

Integrated Dashboard

Board of Directors

31st July 2023

Integrated Dashboard

31st July 2023

To provide outstanding care for patients,
delivered with kindness



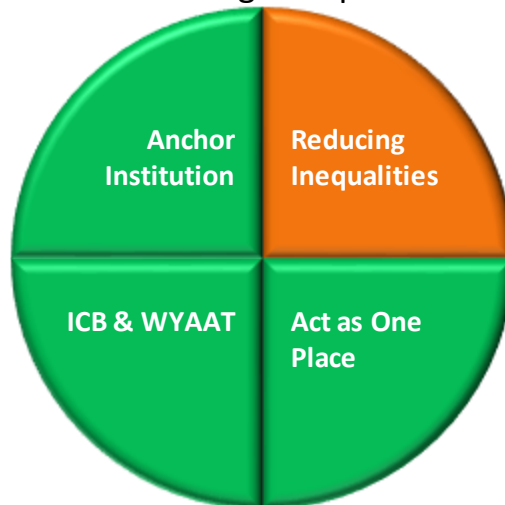
To deliver our financial plan
and key performance targets



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 (July 2023): 106.65– High (>95%).</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 (July 2023): 112.54 – within expected range.</p>	
<div>Readmissions</div>		<p>Re-admission rates within 28 days continues to fall in line with regional average. There is evidence to show there is a correlation between shorter length of stays (LoS) with higher re-admission rates. During 2019/20 our average LoS for non-elective spells was 3.1 days (lowest in region) and our re-admission rates were 11% (highest in region). In 2022/23 our average Length of Stay has increased to 4.2 days and our re-admission rates have fallen to 8% (both in line with regional average).</p>	


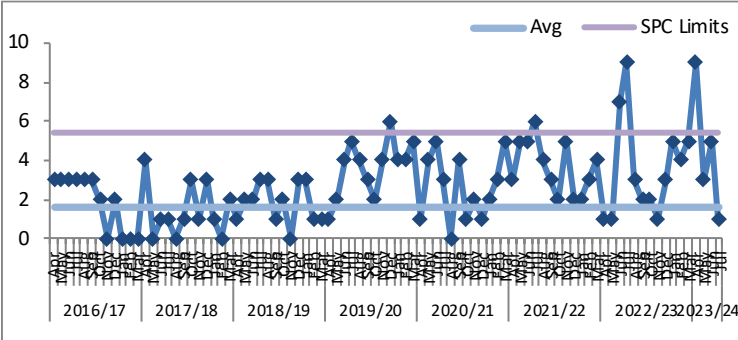
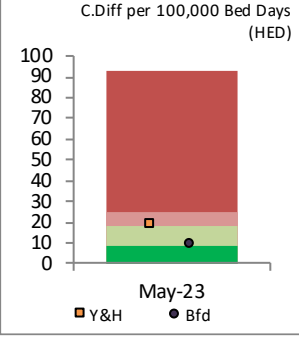

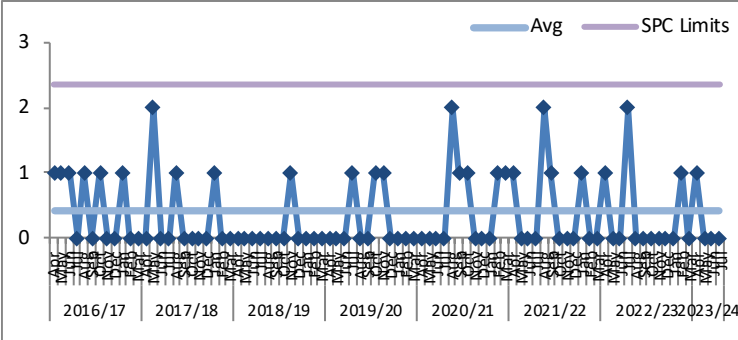
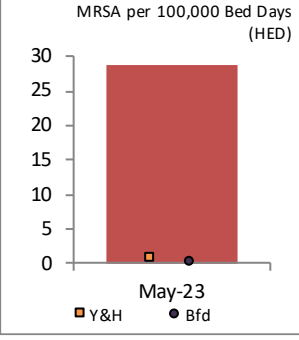

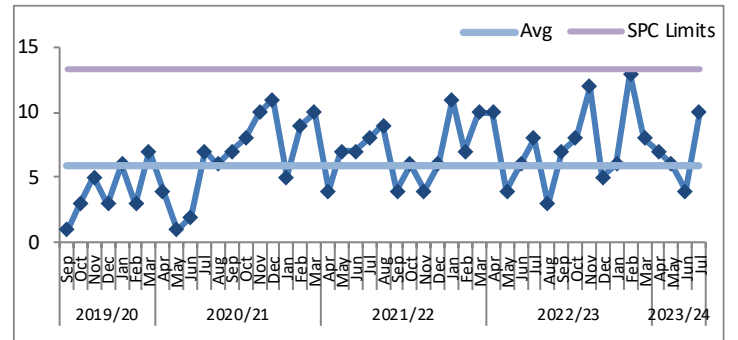
To provide outstanding care for patients

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 113 hospital deaths dealt with via our office in July 2023. We have engaged with all of the GP practices in our remit (55 out of 55 GP sites) and 70% of practices are routinely referring deaths through to the Medical Examiner's office. In July 2023, we scrutinised 61 Community deaths.</p>	
<div>Number of SJR Requests raised</div>		<p>There were eight SJRs requested via the Medical Examiner's office for July 2023. A total of five SJRs were completed by reviewers throughout July with four scoring between Adequate to Excellent overall care and one scoring Poor. This case has been reviewed at the Mortality Review Improvement Group (MRIG) and by the Safety Event Group (SEG). Reasons for the SJR's requests raised in July 2023 include: Where the bereaved or staff have raised significant concerns (n=5) Where learning will inform the provider's Quality Improvement work (n=3).</p>	

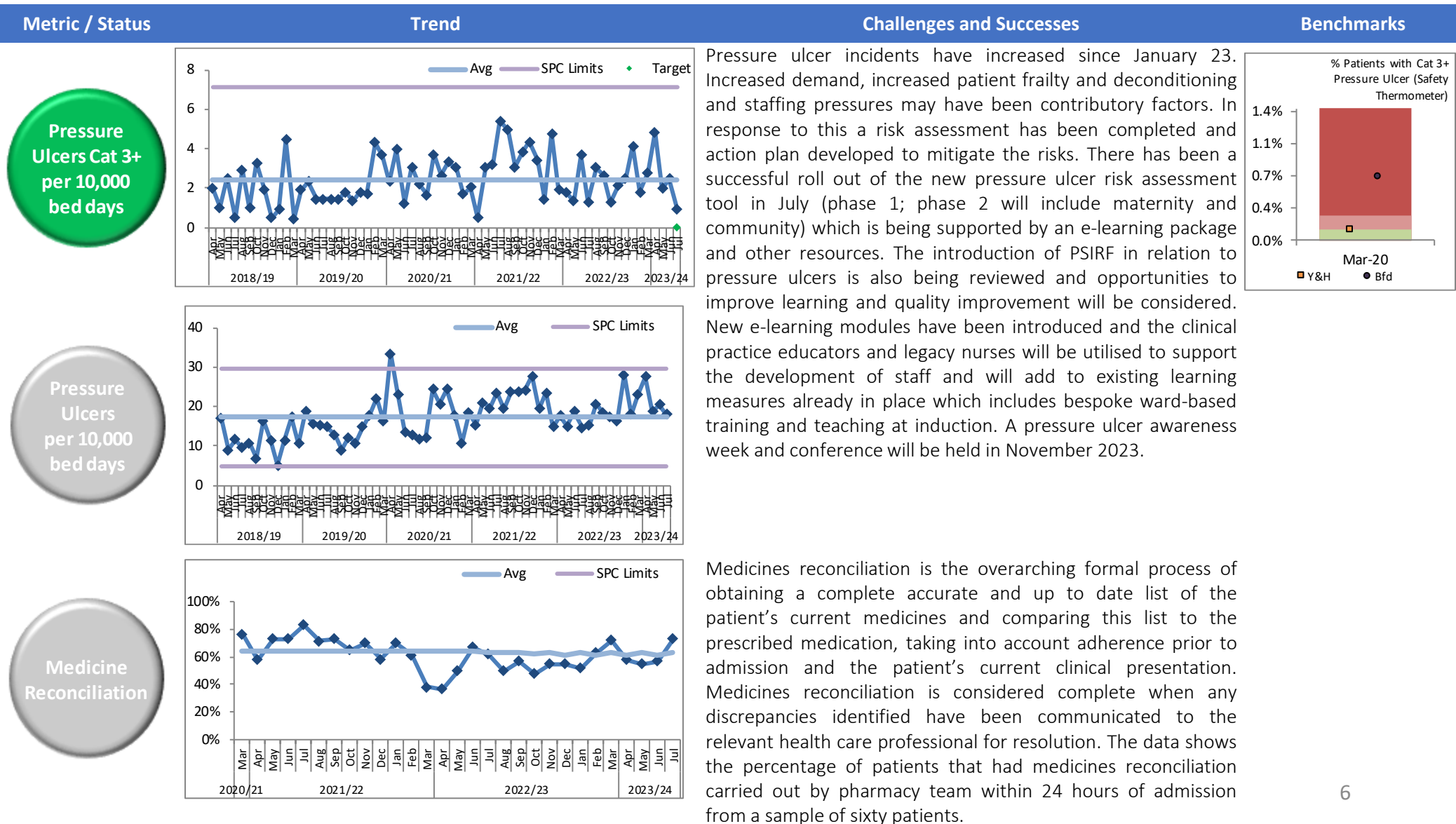
To provide outstanding care for patients

