# Quality and Performance Report

June 2016

# Contents



| RAG Key | |
|---|---|
| Not achieving target or threshold | |
| Achieving target | |
| Between target and threshold | |

# Executive Summary

The report covers the period from June 2015 to allow comparison with historic performance. However the key messages and targets relate to June 2016 for the financial year 2016/17.

| Area | Domain |
|---|---|
| **Safe** | • **Harm Free Care - P**erformance decreased this month. A number of pieces of work looking to reduce at falls and pressure ulcer reduction have commenced.<br>• **Maternity - % PPH ≥ 1500ml - Previously month's** Improvements not sustained during June, continues to be monitored closely. |
| **Effective** | • **Hospital Acquired Infections -** There were no avoidable HAIs in June.<br>• **Perinatal Deaths (0-7 days) -** at 0.41% are above the 0.1% target. A New SOP for Perinatal deaths and quarterly reports have been produced. Perinatal mortality group meet monthly to review cases and feedback learning. All perinatal deaths are logged on datix as an incident and fully investigated.<br>• **Local SHMI - Relative Risk** (1yr Rolling Data January 15 - December 15) 113.88 - The two diagnostic groups that are negative outliers are Acute Cerebrovascular Disease and Pneumonia. There is an improvement plan in place to address both of these. A new piece of work with CCG is in place to undertake joint mortality reviews on patients who die within 30 days of discharge.<br>• **Hospital Standardised Mortality Rate** (1 yr Rolling Data April 15 - Mar 16) 111.6 - Trust predicts further modest reductions in the coming months.<br>• **Mortality Reviews** - The completion rate for Level 1 reviews has improved and is in line with previous performance levels of just under 50%. More consultant level one reviewers are being recruited and the programme is anticipated to be consultant led in the future.<br>• **Crude Mortality Rate** - has dropped considerably to 1.32% for June 16.<br>• **Average Diagnosis per Coded Episode -** Improvements in month continue.<br>• **Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge improved to 75**% against 85% target. In June 18 of 24 people received an operation within 36 hours. There were 3 clinical breaches and 3 organisational breaches. RCAs are carried on all breaches. |
| **Caring** | • **Only 33% of complaints were closed within timeframe against a target of 100%.** This is the lowest position in the last 12 months but is a consequence of focused effort on reducing overdue complaints. 70 complaints were close in June which is the highest for a number of months.<br>• **Friends and Family Test Outpatients Survey** - % would recommend is stabilising at 90- 91% against a target of 95%. Improvement plans are in place around car parking and clinic waiting times.<br>• **Friends and Family Test Community Survey** - 85% would recommend the Service against 96.2% target. A more in death survey is now being developed to gain further insight into the drivers behind these responses. |

**Background Context**

June was another busy month for non-elective activity; a position reflected across West Yorkshire. AED attendances are high with evening surges increasing in frequency and there is an increasing pressure in General Surgery where non-elective demand is exceptionally high.

Despite the non-elective pressures in AED conversion rates to admission are below plan, this conversion rate improvement correlates with ECS delivery.

The system DTOC group has expanded its scope to ensure focus on the non reportable delays which remain high and continue to drive high bed occupancy rates.

Elective activity continues with some peaks and troughs in admission profiles resulting in bed pressures early in the week .

Despite continuation of elective activity the waiting list is growing, work on validation has commenced to ensure data quality is robust and pre EPR capacity increases are being planned to ensure no performance risk. In several specialties demand continues to increase most noticably Ophthalmology, ENT, Cardiology the latter 2 more pronounced in Calderdale GPs

Improvement plans are in place for several areas of risk and the new Divisional PRM process went live in June with good initial feedback around process and discussion. All Divisional action plans will be monitored by the Executive through this route to enable triangulation.

Dr Mohamed Mohamed has been commissioned to undertake some specific work with the Trust around mortality

# Executive Summary

The report covers the period from June 2015 to allow comparison with historic performance. However the key messages and targets relate to June 2016 for the financial year 2016/17.

| Area | Domain |
|---|---|
| **Responsive** | • **Emergency Care Standard 4 hours.** June's position saw 95.07% patient seen within 4 hours, the best position for a number of months. The Trust secured a quarter one position of 94.1% and are seeking to achieve 95% month in month for Q2<br>• **% Daily Discharges - Pre 12pm.** 23% in month against 40% target. However the anticipated month on month improvement of 10% per month has not been seen and the 40% is remains challenging. Currently undergoing small tests of change to improve compliance<br>• **Green Cross Patients (Snapshot at month end)** remains high at 94 patients, discharge coordinators now using a case management model to improve patient experience, discharge planning, continuity and integration with social care.<br>• **Stroke -** Improvements noted in all indicators and ongoing work to achieve full compliance continues.90% stay on stroke ward now at 87.50% and 100% of stroke patients were thrombolysed within an hour.<br>• **% Last Minute Cancellations to Elective Surgery -** Improved to 0.56%<br>• **RTT pathways over 26weeks** lowest in 6 months. Father reduction needed and validation continues.<br>• **38 Day Referral to Tertiary has deteriorated to 38%** against 85% target. Action plans being worked through with a requirement to achieve by July reflecting changes to reporting rules from Q3. |
| **Workforce** | • **Sickness Absence rate continues to fall to** 4.1% against 4% target the lowest position for over 12 months with improvements across all divisions. Within this long term sickness is 2.9% against 2.7% with the short term 1.24% against 1.3% target also the lowest position in the last 12 months.<br>• **Return to work Interviews** are a key contributor to effective sickness management and are running at an improved position on last month of 44% but still some way short of 100% target.<br>• **Mandatory Training and appraisal** compliance remains a challenge. Appraisal training proposal paper received at the Education Learning Group in June 2016. |
| **Efficiency/ Finance** | • **Finance:** Year to date: Financial position stands at a deficit of £5.02m, a favourable variance of £0.15m from the planned £5.17m. In month, the Trust has seen a strong performance against the clinical activity contract, driven primarily through non elective, A&E and outpatients. However to deliver activity and access standards and maintain nurse staffing ratios the Trust continues to rely heavily upon agency staffing to cover clinical vacancies driving a continued pay overspend. Total agency spend in month was £2.3m, a slight fall on last month but above the NHSI trajectory.<br>• **Theatre Utilisation has stabilised around 83% with** room for further improvement due to insufficiently filled lists and large number of patient cancellations. |
| **CQUIN** | • **Sepsis - % of patients Screened (admission Units)** - On plan to hit 3 out of 4 Q1 targets, risk in achieving 90% of patients screened following an admitted to an admission unit in Q1. . ED staff have identified a way to ensure that all staff have a trigger to 'think sepsis' during triage. The pathway and triggers for those patients who present directly to MAU/SAU is next to be improved and engagement with colleagues in those areas is underway. |
| **Activity** | • Planned day case and elective activity performance has worsened and is 1.2% above the month 3 plan. This continues to be driven by over-performance within day case activity, with elective activity remaining below plan. Non-elective activity overall is 2.6% above the month 3 plan which is an increase in admissions from May. The over-performance is mainly within emergency short stay but an increase in long stay admissions has also been seen. A&E has seen activity 2.4% above the month 3 plan which is a continued over-performance but a reduction from that seen in month 2. Outpatient activity has continued to see a further significant increase across first and follow-ups and is 6.7% above the month 3 plan |

## Background Context

Additional beds were closed for most of June, some small peaks required a short injection of capacity but Divisions worked hard to close this quickly.

Staffing remains a challenge with increased focus on good roster management and in hours planning. A decision to centralise all Flexible workforce capacity was agreed and the implementation of this is being expedited.

Standard Operating Protocols (SOPs) have been developed to increase controls on agency usage and a full review of all posts with agency attributed has been undertaken.

The vacancy control process has been improved with clinical, operational and financial input reviewing requests weekly so a maximum of 7days between decision points and identifying trends where delays occur

Within the Community services division two senior clinicians have been supporting the SAFER patient flow programme and are leading pieces of transformation work that will support reducing hospital admission, reducing length of stay and improving flow through the medical and rehabilitation wards.
The division is looking at better ways of communication and is going to introduce a divisional twitter account over the next month.

The development of Hospital @ Night and 7/7 services continues but has required a refocus on engagement to ensure fully inclusive

Outpatients are busy with actions related to the CIP scheme on clinic utilisation delivering results as activity across first and follow-ups is above the month 3 plan. Divisions continue to drive through the implementation of their CIP plans including active involvement in the Safer programme and development of responses to the Carter review.

A system Transformation Board has been established with CIP & QIPP plans shared and priorities identified. Ensuring robust clinical and operational input to CCG QIPP schemes is essential and is being developed through clear Terms of Reference. The connection with Local Authority plans still requires development to ensure no duplication or unintended consequences.

In summary June has seen a significant improvement in Performance for the organisation with the overall Performance Score moving from 56% in May to 64% (see page 5).
The Trust achieved all of its Regulatory Targets in month with the following areas moving from Red to Green:
Total Number & avoidable number of Clostridium Difficile Cases
Emergency Care Standard 4 hours
62 Day Referral From Screening to Treatment

4 of the 6 domains improved their Performance Score in month most notably 'Responsive' which now has a Green rating.

A number of indicators had their best performance for some months including the Emergency Care Standard where we delivered the first green month since December15. Several Stroke metrics and cancelled operations.

# Performance Summary

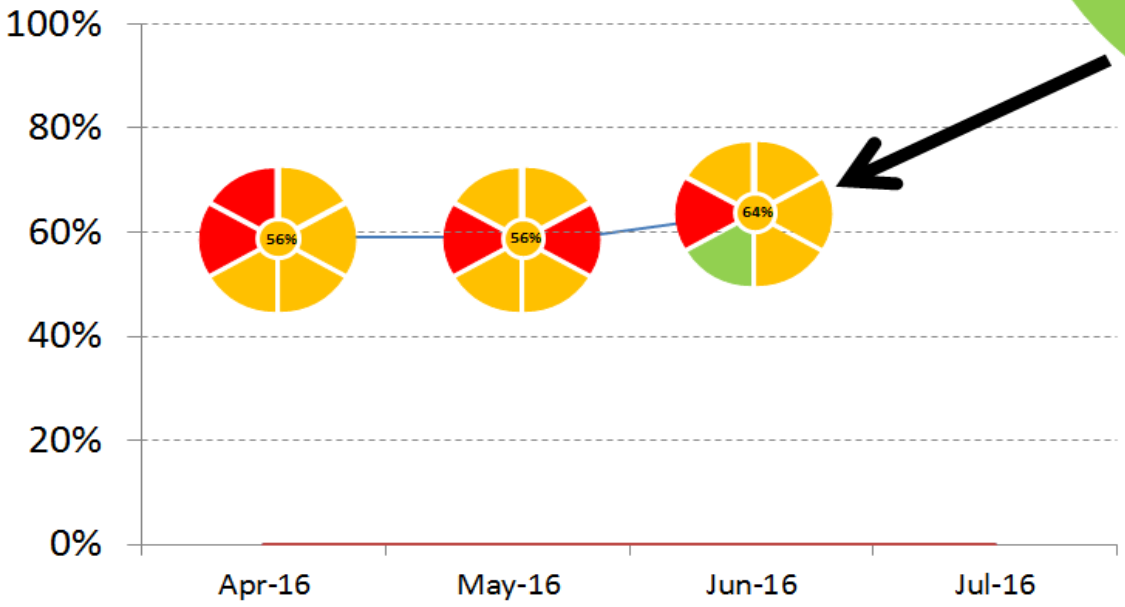
## Most recent month's performance

**RAG Movement**

Within the **Effective** domain an improved performance within number of CDiff cases, number of E.Coli - Post 48 Hours, Stillbirths rate, Crude mortality rates and Emergency Readmissions for GH CCG have resulted in an improved AMBER rating.

Within the **Responsive** domain improved performance in the Emergency Care Standard, % Stroke patients spending 90% of their stay on a stroke unit, % Stroke patients Thrombolysed within 1 hour and 62 Day Referral From Screening to Treatment have resulted in a GREEN rating.

## Total performance score by month




CHFT


**June Score by Domain**

| | |
|---|---|
| Safe | 56% |
| Effective | 56% |
| Caring | 70% |
| Responsive | 80% |
| Workforce | 36% |
| Efficiency & Finance | 65% |
| **Performance Score** | **64%** |

**Regulatory Targets**

| | |
|---|---|
| CDiff Cases | Cancer 62 day Referral to Treatment |
| Avoidable CDiff | Cancer 62 day Screening to Treatment |
| ECS 4 hours | Cancer 31 day targets x3 |
| RTT Incomplete Pathways | Cancer 2 Week Referral to Date first seen |
| Data Completeness Community Care x3 | Cancer 2 week Breast Symptoms |

**Other Key Targets**

| | |
|---|---|
| VTE Assessments | FFT targets x7 |
| Never events | FFT A&E 88.56% (90%) |
| MRSA | FFT OP 90.6% (95%) Community 85% (96%) |
| SHMI 113.88 (100) | Stroke % admitted 4 hours 68.75% (90%) |
| HSMR 111.62 (100) | Diagnostics 6 weeks |
| Emergency Readmissions GHCCG 7.69% (7.05%) | Net surplus/ (deficit) 0.15 |
| % Complaints closed 33% (100%) | Sickness 4.14% (4%) |

## Carter Dashboard

TREND ARROWS:
Red or Green depending on whether target is being achieved
Arrow upwards means improving month on month
Arrow downwards means deteriorating month on month.

| | | Current Month Score | Previous Month | Trend | Target |
|---|---|---|---|---|---|
| CARING | Friends & Family Test (IP Survey) - % would recommend the Service | 97.8% | 97.7% | ↑ | 96% |
| | Inpatient Complaints per 1000 bed days | 2.1 | 2.2 | ↑ | TBC |
| EFFECTIVE | Average Length of Stay - Overall | 5.0 | 5.4 | ↑ | 5.17 |
| | Delayed Transfers of Care | 2.58% | 2.31% | ↓ | 5% |
| | Green Cross Patients (Snapshot at month end) | 94 | 90 | ↓ | 40 |
| | Hospital Standardised Mortality Rate (1 yr Rolling Data) | 111.60 | 114.04 | ↑ | 100 |
| | Theatre Utilisation (TT) - Trust | 83.85% | 85.60% | ↓ | 92.5% |
| RESPONSIVE | % Last Minute Cancellations to Elective Surgery | 0.56% | 1.04% | ↑ | 0.6% |
| | Emergency Care Standard 4 hours | 95.07% | 93.40% | ↑ | 95% |
| | % Incomplete Pathways <18 Weeks | 96.3% | 96.0% | ↑ | 92% |
| | 62 Day GP Referral to Treatment | 94.7% | 88.4% | ↑ | 85% |
| SAFE | % Harm Free Care | 91.88% | 93.94% | ↓ | 95.0% |
| | Number of Outliers (Bed Days) | 838 | 1363 | ↑ | 495 |
| | Number of Serious Incidents | 4 | 6 | ↑ | 0 |
| | Never Events | 0 | 1 | ↑ | 0 |

### MOST IMPROVED

**Improved: Performance against the 4 hour standard has improved and reached the 95% target for the first time this year.**

**Improved: Sickness Absence rate have futher reduced to 4.14% against 4% target the lowest position for several months. Short term sickness is now below target at 1.24% against 1.3%.**

**Improved: Number of Outliers - Noticable improvement on the previous two months performance, with 838 outliers as opposed to 1363 the previous month. Still some way to target but improvement being seen.**

### MOST DETERIORATED

**Deteriorated: Harm Free Care - the % of patients free of harm (not experienced either a fall, old or new pressure ulcer, a UTI (+catheter) or a VTE) has decreased this month. Poorer performance was driven by increases in the number of old pressure ulcers - (ulcers that are present on admission as opposed to being hospital acquired).**

**Deteriorated: Theatre Utilisation has deteriorated in month. This is impacted by on the day cancellations for both clinical and non clinical reasons.**

**Deteriorated: Vacancies - The vancancy increase is mainly attributable to additional posts that have recently been approved but recruitment has only just commenced. There are 10 Medical and Dental posts plus 18 Nursing.**

### ACTIONS

**Action: Safety Huddles are being implemented across the hospital to ensure there is an increased awareness of patient who are at risk of harm. Surgical division has a plan in place to look at the Catheter related infections.**

**Action: Individual and Sub Specialty team discussions have taken place and there is a a refreshed Service Improvement Group with involvement of Membership Councillor to support us with our service improvement approach.**

**Action: Recruitment has commenced for all posts.**

| PEOPLE, MANAGEMENT & CULTURE: WELL-LED | Current Month Score | Previous Month | Trend | Target |
|---|---|---|---|---|
| Doctors Hours per Patient Day | | | | |
| Care Hours per Patient Day | Available from Q2 | | | |
| Sickness Absence Rate | 4.1% | 4.4% | ↑ | 4.0% |
| Turnover rate (%) (Rolling 12m) | 14.0% | 14.3% | ↑ | 12.3% |
| Vacancy | 514.6 | 496.7 | ↓ | NA |
| FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q4 | 82.00% | Different division sampled each quarter. Comparisons not applicable | | |
| FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q4 | 64.00% | Different division samples each quarter. Comparisons not applicable | | |

| OUR MONEY | Current Month Score | Previous Month | Trend |
|---|---|---|---|
| Income vs Plan var (£m) | £1.31 | £0.53 | ● |
| Expenditure vs Plan var (£m) | £1.41 | -£0.78 | ● |
| Liquidity (Days) | | | |
| I&E: Surplus/(Deficit) var (£m) | £0.15 | -£0.06 | ● |
| CIP var (£m) | £0.69 | £0.02 | ● |
| FSRR | 2 | 2 | ● |
| Temporary Staffing as a % of Trust Pay Bill | | | |

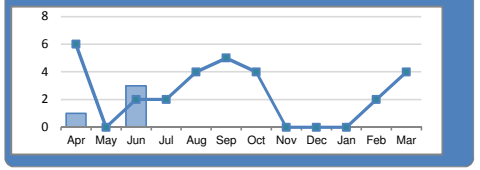
# Safe, Effective, Caring, Responsive - Community Key messages

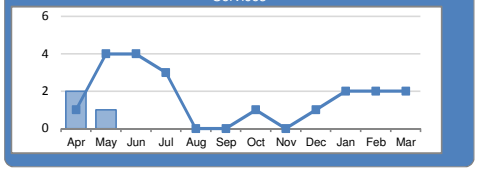
| Area | Issue | Corrective actions | Impact & Accountability |
|---|---|---|---|
| **Safe** | Community acquired grade 3 or 4 pressure ulcers 3 have been reported for June for community services | Community acquired grade 3 or 4 pressure ulcers service leads to establish whether these were actually attributed to community services / care and if so investigate circumstances. The 3 for June were found to be not attributed to community care. | Community acquired grade 3 or 4 pressure ulcers to reduce the number of pressure ulcers occurring as a result of community care<br>Accountable: Karen Barnett |
| **Effective** | Length of stay in reablement has significantly increased this month | Length of stay in reablement working with social care and the team leaders to establish whether a new way of structuring reablement services (including Support and independence team, crisis intervention team) would improve access and length of stay within the service. | Length of stay in reablement to reduce length of stay in reablement and free up capacity to support hospital discharges and admission avoidance.<br>Accountable: Karen Barnett |
| **Caring** | Patients dying in their preferred place 25/30 patients died in their preferred place of death.<br>FFT 4% of responders have reported they would not recommend the service. One major theme emerging is attitude.<br>Community - No access visits 240 no access visits in June | Patients dying in their preferred place Matrons reviewing the patients that did not. Supporting staff to be more confident with new ICOD pathway.<br>FFT Standards for communicating effectively by telephone and email to be shared across division. To share messages re behaviour expectations across the division at every meeting.<br>Community - No access visits Reviewing reasons and developing a strategy to increase compliance . | Patients dying in their preferred place To provide the opportunity for all patients to die in their preferred place.<br>Accountable: Diane Catlow<br>FFT To reduce the % not recommend by end August 2016.<br>Accountable: Nicola Sheehan<br>No access visits Reduce number of no access visits in community nursing by 1% month on month.<br>Accountable: Mandy Gibbons-Phelan |
| **Responsiveness** | ASI's for MSK Issue is generally in spinal pathway. Whilst capacity has remained there has been a 7.5% increase in demand for this service in the last year.<br>Typing turnaround the delay is now 17 day turnaround for typing letters post clinic for MSK. | ASI's Job planning has been undertaken through June which has identified a small amount of additional capacity. Writing a business case for increasing capacity<br>Typing turnaround reviewed opportunity to use voice recognition. Agreed some agency to reduce backlog and then include admin in business case | ASI's Reduce the number of ASI's in MSK.<br>Accountable: Nicola Sheehan<br>Typing turnaround Week on week improvement on typing turnaround<br>Accountable: Nicola Sheehan |

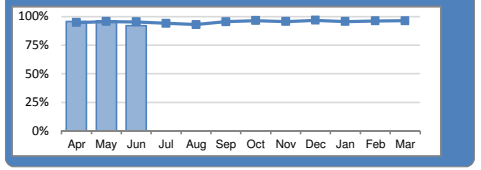
# Dashboard - Community

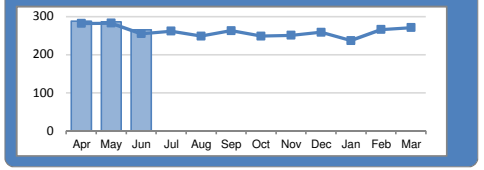
Bar Chart = 16/17 figures  Line graph = 15/16 figures

