Integrated Dashboard

Board of Directors

31st May 2023

Integrated Dashboard

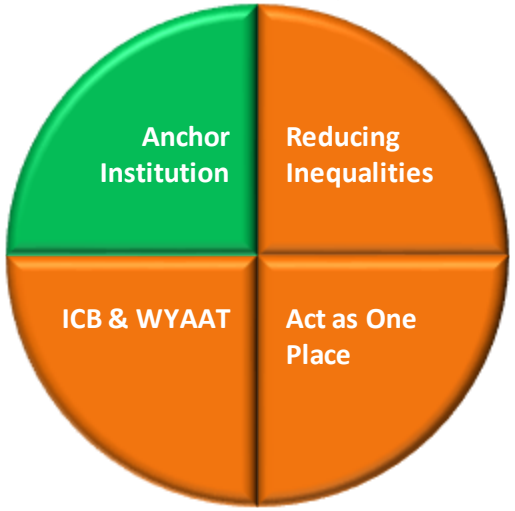
31st May 2023

To provide outstanding care for patients, delivered with kindness

To deliver our financial plan and key performance targets

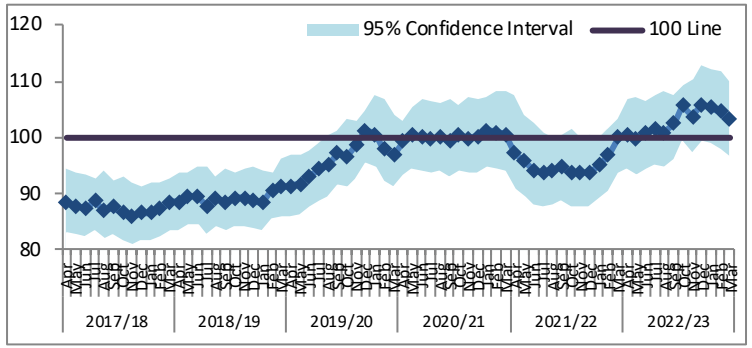
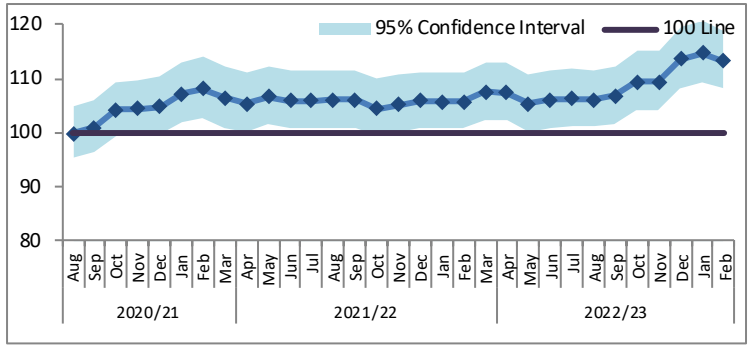
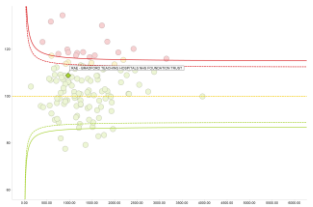
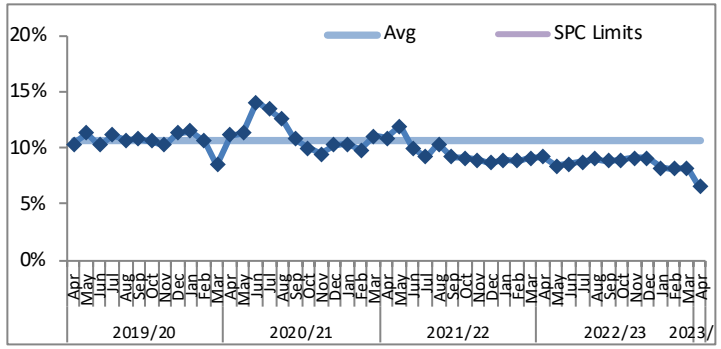
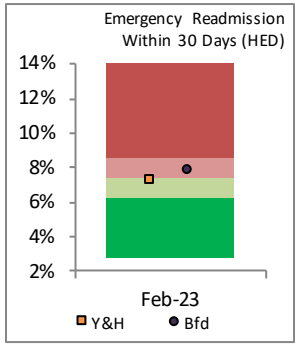
To be one of the best NHS employers, Prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion

To collaborate effectively with local and regional partners

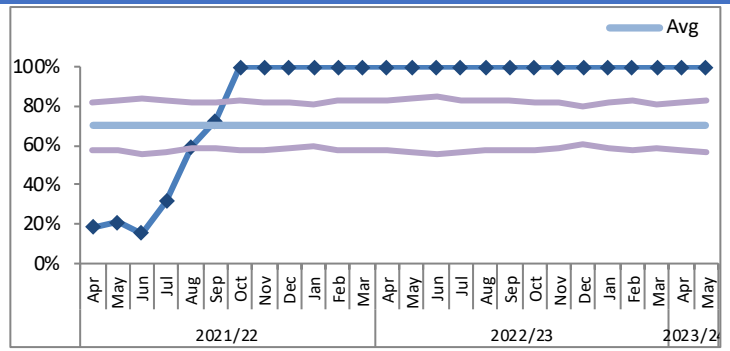
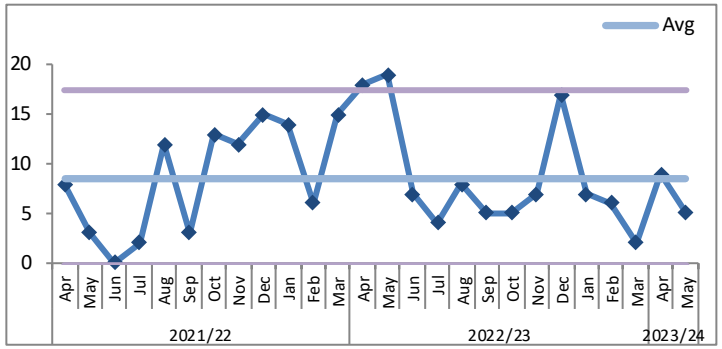


To be a continually learning organisation and recognised as leaders in research, education and innovation

To provide outstanding care for patients
Clinical Effectiveness

Metric / Status	Trend	Challenges and Successes	Benchmarks
Hospital Standardised Mortality Ratio		The Hospital Standardised Mortality Ratio (HSMR) shows the ratio of the observed to the expected number of in-hospital deaths at the end of a continuous inpatient (CIP) spell, multiplied by 100 for 56 diagnosis groups in a specified patient group. If the HSMR is significantly higher or lower than expected this will trigger further investigation, as this could signal data quality issues, changes in pathways/practices, or issues with quality of care. HSMR (12 month rolling) HES inpatients (May 2023): 103.15 – within expected range.	No benchmark comparator available
Summary Hospital-level Mortality Indicator		The Summary Hospital-level Mortality Indicator (SHMI) shows the ratio of the observed to the expected number of deaths up to 30 days after discharge from hospital, multiplied by 100. The SHMI reports on mortality at trust level for acute trusts across the NHS in England, and is evaluated over all diagnosis groups in a specified patient group. It excludes stillbirths, and a death is counted only once and to the last discharging acute provider. The SHMI value is not an indication of avoidable deaths or a measure of the quality of care delivered. If the HSMR is significantly higher or lower than expected this will trigger further investigation, as this could signal data quality issues, changes in pathways/practices, or issues with quality of care. SHMI (12 month rolling) HES-ONS Linked Mortality Datasets (May 2023): 113.33 – High (>95%).	
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).	

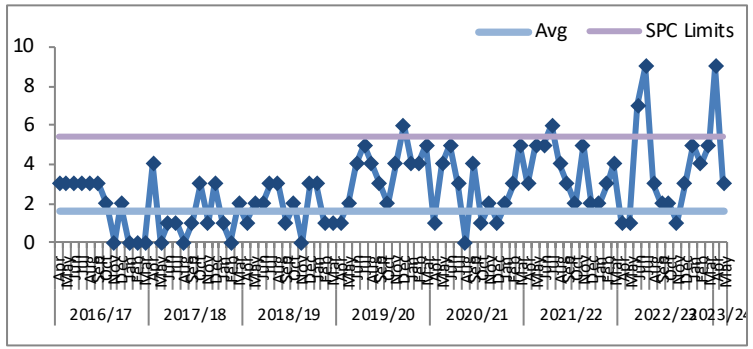
To provide outstanding care for patients
Learning from Deaths

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 108 hospital deaths dealt with via our office in May 2023. We have engaged with all of the GP practices in our remit (55 out of 55 GP sites) and 45% of practices are routinely referring deaths through to the Medical Examiner's office. In May 2023, we scrutinised 79 Community deaths.	
Number of SJR Requests raised		There were five SJRs requested via the Medical Examiner's office for May 2023. A total of four SJRs were completed by reviewers throughout May with three scoring between Adequate to Excellent overall care and one scoring Very 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 May 2023 include: Where the bereaved or staff have raised significant concerns (n=2) Those with Learning Disabilities (n=1) Those with severe mental health illnesses (n=2).	

