NHS
East of England

SELF-CERTIFICATION RETURNS
Organisation Name:
West Hertfordshire Hospitals
Monitoring Period:
June 2012

NHS EoE
Provider Management Regime
2012/13

NHS East of England

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

Name of Organisation:	West Hertfordshire Hospitals	Period:	June 2012

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance as per the 2011/12 Provider Management Regime, 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 NHS EoE PMR guidance)	A/R
Financial Risk Rating (Assign number as per NHS EoE PMR guidance)	A
Contractual Position (RAG as per NHS EoE PMR guidance)	G

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

Governance Declarations

NHS East of England organisations, subject to the Provider Management Regime, 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 :	Thomas Hanahoe
on behalf of the Trust Board	Acting in capacity as:	Chairman	
Signed by :		Print Name :	Jan Filochowski
on behalf of the Trust Board	Acting in capacity as:	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:	Code of Practice for the Prevention and Control of Healthcare Associated Infections (including the Hygiene Code)
The Issue :	The Trust's services are acknowledged to be safe, but due to the requirements of building technical notes for the physical environment, the Trust cannot achieve full compliance
Action :	Purchase and installation of new endoscopy decontamination units at Watford and Hemel. The Hemel Endoscopy scheme is now completed and operational. A P21+ partner has been appointed to develop and deliver the Watford scheme ready for completion before end of 2012/13 and contracts have been signed. A compliant service is expected to go live in early 2013. The Trust signed contracts with the NW London collaboration and their provider of TSSU services on 14th May 2012. Precise timelines for a transition to the compliant unit are being finalised, but it is anticipated this will happen in early 2013.

Target/Standard:	Clostridium Difficile: Are you below the ceiling for your monthly trajectory?
The Issue :	The profile for C Diff infections provided for a ceiling of three cases for June. The Trust had four. The annual ceiling is 33 cases.
Action :	The Trust will continue with its very effective infection control programme seeking to improve where possible.

Target/Standard:	Cancer: 2 week wait from referral to date first seen for symptomatic breast patients where cancer is not initially suspected
The Issue :	In June 16 patients were offered appointments within the 14 day target period but chose to refuse or cancel these offers in favour of an appointment outside the target period. The situation was exacerbated by the double bank holiday and the reluctance of patients to take appointments during the bank holiday week or the preceding week.
Action :	The Trust has increased the availability of appointment slots, as of 10th July. Steps have also been taken to ensure that patients' expectations are appropriately set by GPs - to expect a fast response from the Trust and that there is an expectation on the patient to accept an appointment within 14 days.

Target/Standard:	All cancers: 62-day wait for first treatment, comprising a consultant screening service referral
The Issue :	There were eight patients on this pathway. One elected to wait for a colonoscopy until a friend returned from abroad to accompany him. This delayed the pathway by one month and inevitably resulted in a breach.
Action :	This is a one-off patient choice and no general guidance or modifications to the pathway result

ACUTE
GOVERNANCE RISK RATINGS 2012/13

West Hertfordshire Hospitals

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

Ref	Area	Indicator	Sub Sections	Threshold	Weighting	April 2012	May 2012	Jun 2012	July 2012	Aug 2012	Sept 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Comments where target not achieved in month?
1	Safety	Clostridium Difficile	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	Yes	Yes	No										4 cases of unrelated C Diff in month against a ceiling of 3 and an annual trajectory of 33
2	Safety	MRSA	Are you below the ceiling for your monthly trajectory	Contract with PCT	1.0	Yes	Yes	Yes										
3	Quality	All cancers: 31-day wait for second or subsequent treatment, comprising either:	Surgery	94%	1.0	Yes	Yes	Yes										
			Anti cancer drug treatments	98%														
			Radiotherapy	94%														
4	Quality	All cancers: 62-day wait for first treatment, comprising either:	From urgent GP RTT	85%	1.0	Yes	Yes	No										June: A single screening patient elected to delay initial colonoscopy by 1 month until a friend returned from abroad
			From consultant screening service referral	90%														
5a	Patient Experience	RTT waiting times – admitted	95th percentile	23 wks	1.0	Yes	Yes	Yes										
5b	Patient Experience	RTT waiting times – non-admitted	95th percentile	18.3 wks	1.0	Yes	Yes	Yes										
6	Quality	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes										
7	Quality	Cancer: 2 week wait from referral to date first seen, comprising either:	all cancers	93%	0.5	No	Yes	No										Decline in performance as patients had an increased tendency to decline and/or cancel OPAs in week either side of
			for symptomatic breast patients (cancer not initially suspected)	93%														
8a	Quality	A&E (Q1): Total time in A&E	Total time in A&E (95th percentile)	≤ 4 hrs	1.0	95.80%	96.20%	96.3%										A&E 8a indicator used rather than 8b on telephone advice from SHA informed by Monitor letter
8b	Quality	A&E (from Q2): NB Please record actual number failing	Total time in A&E (95th percentile)	≤4 hrs	1.0 (failing 3 or more) OR 0.5 (failing 2 or													See comment above
			Time to initial assessment (95th percentile)	≤15 mins														
			Time to treatment decision (median)	≤60 mins														
			Unplanned re-attendance rate	≤5%														
			Left without being seen	≤5%														
9	Quality	Stroke indicator:		TBC	0.5													
17	Patient experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes										
		CQC Registration																
A	Safety	CQC Registration	Are there any compliance conditions on registration outstanding	0	1.0	No	No	No										
B	Safety	CQC Registration	Are there any restrictive compliance conditions on registration outstanding	0	2.0	No	No	No										
C	Safety	Moderate CQC concerns regarding the safety of healthcare provision		0	1.0	No	No	No										
D	Safety	Major CQC concerns regarding the safety of healthcare provision		0	2.0	No	No	No										
E	Safety	Failure to rectify a compliance or restrictive condition(s) by the date set by the CQC with the condition(s)		0	3.0	No	No	No										
NB	**Safety**	**Any CQC Enforcement Actions**		**0**	**4.0**	No	No	No										
				TOTAL		**0.5**	**0.0**	**2.5**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	

FINANCIAL RISK RATING 2012/13

West Hertfordshire Hospitals

Insert the Score (1-5) Achieved for each Criteria Per Month

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Annual Plan 2012/13	Apr 2012	May 2012	June 2012	Jul 2012	Aug 2012	Sept 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Comments on Performance in Month
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	3	2	2	3										
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	5	5	5	4										
Financial efficiency	**Return on assets %**	20%	6	5	3	-2	<-2	4	4	4	4										
	I&E surplus margin %	20%	3	2	1	-2	<-2	3	1	2	3										
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	4	4	4	4										
Average	**Weighted Average**	**100%**						**3.7**	**3.0**	**3.2**	**3.6**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	
Overriding rules	**Overriding rules**																				
Overall rating	**Final Overall rating**							**4.0**	**2.0**	**2.0**	**4.0**										

Overriding Rules :

Max Rating	Rule
3	Plan not submitted on time
3	Plan not submitted complete and correct
2	PDC divident not paid in full
2	One Financial Crieterion at "1"
3	One Financial Crieterion at "2"
1	Two Financial Criteria at "1"
2	Two Financial Criteria at "2"

FINANCIAL RISK TRIGGERS 2011/12

West Hertfordshire Hospitals

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

	Criteria	Apr 2012	May 2012	June 2012	Jul 2012	Aug 2012	Sept 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Comments on Performance in Month
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	No										
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										
3	FRR 2 for any one quarter	No	No	No										
4	Working capital facility (WCF) agreement includes default clause	No	No	No										
5	Debtors > 90 days past due account for more than 5% of total debtor balances	No	No	No										
6	Creditors > 90 days past due account for more than 5% of total creditor balances	No	No	No										
7	Two or more changes in Finance Director in a twelve month period	No	No	No										
8	Interim Finance Director in place over more than one quarter end	No	No	No										
9	Quarter end cash balance <10 days of operating expenses	No	No	No										
10	Capital expenditure < 75% of plan for the year to date	No	No	No										
	TOTAL	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	

NB **Scoring: An answer of "YES" = 1.0**

RAG RATING :

GREEN	**= Score between 0 and 1**
AMBER	**= Score between 2 and 4**
RED	**= Score over 5**

CONTRACTUAL RISK RATINGS 2011/12

West Hertfordshire Hospitals

Insert R, A or G into appropriate row for the Month

Criteria	RAG	Apr 2012	May 2012	June 2012	Jul 2012	Aug 2012	Sept 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Comments on Performance in Month
Contracts agreed and signed Both provider and commissioner fulfilling terms of contract	G	G	G	G										
Provider and Commissioner are in dispute over terms of the contract Performance notices have been issued by either provider or commissioner for breach of contract	A													
Provdider and Commissioner are in dispute over the terms of the contract, with NHS EoE being asked to intervene / arbitrate. A number of performance notices have been issued by either provider or commissioner for breach of contract	R													

QUALITY

West Hertfordshire Hospitals

Insert Performance in Month

	Criteria	Unit	Apr 2012	May 2012	June 2012	Jul 2012	Aug 2012	Sept 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	Mar 2013	Comments on Performance in Month
1	Hospital Mortality Standardised Ratio (HSMR)	Ratio	102.0	102.0	102.0										Monthly figures show latest annual rolling average for latest quarter available: Jul/Aug/Sep 11 - Dr Foster via QIE. Earlier months corrected.
2	Venous Thromboembolism (VTE) Screening	%	94.7	98.4	94.8										
3a	Elective MRSA Screening	%	98.4	98.6	98.7										Earlier months amended
3b	Non Elective MRSA Screening	%	93.1	94.1	92.8										
4	Single Sex Accommodation Breaches	Number	0	0	0										
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	31	32	31										
6	"Never Events" in month	Number	0	0	0										
7	CQC Conditions or Warning Notices	Number	0	0	0										
8	Central Alert System (CAS) Alerts	Number	0	0	0										These figures show the CAS Alerts beyond their deadline
9	RED rated areas on your maternity dashboard?	Number	6	4	5										Booked by 12+6, Rate normal deliveries, C-section rate, Staff sickness, Nr shoulder dysocia
10	Falls resulting in severe injury or death	Number	0	0	1										A patient fall resulting in fractured neck of femour
11	Grade 3 or 4 pressure ulcers	Number	1	5	4										4 x grade 3 - RCA outstanding. Note: These occurred in month and may be reported in later month.
12	100% compliance with WHO surgical checklist	Y/N	Yes	Yes	Yes										
13	Formal complaints received	Number	42	47	50										Current month figure is provisional. Earlier months are amended to show final figures
14	Agency and bank spend as a % of turnover	%	3.7% 5.7%	4.0% 5.4%	3.5% 6.8%										Agency and bank split out as per request from SHA
15	Sickness absence rate	%	4.1	3.9	4.1										

Board Statements

West Hertfordshire Hospitals

June 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), its NHS 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.	✓

If the Trust Board is unable to make the above statement, the Board must:

2	Be satisfied that, to the best of its knowledge and using its own processes (supported by CQC information and including any further metrics it chooses to adopt), its 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.	✓
3	Be satisfied that, to the best of its knowledge and using its own processes, plans in place are sufficient to ensure ongoing compliance with the CQC's registration requirements	✓
4	Certify it is satisfied that processes and procedures are in place to ensure that all medical practitioners providing care on behalf of the NHS foundation trust have met the relevant registration and revalidation requirements.	✓
4	Be satisfied that the Trust is embedding patient experience into the service design, improvement and delivery cycle.	✓

	For SERVICE PERFORMANCE, that:	Response
5	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds), and compliance with all targets due to come into effect during 2011/12.	✓

	For RISK MANAGEMENT PROCESSES, that:	Response
6	Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner	✓
7	All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned	✓
8	The necessary planning, performance management and risk management processes are in place to deliver the annual plan	✓
9	A Statement of Internal Control ("SIC") is in place, and the trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the most up to date guidance from HM Treasury (see http://www.hm-treasury.gov.uk)	✓
10	The trust has achieved a minimum of Level 2 performance against the key requirements of the Department of Health's Information Governance Toolkit	✗

	For COMPLIANCE WITH THE NHS CONSTITUTION, that:	Response
11	The Board is assured that the trust will, at all times, have regard to the NHS constitution	✓

	For BOARD, ROLES, STRUCTURES AND CAPACITY, that:	*Response*
12	The Board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the Board	✓
13	The Board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability	✓
14	The selection process and training programmes in place ensure that the non-executive directors have appropriate experience and skills	✓
15	The management team have the capability and experience necessary to deliver the annual plan	✓
16	The management structure in place is adequate to deliver the annual plan objectives for the next three years.	✓

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO		**Jan Filochowski**	
Chair		**Thomas Hanahoe**	

