

# Integrated Dashboard Board of Directors

31<sup>st</sup> March 2020

# Integrated Dashboard

31<sup>st</sup> March 2020

To provide outstanding care for patients



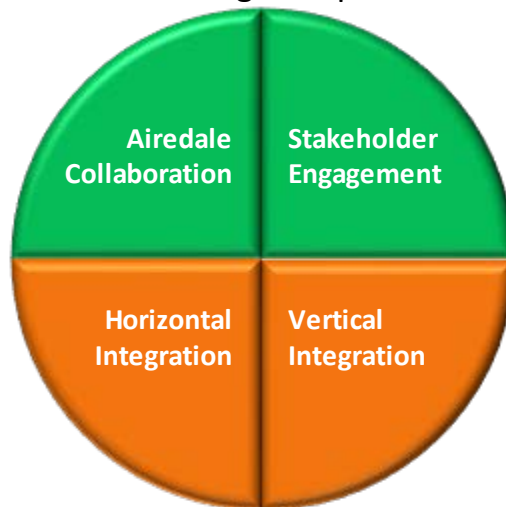
To deliver our key performance targets and financial plan



To be in the top 20% of employers



To collaborate effectively with local and regional partners

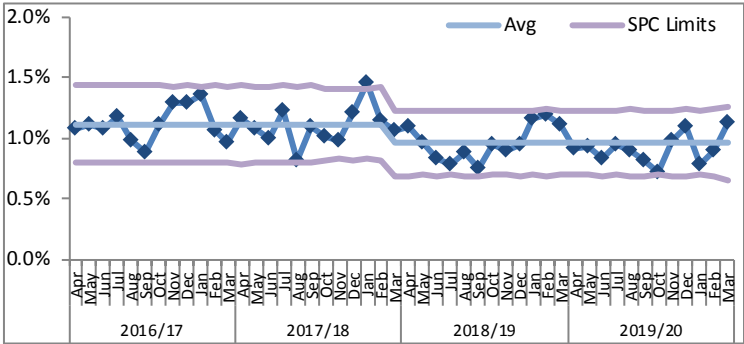
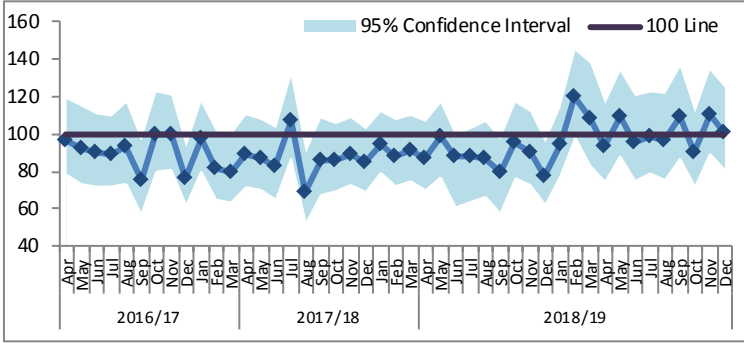
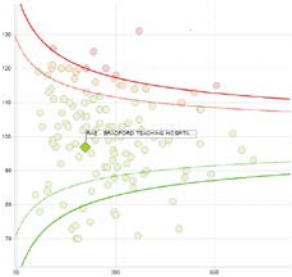
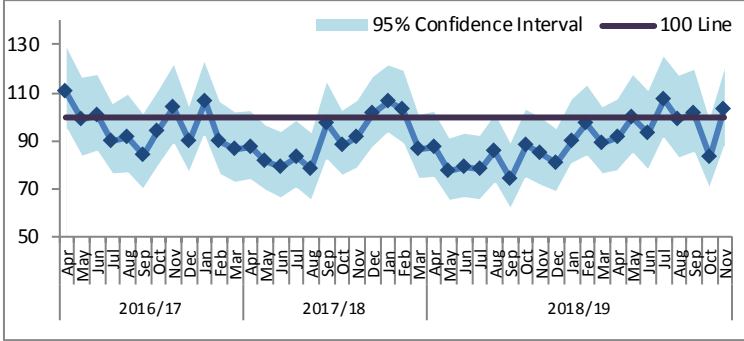
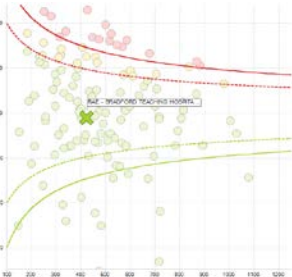


To be a continually learning organisation



# To provide outstanding care for patients

## Clinical Effectiveness

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Crude Mortality</div>		<p>Whilst the crude death rate remains within the limits during Covid-19 Pandemic it is expected that the Crude death rate will rise as the number of inpatients (denominator) will fall significantly whilst the deaths from patients admitted to hospital is known to be high. Further months may see a sharp rise in this measure.</p>	<p>No benchmark comparator available</p>
<div>Hospital Standardised Mortality Ratio</div>		<p>Our Hospital Standardised Mortality Ratio (HSMR) demonstrates that the Trust is 'within expected' for this metric. It is unclear what will happen to the HSMR as a result of the Covid-19 pandemic although this will be delayed for many months.</p>	
<div>Summary Hospital-level Mortality Indicator</div>		<p>The Summary Hospital-level Mortality Indicator (SHMI) demonstrates that the Trust is 'within expected' for this metric. It is unclear what will happen to the HSMR as a result of the Covid-19 pandemic although this will be delayed for many months.</p>	

# To provide outstanding care for patients

## Clinical Effectiveness

Metric / Status	Trend	Challenges and Successes	Benchmarks
Stillbirths		<p>This is a new metric which aims to monitor the number and rates of stillbirths. The are two lines which reflect the total and those where the foetus is &gt; 500g and normally formed.</p>	<p>No benchmark comparator available</p>
Deaths Screened		<p>The Trust has shown a steady improvement in the screening of deaths. Work to progress with colleagues from Airedale to implement the national medical examiner role has been delayed due to the Covid-19 pandemic.</p>	<p>No benchmark comparator available</p>
Learning From Deaths		<p>The Trust has consistently provided good or excellent care to 80% of our patients reviewed by structure judgement review.</p>	<p>No benchmark comparator available</p>

# To provide outstanding care for patients

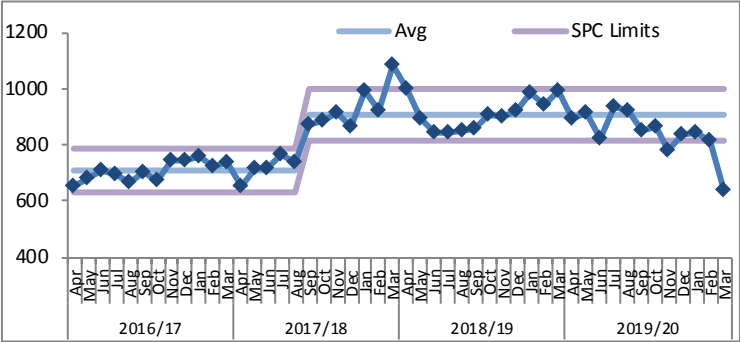
## Clinical Effectiveness

Metric / Status

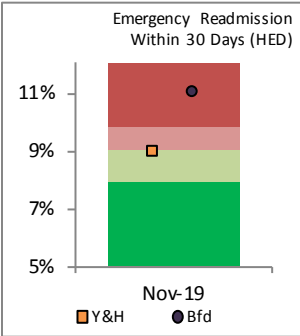
Trend

Challenges and Successes

Benchmarks

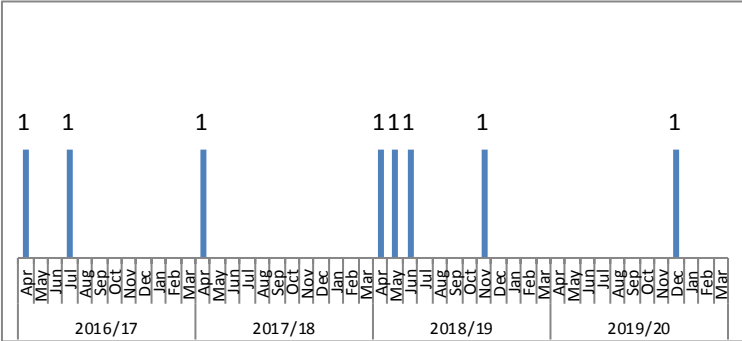
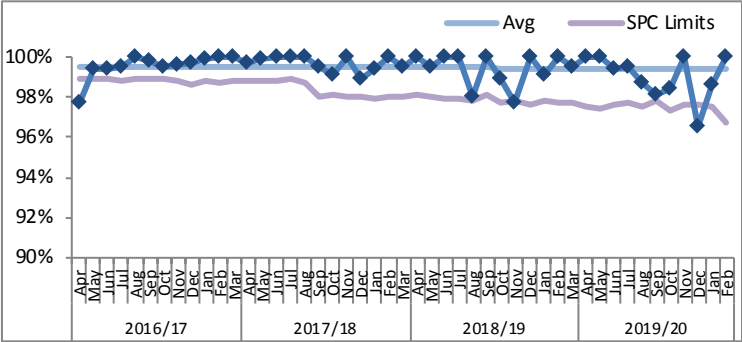


The drop in readmissions needs to recognise that this is likely to be the impact of the Covid-19 pandemic as the audit programme has been paused at this time.



# To provide outstanding care for patients

## Patient Safety

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Never Events</div>		<p>No Never Events since December 2019. Total of 1, year to date. (YTD).</p>	<p>No benchmark comparator available</p>
<div>Audit of WHO Checklist</div>		<p>Compliance has recovered and continues to be &gt;98% YTD. Fall in December 2019 has now corrected following detailed work with the relevant theatre areas. The value of this measure will diminish during the Covid-19 pandemic as the number of theatre lists has significantly reduced. Based on the CQC feedback we intend to roll out observational audits.</p>	<p>No benchmark comparator available</p>

# To provide outstanding care for patients

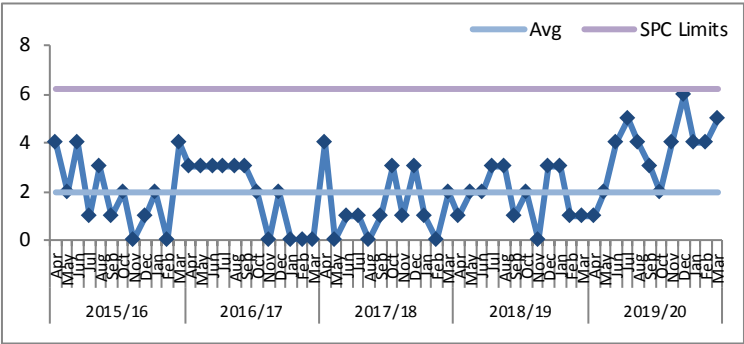
## Patient Safety

Metric / Status

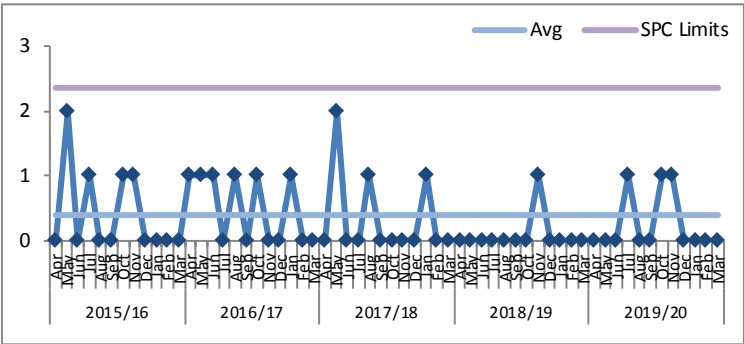
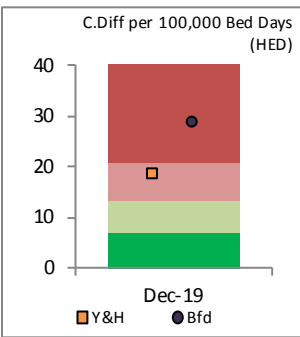
Trend