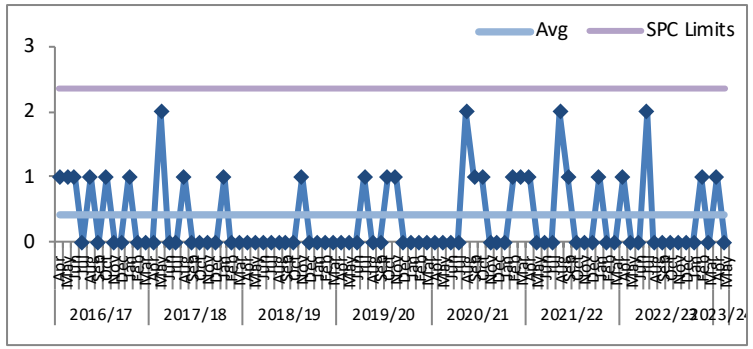
To provide outstanding care for patients
Patient Safety

Metric / Status	Trend	Challenges and Successes	Benchmarks

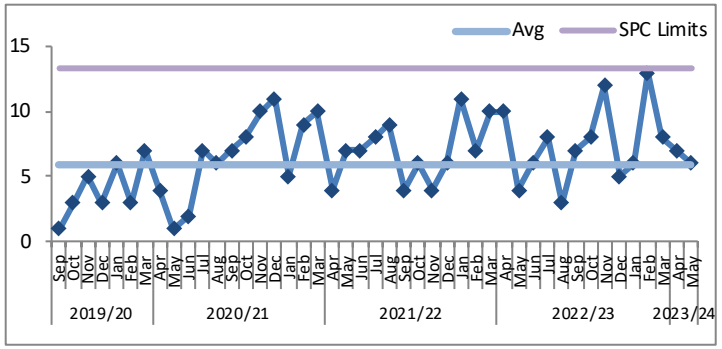
C Difficile



MRSA



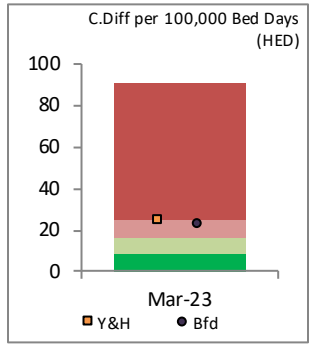
E.Coli

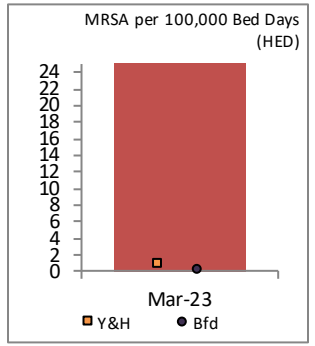


The Trust reported 46 trust attributable cases during 2022/23 against an objective of 43. There were 9 trust attributable cases in the April 2023. There was no evidence of an outbreak or transmission between patients. Antibiotic usage was considered the most common risk factor associated with these cases. 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, only 3 trust attributable cases were identified in May 2023. The role of antibiotic stewardship is a primary preventative strategy in the prevention of C. diff infection and will be a focus during 2023/24 to reduce the usage of the high risk antibiotics.

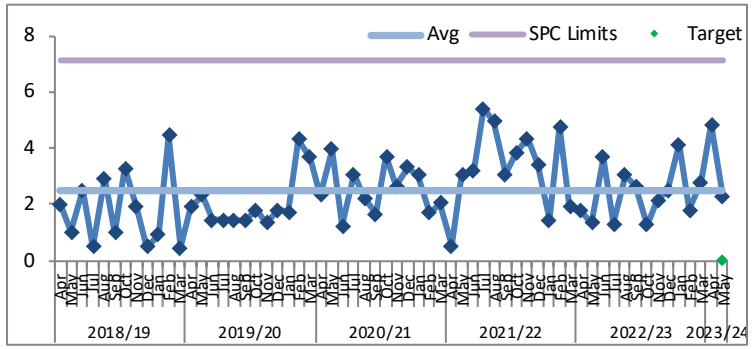
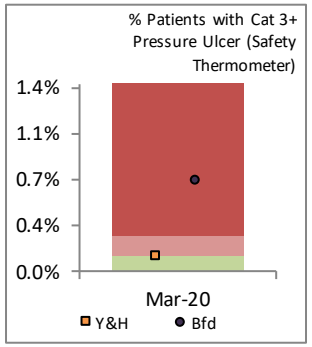
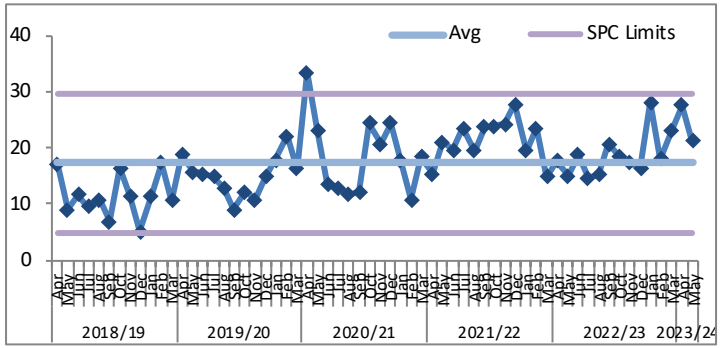
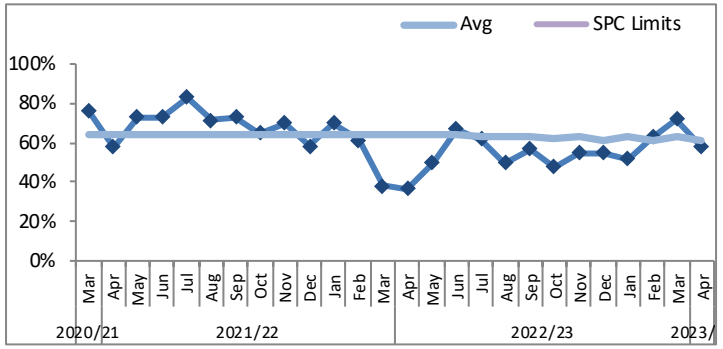
There was no MRSA bacteraemia identified in May 2023. The trust has reported 4 cases of MRSA bacteraemia during 2022/2023. A reducing Staphylococcus aureus improvement plan is in place with Progress against actions are monitored at IPCC. Since December 2022 there has been a particular focus on providing all acutely admitted patients with a 5 day supply of Octenisan body wash with compliance monitored using EPR. All patients with new CVC's followed up post insertion by IPCT until discharge to ensure high standards of aftercare are maintained

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, iniatives 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.

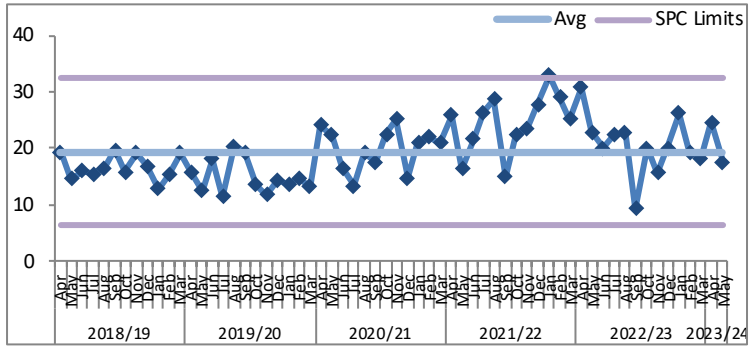
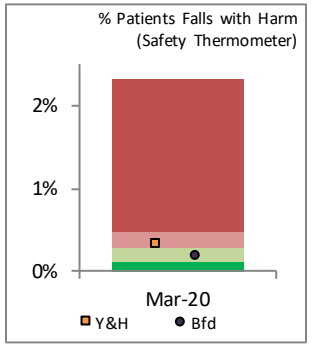
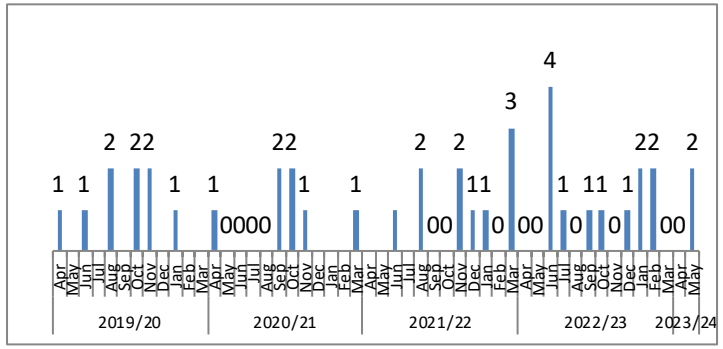




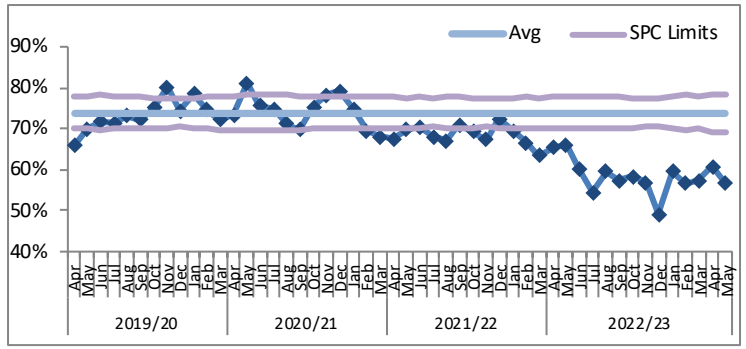
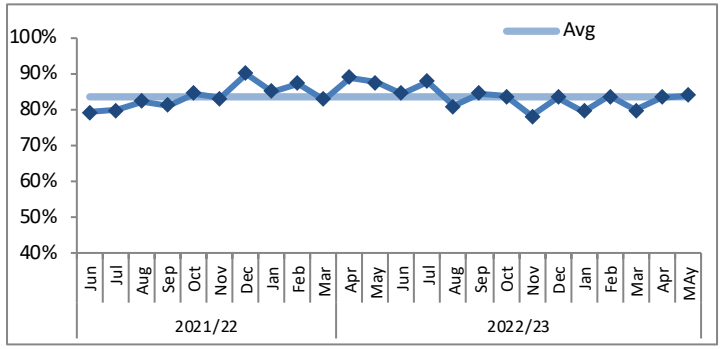
To provide outstanding care for patients
Patient Safety

Metric / Status	Trend	Challenges and Successes	Benchmarks
Pressure Ulcers Cat 3+ per 10,000 bed days		Pressure ulcer incidents have increased since January 23. Increased demand, increased patient frailty and deconditioning and staffing pressures may have been contributory factors. In response to this a risk assessment has been completed and action plan developed to mitigate the risks. This includes the roll out of a 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 being reviewed and opportunities to improve learning and quality improvement will be considered. New e-learning modules have been introduced and the clinical practice educators and legacy nurses will be utilised to support the development of staff and will add to existing learning measures already in place which includes bespoke ward-based training and teaching at induction. A pressure ulcer awareness week and conference will be held in November 2023.	
Pressure Ulcers per 10,000 bed days			
Medicine Reconciliation		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.	

