Barking, Havering and Redbridge NHS
University Hospitals
NHS Trust

TRUST BOARD MEETING
Tuesday, 29 March 2011 at 1.00 pm
Lecture Theatre, James Fawcett Education Centre
King George Hospital

A G E N D A

1. Apologies for Absence

2. Minutes of the meeting held on 25 January 2011 (Attachment A)

3. Matters Arising and Actions

4. ***STRATEGY:***
   - 4.1 Interim Chair & Chief Executive's Report (ED/AD) (Attachment B)
   - 4.2 Health4NEL Update (RR) (Verbal)

5. ***GOVERNANCE:***
   - 5.1 Board Assurance Framework (MS) (Attachment C)
   - 5.2 Safeguarding Children Annual Report 2010 (DCW) (Attachment D)
   - 5.3 Declaration of Compliance for Same Sex Accommodation (DCW) (Attachment E)

6. ***CLINICAL:***
   - 6.1 Emergency Care Report (NM) (Attachment F)

7. ***QUALITY, PATIENT STANDARDS and FINANCE:***
   - 7.1 Quality and Patient Standards Performance Report – February 2011 (NM/DCW/RMcA) (Attachment G)
   - 7.2 Income & Expenditure Budgets/Operating Plan 2011/12 (DIW) (Attachment H)
   - 7.3 Workforce Key Performance Indicators (RMcA) (Attachment I)
   - 7.4 Finance Report for period ending 28 February 2011 (DIW) (Attachment J)
   - 7.5 Reference Costs Score 2009/10 (DIW) (Attachment K)

8. ***INFRASTRUCTURE:***
   - 8.1 BHRUT Staff Survey (RMcA) (Attachment L)
   - 8.2 External visits to the Trust (IS) (Attachment M)
   - 8.3 International Nurses Day 12 May 2011 (DCW) (Attachment N)

9. ***INFORMATION***
   Matters for Noting:
   - 9.1 Minutes of the Strategic Partnership Board meeting held on the 29 November 2010. (Attachment O)
   - 9.2 Minutes of the Charitable Funds Committee meeting held on the 7 December 2010. (Attachment P)

10. Draft Agenda for May 2011 Trust Board Meeting and Rolling Programme for 2011 (Attachment Q)

11. Any Other Business

    Date of Next Meeting: The next public meeting will be held on Tuesday, 31 May 2011 at 1.00 p.m. in the Board Room, Trust Headquarters, Queen's Hospital.

12. Questions from the Public

13. Exclusion of the Public and Press In accordance with the Public Bodies Admission to Meetings Act), to resolve to exclude members of the public and press from the remainder of the meeting.

Barking, Havering and Redbridge NHS
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Minutes of the Part I Trust Board Meeting held on the 25 January 2011 in the Board Room, Trust Headquarters, Queen's Hospital

Present:	Mr Edwin Doyle	Interim Chair
	Ms Deborah Wheeler	Acting Chief Executive/Director of Nursing
	Mr Stephen Burgess	Acting Medical Director
	Mr William Langley	Non-Executive Director
	Mrs Barbara Liggins	Non-Executive Director/Vice Chair
	Mrs Ruth McAll	Director of Human Resources & OD
	Mr Keith Mahoney	Non-Executive Director
	Mr Neill Moloney	Director of Delivery
	Prof Ray Playford	Non-Executive Director
	Mr Robert Royce	Director of Strategy & Planning
	Mr George Wood	Non-Executive Director
	Mr David Wragg	Director of Finance
In Attendance:	Ms Imogen Shillito	Director of Communications
	Mrs Carol Drummond	Divisional Director, Women & Children's Division, Director of Midwifery
	Mrs Sue Williams	Executive Assistant/Trust Board Secretary
	Mrs Averil Dongworth	Chief Executive (Designate)

Mr Doyle started the meeting by confirming that Ms Wheeler had been appointed as the Acting Chief Executive and SRO for the Trust and would be in post until the arrival of the new Chief Executive, Averil Dongworth, who would officially take over her role on the 1 February 2011. Mr Doyle thanked Ms Wheeler for taking on this responsibility, which covered the Christmas and New Year period and the current month. He also confirmed that Mr Stephen Burgess had agreed to take on the responsibility of Acting Medical Director until further notice.

Mr Doyle welcomed the new Chief Executive, Averil Dongworth, to the meeting and asked the Board to agree for her to enter into discussions during the meeting, but not to be party to any decisions agreed by the Board. This was endorsed by all Board members.

2010/080 APOLOGIES FOR ABSENCE

Mr Michael White, Non-Executive Director.

2010/081 MINUTES OF THE PART I MEETING HELD ON 30 NOVEMBER 2010

The minutes of the meeting were noted as a true record and signed by the Interim Chair.

2010/082 MATTERS ARISING

It was noted by the Board that they had not received the short paper on the work being undertaken in the redesign of the workforce and the rotas, as well as the focus work within the seven Workstreams being monitored by the Emergency Care Taskforce, in relation to the Implementation Plan for improving the Trust's Emergency Care pathways**.** Mrs McAll and Mr Moloney would arrange for this paper to be prepared and forwarded to all members of the Board, prior to the next meeting.

In relation to agenda item 2010/031, Ms Wheeler would rearrange this training once the Designated Nurse for Havering returned from sick leave.

Mrs McAll confirmed that the Trust Pledge to all staff, agenda item 2010/061, would be discussed at the next Workforce Committee meeting.

Mr Langley confirmed that the Audits mentioned in agenda item 2010/064 would be analysed and a decision made on the best place for them to be reviewed.

2010/070; Mr Wragg would complete the 'due diligence' on the Research & Development Department Business Case and agree if it should be presented to the Finance Committee, or the Trust Board, for approval.

It was noted by the Board that the Trust's Hospital Standardised Mortality Ratio (HSMR) as at December 2010 was 102. The Quality & Strategy Committee would monitor the Trust's HSMR performance and report back to the Trust Board at their March 2011 meeting.

Action: Ruth McAll/Neill Moloney 22.2.11
Stephen Burgess 29.3.11

2010/083 INTERIM CHAIR & CHIEF EXECUTIVE'S REPORT

Mr Doyle and Ms Wheeler provided a verbal update to the Board.

Mr Doyle reported that the Trust had been very busy over the last couple of months and as a result he felt that the organisation remained inwardly focused dealing with priorities, as a result of the recent pressures and period of change. The Trust needed to think through its strategy going forward in relation to external influencers, e.g. Patient Groups, Strategic Partners and the Strategic Health Authority and he would personally get this work back on track.

Ms Wheeler referred to the Emergency Care performance and the pressures over the Christmas period. She informed the Board that the Trust had been under pressure again this week, resulting in significant pressure within the department and work continued to get the flows going through the hospitals. It was noted by the Board that the Department of Health Intensive Support Team was now working with the Trust on the Emergency Care pathway, to provide some benefits in this area.

The incidents of swine flu had diminished within the organisation and as of yesterday the Trust had seven patients, two in ITU, which was significantly fewer than over the Christmas period. Whipps Cross NHS Trust had reported a significant outbreak of Norovirus in their hospital, but no cases had been reported at Queen's, although one had been confirmed at King George Hospital last week.

Ms Wheeler also informed the Board that the Care Quality Commission had made two unannounced visits to the Trust last week and were in the Trust again today. They were looking at the condition around midwifery staffing levels.

The Board was informed that the External Auditor, under Section 8 of the Audit Commission Act 1998, had submitted a Report in the Public Interest to the Secretary of State, as the Trust had failed to meet its statutory financial duty to achieve cumulative breakeven over the five year period ending 31 March 2010.

2010/084 HEALTH FOR NORTH EAST LONDON UPDATE

Mr Royce presented the Board with the briefing provided by the Health for North East London Programme Team for all Trust Boards in the Sector. He confirmed that a joint meeting of JCPCTs had taken place on the 15 December 2010, where they had considered the proposals for urgent and Emergency Care, Maternity, Children's Services and the vision for King George Hospital. Mr Royce reported that all the proposals had been approved at that meeting. Implementation work was now moving forward. Mr Royce informed the Board that it was extremely likely that the proposals would be referred to an Independent Reconfiguration Panel (IRP) and would therefore go into suspension until the IRP had considered them and reported to the Secretary of State. The IRP process would probably begin around March/April of this year, with the report to the Secretary of State being submitted in the Summer, and a decision made some time thereafter.

The Trust would now start preparing the evidence to be presented to the IRP and commence the work on the practical implementation of what was required to action the proposals agreed. Mr Royce informed the

Board that the Trust had a meeting with the Health for North East London team next week to discuss implementation issues and he agreed to keep the Trust Board updated on developments.

In answer to Mr Mahoney's concerns regarding delays to service configuration, Mr Royce confirmed that the Breast and Vascular reconfiguration was going ahead and would be completed by March of this year. The other service change not affected by the IRP was the establishment of a co-located Midwifery Led Unit at Queen's. The Board acknowledged that other changes around the King George site were obviously within the IRP process.

The Trust Board noted the report.

2010/085 BOARD ASSURANCE FRAMEWORK QUARTER 2 FOR THE PERIOD BETWEEN JULY – SEPTEMBER 2010

Mr Burgess presented the Board with the background to the establishment of the Board Assurance Framework, the proposed changes and the extreme risks taken from the Risk Register, in relation to Quarter 2. The Board was asked to consider and reach a decision on the points described in item 3.0 and to note the content of the Framework.

The Interim Chair asked the Board to agree that 'extreme - catastrophic' was 'multiple death' and 'extreme – major' and 'high' was 'death'. This would recognise the difference between a single flu victim death and multiple deaths from a terrorist attack. Mr Burgess would arrange for these changes to be checked against the NPSA guidelines and to make sure that the Trust's Risk Management Team was clear on how these risks were reported and correctly mapped. The Board accepted that they would receive risks rated at 15 and above, which was 60 on the scoring system used. Anything below 15 would be monitored by the Divisions. The Board members agreed that it was their responsibility when making an assessment of risk to review the table and if a risk was not represented, they should identify this to the Board. The Board also agreed that it was important to have the right culture within the organisation for staff to feel comfortable in reporting risks. Based on anecdotal evidence, Ms Wheeler did not feel that this was the case and the message that the Board encouraged the reporting of risks would need to be well communicated to staff in the organisation and asked the Director of Communications to undertake this work. Mrs McAll reported that the recent staff survey results showed that there had been an incremental improvement in this area.

The Board noted that there was no mitigating action included in the paper regarding risk 216 relating to the Radiotherapy KGH Gamma camera and associated equipment overdue for replacement, which had been rated as high at 64. Mr Royce confirmed that he was taking forward a Business Case in relation to this issue. The Board acknowledged that this reported risk was the responsibility of the Clinical Support Services Division, as it was a Radiotherapy issue. The Interim Chair asked the Acting Medical Director to review this to see if it should appear in the Risk Register and why it had been rated at 64.

The Trust Board considered and agreed on the points described in item 3.0 and noted the content of the Framework.

Action: Stephen Burgess 8.2.11

2010/086 RISK MANAGEMENT STRATEGY AND POLICY

Ms Wheeler presented the Risk Management Strategy and Policy and highlighted to the Board that the policy had been through a thorough review process led by the Risk Management Team to ensure it met the NHSLA Risk Management Strategy Checklist, and changes relating to practice, legislation or national guidance. It had been presented and approved by the Clinical Governance Committee. She confirmed that there had been no changes to the processes and risk management structure outlined in the 2009 Risk Management Strategy & Policy. Discussions were held around the risk grading matrix and it was agreed that the Trust would report any items on the Risk Register identified as being higher than 15 on the 5x5 matrix.

The Trust Board reviewed and approved the Risk Management Strategy and Policy.

2010/087 CARE QUALITY COMMISSION CONDITIONS

Ms Wheeler provided the Board with an update on the current position and confirmed that the variation forms and supporting evidence requested by the end of December 2010 had been submitted. The Trust was currently waiting to hear regarding the removal of its three conditions. A further submission, at a cost of £5,000, had been made to the CQC to vary the Trust's registration to include family planning as a registered activity at Queen's Hospital, as this had been omitted from the original registration. The cost of any submissions would now be charged at £2,000, as the initial free period had expired. Work on staff appraisals, pressure damage and resuscitation training had already started for this year and a programme was in place and on course. All staff appraisals were being captured and up to date information was available for the Divisions to review on a regular basis.

Mr Wood raised the issue of performance management and asked to review data to see how many people within the Trust were being performance managed. The Director of Human Resources confirmed that this information had been presented at the Workforce Committee, but if it was not in the format required, she would be happy to discuss this further with him. Mrs McAll indicated that there was also a section in the Workforce Key Performance Indicators paper on performance management.

The Trust Board noted the report and the outstanding requirement to submit the evidence in relation to Resuscitation Training by the 31 January 2011.

2010/088 EMERGENCY CARE UPDATE

Mr Moloney reported that it had been a challenging month and the Trust had on two occasions declared Internal Major Incidents, which reflected the level of pressure within the A&E departments. In response to this the Trust had cancelled non urgent activity, redeployed staff to support discharging patients and opened up additional bed capacity. The Trust had received a good response from the community with the opening of additional beds and GPs offering to come in and work in the A&E departments. The Independent Sector Treatment Centre (ISTC) had also supported the Trust in taking some of the urgent elective work. Mr Moloney informed the Board that one de-brief session on the Internal Major Incidents had taken place, in order to learn from these and to look at identifying other things the Trust could have done to prevent them being declared. He would pull all of this together in a final report over the next month and present it at the next Trust Board meeting.

As previously mentioned the Department of Health's Intensive Support Team had agreed to provide their support. Mr Moloney was reviewing the governance arrangements within the Emergency Care Quality Improvement Programme (ECQIP) and was looking to reduce the number of Workstreams and to focus on the actions around clinical redesign. He would include an update on this in his report next month.

Mr Moloney reported that due to the acute pressures during the first week of January the Trust had, following a conversation with the Care Quality Commission, admitted a number of patients into treatment rooms. The CQC was provided with the Trust's full risk assessment and patients' were moved within 48 hours. The Board noted that there was an agreed London Ambulance Service policy in place to follow in the case of re-direction of ambulances, should this be necessary. The implementation of revised job plans within the Medicine Division would be in place by 1 April 2011 and this would provide some additional Consultant support over the weekend. In order to demonstrate the level of pressure in the Emergency Care Department over the Christmas period, Mr Moloney would send out information to all Board members, before the next meeting, on the level of admissions and discharges.

It was noted that the subject of the high turnover of staff in the Emergency Care Department and the management team's view in the Division that they felt restricted to only recruiting to vacancies was discussed at the Workforce Committee. Mr Moloney confirmed that they had been given authorisation to recruit as many staff as they could within that department and he would talk to the team outside of this meeting.

Mr Wood remarked that it was commendable the way people had worked together during this time of acute pressure, but the Trust had now run for twenty weeks below the 95% target, which indicated it might not have the right people working on the Emergency Care strategy and should the organisation consider bringing in an A&E specialist. It was agreed that the new Chief Executive would assess the management of A&E and the strategy and also consider an Independent Review when she took up her role in February. The Chief Executive (Designate) highlighted to the Board that the Trust needed to get on top of this area as soon as possible, bearing in mind that from April 2011 the current target would be replaced with a new standard. There needed to be some radical changes made, as well as delivering on the financials, and she would be looking at the root causes and looking to do things differently with the resources available.

The Board agreed that the discharges before 12 noon were woefully below the target set. This was a process issue, not a clinical issue, and the Trust should be able to meet this target. The whole hospital needed to work towards achievement of this target and the Board agreed that this should be communicated to all staff. It was important for prescriptions to be written up by clinicians well before the discharge date and for the Divisions to change the culture of how the wards were being run.

The Trust Board noted the content of the report and supported the actions to bring the performance back in line with target and agreed that the Board should receive monthly reports.

Action: Neill Moloney 22.2.11/29.3.11 and monthly thereafter

2010/089 MATERNITY REPORT 2011

Mrs Drummond presented to the Board on the current birth trends, the proposed reconfiguration of maternity services, workforce and clinical challenges, external scrutiny and the next steps for 2011/12. She highlighted to the Board that the projected birth rate for 2010/11, based on the first nine months, was 10,100 (the year to date delivery rate had increased by 2.5%). The Health for North East London Programme Team was predicting a significant increase in births over the next five years. The Board noted the Maternity Campus Model and the Maternity Model of Care presented by Mrs Drummond.

The biggest workforce challenges were around midwifery and although funding had been resolved, recruitment remained a significant challenge. A recent survey across London had assessed the local needs of BHRUT to be a midwife to birth ratio of 1:29. Based on the projected level of births for 2010/11 quoted above, to maintain the 1:29 ratio the Trust would need to increase the midwifery workforce by sixteen whole time equivalents. Recruitment remained difficult and despite this being ongoing, with innovative approaches being undertaken, the vacancy rate remained high. Mrs Drummond informed the Board that the team had worked extremely hard to achieve a reduction from a 17% vacancy rate in July 2010 to the current position, including commencement of recent recruits, to 11% for midwifery. The retention and turnover of staff for Band 6 midwives was on average 12% in the NHS, but BHRUT was 5.8%. Professor Playford mentioned that perhaps the Trust should consider offering bursaries to students, or recommending a friend proposed by Mrs Liggins. Mrs Drummond confirmed that they did not have any problem recruiting newly qualified midwives, the issue was the more experienced ones and informed the Board that the Trust was already sponsoring midwives whilst undertaking their Masters Degrees. It was agreed that these proposals from the Non-Executives would be considered by the Workforce Committee. Mrs Drummond also informed the Board that the external scrutiny had included a review commissioned by ONEL, two unannounced visits by the Care Quality Commission, with more expected, a Deanery review and a maternity survey.

Mrs Drummond informed the Board that the Division had a Maternity Taskforce to oversee all of the above Workstreams and an Action Plan was in place to monitor these and report exceptions through to the Productivity, Efficiency & Quality Board (PEQ). The Director of Strategy & Planning also attended the Maternity Taskforce meetings. The Interim Chair proposed that a link through to the Board Committees needed to be established, in order for the Trust Board to receive assurance and know that the Plan was being implemented. The Chief Executive (Designate) would review this with the Executive Team and Non-Executive Directors when she took up her post.

Mrs Drummond was working with the Director of Nursing to establish 'real time' surveys in Maternity. The implementation programme for 'real time' surveys had commenced two weeks ago and was being rolled out into five departments a week. Ms Wheeler would arrange for all Board members to receive a copy of the Implementation Plan. In relation to sickness absence, maternity remained an outlier and Mrs Drummond confirmed that the Division was dealing with this as a priority and it was at the top of the list in respect of next steps for 2011/12.

The Trust Board thanked Mrs Drummond for her update and reiterated that the Division had the full support of the Board and agreed for the Business Case to be presented at the next Trust Board meeting.

The Trust Board noted the update on Maternity Matters, Clinical Governance, Recruitment, Partnership Working and Activity.

Action: Carol Drummond 22.2.11

2010/090 QUALITY AND PATIENT STANDARDS PERFORMANCE REPORT – DECEMBER 2010

Mr Moloney highlighted three areas contained in the report; three cases of MRSA had been reported in December bringing the total to eleven cases. Two more cases had already been reported in January, so the Trust was now recording thirteen. Two of the cases in December and one in January were the same patient and the Board noted that the Trust was having discussions with the Health Protection Agency as to whether these had to be counted as three or one. The biggest issue was the identification of patients who were known to have previously been positive. Mr Moloney confirmed that non elective screening had commenced in early December 2010.

The Cancer targets had been achieved in December and the Trust was currently focusing on January, February and March this year to see if a good performance over the three months would bring the 62 day performance for the end of the year up to target. There would need to be a considerable improvement and a huge amount of work to do this.

Delayed Transfers of Care had reduced considerably, with Japonica Ward being managed by the Community as a DTOC ward. Additional capacity had also been opened in the Community to maintain this lower figure, although not meeting the 1% target set, it was the lowest the Trust had seen for a considerable time.

As previously reported at the last Board meeting, the Trust's HSMR in 2008/09 was 111, but improved in 2009/10 to 102. Rebasing the 2009/10 Trust HSMR against the national position for that year resulted in a figure of 115. Other organisations had improved at a significantly faster rate than the 9 point improvement achieved by BHRUT and the Trust identified three coding issues as the cause of the Trust's adverse HSMR; perinatal deaths, co-morbidities and palliative care. Mr Moloney reported that some organisations had been reporting between 20-30% as palliative care, with the Trust only coding 3-4%. The Board noted that there would be changes to the way the HSMR was calculated in the future and it was important for the Medical Director to ensure correct coding, to improve quality and to have the right processes in place. The HSMR for the Trust as at December 2010 was 102 and it was not expected to change when rebasing this year, resulting in a better performance by the end of this year.

The Trust Board noted the content of the report and supported the actions to bring the performance back in line with trajectory/target.

2010/091 WORKFORCE KEY PERFORMANCE INDICATORS

Mrs McAll highlighted key areas within the Workforce Key Performance Indicators report. Benchmarking BHRUT's performance against other Trusts of a similar size, had shown that the stability of the workforce had improved. Overall sickness rates had vastly improved from twelve months ago. During October, November and December 2010 the Trust had seen the first rise in sickness absence rates for four months on the September rate of 3.73%. Mrs McAll mentioned that as a consequence of establishing the In-House Bank, the Trust had improved its fill targets and costs. Following Mr Wood's comments regarding employer relations, Mrs McAll confirmed that during 2010 the Trust had dealt with and closed in the region

of 140 employee relation issues and cases. A significant number of these had been long outstanding. Some complex and quite intricate cases remained open and a total of 72 cases were currently being formally managed.

For areas such as A&E where vacancy and turnover 'hotspots' were a real issue and significantly contributed to temporary staff spend, the Workforce Committee had focused their discussions on mitigating actions to address the gap, such as recruitment strategies and in particular whether Divisions should be able to over recruit and to what level to address the high levels of turnover and poor staff retention that had been identified. The Board agreed that bank and agency should be presented separately, as they had different financial and quality implications. A lot of work had been undertaken in relation to bank and agency to enable weekly data to be provided to Divisions in advance of bookings. This data also informed the Divisions how many staff they had ordered and could be used to drill down to see the detail behind each booking. The Board agreed that it was important to establish what was happening in each Division/Directorate to ensure that they were working to their establishments and Workforce Plans. Ms Wheeler would start the discussions at the PEQ meeting this week, so everyone was aware of the processes involved, aligned to the financial constraints.

The Focus Group established by the Finance Committee to look at bank and agency staff used in A&E had agreed that it was a fundamental problem in that area. The Board agreed that this piece of work would now be subsumed into the Workforce Committee.

The Trust Board noted the report.

Action: Deborah Wheeler 26.1.11

2010/092 FINANCE REPORT FOR PERIOD ENDING 31 DECEMBER 2010

Mr Wragg reported that the financial position was extremely difficult, as all major categories of expenditure against budget had worsened and there had been an adverse movement in month. The plans for month 9, with a reduction in expenditure and additional Cost Improvement Programmes (CIP) coming through, had not been delivered. All Divisions had either worsened marginally or substantially and the income and expenditure position was very difficult indeed. The income position had not improved to anything like that expected and the position at the end of December showed a net deficit of £27m, which represented an £11m adverse variance against the profiled plan and exceeded the annual plan deficit of £19.9m. In month there was a deficit of £2.9m, against a plan of £1.4m, giving an adverse variance of £1.5m in the month. Overspend on pay of £1.1m, non-pay of £1.1m and unidentified CIP had continued.

Mr Wragg reported that the Trust's most optimistic projection for the year end was £31.4m, but with income accounting for the best part of £2m and high risk CIPs of £2m, it took the figure closer to £36m. The Board was therefore being asked to consider a whole range of options, which some members of the Executive Team had discussed at a meeting with NHS London and ONEL Sector and at the Finance Committee meeting earlier in the day and had agreed to forward them a paper outlining the Trust's proposals by Friday of this week. Mr Wragg reported that the Trust had agreed a revised year end outturn deficit position of £30m with NHS London, on which basis they had agreed to £30m cash support. It had been agreed at the Finance Committee meeting that the Trust could not afford to go into next year storing up problems, this was completely unacceptable. Also unacceptable was any risk to patient care.

The Executive Team would now need to focus on areas, particularly temporary/agency staff, and redouble their efforts to have a range of saving schemes in place, without impairing services, to meet the revised control total. It was made clear that this was a Board decision, not an Executive Team decision and they needed to get the Board's acceptance to their proposals.

It was agreed that Mr Wragg would arrange for all Board members to receive a Draft Plan setting out what could be delivered, including the total amount and the impact/consequences of any decisions, by the end of this week. It was proposed that a further Board meeting would be called at short notice for next week to review and approve the Plan before being forwarded to NHS London and the Commissioners.

The Board noted the report.

Action: David Wragg 28.1.11

2010/093 MATTERS FOR NOTING: MINUTES OF THE CLINICAL GOVERNANCE MEETING HELD ON 16 NOVEMBER 2010
The Trust Board noted the minutes of the Clinical Governance meeting held on the 16 November 2010.

2010/094 MATTERS FOR NOTING: MINUTES OF THE STRATEGIC PARTNERSHIP BOARD MEETING HELD ON 27 JULY 2010
The Trust Board noted the minutes of the Strategic Partnership Board meeting held on the 27 July 2010.

2010/095 MATTERS FOR NOTING: MINUTES OF THE CHARITABLE FUNDS COMMITTEE MEETING HELD ON THE 26 OCTOBER 2010
The Board noted the minutes of the Charitable Funds Committee meeting held on the 26 October 2010.

2010/096 MATTERS FOR NOTING: BHR HOSPITALS CHARITY ANNUAL REPORT & ACCOUNTS 2009/10
The Board noted the BHR Hospitals Charity Annual Report & Accounts for 2009/10.

2010/097 MATTERS FOR NOTING: DRAFT AGENDA FOR MARCH 2011 TRUST BOARD MEETING AND ROLLING PROGRAMME FOR 2011
The Board noted the draft agenda for March 2011 Trust Board meeting and the rolling programme for 2011.

2010/098 ANY OTHER BUSINESS
Following Professor Playford's comments regarding flu vaccinations for staff, Mrs McAll confirmed that the Trust had completed its staff vaccination programme.

Meeting closed at 3.15 p.m.

The next meeting of the Barking, Havering and Redbridge University Hospitals NHS Trust Board will take place at 1.00 p.m. on Tuesday, 29 March 2011 in the Lecture Theatre, James Fawcett Education Centre, King George Hospital.

Barking, Havering and Redbridge NHS
University Hospitals
NHS Trust

CONFIDENTIAL

TRUST BOARD MEETING

Actions from Minutes of Part I meeting held on 25 January 2011
in the Board Room, Trust Headquarters, Queen's Hospital

Agenda Item		Action	Deadline Date	Date Completed/ Update/ Agenda Item
2010/031	DCW to arrange Safeguarding Children training at the October or December Trust Board meeting.	DCW	26.10.10 or 14.12.10	14.12.10 (deferred, to be rearranged)
2010/063	DCW to prepare an implementation paper and circulate to all Board members.	DCW	Jan 2011	March 2011
2010/082	RMcA/NM to forward a short paper, prior to the next Board meeting, to all Board members on the work being undertaken in the redesign of the workforce and the rotas, as well as the focus work within the seven workstreams being monitored by the Emergency Care Taskforce, in relation to the Implementation Plan for improving the Trust's Emergency Care pathways.	RMcA/NM	22.2.11	29.3.11
2010/085	SB to review if risk 216 should appear on the Risk Register. SB to provide an update on HSMR at the March Trust Board meeting.	SB SB	8.2.11 29.3.11	8.2.11 Deferred to April 2011
2010/088	NM to prepare a paper on the Internal Major Incidents in January 2011, including the feedback from the de-brief sessions. NM to forward information to all Board members, before the next meeting, on the level of admissions and discharges over the Christmas period.	NM NM	22.2.11 22.2.11	22.2.11 22.2.11
2010/089	CD to present the Business Case on the reconfiguration of Maternity and Neonatal Services at the February Trust Board meeting.	CD	22.2.11	22.2.11
2010/091	DCW to initiate discussions at PEQ meeting to ensure Divisions/Directorates are working to their establishments and Workforce Plans and that everyone is aware of the processes involved, aligned to the financial constraints.	DCW	26.1.11	26.1.11

Agenda Item		Action	Deadline Date	Date Completed/ Update/ Agenda Item
2010/092	DIW to forward a draft plan to all Board members by the end of the month, setting out the financial schemes that can be delivered, including the total amount and the impact/consequences of any decisions.	DIW	28.1.11	2.2.11
	Interim Chair ……. Date ……..			

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Interim Chair & Chief Executive's Report	Trust Board
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
To keep the Board informed of topical, legal and regulatory issues. To also update the Board on National and Local News/Issues.	□ **PEQ** …… □ **STRATEGY**…… □ **FINANCE** …… □ **AUDIT** …… □ **CLINICAL GOVERNANCE** …… □ **CHARITABLE FUNDS** …… □ **TRUST BOARD** …… □ **REMUNERATION** …… □ **OTHER** …… (please specify)
2. DECISION REQUIRED:	**CATEGORY:**
The Trust Board is asked to note the report.	□ **NATIONAL TARGET** □ **CNST** □ **CQC REGISTRATION** □ **HEALTH & SAFETY** □ **ASSURANCE FRAMEWORK** □ **CQUIN/TARGET FROM COMMISSIONERS** □ **CORPORATE OBJECTIVE** …… □ **OTHER** …… (please specify)
	AUTHOR/PRESENTER: Averil Dongworth
	DATE: 18 March 2011
3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
None.	
4. DELIVERABLES	
N/A	
5. KEY PERFORMANCE INDICATORS	
N/A	
AGREED AT _____ **MEETING** **OR** **REFERRED TO:** _____	**DATE:** _____ **DATE:** _____
REVIEW DATE (if applicable) _____	

Barking, Havering and Redbridge University Hospitals NHS Trust

REPORT TO: Trust Board

REPORT FROM: Chief Executive

DATE: 18 March 2011

SUBJECT: CHIEF EXECUTIVE'S REPORT

FOR: Information

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1. INTRODUCTION

This report contains a summary of:

- Actions taken under emergency powers
- Executive decisions
- National Issues/News
- Local Issues/News

2. RECOMMENDATION

The Board is asked to note this report.

3. ACTIONS TAKEN UNDER EMERGENCY POWERS

No actions have been taken by the Chairman or Chief Executive acting under emergency powers.

4. EXECUTIVE DECISIONS

The Trust Executive have been meeting on a weekly basis and have reviewed and inputted into several reports prior to their submission to the Trust Board, such as the Integrated Performance Report, Operating Plan 2011/12, Finance Report for period ending 28 February 2011 and the Staff Survey.

5. **NATIONAL ISSUES/NEWS**

Health Visitor Implementation Plan 2011/15:
The Health Visitor Implementation Plan 2011/15 was recently published. It confirms the Government's intention to recruit an extra 4,200 health visitors by 2015 – a 42% increase on current numbers. The Plan is supported by a letter from David Flory and Dame Christine Beasley, Chief Nursing Officer.

Eliminating mixed sex accommodation:
The 2011/12 NHS Operating Framework requires all providers of NHS funded care to publish a declaration on or by 1 April 2011 that they are compliant 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. All providers must have plans in place to deliver this commitment and the declaration should be accompanied by a commitment to audit data quality and publish the results.

A&E Clinical Quality Indicators:
A&E clinical quality indicators replace the four-hour waiting time standard from April 2011, aiming to provide a balanced and comprehensive view of care quality.

Care and Compassion – A letter from David Nicholson about the report of the Health Service Ombudsman into NHS care for older people:
On 15 February, the Parliamentary and Health Service Ombudsman published a report on investigations into NHS care of older people. The report raised important issues which emphasise that patients should receive the highest quality of care. David Nicholson's letter draws attention to this report and urges NHS Chairs to learn from its findings and share it with board members. The letter also emphasises the need to act on patient feedback and clarifies the importance of treating all patients with dignity, respect and professionalism.
www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_124343

Equity and Excellence: Liberating the NHS – Managing the Transition:
Sir David Nicholson has published a letter to all NHS Chief Executives, providing an update on transition arrangements, with a particular focus on the new commissioning system and provides answers to some frequently asked questions on the Health and Social Care Bill.
Link:
www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_124440

The guidance on Retention and Exit Terms scheme has been developed to help retain staff fulfilling business critical roles during the transition and will be published on the Social Partnership Forum website.

Benchmarking tool for setting CQUIN patient experience goals:
To support the NHS in setting CQUIN goals for patient experience in 2011/12, the Department of Health, together with the Care Quality Commission and its coordination centre, will make available early results of the annual inpatient survey. The results are available as part of a benchmarking tool sent recently to SHA/CQUIN/Patient Experience Leads. A link to information on the benchmarking tool can be found under the Latest Resources heading on the NHS Institute for Innovation and Improvement webpage - (www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html)

National One Week: Prevalence Audit of MRSA Screening:
Led by UCL, a national voluntary audit of MRSA screening will take place on 9-15 May 2011. Infection Control teams for all acute NHS Trusts have been asked to return a questionnaire giving data on areas such as numbers of patients newly identified with MRSA following admissions, or elective screens.

New Chief Medical Officer Announced:
Professor Dame Sally Davies has been named as the Chief Medical Officer (CMO) for England, the first woman to hold the post.

As CMO, one of Dame Sally's responsibilities will be to chair a public health system advisory board, bringing the public health service together with the NHS Commissioning Board and local government.

New Year 2012 Honours Round:
The Permanent Secretary has written to Chief Executives of Strategic Health Authorities, NHS Trusts, PCTs, NHS Foundation Trusts, Arms Length Bodies and Directors of Adult Social Services (England) inviting them to nominate candidates for consideration at the next honours round (New Year 2012).

When considering names to put forward, respondents are asked to pay particular attention to candidates who have:-

- Worked to strengthen communities in deprived areas
- Organised community and neighbourhood groups/events
- Provided voluntary contributions such as fundraising

The Prime Minister has emphasised the importance of supporting the Big Society. Its purpose is not only to build a bigger, stronger society where individuals as well as communities can do more for themselves, but is also a space in which cultural change can take place. Closing date for nominations is Monday,11 April 2011.

Venous Thromboembolism (VTE) Leadership Summit – 30 March 2011:
VTE prevention is a clinical priority for the NHS for 2010/11, accounting for an estimated 25,000 deaths a year in hospitals in England, many of which are avoidable. VTE prevention is also cost effective; NICE estimates that millions of pounds can be saved annually to the NHS by effective VTE prevention. This high level summit will provide national leadership on delivering the national VTE prevention programme.

The functions of GP Commissioning Consortia:
The DH, working in partnership with the Royal College of GPs, NHS Alliance, National Association of Primary Care and Family Doctor Association, has developed a working document describing the proposed statutory functions of GP consortia. The document sets out the proposed key statutory duties of consortia, the proposed key statutory powers (the things consortia have the freedom to do, if they wish, to help meet these duties) and illustrative examples of what this could look like in the future. The document is not intended to be a substitute for the Health and Social Care Bill, but a helpful summary to which GPs and emerging consortia can refer.

Continued Government support for people with learning disabilities:
On 4 March 2011, Paul Burstow MP, Minister for Care Services, announced continued government support to improve the lives of people with learning disabilities. This includes extending contracts for the Learning Disabilities Confidential Inquiry and Public Health Observatory to March 2013.

Investment for Research in the NHS:
Health Secretary Andrew Lansley has announced £775million in funding for biomedical research centres and units, to be made available through the National Institute for Health Research.

Publication of Organisation Patient Safety Incident Data:
On 2 March 2011, the National Patient Safety Agency (NPSA) published the latest Organisation patient Safety Incident data. High levels of incident reporting provide an indication of an increased safety culture within the organisation.
Link: www.nrls.npsa.nhs.uk/patient-safety-data/organisation-patient-safety-incident-reports

Maintaining and improving quality during the transition:
The DH has published the first report in a two-phase review about maintaining and improving quality during the transition and beyond. Building on the February 2010 Review of Early Warning systems in the NHS, it emphasises how quality must remain the guiding principle as

organisations move to implement NHS modernisation, and is clear that healthcare professionals are ultimately responsible for the quality of care provided to patients. Focusing on 2011/12, it describes the key roles and responsibilities for maintaining and improving quality; suggests practical steps to safeguard quality during the transition; and emphasises the importance of the effective handover of knowledge and intelligence on quality between old and new organisations. For further information to maintaining and improving quality during the transition: *safety, effectiveness, experience* – www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125234 and 125238.

Third party assurance for NHS Trusts' Quality Accounts 2010/11:
Following a similar exercise for NHS Foundation Trusts in 2009/10, the DH has asked the Audit Commission to hold a dry-run external audit of NHS Trusts Quality Accounts 2010/11. For reference, the Audit Commission has prepared a briefing summarising the findings from Foundation Trust's 2009/10 Quality Accounts audits.

NHS Litigation Authority Industry Review:
The DH has commissioned Marsh to undertake an industry review of the NHS Litigation Authority (NHSLA) focusing on the delivery of risk pooling functions, the upward trend in scheme liabilities, and opportunities to introduce wider commercial management into the NHSLA.

Diagnostic Testing for Clostridium Difficile Infection:
Dame Christine Beasley, Chief Nursing Officer, has written to remind staff of the current advice to the NHS on testing for C.difficile infection (CDI) to ensure they are aware of the programme of work the DH has commissioned to support improvements in CDI testing.

