

Integrated Dashboard

Board of Directors

31st March 2022

Please note:

Full suite of Quality metrics is not included as there is an ongoing process to resolve data quality issues relating to some metrics.

Integrated Dashboard

31st March 2022

To provide outstanding care for patients



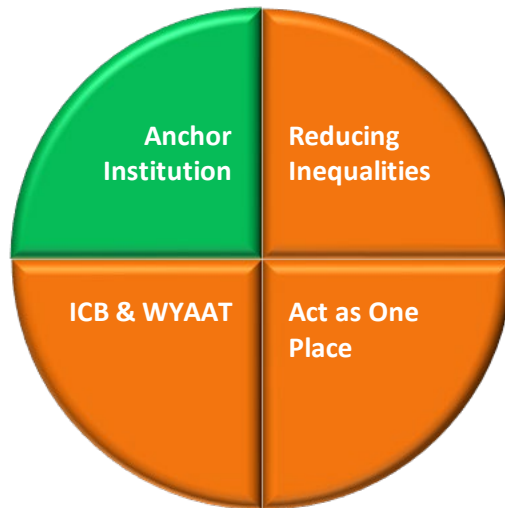
To deliver our key performance targets and financial plan



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



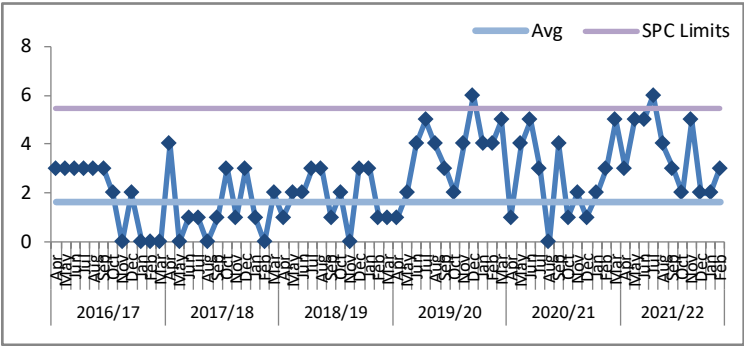
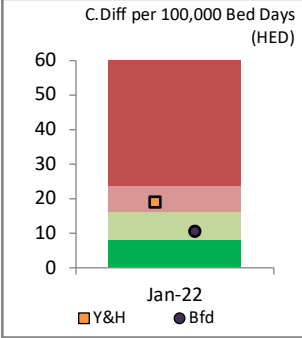
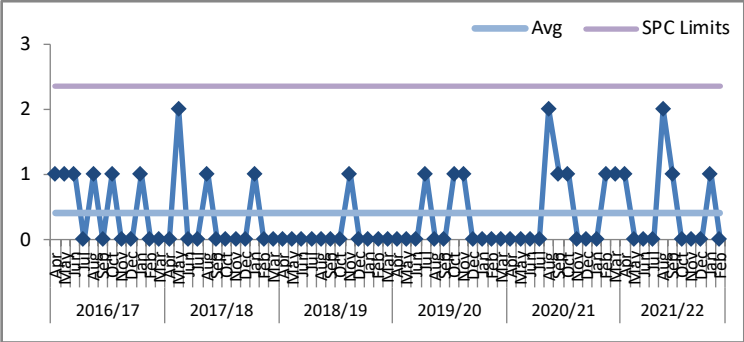
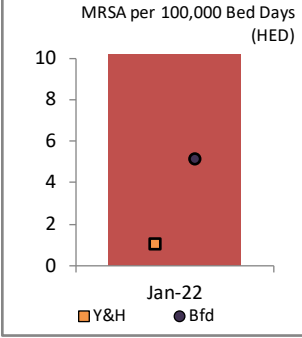
Bradford Teaching Hospitals

NHS Foundation Trust

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Hospital Standardised Mortality Ratio</div>		<p>The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups in a specified patient group. Through work between the Learning from Deaths team and Business Intelligence we have identified the coding error which impacted negatively on our HSMR figures. Work is underway to identify individual cases in order to ascertain how to improve our coding for HSMR.</p> <p>HSMR (12 mth rolling) HES Inpatients (Feb 2022): 91.98 – lower than expected.</p>	<p>No benchmark comparator available</p>
<div>Summary Hospital-level Mortality Indicator</div>		<p>The SHMI is the ratio between the actual number of patients who die during or within 28 days of 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. The Learning from Deaths team and Business Intelligence have identified a coding error that has negatively effected SHMI. Work is underway to identify individual cases in order to ascertain how to improve our coding for SHMI. It is important to note that SHMI is not an indication of avoidable deaths or of quality of care.</p> <p>SHMI (12 mth rolling) HES-ONS Linked Mortality Datasets (Feb 2022) : 104.84 – within expected range.</p>	<p>No benchmark comparator available</p>
<div>Readmissions</div>		<p>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-launching the improvement programme.</p>	

To provide outstanding care for patients

Patient Safety

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>C Difficile</div>		<p>No lapses in care or outbreaks reported. Cases within normal control limits and below national contract objectives.</p>	
<div>MRSA</div>		<p>MRSA improvement plan in place and monitored through IPCC.</p>	

To provide outstanding care for patients

Patient Safety



Bradford Teaching Hospitals

NHS Foundation Trust

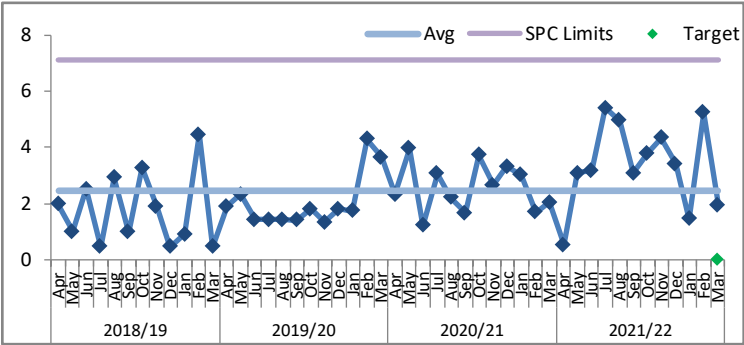
Metric / Status

Trend

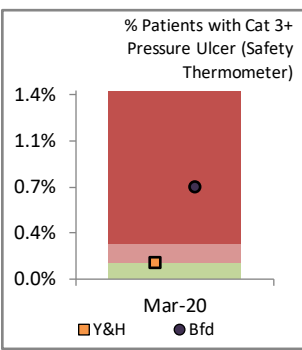
Challenges and Successes

Benchmarks

Pressure
Ulcers Cat 3+
per 10,000
bed days



Pressure Ulcers are below average. This will be attributed to the decrease in non-invasive ventilation and targeted work by the tissue viability nurse team.



To provide outstanding care for patients

Patient Safety



Bradford Teaching Hospitals

NHS Foundation Trust

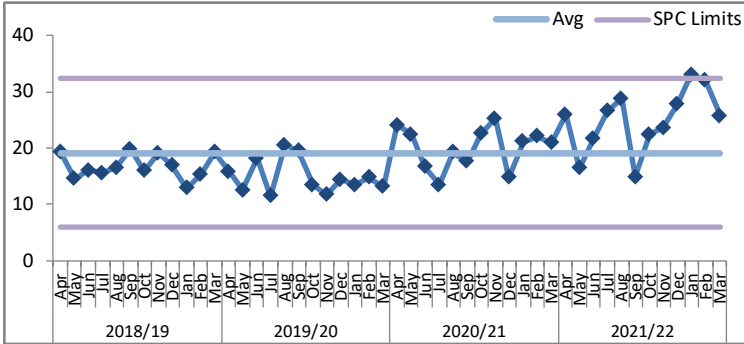
Metric / Status

Trend

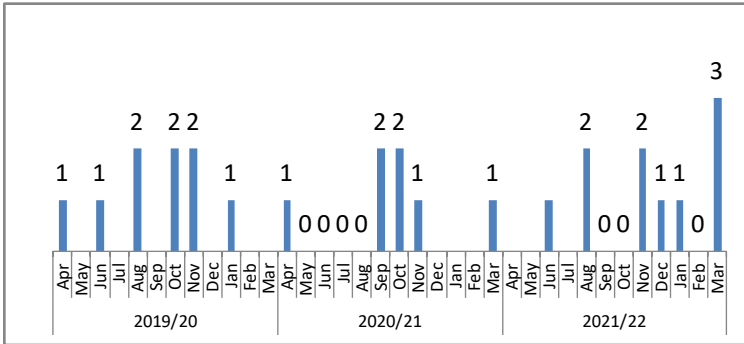
Challenges and Successes

Benchmarks

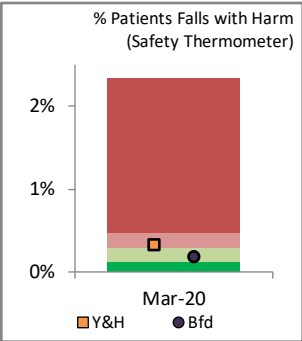
Falls with Harm per 10,000 bed days



Falls with Severe Harm



Falls remain within Statistical Process Control (SPC) limits.



