

Integrated Dashboard Board of Directors

30th September 2022

Integrated Dashboard

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To provide outstanding care for patients,
delivered with kindness



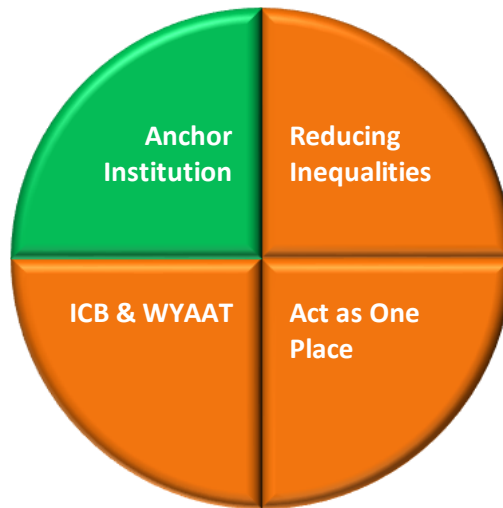
To deliver our financial plan
and key performance targets



To be one of the best NHS employers,
Prioritising the health and wellbeing of our
people and embracing equality, diversity
and inclusion



To collaborate effectively with
local and regional partners



To be a continually learning organisation and
recognised as leaders in research, education and innovation



To provide outstanding care for patients

Clinical Effectiveness

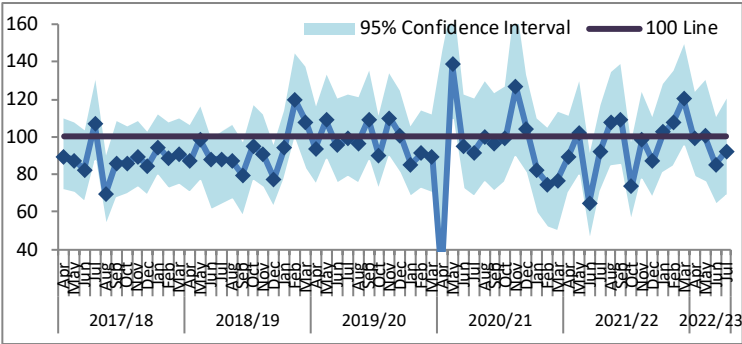
Metric / Status

Trend

Challenges and Successes

Benchmarks

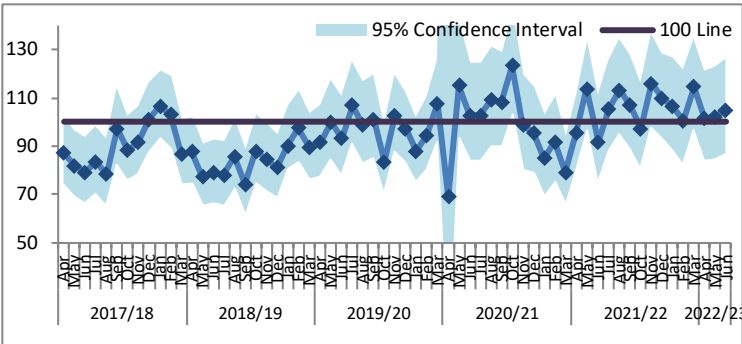
Hospital Standardised Mortality Ratio



The Hospital Standardised Mortality Ratio (HSMR) shows the ratio of the observed to the expected number of in-hospital deaths at the end of a continuous inpatient (CIP) spell, multiplied by 100 for 56 diagnosis groups in a specified patient group. If the HSMR is significantly higher or lower than expected this will trigger further investigation, as this could signal data quality issues, changes in pathways/practices, or issues with quality of care. HSMR (12 month rolling) HES inpatients (September 2022): 102.11 – within expected range.

No benchmark comparator available

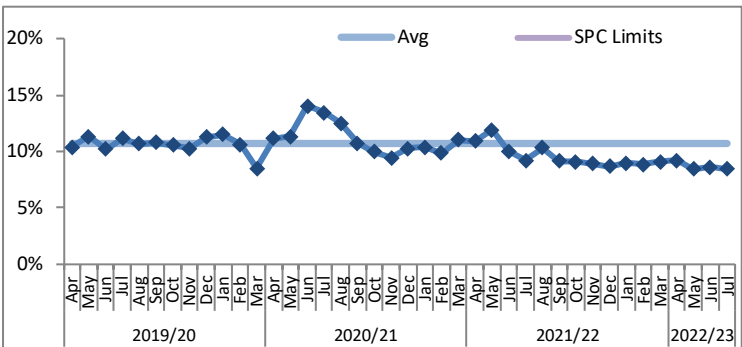
Summary Hospital-level Mortality Indicator



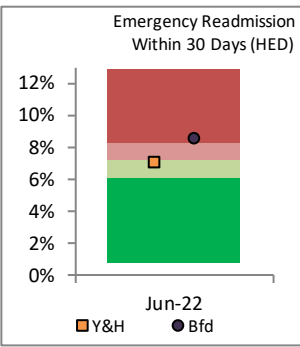
The Summary Hospital-level Mortality Indicator (SHMI) shows the ratio of the observed to the expected number of deaths up to 30 days after discharge from hospital, multiplied by 100. The SHMI reports on mortality at trust level for acute trusts across the NHS in England, and is evaluated over all diagnosis groups in a specified patient group. It excludes stillbirths, and a death is counted only once and to the last discharging acute provider. The SHMI value is not an indication of avoidable deaths or a measure of the quality of care delivered. If the HSMR is significantly higher or lower than expected this will trigger further investigation, as this could signal data quality issues, changes in pathways/practices, or issues with quality of care. SHMI (12 month rolling) HES-ONS Linked Mortality Datasets (September 2022): 107.97 – within expected range.

No benchmark comparator available

Readmissions



BTHFT readmission rates continue to fall and are consistently below the 3 year average of 10.1%, with the last 3 months being at 8.5%. This may reflect the impact of additional post-discharge follow-up clinics that have been implemented in a number of specialties post-COVID. Whilst this is slightly higher than the Y&H average (8.4% vs 7.1%) this has to be balanced against the fact that Bradford have significantly lower length of stays than other Trusts in the region.

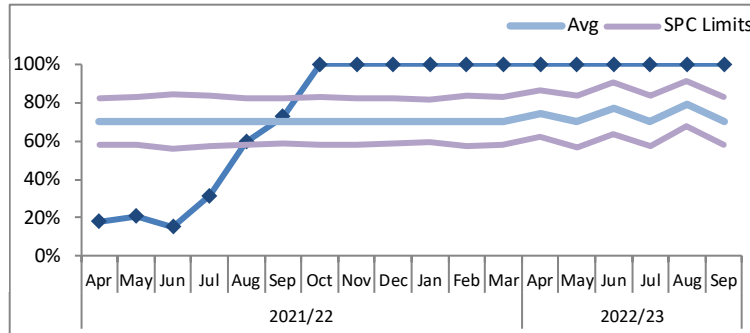


To provide outstanding care for patients

Learning from Deaths

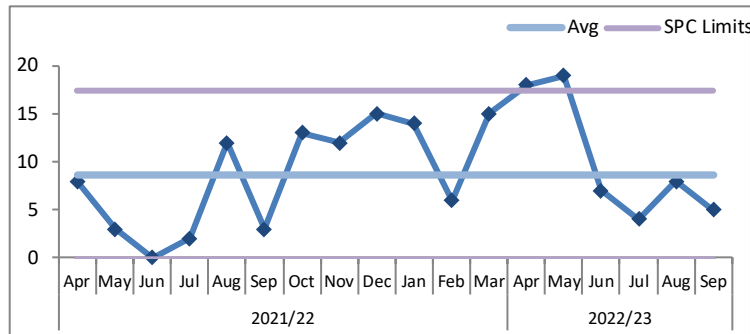
Metric / Status	Trend	Challenges and Successes	Benchmarks
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Percentage of deaths Scrutinised by the Medical Examiner



Since October 2021, the ME Office routinely scrutinise 100% of adult deaths at BTHFT. With regards to deaths scrutiny for the community setting there are 55 GP practices and 1 hospice in our local areas. Out of the 55 practices we have 6 on board and are receiving referrals from them. We have dealt with 146 deaths from these practices so far.

Number of SJR Requests raised



There were five SJRs requested via the Medical Examiner's office for September 2022 with two completed two on indefinite hold as the cases have gone to the Coroner's Office as inquests and one to be completed by the reviewer. Reasons for the SJR's requests include:

- Where the bereaved or staff raise significant concerns about care (n=3)
- learning to help inform our quality improvement work (n=1)
- those with learning disabilities (n=1)

There are currently four SJR requests outstanding that are awaiting completion from May to July 2022. Testing of the Learning from Deaths (LfD) App (an online database developed by Informatics) is due to take place in November 2022. This app is designed to record SJR data in order to support analysis and LfD's governance/reporting requirements. Feedback from users will be used to inform the final product before spreading the innovation across specialities trust wide.

