SELF-CERTIFICATION RETURNS
Organisation Name:
The Whittington Hospital
Monitoring Period:
November 2012
NHS Trust Over-sight self certification template

Return to: som@London.nhs.uk by 17th January at NOON

NHS Trust Governance Declarations : 2012/13 In-Year Reporting

Name of Organisation:	The Whittington Hospital	Period:	November 2012

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance, in addition to providing comment with regard to any contractual issues and compliance with CQC essential standards:

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per SOM guidance)	G
Normalised YTD Financial Risk Rating (Assign number as per SOM guidance)	3

*** Please type in R, AR, AG or G and assign a number for the FRR**

Governance Declarations

Declaration 1 or declaration 2 reflects whether the Board believes the Trust is currently performing at a level compatible with FT authorisation.

Supporting detail is required where compliance cannot be confirmed.

Please complete sign **one** of the two declarations below. If you sign declaration 2, provide supporting detail using the form below. Signature may be either hand written or electronic, you are required to print your name.

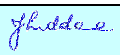
Governance declaration 1

The Board is sufficiently assured in its ability to declare conformity with **all** of the Clinical Quality, Finance and Governance elements of the Board Statements.

Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		
Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		

Governance declaration 2

At the current time, the board is yet to gain sufficient assurance to declare conformity with all of the Clinical Quality, Finance and Governance elements of the Board Statements.

Signed by :		Print Name :	Joe Liddane
on behalf of the Trust Board	Acting in capacity as:	Chairman	
Signed by :		Print Name :	Dr YiMien Koh
on behalf of the Trust Board	Acting in capacity as:	Chief Executive	

If Declaration 2 has been signed:

For each target/standard, where the board is declaring insufficient assurance please state the reason for being unable to sign the declaration, and explain briefly what steps are being taken to resolve the issue. Please provide an appropriate level of detail.

Target/Standard:	**12. Achieved a minimum of Level 2 of the IG Toolkit.**
The Issue :	**All level 2 CfH IG standards will be achieved by March 2013**
Action :	**Actions being taken to meet IGT level 2:**

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Board Statements

The Whittington Hospital

November 2012

For each statement, the Board is asked to confirm the following:

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SOM's Oversight Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	Yes
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	Yes
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes
	For FINANCE, that:	**Response**
4	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.	Yes
5	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	Yes
	For GOVERNANCE, that:	**Response**
6	The board will ensure that the trust at all times has regard to the NHS Constitution.	Yes
7	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner	Yes
8	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of occurrence and the plans for mitigation of these risks.	Yes
9	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Yes
10	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	Yes
11	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the Governance Risk Rating; and a commitment to comply with all commissioned targets going forward.	Yes
12	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	No
13	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies, and that any elections to the shadow board of governors are held in accordance with the election rules.	Yes
14	The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Yes
15	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual plan; and the management structure in place is adequate to deliver the annual plan.	Yes

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO		**Dr YiMien Koh**	
Chair		**Joe Liddane**	

