Monitoring Self-Certification

NHS London

Provider Agency

1. Declarations and self-certification

The Board of Directors is required to confirm that:	
SERVICES PROVIDED STATEMENTS	**Tick**
No disputes with commissioners have arisen that could have a material effect on the trust's finances.	☒
QUALITY AND SAFETY STATEMENTS	**Tick**
The Board is satisfied that all relevant national core standards and targets have been met, with the exception of the planned reduction in MRSA bacteraemias (see narrative), and that plans are in place to ensure ongoing compliance with existing national core standards and targets and a commitment to comply with all targets due to come into force within the following 12 months *[see table in section 2]*	☒
Signed on behalf of the Board of Directors	
Chief Executive and Accounting Officer	**Chairman**
David Sloman 	Joe Liddane 
Trust name The whittington Hospital NHS Trust	

2. Healthcare standards and targets

The Board must confirm it is satisfied that all relevant national core standards and targets can be validated as being met, and that plans are in place to ensure that all relevant national core standards and targets can be met going forwards, including all national core standards and targets due to come into force within the following 12 months.

The table below shows the current relevant targets.

Targets-weighted 1.0 (national requirements)	Threshold	Monitoring period	Relevant trusts*
Clostridium difficile –meeting the agreed trajectory	0	Year-to-date and quarterly	Acute
MRSA – meeting the agreed trajectory [1]	0	Year-to-date and quarterly	Acute
Maximum waiting time of 31 days from decision to treat (with subsequent treatments) to start of treatment extended to cover all cancer treatments [2]	To be confirmed	To be achieved from end December 08 and monitored quarterly thereafter	Acute
Maximum waiting time of 62 days from all referrals to treatment for all cancers [3]	To be confirmed	To be achieved from end December 08 and monitored quarterly thereafter	Acute
Maximum waiting time of 6 months for inpatients	99.97%	Monthly	Acute
Maximum waiting time of 13 weeks for outpatients	99.97%	Monthly	Acute
18-week maximum wait by 2008 [4] -admitted patients	90%	Up to December 08 :- Monitored against agreed trajectory up to target with tolerance of 1% below trajectory provided no lower than 85% After December 08:- monitored each month against target	Acute & Mental Health (as appropriate)
18-week maximum wait by 2008 [4] -non- admitted patients	95%	Up to December 08 :- Monitored against agreed trajectory up to target with tolerance of 1% below trajectory provided no lower than 90% After December 08:- monitored each month against target	Acute & Mental Health (as appropriate)
Targets-weighted 0.5	**Threshold**	**Monitoring period**	**Relevant trusts***
Respond to 75% of category A calls within 8 minutes (call connect)	75%	Monthly	Ambulance
Respond to 95% of category A calls within 19 minutes (call connect)	95%	Monthly	Ambulance

Respond to 95% of category B calls within 19 minutes (call connect)	95%	Monthly	Ambulance
Targets-weighted 0.5	**Threshold**	**Monitoring period**	**Relevant trusts***
Minimise the number of operations cancelled for non-clinical reasons on the day of admission or after (last minute cancellations). All such patients to be offered another binding date within 28 days.	No more than 0.8% cancellations; No more than 5% breaches of 28 day standard	Quarterly	Acute
Maximum waiting time of 31 days from diagnosis to treatment for all cancers [5]	98%	Quarterly	Acute
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	98%	Year-to-date and quarterly	Acute
Maximum waiting time of 62 days from urgent referral to treatment for all cancers [6]	95%	Quarterly	Acute
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	98%	Quarterly	Acute
Minimising delayed transfers of care by 2008	No more than 3.5%	Quarterly	Acute
Maximum waiting time of 3 months for revascularisation	99.9%	Quarterly	Acute
Maximum waiting time of 2 weeks for rapid access chest pain clinics	98%	Quarterly	Acute
Sexual health – 48-hour access to GUM clinics by March 2008	98%	Monthly	Acute
Mental Health targets-weighted 1.0	**Threshold**	**Monitoring period**	**Relevant trusts***
100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital [7]	95%	Quarterly	Mental Health
Minimising delayed transfers of care [8]	No more than 7.5%	Quarterly	Mental Health
Admissions to inpatient services had access to crisis resolution home treatment teams [9]	90%	To be achieved from end December 2008 and monitored quarterly thereafter	Mental Health
Maintain level of crisis resolution teams set in 03/06 planning round (or subsequently contracted with PCT)	-	Quarterly	Mental Health
National core standards-weighted 0.4	**Threshold**	**Monitoring period**	**Relevant trusts***
Each national core standard which either the trust or Healthcare Commission has assessed as not met or having insufficient assurance	-	Quarterly	All

