

Integrated Dashboard

Board of Directors

31st March 2023

Integrated Dashboard

31st March 2023

To provide outstanding care for patients,
delivered with kindness



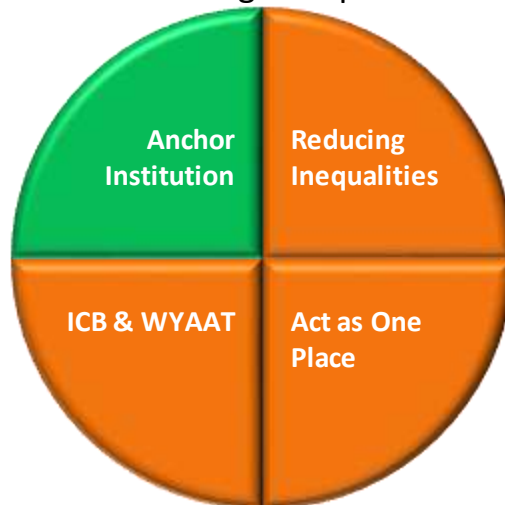
To deliver our financial plan
and key performance targets



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
<div>Hospital Standardised Mortality Ratio</div>		<p>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 (March 2023): 105.81 – within expected range.</p>	<p>No benchmark comparator available</p>
<div>Summary Hospital-level Mortality Indicator</div>		<p>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 (March 2023): 113.89 – within expected range.</p>	
<div>Readmissions</div>		<p>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.</p>	


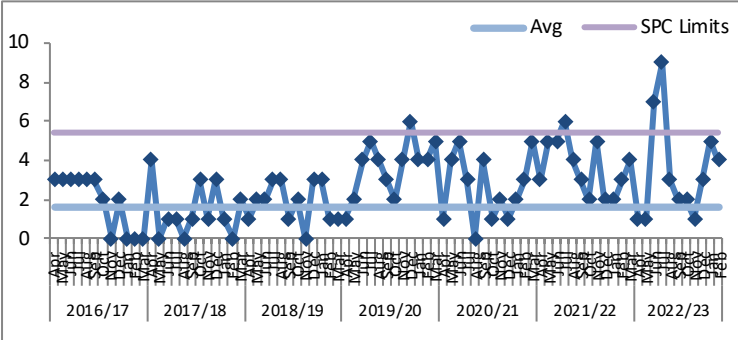
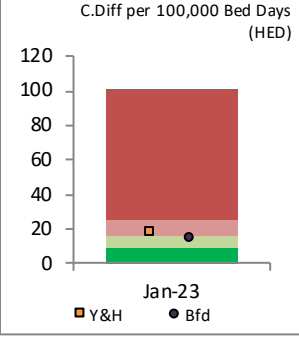

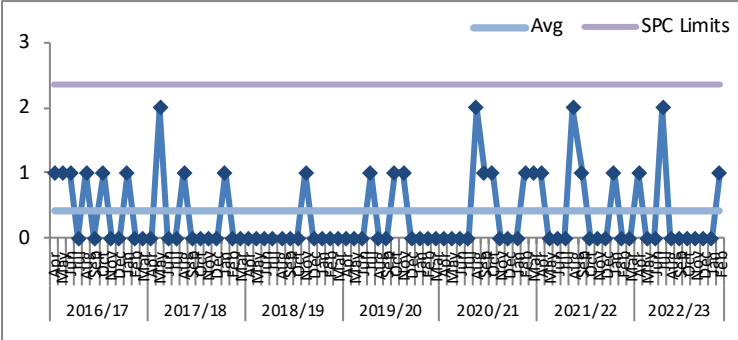
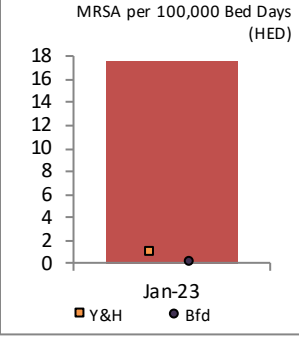

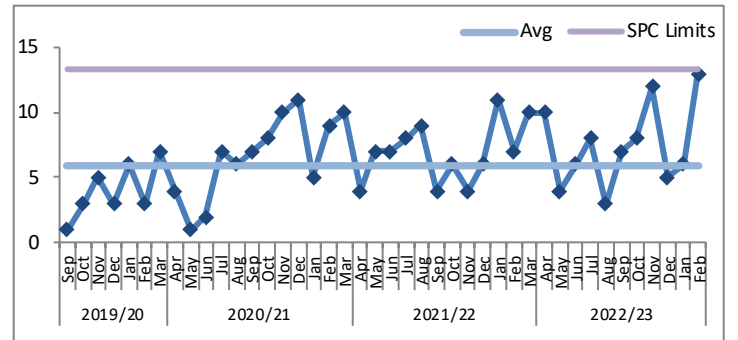
To provide outstanding care for patients

Learning from Deaths

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Percentage of deaths Scrutinised by the Medical Examiner</div>		<p>We continue to meet 100% scrutiny for all hospital deaths. There were 149 hospital deaths dealt with via our office in March 2023. We have engaged with all of the GP practices in our remit (55 out of 55 GP sites) and 28% of practices are routinely referring deaths through to the Medical Examiner's office. In March 2023, we scrutinised 79 Community deaths.</p>	
<div>Number of SJR Requests raised</div>		<p>There were three SJRs requested via the Medical Examiner's office for March 2023. A total of seven SJRs were completed by reviewers throughout March with six scoring between Adequate to Excellent overall care and one scoring Poor. This case will be reviewed at the Mortality Review Improvement Group (MRIG) being held w/c 17th April.</p> <p>Reasons for the SJR's requests raised in March 2023 include: Where learning will inform Quality Improvement work (n=1) Those with Learning Disabilities (n=2).</p>	

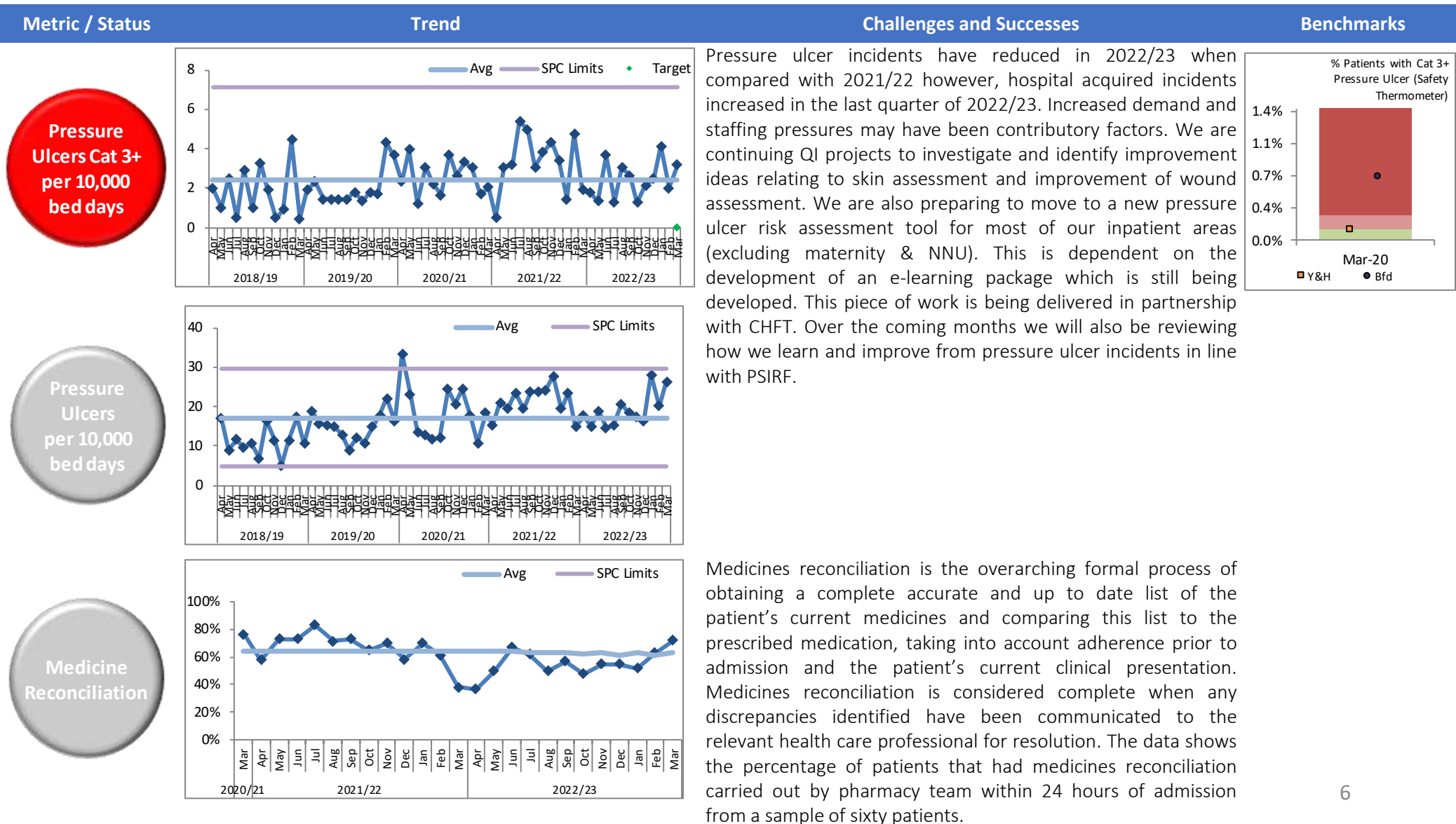
To provide outstanding care for patients

Patient Safety

Metric / Status	Trend	Challenges and Successes	Benchmarks
 <p>C Difficile</p>		<p>The Trust reported 46 hospital attributable C difficile cases during 2022/23 against an objective of 43 cases. All hospital attributable cases are subject to a comprehensive Post Infection review (PIR) process to identify any lessons to learn. Each room occupied by a patient with C. difficile receives a full decontamination utilising hydrogen peroxide vapour. Antibiotic usage is the most common risk factor associated with Clostridioides difficile infection. The role of antibiotic stewardship is a primary preventative strategy in the prevention of Clostridioides difficile infection and will be a focus during 2023/24 to reduce the usage of the high risk antibiotics</p>	
 <p>MRSA</p>		<p>The trust has reported 4 cases of MRSA bacteraemia during 2022/2023. A reducing Staphylococcus aureus improvement plan is in place with Progress against actions are monitored at IPCC. Since December 2022 there has been a particular focus on providing all acutely admitted patients with a 5 day supply of Octenisan body wash with compliance monitored using EPR. All patients with new CVC's followed up post insertion by IPCT until discharge to ensure high standards of aftercare are maintained.</p>	
 <p>E.Coli</p>		<p>A quality improvement initiative to improve hydration in the elderly has begun. In addition, initiatives to promote care and maintenance of both urinary catheter and mouthcare are being worked up by IPCT to support the hydration improvement plan with elderly patients in the first instance.</p>	