To provide outstanding care for patients

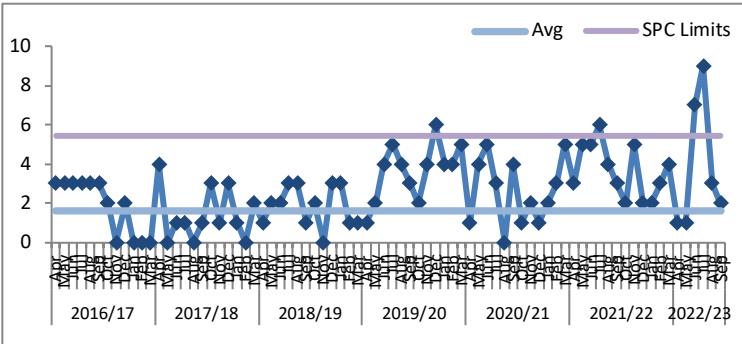
Patient Safety

Metric / Status

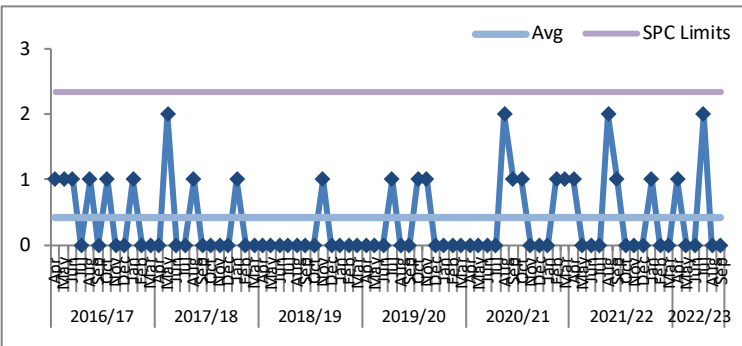
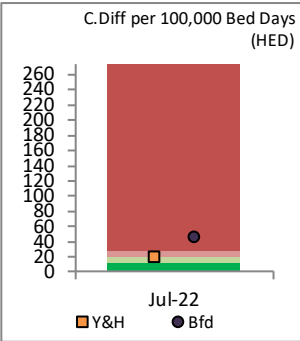
Trend

Challenges and Successes

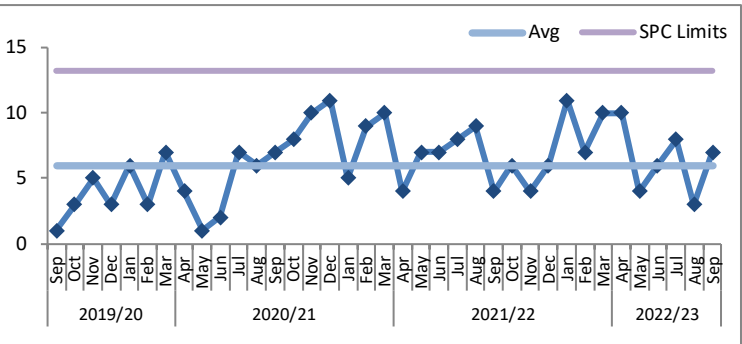
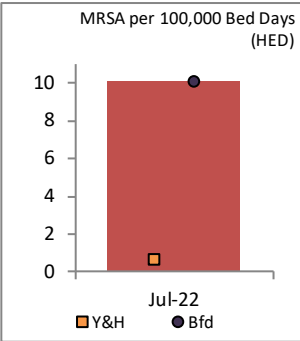
Benchmarks



A decrease in hospital onset cases in August and September reported following the deep clean of affected wards. C difficile improvement plan in place and monitored at IPCC.



The improvement plan continues to be monitored at IPCC.



The Trust continues to work with regional partners and NHSE through the AMR programme. Improvement plans to improve hydration in the elderly are being developed.

To provide outstanding care for patients

Patient Safety

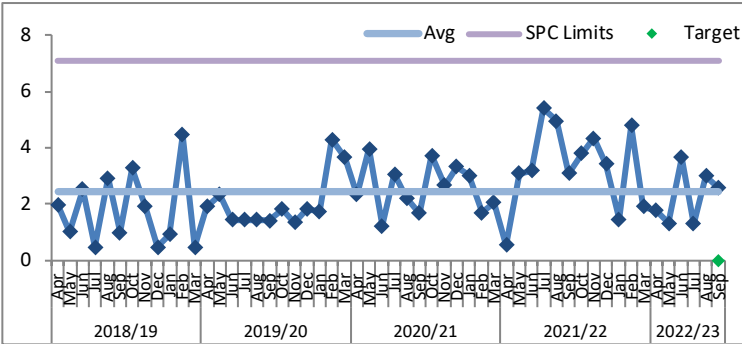
Metric / Status

Trend

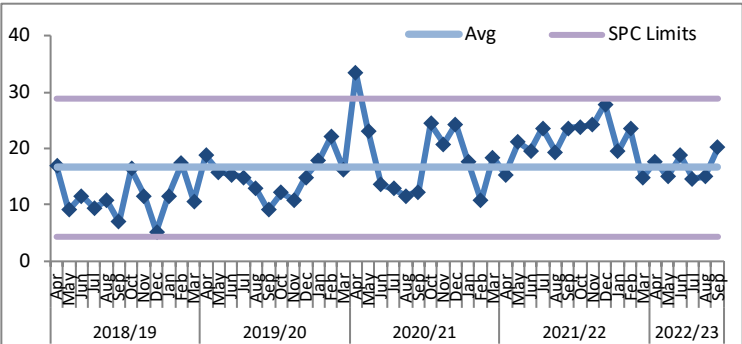
Challenges and Successes

Benchmarks

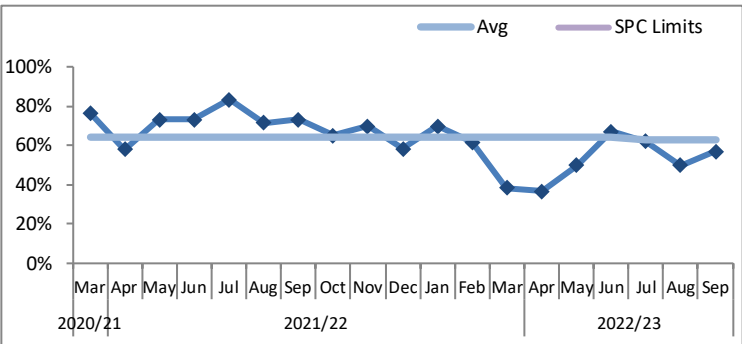
Pressure
Ulcers Cat 3+
per 10,000
bed days



Pressure
Ulcers
per 10,000
bed days



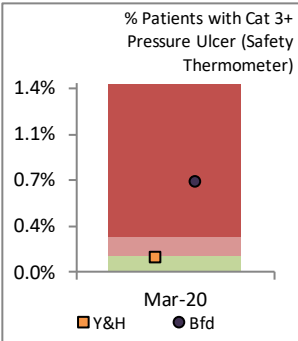
Medicine
Reconciliation



We experienced another covid wave late 2021/early 2022 however, pressure ulcers have reduced since the beginning of the year. We have started a QI project to investigate and identify improvement ideas relating to wound assessment. We are also preparing to move to a new pressure ulcer risk assessment tool for most of our inpatient areas (excluding maternity & NNU). This is provisionally planned for the end of November but is dependent on the development of an e-learning package. This piece of work is being delivered in partnership with CHFT.

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Medicines reconciliation is the overarching formal process of obtaining a complete accurate and up to date list of the patient's current medicines and comparing this list to the prescribed medication, taking into account adherence prior to admission and the patient's current clinical presentation. Medicines reconciliation is considered complete when any discrepancies identified have been communicated to the relevant health care professional for resolution. The data shows the percentage of patients that had medicines reconciliation carried out by pharmacy team within 24 hours of admission from a sample of sixty patients.



To provide outstanding care for patients

Patient Safety



Bradford Teaching Hospitals NHS Foundation Trust

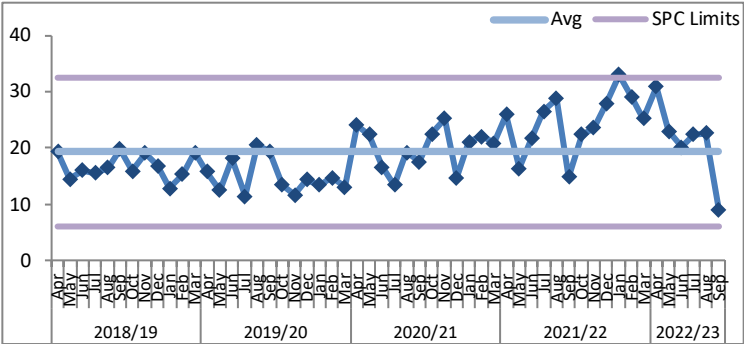
Metric / Status

Trend

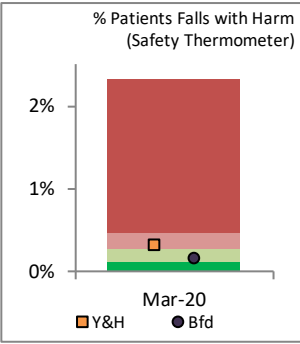
Challenges and Successes

Benchmarks

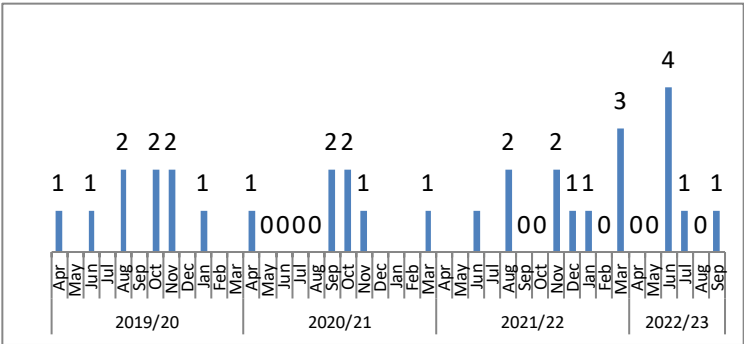
Falls with Harm per 10,000 bed days



There has been a decrease in the total number of falls with and without harm per 10,000 bed days in September. The data is currently at the lowest point observed since April 2018. The reported falls data has been the driving force behind the delivery of the 'Falls Roadshow'. Over the last three months, 18 areas have been visited. Each visit consists of: presentation of an SPC chart displaying area specific data for falls, delivery of Quality Improvement Foundation Training, delivery of falls improvement package and general conversations around falls management to facilitate a bespoke response for future improvement work. The Falls Improvement Group aim to maintain a reduction in the total number of falls observed. By Dec 2022, we anticipate all areas will have had their introductory falls roadshow visit. We also aspire to have started some more focused improvement work in high priority areas, identified through data.



Falls with Severe Harm



There are no reported Falls with Severe Harm reported during August 2022.

