

# **Integrated Dashboard**

## **Board of Directors**

31<sup>st</sup> March 2021



# Integrated Dashboard

## 31<sup>st</sup> March 2021

To provide outstanding care for patients



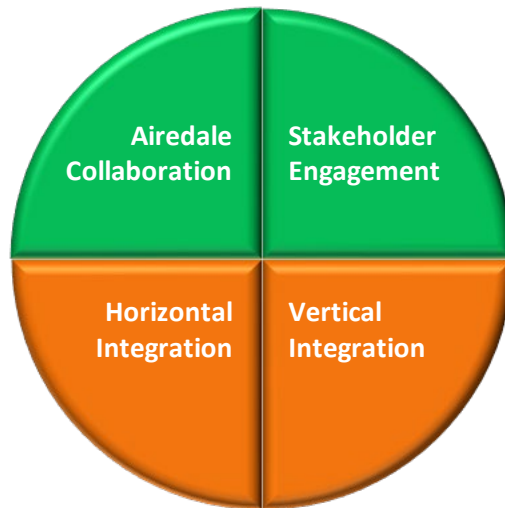
To deliver our key performance targets and financial plan



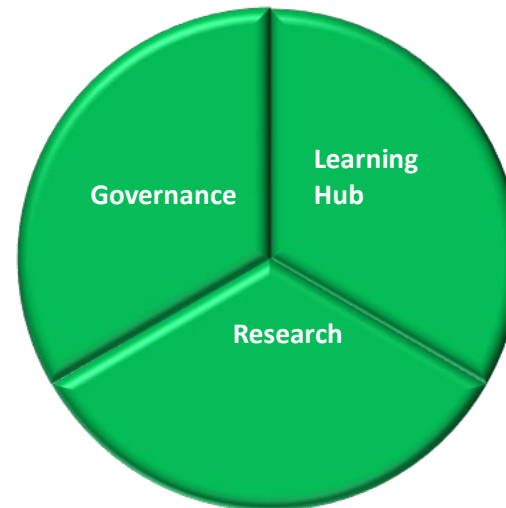
To be in the top 20% of employers



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
Crude Mortality		<p>There was a small rise at the end of 2020 in line with the second wave of COVID-19 and reduced elective activity. This has reduced in January 2021 but will continue to be monitored. A deeper analysis of our Healthcare Evaluation Dataset (HED) has commenced to understand the trusts Summary Hospital-level Mortality Indicator (SHMI) against the national data.</p>	<p>No benchmark comparator available</p>
Stillbirths		<p>Review process embedded in practice.</p>	<p>No benchmark comparator available</p>



# To provide outstanding care for patients

## Clinical Effectiveness

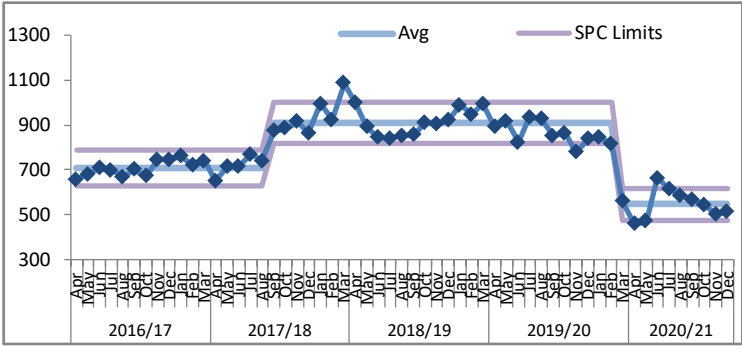


Metric / Status

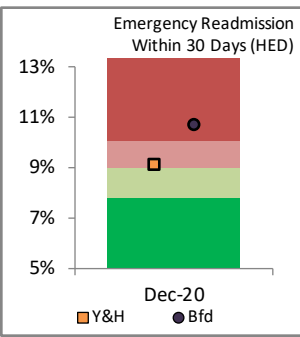
Trend

Challenges and Successes

Benchmarks



The fall in readmissions is likely to be as a consequence of COVID-19 and reduction in all other activity. It may be some months before we understand the 'steady state' for readmissions to consider re-launch the improvement programme.





# To provide outstanding care for patients

## Patient Safety

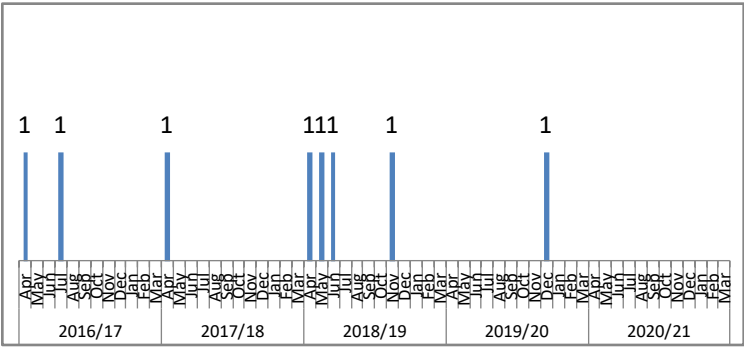
Metric / Status

Trend

Challenges and Successes

Benchmarks

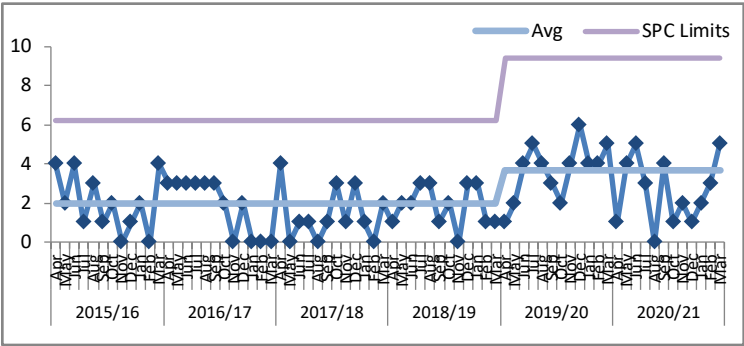
Never Events



In the year 2019/20 there was one never event. There have been no never events reported since December 2019.

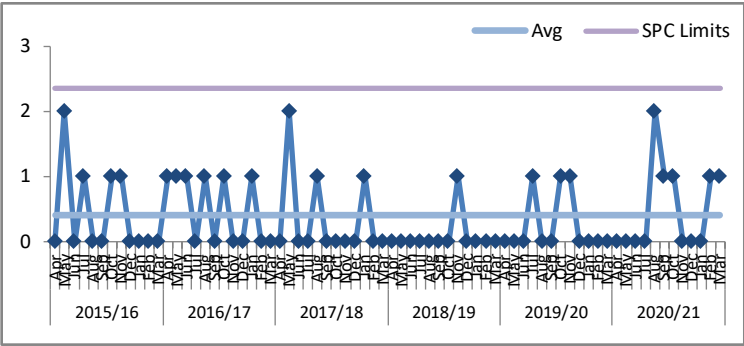
No benchmark comparator available

C Difficile

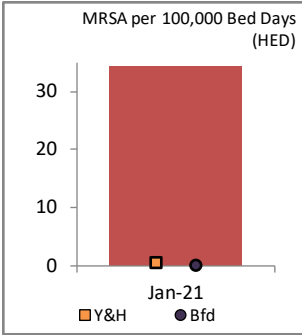


No lapses in care or outbreaks reported.