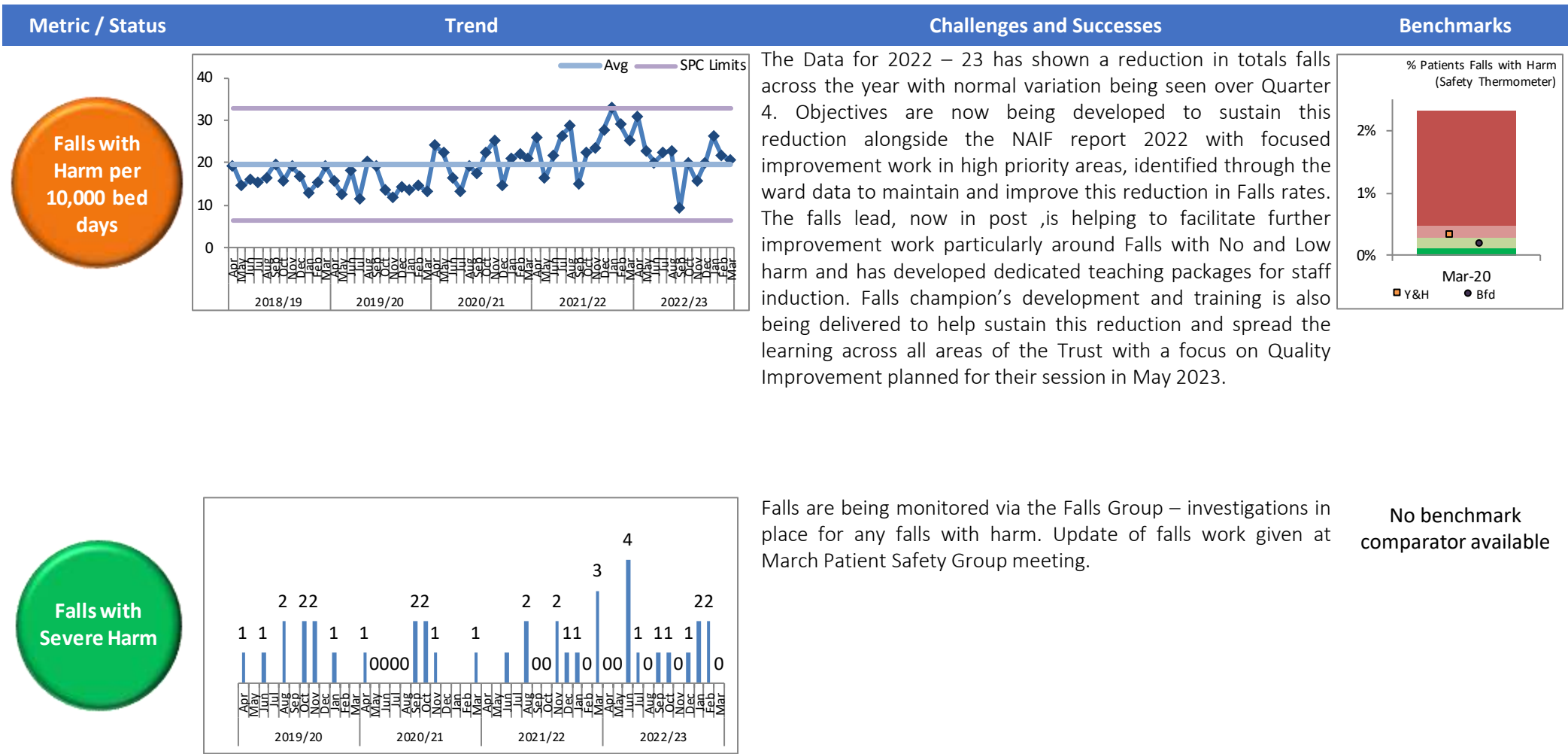
To provide outstanding care for patients

Patient Safety



To provide outstanding care for patients

Patient Safety




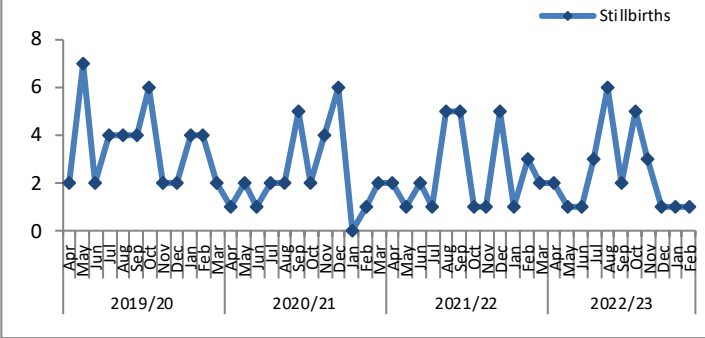

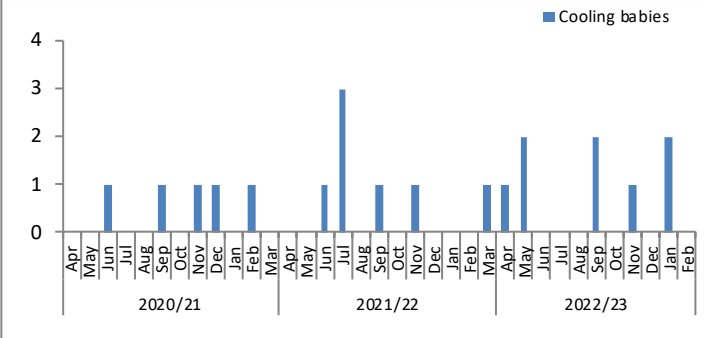

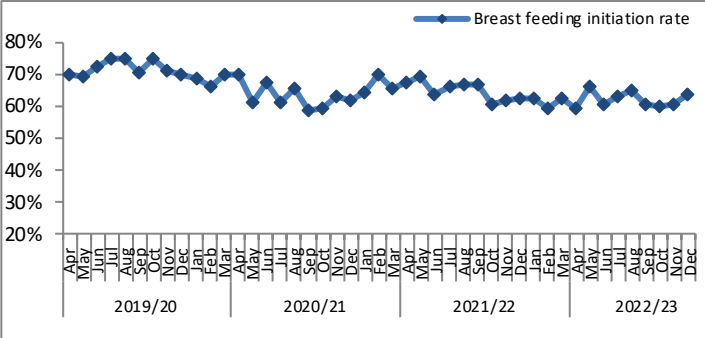
To provide outstanding care for patients

Patient Safety

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Sepsis Percentage of Patients Screened</div>	<p>The chart displays the percentage of patients screened for sepsis over a four-year period. The y-axis ranges from 40% to 90%. The x-axis shows months from April 2019 to March 2023. A blue line represents the average performance, which starts around 75% and shows a significant decline after 2021, reaching approximately 50% by March 2023. Two horizontal purple lines represent the SPC (Special Cause Process Control) limits at 75% and 80%.</p>	<p>Sepsis screening performance has started to improve over the last 3 months and is currently at 58%. This remains lower than our expected operational target of 90%. Work is ongoing across all areas of the trust to identify measures for continuing improvement to be sustained. The data excludes maternity and children under the age of 16 as recommended in the NHS standard contract 2023/24. Currently in discussion with CHFT with the aim to de-escalate current alert sooner for improved compliance, whilst awaiting NICE (NG51) pathway to be updated in July 2023.</p>	
<div>Severe Sepsis antibiotics given within an hour</div>	<p>The chart displays the percentage of severe sepsis cases where antibiotics were given within an hour. The y-axis ranges from 40% to 100%. The x-axis shows months from June 2021 to March 2023. A blue line represents the average performance, which fluctuates between approximately 78% and 90% throughout the period, generally staying above the 80% mark.</p>	<p>Performance is at 85% and 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.</p>	


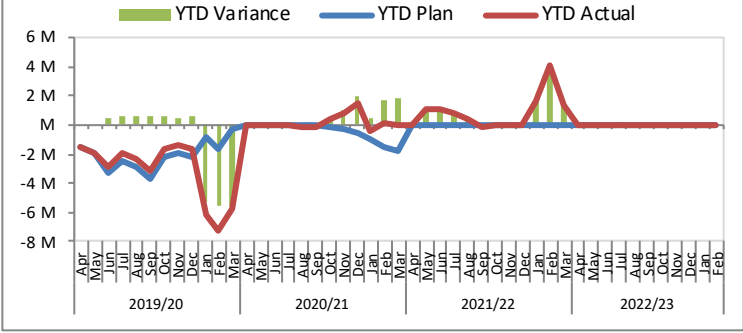

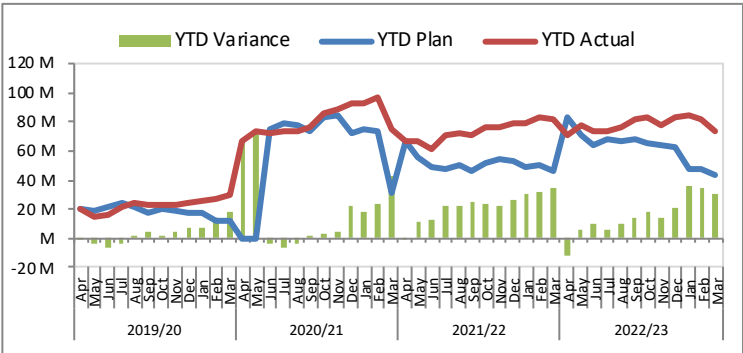
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Patient Safety

Metric / Status	Trend	Challenges and Successes	Benchmarks
 <p>Stillbirths</p>		<p>The total number of stillbirths in 2022 is 32, 8 of whom were babies with a known anomaly, not expected to survive. This is an increase on the 25 deaths occurring in 2021, however there is also a significant increase in the number of babies not expected to survive from 2 in 2021 to 8 in 2022. This demonstrates that the service is proactively supporting the choices of women and their families in continuing a pregnancy where the outcome is known to be poor and should be celebrated as good practice. The stillbirth rate for the calendar year January to December 2022, based on a birth rate of 5001, is 6.39/1000 births. However, when the 8 Butterfly babies for 2022 are removed the adjusted rate is 4.8/1000.</p> <p>There was 1 case of HIE since the previous reporting period. This case was referred to HSIB but declined as the baby had a normal MRI. It is being reviewed as an internal level 1.</p>	
 <p>Cooling babies</p>			
 <p>Breast feeding</p>		<p>The Trust has committed to the long term plan to achieve, embed and sustain Unicef Baby Friendly standards. The Infant Feeding co-ordinator appointed a number of midwives (with a special interest in breastfeeding based on M4) to support good practice, improve initiation rates and provide education for mothers and staff. At the October QPSA meeting it was agreed that this metric would be temporarily suspended from the dashboard as the data is not accurate due to missing data fields/DQ issues. Processes to validate data are being reviewed by maternity services and Business Intelligence.</p>	