Patient Safety

Metric / Status	Trend	Challenges and Successes	Benchmarks
 C Difficile		<p>There were 9 trust attributable cases in the April 2023. There was no evidence of an outbreak or transmission between patients. Antibiotic usage was considered the most common risk factor associated with these cases. A review meeting was convened with all stakeholders to review the antibiotic prescribing practices. Enhanced cleaning and disinfection was also carried out. As a result, there has been significant reduction in the number of cases in May- July 2023 and there was only trust attributable case of CDI in July 2023.</p>	
 MRSA		<p>The trust 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. Particular focus has been 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. Due to these measures, so far one case was identified in April 2023 but there was no MRSA bacteraemia identified May- July 2023.</p>	
 E.Coli		<p>The Trust reported 91 trust attributable E. coli bacteraemia cases during 2022/23 against an objective of 80 cases. All hospital attributable cases are subject to a comprehensive Post Infection review (PIR) process to identify any lessons to learn. A quality improvement initiative to improve hydration in the elderly began in April 2023. 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. There has been a consistent decline in cases in the last three months. An increase in number of cases was observed in July 2023. Most of them were categorised as COHA.</p>	

To provide outstanding care for patients

Patient Safety



To provide outstanding care for patients

Patient Safety

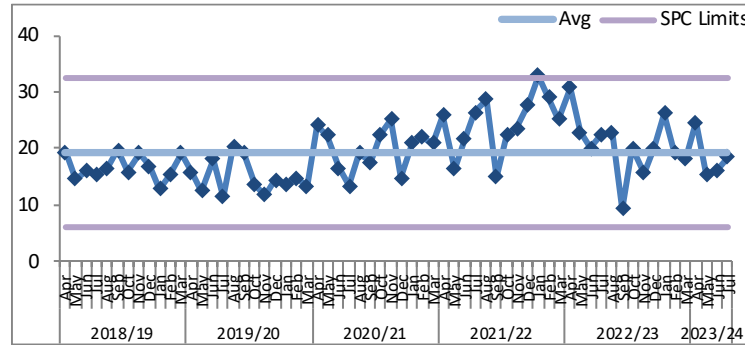
Metric / Status

Trend

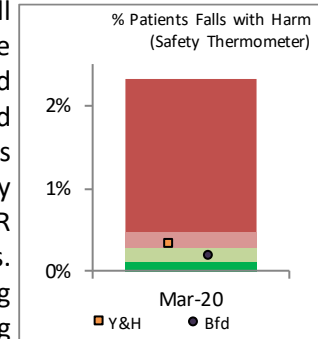
Challenges and Successes

Benchmarks

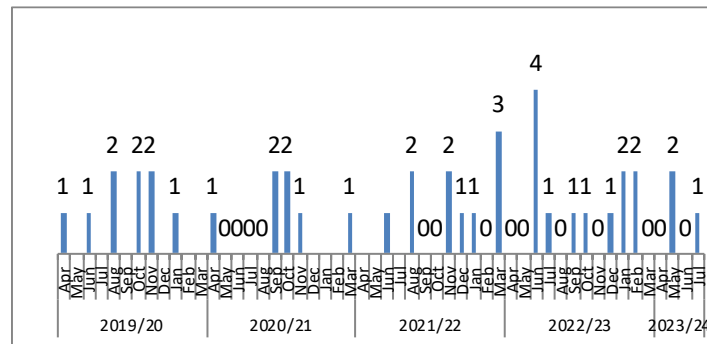
Falls with Harm per 10,000 bed days



The Data for 2023-2024 is showing normal variation for overall falls across the organisation up to End July. Objectives have been developed to sustain the reduction seen in 22-23 and improve this alongside the NAIF report 2022 with focused improvement work in high priority areas continuing. The falls lead is facilitating further improvement work particularly around Falls with No and Low harm and has developed an ESR training link covering Lying / Standing BP for all staff to access. Falls champion's development and training is also being delivered to help sustain this reduction and spread the learning across all areas of the Trust with a focus on the new PSIRF falls process delivered at their session in August 2023.



Falls with Severe Harm


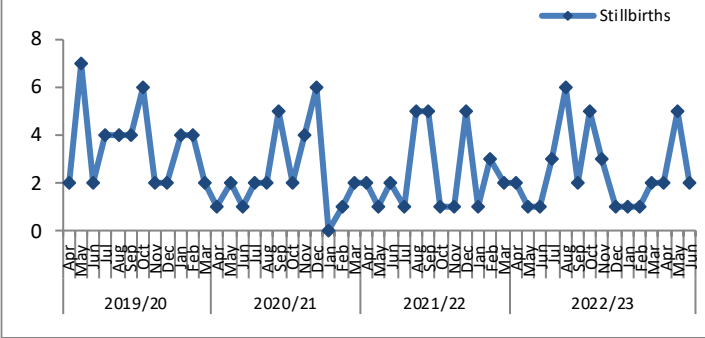

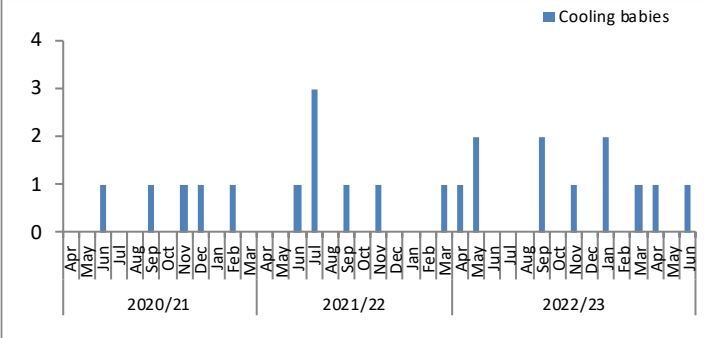

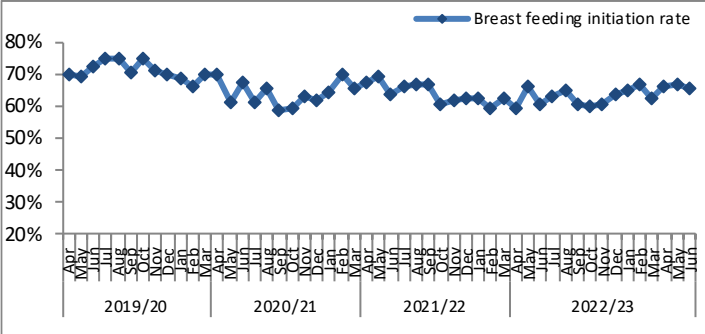


Falls are being monitored via the Falls Group – a new process is being put in place from September in line with PSIRF to meet learning and assurance needs for individuals and the wider organisation. CSU teams will now be asked to attend the Falls Steering group to present their themes around learning from all falls and how they are implementing the actions or QI work they have identified. This will replace the current panel process in place.

No benchmark comparator available


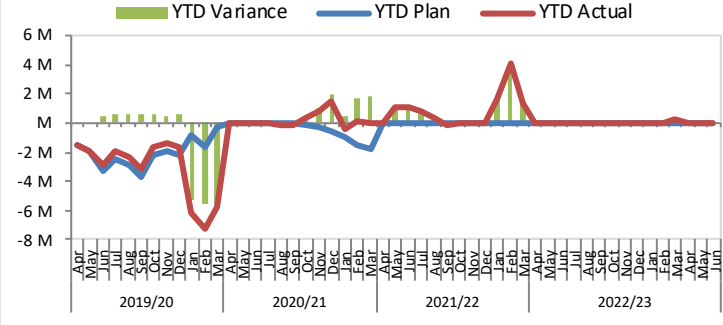

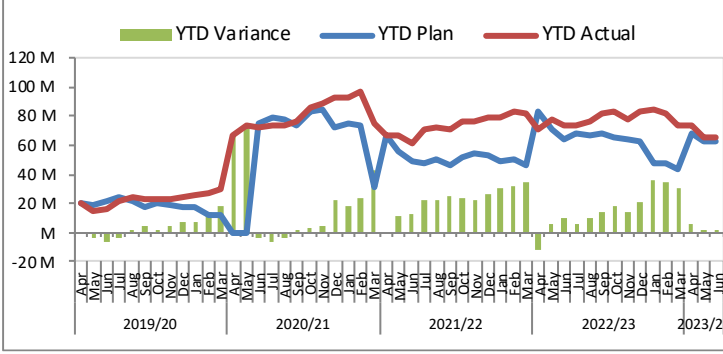
To provide outstanding care for patients

