Executive Offices
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The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

# Whittington Health Trust Board

27 March 2013

| | | | |
|---|---|---|---|
| **Title:** | **Foundation Trust application – SOM submission** | | |
| **Agenda item:** | **13/043** | **Paper** | **4** |
| **Action requested:** | ***For discussion*** | | |
| **Executive Summary:** | The Single Operating Model December submission<br><br>The SOM requires the Trust to calculate its risk score and RAG rate current performance against the FT application milestones, in addition to providing comment with regard to any contractual issues and compliance with CQC essential standards. The January submission was signed on behalf of the Board by the Chairman and CEO and are included for Board ratification. | | |
| **Summary of recommendations:** | • The Board is recommended to ratify the SOM submission | | |
| **Fit with WH strategy:** | This report provides an update on key issues that could affect the achievement of Foundation Trust Status. | | |
| **Reference to related / other documents:** | Finance Report | | |
| **Date paper completed:** | 19 March 2013 | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Author name and title:** | | **Fiona Smith Director Planning & Programmes** | | **Director name and title:** | | **Richard Martin Director of Finance** | |
| **Date paper seen by EC** | **N/A** | **Equality Impact Assessment complete?** | **N/A** | **Risk assessment undertaken?** | **N/A** | **Legal advice received?** | **N/A** |

# FT application progress report

**27 March 2013**

## 1. Single Operating Model

The Trust is required to submit its "Single Operating Model" for aspirant foundation trust's return to NHS London each month. This compliance regime mirrors the Monitor compliance regime and covers aspects of clinical corporate and financial governance. The board delegated responsibility to the Chairman and Chief Executive for signing these returns where the dates for submission fall outside the timings of the Board meetings. The January submission is attached at appendix 1 for the Board to review in detail.

The SOM also requires the Trust to calculate its risk score and RAG rate performance, assessment of contractual issues with commissioners and compliance with CQC essential standards. Having completed the assessment using the SOM model the overall risk ratings for January is as follows:

January 2013

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

The governance risk and finance risk RAG rating remain unchanged at amber/green and green, as they were for the December report. The governance RAG reflects the combined **January** under - performance against the Emergency Department four hour target, the cancer two week wait target and the two MRSA cases (reported in the performance dashboard report to the Trust Board in December).

**ACTION: the board is asked to discuss and ratify the SOM submission**

**Fiona Smith** **18 March 2013**

| SELF-CERTIFICATION RETURNS |
| --- |
| |
| **Organisation Name:** |
| **The Whittington Hospital** |
| **Monitoring Period:** |
| **January 2013** |
| **NHS Trust Over-sight self certification template** |

**Return to: som@London.nhs.uk by 19th March at NOON**

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

| Name of Organisation: | The Whittington Hospital | Period: | January 2013 |
|---|---|---|---|

**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) | AG |
| **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.

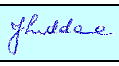
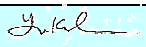
## Governance declaration 1

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 :** | **The Trust is not currently achieving L2 IGT compliance** |
| **Action :** | **Actions being taken to meet IGT level 2: Programme Management of delivery by end June 2013 include:** |

| | |
|---|---|
| **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

January 2013

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** | **19/03/2013** |
| **Chair** |  | **Joe Liddane** | **19/03/2013** |