QUALITY

Information to inform the discussion meeting

The Whittington Hospital

Insert Performance in Month

Refresh Data for new Month

	Criteria	Unit	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Board Action
1	SHMI - latest data	Score	-	0.7	-	-	0.7	-	-	0.7	-	-	0.7	-	
2	Venous Thromboembolism (VTE) Screening	%	91.16	91.3	91.27	91.36	95.37	95.12	96.71	95.31	95.6	95.8	95.1	97.1	
3a	Elective MRSA Screening	%	88.4	89.3	85	87.2	77.4	81.8	80.5	80.1	76.7	96.8	93.0	96.6	
3b	Non Elective MRSA Screening	%	90.8	91.9	91	93	92.4	84	82.4	79.9	84.8	94.06	94.5	93.4	
4	Single Sex Accommodation Breaches	Number	0	0	0	0	0	0	1	7	0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	10	10	6	19	6	11	16	16	8	12	17	5	
6	"Never Events" occurring in month	Number	0	0	1	0	0	2	0	0	0	0	1	0	
7	CQC Conditions or Warning Notices	Number	0	0	0	0	0	0	0	0	0	0	0	0	
8	Open Central Alert System (CAS) Alerts	Number	0	0	0	0	0	0	0	0	0	0	0	0	
9	RED rated areas on your maternity dashboard?	Number	0	1	1	1	1	1	1	0	1	0	1	1	
10	Falls resulting in severe injury or death	Number	0	0	2	1	1	0	0	1	0	0	0	0	
11	Grade 3 or 4 pressure ulcers	Number	0/2	0/9	4/3	1/5	1/5	2/4	0/7	1/8	1/4	1/3	2/6	0/4	Acute/community
12	100% compliance with WHO surgical checklist	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
13	Formal complaints received	Number	31	33	41	50	49	62	37	59	49	41	48	38	
14	Agency as a % of Employee Benefit Expenditure	%	4.92	3.65	5.69	7.11	5.46	6.65	5.07	5.77	6.23	4.45	6.35	5	
15	Sickness absence rate	%	3.3	3.1	2.9	2.9	2.8	3.2	2.9	2.7	2.8	3.1	2.8	3.5	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%	-	-	-	-	-	-	-	94	-	-	-	-	NB: Annual appraisals are conducted in the Sept to Nov period each year. The reported figure relates to the % of Consultants who had a PDP when appraised. The next figure will be available in Feb 2013 following the Sept to Nov 2012 appraisal period. The Trust has in place a process for escalation to the Responsible Officer (Medical Director) where any incompletion of a PDP gives cause for concern. No escalations were made for this reason for the 2010-2011 appraisal period.

FINANCIAL RISK RATING

The Whittington Hospital

								Insert the Score (1-5) Achieved for each Criteria Per Month				
			Risk Ratings					Reported Position		Normalised Position*		
Criteria	Indicator	Weight	5	4	3	2	1	Year to Date	Forecast Outturn	Year to Date	Forecast Outturn	Board Action
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	3	3	3	3	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	5	5	3	5	
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	4	4	3	4	
	I&E surplus margin %	20%	3	2	1	-2	<-2	3	3	2	3	CIP run rate improving and the forecas to meet target
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	2	2	2	2	Within the reported position the liquidit is extremly close to the requirement of achieve a risk rating of 3, this includes Working Capital Facility. In terms of th normalised position we anticipate the p improve in month 9.
Weighted Average		**100%**						**3.2**	**3.2**	**2.6**	**3.2**	
Overriding rules								3	3	3	3	
Overall rating								**3**	**3**	**3**	**3**	

Overriding Rules :

Max Rating	Rule					
3	Plan not submitted on time	No				
3	Plan not submitted complete and correct	No				
2	PDC dividend not paid in full	No				
2	Unplanned breach of the PBC	No				
2	One Financial Criterion at "1"					
3	One Financial Criterion at "2"		3	3	3	3
1	Two Financial Criteria at "1"					
2	Two Financial Criteria at "2"					

* Trust should detail the normalising adjustments made to calculate this rating within the comments box.

FINANCIAL RISK TRIGGERS

The Whittington Hospital

Insert "Yes" / "No" Assessment for the Month

Refresh Triggers for New Quarter

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Mar-12	Qtr to Jun-12	Qtr to Sep-12	Oct-12	Nov-12	Dec-12	Qtr to Dec-12	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	No	No	No			
2	Quarterly self-certification by trust that the normalised financial risk rating (FRR) may be less than 3 in the next 12 months	No	No	No	No	No			
3	Working capital facility (WCF) agreement includes default clause	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
4	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes	Yes			The most significant element which contributes towards ths level of outstanding debt over 90 days relates to NHS Islington and NHS Haringey, which reflects ongoing issues which the Trust have had over the last 12-18 months. While no formal disputes have been raised for any of the invoices, securing payment for outstanding debts continues to require significant effort.
5	Creditors > 90 days past due account for more than 5% of total creditor balances	Yes	Yes	Yes	Yes	Yes			The deterioration in performance in respect of NHS payables relates to pass through payments payable to NCL which are currently on hold. Payments are currently being withheld because of the level of outstanding debts owed by NCL to the Trust, and to maintain some equilibrium in terms of cash balances.
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No			
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No			
8	Quarter end cash balance <10 days of operating expenses	No	No	No	No	No			
9	Capital expenditure < 75% of plan for the year to date	No	Yes	Yes	No	No			
10	Yet to identify two years of detailed CIP schemes				No	No			

