Integrated Dashboard

Board of Directors

30th September 2023

Integrated Dashboard

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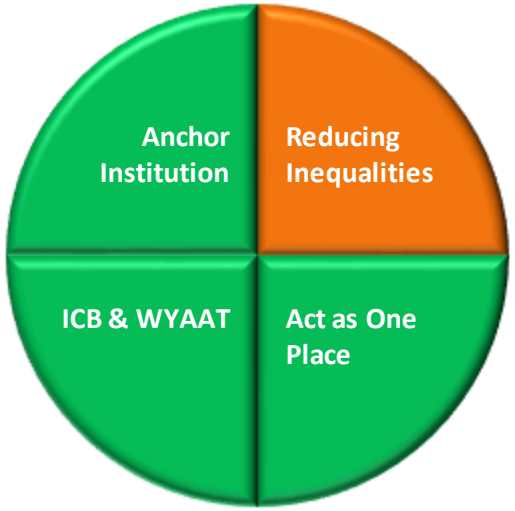
To provide outstanding care for patients, delivered with kindness

To deliver our financial plan and key performance targets

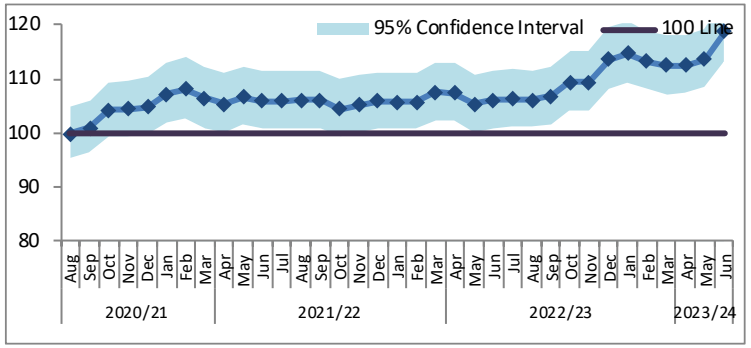
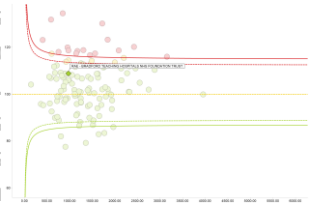
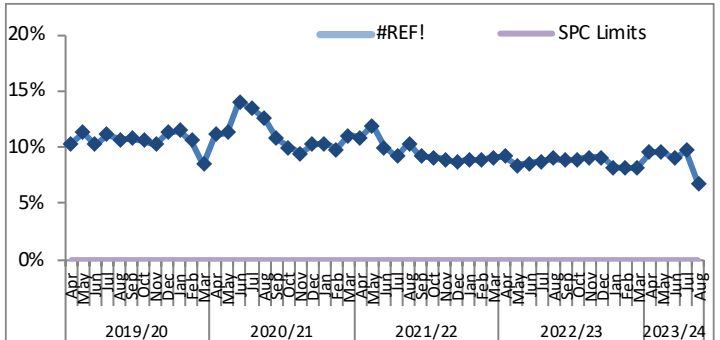
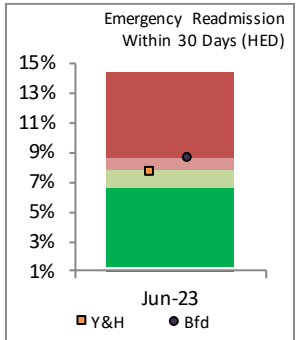
To be one of the best NHS employers, Prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion

To collaborate effectively with local and regional partners

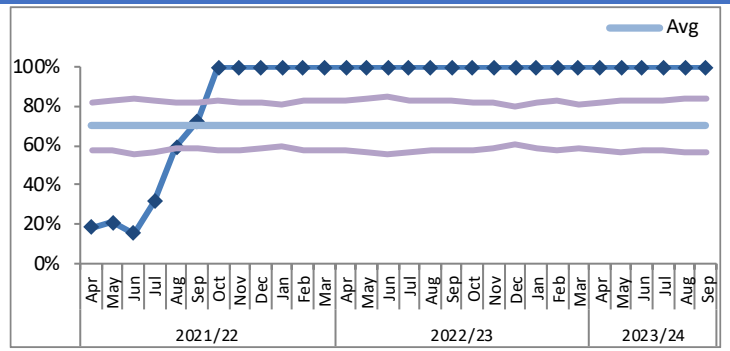
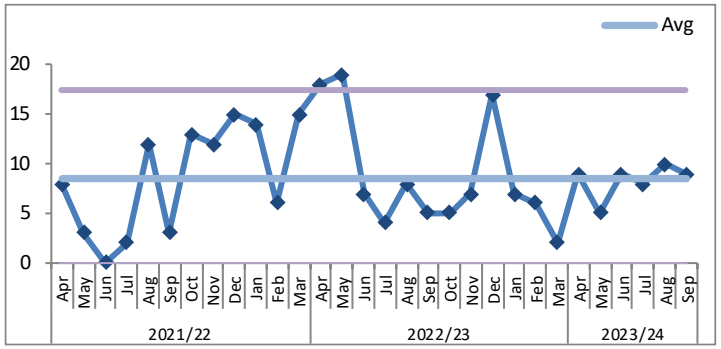


To be a continually learning organisation and recognised as leaders in research, education and innovation

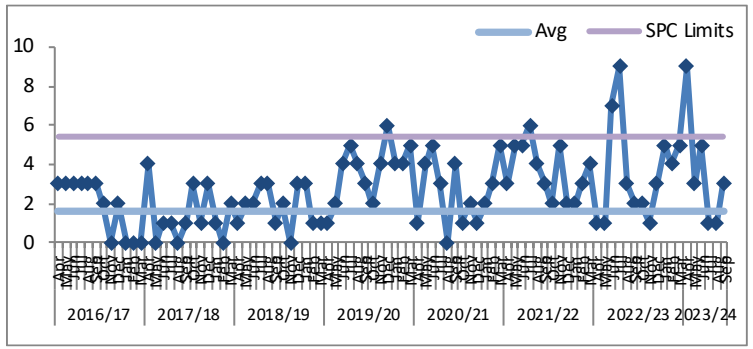
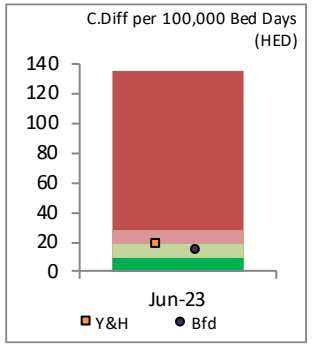
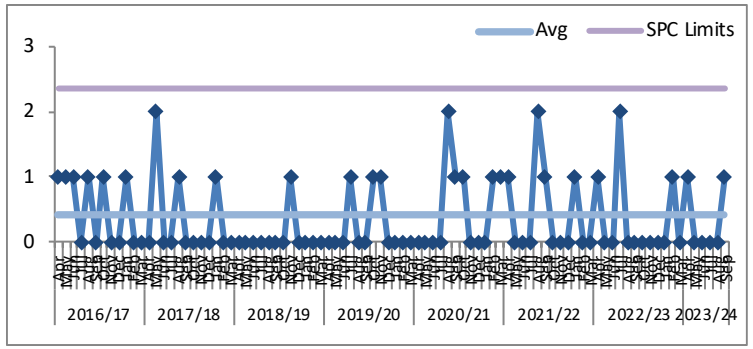
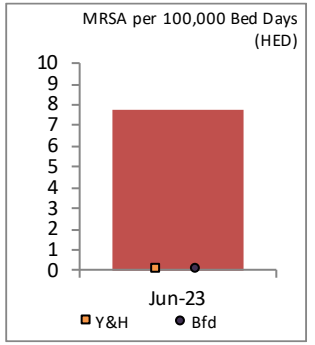
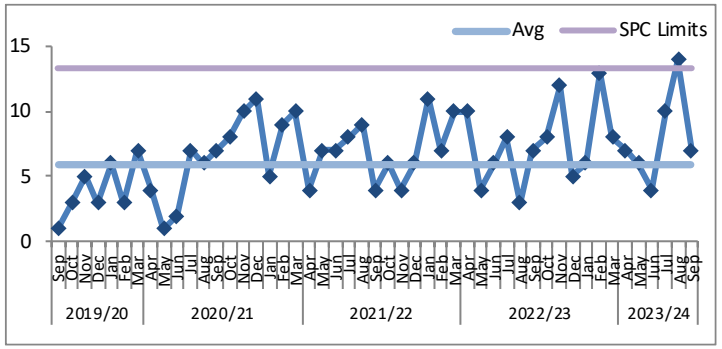
To provide outstanding care for patients
Clinical Effectiveness

Metric / Status	Trend	Challenges and Successes	Benchmarks
Summary Hospital-level Mortality Indicator		The Summary Hospital-level Mortality Indicator (SHMI) shows the ratio of the observed to the expected number of deaths up to 30 days after discharge from hospital, multiplied by 100. The SHMI reports on mortality at trust level for acute trusts across the NHS in England, and is evaluated over all diagnosis groups in a specified patient group. It excludes stillbirths, and a death is counted only once and to the last discharging acute provider. The SHMI value is not an indication of avoidable deaths or a measure of the quality of care delivered. If the HSMR is significantly higher or lower than expected this will trigger further investigation, as this could signal data quality issues, changes in pathways/practices, or issues with quality of care. SHMI (12 month rolling) HES-ONS Linked Mortality Datasets (September 2023): 118.17 – high (>95%). We are aware of movement within our SHMI over recent months. Examination of the data has revealed that NHS England has been reducing our number of 'expected deaths' within the SHMI algorithm (this month it was reduced by over 40%). The Business Intelligence Team and the Associate Director for Learning from Deaths are collaborating to determine why. This work will involve a deep-dive of monthly deaths to capture all patient conditions, test results and disease progression within our coding systems as these contribute to the NHSE expected death number.	
Readmissions		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)	

