SOUTH LONDON HEALTHCARE NHS TRUST

There will be a meeting of the Trust Board on

WEDNESDAY 23rd MARCH 2011
09.30am in the
Lord Wallace Dining Room, Frognal Postgraduate Centre, Queen Mary's Hospital, Sidcup

George Jenkins
Chairman

SESSION TO BE HELD IN PUBLIC

Time	No.	Item	Lead / Enc
0930	1	**QUESTIONS FROM THE FLOOR** There will be an opportunity for members of the public to ask questions.	
0955		**BREAK**	
1000	2	**CHAIRMAN'S OPENING REMARKS**	
1005	3	**APOLOGIES FOR ABSENCE**	
1010	4	**DECLARATION OF INTERESTS** Members to declare any interests in relation to the agenda items below	
1015	5	**MINUTES OF TRUST BOARD 26TH JANUARY 2011** To agree the minutes of the previous meeting and follow up on action points as matters arising from the minutes	**ENC A**

PATIENT SAFETY & EXPERIENCE

Time	No.	Item	Lead / Enc
1020	6	**PATIENT SAFETY AND EXPERIENCE** Report to include the following additional items: – Infection Prevention Update Report – Learning Disabilities – Progress report on key work undertaken following the recommendations of the review of the Ombudsman's Report into 'Six Lives', Sir Jonathan Michael's report 'Healthcare for All' and Self Assessment Framework. – Care Quality Commission Review – Progress Report	**AB** **ENC B**

PERFORMANCE

Time	No.	Item	Lead / Enc
1040	7	**PERFORMANCE REPORT**	**JH** **ENC C**
1050	8	**FINANCE REPORT**	**TB** **ENC D**

ITEMS FOR DISCUSSION AND APPROVAL

Time	No.	Item	Lead / Enc
1100	9	**OPERATIONAL CAPABILITY STATEMENT** Operational Capability Statement Constituting part of the Department of Health Research Support Services Initiative	**RS** **ENC E**

ITEMS FOR DISCUSSION AND APPROVAL

Time	No.	Item	Lead / Enc
1110	**10**	**FOUNDATION TRUST - TRIPARTITE FORMAL AGREEMENT**	**CS** **ENC F**

REPORTS FROM TRUST BOARD COMMITTEES

Time	No.	Item	Lead / Enc
1125	**11**	**TRUST GOVERNANCE COMMITTEE** To receive the minutes from meetings held on 20th September 2010 and 8th November 2010. To receive a verbal report from the meeting held on 27th January 2011.	**GH** **ENC G**
1130	**12**	**TRUST AUDIT COMMITTEE** To receive the minutes from meetings held on 13th January 2011.To receive a verbal update from the meeting held on 3rd March 2011.	**JB** **ENC H**
1135	**13**	**TRUST FINANCE COMMITTEE** To receive the minutes from the meeting held on 9th December 2010.	**HA** **ENC I**
1140	**14**	**TRUST HUMAN RESOURCES SUB COMMITTEE** To receive and note the Human Resources Committee Terms of Reference dated 31st January 2011. To receive the minutes of the meeting held on 24th November 2010.	**JT** **ENC J**

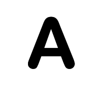
ITEMS FOR INFORMATION AND ANY OTHER BUSINESS

Time	No.	Item
1145	**15**	**ANY OTHER BUSINESS**
1200	**16**	**DATE OF NEXT BOARD MEETING** The next meeting of the Trust Board will take place on Wednesday 25th May, Conference Centre, Queen Elizabeth Hospital.

In accordance with Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960, representatives of the press and other members of the public will be .excluded from the first part of the meeting having regard to the confidential nature of the business to be transacted, which relate to financial and commercial issues and publicity upon which would be prejudicial to the public interest.

Agreed Action Tracker for the Trust Board in Public session of the South London Healthcare NHS Trust Board meeting held 26th January 2011

Agenda Item	Agreed Action	Minute Ref.	Date that Item is to be reported	Responsible Officer
093/10 Patient Safety and Experience	**NOTED** the Ombudsman's Report into 'Six Lives', Sir Jonathan Michael's report 'Healthcare for All' the implementation work that had occurred since July 2009, and the intention to provide a follow up report in March 2011.	Minutes 29/09/10 093/10	March 2011	Ms Hall
110/10 Patient Safety and Experience	**ASKED** to receive a report on the review of legionella management and control from February 2009 onwards.	Minutes 24/11/10 110/10	March 2011	Ms Hall
110/10 Patient Safety and Experience	**ASKED** the Terms of Reference for the Trust Decontamination Group to include looking nationally at best practice	Minutes 24/11/10 110/10	March 2011	Ms Hall
003/11 Declaration of Interests	**ASKED** the Trust Board Secretary to ensure the interests of the Local Involvement Network representatives were recorded in the Trust Register of Interests	Draft Minutes 26/01/11 003/11	March 2011	Trust Board Secretary
006/11 Patient Safety and Experience	The Board **NOTED** that Ms Hall would report progress made to improve the management of Patient Falls.	Draft Minutes 26/01/11 006/11	March 2011	Ms Hall
006/11 Patient Safety and Experience	Care Quality Commission (CQC) Report **- AGREED** the Board would receive a further report at its meeting in March 2011.	Draft Minutes 26/01/11 006/11	March 2011	Ms Hall
006/11 Patient Safety and Experience	**AGREED** Ms Hall would bring a report on safeguarding adults back to the Board on 25th May 2011 following a report to the Trust Board Governance Committee.	Draft Minutes 26/01/11 006/11	May 2011	Ms Hall
006/11 Patient Safety and Experience	**NOTED** an annual report on the safeguarding of both children and adults, including training compliance, would be reported to the Board on 25th May 2011	Draft Minutes 26/01/11 006/11	May 2011	Ms Hall



Minutes of the public session of the South London Healthcare NHS Trust Board meeting held on
WEDNESDAY 26th JANUARY 2011

Held in the
Lecture Hall, Postgraduate Centre, Princess Royal University Hospital

MINUTES

PRESENT	Mr G Jenkins	Chairman, SLHT
	Dr C Streather	Chief Executive
	Mr J Ballard	Deputy Chairman
	Ms G Hart	Non Executive Director
	Ms H Allen	Non Executive Director
	Ms L Roberts	Non Executive Director
	Ms J Townsend	Non Executive Director
	Ms L Simpson	Deputy Chief Executive
	Ms J Hall	Director of Nursing, Governance and Patient Experience
	Mr R Smith	Medical Director
	Ms T Choppin	Nominated Representative, Bromley Local Involvement Network
IN ATTENDANCE	Ms C Trevena	Associate Director of Finance (Attending on behalf of Mr Bolot)
	Ms A Bhatia	Deputy Nurse Director
	Mr M Weaver	Trust Board Secretary (Minute Taker)
ITEM 010/11	Mr J Pearce	Director of Estates and Facilities

PRESENT IN AUDIENCE

There were approximately 25 members of staff and public present.

001/11 CHAIRMAN'S OPENING REMARKS **ACTION**

The Board had been reflecting for some time how it could improve its engagement with the public. The Chairman was therefore pleased to announce that each of the three Local Involvement Networks (LINks) had agreed to provide a representative to sit as a non voting member of the Board, when it met in their respective borough. Ms Choppin had kindly agreed to to be the Bromley LINks representative at this meeting. Ms Choppin thanked the Chairman for making this helpful change and reported that all three LINks would hold a pre meeting before each Board to ensure that questions from each LINks could be raised by the representative attending the Trust Board meting.

The Chairman also announced that Ms Simpson would be ending her secondment as Chief Operating Officer and Deputy Chief Executive and returning to the Department of Health. The Chairman thanked Ms Simpson for the enormous contribution she had made whilst at South London Healthacre NHS Trust (SLHT). Ms Simpson would continue to support the Trust with its Foundation Trust Pathway. In the interim, the Chairman was pleased to announce that Ms Hall had agreed to take on the role of Acting Chief Operating Officer.

002/11 APOLIGIES FOR ABSENCE

Mr T Bolot Director of Finance

		ACTION
003/11	**DECLARATION OF INTERESTS**	
	No interests were declared. The Chairman	
	– **ASKED** the Trust Board Secretary to ensure the interests of the Local Involvement Network representatives were recorded in the Trust Register of Interests	**MW**
004/11	**MINUTES**	
	Minutes of the meeting held on 24 November were **AGREED** as a correct record, subject to the following amendment:	
	Final sentence of paragraph headed 18 weeks RTT Admitted & Non-Admitted to read: "Such reductions would be achieved through continued additional funding whilst we improved productivity".	**MW**
005/11	**MATTERS ARISING**	
	18 weeks Referral To Treatment (RTT) waiting List by Specialty	
	The Board had **ASKED** to receive a report that quantified the18 Weeks RTT Waiting list by speciality. This action would be discussed under Agenda Item 8, Performance Report of the current agenda.	
	External Review of Catering Services	
	The Board had **ASKED** to receive details of Trust plans to conduct an external review of catering services to the Trust Board Finance Committee The Board **NOTED** that details of the Trust plans to conduct an external review of catering services would be submitted to the Trust Board Finance Committee in March 2011.	
	Trust Workforce Data	
	The Board **NOTED** that it would receive a report on Trust Workforce Data at its meeting in March 2011.	
	Summary of Trust Efficiency Data	
	The Board **NOTED** that a summary of Trust efficiency data was incorporated within the Performance Report.	
006/11	**PATIENT SAFETY AND EXPERIENCE**	
	Ms Hall introduced the Patient Safety and Experience Report and **ASKED** the Board to note the following points.	
	Serious Incidents (SIs)	
	There had been an increased number of SIs reported in October and November 2010 due to delays in both validation and reporting of Pressure Ulcers. Since this time appropriate processes for timely reporting had been fully embedded. In December 2010, 9 SIs have been reported across all Divisions which are more in line with previous months reporting. Further work to validate the pressure ulcer profile began at the beginning of the year.	

006/11 PATIENT SAFETY AND EXPERIENCE **ACTION**

Serious Incidents (SIs)

Five SI investigations were overdue at the end of December and had reduced further. The number of London Ambulance Service (LAS) breaches in Quarter 3 was currently being validated and would be reported at the next Board report. All SIs were subject to investigation using Root Cause Analysis (RCA) and action plans are developed and monitored by the Divisional Clinical Governance Committees. Particular attention was being given to SIs and other Patient Safety Incidents subsequent to the temporary closure programme which is referred to elsewhere in the Board papers. The Patient Safety leads in each Division produce a monthly report for the Divisional Clinical Governance Committees describing trends and evidencing learning from incidents. Ms Hart commented on the graph contained within the report and made observations on how the information contained in it could be improved and made clearer. Ms Hall noted her comments and would revise future reports.

Safeguarding

The CQC target that 80% of staff must receive the appropriate level of safeguarding training is being sustained and improved upon. The Trust has achieved 100% compliance with level 1 training. Lead nurses and midwives already receive regular safeguarding supervision and this was being extended to all medical staff. The Royal College of Paediatrics and Child Health have recently issued revised guidelines for training requirements and the Trust will need to reassess compliance with this and report accordingly. Safeguarding adult training is not a statutory requirement but will be given increased emphasis through the monthly updates from each site and inclusion in mandatory staff training programmes. Ms Hart enquired whether training, specific to the needs of patients with mental health or learning disabilities, was available to staff. Ms Hall replied that appropriate training of staff was part of the Trust's Dementia Strategy and included in staff induction training. The Trust also worked in partnership with Oxleas NHS Foundation Trust with regard to mentally ill patients. The Board:

- **AGREED** Ms Hall would bring a report on safeguarding adults back to the Board on 25th May 2011 following a report to the Trust Board Governance Committee.
- **NOTED** an annual report on the safeguarding of both children and adults, including training compliance, would be reported to the Board on 25th May 2011

Hospital Standardised Mortality Rates (HSMR)

The Trust's HSMR for October 2010 was 90.4, which indicated fewer than expected deaths across the Trust. Ms Choppin enquired why the HSMR for Queen Elizabeth Hospital (QEH) Woolwich was higher than for other Trust sites. Mr Smith replied that differences in demographics adversely affected mortality rates. The software used to produce HSMRs did not always control for these factors. Mr Smith also reminded the Board that natural seasonal variations accounted for rises and falls in HSMR at different points in the year.

- The Board **NOTED** the improving trend in HSMR rates.

006/11 PATIENT SAFETY AND EXPERIENCE **ACTION**

Hospital Acquired Pressure Ulcers

The overall number of pressure ulcers reduced for both November and December and there were no grade 3 or 4 ulcers reported in November. The target for quarter 4 is to have no hospital acquired level 2, 3 or 4 ulcers reported.

Noting that the Trust was not yet achieving its stretch target with regard to reducing pressure ulcers, Ms Choppin enquired whether membership of the Pressure Ulcer (PU) Group needed to be reviewed and if attendance at the PU Group was mandatory. Ms Bhatia replied that the stretch target was very ambitious and progress in reducing incidences had been made. Membership of the PU Group had been refreshed and now included ward managers on a rotating basis. In addition Panels, chaired by Ms Hall or Ms Bhatia were convened to review all cases of grade 3 and 4 pressure ulcers. Ms Hart asked whether wards were sufficiently staffed to allow patients at risk of pressure sores to be turned every two hours. Ms Bhatia replied that staffing levels were set to meet the dependency of patients and were increased to reflect increases when necessary.

Falls

Ms Hall was disappointed to report an increase in the number of falls on the Princess Royal University Hospital (PRUH) site since September. At the same time a new electronic incident reporting process, using the Datix system was introduced at PRUH, which made it easier for staff to report falls. This may account for some of the increase. The Trust has appointed a High Impact Lead Nurse for falls that would be checking that all patients are properly assessed on admission and throughout their stay and that appropriate preventative action was taken as a result of those assessments. The work of the High Impact Lead Nurse will initially focus on the PRUH, where any ward recording more than 2 falls per month will be reviewed. Ms Choppin enquired why the number of falls had increased. Ms Hall replied that there tended to be an increase at staff hand over periods. She also reminded the Board that patients were encouraged to mobilise as soon as possible and some may attempt to do so before they were ready.

- The Board **NOTED** that Ms Hall would report progress made to improve the management of Patient Falls. **JH**

Single Sex Accommodation

Ms Hall reported that since 1st December 2010 the Trust was monitored against a new national standard requiring reporting of all mixed sex accommodation breaches including in areas not previously included, such as Day Surgery, Surgical Assessment and Endoscopy. This has led to an increase in the number of breaches reported and a closer review of these areas was being undertaken to ensure compliance with the new requirement. The non clinical breaches of the standard at PRUH and QEH all related to delays in transferring patients who no longer required critical care from critical care beds to a ward.

006/11 PATIENT SAFETY AND EXPERIENCE

ACTION

Food and Nutrition

Patient satisfaction using the patient experience trackers continues to show inconsistent levels of response. In December 2010 adult satisfaction with food improved to 71% but that for children remained low at 42%. An external consultant had been employed to review the catering service and identify where it needed to be in 2012, when the catering contract was t be reviewed. Representatives from the Royal College of Nursing and the National Patient Safety Agency are supporting the Trust in organising a Food and Nutrition Conference which will highlight good practice within the Trust and raise awareness of key initiatives aligned with food and nutrition for patients. The Chairman expressed concern that satisfaction amongst children remained low and enquired whether the Trust had information about how other similar trusts performed. Ms Hall replied that she would look into comparative data to see whether the Trust was an outlier. The Trust Food Group was currently adult focused and asked Ms Choppin to consider whether the LINks could assist in broadening it to include children. In response to a question from Ms Choppin, Ms Hall replied that the “mystery shoppers” the Trust was using to get obtain patient experience feedback would be monitoring the food quality.

Cleanliness and the Environment

For the first time the report included information from the cleaning audit programme as well as patient feedback. The Trust was currently working to bring all three sites up to the National Patient Safety Agency 2007 standards (currently only the PRUH complies with these). This work is being led by the Environmental Strategy Group that will monitor achievement of the necessary action plans. The recently published CQC reported had identified minor concerns relating to “clutter” at the Queen Mary’s Hospital, QMS site. The Environmental Strategy Group would examine the results in more detail at its next meeting.

Complaints

The number of complaints across the Trust fell in December. Consistent performance against the standard of responding to complaints within 25 working days remained challenging with Women’s, Children’s and Support Services achieving 91%, Planned Care 54% and Emergency Care and Specialist Medicine 27%. In addition to the actions identified in the report, Ms Hall mentioned the introduction of complaints managers aligned to Divisions rather than sites. She assured the Board that the backlog in responding to complaints was being addressed and that performance; especially in Emergency Care was being closely monitored.

Ms Allen highlighted the importance of ensuring patients received prompt replies to their complaints. Ms Hall agreed and noted that where a complaint could not be responded to within the timescales, the patient was kept informed of progress. Ms Townsend noted the usefulness of new media in keeping patients informed, in real time, of key information. In other industries this had assisted in reducing the number of complaints associated with poor communication. Ms Hall and Ms Townsend agreed to explore this further. Ms Choppin asked whether information about complaints was shared with staff as a learning tool. Ms Bhatia replied that all complaints were logged so that themes could be identified and these were shared at Departmental level.

		ACTION

006/11 PATIENT SAFETY AND EXPERIENCE

Care Quality Commission (CQC)

At the Chairman's invitation Ms Hall reported that the Trust had now received the formal report from the CQC following their inspection of the Trust last September. The report identified no major concerns requiring formal action. It was also reassuring that the picture painted in the report was one already recognised by the Trust. A number of other issues of moderate concern had been identified and the Trust had already submitted its action plan to the CQC. The Trust expected to be able to complete most actions by the end of March 2011. Dr Streather added that the Trust had already taken action in response to verbal feedback following the visit and had therefore been able to submit its action plan within 7 days rather than the 20 days normally allowed. The Board:

- **NOTED** the report
- **NOTED** the action plan would be published on the Trust Website
- **AGREED** the Board would receive a further report at its meeting in March 2011. **JH**

007/11 FINANCE REPORT

Ms Trevena, Associate Director of Finance introduced the Month 9 Finance Report and **ASKED** the Board to note the following points.

At month 9 the Trust was reporting a loss of £5.3m. In December the Trust received the result of the NHS London arbitration with PCTs over activity for the second half of the year. This imposed a block contract, the net result of which was to reduce the Trust's income by £4m. Whilst accepting the arbitration result, the Chairman placed on record his disappointment with the decision.

The Trust had been able to significantly reduce costs during the current financial year through tight controls over both pay and non pay expenditure. Run rates for Divisions were showing evidence of stabilisation and the Trust's forecasts assume further improvement towards the end of the year. Ms Townsend congratulated the executive on controlling its expenditure. The Board

- **NOTED** the Month 9 Finance Report

008/11 PERFORMANCE REPORT

Ms Simpson introduced the Performance Report that aimed to provide the following update to members of the Trust Board:

- A broad overview of progress on the Trust's priorities for 2010/11
- To provide assurance that patients are being treated safely and appropriately and highlight where remedial action is being taken and/or further action is required to improve performance
- To update members of the Trust Board on the forecast performance for Quarter 2, 2010/11 against the NHS Performance Framework, which is the mechanism by which SLHT's performance would be judged by external stakeholders
- To update on the performance of the Trust to month 9 2010/11 and forecast performance at year-end using a number of key indicators.

008/11 PERFORMANCE REPORT

ACTION

NHS Performance Framework

Against the NHS Performance Framework the Trust was rated Red for Finance and Green for Quality of Service. Ms Simpson asked the Board to note that in 2011/2012 the Trust would be measured against a Performance Framework based upon outcome rather than process measures. Ms Simpson suggested that implications of this change could be discussed at a future Trust Board Informal Seminar.

Hospital Associated Infection

The Trust was performing exceptionally well against its targets for Hospital Associated Infection. There had been no cases of MRSA bacteraemia since August 2010. The Trust was also well ahead of its trajectory with regard to C.difficile.

Hospital Standardised Mortality Rates

The Trust continued to deliver low mortality rates against national averages, with all three sites rated Green in October 2010, the latest available data.

Emergency Care

Emergency care performance against the Accident and Emergency (A&E) 4 hour target had deteriorated in December to 80.1% giving a year to date performance of 92.1%. This meant that a significant number of A&E attendees were receiving a poor service from the Trust. In order to reach the 95% target, the Trust would now need to perform at 98.04% for the remainder of the year. Ms Simpson informed the Board that the 4 hour target was the Trust's top priority and a number of improvement plans were in place to achieve it.

Ms Allen enquired why the target was not being achieved. She was also concerned that in its efforts to turn around the position, the Trust did not lose financial control. Ms Simpson replied that there were multiple causes why the target had not been reached but the Trust understood these and had action plans to address them. Some investment would be necessary but financial control would be maintained.

During December the Board noted that the number of patients over 85 years of age admitted to hospital had increased. These patients often had complex health needs and required longer lengths of stay. The severe winter had also led to an increase in patients with respiratory problems which had led to pressures on Intensive Treatment Unit (ITU) beds particularly on the QEH site. Ms Townsend emphasised the importance of proactive communication with the public so that expectations could be managed at difficult times. Ms Simpson and Ms Townsend agreed to discuss this further outside the meeting.

Dr Streather added that recent 4 hour performance had been good and that the difficulties were not insoluble. He also reported staff sickness during December had been high and this had also impacted upon performance. In response to a question from Ms Allen Ms Simpson replied that each occasion of staff sickness was followed up by managers to ensure that it was genuine.

ACTION

008/11 PERFORMANCE REPORT

Emergency Care

Ms Hart noted that many of the staff released by the temporary closure of A&E at QMS had chosen to leave the Trust rather than relocate to QEH or the PRUH. Ms Simpson replied that the staff had left for a variety of reasons. The Chairman added that this was not unusual when organisations underwent major reorganisations. It was also the case that many staff decided to return to the organisation within a relatively short time. Mr Ballard asked whether the difficulties in A&E did not indicate structural problems elsewhere within the organisation. Dr Streather replied that the Emergency care pathway was the most complex within the Trust and problems there did not carry through to other areas.

Referral to Treatment – 18 Weeks

The Trust's performance between months 8 and 9 for admitted patients had deteriorated from 87.5% to 84.06% against a target of 90%. The target for non admitted patients continued to be met.

Referral to Treatment – Median Waiting Times for Patients

The Department of Health's new referral to treatment target was Median waits. Against this measure, for admitted patients, the Trust was achieving 11.5 weeks against a target of 11.1. A number of specialties were finding the target particularly challenging especially Trauma and Orthopaedics and Surgery. The Trust was looking to improve performance by clearing its backlog of cases and addressing demand and capacity issues. For non admitted patients the Trust was achieving 5.5 weeks against a target of 6.6.

Maternity and Midwifery

Ms Simpson was pleased to report an improvement in the midwife to birth ratio as a result of the recent temporary closure of the service on the QMS site. The Trust had agreed with its PCTs that in future it would report an aggregate figure for the whole Trust rather than one for each site.

Efficiency Overview – Theatre Efficiency and Day case Review

In reply to a question from Ms Choppin, Ms Simpson stated that the Trust would be rolling out the Productive Operating Theatre Project. The Board

- **NOTED** the performance of the Trust to month 9 2010/11

009/11 TEMPORARY CLOSURE PROGRAMME

This report was the final update to the Board on the work undertaken to progress the temporary closure plan for Queen Mary's Hospital A&E and Maternity Departments. The Trust had identified this as necessary because staff shortages in these departments were likely to present an unacceptable risk to patient safety over the winter period.

The report concluded that, despite intense operational pressures in December, the Trust had successfully completed the tasks associated with implementing the closure programme with the full support and co-operation of their partner agencies. The Trust had received feedback that its execution of the plans had been very good and all parties had felt involved in the process.

ACTION

009/11 TEMPORARY CLOSURE PROGRAMME

The Trust's activity assumptions had been largely correct. There had been a small increase in maternity patient flows from QMS to PRUH but these were still within the safe capacity of that hospital. Ms Simpson also reported that, despite the winter pressures, implementation had been achieved without the need to request any diversions of blue light ambulances to other hospitals.

The Chairman commented that the Trust's decision not to close capacity elsewhere in the Trust during this period had proved correct. The Board:

- **NOTED** the report and **AGREED** that this item could now be removed from future agendas.

010/11 PATIENT TRANSPORT

The Chairman welcomed, Mr J Pearce, Director of Estates and Facilities, who introduced a report which provided an update on the progress with the implementation of the Non Emergency Patient Transport Service (NEPTS) since the awarding of a contract to Savoy Ventures Limited (SVL).

The Trust Board was advised that winter pressures had highlighted pinch points which affected capacity issues for vehicles and crews. The contractor had responded by: deploying a dedicated control manager to focus on patient pick ups; providing 4x4 vehicles on standby as a precautionary measure against adverse weather; deployment of dedicated controllers on each site; dedicated vehicles assigned to Accident and Emergency at QEH and PRUH to support discharges; deployment of an additional 15 vehicles dedicated to the contract; providing dedicated drivers had been allocated to each site. It was confirmed that the cost of the above provisions would be borne by the contractor.

It was confirmed that further measures would be taken to ensure high levels of competency and training for contractors and that livery arrangements for the vehicles would be discussed with the contractor.

The Board **NOTED** that:

- The NEPTS contract had been implemented on 1 December 2010;
- The Provider performed well against the background of the adverse weather conditions that prevailed in the first two weeks of the contract;
- Performance issues relating to capacity and transport systems and processes have routinely been identified as part of the implementation phase, and these have been quickly and effectively addressed to minimise the impact on patient care.

011/11 TRUST GOVERNANCE COMMITTEE

Ms Hart provided a verbal report on items of business discussed at Trust Governance Committee held on 20th September 2010.

		ACTION

012/11 TRUST AUDIT COMMITTEE

At its meeting held on 13th January 2011 Mr Ballard reported the committee had received a presentation on the changes the Trust had made to information on activity and income. These had assisted the Trust in presenting its case at the recent arbitration with its PCTs and the Committee were concerned to ensure these data improvements were maintained. The Audit committee would also be considering the data warehouse and wished to ensure that representatives from the Finance Department were involved in any review. No significant issues had so far emerged from reports from the Trust's internal and external auditors. A final audit plan had been agreed. The committee were reassured by the pace at which the Trust was implementing internal audit recommendations. It would continue to monitor those rated as red and would ask directors to account to the Committee where adequate progress was not being made.

- The Trust Board **RECEIVED** as a matter of record, the minutes of the Audit Committee Meeting held on 9th December 2010.

013/11 TRUST FINANCE COMMITTEE

Ms Allen provided a verbal report on items of business discussed at Trust Finance Committee held on 9th December 2010.

014/11 TRUST HUMAN RESOURCES COMMITTEE

Ms Townsend provided a verbal report on items of business discussed at Trust Human Resources Sub Committee held on 20th September 2010. Ms Townsend advised that the Human Resources Committee would be meeting in the afternoon. It expected to agree Terms of Reference for a Trade Union Consultative Forum and to review the arrangements for forthcoming Employment Tribunals.

015/11 RESPONSIBLE OFFICER

Mr Smith informed the Board that the Trust needed to appoint an officer to be responsible for the revalidation of medical staff with the GMC. A process that had to be undertaken every five years. In other Trusts the Medical Director had been appointed to this role. The Board

- **APPOINTED** the Medical Director to this role **SUBJECT TO** the job description and any implications for the Trust's Scheme of Delegation being approved by the Governance Committee. Mr Smith agreed to present a paper to the next meeting of that Committee. — **RS**

016/11 USE OF THE SEAL

Ms Simpson referred to the paper which noted that the hard facilities provider at PRUH had changed its name from Taylor Woodrow PLC to Vinci PLC. No new legal, commercial or financial implications arose from this change. The new name must be reflected in the PFI Project Agreement and changes to that document can only be made under seal. The Board

- **RATIFIED** the use of the seal **SUBJECT TO** confirmation that the appropriate due diligence process had been undertaken.

		ACTION

017/11 CORPORATE GOVERNANCE

Dr Streather referred to the paper and asked the Board to approve amendments to the Trust's Standing Orders to reflect the current Trust Board committee structure. The Board:

- **APPROVED** the amendment as set out in the paper

018/11 ANY OTHER BUSINESS

None

019/11 DATE OF NEXT MEETING

The next meeting of the Trust Board will take place on Wednesday 23rd March, in the Lord Wallace Dining Room, Frognal Postgraduate Centre, Queen Mary's Hospital.

020/11 CLOSURE OF THE PUBLIC PART OF THE MEETING

In accordance with section 1(2) of the Public Bodies (Admissions to Meetings) Act 1960, the Board **APPROVED** the motion that representatives of the press and other members of the public will now be excluded from the meeting having regard to the confidential nature of the business to be transacted.

Patient Safety and Patient Experience Report
Trust Board

23 March 2011

South London Healthcare NHS Trust
Patient Safety and Patient Experience Report

Patient Safety Improvement Priorities 2010/11

Trust's overall patient safety objective is to reduce harm by 50% by December 2011. This will be delivered through the following actions:

Development of Corporate Measures
Establish Measures and Monitor Avoidable Deaths and Avoidable Harm
Executive Patient Safety Walkrounds
Reduce Pressure Ulcers
Falls Management
Reducing Harm from Deterioration
Healthcare Associated Infections*
Communication and Teamwork

*Reported to Trust Board via separate report

Patient Experience Improvement Priorities 2010/11

The Trust patient experience strategy contains seven key work streams to improve the overall patient experience.
The key areas are as follows:

1. Communicating with Patients
2. Cleanliness and the environment
3. Dignity and Respect
4. Spiritual care needs of patients
5. Fundamentals of patient care
6. Using patient experience feedback
7. Food and Nutrition

South London Healthcare NHS
NHS Trust

Patient Safety and Patient Experience Indicators - Executive Summary

Board Action

The Trust Board are requested to note and understand the Trust position against key patient safety and quality indicators included within this report. A summary is provided below of progress and compliance against each indicator.

1. Serious Incidents

The total number of SIs reported increased in comparison to December i.e. 12 in January and 12 in February. This is primarily attributable to 5 grade 3 and above pressure ulcers and the inclusion of 2 LAS breaches.

2. HSMR

The Trust continues to show a green position across all 3 sites with November being the latest data available.

3. Safeguarding Children

The CQC target that 80% of all staff must be compliant with the appropriate level of training is being sustained and improved upon. The Trust has now achieved 100% compliance for level 1 training. From April reporting will be in line with the new guidance from The Royal College of Paediatrics and Child Health.

4. Safeguarding Adults

The Trust has made significant progress since January 2011 in training frontline staff. Over 60% of frontline staff have now been trained with the aim to have 100% trained by end of May 20011. Awareness has also been increased across the Trust by providing comprehensive information in many different formats to staff and patients.

5. Hospital Acquired Pressure Ulcers

In January 5 pressure ulcers (3 grade 3 and 2 grade 4) were validated as hospital acquired and reported as serious incidents. A swift corporate and divisional response ensured that no patients acquired grade 3 and above ulcers in February. In addition there has been a significant improvement in the overall numbers with only 20 being acquired in February. A new care bundle based on evidence-based guidance, expert advice and national policy has been published for the prevention of pressure ulcers. This care bundle is now being reviewed to ensure early implementation across the Trust.

6. Falls

There has been a slight decrease in the number of falls in January and February specifically on the PRUH site. For the two months there were 5 falls that resulted in major harm and 11 resulted in moderate harm. A falls audit undertaken in February across all sites demonstrated that 80% of patients are risk assessed on admission but the follow through of the assessment does not always lead the nurse to instigate appropriate preventative actions and care. The immediate action to ensure that the appropriate preventative processes are put in place relating to the patients who have been identified as being at risk of falling . A comprehensive falls care plan has been developed that details all preventative actions that need to be considered immediately following the falls risk assessment.

7. VTE Prevention

The Trust's aim is to ensure that 90% of patients are VTE risk assessed on admission. There is a percentage of admitted patients that are assessed as being low risk and hence do not require a full risk assessment (31% in February). A VTE audit carried out in February reviewed 183 sets of notes. The notes audited were taken from all wards including Day Care Unit. The audit showed that 48% of patients had been risk assessed. 66% of patients that had been risk assessed received mechanical or pharmacological intervention. We are currently working to develop our procedures for capturing data on completion of risk assessments whilst also continuing to raise the importance of completing risk assessment and taking the necessary preventative action.

8. Single Sex Accommodation

From 1st April 2011 all Trusts are required to publish a declaration to confirm we are complaint with the national definition to eliminate mixed sex accommodation except where it is in the overall best interest of the patient, or reflects their patient choice. Declarations need to reflect all areas of same sex accommodation, not just sleeping accommodation. There were a total of 33 mixed sex breaches for January and 87 mixed sex breaches for February .The sharp increase in February is as a result of the need for the Trust to include breaches in endoscopy services. The numbers of patients who experienced a delay in discharge from critical care has reduced overall for the month of February in line with improved capacity management; however this is a key priority for the Trust to ensure that such patients are moved as a priority following a decision to transfer to a ward. Work is ongoing with the divisional teams to review all the options, including the introduction of single sex endoscopy lists which will significantly reduce the possibility of the mixed sex breaches. All of this work will result in the elimination of mixed sex breaches and a declaration from the Trust to confirm this.

9. Food and Nutrition

Patient satisfaction (using patient experience trackers for children and adults) continues to show inconsistent level of responses with a very poor response rate from adults for the month of February where only 9 patients provided feedback. The level of satisfaction from both adults and children has remained consistent with some improvement noted from paediatrics for the month of February where patient satisfaction rose to 55%. The external review of Catering Services is currently being finalised and its conclusions will be described in more detail at the May Board meeting. The Trust is hosting a food and nutrition event on the 13th April where there will be an opportunity to raise the profile of food and nutrition and to promote best practice within the Trust. Volunteers play an important role in the support of patients during protected mealtimes. The Trust has developed a training session to ensure that volunteers understand clearly how best they can contribute to the overall patient experience at mealtimes in addition to the many other services that they support.

10. Cleanliness and Environment

Patient feedback for both adult and maternity services has remained consistent for the months of January and February. There has however been some variation in the total number of responses received each month. In line with other patient feedback there is a clear need to continue encouraging and supporting patients to provide us with real time patient feedback. For the months of January and February the technical audits on all sites (where the contractors concentrate on the service level agreements for cleanliness) have been achieving their target scores. There has also been improvement in the Managerial audits results (which include all elements of cleanliness in the environment: Soft FM, Estates issues and Nursing cleaning responsibilities). The Trust is able to report back on the results of the PEAT audits. The Trust has scored as ‘Good’ on all elements on the three sites with the exception of the QM site which scored as excellent on food. The full results from the PEAT audit will be reported to the Environmental Strategy Group and the Infection Prevention Control Committee.

Following a successful training workshop for LINk colleagues late last year the Trust is facilitating a second event on the 31st March for further members of LINks who would like to participate in managerial audi

11. Complaints

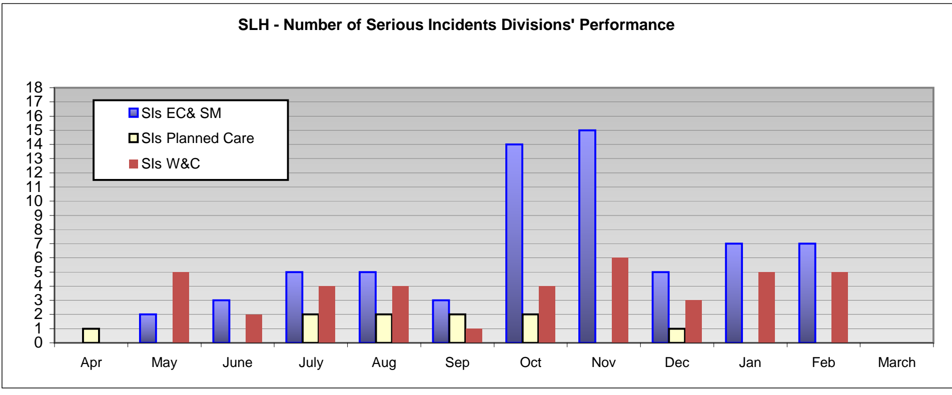
The Planned Care, Women & Children and Clinical Support Services Divisions have maintained a consistent level of response times and are now rightly focussing on ways to reduce the numbers of formal complaints. The Trust has worked with NHSElect with a technique called The Fishbowl Approach , whereby patients are given the opportunity to tell staff about their experience without challenge. It is hoped that this alongside other approaches will lead to meaningful changes in practice that have a positive impact on patient care. The Emergency Care & Specialist Medicine Division are undertaking a complete overview of their processes in managing and responding to complaints as progress to date has been limited.

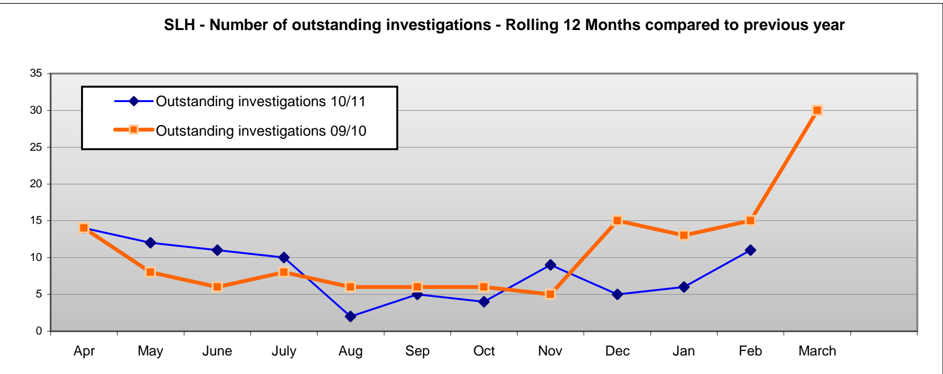
There are some consistent themes namely around clinical treatment and staff attitude across all sites. Recognising this the Trust is promoting the ongoing roll out of the Trust values and promoting leadership development opportunities and communication skills courses. Work has also been commissioned with Kings College London to work with teams where there have been high numbers of complaints.