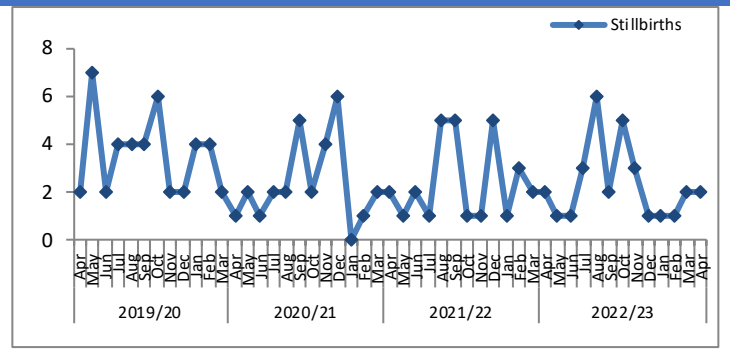
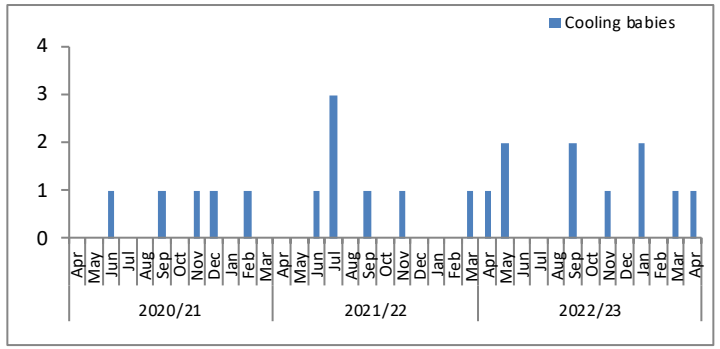
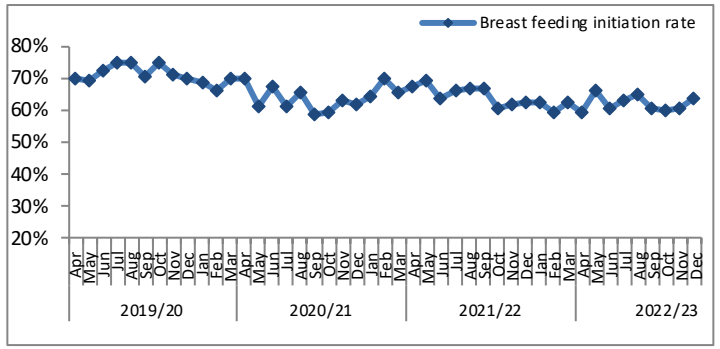
To provide outstanding care for patients
Patient Safety

Metric / Status	Trend	Challenges and Successes	Benchmarks
Falls with Harm per 10,000 bed days		The Data for Q1 2023-2024 is showing normal variation for overall falls across the organisation. 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, identified through the ward data to maintain and improve this reduction in Falls rates. The falls lead is facilitating further improvement work particularly around Falls with No and Low harm and has developed dedicated teaching packages for staff induction. 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 planned for their session in August 2023. The recent Internal Audit undertaken has given Significant Assurance and the actions identified are now being completed.	
Falls with Severe Harm		Falls are being monitored via the Falls Group – investigations in place for any falls with harm. Update of falls work given at March Patient Safety Group meeting.	No benchmark comparator available

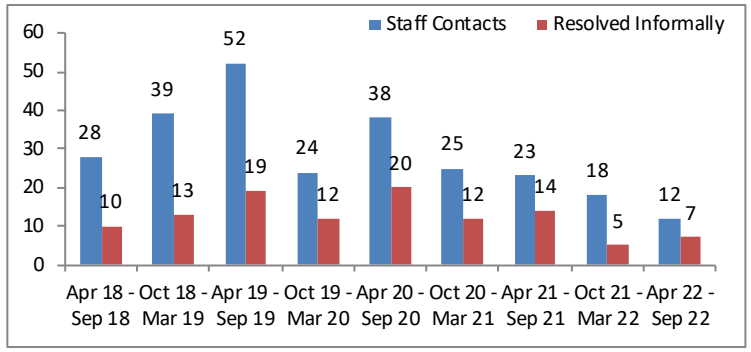
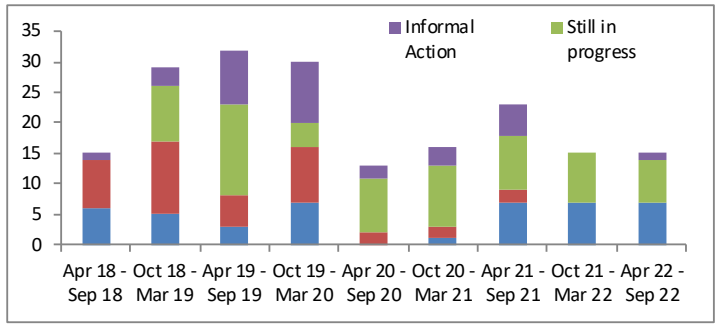
To provide outstanding care for patients
Patient Safety

Metric / Status	Trend	Challenges and Successes	Benchmarks
Sepsis Percentage of Patients Screened		Sepsis screening performance remains static at around 60%. This remains lower than our expected operational target of 90%. Work is ongoing across all areas of the trust to identify measures for continuing improvement to be sustained. The data excludes maternity and children under the age of 16 as recommended in the NHS standard contract 2023/24. Awaiting NICE (NG51) pathway to be updated and to move forward with making changes to the current triggers and management pathway.	
Severe Sepsis antibiotics given within an hour		Performance is at 85% and remains lower than our expected target of >90%, however we have seen improvements over the last 3 months in time to antibiotics. Ongoing monitoring to understand data and barriers. Data currently shared via IPC meetings and will be shared more widely once dashboard available.	

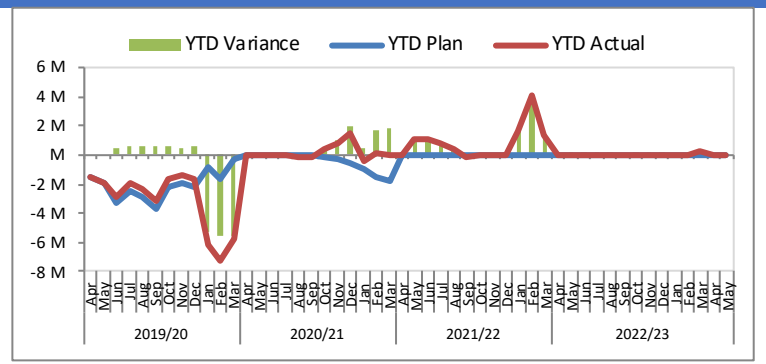
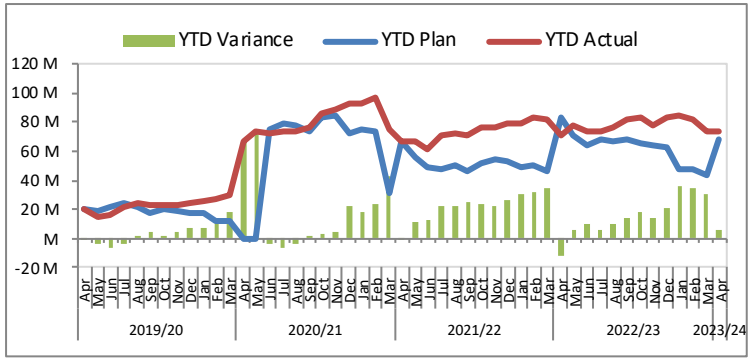
To provide outstanding care for patients
Patient Safety

Metric / Status	Trend	Challenges and Successes	Benchmarks
Stillbirths		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 April.	
Cooling babies		There was 1 case of HIE since the previous reporting period. This case was referred to and accepted by HSIB	
Breast feeding		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.	

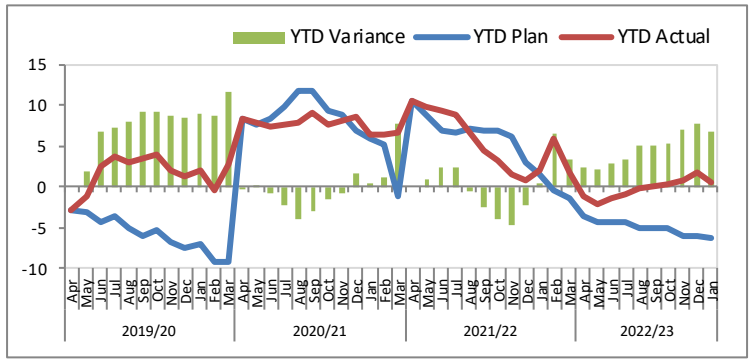
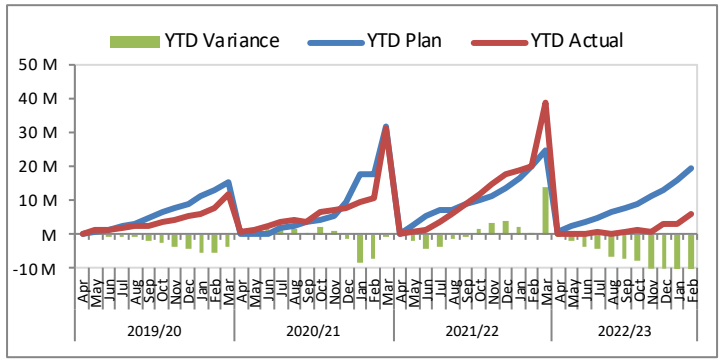
To be in the top 20% of employers
Engagement