Challenges and Successes

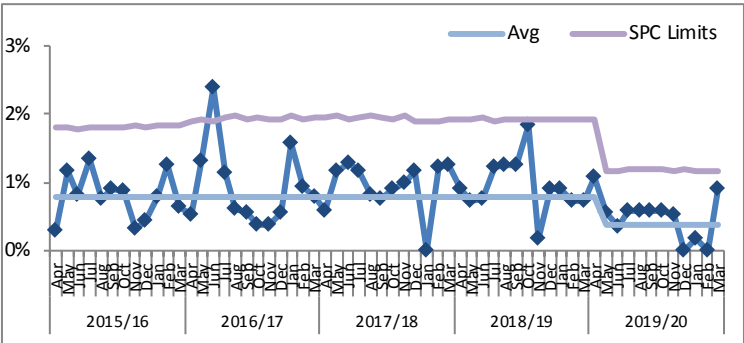
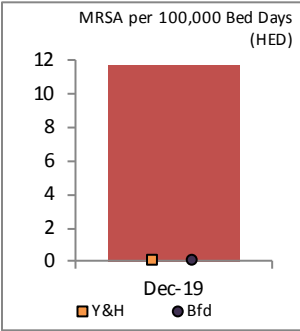
Benchmarks



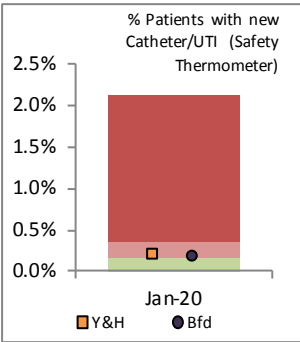
Clostridium difficile (C.Diff) continues to trend higher than previous year. No lapses in care or outbreaks reported.



Nil new cases.



Increase in month, to evaluate via Infection Control Committee (ICC).



# To provide outstanding care for patients

## Patient Safety

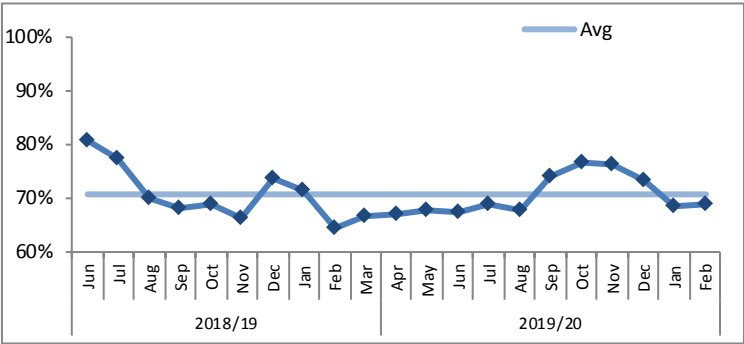
Metric / Status

Trend

Challenges and Successes

Benchmarks

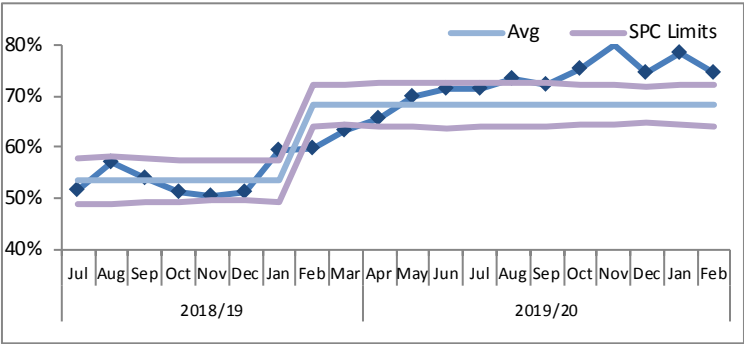
Sepsis patients receive antibiotics within an hour



Pressures on service continue, this position may deteriorate due to Covid-19.

No benchmark comparator available

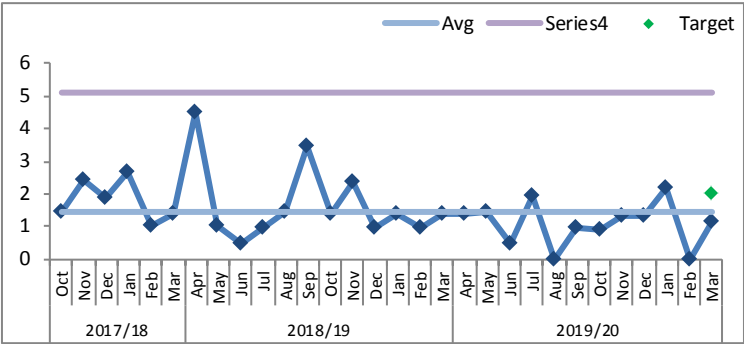
Sepsis Percentage of Patients Screened



Progress remains as expected.

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

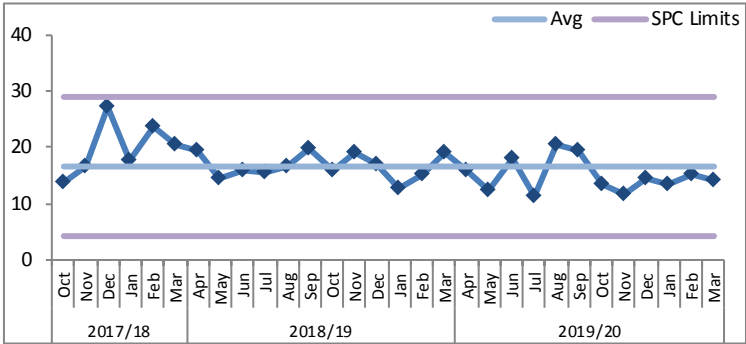
Metric / Status

Trend

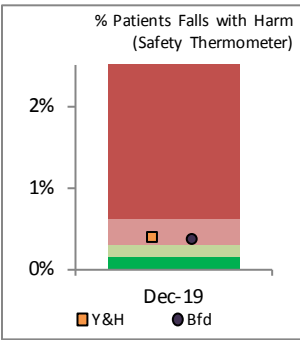
Challenges and Successes

Benchmarks

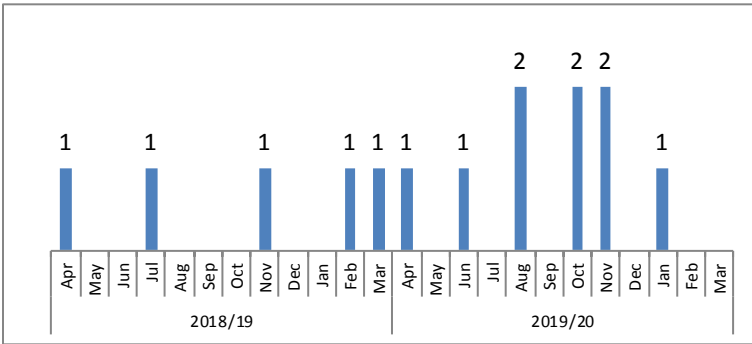
Falls with Harm per 10,000 bed days



Numbers remain static.



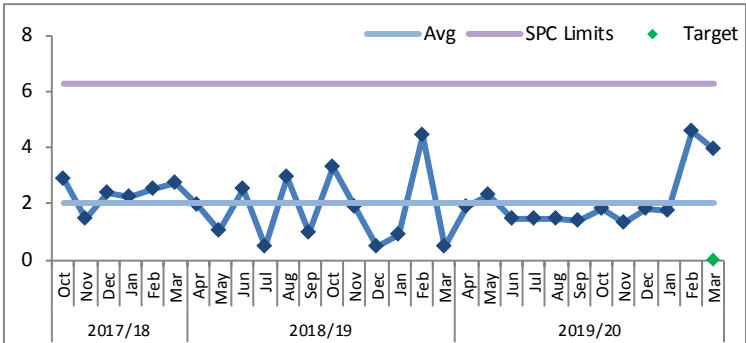
Falls with Severe Harm



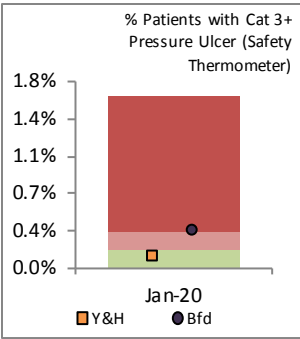
Nil falls with severe harm.

No benchmark comparator available

Pressure Ulcers Cat 3+ per 10,000 bed days



This indicator shows all pressure ulcers (PU's) and not just ones with lapse in care. This number will increase as part of pandemic.



# To provide outstanding care for patients

## Patient Safety

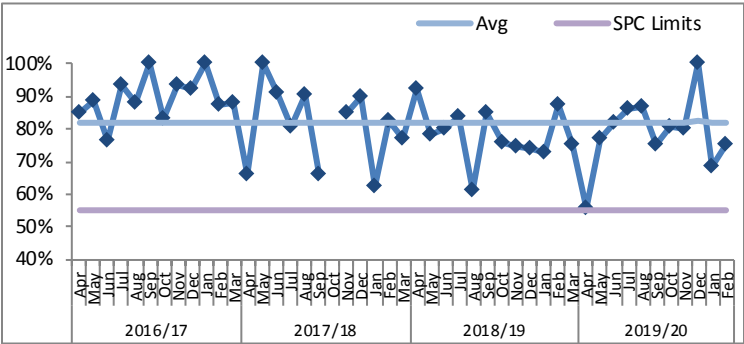
Metric / Status

Trend

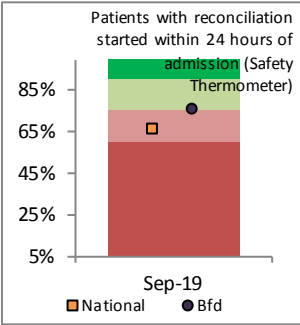
Challenges and Successes

Benchmarks

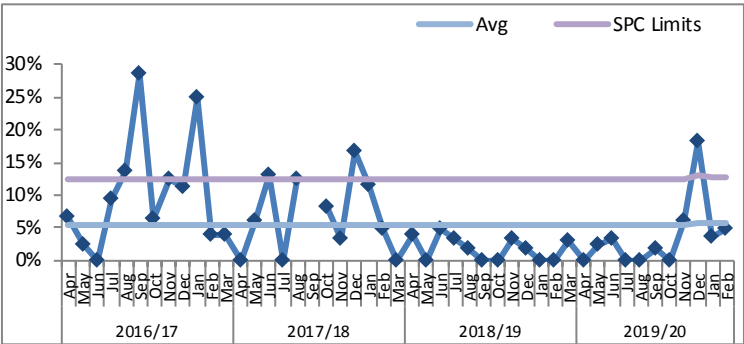
Medicine Reconciliation



The Trust performs well against this standard and benchmarks positively compared to peers. The fall in January 2020 is now showing signs of recovery after increased focus across the pharmacy service. The impact of Covid-19 on this measure needs to be determined.