MRSA



We have seen an increase in line infections, reviews are in process





## To provide outstanding care for patients

### Patient Safety

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Sepsis patients receive antibiotics within an hour</div>		<p>Reduction in prompt antibiotic administration reflects the ongoing challenge of dealing with COVID-19 patients throughout the pandemic.</p>	<p>No benchmark comparator available</p>
<div>Sepsis Percentage of Patients Screened</div>		<p>Percentages are improving with continued improvement work.</p>	<p>No benchmark comparator available</p>
<div>Serious Incidents per 10,000 bed days</div>		<p>Learning from all Serious Incidents (SI's) investigations is presented and discussed at Quality academy and Regulation Committee.</p>	<p>No benchmark comparator available</p>



# To provide outstanding care for patients

## Patient Safety

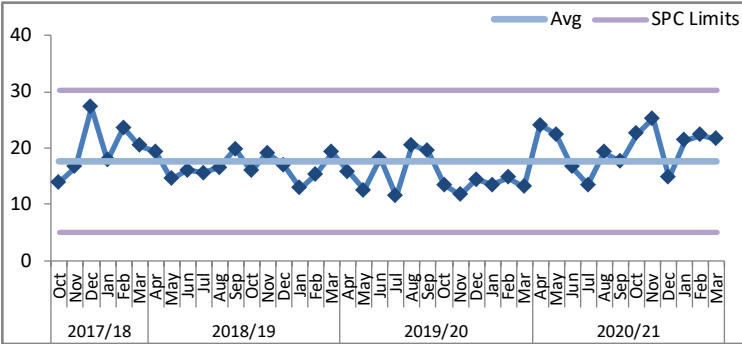
Metric / Status

Trend

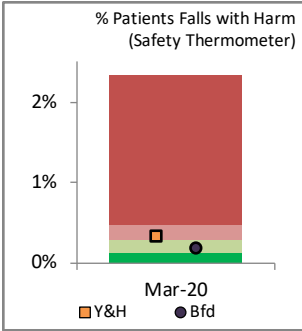
Challenges and Successes

Benchmarks

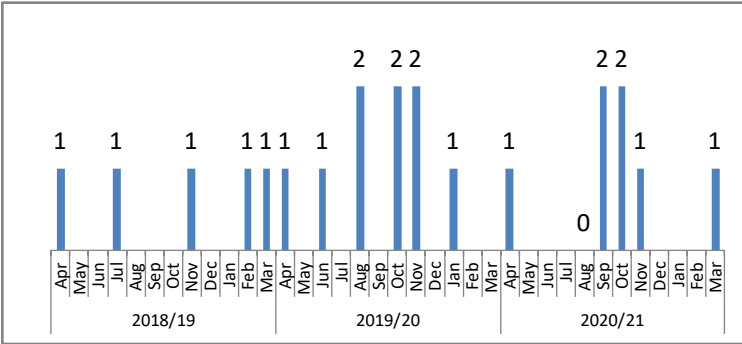
Falls with Harm per 10,000 bed days



Falls remain within Statistical Process Control (SPC) limits.



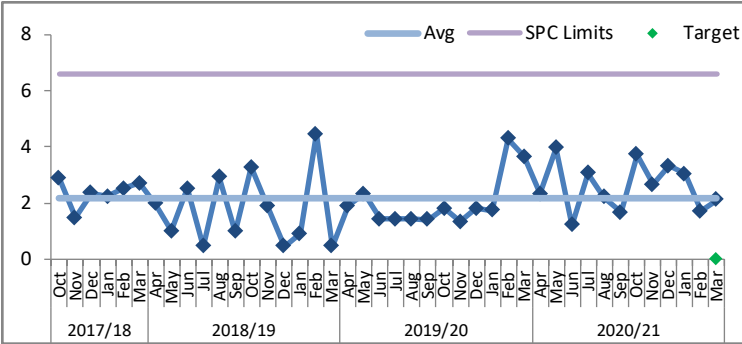
Falls with Severe Harm



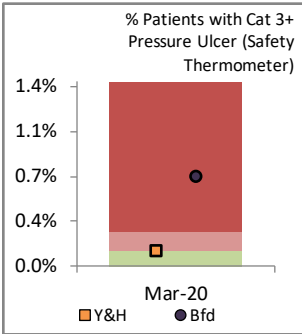
Full Root Cause Analysis (RCA) in progress.

No benchmark comparator available

Pressure Ulcers Cat 3+ per 10,000 bed days



Tissue Viability Nurse (TVN) team continues to work across clinical teams .





# To provide outstanding care for patients

## Patient Experience



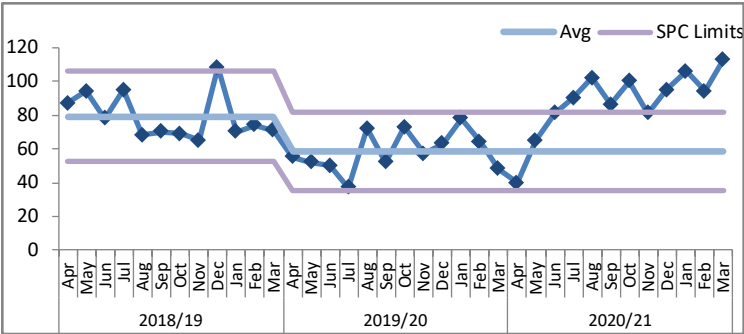
Metric / Status

Trend

Challenges and Successes

Benchmarks

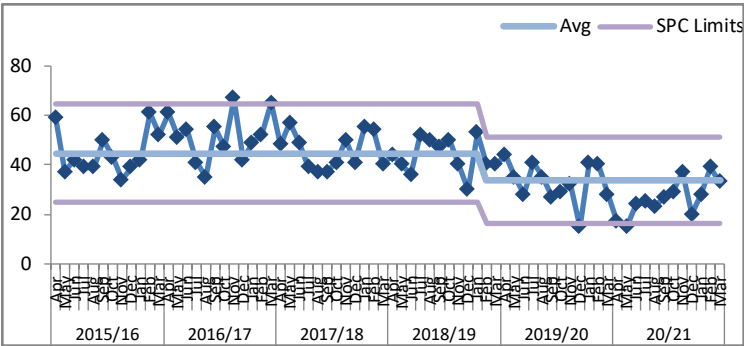
Night Time Discharges



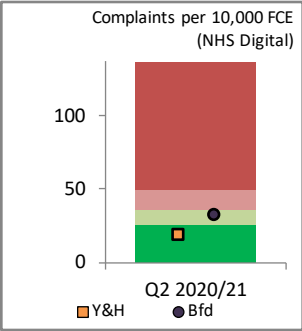
Regular audit is being undertaken to understand the data. Audit suggests data quality issues and not increasing night time discharges

No benchmark comparator available

Complaints



Complaints remain static.





# To deliver our key performance targets and financial plan

## Finance



### Bradford Teaching Hospitals

NHS Foundation Trust

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Delivery of Income and Expenditure Plan</div>		<p>The Trust has reported a break even position at Month 12, which is £1.8m favourable to the planned £1.8m deficit. Within this position, the Trust has been able to accommodate a significant increase to accrued liabilities for untaken annual leave in 2020/21 (£6.6m) and a provision for the Flowers legal case (£0.6m) due to the provision of non-recurrent funding streams from NHS England/Improvement specifically for these items.</p> <p>This is the draft unaudited position which will not be confirmed until the statutory audit has concluded.</p>	<p>No benchmark comparator available</p>
<div>Delivery of Cash Plan</div>		<p>Closing cash is £75m which is £44.5m above plan (£30.5m). Extra cash of £29.2m has been generated from operating activities including increases of £22.2m to payables balances and £8.9m deferred income. A further £4.8m has been generated on investment to the capital programme due to less than planned cash spend. Cash of £10.2m was generated from financing activity due to receipt of Public dividend capital (PDC) funding to fund the capital programme.</p>	<p>No benchmark comparator available</p>



# To deliver our key performance targets and financial plan

## Finance



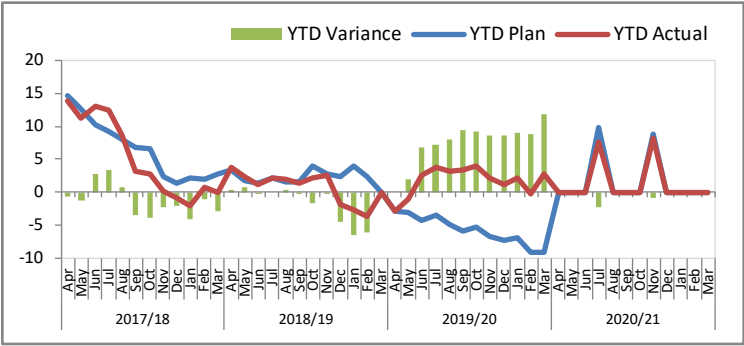
Bradford Teaching Hospitals  
NHS Foundation Trust

Metric / Status

Trend

Challenges and Successes

Benchmarks



Year to date (YTD) liquidity is 5.5 days which is 6.6 days higher than plan and an in year decrease of 1.2 days from the opening balance. The higher than plan balance is due to better than planned working capital due to higher than planned income and expenditure surplus and slippage on Trust funded capital schemes.