To provide outstanding care for patients
Learning from Deaths

Metric / Status	Trend	Challenges and Successes	Benchmarks
Percentage of deaths Scrutinised by the Medical Examiner		We continue to meet 100% scrutiny for all hospital deaths. There were 101 hospital deaths dealt with via our office in September 2023. We have engaged with all of the GP practices in our remit (55 out of 55 GP sites) and 75% of practices are routinely referring deaths through to the Medical Examiner's office. In September 2023, we scrutinised 63 Community deaths.	
Number of SJR Requests raised		There were nine SJRs requested via the Medical Examiner's office for September 2023 on a background of 100 adult inpatient deaths. A total of five SJRs were completed by reviewers throughout September with four scoring between Adequate to Excellent overall care and one scoring Poor. This case will be reviewed at the Mortality Review Improvement Group (MRIG) on 8th November 2023. Reasons for the SJR's requests raised in September 2023 include: Where the bereaved or staff have raised significant concerns (n=1) Those with Learning Disabilitites (n=2) Those with severe mental health illnesses (n=1) Those who were elective admissions (N=1) Those in the community (n=1) Where learning will inform the provider's Quality Improvement work (n=3)	

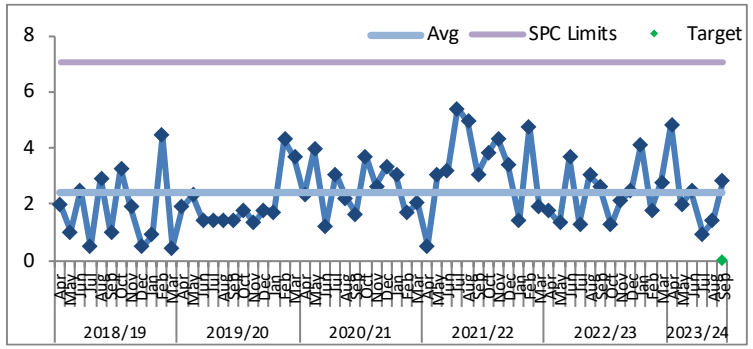
To provide outstanding care for patients
Patient Safety

Metric / Status	Trend	Challenges and Successes	Benchmarks
C Difficile		The Trust reported 43 cases of C. diff infection during 2022/23. So far 22 trust attributable cases have been identified. 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 attributable cases since May 2023.	
MRSA		The trust reported 4 cases of MRSA bacteraemia during 2022/2023. So far 2 cases of MRSA bacteraemia have been identified in 2023/2024 with one case each in April and September 2023. 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.	
E.Coli		The Trust reported 91 trust attributable E. coli bacteraemia cases during 2022/23. So far 50 cases of trust attributable E. coli bacteraemia have been identified. Most of them were categorised as Community onset healthcare associated (COHA). 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.	

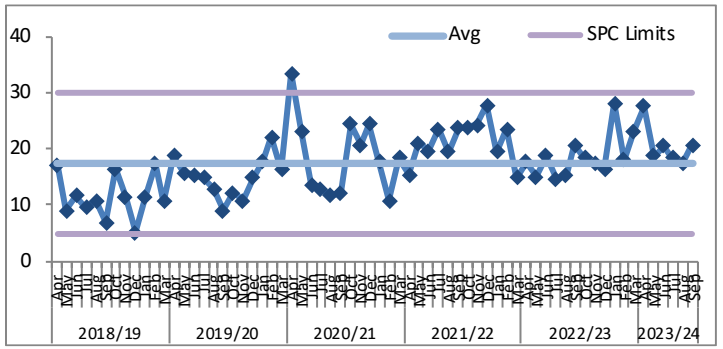
To provide outstanding care for patients
Patient Safety

Metric / Status	Trend	Challenges and Successes	Benchmarks

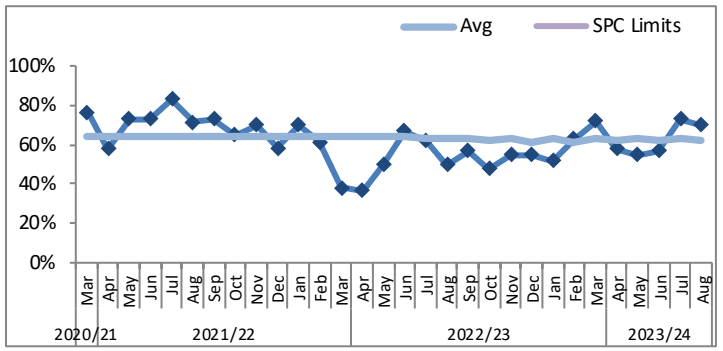
Pressure Ulcers Cat 3+ per 10,000 bed days



Pressure Ulcers per 10,000 bed days

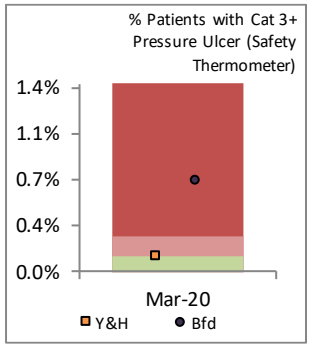


Medicine Reconciliation

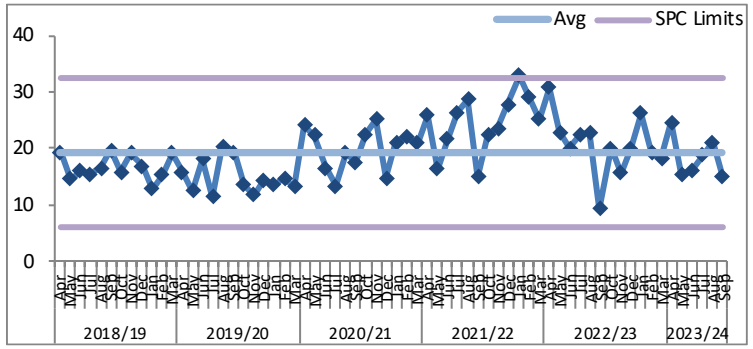
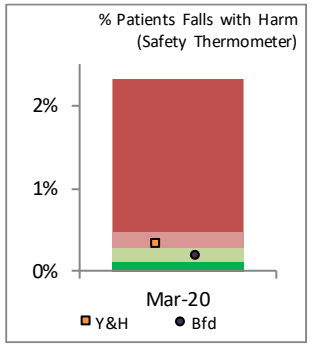
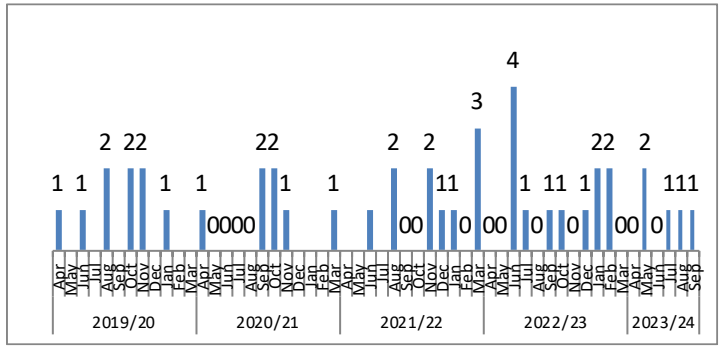


Pressure ulcer incidents increased at the beginning of 2023. Increased demand, increased patient frailty and deconditioning and staffing pressures may have been contributory factors. A risk assessment was completed and action plan developed to mitigate the risks. There has been a successful roll out of the new pressure ulcer risk assessment tool in July (phase 1; phase 2 will include maternity and community) which is being supported by an e-learning package and other resources. The introduction of PSIRF in relation to pressure ulcers is also in development – this will include the use of after action learning to replace root cause analysis and development of feedback process at the pressure ulcer improvement group to share learning and improvement. New e-learning modules were introduced this year and the clinical practice educators and legacy nurses are being utilised to support the development of staff which will add to existing learning measures already in place which includes bespoke ward-based training and teaching at induction. A tissue viability conference will be held in November 2023.

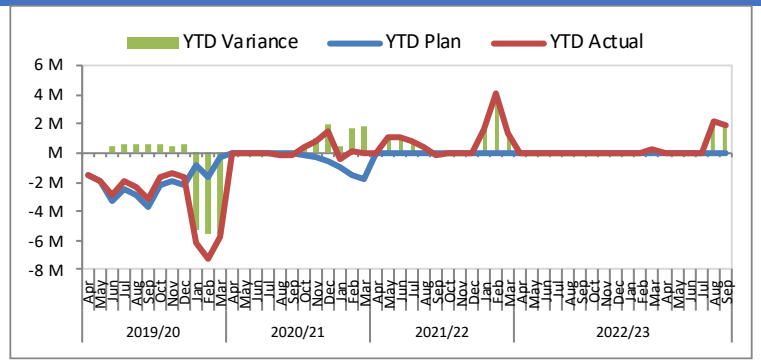
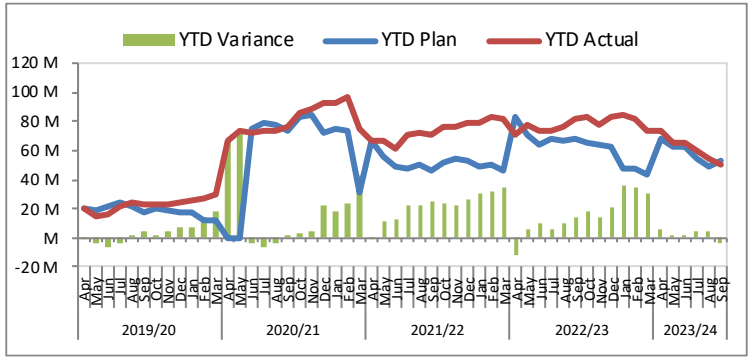
Medicines reconciliation is the overarching formal process of obtaining a complete accurate and up to date list of the patient's current medicines and comparing this list to the prescribed medication, taking into account adherence prior to admission and the patient's current clinical presentation. Medicines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