Missed Doses

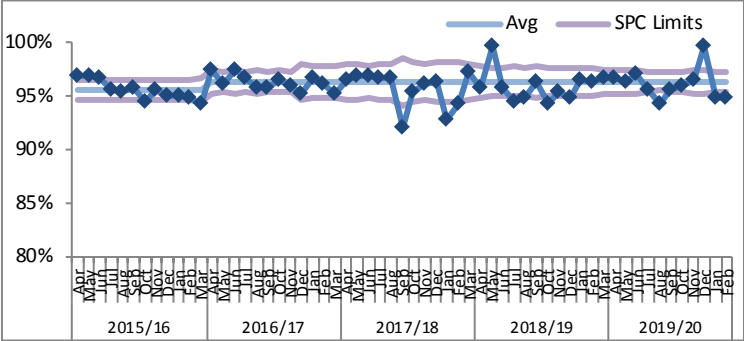
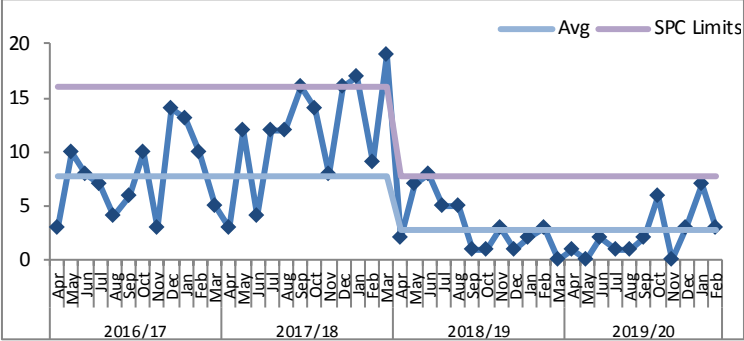
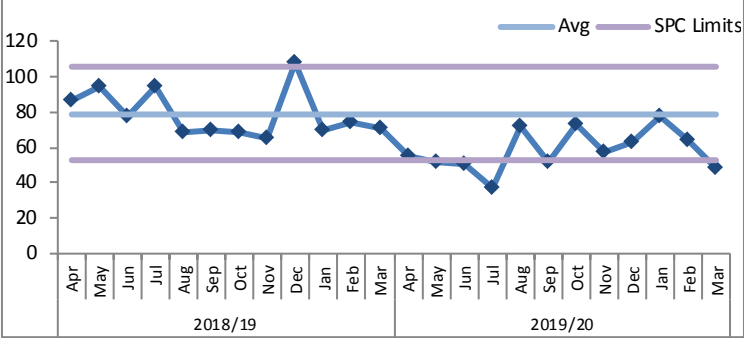


This new metric has shown significant improvement over the past 18 months. Benchmark data is not yet available but will be sourced for future reports. Chief Nurse has asked the Chief Pharmacist to report on the missed doses to the patient safety committee.

No benchmark comparator available

# To provide outstanding care for patients

## Patient Experience

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Friends &amp; Family Test</div>		<p>Friends and Family Test (FFT) shows steady progress. Detail is provided in the Q3 Patient Experience Report.</p>	<p>No benchmark comparator available</p>
<div>Night Time Transfers</div>		<p>Seasonal demand and variation, need to understand further the increases. Exception report requested to go to March 2020 Patient safety committee.</p>	<p>No benchmark comparator available</p>
<div>Night Time Discharges</div>		<p>Await response from Patient Safety Sub-Committee.</p>	<p>No benchmark comparator available</p>



# To deliver our key performance targets and financial plan

## Finance

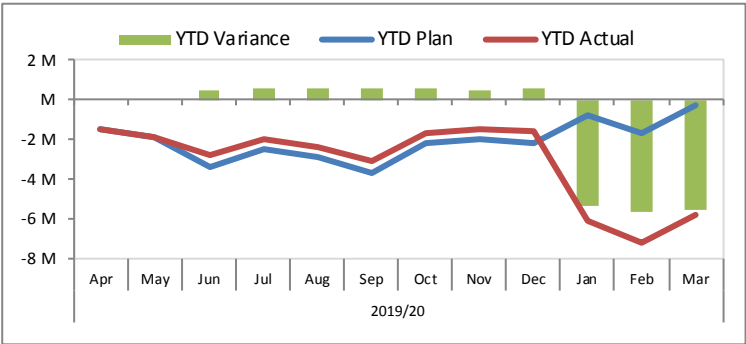
Metric / Status

Trend

Challenges and Successes

Benchmarks

Delivery of Income and Expenditure Plan



The £18.7m year to date (YTD) deficit excluding Provider Sustainability Fund (PSF) is £6.2m adverse to the control total plan of £12.5m. The £6.2m represents the YTD adverse financial impact of not progressing with the Wholly Owned Subsidiary (WOS). The regulators have confirmed that dispensation will be given to exclude the full impact of the WOS cancellation from the 2019/20 control total. £0.5m of bonus PSF relating to 2018/19 was received in 2019/20 which means the bottom line including PSF is a deficit of £5.7m.

No benchmark comparator available

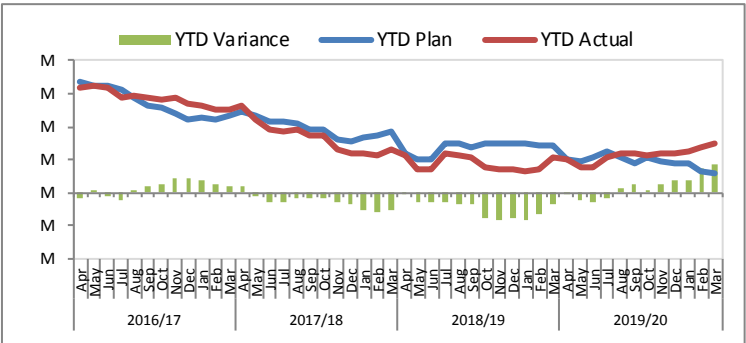
Use of Resources

NHSI Use of Resources	Plan	Actual	Last	RAG
Risk Rating (UoR)	YTD	YTD	Month	
As at 31/03/2020				
Capital service cover rating	2	4	4	
Liquidity rating	3	1	2	
I&E margin rating	2	4	4	
I&E margin: distance from financ	1	3	3	
Agency rating	1	1	1	
Combined UoR (after triggers)	2	3	3	

At Month 12 the Trust has an overall rating of 3 which is in line with plan. Although the Income and Expenditure (I&E) position is in line with plan, the I&E margin percentage metric is rated at 3 due to the phasing of the Trust's efficiency plans and weighting of the PSF / Financial Recovery Fund both being towards the latter months of the financial year.

No benchmark comparator available

Delivery of Cash Plan



Year to date cash is ahead of plan by £17.7m. The Trust has more cash than planned as a result of an liabilities (£3.4m), deferred income (£4.5m) being higher than plan and receivables (£1.4m) and capital expenditure (£3.7m) being lower than plan. The Trust also received £7.1m unplanned PSF bonus during 2019/20.

No benchmark comparator available

# To deliver our key performance targets and financial plan

## Finance



Bradford Teaching Hospitals  
NHS Foundation Trust

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Liquidity rating</div>		<p>Year to date (YTD) liquidity 3 days which is 12.1 days above plan. Higher than planned working capital, due to the improved cash position, has provided an additional 14 days of liquidity against plan. This has partially been offset by operational costs than are higher than planned. Higher than planned cash is a result of the PSF bonus from 18/19, capital slippage and additional deferred income.</p>	<p>No benchmark comparator available</p>
<div>Bradford Improvement Plan</div>		<p>The Trust has delivered £12.8m of efficiencies by Month 12 which is below the plan of £16.2m. Clinical Business Unit (CBU) and corporate management teams have recorded only £8.2m of recurrent Cost Improvement Plan (CIP) savings to date. The balance has been delivered via non-recurrent savings.</p>	<p>No benchmark comparator available</p>

# To deliver our key performance targets and financial plan

## Performance



Bradford Teaching Hospitals  
NHS Foundation Trust

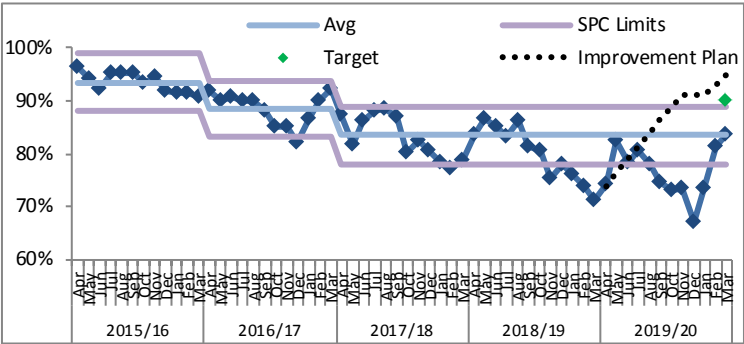
Metric / Status

Trend

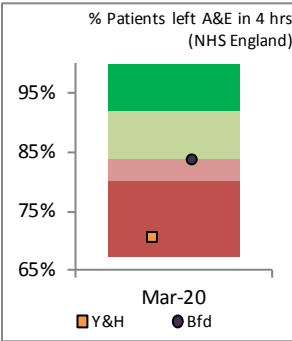
Challenges and Successes

Benchmarks

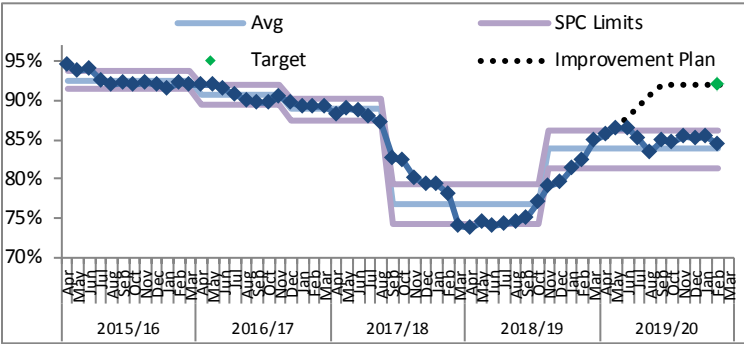
Emergency  
Care  
Standard



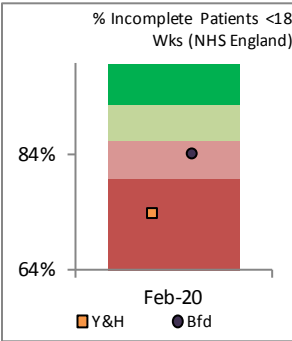
Emergency Care Standard (ECS) performance (type 1 and 3) improved to 83.59% in March 2020. The COVID-19 outbreak has reduced attendances, predominately for minor illness and injury, but created numerous challenges for the emergency department and flow through the hospital. Performance in April 2020 is expected to improve further due to the well managed response to the COVID-19 incident.