Serious Incidents (SIs)

NHS Trusts are required to have an effective policy and procedures in place to report and investigate SIs. The purpose of the investigation, which should be completed within 45 days, is to ensure that appropriate actions are taken and change is achieved.

Indicator	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March	YTD
SIs EC& SM	0	2	3	5	5	3	14	15	5	7	7		66
SIs Planned Care	1	0	0	2	2	2	2	0	1	0	0		10
SIs W&C	0	5	2	4	4	1	4	6	3	5	5		39
Outstanding investigations over 45 days 10/11	14	12	11	10	2	5	4	9	5	6	11		
Outstanding investigations over 60 days 09/10	14	8	6	8	6	6	6	5	15	13	15	30	





Analysis

The total number of SIs reported: January is 12 and 12 for February. The EC&SM had a total of 14 SIs in two months, 5 of these SIs are pressure ulcers grade 3 and 4 acquired in January. 2 SIs are due to LAS breaches and 2 due to fractures following a fall.

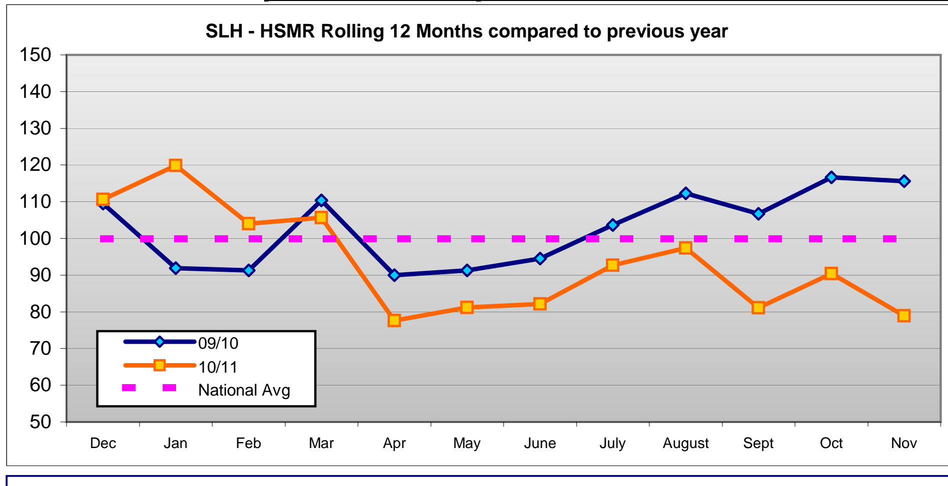
The total number of overdue reports has increased, primarily as a consequence of the high volume reported in EC&SM in October and November that are now due. The re-configuration of services has had an impact on staff being able to commit time to undertake the detail of investigation required, however this situation is now improving. Intense work remains in progress to reduce the volume of overdue reports through the month of March in order to achieve 5 or less by the end of March.

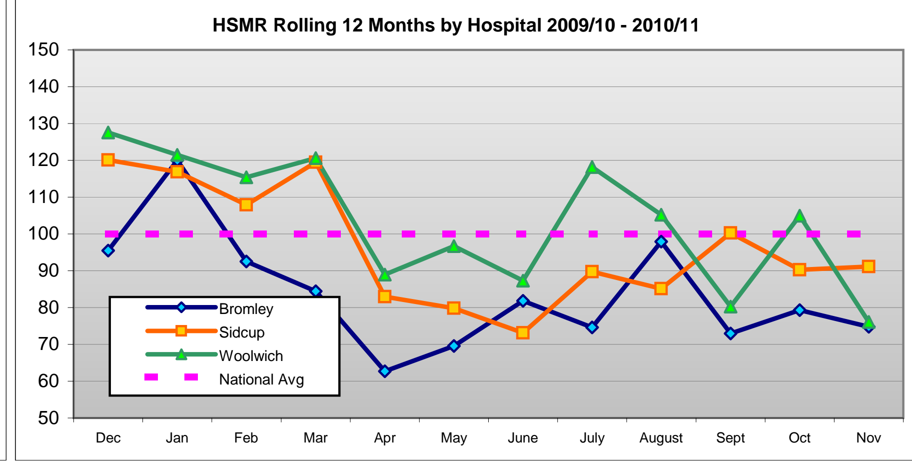
Training has been provided to key Trust staff in January in relation to techniques and skills for investigating SIs.

Hospital Standardised Mortality Rate

Local Priority - **(CE10)** To ensure the HSMR remains below the expected rate based on a national average of 100 incorporating adjustments for local population characteristics
Supports Compliance with CQC Outcome 4

Indicator	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	August	Sept	Oct	Nov
HSMR 10/11	115.6	110.6	119.9	104	105.7	77.6	81.2	82.1	92.7	97.4	81.1	90.4	78.9
HSMR 09/10	110.9	109.5	91.9	91.3	110.4	90	91.3	94.5	103.7	112.3	106.7	116.6	115.6
National Avg	100	100	100	100	100	100	100	100	100	100	100	100	100
Bromley	102.9	95.5	120	92.5	84.4	62.7	69.6	81.8	74.6	97.9	73	79.3	74.8
Sidcup	98.1	120.1	116.9	107.9	119.5	83	79.8	73.1	89.7	85.1	100.3	90.3	91.1
Woolwich	145.6	127.6	121.5	115.4	120.6	89	96.7	87.3	118.2	105.2	80.3	105	76.1





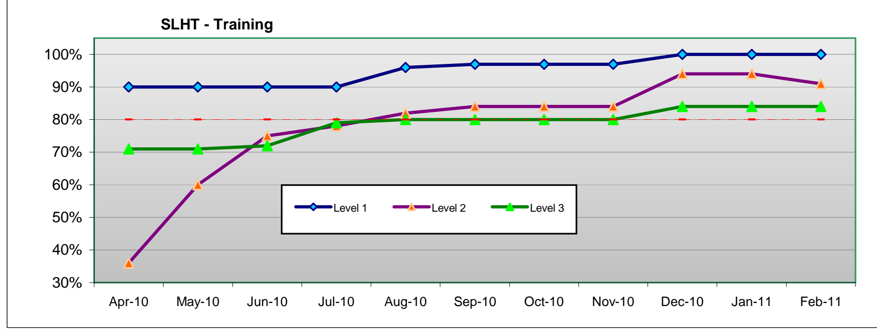
Analysis

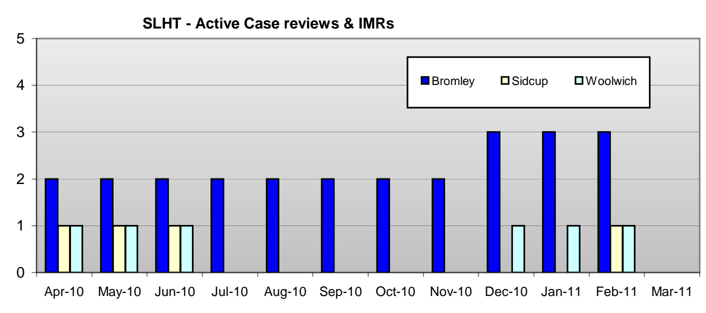
HSMR compares an organisation's actual number of deaths with their expected (or predicted) number of deaths. The prediction calculation takes account of factors such as the age and sex of patients, their diagnosis, whether the admission was planned or an emergency, and the length of stay. The HSMR for November for the Trust was 78.9, which indicates fewer than expected deaths, with the HSMR for the PRUH being particularly low, 74.8. (Data for this indicator is published in arrears on an independent national system).

Children's Safeguarding

The Trust has responsibility under section 11 of the Children Act 2004 to ensure that policies and procedures are in place to safeguard children at all times

Indicator	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Supervision for safeguarding staff	50%	50%	50%	50%	63%	63%	63%	63%	63%	63%	63%	
SLHT Training: **Level 1**	90%	90%	90%	90%	96%	97%	97%	97%	100%	100%	100%	
Level 2	36%	60%	75%	78%	82%	84%	84%	84%	94%	94%	91%	
Level 3	71%	71%	72%	79%	80%	80%	80%	80%	84%	84%	84%	
Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Active Case reviews & MRs: **Bromley**	2	2	2	2	2	2	2	2	3	3	3	
Sidcup	1	1	1	0	0	0	0	0	0	0	1	
Woolwich	1	1	1	0	0	0	0	0	1	1	1	





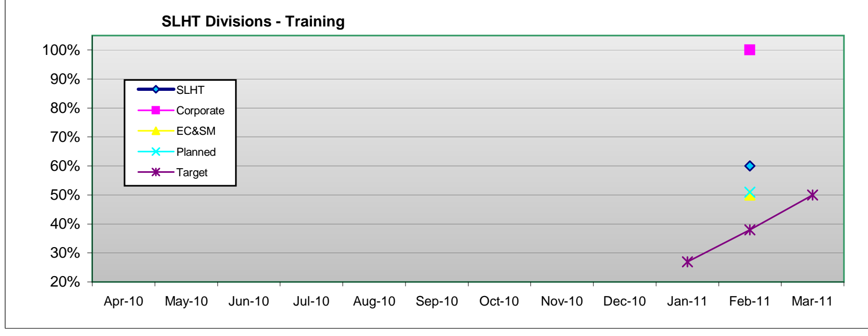
Analysis

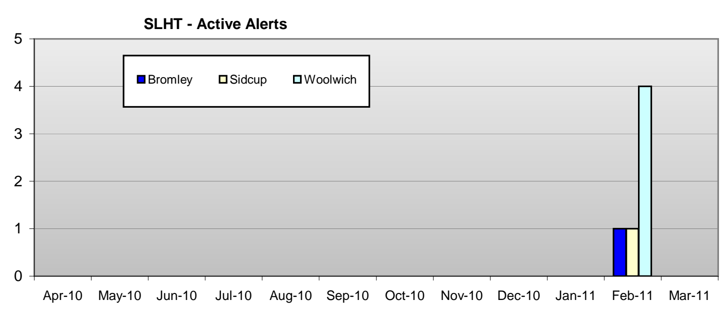
Training continues as a priority and the new RCPCH guidelines will be taken into account in next years standards. Supervision is being resourced externally to address the need of supervision for SLHT Named Doctors. There has been a further SCR in Bexley and further information is awaited relating to the Bromley SCR's.

Adult Safeguarding

The Trust has responsibility for the protection of vulnerable adults. Safeguarding vulnerable adults from abuse is central to the main themes of deprivation and inequalities; the social care of those who cannot care for themselves and the effects of long-term conditions on older people, i.e. admissions to hospital, care homes or using domiciliary care services.

Indicator	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
SLHT Training											60%	
Corporate											100%	
EC&SM											50%	
Planned											51%	
Support Servises											80%	
Target										27%	38%	50%
Active Alerts:												
Bromley											1	
Sidcup											1	
Woolwich											4	





Analysis

The Trust's wide training figures are based on frontline headcount of 3084. To date 1864 frontline staff have been trained in adult safeguarding (including Mental Capacity Act and Deprivation of Liberty training). The aim is achieve 100% training for all frontline staff by end of April 2011. Safeguarding, MCA and DoLs trainers from all 3 boroughs and Greenwich University have made themselves available to support our training schedule.

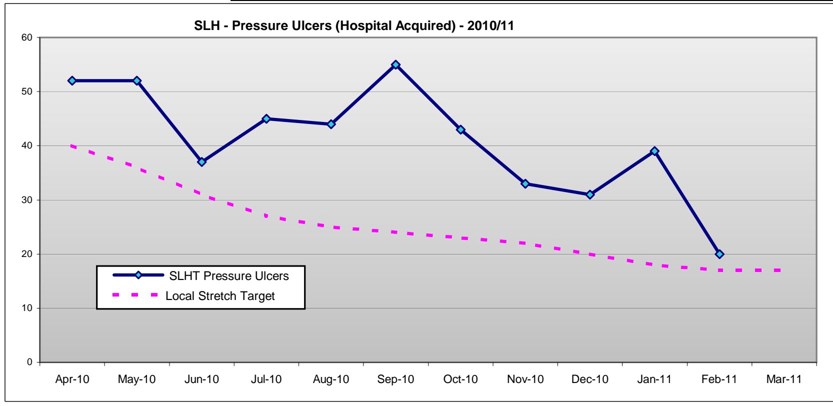
In addition to training, awareness across the Trust has been increased by providing information (posters, leaflets, CD's, Safeguarding handbooks) to staff and making sure it is readily accessible. The Intranet page on Safeguarding has also been developed with up to date guidelines on MCA and DoLs procedures.

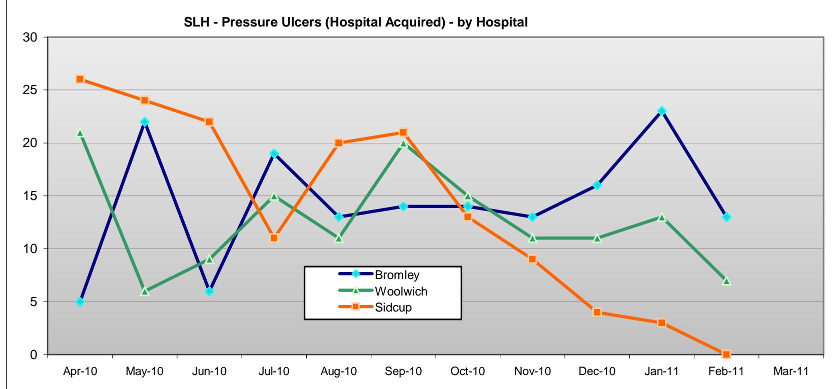
The Adult Safeguarding Committee monitors all Safeguarding investigations and provides the forum for direct discussion with the borough safeguarding leads on progress and actions taken following investigations. The Adult Safeguarding led nurse holds a database detailing all safeguarding activity within the Trust and this cross referenced with the Social Services database to ensure all cases are fully investigated, learning implemented and cases closed.

Pressure Ulcers (Hospital Acquired)

Overall aim - no patients being cared for at South London Healthcare Trust should develop pressure ulcers.
Local target - Zero level 3 and 4 hospital acquired pressure ulcers and a month on month reduction in the numbers of grade 1 and 2 ulcers.

Indicator	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	2010/11 Forecast
SLHT Pressure Ulcers (Hospital Acquired)	52	52	37	45	44	55	43	33	31	39	20		<300
Local Stretch Target	40	36	31	27	25	24	23	22	20	18	17	17	
Bromley	5	22	6	19	13	14	14	13	16	23	13		
Sidcup	26	24	22	11	20	21	13	9	4	3	0		
Woolwich	21	6	9	15	11	20	15	11	11	13	7		





Analysis

In January 5 pressure ulcers (3 grade 3 and 2 grade 4) were validated as hospital acquired and reported as serious incidents. In February no grade 3 or above ulcers were validated as hospital acquired. Although the overall number slightly increased in January there has been a noticeable improvement in February.

There are a number of reasons that attributed to the January position. These ulcers developed over a period of time that was particularly operationally challenging for the organisation. It is also important to note that 3 of the 5 ulcers are attributable to one ward which was being staffed by a higher level than usual of temporary staffing and without consistent leadership. These issue have been rectified.

It is also important to acknowledge that since September no ward has had a repeated grade 3 or above hospital acquired pressure ulcer.

Improvements continue to be made in regards to the prevention, recognition & treatment of Pressure Ulcers within the Trust. These are tangible in:

Rental equipment: there has been a noticeable increase in the use of pressure reliving equipment across the Trust; within the last month this has also been noticed in the increase of cushions in use on the PRUH site.

Bed stores: an increase in demand for pressure reliving mattresses has meant having to increase the availability of mattresses out of hours to ensure patient care is not delayed

Education: a robust monthly teaching programme for the Trust is now in place, in conjunction with the University of Greenwich. These incorporate all areas of pressure area care & ulcers, plus highlighting effective record keeping

Huntleigh Audits: these are scheduled for this month, across all 3 sites. Results of which will allow specific focus on necessary areas

PU meetings: the monthly Strategic Trust Meetings will continue; however to allow better access from ward level – site specific meetings monthly meetings have also been scheduled.

Wound Care Link Nurse Forum – this is now organised with the first Trust Wide meeting planned for 28th March. Every ward throughout the Trust has identified 1 or 2 members of staff to attend. The main focus of this group will combine knowledge & appropriate use of the new dressings; plus a wider understanding of Pressure Ulcers from both a patient & Trust perspective. Future days for this group will also incorporate input from the Universities.

Pressure Ulcer Rounds: HIA Delivery Lead has started rounds on wards. Currently focus is on wards where issues have been raised. Time is spent looking at every patient's pressure areas & their documentation. This is done in collaboration with the ward staff, thus improving knowledge of both documentation, pressure area care & grading.

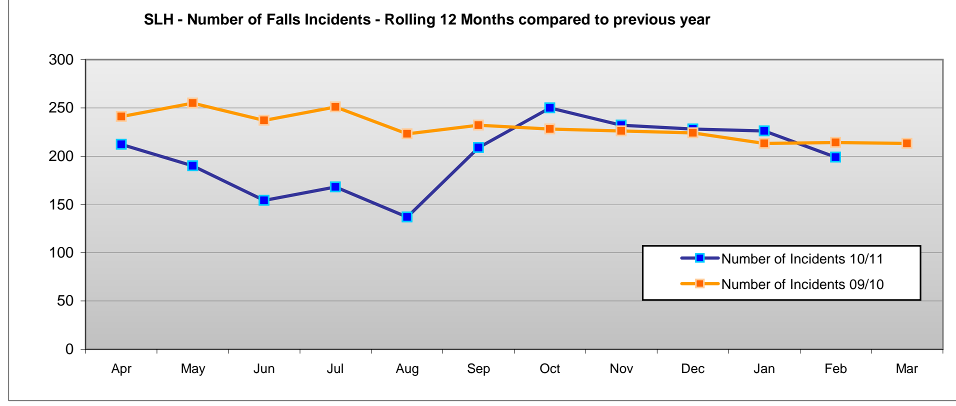
Huntleigh Resource Folder: This is located on the Trust Intranet page, which is accessible to all staff. The folder gives advice regarding pressure area care, correct ordering of mattresses, etc.

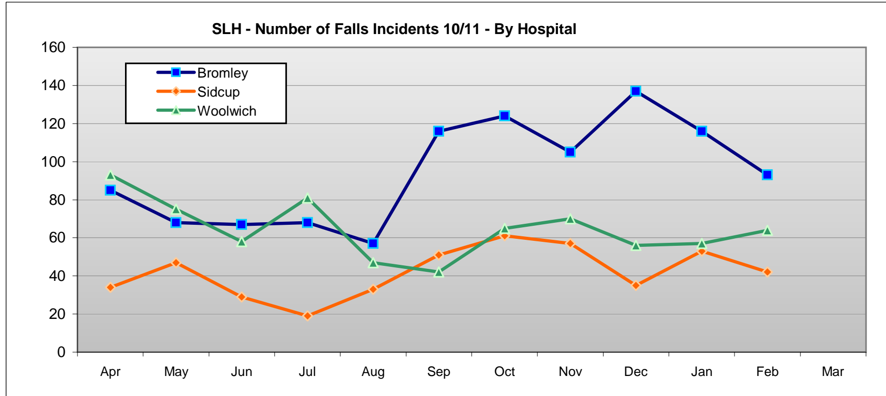
In addition to the above a Care Bundle based on evidence-based guidance, expert advice and national policy has been published for the prevention of pressure ulcers. This care bundle is now being reviewed to

Falls Management

Trust aim is to reduce harm caused to patients by falling

Indicator	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2010/11 Forecast
Number of Incidents 10/11	212	190	154	168	137	209	250	232	228	226	199		
Number of Incidents 09/10	241	255	237	251	223	232	228	226	224	213	214	213	2757
YTD 10/11	212	402	556	724	861	1070	1320	1552	1780	2006	2205		
Site Breakdown	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Bromley	85	68	67	68	57	116	124	105	137	116	93		
Sidcup	34	47	29	19	33	51	61	57	35	53	42		
Woolwich	93	75	58	81	47	42	65	70	56	57	64		





Analysis

There has been slight decrease in the number of falls for January and February specifically on the PRUH site. Data analysis shows that in January there were 2 falls causing major harm and in February there were 3 falls causing major harm, of which 2 resulted in fractures and 1 required further surgery post hip replacement. The number of falls causing moderate harm can be categorised as follows: 5 in January and 6 in February. All these falls were either a bang to head or lacerations.

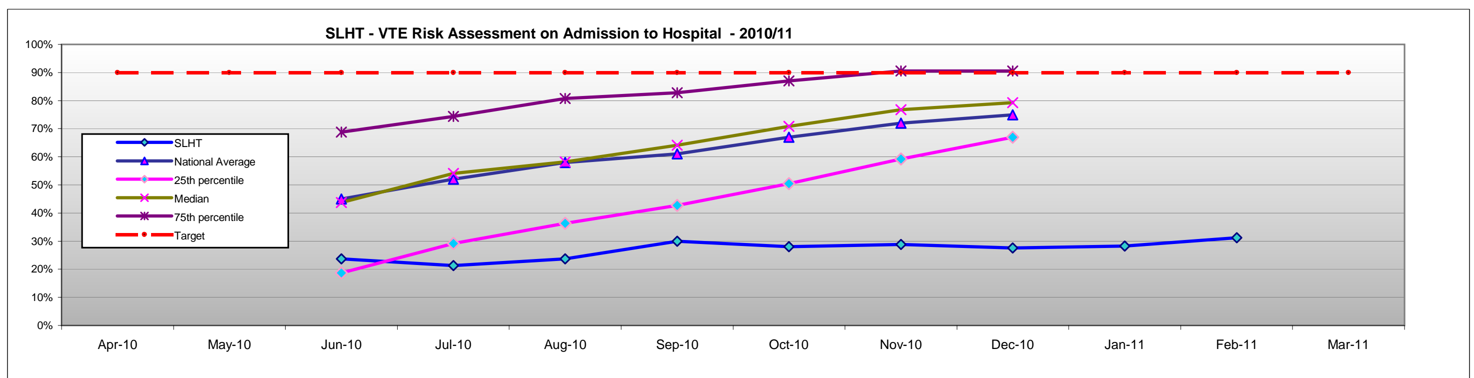
It is evident that the number of falls on the PRUH site is higher than the other sites, further analysis has taken place. Findings show that many falls are unwitnessed and that, regardless of site, there is an almost equal distribution of falls throughout the night and day. A Falls Audit undertaken in February demonstrated that over 80% of patients are risk assessed on admission but the follow through of the assessment does not always lead the nurse to instigate appropriate preventative actions and care. Therefore the immediate action is to ensure that patients who have been identified at risk of falling have the appropriate preventative processes put in place.

The Strategic Falls group continues to review in detail all falls across the Trust, including observing for trends and clusters. Standardised documentation relating to Falls Policy and Procedures will be implemented across all 3 sites from March onwards with the focus on good risk assessment and clear identification of potential patients at risk of falling and instigation of preventative actions. This will include an updated risk assessment tool, identifying potential falls patients using red cards above the bed and red stickers in the notes. A new care plan, detailing preventable actions to be taken to all patients scoring medium or high risk on the risk assessment, has been devised and implemented. A fall reduction equipment needs analysis is also underway. Guidelines for post fall care, incorporating the recent NPSA alerts will also be implemented. An interagency study day and various teaching sessions continue to raise awareness of the Falls Agenda.

VTE Risk Assessment

The national aim is for Trusts to VTE risk assess 90% of patients on admission

Indicator	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	2010/11 Forecast
Low risk admissions			24%	21%	24%	30%	28%	29%	28%	28%	31%		
VTE clinical audit results											48%		
National Average			45%	52%	58%	61%	67%	72%	75%				62%
25th percentile			18.7%	29.2%	36.3%	42.7%	50.5%	59.2%	67.0%				44.0%
Median			43.7%	54.1%	58.2%	64.1%	70.8%	76.8%	79.3%				64.4%
75th percentile			68.8%	74.4%	80.8%	82.8%	87.0%	90.5%	90.5%				82.0%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	



Analysis

A VTE audit tool has been designed to capture information on the completion and use of the VTE risk assessment forms. The audit was undertaken week commencing 21st February 2011. Up to 5 sets of notes were audited from each ward and day case units. In total 183 sets of notes were audited. 48% had a VTE risk assessment form completed. 31% of patients who had a completed VTE risk assessment were offered a Patient Information Leaflet regarding VTE risks. 66% of patients, following the assessment, received either mechanical or pharmacological intervention (application of thromboembolic stockings or prescribed anticoagulants).

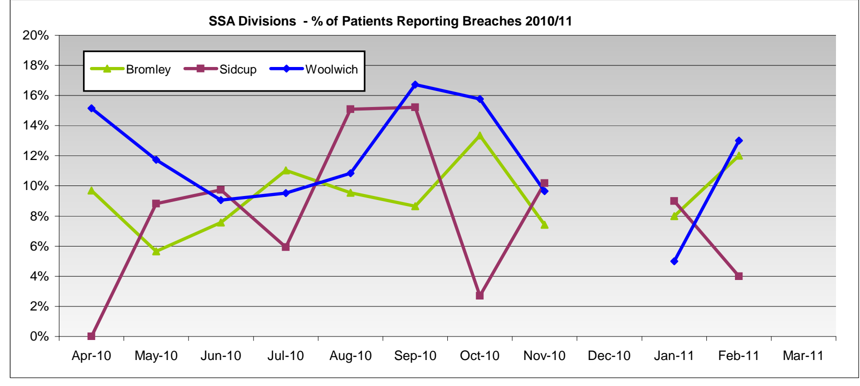
For February 31% of admitted patients were assessed (against defined criteria by procedure) as being at low risk of developing VTE.

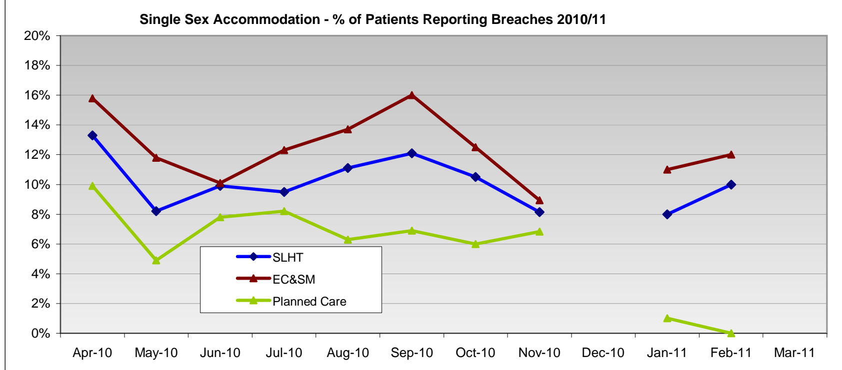
We are currently working to develop our procedures for capturing data on completion of risk assessments whilst also continuing to raise the importance of completing risk assessments and taking the necessary preventative action.

Same Sex Accommodation

Trust compliance with national requirements to ensure that patients do not have to share the same facilities as members of the opposite sex.

Indicator	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Non-clinical Breaches: **Bromley**				0	0	0	0	5	10	7	55	
Sidcup				0	0	0	0	0	0	0	21	
Woolwich				0	2	2	0	15	18	26	11	
SLHT Inpatient Survey - % of Patients Reporting breaches	13.3%	8.2%	9.9%	9.5%	11.1%	12.1%	10.5%	8.1%		8.0%	10.0%	
EC&SM	15.8%	11.8%	10.1%	12.3%	13.7%	16.0%	12.5%	8.9%		11.0%	12.0%	
Planned Care	9.9%	4.9%	7.8%	8.2%	6.3%	6.9%	6.0%	6.8%		1.0%	0.0%	
Bromley	9.7%	5.6%	7.6%	11.0%	9.5%	8.7%	13.4%	7.4%		8.0%	12.0%	
Sidcup	0.0%	8.8%	9.7%	5.9%	15.1%	15.2%	2.7%	10.2%		9.0%	4.0%	
Woolwich	15.2%	11.7%	9.0%	9.5%	10.8%	16.7%	15.8%	9.7%		5.0%	13.0%	





Analysis

Since the introduction of the new National reporting and monitoring system which was introduced on the 1st December 2010 the Trust has been developing and embedding processes into place to record the number of mixed sex breaches in all inpatient areas, with the addition of endoscopy units and Day surgery units. In line with the guidance we have began to report all breaches of sleeping accommodation externally which is available to the public.

From 1st April 2011 all Trusts are required to publish a declaration to confirm we are complaint with the national definition to eliminate mixed sex accommodation except where it is in the overall best interest of the patient, or reflects their patient choice. Declarations need to reflect all areas of same sex accommodation, not just sleeping accommodation.

The above figures identify the numbers of patients on each site who have experienced a mixed sex breach where there are no clinical justifications and also the feedback from the inpatient survey. There is an increase in the numbers of reported mixed sex breaches which accounts for breaches in the endoscopy units on each of the sites which was not required prior to 1st December 2010.. For the month of January there were a total of 33 mixed sex breaches for the Trust all as a result of delays in discharge from critical care. 26 of these breaches occurred on the QE site and 7 for the PRUH site. For the month of February there is a sharp increase in the total numbers of mixed sex breaches for the Trust with a total figure of 87 mixed sex breaches. 55 of these breaches occurred on the PRUH site with a breakdown of 40 for endoscopy and 15 for delays in discharge from critical care. There were 21 reported mixed sex breaches for endoscopy on the QM site. On the QE site there were 5 reported breaches for endoscopy and 6 breaches for delays in discharge from critical care.

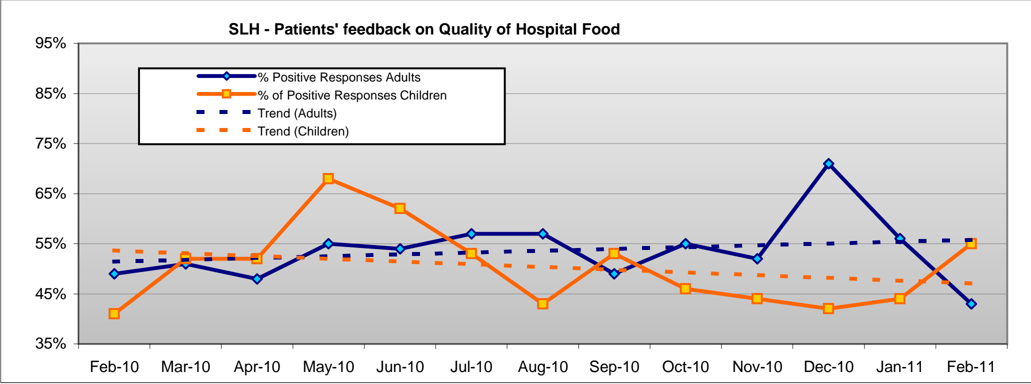
Patient feedback is beginning to change in line with some of the changes across the sites which is encouraging. The feedback from patients in planned care has dropped to 1% and 0% for the months of January and February which reflects the work that has been ongoing in that division to move to single sex wards. Feedback overall on the QM site has began to reflect the configuration of the wards on the site with a drop from 9% in January to 4% in February of patients who have reported that they have either shared sleeping accommodation or have used the same bathroom or shower room as patients of the opposite sex. Patient perception on the PRUH and the QE sites possibly reflects the current challenges that have been experienced on those two sites specifically in relation to delays in discharge from critical care.

Work is ongoing within the divisional teams to introduce single sex endoscopy lists which will significantly the potential for mixed sex breaches. The numbers of patients who experienced a delay in discharge from critical care has reduced overall for the month of February in line with improved capacity management; however this is a key priority for the Trust to ensure that such patients are moved as a priority following a decision to move to a ward. All of this work will result in the elimination of mixed sex breaches and a declaration from the Trust to confirm this.

Hospital Food & Nutrition

Ensure quality and choice of food for patients

Indicator	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Number of Responses (Adults)	162	131	125	87	149	130	106	160	88	156	58	63	9	
% of Positive Responses (Adults)	49%	51%	48%	55%	54%	57%	57%	49%	55%	52%	71%	56%	43%	
Number of Responses (Children)	57	59	8	29	15	27	111	107	9	42	16	37	59	
% of Positive Responses (Children)	41%	52%	52%	68%	62%	53%	43%	53%	46%	44%	42%	44%	55%	



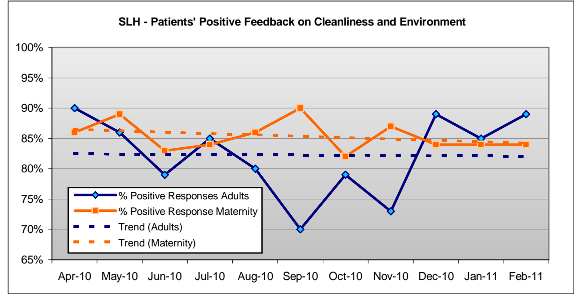
Analysis

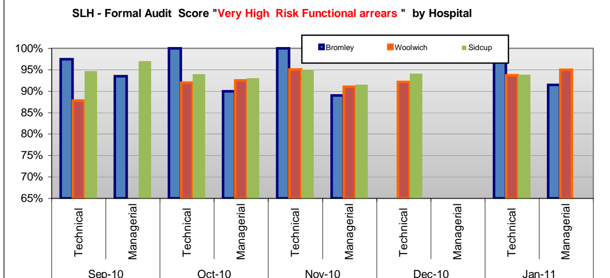
Using feedback from the patient experience trackers the response rate from children on the PRUH and the QE sites has remained fairly consistent in comparison to previous months. In response to the question "how would you rate hospital food" the number of positive responses was 44% for January with an increase to 55% for February. The total number of responses has continued to be inconsistent with 37 responses for January and 59 for February. The level of responses from adult patients (on the PRUH site) has also been inconsistent for the last two months with 63 responses for the month of January and only 9 for the month of February. The level of positive feedback from these respondents was 56% for January and 43% for February. The level of positive responses from adults has reduced over the last few months which is of concern, however with a significant reduction in the response rate for February this may possibly have resulted in results which may not accurately reflect the views of all patients across the Trust. There is a clear requirement for the Trust to encourage and support increased opportunities for patients to provide more real time feedback. The external review of Catering Services is currently being finalised and its conclusions will be described in more detail at the May Board meeting. To support this review and other work around food and nutrition in the Trust LINk members have recently met with Trust staff and have outlined their continued wish to be involved in work streams around food and Nutrition. As a result of this meeting members will be joining the food project group on the QM site which reports to the Trusts Food and Nutrition steering committee. Through this meeting we agreed to take forward the idea of introducing the concept of the 'Mystery shopper' which will commence on the PRUH site as a starting point with the support of Bromley LINk. As outlined in the last board report the Trust is hosting a food and nutrition event on the 13th April which will be attended by all Trust staff and members of the three local LINks. The event is being supported by the Royal College of Nursing and the Patient Safety Agency. This will be an opportunity to promote best practice in relation to a number of key initiatives relating to food and nutrition. In addition to this event a training programme has been developed specifically to support volunteers and Hostess staff to understand how best they can support patients during mealtimes. Volunteers play an important role in the support of patients during protected mealtimes and it is vital that they understand clearly how best they can contribute to the overall patient experience at mealtimes. Discussions are progressing to ensure that the Trust maintains the support of the current VIBE volunteers, many of these young volunteers have expressed an interest to continue to volunteer for the Trust.

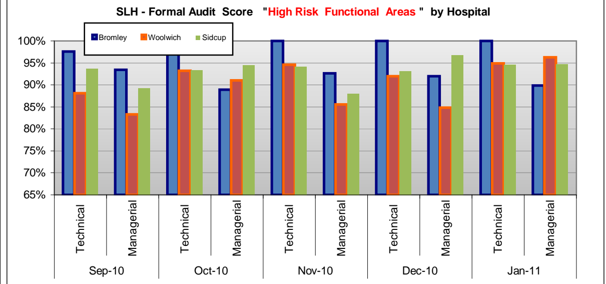
Cleanliness and Environment

Technical Audits undertaken by the Soft FM contractor and form a continuous and inseparable part of the day-to-day management and supervision of cleaning services. **Managerial Audits** weekly audits undertaken by the Trust to verify cleaning outcomes of technical audits and identify areas for improvement. **• Very High-Risk Functional Areas** include operating theatres, ICUs, SCBUs, A&E departments, and other departments where invasive procedures are performed or where immuno-compromised patients are receiving care. **• High-Risk Functional Areas** include general wards (acute, nonacute and mental health), sterile supplies, public thoroughfares and public toilets. **• Significant-Risk Functional Areas** may include pathology, outpatient departments, laboratories and mortuaries.