Three Falls with Severe Harm in March, all subjected to panel review and incident reporting framework. Update will be published once investigations concluded. A quality improvement programme for fall preventions is being co-led and developed by the Chief Nurses Team and Quality Improvement Team, with the aim of launching the programme in May 2022. This will involve reviewing the current process to monitor and manage reported in-patient falls. It is anticipated that we will enhance the way we learn and improve from our data to reduce the number of in-patient falls (with and without harm) by March 2023.

No benchmark comparator available

To provide outstanding care for patients

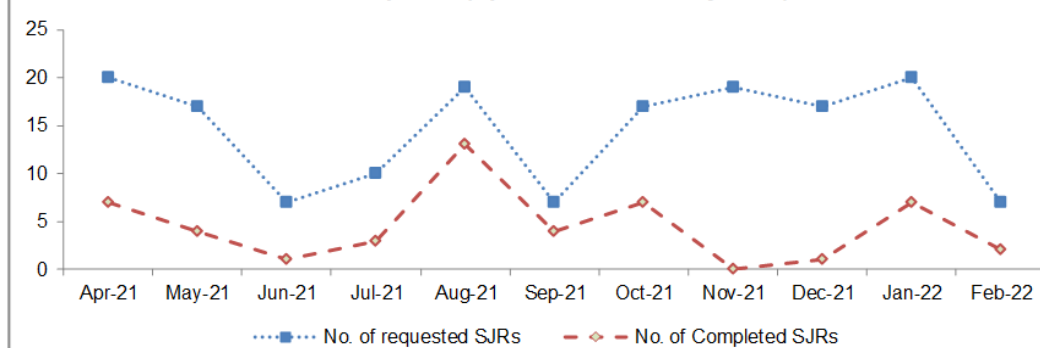
Mortality Structured Judgement Review (SJR)

Metric / Status

Trend

Challenges and Successes

SJR Requests (April 2021 – February 2022)



In order to address the backlog of requested SJRs it has been agreed between that the following SJR Criteria requests will be prioritised:

- All deaths of those with Learning Disabilities (LeDer)
- All deaths of those with serious Mental Health illnesses
- All deaths related to Hospital-acquired Covid-19
- All deaths linked to the Patient Experience process (Complaints)

For February 2022

Number of In-patient deaths : n=109

SJR Requests : n=7

SJR completed: n=2

SJR outstanding: n=5

SJR 3 and above: n=2

SJR 2 and below: n=0

Criteria for SJR Request

Death related to Hospital-acquired Covid-19: n=5

Death of those with severe Mental Health Illness: n=1

Death where the bereaved or staff have raised concerns: n=1

Completed SJR Thematic Analysis (February 2022)

What worked well:

Patients have been receiving excellent care on admission from ED staff.

Positive themes of care such as holistic support, and communication with family

There is evidence of frequent communication between staff and patients and their families with a supportive approach to cares and needs.

Good support with a number of teams/professionals to review needs of patients at the end of life.

What could have been done differently/improved:

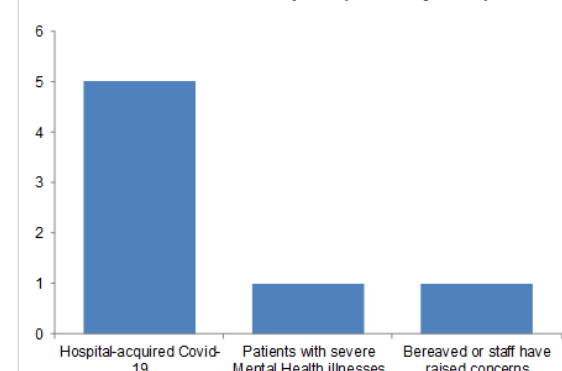
A clear issue of the lack of evidenced administration of mental health medications to support ongoing mental health needs of a patient.

Delayed review of patient in ED – only seen after first 6 hours of presentation.

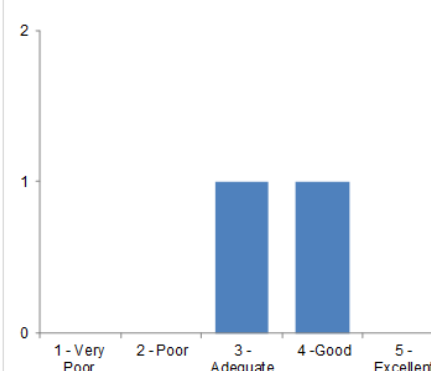
Celebrating excellent practice:

ED Consultant made time to speak with patient and son about ill health and various options of treatment to help understand situation – this was of great benefit to the patient's anxiety.

Criteria for SJR request (February 2022)



Overall Care Scores (February 2022)



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 surplus of £4.0m at Month 11 against a cumulative plan to breakeven. The Year To Date (YTD) position includes £1.3m of Elective Recovery Funding (ERF). The current forecast is a £4m surplus position at year end, although a number of variables remain unresolved which may impact on this projection. No scenarios are anticipated in which a position worse than breakeven will be reported for 2021/22.</p> <p>Commentary not updated.</p>	<p>No benchmark comparator available</p>
<div>Delivery of Cash Plan</div>		<p>Cash as at 28 February 2022 (£82.7m) was ahead of plan (£50.4m) by £32.3m. Additional cash has been generated from operating activities (I&E and depreciation) of £3.5m, working capital movements of £27.6m, of which £27m related to higher than planned payables, and lower than planned financing costs due to £1.5m extra PDC funding received and a £0.6m reduction on PDC dividend paid. Forecast outturn cash is £79.3m which is £32.8m above plan. The extra forecast cash is a result of higher than planned working capital of £32m, an additional £4.7m generated by additional I&E surplus and £1.8m generated by additional depreciation charges. This has been partially offset by a further £5.7m in the capital programme.</p> <p>Commentary not updated.</p>	<p>No benchmark comparator available</p>

To deliver our key performance targets and financial plan

Finance



Bradford Teaching Hospitals NHS Foundation Trust

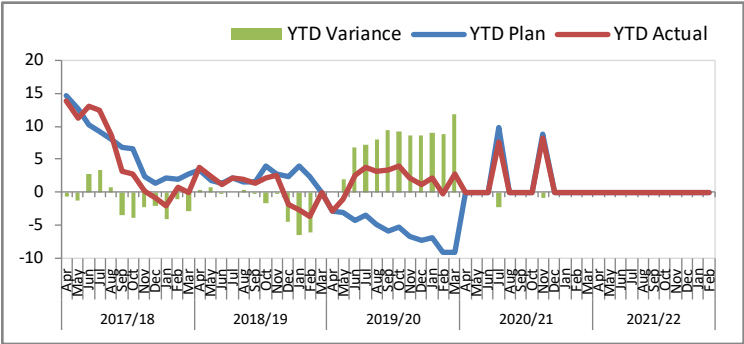
Metric / Status

Trend

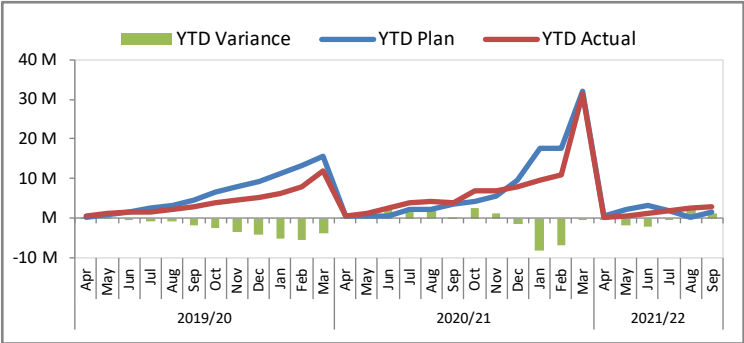
Challenges and Successes

Benchmarks

Liquidity rating



Delivery of Capital Plan



Year to date (YTD) liquidity is 6.0 days which is 6.4 days higher than plan (-0.4 days). Liquidity is higher than plan due to delivery of an unplanned I&E surplus of £4.9m, receipt of additional PDC funding of £1.5m and profiling of non-current deferred income of which an additional £1.6m won't be utilised in the next 12 months. Liquidity is forecast to reduce in the next month to 0.5 days due to investment in the capital programme (£12.6m), an increase in provisions (£0.5m) and receipt of further PDC funding (£5.8m).