NHS EoE Provider Management Regime

NHS East of England

Ref	Area	Details
Thresh-olds		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%.
1	C.Diff	Performance against contract with main commissioner
2	MRSA	MRSA objective: those trusts which 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 DH. The SHA expects those NHS trusts without a centrally calculated MRSA objective to agree an MRSA target for 2011/12 that at least maintains existing performance. Where a trust has an annual MRSA objective of six cases or fewer and has reported six cases or fewer in the year to date, the MRSA objective will not apply for the purposes of the SHA's Provider Management Regime If a trust with an annual objective of six cases or fewer declares a risk of exceeding the de minimis level and its annual MRSA objective in-year, but has not yet done so, it will be required to [provide, and then] report monthly against, an MRSA action plan until the risk has been satisfactorily addressed.
3	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.
4	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, including consultant upgrades. 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. 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 there is 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.
5a&b	RTT	While performance is measured on an aggregate basis, NHS trusts are required to meet the threshold on a monthly basis – consequently failure in any month represents failure for the quarter and should be reported via the exception reporting process.
6	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.
7	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. Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation
8a	A&E (Q1)	In Quarter one - 95th percentile waits for 4 hours or less to be used
8b	A&E (Q2)	From Quarter two: • 95th percentile waits for 4 hours or less to be used • Time to initial assessment: for ambulance arrivals. Initial assessment to include a pain score and early warning score. • Time to treatment decision: time from arrival to see a decision-making clinician (defining management plan and may potentially discharge the • Unplanned reattendance rate: within 7 days of original attendance. Includes patients referred back by another health professional. The SHA will not score this for paediatric specialist NHS trusts. • Left without being seen The SHA will keep these measures under review during 2011/12 and may change its implementation in line with national policy.
9	Stroke	The SHA will consider its introduction during 2011/12 following publication of DH's technical guidance.
10	Mental Health: CPA	7-day follow up: **Numerator**: The number of people under adult mental illness specialties on Care Programme Approach 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 Care Programme Approach who were discharged from psychiatric inpatient Contact can include face-to-face or telephone contact. Guidance on what should and should not be counted when calculating the achievement of this target can be found on Unify2. 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. Date last seen by care coordinator will be used as a proxy for formal Care Programme Approach review during 2011/12. **Denominator:** The total number of adults who have received secondary mental health services and who were on the Care Programme Approach at any point during the reporting period. For full details of the changes to the Care Programme Approach process, please see the implementation guidance, Refocusing the Care Programme Approach on the Department of Health's website. 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.
11	Mental Health: DTOC	**Numerator:** The number of non-acute patients (aged 18 and over) whose transfer of care was delayed averaged over the quarter. **Denominator:** Number of non-acute patients (aged 18 and over) admitted to the trust, summed across the quarter. Delayed transfers of care attributable to social care are excluded.
12	Mental Health: I/P and CRHT	This indicator applies only to admissions to the NHS trust's mental health psychiatric inpatient care. The following cases can be excluded: • admissions to psychiatric intensive care 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. 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 Guidance Statement on Fidelity and Best Practice for Crisis Services the crisis resolution home treatment team should: a) provide a mobile 24 hour, seven day 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;

Ref	Area	Details
d) e)		be assessing all these cases before admission happens; and be central to the decision making process in conjunction with the rest of the multidisciplinary team
13	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
14 NB	Mental Health: MDS	Patient identity data completeness metrics (from Mental Health Minimum Data Set) 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 visit the data quality constructions available on the Information Centre's website: www.ic.nhs.uk/services/mhmds/dq Denominator: total number of entries.
15	Mental Health: CPA	**Outcomes for patients on Care Programme Approach:** • Employment status: **Numerator:** The number of adults in the denominator in paid employment (i.e. those recorded as 'employed') 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 quarter. **Denominator:** The total number of adults (aged 18-69) who have received secondary mental health services and who were on the Care Programme Approach at any point during the reported quarter. • In settled accommodation: **Numerator:** The number of adults in the denominator who were in settled accommodation 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 quarter. **Denominator:** The total number of adults (aged 18-69) who have received secondary mental health services and who were on the Care Programme Approach at any point during the reported quarter. • Having an 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. NOTE: When implemented MHMDS v4 will allow services to report all HoNOS variants, including those for young people and people in secure services. Until this time trusts should report standard HoNOS inclusive of all ages and ward types. **Denominator:** The total number of adults who have received secondary mental health services and who were on the Care Programme Approach during the reference period.
16a	Ambulance Cat A	Life threatening
17 a) b) c) d) e) f)	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 (2008): Does the NHS 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? Does the NHS trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria?: • treatment options; • complaints procedures; and • appointments. Does the NHS trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? Does the NHS trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? Does the NHS trust have protocols in place to encourage representation of people with learning disabilities and their family carers? Does the NHS 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: Boards are required to certify that their trusts meet requirements a to f above at the annual plan and in each quarter. Failure to do so will result in the application of the service performance score for this indicator.
18	DTCs	Performance against contract with main commissioner
19	GUM Access	Access to GUM within 48hours against a target of 95% compliance.
20	Chlamydia Screening	Performance against contract with main commissioner
21	Smoking Quitters	Performance against contract with main commissioner
22	6 Wk Wait Diagnostics	Access to diagnostics against a target of 100% compliance
23	New birth visits	Performance against contract with main commissioner
24	HPV	Human Papillomavirus (HPV) uptake Performance against contract with main commissioner
25	Comm'ty Equip Store	Responses within 7 days
26 a	Urgent DN	Response by a DN within 24 hours of receiving an urgent request / referral
26 b	Non-Urgent DN	Response by a DN within 48 hours of receiving a non-urgent request / referral