No benchmark comparator available



# To deliver our key performance targets and financial plan

## Performance

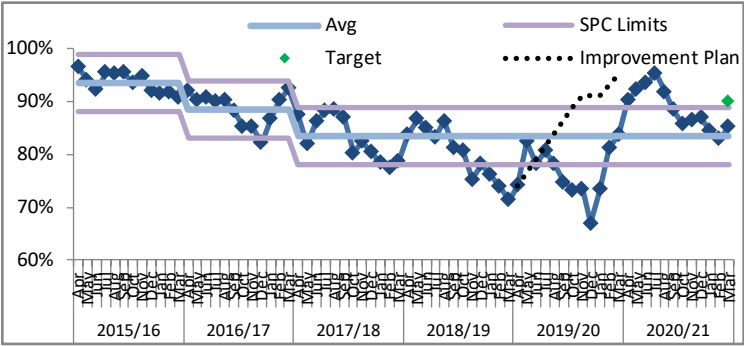
Metric / Status

Trend

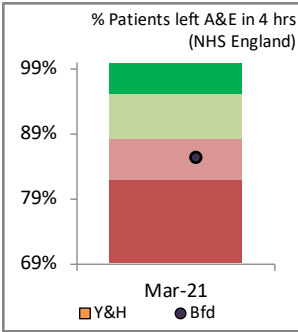
Challenges and Successes

Benchmarks

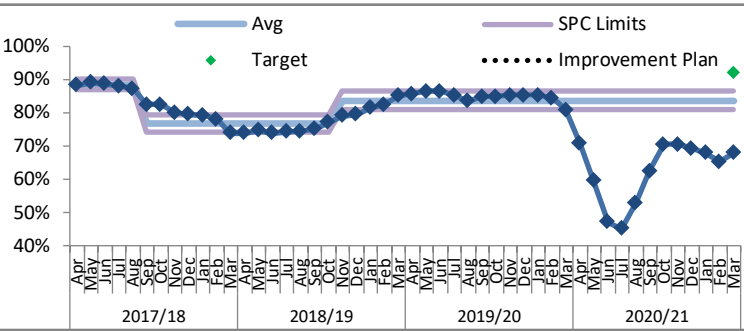
Emergency  
Care  
Standard



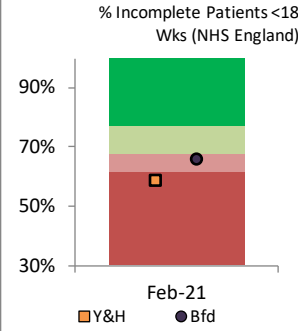
Emergency Care Standard (ECS) performance was at 85.41% for March 2021, which is in line with the peer average but slightly below the England average. This performance is for type 1 only as the GP stream has moved off site – inclusion of these attendances as type 3 would increase overall performance by an average of 1.25%. The use of see and treat and same day emergency care (SDEC) pathways are helping to sustain higher ECS performance than that seen in 2019/20. Type 1 attendances were above historic levels in March and have increased further in April 2021.



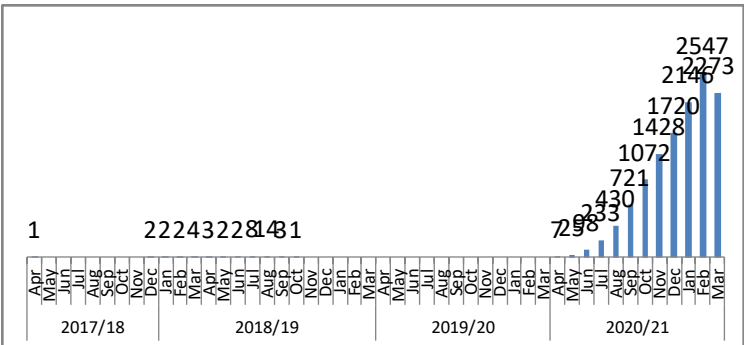
RTT 18 Week  
Incomplete



Referral to Treatment (RTT) performance was 67.81% in March 2021. This continues to reflect the loss of elective capacity accompanying the Trust's response to COVID-19 and demand for the Trust's services is increasing. February and March inpatient capacity was impacted by an electrical fire affecting 2 wards and 4 theatres. Our performance is in line with other Trusts across the region.



RTT 52  
Week Wait



The Trust is forecasting 2,273 incomplete 52 week waits for March 2021. All long waits have been reviewed using clinical prioritisation guidelines and the daily review of management plans for patients waiting over 40 weeks continues. Services are also transferring long waits to the independent sector under revised contractual arrangements. To ensure no clinically urgent cases wait longer than necessary but due to ongoing COVID-19 pressures treatment capacity will continue to be allocated based on clinical urgency. The Trust is engaged with the national clinical validation programme and will support patients in understanding their options.

No benchmark comparator available



# To deliver our key performance targets and financial plan

## Performance



Bradford Teaching Hospitals  
NHS Foundation Trust

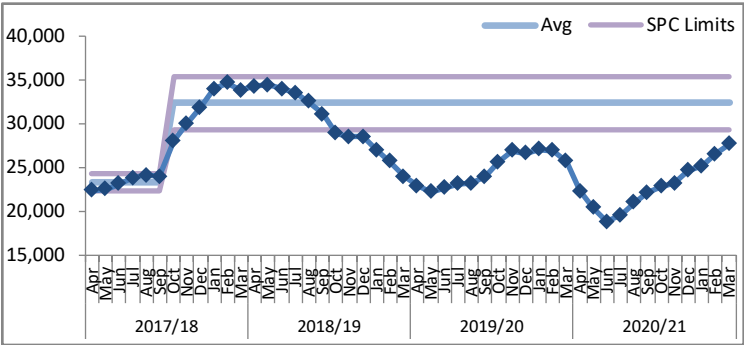
Metric / Status

Trend

Challenges and Successes

Benchmarks

Elective  
Waiting  
List



The total elective waiting list is forecast to increase by 1,363 during March 2021 in line with a growth in clock starts during this period.

No benchmark comparator available



# To deliver our key performance targets and financial plan

## Performance

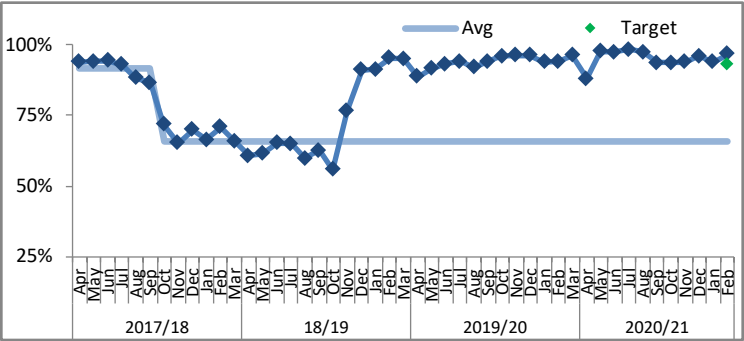
Metric / Status

Trend

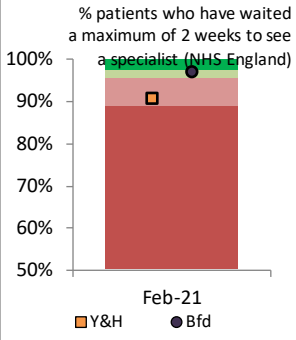
Challenges and Successes

Benchmarks

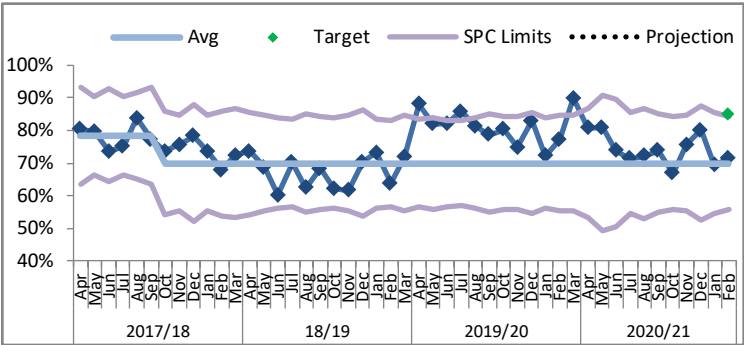
Cancer  
2 Week  
GP



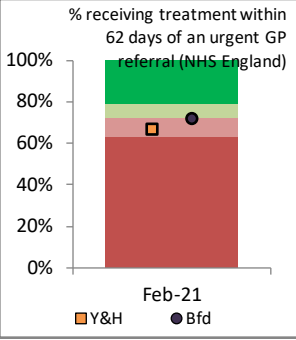
February 2021 performance against the 2 Week-Wait Cancer standard was 96.82% with tumour groups continuing to prioritise capacity for Cancer referrals. March 2021 performance is also expected to also meet this standard. In comparison to other providers in Yorkshire and Humber our performance remains above average.