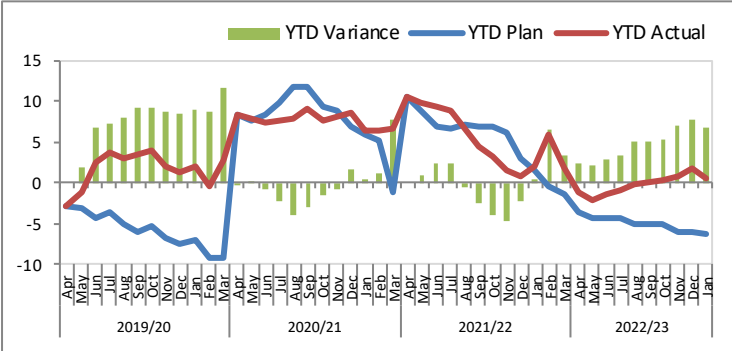

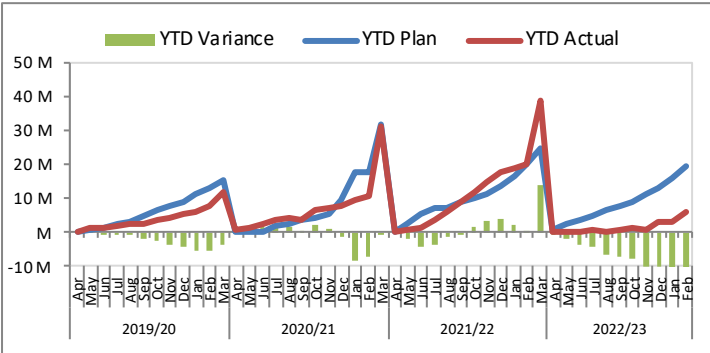
To deliver our key performance targets and financial plan

Finance

Metric / Status	Trend	Challenges and Successes	Benchmarks
 <p>Delivery of Income and Expenditure Plan</p>		<p>The unaudited month 12 position for the Trust is a small cumulative surplus Income & Expenditure (I&E) position of £0.2m. This represents a slight improvement on the breakeven plan for 2022/23.</p>	<p>No benchmark comparator available</p>
 <p>Delivery of Cash Plan</p>		<p>Closing cash is £73.1m which is £30.3m above plan (£42.8m). The main reasons for the variance from plan are:</p> <ol style="list-style-type: none"> 1. Increase in trade and other payables £39.2m 2. Reduction in capital expenditure (including capital payables) £10.8m 3. Increase in provisions £3.1m 4. Increase in receivables (£12.0m) 5. Decrease in deferred income (£7.0m) 6. Increase in inventories (£1.7m) 7. Decrease in borrowings (£2.2m) 	<p>No benchmark comparator available</p>

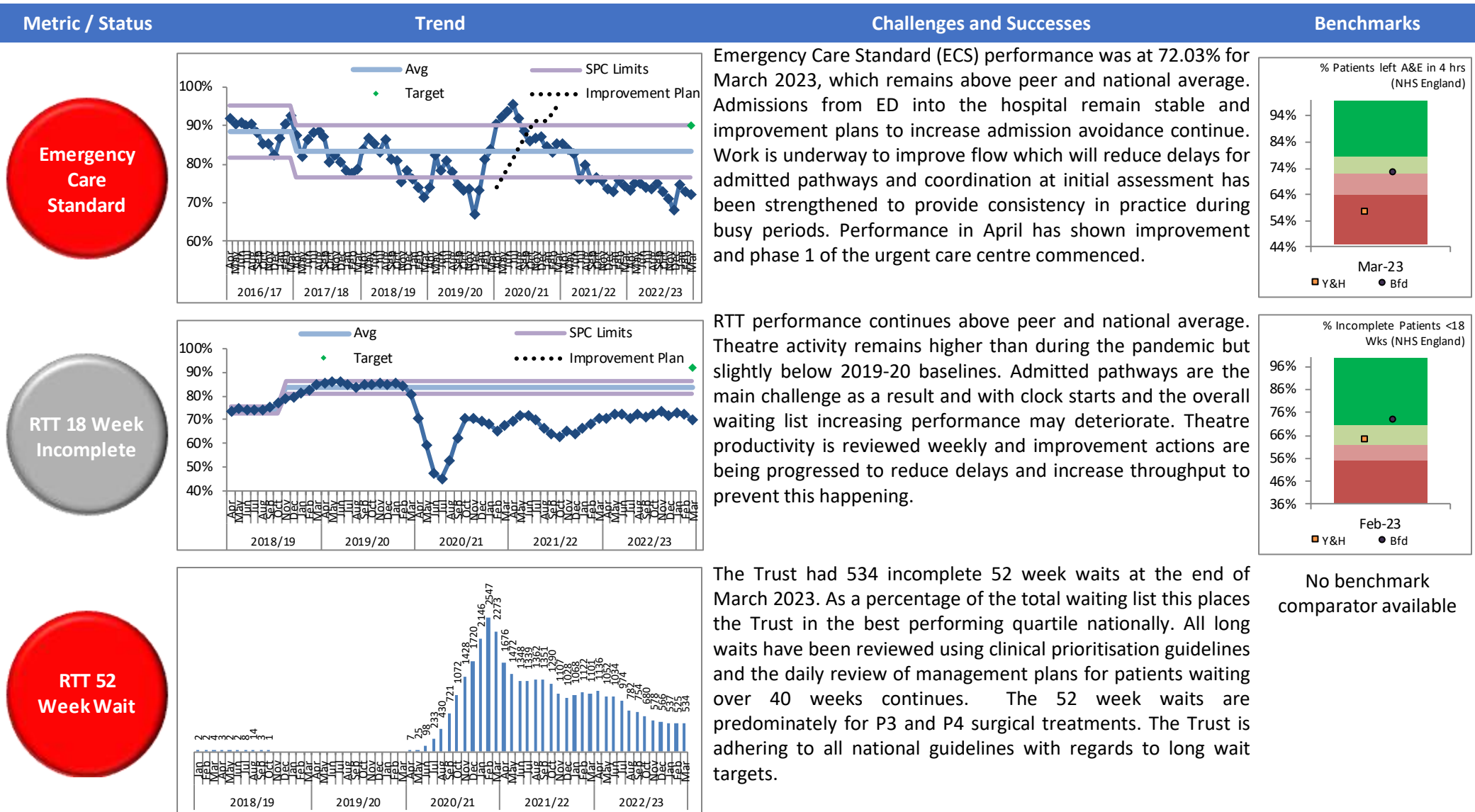
To deliver our key performance targets and financial plan

Finance

Metric / Status	Trend	Challenges and Successes	Benchmarks
 <p>Liquidity rating</p>		<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).</p> <p>Year to date liquidity is negative 7.6 days which is 4.0 days higher than plan (negative 11.6 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 £2.6m 2. Less than plan : 2022/23 Capital Expenditure £5.3m 3. Less than plan: Deferred income £5.1m 	<p>No benchmark comparator available</p>
 <p>Delivery of Capital Plan</p>		<p>Total capital expenditure in 2022/23 is £21.5m which is £5.4m lower than plan (£26.9m). Key variances are:</p> <ol style="list-style-type: none"> 1. Underspend on IFRS 16 leases (£3.2m) 2. Underspend on works to the Estate (£1.5m) 3. Underspend on IT improvements (£0.7m) 4. Underspend on Medical Equipment (£1.8m) 5. Net increase to PDC allocations £1.8m 	

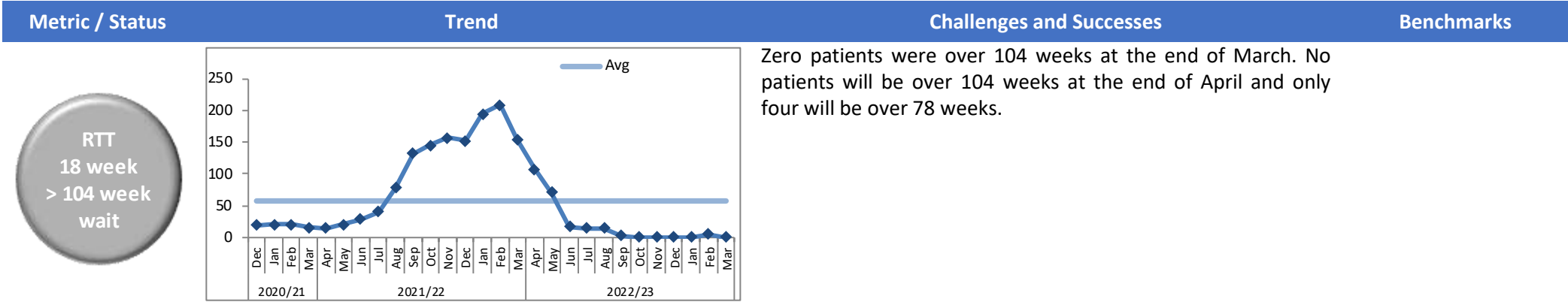
To deliver our key performance targets and financial plan

