To:	**Trust Board**
From:	**Jim Birrell, Interim Chief Executive**
Date:	**20 December 2012**
CQC regulation:	All applicable

Trust Board Paper AA

Title:	NHS trust over-sight self certifications

Author/Responsible Director: Helen Harrison – FT Programme Manager / Jim Birrell, Interim Chief Executive

Purpose of the Report:

In August 2012, the Department of Health (DoH) launched part two of the Single Operating Model (SOM) for strategic health authority (SHA) clusters, focusing on SHA oversight of NHS trusts in the foundation trust application pipeline.

In line with this operating model, the SHA have issued a revised version of what was the monthly PMR self certification template.

This paper:

- Summarises the key changes to the monthly self certification template
- Presents UHL's December trust over-sight self certification - attached as Appendix A

The Report is provided to the Board for:

Decision	X	Discussion	X
Assurance		Endorsement	

Summary / Key Points:

- The monthly self certification is now called the 'NHS trust over-sight self certification'
- The governance declaration (on page 3) now only includes a governance risk rating and a Normalised YTD Financial Risk Rating
- Within the self certification submission, the Chairman and the Chief Executive are required to sign one of two Governance Declarations. Both of these declarations have been reworded within the template
- The Board Statements are now more prominently placed on page 4 of the over-sight self certification, rather than at the back of the document
- The 'comments' column on each of the performance data work sheets (including TFA Progress) has been replaced with a 'Board action' column.
- The contractual data worksheet includes a new criteria: 'Has the Trust received income support outside of the NHS standard contract e.g. transformational support?'

- An Executive Lead has been assigned to each of the over-sight self certification standards and they have been asked to provide details of the actions being taken to address non compliance with the following standards
- These actions and the timescales for achievement will be incorporated into the December oversight-sight self certification submission to the SHA

Recommendations:

The Trust Board is asked to:

- **Note** the changes to the monthly self certification template, in particular:
  - The changes to the wording within the governance declaration
  - The increased prominence of the Board Statements within the oversight-sight self certification return
  - The need for Board approved actions to be included where standards are not being met
- **Approve** UHL's December trust over-sight self certification submission

Previously considered at another corporate UHL Committee?

Strategic Risk Register	**Performance KPIs year to date**

Resource Implications (eg Financial, HR)

Assurance Implications

Yes

Patient and Public Involvement (PPI) Implications

No

Equality Impact

None

Information exempt from Disclosure

None

Requirement for further review ?

Any future changes to the NHS Trust over-sight self assessments will be discussed at the private Trust Board in advance of the public Trust Board meeting that same day

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: Trust Board

DATE: 20th December 2012

REPORT FROM: Jim Birrell, Interim Chief Executive

SUBJECT: NHS trust oversight-sight self certification

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1) Introduction

In August 2012, the Department of Health (DoH) launched part two of the Single Operating Model (SOM) for strategic health authority (SHA) clusters, focusing on SHA oversight of NHS trusts in the foundation trust application pipeline.

In line with this operating model, the SHA have issued a revised version of what was the monthly PMR self certification template.

This paper:

- Summarises the key changes to the monthly self certification template
- Presents UHL's December trust over-sight self certification - attached as Appendix A

2) Key changes to the monthly self certification

- The monthly self certification is now called the 'NHS trust oversight-sight self certification'
- The governance declaration (on page 3) now only includes a governance risk rating and a Normalised YTD Financial Risk Rating. Previously the governance declaration also included a contractual risk rating
- Within the self certification submission, the Chairman and the Chief Executive are required to sign one of two Governance Declarations. Within the template, both declarations have been reworded as follows:

Governance Declaration 1

Reworded from:	To:
'The Board is satisfied that plans in place are sufficient to ensure continuing compliance with all existing targets (after the application of thresholds), and with all known targets going forward. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections (including the Hygiene Code) and CQC Essential standards. The board also confirms that there are no material contractual disputes.'	*'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.'*

Governance Declaration 2

Reworded from:	To:
'For one or some of the following declarations Governance, Finance, Service Provision, Quality and Safety, CQC essential standards or the Code of Practice for the Prevention and Control of Healthcare Associated Infections the Board cannot make Declaration 1 and has provided relevant details below. The board is suggesting that at the current time there is insufficient assurance available to ensure continuing compliance with all existing targets (after the application of thresholds) and/or that it may have material contractual disputes.'	*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.*

- The Board Statements are now more prominently placed on page 4 of the oversight-sight self certification, rather than at the back of the document

- The 'comments' column on each of the performance data work sheets (including TFA Progress) has been replaced with a 'Board action' column. If a standard is being missed then this column needs to be completed to indicate what action the Board has agreed to take

- The contractual data worksheet includes a new criteria: 'Has the Trust received income support outside of the NHS standard contract e.g. transformational support?'