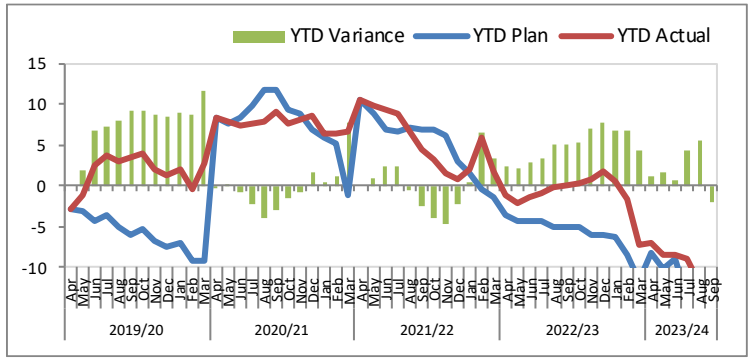
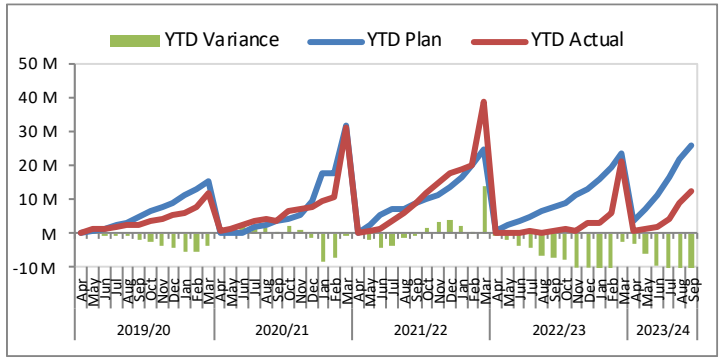
To provide outstanding care for patients
Patient Safety

Metric / Status	Trend	Challenges and Successes	Benchmarks
Falls with Harm per 10,000 bed days		Falls are being reviewed by the Lead for falls Improvement. A new process has started, in line with PSIRF, to meet learning and assurance needs for individuals and the wider organisation. CSU teams will be asked to attend the Falls Improvement group to present all falls and their themes for learning and improvement. They will discuss how they are implementing the actions or QI work they have identified. The new process involves – • Completion of DATIX • Fall reviewed by falls lead • If a fall has lapses in care, this will be escalated to the Quality and Patient Safety facilitators to be taken to SEG/QuoC • Completion of the hot debrief form by Registered Nurse(on the same shift as the fall happened) • An After Action Review will be completed within 5 days of the fall. This is an MDT approach. This will be monitored by the Quality and Patient Safety facilitators. • The completed form will be sent to the falls Lead for accuracy and learning points. • This will then be signed and sent back to the ward manager to attach to DATIX • Moderate and severe harm falls will still include Duty of Candour and RIDDOR (if appropriate) • When invited, the CSU will discuss their falls and themes for learning at the Falls Improvement group	
Falls with Severe Harm		The hot debrief and after action review have now been merged into one document to prevent repetition and make the process easier, whilst including all aspects of falls management. This whole process will replace the previous panel process. Resources are also available on our Frailty Padlet - Frailty (https://padlet.com/paulstreet2/frailty-reur5ccm1crymiyq) so staff can access this 24 hours a day.	No benchmark comparator available

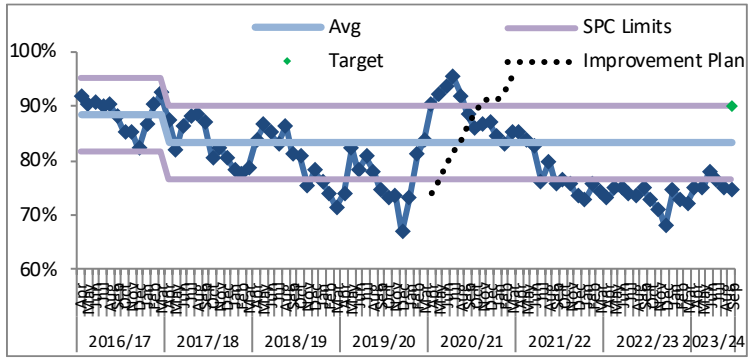
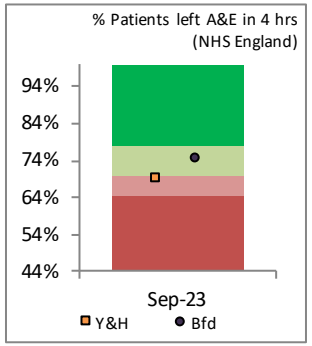
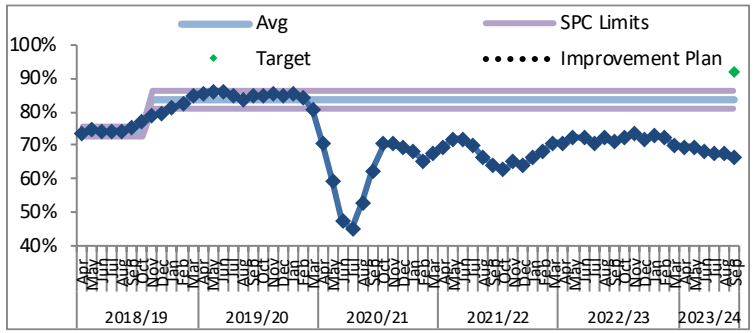
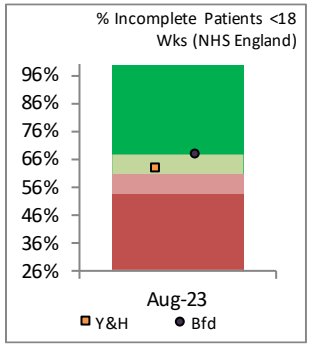
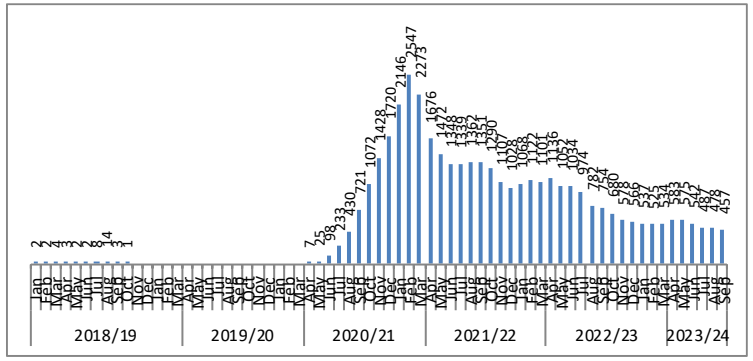
To deliver our key performance targets and financial plan
Finance

Metric / Status	Trend	Challenges and Successes	Benchmarks
Delivery of Income and Expenditure Plan		The Trust has formally reported a year to date deficit position of £2.0m at Month 6. This is a £0.2m improvement on the position reported at Month 5, which reflects a more accurate assesssment of the mitigating impact of salary deductions resulting from the Industrial Action. The Month 6 deficit position now accurately reflects the net YTD impact of the costs of covering the strike days and the associated salary deductions. The Trust continues to formally forecast to NHSE a year end breakeven position for the financial year, which is in line with the plan. Internal forecasting suggests that without increased WRP delivery the year end deficit is likely to be £3.6m if additional NHSE funding is received to offset IA costs and £8.0m if no additional IA funding is received. The WY ICS has agreed to review all forecasts at Month 8, at which point a decision will be taken on whether organisations should change their formal forecasts to NHSE if an off-plan year end position remains the most likely scenario.	No benchmark comparator available
Delivery of Cash Plan		Closing cash at month 6 is £50.2m which is £3.0m lower than plan (£53.2m). The main reasons for the variance from plan are: 1. Lower than planned operating surplus (£3.7m less cash) 2. Higher than planned receivables (£5.9m less cash) 4. Higher than planned deferred income (£3.9m more cash) 5. Lower than planned capital cash spend (£15.4m more cash) 6. Higher than planned interest received (£1.2m more cash) 7. Lower than planned PDC dividend balance (£13.3m less cash) Year-end forecast cash is £47.6m which is £1.6m lower than planned (£49.2m). This is due to a reduction in the year end forecasts for deferred income (£1.5m) and provisions (£0.6m). The Trust is not expecting to require any cash support during 2023/24.	No benchmark comparator available

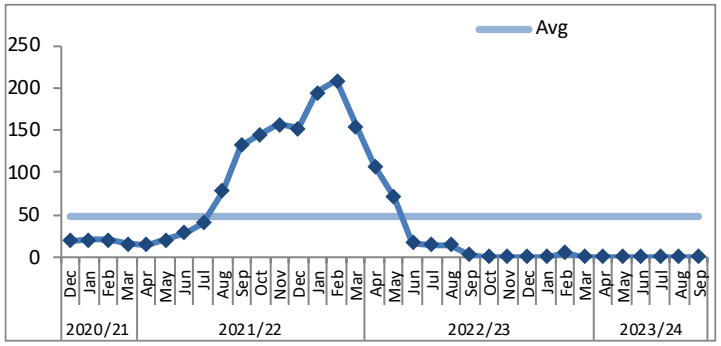
To deliver our key performance targets and financial plan
Finance

Metric / Status	Trend	Challenges and Successes	Benchmarks
Liquidity rating		Liquidity represents the number of days the Trust could meet its operating costs from its liquid resources (current assets less stocks and current liabilities). Year to date liquidity is negative 14.8 days which is 2.0 days lower than plan (negative 12.8 days). Liquidity is lower than plan due to the behind plan capital expenditure by £12.3m and current liabilities being higher than plan by £6.4m. Liquidity is forecast to fall to negative 18.2 days by year end. This is 0.4 days lower than planned due to a reduction in the non-current deferred income forecast of £1.5m. This reflects the year-to-date movement of Research and Development deferred income.	No benchmark comparator available
Delivery of Capital Plan		Total capital departmental expenditure limit ("CDEL") for 2023/24 is £59.3m. The Trust is forecasting to spend its full CDEL allocation by 31 March 2024. At month 6 the Trust reported a year-to-date underspend of £12.9m. This is due to delays in the delivery of digital equipment (£2.0m) and Estates schemes (£4.4m). PDC funded schemes are behind plan due to delays to the Eccleshill Community Diagnostic Centre (£2.6m). The TIF funded Day Case Unit is behind plan by £3.6m due to delays in starting the project. The slippage reported on the schemes identified will be recovered by the end of the year. Year-end forecast exceeds plan by £9.6m which is largely due to the approval of the Endoscopy Transformation Project (23/24 spend £8.8m) after the plan was submitted.	

