Ashford and St. Peter's Hospitals
NHS Foundation Trust

TRUST BOARD
JUNE 2018

AGENDA ITEM	16.2	
TITLE OF PAPER	Balanced Scorecard	
Confidential	**NO**	
Suitable for public access	**YES**	
PLEASE DETAIL BELOW THE OTHER SUB-COMMITTEE(S), MEETINGS THIS PAPER HAS BEEN SUBMITTED		
N/A		
STRATEGIC OBJECTIVE(S):		
Quality Of Care	✓	This paper measures achievement
People	✓	
Modern Healthcare	✓	
Digital	✓	
Collaborate	✓	
EXECUTIVE SUMMARY		
	Five of 'Best outcomes' KPIs were met and four were identified as having concerns Five 'Excellent experience' KPIs were identified as having concerns and seven were met Three 'Workforce' KPIs were identified as having concerns and three were met The Trust reported a YTD surplus of £1.3m against a planned surplus of £2.0m resulting in a deficit to plan of £0.7m, this resulted in an FSR score of 2 compared to plan of 1. . On the basis that the Trust is still striving to achieve the Q1 PSF finance and A&E targets, the full pro-rata PSF allocation has been accrued. Capital is overspent by £0.1m (26%) against the NHSI plan - although the full year forecast is expected to be in line with plan.	

RECOMMENDATION:	Note and make recommendations on remedial actions where required
SPECIFIC ISSUES CHECKLIST:	
Quality and safety	*n/a*
Patient impact	*n/a*
Employee	*n/a*
Other stakeholder	*n/a*
Equality & diversity	*n/a*
Finance	*n/a*
Legal	*n/a*
Link to Board Assurance Framework Principle Risk	*n/a*
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PRESENTED BY DIRECTOR(s)	David Fluck, Medical Director Louise McKenzie, Director of Workforce Simon Marshall, Director of Finance and information
DATE	22 June 2018
BOARD ACTION	Assurance

Balanced Scorecard

1.0 Introduction

The Trust has developed an updated strategy which was launched in May 2018. The revised strategy states that "Our vision is to provide an outstanding experience and the best outcome for patients and the team"

By achieving our aims every patient will say…

- *I was treated with compassion*
- *I was involved in a plan for my care which was understood and followed*
- *I was treated in a safe way, without delay*
- *And every member of our team was able to give their best and feel valued doing so.*

The Strategy sets out that ASPH will continue to be a vitally important centre for the delivery of urgent and emergency care supported by a breadth of critical care. We will seek to reinforce our position as the major emergency centre to the people of Surrey by developing the strength of our elective services to enable us to develop the critical mass of clinicians to offer specialist on-call rotas and out of hours provision that reinforces all care pathways.

Strategic objectives have been developed to support the delivery of the strategy which include:

Strategic Objective	Core Result
Quality of Care	Creating a learning organisation and culture of continuous improvement to reduce repeated harms and improve patient experience
People	Being a great place to work and be a patient, where we listen, empower and value everyone
Modern Healthcare	Delivering the most effective and efficient treatment and care by standardising the delivery and outcomes of clinic services
Digital	Using digital technology and innovations to improve clinical pathways, safety and efficiency, and empower patients
Collaborate	Working with our partners in health and care to ensure provision of a high quality, sustainable NHS to the communities we serve

The attached scorecard is the core is one of the ways by which assurance is provided to the Trust Board that action is being taken to ensure high quality care.

2.0 Best Outcomes

The SHMI mortality ratio for May was 64.6, which represents a slight increase on recent months compared to the previous stability. The current rate is significantly lower than the 16/17 average of 70, but slightly higher than 17/18 average of 61.1. The actual number of deaths in May was 100, which was an increase on April.

There was 1 cardiac arrest in non-critical care areas in May. The outturn for 17/18 was 42 which is lower than in 2016/17 which represents a significant improvement with the underlying aim to achieve zero.

