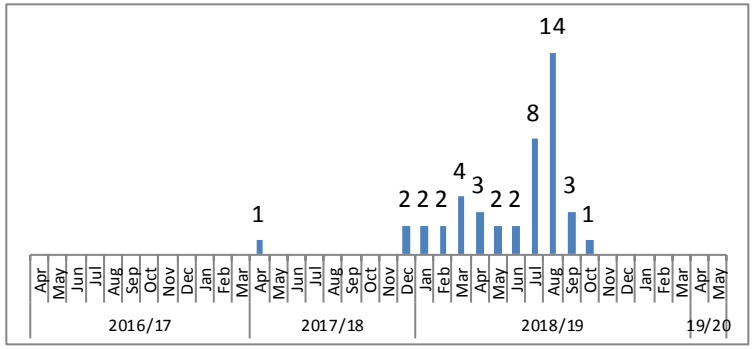
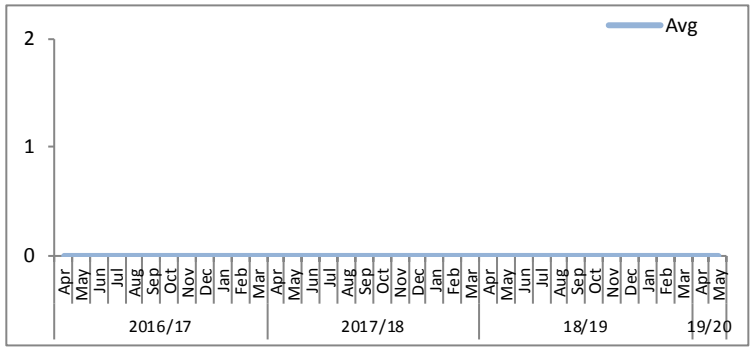
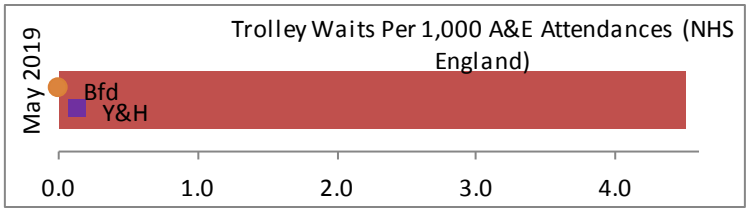
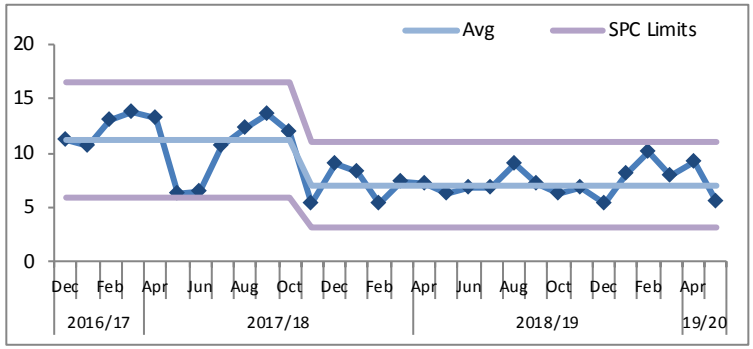
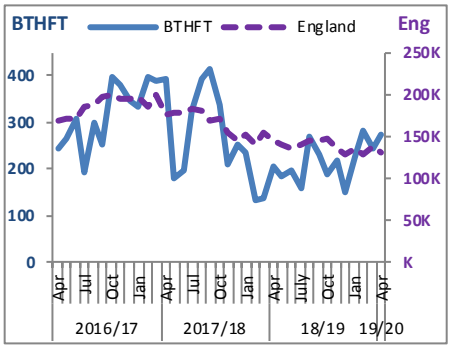
# National Indicators

## Single Oversight Framework

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Emergency Care Standard |  | Emergency Care Standard (ECS) performance (type 1 and 3) was 82.32% in May 2019. This is a significant improvement from previous months, particularly across Majors where time to treatment and time from decision to admit to leaving the Emergency Department has reduced. Attendances were lower than in April 2019 and Green Zone was fully operational. The introduction of the new roles of Majors Coordinator and Navigator in May 2019 also correlate positively with this improvement. |  | Chief Operating Officer |
| Cancer Urgent 62 Day GP |  | April 2019 performance against the 62-day cancer standard was 88.10% which is the highest level since March 2017. Delays in the Lower Gastrointestinal (GI) diagnostic phase and longs waits for clinical oncology for Urology remain a significant challenge. 2 week wait and treatment capacity is good suggesting that once diagnostic performance is recovered overall cancer performance will routinely be above the national standard. |  | Chief Operating Officer |

