| Domain | Key Performance Indicator | Rationale | Performance Bands | Method of Assessment | SOR Ref |
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| **1. Safe.** BFC/SBAA Clinical Service User are protected from abuse and avoidable harm. | 1.1 **Safeguarding**. All provider clinical and non-clinical staff must have completed Safeguarding for Children, Young People and Adults training, commensurate with their role, and maintain the competence as required. | Safeguarding of vulnerable people is underpinned by UK law and the Authority has a Statutory Duty to ensure that those delivering care are suitable trained. | **Green: >90%** of all Clinical and Non-Clinical Staff who treat BFC/SBAA Clinical Service Users have completed Safeguarding Training and have a supporting certified documentation.<br>**Amber: 75-90%** of all Clinical and Non-Clinical Staff who treat BFC/SBAA Clinical Service Users have completed Safeguarding Training and have a supporting certified documentation.<br>**Red: <75%** of all Clinical and Non-Clinical Staff who treat BFC/SBAA Clinical Service Users have completed Safeguarding Training and have a supporting certified documentation. | Evidence of training to be presented at Monthly Management and Liaison Meeting (MM&LM) and included in Quarterly and Annual Reports. The Authority reserves the right to audit the presented evidence. | Part 4, Para 4.11 |
| | **1.2 Patient Safety Incidents**. Patient Safety Incidents involving BFC/SBAA Clinical Service Users reported to the Authority no later than 15 working days after the event, outlining what measures have been taken to prevent recurrence. | Patient Safety Incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more BFC/SBAA Clinical Service Users receiving healthcare. Reporting them supports learning from mistakes and to take action to keep BFC/SBAA Clinical Service User safe. | **Green: <5%** of total monthly clinical service user episodes per month.<br>**Amber: 5-10%** of total monthly clinical service user episodes per month.<br>**Red: >10%** of total monthly clinical service user episodes per month. | Patient Safety Incidents to be reviewed at M&LM, Quarterly Management Meeting (QMM) and included in Quarterly and Annual Reports. The Authority reserves the right to audit the presented evidence. | Part 4, Para 4.10 |
| **2. Effective.** BFC/SBAA Clinical Service User care, treatment and support achieves good outcomes and is based on the best available evidence. | **2.1 Informed Consent**. Consent to be evidenced in all procedures and treatments given. | Consent to treatment means a person must give permission before they receive any type of medical treatment, test or examination. This must be done on the basis of an explanation by a clinician.The principle of consent is an important part of medical ethics and international human rights law. | **Green: >90%** of procedures and treatments given have evidence of informed consent.<br>**Amber: 75-90%** of procedures and treatments given have evidence of informed consent.<br>**Red: <75%** of procedures and treatments given have evidence of informed consent. | Quarterly audit, by the Authority, of a minimum of 20% of all BFC/SBAA Clinical Service User records. | Part 4, Para 4.14. |
| | **2.2 Communication**. All consultations are to be conducted in English. All clinical service user documentation is to be translated into English. | | **Green: >80%** of Clinical Service User documentation is typewritten and in English.<br>**Amber: 60-80%** of Clinical Service User documentation is typewritten and in English.<br>**Red: <60%** of Clinical Service User documentation is typewritten and in English. | Quarterly Audit, by the Authority, of a minimum of 20% of IP and 20% of OP clinical service user records | Part 1, Section 3, Para 3 |
| | **2.3 Discharge Documentation (routine and urgent).** Clinician to provide written discharge note to BFC/SBAA Clinical Service User on discharge from the hospital and to the referring PHC centre within 10 working days of discharge. Both documents are to be in English. | | **Green: >80%** of discharge notes, typewritten and in English, received by PHC centre within 10 working days.<br>**Amber: 60-80%** of discharge notes, typewritten and in English, received by PHC centre within 10 working days.<br>**Red: <60%** of discharge notes, typewritten and in English, received by PHC centre within 10 working days. | Quarterly Audit of all discharge notes by the Authority. | Part 3, Section 1, Para 17. |
| **3. Caring.** The service involves and treats BFC/SBAA Clinical Service User with compassion, kindness, dignity and respect. | **3.1 Clinical Service User Experience**. Appropriate comfort services have been provided (Menu selection of nutritionally and culturally appropriate meals and alternative diets, access to suitable canteen or refreshment facilities and facilities for relaxation purposes, assistance with feeding, taking medication or maintaining personal hygiene). | The NHS clinical service user Experience Framework (2012) NHS Quality Board (NQB) & Compassion in Practice (2013) emphasis the importance of the clinical service user experience as a determinant of the quality of care. | **Green:** BFC/SBAA Clinical Service User Satisfaction rates of **>75%**.<br>**Amber:** BFC/SBAA Clinical Service User Satisfaction rates of **60-75%**.<br>**Red:** BFC/SBAA Clinical Service User Satisfaction rates of **<60%**. | Provider clinical service user Feedback survey results to be reported at the QMM. The Authority reserves the right to audit the presented evidence. | Section 5 |
| | **3.2 Friends and Family Test**. The Authority will introduce an anonymised Friends and Families Test as an independent indicator that will enable BFC/SBAA Clinical Service User to indicate their satisfaction with the service | The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether BFC/SBAA Clinical Service User are happy with the service provided | **Green:** BFC/SBAA Clinical Service User Satisfaction rates of **>75%**.<br>**Amber:** BFC/SBAA Clinical Service User Satisfaction rates of **60-75%**.<br>**Red:** BFC/SBAA Clinical Service User Satisfaction rates of **<60%**. | Results to be reported by the Authority at the QMM. The Authority reserves the right to audit the presented evidence. | Part 3, Section 5, Para 8 |
| **4. Responsive.** The service meets the needs of BFC/SBAA Clinical Service User. | **4.1 Waiting Times**. The Provider(s) shall ensure maximum waiting times from point of referral to start of treatment is consistent with the UK National Health Service standard; no longer than 18 weeks for non-urgent, consultant-led treatments. | | **Green: >80%** of waiting times from referral to start of treatment are consistent with the UK National Health Service Standard.<br>**Amber: 60-80%** of waiting times from referral to start of treatment are consistent with the UK National Health Service Standard.<br>**Red: <60%** of waiting times from referral to start of treatment are consistent with the UK National Health Service Standard. | Evidence to be presented by the Provider at the M&LM and QMM. Quarterly audit of a minimum of 20% of all BFC/SBAA Clinical Service User records by the Authority. | Part 3, Section 1, Para 38 |
| | **4.2 Complaints**. The Provider is responsible for ensuring that a full and written response is made to the complainant within 28 working days of receipt of the complaint. | Effective complaints management is part of the commitment of the Authority to provide the best possible service to BFC/SBAA Clinical Service User. | **Green: >90%** of complaints receive a full and written response within 28 working days of receipt.<br>**Amber: 75-90%** of complaints receive a full and written response within 28 working days of receipt.<br>**Red: <75%** of complaints receive a full and written response within 28 working days of receipt. | Evidence from Provider Complaints Database to be presented at QMM and to be included in Quarterly and Annual Reports as part of the KPI report. The Authority reserves the right to audit the presented evidence. | Part 4, Para 4.11 |
| | **4.4 Complaints**. A measure of the percentage of BFC/SBAA Clinical Service User registering a complaint against all services provided by the YPC, from the overall number of BFC/SBAA | Complaints will provide an indication of the quality of healthcare provision, the clinical environment and the behaviour of medical staff. | **Green: <5%** of total monthly clinical service user episodes per month.<br>**Amber: 5-10%** of total monthly clinical service user episodes per month. | Evidence from Authority Complaints Database to be discussed at M&LM and presented at QMM | Part 4, Para 4.11 |

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| | Clinical Service User. | | **Red: >10%** of total monthly clinical service user episodes per month. | presented at QMM. | |

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| **5. Well-led**. The Providers leadership, management and governance assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture. | **5.1 Clinical Audit**. The Provider is required to ensure that regular clinical audits, including Authority agreed surveys, are undertaken. | Clinical Audit forms the system for improving standards of clinical practice. Aspects of clinical service user care are evaluated against expected standards of care and where necessary, changes are made at an individual, team or service level. A re-audit can then be used to confirm that improvements have been effective. | **Green: >15** Clinical Audits across all services completed quarterly.<br>**Amber: 10-15** Clinical Audits across all services completed quarterly.<br>**Red: <10** Clinical Audits across all services completed quarterly. | Inclusion of clinical audit programme/outcomes to be presented at QMM and in Quarterly and Annual Reports. The Authority reserves the right to audit the presented evidence. | Part 4, Para 4.5 |
| | **5.2 Training**. All clinical and nursing staff responsible for the care of BFC/SBAA Clinical Service User are to maintain the standards of training and proficiency. | Continuing professional development ensures continuous growth in clinical practice and facilitates optimal quality clinical service user care. | **Green: >80%** of all Clinical Staff who treat BFC/SBAA Clinical Service User have completed CPD within the preceding quarter.<br>**Amber: 60-80%** of all Clinical Staff who treat BFC/SBAA Clinical Service User have completed CPD within the preceding quarter.<br>**Red: <60%** of all Clinical Staff who treat BFC/SBAA Clinical Service User have completed CPD within the preceding quarter. | Inclusion of training programme/delivery in Quarterly and Annual Reports. The Authority reserves the right to audit the presented evidence. | Part 3, Section 4, Para 3.4.8 |
| | **5.3 Reporting**. Quarterly and Annual Reports to be submitted within the described timelines and containing the correct data. | | **Green: >90%** of Quarterly and Annual Reports are submitted within the described timelines and contain the correct data.<br>**Amber: 75-90%** of Quarterly and Annual Reports are submitted within the described timelines and contain the correct data.<br>**Red: <75%** of Quarterly and Annual Reports are submitted within the described timelines and contain the correct data. | Reports received by the Authority within prescribed timelines. The Authority reserves the right to audit the presented evidence. | Part 2, Annex C |
| | **5.4 Caseload Timeliness**. Caseload lists for the preceding month are to be with the Authority by the 10th working day of the following month | Payment cannot be made by the Authority if documentation is not submitted in a timely manner. | **Green: >90%** of Caseload Lists are submitted by the 10th working day after the preceding month.<br>**Amber: 75-90%** of Caseload Lists are submitted by the 10th working day after the preceding month.<br>**Red: <75%** of Caseload Lists are submitted by the 10th working day after the preceding month. | Caseload lists received by the Authority within the prescribed timelines. | Part 2, Section 4, Para 2.4.5 |
| | **5.5 Caseload Accuracy**. Accurate caseload lists must be presented to the Authority. | Payment cannot be made by the Authority if inaccurate documentation is submitted. | **Green:** Accuracy of Caseload list is **>90%.**<br>**Amber:** Accuracy of Caseload list is **75-90%.**<br>**Red:** Accuracy of Caseload list is **<75%**. | Percentage of payment witheld due to inaccuracies. | Part 2, Section 4, Para 2.4.4 |