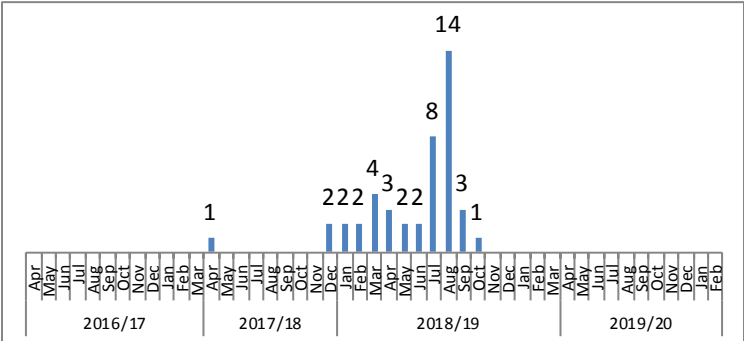
RTT 18 Week  
Incomplete



Incomplete performance deteriorated to 80.73% for March 2020. The position has been significantly impacted by elective cancellations since mid-March 2020 in response to COVID-19. A reduction in the waiting list size below 18 weeks due to a reduction in referrals will have a significant impact on April 2020 performance. A standard operating procedure (SOP) is in place to prioritise all patients currently on the inpatient waiting list and ensure that available theatre capacity is fully utilised for cancer patients and long waiters where available. Alternative outpatient capacity is being created through the use of virtual and video clinics.



RTT 52  
Week Wait



The Trust reported 0 incomplete 52 week waits in March 2020, which is the 17th consecutive month with no breaches. Daily review of all management plans for patients waiting over 32 weeks continues but the reduction in elective activity in response to COVID-19 poses a risk to future performance. The clinical impact of long waiting times is considered as part of the prioritisation SOP.

No benchmark comparator available

# To deliver our key performance targets and financial plan

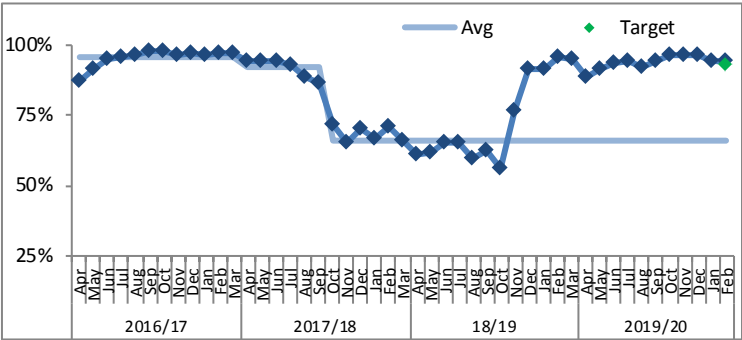
## Performance

Metric / Status

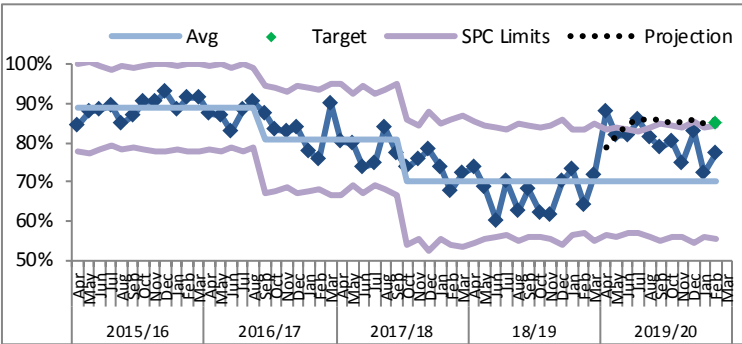
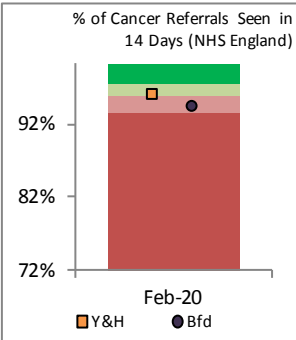
Trend

Challenges and Successes

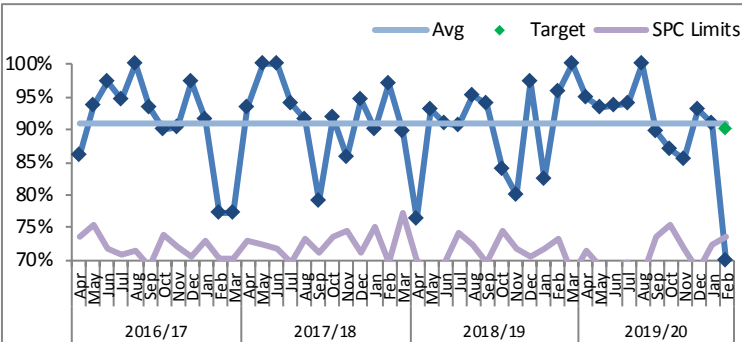
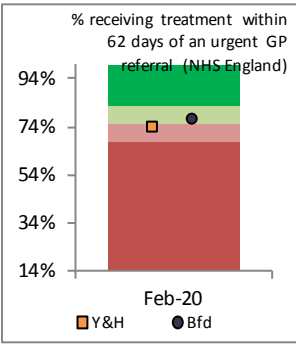
Benchmarks



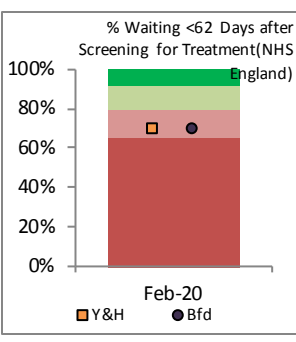
February 2020 performance against the 2 Week-Wait cancer standard was 94.17% which remains above the 93% target.



Cancer 62 Day First Treatment performance for February 2020 was 77.27% against a target of 85%. Delays in the Lower and Upper Gastrointestinal (GI) diagnostic phase and delays for Clinical Oncology and surgical treatment for Urology due to capacity remained the main challenges to performance.



Performance was below the 90% standard in February 2020 due to capacity issues in Endoscopy.





# To deliver our key performance targets and financial plan

## Performance



Bradford Teaching Hospitals  
NHS Foundation Trust

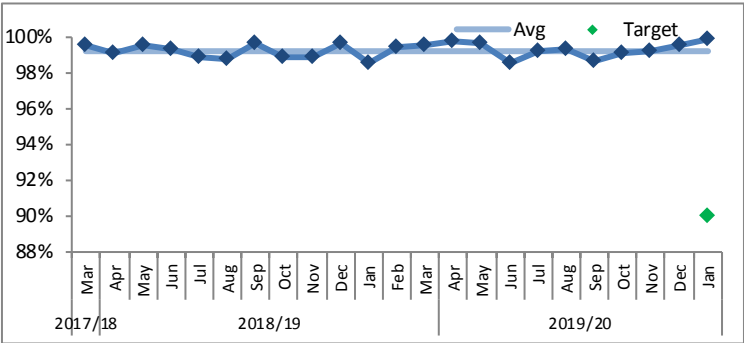
Metric / Status

Trend

Challenges and Successes

Benchmarks

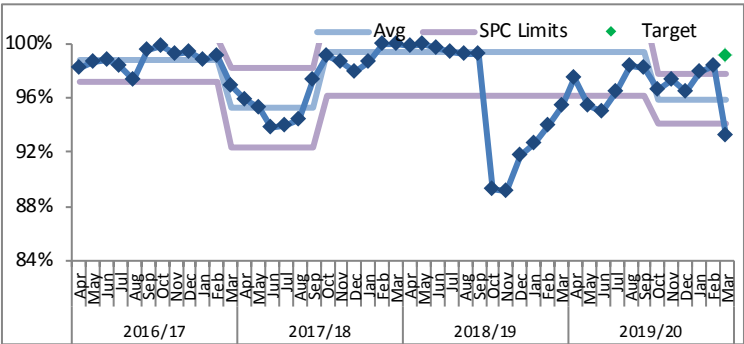
Full Blood Count to Wards < 2 Hours



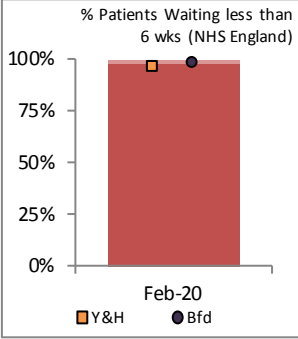
Performance continues to achieve compliance with target.

No benchmark comparator available

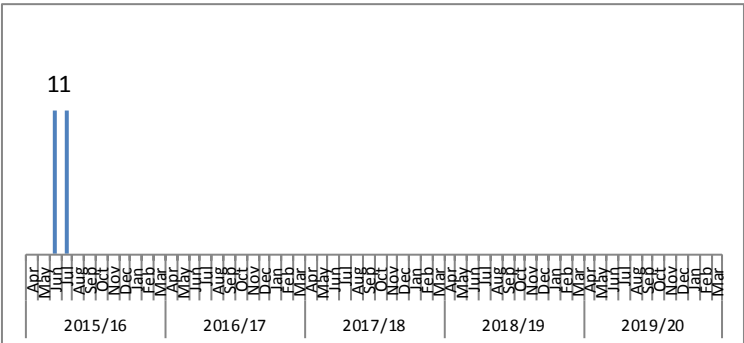
Diagnostic Waits



Performance for March 2020 was 93.21% with a deterioration in Endoscopy and Radiology. As part of the COVID-19 response routine diagnostic tests for these modalities have been suspended.



Mixed Sex Breaches



There have been no mixed sex breaches.

