Oxford University Hospitals NHS
NHS Trust

Trust Board Meeting: Wednesday 10 July 2013

TB2013.84

Title	**NHS Trust Oversight Self-Certification**

Status	For information
History	Regular Board papers, most recently 12 February 2013 and 13 March 2013 and 8 May 2013.

Board Lead(s)	Mr Andrew Stevens, Director of Planning and Information			
Key purpose	Strategy	Assurance	Policy	**Performance**

Summary

1	The Trust's NHS Trust Oversight Self-Certification return for May 2013 shows an Amber-Green Governance Risk Rating (GRR) score of 1.0.
2	This score is based on non-delivery of the 62-day wait cancer standard for GP referral to first treatment.
3	The Trust's Governance Risk Rating for April was 2.0, with the Accident and Emergency four-hour wait and 62-day wait cancer standards not met, giving an Amber-Red rating.
4	The Trust Board is asked to review the latest self-certification.

NHS Trust Oversight Self-Certification

Introduction

1. The Trust has submitted its self-certification template for May 2013 to the Trust Development Authority (TDA) as required of all applicant NHS Foundation Trusts on a monthly basis. This most recent self-certification is attached.
2. Since the most recent self-certification report to the Trust Board at its meeting on 8 May 2013, the return for April 2013 has also been submitted.

Current Status

3. In April's submission the Trust's Governance Risk Rating (GRR) scored 2.0, giving an Amber-Red rating. Lower GRR scores represent lower risk.
4. The GRR for April was composed of scores due to not meeting the standard for four-hour Accident and Emergency waits and for not achieving the 62-day wait cancer standard.
5. For May, however, the Trust's GRR score reduced to 1.0, giving an Amber-Green rating. This is based on the Trust again falling short of the 62-day wait cancer standard.
6. One case of MRSA was reported during May but this has been assessed as having been unavoidable by Oxfordshire CCG and does not therefore represent a breach of the MRSA standard of zero avoidable breaches.
7. It should be noted that 2012/13 *clostridium difficile* figures were also revised following the application of new definitions and on this basis OUH remained below the threshold in March 2013 contrary to the previous report to the Board with the relevant self-certification.
8. Data quality issues have historically prevented the Trust from being able to submit current data for the incomplete RTT measure. Reporting of actual data recommenced in May, however, and the incomplete RTT standard was delivered for the month.
9. The Trust continues to report internally validated figures for access to its cancer services for the relevant month. During April the Trust failed to deliver the 62-day standard for first treatment from urgent GP referral. Internally validated data indicate that OUH again fell just short of this standard for the month of May.
10. OUH achieved the Accident and Emergency four hour wait standard in May, delivering a figure of 96.12% against the 95% target compared with 85.17% in April. Consistent delivery of this standard remains a risk for the Trust.
11. As part of the Board Statement, the Trust continues to be unable to confirm achievement of Level 2 compliance with the requirements of the Information Governance Toolkit, due to the percentage of staff trained in Information Governance being below target. However plans are in place to deliver compliance by September this year.
12. The Trust's Financial Risk Rating (FRR) score remains 3 which corresponds to a Green rating. The FRR scale is 1 to 5 with higher scores representing lower risk.

Conclusion

13. During April, OUH had an Amber-Red GRR score of 2.0, resulting from the 62-day wait to first treatment for cancer referrals and the Accident and Emergency four hour wait standard not being achieved for the month.
14. Self-certification for May 2013 gives an Amber-Green Governance Risk Rating score of 1.0 as a result of non-delivery of the 62-day cancer wait target.
15. The Trust remains non-compliant with Level 2 of the Information Governance toolkit.
16. The Trust's Financial Risk Rating remains Green.

Recommendation

17. The Board is asked to **review** the content of the self-certification return for March.

Neil Scotchmer
Programme Manager
July 2013

SELF-CERTIFICATION RETURNS
Organisation Name:
Oxford University Hospitals NHS Trust
Monitoring Period:
May 2013

NHS Trust Over-sight self certification template

Returns by the last working day of each month to:

Sadie.male@southwest.nhs.uk

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

Name of Organisation:	Oxford University Hospitals NHS Trust	Period:	May 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 **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:	Sir Jonathan Michael FRCP
on behalf of the Trust Board	Acting in capacity as:	Chief Executive	
Signed by :		Print Name:	Dame Fiona Caldicott
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:	**12. Achieved a minimum of Level 2 of the IG Toolkit.**
The Issue :	**Trust remains at level 1 as it has not achieved 95% of staff trained in Information Governance.**
Action :	**Drive on statutory and mandatory training will help to improve the IG training numbers.**

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

Board Statements

Oxford University Hospitals NHS Trust

May-13

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		**Sir Jonathan Michael FRCP**	
Chair		**Dame Fiona Caldicott**	

Note re 12 For 2013/14 the Trust remains able to achieve only level 1 in IGT/112 (Training) as it is below the 95% standard of staff trained in Information Governance (IG). The figure was 81.7% as at 14 May 2013. The Trust's drive on statutory and mandatory training is anticipated to raise levels of IG training. Specific plans to achieve this will be included in the 2013/14 Training Plan which is being completed for sign off by the Information Governance Group.