6. LOCAL ISSUES/NEWS

BHRUT Maternity Services:
Following a visit by Inspectors to the Maternity Unit at Queen's Hospital, the Care Quality Commission (CQC) found the Trust was not taking all proper steps to ensure the safety of women in the maternity unit and a Warning Notice was issued.

Inspectors found that the maternity unit was often understaffed and that some staff were carrying out tasks for which they did not feel appropriately skilled, putting women and babies at risk.

They also found that the hospital was not following some of its own guidelines for planning and providing safe care, such as timescales for transferring women from the antenatal ward to the labour ward. Some equipment necessary for the safe care of women and their babies, such as machines for monitoring contractions, was found to be unavailable, poorly maintained, or not working.

CQC said the Trust must fully address the first two of these issues by 30 March and address the equipment problems by 15 April. If the Trust fails to comply, the next steps may include prosecution, or restriction of services.

NHS Staff Survey Results:
The 2010 NHS Staff Survey results have now been published by the CQC. They confirm that the White Paper commitment to promote staff experience and engagement is holding up well during this time of significant modernisation. Continuing to support staff over this coming year will be critical to delivering the changes to make services more responsive to patients. The Executive team will be developing a plan to ensure that the results of the local Staff Survey are improved and will be reporting to the Board on this in May 2011.

Executive Director Restructure:
The roles of Neill Moloney, Director of Delivery and Robert Royce, Director of Strategy and Planning, have been changed, in order to provide the organisation with more clarity on their areas of responsibility. The new structure is set out on Appendix A.

The Board should also note that Estates is now the responsibility of the Director of Strategy and Planning and not the Director of Finance. David Wragg will concentrate on Finance and Procurement.

The four Clinical Divisions continue to report directly to the Chief Executive for operational performance.

Independent Reconfiguration Panel (IRP):
Redbridge, Barking and Dagenham and Havering OSCs and the ONEL JOSC referred the Health for North East London programme to the Secretary of State for Health for an independent review. Following an initial assessment, the Secretary of State for Health has asked the Independent Reconfiguration Panel (IRP) to undertake a full review of the programme and report back by the 22 July 2011. We anticipate the review of the programme will take place in May, or early June 2011.

Care Quality Commission Unannounced Visit:
The CQC made an unannounced visit last week to King George Hospital to look at nutrition and patient dignity (this is one of the visits that CQC are undertaking as a result of the recent Ombudsman's report into the care of elderly patients nationally). Although there is no formal report as yet, the visit passed without the CQC bringing any major concerns to the Trust's attention. We will, of course, share the report with the Trust Board as soon as it is received; it is expected by mid April.

Appendix A

Robert Royce

Health4NEL Planning for Implementation
Major Service Change
FT Trajectory
IT
Integrated Pathway Model
Capital Programme
Estates
PFI

Neill Moloney

Information
Information Governance
Business Planning
Commissioning and Contracting
Performance Monitoring/Management

David Wragg

Finance and Procurement

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Board Assurance Framework Q3. (Oct-Dec 2010)	Trust Board
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
The Board Assurance Framework (BAF) containing the high/extreme risks for Quarter 3 (Oct-Dec) is attached for Trust Board consideration. The overview chart provides an "at a glance" position statement of changes that have occurred in relation to the Q2 position. The BAF highlights the extreme risks (in red) faced by the Trust which threaten the meeting of the Trust agreed objectives and the controls in place to mitigate those risks. As part of the development of a robust and timely risk management process the Divisional Boards are reviewing their individual risk registers on a monthly basis. Each extreme risk identified has an action plan as described on the framework.	**X PEQ** …….. □ **STRATEGY**…….. □ **FINANCE** ……..…… x **AUDIT** ……..….. □ **CLINICAL GOVERNANCE** ……..……..…… □ **CHARITABLE FUNDS** ……..… □ **TRUST BOARD** ……..…… □ **REMUNERATION** ……..….. □ **OTHER** ……..…… (please specify)
2. DECISION REQUIRED:	**CATEGORY:**
The Trust Board is asked to review the BAF and note the controls in place to mitigate the extreme risks to the Trust meeting its objectives	□ **NATIONAL TARGET** □ **CNST** x **CQC REGISTRATION** □ **HEALTH & SAFETY** X **ASSURANCE FRAMEWORK** □ **CQUIN/TARGET FROM COMMISSIONERS** □ **CORPORATE OBJECTIVE** …….. □ **OTHER** …….. (please specify)
	AUTHOR/PRESENTER: Pam Strange
	DATE: 8th February 2011
3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
As described in the action plans.	
4. DELIVERABLES	
As described in the action plans.	
5. KEY PERFORMANCE INDICATORS	
As described in the action plans.	
AGREED AT _____ **MEETING** **OR** **REFERRED TO:** _____	**DATE:** _____ **DATE:** _____
REVIEW DATE (if applicable) _____	

Barking, Havering and Redbridge University Hospitals NHS Trust

Board Assurance Framework 2010/2011
Including Extreme Risks from the Trust Risk Register
Quarter 3 October – December 2010

- The Board Assurance Framework identifies all the Trust's principal objectives within its five ambitions:- Productivity, Efficiency, Quality, Strategy and Leadership

- It also describes the risks which present a major threat to achievement of any of the objectives and are not well controlled.

- Those risks are identified initially through review of the objectives themselves. Alternatively they may initially be identified by Divisions as operational risks.

- All significant risks whether to the objectives or otherwise are also described on the Trust Risk Register.

- The Framework and the Risk Register will provide confirmation that there are action plans to put in place controls for the risks they contain and that there is assurance that plans and controls are robust.

- Those risks which present a major threat to any of the objectives and are not well controlled are defined and graded as Extreme (red). By definition all the Trust's Extreme risks appear on the Framework. Each has an action plan attached.

- Significant risks which require high level attention but do not present a major threat to any of the objectives are defined and graded as High (orange) and are described on the Risk Register but not on the Framework. Oversight of their control and assurance is allocated to the responsible Division.

- Extreme risks that threaten any of the objectives but which then become better controlled will be downgraded to High and will be relegated from the Framework to the Risk Register alone and oversight of their control will be allocated to the responsible Division.

- The Framework will be reviewed by the Audit Committee at each meeting and by the Board 6 monthly.

- For all objectives which are threatened by risks that are High (orange) but not Extreme (red), for ease of reference those High risks are noted on the Framework but not fully described.

Overview of the Trust Objectives: Red Not Assured, Amber Partially Assured, Green Fully Assured

Objective 1	2nd	3rd	Objective 2	2nd	3rd	Objective 3	2nd	3rd	Objective 4	2nd	3rd	Objective 5	2nd	3rd
Productivity			**Efficiency**			**Quality**			**Strategy**			**Leadership**		
Emergency Medicine	60	68	Cost Control Improvement	48	80	Mortality	60	60	Health 4 NEL		40	Clinical Networks		
Length of Stay	36	36	Workforce Planning	36	36	CGC Registration Conditions	48	48	ICT Services					
Cancer Waits			Financial Governance	36	36	Patient Safety	64	64	Estate Rationalisation					
18 Week Target			Income Maximisation	48	80	Patient Satisfaction	36	36						
Diagnostic Services	36	36	Training			Health & Safety	36	36						
Contract Management						Infection Control Targets	32	60						
Colposcopy Services (Diagnostics)						Resuscitation	48	48						
Information – Choose & Book	46	40				T&O Services	36	36						
						Maternity	48	48						
						Endoscopy Services	48	48						
						Safeguarding Service								
						Maintain RMS Level 1								
						Information Governance								

Risk Description	Residual Risk	Control Description	Assurance in Place	Effectiveness of Control & Assurances	Action to improve Control/Assurance Effectiveness	Assurance
Objective 1.0 Productivity - The Productivity framework ensures systems and services are robust and supports clinical standards and improved patient experience and outcomes						
Principal Objective 1.1 Emergency Medicine– To ensure KPIs are met Lead – Divisional Director for Medicine - Source: PEQ						
Risk 126 Emergency Medicine Service Improvement – Risk of KPIs not being met.: • Non delivery of 4 hour target to achieve 98% of patients seen and treated in 4 hours. • Poor patient experience. • Delays in patient being transferred from LAS to Trust resulting in SUI reporting for black breaches. • All of the above risks will impact on patient and stakeholder confidence and the risk to the Trust's reputation.	68	• SRO - NM/RS Increase flexible bed availability to reduce patients staying within the A & E department more than 4 hours Maintain improved resilience within the A & E systems and throughput to the MAAU Introduction of 'Ambutime' to monitor patient waiting times within 1 hour.	Ongoing monitored by PEQ Board. Emergency care task force in place to mitigate the ongoing non delivery of the 4 hour target Monitored by PEQ	Implementation of Service Improvement Plan is not achieving set goals to reduce the risk. Review Senior Management input. Failure to meet 4 hour target. Black breaches reported as SUIs to NHS London = 35 ie: October – 12 November – 6 December - 17	Increased senior management input. Update: Action taken in Q4 to realign the service with the Medical Division, to be reported in Q4 Board Assurance Framework.	
Risk 233 Patients detained in the A&E dept. due to reduced bed availability. • Reduction in positive patient experience and quality of care due to patients being cared for on trolleys.	68	• SRO - NM/SS Escalation Plan in place. Constant monitoring of Escalation Plan and regular SIE meetings to manage patient flow. Community bed base flexibility reviewed with Partners.	SIE meetings. Internal monitoring through Bed Meetings. Continuous external monitoring and	Ongoing monitoring of Escalation Plan.	Full implementation of Jonah system;	

Risk Description	Residual Risk	Control Description	Assurance in Place	Effectiveness of Control & Assurances	Action to improve Control/Assurance Effectiveness	Assurance
• Reduced space and access to patient facilities. • Non achievement of 4-hour target. • Reduction of flow from the dept. to MAU and through to the wards.		Patients' early transfer to Discharge Lounge. Increased patient review rounds.	reporting.		Update: Action taken in Q4 to realign the service with the Medical Division, to be reported in Q4 Board Assurance Framework.	
Objective 2.0 Efficiency - In conjunction with the productivity framework the efficiency programme drives forward the changes to transform services to patients and manage resources efficiently and effectively.						
Principal Objective 2.1 Cost Control/Improvement as part of the Turnaround Programme Lead – Director of Finance - Source: PEQ						
Risk 104 Failure in financial management and budgetary control, including expenditure restrictions, leading to supply chain disruption.	**80**	• SRO DW - All Divisional Managers Budget statements. Finance reports, Vacancy Panel Procurement Control, Oracle Revised financial reporting and management framework established Finance Programme Management Committee to be established at November Board Planned outturn for 2010/11 now agreed with SHA - £19.5m deficit before impairment Under constant review by PEQ, Finance Programme Management Committee and Board. Establish a Workforce Committee to deliver Workforce Programme	Care Quality Commission Audit Commission Parkhill, Internal Audit Programme Payroll Audit External audit, review Run rate analysis Purchase order compliance Finance team structure and appointment to posts	Contributing factors include: Partial failure of LoS programme, some due to DoCs Partial failure of workforce cost reduction due in large part to demand management. Failure by commissioners to fully fund activity	Under constant review by PEQ and Finance Committee	
Principal Objective 2.4 Income Maximisation as part of the Turnaround Programme Lead – Director of Finance - Source PEQ						
Risk 105 Not achieving Financial Target: • Turnaround	**80**	• SRO -DW - All Divisional Managers Programme management controls CIP built into budgets at £37m	Care Quality Commission	Contributing factors include:		

Risk Description	Residual Risk	Control Description	Assurance in Place	Effectiveness of Control & Assurances	Action to improve Control/Assurance Effectiveness	Assurance
programme and cost improvement. • Failure to deliver turnaround efficiency programme leaves Trust vulnerable to reputational damage		gross, £34m net. Currently risk assessed position stands at £6m, with extra pressures of £4m Under constant review by PEQ	Audit Commission Parkhill, Internal Audit Programme Payroll Audit External audit, review Run rate analysis Purchase order compliance Finance team structure and appointment to posts	Partial failure of LoS programme, some due to DoCs Partial failure of workforce cost reduction due in large part to demand management. Failure by commissioners to fully fund activity		
Objective 3.0 - Quality - Ensures that BHURT has clear accountability arrangements for the delivery of clinical standards, operational and financial targets						
Objective 3.6 Infection Control Targets – To achieve and maintain Infection Control Targets Lead – Head of Infection Control - Source: PEQ						
Risk 259 Failure to achieve MRSA bacteraemia targets for 2010/11.	**60**	• SRO - DCW Infection Control Policy MRSA Policy Root Cause Analysis of all bacteraemias reported to DIPC. Action Plan progress reported to Infection Control Committee. MRSA screening for elective and emergency patients. Insertion and care of all peripheral lines and catheters subject to daily scrutiny.	MRSA action plan implementation. Visible Leadership audits.	The Trust's trajectory for MRSA allowed for 11 cases of MRSA bacteraemias in year. At the end of Q3; 13 cases have been declared.	Trust wide action plan in situ and will be reviewed at Infection Control Committee	

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Safeguarding Children Annual Report 2010	Trust Board 29 March 2011
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
The Trust continues to treat significant numbers of children and families who face significant stressors that require additional and responsive support and interventions to keep children safe and promote their welfare. The impact of adult needs (including alcohol misuse, domestic abuse and mental health problems) on parenting continues to be a significant factor in serious case reviews. During the last year all staff within the Trust have been targeted for safeguarding children training commensurate with their roles and responsibilities. A robust monitoring system is now in operation and performance around training is significantly improved. Nationally, a number of significant changes have been announced in relation to safeguarding children. These include: an independent review of child protection led by Professor Eileen Munro; the publication of serious case review overview reports in full; and disbanding the National Safeguarding Delivery Unit and ContactPoint. The Vetting and Barring Scheme for people working with children and vulnerable adults has been halted subject to a full review. The impact of these changes is not yet clear. Considerable restructuring is anticipated following the NHS White Paper in July 2010. Reorganisation and uncertainty can create risks to safeguarding children arrangements. It is vital that safeguarding standards are maintained within the trust at this time of external change, and that we continue to improve with clear and unambiguous accountability.	□ **PEQ** ……..….. □ **STRATEGY**……..….. □ **FINANCE** ……..…… □ **AUDIT** ……..….. □ **CLINICAL GOVERNANCE** ……..……..…….. □ **CHARITABLE FUNDS** ……..….. □ **TRUST BOARD** ……..…… □ **REMUNERATION** ……..….. **x□ OTHER ……safeguarding children committee** ……..…..…….. (please specify)

2. DECISION REQUIRED:	CATEGORY:
Trust Board members are asked to note the work undertaken for safeguarding children in the Trust over the last year.	□ **NATIONAL TARGET** □ **CNST** □ **CQC REGISTRATION** □ **HEALTH & SAFETY** □ **ASSURANCE FRAMEWORK** □ **CQUIN/TARGET FROM COMMISSIONERS** □ **CORPORATE OBJECTIVE ……...** □ **OTHER ……..** (please specify)
	AUTHOR/PRESENTER: Deborah Wheeler, Executive Director of Nursing
	DATE: 18.3.11

3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:
None

4. DELIVERABLES

5. KEY PERFORMANCE INDICATORS

AGREED AT _____ MEETING **OR** **REFERRED TO: _____**	**DATE: _____** **DATE: _____**
REVIEW DATE (if applicable) _____	

SAFEGUARDING CHILDREN ANNUAL REPORT 2010

Executive Summary

The Trust continues to treat significant numbers of children and families who face significant stressors that require additional and responsive support and interventions to keep children safe and promote their welfare.

The impact of adult needs (including alcohol misuse, domestic abuse and mental health problems) on parenting continues to be a significant factor in serious case reviews.

During the last year all staff within the Trust have been targeted for safeguarding children training commensurate with their roles and responsibilities. A robust monitoring system is now in operation and performance around training is significantly improved.

Nationally, a number of significant changes have been announced in relation to safeguarding children. These include: an independent review of child protection led by Professor Eileen Munro; the publication of serious case review overview reports in full; and disbanding the National Safeguarding Delivery Unit and ContactPoint. The Vetting and Barring Scheme for people working with children and vulnerable adults has been halted subject to a full review. The impact of these changes is not yet clear.

Considerable restructuring is anticipated following the NHS White Paper in July 2010. Reorganisation and uncertainty can create risks to safeguarding children arrangements. It is vital that safeguarding standards are maintained within the trust at this time of external change, and that we continue to improve with clear and unambiguous accountability.

1.0 Introduction

Safeguarding Children is everyone's responsibility and as such the Safeguarding Children's agenda within the Trust has continued to have a high profile during 2010.

The abuse of a child, whether physical, emotional, sexual or through neglect, can have a serious impact on all aspects of a child's health, development and well being, which can last throughout adulthood. The high cost of abuse and neglect, both to the individual and to society in general, underpins the duty of all agencies to be proactive in safeguarding children.

"Safeguarding" and "promoting the welfare of children" are used to describe the areas of preventing children and young people from being harmed, safeguarding those who are likely to suffer significant harm, and facilitating optimal outcomes for those who have been harmed.

The government plans to reform the child protection system; new measures have been introduced and further changes are expected. This is a critical time for all agencies who are involved in safeguarding children. Reorganisation and uncertainty can create risks to safeguarding children arrangements. It is vital that safeguarding standards are maintained and continue to improve and accountability remains clear and unambiguous.

The purpose of this report is to:

- Provide assurance to the Trust Board that Barking, Havering and Redbridge University Hospitals NHS Trust is fulfilling its statutory responsibilities in relation to Safeguarding Children;
- Provide an update to the Board on service developments in relation to Safeguarding Children;

2.0 National Context

2.1 Working Together to Safeguard Children 2010

The complete revised version of Working Together to Safeguard Children was published in March 2010. Many of Lord Laming's recommendations from the review of safeguarding undertaken following the case of Baby Peter in Haringey are reflected in this revised guidance. It has also been updated to reflect developments in legislation, policy and practice.

A number of key changes within Part 1: Statutory Guidance of Working Together 2010 are of particular relevance to the Trust:

- Expectations on all organisations regarding CRB checks.
- A significant expansion of infrastructure for all organisations providing services to children, parents or families, taking into account the importance of explicitly stating the safeguarding policy within commissioning strategies; a culture of listening to children; a complaints procedure and the importance of understanding online risks.

- A reference to the Care Quality Commission and new registration requirements.
- All health professionals working with children will complete Common Assessment Frameworks (CAFs).

Whilst the above remains current, the planned changes outlined in the 2010 White Paper Equity and Excellence: Liberating the NHS, will necessitate new safeguarding children governance and leadership arrangements within the health service.

2.2 Munro review of safeguarding

The government announced in June 2010 that Professor Eileen Munro of the London School of Economics had been asked to carry out an independent review to improve child protection. Professor Munro has been asked to set out the obstacles preventing improvements and the steps required to bring about improved social work practice. This will include considering how effectively children's social workers and professionals in other agencies work together, and is likely to impact on health organisations.

Whilst previous reforms and the dedication and hard work of front line professionals are acknowledged, it is the view of the Government that a fundamental review of the child protection system is required on the basis of their assessment that the child protection system in our country is not working as well as it should do.

Three principles will underpin the Government's approach to reform of child protection: early intervention; trusting professionals and removing bureaucracy so they can spend more of their time on the frontline; and greater transparency and accountability. Professor Munro's final report is expected to be available in April 2011, with an interim report in January 2011 and a first report in September 2010.

2.3 Publication of Serious Case Reviews

In June, Ministers wrote to the Chairs of all Local Safeguarding Children Boards and Directors of Children's Services to confirm that, with immediate effect, the overview report and the executive summary of all new serious case reviews initiated from 10 June 2010 should be published.

Overview reports and executive summaries are to be published unless there are compelling reasons relating to the welfare of any children directly concerned in the case for this not to happen. Publication of serious case reviews is a sensitive and complex matter. Overview reports contain information of a personal nature and must be anonymised to protect the privacy and welfare of vulnerable children and their families. This will mean preparing serious case review overview reports in a form suitable for publication. There is an important balance to be struck between transparency and openness so that lessons can be learnt, while ensuring the welfare of the

very vulnerable children and young people involved in these serious cases is not affected.

The Government believes that publication to the extent that is proposed is reasonable and in the greater public interest.

2.4 Contact Point

Contact Point was launched in January 2009 to provide demographic data on every child in the country, plus the name and address of any professional working with them. In May 2010, the government announced its decision to withdraw the children's database Contact Point.

2.5 Vetting and Barring Scheme

On 15 June 2010 it was announced that registration with the Vetting and Barring Scheme (VBS) has been halted to allow the Government to remodel the scheme back to more proportionate levels.

Voluntary registration with the VBS for new employees and job movers working or volunteering with children or vulnerable adults was due to start on 26 July 2010. The scope of the remodelling process- to be coordinated by the Home Office in partnership with Department for Health and Department for Education- is currently being finalised and will be announced shortly.

2.6 Care Quality Commission Integrated Inspection

In June 2009 a three year inspection programme of all 152 Local Authority Children's Services and their partners (including health) began. It was anticipated that there would be around 50 inspections per year over the following 3 years.

Ofsted has the lead on the inspections working closely with CQC inspectors. The CQC focus is on health partners within the authority area and the CQC inspection methodology contributes fully to the overarching judgements for the inspection. The findings of the CQC support the assessment and reporting of health performance, and also feed into the Comprehensive Area Assessments.

Each inspection will be conducted with ten days working notice and there will be two weeks on site. Led by Ofsted, a team of around four inspectors will conduct the inspection, and will include a suitably trained and experienced CQC inspector.

The inspections examine the arrangements for safeguarding children, and the outcomes for children and young people who are looked after. The CQC will focus on two specific themes in commissioning PCT's and chosen provider units:

- How boards assure themselves in relation to safeguarding and the health of looked after children.

- Whether staff have the right skills and expertise to recognise concerns, share information and escalate problems where necessary.

Work has been undertaken within Barking & Dagenham, Havering and Redbridge in preparation for an inspection.

3.0 Local Context

3.1 Trust Safeguarding Team

Following an external review and subsequent business case in 2009, additional posts were created within an integrated children and adult safeguarding team, so that the trust had the capacity to manage the required work.

For safeguarding children, two new nursing posts at band 7 and band 6, were established and recruited to in 2010, although the impact of these was limited due to other long term sickness within the team members. The two new administrative support posts were also recruited to. Recruitment to the safeguarding adults post was, however unsuccessful, and the safeguarding children roles continued to undertake and support some of the work in safeguarding adults in the trust.

A further review of the structure in autumn 2010 resulted in a decision to separate the management of children and adult safeguarding and the removal of the post that managed the integrated service. The safeguarding children team are now managed by the Director of Nursing and the safeguarding adults team by the Deputy Director of Nursing.

The revised safeguarding children team now consists of:
1wte Named Nurse Safeguarding Children (Band 8a)
1wte Named Midwife Safeguarding Children (Band 7)
1wte Paediatric liaison Nurse (Band 6)
3 PAs Named Doctor Safeguarding Children
1wte team administator

All these post have been recruited to, although there is expected to be some turnover of postholders in 2011. Professional supervision arrangements are now also in place for all members of the team.

3.2 Safer Recruitment

The Trust meets statutory requirements in relation to CRB checks. All relevant staff under go a CRB check prior to employment and those working with children undergo an enhanced level of assessment. In addition the Trust has taken steps to complete CRB checks on staff who were employed prior to such checks being introduced. Systems are in place to ensure that all healthcare professionals and members of staff who work with vulnerable adults or children, or staff who have access to patients' personal information should have a CRB disclosure every three years.

3.3 Local Safeguarding Children Boards and Partnership Working

The Children Act 2004 replaced the Area Child Protection Committees with Local Safeguarding Children Boards (LSCB) and gave them statutory responsibilities. The LSCB's in Barking and Dagenham, Havering and Redbridge have the lead role in co-ordinating and improving services to safeguard children and young people in our area.

The LSCB key responsibilities are to:

- Provide the strategic lead in the continued development of Child Protection Services
- Co-ordinate and scrutinise local agency arrangements for safeguarding children
- Ensure the effectiveness of the other agencies' agreements for safeguarding children
- Ensure that safeguarding is planned within all service developments
- Ensure that lessons are learnt from every child's death and serious incident and that families are provided with appropriate support when a child dies
- Promote safeguarding prevention strategies to minimise the requirement for protection.

The LSCB has high level membership from all agencies across the local economy. The Trust representative on all three local boroughs' LSCBs is the Executive Director of Nursing, Deborah Wheeler.

Each LSCB is supported by a number of sub-groups that support it in fulfilling its responsibilities:

- Serious Case Review Panel
- Child Death Overview Panel
- Training and Development Sub Group
- Performance Monitoring Sub Group
- Policy and Procedures Sub Group
- E-Safety and Hidden Harm Sub Group
- Domestic Violence Forum

Members of the Trust's Safeguarding Children Team attend these regular meetings and provide feedback via the Trust Safeguarding Children Committee.

3.4 Trust Safeguarding Children Committee

The role and terms of reference of the Safeguarding Children Committee were revised in 2010. The meeting is now more representative of trust staff, and focuses on internal standards and work within the trust. Previously it had been more focused on working as a multi-agency forum to share information; much of that role, however, should be fulfilled by the LSCBs and their sub-groups.

The committee now meets every two months, and the terms of reference agreed in July 2010 are attached to this report. They are due to now be revised following the establishment of the trust's Quality and Strategy Committee.

3.5 Serious Case Reviews

The trust participates in serious case reviews declared by each of the three local LSCBs, usually after the death of a child. For every SCR, an individual management review (IMR) is completed for the trust, together with a chronology of all contact with the child and family members. IMRs are generally completed by a member of the safeguarding children's team, who will not have previously had contact with the child or their family, and can therefore undertake an independent review.

The trust's IMR forms part of the health overview report, which is completed by the designated nurse for the commissioning PCT. They also are used to complete the main overview report of the SCR.

There are therefore usually three sets of recommendations for the trust from each SCR: those from the trust's own IMR, those from the health overview report and finally the main recommendations from the independent overview report. The trust completes action plans in respect of these, which are monitored through the Safeguarding Children Committee and reported to the Quality and Safety Committee.

Key changes that have been implemented in the last year in response to SCRs include:

- Participation in a campaign with LSCB partners to highlight the risks fo co-sleeping to parents
- Review of content BHR safeguarding children training sessions
- Implementation of a policy on supervision of staff who work with children subject to a child protection plan
- Review and amendment of maternity discharge form when women handed over to the care of community midwives

3.6 NHS London Safeguarding Improvement Team

Overview

One of the SHA's roles is to performance manage and support the development of NHS organisations' arrangements to safeguard and promote the welfare of children and young people. Following the Baby Peter Serious Case Review, NHS London took a number of steps to deliver continued improvements in safeguarding children. A Safeguarding Improvement Team (SIT) was created to provide additional support for the NHS in London by establishing a process of peer review.

Alan Bedford, an experienced former NHS Chief Executive, who is also a chair of an LSCB, was appointed to lead the process and chair the visits. The team was made up of safeguarding experts from the NHS across London who visited each of the 31 PCTs and surrounding NHS organisations for a two day

peer review including feedback. This lead to individual action plans for each cluster of organisations visited and the SHA planned to monitor progress.

As the visits were based around PCTs, rather than acute services, BHRUT contributed to three separate visits over a four month period in 2010.

Barking and Dagenham SIT Visit
The summary from the SIT stated: "Overall it felt to us that your services were safe. You have been handling change well. There are issues around the safeguarding infrastructure that need some further work".

Plaudits were given for the following aspects of BHRUT services:

- The Family Care Coordinator Post in NICU
- The great new buildings
- Interagency relations
- Top management commitment to safeguarding priority
- Flagging systems
- Investment in safeguarding expertise.

There were some areas that were identified as worthy of some attention, namely:

- Completion of child protection assessment documentation by A&E doctors
- Paediatrician input in A&E
- Child protection supervision for midwives
- Level 3 training for midwives.

These issues have been addressed and all actions completed to achieve compliance / acceptable level of practice.

Havering SIT Visit
The SIT panel did not visit BHRUT or their services on their visit to NHS Havering, due to earlier visits, but the panel did meet the executive lead.

Plaudit was given for the following aspects of BHRUT services:

- The progress made since those earlier visits when reviewing NHS Barking & Dagenham and Redbridge.
- The Trust liaises with three LSCBs, and the executive lead attends each.
- BHRUT also arrange things so the same subgroup in each LSCB is attended by the same representative to aid consistency.
- The named doctor now has formal supervision arranged with the Redbridge designated doctor.
- Safeguarding supervision in midwifery is now mandatory which is what the SIT panel recommended on an earlier visit.

An area of attention that was noted included that Midwifery social care referrals do not contain sufficient information. This issue has been addressed and is being monitored as changes evolve

Redbridge SIT Visit
The summary from the SIT stated: "Overall we thought that services seemed satisfactory, but there were some risks and issues for focus that we discussed with you. Our list of key issues matched those you had earlier flagged with us and we hope our views about them will help your local decision making".

Plaudits were given for the following aspects of BHRUT services:

- Social work lead at King George Hospital
- Cohesive service in A&E
- Good specialist roles in maternity.

There were some areas that were identified as worthy of some attention, namely:

- To keep the roles and capacity of named and designated professionals under review as focus changes
- Finalising the decisions about child protection medicals.

These issues have been addressed and are being monitored as changes evolve.

3.6 Safeguarding Children Training
With children accessing all areas of the Trust Safeguarding Children training is vitally important. The Safeguarding Team provide Safeguarding Children multi – disciplinary training sessions throughout the year.

Level 1
Since 2006, all staff within BHR have received level 1training on induction. This includes a basic awareness of what to do if they have a concern regarding safeguarding children and how to identify abuse. At 31 December 2010 96% of nursing & midwifery staff had received level 1 training.

The Trust's PFI partner, Sodexho, who employ the domestic, catering and portering staff, provide level 1 training for all their staff and report 96% compliance at 31 December 2010.

Level 2
All clinical and non-clinical staff who have frequent contact with parents, children and young people are required to undergo level 2 training. At 31 December 2010 81% of relevant Trust staff had received training.

Sodexho staff working in designated areas access Level 2 training provided by the Trust's safeguarding children team; of the required staff, 95% have been trained as at 31 December 2010.

Level 3
All staff working predominantly with children, young people and parents are required to undergo level 3 training. At 31 December 2010 91% of relevant Trust staff had received training.

In September 2010 the Intercollegiate document *Safeguarding Children and Young people: roles and competences for health care staff* was updated. The Trust Training Strategy for 2011 will be updated to reflect the recommendations of this document and training programmes will be reviewed to ensure that all required areas are included. The recommendations arising from the Baby P case and information from revised Working Together document have already been incorporated into the trust training materials

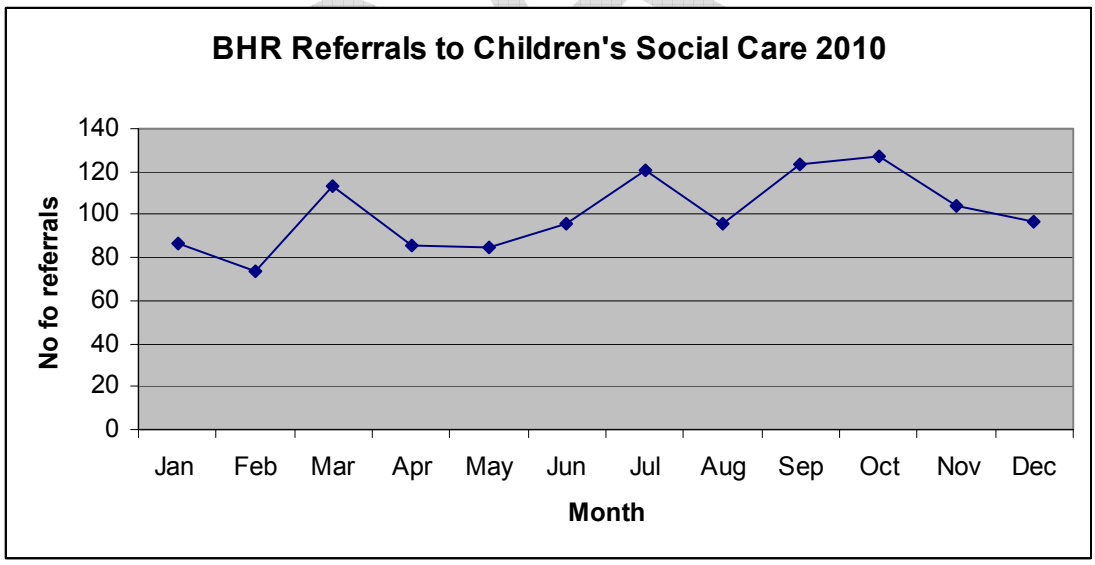
3.7 Children Subject to a Child Protection Plan

All children who are subject to a child protection plan in Barking & Dagenham, Havering and Redbridge are flagged by the Safeguarding Office onto the trust's patient administration system and the A&E system, Symphony. There are approximately 500 children with alerts at any one time.

If a child attending either of the Trust's A&E Departments has a Child Protection Plan in place, even when there are no safeguarding concerns with the presentation, a referral form is completed and faxed to Children's Social Care to advise them of the child's attendance for their records.

All unborn babies who have been made the subject of a child protection plan are highlighted on the maternity E3 database so that at birth the child can be immediately flagged on the PAS and Symphony systems.

3.8 Safeguarding Children Activity



Copies of all referrals to children's social care are received by the safeguarding team, who confirm receipt. They also follow up what action, if any, has been taken as a result of the referral, and that they are appropriate.

Members of the safeguarding team attend the multi-professional and strategy meetings in respect of safeguarding cases admitted to hospital. They also

attend core group meetings in the community and weekly psychosocial meetings in the trust.

4.0 Conclusion

In view of the increasingly raised profile of safeguarding children nationally, the safeguarding children agenda has remained high within the Trust during 2010.

The Safeguarding Children's Team continue to work to ensure the safe admission and discharge of all children and continue to be committed to safeguarding children at the highest level.

The new Government changes that have been implemented and the scale of health service reform that is planned will create safeguarding children risks that need to be minimised and managed throughout the coming year.

Leila Francis
Named Nurse for Safeguarding Children
March 2011

Barking, Havering and Redbridge University Hospitals NHS Trust

SAFEGUARDING CHILDREN COMMITTEE

Terms of Reference

Overall Purpose of the Group

To oversee and monitor the infrastructure and arrangements for safeguarding children, so that the Trust meets its statutory obligations and demonstrates best practice. To ensure a multidisciplinary approach to safeguarding children within the Trust.

Objectives

1. To agree the annual work programme of the safeguarding children team.
2. To ensure that there are safeguarding children policies and systems throughout the Trust, in line with current legislation, government statutory guidance and accepted best practice, and that they are regularly reviewed.
3. To ensure that a training strategy is in place and monitor its implementation
4. To ensure that staff are supported in safeguarding children work, and that they receive adequate training and supervision
5. To ensure that there is a prompt and effective 'needs-led' response when it appears that a child may be at risk of abuse or neglect.
6. To ensure that there are effective quality assurance systems in place for monitoring the Trust's work in safeguarding children.
7. To oversee the production of an annual report on safeguarding children and provide regular reports to the Trust Board on the annual work programme.
8. To ratify and review responses to recommendations and standards, for example the Laming Report, serious case reviews, Children Act, and National Service Framework for Children, Young People and Maternity Services.
9. To encourage and facilitate effective information sharing and dissemination throughout the Trust and with partner organisations

Governance

The board will meet every two months. It will report to the Clinical Governance Committee.

A quorum will consist of six people, including one of the trust named professionals, one manager and one external representative.

