

Integrated Dashboard Board of Directors

30th September 2019

Integrated Dashboard

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To provide outstanding care for patients



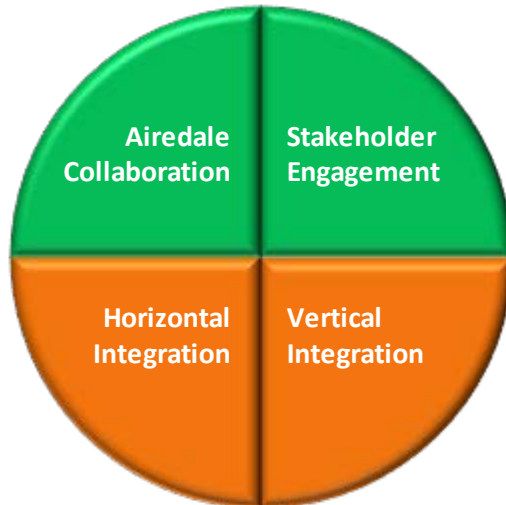
To deliver our key performance targets and financial plan



To be in the top 20% of employers



To collaborate effectively with local and regional partners



To be a continually learning organisation



Headlines

The **month 6 position** is a pre-PSF deficit of £7.9m which is in line with the plan and control total. The **CIP efficiency** programme has been achieved against the £5.3m cumulative CIP target in the first 6 months of the financial year. There remains a significant forecast savings gap which must be resolved to deliver the control total. The internal mid-case pre-PSF **I&E forecast** has been revised at Month 6 to a deficit of £19.5m (£7.0m adverse variance). The trajectory of this forecast suggests that Q3 and Q4 control totals will not be achieved, resulting in a loss to the Trust of £8.1m PSF cash.

The **Emergency Care Standard** performance for Type 1 & 3 attendances was 74.7% for September 2019. The Improvement Programme continues with focus on expansion in the use of green zone, effective navigation, clinical co-ordination and increasing same day emergency care. Additional actions are currently in place to reduce the demand on Majors following an increase in flow to this zone causing performance to deteriorate.

There have been no **never events** reported for nearly 12 months. There is continuing strong performance on **mortality rates** and clear evidence of **learning from deaths**.

Whilst noting the good performance in **MRSA and Catheter associated UTI** indicators, **C-Diff** levels have increased primarily as a result of national changes to reporting.

Cancer 2 Week Wait performance for August 2019 was 92.15% and is currently projected at 94.16% for September 2019. Reduced Endoscopy capacity created a drop in performance. **Cancer 62 Day First Treatment** performance for August 2019 was 81.31% and forecasted to remain below the standard in September 2019. Improvement work continues. Clinical Oncology capacity is being closely managed to reduce the wait time further, alongside increased surgical capacity to support treatment of long waiting patients. Whilst this initially has a negative impact on performance it will allow recovery to above standard during December 2019.

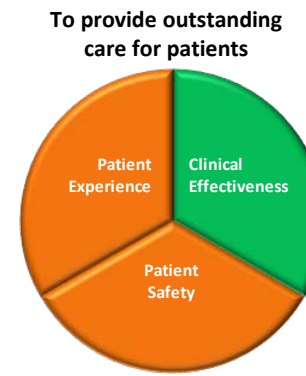
The **Referral to Treatment** (RTT) Incomplete performance was 84.8% for September 2019 and the total waiting list increased by 760 patients; growth was for patients waiting less than 18 weeks. There were no patients waiting more than 52 weeks at the end of September 2019. The **diagnostic waiting list** (DM01) performance improved to 98.18% in September 2019.

The Trust's **Engagement** indicator has improved overall due to Staff Friend and Family Test work. Staff turnover is stable. Improvement continues in use of agency staff.

The Trust continues to **work collaboratively** with local Bradford District & Craven partners and partners across West Yorkshire & Harrogate, building sustainable integrated care systems.

Quality Dashboard

30th September 2019



Whilst noting the good performance in **MRSA and Catheter associated UTI** indicators, **C-Diff** levels have increased primarily as a result of national changes to reporting. Strong assurance has been received through quarterly infection control reports. **Sepsis** screening rates demonstrate sustained improvements. **Medicines reconciliation** is significantly higher than peers. There have been no **never events** reported for nearly 12 months.

There is continuing strong performance on **mortality rates** and clear evidence of **learning from deaths**.

Night time transfers continue to be low and **night time discharges** continue to improve.

Finance & Performance Dashboard

30th September 2019

To deliver our key performance targets and financial plan



The **month 6 position** is a pre-PSF deficit of £7.9m which is in line with the plan and control total. 100% of the PSF available for Month 6 has been assumed in the position, equating to £4.9m. An additional £0.5m of bonus PSF relating to 18/19 was received in June. This therefore shows that the Trust is ahead of plan on PSF cash. This results in a post-PSF deficit of £3.1m which is ahead of plan by the £0.5m.

The **CIP efficiency** programme has been achieved against the £5.3m cumulative CIP target in the first 6 months of the financial year. There remains a significant forecast savings gap which must be resolved to deliver the control total. Projections show £10.8m CIP savings will be delivered by year end against a £16.2m target. Weekly CIP meetings have improved projections from CBUs, however the pace of progress provides inadequate assurance. The NHS I shared forecast at Month 6 is delivery of £12.5m pre-PSF control total deficit and recovery of £12.5m PSF to achieve breakeven post-PSF control total.

The internal mid-case pre-PSF **I&E forecast** has been revised at Month 6 to a deficit of £19.5m (£7.0m adverse variance). The trajectory of this forecast suggests that Q3 and Q4 control totals will not be achieved, resulting in a loss to the Trust of £8.1m PSF cash. Care Groups have been tasked with developing detailed recovery plans for executive review and implementation in early November, however the risk to control total delivery in 2019/20 is now significant.

The **Emergency Care Standard** Type 1 & 3 performance was 74.7% for September 2019. Average daily attendances to date are in line with 2018/19, an increase of 3.8% from 2017/18. The Improvement Programme continues focussing on expansion in green zone use, effective navigation, clinical co-ordination and increasing same day emergency care. Additional actions in place to reduce Majors demand post increase in flow causing performance deterioration.

Cancer 2 Week Wait performance for August 2019 was 92.15% and is currently projected at 94.16% for September 2019. Reduced Endoscopy capacity created a drop in performance for Lower and Upper GI during August 2019; this remains the main concern following recovery to standard for all other tumour groups.

Cancer 62 Day First Treatment performance for August 2019 was 81.31% and is forecast to remain below the standard in September 2019. Earlier diagnosis and improvements in inter-provider transfer performance are supporting all tumour groups with main concern remaining Urology. Clinical Oncology capacity is being closely managed and extra sessions planned to reduce the wait time further, alongside increased surgical capacity to support treatment of long waiting patients. Whilst this initially has a negative impact on performance it will allow recovery to above standard during December 2019.

The **Referral to Treatment** (RTT) Incomplete performance was 84.8% for September 2019 and the total waiting list increased by 760 patients; growth was for patients waiting less than 18 weeks. There were no patients waiting more than 52 weeks at the end of September 2019 and the same is anticipated at the end of October 2019. Recovery plans are being monitored weekly for each specialty where performance is behind plan.

The **diagnostic waiting list** (DM01) performance improved to 98.18% in September 2019 following improvement to only 6 patients waiting over 6 weeks for Cystoscopy. The Endoscopy position is also improving however cancer pressures continue which impacts on the capacity to support DMO1 recovery. An additional Colorectal Consultant is in post from October 2019 and Gastro Consultant post is out to advert with the interview planned for December 2019.

Workforce Dashboard

30th September 2019



The **Engagement** indicator has improved overall due to Staff Friend and Family Test work. The Trust is benchmarking the same as other Trusts in Yorkshire and Humber. Appraisal rates are increasing and on track to meet the Trust's 95% target by the end of December 2019.

The **Equality and diversity indicators** have been updated. The BAME Senior Leaders indicator continues to show improvement but is behind the Trust's target trajectory. A full equality update report is to be received at the next Workforce Committee.

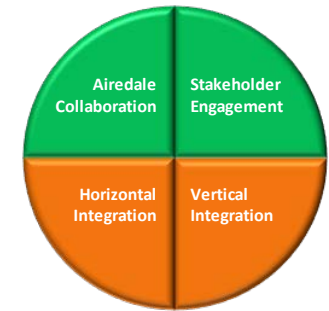
Agency usage continues to improve with continued reduction and staff turnover is stable. There has been little change in sickness rates.

The Workforce Committee meeting is scheduled for 7 November 2019 at which point in time the Workforce Dashboard will be reviewed.

Partnership Dashboard

30th September 2019

To collaborate effectively with
local and regional partners



With respect to **Stakeholder engagement**, account managers are being consulted to assess the current position of the Trust's relationships with their respective stakeholders.

Vertical integration - The Trust is working through how to engage with the new Primary Care Networks and the opportunities and risks that might be associated with them.

Horizontal integration – The Trust is undertaking work to understand its position in the work the West Yorkshire and Harrogate Association of Acute Trusts is doing to create a secondary care strategy for region.

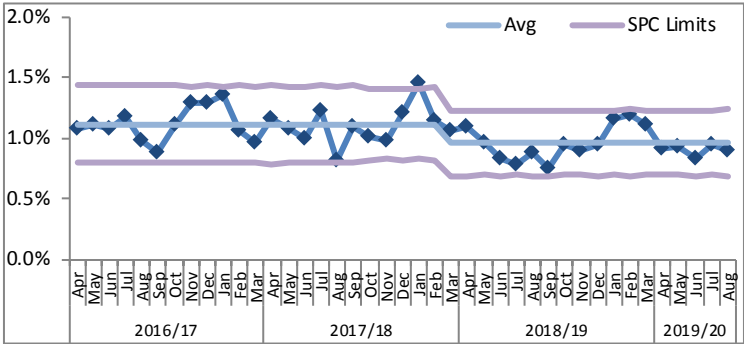
The **Airedale collaboration** work continues to create a joint clinical strategy between Airedale NHS Foundation Trust and Bradford Teaching Hospitals NHS Foundation Trust.

To provide outstanding care for patients

Clinical Effectiveness

Metric / Status	Trend	Challenges and Successes	Benchmarks
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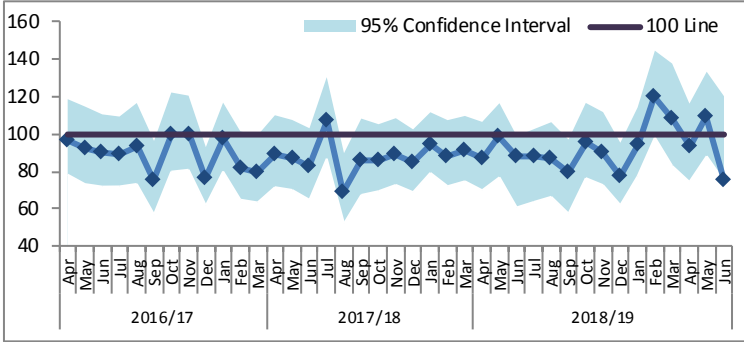
Crude Mortality



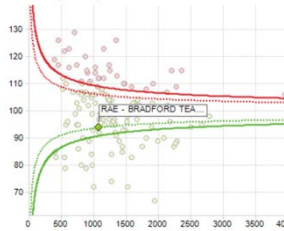
Crude death rate has remained constant throughout the last eighteen months, with expected seasonal variation. Improving learning from mortality is now delivered through the ‘learning from deaths’ process. Reporting on progress to the Quality Committee is via the quarterly learning from deaths report.

No benchmark comparator available

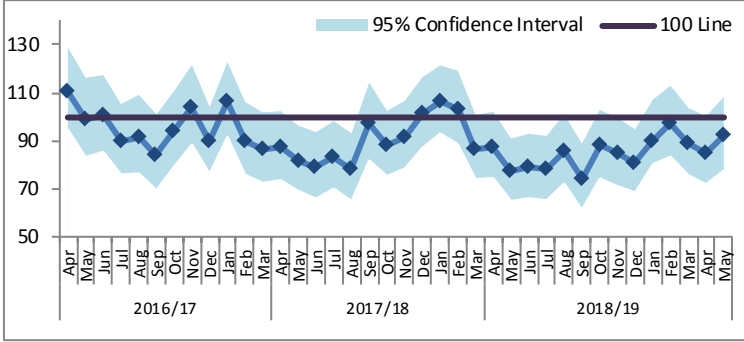
Hospital Standardised Mortality Ratio



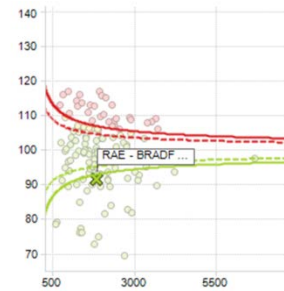
Our Hospital Standardised Mortality Ratio (HSMR) continues to demonstrate a ‘better than expected’ rate.



Summary Hospital-level Mortality Indicator



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



To provide outstanding care for patients

Clinical Effectiveness

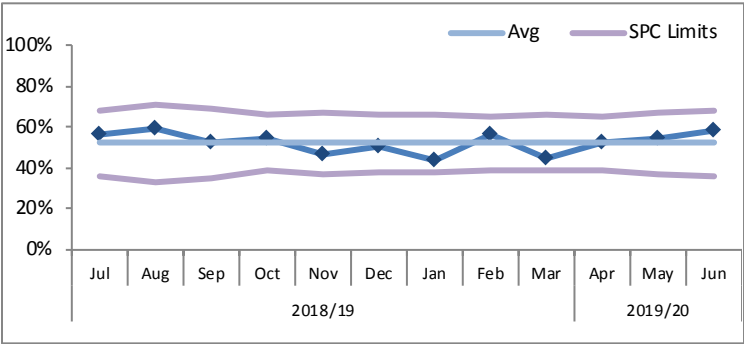
Metric / Status

Trend

Challenges and Successes

Benchmarks

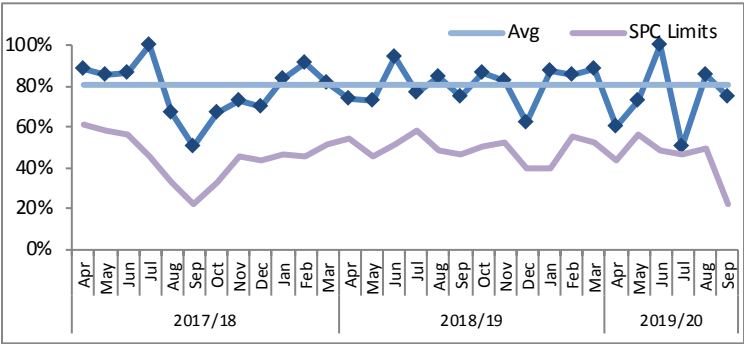
Deaths Screened



The trust is working with colleagues from Airedale to implement the national medical examiner role from April 2020.

No benchmark comparator available

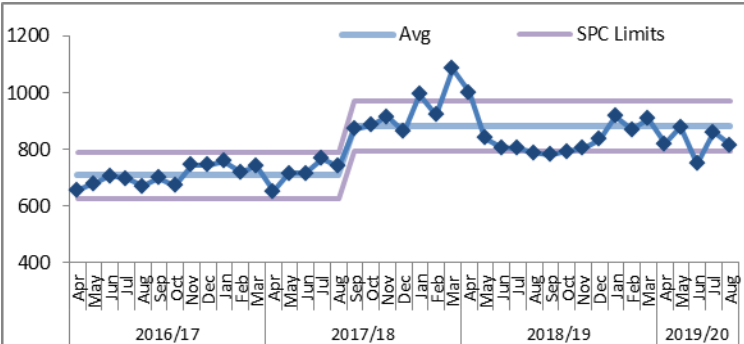
Learning From Deaths



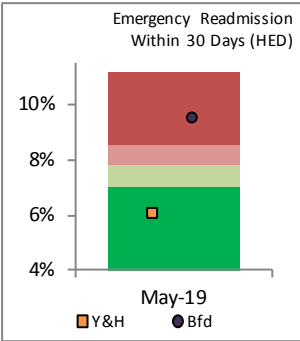
The trust has consistently provided good or excellent care to over 80% of our patients reviewed by structure judgement review.

No benchmark comparator available

Readmissions

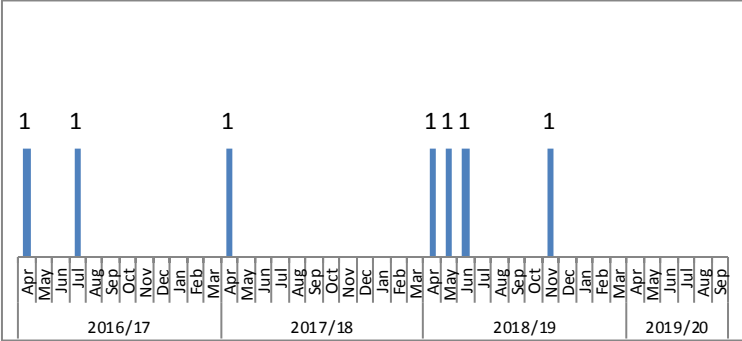
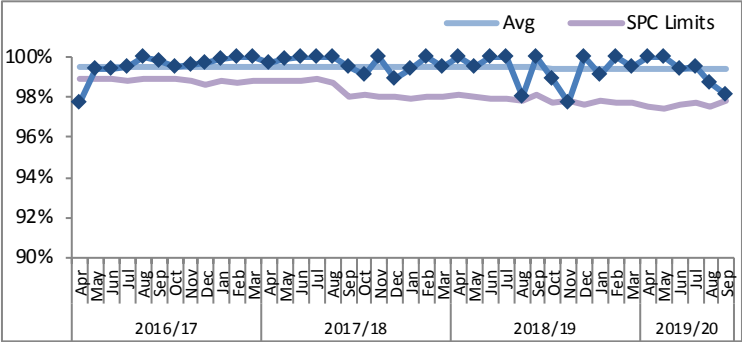


Readmissions are within control limits for September 2019. Trends at a specialty level have been reviewed and a clinical review of readmissions is being undertaken by the Chief Medical Officers (CMO's) office.



To provide outstanding care for patients

Patient Safety

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Never Events</div>		<p>There have been no never events in 2019/20 to date.</p>	<p>No benchmark comparator available</p>
<div>Audit of WHO Checklist</div>		<p>Compliance has sustained at or above 98% compliance with many months at 100%. Data by theatre block is shared directly with leaders to help drive this sustained improvement. Recent dip is being investigated and communication to all staff (learning matters) has been undertaken.</p>	<p>No benchmark comparator available</p>

To provide outstanding care for patients

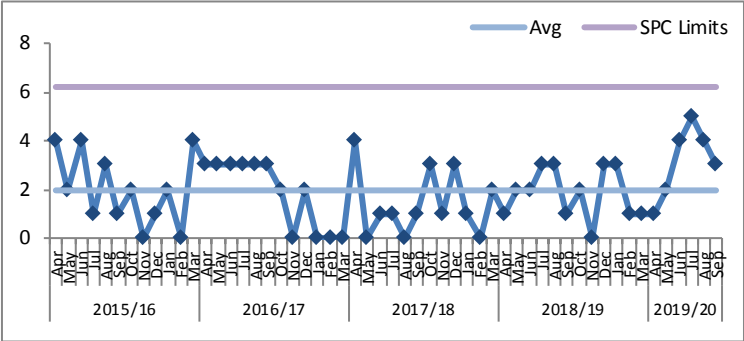
Patient Safety

Metric / Status

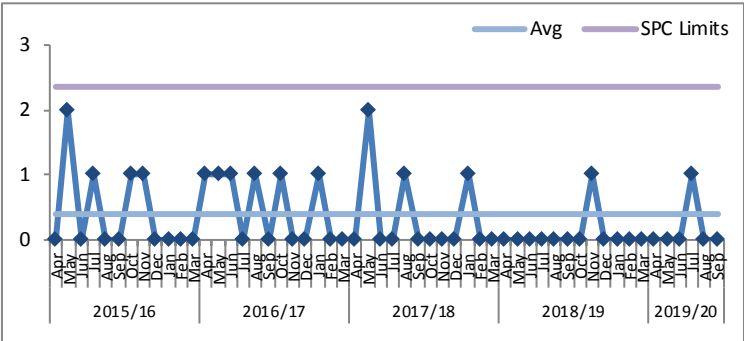
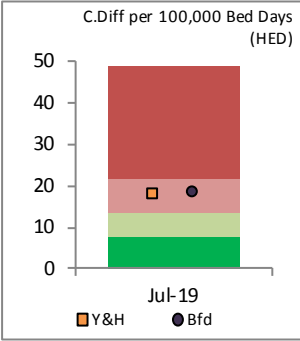
Trend

Challenges and Successes

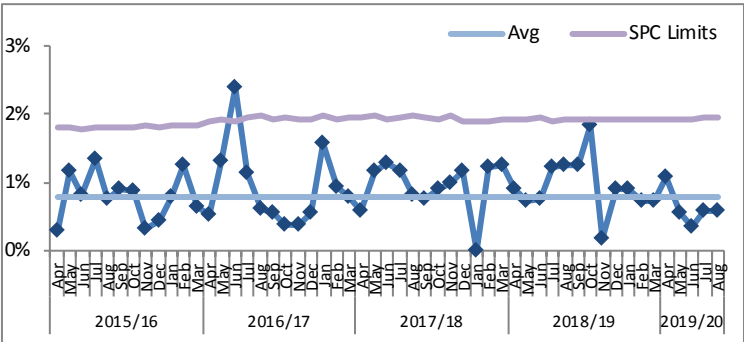
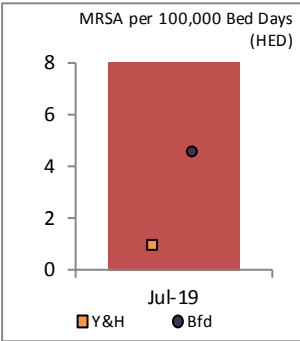
Benchmarks



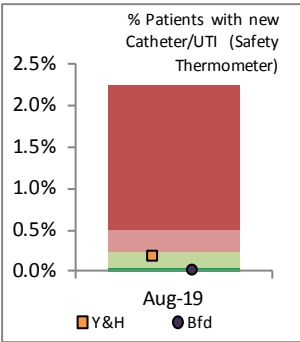
An increase in Trust attributed cases has been reported in June/July. These cases are related to The changes to the reporting algorithm for financial year 2019/20 are; Adding a prior healthcare exposure (i.e. previous admission within 4 weeks), reducing the number of days to apportion Trust attributed cases from three or more (post 72hr) to 2 or more (post 48hrs) days following admission. A PIR (post infection review) for each case has been undertaken and lessons learnt and action plans agreed with the relevant Clinical Business Unit (CBU).



Nil Episodes.



Catheters and Urinary Tract Infections (CAUTI) remains stable and in line with peers.



To provide outstanding care for patients

Patient Safety

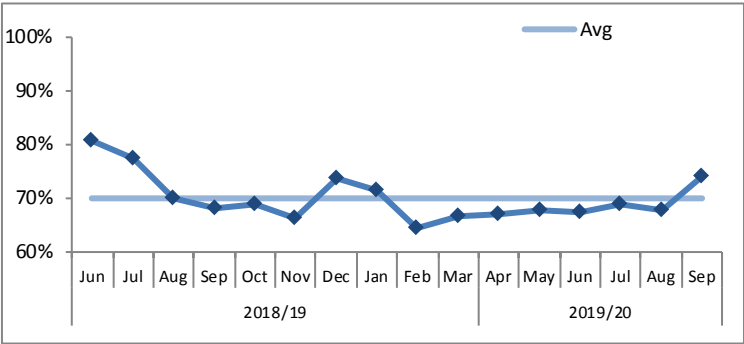
Metric / Status

Trend

Challenges and Successes

Benchmarks

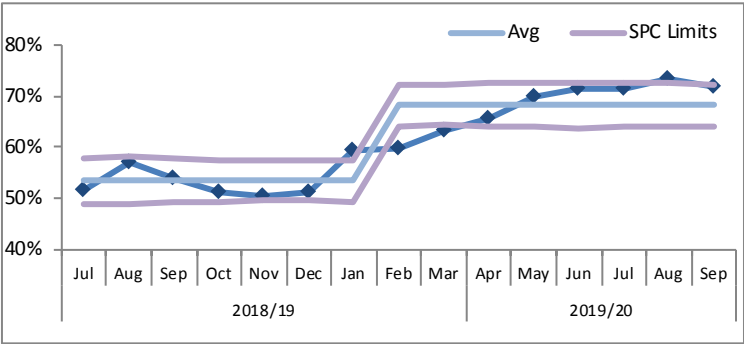
Sepsis patients receive antibiotics within an hour



Improvement in month in line with plans.

No benchmark comparator available

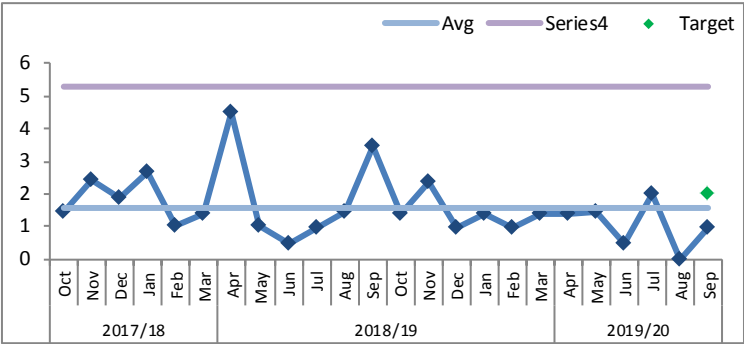
Sepsis Percentage of Patients Screened



Shows improvement journey.

No benchmark comparator available

Serious Incidents per 10,000 bed days

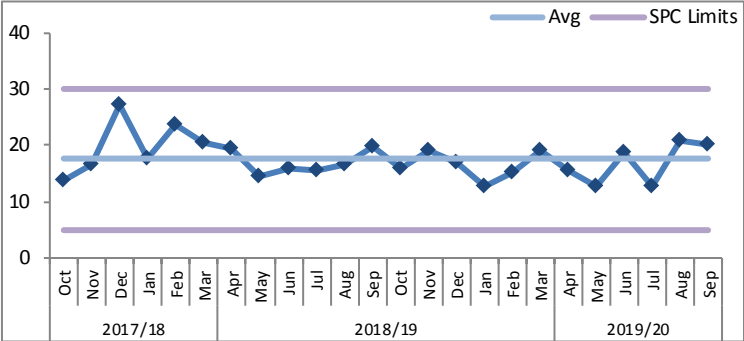
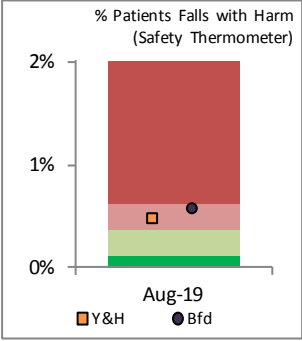
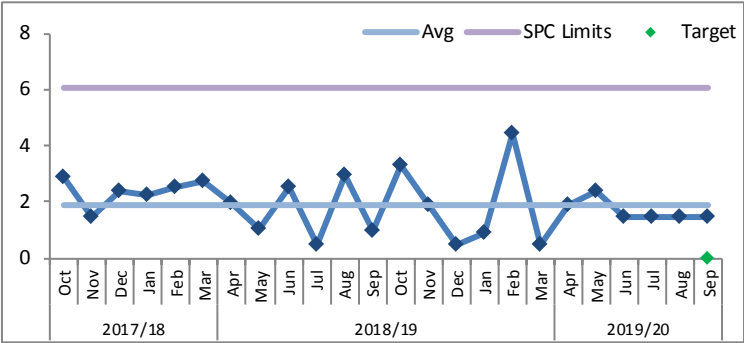
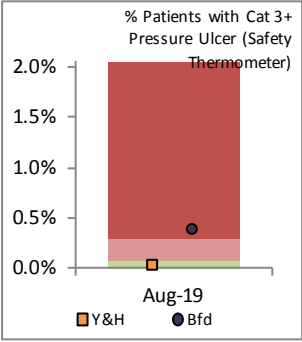


Incidents that meet the criteria for the declaration of a serious incident (SI) are reported on the Strategic Executive Information System (StEIS) and a root cause investigation is commissioned. They are reported to the Quality Committee. All recommendations made are subject to action planning to minimise risk of reoccurrence. There is a detailed process of assurance to assess the effectiveness of action planning. Fluctuations in the number of monthly Serious Incidents (SI's) are anticipated and the Quality Oversight System is in place to ensure identified themes or trends are acted upon.