QUALITY

Information to inform discussion meeting

Oxford University Hospitals NHS Trust

Insert Performance in Month

	Criteria	Unit	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Board Action
1	SHMI - latest data	Score	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	The latest rolling 12 month average released in January for July 2011 to June 2012 improved to 0.96.
2	Venous Thromboembolism (VTE) Screening	%	91.58	91.7	91.98	92.08	93.19	93.28	92.33	93.32	93.41	93.11	94.24	95.6	
3a	Elective MRSA Screening	%	64.9	64.19	64.5	61.7	63.33	64.34	64.11	63.2	62.87	65.39	83.3	82.64	
3b	Non Elective MRSA Screening	%	55.62	53.26	53.62	52.7	53.53	67.82	65.85	66.29	66.67	63.17	64.5	64.3	
4	Single Sex Accommodation Breaches	Number	0	0	0	0	8	0	0	5	0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	2	6	1	2	3	5	1	4	4	3	3	9	
6	"Never Events" occurring in month	Number	0	1	0	0	0	0	0	1	0	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	17	16	23	27	28	6	3	4	8	13	8	2	Figures are total alerts open at month end for Medical Devices Agency, National Patient Safety Agency and Estates & Facilities Alerts.
9	RED rated areas on your maternity dashboard?	Number	1	0	0	1	1	1	1	0	1	1	0	0	
10	Falls resulting in severe injury or death	Number	3	0	1	0	1	0	1	0	0	0	4	3	
11	Grade 3 or 4 pressure ulcers	Number	1	3	2	3	5	3	2	1	3	6	5	2	Figures are for hospital-acquired pressure ulcers.
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	68	74	60	66	66	64	58	88	68	85	78	66	
14	Agency as a % of Employee Benefit Expenditure	%	3.35	3.58	3.61	4.27	3.24	4.39	4.13	3.27	3.76	5.83	3.41	4.41	Agency spend overall for April - May 2013 was 3.91% of Employee Benefit Expenditure.
15	Sickness absence rate	%	2.86	3.08	2.92	2.83	3.25	3.32	3.24	3.56	3.51	2.97	3.33	3.23	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%	84.9	84.9	84.9	84.9	84.9	84.9	84.9	84.9	84.9	84.9	93.2	93.2	Appraisal period runs from October to March. Percentage shows appraisals completed in year for the medical staff with whom OUH has a prescribed connection for revalidation purposes. A small proportion of these will be non-consultant medical staff.

FINANCIAL RISK RATING

Oxford University Hospitals NHS Trust

								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	5	5	
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	3	3	3	3	
	I&E surplus margin %	20%	3	2	1	-2	<-2	2	3	2	3	Year to date month 1 planned deficit. Planned 1% surplus for the year.
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	4	3	4	Year to date includes modelled working capital facility. Forecast outturn also includes FT loan.
Weighted Average		**100%**						**3.0**	**3.5**	**3.0**	**3.5**	
Overriding rules												
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 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"					

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

FINANCIAL RISK TRIGGERS

Oxford University Hospitals NHS Trust

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

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Sep-12	Qtr to Dec-12	Qtr to Mar-13	Apr-13	May-13	Jun-13	Qtr to Jun-13	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	No	No	No			
2	Quarterly self-certification by trust that the normalised financial risk rating (FRR) may be less than 3 in the next 12 months	No	No	No	No	No			
3	Working capital facility (WCF) agreement includes default clause	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
4	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes	Yes			
5	Creditors > 90 days past due account for more than 5% of total creditor balances	Yes	Yes	Yes	Yes	Yes			
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No			
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No			
8	Quarter end cash balance <10 days of operating expenses	No	No	No	No	No			
9	Capital expenditure < 75% of plan for the year to date	No	No	No	Yes	Yes			Net Capital expenditure for May is £1,419k against a CRL of £2,336k year to date (61% of plan).
10	Yet to identify two years of detailed CIP schemes	Yes	Yes	No	No	No			