Performance



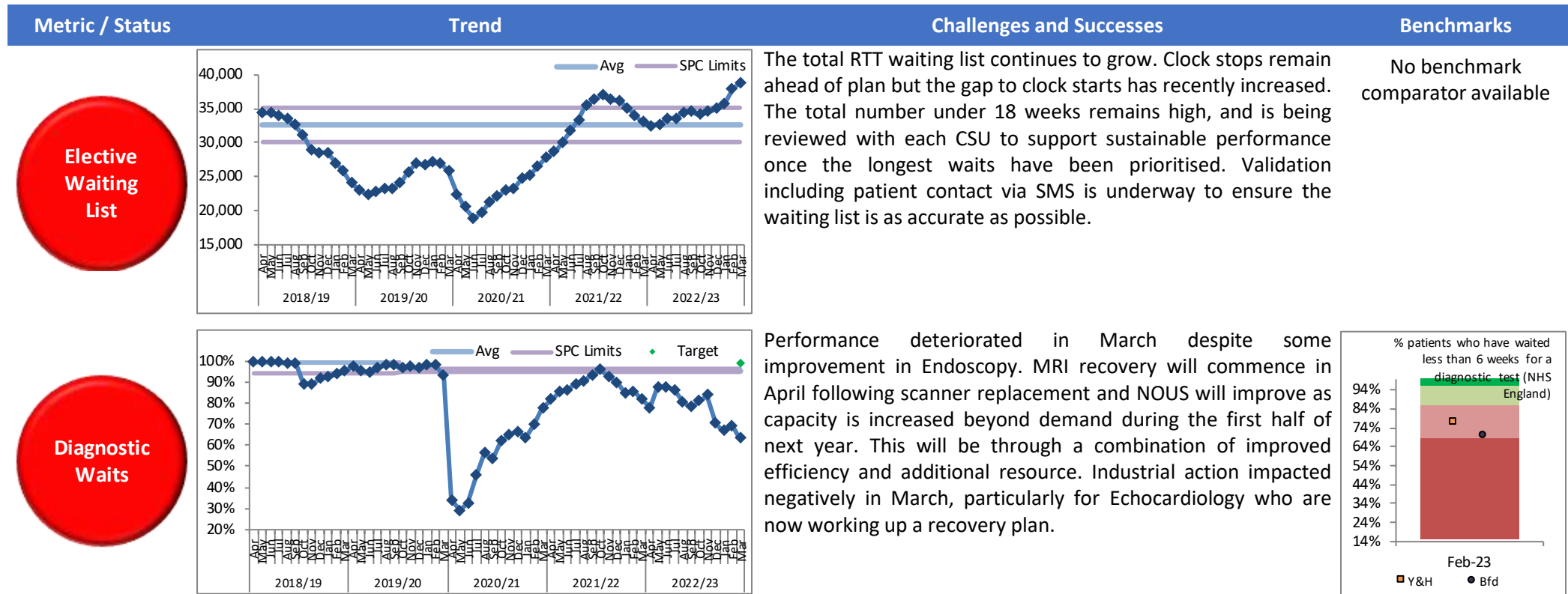
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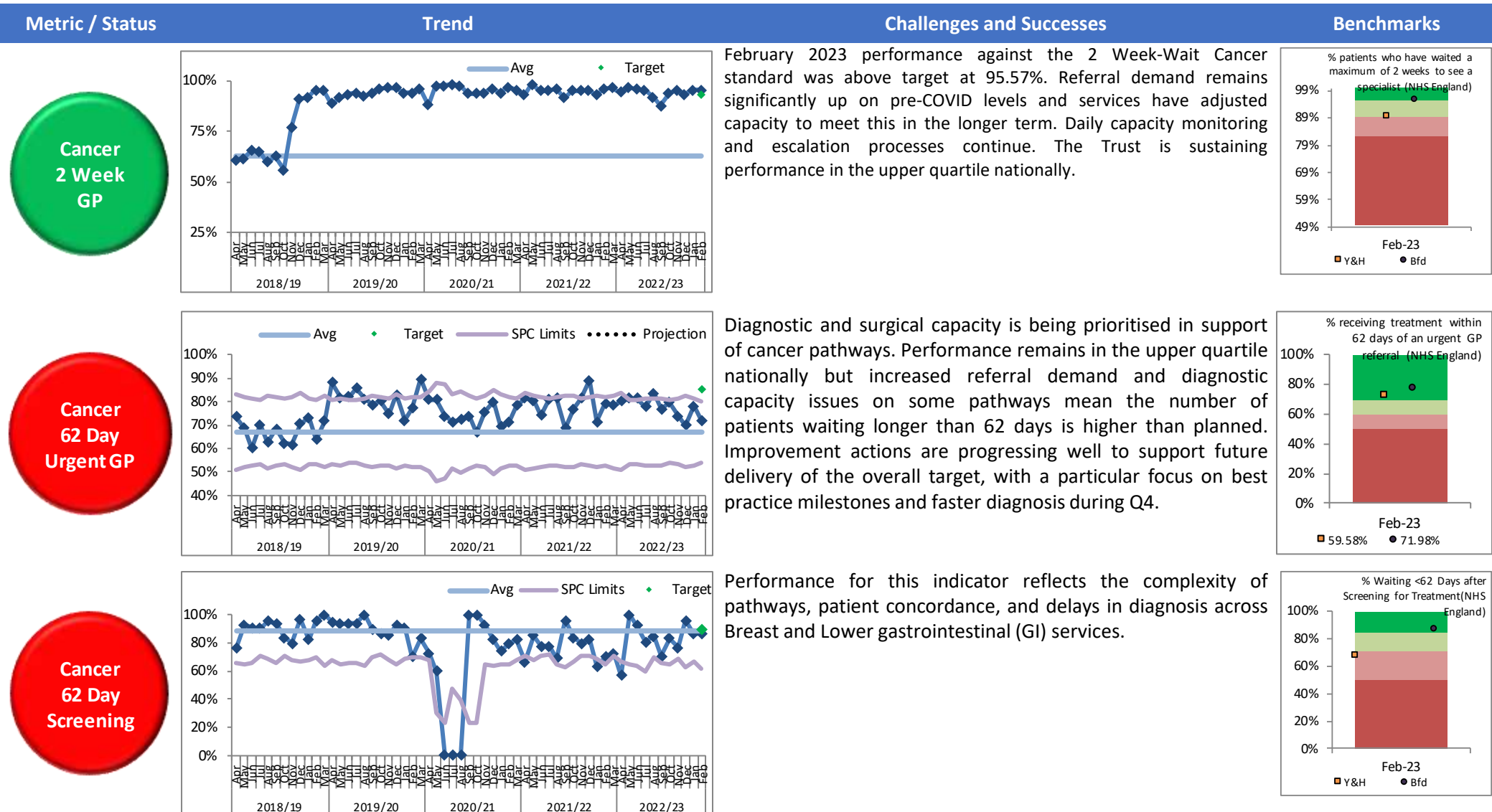
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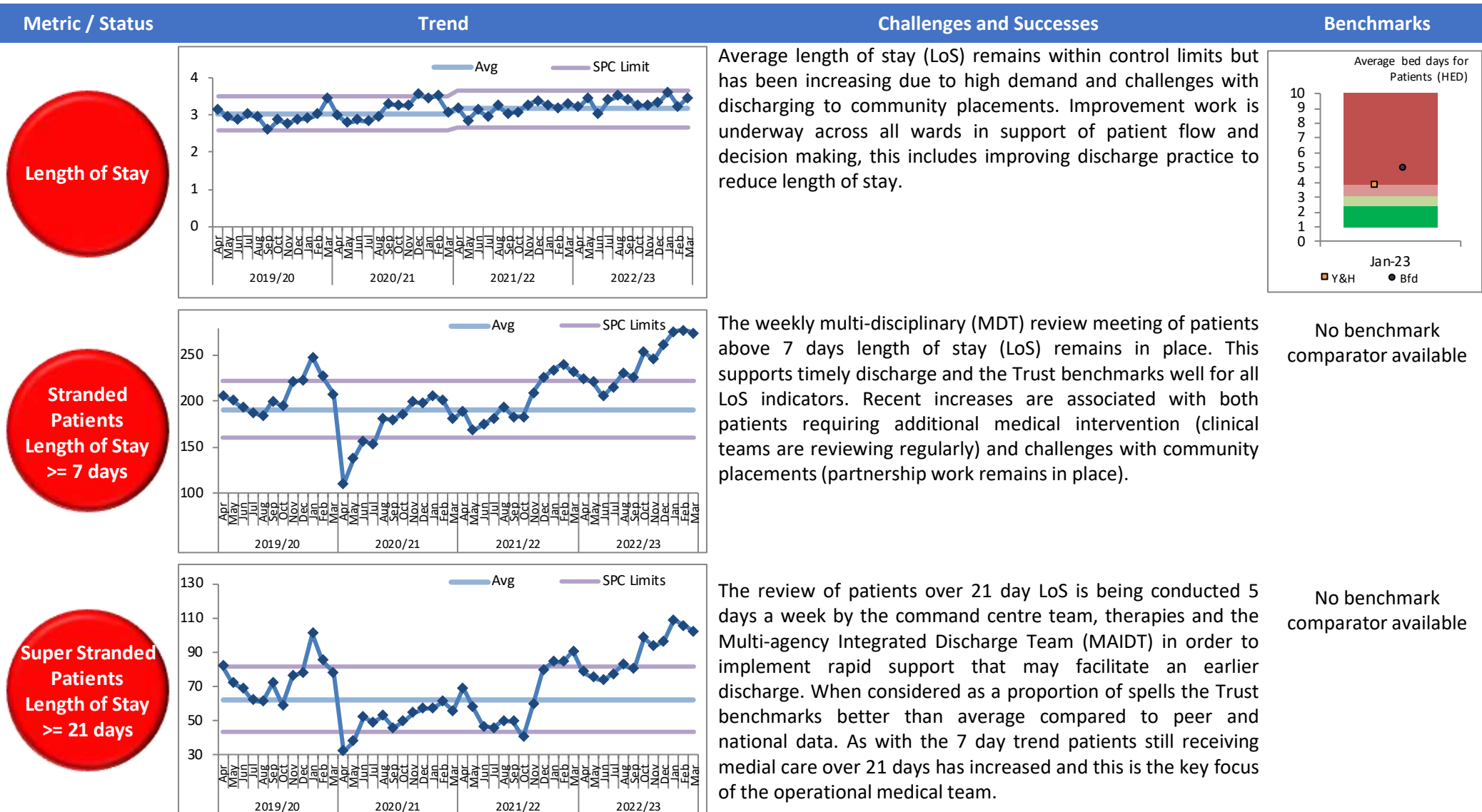
To deliver our key performance targets and financial plan

Performance



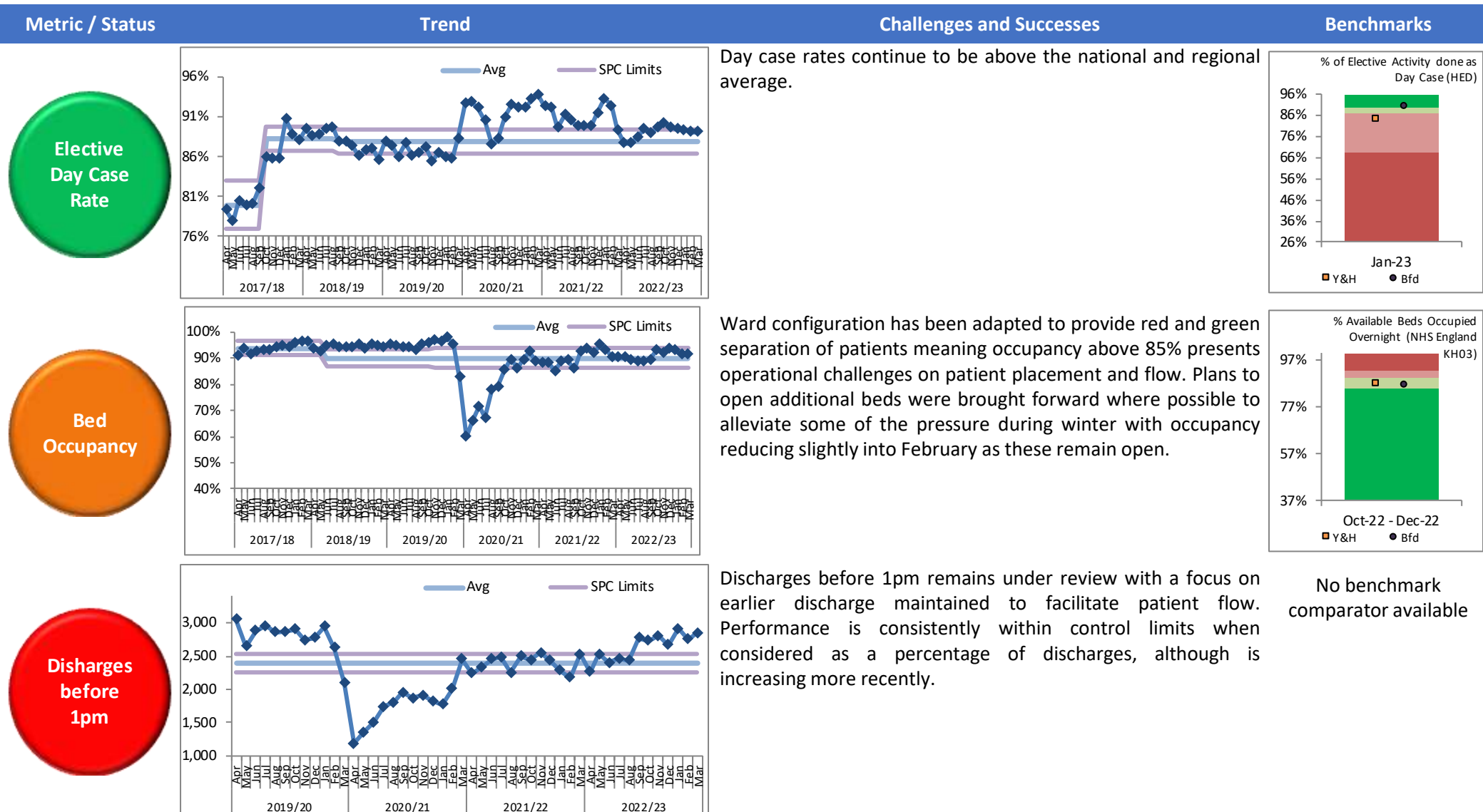
To deliver our key performance targets and financial plan