Patient Safety

Metric / Status	Trend	Challenges and Successes	Benchmarks
 <p>Stillbirths</p>		<p>Stillbirths continue to be monitored on a monthly basis with each case subject to a 72 hour clinical review, reporting to PMRT, referral to HSIB in cases of term babies where the mother was in labour at the time death was diagnosed. There is nothing significant to update for August.</p>	
 <p>Cooling babies</p>		<p>Review of the Yorkshire and Humber Regional annual data, suggests that Bradford may be an outlier for HIE compared to other similar sized units in the region. All cases have been individually reviewed and referred to HSIB for independent review as appropriate. A thematic review of the last 12 months will be undertaken in September, and any findings/learning will be shared with QPSA in October.</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 Trust has reported a cumulative breakeven Income & Expenditure (I&E) position for the year to Month 3, which is in line with the annual plan. The underlying position is a cumulative deficit of £3.4m, which has been offset by non-recurrent measures to report the breakeven position. The latest WRP forecasts from the CSUs suggest the Trust will fall some way short of the required £29m efficiencies. If forecast WRP delivery does not improve in Quarter 2, there is a significant risk that the Trust may fall into deficit in Quarter 3 once all non-recurrent measures are exhausted. The Trust is formally forecasting delivery of a breakeven position at year end however there are significant risks to this forecast which include ongoing industrial action and challenges with delivering the WRP.</p>	No benchmark comparator available
 <p>Delivery of Cash Plan</p>		<p>Closing cash at month 3 is £64.9m which is £1.7m above plan (£63.2m). The main reasons for the variance from plan are:</p> <ol style="list-style-type: none"> 1. Lower than planned operating surplus (£0.5m less cash) 2. Higher than planned trade and other payables (£5.3m more cash) 3. Higher than planned receivables (£4.3m less cash) 4. Higher than planned deferred income (£0.7m more cash) 5. Lower than planned capital cash spend (£2.6m more cash) 6. Higher than planned interest received (£0.6m more cash) 7. Lower than planned PDC dividend balance (£2.6m less cash) <p>Cash is forecast to be on plan (£49.2m) as at 31st March 2023 and the Trust is not expecting to require any cash support during 2023/24.</p>	No benchmark comparator available

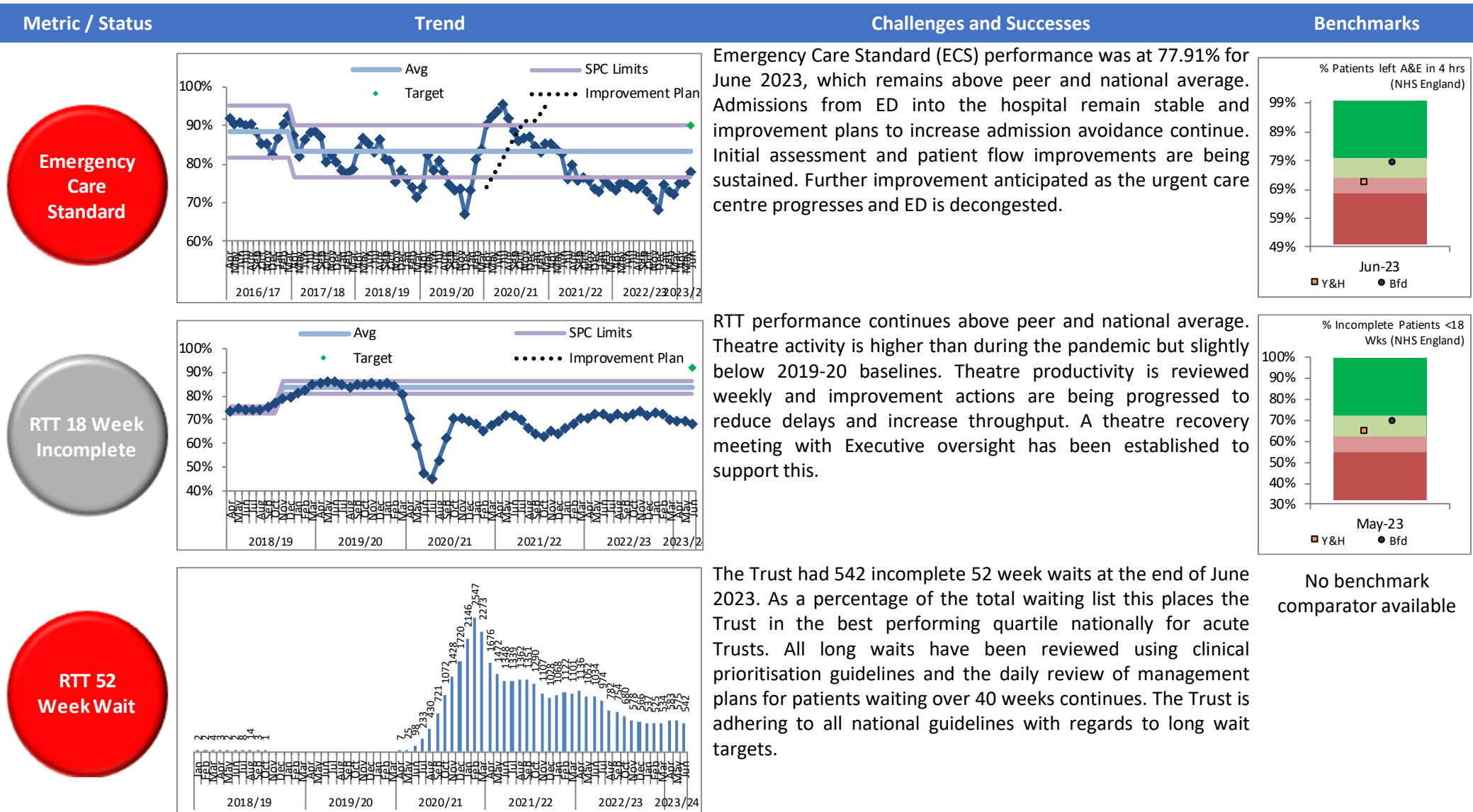
To deliver our key performance targets and financial plan

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).</p> <p>Year to date liquidity is negative 8.3 days which is 0.7 days higher than plan (negative 9 days). Liquidity is higher than planned due to slippage in capital programme of £9.1m.</p> <p>Closing liquidity is forecast on plan (negative 17.8 days).</p>	<p>No benchmark comparator available</p>
<div>Delivery of Capital Plan</div>		<p>Total capital departmental expenditure limit ("CDEL") for 2023/24 is £50.1m. The Trust is forecasting to spend its full CDEL allocation by 31 March 2024.</p> <p>At month 3 the Trust reported a year-to-date underspend of £9.1m. This is due to slippage on non-operational capital (St Luke's Hospital Day Case Unit and Eccles Hill Community Diagnostic Centre). PDC funding for Endoscopy Transformation project (£8.7m) will be reported next month.</p>	

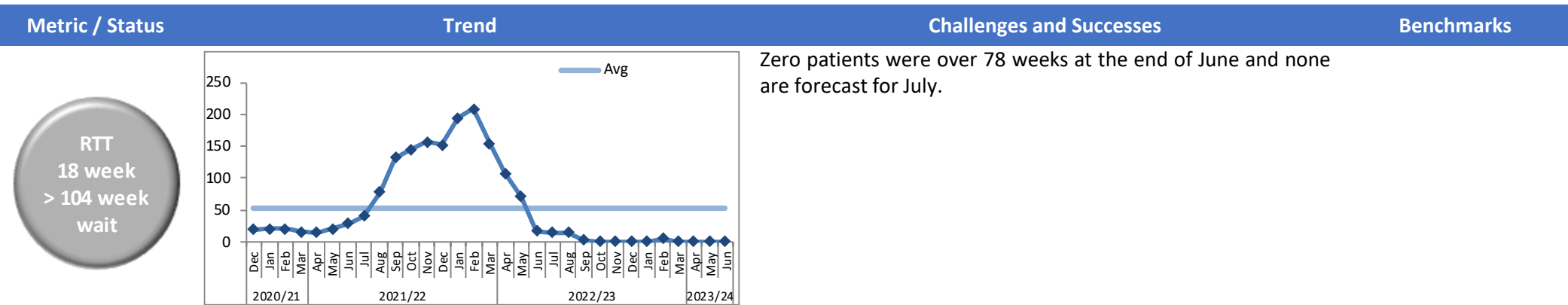
To deliver our key performance targets and financial plan

