Croydon Health Services NHS
NHS Trust

REPORT TO TRUST BOARD

Date: 26 November 2012	**Agenda No: 9.3**

Title of Document: Foundation Trust application Single Operating Model (SOM) reports

Report Author: Sven Bunn, FT Project Manager

Lead Director: John Goulston, Interim Chief Executive

Summary:
The Department of Health has developed a single operating model (SOM) for managing foundation trust applications to ensure a consistent approach which addresses all of the development and regulatory requirements applicant Trusts need to meet. As part of this process, a standard reporting system has been developed.

The Trust Board is required to approve the submission of the data and statements set out in the reports attached. As part of the assessment process, NHS London will test the basis used by the board to approve the statements, with reference to the supporting evidence and assurance provided by the Trust.

Reports based on data for September and October 2012 are attached for approval. The September data was reviewed at the board meeting on 29 October 2012, but there has been a material change with the addition of performance against cancer waiting times targets, which was available for the previous draft.

Recommendations:

Trust Board is requested to approve the SOM reports for September and October 2012.

NHS Constitution considerations: None
Copy available at http://www.dh.gov.uk/en/Healthcare/NHSConstitution/DH_093184

Who have you engaged with in the production of this document:

- ☐ **Patients** ☐ **Public** ☐ **Staff**
- ☐ **Partners** ☐ **Patient Assembly**
- ☐ **Other *please state***
- ☒ **Trust Committees *please state :*** Foundation Trust application steering group

Outcomes of engagement:

Agreed process for board approval for the SOM reports.

Has an equality impact assessment form been completed?

Not applicable for this document.

Key Risks:
None

Risks reflected in risk register

Other implications including financial /legal/governance/diversity/human resources:
None

SELF-CERTIFICATION RETURNS
Organisation Name:
Croydon Health Services NHS Trust
Monitoring Period:
September 12
NHS Trust Over-sight self certification template

Returns to XXX by the last working day of each

TFA Progress

Sep-12

Croydon Health Services NHS Trust

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Performance	Comments where milestones are not delivered or where a risk to delivery has been identified
1	TFA/AA: SHA Introductory meeting with Char, CE & FT Director (SHA Gateway 1). (GREEN)	Jul-12	Fully achieved in time	
2	AA: SHA initial Board Interviews - 19th July to 6th August (GREEN)	Aug-12	Fully achieved in time	
3	AA: Self Assessments - BGAF and Quality Governance	Aug-12	Fully achieved in time	
4	AA: BGAF action plans developed and agreed by Trust Board	Sep-12	On track to deliver	
5	AA: Independent Assessment - BGAF. Action plan October.	Oct-12	On track to deliver	
6	TFA/AA: Draft IBP/LTFM developed with enabling strategies and approved by Trust Board	Oct-12	Risk to delivery within timescale	Completion of supporting strategies and IBP drafting has been delayed 2-3 weeks.
7	TFA/AA: HDD1 - PwC	Nov-12	On track to deliver	
8	TFA/AA: HDD1 action plan	Nov-12	On track to deliver	
9	TFA/AA: LTFM/IBP for FT readiness review meeting	Nov-12	On track to deliver	
10	AA: Public Consulation Review	Nov-12	On track to deliver	
11	TFA/AA: SHA FT readiness review meeting with Chair, CE & FT Director SHA Gateway 2).	Jan-13	On track to deliver	
12	AA: SHA agrees to HDD2 commencing	Jan-13	On track to deliver	
13	AA: LTFM/IBP for HDD2	Jan-13	On track to deliver	
14	TFA/AA: HDD2	Mar-13	On track to deliver	
15	AA: SHA Quality & Governance Desktop review completion - tbc	Mar-13	On track to deliver	
16	TFA/AA: Commissioner convergence letter	Mar-13	On track to deliver	

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

Name of Organisation:	Croydon Health Services NHS Trust	Period:	September 12

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)	8.0 (Red)
Financial Risk Rating (Assign number as per SOM guidance)	2
Contractual Position (RAG as per SOM guidance)	Amber / Green

*** Please type in R, A or G**

Governance Declarations

NHS Trusts must ensure that plans in place are sufficient to ensure compliance in relation to all national targets and including ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections, CQC Essential standards and declare any contractual issues.

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 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.

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

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.

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

Signed by :		Print Name :	John Goulston
on behalf of the Trust Board	Acting in capacity as:	Interim Chief Executive	

If Declaration 2 has been signed:

Please identify which targets have led to the Board being unable to sign declaration 1. For each area such as Governance, Finance, Contractual, CQC Essential Standards, 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:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

GOVERNANCE RISK RATINGS

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

Croydon Health Services NHS Trust

Insert YES (target met in month), NO (not met in month) or N/A (as appropriate)
See separate rule for A&E

Area	Ref	Indicator	Sub Sections	Threshold	Weighting	Historic Data: Qtr to Dec-11	Historic Data: Qtr to Mar-12	Historic Data: Qtr to Jun-12	Current Data: Jul 12	Current Data: Aug-12	Current Data: Sep-12	Current Data: Qtr to Sep-12	Comments where target not achieved
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0		No	No	Yes	Yes	Yes	Yes	
			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	Yes	Community Services team are not yet shadow monitoring these measures.
			Patients dying at home / care home	50%			N/a		N/a	N/a	N/a	Yes	Community Services team are not yet shadow monitoring these measures.
	1c	Data completeness: identifiers MHMDS		97%	0.5				N/a	N/a	N/a	Yes	Items 1c - 1d relate to Mental Health Providers
	1c	Data completeness: outcomes for patients on CPA		50%	0.5				N/a	N/a	N/a	Yes	Items 1c - 1d relate to Mental Health Providers
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	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		No	No	Yes	No	No	No	Open pathways currently undergoing validation.
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5		No	No	No	No	No	No	The issue is that we do not currently have an IT system that allows the trust to identify patients with LD. However the trust meets all the other standards, and the forthcoming IT system (Cerner) will address this.
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising :	Surgery	94%	1.0		Yes	Yes	Yes	Yes	Yes	Yes	
			Anti cancer drug treatments	98%					Yes				
			Radiotherapy	94%					Yes				
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0		Yes	Yes	Yes	Yes	No	No	
			From NHS Cancer Screening Service referral	90%					Yes				
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5		Yes	Yes	Yes	Yes	No	No	
	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%					Yes				
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0		Yes	No	Yes	Yes	Yes	Yes	It should be noted that July for Monitor reporting is from 1 July to 31 July. For DH reporting July is comprised of the weeks ending in month which in this case was 2 July to 29 July. The Trust achieved 95% for the latter time period.
	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	N/a	Yes	Items 3f - 3i relate to Mental Health Providers
			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	N/a	Yes	Items 3f - 3i relate to Mental Health Providers
	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	N/a	Yes	Items 3f - 3i relate to Mental Health Providers
	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	N/a	Yes	Items 3f - 3i relate to Mental Health Providers
	3j	Category A call – emergency response within 8 minutes		75%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	Items 3j - 3k relate to Ambulance Trust
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	Items 3j - 3k relate to Ambulance Trust
Safety	4a	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0		Yes	No	Yes	No	No	No	No single cause. Deep clean is 1 month behind schedule due to bed pressures. 2 patients took in excess of 1 week to isolate. Currently under investigation.
	4b	MRSA	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0		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	No	No	No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0		No	Yes	Yes	Yes	Yes	Yes	2 Warning Notices issued (Outcome 4 and Outcome 11)
	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		0.0	2.5	8.5	4.5	6.5	8.0	8.0	

RAG RATING :

GREEN	= Score of 1 or under
AMBER/GREEN	= Score between 1 and 1.9
AMBER / RED	= Score between 2 and 3.9
RED	= Score of 4 or above

	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 either:											
		Breaches the cumulative year-to-date trajectory for three successive quarters											
		Breaches its full year objective											
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											
		Breaches its full year objective											
		Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency.											
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											
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.											
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											
vi)	Ambulance Response Times	Breaches either:											
		the category A 8-minute response time target for a third successive quarter											
		the category A 19-minute response time target for a third successive quarter											
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											
viii)	Any Indicator weighted 1.0	Breaches the indicator for three successive quarters.											
			Number of Overrides Triggered			***0.0***	***0.0***	***0.0***	***0.0***	***0.0***	***0.0***	***0.0***	

FINANCIAL RISK RATING

Croydon Health Services NHS Trust

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Insert the Score (1-5) Achieved for each Criteria Per Month: Reported Position Year to Date	Reported Position Forecast Outturn	Normalised Position* Year to Date	Normalised Position* Forecast Outturn	Comments where target not achieved
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	2	2	2	2	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	1	3	1	3	
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	1	2	1	2	
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	3	3	3	3	
Weighted Average		**100%**						**2.0**	**2.6**	**2.0**	**2.6**	
Overriding rules								2	3	2	3	Check if overriding rules are being applied correctly in template
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	One Financial Criterion at "1"		2		2	
3	One Financial Criterion at "2"			3		3
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

Croydon Health Services NHS Trust

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

	Criteria	Historic Data			Current Data				Comments where risks are triggered
		Qtr to Dec-11	Qtr to Mar-12	Qtr to Jun-12	Jul 12	Aug-12	Sep-12	Qtr to Sep-12	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	No	No	Yes	Yes	Yes	Trust has put in place financial recovery plan to improve EBITDA Margin
2	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months	No	No	No	No	Yes	Yes	Yes	Delivery of Financial recovery plan will deliver a Financial risk rating of 2
3	Working capital facility (WCF) agreement includes default clause								
4	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Main balances > 90 days are with local commissioner PCT; discussions are ongoing to resolve disputes, and significant headway has been made with very aged balances.
5	Creditors > 90 days past due account for more than 5% of total creditor balances	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Main balances > 90 days are with local commissioner PCT; discussions are ongoing to resolve disputes, and significant headway has been made with very aged balances.
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No	No	No	
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No	No	No	
8	Quarter end cash balance <10 days of operating expenses	Yes	No	No	No	No	Yes	Yes	
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No	No	No	No	

CONTRACTUAL DATA

Croydon Health Services NHS Trust

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

Criteria	Historic Data			Current Data				Comments where reds are triggered
	Qtr to Dec-11	Qtr to Mar-12	Qtr to Jun-12	Jul 12	Aug-12	Sep-12	Qtr to Sep-12	
Are the prior year contracts* closed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Are there any disputes over the terms of the contract?	No	No	No	No	No	No	No	
Might the dispute require SHA intervention or arbitration?	N/a	N/a	N/a	N/a	N/a	N/a	No	
Are the parties already in arbitration?	No	No	No	No	No	No	No	
Have any performance notices been issued?	Yes	No	No	No	No	No	No	VTE and Clostridium difficile Clause 32 notices issued
Have any penalties been applied?	No	No	No	Yes	Yes	Yes	Yes	Currently breaching contract KPIs