3) Board agreed actions and Board approval of the December self certification submission

An Executive Lead has been assigned to each of the oversight-sight self certification standards and they have been asked to provide details of the actions being taken to address non compliance with the following standards:

- Compliance with the A&E 4 hour target
- Non compliance with CQC standards resulting in a major impact on patients
- Non compliance with CQC standards resulting in enforcement action
- Financial efficiency
- Financial Risk Rating of less than 3 in the next 12 months
- Debtors >90 days past due accounting for more than 5% of total creditor balances
- Contractual performance notices issued
- Contractual penalties applied

These actions and the timescales for achievement will be incorporated into the December oversight-sight self certification submission to the SHA.

4) Recommendations

The Trust Board is asked to:

- **Note** the changes to the monthly self certification template, in particular:
  - The changes to the wording within the governance declaration
  - The increased prominence of the Board Statements within the oversight-sight self certification return
  - The need for Board approved actions to be included where standards are not being met
- **Approve** UHL's December trust over-sight self certification submission

SELF-CERTIFICATION RETURNS
Organisation Name:
University Hospitals of Leicester
Monitoring Period:
December 2012
NHS Trust Over-sight self certification template

emsha.providerdevelopments.nhs.net by the last working day of each month

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

Name of Organisation:	University Hospitals of Leicester	Period:	December 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)	R
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 :	
on behalf of the Trust Board	Acting in capacity as:	Interim Chief Executive	
Signed by :		Print Name :	
on behalf of the Trust Board	Acting in capacity as:	Chairman	

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:	**4. The trust will maintain a FRR ≥ 3 over the next 12 months.**
The Issue :	**There is a risk within the next 12 months that the Trust may have a FRR below 3.**
Action :	**Particular focus is on delivering the I&E surplus and the planned EBITDA margin.**

Target/Standard:	**11. Plans in place to ensure ongoing compliance with all existing targets.**
The Issue :	**The Trust is currently non-compliant against the A&E 4 hour target.**
Action :	**Implementation of the LLR Accident & Emergency Performance Recovery Plan.**

Board Statements

University Hospitals of Leicester

December 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.	No
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.	No
12	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	Yes
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			
Chair			

QUALITY

Information to inform the discussion meeting

University Hospitals of Leicester

Insert Performance in Month

Refresh Data for new Month

	Criteria	Unit	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Board Action
1	SHMI - latest data	Score	91.4	102.1	97.7	108.3	92.6	90.9	99.8	90.7	102.6				
2	Venous Thromboembolism (VTE) Screening	%	94.1	93.8	93.7	95.5	95.6	94.7	94.8	95.1	94.1	95.2	95.4		
3a	Elective MRSA Screening	%	100	100	100	100	100	100	100	100	100	100	100		
3b	Non Elective MRSA Screening	%	100	100	100	100	100	100	100	100	100	100	100		
4	Single Sex Accommodation Breaches	Number	0	0	13	7	0	0	0	0	0	0	0		
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	118	136	165	189	194	112	123	126	98	93	123		
6	"Never Events" occurring in month	Number	0	0	0	2	1	0	0	1	0	1	0		
7	CQC Conditions or Warning Notices	Number	0	0	0	1	0	0	1	1	1	1	0		
8	Open Central Alert System (CAS) Alerts	Number	3	3	15	8	14	13	14	15	8	9	5		
9	RED rated areas on your maternity dashboard?	Number	2	5	4	2	2	1	1	2	3	1	1		
10	Falls resulting in severe injury or death	Number	1	0	1	1	1	1	1	0	0	1	0		
11	Grade 3 or 4 pressure ulcers	Number	12 (9)	8 (4)	22 (10)	10 (7)	11 (7)	7 (4)	12 (2)	10 (8)	10(2)	18(11)			
12	100% compliance with WHO surgical checklist	Y/N	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N		
13	Formal complaints received	Number	145	140	165	133	156	144	144	146	101	108	133		
14	Agency as a % of Employee Benefit Expenditure	%	1.6	1.6	2.5	2.2	2.5	2.9	3.4	3.7	3.7	4.2	4.1		
15	Sickness absence rate	%	3.7	3.7	3.5	3.2	3.5	3.1	3.3	3.2	3.2	3.6	4.1		
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%							95	95	95	95	95		

FINANCIAL RISK RATING

University Hospitals of Leicester

			Risk Ratings					Insert the Score (1-5) Achieved for each Criteria Per Month				
								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	2	3	2	3	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	2	4	2	4	
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	2	3	2	3	
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	2	2	2	
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	3	3	3	
Weighted Average		**100%**						**2.3**	**2.9**	**2.3**	**2.9**	
Overriding rules								2		2		
Overall rating								**2**	**3**	**2**	**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"							
1	Two Financial Criteria at "1"							
2	Two Financial Criteria at "2"		2		2			

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

FINANCIAL RISK TRIGGERS

University Hospitals of Leicester

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		No	
2	Quarterly self-certification by trust that the normalised financial risk rating (FRR) may be less than 3 in the next 12 months	Yes	Yes	Yes	Yes	Yes		Yes	
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	No	No	Yes	Yes	Yes		Yes	
5	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No	No	No		No	
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No		No	
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No		No	
8	Quarter end cash balance <10 days of operating expenses	No	No	No	No	No		No	
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No	No		No	
10	Yet to identify two years of detailed CIP schemes	No	No	No	No	No		No	