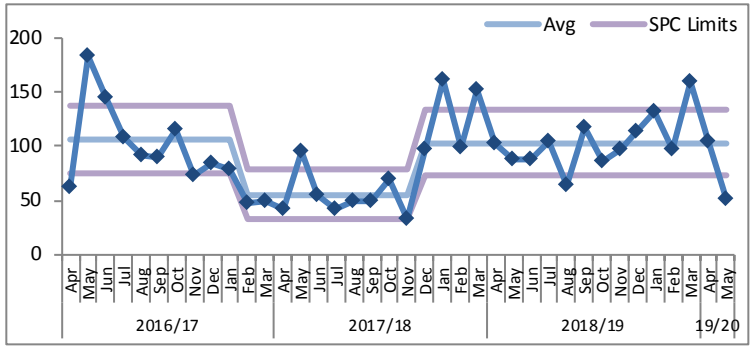
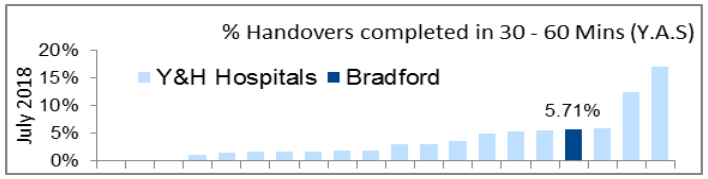
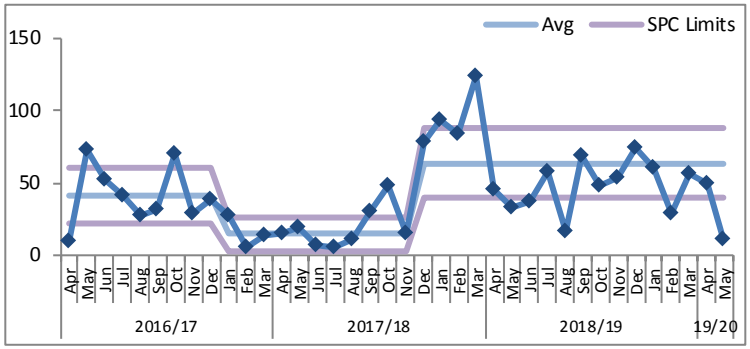
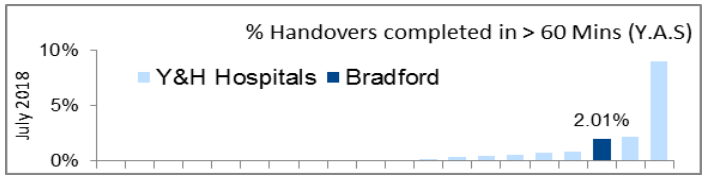
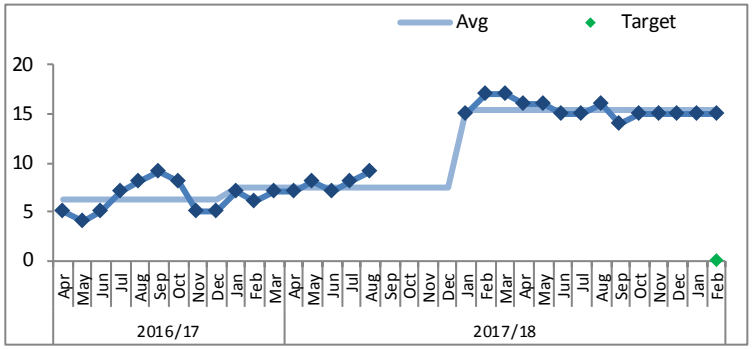
# National Indicators

## National Target – Non-Financial

| | Trend | Challenges and Successes | Exec Lead |
|---|---|---|---|
| RTT 52 Week Wait |  | The Trust reported 0 incomplete 52 week waits in May 2019, which is the 7th 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 |
| Trolley Waits > 12 Hours |   | There have been no over 12 hour trolley waits. | Chief Operating Officer |
| Delayed Transfers of Care |   | Performance remains within statistical process control (SPC) limits for the Trust and better than the national standard. | Chief Operating Officer |

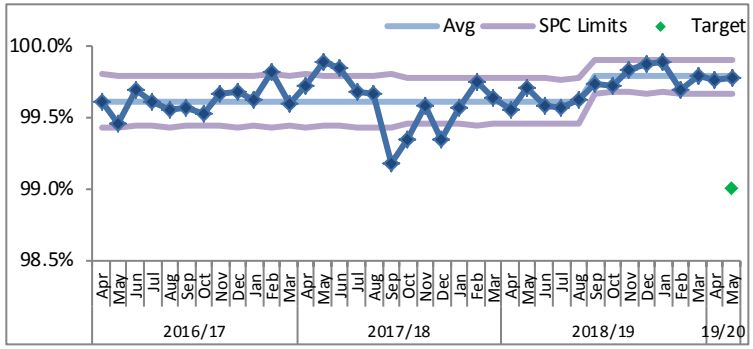
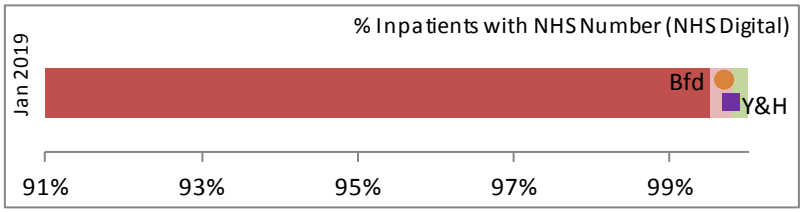
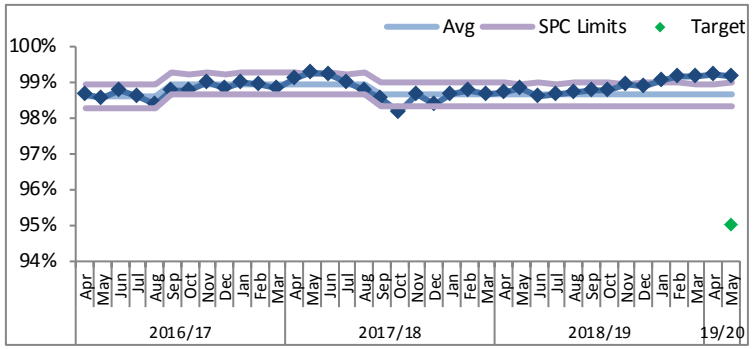
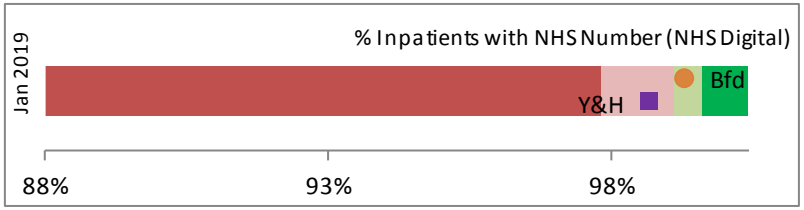
# National Indicators

## National Target – Non-Financial

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Ambulance Handover 30-60 mins |   | In May 2019 the number of ambulance handover delays attributable to the Trust taking 30-60 minute was 51 (fully validated) which is a significant improvement compared to previous months. The fit to sit model is having a positive impact and improved flow within the department also helped. Administrative support is to be introduced in the Ambulance assessment area to further reduce delays in registering patients.   | | Chief Operating Officer |
| Ambulance Handover >60 mins |   | In May 2019 the number of ambulance handovers delays attributable to the Trust taking over 60 minutes was 11 (fully validated) which is a significant improvement when compared to previous months.   | | Chief Operating Officer |
| RTT Number of Specialties |   | Recovery plans are in place for all specialties and progress is tracked weekly at the planned care performance meeting. | | Chief Operating Officer |