Indicator: Formal Audit Score	Aug-10		Sep-10		Oct-10		Nov-10		Dec-10		Jan-11		Feb-11		Mar-11	
	Technical	Managerial	Technical	Managerial	Technical	Managerial	Technical	Managerial	Technical	Managerial	Technical	Managerial	Technical	Managerial	Technical	Managerial
Bromley: Risk Categories																
Very High			97%	94%	100%	90%	100%	89%			100%	92%				
High			98%	93%	100%	89%	100%	93%	100%	92%	100%	90%				
Significant			95%	89%	100%	89%	100%		100%	84%	100%	98%				
Woolwich: Risk Categories																
Very High			88%		92%	93%	95%	91%	92%		94%	95%				
High			88%	83%	93%	91%	95%	86%	92%	85%	95%	96%				
Significant			88%		94%	90%	95%	78%	93%		95%	88%				
Sidcup: Risk Categories																
Very High			95%	97%	94%	93%	95%	92%	94%		94%					
High			94%	89%	93%	95%	94%	88%	93%	97%	95%	95%				
Significant			91%		91%	71%	91%		91%	82%	90%	100%				







Analysis

Patient feedback for maternity services on the QE and PRUH sites has continued to be consistent for the months of January and February with 84% of patients reporting positive feedback for both months in response to the question on the Doctor Foster hand held devices; How clean was the maternity unit? There has however been some variation in the total number of responses received each month with 143 responses for January and a reduction to 70 in February. In response to the question; "In your opinion how clean was the hospital room or ward that you were in?" Feedback from adult patients on the QE site has again been consistent with positive responses of 85% in January and 89% in February. The number of patients responding to this question has varied from 106 responses in January to 72 responses in February. In line with other patient feedback there is a clear need to continue to encourage and support patients to provide us with real time patient feedback.

In January and February the technical audits on all sites (where the contractors concentrate on the service level agreements for cleanliness) have been achieving their target scores. There has also been improvement in the Managerial audits results (which include all elements of cleanliness in the environment: Soft FM, Estates issues and Nursing cleaning responsibilities)

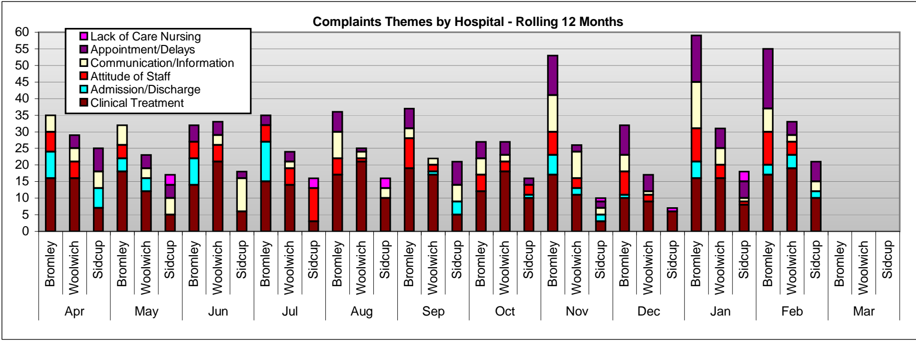
LINk members have continued to support the Trust by participating in the site managerial audits and the most recent Trust wide PEAT audits. Their support and involvement with this audit work are invaluable. The Trust is able to report back on the results of the PEAT audits. As part of the PEAT process the Trust is audited on three key areas which are the Environment, food and privacy and Dignity. The Trust has scored as 'Good' on all elements on the three sites with the exception of the QM site which scored as excellent on food. The Trust is pleased with these results particularly following a year when the Trust has seen significant changes across the sites. The full results from the PEAT audit will be reported to the Environmental Strategy Group and the Infection Prevention Control Committee.

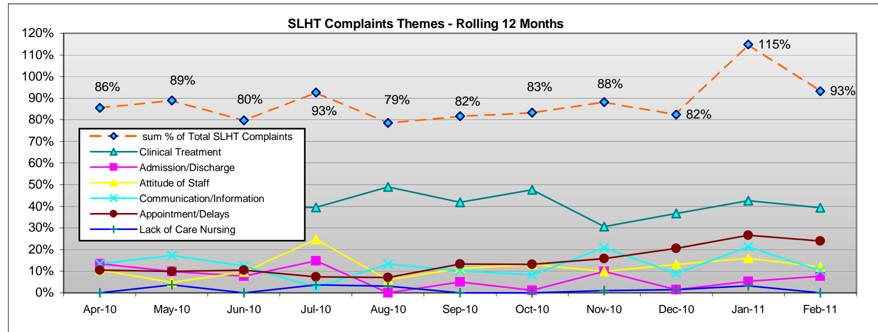
The trust is currently working to strengthen the collaborative working between all those involved in ensuring we achieve high standards, and that we are setting a goal to achieve improved PEAT scores over the next year.

Complaints

Reduce the number of complaints, ensure timely responses and organisational learning

Indicator	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Sep-10
Bromley	47	37	44	39	47	43	39	60	38	42	54		
Clinical Treatment	16	18	14	15	17	19	12	17	10	16	17		
Admission/Discharge	8	4	8	12	0	0	0	6	1	5	3		
Attitude of Staff	6	4	5	5	5	9	5	7	7	10	10		
Communication/Information	5	6	0	0	8	3	5	11	5	14	7		
Appointment/Delays	0	0	5	3	6	6	5	12	9	14	18		
Woolwich	32	27	40	26	33	28	29	29	21	34	42		
Clinical Treatment	16	12	21	14	21	17	18	11	9	16	19		
Admission/Discharge	0	4	0	0	0	1	0	2	0	0	4		
Attitude of Staff	5	0	5	5	1	2	3	3	2	4	4		
Communication/Information	4	3	3	2	2	2	2	8	1	5	2		
Appointment/Delays	4	4	4	3	1	0	4	2	5	6	4		
Sidcup	25	17	20	16	18	27	16	12	9	18	21		
Clinical Treatment	7	5	6	3	10	5	10	3	6	8	10		
Admission/Discharge	6	0	0	0	0	4	1	2	0	0	2		
Attitude of Staff	0	0	0	10	0	0	3	0	0	1	0		
Communication/Information	5	5	10	0	3	5	0	2	0	1	3		
Appointment/Delays	7	4	2	0	0	7	2	2	0	5	6		
Lack of Care Nursing	0	3	0	3	3	0	0	1	1	3	0		





Analysis

The Planned Care, Women & Children and Clinical Support Services Divisions have maintained a consistent level of response times and are now rightly focussing on ways in which we reduce the numbers of formal complaints received within the Trust.

The Trust have recently worked with NHSElect with a technique called The Fishbowl Approach; whereby patients are given the opportunity to tell staff about their experience in their own words without challenge. We are looking at ways in which we can support patients and relatives to use this, and other methods as a safe way in which to share their experience. It is hoped that such approaches will lead to meaningful changes in practice that have a positive impact on patient care.

In the first instance it is important for patients and relatives to know how to raise concerns so that the Trust can be proactive in dealing immediately with the issues which can frequently lead to earlier resolution of the issues. To address this the Planned Care Division have introduced posters on all clinical areas outlining the names and roles of staff to encourage escalation of issues to enable early intervention and provision of senior support. The Division of Emergency Care and Specialist Medicine recognise the lack of improvement in their response times. They are currently reviewing internal processes and will agree a clear plan for managing the backlog of complaints whilst simultaneously streamlining processes for new complaints.

There are some consistent themes namely around clinical treatment and staff attitude that are highlighted as concerns across all sites. Recognising this the Trust is promoting the ongoing roll out of the Trust values and training that is available to develop leadership and communication skills at all levels. We have commissioned some project work with Kings College London to work with clinical teams where there have been high numbers of complaints. This work is in the early stages and is being scoped out to meet our need.

B

TRUST BOARD MARCH 2011

Title:	**Infection Prevention Update Report**

Date of Meeting: 23rd March 2011

For:		**Discussion**	**Information**	(delete as applicable)

Report introduced by: Jennie Hall, Chief Operating Officer

Report author: Tracey Cooper, Director of Infection Prevention & Control

Purpose of report:
This report provides Trust Board with an update on:

- Performance against MRSA bacteraemia and *Clostridium difficile* targets, and initial data on MSSA bacteraemia
- Infection prevention issues and challenges across SLHT, including an update on progress with issues reported earlier in the year.
- A summary of outbreaks of significance, and the issues identified as a result.
- Next steps to be taken to further drive infection reduction and improve safety

Recommendation / action required:
The Board is asked to:

1. Note the continued good performance in relation to MRSA and *Clostridium difficile* for 2010-11.

2. Discuss the challenges identified in this report, note the progress made on those reported previously, and support the actions proposed to address issues identified.

3. Critically review the contents of this report, and identify any areas where further information or assurance is required.

Trust Objective:
OBJECTIVE .5: Healthcare acquired infections.
We will continue to drive forward improvements in reducing health care acquired infections, to ensure that patients receive safe care that conforms to nationally agreed best practice and which leads to reductions in the incidents of *Clostridium difficile* infections and MRSA.

CQC Registration
Does this item support a CQC outcome? If yes which one?
Yes: Outcome 8

Are there legal implications arising from this item?
If advice has been sought please summarise the advice in the text.

The Trust is legally required to demonstrate full compliance with the Health & Social Care Act (2008) Code of Practice (known as 'The Hygiene Code') as part of the CQC regulatory framework. This is assessed via unannounced inspection annually by the Care Quality Commission. Non-compliance can result in a range of measures including financial penalties, restriction on activity, complete suspension of a clinical service or activity and prosecution.

Key Risks to the Trust:
Non-compliance with the Hygiene Code, breaching key infection targets, or increased rates of other avoidable infection would result in a range of risks including:

1. Possible avoidable harm to patients with resulting complaints and litigation
2. Loss of reputation impacting upon patient choice with fewer patients choosing us
3. Increased length of stay due to infection, impacting adversely on activity targets
4. Increased acuity and treatment costs due to infection, resulting in additional avoidable expenditure
5. Possible increase in short-term readmissions due to infection, with impact upon morbidity, mortality, capacity and income as these will no longer be funded
6. Possible financial penalty from commissioners due to breach of key infection targets, or from the CQC due to Hygiene Code penalties

Is an Equality Impact Assessment required?
If yes, please attach it to the paper
No

EXECUTIVE SUMMARY

Healthcare Associated Infection: Performance Against Key Targets

- Trust performance remains good: within stretch targets for both MRSA bacteraemia (1 case to end Feb) and *Clostridium difficile* infection (62 cases to end Feb).

- Universal MRSA screening policy has been implemented in accordance with national requirements.

- Initial data on Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia shows low numbers of cases per month.

Hygiene Code Compliance

- Additional evidence continues to be mapped and mitigation plans implemented to provide robust assurance of compliance against the Hygiene Code.

- Current self-assessment is that 5 criteria are green-rated, and the remaining 5 are rated amber. Work continues to improve the evidence for all amber-rated criteria.

Key Issues and Challenges

- Legionella: The additional review of Legionella management between February 2009 and the incident in 2010 has been completed. The report recommended that a number of additional actions be put into place by the Trust to strengthen governance processes, and these are currently being implemented.

- Decontamination: Work to bring the Sterile Services Departments under a single management and accreditation framework is progressing well. Focussed work on the decontamination of endoscopes has commenced, and though slower than planned, work continues to progress the trustwide decontamination survey.

- Cleanliness: All 3 sites received a rating of 'good' in the external PEAT inspections that took place in February 2011. In January the Trust implemented a cleanliness campaign which will run throughout the summer, and is in the process of reviewing and strengthening the monitoring and assurance framework for cleanliness to further drive standards upwards.

- Essential Standards: Work to increase the consistency of audit returns continues. The summary dashboard is now integrated in Divisional Governance reports to facilitate divisional work to focus on this programme and continually improve standards.

Significant Outbreaks

- An update on the outbreaks of Norovirus and VRE in critical care is reported, along with key learning. Norovirus continues to challenge London, and the trust has managed recent episodes extremely well.

- Since the last DIPC report to Board there have been a further 3 outbreaks of significance, and a summary of each incident, issues identified and action taken is included in the report. .

Next Steps

- Key issues reported last time have been progressed, and will be included in the Trust annual infection prevention programme for 2011-12, which will be reviewed and approved by the Infection Prevention Committee in March 2011.

- Work to drive continual improvement in practice standards, strengthen assurance on a range of issues, and embed a strong culture of infection prevention across the Trust will continue in 2011-12, aiming for excellence in infection prevention.

1.0 Background

This is a regular report from the Director of Infection Prevention and Control (DIPC), and is a follow-up to the report presented to Trust Board in November 2010.

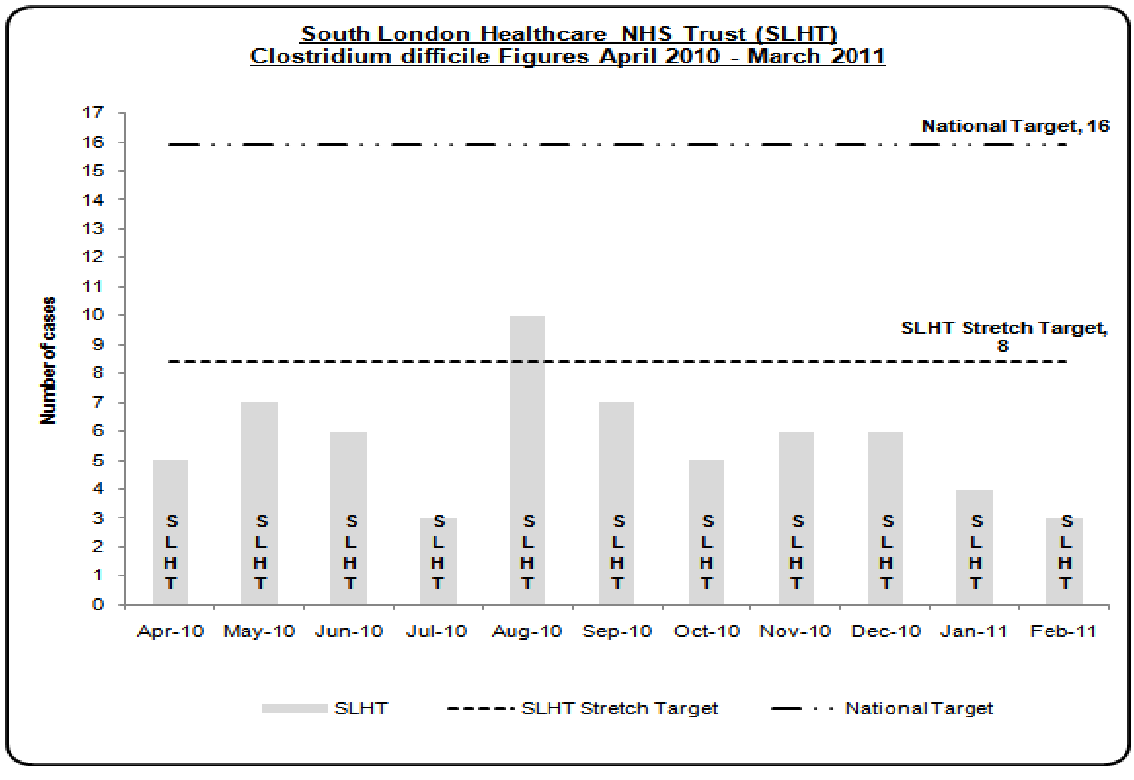
2.0 Healthcare Associated Infection: Performance Against Key Targets

Meticillin-resistant *Staphylococcus aureus* (MRSA)

- To end February the Trust had recorded only 1 case of trust-acquired MRSA bacteraemia, against a stretch target of 7 cases.
- During the same period there were 7 cases attributed to primary care.
- A Trust policy for universal MRSA screening was implemented in December 2010, as required by the Department of Health.

Clostridium difficile Infection (CDI)

- The national 3-year performance target to be achieved by March 2011 is no more than 191 cases. The Trust stretch target of a further 10% reduction from 2009-10 is 101 cases.
- To end February the Trust had recorded 62 cases, against a stretch target of 93 cases.



Meticillin-sensitive *Staphylococcus aureus* (MSSA)

- With effect from 1st January 2011 the Trust was required to report Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia to the national reporting system.
- MSSA is a normal skin organism, carried harmlessly by approximately 30% of the population. It is therefore much more common than MRSA, and is known to cause significantly more infection than MRSA as a result.
- In January and February there were 6 cases attributable to the Trust, with 15 attributable to the community. Further work is underway to identify practice themes that can be targeted to reduce this number.

Financial Impact of Key Infections
Based upon published economic data, the cost of these key infections to SLHT in 2009-10 was 602K. Further reduction in numbers of infection during 10-11 continues to result in cost reductions which support optimum use of trust resources.

	Cost per case	Number of cases on national trajectory	Cost of cases if on trajectory with national target	10-11 Number of cases to end Feb 2010	10-11 cost to end Feb 2010	Cost reduction against costs of national target number
MRSA Bacteraemia	10K (DH costing)	8	80K	1	10K	70K
Clostridium difficile	4K (Wilcox 1996)	175	700K	62	248K	452K
			780K		258K	**522K**

Operational Impact of Key Infections
National data shows that each patient with infection stays an average of 11 extra days in hospital. The reduction in cases below national trajectory is estimated to have released 1320 bed-days into the system to support delivery of activity targets.

	Number of cases on national trajectory	Additional bed-days used if on trajectory with national target	10-11 Number of cases to end Feb 2011	Additional bed-days to end Feb 2011	Bed-days released as a result of infection reduction against national target
MRSA Bacteraemia	8	88	1	11	77
Clostridium difficile	175	1925	62	682	1243
		2013		693	**1320 bed-days**

2.0 <u>Compliance With The Hygiene Code – Update</u>
The Hygiene Code is assessed under outcome 8 of the Care Quality Commission regulatory framework.

Summary of Available Evidence:
* Definitions taken from DH Board Assurance Frameworks for HCAI (2008):

<u>Green: Full assurance</u>**:** There are sufficient relevant, positive assurances to confirm the effectiveness of key controls and that objectives can be met.

<u>Amber: Gaps in assurance</u>**:** There is a lack of assurance, either positive or negative, about the effectiveness of one or more of the key controls. This may be due to a lack of relevant reviews, or concerns about the scope or depth of reviews that have taken place.

<u>Red: Gaps in control</u>**:** There is a clear conclusion, based on sufficient and relevant work, that one or more of the key controls on which the organisation is relying are not effective.

Criterion	Requirement	Status
1	Systems to manage and monitor the prevention and control of infection; including risk assessment	G
2	Provide a clean and appropriate environment	A
3	Provide suitable accurate information on infection to service users and patients	A
4	Provide suitable accurate information on infection to those providing further support or care	A
5	Provide appropriate treatment to reduce the risk of passing on an infection	G
6	Ensure that all staff are fully involved in the process of preventing and controlling infection	G
7	Provide adequate isolation facilities	G
8	Adequate access to laboratory support	G
9	Adhere to policies that help to prevent and control infections	A
10	Ensure care workers are free of and protected from infection	A

Summary of Further Action to Build Evidence and Strengthen Assurance	Lead
Criterion 2: • Concerns regarding robustness of assurance processes for key issues relating to policies on the environment, including Legionella management, and board to ward assurance on decontamination. • Plans to test assurances are being implemented to improve robustness, via the Statutory Compliance Committee, led by the Director of Estates.	Director of Estates & Facilities, and DIPC
Criterion 3: • Interim strategy agreed for availability of patient information. • Public website updated and key information is available. Further work planned. • Leaflet availability confirmed by ward-walk review in February 2011.	DIPC & Director of Communications
Criterion 4: • Evidence of information on infection provided at discharge or transfer is required: audit of practice in relation to MRSA demonstrates moderate compliance. • Discharge policy is to be strengthened further specifically to include infection information. This work is in progress	Divisions (IPT linking with Divisions)
Criterion 8: • The outstanding issue is a laboratory policy for the investigation and reporting of HCAI. This is currently work in progress.	Microbiology Manager
Criterion 9: • Only 4 core policies remain in draft format, with 24 approved and in-date. • Some Estates policies are also still in draft, with some approved. • Audit programme is in place, with work in progress to increase consistency and number of returns. • Detailed dashboard to support assurance framework now in place and reported monthly to divisions.	DIPC and Director of Estates & Facilities

Summary of Further Action to Build Evidence and Strengthen Assurance	Lead
Criterion 10: • Training is in place at induction and annual refresher. This element is green. • Occupational Health service provided under contract. HR Department working with DIPC to ensure evidence of Occupational Health systems and processes to manage occupational exposure to blood-borne viruses is available. • Occupational Health Review Group established to provide formal platform for this work. First meeting held. SLA currently being re-negotiated, and will include all Hygiene Code requirements • An improved amount of evidence now available centrally to demonstrate OH aspects. Some gaps in assurance for this standard remain.	Deputy Director of HR & DIPC

4.0 Key Infection Prevention Issues And Challenges

Legionella Management - Update

- As reported previously, the Trust initiated a review of Legionella management and control between February 2009 and July 2010, when the case of Legionella infection at QEH was detected.

- The report concluded that the governance of Legionella in the period up to around April 2010 was not sufficiently robust, as evidenced by the absence of a Legionella Policy, lack of clarity around roles and responsibilities, and process and reporting mechanism for water outlet flushing.

- Since then an external review of Statutory Compliance, the renewed focus on Statutory Compliance through the Executive Health and Safety Committee and the reports from the Director of Estates and Facilities, through several Trust committees, have brought greater clarity and assurance.

- An approved trustwide Legionella policy, and Legionella flushing procedure are in place, with clear roles and responsibilities. An Authorised Person, responsible for the management of Legionella across the Trust was formalised in July 2010. A Legionella assurance dashboard is also now in use, which is being populated by the appointed Authorised Person for Legionella, and this will provide ongoing assurance on the management and control of Legionella.

- The review concluded that the Trust take a number of additional actions to ensure roles and responsibilities for all statutory issues is clearly understood, and that responsibilities of the Trust and its partner organizations are clearly established as part of this work. It also recommended action to strengthen the framework for monitoring key policies, strengthen mechanisms used by Trust committees to monitor completion of agreed actions, strengthen trustwide representation at the Executive Health & Safety Committee, and to provide a shorter, more focused Board Assurance Framework to enable greater attention to key organizational risks.

- All the actions recommended in this review are being progressed and implemented, with monitoring via the Associate Director of Governance to ensure completion.

Decontamination of Medical Devices – Update

- The Trust now has a single management and leadership structure for its two Sterile Services Departments, and work to rationalise processes, procedures and the staffing model is underway. Both units are now also accredited by the same Notified Body, an important step that enables use of a single Quality System and training scheme.
- The Decontamination Action Group continues to meet, though progress to ensure the work programme on decontamination is comprehensive, and provides suitable assurance of good practice is slower than planned, which does present some risk.

- Currently work is underway in collaboration with the Division of Planned Care to review and strengthen assurance on the decontamination of endoscopes, including a plan to develop a single trust policy, and the Decontamination Action Group is continuing to progress the trustwide decontamination survey.
- Any decontamination issues that arise continue to be dealt with in a proactive manner with clinical teams to mitigate risk.

Environmental Cleanliness – Update

- The Trust received annual external PEAT inspections in February 2011, and all 3 sites have received a 'Good' rating. Regular Trust internal PEAT visits also continue for all sites, with involvement from LINks Groups, nursing and the Infection Prevention Team.
- In January the Trust launched a campaign on cleanliness and hand hygiene. This campaign will run throughout the spring/summer, and aims to reinforce basic hygiene measures and assist with driving up cleanliness standards further. Campaign messages such as 'clear the clutter' are designed to be memorable, and prompt individual and collective action at ward/department level, and the Trust will showcase those who achieve excellence through a variety of mechanisms.
- The monitoring and assurance framework for cleanliness is currently under review, with the aim of strengthening further the processes and mechanisms in place so that excellence can be achieved. This includes work with cleaning partners on standards to be achieved.
- The Trust has also reviewed the learning from outbreaks (see later in the report) in relation to environmental cleanliness, and is in the process of implementing an enhanced monitoring protocol for critical risk areas so that any problem with standards is more rapidly detected and corrected.

Essential Standards of Infection Prevention Practice – Update

- Infection Prevention audit dashboards provide a summary of audit results and provide the information needed for Matrons and Divisions to identify good practice and hotspot areas, and focus work to drive up standards for patients. Matrons continue to provide leadership and support to clinical areas to improve the audit return rate, though this does still remain variable.
- A summary of results is integrated into Divisional Governance reports, to support divisional action through governance mechanisms.
- A new set of national Quality Improvement Tools will be launched shortly by the Infection Prevention Society, endorsed by the Department of Health. These tools will be utilised as part of the annual programme for 2011-12, with the current monitoring framework developed to support their implementation.

5.0 Significant Outbreaks of Infection

Since the last DIPC report to Board there have been a number of significant outbreaks of infection that the Board will wish to be briefed on. An update is also provided on outbreaks reported previously to Board. It is important to note that the Trust takes a proactive approach to outbreak detection and management, and this is reflected in the number of issues detected and reported.

Norovirus - update

- In December 2010 a further major outbreak was declared at the PRU site. Again, this occurred at a time when the PCT had detected high levels of diarrhoea and vomiting in the local population. The outbreak has been reviewed with external support from the HCAI Lead at NHS London, and concludes that the outbreak was well managed, and lessons from the previous outbreak had been implemented. As would be expected, the review also identified further additional actions that the Trust can implement, and these are being actionned.
- Norovirus continues to circulate across London in the local population, and both QEH and PRU have recently seen small clusters of cases, including a single ward outbreak at QEH in February 2011. These have been contained, with no further internal spread detected.

VRE Outbreak in Critical Care - Update

- As reported previously, in October 2010 the laboratory detected 2 cases of VRE in blood cultures taken from 2 patients in the ICU at QEH. An outbreak was declared in view of this and control measures put into place. Patients were screened as part of the investigation and control plan for this outbreak, and several other cases were detected, though these were not causing clinical infection. Typing from the national reference laboratory confirmed that some cross-infection had occurred, but not all the cases were linked.
- The review concluded that improvements were required in infection prevention practice, cleanliness standards, antimicrobial prescribing, and storage on the unit. The action plan is being implemented through the Critical Care Directorate.

Resistant E.coli on Special Care Baby Unit

- In November 2010 the laboratory detected several cases of a resistant E.coli in babies on the Neonatal Unit at QEH. A total of 15 babies were eventually colonised.
- E.coli is a normal bacteria found in the bowel of all individuals, but it can lead to infection in vulnerable individuals. Resistant strains are of concern as they are more difficult to treat if they do lead to infection. No harm resulted to any of the babies due to this organism.
- An outbreak was declared, and initial review of the unit found significant concerns about standards of environmental cleanliness, standards of hand hygiene, and the use of items designed to make the environment more 'homely' for parents which were extremely difficult to clean properly. There was also a significant amount of necessary equipment on the unit but inadequate storage, making the environment cluttered and more difficult to clean.
- The unit was closed to admissions, and significant work was put in by the Infection Prevention Team and the Division to ensure all necessary control measures were implemented.
- Due to the challenge in ensuring this organism had been eradicated from the environment, the Trust arranged for environmental disinfection using hydrogen peroxide vapour. This proved successful, and no further cases have been detected since the outbreak was closed in December 2010.
- Since this outbreak the leadership on the unit has been significantly strengthened, and the Division are monitoring implementation of the action plan.

Resistant *Pseudomonas aeruginosa* in Critical Care

- In February 2011 the laboratory detected 3 cases of *Pseudomonas aeruginosa* that were resistant to an antibiotic called Meropenem. This is a bacteria that lives in the environment, and can cause infection in critically ill patients, though the presence of Meropenem resistance is unusual.
- The Health Protection Agency has recently issued guidance on the potential seriousness of resistance to Meropenem and other similar antibiotics, and as a precaution the Trust declared this as an outbreak in order to ensure focussed action to prevent spread.
- All 3 isolates were sent to the national reference laboratory for typing to check if they are linked, and the outcome is currently awaited.
- Control measures focussed on core clinical practices including hand hygiene, environmental cleanliness, and antimicrobial prescribing were implemented rapidly. Following this no further cases have been detected.
- A serious incident review is underway.

MRSA colonisation on Special Care Baby Unit

- In February 2011 the laboratory detected 3 cases of MRSA in babies on the Neonatal Unit at QEH. All three were colonisation, rather than infection, and the babies have suffered no adverse harm as a result.
- An outbreak was declared, and initial review demonstrated that many of the lessons learned from the previous outbreaks on the unit had been implemented, though some gaps remained.
- Control measures focussed on reinforcing the good practice already in existence, plus improving hand hygiene, and some issues relating to environmental cleanliness. In addition, the review of standards has extended to the delivery suite at QEH as a precaution.

- External review by colleagues at another Neonatal Unit has been sought, and a serious incident review is underway.
- No further cases have been detected following implementation of the enhanced control measures.

The outcomes of the repeated outbreaks at QEH will be further reviewed on completion of the latest serious incident reviews, to identify additional actions the relevant Divisions need to take to prevent further problems. This work will be led by the DIPC in collaboration with Divisional Management Teams.

6.0 Further Developments and Next Steps

Progress continues on a range of issues. Next steps include:

1. Completing the mapping of evidence of compliance for the Hygiene Code criteria that are amber.

2. Accelerating the Decontamination work programme to ensure it is comprehensive and robust.

3. Completing the mapping of evidence of assurance for Legionella management, and completing implementation of the additional actions identified in the review that has been performed.

4. Complete the review of the cleanliness assurance framework, and implement a revised framework for cleanliness assurance to further drive up standards.

5. Reviewing the learning from individual outbreak reviews to identify trends and themes, and focus work at divisional and/or corporate level to improve standards and prevent further outbreaks.

7.0 Summary

- The Trust continues to perform very well against MRSA and *Clostridium difficile* reduction targets in 2010-11, and remains within the internal stretch target limits. This improvement contributes to improved patient experience and improved safety, assists the Trust to deliver cost-reductions and supports work to increase activity.

- Monitoring and assurance frameworks using dashboard reports have been implemented for key infection prevention standards and for cleanliness. Outcomes of this work are being used to identify areas for action and to drive improvement.

- Work on key issues requiring further assurance continues, issues identified in the previous paper to Board have been progressed, and information on these will continue to be reported so that progress can be monitored.

B

Trust Board March 2011

Title: Learning Disabilities – Progress report on key work undertaken following the recommendations of the review of the Ombudsman's Report into 'Six Lives', Sir Jonathan Michael's report 'Healthcare for All' and Self Assessment Framework.

Report introduced by: Avey Bhatia Acting Director Nursing, and Patient Experience

Report author: Claire O'Brien Associate Nurse Director, Patient Experience.

Purpose of report:
To provide the Trust Board with a progress report on key work undertaken following the Board report in September 2010 which outlined recommendations made by the Ombudsman's 'Six Lives' Report March 2009 and Sir Jonathan Michael's report, 'Healthcare for All' July 2009.

Board action required:

The Board is requested to note progress made and to note the intention to provide a follow up report in September 2011.

Trust Objective:

We will put patients at the centre of everything we do. We will ensure that all patients experience care that is safe, maintains their dignity, treats them with respect and leads to agreed outcomes.

We will deliver high quality clinical care through the application of best clinical practice and by ensuring that the principles of clinical governance underpins our organisational culture, our systems and the working practices of our clinical teams and clinical services.

Standards for Better Health

Does this report a CQC standard?
CQC Outcome No 7 Safeguarding

Are there any legal implications arising from this item?

The Mental Capacity Act (MCA) Code of Practice and Development and Deprivation of Liberty Safeguards Code of Practice are Statutory Frameworks. Section 44 of the MCA introduced a new offence of ill treatment or wilful neglect of a person who lacks capacity.

Key Risks to the Trust: Non compliance with CQC Standard 7.

1.0 **Executive Summary**

The Trust Board received a comprehensive report in September 2010 which provided an overview of the reports; 'Six Lives' and Healthcare for All', both of which highlighted deficiencies in healthcare for people with a learning disability. The request for all organisations was to use the report findings to improve the patient experience of those who have a learning disability.

This report will inform the board of key work undertaken within the Trust since September and will also update on some of the key work streams that have been agreed at the Learning Disability Equality Group (previously called The SLHT Learning Disabilities Group) This group includes membership from the three Boroughs and is jointly managed and chaired by the Health Facilitator from Oxleas NHS Foundation Trust.

2.0 **Progress with the development of a work programme**

The Trust has now established a Learning Disability Equality group with membership from the three Boroughs with multi professional staff and includes representation from Bromley Mencap, University of Greenwich and a range of multi agency partners.

The group have agreed Terms of reference with specific objectives that include the key recommendations from the Six Lives' and Healthcare for All', reports and also include the outcome measures within the Care quality commission Learning disability indicator and the NHS London assessment and performance framework. Please note that these recommendations were outlined in detail in the last Board report.

There are a range of recommendations within all of the documents and the group have incorporated all of these into one work programme and are in the process of agreeing timescales for all of the work streams involved. In order to simplify the required action it is proposed that we establish some sub groups to take forward the following key objectives under each of the identified work streams.

Audit and Benchmarking-

The Trust will introduce protocols to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports.

The Trust will undertake a retrospective audit of a sample of clinical case notes against clinical benchmarks, legislative and policy frameworks.

People with learning disabilities access disease prevention, screening and health promoting activities in their practice and locality to the same extent as the rest of the population

To review and analyse complaints and adverse incidents affecting people with learning disabilities to ensure that this leads to altered or improved practice in the Trust.

Policy and Development

To ensure that the Trust provides appropriate support for family and carers who support patients with learning disabilities, including the provision of information regarding learning disabilities, relevant legislation and carers' rights.

To approve and launch a carer's policy; including promoting the policy and entitlements to patient/carer's groups and stakeholders.

To write an SLHT policy on caring for people with learning disability that ensures equality of access and equity for patients with learning disabilities patients.

To demonstrate that the Trust has protocols in place to routinely include training on learning disability awareness, relevant legislation, human rights, communication techniques for working with people with learning disabilities and person centred approaches in their staff development and/or induction programmes for all staff?

To ensure that the Trust has systems in place to provide safe and reasonably adjusted care for people with learning disabilities and other vulnerable groups.

Information and Communication

To ensure that the Trust adopts a long-term strategy to ensure that it can routinely provide accessible information (easy read) with regards to its services, treatments and conditions is readily available throughout its services and treatments; including health promotion.

To ensure that the Trust adopts strategies to ensure that patient information meets the needs of all patients equally.

Ensure that people with learning disabilities and carers are involved in the design and checking of easy read information.

Flagging

The Trust requires a mechanism to be put in place that will 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?

To ensure that the Trust collects sufficient data and information to allow people with learning disability to be identified by the health service and their pathways of care tracked.

All healthcare organisations should ensure that they collect the data and information necessary to allow people with learning disability to be identified by the health service and their pathways of care tracked.

To ensure that patients with learning disabilities are identified within complaints and serious incident procedures in order to identify trends and to promote organisational learning.

Inclusion

To ensure that people with learning disabilities and family carers are represented within the Trust's local groups and other relevant forums; ensuring that their views and interests are included in the planning and development of health services.

To ensure that the Trust has protocols in place to encourage representation of people with learning disabilities and their family carers within Trust Boards, local groups and other relevant forums, which seek to incorporate their views and interests in the planning and development of health services.

People with learning disabilities and their families/supporters are supported and empowered to fully contribute to and participate in discussion, as well as in the planning, prioritisation and delivery of health services generally.

Family and other carers should be involved as a matter of course as partners in the provision of treatment and care, unless good reason is given, and Trust Boards should ensure that

reasonable adjustments are made to enable them to do this effectively. This will include the provision of information, but may also involve practical support and service co-ordination.

Section 242 of the National Health Service Act 2006 requires NHS bodies to involve and consult patients and the public in the planning and development of services, and in decisions affecting the operation of services. All Trust Boards should ensure that the views and interests of people with learning disabilities and their carers are included.

Training

To include mandatory training in learning disabilities, which should be competence based and involve people with learning disabilities and their carers in the provision of training?

To agree a long- term strategy to routinely include training on learning disability awareness relevant legislation, human rights , communication techniques for working with people with learning disabilities and delivering person centred care.

3.0 Other work being supported through the Learning Disability Equality Group.

In support of one of the actions in the NHS London Assessment and Performance Framework we have set up a small review group to retrospectively review the case notes of one patient for whom there have been shortcomings in their care whilst in the Acute Trust.

The findings from this review of case notes will be reported back to the learning Disability Equality group and key action agreed.

The Trust is working with Bromley Learning Disability services a Learning disability project which is been supported by NHS London.

The overall aims of this project is to map the local journey of people with a learning disability who have complex health needs and or a co-morbidity and who are high users of local primary and acute hospital services.

The team are going to focus on the experience of adults with complex health needs from admission to a ward on the PRUH site to discharge. They are hoping to develop an integrated pathway which will impact on the overall experience of patients whilst in hospital and on discharge.

Matrons on the PRUH site have already met with members of the community Learning Disability team to engage their support and involvement with this project work.

It is anticipated that this will improve partnership working between the specialist learning disability team, the wider NHS and people with learning disabilities and their families or carers.

Progress with this project will be reported to the learning Disability Equality Group and any learning will be cascaded throughout the whole Trust.

6.0 Further action required by SLHT

The Learning Disability Equality Group has taken some time to become established, there is however now momentum and commitment within the group to ensure that we deliver against some of the key objectives.

As stated in the report the group have not yet agreed time scales on each of the objectives; this will be completed at the next meeting on the 14th April 2011. It is hoped that that by the introduction of sub groups that we will be able to expedite progress in key areas.

A further update to the Board outlining progress against this action plan will be presented at the September 2011 meeting.

B

Trust Board March 2011

Title:	Care Quality Commission Review – Progress Report

Date of Meeting: 23rd March 2011

For:		**Discussion**	**Information**	(delete as applicable)

Report introduced by: Avey Bhatia, Acting Director of Nursing and Patient Experience

Purpose of report:

Provide the Trust Board with an update on progress being made to demonstrate compliance against 8 CQC standards assessed as moderate concerns.

Board action required:

The Board is requested to note the progress made to date and the ongoing work in addressing the CQC 8 moderate concerns.