Co-ordination of agendas and meeting minutes will be provided by the safeguarding team administration

Membership

Deborah Wheeler (Chair)	Executive Director of Nursing
Carol Drummond (Vice Chair)	Divisional Director, Women & Children Services
Pam Strange	Director of Clinical Governance
Liz Wright	Deputy Director of Nursing
Leila Francis	Nurse Consultant Safeguarding
Dr. Junaid Solebo	Named Doctor Safeguarding Children
Bernadette Gibbings	Named Midwife safeguarding Children
Gillian Watson	Named Nurse, safeguarding Children
Jacqueline Jaggs	Safeguarding Children Nurse
Sue Lovell	Head of Midwifery/ Divisional Nurse
Clare Emery	General Manager Paediatrics
	Clinical Director Paediatrics
Trish Stone	Paediatric Matron
Dr. Helen Salter	A&E safeguarding lead
	Clinical representative, trauma & orthopaedics
	Clinical representative, ENT
	Clinical representative sexual health
	Clinical representative, radiology
	B&D LSCB Representative
Eifion Price/Eileen Collier	Havering LSCB Representative
Roger Carruthers	Redbridge LSCB Representative
Mrs Liz Doherty	Designated Nurse, NHS B&D
Ms Anna Jones	Designated Nurse, NHS Havering
Yolander Davies	Designated Nurse, NHS Redbridge
Caroline Jones	Named Nurse, NELFT
Andy Keen	Detective Inspector, CAIT, Metropolitan Police

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Declaration of compliance for same sex accommodation	**Trust Board 29 March 2011**
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
All Trusts have been asked to refresh and republish their declaration of compliance for same sex accommodation by the end of March. This paper summarises the trust's position, which has been reinforced by a recent self-assessment process, led by the Deputy Director of Nursing, reviewing each area in the Trust. The Trust has clear processes in place for ensuring patients are cared for in same sex accommodation. All critical care areas have been identified as being at risk of breaching the standard and there are robust reporting mechanisms to identify when this occurs. These breaches are reported to Trust Board every month in the performance report, as there will be a penalty "fine" for every same sex breach after April 2011.	**X□ PEQ ……9.3.11……..…..** **□ STRATEGY……..……..** **□ FINANCE ……..……** **□ AUDIT ……..……** **□ CLINICAL GOVERNANCE ……..……....……** **□ CHARITABLE FUNDS**
2. DECISION REQUIRED:	**CATEGORY:**
.Trust Board are asked to agree the attached declaration for publication on the Trust's website	**Quality** **AUTHOR: Liz Wright, Deputy Director of Nursing** **PRESENTER: Deborah Wheeler, Director of Nursing** **DATE: 9.3.2011**
3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
To adhere to elimination of mixed sex breaches which will cost £250 per breach after 1.4.2011	

4. DELIVERABLES	
• All ward inpatient areas have eliminated mixed sex • The critical care areas i.e. ITU, HDU and CCU are liable to breach if level 1 patients are unable to step down and be placed in an appropriate ward within 6 hours. • HASU and Acute areas within cardiology and respiratory wards are drafting protocols for their staff to adhere to ensuring mixed sex breaches do not occur. • Children and young people are able to have the choice of whether care is segregated according to age and gender	
▪ The incidents of mixed sex breaches occur within critical care areas, which included :General ITU and HDU and Neuro ITU at Queens in February 2011 as well as CCU in March 2011	
AGREED AT _____ MEETING **OR** **REFERRED TO:** **_____**	**DATE: _____** **DATE: _____**
REVIEW DATE (if applicable) _____	

Achieving same sex compliance

In 2009 the Trust reviewed its same sex compliance. The Deputy Director of Nursing and Estates Manager reviewed each clinical area and specifically King George's Hospital which had less flexible accommodation and toilet facilities. Two wards were identified where same sex compliance was being breached within acute observation/monitoring areas within the cardiology and respiratory specialty wards. Additionally many wards had insufficient toilet facilities to meet the same sex compliance. Seven wards were identified for loss of a bed in order to construct an additional toilet/shower facility to enable compliance. Several other wards were provided with flexible toilet signage to enable them to be used for either sex, dependent upon the prevalence of males to females and vice versa. Provision has also been made to improve dignity through frosting glass windows between different sex bays.

The acute bays in the two wards that were non compliant changed the bays to include both monitored and unmonitored beds so that they became compliant with same sex patients. The organisation of the nursing allocation accommodated to this change in dependency within the bay areas. King George's Hospital then became totally compliant for same sex accommodation

Queens' Hospital was opened in 2006 and all the wards are constructed in a circuit formation with 4 bedded bays and side rooms with en suite facilities. The maternity units on both sites and the gynaecology ward at Queens are all single sex. Same sex compliance is maintained across all wards with occasional breaches from critical care areas when there are level 1 patient step down delays to a an appropriate ward within 6 hours. This has been due principally to bed pressures during the winter and delays in the patients' pathway.

The overall culture that has developed over the past two years has been one of much improved staff awareness that same sex compliance must be a priority in terms of inpatient placement, and is a particular focus for the Bed Management Team. Staff have become proactive in the way they strive to avoid mix sex situations occurring i.e. Elderly Medical Assessment Unit where there is a mix of bays with bedded areas and chairs, breaches do not occur due to the use of the mix between these areas as the patients' pathway is via A&E. Likewise the GP Assessment unit is made up of two bays and contains a mixture of trolleys and beds in order that the bays remain same sex.

Reporting Processes

Matrons for clinical areas report breaches in same sex accommodation to the Bed & Site Management Team. These are recorded and reported weekly to the commissioners.

Any breaches are escalated and reported to the Divisional Nurse Directors, the reasons for the breaches are identified and action taken to address the causes.

The principal area of weakness where breaches occur are from critical care areas at the point of level 1 step down, while waiting for transfer to the appropriate ward. NHS Lodnon have agreed a six hour "window" to allow time to transfer a patient safely out of critical care areas before it becomes a breach.

Audit Processes for Trust assurance

There was a visit to the Trust by NHS London same sex leads, the sector lead and local commissioner at the end of February. They walked around key areas on both sites, to provide assurance as to the compliance for same sex accommodation, wash/toilet facilities and understanding as to the areas of weaknesses and reasons for that.

The breach reports are reviewed and reported weekly to the sector lead, with the reason for each breach. Compliance has been achieved except occasional incidents when patient flow is reduced in relation to stepping down level 1 patients from critical care areas.

Reports are submitted monthly and included within the Performance Assurance Report submitted to the monthly Trust Board, with regard to the compliance status for same sex accommodation.

The Dignity policy contains details regarding the Trust's strategy and requirement to maintain single sex sleeping accommodation and toilet facilities as well as the need to enable patients to feel they have privacy within same sex areas except in areas of critical care while receiving level 3 or 2 care.

The Senior Nursing Team undertakes 3 monthly Dignity Surveys which include elements of patients' feedback related to same sex compliance with regard to sleeping accommodation and toilet facilities. However the trust has also recently established a 'real time' survey system which will provide detailed patient feedback based on larger survey samples that can identify the feedback by individual clinical areas, allowing for a more focused approach to addressing these issues.

Delivering Same-Sex Accommodation
Declaration of compliance
Updated March 2011

We are proud to confirm that mixed sex accommodation has been eliminated in all our hospitals.

Further information on our work to deliver same sex accommodation
Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. Barking, Havering & Redbridge University Hospitals NHS Trust is committed to providing every patient with same sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.

Barking, Havering & Redbridge University Hospitals NHS Trust is pleased to confirm that we are compliant with the Government's requirement to eliminate mixed sex accommodation, except when it is in the patient's overall best interest, or reflects their personal choice. We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as when intensive or coronary care, or when patients actively choose to share, as for example in the Children's Ward.)

If our care should fall short of the required standard, we will report it. We have also set up an audit mechanism to make sure that we do not misclassify any of our reports. We publish the results of that audit monthly within performance reports to the Trust Board, but also report weekly to the Outer North East London sector lead, who monitors same sex compliance

What does this mean for patients?
Other than in the circumstances set out above, patients admitted to Barking, Havering & Redbridge University Hospitals NHS Trust can expect to find the following:

Same sex-accommodation means:

- The **room where your bed is** will only have patients of the same sex as you
- Your **toilet and bathroom** will be just for your gender, and will be close to your bed area

It is possible that there will be both men and women patients on the ward, but they will not share your sleeping area. You may have to cross a ward corridor to reach your bathroom, but you will not have to walk through opposite-sex areas.

You may share some communal space, such as day rooms or dining rooms, and it is very likely that you will see both men and women patients as you move around the hospital (eg on your way to X-ray or the operating theatre).

It is probable that visitors of the opposite gender will come into the room where your bed is, and this may include patients visiting each other.

It is almost certain that both male and female nurses, doctors and other staff will come into your bed area.

If you need help to use the toilet or take a bath (eg you need a hoist or special bath) then you may be taken to a "unisex" bathroom used by both men and women, but a member of staff will be with you, and other patients will not be in the bathroom at the same time.

The NHS will not turn patients away just because a "right-sex" bed is not immediately available

same-sex accommodation:
your privacy, our responsibility

DH Department of Health

What are our plans for the future?
Barking, Havering and Redbridge University Hospitals NHS Trust has undertaken considerable building work at King George Hospital to ensure that the trust is able to offer privacy and dignity to our patients. Staff also reviewed the way in which they provide care, and patients are separated into bays nearest their washing and toilet facilities. Opaque screening was also provided for the glass panels between the bay areas.

Queens Hospital is a new building and so was already compliant, as there are bathroom facilities in each ward bay. We will continue to monitor same sex accommodation through our patient survey results and feedback from our patients, and will be constantly be aware that staff need to uphold a culture whereby privacy and dignity are actively preserved.

NHS London staff have recently visited the Trust in late February 2011, to review the actions the Trust has taken, as well as to understand the initiatives staff have taken to improve segregation and eliminate mix sex accommodation/wash facilities.

How will we measure success?
The trust has undertaken local surveys as well as participating in the annual national inpatient survey.

The Care Quality Commission (CQC) patient survey scores with reference to single sex accommodation for 2009 are highlighted below. The building works at King George Hospital took place during the summer of 2009 and some of these results may be from patients who were in hospital before the work was completed:

2009 CQC scores:
- 86% of patients did not share a sleeping area with patients of the opposite sex when first admitted
- 90% of patients did not share a sleeping area with patients of the opposite sex after moving wards
- 89 % of patients did not share a bathroom or shower area with patients of the opposite sex

The 2010 CQC patient survey scores have not yet been published, although we anticipate that these will reflect an improvement, due to the actions we have undertaken as a trust. These will be published on a revised declaration when they are received.

Local dignity audits, which ask about patients' experience of same sex accommodation have audits are being undertaken every three months.

Plans:
We are in the process of introducing an electronic system to allow patients to give us their feedback before they leave the hospital. We expect to the have the system rolled out over the next 3 months across all inpatient/day areas. This has also been reviewed by patients and members of the Patient Experience Board.

What do I do if I think I am in mixed sex accommodation?
We want to know about your experiences and would invite comment and suggestions which are constructive and helpful in the drive to improve our services for patients and their families. Please either contact::

Nichole McIntosh, Assistant Director Patient Experience Improvement, on 01708 435000 ext. 3391, or the PALS office if you wish to feedback directly.

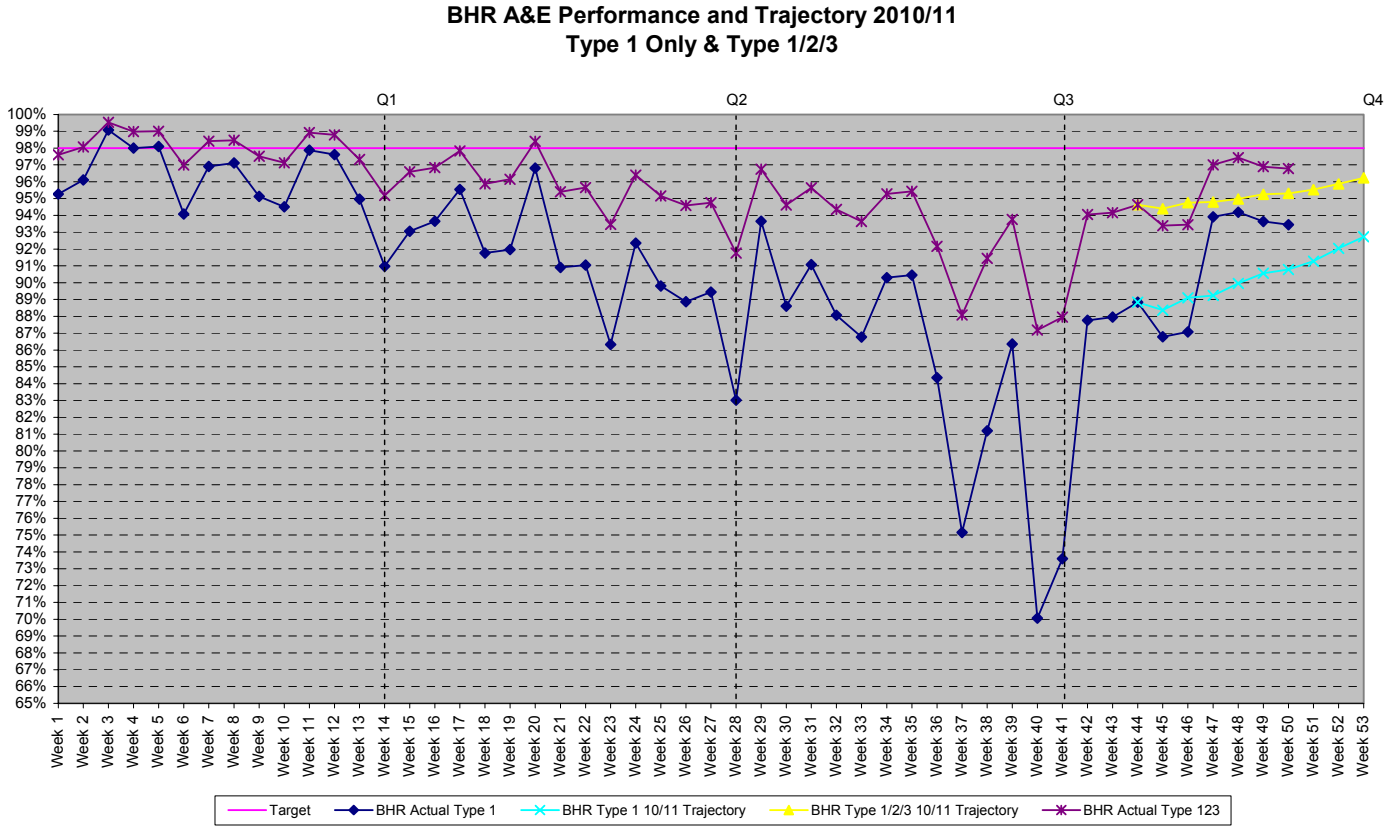
Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Emergency Care Report	**Trust Board**
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
This Emergency Care report provides the following: ▪ Update on performance against the Emergency Care standard for 2010/11 ▪ Informs the board of the current performance against the new emergency care standards to be in place from 1 April 2011. ▪ Provides an update on the work included in the Emergency Care Programme.	□ **PEQ**……..…… □ **STRATEGY**……..…….. □ **FINANCE** ……..…… □ **AUDIT** ……..……..….. □ **CLINICAL GOVERNANCE** ……..……..……..…… □ **CHARITABLE FUNDS** ……..…….. ☑ **TRUST BOARD – 29th March 2011** □ **REMUNERATION** ……..……... □ **OTHER** ……..…… (please specify)
2. DECISION REQUIRED:	**CATEGORY:**
The Trust Board is asked to note the performance and the progress in the Emergency Care Programme.	☑ **NATIONAL TARGET** □ **CNST** □ **CQC REGISTRATION** □ **HEALTH & SAFETY** □ **ASSURANCE FRAMEWORK** □ **CQUIN/TARGET FROM COMMISSIONERS** ☑ **CORPORATE OBJECTIVE** ……..……... □ **OTHER** …….. (please specify)
	AUTHOR: Neill Moloney, Director of Delivery **PRESENTER:** Neill Moloney, Director of Delivery
	DATE: 18 March 2011
3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
Not applicable.	
4. DELIVERABLES	
Existing and new emergency care performance standards	
5. KEY PERFORMANCE INDICATORS	
AGREED AT _____ **MEETING** **OR** **REFERRED TO:** _____	**DATE:** _____ **DATE:** _____
REVIEW DATE **(if applicable)** _____	

Performance

The trajectory showing the current performance is shown below against the revised trajectory agreed with NHS London.



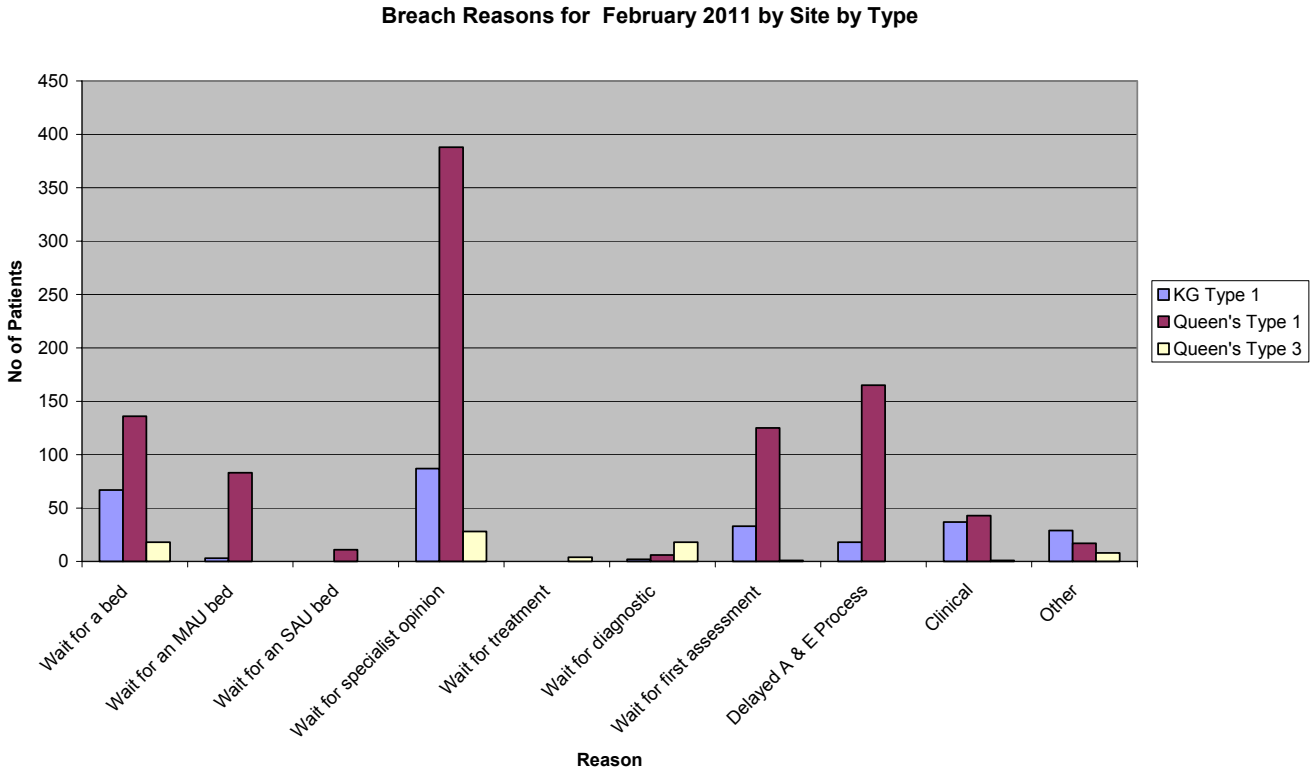
Since the fist week of February 2011, the Trust has experienced an exponential improvement in performance that has seen A&E for both Type 1 and ALL Types exceed the trajectory provided to NHS London.

For Type 1 only, the Trust performance saw a move from 87.07% at the end of January '11 to 93.64% at the end of February 2011 (with a peak during February '11 at 94.19%). For ALL types, the Trust performance saw a move from 93.45% at the end of January '11 to 96.89% at the end of February 2011 (with a peak during February '11 at 97.43%).

The improvements resulting from the continued efforts of staff during the last few months seeking to improve the performance, is attributable in part to a Divisional restructure that saw the Division of Emergency Care reintegrated into the Division of Medicine. This approach appears to have reinvigorated the A&E department with the subsequent results demonstrating significant improvements.

Although the Trust is now unable to achieve the 95% A&E standard for the 2010/11 assessment period, NHS London has acknowledged the significant improvement the Trust has achieved and that the performance is better than trajectory with strong signals that such performance will be maintained and (subject to the implementation of a revised Emergency Care Programme) improved upon.

The current breach analysis is shown below:



The report shows that the reasons for breaches continue to relate to waits for specialist opinion, first assessment and delayed A&E processes. However during February '11, the Trust experienced a spike in attendances at A&E and resulting admissions which subsequently led to an additional demand on beds (thereby leading to the delay listed above).

In some cases breaches relating to waiting times for first assessment continue to result from a lack of assessment capacity in the A&E Department. The new arrangements for escalation and response to referrals for specialist opinion, although agreed, are in the process of becoming embedded within the organisation. Therefore there has been a slight delay regarding progress in achieving a reduction in waiting times for response from a specialist – however these continue to be monitored on a daily basis at the daily breach meetings.

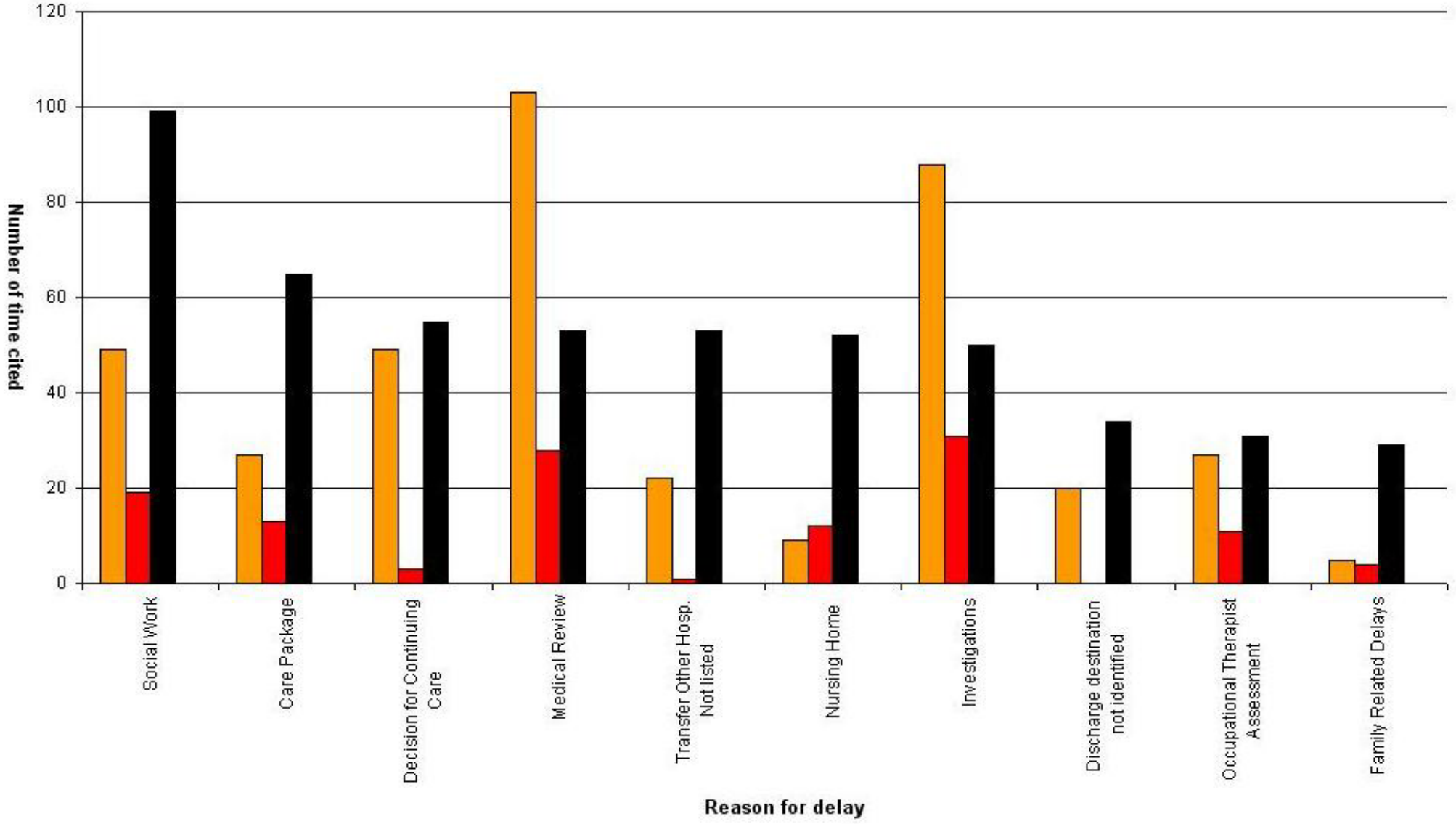
From February '11, daily A&E breach meetings are now in place from Monday to Friday whereby a senior member of each Divisional Management Team is in attendance to review and address breach delays. Actions are identified to address A&E breaches in order that that there will be a demonstrable reduction in A&E breaches that will further improve the Trust's A&E performance.

The report on discharge delays using Jonah data for February 2011 is shown below:

Top Delay reasons (All Delay Types)

All Hospitals, All Specialty Groups

Go Back



New ‘Clinical Quality Indicators’ for A&E

NB: Plans to achievement the new ‘Clinical Quality Indicators’ will be included within Workstream 2: Clinical Pathway Redesign of the revised Emergency Care Programme which is currently under development.

The new standards are shown below with current performance where it is available.

Although several of the data items were available within the A&E system ‘Symphony’, the remainder were not reported routinely. Over the last month, IT, the Information department and the Medical division have been seeking ways in which to resolve those data collection issues.

Where data has become available, it should be borne in mind that the methodology of capturing, and the accuracy of the data is in its formative stages therefore as at the end of February ’11, the position may not be that once formal recording commences from April ’11 – therefore caution should be used when considering the information presented.

New A&E Standards								
No	**Indicator**	**Period**	**Indicator Description**	**Source**	**Likely Performance from April 2011**	**Target**	**Feb '11**	**Performance**
1	Unplanned re-attendance rate	Monthly	Unplanned re-attendance at A&E within 7 days of original attendance (including if referred back by another health prof)	Symphony data.	A severe risk on current performance. Particular focus needs to be given to addressing the achievement of this target.	<5%	8.30%	
2	Total time in the A&E department	Monthly	The median, 95th percentile and single longest total time spent by patients in the A&E department, for admitted and non-admitted patients	Symphony data	A severe risk on current performance. Particular focus needs to be given to addressing the achievement of this target.	240 mins	388 mins	
3	Left without being seen (LWBS) rate	Monthly	The percentage of people who leave the A&E department without being seen	Symphony data	Current position of 6% against a standard of <5%.	<5%	4.1%	
4	Time to initial assessment	Monthly	Time from arrival to start of full initial assessment, which includes a brief history, pain and early warning scores (including vital signs), for all patients arriving by emergency ambulance	Symphony data. This needs to be added to the current Symphony system. IT teams are aware.	Subject to the implementation of the revised Emergency Care Programme	<15 mins	28	
5	Time to treatment	Monthly	Time from arrival to start of definitive treatment from a decision-making clinician (someone who can define the management plan and discharge the patient)	Symphony data although this field is not currently widely used and work will need to be done to step this up.	Previous performance to date indicates that the waiting time has been reducing and is an achievable target in the short term (timescales TBC)	<60 mins	76	
6	Ambulatory care	Quarterly	Ambulatory care for emergency conditions: the percentage of A&E attendances for cellulitis and DVT that end in admission	Ambulatory Care Team through Symphony	Performance is likely to be good based on current ambulatory care model (with further development due during 2011/12)	Improvement	Data Not Available	

7	Service experience	Quarterly – April, July, October, January of each year	Qualitative description of what has been done to assess the experience of patients using A&E services, their carers and staff, what the results were, and what has been done to improve services in light of the results	Requires further work to tie in with existing and planned patient survey work by the Trust.	Experience of other surveys of non-elective admission suggestions that the Trust performs poorly with regard to the non-elective pathway. There is no data currently to draw on but waiting times is likely to be a significant factor in a patient's experience.	Improvement	Data Not Available	
8	Consultant sign-off	Six Monthly – October and March of each year	The percentage of patients presenting at type 1 and 2 (major) A&E departments in certain high-risk patient groups (adults with non-traumatic chest pain, febrile children less than 1 year old and patients making an unscheduled return visit with the same condition within 72 hours of discharge) who are reviewed by an emergency medicine consultant before being discharged.	Not previously measured and so will require a measuring tool/system.	Given Consultant numbers there should be little risk to achieving this within hours. However, due to the current on-call system this may be difficult out of hours. Requires further work with the Consultant team regarding job planning.	Improvement	Data Not Available	

The key operational challenges remain:

- Recruitment and retention of an appropriate clinical workforce (medical, nursing and others) particularly in A&E and acute areas to deliver care;
- Development of Emergency Ambulatory Care to deliver across all 49 clinical conditions identified;
- Improving bed flow – planning discharge at the point of admission, case management of complex patients;
- Integration of Medical and Surgical Assessment facilities together with A&E;
- Urgent Care centre – development and management from April 2011;
- Changes in the management of emergency/urgent GP referrals;
- Development of clinical pathways for single condition admissions;
- Successful implementation of Jonah as a management support tool
- Integration with community services.

The Emergency Care Intensive Support Team continue to work with the Trust to support the implementation of the existing and new standards. They are offering support in three areas.

- The development of a rapid assessment and treatment model for the Emergency Department at Queens Hospital;
- The development of a Trust wide emergency ambulatory care strategy and implementation plan;
- The implementation of new internal professional standards that support patient flow across the acute Trust.

The successful roll out of Discharge Jonah and formal cross buffer arrangements has significantly improved continuous bed flow and is assisting in reducing length of stay.

<u>Emergency Care Programme</u>

This programme has three work streams focussing on Internal Professional Standards, Complex Discharges and Clinical Redesign. An update from each of the work streams is shown below:

Internal Professional Standards

One of the Emergency Care Intensive Support Team recommendations was that each Division within the Trust should identify a range of Internal Professional Standards (IPS) that will enable them to establish a performance management framework so that they may ensure that the services they deliver are done so to expected standards and so that they are aligned to the overall efforts of the Trust in working towards the achievement of the new Emergency Care Clinical Quality Indicators.

Given that the Trust delivers a vast number of services, and there being a large number of professional standards associated with them, it was acknowledged that it would be impractical for the Trust to performance manage every IPS the Divisional teams would be expected to work to; therefore it was agreed that there would be no

more than 10 IPS identified within each division that would be subject to performance management within the Divisions day to day and subsequently by the Emergency Care Programme Board.

There is a consensus that not all of the IPS are achievable immediately and that there will need to be a phased approach to them becoming practical to achieve. Therefore in order to agree and embed the performance management of the IPS, the Divisions have done/are doing the following:

- Established fortnightly Performance Management meetings to agree and subsequently performance managing the delivery of the IPS (NB: It is envisaged that the fortnightly performance management meetings will reduce in frequency once there has been demonstrable achievement of the IPS)

- Agreeing *all* IPS across their Divisions (with Clinical Leads et al)

- Identifying the IPS to be managed via the fortnightly performance management meetings and the Emergency Care Programme Board (expected by 25/3/11)

- Agreeing the milestones and dates of key stages in the embedding of the IPS (expected 25/3/11)

- Identifying the 'due date' as to when IPS performance are to be being achieved that they become Business as Usual (expected by 25/3/11 – variable subject to vagaries of each Division)

- Confirming the method of measurement of the IPS (expected by 31/3/11)

- Identifying the resources/support required to achieve the IPS standards (expected by 25/3/11)

- Implementing the IPS (this varies from immediately through to several years due to the required changes in service provision/staffing requirements – the majority are expected to be performance managed from 1/4/11)

Complex Discharges

The Discharge Partnership Board (DPB), is a multi-agency group which focuses on developing effective pathways from acute care into the community.

For the last 3 months, the DPB has acted as the Project Board for the Community Support Programme, which has focused on:

- BHRUT development of systems which provide accurate, timely and trusted data on patients requiring discharge to the community and achieving reductions in Delayed Transfers of Care (DTOC), Length of Stay (LOS) and improve bedflow.
- Improving complex discharge pathways, by focusing on better processes for managing continuing care and family choice issues
- Reducing delays due to specialist rehabilitation placements
- Reducing admissions from Nursing Homes

- Improving Community Support at the front end of Acute to reduce admissions
- Looking at how we maintain more patients with long-term conditions in the community and reduce multiple A&E Attendances and Admissions
- Introduce Intensive Therapy to get more patients home on Reablement pathways
- Promote improved 7-day and Bank Holiday Partnership working to maximise discharges in out-of-hours periods
- Reduce delays due to Equipment

Main Achievements

- Daily information is now accurate, this holds all partners to account for their contribution to reducing delays and cuts out time wasted arguing about responsibility and on abortive Section 2's and 5's.
- Average Daily DTOCS - **Oct-Dec 2010 -** ***4.9%*** - **Jan-Mar 2011 -** ***3.8%***
- Average Total Daily Days in DTOC - **Oct-Dec 2010 -** ***934 Days*** - **Jan-Mar 2011 -** ***487 days***
- Average LOS in DTOC per patient **Oct-Dec 2010** - ***15.2 Days*** - **Jan-Mar 2011** - ***10.3 days***
- Above reductions on LOS due to introduction of Case management for Complex cases
- Reductions by 50% of patients 'in black' on Jonah (i.e. beyond Predicted date of Discharge)
- supporting development of training programme and new processes to support improved discharge where Continuing Care or Family Choice issues are a major factor
- Intensive Therapy programme has got 50+ patient home who otherwise would have needed Community beds
- Improved Discharges at Week-ends, Improved Planning and Support for Holiday periods
- Extended Discharge Facilitation Team continues to get patients Home from A&E and looking to extend to EMDU
- Work in progress on Nursing Homes, Specialist Rehabilitation, Equipment, Admission avoidance and Avoiding Multiple Attendances and Multiple Admissions
- Introduction of GP Streaming at Front Door has re-directed an average of 15-20 patients per day back into the Community and increased level of acuity being seen in UCC.

As a result of the work of the Board, partnership working is very strong and is now tackling areas of blockage to Discharge that have been consistently resistant to change.

Clinical Pathway Redesign

The aim of this work stream is to bring together a series of initiatives that assist the divisions to achieve the effective delivery of their associated services that will ultimately contribute to the Trust achieving the new A&E Clinical Quality Indicators.

The work stream has been broken down into x3 projects each with a defined set of objectives, they include:

- (Re) Attendance / Admission Avoidance
- A&E Improvement
- Treatment, Diagnosis & Discharge (In-Patient)

Each project will be allocated an overall project Manager who will then ensure that each of the objectives are delivered in accordance with the expected due dates.

NB: The information provided below is the *first draft* of the work stream's content and therefore should be read with caution as it is subject to change both in terms of objectives, milestones to achieve those objectives and/or associated due dates. It is expected that the final content of work stream will be agreed and work commenced to deliver it from 1/4/11.

Workstream 2 (Provisional Content)	
Project 1: **(Re) Attendance / Admission Avoidance**	**Due Date** **(**Provisional)
GP calls taken by Consultant at each site	Jun-11
Development of Intermediate Care	Sep-11
LAS Alternative Care Pathways (Community)	Sep-11
Nursing Home Support / Education	Oct-11
Residential Home Support / Education	Oct-11
Expansion of Ambulatory Care Pathways	Apr-12
Readmissions reduction to the national average of outlying HRGs	Apr-12
Use of Rapid Response Teams	Apr-12
Expansion of Pharmacy usage in the Community	Apr-12
Development of the Virtual Hospital	Apr-12
Expansion of GP Service usage (Emergency Appointments/ Extended Hours/ Management of Frequent Fliers)	Apr-12
Develop Palliative Care Services	Apr-12
Develop Home Based Care	Apr-12

Project 2: **A&E Improvement**	**Due Date** **(**Provisional)
UCC Development pre August '11 - Adults & Paeds	Apr-11
Develop and Embed Emergency Ambulatory Care (Content TBC)	Apr-11
GP calls taken by Consultant at each site	Jun-11
UCC Development post August '11 - Adults & Paeds	Aug-11
Increase MAU discharges out of hospital to 55%	Sep-11
LAS Alternative Care Pathways (Community)	Sep-11

RATting or Equivalent Embedded	Sep-11
Refine assessment and admissions procedures	Sep-11
Improve Discahrge Practices to correct location (Home/Ambulatory Care/Community etc)	Sep-11
Expansion of Ambulatory Care Pathways	Apr-12
Readmissions reduction to the national average of outlying HRGs	Apr-12
Reduction of temporary staff by:	Apr-12
5 day ward round Consultant cover	Apr-12
Link to community Initiatives (See Project 1)	As Project 1

Project 3: **Treatment, Diagnosis & Discharge (In-Patient)**	**Due Date** **(**Provisional)
Reassess AEU capacity	May-11
Refine Transfer & Treat Protocols	Jun-11
Refine Internal Referral Processes	Jun-11
Increase MAU discharges out of hospital to 55%	Sep-11
Reduce the number of patients with a LoS of over 14 days from 30% to 24% (national average).	Sep-11
Embed use of Performance & Information Management Systems (Jonah/Bedweb/PACS/PAS/CMS/Ambutime)	Sep-11
Embed agreed Diagnostic turnaround time standards	Sep-11
Improve Discahrge Practices to correct location (Home/Ambulatory Care/Community etc)	Sep-11
Creation of winter surge capacity with substantive staff	Oct-11
Expansion of Ambulatory Care Pathways	Apr-12
Readmissions reduction to the national average of outlying HRGs	Apr-12
Reduction of temporary staff	Apr-12
5 day ward round Consultant cover	Apr-12
Refine External referral Processes	Apr-12
Embed Trust Wide discharge planning standards (board rounds/TTAs/Therapies/Family & Carer Involvement/Transport/Community-Social Services)	Apr-12
7 day Consultant ward rounds in all in-patient medical areas	Apr-13

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Quality and Patient Standards Performance Report – February 2011	**Trust Board**
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
The Quality and Patient Standards Performance Report provides an analysis of performance against trajectory and Trust-wide targets for the following domains: 1. Department of Health Performance Framework 2009/10 and 2010/11 2. DH Framework Performance Targets 3. Other Performance Indicators 4. Contractual Key Performance Indicators (KPIs) and Commissioning for Quality and Innovation (CQUIN) Schedule Areas where performance is of concern for the month and/or for the year are discussed within the report are as follows: • Four-Hour Maximum Wait In A&E From Arrival To Admission, Transfer Or Discharge • MRSA • RTT Incomplete Pathways • 62 days urgent referral to treatment of all cancers • Delayed transfers of care • Length of stay • DNA Rates • First to Follow-up rates • Re-admission Rates • Freedom of Information • Data Quality • Complaints • Mixed Sex Breeches This report includes the key actions that are being undertaken to bring performance back in line with trajectory or target.	□ **PEQ**……..……. □ **STRATEGY**…….…….. □ **FINANCE** ……..…… □ **AUDIT** ……..……..….. □ **CLINICAL GOVERNANCE** ……..……..……..…… □ **CHARITABLE FUNDS** ……..…….. ☑ **TRUST BOARD – March 2011** □ **REMUNERATION** ……..…….. □ **OTHER** ……..…….. (please specify)

2. DECISION REQUIRED:	CATEGORY:
The Trust Board is asked to note the content of the report and support the actions to bring the performance back in line with trajectory/target.	☑ **NATIONAL TARGET** □ **CNST** □ **CQC REGISTRATION** □ **HEALTH & SAFETY** □ **ASSURANCE FRAMEWORK** ☑ **CQUIN/TARGET FROM COMMISSIONERS** □ **CORPORATE OBJECTIVE ……....** □ **OTHER ……..** (please specify)
	AUTHOR: Steve Rubery, Head of Business Delivery **PRESENTER:** Neill Moloney, Director of Delivery
	DATE: 21th March 2011

3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:
Not applicable.