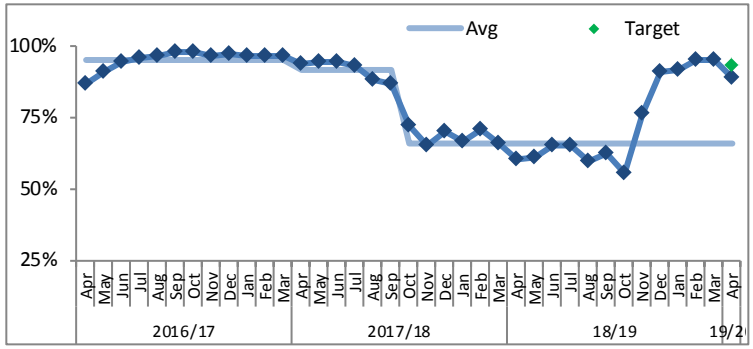
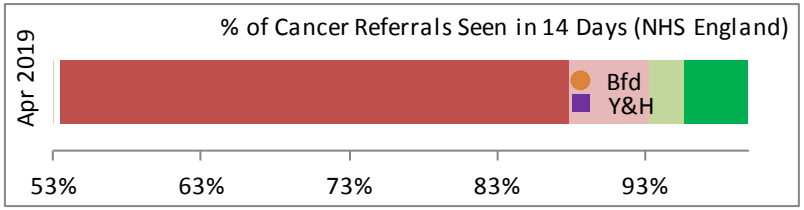
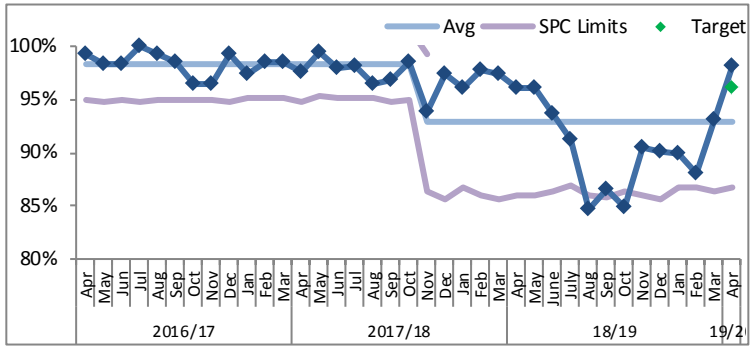
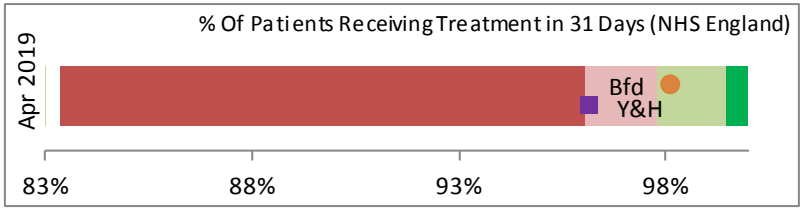
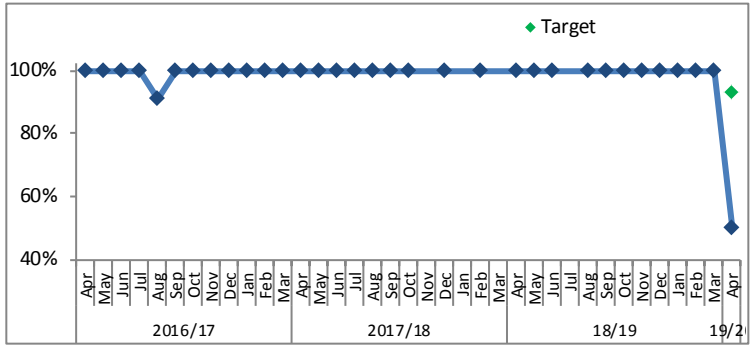
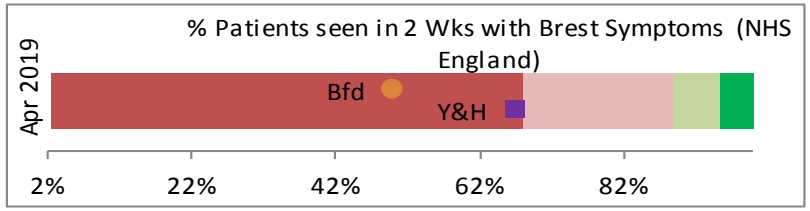
# National Indicators

## National Target – Non-Financial

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| NHS No's Acute |  | With the standardisation and integration of the patient administration system (PAS) data, as the one source of truth, the Trust compliance to NHS Number use is strong. Issues are related to EPR embedding and will improve. |  | Chief Digital and Information Officer |
| NHS No's A&E |  | With the standardisation and integration of the patient administration system (PAS) data, as the one source of truth, the Trust compliance to NHS Number use is strong. |  | Chief Digital and Information Officer |

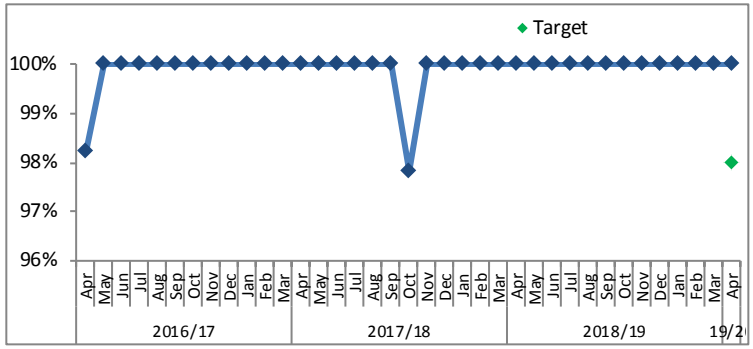
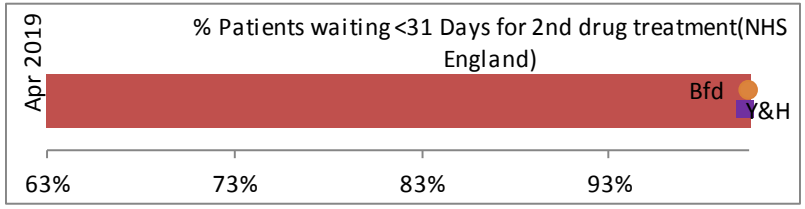
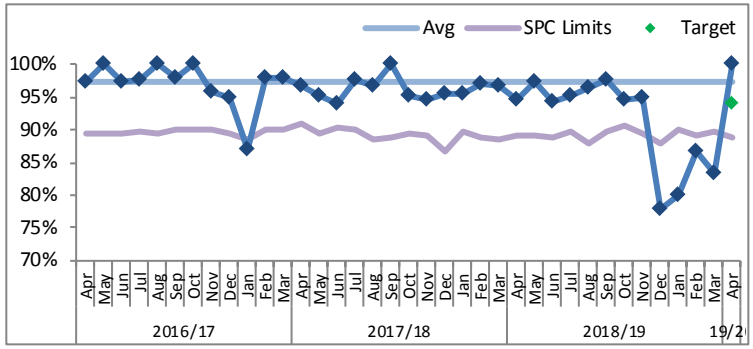
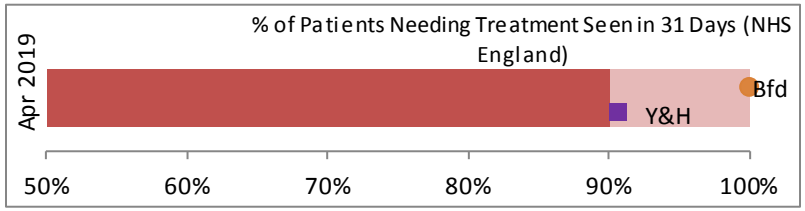
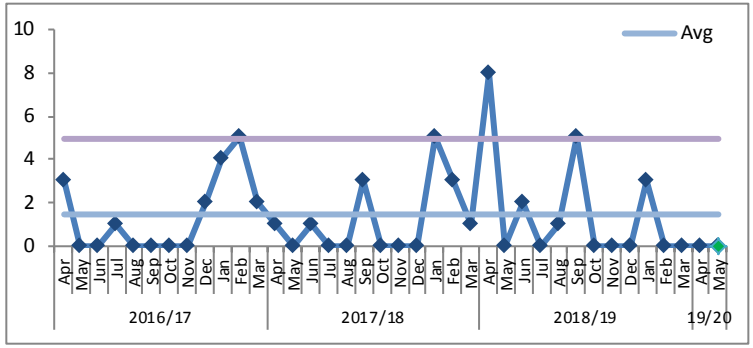
# National Indicators