59.1% of stroke patients admitted in May reached the stroke ward within 4 hours of being admitted to the hospital based on discharged patients and is the primary stroke indicator which the Trust struggles to achieve. This rate remains a significant decline on the previous levels. This is due to a variety of issues including ring fencing of beds and the overall pathway from A&E to the ward. In addition due to increased demand on medical beds some patients continue to be admitted into stroke allocated beds. Overall the stroke service is rated as an "A" unit in the national stroke audit.

Readmissions were at 12.1%. Readmissions continue to run at a similar rate to the previous year.

The number of falls in May per 1000 bed days was 2.91, representing a slight decline on last month. This reverses the recent trend of better performance than in the previous year. The out turn for last year was higher than the previous year and the first month of 18/19 is higher than last year.

There was no cases of hospital acquired MRSA and three C-Diff cases.

Pressure Ulcers (per 1000 bed days) at 1.49 is below the target rate of 1.88. The work undertaken by the quality department implementing an action plan to support a reduction in the number of ulcers continues to show a positive outcome as pressure ulcers continue to decline. The recent focus has been on preventing ulcers on the heel as this has been a particular area of increase.

3.0 Excellent Experience

ASPH did not meet the four hour emergency access standard (93.2%) during May. This represents an improvement on last month even with the continuing demand.

The Trust improved on last month's performance but did not meet the 18 week target at Trust level, (Incomplete 91.5%). A recovery plan has been developed with the commissioners allocating additional funds during 2018/19 to support the recovery.

The Friends and Family Test score for inpatients' in May was 98.3%, remaining above the target of 95% following several months of improvement. The score for A&E is at 80.3% which is a very good improvement on previous years but the decline over winter represents the pressure the department has been under.

The follow-up complaints rate in May was 13.9% which represents an increase and is above the target of <9.5%.

5 out of 7 cancer waiting times targets were met.

4.0 Skilled, motivated workforce

Establishment and Vacancies

The vacancy rate is 12.9% against a Trust establishment of 3910 wte.
The Trust welcomed 7 new staff members on 1st May as a result of a transfer from Guildford and Waverley Community Dermatology services.
The current registered nursing vacancy rate is 21.8%, equating to 269 wte vacancies against a budgeted establishment of 1234 wte.

Bank and Agency

Agency spend as a percentage of the total pay was 6.4% in May 18 against bank spend of 9.0%.
The new ASPH Bank pay rates for Agenda for Change staff were published in May. The new rates have required a significant amount of changes to be made in Healthroster and ESR by the Trust's Payroll and Workforce Information teams, which has meant that payments will be made from the end of June 2018 onwards and backdated to 1 May 2018.
Bank bookings for Nursing staff have not yet increased as a result of the new rates, however this is reported as due to the later implementation. Agency spend has been higher in May in Medicine (ED, Acute Medicine, Senior Adult Wards).

Turnover and Stability

Turnover is based on the number of leavers against the average staff in post over the previous 12 months, and it excludes training doctors and other rotational posts. Employees TUPE'ing out are excluded from turnover calculations. The stability rate shows the percentage of staff at the start of a 12 period that do not leave the specified group during the period in question and is useful for showing retention.
The turnover for the rolling year is 15.9% with the voluntary turnover rate at 13.3%, an increase of 0.2% from last month.
Of the staff who have left the Trust voluntarily in the preceding 12 months, 26% left to relocate, 37% left for 'Other' reasons and 13% left due to promotion.

Sickness

The sickness rate is reported a month in arrears, and remained steady at 2.8% for April 2018 and is within the 3% target. The 12 month rolling sickness rate is also just within target at 3.05%.
Additional Clinical Services and Estates and Ancillary staff experienced the highest sickness absence for April with both rates at 4.1%. Medical and Dental staff had the lowest rate of 1.37% followed by AHPs at 2.11%.