4. DELIVERABLES
The delivery of the Trust wide objectives.

5. KEY PERFORMANCE INDICATORS
Please see attached Quality and Patient Standards Performance Dashboard.

AGREED AT _____ MEETING **OR** **REFERRED TO: _____**	**DATE: _____** **DATE: _____**
REVIEW DATE (if applicable) _____	

Quality and Patient Standards Performance Report February 2011

1. Department Of Health (DH) Performance Framework 2009/10 and 2010/11

The DH NHS Performance Framework assesses the performance of NHS Commissioners and Providers against minimum standards. The Quality and Patient Standards Performance Dashboard (the "Dashboard") is designed to guide the Trust Board in progress against this framework, which assesses Trusts in the areas of:

- Standards and Targets;
- Finance;
- Quality and Safety;
- User Experience.

The revisions to the Framework 2010/11 set out a number of changes, which are reflected in the Dashboard and are noted in previous reports. Additionally, the Trust has, elected to ensure that there is no deterioration in Four-Hour Maximum Wait in A&E performance. To this end, the Internal Performance Scorecard displays the thresholds as 98% and 95% as 'Performing' and 'Performance Under Review' respectively. Additionally, this internal measure displays performance against the Type 1 attendances[1] only, which is the measure that relates directly to the Trust's A&E Departments as opposed to all emergency attendances within the entirety of the health economy:

Measure	Upper Threshold (Performing/ Green)	Lower Threshold (Performance Under Review/ Amber)	Attendance Types
DH Performance Framework	95%	94%	All Types
BHRUT Internal Target – All Types	98%	95%	All Types
BHRUT Internal Target – Type 1 Attendances	95%	94%	Type 1 Only

The revised DH Framework target of 95% came into effect from Q2 of 2010/11, with the Trust being monitored against the previous 98% target for Q1.

This month (February) the MRSA screening performance indicator has been increased to two performance indicators in line with a DOH requirement. In addition to reporting the percentage of elective admissions screened the percentage of emergency admissions screened is being reported.

2. DH Framework Performance Targets

The Trust is achieving the published performance targets in the following areas:

[1] The NHS Data Dictionary defines type 1 patients as "Emergency departments are a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients." This therefore does not include services such as ophthalmology, or Urgent Care or NHS walk-in centres.

- Cancelled Operations - Breaches Of 28 Days Re-admission Guarantee As Percentage Of Cancelled Operations;
- Clostridium Difficile (C Diff)
- RTT (Previously 18 Weeks RTT), admitted and non-admitted pathways;
- 2 Week GP Referral To 1st Outpatient;
- 2 Week GP Referral To 1st Outpatient - Breast Symptoms;
- 31 Day Second Or Subsequent Treatment – Surgery;
- 31 Day Second Or Subsequent Treatment – Drug;
- 31 Day Diagnosis To Treatment For All Cancers;
- 62 Day Referral To Treatment From Screening;
- 62 Day Referral To Treatment From Hospital Specialist;
- 2 Week Rapid Access Chest Pain (RACP);
- 48 Hours GUM Access;
- Patients That Have Spent More Than 90% of Their Stay in Hospital on a Stroke Unit.

For 2010/11, the Quality and Patient Standards Performance Report provides a focus on areas where the published standards are not being achieved or fully achieved.

2.1 Four-Hour Maximum Wait In A&E From Arrival To Admission, Transfer Or Discharge A&E

For the first time since November 2010 the Trust has achieved above 95% for the all-type standard. Type 1 performance has been consistently below the 95% standard since August but has improved to 94.19% Trust-wide performance for the last week in February 2011 with QH performance at 91.68% and KGH at 97.6%

The additional bed capacity opened at KGH in response to the pressures has now been closed and the focus is now to close the contingency area at QH – Sky A by the end of March or sooner whist still maintaining the improved A&E performance.

The key operational challenges remain:

- Recruitment and retention of an appropriate clinical workforce (medical, nursing and others) particularly in A&E and acute areas to deliver care;
- Development of Emergency Ambulatory Care to deliver across all 49 clinical conditions identified;
- Improving bed flow – planning discharge at the point of admission, case management of complex patients;
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- Urgent Care centre – development and management from April 2011;
- Changes in the management of emergency/urgent GP referrals;
- Development of clinical pathways for single condition admissions;
- Successful implementation of Jonah as a management support tool
- Integration with community services.

The Emergency Care Intensive Support Team continue to work with the Trust to support the implementation of the existing and new standards. They are offering support in three areas.

- The development of a rapid assessment and treatment model for the Emergency
- Department at Queens Hospital;
- The development of a Trust wide emergency ambulatory care strategy and implementation plan;
- The implementation of new internal professional standards that support patient flow across the acute Trust.

The successful roll out of Discharge Jonah and formal cross buffer arrangements has significantly improved continuous bed flow and is assisting in reducing length of stay.

From April 1st 2011 eight new A&E indicators will be used to assess the quality of services provided. There are five headline measures which will be performance managed against a minimum threshold that delineates poor and potentially unsafe care. Data capture mechanisms have been agreed and put in place and we are able to report against each of the five headline measures.

2.2 MRSA

The Trust have a YTD total of 14 cases of MRSA bacteraemia against a target of 11. We are still awaiting the outcome of the appeal to the Department of Health against 2 episodes of recurrent infection in one patient. Despite the failure to achieve the target assigned by the Department of Health, it should be noted that we have improved the number of reported cases compared with 2009/10 when we had 17 cases in the same time period.

Clostridium difficile cases continue to be in single figures for the third consecutive month, bringing the yearly total to 105 against a target of 128 cases. This suggests that the plan to individually review cases with senior clinical staff has been effective in improving practice.

Although there is widespread Norovirus (diarrhoea and vomiting virus) in the rest of London, the Trust has not as yet been severely affected. So far in January and February 2011 we have had only 3 ward closures, compared with 18 in the same period last year.

2.3 RTT – Incomplete Pathways

The Trust continues to perform within all RTT targets with the exception of the median for incomplete pathways. As a result of the intensive validation of 4000 pathways there has been an improvement in performance against the incomplete median reducing from 15.7 weeks to 12.4 weeks. This is against a target of 7.2 weeks.

In order to achieve the median wait standard for incomplete pathways, of the current patients with an incomplete pathway 3000 patients will need to be treated. This data has been shared with commissioners so that the activity can be built into the 2011/12 activity plan over and above original planning assumptions. Approximately 2200 patients will sit within non-admitted pathways and 800 within admitted pathways. The possible value of the backlog is circa £2.5m. The Trust will look to incorporate this activity in existing capacity within QH or KGH and has no plans to outsource this. These patients would need to be cleared in order that the Trust achieve the new 2011/12 RTT waiting times. For admitted 95th percentile the performance target is reduced from 27.7 to 23 weeks, the incomplete 95th percentile target is reduced from 36 to 28 week whilst the 7.2 weeks target for the median incomplete pathway remains unchanged. When comparing current performance against the new standards for 11/12 the Trust would also fail the RTT admitted 95th percentile by 1.6 weeks, however it is anticipated that with further validation the one target that will be the challenge for 2011/12 will continue to be the incomplete median.

2.4 62 Days Urgent Referral To Treatment Of All Cancers

Note: Latest Cancer data is not complete and fully validated until 25 days past the end of the month reported on and uploaded to the Open Exeter national cancer database. The most recent figures in the month reported on should therefore be treated with caution and looked at in the context of previous validated months)

February's performance continued to achieve the majority of the targets except for the 62-day target which fell to 77.32% in month, 83.43% YTD. This was due mainly to an underachievement of tumour specific performance within Breast, Haematology, Upper GI, Lower GI, Gynaecology and Urology. Initial breach analysis has shown that over half the patient pathways were where the patients had to wait up to 2 weeks between each test or appointment which has led to the pathway being slow; if these tests were moved forward the breach may have been avoided, but this needs to be confirmed by reviewing the patient notes. The other breaches were caused by genuinely complex pathways.

With the re-organisation of the weekly CWT meetings the slow patient pathways will now be picked up within sufficient time to avoid patients breaching and to ensure that there is reasonable time, the PTL list has been extended to include all those patient who are due to breach within 31-days. Nearly all of the GMs and SMs have been trained on the Somerset cancer system so they can now access the information. Further work is needed to ensure that the tracking notes reflect what is actually happening and that the database is used in real time and at the MDT Meetings.

Regular meetings with the MDT Coordinators are taking place to monitor their performance and reiterate the importance of timely escalation. We are expecting that the 62-day target will be achieved in 2011/12, but not in 2010/11; the number of the patients waiting beyond their breach date has reduced significantly but not enough to allow us to achieve the 62-day target this year.

2.5 Delayed Transfers Of Care (DTOC)

The Trust's DTOC performance has this month failed to meet both the DH Performance Framework target of 3.5% and the local target of 1.0%. Daily DTOC management numbers have decreased to an average of 36 listed patients at any one time; this is due to close scrutiny of each case and improved joint working.

A regular meeting with Essex to develop policy around referrals to Brentwood Community Hospital as well as the community has improved the speed of the transfer process to the Essex area. Regular meetings continue to audit the quality as well as the speed of transfer of care. There has been an increase in discharged patients to the Thurrock area and with that in mind partnership working on joint referral pathways has commenced.

The discharge team is now at full staffing establishment with new staff members carrying out training and induction into the organisation. Team meetings and team building continues to ensure new system and processes are adhered to supporting the organisation in reducing DTOC and reduced lengths of stay in general.

The DTOC ward at KGH (Japonica) for Barking and Dagenham and Redbridge patients is now closed to admission.

The Complex Discharge Partnership Board meetings continue to run fortnightly involving PCTs, Social Services and Community Health Services and continue to drive forward the actions for change. The most recent focus being:

- Community support – implementation of JONAH as the main discharge planning tool is also useful in early identification of complex discharges. BHRUT can work closely with the community using accurate information to ensure early identification of

complex cases and individual case management where appropriate. This has enabled some of the longer staying patients to be discharged safely in the past month and rapid reduction in LoS for patients over 14 days

- Continuing Care Framework
- Leadership of Therapies and implementation of single intermediate care re-ablement pathway
- Admission Avoidance out of Hospital

3. Other Performance Indicators

3.1 Length Of Stay

Elective Length of Stay (LoS) reduced in February to 3.49 days from 3.53 days in January. Non-elective LOS reduced from 5.54 days in January to 5.34 days in February. This is also a reduction from the February 2010 position when NEL LoS was 5.69 days.

The Non Elective (NEL) specialty ward LoS plans are now in place and are managing to maintain the LoS reduction seen this year and for some specialties there were significant decreases in LoS, in particular Neurology and Care of the Elderly.

The acute medical take has been outlying from its bed base as a result of winter pressure but is now almost back to within it. Compared to February 2010, Medicine has managed similar NEL activity in circa 1800 less bed days and although the closed wards have been used for contingency this has allowed circa 30 beds to remain permanently closed (beds closed for EMDU, CDU, treatment rooms).

The main approach for reducing LoS and in particular the number of patients with an LoS over 14 days is to use Jonah data at a daily meeting with Matrons and external partner representation which monitors all patients in delay and where appropriate escalation measures to resolve the delay are agreed. This is being lead by the Divisional Manager for Medicine reporting into the Emergency Programme Board. The flow has improved considerably throughout February which has supported the improvement in the A&E access target. At the beginning of February there were over 180 patients in delay this has now reduced to below 100. However LoS and the number of patients with a LoS of over 14 days have not reduced as much as would be expected. Therefore the next step is to challenge why the patients not in delay remain in hospital. Again this will be done using Jonah data. The number of delayed patient days is a good indicator of flow. The target is to have no more than 400 delayed patient days for Queens and 150 delayed patient days for KGH. Currently QH is at 700 and KGH 150 delayed patient days. In addition the very complex discharges are being case managed on an individual basis.

The Compstat meetings have resulted in clear pathways for UTI, Dementia and Pneumonia, which are being implemented.

The Acute Elderly Unit (AEU) at QH continues to function well and patients who require admission to this unit are being transferred in a timely manner. However the demand for AEU beds is not currently met, with AEU patients outlying in Medicine. Therefore one of the plans for the coming year is to reconfigure an additional 30 beds to be used to expand AEU with the intention of reducing CoE LoS still further.

The LoS plans for 2011/12 are:

- Reduction in patients with a length of stay of over 14 days to 24%
- Centralisation of Vascular Services
- Improving Out of Hours repatriations for Neurosurgical patients

- Extend Ambulatory Care Pathways – first 6 to focus on will be
    - COPD
    - Pleural effusions
    - Pulmonary Embolism
    - Deliberate self harm
    - Congestive Cardiac failure
    - Supraventricular tachycardias
- Increase daycase treatment for bladder tumours
- Increase MAU discharges to 55%
- Further roll out of Enhanced Recovery Programme
- Improved Efficiency of Surgical Discharge Process
    - Colectomy
    - Excision of rectum
    - Prostatectomy
    - Primary hip replacement
    - Primary knee replacement
    - Abdominal surgery
    - Vaginal Hysterectomy

3.2 DNA Rates

There has been an overall improvement in performance in DNA rates for both first and follow-up appointments in month of 9.81% and 11.76% respectively. This represents the lowest monthly rate since for both measures since November 2010. However, there has been marked variation between specialities over this period. The year to date figures show a disappointing underperformance against the standards of 10.2% for first and 11.8% for follow-ups. There has been an overall improvement in performance in DNA rates for both first and follow-up appointments in month to 9.81% and 11.76% respectively. This represents the lowest monthly rate since for both measures since November 2010. However, there has been marked variation between specialities over this period.

DNA rates will form part of the outpatient improvement workstream.

3.3 First to Follow-up Ratio

In terms of the first to follow-up ratios there has been deterioration in month to 2.31. An element of this is down to trying to catch up from the appointments cancelled due to the poor weather and recent major incidents. However, we have not seen the sustained improvements across the specialities that should have been delivered with the detailed action plans that have been drafted.

The inaugural meeting of the workstream to focus on outpatient performance has now taken place and this group will focus on a number of initiatives including how we reduce DNA rates and first to follow-up ratios. This is an Executive-led group and has representation from each Division. The increased emphasis and drive to achieve both these outpatient standards will deliver significant enhancements in performance over the coming months. It is extremely disappointing that further progress has not been made so far this year.

3.4 Re-admission Rates within 28 days

(Note: Re-admissions rates are reported one month in arrears)

General Medicine continue to have high readmission rates at around 15% however Care of the Elderly (CoE) readmissions reduced by 10% from 29% to 19% in December and this has been sustained into January. This is probably a result of the combination of AEU and the work with community partners to support safe discharge and re-ablement packages of care for patients to go home.

There is now a readmission group established lead by a CoE Consultant to drive the following actions:

- Work with community partners to improve and build on our ambulatory care pathways to provide seamless care
- Methods to arrange more elective admissions not involving the acute care pathway for general medical/oncology/haematology patients and other specialities need developing
- Strengthening relationships with community partners regarding robust admission avoidance schemes
- More viable community alternatives to hospital admission must be established and developed
- Patient plans and pathways from Nursing Homes and Care homes regarding secondary care support need to be developed and established
- Acute care/elderly care physicians to work in partnership with community colleagues to help with pathways for both short stay and recurrent complex admissions
- More interaction with our Mental Health Trust Partner

On going work with Nursing Homes through the Associate Director of Nursing will to pick up some of the above points and link into the Divisional plans.

3.5 Freedom of Information

	Aug-10		Sep-10		Oct-10		Nov-10		Dec-10		Jan-11			
Division/Department	**Number Received**	**% responded to within deadline**	**Number Received**	**% responded to within deadline**	**Number Received**	**% responded to within deadline**	**Number Received**	**% responded to within deadline**	**Number Received**	**% responded to within deadline**	**Number Received**	**% responded to within deadline**	**Total number outstanding (including frozen)**	**Number frozen**
A&E	0	0%	3	100%	0	0%	2	100%	0	0%	1	100%	0	0
Catalyst	0	0%	0	0%	1	100%	1	100%	0	0%	0	0%	0	0
Clinical Governance	0	0%	2	100%	2	100%	2	50%	3	100%	3	100%	0	0
Clinical Support	6	83%	4	75%	3	100%	6	100%	1	100%	4	100%	0	0
Communications	0	0%	0	0%	0	0%	0	0%	1	100%	0	0%	0	0
Discharge Team	0	0%	0	0%	0	0%	1	100%	0	0%	0	0%	0	0
Education	1	100%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0
Education & Learning	0	0%	0	0%	1	100%	0	0%	0	0%	0	0%	0	0
Emergency	3	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0
Estates & Facilities	1	100%	1	100%	0	0%	1	0%	0	0%	1	100%	0	0
Executive Offices	0	0%	1	100%	0	0%	0	0%	0	0%	1	100%	0	0
Finance Other	4	100%	2	50%	2	100%	3	33%	1	100%	7	100%	0	0
Human Resources	5	40%	1	0%	3	67%	2	100%	3	100%	2	100%	0	0
IT	3	100%	2	100%	0	0%	10	100%	2	100%	4	100%	0	0
Medical	0	0%	1	100%	0	0%	0	0%	0	0%	0	0%	0	0
Nursing Other	1	100%	1	100%	2	100%	2	100%	0	0%	1	100%	0	0
Occupational Health	0	0%	0	0%	0	0%	0	0%	1	0%	1	0%	1	0
Performance/Information	1	100%	1	100%	3	100%	3	100%	0	0%	2	100%	0	0
Procurement	0	0%	1	100%	0	0%	0	0%	0	0%	0	0%	0	0
Resuscitation Services	0	0%	1	100%	0	0%	1	0%	0	0%	0	0%	0	0
Surgical	0	0%	1	100%	0	0%	2	50%	3	67%	1	0%	0	0
Women and Children	1	100%	0	0%	2	100%	1	100%	0	0%	1	100%	0	0
Grand Total	**26**	**73%**	**22**	**86%**	**19**	**95%**	**37**	**84%**	**15**	**87%**	**29**	**93%**	**1**	**0**

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Having received above the monthly average number of FOI requests (25), this month's performance rate (93.10%) is higher than the average of the last 6 months (86.29%). Although no pattern can be derived of Departments/Divisions who constantly do not meet timeframes, Clinical Support, Finance, HR and IT continue receive a high number of requests each month.

The first questionnaires have been returned from FOI applicants, which show positive feedback and satisfaction with the service.

3.6 Data Quality Issues

The PAS Team have been working with McKesson on an enhancement to PAS to ensure that 'Maternity Episodes' are correctly identified within the extracts submitted to the Secondary User Service (SUS). This change is aimed at additional validation against episode diagnosis codes applied against inpatient records. The enhanced validation was implemented within the "live" PAS. Whilst passing initial testing final confirmation required the extracted data to be submitted to, and validated by, the SUS. The initial March SUS run identified an issue, caused as a result of the enhanced validation, and a decision was taken to "roll back" the change to ensure the integrity of the Trust's March SUS submission. Assuming it's possible to enhance the extract validation as required, a further attempt will be made to implement the change during April 2011.

3.7 Complaint Numbers and complaints responded to within 30 days

(Note: Complaints responded to are reported one month in arrears)

The number of complaints received for the month of February 2011 was 73. This continues the higher trend in complaint numbers and is the highest number for the whole of the financial year. The highest percentage of complaints for this month (30%) has again been received by the surgical directorate. In 2009 the NHS and social care complaints regulations changed and there is now an expectation that the date for response is agreed with the complainant at the start of the process. This means that at the time of reporting to the Board each month a proportion of complaints have not reached their due date for response. This month for instance, over 10% of the month's complaints have not yet reached their due date. The report to the Board can therefore be misleading and it is proposed that, in future months, the Board receives a performance report detailing the complaint response rate two months in arrears. On that basis, next month if the complaint response performance target for January 2011 is not met a commentary will be provided.

The review of the complaint processes is progressing and the style of responses has been changed in line with Ombudsman's feedback. It is expected that the review will be complete by end March 2011.

3.8 Mixed Sex Breaches

There have been 19 breaches in the last month, relating to sleeping accommodation for patients; this is 10 fewer than in January. All the breaches occurred in critical care areas (general HDU, neuro ITU and HDU), and involved patients who no longer required that level of specialist care and were awaiting transfer to a general ward. NHS London have agreed a six hour "preparation period" for all of these areas, after a patient is stepped down to level 1 care. If the patient remains in the specialist area, which is mixed sex, for longer than that whilst waiting to move to a ward, then they are reported as a breach. All of the breaches have related to ward bed availability whilst the hospital has been under continued pressure. There have been no breaches of same sex accommodation in the general inpatient wards.

4. Commissioning for Quality and Innovation (CQUIN) Schedule and Contractual Key Performance Indicators (KPIs)

Progress against each of the CQUIN schemes and KPIs is monitored on a monthly basis with exception reports being submitted to the Productivity PEQ meeting. The detailed performance data is included in the Performance Dashboard this month for information.

Barking, Havering and Redbridge University Hospitals NHS Trust

Quality and Patient Standards Dashboard February 2011

Service Performance Scorecard - DH Performance Framework 2010/11

	Indicator	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Thresholds		Performance
Standards and Targets	Four-Hour Maximum Wait In A&E From Arrival To Admission, Transfer Or Discharge[1]	98.91%	97.97%	97.37%	97.04%	96.12%	94.62%	95.00%	94.47%	90.59%	92.18%	95.42%		94.60%	98.0%	94.0%	Performance Under Review
	Cancelled Ops - Breaches Of 28 Days Readmission Guarantee As % Of Cancelled Ops[5]	0.00%	0.00%	0.00%	10.53%	0.00%	0.00%	0.00%	4.35%	0.00%	14.29%			2.92%	5.0%	15.0%	Performing
	MRSA	1	1	1	0	1	1	1	2	3	2	1		14	0SD	>1SD	Underperforming
	C Diff (128)	11	4	11	10	12	14	16	12	4	4	6		104	0SD	>1SD	Performing
	RTT Admitted - Median	6.2	5.8	6.7	6.3	6.4	8.1	7.3	7.3	7.2	8.1	7.9		N/A	<=11.1		Performing
	RTT Admitted - 95th Percentile	18.9	18.5	18.0	17.1	16.9	20.6	22.1	22.5	21.9	25.0	24.6		N/A	<=27.7		Performing
	RTT Non-Admitted - Median	4.5	4.5	5.1	4.2	5.1	5.6	3.9	3.7	3.8	5.3	3.9		N/A	<=6.6		Performing
	RTT Non-Admitted - 95th Percentile	13.6	14.0	14.5	14.7	13.1	13.9	13.8	15.0	14.6	15.3	15.8		N/A	<=18.3		Performing
	RTT Incomplete - Median	12.6	13.5	13.2	13.5	13.8	13.4	14.3	14.7	14.9	15.7	12.4		N/A	<=7.2		Underperforming
	RTT Incomplete - 95th Percentile	31.9	30.0	30.6	30.1	32.8	32.7	30.4	29.8	29.1	28.3	27.8		N/A	<=36		Performing
	2 Week GP Referral To 1st Outpatient	99.89%	99.90%	99.91%	99.91%	99.80%	99.67%	99.90%	99.59%	99.28%	99.38%	99.90%		99.76%	93.0%	88.0%	Performing
	2 Week GP Referral To 1st Outpatient - Breast Symptoms	99.44%	100.00%	99.49%	100.00%	98.22%	99.42%	100.00%	100.00%	100.00%	100.00%	99.00%		99.59%	93.0%	88.0%	Performing
	31 Day Second Or Subsequent Treatment - Surgery	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.43%	100.00%	100.00%	96.30%	100.00%		99.33%	94.0%	89.0%	Performing
	31 Day Second Or Subsequent Treatment - Drug	100.00%	100.00%	96.30%	95.83%	100.00%	100.00%	100.00%	100.00%	100.00%	96.30%	100.00%		98.94%	98.0%	93.0%	Performing
	31 Day Diagnosis To Treatment For All Cancers	98.98%	98.48%	98.40%	98.72%	98.57%	99.53%	100.00%	100.00%	98.92%	100.00%	98.31%		99.07%	96.0%	91.0%	Performing
	62 Day Referral To Treatment From Screening	93.33%	95.65%	100.00%	90.00%	92.31%	94.29%	100.00%	81.82%	100.00%	84.21%	87.50%		92.70%	90.0%	85.0%	Performing
	62 Day Referral To Treatment From Hospital Specialist	89.47%	87.88%	100.00%	85.71%	100.00%	79.41%	88.24%	100.00%	100.00%	83.78%	33.33%		86.97%	85.0%	80.0%	Performing
	62 Days Urgent Referral To Treatment Of All Cancers (exclusions applied)	83.98%	79.89%	83.11%	81.74%	85.15%	81.31%	89.36%	82.94%	88.61%	81.87%	77.32%		83.43%	85.0%	80.0%	Performance Under Review
	2 Week RACP	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		100.00%	98.0%	95.0%	Performing
	48 Hours GUM Access	100.00%	100.00%	100.00%	100.00%	99.45%	97.76%	98.29%	99.41%	98.74%	98.75%	98.15%		99.14%	98.0%	95.0%	Performing
	Patients That Have Spent More Than 90% Of Their Stay In Hospital On A Stroke Unit	81.8%	86.4%	83.6%	86.1%	86.8%	77.8%	82.4%	84.3%	92.2%	93.2%	95.8%		87.4%	60.0%	30.0%	Performing
	Delayed Transfers Of Care	3.85%	4.12%	4.27%	5.41%	3.82%	5.64%	5.77%	4.95%	3.32%	2.84%	3.09%		4.39%	3.5%	5.0%	Performance Under Review

DOMAIN	Performance
Standards and Targets	Performing

	Initial Planning	Year to Date		Forecast Outturn			Underlying Financial Position		Finance Processes & Balance Sheet Efficiency				
Finance[2]	Planned Outturn as a proportion of Turnover	YTD Operating Performance	YTD EBITDA	Forecast Operating Performance	Forecast EBITDA	Rate of Change in Forecast Surplus or Deficit.	Underlying Position %	EBITDA Margin (%)	Better Payment Practice Code Value %	Better Payment Practice Code Volume %	Current Ratio	Receivable Days	Payable Days

DOMAIN	Performance
Finance	Underperforming

	Experience of Patients				Public Confidence		
User Experience[3]	Access and waiting	Safe, high quality, coordinated care	Better information, more choice	Building closer relationships	Clean, friendly, comfortable place to be	Focus on the person	Learning organisation	Dignity and respect

DOMAIN	Performance
User Experience	Performance Under Review

	CQC Registration Status
Quality and Safety[4]	

DOMAIN	Performance
Quality and Safety	Performance Under Review

TRUST ASSESSMENT
Underperforming

As of 16 March 2011 CQC decisions are awaited in relation to the request to remove the following conditions

		Sites:
Maternity staffing	-	Queen's Hospital*
		*Maternity Services Unannounced visits in January; report received for checking accuracy
		3 Warning Notices and 3 letters advising of moderate concerns received. All areas receiving urgent attention to meet CQC deadlines
Pressure damage	-	King George Hospital and Queen's Hospital
Resusitation	-	King George Hospital, Queen's Hospital, Barking Community and Victoria Hospital
Staff appraisal	-	King George Hospital, Queen's Hospital, Barking Community and Victoria Hospital

Notes:

[1] The Trust will be assessed from Q2 onwards and this is reflected in the YTD figure

[2] For detail please see separate Finance Report

[3] The 'Experience of patients' scores are derived from the adult inpatient survey, while the indicators for 'Public confidence' are from a number of sources including the NHS national patient survey programme, the NHS national staff survey programme and written complaints data. As some of this data is not yet available to the Trust, staff are developing internal surveying methods according to the Patient Experience

[4] For detail please see separate CQC Action Plan

[5] Of patients cancelled in month the number that went onto breach. An 'as at' unvalidated month end position

Barking, Havering and Redbridge NHS University Hospitals NHS Trust

Quality and Patient Standards Dashboard February 2011

Performance Scorecard - **BHRUT Internal Targets 2010/11**

	Indicator	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Thresholds		YTD Performance
A&E (Type 1,2)	Four-Hour Maximum Wait In A&E From Arrival To Admission, Transfer Or Discharge[1]	93.03%	96.74%	97.86%	96.03%	95.03%	93.98%	92.36%	89.12%	90.01%	88.73%	80.24%	83.84%	90.89%		89.13%	98.00%	95.00%	Underperforming
Mortality (HSMR Data is from Dr Foster and two months in arrears)	Hospital Standardised Mortality Ratio (Monthly)	105.1	109.4	110.8	109.5	104.2	97.7	118.3	101.0	98.7	83.8	91.0					N/A	N/A	
	HSMR Relative Risk (Low)	90.2	94.7	95.7	93.9	89.0	82.9	101.1	86.6	84.4	71.7	82.2					N/A	N/A	
	HSMR Relative Risk (High)	121.8	125.7	127.6	127.0	121.2	114.4	137.6	117.1	114.8	97.3	110.5					N/A	N/A	
	Hospital Standardised Mortality Ratio (Rolling 12 Monthly)	115.6	115.7	114.2	114.2	112.4	110.2	111.5	110.8	109.4	104.2	103.9					N/A	N/A	
	HSMR Relative Risk Rolling 12 Monthly (Low)	110.9	111.0	109.6	109.5	107.8	105.7	107.0	106.3	105	99.9	99.6					N/A	N/A	
	HSMR Relative Risk Rolling 12 Monthly (High)	120.5	120.6	119.1	119.0	117.1	114.9	116.2	115.4	114	108.7	108.3					N/A	N/A	
	Mortality rate - elective cases (%)	0.20%	0.02%	0.04%	0.10%	0.12%	0.12%	0.06%	0.02%	0.07%	0.11%	0.04%	0.06%	0.15%		0.07%	N/A	N/A	
	Mortality rate - non-elective cases (%)	3.62%	3.79%	3.83%	3.47%	3.64%	3.64%	3.28%	3.60%	3.49%	3.42%	4.40%	5.07%	2.94%		3.66%	N/A	N/A	
.	C&B Slot issues per successful DBS booking	0.03	0.02	0.02	0.03	0.03	0.03	0.02	0.01	0.02	0.02	0.01	0.01	0.02		0.02	0.04	0.10	Performing
Length of Stay	LOS (Elective)	3.7	3.8	4.07	3.58	3.88	3.26	4.23	3.09	2.92	3.52	3.68	3.53	3.49		3.55	3.6	4.2	Performing
	LOS (Non-Elective)	5.7	5.5	5.52	5.30	5.71	5.31	5.03	5.29	5.29	5.27	5.92	5.54	5.34		5.41	5.0	5.5	Performance Under Review
First to Follow-Up Ratios	FFU Ratio (Less Midwifery, Ophthalmology and Rheumatology)	2.29	2.30	2.29	2.17	2.15	2.13	2.28	2.27	2.19	2.31	2.32	2.19	2.31		2.23	2.22	2.27	Performance Under Review
DNA	DNA First	8.22%	8.96%	9.71%	9.34%	9.55%	9.91%	10.88%	10.62%	10.03%	9.76%	11.51%	10.33%	9.81%		10.12%	9.70%	10.20%	Performance Under Review
	DNA Follow-Up	10.64%	10.88%	11.38%	10.62%	11.10%	11.24%	11.27%	12.27%	11.87%	11.85%	13.55%	12.76%	11.76%		11.77%	10.30%	10.80%	Underperforming
Day Case Rates	Basket of 25 procedures	75.24%	78.59%	77.43%	78.93%	79.43%	81.61%	83.97%	84.28%	82.43%	79.28%	79.09%	81.46%	79.76%		80.59%	75.00%	70.00%	Performing
	All procedures	85.30%	86.11%	85.92%	84.88%	87.03%	86.44%	88.21%	86.53%	86.07%	86.50%	87.37%	88.81%	86.89%		86.75%	75.00%	70.00%	Performing
Elective Admissions	Elective Admissions on Day of Surgery	89.42%	88.20%	95.52.%	95.35%	97.00%	97.22%	98.12%	97.77%	97.47%	98.03%	98.12%	97.62%	97.88%		97.26%	85.00%	80.00%	Performing
Readmission Rates within 28 Days	Readmission Rates	7.89%	7.36%	7.95%	7.69%	7.27%	7.53%	7.87%	7.91%	7.80%	8.04%	8.28%	8.31%			7.86%	7.00%	7.35%	Underperforming
	Readmission Rates to same specialty	3.93%	3.76%	4.12%	4.03%	3.79%	3.92%	3.92%	3.92%	4.14%	4.05%	4.47%	4.30%			4.06%	3.50%	4.00%	Underperforming
FOI	FOI Requests responded to within 20 working days	65%	56%	45.00%	47.62%	44.44%	62.86%	73.08%	86.36%	94.74%	83.78%	86.67%	93.10%			71.77%	100%	-	Underperforming
Data Quality	Significant SUS-SEM Data Quality Issues	1	1	1	1	1	1	1	1	1	1	1	1	1		1	0	2	Performance Under Review
Infection Control	MRSA Screening8	79.44%	73.33%	81.12%	76.93%	70.39%	75.84%	85.71%	84.53%	81.38%	75.55%	n/a[7]	71.00%			n/a	TBC	TBC	
	MRSA Screening - Elective													84%		n/a			
	MRSA Screening - Emergency													74%		n/a			
	MSSA Infection					2	6	11	3	5	3	6	6	9		51	TBC	TBC	
Safety Reporting	Incident reporting rate per 100 admissions	6.48%	5.51%	5.69%	5.61%	5.10%	4.96%	5.55%	4.95%	5.94%	5.13%	4.43%	4.64%	5.52%		5.22%	TBC	TBC	
	Serious Untoward Incidents (SUI) as a % of incidents reported	0.60%	0.31%	0.33%	0.17%	0.52%	1.41%	0.34%	1.70%	0.91%	1.57%	2.20%	1.24%	0.90%		0.98%	TBC	TBC	
Complaints	Complaint Numbers (excluding enquiries)	44	56	42	35	45	45	31	44	41	64	47	72	73		539	456	475	Underperforming

	Indicator	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Thresholds		YTD Performance
Complaints	Complaints responded to within 30 working days	79%	79%	81%	89%	82%	64%	65%	64%	83%	73%	38%	39%			68%	80%	75%	Underperforming
Mixed Sex Breaches	No. of patients in mixed sex wards	86	52	0	0	0	0	0	0	0	0	0	29	19		48	0	1	Underperforming
Ambulance Handover	LAS Arrival to Patient Handover Time - % Greater than 15 minutes			45.60%	46.00%	49.00%	52.70%	58.60%	53.10%	62.40%	57.90%	62.80%				55.72%	85.00%	75.00%	Underperforming
Chief Nursing Officer High Impact Changes	Increase in permanent nursing and midwifery staffing ratios			87.97%			84.90%			86.10%						86.32%	84.40%		
	Reduction in in-hospital Pressure Ulcer rates			0.07%			0.11%			0.06%						0.08%	See Note[2]		
	Reduction in the rate of in-hospital catheter-related Urinary Tract Infections			Awaiting DoH guidance on recording data - TBC end of July			Still awaiting DoH guidance			Still awaiting DoH guidance							TBC		
Critical Care	Transfers out of ICU Department between 22:00 and 08:00			14.10%	22.65%	19.90%	11.25%	20.10%	17.14%	15.78%						17.27%	5 per Quarter		
Fractured Neck of Femur (#NOF)	Decrease 30 day mortality for #NOF			7.23%			3.16%			3.57%						5.25%	See Note[3]		
Maternity	Decrease Caesarean Section (CS) rates			23.25%			20.00%			23.00%						22.08%	See Note[4]		
	Increase the percentage of women provided with 1:1 care in Labour			89.50%			Not yet available			Not yet available							See Note[5]		
	% of women who have seen a midwife or maternity healthcare professional, for assessment of health and social care needs, risk and choices by 12 completed weeks of pregnancy.			77.00%			85.84%			89.00%						83.95%	See Note[6]		

Notes:

[1] The Trust will be assessed from Q2 onwards and this is reflected in the YTD figure

2 Decreased % of grade 3 and grade 2 pressure ulcers by end of Q4 2010/11

[3] Target is for the 75th centile as compared to Dr Foster figures on 01/03/2010