## National Target – Non-Financial

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Cancer 2 Week GP |  | April 2019 performance against the 2 week-wait cancer standard was 88.77% which is below the 93% target and deteriorated due to a 25% increase in suspected Breast cancer referrals. Additional activity has been provided and the waiting list growth has stabilised over recent weeks as a result. |  | Chief Operating Officer |
| Cancer 31 Day 1st Treatment |  | This standard was recovered in April 2019 following improvements across the treatment phase, particularly in Urology and specifically robotic surgery capacity. |  | Chief Operating Officer |
| Cancer 2 Week - Breast |  | This standard was not achieved in April 2019. Performance at 50% is due to the low numbers reported against this specific measure (1 fail for patient choice of only 2 patients seen). |  | Chief Operating Officer |

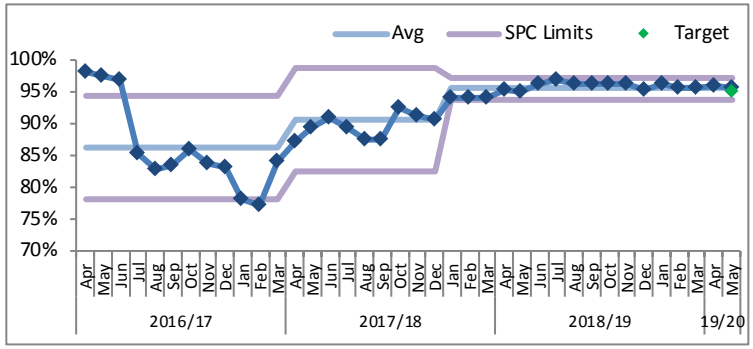
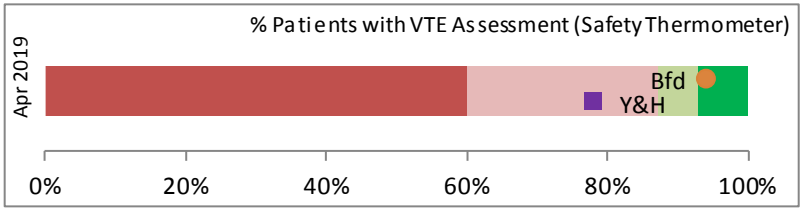
# National Indicators

## National Target – Non-Financial

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Cancer 2nd Treatment Drugs |  | This standard was achieved in April 2019 and is projected to be achieved in May 2019. |  | Chief Operating Officer |
| Cancer 2nd Treatment Surgery |  | This standard was recovered in April 2019 following improvements across the treatment phase, particularly in Urology and specifically robotic surgery capacity. |  | Chief Operating Officer |
| Cancelled Operations 28 day |  | There were 0 breaches of the 28 day standard in May 2019. | | Chief Operating Officer |

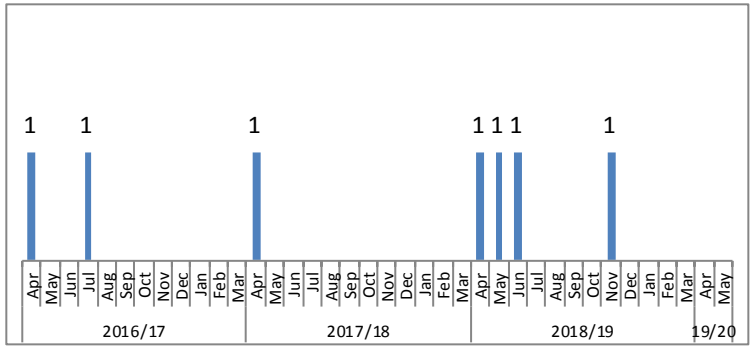
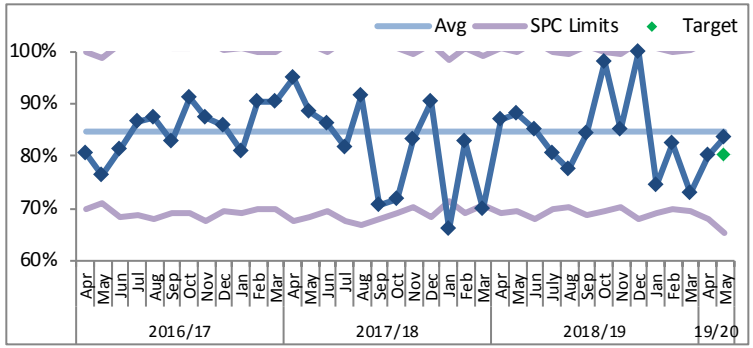
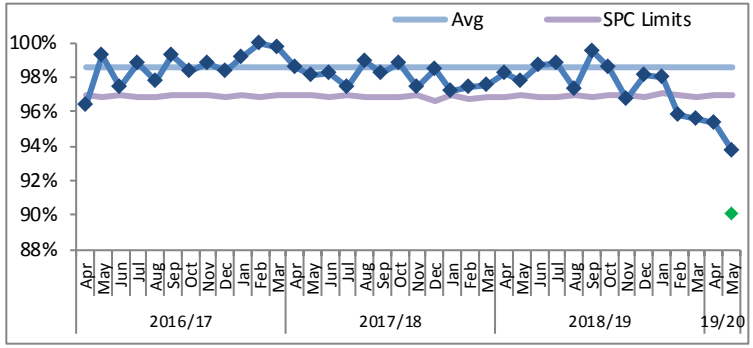
# National Indicators