Trust Objective:

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Standards for Better Health

Does this report a CQC standard? Yes

CQC Outcomes 4, 5, 7, 9, 12 , 13, 16 and 21.

Key Risks to the Trust: Non compliance with 8 CQC Outcomes

Is an Equality Impact Assessment required?

If yes, please attach it to the paper **NO**

1.0 **Executive Summary**

Following the CQC planned review against 16 Quality and Safety standards in September 2010 and the publication of the final report in January 2011 the Trust submitted its action plan to the CQC on 25th January 2011. A meeting also took place with the CQC on the 24th February and another meeting is scheduled for the 22nd March 2011 to review progress.

Following the Review the Trust was judged to be compliant against eight standards with moderate concerns identified against a further eight.

Considerable work has been undertaken to address the assessments made by the CQC and work is ongoing. The focus is now to assess the impact of awareness-raising and communication initiatives through spot checks and more formal clinical audits. The work has now begun by the introduction of the Quality Road Map with assess compliance against each of CQC outcomes

2.0 **Moderate Concerns**

CQC found no major concerns but judged moderate concerns for the following outcomes, which are the focus of this report:

A moderate concern means that people who use services are safe but are not always experiencing the outcomes relating to the essential standard and there is an impact on their health and wellbeing because of this.

Outcome 4: Care and welfare of patients

CQC concern: awareness of incident report; assurance of learning from incidents; falls management (QMS); waiting times for appointments and physiotherapy waits at Beckenham Beacon (BB).

Progress

- There is good evidence of a healthy incident reporting culture with an increase in reported incidents from 1200 in Q1 2010, to 2684 in Q3. A clear training strategy for Datix has been implemented and a wide range of materials and support tools made available; with a number of global messages. Over 800 front-line staff have received in Datix-web to date, together with staff who have received ad hoc training and support. There is reasonably strong assurance of learning from incidents in reporting through committees and learning logs, which are being strengthened further. On-line reporting also enables rapid analysis and learning.

- The Trust was successful in complying with the NHSLA risk management standards at level 1 in the assessment on 7th February 2011.

- The Trust Falls policy has been published with the falls programme being led by the Strategic Falls Group. Falls audits have been undertaken at across all sites. The audit found good completion of falls risk assessments which do however, not always translate into effective preventative action.

- There has been a significant reduction in the waiting time for physiotherapy services at Beckenham Beacon however; issues around waiting times at appointments for phlebotomy are still being worked through.

Outcome 5: Food and nutrition (QMS)

CQC concern: elderly and vulnerable patients were not always supported with their nutritional needs at QMS.

Progress

- Observational audits took place on 10th February which demonstrated exemplary practice in some areas but also identified areas that required improvements. A Therapy Assistant Practitioner has arranged to work with QMS Matrons to promote nutritional support agenda. This agenda is also due to be promoted at a nutritional event being held on 13th April.

- Evidence from the national patient surveys suggests that while patients are critical of food quality, results for the Trust are comparable with other Trusts regarding the support patients perceive with their nutritional needs. The recent PEAT inspection at QMS scored food as excellent, the only site to achieve this score.

Outcome 5: Safeguarding Adults

CQC concern: Staff understanding of safeguarding adults and the Mental Capacity Act training; security awareness on all sites and the numbers of doors left unlocked.

Progress

- Training – aim is to have 50% of frontline workforce trained by end of March 2011. To date over 60% of frontline staff have received training. The medical and nursing workforce is being targeted specifically. There continues to be good partnership working with the boroughs who are supporting our training programme.

- Raising awareness campaign is being undertaken generally, with posters and information leaflets throughout the Trust. Awareness is increasing as issues are being logged and responded to.

- A Dementia Strategy Implementation Group and Joint (with Oxleas) Learning Equality Group to ensure all aspects of care for vulnerable adults are addressed.

- Security advice has been re-issued to staff via global email. Top 10 security tips will be laminated and issued to all wards and departments.

Outcome 9: Medicines Management

CQC concern: Safe storage of medicines, lack of self-administration policy for patients, drug charts incomplete, and timely writing of discharge medication.

Progress

- Self-administration policy approved by Medicines Management Committee.

- Global messages around storage, administration and prescribing issued. All desk emails being sent with overview for individual policies.
- Pharmacy audits of storage issues and audit of drug charts being undertaken.
- Storage and administration also being checked within the Quality Roadmaps.
- Medicines management included within mandatory training.

Outcome 12: Staffing

CQC concern: Number of eligible staff without current CRB checks in high-risk areas.

Progress

Timescales included in the CQC action plan were as follows:

- CRB forms issued to all eligible staff in high risk areas by the end of February 2011. All 714 forms have now been sent to eligible staff.
- Completed forms returned to CRB for 50% eligible staff in high risk areas March 2011. To date 182 forms have been received from those sent out.
- Completed forms returned to CRB for 100% eligible staff in high risk areas by October 2011.

The following actions have been taken in order to seek an improvement in the completion rates:

- Letters signed by Medical Director or Nurse Director have been sent to all staff who have not returned their CRB.
- Line managers have received staff lists and are chasing up with staff who have not responded.
- All desks emails have been sent out to improve completion rates
- Validation work is in progress on the numbers of staff in high risk areas who have a CRB which is more than 3 years old. It is planned for 788 forms to be sent out week beginning 14th March. The target date for all forms to be returned and sent to CRB is by October 2011.
- The CRB Policy has been agreed and is now on the Intranet

This is a challenging target and additional resources will be required to achieve these timeframes. Surgeries continue to be undertaken to ensure the correct documentation is returned and to improve completion rates. A further 3 surgeries are planned to take place between 17th -31st March, with more likely to be set up in order to meet the target number.

Outcome 13: Safe staffing

CQC concern: Whether night staffing levels were safe in all areas.

Progress

- Limited evidence provided to support this judgement. The reconfiguration of services has enabled safer staffing levels. Nurse staffing levels are set at safe levels for the night shifts. Workforce reviews are currently underway as part of workforce planning. Specialist areas staffing levels e.g. A&E, Critical Care and Stroke are set in line with National standards.

Outcome 16: Assessing the quality of care

CQC concern: As above for outcome 4

Outcome 21: Patient records

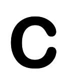
CQC concern: Secure storage of records; inaccuracies and gaps in records (QMS)

Progress

- Information Governance (IG) roadshows have taken place on every Trust site. To meet staff demand more roadshows are taking place in March.
- A letter has been distributed to all Consultants and Senior Nurses from the Caldicott Guardian outlining roles and responsibilities for IG.
- Further Trust wide all desks emails have been circulated promoting the IG training tool.
- Spot checks are ongoing and the Trust records audit will be completed and reported to the Trust Clinical Governance Committee.

Conclusion

Considerable work has been undertaken to address the judgements made by the CQC in its planned reviews. Key risks will be where cultural shifts are required in practice, and where shortcomings in individual wards or departments may again be identified. This would apply, for example with medicines storage and administration or the secure storage of records.



TRUST BOARD MARCH 2011

Title: Performance Report

For	~~**Decision**~~	**Discussion**	~~**Information**~~	(delete as applicable)

Report introduced by: Jennie Hall, Acting Chief Operating Officer

Report author: Ruth Holland, Associate Director of Performance and Information

Purpose of report:

The Trust Board Performance Report aims to provide a broad overview of progress on the Trust's priorities for 2010/11. Other reports to the Trust Board provide more detail on specific issues, e.g. regular reports on Healthcare Associated Infections and Patient Safety and Experience.

To provide the Board with assurance that patients are being treated safely and appropriately and highlight where remedial action is being taken and/or further action is required to improve performance.

To update members of the Trust Board on the performance for Quarter 2 2010/11 against the NHS Performance Framework, which is the mechanism by which South London Healthcare NHS Trust's (SLHT) performance will be judged by external stakeholders.

To update on the Performance of the Trust to month 11 2010/11 and forecast performance at year-end using a number of key indicators including:

- Healthcare Associated Infections (HCAIs)
- Hospital Standardised Mortality Ratios (HSMR)
- Referral to treatment (RTT) Access target
- Emergency Care (total time in Accident and Emergency (A&E) 4 hours or less)
- Maternity
- Workforce
- Efficiency

To provide assurance that the Trust is meeting the requirements of Care Quality Commission (CQC) and NHS Operating Framework 2010/11.

Board Recommendation/Board action required:

- Consider whether sufficient assurance has been provided that patients are being treated safely and appropriately and the Trust is meeting the requirements of the CQC and NHS Operating Framework 2010/11.
- Consider the performance of the Trust against key performance indicators to Month 11 2010/11.

Trust Objective:

Objective 4 - High Quality Clinical Care. We will deliver, high quality clinical care through the application of best clinical practice and by ensuring that the principles of clinical governance underpin our organisation's culture, our systems and the working practices of our clinical teams and clinical services.

Objective 5 - Healthcare acquired infections. We will continue to drive forward improvements in reducing health care acquired infections, to ensure that patients receive safe care that conforms to nationally agreed best practice and which leads to reductions in the incidents of Clostridium difficile infections and MRSA.

Objective 6 - National and Local Priorities: We will demonstrate that the Trust is providing high quality cost effective services through achieving the national priorities highlighted in the Operating Framework and through the achievement of a high level of performance in the measures included within the Annual Health Check (or Care Quality Commission equivalent), including the Auditor's Local Evaluation Assessments.

CQC Registration

Does this item support a CQC outcome? Yes

4. Care and welfare of people who use services
8. Cleanliness and infection control
12. Requirements relating to workers
13. Staffing
16. Assessing and monitoring the quality of service provision
17. Complaints

Are there legal implications arising from this item? No

Key Risks to the Trust:

- Risk that patients will be dissatisfied with waits in A&E services. Potential impact on care. Risk that good reputation of the Trust is damaged. The 4 hour maximum wait in A&E from arrival to admission may be failed.
- Risk that patients will be dissatisfied with the attitudes of staff, and the communication with them. Risk that good reputation of the Trust is damaged.
- Risk of non-compliance within 2010/11 of CQC performance assessment.
- Risk of non-compliance with Hygiene Code and failure to reduce numbers of HCAIs.
- Risk of available capacity not managed effectively to meet national key targets.
- Risk of failure to meet the National Cancer Targets and Cancer IOG (Improving Outcomes Guidance) Standards.

Is an Equality Impact Assessment required? No

Monthly Performance Report:
Level 1 - Trust Board

Month 11, February 2010/11

Ruth Holland - Associate Director of Performance & I*nformation (ruth.holland@nhs.net)*
Peter Ely - Head of Performance - EC & SM (peter.ely@nhs.net),
James Eaton - Head of Planned Care Performance (jameseaton@nhs.net)

South London Healthcare NHS Trust
Performance Report (Level 1 - Trust Board)

South London Healthcare NHS Trust

- (<2.0) Under Performing
- (2.0-2.4) Performance under review
- (>2.4) Performing

Trust Performance on NHS Performance Framework

The NHS Performance Framework measures progress on the key priorities detailed in the NHS Operating Framework 2010/11. It is the mechanism by which SLHT's performance will be judged by external stakeholders and links closely to SLHT's internal priorities.

Performance Domain	Quarter 2 2009/10 Actual		Quarter 3 2009/10 Actual		Quarter 4 2009/10 Actual		Quarter 1 2010/11 Actual		Quarter 2 2010/11 Actual	
	Score	Category	Score	Category	Score	Category	Score	Category	Score	Category
Finance	-	Under Performing	-	Under Performing	-	Under Performing	-	Under Performing	-	Under Performing
Quality: Standards & Vital Signs	2.9	Performing	2.46	Performing	2.63	Performing	3.00	Performing	2.89	Performing
Quality: User Experience	-	Not known	-	Not known	-	Not known	2	Performance Under Review	2	Performance Under Review
Quality: Registration	-	Not applicable	-	Not applicable	-	Not applicable	-	Performing	-	Performing
Quality of Service: Overall	-	Performing	-	Performing	-	Performing	-	Performing	-	Performing

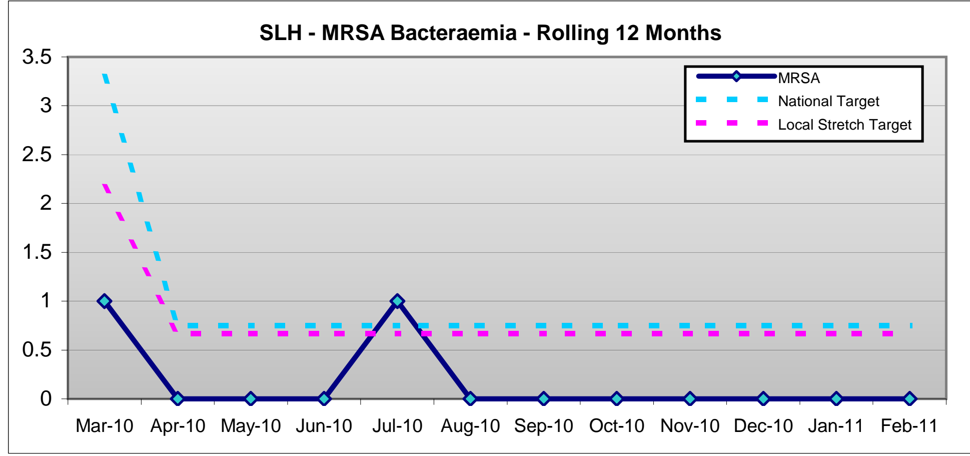
Analysis

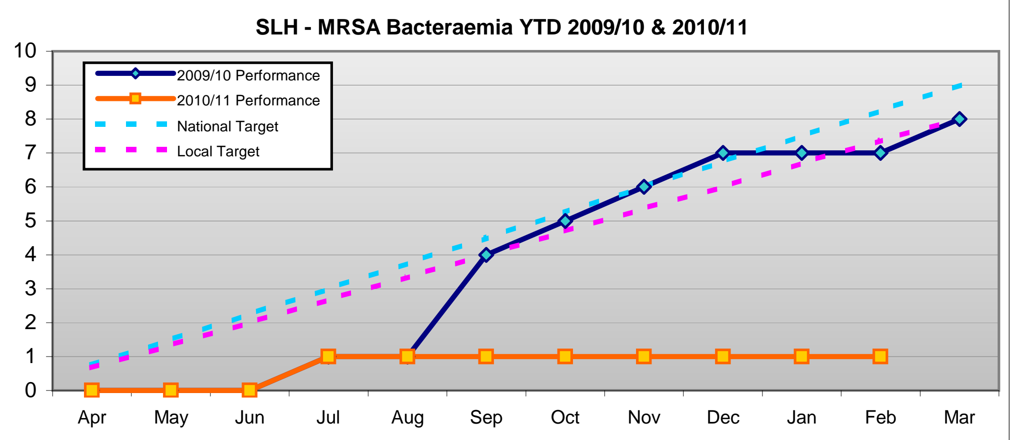
The results of the 2010/11 Q1 Framework are the first to illustrate the recent revision to the NHS Performance Framework. Organisations are now given two separate, equally-weighted performance ratings: one for Finance, and one for Quality of Services. SLHT has been 'under-performing' on Finance for more than 3 consecutive quarters and it, therefore, has an escalated status of 'Challenged' along with 5 other acute trusts in England. SLHT's was 'Performing' on Quality overall in Q1 and Q2 2010/11 (latest results available). SLHT's score in the User Experience section was made available for the first time in the Q1 10/11 results and attained 'Performance Under Review' status. Please refer to the Patient Safety and Experience Report for further detail on the action being taken to address this important part of the Trust's performance. The Performance Framework will be replaced in 2011/12 with an NHS Outcomes Framework containing a nationally determined set of outcome goals, which was published in December 2010 and will be implemented locally as the detail becomes available.

Healthcare Associated Infection - MRSA Bacteraemia

National Priority - **(PS1)** To ensure the incidence of MRSA Bacteraemia does not exceed 9
Local Stretch Target - To ensure the incidence of MRSA Bacteraemia does not exceed 8
Supports Compliance with CQC Outcome 8

Indicator	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	2010/11 Forecast
MRSA (Number)	1	0	0	0	1	0	0	0	0	0	0	0	<1
National Target	3.3	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	
Local Stretch Target	2.2	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	0.67	
YTD Local Stretch Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
YTD 2009/10	0	0	0	1	1	4	5	6	7	7	7	8	
YTD 2010/11	0	0	0	1	1	1	1	1	1	1	1		
YTD National Target	0.8	1.5	2.3	3.0	3.8	4.5	5.3	6.0	6.8	7.5	8.3	9.0	
YTD Local Target	0.7	1.3	2.0	2.7	3.4	4.0	4.7	5.4	6.0	6.7	7.4	8.0	





Analysis

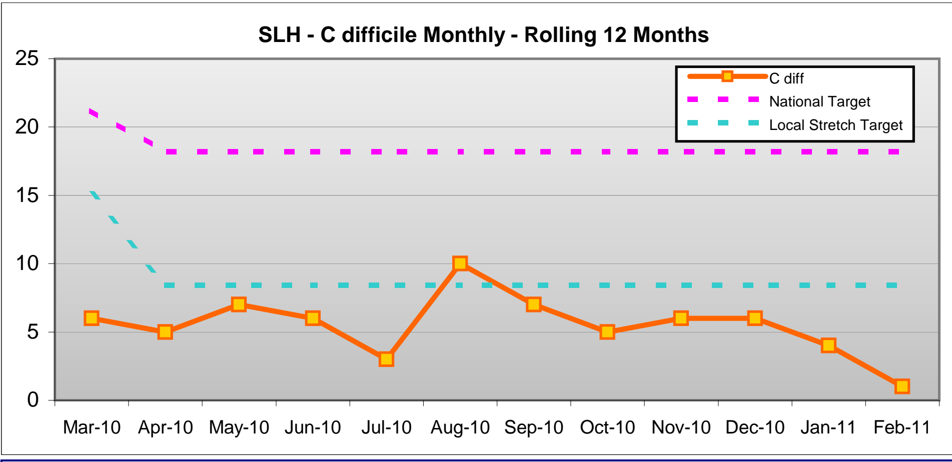
No MRSA bacteraemia were reported in February 2011 giving a Year to date total of 1 compared to a threshold of 7.4 (local target). The definition for this national target changed in 2010/11 and the Trust is now only monitored against hospital acquired MRSA bacteraemia (ie community acquired are excluded).

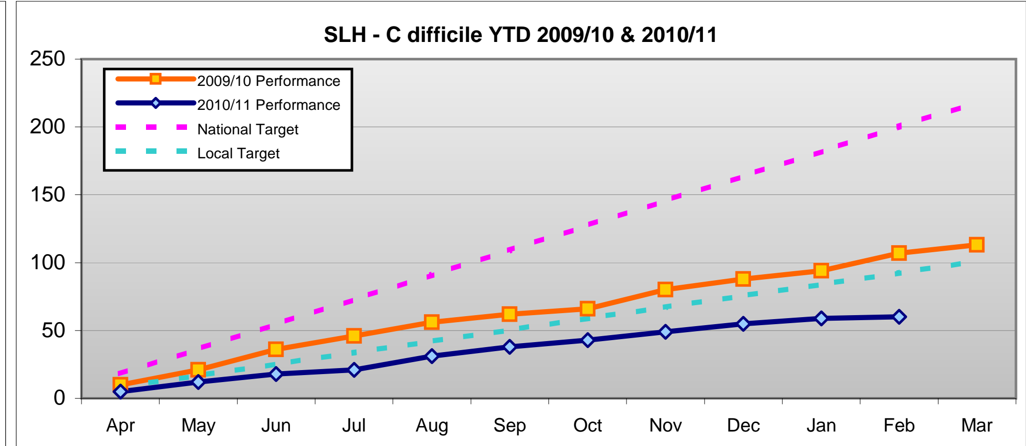
Lead - Avey Bhatia, Acting Director of Nursing

Healthcare Associated Infection - C. difficile

National Priority - **(PS4)** To reduce the incidence of C. difficile by 30% from 2007/08 levels
Local Stretch Target - To reduce the incidence of C. difficile by 10% from 2009/10 outturn
Supports Compliance with CQC Outcome 8

Indicator	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	2010/11 Forecast
C diff (Number)	6	5	7	6	3	10	7	5	6	6	4	1	<101
National Target	21.2	18.2	18.2	18.2	18.2	18.2	18.2	18.2	18.2	18.2	18.2	18.2	
Local Stretch Target	15.1	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.4	8.4	
YTD Local Stretch Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
YTD 2009/10	10	21	36	46	56	62	66	80	88	94	107	113	
YTD 2010/11	5	12	18	21	31	38	43	49	55	59	60		
YTD National Target	18.2	36.4	54.6	72.8	91.0	109.2	127.4	145.6	163.8	182.0	200.2	218.0	
YTD Local Target	8.4	16.8	25.2	33.6	42.0	50.4	58.8	67.2	75.6	84.0	92.4	101.0	





Analysis

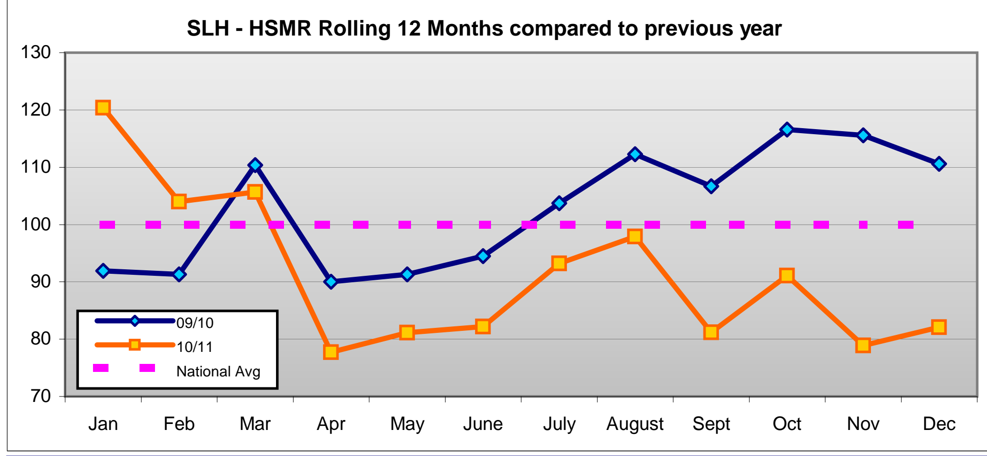
More challenging national and local targets have been set for 2010/11 to ensure year-on-year improvement, ie a national target of 218 compared to a local target of 101 for the full year. There was 1 reported cases of C. difficile in February 2011 with a year-to-date total of 60. The Trust is well ahead of its' trajectory, however, it continues to strive towards zero Healthcare Associated Infections.

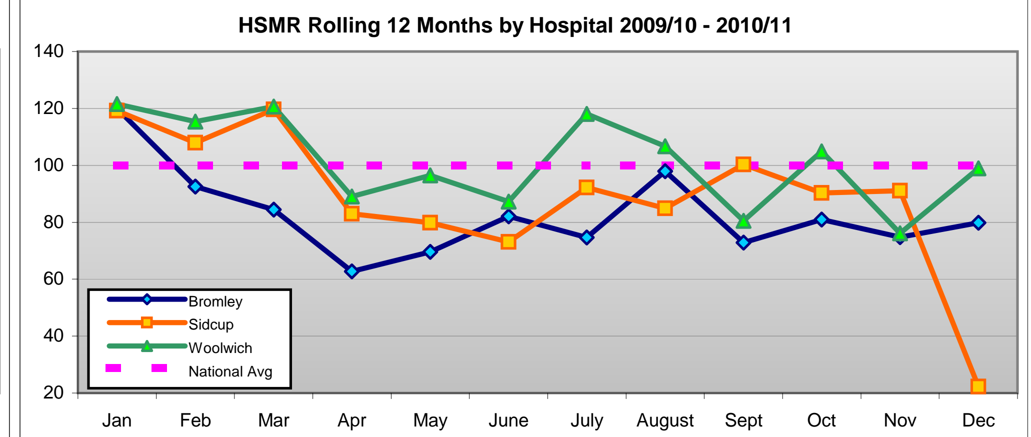
Lead - Avey Bhatia, Acting Director of Nursing

Hospital Standardised Mortality Rate

Local Priority - (**CE10**) To ensure the HSMR remains below the expected rate based on a national average of 100 incorporating adjustments for local population characteristics
Supports Compliance with CQC Outcome 4

Indicator	Jan	Feb	Mar	Apr	May	June	July	August	Sept	Oct	Nov	Dec
HSMR 10/11	120.4	104	105.7	77.7	81.1	82.2	93.2	97.9	81.2	91.1	78.9	82.1
HSMR 09/10	91.9	91.3	110.4	90	91.3	94.5	103.7	112.3	106.7	116.6	115.6	110.6
National Avg	100	100	100	100	100	100	100	100	100	100	100	100
Bromley	120	92.5	84.4	62.7	69.6	82.1	74.7	97.9	72.9	80.9	74.8	79.8
Sidcup	119.2	107.9	119.6	83	79.8	73.1	92.2	84.9	100.3	90.3	91.1	22.2
Woolwich	121.5	115.4	120.6	89	96.5	87.3	118.1	106.7	80.5	104.9	76.1	99





Analysis

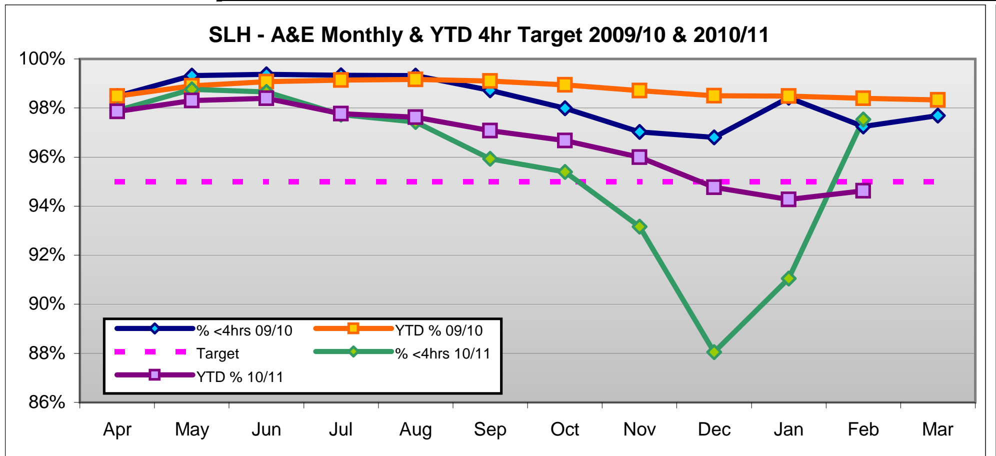
HSMR compares an organisation's actual number of deaths in hospital with their expected (or predicted) number of deaths. The prediction calculation takes account of factors such as the age and sex of patients, their diagnosis, whether the admission was planned or an emergency, and the length of stay. Standardisation of the ratio allows valid comparison between different hospitals serving different communities. It is important to note that the Trust (or an individual site) can still be Green even if its score is above 100 due to local population characteristics being taken into account. The Trust and all 3 sites were Green in December 2010 - latest data available - and continue to deliver low mortality rates. (Data for this indicator is published in arrears on an independent national system).

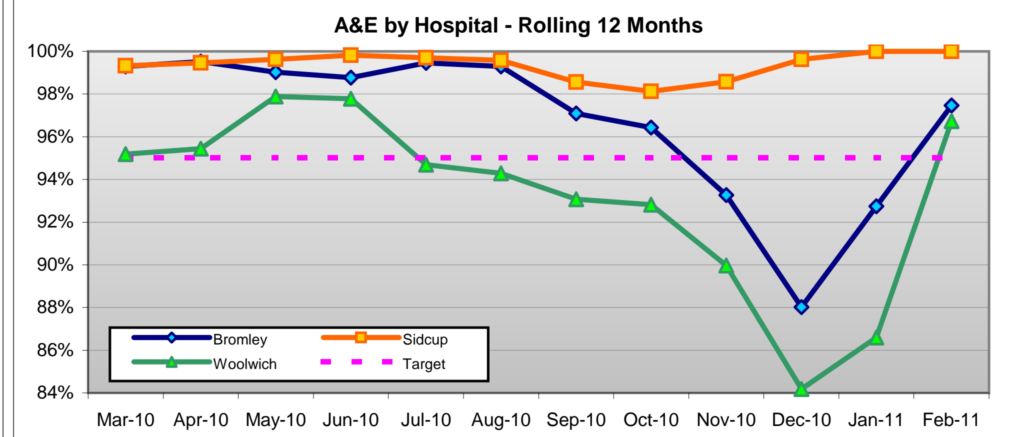
Lead - Roger Smith, Medical Director

Emergency Care - Total time in A&E 4 hours or less (Type 1 & 3)

National Priority - **(A24)** 95% of patients to spend 4 hours or less in A&E (Type 1 & 3)
Supports Compliance with CQC Outcome 4

Indicator	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2010/11 Forecast
<4hrs (%) 2009/10	98.5%	99.3%	99.4%	99.3%	99.3%	98.7%	98.0%	97.0%	96.8%	98.4%	97.2%	97.7%	
YTD (%)	98.5%	98.9%	99.1%	99.1%	99.2%	99.1%	98.9%	98.7%	98.5%	98.5%	98.4%	98.3%	
<4hrs (%) 2010/11	97.9%	98.8%	98.7%	97.7%	97.4%	95.9%	95.4%	93.2%	88.1%	91.1%	97.5%		95.00%
YTD (%)	97.9%	98.3%	98.4%	97.8%	97.6%	97.1%	96.7%	96.0%	94.8%	94.3%	94.6%		
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	
	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	
Bromley (%)	99.3%	99.5%	99.0%	98.8%	99.5%	99.3%	97.1%	96.4%	93.3%	88.0%	92.7%	97.5%	
Sidcup (%)	99.3%	99.5%	99.6%	99.8%	99.7%	99.6%	98.6%	98.1%	98.6%	99.6%	100.0%	100.0%	
Woolwich (%)	95.2%	95.4%	97.9%	97.8%	94.7%	94.3%	93.1%	92.8%	90.0%	84.2%	86.6%	96.7%	





Analysis

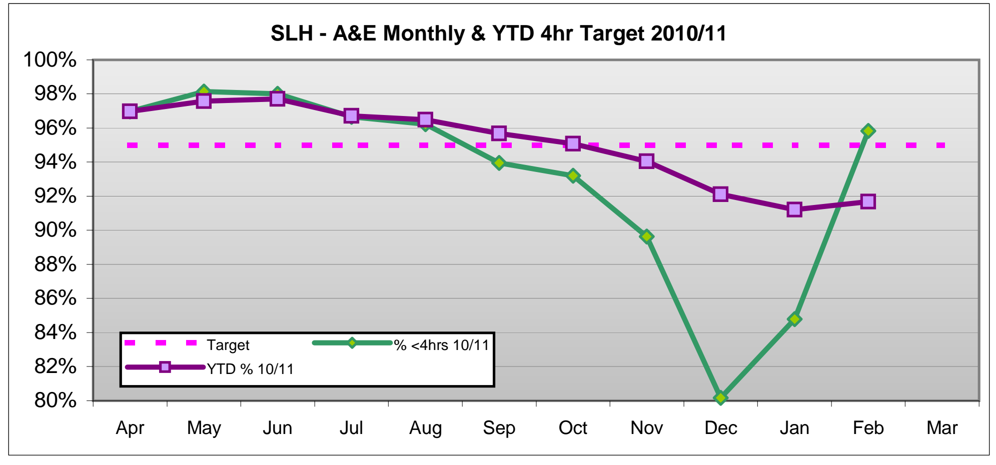
This section includes the combined performance of all Type 1&3 Emergency Care Services in outer SE London, which is monitored closely by the Department of Health. Type 1 A&E Departments are consultant led 24 hour services with full resuscitation facilities. Type 3 A&E Departments are other type of A&E/minor injury units (MIUs)/Walk-in Centres which may be doctor led or nurse led and can be managed by other service providers. Performance for February 2011 at Trust aggregate level was 97.5% for Type 1&3 with a year-to-date performance of 94.6% against a national target of 95%. (YTD is measured from July to December in line with national guidance).

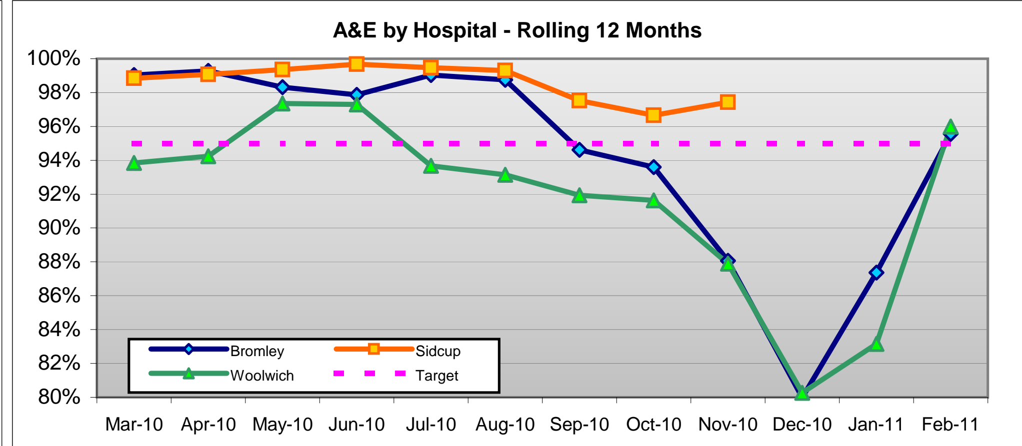
Lead - Jennie Hall, Acting Chief Operating Officer

Emergency Care - Total time in A&E 4 hours or less (Type 1)

National Priority - **(A24)** 95% of patients to spend 4 hours or less in A&E (Type 1)
Supports Compliance with CQC Outcome 4

Indicator	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2010/11 Forecast
<4hrs (%) 2010/11	97.0%	98.1%	98.0%	96.7%	96.2%	93.9%	93.2%	89.6%	80.2%	84.8%	95.8%		
YTD (%)	97.0%	97.6%	97.7%	96.7%	96.5%	95.7%	95.1%	94.0%	92.1%	91.2%	91.7%		<95%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	
	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	
Bromley (%)	99.0%	99.3%	98.3%	97.9%	99.0%	98.7%	94.6%	93.6%	88.1%	80.0%	87.4%	95.6%	
Sidcup (%)	98.8%	99.1%	99.4%	99.7%	99.5%	99.3%	97.5%	96.7%	97.4%				
Woolwich (%)	93.9%	94.2%	97.4%	97.3%	93.7%	93.1%	91.9%	91.6%	87.9%	80.3%	83.2%	96.0%	





Analysis

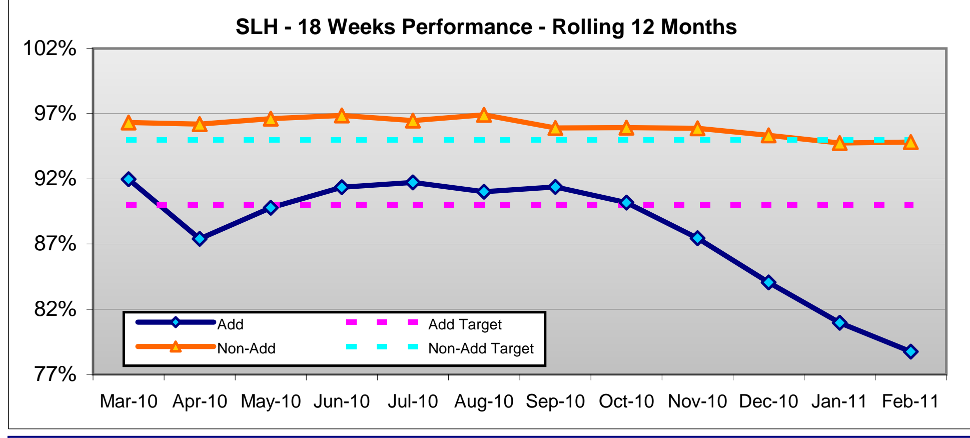
This section includes the performance of Type 1 A&E Departments directly managed by SLHT which is monitored closely by the London Strategic Health Authority. (Type 1 A&E Departments are consultant led 24 hour services with full resuscitation facilities). Performance for February 2011 at Trust aggregate level was 95.8% with a year-to-date performance of 91.7% against a national target of 95%.