GOVERNANCE RISK RATINGS

University Hospitals of Leicester

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
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	No	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		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		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		Yes	
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	No	Yes	Yes	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	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	Yes		Yes	
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes		Yes	
			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	No	Yes	No	No		No	
Safety	4a	Clostridium Difficile	Is the Trust below the de minimus	*12*	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*		Yes	Yes	Yes	Yes	Yes		Yes	
	4b	MRSA	Is the Trust below the de minimus	*6*	1.0	Yes	Yes	Yes	Yes	Yes		Yes	
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*		Yes	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	Yes	No		Yes	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	Yes	Yes	Yes	No		Yes	
	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		No	
			TOTAL			**3.0**	**6.0**	**4.0**	**5.0**	**1.0**	**0.0**	**5.0**	
						AR	R	R	R	AG	G	R	

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

University Hospitals of Leicester

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				
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.	Yes	Yes	Yes	Yes	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			
viii)	Any other Indicator weighted 1.0	Breaches the indicator for three successive quarters.	No	No	No	No	No			
		Adjusted Governance Risk Rating	**4.0**	**6.0**	**4.0**	**5.0**	**1.0**	**0.0**	**5.0**	
			R	R	R	R	AG	G	R	

CONTRACTUAL DATA

University Hospitals of Leicester

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		Yes	
2	Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes	Yes		Yes	
3	Has the Trust received income support outside of the NHS standard contract e.g. transformational support?	Yes	Yes	Yes	Yes	Yes		Yes	
4	Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes	Yes			
5	Are there any disputes over the terms of the contract?	No	No	No	No	No		No	
6	Might the dispute require third party intervention or arbitration?	N/a	N/a	N/a	N/a	N/a		N/a	
7	Are the parties already in arbitration?	N/a	N/a	N/a	N/a	N/a		N/a	
8	Have any performance notices been issued?	No	Yes	Yes	Yes	Yes		Yes	
9	Have any penalties been applied?	No	Yes	Yes	Yes	Yes		Yes	

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

TFA Progress

Dec-12

University Hospitals of Leicester

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	Engagement with stakeholders on principles underpinning LLR Reconfiguration Programme (April - August 2012)	Jul-12	Fully achieved in time		
2	Development of LLR Clinical Strategy and Site and Service Reconfiguration Proposals	Sep-12	Not fully achieved		
3	Complete financial assessment of target health system model	Jul-12	Not fully achieved		
4	Achievement of 2012/13 financial plan	Jun-12	Not fully achieved		
5	Complete Quality Governance Framework and Board Governance Assurance Framework self assessments	Jun-12	Fully achieved but late		
6	Confirm specific LLR reconfiguration priorities over a 3 year time horizon	Jul-12	Not fully achieved		
7	Draft pre-consultation Business Case considered by Trust Boards	Sep-12	Not fully achieved		
8	Pre-consultation Business Case and timelines for LLR service reconfigurations finalised	Oct-12	Not fully achieved		
9	UHL Clinical Strategy developed and preferred options costed	Oct-12	Not fully achieved		
10	Submit early draft IBP / LTFM to the SHA	Oct-12	Fully achieved in time		
11	Third party review of self assessment against the Quality Governance Framework and Board Governance Assurance Framework	Oct-12	Not fully achieved		
12	Formal consultation on LLR Reconfiguration Proposals	Dec-12		Risk to delivery within timescale	
13	SHA Board and Committee Observations	Oct-12	Fully achieved in time		
14	Submit FT Application documents (including a draft IBP/LTFM) to the SHA.	Dec-12	Fully achieved in time		
15	Readiness review meeting held	Dec-12		On track to deliver	
16	HDD1 Review underway	Jan-13		On track to deliver	
17	Public consultation on FT Application	May-13		On track to deliver	
18	HDD2 Review	May-13		On track to deliver	
19	Final submission of FT Documentation to inform SHA sign off of FT application	Jul-13		On track to deliver	
20	SHA / trust Board to Board	Jul-13		On track to deliver	
21	Submit FT Application to the DoH	Aug-13		On track to deliver	

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 reported month. • 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 do so will result in the application of the service performance score for this indicator.
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 nature has been reached, the SHA will consider applying the terms of the agreement to trusts party to the arrangement.
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.

Ref	Indicator	Details
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
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 months on CPA (by the end of the reporting period OR when their time on CPA ended). For full details of the changes to the CPA process, please see the implementation guidance Refocusing the Care Programme Approach on the Department of Health's website.
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 demonstrated that face-to-face contact was not appropriate or possible. For each case where face-to-face contact is deemed inappropriate, a declaration that the face-to-face contact was not the most appropriate action from a clinical perspective will be required; 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 may apply a score.
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