GOVERNANCE RISK RATINGS

The Whittington Hospital

Insert YES, NO or N/A (as appropriate)

Refresh GRR for New Quarter

See 'Notes' for further detail of each of the below indicators

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Mar-12	Historic Data: Qtr to Jun-12	Historic Data: Qtr to Sep-12	Current Data: Oct-12	Current Data: Nov-12	Current Data: Dec-12	Current Data: Qtr to Dec-12	Board Action
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	Yes	Yes	Yes	Yes	Yes			
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		Yes	Yes	Yes	Yes	Yes			
			Patients dying at home / care home	50%		Yes	Yes	Yes	Yes	Yes			
	1c	Data completeness: identifiers MHMDS		97%	0.5	Yes	Yes	Yes	Yes	Yes			
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a			
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes	Yes			
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes	Yes			
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	Yes	Yes	Yes	Yes	Yes			
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes	Yes	Yes			
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0			Yes	Yes	Yes			
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	No	Yes	No	Yes			
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes			
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	No	No	No			1st OP: Range of action agreed incl. sufficient grading of referrals to identify priority appointments and action to ensure patients are encouraged to attend within 2 weeks. Breast 14 day: - Focus of action is on encouraging patients to attend within 14 days.
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	Yes	No	Yes	Yes	Yes			
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a	N/a			
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a			
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a	N/a			
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a	N/a			
	3j	Category A call –emergency response within 8 minutes	Red 1	80%	0.5	N/a	N/a	N/a	N/a	N/a			
			Red 2	75%	0.5	N/a	N/a	N/a	N/a	N/a			
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a			
Safety	4a	Clostridium Difficile	Is the Trust below the de minimus	*12*	1.0		Yes	Yes	Yes	Yes			
			Is the Trust below the YTD ceiling	*21*		No	Yes	Yes	Yes	Yes			
	4b	MRSA	Is the Trust below the de minimus	*6*	1.0		Yes	Yes	Yes	Yes			
			Is the Trust below the YTD ceiling	*1*		Yes	Yes	Yes	Yes	Yes			
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No	No			
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No	No			
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No	No	No	No			

GOVERNANCE RISK RATINGS

See 'Notes' for further detail of each of the below indicators

The Whittington Hospital

Insert YES, NO or N/A (as appropriate)

Refresh GRR for New Quarter

Historic Data			Current Data			
0.0	2.0	0.5	1.5	0.5	0.0	0.0
G	AR	G	AG	G	G	G

TOTAL

RAG RATING :

GREEN	= Score less than 1
AMBER/GREEN	= Score greater than or equal to 1, but less than 2
AMBER / RED	= Score greater than or equal to 2, but less than 4
RED	= Score greater than or equal to 4

GOVERNANCE RISK RATINGS

See 'Notes' for further detail of each of the below indicators

The Whittington Hospital

Insert YES, NO or N/A (as appropriate)