No benchmark comparator available

Commentary not updated.

Year to date capital expenditure is £20.4m which is £0.2m above plan (£20.2m). The full year capital forecast is £38.6m which is £13.9m above plan (£24.8m). The additional expenditure is funded by £5.7m of additional Trust financing, £7.2m of external PDC funding awarded in year and £1m of asset donations largely as a result of DHSC COVID support.

Commentary not updated.

To deliver our key performance targets and financial plan

Performance

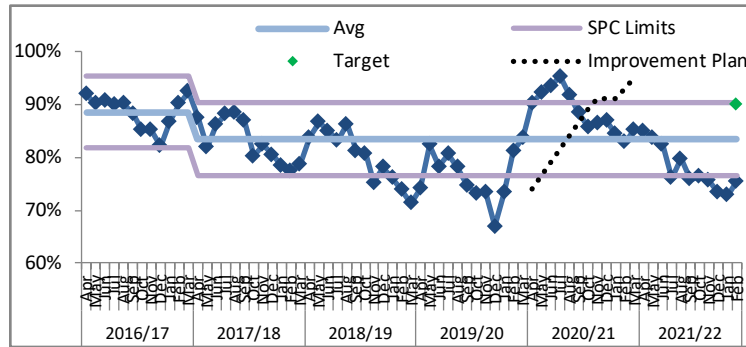
Metric / Status

Trend

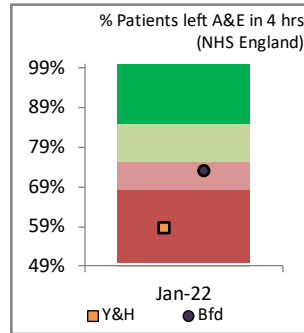
Challenges and Successes

Benchmarks

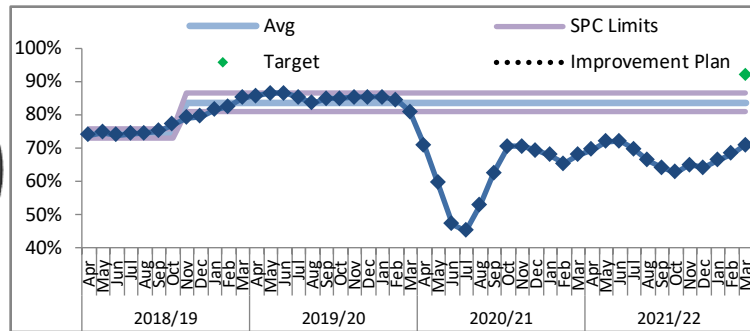
Emergency
Care
Standard



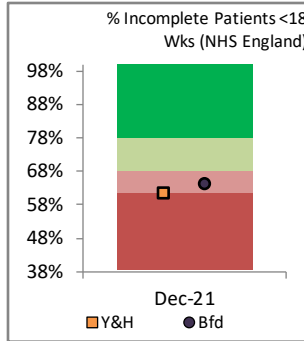
Emergency Care Standard (ECS) performance was at 74.07% for March 2022, which remains above peer and national average. We continue to use see and treat and Same Day Emergency Care (SDEC) pathways to help avoid admissions and congestion within the department whilst longer term improvement plans are being progressed which will divert unnecessary attendances and further improve flow. Attendances remain at or above pre-COVID levels.



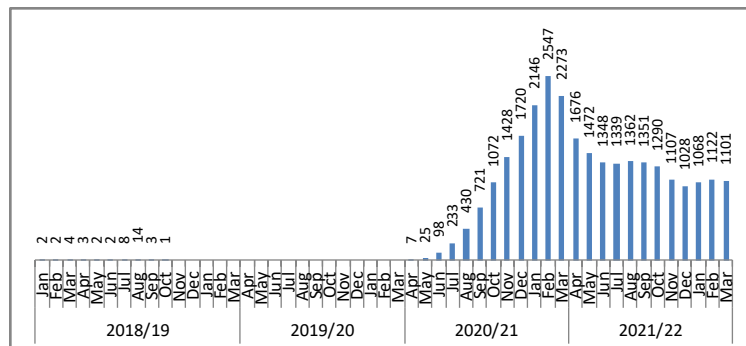
RTT 18 Week
Incomplete



RTT performance continues to track the national trend and is marginally above peer and national average. From March 2022 theatre capacity has been significantly increased which will support a step change in admitted clock stops and an improvement in RTT performance.



RTT 52
Week Wait



The Trust had 1,101 incomplete 52 week waits at the end of March 2022. All long waits have been reviewed using clinical prioritisation guidelines and the daily review of management plans for patients waiting over 40 weeks continues. The 52 week waits are predominately for P3 and P4 surgical treatments.

No benchmark comparator available

To deliver our key performance targets and financial plan

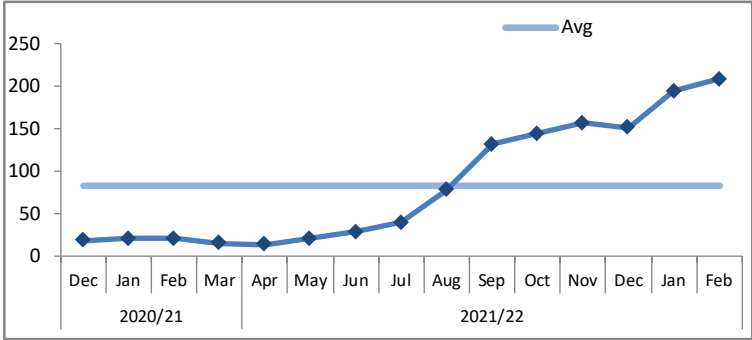
Performance



Bradford Teaching Hospitals
 NHS Foundation Trust

Metric / Status	Trend	Challenges and Successes	Benchmarks
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RTT
 18 week
 > 104 week
 wait



All 104 week waits are reviewed by senior operational staff weekly and plans expedited where possible. The reduction in theatre capacity and elective bed availability has meant P3 and P4 waits at 104 weeks or more haven't been listed in line with plan as priority must be given to P2 and cancer patients. This will improve as theatre and elective bed capacity is increased. The focus is to achieve a zero position by the end of Jun 2022.

To deliver our key performance targets and financial plan

Performance



Bradford Teaching Hospitals NHS Foundation Trust

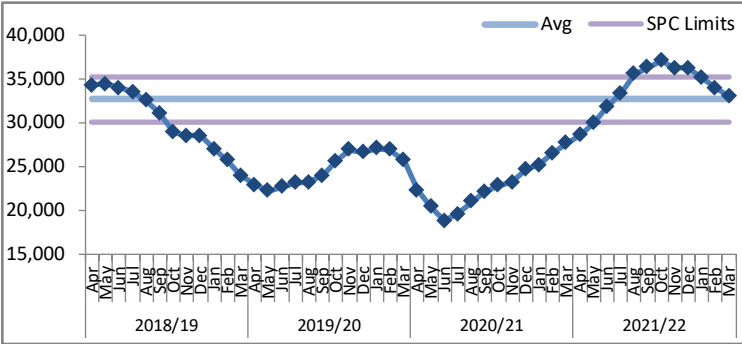
Metric / Status

Trend

Challenges and Successes

Benchmarks

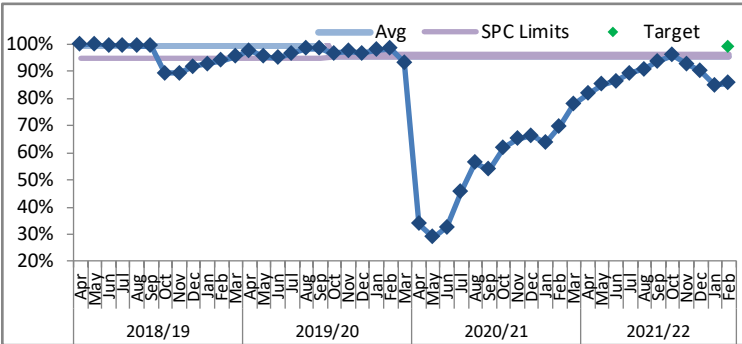
Elective
Waiting
List



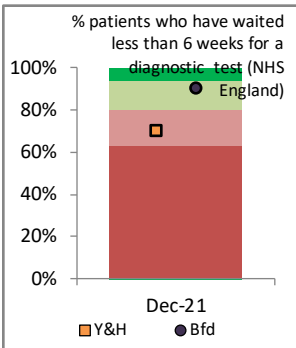
The total RTT waiting list has reduced in recent months. Referral triage and the use of advice and guidance have reduced demand, data quality processes have been strengthened and elective recovery plans agreed. As theatre capacity increases the waiting list will reduce further.