Notes

* Only a subset of targets may apply in specialist trusts.

[1] Where trusts have less than 12 cases in a year, this target will not apply as long as there is no increase in the actual number of cases reported compared to the prior year.

[2] This extended target relates to surgery and chemotherapy only in 2008/09 (for subsequent treatments). By the end of 2010 this target will cover radiotherapy for subsequent treatments. This target differs from the existing 31 day and 62 day cancer targets as it covers subsequent treatments and the existing commitments cover time to first treatment. Specialist cancer trusts treating one tumour type may be subject to a specific threshold based on tumour type's clinical exception rate.

[3] This target will replace the 62 day cancer target (weighted 0.5) from 1 January 2009.This target extends the existing 62 day cancer target to cover all referrals including screening services and consultant referrals. It is intended that measurement of performance against this target will take account of the re-allocation of late shared breaches (subject to these being completed in line with the agreed Healthcare Commission ratification process and there being written evidence that both Chief Executives, from referrer and recipient, approve the re-allocation). Specialist cancer trusts treating one tumour type may be subject to a specific threshold based on tumour type's clinical exception rate.

[4] *The Operating Framework for 2007/08* introduced key milestones to be achieved as a minimum by all providers by the end of March 2008 as follows: 85% of pathways where patients are admitted for hospital treatment should be completed within 18 weeks; 90% of pathways that do not end in admission should be completed within 18 weeks. Trusts will be assessed against data completeness measures and those trusts that do not achieve the minimum standards will be classed as not achieving the 18 week target.

[5] This target differs from the new 31 day cancer target as it covers first treatments. Specialist cancer trusts treating one or more tumour types may be subject to a specific threshold based on those tumours clinical exception rates.

[6] This target will be replaced by the new 62 day cancer target from 1 January 2009. Measurement of performance against this target will take account of the re-allocation of late shared breaches (subject to these being completed in line with the agreed Healthcare Commission ratification process and there being written evidence that both Chief Executives, from referrer and recipient, approve the re-allocation). Specialist cancer trusts treating one tumour type may be subject to a specific threshold based on tumour type's clinical exception rate.

[7] Follow up contact can include face to face or telephone contact. Guidance on what should and should not be counted when calculating the achievement of this target can be found on Unify2 and STEIS.

[8] The definition of delayed discharge is set out in the National Institute for Mental Health in England (NIMHE) guidance http://www.nimhe.csip.org.uk/silo/files/delayed-transfers-final-guidance-1doc.doc.

[9] This target applies to all admissions of working age adults, excluding transfers and Psychiatric Intensive Care Unit (PICU). As set out in the Guidance Statement on Fidelity and Best Practice for Crisis Services the crisis resolution home treatment team should:
1. provide a mobile 24 hour, seven days a week response to requests for assessments;
2. be actively involved in all requests for admission. For the avoidance of doubt, actively involved requires face to face contact unless it can be demonstrated that face to face contact was not appropriate or possible. For each case where face to face contact is deemed inappropriate, a self-declaration that the face to face contact was not the most appropriate action from a clinical perspective will be required;
3. be notified of all pending mental health act assessments;
4. be assessing all these cases before admission happens; and
5. be central to the decision making process in conjunction with the rest of the multidisciplinary team.

This target will first be measured for the purposes of the Provider Agency in the Q4 2008/09 review (i.e. from January 2009) although we will wish to collect information on performance against this target in Q3 2008/09 to assess likely future compliance (and the need for action plans).