Productivity



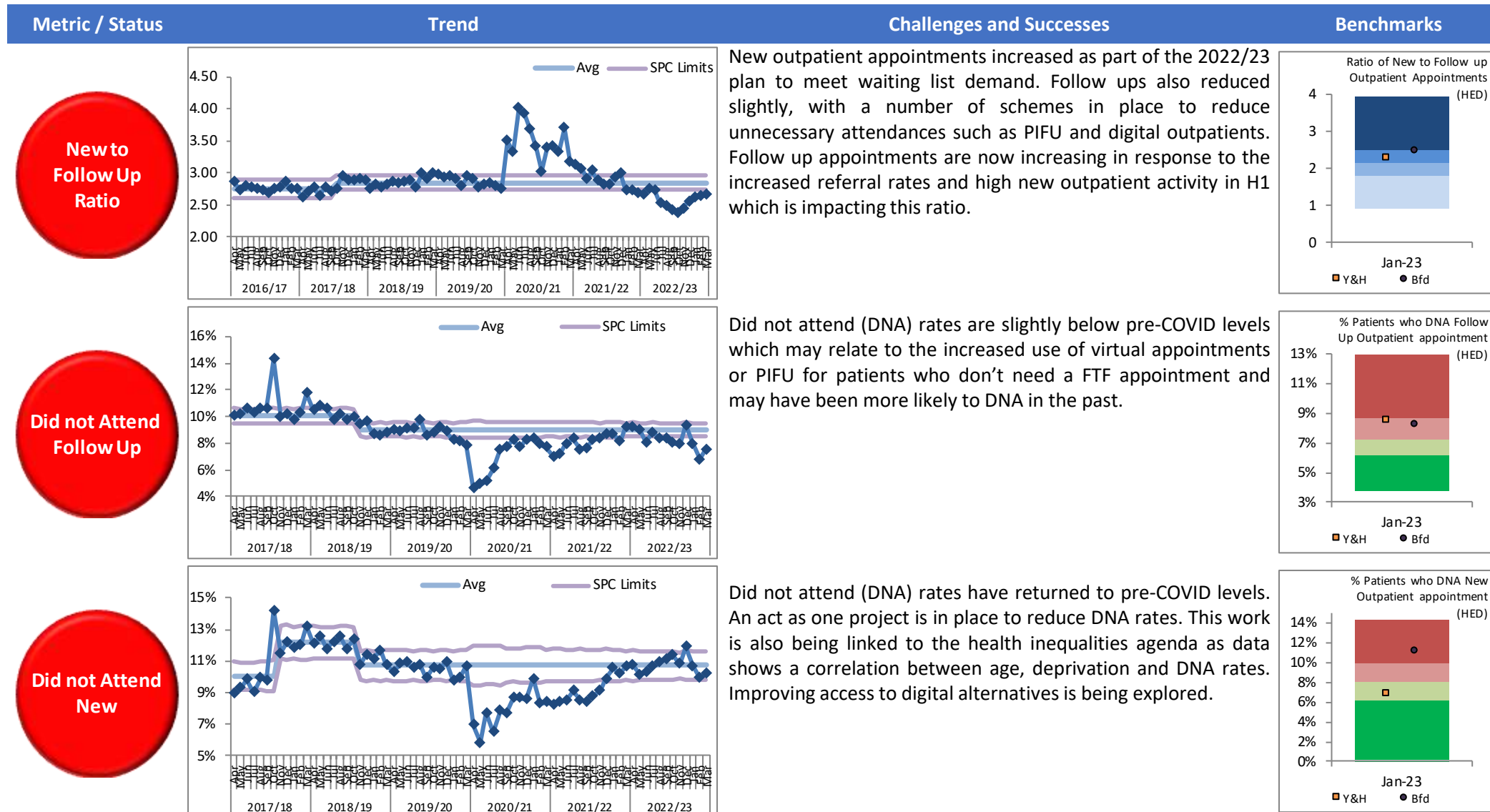
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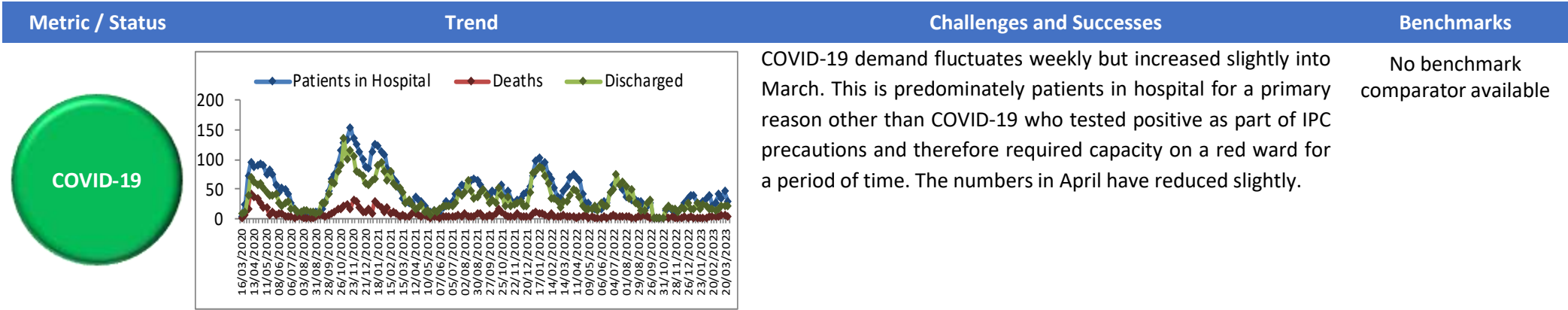


To deliver our key performance targets and financial plan

Productivity

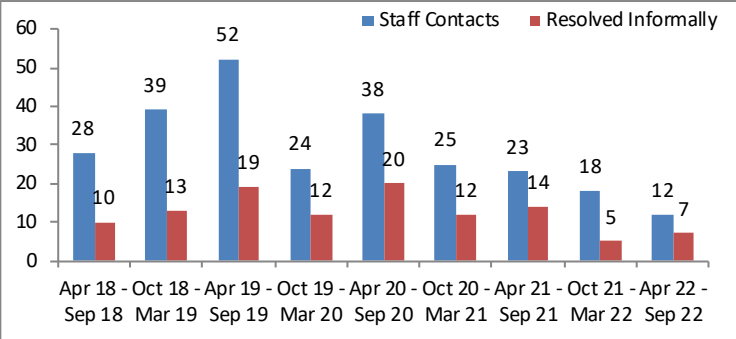
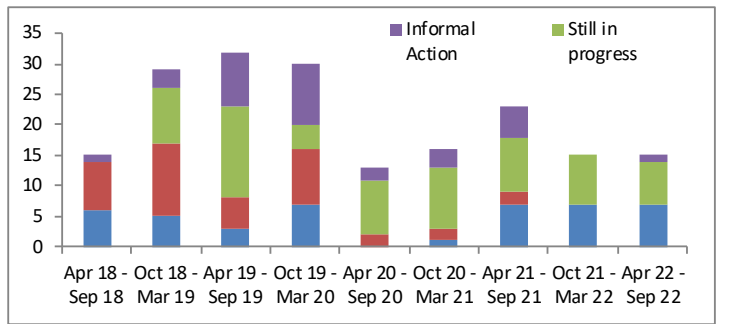


Covid-19



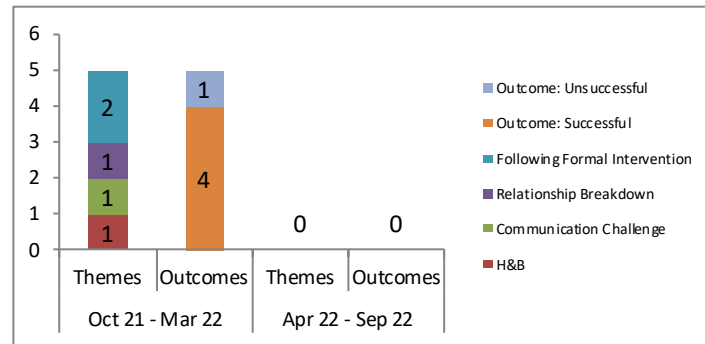
To be in the top 20% of employers

Engagement

Metric / Status	Trend	Challenges and Successes	Benchmarks																														
<div>Contacts with Advocacy service</div>	<div><table><caption>Contacts with Advocacy Service Data</caption><thead><tr><th>Period</th><th>Staff Contacts</th><th>Resolved Informally</th></tr></thead><tbody><tr><td>Apr 18 - Sep 18</td><td>28</td><td>10</td></tr><tr><td>Oct 18 - Mar 19</td><td>39</td><td>13</td></tr><tr><td>Apr 19 - Sep 19</td><td>52</td><td>19</td></tr><tr><td>Oct 19 - Mar 20</td><td>24</td><td>12</td></tr><tr><td>Apr 20 - Sep 20</td><td>38</td><td>20</td></tr><tr><td>Oct 20 - Mar 21</td><td>25</td><td>12</td></tr><tr><td>Apr 21 - Sep 21</td><td>23</td><td>14</td></tr><tr><td>Oct 21 - Mar 22</td><td>18</td><td>5</td></tr><tr><td>Apr 22 - Sep 22</td><td>12</td><td>7</td></tr></tbody></table></div>	Period	Staff Contacts	Resolved Informally	Apr 18 - Sep 18	28	10	Oct 18 - Mar 19	39	13	Apr 19 - Sep 19	52	19	Oct 19 - Mar 20	24	12	Apr 20 - Sep 20	38	20	Oct 20 - Mar 21	25	12	Apr 21 - Sep 21	23	14	Oct 21 - Mar 22	18	5	Apr 22 - Sep 22	12	7	<p>Contacts with the Staff Advocacy service have dipped slightly in the last 6 months. However, of those who contacted the service 58% of issues were resolved informally. A full review of the role and remit of staff advocates is currently underway, with insights from the civility advisory panel being sought to help shape the service in going forward and to ensure we maximise its potential). This may indicate a need to both expand and promote the refreshed service more widely.</p> <p>Next update May 2023 (for the period 01/10/22 to 31/03/23).</p>	<p>No benchmark comparator available</p>
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To be in the top 20% of employers Equality & Diversity

Metric / Status	Trend	Challenges and Successes	Benchmarks
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* (please see narrative)