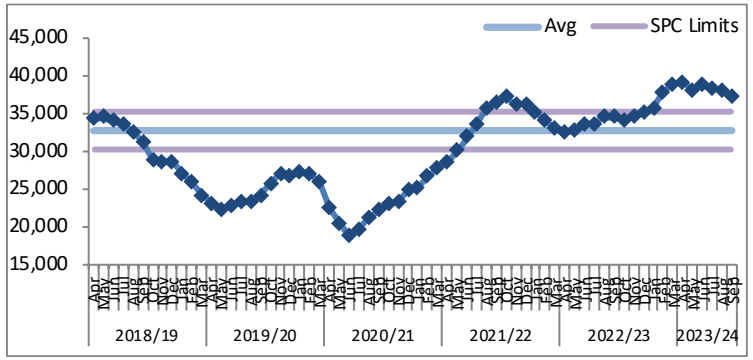
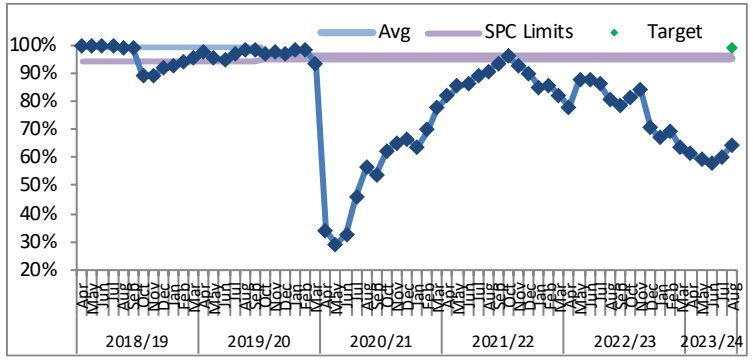
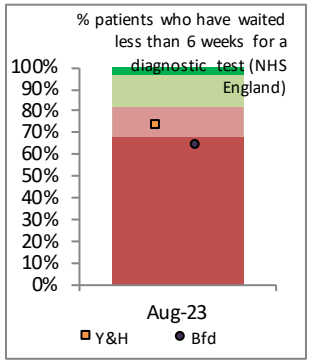
To deliver our key performance targets and financial plan
Performance

Metric / Status	Trend	Challenges and Successes	Benchmarks
Emergency Care Standard		Emergency Care Standard (ECS) performance was at 74.48% for September 2023, which remains above peer and national average. Admissions from ED into the hospital remain stable and improvement plans to increase admission avoidance continue. Initial assessment and patient flow improvements are being sustained. Further improvement anticipated as the urgent care centre progresses and ED is decongested.	
RTT 18 Week Incomplete		RTT performance continues above peer and national average. Theatre activity is higher than during the pandemic but slightly below 2019-20 baselines. Theatre productivity is reviewed weekly and improvement actions are being progressed to reduce delays and increase throughput. A theatre recovery meeting with Executive oversight has been established to support this.	
RTT 52 Week Wait		The Trust had 457 incomplete 52 week waits at the end of September 2023. As a percentage of the total waiting list this places the Trust in the best performing quartile nationally for acute Trusts. Recent trends are deviating from the plan however as industrial action has reduced clearance rates. This is in line with national trends as all Trusts experience a similar impact.	No benchmark comparator available

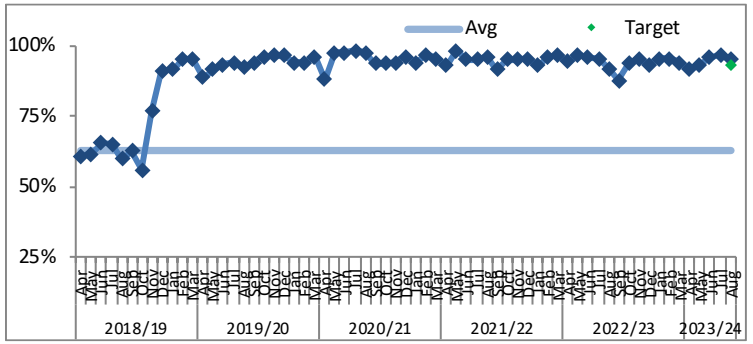
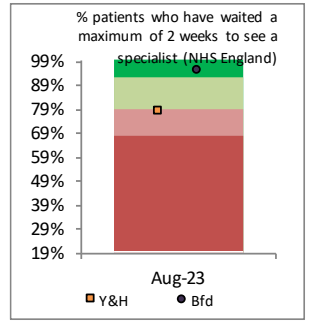
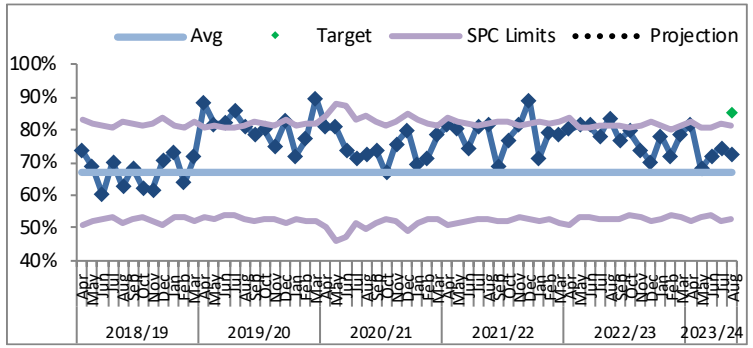
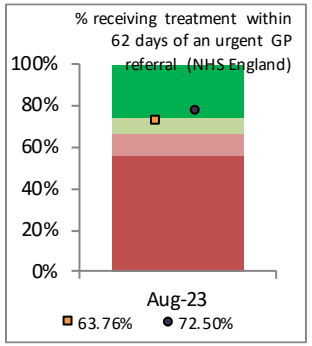
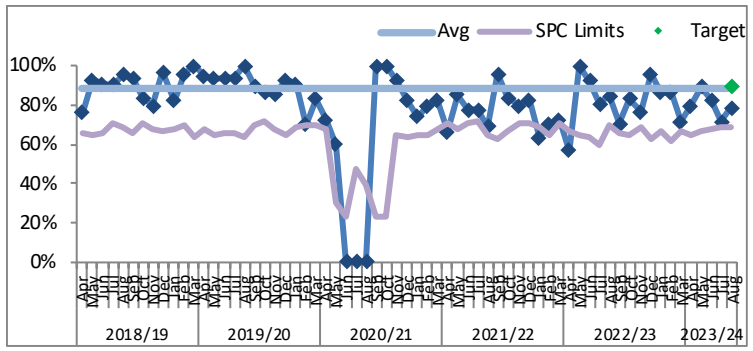
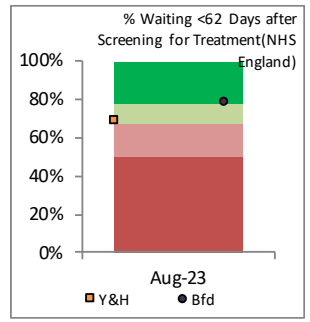
To deliver our key performance targets and financial plan
Performance

Metric / Status	Trend	Challenges and Successes	Benchmarks
RTT 18 week > 104 week wait		There was 1 patient reported over 78 weeks at the end of September due to national issues with Corneal tissue supplies however the Trust is projecting 0 patients to breach 78 weeks wait by the end of October.	

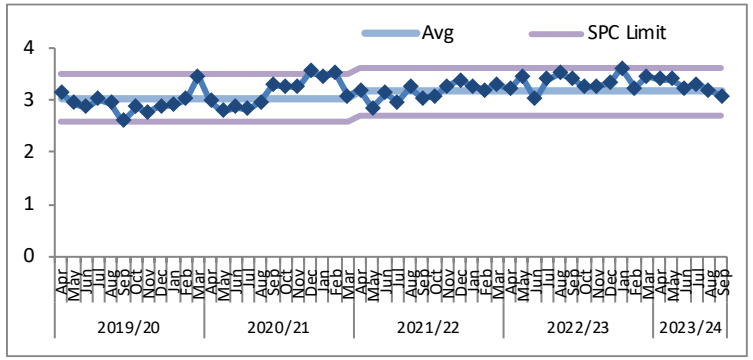
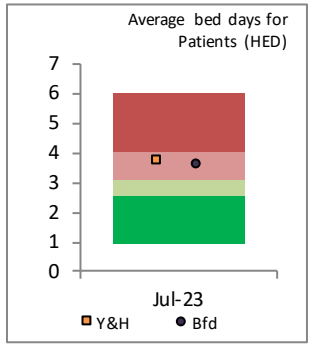
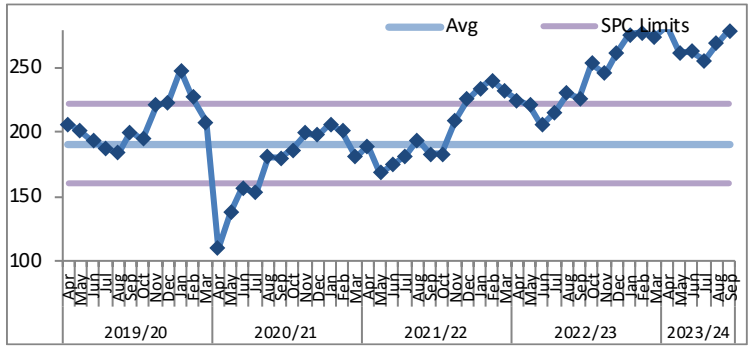
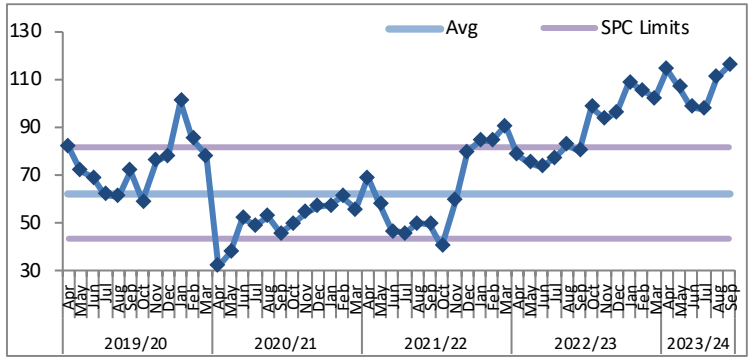
To deliver our key performance targets and financial plan
Performance

Metric / Status	Trend	Challenges and Successes	Benchmarks
Elective Waiting List		The total RTT waiting list has stabilised following increased validation efforts. We estimate that industrial action in 2023/24 to date has increased the waiting list by more than 1000 patients, which explains why we haven't been able to reduce in line with plan.	No benchmark comparator available
Diagnostic Waits		Performance has started to improve with outsourcing of NOUS the biggest change. MRI and Endoscopy have also improved their respective performance in this period.	

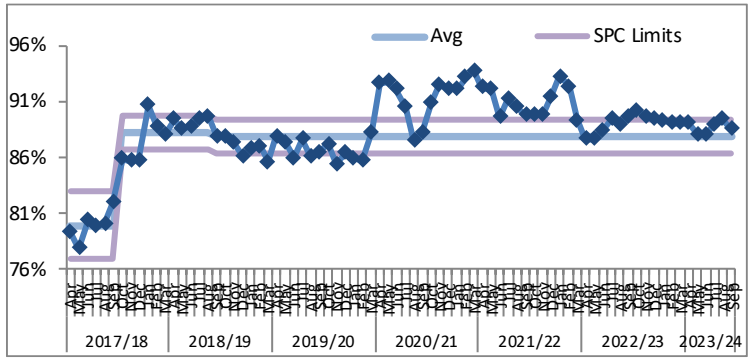
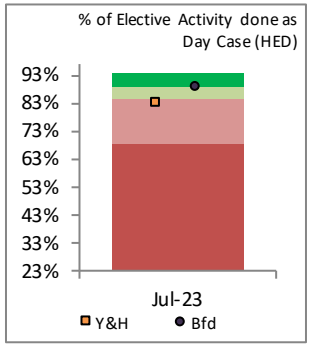
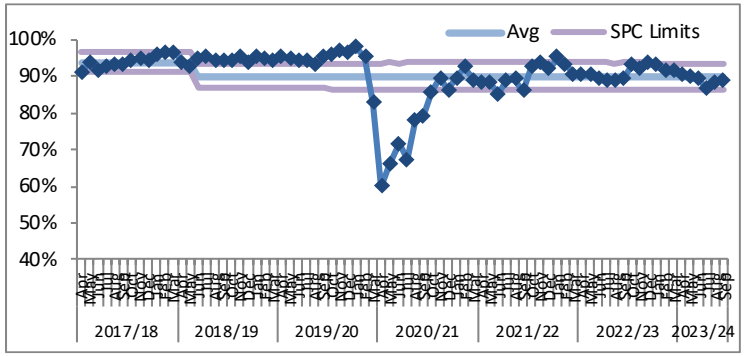
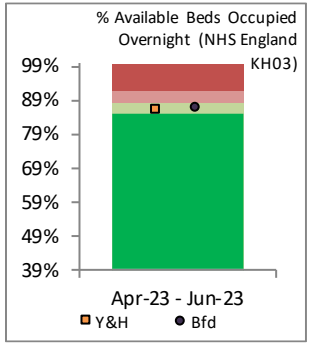
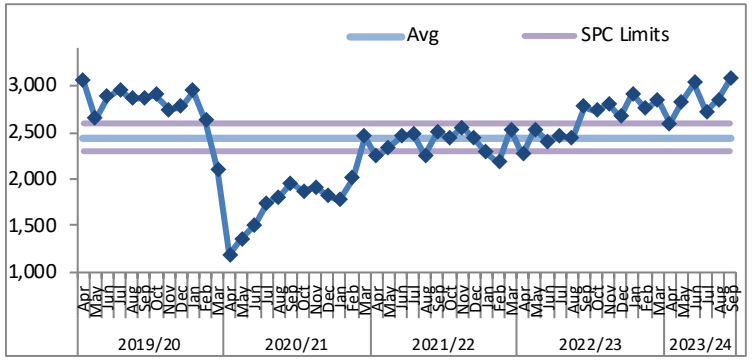
To deliver our key performance targets and financial plan
Performance

Metric / Status	Trend	Challenges and Successes	Benchmarks
Cancer 2 Week GP		Performance against the 2 Week-Wait Cancer standard was above target. Referral demand remains significantly up on pre-COVID levels and services have adjusted capacity to meet this in the longer term. Daily capacity monitoring and escalation processes continue. The Trust is sustaining performance in the upper quartile nationally but lost capacity for industrial action will impact negatively.	
Cancer 62 Day Urgent GP		Diagnostic and surgical capacity is being prioritised in support of cancer pathways. Performance remains in the upper quartile nationally but increased referral demand and diagnostic capacity issues on some pathways mean the number of patients waiting longer than 62 days is higher than planned. Improvement actions are progressing well to support future delivery of the overall target, with a particular focus on best practice milestones and faster diagnosis.	
Cancer 62 Day Screening		Performance for this indicator reflects the complexity of pathways, patient concordance, and delays in diagnosis across Breast and Lower gastrointestinal (GI) services. This KPI will merge with the GP one as part of CWT version 12 changes happening in Q3.	

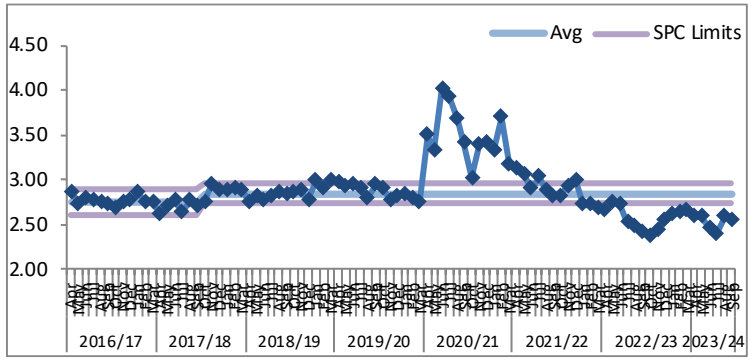
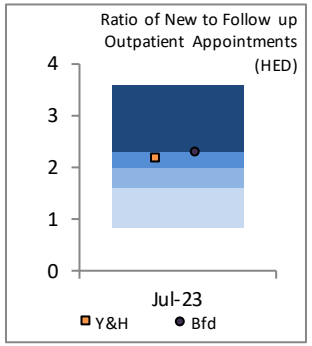
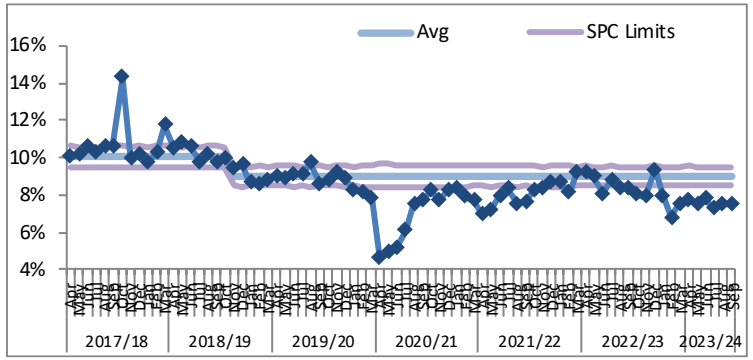
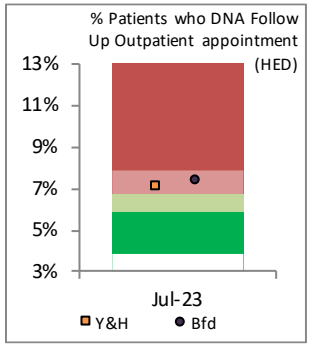
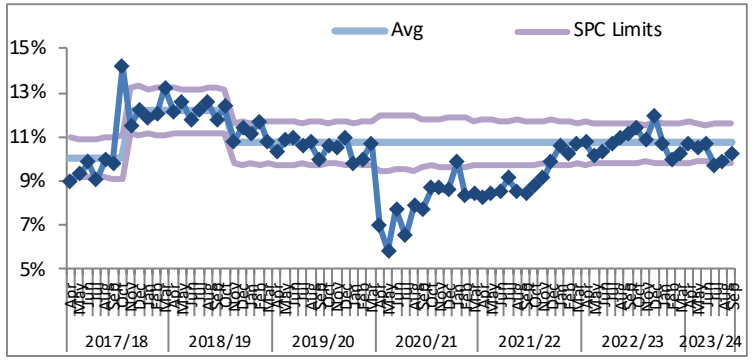
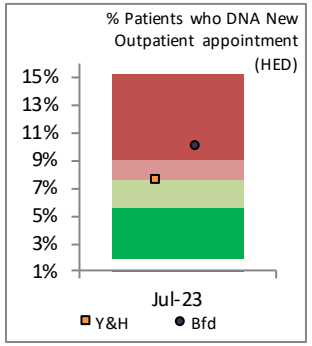
To deliver our key performance targets and financial plan
Productivity

Metric / Status	Trend	Challenges and Successes	Benchmarks
Length of Stay		Average length of stay (LoS) remains within control limits. Improvement work is underway across all wards in support of patient flow and decision making, this includes improving discharge practice to reduce length of stay.	
Stranded Patients Length of Stay >= 7 days		The weekly multi-disciplinary (MDT) review meeting of patients above 7 days length of stay (LoS) remains in place. This supports timely discharge and the Trust benchmarks well for all LoS indicators. Recent increases are associated with both patients requiring additional medical intervention (clinical teams are reviewing regularly) and challenges with community placements (partnership work remains in place). The latter issue increasing further in September.	No benchmark comparator available
Super Stranded Patients Length of Stay >= 21 days		The review of patients over 21 day LoS is being conducted 5 days a week by the command centre team, therapies and the Multi-agency Integrated Discharge Team (MAIDT) in order to implement rapid support that may facilitate an earlier discharge. When considered as a proportion of spells the Trust benchmarks better than average compared to peer and national data. Increases are as per the 7 day metric.	No benchmark comparator available

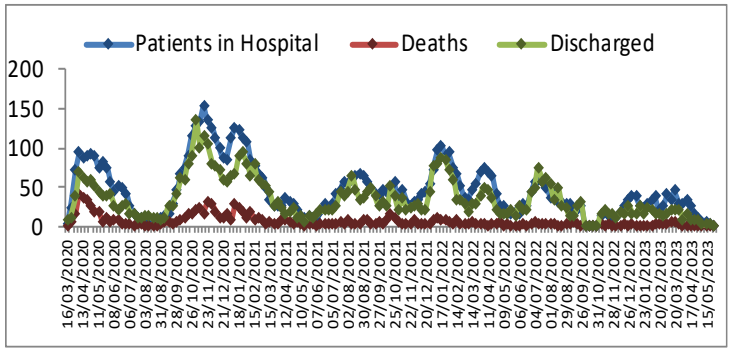
To deliver our key performance targets and financial plan
Productivity

Metric / Status	Trend	Challenges and Successes	Benchmarks
Elective Day Case Rate		Day case rates continue to be above the national and regional average.	
Bed Occupancy		Ward configuration has been adapted to provide ring fenced elective capacity which means occupancy above 85% presents operational challenges on patient placement and flow. Occupancy is around 25 adults per day higher than forecast with work planned to revisit admission avoidance schemes and ED admission processes to try and reduce this.	
Disharges before 1pm		Discharges before 1pm remains under review with a focus on earlier discharge maintained to facilitate patient flow. Performance is consistently within control limits when considered as a percentage of discharges, although is increasing more recently.	No benchmark comparator available

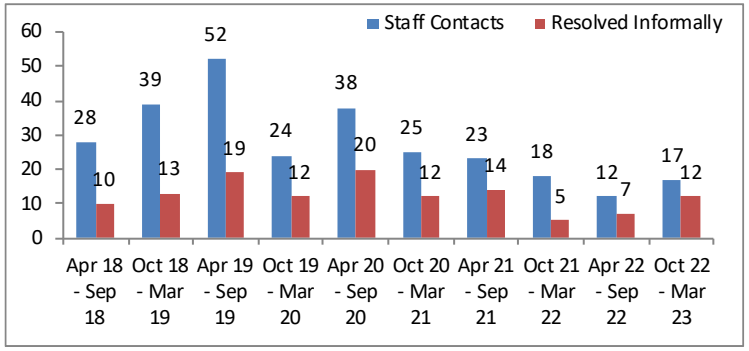
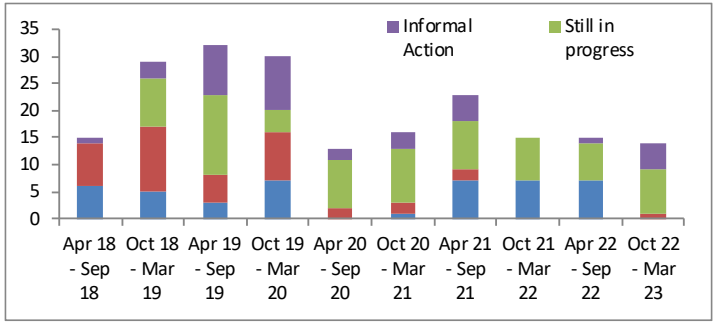
To deliver our key performance targets and financial plan
Productivity

Metric / Status	Trend	Challenges and Successes	Benchmarks
New to Follow Up Ratio		New outpatient appointments increased as part of the 2022/23 plan to meet waiting list demand. Follow ups also reduced slightly, with a number of schemes in place to reduce unnecessary attendances such as PIFU and digital outpatients.	
Did not Attend Follow Up		Did not attend (DNA) rates are slightly below pre-COVID levels which may relate to the increased use of virtual appointments or PIFU for patients who don't need a FTF appointment and may have been more likely to DNA in the past.	
Did not Attend New		Did not attend (DNA) rates have returned to pre-COVID levels. An act as one project is in place to reduce DNA rates. This work is also being linked to the health inequalities agenda as data shows a correlation between age, deprivation and DNA rates. Improving access to digital alternatives is being explored.	

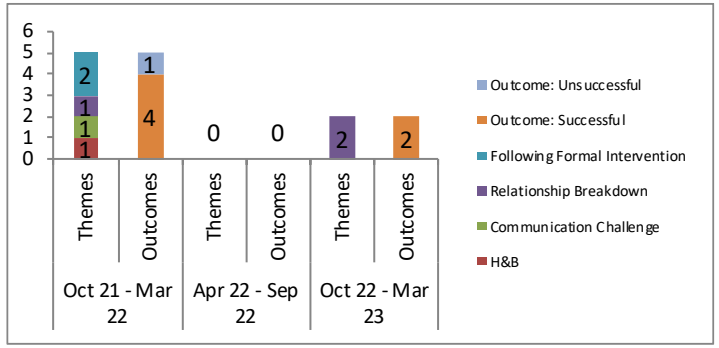
Covid-19

Metric / Status	Trend	Challenges and Successes	Benchmarks
COVID-19		COVID-19 demand remains low.	No benchmark comparator available

To be in the top 20% of employers
Engagement

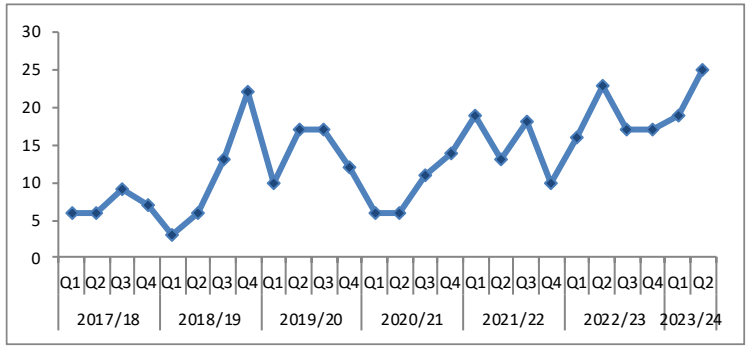
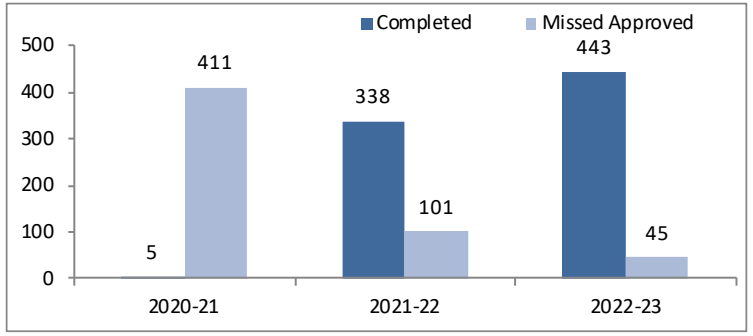
Metric / Status	Trend	Challenges and Successes	Benchmarks
Contacts with Advocacy service		Contacts with the Staff Advocacy service have risen again slightly in the last 6 months as has the proportion of issues being resolved informally (from 37% of cases to 41% of cases). A full review of the role and 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. Next update November 2023 (for the period 01/04/23 to 30/09/23	No benchmark comparator available
Harassment & Bullying Outcomes		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. Next update November 2023 (for the period 01/04/23 to 30/09/23	No benchmark comparator available

To be in the top 20% of employers
Equality & Diversity

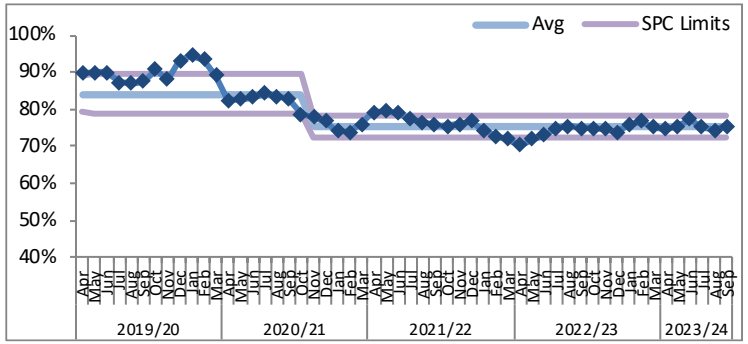
Metric / Status	Trend	Challenges and Successes	Benchmarks
Contacts with Mediation Service		2 mediation referrals have taken place over the last 6 months with both cases managing to achieve some level of successful outcomes. Additionally 5 other parties have been in discussions with the mediation co-ordinator 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	

* (please see narrative)

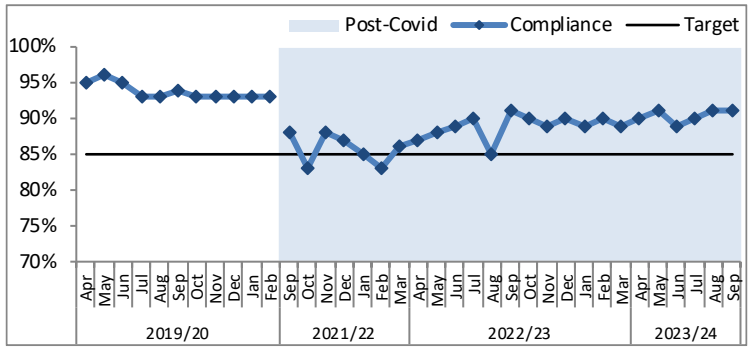
To be in the top 20% of employers
Engagement

Metric / Status	Trend	Challenges and Successes	Benchmarks
Referrals to FTSU		In Q2 there were 25 concerns raised to 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. Of the 25 concerns* raised in Q2, 10 concerns were raised due to patient safety, 8 concerns were raised due to inappropriate attitudes and behaviours, 3 for bullying and harassment and 7 for worker safety or wellbeing. (*- some concerns have more than one category).	
Appraisal Rate Medical		Suspended following the onset of Covid. At 31st March 2023, 488 doctors had a prescribed connection with the Trust. This was comprised of: 340 Consultant staff 38 Specialty doctor grades 110 Doctors with temporary or short-term contracts. For the appraisal year 2022-2023: 443 (90.78%) doctors received an Outcome Measure 1 (Completed appraisal). 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. There were 2 Outcome Measure 3 appraisals (0.41%) (Unapproved Missed) for this period. The AOA and board sign off has been submitted to NHSE All doctors with a prescribed connection have been allocated an appraisal month for 2023-24.	

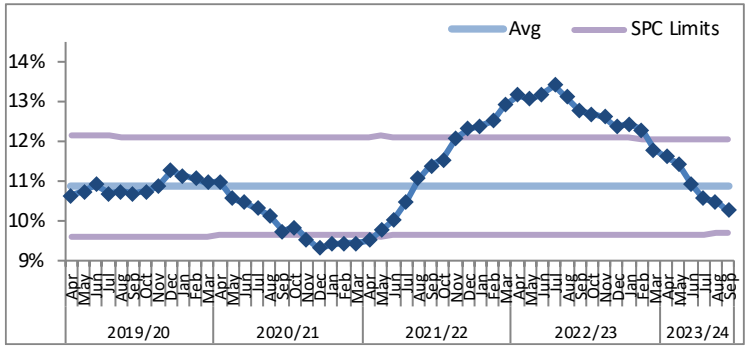
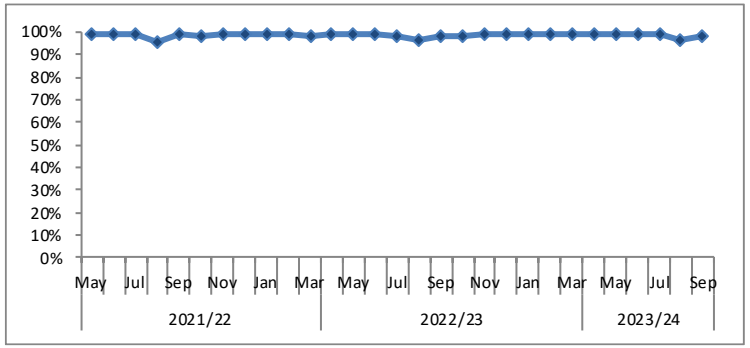
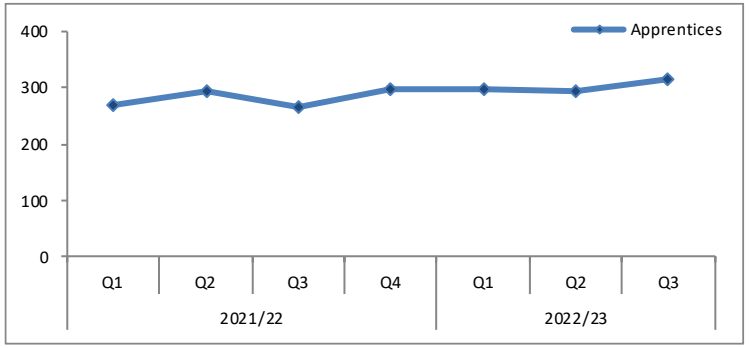
To be in the top 20% of employers
Engagement

Metric / Status	Trend	Challenges and Successes	Benchmarks
Appraisal Rate Non-Medical		The non-Medical appraisal rate for September 2023 has increased from 74.35% in August to 75.70%. Increases were seen in Research, Planned Services and Estates & Facilities all other areas have shown a slight decrease. Research has seen the largest increase of 5.33%.	

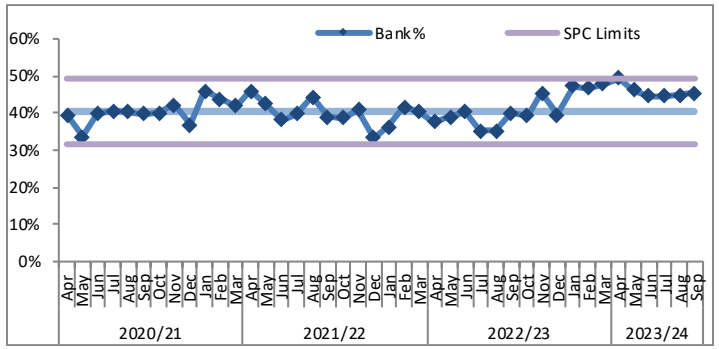
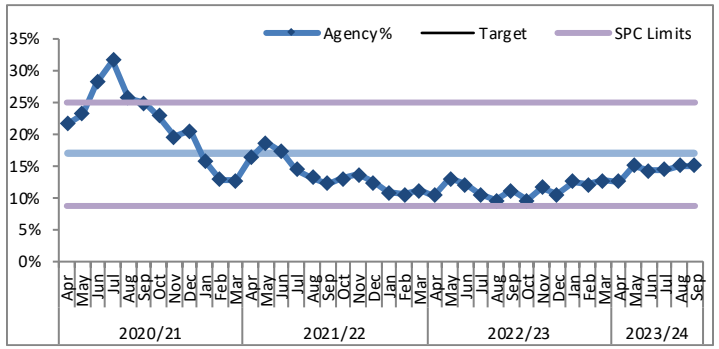
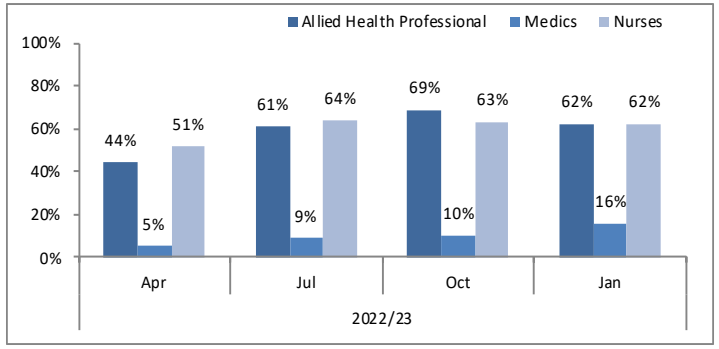
To be in the top 20% of employers
Training & Development

Metric / Status	Trend	Challenges and Successes	Benchmarks
Core Mandatory Training		The overall Compliance metric for core mandatory training is set at 85% across all 11 core subjects. The overall compliance across all mandatory topics is 91%, no increase from last month. Preventing Radicalisation (Basic) compliance is 80%, an increase of 5% from last month. Conflict Resolution and Infection Control Level 1 compliance have both seen a 1% increase from last month. Corporate Services has seen a 1% increase in compliance from last month. All of the broad service areas are achieving >85% compliance. Targeted actions continue to promote overall compliance across all service areas.	

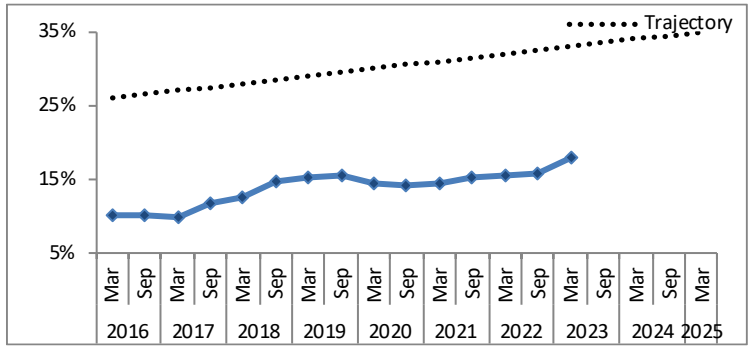
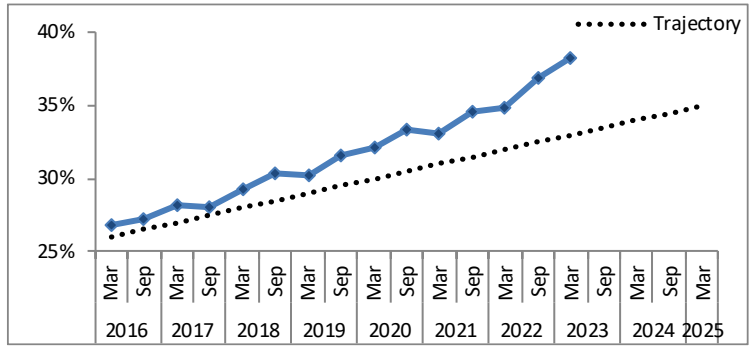
To be in the top 20% of employers
Staffing

Metric / Status	Trend	Challenges and Successes	Benchmarks
Staff Turnover		Turnover has seen a decrease by 0.23% to 10.25% in September 2023 from 10.48% in August 2023. All areas have shown a slight reduction apart from Planned Services which has shown a slight increase.	No benchmark comparator available
Staff Stability		The stability index shows the percentage of staff who are in post at the start of each month and remain in post at the end of the month. The stability rate is 98.61% in September 2023 which is an increase from 96.33% in August 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.	
Number on an apprenticeship programme		Bradford Teaching Hospitals NHS Foundation Trust currently has 311 members of staff on an apprenticeship programme. These are in a wide range of levels, ranging from an entry level qualification to masters level qualifications The subjects mirror the variety of roles offered across the trust, including Nursing, Allied Health Professionals and Health Scientists to technical, administrative and trade roles	

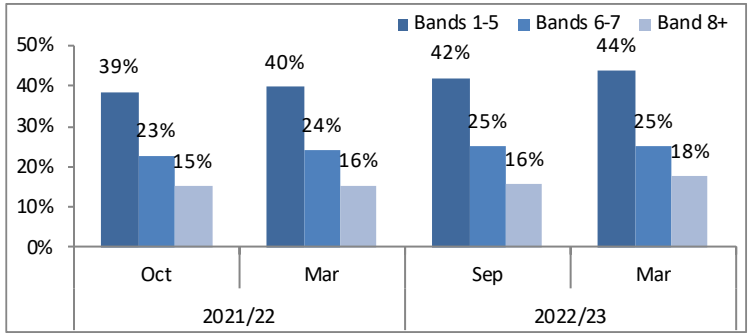
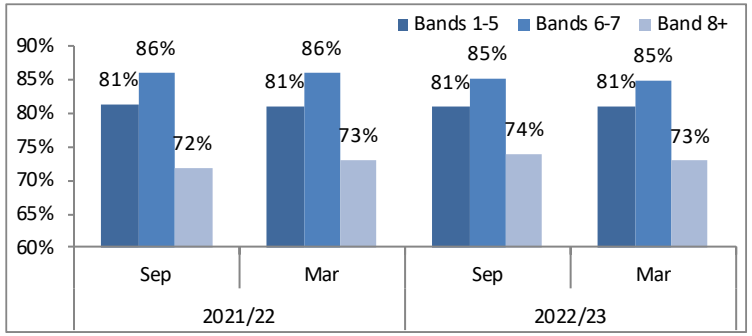
To be in the top 20% of employers
Staffing

Metric / Status	Trend	Challenges and Successes	Benchmarks
Nursing Bank Fill Rate		In September the total number of requests sent to bank was 12370 compared with Augusts requests of 13028 a decrease of -658 requests. This is split as 5417 requests for registered staff and 6953 requests for unregistered staff. Of those 12370 requests a total of 7487 were filled by bank staff which is 60.5% compared with 59.4% in August – a increase of 1.1%. 2456 are filled by registered and 5031 filled by unregistered staff. Out of the 5417 requests for registered staff, the filled shifts were 2456 (45.3%) and for the 6953 requests for unregistered staff the filled shifts were 5031 (72.4%). Compared with August, fill rates increased by 0.6% for registered and increased by 1.2% for unregistered. Out of the 2456 filled registered shifts, 415 were filled by registered Theatre staff.	
Nursing Agency Fill Rate		Agency staff filled 822 shifts in the month of September. This is split 819 registered and 3 unregistered staff. Out of the 819 filled registered shifts, 221 were filled with registered theatre staff. In September Agency fill rates increased by .1% for registered staff and decreased by 0 for unregistered staff.	
e-Job Planning		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 905 clinicians registered within the system, all with a job plan either in progress or signed off. This figure is made up of 374 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 310 job plans in review and 64 awaiting the 2nd sign off, which indicates job plans are being published following recent user guides sent out.	