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
<div>Radiology Turnaround Time Outpatients</div>		<p>Turnaround times for routine reports deteriorated in March 2020 as capacity is prioritised differently during the COVID-19 response.</p>	<p>No benchmark comparator available</p>
<div>Radiology Turnaround Time Frast Track</div>		<p>Performance remained stable in March 2020.</p>	<p>No benchmark comparator available</p>
<div>Mission Critical Systems Uptime</div>		<p>The uptime metric has been revised to include fixed line (i.e., not mobile) telephony as a Mission Critical Systems, which are all included in this metric. This metric monitors downtime regardless of cause. The Trust has experienced a number of unplanned partial downtimes to the telephony networks, some as a result of external issues and two internally in the past six months. The Trust is in the process of replacing its private automatic branch exchanges (PABX), which operates the fixed line telephony networks. This work is expected to complete by the end of the Summer 2020.</p>	<p>No benchmark comparator available</p>

# To deliver our key performance targets and financial plan

## Productivity



Bradford Teaching Hospitals  
NHS Foundation Trust

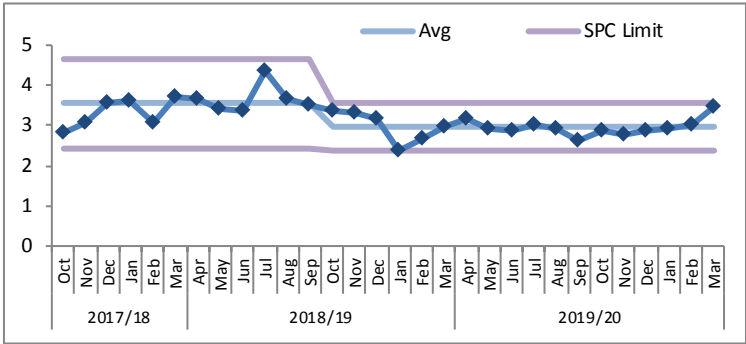
Metric / Status

Trend

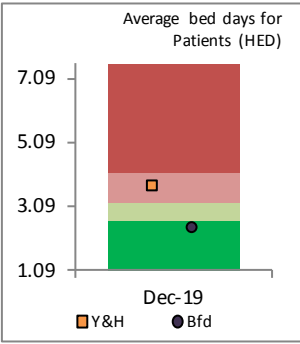
Challenges and Successes

Benchmarks

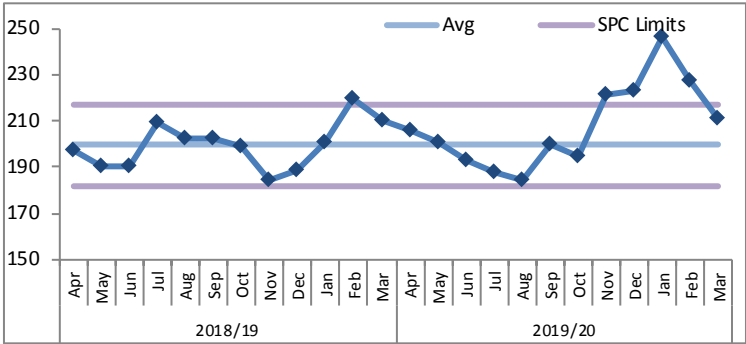
Length of Stay



Average length of stay (LoS) increased in March 2020. Reduced elective activity and reduced overall occupancy numbers correlate with this change which have occurred in response to COVID-19.



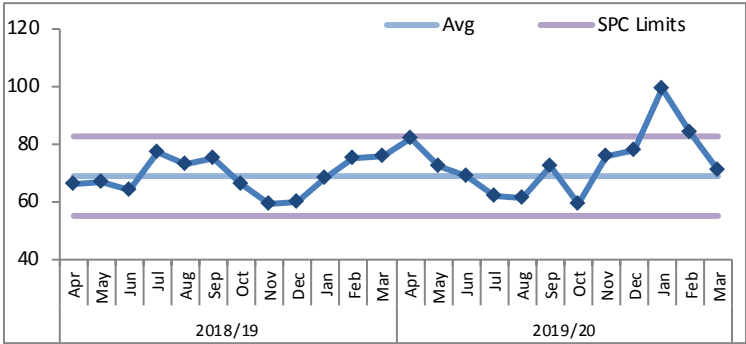
Stranded Patients  
Length of Stay  
>= 7 days



The number of patients staying over 7 days decreased in March 2020. This follows a reduction in overall occupancy numbers. Senior leadership alongside the Multi-Agency Integrated Discharge Team (MAIDT) service continue to support the discharge process.

No benchmark comparator available

Super Stranded Patients  
Length of Stay  
>= 21 days



The daily average number of patients staying above 21 days LoS also reduced in March 2020. Weekly oversight remains in place and senior leadership alongside the MAIDT service continue to support the discharge process.

No benchmark comparator available

# To deliver our key performance targets and financial plan

## Productivity



**Bradford Teaching Hospitals**  
 NHS Foundation Trust

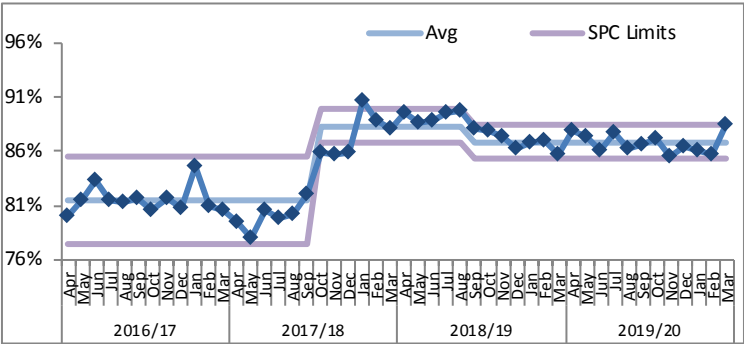
Metric / Status

Trend

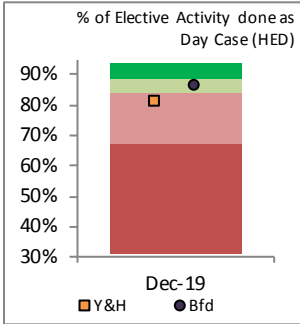
Challenges and Successes

Benchmarks

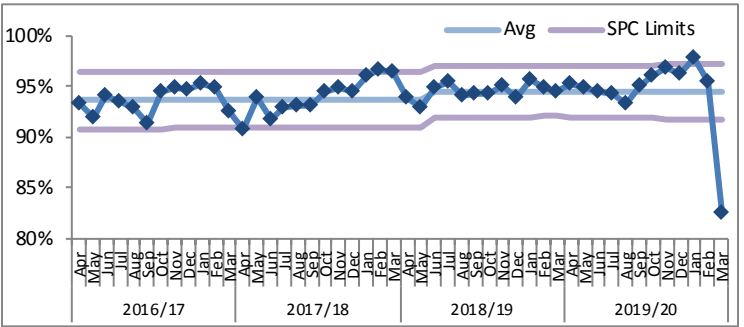
**Elective Day Case Rate**



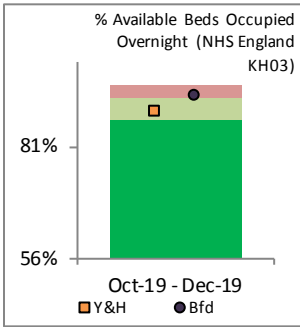
Day case rates continue to be above the national and regional average.



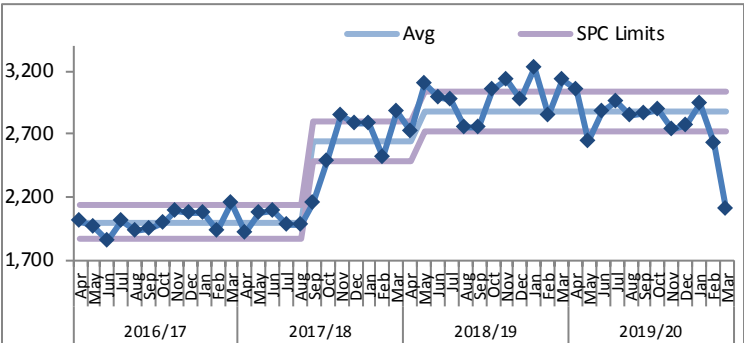
**Bed Occupancy**



Bed occupancy decreased significantly in March 2020 as the hospital responded to the COVID-19 outbreak. Ward configuration has been adapted to help deal with this crisis and lower bed occupancy has been sustained to help support the anticipated growth of COVID-19 positive patients.



**Discharges before 1pm**



The total number of discharges before 1pm in March 2020 reduced.

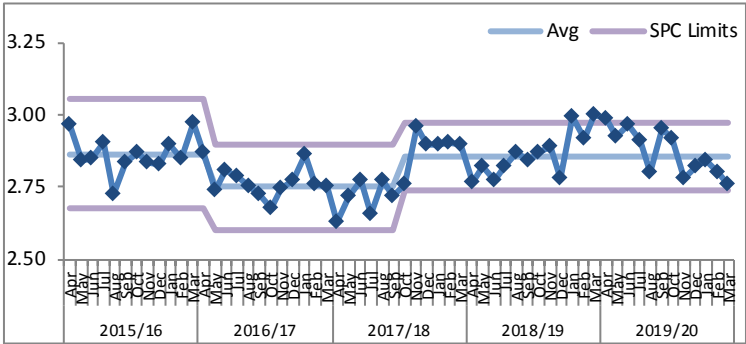
No benchmark comparator available

# To deliver our key performance targets and financial plan

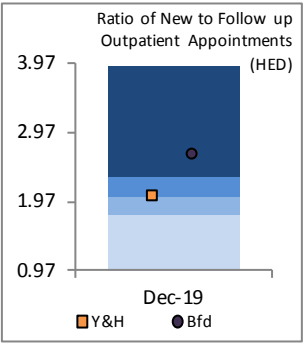
## Productivity

Metric / Status	Trend	Challenges and Successes	Benchmarks
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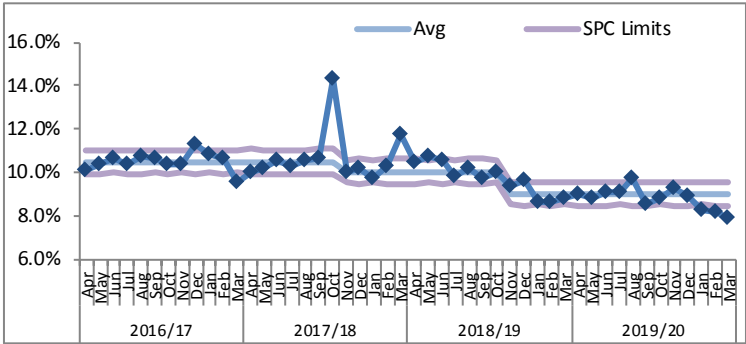
New to Follow Up Ratio



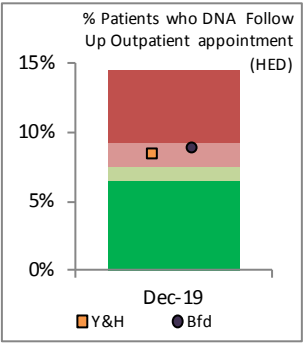
The new to follow up ratio in March 2020 remained below the mean but within control limits.



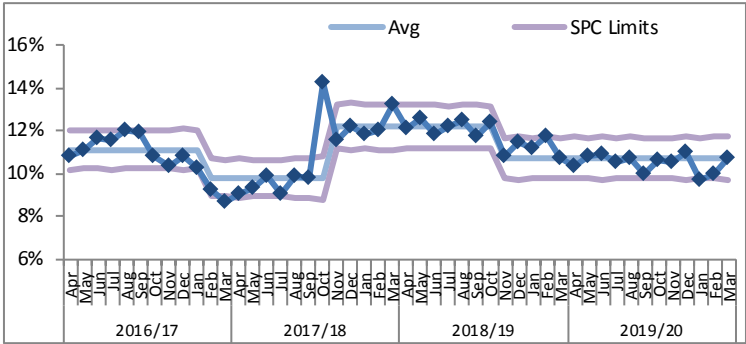
Did not Attend Follow Up



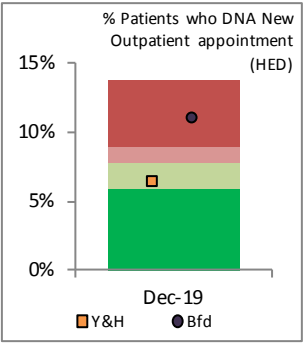
Did not attend (DNA) rate for follow ups continue to improve.



Did not Attend New



Did not attend (DNA) rates for new appointments increased which could be related to patients responding to COVID-19 concerns.