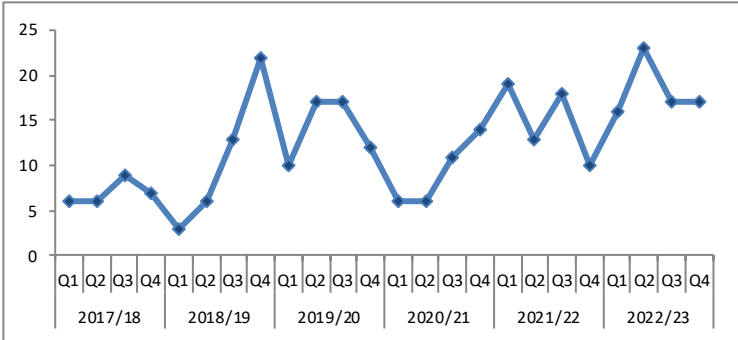
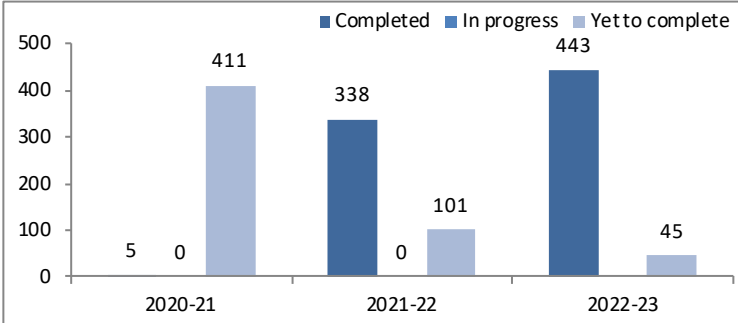
Although no interactive mediation sessions have taken place during the 6 month period, there have been 4 contacts with the service. One of these withdrew from the process, 1 case is on hold (until both parties are ready), and 2 cases are still at the initial discussion stage. The role of the mediation co-ordinator often involves active engagement with both parties in explaining how mediation works. This often involves a discussion on the best possible options in dealing with any workplace disagreements/conflict, this plays a crucial role in getting parties to understand the mediation process and the importance of 'nipping things in the bud'.

Work is underway to promote the service with a myth busting Let's Talk article planned, further sharing of the published information leaflet, a stand on the main concourse at BRI for "anti-bullying week", and a series of further launch events to follow (aligned to the workplace civility work) and with an opportunity for managers/ staff to talk to the mediators about the service.

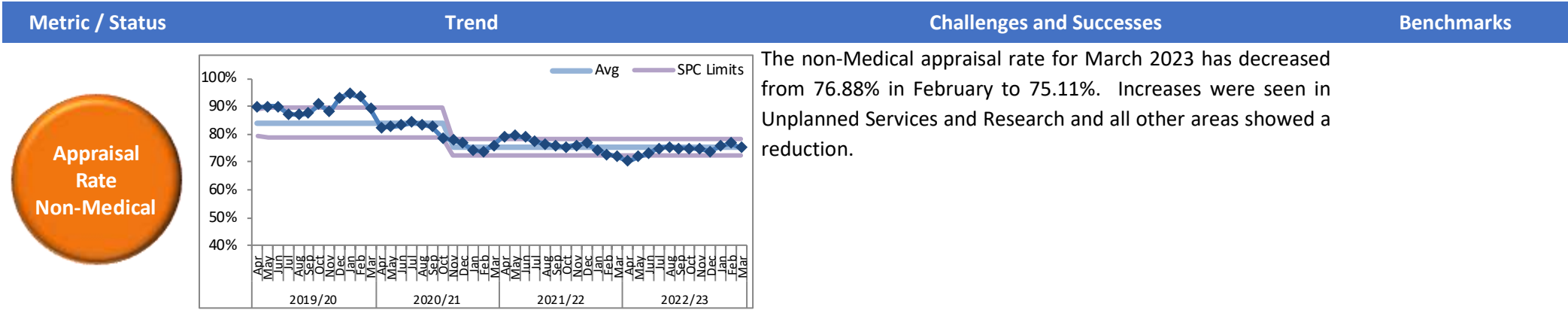
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To be in the top 20% of employers

Engagement

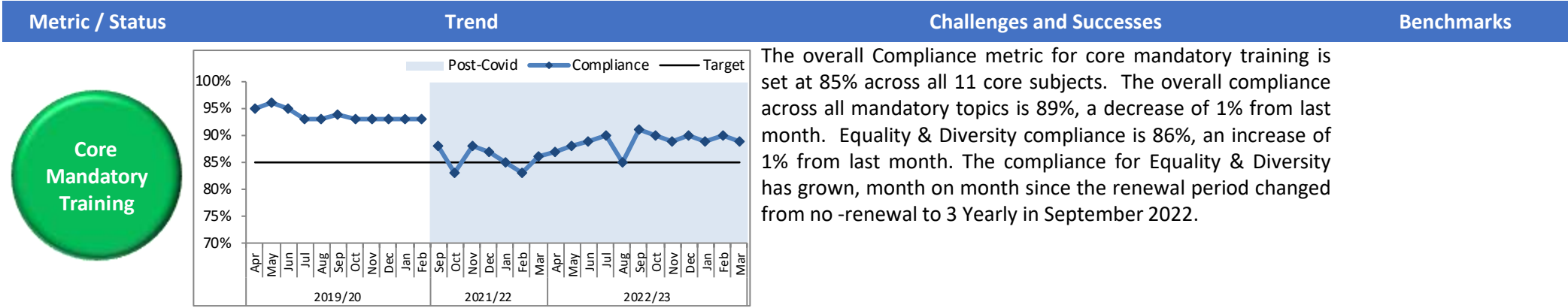
Metric / Status	Trend	Challenges and Successes	Benchmarks																																			
<div>Referrals to FTSU</div>	 <table><caption>Referrals to FTSU (Line Chart Data)</caption><thead><tr><th>Year</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr></thead><tbody><tr><td>2017/18</td><td>6</td><td>6</td><td>9</td><td>7</td></tr><tr><td>2018/19</td><td>3</td><td>6</td><td>13</td><td>22</td></tr><tr><td>2019/20</td><td>10</td><td>17</td><td>17</td><td>12</td></tr><tr><td>2020/21</td><td>6</td><td>6</td><td>11</td><td>14</td></tr><tr><td>2021/22</td><td>19</td><td>13</td><td>18</td><td>10</td></tr><tr><td>2022/23</td><td>16</td><td>23</td><td>17</td><td>17</td></tr></tbody></table>	Year	Q1	Q2	Q3	Q4	2017/18	6	6	9	7	2018/19	3	6	13	22	2019/20	10	17	17	12	2020/21	6	6	11	14	2021/22	19	13	18	10	2022/23	16	23	17	17	<p>In Q3 14 concerns were raised with the Freedom to Speak Up team. 3 concerns were raised anonymously via the FTSU app. Anonymous concerns are dealt with on an individual basis; the National Guardian’s office advocate that staff should be able to raise concerns anonymously if necessary.</p> <p>Of the 14 concerns raised in Q3, 2 concerns were raised due to inappropriate attitudes and behaviours, 3 for patient safety or quality, 2 for bullying and harassment, 5 for worker safety or wellbeing, 2 for other reasons.</p> <p>October was FTSU week. The team promoted FTSU via global emails and newsletters, social media, a quiz and held 4 stands in the concourse.</p> <p>The FTSU team have developed a new web based app to replace the previous FTSU app which stopped working on some mobile devices.</p> <p>Sue Franklin has attend training and been approved to become a national FTSU mentor.</p>	
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2017/18	6	6	9	7																																		
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<div>Appraisal Rate Medical</div>	 <table><caption>Appraisal Rate Medical (Bar Chart Data)</caption><thead><tr><th>Year</th><th>Completed</th><th>In progress</th><th>Yet to complete</th></tr></thead><tbody><tr><td>2020-21</td><td>5</td><td>0</td><td>411</td></tr><tr><td>2021-22</td><td>338</td><td>0</td><td>101</td></tr><tr><td>2022-23</td><td>443</td><td>0</td><td>45</td></tr></tbody></table>	Year	Completed	In progress	Yet to complete	2020-21	5	0	411	2021-22	338	0	101	2022-23	443	0	45	<p>As of January 2023 we have 440 doctors with a prescribed connection to BTHFT.</p> <p>332 (75%) have completed their appraisal for this year so far with 108 (25%) yet to complete</p>																				
Year	Completed	In progress	Yet to complete																																			
2020-21	5	0	411																																			
2021-22	338	0	101																																			
2022-23	443	0	45																																			