No benchmark comparator available

Diagnostic
Waits



Performance has deteriorated slightly over winter due to the loss of an MRI scanner and delays in procuring Respiratory Physiology equipment. Endoscopy performance has improved in this period but increased demand and a short term loss of capacity due has caused a deteriorating position in March and April. MRI capacity has been increased and recovery is planned from the end of April 2022, whereby the Trust anticipates performance returning to the upper quartile nationally.



To deliver our key performance targets and financial plan

Performance

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Cancer 2 Week GP</div>		<p>March 2022 performance against the 2 Week-Wait Cancer standard is forecast above target at 96.26%. Overall referral demand remains above historic averages which has resulted in some tumour groups booking at day 13 and increases in COVID meant performance deteriorated. BTHFT benchmarks in the upper quartile nationally for this standard.</p>	
<div>Cancer 62 Day Urgent GP</div>		<p>Diagnostic and surgical capacity is being prioritised in support of long cancer waits with improvements in time to diagnosis and decision to treat. The total waiting list over 62 days has reduced during Q4. The Trust is forecasting attainment of this target from May 2022.</p>	
<div>Cancer 62 Day Screening</div>		<p>Performance for this indicator reflects the complexity of pathways, patient concordance, and delays in diagnosis across Breast and Lower gastrointestinal (GI) services.</p>	

To deliver our key performance targets and financial plan

Productivity

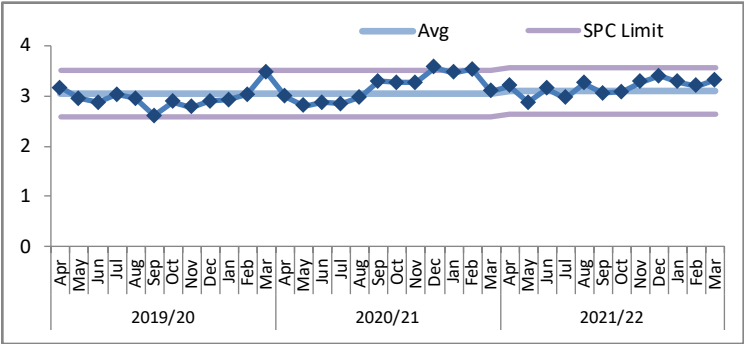
Metric / Status

Trend

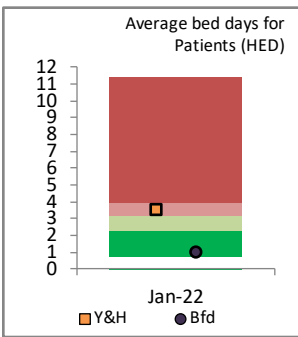
Challenges and Successes

Benchmarks

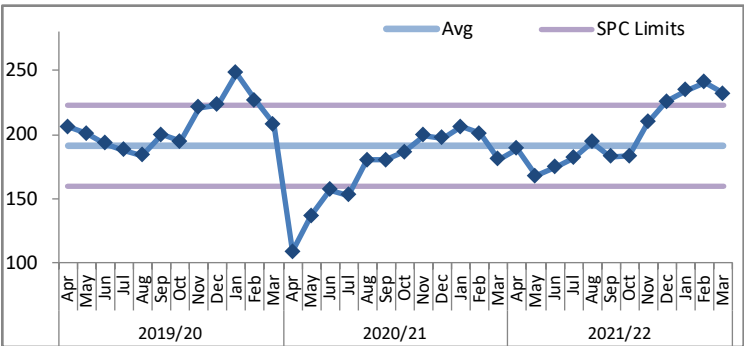
Length of Stay



Average length of stay (LoS) remains within control limits and benchmarks better than peers.



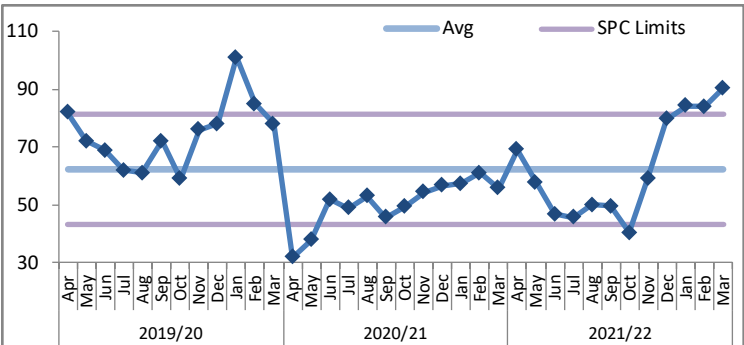
Stranded Patients
Length of Stay
≥ 7 days



The weekly multi-disciplinary (MDT) review meeting of patients above 7 days length of stay (LoS) remains in place. This supports timely discharge and the Trust benchmarks well for all LoS indicators. Increases in long length of stay relate to the increased COVID demand and are reducing from the end of February onwards.

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. When considered as a proportion of spells the Trust benchmarks better than average compared to peer and national data.

No benchmark comparator available

To deliver our key performance targets and financial plan

Productivity



Bradford Teaching Hospitals NHS Foundation Trust

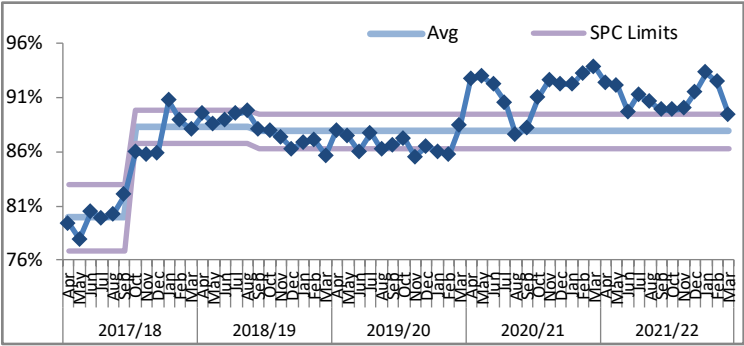
Metric / Status

Trend

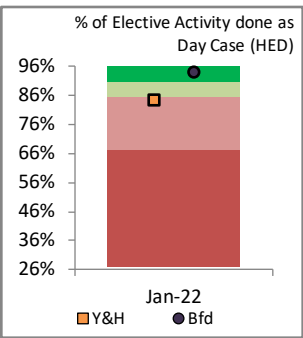
Challenges and Successes

Benchmarks

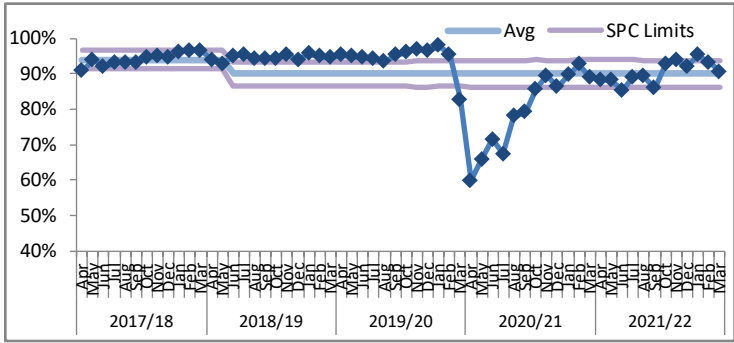
Elective Day Case Rate



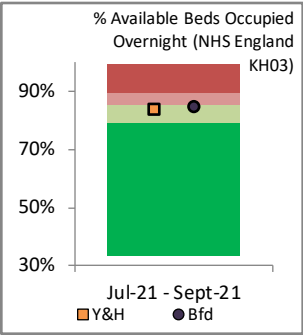
Day case rates continue to be above the national and regional average.



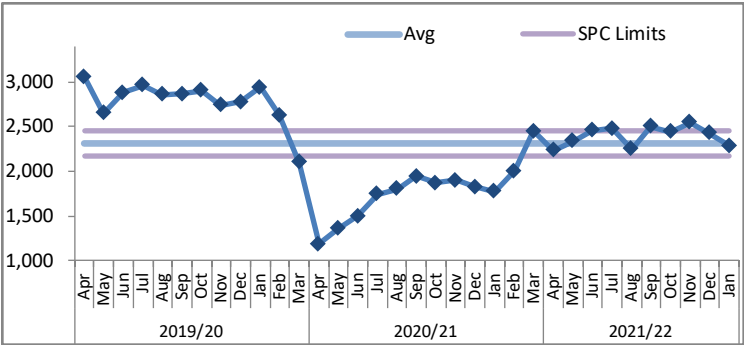
Bed Occupancy



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. This was evident during January when bed delays from ED and length of stay in the department increased in line with occupancy levels.