# QUALITY

**Information to inform the discussion meeting**

## The Whittington Hospital

**Insert Performance in Month**

Refresh Data for new Month

| | Criteria | Unit | Feb-12 | Mar-12 | Apr-12 | May-12 | Jun-12 | Jul-12 | Aug-12 | Sep-12 | Oct-12 | Nov-12 | Dec-12 | Jan-13 | Board Action |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | SHMI - latest data | Score | - | - | 0.7 | - | - | 0.7 | - | - | 0.7 | - | - | - | |
| 2 | Venous Thromboembolism (VTE) Screening | % | 91.27 | 91.36 | 95.37 | 95.12 | 96.71 | 95.31 | 95.6 | 95.8 | 95.1 | 97.1 | 95.6 | 96.1 | |
| 3a | Elective MRSA Screening | % | 85 | 87.2 | 77.4 | 81.8 | 80.5 | 80.1 | 76.7 | 96.8 | 93.0 | 96.6 | 100 | 97.6 | |
| 3b | Non Elective MRSA Screening | % | 91 | 93 | 92.4 | 84 | 82.4 | 79.9 | 84.8 | 94.06 | 94.5 | 93.4 | 91.1 | 93.6 | |
| 4 | Single Sex Accommodation Breaches | Number | 0 | 0 | 0 | 0 | 1 | 7 | 0 | 0 | 0 | 0 | 0 | 0 | |
| 5 | Open Serious Incidents Requiring Investigation (SIRI) | Number | 6 | 19 | 6 | 11 | 16 | 16 | 8 | 12 | 17 | 5 | 8 | 9 | |
| 6 | "Never Events" occurring in month | Number | 1 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 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 | 1 | |
| 9 | RED rated areas on your maternity dashboard? | Number | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 0 | 1 | 1 | 0 | 1 | |
| 10 | Falls resulting in severe injury or death | Number | 2 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | |
| 11 | Grade 3 or 4 pressure ulcers | Number | 4/3 | 1/5 | 1/5 | 2/4 | 0/7 | 1/8 | 1/4 | 1/3 | 2/6 | 0/4 | 0/2 | 1/6 | 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 | 41 | 50 | 49 | 62 | 37 | 59 | 49 | 41 | 48 | 38 | 24 | 41 | |
| 14 | Agency as a % of Employee Benefit Expenditure | % | 5.69 | 7.11 | 5.46 | 6.65 | 5.07 | 5.77 | 6.23 | 4.45 | 6.35 | 5 | 4.9 | 4.7 | |
| 15 | Sickness absence rate | % | 2.9 | 2.9 | 2.8 | 3.2 | 2.9 | 2.7 | 2.8 | 3.1 | 2.8 | 3.5 | 3.2 | 3.2 | |
| 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 | 4 | 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 | The improvement in the normalised forec outturn position relates to an improveme CIP run rate. |
| Liquidity | **Liquid ratio days** | 25% | 60 | 25 | 15 | 10 | <10 | 2 | 2 | 2 | 2 | In 2012/13 the current liquid ratio days is calculated at 12 days. The 2013/14 liquic rating is anticipated to reduce on accoun slightly weaker net current liabilities and abatement to the benefit derived from the working capital facility. |
| **Weighted Average** | | **100%** | | | | | | **3.2** | **3.2** | **2.7** | **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

| | | Historic Data | | | Current Data | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Criteria | Qtr to Jun-12 | Qtr to Sep-12 | Qtr to Dec-12 | Jan-13 | Feb-13 | Mar-13 | Qtr to Mar-13 | Board Action |
| 1 | Unplanned decrease in EBITDA margin in two consecutive quarters | 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 | | | | |
| 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 | | | | 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.<br>This is a longstanding issue, and Yi Mien wrote to Caroline Taylor on the 21st November 2011, following which Caroline responded outlining a timetable outlining resolution of this issue. We have subsequently worked closely with the account team and finance colleagues at NCL, and despite receiving assurances on several occasions that the situation would be resolved, progress until very recently has remained slow.<br>In the last couple of months, following productive meetings with NCL Director of Finance Beverley Evans, considerable effort – including re-providing supporting evidence previous sent and numerous one to one meetings - is being made to seek resolution before the end of the financial year resulting in the NCL total outstanding debt reducing from £4.1m in mid-January to under £2m by the end of February. |
| 5 | Creditors > 90 days past due account for more than 5% of total creditor balances | Yes | Yes | Yes | Yes | | | | The deterioration in performance in respect of NHS payables relates to 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.<br>The resolution of this issue is intrinsically linked to resolving the outstanding debt with NCL due to the Trust withholding payments to NCL while the value of outstanding debt was high in order to maintain an adequate cash balance. As indicated above, in recent months with the progress that has been made we have reduced the value of NCL total outstanding creditor balance from £4m to £2.1m between January and February |
| 6 | Two or more changes in Finance Director in a twelve month period | No | No | No | No | | | | |
| 7 | Interim Finance Director in place over more than one quarter end | No | No | No | No | | | | |
| 8 | Quarter end cash balance <10 days of operating expenses | No | No | No | No | | | | |
| 9 | Capital expenditure < 75% of plan for the year to date | No | Yes | Yes | No | | | | |
| 10 | Yet to identify two years of detailed CIP schemes | | | | 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 Jun-12 | Historic Data: Qtr to Sep-12 | Historic Data: Qtr to Dec-12 | Current Data: Jan-13 | Current Data: Feb-13 | Current Data: Mar-13 | Current Data: Qtr to Mar-13 | Board Action |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Effectiveness | 1a | Data completeness: Community services comprising: | Referral to treatment information | 50% | 1.0 | Yes | Yes | Yes | Yes | | | | Anita |
| | | | Referral information | 50% | | | | | | | | | |
| | | | Treatment activity information | 50% | | | | | | | | | |
| | 1b | Data completeness, community services: *(may be introduced later)* | Patient identifier information | 50% | | Yes | Yes | Yes | Yes | | | | |
| | | | Patients dying at home / care home | 50% | | Yes | Yes | Yes | Yes | | | | |
| | 1c | Data completeness: identifiers MHMDS | | 97% | 0.5 | Yes | Yes | Yes | Yes | | | | |
| | 1c | Data completeness: outcomes for patients on CPA | | 50% | 0.5 | 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 | | | | |
| | 2b | From point of referral to treatment in aggregate (RTT) – non-admitted | Maximum time of 18 weeks | 95% | 1.0 | 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 | | | | |
| | 2d | Certification against compliance with requirements regarding access to healthcare for people with a learning disability | | N/A | 0.5 | Yes | Yes | Yes | Yes | | | | |
| Quality | 3a | All cancers: 31-day wait for second or subsequent treatment, comprising: | Surgery | 94% | 1.0 | | | 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 | No | Yes | Yes | 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 | | | | |
| | 3d | Cancer: 2 week wait from referral to date first seen, comprising: | all urgent referrals | 93% | 0.5 | Yes | No | No | No | | | | Actions agreed as follows:<br>- Review arrangements for CNS cover to ensure capacity contact all patients<br>- Audit skin referrals to decide whether to implement full grading of cancer referral letters.<br>- Update Trust Access Policy to provide more stringent standard for consultant grading<br>- A realignment of management supervisors will ensure that daily chasing of cancer pathway patients is completed.<br>- The National Intensive Support Team to report in April on recommendations for improvement |
| | | | 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 | No | Yes | Yes | No | | | | Ongoing work focuses on three areas:<br>1. Reduce time to treatment by introducing a "Rapid Assessment and Treatment Model" by which every patient arriving at the major's area is seen by a senior medical officer on arrival.<br>2. Introduce 'hot floor' concept and optimize the impact of new rota. This improves joint working / flow between ED and Acute Medicine. This helps admission avoidance by ensuring fast track consultant decisions<br>3. Focus on floor leadership competences and queue management. This includes building on the introduction of internal professional standards which happened last month.<br>In addition winter pressures funding was received from NHS London (£108,000) which is being used to fund extra consultant and middle grade doctor support for rapid assessment. |
| | 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 | | | | |
| | | | 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 | | | | |
| | 3h | Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams | | 95% | 1.0 | N/a | N/a | N/a | N/a | | | | |