QUALITY

Croydon Health Services NHS Trust

Insert Performance in Month

	Criteria	Unit	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Comments on Performance in Month
1	SHMI - latest data	Ratio										100.6			July is the latest data avilable at this time.
2	Venous Thromboembolism (VTE) Screening	%		94.06	93.08	87.53	86.94	87.48	85.12	88.61	89.96	90.97	90.54	85.03	
3a	Elective MRSA Screening	%													
3b	Non Elective MRSA Screening	%							81.63	79.54	83.33	83.75	83.95	75.82	
4	Single Sex Accommodation Breaches	Number				1	5	7	12	14	13	14	11	14	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number		10	18	19	12	12	19	27	27	41	43	38	
6	"Never Events" in month	Number		0	0	1	0	2	0	0	1	1	0	0	
7	CQC Conditions or Warning Notices	Number		0	0	0	0	0	0	0	2	9	9	9	2 Warning notices (Outcome 4 and 11); 7 Compliance actions (Maternity Services: Outcome 4 and 13; Adult Inpatients : Outcome 9, 14,4,13,16).
8	Open Central Alert System (CAS) Alerts	Number										11	11	16	
9	RED rated areas on your maternity dashboard?	Number										6	7		1:1 care in labour / Supervisor: Midwife ratio / Still births / Cases of HIE / No.of SIs / Breast feeding / IUD
10	Falls resulting in severe injury or death	Number		1	2	0	0	1	2	3	0	1	0	0	
11	Grade 3 or 4 pressure ulcers	Number		1	2	0	0	1	2	3	0	13	4	3	All presure ulcer CHS acquired (inclusive of community, all grade 3. Have not included non-CHS acquired.
12	100% compliance with WHO surgical checklist	Y/N										N			
13	Formal complaints received	Number		50	45	55	61	67	38	52	29	45	42	49	
14	Agency as a % of Employee Benefit Expenditure	%	4.1	3.7	3.4	6.4	6.2	8.08	6.66	8.43	9.34	8.94	8.62	8.68	
15	Sickness absence rate	%	3.42	3.36	3.51	3.37	3.68	3.29	3.05	3.43	3.49	3.28	2.95	2.89	August Data latest available
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%													

Board Statements

Croydon Health Services NHS Trust

September 12

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 SHA's Provider Management 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	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 remains at all times compliant with 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 it occurring 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 operating 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 relevant GRR; and a commitment to comply with all known targets going forwards.	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.	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 operating plan; and the management structure in place is adequate to deliver the annual operating plan.	No

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO		**JOHN GOULSTON**	
Chair		**MICHAEL PARKER**	

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.
3d	Cancer	Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners and any primary care professional).Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation

Notes

Ref	Indicator	Details
3e	A&E	Waiting time is assessed on a site basis: no activity from off-site partner organisations should be included. The 4-hour waiting time indicator will apply to minor injury units/walk in centres.
3f	Mental	7-day follow up: **Numerator**: the number of people under adult mental illness specialties on CPA who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. **Denominator:** the total number of people under adult mental illness specialties on CPA who were discharged from psychiatric inpatient care. All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemptions from both the numerator and the denominator of the indicator include: - patients who die within seven days of discharge; - where legal precedence has forced the removal of a patient from the country; or - patients discharged to another NHS psychiatric inpatient ward. For 12 month review (from Mental Health Minimum Data Set): **Numerator:** the number of adults in the denominator who have had at least one formal review in the last 12 months. **Denominator:** the total number of adults who have received secondary mental health services during the reporting period (month) who had spent at least 12 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
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

SELF-CERTIFICATION RETURNS
Organisation Name:
Croydon Health Services NHS Trust
Monitoring Period:
October 2012
NHS Trust Over-sight self certification template