Refresh GRR for New Quarter

			Historic Data			Current Data				
Overriding Rules - Nature and Duration of Override at SHA's Discretion										
i)	Meeting the MRSA Objective	Greater than six cases in the year to date, and breaches the cumulative year-to-date trajectory for three successive quarters	No	No	No	No	No			
ii)	Meeting the C-Diff Objective	Greater than 12 cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency.	No	No	No	No	No			
iii)	RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter The non-admitted patients 18 weeks waiting time measure for a third successive quarter The incomplete pathway 18 weeks waiting time measure for a third successive quarter	No	No	No	No	No			
iv)	A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.	No	No	No	No	No			
v)	Cancer Wait Times	Breaches either: the 31-day cancer waiting time target for a third successive quarter the 62-day cancer waiting time target for a third successive quarter	No	No	No	No	No			
vi)	Ambulance Response Times	Breaches either: the category A 8-minute response time target for a third successive quarter the category A 19-minute response time target for a third successive quarter either Red 1 or Red 2 targets for a third successive quarter	N/a	N/a	N/a	N/a	N/a			
vii)	Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter	No	No	No	No	No			
viii)	Any other Indicator weighted 1.0	Breaches the indicator for three successive quarters.	No	No	No	No	No			
		Adjusted Governance Risk Rating	**0.0**	**2.0**	**0.5**	**1.5**	**0.5**	**0.0**	**0.0**	
			G	AR	G	AG	G	G	G	

CONTRACTUAL DATA

The Whittington Hospital

Information to inform the discussion meeting

Insert "Yes" / "No" Assessment for the Month

Refresh Data for new Quarter

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Mar-12	Qtr to Jun-12	Qtr to Sep-12	Oct-12	Nov-12	Dec-12	Qtr to Dec-12	
1	Are the prior year contracts* closed?	Yes	Yes	Yes	Yes	Yes			
2	Are all current year contracts* agreed and signed?	Yes	No	Yes	Yes	Yes			
3	Has the Trust received income support outside of the NHS standard contract e.g. transformational support?				No	No			
4	Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	No	Yes	Yes	Yes			
5	Are there any disputes over the terms of the contract?	No	No	No	No	No			
6	Might the dispute require third party intervention or arbitration?	No	N/a	N/a	N/a	N/a			
7	Are the parties already in arbitration?	No	N/a	N/a	N/a	N/a			
8	Have any performance notices been issued?	No	Yes	No	No	No			
9	Have any penalties been applied?	No	No	No	No	No			

*All contracts which represent more than 25% of the Trust's operating revenue.