Appraisals

The overall appraisal rate is currently 69.7%. The new condensed appraisal conversation form and policy will be formally launched later this month.

Mandatory Training

Compliance has improved by 0.2% to 82.3% this month. Finance and Operations have compliancy well above the Trust average whilst TASCC is the clinical directorate with the highest rate at 85.3%.

FFT

The Friends and Family Test for quarter one has been completed and the results will become available in July. The quarter two test will be launched in August.

5.0 Top productivity

The Trust reported a YTD surplus of £1.3m against a planned surplus of £2.0m resulting in a deficit to plan of £0.7m. The Trust missed the NHSI financial control total for month 2 by £0.6m and, when combined with missing the NHSI agency target, this resulted in an FSR score of 2 compared to plan of 1. On the basis that the Trust is still striving to achieve the Q1 PSF finance and A&E targets, the full pro-rata PSF allocation has been accrued.

The main reasons for the YTD variances are

(i) pay costs £15k below budget - this is unlike 2017/18 when the Trust had a significant underspend against its budget,

(ii) non-pay £0.4m overspent with overspends in Outsourcing £0.3m, Drugs £0.1m and Premises £0.1m which were partially offset by savings in Clinical Supplies, and

(iii) income £0.3m behind the NHSI phased plan YTD. CIP's came in £0.3m behind plan at £1.3m due to delays in some schemes starting. The CIP forecast, which is now forecast to be £0.9m behind plan.

Month end cash balances were £27.1m, which was £0.5m behind plan. The outstanding STF payments, for Q3 and Q4, of £6.9m is not expected to be received until July 2018.

Capital is overspent by £0.1m (26%) against the NHSI plan - although the full year forecast is expected to be in line with plan.

The forecast has been held at plan in month 2.

Activity in SLAM (including MSK) was at an equivalent level as the same period last year (last month was 2% higher), with A&E 4% higher than last year, outpatients 5% lower, Elective 33% higher and Maternity 2% lower. Emergency activity was 4% lower than last year. The reason elective activity was higher this year was due to only one day of Easter falling within April 2018, combined with RTT backlog work.

Trust Balanced Scorecard - 2018/19

Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

1. Best outcomes

	Measure	Outturn 17/18	Annual Target 18/19	May 18 Actual	6-month trend	YTD 18/19	Data Quality
1-01	In-hospital SHMI	61.1	<68.4	64.6		61.1	
1-02	RAMI ***	90.79	<100	83.3		90.53	
1-03	In-hospital deaths	1184	<1082	100		88	
1-04	Proportion of mortality reviews*	56.70%	>90%	84.3%		84.3%	
1-05	Number of cardiac arrests not in critical care areas	42	-	1		7	
1-06	MRSA (Hospital only)	1	0	0		0	
1-07	C.Diff (Hospital only)	15	16	3		5	
1-08	Falls (Per 1000 Beddays)	2.45	2.13	2.91		3.03	
1-09	Pressure Ulcers (Per 1000 Beddays)	1.79	1.88	1.49		1.70	
1-10	Readmissions within 30 days - emergency only	14.20%	12.5%	12.1%		13.0%	
1-11	Stroke Patients (% admitted to stroke unit within 4 hours)	54.30%	90%	59.1%		56.3%	
1-12	Medication errors - rate per 1000 bed days	2.59		2.98		2.24	
1-13	Sepsis Screening audits undertaken *	89.10%	80%	Quarterly Measure		89.1%	
1-14	Sepsis Antibiotic Administration Audits undertaken *	87.50%	80%			87.5%	

* - 2016/17 Sepsis results for ED only (2016/17 Quarter 2 onwards) Position amended after submission to Unify reporting 77%