[4] Aim for 20% for end of 2010/11

[5] 95% by end of Q4. Trajectory to be confirmed

[6] 90% by end of Q2 2011/12

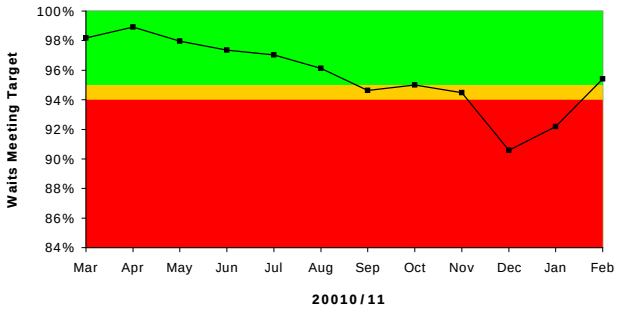
[7] Data not available with the introduction of emergency admission 8 Includes emergency and elective for Jan 2011

Barking, Havering and Redbridge NHS University Hospitals NHS Trust

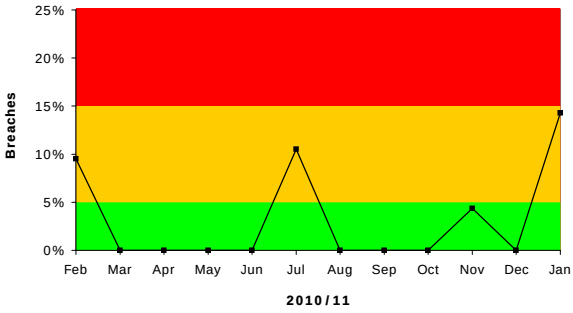
Key:

= Performing
= Performance Under Review
= Underperforming

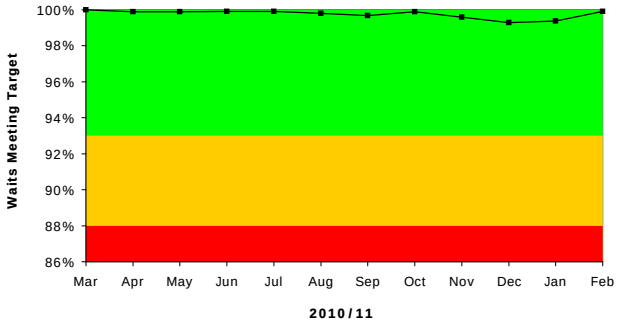
Four-Hour Maximum Wait In A&E From Arrival To Admission, Transfer Or Discharge (All Attendances)



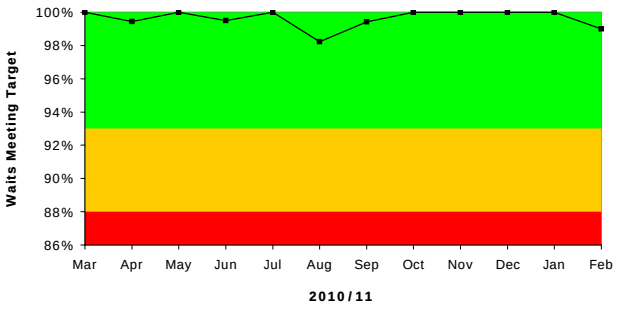
Cancelled Ops - Breaches Of 28 Days Readmission Guarantee As % Of Cancelled Ops



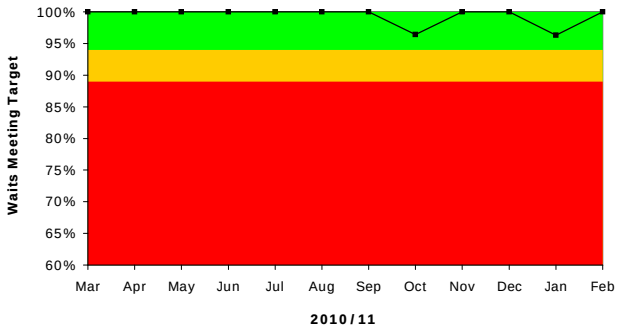
2 Week GP Referral To 1st Outpatient



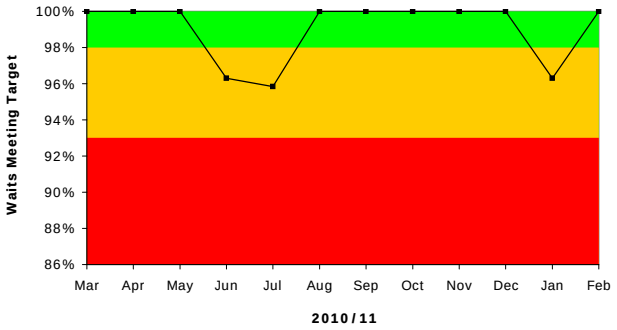
2 Week GP Referral To 1st Outpatient - Breast Symptoms (Live from December 2009 Onwards)



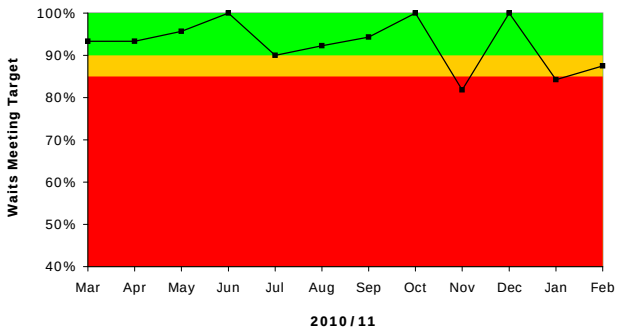
31 Day Second Or Subsequent Treatment - Surgery



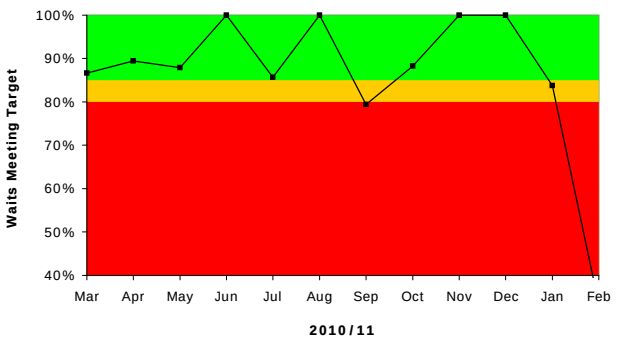
31 Day Second Or Subsequent Treatment - Drug



62 Day Referral To Treatment From Screening



62 Day Referral To Treatment From Hospital Specialist

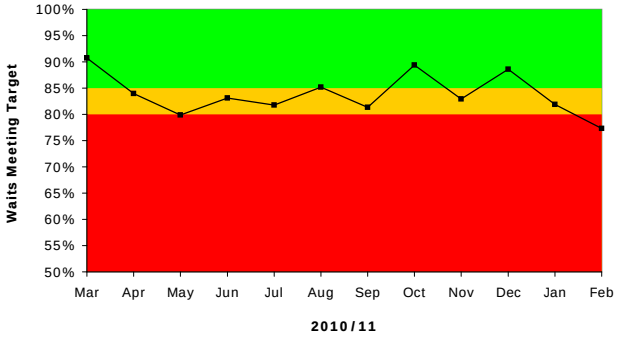


Barking, Havering and Redbridge University Hospitals NHS Trust

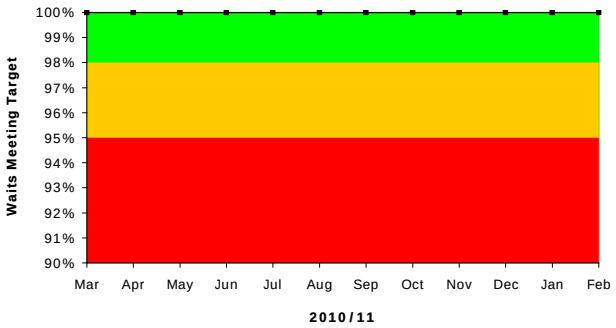
Key:

= Performing
= Performance Under Review
= Underperforming

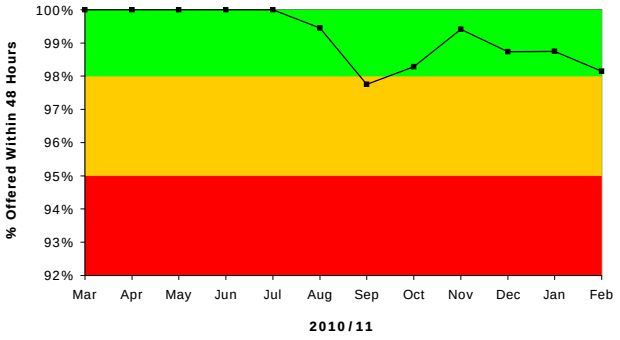
62 Days Urgent Referral To Treatment Of All Cancers



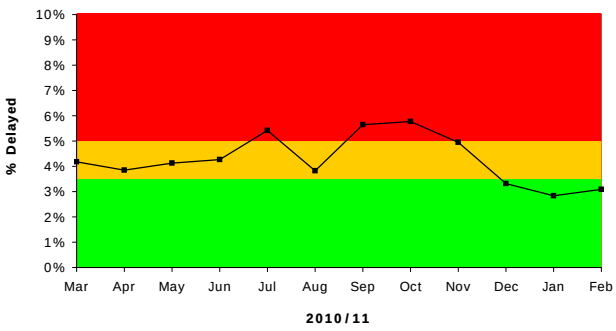
2 Week RACP



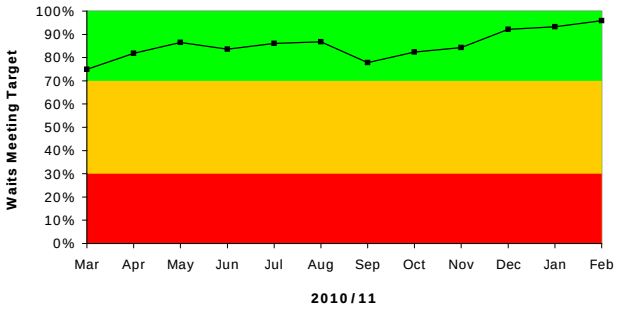
48 Hours GUM Access



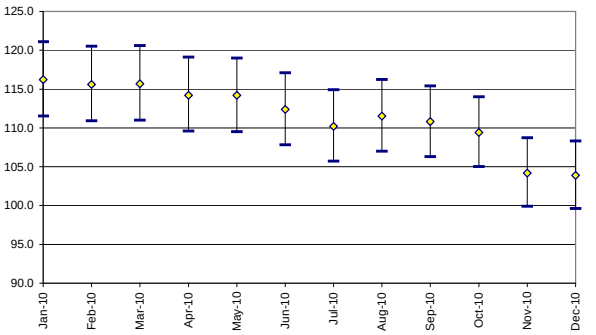
Delayed Transfers Of Care



Patients That Have Spent More Than 90% Of Their Stay In Hospital On A Stroke Unit



Hospital Standardised Mortality Ratio (HSMR) - Rolling 12 Month Figure



g and Redbridge NHS
iversity Hospitals
NHS Trust

Quality and Patient Standards Dashboard February 2011
Performance Scorecard - KPI & CQUINs 2010/11

									0910	2010-11													
Indicator	Indicator Description	Reponsible	Incentive/Penalty	Reporting Frequency	Target	Target	Baseline	Baseline	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Ambulance Handover	If an LAS Arrival to Patient Handover Time is ever greater than 60 minutes it shall be reported by the Hospital Trust as a Serious Untoward Incident (SUI).	Performance & Information	Standard SUI process	Monthly	None	None	None	None		0.00%	0.00%	0.00%	0.00%	0%	0%	0%						0.00%
Ambulance Handover	The percentage of times the LAS Arrival to Patient Handover Time is greater than 15 minutes shall not exceed 15% in any calendar month during 2010/11.	Collette Wood	£225k	Monthly	85%	85%	TBC	48.40%		45.60%	46.00%	49.00%	52.70%	58.60%	53.10%	62.40%	57.90%	62.80%	63.60%	61.20%		55.72%
Ambulance Handover	The percentage of times the LAS Arrival to Patient Handover Time is greater than 30 minutes shall not exceed 5% in any calendar month during 2010/11.	Collette Wood	Remedial Action Plan	Monthly	5%	5%	TBC	7.20%		3.50%	5.50%	6.00%	7.70%	9.40%	9.90%	12.50%	10.70%	15.40%	15.50%	10.40%		9.68%
First to Follow-up Ratios -5% reduction in first to follow up ratios overall and achievement of 5% improvement in the top 10 specialties of: Trauma and Orthopaedics, Gynaecology, General Medicine, General Surgery, Paediatrics, Cardiology, Urology, Ophthalmology, ENT and Gastroenterology	Trust wide	Performance & Information	£600k	Quarterly	5% reduction on 2009/10 out-turn	2.22		2.34		2.20			2.21			2.22						2.21
	Trauma & Orthopaedics	Performance & Information				1.58		1.66		1.60			1.61			1.61						1.60
	Gynaecology	Performance & Information				1.15		1.21		1.10			1.17			1.15						1.13
	General Medicine	Performance & Information				3.01		3.17		3.30			3.23			3.28						3.26
	General Surgery	Performance & Information				1.90		2.00		2.01			1.98			1.98						1.99
	Paediatrics	Performance & Information				1.71		1.80		1.78			1.86			1.89						1.82
	Cardiology	Performance & Information				1.77		1.87		1.97			1.95			1.96						1.96
	Urology	Performance & Information				2.62		2.75		3.00			2.80			2.96						2.90
	Dermatology	Performance & Information				1.38		1.45		2.04			2.38			2.33						2.20
	ENT	Performance & Information				1.49		1.57		1.63			1.63			1.66						1.63
	Gastroenterology	Performance & Information				2.06		2.17		2.22			2.32			2.31						2.28
Learning Disability	Specific learning disability patient satisfaction 50% of the payment linked to performing two (2) patient surveys. The first to establish a benchmark. 50% of the payment linked to improved performance of the second patient survey over the first.	Nichole McIntosh	5% total KPI financial value	Bi-annually	TBC after first patient survey	TBC after first patient survey	TBC after first patient survey			The first of two patient experience survey for patients with a learning disability will be completed in July 2010. This will be to benchmark against the CQC indicator set for access to healthcare for patients with a leraning disabilityand agree a plan of action prior to a re-audit later in the year.			There have been delays with the survey due to the consultation process that has been undertaken to provide assurance that the survey tool will be in the most accessible format for the patient group.The survey tool has been drafted and will be presented to the Nursing and Midwifery Board on 21st			The survey has been distributed to the Learning Disability Community Matrons for the boroughs of Havering, Redbridge and Barking and Dagenham to complete with their clients who have been hospitalised in either King George or Queens Hospitals between the period Dec 09 - Dec 2010. The rseponse rate				
Reduction in Length of Stay by specialty	Trust Wide spell LOS	Performance & Information	£600k	Quarterly	12% reduction	4.72	2009/10 outturn	5.36		5.31			5.03			5.27						5.17
	NEL General Medicine spell LOS	Performance & Information				7.27		8.26		8.39			7.98			7.95						8.19
	NEL Geriatric Medicine spell LOS	Performance & Information				9.77		11.10		12.57			13.31			14.14						12.99
	#NOF - episode LOS for 1ary diagnosis #NOF	Performance & Information				7.92		9.00		11.49			8.77			10.52						10.13
	Critical Care - ward LOS for critical care wards	Performance & Information				3.59		4.08		4.00			3.83			3.93						3.91
	Trust wide EL spell LOS	Performance & Information				3.30		3.75		3.84			3.47			3.34						3.67
	Trust wide NEL spell LOS	Performance & Information				4.92		5.59		5.51			5.21			5.50						5.21
Safeguarding Children	Bi-annual audit by providers of their adherence to safe-guarding standards within local and Londonwide policies	Deborah Wheeler	Remedial Action Plan	Bi-annually	Full compliance with local and London wide policies	Full compliance with local and London wide policies	N/A	N/A		Bi annual audit to be undertaken												

Maternity	Birth Notifications - Level of accuracy to be monitored with support of the ONEL PCTs sending the required information to BHRUT in a timely manner. Reporting by individual PCT.	Sue Lovell	Remedial Action Plan	Quarterly	98%	98%	TBC			No feedback from PCT's			No feedback from PCT's			89% is for Redbridge only as ithey are the only one to notify us											
Maternity	Evidence of working towards the achievement of UNICEF Standard Baby Friendly	Sue Lovell	Remedial Action Plan	Annual report to Maternity JPB	TBC	TBC	TBC			BF Training commenced Peer supporters in place BHRUT participants in the breast			BF Training commenced Peer supporters in place BHRUT participants in the			BF Training commenced Peer supporters in place BHRUT participants in the											
Maternity	Increased percentage of home births.	Sue Lovell	Remedial Action Plan	Monthly	1% increase from March 2010 outturn	1% increase from March 2010 outturn	March 2010 OT 2.4%	March 2010 OT 2.0%	2.40%	2.50%	2.40%	1.46%	2.30%	1.44%	2.57%	1.50%	1.89%	2.10%	2%	2.80%								2.09%
Maternity	Level of Did Not Attend (DNA) rates for antenatal appointments	Performance & Information	Remedial Action Plan	Monthly	Decreasing trend	Decreasing trend	TBC	0910 OT 6.99%	7.87%	9.03%	8.52%	8.14%	9.46%	8.03%	8.18%	7.28%	8.29%	9.55%	8.14%	8.70%								7.50%
Maternity	Low birth weight babies proportion (<2,500g)	Sue Lovell	Remedial Action Plan	Quarterly	Peer group upper quartile by March 2013 via Dr Foster. Trajectory to be confirmed in Q1 with involvement of Public Health. Sign off by Maternity JPB in June 2010.	Peer group upper quartile by March 2013 via Dr Foster.	TBC in Q1	0910 OT 7.25%		7.90%			7.80%			7.60%											7.90%
Maternity	Percentage Breast Feeding at initiation and discharge from Community Midwife (10 - 12 days)	Sue Lovell	Remedial Action Plan	Monthly	TBC in Q1 and agreed at Maternity JPB in June 2010	TBC in Q1 and agreed at Maternity JPB in June 2010	TBC in Q2	0910 OT 70.42%	72.00%	75.60%	74.00%	73.40%	74.20%	72%	75.20%	76.50%	76.50%	75.60%	75.60%	74.60%								74.84%
Maternity	Percentage of women who were offered referral to smoking cessation services during pregnancy	Sue Lovell	Remedial Action Plan	Monthly	100%	100%	TBC	0910 OT 100%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%								100.00%
Maternity	Percentage of women with midwife as first point of contact	Sue Lovell	Remedial Action Plan	Bi-annual report to Maternity JPB	TBC	TBC	TBC	0910 OT 100%		100%			100%			100%											100%
Maternity	Perinatal mortality rates	Sue Lovell	Remedial Action Plan	Quarterly	Peer group upper quartile by March 2013 via Dr Foster. Trajectory to be confirmed in Q1 with involvement of Public Health. Sign off by Maternity JPB in June 2010.	Peer group upper quartile by March 2013 via Dr Foster. Trajectory to be confirmed in Q1 with involvement of Public Health. Sign off by Maternity JPB in June 2010.	TBC in Q1	0910 OT 5.4/1000		10.1/1000			7.7/1000			10/1000											8.9/1000
Maternity	Proportion of pregnant women with recorded offer of HIV counselling and testing	Sue Lovell	Remedial Action Plan	Quarterly	1	100%	TBC	0910 OT 100%		100%			100%			95%											100.00%
Maternity	Stillbirth rates	Sue Lovell	Remedial Action Plan if trend persists greater than 3 months	Quarterly	Peer group upper quartile by March 2013 via Dr Foster. Trajectory to be confirmed in Q1 with involvement of Public Health. Sign off by Maternity JPB in June 2010.	Peer group upper quartile by March 2013 via Dr Foster. Trajectory to be confirmed in Q1 with involvement of Public Health. Sign off by Maternity JPB in June 2010.	TBC in Q1	0910 OT 6.8/1000		6.7/1000			6.9/1000			7.8/1001											6.8/1000
Transplant	Increase BME awareness & participation in donation	Mr Charles Claoue de Gohr, Maria Curtin	Action Plan	Annual	Annual statement of BME representation on Trust Transport and Organ Donation Board. Action plan in place for increasing BME organ and tisse donation.	Action plan in place for increasing BME organ and tisse donation.	N/A	N/A		Not yet available			Not yet available			Not yet available											
Transplant	Increase in A&E referrals for organ donation	Mr Charles Claoue de Gohr, Maria Curtin	Action Plan	Quarterly	5%	5%	TBC in Q1	50%		100%			100%			100%											100%

Transplant	Mandatory educational sessions for all Trust clinical staff -Bi-annual declaration that transplant is part of mandatory training for all clinical staff	Mr Charles Claoue de Gohr	Action Plan	Bi-annual	90%	90%	N/A	N/A		Not yet available			The Trust is committed to making Organ Donation a Part of Mandatory Training for all Clinical Staff and is actively working towards achieving this			The Trust is committed to making Organ Donation a Par of Mandatory Training for all Clinical Staff and is actively working towards achieving						
Transplant	Number of ITU patients referred for organ and tissue donation as a % of total admissions/total deemed referable	Mr Charles Claoue de Gohr, Maria Curtin	Action Plan	Quarterly	100%	100%	TBC	76%		88%			95%			93%						88%
Trauma and Orthopaedics	% trauma patients operated on in 36 hours - All Non-Elective	Performance & Information	Action Plan except KPI element	Monthly	90% all cases. Trajectory TBC	90% all cases. Trajectory TBC	TBC	Trust wide 0910 data not available		99.06%	100.00%	97.73%	100.00%	99.00%	100.00%	99.40%						99.31%
Trauma and Orthopaedics	% trauma patients operated on in 36 hours - #NOF	Performance & Information	Action Plan except KPI element	Monthly	90% all cases. Trajectory TBC	90% all cases. Trajectory TBC	TBC	Trust wide 0910 data not available		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%						100.00%
Trauma and Orthopaedics	Emergency readmissions within 28 days of discharge	Performance & Information	Action Plan except KPI element	Monthly	76th centile as compared to Dr Foster figures on 01/03/2010 Figure and trajectory tbc	5% (Dr Foster 75th Percentile)	TBC	0910 out-turn 5.7%	5.88%	5.13%	5.60%	3.43%	6.39%	6.74%	4.64%	3.52%	5.82%	4.70%	6.86%			5.27%
Trauma and Orthopaedics	Emergency readmissions within 14 days of discharge	Performance & Information	Action Plan except KPI element	Monthly	76th centile as compared to Dr Foster figures on 01/03/2010 Figure and trajectory tbc	TBC	TBC	0910 out-turn 3.95%	3.62%	3.59%	3.64%	2.21%	3.74%	3.37%	3.01%	2.26%	4.16%	3.04%	6.14%			3.43%
Trauma and Orthopaedics - Mortality within 30 days of admission	Elective	Performance & Information	Action Plan except KPI element	Quarterly	75th centile as compared to Dr Foster figures on 01/03/2010 Figure and trajectory tbc	75th centile as compared to Dr Foster figures on 01/03/2010	TBC	0.11%		0%			0%			0%						0%
	Non-Elective	Performance & Information						1.68%		2.50%			0.87%			1.39%						1.66%
	#NOF	Performance & Information						4.71%	5.66%	4.22%			2.53%			2.86%						3.40%
Tuberculosis (TB)	Increase in number of PA as per NEL Network and Royal College recommendations	Jane Hustler	Action Plan	Quarterly	TBC	TBC	TBC	Not available		Not Available			Not Available			Not Available						Not Available
Tuberculosis (TB)	Laboratories report smear turnaround within 1 working day	Robert Davis	Action Plan	Quarterly	96%	96%	TBC	0910 OT 75.12%	69%	68%	80%	89%	96%	99%	96%	99%	98%	80%				89%
Tuberculosis (TB)	Liquid culture is used for TB culture	Robert Davis	Action Plan	Quarterly	100%	100%	TBC	0910 OT 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%
Tuberculosis (TB)	Percentage of patients that have a recorded risk assessment for illicit drug use, alcohol misuse, homelessness, immigration and language	Jane Hustler	Action Plan	Quarterly	96%	96%	TBC	Not available		97.10%			100%			100%	100%	100%				97%
Tuberculosis (TB)	Percentage of TB patients over 18 years that have a recorded offer of HIV testing	Jane Hustler	Action Plan	Quarterly	96%	96%	TBC	Not yet available		97.10%			100%			100%	100%	100%				97%
Tuberculosis (TB)	Percentage of TB patients over 18 years that have accepted an offer of HIV testing	Jane Hustler	Action Plan	Quarterly	70%	70%	TBC	Not available		Not Available			95%			100%	100%	100%				Not Available
Tuberculosis (TB)	Proportion of patients completing treatment within 1 year of start of treatment	Jane Hustler	Action Plan	Quarterly	95%	95%	2009/10 outturn	2009/10 outturn 68.9%		75%			81%			87%	94%	69%				75%
Tuberculosis (TB)	Services are able to report their quarterly contact tracing activity and the outcome of these contacts	Jane Hustler	Action Plan	Quarterly	100%	100%	TBC	Not available		Yes			Yes			Yes						Yes
Tuberculosis (TB)	There is 1 nurse for every 40 notifications with full administrative support (network standard)	Jane Hustler	Action Plan	Quarterly	95%	95%	TBC	Not available		71%			no = nurses = 5.1 should be 6.4 based on last years figures. No admin support since August.			yes nursing no admin	yes nursing no admin	yes nursing no admin				71%
Diabetes	100% of people with diabetes under the care of a consultant diabetologist to be offered screening for the early detection (& treatment if needed) of diabetic retinopathy	Magda Smith/ Shelagh Smith/ Claire Dixon	Remedial Action Plan	Quarterly	100% by Q4 Trajectory to be based on achieving this from current (baseline)	100% by Q4 Trajectory to be based on achieving this from current (baseline)	(blank)	Not available		Not available			Not available			Not available						
Stroke	100% appropriate patients and carers to receive contemporary patient information and care plans provided in a variety of formats	Cass O'Reilly	Remedial Action Plan	Quarterly	100%	100%	0	0		Patient information leaflet in a stroke-friendly format is being developed and will be distributed routinely to patients by end August. An audit of patients will			Not available			80%						
Stroke	95 % of all stroke patients to be admitted directly to SU on HASU transfer	Cass O'Reilly	Remedial Action Plan	Monthly	95%	95%	TBC	TBC		Not Available												

Stroke	95% of stroke patients who have had brain imaging within 24 hours o first onset of symptoms	Cass O'Reilly	Remedial Action Plan	Monthly	95%	95%	TBC	2009/10 out-turn 96.7%	98.70%	100%	98.80%	100.00%	100.00%	98.92%	100.00%	98.97%	97.48%	99.10%	100.00%	100.00%		99.30%
Stroke	95% Patients to spend all of their time on the Stroke Unit	Cass O'Reilly	Remedial Action Plan	Monthly	95%	95%	TBC	TBC		69.09%	66.10%	68.66%	76.39%	83.02%	66.67%	75.00%	76.92%	90.57%	93.24%	95.83%		77.81%
Stroke	Arrangements for timely discharge of patient from SU with appropriate support	Cass O'Reilly	Remedial Action Plan	Monthly	100%	100%	TBC	TBC		TBC Q2					Definitions sought from network							
Stroke	Provision of a named contact within the care setting for each patient	Cass O'Reilly	Remedial Action Plan	Monthly	N/A	N/A	TBC	TBC		TBC Q2					Definitions sought from network							0.00%
Stroke	Quality of stroke care - reduction in stroke related mortality & disability - *Mortality within 7 days*	Kaled Darawil	Remedial Action Plan	Monthly	TBC	TBC	TBC	2009/10 out-turn 7.9%	9.50%	3.03%	3.61%	7.89%	6.74%	9.38%	6.25%	8.33%	6.52%	5.63%	6.10%	3.08%		6.32%
Stroke	Quality of stroke care - reduction in stroke related mortality & disability - *Mortality within 30 days*	Kaled Darawil	Remedial Action Plan	Monthly	TBC	TBC	TBC	2009/10 out-turn 13.8%	14.70%	10.61%	10.84%	12.20%	15.73%	17.19%	11.25%	18.06%	11.96%	12.68%	12.2%	7.69%		13.19%
Stroke	Recruitment plan for vacant positions - plan and success in filling vacant positions	Cass O'Reilly	Remedial Action Plan	Quarterly	TBC	TBC	(blank)			Successfully recruited a further 10 nurses at our Open Day in June and have recruited a CNS			Not available			Yes						
Stroke	Reduction in LoS to London averag - *Spell LOS on both sites*	Kaled Darawil	Remedial Action Plan	Monthly	TBC	Peer SHA 0910 (Spells with 1ary Diag Stroke) 20.1	2009/10 out-turn			21.10	29.90	26	22.00	21.46	19.6	24.50	24.77	24.6	14.72	31.47		23.42
Stroke	Reduction in XS Bed Days for stroke	Cass O'Reilly	Remedial Action Plan	Monthly	20% reduction on baseline to be phased across 4 quarters	20% reduction on baseline to be phased across 4 quarters (1464)	2009/10 out-turn 1830	2009/10 out-turn 1830	78	152	78	147	77	7	115	87	74	126	0			863
Chief Nursing Officer High Impact Changes	Increase in permanent nursing and midwifery staffing ratios -*Nursing & Midwifery % vacancies (staff in post V budget)*	Deba Misra	20% of CQUIN payment	Quarterly	TBC	TBC	TBC	84.40%		87.97%			84.90%			86.10%						86.32%
Chief Nursing Officer High Impact Changes	Increase the number of patients in NHS provided care who have their discharge managed and implemented using set criteria where appropriate. To be reported by % nurse and midwife led and % of others	Wendy Thomas	10% of CQUIN payment	Quarterly	2/3 wards to have 50 sets of notes reviewed each to set baseline in Q1. Exercise to be repeated in Q3 to demonstrate improvement in % managed by nurse/midwife.	2/3 wards to have 50 sets of notes reviewed each to set baseline in Q1. Exercise to be repeated in Q3 to demonstrate improvement in % managed by nurse/midwife.	To be set during Q1.	2 Surgical wards at Queens - baseline Q1 April - June 10 : Ocean A had 531 discharges of which 5 Nurse Facilitated = 0.9%. Ocean B had 448 discharges of which 3 Nurse Facilitated = 0.7%		Baseline set - targeted 100% improvement by Q3. Audit to take place after December			2 Surgical wards at Queens - Q2 July - Aug 10 : Ocean A had 524 discharges of which 2 Nurse Facilitated = 0.38%. Ocean B had 413 discharges of which 2 Nurse Facilitated = 0.48% (these figures are less due to the fact that many patients that are criteria led discharged, have been moved to the Surgical Day Unit as day cases or are discharged within 23 hours of surgery from extended recovery - the audit will extend to those areas for						
Chief Nursing Officer High Impact Changes	Reduction in in-hospital Pressure Ulcer rates	Bev Wilson/Kim King	30% of CQUIN payment	Quarterly	No in-hospital occurrence of a stage 4 pressure ulcer (subject to clinical assessment of presenting circumstances) and a decreased % of grade 3 and grade 2 pressure ulcers by end of Q4	No in-hospital occurrence of a stage 4 pressure ulcer (subject to clinical assessment of presenting circumstances) and a decreased % of grade 3 and grade 2 pressure ulcers by end of Q4	N/A	0.05%		0.07%			0.11%			0.06%						0.08%
Chief Nursing Officer High Impact Changes	Reduction in the number of in-hospital falls (split by high and low impact) sustained by older people.	Lesley Marsh	20% of CQUIN payment	Quarterly	TBC	TBC	TBC	1746 low 36 high		168 low 3 high	137 low 2 high	116 low 2 high	44 low	41 low	NYA	No Data at present						
Chief Nursing Officer High Impact Changes	Reduction in the rate of in-hospital catheter-related Urinary Tract Infections (UTIs) for patients in NHS and other provided care	Sheila O'Mahoney	20% of CQUIN payment	Quarterly	42 (10.5 per quarter)	TBC	TBC	Awaiting DoH guidance on recording data - TBC end of July		Awaiting DoH guidance on recording data - TBC end of July			Still awaiting DoH guidance			Still awaiting DoH guidance						

Chief Nursing Officer High Impact Changes	Stop inappropriate in-hospital weigh loss and dehydration. Acute providers to provide quarterly reports on percentage of patients screened on admission using the MUST tool, percentage of patients that have care standard completed if at risk and percentage of patients that are re-assessed as per care standard.	Caroline Moore	20% of CQUIN payment	Quarterly	6 monthly audits against Essence of Care benchmarking tool for nutrition on a minimum of TBC wards.	6 monthly audits against Essence of Care benchmarking tool for nutrition on a minimum of TBC wards.	TBC	BHRUT AVG - Jan 2010 39%. QH AVG March 2010 56% (March KGH N/A)		63%			QH 58%, KGH 78%			No Data at present							66%
Critical Care	% readmissions to ICU during same hospital spell	Nick Nadaff		Quarterly	5%	5%	TBC	13.5% (0910)		3.85%	7.29%	10.34%	6.91%	6.05%	3.71%	No Data at present							6.36%
Critical Care	Central-line bundle compliance	Farrell Igielman/Nicola Dearson		Quarterly	Q2 - 98% Q4 – 98%	Q2 - 98% Q4 – 98%	0	Not yet available		Not yet available			Data is being collected as part of the cyclical audits. Results										
Critical Care	Central-line catheter related bloodstream infections rate per 1000 central-line days	Rajesh Jain	30% of Critical Care CQUIN	Quarterly	TBC	TBC	TBC	Not yet available		1.96			1.34			1.84							1.71
Critical Care	Decreasing incidence of hypoglycaemic episode	Farrell Igielman/Nicola Dearson	20% of Critical Care CQUIN	Quarterly	TBC	TBC	TBC	Bi annual audit and will be undertake prospectively in Sept and Jan		Bi annual audit will be undertaken prospectively in Sep and Jan			10 episodes of hypoglycaemia two weeks audit of patients			Bi annual audit will be available in Mar 11							
Critical Care	Evaluation of hypoglycaemic contro to be measured by bi-annual audit	Farrell Igielman/Nicola Dearson	20% of Critical Care CQUIN	Bi-annually	TBC	TBC	TBC	Bi annual audit and will be undertake prospectively in Sept and Jan		Bi annual audit will be undertaken prospectively in Sep and Jan			non compliance 3.8% (10 episodes out of total episodes)										
Critical Care	Mortality rate	Nick Nadaff		Quarterly	TBC or 10% reduction on baseline	TBC or 10% reduction on baseline	TBC	Hospital Mortality (29.2%)		24.94%	21.95%	17.55%	20.33%	29.00%	24.20%	No Data at present							22.99%
Critical Care	Number of 'cardiac arrest' calls per 1000 inpatient discharges (Trust-wide, not solely ITU)	Karen Richards	15% of Critical Care CQUIN	Quarterly	TBC	TBC	TBC	84.5 (0910 OT)	46	45	44	65	65	84	83	68	98	106					658
Critical Care	Transfers out of ICU Department between 22:00 and 08:00	Nick Nadaff		Quarterly	5 per Quarter	5 per Quarter	TBC	142 (19.8%)		14.10%	23%	19.90%	11.25%	20.10%	17.14%	15.78%							17.27%
Critical Care	Utilisation of rapid response team	Farrell Igielman	5% of Critical Care CQUIN	Quarterly	Q1 – Clinical and business review of implementation of rapid response team Q2 – Business case for rapid response team agreed by BHRUT Board and start of recruitment process Q3 – Complete recruitment process and final implementation of rapid response team Q4 – Rapid response team in place	Q1 – Clinical and business review of implementation of rapid response team Q2 – Business case for rapid response team agreed by BHRUT Board and start of recruitment process Q3 – Complete recruitment process and final implementation of rapid response team Q4 – Rapid response team in place	0	24 hrs Rapid Response Team not available		24 hrs Rapid Response Team not available			Not available									
Critical Care	Ventilator bundle compliance	Farrell Igielman/Nicola Dearson	30% of Critical Care CQUIN	Quarterly	Q2 - 98% Q4 – 98%	Q2 - 98% Q4 – 98%	0	Bi annual audit to take place in sep		Bi annual audit to take place in sep			97.04% audit										
Critical Care	Ventilator-Associated Pneumonia (VAP) rate per 1000 ventilator days	Farrell Igielman/Nicola Dearson	30% of Critical Care CQUIN	Quarterly	TBC	TBC	TBC	TBC		TBC			ta collection started 1.9.20										
Fractured Neck of Femur (#NOF)	Decrease 30 day mortality for #NOF	Performance & Information	CQUIN	Quarterly	75th centile as compared to Dr Foster figures on 01/03/2010 Figure and trajectory tic	75th centile as compared to Dr Foster figures on 01/03/2010	TBC	0910 OT 5.88%	5.66%	7.23%			3.16%			3.57%							5.25%
Fractured Neck of Femur (#NOF)	Decrease in emergency readmissions within 28 days of discharge for #NOF	Performance & Information	CQUIN	Monthly	75th centile as compared to Dr Foster figures on 01/03/2010 Figure and trajectory tbc	13.1% (Dr Foster 75th percentile)	TBC	0910 out-turn 10.92%	18.87%	6.89%	5.71%	3.84%	16.65%	11.99%	12.77%	9.26%	14.29%	12.73%					7.22%