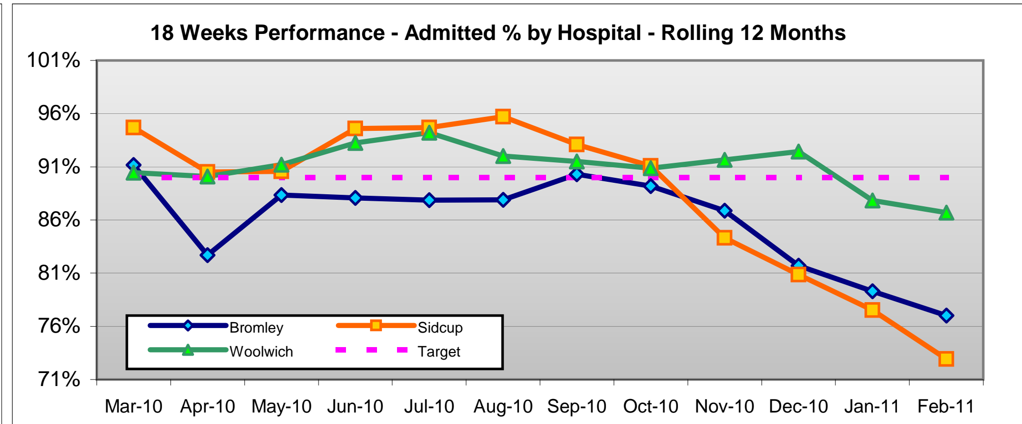
Lead - Jennie Hall, Acting Chief Operating

Referral to Treatment - 18 Weeks - Admitted & Non-Admitted Patients

National Priority – **(A8/A9)** 90% of admitted and 95% of non-admitted patients to be treated within 18 weeks of Referral
Supports Compliance with CQC Outcome 4

Indicator	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	2010/11 Forecast
Admitted (%)	92.0%	87.4%	89.8%	91.4%	91.7%	91.0%	91.4%	90.2%	87.5%	84.1%	81.0%	78.7%	<90%
Bromley	91.2%	82.7%	88.3%	88.1%	87.9%	87.9%	90.3%	89.2%	86.9%	81.7%	79.3%	77.0%	
Sidcup	94.7%	90.5%	90.6%	94.6%	94.7%	95.7%	93.1%	91.1%	84.3%	80.9%	77.5%	72.9%	
Woolwich	90.5%	90.1%	91.2%	93.2%	94.2%	92.0%	91.5%	90.9%	91.6%	92.4%	87.8%	86.7%	
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	
Non-Admitted (%)	96.3%	96.2%	96.6%	96.9%	96.5%	96.9%	95.9%	95.9%	95.9%	95.4%	94.8%	94.8%	>95%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	





Analysis

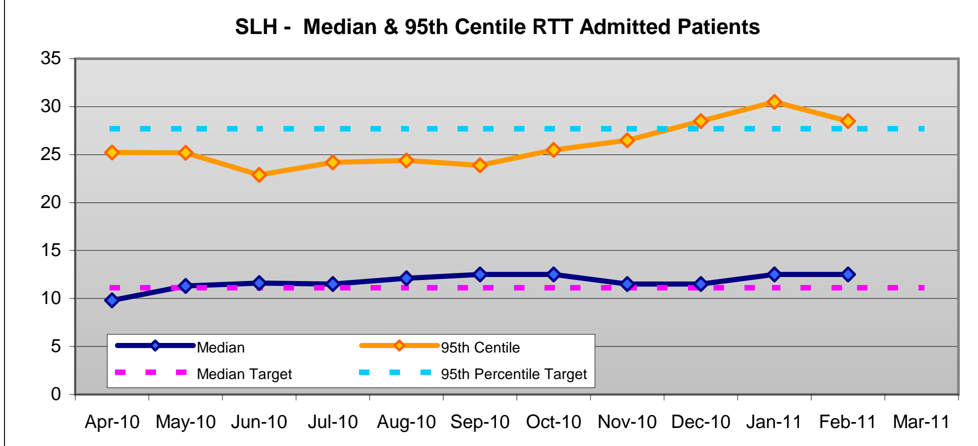
Performance for Month 11 2010/11 was 78.7% for admitted patients, ie less than 90% of patients were treated within 18 weeks of referral (Red). 94.8% of non-admitted patients were treated within 18 weeks of referral (Amber) compared to a national standard of 95%. Although the Revised NHS Operating Framework confirmed that the Department of Health is no longer performance managing Trusts on whether they treat patients within 18 weeks, the Trust is still contractually required to deliver this standard. A baseline review of demand and capacity has identified services where there is a capacity shortfall and a defined amount of non-recurring funding for additional capacity was supported by the Trust Board at its seminar in October 10. Commissioners have agreed that the Trust should focus on treating the current backlog of patients as a priority in Q3 and Q4 2010/11 and have accepted that this will impact on levels of performance. Clinical leadership & engagement is being sought to change pathways, become more productive and address capacity shortfalls in a sustainable way. A Control Plan to manage the improvement is in place.

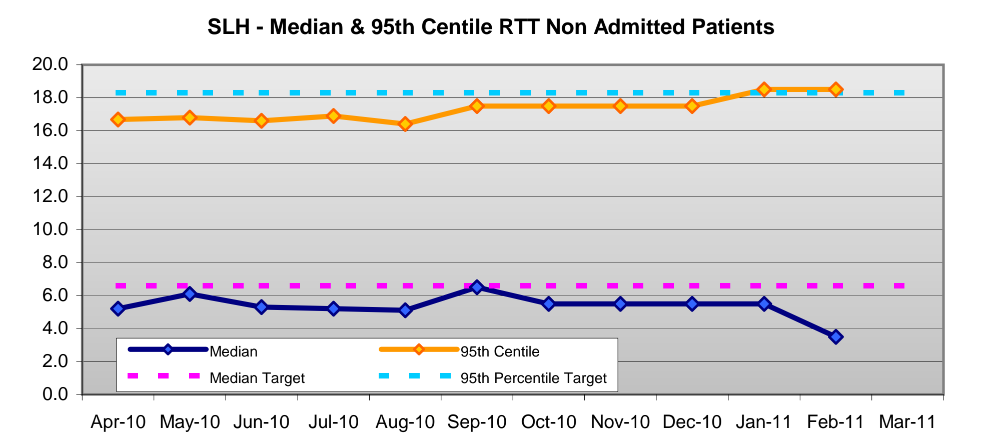
Lead - Jennie Hall, Acting Chief Operating Officer

Referral to Treatment - Median Waiting Times for Patients

(A16/A18) Median referral to treatment time for admitted and non admitted patients
(A17/A19) 95th centile referral to treatment time for admitted and non admitted patients
Supports Compliance with CQC Outcome 4

Indicator	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Admitted - Median	9.82	11.3	11.6	11.5	12.1	12.5	12.5	11.5	11.5	12.5	12.5	
Target	11.1	11.1	11.1	11.1	11.1	11.1	11.1	11.1	11.1	11.1	11.1	11.1
95th Centile	25.2	25.2	22.9	24.2	24.4	23.9	25.5	26.5	28.5	30.5	28.5	
Target	27.7	27.7	27.7	27.7	27.7	27.7	27.7	27.7	27.7	27.7	27.7	27.7
Non Admitted - Median	5.2	6.1	5.3	5.2	5.1	6.5	5.5	5.5	5.5	5.5	3.5	
Target	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6
95th Centile	16.7	16.8	16.6	16.9	16.4	17.5	17.5	17.5	17.5	18.5	18.5	
Target	18.3	18.3	18.3	18.3	18.3	18.3	18.3	18.3	18.3	18.3	18.3	18.3





Analysis

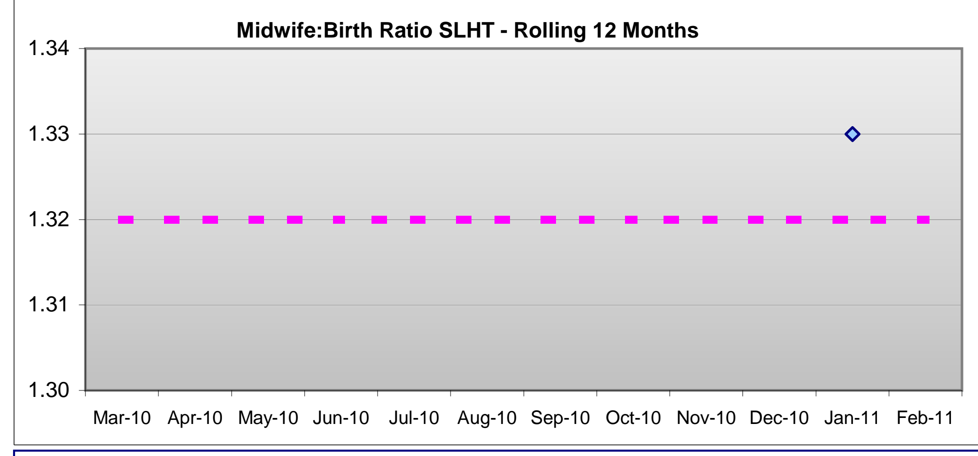
The Trust is now monitoring median waiting times for treatment in line with the shift in focus at national level indicated by the Revised NHS Operating Framework 2010/11. The median waiting time is identified by listing patient waiting times from the lowest to the highest and picking the middle cohort. The median waiting time for admitted patients was 12.5 weeks in February 2011 (Red), which is above the national threshold of of 11.1 weeks. The median waiting time for non admitted patients was 3.5 weeks (Green) in February 2011. The distribution of waits for treatment is also being monitored locally and nationally by tracking how long patients on the 95th centile have waited - in February this was 28.5 weeks for admitted patients and 18.5 for non-admitted patients (both Red).

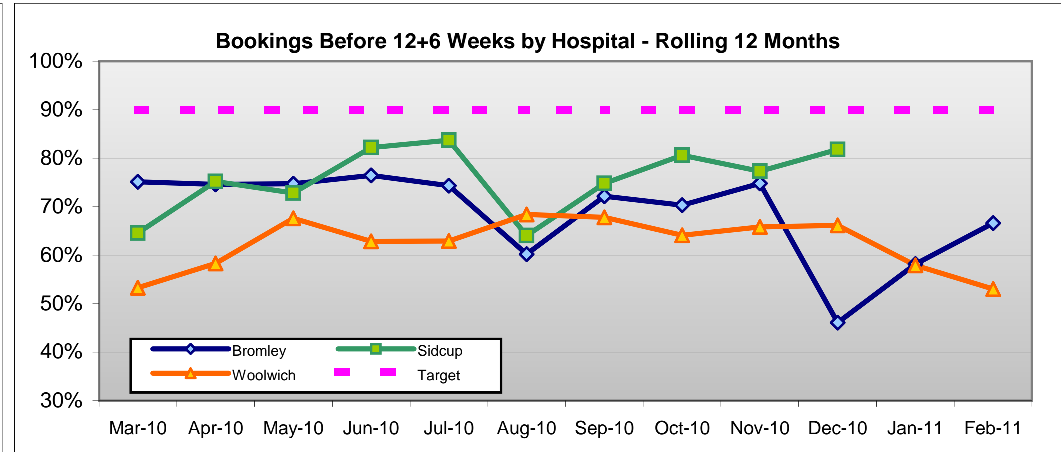
Lead - Jennie Hall, Acting Chief Operating

Maternity & Midwifery Services

Local Priority - **(CE20)** to reduce the midwife:birth ratio to 1:32
Local Priority - **(A32)** 90% of women to have seen a midwife for assessment by 12 weeks and 6 days of pregnancy
Supports Compliance with CQC Outcome 13 (CE20) and 4 (A32)

Indicator	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	2010/11 Forecast
Midwife:Birth - SLHT	Data not available due to change in indicator										1.33		
Target	1.32	1.32	1.32	1.32	1.32	1.32	1.32	1.32	1.32	1.32	1.32	1.32	
12+6wks - Bromley	75.1%	74.6%	74.7%	76.5%	74.4%	60.2%	72.2%	70.3%	74.8%	46.1%	58.2%	66.6%	
12+6wks - Sidcup	64.6%	75.2%	72.8%	82.2%	83.7%	64.0%	74.8%	80.6%	77.3%	81.8%			
12+6wks - Woolwich	53.3%	58.3%	67.6%	62.8%	62.9%	68.4%	67.8%	64.1%	65.8%	66.2%	57.9%	53.0%	
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	





Analysis

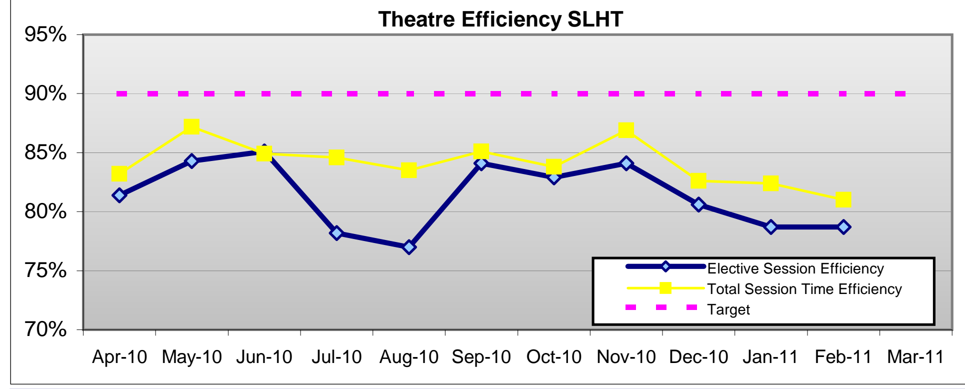
Significant progress has been made towards the target midwife to birth ratio of 1:32 following the temporary closure of the maternity service on the QMS site in December 2010. Early access to maternity services is a shared target with Primary Care Trusts and the Trust is working jointly with local Primary Care Trusts on measures to improve performance. The main issues are patients that do not attend appointments and patients that present who are already over 13 weeks pregnant. The Trust and PCTs have undertaken an audit to understand the reasons why women are presenting late and any barriers to accessing services and information on the importance of early booking and attendance has been circulated to GP practices. Direct access services are being developed and a more streamlined referrals process across primary and secondary care is being implemented. NB. Midwife:Birth ratio is based on actual whole time equivalents.

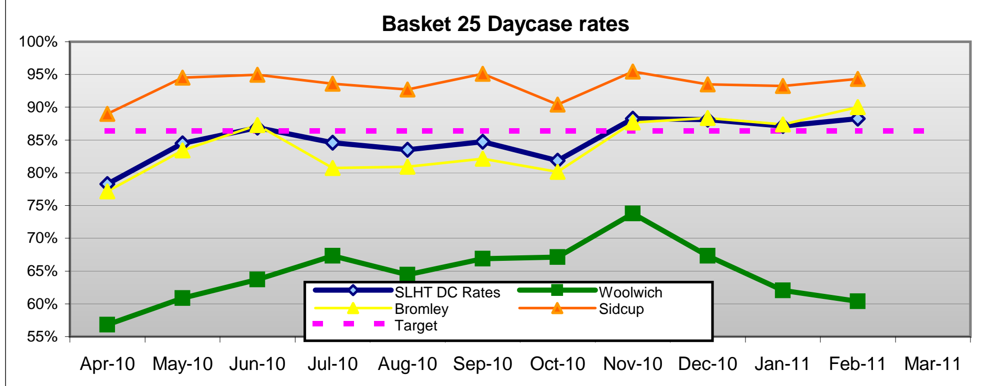
Lead - Avey Bhatia, Acting Director of Nursing

Efficiency Overview - Theatre Efficiency & Daycase Rates

Local Priority - **(E4)** to improve the Daycase rate of 25 procedures (identifed nationally) to the best 25% in England
Local Priority **- (E14)** to improve Theatre Efficiency to 90% to get maximum use of and value from Trust assests
Supports Compliance with CQC Outcome 4

Indicator	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Elective Session Efficiency	81.4%	84.3%	85.1%	78.2%	77.0%	84.1%	82.9%	84.1%	80.6%	78.7%	78.7%	
Total Session Time Efficiency	83.2%	87.2%	84.9%	84.6%	83.5%	85.1%	83.8%	86.9%	82.6%	82.4%	81.0%	
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
SLHT DC Rates	78.3%	84.5%	86.9%	84.6%	83.5%	84.7%	81.8%	88.2%	88.1%	87.1%	88.3%	
Woolwich	56.8%	60.9%	63.7%	67.4%	64.5%	66.9%	67.1%	73.8%	67.3%	62.0%	60.4%	
Bromley	77.2%	83.4%	87.3%	80.7%	80.9%	82.2%	80.2%	87.7%	88.4%	87.4%	90.0%	
Sidcup	89.0%	94.5%	95.0%	93.6%	92.7%	95.1%	90.4%	95.5%	93.5%	93.3%	94.3%	
Target	86.4%	86.4%	86.4%	86.4%	86.4%	86.4%	86.4%	86.4%	86.4%	86.4%	86.4%	86.4%





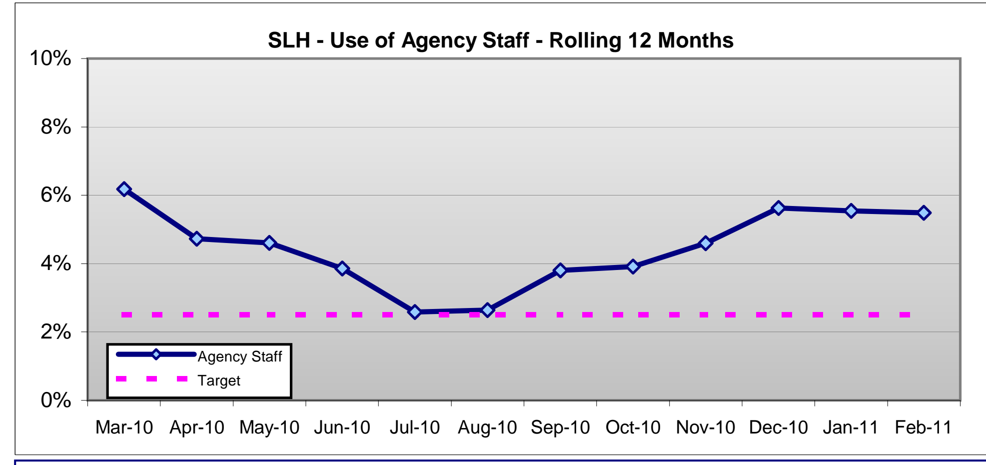
Analysis

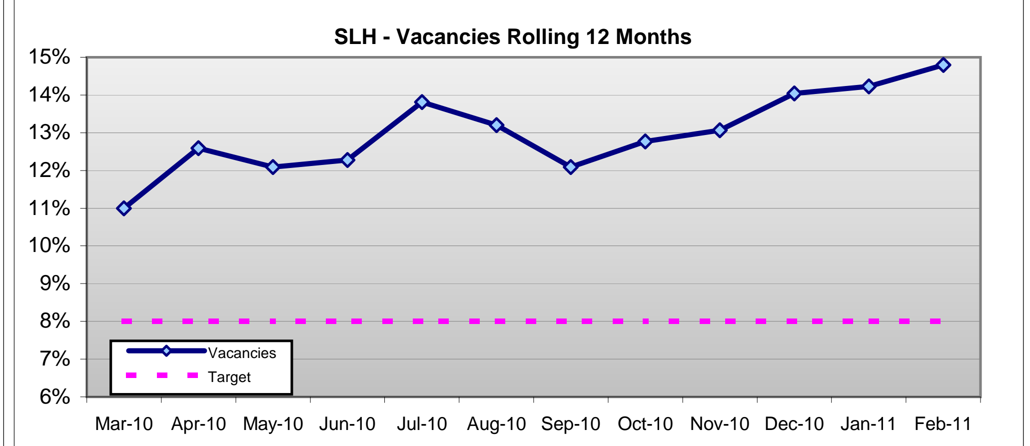
Elective session efficiency indicates whether best use was made of the scheduled theatre sessions with 78.7% (Red) of the scheduled capacity being used in February 2011 compared to a target of 90%. Session time efficiency indicates the use made of the sessions that actually took place with 81.0% (Red) of capacity being used effectively. Theatre efficiency information is not submitted nationally, however, efficiency is commonly expected to achieve levels of 85-90% in the NHS to ensure maximum use of assets. Improving theatre efficiency is a key workstream in the Referral to Treatment Control Plan and a productivity priority for 2011/12.
Daycases rates are calculated for a 'basket' of 25 procedures that are defined nationally and allows comparison with other Trusts. Of those procedures that could have been carried out as daycases, SLHT carried out 88.3% of them in this way in February 2011 (latest data available in national system) compared to a target of 86.4%.

Workforce

Local Priority - **(W4)** to minimise the use of agency staff
Local Priority **- (W8)** to keep the vacancy rate below 8%
Supports Compliance with CQC Outcome 13

Indicator	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	2010/11 Forecast
Use of Agency	6.2%	4.7%	4.6%	3.9%	2.6%	2.6%	3.8%	3.9%	4.6%	5.6%	5.5%	5.5%	
Target	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	
Vacancies	11.0%	12.6%	12.1%	12.3%	13.8%	13.2%	12.1%	12.8%	13.1%	14.0%	14.2%	14.8%	
Target	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	





Analysis

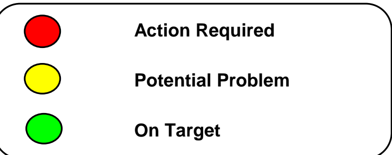
Use of agency staff has remained fairly static for the past 3 months at around 5.5%. Reductions in spend in specific areas are being considered alongside clinical quality and patient safety requirements. Further detail is available in the Financial Performance Report to Trust Board.

The overall vacancy rate has increased slightly to 14.8% in Month 11 from 14.2% in Month 10. The Vacancy Control Group meets regularly to ensure no delays in recruiting substantive staff to business critical positions.

Lead - Louise McKenzie, HR&OD Director

South London Healthcare NHS Trust
Performance Scorecard (Level 1 - Trust Board)

The scorecard shows the latest performance against 10 other KPIs, which are a combination of national and local priorities in addition to the priorities shown earlier in the report.



Some of the indicators below are reported 1 month in arrears to ensure completeness of data.

		CQC Outcome	Trust Key Performance Indicators	Target	Mar 10	Apr 10	May 10	Jun 10	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Trend	YTD*	Y/End* Forecast
Clinical Effectiven	CE2	4	NHS London Stroke Unit Target (Bromley & Woolwich sites only) % of patients with stroke spending 90% of time on a stroke unit	>=70%	Data not availabl e - New	55.2%	70.1%	75.9%	72.1%	78.2%	73.2%	74.5%	67.9%	69.6%	72.4%		▲	70.9%	>70%
	CE14	4	Fractured neck of femur - % patients having surgery within 48 hours	>=88%	93.1%	77.1%	76.8%	63.0%	85.7%	81.1%	77.8%	93.5%	83.3%	84.2%	80.6%		▼	80.0%	>81%
	CE15**	4	Hospital acquired pressure ulcers (All grades)	<300	Data not	52	52	37	45	44	55	43	33	31	39	20	▼	451	>300
Patient Exp.	PE3**	1	Same Sex Accommodation - number of not clinically justified breaches	0	Data not available				0	2	2	0	16	26	33	21	▲	100	>0
		1	Same Sex Accommodation - patient survey - % reporting breaches	<=5%	13.8%	13.3%	8.2%	8.8%	9.5%	11.1%	12.1%	10.5%	8.1%	Data not available	7.8%	10.5%	▼	10.1%	<10%
Cancer	C2	4	14 day wait for breast symptom referrals from December 2009 (% of patients seen waiting less than 14 days) (reported one month in arrears)	>=93%	88.6%	90.5%	94.9%	95.1%	95.4%	92.6%	94.1%	96.9%	98.1%	98.4%	100.0%		▲	95.3%	>93%
Work force	W7	14	Sickness absence	<=4%	3.75%	3.70%	3.36%	3.62%	3.64%	3.87%	3.22%	3.52%	3.22%	3.43%	4.18%	3.66%	▼	3.45%	<4%
	W9	13	Staff Turnover	<=12%	8.44%	8.59%	8.50%	8.50%	8.63%	8.41%	8.42%	8.67%	8.33%	8.08%	8.12%	8.21%	▲	8.21%	<12%

*YTD and Y/End Forecast figures relate to current financial year only.
**Please refer to the Patient Safety and Experience Report for performance by site

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South London Healthcare

Report to Trust Board

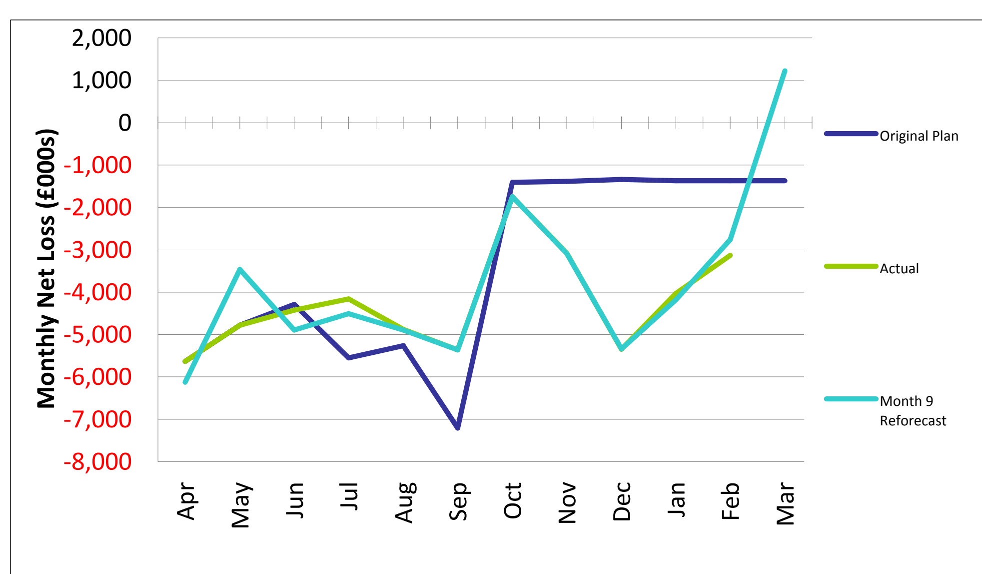
Month 11

22 March 2011

Agenda

- Executive Summary
- Month 11 Financial Summary

Executive Summary – Trading Position and Outlook



The month 11 position was a loss of £3.1m which is slightly behind the re-forecast calculated at month 9 of £2.8m. A bridge analysis of the movement from the month 10 position and also the re-forecast is provided below

Trading in the ECSM division remains extremely difficult with pay costs increasing despite reduced top-line activity. Usage of temporary staffing has remained elevated since December. Trading is £2m lower than originally forecast due primarily to reduced income and increased costs in ECSM

Delivery of the full year forecast is dependent on £5m balance sheet releases in the final month of the year (month 12). While the risks and opportunities identified by the Trust indicate this is possible, there is an element of risk.

Bridge Analysis Actual Month 10 to Actual Month 11

	£000
Actual Position Month 10	(4,032)
Block Contract Income Phasing	(338)
Increased Non Pay Expenditure in Theatres on MSSE	(121)
Reduced Non Pay Expenditure in ICU due to decreased activity	50
Reduced Income in WCCS relating to R&D	(146)
Transfer of Mammography To Kings	(21)
Lower Bank & Agency in WCCS	66
Reduced Drug expenditure in WCCS	154
Phasing of CNST and Rates	1,300
Other Minor Movements	(44)
Actual Position Month 11	(3,132)

Bridge Analysis Forecast to Actual Month 11

	£000
Forecast Position Month 11	(2,765)
Block Contract Income Phasing	175
A&E Additional Staffing / QMS Overflow Beds	(478)
Excluded devices in Cardiology	(89)
Increased Non Pay Expenditure in Theatres on MSSE	(121)
Transfer of Mammography To Kings	(21)
MRI Scanner	(90)
Pay Savings in WCCS (Pharmacy, Bank & Agency, Catch Up of Salary Recharges)	211
Reduction in Bromley CT Scans	43
Reduced Drug expenditure in WCCS	75
Additional Income for Orpington Diabetic Unit	118
Non Pay Costs in Corporate	(259)
Other Variances	69
Actual Position Month 11	(3,132)

Agenda

- Executive Summary
- Month 11 Financial Summary

Consolidated Profit & Loss (Month 11) - Forecast

	Month 11 (February)			Year to Date			Notes
	Actual £000	Forecast £000	Variance £000	Actual £000	Forecast £000	Variance £000	
TOTAL INCOME	36,451	36,276	175	402,062	404,451	(2,389)	(a)
Pay	(24,694)	(24,437)	(257)	(270,676)	(270,297)	(379)	(b)
Non-Pay (excl. Depreciation)	(11,229)	(10,951)	(278)	(137,778)	(140,326)	2,548	(c)
Asset Impairment						0	
TOTAL OPERATING EXPENDITURE	(35,923)	(35,388)	(535)	(408,454)	(410,624)	2,170	
EBITDA	**528**	**888**	**(360)**	**(6,392)**	**(6,173)**	**(219)**	
% of Income	**1.4%**	**2.4%**		**-1.6%**	**-1.5%**		
Depreciation	(1,267)	(1,263)	(4)	(13,895)	(13,892)	(3)	
Finance Charges	(2,393)	(2,390)	(3)	(26,299)	(26,298)	(1)	
	(3,660)	(3,653)	(7)	(40,194)	(40,190)	(4)	
NET LOSS	**(3,132)**	**(2,765)**	**(367)**	**(46,586)**	**(46,363)**	**(223)**	

Notes - SPECIFIC

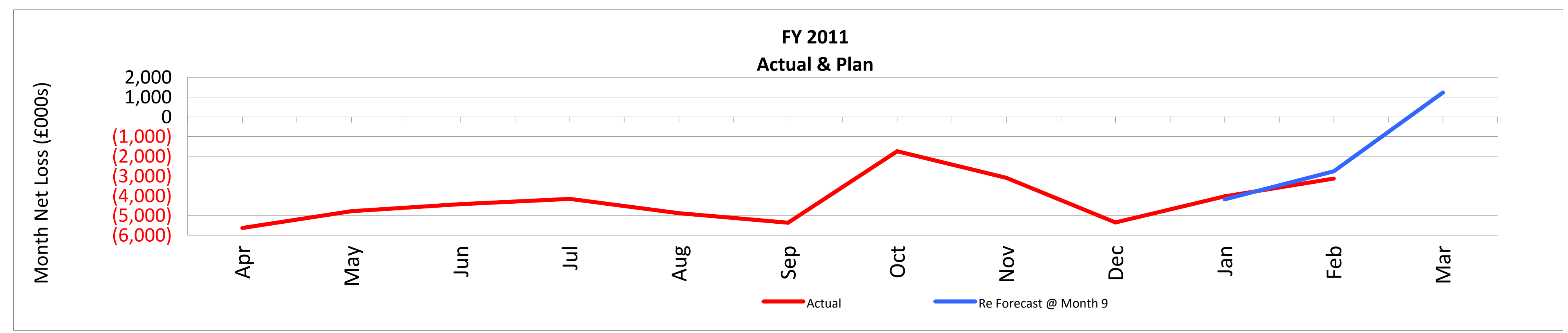
Actual income reflects the 2010/11 contract income. Income reflects the fixed block contract up to month 11. Additional analysis of income is included later in the report.

Pay continues to trend per the previous months. Overall there has been a marginal decrease in spend. The position is behind the forecast for the month due to A&E Staffing, which is offset by savings elsewhere.

Non Pay is behind forecast due to increased expenditure in Theatres and excluded devices in Cardiology.

Notes - GENERAL

The reported loss for month 11 is £0.4m behind the revised forecast for the month. The loss is worse than the forecast mainly due to additional staffing in A&E. There are other minor variances to forecast which are explained in the Divisions later in the report. On a YTD basis the loss is £46.6m which is £0.2m behind the forecast. This is due to the variances on the current trading position within the Trust. The forecast assumes continued improvement in run rate to the year end which includes the use of balance sheet flexibility.



Consolidating Profit & Loss (Month 11)

Actual In Month Trading Position Month 11 (February)

	Central Income	Planned Care	ECSM	WCCS	Corporate Services	Total
	£000s	£000s	£000s	£000s	£000s	**£000s**
TOTAL INCOME	34,427	142	278	531	1,073	**36,451**
Pay	0	(6,811)	(7,802)	(7,340)	(2,741)	**(24,694)**
Non-Pay (excl. Depreciation)	0	(2,199)	(2,189)	(1,668)	(5,173)	**(11,229)**
TOTAL OPERATING EXPENDITURE	0	(9,010)	(9,991)	(9,008)	(7,914)	**(35,923)**
EBITDA	**34,427**	**(8,868)**	**(9,713)**	**(8,477)**	**(6,841)**	**528**

Trend Analysis (EBITDA)

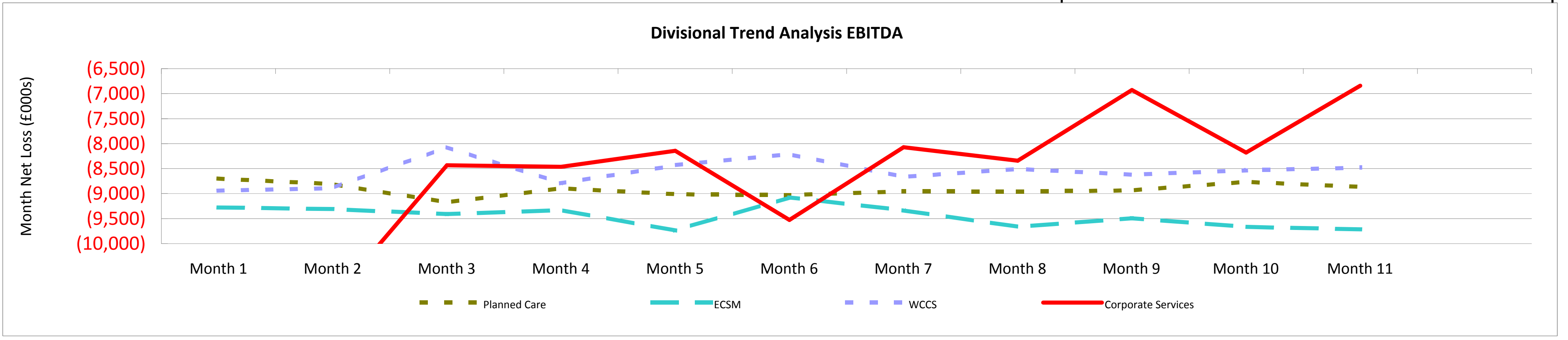
	Central Income	Planned Care	ECSM	WCCS	Corporate Services	Total
Month 7 Actual	36,050	(8,953)	(9,334)	(8,666)	(8,071)	1,026
Month 8 Actual	36,039	(8,958)	(9,664)	(8,503)	(8,344)	570
Month 9 Actual	32,276	(8,935)	(9,490)	(8,622)	(6,928)	(1,699)
Month 10 Actual	34,765	(8,766)	(9,662)	(8,534)	(8,181)	(378)
Month 11 Actual	34,427	(8,868)	(9,713)	(8,477)	(6,841)	528
Month 12 Actual						
Movement 10 to 11	**(338)**	**(102)**	**(51)**	**57**	**1,340**	**906**
YTD EBITDA	**384,066**	**(98,099)**	**(103,999)**	**(94,134)**	**(94,226)**	**(6,392)**

Notes

Contract income is in line with the original plan and is slightly ahead of forecast in month due to phasing of the block income.

Run rates within the Planned Care Division have stabilised over the last three months. ECSM has seen a worsening of their run rate due to staffing issues in A&E. WCCS have improved their run rate in month which is explained in detailed later in the report. The forecast assumes the position to improve towards the year end.

The significant improvement in Corporate relates to the phasing of CNST and Rates. The full year expenditure was incldued in the YTD month 10 position.