## Safe

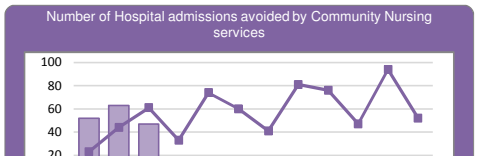


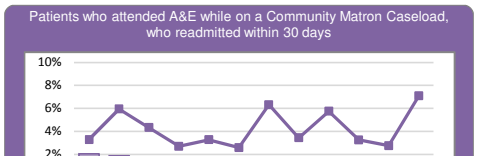



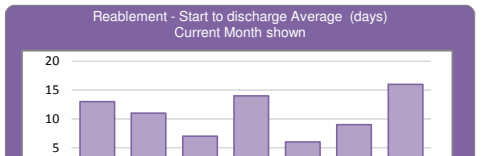



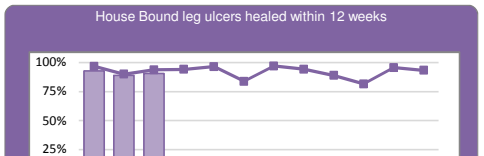




## Effective

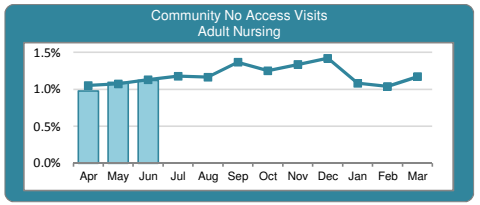


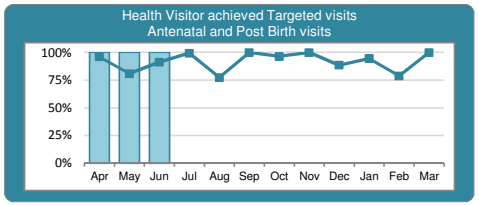



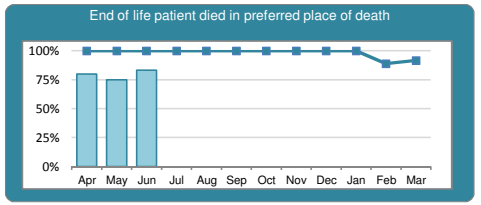



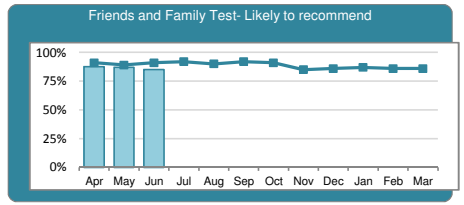




## Caring

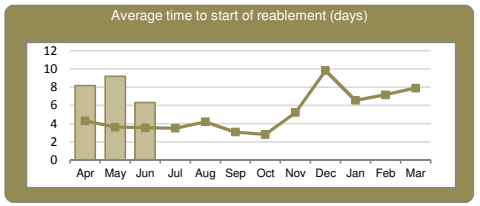


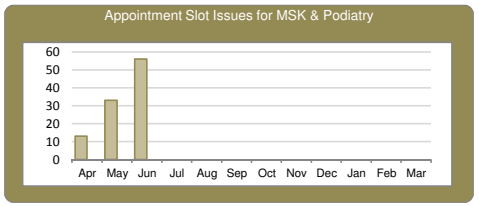



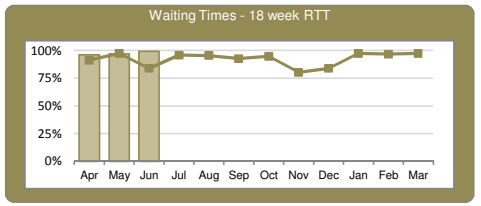



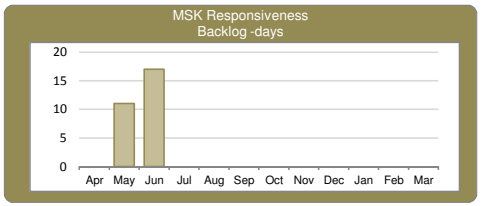




## Responsive



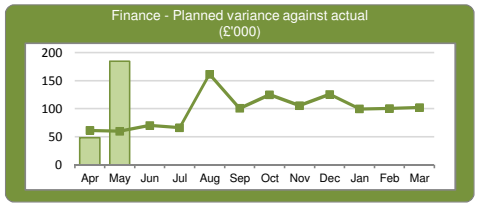



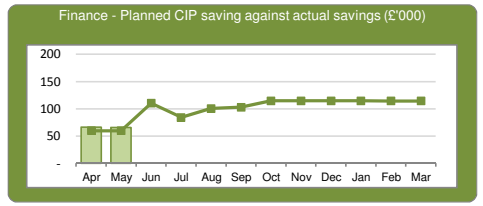




## Well Led





# Safe - Key messages

| Area | Issue | Corrective actions | Impact & Accountability |
|---|---|---|---|
| **Harm Free Care** | Harm Free Care:<br><br>Each month a point prevalence audit is done across the Trust, including Inpatient and Community areas to establish the % of patient who are free of any pressure ulcers, UTIs, VTE and have not experienced a fall in previous 3 days.<br><br>This month Harm free care for the trust is at 91.88%. The harm events contributing to this are primarily old pressure ulcers, of which there were 61, this is a large increase from the 34 in May. These are ulcers which are present on admission or developed within the first 72 hours of admission.<br>Alongside this there were also 12 new pressure ulcers, 4 harm falls, 9 UTI's in patients with a catheter and 7 VTEs. | The trust is introducing Safety Huddles across the organisation, Huddles have been shown to reduce rates of harm through a short multi-disciplinary conversation each day which focuses on reviewing the patient on the ward and any areas of risk. There are additional plans in place to look at Falls and Ulcer.<br><br>Falls: To enable improvements there has been an appointment of a specialist falls lead who will lead an agreed Falls quality improvement initiatives. The falls multidisciplinary collaborative meeting is recommencing in June which will engage clinicians across the trust to engage in a strategic approach to reviewing current practice and in managing a reduction in falls.<br><br>Pressure Ulcers: Investigations into category 3 ulcers are underway to increase learning. A report expected at the end of June .<br><br>CA-UTI: Surgical monitoring plan in place from matron for Ward 22.<br>Team re visiting discharge information given re catheter care and care | The improvements being rolled out to address Falls and Pressure ulcers will impact on the overall harm free care % throught Q2.<br><br>Accountable: Director of Nursing |
| **% PPH > 1500ml - all deliveries** | % of PPH continues to be above target.<br>An improvement in overall PPH rates had been recorded in April and May 2016, however, we are still above the target and this has increased in June 16.<br><br>We are building up more intelligence on the causes of PPH and impact of protocol. CHFT Colleagues are leading on Regional Maternity Dashboard developments. | PPH's monitored on a weekly basis as part of weekly Governance meeting.<br>(ongoing)<br>Changes to measurement of blood loss now in place<br>(ongoing)<br>RCOG Visit week commencing 25th July<br>(Complete in July) | 1% reduction in PPH rates >1500mls by the end of Q2 2016-2017 (3.8% reduced to 2.8%),<br>with a further 0.8% reduction in PPH rates >1500mls by the end of Q4 2016-2017 (3.8% reduced to 2%). |
| **Total C-Section Rate** | We have not met our internal target in Month (25.3% vs target 22.5%). However we remain below the regional threshold of 26.2%. We have seen a reduction YTD in the Total C-Section Rate vs 2015/16,<br><br>Whilst we have seen an increase in total number of C-sections, the weekly governance meeting enables robust analysis of indications for caesarean section and decision making. In the month of June 16 there were no cases assessed to be | Emergency Caesarean Sections are monitored on a weekly basis as part of weekly Governance meeting.<br>(Ongoing)<br><br>We continue with our work to reduce clinical variation, which includes peer review of clinical decisions and review of overall hot week and on call outcomes at the weekly governance meetings. (Ongoing) | Accountable: CD for Women's Directorate |

# Safe - Key measures

| | 15/16 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | YTD | Annual Target | Monthly Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Falls / Incidents and Harm Free Care** | | | | | | | | | | | | | | | | | |
| All Falls | 2033 | 167 | 144 | 155 | 172 | 180 | 168 | 194 | 187 | 167 | 156 | 152 | 184 | **164** | **500** | Monitoring Trajectory | |
| Inpatient Falls with Serious Harm | 29 | 4 | 2 | 2 | 4 | 3 | 0 | 2 | 3 | 3 | 2 | 6 | 5 | **4** | **15** | Monitoring Trajectory | |
| Falls per 1000 bed days | 7.7 | 7.8 | 6.8 | 7.4 | 8.3 | 8.1 | 7.7 | 8.9 | 7.9 | 7.2 | 6.7 | 6.9 | 7.1 | **7.5** | **7.2** | Monitoring Trajectory | |
| % Harm Free Care | 93.63% | 94.69% | 93.96% | 92.19% | 93.46% | 93.30% | 93.29% | 92.27% | 93.47% | 93.25% | 93.04% | 94.16% | 93.94% | **91.88%** | **93.33%** | >=95% | 95.00% |
| Number of Serious Incidents | 78 | 15 | 5 | 5 | 7 | 13 | 10 | 2 | 2 | 3 | 3 | 3 | 6 | **4** | **13** | Monitoring Trajectory | |
| Number of Incidents with Harm | 1751 | 201 | 89 | 111 | 176 | 159 | 203 | 97 | 147 | 139 | 156 | 160 | 169 | **153** | **482** | Monitoring Trajectory | |
| Percentage of SI's investigations where reports submitted within timescale (60 days unless extension agreed) | Not Collected | 50.00% | 100.00% | 100.00% | 90.00% | 0.00% | 0.00% | 21.00% | 33.00% | 28.00% | 100.00% | 80.00% | 66.00% | **None to report** | **75.00%** | 100.00% | 100.00% |
| Never Events | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | **0** | **1** | 0 | 0 |
| Percentage of Non-Compliant Duty of Candour informed within 10 days of Incident | 92.00% | 100.00% | 100.00% | 100.00% | 100.00% | 89.00% | 70.50% | 100.00% | 100.00% | 100.00% | 80.00% | In arears | In arears | **In arears** | **In arears** | 100% | 100% |
| Total Duty of Candour shared within 10 days | 94.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 86.00% | 91.00% | In arears | In arears | **In arears** | **In arears** | 100% | 100% |
| **Maternity** | | | | | | | | | | | | | | | | | |
| Elective C-Section Rate | 9.00% | 7.50% | 8.50% | 7.50% | 9.60% | 9.60% | 9.10% | 9.00% | 7.60% | 9.50% | 9.00% | 9.10% | 9.60% | **9.90%** | **9.60%** | <=10% | 10.00% |
| Total C-Section Rate | 23.90% | 21.90% | 24.20% | 25.30% | 20.40% | 28.30% | 22.60% | 25.70% | 22.60% | 23.10% | 23.60% | 22.20% | 21.30% | **25.30%** | **23.00%** | <=22.5% | 22.50% |
| Major PPH - Greater than 1000mls | 10.40% | 14.60% | 9.60% | 9.50% | 7.60% | 11.60% | 11.00% | 9.60% | 11.20% | 11.80% | 10.60% | 10.20% | 7.30% | **9.90%** | **9.60%** | <=8% | 8.00% |
| % PPH ≥ 1500ml - all deliveries | 3.78% | 6.90% | 4.80% | 2.30% | 3.30% | 4.20% | 3.50% | 2.90% | 4.00% | 2.80% | 3.60% | 2.90% | 2.40% | **3.40%** | **2.90%** | <=2.2% | 2.20% |
| Antenatal Health Visiting Contact by 32 Weeks | 91.80% | 96.00% | 98.00% | 85.00% | 113.00% | 95.00% | 100.00% | 77.00% | 95.00% | 87.00% | 100.00% | 103.00% | 115.00% | **101.20%** | **106.47%** | >=90% | 90.00% |
| **Pressure Ulcers** | | | | | | | | | | | | | | | | | |
| Number of Trust Pressure Ulcers Acquired at CHFT | 498 | 61 | 65 | 53 | 32 | 35 | 41 | 20 | 24 | 29 | 44 | 41 | 36 | **54** | **131** | Review after Q1 | |
| Pressure Ulcers per 1000 bed days | 1.9 | 2.8 | 3.1 | 2.5 | 1.5 | 1.6 | 1.9 | 0.9 | 1.0 | 1.3 | 1.9 | 1.8 | 1.6 | **2.5** | **2.0** | Review after Q1 | |
| Number of Category 2 Pressure Ulcers Acquired at CHFT | 403 | 51 | 53 | 46 | 26 | 25 | 38 | 13 | 21 | 22 | 35 | 31 | 24 | **33** | **88** | Review after Q1 | |
| Number of Category 3 Pressure Ulcers Acquired at CHFT | 86 | 9 | 10 | 7 | 6 | 9 | 3 | 6 | 3 | 7 | 8 | 9 | 12 | **20** | **41** | Review after Q1 | |
| Number of Category 4 Pressure Ulcers Acquired at CHFT | 9 | 1 | 2 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | **1** | **2** | 0 | 0 |
| Percentage of Completed VTE Risk Assessments | 95.30% | 95.20% | 95.90% | 95.60% | 95.20% | 95.20% | 95.30% | 95.40% | 95.40% | 95.10% | 95.10% | 95.01% | 95.14% | **95.25%** | **95.08%** | >=95% | 95.00% |
| **Safeguarding** | | | | | | | | | | | | | | | | | |
| Alert Safeguarding Referrals made by the Trust | 157 | 18 | 29 | 12 | 8 | 16 | 6 | 7 | 12 | 8 | 11 | 20 | 16 | **9** | **45** | Not applicable | |
| Alert Safeguarding Referrals made against the Trust | 99 | 9 | 10 | 6 | 4 | 9 | 6 | 8 | 7 | 12 | 13 | 7 | 10 | **8** | **25** | Not applicable | |

# Effectiveness - Key messages

| Area | Issue | Corrective Actions | Impact and Accountability |
|---|---|---|---|
| **Coding Indicators:**<br>**Average Diagnosis per Coded Episode**<br>**Average co-morbidity score**<br>**% Sign and Symptoms** | Average diagnosis per coded episode:<br><br>The average diagnosis per coded episode is still lower than target but performance continues to improve month on month.<br><br>Sign and Symptoms<br><br>Performance this month has seen an increase in the % of patients who were coded to a sign and symptom diagnosis. this increase was most noticeable in FSS and Medical Division. The overall trend in recent months is favorable.<br><br>Average Comorbidies<br><br>Following the peak of 4.2 last month performance has dropped slightly in month. The overall trend in recent months is favorable and performance is expected to remain on an upward trajectory. | Improvements in coding indicators are enabled through improved document and awareness of the standards required to code. Clinical engagement is driving this work forward and sustained improves are being seen.<br><br>There are some specific actions :<br><br>Women's Service: Audit the Sign and Symptom Primary Diagnosis patients from June 2016 - Complete in July 2016<br><br>Childrens Services: concentrate efforts to improve documentation quality on the Paediatric Assessment Unit where the co-morbidity documentation could be improved. By September 2016 (extra time allocated as more complex on the assessment unit due to short length of stays).<br><br>Surgical: looking into ways to use the information captured on the | Improvements in the coding indicators indicate that the trust is improving the quality of the documentation.<br><br>Expect to see continued improvement month on month across each average diagnoses and average co-morbidity, with a trajectory to hit targets in 2016/17<br><br>Accountable: ADD Surgery/Director of THIS/Head of Clinical Coding |
| **Hospital Mortality** | Local SHMI - Relative Risk (1yr Rolling Data)<br>The latest release is for Jan 15 - Dec 15 and is consistent with the previous release of 113. Data continues to be closely reviewed. The two diagnostic groups that are negative outliers within our SHMI data currently are Acute Cerebrovascular Disease and Pneumonia. The trust has invited service reviews in both stroke and respiratory specialities.<br><br>Hospital Standardised Mortality Rate (1 year Rolling Data)<br>The latest HSMR release is for April 15 to March 16, and has shown a fall to 111.6. Our prediction is for further modest reductions in the coming months.<br><br>Mortality Reviews<br>The completion rate for Level 1 reviews has come back in line with previous performance levels, levelling out at 48% YTD, with 45% of the May deaths having had a corporate level one review. The trust is aware that colleagues in the surgical division are doing mortality reviews on a number of patients in line with their own governance processes. Work has begun on how to integrate these reviews into the corporate process.<br><br>Crude Mortality Rate<br>For June 16 the crude in-hospital death rate at CHFT had | Mortality Ratios:<br><br>The difference between in hospital and post discharge standardised mortality ratios on each site continues to be monitored closely, and at present on the data available it cannot be said if this is the result of random variation or a real phenomenon. Nonetheless a new project to look at post discharge deaths with the CCG is at the pilot stage<br><br>There is a stroke service improvement plan overseen by the Medical Director.<br><br>Mortality Reviews:<br><br>Awaiting review of guidance for roll out of the Trust's new mortality reviews by consultants. In addition, further mortality reviews in respiratory service and stroke medicine have occurred. No key themes but additional work completed by Dr Nair. | The next SHMI is expected to remain at a similar level, as it reflects a delayed period of time when the HSMR was also stablised.<br><br>HSMR performance is expected to continue to reduce of the coming months.<br><br>Mortality review compliance will rise once the new process for involving all consultants in the process is established This will not be until the end of Q2.<br><br>Accountable : Associate Medical Director |
| **Peri-natal Deaths** | In June there were 2 Perinatal deaths. Our rate for the month was 0.41% which is above the threshold of 0.1%. Both cases are being reviewed through the Trust internal mechanisms. | A New SOP for Perinatal deaths and quarterly reports have been produced. Perinatal mortality group meet monthly to review cases and feedback learning. All perinatal deaths are logged on datix as an incident and fully investigated. (ongoing) | Accountable: Head of Midwifery /AND FSS |
| **Fracture Neck of Femur - Best Practice Guidance** | The National Hip Fracture Database for June records CHFT performing at 75% of patients to surgery within 36 hours. There were only 3 organisational breaches, 2 related to patient requiring THR and 1 related to theatre capacity. The remainder were either clinical delays or patient choice.<br>1 patient chose not to have surgery, but changed her mind after a week.<br><br>A national report due imminently which will enable benchmarking of the Trust position. | Twice daily updates with Trauma coordinator and GM "Plans for every trauma patient".<br>Automatic allocation of fallow laminar theatre lists to Orthopaedics where surgeons are available.<br>Use of downtime on CEPOD list where patients do not require Laminar flow theatre.<br>Further work is underway regarding the timeliness of all trauma capacity with a view to improve the whole service for our patients.<br>Continue RCA for every patient that breaches with a focus on | The whole plan will be completed in Q3 2016<br><br>Accountable: General Manager Orthopaedics |