Performance



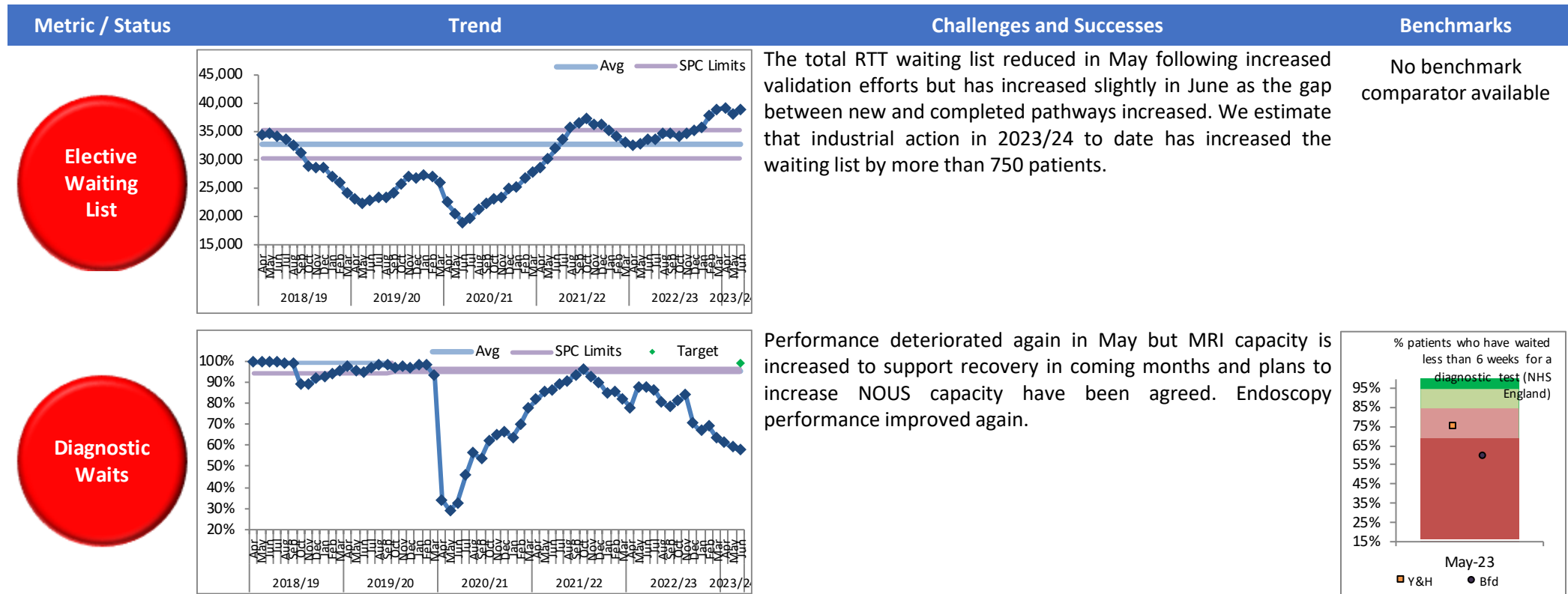
To deliver our key performance targets and financial plan

Performance



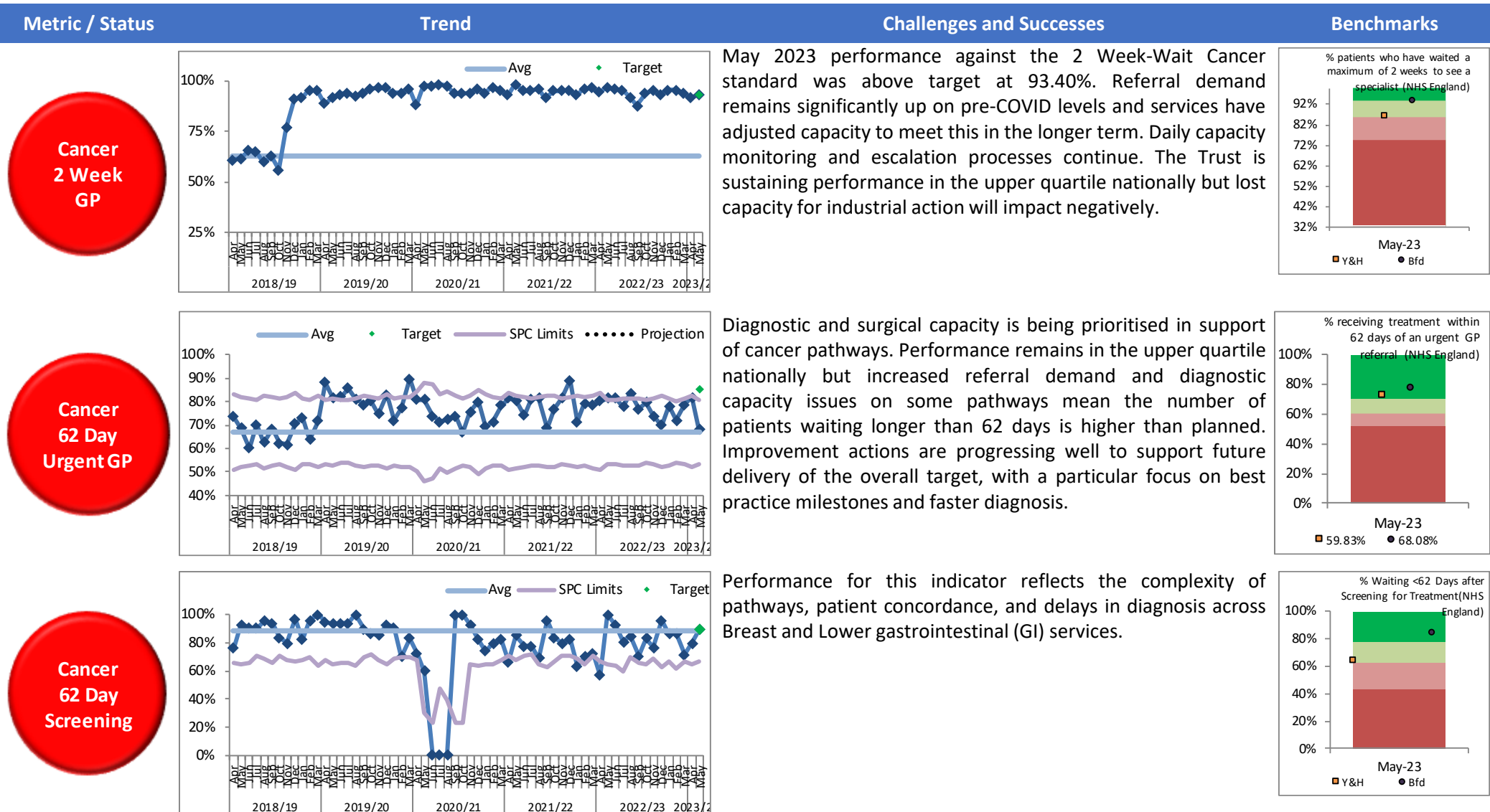
To deliver our key performance targets and financial plan

Performance



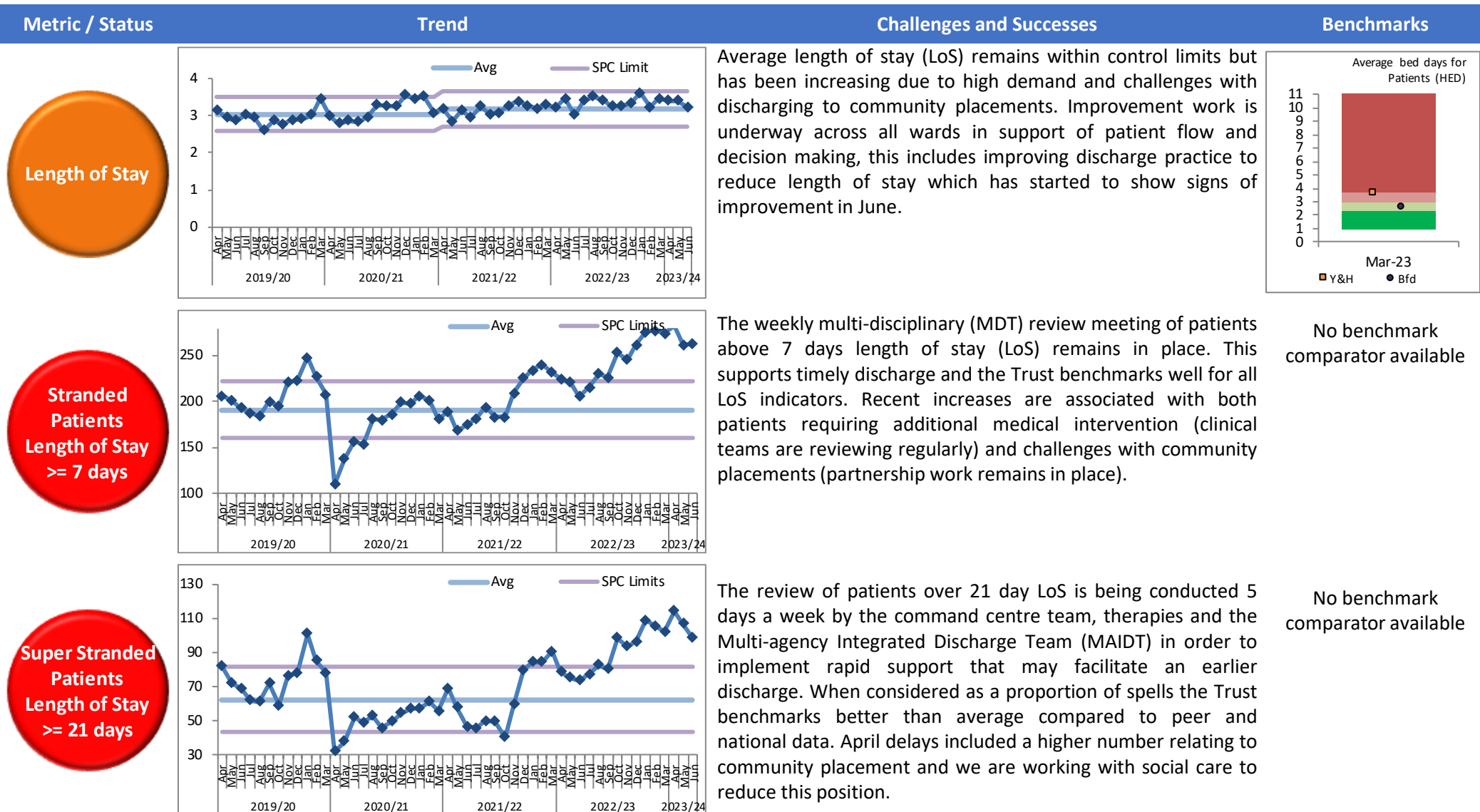
To deliver our key performance targets and financial plan