To be in the top 20% of employers
Engagement



To be in the top 20% of employers

Training & Development



To be in the top 20% of employers

Staffing

Metric / Status	Trend	Challenges and Successes	Benchmarks																																																																																																																																																																																																				
<div>Staff Turnover</div>	<div><table><caption>Staff Turnover Data (Estimated)</caption><thead><tr><th>Month</th><th>Avg (%)</th><th>SPC Upper (%)</th><th>SPC Lower (%)</th></tr></thead><tbody><tr><td>Apr 2019</td><td>10.5</td><td>12.2</td><td>9.8</td></tr><tr><td>May 2019</td><td>10.8</td><td>12.2</td><td>9.8</td></tr><tr><td>Jun 2019</td><td>10.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Jul 2019</td><td>10.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Aug 2019</td><td>10.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Sep 2019</td><td>10.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Oct 2019</td><td>10.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Nov 2019</td><td>10.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Dec 2019</td><td>11.2</td><td>12.2</td><td>9.8</td></tr><tr><td>Jan 2020</td><td>11.0</td><td>12.2</td><td>9.8</td></tr><tr><td>Feb 2020</td><td>11.0</td><td>12.2</td><td>9.8</td></tr><tr><td>Mar 2020</td><td>10.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Apr 2020</td><td>10.5</td><td>12.2</td><td>9.8</td></tr><tr><td>May 2020</td><td>10.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Jun 2020</td><td>10.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Jul 2020</td><td>10.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Aug 2020</td><td>10.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Sep 2020</td><td>10.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Oct 2020</td><td>10.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Nov 2020</td><td>9.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Dec 2020</td><td>9.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Jan 2021</td><td>9.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Feb 2021</td><td>9.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Mar 2021</td><td>9.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Apr 2021</td><td>9.5</td><td>12.2</td><td>9.8</td></tr><tr><td>May 2021</td><td>9.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Jun 2021</td><td>10.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Jul 2021</td><td>11.0</td><td>12.2</td><td>9.8</td></tr><tr><td>Aug 2021</td><td>11.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Sep 2021</td><td>12.0</td><td>12.2</td><td>9.8</td></tr><tr><td>Oct 2021</td><td>12.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Nov 2021</td><td>12.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Dec 2021</td><td>12.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Jan 2022</td><td>13.0</td><td>12.2</td><td>9.8</td></tr><tr><td>Feb 2022</td><td>13.0</td><td>12.2</td><td>9.8</td></tr><tr><td>Mar 2022</td><td>13.0</td><td>12.2</td><td>9.8</td></tr><tr><td>Apr 2022</td><td>13.0</td><td>12.2</td><td>9.8</td></tr><tr><td>May 2022</td><td>13.0</td><td>12.2</td><td>9.8</td></tr><tr><td>Jun 2022</td><td>13.0</td><td>12.2</td><td>9.8</td></tr><tr><td>Jul 2022</td><td>13.0</td><td>12.2</td><td>9.8</td></tr><tr><td>Aug 2022</td><td>12.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Sep 2022</td><td>12.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Oct 2022</td><td>12.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Nov 2022</td><td>12.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Dec 2022</td><td>12.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Jan 2023</td><td>12.5</td><td>12.2</td><td>9.8</td></tr><tr><td>Feb 2023</td><td>12.3</td><td>12.2</td><td>9.8</td></tr><tr><td>Mar 2023</td><td>11.8</td><td>12.2</td><td>9.8</td></tr></tbody></table></div>	Month	Avg (%)	SPC Upper (%)	SPC Lower (%)	Apr 2019	10.5	12.2	9.8	May 2019	10.8	12.2	9.8	Jun 2019	10.5	12.2	9.8	Jul 2019	10.5	12.2	9.8	Aug 2019	10.5	12.2	9.8	Sep 2019	10.5	12.2	9.8	Oct 2019	10.5	12.2	9.8	Nov 2019	10.5	12.2	9.8	Dec 2019	11.2	12.2	9.8	Jan 2020	11.0	12.2	9.8	Feb 2020	11.0	12.2	9.8	Mar 2020	10.5	12.2	9.8	Apr 2020	10.5	12.2	9.8	May 2020	10.5	12.2	9.8	Jun 2020	10.5	12.2	9.8	Jul 2020	10.5	12.2	9.8	Aug 2020	10.5	12.2	9.8	Sep 2020	10.5	12.2	9.8	Oct 2020	10.5	12.2	9.8	Nov 2020	9.5	12.2	9.8	Dec 2020	9.5	12.2	9.8	Jan 2021	9.5	12.2	9.8	Feb 2021	9.5	12.2	9.8	Mar 2021	9.5	12.2	9.8	Apr 2021	9.5	12.2	9.8	May 2021	9.5	12.2	9.8	Jun 2021	10.5	12.2	9.8	Jul 2021	11.0	12.2	9.8	Aug 2021	11.5	12.2	9.8	Sep 2021	12.0	12.2	9.8	Oct 2021	12.5	12.2	9.8	Nov 2021	12.5	12.2	9.8	Dec 2021	12.5	12.2	9.8	Jan 2022	13.0	12.2	9.8	Feb 2022	13.0	12.2	9.8	Mar 2022	13.0	12.2	9.8	Apr 2022	13.0	12.2	9.8	May 2022	13.0	12.2	9.8	Jun 2022	13.0	12.2	9.8	Jul 2022	13.0	12.2	9.8	Aug 2022	12.5	12.2	9.8	Sep 2022	12.5	12.2	9.8	Oct 2022	12.5	12.2	9.8	Nov 2022	12.5	12.2	9.8	Dec 2022	12.5	12.2	9.8	Jan 2023	12.5	12.2	9.8	Feb 2023	12.3	12.2	9.8	Mar 2023	11.8	12.2	9.8	Turnover has seen a decrease by 0.5% to 11.80% in March 2023 from 12.30% in February 2023. All areas have shown a slight reduction apart from Corporate Services which has shown a slight increase.	No benchmark comparator available
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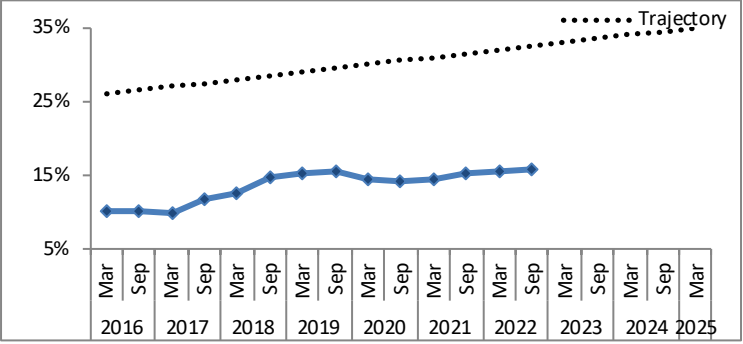

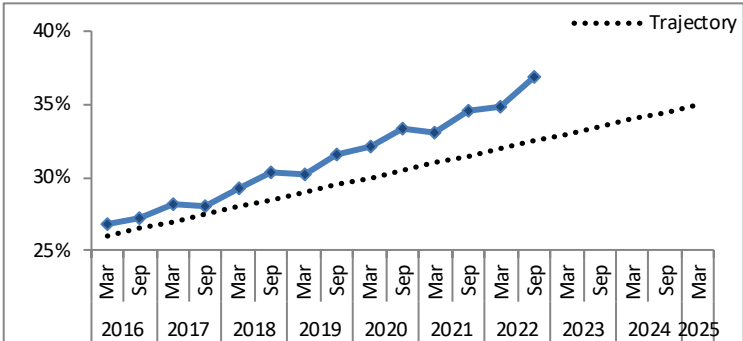
To be in the top 20% of employers

Staffing

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Nursing Bank Fill Rate</div>		<p>In March the total number of requests sent to bank was 13,147 compared with February's requests of 11,862, an increase of 1,285 requests. This is split as 6141 requests for registered staff and 7006 requests for unregistered staff. Of those 13,147 requests a total of 7,678 were filled by bank staff which is 58.40% compared with 57.63% in February – an increase of 0.77%. 2,940 are filled by registered and 4,738 filled by unregistered staff. Out of the 6141 requests for registered staff, the filled shifts were 2940 (47.9%) and for the 7,006 requests for unregistered staff the filled shifts were 4738 (67.6%). Fill rates increased by 1.3% for registered and increased by 0.4% for unregistered Out of the 2940 filled registered shifts, 483 were filled by registered Theatre staff. Agency staff filled 848 shifts in the month of March. This is split 782 registered staff and 66 unregistered. Out of the 782 filled registered shifts, 45 were filled by registered Theatre staff. In March Agency fill rates increased by 0.6% for Registered and a decrease of -0.3% for unregistered. The biggest difference was found in filled agency shifts for theatres. Only 45 were filled in March compared with 124 for February.</p>	
<div>Nursing Agency Fill Rate</div>			
<div>e-Job Planning</div>		<p>This data highlights the percentage of signed off job plans within the electronic system. Medics (consultants/specialist doctors), Allied Health Professionals and Nurses (Clinical Nurse Specialists) are all required to have a signed off job plan. There are currently 910 clinicians registered within the system, all with a job plan either in progress or signed off. This figure is made up of 374 Medics, 354 AHPs and 182 Nurses. The focus going forward is to continue to improve on the amount of job plans signed off within each CSU.</p>	

To be in the top 20% of employers

Equality & Diversity

Metric / Status	Trend	Challenges and Successes	Benchmarks
 <p>Ethnic Minority Senior Leaders</p>		<p>A further slight increase in our Ethnic Minority representation at Senior Management levels over the last 6 months which has risen from 15.5% to 15.85%. Whilst the overall proportion of staff at Band 8a+ remains fairly static (c. 16%), there have been improvements within that group. Although only small numbers, in the last 6 months there have been increases at 8d for non-clinical staff and 8c for clinical staff, which is really positive. At our current rate of trajectory, achieving our ambition to have a senior workforce reflective of the local population (35% by 2025) will be challenging. However, this continues to be a key focus of our WRES action plan as 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. Next update May 2023 (for the period 01/10/22 to 31/03/23)</p>	<p>No benchmark comparator available</p>
 <p>Ethnic Minority Workforce</p>		<p>The proportion of ethnic minority staff in the workforce has increased again in the last 6 months from 34.9% to 36.96%. We are now surpassing 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 representation at all levels in the organisation. Next update May 2023 (for the period 01/10/22 to 31/03/23).</p>	<p>No benchmark comparator available</p>

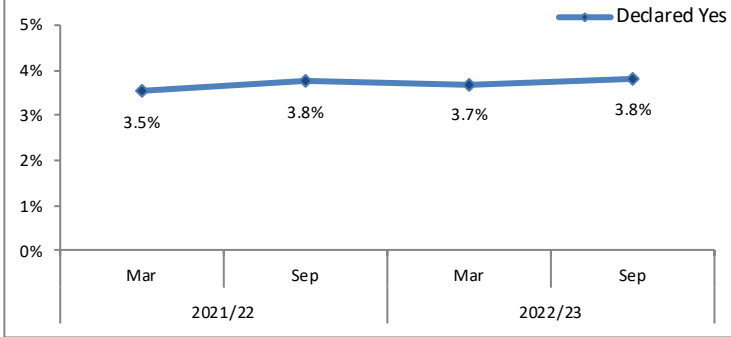
To be in the top 20% of employers

Equality & Diversity

Metric / Status	Trend	Challenges and Successes	Benchmarks																
<div data-bbox="249 329 479 554"> <p>Ethnic minority workforce by band group</p> </div>	<div data-bbox="496 289 1230 615"> <table border="1"> <thead> <tr> <th>Period</th> <th>Bands 1-5</th> <th>Bands 6-7</th> <th>Band 8+</th> </tr> </thead> <tbody> <tr> <td>Oct 2021/22</td> <td>39%</td> <td>23%</td> <td>15%</td> </tr> <tr> <td>Mar 2021/22</td> <td>40%</td> <td>24%</td> <td>16%</td> </tr> <tr> <td>Sep 2022/23</td> <td>42%</td> <td>25%</td> <td>16%</td> </tr> </tbody> </table> </div>	Period	Bands 1-5	Bands 6-7	Band 8+	Oct 2021/22	39%	23%	15%	Mar 2021/22	40%	24%	16%	Sep 2022/23	42%	25%	16%	<p>The data shows that there is an over-representation of ethnic minority staff in lower bands with the representation at Bands 1-5 increasing from 40% to 42%. Above Band 5 there continues to be an under-representation, but positively, this senior level under-representation is gradually reducing. We have seen a further 1% increase in ethnic minority staff at Bands 6 to 7 over the last 6 months from 24% to 25%. Our WRES action plan continues to focus on engaging with the race equality staff inclusion network in ensuring that development offers meet the needs of our ethnically diverse staff and with consideration of some targeted approaches for staff at Bands 5-7.</p> <p>Next update May 2023 (for the period 01/10/22 to 31/03/23)</p>	
Period	Bands 1-5	Bands 6-7	Band 8+																
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<div data-bbox="249 843 479 1068"> <p>Female workforce by band group</p> </div>	<div data-bbox="496 803 1230 1129"> <table border="1"> <thead> <tr> <th>Period</th> <th>Bands 1-5</th> <th>Bands 6-7</th> <th>Band 8+</th> </tr> </thead> <tbody> <tr> <td>Sep 2021/22</td> <td>81%</td> <td>86%</td> <td>72%</td> </tr> <tr> <td>Mar 2021/22</td> <td>81%</td> <td>86%</td> <td>73%</td> </tr> <tr> <td>Sep 2022/23</td> <td>81%</td> <td>85%</td> <td>74%</td> </tr> </tbody> </table> </div>	Period	Bands 1-5	Bands 6-7	Band 8+	Sep 2021/22	81%	86%	72%	Mar 2021/22	81%	86%	73%	Sep 2022/23	81%	85%	74%	<p>Females currently make up 82% of our non-medical workforce. Whilst they are proportionately represented at lower levels (81%), they continue to be under-represented at senior levels (74%), and slightly over-represented at middle management levels (85%). Positively, over the last 6 months there has been a 1% increase in females at Band 8+ and a 1% decrease in females at Band 6 to 7 (moving both groups closer to proportionate representation).</p> <p>We are working collaboratively with our gender equality reference group and the wider ICS to address gender inequalities in the workplace, with focus on women in leadership and addressing potential blockages to development.</p> <p>Next update May 2023 (for the period 01/10/22 to 31/03/23).</p>	
Period	Bands 1-5	Bands 6-7	Band 8+																
Sep 2021/22	81%	86%	72%																
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Equality & Diversity