Metric / Status	Trend	Challenges and Successes	Benchmarks
Contacts with Advocacy service		Contacts with the Staff Advocacy service have dipped slightly in the last 6 months. However, of those who contacted the service 58% of issues were resolved informally. A full review of the role and remit of staff advocates is currently underway, with insights from the civility advisory panel being sought to help shape the service in going forward and to ensure we maximise its potential). This may indicate a need to both expand and promote the refreshed service more widely. Next update May 2023 (for the period 01/10/22 to 31/03/23).	No benchmark comparator available
Harassment & Bullying Outcomes		The number of formal cases has remained fairly static over the last 6 months and at lower than pre-pandemic levels, which is a positive. Of the 8 cases that were completed during the period 90% of the outcomes were “no case to answer” with just 1 case resulting in “informal action”. Our Trust-wide civility in the workplace campaign has now been launched. The Introduction of a new staff charter, workplace mediation service, poster campaign and training for line managers and staff amongst other initiatives under development 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 May 2023 (for the period 01/10/22 to 31/03/23).	No benchmark comparator available

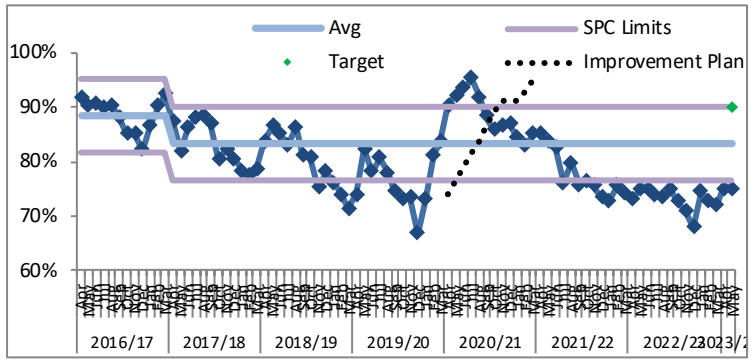
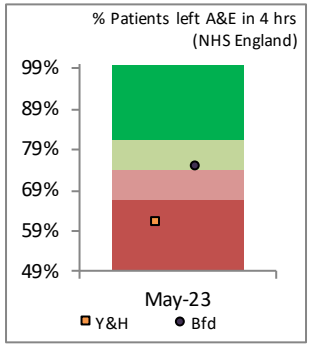
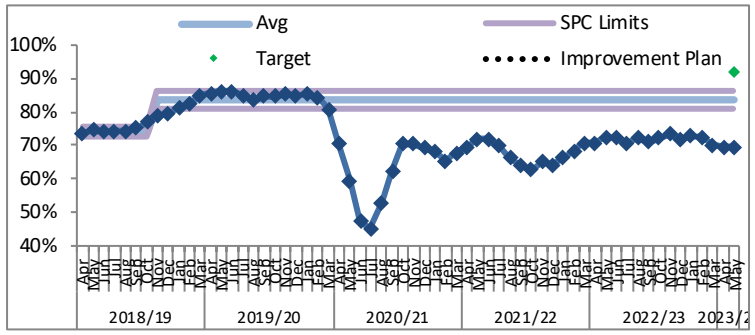
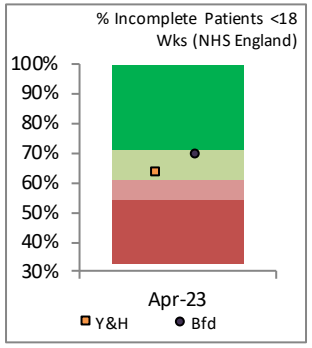
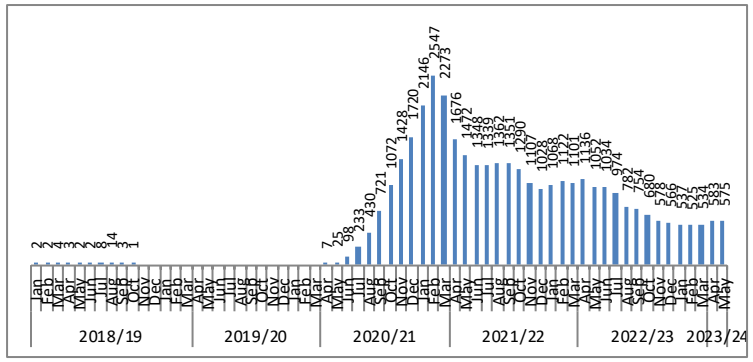
To deliver our key performance targets and financial plan
Finance

Metric / Status	Trend	Challenges and Successes	Benchmarks
Delivery of Income and Expenditure Plan		The Trust has reported a cumulative breakeven Income & Expenditure (I&E) position for the year to Month 2, which is in line with the breakeven plan submitted to NHS England. The underlying position is a cumulative deficit of £2.2m. Waste Reduction Plans (WRP) of £2.2m have been delivered to achieve the YTD position. The Trust is 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.	No benchmark comparator available
Delivery of Cash Plan		Closing cash at month 2 is £65.7m which is £2.5m above plan (£63.2m). The main reasons for the variance from plan are: • Increase in trade and other payables (£3.7m more cash) • Increase in receivables (£6.1m less cash) • Increase in deferred income (£2.2m more cash) • Cash spend on the capital programme (£2.5m more cash) 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.	No benchmark comparator available

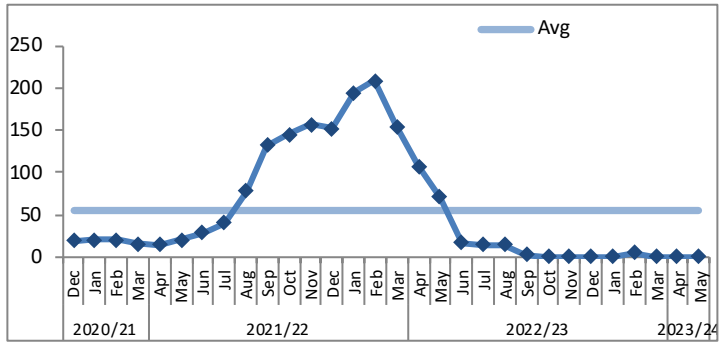
To deliver our key performance targets and financial plan
Finance

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 8.3 days which is 1.8 days higher than plan (negative 10.1 days). Liquidity is higher than planned due to slippage in capital programme of £5.7m. Closing liquidity is forecast on plan (negative 17.8 days).	No benchmark comparator available
Delivery of Capital Plan		At month 2 capital expenditure is £1.4m which is £5.7m under plan (£7.1m). This is largely because there has been a delay in starting the estates work at Eccleshill Community Diagnostics Centre (£1.5m) and St Luke's Day Case Unit (£3.4m). Total capital expenditure for 2023/24 is £51.1m. The Trust is forecasting to spend its full allocation by 31 March 2024.	

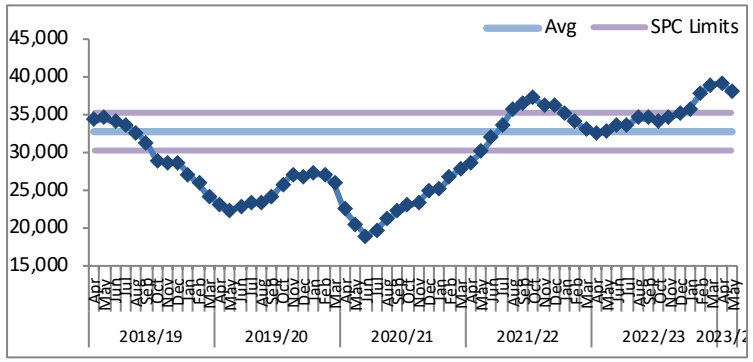
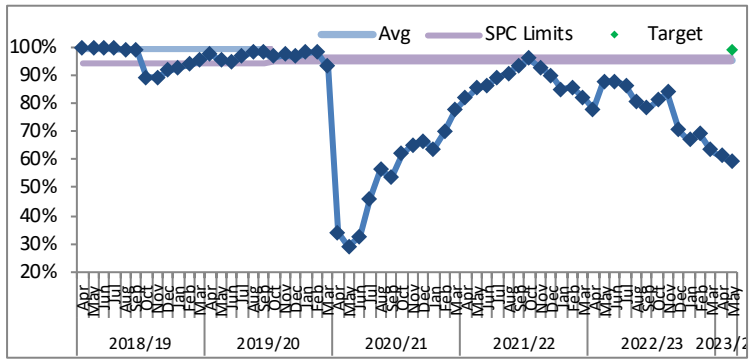
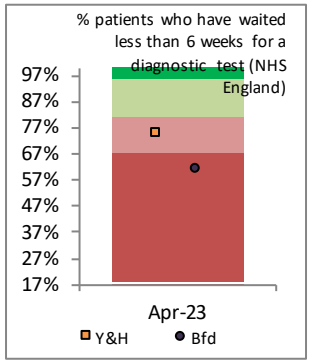
To deliver our key performance targets and financial plan
Performance

Metric / Status	Trend	Challenges and Successes	Benchmarks
Emergency Care Standard		Emergency Care Standard (ECS) performance was at 74.78% for April 2023, which remains above peer and national average. Admissions from ED into the hospital remain stable and improvement plans to increase admission avoidance continue. Work is underway to improve flow which will reduce delays for admitted pathways and coordination at initial assessment has been strengthened to provide consistency in practice during busy periods.	
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 575 incomplete 52 week waits at the end of May 2023. As a percentage of the total waiting list this places the Trust in the best performing quartile nationally for acute Trusts. All long waits have been reviewed using clinical prioritisation guidelines and the daily review of management plans for patients waiting over 40 weeks continues. The 52 week waits are predominately for P3 and P4 surgical treatments. The Trust is adhering to all national guidelines with regards to long wait targets.	No benchmark comparator available