## 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

| | | | | | | Historic Data | | | Current Data | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3i | Meeting commitment to serve new psychosis cases by early intervention teams | | 95% | 0.5 | 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 | | | | |
| | | | Red 2 | 75% | 0.5 | 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 | | | | |
| 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* | | 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 | No | | | | |
| | | **CQC Registration** | | | | | | | | | | | |
| | **A** | Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients | | 0 | 2.0 | No | No | No | No | | | | |
| | **B** | Non-Compliance with CQC Essential Standards resulting in Enforcement Action | | 0 | 4.0 | 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 | | | | |
| | | | | **TOTAL** | | **2.0** | **0.5** | **0.5** | **1.5** | **0.0** | **0.0** | **0.0** | |
| | | | | | | AR | G | G | AG | G | G | G | |

**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

**The Whittington Hospital**

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

**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 | | | | |
| ii) | Meeting the C-Diff Objective | Greater than 12 cases in the year to date, and either:<br>Breaches the cumulative year-to-date trajectory for three successive quarters<br>Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency. | No | No | No | No | | | | |
| iii) | RTT Waiting Times | Breaches:<br>The admitted patients 18 weeks waiting time measure for a third successive quarter<br>The non-admitted patients 18 weeks waiting time measure for a third successive quarter<br>The incomplete pathway 18 weeks waiting time measure for a third successive quarter | 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 | | | | |
| v) | Cancer Wait Times | Breaches either:<br>the 31-day cancer waiting time target for a third successive quarter<br>the 62-day cancer waiting time target for a third successive quarter | No | No | No | No | | | | |
| vi) | Ambulance Response Times | Breaches either:<br>the category A 8-minute response time target for a third successive quarter<br>the category A 19-minute response time target for a third successive quarter<br>either Red 1 or Red 2 targets for a third successive quarter | N/a | N/a | N/a | N/a | | | | |
| vii) | Community Services data completeness | Fails to maintain the threshold for data completeness for:<br>referral to treatment information for a third successive quarter;<br>service referral information for a third successive quarter, or;<br>treatment activity information for a third successive quarter | No | No | No | No | | | | |
| viii) | Any other Indicator weighted 1.0 | Breaches the indicator for three successive quarters. | No | No | No | No | | | | |
| | | ***Adjusted Governance Risk Rating*** | **2.0** | **0.5** | **0.5** | **1.5** | **0.0** | **0.0** | **0.0** | |
| | | | AR | G | 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 Jun-12 | Qtr to Sep-12 | Qtr to Dec-12 | Jan-13 | Feb-13 | Mar-13 | Qtr to Mar-13 | |
| 1 | Are the prior year contracts* closed? | Yes | Yes | Yes | Yes | | | | |
| 2 | Are all current year contracts* agreed and signed? | 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? | No | Yes | Yes | Yes | | | | |
| 5 | Are there any disputes over the terms of the contract? | No | No | No | No | | | | |
| 6 | Might the dispute require third party intervention or arbitration? | N/a | N/a | N/a | N/a | | | | |
| 7 | Are the parties already in arbitration? | N/a | N/a | N/a | N/a | | | | |
| 8 | Have any performance notices been issued? | Yes | No | No | No | | | | |
| 9 | Have any penalties been applied? | No | No | No | No | | | | |