# Effectiveness - Key measures

| | 15/16 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | YTD | Target | Threshold/Monthly |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Infection Control** | | | | | | | | | | | | | | | | | |
| Number of MRSA Bacteraemias – Trust assigned | 3 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **0** | 0 | 0 |
| Total Number of Clostridium Difficile Cases - Trust assigned | 25 | 1 | 1 | 3 | 3 | 4 | 2 | 1 | 3 | 3 | 2 | 2 | 3 | **1** | **6** | <=21 | < = 2 |
| Avoidable number of Clostridium Difficile Cases | 5 | 1 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 2 | **0** | 3 | 0 | 0 |
| Number of MSSA Bacteraemias - Post 48 Hours | 9 | 1 | 0 | 2 | 0 | 1 | 0 | 1 | 1 | 1 | 0 | 1 | 1 | **0** | **2** | <=12 | 1 |
| Number of E.Coli - Post 48 Hours | 26 | 5 | 3 | 3 | 0 | 5 | 4 | 1 | 0 | 1 | 0 | 2 | 3 | **0** | **5** | <=26 | 2.17 |
| MRSA Screening - Percentage of Inpatients Matched | 99.52% | 95.74% | 96.78% | 93.60% | 95.29% | 96.00% | 95.55% | 96.08% | 96.08% | 96.37% | 95.11% | 95.35% | 95.64% | **95.33%** | **95.06%** | >=95% | 95% |
| **Mortality** | | | | | | | | | | | | | | | | | |
| Stillbirths Rate (including intrapartum & Other) | 0.41% | 0.21% | 0.41% | 0.00% | 0.64% | 0.80% | 0.20% | 0.42% | 0.42% | 0.68% | 0.22% | 0.66% | 0.85% | **0.41%** | **0.64%** | <=0.5% | 0.5% |
| Stillbirth numbers | | 1/472 | 2/484 | 0/449 | 3/466 | 4/482 | 1/493 | 2/480 | 2/481 | 3/438 | 1/450 | 3/456 | 4/469 | **2/483** | **9/1408** | Not applicable | |
| Perinatal Deaths (0-7 days) | 0.16% | 0.00% | 0.00% | 0.21% | 0.21% | 0.00% | 0.43% | 0.00% | 0.21% | 0.21% | 0.22% | 0.00% | 0.65% | **0.41%** | **0.36%** | <=0.1% | 0.1% |
| Perinatal Deaths (0-7 days) numbers | | 1/472 | 1/484 | 0/449 | 2/466 | 0/480 | 0/493 | 1/480 | 1/481 | 0/438 | 1/450 | 0/456 | 3/469 | **2/483** | **5/1408** | Not applicable | |
| Neonatal Deaths (8-28 days) | 0.04% | 0.00% | 0.00% | 0.00% | 0.00% | 0.22% | 0.00% | 0.00% | 0.21% | 0.00% | 0.00% | 0.00% | 0.00% | **0.00%** | **0.00%** | <=0.1% | 0.1% |
| Local SHMI - Relative Risk (1yr Rolling Data ) | 109.10 | 111.10 | 113.88 | 113.88 | 113.88 | 113.80 | 113.80 | 113.80 | In arrears | In arrears | In arrears | in arrears | In arrears | **In arrears** | **113.88** | <=100.0 | 100 |
| Hospital Standardised Mortality Rate (1 yr Rolling Data) | 113.00 | 114.20 | 116.00 | 116.24 | 116.18 | 116.22 | 116.06 | 116.49 | 116.30 | 114.04 | 111.62 | in arrears | in arrears | **in arrears** | **111.60** | <=100.0 | 100 |
| Mortality Reviews | 48.80% | 31.80% | 76.90% | 56.70% | 64.10% | 60.20% | 62.60% | 56.60% | 46.20% | 43.90% | 46.20% | 50.40% | 46.30% | **In arrears** | **48.24%** | 100% | 100% |
| Crude Mortality Rate | 1.34% | 1.19% | 1.08% | 1.18% | 1.22% | 1.21% | 1.33% | 1.41% | 1.53% | 1.46% | 1.49% | 1.43% | 1.60% | **1.32%** | **1.45%** | <=1.32% | 1.32% |
| **Coding and submissions to SUS** | | | | | | | | | | | | | | | | | |
| Completion of NHS numbers within acute commissioning datasets submitted via SUS | 99.94% | 99.94% | 99.94% | 99.93% | 99.94% | 99.93% | 99.93% | 99.94% | 99.93% | 99.95% | 99.95% | 99.92% | 99.94% | **99.94%** | **99.94%** | >=99% | 99% |
| Completion of NHS numbers within A&E commissioning datasets submitted via SUS | 99.04% | 99.10% | 99.10% | 98.80% | 99.10% | 98.80% | 99.00% | 99.10% | 98.50% | 98.60% | 98.89% | 98.99% | 99.22% | **99.14%** | **99.21%** | >=95% | 95% |
| % Sign and Symptom as a Primary Diagnosis | 9.63% | 9.57% | 10.03% | 9.43% | 10.81% | 10.08% | 9.65% | 9.46% | 8.99% | 8.90% | 9.37% | 9.14% | 8.70% | **9.58%** | **9.10%** | <=9.4% | 9.40% |
| Average co-morbidity score | 3.48 | 3.32 | 3.15 | 3.27 | 3.36 | 3.51 | 3.59 | 3.82 | 3.62 | 3.94 | 3.84 | 3.77 | 4.2 | **3.9** | **4.0** | >=4.4 | 4.40 |
| Average Diagnosis per Coded Episode | 4.34 | 3.94 | 3.98 | 4.11 | 4.35 | 4.39 | 4.53 | 4.74 | 4.68 | 4.84 | 4.89 | 4.94 | 5.05 | **5.1** | **5.04** | >=5.3 | 5.30 |
| CHFT Research Recruitment Target | 1029 | 44 | 49 | 75 | 79 | 142 | 128 | 114 | 111 | 96 | 96 | 90 | 70 | **In arrears** | **160** | >=1008 | 92 |
| **Best Practice Guidance** | | | | | | | | | | | | | | | | | |
| Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge | 69.40% | 76.74% | 66.67% | 63.16% | 55.56% | 73.81% | 79.49% | 86.00% | 71.79% | 70.70% | 61.29% | 67.50% | 67.40% | **75.00%** | **69.20%** | >=85% | 85% |
| IPMR - Breastfeeding Initiated rates | 79.80% | 79.20% | 77.30% | 76.10% | 80.20% | 80.20% | 83.90% | 77.60% | 79.50% | 77.60% | 78.30% | 77.50% | 78.50% | **75.60%** | **77.20%** | >=70% | 70% |
| **Readmissions** | | | | | | | | | | | | | | | | | |
| Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG | 7.85% | 8.30% | 7.77% | 6.35% | 7.13% | 8.73% | 7.09% | 6.60% | 6.78% | 7.81% | 7.08% | 7.70% | 7.84% | **6.35%** | **7.38%** | <=7.97% | 7.97% |
| Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG | 7.95% | 8.96% | 8.34% | 7.21% | 6.45% | 7.35% | 6.95% | 7.06% | 7.51% | 8.07% | 8.06% | 7.88% | 9.44% | **7.69%** | **8.31%** | <=7.05% | 7.05% |
| % of patients under the care of the community specialist matron who have been readmitted to hospital with the same LTC in less than 30 days | 4.20% | 4.30% | 2.70% | 3.30% | 2.60% | 6.30% | 3.40% | 5.70% | 5.70% | 3.30% | 2.75% | 4.20% | 2.90% | **In arrears** | **3.55%** | <=10% | 10% |

# Caring - Key messages

| Area | Issue | Corrective Actions | Impact and Accountability |
|---|---|---|---|
| **Friends & Family Test A&E** | The in month performance has deteriorated slightly from 90% to 88.6% and on average remains a better position than seen previously. .<br><br>Staff in the department continue to work together to improve compliance with response rates. | There is a focused piece of work on the comment being received which indicate that patients 'would not recommend' to understand key themes.<br><br>To ensure the response rate continues above target, staff are prompted at handover to give cards out, this includes medical and nursing staff. Reception staff prompted to ask for mobile | Qualitative data capture is improving with increased response rates and information through text messages. This will aid accurate actions to address the reasons behind 'would not recommend' responses.<br><br>Accountable : Emergency Network Matron |
| **Friends & Family Test - Outpatients** | Our Would Recommend % for Outpatients consistently performs around 90% with most negative comments about car parking facilities and waiting times.<br><br>The Main specialities with negative feedback are, General Surgery, General Medicine, ENT and Ophthalmology. This has been balanced with positive comments including the helpfulness and friendliness of the staff. The early data we have for July suggests that we are starting to see an improvement | FFT Responses are being monitored via the weekly OP Manager meeting and specialty level action plans are in place. (Ongoing)<br><br>The Process for reporting Waiting time delays in clinics has been reviewed and more robust procedures put in place (July 11th 2016) | Ambition to achieve increase over 91% for Q2 2016/17.<br><br>Accountable: Matron for Outpatients |
| **Friends & Family Test - Community** | 85% of patients who responded said they would recommend the service with 4% saying they would not recommend. | A more in depth survey has been developed for those areas where people are saying they would not recommend to understand the areas that need to be worked on. | The % would not recommend is expected to reduce by the end August 2016. |

# Caring - Complaints Key messages

| Area | Issue | Corrective Actions | Impact and Accountability |
|---|---|---|---|
| **% Complaints closed within target timeframe** | 33% of the complaints closed in June were closed within agreed timescale. In total 70 complaints were closed in month, which is an 8% increase from May. This has resulted in the number of overdue complaints decreasing by 35% to 44 . This is a significant decrease from June and explains the low percentage of complaints closed within time .<br><br>In June SAS closed 50% of their complaints within the agreed timescale, Medicine closed 34%, FSS closed 42% and community 25%. The Trust has a target of 100% complaints to be closed within the agreed timescale; year to date the Trust has closed 46% within the agreed timescale. | Weekly meeting with Divisions and Complaints Team continue, improving responsiveness of complaints and providing guidance for older more complex complaints. The complaint investigation training package is now fully developed and we are looking for dates to start delivering this. This training will help improve the quality of complaints investigations, resolving the complaint quicker and reducing the likelihood of a complaint being reopened. | As training is rolled out then the timeliness and quality of the response should improve.<br><br>Accountable : Head of Risk and Governance and Divisional Leads |

## Complaints Background

The Trust received 49 new complaints June 2016, which is an 8% decrease from May. The total number of opened complaints at the end of June 2016 was 107 which is a decrease of 18% from May; 41% of these complaints are overdue. Of the 44 overdue complaints medicine represent 54% (24 complaints), SAS represent 30% (13 complaints), FSS represent 14% (6 complaints) and Community represent 2% (1 complaint)

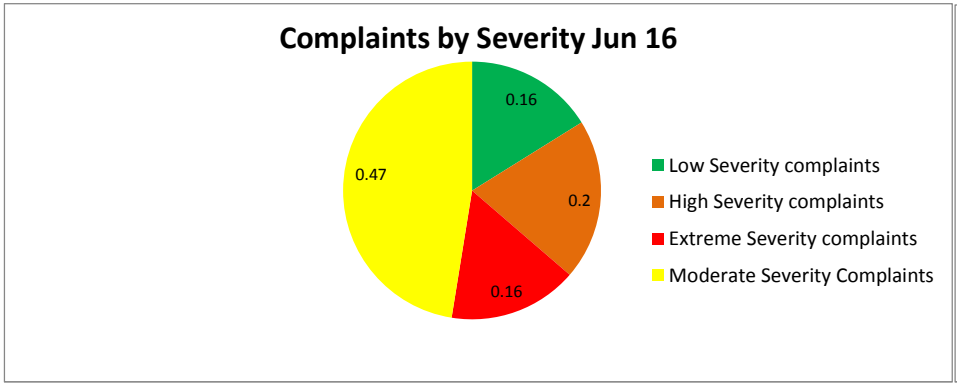
The top 3 Complaints subjects were:

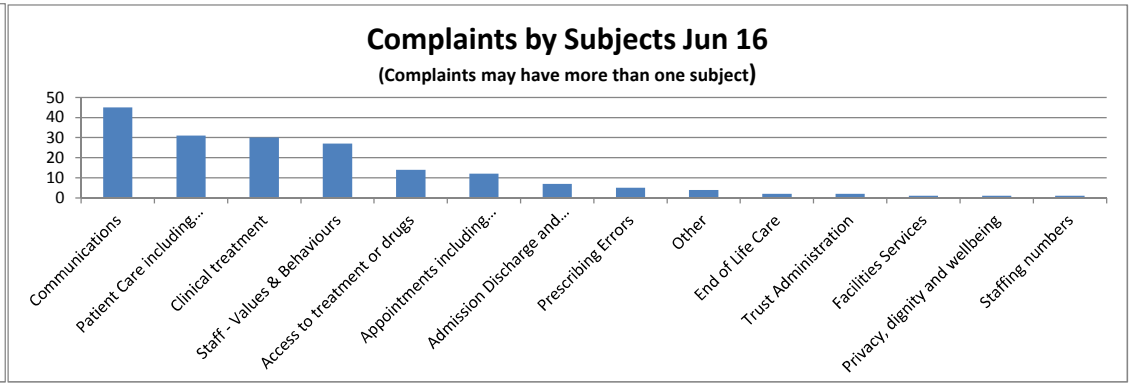
Communications
Patient Care including Nutrition/Hydration
Clinical Treatment

Whilst communication was within the top three complaints subject in May 2016, it is now the top subject complained about. There has also been an increase in Patient Care including Nutrition/Hydration, which had not previous been in the top 3 complaints subjects.

Severity: The Trust received 8 new Red complaints in June which is an increase of 63% from May 2016. Medicine received 5 Red complaints, SAS received 2 Red complaints and FSS received 1.

PHSO Cases:
The Trust received 1 new Ombudsman / PHSO case received in June 2016.
2 PHSO complaints were closed in June 2016; 1 was withdrawn and the other was partially upheld.
There were 16 active cases under investigation by the Ombudsman as at the end of June 2016.



# Caring - Key measures

| | 15/16 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | YTD | Target | Threshold/ Monthly |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Complaints** | | | | | | | | | | | | | | | | | |
| % Complaints closed within target timeframe | 48.45% | 55.68% | 61.11% | 56.41% | 51.85% | 61.11% | 39.68% | 39.73% | 47.73% | 43.94% | 45.45% | 66.67% | 37.88% | **33.00%** | **45.00%** | 100.00% | 100.00% |
| Total Complaints received in the month | 641 | 62 | 50 | 41 | 48 | 52 | 58 | 49 | 55 | 51 | 65 | 52 | 53 | **49** | **154** | Monitoring Trajectory | |
| Complaints re-opened | Not Collected | Not collected for 15/16 | | | | | | | | | | 9 | 5 | **5** | **19** | 0 | 0 |
| Inpatient Complaints per 1000 bed days | 2.20 | 2.42 | 2.23 | 1.77 | 2.27 | 2.35 | 2.36 | 2.24 | 2.26 | 2.05 | 2.72 | 2.10 | 2.20 | **2.15** | **2.10** | Monitoring Trajectory | |
| **Friends & Family Test** | | | | | | | | | | | | | | | | | |
| Friends & Family Test (IP Survey) - Response Rate | 28.60% | 21.94% | 26.50% | 28.10% | 24.40% | 31.10% | 32.90% | 34.30% | 32.10% | 33.50% | 30.70% | 30.98% | 31.41% | **35.53%** | **32.17%** | >=28.0% | 28.00% |
| Friends & Family Test (IP Survey) - % would recommend the Service | 96.90% | 97.37% | 96.60% | 97.10% | 96.50% | 96.70% | 96.70% | 96.40% | 97.10% | 97.00% | 96.94% | 97.09% | 97.70% | **97.75%** | **97.62%** | >=96.0% | 96.00% |
| Friends and Family Test Outpatient - Response Rate | 13.50% | 13.60% | 13.80% | 13.50% | 13.30% | 13.20% | 13.10% | 12.90% | 13.60% | 13.70% | 13.20% | 13.50% | 12.79% | **12.20%** | **12.83%** | >=5.0% | 5.00% |
| Friends and Family Test Outpatients Survey - % would recommend the Service | 89.60% | 88.40% | 89.50% | 89.20% | 89.20% | 90.20% | 90.50% | 91.60% | 90.50% | 89.70% | 90.70% | 90.50% | 90.79% | **90.60%** | **90.63%** | >=95.0% | 95.00% |
| Friends and Family Test A & E Survey - Response Rate | 8.50% | **8.60%** | **5.70%** | **2.70%** | **9.50%** | **12.10%** | 9.20% | 9.10% | 10.20% | 9.70% | 8.37% | 13.27% | 15.66% | **14.44%** | **14.49%** | >=14.0% | 14.00% |
| Friends and Family Test A & E Survey - % would recommend the Service | 86.90% | 91.10% | 91.10% | 84.80% | **86.20%** | 86.80% | 81.60% | 85.40% | 86.50% | 84.80% | 84.59% | 90.02% | 88.58% | **88.56%** | **88.88%** | >=90.0% | 90.00% |
| Friends & Family Test (Maternity Survey) - Response Rate | 30.80% | 26.30% | 27.50% | 29.60% | 42.60% | 30.90% | 40.80% | 33.60% | 30.30% | 30.70% | 34.47% | 26.99% | 33.16% | **45.11%** | **35.09%** | >=22.0% | 22.00% |
| Friends & Family Test (Maternity) - % would recommend the Service | 96.30% | 95.30% | 97.80% | 95.20% | 98.80% | 95.00% | 97.00% | 96.50% | 97.80% | 96.80% | 97.82% | 96.32% | 96.90% | **98.09%** | **97.10%** | >=96.9% | 96.90% |
| Friends and Family Test Community - Response Rate | 11.60% | 6.00% | 7.00% | 7.00% | 6.00% | 2.00% | 14.00% | 10.00% | 11.00% | 10.00% | 10.00% | 13.20% | 9.00% | **9.00%** | **10.40%** | >=3.4% | 3.40% |
| Friends and Family Test Community Survey - % would recommend the Service | 88.80% | 90.68% | 92.00% | 90.00% | 92.00% | 91.00% | 85.00% | 86.00% | 87.00% | 86.00% | 85.80% | 87.50% | 87.00% | **85.00%** | **86.50%** | >=96.2% | 96.20% |
| **Maternity** | | | | | | | | | | | | | | | | | |
| Proportion of Women who received Combined 'Harm Free' Care | 72.43% | 77.78% | 70.40% | 60.90% | 73.50% | 76.92% | 76.92% | 70.73% | 91.84% | 66.00% | 78.95% | 71.15% | 75.50% | **in arrears** | **73.33%** | >=70.9% | 70.90% |
| **Caring** | | | | | | | | | | | | | | | | | |
| Number of Mixed Sex Accommodation Breaches | 14 | 2 | 0 | 0 | 7 | 0 | 0 | 0 | 5 | 0 | 0 | 0 | 0 | **0** | **0** | 0 | 0 |

# Caring - What our patients are saying

## Some of the positive feedback we have received

**DAYCASE - HRI** - Staff were very courteous and explained the procedure very well.

**CRH 8C** - Nursing care from Ward 8C staff was excellent.

**AECDU HRI** - Very pleasant staff. Lovely Reception manager when booking in. Nice Nurses and Doctors. All went wll with treatment..

**DAYCASE - CRH** - Everything taken care of. Fast, efficient and friendly. All staff introduced themselves and talked me through the process, every step of the way. I came in very anxious but soon relaxed, making the process easier.

**CRH 8AB** - Staff are very polite and nothing is too much trouble, even though they are busy. Well appreciated. Operation went well and aftercare was good. Everything was clean and tidy. Polite staff, nothing too much trouble. Time was appreciated and Surgeon was excellent.

**HRI SAU** - Care was excellent throughout. Paramedics, A&E staff, X-ray, CT staff and Porters, also staff on SAU. Thank God for you all! Where would we be without these people?

**Labour & Birth: CRH** - Excellent care from beginning to the end. Really lovely that my husband could stay in my room overnight. Great relaxed atmosphere and staff gave input when asked and left us to do things at our own pace. A great experience thank you.you..

## Where can we improve

A private place to discuss your concerns, etc not the public waiting area. Individual empathy required, in some cases.

Less noise and general disturbance in ward. Food available was not appropriate for digestive condition, menu choices not available. No information given about recuperation needs.

More thorough and need to use multi-agency approach to help patients, not only with being admitted with a problem in the moment, but also underlying issues. Main Doctor very unsympathetic and very abrupt.

Lubricant from ET tube left a very nasty taste in my throat for quite some time after my operation. Could it be available in a nicer flavour?

More space for wheelchair and toilet rearranged to allow access with carer.

To be informed about treatment and to be on the proper ward to do with my condition (cardiac) and then seeing how I really am. Ward chaotic at times and didn't feel it was the right place for me.

Lack of information, not kept updated.

Improve sleep by being quieter on the ward.

# Responsive - Key messages

| Area | Issue | Corrective Actions | Impact and Accountability |
|---|---|---|---|
| **Emergency Care Standard 4 hours** | Improving patient flow through the Emergency Department and the hospital through to discharge into the community is essential.<br><br>Patients continue to experience on occasions long waits for inpatient beds.<br><br>Lack of consistent compliance with achieving 'bed before 11' - this prevents good capacity and demand management.<br><br>Over 50 days LOS has not reduced as would have expected at this period of the year.<br>High number of patients waiting for social assessment specifically community social workers.<br><br>There are differences in conversation rates and ambulatory care across the 2 sites. Some of this relates to the specialty differences however there is a slightly different model at CRH where, in addition to Ambulatory Care there is Admission Avoidance in ED. Whilst this offers some benefits it does mean an extended stay in AED and causes some confusion in relation to the | *Continuous Improvement*<br><br>Safer Patient Flow Programme launched. This includes :<br>1. Further roll out of Internal Professional Standards<br>2. Driving a reduction in LOS through the Ambulatory Emergency Care Collaborative which will deliver improvements in patient experience, improve patient flow and aid the delivery of the 4 hour ECS.<br>3. Acute Frailty model being tested, this will look to integrate with the care closer to home frailty model.<br>4. Escalation through SRG to improve system response to delays.<br>5. Review options for CHFT to provide rehab services in the community and social care in the community.<br>6. Community ward being planned.<br>7. Elderly Review Day in place.<br>8. Meeting to review patients with a LOS over 100 days arranged- with partners<br>9. ESCIT Action Plan being developed.<br><br>Working with the Ambulatory Collaborative on the optimal model for the service, ensuring all appropriate activity happens within the ambulatory setting; admission rates from each unit form part of the KPIs for this programme. | Q2 to be delivered month on month at 95%.<br><br>Accountable : ADD Medicine |
| **Patient Flow** | Pre 12 o'clock Discharges<br>The pre 12 o'clock discharges has not improved in month but still some distance from required 40% performance.<br><br>Green Cross<br>The number of patients with a LOS on or over 50 has increased.<br>Lack of internal professional standards.<br>Increasing delays due to lack of social assessments noted.<br><br>Number of Outliers (Bed Days)<br>Decrease in LOS from 6.0 to 5.5 days. Outliers reduced and flex capacity closed. | Pre 12 o'clock Discharges<br><br>1. ADN leading by supporting ward sisters with small tests of change to improve compliance. The performance target is 40%. May 16 performance improved with 2 wards now achieving 50%. Focused work starting on both short stay wards as these have the highest number of discharges.<br>2. Divisional Director engaging with consultants with a focus on identification of next day discharges , robust discharge planning, timely completion of TTO's and criteria led discharge.<br>Green Cross<br>1.Focused MDT discharge planning for all patients over 50/100 days in place.<br>2. Introduction of internal professional standards.<br>3. Discharge coordinators now using a case management model to improve patient experience, discharge planning, continuity and integration with social care Screen tool now in place to prevent unnecessary referrals<br>4. Escalation through SRG to improve system response to delays<br>Number of Outliers (Bed Days)<br>1.Discharge coordinators are pre-screening patients so ensure a coordinated approach prior to social care assessment which prevents delays.<br>2. Dedicated consultant and junior medical team to support outliers on the Calderdale site. Position much improved.<br>3. Escalation to SRG to ensure wider visibility of the reality.<br>4. Safer Patient Flow Programme ( all projects | Pre 12 o'clock Discharges<br>A weekly meeting with ward sisters 'buddy meetings' to monitor impact of the 'tests of change' is in place.<br>Focused work now on the two short stay wards as these have the highest number of discharges. The aim is to achieve full compliance with the target of 40% the end of Q2.<br><br>Accountable : ADN Medicine<br><br>Green Cross & Outliers<br>There is no resilience within the system and therefore a reduction of 5% can only be expected in the number of patients on a green cross pathway per month.<br>To be discussed as a key improvement target at SRG<br><br>Accountable: ADD |