No benchmark comparator available

To provide outstanding care for patients

Patient Safety

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Falls with Harm per 10,000 bed days</div>		<p>Remains stable. Detailed work commenced to implement falls Commissioning for Quality and Innovation (CQUIN).</p>	
<div>Pressure Ulcers Cat 3+ per 10,000 bed days</div>		<p>The trend remains static.</p>	

To provide outstanding care for patients

Patient Safety

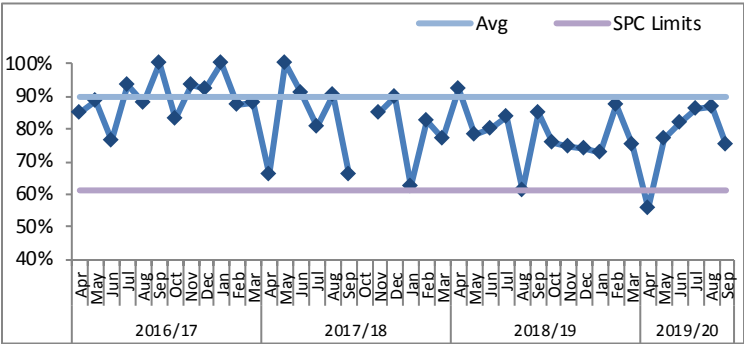
Metric / Status

Trend

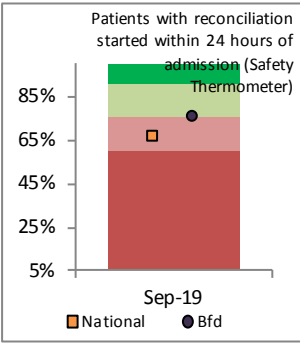
Challenges and Successes

Benchmarks

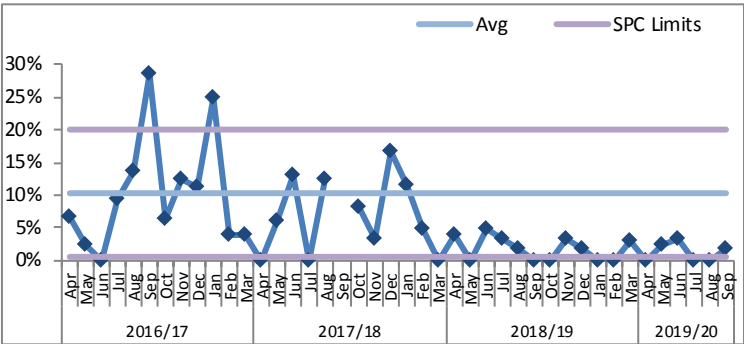
Medicine Reconciliation



The Trust performs well against this standard and benchmarks positively compared to peers.



Missed Doses

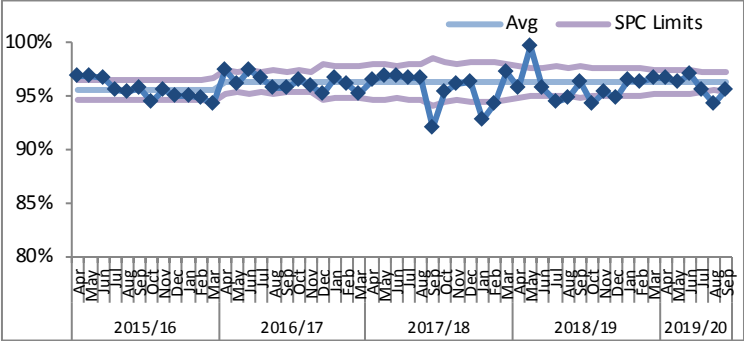
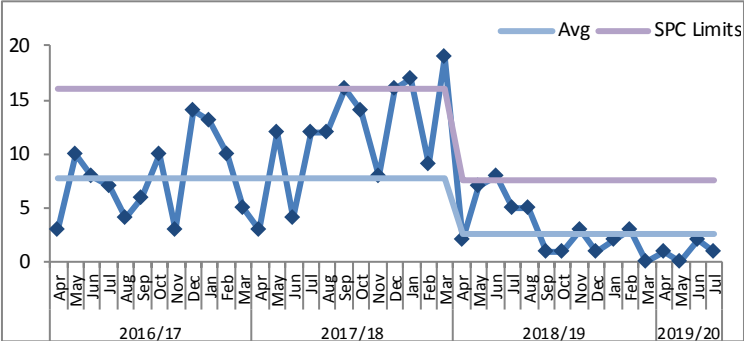
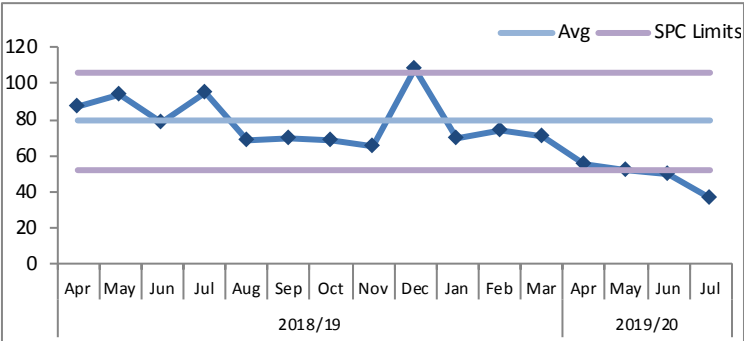


This new metric has shown significant improvement over the past 18 months. Benchmark data is not yet available but will be sourced for future reports.

No benchmark comparator available

To provide outstanding care for patients

Patient Experience

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Friends & Family Test</div>		<p>The Friends and Family Test (FFT) has recovered back to normal baseline after a drop in September 2017/18. Further detailed work to improve number of returns has started. New national guidance has been issued to take effect from 1st April 2020.</p>	<p>No benchmark comparator available</p>
<div>Night Time Transfers</div>		<p>Night time transfers remain low.</p>	<p>No benchmark comparator available</p>
<div>Night Time Discharges</div>		<p>The number of night time discharges continues to reduce.</p>	<p>No benchmark comparator available</p>

To provide outstanding care for patients

Patient Experience

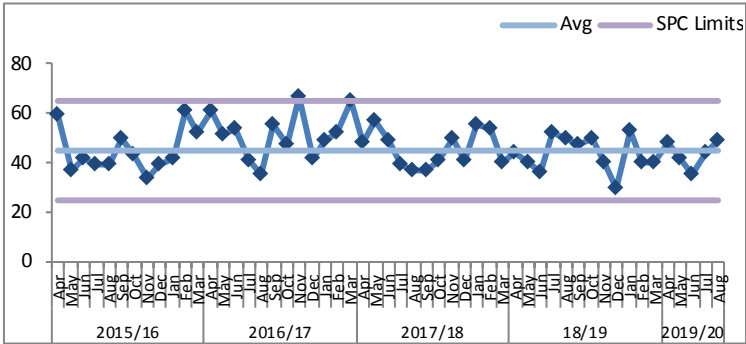
Metric / Status

Trend

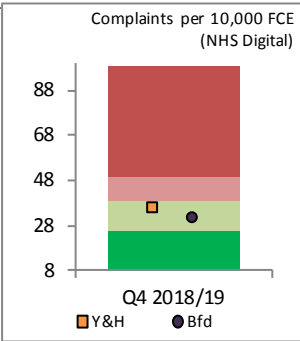
Challenges and Successes

Benchmarks

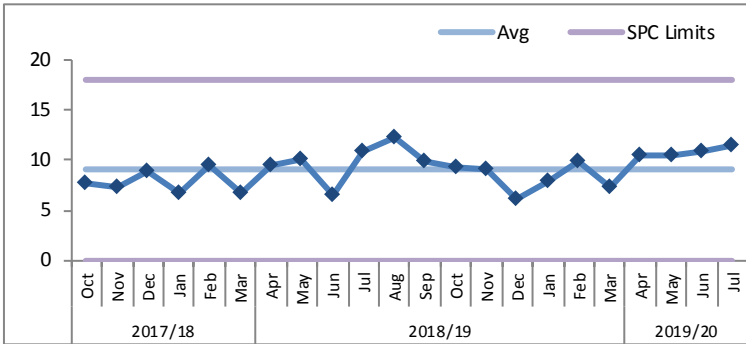
Complaints



Monitoring continues on a weekly basis of the number of complaints by Clinical Business Units (CBU's).



Complaints Closed per 10,000 bed days



The trajectories are now beyond the improvement period set and need to be revised as part of the 2019/20 metrics. Proposal due from Patient first committee following analysis of Q4 2018/19.

No benchmark comparator available

To deliver our key performance targets and financial plan

Finance

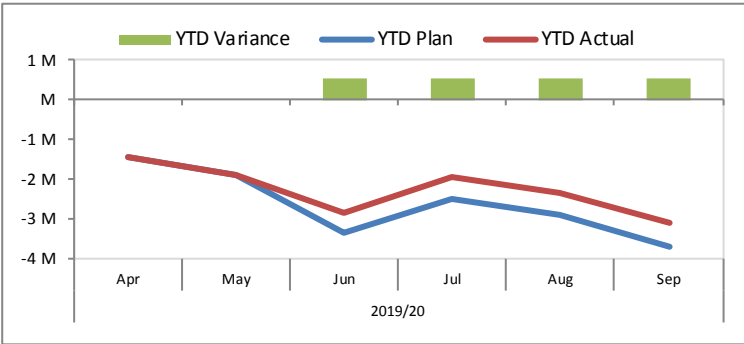
Metric / Status

Trend

Challenges and Successes

Benchmarks

Delivery of Income and Expenditure Plan



The year to date (YTD) deficit excluding Provider Sustainability Fund (PSF) is in line with the control total plan of £7.9m. The bottom line including PSF is £0.5m ahead of plan due to the bonus PSF received in Month 3. The forecast presented to NHS Improvement represents full delivery of the £12.5m deficit pre-PSF control total in 2019/20. Internal forecasts suggest a most likely pre-PSF deficit of £19.5m at year end. The Care Groups have been tasked with developing detailed recovery plans for executive review and implementation in early November, however the risk to control total delivery in 2019/20 is now significant.

No benchmark comparator available

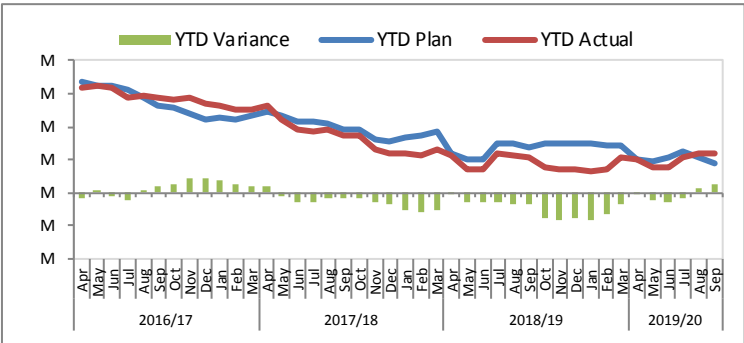
Use of Resources

NHSI Use of Resources	Plan	Actual	Last	RAG
Risk Rating (UoR)	YTD	YTD	Month	
As at 30/09/2019				
Capital service cover rating	4	4	4	Red
Liquidity rating	2	1	2	Green
I&E margin rating	4	4	4	Red
I&E margin: from financial plan	1	1	1	Green
Agency rating	1	1	1	Green
Combined UoR (after triggers)				

At Month 6, the Trust has an overall rating of 3 which is in line with plan. Although the scores for three of the five metrics are 1 and the Liquidity score is better than planned, the presence of two ratings of 4 means the Trust cannot achieve a rating better than 3.

No benchmark comparator available

Delivery of Cash Plan



Year to date cash is ahead of plan by £5.0m. The key cash flow movements include an decrease in receivables (£1.6m), reduced capital expenditure (£1.5m), increase in deferred income (£1.0m), and decrease in PDC paid (£0.4m). Forecast closing cash, assuming full delivery of the efficiency programme, is £18.4m which is £6.4m above plan. This is primarily due to the £7.1m PSF bonus and the decrease of deferred income of £0.9m. Should the Trust fail to deliver any further efficiencies in the current year closing cash is forecast to be £8.1m.

No benchmark comparator available

To deliver our key performance targets and financial plan

Finance



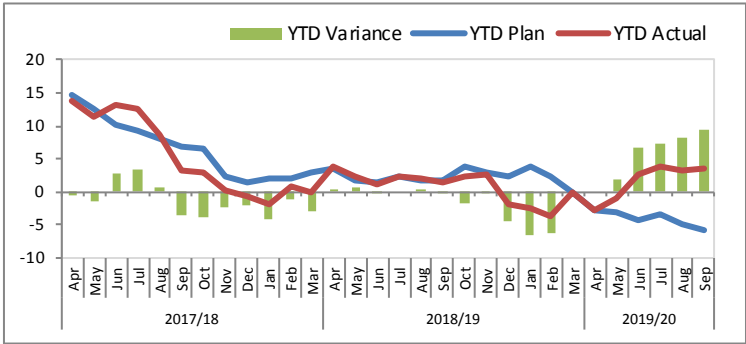
Metric / Status

Trend

Challenges and Successes

Benchmarks

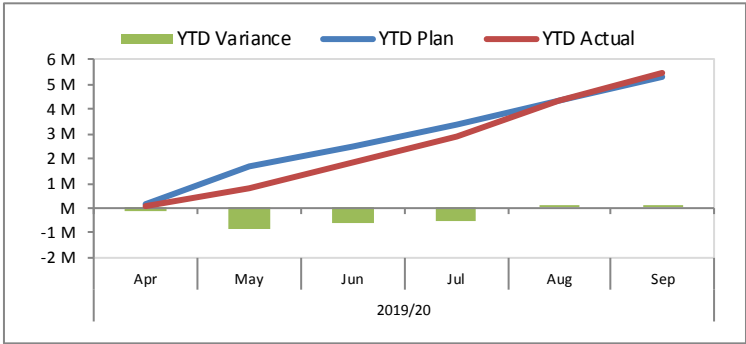
Liquidity rating



Year to date liquidity is 3.4 days which is 9.4 days above plan. This is a result of achieving the control total set by NHS Improvement in 18/19 and receiving Provider Sustainability Fund (PSF) above the planned amount (£7.1m). Forecast closing liquidity is -1.0 day, 8.1 days above plan. This forecast assumes full delivery of the Trusts efficiency programme. Should the Trust fail to deliver further efficiencies liquidity is forecast to fall to a closing balance of negative 14.1 days.

No benchmark comparator available

Bradford Improvement Plan



The Trust has delivered £5.3m of efficiencies by Month 6 which is in line with plan. However, Clinical Business Unit (CBU) and corporate management teams have recorded only £3.4m of recurrent Cost Improvement Plan (CIP) savings to date. The balance of £2m has been delivered via non-recurrent savings. A total of £10.8m of projected efficiency plans have been forecast by budget holders. If this position remains unchanged, this would leave the Trust £5.4m short of its efficiency target for 2019/20, jeopardising delivery of the control total.

No benchmark comparator available

To deliver our key performance targets and financial plan

Performance



Bradford Teaching Hospitals NHS Foundation Trust

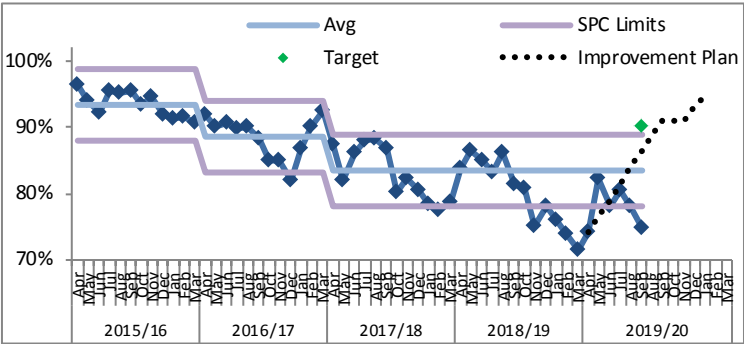
Metric / Status

Trend

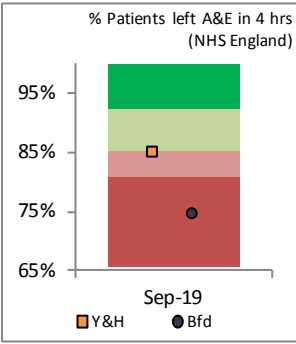
Challenges and Successes

Benchmarks

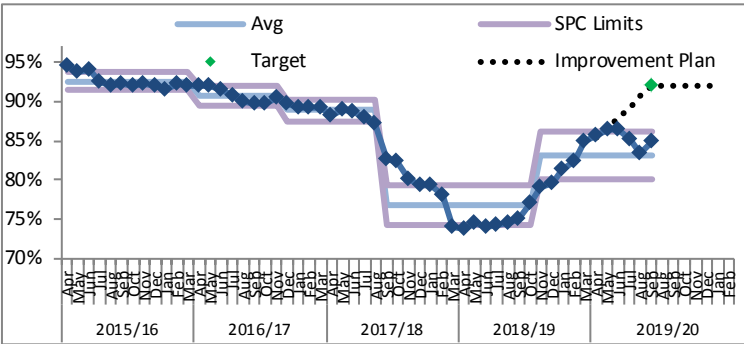
Emergency
Care
Standard



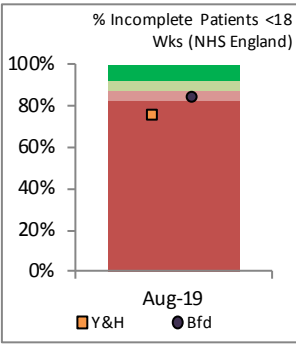
Emergency Care Standard (ECS) performance (type 1 and 3) was 74.7% in September 2019 with increased flow into Majors being the main issue. There is a continued focus on strengthening navigation, streaming and the major's co-ordinator roles to ensure better flow within the department. The implementation of Same Day Emergency Care continues and the number of admissions to ACU from the Emergency Department (ED) has increased.



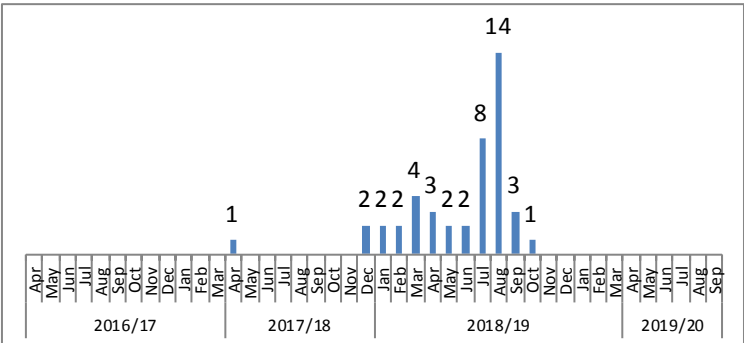
RTT 18 Week
Incomplete



Incomplete performance improved to 84.8% for September but remains below the improvement trajectory. This is mainly due to an increase in annual leave, the reduction in premium rate activity uptake and capacity gaps across several specialties. The planned care improvement programme is focused on increasing elective productivity and improved waiting list management.



RTT 52
Week Wait



The Trust reported 0 incomplete 52 week waits in September 2019, which is the 11th consecutive month with no breaches. Daily review of all management plans for patients waiting over 35 weeks continues, with weekly escalation through the Planned Care Access Group and updates to the Chief Operating Officer (COO).

No benchmark comparator available

To deliver our key performance targets and financial plan

Performance

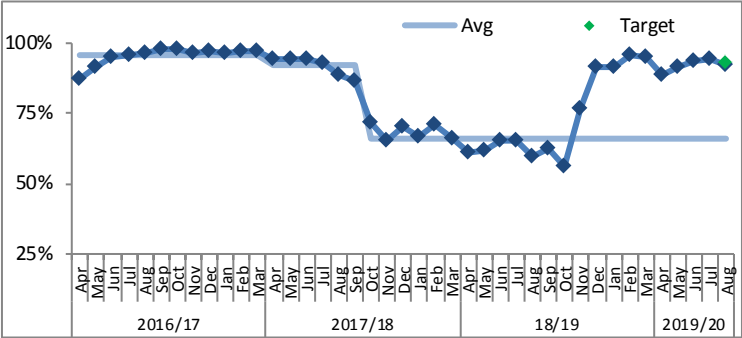
Metric / Status

Trend

Challenges and Successes

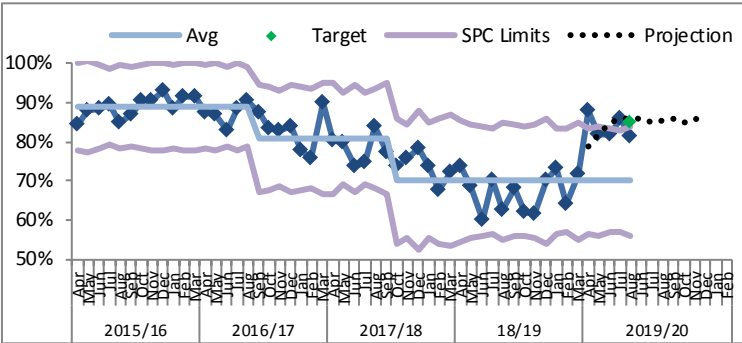
Benchmarks

Cancer
2 Week
GP



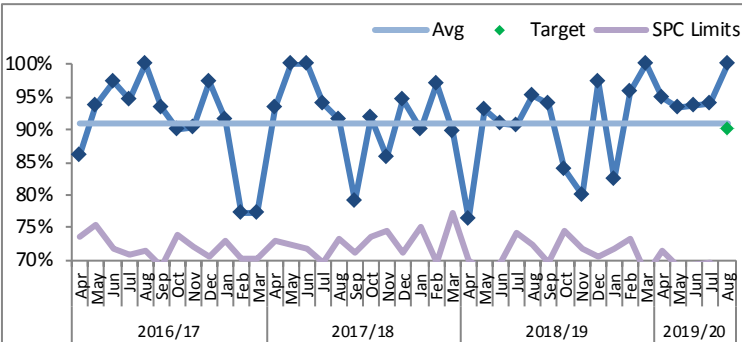
August 2019 performance against the 2 week-wait cancer standard dropped to 92.15% following reduced Endoscopy capacity due to sickness being an issue for Lower and Upper Gastrointestinal (GI). Performance improved across all other tumour groups and is forecast to meet the standard at 94.16% in September 2019.

Cancer
62 Day
Urgent GP

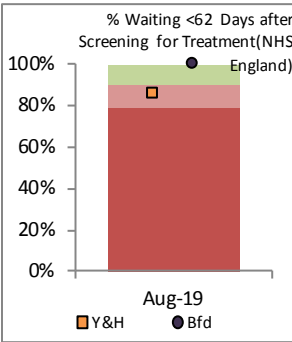
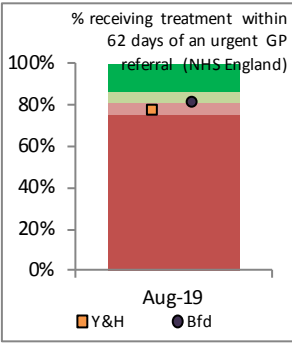
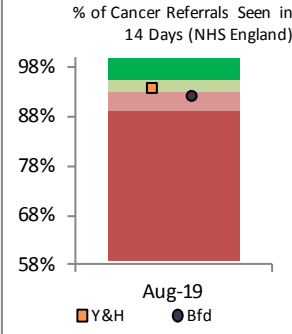


Cancer 62 Day First Treatment performance for July 2019 was 81.31% against a target of 85%. Delays in the Lower Gastrointestinal (GI) diagnostic phase and long waits for clinical oncology for Urology remain the main challenges to future performance. 2 week wait and 62 day treatment capacity matches demand suggesting that once diagnostic performance is improved overall cancer standards can be sustained.

Cancer
62 Day
Screening



This standard continues to be met.



To deliver our key performance targets and financial plan

Performance



Bradford Teaching Hospitals
NHS Foundation Trust

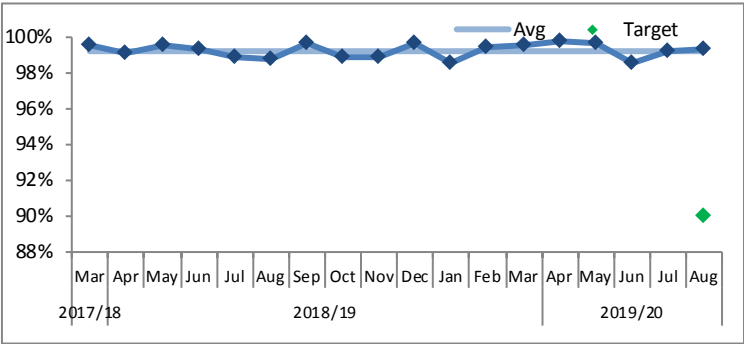
Metric / Status

Trend

Challenges and Successes

Benchmarks

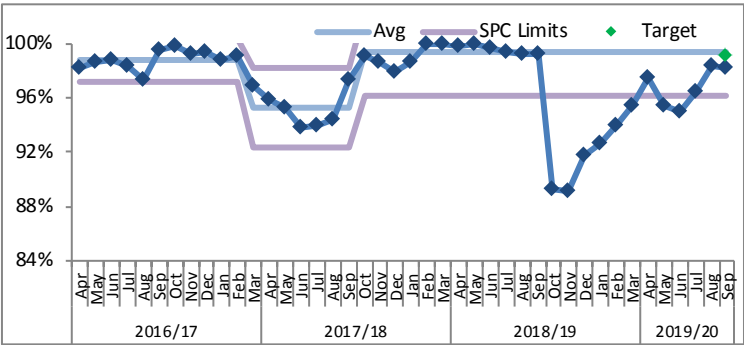
Full Blood Count to Wards < 2 Hours



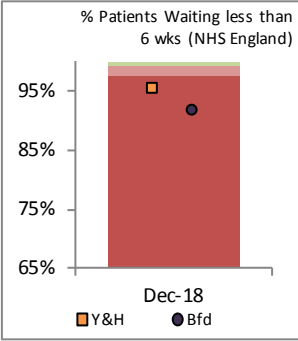
Performance continues to achieve compliance with target.

No benchmark comparator available

Diagnostic Waits



Performance for September 2019 improved to 98.18% for DM01 (monthly Diagnostics Waiting Times and Activity data) reportable tests. Endoscopy performance improved slightly following additional Locum capacity being secured in the short term. Only 6 waits for Cystoscopy were over 6 weeks at month end which is a significant improvement following recovery activity.



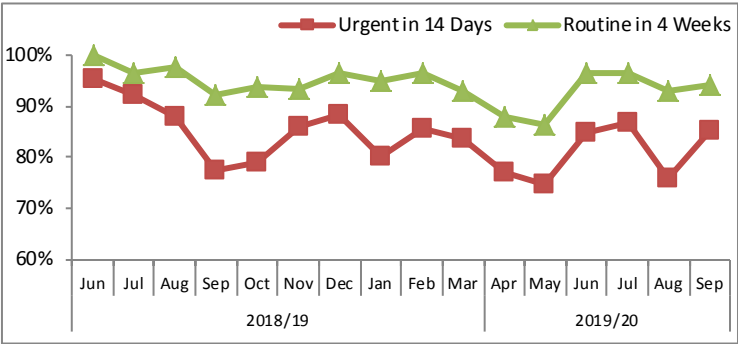
To deliver our key performance targets and financial plan

Performance



Metric / Status	Trend	Challenges and Successes	Benchmarks
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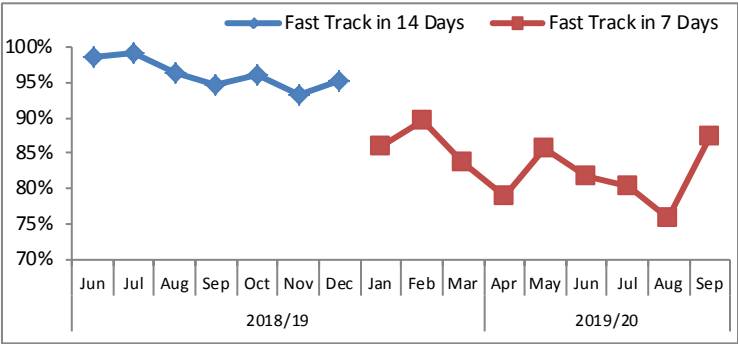
Radiology
Turnaround
Time
Outpatients



Turnaround times for routine and urgent reports improved following the use of a Locum to reduce the reporting waiting list. Uptake of additional sessions remains a challenge but to offset some of the reduction the Trust continues to send a number of general Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) scans to an outsourcing company for reporting.

No benchmark comparator available

Radiology
Turnaround
Time
Frast Track



Performance for September 2019 improved following the use of a Locum to reduce the reporting waiting list. One of three radiologist vacancies has been filled and the member of staff started in September 2019 which will help sustain this improvement.

No benchmark comparator available

To deliver our key performance targets and financial plan

Performance



Bradford Teaching Hospitals
NHS Foundation Trust

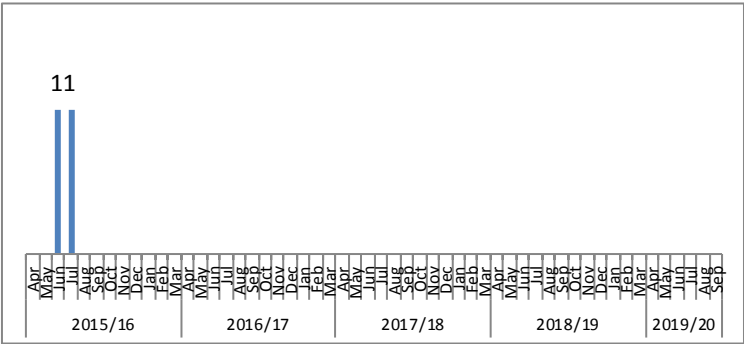
Metric / Status

Trend

Challenges and Successes

Benchmarks

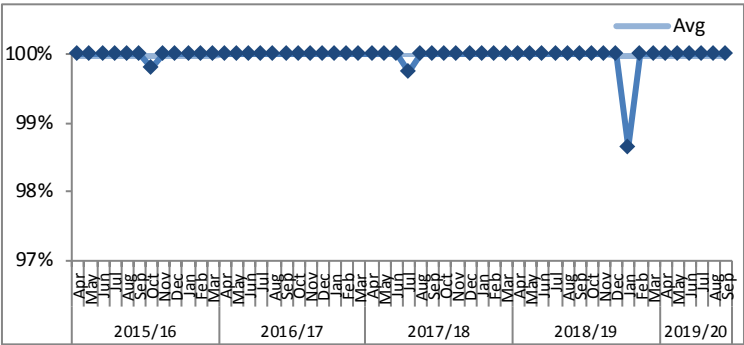
Mixed Sex Breaches



There have been no Mixed Sex Breaches.

No benchmark comparator available

Mission Critical Systems Uptime



The Trust is maintaining a high level of uptime.

No benchmark comparator available

To deliver our key performance targets and financial plan

Productivity



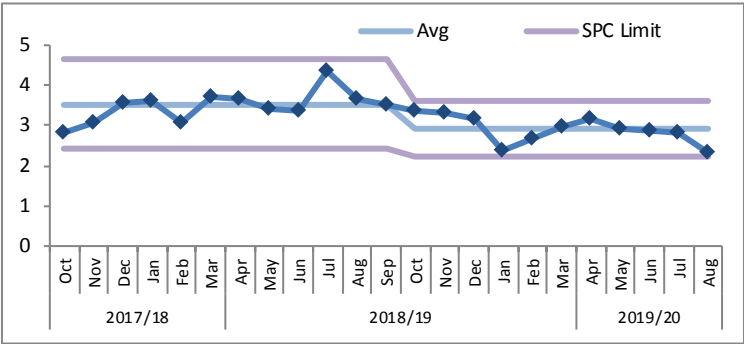
Metric / Status

Trend

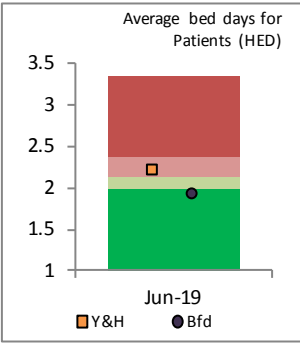
Challenges and Successes

Benchmarks

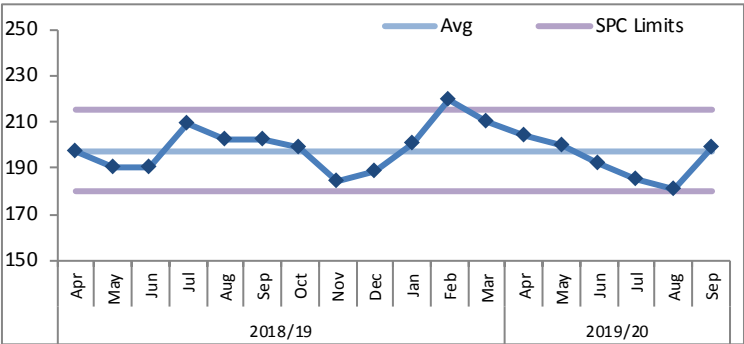
Length of Stay



Length of stay reduced slightly in September although remained within control limits. The Trust continues to benchmark positively against regional and national averages for both elective and non-elective length of stay.



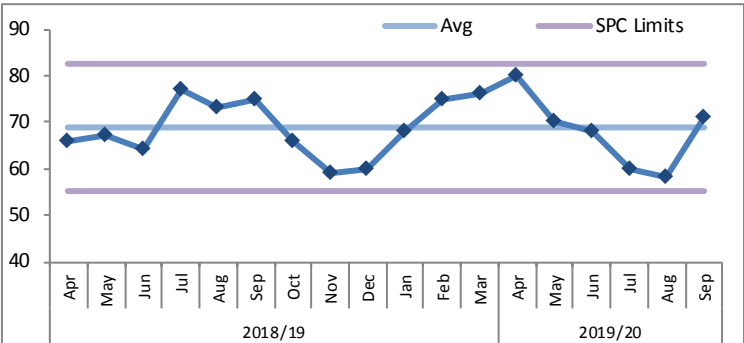
Stranded Patients Length of Stay >= 7 days



Weekly multi-disciplinary reviews continue to support positive performance against this measure.

No benchmark comparator available

Super Stranded Patients Length of Stay >= 21 days



The daily average increased in September 2019 but remains ahead of the national improvement trajectory. Weekly oversight remains in place and identified issues with transferring patients to other Trusts who were experiencing capacity issues and an increase in delayed discharges for patients awaiting care packages. Senior leadership and the MAIDT team has been providing continuous support in reducing the impact of these issues and performance is forecast to improve in October 2019.

No benchmark comparator available

To deliver our key performance targets and financial plan

Productivity

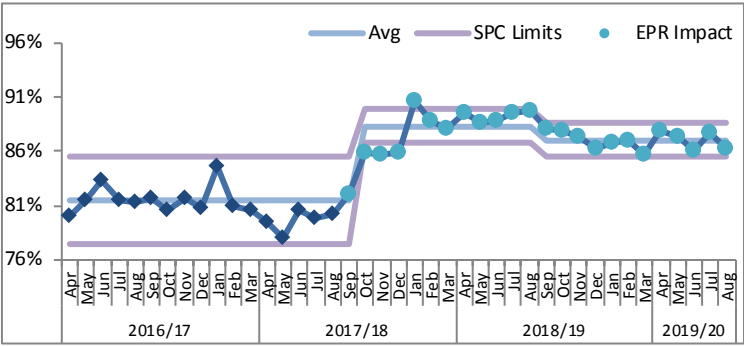
Metric / Status

Trend

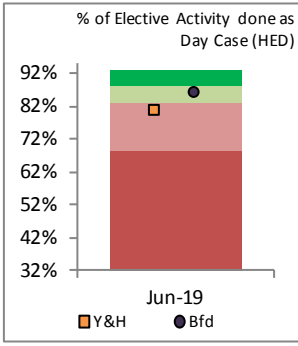
Challenges and Successes

Benchmarks

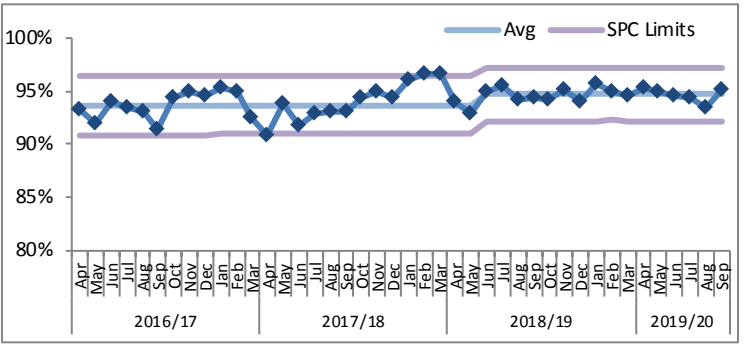
Elective Day Case Rate



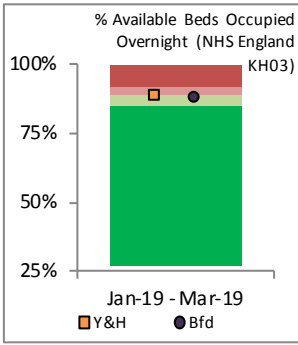
Day case rates continue to be above the national and regional average.



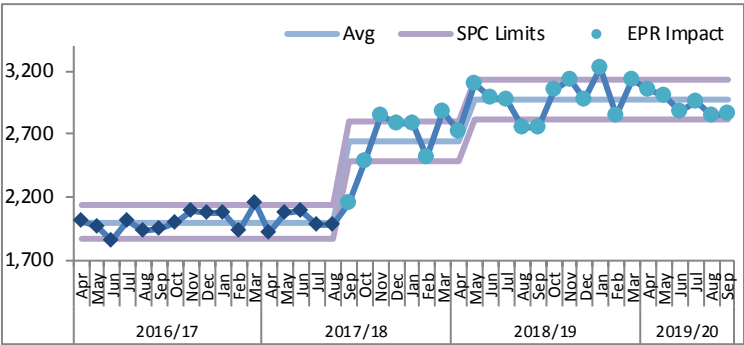
Bed Occupancy



Bed occupancy increased slightly during September 2019. The Trust is involved in the national SAFER collaborative and there are a number of actions within the Emergency Care Improvement Plan which will help reduce admissions, improve timely discharge and support reduced bed occupancy.



Discharges before 1pm



Discharge targets by ward have been implemented with a daily review in place. The total number of discharges before 1pm remained above the lower control limit during September 2019.

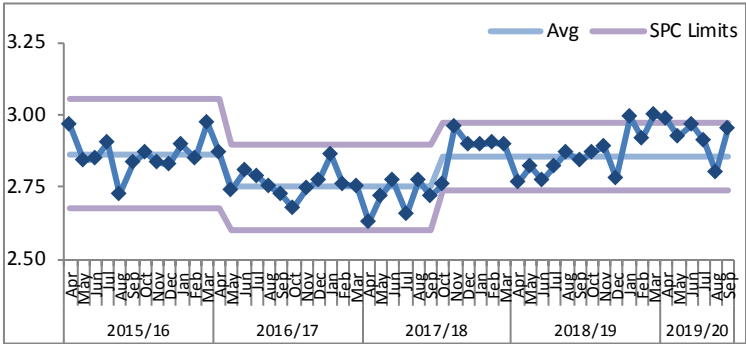
No benchmark comparator available

To deliver our key performance targets and financial plan

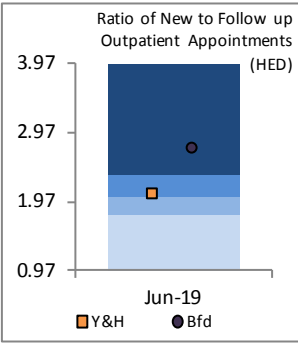
Productivity

Metric / StatusTrendChallenges and SuccessesBenchmarks

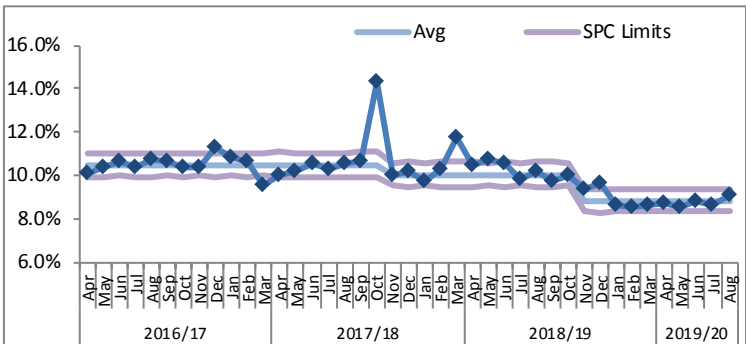
New to Follow Up Ratio



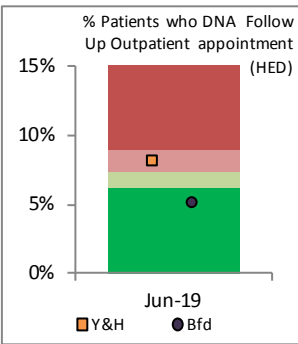
Increased outpatient activity in the latter part of September 2019 resulted in a new to follow up ratio in line other months when August 2019 is ignored. Improvement initiatives are underway to reduce follow up attendances.



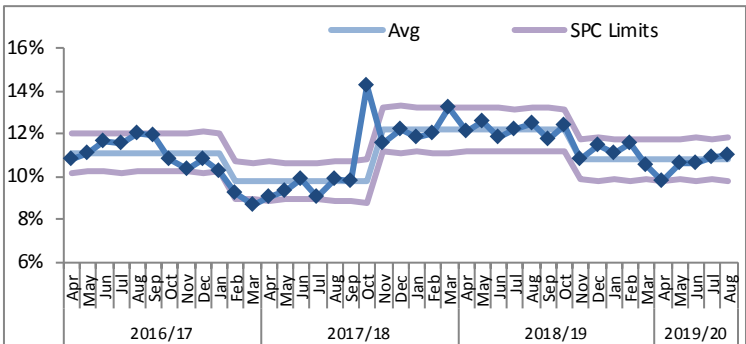
Did not Attend Follow Up



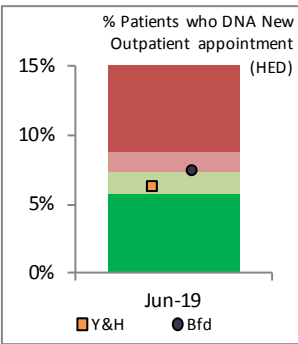
Did not attend (DNA) rates have improved during 2018/19 following an increase post EPR. The trend has been more consistent in recent months.



Did not Attend New



Did not attend (DNA) rates have improved during 2018/19 following an increase post EPR. Reducing unnecessary referrals and follow up appointments will support a reduction in DNA's.



To deliver our key performance targets and financial plan

Productivity



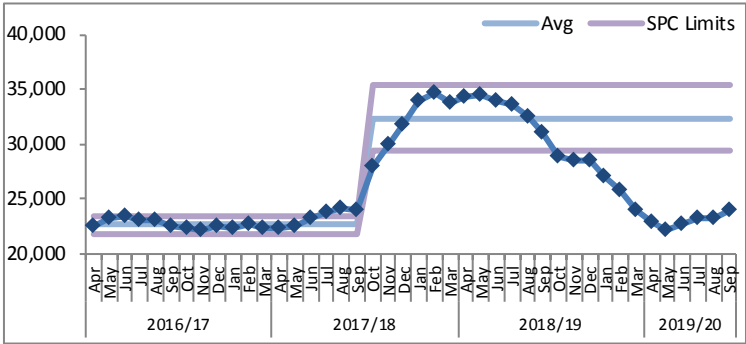
Bradford Teaching Hospitals
NHS Foundation Trust

Metric / Status

Trend

Challenges and Successes

Benchmarks



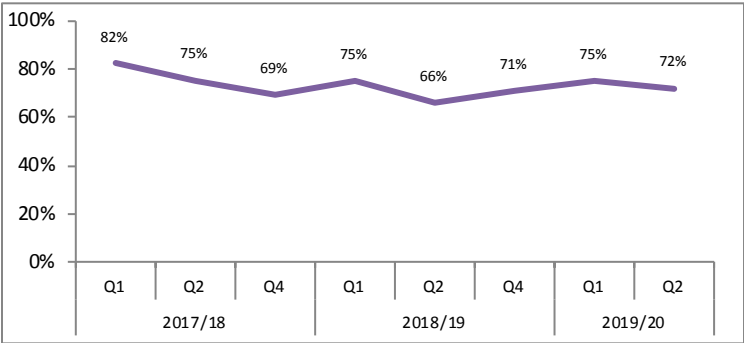
The total elective waiting list increased by 760 patients during September 2019. This correlates with reduced outpatient activity, which has since improved.

No benchmark comparator available

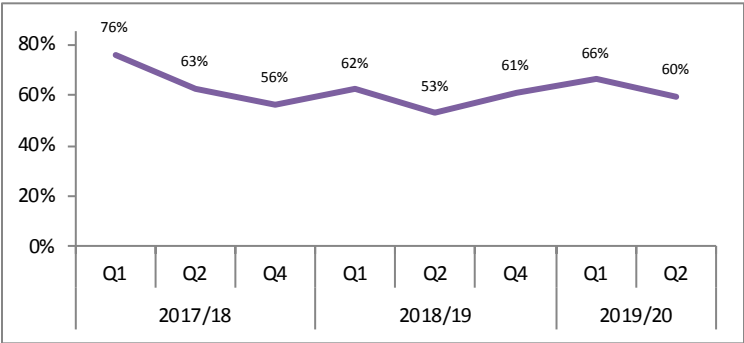
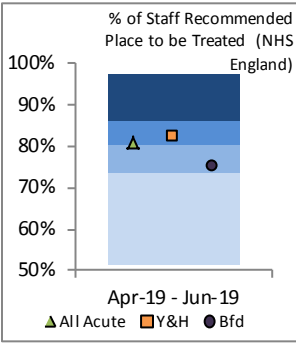
To be in the top 20% of employers

Engagement

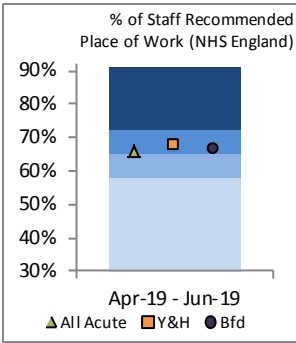
Metric / Status	Trend	Challenges and Successes	Benchmarks
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There is no new information from that reported last month. Staff Friends and Family Test (SFFT) did not run in Q3 2019/20 due to the NHS Staff Survey. Q2 benchmarking results are not available until the 21st November 2019.



Staff Friends and Family Test (SFFT) did not run in Q3 2019/20 due to the NHS Staff Survey. Q2 benchmarking results are not available until the 21st November 2019.



To be in the top 20% of employers

Engagement

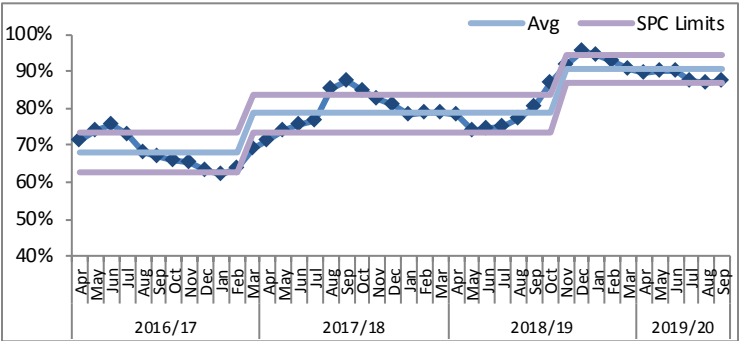
Metric / Status

Trend

Challenges and Successes

Benchmarks

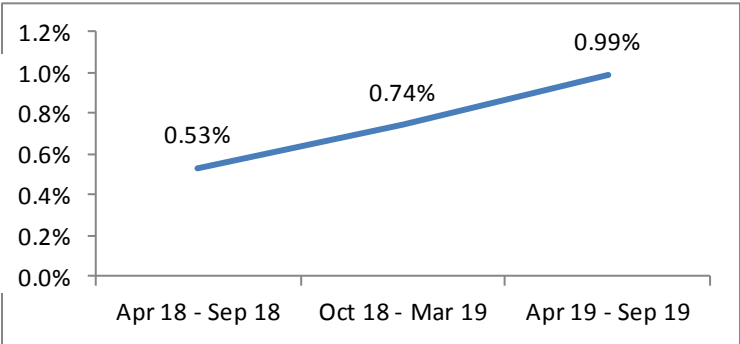
Appraisal Rate
Non-Medical



The number of appraisals has increased slightly to 87.64% in September 2019. An increased number of departments have completion rates over 90%. Completion rate for Care Groups are 89.88% for Unplanned, 88.97% for Planned. Care Group Directors continue to focus on appraisals as a priority during with plans to meet 95% by the end of December 2019. Human Resources (HR) are working with departments and Clinical Business Units (CBU's) to provide extra support. Managers are being reminded to record completed appraisals promptly so records held on ESR are accurate and up to date.

No benchmark comparator available

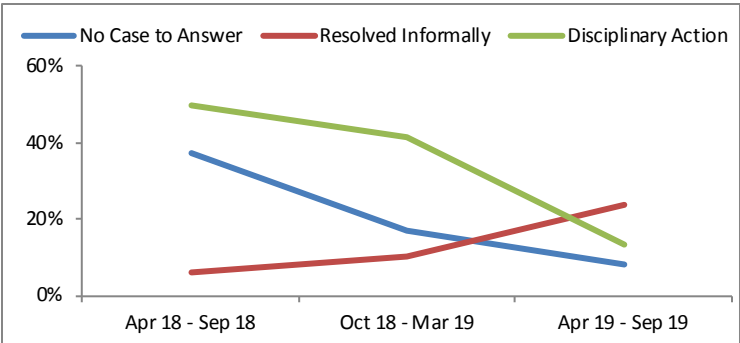
Contacts with
Advocacy
service



The number of contacts with the Staff Advocacy Service has risen steadily since its introduction in August 2018. In the last six months 37% of all contacts with the service were resolved informally. Next update April 2020 (for period ending 31 March 2020).

No benchmark comparator available

Harassment &
Bullying
Outcomes



The graph shows that the percentage of Bullying and Harassment cases resulting in Disciplinary Action has continued to decrease in the last 6 months to 13% of all investigations commenced in the 6 month period from April 2019 to September 2019. The largest proportion of cases (24%) were resolved informally. The number of investigations resulting in no case to answer has also steadily declined. Next update April 2020 (for period ending 31 March 2020).

No benchmark comparator available

To be in the top 20% of employers

Training & Development



Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>New Starter Training</div>		<p>The slight variance in performance is being investigated and rectified. There is a comprehensive escalation process in place to track delivery of performance at an individual level.</p>	<p>No benchmark comparator available</p>
<div>Refresher Training</div>		<p>The Trust has consistently exceeded its target refresher training standard since April 2018, averaging over 95%. Work now focussed on performance at service line level.</p>	<p>No benchmark comparator available</p>

To be in the top 20% of employers

Staffing

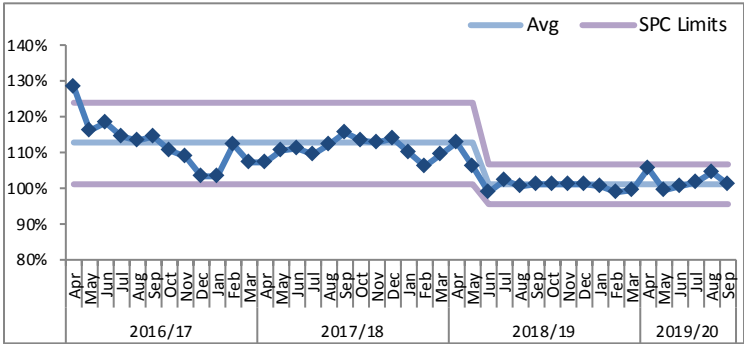
Metric / Status

Trend

Challenges and Successes

Benchmarks

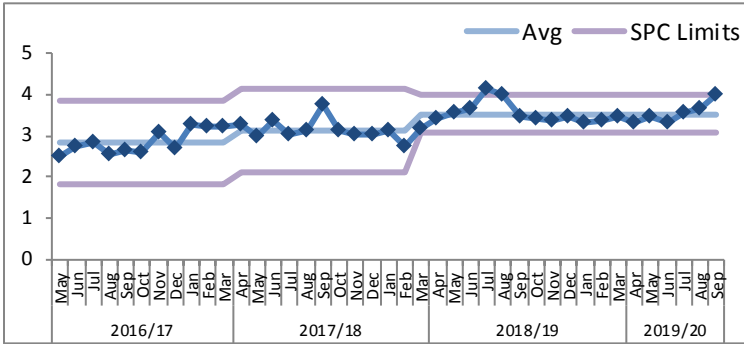
Care Staff Shifts Filled



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

No benchmark comparator available

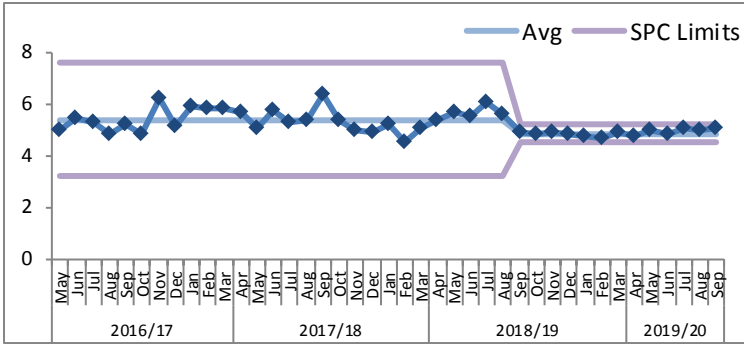
Care Staff Care Hours



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

No benchmark comparator available

Nursing Care Hours



Rate remains stable and benchmarks appropriately with model hospital data.

No benchmark comparator available

To be in the top 20% of employers

Staffing



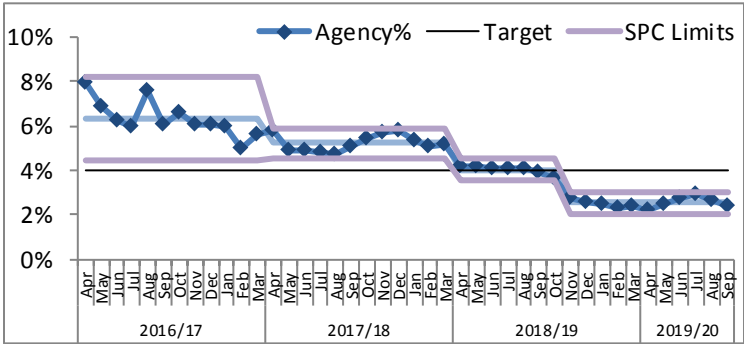
Metric / Status

Trend

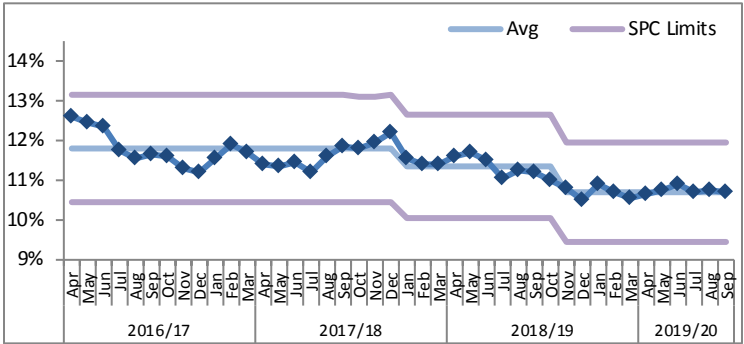
Challenges and Successes

Benchmarks

Use of Agency Staff



Staff Turnover



There has been a continued slight reduction in agency usage since the last reporting period. Bank and agency registered nursing has remained static with no agency Healthcare Assistants (HCA's) used this month. Administrative and Clerical agency use has reduced to just 0.51 FTE. Agency use across the Medical and Dental staff group has remained static in the reporting period; as has the use of Allied Health Professionals (AHP's).

Exploring appropriate benchmark data

Turnover has decreased slightly at Trust level in September 2019 to 10.68% from 10.73% in August 2019. Increases were seen in Corporate services, with all other areas seeing reductions. Turnover remains low compared to historical levels in the Trust.