Performance



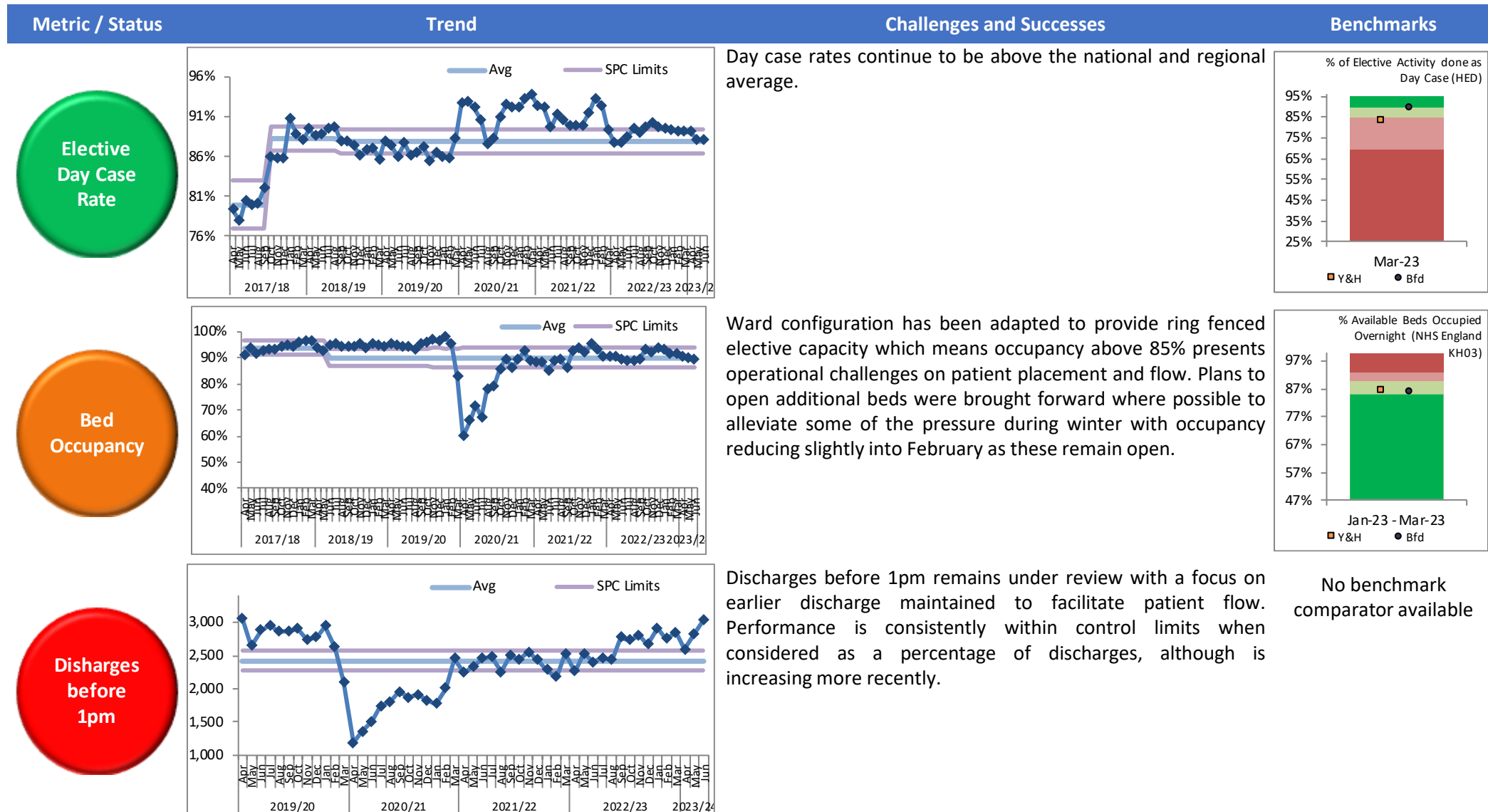
To deliver our key performance targets and financial plan

Productivity



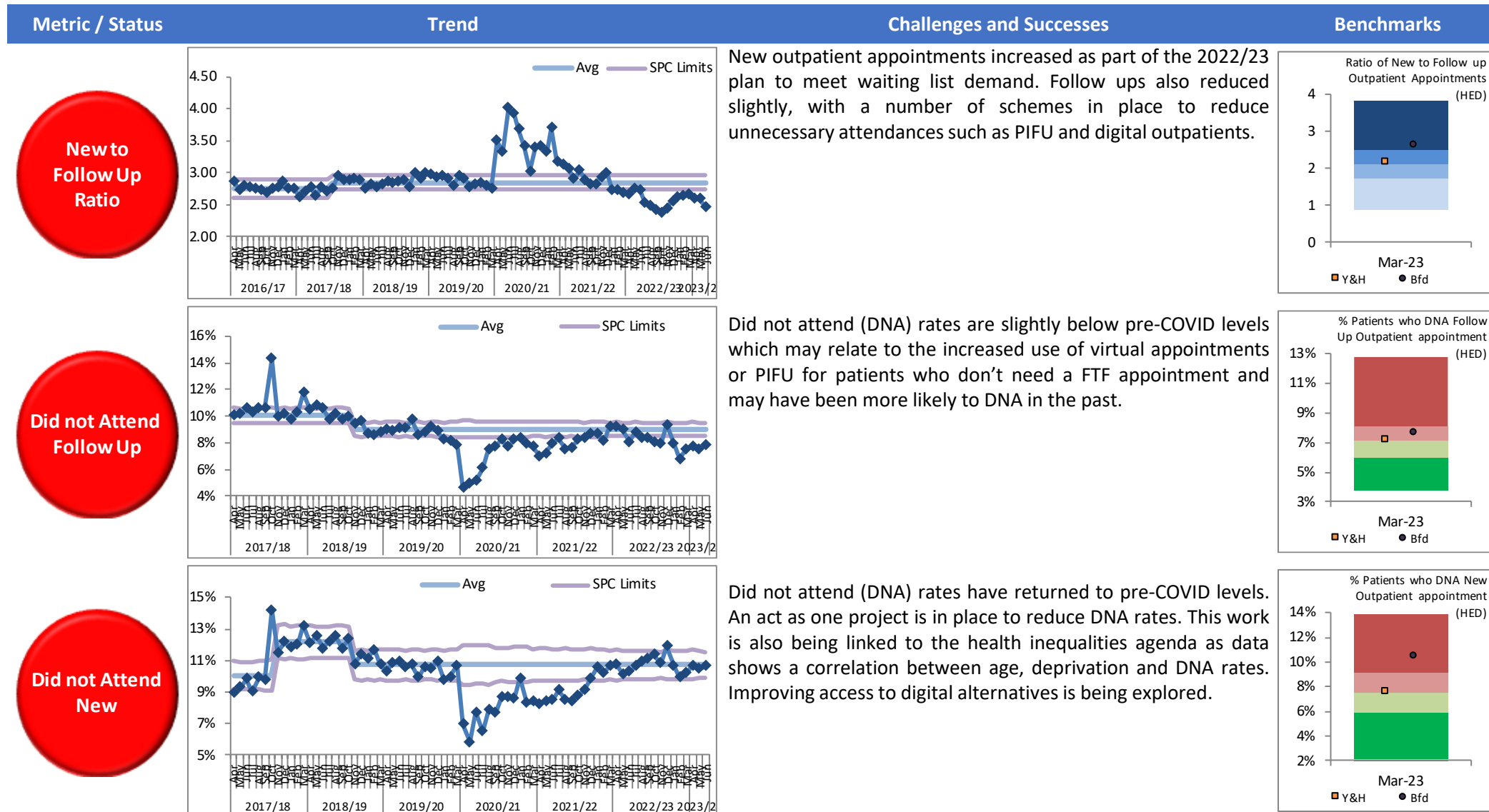
To deliver our key performance targets and financial plan