TFA Progress

Jan-13

The Whittington Hospital

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Due or Delivered Milestones	Future Milestones	Board Action
1	TFA Agree new ICO payment mechanisms that might be reflected in 2012/13 contract	Dec-11	Fully achieved but late		The LTFM is now constructed and the Board received first draft assumptions in January. The IBP is partially complete with the remaining parts to be ready by the end of February as HDD 1 will start and finish in
2	TFA First draft Foundation Trust Integrated Business Plan (IBP) and Long Term Financial Model (LTFM) approved by ICO Trust Board & submitted to NHS London	Jan-12	Fully achieved but late		The LTFM is now constructed and the Board received first draft assumptions in January. The IBP is partially complete with the remaining parts to be ready by the end of February as HDD 1 will start and finish in
3	TFA Public consultation finishes	Jan-12	Fully achieved in time		
4	TFA Draft LTFM	Feb-12	Fully achieved but late		Revised date of w/c 26th March 2012
5	TFA Progress update on agreement of new ICO payment mechanisms that might be reflected in 2012/13 contract (	Feb-12	Fully achieved in time		
6	TFA ICO Historic Due Diligence part one undertaken	Mar-11	Fully achieved but late		Not started because Monitor have not allocated a firm of accountants. Delayed to April 2012
7	TFA Revised IBP to SHA	Mar-11	Fully achieved in time		
8	TFA Return of signed Accountability Agreement	Mar-11	Fully achieved in time		
9	TFA BGAF - Self Assessment	Mar-11	Fully achieved in time		
10	TFA Board Development and Performance Monitoring Programme	Mar-11	Fully achieved in time		
11	TFA Start of Safety & Quality gateway review start	Mar-11	Fully achieved in time		
12	TFA BGAF - action plans	Apr-12	Fully achieved in time		
13	TFA Working Capital - Self Assessment/action plans	Apr-12	Fully achieved but late		Self assessment completed in May 2012. Action plans being revised to reflect revised working capital assessment following new implied efficiency requirements.
14	TFA Monitor Quality Governance Framework independent assessment and action plans	May-12	Fully achieved in time		
15	TFA Formal submission of IBP and LTFM including enabling strategies	Jun-12	Fully achieved in time		
16	AA Trust BGAF action plan and Trust Quality Governance action plan updated post independent review and approved by Trust Board	Jun-12	Fully achieved but late		MQGF action plan and actions required post SHA Quality Gateway to be amalgamated and presented to the Trust Board in Sept 2012.
17	AA Constitution - legal opinion obtained and approved by Trust Board	Jun-12	Fully achieved in time		
18	TFA HDD1	Jul-12	Fully achieved but late		Deloittes are undertaking HDD1 and are due to complete by mid June. HDD1 report will be presented to June TB.
19	AA Revised LTFM received by SHA	Aug-12	Fully achieved in time		
20	AA SHA Interview with commissioners	Sep-12	Not fully achieved		SHA advised that this will be actioned by them at an appropriate point
21	AA SHA - Board interviews/Audit Committee observation /Trust Board Observation	Sep-12	Fully achieved in time		
22	AA Monitor Board self certification assessment and action plans	Sep-12	Fully achieved in time		
23	AA SHA Quality & Safety Gateway Review completed/Observation of Finance & Development committee	Oct-12	Fully achieved in time		
24	AA SHA Readiness review meeting (Gateway 2)	Oct-12	Fully achieved in time		
25	TFA NHSL agrees to commencement of ICO Historic Due Diligence part two/HDD2 action plans	Oct-12	Fully achieved in time		HDD2 commenced 22 Oct. Report due 21st Nov 2012 HDD2 action plans to follow
26	TFA IBP/LTFM updated for SHA B2B (SHA Gateway 3)	Oct-12	Not fully achieved		On 16 November 2012 the Trust took the decision to delay its FT application and agreed a revised SHA B2B date of 21/02/2013 with NHSL
27	TFA CIPs/Downside & Mitigations/Commissioner convergence letter	Oct-12	Not fully achieved		On 16 November 2012 the Trust took the decision to delay its FT application and agreed a revised SHA B2B date of 21/02/2013 with NHSL
28	AA SHA Interview with commissioners/Interview with lead HDD reviewer/Gain view of CQC.	Oct-12	Not fully achieved		On 16 November 2012 the Trust took the decision to delay its FT application and agreed a revised SHA B2B date of 21/02/2013 with NHSL
29	TFA Trust Agree Working Capital Facility	Nov-12	Not fully achieved		On 16 November 2012 the Trust took the decision to delay its FT application and agreed a revised SHA B2B date of 21/02/2013 with NHSL
30	TFA Successful SHA Board to Board (Gateway 4)	Nov-12	Not fully achieved		On 16 November 2012 the Trust took the decision to delay its FT application and agreed a revised SHA B2B date of 21/02/2013 with NHSL
31	TFA SHA CMG/CIC (SHA Gateway 5)	Dec-12	Not fully achieved		On 16 November 2012 the Trust took the decision to delay its FT application and agreed a revised SHA B2B date of 21/02/2013 with NHSL
32	Submission to DH, including SHA NHSFT Applicant Support form.	01/01/2013	Not fully achieved		On 16 November 2012 the Trust took the decision to delay its FT application and agreed a revised SHA B2B date of 21/02/2013 with NHSL and DH submission is due 28 March 2013
33					
34					
35					
36					
37					
38					
39					
40					