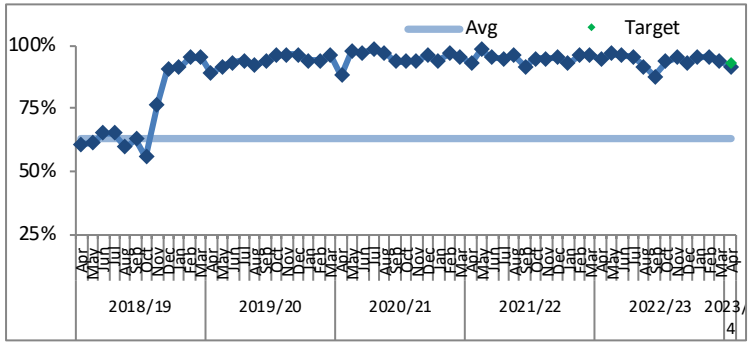
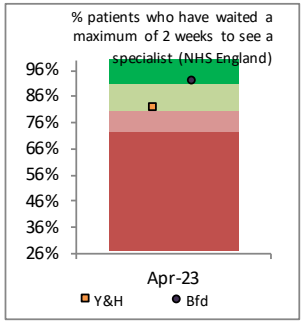
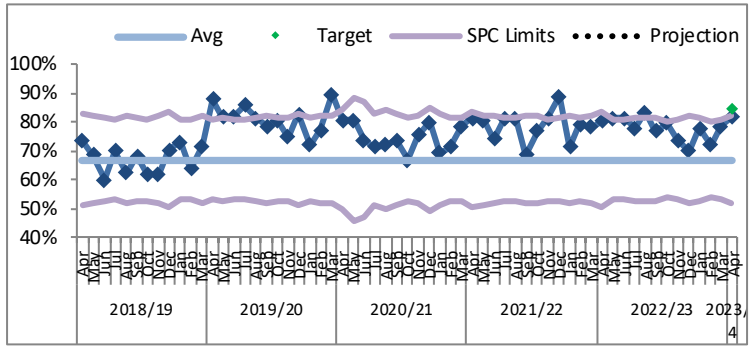
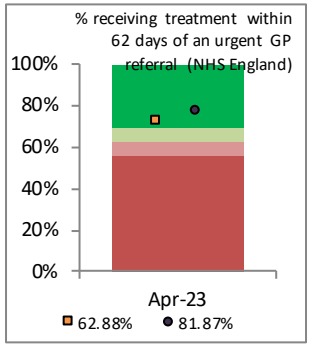
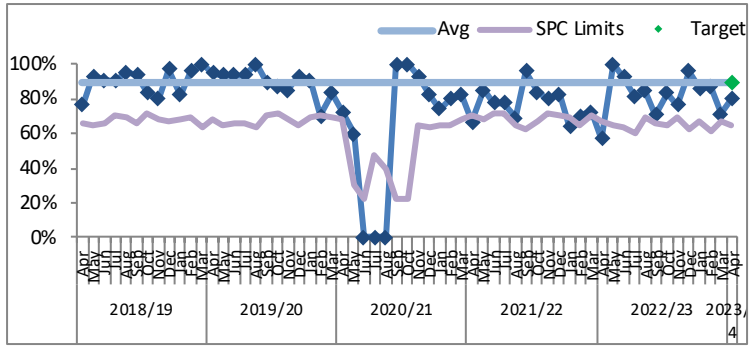
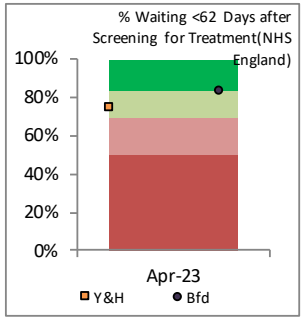
To deliver our key performance targets and financial plan
Performance

Metric / Status	Trend	Challenges and Successes	Benchmarks
RTT 18 week > 104 week wait		Zero patients were over 104 weeks at the end of May. No patients will be over 78 weeks at the end of June.	

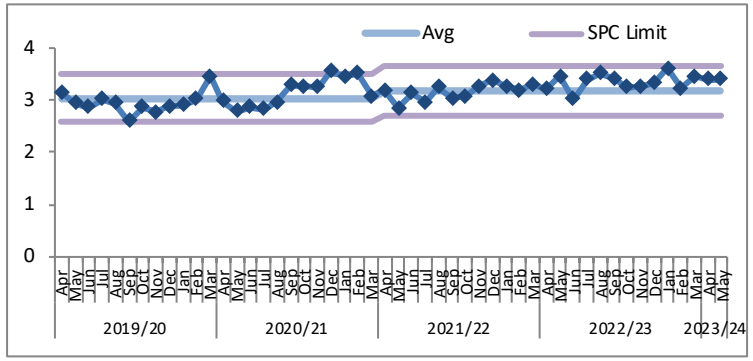
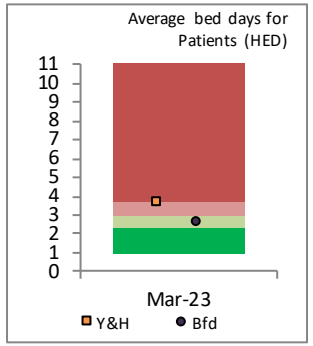
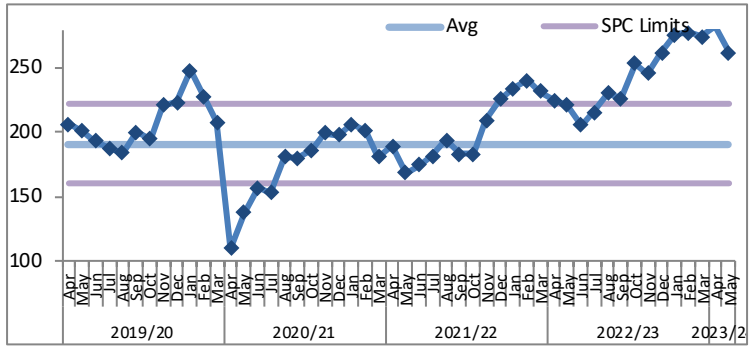
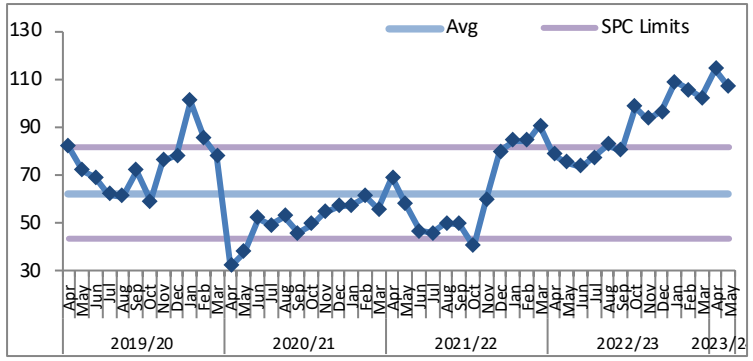
To deliver our key performance targets and financial plan
Performance

Metric / Status	Trend	Challenges and Successes	Benchmarks
Elective Waiting List		The total RTT waiting list reduced in May. Validation including patient contact via SMS is underway to ensure the waiting list is as accurate as possible which has supported this reduction.	No benchmark comparator available
Diagnostic Waits		Performance deteriorated again in May but MRI capacity is increased to support recovery in coming months and plans to increase NOUS capacity have been agreed. Endoscopy performance improved again.	

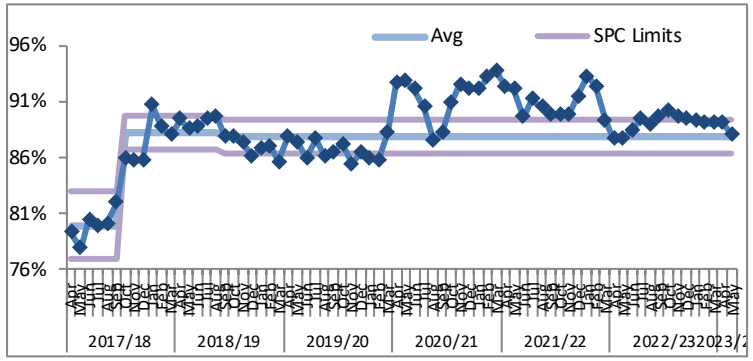
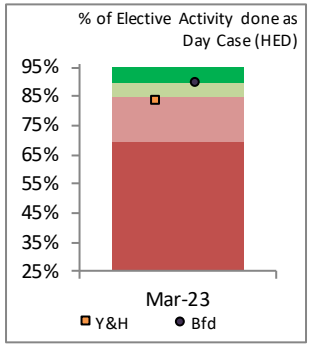
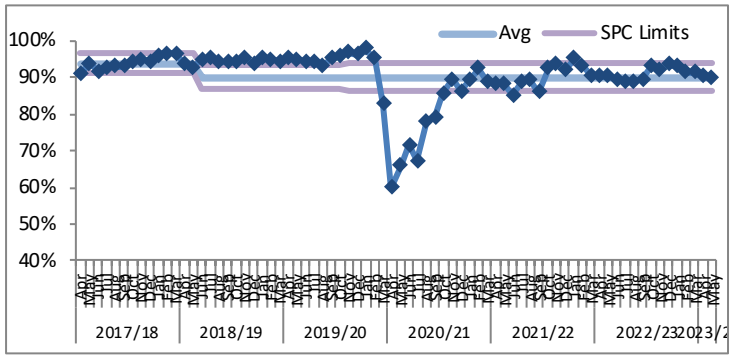
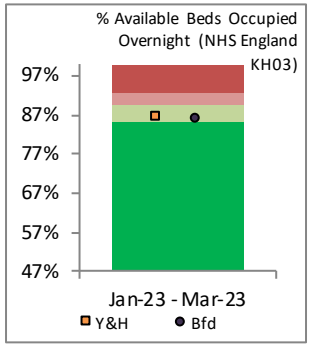
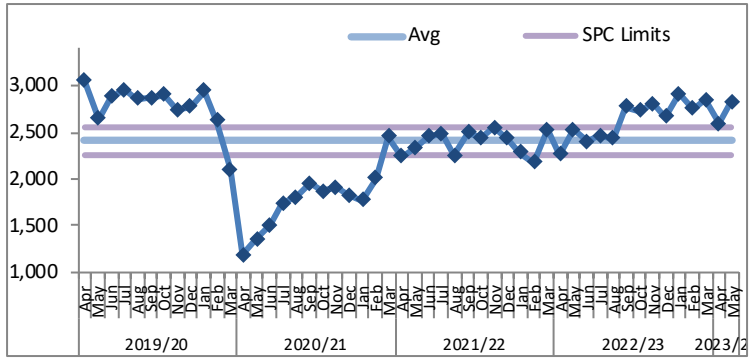
To deliver our key performance targets and financial plan
Performance

Metric / Status	Trend	Challenges and Successes	Benchmarks
Cancer 2 Week GP		May 2023 performance against the 2 Week-Wait Cancer standard was above target at 93.40%. 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.	