Productivity

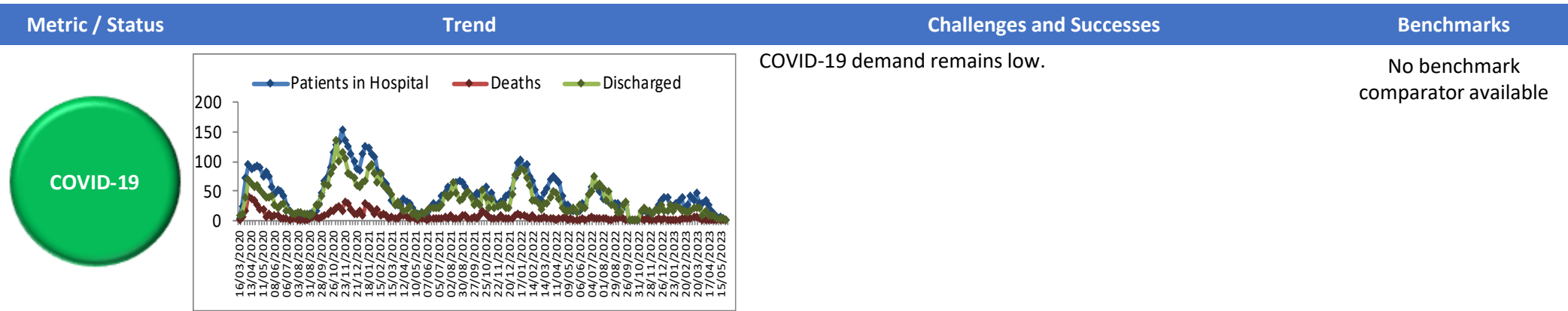


To deliver our key performance targets and financial plan

Productivity



Covid-19



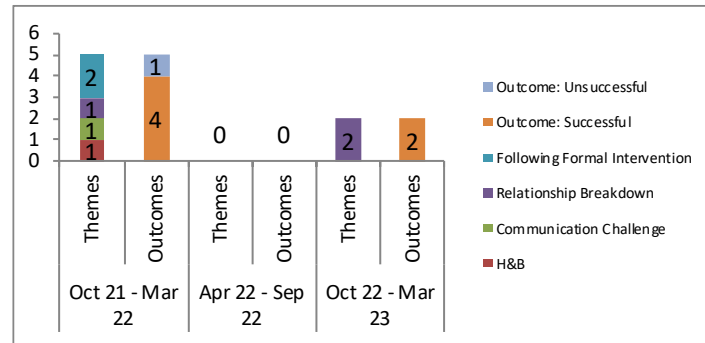
To be in the top 20% of employers

Engagement

Metric / Status	Trend	Challenges and Successes	Benchmarks																																	
<div>Contacts with Advocacy service</div>	<div><table><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><tr><td>Oct 22 - Mar 23</td><td>17</td><td>12</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	Oct 22 - Mar 23	17	12	<p>Contacts with the Staff Advocacy service have risen again slightly in the last 6 months as has the proportion of issues being resolved informally (from 37% of cases to 41% of cases). A full review of the role and remit of staff advocates has taken place and after publicising our expansion of the service; we have a number of applicants who are now waiting to be trained as Staff Advocates. Staff Advocates are a key enabler to early informal workplace resolution.</p> <p>Next update November 2023 (for the period 01/04/23 to 30/09/23)</p>	No benchmark comparator available
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<div>Harassment & Bullying Outcomes</div>	<div><table><thead><tr><th>Period</th><th>Informal Action</th><th>Still in progress</th></tr></thead><tbody><tr><td>Apr 18 - Sep 18</td><td>15</td><td>0</td></tr><tr><td>Oct 18 - Mar 19</td><td>12</td><td>10</td></tr><tr><td>Apr 19 - Sep 19</td><td>10</td><td>15</td></tr><tr><td>Oct 19 - Mar 20</td><td>12</td><td>10</td></tr><tr><td>Apr 20 - Sep 20</td><td>12</td><td>0</td></tr><tr><td>Oct 20 - Mar 21</td><td>15</td><td>0</td></tr><tr><td>Apr 21 - Sep 21</td><td>12</td><td>10</td></tr><tr><td>Oct 21 - Mar 22</td><td>15</td><td>0</td></tr><tr><td>Apr 22 - Sep 22</td><td>12</td><td>0</td></tr><tr><td>Oct 22 - Mar 23</td><td>12</td><td>0</td></tr></tbody></table></div>	Period	Informal Action	Still in progress	Apr 18 - Sep 18	15	0	Oct 18 - Mar 19	12	10	Apr 19 - Sep 19	10	15	Oct 19 - Mar 20	12	10	Apr 20 - Sep 20	12	0	Oct 20 - Mar 21	15	0	Apr 21 - Sep 21	12	10	Oct 21 - Mar 22	15	0	Apr 22 - Sep 22	12	0	Oct 22 - Mar 23	12	0	<p>The number of formal cases has stayed fairly static since the last 6 month update. Of the 8 cases that were completed during the period 62% resulting in some form of “informal action” (e.g. recommendation for mediation). 25% resulted in a resignation and 13% (just 1 case) resulted in disciplinary action. Our Trust wide civility in the workplace campaign is now well under way. The Introduction of a new people charter, workplace mediation service, refresh of the staff advocacy service, EDI training for line managers, poster campaign, refresh of the harassment & bullying policy and drama based training based around case studies will all play a crucial role in the wider culture change required to reduce the number of formal cases, with a focus on “nipping issues in the bud” at an early stage.</p> <p>Next update November 2023 (for the period 01/04/23 to 30/09/23)</p>	No benchmark comparator available
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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)

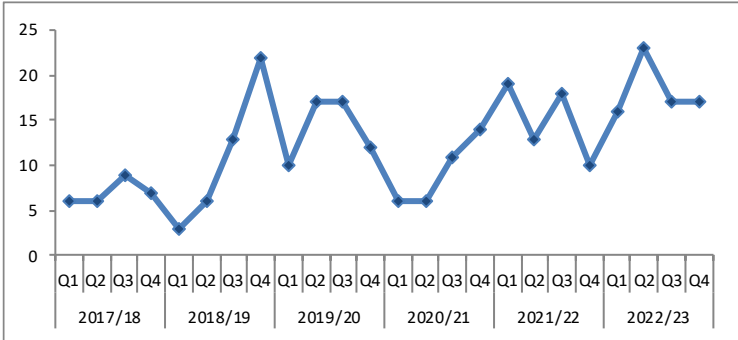
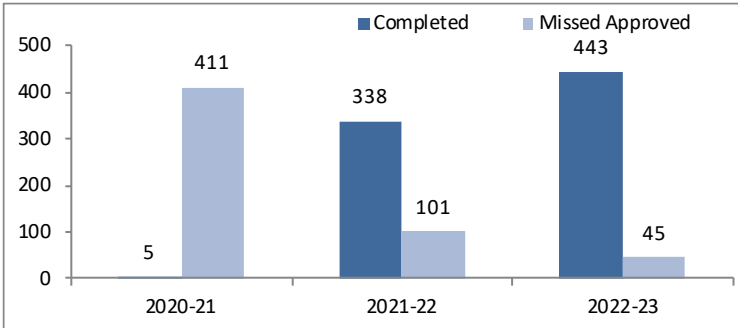
2 mediation referrals have taken place over the last 6 months with both cases managing to achieve some level of successful outcomes. Additionally 5 other parties have been in discussions with the mediation co-ordinator and a further interactive mediation session is being arranged and pending. The role 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'.

The mediation service will become a key component of the refreshed Harassment & Bullying policy and process when it is finalised over the next couple of months.

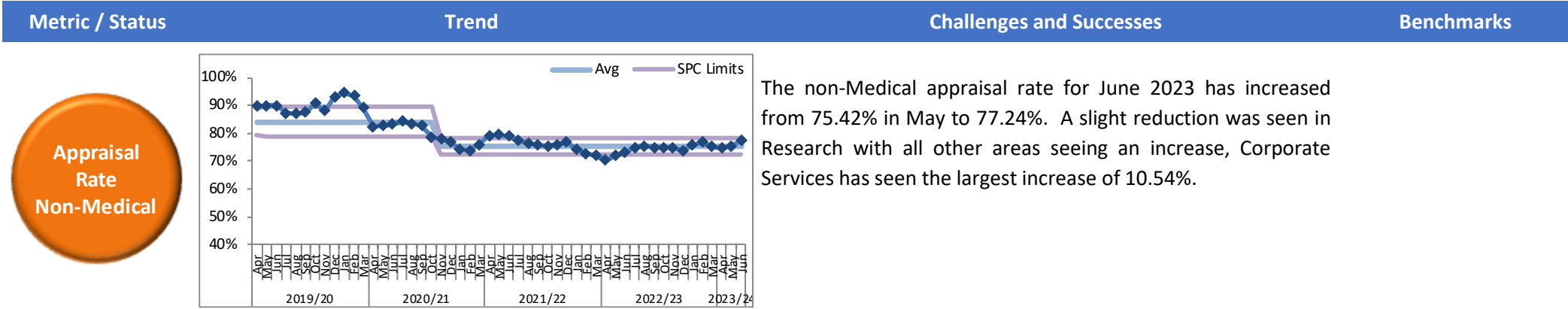
Next update November 2023 (for the period 01/04/23 to 30/09/23)