Notes

Ref	Indicator	Details
Thresholds	The SHA will not utilise a general rounding principle when considering compliance with these targets and standards, e.g. a performance of 94.5% will be considered as failing to achieve a 95% target. However, exceptional cases may be considered on an individual basis, taking into account issues such as low activity or thresholds that have little or no tolerance against the target, e.g. those set between 99-100%.	
1a	Data Completeness: Community Services	Data completeness levels for trusts commissioned to provide community services, using Community Information Data Set (CIDS) definitions, to consist of: - Referral to treatment times – consultant-led treatment in hospitals and Allied Healthcare Professional-led treatments in the community; - Community treatment activity – referrals; and - Community treatment activity – care contact activity. While failure against any threshold will score 1.0, the overall impact will be capped at 1.0. Failure of the same measure for three quarters will result in a red-rating. **Numerator:** all data in the denominator actually captured by the trust electronically (not solely CIDS-specified systems). **Denominator:** all activity data required by CIDS.
1b	Data Completeness Community Services (further data):	The inclusion of this data collection in addition to Monitor's indicators (until the Compliance Framework is changed) is in order for the SHA to track the Trust's action plan to produce such data. This data excludes a weighting, and therefore does not currently impact on the Trust's governance risk rating.
1c	Mental Health MDS	Patient identity data completeness metrics (from MHMDS) to consist of: - NHS number; - Date of birth; - Postcode (normal residence); - Current gender; - Registered General Medical Practice organisation code; and - Commissioner organisation code. **Numerator:** count of valid entries for each data item above. (For details of how data items are classified as VALID please refer to the data quality constructions available on the Information Centre's website: www.ic.nhs.uk/services/mhmds/dq) **Denominator:** total number of entries
1d	Mental Health: CPA	**Outcomes for patients on Care Programme Approach:** • Employment status: **Numerator:** the number of adults in the denominator whose employment status is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting, in a financial year. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Accommodation status: **Numerator:** the number of adults in the denominator whose accommodation status (i.e. settled or non-settled accommodation) is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the re • Having a Health of the Nation Outcome Scales (HoNOS) assessment in the past 12 months: **Numerator:** The number of adults in the denominator who have had at least one HoNOS assessment in the past 12 months. **Denominator:** The total number of adults who have received secondary mental health services and who were on the CPA during the reference period.
2a-c	RTT	Performance is measured on an aggregate (rather than specialty) basis and trusts are required to meet the threshold on a monthly basis. Consequently, any failure in one month is considered to be a quarterly failure. Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process. Will apply to consultant-led admitted, non-admitted and incomplete pathways provided. While failure against any threshold will score 1.0, the overall impact will be capped at 2.0. The measures apply to acute patients whether in an acute or community setting. Where a trust with existing acute facilities acquires a community hospital, performance will be assessed on a combined basis. The SHA will take account of breaches of the referral to treatment target in 2011/12 when considering consecutive failures of the referral to treatment target in 2012/13. For example, if a trust fails the 2011/12 admitted patients target at quarter 4 and the 2012/13 admitted patients target in quarters 1 and 2, it will be considered to have breached for three quarters in a row.
2d	Learning Disabilities: Access to healthcare	Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (DH, 2008): a) Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? b) Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: - treatment options; - complaints procedures; and - appointments? c) Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? d) Does the trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? e) Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers? f) Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? Note: trust boards are required to certify that their trusts meet requirements a) to f) above at the annual plan stage and in each month. Failure to d
3a	Cancer: 31 day wait	31-day wait: measured from cancer treatment period start date to treatment start date. Failure against any threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter.. Will apply to any community providers providing the specific cancer treatment pathways
3b	Cancer: 62 day wait	62-day wait: measured from day of receipt of referral to treatment start date. This includes referrals from screening service and other consultants. Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. National guidance states that for patients referred from one provider to another, breaches of this target are automatically shared and treated on a 50:50 basis. These breaches may be reallocated in full back to the referring organisation(s) provided the SHA receive evidence of written agreement to do so between the relevant providers (signed by both Chief Executives) in place at the time the trust makes its monthly declaration to the SHA. In the absence of any locally-agreed contractual arrangements, the SHA encourages trusts to work with other providers to reach a local system-wide agreement on the allocation of cancer target breaches to ensure that patients are treated in a timely manner. Once an agreement of this natu
3c	Cancer	Measured from decision to treat to first definitive treatment. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways.
3d	Cancer	Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners and any primary care professional).Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation

Notes

Ref	Indicator	Details
3e	A&E	Waiting time is assessed on a site basis: no activity from off-site partner organisations should be included. The 4-hour waiting time indicator will apply to minor injury units/walk in centres.
3f	Mental	7-day follow up: **Numerator**: the number of people under adult mental illness specialties on CPA who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. **Denominator:** the total number of people under adult mental illness specialties on CPA who were discharged from psychiatric inpatient care. All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemptions from both the numerator and the denominator of the indicator include: - patients who die within seven days of discharge; - where legal precedence has forced the removal of a patient from the country; or - patients discharged to another NHS psychiatric inpatient ward. For 12 month review (from Mental Health Minimum Data Set): **Numerator:** the number of adults in the denominator who have had at least one formal review in the last 12 months. **Denominator:** the total number of adults who have received secondary mental health services during the reporting period (month) who had spent at least 12 mor For full details of the changes to the CPA process, please see the implementation guidance Refocusing the Care Programme Approach on the De
3g	Mental Health: DTOC	**Numerator:** the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed during the month. For example, one patient delayed for five days counts as five. **Denominator:** the total number of occupied bed days (consultant-led and non-consultant-led) during the month. Delayed transfers of care attributable to social care services are included.
3h	Mental Health: I/P and CRHT	This indicator applies only to admissions to the foundation trust's mental health psychiatric inpatient care. The following cases can be excluded: - planned admissions for psychiatric care from specialist units; - internal transfers of service users between wards in a trust and transfers from other trusts; - patients recalled on Community Treatment Orders; or - patients on leave under Section 17 of the Mental Health Act 1983. The indicator applies to users of working age (16-65) only, unless otherwise contracted. An admission has been gate-kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission. For full details of the features of gate-keeping, please see Guidance Statement on Fidelity and Best Practice for Crisis Services on the Department of Health's website. As set out in this guidance, the crisis resolution home treatment team should: a) provide a mobile 24 hour, seven days a week response to requests for assessments; b) be actively involved in all requests for admission: for the avoidance of doubt, 'actively involved' requires face-to-face contact unless it can be d c) be notified of all pending Mental Health Act assessments; d) be assessing all these cases before admission happens; and e) be central to the decision making process in conjunction with the rest of the multidisciplinary team.
3i	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
3j-k	Ambulance Cat A	For patients with immediately life-threatening conditions. The Operating Framework for 2012-13 requires all Ambulance Trusts to reach 75 per cent of urgent cases, Category A patients, within 8 minutes. From 1 June 2012, Category A cases will be split into Red 1 and Red 2 calls: • Red 1 calls are patients who are suffering cardiac arrest, are unconscious or who have stopped breathing. • Red 2 calls are serious cases, but are not ones where up to 60 additional seconds will affect a patient's outcome, for example diabetic episodes and fits. Ambulance Trusts will be required to improve their performance to show they can reach 80 per cent of Red 1 calls within 8 minutes by April 2013.
4a	C.Diff	Will apply to any inpatient facility with a centrally set C. difficile objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Both avoidable and unavoidable cases of C. difficile will be taken into account for regulatory purposes. Where there is no objective (i.e. if a mental health trust without a C. difficile objective acquires a community provider without an allocated C. difficile objective) we will not apply a C. difficile score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of C. difficile is set at 12. However, Monitor may consider scoring cases of <12 if the Health Protection Agency indicates multiple outbreaks. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation. If the Health Protection Agency indicates that the C. difficile target is exceeded due to multiple outbreaks, while still below the de minimis, the SHA
4b	MRSA	Will apply to any inpatient facility with a centrally set MRSA objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Those trusts that are not in the best performing quartile for MRSA should deliver performance that is at least in line with the MRSA objective target figures calculated for them by the Department of Health. We expect those trusts without a centrally calculated MRSA objective as a result of being in the best performing quartile to agree an MRSA target for 2012/13 that at least maintains existing performance. Where there is no objective (i.e. if a mental health trust without an MRSA objective acquires a community provider without an allocated MRSA objective) we will not apply an MRSA score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of MRSA is set at 6. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation