

Board of Directors: 08.03.2018  
 Agenda Item: Bo.3.18.8

## Integrated Dashboard

<b>Presented by:</b>	Clive Kay, Chief Executive	<b>Author:</b>	Cindy Fedell, Director of Informatics
<b>Previously considered by:</b>	Committees		

<b>Key points</b>	<b>Purpose:</b>
1. The Integrated Dashboard for January 2018 is attached for the consideration by the Board of Directors.	To discuss and note

<b>Executive Summary:</b>
The Integrated Dashboard for January 2018 is attached for the consideration by the Board of Directors.

<b>Financial implications:</b>
No

<b>Regulatory relevance:</b>
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<b>Monitor:</b>	
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<b>Equality Impact / Implications:</b>	<b>Is there likely to be any impact on any of the protected characteristics?</b> (Age, Disability, Gender, Gender Reassignment, Pregnancy and Maternity, Race, Religion or Belief, Sexual Orientation, Health Inequalities, Human Rights) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, what is the mitigation against this?
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<b>Other:</b>	
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<b>Strategic Objective:</b>	To provide outstanding care for patients
<i>Reference to Strategic Objective(s) this paper relates to</i>	To deliver our financial plan and key performance targets
	To be in the top 20% of NHS employers
	To be a continually learning organisation
	To collaborate effectively with local and regional partners



**Bradford Teaching Hospitals**  
NHS Foundation Trust

# Integrated Dashboard Board of Directors

31<sup>st</sup> January 2018

# 31st January 2018

To provide outstanding care for our patients



To collaborate effectively with local and regional partners



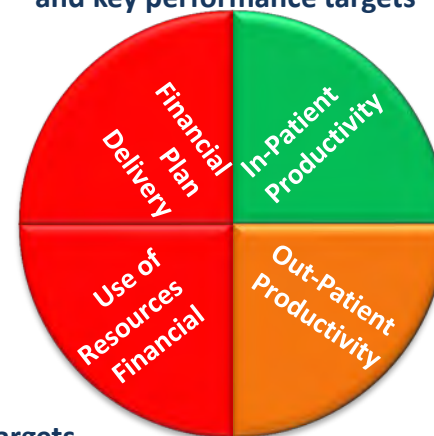
To be a continually learning organisation



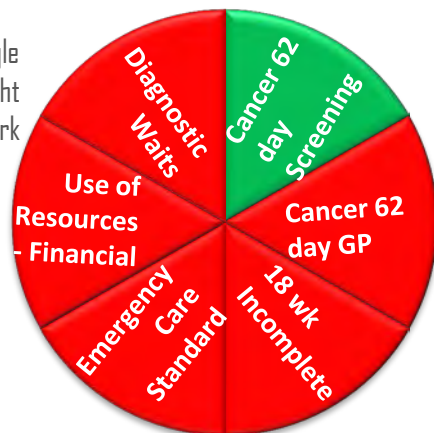
To be in the top 20% of employers in the NHS



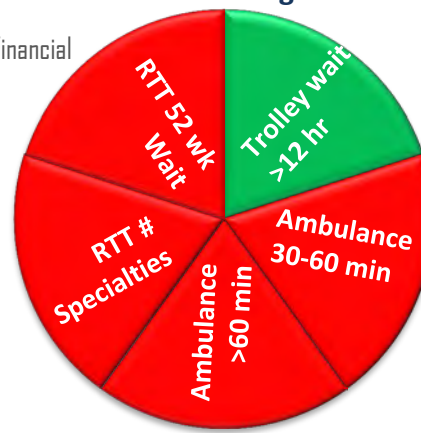
To deliver our financial plan and key performance targets



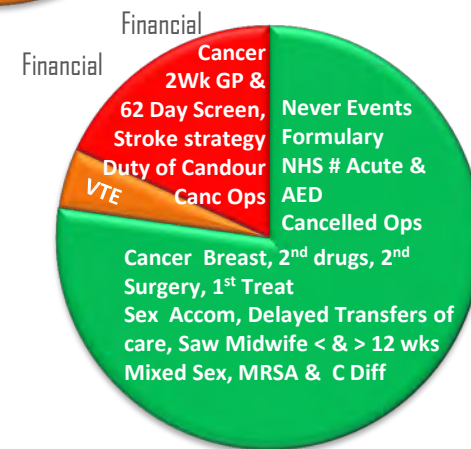
Single Oversight Framework



Non-Financial



National targets



# Headlines

**Finances have deteriorated and are not expected to hit year end targets** – There is a significant risk that the Trust will not deliver its financial control total in 2017/18. The Trust delivered a pre-STF deficit of £7.8m at the end of Month 10 which is £1m behind the pre-STF control total. A YTD pre-STF deficit £7.9m was forecast in the Improvement Plan, which means the Trust is in line with the Improvement Plan trajectory at Month 10. The YTD post-STF position is a deficit of £4.6m against a planned £0.7m surplus, meaning the Trust is £5.3m behind the cumulative post-STF control total. The currently agreed Improvement Plan measures result in a forecasted shortfall of £4.8m against the year-end pre-STF control total. Although work is ongoing to mitigate this, there remains a significant risk that the control total will not be delivered in 2017/18.

**December and January have been pressured months in the Trust** – The Trust has struggled with high bed occupancy, running above 96% most days. In addition, high numbers of outliers has created further challenge in managing flow. Targeted work has taken place to reduce avoidable discharge delays and reduce the number of patients waiting for social care support. As a result bed occupancy has started to reduce to below 95%.

**Caring for non-elective patients** – Emergency Care Standard performance remains a challenge. A number of factors have contributed to this position including peaks in attendance and staff shortfalls, causing long waits to be seen by a doctor and for a beds. This has led to Emergency Department crowding and contributing to further delays. Key actions taken include expansion of the initial streaming and triage capacity to prevent ambulance handover delays and safe patient flow management to avoid long bed waits. In addition, Transformation Team support is being given to undertake value stream mapping and staff observations to identify where delays are occurring in the patient journey. The Trust also cancelled all non-urgent elective activity during December and January to create additional bed capacity, although this has now recommenced.

**Cancer** – The Trust did not achieve the 62 day RTT target in December. Specialty recovery plans are in place for all tumour sites and these are being monitored at the weekly cancer delivery group. Focus continues on reducing the 62 day backlog. The first breach review panel took place in January to identify opportunities for pathways improvements. The 2 Week Wait standard was not achieved in December, predominantly due to capacity issues in the Dermatology and Endoscopy services. Detailed recovery plans are in place.

**Elective Wait List & RTT has grown** – In February the Trust formally reported its January RTT position. Overall RTT performance has deteriorated predominantly due to a reduction in productivity since the Electronic Patient Record implementation. Demand and capacity modelling continues which will be used to inform the development of recovery plans. There is also need to undertake a full waiting list validation to remove all data quality errors. The Trust reported two incomplete 52 Week breaches in January and will report two in February. The main risks are in ENT and Trauma & Orthopaedics. Additional activity is being undertaken to reduce overall waiting times.

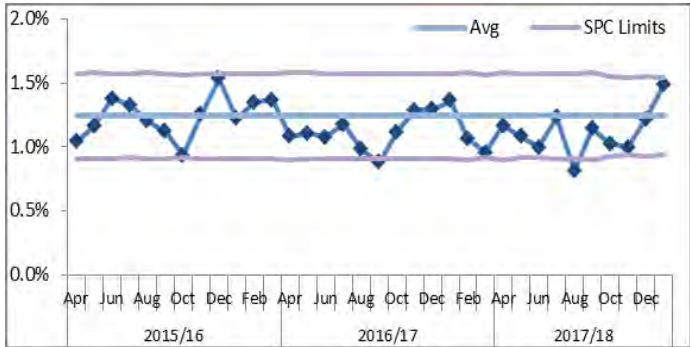
**VTE improvement** – The performance against the VTE standard continues to improve but in January remains below the expected standard at 92.4%. Daily reports of non compliance by ward are being used to drive improvement. Any areas consistently failing have been contacted by the Medical Director. In addition the VTE cohort rules have been updated with clinical speciality sign off.

**Workforce** – Following a decline the number of staff in post has increased again in January against a reduction in agency usage and an increase in bank staff usage. The Trust's sickness rates, whilst lower than this time last year, have increased over the last three months which means that the two year target will not be met. The work plan and target is being re-assessed for 2018/2019. Appraisal rates have declined with work continuing with Divisions to support managers and appraisees in having an effective appraisal and to halt this decline.

# To provide outstanding care for patients

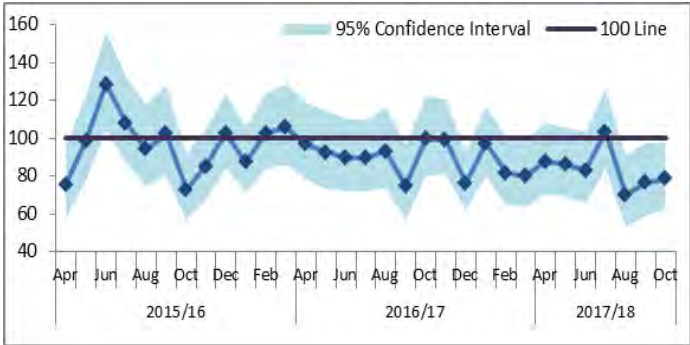
Trend	Challenges & Successes	Comparison	Exec Lead
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Crude Mortality



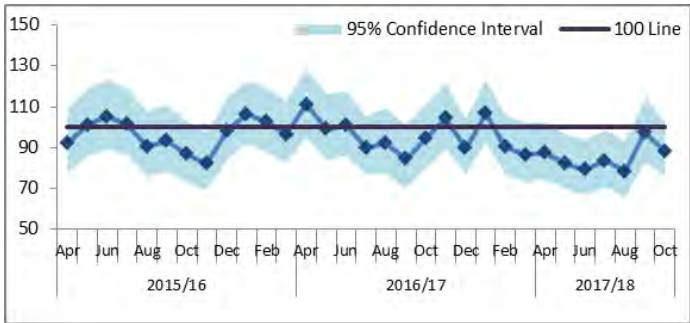
Crude death rate has remained constant throughout the last 18 months. The Medical Usual winter spike is demonstrated for December/January. There is no national Director benchmarking data for this measure.

Hospital Standardised Mortality Ratio

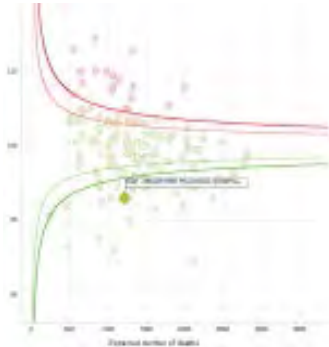


Our HSMR continues to be 'better than expected'. Over the past 12 months we are statistically low compared to other Trusts.

Summary Hospital-level Mortality Indicator



Our SHMI continues to be relatively low at 83.9 compared to 88.1 in April. Over the past 12 months we are statistically low compared to other Trusts.



Medical Director



Medical Director

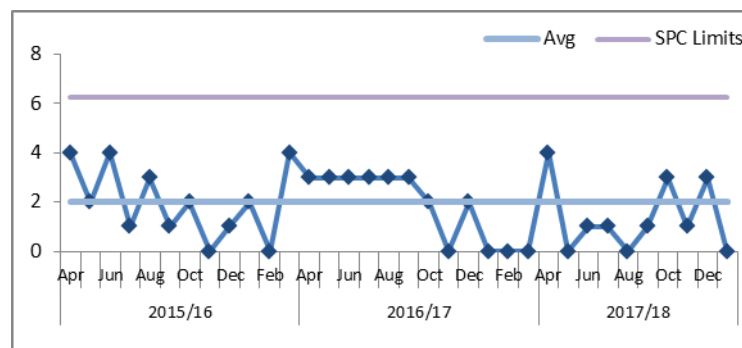
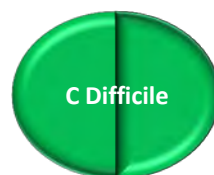
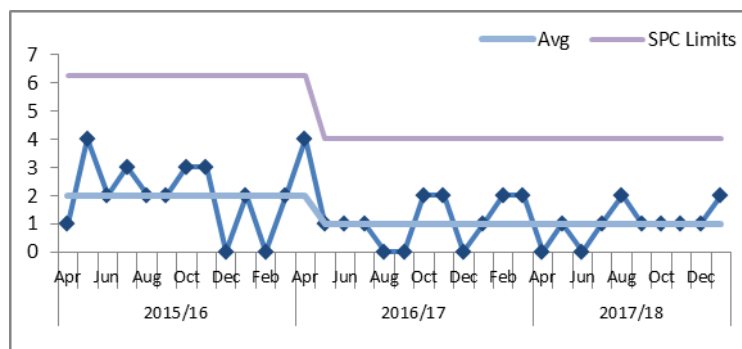
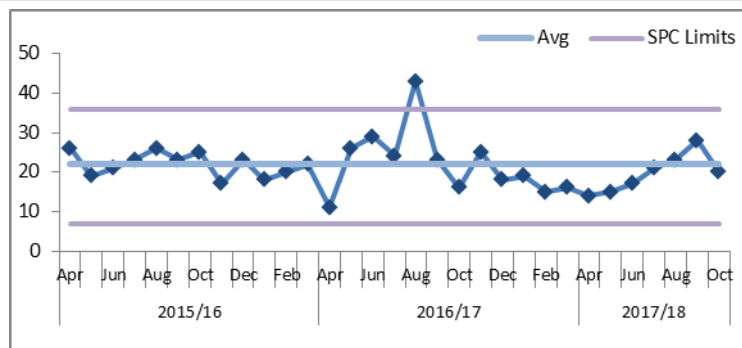
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Trend

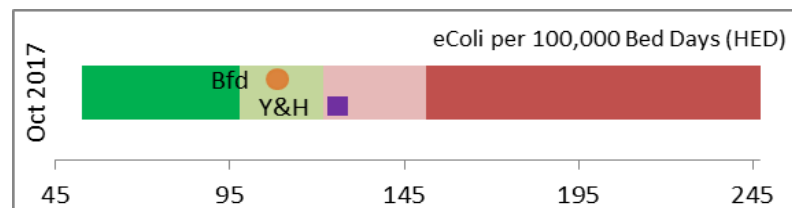
Challenges & Successes

Comparison

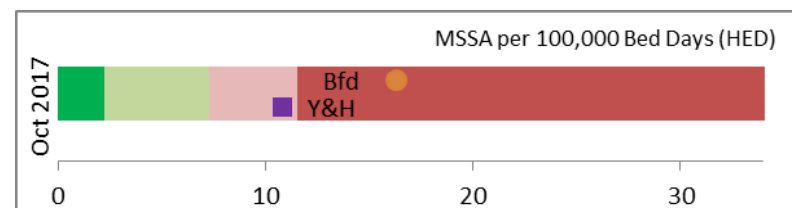
Exec Lead



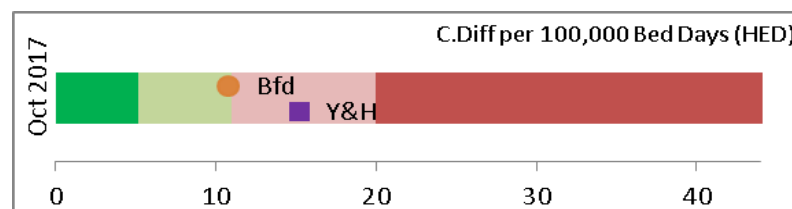
As part of the 2018/19 work plan we will focussing on all Chief Nurse bacteraemias.



Ongoing challenges with consistency of MRSA/MSSA. Part of Chief Nurse national improvement collaborative for Infection Prevention & Control (IPC). Ongoing improvements overseen by IPC and reviewed in the Quarter 2 report.



Sustained reduction in C.difficile has been achieved. Robust PIR Chief Nurse process in place.





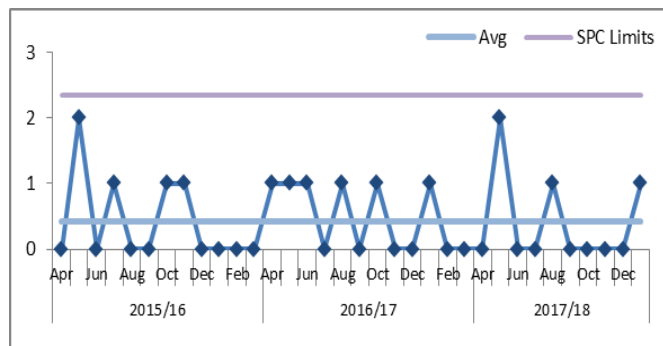
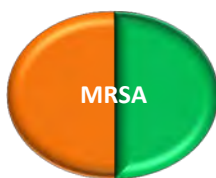
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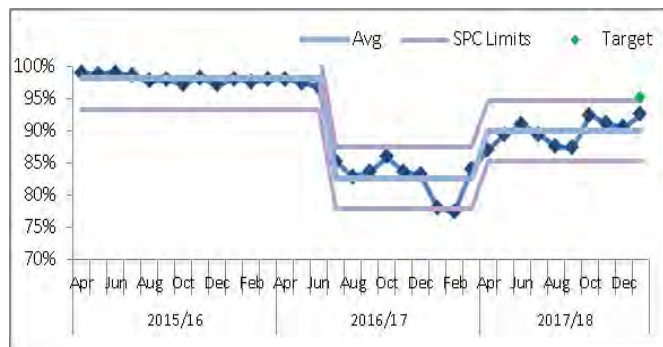
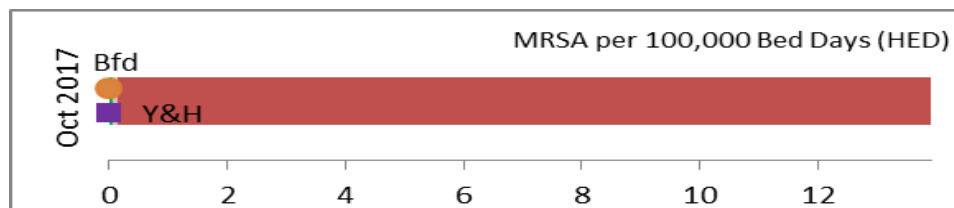
Challenges & Successes

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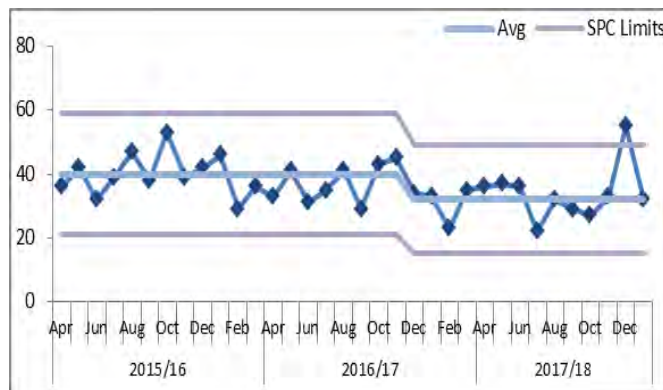
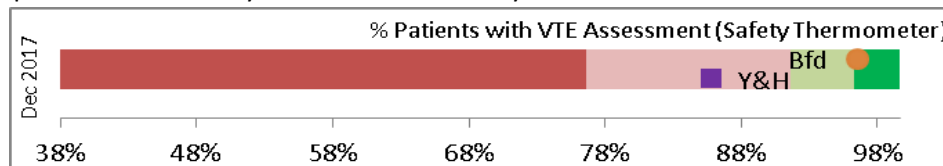
Exec Lead



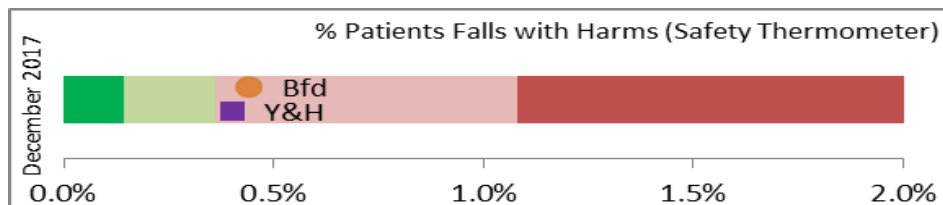
1 occurrence of MRSA bacteraemia, awaiting PIR, no common themes, not Chief Nurse statistically significant, performance improved on 2016/17.



VTE performance following daily and weekly performance has improved to Medical 92.47%. This has been achieved by a combination of direct engagement, daily, Director with specialties showing failures to undertake assessments and appropriate application of the cohort rules. A full report of progress and trajectory was presented at Quality Committee in January.



Number of falls has reduced over the last month, Quality Improvement work continues with top 10 wards



Chief Nurse

# To provide outstanding care for patients

	Trend	Challenges & Successes	Comparison	Exec Lead
<div>Catheters &amp; UTIs</div>		<p>Plans in place to undertake work (overseen by the IPC) to reduce the point prevalence of CAUTI. Opportunity to use the EPR to audit care and support improvement being explored with chief nurse team. The trend continues to mirror previous 3 years</p>		Chief Nurse
<div>Pressure Ulcers Cat 3+</div>		<p>Continue to be below trend line following EPR documentation issues in September.</p>		Chief Nurse
<div>Pressure Ulcers Cat 2</div>		<p>Continue to monitor any variances.</p>		Chief Nurse



# To provide outstanding care for patients

Trend

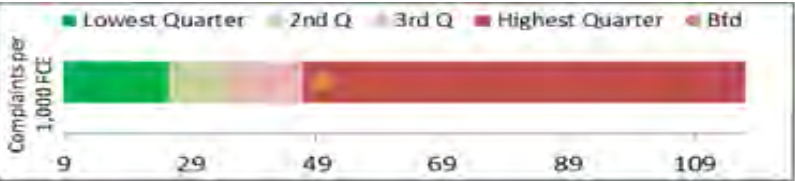
Challenges & Successes

Comparison

Exec Lead

Chief Nurse

Since a reduction in March we continue to see a stable position.

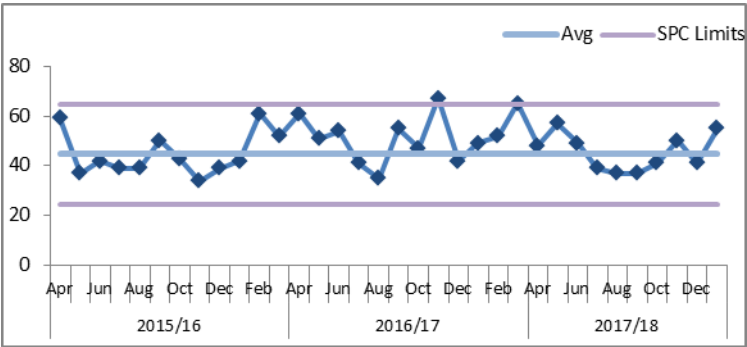


The Friends and Family Test has recovered back to normal baseline Chief Nurse after a drop in September 2017.

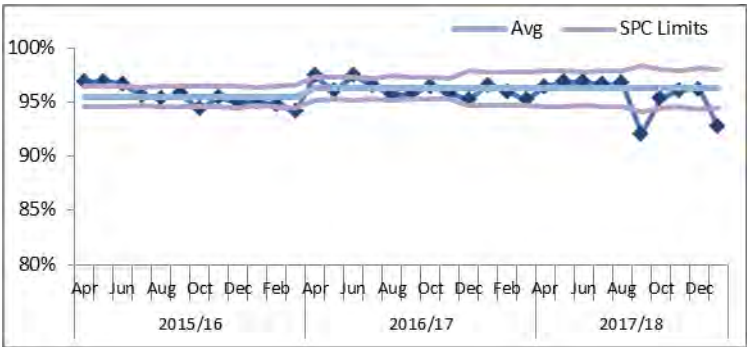
A detailed review of night time transfers over January has been undertaken by the COO. In summary there were 12 night time patient transfers took place over 9 nights in the month. In all cases the moves were clinically necessary in order to create either a side room for a patient flu or gastrointestinal infection or to create a specific specialty bed such as a cardiology monitored bed. Work is ongoing to reduce outliers and overall Length of Stay (LOS) in order to avoid the need for night time transfers. Trend analysis will be undertaken on a monthly basis.

Chief Operating Officer

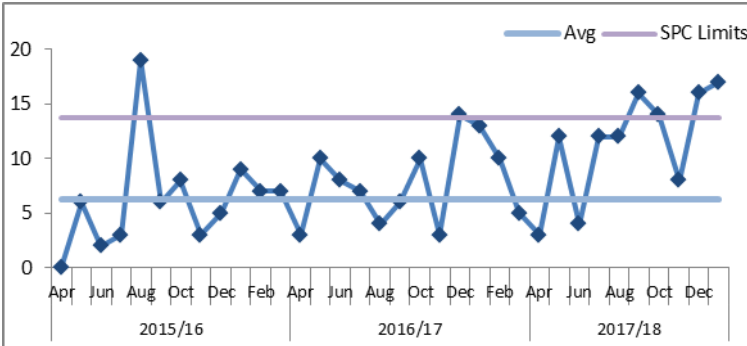
Complaints



Friends and Family Test



Night-time Transfers



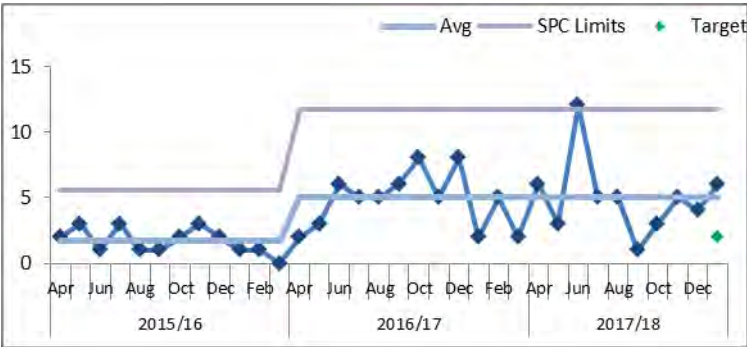
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<div>Readmissions from Elective</div> <table border="1"><caption>Readmissions from Elective (Approximate Data)</caption><thead><tr><th>Month</th><th>Avg</th><th>SPC Limits</th><th>EPR Impact</th></tr></thead><tbody><tr><td>Apr 2015</td><td>135</td><td>105-178</td><td></td></tr><tr><td>Jun 2015</td><td>158</td><td>105-178</td><td></td></tr><tr><td>Aug 2015</td><td>142</td><td>105-178</td><td></td></tr><tr><td>Oct 2015</td><td>162</td><td>105-178</td><td></td></tr><tr><td>Dec 2015</td><td>152</td><td>105-178</td><td></td></tr><tr><td>Feb 2016</td><td>128</td><td>105-178</td><td></td></tr><tr><td>Apr 2016</td><td>132</td><td>105-178</td><td></td></tr><tr><td>Jun 2016</td><td>138</td><td>105-178</td><td></td></tr><tr><td>Aug 2016</td><td>135</td><td>105-178</td><td></td></tr><tr><td>Oct 2016</td><td>162</td><td>105-178</td><td></td></tr><tr><td>Dec 2016</td><td>148</td><td>105-178</td><td></td></tr><tr><td>Feb 2017</td><td>118</td><td>105-178</td><td></td></tr><tr><td>Apr 2017</td><td>172</td><td>105-178</td><td></td></tr><tr><td>Jun 2017</td><td>132</td><td>105-178</td><td></td></tr><tr><td>Aug 2017</td><td>158</td><td>105-178</td><td></td></tr><tr><td>Oct 2017</td><td>162</td><td>105-178</td><td></td></tr><tr><td>Dec 2017</td><td>208</td><td>105-178</td><td></td></tr><tr><td>Feb 2018</td><td>158</td><td>105-178</td><td></td></tr><tr><td>Apr 2018</td><td>122</td><td>105-178</td><td></td></tr></tbody></table>	Month	Avg	SPC Limits	EPR Impact	Apr 2015	135	105-178		Jun 2015	158	105-178		Aug 2015	142	105-178		Oct 2015	162	105-178		Dec 2015	152	105-178		Feb 2016	128	105-178		Apr 2016	132	105-178		Jun 2016	138	105-178		Aug 2016	135	105-178		Oct 2016	162	105-178		Dec 2016	148	105-178		Feb 2017	118	105-178		Apr 2017	172	105-178		Jun 2017	132	105-178		Aug 2017	158	105-178		Oct 2017	162	105-178		Dec 2017	208	105-178		Feb 2018	158	105-178		Apr 2018	122	105-178		<p>This is impacted on by Data Quality (DQ) issues following EPR implementation and forms part of the DQ recovery programme.</p> <div>Emergency Readmission Within 30 Days (HED)</div> <table border="1"><caption>Emergency Readmission Within 30 Days (HED) - Oct 2017</caption><thead><tr><th>Category</th><th>Percentage</th></tr></thead><tbody><tr><td>Green</td><td>4.2%</td></tr><tr><td>Light Green</td><td>5.2%</td></tr><tr><td>Purple</td><td>6.2%</td></tr><tr><td>Pink</td><td>7.2%</td></tr><tr><td>Red</td><td>8.2%</td></tr><tr><td>Bfd</td><td>10.2%</td></tr></tbody></table>	Category	Percentage	Green	4.2%	Light Green	5.2%	Purple	6.2%	Pink	7.2%	Red	8.2%	Bfd	10.2%	Chief Operating Officer
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<div>Information Governance Breaches</div> <table border="1"><caption>Information Governance Breaches (Approximate Data)</caption><thead><tr><th>Month</th><th>Avg</th></tr></thead><tbody><tr><td>Apr 2015</td><td>1</td></tr><tr><td>Jun 2015</td><td>0</td></tr><tr><td>Aug 2015</td><td>1</td></tr><tr><td>Oct 2015</td><td>2</td></tr><tr><td>Dec 2015</td><td>2</td></tr><tr><td>Feb 2016</td><td>0</td></tr><tr><td>Apr 2016</td><td>0</td></tr><tr><td>Jun 2016</td><td>0</td></tr><tr><td>Aug 2016</td><td>0</td></tr><tr><td>Oct 2016</td><td>0</td></tr><tr><td>Dec 2016</td><td>0</td></tr><tr><td>Feb 2017</td><td>1</td></tr><tr><td>Apr 2017</td><td>1</td></tr><tr><td>Jun 2017</td><td>0</td></tr><tr><td>Aug 2017</td><td>0</td></tr><tr><td>Oct 2017</td><td>0</td></tr><tr><td>Dec 2017</td><td>1</td></tr></tbody></table>	Month	Avg	Apr 2015	1	Jun 2015	0	Aug 2015	1	Oct 2015	2	Dec 2015	2	Feb 2016	0	Apr 2016	0	Jun 2016	0	Aug 2016	0	Oct 2016	0	Dec 2016	0	Feb 2017	1	Apr 2017	1	Jun 2017	0	Aug 2017	0	Oct 2017	0	Dec 2017	1	<p>There has been one breach in December 2018. Awareness remains high as training was incorporated into EPR training.</p> <p>No comparator data is published.</p>	Director of Informatics																																																										
Month	Avg																																																																																															
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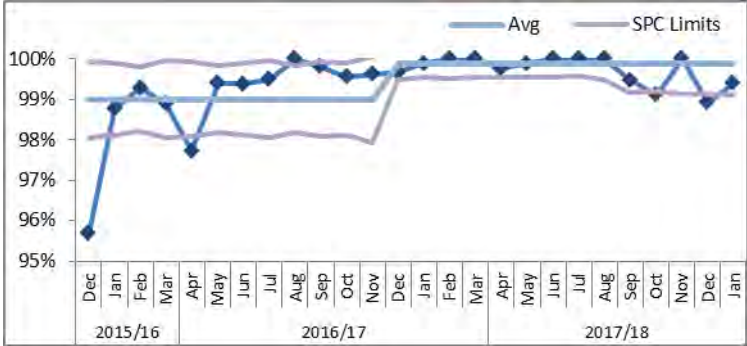
# To provide outstanding care for patients

Trend	Challenges & Successes	Comparison	Exec Lead
-------	------------------------	------------	-----------

Serious Incidents



Audit of WHO Checklist






Each serious incident is investigated and reported to the Quality Committee. No comparator data is available.

Director of Governance & Corporate Affairs

Audited data has shown high compliance, however, recent observation work has identified that there is still work needed to continue to develop the culture of safety in theatres. No comparator data is available.

Medical Director

# To collaborate effectively with local and regional partners

Trend	Challenges & Successes	Comparison	Exec Lead
	<p>BTHFT's systematic approach to stakeholder management identifies key external partners, and for each an executive sponsor and an account manager has been identified, with responsibility for maintaining/improving the health of the relationship. To establish the baseline an initial survey has been sent out by account managers to a cohort of the various stakeholder organisations (we are phasing the introduction to test the approach). The findings will help us determine whether an action plan is required to improve any of the individual relationships (to be measured on a "maturity index"). KPIs for this programme of work will focus initially on the achievement of basic inputs/milestones, and in time will evolve into evidence based measures of the extent of improvement based on stakeholder surveys.</p>		<p>Director of Strategy &amp; Integration</p>
	<p>Our clinical strategy commits us to "work with local partners and contribute to the formal establishment of a responsive, integrated care system", in which Bradford service providers will work together to develop models of care which best meet the needs of service users, manage demand and achieve optimal vfm. This will be achieved by improving information and education, supporting self-care, and enhancing primary and community care arrangements. The aim is that attendance at the acute hospital is only for those patients that require care which cannot be provided elsewhere. Initially, CCGs have asked providers to develop a model for diabetes; in time, the ambition is for a broader range of "out of hospital" care to be managed in this way. KPIs for this programme of work will focus initially on the achievement of basic inputs/milestones, and in time will evolve into evidence based measures of growth in range and value of services covered.</p>		<p>Director of Strategy &amp; Integration</p>
	<p>The Trust is committed to work with other acute providers to ensure resilient services, reduce outcome variation, address workforce shortages, achieve efficiencies, meet national activity volume standards, etc. However the collaboration environment is difficult – Trusts are funded and regulated separately, with individual financial and performance targets. With no prospect of legislative change, radical developments involve risk, and are undertaken against a historic backdrop of competition. KPIs for this work programme initially focus on the achievement of basic inputs/milestones, and in time will evolve into evidence based measures of growth in range and value of services covered.</p>		<p>Director of Strategy &amp; Integration</p>

# To be a continually learning organisation

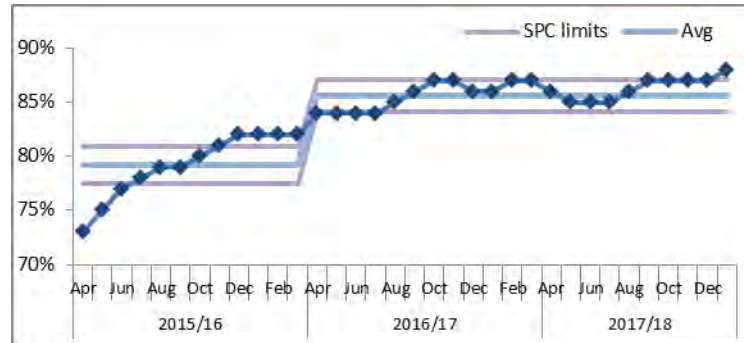
Trend

Challenges & Successes

Comparison

Exec Lead

Core Training

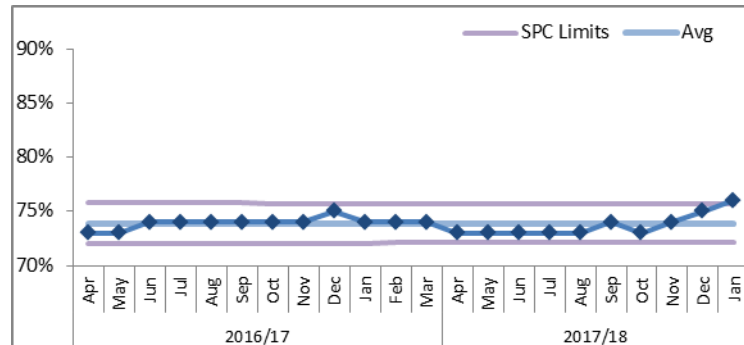


Core (mandatory) training compliance is not achieving the standard for the Trust

Comparator data not available.

Medical Director

High Priority Training



High Priority training compliance has not improved and is achieving the 75% standard for the past 2 months.

Comparator data not available.


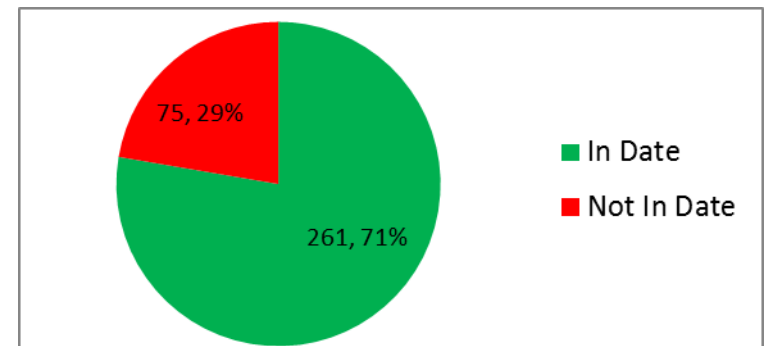

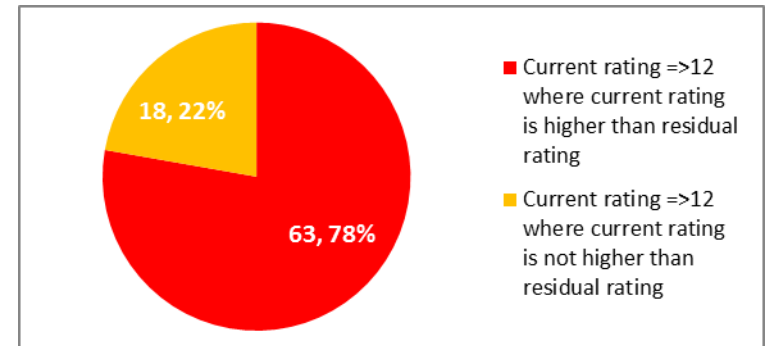


Medical Director

Learning Hub

The Learning Hub is becoming well established within the Trust and is meeting expectations in relation to delivery of the agreed learning outputs, for example, Learning Matters. A full review is planned for Q1 2018/19.

Director of Governance & Corporate Affairs

# To be a continually learning organisation

Trend	Challenges & Successes	Comparison	Exec Lead
 <p>Out of date policies</p>	 <p>■ In Date ■ Not In Date</p>	<p>A focussed programme of work commenced in Quarter 3 in order to improve the Trust position in relation to Trust-wide policies and their management. There is significant confidence about the approach to managing locally-developed guidance within Divisions</p>	<p>Comparator data not available.</p> <p>Director of Governance &amp; Operations</p>
 <p>Risks not mitigated</p>	 <p>■ Current rating =&gt;12 where current rating is higher than residual rating ■ Current rating =&gt;12 where current rating is not higher than residual rating</p>	<p>There is a clear work programme to improve the risk assessments and plans by the end of Quarter 3. Skilled risk staff have been devolved to the divisions to support and sustain this work. The Integrated Governance and Risk Committee review has commenced. The refreshed Risk Management Strategy has been completed and approved.</p>	<p>Comparator data not available.</p> <p>Director of Governance &amp; Operations</p>
 <p>Research patients recruited</p>	 <p>— YTD Target</p>	<p>Number of participants recruited to National Institute for Health Research Portfolio Studies since 2015, including commercial and non-commercial studies, remains strong and in line with expectation.</p>	<p>Comparator data not available.</p> <p>Medical Director</p>



# To be in the top 20% of employers in the NHS

Trend

Challenges & Successes

Comparison

Exec Lead

Appraisal  
Rate Non-  
Medical



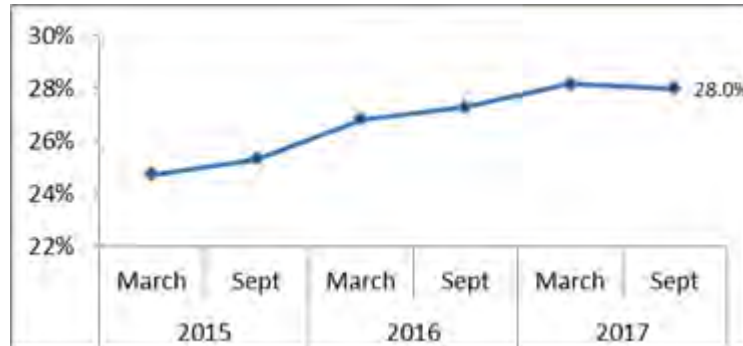
Appraisal rates have fallen slightly again in January. The importance of undertaking appraisals have been reiterated at the Divisions Human Performance Review meetings this month. ESR data is being checked Resources to ensure it accurately reflects appraisals completed and work continues to support managers and employers so everyone has an effective appraisal.

BAME %  
Senior Leaders



We have made a significant increase in the No comparator data Director of number of BAME staff at Bands 8 & 9 over the is available. Human Resources past six months. However, based on the current employment target to have a senior workforce reflective of the local population by 2025 by around 14%.

BAME %  
Workforce



Good progress is being made. We are ahead of No comparator data Director of our trajectory to have a workforce reflective of is available. Human Resources the local ethnic local population by 2025.

# To be in the top 20% of employers in the NHS

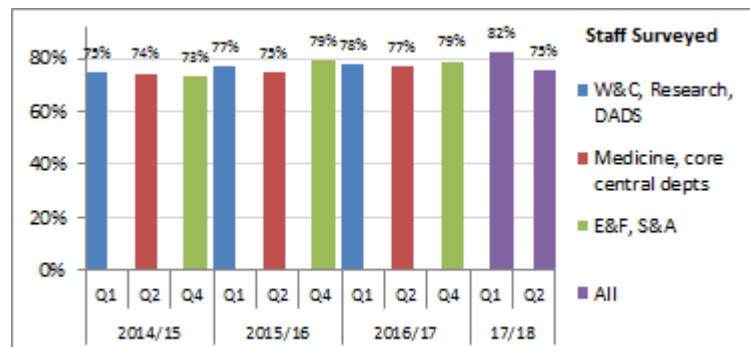
Trend

Challenges & Successes

Comparison

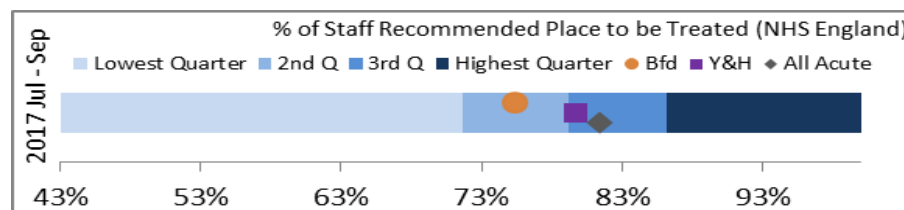
Exec Lead

Staff FFT  
Treatment

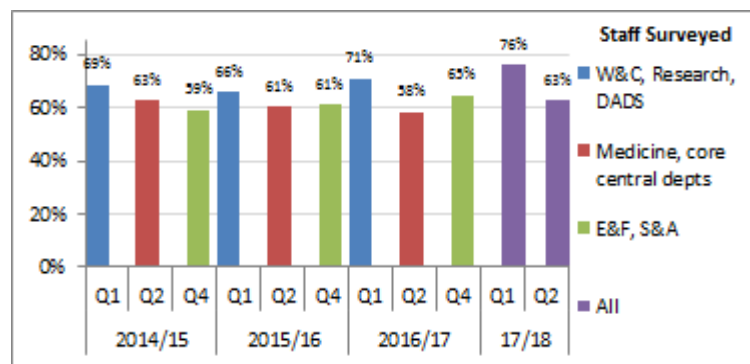


BTHFT is currently below the Yorkshire and Humber average, and also below average for all acute sites. The Trust target is to be agreed in line with the NHS Quest Employment Brand Standards and Criteria.

Director of  
Human  
Resources

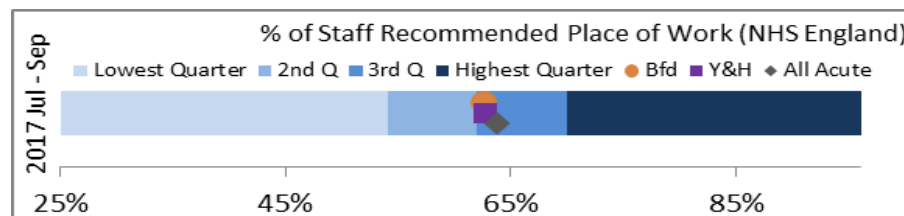


Staff FFT  
Work



The target is to be agreed in line with NHS Quest Employment Brand Standards and Criteria. Significant work is ongoing to improve the employee engagement and experience at work through the actions plans agreed as part of the People Strategy. These action plans are monitored through the Trust Education and Workforce Committee. We are currently on par with Yorkshire and Humber and Acute Trusts.

Director of  
Human  
Resources



# To be in the top 20% of employers in the NHS

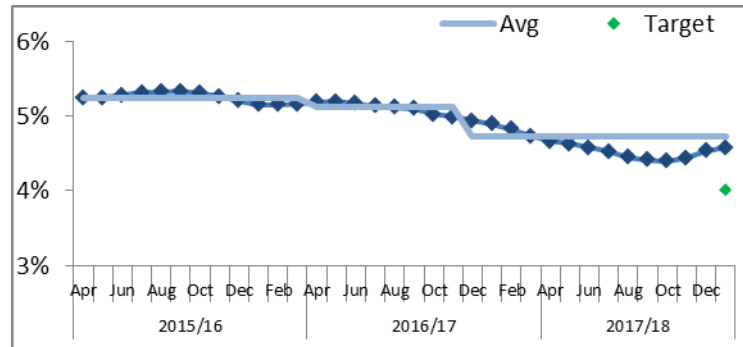
Trend

Challenges & Successes

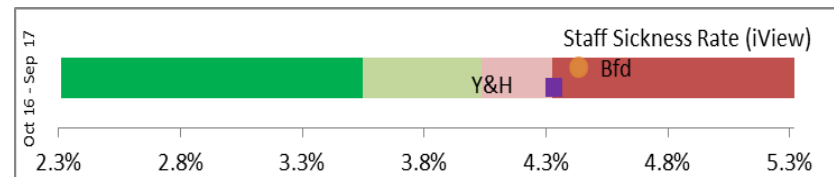
Comparison

Exec Lead

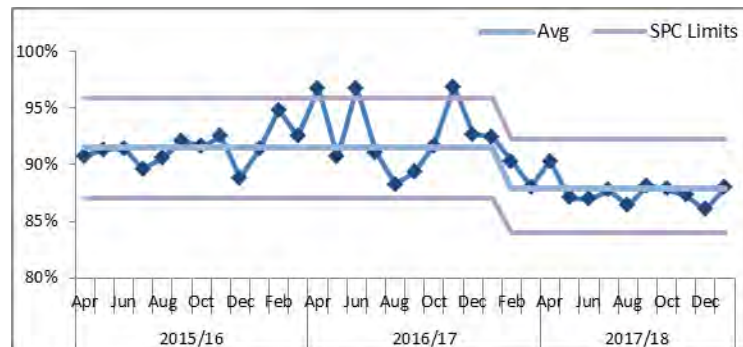
Sickness



Sickness has continued to increase and now stands at 4.58% over the rolling 12 month period to 31st Jan 18. Sickness rates have increased in all Clinical Divisions this month. The Trust was slightly above the average sickness rate for the region in September at 4.4% against an average of 4.38%. Average sickness rates for the NHS in England between July and September 2017 was 4%.



Nursing Shifts Filled



Standing item on the agenda regarding nurse fill rate and staffing levels. No areas have been unsafe or have had less than 2 qualified staff on duty.

Care Staff Shifts Filled



The fill rates for care staff has been consistently over the planned, but this reflects the fact that care staff are used to backfill gaps in registered nurses and as part of ongoing reconfiguration.

# To be in the top 20% of employers in the NHS

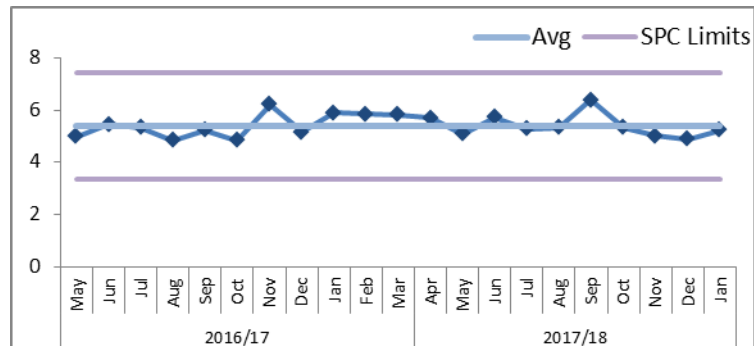
Trend

Challenges & Successes

Comparison

Exec Lead

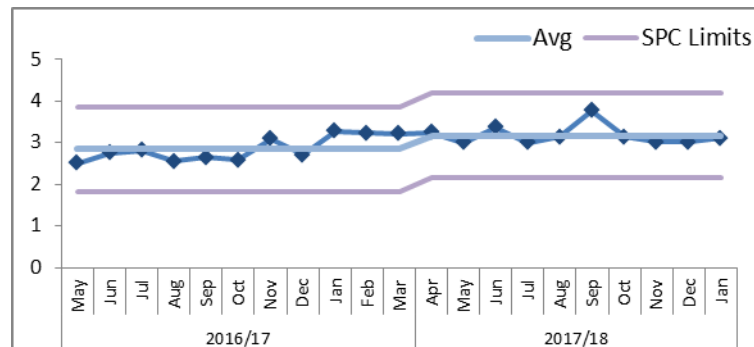
Nursing Care Hours



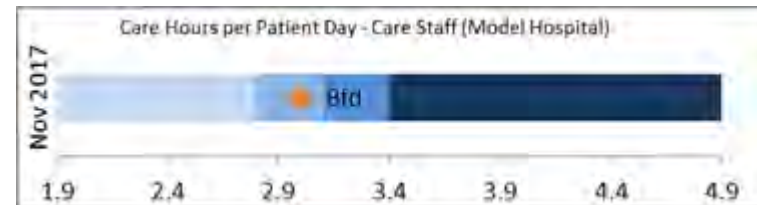
Care hours per day is a rough measure that is expected to remain stable. Care hours vary by type of care being given and patient acuity, for example, intensive care. Chief Nurse



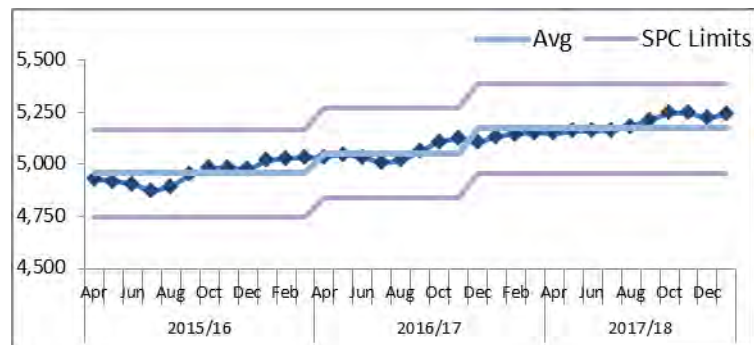
Care Staff Care Hours



Care hours per day is a rough measure that is expected to remain stable. Care hours vary by type of care being given and patient acuity, for example, intensive care. Chief Nurse



Staff in Post



FTE in post has increased slightly this month with the largest increases being in the Divisions of Medicine and Surgery. Director of Human Resources.

# To be in the top 20% of employers in the NHS

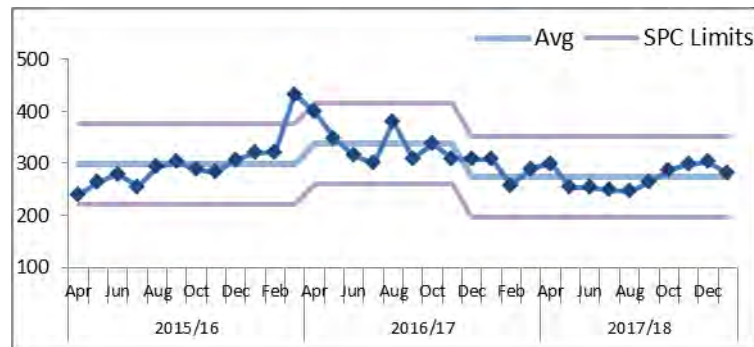
Trend

Challenges & Successes

Comparison

Exec Lead

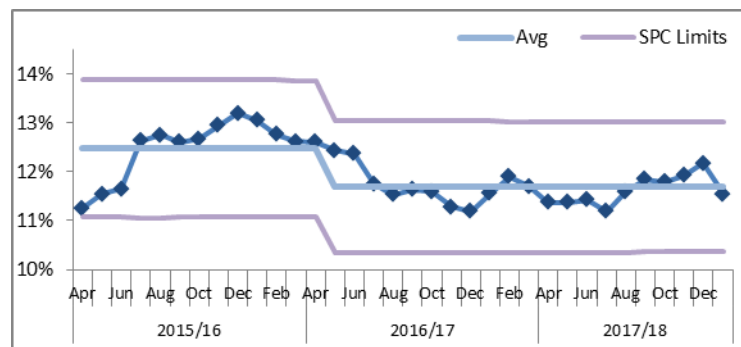
Use of  
Agency  
(WTE)



Use of Agency staff continues to be monitored closely and is subject to robust approval mechanisms. Agency cover for vacant clinical posts remains the primary reason for usage. Director of Human Resources

Agency reduced in January with greater bank usage reported.

Turnover



Turnover has reduced this month, reductions in turnover were seen in the estates and facilities and nursing and midwifery registered staff groups. Director of Human Resources

# To deliver our financial plan and key performance targets

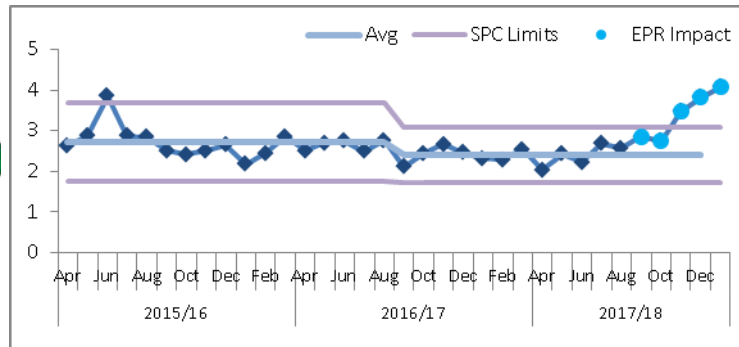
Trend

Challenges & Successes

Comparison

Exec Lead

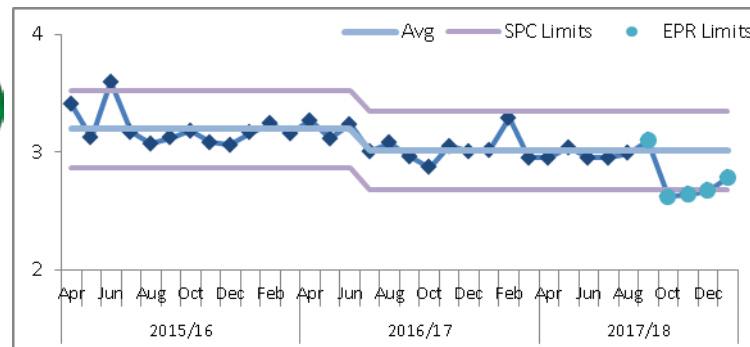
Length of Stay  
Elective



This position indicates an ongoing data quality issue following EPR implementation caused by an increase in patients, particularly day case, being admitted non-electively instead of electively and resulting in a higher average length of stay for the remaining elective

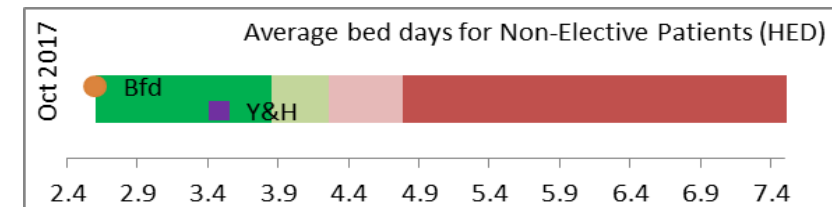
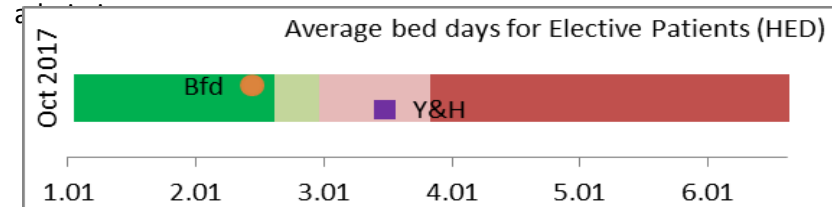
Chief  
Operating  
Officer

Length of Stay  
Non-Elective



The same data quality issue as the previous indicator with elective and assessment patients being incorrectly admitted as non-elective patients. These very short length of stay spells will reduce the overall LOS for non elective admissions.

Chief  
Operating  
Officer





# To deliver our financial plan and key performance targets

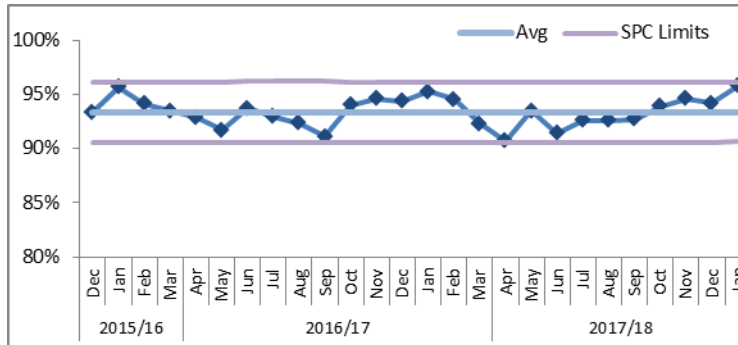
Trend

Challenges & Successes

Comparison

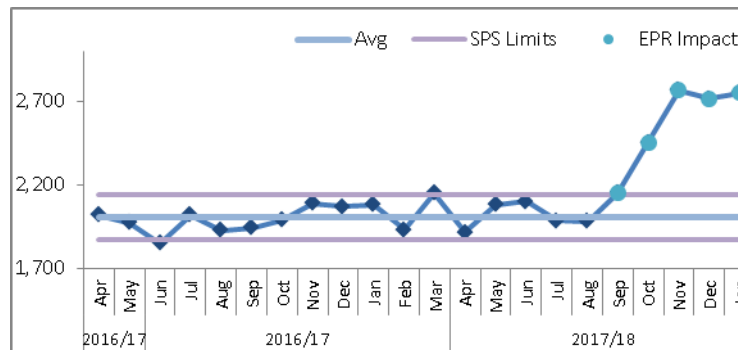
Exec Lead

Bed  
Occupancy



The Trust has been operating at an average bed occupancy of over 96% since January. This is the usual January/ winter pressures picture where higher patient acuity leads to an increase in length of stay, particularly for frail older people. A key action is to focus on reducing the number of escalation beds open and proactively managing discharges and avoiding delays in the patient journey.

Discharges  
before 1  
PM



Metric impacted by EPR issues. Trend analysis shows no significant change in discharges before 1pm. Targeted work has commenced to reinforce the 'home for lunch' programme. A daily report is being developed to monitor discharges by hour as a percentage of all discharges

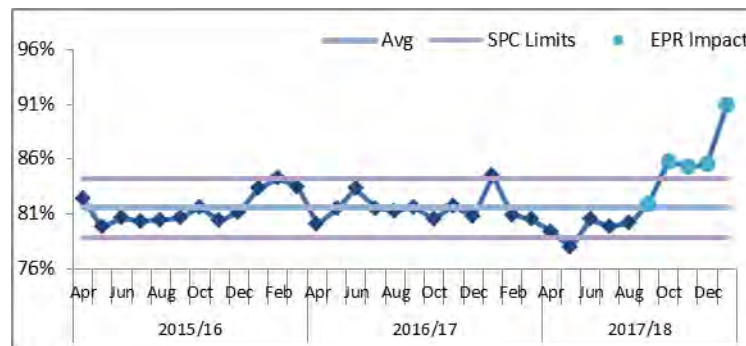
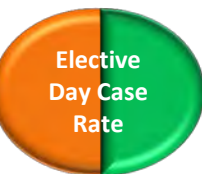
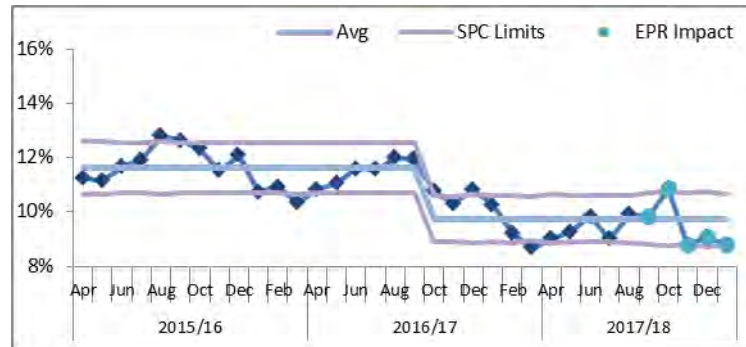
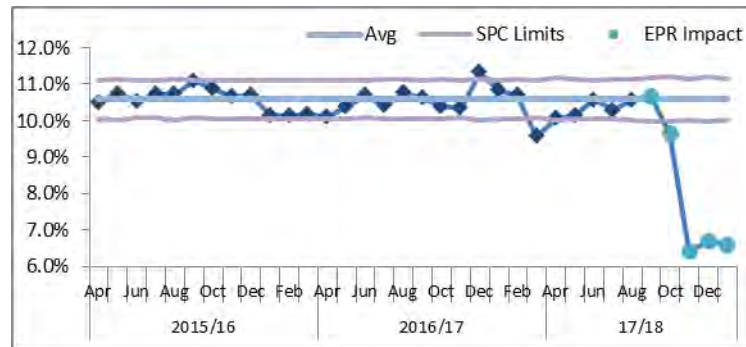
# To deliver our financial plan and key performance targets

Trend

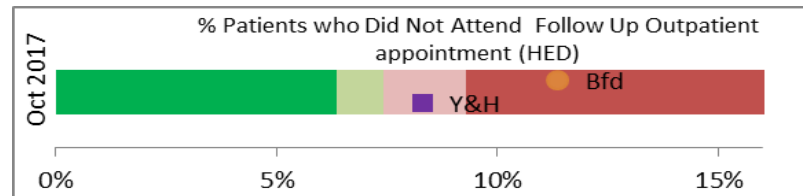
Challenges & Successes

Comparison

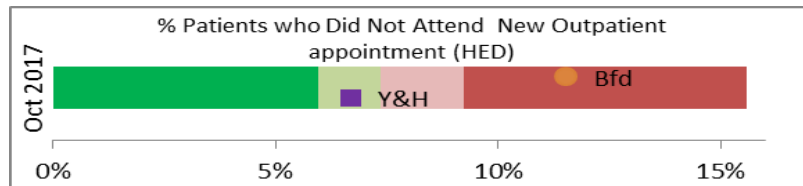
Exec Lead



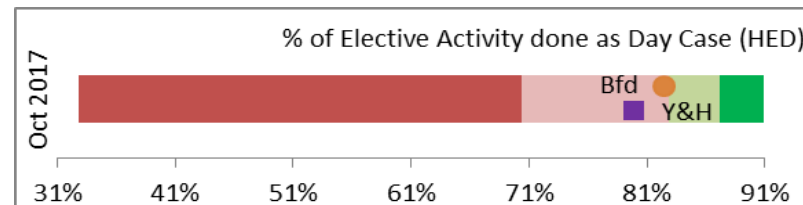
Did Not Attend (DNA) rates are being reviewed within the Out- Chief Operating  
Patient Improvement Programme. There are likely to be a number Officer  
of data quality issues that impact on the DNA rates. This forms  
part of the data quality recovery programme.



Did Not Attend rates are being reviewed within the Out Patient Chief Operating  
Improvement Programme. There are likely to be a number of DQ Officer  
issues that impact on the DNA rates. This forms part of the DQ  
recovery programme.



GIRFT data has been provided to specialties to identify areas for Chief Operating  
focussed work. This is affected by the non-elective/elective Officer  
admission data quality issue. That is, the reduction in elective  
inpatients recorded will lead to a day case rate as a proportion of  
the total elective.



# To deliver our financial plan and key performance targets

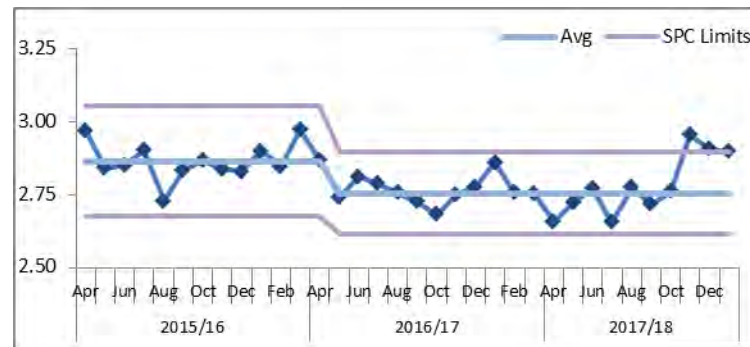
Trend

Challenges & Successes

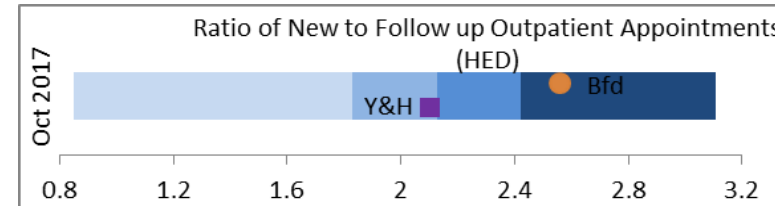
Comparison

Exec Lead

New to Follow-up Ratio

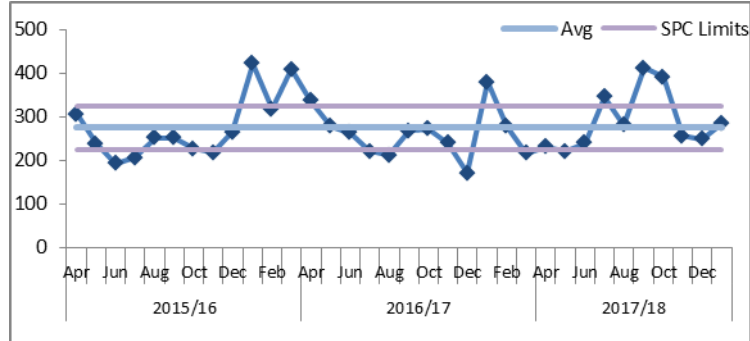


This metric is being reviewed as part of the Out-Patient Chief Operating Improvement Programme. Each Division is focusing on two main Officer specialties where there are the biggest opportunities for improvement.



Chief Operating Officer

Short notice Clinic Cancellations



This metric is within normal variation. The peak in cancellations immediately after EPR implementation is likely to be the increase in rescheduling requests that had been put on hold the freeze phase over implementation.

Elective Wait List



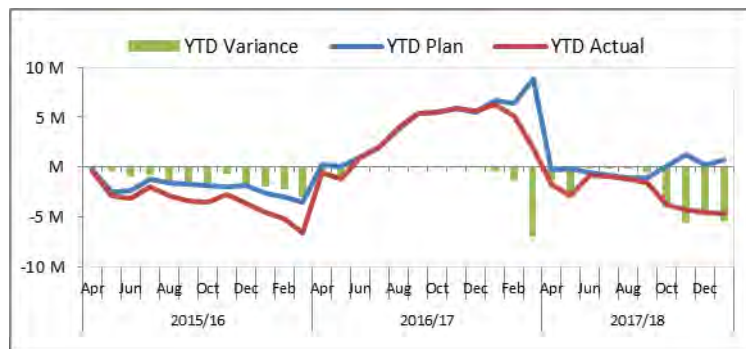
Waiting Lists and waiting times have increased as a result of the Director of planned reduction in elective activity during the EPR Governance & implementation and during winter pressures. In addition data Operations quality issues have had an impact on the overall waiting list size. There is a need to undertake a full waiting list validation to remove data quality issues.

# To deliver our financial plan and key performance targets

Trend

Challenges & Successes

Exec Lead



The Trust delivered a pre-STF deficit of £7.8m at the end of Month 10 of which is £1m behind the pre-STF control total. A YTD pre-STF deficit of £7.9m was forecast in the revised Improvement Plan, which means the Trust is in line with this trajectory at Month 10. The YTD post-STF position is a deficit of £4.6m against a planned £0.7m surplus, meaning the Trust is £5.3m behind the cumulative post-STF control total. The in-month position is a favourable pre-STF variance of £0.5m, reflecting non-recurrent flexibility deployed. The FYE forecast presented is full delivery of the pre-STF control total, although there remain unmitigated risks to this forecast.

NHSI Use of Resources	Plan	Actual	Last	RAG
Risk Rating (UoR)	YTD	YTD	Month	
As at 31.1.18				
Capital Servicing Capacity	2	4	4	
Liquidity	1	2	1	
I & E Margin	3	4	4	
Variance from plan (I & E Margin)	1	4	4	
Agency Spend	2	2	2	
Combined UoR (after triggers)	2	3	3	

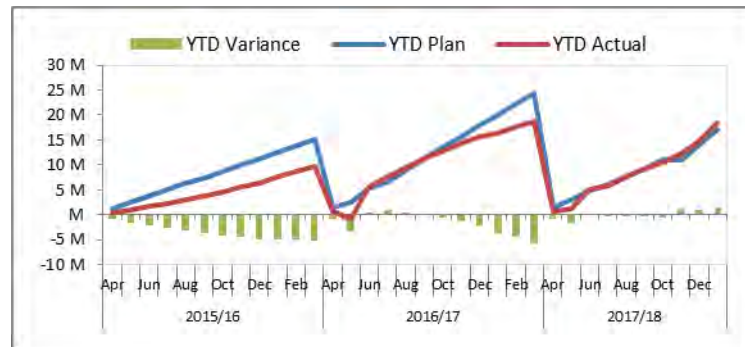
The deterioration in the financial position in Months 7 - 10 has impacted on the 'UoR' rating which overall is reporting a rating of 3. The two metrics deteriorating in recent months are 'I&E Margin' and 'Variance from Control Total'. The annual plan was to deliver an overall rating of 2 by the end of the year. Delivery of the improvement plan would secure the planned 'UoR' rating.

# To deliver our financial plan and key performance targets

Trend

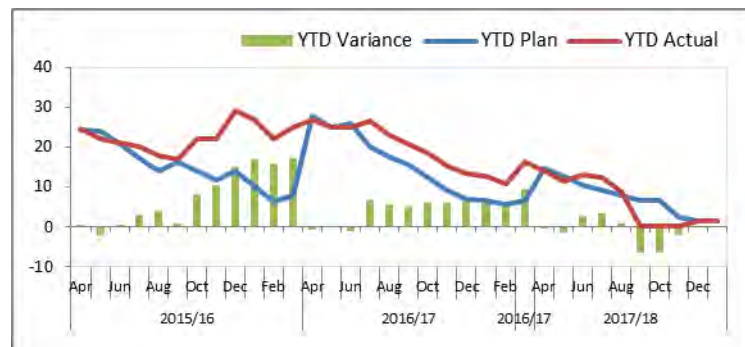
Challenges & Successes

Exec Lead



The forecast delivery from the original CIP programmes have been Director of  
amalgamated with the £12.2m Improvement Plan requirement and Finance  
run rate deterioration to arrive at a projected combined efficiency  
requirement of £29.2m in 2017/18. This target increase reflects  
deteriorations in the income and expenditure run rate in recent  
months and additional unplanned cost pressures arising in the year,  
as well as, the reliance on non-recurrent measures to deliver the  
improvement plan trajectory in Months 7-10.

Although the savings delivered against the original plan suggest a  
£1.4m surplus, the re-phasing of the savings requirement into  
Months 11 & 12 results in a year end shortfall of £4.8m. At present,  
plans are in place to deliver £24.4m of efficiencies against the £29.2m  
target. Even this forecast contains a significant degree of risk and the  
actual outturn may be even less favourable.



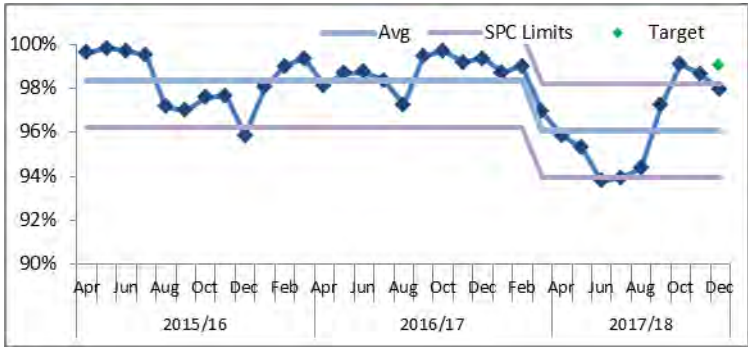
Liquidity is negative and is 3.5 days below plan at the end of January Director of  
reflecting the use of non-recurrent measures to offset improvement Finance  
plan shortfalls, lower than planned levels of clinical income and  
delays with STF payments. Liquidity is forecast to remain negative  
from December onwards in both the Improvement Plan and the do  
nothing scenarios. The current improvement plan trajectory is  
forecast to result in negative liquidity of -10.3 days at the end of  
March. This could potentially be mitigated by increased  
improvement plan delivery.



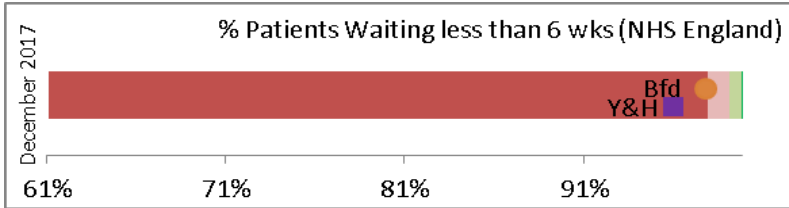
# National Indicators

## Single Oversight Framework

Trend	Challenges & Successes	Comparison	Exec Lead
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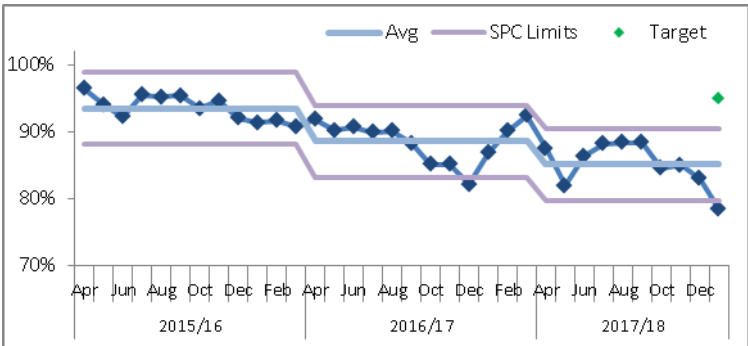


The January DM01 is position will be 98.57%, (excluding Chief Operating Endoscopy), just below the standard. This is due to predominantly Officer to Rheumatology Non-Obstetric Ultrasound and Urodynamics, both of which are showing improvement in February.

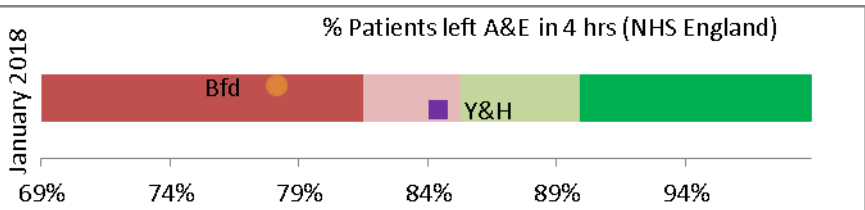


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Liquidity	1	2	1	
I & E Margin	3	4	4	
Variance from plan (I & E Margin)	1	4	4	
Agency Spend	2	2	2	
Combined UoR (after triggers)	2	3	3	

The deterioration in the financial position in Months 7 - 10 has impacted on the 'UoR' rating which overall is reporting a rating of 3. The two metrics deteriorating in recent months are 'I&E Margin' and 'Variance from Control Total'. The annual plan was to deliver an overall rating of 2 by the end of the year. Delivery of the improvement plan would secure the planned 'UoR' rating.



ECS performance remains a challenge with bed delays and long waits to be seen by a doctor causing the majority of breaches. Recent action includes expansion of the initial streaming and triage capacity and safe patient flow management to avoid long bed waits and Emergency Department crowding.



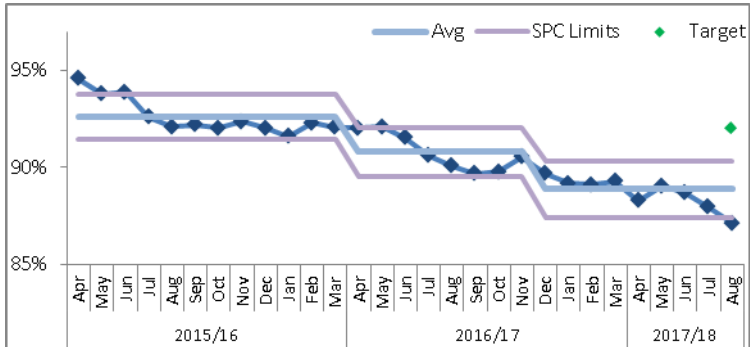


# National Indicators

## Single Oversight Framework

Trend	Challenges & Successes	Comparison	Exec Lead
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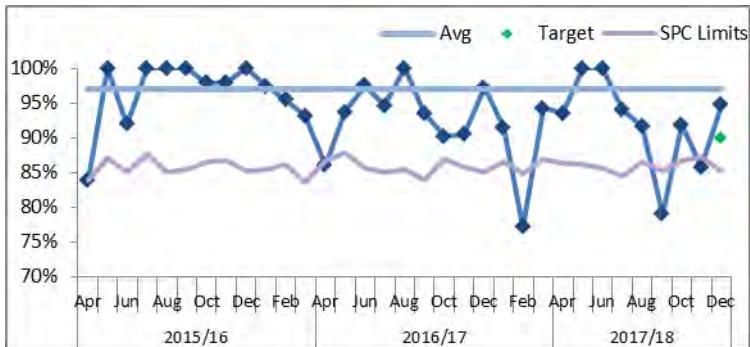
RTT 18 Week Incomplete



The Trust recommended 18 weeks RTT reporting for January. Chief Recovery plans will be developed with all specialties to increase Operating activity and reduce overall waiting list sizes and compliance with 18 Officer week RTT.



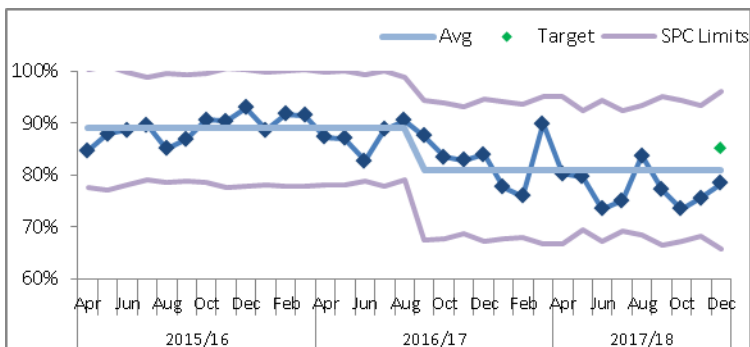
Cancer Urgent 62 Day Screening



This standard was achieved in January.

Chief Operating Officer

Cancer Urgent 62 Day GP



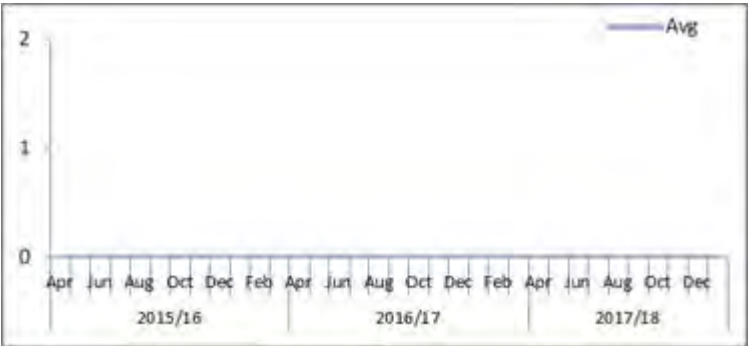
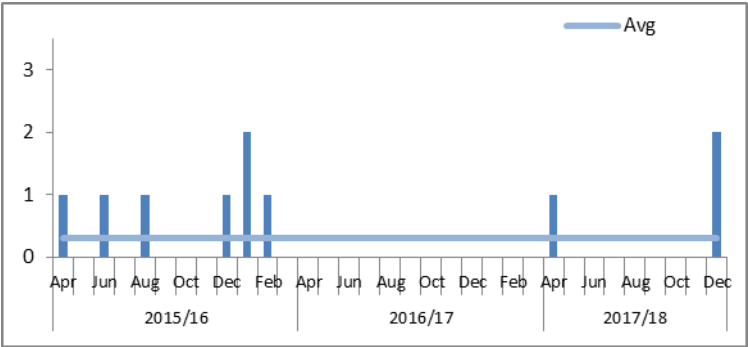
The position continues to be managed via the cancer lead in Chief conjunction with the divisional teams. Speciality level action plans Operating have been agreed and a focus on –  
 1.Reducing 62 day backlog.  
 2.Improved operational grip and close daily tracking of patient lists.  
 3.Demand and capacity analysis  
 A weekly cancer access group reviews patient by patient all long waiters.

Chief Operating Officer

# National Indicators

## National Target Non-Financial

Trend	Challenges & Successes	Comparison	Exec Lead
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The weekly planned care access group continues to review all long waiting patients on a weekly basis.

Chief Operating Officer

The Trust reported 2 incomplete 52 week breaches in January and will report 2 in February. The main risks are in ENT and Trauma & Orthopaedics.

There have been no > 12 hour trolley waits.

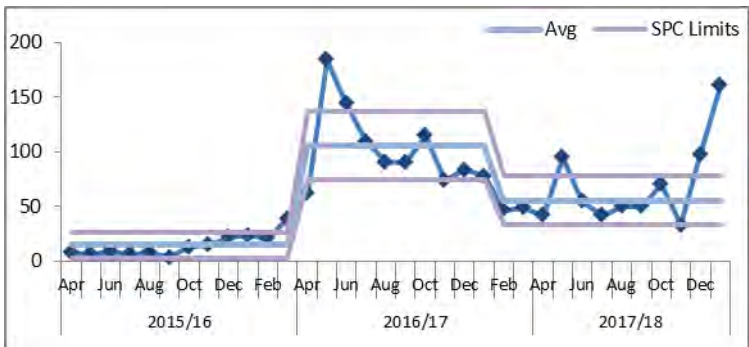
Chief Operating Officer

# National Indicators

## National Target Non-Financial

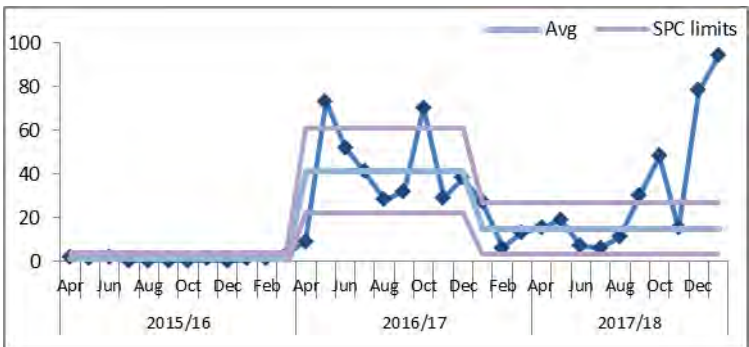
Trend	Challenges & Successes	Comparison	Exec Lead
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Ambulance Handover 30-60 mins



The Trust is not currently meeting the standard for ambulance Chief handover. Actions for improvement include: Increasing initial Operating assessment capacity and implementing Fit to Sit processes, to Officer avoid the need for patients to remain on trolleys.

Ambulance Handover >60 mins



The Trust is not currently meeting the standard for ambulance Chief handover. Plans are in place, as part of the Emergency Operating Department Improvement Plan to improve this position.

RTT Number of Specialties



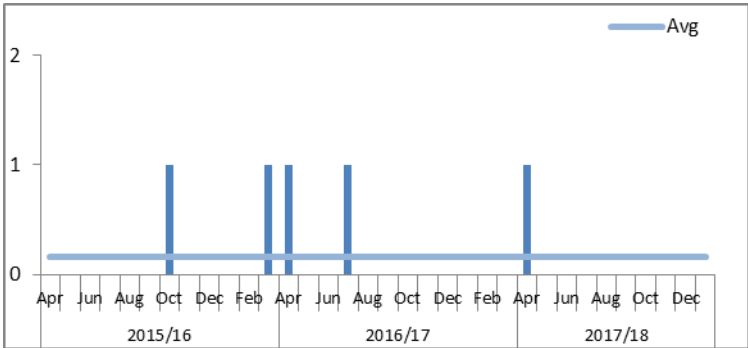
The Trust is now reporting RTT, but performance is affected by Chief data quality issues and a growth in waiting times due to reduced Operating productivity. The weekly planned care access group continues to challenge the position on a patient-by-patient level with all divisions. There are currently nine specialties failing the RTT target. Focussed work is in progress to develop recovery plans. There is local management through the weekly planned access meetings.

# National Indicators

## National Target Financial



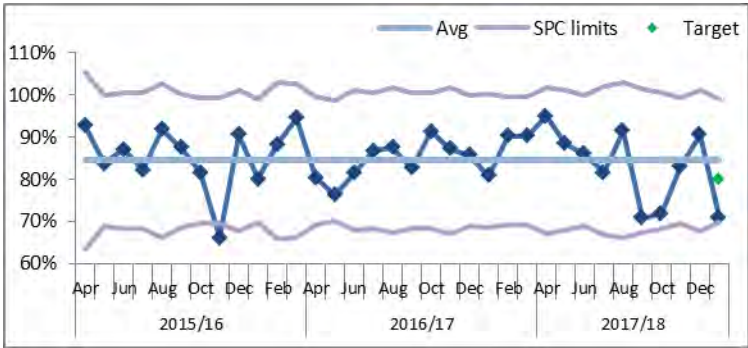
Trend	Challenges & Successes	Comparison	Exec Lead
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No Never Events reported this month.

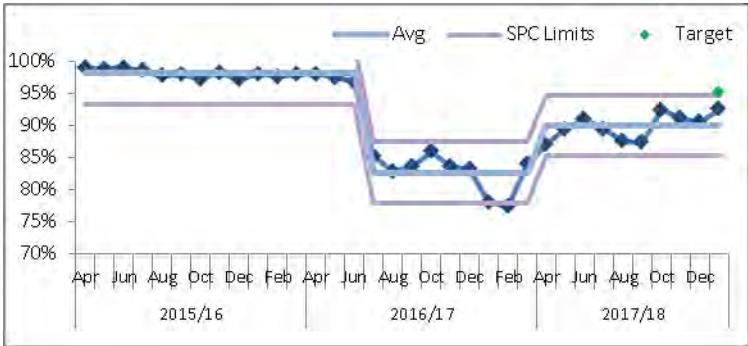
No comparator data is available.