# To deliver our key performance targets and financial plan

## Productivity



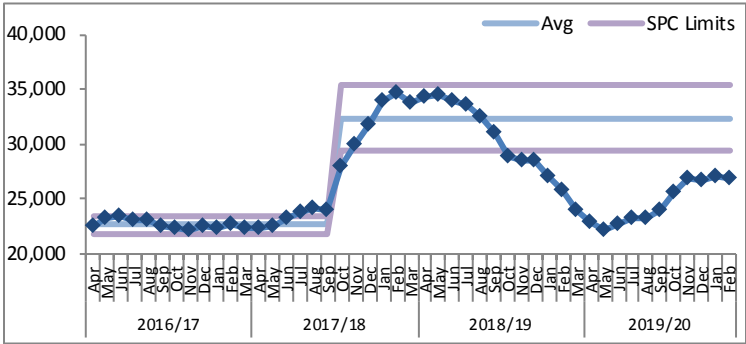
Bradford Teaching Hospitals  
NHS Foundation Trust

Metric / Status

Trend

Challenges and Successes

Benchmarks



The total elective waiting list reduced by over 1,000 in March 2020. Waiting list validation was concluded in this period whilst referrals significantly reduced towards the end of the month in response to COVID-19.

No benchmark comparator available

# To be in the top 20% of employers

## Engagement

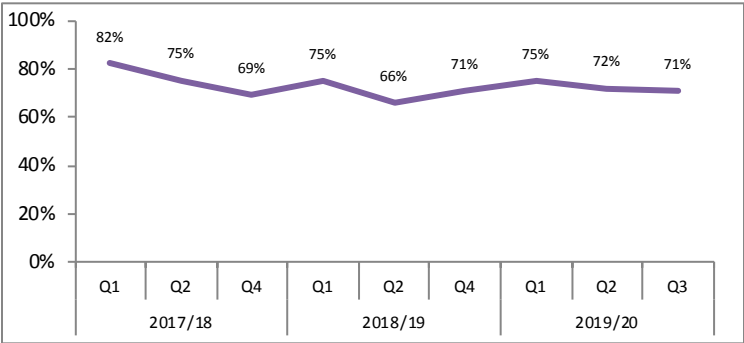
Metric / Status

Trend

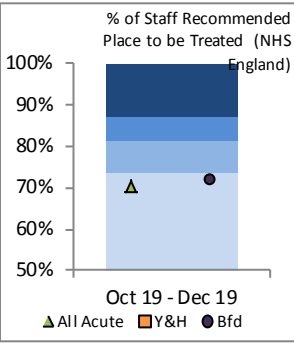
Challenges and Successes

Benchmarks

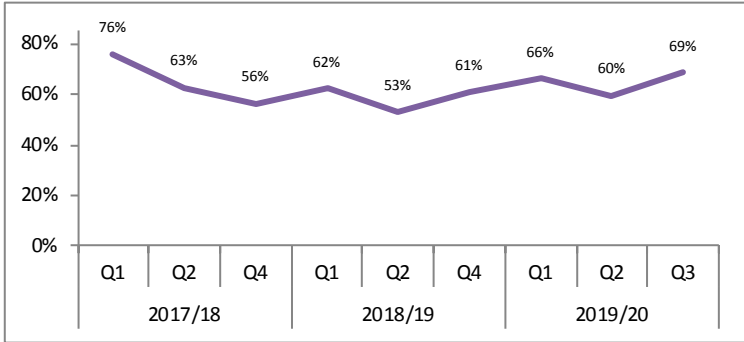
Staff FFT Treatment



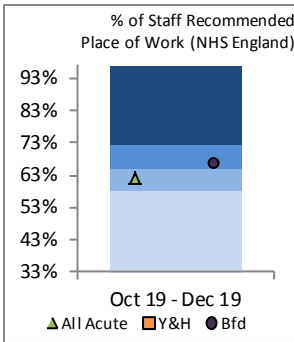
NHS England and Improvement has temporarily suspended carrying out the Staff Friends and Family Test (FFT) during the pandemic. There will be no data submission (including Q4 2019/20 data) or publication until further notice.



Staff FFT Work

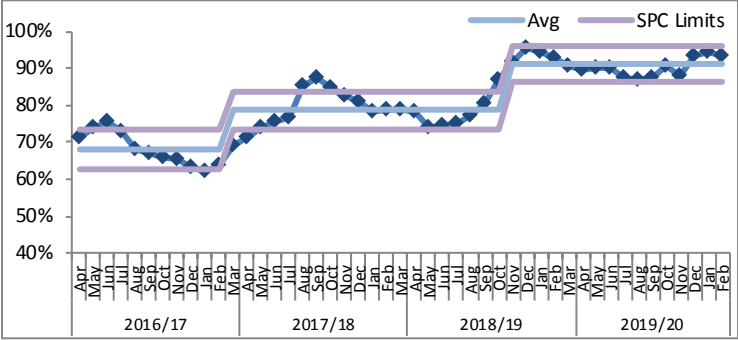
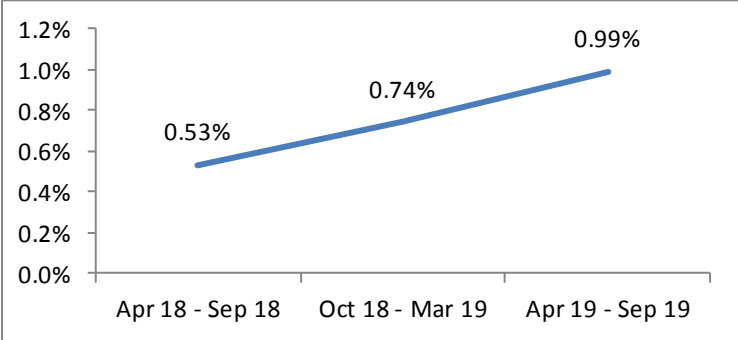
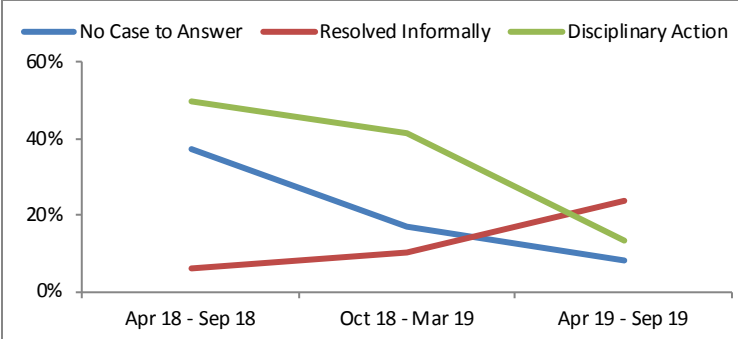


NHS England and Improvement has temporarily suspended carrying out the Staff FFT during the pandemic. There will be no data submission (including Q4 2019/20 data) or publication until further notice.



# To be in the top 20% of employers

## Engagement

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Appraisal Rate Non-Medical</div>		Reporting Suspended.	No benchmark comparator available
<div>Contacts with Advocacy service</div>		Reporting Suspended.	No benchmark comparator available
<div>Harassment &amp; Bullying Outcomes</div>		Reporting Suspended.	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 new starter compliance rate has been achieved for the past 4 months. The impact of the Covid-19 pandemic needs to be determined.</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%. The decision to suspend all mandatory training for established staff means that this measure will be paused from March 2020 through to the end of the pandemic period.</p>	<p>No benchmark comparator available</p>

# To be in the top 20% of employers

## Staffing

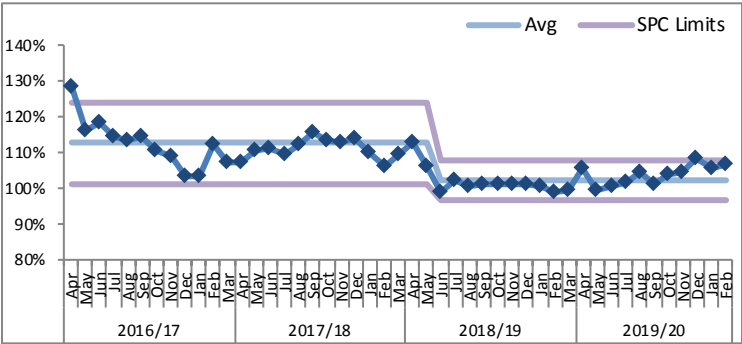
Metric / Status

Trend

Challenges and Successes

Benchmarks

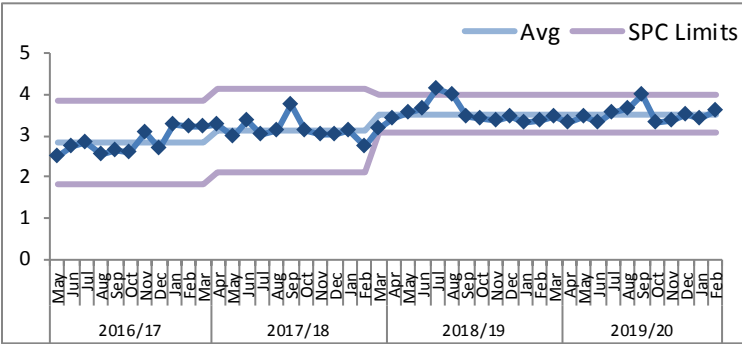
Care Staff  
Shifts Filled



Text not updated in April  
Fill rates are now consistently 100% and are as expected.

No benchmark comparator available

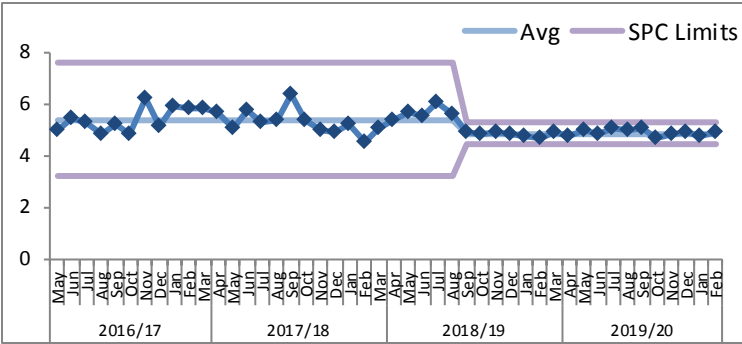
Care Staff  
Care Hours



Text not updated in April  
The carer workforce has stabilised in line with our workforce plans, benchmarks appropriately with model hospital data.

No benchmark comparator available

Nursing  
Care Hours



Text not updated in April  
Rate remains stable and benchmarks appropriately with model hospital data.

No benchmark comparator available

# To be in the top 20% of employers

## Staffing

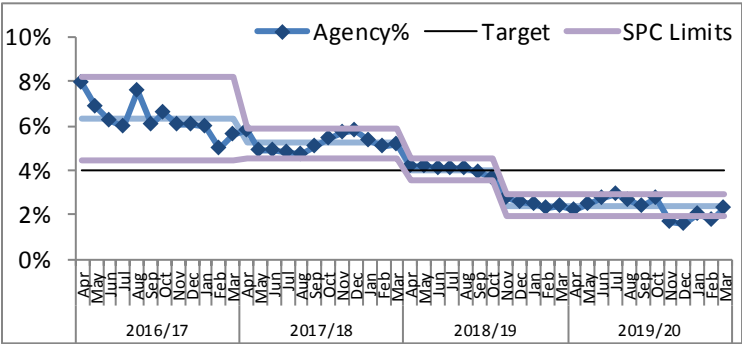
Metric / Status

Trend

Challenges and Successes

Benchmarks

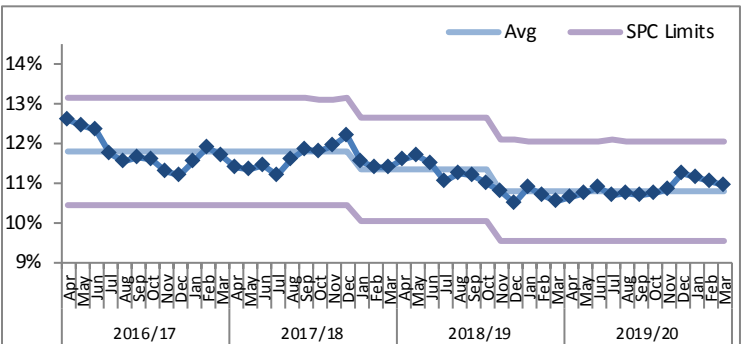
Use of Agency Staff



Agency use overall has increased in March 2020 with bank usage also having increased, in particular the Nursing & Midwifery staff group. Agency use across the Medical and Dental staff group has remained the same as the previous reporting period. The Allied Health Professionals (AHP's) group has also remained stable. The main reason for the increase was due to additional demand due to Covid-19. Our agency spend continues to be under the maximum ceiling and agency usage continues to be tightly managed.

No benchmark comparator available

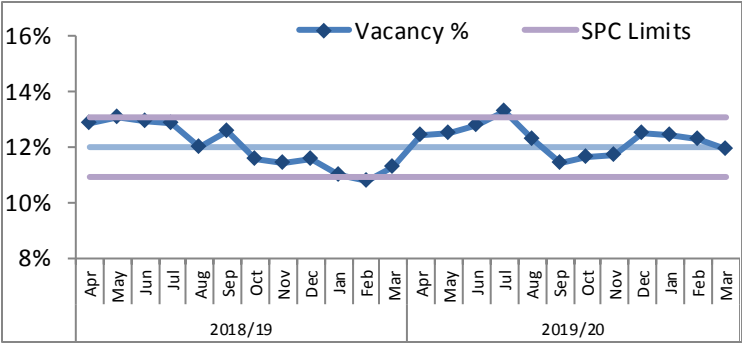
Staff Turnover



Turnover has continued to reduce slightly at Trust level in March 2020 to 10.96% from 11.07% in February 2020. Reductions were seen in Corporate Service, Estates and Facilities and Research with all other areas seeing slight Increases.

No benchmark comparator available

Vacancies



The vacancy data at present does not reflect the true vacancy position in the Trust due to the deployment of staff in relation to COVID-19.

No benchmark comparator available

# To be in the top 20% of employers

## Staffing



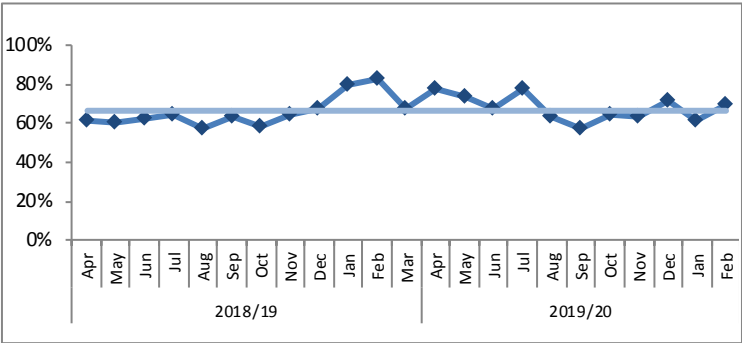
Metric / Status

Trend

Challenges and Successes

Benchmarks

Maternity patients receiving 1:1 care



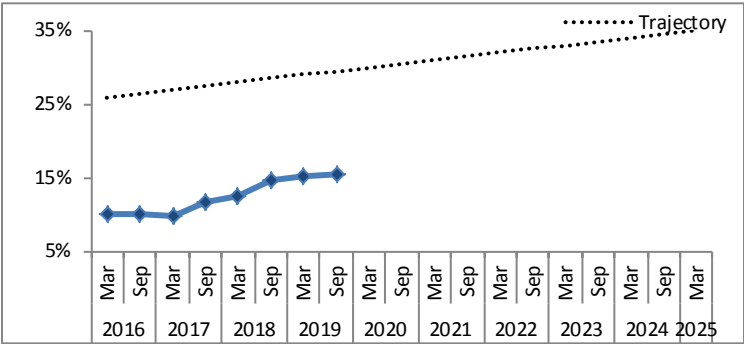
**Text not updated in April**  
A dip in performance in January 2020 due to acuity and volume of women. All mitigations in place and supernumerary coordinator maintained.

No benchmark comparator available

# To be in the top 20% of employers

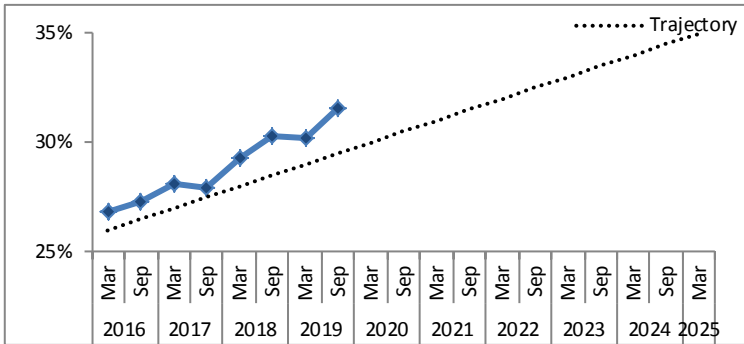
## Equality & Diversity

Metric / Status	Trend	Challenges and Successes	Benchmarks
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Reporting Suspended.

No benchmark comparator available



Reporting Suspended.

No benchmark comparator available

# To be in the top 20% of employers

## Health & Wellbeing

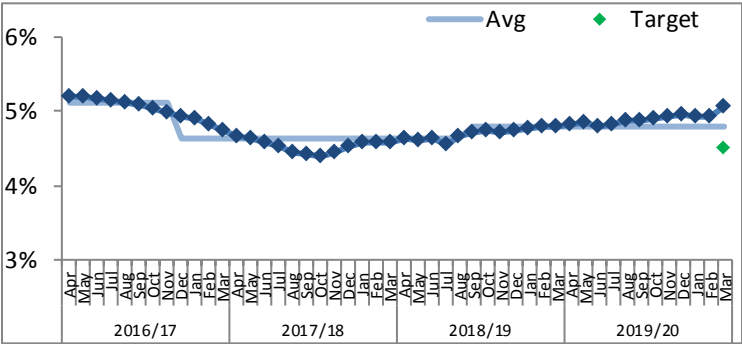
Metric / Status

Trend

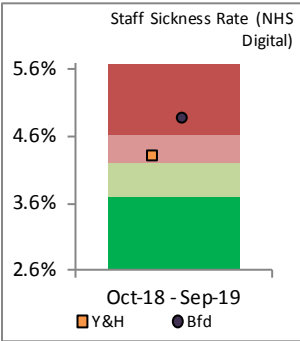
Challenges and Successes

Benchmarks

Staff Sickness Absence



The rolling 12 month sickness absence rate at the end of March 2020 was 5.07% with increases seen in all areas of the Trust. This figure does not include staff who are self-isolating or shielding.



# To collaborate effectively with local and regional partners

## Partnership

**Bradford Teaching Hospitals**  
NHS Foundation Trust

Metric / Status	Trend	Challenges and Successes	Benchmarks
	<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. The stakeholders managed within the framework are being evaluated to ensure those being managed are relevant and benefitting from the process. The creation of criteria to assess whether stakeholders should be included within the stakeholder engagement process are being created and once finalised will be used to test the conditions with account managers. The May 2020 update to Partnerships Committee will include the revised stakeholder list and details of the amended process.</p>		No benchmark comparator available
	<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 2019, and this has been approved by all partners. This sets out how decisions and collaboration will happen at 'place' in the future. A review of the health and care based programmes in BDC is complete, and a new structure for the programmes is planned for the start of the next financial year. The Trust is also contributing to 11 Community Partnerships across Bradford and starting to work with the 10 newly formed Primary Care Networks on joint service developments</p>		No benchmark comparator available
	<p>Partnerships Committee has advised that the 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 Integrated Care System. Outcomes from the WYAAT consultation process on the development of a West Yorkshire Secondary Care Strategy were reported to the WYAAT Programme Executive in February 2020. The Trust is supportive of the findings reported. The feedback included recommendations regarding next steps towards developing and refining the strategy. The WYAAT Programme Executive agreed to discuss these recommendations with their respective Trust teams before agreeing to the recommendations.</p>		No benchmark comparator available
	<p>The Acute Provider Collaboration (APC) programme between BTHFT and Airedale NHS Foundation Trust formally began with a clinical summit on 8 April 2019. A Project Management Office (PMO) led by a joint Executive lead is in place. Workshops have been held in some specialties, and programme governance, incorporating a Strategic Collaboration Board and Steering Group has been established to monitor and oversee progress. Four clinical leads for the programme as a whole have been recruited. A very successful second clinical summit took place in October 2019. The scope of programme in year one was streamlined in January 2020 to reflect the need for more prioritisation of resource, and to "go further faster"</p>		No benchmark comparator available

# To be a continually learning organisation

## Learning Hub, Research

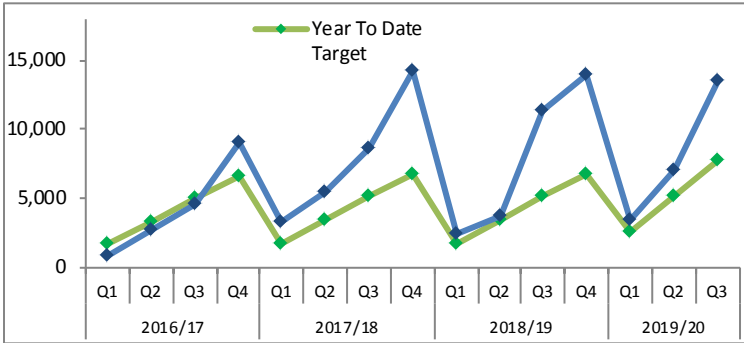
Metric / Status	Trend	Challenges and Successes	Benchmarks
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Learning Hub

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 2020/21.

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. All patient recruitment to trials has been paused for the Covid-9 period.