Exploring appropriate benchmark data

To be in the top 20% of employers

Equality & Diversity



Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>BAME Senior Leaders</div>		<p>We have increased our number of Black, Asian and Minority Ethnic (BAME) staff at Bands 8 and 9 over the past six months. Based on the current trajectory, we would miss our employment target to have a senior workforce reflective of the local population by 2025 by around 8%. However, this is an improvement from April 2019 and this margin has reduced by 2% over the last 12 months (trajectory in September 2018 was set at 10% below target). Senior BAME staff continue to be involved in recruitment for Band 8 and 9 posts, with the aim of accelerating progress on this target. Next update April 2020 (for period ending 31 March 2020).</p>	<p>Exploring appropriate benchmark data</p>
<div>BAME Workforce</div>		<p>The proportion of BAME staff in the workforce has remained static at 30.2% over the past 12 months. However, this trajectory continues to take us ahead of our target of having a workforce reflective of the local population (35%) by 2025. Next update April 2019 (for period ending 31 March 2019).</p>	<p>Exploring appropriate benchmark data</p>

To be in the top 20% of employers

Health & Wellbeing

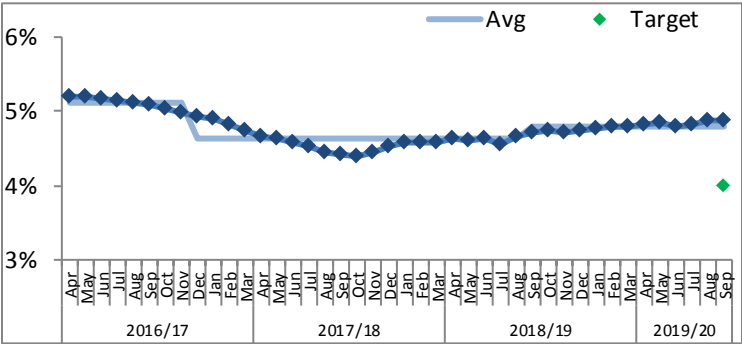


Metric / Status

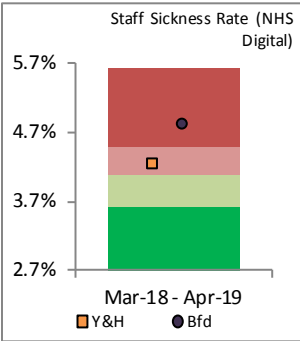
Trend

Challenges and Successes

Benchmarks







The rolling 12 month sickness absence rate at the end of September 2019 was 4.87%. Slight decreases were seen in Planned and Unplanned Care with all other areas showing slight increases. The Trust target has been set at 4.5% which we will be monitoring Care Groups and corporate departments against.



To collaborate effectively with local and regional partners

Partnership

Metric / Status	Trend	Challenges and Successes	Benchmarks
 Stakeholder Engagement	<p>Potential key performance indicators (KPIs) have been discussed at the Partnerships Committee but there was no support for a numerical representation, instead the Committee receives periodic qualitative updates. The Trusts’ systematic approach to stakeholder management identifies key external partners. For each, an executive sponsor and an account manager has been identified, with responsibility for maintaining/improving the health of the relationship. Account managers are in the process of being contacted to provide updates on the relationships they manage to gain an overall picture of the stakeholder engagement for BTHFT.</p>		No benchmark comparator available
 Vertical Integration	<p>Partnerships Committee has advised that the red, amber, green (RAG) rating should be based on a subjective assessment, in the absence of a meaningful, readily understandable hard metric. The Trust is working with its fellow providers in Bradford to work together to develop models of care which best meet the needs of service users and patients. The Trust signed a ‘Strategic Partnering Agreement’, drafted by the partners in Bradford District and Craven (BDC) at the end of March, and this has been approved by all partners. This sets out how decisions and collaboration will happen at ‘place’ in the future. A review of the health and care based programmes in BDC is complete. The Trust is working through how to engage with Primary Care Networks and the opportunities and risks that might be associated with them.</p>		No benchmark comparator available
 Horizontal Integration	<p>Partnerships Committee has advised that the red, amber, green (RAG) rating should be based on a subjective assessment, in the absence of a meaningful, readily understandable hard metric. The Trust is working with its partner organisations in formal governance arrangements and programmes in the West Yorkshire Association of Acute Trusts (WYAAT) the West Yorkshire and Harrogate Health and Care Partnership (WYHCP) Integrated Care System, with Trust executives involved in multiple fora examining both strategic and operational collaboration issues. Recently, the Trust has created a number of service profiles, in response to the service profiles for 26 areas that WYAAT has created. These will be used to help determine what a clinical strategy for secondary care in WY&H might look like.</p>		No benchmark comparator available
 Airedale Collaboration	<p>The Airedale Collaboration programme between BTHFT and Airedale NHS Foundation Trust (ANHSFT), formally started with a clinical summit on 8 April. Workshops have been held in some specialties, and the programme governance, incorporating a Strategic Collaboration Board and Steering Group have been established to monitor and oversee the progress of the work. Clinical leads for a number of specialties, and for the programme as a whole, have been recruited to. The prioritisation for the programme has been completed with specialties divided into those that will be covered in the first year and those that will be covered in the second year of the programme. The programme is in the process of defining its overall strategy, which will be validated with input from execs and wider staff groups across both trusts. This will be discussed by clinicians, and managers from both trusts at a second clinical summit in October.</p>		No benchmark comparator available

To be a continually learning organisation

Learning Hub, Research

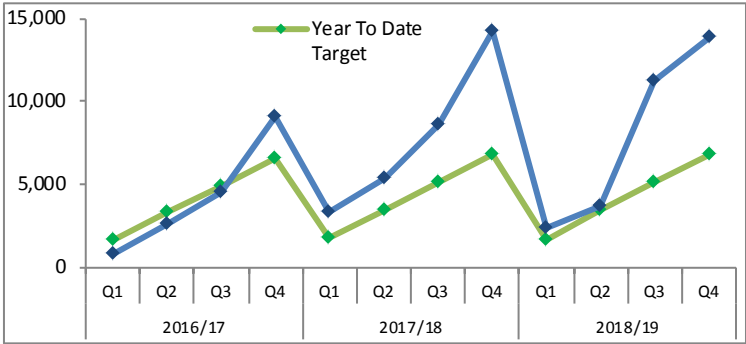
Metric / Status	Trend	Challenges and Successes	Benchmarks
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Learning Hub

The Learning Hub continues to work to generate and assimilate learning from precursor events across the Trust, and now routinely incorporating learning from external events, for instance through the sharing of Serious Incident learning from other organisations, Healthcare Safety Investigation Branch (HSIB) and the National Reporting and Learning System (NRLS). The first monthly learning award, which has been developed with the support of the family of a child whose death in our hospital was the catalyst for significant system wide learning, will be awarded at the end of Q1 2019/20.

No benchmark comparator available

Research Patients Recruited

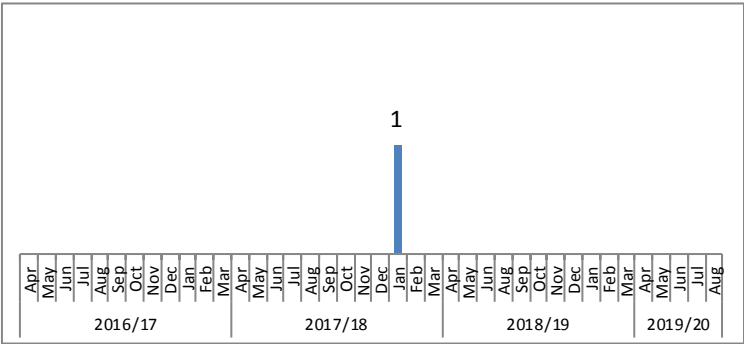
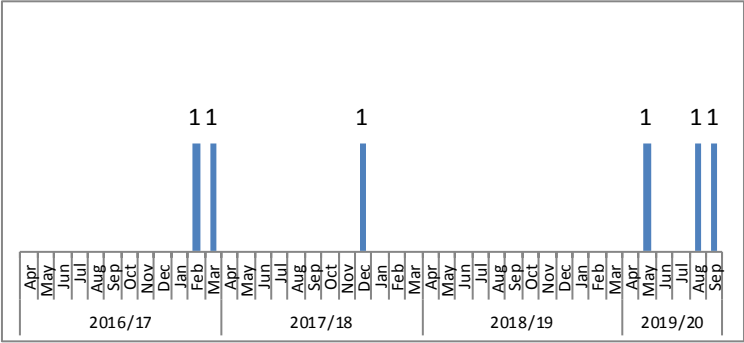
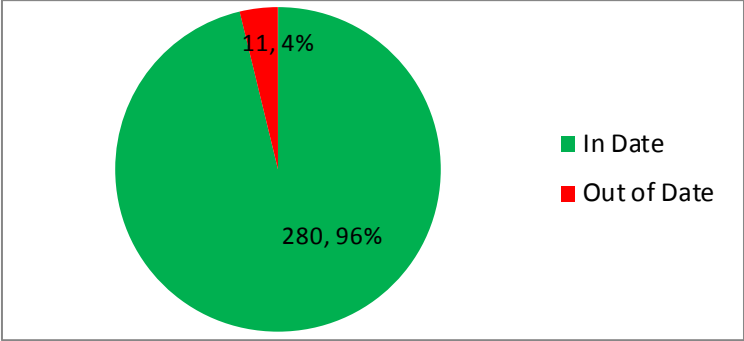


Number of participants recruited to National Institute of Health Research Portfolio Studies since 2016/17, including commercial and non-commercial studies, remains strong and above recruitment target.

No benchmark comparator available

To provide outstanding care for patients

Governance

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Duty of Candour</div>		There were no Duty of Candour breaches to date in 2019/20.	No benchmark comparator available
<div>Information Governance Breaches</div>		There is currently one open IG breach with the Information Commissioner’s Office.	No benchmark comparator available
<div>Out of date Policies</div>		A focussed programme of work continues in order to improve the Trust position in relation to Trust-wide policies and their management. There is significant confidence about the approach to managing locally developed guidance within departments.	No benchmark comparator available

To provide outstanding care for patients

Governance



Metric / Status	Trend	Challenges and Successes	Benchmarks
<div><div>Risks not Mitigated</div></div>	<div><div><div><div>11, 15%</div><div>60, 85%</div></div><div><div>■ Current rating =>12 where current rating is higher than residual rating</div><div>■ Current rating =>12 where current rating is not higher than residual rating</div></div></div></div>	<p>A recent Internal Audit report in relation to the implementation of the risk management strategy resulted in a significant assurance rating. As a result the metrics used to monitor the quality of governance in the Trust are being reviewed.</p>	<p>No benchmark comparator available</p>

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
To provide outstanding care for patients				
Clinical Effectiveness				
Crude Mortality	Crude Mortality rates, i.e., per admissions.	Chief Medical Officer	RAG criteria subjective	3.9
HSMR	The mortality indicator is evaluated from a standardised mortality ratio (SMR). The formula for the ratio is observed deaths divided by expected deaths, multiplied by 100. This is calculated for each provider within the data.	Chief Medical Officer	RAG criteria subjective	4.7
SHMI	The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	Chief Medical Officer	RAG criteria subjective	4.7
Deaths Screened	Percentage of Deaths Screened	Chief Medical Officer	Red Two consecutive points outside control limits, Amber Outside control limits, Green Within control limits	To be confirmed
Learning from Deaths	Proportion of reviews undertaken finding good or excellent care provided	Chief Medical Officer	Red Two consecutive points outside control limits, Amber Outside control limits, Green Within control limits	To be confirmed
Readmissions	The number of readmissions within 30 days of discharge from hospital.	Chief Operating Officer	Red >= 7.8%, Amber >=6.7% & < 7.8%, Green <6.7%	2.4
Patient Safety				
Never Events	The number of serious incidents that occur despite there being defined processes and procedures to prevent them.	Chief Medical Officer	Red > 0, Green = 0	4.0
Audit of WHO checklist	Audit of the World Health Organisation surgical checklist monitoring the number that were complete compared to the number of checklists.	Chief Medical Officer	Red < 90%, Amber >=90% & < 95%, Green >=95%	2.9
Clostridium Difficile (C. Diff)	The number of cases either attributable or pending review.	Chief Nurse	Red >= 3, Amber = 2, Green <=1	3.9
MRSA	Counts of patients with Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia.	Chief Nurse	Per month: Red >= 1, Green 0	3.9
CAUTI	Urinary tract infections in patients with a catheter. The benchmarking data comes from the Safety Thermometer prevalence information.	Chief Nurse	Red > 1.5%, Amber 1%-1.5%, Green < 1%	4.1

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
Patient Safety (cont.)				
Sepsis Patients receive antibiotics within an hour	Percentage of patients who were found to have sepsis during the screening process and received IV antibiotics within 1 hour.	Chief Nurse	Trending – TBC	To be confirmed
Sepsis Patients Screened	Percentage of patients screened for Sepsis	Chief Medical Officer	Red < 50%, Amber 50%-90%, Green >= 90%	5.0
Serious Incidents	Unexpected or avoidable death, serious harm, never events, service delivery prevention compared to all incidents reported.	Director of Strategy and Integration	Red > 5, Amber 3-5, Green <=2	4.0
Falls with Harm	Patient falls resulting from harm per 10,000 bed days. The benchmarking data comes from the Safety Thermometer prevalence information.	Chief Nurse	Red upper quartile, Amber mid quartiles, Green lower quartile	4.3
Pressure Ulcers Cat3+	Number of reported hospital acquired category 3 and 4 pressure ulcers per 10,000 bed days. The benchmarking data comes from the Safety Thermometer prevalence information.	Chief Nurse	Red >= 6, Amber 5, Green < 5	4.3
Medicine Reconciliation	Proportion of patients with reconciliation started within 24 hours of admission	Chief Medical Officer	Red < national average Amber - national average <= 0 - 5% Green >= national average > 5%	3.9
Missed Doses	Proportion of patients with an omission of a critical medicine	Chief Nurse	Red - above national average Amber – 0 - <1% below the average Green - > 1%+ the national average	3.9
Patient Experience				
Friends and Family Test	The percentage of patients who strongly recommend the Trust.	Chief Nurse	RAG criteria subjective	2.6
Night time transfers	The number of non-clinical bed moves out of hours.	Chief Nurse	Red > 0, Green = 0	2.4
Night time discharges	Discharges out of hospital between 12am and 6am. Excludes transfers to other hospital providers, self-discharges and assessment patients.	Chief Nurse	Red = Outside control limits, Green = Inside control limits	2.3
Complaints	Number of complaints.	Chief Nurse	Red >= 50, Amber 40-49, Green < 40	4.7
Complaints closed	Number of complaints closed per 10,000 bed days.	Chief Nurse	Red below average, Green above average	4.7