# Responsive - Key messages

| Area | Issues | Corrective Actions | Impact and Accountability |
|---|---|---|---|
| **Stroke** | SNAPP data showed that the service had moved from a D to a B rating.<br><br>Improvements noted in all indicators although ongoing work to achieve full compliance still continues.<br>90% stay on stroke ward now at 87.50%<br><br>This is the an improvement in month<br>68.75% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival. An improvement of 18.75% in month. | Scanned within 1 hour where indicated<br>The stroke audit and data officer has completed an audit on this matter that has been shared with weekly stroke group. All scans that meet the criteria to be completed within the hour. This was commenced in June 16, this has supported the increase in compliance..<br><br>90% stay on stroke ward<br>On going management through patient flow meetings. Close monitoring through the weekly stroke improvement group. Plan for New protocol/SOP developed for rehab/Stroke Ward to enable increased ASU capacity. New process will launched in July 16.<br><br>% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival<br>The stroke team are working with patient flow to prevent outliers. They are also ensuring any outliers that do occur are moved to the appropriate ward ASAP. The stroke nurses are also now personally reviewing all possible stroke patients to help make sure that a larger percentage of stroke patients are provided with the appropriate diagnosis the first time, which should have a positive influence on outcomes for the patients, 90% stay and patient flow therefore also helping direct admission times. | Improvements are expected in all indicators in month.<br><br>Accountable : GM IMS Directorate |
| **Cancer** | 38 day to Referral to Tertiary<br>Performance has declined, with 10 pathways not being sent within target time out of the 16 referrals. Breaches were seen in all divisions, with delays in Gynae, Lung, Urology and Head and Neck. | 38 day to Referral to Tertiary<br>All division have action plans in place to address performance with patients being closely tracked<br>Lung Actions: Respiratory Consultants are meeting with GPs to discuss the pathway, to look at opportunities to improve the timeliness . Respiratory Patients fast tracked straight to diagnostics prior to be seen in clinic.<br>Lack of substantive Respiratory Consultants has had an impact on performance - 2 consultants short listed for the substantive posts.<br>Gynae Actions: Ongoing review of pathways not meeting standard - discussed and reviewed at women's divisional performance review<br>Urology: Work underway regarding revised prostate pathway<br>Head and Neck: Review of pathway management | Improvement needed prior to Q3 when there is a change in the rules.<br><br>Accountable : Lead Cancer Manager |

## Responsive - Key measures

| | 15/16 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | YTD | Target | Threshold/ Monthly |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Accident & Emergency** | | | | | | | | | | | | | | | | | |
| Emergency Care Standard 4 hours | 93.88% | 95.44% | 95.44% | 95.36% | 95.37% | 95.11% | 94.87% | 95.26% | 91.49% | 89.44% | 89.30% | 93.87% | 93.40% | **95.07%** | **94.10%** | >=95% | 95.00% |
| A and E 4 hour target - No patients waiting over 8 hours | 1351 | 78 | 55 | 57 | 60 | 72 | 69 | 84 | 192 | 250 | 273 | 108 | 144 | **92** | **344** | M | M |
| A&E Ambulance Handovers 30-60 mins (Validated) | 103 | 3 | 4 | 2 | 3 | 7 | 6 | 1 | 13 | 12 | 20 | 10 | 14 | **13** | **37** | 0 | 0 |
| A&E Ambulance 60+ mins | 23 | 0 | 0 | 1 | 2 | 0 | 0 | 2 | 8 | 2 | 7 | 0 | 1 | **0** | **1** | 0 | 0 |
| A&E Trolley Waits | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **0** | 0 | 0 |
| **Patient Flow** | | | | | | | | | | | | | | | | | |
| % Daily Discharges - Pre 12pm | 19.47% | 16.94% | 18.09% | 17.28% | 17.03% | 16.20% | 14.85% | 16.47% | 15.09% | 15.62% | 14.41% | 16.41% | 22.02% | **22.59%** | **21.81%** | >=40% | 40.00 |
| Delayed Transfers of Care | 5.13% | 6.20% | 7.04% | 7.45% | 5.30% | 4.60% | 4.50% | 4.50% | 3.35% | 3.38% | 3.30% | 2.90% | 2.31% | **2.58%** | **2.60%** | <=5% | 5.00% |
| Green Cross Patients (Snapshot at month end) | 98 | 90 | 96 | 62 | 71 | 91 | 91 | 79 | 91 | 115 | 98 | 93 | 90 | **94** | **94** | <=40 | <=40 |
| Number of Outliers (Bed Days) | 9428 | 813 | 859 | 628 | 598 | 508 | 730 | 781 | 1035 | 989 | 883 | 1115 | 1363 | **838** | **3316** | <=495 | <=495 |
| **Stroke** | | | | | | | | | | | | | | | | | |
| % Stroke patients spending 90% of their stay on a stroke unit | 83.00% | 80.39% | 66.67% | 73.40% | 74.60% | 97.80% | 84.60% | 80.00% | 94.40% | 81.30% | 83.70% | 83.30% | 62.00% | **87.50%** | **76.92%** | >=90% | 90.00% |
| % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival | 60.67% | 59.30% | 53.10% | 48.40% | 83.00% | **65.40%** | 60.00% | 66.70% | 58.30% | 56.70% | 67.60% | 50.00% | 50.00% | **68.75%** | **56.94%** | >=90% | 90.00% |
| % Stroke patients Thrombolysed within 1 hour | 55.20% | 12.50% | 50.00% | 28.57% | 80.00% | 50.00% | 80.00% | 50.00% | 57.10% | 100.00% | 80.00% | 66.70% | 40.00% | **100.00%** | **73.33%** | >=55% | 55.00% |
| % Stroke patients scanned within 1 hour of hospital arrival (where indicated) | 68.42% | 75.00% | 56.52% | 75.00% | 90.91% | 72.00% | 75.00% | 66.70% | 78.94% | 50.80% | 47.80% | 64.29% | 64.30% | **77.27%** | **64.30%** | >=90% | 90.00% |
| **Maternity** | | | | | | | | | | | | | | | | | |
| Antenatal Assessments < 13 weeks | 91.60% | 91.48% | 92.10% | 91.10% | **90.40%** | 92.40% | 92.10% | 91.60% | 88.10% | 89.80% | 93.80% | 90.15% | 91.88% | **91.02%** | **91.00%** | >90% | 90.00% |
| Maternal smoking at delivery | 9.90% | 12.00% | 11.30% | 10.20% | 9.80% | **9.30%** | 8.50% | 8.20% | 7.80% | 10.20% | 9.70% | 10.40% | 8.40% | **8.00%** | **8.90%** | <=11.9% | 11.90% |
| **Cancellations** | | | | | | | | | | | | | | | | | |
| % Last Minute Cancellations to Elective Surgery | 0.67% | 0.50% | 0.71% | 0.51% | 0.76% | 0.43% | 0.59% | 0.75% | 0.62% | 0.69% | 0.96% | 0.71% | 1.04% | **0.56%** | **0.77%** | <=0.6% | 0.60% |
| Breach of Patient Charter (Sitreps booked with 28 days of cancellation) | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | **0** | **0** | 0 | 0 |
| No of Urgent Operations cancelled for a second time | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **0** | 0 | 0 |
| **18 week Pathways (RTT)** | | | | | | | | | | | | | | | | | |
| % Non-admitted Closed Pathways under 18 weeks | 98.47% | 98.63% | 98.23% | 98.55% | 98.67% | 98.48% | 98.62% | 98.44% | 98.32% | 98.39% | 98.17% | 98.42% | 98.49% | **98.32%** | **98.41%** | >=95% | 95.00% |
| % Admitted Closed Pathways Under 18 Weeks | 91.92% | 92.67% | 92.79% | 92.03% | 91.64% | 90.20% | 91.63% | 92.04% | 92.21% | 91.86% | 91.96% | 92.12% | 92.42% | **92.06%** | **92.20%** | >=90% | 90.00% |
| % Incomplete Pathways <18 Weeks | 95.70% | 95.44% | 95.55% | 95.44% | 96.07% | 95.80% | 96.04% | 95.45% | 95.95% | 95.80% | 95.70% | 96.16% | 96.01% | **96.35%** | **96.35%** | >=92% | 92.00% |
| 18 weeks Pathways >=26 weeks open | 139 | 246 | 197 | 174 | 137 | 98 | 94 | 126 | 152 | 127 | 139 | 186 | 195 | **121** | **121** | 0 | 0 |
| RTT Waits over 52 weeks Threshold > zero | 0 | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | **0.00%** | **0.00%** | 0 | 0 |
| % Diagnostic Waiting List Within 6 Weeks | 99.54% | 99.89% | 99.93% | 99.48% | 98.56% | 99.82% | 99.94% | 99.65% | 98.48% | 99.71% | 99.52% | 99.91% | 99.86% | **99.92%** | **99.83%** | >=99% | 99.00% |
| **Cancer** | | | | | | | | | | | | | | | | | |
| Two Week Wait From Referral to Date First Seen | 97.34% | 96.55% | 95.64% | 93.78% | 97.82% | 98.73% | 96.84% | 97.06% | 98.86% | 99.27% | 98.95% | 94.98% | 98.09% | **98.06%** | **97.07%** | >=93% | 93.00% |
| Two Week Wait From Referral to Date First Seen: Breast Symptoms | 95.82% | 94.92% | 94.87% | 98.60% | 98.47% | 94.85% | 95.89% | 94.05% | 96.85% | 96.55% | 96.55% | 90.07% | 93.67% | **97.66%** | **93.59%** | >=93% | 93.00% |
| 31 Days From Diagnosis to First Treatment | 99.81% | 99.24% | 100.00% | 100.00% | 100.00% | 100.00% | 99.12% | 99.30% | 100.00% | 99.09% | 100.00% | 99.14% | 100.00% | **99.14%** | **99.42%** | >=96% | 96.00% |
| 31 Day Subsequent Surgery Treatment | 99.15% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 96.77% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | **100.00%** | **100.00%** | >=94% | 94% |
| 31 day wait for second or subsequent treatment drug treatments | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | **100.00%** | **100.00%** | >=98% | 98% |
| 38 Day Referral to Tertiary | 49.54% | 41.40% | 56.50% | 35.30% | 60.00% | 72.20% | 68.80% | 57.90% | 7.10% | 59.10% | 52.90% | 47.06% | 68.18% | **37.50%** | **52.73%** | >=85% | 85.00% |
| 62 Day GP Referral to Treatment | 91.19% | 90.00% | 88.95% | 93.94% | 88.24% | 91.77% | 95.00% | 93.98% | 91.04% | 94.53% | 89.40% | 92.31% | 88.41% | **94.67%** | **91.99%** | >=85% | 85% |
| 62 Day Referral From Screening to Treatment | 95.74% | 100.00% | 100.00% | 100.00% | 100.00% | 95.65% | 88.24% | 96.67% | 94.44% | 100.00% | 100.00% | 91.30% | 88.00% | **93.75%** | **90.32%** | >=90% | 90% |
| 104 Referral to Treatment | 98.22% | 97.70% | 96.22% | 98.50% | 99.36% | 98.20% | 97.90% | 100.00% | 97.10% | 98.44% | 97.81% | 100.00% | 98.55% | **98.80%** | **99.08%** | 100.00% | 100.00% |
| **Elective Access** | | | | | | | | | | | | | | | | | |
| Appointment Slot Issues on Choose & Book | 18.60% | 25.70% | 35.80% | 34.50% | 19.60% | 18.60% | 17.80% | 13.00% | 9.90% | 15.52% | 16.80% | 16.50% | 15.28% | **In arrears** | **15.90%** | >=5% | 5.00% |
| **Data Completeness** | | | | | | | | | | | | | | | | | |
| Community care - referral to treatment information completeness | 50.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | **100.00%** | **100.00%** | >=50% | 50.00% |
| Community care - referral information completeness | 98.06% | 98.39% | **99.52%** | 98.77% | 97.92% | 97.85% | 98.81% | 98.30% | 97.86% | 97.76% | 97.68% | 99.87% | 99.30% | **98.39%** | **99.20%** | >=50% | 50.00% |
| Community care - activity information completeness | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | **100.00%** | **100.00%** | >=50% | 50.00% |

# Workforce - Monitor Key messages

| Area | Issue | Corrective Action | Impact and Accountability |
|---|---|---|---|
| **Sickness Absence** | 1. Long term absence is above target at 2.90% (2.86% YTD).<br><br>2. Short term absence is below target at 1.24% (1.37% YTD).<br><br>3. Return to work interviews are not consistently undertaken or recorded. | 100% of long term sickness absence have a 'wrap round' management plan. This is monitored on a routine basis and reported to the Board monthly.<br><br>Cases moving from short term to long term are monitored and reviewed by the end of 2nd week each month.<br><br>Return to work forms analysed to ensure short term absence is managed in accordance with policy triggers.<br><br>Return to work interview dates to be automatically transferred from e-roster to ESR - 31 August 2016.<br><br>On a monthly basis contact non-compliance areas to obtain an understanding of the reasons why return to work interviews are not undertaken or recorded - 31 July 2016.<br><br>Drop in open surgery sessions for line managers organised - up to 31 August 2016.<br><br>5 worst performing areas identified in each Division and meetings to be held with Directorate Managers to discuss action required - 31 August 2016.<br><br>Improved monthly sickness data to be circulated to Divisional and Directorate Management teams with specific focus on return to work interviews - 31 July 2016.<br><br>Comprehensive procedure for absence reporting for medical staff issued to new and existing colleagues in week commencing 4 July 2016. Impact to be reviewed | December 2016<br><br>**Accountable : Director of Workforce and OD.** |
| **Vacancies** | 1. 21 Consultant vacancies across hard to fill specialties<br><br>2. 203.85 FTE qualified staff nurse vacancies<br><br>3. 14.04% turnover rate<br><br>4. Overall vancancy increase is mainly attributable to additional posts that have recently been approved but recruitment has only just commenced. | International recruitment continuing for qualified nursing posts with Executive Board approval to expand search to India and the Philippines - Autumn 2016.<br><br>42 newly qualified nurses commence employment with the Trust - September 2016.<br><br>International recruitment programme agreed for Consultant posts – 31 August 2016.<br><br>Recruitment process improvements – May to September 2016.<br><br>Scoping work commenced with Huddersfield University in relation to Band 4 Associate Nursing Posts.<br><br>Design a comprehensive leaver survey/interview process - 31 July 2016.<br><br>Refresh recruitment campaign for nursing including the use of social media - 31 August 2016. | 31 July 2016<br><br>**Accountable :**<br><br>**Medical Director**<br>**Director of Nursing**<br>**Chief Operating Officer**<br>**Director of Workforce and OD** |

# Workforce - Monitor Key messages

| Area | Issue | Corrective Action | Impact and Accountability |
|---|---|---|---|
| **Appraisal** | 1. There is an absence of a sanction for non-compliance.<br><br>2. The appraisal scheduler tool which captures planned activity has not in previous years been fully or consistently utilised.<br><br>3. Limited opportunity for appraiser training. | Appraisal compliance to be monitored monthly through the divisional performance meetings<br><br>Design a proposal for a link to incremental pay progression and mandatory training and appraisal compliance – 31 July 2016.<br><br>Audit the use of the appraisal scheduler in Division/ corporate directorates to ensure a robust plan exists for all service areas - 15 August 2016.<br><br>A proposal for a pilot three-step appraisal training programme is being costed as part of a business case for resource for the Education and Learning Group. | 31 July 2016<br><br>**Accountable : Director of Workforce and OD**. |
| **Mandatory Training** | The functionality of the Oracle Learning Management (OLM) system in the national Electronic Staff Record (ESR) is limited and is not user friendly which has deterred some colleagues from using the tool enabling them to be fully compliant.<br><br>A specific functionality limitation has been highlighted regarding refresher training and the length of 'window' prior to renewal. This is currently set at 3/12 months before compliance expires.<br><br>There is an absence of a sanction for non-compliance.<br><br>The PREVENT element of mandatory training is delivered on a classroom basis through the Safeguarding team and capacity to deliver sufficient sessions to facilitate full compliance is limited. The requirement to deliver this training in a classroom environment is a DH requirement placed on all public sector bodies. | Business case for replacement learning management system considered and approved by the July Commercial Investment and Strategy Committee meeting.<br><br>Design a proposal for a link to incremental pay progression and mandatory training and appraisal compliance – 31 July 2016.<br><br>Prevent paper to be submitted to Executive Board in July 2016 by Head of Safeguarding .<br><br>A paper describing the options to manage mandatory training compliance , as a consequence of EPR implementation in 2016, to be considered by Executive Board on 14 July 2016. | 31 July 2016<br><br>**Accountable : Director of Workforce and OD**. |

# Workforce Information - Key measures

| | 15/16 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | YTD | Target | Threshold/Monthly |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Sickness YTD** | | | | | | | | | | | | | | | | | |
| Sickness Absence rate (%) *Target date - 31 Dec 2016* | 4.60% | 4.53% | 4.48% | 4.43% | 4.38% | 4.44% | 4.52% | 4.57% | 4.61% | 4.61% | 4.60% | 4.36% | 4.24% | * | **4.24%** | **4.00%** | =< 4.00% - Green 4.01 -4.5 Amber >4.5% Red |
| Long Term Sickness Absence rate (%) *Target date - 31 Dec 2016* | 3.10% | 3.15% | 3.14% | 3.10% | 3.05% | 3.05% | 3.09% | 3.12% | 3.12% | 3.11% | 3.09% | 2.79% | 2.86% | * | **2.86%** | **2.70%** | =< 2.7% Green 2.71% -3.0% Amber >3.0% Red |
| Short Term Sickness Absence rate (%) *Target date - 31 Dec 2016* | 1.50% | 1.37% | 1.34% | 1.33% | 1.33% | 1.39% | 1.43% | 1.45% | 1.49% | 1.51% | 1.50% | 1.57% | 1.37% | * | **1.37%** | **1.30%** | =< 1.3% - Green 1.31% -1.5% Amber >1.5% Red |
| **Sickness Monthly** | | | | | | | | | | | | | | | | | |
| Sickness Absence rate (%) | - | 4.45% | 4.36% | 4.23% | 4.13% | 4.77% | 5.07% | 5.02% | 4.94% | 4.65% | 4.40% | 4.36% | 4.14% | * | - | **4.00%** | =< 4.00% - Green 4.01 -4.5 Amber >4.5% Red |
| Long Term Sickness Absence rate (%) | - | 3.14% | 3.11% | 2.95% | 2.80% | 3.03% | 3.34% | 3.41% | 3.11% | 2.97% | 2.93% | 2.79% | 2.90% | * | - | **2.70%** | =< 2.7% Green 2.71% -3.0 Amber >3.0% Red |
| Short Term Sickness Absence rate (%) | - | 1.30% | 1.25% | 1.28% | 1.33% | 1.74% | 1.74% | 1.61% | 1.83% | 1.68% | 1.47% | 1.57% | 1.24% | * | - | **1.30%** | =< 1.3% - Green 1.31% -1.5% Amber >1.5% Red |
| **Attendance Management KPIs** | | | | | | | | | | | | | | | | | |
| Sickness returns submitted per month (%) *Target date - 30 April 2016* | 76.00% | | | | | | | | | 100% | 100% | 100% | 100% | * | - | **100.00%** | 100% Green 95%-99% Amber <95% Red |
| Return to work Interviews (%) *Target date - 31 Dec 2016* | 38.00% | | | | | | | | | 43.15% | 33.10% | 34.60% | 44.35% | * | - | **100.00%** | 100% Green 95%-99% Amber <95% Red |
| Number of cases progressing/not progressing from short term absence to long term absence | - | | | | | | | | | *** | 9 / 556 | **12/606** | 18/583 | * | - | - | |
| Long Term Sickness cases with a defined action plan *Target date - 30 April 2016* | - | | | | | | | | | 100.00% | 100.00% | 100.00% | 100.00% | * | - | **100.00%** | 100% Green 95%-99% Amber <95% Red |
| Number of short term absence cases managed at each stage in the formal procedure | - | | | | | | | | | *** | 344 | 385 | 441 | * | - | - | |
| Number of visits to dedicated intranet web pages. | - | | | | | | | | | 1261 | 1514 | 1339 | 1519 | * | - | - | |
| **Staff in Post** | | | | | | | | | | | | | | | | | |
| Staff in Post Headcount | 5820 | 5732 | 5701 | 5701 | 5749 | 5696 | 5730 | 5721 | 5753 | 5806 | 5820 | 5812 | 5816 | 5835 | - | - | |
| Staff in Post (FTE) | 5084.37 | 4961.18 | 4934.68 | 4941.67 | 4986.92 | 4956.52 | 4995.31 | 4987.74 | 5021.53 | 5077.42 | 5084.37 | 5070.90 | 5074.47 | 5092.63 | - | - | |
| **Staff Movements** | | | | | | | | | | | | | | | | | |
| Turnover rate (%) (Rolling 12m) | 15.71% | 15.14% | 15.64% | 15.71% | 16.76% | 16.56% | 16.57% | 16.63% | 16.84% | 16.79% | 15.71% | 14.80% | 14.28% | 14.04% | - | - | |
| **Vacancies** | | | | | | | | | | | | | | | | | |
| Establishment (Position FTE)** | 5572.34 | | | | | | | | | 5410.68 | 5572.34 | 5575.34 | 5575.37 | 5618.44 | - | - | |
| Vacancies (FTE)** | 495.19 | | | | | | | | | 387.12 | 484.70 | 494.92 | 496.71 | 514.63 | - | - | |
| Vacancies (%)** | 8.89% | | | | | | | | | 7.15% | 8.70% | 8.88% | 8.91% | 9.16% | - | - | |
| Agency Spend* | £19.93M | | | | | | | | | | | £2.13M | £2.44M | £2.31M | **£6.87M** | - | |
| **Hard Truths** | | | | | | | | | | | | | | | | | |
| Hard Truths Summary - Nurses/Midwives | - | 90.07% | 88.33% | 84.61% | 87.47% | 87.82% | 88.66% | 90.18% | 89.54% | 90.18% | 89.58% | 90.51% | 90.06% | 87.44% | - | **100.00%** | |
| Hard Truths Summary - Day Care Staff | - | 95.68% | 95.80% | 94.76% | 94.31% | 99.69% | 97.29% | 99.51% | 101.73% | 99.51% | 102.83% | 103.59% | 105.97% | 97.45% | - | **100.00%** | |
| Hard Truths Summary - Night Nurses/Midwives | - | 88.81% | 89.36% | 86.91% | 89.37% | 90.67% | 92.54% | 94.18% | 95.39% | 94.18% | 95.40% | 94.84% | 94.58% | 92.81% | - | **100.00%** | |
| Hard Truths Summary - Night Care Staff | - | 113.16% | 113.73% | 111.02% | 110.06% | 113.43% | 111.27% | 111.86% | 116.04% | 111.92% | 119.06% | 120.13% | 119.17% | 118.23% | - | **100.00%** | |
| **FFT Staff** | | | | | | | | | | | | | | | | | |
| FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q4 | - | | | | | | | | | | | | | | **82.00%** | - | |
| FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q4 | - | | | | | | | | | | | | | | **64.00%** | - | |
| **Mandatory Training** | | | | | | | | | | | | | | | | | |
| Fire Safety (1 Year Refresher) | 73.38% | 19.00% | 26.70% | 31.50% | 34.40% | 60.80% | 61.80% | 63.50% | 68.70% | 73.10% | 73.40% | 7.52% | 11.54% | 13.10% | **13.10%** | **100.00%** | 24% (100% at 31 March 17) |
| Information Governance (1 Year Refresher) | 84.24% | 73.20% | 73.30% | 70.30% | 70.90% | 72.20% | 72.90% | 76.50% | 79.10% | 82.30% | 84.20% | 5.68% | 8.27% | 12.19% | **12.19%** | **100.00%** | 24% (100% at 31 March 17) |
| Infection Control (1 Year Refresher) | 85.07% | 8.50% | 22.10% | 31.40% | 39.20% | 49.30% | 58.40% | 66.70% | 73.00% | 80.90% | 85.10% | 6.07% | 8.49% | 12.38% | **12.38%** | **100.00%** | 24% (100% at 31 March 17) |
| Manual Handling (2 Year Refresher) | 86.73% | 8.10% | 21.40% | 31.30% | 39.30% | 58.60% | 65.40% | 72.00% | 77.40% | 83.10% | 86.70% | 88.36% | 88.25% | 88.89% | **88.89%** | **100.00%** | 100% Green 95%-99% Amber <95% Red |
| Health and Safety (3 Year Refresher) | 84.60% | 7.90% | 21.10% | 31.10% | 38.50% | 48.60% | 58.40% | 66.50% | 73.00% | 80.40% | 84.60% | 86.80% | 87.18% | 87.81% | **87.81%** | **100.00%** | 100% Green 95%-99% Amber <95% Red |
| Equality and Diversity (3 Year Refresher) | 85.89% | 18.90% | 29.00% | 37.70% | 46.10% | 56.00% | 63.30% | 70.40% | 75.80% | 82.40% | 85.90% | 87.61% | 87.74% | 88.24% | **88.24%** | **100.00%** | 100% Green 95%-99% Amber <95% Red |
| Safeguarding (3 Year Refresher) | 78.34% | 4.00% | 12.20% | 19.60% | 25.20% | 57.90% | 61.00% | 66.00% | 69.80% | 73.60% | 78.30% | 81.09% | 81.37% | 81.90% | **81.90%** | **100.00%** | 100% Green 95%-99% Amber <95% Red |
| Dementia Awareness (3 Year Refresher) | 81.88% | | | | | 8.40% | 32.90% | 54.10% | 65.20% | 76.60% | 81.90% | 84.90% | 85.14% | 86.07% | **86.07%** | **100.00%** | 100% Green 95%-99% Amber <95% Red |
| Conflict Resolution (3 Year Refresher) | 77.63% | | | | | 7.40% | 27.80% | 47.70% | 58.70% | 70.80% | 77.60% | 81.73% | 82.58% | 83.40% | **83.40%** | **100.00%** | 100% Green 95%-99% Amber <95% Red |
| PREVENT (No renewal) | 61.59% | 32.70% | 33.60% | 35.50% | 37.50% | 39.90% | 43.40% | 51.40% | 51.80% | 54.80% | 61.60% | 63.71% | 65.70% | 65.41% | **65.41%** | **100.00%** | 100% Green 95%-99% Amber <95% Red |
| **Appraisal** | | | | | | | | | | | | | | | | | |
| Appraisal (1 Year Refresher) | 78.57% | 7.24% | 10.74% | 14.46% | 25.17% | 33.42% | 45.70% | 56.50% | 60.10% | 74.10% | 78.57% | 1.68% | 4.28% | 6.77% | **6.77%** | **100.00%** | 24% (100% at 31 March 17) |