To be in the top 20% of employers

Engagement

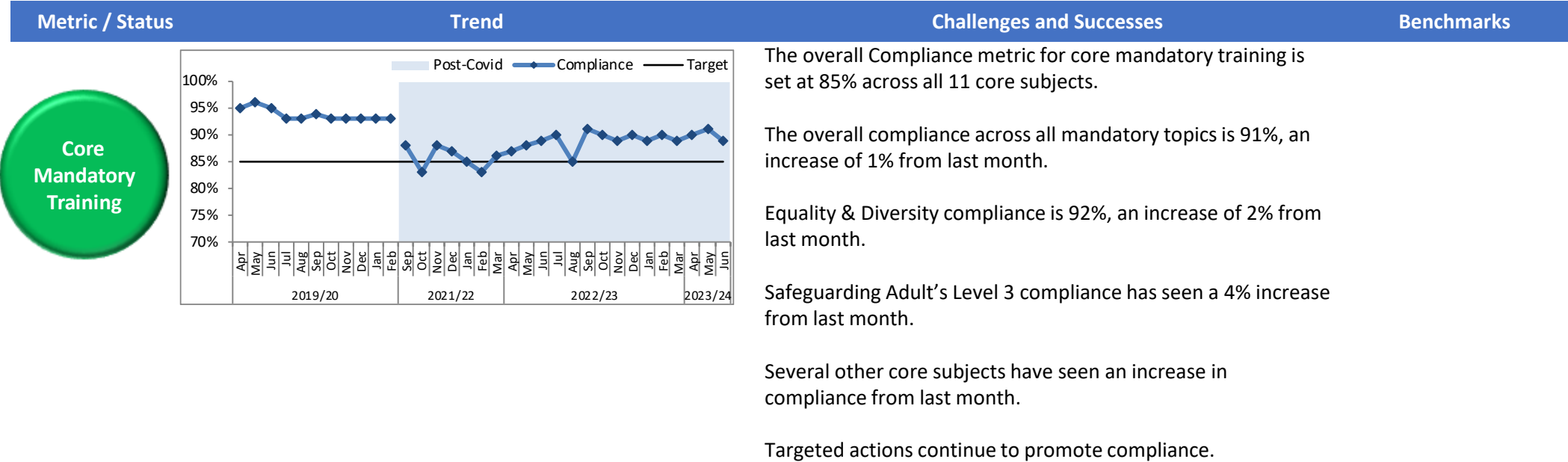
Metric / Status	Trend	Challenges and Successes	Benchmarks																																			
<div>Referrals to FTSU</div>	 <table><caption>Referrals to FTSU (Line Chart Data)</caption><thead><tr><th>Period</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr></thead><tbody><tr><td>2017/18</td><td>6</td><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>	Period	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 Q4 12 concerns were raised with the Freedom to Speak Up team. 5 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. Of the 12 concerns raised in Q4, 2 concerns were raised due to inappropriate attitudes and behaviours, 6 for bullying and harassment, 3 for worker safety or wellbeing, 1 for other reasons. The FTSU team have developed a new web based app to replace the previous FTSU app where staff can report a concern anonymously if needed.</p> <p>Sue Franklin has attend training and been approved to become a national FTSU mentor.</p>	
Period	Q1	Q2	Q3	Q4																																		
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>Period</th><th>Completed</th><th>Missed Approved</th></tr></thead><tbody><tr><td>2020-21</td><td>5</td><td>411</td></tr><tr><td>2021-22</td><td>338</td><td>101</td></tr><tr><td>2022-23</td><td>443</td><td>45</td></tr></tbody></table>	Period	Completed	Missed Approved	2020-21	5	411	2021-22	338	101	2022-23	443	45	<p>Suspended following the onset of Covid.</p> <p>At 31st March 2023, 488 doctors had a prescribed connection with the Trust. This was comprised of:</p> <ul style="list-style-type: none">340 Consultant staff38 Specialty doctor grades110 Doctors with temporary or short-term contracts. <p>For the appraisal year 2022-2023:</p> <p>443 (90.78%) doctors received an Outcome Measure 1 (Completed appraisal).</p> <p>43 (8.81%) doctors were allocated an Outcome Measure 2 (Approved Missed appraisal). This includes doctors on long-term sick leave, maternity leave, recent retirements and new connections at 31st March 2023 who have not been in post for a sufficient duration to have undertaken the appraisal process.</p> <p>There were 2 Outcome Measure 3 appraisals (0.41%) (Unapproved Missed) for this period.</p> <p>The AOA and board sign off has been submitted to NHSE</p>																								
Period	Completed	Missed Approved																																				
2020-21	5	411																																				
2021-22	338	101																																				
2022-23	443	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>		<p>Turnover has seen a decrease by 0.53% to 10.90% in June 2023 from 11.43% in May 2023. All areas have shown a slight reduction apart from Estates & Facilities which remained stable.</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 99.47% in June 2023 which is a slight increase from 99.33% in May 2023. 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 336 members of staff on an apprenticeship programme. Which is 5.1% of the workforce of which 1.5% are clinical. 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>	


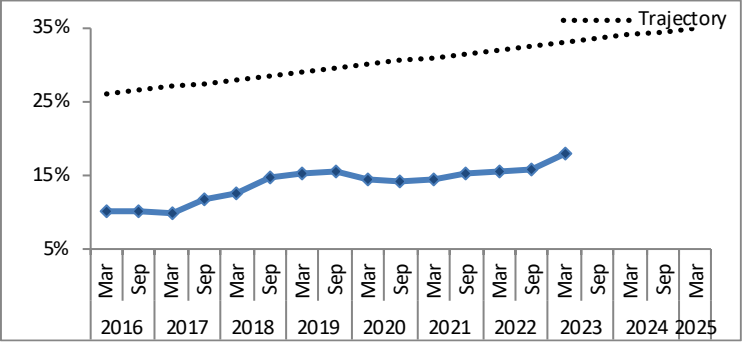

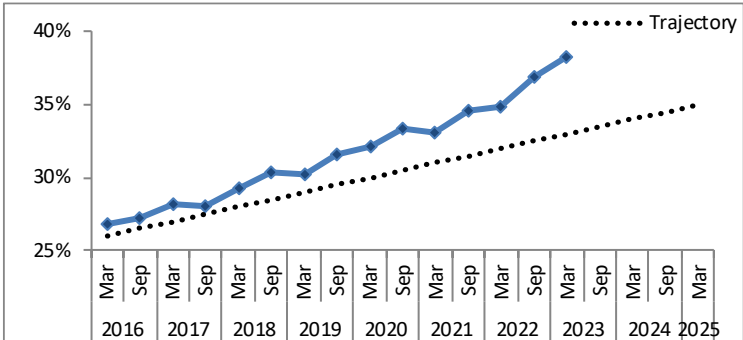
To be in the top 20% of employers

Staffing

Metric / Status	Trend	Challenges and Successes	Benchmarks
<div>Nursing Bank Fill Rate</div>		<p>In June the total number of requests sent to bank was 12344 compared with May's requests of 12465, a decrease of -121 requests. This is split as 5647 requests for registered staff and 6697 requests for unregistered staff. Of those 12344 requests a total of 7234 were filled by bank staff which is 58.60% compared with 60.79% in May – a decrease of -2.19%. 2,512 are filled by registered and 4722 filled by unregistered staff. Out of the 5647 requests for registered staff, the filled shifts were 2512 (44.5%) and for the 6697 requests for unregistered staff the filled shifts were 4722 (70.5%). Compared with May, fill rates decreased by 1.7% for registered and decreased by 2.3% for unregistered. Out of the 2512 filled registered shifts, 447 were filled by registered Theatre staff.</p>	
<div>Nursing Agency Fill Rate</div>		<p>Agency staff filled 1095 shifts in the month of June. This is split 802 registered staff and 293 unregistered. Out of the 802 filled registered shifts, 184 were filled by registered Theatre staff. In June Agency fill rates decreased by 0.8% for Registered and increased by 1.3% for unregistered. The biggest difference was found in the amount of HCA agency filled for June (293) compared to May's filled Agency of 210 .</p>	
<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 908 clinicians registered within the system, all with a job plan either in progress or signed off. This figure is made up of 377 Medics, 351 AHPs and 180 Nurses. The focus going forward is to continue to improve on the amount of job plans signed off within each CSU. There has been a dip in Signed off job plans but an increase of 23 job plans in review and 8 awaiting the 2nd sign off, which indicates job plans are being published following recent user guides sent out or job plans are coming to an end and need re-publishing.</p>	