No benchmark comparator available

To provide outstanding care for patients

Patient Safety

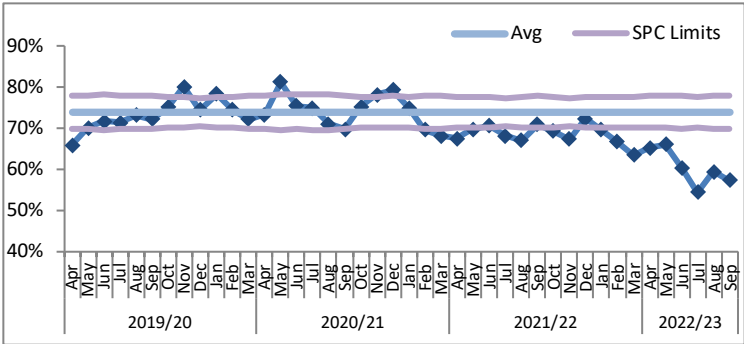
Metric / Status

Trend

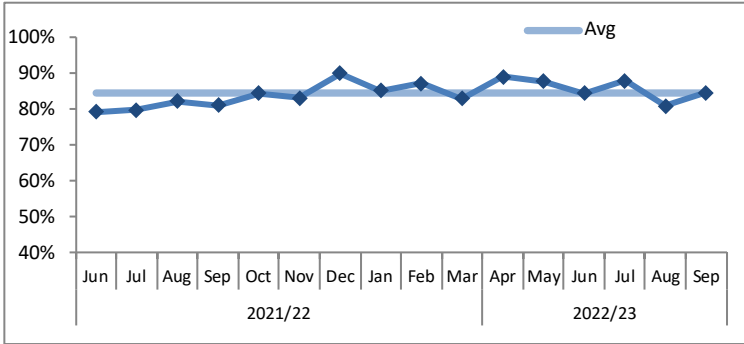
Challenges and Successes

Benchmarks

Sepsis
Percentage
of Patients
Screened



Severe Sepsis
antibiotics
given within an
hour



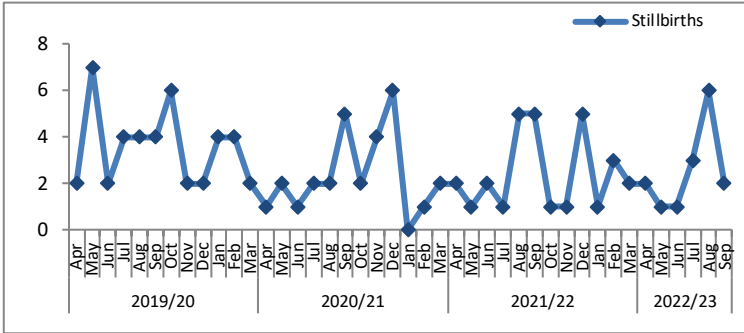
The Sepsis dashboard is currently functioning and we are able to extract data. Screening % sitting around 60% as a trust, engagement with key areas made and looking at ways of making improvements. Email sent to CSU leads to highlight areas with lower performance %. Junior doctors starting QIP's to make improvements in specific areas. Training delivered to junior Dr's to increase awareness and need to complete screening.

Performance is at 85%, a small increase from last month but remains lower than our expected target of >90%. Closely monitoring to understand data and highlighted to CSU leads for wider dissemination and discussion within clinical areas.

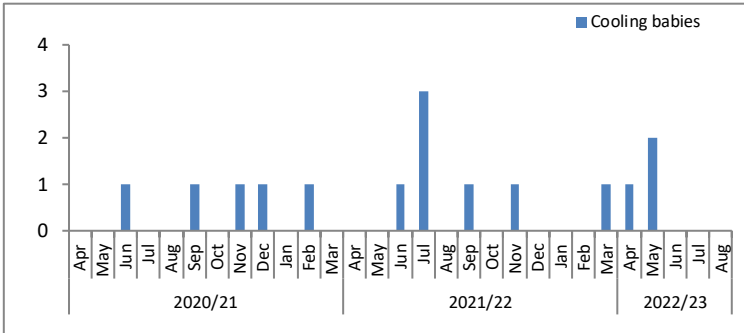
To provide outstanding care for patients

Patient Safety

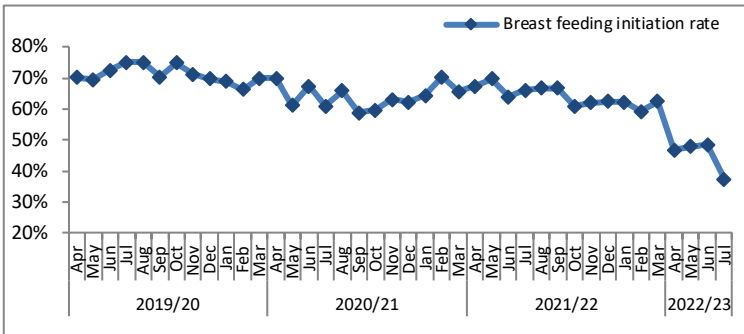
Metric / Status	Trend	Challenges and Successes	Benchmarks
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An increase in stillbirths during August triggered the agreed internal escalation process. All cases were subject to a 72 hour clinical review. Any cases meeting HSIB criteria were referred accordingly. Any cases requiring further investigation have been agreed at QUOC. The 6 cases were reviewed as a table top exercise to determine any emerging themes and trends and lessons learned have been shared with the relevant staff groups. Trust Board, CQC, LMS and commissioners have all been appraised of the position and actions taken.



There were no babies requiring cooling in the last 3 months. HIE cases are reported to Trust Board monthly and are referred to HSIB for independent investigation.



Infant Feeding co-ordinator has appointed a number of midwives with a special interest in breastfeeding based on M4, to support good practice, improve initiation rates, education for mothers and staff. It is hoped that targeted work will lead to an improvement, but this is not likely to be rapid. The Trust has committed to the long term plan to achieve, embed and sustain Unicef Baby Friendly standards. There are data quality issues with this indicator that is affecting the current trend. Processes to validate data to ensure figures are accurate are being reviewed by maternity services and Business Intelligence.

To deliver our key performance targets and financial plan

Finance

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Liquidity rating</div>		<p>Liquidity represents the number of days the Trust could meet its operating costs from its liquid resources (current assets less stocks and current liabilities). Year to date liquidity is negative 0.2 days which is 5.1 days higher than plan (4.9 days). The Trust has higher than planned net current (liquid) assets which has led to an above plan liquidity rating. The main reasons for this are:</p> <ol style="list-style-type: none"> 1. Less than plan : IFRS 16 Leases current liability £1.4m 2. Less than plan : 2022/23 Capital Expenditure £7.2m <p>Plan £-4.9m Actual £0.2m Variance £5.1m</p>	<p>No benchmark comparator available</p>
<div>Delivery of Capital Plan</div>		<p>Year to date 2022/23 capital spend is £0.7m which is £7.2m lower than plan. This is due to slippage against the profiled capital spend for:</p> <ol style="list-style-type: none"> 1. Maternity Theatres £1.6m 2. Cardiology Digital Systems £0.8m 3. Radiology Room 6 Equipment £1.3m 4. Other digital schemes £2.5m 5. Other estate improvement and backlog schemes £1.6m <p>2022/23 forecast capital expenditure is expected to be £25.8m which is £1.1m below plan (£26.9m).</p> <p>Plan £7.9m Actual £0.7m Variance £-7.2m</p>	

To deliver our key performance targets and financial plan

Performance

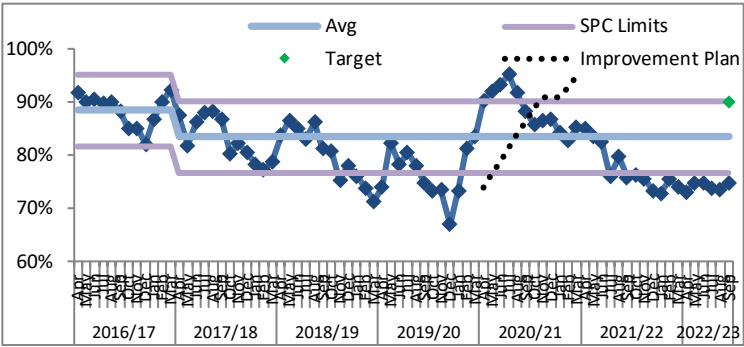
Metric / Status

Trend

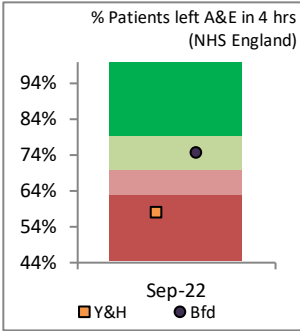
Challenges and Successes

Benchmarks

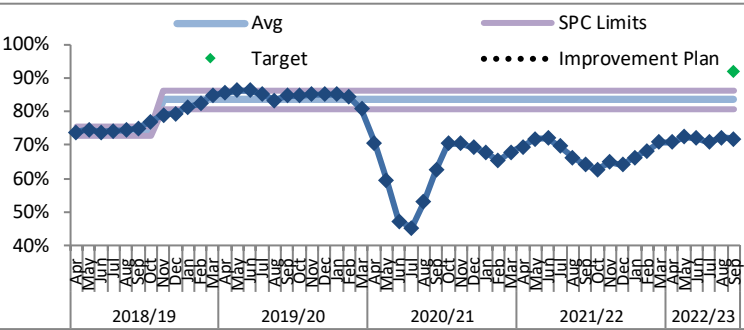
Emergency
Care
Standard



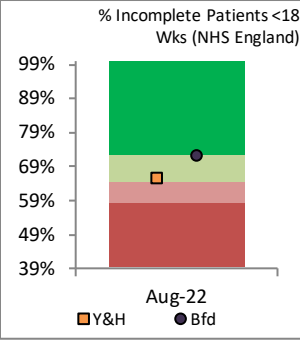
Emergency Care Standard (ECS) performance was at 74.82% for September 2022, which remains above peer and national average. We continue to use see and treat and Same Day Emergency Care (SDEC) pathways to help avoid admissions and congestion within the department whilst longer term improvement plans are being progressed which will divert unnecessary attendances. There has also been additional work undertaken to further improve flow which will reduce delays for admitted pathways. Attendances remain at or above pre-COVID levels.