* Data one month behind

** Vacancy information is updated monthly and is based on the funded establishment in ESR, this is fed by the establishment

# Workforce - Agency Staffing

## EXECUTIVE SUMMARY: Trust Financial Overview as at 30th Jun 2016 - Month 3

### YEAR TO DATE POSITION: M3

| | M3 Plan £m | M3 Actual £m | Var £m |
|---|---|---|---|
| Total Income | £92.46 | £93.77 | £1.31 |
| Total Expenditure | (£91.25) | (£92.66) | (£1.41) |
| EBITDA | £1.21 | £1.11 | (£0.10) |
| Non Operating Expenditure | (£6.37) | (£6.13) | £0.25 |
| Deficit excl. Restructuring | (£5.17) | (£5.02) | £0.15 |
| Restructuring Costs | (£0.00) | £0.00 | £0.00 |
| Surplus / (Deficit) | (£5.17) | (£5.02) | £0.15 |

### YEAR END 2016/17

| | Plan £m | Forecast £m | Var £m |
|---|---|---|---|
| Total Income | £371.52 | £375.00 | £3.48 |
| Total Expenditure | (£361.96) | (£365.92) | (£3.96) |
| EBITDA | £9.56 | £9.09 | (£0.47) |
| Non Operating Expenditure | (£25.66) | (£25.14) | £0.52 |
| Deficit excl. Restructuring | (£16.10) | (£16.06) | £0.05 |
| Restructuring Costs | (£0.00) | £0.00 | £0.00 |
| Surplus / (Deficit) | (£16.10) | (£16.06) | £0.05 |

### KEY METRICS

| | Year To Date | | | Year End: Forecast | | |
|---|---|---|---|---|---|---|
| | M3 Plan £m | M3 Actual £m | Var £m | Plan £m | Forecast £m | Var £m |
| I&E: Surplus / (Deficit) | (£5.17) | (£5.02) | £0.15 | (£16.10) | (£16.06) | £0.05 |
| Capital | £4.10 | £3.67 | £0.43 | £28.22 | £27.61 | £0.61 |
| Cash | £1.94 | £1.91 | (£0.03) | £1.95 | £1.90 | (£0.05) |
| Borrowing | £44.00 | £48.97 | £4.97 | £67.87 | £67.51 | (£0.36) |
| CIP | £1.78 | £2.47 | £0.69 | £14.00 | £14.04 | £0.04 |
| Financial Sustainability Risk Rating | 2 | 2 | | 2 | 2 | |

**Year to date:** The year to date financial position stands at a deficit of £5.02m, a favourable variance of £0.15m from the planned £5.17m. In month, the Trust has seen a strong performance against the clinical activity contract, driven primarily through non elective, A&E and outpatients. However, as has been the case in recent months, to deliver activity and access standards and maintain nurse staffing ratios the Trust continues to rely heavily upon agency staffing to cover clinical vacancies driving a continued pay overspend. Total agency spend in month was £2.3m, a slight fall on last month but above the NHSI trajectory and a significant draw on limited cash resources contributing to the need to bring forward borrowing.

The impact of this operational position is as follows at headline level:

- EBITDA of £1.11m, an adverse variance of £0.10m from the plan.
- A bottom line deficit of £5.02m, a £0.15m favourable variance from plan.
- Delivery of CIP of £2.47m against the planned level of £1.78m.
- Contingency reserves of £0.75m have been released against pressures.
- Capital expenditure of £3.67m, this is below the planned level of £4.10m.
- A cash balance of £1.94m in line with the planned level of £1.91m, supported by borrowing.
- A Financial Sustainability Risk Rating (FSRR) of level 2, in line with the plan.

In the year to date, the activity over performance has driven overall income recovery in excess of plan by £1.31m. This, coupled with strong CIP delivery in the first quarter, has been sufficient to offset the pay expenditure pressures. Further pressure has been borne in the first quarter as a result of the Junior Doctors' strike action which impacted operational performance and consequently financial performance by £0.5m. Of the £2m contingency reserves, £0.75m has been released in the year to date, offsetting this pressure but reducing the potential to mitigate against the greater outstanding risks in the remainder of the year.

**Forecast:** Whilst the year to date position is favourable, the expenditure run rate brings ongoing pressure with particular risk around high agency expenditure and the cash challenge. CIP has delivered in excess of plan in the year to date but this is a timing difference which is not forecast to continue, indeed the higher risk schemes are forecast to commence delivery in the last 6 months. EPR implementation and the introduction of the new Junior Doctors' contract bring further uncertainty and risk. By design, they are not within the control total and therefore the I&E and cash implications are subject to ongoing conversations with NHSI. Acknowledging these risks, the year end forecast position continues to be to deliver the planned £16.1m deficit. Divisions are required to deliver recovery plans to mitigate against the risks and pressures. In addition, it is assumed that the Trust will achieve the conditions to secure the £11.3m Sustainability and Transformation Funding which is intrinsic to delivery of the plan.

# Hard Truths: Safe Staffing

**Introduction**

This is a routine, monthly report to the Board of Directors which will provide headlines on the nursing workforce staffing position in June 2016.

**Fill Rates**

Average fill rates reported to Unify for registered nurse (RN) on both day and night shifts decreased in June on both sites in comparison to May 2016, resulting in average fill rates of less than 90% (Table 1).

One area achieved average fill rates of for RN night shift of 106% (Ward 8C) which was attributed to increased staffing levels due to the acuity of patients on 4 separate shifts.

Average fill rates for day shifts decreased this month for care staff in comparison to May 2016, with the average fill rate falling below 100% on the day shift on CRH site. Fill rates on both day and night shifts on the HRI site and the night shift at CRH remain above 100%.

Table 1: Average Fill Rates Registered Nurses and Care Staff

| Average Fill Rates: | Registered Nurses | | Care Staff | |
|---|---|---|---|---|
| | Day | Night | Day | Night |
| **June 2016 HRI** | **87.10%** | **94.00%** | **104.90%** | **128.60%** |
| **June 2016 CRH** | **83.70%** | **92.00%** | **96.30%** | **110.10%** |
| May 2016 HRI | 91.94% | 94.24% | 107.48% | 125.10% |
| May 2016 CRH | 89.60% | 94.55% | 104.84% | 113.97% |

June fill rates for Registered Nurses resulted in four clinical areas in comparison to three in May 2016 reporting average fill rates below 75%.

Ward 5AD continues to regularly report average fill rates of less than 75% (Day shift) due to the proportion of Registered Nurses working long days against planned.

Ward 5B reported average fill rate of 69.2% for Day shifts in June 2016 due to a level of vacancy.

Ward 8AB reported average fill rates of less than 75% (Day shift) for June 2016 in part due to 8B having closed beds and staff being redeployed to other areas and also due to Registered Nurse vacancies.

Ward 17 reported average fill rate for Registered Nurses on the Night shift in June 2016 of 72.4% which has been attributed to the vacancy level within this clinical area.

# Hard Truths: Safe Staffing (2)

Average fill rates (day and night) of less than 75% for care staff have been reported in four clinical areas which are LDRP, 4C, NICU and 3 (paediatrics). Recruitment to vacancies contributing to decreased fill rates are in process. Additional recruitment was completed on 11th July to assist with filling vacancies.

Fill rates in excess of 100% can be attributed to supporting 1-1 care requirements; realisation of supervisory time for band 7 registered nurses and for care staff supporting reduced fill rate of registered nurse hours.

Ward 3 reported an average fill rate on night shift for care staff of 223% which was due to significant demand for the whole month in supporting two patients. Whilst the desired level of staffing was not always achieved on Day shift (fill rate 119%) it was on the night shift. Staffing requirements were reviewed daily and a level of bank and agency usage approved within the division.

Wards 6A and 5B both reported fill rates for care staff (night shift) of 163.3% and 183.3% respectively, with a 100% fill rate for RN. These areas have had additional care staff following divisional review. Going forward these areas are not expected to report excessive fill rates. Vacancy and short term sickness – all LDRP vacancies have been filled, Ward 4C have ongoing vacancy as staff appointed have taken posts elsewhere.

Table 2: Rag Rating of Average Fill Rates Clinical Areas June 2016

| | Day | | Night | | Total |
|---|---|---|---|---|---|
| Average fill rate | RN | Care Staff | RN | Care Staff | |
| Red (less than 75% fill rate) | 3 | 2 | 1 | 2 | 8 |
| Amber (75 – 89% fill rate) | 21 | 8 | 6 | 2 | 37 |
| Green (90 – 100% fill rate) | 12 | 8 | 24 | 8 | 52 |
| Blue (greater than 100% fill rate) | 0 | 17 | 5 | 19 | 41 |

**Care Hours Per Patient Day**

CHFT submitted Care Hours Per Patient Day (CHPPD) for the first time in June 2016. Benchmarking data is not available yet, but expected soon through the efficiency portal.

A review of June 2016 CHPPD data indicates that the combined (RN and Care staff) metric resulted in 29 clinical areas of the 35 reviewed had CHPPD less than planned. 6 areas reported CHPPD slightly in excess of those planneTable 2: Rag Rating of Average Fill Rates Clinical Areas June 2016

# Hard Truths: Safe Staffing (3)

**Internal Never Events**

Four clinical areas have reported having less than the minimum 2 RN at all times in June.

Maternity reported two incidents where staffing levels resulted in less than 2 Registered Midwives at all times in June 2016 (23.6.16 and 25.6.16). The incidents reflect a period of high activity and critical staffing levels. The Matron and General Manager are reviewing and reporting any resulting impact in July.

Ward 4C reported less than two qualified nurses on the ward on 24.6.16 due to short term absence on 24.6.16

Ward 8AB on four nights (4th, 12th, 18th and 19th June) had 1 RN and 1 HCA.
On all four shifts 8B was closed. The nursing workforce worked across the floor (8C, 8D and 8AB) to ensure safe care was provided to all patients.
No adverse impact on patient care was reported.

8D had one qualified nurse on two night shifts in June (24th and 25th). On these shifts the qualified nurse on 8D was supported by the night matron and qualified nurses across the floor (8C and 8AB).

**Vacancies and Retention**

Registered nurse vacancies reported via ESR have decreased to 183 wte RN. The decrease is not as a result of increased recruitment, but attributed to cleansing the data within ESR. 52 wte HCA vacancies have been reported via ESR in June 2016 which are being reviewed by divisional teams as early indications suggest this figure may in reality be lower.

Recruitment events continue with monthly recruitment to band 5 nurses and additional events targeting areas with high levels of vacancies such as Medical Assessment Unit; Operating Department and Emergency Department. Successful recruitment to band 2 HCA's and apprentice HCA's completed this month has yielded 25 new recruits to the unregistered nursing workforce.

Engagement of third year student nurses at local universities has been completed (Leeds, Bradford, Huddersfield, UCLAN). A welcome event to meet both the senior nursing team and ward teams was completed on 20th June 2016 with 48 recruits attending.

International recruitment activity from the EEA has reduced as anticipated following the introduction of IELTs. The Corporate Risk Register has been updated in light of the reduction in availability of nurses within the EEA. The nursing workforce team continue to work with our provider agency to recruit nurses from the EEA and is working with colleagues in HR to develop a proposal to manage the IELTs requirements at CHFT.

The Nursing Workforce team are working with the Workforce and Development and Procurement teams to develop an overseas nursing campaign to recruit a cohort of 75 nurses.

The Nursing Workforce team have been working with the Communications team to improve information available through the CHFT website for external candidates considering a career at CHFT.

The Nursing Strategy Group has a sub group reviewing opportunities to develop new roles within the nursing workforce including Advanced Clinical Practitioners; Associate Nurses and Assistant Practitioners. The subgroup have commenced preliminary work with a local further education college to consider a higher apprentice qualification for assistant practitioners within the nursing workforce. The sub group are also in the process of completing an application to Health Education England to be a test pilot site for the nursing associate national pilot.

**Conclusion**

The Trust remains committed to achieving it's nurse staffing establishments. A range of actions are being developed and undertaken to recruit and retain the nursing workforce, and to develop data collection and reporting to support the nursing workforce.

# FINANCIAL POSITION

## YEAR TO DATE POSITION: M3

| | M3 Plan £m | M3 Actual £m | Var £m | |
|---|---|---|---|---|
| **Total Income** | **£92.46** | **£93.77** | **£1.31** | |
| **Total Expenditure** | **(£91.25)** | **(£92.66)** | **(£1.41)** | |
| **EBITDA** | **£1.21** | **£1.11** | **(£0.10)** | |
| Non Operating Expenditure | (£6.37) | (£6.13) | £0.25 | |
| **Deficit excl. Restructuring** | **(£5.17)** | **(£5.02)** | **£0.15** | |
| Restructuring Costs | (£0.00) | £0.00 | £0.00 | |
| **Surplus / (Deficit)** | **(£5.17)** | **(£5.02)** | **£0.15** | |

## YEAR END 2016/17

| | Plan £m | Forecast £m | Var £m | |
|---|---|---|---|---|
| **Total Income** | **£371.52** | **£375.00** | **£3.48** | |
| **Total Expenditure** | **(£361.96)** | **(£365.92)** | **(£3.96)** | |
| **EBITDA** | **£9.56** | **£9.09** | **(£0.47)** | |
| Non Operating Expenditure | (£25.66) | (£25.14) | £0.52 | |
| **Deficit excl. Restructuring** | **(£16.10)** | **(£16.06)** | **£0.05** | |
| Restructuring Costs | (£0.00) | £0.00 | £0.00 | |
| **Surplus / (Deficit)** | **(£16.10)** | **(£16.06)** | **£0.05** | |

## KEY METRICS: YEAR TO DATE M3

| | Year To Date | | | |
|---|---|---|---|---|
| | M3 Plan £m | M3 Actual £m | Var £m | |
| **I&E: Surplus / (Deficit)** | (£5.17) | (£5.02) | £0.15 | |
| **Capital** | £4.10 | £3.67 | £0.43 | |
| **Cash** | £1.94 | £1.91 | (£0.03) | |
| **Borrowing** | £44.00 | £48.97 | £4.97 | |
| **CIP** | £1.78 | £2.47 | £0.69 | |
| **Financial Sustainability Risk Rating** | 2 | 2 | | |

## KEY METRICS: YEAR END 2016/17

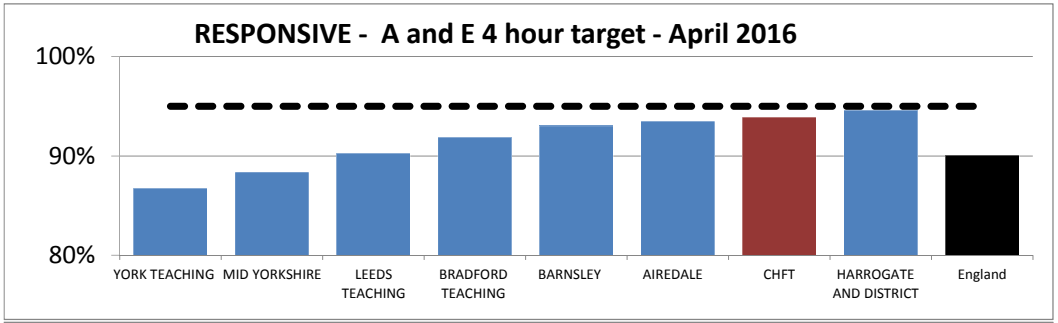
| | Year End: Forecast | | | |
|---|---|---|---|---|
| | Plan £m | Forecast £m | Var £m | |
| **I&E: Surplus / (Deficit)** | (£16.10) | (£16.06) | £0.00 | |
| **Capital** | £28.22 | £27.61 | £0.61 | |
| **Cash** | £1.95 | £1.90 | £0.00 | |
| **Borrowing** | £67.87 | £67.51 | (£0.36) | |
| **CIP** | £14.00 | £14.04 | £0.04 | |
| **Financial Sustainability Risk Rating** | 2 | 2 | | |

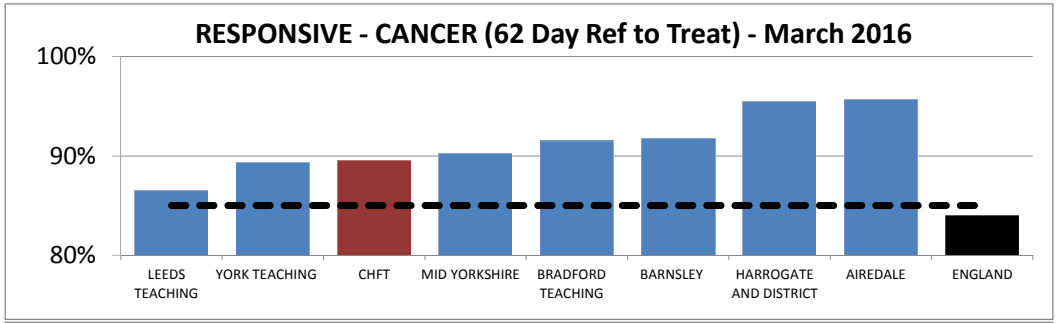
**RAG KEY:** (Excl: Cash)
- Actual / Forecast is on plan or an improvement on plan
- Actual / Forecast is worse than planned by <2%
- Actual / Forecast is worse than planned by >2%