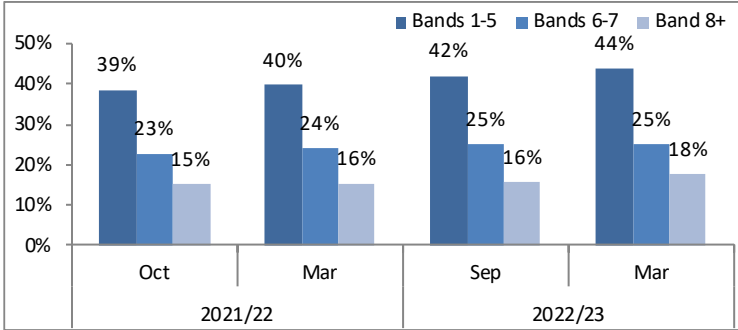

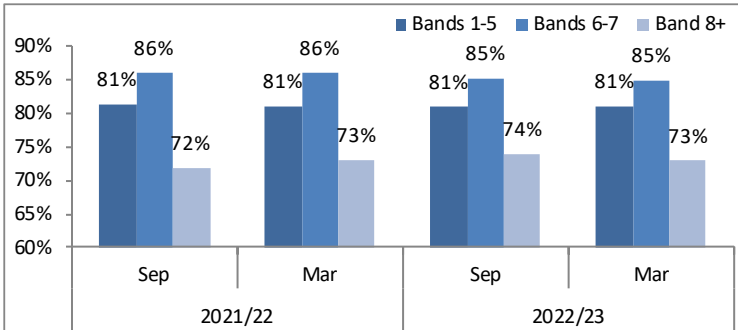
To be in the top 20% of employers

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 15.85% to 17.84%. Although only small numbers, in the last 6 months there have been increases at 8a and 8d for both clinical and non-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.</p> <p>Next update November 2023 (for the period 01/04/23 to 30/09/23)</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 36.96% to 38.22%. We continue to exceed 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.</p> <p>Next update November 2023 (for the period 01/04/23 to 30/09/23)</p>	<p>No benchmark comparator available</p>

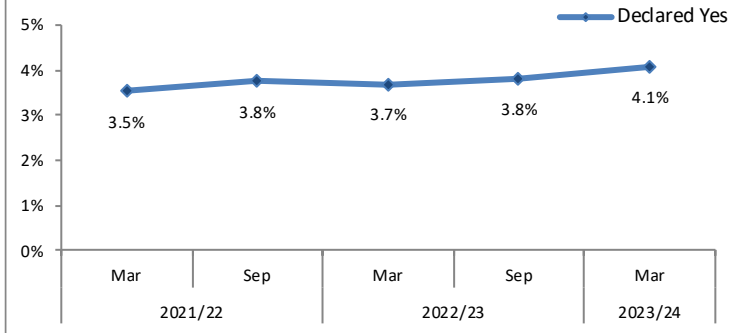
To be in the top 20% of employers

Equality & Diversity

Metric / Status	Trend	Challenges and Successes	Benchmarks																				
 <p>Ethnic minority workforce by band group</p>	 <table border="1"> <caption>Ethnic minority workforce by band group</caption> <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> <tr> <td>Mar 2022/23</td> <td>44%</td> <td>25%</td> <td>18%</td> </tr> </tbody> </table>	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%	Mar 2022/23	44%	25%	18%	<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 again from 42% to 44%. Above Band 5 there continues to be an under-representation, and although this under-representation is gradually reducing; at Bands 6 to 7 the proportions have stayed roughly the same (slight increase from 25% to 25.14%).</p> <p>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 November 2023 (for the period 01/04/23 to 30/09/23)</p>	
Period	Bands 1-5	Bands 6-7	Band 8+																				
Oct 2021/22	39%	23%	15%																				
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 <p>Female workforce by band group</p>	 <table border="1"> <caption>Female workforce by band group</caption> <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> <tr> <td>Mar 2022/23</td> <td>81%</td> <td>85%</td> <td>73%</td> </tr> </tbody> </table>	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%	Mar 2022/23	81%	85%	73%	<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 (73%, with a 1% decrease this time) and slightly over-represented at middle management levels (85%). This position has stayed roughly the same for the last 12 months.</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 November 2023 (for the period 01/04/23 to 30/09/23)</p>	
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%																				
Mar 2022/23	81%	85%	73%																				

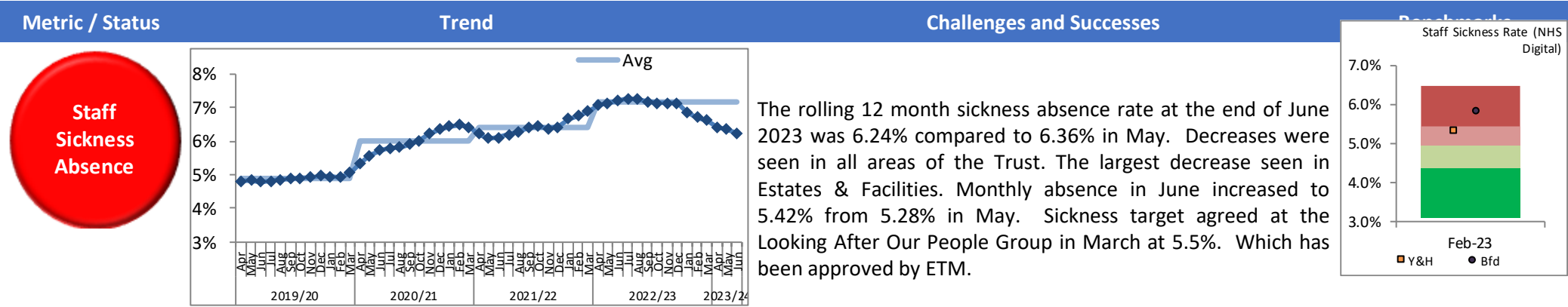
To be in the top 20% of employers

Equality & Diversity

Metric / Status	Trend	Challenges and Successes	Benchmarks												
<div><div>Disability Declaration Rate</div></div>	<div><div>Declared Yes</div><table><thead><tr><th>Period</th><th>Rate</th></tr></thead><tbody><tr><td>Mar 2021/22</td><td>3.5%</td></tr><tr><td>Sep 2021/22</td><td>3.8%</td></tr><tr><td>Mar 2022/23</td><td>3.7%</td></tr><tr><td>Sep 2022/23</td><td>3.8%</td></tr><tr><td>Mar 2023/24</td><td>4.1%</td></tr></tbody></table></div>	Period	Rate	Mar 2021/22	3.5%	Sep 2021/22	3.8%	Mar 2022/23	3.7%	Sep 2022/23	3.8%	Mar 2023/24	4.1%	<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. Whilst the 2022 staff survey results only represent 37% of our workforce, there continues to be a much higher proportion of staff survey respondents (c. 25% in 2022) who declared a disability/ long term health condition, indicating there may be a number of staff who are not declaring their status in ESR. We continue to work with our Enable staff network in increasing confidence to declare a disability. The WDES Innovation Fund display and video has been shared widely on a regional and national basis, and with a number of events taken place across the Trust to raise the profile of disability equality and managing long-term health conditions. This has been really helpful in raising the profile of EDI across the Trust and has recently generated lots of interest from wider staff in joining the Enable network and with staff registering their interest for key roles within the network core group.</p> <p>Next update November 2023 (for the period 01/04/23 to 30/09/23)</p>	
Period	Rate														
Mar 2021/22	3.5%														
Sep 2021/22	3.8%														
Mar 2022/23	3.7%														
Sep 2022/23	3.8%														
Mar 2023/24	4.1%														





To be in the top 20% of employers

Health & Wellbeing



To collaborate effectively with local and regional partners

Partnership

Metric / Status	Trend	Challenges and Successes	Benchmarks
 <p>Reducing Inequalities</p>	<p>There is significant activity across the Trust 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 (published June 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 & Diversity Council agenda</p>		No benchmark comparator available
 <p>Act as One Place</p>	<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. BTHFT supports these priorities, and is prominent in 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 for the ICB of the reduction in central funding.</p>		No benchmark comparator available
 <p>ICB & WYAAT</p>	<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 also contributed to the ongoing NHS75 review work led by the NHS Assembly.</p>		No benchmark comparator available
 <p>Anchor Institution</p>	<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.	
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

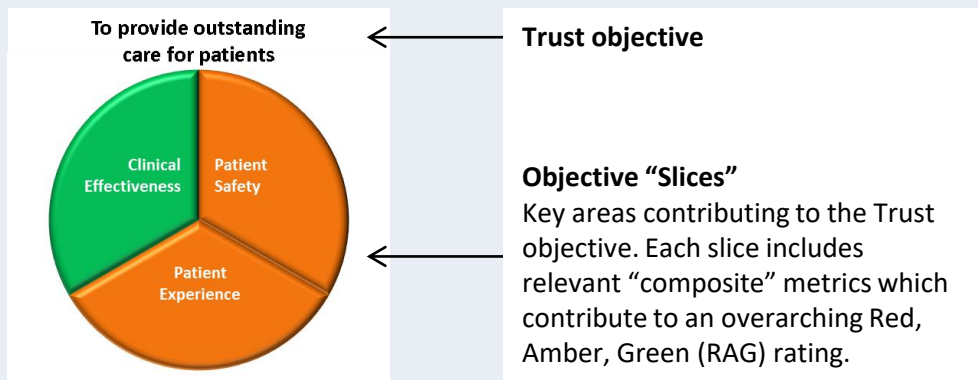
Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals				
Partnership				
Reducing Inequalities	Working with partners to contribute to the overall reduction of health inequalities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