Original Consolidated Plan

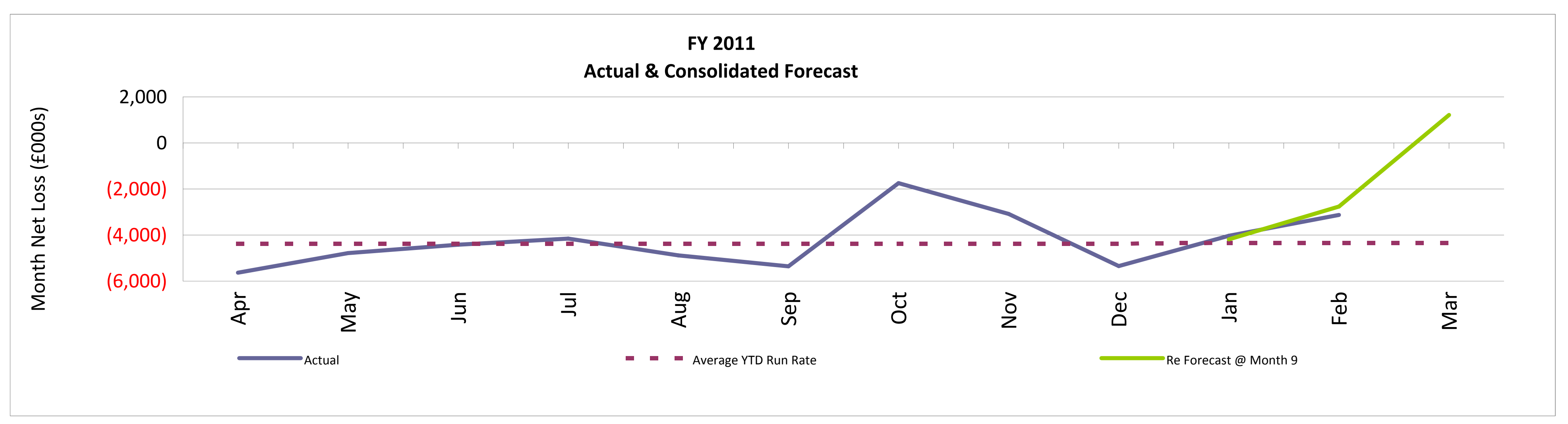
Financial Year 2010/11

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Variance	FY 2011
	actual	actual	actual	actual	actual	actual	actual	actual	actual	actual	actual	plan	to plan	plan
INCOME														
PCT Clinical Income (BBG)	28,803	30,193	29,499	29,293	28,835	28,101	30,161	29,686	26,939	28,839	28,740	30,046	(978)	348,157
PCT Clinical Income (Other)	3,723	3,723	3,162	3,773	3,192	3,356	3,725	3,459	2,914	3,031	3,371	4,026	3,619	45,074
Other Clinical Income	879	744	709	398	526	646	653	1,055	626	613	678	682	(29)	8,181
Total Clinical Income	33,405	34,660	33,370	33,464	32,553	32,103	34,539	34,200	30,479	32,483	32,789	34,754	2,612	401,412
Other Operating Income	2,747	1,779	3,910	3,561	3,667	4,478	3,527	4,407	3,861	5,055	3,662	3,519	(4,169)	40,004
	36,152	36,439	37,280	37,025	36,220	36,581	38,066	38,607	34,340	37,538	36,451	38,273	(1,556)	441,416
OPERATING EXPENDITURE														
Pay	(24,704)	(24,727)	(24,495)	(24,262)	(24,882)	(24,709)	(24,487)	(24,515)	(24,273)	(24,931)	(24,694)	(22,652)	9,261	(284,070)
Non Pay (Excl Depreciation)	(13,225)	(12,603)	(13,400)	(13,194)	(12,454)	(13,413)	(12,541)	(13,523)	(11,763)	(12,985)	(11,229)	(13,118)	1,595	(151,853)
	(37,929)	(37,330)	(37,895)	(37,456)	(37,336)	(38,122)	(37,028)	(38,038)	(36,036)	(37,916)	(35,923)	(35,770)	10,856	(435,923)
EBITDA	**(1,777)**	**(891)**	**(615)**	**(431)**	**(1,116)**	**(1,541)**	**1,038**	**569**	**(1,696)**	**(378)**	**528**	**2,503**	**9,300**	**5,493**
Depreciation	(1,430)	(1,429)	(1,365)	(1,408)	(1,405)	(1,417)	(469)	(1,263)	(1,263)	(1,264)	(1,267)	(1,429)	(1,740)	(17,149)
Net Interest Payable(receivable)	(1,669)	(1,697)	(1,683)	(1,669)	(1,629)	(1,668)	(1,669)	(1,671)	(1,668)	(1,668)	(1,670)	(1,683)	(152)	(20,196)
PDC Dividend Payable	(761)	(761)	(761)	(651)	(733)	(733)	(651)	(722)	(722)	(722)	(722)	(761)	(433)	(9,132)
NET LOSS (ACTUAL / FORECAST)	(5,637)	(4,778)	(4,424)	(4,159)	(4,883)	(5,359)	(1,751)	(3,087)	(5,348)	(4,032)	(3,131)	(1,370)	6,974	(40,984)
Implied Annual Run Rate						(50,824)						(16,440)		
ORIGINAL PLAN	(5,637)	(4,778)	(4,290)	(5,552)	(5,264)	(7,210)	(1,412)	(1,390)	(1,341)	(1,371)	(1,369)	(1,370)		
VARIANCE FROM ORIGINAL PLAN	0	0	(134)	1,393	381	1,851	(339)	(1,697)	(4,007)	(2,661)	(1,762)	0		
YTD ACTUAL	(5,637)	(10,415)	(14,839)	(18,998)	(23,881)	(29,240)	(30,991)	(34,078)	(39,426)	(43,458)	(46,588)			
YTD PLAN	(5,637)	(10,415)	(14,705)	(20,257)	(25,521)	(32,731)	(34,143)	(35,533)	(36,874)	(38,245)	(39,614)			
YTD VARIANCE FROM PLAN	0	0	(134)	1,259	1,640	3,491	3,152	1,455	-2,552	-5,213	-6,974			

Consolidating Re Forecast (as at Month 9)

Financial Year 2010/11

	Apr actual	May actual	Jun actual	Jul actual	Aug actual	Sep actual	Oct actual	Nov actual	Dec actual	Jan actual	Feb actual	Mar forecast	Variance to forecast	FY 2011 forecast
Central Income	35,322	37,215	34,458	35,035	34,196	34,282	36,050	36,039	32,277	34,765	34,427	35,215	281	419,000
Planned Care	(8,701)	(8,812)	(9,178)	(8,893)	(9,011)	(9,026)	(8,953)	(8,958)	(8,934)	(8,766)	(8,868)	(8,715)	185	(107,000)
Emergency Care & Specialist Medicine	(9,275)	(9,310)	(9,410)	(9,326)	(9,740)	(9,074)	(9,334)	(9,664)	(9,491)	(9,662)	(9,713)	(9,093)	(789)	(112,303)
Women's, Children's & Clinical Support	(8,943)	(8,889)	(8,065)	(8,795)	(8,431)	(8,209)	(8,666)	(8,503)	(8,622)	(8,534)	(8,477)	(8,693)	373	(103,200)
Corporate Services	(10,192)	(11,108)	(8,432)	(8,463)	(8,142)	(9,527)	(8,071)	(8,344)	(6,928)	(8,181)	(6,841)	(3,840)	(271)	(97,798)
Financial Charges	(3,848)	(3,874)	(3,797)	(3,717)	(3,755)	(3,806)	(2,777)	(3,656)	(3,651)	(3,654)	(3,659)	(3,653)	(4)	(43,843)
	(5,637)	(4,778)	(4,424)	(4,159)	(4,883)	(5,360)	(1,751)	(3,086)	(5,349)	(4,032)	(3,131)	1,221	(225)	(45,144)
Implied Annual Run Rate						(50,826)						14,652		
Re forecast @ Month 5	(5,637)	(4,778)	(4,424)	(4,159)	(4,883)	(3,116)	(2,627)	(2,774)	(2,412)	(2,223)	(2,004)	(1,947)		(40,984)
Variance from Re Forecast	0	0	(0)	(0)	(0)	(2,244)	876	(312)	(2,937)	(1,809)	(1,127)	3,168		(4,385)
YTD Actual	(5,637)	(10,414)	(14,839)	(18,998)	(23,881)	(29,241)	(30,993)	(34,078)	(39,427)	(43,459)	(46,590)			
YTD Forecast	(5,637)	(10,415)	(14,839)	(18,998)	(23,881)	(26,997)	(29,624)	(32,398)	(34,810)	(37,033)	(39,037)			
YTD Variance From Forecast	0	1	0	0	(0)	(2,244)	(1,369)	(1,680)	(4,617)	(6,426)	(7,553)			



Balance Sheet Month - 11

	SLHT Balance Sheet			
	28-Feb-11	31-Jan-11	Movement	Notes
	£m	£m	£m	
Non-Current Assets				
Fixed Assets	480.6	483.4	(2.8)	(a)
Other Receivables	18.4	18.3	0.1	(b)
Sub-Total Non-Current Assets	499.0	501.7	(2.7)	
Current Assets				
Inventories	5.8	6.0	(0.2)	
Trade and Other Receivables	37.5	38.2	(0.7)	(c)
Cash and Cash Equivalents	14.5	15.7	(1.2)	(d)
Sub-Total Current Assets	57.8	59.9	(2.1)	
Current Liabilities	(88.4)	(89.6)	1.2	(e)
NET CURRENT ASSETS / (LIABILITIES)	(30.6)	(29.7)	(0.9)	
TOTAL ASSETS LESS CURRENT LIABILITIES	468.4	472.0	(3.6)	
Non-Current Liabilities				
Borrowings	(225.1)	(225.6)	0.5	
Provision for Liabilities and Charges	(5.3)	(5.3)	0.0	
Sub-Total Non-Current Liabilities	(230.4)	(230.9)	0.5	
TOTAL ASSETS EMPLOYED	238.0	241.1	(3.1)	
Financed by Taxpayers Equity				
Public Dividend Capital	373.2	373.2	0.0	
Retained Earnings	(135.4)	(132.3)	(3.1)	
Revaluation Reserve	0.0	0.0	0.0	
Donated Asset Reserve	0.2	0.2	0.0	
TOTAL TAXPAYERS EQUITY	238.0	241.1	(3.1)	

Balance Sheet Month - 11 Notes

a) Reduction in fixed assets is due to 1.2m of depreciation plus other small corrections in assets register.

b) Small increase in other receivables relates to PRUH PFI lifecycle prepayment.

c) Trade and Other Receivables

	28-Feb-11	31-Jan-11	Movement	
NHS Debt	16.2	25.2	(9.0)	Jan 11 figure includes £11.9m of February Contract invoices raised in advance and paid in Feb. Therefore the movement in real terms from Jan to Feb is a net increase of £2.9m of invoiced activity over cash received.
Non NHS Debt	2.2	2.2	0.0	
	18.4	**27.4**	**(9.0)**	
Other Receivables	0.2	0.2	0.0	
Provisions for Bad Debts	(2.2)	(2.2)	0.0	
Accrued Income	7.4	3.8	3.6	Material movements relate to: NHS - Corporate £2.3m increase, Central £1.5m decrease. Non NHS - Corporate increase £0.7m. All accrued income has now been reviewed and Divisions have raised invoices in month 12. The increase in Corporate is due to change: in accounting treatment, previously income accruals were offset against expenditure
Accruals (Partial Completed Spells)	3.7	3.7	0.0	
	9.1	**5.5**	**3.6**	
Prepayments PFI	1.2	1.2	0.0	
Prepayments Other	5.9	3.0	2.9	Increase due you prepayment of United Healthcare invoices for Mar-11
VAT	2.9	1.1	1.8	
	37.5	**38.2**	**(0.7)**	

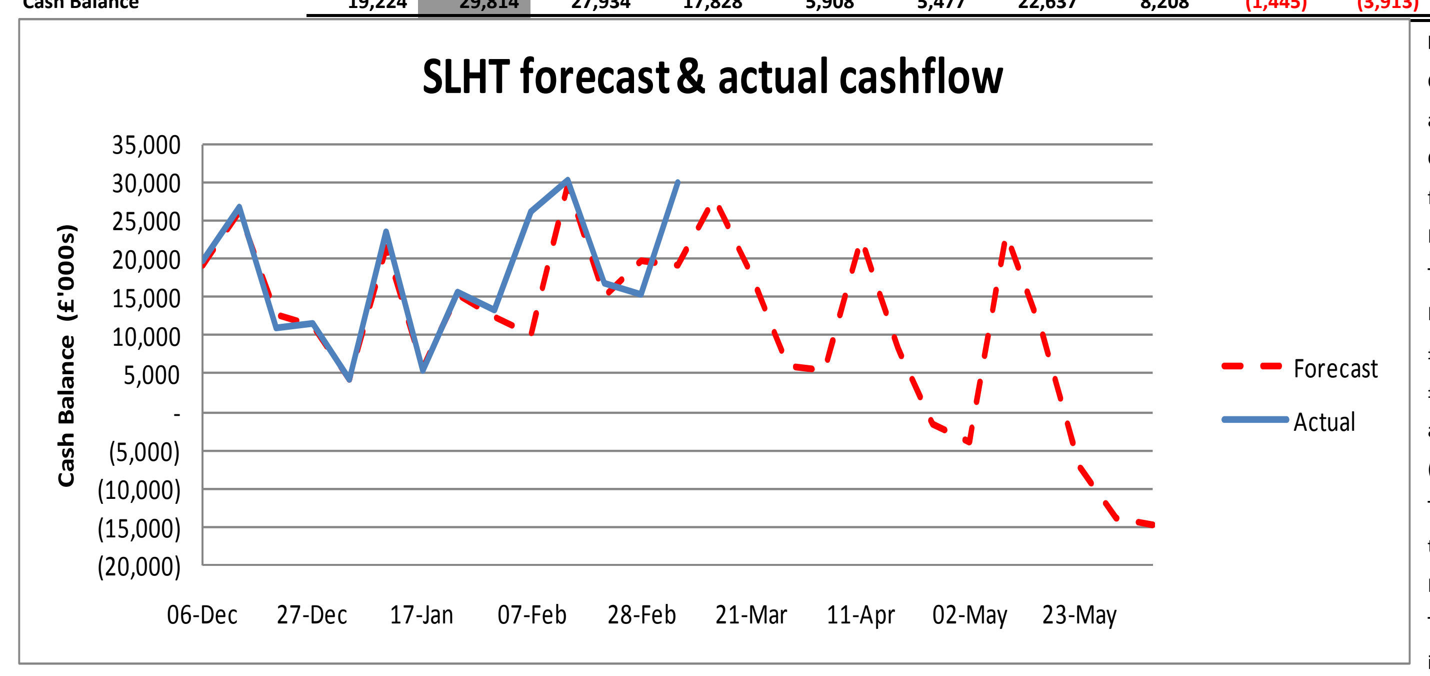
d) Cash has reduced in the month mainly due to the decrease in capital Creditors.

e) Current Liabilities

	28-Feb-11	31-Jan-11	Movement	
NHS Payables	(11.4)	(10.9)	(0.5)	Payments to NHS suppliers are only made once a month. Creditor days are increasing for NHS due to the cash position.
Non NHS Payables	(22.7)	(17.4)	(5.3)	Increase in Non-NHS payables is due to PO matching issues, these are being investigate with the help of Procurement.
	(34.1)	**(28.3)**	**(5.8)**	
Other Payables	(0.5)	(0.6)	0.1	
Accruals	(19.2)	(16.1)	(3.1)	Correction of the treatment of accrued income in Corporate has increased expenditure accruals
Capital Accruals	(1.5)	(3.6)	2.1	Capital accruals have reduced due cash funding received from DH and more accurate information being provided.
Deferred Income	(13.7)	(26.5)	12.8	Unlike previous months only the March-10 contract invoice for Greenwich has been raised in advance. Resulting in a decrease ir deferred income
	(34.9)	**(46.8)**	**11.9**	
Borrowings	(5.1)	(5.1)	0.0	
Legal Provisions	(2.9)	(2.9)	0.0	
Payment Received in Advance	(5.0)	0.0	(5.0)	Advance payment from NHSL which will be repaid in March-11
Tax & Social Security	(6.4)	(6.5)	0.1	
	(88.4)	(89.6)	1.2	

13 week cashflow forecast starting 14 March 2011

Week commencing	07-Mar	07-Mar	14-Mar	21-Mar	28-Mar	04-Apr	11-Apr	18-Apr	25-Apr	02-May	09-May	16-May	23-May	30-May	06-Jun
	Forecast	*Actual*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*
Cash receipts															
BBG	-	7,577	13,411	-	-	-	25,696	-	-	-	25,696	-	-	-	-
Other	288	2,539	3,667	324	424	324	5,902	369	469	369	5,226	369	469	369	2,167
Total cash receipts	***288***	***10,115***	***17,078***	***324***	***424***	***324***	***31,597***	***369***	***469***	***369***	***30,922***	***369***	***469***	***369***	***2,167***
Payments															
Pay and pay related	350	377	9,858	12,649	350	350	9,858	12,649	350	350	350	9,858	12,649	350	350
Non-pay	3,047	2,314	4,843	4,982	-	-	4,579	2,149	2,779	2,082	3,482	3,512	2,282	2,480	2,228
PFI	1,053	1,054	-	-	6,994	405	-	-	6,994	405	-	-	2,835	4,159	405
Total payments	***4,450***	***3,745***	***14,701***	***17,630***	***7,344***	***755***	***14,437***	***14,798***	***10,123***	***2,837***	***3,832***	***13,369***	***17,765***	***6,989***	***2,983***
Net operating cash inflow / (outflow)	**(4,162)**	**6,370**	**2,378**	**(17,306)**	**(6,919)**	**(431)**	**17,161**	**(14,429)**	**(9,654)**	**(2,468)**	**27,090**	**(13,000)**	**(17,296)**	**(6,620)**	**(816)**
Cash support / dividends	8,000	8,058	(4,258)	7,200	(5,000)	-	-	-	-	-	-	-	-	-	-
Cash Balance	**19,224**	**29,814**	**27,934**	**17,828**	**5,908**	**5,477**	**22,637**	**8,208**	**(1,445)**	**(3,913)**	**23,177**	**10,177**	**(7,118)**	**(13,738)**	**(14,554)**



Key variances / assumptions

Creditor payments have been increased w/c 21 Mar and reduced 28 Mar to meet the Trust's target cash balance.

Capital spend was cumulatively £951k less than forecast and future weeks have been adjusted accordingly.

Receipts of £9.5m were received ahead of the expected date.

The above cash forecast assumes cash support during March of :-

£8m permanent PDC for capital cash support

£7.2m PDC to support the Trust's trading position

a further £5m cash from the Challenge Trust Board (assumed repayable w/c 28 Mar)

The Trust is working to a year-end cash balance of £4,876k to meet its EFL. PFI payments will be brought forward or NHS creditors paid as necessary.

The assumption for income for 2011/12 is based on receipts in Jan 2011 until contracts have been confirmed.

Agenda

- Executive Summary
- Month 11 Financial Summary
- Discussion Topics

South London Healthcare

Puplic Board

Financial Highlights – FY 2011

March 2011

Significant Progress Has Been Made in FY 2011

	2010 actual £m	movement £m	2011 forecast £m
TOTAL INCOME	459.4	(28.0)	431.4
Pay	(306.4)	14.4	(292.0)
Non Pay	(153.9)	13.2	(140.7)
	(460.3)	27.6	(432.7)
EBITDA	(0.9)	(0.4)	(1.3)
% of income	*-0.2%*	*1.4%*	*-0.3%*
Depreciation	(16.5)	1.3	(15.2)
Finance Charges	(30.5)	1.8	(28.7)
	(46.9)	3.1	(43.8)
Net Loss	**(47.8)**	**2.7**	**(45.1)**
% of income	*-10.4%*		*-10.5%*

Note: the figures above exclude income and costs associated with community paediatrics (net impact of £0) which was transferred from Bexley Care Trust in the course of FY11

Opservations

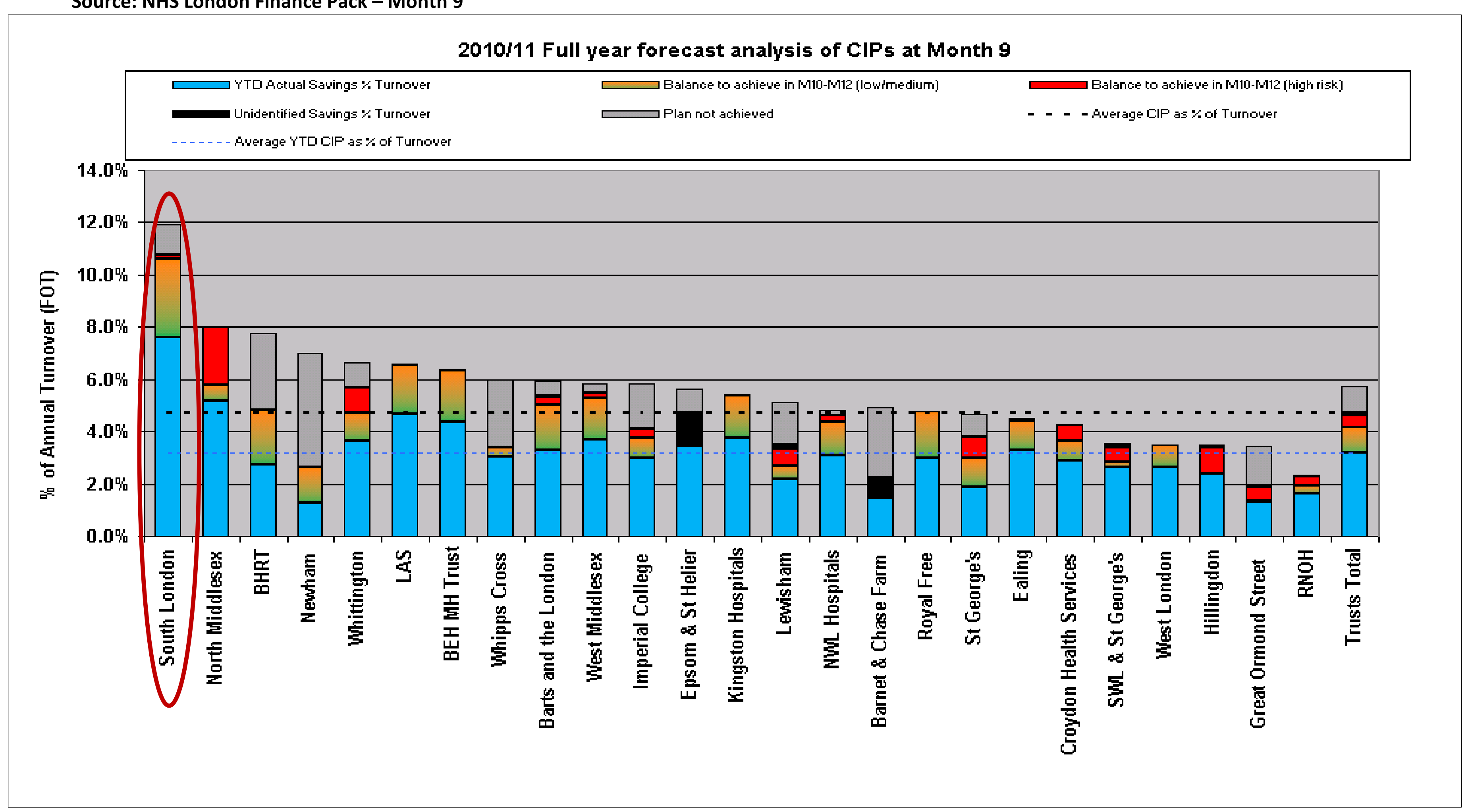
- At month 11, SLHT is forecasting a loss of £45.1m. While SLHT has delivered in excess of £40m of savings to the health economy, income is significantly lower than the prior year (and was adjusted down by £4m for the 2nd half year following the arbitration settlement).
- Key elements of the result:
- **Income (net reduction of £28m)**
  1. The original plan included a reduction of £21m in income from the prior year. The actual reduction was £25m, with the blocked value set for the year for BBG.
  2. This reduction is greater if tariff inflation is taken into account.
- **Operating Costs (net reduction of £27.6m)**
  1. Costs have been significantly reduced in the year, driven by tight tactical controls over headcount (substantive and temporary), tighter controls over non pay and a CTB funding of costs of £5m;
  2. After allowing for inflation and service developments, SLHT has delivered c. £40m of genuine savings to the health economy

- **The result:** despite an absolute reduction in income of £28m the inability to implement APOH on 1st October 2010, and a level of blocked income significantly below delivered activity, SLHT is forecasting a reduction in the deficit from the prior year. This is one of the most significant reductions in cost base (particularly in light of the fixed estate).

(ii) The Starting Point FY11 – Achievement

SLHT has significantly outperformed all other NHS London Trusts in terms of cost reduction in FY11.

Source: NHS London Finance Pack – Month 9



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TRUST BOARD 23rd March 2011

Title: Operational Capability Statement Constituting part of the DH Research Support Services Initiative

For	Decision	~~Discussion~~	~~Information~~	(delete as applicable)

Report introduced by: Stephen Kegg, Clinical Director for Research and Development

Report authors: Stephen Kegg

Purpose of report: The purpose of this report is to provide the Board with information about the initial phase of the Research Support Service initiative from DH. All Trusts are requested to make publically available a Research and Development Operational Capability statement (RDOC) which provides information on the infrastructure and resources available at SLHT for research.

Board Recommendation/Board action required:

- To consider the RDOC and decide if the Trust is appropriately represented in the document prior to it being made publically available.

Trust Objective: To be research active

CQC Registration
Does this item support a CQC outcome? Yes

Are there legal implications arising from this item? No

Key Risks to the Trust: Non Compliance with DH policy

Is an Equality Impact Assessment required? Yes

1.0 Introduction

In September 2010, the Department of Health launched the Research Support Services (RSS) initiative. The aim of this initiative is to support pragmatic and proportional review of research projects and for organisations to be able to give prospective research partners an overview of the research facilities available at their sites.

1.1 **Component parts of RSS**

The RSS initiative is comprised of four discrete sections:

- An Operational capability statement (presented in this paper)
- Project review templates – to enable proportional research governance review
- Standard operating procedures – ensuring the full range of SOPs are in place
- Competencies for R&D staff – to be used for recruitment and identifying training needs

2.0 Operational Capability Statement

The Operational capability statement will become mandatory for all research active organisations in 2011. It is designed to be a publically available document which states the research facilities an organisation has available and the type of research it has a particular interest in undertaking. The aim is to enable potential research partners to decide if an organisation has the facilities and expertise required to support their research i.e. Particular types of scanner/equipment/research facilities.

2.1 The Operational capability statement will be a live document and will be kept up to date by the staff of the R&D Office. The status of the document will depend upon all departments being aware of the importance of informing R&D of any changes to staff, equipment and resource availability.

2.2 A completed capability statement for South London Healthcare Trust is included at Appendix 1.

3.0 Equality Impact Assessment

The recommendations that follow have been subject to a preliminary screening assessment for their relevance to the Trust's duties *as set out in the Single Equality Scheme adopted by the Board.* No adverse impact was identified.

The potential for any adverse impact to arise during the implementation of the recommendations will be monitored and, if arising, will be addressed

There is a positive impact because by collating all information about the organisation's research facilities and capability we will be able to demonstrate to prospective research partners the full range of research we are able to undertake which may not previously have been publically available.

4.0 Recommendation

– The Trust Board is asked to agree the content of the Operational Capability Statement.

NIHR Guideline B01
R&D Operational Capability Statement

Version History

Version number	Valid from	Valid to	Date approved	Approved by	Updated by
RDOCS 001	01/01/2001	31/01/2001	01/12/2000	xxx	rrr
RDOCS 002	01/01/2002	31/01/2002	01/12/2001	yyy	rrr

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Organisation R&D Management Arrangements
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Organisation Services
Organisation R&D Interests
Organisation R&D Planning and Investments
Organisation R&D Standard Operating Procedures Register
Planned and Actual Studies Register
Other Information

Organisation R&D Management Arrangements

Information on key contacts

Organisation Details	
Name of Organisation	South London Healthcare NHS Trust
R&D Lead / Director (with responsibility for reporting on R&D to the Organisation Board)	Dr Stephen Kegg, Clinical Director for Research & Development
Key Contact Details e.g. Research Governance Lead, NHS Permissions Signatory contact details	
Contact 1:	
Role:	Research & Development Facilitator
Name:	Sharan Sandhu
Contact Number:	0208 836 5911
Contact Email:	sharansandhu@nhs.net
Contact 2:	
Role:	Research & Development Facilitator
Name:	Karen Wilson
Contact Number:	0208 302 2678 x4449
Contact Email:	karenj.wilson@nhs.net

Add further lines as required

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Information on staffing of the R&D Office

R&D Team		
R&D Office Roles (e.g. Governance, Contracts, etc)	Whole Time Equivalent	Commments indicate if part time/full time/shared/joint etc
R&D Facilitator	**1**	**Full-time. Role deals with all RM&G issues**
R&D Facilitator	**0.8**	**Part-time. Role deals with all RM&G issues**
R&D Administrator	**1.5**	**Temporary posts providing office admin and database support**

Add further lines as required

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Information on reporting structure in organisation (include information on any relevant committees, for example, a Clinical Research Board / Research Committee / Steering Committee.)

Reporting Structures
The R&D Department reports to the Trust Governance Committee, which in turn reports to the Trust Board. The R&D Committee is a multidisciplinary group which reviews and approves studies as part of the overall Trust R&D governance approval process.

Add further lines as required

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Information on Research Networks supporting/working with the Organisation.
Information on how the Organisation works with the Comprehensive Local Research Network (CLRN), Primary Care Research Network (PCRN), Topic Specific Clinical Research Networks (TCRN)

Research Networks	
Research Network (name/location)	Role/relationship of the Research Network eg host Organisation
South East London Cancer Research Network	SLHT hosts SELCRN studies, SELCRN provides research nurses and clinical trial officers across 3 sites to support recruitment to studies
South East Stroke Research Network	SLHT is starting to host SESRN studies, SESRN provides a clinical trial officer to support recruitment to studies
London South CLRN	SLHT is a member of the London South CLRN and works with them to improve recruitment to NIHR adopted studies

Add further lines as required

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Information on collaborations and partnerships for research activity (e.g. BRC, BRU, Other NHS Organisations, Higher Education Institutes, Industry)

Current Collaborations / Partnerships				
Organisation Name	Details of Collaboration / Partnership (eg University/Organisation Joint Office, external provider of pathology services to Organisation, etc, effective dates)	Contact Name	Email address	Contact Number
University of Greenwich	Joint Research for Patient Benefit grant bid for	Professor Elizabeth West	lizwestbarron@gmail.com	
Royal Brompton Hospital Trust	COPD Clinical/research facility collaboration	Professor Michael Polkey	m.polkey@rbht.nhs.uk	

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Organisation Study Capabilities

Information on the types of studies that can be supported by the Organisation to the relevant regulatory standards

Types of Studies Organisation has capabilities in (please tick applicable)							
	CTIMPs (indicate Phases)	Clinical Trial of a Medical Device	Other Clinical Studies	Human Tissue: Tissue Samples Studies	Study Administering Questionnaires	Qualitative Study	OTHER
As Sponsoring Organisation			√		√	√	
As Participating Organisation	√	√	√	√	√	√	
As Participant Identification Centre	√	√	√	√	√	√	

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Which licences does the organisation hold which may be relevant to research?

Organisation Licences			
Licence Name Example: Human Tissue Authority Licence	Licence Details	Licence Start Date (if applicable)	Licence End Date (if applicable)
Human Tissue Authority Licence	To provide body storage and post mortems	tbc	tbc

Add further lines as required

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PCT ONLY: Information on the practices which are able to conduct research

Number/notes on General Practitioner (GP) Practices

Add further lines as required

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Organisation Services

Information on key clinical services contacts and facilities/equipment which may be used in studies for suporting R&D governance decisions across the organisation.

Clinical Service Departments					
Service Department	Specialist facilities that may be provided (eg number/type of scanners)	Contact Name within Service Department	Contact email	Contact number	Details of any internal agreement templates
Pathology	*Standard pathology facilities*	*Dave Barnett*	dave.barnett@nhs.net	*07795 506146*	
Radiology	*3 CT Scanners - one on each main site; SPECT/CT Nuc Med Gamma Camera- Pru site; Gamma Camera QEW site; MRI Scanners PRU & QEW; Multiple US scanners - multiple sites; Fluoroscopy and X-ray - all sites; DXA scanner (Bone Densitometry) QEW; mammography QEW & PRU*	*Nigel Andrews, Radiology General Manager*	nigel.andrews@nhs.net	*020 8836 4783*	
		Mark Judge Radiology Governance Manager	mark.judge@nhs.net	*020 8836 4783*	
Pharmacy	*Aseptic preparatory units. Specialist Pharmacists - ITU, Cardiology, HIV & Infectious Diseases*	*Namrita Sen*	namrita.sen@nhs.net	*020 8836 4934*	

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Information on key management contacts for suporting R&D governance decisions across the organisation.

Management Support e.g. Finance, Legal Services, Archiving					
Department	Specialist services that may be provided	Contact Name within Service Department	Contact email	Contact number	Details of any internal agreement templates
Archiving	*Currently no external archiving facility*				
Data management support	*Information Governance guidance and approval*	*Louis Lau*	louislau@nhs.net	*020 8836 6825*	
Finance	*Costing & Signing off Feasibility Forms*	*Julie Kennedy*	julie.kennedy@nhs.net		
Information Technology		*Dil Bhadare*	dil.bhardare@nhs.net		
Legal	*Contract review*	*David Heap*	david.heap@nhs.net		
Personnel	*Honorary Contracts/Letters of Access*	*Sharan Sandhu*	sharansandhu@nhs.net	*020 8836 5911*	
Statistical support	*Off site at Greenwich University*	*Dr Swattee Patel*	S.P.Patel@gre.ac.uk	*020 8331 8000*	

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Organisation R&D Interests

Information on the areas of research interest to the Organisation

Organisation R&D Areas of Interest				
Area of Interest	Details	Contact Name	Contact Email	Contact Number
Cancer	Clinical Director for Cancer	Mr Kislaya Thakur	kislaya.thakur@nhs.net	
Dermatology	Consultant Dermatologist	Dr Stephanie Munn	stephanie.munn@nhs.ne	
Haematology	Consultant Haematologist	Dr Anil Lakhani	anil.lakhani@nhs.net	
Infectious Diseases (HIV)	Consultant Physician	Dr Stephen Kegg	stephen.kegg@nhs.net	
Ophthalmology	Consultant Ophthalmologist	Dr Saurabh Goyal	saurabhgoyal@nhs.net	
Rheumatology	Consultant Rheumatologist	Dr Louise Dolan	louise.dolan@nhs.net	
Stroke	Consultant Neurologist	Dr Barlomeij Piechowski-Jozwiak	b.piechowski-jozwiak@nhs.net	

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Information on Local / National Specialty group membership within the Organisation which has been shared with the CLRN

Specialty Group Membership (Local and National)					
National / Local	Specialty Group	Specialty Area (if only specific areas within group)	Contact Name	Contact Email	Contact Number
Local	Dermatology		*Dr Anna Chapman*	anna.chapman3@nhs.net	
Local	Infectious Diseases		*Dr Stephen Kegg*	stephen.kegg@nhs.net	
Local	Ophthalmology		*Dr Saurabh Goyal*	saurabh.goyal@nhs.net	
Local	Neurosciences		*Dr Jennifer Quirk*	jennifer.quirk@nhs.net	
Local	Paediatrics		*Dr Jacob Eyers*	jacob.eyers@nhs.net	
Local	Respiratory		*Dr Charles Shee*	cshee@nhs.net	

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Organisation R&D Planning and Investments

Planned Investment			
Area of Investment (e.g. Facilities, Training, Recruitment, Equipment etc.)	Description of Planned Investment	Value of Investment	Indicative dates
Training	Good Clinical Practice training sessions for research active staff	£2,280	13/1/2011 & 7/10/2011
Staff Resources	Supporting Pharmacy posts where research forms significant portion of workload	tbc	tbc
Recruitment	Joint Research Nurse mentor post with UHL	tbc	tbc

Add further lines as required

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Organisation R&D Standard Operating Procedures Register

Standard Operating Procedures				
SOP Ref Number	SOP Title	SOP Details	Valid from	Valid to
We are currently working on the production of SLHT R&D SOPs				

Add further lines as required

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Information on the processes used for managing Research Passports

Indicate what processes are used for managing Research Passports
SLHT uses the NIHR Human Resources Good Practice Resource Pack to manage Research Passpoprts. SLHT HR have delegated authority for the R&D Department to issue research Honarary Contracts or Letters of Access as necessary

Add further lines as required

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Information on the agreed Escalation Process to be used when R&D governance issues cannot be resolved through normal processes

Escalation Process
The Clinical Director for Research & Development personally reports directly to the Medical Director and the R&D Department reports to the Trust Governance Committee. Any issues requiring escalation will be done so via these two routes.

Add further lines as required

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Planned and Actual Studies Register

The Organisation should maintain or have access to a current list of planned and actual studies which its staff lead or collaborate in.

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Other Information

For example, where can information be found about the publications and other outcomes of research which key staff led or callaborated in?

Other Information (relevant to the capability of the Organisation)
R&D & Library & Knowledge Services (LKS) are working collaboratively on the compilation of a database of publications authored by SLHT staff.

Add further lines as required

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Supporting all NHS Trusts to achieve NHS Foundation Trust status by April 2014

Tripartite Formal Agreement between:

- South London Healthcare NHS Trust
- NHS London
- Department of Health

Date: 2 March 2011

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Introduction

This tripartite formal agreement (TFA) confirms the commitments being made by the NHS Trust, their Strategic Health Authority (SHA) and the Department of Health (DH) that will enable achievement of NHS Foundation Trust (FT) status before April 2014.

Specifically the TFA confirms the date (Part 1 of the agreement) when the NHS Trust will submit their "FT ready" application to DH to begin their formal assessment towards achievement of FT status.

The organisations signing up to this agreement are confirming their commitment to the actions required by signing in part 2a. The signatories for each organisation are as follows:

NHS Trust – Chief Executive Officer
SHA – Chief Executive Officer
DH – Ian Dalton, Managing Director of Provider Development, DH

In addition the lead commissioner for the Trust will also sign the agreement to ensure commissioner support exists for the actions that need to be undertaken locally as well as agreeing to resolve any commissioner issues.

The information provided in this agreement does not replace the SHA assurance processes that underpin the development of FT applicants. The agreed actions of all SHAs will be taken over by the Provider Development Authority (PDA) when that takes over the SHA provider development functions.

The objective of the TFA is to identify the key strategic and operational issues facing each NHS Trust (Part 4) and the actions required at local, regional and national level to address these (Parts 5, 6 and 7).

Part 8 of the agreement covers the key milestones that will need to be achieved to enable the FT application to be submitted to the date set out in part 1 of the agreement.

Standards required to achieve FT status

The establishment of a TFA for each NHS Trust does not change, or reduce in anyway, the requirements needed to achieve FT status.

That is, the same exacting standards around quality of services, governance and finance will continue to need to be met, at all stages of the process, to achieve FT status. The purpose of the TFA for each NHS Trust is to provide clarity and focus on the issues to be addressed to meet the standards required to achieve FT status.

Alongside development activities being undertaken to take forward each NHS Trust to FT status by April 2014, it is paramount that high quality services are maintained. To remove any focus from quality healthcare provision in this interim period would completely undermine the wider objectives of all NHS Trusts achieving FT status, to establish autonomous and sustainable providers best equipped and enabled to provide the best quality services for patients.

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Part 1a - Date when NHS foundation trust application will be submitted to Department of Health

1 April 2013

Part 1b – FT pipeline categorisation of NHS Trust

Mark one of the below categories only

Category	Category description	Mark X in one category only
1	NHS Trust with no quality/financial/performance issues that should be preventing them becoming FTs	
2	NHS Trust with quality/financial/performance issues requiring external support to make ready for applying for FT-status	
3	NHS Trust with major financial issues e.g. PFI/legacy debt currently making difficult to achieve FT-status in near future	X
4	NHS Trust where not clinically/financially viable in current organisation form	
5	Potential Community FTs	

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Part 2a - Signatories to agreements

By signing this agreement the following signatories are formally confirming:

- their agreement with the issues identified;
- their agreement with the actions and milestones detailed to support achievement of the date identified in part 1;
- their agreement with the obligations they, and the other signatories, are committing to;

as covered in this agreement.