Returns to XXX by the last working day of each month

TFA Progress

Oct-12

Croydon Health Services NHS Trust

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Performance	Comments where milestones are not delivered or where a risk to delivery has been identified
1	TFA/AA: SHA Introductory meeting with Char, CE & FT Director (SHA Gateway 1). (GREEN)	Jul-12	Fully achieved in time	
2	AA: SHA initial Board Interviews - 19th July to 6th August (GREEN)	Aug-12	Fully achieved in time	
3	AA: Self Assessments - BGAF and Quality Governance	Aug-12	Fully achieved in time	
4	AA: BGAF action plans developed and agreed by Trust Board	Sep-12	Fully achieved in time	
5	AA: Independent Assessment - BGAF. Action plan October.	Oct-12	On track to deliver	
6	TFA/AA: Draft IBP/LTFM developed with enabling strategies and approved by Trust Board	Oct-12	Will not be delivered on time	Delay in production of IBP and supporting strategies. Draft IBP to be reviewed by Board in November 12
7	TFA/AA: HDD1 - PwC	Nov-12	Will not be delivered on time	HDD1 will be rescheduled for January 13.
8	TFA/AA: HDD1 action plan	Nov-12	Will not be delivered on time	Action plan will follow HDD1 review in January.
9	TFA/AA: LTFM/IBP for FT readiness review meeting	Nov-12	Will not be delivered on time	First draft IBP will be completed December 12
10	AA: Public Consulation Review	Nov-12	On track to deliver	
11	TFA/AA: SHA FT readiness review meeting with Chair, CE & FT Director SHA Gateway 2).	Jan-13	Will not be delivered on time	Readiness review meeting will be rescheduled for February 13.
12	AA: SHA agrees to HDD2 commencing	Jan-13	On track to deliver	
13	AA: LTFM/IBP for HDD2	Jan-13	On track to deliver	
14	TFA/AA: HDD2	Mar-13	On track to deliver	
15	AA: SHA Quality & Governance Desktop review completion - tbc	Mar-13	On track to deliver	
16	TFA/AA: Commissioner convergence letter	Mar-13	On track to deliver	

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

Name of Organisation:	Croydon Health Services NHS Trust	Period:	October 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)	2.5 (Amber/Red)
Financial Risk Rating (Assign number as per SOM guidance)	2
Contractual Position (RAG as per SOM guidance)	Amber / Green

*** Please type in R, A or G**

Governance Declarations

NHS Trusts must ensure that plans in place are sufficient to ensure compliance in relation to all national targets and including ongoing compliance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections, CQC Essential standards and declare any contractual issues.

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 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.

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

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.

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

Signed by :		Print Name :	John Goulston
on behalf of the Trust Board	Acting in capacity as:	Interim Chief Executive	

If Declaration 2 has been signed:

Please identify which targets have led to the Board being unable to sign declaration 1. For each area such as Governance, Finance, Contractual, CQC Essential Standards, 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:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

GOVERNANCE RISK RATINGS

Croydon Health Services NHS Trust

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

Insert YES (target met in month), NO (not met in month) or N/A (as appropriate)
See separate rule for A&E

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	Comments where target not achieved
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	Yes	Yes	Yes	Yes			Yes	
			Referral information	50%		No	No		Yes				
			Treatment activity information	50%		Yes	Yes		Yes				
	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	Yes	Community Services team are not yet shadow monitoring these measures.
			Patients dying at home / care home	50%		N/a	N/a	N/a	N/a	N/a	N/a	Yes	Community Services team are not yet shadow monitoring these measures.
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	Yes	Items 1c - 1d relate to Mental Health Providers
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	Yes	Items 1c - 1d relate to Mental Health Providers
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	
	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	N/a	No	No	No			No	Open pathways currently undergoing validation.
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5		No	No	No			No	The issue is that we do not currently have an IT system that allows the trust to identify patients with LD. However the trust meets all the other standards, and the forthcoming IT system (Cerner) will address this.
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising :	Surgery	94%	1.0	Yes	Yes	Yes					Cancer data items one month in arrears
			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	Yes	No					For Qtr to Jun'12 and Qtr to Sep'12, there were upto 5 referrals, so target doesn't apply.
			From NHS Cancer Screening Service referral	90%		No	N/a	N/a					
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	No					
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	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	Yes	No	Yes	Yes			Yes	It should be noted that July for Monitor reporting is from 1 July to 31 July. For DH reporting July is comprised of the weeks ending in month which in this case was 2 July to 29 July. The Trust achieved 95% for the latter time period.
	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	N/a	Yes	Items 3f - 3i relate to Mental Health Providers
			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	N/a	Yes	Items 3f - 3i relate to Mental Health Providers
	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	N/a	Yes	Items 3f - 3i relate to Mental Health Providers
	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	N/a	Yes	Items 3f - 3i relate to Mental Health Providers
	3j	Category A call – emergency response within 8 minutes		75%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	Items 3j - 3k relate to Ambulance Trust
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	Yes	Items 3j - 3k relate to Ambulance Trust
Safety	4a	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0	Yes	No	No	No			No	No single cause. Deep clean is 1 month behind schedule due to bed pressures. 2 patients took in excess of 1 week to isolate. Currently under investigation.
	4b	MRSA	Are you below the ceiling for your monthly trajectory	*Enter contractual ceiling*	1.0	Yes	Yes	Yes	Yes			Yes	
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No			No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	Yes	Yes	No			No	2 Warning Notices lifted in Sep'12
	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					
				TOTAL		1.0	7.5	8.0	2.5	0.0	0.0	2.5	