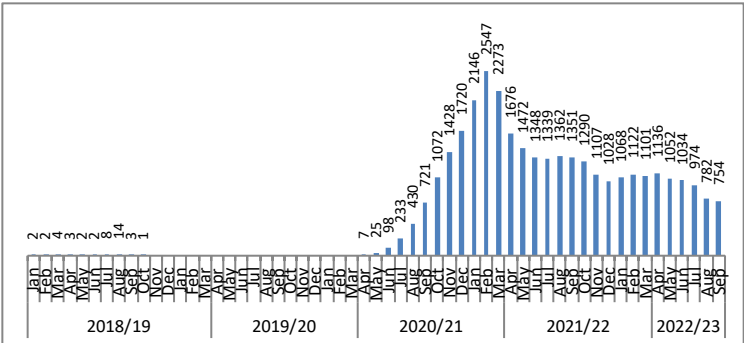
RTT 18 Week
Incomplete



RTT performance continues to track the national trend and is above peer and national average. Theatre activity remains higher than during the pandemic but slightly below 2019-20 baselines. Admitted pathways are the main challenge as a result and with clock starts increasing performance may deteriorate. Theatre productivity is reviewed weekly and improvement actions are being progressed to reduce delays and increase throughput to prevent this happening.



RTT 52
Week Wait



The Trust had 754 incomplete 52 week waits at the end of September 2022 which is an improving trend. As a percentage of the total waiting list this places the Trust in the best performing quartile nationally. 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

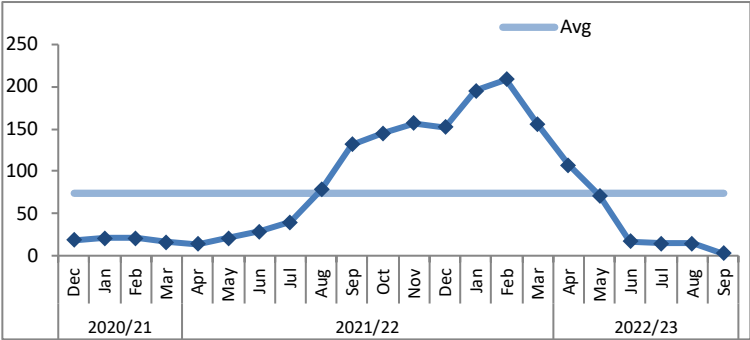
To deliver our key performance targets and financial plan

Performance



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. A good level of reduction has been seen, there were 3 patients waiting over 104 weeks at the end of September and none are forecast to be waiting at the end of October.

To deliver our key performance targets and financial plan

Performance

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Elective Waiting List</div>		<p>The total RTT waiting list started to increase. Clock stops remain ahead of plan but clock starts have increased to levels greater than those originally modelled. This is being investigated and activity targets will be adjusted to respond to any growth in demand.</p>	<p>No benchmark comparator available</p>
<div>Diagnostic Waits</div>		<p>MRI recovery has been delayed due to increased GP demand and further unexpected downtime of the scanners, additional sessions have been extended in response and improvement is forecast. Endoscopy capacity has been increased but demand is also increasing, particularly for cancer which is putting pressure on routine wait times. As further vacancies are recruited to performance will improve. Obstetric ultrasound capacity is up 25% on baseline which impacted on Non-Obstetric performance in September. Additional sessions are running in October and a longer term plan is being finalised to accommodate the overall growth in demand.</p>	

To deliver our key performance targets and financial plan

Performance

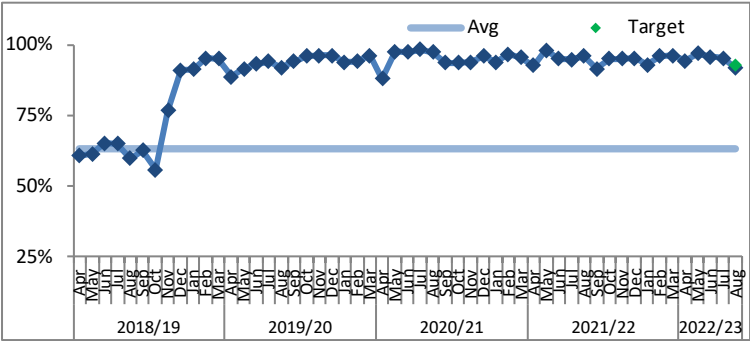
Metric / Status

Trend

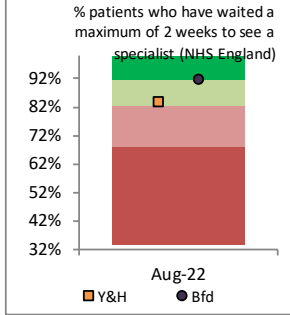
Challenges and Successes

Benchmarks

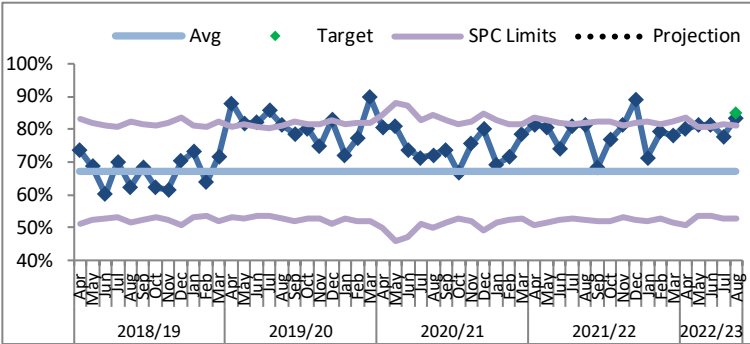
Cancer
2 Week
GP



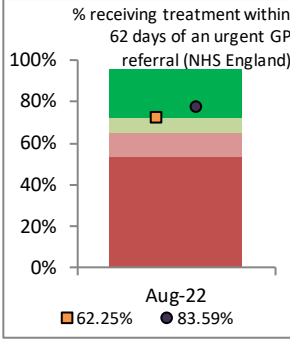
August 2022 performance against the 2 Week-Wait Cancer standard was below target at 87.58%. This was a result of the capacity issues within Lower GI which also impacted on Upper GI due to cover arrangements. Increases in workforce throughout Q3 will support recovery against this KPI in November or December.



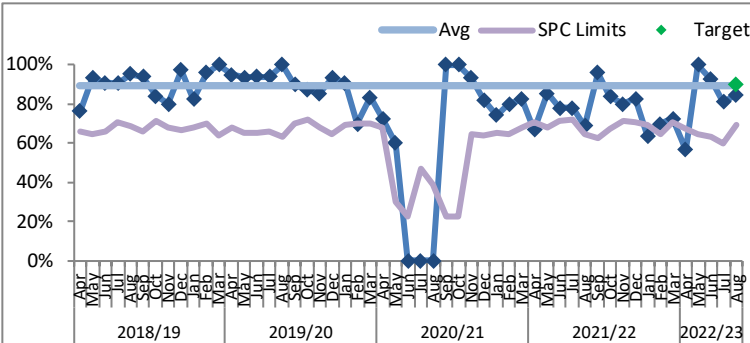
Cancer
62 Day
Urgent GP



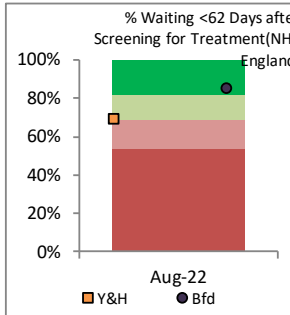
Diagnostic and surgical capacity is being prioritised in support of long cancer waits with improvements in time to diagnosis and decision to treat. Performance remains in the upper quartile nationally with the high volume tumour groups of Skin, Breast and Urology sustaining performance above the 85% target. Increased referral demand and capacity issues on some of the other tumour groups mean the number of patients waiting longer than 62 days is higher than planned but improvement actions are progressing well to support future delivery of the overall target.



Cancer
62 Day
Screening



Performance for this indicator reflects the complexity of pathways, patient concordance, and delays in diagnosis across Breast and Lower gastrointestinal (GI) services.



To deliver our key performance targets and financial plan

Productivity

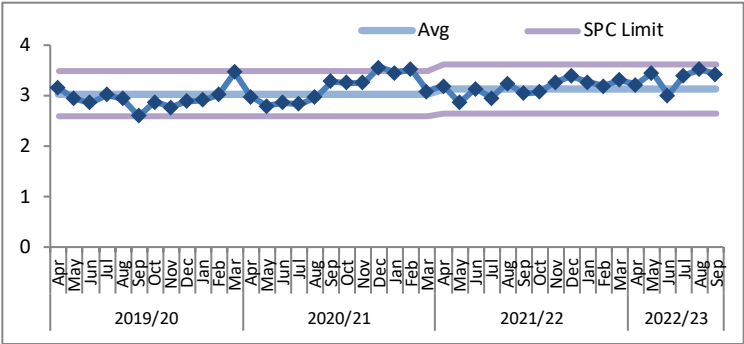
Metric / Status

Trend

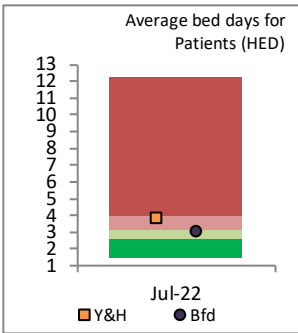
Challenges and Successes

Benchmarks

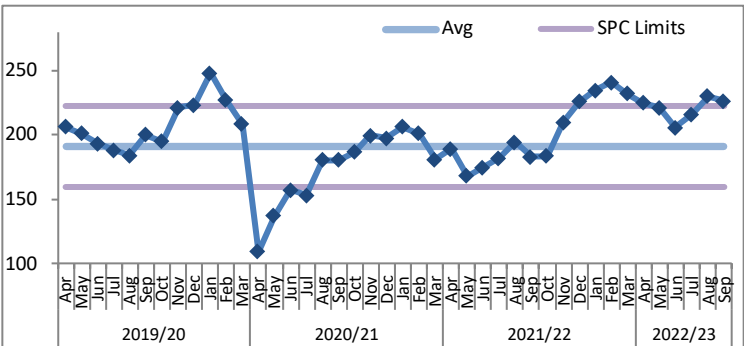
Length of Stay



Average length of stay (LoS) remains within control limits but has been increasing due to high demand and challenges with discharging to community placements. Improvement work is underway across all wards in support of patient flow and decision making, this includes improving discharge practice to reduce length of stay.