Fractured Neck of Femur (#NOF)	Increase % medically fit (clinically appropriate) #NOF patients who are operated on within 36 hours	Performance & Information	CQUIN	Monthly	TBC	TBC	TBC	Trust wide 0910 data not available		100%	100%	100%	100%	100%	100%	100%						100%
Implement HfL dementia pathway in acute hospitals	Achievement of milestones in the implementation of the general hospital care pathway	Magda Smith	15% of Regional CQUIN	Quarterly	End of Q1 - Lead clinician for dementia identified and implementation plan for the general hospital care pathway set out in HfL Dementia Guide signed off by Trust Board and commissioners. End of Q2 - Induction for all newly appointed clinical staff includes a session on basic dementia awareness and care. Local protocol for brief assessment of memory impairment on admission for all patients aged 65 or over, with triggers for the admitting clinician to perform a mini-mental state examination as	End of Q1 - Lead clinician for dementia identified and implementation plan for the general hospital care pathway set out in HfL Dementia Guide signed off by Trust Board and commissioners. End of Q2 - Induction for all newly appointed clinical staff includes a session on basic dementia awareness and care. Local protocol for brief assessment of memory impairment on admission for all patients aged 65 or over, with triggers for the admitting clinician to perform a mini-mental state examination as appropriate. End of Q3 - The trust is able to demonstrate increased uptake of enhanced training in dementia awareness and care, with annual refreshers provided to nursing staff in medical and geriatric settings. End of Q4 - Trust has met all key objectives and milestones in its locally agreed dementia implementation plan (including quality and productivity gains) as evidenced by a report to Trust Board and commissioners.	N/A	N/A		Lead clinician for dementia identified and implementation plan for the general hospital care pathway set out in HfL Dementia Guide signed off by Trust Board and commissioners			Dementia strategy (includes general hos care pathway) developed. To go to PEC Nov.for sign off. Education programme agreed but not yet implemented. Protocol for delirium agreed.			Q3 Education programme agreed for nursing , medicine and therapy agreed with roll out from February. Protocol in place for MTS and included in emergency clerking proforma.						
Improve responsiveness to personal needs of patients	Patient experience - The indicator will be a composite, calculated from 5 survey questions.	Nichole McIntosh		Quarterly	TBC	TBC	decisions about treatment/care (Yes definitely): Trust 41%, All 53%. Hospital staff available to talk about worries/concerns (Yes definitely): Trust 32%, All 41%. Privacy when discussing condition/treatment (Yes always): Trust 64%, All 71%. Informed about medication side effects (Yes completely): Trust 35%, All 36%. Informed who to contact if worried about condition after leaving	Involved in decisions about treatment/care (Yes definitely): Trust 41%, All 53%. Hospital staff available to talk about worries/concerns (Yes definitely): Trust 32%, All 41%. Privacy when discussing condition/treatment (Yes always): Trust 64%, All 71%. Informed about medication side effects (Yes completely): Trust 35%, All 36%. Informed who to contact if worried about condition after leaving hospital (Yes): Trust 57%, All 70% Hospital staff available to talk about worries/concerns (Yes definitely): Trust 32%, All 41%		The action plan based on the five National Inpatient survey questions will be presented to the Nursing & Midwifery Board for approval on 15th July 2010			Action plans are in place for each of the 5 inpatient survey questions and progress is being made against each of the plans. Further detail is available			**Ward information panels with staff photo gallery** - Medical Photography are in the process of taking the staff photos. Panels installed with central core text informing patients and reltives of who to contact including PALS and chaplains. Staff are encouraged to involve patients and relatives in care planning especially in discharge planning where nex of kin has to sign forms to agree the care management plan. **Real time patient survey** - Start date 17th January beginning at Queens Hospital and a phased implementation plan up to May 2011. **Patient curtain signs -** have been introduced to promote patients' privacy and dignity by reducing unwelcome interruptions. **Visible Leadership programme** - patient day is being reviewed with a focus on extending visiting hours and protected mealtimes. This will enable greater access to staff for patients and relatives to ask questions. The patient information booklet has been launched and is distributed as						
Increase effectiveness of outpatient care planning	90% of new outpatients to have a letter sent to their GP and any other relevant primary care clinician within five days of the first outpatient appointment	Hilary Robers	10% of Regional CQUIN	Quarterly	90% by Q4. Trajectory to be set in Q1.	90% by Q4. Trajectory to be set in Q1.	Hospital staff available to talk about worries/concerns (Yes definitely): Trust 32%, All 41%	Not Available		Not Available			The reporting facility for this target has been delayed due to IT issues. This should be resolved in the near future and details should be available from early November onwards			Unable to report November and October due to the software not being ready or implemented.	43.60%				

Increase effectiveness of inpatient discharge information	100% of all in-patient discharge summaries are compliant with clause 18, schedule 1 definitions and interpretations and schedule 2.2 transfer of and discharge from care protocols. In addition the quality of discharge summaries to be improved and incentivised through completion of additional information and sent electronically	Magda Smith/ Shelagh Smith	10% of Regional CQUIN	Quarterly	100%	100%	Q1 to act as baseline exercise	Q1 to act as baseline exercise		The Trust is currently rolling out electronic discharge planning starting with 3 wards at Queens, the mandatory fields are compliant with Schedule 18 part 2.2. The roll out plan will provide electronic discharge planning throughout the Trust which in turn will enable 100% of all in-patient discharge summaries to be compliant			The Trust is continuing rolling out electronic discharge planning and has now implemented it across the Medical and Surgical Divisons at Queens, the mandatory fields are compliant with Schedule 18 part 2.2. The roll out plan will provide electronic discharge planning throughout the Trust which in turn will enable 100% of all in-patient			The Trust continues to use EDS where it has been rolled out however there are issues with the Pharmacy resource to support this which is cuurrently being worked through. Once resolved the roll out will continue.				
Maternity	Decrease Caesarean Section (CS) rates	Sue Lovell	15% of Maternity CQUIN payment	Quarterly	Aim for 20% for end of 2010/11.	Aim for 20% for end of 2010/11.	Informed about medication side effects	22.50%		23.25%			20%			23%					22.08%
Maternity	Increase the percentage of women provided with 1:1 care in Labour	Sue Lovell	15% of Maternity CQUIN payment	Quarterly	95% by end of Q4. Trajectory to be confirmed.	95% by end of Q4. Trajectory to be confirmed.	(Yes completely): Trust 35%, All 36%	Q4 2009/10		89.50%			Not yet available			Not yet available					
Maternity	Increase the percentage of women who have seen a midwife or maternity healthcare professional, for assessment of health and social care needs, risk and choices by 12 completed weeks of pregnancy.	Sue Lovell	15% of Maternity CQUIN payment	Quarterly	90% by end of 2011/12 Q2. Straight line trajectory to be confirmed in 2010/11 Q1 between baseline and 2011/12 Q2 target	90% by end of 2011/12 Q2. Straight line trajectory to be confirmed in 2010/11 Q1 between baseline and 2011/12 Q2 target	Informed who to contact if worried about condition after leaving hospital (Yes): Trust 57%, All 70%	0910 OT N/A		77.0%			85.8%			89%					84%
Maternity	Increase weekly consultant Obstetrician labour ward cover	Sue Lovell	75% of 20% Maternity CQUIN value	Quarterly	Queen's Hospital - 98 hours consultant obstetrician labour ward cover per week (RCOG standard) to be maintained for all quarters -	Queen's Hospital - 98 hours consultant obstetrician labour ward cover per week (RCOG standard) to be maintained for all quarters -	98 hours	98 hours		Achieved			98 hours cover			40 hours KGH 98 hours Queens					
Maternity	Maternity patient experience: a) Choice regarding place of birth (QH, KGH or Home) b) Communication c) Treating with Dignity and Respect d) Continuity of care in the antenatal period e) Environmental issues	Sue Lovell	20% of Maternity CQUIN payment	Bi-annually	Payment on improvement in key areas of biannual survey	Payment on improvement in key areas of biannual survey	N/A	N/A					To be measured in December								
Maternity	Midwife to birth ratios	Sue Lovell	15% of Maternity CQUIN payment	Quarterly	In post, including agency ratio of 1:29 by end of Q4. Nursing establishment can account for up to two thirds.	In post, including agency ratio of 1:29 by end of Q4. Nursing establishment can account for up to two thirds.	TBC	March 2010 OT 1:33		01:29			01:29			Funded 1:27.7 In post 1:33					01:29
Reduce avoidable death, disability and chronic ill health from Venous-thrombo embolism (VTE)	VTE risk assessment - *percentage of adult patients admitted in the month who were assessed for risk of VTE on admission to hospital*	Performance & Information		Monthly	Q2: 50% Q3: 75% Q4: 90%	Q2: 50% Q3: 75% Q4: 90%	(blank)	TBC				41.20%	59.10%	66.34%	79.66%	82.00%	76.83%	88.58%	93.24%	94.12%		76%
Supporting effective discharges within a hospital setting	Increase in numbers of patients going home on their Estimated Discharge Date (first EDD recorded to be used)	Performance & Information	10% of Regional CQUIN	Quarterly	TBC	90%	TBC	TBC		Avg weekly 76%			Not available								Avg weekly 76%
Supporting effective discharges within a hospital setting	Increased percentage of weekend discharges (not applicable to Mon-Friday wards)	Performance & Information	10% of Regional CQUIN	Quarterly	TBC	TBC	TBC	19.38%		18.25%	23.88%	18.40%	21.63%	22.05%	19.12%						20.60%
Supporting effective discharges within a hospital setting	Percentage of discharges that occu by twelve noon (excluding Obstetrics and Maternity)	Taj Rehal	10% of Regional CQUIN	Quarterly	TBC	TBC	TBC	TBC		16.93%	17.87%	18.24%	Not available								17.68%

To improve patient safety through the systematic implementation of validated approaches	Implement the Enhanced Recovery Programme (ERP)	Eileen Moore	12.5% of Regional CQUIN	Quarterly	End of Q1 - Trust identifies the specialties (Gynaecology, Urology and Colorectal) and produces an implementation plan which includes details of the resources, clinical leads and methodology. It is an expectation that every trust during Q1 establishes its baseline data, defines the measures and identifies the data collection tool drawing on learning from the national tool to be agreed with the lead commissioner. Trust provides evidence that systems are in place to deliver	End of Q1 - Trust identifies the specialties (Gynaecology, Urology and Colorectal) and produces an implementation plan which includes details of the resources, clinical leads and methodology. It is an expectation that every trust during Q1 establishes its baseline data, defines the measures and identifies the data collection tool drawing on learning from the national tool to be agreed with the lead commissioner. Trust provides evidence that systems are in place to deliver the ERP via a progress report to lead commissioner, which is also submitted to the Trust Board for executive sponsorship. End of Q2 - Evidence of implementation within the agreed specialities in accordance with national and regional guidance. End of Q4 - Achievement against agreed performance measures and evidence that the new system is embedded and the model is sustainable by the trust	N/A	N/A		Update due in December 2010							
To improve patient safety through the systematic implementation of validated approaches	Implement the IHI Global Trigger Tool	Pam Strange	12.5% of Regional CQUIN	Quarterly	End Q1 - Baseline data collection and methodology agreed between commissioner and provider. An agreed plan for implementation of the IHI Global Trigger Tool aligned to the national guidance is in place, evidenced in a formal report to the lead commissioner and the Trust Board for executive sponsorship. End of Q2 - Trust provides a report (reported to the Trust Board) on the results of an audit of 50 consecutive deaths (used as a baseline for understanding	End Q1 - Baseline data collection and methodology agreed between commissioner and provider. An agreed plan for implementation of the IHI Global Trigger Tool aligned to the national guidance is in place, evidenced in a formal report to the lead commissioner and the Trust Board for executive sponsorship. End of Q2 - Trust provides a report (reported to the Trust Board) on the results of an audit of 50 consecutive deaths (used as a baseline for understanding the technique) . Evidence of implementation. End of Q4 - Evidence of a minimum of 6 consecutive months of full implementation of the IHI Global Trigger Tool with the 'run charts' used to demonstrate results in accordance with the London Guidance on measurement. This will be reported to the Trust Board and shared across London to support ongoing learning. 40 case notes per month to be audited thereafter.	N/A	N/A		Q1 targets achieved	Q2 targets achieved			Q3 targets achieved				
To improve the care, safety and experience of patients with defined long-term conditions: diabetes, COPD and heart failure. -Reduction in emergency re-admissions within 14 and 28 days for the following long-term conditions as primary diagnosis: COPD, heart failure and diabetes (Excluding Paediatrics and Maternity)	Readmissions within 14 days - COPD	Performance & Information	30% of Regional CQUIN	Quarterly	TBC	Peer (% casemix by volume) 0910 14.4%	TBC	0910 OT 17.54% (Dr F 15.9%)	21.43%	8.15%	6.00%	2.72%					6.68%
	Readmissions within 14 days - Heart Failure					Peer (% casemix by volume) 0910 11%		0910 OT 13.7%	14.89%	9.33%	4.82%	12.33%					8.92%
	Readmissions within 14 days - Diabetes					Peer (% casemix by volume) 0910 6.2%		0910 OT 4.38%	0.77%	1.61%	1.72%	1.92%					1.68%
	Readmissions within 28 days - COPD					Peer (% casemix by volume) 0910 22.4%		0910 OT 25.28%	30.95%	13.09%	11.33%	7.48%					11.66%
	Readmissions within 28 days - Heart Failure					Peer (% casemix by volume) 0910 18%		0910 OT 22.43% (Dr F 24.1%)	14.89%	12.00%	13.25%	23.29%					14.44%
	Readmissions within 28 days - Diabetes					Peer (% casemix by volume) 0910 9.6%		0910 OT 6.61%	2.31%	2.62%	1.72%	2.30%					2.37%

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Income and Expenditure Budgets 2010/11	Trust Board – 29 March 2011
1. KEY ISSUES:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
• This report sets out the proposed income and expenditure budgets for 2011/12. • The position shows a proposed I&E budget deficit of £28.8m (excluding the impact of impairments and IFRS) • The report sets out the bridge reconciliation from the 2010/11 outturn position, proposed budget control totals at Divisional level, CIP targets for 2011/12 and the key assumptions and risks within the budgets • Also attached to the report are the Operating Plan submission to the SHA for 2011/12, together with the supporting detailed financial (FIMS) templates	☐ **S&SIB** ……☐ **EPB**…… ☐ **FINANCE** ……☐ **AUDIT** …… ☐ **CLINICAL GOVERNANCE** …… ☐ **CHARITABLE FUNDS** …… ☑ **TRUST BOARD** …… ☐ **REMUNERATION** …… ☐ **OTHER** ……(please specify) **CATEGORY:** ☐ **NATIONAL TARGET** ☐ **CNST** ☐ **STANDARDS FOR BETTER HEALTH** ☐ **ASSURANCE FRAMEWORK** ☐ **TARGET FROM COMMISSIONERS** ☑ **CORPORATE OBJECTIVE** To monitor the Trust's progress in achieving its financial turnaround, achieving control targets and meeting its statutory financial duties going forward. ☐ **OTHER** …… (please specify) **AUTHOR/PRESENTER:** David Wragg, Director of Finance **DATE:** March 2010
2. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
Set out under key issues	
3. ALTERNATIVES CONSIDERED/REASONS FOR REJECTION:	
N/A	

4. DELIVERABLES:	
N/A	
5. EVIDENCE :	
N/A	
6. RECOMMENDATION/ACTION REQUIRED:	
The Trust Board is asked to agree the proposed budgets for 2011/12.	
AGREED AT _____ MEETING **OR** **REFERRED TO: _____**	**DATE: _____** **DATE: _____**
REVIEW DATE **_____** **(if applicable)**	

Income and Expenditure Budgets 2011/12

1. Introduction

This report sets out the proposed income and expenditure budgets for 2011/12, including:

- the bridge from the 2010/11 forecast outturn position
- the budget control totals for 2011/12, at Divisional level
- CIP targets for 2011/12
- Key assumptions
- key risks

2. Bridge

The following sets out the bridge of the proposed 2011/12 income and expenditure budget from the 2010/11 forecast outturn. This is in the format required by the SHA

	£'000	£'000	
Month 9 FCOT per detailed bridge model		-31451	
Adjustments to M9 forecast:			
- PCT income (reduced EL activity / year end settlement)		-1,800	
- Demand management schemes in Surgical Division		-897	
- Reduction in redundancy forecast		1809	
- eduction in central recovery schemes forecast		-1450	
- Other		-482	
Revised M11 FCOT incl. IFRS		-34271	Incl. IFRS impact of £442k
Non-recurrent commitments in previous year			
Redundancies		1391	
Non-recurrent benefits in previous year			
Central recovery schemes	-2700		
Less: repeat N/R balance sheet reversals	1000		
Ward closure programme	-2700		Shown as N/R here - FYE built in to 2011/12 CIP
Midwifery underspending	-1993		
Divisional recovery schemes	-1014		
Other adjustment to M9 forecast	482		
Other (net)	-1076		
		-8001	
FYE recurrent costs not included as next years investments			
- Ward staffing levels (CQC)	-2076		
- Local cost pressures	-2126		
		-4202	
FYE recurrent savings not included as next years efficiency/service change benefits		3595	
Adjusted Underlying position at 1st April:		**-41488**	
Income Changes :			
Gross inflationary uplift		10800	2.5% per tariff

Volume uplift:			
- Net volume changes	-2600		Demand management partially mitigated by ISTC & RTT
- Marketing strategy	2000		
		-600	
Expected CQUIN income		1200	Increase over 2010/11
Efficiency		-17280	-4% per tariff
Other income changes			
- Challenged Trust Board funding (N/R)	-3243		
- Change in Risk pool support	2000		
- Chemotherapy & High Cost drugs	6900		
- Income generation / CIPs	637		
- Other aggregated price changes	1771		
		8065	
Total income changes for the year		**2185**	
TOTAL RESOURCES AVAILABLE IN YEAR		**-39303**	
Expenditure changes 2011/12 :			
Pay inflation:			
- Incremental drift		3024	
Prices inflation:			
- VAT increase	1341		
- Contractual uplifts incl. PFI	4457		
- Other non-pay @ 2.5%	1662		
- Other generic pressures	2399		CNST, MRSA screening
		9859	
Drugs inflation / cost pressures		2802	
Volume changes		-1566	
QIPP/CIP:			
- Scale-back 2010/11 overspending	-6595		
- 2011/12 CIP targets	-20550		
- Management of local cost pressures	-2126		
	-29271		
- Less income related CIPs (shown above)	637		
		-28634	
Impairments		-5318	Following revaluation of buildings
Other:			
- IFRS	-191		
- Contingency	4000		
		3809	
Total expenditure changes for the year		**-16024**	
Resources Less Applications		**-23279**	
Incl IFRS		-23470	
Note:			
1. Other aggregated price changes for the year:			
Gross inflationary uplift	10800		
Efficiency	-17280		
	-6480		
Actual price changes	-4700		Excl. chemo/HC drugs
Difference	1780		
2. CQUIN			
Aggregated price changes	-3500		
Including CQUIN change	1200		
Net other changes	-4700		

3. Proposed Budget Control Totals

The following sets out the proposed budget control totals at Divisional level and main central budget heading. This summary is supported by a detailed budget setting database, at detailed subjective account code, within individual cost centre, and represents the outcome of a detailed line by line review by the Finance team, in conjunction with budget holders and Divisional management teams. A more detailed reconciliation is given at Appendix A.

(£'000)	Central Income	Total Central Income & Expenditure	Clinical Support	Corporate	Emergency	Medical	Surgical	Women & Children	Trust Total
10-11 Budget	-357,358	-319,274	75,849	74,457	16,793	44,168	84,816	43,070	19,879
10-11 Forecast Outturn Month 9	-374,596	-341,620	83,959	77,427	22,870	48,173	95,224	45,418	31,451
10-11 Forecast Variance Month 9	-17,238	-22,346	8,109	2,970	6,076	4,005	10,409	2,348	11,572
Non-Recurrent / FYE adjustments:	**3,043**	**3,043**	**617**	**1,038**	**-299**	**3,178**	**3,300**	**1,922**	**12,799**
2010-2011 FYE CIP	**0**	**0**	**-1,138**	**-1,221**	**0**	**-126**	**-249**	**-861**	**-3,595**
Reduction to 11/12 Baseline - Scaling back overspend.	0	0	-1,899	-1,341	-244	-553	-1,555	-1,002	-6,595
2010-2011 Central Recovery Schemes	**9**	**959**	**0**	**0**	**0**	**0**	**0**	**0**	**959**
Full Year Effect of 2010-2011 Activites	**-371,544**	**-337,618**	**81,538**	**75,903**	**22,326**	**50,672**	**96,720**	**45,477**	**35,019**
Cost Pressures:									
Local Cost Pressures - to be managed by Divisions	**0**	**0**	**360**	**237**	**0**	**59**	**702**	**0**	**1,358**
Other local cost pressures built in to CIP targets		**0**	**1,413**		**809**	**529**	**-1,055**	**250**	**1,946**
Generic Cost Pressures	**0**	**15,076**	**609**	**0**	**0**	**0**	**0**	**0**	**15,685**
Other Adjustments:									
Aggregate price / tariff changes	3,500	3,500	0	0	0	0	0	0	3,500
2011/12 management of Local Cost Pressures (from above)	0	0	-360	-237	0	-59	-702	0	-1,358
2011/12 CIP target	0	0	-3,959	-1,446	-2,039	-4,817	-6,380	-1,409	-20,050
2011/12 CIP target - local cost pressures built in to targets	0	0	-1,413	0	-809	-529	1,055	-250	-1,946
2011/12 CIP Balance Sheet - repeat accruals reversals		-1,000							-1,000
2011/12 CIP Contract Review		0		-500					-500
2011/12 CIP Marketing	-2,000	-2,000							-2,000
Contingency	0	4,000	0	0	0	0	0	0	4,000
Planned acitivity changes from 10/11 outturn	4,200	4,200	-716	0	-400	0	-1,300	250	2,034
2010/11 High Cost Drugs Funding	-6,900	-6,900	0	0	0	0	0	0	-6,900
ISTC Repatriation Activity	-1,600	-1,600	0	0	0	0	600	0	-1,000
	0	0	0	0	0	0	0	0	0
Sub-Total	**-2,800**	**200 0**	**-6,447**	**-2,183**	**-3,248**	**-5,405**	**-6,727**	**-1,409**	**-25,219**
2011-2012 Trust Balances	**-374,344**	**-322,342**	**77,473**	**73,957**	**19,887**	**45,855**	**89,640**	**44,318**	**28,788**
Impairment reversal		**-5318**							**-5,318**
2011-2012 Trust Balances after impairment (per FIMs)	**-374,344**	**-327,660**	**77,473**	**73,957**	**19,887**	**45,855**	**89,640**	**44,318**	**23,470**
2011-2012 CIP/Recovery Memorandum									
Reduction to 11/12 Baseline - Scaling back overspend.	0	0	-1,899	-1,341	-244	-553	-1,555	-1,002	-6,595
2011/12 CIP target	0	0	-3,959	-1,446	-2,039	-4,817	-6,380	-1,409	-20,050
Local cost pressures built in to targets	0	0	-1,413	0	-809	-529	1,055	-250	-1,946
Contract review	0	0	0	-500	0	0	0	0	-500
Sub-total (headline CIP targets)	**0**	**0**	**-7,271**	**-3,287**	**-3,092**	**-5,899**	**-6,880**	**-2,661**	**-29,091**
- % of 2010/11 outturn			**-8.7%**	**-4.2%**	**13.5%**	**12.2%**	**-7.2%**	**-5.9%**	**-7.8%**
Control total as % of 2010/11 budget	4.8%	1.0%	2.1%	-0.7%	18.4%	3.8%	5.7%	2.9%	44.8%
Control total as % of 2010/11 outturn	-0.1%	-5.6%	-7.7%	-4.5%	-13.0%	-4.8%	-5.9%	-2.4%	-8.5%

4. CIP targets 2011/12

The table below sets out the proposed CIP Programme for 2011/12, with risk assessment. There is at the time of writing a gap of £2.5m, in terms of schemes yet to be identified against Divisional CIP targets.

(£'000)	Total	Low	Med	High
Outpatient productivity	947	947	0	0
Length of stay / Ward closures	5,606	0	5,606	0
Pathology Outsourcing/Efficiency	2,165	873	292	1,000
KGH A&E night closure	0	0	0	0
Other outsourcing / shared services	274	274	0	0
Collaboration with other Trusts	0	0	0	0
Theatre productivity	1,657	1,657	0	0
Ward productivity	0	0	0	0
Pharmacy productivity	1,045	0	845	200
Medical staffing productivity	6,013	1,531	4,219	263
Senior Nurse staffing	1,342	33	1,309	0
Procurement automation	43	0	43	0
Procurement - other	1,230	500	580	150
A&E	0	0	0	0
Estates	503	503	0	0
Pay increments	0	0	0	0
IT	40	40	0	0
Decommission loss making services	500	0	500	0
Care pathways (see below for QIPP headings)	0	0	0	0
KGH elective activity	0	0	0	0
PFI renegotiation	0	0	0	0
Management Structure	3,222	2,647	575	0
Key Recruitment	300	0	300	0
Staff Absence	0	0	0	0
Other automation opportunities	74	24	50	0
Divisional CIP	1,788	863	924	0
To be identified	**2,522**	**0**	**0**	**2,522**
Total	**29,271**	**9,893**	**15,243**	**4,134**

5. Key assumptions

The key assumptions within the budget are as follows:

- The Activity Plan is based on baseline 10/11 activity +/- waiting list growth (baseline agreed with PCTs), less 5% reduction in out-patient follow-up activity and £4.7m of elective demand management plans by PCTs. As mitigation, the Trust is assuming £1.6m income growth from repatriation of ISTC activity and £2m from 18 week RTT activity, plus a further £2m growth from marketing of services outside the local area, or from repatriation of activity from providers out of area.
- Income price increase of £6.9m for chemotherapy and high cost drugs
- Net £3.5m price reductions from PbR and non-PbR tariffs, including a £6.2m reduction in respect of Non-elective re-admission of patients within 30 days of an elective episode
- Zero pay uplift assumed, in line with national assumptions, although incremental drift (c.£3m) is included
- Non-pay inflation of 2.5% assumed, except PFI and other contractual commitments where RPI is assumed (see attached Appendix for details)
- CIP target of £29.1m, comprising £20.6m new CIPs target, £6.6m from reduction in budget overspendings and £1.9m to meet other local Divisional cost pressures

6. Key risks

The key risks within the Plan are summarised below:

Explanation of the risk	High/ Medium/ Low risk	Mitigating actions
Cost Improvement Programme £29.7m	Medium	Finance Committee and PEQ Board to monitor development and implementation of Programme Risk assessment (see template for further detail): High £4.1m Medium £15.1m Low £9.4m
PCT Pricing: High Cost Drugs £6.9m	High	Trust has submitted an arbitration case to address under-funding of chemotherapy and high cost drugs excluded from PbR
Difference in activity assumptions with PCTs £11.4m	High	Trust has differing assumptions to PCTs in respect of: • A&E shift of activity to UCC £0.9m • Non-elective demand management £3.7m • Polyclinic activity & price £1.2m • Day case to out-patient settings £2.3m • Ambulatory care impact on NEL activity £1.4m • RTT activity £2m
ISTC activity £1.0m	Medium	The Trust is assuming that it will capture ISTC activity for the last 4 months of the financial year (£1m contribution). The Trust will be developing a marketing strategy / tender submission
Marketing of services £2m	Medium	Trust to develop and implement marketing strategy (see above)
Aggregate risks c. £49.9m		

7. Conclusion / Recommendation

The Board is requested to approve the budget control totals set out in Section 3. and note the underlying key assumptions and risks

Income

The income budgets are based on the following position:

	ONEL ACU £m	Total Clinical £m	Total Income £m	Note
Forecast Outturn 09/10	303.4	360.4	392.3	
Non-recurrent PCT support	(8.0)	(8.0)	(8.0)	
Sub-total	295.4	352.4	384.3	
Non-recurrent: PFI transitional support	(1.4)	(1.4)	(1.4)	
Non-recurrent: HCA International milestone payments			(2.7)	
Recurrent outturn position	**294.0**	**351.0**	**380.2**	
Developments	2.9	2.9	2.9	1
Price/funding adjustments	5.2	5.2	5.2	2
Net increase in out-patient funding	11.2	11.2	11.2	3
Procedures of limited clinical value (POLCV)	(1.6)	(1.6)	(1.6)	
Elective and PSD (planned same day) tariff	3.2	3.2	3.2	4
Divisional income generation schemes			6.3	
Other changes	1.8	0.4	0.4	
Total proposed income budget 10/11	**316.7**	**372.3**	**407.8**	

Notes:

1. Developments:

	£'000
Stroke (HASU & TIA)	2,117
Critical Care beds (1 ITU, 1 HDU)	750
Total	2,867

2. Tariff / funding adjustments:

	£'000
High cost drugs	3,211
Drugs handling charge	350
CQUIN	3,007
Breast screening	661
Emergency tariff reduced to 30% over 08/09 baseline	(1,991)
Total	5,238

3. Net increase in out-patient funding includes the impact of 're-bundling' diagnostic activity in to the tariff from non-PbR, the removal of the out-patient scaling factor, less a reduction in out-patient activity of 17,000 attendances from 09/10 outturn levels

4. This is primarily represented by an increase to the Planned Same Day (PSD) tariff

The key activity assumptions driving this position are:

- Elective and non-elective in-patients and day cases at 09/10 outturn levels
- Reduction of 17,000 out-patient attendances from the 09/10 outturn of 603,000 (55,000 from predicted demand levels of 641,000), through reduction of follow up ratios and demand management. PCTs are proposing a reduction to 543,000.

The income position is £18.0m above the proposal from the PCTs (£298.7m) as at 23 March. Based on this offer, the Trust submitted arbitration documents to NHS London on 23 March in respect of the following specific issues:

- £6.0m further out-patient demand management, not backed by specific proposals
- £3.6m funding for high cost drugs
- £2.9m difference in baseline for calculation of 30% emergency tariff
- £2.0m re-designation of day case procedures to out-patients
- £1.6m pricing issues (critical care, anti-coag and planned procedures)
- £1.1m Maternity Matters
- £17.2m total of above

Since 23 March, the PCTs have increased their offer by £5.2m, to £303.9m, in respect of:

- £1.1m additional out-patient activity
- £0.9m amendment of day case procedures to out-patients reduction
- £3.2m developments, in respect of ARMD, diabetic retinopathy, rheumatology and critical care (3rd additional bed).

The first two items help to reduce the gap by £2m to £16.0m The developments were not priced in to the Trust proposal, so do not help to reduce the gap.

At the time of writing (25 March), the Trust has received a further proposal from the PCTs, to utilise a transition grant from the Challenge Trust Board of between £16m and £21m (above the PCT baseline of £304m) to close the gap. The £16m would close the gap with the PCTs and enable the Trust to plan for the surplus of £1.9m shown above. The £21m would provide either provide further contingency of £5m for the Trust to mitigate against risks in its plan not provided for (e.g. non-recurrent re-structuring costs) or enable it to repay £5m of the £8m support received by the PCTs.

Expenditure

Expenditure budget control totals have been based on the 09/10 outturn position, with adjustments for non-recurrent or full-year effect items, increases for pay & non-pay inflationary pressures and other specific unavoidable cost pressures, with reductions for cost improvements. The overall expenditure position can be reconciled as follows:

	£m	£m	Note
Total 2009/10 Outturn expenditure		445.8	
Less impairments		(32.3)	
Add: non-recurrent savings in 09/10		9.3	1
Less non-recurrent outsourcing costs		(1.1)	
Reduction in depreciation & capital dividend		(1.3)	
Other adjustments		(0.4)	
Recurrent baseline		**420.0**	
Pay & non-pay inflation		9.0	2
Other cost pressures		3.8	3
Cost of developments		2.9	4
Cost reduction from decreased activity		(1.2)	5

Cost improvements:		6
- Identified	(27.3)	
- Unidentified to £34.5m target	(0.9)	
- Total		(28.2)
Total Proposed Expenditure budget 2010/11		**406.3**

Notes:

1. Assumes £9.3m of the £14.1m additional 09/10 recovery measures are non-recurrent, e.g. commercial deals, stock and other balance sheet adjustments. £4.8m is therefore assumed to be recurrent (in addition to the 10/11 CIP target of £34.5m)
2. Pay inflation assumed at 2.25% per NHS London planning guidance (in line with AfC pay deal). Non-pay based on GDP deflator of 2.75%
3. Other specific unavoidable cost pressures comprise:

	£'000
VAT Increase	806
CNST premium increase	827
A&E staffing levels	400
FYE of PFI variations	350
Carbon Emissions levy	350
Loss of rent from SBU at Harold Wood	257
Other	1,237
Total	3,877

   A further review of these costs will be undertaken before funding is released to budgets. Total inflationary and other specific cost pressures of £12.9m represents 3.1% of 09/10 outturn spend, which is within the 3.5% tariff assumption

4. Funding for the stroke and critical care developments have fully been earmarked for investment in the services
5. An estimated £1.2m reduction in cost should arise from reduction in activity levels, primarily in out-patients

Cost Improvement Programme

The Trust has established a CIP target of £34.5m, which it believes to be at the upper end of deliverability. Cost improvements of £27.3m have been identified by Clinical Divisions and Corporate Directorates, in addition to income generation schemes of £6.3m, giving a total figure identified of £33.6m, leaving a shortfall of £0.9m schemes to be identified. A risk assessment of the schemes shows that c£25.0m of the savings are likely, leaving a shortfall of £9.5m to be addressed.

An analysis of the schemes, within Division / Directorate, together with the risk assessment and monthly profile is given at Appendix A.