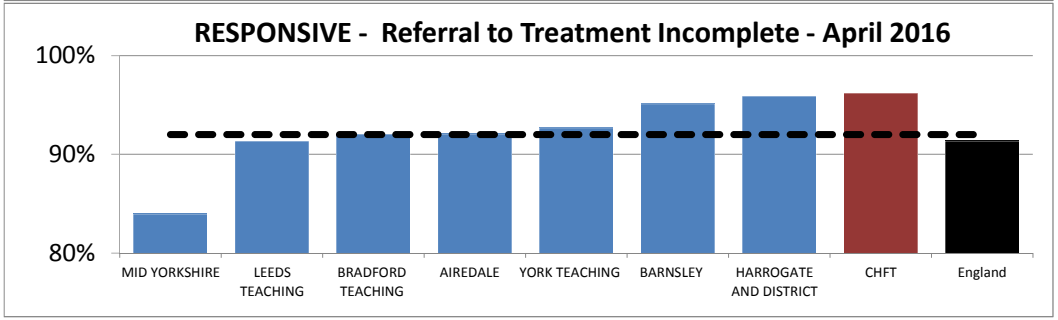
NB. In addition to the above rules, if Capital expenditure <85% of planned then Red, (per Monitor risk indicator)

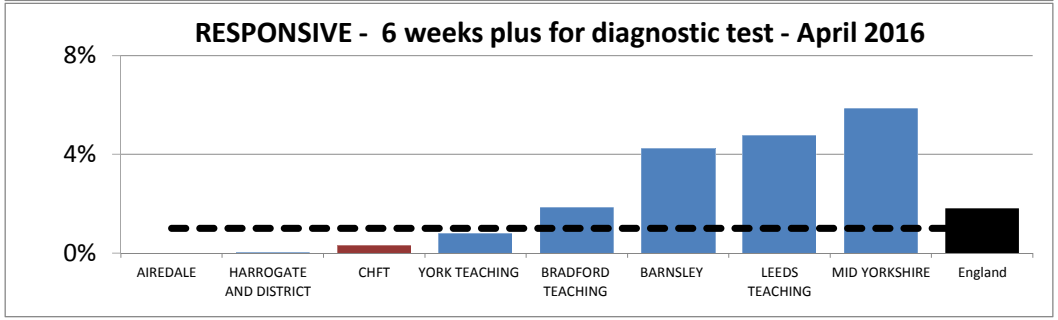
**RAG KEY - Cash:**
- At or above planned level or > £21.2m (20 working days cash)
- < £21.2m (unless planned) but > £10.6m (10 working days cash)
- < £10.6m (less than 10 working days cash)

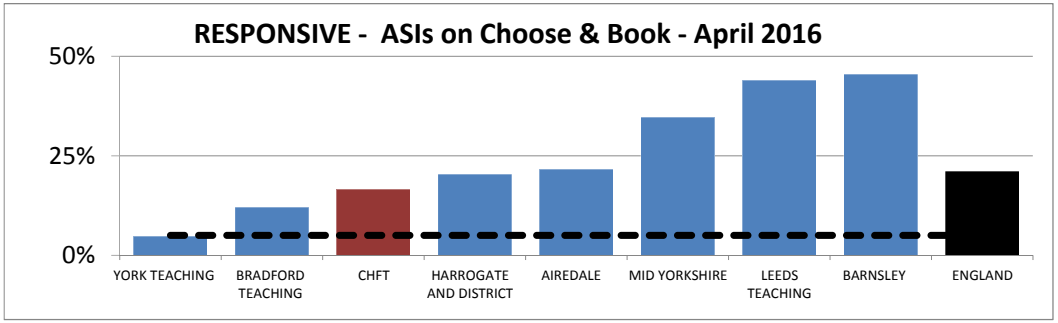
## Benchmarking - Selected Measures

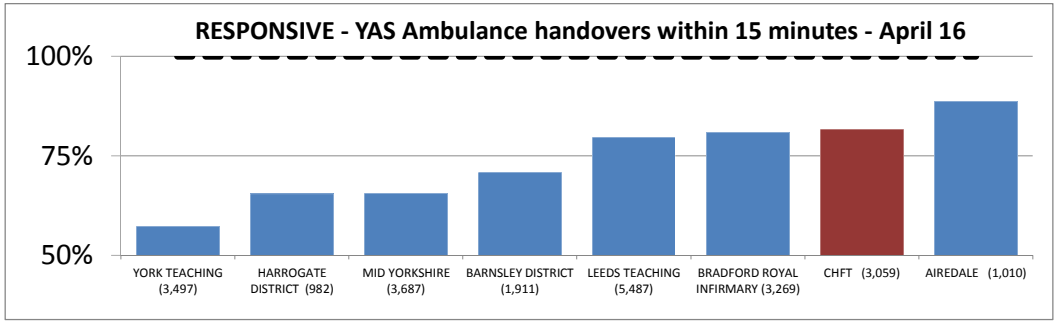


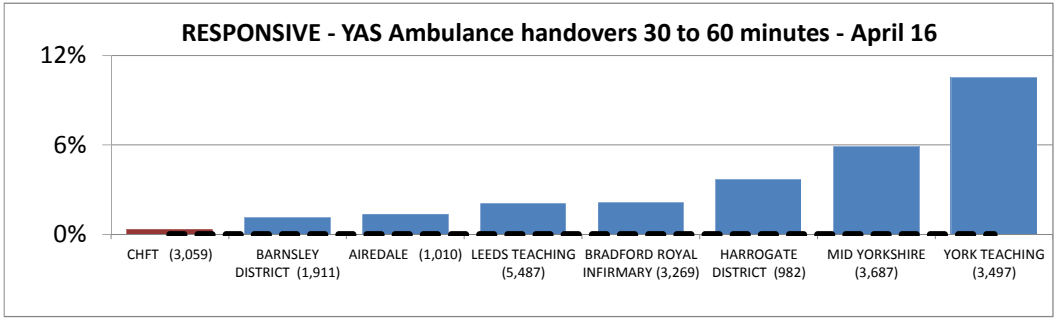



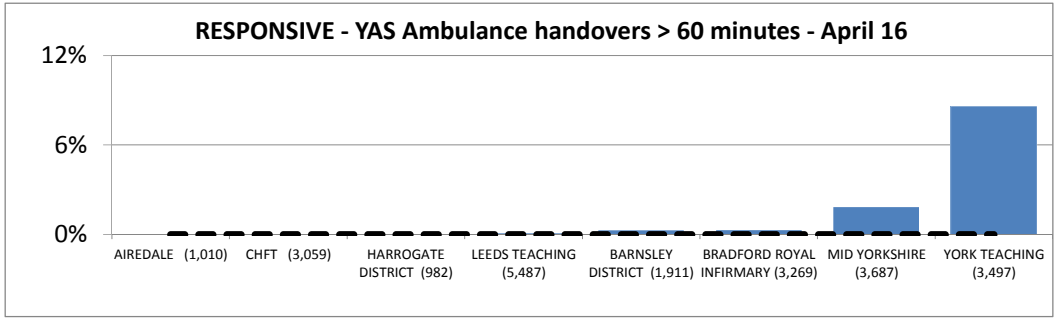



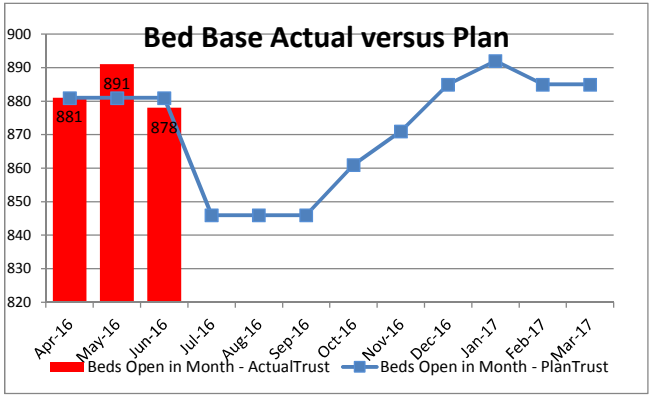



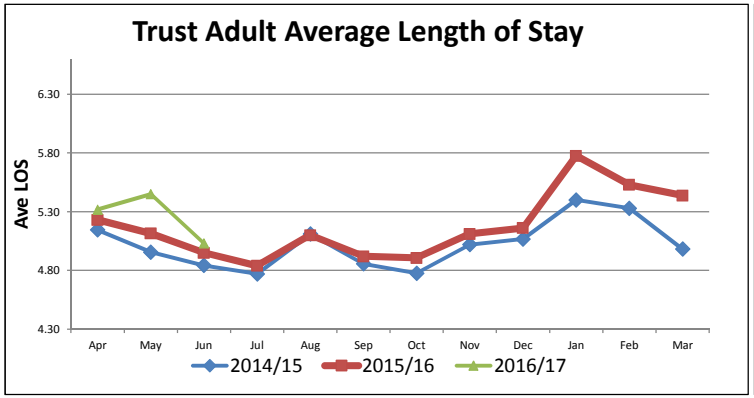
# Efficiency & Finance - Efficiency Key Messages

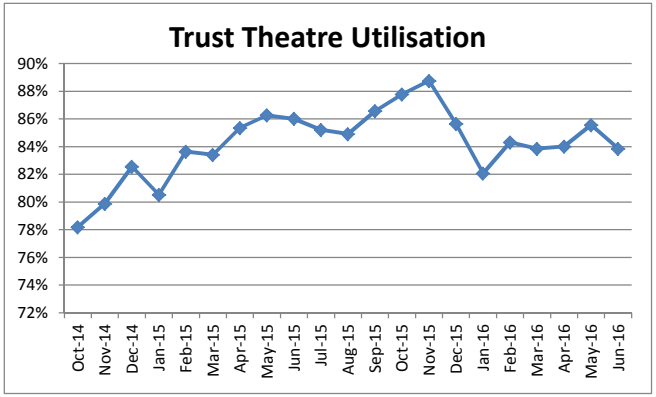
| Area | Issue | Corrective Actions | Impact and Accountability |
|---|---|---|---|
| **Theatre Utilisation** | Theatre utilisation fluctuating in month impacted by on day cancellations for clinical and non clinical reasons.<br>30 Sitrep reportable cancellations (13 CRH, 12 DSU , 5 Main theatre, 0 SPU) but overall 177 patients cancelled from the operating lists, impacting upon theatre utilisation and contracted activity (55 CRH, 26 Main Theatre, 48 DSU, 18 SPU).<br>Fallow lists reviewed on a weekly basis at scheduling meeting and reallocated were possible. Fully utilising job planned flexible sessions and locum flexibility. | Full review of '2 day call' to be carried out to consider opportunities for improvement.<br>Individual and Sub Specialty team discussions have taken place.<br>Targeted work undertaken to reduce number of cancellations due to equipment failure/torn wraps from pervious months - numbers now reduced.<br>Refreshed Service Improvement Group.<br>Involvement of Membership Councillor to support us with our service improvement approach. | Anticipated improvement in cancellations (Sitrep and non sit rep reportable) will improve theatre utilisation and contracted activity.<br><br>The Division will be working hard with clinical specialties to improve and maintain that position.<br><br>Accountable: GM for Theatres |
| **Surgical Activity Variance** | In month daycase and elective combined 101 SPELLS below plan driven by General Surgery, ENT, Urology and Maxillofacial.<br>Reliance on non substantive workforce e.g. agency or WLIs results in fluctuation in capacity. Weekly theatre schedule meeting to focus on achieving no more than 1 fallow list to maximise theatre capacity alongside availability of workforce.<br>Non elective 90 SPELLS above plan within Orthopaedic and General Surgery , which is an increase on the previous month run rate.<br>Outpatients continues to be above plan. In month positive variance 1366 attendances. Drivers orthopaedics and ophthalmology associated with ASI performance and agency workforce capacity respectively. | Fill vacancies asap – Panels to be held in July and August for ENT, Ophthalmology, Upper GI and Urology.<br>Provide full cover for sickness at the earliest opportunity (covered in Breast ).<br>Increase operating for new hand surgeon by picking up cases from other surgeons, and thereby reduce waiting times.<br>Ensure additional paediatric all day ENT lists are scheduled each month and additional Lap Chole lists until Theatre 6 comes back on line.<br>Aim to reduce fallow lists to no more than 1 per week.<br>Ensure scheduling meeting is effective, by improved pre-work with specialties.<br>Ensure continued validation of all >24 week pathways. | It is expected that most capacity gaps within the Division will be filled in July/August following AACs which will stop the deterioration of the current position. Substantive appointments anticipated to come on line by the end of Q2, early Q3.<br>There remains a risk with Consultant capacity in Ophthalmology with variable locum agency support and an increasing number of Consultant vacancies..<br><br>Accountable : ADD Surgery |

# Efficiency & Finance - Key measures

| | 15/16 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | YTD | Target | Threshold/ Monthly |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Did Not Attend Rates** | | | | | | | | | | | | | | | | | |
| First DNA | 6.80% | 6.65% | 7.86% | 7.07% | 6.52% | 6.64% | 6.55% | 7.22% | 6.37% | 6.26% | 6.80% | 6.60% | 6.42% | **6.03%** | **6.35%** | <=7% | 7.00% |
| Follow up DNA | 7.70% | 7.66% | 8.65% | 7.91% | 8.19% | 7.54% | 7.21% | 7.63% | 6.79% | 6.60% | 7.17% | 6.55% | 6.44% | **6.73%** | **6.58%** | <=8% | 8.00% |
| **Average length of stay** | | | | | | | | | | | | | | | | | |
| Average Length of Stay - Overall | 5.17 | 4.95 | 4.85 | 5.11 | 4.88 | 4.91 | 5.11 | 5.16 | 5.78 | 5.53 | 5.45 | 5.32 | 5.45 | **5.03** | **5.27** | <=5.17 | 5.17 |
| Average Length of Stay - Elective | 2.85 | 2.87 | 2.72 | 2.90 | 2.82 | 2.73 | 2.89 | 2.80 | 3.25 | 2.92 | 3.07 | 2.50 | 2.67 | **2.67** | **2.62** | <=2.85 | 2.85 |
| Average Length of Stay - Non Elective | 5.63 | 5.41 | 5.31 | 5.57 | 5.34 | 5.36 | 5.62 | 5.60 | 6.24 | 5.96 | 5.79 | 5.87 | 5.97 | **5.52** | **5.79** | <=5.63 | 5.63 |
| **Day Cases** | | | | | | | | | | | | | | | | | |
| Day Case Rate | 85.00% | 85.15% | 85.14% | 84.52% | 84.74% | 84.55% | 84.30% | 86.34% | 86.35% | 87.90% | 88.50% | 87.40% | 87.23% | **86.63%** | **85.62%** | >=85% | 85.00% |
| Failed Day Cases | 1440 | 121 | 132 | **116** | 147 | 136 | 119 | 93 | 103 | 112 | 93 | 138 | 99 | **148** | **365** | 120 | 480 |
| Elective Inpatients with zero LOS | 1630 | 171 | 163 | 136 | 152 | 132 | 142 | 122 | 135 | 110 | 97 | 115 | 109 | **121** | **334** | 136 | 544 |
| **Beds** | | | | | | | | | | | | | | | | | |
| Beds Open in Month - Plan | | 820 | 816 | 809 | 809 | 809 | 820 | 835 | 866 | 878 | 878 | 881 | 881 | **881** | **881** | Not applicable | |
| Beds Open in Month - Actual | | 869 | 850 | 849 | 855 | 872 | 873 | 878 | 922 | 906 | 890 | 881 | 891 | **878** | **878** | Not applicable | |
| **Theatre Utilisation** | | | | | | | | | | | | | | | | | |
| Theatre Utilisation (TT) - Main Theatre - CRH | 86.05% | 87.10% | 86.18% | 85.64% | 89.70% | 88.07% | 88.30% | 85:93% | 80.13% | 81.36% | 83.99% | 87.41% | 85.59% | **86.81%** | **86.60%** | >=92.5% | 92.50% |
| Theatre Utilisation (TT) - Main Theatre -HRI | 94.92% | 96.08% | 93.73% | 89.87% | 93.13% | 96.00% | 99.25% | 95.01% | 92.02% | 101.14% | 88.36% | 89.04% | 94.67% | **87.32%** | **90.26%** | >=92.5% | 92.50% |
| Theatre Utilisation (TT) - HRI DSU | 78.04% | 76.41% | 76.50% | 75.31% | 79.83% | 81.42% | 82.36% | 76.33% | 76.58% | 79.92% | 78.00% | 75.08% | 78.09% | **76.21%** | **76.50%** | >=92.5% | 92.50% |
| Theatre Utilisation (TT) - HRI SPU | 82.73% | 83.48% | 85.03% | 84.41% | 81.97% | 80.01% | 81.94% | 80.94% | 82.01% | 83.98% | 84.68% | 79.95% | 81.00% | **80.63%** | **80.51%** | >=92.5% | 92.50% |
| Theatre Utilisation (TT) - Trust | 85.60% | 86.07% | 85.25% | 84.38% | 83.92% | 85.57% | 87.05% | 88.18% | 84.67% | 81.77% | 84.65% | 83.82% | 84.13% | **83.85%** | **84.42%** | >=92.5% | 92.50% |



# Activity - Key measures

| | 15/16 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | YTD | YTD % Change |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **GP referrals to all outpatients** | | | | | | | | | | | | | | | | |
| 02T - NHS CALDERDALE CCG | 41532 | 3586 | 3514 | 3194 | 3681 | 3693 | 3368 | 2989 | 3555 | 3437 | 3651 | 3763 | 3851 | **3889** | **11517** | 10.7% |
| 03A - NHS GREATER HUDDERSFIELD CCG | 38613 | 3456 | 3357 | 2921 | 3465 | 3423 | 3206 | 2862 | 3171 | 3241 | 3367 | 3320 | 3139 | **3444** | **9907** | 5.0% |
| 03J - NHS NORTH KIRKLEES CCG | 2830 | 256 | 227 | 193 | 222 | 243 | 224 | 198 | 246 | 296 | 299 | 283 | 308 | **349** | **940** | 38.0% |
| 02R - NHS BRADFORD DISTRICTS CCG | 3055 | 251 | 280 | 232 | 271 | 273 | 265 | 213 | 283 | 244 | 250 | 242 | 266 | **262** | **770** | 2.0% |
| 03R - NHS WAKEFIELD CCG | 444 | 41 | 36 | 26 | 40 | 37 | 29 | 25 | 35 | 48 | 52 | 56 | 63 | **59** | **180** | 58.7% |
| 02W - NHS BRADFORD CITY CCG | 519 | 37 | 35 | 58 | 53 | 66 | 41 | 49 | 39 | 40 | 37 | 24 | 34 | **37** | **95** | -10.9% |
| 01D - NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG | 206 | 3 | 17 | 8 | 22 | 23 | 19 | 9 | 25 | 35 | 30 | 42 | 38 | **47** | **127** | 433.3% |
| 03C - NHS LEEDS WEST CCG | 78 | 10 | 6 | 6 | 10 | 6 | 3 | 5 | 7 | 4 | 11 | 7 | 3 | **7** | **16** | -9.1% |
| 02N - NHS AIREDALE, WHARFEDALE AND CRAVEN CCG | 63 | 9 | 5 | **7** | 3 | 5 | 7 | 5 | 6 | 2 | 6 | 6 | 7 | **3** | **16** | 62.5% |
| 03G - NHS LEEDS SOUTH AND EAST CCG | 19 | **2** | **3** | **0** | **2** | **0** | 4 | 2 | 0 | 1 | 0 | 0 | 2 | **3** | **5** | -60.0% |
| 02V - NHS LEEDS NORTH CCG | 19 | 2 | 3 | 0 | **2** | 0 | 4 | 2 | 0 | 1 | 0 | 0 | 2 | **3** | **5** | -80.0% |
| Other | 993 | 79 | 97 | 64 | 74 | 71 | 96 | 82 | 103 | 90 | 99 | 68 | 72 | **108** | **249** | -5.0% |
| Total | 88371 | 7730 | 7579 | 6711 | 7846 | 7841 | 7263 | 6442 | 7471 | 7438 | 7803 | 7812 | 7783 | **8209** | **23824** | 67.2% |
| % Change on Previous year | 3.5% | 9.4% | -2.0% | 6.1% | 4.9% | 0.9% | 7.1% | 4.0% | 16.3% | 1.0% | -3.0% | 9.3% | 9.6% | **6.2%** | **8.4%** | |
| **Activity** | | | | | | | | | | | | | | | | |
| % of spells with > 5 ward movements (No Target) | 0.06% | 0.07% | 0.03% | 0.03% | 0.09% | 0.06% | 0.06% | 0.06% | 0.02% | 0.16% | 0.04% | 0.06% | 0.08% | **0.10%** | **0.10%** | 0.0% |

| **ACTIVITY VARIANCE AGAINST CONTRACT** | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Day Case Variance against Contract | | | | | | | | | | | | **8** | **97** | **44** | **150** | |
| % Day Case Variance against Contract | | | | | | | | | | | | **0.3%** | **3.3%** | **1.4%** | **1.6%** | |
| Elective Variance against Contract | | | | | | | | | | | | **-109** | **-124** | **-96** | **-328** | |
| % Elective Variance against Contract | | | | | | | | | | | | **-14.8%** | **-17.6%** | **-12.4%** | **-14.9%** | |
| Non-elective Variance against Contract | | | | | | | | | | | | **-90** | **-99** | **109** | **-79** | |
| % Non-elective Variance against Contract | | | | | | | | | | | | **-2.1%** | **-2.3%** | **2.6%** | **-0.6%** | |
| Outpatient Variance against Contract | | | | | | | | | | | | **-122** | **1483** | **1993** | **3354** | |
| % Outpatient Variance against Contract | | | | | | | | | | | | **-0.4%** | **5.5%** | **6.7%** | **3.9%** | |
| Accident and Emergency Variance against Contract | | | | | | | | | | | | **-212** | **960** | **301** | **1049** | |
| **% Accident and Emergency Variance against Contract** | | | | | | | | | | | | **-1.7%** | **7.6%** | **2.4%** | **2.8%** | |

Please note further details on the referral position including commentary is available within the appendix.