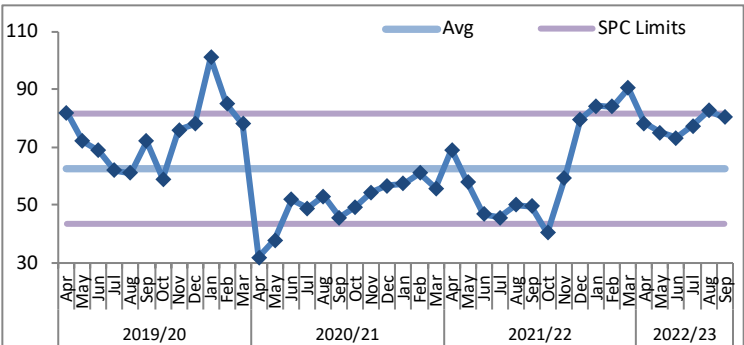
Stranded Patients
Length of Stay
≥ 7 days



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.

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.

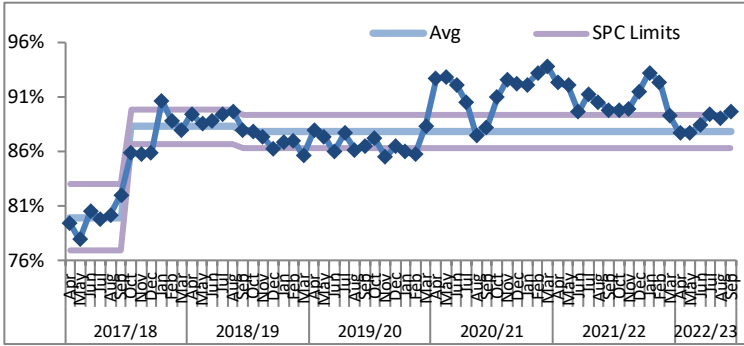
No benchmark comparator available

To deliver our key performance targets and financial plan

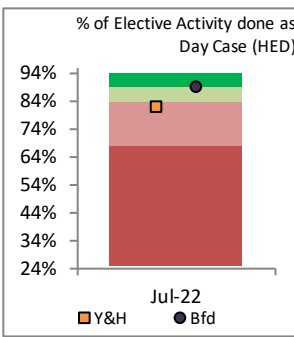
Productivity

Metric / Status	Trend	Challenges and Successes	Benchmarks
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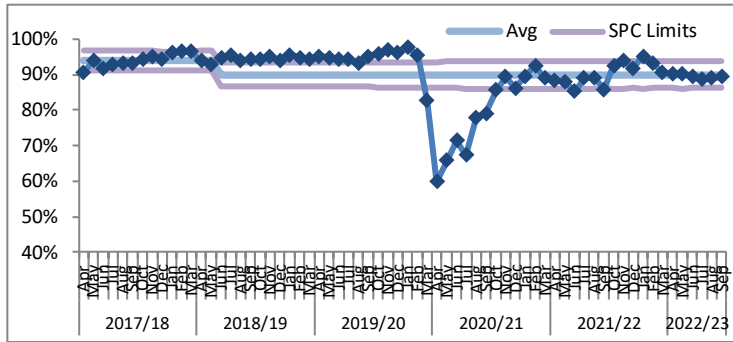
Elective Day Case Rate



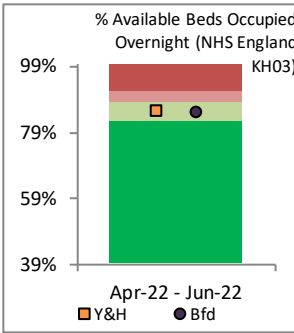
Day case rates continue to be above the national and regional average.



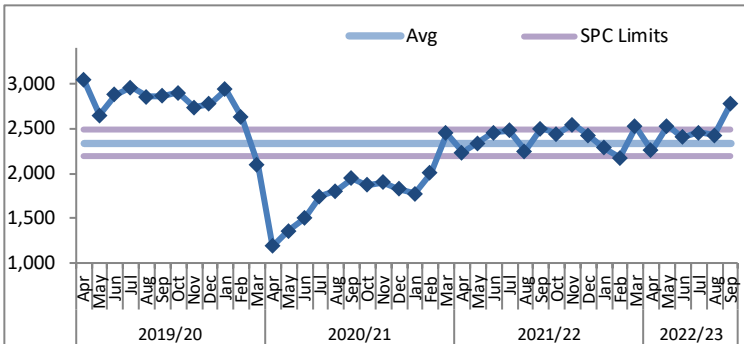
Bed Occupancy



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.



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.

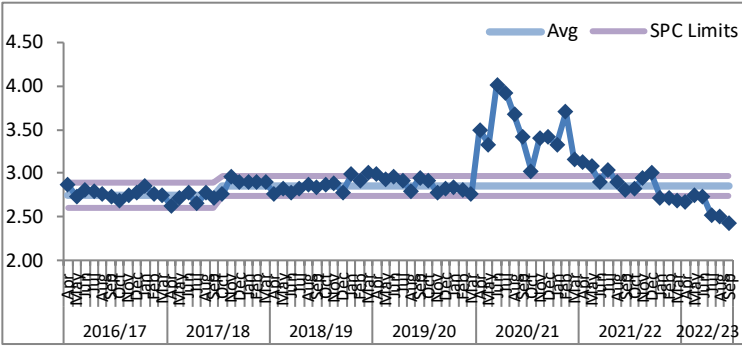
No benchmark comparator available

To deliver our key performance targets and financial plan

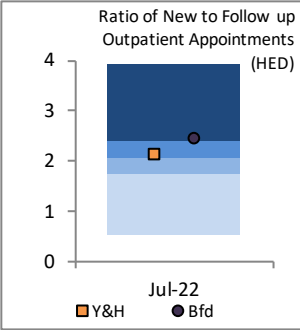
Productivity

Metric / Status Trend Challenges and Successes Benchmarks

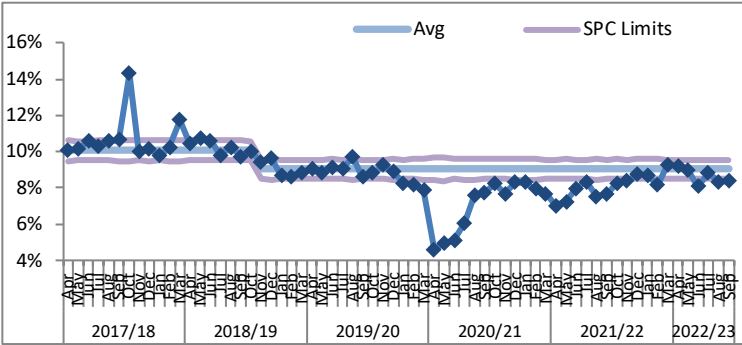
New to Follow Up Ratio



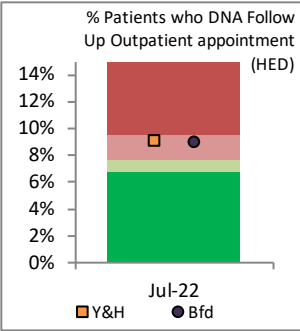
New outpatient appointments have increased as part of the 2022/23 plan to meet waiting list demand. Follow ups have reduced slightly, with a number of schemes in place to reduce unnecessary attendances such as PIFU and digital outpatients.



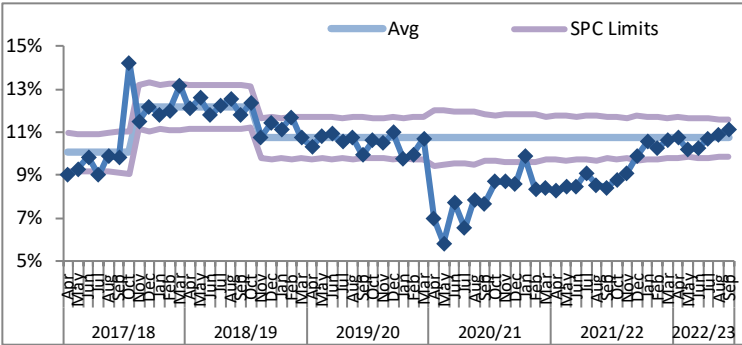
Did not Attend Follow Up



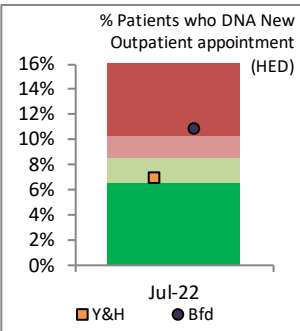
Did not attend (DNA) rates are slightly below pre-COVID levels which may relate to the increased use of virtual appointments or PIFU for patients who don't need a FTF appointment and may have been more likely to DNA in the past.



Did not Attend New



Did not attend (DNA) rates have returned to pre-COVID levels. An act as one project is in place to reduce DNA rates. This work is also being linked to the health inequalities agenda as data shows a correlation between age, deprivation and DNA rates. Improving access to digital alternatives is being explored.

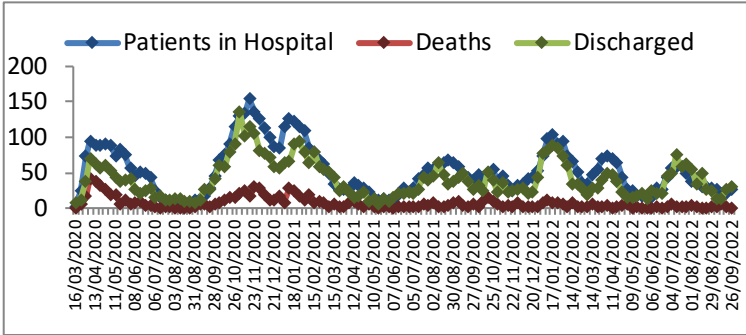


Metric / Status

Trend

Challenges and Successes

Benchmarks



COVID-19 demand is once again increasing which is putting pressure on a number of KPI's. due to reduced beds and increased percentage occupancy.