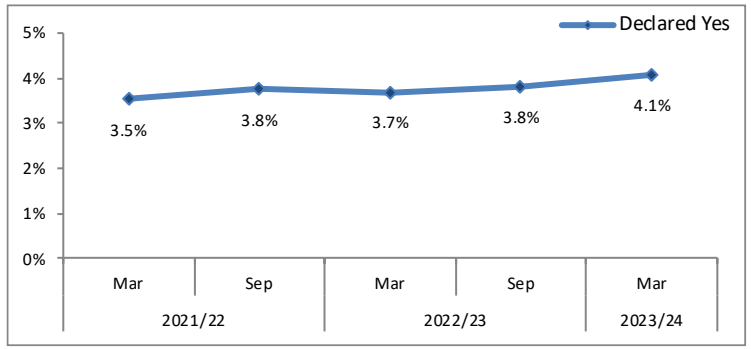
To be in the top 20% of employers
Equality & Diversity

Metric / Status	Trend	Challenges and Successes	Benchmarks
Ethnic Minority Senior Leaders		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. Next update November 2023 (for the period 01/04/23 to 30/09/23	No benchmark comparator available
Ethnic Minority Workforce		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. Next update November 2023 (for the period 01/04/23 to 30/09/23	No benchmark comparator available

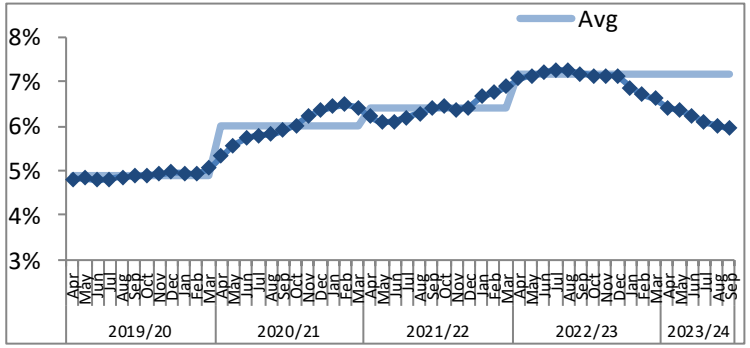
To be in the top 20% of employers
Equality & Diversity

Metric / Status	Trend	Challenges and Successes	Benchmarks
Ethnic minority workforce by band group		The data shows that 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%). 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. Next update November 2023 (for the period 01/04/23 to 30/09/23	
Female workforce by band group		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. 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. Next update November 2023 (for the period 01/04/23 to 30/09/23	

To be in the top 20% of employers
Equality & Diversity

Metric / Status	Trend	Challenges and Successes	Benchmarks
Disability Declaration Rate		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. Next update November 2023 (for the period 01/04/23 to 30/09/23	

To be in the top 20% of employers
Health & Wellbeing

Metric / Status	Trend	Challenges and Successes	Benchmarks
Staff Sickness Absence		The rolling 12 month sickness absence rate at the end of September 2023 was 5.96% compared to 6.02% in August. Decreases were seen in all areas of the Trust apart from Planned Services, Corporate Services and Research which have showen a slight increase. The largest decrease seen in Estates & Facilities. Monthly absence in September decreased to 5.60% from 5.79% in August. Sickness target agreed at the Looking After Our People Group in March at 5.5% Which has been approved by ETM.	

To collaborate effectively with local and regional partners
Partnership

Metric / Status	Trend	Challenges and Successes	Benchmarks
	Significant activity across the Trust to address inequalities in access, experience and outcomes, continues. 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) showed variation in referral rates that is being investigated. Health Inequalities has a dedicated section in the new EDI Strategy (published June 2023) and 5 priorities have been agreed and published in this strategy. These are "making HIs a priority of focus for our teams", "utilising data", "our role as an anchor organisation", "care based on population profiles" and "collaboration with other organisations to address HIs". An action plan aligned to these workstreams has been refreshed. An Anchor Institution Assessment for BTHFT has been carried out to understand any potential areas of focus. The Health Equity Assessment Tool (HEAT) training module has been integrated into ESR and communicated across the Trust. 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	No benchmark comparator available
	BD&C Health & Care Partnership was formally established 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. The implications of the reduction in funding through the ICB mean that the workforce is under review, with redundancies among ICB staff expected. Some of the priority programmes may have to review current workload to ensure it is manageable with the revised staffing figures.	No benchmark comparator available
	BTHFT is actively involved in new and existing clinical and operational networks, and discussions about sustainability of WY-wide services. For example, the future of non-surgical oncology, with the intention of consolidating provision of the service across WY. Agreement has been reached on a joint approach to the provision of aseptic services, with a super hub at Leeds and further investment in BTHFT's "spoke". Work is progressing to consider the implications and how efficiencies across the ICB might be made. The Trust's status as one of 10 national test and evaluation sites of the NHS Clinical Entrepreneur Programme alongside Leeds Teaching Hospitals has created an opportunity to develop a WYAAT-wide approach to innovation – discussions on how best to progress this are underway.	No benchmark comparator available
	Act as One enables BTHFT to work with partners to address the big issues that affect the health of local people. We have programmes to widen access to employment e.g. Project Search, Apprenticeships, improving Band 8/8+ BAME representation at BTHFT and school outreach projects. A new initiative was launched in September 2023 and is the partnership, as a Bradford Place, with Generation Medics in a project aimed at assisting young people from underprivileged communities into careers in health and social care. The Bradford Inequalities Research Unit (BIRU) is also 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" which brings together system partners with a focus on early years, educational attainment & employment prospects	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 < 50th Percentile England, Amber 50 – 25th 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 < 50th Percentile England, Amber 50 – 25th 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 < 50th Percentile England, Amber 50 – 25th 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				
Staff FFT Treatment	Percentage of staff recommending the Trust as a place to receive care or treatment as part of the staff Friends and Family Test.	Director of Human Resources	Red <Yorkshire &Humber, Green >Yorkshire &Humber	4.4
Staff FFT Work	Percentage of staff recommending the Trust as a place to work as part of the staff Friends and Family Test.	Director of Human Resources	Red <Yorkshire &Humber, Green >Yorkshire &Humber	4.4
Appraisal Rate Non-medical	Percentage of eligible staff employed at the Trust who have had an appraisal in the last 12 months.	Director of Human Resources	Red <75%, Amber >=75% and <95%, Green >=95%	5.0
Contacts with Advocacy service	Percentage of Staff Advocate Service Contacts resulting in investigations.	Director of Human Resources	New metric in a phase of trending therefore RAG criteria subjective. – Executive informed.	3.6
Harassment & Bullying outcomes	Percentage of Harassment and Bullying related Contacts resulting in disciplinary action.	Director of Human Resources	New metric in a phase of trending therefore RAG criteria subjective. – Executive informed.	4.6
Training & Development				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 Manger roles at the Trust who are of Black, Asian or Minority Ethnic (BAME) background.	Director of Human Resources	Red >=2% below Trajectory Target, Amber >2% of Target, Green >= Target	4.6
BAME Workforce	Percentage of staff employed at the Trust who are of Black, Asian or Minority Ethnic (BAME) background.	Director of Human Resources	Red >=2% below Trajectory Target, Amber >2% of Target, Green >= Target	5.0
Health & Wellbeing				
Staff Sickness Absence	Percentage of staff time lost due to sickness in a given period (the reported month, year to date is the previous 12 months rolling average for which the Trust target is 4.5%.	Director of Human Resources	Red >1% point above Target, Amber within 1% point above Target, Green <= Target	4.0
Frontline Staff Flu Vaccination	Flu vaccine uptake percentage amongst frontline staff	Director of Human Resources	RAG Criteria being reviewed.	4.6

Glossary Continued

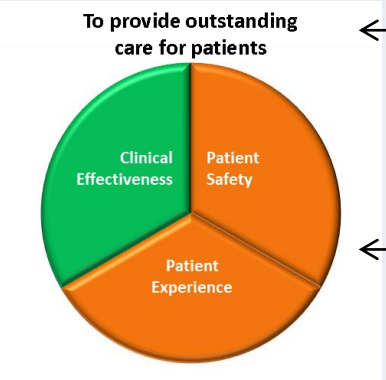
Indicator	Definition	Responsible Exec	RAG Criteria	DQ Kitemark Score
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals				
Partnership				
Reducing Inequalities	Working with partners to contribute to the overall reduction of health inequalities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



Trust objective

Objective "Slices"
Key areas contributing to the Trust objective. Each slice includes relevant "composite" metrics which contribute to an overarching Red, Amber, Green (RAG) rating.

RAG Rating Calculations

Objective Slice RAG
Weighted score of composite metric RAGs within a slice divided by the number of composite indicators within a slice.
Red =< 1.5
Amber > 1.5
Green => 2.5

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

DQ Kite Mark

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

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

Statistical Process Control (SPC) Chart

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

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