RAG RATING :

GREEN	= Score of 1 or under
AMBER/GREEN	= Score between 1 and 1.9
AMBER / RED	= Score between 2 and 3.9
RED	= Score of 4 or above

	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 either:											
		Breaches the cumulative year-to-date trajectory for three successive quarters											
		Breaches its full year objective											
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											
		Breaches its full year objective											
		Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency.											
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											
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.											
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											
vi)	Ambulance Response Times	Breaches either:											
		the category A 8-minute response time target for a third successive quarter											
		the category A 19-minute response time target for a third successive quarter											
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											
viii)	Any Indicator weighted 1.0	Breaches the indicator for three successive quarters.											
		Number of Overrides Triggered				*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*	

FINANCIAL RISK RATING

Croydon Health Services NHS Trust

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Insert the Score (1-5) Achieved for each Criteria Per Month: Reported Position Year to Date	Reported Position Forecast Outturn	Normalised Position* Year to Date	Normalised Position* Forecast Outturn	Comments where target not achieved
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	2	2	2	2	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	2	3	2	3	
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**	**2.6**	**2.3**	**2.6**	
Overriding rules								2	3	2	3	
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	One Financial Criterion at "1"							
3	One Financial Criterion at "2"			3		3		
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

Croydon Health Services NHS Trust

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

	Criteria	Historic Data			Current Data				Comments where risks are triggered
		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	Yes	Yes			Yes	Trust has put in place financial recovery plan to improve EBITDA Margin
2	Quarterly self-certification by trust that the financial risk rating (FRR) may be less than 3 in the next 12 months	No	No	Yes	Yes			Yes	Delivery of Financial recovery plan will deliver a Financial risk rating of 2
3	Working capital facility (WCF) agreement includes default clause								
4	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	Yes			Yes	Main balances > 90 days are with local commissioner PCT; discussions are ongoing to resolve disputes, and significant headway has been made with very aged balances.
5	Creditors > 90 days past due account for more than 5% of total creditor balances	Yes	Yes	Yes	Yes			Yes	Main balances > 90 days are with local commissioner PCT; discussions are ongoing to resolve disputes, and significant headway has been made with very aged balances.
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No			No	
7	Interim Finance Director in place over more than one quarter end	No	No	No	No			No	
8	Quarter end cash balance <10 days of operating expenses	No	No	Yes	Yes			Yes	High level expenditure in month, but cash level is still above plan. Cash levels being closely monitored by monthly Working Capital Group
9	Capital expenditure < 75% of plan for the year to date	No	No	No	No			No	