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
To deliver our key performance targets and financial plan				
Finance				
Delivery of Income & Expenditure Plan	Delivery of finances against plan.	Director of Finance	RAG criteria subjective.	3.3
Use of Resources – Financial	Use of resources is a calculation on the status of a number of financial measures – Capital Servicing Capacity, Liquidity, I & E Margin, and Agency Spend.	Director of Finance	RAG criteria subjective.	3.3
Delivery of Cash Plan	Delivery of cash against plan.	Director of Finance	<div>Red</div> Cash below £5m <div>Amber</div> Cash between £5m & £10m <div>Green</div> Cash over £10m	3.3
Liquidity Rating	A measure of how many days an organisation can continue to fund its operations based on the level of net current assets and available borrowing.	Director of Finance	RAG criteria subjective.	4.1
Bradford Improvement Plan	Bradford Improvement Plan progress against target.	Director of Finance	RAG criteria subjective.	3.3

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
Performance				
Emergency Care Standard	Percentage of patients seen in A&E within 4 hours.	Chief Operating Officer	Red < 90%, Green >= 90%	2.4
RTT 18 weeks Incomplete	Percentage of patients waiting within 18 weeks on an incomplete pathway.	Chief Operating Officer	Red < 92%, Green >= 92%	3.9
RTT 52 weeks waits	Number of patients waiting more than 52 weeks.	Chief Operating Officer	Red > 0, Green = 0	4.0
Cancer 2 week wait GP	Percentage of patients who have waited a maximum of 2 weeks to see a specialist for all patients referred with suspected cancer symptoms	Chief Operating Officer	Red < 93%, Green >= 93%	3.9
Cancer Urgent 62 day GP	Proportion of patients receiving treatment for cancer within 62 days of an urgent GP referral for suspected cancer.	Chief Operating Officer	Red < 85%, Green >= 85%	3.9
Cancer Urgent 62 day Screening	Proportion of patients receiving treatment for cancer within 62 days of an NHS Cancer Screening service.	Chief Operating Officer	Red < 96%, Green >= 96%	3.9
Full Blood Count acute wards 2 hours	The time taken for the laboratory to process Full Blood Counts samples from all Acute Wards and validated results are available on the Laboratory Information Management System (LIMS). The time measured is from the sample being booked on to the LIMS and results being validated on the LIMS and available to requestors	Chief Operating Officer	Red <85%, Amber >=85% & < 90%, Green >=90%	3.9
Diagnostic Waits	Percentage of patients who have waited less than 6 weeks for a diagnostic test.	Chief Operating Officer	Red < 99%, Green >= 99%	3.4
Radiology Turnaround Time OP	Radiology Turnaround Time for Outpatient Scan to Report. Percentage reported within 14 days for Urgent and within 4 weeks for Routine.	Chief Operating Officer	Red <95%, Amber >=95% & < 98%, Green >=98%	3.8
Radiology Turnaround Time Fast Track	Radiology Turnaround Time for Fast Track Scan to Report. Percentage reported within 14 days.	Chief Operating Officer	Red <95%, Amber >=95% & < 98%, Green >=98%	3.8
Mixed Sex Breaches	Number of occurrences of unjustified mixing in relation to sleeping accommodation.	Chief Operating Officer	Red > 0, Green = 0	5.0
Mission Critical Systems Uptime	Percentage of time all Mission Critical Systems were up and running	Chief Digital and Information Officer	Red <99.7%, Amber >=99.7% & < 99.9%, Green >=99.9%	4.3

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
Productivity				
Length of Stay	The average length of stay for patients, in days.	Chief Operating Officer	RAG criteria subjective.	2.0
Stranded Patients LoS >=7	The average number of patients (excluding Maternity) who have been in hospital 7 days or more.	Chief Operating Officer	RAG criteria subjective.	4.1
Super Stranded Patients LoS >=21	The average number of patients (excluding Maternity) who have been in hospital 21 days or more.	Chief Operating Officer	Red >71, Amber 62-71, Green <= 62	4.1
Elective Day Case Rate	The number of patients admitted for planned procedure and leave same day as a % of all procedures.	Chief Operating Officer	Red < 83%, Amber <87% & >=83%, Green >= 87%	1.0
Bed Occupancy	Average percentage of available beds which were occupied overnight.	Chief Operating Officer	Red >=95%, Amber 85-95%, Green <85%	2.3
Discharges before 1pm	Number of discharges from hospital which happened before 1 pm.	Chief Operating Officer	Red = Outside control limits, Green = Inside control limits	2.3
New to Follow-up Ratio	The ratio between New and Follow Up Outpatient appointments. Benchmarking data is from HED, which has a subtly different calculation, which can result in very small differences in numbers.	Chief Operating Officer	Red < 50 th Percentile England, Amber 50 – 25 th Percentile, Green Upper Quartile England	2.4
DNA Follow-up	This is the % of Follow-up Outpatient appointments where the patient does not attend.	Chief Operating Officer	Red < 50 th Percentile England, Amber 50 – 25 th Percentile, Green Upper Quartile England	2.6
DNA New	This is the % of New Outpatient appointments where the patient does not attend.	Chief Operating Officer	Red < 50 th Percentile England, Amber 50 – 25 th Percentile, Green Upper Quartile England	2.6
Elective wait list	Wait list of patients on an elective pathway.	Chief Operating Officer	Red Greater than last month Green Less than last month	3.7

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
To be in the top 20% of employers				
Engagement				
Staff FFT Treatment	Percentage of staff recommending the Trust as a place to receive care or treatment as part of the staff Friends and Family Test.	Director of Human Resources	Red <Yorkshire &Humber, Green >Yorkshire &Humber	4.4
Staff FFT Work	Percentage of staff recommending the Trust as a place to work as part of the staff Friends and Family Test.	Director of Human Resources	Red <Yorkshire &Humber, Green >Yorkshire &Humber	4.4
Appraisal Rate Non-medical	Percentage of eligible staff employed at the Trust who have had an appraisal in the last 12 months.	Director of Human Resources	Red <75%, Amber >=75% and <95%, Green >=95%	5.0
Contacts with Advocacy service	Percentage of Staff Advocate Service Contacts resulting in investigations.	Director of Human Resources	RAG criteria subjective.	3.6
Harassment & Bullying outcomes	Percentage of Harassment and Bullying related Contacts resulting in disciplinary action.	Director of Human Resources	RAG criteria subjective.	4.6
Training & Development				
New Starter Training	Percentage of new staff who are compliant with mandatory training requirements.	Chief Medical Officer	Red < 90%, Amber >=90% & <100%, Green = 100%	4.4
Refresher Training	Percentage of staff who are compliant with mandatory training requirements.	Chief Medical Officer	Red < 75%, Amber >=75% & <85%, Green >= 85%	4.4

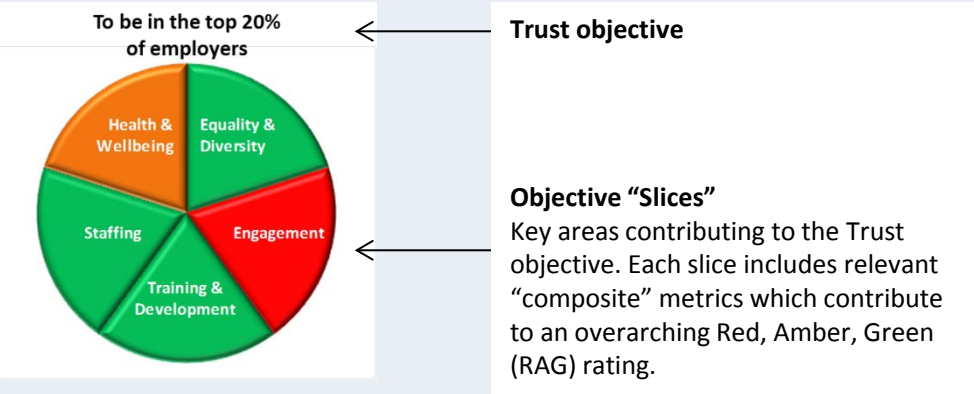
Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
Staffing				
Care Staff Shifts filled	Percentage of time care staff staffing hours are filled compared with planned.	Chief Nurse	Red < 80%, Amber 80% – 95%, Green > 95%	3.7
Care Staff Care Hours	Total of the actual number care staff hours for the month divided by the total number of patients who were an inpatient at midnight for each day of that month.	Chief Nurse	Red = Lower two quartiles, Green = Upper two quartiles	3.7
Nursing Care Hours	Total of the actual number of Registered Nurse / Midwife hours for the month divided by the total number of patients who were an inpatient at midnight for each day of that month.	Chief Nurse	Red = Lower two quartiles, Green = Upper two quartiles	3.7
Use of Agency Staff	Agency Full Time Equivalents (FTE's) as a percentage of all FTE's.	Director of Human Resources	RAG criteria subjective.	4.0
Staff Turnover	Number of employees who have left the organisation in the past 12 months as a percentage of the average number of employees over the same period.	Director of Human Resources	Red > 14%, Amber 12% – 14%, Green < 12%	4.0
Vacancies	Percentage of vacancies against the funded establishment	Director of Human Resources	Red = Above average, Green = Below average	To be confirmed
Equality & Diversity				
BAME Senior Leaders	Percentage of staff employed in Band 8+ Senior Manger roles at the Trust who are of Black, Asian or Minority Ethnic (BAME) background.	Director of Human Resources	Red >=2% below Trajectory Target, Amber >2% of Target, Green >= Target	4.6
BAME Workforce	Percentage of staff employed at the Trust who are of Black, Asian or Minority Ethnic (BAME) background.	Director of Human Resources	Red >=2% below Trajectory Target, Amber >2% of Target, Green >= Target	5.0
Health & Wellbeing				
Staff Sickness Absence	Percentage of staff time lost due to sickness in a given period (the reported month, year to date is the previous 12 months rolling average for which the Trust target is 4%.	Director of Human Resources	Red >1% point above Target, Amber within 1% point above Target, Green <= Target	4.0

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
To collaborate effectively with local and regional partners				
Partnership				
Stakeholder Engagement	The Hospital’s systematic approach to stakeholder management identifies key external partners, and for each an executive sponsor and an account manager has been identified, with responsibility for maintaining/improving the health of the relationship.	Director of Strategy & Integration	RAG rating subjectively agreed by the committee	Qualitative Metric
Vertical Integration	Working with local partners and contribute to the formal establishment of a responsive, integrated care system.	Director of Strategy & Integration	RAG rating subjectively agreed by the committee	Qualitative Metric
Horizontal Integration	Working with other providers to ensure resilient services, reduce outcome variation, address workforce shortages, and achieve efficiencies. Contribute to the establishment of an effective Integrated Care System in West Yorkshire and Harrogate.	Director of Strategy & Integration	RAG rating subjectively agreed by the committee	Qualitative Metric
Airedale Collaboration	Working with Airedale NHS Foundation Trust to collaborate effectively to improve the services offered to patients, ensuring they are more resilient. The programme will address workforce shortages together.	Director of Strategy & Integration	RAG rating subjectively agreed by the committee	Qualitative Metric

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
To provide outstanding care for patients				
Learning Hub				
Learning Hub Progress	Progress on embedding the Learning Hub in the Trust against the plan.	Director of Strategy and Integration	RAG criteria subjective.	Qualitative Metric
Research				
Research patients recruited	Number of patients recruited to studies against the planned recruitment.	Chief Medical Officer	Red <60%, Amber >=60% & <80%, Green >=80%	4.0
Governance				
Duty of Candour	Patient informed duty of candour.	Director of Strategy and Integration	Red > 0, Green = 0	4.0
Information Governance Breaches	The number of reported breaches of information governance standards.	Chief Digital and Information Officer	Red > 6, Amber <=6 & > 2, Green <=2	3.7
Out of Date Policies	Percentage of policies that are currently out of date.	Director of Strategy and Integration	Red < 95%, Amber >=95% & <100%, Green = 100%	3.3
Risk not Mitigated	Risks 12 and above whose current rating is above the target (residual) rating.	Director of Strategy and Integration	Red > 15%, Amber >5% and <=15%, Green <=5%	3.1

Dashboard Key

Summary Charts



DQ Kite Mark

RAG status of assurance of the data quality of the information being presented – average score RAG rated across 7 domains; timeliness, audit, reliability, relevance, granularity, validation and completeness.

DQ Score	Summary
1.0	Insufficient systems, processes or documentation available to provide assurance on the asset (i.e. dataset).
2.0	Limited systems, process and documentation are available and therefore assurance is limited.
3.0	Systems, processes and documentation are available and the asset has been locally verified to provide assurance.
4.0	Full systems, processes and documentation are available and the asset has been locally verified to provide assurance.
5.0	Full systems, processes and documentation are available and the asset has been independently verified with full assurance provided.

RAG Rating Calculations

Objective Slice RAG

Weighted score of composite metric RAGs (Red=1, Amber=2, Green=3) within a slice divided by the number of composite indicators within a slice.

- Red =< 1.5
- Amber > 1.5
- Green => 2.5

Metric RAG

Each metric has separate RAG criteria updated on a monthly basis by Responsible Owners as defined in the Metric glossary. This demonstrates the current status of the metric.

Statistical Process Control (SPC) Chart

The information is generally presented using "control limits" to determine whether any one month is statistically high or low. The average is calculated over the first 12 months, and after this time if there is a period of 8 months in a row which are all above (or below) the average, a new average and control limits are calculated from this point.

Benchmarking

The majority of benchmarking charts show information for the most recently available period. The range of other Acute Trusts values are split into 4 quartiles, showing the range of the bottom 25% of Trust values, 25-50% of Trust values etc. The value for Bradford Teaching Hospitals is shown alongside a single value looking at the average of Acute trusts in Yorkshire and Humber.