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

## TFA Progress

**Mar-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 March. |
| 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 March. |
| 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<br>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 |
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## 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:<br>- Referral to treatment times – consultant-led treatment in hospitals and Allied Healthcare Professional-led treatments in the community;<br>- Community treatment activity – referrals; and<br>- Community treatment activity – care contact activity.<br><br>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.<br><br>**Numerator:**<br>all data in the denominator actually captured by the trust electronically (not solely CIDS-specified systems).<br>**Denominator:**<br>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.<br><br>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:<br>- NHS number;<br>- Date of birth;<br>- Postcode (normal residence);<br>- Current gender;<br>- Registered General Medical Practice organisation code; and<br>- Commissioner organisation code.<br><br>**Numerator:**<br>count of valid entries for each data item above.<br>(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)<br>**Denominator:**<br>total number of entries |
| 1d | Mental Health: CPA | **Outcomes for patients on Care Programme Approach:**<br>• Employment status:<br>**Numerator:**<br>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.<br>**Denominator:**<br>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.<br><br>• Accommodation status:<br>**Numerator:**<br>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.<br>**Denominator:**<br>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<br><br>• Having a Health of the Nation Outcome Scales (HoNOS) assessment in the past 12 months:<br>**Numerator:**<br>The number of adults in the denominator who have had at least one HoNOS assessment in the past 12 months.<br>**Denominator:**<br>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.<br><br>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.<br><br>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):<br>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?<br>b) Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria:<br>- treatment options;<br>- complaints procedures; and<br>- appointments?<br>c) Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?<br>d) Does the trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?<br>e) Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers?<br>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?<br><br>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.<br><br>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.<br><br>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.<br><br>Specific guidance and documentation concerning cancer waiting targets can be found at:<br>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:<br>**Numerator**:<br>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.<br>**Denominator:**<br>the total number of people under adult mental illness specialties on CPA who were discharged from psychiatric inpatient care.<br><br>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.<br><br>Exemptions from both the numerator and the denominator of the indicator include:<br>- patients who die within seven days of discharge;<br>- where legal precedence has forced the removal of a patient from the country; or<br>- patients discharged to another NHS psychiatric inpatient ward.<br><br>For 12 month review (from Mental Health Minimum Data Set):<br>**Numerator:**<br>the number of adults in the denominator who have had at least one formal review in the last 12 months.<br>**Denominator:**<br>the total number of adults who have received secondary mental health services during the reporting period (month) who had spent at least 12 mor<br><br>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:**<br>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.<br>**Denominator:**<br>the total number of occupied bed days (consultant-led and non-consultant-led) during the month.<br><br>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:<br>- planned admissions for psychiatric care from specialist units;<br>- internal transfers of service users between wards in a trust and transfers from other trusts;<br>- patients recalled on Community Treatment Orders; or<br>- patients on leave under Section 17 of the Mental Health Act 1983.<br><br>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.<br><br>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:<br>a) provide a mobile 24 hour, seven days a week response to requests for assessments;<br>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<br>c) be notified of all pending Mental Health Act assessments;<br>d) be assessing all these cases before admission happens; and<br>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.<br><br>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:<br>• Red 1 calls are patients who are suffering cardiac arrest, are unconscious or who have stopped breathing.<br>• 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.<br>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.<br><br>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.<br><br>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.<br><br>If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied.<br>If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply.<br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied.<br>If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply.<br>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 |