CONTRACTUAL DATA

Croydon Health Services NHS Trust

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

Criteria	Historic Data			Current Data				Comments where reds are triggered
	Qtr to Mar-12	Qtr to Jun-12	Qtr to Sep-12	Oct-12	Nov-12	Dec-12	Qtr to Dec-12	
Are the prior year contracts* closed?	Yes	Yes	Yes	Yes			Yes	
Are all current year contracts* agreed and signed?	Yes	Yes	Yes	Yes			Yes	
Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes			Yes	
Are there any disputes over the terms of the contract?	No	No	No	No			No	
Might the dispute require SHA intervention or arbitration?	N/a	N/a	N/a	N/a	N/a	N/a	No	
Are the parties already in arbitration?	No	No	No	No			No	
Have any performance notices been issued?	No	No	No	No			No	
Have any penalties been applied?	No	No	Yes	Yes			Yes	Currently breaching contract KPIs

QUALITY

Croydon Health Services NHS Trust

Insert Performance in Month

	Criteria	Unit	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Comments on Performance in Month
1	SHMI - latest data	Ratio									100.6				July is the latest data avilable at this time.
2	Venous Thromboembolism (VTE) Screening	%	94.06	93.08	87.53	86.94	87.48	85.12	88.61	89.96	90.97	90.54	85.03	83.25	
3a	Elective MRSA Screening	%													
3b	Non Elective MRSA Screening	%						81.63	79.54	83.33	83.75	83.95	75.82		Data availble from Apr'12 onwards
4	Single Sex Accommodation Breaches	Number			1	5	7	12	14	13	14	11	14	5	Started collecting only from Jan'12
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	10	18	19	12	12	19	27	27	41	43	38	28	
6	"Never Events" in month	Number	0	0	1	0	2	0	0	1	1	0	0	0	
7	CQC Conditions or Warning Notices	Number	0	0	0	0	0	0	0	2	2	2	0	0	2 Warning notices lifted in Sep'12
8	Open Central Alert System (CAS) Alerts	Number									11	11	16		
9	RED rated areas on your maternity dashboard?	Number									6	7			1:1 care in labour / Supervisor: Midwife ratio / Still births / Cases of HIE / No.of SIs / Breast feeding / IUD
10	Falls resulting in severe injury or death	Number	1	2	0	0	1	2	3	0	1	0	0	4	
11	Grade 3 or 4 pressure ulcers	Number	6	3	1	0	2	2	4	1	13	4	3	2	
12	100% compliance with WHO surgical checklist	Y/N									N				
13	Formal complaints received	Number	50	45	55	61	67	38	52	29	45	42	49		
14	Agency as a % of Employee Benefit Expenditure	%	3.7	3.4	6.4	6.2	8.08	6.66	8.43	9.34	8.94	8.62	8.68		
15	Sickness absence rate	%	3.36	3.51	3.37	3.68	3.29	3.05	3.43	3.49	3.28	2.95	2.89		September Data latest available
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%													

Board Statements

Croydon Health Services NHS Trust

October 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 SHA's Provider Management 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	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 remains at all times compliant with 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 it occurring 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 operating 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 relevant GRR; and a commitment to comply with all known targets going forwards.	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.	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 operating plan; and the management structure in place is adequate to deliver the annual operating plan.	No

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO		**JOHN GOULSTON**	
Chair		**MICHAEL PARKER**	

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.
3d	Cancer	Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners and any primary care professional).Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation

Notes

Ref	Indicator	Details
3e	A&E	Waiting time is assessed on a site basis: no activity from off-site partner organisations should be included. The 4-hour waiting time indicator will apply to minor injury units/walk in centres.
3f	Mental	7-day follow up: **Numerator**: the number of people under adult mental illness specialties on CPA who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. **Denominator:** the total number of people under adult mental illness specialties on CPA who were discharged from psychiatric inpatient care. All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemptions from both the numerator and the denominator of the indicator include: - patients who die within seven days of discharge; - where legal precedence has forced the removal of a patient from the country; or - patients discharged to another NHS psychiatric inpatient ward. For 12 month review (from Mental Health Minimum Data Set): **Numerator:** the number of adults in the denominator who have had at least one formal review in the last 12 months. **Denominator:** the total number of adults who have received secondary mental health services during the reporting period (month) who had spent at least 12 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
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