## National Target – Non-Financial

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| VTE Assessment |  | The Venous Thromboembolism (VTE) assessment shows sustained compliance with the standard.  | | Chief Medical Officer |
| Formulary | | The Trust ensures that the Formulary is published on the website. | No comparator data is available. | Chief Digital and Information Officer |

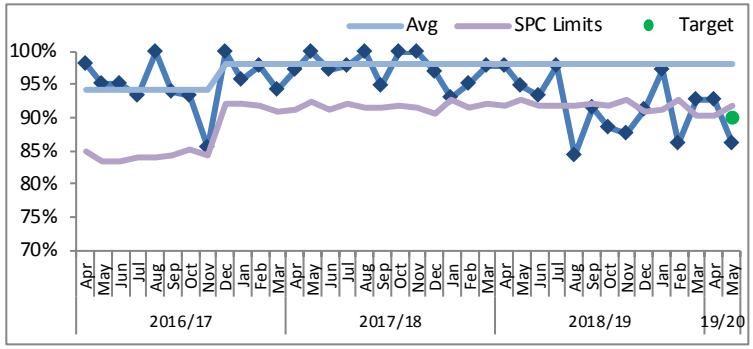
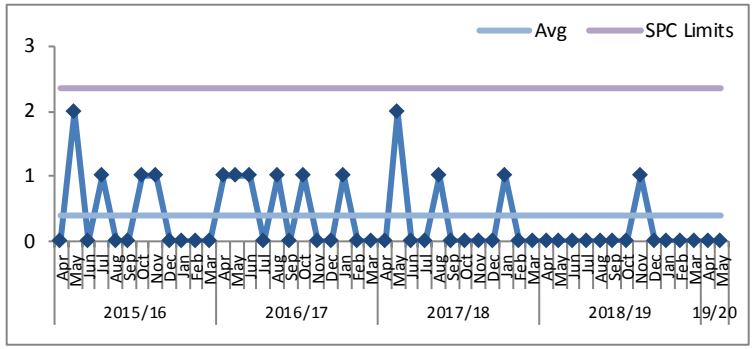
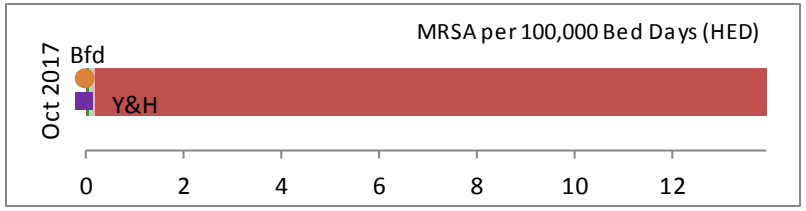
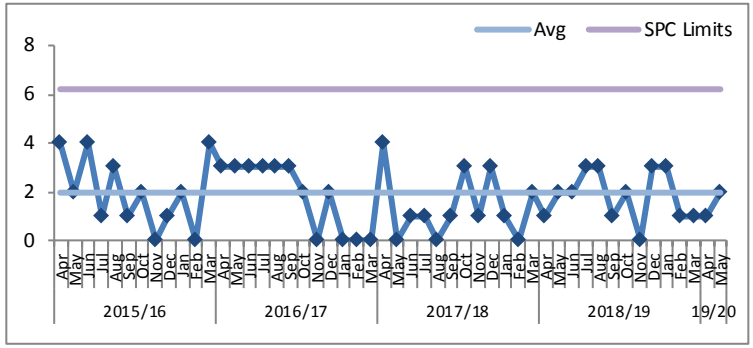
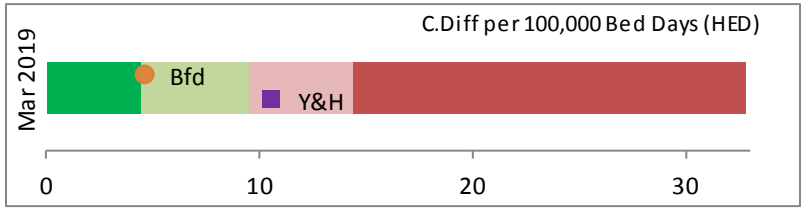
# National Indicators

## National Target – Financial

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Never Events |  | There were no never events in May 2019. | No comparator data is available. | Chief Operating Officer |
| Stroke Strategy |  | Performance remained above target in May 2019. Capacity issues continue to be a challenge but the service have been able to mitigate these to date. | | Chief Operating Officer |
| Seen By Midwife <13 Weeks |  | The threshold continues to be achieved. | | Chief Operating Officer |

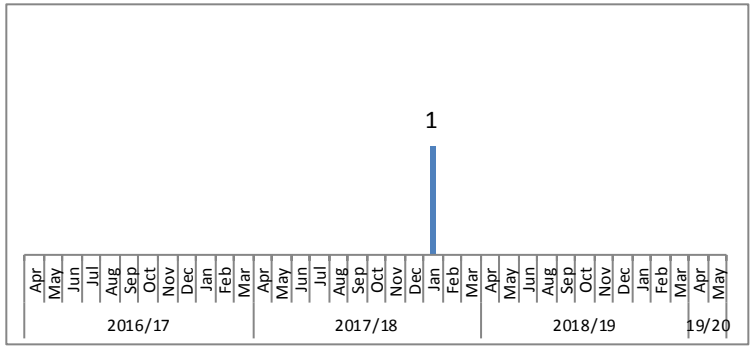
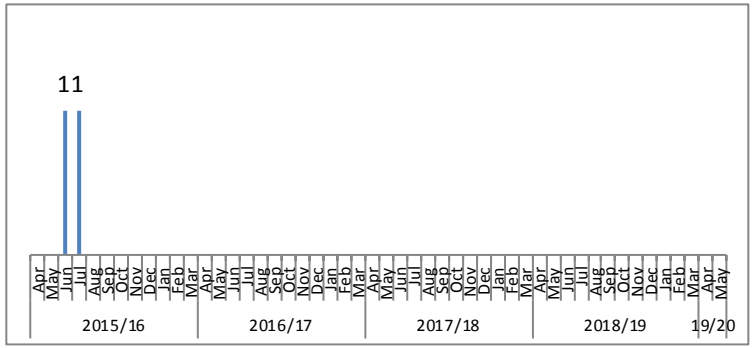
# National Indicators

## National Target – Financial

| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Seen By Midwife > 12 Weeks |  | Performance in May 2019 was below target due to the number of women who were not rebooked within target after failing to attend their first appointment. The booking and escalation process has been further refined to prevent future instances of this occurring. | | Chief Operating Officer |
| MRSA |  | One case in November 2018 has been apportioned to the Trust. The 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 |
| C. Difficile |  | Continues as per previous years and is within expected range. |  | Chief Nurse |

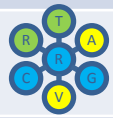
# National Indicators

## National Target – Financial

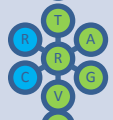
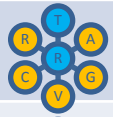
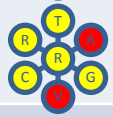
| | Trend | Challenges and Successes | Comparison | Exec Lead |
|---|---|---|---|---|
| Duty of Candour |  | There were no Duty of Candour breaches to date in 2019/20. | | Director of Strategy and Integration |
| Mixed Sex Breaches |  | There have been no Mixed Sex Breaches. | | Chief Operating Officer |

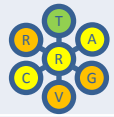
# Glossary

| Indicator | Definition | Data Quality Kite-Mark |
|---|---|---|
| **To provide outstanding care for our patients** | | |
| **Mortality** | | |
| Crude Mortality | Crude Mortality rates, i.e., per admissions. |  |
| Hospital Standardised Mortality Ratio | The mortality indicator is evaluated from a standardised mortality ratio (SMR). The formula for the ratio is observed deaths divided by expected deaths, multiplied by 100. This is calculated for each provider within the data. |  |
| SHMI | The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. |  |
| **Infections** | | |
| C Difficile | The number of cases either attributable or pending review.<br>Red >= 3, Amber = 2, Green <=1 |  |
| eColi | Counts of patients with Escherichia coli (eColi).<br>Red >=30 Amber >=20 and <30, Green <20 |  |
| MRSA | Counts of patients with Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia<br>Per month: Red >= 1, Green 0 |  |
| MSSA | Counts of patients with Meticillin Sensitive Staphylococcus aureus (MSSA) bacteraemia<br>Per month: Red >= 3, Amber 2, Green <= 1<br>Per year: Red >= 30, Amber 20-29, Green < 20 |  |

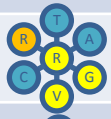
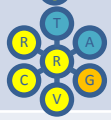
| Indicator | Definition | Data Quality Kite-Mark |
|---|---|---|
| **Harm Free Care** | | |
| VTE Assessment | VTE risk assessments completed<br>Red < 90%, Amber >=90% & < 95%, Green >=95% |  |
| Falls with Harm | Patient falls resulting from harm. The benchmarking data comes from the Safety Thermometer prevalence information.<br>Red >= 40, Amber >=25 & < 40, Green <25 |  |
| Catheters & UTIs | Urinary tract infections in patients with a catheter. The benchmarking data comes from the Safety Thermometer prevalence information.<br>Red > 1.5%, Amber 1%-1.5%, Green < 1% |  |
| Pressure Ulcers Cat 3+ | Number of reported hospital acquired category 3 and 4 pressure ulcers. The benchmarking data comes from the Safety Thermometer prevalence information.<br>Red >= 6, Amber 5, Green < 5 |  |
| Pressure Ulcers Cat 2+ | Number of reported hospital acquired category 2 pressure ulcers. The benchmarking data comes from the Safety Thermometer prevalence information.<br>Red >= 20, Amber 15-19, Green < 15 |  |
| Sepsis patients receive antibiotics within an hour | Percentage of patients who were found to have sepsis during the screening process and received IV antibiotics within 1 hour |  |

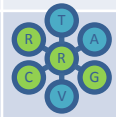
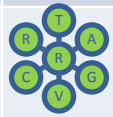
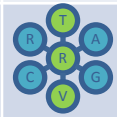
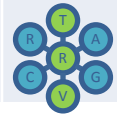
# Glossary

| Indicator | Definition | Data Quality Kite-Mark |
|---|---|---|
| **Patient Experience** | | |
| Complaints | Number of complaints.<br>Red >= 50, Amber 40-49, Green < 40 |  |
| Complaints Closed | Percentage of complaints closed within agreed timescales<br>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<br>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.<br>Red = Outside control limits, Green = Inside control limits |  |
| Information Governance Breaches | The number of reported breaches of the information governance standards<br>Red > 6, Amber <=6 & > 2, Green <=2 |  |
| **Readmissions** | | |
| 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 |
|---|---|---|
| **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<br>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<br>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.<br>Red <60%, Amber >=60% & <80%, Green >=80% |  |

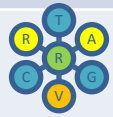
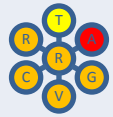
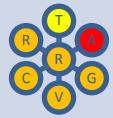
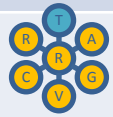
# Glossary

| 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<br>Red < 90%, Amber >=90% & <100%, Green = 100% |  |
| Refresher Training | % of staff who are compliant with mandatory training requirements<br>Red < 75%, Amber >=75% & <85%, Green >= 85% |  |
| **Governance Mechanisms** | | |
| Out of date policies | % of policies that are currently out of and within date.<br>Red < 95%, Amber >=95% & <100%, Green = 100% |  |
| Risks not mitigated | Risks 12 and above whose current rating is above the target (residual) rating.<br>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.<br>RAG rating subjectively agreed by the Committee | Qualitative Metric |
| Horizontal Integration | Working with other providers to ensure resilient services, reduce outcome variation, address workforce shortages, and achieve efficiencies. Contribute to the establishment of an effective Integrated Care System in West Yorkshire and Harrogate.<br>RAG rating subjectively agreed by the Committee | Qualitative Metric |
| Airedale Collaboration | Working with Airedale NHS Foundation Trust to collaborate effectively to improve the services offered to patients, ensuring they are more resilient. The programme will address workforce shortages together. RAG rating subjectively agreed by the Committee. | Qualitative Metric |