Discharges before 1pm



Discharges before 1pm remains under review with a focus on earlier discharge maintained to facilitate patient flow. Performance is consistently within control limits when considered as a percentage of discharges.

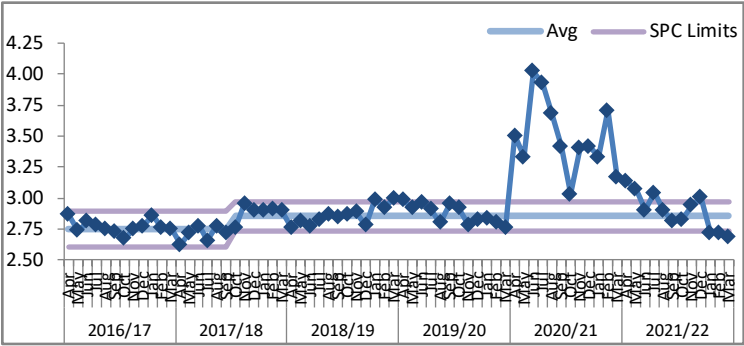
No benchmark comparator available

To deliver our key performance targets and financial plan

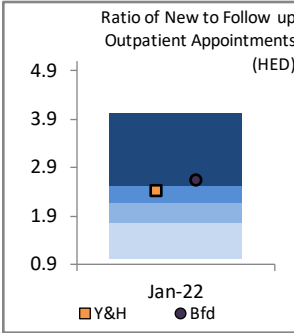
Productivity

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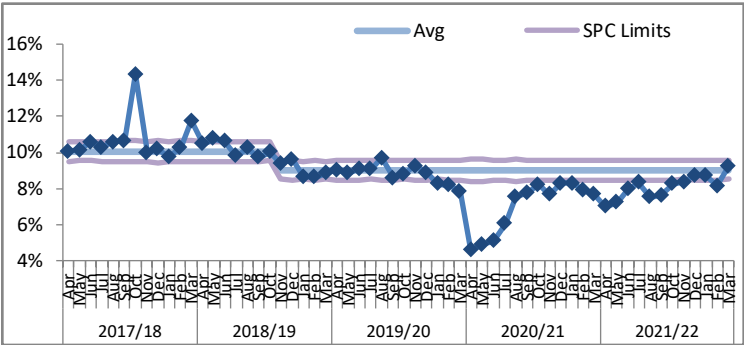
New to Follow Up Ratio



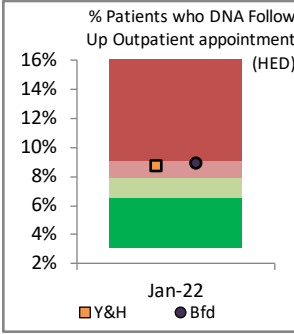
The use of video and telephone clinics in response to COVID-19 has impacted a number of outpatient measures including the new to follow up ratio. As new clinic templates have been implemented this has returned to the mean.



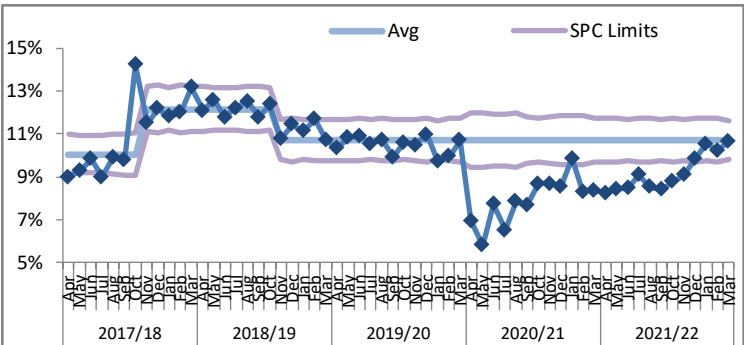
Did not Attend Follow Up



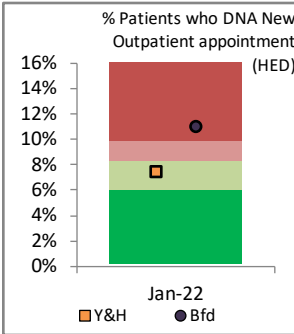
Did not attend (DNA) rates also appear to have been impacted by changes made in response to COVID-19, particularly the change from face to face to video or telephone contact. This is being explored by the VRI programme.



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 change from face to face to video or telephone contact. This is being explored by the VRI programme.

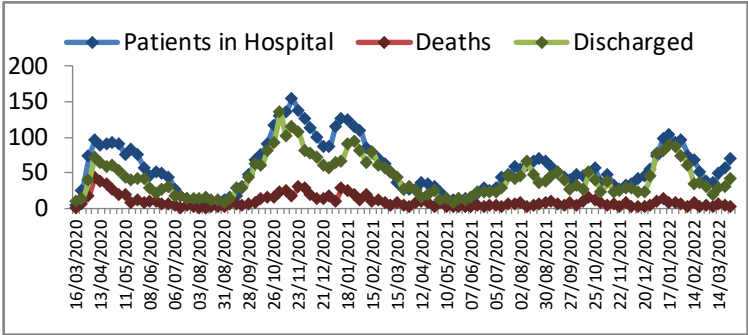


Metric / Status

Trend

Challenges and Successes

Benchmarks



COVID-19 demand increased significantly due to the Omicron variant. Command and Control meetings remain in place and COVID-19 surge plans are being followed in response. Community positivity rates and subsequently inpatient COVID spells increased again during March 2022.

No benchmark comparator available

To be in the top 20% of employers

Engagement

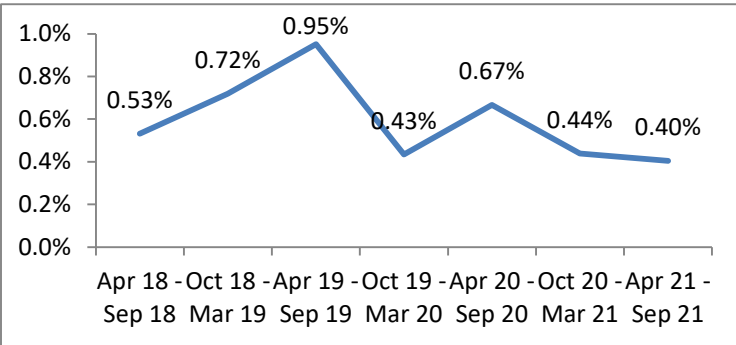
Metric / Status

Trend

Challenges and Successes

Benchmarks

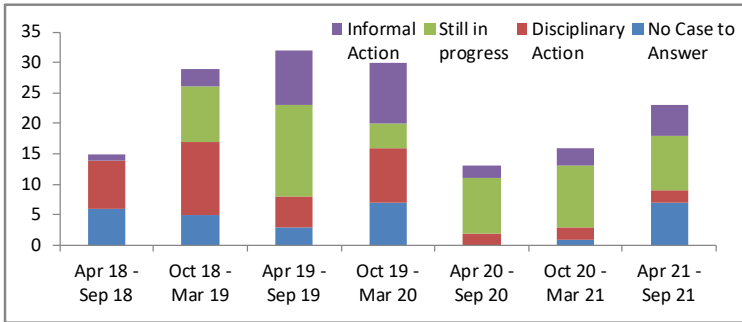
Contacts with
Advocacy
service



Contacts with the staff advocacy service remain fairly constant. 61% of contacts were successfully resolved informally. Although three contacts were engaged in formal processes, they were all referred to the staff advocacy for support with an existing formal complaint. A number of contacts related to advice around the provision of reasonable adjustments and interpretation of the disability equality policy. It is hoped the roll out of disability equality training over the coming months will alleviate some of these issues and improve the experience of staff with long term health conditions. The Trust is in the process of launching its Workplace Mediation Service. The service will facilitate informal cases focussing on win, win outcomes for all parties involved. Next update May 2022 (for 01/10/21 to 31/03/22).

No benchmark
comparator available

Harassment &
Bullying
Outcomes



Although the number of harassment and bullying related investigations is slightly higher in this period than in the previous six months, this is only by seven cases. 36% of cases are still ongoing. It is worth noting that Employee Relations cases were paused for much of 2020 and early 2021, resulting in an unusual reduction in the number of cases. ER work recommenced in April this year. There is a noticeable increase in ER cases related to Bullying and Harassment/ general conduct as a result of lockdown/ the pandemic, with resilience/ tolerance lower due to fatigue. 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, with focus on “nipping things in the bud” at an early stage. The new Trust mediation service is also hoped to have a positive impact on the number of formal cases. Next update May 2022 (for the period 01/10/21 to 31/03/22).

No benchmark
comparator available

To be in the top 20% of employers

Engagement

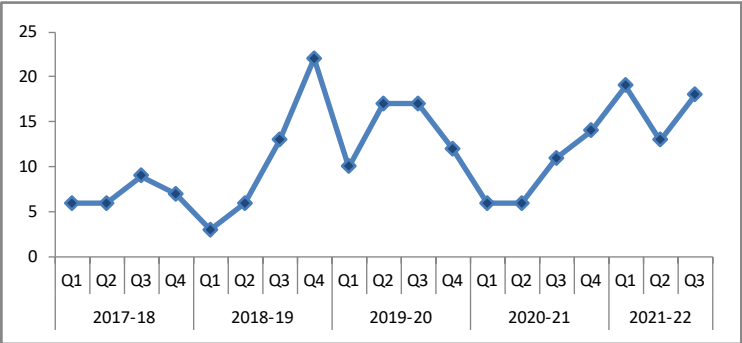
Metric / Status

Trend

Challenges and Successes

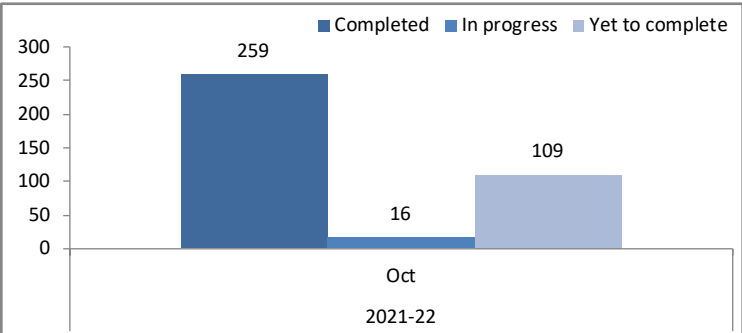
Benchmarks

Referrals to
FTSU



18 concerns were raised to the Freedom to Speak Up team in Q3. 10 of the 18 concerns were reported anonymously via the FTSU App. These are dealt with on an individual basis; the National Guardian's Office advocate that staff should be able to raise concerns anonymously if necessary. Of the 18 concerns raised in Q3, 8 were due to bullying and harassment, 1 was for Covid issues, 2 were due to safe staffing, 2 were patient safety issues, 1 was a concern raised about racism and 5 categorised as other. The National Guardian's Office have specific categories to report on only. (Updated quarterly – next update June 2022 (for 01/03/22 to 31/05/22.)

Appraisal
Rate
Medical



The appraisal year for medical appraisals runs 1st April to 31st March. Because of the suspension of appraisal activity during January and February 2022 due to the surge in Covid cases, it is inevitable that some appraisals will be missed. We anticipate that number to be around 40, and these will be categorised as approved missed appraisals (outcome 2). We have not had any unapproved missed appraisals (outcome 3) for the 2021/22 year.

To be in the top 20% of employers

Engagement

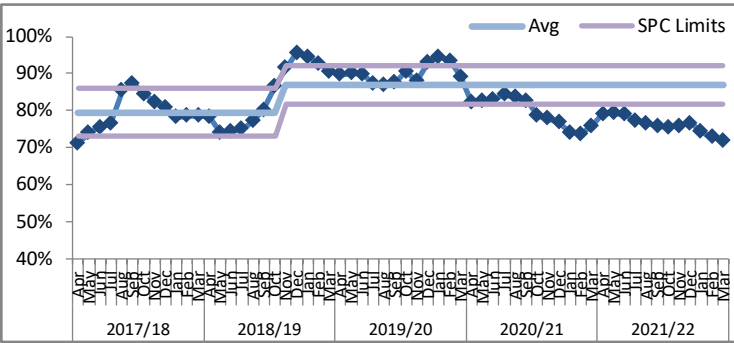


Metric / Status

Trend

Challenges and Successes

Benchmarks



The non-Medical appraisal rate for March 2022 has reduced slightly to 71.92% from 72.65% in February 2022. All areas of the Trust have shown a decrease in appraisal rate with the exception of Pharmacy which has seen a slight increase. Amended appraisal forms were introduced across the Trust in July 2021 and webinars have been developed for both the 'appraisee' and 'appraiser' focused on having a coaching style conversation. These sessions also form an integral part of the newly developed 'Leadership Pathways' which have over 250 members of staff currently taking part or registered to do so. Further work is underway to evaluate the webinars and explore other opportunities to support both staff and managers with the appraisal process and highlight its importance. The 2021 staff survey results are also being used to explore more around appraisals and the impact of them on staff feeling valued, understanding their impact and ensuring they have clear objectives as a result of the conversation. Appraisal performance is monitored through the Executive to CBU meetings. Executive Directors have also received appraisal reports for their areas.

To be in the top 20% of employers

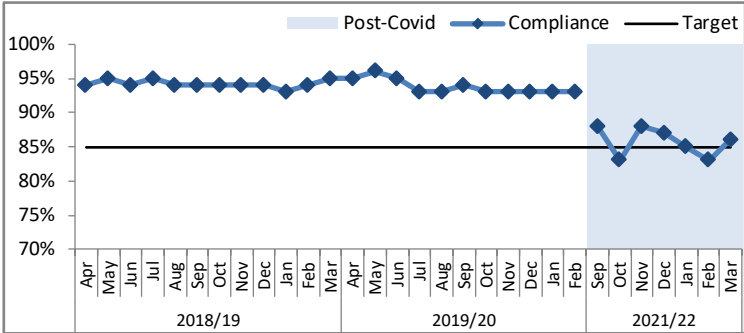
Training & Development

Metric / Status

Trend

Challenges and Successes

Benchmarks



The compliance metric for mandatory training is set at 85% - which in March was 86 % overall. A total of six subjects now have compliance rates below the target. Mandatory training compliance reporting has been reinstated and an action plan is in place to address those subjects where compliance is not being met. Basic Life Support training has dropped to 65%, as there are no options to complete virtual learning for this subject, the resuscitation team are providing face to face sessions in the clinical environment to rapidly increase compliance. The risk register has been updated to reflect the current situation.

To be in the top 20% of employers

Staffing

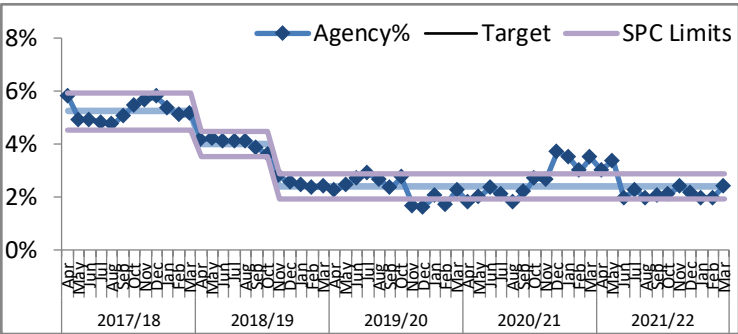
Metric / Status

Trend

Challenges and Successes

Benchmarks

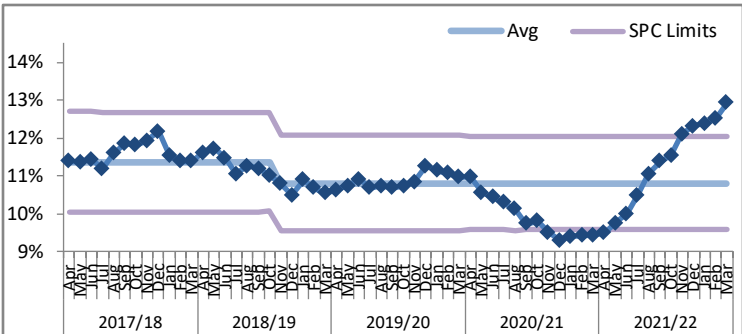
Use of Agency Staff



There has been an overall increase in the deployment of our temporary workforce in March 2022. Healthcare Assistants (HCAs) agency use has ceased, unless in exceptional patient safety circumstances. Internal bank fill rates have remained around 61% fill rate for unregistered and 50% for registered nurses. Agency use across the Medical & Dental and Allied Health Professional staff groups has remained static in the reporting period. There has been an increase in the use of bank doctors.