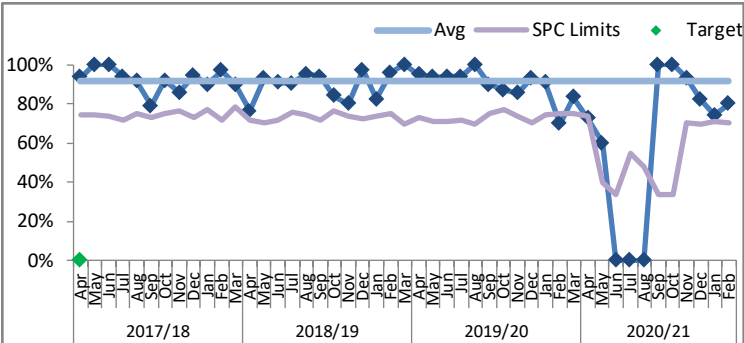
Cancer  
62 Day  
Urgent GP



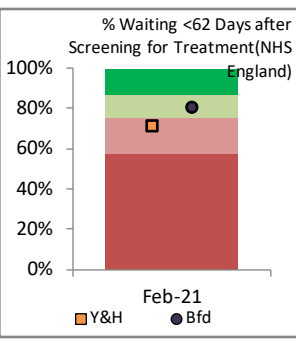
Cancer 62 Day First Treatment performance for February 2021 was 71.28%. Diagnostic and surgical capacity is being prioritised in support of long cancer waits created during the first wave of COVID-19. Improvements in time to diagnosis and decision to treat can be noted and the total waiting list over 62 days has reduced from 177 in July 2020 to 34 at the end of March 2021. Performance will remain below target whilst long waiters are being treated.



Cancer  
62 Day  
Screening



Performance for this indicator was 80% in February 2021. The breaches were due to complexity of pathways, patient concordance, and delays in diagnosis.





# To deliver our key performance targets and financial plan

## Performance



### Bradford Teaching Hospitals

NHS Foundation Trust

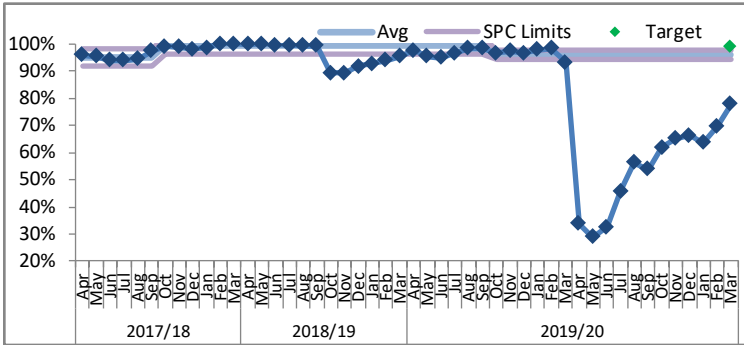
Metric / Status

Trend

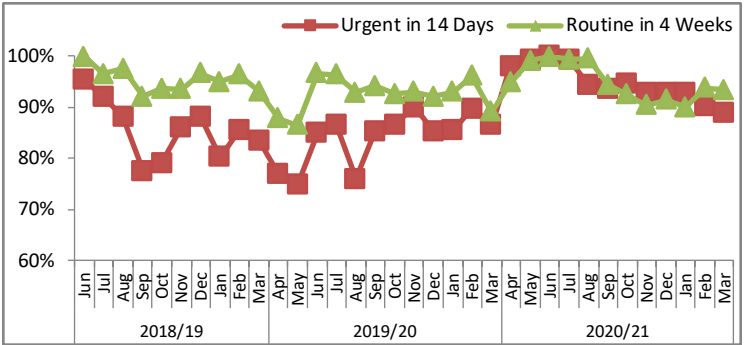
Challenges and Successes

Benchmarks

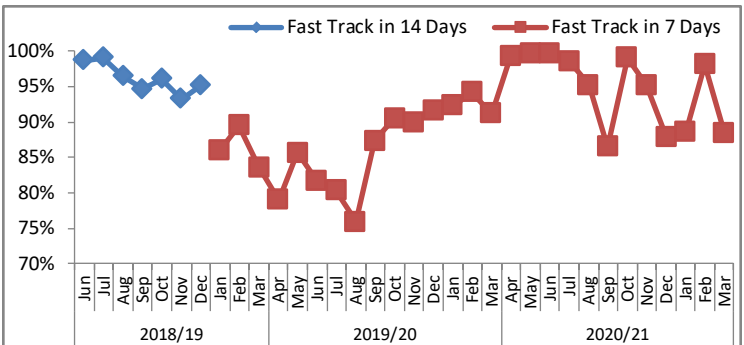
Diagnostic Waits



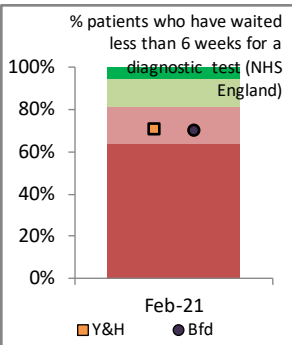
Radiology Turnaround Time Outpatients



Radiology Turnaround Time Frast Track



March 2021 performance improved to 77.70%. Endoscopy and Echocardiography performance remains challenged which is impacting on our overall diagnostic position. This is a national/regional issue and we continue to work with the independent sector and partners at a place based level.



No benchmark comparator available

Turnaround times (scan to report) have reduced in recent months but improvements in time from request to scan mean overall performance from request to report has not been negatively impacted.

Turnaround times reduced during March 2021 with additional sessions planned to recover the position in April.

No benchmark comparator available



# To deliver our key performance targets and financial plan

## Productivity

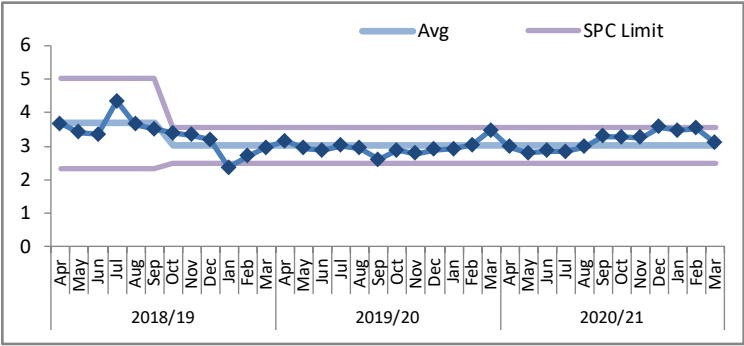
Metric / Status

Trend

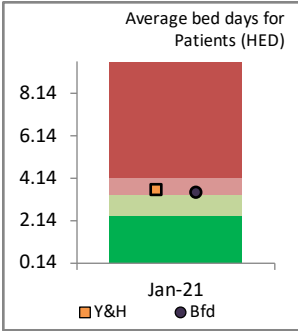
Challenges and Successes

Benchmarks

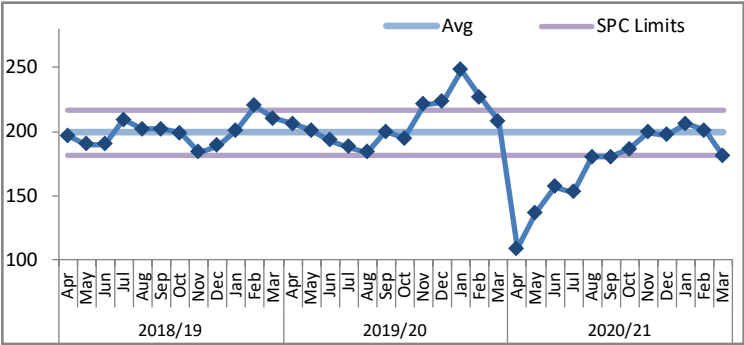
Length of Stay



Average length of stay (LoS) reduced and remains within control limits.