Key risks

The key risks in the budget proposals can be summarised as follows:

- PCT clinical income. There is currently a gap of c.£16m income assumptions, compared with the PCT offer, as described above, subject to arbitration an/or confirmation of the proposed transitional funding arrangements
- There is a risk of c£9.5m in achieving the CIP targets. In addition, the £4.8m of assumed recurrent savings from the additional 09/10 recovery schemes has yet to be firmed up. Further work will be undertaken through the PEQ to address this risk and ensure the CIP target is met.
- Contingency for potential re-structuring costs is not provided for within the plans

8. Conclusion

The Board is requested to approve the Income and Expenditure budgets for 2010/11 and note the key risks and next steps

Barking, Havering and Redbridge University Hospitals NHS Trust

TRUST 2011-2012 FINANCIAL PLAN

	Central Income	Finance Adjustments	Reserves	Depreciation	Below the Line	Total Central Income & Expenditure	Division: Clinical Support	Corporate	Emergency	Medical	Surgical	Women & Children	Trust
10-11 Budget	-357,358	0	2,340	12,644	23,100	-319,274	75,849	74,457	16,793	44,168	84,816	43,070	19,879
10-11 Forecast Outturn Month 9	-374,596	-3,145	641	12,584	22,897	-341,620	83,959	77,427	22,870	48,173	95,224	45,418	31,451
10-11 Forecast Variance Month 9	-17,238	-3,145	-1,699	-60	-204	-22,346	8,109	2,970	6,076	4,005	10,409	2,348	11,572
2010-2011 N/r Exp 09-10 Rev	0	0	0	0	0	0	-15	-21	0	36	0	-95	-96
2010-2011 N/r Exp Maint	0	0	0	0	0	0	-17	0	0	0	0	0	-17
Inter Division	0	0	0	0	0	0	65	0	-226	161	0	0	0
2010-2011 N/r Exp 09-10 VAT adjust	0	0	0	0	0	0	8	0	0	0	0	0	8
2010-2011 N/r Exp Blood Price adj	0	0	0	0	0	0	30	0	0	0	0	0	30
2010-2011 N/r Exp Patient Access	0	0	0	0	0	0	-17	0	0	0	0	0	-17
2010-2011 N/r Exp Drug Credit Note	0	0	0	0	0	0	47	0	0	0	0	0	47
2010-2011 Outsourcing N/R	0	0	0	0	0	0	0	0	0	0	0	0	0
Credit Note From Siemens relating to prior yr	0	0	0	0	0	0	0	0	0	0	87	0	87
Back Pay Relating to Prior Yr	0	0	0	0	0	0	0	0	0	0	-176	0	-176
Ring Fenced Income For 1 YR	0	0	0	0	0	0	0	0	0	0	21	0	21
Recruitment Fees	0	0	0	0	0	0	0	-61	-59	-11	0	0	-131
NHS Disengagement Fees	0	0	0	0	0	0	0	-21	0	0	0	0	-21
Computer Hardware Purchases	0	0	0	0	0	0	0	0	-14	0	0	0	-14
2010-2011 N/r Ex-Gratia Pay	0	0	0	0	0	0	0	26	-0	-12	-2	-0	12
2010-2011 N/r Recovery Plans	0	0	0	0	0	0	416	0	0	80	518	0	1,014
2010-2011 N/r Ward Closures	0	0	0	0	0	0	0	455	0	2,245	0	0	2,700
2010-2011 N/r underspend against CQC funding	0	0	0	0	0	0	0	0	0	679	1,396	0	2,076
2010-2011 N/r PCT Demand Mgmt	1,800	0	0	0	0	1,800	0	0	0	0	897	0	2,697
CTB Income	3,243	0	0	0	0	3,243	0	-111	0	0	0	0	3,132
Rugby Club Car Park	0	0	0	0	0	0	0	-33	0	0	0	0	-33
Utility Bills	0	0	0	0	0	0	0	26	0	0	0	0	26
Rates Rebate	0	0	0	0	0	0	0	29	0	0	0	0	29
Moorfields	0	0	0	0	0	0	0	32	0	0	0	-96	-64
Away Day Course Fees	0	0	0	0	0	0	0	0	0	0	0	-26	-26
Foyer Income -One off	0	0	0	0	0	0	0	0	0	0	0	38	38
Parkhill Audit Fees -Contribution	0	0	0	0	0	0	0	-275	0	0	0	0	-275
Other non recurrent income	0	0	0	0	0	0	50	460	0	0	0	14	524
Flexi Trainee Income Non Rec	0	0	0	0	0	0	0	0	0	0	0	95	95
2010-11 Midwifery N/R underspend	0	0	0	0	0	0	0	0	0	0	0	1,993	1,993
Price discounts (Risk Pool)	-2,000	0	0	0	0	-2,000	0	0	0	0	0	0	-2,000
Sodexo Insurance Rebate	0	0	0	0	0	0	0	400	0	0	0	0	400
Ortho Geriatric FYE (Therapies)	0	0	0	0	0	0	50	0	0	0	560	0	610
IMT Capitalisation Nrec (no longer realisable)	0	0	0	0	0	0		300	0	0	0	0	300
SBS Contract	0	0	0	0	0	0		-168	0	0	0	0	-168
Midwives - reduction to assumed n/r underspend above	0	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-Recurrent / FYE adjustments:	**3,043**	**0**	**0**	**0**	**0**	**3,043**	**617**	**1,038**	**-299**	**3,178**	**3,300**	**1,922**	**12,799**
2010-2011 FYE CIP	**0**	**0**	**0**	**0**	**0**	**0**	**-1,138**	**-1,221**	**0**	**-126**	**-249**	**-861**	**-3,595**
Reduction to 11/12 Baseline - Scaling back overspend.	0	0	0	0	0	0	-1,899	-1,341	-244	-553	-1,555	-1,002	-6,595
Soft FM	0	0	500	0	0	500	0	0	0	0	0	0	500
Drugs	0	0	900	0	0	900	0	0	0	0	0	0	900

	Central Income	Finance Adjustments	Reserves	Depreciation	Below the Line	Total Central Income & Expenditure	Clinical Support	Corporate	Emergency	Medical	Surgical	Women & Children	Trust
Stock	0	0	1,000	0	0	1,000	0	0	0	0	0	0	1,000
Consumables	0	0	250	0	0	250	0	0	0	0	0	0	250
Balance Sheet	0	0	1,500	0	0	1,500	0	0	0	0	0	0	1,500
Redundancies	0	0	-3,200	0	0	-3,200	0	0	0	0	0	0	-3,200
RTA Income	9	0	0	0	0	9	0	0	0	0	0	0	9
	0	0	0	0	0	0	0	0	0	0	0	0	0
2010-2011 Central Recovery Schemes	**9**	**0**	**950**	**0**	**0**	**959**	**0**	**0**	**0**	**0**	**0**	**0**	**959**
Full Year Effect of 2010-2011 Activites	**-371,544**	**-3,145**	**1,591**	**12,584**	**22,897**	**-337,618**	**81,538**	**75,903**	**22,326**	**50,672**	**96,720**	**45,477**	**35,019**
Cost Pressures:													
Local Cost Pressures - to be managed by Divisions	**0**	**0**	**0**	**0**	**0**	**0**	**360**	**237**	**0**	**59**	**702**	**0**	**1,358**
Other local cost pressures built in to CIP targets						**0**	**1,413**		**809**	**529**	**-1,055**	**250**	**1,946**
Generic Cost Pressures	**0**	**0**	**14,985**	**91**	**0**	**15,076**	**609**	**0**	**0**	**0**	**0**	**0**	**15,685**
Other Adjustments:													
Aggregate price / tariff changes	3,500	0	0	0	0	3,500	0	0	0	0	0	0	3,500
2011/12 management of Local Cost Pressures (from above)	0	0	0	0	0	0	-360	-237	0	-59	-702	0	-1,358
2011/12 CIP target	0	0	0	0	0	0	-3,959	-1,446	-2,039	-4,817	-6,380	-1,409	-20,050
2011/12 CIP target - local cost pressures built in to targets	0	0	0	0	0	0	-1,413	0	-809	-529	1,055	-250	-1,946
2011/12 CIP Balance Sheet - repeat accruals reversals		-1,000				-1,000							-1,000
2011/12 CIP Contract Review						0		-500					-500
2011/12 CIP Marketing	-2,000					-2,000							-2,000
Contingency	0	0	4,000	0	0	4,000	0	0	0	0	0	0	4,000
Planned acitivity changes from 10/11 outturn	4,200	0	0	0	0	4,200	-716	0	-400	0	-1,300	250	2,034
2010/11 High Cost Drugs Funding	-6,900	0	0	0	0	-6,900	0	0	0	0	0	0	-6,900
ISTC Repatriation Activity	-1,600	0	0	0	0	-1,600	0	0	0	0	600	0	-1,000
	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-Total	**-2,800**	**-1,000**	**4,000**	**0**	**0**	**200**	**-6,447**	**-2,183**	**-3,248**	**-5,405**	**-6,727**	**-1,409**	**-25,219**
2011-2012 Trust Balances	**-374,344**	**-4,145**	**20,575**	**12,675**	**22,897**	**-322,342**	**77,473**	**73,957**	**19,887**	**45,855**	**89,640**	**44,318**	**28,788**
Impairment reversal					**-5,318**	**-5,318**							**-5,318**
2011-2012 Trust Balances after impairment (per FIMs)	**-374,344**	**-4,145**	**20,575**	**12,675**	**17,579**	**-327,660**	**77,473**	**73,957**	**19,887**	**45,855**	**89,640**	**44,318**	**23,470**
2011-2012 CIP/Recovery Memorandum													
Reduction to 11/12 Baseline - Scaling back overspend.	0	0	0	0	0	0	-1,899	-1,341	-244	-553	-1,555	-1,002	-6,595
2011/12 CIP target	0	0	0	0	0	0	-3,959	-1,446	-2,039	-4,817	-6,380	-1,409	-20,050
Local cost pressures built in to targets	0	0	0	0	0	0	-1,413	0	-809	-529	1,055	-250	-1,946
Contract review	0	0	0	0	0	0	0	-500	0	0	0	0	-500
Sub-total (headline CIP targets)	**0**	**0**	**0**	**0**	**0**	**0**	**-7,271**	**-3,287**	**-3,092**	**-5,899**	**-6,880**	**-2,661**	**-29,091**
- % of 2010/11 outturn							**-8.7%**	**-4.2%**	**-13.5%**	**-12.2%**	**-7.2%**	**-5.9%**	**-7.8%**
Other cost reduction:													
FYE 2010/11 CIP	0	0	0	0	0	0	-1,138	-1,221	0	-126	-249	-861	-3,595
Management of 2011/12 local Cost Pressures	0	0	0	0	0	0	-360	-237	0	-59	-702	0	-1,358
Gross total	**0**	**0**	**0**	**0**	**0**	**0**	**-8,769**	**-4,745**	**-3,092**	**-6,084**	**-7,831**	**-3,522**	**-34,044**
Control total as % of 2010/11 budget	4.8%	#DIV/0!	779.3%	0.2%	-0.9%	1.0%	2.1%	-0.7%	18.4%	3.8%	5.7%	2.9%	44.8%
Control total as % of 2010/11 outturn	-0.1%	31.8%	3111.0%	0.7%	0.0%	-5.6%	-7.7%	-4.5%	-13.0%	-4.8%	-5.9%	-2.4%	-8.5%

Barking, Havering And Redbridge University Hospitals NHS Trust
Org Code - , Region Code - Y29, HA Code - Q56, Period - 2011/2012P14
CPID - 1042, WebBkName - 1112TRU01_SOCI_P14, WebBID - 1264070
Financial Monitoring and Accounts Forms - 2011/12 Plan
Statement of Comprehensive Income (SOCI)

ROC/R/OR/0150/002

TRU01_SOCI

KEY REVENUE DATA	Sub Code	Maincode 01 2011/12 Full Year Plan £000s	Maincode 02 April £000s	Maincode 03 May £000s	Maincode 04 June £000s	Maincode 05 July £000s	Maincode 06 August £000s	Maincode 07 September £000s	Maincode 08 October £000s	Maincode 09 November £000s	Maincode 10 December £000s	Maincode 11 January £000s	Maincode 12 February £000s	Maincode 13 March £000s	SIGN
Revenue from Patient Care Activities	100	376,922	31,410	31,410	31,410	31,410	31,410	31,410	31,410	31,410	31,410	31,410	31,410	31,402	+
Other Operating Revenue	110	29,207	2,434	2,434	2,434	2,434	2,434	2,434	2,434	2,434	2,434	2,434	2,434	2,433	+
Employee Benefits	120	(267,495)	(22,290)	(22,290)	(22,290)	(22,290)	(22,290)	(22,290)	(22,290)	(22,290)	(22,290)	(22,290)	(22,290)	(22,305)	-
Operating Expenses	130	(137,521)	(6,588)	(11,903)	(11,902)	(11,903)	(11,902)	(11,903)	(11,903)	(11,904)	(11,903)	(11,904)	(11,903)	(11,899)	-
OPERATING SURPLUS/(DEFICIT)	140	1,125	4,966	(348)	(348)	(349)	(348)	(349)	(349)	(358)	(349)	(350)	(349)	(369)	+/-
Investment Revenue	150	804	67	67	67	67	67	67	67	67	67	67	67	67	+
Other Gains and Losses	160	0	0	0	0	0	0	0	0	0	0	0	0	0	+/-
Finance Costs	170	(21,723)	(1,810)	(1,810)	(1,810)	(1,810)	(1,810)	(1,810)	(1,810)	(1,810)	(1,810)	(1,810)	(1,810)	(1,813)	-
SURPLUS/(DEFICIT) FOR THE FINANCIAL YEAR	180	(19,793)	3,223	(2,091)	(2,091)	(2,092)	(2,091)	(2,092)	(2,092)	(2,101)	(2,092)	(2,093)	(2,092)	(2,095)	+/-
Dividends Payable on Public Dividend Capital (PDC)	190	(3,677)	(307)	(307)	(307)	(307)	(307)	(307)	(307)	(307)	(307)	(307)	(307)	(304)	-
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR	200	(23,470)	2,916	(2,398)	(2,398)	(2,399)	(2,398)	(2,399)	(2,399)	(2,408)	(2,399)	(2,400)	(2,399)	(2,399)	+/-

Additional Information	Sub Code	Maincode 01 2011/12 Full Year Plan £000s	Maincode 02 April £000s	Maincode 03 May £000s	Maincode 04 June £000s	Maincode 05 July £000s	Maincode 06 August £000s	Maincode 07 September £000s	Maincode 08 October £000s	Maincode 09 November £000s	Maincode 10 December £000s	Maincode 11 January £000s	Maincode 12 February £000s	Maincode 13 March £000s	SIGN
Value of Contingency Included in Retained Surplus/(Deficit) for the Year	210	(4,000)	(333)	(333)	(333)	(333)	(333)	(333)	(333)	(333)	(333)	(333)	(333)	(339)	+/-
Value of non recurrent commitments included in Retained Surplus/(Deficit) for the Year	220	(3,000)	(250)	(250)	(250)	(250)	(250)	(250)	(250)	(250)	(250)	(250)	(250)	(250)	+/-
IFRIC 12 Impairments included in Retained Surplus/(Deficit) for the Year	230	(4,128)	(4,128)	0	0	0	0	0	0	0	0	0	0	0	+
Other Impairments (Non IFRIC 12) included in Retained Surplus/(Deficit) for the Year	240	(1,190)	-1,190	0	0	0	0	0	0	0	0	0	0	0	+
Total impairments impacting on the Operating Position	250	(5,318)	(5,318)	0	0	0	0	0	0	0	0	0	0	0	+/-
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR BEFORE IMPAIRMENTS	260	(28,788)	(2,402)	(2,398)	(2,398)	(2,399)	(2,398)	(2,399)	(2,399)	(2,408)	(2,399)	(2,400)	(2,399)	(2,399)	+/-
Value of net change from UK GAAP / ESA95 to IFRS for IFRIC12 schemes included in retained surplus/(deficit) for the year excluding impairments	270	637	54	54	53	53	53	53	53	53	53	53	53	53	+
ADJUSTED RETAINED SURPLUS/(DEFICIT) FOR THE YEAR (in Operating Surplus/(Deficit))	280	(28,151)	(2,348)	(2,345)	(2,345)	(2,346)	(2,345)	(2,346)	(2,346)	(2,347)	(2,346)	(2,347)	(2,346)	(2,345)	+/-

Underlying financial position:															
Underlying income	290	409,943	34,161	34,161	34,161	34,161	34,161	34,161	34,161	34,161	34,161	34,161	34,161	34,172	+
Underlying expenditure	300	(436,730)	(36,313)	(36,310)	(36,309)	(36,310)	(36,309)	(36,310)	(36,310)	(36,311)	(36,311)	(36,311)	(36,310)	(36,318)	-
Underlying financial position	310	(26,788)	(2,152)	(2,149)	(2,148)	(2,149)	(2,148)	(2,149)	(2,149)	(2,150)	(2,150)	(2,150)	(2,149)	(2,146)	+/-

Calculations	Outturn	Validate -ve
Operating Expenses (Note 8)	137,521	0
		0
		0
Total Revenue	406,943	0

	April	May	June	July	August	September	October	November	December	January	February	March
Employee Benefits	22,290	22,290	22,290	22,290	22,290	22,290	22,290	22,290	22,290	22,290	22,290	22,302
Operating exp	6,588	11,903	11,902	11,903	11,902	11,903	11,903	11,904	11,903	11,904	11,903	11,899

Barking, Havering And Redbridge University Hospitals NHS Trus
Org Code - , Region Code - Y29, HA Code - Q36, Period - 2011/2012P1
CPID - 1042, WkBkName - 1112TRU02_SOFP_P14, WkBkID - 1263846
ROCR/OR/0190/002 TRU02_SOFP
Financial Monitoring and Accounts Forms - 2011/12 Pla

Statement of Financial Position as at "2011/12 Plan" (SOFP)	Sub Code	Maincode 01 Opening Balance "01/04/11" £000s	Maincode 02 Closing Balance "31/03/12" £000s	Maincode 03 Full year Movement in Balances £000s	Maincode 04 Prior Year "31/03/11" £000s	SIGN
NON-CURRENT ASSETS						
Property, Plant and Equipment	100	359,114	384,037	24,923		+
Intangible Assets	110	2,678	1,843	(835)		+
Investment Property	120	0	0	0		+
Other Financial Assets	130	0	0	0		+
Trade and Other Receivables	140	23,768	23,454	(314)		+
TOTAL NON-CURRENT ASSETS	150	**385,560**	**409,334**	**23,774**		+
CURRENT ASSETS:						
Inventories	160	7,033	7,033	0		+
Trade and Other Receivables	170	34,805	34,805	0		+
Other Financial Assets	180			0		+
Other Current Assets	190			0		+
Cash and Cash Equivalents	200	2,182	2,182	0		+
CURRENT ASSETS:	210	**44,020**	**44,020**	**0**		+
Non- Current Assets Held for Sale	220			0		+
TOTAL CURRENT ASSETS	230	**44,020**	**44,020**	**0**		+
TOTAL ASSETS	240	**429,580**	**453,354**	**23,774**		+
CURRENT LIABILITIES						
Trade and Other Payables	250	(59,991)	(58,048)	1,943		-
Other Liabilities	260			0		-
DH Working Capital Loan	270			0		-
DH Capital Loan	280			0		-
Borrowings	290	(5,277)	(5,292)	(15)		-
Other Financial Liabilities	300			0		-
Provisions for Liabilities and Charges	310	(2,925)	(864)	2,061		-
TOTAL CURRENT LIABILITIES	320	**(68,193)**	**(64,204)**	**3,989**		-
NET CURRENT ASSETS/(LIABILITIES)	330	**(24,173)**	**(20,184)**	**3,989**		+/-
TOTAL ASSETS LESS CURRENT LIABILITIES	340	**361,387**	**389,150**	**27,763**		+
NON-CURRENT LIABILITIES						
Borrowings	350	(260,150)	(257,998)	2,152		-
DH Working Capital Loan	360			0		-
DH Capital Loan	370			0		-
Trade and Other Payables	380	(5,130)	(4,918)	212		-
Other Financial Liabilities	390			0		-
Provisions for Liabilities and Charges	400	(2,748)	(4,098)	(1,350)		-
Other Liabilities	410			0		-
TOTAL NON-CURRENT LIABILITIES	420	**(268,028)**	**(267,014)**	**1,014**		-
TOTAL ASSETS EMPLOYED	430	**93,359**	**122,136**	**28,777**		+
FINANCED BY TAXPAYERS EQUITY:						
Public Dividend Capital	440	307,275	355,475	48,200		+
Retained Earnings	450	(225,174)	(248,644)	(23,470)		+
Revaluation Reserve	460	11,258	15,305	4,047		+
Donated Asset Reserve	470					+
Government Grant Reserve	480					+
Other Reserves	490			0		+
TOTAL TAXPAYERS EQUITY	500	**93,359**	**122,136**	**28,777**		+
Cash in GBS Accounts	510			0		+

Validate -ve

				0
				0
				0
				0
				0
				0
Provisions	864	5,673	4,962	0
				0
				0
				0
				0
				0
				0
				0
Provisions	4,098			0
				0
				0
				0
				0

Barking, Havering And Redbridge University Hospitals NHS Trust
Org Code - , Region Code - Y29, HA Code - Q36, Period - 2011/2012P14
CPID - 1042, WkBkName - 1112TRU04_CF_P14, WkBkID - 1263853

ROCR/OR/0190/002

Financial Monitoring and Accounts Forms - 2011/12 Plan

TRU04_CF

Statement of Cash Flows (CF)	Sub Code	Maincode 01 2011/12 Full Year Plan £000s	Maincode 02 April £000s	Maincode 03 May £000s	Maincode 04 June £000s	Maincode 05 July £000s	Maincode 06 August £000s	Maincode 07 September £000s	Maincode 08 October £000s	Maincode 09 November £000s	Maincode 10 December £000s	Maincode 11 January £000s	Maincode 12 February £000s	Maincode 13 March £000s	Maincode 14 Prior Year "31/03/11" £000s	SIGN	Validate -ve
CASH FLOWS FROM OPERATING ACTIVITIES																	
Operating Surplus/(Deficit)	100	1,126	4,966	(349)	(348)	(349)	(348)	(349)	(349)	(350)	(349)	(350)	(349)	(346)		+/-	
Depreciation and Amortisation	110	13,872	1,155	1,156	1,155	1,156	1,155	1,156	1,156	1,157	1,156	1,157	1,156	1,157		+	
Impairments and Reversals	120	(5,318)	(5,318)	0	0	0	0	0	0	0	0	0	0	0		+	
Other Gains / (Losses) on foreign exchange	130	0	0	0	0	0	0	0	0	0	0	0	0	0		+/-	
Transfer from the Donated Asset Reserve	140															-	0
Transfer from the Government Grant Reserve	150															-	0
Interest Paid	160	(21,723)	(5,431)			(5,431)			(5,431)			(5,431)				-	0
Dividend Paid	170	(3,677)						(1,839)						(1,839)		+/-	
(Increase)/Decrease in Inventories	180	0												0		+/-	
(Increase)/Decrease in Trade and Other Receivables	190	314	8,000	(4,000)	(4,000)	8,000	(4,000)	(4,000)	8,000	(4,000)	(4,000)	8,000	(4,000)	(3,686)		+/-	
(Increase)/Decrease in Other Current Assets	195	0												0		+/-	
Increase/(Decrease) in Trade and Other Payables	200	(2,155)		1,000	6,000	(2,000)	4,000	(9,000)						(2,155)		+/-	
(Increase)/Decrease in Other Current Liabilities	202	0														+/-	
Increase/(Decrease) in Provisions	210	(711)												(711)		+/-	
Net Cash Inflow/(Outflow) from Operating Activities	220	(18,272)	3,372	(2,193)	2,807	1,376	807	(14,032)	3,376	(3,193)	(3,193)	3,376	(3,193)	(7,580)		+/-	
CASH FLOWS FROM INVESTING ACTIVITIES																	
Interest received	230	804	67	67	67	67	67	67	67	67	67	67	67	67		+	
(Payments) for Property, Plant and Equipment	240	(25,253)	(708)	(1,075)	(2,075)	(1,074)	(708)	(3,608)	(708)	(708)	(4,108)	(4,065)	(3,208)	(3,208)		-	0
Proceeds of disposal of assets held for sale (PPE)	250	0														+	
(Payments) for Intangible Assets	260	0														-	0
Proceeds of disposal of assets held for sale (intangible)	270	0														+	
(Payments) for Investments with DH	280	0														-	0
(Payments) for Other Financial Assets	290	0														-	0
Proceeds from Disposal of Investment with DH	300	0														+	
Proceeds from Disposal of Other Financial Assets	310	0														+	
Revenue Rental Income	315	0														+	
Net Cash Inflow/(Outflow)from Investing Activities	320	(24,449)	(641)	(1,008)	(2,008)	(1,007)	(641)	(3,541)	(641)	(641)	(4,041)	(3,998)	(3,141)	(3,141)		+/-	Feed to TRU21 - Cash Flow Financing
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	330	(42,721)	2,731	(3,201)	799	369	166	(17,573)	2,735	(3,834)	(7,234)	(622)	(6,334)	(10,721)		+/-	42,721 0 42,721
CASH FLOWS FROM FINANCING ACTIVITIES																	
Public Dividend Capital Received	340	48,200						48,200								+	
Public Dividend Capital Repaid	350	0														-	
New Capital Investment Loans	360	0														+	
New Working Capital Loans	370	0														+	
Other Loans Received	380	0														+	
Capital Investment Loans Repayment of Principal	390	0														-	0
Working Capital Loans Repayment of Principal	400	0														-	0
Other Loans Repaid	410	0														-	0 Feed to TRU21 - Other Capital Receip
Other Capital Receipts	420	0														+	0
Capital Element of Finance Leases and PFI	430	(5,479)	(1,370)			(1,370)			(1,370)			(1,370)				-	0
Cash transferred to NHS Foundation Trusts	450	0														+/-	
Net Cash Inflow/(Outflow)from Financing	460	42,721	(1,370)	0	0	(1,370)	0	48,200	(1,370)	0	0	(1,370)	0	0		+/-	
Net Increase/(Decrease) in Cash and Cash Equivalents	470	0	1,361	(3,201)	799	(1,001)	166	30,627	1,365	(3,834)	(7,234)	(1,992)	(6,334)	(10,721)		+/-	
Cash (and) Cash Equivalents (and Bank Overdrafts) at the Beginning of the Period	480	2,182	2,182	3,543	342	1,141	140	305	30,933	32,298	28,463	21,229	19,237	12,903		+	
Effect of Exchange Rates Changes on the Balance of Cash Held in Foreign Currencies	490	0														+/-	
Cash (and) Cash Equivalents (and Bank Overdrafts) at the End of the Financial Year	500	2,182	3,543	342	1,141	140	305	30,933	32,298	28,463	21,229	19,237	12,903	2,182		+	

* This line can only be used by NHS Trusts established or dissolved part-way through the year

Barking, Havering And Redbridge University Hospitals NHS Trust
Org Code - , Region Code - Y29, HA Code - Q36, Period - 2011/2012P14
CPID - 1042, WkBkName - 1112TRU08_SOCI_P14, WkBkID - 1264077

ROCR/OR/0190/002

Financial Monitoring and Accounts Forms - 2011/12 Plan

TRU08_SOCI

Employee Benefits:	Sub Code	Maincode 01 Total 2011-12 Full Year Plan £000s	Maincode 02 2011-12 Permanently Employed £000s	Maincode 03 2011-12 Other £000s	SIGN
Salaries and Wages	100	223,306	214,216	9,090	+
Social Security Costs	110	20,155	20,155	0	+
Employers Contributions to NHSPA	120	24,031	24,031	0	+
Other Pension Costs	130	0	0	0	+
Other Post Employment Benefits	140	0	0	0	+
Other Employment Benefits	150	0	0	0	+
Termination Benefits	160	0	0	0	+
TOTAL (including capitalised costs)	170	267,492	258,402	9,090	+
Recognised as					
Costs capitalised as part of assets	180	0			+
Total Employee Benefits excluding capitalised costs	190	267,492			+

Feed to TRU27

2,003	2,003	2,003	2,003	2,003	2,003	2,003	2,003	2,003	2,003	2,003	2,003
April	May	June	July	August	September	October	November	December	January	February	March

Employee Benefits Permanently Employed	Sub Code	Maincode 01 Total 2011-12 Full Year Plan £000s	Maincode 02 Permanently Employed April £000s	Maincode 03 Permanently Employed May £000s	Maincode 04 Permanently Employed June £000s	Maincode 05 Permanently Employed July £000s	Maincode 06 Permanently Employed August £000s	Maincode 07 Permanently Employed September £000s	Maincode 08 Permanently Employed October £000s	Maincode 09 Permanently Employed November £000s	Maincode 10 Permanently Employed December £000s	Maincode 11 Permanently Employed January £000s	Maincode 12 Permanently Employed February £000s	Maincode 13 Permanently Employed March £000s	SIGN
Salaries and wages	200	214,216	17,851	17,851	17,851	17,851	17,851	17,851	17,851	17,851	17,851	17,851	17,851	17,857	+
Social Security costs	210	20,155	1,680	1,680	1,680	1,680	1,680	1,680	1,680	1,680	1,680	1,680	1,680	1,680	+
Employers Contributions to NHSPA	220	24,031	2,003	2,003	2,003	2,003	2,003	2,003	2,003	2,003	2,003	2,003	2,003	2,003	+
Other pension costs	230	0													+
Other Post Employment Benefits	240	0													+
Other Employment Benefits	250	0													+
Termination Benefits	260	0													+
TOTAL - including capitalised costs	270	258,402	21,533	21,533	21,533	21,533	21,533	21,533	21,533	21,533	21,533	21,533	21,533	21,539	+
Recognised as:															
Costs Capitalised as part of assets	280	0													+
Total Employee Benefits excluding capitalised costs	290	258,402	21,533	21,533	21,533	21,533	21,533	21,533	21,533	21,533	21,533	21,533	21,533	21,539	+

Employee Benefits Other	Sub Code	Maincode 01 Total 2011-12 Full Year Plan £000s	Maincode 02 Other April £000s	Maincode 03 Other May £000s	Maincode 04 Other June £000s	Maincode 05 Other July £000s	Maincode 06 Other August £000s	Maincode 07 Other September £000s	Maincode 08 Other October £000s	Maincode 09 Other November £000s	Maincode 10 Other December £000s	Maincode 11 Other January £000s	Maincode 12 Other February £000s	Maincode 13 Other March £000s	SIGN
Salaries and wages	300	9,090	757	757	757	757	757	757	757	757	757	757	757	763	+
Social Security costs	310	0													+
Employers Contributions to NHSPA	320	0													+
Other pension costs	330	0													+
Other Post Employment Benefits	340	0													+
Other Employment Benefits	350	0													+
Termination Benefits	360	0													+
TOTAL - including capitalised costs	370	9,090	757	757	757	757	757	757	757	757	757	757	757	763	+
Recognised as:															
Costs Capitalised as part of assets	380	0													+
Total Employee Benefits excluding capitalised costs	390	9,090	757	757	757	757	757	757	757	757	757	757	757	763	+

total for TRU 06	22,290	22,290	22,290	22,290	22,290	22,290	22,290	22,290	22,290	22,290	22,290	22,290	22,302	

Barking, Havering And Redbridge University Hospitals NHS Trust
Org Code - , Region Code - Y29, HA Code - Q36, Period - 2011/2012P14
CPID - 1042, WkBkName - 1112TRU13_SOFP_P14, WkBkID - 1264078

ROCR/OR/0190/002

Financial Monitoring and Accounts Forms - 2011/12 Plan

TRU13_SOFP

NOTES TO THE ACCOUNTS

Analysis of Impairments & Reversals	Sub Code	Maincode 01 Full Year Plan £000s	Maincode 02 April £000s	Maincode 03 May £000s	Maincode 04 June £000s	Maincode 05 July £000s	Maincode 06 August £000s	Maincode 07 September £000s	Maincode 08 October £000s	Maincode 09 November £000s	Maincode 10 December £000s	Maincode 11 January £000s	Maincode 12 February £000s	Maincode 13 March £000s	Maincode 14 "31/03/11" £000s	SIGN
Property, Plant and Equipment impairments and reversals I&E																
Loss or Damage Resulting from Normal Operations	100	0														+/-
Over Specification of Assets	110	0														+/-
Abandonment of Assets in the Course of Construction	120	0														+/-
TOTAL DEL	130	0	0	0	0	0	0	0	0	0	0	0	0	0	0	+/-
Unforeseen Obsolescence	140	0														+/-
Loss as a Result of a Catastrophe	150	0														+/-
Other	160	(5,318)	(5,318)													+/-
Changes in Market Price	170	0														+/-
TOTAL AME	180	(5,318)	(5,318)	0	0	0	0	0	0	0	0	0	0	0	0	+/-
Property, Plant and Equipment impairments and reversals charged to the Revaluation Reserve																
Loss or Damage Resulting from Normal Operations	190	0														+/-
Over Specification of Assets	200	0														+/-
Abandonment of Assets in the Course of Construction	210	0														+/-
Unforeseen Obsolescence	220	0														+/-
Loss as a Result of a Catastrophe	230	0														+/-
Other	240	(4,047)	(4,047)													+/-
Changes in Market Price	250	0														+/-
TOTAL impairments for PPE charged to Reserves	260	(4,047)	(4,047)	0	0	0	0	0	0	0	0	0	0	0	0	+/-
Total Impairments of Property, Plant and Equipment	270	(9,365)	(9,365)	0	0	0	0	0	0	0	0	0	0	0	0	+/-
Intangible Assets impairments and reversals charged to I&E																
Loss or Damage Resulting from Normal Operations	280	0														+/-
Over Specification of Assets	290	0														+/-
Abandonment of Assets in the Course of Construction	300	0														+/-
TOTAL DEL	310	0	0	0	0	0	0	0	0	0	0	0	0	0	0	+/-
Unforeseen Obsolescence	320	0														+/-
Loss as a Result of a Catastrophe	330	0														+/-
Other	340	0														+/-
Changes in Market Price	350	0														+/-
TOTAL AME	360	0	0	0	0	0	0	0	0	0	0	0	0	0	0	+/-
Intangible Assets impairments and reversals charged to the Revaluation Reserve																
Loss or Damage Resulting from Normal Operations	370	0														+/-
Over Specification of Assets	380	0														+/-
Abandonment of Assets in the Course of Construction	390	0														+/-
Unforeseen Obsolescence	400	0														+/-
Loss as a Result of a Catastrophe	410	0														+/-
Other	420	0														+/-
Changes in Market Price	430	0														+/-
TOTAL impairments for Intangible Assets charged to Reserves	440	0	0	0	0	0	0	0	0	0	0	0	0	0	0	+/-
Total Impairments of Intangibles	450	0	0	0	0	0	0	0	0	0	0	0	0	0	0	+/-
Financial Assets charged to I&E																
Loss or Damage Resulting from Normal Operations	460	0														+/-
TOTAL DEL	470	0	0	0	0	0	0	0	0	0	0	0	0	0	0	+/-
Loss as a Result of a Catastrophe	480	0														+/-
Other	490	0														+/-
TOTAL AME	500	0	0	0	0	0	0	0	0	0	0	0	0	0	0	+/-
Financial Assets impairments and reversals charged to the Revaluation Reserve																
Loss or Damage Resulting from Normal Operations	510	0														+/-
Loss as a Result of a Catastrophe	520	0														+/-
Other	530	0														+/-
TOTAL impairments for Financial Assets charged to Reserves	540	0	0	0	0	0	0	0	0	0	0	0	0	0	0	+/-
Total Impairments of Financial Assets	550	0	0	0	0	0	0	0	0	0	0	0	0	0	0	+/-
Non Current Assets held for sale - impairments and reversals charged to I&E																
Loss or Damage Resulting from Normal Operations	560	0														+/-
Abandonment of Assets in the Course of Construction	570	0														+/-
TOTAL DEL	580	0	0	0	0	0	0	0	0	0	0	0	0	0	0	+/-
Unforeseen Obsolescence	590	0														+/-
Loss as a Result of a Catastrophe	600	0														+/-
Other	610	0														+/-
Changes in Market Price	620	0														+/-
TOTAL AME	630	0	0	0	0	0	0	0	0	0	0	0	0	0	0	+/-
Non Current Assets held for sale impairments and reversals charged to Revaluation Reserve																
Loss or Damage Resulting from Normal Operations	640															+/-
Over Specification of Assets	650															+/-
Abandonment of Assets in the Course of Construction	660															+/-
Unforeseen Obsolescence	670															+/-
Loss as a Result of a Catastrophe	680															+/-
Other (Free text note required)*	690															+/-
Changes in Market Price	700															+/-
TOTAL impairments for Non Current Assets charged to Revaluation Reserves	710															+/-
Total impairments of Non Current Assets held for sale	720	0	0	0	0	0	0	0	0	0	0	0	0	0	0	+/-
Investment Property impairments charged to I&E																
Loss as a Result of a Catastrophe	730	0														+/-
Other	740	0														+/-
Changes in Market Price	750	0														+/-
TOTAL AME	760	0	0	0	0	0	0	0	0	0	0	0	0	0	0	+/-
Total Investment Property impairments charged to I&E	770	0	0	0	0	0	0	0	0	0	0	0	0	0	0	+/-
Overall Impairments	780	(9,365)	(9,365)	0	0	0	0	0	0	0	0	0	0	0	0	+/-
Of which:																
MEA Impairments	790	0														+/-

Barking, Havering And Redbridge University Hospitals NHS Trus
Org Code - , Region Code - Y29, HA Code - Q36, Period - 2011/2012P1
CPID - 1042, WkBkName - 1112TRU19_SOFP_P14, WkBkID - 126407!