No benchmark comparator available

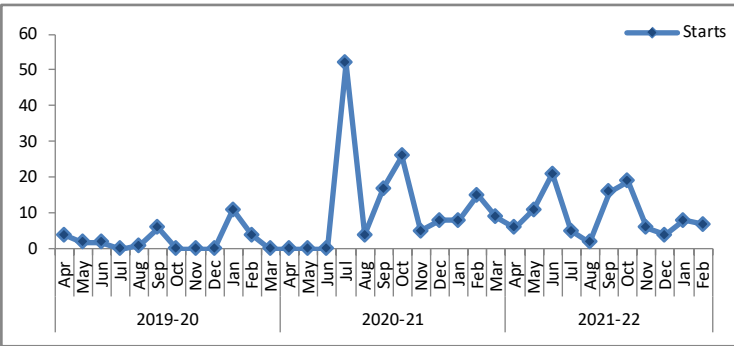
Staff Turnover



Turnover has seen an increase to 12.93% in March 2022 from 12.52% in February 2022. Turnover has increased slightly across all areas of the Trust apart from Estates & Facilities and Research which have both shown a slight reduction.

No benchmark comparator available

Apprentice Starts



267 members of staff are on an apprenticeship programme. For the period 1st April 2021 to February 2022 141 staff members have been recruited onto an apprenticeship programme and there have been 24 completers. Apprenticeship programmes are wide-ranging with examples being the Advanced Care Practitioner, Registered Nurse degree apprenticeship and Nursing Associate, ranging across administrative, technical and trades roles in the Trust. We have successfully taken part in a pilot scheme project to recruit and start Healthcare Science apprentices and we are currently working with other departments including AHPs to increase apprenticeships in this area and beyond. (Updated quarterly – next update June 2022 (for 01/03/22 to 31/05/22.)

To be in the top 20% of employers

Equality & Diversity



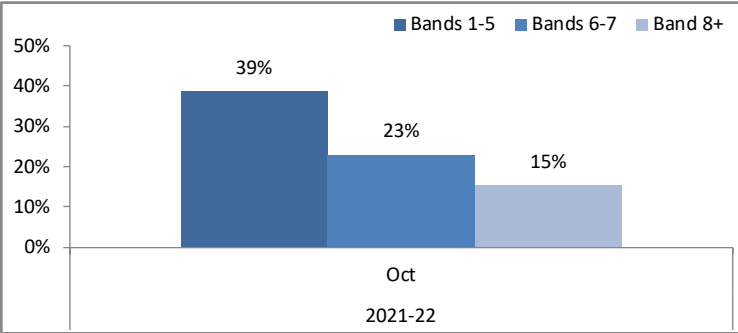
Metric / Status

Trend

Challenges and Successes

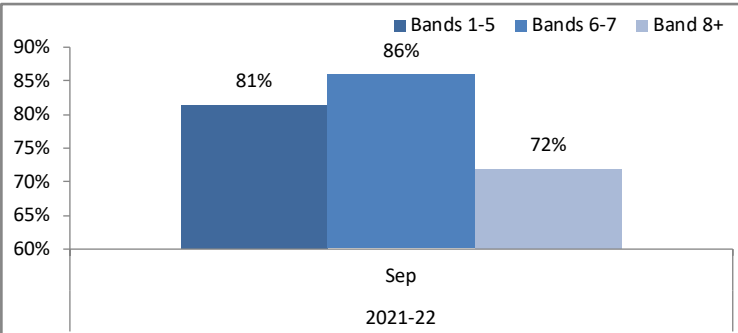
Benchmarks

Ethnic minority workforce by band group



With the overall proportion of ethnic minority staff in the workforce now around 35% and representative of the local community; the data shows that ethnic minority staff are over represented in the lower bands (at 39%) and representation decreases as banding increases, with most significant under representation at senior levels (15%). Recent dashboard analysis indicates that this figure is travelling in the right direction but trajectory still remains 4% below our target of 35% at senior levels by 2025. Our recent WRES action plan continues to focus our efforts in supporting senior ethnic minority colleagues to develop and progress within the organisation and this years' action plan also recognises the need to empower those in lower bands with the skills and opportunity to progress. Next update May 2022 (for the period 01/10/21 to 31/03/22).

Female workforce by band group



Our recent Gender Pay Gap submission showed that females made up 77% of our workforce (including medical & dental staff), but were proportionately under-represented at senior leadership levels (data as at March 2020). Initial indications from the March 2021 GPG data suggests this is improving. However, the current data (as shown) demonstrates; whilst females make up 82% of the non-medical workforce; they are significantly under-represented at senior levels (72%) and are slightly over-represented at middle management levels (86%). We are concentrating our efforts in this years' gender equality action plan in addressing this inequality by raising the profile of women in leadership and in analysing and starting to address potential blockages to progression. Next update May 2022 (for the period 01/10/21 to 31/03/22).

To be in the top 20% of employers

Health & Wellbeing

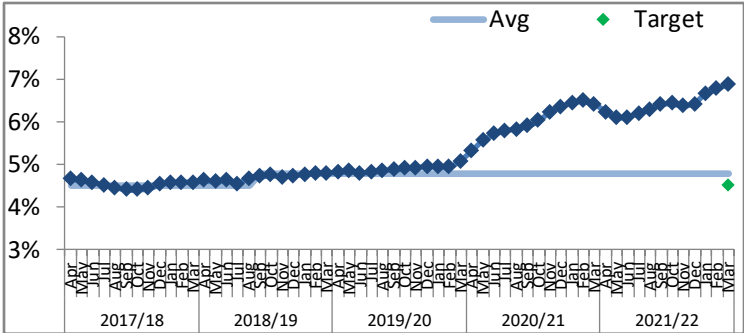


Metric / Status

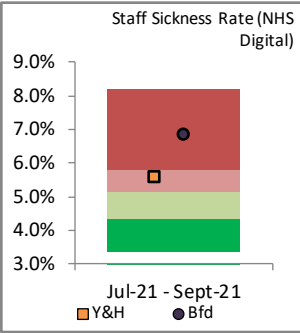
Trend

Challenges and Successes

Benchmarks







The rolling 12 month sickness absence rate at the end of March 2022 was 6.89% with increases seen in all areas of the Trust apart from Research which has shown a slight reduction. This figure does not include staff who are self-isolating which is 0.22% in March, which is a decrease from 0.28% in February 2022. Covid-19 related sickness has reduced from 1.86% in February to 1.77% in March 2022.



To collaborate effectively with local and regional partners

Partnership

Metric / Status	Trend	Challenges and Successes	Benchmarks
 <p>Reducing Inequalities</p>	<p>There is wide agreement on the scale of the challenge but not yet a single coherent programme of action; BTHFT will focus on the factors it can directly influence while collaborating to achieve greater impact. Work is underway to collate details of all Trust work across the CBUs and identify opportunities to address health inequalities. A need has been identified for increased community engagement and to raise awareness for staff. Data to support Population Health Management has been sourced from the Performance team at the CCG relating to the Stroke specialty to support discussion on the team in relation to inequalities. This pilot approach will be evaluated and then repeated with each specialty. BTHFT is a member of the BD&C Inequalities Alliance, RIC Steering Group and there is also now a standing item on the Equality and Diversity Council agenda to discuss inequalities.</p>		No benchmark comparator available
 <p>Act as One Place</p>	<p>The Place Based Partnership across Bradford District and Craven is operating in shadow form in anticipation of the legislation passing through Parliament and coming into effect in July 2022. A revised governance structure has been developed, with new committees being created including a new Children’s Partnership Board ensures there is a focus on improving care for children and young people following external scrutiny. BTHFT is actively involved in all 7 system-wide transformation programmes, and leading on three of them (access, diabetes and respiratory).</p>		No benchmark comparator available
 <p>ICB & WYAAT</p>	<p>Recruitment to most of the senior roles in the new ICS structure has been completed and the shadow ICS has been operating from 1 April 2022. The Health and Care Bill remains in Parliamentary process, although it is anticipated that it will progress in time to come into effect in July 2022. BTHFT is actively involved in new and existing clinical and operational networks, and discussions about sustainability of WY-wide services. Proposals for the future of non-surgical oncology are taking shape following work carried out by Sir Mike Richards in 2021, with the intention of consolidating provision of the service across WY. The recommended lead providers for these services are CHFT (Huddersfield) and LTHT (SJH) with some provision for acute oncology for those sites with an ED. BTHFT will be affected; inpatient bed numbers will be reconfigured across trusts accordingly.</p>		No benchmark comparator available
 <p>Anchor Institution</p>	<p>The Bradford Inequalities Research Unit (BIRU) is taking a data driven approach to understand poor detection rates and management of chronic illnesses and premature mortality. Act as One enables BTHFT and other organisations to work together to address the big issues that affect the health and wellbeing of the people of Bradford. BTHFT has programmes underway to widen access to employment with Project Search, Apprenticeships, improving the band 8/8+ BAME representation at BTHFT and school outreach projects. Similarly, many sustainability initiatives are proceeding involving procurement, asset management and travel. Use of our facilities is being explored and there will be a focus on Population Health Management (via the Reducing Inequalities workstream above). BTHFT is actively supporting the new “Alliance for Life Chances” (formerly “Opportunity Areas”) which brings together system partners with a focus on early years, educational attainment & employment prospects</p>		No benchmark comparator available