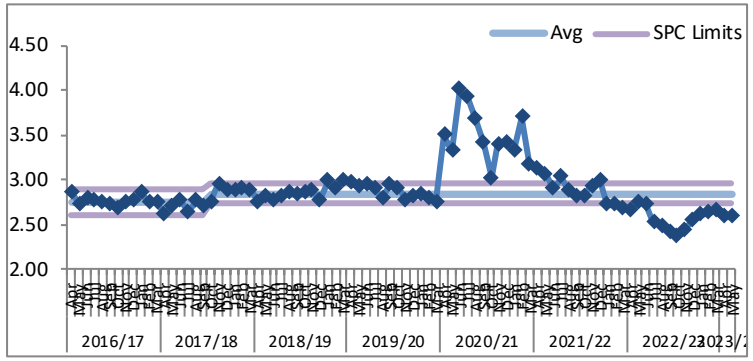
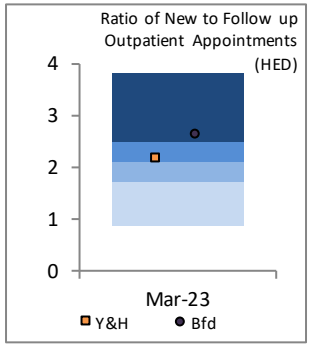
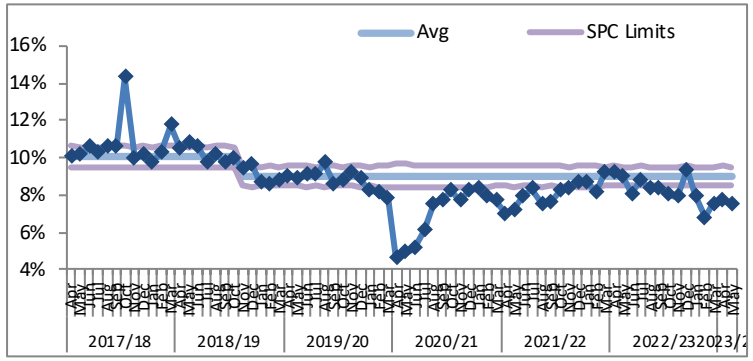
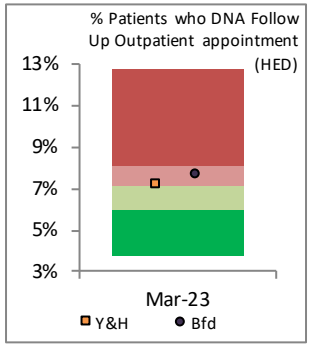
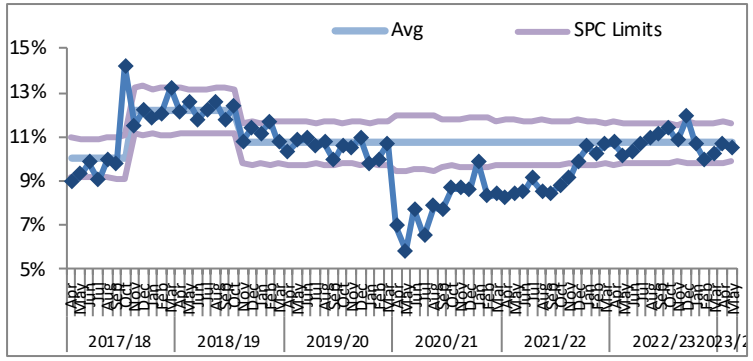
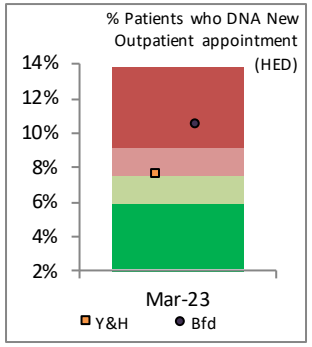
To deliver our key performance targets and financial plan
Productivity

Metric / Status	Trend	Challenges and Successes	Benchmarks
Length of Stay		Average length of stay (LoS) remains within control limits but has been increasing due to high demand and challenges with discharging to community placements. Improvement work is underway across all wards in support of patient flow and decision making, this includes improving discharge practice to reduce length of stay.	
Stranded Patients Length of Stay >= 7 days		The weekly multi-disciplinary (MDT) review meeting of patients above 7 days length of stay (LoS) remains in place. This supports timely discharge and the Trust benchmarks well for all LoS indicators. 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).	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. April delays included a higher number relating to community placement and we are working with social care to reduce this position.	No benchmark comparator available

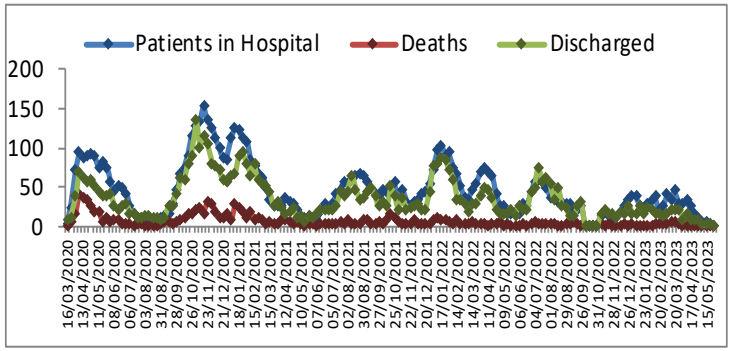
To deliver our key performance targets and financial plan
Productivity

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 red and green separation of patients meaning occupancy above 85% presents operational challenges on patient placement and flow. Plans to open additional beds were brought forward where possible to alleviate some of the pressure during winter with occupancy reducing slightly into February as these remain open.	
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

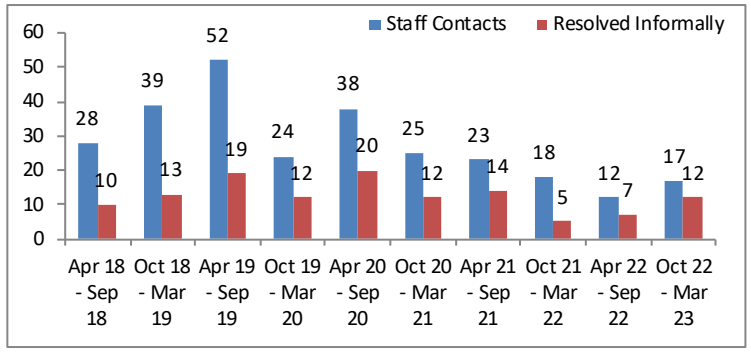
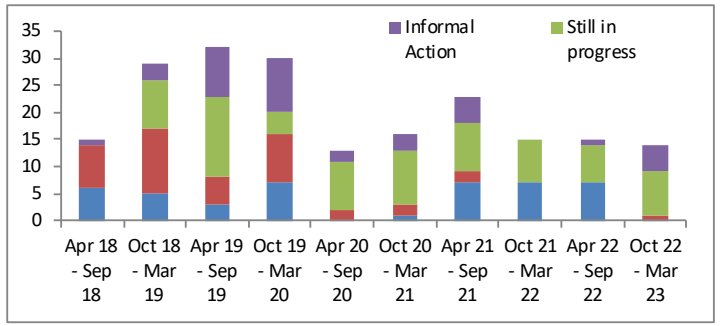
To deliver our key performance targets and financial plan
Productivity

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. Follow up appointments are now increasing in response to the increased referral rates and high new outpatient activity in H1 which is impacting this ratio.	
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.	