No benchmark comparator available

To be in the top 20% of employers

Engagement

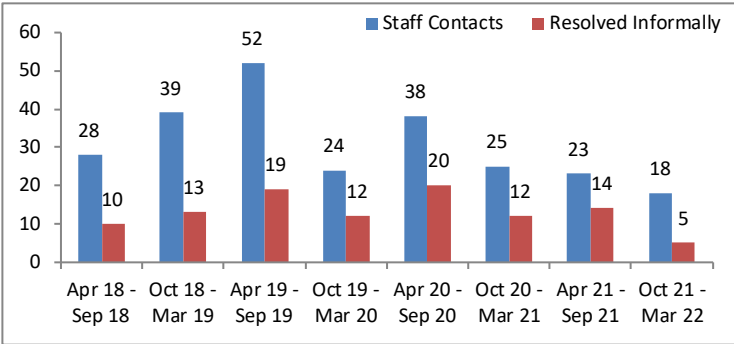
Metric / Status

Trend

Challenges and Successes

Benchmarks

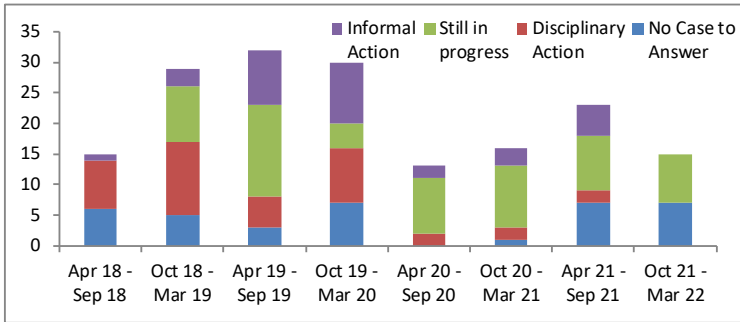
Contacts with
Advocacy
service



Contacts with the Staff Advocacy service have dipped slightly in the last 6 months and the proportion of cases being resolved informally has also reduced slightly to 28%. 28% of cases involved providing valuable support to staff already undergoing formal processes. The service will undergo a review in the coming months as part of the planned work around civility in the workplace. This may indicate a need to expand and promote the refreshed service more widely and ensure that it complements other ongoing activity/ support provided, including the new workplace mediation service (which now provides a further avenue for resolving conflict informally).
Next update November 2022 (for the period 01/04/22 to 30/09/22)

No benchmark
comparator available

Harassment &
Bullying
Outcomes



The number of formal cases ongoing during the last 6 months has dipped significantly from 25 to 15 cases (with 8 of these cases still in progress). This is a really positive reduction in the number of formal cases. However, it is worth noting that the hold on formal cases as a result of the pandemic may still be impacting on the figures. Of the 7 cases that were completed during the period 100% of the outcomes were “no case to answer”. The Trust is planning to launch its civility in the workplace campaign in June 2022 and, along with the new workplace mediation service this will play a crucial role in the wider culture change required, with focus on “nipping things in the bud” at an early stage.
Next update November 2022 (for the period 01/04/22 to 30/09/22)

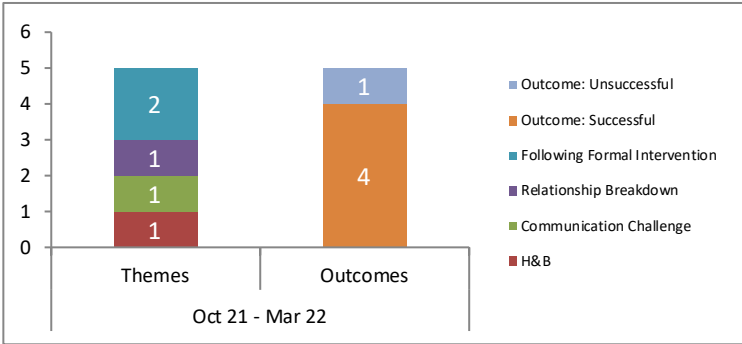
No benchmark
comparator available

Metric / Status

Trend

Challenges and Successes

Benchmarks



7 staff were trained as accredited workplace mediators and the workplace mediation service underwent a soft launch in October 2021 with plans for a more formal launch and wider comms as part of the civility launch (June 2022). 5 cases with a range of themes were undertaken during the 6 month reference period with successful outcomes/ actions agreed in 4 out of the 5 cases (80%). Initial feedback has been very positive, although has highlighted a need to ensure cases are appropriately referred.

Next update November 2022 (for the period 01/04/22 to 30/09/22)

To be in the top 20% of employers

Engagement

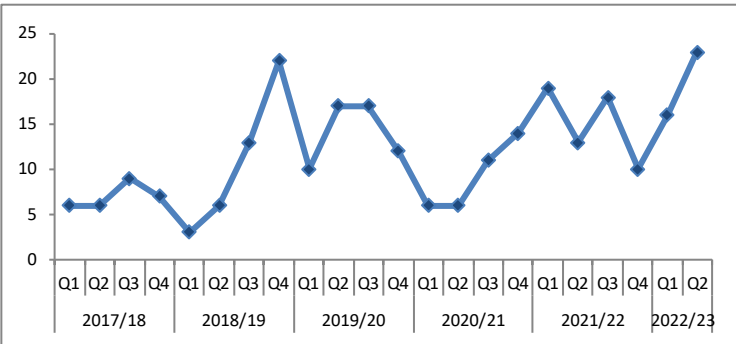
Metric / Status

Trend

Challenges and Successes

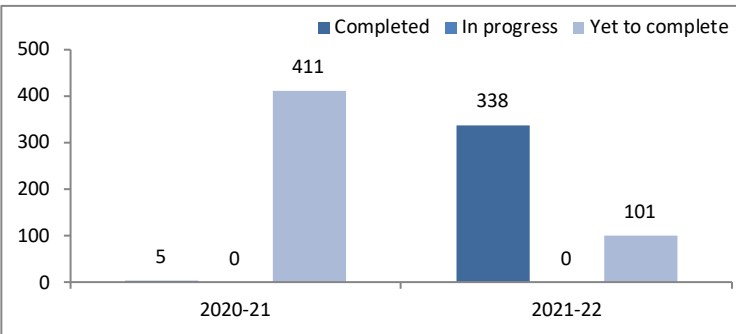
Benchmarks

Referrals to FTSU



In Q2 there were 23 concerns raised to the Freedom to Speak Up team. 2 concerns was raised 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 23 concerns raised in Q2, 10 concerns were raised due to inappropriate attitudes and behaviours, and 5 concerns were raised about patient safety or quality. 5 concerns were raised due to bullying or harassment. 4 concerns were due to worker safety or wellbeing. The National Guardian’s Office have specific categories to report on only.

Appraisal Rate Medical



2020-21: Limited number of appraisals between 1st April 2020 and 31st March 2021 as permitted by the guidance of flexibility during this period by NHSE. This was due to high caseload of Covid-19 seen in Bradford with resultant sustained pressures in workloads throughout the Trust.

2021-22: 338 (76.99%) doctors received an Outcome Measure 1 (Completed appraisal). 101 (23.01%) doctors were allocated an Outcome Measure 2 (Approved Missed appraisal). This group includes doctors on sick leave, maternity leave, recent retirements and new connections at 31st March 2022 who have not been in post for a sufficient duration to have undergone the appraisal process. There were no Outcome Measure 3 appraisals (Unapproved Missed appraisal) for this period.

To be in the top 20% of employers

Engagement

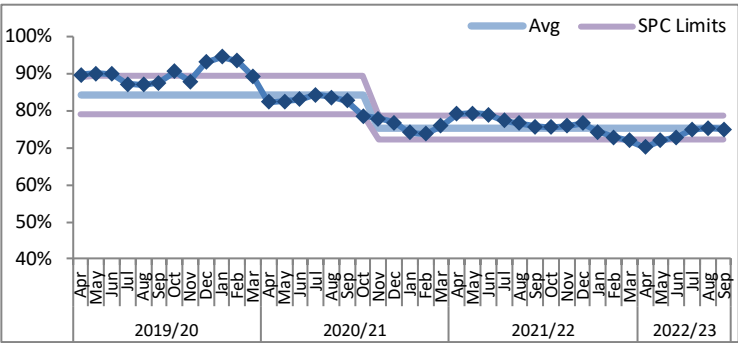
Metric / Status

Trend

Challenges and Successes

Benchmarks

Appraisal
Rate
Non-Medical



The non-Medical appraisal rate for September 2022 is at 75.00%. Work is underway to update the Time2Talk appraisal paperwork to include discussion and feedback around behaviours and values. This will be launched in November and provides a good opportunity to promote non-medical appraisals. We are currently awaiting the final report from internal audit on non medical appraisals.

To be in the top 20% of employers

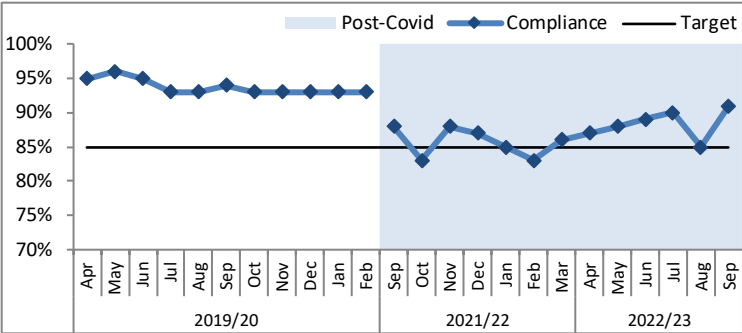
Training & Development

Metric / Status

Trend

Challenges and Successes

Benchmarks



The overall Compliance metric for core mandatory training is set at 85% across all 11 core subjects. The overall compliance across all mandatory topics is 91% an increase of 6% from last month. Safeguarding adults level 4 has the lowest compliance rate with 50% of the 22 people required to complete remaining non compliant. Each of the broad service areas are achieving >85% compliance apart from Planned Services who are at a total Of 82%. Targeted actions continue to promote compliance.

To be in the top 20% of employers

Staffing

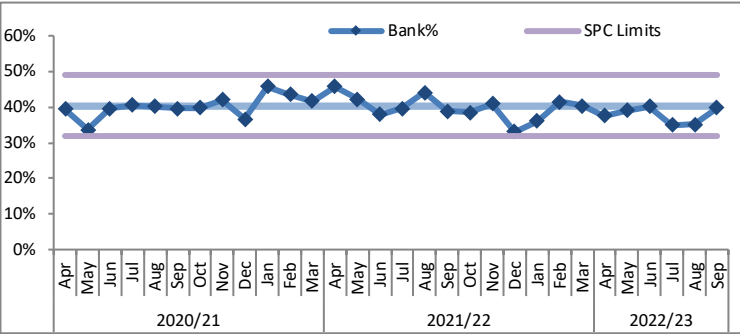
Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Staff Turnover</div>		<p>Turnover has seen a slight decrease to 12.77% in September 2022 from 13.11% in August 2022.</p>	<p>No benchmark comparator available</p>
<div>Staff Stability</div>		<p>The stability index shows the percentage of staff who are in post at the start of each month and remain in post at the end of the month. The stability rate is 98.40% in September 2022 which is an increase from 96.28% in August 2022. The rate is consistently around 98% to 99% throughout the year however it does dip in August which is due to staff on fixed term contracts being included, and there are large numbers of junior doctors who leave in August.</p>	
<div>Number on an apprenticeship programme</div>		<p>Bradford Teaching Hospitals NHS Foundation Trust currently has 295 members of staff on an apprenticeship programme. These are in a wide range of levels, ranging from an entry level qualification to masters level qualifications. The subjects mirror the variety of roles offered across the trust, including Nursing, Allied Health Professionals and Health Scientists to technical, administrative and trade roles.</p>	

To be in the top 20% of employers

Staffing

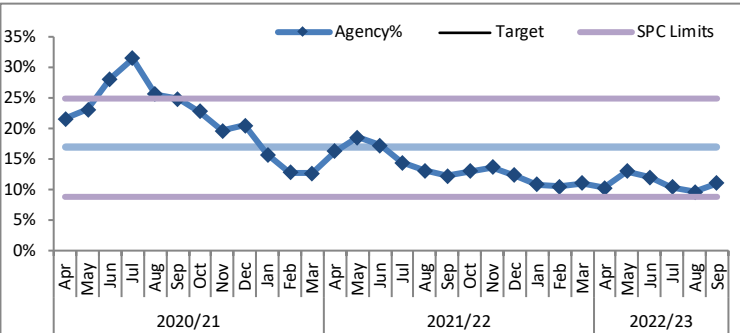
Metric / Status	Trend	Challenges and Successes	Benchmarks
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Nursing Bank Fill Rate



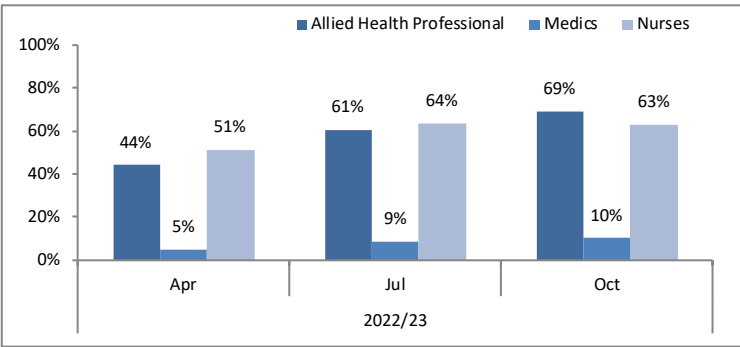
This newly introduced metric reports on the monthly fill rates for bank staff working as Registered Nurses, HCA/HCSW, Midwives and Theatre Practitioners and ODPs. In September the fill rates we filled were 5669 shifts in the month with bank staff. This is split 2367 registered staff and 3302 unregistered. Out of the 2367 filled registered shifts, 324 were filled by registered Theatre staff.

Nursing Agency Fill Rate



This newly introduced metric reports on the monthly fill rates for agency staff working as Registered Nurses, HCA/HCSW, Midwives and Theatre Practitioners and ODPs. We only use agency HCA/HCSW in exceptional circumstances, hence the low number. Agency staff filled 740 shifts in the month of September. This is split 649 registered staff and 91 unregistered. Out of the 649 filled registered shifts, 25 were filled by registered Theatre staff.

e-Job Planning



This newly shared data highlights the percentage of signed off job plans within the recently rolled out electronic system. The electronic job planning system has been implemented for Medics (consultants/specialist doctors), Allied Health Professionals and Nurses (Clinical Nurse Specialists). Over the past 6 months we have seen an increase in each area for agreed job plans. There are currently 868 clinicians registered within the system, all with a job plan either in progress or signed off. This figure is made up of 369 Medics, 318 AHPs and 181 Nurses. A Programme Board is also in place and is regularly monitoring the process and signed off plans.

To be in the top 20% of employers

Equality & Diversity

Metric / Status	Trend	Challenges and Successes	Benchmarks																																																												
<div><div></div><div>BAME Senior Leaders</div></div>	<table><tr><th>Year</th><th>Month</th><th>Value (%)</th></tr><tr><td>2016</td><td>Mar</td><td>10.0</td></tr><tr><td>2016</td><td>Sep</td><td>10.0</td></tr><tr><td>2017</td><td>Mar</td><td>9.5</td></tr><tr><td>2017</td><td>Sep</td><td>11.0</td></tr><tr><td>2018</td><td>Mar</td><td>11.5</td></tr><tr><td>2018</td><td>Sep</td><td>13.0</td></tr><tr><td>2019</td><td>Mar</td><td>14.5</td></tr><tr><td>2019</td><td>Sep</td><td>15.0</td></tr><tr><td>2020</td><td>Mar</td><td>15.0</td></tr><tr><td>2020</td><td>Sep</td><td>14.5</td></tr><tr><td>2021</td><td>Mar</td><td>14.0</td></tr><tr><td>2021</td><td>Sep</td><td>14.5</td></tr><tr><td>2022</td><td>Mar</td><td>15.0</td></tr><tr><td>2022</td><td>Sep</td><td>15.5</td></tr><tr><td>2023</td><td>Mar</td><td>-</td></tr><tr><td>2023</td><td>Sep</td><td>-</td></tr><tr><td>2024</td><td>Mar</td><td>-</td></tr><tr><td>2024</td><td>Sep</td><td>-</td></tr><tr><td>2025</td><td>Mar</td><td>-</td></tr></table>	Year	Month	Value (%)	2016	Mar	10.0	2016	Sep	10.0	2017	Mar	9.5	2017	Sep	11.0	2018	Mar	11.5	2018	Sep	13.0	2019	Mar	14.5	2019	Sep	15.0	2020	Mar	15.0	2020	Sep	14.5	2021	Mar	14.0	2021	Sep	14.5	2022	Mar	15.0	2022	Sep	15.5	2023	Mar	-	2023	Sep	-	2024	Mar	-	2024	Sep	-	2025	Mar	-	<p>A further slight increase in our Ethnic Minority representation at Senior Management levels over the last 6 months which has risen from 15.22% to 15.5%. This is a positive step in our ambitions to have a senior workforce reflective of the local population (35% by 2025). We continue to focus our efforts on providing development opportunities for aspiring leaders from an Ethnic Minority background and in ensuring we consider positive action approaches to recruitment for senior level roles as they arise.</p> <p>Next update November 2022 (for the period 01/04/22 to 30/09/22)</p>	No benchmark comparator available
Year	Month	Value (%)																																																													
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<div><div></div><div>BAME Workforce</div></div>	<table><tr><th>Year</th><th>Month</th><th>Value (%)</th></tr><tr><td>2016</td><td>Mar</td><td>27.0</td></tr><tr><td>2016</td><td>Sep</td><td>27.5</td></tr><tr><td>2017</td><td>Mar</td><td>28.5</td></tr><tr><td>2017</td><td>Sep</td><td>28.0</td></tr><tr><td>2018</td><td>Mar</td><td>29.5</td></tr><tr><td>2018</td><td>Sep</td><td>30.5</td></tr><tr><td>2019</td><td>Mar</td><td>30.0</td></tr><tr><td>2019</td><td>Sep</td><td>31.5</td></tr><tr><td>2020</td><td>Mar</td><td>32.0</td></tr><tr><td>2020</td><td>Sep</td><td>33.0</td></tr><tr><td>2021</td><td>Mar</td><td>33.0</td></tr><tr><td>2021</td><td>Sep</td><td>34.5</td></tr><tr><td>2022</td><td>Mar</td><td>34.65</td></tr><tr><td>2022</td><td>Sep</td><td>34.9</td></tr><tr><td>2023</td><td>Mar</td><td>-</td></tr><tr><td>2023</td><td>Sep</td><td>-</td></tr><tr><td>2024</td><td>Mar</td><td>-</td></tr><tr><td>2024</td><td>Sep</td><td>-</td></tr><tr><td>2025</td><td>Mar</td><td>-</td></tr></table>	Year	Month	Value (%)	2016	Mar	27.0	2016	Sep	27.5	2017	Mar	28.5	2017	Sep	28.0	2018	Mar	29.5	2018	Sep	30.5	2019	Mar	30.0	2019	Sep	31.5	2020	Mar	32.0	2020	Sep	33.0	2021	Mar	33.0	2021	Sep	34.5	2022	Mar	34.65	2022	Sep	34.9	2023	Mar	-	2023	Sep	-	2024	Mar	-	2024	Sep	-	2025	Mar	-	<p>The proportion of Ethnic Minority staff in the workforce has increased slightly again in the last 6 months from 34.65% to 34.9% indicating we have effectively achieved our target of having an overall workforce reflective of the local population (35%). Our focus in going forward will be to ensure we achieve this at all levels in the organisation.</p> <p>Next update November 2022 (for the period 01/04/22 to 30/09/22)</p>	No benchmark comparator available
Year	Month	Value (%)																																																													
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To be in the top 20% of employers

Equality & Diversity

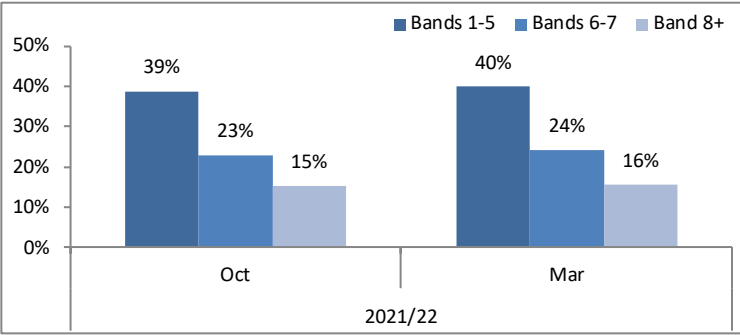
Metric / Status

Trend

Challenges and Successes

Benchmarks

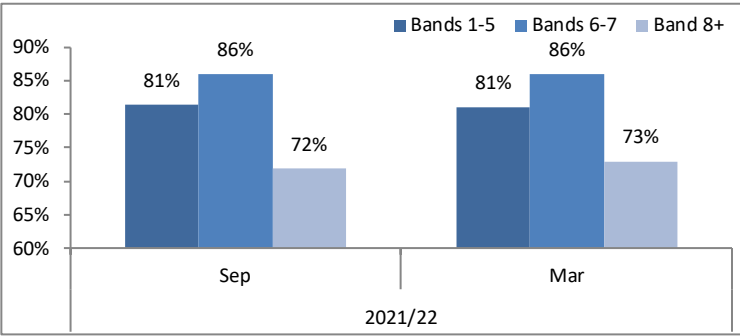
Ethnic minority workforce by band group



The data shows that ethnic minority staff are over represented in the lower bands (at 39.84%) and representation decreases as banding increases, with the most significant under representation at senior levels (15.5%). Positively there has been a 1% increase over the last 6 months at every level (which is reflected in our overall workforce figure). The focus of our WRES action plan will continue to address the need to work with our Race Equality Staff Inclusion network to ensure the development offers provided meet the required need of our ethnically diverse staff and with consideration of some targeted approaches for staff at bands 5-7 and above.