** - 2016/17 Q2 Quarterly target 80% (2016/17 Q1 Quarterly target 90%)

*** - CHKS has revised the Algorithm for the RAMI calculation to improve accuracy

2. Skilled, motivated workforce

	Measure	Outturn 17/18	Annual Target 18/19	May 18 Actual	6-month trend	YTD 18/19	Data Quality
2-01	Establishment (WTE)	3920	3,935	3910			
2-02	Establishment (£ Pay)	£179,016	£185.5m	£ 15,504		£ 30,928	
2-03	Agency Staff Spend as a Percentage of Total Pay	5.60%	<5.4%	6.4%			
2-04	Bank Staff Spend as a Percentage of Total Pay	8.30%	<8.6%	9.0%			
2-05	Vacancy Rate (%) Excluding Headroom *Note 1	12.60%	<10%	12.9%			
2-06	Staff turnover rate	15.80%	<15%	15.9%			
2-07	Voluntary turnover rate (NEW)	13.00%	<12%	13.3%			
2-08	Stability	86.50%	>88%	86.3%			
2-09	Sickness absence	3.27%	<3.0%	2.8%			
2-10	Staff Appraisals	70.90%	>90%	69.7%			
2-11	Statutory and Mandatory Training	81.60%	>90%	82.3%			
2-12	F&F: Recommend for Treatment (Extremely likely/likely % : Extremely unlikely/unlikely %)	81.00%		Survey in progress			
2-13	F&F: Recommend to Work (Extremely likely/likely % : Extremely unlikely/unlikely %)	71.00%					

Note 1 - Vacancy Percentage rate is adjusted to reflect posts within the nursing Headroom held for bank fill

3. Excellent experience

	Measure	Outturn 17/18	Annual Target 18/19	May 18 Actual	6-month trend	YTD 18/19	Data Quality
3-01	A&E 4 hour target (including Ashford & Woking)*	91.04%	>95%	93.2%		92.3%	
3-02	Emergency Conversion Rate	23.40%	<22.64%	21.4%		21.8%	
3-03	Serious Incidents Requiring Investigation (SIRI) Reports Overdue to CCG	9	N/A	13		13	
3-04	Serious Incidents Requiring Investigation (SIRI) Reports Submitted to CCG	89	N/A	5		11	
3-05	Average Bed Occupancy (exc escalation beds)	84.60%	<87.4%	83.2%		84.0%	
3-06	Patient Moves (ward changes >=3) **	4.90%	<5.87%	3.9%		4.7%	
3-07	Discharge rate to normal place of residence (Stroke&FNOF)	62.80%	>62.1%	58.0%		63.5%	
3-08	Friends & Family Satisfaction Score - InPatients (incld Daycases)	96.30%	95%	98.3%		96.3%	
3-09	Friends & Family Satisfaction Score - A&E (incld Paeds)	83.90%	87%	80.3%		79.8%	
3-10	Friends & Family Satisfaction Score - Maternity (Touch Point 2)	81.60%	97%	100.0%		96.7%	
3-11	Friends & Family Satisfaction Score - Outpatients	95.90%	92%	97.4%		97.3%	
3-12	Complaints - FollowUp Rate	8.70%	<9.5%	13.9%		9.8%	
3-13	Dementia screening - Asked case finding question within 72 hrs of adm	35.50%	90%	39.1%		35.5%	
3-13a	Dementia screening - Scored positively to case finding question	99.50%	90%	76.9%		80.0%	
3-13b	Dementia screening - Diagnostic Assessment	99.60%	90%	100.0%		100.0%	
3-14	RTT - Admitted pathway (Unadjusted)	53.00%	>90%	45.9%		45.9%	
3-15	RTT - Non-admitted pathway	92.30%	>95%	91.7%		91.0%	
3-16	RTT - Incomplete pathways	92.00%	>92%	91.5%		90.7%	
3-17	Cancer waiting times targets achieved	7 out of 7	7 out of 7	5 out of 7		5 out of 7	

* As of Nov 2017, Woking activity included in ASPH Total, As of Jan 2018, EPU Activity excluded from ASPH Total