# CQUIN - Key Messages

| Area | Issues | Corrective Actions | Impact and Accountability |
|---|---|---|---|
| **CQUINS** | **There are several CQUINs which have not yet been assigned a target / threshold. A large proportion of them are establishing baseline measures in Q1.** | | |
| **Staff Wellbeing:** | The Staff Wellbeing is on plan to hit all Q1 Targets. A risk is being raised in achieving the third element, regarding 75% of front line staff receiving the Flu Vaccination. The previous year achieved a year end position of 53%.<br><br>The final payment is staged,<br>0-64% vaccinated = £0<br>64-75% vaccinated 50% payment = £324,701.15 | The campaign planning is underway, with a number of event scheduled over Q1/Q2 to engage with the vaccinators from last year and address what barriers there were.<br><br>The First National Flu Conference takes place in July with an opportunity to learn from the top performers in previous years | The Campaign starts in October 16 and ends 31st December 16. Performance will be monitored weekly during this stage.<br><br>Accountable: Director of Workforce |
| **Sepsis** | The Sepsis CQUIN is meeting performance levels for three out of the four measures. there is only partial compliance with the % of patients being screened in A&E and the target of 90% will not be reached this quarter. The Trust is on track to deliver >50% for Q1 and receive 50% of the CQUIN (£16k).<br><br>Payments are as follows:<br>0-50% = £0<br>50% - 90% = £16,235.06<br>>90% = £32,470.12 | All patients being seen in A&E are now being screened for sepsis during the triage stage, and further engagement work will be carried out in other emergency admission areas, such as MAU, SAU and Ward 12.<br><br>A Development Matron with focus on Sepsis is due to be recruited to support the level of improvement required. | The improvement in ED is expected to improve performance in this area.<br><br>Accountable: ADN Medicine |
| **Antimicrobial Resistance** | At present this CQUIN is in on plan to hit all Q1 Targets<br><br>A risk is however being raised against achieving the:<br><br>1) The 1% reduction in the consumption of Carbopenum<br>1% reduction in the consumption of Tazobactam<br>1% in overall antibiotics consumption | The 1% reduction will be against a baseline of 13/14 consumption. Raw data for 13/14, 14/15 and 15/16 shows that consumption has been steadily increasing. this make the 1% reduction even more challenging. High consuming wards will be the focus of improvement work in Q2. | Internal trajectories will be set following the release of data from PHE following submission of baseline figures. This however does not prevent the improvement work from commencing. The highest consuming wards will be identified by the end of June and improvements are expected to be seen at the end of Q2 onwards.<br><br>Accountable: Director of Pharmacy |

# CQUIN - Key measures

| | £ Annual Value | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | YTD | Target | Threshold/Monthly |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Staff Well Being** | | | | | | | | | | | | | | | | |
| Well Being Initiatives | £649,402.30 | Plan in Development for three Initiatives - Mental Health, Physical Health, MSK access | | | | | | | | | | | | | Qrtly Written Rpt to Commissioner | |
| Healthy Food for Visitors | £649,402.30 | submit national data collection returns by July | | | | | | | | | | | | | Qrtly Written Rpt to Commissioner | |
| Flu Vaccination Uptake | £649,402.30 | Campaign Starts in October 16 | | | | | | | | | | | | | >75% | >75% |
| **Sepsis** | | | | | | | | | | | | | | | | |
| % of patients Screened (admission Units) | £129,880.46 | 48.00% | 40.00% | In Arrears | | | | | | | | | | **44.00%** | >90% | >90% |
| % of patients receiving Antibiotic in timeframe and undertake Antibiotic Review (admission units) | £194,820.69 | 71.43% | 75.00% | In Arrears | | | | | | | | | | **72.73%** | Yr End = To be agreed post Q2 | Q1 = Baseline Data Only |
| % of patients Screened (Inpatients) | £129,880.46 | 8.51% | 11.76% | In Arrears | | | | | | | | | | **9.38%** | >90% | Q1 = Baseline Data Only |
| % of patients receiving Antibiotic in timeframe and undertake Antibiotic Review (inpatients) | £194,820.69 | 25.00% | 50.00% | In Arrears | | | | | | | | | | **71.43%** | Yr End = To be agreed post Q2 | Q1 = Baseline Data Only |
| **Antimicrobial Resistance** | | | | | | | | | | | | | | | | |
| Antibiotic Consumption - All | £259,760.92 | Raw Baseline Data Submitted. Awaiting Calculations from PHE | | | | | | | | | | | | **Awaiting PHE** | TBC - Post Q1 data | Q1 = Baseline Data Only |
| Antibiotic Consumption - Carbopenum | £129,880.46 | | | | | | | | | | | | | | TBC - Post Q1 data | Q1 = Baseline Data Only |
| Antibiotic Consumption - piperacillin -tazobactam | £129,880.46 | | | | | | | | | | | | | | TBC - Post Q1 data | Q1 = Baseline Data Only |
| Empiric review of antibiotic prescriptions within 72 hours | £129,880.46 | 72.00% | 96.00% | 94.00% | | | | | | | | | | **88.00%** | >90% | Q1 = >25% |
| **Safety Huddle (SH) Roll Out** | | | | | | | | | | | | | | | | |
| Number of Wards with SHs in place | £1,168,924.14 | 2 | | | | | | | | | | | | **2** | **8** | 2 |
| Ulcer performance on SH ward | | Under Development | | | | | | | | | | | | **In Dev** | TBC - Post Q1 data | Q1 = Baseline Data Only |
| Falls performance on SH ward | | Under Development | | | | | | | | | | | | **In Dev** | TBC - Post Q1 data | Q1 = Baseline Data Only |
| **Self Administration of Medication** | | | | | | | | | | | | | | | | |
| % of patients assessed for self medication | £389,641.38 | 67.00% | 100.00% | 100.00% | | | | | | | | | | **87.50%** | **>=50%** | 50.00% |
| **Hospital at Night** | | | | | | | | | | | | | | | | |
| Roll out of System | £1,168,924.14 | Technical specification complete, testing started | | | | | | | | | | | | | Qrtly Written Rpt to Commissioner | |
| **Community Experience** | | | | | | | | | | | | | | | | |
| Service Users experience of Community Care | £519,521.84 | Reporting tool in development | | | | | | | | | | | | | TBC - Post Q1 data | Q1 = Tool Dev |
| **NHS ENGLAND CQUINS** | | | | | | | | | | | | | | | | |
| Dose Banding Intravenous SACT | £20,000.00 | In Progress | | | | | | | | | | | | | TBC - Post Q1 data | Q1 = Baseline Data Only |
| Activation for LTC Patients - HIV Embedding Self Management (Patient Activated Management) | £50,000.00 | In Progress | | | | | | | | | | | | | TBC - Post Q1 data | Not Due until Q2 |
| Optimal Device | £20,000.00 | In Progress | | | | | | | | | | | | | TBC - Post Q1 data | Q1 = Baseline Data Only |
| QIPP | £233,121.00 | In Progress | | | | | | | | | | | | | TBC - Post Q1 data | Multiple |

# Appendices

# Appendix - Appointment Slot Issues

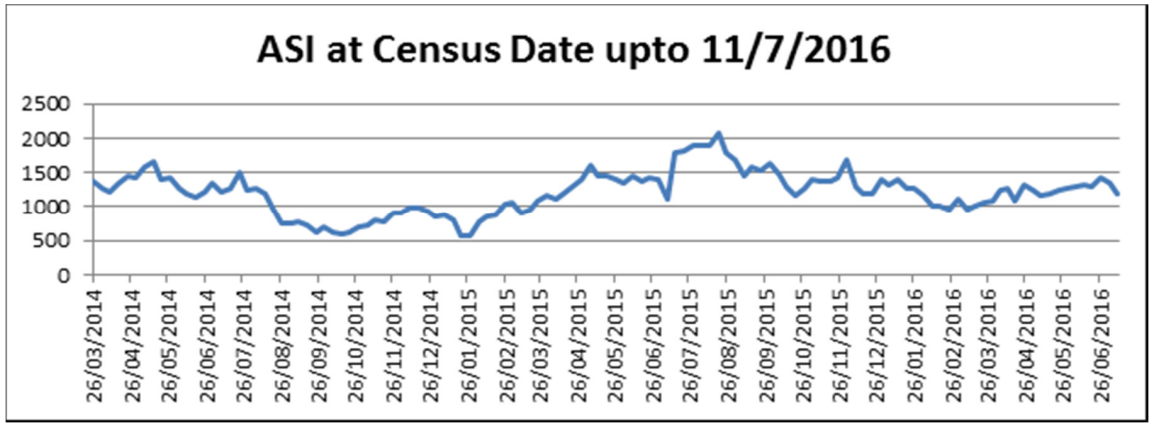
ASIs

An Analysis of the national ERS data (which is 3 months in arrears) has taken place and shows that in the month of April, 1159 patients were unable to book an appointment at the first attempt and were "deferred to provider" for booking. The data confirms that 531 (46%) of these patients were allocated appointments on the same or next working day. Excluding these patients who were given an appointment within 24 hours reduces the Trust's ASI position for April to just 8%. This is a month on month improvement (February 39% and March 40%).

As at 15th July there are 1050 referrals awaiting appointment, of which 343 are e-referrals. This is a reduction of 244 referrals and 53 e-referrals on the 21 June position.

The top 3 specialties for E-referral ASIs backlog are: Respiratory Medicine, Ophthalmology and Colorectal. Specialty action plans are in place to continue to reduce the ASIs over the forthcoming weeks.

| | Respiratory Medicine | | Total | Colorectal Surgery | | Total | Ophthalmology | | Total | Cardiology | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Row Labels | ERS | Paper | | ERS | Paper | | ERS | Paper | | ERS | Paper | |
| 0 Weeks | 5 | 3 | 8 | 3 | 15 | 18 | 18 | | 18 | 4 | | 4 |
| 1 Week | 6 | 10 | 16 | 13 | | 13 | 9 | 4 | 13 | 9 | 7 | 16 |
| 2 Weeks | 4 | 23 | 27 | 17 | 4 | 21 | 2 | 15 | 17 | 1 | 9 | 10 |
| 3 Weeks | 2 | 22 | 24 | 14 | 6 | 20 | 14 | 15 | 29 | 7 | 21 | 28 |
| 4 Weeks | 1 | 45 | 46 | 7 | 6 | 13 | 16 | 16 | 32 | | 13 | 13 |
| 5 Weeks | 1 | 27 | 28 | 1 | 11 | 12 | 7 | 11 | 18 | 1 | 11 | 12 |
| 6 Weeks | 9 | 8 | 17 | 1 | 8 | 9 | | 5 | 5 | | 7 | 7 |
| 7 Weeks | 8 | 13 | 21 | 3 | 6 | 9 | | 3 | 3 | 1 | 2 | 3 |
| 8 Weeks | 5 | 12 | 17 | 1 | 13 | 14 | | 1 | 1 | 1 | 3 | 4 |
| 3 Months | 6 | 27 | 33 | 10 | 9 | 19 | 2 | 8 | 10 | | 3 | 3 |
| 4 Months | 2 | 4 | 6 | 1 | 5 | 6 | | 6 | 6 | | 2 | 2 |
| 5 Months | | 1 | 1 | | 1 | 1 | | 1 | 1 | | | |
| 6 Months | | | | | | | | 1 | 1 | | | |
| Grand Total | 49 | 195 | 244 | 71 | 84 | 155 | 68 | 86 | 154 | 24 | 78 | 102 |



# Appendix - Efficiency Key Measures

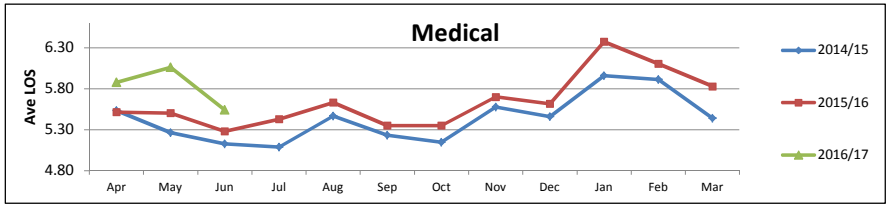
## BEDS

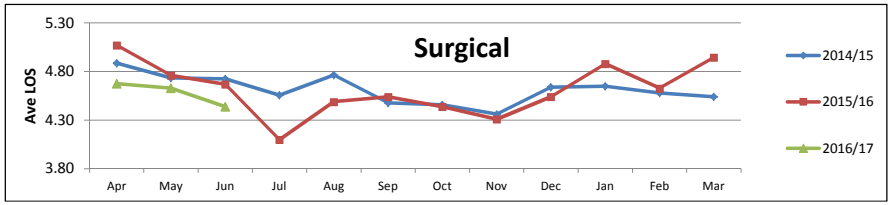
**Divisional Breakdown of Bed Base - Actual versus Plan - 2016 / 2017**

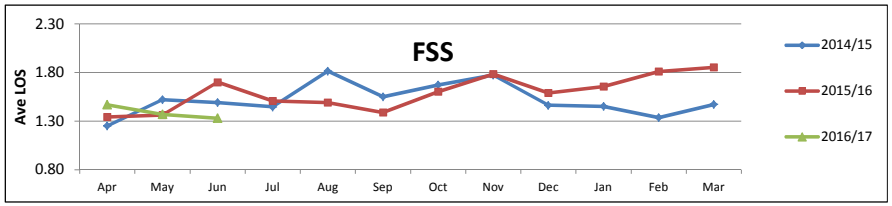
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Surgical Bed Base Plan | 213 | 213 | 213 | 193 | 193 | 193 | 193 | 193 | 193 | 193 | 193 | 193 |
| Surgical Bed Base Actual | 209 | 213 | 209 | | | | | | | | | |
| FSS Bed Base Plan - Adult | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 |
| Paediatrics | 43 | 43 | 43 | 43 | 43 | 43 | 43 | 43 | 43 | 43 | 43 | 43 |
| Mother | 63 | 63 | 63 | 63 | 63 | 63 | 63 | 63 | 63 | 63 | 63 | 63 |
| Cots (inc NICU) | 80 | 80 | 80 | 80 | 80 | 80 | 80 | 80 | 80 | 80 | 80 | 80 |
| FSS Bed Base Plan - TOTAL | 202 | 202 | 202 | 202 | 202 | 202 | 202 | 202 | 202 | 202 | 202 | 202 |
| FSS Bed Base Actual | 202 | 202 | 202 | | | | | | | | | |
| Medical Bed Base Plan core | 451 | 451 | 451 | 451 | 451 | 451 | 451 | 451 | 451 | 451 | 451 | 451 |
| Flex | 15 | 15 | 15 | 0 | 0 | 0 | 15 | 25 | 39 | 46 | 39 | 39 |
| Medical Bed Base Plan - TOTAL | 466 | 466 | 466 | 451 | 451 | 451 | 466 | 476 | 490 | 497 | 490 | 490 |
| Medical Bed Base Actual | 470 | 476 | 467 | | | | | | | | | |
| TRUST Bed Base Plan - TOTAL | 881 | 881 | 881 | 846 | 846 | 846 | 861 | 871 | 885 | 892 | 885 | 885 |
| TRUST Bed Base - ACTUAL | 881 | 891 | 878 | | | | | | | | | |
| Beds Above (+ve) / Below (-ve) Plan | 0 | 10 | -3 | | | | | | | | | |

## AVERAGE LENGTH OF STAY

- Trust length of stay (LOS) decreased in June with decrease relating to the all divisions.
- Medical LOS in month was 5.5 days, decreasing from 6.1 (plan is 5.6 days). YTD position is 5.8 days.
- Contributing factors to improvement as follows -
- Reduction in Medical green x patients – from 90 to 81 as at 30 June 2016 (however profile is set at 60).
- Reduction in number of medical outliers has helped efficiency .. avg of 16 patients per day in June 2016, compared with 31 per day in May 2016
- Reduced occupancy levels – 93% in month.
- Still a notable lack of nursing home/intermediate care beds.
- Acute spells for June very much in line with plan for Medicine



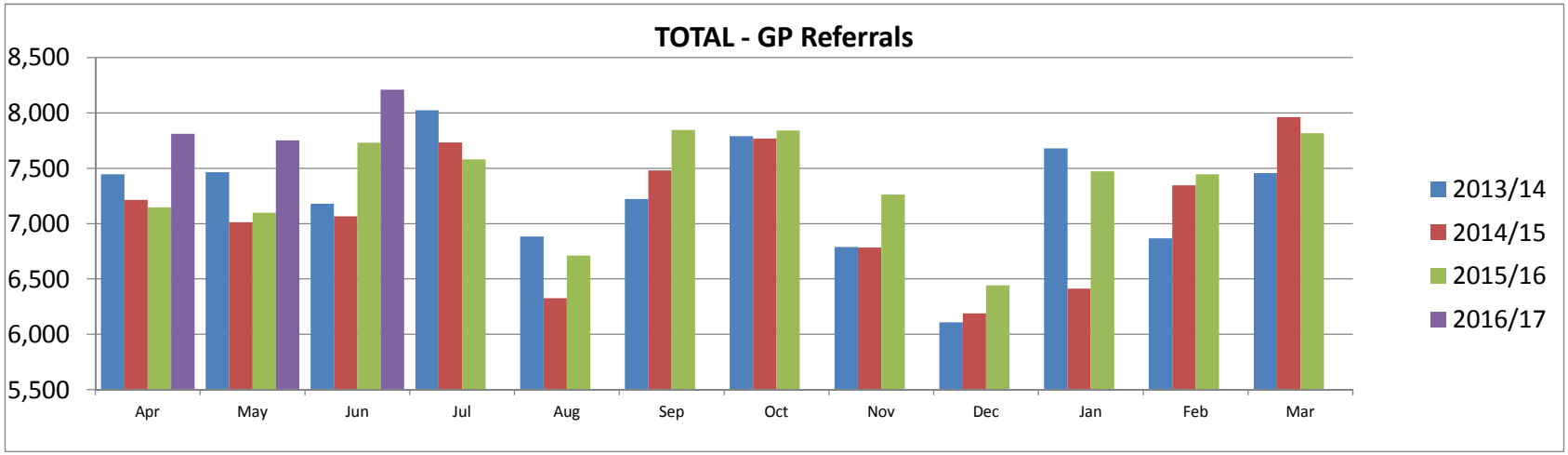



# Appendix - Referrals

**KEY MESSAGES**

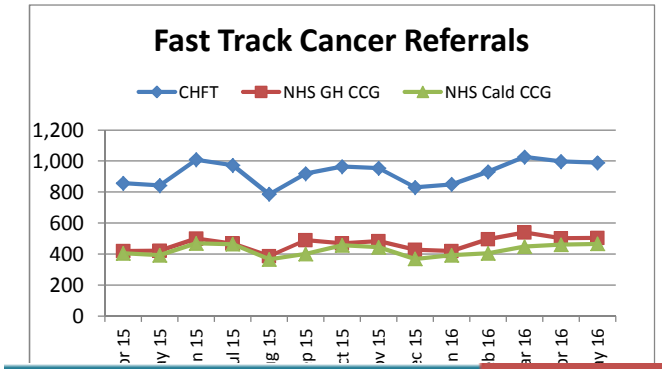
- GP Referrals up 6.2% in June 2016 compared with June 2015.
- With the same working days in June 16 one would not necessarily expect an increase in referrals.
- YTD there have been 2 more working days compared to April to June 2015 so one would expect this to result in a referral increase of 3.2%.
- Non GP referrals (37% of all referrals) up 10.9% YTD, specialties contributing Trauma and Orthopaedics, Obstetrics, Gynaecology, Oral Surgery, Ophthalmology and Cardiology.
- NHS Calderdale GP referrals have an increase (more than expected) of 10.2% (1,070) YTD principally due to Orthopaedics 21% (379), ENT 15% (176), Cardiology 31% (120) and Dermatology 25% (114)
- NHS Greater Huddersfield GP referrals increase (in line with expectations) of 3.3% (313) YTD principally due to Ophthalmology 12% (99), Gastroenterology 11% (54) and Urology 9.9% (48).
- YTD there have been notable GP referral increases (above the 3.2% mentioned earlier) for NHS North Kirklees (39%, 263 referrals, numerous practices, Undercliffe surgery in particular, Neurology and ENT receiving many extra referrals), NHS Wakefield (57%, 65 referrals, half of the increase from Middlestown practice, Neurology receiving many extra referrals) and particularly NHS Heywood, Middleton and Rochdale (over 560%, 108 referrals, chief rises in Paediatrics, Dermatology and ENT).
- At July's Finance and Performance committee a paper evaluating recent market share movements was tabled, including the potential missed impact due to loss of market share. This was well received and it was agreed that a high level dashboard would be updated at minimum quarterly to enable continual market share evaluation. This dashboard will feature in future IPR appendices.