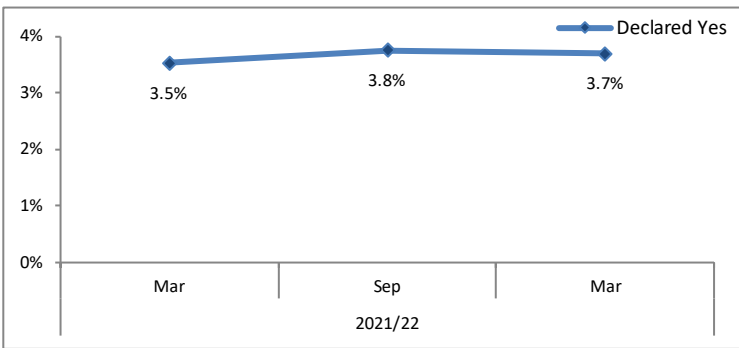
Next update November 2022 (for the period 01/04/22 to 30/09/22)

Female workforce by band group



Females currently make up 82% of our non-medical workforce (Nb Gender pay gap figures are slightly different as they incorporate medical & dental staff). Whilst they are proportionately represented at lower levels (81%), they continue to be significantly under-represented at senior levels (73%) and slightly over-represented at middle management levels (86%). In the last 6 months we have seen a 1% increase at senior management levels, which is positive, but with no change at middle management level (Bands 6/7). We are working collaboratively with our gender equality reference group to address gender inequalities in the workplace, with focus on women in leadership and addressing potential blockages to development (including flexible working).

Next update November 2022 (for the period 01/04/22 to 30/09/22)

Metric / Status	Trend	Challenges and Successes	Benchmarks								
<div>Disability Declaration Rate</div>	 <table><caption>Disability Declaration Rate Trend</caption><tr><th>Period</th><th>Declared Yes (%)</th></tr><tr><td>Mar</td><td>3.5%</td></tr><tr><td>Sep 2021/22</td><td>3.8%</td></tr><tr><td>Mar</td><td>3.7%</td></tr></table>	Period	Declared Yes (%)	Mar	3.5%	Sep 2021/22	3.8%	Mar	3.7%	<p>Our current disability declaration rate as recorded in the Electronic Staff Record (ESR) has remained fairly static at around 4% since we commenced reporting this for the Workforce Disability Equality Standard (WDES) in 2018. There continues to be a significantly higher proportion of staff survey respondents (c. 23% in 2021) who declare a disability/ long term health condition, indicating there are at least 19% of staff who have not declared their status in ESR.</p> <p>Increasing confidence in declaring a disability is a key focus for the WDES action plan, including; roll out of the disability equality training, collaborative work with the Enable staff equality network to raise the profile of disability equality across the Trust combined with a further equality census.</p> <p>Next update November 2022 (for the period 01/04/22 to 30/09/22)</p>	
Period	Declared Yes (%)										
Mar	3.5%										
Sep 2021/22	3.8%										
Mar	3.7%										

To be in the top 20% of employers

Health & Wellbeing

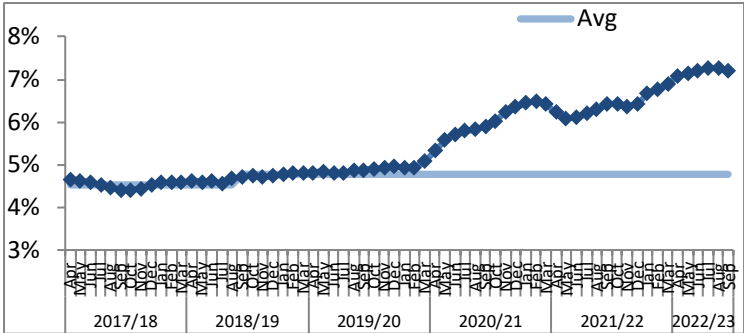


Metric / Status

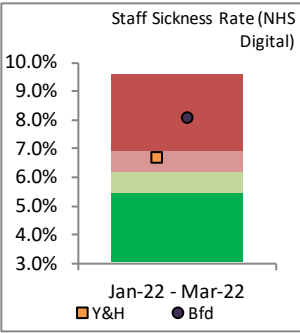
Trend

Challenges and Successes

Benchmarks



The rolling 12 month sickness absence rate at the end of September 2022 was 7.19% compared to 7.26% in August. This figure does not include staff who are self-isolating which is 0.02% in September, which is the same as in August 2022. Covid-19 related sickness has reduced from 1.03% in August to 0.75% in September 2022. Monthly absence in September reduced to 6.18% from 6.71% in August. Sickness target to be reviewed by the Looking After Our People Delivery Group.



To collaborate effectively with local and regional partners

Partnership

Metric / Status	Trend	Challenges and Successes	Benchmarks
	<p>BTHFT will focus on the factors it can directly influence while collaborating to achieve greater impact. For example there are links to our position as an Anchor organisation within BD&C. There is already a significant amount of activity by our teams to address inequalities but not always recognised as such as we are collating information across the CSUs and identifying opportunities to share best practice and address health inequalities. An analysis of waiting times has been undertaken to understand the impact of factors – including ethnicity and deprivation - on time to treatment. As a pilot exercise, Population Health Management data relating to the Stroke has been sourced to support CSU inequalities discussion. This approach will be repeated with each CSU in the new structure. BTHFT is a member of the BD&C Reducing 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>BD&C Health & Care Partnership was formally established as a committee of the WY ICB in July 2022, with a renewed focus on five topics: Children & Young People; Workforce Development; Communities; Access to Care; Mental Health, LD & Neurodiversity. Each has an oversight Board which effectively replaces the previous Bradford and AWC Partnership Boards. BTHFT continues to support the diabetes and respiratory transformation work although these are no longer entirely discrete programmes. All BD&C HCP activity is aligned to the Core 20 plus 5 inequalities approach.</p>		No benchmark comparator available
	<p>BTHFT is actively involved in new and existing clinical and operational networks, and discussions about sustainability of WY-wide services. For example, 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. There is agreement on a joint approach to the provision of aseptic services, with a super hub at Leeds and further investment in BTHFT’s “spoke”. The WY 5 year strategy is being renewed and will be published in March 2023, after sign off by the Partnership Board and NHSE. The 10 Big Ambitions will remain, with renewed emphasis on wellbeing, sustainability and other issues. The remainder of the strategy will change to reflect local priorities as well as the national asks.</p>		No benchmark comparator available
	<p>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. 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. BTHFT is 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, delivered with kindness				
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 financial plan and key performance targets				
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 one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion				
Engagement				4.4
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	5.0
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%	3.6
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.	4.6
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				4.4
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%	

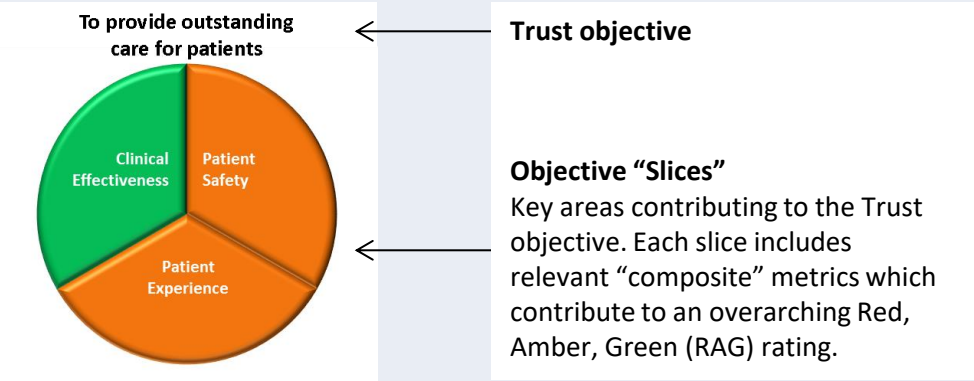
Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
Staffing				
Care Staff Shifts filled	Percentage of time care staff staffing hours are filled compared with planned.	Chief Nurse	Red < 80%, Amber 80% – 95%, Green > 95%	3.7
Care Staff Care Hours	Total of the actual number care staff 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 Manger roles at the Trust who are of Black, Asian or Minority Ethnic (BAME) background.	Director of Human Resources	Red >=2% below Trajectory Target, Amber >2% of Target, Green >= Target	4.6
BAME Workforce	Percentage of staff employed at the Trust who are of Black, Asian or Minority Ethnic (BAME) background.	Director of Human Resources	Red >=2% below Trajectory Target, Amber >2% of Target, Green >= Target	5.0
Health & Wellbeing				
Staff Sickness Absence	Percentage of staff time lost due to sickness in a given period (the reported month, year to date is the previous 12 months rolling average for which the Trust target is 4.5%.	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, to reduce health inequalities and achieve shared goals				
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 and recognised as leaders in research, education and innovation				
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.