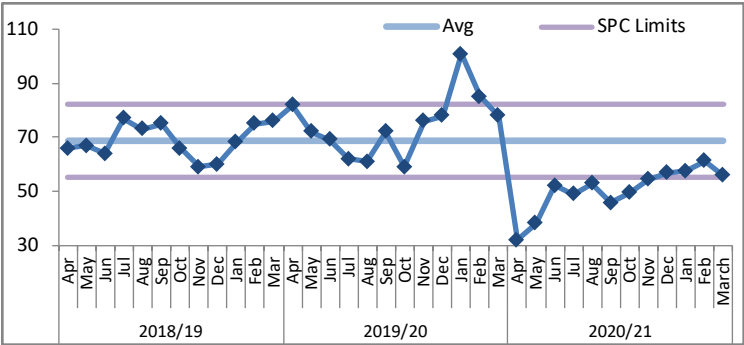
Stranded Patients  
Length of Stay  
>= 7 days



The weekly multi-disciplinary (MDT) review meeting of patients above 7 days length of stay remains in place. Numbers have reduced as COVID-19 spells have also reduced.

No benchmark comparator available

Super Stranded Patients  
Length of Stay  
>= 21 days



The review of patients over 21 day LoS is being conducted 5 days a week by the command centre team, therapies and the Multi-agency Integrated Discharge Team (MAIDT) in order to implement rapid support that may facilitate an earlier discharge. Performance has improved during March 2021. The overall position remains favourable when compared to the same point last year.

No benchmark comparator available



# To deliver our key performance targets and financial plan

## Productivity

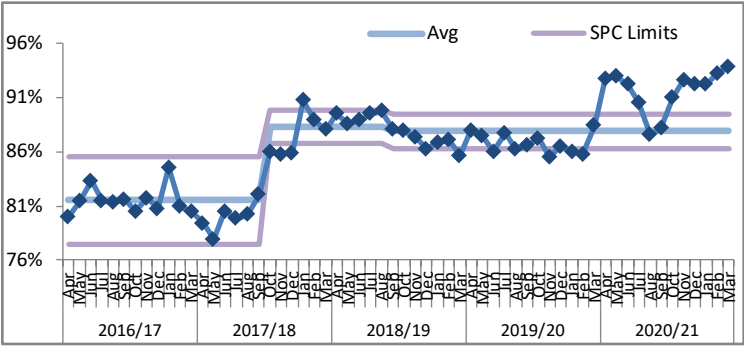
Metric / Status

Trend

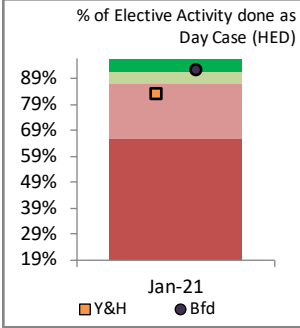
Challenges and Successes

Benchmarks

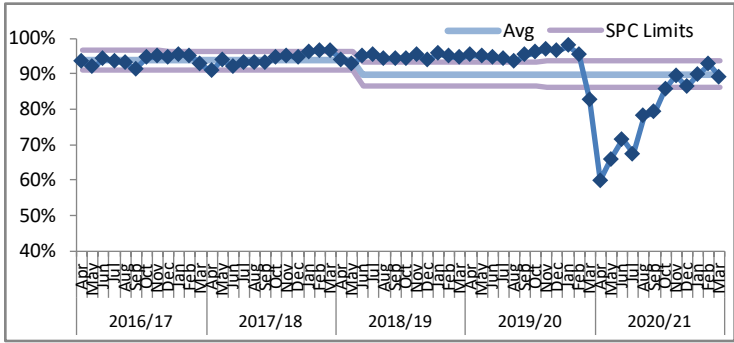
Elective Day Case Rate



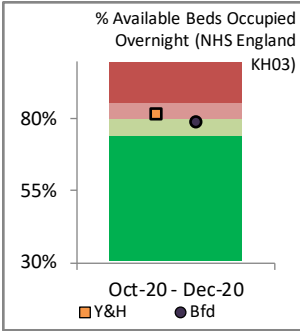
Day case rates continue to be above the national and regional average. Elective spells remain lower than plan due to theatre and elective ward capacity whilst day case activity is increasing.



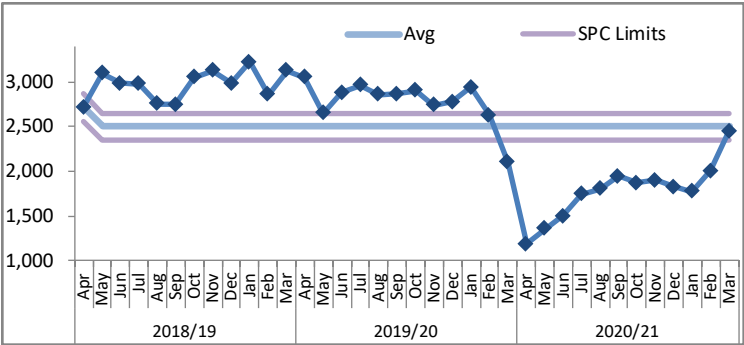
Bed Occupancy



Bed occupancy remains below pre-COVID-19 levels however there has been an increase since August 2020 which is in line with the increase in the number of Accident and Emergency (A&E) attendances (and subsequent admissions). Ward configuration has been adapted to provide red and green separation of patients meaning occupancy above 85% presents operational challenges on patient placement and flow.



Discharges before 1pm



The percentage discharged before 1pm remains under review with a focus on earlier discharge maintained to facilitate patient flow. Volumes in February and March 2021 have increased although the percentage before 1pm remains consistently within control limits.

No benchmark comparator available



# To deliver our key performance targets and financial plan

## Productivity



### Bradford Teaching Hospitals

NHS Foundation Trust

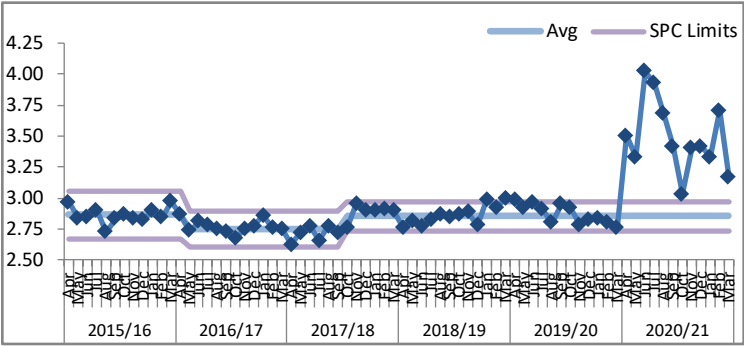
Metric / Status

Trend

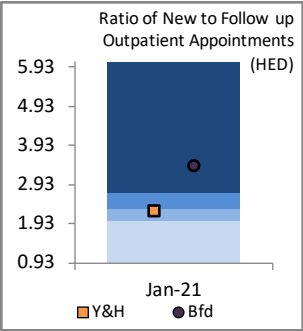
Challenges and Successes

Benchmarks

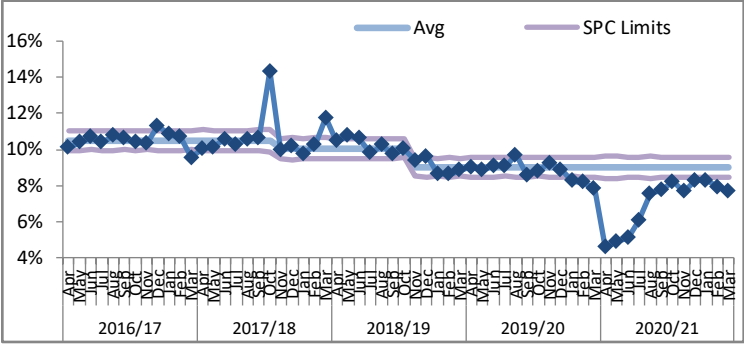
New to Follow Up Ratio



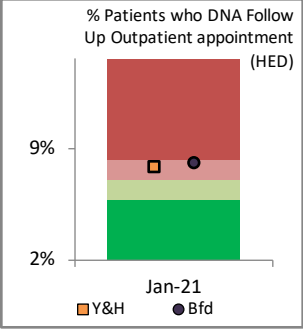
The use of video and telephone clinics in response to COVID-19 has impacted a number of outpatient measures including the new to follow up ratio. As new clinic templates are built and become operational this data will improve. Template updates will be complete by May 2021.