Chief Operating Officer



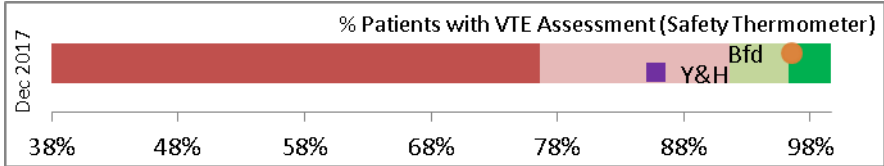
All breaches of the target continue to be reviewed by the lead clinician. A detailed recovery plan is in development

Chief Operating Officer



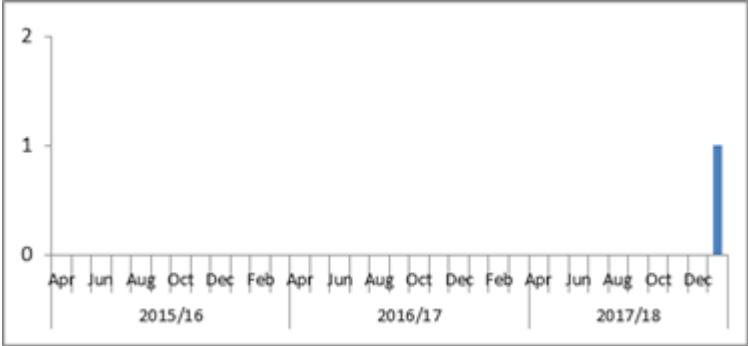
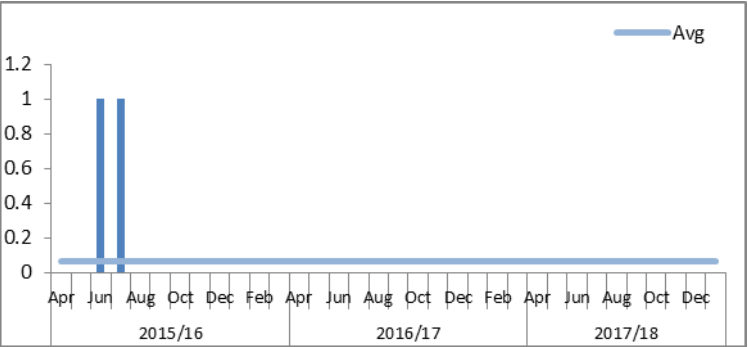
VTE performance following daily and weekly performance has improved to 92.47%. This has been achieved by a combination of direct engagement, daily, with specialities showing failures to undertake assessments and appropriate application of the cohort rules. A full report of progress and trajectory has been discussed at Quality Committee in January.

Medical Director



# National Indicators

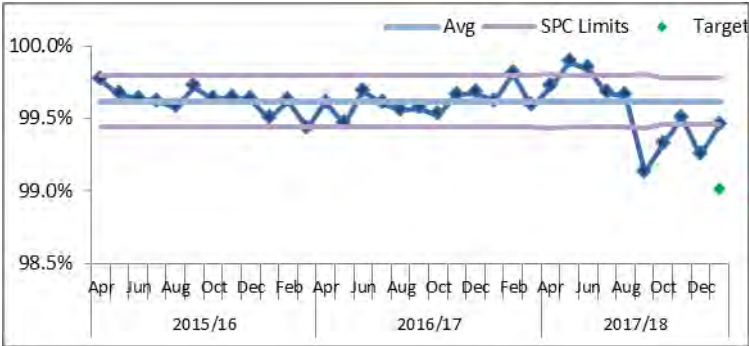
## National Target Financial

	Trend	Challenges & Successes	Comparison	Exec Lead
<div>Duty of Candour</div>		<p>This was in relation to the timeliness of providing a report to a patient. Unfortunately due to a failure in communication the letter and report was sent to the patient a day later than it should have been.</p>		<p>Director of Governance &amp; Corporate Affairs</p>
<div>Formulary</div>	<p>The Trust ensures that the Formulary is published on the website</p>		<p>No comparator data available.</p>	<p>Director of Informatics</p>
<div>Mixed Sex Breaches</div>		<p>There have been no Mixed Sex Breaches.</p>		<p>Chief Operating Officer</p>

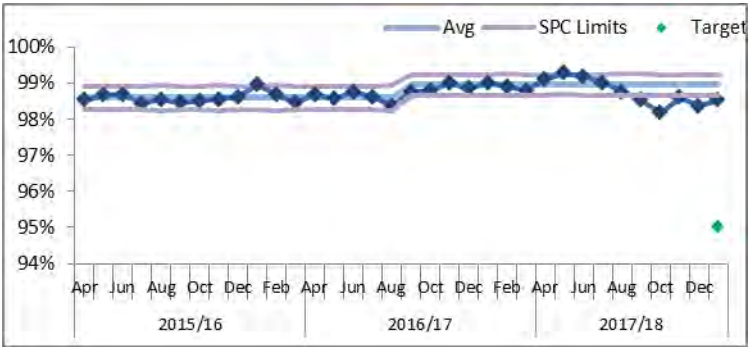
# National Indicators

## National Target Financial

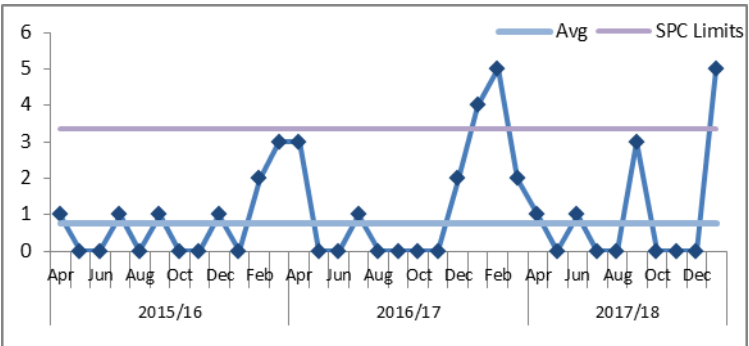
Trend	Challenges & Successes	Comparison	Exec Lead
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With the standardisation and integration of the patient Director of administration system data, as the one source of truth, the Trust Informatics compliance to NHS Number use is strong. Issues are related to EPR embedding and will improve.



With the standardisation and integration of the patient Director of administration system data, as the one source of truth, the Trust Informatics compliance to NHS Number use is strong.

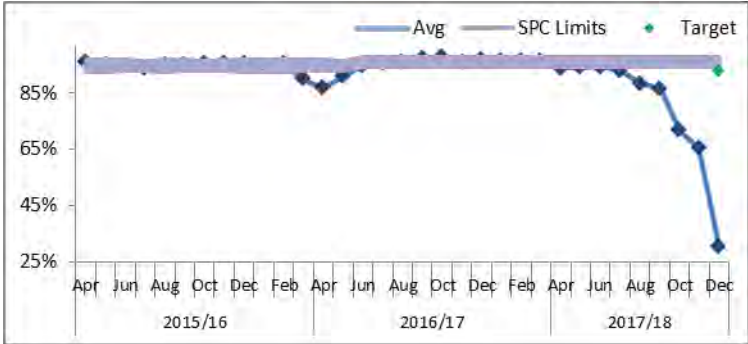
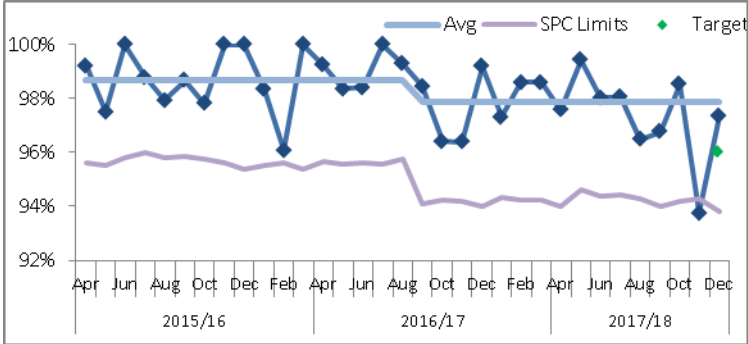
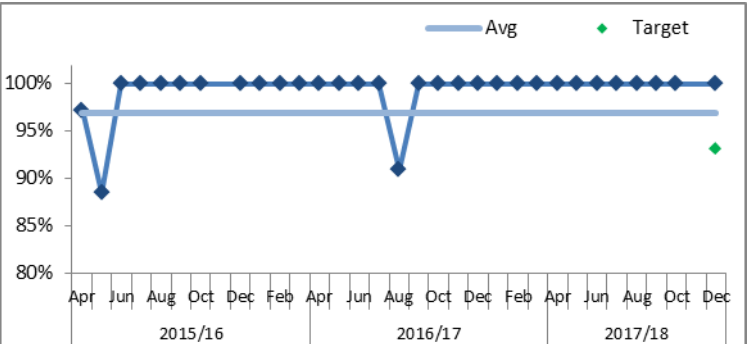


All cases have been reviewed for September 2017 and there was no systematic root cause. No cases since. Chief Operating Officer



# National Indicators

## National Target Financial

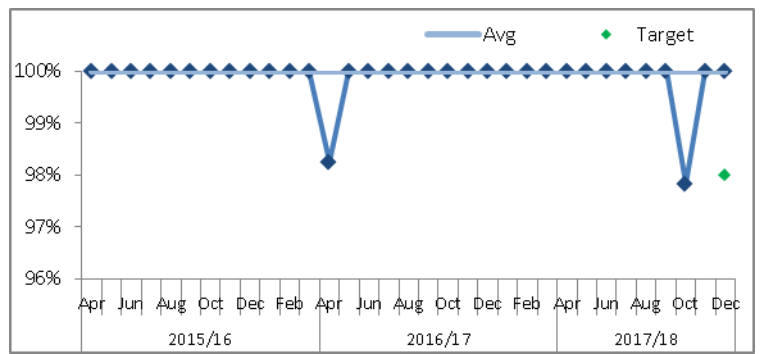
	Trend	Challenges & Successes	Comparison	Exec Lead
<div>Cancer 2 Week GP</div>	 <p>This line chart tracks the 'Cancer 2 Week GP' indicator from April 2015/16 to December 2017/18. The y-axis represents a percentage from 25% to 85%. The chart includes three data series: 'Avg' (blue line with diamond markers), 'SPC Limits' (grey horizontal line), and 'Target' (green diamond). The 'Avg' line remains stable near 85% until late 2017, where it drops sharply to approximately 30% by December 2017/18, well below the 'SPC Limits' and 'Target'.</p>	Cancer patients are carefully being managed patient-by-patient and reported through the access meetings.		Chief Operating Officer
<div>Cancer 31 Day 1st Treatment</div>	 <p>This line chart tracks the 'Cancer 31 Day 1st Treatment' indicator from April 2015/16 to December 2017/18. The y-axis represents a percentage from 92% to 100%. The chart includes three data series: 'Avg' (blue line with diamond markers), 'SPC Limits' (purple line), and 'Target' (green diamond). The 'Avg' line fluctuates significantly, mostly staying between 96% and 100%, with a notable dip to around 94% in late 2017/18. The 'SPC Limits' are set around 95.5%.</p>	Cancer patients are carefully being managed patient-by-patient and reported through the access meetings.		Chief Operating Officer
<div>Cancer 2 Week - Breast</div>	 <p>This line chart tracks the 'Cancer 2 Week - Breast' indicator from April 2015/16 to December 2017/18. The y-axis represents a percentage from 80% to 100%. The chart includes two data series: 'Avg' (blue line with diamond markers) and 'Target' (green diamond). The 'Avg' line is consistently high, near 100%, with a single dip to about 91% in late 2016/17. The 'Target' is set at 100%.</p>	Cancer patients are carefully being managed patient-by-patient and reported through the access meetings.		Chief Operating Officer

# National Indicators

## National Target Financial

Trend	Challenges & Successes	Comparison	Exec Lead
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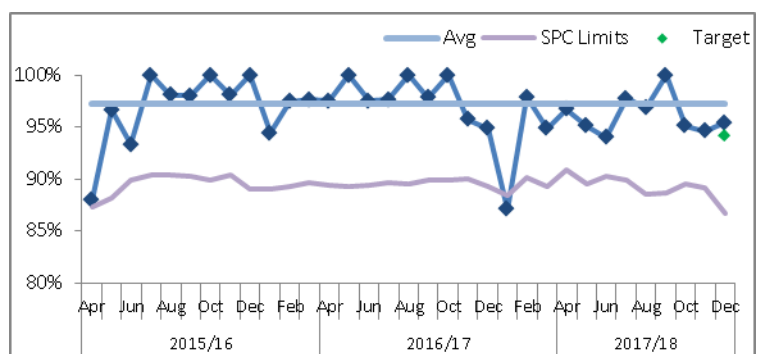
Cancer 2<sup>nd</sup> Treatment Drugs



Cancer patients are carefully being managed patient-by-patient and reported through the access meetings.

Chief Operating Officer

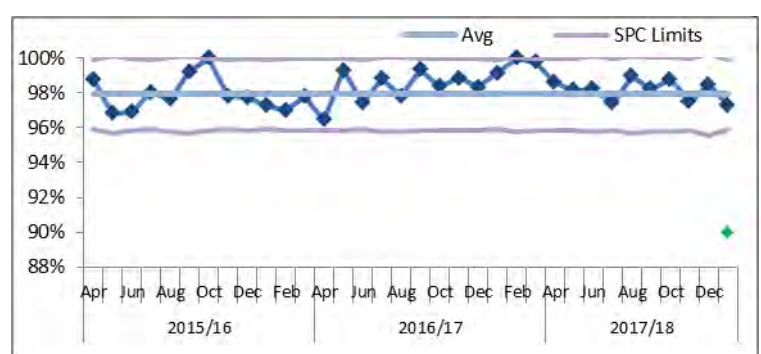
Cancer 2<sup>nd</sup> Treatment Surgery



Cancer patients are carefully being managed patient-by-patient and reported through the access meetings.

Chief Operating Officer

Seen By Midwife <13 Weeks



The target for women being seen by a midwife within the timeframe is currently being met.

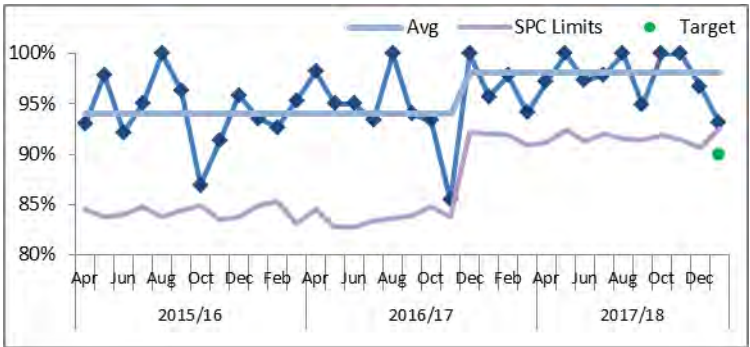
Chief Operating Officer

# National Indicators

## National Target Financial

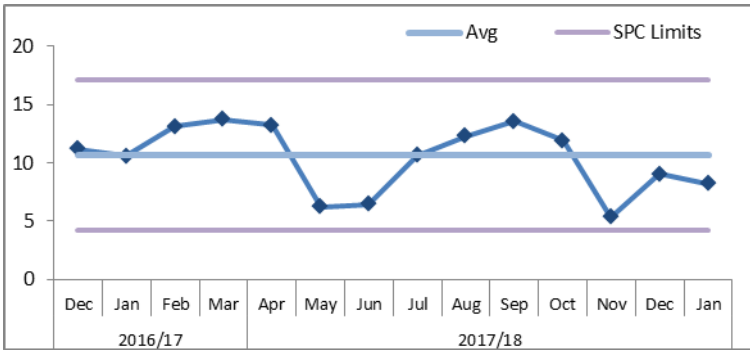
Trend	Challenges & Successes	Comparison	Exec Lead

Seen By  
Midwife > 12  
Weeks

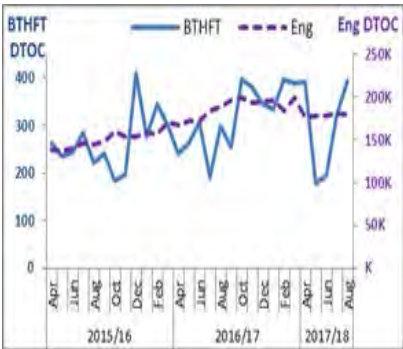


The target for women being seen by a midwife within the time frame is currently being met. Chief Operating Officer

Delayed  
Transfers of  
Care



Delayed Transfers Of Care have reduced in January and are currently below 1%.