Chris Streather, Chief Executive, South London Healthcare NHS Trust	Signature

Ruth Carnall, CBE Chief Executive, NHS London	Signature

Ian Dalton Managing Director of Provider Development, Department of health	Signature

Part 2b – Commissioner agreement

In signing, the lead commissioner is committing to support the process and the actions of the local organisations as well as resolving any local commissioning issues pertinent to the FT application.

Simon Robbins, Chief Executive, NHS South East London Sector	Signature

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Part 3 – NHS Trust summary

Short summary of services provided, geographical/demographical information, main commissioners and organisation history (No more than half a page of A4)
South London Healthcare NHS Trust (SLHT) comprises 3 district general hospitals Queen Mary's, Sidcup, Queen Elizabeth, Woolwich and Princess Royal University Hospital in Bromley, with additional, mostly outpatient services, being provided from other locations including Orpington Hospital, Beckenham Beacon and Erith Hospital. SLHT serves a population of approximately 1 million people providing a range of secondary care services across the emergency and elective pathways. The Trust currently provides 24-hour A&E services from both the QE and PRUH sites. In 2009 SLHT was formed by the merger of 3 Trusts – Queen Mary's Hospital NHS Trust, Queen Elizabeth Hospital NHS Trust and Bromley Hospitals NHS Trust. Each of these legacy Trusts had a history of weak financial and operational performance. Since the merger, the combined Trust, has experienced continued financial and service operational pressure. In 2010/11 SLHT forecasts a reduction in costs by £43m or 12%. This proportion is higher if PFI fixed costs are excluded. In FY 2010, SLHT reported a significant net deficit (£43m prior to impairments and IFRS adjustments). Without drastic remedial action the comparable net deficit would have risen a c. £88m in FY 2010/11, driven by a £20m "net" reduction in clinical income from commissioners and cost increases. From a performance perspective, the Trust has seen: • An improvement in HSMR with Dr Foster's reporting that up to Nov 2010 the 12 month average was 93.5, compared to a legacy figure over 100, with the monthly score being much lower than this, 73.6. • SLHT has seen an exceptional year with regards to MRSA with a single case being reported from April 2010 to date, and C. *difficile* being 30% lower than the national target. However, SLHT has not consistently delivered the 18 week target. Focus and interventions are being put in place to resolve these issues, and it is expected that the Trust's 18 week performance will be on plan by the end of Q2 2011/12. The Trust's main commissioners are NHS Greenwich, Bexley NHS Care Trust and Bromley Primary Care Trust. In addition to the merger the Trust has delivered significant service reconfiguration with the near complete implementation of elements of the "A Picture of Health" clinical strategy. This has included the closure of A&E, Maternity and Inpatient Paediatrics on one of our sites.

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Part 4 – Key issues to be addressed by NHS trust

Key issues affecting NHS Trust achieving FT	
Strategic and local health economy issues	
Service reconfigurations	☒
Site reconfigurations and closures	☒
Integration of community services	☐
Not clinically or financially viable in current form	☐
Local health economy sustainability issues	☐
Contracting arrangements	☒
Financial	
Current financial Position	☒
Level of efficiencies / QIPP	☒
PFI plans and affordability	☐
Other Capital Plans and Estate issues	☐
Loan Debt	☐
Working Capital and Liquidity	☐
Quality and Performance	
Quality and clinical governance issues	☐
Service performance issues	☒
Governance and Leadership	
Board capacity and capability, and non-executive support	☒

Please provide any further relevant local information in relation to the key issues to be addressed by the NHS Trust:

Service reconfigurations and site reconfigurations and closures

Work is on-going to see the completion of the A Picture of Health programme, which included a substantial out of hospital component, including proposals for the development of the QMS/Bexley Campus being advanced with the GP commissioners and the local authority.

It is acknowledged that as services evolve existing models of provision will change, with effective demand management and the commissioning of services outside of hospitals.

Contracting Arrangements

2010/11 saw contracting issues with SLHT's main commissioners which resulted with a block contract arrangement being put in place that had a negative position on SLHT's financial position. The "underpayment" resulting from the block arrangement in 2010/11 is estimated at £14m. Following a significant amount of work in 2010/11 on reporting of income and reconciliation processes, a return to PBR will be seen in 2011/12

Finance

SLHT delivered £43 m cost savings in 2010/11 whilst also seeing an improvement in service quality.

SLHT are forecasting an improved position for 2011/12, and needs to deliver further significant efficiencies for the year to come.

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SLHT is due to enter phase 2 of the London Challenged Trust Board process .

Quality and Performance

Whilst SLHT is on course to deliver the A&E access target, there have been acknowledged issues in the delivery of the 18 week referral to treatment target. (see below)

Governance and Leadership

SLHT has been formed from the merger of 3 former Trust's. Whilst there are signs of a new organisational culture developing in parts of the organisation, the integration of people and the development of a single organisational culture are still areas where further development needs to be undertaken to support the Foundation Trust. To support this work a values development process, encouraging participation from throughout the Trust, has been undertaken.

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Part 5 – NHS Trust actions required

Key actions to be taken by NHS Trust to support delivery of date in part 1 of agreement	
Strategic and local health economy issues	
Integration of community services	☐
Financial	
Current financial position	☒
Local / regional QIPP	☒
Other capital and estate Plans	☐
Quality and Performance	
Service Performance	☒
Quality and clinical governance	☐
Governance and Leadership	
Board Development	☒
Other key actions to be taken (please provide detail below)	☐

Please provide any further relevant local information in relation to the key actions to be taken by the NHS Trust with an identified lead and delivery dates:

Financial

SLHT have developed plans which will deliver further operational savings. These include reduction in the duplication of services, further consolidation of services offered on the Sidcup site, estate rationalisation and the development of the Bexley Health Campus in conjunction with the commissioners and local authority. There is also significant additional work planned on clinical productivity after the initial progress made in FY2011.

Options for the strategic development of the organisation are currently being developed, to be considered by SLHT's Board, which will deliver significant savings

Quality and Performance

2010/11saw improvements in the quality of service with HSMR showing considerable improvement (with the 12 month reported average in November being 93.5 in comparison to Apr09-Mar 10 being reported at 109)and HCAI being much better than trajectory. A&E performance is scheduled to meet the target. In part we have been able to achieve this by using a programme management approach to focus attention and resources to delivering the desired standards. The achievement of the referral to treatment target remains an issue to which this approach has been applied and plans are in place, and it is expected that the Trusts 18 week performance will be on plan by the end of Q2 2011/12 (Jennie Hall, Acting Chief Operating Officer)

Board Development

Phase 1 of SLHT's Board development programme has been commissioned from Health Skills and this will help support the Board to become ever more effective in discharging their role (Louise McKenzie, Director of Human Resources)

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Part 6 – SHA actions required

Key actions to be taken by SHA to support delivery of date in part 1 of agreement	
Strategic and local health economy issues Local health economy sustainability issues (including reconfigurations)	☐
Contracting arrangements	☐
Transforming Community Services	☐
Financial Regional and local QIPP	☐
Quality and Performance Quality and clinical governance	☐
Service Performance	☐
Governance and Leadership Board development activities	☒
Other key actions to be taken (please provide detail below)	☐

Please provide any further relevant local information in relation to the key actions to be taken by the SHA with an identified lead delivery dates:

Board Development Activity

The People, and Organisational Development Department at NHS London have been assisting with funding for SLHT's Board Development programme.

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Part 7 – DH actions required

Key actions to be taken by DH to support delivery of date in part 1 of agreement	
Strategic and local health economy issues Alternative organisational form options	☐
Financial NHS Trusts with debt	☐
Short/medium tem liquidity issues	☐
Current/future PFI schemes	☐
National QIPP workstreams	☐
Quality and Performance -	
Governance and Leadership Board development activities	☐
Other key actions to be taken (please provide detail below	☐
Please provide any further relevant local information in relation to the key actions to be taken by DH with an identified lead and delivery dates:	

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Part 8 – Key milestones towards achievement of date agreed in part 1

Date	Milestone
April 2011	Commence Phase 2 CTB Process
June 2012	First draft IBP and LTFM
June/July 2012	Historical Due Diligence part one
June 2012	Consultation begins
Oct 2012	Historical Due Diligence part two
December 2012	Final IBP and LTFM
Jan/Feb 2013	Board to Board
The Programme Management Office (PMO) will run the SLHT FT application to ensure that key milestones do not slip and where there are issues these are detected early and appropriately managed. The Chief Executive and Chairman .will monitor progress and will undertake a review if any slippage is incurred.	

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Key Milestones will be reviewed every quarter, so ideally milestones may be timed to quarter ends, but not if that is going to cause new problems. The milestones agreed in the above table will be monitored by senior DH and SHA leaders until the PDA takes over formal responsibility for this delivery. Progress against the milestones agreed will be monitored and managed at least quarterly, and more frequent where necessary as determined by the SHA (or PDA subsequently). Where milestones are not achieved, or for some reason the date agreed in part 1a is at risk, the SHA (PDA) and DH will reserve the right to change the categorisation in part 1b and the agreed plans underpinning this.

Part 9 – Key risks to delivery

In SLHT's November return the three key risks highlighted were around financial balance, the implementation of APOH and organisational culture and these have now been refined into three categories a) Finance b) Strategic Change and c) Organisational Culture

SLHT has a well developed risk management register, alongside of which the FT programme risks need to be considered.

	Risk	Mitigation including named lead
A) Finance	A1) The successful delivery of the financial model	The delivery of the required cost reductions will be achieved through a number of different approaches. The implementations of the clinical service redesign programme, organisational efficiencies and rationalisations.

		However, work has been undertaken to identify the options available. to deliver significant cost reductions to underpin long term financial performance and which will need to be approved by the Board. This work will focus on productivity, right sizing capacity and estate rationalisation (Director of Finance).
	A2) Ability to deliver service reconfiguration without delay	The LTFM will be based on a schedule of service changes. This will be mitigated by building strong relationships with engaged key stakeholders and having clear communication channels (Chris Streather, Chief Executive)
	A3) Phase 2 approval from the London Challenged Trust Board	In order to mitigate the risk to a successful outcome and delays in the process the focus will be on developing a comprehensive quality submission that is fit for purpose, which will detail the necessary reconfiguration highlighted in section B, below. (Chris Streather, Chief Executive)
B) Strategic Change	B1) Remaining in Category 3	SLHT have commissioned work to look at service models and the resultant requirement for estate that will be required for SLHT to meet the challenges faced. This work is nearing its conclusion, showing a viable future for SLHT. Significant productivity changes are required to be achieved against national benchmarks, rationalisation of estate, and a parallel continued improvement in quality. In light of this strategic outline SLHT will develop a case with business discipline over the next six months. (Chris Streather, Chief Executive)
	B2) Out of Hospital Capacity and Demand Management	Estate rationalisation, reducing capacity, is dependent on reductions in demand for services, and out of hospital provision, in line with regional and national policy. (Chris Streather, Chief Executive)

Confidential - Draft for Review

	B3) GP Commissioning decision on the future of the Bexley Campus	GP commissioners and local authorities are about to complete a review to determine the future of the Bexley Campus. The Board and stakeholders will need to reflect on the results of this and amend the LTFM as appropriate. (Chris Streather, Chief Executive)
C) Organisational Culture	Organisation Culture Development	Organisational culture was highlighted as a key risk in SLHT's autumn letter, detailed plans have been developed, including some referred to earlier. However SLHT does not underestimate the size or importance of this work. (Chris Streather, Chief Executive)

Confidential - Draft for Review

Minutes of the South London Healthcare NHS Trust Governance Committee held on Monday 13th September 2010, at 9.00 Boardroom, Princess Royal University Hospital

Present:

Mr John Ballard	Non Executive Director (Chaired the meeting until Ms Hart arrived)
Mr Roger Smith	Medical Director
Ms Louise McKenzie	Director of HR

In attendance:

Ms Tracey Cooper	Director of Infection Prevention and Control
Mr Dominic Ford	Assistant Director of Governance
Mr Michael Weaver	Trust Board Secretary
Ms Sarah Carroll	Administrator to AD of Governance
Mr Stephen Orpin	Director of Financial Operations
Mr Kevin Platt	Emergency Planning Liaison Officer
Ms Avey Bhatia	Deputy Director of Nursing
Ms Nicky Barker-King	Divisional Director of Nursing ECSM

GC63/10 TO RECEIVE APOLOGIES FOR ABSENCE

Ms Gill Hart sent her apologies that she had been unavoidably detained and would be attending the meeting late. Ms. Simpson, Ms Knight

GC64/10 MINUTES OF THE MEETING HELD ON 12 JULY 2010

The minutes were approved as a correct record.

GC65/10 MATTERS ARISING

Norovirus review panel report

Ms Tracey Cooper Confirmed that the action plan was progressing well. Paper to be brought to next meeting. Draft document to be circulated to the Committee.

ACTION: Document to be circulated and brought to the next meeting

Governance Committee format

This matter was discussed when Ms Hart arrived at the meeting.

Ms Hart and the Committee discussed the timing of the meetings and it was agreed that the meetings would remain bi-monthly, unless the need arose for them to be more frequent.

Discussions took place around a work plan for the Committee in order that due time and consideration was given to the business of the Committee.

ACTION: Mr Ford to devise work plan for future meetings

GC66/10 DIVISONAL CLINICAL GOVENANCE REPORT

Ms Barker-King introduced the Divisional Clinical Governance report for the Division of Emergency Care and Specialist Medicine. This was the first report for the first quarter under the new structure:

The key risks from Quarter 1:

- Pressure Ulcer Care
- Falls
- Risks within the A&E department (addressed by departmental risk register
- Patient Experience
- Backlog of SUI's and lack of information regarding incidents

Ms Barker-King gave an overview of the following topics

- Serious Untoward Incidents
- Hospital Standardised Mortality Ratio (HSMR)
- Adverse Incidents
- Pressure Ulcers
- There was discussion around pressure ulcers. Ms Bhatia confirmed that there was much work going on around this. Regular meetings take place across SLHT and a report would be going to the EMT regarding this. Ms Bhathia had reviewed data from both Imperial and St Georges in order to benchmark. This work continues to remain high profile and a major aim is to detect pressure ulcers at an early state and to ensure that all staff are aware of their responsibilities
- Risk Register
  It was agreed that this is a fluid document and at the time of the meeting was not up-to-date. Changes had been made some of the risks which were not apparent in the document Mr Ballard commented on the need for there to be a risk owner for each item
- Infection Control
  Mr Smith confirmed and appreciated the good results obtained
- Litigation - Legal Claims Coroner's Inquests
- Patient Experience - Complaints/Ombudsman Enquiries
  Backlogs from legacy sites, delays due to change in personnel. Some complaints very complex. Improvements to process ongoing and should see improvement in the next quarter.

A number of these topics were discussed under other agenda items and the key priorities for quarter 2 are:

- Managing the risk within A&E
- Clinical Engagement
- Raising the profile of patient safety within the clinical areas

- Learning from incidents

Mr Ford confirmed that each division presented their report once a quarter and that quarter 2 reports would soon be available and presented at future meetings.

ACTION: **Ms Barker-King to circulate the quarter 2 report to the Committee when finalised**

GC67/10 SUSTAINABILITY OF SERVICES – SAFETY

Mr Smith confirmed a paper had been written for the Executive Management Team 2 weeks prior and a further version would be going to the EMT the following day. EMT to consider the paper and decide what recommendations to make to the board. Next board meeting 29th September 2010.

Mr Smith and Ms Hall had written to NHS London with concerns about risks in maternity and emergency services and their sustainability during the winter months. Following this NHS London have carried out an external assessment visiting all sites and their report is awaited.

Divisions have formally risk assessed their services for safety and sustainability. ITU and A&E appear to be sustainable although they are a small and fragile department. there is good leadership and effective processes in place. They have both been rated as amber. The acute medical pathway has also caused concern as the Deanery have removed 8 Doctors, therefore this stands at amber (Locums have been recruited). The nursing profile in this area also stands at amber. The ability to staff the blood bank has been reviewed and recruitment has started and the expectation is that the post will be filled.

The safety at the midwifery unit at the QMS site has become an issue due to uncertainty and a substantial loss of midwifery staff. Using agency midwifes but key trigger point will be at the end of October with twelve trained midwifes leaving so the staffing profile is crucial. Ongoing recruitment drive but site will be lacking in trained staff to run the unit at QMS. If the unit shuts this will free up 10/11 midwifes this would need to be co-ordinated with the opening of the unit on the PRUH site. The Board will need to consider closing the labour ward due to lack of staff. This is currently at Red.

A&E QE site

Currently a 50% middle grade doctor vacancy rate, lack of senior clinical decision makers. Also as a high level of nursing vacancies within the department. Another consultant due to leave department. SUI profile for QE higher than the other sites. Variation in incident reporting on the 3 sites, but higher numbers of patient safety incidents at QE. Number of reported incidents may not be a true

indication. The A&E appears to be unsustainable due to risk to patients and staffing profile. Mr. Smith agreed to make a further update to the Committee.

GC68/10 CARE QUALITY COMMISSION REGISTRATION

The Trust has been registered with the Care Quality Commission from 1st April 2010, without conditions. The Trust declared non compliance for 3 standards all regulated activities at all locations: outcome 2 – consent to treatment; outcome 7 – safeguarding people who use services from abuse, an d outcome 14 – supporting workers; and for one stand at QMDS only: outcome 1 – respecting and involving people who use services

It was expected that the Trust would receive a visit from CQC any time from October 2010. Mr Ford confirmed that evidence had been gathered to support the Trust's compliance position and preparations had been made in anticipation of this visit. Mr Ballard confirmed that evidence and communication around this was a very important issue

GC69/10 WORKFORCE

Ms McKenzie outlined the key headlines of the Trust Single Equality Scheme. The document will provide a means of measuring and demonstrating the Trust's ongoing commitment to promoting equality through the setting of equality together with systematic monitoring and regular reviews. Sections of the report that were highlighted are:

- 3.0 Equality scheme Legislation
- 4.0 Purpose of the Equality Scheme
- 5.0 SHLT aims for equality and diversity
- 6.0 Equality impact assessments
- 7.0 The six equality dimensions
- 9.0 Arrangements for carrying out consultation
- 15.0 Training staff. The Committee briefly reviewed the Appendix's

The Committee confirmed that in order to communicate this effectively to all staff a single sheet summary should be available at the front of the document.

ACTION: Ms McKenzie to check and clarify under section 4 on Appendix 1 Action required the action required and lead/timescale for the last item in this section
On the attendance of Ms Hart, the policy was approved for submission to the Trust Board

GC70/10 NURSE STAFFING

Ms Bhatia presented this paper which followed on from the paper Ms Hall had presented at the previous meeting. Rationale for 20% headroom has taken into account;

- Staffing levels across the 3 sites

- Annual leave
- Bank holidays
- 3% for sickness
- Study leave

No allowance has been made for

- Maternity Leave
- Other leave (compassionate etc...)

To date it has been difficult to quantify the exact investment required to implement the principles of ward staffing across the Trust due to the final configuration of the wards subject to confirmation. The breakdown for the PRUH wards is due to be finalised by the end of September. Ms Bhatia will be meting with the Director of Finance to understand all the financial implications involved

GC71/10 POLICIES FOR APPROVAL

Whistle-blowing (for approval at Trust Board)

Ms McKenzie outlined the main of this policy which are is to enable the Trust to investigate and deal with issues raised in good faith by employees and to offer clear guidance to those employees about the way in which to raise and resolve these concerns in a responsible, legitimate and timely manner. Key points highlighted

- Robust Training
- Reduce the number of stages
- Increase the number of senior Staff involvement
- Flow chart Appendix 2 to help staff understand process

In the absence of Ms Hart the policy was reviewed and on her attendance agreed subject to the action below.

ACTION: Ms McKenzie to review list of Designated Directors on page 16.
Policy to be circulated

Business Continuity Policy

Mr Platt presented this paper and confirmed that the Business Continuity plan is separate from, but will operate alongside the Trust's Major Incident Plan, the basic framework being the same. The policy had been devised to bring together the 3 policies in existence from the legacy sites.

Ms Cooper noted that if the was a major outbreak as the policy stands there is no command and control.

Major points reviewed

- Training – by way of training Tracker Modules
- Additional training can be given if required
- Action to be escalated at the earliest point

ACTION: Policy agreed in principle, on the attendance of Miss Gill this was reviewed and agreed

Emergency Planning

Mr Platt gave a brief overview of this policy which sets out the arrangements by which SLHT will ensure an effective response to a Major Incident and will ensure that plans follow national and local guidance. The policy will ensure that specific staff roles and responsibilities are clearly defined throughout the planning cycle
Areas discussed

- Action plans and templates
- Exercise to be carried out with Directors
- Each site's switchboard able to contact other sites quickly

ACTION: On the attendance of Ms Hart this policy was agreed

Major Incident Plan

Mr Platt gave a brief overview of this policy which outlines the core Trust response to a Major Incident. It is a generic plan, which outlines systems and structures such as communication and command and control, which are vital to a coordinated response to a Major Incident. It should be read in conjunction with the Trust Major Incident Management policy. It is relevant to all staff. Areas of discussion:

- No direct phone number for Jonathan Pearce
- Action cards
- Each site's switchboard able to contact other sites quickly
- The order of the policy to be reviewed i.e. staff knowing who to contact being nearer the front of the policy as a large document
- Action plans reviewed and put on templates
- A4 sheet to give staff a quick precise of what to do
- Ask PFI partners for their plans
- Exercise to test this
- Training – include as part of induction
- Global email to highlight policy to all staff
- Cascade policy through divisions
- All staff to be aware

ACTION: KP to revise and policy agreed. KP to come to November meeting with action plan

GC72/10 INFORMATION GOVERNANCE TOOLKIT

Mr Ford presented in the absence of Ms Knight.

The committee reviewed the amended paper and concerns were raised regarding:

- Clarity required around resources required, were they additional or within existing establishment.
- Achievability of plan

It was agreed that any comments should be directed back to Ms Knight directly

GC73/10 BOARD ASSURANCE FRAMEWORK

Mr Ford introduced the latest iteration of the Board Assurance Framework which the Committee noted. The risks and mitigation plans had been substantially revised and considered by the EMT prior to Governance Committee.

GC74/10 INTERNAL CONTROL ISSUES

None

GC75/10 ITEMS FOR INFORMATION

GOVERNANCE SUB-COMMITTEES

Minutes received from the following sub-committees:-

- Clinical Governance Committee
- Information Governance Committee

GC76/0 ANY OTHER BUSINESS

None

GC77/10 DATE OF NEXT MEETING

Monday 8th November 2010, Board Room, PRUH, at 9.00

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Minutes of the South London Healthcare NHS Trust Governance Committee held on Monday 8th November 2010, at 9.00 Boardroom, Princess Royal University Hospital

Present:

Ms Gill Hart	Non Executive Director (Chair)
Mr John Ballard	Non Executive Director
Ms Louise McKenzie	Director of HR
Ms Jennie Hall	Director of Nursing, governance & Patient Experience
Mr Jonathan Pearce	Director of Estates & Facilities
Ms Lorraine Knight	Delivery Director/Interim Director of IT

In attendance:

Ms Tracey Cooper	Director of Infection Prevention and Control
Ms Fiona Allsop	Director of Nursing – Planned Care
Ms Angela Keating	Head of Patient Safety
Ms Sarah Carroll	Administrator to AD of Governance

GC63/10 TO RECEIVE APOLOGIES FOR ABSENCE

Mr Ford, Ms. Simpson, Mr Smith, Mr Weaver, Mr Bolot

GC79/10 MINUTES OF THE MEETING HELD ON 13 SEPTEMBER 2010

The minutes were approved as a correct record. Subject to the following 2 amendments:

1. Ms Hart, to be noted as present at the meeting
2. Under GC78/10 amend to Ms Hart

GC80/10 MATTERS ARISING FROM THE MINUTES

Governance Committee arrangements and work plan

Ms Hall confirmed that a scorecard had been developed for Governance and was in draft format. The committee discussed that for 2011 the day and time of the meeting may need to be realigned with other meetings in order for full attendance to be maintained. It was discussed that there be a set agenda in order that all issues were fully discussed and additional items added only when required

ECSM Q2 Report

Ms Hall confirmed that this report had been circulated but further discussion/amendment was required and that she would be meeting with Ms Barker-King in two weeks time. Following this meeting the report would re-circulated.

Workforce

An email had been circulated to the Committee with the required changes.

GC81/10 DIVISONAL CLINICAL GOVENANCE REPORT Q2

Ms Allsop introduced the Divisional Clinical Governance report for the Division of Planned Care for Q2. This was the first time the report had been presented to the committee. Ms Allsop outlined the key risks, achievements for quarter 2 and the key priorities for quarter 3

The key risks from Quarter 2:

- Pressure Ulcer management and reporting
- Patient experience/complaints relating to patient dignity, staff attitude and communication skills

Key achievements from Quarter 2

- Pressure ulcer management and reporting – no grade 4 hospital acquired pressure ulcers reported in Q2
- Patient experience/complaints
- Introduction of Clinical Wednesdays
- Implementing and evaluation nursing KPI's

Key priorities for next Quarter (3)

- Pressure ulcer management and reporting
- Patient experience/complaints
- Consolidation of Big 3 and clinical Wednesdays
- Recognition and management of the deteriorating patient

Ms Allsop gave an overview of the following topics

- Serious Untoward Incidents
- Hospital Standardised Mortality Ratio (HSMR)
- Adverse Incidents
- Pressure Ulcers
- Infection Prevention
- Clinical Audit and Effectiveness
  Ms Allsop confirmed that Rob Bowes for the Audit and Effectiveness team had worked hard in helping implement the action plans
- Patient Experience - Complaints/Ombudsman Enquiries
  Discussion took place around the patient experience data and it was confirmed that the Trust followed the set questions devised and these could not be changed. Care needed to be taken when reviewing this data

Ms Allsop confirmed that the division was working hard in all areas to improve results.

GC82/10 COMPLAINTS, INCIDENTS AND CLAIMS THEMED REPORT

Serious incidents

Ms Hall presented this paper and confirmed 27 SI's were reported in the second quarter of 2010/11. Some of the variation between quarters is attributed to changing criteria for reporting serious incidents e.g. the reporting of delays in LAS handover and grade3/4 pressure ulcers, which will increase reported SI's in quarter 3. The types of serious incidents include a number of deaths concerning missed diagnosis in the Emergency /Department at QE. These have been summarised and reviewed by the Executive Management Team and an internal review of the meningitis cases is being undertake. Two serious incidents concerned the deterioration of patients not being recognised by staff, 1 at PRUH and one at QMS
Allegations of misdiagnosis or mistreatment are also noted in reported claims at QE. Ms Hall confirmed that Ian Stell is working closely with the emergency departments and consultants are visible in the departments at all times to support staff. There is now more robust data available for patient safety and the roll out of Datix has been met with a very positive response.

Complaints

The volume of complaints at the PRUH has significantly exceeded the other 2 sites in every quarter. ECSM received approximately 40% of the Trust complaints, Planned Care 33% and WCSS 25%. The greatest scope for reducing numbers of complaints is in the Planned and WCSS divisions. In these divisions the complaints are more often about the organisation of care and communication. In the ECSM division the complaints are often more complex and concerned with the content of patient care. Ms Hall confirmed that the divisions write their own responses and these is proving more difficult in some departments, which is masking good practice overall. Mr Ballard suggested that maybe the simple complaints should be answered as quickly as possible in order to allow more time to be spent on the more complex ones

Claims

42 CNST claims were received at QE in the first 6 months of 2010/11 against 44 for the whole of the previous year. Claims at the PRUH and QMS site which had increased year on year appear to have levelled off.

ACTION: Ms Hall to respond to Mr Ballard as to the level of claims in comparison to other Trusts

Risk Management reports

The NHS Litigation Authority has introduced a risk management initiative designed to ensure Trusts take action following legal claims

Discussion took place around staffing on the QE site and Ms Hall confirmed that there had been a change in approach by the senior

management team and the culture of the department was changing in a positive way

ACTION: Ms Hall to provide a summary of each of the areas for the next meeting

GC83/10 SUSTAINABILITY OF SERVICES

Ms Hall verbally updated the Committee as follows:

- Key risks – the operational profile of QE
  The focus has been on improving the performance of the department who faced a challenging week last week.
  Small task force reviewing on a daily basis

- The milestones were on track for both the Midwifery departments and the QE profile

- The reconfiguration of services had commenced with a few minor teething problems in some areas

- Ms Hall confirmed that there would be 2 "medically fit" wards on the QM site. The term was defined by Ms Hall and discussion took place around the need for close collaboration between the Trust, PCT's and social services to ensure capacity on these wards was utilised. (Ms Hart gave a recent personal experience as an example of this point)

- Discussion took place around the orthogeriatric ward that would be on the QMS site and the movement of other services to other sites e.g. Urology, maternity, general surgery

- Ms Hall confirmed that there would be performance challenges regarding the Paediatric dept building on the PRUH site

- Resources would be re-aligned once site changes had been completed

- The discharge team would be lead by the General Manager of Emergency Care. Mechanisms to be put in place to speed up the process

- Ward managers would be expected to help with the streamlining of the discharge process by being set targets, e.g. I discharge by 10am, 2 by 12 noon

GC84/10 CARE QUALITY COMMISSION PLANNED REVIEW

Ms Hall informed the Committee that the Trust had received verbal feedback from the CQC planned review but was waiting for the draft written report.

GC85/10 SAFETY & SECURITY MANAGEMENT REPORT

Mr Pearce presented this paper and confirmed

- Satisfactory progress is being made on obtaining evident to support the Trust's Statutory Compliance obligations
- The not and cold water system in QEH is colonized with legionella, and the Health and Safety Executive is supporting SLHT in its management of the issue
- Good progress is being made with developing and publishing H&S policies
- A Non Executive Director for security as required by the NHS Counter Fraud and Security Management Services remains unconfirmed
- The series of communications and table top exercises designed to familiarise staff with their roles and incident management remains ongoing, and communications exercises and tabletop exercise have also taken place
- Mr Pearce thanked Ms Cooper for her support in connection with the Legionella incident
- Following a number of thefts of IT equipment from secure locations at QMS, the Metropolitan Police Safer Neighbourhood Team at Sidcup conducted covert CCTV operations on site. The operation commence on 27 September 2010 and resulted in the arrest of one person (a contractor)
- A single Gold Control Room for the Trust has been established in the Estates Building at QMS
- The presence of a 500 ton crane on the PRUH site over the weekend of 17-19 September 2010 passed smoothly due to the identification of risks and issues and the development and implementation of mitigating actions
- Discussion took place around the responsibility around Flushing by the PFI partners and where this sits in relation to Legionella. Mr Pearce confirmed that the ultimate responsibility sits with the Trust

ACTION: Mr Pearce and Ms Hall to review membership of the Health and Safety Executive to see if it is appropriate

ACTION: Ms Hart to confirm the name of a Non Executive Director for security to Mr Pearce

GC86/10 NOROVIRUS ACTION PLAN

Ms Cooper outlined the main events that had taken place regarding The norovirus outbreak that had occurred earlier in the year. Following on from this an action plan had been devised. Ms Cooper Highlighted the sections of the plan where there were still gaps in assurance. These were under sections 2,4,5,7 and 8.

The Committee asked Ms Cooper if there were to be another outbreak would the Trust be ready. Ms Cooper confirmed that the Trust was

now in a better position and would be able to act more effectively if there were to be an outbreak

ACTION: Mr Ford to chase WC & CSS under section 5 of the action plan

ACTION: Any comments regarding this plan to be emailed to Ms Cooper

GC87/10 INFORMATION GOVERNANCE TOOLKIT ASSESSMENT

Ms Knight presented this paper and an update as follows:

- The information Governance Toolkit scores have been submitted to Department of Health on 3rd November 2010. this was displayed in table format within the Action Plan.
- The paper highlights areas when there is a risk of not meeting the required level 2 targets for the final annual submission at the end of March 2011
- Resources required to achieve compliance level 2 as on the paper presented to the Governance Committee on 13th September 2010-11-19
- The Information Governance Committee have highlighted the following requirements that are at risk of achieving the Level 2 compliance without substantial resources, particularly financial resources

1. NHS Number Compliance – The Trust must ensure that service user records both paper and electronic, have an NHS Number stored on them as early as possible in the episode of care, In order to comply with Level 2, the Trust needs to demonstrate an active project and progress of implementation . A 0.5WTE temporary project management resource is required for a period of 6 month (approx £60,000). Capital resources will also be required for key IT System changes and these to be assessed and quantified as part of the project. Ms Knight to discuss with Ms Simpson this will need to go EMT and provide a paper to support the above. Ms Hart suggested if this required further support to come back to the Governance Committee
2. Corporate Records Management - Effective Corporate records management requires that an organisation is able to identify and retrieve information when and where needed. The Trust must have records management procedure in place that covers the lifecycle of corporate records in accordance with NHS standards. A health check and audit of corporate records need to be undertaken in at least 4 corporate areas of the Trust. Ms Knight confirmed that Mr Weaver had been trying to assist with this

- Discussion took place around the different methods of numbering patient records across the site. Concern was raised around procedures in place when notes need to go across the

sites. Ms Knight confirmed that there were flow charts in place for staff

- It was agreed by the Committee that for this to be successful it would require engagement from all staff
- The CQC will take this over from the DOH next year
- The Committee discussed the fact that there had been a data loss and that the Trust may come under scrutiny

ACTION: Ms Knight to email flow charts to the committee

ACTION: Ms Knight to provide a progress report to the Committee in January 2011

GC88/10 BOARD ASSURANCE FRAMEWORK

Ms Hall confirmed that the framework was currently challenging and that EMT were meeting in December2 010 to discuss this in depth. One of the ways forward suggested is to list the top 10 risks in detail and bring them to the Governance Committee for review. The remaining risks to sit beneath these on the register. Headline issues to be explained under the risk. Ms Hart suggested reviewing those risks listed which may have easier actions, so that could be updated and closed.

GOVERNANCE SCORECARD

Ms Hall confirmed that she was meeting with the CQC the following week. Mr Ballard asked that Ms Hall ask when the written report from the CQC would be available to the Trust.

The Committee discussed media around Mid Staffs and they were non compliant in some areas and the Trust does not want to find itself in a similar position

Mr Ballard reiterated the point that the Trust actions any recommendations made and that thought is given to how the media is handled

Ms Hall confirmed that verbal feedback given has been quite positive, a concern had been that the CQC when visiting the sites had not been challenged by staff in certain areas. It was confirmed that the CQC inspectors were wearing visitor's passes

ACTION: Ms Hall to circulate the CQC compliance categories to the Committee

ACTION: Ms Hall to chase CQC for written report when she meets them next week

Ms Hall presented the Governance Compliance Dashboard

- Page 1 – Hand hygiene compliance- under this section the requirements were listed and their current status

- Page 2 – CQC registration status – as above
- Page 3 Information Governance toolkit requirements – This item discussed by the Committee under agenda item 11.
- Page 4 – Corporate Governance and Risk Management – under item 14 supporting staff Ms McKenzie confirmed that approximately 60% of staff had had an appraisal. The staff survey had been distributed and email reminders and internet reminders sent to staff. The results will be available early in 2011.

These have been rated under 2 categories internal assurance and CQC/QRP.

GC89/10 PATIENT SAFETY ACTION PLAN

Ms Hall presented the paper and confirmed that the plan was on track and there were some key areas that required further work. The objectives are divided into the following sections:

- Development of Corporate Measures
- Establish and monitor explicit system level measures
- GTT audit report to Trust Clinical Governance Committee in October 2010. Assess level of harm, has the engagement of consultants
- Executive Patient Safety Walkarounds
- Ms Hall confirmed that there would be executive walkabouts during patient safety week across the 3 sites (15-17 November 2010)
- The reduction of pressure ulcers
- Falls Management
- Reducing harm from deterioration work stream
- Healthcare Associated infections
- Matching Michigan Project
- WHO surgical checklist
- VTE risk assessment

Ms Hall confirmed that Ms Allsop and Ms Bhatia were taking corporate leadership for Pressure ulcers and falls management

GC90/10 INTERNAL CONTROL ISSUES

Ms Hart confirmed there were 2 control issues

1. Medical equipment- internal audit review
2. Medical records – internal audit review

GC91/0 ITEMS FOR INFORMATION

GOVERNANCE SUB-COMMITTEES

Minutes received from the following sub-committees:-

- Executive Health & Safety Committee
- Information Governance Committee

- Safeguarding Children Committee
- Infection Prevention Board

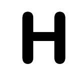
GC92/10 ANY OTHER BUSINESS

Ms Hart confirmed that a joint report on governance had been discussed by the board. Feedback and action plan will come back to the Governance Committee

ACTION: Action plan from this meeting to be emailed out to committee members

GC93/10 DATE OF NEXT MEETING

Dates for 2011 to be reviewed and emailed out to committee members



SOUTH LONDON HEALTHCARE NHS TRUST
TRUST BOARD AUDIT COMMITTEE
THURSDAY 9TH DECEMBER 2010
Held in the Ranken House, 1st Floor Meeting Room, QEH

MINUTES

PRESENT

Mr J Ballard	Non Executive Director (Chair)
Ms G Hart	Non Executive Director (in conference)

IN ATTENDANCE

Mr T Bolot	Finance Director
Mr A Shah	Audit Manager, London Audit Consortium
Mr D Corbett	Director of Internal Audit
Mr M Hughes	Assistant Director of Audit, LAC
Ms C Trevena	Associate Director of Finance
Ms C Purton	Counter Fraud Lead
Ms L McKenzie	Director of Human resources and Organisational Development
Ms T Tucci	Head of Workforce Intelligence and Systems
Mr M Weaver	Trust Board Secretary (Minute Taker)
Mr N Beth	Audit Commission
Mr D Ford	Assistant Director of Governance
Ms T Cooper	Director of Infection Prevention and Control
Ms M Donbavand	Finance Project Manager
Mr P Dowell	Head of Procurement
Ms V Rogers	Senior Accountant (Capital)

Committee members met privately with the auditors prior to the start of the business meeting.