4. Top productivity

	Measure	Outturn 17/18	Annual Target 18/19	May 18 Actual	6-month trend	YTD 18/19	Data Quality
4-01	NHSI Finance Score Rating	1	1	2		2	
4-02	Total income excluding interest (£000)	£306,368	£300,137	£25,946		£50,674	
4-03	Total expenditure (£000)	£274,242	£272,850	£23,831		£47,156	
4-04	EBITDA (£000)	£32,126	£27,287	£2,115		£3,518	
4-05	Month end cash balance (£000)	£25,115	£22,788	£27,108		£27,108	
4-06	Capital Expenditure Purchased (£000)	£7,226	£8,712	£553		£777	
4-07	CIP Savings achieved (£000)	£11,267	£10,541	£707		£1,311	
4-08	STF Funding within income £000)	£11,148	£7,672	£540		£1,079	
4-09	CQUINs (£000)	£4,859	£4,367	£369		£737	
4-10	Joint Delivery Plan with CCG (Income Only)	£3,925	£8,000	£30		£223	
4-11	Average LoS Elective (RealTime)	3.76	3.32	3.52		3.78	
4-12	Average LoS Non-Elective (RealTime)	6.15	6.13	6.28		6.25	
4-13	Outpatient First to Follow ups	1.24	1.24	1.14		1.13	
4-14	Daycase Rate (whole Trust)	85.80%	>84%	78.8%		85.5%	
4-15	Theatre Utilisation	74.20%	>79%	76.3%		76.1%	
4-16	A&E Activity (Attendances)	93533	< 17148	9039		17365	
4-17	Emergency Activity (Spells)	51814	< 5058	3306		6303	
4-18	Elective Activity (Spells)	32912	> 4582	3385		6375	
4-19	% Elective inpatient activity taking place at Ashford	52.20%	>54.65%	52.4%		51.1%	
4-20	Outpatient Activity (New Attendances)	107053	> 16056	10318		19893	

** - Note March 2018 data currently draft

Delivering or exceeding Target	
Underachieving Target	
Failing Target	

Patients first • Personal responsibility • Passion for excellence • Pride in our team

Prepared by Information Services
Additional data provided by: Finance, Workforce and Quality