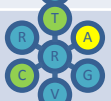
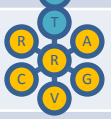
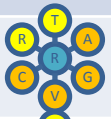
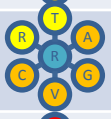
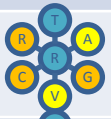
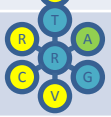
| Indicator | Definition | Data Quality Kite-Mark |
|---|---|---|
| **To be in the top 20% of employers in the NHS** | | |
| **Appraisals** | | |
| Appraisal Rate Non-Medical | % of eligible staff employed at the trusts who have had an appraisal in the last 12 months.<br>Red <75%, Amber >=75% and <95%,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

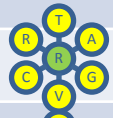
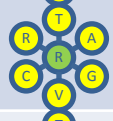
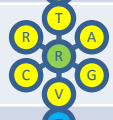
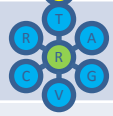
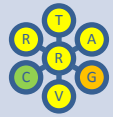
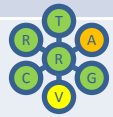
# Glossary

| Indicator | Definition | Data Quality Kite-Mark |
|---|---|---|
| **Sickness** | | |
| Sickness | % of time lost due to sickness in a given period (the reported month, year to date is the previous 12 months rolling average for which Trust target is 4.00%)<br>Red >1% point above Target, Amber within 1% point above Target, Green <= Target |  |
| **Staffing Levels** | | |
| Nursing Staff Fill Rate | % of time nursing staff staffing hours filled as planned<br>Red < 80%, Amber 80% – 95%, Green > 95% |  |
| Care Staff Fill Rate | % of time care staff staffing hours filled as planned<br>Red < 80%, Amber 80% – 95%, Green > 95% |  |
| Nursing Care Hours | Total of the actual number of RN /RM hours for the month divided by the total number of patients who were an inpatient at midnight for each day of that month.<br>Red = Lower two quartiles, Green = Upper two quartiles |  |
| 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.<br>Red = Lower two quartiles, Green = Upper two quartiles |  |
| Agency % of FTE | Agency FTEs as a percentage of all FTEs |  |

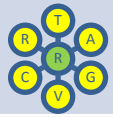
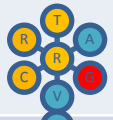
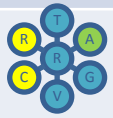
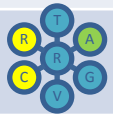
| Indicator | Definition | Data Quality Kite-Mark |
|---|---|---|
| **Retention** | | |
| Turnover | Number of employees who have left the organisation in the past 12 months as a % of the average number of employees over the same period<br>Red > 14%, Amber 12% – 14%, Green < 12% |  |
| **Additional Workforce metrics** | | |
| Staff Advocate Service Contacts and Outcomes | Contacts and Outcomes for the Staff Advocate Service |  |
| Harassment & Bullying Related Investigations | Investigations arising from Harassment & Bullying and outcomes |  |
| **To deliver our financial plan and key performance targets** | | |
| **In-Patient Productivity** | | |
| Length of Stay Elective | The average length of stay for elective patients, in days. The benchmark data is for Acute trusts for June 2017 from HED, which has a subtly different calculation, which can result in very small differences in numbers. Red < 50th Percentile England, Amber 50 – 25th Percentile ,Green Upper Quartile England |  |
| Length of Stay Non-Elective | The average length of stay for non-elective patients, in days. The benchmark data is for Acute trusts for June 2017 from HED, which has a subtly different calculation, which can result in very small differences in numbers. Red < 50th Percentile England, Amber 50 – 25th Percentile, Green Upper Quartile England |  |
| Bed Occupancy | Average % of available beds which were occupied overnight.<br>Red >=95%, Amber 85-95%, Green <85% |  |

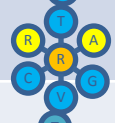
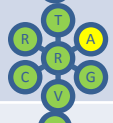
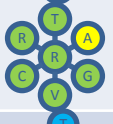
# Glossary

| Indicator | Definition | Data Quality Kite-Mark |
|---|---|---|
| **In-Patient Productivity (cont.)** | | |
| Stranded Patients LoS >= 7 days | The average number of patients (excluding Maternity) who have been in hospital 7 days or more. |  |
| Super Stranded Patients LoS >= 21 days | The average number of patients (excluding Maternity) who have been in hospital 21 days or more. Red >= 62, Amber 56-61, Green <= 55 (Based on the baseline of 72) |  |
| Discharges before 1 pm | Number of discharges from hospital which happened before 1 pm. Red = Outside control limits, Green = Inside control limits |  |
| **Out-Patient Productivity** | | |
| Did Not Attend Follow-Up | This is the % of Follow-up Outpatient appointments where the patient does not attend. Red < 50th Percentile England, Amber 50 – 25th Percentile, Green Upper Quartile England |  |
| Did Not Attend New | This is the % of New Outpatient appointments where the patient does not attend. Red < 50th Percentile England, Amber 50 – 25th Percentile, Green Upper Quartile England |  |
| Elective Day Case Rate | The number of patients admitted for planned procedure and leave same day as a % of all procedures. Red < 83%, Amber <87% & >=83% ,Green >= 87% |  |
| New to Follow-Up ratio | The ratio between New and Follow Up Outpatient appointments. Benchmarking data is from HED, which has a subtly different calculation, which can result in very small differences in numbers. Red < 50th Percentile England, Amber 50 – 25th Percentile, Green Upper Quartile England |  |
| Short Notice Clinic Cancellations | Clinics cancelled within the 6 week timeframe. Red 5% higher 17/18 avg, Amber within 5% of 17/18 avg, Green 5% less 17/18 avg |  |
| Elective Wait List | Wait list of patients on an elective pathway. Red Greater than last month, Amber , Green Less than last month |  |