Metric / Status	Trend	Challenges and Successes	Benchmarks													
<div>Disability Declaration Rate</div>	<div><table><caption>Disability Declaration Rate Trend</caption><thead><tr><th>Period</th><th>Month</th><th>Rate (%)</th></tr></thead><tbody><tr><td rowspan="2">2021/22</td><td>Mar</td><td>3.5%</td></tr><tr><td>Sep</td><td>3.8%</td></tr><tr><td rowspan="2">2022/23</td><td>Mar</td><td>3.7%</td></tr><tr><td>Sep</td><td>3.8%</td></tr></tbody></table></div>	Period	Month	Rate (%)	2021/22	Mar	3.5%	Sep	3.8%	2022/23	Mar	3.7%	Sep	3.8%	<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 declared a disability/ long term health condition, indicating there are at least 19% of staff who have not declared their status in ESR. We continue to work with our Enable staff network in increasing confidence to declare a disability which includes our recently developed and launched disability equality video. The video highlights the positive experiences of a number of staff working at the Trust who share their positive lived experiences. The video will be accompanied by a travelling photography exhibition and will be shared across our sites. In addition to this we will be showcasing both the video and photography exhibition during Disability History Month (DHM) in December 2022. As part of our DHM celebrations the Trust has also worked with partners in the Bradford District and Craven Health & Care Partnership to develop and deliver a programme of events to take place during the week of 5 to 9 December. These events entitled “Inspire & Enable Disability Festival” have been co-produced and will be co-delivered with colleagues from our disabled staff networks and other staff who have lived experience of a disability.</p> <p>Next update May 2023 (for the period 01/10/22 to 31/03/23)</p>	
Period	Month	Rate (%)														
2021/22	Mar	3.5%														
	Sep	3.8%														
2022/23	Mar	3.7%														
	Sep	3.8%														





To be in the top 20% of employers

Health & Wellbeing

Metric / Status	Trend	Challenges and Successes	Benchmarks																																																																							
<div>Staff Sickness Absence</div>	<table><caption>Staff Sickness Absence Trend Data (Estimated %)</caption><thead><tr><th>Year</th><th>Apr</th><th>May</th><th>Jun</th><th>Jul</th><th>Aug</th><th>Sep</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th></tr></thead><tbody><tr><td>2019/20</td><td>4.8</td><td>4.8</td><td>4.8</td><td>4.8</td><td>4.8</td><td>4.8</td><td>4.8</td><td>4.8</td><td>4.8</td><td>4.8</td><td>4.8</td><td>4.8</td></tr><tr><td>2020/21</td><td>5.0</td><td>5.0</td><td>5.0</td><td>5.0</td><td>5.0</td><td>5.0</td><td>5.0</td><td>5.0</td><td>5.0</td><td>5.0</td><td>5.0</td><td>5.0</td></tr><tr><td>2021/22</td><td>5.5</td><td>5.5</td><td>5.5</td><td>5.5</td><td>5.5</td><td>5.5</td><td>5.5</td><td>5.5</td><td>5.5</td><td>5.5</td><td>5.5</td><td>5.5</td></tr><tr><td>2022/23</td><td>6.0</td><td>6.0</td><td>6.0</td><td>6.0</td><td>6.0</td><td>6.0</td><td>6.0</td><td>6.0</td><td>6.0</td><td>6.0</td><td>6.0</td><td>6.0</td></tr></tbody></table>	Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8	2020/21	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	2021/22	5.5	5.5	5.5	5.5	5.5	5.5	5.5	5.5	5.5	5.5	5.5	5.5	2022/23	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	<p>The rolling 12 month sickness absence rate at the end of March 2023 was 6.62% compared to 6.72% in February. Decreases were seen in all areas apart from Planned Services which saw a slight increase. The largest decrease seen in Estates & Facilities. Covid-19 related sickness has increased slightly to 0.62% in March from 0.60% in February. Monthly absence in March increased to 6.07% from 5.77% in February. Sickness target agreed at the Looking After Our People Group in March at 5.5%. Paper to go to ETM in April 2023.</p>	<table><caption>Staff Sickness Rate (NHS Digital) - Apr-22 - Jun-22</caption><thead><tr><th>Entity</th><th>Sickness Rate (%)</th></tr></thead><tbody><tr><td>Y&H</td><td>~5.5</td></tr><tr><td>Bfd</td><td>~6.8</td></tr></tbody></table>	Entity	Sickness Rate (%)	Y&H	~5.5	Bfd	~6.8
Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar																																																														
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<div>Frontline Staff Flu Vaccination</div>	<table><caption>Frontline Staff Flu Vaccination Progress Data (Estimated %)</caption><thead><tr><th>Week No.</th><th>Progress 22/23 (%)</th><th>Progress 21/22 (%)</th></tr></thead><tbody><tr><td>1</td><td>0</td><td>20</td></tr><tr><td>2</td><td>5</td><td>20</td></tr><tr><td>3</td><td>10</td><td>20</td></tr><tr><td>4</td><td>15</td><td>20</td></tr><tr><td>5</td><td>20</td><td>20</td></tr><tr><td>6</td><td>25</td><td>20</td></tr><tr><td>7</td><td>30</td><td>25</td></tr><tr><td>8</td><td>35</td><td>30</td></tr><tr><td>9</td><td>40</td><td>35</td></tr><tr><td>10</td><td>45</td><td>40</td></tr><tr><td>11</td><td>48</td><td>45</td></tr><tr><td>12</td><td>50</td><td>48</td></tr><tr><td>13</td><td>52</td><td>50</td></tr><tr><td>14</td><td>53</td><td>52</td></tr><tr><td>15</td><td>53</td><td>53</td></tr><tr><td>16</td><td>53</td><td>53</td></tr><tr><td>17</td><td>53</td><td>53</td></tr><tr><td>18</td><td>53</td><td>53</td></tr><tr><td>19</td><td>53</td><td>53</td></tr><tr><td>20</td><td>53</td><td>53</td></tr><tr><td>21</td><td>53</td><td>53</td></tr><tr><td>22</td><td>53</td><td>53</td></tr></tbody></table>	Week No.	Progress 22/23 (%)	Progress 21/22 (%)	1	0	20	2	5	20	3	10	20	4	15	20	5	20	20	6	25	20	7	30	25	8	35	30	9	40	35	10	45	40	11	48	45	12	50	48	13	52	50	14	53	52	15	53	53	16	53	53	17	53	53	18	53	53	19	53	53	20	53	53	21	53	53	22	53	53	<p>Flu Vaccination – Foundry uptake figures show 53% of frontline healthcare workers have had their flu vaccination, with a total of 3546 doses given to all Trust staff (49.9%). This compares with a National uptake figure of 51.8% and ICB uptake figure of 52.4%. Throughout the campaign staff have been given opportunities in a variety of settings to access their vaccination and delivery has been on a daily basis. Despite increased availability and regular comms uptake has been considerably lower this year than in previous campaigns.</p>			
Week No.	Progress 22/23 (%)	Progress 21/22 (%)																																																																								
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		<p>Covid Vaccination – Foundry uptake figures show 45.7% of all BTHFT staff have had their Covid booster (2974 staff). This compares with a national uptake figure of 50.2% and ICB uptake figure of 51.1%. The booster campaign ended on 12 February 2023 and further campaigns will follow JCVI guidance.</p>																																																																								

To collaborate effectively with local and regional partners

Partnership

Metric / Status	Trend	Challenges and Successes	Benchmarks
	<p>There is significant activity to address inequalities in access, experience and outcomes, but not always recognised as such. We are collating information from CSUs and identifying opportunities to share best practice. An analysis of waiting times to understand the impact of factors – including ethnicity and deprivation - shows variation in referral rates needing further investigation. Health inequalities has a dedicated section of the new EDI Strategy (to be published May 2023). Five priorities have been agreed (at EDC in March 2023): making HIs a priority of focus for our teams; utilising data; our role as an anchor organisation; care based on population profiles; collaboration with other organisations to address HIs. A refreshed action plan - based on these priorities - is being developed. BTHFT is a member of BD&C Reducing Inequalities Alliance, RIC Steering Group, and inequalities is now a standing item on the Equality and Diversity Council agenda</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 and Families; 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 discrete programmes. All BD&C HCP activity is aligned to the Core 20 plus 5 inequalities approach. Consideration is being given to the implications of the reduction in central funding.</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". BTHFT has contributed to the WY 5 year integrated care strategy (published March 2023), and is supporting WYAAT's strategy development (publication due April 2024). Following announcements on reduction in funding for ICBs nationally, work is underway to consider the implications and how efficiencies across the system might be made. The recommendations from the Hewitt review are also being considered alongside this to ensure consistency in the way both are implemented. BTHFT will also contribute to current NHS75 review work led by the NHS Assembly.</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

Glossary

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

Glossary Continued

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

Glossary Continued

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

Glossary Continued

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

Glossary Continued

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

Glossary Continued

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%	

Glossary Continued

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

Glossary Continued

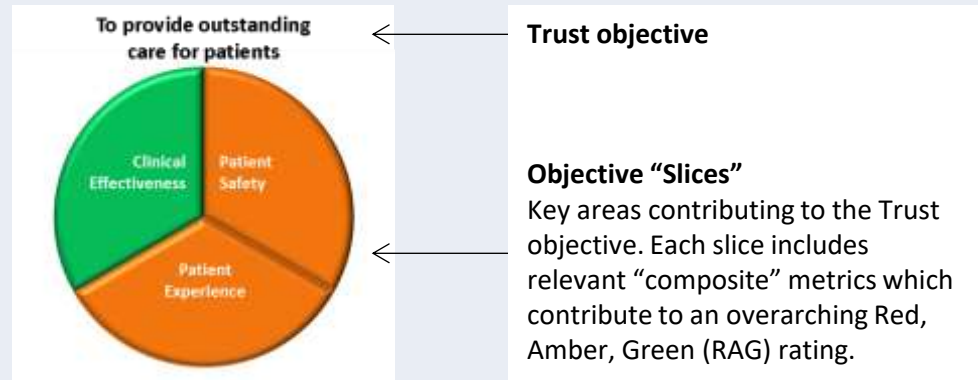
Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals				
Partnership				
Reducing Inequalities	Working with partners to contribute to the overall reduction of health inequalities 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

Glossary Continued

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 $\Rightarrow 2.5$

Metric RAG

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

DQ Kite Mark

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

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

Statistical Process Control (SPC) Chart

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

Benchmarking

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