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 Nurse	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
Patient Safety				
Never Events	The number of serious incidents that occur despite there being defined processes and procedures to prevent them.	Chief Medical Officer	Red > 0, Green = 0	4.0
Audit of WHO checklist	Audit of the World Health Organisation surgical checklist monitoring the number that were complete compared to the number of checklists.	Chief Medical Officer	Red < 90%, Amber >=90% & < 95%, Green >=95%	2.9
Clostridium Difficile (C. Diff)	The number of cases either attributable or pending review.	Chief Nurse	Red >= 3, Amber = 2, Green <=1	3.9
MRSA	Counts of patients with Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia.	Chief Nurse	Per month: Red >= 1, Green 0	3.9
CAUTI	Urinary tract infections in patients with a catheter. The benchmarking data comes from the Safety Thermometer prevalence information.	Chief Nurse	Red > 1.5%, Amber 1%-1.5%, Green < 1%	4.1
Sepsis Patients antibiotics	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
Sepsis Patients Screened	Percentage of patients screened for Sepsis	Chief Medical Officer	Red < 50%, Amber 50%-90%, Green >= 90%	5.0
Pressure Ulcers Cat3+	Number of reported hospital acquired category 3 and 4 pressure ulcers per 10,000 bed days. The benchmarking data comes from the Safety Thermometer prevalence information.	Chief Nurse	Red >= 6, Amber 5, Green < 5	4.3
Serious Incidents	Unexpected or avoidable death, serious harm, never events, service delivery prevention compared to all incidents reported.	Director of Strategy and Integration	Red > 5, Amber 3-5, Green <=2	4.0
Falls with Harm	Patient falls resulting from harm per 10,000 bed days. The benchmarking data comes from the Safety Thermometer prevalence information.	Chief Nurse	Red upper quartile, Amber mid quartiles, Green lower quartile	4.3
Falls with Severe Harm	Falls with Harm classed as Severe	Chief Nurse	Red = reported for consecutive months, Amber = 1, Green = 0	4.3
Missed Doses	Proportion of patients with an omission of a critical medicine	Chief Nurse	Red - above national average Amber – 0 - <1% below the average Green - > 1%+ the national average	3.9



Glossary Continued

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
Complaints	Number of complaints.	Chief Nurse	Red >= 50, Amber 40-49, Green < 40	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 14 days liquidity Green – greater than 0 days liquidity	4.1

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
Performance				
Emergency Care Standard	Percentage of patients seen in A&E within 4 hours.	Chief Operating Officer	Red < 90%, Green >= 90%	2.4
RTT 18 weeks Incomplete	Percentage of patients waiting within 18 weeks on an incomplete pathway.	Chief Operating Officer	Red < 92%, Green >= 92%	3.9
RTT 52 weeks waits	Number of patients waiting more than 52 weeks.	Chief Operating Officer	Red > 0, Green = 0	4.0
Elective wait list	Wait list of patients on an elective pathway.	Chief Operating Officer	Red Greater than last month Green Less than last month	3.7
Diagnostic Waits	Percentage of patients who have waited less than 6 weeks for a diagnostic test.	Chief Operating Officer	Red < 99%, Green >= 99%	3.4
Cancer 2 week wait GP	Percentage of patients who have waited a maximum of 2 weeks to see a specialist for all patients referred with suspected cancer symptoms	Chief Operating Officer	Red < 93%, Green >= 93%	3.9
Cancer Urgent 62 day GP	Proportion of patients receiving treatment for cancer within 62 days of an urgent GP referral for suspected cancer.	Chief Operating Officer	Red < 85%, Green >= 85%	3.9
Cancer Urgent 62 day Screening	Proportion of patients receiving treatment for cancer within 62 days of an NHS Cancer Screening service.	Chief Operating Officer	Red < 96%, Green >= 96%	3.9
Full Blood Count acute wards 2 hours	The time taken for the laboratory to process Full Blood Counts samples from all Acute Wards and validated results are available on the Laboratory Information Management System (LIMS). The time measured is from the sample being booked on to the LIMS and results being validated on the LIMS and available to requestors	Chief Operating Officer	Red <85%, Amber >=85% & < 90%, Green >=90%	3.9

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
Productivity				
Length of Stay	The average length of stay for patients, in days.	Chief Operating Officer	Red Top 25% of Trusts, Amber 50-75% of Trusts, Green Better than mean	2.0
Stranded Patients LoS >=7	The average number of patients (excluding Maternity) who have been in hospital 7 days or more.	Chief Operating Officer	Red >208, Amber 189-207, Green <= 189	4.1
Super Stranded Patients LoS >=21	The average number of patients (excluding Maternity) who have been in hospital 21 days or more.	Chief Operating Officer	Red >71, Amber 62-71, Green <= 62	4.1
Elective Day Case Rate	The number of patients admitted for planned procedure and leave same day as a % of all procedures.	Chief Operating Officer	Red < 83%, Amber <87% & >=83%, Green >= 87%	1.0
Bed Occupancy	Average percentage of available beds which were occupied overnight.	Chief Operating Officer	Red >=95%, Amber 85-95%, Green <85%	2.3
Discharges before 1pm	Number of discharges from hospital which happened before 1 pm.	Chief Operating Officer	Red = Outside control limits, Green = Inside control limits	2.3
New to Follow-up Ratio	The ratio between New and Follow Up Outpatient appointments. Benchmarking data is from HED, which has a subtly different calculation, which can result in very small differences in numbers.	Chief Operating Officer	Red < 50 th Percentile England, Amber 50 – 25 th Percentile, Green Upper Quartile England	2.4
DNA Follow-up	This is the % of Follow-up Outpatient appointments where the patient does not attend.	Chief Operating Officer	Red < 50 th Percentile England, Amber 50 – 25 th Percentile, Green Upper Quartile England	2.6
DNA New	This is the % of New Outpatient appointments where the patient does not attend.	Chief Operating Officer	Red < 50 th Percentile England, Amber 50 – 25 th Percentile, Green Upper Quartile England	2.6
Covid-19				
COVID-19	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

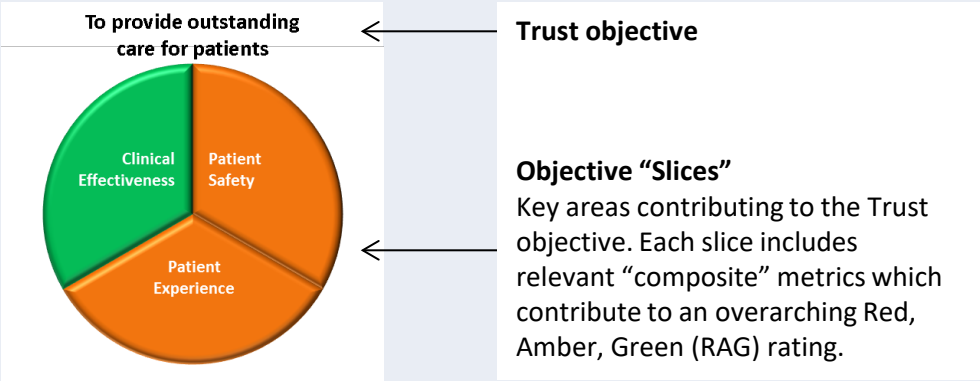
Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
Staffing				
Care Staff Shifts filled	Percentage of time care staff staffing hours are filled compared with planned.	Chief Nurse	Red < 80%, Amber 80% – 95%, Green > 95%	3.7
Care Staff Care Hours	Total of the actual number care staff 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
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 Manager 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 4.5%.	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.	4.6

Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
To collaborate effectively with local and regional partners				
Partnership				
Reducing Inequalities	Working with partners to contribute to the overall reduction of health inequalities across Bradford District and Craven.	Director of Strategy & Integration	RAG rating subjectively agreed by the committee	Qualitative Metric
Act as One Place	Working with local partners and contribute to the formal establishment of a responsive, integrated care system, and to actively participate in system-wide programmes of work.	Director of Strategy & Integration	RAG rating subjectively agreed by the committee	Qualitative Metric
ICS and WYAAT	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.	Director of Strategy & Integration	RAG rating subjectively agreed by the committee	Qualitative Metric
Anchor Institution	Working across Bradford to ensure the Trust is actively engaging with the population to support community development through anchor attributed such as employment initiatives, local procurement and developing the estate as a community asset.	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

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.