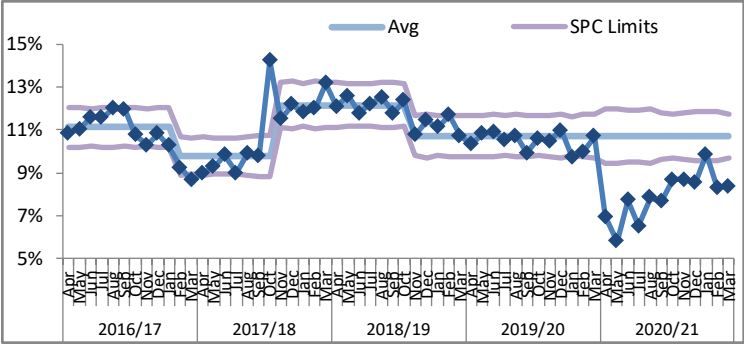
Did not Attend Follow Up



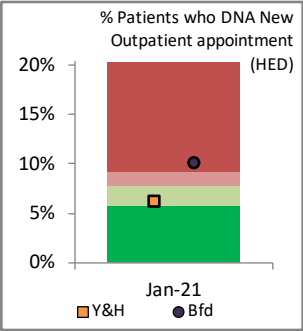
Did not attend (DNA) rates also appear to have been impacted by changes made in response to COVID-19, particularly the change from face to face to video or telephone contact.



Did not Attend New



Did not attend (DNA) rates also appear to have been impacted by changes made in response to COVID-19, particularly the shift from face to face to video or telephone contact.



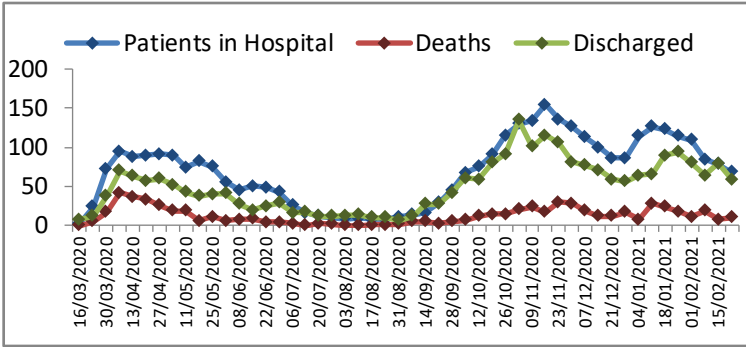


Metric / Status

Trend

Challenges and Successes

Benchmarks



COVID-19 demand reduced further in March 2021. As lockdown measures ease it is forecast that transmission rates will increase and hospital demand may increase again during April and May 2021, the latest position supports this forecast trend.

No benchmark comparator available



## To be in the top 20% of employers

### Engagement

Metric / Status	Trend	Challenges and Successes	Benchmarks																												
<div>Contacts with Advocacy service</div>	<table><thead><tr><th>Period</th><th>Percentage</th></tr></thead><tbody><tr><td>Apr 18 - Sep 18</td><td>0.53%</td></tr><tr><td>Oct 18 - Mar 19</td><td>0.74%</td></tr><tr><td>Apr 19 - Sep 19</td><td>0.99%</td></tr><tr><td>Oct 19 - Mar 20</td><td>0.46%</td></tr><tr><td>Apr 20 - Sep 20</td><td>0.72%</td></tr><tr><td>Oct 20 - Mar 21</td><td>0.48%</td></tr></tbody></table>	Period	Percentage	Apr 18 - Sep 18	0.53%	Oct 18 - Mar 19	0.74%	Apr 19 - Sep 19	0.99%	Oct 19 - Mar 20	0.46%	Apr 20 - Sep 20	0.72%	Oct 20 - Mar 21	0.48%	Contacts with the staff advocacy service continue to fluctuate and are down by about 35% from the last 6 monthly reporting period. However, 48% of all contacts continue to be resolved informally. The Trust is currently reviewing its approach to Civility in the workplace and this will play a crucial role in the wider culture change required for this area. The staff advocacy service will be refreshed as part of this review. The Trust is also in the process of developing an internal mediation service with the aim of launching this in July 2021. Next update October 2021 (for the period 01/04/21 to 30/09/21).	No benchmark comparator available														
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<div>Harassment &amp; Bullying Outcomes</div>	<table><thead><tr><th>Period</th><th>No Case to Answer (%)</th><th>Resolved Informally (%)</th><th>Disciplinary Action (%)</th></tr></thead><tbody><tr><td>Apr 18 - Sep 18</td><td>38%</td><td>5%</td><td>50%</td></tr><tr><td>Oct 18 - Mar 19</td><td>18%</td><td>10%</td><td>42%</td></tr><tr><td>Apr 19 - Sep 19</td><td>8%</td><td>22%</td><td>15%</td></tr><tr><td>Oct 19 - Mar 20</td><td>22%</td><td>32%</td><td>28%</td></tr><tr><td>Apr 20 - Sep 20</td><td>0%</td><td>15%</td><td>15%</td></tr><tr><td>Oct 20 - Mar 21</td><td>5%</td><td>18%</td><td>12%</td></tr></tbody></table>	Period	No Case to Answer (%)	Resolved Informally (%)	Disciplinary Action (%)	Apr 18 - Sep 18	38%	5%	50%	Oct 18 - Mar 19	18%	10%	42%	Apr 19 - Sep 19	8%	22%	15%	Oct 19 - Mar 20	22%	32%	28%	Apr 20 - Sep 20	0%	15%	15%	Oct 20 - Mar 21	5%	18%	12%	Although the number of harassment and bullying related investigations is higher in this period than in the previous 6 months, this is only by 5 cases and compares favourably with the same period last year (01/10/19 to 31/03/20) when cases were 58% higher (31 cases compared to 18 cases). There continues to be some scope for resolving more issues informally, with 4 out of 8 cases (those with outcomes) with an outcome of either 'no case to answer' or 'informal action taken'. The ongoing work around Civility in the Workplace may help to deal with issues more informally with focus on 'nipping things in the bud' and prevent some of these cases being taken formally. Next update October 2021 (for the period 01/04/21 to 30/09/21).	No benchmark comparator available
Period	No Case to Answer (%)	Resolved Informally (%)	Disciplinary Action (%)																												
Apr 18 - Sep 18	38%	5%	50%																												
Oct 18 - Mar 19	18%	10%	42%																												
Apr 19 - Sep 19	8%	22%	15%																												
Oct 19 - Mar 20	22%	32%	28%																												
Apr 20 - Sep 20	0%	15%	15%																												
Oct 20 - Mar 21	5%	18%	12%																												



# To be in the top 20% of employers

## Staffing

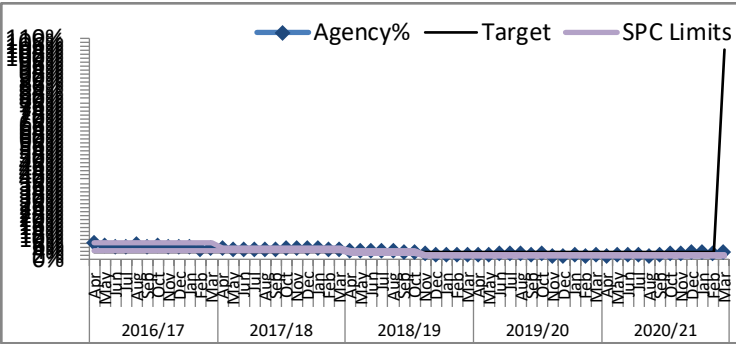
Metric / Status

Trend

Challenges and Successes

Benchmarks

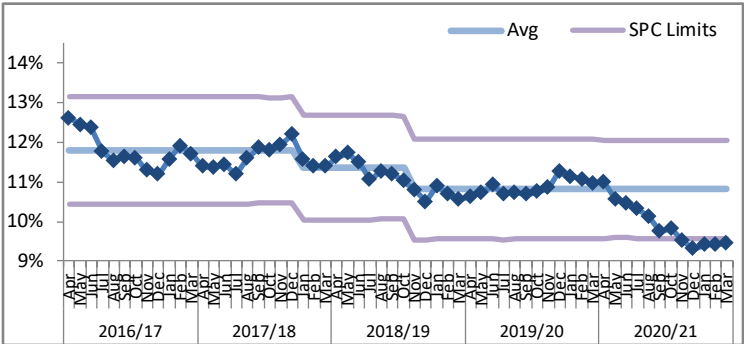
Use of Agency Staff



We have seen a slight increase in both bank and agency deployment in the registered nursing & midwifery staff group. There was growth too in the number of bank shifts worked by Healthcare Assistants in March 2021. Annual Leave payments are paid in March if not claimed throughout the year so this is also reflected in a sharp increase in Full Time Equivalents (FTE) paid for. Agency staffing across the Medical and Dental staff group has remained static. Allied Health Professional bank and agency use has also remained unchanged. Due to COVID-19 we have continued to use agency in the Administrative and Clerical group due to additional resources to being deployed in the Trust during the pandemic and also due an increased requirement to cover the door security.