Trust Balanced Scorecard 2018/19

Definitions

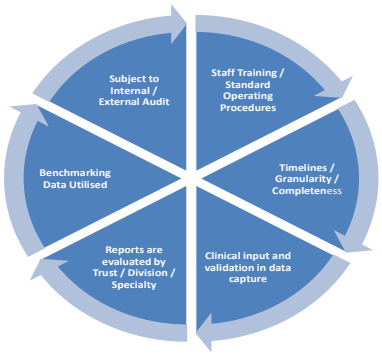
Quadrant 1	Best Outcomes
1-01	IN-HOSPITAL SHMI - The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a provider. The observed number of deaths is the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days post discharge from the hospital. The expected number of deaths is calculated from a risk adjusted model with a patient case-mix of age, gender, admission method, year index, Charleston Comorbidity Index and diagnosis grouping. A 3 year dataset is used to create the risk adjusted models. A 1 year dataset is used to score the indicator. The 1 year dataset used for scoring is a full 12 months up to, and including, the most recently available data. The 3 years used for creating the dataset is a full 36 months up to, and including, the most recently available data. The data source is CHKS. The monthly figure shown is a rolling 6 month position, reported one month in arrears and the YTD figure shown is a rolling 12 month position, reported one month in arrears
1-02	RAMI (Risk Adjusted Mortality Index) uses a method developed by CHKS to compute the risk of death for hospital patients on the basis of clinical and hospital characteristic data.The model calculates the expected probability of death for each patient based on the experience of the norm for patients with similar characteristics (age, sex, diagnoses, procedures, clinical grouping, admission type) at similar hospitals (teaching status). After assigning the predicted probability of death for each patient, the patient-level data is aggregated. The data source is CHKS. The monthly figure and YTD is reported one month in arrears.
1-03	The total number of in-hospital deaths (Uses a previous CQUIN definition i.e. excludes age<18, maternity and ICD10 codes that relate to trauma - V01, X*, W*, Y*, O*)
1-04	Proportion of mortality reviews. Number of mortality reviews (numerator) divided by total number of deaths (denominator). Unlike 1-03, the denominator has no exclusions, i.e. all deaths are counted. This measure is reported one month in arrears to account for the time lag to carry out and record the mortality review.
1-05	Number of cardiac arrests not in critical care areas (i.e. not in MAU, CCU, SDU, SAU, Endoscopy, Cardiac cath lab, A&E, ICU, Theatres, MHDU, Paeds A&E)
1-06	Number of Hospital acquired MRSA
1-07	Number of Hospital acquired C-Diff
1-08	Falls (Per 1000 Beddays)
1-09	Pressure Ulcers - total number of hospital acquired pressure ulcers (Per 1000 Beddays)
1-10	Re-admissions within 30 days of first admission where the first admission was an emergency. CQUIN definition
1-11	Stroke Patients (% admitted to stroke unit within 4 hours)
1-12	Medications Errors - Administration& Prescribing (Per 1000 Beddays)
1-13	The percentage of patients who met the criteria of the local protocol for sepsis screening and were screened for sepsis and for whom sepsis screening is appropriate.
1-14	The percentage of patients who present with severe sepsis, Red Flag Sepsis or septic shock to emergency departments and other units that directly admit emergencies, and were administered intravenous antibiotics within 1 hour of ARRIVAL.
Quadrant 2	**Skilled, Motivated Workforce**
2-01	Establishment is the pay budget of the Trust, described in numbers of posts (WTE). Whole Time Equivalent is the method of counting staff or posts to reflect the contracted hours of staff against the standard full-time hours e.g. a full-time worker is 1.0 WTE and a member of staff who works half the full time hours would be 0.5 WTE
2-02	Pay bill for staff employed (£k)
2-03	Agency WTE is reported from Healthroster for all staff groups. Agency % is reported as the expenditure on agency as a % of the total paybill including permanent, bank and agency
2-04	Bank WTE is reported from Healthroster for all staff groups. Bank % is reported as the expenditure on Bank as a % of the total paybill including permanent, bank and agency
2-05	The vacancy factor is the difference between the number of substantively employed staff and the budgeted establishment, measured in WTE or reported as a percentage of establishment.
2-06	Turnover is cumulative, and is the number of staff (headcount) leaving in last 12 months divided by the average number of staff in post now and 12 months previously, as a percentage. Doctors in training are excluded from the figures as this is planned rotation.
2-07	Vancancy Turnover Rate
2-08	Stability is the number of staff (headcount) with more than one year's service, divided by the current number of staff in post, as a percentage
2-09	Sickness is the number of WTE days lost due to sickness divided by the number of WTE days available, as a percentage for the period.
2-10	Staff Appraisals
2-11	Mandatory Training is reported as the number of employees compliant with individual competences at month end, as a percentage of the number of employees required to be compliant with each competence
2-12	F&F: Recommend for Treatment (Extremely likely/likely % : Extremely unlikely/unlikely %)