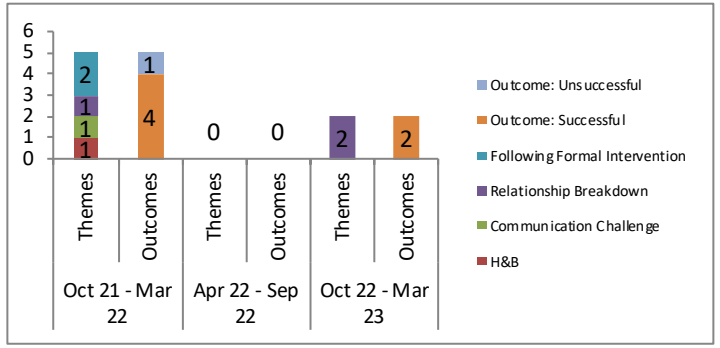
Covid-19

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

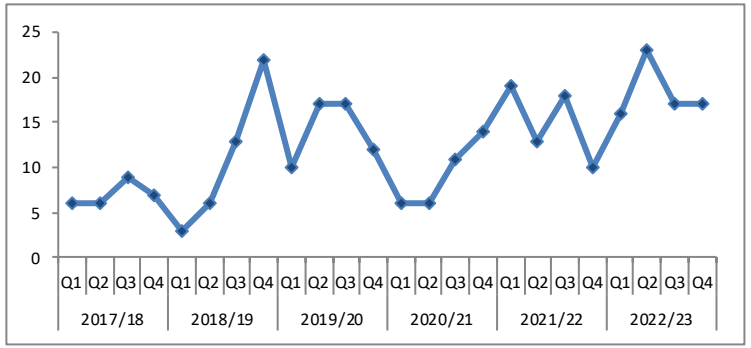
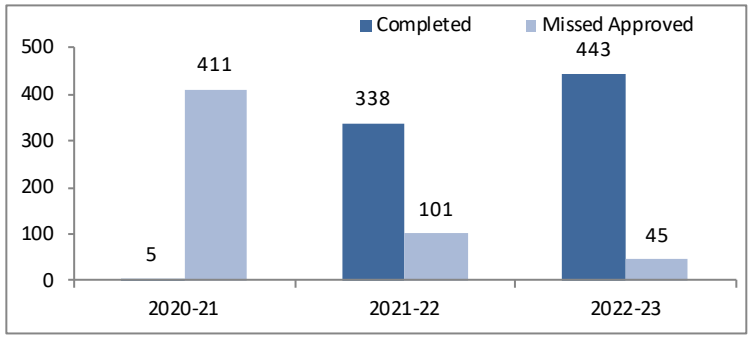
Metric / Status	Trend	Challenges and Successes	Benchmarks
Contacts with Advocacy service		Contacts with the Staff Advocacy service have risen again slightly in the last 6 months as has the proportion of issues being resolved informally (from 37% of cases to 41% of cases). A full review of the role and 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

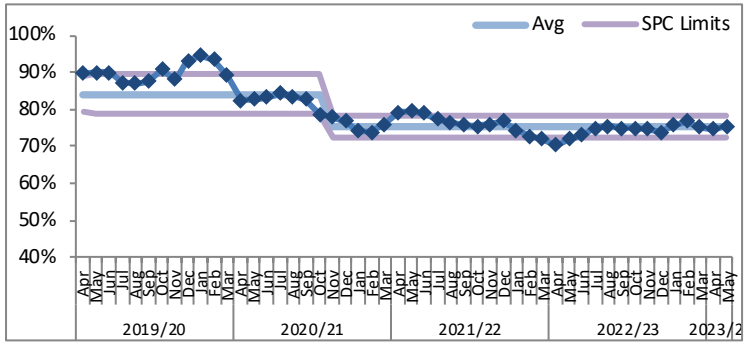
Metric / Status	Trend	Challenges and Successes	Benchmarks
Contacts with Mediation Service		2 mediation referrals have taken place over the last 6 months with both cases managing to achieve some level of successful outcomes. Additionally 5 other parties have been in discussions with the mediation co-ordinator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

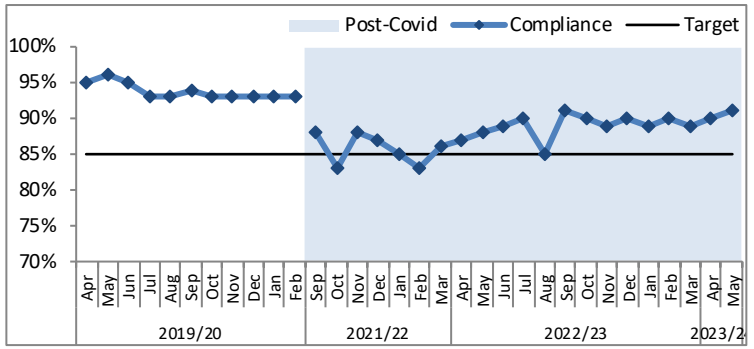
To be in the top 20% of employers
Engagement

Metric / Status	Trend	Challenges and Successes	Benchmarks
Referrals to FTSU		In 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. Sue Franklin has attend training and been approved to become a national FTSU mentor.	
Appraisal Rate Medical		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. Submission of the Annual Organisation Audit (AOA) to NHSE was suspended following the onset of the Covid	

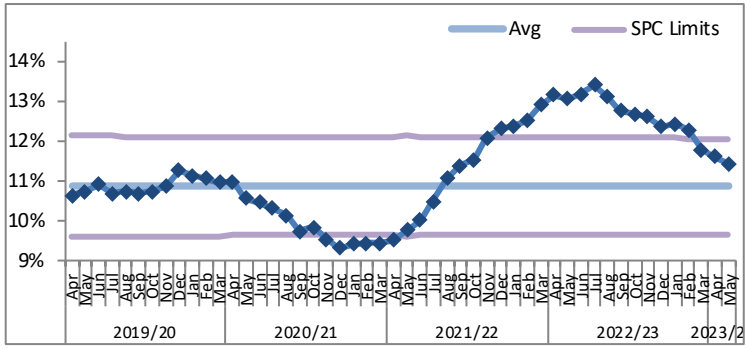
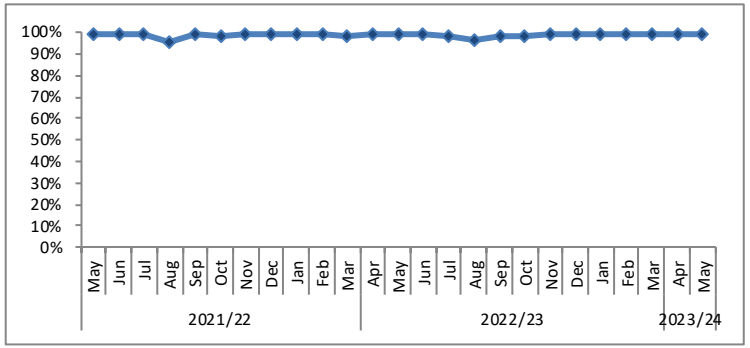
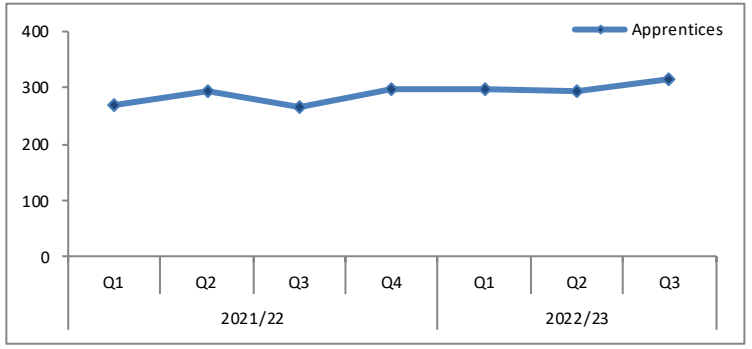
To be in the top 20% of employers
Engagement

Metric / Status	Trend	Challenges and Successes	Benchmarks
Appraisal Rate Non-Medical		The non-Medical appraisal rate for May 2023 has increased from 74.53% in April to 75.42%. A slight reduction was seen in Unplanned Services and Estates & Facilities but all other areas have shown an increase.	

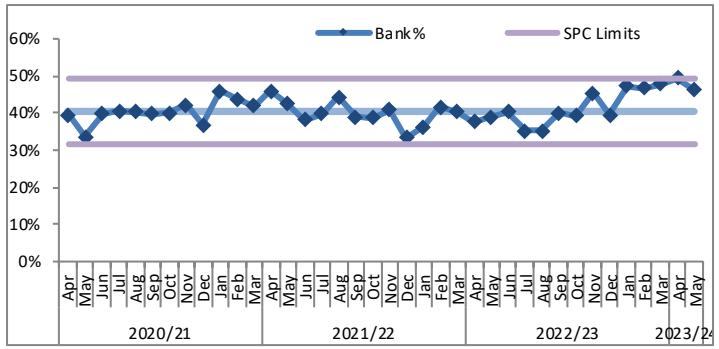
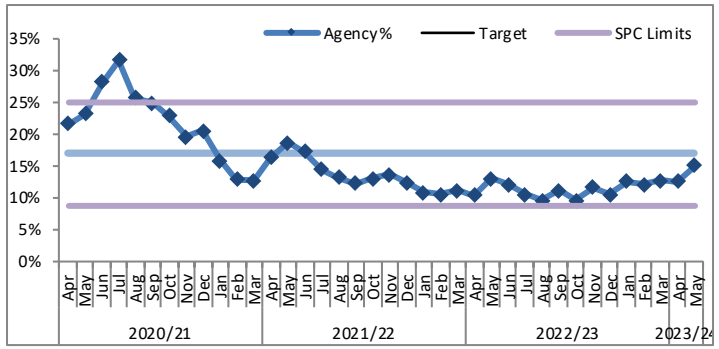
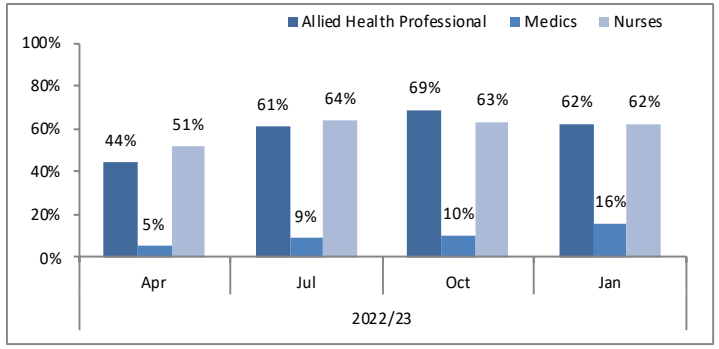
To be in the top 20% of employers
Training & Development

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%, an increase of 1% from last month.** **Equality & Diversity compliance is 92%, an increase of 2% from last month.** **Safeguarding Adult's Level 3 compliance has seen a 4% increase from last month.** **Several other core subjects have seen an increase in compliance from last month.** **Targeted actions continue to promote compliance.**	

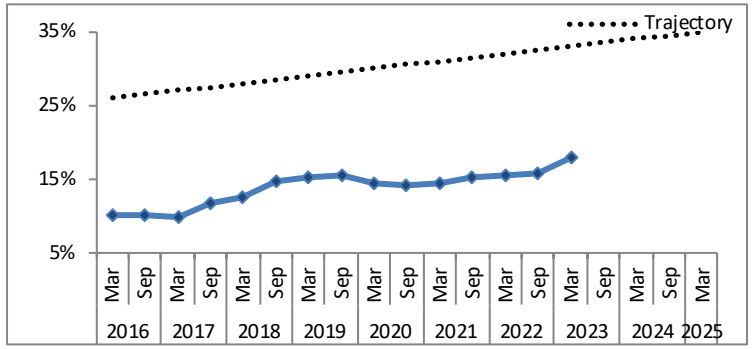
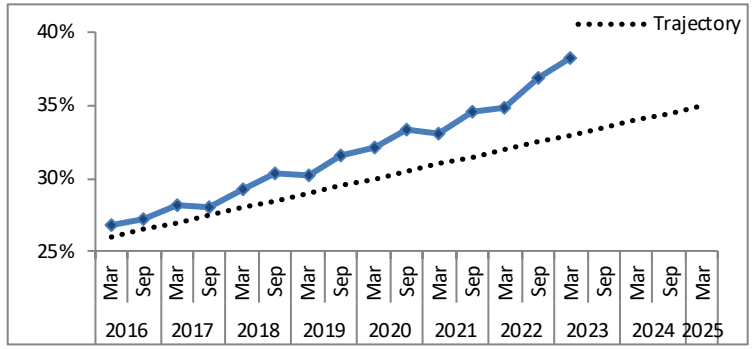
To be in the top 20% of employers
Staffing

Metric / Status	Trend	Challenges and Successes	Benchmarks
Staff Turnover		Turnover has seen a decrease by 0.19% to 11.43% in May 2023 from 11.62% in April 2023. All areas have shown a slight reduction apart from Diagnostic & Corporate Operational Services which has shown a slight increase and Research which remained stable.	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 99.33% in May 2023 which is a slight increase from 99.12% in April 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 321 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.	

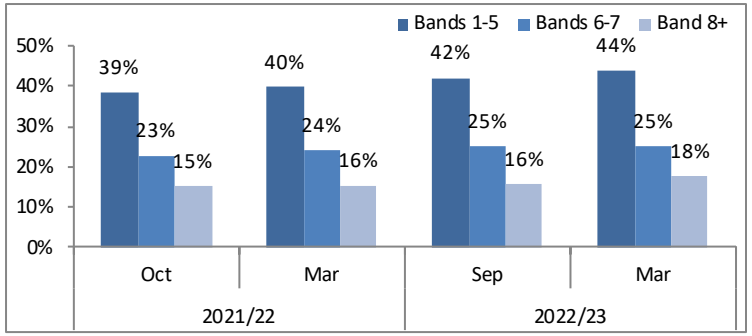
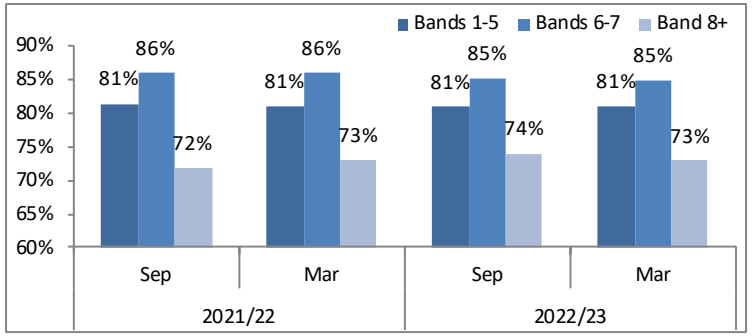
To be in the top 20% of employers
Staffing

Metric / Status	Trend	Challenges and Successes	Benchmarks
Nursing Bank Fill Rate		In May the total number of requests sent to bank was 12465 compared with April's requests of 12022, an increase of 443 requests. This is split as 5615 requests for registered staff and 6850 requests for unregistered staff. Of those 12465 requests a total of 7578 were filled by bank staff which is 60.79% compared with 62.36% in April – a decrease of 1.57%. 2,590 are filled by registered and 4988 filled by unregistered staff. Out of the 5615 requests for registered staff, the filled shifts were 2590 (46.1%) and for the 6850 requests for unregistered staff the filled shifts were 4988 (72.8%). Compared with April, fill rates decreased by 3.30% for registered and decreased by 0.6% for unregistered. Out of the 2590 filled registered shifts, 441 were filled by registered Theatre staff.	
Nursing Agency Fill Rate		Agency staff filled 1052 shifts in the month of May. This is split 842 registered staff and 210 unregistered. Out of the 842 filled registered shifts, 160 were filled by registered Theatre staff. In May Agency fill rates increased by 2.4% for Registered and increased by 1.4% for unregistered. The biggest difference was found in filled registered shifts where the fill rates were decreased by 3.30% despite 101 extra requests compared to April.	
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.	

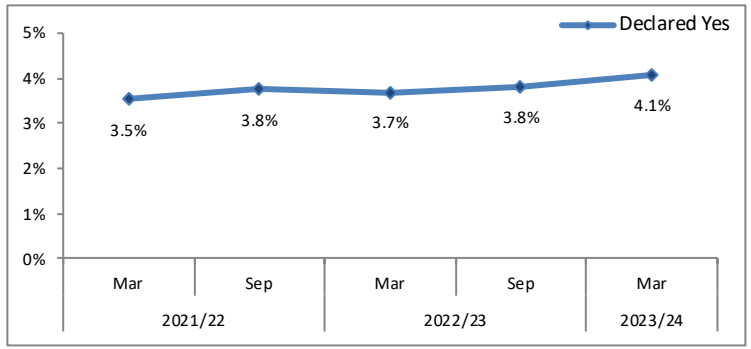
To be in the top 20% of employers
Equality & Diversity

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

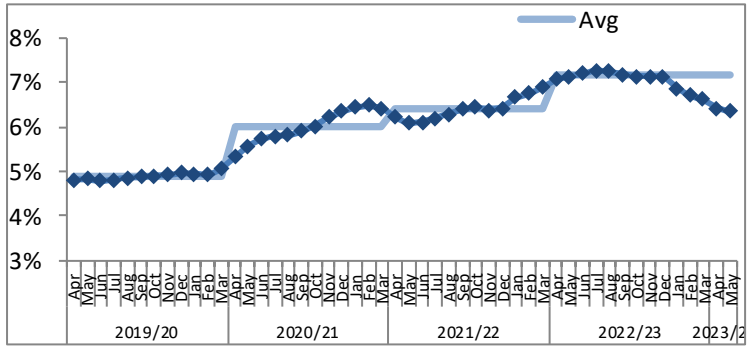
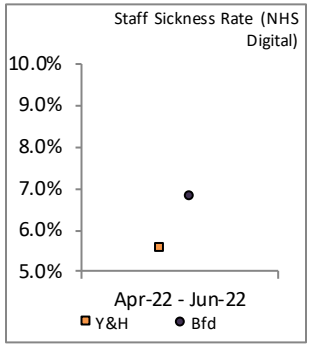
To be in the top 20% of employers
Equality & Diversity

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 May 2023 was 6.36% compared to 6.43% in April. Decreases were seen in all areas apart from Planned Service and Corporate Services which both saw a slight increase. The largest decrease seen in Estates & Facilities. Covid-19 related sickness has reduced to 0.23% in May from 0.39% in April. Monthly absence in May increased to 5.28% from 5.17% in April. 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
Reducing Inequalities	There is significant activity to address inequalities in access, experience and outcomes, but not always recognised as such. We are collating information from CSUs and identifying opportunities to share best practice. An analysis of waiting times to understand the impact of factors – including ethnicity and deprivation - shows variation in referral rates needing further investigation. Health inequalities has a dedicated section of the new EDI Strategy (to be published May 2023). Five priorities have been agreed (at EDC in March 2023): making HIs a priority of focus for our teams; utilising data; our role as an anchor organisation; care based on population profiles; collaboration with other organisations to address HIs. A refreshed action plan - based on these priorities - is being developed. BTHFT is a member of BD&C Reducing Inequalities Alliance, RIC Steering Group, and inequalities is now a standing item on the Equality and Diversity Council agenda		No benchmark comparator available
Act as One Place	BD&C Health & Care Partnership was formally established as a committee of the WY ICB in July 2022, with a renewed focus on five topics: Children, Young People and Families; Workforce Development; Communities; Access to Care; Mental Health, LD & Neurodiversity. Each has an oversight Board which effectively replaces the previous Bradford and AWC Partnership Boards. BTHFT continues to support the diabetes and respiratory transformation work although these are no longer discrete programmes. All BD&C HCP activity is aligned to the Core 20 plus 5 inequalities approach. Consideration is being given to the implications of the reduction in central funding.		No benchmark comparator available
ICB & WYAAT	BTHFT is actively involved in new and existing clinical and operational networks, and discussions about sustainability of WY-wide services. For example, proposals for the future of non-surgical oncology are taking shape following work carried out by Sir Mike Richards in 2021, with the intention of consolidating provision of the service across WY. There is agreement on a joint approach to the provision of aseptic services, with a super hub at Leeds and further investment in BTHFT's "spoke". BTHFT has contributed to the WY 5 year integrated care strategy (published March 2023), and is supporting WYAAT's strategy development (publication due April 2024). Following announcements on reduction in funding for ICBs nationally, work is underway to consider the implications and how efficiencies across the system might be made. The recommendations from the Hewitt review are also being considered alongside this to ensure consistency in the way both are implemented. BTHFT will also contribute to current NHS75 review work led by the NHS Assembly.		No benchmark comparator available
Anchor Institution	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		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.