No benchmark comparator available

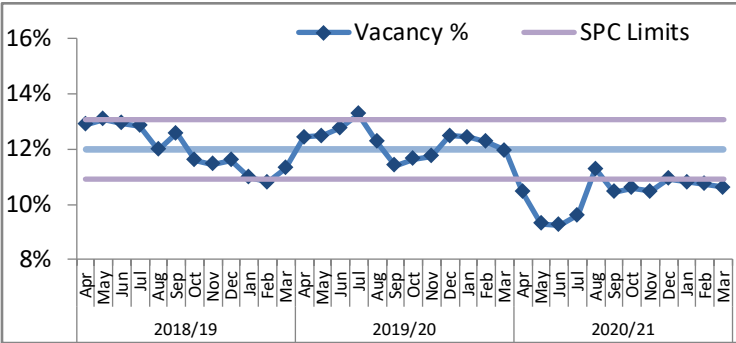
Staff Turnover



The Trust Turnover rate has increased slightly to 9.44% in March 2021 from 9.43% in February 2021. Increases were seen in all areas with the exception of Unplanned Care and Estates and Facilities which both showed decreases.

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



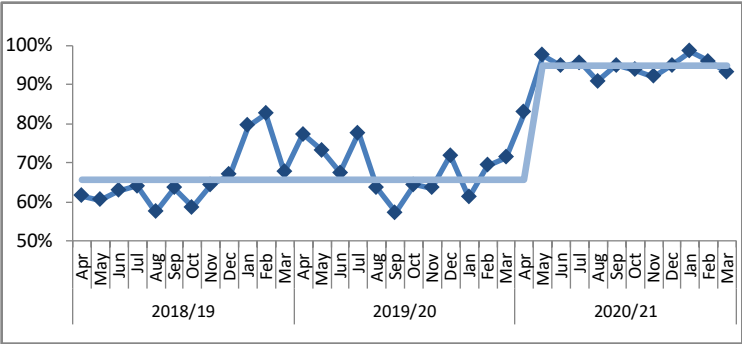
Metric / Status

Trend

Challenges and Successes

Benchmarks

Maternity patients receiving 1:1 care



The number is consistently over 90%.

No benchmark comparator available



## To be in the top 20% of employers

### Equality & Diversity

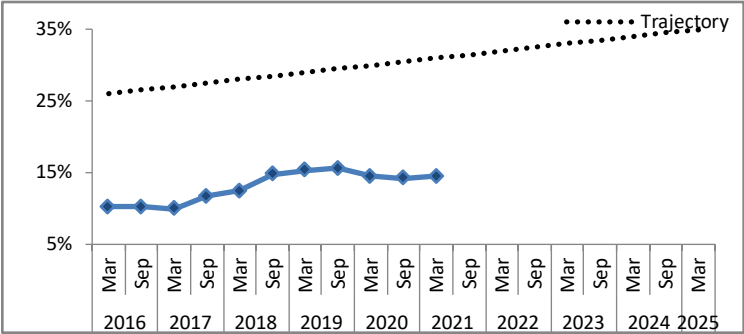
Metric / Status

Trend

Challenges and Successes

Benchmarks

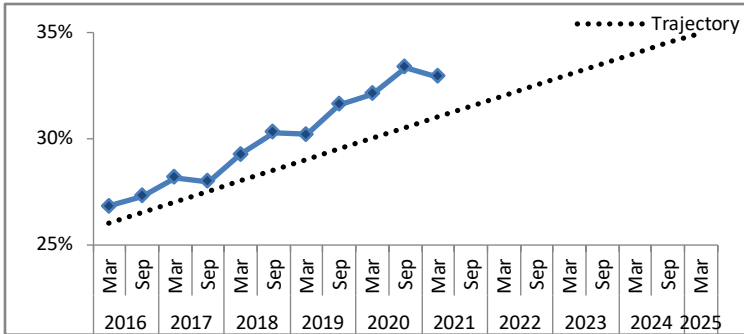
BAME Senior Leaders



In October 2020 the Trust appointed a new Chief Operating Officer from a BAME background. This means we now have BAME representation on our Executive Management Team and increases the BAME representation of our Trust Board. This Executive representation will help to accelerate our progress of having a senior workforce reflective of the local population (35% by 2025), which currently stands at 14.45%. In addition to this, we are taking a positive action and targeted approach in the recruitment to senior leadership roles. For example; we recently developed a 6-month secondment to an Associate Director (8b) role and a BAME colleague was successfully appointed. We continue to focus our efforts in supporting senior BAME colleagues in various leadership development programmes, including 2 who have joined the West Yorkshire and Harrogate BAME Fellowship and 5 who have joined the REACH mentorship programme. With our continued focussed efforts we are on a unique journey in ensuring our workforce reflects the communities that we serve across all levels of the organisation. Next update October 2021 (for the period 01/04/21 to 30/09/21).

No benchmark comparator available

BAME Workforce



The proportion of BAME staff in the workforce has fluctuated slightly over the last 6 months, but our trajectory continues to take us 4% ahead of our target of having a workforce reflective of the local population (35%) by 2025. Current work ongoing to raise the profile of Race Equality in the Trust, an Equality Impact Assessment and review of our Recruitment & Selection practices and an exploration of best practice approaches to improving the culture in the organisation should help in ensuring we continue to be an outstanding employer in this respect. Next update October 2021 (for the period 01/04/21 to 30/09/21).

No benchmark comparator available



# To be in the top 20% of employers

## Health & Wellbeing

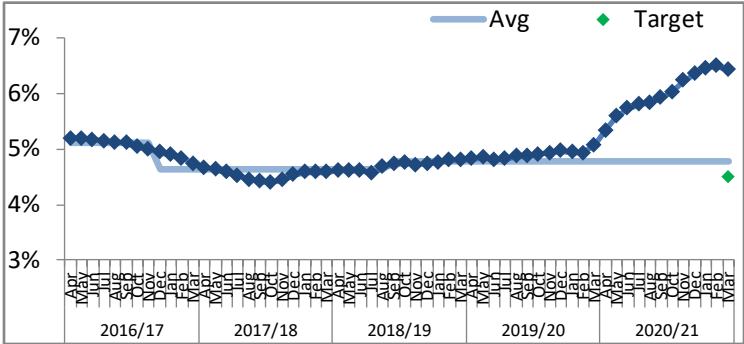


Metric / Status

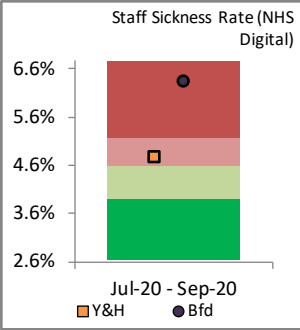
Trend

Challenges and Successes

Benchmarks



The rolling 12 month sickness absence rate at the end of March 2021 was 6.42% with decreases seen in all areas of the Trust apart from Pharmacy and Research which both showed slight increases. This figure does not include staff who are self-isolating which is 1.67% in March 2021. COVID-19 related sickness has reduced from 1.17% in February to 0.82% in March 2021.