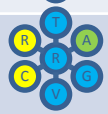
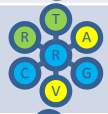
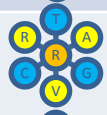
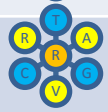
| Indicator | Definition | Data Quality Kite-Mark |
|---|---|---|
| **Finance** | | |
| Delivery of financial plan | Delivery of finances against plan. |  |
| Use of Resources - Financial | Use of resources is a calculation on the status of a number of financial measures – Capital Servicing Capacity, Liquidity, I & E Margin, and Agency Spend. |  |
| Cost Improvement Plan | Cost Improvement Plan progress against target. |  |
| Liquidity | A measure of how many days an organisation can continue to fund its operations based on the level of net current assets and available borrowing. |  |
| **Cost Per Weighted Activity Unit** | | |
| 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 – 4th quartile, Amber – 2nd/3rd quartiles, Green – 1st quartile |  |
| 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 – 4th quartile, Amber – 2nd/3rd quartiles, Green – 1st quartile |  |
| **Service Level Agreements** | | |
| Mission Critical Systems | Percentage of time all Mission Critical Systems were up and running Red <99.7%, Amber >=99.7% & < 99.9%, Green >=99.9% |  |
| Full Blood Count Acute Wards within 2 Hours | The time taken for the laboratory to process Full Blood Counts samples from all Acute Wards and validated results are available on the Laboratory Information Management System (LIMS). The time measured is from the sample being booked on to the LIMS and results being validated on the LIMS and available to requestors Red <85%, Amber >=85% & < 90%, Green >=90% |  |

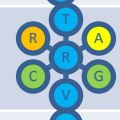
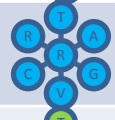
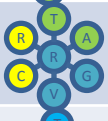
# Glossary

| Indicator | Definition | Data Quality Kite-Mark |
|---|---|---|
| **Service Level Agreements - continued** | | |
| 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% |  |
| 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% |  |
| **National Indicators** | | |
| **Single Oversight Framework** | | |
| Diagnostic waits | % of patients who have waited less than 6 weeks for a diagnostic test. Red < 99%,Green >= 99% |  |
| User of Resources | Calculation on the status of a number of financial measures – Capital Servicing Capacity, Liquidity, I & E Margin, and Agency Spend. |  |
| Emergency Care Standard | % patients seen in A&E within 4 hours. Red < 90%, Green >= 90% |  |
| RTT 18 Week Incomplete | Percentage of patients waiting within 18 weeks on an incomplete pathway. Red < 92%, Green >= 92% |  |
| Cancer Urgent 62 day Screening | Proportion of patients receiving treatment for cancer within 62 days of an NHS Cancer Screening service. Red < 96%, Green >= 96% |  |
| Cancer Urgent 62 Day GP | Proportion of patients receiving treatment for cancer within 62 days of an urgent GP referral for suspected cancer. Red < 85%, Green >= 85% |  |

| Indicator | Definition | Data Quality Kite-Mark |
|---|---|---|
| **Non-Financial** | | |
| Trolley Waits >12 hours | Trolley waits of > 12 hours. Red > 0, Green = 0 |  |
| Delayed Transfers of Care | Average number of patients per day who had a delayed transfer; when an adult inpatient is ready to go home or move to a less acute stage of care but is prevented from doing so. Red > 12.44, Green <= 12.44 |  |
| Ambulance Handover 30-60 mins | Ambulance handover taking longer than 30 – 60 minutes to handover. Red > Same Month LY, Green <=Same Month LY |  |
| Ambulance Handover >60 mins | Ambulance handover taking longer than 60 minutes to handover. Red > Same Month LY, Green <=Same Month LY |  |
| RTT # Specialties | Number of specialties not achieving RTT incomplete. Red > 0, Green = 0 |  |
| NHS # field completion acute | Completion of valid NHS # field in acute commissioning data sets submitted via SUS Red < 99%, Green >= 99% |  |
| NHS # field completion AED | Completion of valid NHS # field in AED commissioning data sets submitted via SUS. Red < 95%, Green >= 95% |  |
| Cancer 2 Week GP | % patients who have waited a maximum of 2 weeks to see a specialist for all patients referred with suspected cancer symptoms Red < 93%, Green >= 93% |  |
| Cancer 1st Treatment | Patients that have a decision to treat them surgically for a cancer diagnosis should have a date for their treatment within 31 days of the decision to treat. Red < 94%, Green >= 94% |  |

# Glossary

| Indicator | Definition | Data Quality Kite-Mark |
|---|---|---|
| **Non-Financial continued** | | |
| 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.<br>Red < 93%, Green >= 93% |  |
| Cancer 2nd Treatment Drugs | Proportion of patients waiting no more than 31 days for second or subsequent drug treatments.<br>Red < 98%, Green >= 98% |  |
| Cancer 2nd Treatment Surgery | Patients that require further surgery following initial treatment should receive treatment within 31 days .<br>Red < 94%, Green >= 94% |  |
| VTE Assessments | VTE risk assessments completed.<br>Red < 90%, Amber >= 90% & < 95%, Green >= 95% |  |
| Formulary published | Hospital formulary is published on the Trust's external website.<br>Red Not published, Green Published |  |
| Stroke Strategy | Implementation of the Stroke Strategy – patients who spend at least 90% of their time on a stroke unit.<br>Red < 80%, Green >= 80% |  |
| Seen by Midwife < 13 wks | Percentage of women who presented before 12 weeks 6 days who have seen a midwife within 12 weeks and 6 days of pregnancy.<br>Red <85 %, Amber >= 85% & < 90 %, Green >= 90% |  |
| Seen by Midwife > 12 wks | Percentage of women who presented after 12 weeks 6 days who have seen a midwife within 2 weeks.<br>Red <85 %, Amber >= 85% & < 90 %, Green >= 90% |  |

| Indicator | Definition | Data Quality Kite-Mark |
|---|---|---|
| **Financial** | | |
| Never Events | The number of serious incidents that occur despite there being defined processes and procedures to prevent them.<br>Red > 0, Green = 0 |  |
| MRSA | Counts of patients with Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia.<br>Red > 0, Green = 0 |  |
| C Difficile | Number of cases either attributable or pending review.<br>Red > 4, Amber 3, Green <3 |  |
| Duty of Candour | Patient informed duty of candour.<br>Red > 0, Green = 0 |  |
| Mixed Sex Accommodation | Number of occurrences of unjustified mixing in relation to sleeping accommodation.<br>Red > 0, Green = 0 |  |
| RTT 52 Week Wait | Number of patients waiting more than 52 weeks.<br>Red > 0, Green = 0 |  |
| Cancelled Operations 28 Days | Number of patients who were cancelled on day of surgery and subsequently not been treated.<br>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. |