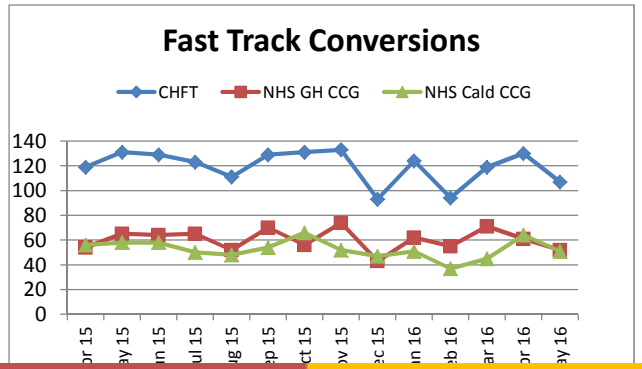


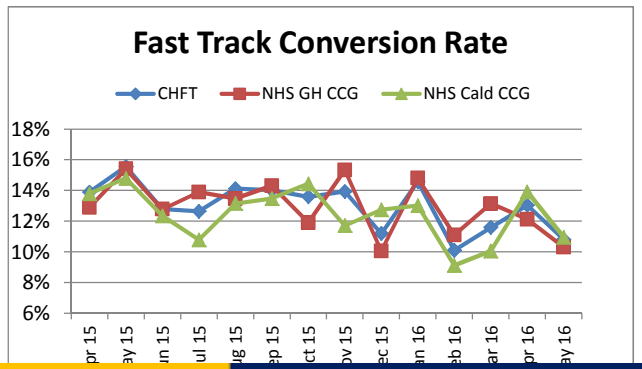
# Activity - Key measures

| | 15/16 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | YTD | YTD % Change |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Fast Track Cancer referrals in month and of those referrals numbers that diagnosed with cancer (conversions)** | | | | | | | | | | | | | | | | |
| NHS CALDERDALE CCG Referrals | 5014 | 470 | 464 | 365 | 401 | 457 | 444 | 369 | 392 | 406 | 448 | 460 | 466 | **455** | **926** | 16.0% |
| NHS CALDERDALE CCG Conversions | 622 | 58 | 50 | 48 | 54 | 66 | 52 | 47 | 51 | 37 | 45 | 64 | 51 | **in arrears** | **115** | *0.9%* |
| NHS CALDERDALE CCG Conversion Rate | 12.4% | 12.3% | 10.8% | 13.2% | 13.5% | 14.4% | 11.7% | 12.7% | 13.0% | 9.1% | 10.0% | 13.9% | 10.9% | **in arrears** | **12.5%** | |
| NHS GREATER HUDDERSFIELD CCG Referrals | 5521 | 501 | 468 | 386 | 489 | 470 | 483 | 428 | 419 | 496 | 540 | 503 | 505 | **519** | **1008** | 19.9% |
| NHS GREATER HUDDERSFIELD CCG Conversions | 731 | 64 | 65 | 52 | 70 | 56 | 74 | 43 | 62 | 55 | 71 | 61 | 52 | **In arrears** | **113** | *-5.0%* |
| NHS GREATER HUDDERSFIELD CCG Conversion Rate | 13.2% | 12.8% | 13.9% | 13.5% | 14.3% | 11.9% | 15.3% | 10.0% | 14.8% | 11.1% | 13.1% | 12.1% | 10.3% | **In arrears** | **11.0%** | |
| Other CCG Referrals | 410 | 38 | 41 | 35 | 30 | 37 | 28 | 34 | 39 | 29 | 39 | 34 | 19 | **37** | **53** | -11.7% |
| Other CCG Conversions | 83 | 7 | 8 | 11 | 5 | 9 | 7 | 3 | 11 | 2 | 3 | 5 | 4 | **in arrears** | **9** | *-47.1%* |
| Other CCG Conversion Rate | 20.2% | 18.4% | 19.5% | 31.4% | 16.7% | 24.3% | 25.0% | 8.8% | 28.2% | 6.9% | 7.7% | 14.7% | 21.1% | **in arrears** | **16.1%** | |
| CHFT Fast Track Referrals | 10945 | 1009 | 973 | 786 | 920 | 964 | 955 | 831 | 850 | 931 | 1027 | 997 | 990 | **1011** | **1987** | 17.0% |
| CHFT Fast Track Conversions | 1436 | 129 | 123 | 111 | 129 | 131 | 133 | 93 | 124 | 94 | 119 | 130 | 107 | **in arrears** | **237** | *-5.2%* |
| CHFT Fast Track Conversion Rate | 13.1% | 12.8% | 12.6% | 14.1% | 14.0% | 13.6% | 13.9% | 11.2% | 14.6% | 10.1% | 11.6% | 13.0% | 10.8% | **in arrears** | **11.8%** | |
| % Change on Previous year | | | | | | | | | | | | | | | | |

Note YTD Change for conversions is a month in arrears as latest month will still have conversions to feed through.
YTD referrals excludes most recent month to enable reliabel conversion rate YTD comparison.



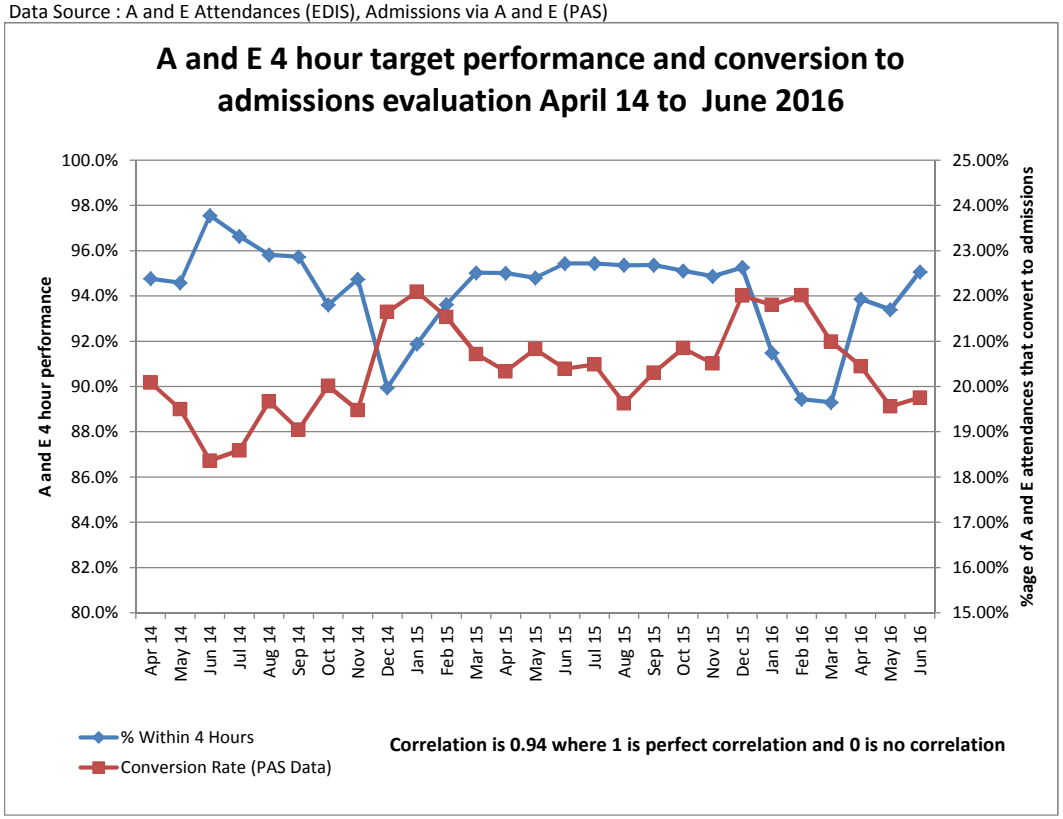



# Appendix - A and E Conversion rates and Delayed Transfers

| | 15/16 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | YTD | YTD % Change |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Analysis of A and E activity including conversions to admission** | | | | | | | | | | | | | | | | |
| A and E Attendances | 147625 | 12313 | 12388 | 11992 | 12106 | 12495 | 11950 | 12040 | 12399 | 11712 | 13372 | 12120 | 13588 | **12781** | **38489** | 3.5% |
| A and E 4 hour Breaches | 9030 | 562 | 565 | 557 | 561 | 611 | 613 | 571 | 1055 | 1237 | 1431 | 743 | 897 | **630** | **2270** | 24.1% |
| A and E 4 hour performance | 93.9% | 95.4% | 95.4% | 95.4% | 95.4% | 95.1% | 94.9% | 95.3% | 91.5% | 89.4% | 89.3% | 93.9% | 93.4% | **95.1%** | **94.1%** | -1.0% |
| | | | | | | | | | | | | | | | | |
| Admissions via Accident and Emergency | 30770 | 2511 | 2538 | 2353 | 2458 | 2605 | 2451 | 2650 | 2703 | 2578 | 2807 | 2478 | 2658 | **2525** | **7661** | 0.4% |
| % A and E Attendances that convert to admissions | 20.8% | 20.4% | 20.5% | 19.6% | 20.3% | 20.8% | 20.5% | 22.0% | 21.8% | 22.0% | 21.0% | 20.4% | 19.6% | **19.8%** | **19.9%** | *-3.0%* |

Data Source : A and E Attendances (EDIS), Admissions via A and E (PAS)




| Delayed Transfers of Care : Snapshot on 5 July 2016 | Calderdale | Kirklees | Other | Total |
|---|---|---|---|---|
| Total number of patients on TOC Pathway | **92** | 56 | 2 | 150 |
| Patients awaiting assessment by a Social Worker | 39 | 9 | **2** | 50 |
| Ongoing assessments inc. SW, Therapy, BIM, Case Conference, MCA, DST | 21 | 26 | | 47 |
| Awaiting 24 hour care, res or nursing | 7 | 14 | | 21 |
| Awaiting Package of Care inc. re-ablement | 20 | 4 | | 24 |
| Awaiting housing | 1 | 1 | | 2 |
| Awaiting short stay or transitional bed | 2 | 1 | | 3 |
| Awaiting Intermediate Care bed | 2 | 1 | | 3 |

# Appendix - Responsive Key Measures

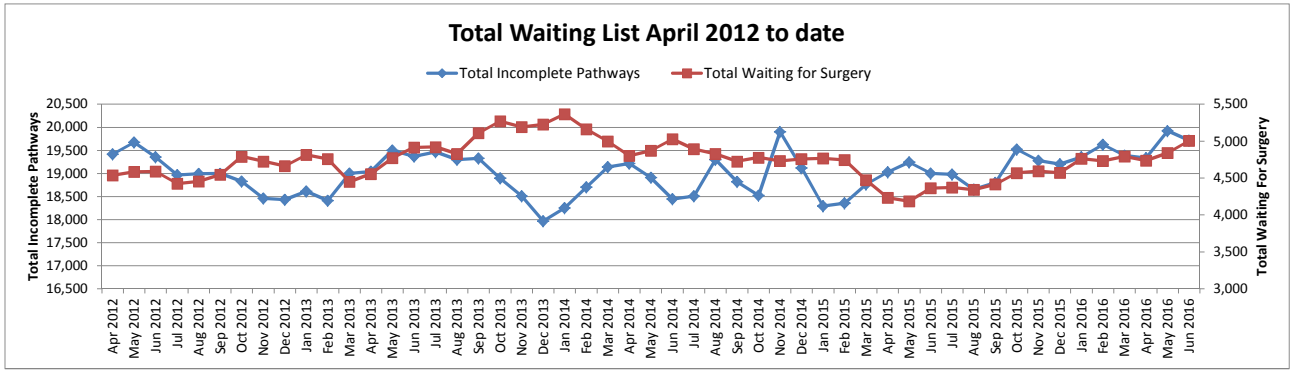
| | 15/16 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Target | Threshold |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Outpatient Total Waiting List** | | | | | | | | | | | | | | | | |
| GP/GDP sourced referrals | 9,014 | 9,213 | 8,978 | 8,993 | 9,452 | 9,533 | 9,112 | 8,728 | 8,921 | 9,258 | 9,298 | 9,505 | 9,255 | **9,255** | Not applicable | |
| Other sourced referrals | 8,548 | 9,340 | 9,285 | 8,994 | 8,850 | 8,537 | 8,428 | 8,296 | 8,107 | 8,389 | 8,037 | 8,515 | 9,067 | **9,067** | Not applicable | |
| Total | 17,562 | 18,553 | 18,263 | 17,987 | 18,302 | 18,070 | 17,540 | 17,024 | 17,028 | 17,647 | 17,335 | 18,023 | 18,322 | **18,322** | Not applicable | |
| Elective Total Waiting List | | | | | | | | | | | | | | | | |
| 18 week pathway | 4,314 | 4,363 | 4,374 | 4,344 | 4,418 | 4,570 | 4,593 | 4,573 | 4,763 | 4,732 | 4,794 | 4,738 | 5,006 | **5,006** | Not applicable | |
| Non 18 week pathway | 4,340 | 4,551 | 4,572 | 4,565 | 4,640 | 4,719 | 4,729 | 4,792 | 4,833 | 4,877 | 4,956 | 4,944 | 5,029 | **5,029** | Not applicable | |
| Not on Active List | 172 | 216 | 234 | 186 | 192 | 181 | 207 | 170 | 155 | 166 | 153 | 207 | 225 | **225** | Not applicable | |
| Unavailable | 274 | 361 | 370 | 354 | 287 | 227 | 289 | 373 | 231 | 231 | 254 | 238 | 313 | **313** | Not applicable | |
| Total | 9,100 | 9,491 | 9,550 | 9,449 | 9,537 | 9,697 | 9,818 | 9,908 | 9,982 | 10,006 | 10,157 | 10,127 | 10,573 | **10,573** | Not applicable | |
| **Referral to Treatment (RTT)** | | | | | | | | | | | | | | | | |
| RTT Total incomplete waiting list | 19,390 | 19,002 | 18,981 | 18,655 | 18,799 | 19,525 | 19,282 | 19,201 | 19,355 | 19,625 | 19,390 | 19,337 | 19,716 | **19,927** | Not applicable | |
| RTT Waiting 18 weeks and over (backlog) | 833 | 866 | 845 | 1052 | 764 | 820 | 758 | 873 | 783 | 825 | 833 | 743 | 759 | **796** | Not applicable | |
| % Non-admitted Closed Pathways under 18 weeks | 98.47% | 98.63% | 98.23% | 98.55% | 98.67% | 98.48% | 98.62% | 98.44% | 98.32% | 98.39% | 98.17% | 98.42% | 98.49% | **98.32%** | >=95% | **95.00** |
| % Admitted Closed Pathways Under 18 Weeks | 91.92% | 92.67% | 92.79% | 92.03% | 91.64% | 90.20% | 91.63% | 92.04% | 92.21% | 91.86% | 91.96% | 92.12% | 92.42% | **92.06%** | >=90% | **90.00%** |
| % Incomplete Pathways <18 Weeks | 95.70% | 95.44% | 95.55% | 95.44% | 96.07% | 95.80% | 96.04% | 95.45% | 95.95% | 95.80% | 95.70% | 96.16% | 96.01% | **96.35%** | >=92% | 92.00% |
| 18 weeks Pathways >=26 weeks open | 139 | 246 | 197 | 174 | 137 | 98 | 94 | 126 | 152 | 127 | 139 | 186 | 195 | **121** | **0** | **0** |
| RTT Waits over 52 weeks Threshold > zero | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** | **0** | **0** |
| % Diagnostic Waiting List Within 6 Weeks | 99.54% | 99.89% | 99.93% | 99.48% | 98.56% | 99.82% | 99.94% | 99.65% | 98.48% | 99.71% | 99.52% | 99.91% | 99.86% | **99.92%** | >=99% | **99.00%** |

**RTT KEY MESSAGES:**

Total number of patients on waiting list (including outpatients, diagnostics, surgery) = 19,716

Total number of patients waiting for surgery = 5,006, this is and increase of 643 compared to the position at end June 2015.

Total number of patients waiting over 18 weeks = 796



# Appendix - Cancer - By Tumour Group

| | 15/16 | Jun-15 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | YTD | Target | Threshold/ Monthly |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **62 Day Referral to Treatment** | | | | | | | | | | | | | | | | | |
| Breast | 98.75% | 100.00% | 100.00% | 100.00% | 81.82% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | **100.00%** | **100.00%** | >=85% | 85.00% |
| Gynaecology | 85.71% | 100.00% | 100.00% | 100.00% | 50.00% | 100.00% | 100.00% | 84.62% | 75.00% | 77.78% | 70.00% | 100.00% | 87.50% | **95.24%** | **95.00%** | >=85% | 85.00% |
| Haematology | 91.27% | 100.00% | 85.71% | 71.43% | 85.71% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 60.00% | 100.00% | 83.33% | **78.95%** | **85.37%** | >=85% | 85.00% |
| Head & Neck | 74.58% | 72.73% | 75.00% | 100.00% | 100.00% | 71.43% | 100.00% | 66.67% | 66.67% | - | 80.00% | 100.00% | 42.86% | **100.00%** | **69.23%** | >=85% | 85.00% |
| Lower GI | 92.70% | 100.00% | 96.15% | 100.00% | 100.00% | 83.33% | 80.00% | 84.62% | 100.00% | 93.33% | 100.00% | 80.00% | 83.33% | **100.00%** | **88.24%** | >=85% | 85.00% |
| Lung | 85.02% | 75.86% | 91.67% | 100.00% | 83.33% | 90.48% | 100.00% | 85.71% | 61.54% | 100.00% | 92.31% | 100.00% | 100.00% | **100.00%** | **100.00%** | >=85% | 85.00% |
| Sarcoma | 70.00% | - | 0.00% | 0.00% | 50.00% | - | - | - | 100.00% | 100.00% | 100.00% | - | - | **100.00%** | **100.00%** | >=85% | 85.00% |
| Skin | 95.83% | 92.31% | 76.19% | 100.00% | 95.65% | 100.00% | 94.44% | 90.00% | 95.45% | 100.00% | 100.00% | 100.00% | 100.00% | **87.50%** | **95.92%** | >=85% | 85.00% |
| Upper GI | 87.97% | 100.00% | 87.50% | 100.00% | 88.89% | 70.59% | 100.00% | 100.00% | 92.86% | 57.14% | 37.50% | 75.00% | 72.73% | **100.00%** | **81.58%** | >=85% | 85.00% |
| Urology | 89.60% | 66.67% | 79.41% | 85.71% | 92.50% | 93.75% | 88.57% | 95.92% | 97.06% | 96.77% | 90.91% | 90.70% | 90.00% | **93.75%** | **91.30%** | >=85% | 85.00% |
| Others | 95.24% | 66.67% | 100.00% | - | 0.00% | - | 100.00% | 100.00% | 66.67% | - | - | - | 100.00% | **100.00%** | **100.00%** | >=85% | 85.00% |
| **14 Day Referral to Date First Seen** | | | | | | | | | | | | | | | | | |
| Brain | 98.73% | 80.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 93.33% | **100.00%** | **96.55%** | >=93% | 93.00% |
| Breast | 97.81% | 96.84% | 93.17% | 98.53% | 97.52% | 98.32% | 98.77% | 97.96% | 98.43% | 99.25% | 97.12% | 99.22% | 96.00% | **98.84%** | **97.90%** | >=93% | 93.00% |
| Childrens | 96.85% | 100.00% | 100.00% | - | 100.00% | - | 100.00% | - | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | **100.00%** | **100.00%** | >=93% | 93.00% |
| Gynaecology | 96.83% | 97.96% | 94.87% | 90.67% | 97.59% | 98.78% | 94.95% | 91.82% | 97.37% | 98.99% | 100.00% | 96.81% | 99.00% | **100.00%** | **98.63%** | >=93% | 93.00% |
| Haematology | 97.89% | 93.75% | 90.91% | 100.00% | 90.48% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 90.91% | 100.00% | **100.00%** | **96.97%** | >=93% | 93.00% |
| Head & Neck | 98.54% | 98.29% | 97.94% | 95.08% | 100.00% | 97.73% | 99.12% | 98.92% | 98.51% | 97.96% | 100.00% | 78.10% | 95.79% | **91.74%** | **88.31%** | >=93% | 93.00% |
| Lower GI | 98.98% | 99.31% | 96.83% | 98.18% | 99.24% | 97.44% | 98.77% | 99.41% | 100.00% | 100.00% | 100.00% | 89.93% | 98.09% | **97.59%** | **95.45%** | >=93% | 93.00% |
| Lung | 99.14% | 100.00% | 100.00% | 100.00% | 100.00% | 96.77% | 100.00% | 91.67% | 95.00% | 100.00% | 100.00% | 96.43% | 100.00% | **100.00%** | **99.04%** | >=93% | 93.00% |
| Sarcoma | 98.68% | 100.00% | 80.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 91.67% | 100.00% | **100.00%** | **95.83%** | >=93% | 93.00% |
| Skin | 93.26% | 91.32% | 93.29% | 83.33% | 96.61% | 100.00% | 90.41% | 93.67% | 100.00% | 99.41% | 97.58% | 98.20% | 99.35% | **98.43%** | **98.59%** | >=93% | 93.00% |
| Testicular | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | **100.00%** | **100.00%** | >=93% | 93.00% |
| Upper GI | 97.59% | 98.94% | 96.00% | 95.18% | 95.70% | 100.00% | 99.02% | 98.15% | 100.00% | 99.00% | 98.81% | 98.99% | 98.10% | **97.53%** | **98.25%** | >=93% | 93.00% |
| Urology | 99.07% | 98.95% | 100.00% | 97.00% | 100.00% | 100.00% | 99.08% | 100.00% | 96.67% | 99.07% | 99.30% | 100.00% | 100.00% | **100.00%** | **100.00%** | >=93% | 93.00% |

## Methodology for calculating the performance score

**Standard KPIs and "Key" targets**

- Each RAG rating has a score - **red** 0 points; **amber** 2 points; **green** 4 points
- For "Key" targets, scores are weighted more heavily and are multiplied by a factor of 3 - **red** 0 points; **amber** 6 points; **green** 12 points

**Calculating Domain Scores**

- Add up the scores for each KPI per domain; divide by the maximum total score possible for that domain to get a percentage score.
- Apply the thresholds for the overall domain to get a RAG rating for each domain.
- Thresholds: < 50% is **red**, 50% to < 75% is **amber** and 75% and above is **green.**

**Calculating Trust Performance Scores**

- Calculate the overall performance score by adding up the scores for all domains; dividing by the maximum total score possible for all domains to get a percentage
- Apply the same thresholds as above to RAG rate the overall score

# "Key" targets

*The proposed "key" targets are all measures included in NHS Improvement's Single Oversight Framework or measures on which the Trust is particularly focussing and are deemed more important.*

| Domain | Measure |
|---|---|
| **Safe** | |
| | • VTE assessments |
| | • Never events |
| **Effective** | |
| | • MRSA |
| | • SHMI |
| | • HSMR |
| | • Emergency readmissions |
| **Caring** | |
| | • % Complaints closed within target timeframe |
| | • Friends and family test |

| Domain | Measure |
|---|---|
| **Responsive** | |
| | • Stroke - % of patients admitted directly to the stroke unit within 4 hours |
| | • Diagnostics waiting over 6 weeks |
| | • Avoidable number of Clostridium difficile cases |
| | • A&E 4 hour target |
| | • RTT target for incomplete pathways |
| | • Cancer standards |
| **Workforce** | |
| | • Sickness/Absence % |
| **Efficiency & Finance** | |
| | • Net / surplus deficit |