GOVERNANCE RISK RATINGS

Oxford University Hospitals NHS Trust

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

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

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Sep-12	Historic Data: Qtr to Dec-12	Historic Data: Qtr to Mar-13	Current Data: Apr-13	Current Data: May-13	Current Data: Jun-13	Current Data: Qtr to Jun-13	Board Action
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Patients dying at home / care home	50%		N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes	Yes			
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes	Yes			
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	Yes	Yes	Yes		Yes			Reporting based on live data reintroduced in May 2013 following data quality issues within Cerner Millennium.
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	No	No	Yes	Yes	Yes			
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising :	Surgery	94%	1.0	Yes	Yes	Yes	Yes	Yes			
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									Based on internally validated data uncorrected for shared breaches.
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	No	Yes	Yes	No	No			
			From NHS Cancer Screening Service referral	90%									Based on internally validated data uncorrected for shared breaches.
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes			Based on internally validated data uncorrected for shared breaches.
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes			
			for symptomatic breast patients (cancer not initially suspected)	93%									Based on internally validated data uncorrected for shared breaches.
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	Yes	Yes	No	No	Yes			85.17% in April and 96.12% in May.
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a	N/a			
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a			
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a	N/a			
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a	N/a			
	3j	Category A call – emergency response within 8 minutes	Red 1	80%	0.5	N/a	N/a	N/a	N/a	N/a			
			Red 2	75%	0.5	N/a	N/a	N/a	N/a	N/a			
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a			
Safety	4a	Clostridium Difficile	Is the Trust below the de minimus		1.0	No	No	No	Yes	Yes			
			Is the Trust below the YTD ceiling	*70*		Yes	Yes	Yes	Yes	Yes			8 cases in April with 11 cases ytd against a trajectory of 11.
	4b	MRSA	Is the Trust below the de minimus	*0*	1.0	Yes	Yes	Yes	Yes	Yes			
			Is the Trust below the YTD ceiling	*0*		Yes	Yes	Yes	Yes	Yes			One case in May; this was assessed as unavoidable by Oxfordshire CCG and is not therefore recorded against the zero avoidable cases target.
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No	No			
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No	No			
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No	No	No	No			
			TOTAL			**1.5** AG	**0.5** G	**1.0** AG	**2.0** AR	**1.0** AG	**0.0** G	**0.0** 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**

Overriding Rules - Nature and Duration of Override at SHA's Discretion													
i)	Meeting the MRSA Objective	Greater than six cases in the year to date, and breaches the cumulative year-to-date trajectory for three successive quarters				No	No	No	No	No			
ii)	Meeting the C-Diff Objective	Greater than 12 cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters; Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency.				No	No	No	No	No			
iii)	RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter; The non-admitted patients 18 weeks waiting time measure for a third successive quarter; The incomplete pathway 18 weeks waiting time measure for a third successive quarter				No	No	No	No	No			
iv)	A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.				No	No	No	No	No			Currently 2 failures during a 12 month period (Qtr to Jun-12 and Qtr to Mar-13)
v)	Cancer Wait Times	Breaches either: the 31-day cancer waiting time target for a third successive quarter; the 62-day cancer waiting time target for a third successive quarter				No	No	No	No	No			
vi)	Ambulance Response Times	Breaches: the category A 8-minute response time target for a third successive quarter; the category A 19-minute response time target for a third successive quarter; either Red 1 or Red 2 targets for a third successive quarter				N/a	N/a	N/a	N/a	N/a			
vii)	Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter				N/a	N/a	N/a	N/a	N/a			
viii)	Any other Indicator weighted 1.0	Breaches the indicator for three successive quarters.				No	No	No	No	No			
		Adjusted Governance Risk Rating				**1.5** AG	**0.5** G	**1.0** AG	**2.0** AR	**1.0** AG	**0.0** G	**0.0** G	

CONTRACTUAL DATA

Information to inform discussion meeting

Oxford University Hospitals NHS Trust

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

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Sep-12	Qtr to Dec-12	Qtr to Mar-13	Apr-13	May-13	Jun-13	Qtr to Jun-13	
1	Are the prior year contracts* closed?	Yes	Yes	Yes	Yes	Yes			
2	Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes	Yes			
3	Has the Trust received income support outside of the NHS standard contract e.g. transformational support?	No	No	No	No	No			
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			
6	Might the dispute require third party intervention or arbitration?	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			
8	Have any performance notices been issued?	No	No	No	No	No			
9	Have any penalties been applied?	No	Yes	No	No	No			

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

Oxford University Hospitals

TFA Progress

Jul-13

Oxford University Hospitals NHS Trust

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Performance	Board Action
1	Integration of NOC and creation of OUH	Nov-11	Fully achieved in time	
2	Submission of Draft 1 IBP, LTFM, update on Board development and Quality Action Plan	Dec-11	Fully achieved in time	
3	Submit sHDD material to SHA	Jan-12	Fully achieved in time	
4	Quality Peer Review by SHA	Apr-12	Fully achieved in time	
5	Submission of Draft 2 IBP, LTFM, draft consultation documents and update on sHDD actions	May-12	Fully achieved in time	
6	SHA to approve consultation	Jun-12	Fully achieved in time	
7	Public consultation	Jun-12	Fully achieved in time	
8	2012/13 Performance & Financial Review	Jul-12	Fully achieved in time	
9	Independent HDD Phase 1	Jul-12	Fully achieved in time	
10	2012/13 Performance & Finance Review	Oct-12	Fully achieved in time	
11	Submission of Draft 3 IBP, LTFM, outcome of consultation, legal confirmation of constitution, letter of support from commissioners	Nov-12	Fully achieved in time	
12	Board-to-Board with SHA approves application	Nov-12	Not fully achieved	Board-to-Board took place on 20 December at SHA request.
13	Independent HDD Phase 2	Dec-12	Fully achieved in time	Completed in October 2012.
14	SHA forwards application to DH	Jan-13	Not fully achieved	SHA agreed in September 2012 to submission to DH 1 February. Superseded by TDA involvement, with submission of information to TDA 1 March.
15				
16				

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