No benchmark comparator available



# To provide outstanding care for patients

## Governance

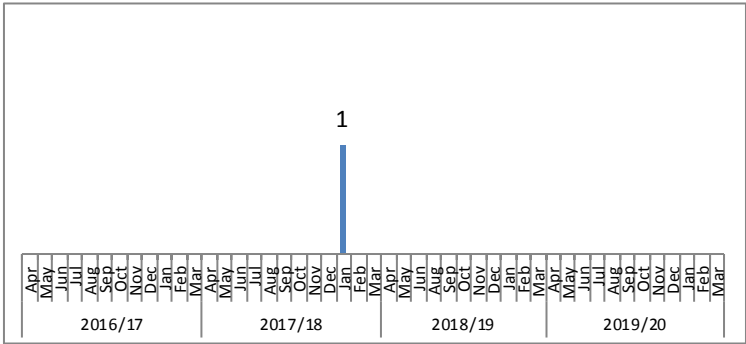


Metric / Status

Trend

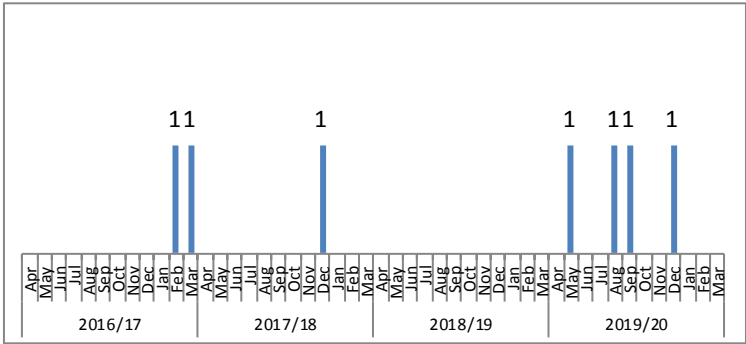
Challenges and Successes

Benchmarks



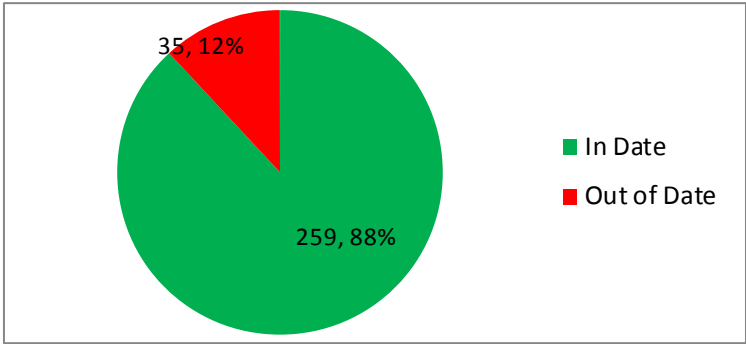
There were no Duty of Candour breaches to date in 2019/20.

No benchmark comparator available



There are no open incidents with the Information Commissioner’s Office.

No benchmark comparator available



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>11, 17%</div><div>53, 83%</div></div><div><div>■ Current rating =&gt;12 where current rating is higher than residual rating</div><div>■ Current rating =&gt;12 where current rating is not higher than residual rating</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	Red – Latest 2 points in a row above upper control limit, Amber – latest point above upper control limit, Green – Below upper control limit	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	Red Benchmark 3 standard deviations above mean, Amber 2 standard deviations above mean, Green within two standard deviations above mean	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	Red Benchmark 3 standard deviations above mean, Amber 2 standard deviations above mean, Green within two standard deviations above mean	4.7
Stillbirths	Number of stillbirths per 1,000 births and number of stillbirths over 500g per 1,000 births	Chief Medical Officer	Red > 7, Amber 5 - 7, Green < 5	To be confirmed
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 Medical Officer	Red bottom 25% of Trusts, Amber middle 50% of Trusts, Green Lowest 25% of trusts	2.4

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
<b>Patient Safety</b>				
<b>Never Events</b>	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
<b>Audit of WHO checklist</b>	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
<b>Clostridium Difficile (C. Diff)</b>	The number of cases either attributable or pending review.	Chief Nurse	Red >= 3, Amber = 2, Green <=1	3.9
<b>MRSA</b>	Counts of patients with Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia.	Chief Nurse	Per month: Red >= 1, Green 0	3.9
<b>CAUTI</b>	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
<b>Sepsis Patients antibiotics</b>	Percentage of patients who were found to have sepsis during the screening process and received IV antibiotics within 1 hour.	Chief Nurse	RAG criteria subjective – Executive informed.	To be confirmed
<b>Sepsis Patients Screened</b>	Percentage of patients screened for Sepsis	Chief Medical Officer	Red < 50%, Amber 50%-90%, Green >= 90%	5.0
<b>Serious Incidents</b>	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
<b>Falls with Harm</b>	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
<b>Falls with Severe Harm</b>	Falls with Harm classed as Severe	Chief Nurse	Red = reported for consecutive months, Amber = 1, Green = 0	4.3
<b>Pressure Ulcers Cat3+</b>	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
<b>Medicine Reconciliation</b>	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
<b>Missed Doses</b>	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

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
Patient Experience				
Friends and Family Test	The percentage of patients who strongly recommend the Trust.	Chief Nurse	RAG criteria subjective – Executive informed.	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	Red – off plan (adverse) Green on plan or better	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	Red - Rating of 4 Amber – Rating of 2 or 3 Green – Rating of 1	3.3
Delivery of Cash Plan	Delivery of cash against plan.	Director of Finance	Red Cash below £5m Amber Cash between £5m & £10m Green 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	Red > minus 14 days liquidity Amber - 0 days to minus 4 days liquidity Green – greater than 0 days liquidity	4.1
Bradford Improvement Plan	Bradford Improvement Plan progress against target.	Director of Finance	Red >10% off plan (adverse) Amber 0% - 10% off plan (adverse) Green – on plan or better	3.3

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
<b>Performance</b>				
<b>Emergency Care Standard</b>	Percentage of patients seen in A&E within 4 hours.	Chief Operating Officer	Red < 90%, Green >= 90%	2.4
<b>RTT 18 weeks Incomplete</b>	Percentage of patients waiting within 18 weeks on an incomplete pathway.	Chief Operating Officer	Red < 92%, Green >= 92%	3.9
<b>RTT 52 weeks waits</b>	Number of patients waiting more than 52 weeks.	Chief Operating Officer	Red > 0, Green = 0	4.0
<b>Cancer 2 week wait GP</b>	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
<b>Cancer Urgent 62 day GP</b>	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
<b>Cancer Urgent 62 day Screening</b>	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
<b>Full Blood Count acute wards 2 hours</b>	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
<b>Diagnostic Waits</b>	Percentage of patients who have waited less than 6 weeks for a diagnostic test.	Chief Operating Officer	Red < 99%, Green >= 99%	3.4
<b>Mixed Sex Breaches</b>	Number of occurrences of unjustified mixing in relation to sleeping accommodation.	Chief Operating Officer	Red > 0, Green = 0	5.0
<b>Radiology Turnaround Time OP</b>	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
<b>Radiology Turnaround Time Fast Track</b>	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
<b>Mission Critical Systems Uptime</b>	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
<b>Productivity</b>				
<b>Length of Stay</b>	The average length of stay for patients, in days.	Chief Operating Officer	Red Top 25% of Trusts, Amber 50-75% of Trusts, Green Better than mean	2.0
<b>Stranded Patients LoS &gt;=7</b>	The average number of patients (excluding Maternity) who have been in hospital 7 days or more.	Chief Operating Officer	Red >208, Amber 189-207, Green <= 189	4.1
<b>Super Stranded Patients LoS &gt;=21</b>	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
<b>Elective Day Case Rate</b>	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
<b>Bed Occupancy</b>	Average percentage of available beds which were occupied overnight.	Chief Operating Officer	Red >=95%, Amber 85-95%, Green <85%	2.3
<b>Discharges before 1pm</b>	Number of discharges from hospital which happened before 1 pm.	Chief Operating Officer	Red = Outside control limits, Green = Inside control limits	2.3
<b>New to Follow-up Ratio</b>	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 <sup>th</sup> Percentile England, Amber 50 – 25 <sup>th</sup> Percentile, Green Upper Quartile England	2.4
<b>DNA Follow-up</b>	This is the % of Follow-up Outpatient appointments where the patient does not attend.	Chief Operating Officer	Red < 50 <sup>th</sup> Percentile England, Amber 50 – 25 <sup>th</sup> Percentile, Green Upper Quartile England	2.6
<b>DNA New</b>	This is the % of New Outpatient appointments where the patient does not attend.	Chief Operating Officer	Red < 50 <sup>th</sup> Percentile England, Amber 50 – 25 <sup>th</sup> Percentile, Green Upper Quartile England	2.6
<b>Elective wait list</b>	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	New metric in a phase of trending therefore RAG criteria subjective. – Executive informed.	3.6
Harassment & Bullying outcomes	Percentage of Harassment and Bullying related Contacts resulting in disciplinary action.	Director of Human Resources	New metric in a phase of trending therefore RAG criteria subjective. – Executive informed.	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

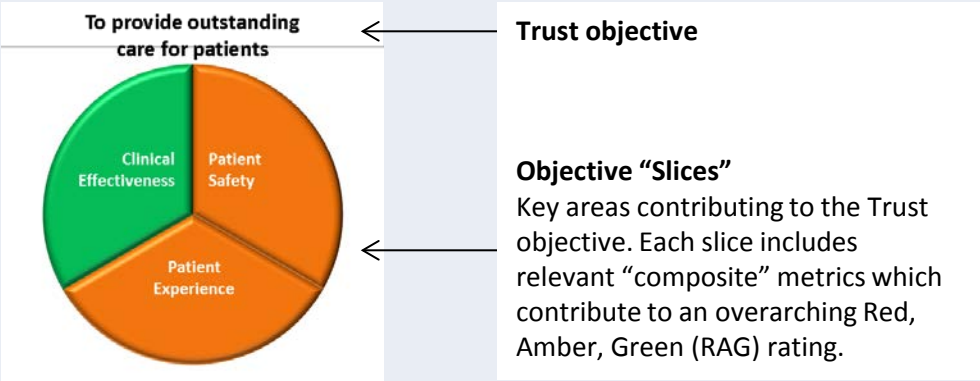
Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
Staffing				
Care Staff Shifts filled	Percentage of time care staff staffing hours are filled compared with planned.	Chief Nurse	Red < 80%, Amber 80% – 95%, Green > 95%	3.7
Care Staff Care Hours	Total of the actual number care staff 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	RAG Criteria being reviewed.	3.6
Maternity patients receiving 1:1 care	Percentage of maternity patients receiving one-to-one care	Chief Nurse	RAG Criteria being reviewed.	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
Frontline Staff Flu Vaccination	Flu vaccine uptake percentage amongst frontline staff	Director of Human Resources	RAG Criteria being reviewed.	To be confirmed

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
<b>To collaborate effectively with local and regional partners</b>				
<b>Partnership</b>				
<b>Stakeholder Engagement</b>	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
<b>Vertical Integration</b>	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
<b>Horizontal Integration</b>	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
<b>Airedale Collaboration</b>	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 be a continually learning organisation				
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 – Executive informed.	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



## RAG Rating Calculations

**Objective Slice RAG**

Weighted score of composite metric RAGs within a slice divided by the number of composite indicators within a slice.

**Red**  $\leq 1.5$

**Amber**  $> 1.5$

**Green**  $\Rightarrow 2.5$

**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.

## 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	Insufficient systems, processes or documentation available to provide assurance on the asset (i.e. dataset).
2	Limited systems, process and documentation are available and therefore assurance is limited.
3	Systems, processes and documentation are available and the asset has been locally verified to provide assurance.
4	Full systems, processes and documentation are available and the asset has been locally verified to provide assurance.
5	Full systems, processes and documentation are available and the asset has been independently verified with full assurance provided.

## 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.