# To collaborate effectively with local and regional partners

## Partnership

Metric / Status	Trend	Challenges and Successes	Benchmarks
	<p>The stakeholder management work programme has not been operating during the COVID-19 response. We are looking at how we manage our “partnerships” as there is now a change of focus onto Act as One and West Yorkshire &amp; Harrogate Healthcare Partnership (WYHHCP) and Bradford Health and Care Partnership Board (BHCPB) rather than necessarily “vertical” or “horizontal”. As such, we’ll need to rethink stakeholder management more generally. Nonetheless there are already some good examples of how in future we might invest more in managing the relationship with a few key partners, for example our Chief Nurse dialogue with the Care Quality Commission, or our Director of Strategy partnering with the University’s Working Academy (responsible for much of our digital development and video film-making).</p>		No benchmark comparator available
	<p>The Trust signed a ‘Strategic Partnering Agreement’ with 13 partners across Bradford District and Craven at the end of March 2019. This SPA has recently been reviewed following its first year in existence. The review assessed where the ICP is now and what the next steps should be particularly around how decisions are made. Linking into this the Bradford Health and Care Partnership Board (BHCPB) has most recently discussed and reflected upon whether the ICP’s current strategic direction is in line with the White Paper. A challenge to better understand the complexities of the changes outlined by the White Paper has been identified along with an opportunity for further engagement to allow system priorities to be agreed. THE BHCPB oversees the Act as One programmes and has commissioned and received a paper to summarise how each individual Act as One programme is considering and addressing health inequalities in their future plans.</p>		No benchmark comparator available
	<p>The Trust is working with partner organisations across the Integrated Care System (ICS) to assess the impact of the White Paper across the whole ICS. In addition we continue to work with partners to oversee the roll out of the COVID-19 vaccination programme. Work is also underway to respond to the NHS Operational Planning guidance on a ICS scale. Plans aimed at restart and recovery, whilst managing residual waves of COVID-19 are also being devised and implemented. These are being informed by engagement work to gather people’s health and care experiences during the COVID-19 pandemic and through a work stream to understand the direct and indirect impacts of COVID-19 on different population groups. Other projects currently underway include shared solutions for imaging services and for pathology.</p>		No benchmark comparator available
	<p>Collaboration between Bradford Teaching Hospitals Foundation Trust and Airedale NHS Foundation Trust remains a high priority for our organisation. Work previously undertaken through the collaboration now informs the Act as One programme, with the benefit of including a wider range of partner organisations, whilst the relationship between the trusts remains important in ensuring the cohesive delivery of acute services.</p>		No benchmark comparator available



# To be a continually learning organisation

## Governance



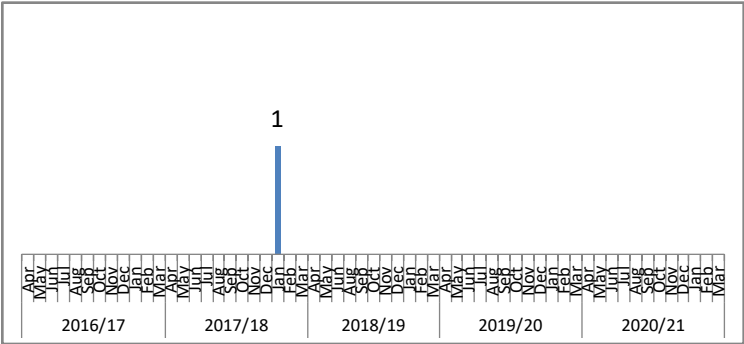
Metric / Status

Trend

Challenges and Successes

Benchmarks

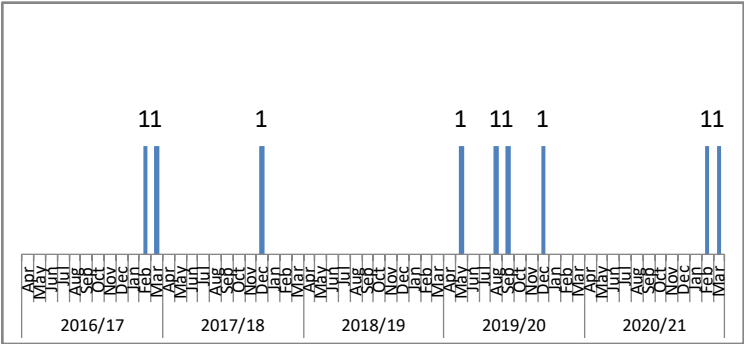
Duty of Candour



No Duty of Candour breaches since January 2018. Suggest removing from dashboard and report via Serious Incident (SI) report. This statement remains the case; it is reported in the monthly SI report.

No benchmark comparator available

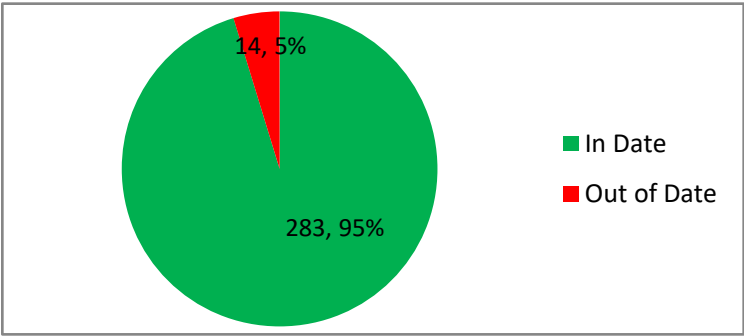
Information Governance Breaches



There is 1 reportable breach (March) currently with the Information Commissioners Office (ICO) ref WR107600. It involves a member of staff inappropriately accessing patient data through Trust systems. Appropriate actions have been taken and senior staff were notified in March 2021. An investigation continues. There is no decision from the ICO to date.

No benchmark comparator available

Out of date Policies



Total Trust wide policies stands at 297. 14 Policies are at present outside their review date. There is 95% compliance (against target of 95%). Focussed work continues to bring out of date policies into date and no policy is more than six months past its review date.

No benchmark comparator available



# To be a continually learning organisation

## Governance



Metric / Status	Trend	Challenges and Successes	Benchmarks
<div><div>Risks not Mitigated</div></div>	<div><div><div><div>29, 91%</div><div>3, 9%</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></div>	<div>The Care Groups are reviewing and updating their local risks. Care group and Clinical Business Unit (CBU) governance meetings are restarting.</div>	<div>No benchmark comparator available</div>



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
<b>Patient Experience</b>				
<b>Friends and Family Test</b>	The percentage of patients who strongly recommend the Trust.	Chief Nurse	RAG criteria subjective – Executive informed.	2.6
<b>Night time transfers</b>	The number of non-clinical bed moves out of hours.	Chief Nurse	Red > 0, Green = 0	2.4
<b>Night time discharges</b>	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
<b>Complaints</b>	Number of complaints.	Chief Nurse	Red >= 50, Amber 40-49, Green < 40	4.7
<b>Complaints closed</b>	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



## Glossary Continued

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
<b>Covid-19</b>				
<b>COVID-19</b>	For Covid-19 patients – average number in hospital, number who died, number discharged to usual place of residence	Chief Operating Officer	RAG criteria subjective – Executive informed.	To be confirmed



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
<b>Staffing</b>				
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
<b>Equality &amp; Diversity</b>				
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
<b>Health &amp; Wellbeing</b>				
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 4.5%.	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

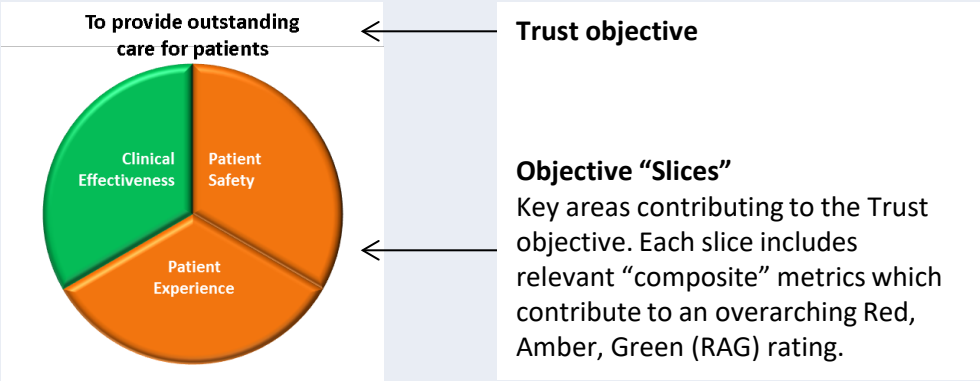


Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
To be a continually learning organisation				
Learning Hub				
Learning Hub Progress	Progress on embedding the Learning Hub in the Trust against the plan.	Director of Strategy and Integration	RAG criteria subjective – Executive informed.	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** =< 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.

**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.