		ACTION
063/10	**APOLIGIES FOR ABSENCE**	
	Mr T Blackman — Audit Commission Mr P Johnstone — Engagement Lead, Audit Commission Ms J Hall — Director of Nursing, Governance and Patient Experience Ms L Knight — Director of Delivery	
064/10	**MINUTES**	
	Minutes of the meeting held on 23rd September 2010 were **AGREED** as an accurate record.	
065/10	**ACTION LOG**	
	Actions agreed as of the 23rd September 2010	
	Item 053/10 Audit Committee Briefing from Trust Board Secretary	
	Mr Weaver informed the committee that recently published guidelines regarding the publication of all contracts valued £10,000 or more would be circulated to the Committee.	**MW**

		ACTION
065/10	**ACTION LOG**	
	Actions agreed as of the 23rd September 2010	
	Item 053/10 Specialist Children's Services	
	Mr Ballard updated the committee on lessons learnt with regard to the transfer of Specialist Children's Services to South London Healthcare NHS Trust. The due diligence carried out before the transfer was made was not as comprehensive as it should have been. Anomalies that should have been clarified before transfer were only now being tackled. Mr Bolot proposed that the Trust Business Case Approval Process be used to improve the process in future. The Committee would need to be satisfied that that process was fir for purpose.	
	– The Committee agreed and **ASKED** for Mr Bolot to bring the Trust Business Case Approval Process back to the Audit Committee in March 2011	**TB**
	Item 053/10 Whistle Blowing policy	
	As reported at the meeting on 23rd September members of the committee had been asked to forward any further comments on the Whistle Blowing policy to Ms Donbavand by the close of 24 September. None had been received and the policy was therefore approved in the form seen by the Committee at its last meeting.	
	Item 053/10 Internal Audit Recommendations	
	Dates for Trust Board Audit Committee are to be finalised for 2011.	
	– Mr Ballard **ASKED** to agree and finalise dates and venues for Trust Board Audit Committee in 2011with Mr Bolot and Ms Trevena.	**JB / TB / CT**
	Item 054/10 Audit Opinion	
	Ms Trevena confirmed that the Trust was meeting with the Audit Commission today. Mr Ballard asked if there were any issues to report in relation to the IT Risk Register. Ms Trevena reported that this item would be reported on later in the meeting.	
	Item 055/10 IT Risk Register	
	Mr Ballard reported upon discussion of the IT Risk Register at Trust Board. Ms Hart asked to know which Trust Director was now responsible for IT as it was understood that Ms Knight had recently taken responsibility for 18 weeks RTT. Mr Ballard confirmed his understanding that the Trust had appointed a Director (Ruth Holland) to cover IT.	
	Item 055/10 External Reviews	
	Mr Bolot reported that a report on Activity and Income processes would be reported on later in the meeting.	
	Item 055/10 Progress Report on 2010-11 Plan (NICE Guidelines)	
	Mr Ford, Assistant Director of Governance would be reporting on this item later in the meeting.	
	Item 056/10 Outstanding Audit Recommendations	
	With regard to outstanding audit recommendations Mr Ballard	

asked to know if actions rated as amber for Human Resources had been implemented. Mr Shah confirmed that these actions had been implemented. A progress report on outstanding audit recommendations would be reported at today's meeting.

065/10 ACTION LOG **ACTION**

Actions agreed as of the 23rd September 2010.

Item 057/10 Local Counter Fraud

Members of the committee welcomed Ms Purton, Counter Fraud Lead to the meeting. Members of the committee were informed that there would be a page on the Trust Intranet for Counter Fraud that included links to the Trust Whistle Blowing Policy and Counter Fraud Services.

Item 059/10 Bad Debt

Ms Hart asked whether the Trust sought payment from oversea visitors before providing services. Ms Travena confirmed that it did so.

Item 060/10 Tendering for Internal Audit Services from 1st April 2011

This item would be reported upon later in the meeting.

066/10 EXTERNAL AUDIT

Annual Audit Letter 2009/10

Members of the committee welcomed Mr Beth to the meeting. Mr Beth would be attending on behalf of Mr Blackman at future Trust Board Audit Committee meetings.

Overall conclusion from the audit

The Trust was to be congratulated on receiving an unqualified opinion on its financial statements on 10th June within the target set by the Department of Health. Nevertheless significant scope existed to improve how the Trust prepared its financial statements and supporting working papers. Although the audit deadline had been met, the deadline for submitting draft accounts was missed by over two weeks. The Trust needed to improve the effectiveness of its asset register and asset management arrangements, and increase the efficiency of its financial reporting by fully merging inherited systems. The audit had also identified many significant errors in the financial statements, particularly in accounting for plant, property and equipment assets.

Value for Money (VFM)

The Trust had received an adverse conclusion in June 2010 that stated the Trust did not have adequate arrangements to secure economy, efficiency and effectiveness in its use of resources. (This conclusion flowed through automatically from the trust being in deficit.)The Trust was aware of these issues and was working with NHS London to address them. Mr Bolot asked to know how many of the six VFM criteria it was likely to fail in the future if it remained in deficit. Mr Beth stated it was not possible at this time to determine if the Trust was likely to fail specific criteria if it remained in deficit. This would depend upon the future approach that would be used to assess VFM.

New approach to the VFM conclusion

For information, Mr Beth introduced a briefing note that provided guidance on the application of the criteria specified by the Audit Commission for auditors' VFM conclusions.

066/10 EXTERNAL AUDIT

ACTION

New approach to the VFM conclusion

Mr Ballard asked that the progress made by the Trust in accounting for expenditure and improving productivity be recognised. Ms Hart expressed her support for ensuring the Trust received recognition for the improvements that it had made. Mr Bolot asked the committee to note that the Trust's deficit had always dwarfed all other Auditors Local Evaluation (ALE) assessments. Mr Beth reported he was waiting to hear how the VFM conclusions will be reported. However he had noted the points made by the Trust.

- Mr Bolot **ASKED** the committee to note the Trust had asked External Audit to undertake work to review the Month 8 position and report on this work at to the Committee at its meeting in March 2011 — **NB**
- Mr Ballard **ASKED** for an update on Trust arrangements for delivering VFM at its meeting in January 2011 — **JB**

Impact of the International Standards of Audit Clarity Exercise on 10/11 audit approach

Mr Beth asked the committee to note the new clarified framework that applied to the audit of the Trusts 2010/11 financial statements. Because of the new standards, the Trust should expect to see some changes in the way the audit team delivered the Trust's audit and the information that was sought from the Trust. Mr Corbett asked if there was a definition of "a significant deficiency in internal control" in relation to the new ISA 265 standard.

- Mr Beth advised the Committee that this was a judgement call for the auditor and **AGREED** to provide the actual wording of the standard. — **NB**

067/10 INTERNAL AUDIT

Internal Audit Progress Report 30th November 2010

Mr Shah updated the Audit Committee on progress made in delivering the Annual Internal Audit Plan 2010/2011 for South London Healthcare NHS Trust and details of all recently issued final Internal Audit reports. Since the last meeting of the Audit Committee on 23rd September 2010, three final reports had been issued to the Trust. These were in respect of reviews on Reducing Hospital Acquired Infection, Staff Absence Management and Patients Monies and Property.

Reducing Hospital Acquired Infection

Attention had been drawn to the potential mismatch between the recent assessments made by Internal Audit and SLH management on the efficacy of the arrangements for the control of infection. . Mr Shah asked the committee to note that Internal Audit had reported significant assurance with regard to the system of control in place

around the management and prevention of Healthcare Acquired Infection (HCAIs) that was regularly monitored through clearly defined Key Performance Indicators. This reflected fieldwork that assessed overall arrangements for the management and prevention of Healthcare Acquired Infection (HCAIs). The paper reported by the Director of Infection Prevention and Control, had focused on the Trust's self-assessment of compliance with the Hygiene Code.

067/10 INTERNAL AUDIT — **ACTION**

Reducing Hospital Acquired Infection

- Ms Hart **ASKED** the Director of Infection Prevention and Control to provide a further update to the committee at its meeting in March 2011 — **TC**

Outstanding Internal Audit Recommendations

Internal Audit together with Trust officers, had sought to determine the progress made with regard to addressing Internal Audit recommendations. A total of 9 new recommendations had been made in the final reports that have been issued to the Trust since the September 2010 meeting of the Audit Committee. Mr Shah asked the committee to note his thanks to Ms Donbavand, Finance Project Manager for work undertaken to review and report on outstanding Internal Audit recommendations.
Mr Hughes asked the committee to note the progress that had been made to address the outstanding IT recommendations. Mr Corbett had met with Ms Knight, Director of Delivery and confirmed that a Disaster Recovery and Business Continuity (DRBC) Plan was on the agenda of the Trust Information Governance Committee on 13th December. Mr Ballard asked whether the Trust would need to take a view on whether its existing priorities were having an impact on Trust capacity to address recommendations made in relation to IT.

Mr Ballard asked to know where the Trust considered Trust compliance with Care Quality Commission (CQC) standards. Ms Hart confirmed CQC compliance was reported to and discussed at the Trust Board Governance Committee and that it would be discussed at its meeting in January 2011. Mr Shah asked the committee to note that Internal audit would be undertaking work to review Trust compliance with CQC standards.

- Mr Hughes **AGREED** he would update the committee on matters related to addressing Internal Audit recommendations made in relation to IT at its meeting in January 2011. — **DH**
- Mr Ballard **ASKED** to receive a report on progress made with regard to addressing Internal Audit recommendations at its meeting in January 2011.

068/10 PAYROLL

Leavers Report

The Finance team produced a weekly Finance Report for the Trust Board that included a report on leavers. The leavers report was produced with input from both Human Resources and Finance. It was agreed that a year to date reconciliation was required to validate the reports. Ms McKenzie asked the committee to note the current process that was followed and discrepancies found during

the audit. Ms Tucci provided further detail of the process followed and reasons why some leavers did not show on the weekly Finance Report. Mr Bolot suggested the Trust should improve its use of the Electronic Staff Record (ESR) rather than rely on a manual system to compensate for system design problems in the ESR.

068/10 PAYROLL **ACTION**

Leavers Report

Ms Tucci asked the committee to note that this was a problem common to many other National Health Service (NHS) Trusts and that there was a particular issue with recording staff that left to take up another post within the Trust. Ms McKenzie assured the committee that action had been taken to implement the recommendations made and to address the discrepancies identified. The Committee:

- **THANKED** Ms Donbavand and Ms Tucci for their work in completing this project
- **ASKED** for the committee to receive a report on this item at the Trust Board audit Committee in March 2011 **LMcK**

069/10 LOCAL COUNTER FRAUD

Counter Fraud Update

Ms Purton, Counter Fraud Lead updated members of the committee on matters related to reactive investigations and proactive work. Ms Hart asked if Counter Fraud had a slot to present at Trust Induction. Ms Purton confirmed that Counter Fraud awareness was included in Trust Induction at all three sites. Mr Ballard asked to know why there appeared to be a delay between initial interviews and Trust action in response to investigations. Ms McKenzie explained that such delays in some cases may be due to the need for the Trust to await an external investigation before it can proceed with its own internal investigation.

Counter Fraud Progress Report

Cathy Purton of London Audit Consortium and Nisha Ladak of South Coast Audit continued to provide collaborative Counter Fraud Services to the Trust. The Counter Fraud and Security Management Service (CFSMS) had been notified of all personnel changes and have amended LCFS nominations as required under the Secretary of State Directions.

Since the report was submitted the provisional QA assessment results had been received at the end of November, the Trust were provisionally rated at a level 2 for 2009/10. CP will be producing an action plan to be discussed with CT at their next planning meeting.

070/10 ACTIVITY/ INCOME PROCESSES

Mr Bolot asked for this item to be deferred to the meeting in January 2011 so that there may be sufficient committee time to discuss the report.The Committee:

- **AGREED** the report on Activity / Income Processes would

be reported at the Trust Board Audit Committee in January 2011. **TB**

071/10 FIXED ASSET REGISTER PROJECT **ACTION**

Mr Bolot introduced Mr Dowell and Ms Rogers.

Background

After the merger of three legacy asset registers, there were major inconsistencies across many assets, on cost valuations, lives and detailed descriptions. Other than QEH, there was no physical verification of assets across the Trust: all of which had led to a serious failure of Corporate Governance through a major audit failure at the year end 31.03.10, and a major risk in terms of Net Realisable Values vs. Net Book Values**. Work had been put in hand to remedy these deficiencies.**

Project Scope

The Trust had undertaken to physically verify and "tag" all 12,767 assets in the Trust, both PFI and owned, and reconcile to the current asset register & Balance Sheet. These assets had to be assessed for cost valuation and asset life, matched to the legacy registers where possible, and then uploaded onto the new asset management system that had been purchased since year end. This project had to be completed with very limited resource, and was expected to take 6 months to complete. It started on 27th July, and at 30th November was 95% complete.

Mr Beth commented that there would need to be verification that the Trust had taken a sufficiently comprehensive approach and received the right advice on asset value. The Trust would also need to ensure that the asset register was maintained and kept up to date following future acquisitions and disposals.The Committee:

- **THANKED** Mr Dowell and Ms Rogers for their work for their work on this project

072/10 SLHT REPORTS

Single Tender Waivers and Losses and Compensations

The Committee:

- **NOTED** there were no reports for Single Tender Waivers and Losses and Compensations

073/10 PROCESS FOR APPOINTING NEW INTERNAL AUDITORS

The Committee:

- **AGREED** a tender specification would be agreed outside of the meeting with members of the audit committee. The target date for the commencement of the new contract was 1 July 2011. The existing contract with Internal audit would need to be extended by 3 months. **TB**

074/10 ANY OTHER BUSINESS

Internal audit report on HCAI/Hygiene code

Mr Ballard welcomed Ms Cooper, Director of Infection Prevention

and Control to the meeting. Ms Cooper asked the committee to note the Trust's self-assessment of compliance with the Hygiene Code and the areas for improvement that had been identified. Ms Hart thanked Ms Cooper for the report and noted the item for action as per 067/10.

074/10 ANY OTHER BUSINESS **ACTION**

Trust NICE Policy

Mr Ballard welcomed Mr Ford, Assistant Director of Governance to the meeting. In relation to the findings from a recent Internal Audit report Mr Ford updated members of the committee on what action the Trust had taken to provide further assurance to the Trust on how the Trust actively monitored the implementation of NICE guidance.

The Trust NICE Guidance Implementation Policy had been approved at the Trust Board Governance Committee in October 2010. The Divisional Quarterly Governance Reports would be discussed in discrete Clinical Governance Committees and the Trust would be responding to NICE Quality Standards for Stroke, dementia, Falls and specialist neonatal services. Mr Ballard thanked Mr Ford for his report and the assurance it provided the committee.

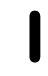
Counter Fraud Update

Ms Hart asked for clarification of the procedure to be followed when the Trust received offers of gifts or hospitality. The Committee:

- **AGREED** that Mr Weaver would circulate the Trust Gifts and Hospitality Procedure to members of the committee. **MW**

075/10 DATE OF NEXT MEETING

Mr Bolot asked the committee to note that a full schedule of meetings to be held in 2011 would be circulated in due course. **MW / CT**



SOUTH LONDON HEALTHCARE NHS TRUST
FINANCE COMMITTEE MEETING
TUESDAY 7th DECEMBER 2010
Held in the Committee Room, Trust Headquarters, Queen Mary's Sidcup

MINUTES

PRESENT	Mr J Ballard	Deputy Chairman (Acting Chair)
	Ms H Allen	Non Executive Director (in conference)
	Ms J Townsend	Non Executive Director
	Dr C Streather	Chief Executive
	Mr R Smith	Medical Director
	Mr T Bolot	Finance Director
IN ATTENDANCE	Mr M Weaver	Trust Board Secretary (Minute Taker)
	Ms C Trevena	Associate Director of Financial Control
	Mr P Attride	PMO Programme Director

For Item 087/10

Mr R Morey	Divisional Director, Planned Care
Mr Rao	Consultant Orthopaedic Surgeon
Mr J Knight	Programme Management Office

STANDING ITEMS — **ACTION**

080/10 APOLIGIES FOR ABSENCE

Mr G Jenkins	Chairman, SLHT
Ms L Simpson	Deputy Chief Exceutive
Ms G Hart	Non Executive Director
Ms L Roberts	Non Executive Director
Ms J Hall	Director of Nursing, Governance and Patient Experience

081/10 MINUTES

Minutes of the meeting held on 2nd November 2010 were **AGREED** as an accurate record subject to amendments received from Ms Allen.

082/10 ACTION POINTS AND MATTERS ARISING NOT ON THE AGENDA

Impact of Temporary Closure

At its meeting on 2nd November 2010 the committee had **ASKED** to receive a report on the financial impact of the temporary closure. This item would be reported on later on in the agenda within the update on service sustainability.

FY 2011 Planning Process

At its meeting on 2nd November 2010 the committee had **ASKED** to see an updated Procurement Plan for the next Finance Committee. This item would be reported on later on in the agenda.

At its meeting on 2nd November 2010 the committee had **AGREED** to arrange Trust Board planning dates for January 2011. This item would be discussed later on in the meeting.

ITEMS FOR DISCUSSION | **ACTION**

083/10 MONTH 7 FINANCIAL SUMMARY

Mr Bolot presented a report to the Finance Committee dated 7th December 2010.

Trading Position and Outlook

The month 7 position was a loss of £1.8m for the month which was £0.8m ahead of forecast loss made at month 5. The main drivers of the positive variance were the correction of over-accrued depreciation (£1.1m) and the re-phasing of block income (£0.6m). The main movements in the in month position were the changes in income phasing (£1.8m), a correction of year to date (YTD) depreciation charges (£1.0m), the inclusion of Challenge Trust Board (CTB) income (£1m) and an overall reduction in Corporate Division (£0.5m).

Consolidated Profit & Loss (Month 7)

On a year to date (YTD) basis the loss was £31m which was £1.4m behind the forecast. This was due to phasing of the block contract income in the forecast and this would fall back in line during the latter part of the year. The forecast assumed continued improvement in run rate to the year end.

Run rates within the Planned Care Division had stabilised over the last three months. Emergency Care and Specialist Medicine (ECSM) and Women's, Children and Support Services (WCCS) had seen a worsening of their run rates mainly due to the catch up of Urgent Care Centre (UCC) billing in Month 6 and an under-accrual in WCCS income of £100k that was expected to reverse. The significant improvement in Corporate related primarily to the correction of prior month depreciation charges (£1m) The underlying run rate for corporate was estimated to be £8.6 - £8.8m per month.

Members of the committee discussed the reported run rate and whilst it was acknowledged that it was coming down Mr Bolot confirmed that the movement in run rate between Month 6 and Month 7 was not as marked as it should have been. Mr Ballard invited Dr Streather to comment on the likely impact of winter pressures over the coming months. Dr Streather confirmed Trust priorities over the winter period would be to deal with the backlog in the 18 weeks referral to treatment target (RTT) and deal with winter pressures.

Mr Bolot asked the committee to note the Trust was awaiting the outcome of a decision on arbitration on the contract with PCTs for the second half of the financial year, at NHS London. The Trust had presented a strong case but it was understood that any decision taken would reflect the need to consider the impact on the whole health economy.

084/10 UPDATE ON SERVICE SUSTAINABILITY

Mr Bolot presented an update on three potential scenarios for changes in activity and income as a consequence of A&E and Maternity activity moving from Queen Marys, Sidcup (QMS) to Princess Royal University Hospital (PRUH) and Queen Elizabeth Hospital, Woolwich (QEH) or flowing to Darent Valley, Dartford and Gravesham NHS Trust and Lewisham Healthcare NHS Trust.

	ITEMS FOR DISCUSSION	ACTION
084/10	**UPDATE ON SERVICE SUSTAINABILITY**	
	Ms Townsend asked if other NHS Trusts had reported any changes in activity as a result of the temporary closure. Dr Streather stated it was too early to tell and that the Trust wouldn't know until the end of January. Dr Streather reported on progress to develop the Midwife Led Birth Unit at the Princess Royal University Hospital (PRU). Ms Townsend suggested the Trust should actively promote the development of new facilities that would serve to inform patients and the public of new services developed by the Trust. [Mike was there not an action to come out of this?] Yes there was! I suggest Dir of Comms.	
	Mr Bolot stated that the impact of temporary closures to support service sustainability would need to be included in next years forecast. Mr Ballard asked how the impact of temporary closures and their resolution in the spring would be allowed for in future Trust Business Planning? Mr Bolot suggested the Board should hold a meeting in January to discuss current assumptions around budget setting and business planning.	
	Mr Ballard asked for an update on the decision around A Picture of Health (APoH). The Board of NHS London had delegated authority to three Board members and a decision was expected on 16th December. There was however always the possibility that the Secretary of State for Health might requirer a further independent clinical review. In which case it could be April 2011 before the Trust received a final decision on APoH. Meanwhile the Trust would continue to monitor Key Performance Indicators (KPIs) for monitoring Patient Safety on a weekly basis.	
	The Committee:	
	– **AGREED** that Mr Bolot would provide an update on observed changes in activity as a result of temporary closures at the Finance Committee meeting in February 2011.	**TB**
	– **AGREED** the Board should meet in January to discuss current assumptions around budget setting and business planning.	
085/10	**PROCUREMENT WORKPLAN**	
	At its meeting on 2nd November 2010 the committee had **ASKED** to see an updated Procurement Plan for the next Finance Committee. Mr Bolot reported a procurement savings tracker as at 30th November 2010 that included details of Trust projects to increase income and reduce costs in 2010/11.	
	The Committee:	
	– **AGREED** that Ms Townsend would follow up with Mr Bolot and the Trust Head of Procurement to discuss the potential for moving to a managed service for taxi services and other areas targeted by Ms Townsend in her organisation.	**JT / TB**

ITEMS FOR DISCUSSION — **ACTION**

086/10 UPDATE ON CORPORATE SERVICES

Mr Bolot presented an update on Corporate Services. The corporate cost base forecast was at £28.5m for the current year (vs. prior year of £30.1m and target of £26m). Notable achievements in reducing the corporate cost base included a reduction in pay costs through headcount controls and temporary staffing reductions.

Work would continue to reduce the corporate cost base and the largest challenges remained within the Chief Operating Officer (COO), Nursing and Information Technology (IT) Directorates. Dr Streather asked the committee to note the Trust would need to continue its investment to ensure it had the operational capacity and expertise to deliver against its objectives. A discussion on the level of corporate overheads concluded that it was too high for the Trust and needed to be reduced to a level of £20-23m per annum. The Trust was considering potential outsourcing options for some corporate services such as Human Resources and IT. It would also be examining existing contracts to ensure they continued to be the most cost effective way of conducting business. Ms Townsend asked the committee to note that the successful outsourcing of services required good contract management.

The Committee:

- **AGREED** that work would continue to identify savings in the Corporate Directorates and an update on progress would be reported in January 2011. **TB**

087/10 TRAUMA AND ORTHOPAEDIC PRODUCTIVITY REVIEW

Mr Ballard welcomed Mr Morey, Mr Rao and Mr Knight to the meeting. The project had followed a methodology based upon principles common to Service Line Management / Service Line Reporting, whose aim was to place decisions in the hands of clinicians.

Introduction to the project

The project had three objectives that were linked to specific project deliverables.

- To identity a detailed range of implementable improvements that would deliver improved operational and financial performance.
- To develop an implementable and measurable action plan to deliver the improvements identified.
- To engage with clinicians and gain their buy-in for the process and the action plans.

Illustrative review outputs

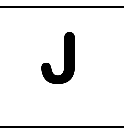
Members of the committee noted and discussed outputs from the project that illustrated differences in cost, activity and income. Such differences reflected differences in models of working and case mix across the three Trust sites. Mr Ballard asked to know how the Trust proposed to measure the quality of services provided. Mr Rao reported Patient Reported Outcome Measures (PROMs) would serve to be an indicator of quality as well as readmission rates.

Overall draft actions

Mr Knight outlined the overall plan for action that proposed 9 key

actions, three of which were expected to be delivered in 2010/11.Mr Ballard thanked Mr Morey, Mr Rao and Mr Knight for their work.

	ITEMS FOR DISCUSSION	**ACTION**
087/10	**TRAUMA AND ORTHOPAEDIC PRODUCTIVITY REVIEW**	
	The Committee:	
	– **AGREED** that the T+O leadership team, working with PMO, would produce a detailed implementation plan that would be delivered in 2010/11 and 2011/12 at the Finance Committee meeting in February 2011	**Patrick Attride (PMO)**
088/10	**ANY OTHER BUSINESS**	
	None	
08910	**DATE OF NEXT MEETING**	
	To be confirmed	



HUMAN RESOURCES COMMITTEE

TERMS OF REFERENCE

1. PURPOSE

To provide assurance to the Board that the HR / Organisational Development function supports the corporate aims of the Trust.

To ensure that the HR agenda is being implemented with appropriate policies and procedures to support the significant organisational change required, and that all aspects of employment law are supported and implemented in a professional way.

2. DUTIES / RESPONSIBILITIES

- To take a strategic overview of HR/Organisational Development practice within the Trust with particular reference to advice, support and monitor the progress of the engaged staff pillar of the Trusts corporate strategy.
- To take a strategic view of the Trust's workforce plans to ensure that they are robust and fit for purpose.
- To review and approve HR policies prior to submission to the Board for ratification (where appropriate).
- To provide assurance to the Board that the HR policies are fit for purpose and support the Trusts corporate aims.
- To ensure that the HR function is able to fully support the organisation in delivering the significant organisational changes and changes to conditions of employment.
- To review and measure the motivation of the workforce and assess the consequences of staff engagement and culture change.
- To review high level employee relations activity and measure the progress in resolving and reducing this activity.
- To make decisions delegated from the Trust Board and Appointment & Remuneration Committee in relation to contractual matters, for example, to review and approve recommendations from job plan appeal hearings.
- To commission and monitor specific pieces of work which the Committee deem necessary in order to provide assurance to the Board.

3. ACCOUNTABLE TO

Trust Board.

DRAFT

4. REPORTS TO AND METHOD (INCLUDING MINUTES CIRCULATION)

The minutes of the meetings of the Human Resources Committee will be formally recorded and submitted to the Trust Board.

5. MEMBERSHIP – NAME / DESIGNATION / CHAIR OR DEPUTY

NAME	DESIGNATION	CHAIR / DEPUTY
Jackie Townsend	Non-Executive Director	Chair
Lyn Roberts	Non-Executive Director	Deputy
Louise McKenzie	Director of HR & OD	

6. QUORUM

1 Non-Executive Director plus 1 other members of the Committee.

7. MEETING FREQUENCY (MINIMUM IF APPLICABLE)

Meetings will be held bi-monthly.

8. REVIEW DATE

January 2012.

9. PROCESS FOR REVIEWING EFFECTIVENESS

Special meeting of the HR Committee and report by the Committee Chair, to the Trust Board.

DRAFT

31st January 2011

J

MINUTES OF HR SUB-COMMITTEE MEETING
Held on 24th November 2010
at Queen Elizabeth Hospital

PART I

PRESENT:

Mrs J Townsend, Non Executive Director (Chair)	(JT)
Ms L Roberts, Non Executive Director	(LR)
Mrs L McKenzie, Director of HR & OD	(LMcK)

IN ATTENDANCE:

Mr Kyriacos Kyriacou, Associate Director of HR	(KK)

APOLOGIES:
None noted

		ACTION
1.	**MINUTES OF THE PREVIOUS MEETING (20TH SEPTEMBER 2010)** These were agreed as a correct record.	
2.	**MATTERS ARISING** **2.1 Criminal Records Bureau checks.** Action from previous meeting to report back on progress at the end of financial year. **2.2 Corporate Induction.** The Committee requested that an evaluation be completed of feedback from the Induction programmes held in 2009/10	**LMcK** **AP**
3.	**POLICIES** **3.1 CEA policy** The final CEA policy dated November 2010 (version 6) was ratified by the committee. **3.2 Update on Policy Agreement** Mr Kyriacou presented an updated on his progress with staff side in agreeing the four draft contractual policies, namely: • Disciplinary Policy • Grievance Policy • Sickness Absence Policy • Prevention of Stress Policy The Committee noted the concerns raised by Mr Kyriacou in relation to the lack of progress made and a number of remedial options were discussed, namely: 1 Escalate the situation to the union full time officers 2 Enforce policies which had not been agreed for a 12 month timescale with a view to agreeing them during the 12 month duration 3 Set deadlines and implementation dates with staff side. It was agreed that KK would attempt to resolve using option 3, and that LMcK would raise the issues with the wider staff side group at the JSPC. **3.3 Appraisal & KSF Gateway Policy** It was agreed that the Committee would revisit the Trust's performance in relation to completion of appraisals and objective setting, and defer any fundamental changes	 **KK** **LMcK**

	that may be necessary to the policy until after this review. **3.4 ESR Access Control Policy** This policy was shared with the Committee for information. It was noted that it had been formally approved by the Information Governance Committee.	**AP**
4.	**WORKFORCE KEY PERFORMANCE INDICATORS** **4.1 QUARTER 2** The Committee reviewed and discussed Trust and Divisional Quarter 2's KPIs including: • Headcount • Sickness • Turnover • Staff Expenditure • Vacancy rates • Recruitment Activity • Compliance data re annual appraisals • Compliance data re statutory & mandatory training It was agreed that the following information would be provided with Quarter 3 data: • Separation of short and long term sickness • Benchmarking data (where appropriate) for example London average turnover rate. • Establishment vacancy rates versus actual vacancies we are actively recruiting to. • Organisational change data ie numbers of posts disestablished as a result of organisational change and associated cost saving and cost expenditure.	**LMcK**
5.	**ORGANISATIONAL DEVELOPMENT UPDATE** **5.1 VALUES** The Committee noted that implementation plan for the Values work programme.	
6.	**WORKFORCE RECONFIGURATION** **6.1 Update report on current consultations** Mrs McKenzie presented a verbal update on the current consultations that are ongoing. **6.2 Administration Consultation** Mrs McKenzie presented an update on the Administration Consultation exercise. It set out the current position in terms of appointing people to new roles, identifying displaced staff, describing the process for managing displaced into vacancies, and an estimation of the savings that would be made from this process. The Committee requested an update in relation to this in 3 months time.	**LMcK**

7.	**REVIEW OF TRANSACTIONAL HR SERVICES** Mrs McKenzie appraised the Committee of the work that the Directorate had started to review the activities, cost, and quality of the transactional HR services. It was noted that the 'HR Fit for Business Programme' would involve a range of diagnostic pieces including a dairy card exercise, a review of performance against current SLAs and a benchmarking analysis. Mrs McKenzie commented that this programme needed to be consistent with the wider piece of work that the Trust had commissioned on corporate service models. It was noted that Ms Roberts was supporting this piece.	
8.	**BOARD APPROVAL OF KINGS HEALTH PARTNERS' MDECS APPLICATION** The Committee noted the paperwork that had been sent to approve the KHPs MDECS application.	
9.	**AOB** There was none noted.	
10.	**FUTURE MEETING DATES** Wednesday 26th January 2011; time and venue to be confirmed.	

SOUTH LONDON HEALTHCARE NHS TRUST
TRUST BOARD MEETING IN PUBLIC
WEDNESDAY 26th JANUARY 2011

QUESTIONS FROM THE FLOOR

The Chairman welcomed members of staff and the public to the Board meeting; a meeting being held in public not a public meeting. The Chairman explained that in response to comments made at previous meetings and suggestions that early provision for public questions could inform subsequent discussion of agenda items, provision for questions from the floor between 9.30 a.m. and 10.00 a.m. would be trialed over the next 3 meetings of the Board. The record of questions and answers provided at the meeting and subsequently in writing would be made available on the Trust Website. A trial protocol for public questions had been circulated with the agenda papers. It was highlighted that members of the public would be restricted to one question each for the duration of the trial period; however other questions would also be welcomed if time permitted.

The Chairman invited questions to be addressed to the Board.

i. Mr Latham:

Q1. My question relates to aircraft flight paths over hospitals. I note that the Chairman has raised this as an issue with the hospital management in the past. In a recent e-mail to the Chairman, I expressed my concern at the increase in flights over the hospitals by larger aircraft flying at a lower altitude, along with the impact of the forthcoming Olympics on the volume of air traffic a reply to which is awaited. Residents have been taking this matter up separately with the Council, which is conducting a brief consultation on the issue.

A. Mr Chairman replied that the Trust had sought advice from an appropriate authority that had conducted a site test and concluded that aircraft noise was not sufficient to present a problem to members of staff and public using the hospital. Aircraft noise had not been raised as an issue with the Trust. The Trust would not therefore be lodging an objection.

ii. Mr Mott:

Q2. I was sent details of the investigation at 19.15pm yesterday 25th January 2011 is this going to be discussed at the board meeting today?

Q3. I notice in the £25000 published spend that BOLT Partners have been paid a total of £863436.oo. I also notice that on four occasions these payments have been duplicated at a cost of £317581.oo. Would you please tell me why these payments were duplicated, has this money been repaid and if so was the interest the Trust lost on this overpayment paid back to the Trust.

A. Dr Streather agreed to look into this and provide a written answer within one week. Dr Streather added that the Trust's expenditure on senior management consultancy was declining and was below that of the legacy Trusts.

Q4. What is point of asking us to submit our questions in advance and still give us no answer to our questions?

A. Your statement is a valid point and has been noted.

iii. Mr Williams:

Q5. I did not receive my board papers on time which should be 7 days before the meeting. I didn't get them until yesterday evening?

Q6. When the Trust is haemorrhaging 4 to 5 million pounds every month why does it need to hire a room at a monthly cost of £2099? What is the address of this room? Why can it not use one of the very good rooms that it has on the PRU site, or the very large room where it held last years Annual Public Meeting?

A. The Chairman stated that due to a major mechanical failure with the photographic printers the papers were sent out. There was no conspiracy to issue the papers late it was due to an unavoidable set of circumstances. On the second point raised, the Trust would investigate this issue and respond outside of the meeting.

iv. Mr Lane:

Q7. Please accept my apologies I did not submit my questions in advance of the meeting as I was away and did not return in time to submit questions. In the past, I have submitted questions relating to the safeguarding of children provisions when seeking registration and how non-compliance with these provisions is investigated. Similar issues with regard to the safeguarding of adults now apply. Can the Trust confirm that: a multi-agency approach to safeguarding adults is in place; staff will have adequate training in safeguarding adults (it is my understanding that only 21% staff have received training so far); organisations such as Link will be contacted for support, as appropriate?

A. The Trust had disclosed to the CQC that it was not compliant in this area the Trust was not assessed and found non-compliant. Safeguarding is dealt with as part of the multi-agency framework. Safeguarding for children is covered by statue but this not the case for adults, however, the Trust treats both in the same way. The Trust is proactively implementing safeguarding standards and training across the organization and is being proactive about this process and the Trust **AGREED** to supply Mr Lane with the training figures. We are also including a learning disabilities framework within this process.

The Board **ASKED** for the Trust to receive an update on the training figures relating to safety and safeguarding.

v. Mrs Latham:

Q8. The Friends of Orpington Hospital continue to raise funds for the Hospital. Can the Trust confirm its intention with regards to the future use of the Hospital?

A. A detailed response to a question relating to the future of Orpington Hospital was given at the last meeting. (See response to Q15, dated 24 November 2010), In essence, the future delivery of services will be determined by commissioners, as opposed to the service provider. A Working Group, led by the GP Commissioning Consortia is examining the future provision of services in Orpington, All major stakeholders are in agreement that health services should be accessible in Orpington and the organisation's strategy is to move towards a community setting, however the final decision on the Orpington Hospital site will rest with the commissioners. The matter will be discussed further at a meeting next week, with representatives of the Primary Care Trust, the GP Commissioning Group and the Clinical Dermatologist who is based at Orpington Hospital. It is also hoped to discuss the issue with Joe Johnson, MP for Orpington.

vi. Mr Warn:

Q9. The CQC had issued a "scathing "report on the Trust. Why has this not been included on the Agenda for this meeting?

A. The CQC report was not received in time for its inclusion on this agenda. It will be discussed throughout the agenda.

vii. A member of the public

Q10. A member of the public enquired whether the management overheads for the new provider of non emergency patient transport made that contract more expensive and whether the fact that operatives required training implied that they were undertrained for the jobs they were being asked to do.

A. The costs will be discussed under the agenda item. Training for contractors is consistently provided within a clinical setting, as we recognise that we need to ensure that our services reflect patients' needs.

viii. Mr Colin Streete

Q11. Last year, Princess Royal University Hospital gained Acute Stroke Unit accreditation. A Hyper Stroke Unit was due to open in late November why had the Hyper Stroke Unit had not yet opened?

A. The decision on when the Trust is ready to commence operation rests with the London Accreditation Team. A peer review of the service was undertaken by the Royal College of Physicians in December. The Hyper Acute Stroke Unit needs to be visited by the London Cardiac Network team. Whilst no visit has yet been scheduled, the Trust is ready for inspection. Five stroke doctors will have increased training in clot busting treatment. Whilst the London rules do not require 2 CT scanners, this was recommended by the peer review team. 6 beds will be opened to start with, with a full complement in October of this year.