2-13	F&F: Recommend to Work (Extremely likely/likely % : Extremely unlikely/unlikely %)
Quadrant 3	**Excellent Experience**
3-01	Trust 4Hr target (Including Ashford)
3-02	Number of patients who were admitted as a percentage of the total number of attendances at A&E
3-03	Serious Incidents Requiring Investigation (SIRI) Reports overdue to CCG
3-04	Serious Incidents Requiring Investigation (SIRI) Reports Submitted to CCG
3-05	Average Bed Occupancy (excluding escalation beds) - based on the midnight bed stay statistic (including paediatric and labour wards)
3-06	The percentage of non-elective patients who were transferred between wards, 3 or more times during their admission. Excludes maternity and paeds. Transfers to the discharge lounge, theatres, endoscopy, between SAUV and SAU have not been included in the count.
3-07	Number of discharges discharged to normal place of residence as a rate of all discharges for stroke and Fractured Neck of Femur
3-08	Friends and Family Satisfaction (Recommend) rate for Inpatients (Test asks following standadised question: "how likely are you to recommend our ward to friends and family if they needed similar care or treatment?" Now includes Daycase Activity
3-09	Friends and Family Satisfaction (Recommend) Rate for A&E (Test asks following standadised question: "how likely are you to recommend our A&E department to friends and family if they needed similar care or treatment?" including Paeds
3-10	Friends and Family Satisfaction (Recommend) Rate for Maternity all four measures combined (Test asks following standadised question: "how likely are you to recommend our ward to friends and family if they needed similar care or treatment?"
3-11	Friends and Family Satisfaction (Recommend) Rate for Outpatients (Test asks following standadised question: "how likely are you to recommend our ward to friends and family if they needed similar care or treatment?"
3-12	The number of follow-up complaints received as a rate of the 12 month rolling average of new complaints
3-13	% of all patients aged 75 and above admitted as emergency inpatients, with length of stay > 72 hours, who are asked the dementia case finding question within 72 hours of admission, or who have a clinical diagnosis of delirium on initial assessment or known diagnosis of dementia, excluding those for whom the case finding question cannot be completed for clinical reasons.
3-13a	% of all patients aged 75 and above admitted as emergency inpatients, with length of stay > 72 hours, who have scored positively on the case finding question, or who have a clinical diagnosis of delirium, reported as having had a dementia diagnostic assessment including investigations.
3-13b	% of all patients aged 75 and above admitted as emergency inpatients, with length of stay > 72 hours, who have had a diagnostic assessment (in whom the outcome is either "positive" or "inconclusive") who are referred for further diagnostic advice in line with local pathways.
3-14	RTT - Admitted Unadjusted (ie. No Clock Pauses) Pathway. Trust percentage compliance with the 18 weeks rules.
3-15	RTT - Non-admitted pathway. Trust percentage compliance with the 18 weeks rules.
3-16	RTT - Incomplete pathways. Trust percentage compliance with the 18 weeks rules. 92% of Incompelte pahways should be waiting less than 18 weeks.
3-17	Cancer waiting times targets achieved
Quadrant 4	**Top Productivity**
4-11	Average Length of Stay for Elective patients using the Real- Time methodology (Excludes 0 days and Gynae/ Paeds/well babies)
4-12	Average Length of Stay for Non- Elective patients using the Real- Time methodology (Excludes 0 days and Gynae/ Paeds/well babies)
4-13	Outpatient first to follow-up appointments (Methodology excludes certain clinic codes in line with the contract)
4-14	* In-hospital SHMI currently unavailable through CHKS due to a technical error
4-15	Theatre Utilisation - In-session utilisation based on time used (Proc End - Anae Induction) as % of available session time. Includes Bluespier records with missing tracking times
4-15	Overall Elective Market Share
4-16	A&E Activity (Attendances)
4-18	Total number of Emergency Spells in the month
4-19	Percentage of elective inpatient activity taken place at Ashford
4-20	Total number of Outpatient New attendances - SLAM figures (for PODS = OPFASPCL, OPFASPNCL and OPFAMPCL) NB: This does not include direct access or POC

Kite-Mark

The kite-mark is designed to appear next to KPIs included on the dashboard to provide visual assurance on quality of a performance indicator

The kite-mark is a visual indicator that acknowledges the variability of data and makes an explicit assessment of the quality of evidence on which the performance measurement is based.

Each measure is assessed as 'sufficient', 'insufficient' or 'not yet assessed' on six distinct elements. For each element a colour code shows the strength of assurance. Each measure has an equal weighting.



Prepared by Information Services
Additional data provided by: Finance, Workforce and Quality