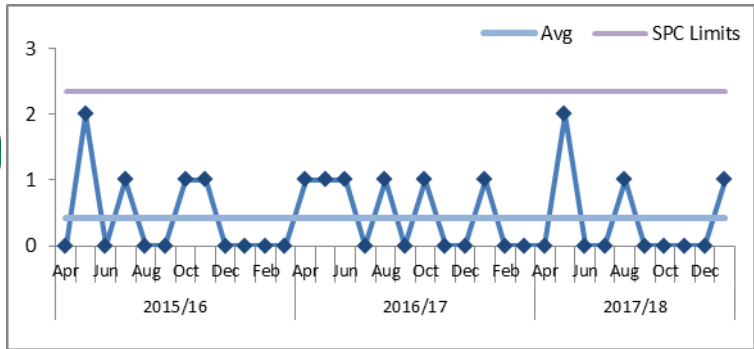


Chief Operating Officer

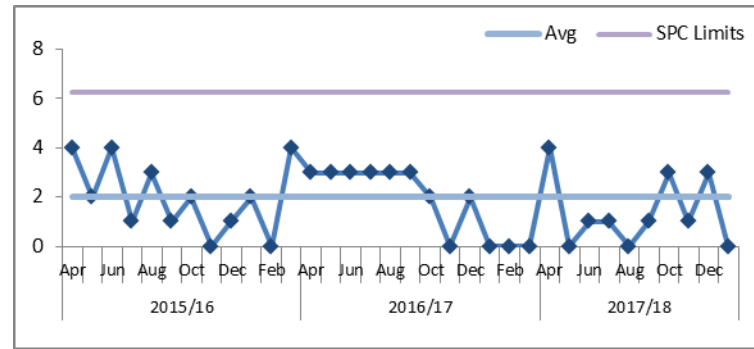
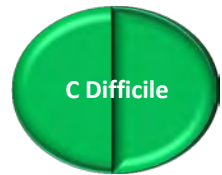
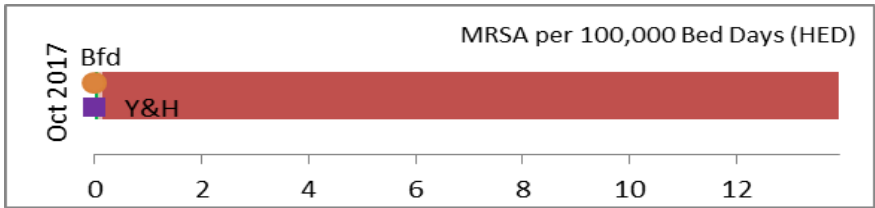
# National Indicators

## National Target Financial

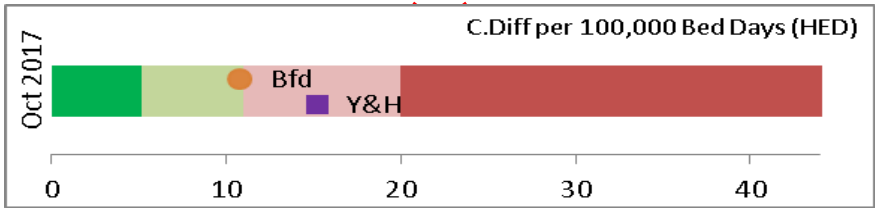
Trend	Challenges & Successes	Comparison	Exec Lead
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Ongoing challenges with consistency of MRSA/MSSA. Part of national Chief Nurse improvement collaborative for IPC. Ongoing improvements overseen by IPC.



Sustained reduction in C.difficile has been achieved. Robust PIR process. Chief Nurse



# Glossary

Indicator	Definition	Data Quality Kite-Mark	Indicator	Definition	Data Quality Kite-Mark
To provide outstanding care for our patients			Harm Free Care		
Mortality			VTE Assessment	VTE risk assessments completed	
Crude Mortality	Crude Mortality rates, i.e., per admissions.		Falls with Harm	Patient falls resulting from harm. The benchmarking data comes from the Safety Thermometer prevalence information.	
Hospital Standardised Mortality Ratio	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. HSMR is made up of 56 diagnosis groups which account for around 80% of deaths and includes only those patients who die whilst in hospital.		Catheters & UTIs	Urinary tract infections in patients with a catheter. The benchmarking data comes from the Safety Thermometer prevalence information.	
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. SHMI includes patients who die in hospital and up to 30 days following discharge.		Pressure Ulcers Cat 3+	Number of reported hospital acquired category 3 and 4 pressure ulcers. The benchmarking data comes from the Safety Thermometer prevalence information.	
Infections			Pressure Ulcers Cat 2+	Number of reported hospital acquired category 2 pressure ulcers. The benchmarking data comes from the Safety Thermometer prevalence information.	
eColi	Counts of patients with Escherichia coli (eColi).				
MSSA	Counts of patients with Meticillin Sensitive Staphylococcus aureus (MSSA) bacteraemia				
C Difficile	The number of cases either attributable or pending review.				
MRSA	Counts of patients with Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia				

# Glossary

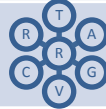





Indicator	Definition	Data Quality Kite-Mark
Patient Experience		
Complaints	Number of complaints.	
Friends and Family Test	The % of patients who Strongly Recommend the Trust.	
Night-time Transfers	The number of non-clinical bed moves out of hours	
Information Governance Breaches	The number of reported breaches of the information governance standards	
Audits		
Audit of WHO Checklist	Audit of the World Health Organisation surgical checklist monitoring the number that were complete compared to the number of checklists	
Serious incidents	Unexpected or avoidable death, serious harm, never events, service delivery prevention compared to all incidents reported	

Indicator	Definition	Data Quality Kite-Mark
Readmissions		
Readmissions from Elective	The number of non-elective readmissions within 30 days of discharge from hospital. This is from discharges originally from elective admissions.	
Readmissions from Non-Elective	The number of non-elective readmissions within 30 days of discharge from hospital. This is from discharges originally from non-elective admissions.	



# Glossary

Indicator	Definition	Data Quality Kite-Mark
To be a continually learning organisation		
Training		
Core Training	% of staff who are compliant with mandatory training requirements	
High Priority Training	% of staff who are compliant with high priority training requirements	
Progress on embedding the Learning Hub	Progress on embedding the Learning Hub in the Trust against the plan.	
Governance Mechanisms		
Out of date policies	% of policies that are currently out of and within date.	
Risks not mitigated	Risks 12 and above whose current rating is above the target (residual) rating.	
Research		
Research patients recruited	Number of patients recruited to studies against the planned recruitment.	







Indicator	Definition	Data Quality Kite-Mark
To be in the top 20% of employers in the NHS		
Appraisals		
Appraisal Rate Non-Medical	% of eligible staff employed at the trusts who have had an appraisal in the last 12 months.	
Experience		
BAME % Senior Leaders	% of staff employed in Band 8+ Senior Manger roles at the trust who are of Black, Asian or Minority Ethnic background	
BAME % Workforce	% of staff employed at the trust who are of Black, Asian or Minority Ethnic background.	
Staff FFT Treatment	% of staff recommending the trust as a place to receive care or treatment.	
Staff FFT Work	% of staff recommending the trust as a place to work.	
Sickness		
Sickness	% of time lost due to sickness in a given period (the reported month, year to date is the previous 12 months rolling average for which Trust target is 4.00%)	





# Glossary

Indicator	Definition	Data Quality Kite-Mark
Staffing Levels		
Nursing Staff Fill Rate	% of time nursing staff staffing hours filled as planned	
Care Staff Fill Rate	% of time care staff staffing hours filled as planned	
Nursing Care Hours	Total of the actual number of RN /RM hours for the month divided by the total number of patients who were an inpatient at midnight for each day of that month.	
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.	
Staff in post	Number of FTE's employed at the trust.	
Use of Agency	Use of agency workers in all areas.	
Retention		
Turnover	Number of employees who have left the organisation in the past 12 months as a % of the average number of employees over the same period	

Indicator	Definition	Data Quality Kite-Mark
To deliver our financial plan and key performance targets		
In-Patient Productivity		
Length of Stay Elective	The average length of stay for elective patients, in days. The benchmark data is for Acute trusts for June 2017 from HED, which has a subtly different calculation, which can result in very small differences in numbers.	
Length of Stay Non-Elective	The average length of stay for non-elective patients, in days. The benchmark data is for Acute trusts for June 2017 from HED, which has a subtly different calculation, which can result in very small differences in numbers.	
Bed Occupancy	Average % of available beds which were occupied overnight.	
Discharges before 1 pm	Number of discharges from hospital which happened before 1 pm.	

# Glossary

Indicator	Definition	Data Quality Kite-Mark
<b>Out-Patient Productivity</b>		
Did Not Attend Follow-Up	This is the % of Follow-up Outpatient appointments where the patient does not attend.	
Did Not Attend New	This is the % of New Outpatient appointments where the patient does not attend.	
Elective Day Case Rate	The number of patients admitted for planned procedure and leave same day as a % of all procedures.	
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.	
Short Notice Clinic Cancellations	Clinics cancelled within the 6 week timeframe.	
Elective Wait List	Wait list of patients on an elective pathway.	

Indicator	Definition	Data Quality Kite-Mark
<b>Finance</b>		
Delivery of financial plan	Delivery of finances against plan.	
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.	
Cost Improvement Plan	Cost Improvement Plan progress against target.	
Liquidity	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.	

# Glossary

Indicator	Definition	Data Quality Kite-Mark
National Indicators		
Single Oversight Framework		
Diagnostic waits	% of patients who have waited less than 6 weeks for a diagnostic test.	
User of Resources	Calculation on the status of a number of financial measures – Capital Servicing Capacity, Liquidity, I & E Margin, and Agency Spend.	
Emergency Care Standard	% patients seen in A&E within 4 hours.	
RTT 18 Week Incomplete	Percentage of patients waiting within 18 weeks on an incomplete pathway.	
Cancer Urgent 62 day Screening	Proportion of patients receiving treatment for cancer within 62 days of an NHS Cancer Screening service.	
Cancer Urgent 62 Day GP	Proportion of patients receiving treatment for cancer within 62 days of an urgent GP referral for suspected cancer.	
Non-Financial		
RTT 52 Week Wait	Number of patients waiting more than 52 weeks.	
Trolley Waits >12 hours	Trolley waits of > 12 hours.	

Indicator	Definition	Data Quality Kite-Mark
Non-Financial Cont'd..		
Ambulance Handover 30-60 mins	Ambulance handover taking longer than 30 – 60 minutes to handover.	
Ambulance Handover >60 mins	Ambulance handover taking longer than 60 minutes to handover.	
RTT # Specialties	Number of specialties not achieving RTT incomplete.	
Financial		
Never Events	The number of serious incidents that occur despite there being defined processes and procedures to prevent them.	
Stroke Strategy	Implementation of the Stroke Strategy – patients who spend at least 90% of their time on a stroke unit.	
VTE Assessments	VTE risk assessments completed.	
Duty of Candour	Patient informed duty of candour.	
Formulary published	Hospital formulary is published on the Trust’s external website.	

# Glossary

Indicator	Definition	Data Quality Kite-Mark	Indicator	Definition	Data Quality Kite-Mark
National Indicators			National Indicators		
Financial Cont'd			Financial Cont'd		
Mixed Sex Accommodation	Number of occurrences of unjustified mixing in relation to sleeping accommodation.		Cancer 2 <sup>nd</sup> Treatment Surgery	Patients that require further surgery following initial treatment should receive treatment within 31 days .	
NHS # field completion acute	Completion of valid NHS # field in acute commissioning data sets submitted via SUS		Saw Midwife < 13 wks	Percentage of women who presented before 12 weeks 6 days who have seen a midwife within 12 weeks and 6 days of pregnancy.	
NHS # field completion A&E	Completion of valid NHS # field in AED commissioning data sets submitted via SUS.		Saw Midwife > 12 wks	Percentage of women who presented after 12 weeks 6 days who have seen a midwife within 2 weeks.	
Cancelled Operations 28 Days	% of patients who have their operation cancelled on the day for non-clinical reasons		Delayed Transfers of Care per Day	Average number of patients per day who had a delayed transfer; when an adult inpatient is ready to go home or move to a less acute stage of care but is prevented from doing so.	
Cancer 2 Week GP	% patients who have waited a maximum of 2 weeks to see a specialist for all patients referred with suspected cancer symptoms		MRSA	Counts of patients with Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia.	
Cancer 1 <sup>st</sup> Treatment	Patients that have a decision to treat them surgically for a cancer diagnosis should have a date for their treatment within 31 days of the decision to treat.		C Difficile	Number of cases either attributable or pending review.	
Cancer 2 Week Breast	Proportion of patients with breast symptoms where cancer not initially suspected referred to a specialist who are seen within 2 weeks of referral.				
Cancer 2 <sup>nd</sup> Treatment Drugs	Proportion of patients waiting no more than 31 days for second or subsequent drug treatments.				

### Status

Colour-coding:

- Red = 2 or more Red Indicators from within the Domain (represented by a circle) or a Composite Indicator. For a single indicator - Off target
- Amber = 0 Red and half or more Amber Indicators from within the Domain, For a single indicator – On target, but at risk
- Green = 0 Red and less than half Amber; or All Green Composite Indicators. For a single indicator - On target

Indicator:

- Left-hand side of Indicator is Current Status
- Right-hand side of Indicator is Planned Status

### 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.

### Data Quality Kite-Mark

RAG status of assurance of the data quality of the information being presented. The DQ Kite-Mark is currently being piloted and will be updated with feedback.

Score/ Rating	Summary
1	Insufficient systems, processes or documentation are available to provide any assurance on the asset (data set). A narrative response on actions being taken to manage the asset is required.
2	Limited systems, processes and documentation are available therefore the assurance on the data set is also limited. A narrative response on actions being taken to manage the asset is required.
3	Systems, processes and documentation are available and the asset has been locally verified with assurance provided. A narrative response on actions being taken to manage the asset is not required.
4	Full systems, processes and documentation are available and the asset has been locally verified with assurance provided.
5	Full systems, processes and documentation are available and the asset has been independently verified with full assurance provided.