ROCR/OR/0190/002

Financial Monitoring and Accounts Forms - 2011/12 Plar | **TRU19_SOFP** | **ROCR/OR/0190/002**

			FORECAST OUTTURN										Validate -ve	
Provisions	**Sub Code**	**Maincode 01 2011/12 Full Year Plan £000s**	**Maincode 02 Pensions to Former Directors £000s**	**Maincode 03 Pensions Relating to Other Staff £000s**	**Maincode 04 Legal Claims £000s**	**Maincode 05 Restructuring £000s**	**Maincode 06 Continuing Care £000s**	**Maincode 07 Equal Pay £000s**	**Maincode 08 Agenda for Change £000s**	**Maincode 09 Other £000s**	**Maincode 10 Redundancy £000s**	**SIGN**		
Balance at "01/04/11"	**100**	5,673		5,422	251							+		
Arising During the Year	**110**	0										+		
Utilised During the Year	**120**	(812)		(812)								-	0	
Reversed Unused	**130**	0										-	0	
Unwinding of Discount	**140**	101		101								+		
Transfers In Year	**150**											+/-		
Transfers to NHS Foundation Trusts	**160**	0										-	0	
Balance as at "31/03/12"	**170**	**4,962**	**0**	**4,711**	**251**	**0**	**0**	**0**	**0**	**0**	**0**	+		Feed to TRU02 4,098
Expected Timing of Cash Flows:														
No Later than One Year	**180**	864		613	251							+		
Later than One Year and not Later than Five Years	**190**	2,452		2,452								+		
Later than Five Years	**200**	1,646	0	1,646	0	0	0	0	0	0	0	+		
Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:														
As at "31/03/12"	**210**											+		
		4,962											0	
													0	

Explanation of Provisions in the "Other" Category (mc16	**Sub Code**	**Maincode 01**	
Breakdown of all Provisions Arising in Year Greater than £1m (mc "other" sc280)	**220**		TEXT
Breakdown of all Provisions Utilised During the Year Greater than £1m (mc"other"sc290)	**230**		TEXT
Breakdown of all Provisions Reversed Unused in Year Greater than £1m (mc "other" sc300)	**240**		TEXT
Breakdown of all Provisions "other" Greater than £1m (mc "other" sc340 mc16	**250**		TEXT

Barking, Havering And Redbridge University Hospitals NHS Trust
Org Code - , Region Code - Y29, HA Code - Q36, Period - 2011/2012P14
CPID - 1042, WkBkName - 1112TRU21_ACCS_P14, WkBkID - 1264080

ROCR/OR/0190/002
Financial Monitoring and Accounts Forms - 2011/12 Plan

TRU21_ACCS

External Financing Limit	Sub Code	Maincode 01 2011/12 Full Year Plan £000s	Maincode 02 2012/13 Full Year Plan £000s	Maincode 04 Prior Year "31/03/11" £000s	SIGN
EXTERNAL FINANCING LIMIT (EFL)	100	46,063	0		+
Cash Flow Financing	110	42,721			+/-
Finance Leases Taken Out in the Year	120	3,342	0		+
Other Capital Receipts	130	0			-
External Financing Requirement	140	46,063	0		+/-
Under/(Over) Spend against EFL	150				+/-

0

Capital Expenditure / Resource Limit Including IFRS Impact	Sub Code	Maincode 01 2011/12 Full Year Plan £000s	Maincode 02 April £000s	Maincode 03 May £000s	Maincode 04 June £000s	Maincode 05 July £000s	Maincode 06 August £000s	Maincode 07 September £000s	Maincode 08 October £000s	Maincode 09 November £000s	Maincode 10 December £000s	Maincode 11 January £000s	Maincode 12 February £000s	Maincode 13 March £000s	Maincode 14 2012/2013 Full Year Plan £000s	Maincode 15 2013/2014 Full Year Plan £000s	Maincode 16 2014/2015 Full Year Plan £000s	Maincode 17 2015/2016 Full Year Plan £000s	Maincode 18 2011/12-2015/16 5 Year Plan £000s	Maincode 19 Prior Year "31/03/11" £000s	SIGN
Assets transferred to existing NHS Trusts under TCS	160	0																	0		-
Assets transferred to New Community Trusts under TCS -16 aspirant CFTs only	170	0																	0		+
X Gross Capital Expenditure including IFRS impact excluding asset transfers under TCS	180	27,738	708	1,075	2,075	1,074	708	3,608	708	708	4,108	6,550	3,208	3,208	18,000	7,000	7,000	7,000	66,738		+
Asset Transfers to NHS Trusts - Non TCS	190	0																	0		-
Gross Capital Expenditure Including IFRS Impact including asset transfers	200	27,738	708	1,075	2,075	1,074	708	3,608	708	708	4,108	6,550	3,208	3,208	18,000	7,000	7,000	7,000	66,738		+
Less: Book Value of Assets Disposed of to NHS Orgs	210	0																	0		-
Less: Book Value of Assets Disposed of to Non-NHS Orgs	220	0																	0		-
less: Net Book Value of Financial Instruments (Investments) Disposed of to NHS bodies	230	0																	0		-
less: Net Book Value of Financial Instruments (Investments) Disposed of to Non-NHS bodies	240	0																	0		-
Plus: Loss on Disposal of Donated Assets	250	0																	0		+
Less: Capital Grants Received	260	0																	0		-
Less: Donations	270	0																	0		-
Charge against the Capital Resource Limit (CRL) Incl IFRS impact	280	27,738	708	1,075	2,075	1,074	708	3,608	708	708	4,108	6,550	3,208	3,208	18,000	7,000	7,000	7,000	66,738		+/-
Capital Resource Limit (CRL) incl IFRS impact	290	27,738	708	1,075	2,075	1,074	708	3,608	708	708	4,108	6,550	3,208	3,208	18,000	7,000	7,000	7,000	66,738		+

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IFRS Capital expenditure IFRIC12 and Non IFRIC12	Sub Code	Maincode 01 2011/12 Full Year Plan £000s	Maincode 02 April £000s	Maincode 03 May £000s	Maincode 04 June £000s	Maincode 05 July £000s	Maincode 06 August £000s	Maincode 07 September £000s	Maincode 08 October £000s	Maincode 09 November £000s	Maincode 10 December £000s	Maincode 11 January £000s	Maincode 12 February £000s	Maincode 13 March £000s	Maincode 14 2012/2013 Full Year Plan	Maincode 15 2013/2014 Full Year Plan	Maincode 16 2014/2015 Full Year Plan	Maincode 17 2015/2016 Full Year Plan	Maincode 18 2011/12-2015/16 5 Year Plan	SIGN
Impact of IFRS on net capital expenditure (IFRIC 12 schemes only)	300	3,342										3,342							3,342	+
Impact of IFRS on net capital expenditure (non-IFRIC 12 schemes)	310	0																	0	+
Total impact of IFRS	320	3,342	0	0	0	0	0	0	0	0	0	3,342	0	0	0	0	0	0	3,342	+
Expected CRL cover	330	3,342	0	0	0	0	0	0	0	0	0	3,342	0	0	0	0	0	0	3,342	+

feeds to TRU33
0 (3,342)

Gross Capital Expenditure including IFRS impacts excluding asset transfers	Sub Code	Project Status (AA to CS)	Committed to Contract (Y / N)	Maincode 01 2011/12 Full Year Plan £000s	Maincode 02 April £000s	Maincode 03 May £000s	Maincode 04 June £000s	Maincode 05 July £000s	Maincode 06 August £000s	Maincode 07 September £000s	Maincode 08 October £000s	Maincode 09 November £000s	Maincode 10 December £000s	Maincode 11 January £000s	Maincode 12 February £000s	Maincode 13 March £000s	Maincode 14 2012/13 Full Year Plan £000s	Maincode 15 2013/2014 Full Year Plan	Maincode 16 2014/2015 Full Year Plan	Maincode 17 2015/2016 Full Year Plan	Maincode 18 2011/12-2015/16 5 Year Plan	Maincode 19 Prior Year "31/03/11" £000s	SIGN
PFI Expenditure	340			3,342										3,342							3,342		+
KGH Polyclinic	350			900									900								900		+
Health 4NEL Service Reconfiguration Works	360			10,000									2,500	2,500	2,500	2,500					10,000		+
PAS Upgrade	370			2,900						2,900											2,900		+
Procurement Automation	380			1,100		367	367	366													1,100		+
Server	390			1,000			1,000														1,000		+
Other Capital Schemes	400			8,496	708	708	708	708	708	708	708	708	708	708	708	708	18,000	7,000	7,000	7,000	47,496		+
	410			0																	0		+
	420			0																	0		+
	430			0																	0		+
	440			0																	0		+
	450			0																	0		+
	460			0																	0		+
	470			0																	0		+
	480			0																	0		+
	490			0																	0		+
	500			0																	0		+
	510			0																	0		+
	520			0																	0		+
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	710			0																	0		+
	720			0																	0		+
	730			0																	0		+
	740			0																	0		+
	750			0																	0		+
	760			0																	0		+
	770			0																	0		+
TOTAL Gross Capital Expenditure including IFRS impacts excluding asset transfers	780			27,738	708	1,075	2,075	1,074	708	3,608	708	708	4,108	6,550	3,208	3,208	18,000	7,000	7,000	7,000	66,738		+

Barking, Havering And Redbridge University Hospitals NHS Trust
Org Code - , Region Code - Y29, HA Code - Q36, Period - 2011/2012P14
CPID - 1042, WkBkName - 1112TRU26a_MI_P14, WkBkID - 1264081

TRU26a_MI

CIPs / Efficiency Savings	Sub Code	Maincode 01 2011-12 Full Year Plan £000s	Maincode 02 April £000s	Maincode 03 May £000s	Maincode 04 June £000s	Maincode 05 July £000s	Maincode 06 August £000s	Maincode 07 September £000s	Maincode 08 October £000s	Maincode 09 November £000s	Maincode 10 December £000s	Maincode 11 January £000s	Maincode 12 February £000s	Maincode 13 March £000s	SIGN
Identified CIPs	100	26,749	1,202	1,383	1,545	2,011	2,152	2,714	2,592	2,672	2,577	2,602	2,602	2,697	+
Unidentified CIPs	110	2,522	0	0	38	97	97	268	337	337	337	337	337	337	+
Total CIPs	120	29,271	1,202	1,383	1,583	2,108	2,249	2,982	2,929	3,009	2,914	2,939	2,939	3,034	+
Percentage of CIPs Achieved Against Plan	130														%

Barking, Havering And Redbridge University Hospitals NHS Trust
Org Code -, Region Code - Y29, HA Code - Q36, Period - 2011/2012P14
CPID - 1042, WkBkName - 1112TRU27_MI_P14, WkBkID - 1264082

TRU27_MI

ROC/OR/0190/002
Financial Monitoring and Accounts Forms - 2011/12 Plan

ROCR/OR/0190/002

Information for HMT Monthly Update	Sub Code	Maincode 01 2011/12 Full Year Plan £000s	Maincode 02 April £000s	Maincode 03 May £000s	Maincode 04 June £000s	Maincode 05 July £000s	Maincode 06 August £000s	Maincode 07 September £000s	Maincode 08 October £000s	Maincode 09 November £000s	Maincode 10 December £000s	Maincode 11 January £000s	Maincode 12 February £000s	Maincode 13 March £000s	Maincode 14 2012/13 Full Year Plan £000s	Maincode 15 2013/14 Full Year Plan £000s	Maincode 16 2014/15 Full Year Plan £000s	Maincode 17 2015/16 Full Year Plan £000s	Maincode 18 2011/12 - 2015/16 5 Year Plan £000s	SIGN	Validate Negative
Revenue from FTs - Healthcare	100	0																		+	
Revenue from FTs - Non Healthcare	110	193	16	16	16	16	16	16	16	16	16	16	16	17						+	
Revenue from Trusts	120	99	8	8	8	8	8	8	8	8	8	8	8	7						+	
Revenue from PCTs	130	371,517	30,959	30,959	30,959	30,959	30,959	30,959	30,959	30,959	30,959	30,959	30,959	30,968						+	
Revenue from DH	140	0	0	0	0	0	0	0	0	0	0	0	0	0						+	
Revenue from SHAs	150	209	17	17	17	17	17	17	17	17	17	17	17	22						+	
Revenue from Others - NHS	160	3,010	251	251	251	251	251	251	251	251	251	251	251	249						+	
Revenue from Non NHS Healthcare Providers	170	0																		+	
Revenue from Others - Non NHS	180	31,919	2,660	2,660	2,660	2,660	2,660	2,660	2,660	2,660	2,660	2,660	2,660	2,659						+	
Staff Costs - Permanently Employed Staff - including pension and other costs at sc210 (including capitalised costs)	190	258,402	21,533	21,533	21,533	21,533	21,533	21,533	21,533	21,533	21,533	21,533	21,533	21,539						+	
Staff costs (locums, agency and bank staff) (including capitalised costs)	200	9,090	757	757	757	757	757	757	757	757	757	757	757	763						+	
Pension Costs and Other Employee Benefits for Permanently Employed Staff (already included in Staff Costs - Permanently Employed Staff sc190) - including capitalised costs	210	24,031	2,003	2,003	2,003	2,003	2,003	2,003	2,003	2,003	2,003	2,003	2,003	2,003						+	
Depreciation	220	13,038	1,086	1,086	1,086	1,086	1,086	1,086	1,087	1,087	1,087	1,087	1,087	1,087						+	
Amortisation	230	834	69	70	69	70	69	70	69	70	69	70	69	70						+	
Provisions - Arising During the Year	240	0																		+	
Provisions - Utilised During the Year	250	(812)												(812)						-	0
Provisions - Reversed Unused	260	0																		-	0
Provisions - Unwinding of Discount	270	101												101						+	
Provisions - Transfers In Year	280																			+	
Provisions-Transfers to NHS Foundation Trusts	290	0																		-	0
Consultancy Costs	300	1,668	139	139	139	139	139	139	139	139	139	139	139	139						+	
Impairments of Receivables	310	240	20	20	20	20	20	20	20	20	20	20	20	20						+	
Inventories Write Offs	320	0	0	0	0	0	0	0	0	0	0	0	0	0						+	
Total DEL Impairments	330	0	0	0	0	0	0	0	0	0	0	0	0	0						+	
Total AME Impairments	340	(5,316)	(5,316)	0	0	0	0	0	0	0	0	0	0	0						+	
Operating Expenses (excluding employee benefits)	350	(137,521)	(6,588)	(11,903)	(11,902)	(11,903)	(11,902)	(11,903)	(11,903)	(11,904)	(11,903)	(11,904)	(11,903)	(11,899)						-	0
Profit/(Loss) on Disposal of Assets	360	0																		+/-	
Interest Receivable	370	0																		+	
Interest Payable	380	0																		-	0
PDC Dividends Payable	390	(3,677)	(307)	(307)	(307)	(307)	(307)	(307)	(307)	(307)	(307)	(307)	(307)	(304)						-	0
Net Book Value of Assets Disposed of to Non-NHS Organisations	400	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	0
Charge against CRL including IFRS impact	410	27,738	708	1,075	2,075	1,074	708	3,608	708	708	4,108	6,550	3,208	3,208	18,000	7,000	7,000	7,000	66,738	+/-	
Revenue costs of IFRS: Arrangements newly brought on SoFP under IFRIC12 (e.g LIFT/PFI)																					
Depreciation charge	420	6,038	504	504	503	503	503	503	503	503	503	503	503	503						+	
Interest expense	430	21,597	1,800	1,800	1,800	1,800	1,800	1,800	1,800	1,800	1,800	1,800	1,800	1,800						+	
Impairment charge - AME	440	(4,128)	(4,128)																	+	
Impairment charge - DEL	450	0																		+	
Other expenditure	460	(24,835)	(2,070)	(2,070)	(2,070)	(2,070)	(2,070)	(2,070)	(2,070)	(2,070)	(2,070)	(2,070)	(2,070)	(2,070)						+	
Revenue receivable from subleasing	470	0																		-	0
Impact on PDC dividend payable	480	(2,159)	(180)	(180)	(180)	(180)	(180)	(180)	(180)	(180)	(180)	(180)	(180)	(179)						+	
Total IFRS expenditure (IFRIC12)	490	(3,491)	(4,074)	54	53	53	53	53	53	53	53	53	53	53						+	
Revenue costs of the same schemes if they had been accounted for under UK GAAP / ESA95 (net of any sublease income)	500	0																		-	0
Net IFRS change (IFRIC12)	510	(3,491)	(4,074)	54	53	53	53	53	53	53	53	53	53	53						+/-	
Capital consequences of IFRS: LIFT/PFI and other items under IFRIC12																					
Capital expenditure 2011-12	520	3,342	0	0	0	0	0	0	0	0	0	3,342	0	0						+	
Average net assets relating to IFRIC12 schemes - IFRS	530	0																		+	
Average net assets relating to IFRIC12 schemes - UKGAAP	540	0																		+	
UK GAAP capital expenditure 2011/12	550	0	0	0	0	0	0	0	0	0	0	0	0	0						+	
Revenue costs of IFRS: all other expenditure associated with IFRS (e.g. finance leases)																					
Depreciation charge	560	0																		+	
Interest expense	570	0																		+	
Impairment charge - AME	580	0																		+	
Impairment charge - DEL	590	0																		+	
Other expenditure	600	0																		+	
Impact on PDC dividend payable	610	0																		+	
Total IFRS expenditure (non IFRIC12)	620	0	0	0	0	0	0	0	0	0	0	0	0	0						+	
Revenue consequences under UK GAAP	630	0																		-	0
Net IFRS change (non IFRIC12)	640	0	0	0	0	0	0	0	0	0	0	0	0	0						+/-	
Capital consequences of IFRS all other expenditure associated with IFRS																					
Capital expenditure 2011-12	650	0	0	0	0	0	0	0	0	0	0	0	0	0						+	
Net assets relating to non-IFRIC12 IFRS - IFRS basis	660	0																		+	
Net assets relating to non-IFRIC12 IFRS - UKGAAP basis	670	0																		+	
Breakdown of Total Gross Capital Expenditure (by type) including IFRS Impact:																					
New Build	680	900									900								900	+	
Maintenance	690	10,000									2,500	2,500	2,500	2,500					10,000	+	
Equipment	700	4,442		367	367	366						3,342							4,442	+	
Information Technology	710	3,900			1,000			2,900											3,900	+	
Other	720	8,496	708	708	708	708	708	708	708	708	708	708	708	708	18,000	7,000	7,000	7,000	47,496	+	
Total Gross Capital Expenditure (see guidance)	730	27,738	708	1,075	2,075	1,074	708	3,608	708	708	4,108	6,550	3,208	3,208	18,000	7,000	7,000	7,000	66,738	+	
Disposables and Transfers	740	0																	0	-	0
Grants and Donations	750	0																	0	-	0
Total Charge against CRL including IFRS impact	760	27,738	708	1,075	2,075	1,074	708	3,608	708	708	4,108	6,550	3,208	3,208	18,000	7,000	7,000	7,000	66,738	+	
Breakdown of Total Gross Capital Expenditure (by programme) including IFRS Impact:																					
Community Hospitals	770	0																	0	+	
Other Central Programme	780	0																	0	+	
Non Central Programme	790	27,738	708	1,075	2,075	1,074	708	3,608	708	708	4,108	6,550	3,208	3,208	18,000	7,000	7,000	7,000	66,738	+	
Total Gross Capital Expenditure (see guidance)	800	27,738	708	1,075	2,075	1,074	708	3,608	708	708	4,108	6,550	3,208	3,208	18,000	7,000	7,000	7,000	66,738	+	
Disposables and Transfers	810	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	0
Grants and Donations	820	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	0
Total Charge against CRL including IFRS impact	830	27,738	708	1,075	2,075	1,074	708	3,608	708	708	4,108	6,550	3,208	3,208	18,000	7,000	7,000	7,000	66,738	+	
Total CRL including IFRS impact	840	27,738	708	1,075	2,075	1,074	708	3,608	708	708	4,108	6,550	3,208	3,208	18,000	7,000	7,000	7,000	66,738	+	

Key Expenditure Items	Sub Code	2010/11 Full Year Plan £000s	April £000s	May £000s	June £000s	July £000s	August £000s	September £000s	October £000s	November £000s	December £000s	January £000s	February £000s	March £000s	2012/2013 Full Year Plan £000s	2013/2014 Full Year Plan £000s	2014/2015 Full Year Plan £000s	2015/2016 Full Year Plan £000s	2011/12-2015/16 5 Year Plan £000s	
Service Reconfiguration	850	0																	0	+
Reducing Backlog Maintenance	860	0																	0	+
Supporting Transition to Foundation Trust status	870	0																	0	+
Total of Key Expenditure Item	880	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	+

Net IFRIC12 calc to TRU01		54	54	53	53	53	53	53	53	53	53	53	53	53						0
																				0
DEL+AME IFRIC12 Imprmnts calc to TRU01		(4,128)	0	0	0	0	0	0	0	0	0	0	0	0						

Barking, Havering And Redbridge University Hospitals NHS Trust
Org Code - , Region Code - Y29, HA Code - Q26, Period - 2011/2012P14
CPID - 1042, WkBkName - 1112TRU3_M_P14, WkBkID - 1264083

ROCR/OR0190/002
Financial Monitoring and Accounts Forms - 2011/12 Plan
SUMMARY OF WORKFORCE

SECTION A - STAFF IN POST EXCLUDING BANK STAFF, LOCUMS AND AGENCY STAFF (FTE)

TRU3/1_MI

FULL-TIME EQUIVALENT STAFF IN POST (at 31st March)	Sub Code	Maincode 01 2011-12 Full Year Plan	Maincode 02 April	Maincode 03 May	Maincode 04 June	Maincode 05 July	Maincode 06 August	Maincode 07 September	Maincode 08 October	Maincode 09 November	Maincode 10 December	Maincode 11 January	Maincode 12 February	Maincode 13 March	SIGN
		Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	
MEDICAL AND DENTAL	100	725.40	756.34	756.34	756.34	756.34	710.00	710.00	710.00	710.00	710.00	710.00	710.00	710.00	+
of which - Medical and Dental Consultants	110	234.85	248.81	248.81	248.81	248.81	228.00	228.00	228.00	228.00	228.00	228.00	228.00	228.00	+
ALL QUALIFIED NURSING, MIDWIFERY AND HEALTH VISITING STAFF	120	1,832.20	1,832.95	1,832.95	1,832.95	1,832.95	1,832.95	1,832.95	1,832.95	1,832.95	1,832.95	1,832.95	1,832.95	1,800.00	+
of which qualified midwives	130	249.00	248.55	248.55	248.55	248.55	248.55	248.55	248.55	248.55	248.55	248.55	248.55	248.55	+
ALL SCIENTIFIC, THERAPEUTIC AND TECHNICAL STAFF	140	780.54	628.63	624.68	620.55	780.60	780.60	780.60	780.60	780.60	780.60	780.60	780.60	770.00	+
Of which - Healthcare Scientists	150	185.00	171.80	171.80	171.80	185.00	185.00	185.00	185.00	185.00	185.00	185.00	185.00	185.00	+
Of which - Allied Health Professionals	160	368.54	319.81	319.81	319.81	383.60	383.60	383.60	383.60	383.60	383.60	383.60	383.60	368.00	+
Ambulance staff	170	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+
Healthcare assistants and other support staff	180	870.00	950.00	950.00	950.00	850.00	850.00	850.00	850.00	850.00	850.00	850.00	850.00	850.00	+
Managers and senior managers	190	727.63	760.00	760.00	760.00	743.00	743.00	743.00	743.00	743.00	730.00	730.00	730.00	720.00	+
Administration and estates	200	747.06	780.00	780.00	780.00	743.00	743.00	743.00	743.00	743.00	730.00	730.00	730.00	720.00	+
Others	210	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+
All staff in post excluding banking staff, locums and agency staff (FTE)	**220**	**5,085.94**	**5,291.11**	**5,286.97**	**5,282.84**	**5,097.29**	**5,040.95**	**5,040.95**	**5,040.95**	**5,040.95**	**5,040.95**	**5,027.95**	**5,022.95**	**4,965.55**	+

SECTION B - BANK STAFF (FTE)

FULL-TIME EQUIVALENT BANK STAFF IN POST (at 31st March)	Sub Code	Maincode 01 2011-12 Full Year Plan	Maincode 02 April	Maincode 03 May	Maincode 04 June	Maincode 05 July	Maincode 06 August	Maincode 07 September	Maincode 08 October	Maincode 09 November	Maincode 10 December	Maincode 11 January	Maincode 12 February	Maincode 13 March	SIGN
		Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	
MEDICAL AND DENTAL	230	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+
of which - Medical and Dental Consultants	240	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+
ALL QUALIFIED NURSING, MIDWIFERY AND HEALTH VISITING STAFF	250	159.62	162.63	162.63	162.63	90.00	100.00	90.00	90.00	90.00	90.00	100.00	90.00	80.00	+
of which qualified midwives	260	12.23	17.38	17.38	17.38	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	+
ALL SCIENTIFIC, THERAPEUTIC AND TECHNICAL STAFF	270	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+
Of which - Healthcare Scientists	280	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+
Of which - Allied Health Professionals	290	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+
Ambulance staff	300	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+
Healthcare assistants and other support staff	310	93.33	125.00	125.00	125.00	80.00	95.00	80.00	80.00	80.00	95.00	95.00	80.00	80.00	+
Managers and senior managers	320	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+
Administration and estates	330	43.08	65.00	65.00	65.00	34.00	34.00	34.00	34.00	34.00	34.00	34.00	34.00	25.00	+
Others	340	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+
All Bank Staff (FTE)	**350**	**243.24**	**352.63**	**352.63**	**352.63**	**204.12**	**229.12**	**204.12**	**204.12**	**204.12**	**204.12**	**225.00**	**225.00**	**200.00**	**160.00**	+

SECTION C - LOCUM STAFF (FTE)

ALL LOCUM STAFF	Sub Code	Maincode 01 2011-12 Full Year Plan	Maincode 02 April	Maincode 03 May	Maincode 04 June	Maincode 05 July	Maincode 06 August	Maincode 07 September	Maincode 08 October	Maincode 09 November	Maincode 10 December	Maincode 11 January	Maincode 12 February	Maincode 13 March	SIGN
		Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	
All Locum Staff (FTE)	**360**	**19.50**	**35.00**	**35.00**	**25.00**	**20.00**	**20.00**	**15.00**	**15.00**	**15.00**	**15.00**	**15.00**	**15.00**	**10.00**	+

SECTION D - AGENCY STAFF (FTE)

AGENCY STAFF	Sub Code	Maincode 01 2011-12 Full Year Plan	Maincode 02 April	Maincode 03 May	Maincode 04 June	Maincode 05 July	Maincode 06 August	Maincode 07 September	Maincode 08 October	Maincode 09 November	Maincode 10 December	Maincode 11 January	Maincode 12 February	Maincode 13 March	SIGN
		Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	Average Number	
MEDICAL AND DENTAL	370	34.05	40.00	40.00	40.00	35.00	40.00	30.00	30.00	30.00	40.00	40.00	30.00	15.00	+
of which - Medical and Dental Consultants	380	7.75	4.51	4.00	3.00	2.00	2.00	2.00	2.00	2.00	3.00	3.00	2.00	2.00	+
ALL QUALIFIED NURSING, MIDWIFERY AND HEALTH VISITING STAFF	390	30.65	40.00	40.00	30.00	25.00	30.00	22.00	22.00	22.00	30.00	30.00	22.00	20.00	+
of which qualified midwives	400	1.68	5.00	5.00	3.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+
ALL SCIENTIFIC, THERAPEUTIC AND TECHNICAL STAFF	410	24.56	40.00	30.00	30.00	25.00	25.00	20.00	20.00	20.00	25.00	20.00	20.00	20.00	+
Of which - Healthcare Scientists	420	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+
Of which - Allied Health Professionals	430	24.87	39.63	35.00	30.00	25.00	25.00	20.00	20.00	20.00	25.00	20.00	20.00	20.00	+
Ambulance staff	440	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+
Healthcare assistants and other support staff	450	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+
Managers and managers	460	3.28	4.00	4.00	4.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	2.00	+
Administration and estates	470	4.31	9.68	9.00	7.00	4.00	4.00	4.00	4.00	2.00	2.00	2.00	2.00	2.00	+
Others	480	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	+
All Agency Staff (FTE)	**490**	**96.91**	**136.68**	**123.00**	**111.00**	**87.00**	**107.00**	**82.00**	**82.00**	**80.00**	**105.00**	**100.00**	**85.00**	**63.00**	+

SECTION E - PAY BILL EXCLUDING BANK STAFF, LOCUMS AND AGENCY STAFF (£000s)

STAFF IN POST SPEND	Sub Code	Maincode 01 2011-12 Full Year Plan £000s	Maincode 02 April £000s	Maincode 03 May £000s	Maincode 04 June £000s	Maincode 05 July £000s	Maincode 06 August £000s	Maincode 07 September £000s	Maincode 08 October £000s	Maincode 09 November £000s	Maincode 10 December £000s	Maincode 11 January £000s	Maincode 12 February £000s	Maincode 13 March £000s	SIGN
MEDICAL AND DENTAL	500	84,960	6,360	6,360	6,360	6,360	6,360	6,360	6,360	6,360	6,360	6,360	6,360	6,360	+
of which - Medical and Dental Consultants	510	31,610	3,380	3,380	3,380	3,380	3,380	3,380	3,380	3,380	3,380	3,380	3,380	3,380	+
ALL QUALIFIED NURSING, MIDWIFERY AND HEALTH VISITING STAFF	520	81,806	7,651	7,651	7,651	7,651	7,651	7,651	7,651	7,651	7,651	7,651	7,651	7,646	+
of which qualified midwives	530	0	0	0	0	0	0	0	0	0	0	0	0	0	+
ALL SCIENTIFIC, THERAPEUTIC AND TECHNICAL STAFF	540	38,541	3,212	3,212	3,212	3,212	3,212	3,212	3,212	3,212	3,212	3,212	3,212	3,208	+
Of which - Healthcare Scientists	550	7,343	112	112	112	112	112	112	112	112	112	112	112	111	+
Of which - Allied Health Professionals	560	14,874	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,240	1,238	+
Ambulance staff	570	0	0	0	0	0	0	0	0	0	0	0	0	0	+
Healthcare assistants and other support staff	580	26,088	2,174	2,174	2,174	2,174	2,174	2,174	2,174	2,174	2,174	2,174	2,174	2,174	+
Managers and senior managers	590	8,156	680	680	680	680	680	680	680	680	680	680	680	674	+
Administration and estates	600	28,240	2,354	2,354	2,354	2,354	2,354	2,354	2,354	2,354	2,354	2,354	2,354	2,350	+
Others	610	(17,665)	(1,472)	(1,472)	(1,472)	(1,472)	(1,472)	(1,472)	(1,472)	(1,472)	(1,472)	(1,472)	(1,472)	(1,469)	+
All Pay Bill, excluding bank staff, locums and agency Staff (Total)	**620**	**266,462**	**21,533**	**21,533**	**21,533**	**21,533**	**21,533**	**21,533**	**21,533**	**21,533**	**21,533**	**21,533**	**21,533**	**21,539**	+

SECTION F - BANK STAFF SPEND (£000s)

BANK STAFF SPEND	Sub Code	Maincode 01 2011-12 Full Year Plan £000s	Maincode 02 April £000s	Maincode 03 May £000s	Maincode 04 June £000s	Maincode 05 July £000s	Maincode 06 August £000s	Maincode 07 September £000s	Maincode 08 October £000s	Maincode 09 November £000s	Maincode 10 December £000s	Maincode 11 January £000s	Maincode 12 February £000s	Maincode 13 March £000s	SIGN
MEDICAL AND DENTAL	630	0	0	0	0	0	0	0	0	0	0	0	0	0	+
of which - Medical and Dental Consultants	640	0	0	0	0	0	0	0	0	0	0	0	0	0	+
ALL QUALIFIED NURSING, MIDWIFERY AND HEALTH VISITING STAFF	650	1,078	90	90	90	90	90	90	90	90	90	90	90	88	+
of which qualified midwives	660	0	0	0	0	0	0	0	0	0	0	0	0	0	+
ALL SCIENTIFIC, THERAPEUTIC AND TECHNICAL STAFF	670	168	0	0	0	0	0	0	0	0	0	0	0	168	+
Of which - Healthcare Scientists	680	0	0	0	0	0	0	0	0	0	0	0	0	0	+
Of which - Allied Health Professionals	690	14	0	0	0	0	0	0	0	0	0	0	0	14	+
Ambulance staff	700	0	0	0	0	0	0	0	0	0	0	0	0	0	+
Healthcare assistants and other support staff	710	52	4	4	4	4	4	4	4	4	4	4	4	4	+
Managers and senior managers	720	0	0	0	0	0	0	0	0	0	0	0	0	0	+
Administration and estates	730	963	47	47	47	47	47	47	47	47	47	47	47	46	+
Others	740	0	0	0	0	0	0	0	0	0	0	0	0	0	+
All Bank Staff Spend	**750**	**1,709**	**142**	**142**	**142**	**142**	**142**	**142**	**142**	**142**	**142**	**142**	**142**	**147**	+

SECTION G - LOCUM SPEND (£000s)

LOCUM SPEND	Sub Code	Maincode 01 2011-12 Full Year Plan £000s	Maincode 02 April £000s	Maincode 03 May £000s	Maincode 04 June £000s	Maincode 05 July £000s	Maincode 06 August £000s	Maincode 07 September £000s	Maincode 08 October £000s	Maincode 09 November £000s	Maincode 10 December £000s	Maincode 11 January £000s	Maincode 12 February £000s	Maincode 13 March £000s	SIGN
All Locum Staff Spend	**760**	**2,079**	**173**	**173**	**173**	**173**	**173**	**173**	**173**	**173**	**173**	**173**	**173**	**176**	+

SECTION H - AGENCY SPEND (£000s)

AGENCY SPEND	Sub Code	Maincode 01 2011-12 Full Year Plan £000s	Maincode 02 April £000s	Maincode 03 May £000s	Maincode 04 June £000s	Maincode 05 July £000s	Maincode 06 August £000s	Maincode 07 September £000s	Maincode 08 October £000s	Maincode 09 November £000s	Maincode 10 December £000s	Maincode 11 January £000s	Maincode 12 February £000s	Maincode 13 March £000s	SIGN
MEDICAL AND DENTAL	770	5,407	453	453	453	453	453	453	453	453	453	453	453	454	+
of which - Medical and Dental Consultants	780	924	69	69	69	69	69	69	69	69	69	69	69	67	+
ALL QUALIFIED NURSING, MIDWIFERY AND HEALTH VISITING STAFF	790	316	27	27	27	27	27	27	27	27	27	27	27	31	+
of which qualified midwives	800	0	0	0	0	0	0	0	0	0	0	0	0	0	+
ALL SCIENTIFIC, THERAPEUTIC AND TECHNICAL STAFF	810	(283)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(20)	(23)	+
Of which - Healthcare Scientists	820	0	0	0	0	0	0	0	0	0	0	0	0	0	+
Of which - Allied Health Professionals	830	1,403	117	117	117	117	117	117	117	117	117	117	117	120	+
Ambulance staff	840	0	0	0	0	0	0	0	0	0	0	0	0	0	+
Healthcare assistants and other support staff	850	50	4	4	4	4	4	4	4	4	4	4	4	6	+
Managers and senior managers	860	0	0	0	0	0	0	0	0	0	0	0	0	0	+
Administration and estates	870	(283)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(19)	+
Others	880	0	0	0	0	0	0	0	0	0	0	0	0	0	+
All Agency Staff Spend	**890**	**5,360**	**442**	**442**	**442**	**442**	**442**	**442**	**442**	**442**	**442**	**442**	**442**	**449**	+

Validate to TRU08 | 9,090

Barking, Havering And Redbridge University Hospitals NHS Trust
Org Code - , Region Code - Y29, HA Code - Q36, Period - 2011/2012P14
CPID - 1042, WkBkName - 1112TRU33_MI_P14, WkBkID - 1264084

Financial Monitoring and Accounts Forms - 2011/12 Plan **TRU33**

ROCR/OR/0190/002

Capital Cash Management Plan - 2011/12	Sub Code	Maincode 01 2011/12 Full Year Plan £000s	SIGN
PLANNED CAPITAL EXPENDITURE (RESOURCES)			
Gross Capital Expenditure (including IFRS impact)	**100**	**27,738**	+
Less IFRS impact (included in sc100)	**110**	(3,342)	-
Gross Capital Expenditure (excluding IFRS impact	**120**	**24,396**	+
PLANNED FINANCING OF CRL (CASH)			
Internal Sources:			
Planned Depreciation - non IFRIC 12 Related	**130**	7,834	+
Planned Depreciation - IFRIC 12 Related	**140**	6,038	+
Less Planned Depreciation - IFRIC 12 Related that forms Depreciation Part of the Unitary Charge	**150**	(5,480)	-
I&E Surplus - Attributed Financing of Capital Expenditure	**160**	0	+
Net Book Value of Non Current Assets Disposed Of to NHS and non-NHS Orgs	**170**	0	+
Movement in payables/receivables - Attributed to Financing of Capital Expenditure	**180**	0	+/-
Grants and Donations	**190**	0	+
Unspent Capital Cash from Previous Year(s)	**200**	104	+
Unspent revenue cash from previous year(s) - Attributed to Financing of Capital Expenditure	**210**	900	+/-
Internally Generated Capital Cash	**220**	**9,396**	+
External Sources:			
New Public Dividend Capital - Central Budget Allocations - Agreed/Anticipated	**230**		+
New Public Dividend Capital - Schemes Eligible For Transitional PDC Per FMWP(07-08)01	**240**		+
New Public Dividend Capital - Exceptions To The Capital Regime	**250**	15,000	+
Asset received from other NHS Trusts, PCTs and FTs	**260**	0	+
Asset disposed to other NHS Trusts, PCTs and FTs	**270**	0	-
Other Loans Received - e.g. Salix Energy Loans	**280**	0	+
New Capital Investment Loans	**290**	0	+
Capital Investment Loan Principal Repayments	**300**	0	-
External Capital Cash Requirement	**310**	**15,000**	+/-
Total Capital Cash Financing	**320**	**24,396**	+/-
Total Capital Cash Financing Available minus Gross Capital Expenditure (excl. IFRS Impact	**330**	**0**	+/-

NET BORROWING REQUIREMENT (NBR)			
External Capital Cash Requirement	**340**	15,000	+/-
New Working Capital Loans	**350**	0	+
Working Capital Loan Principal Repayments	**360**	0	-
NET BORROWING REQUIREMENT	**370**	**15,000**	+/-

I&E ret surp/(def) — I&E ret surp/(def) - if surplus
(23,470) — 0

Planned Depreciation 2011-12
13,872

Rects sale P, P&E — Rect sale intang FA — P/L on disposal
0 — 0 — 0

Grants — Donations
0 — 0

Validate -ve

0
0
0
0
0
0

count
0
0

Organisation	Barking, Havering & Redbridge Hospitals NHS Trust
Org Code	RF4
Org type	TRUST

Plan Submission Bridge	**Additional Info**	**£000's**	**SIGN**
Surplus/(Deficit) Feb Plan Submission		(19,441)	+/-
Tariff Changes	Price changes incl. Chemo, KPIs	5,371	+/-
Additional QIPP	Reduction from £31.1m to £29.3m	(1,874)	+/-
Impairments		5,318	+/-
Volume changes	Reduction of £2.7m contribution partly mitigate	(676)	+/-
N/R commitments in previous year	Reduction in 2011/12 redundancies	(1,807)	+/-
Movement in 2010/11 FCOT		(2,820)	+/-
FYE recurrent costs	Local cost pressures	(2,126)	+/-
Non-recurrent benefits	Difference £26m budget total and £19.6m Op P	(6,400)	+/-
Other		1,176	+/-
	Total	(23,279)	+/-
Surplus/(Deficit) March Submission		(23,279)	+/-
Variance		0	

SLA Reconciliation

Organisation Name	Barking, Havering & Redbridge Hospitals NHS Trust

		Commissioner 1	Commissioner 2	Commissioner 3	Commissioner 4	Commissioner 5	Other - London (Q36)	Other - Out of London	Total
	Select Organisation Code	*5C2*	*5A4*	*5NA*	*5NC*				
	Organisation Name	Barking and Dagenham	Havering	Redbridge	Waltham Forest	#N/A			
		£'000	£'000	£'000	£'000	£'000		£'000	£'000
2010/11	2010/11 Plan	87,625	128,663	79,996	1,694		13,130	40,975	352,083
	2010/11 Outturn	89,183	134,579	84,985	2,258		13,163	40,525	364,692
2011/12 Price changes	**Opening baseline**	89,183	134,579	84,985	2,258	-		40,525	364,692
	Inflation	-	-	-	-	-		-	-
	Other	-	-	-	-	-		-	-
	Total	89,183	134,579	84,985	2,258	-		40,525	364,692
2011/12 Volume Changes	Demand management (-)								-
	Decommissioning (-)								-
	Other change in volume (+/-)	3,527	1,694	(1,192)	(140)			(1,393)	2,496
Quality	CQUINS payment								-
	Total SLA Value	**92,710**	**136,273**	**83,793**	**2,117**	**-**		**39,132**	**367,188**
	(Under)/ over performance assumption	-							-
	Revenue Budget 2011/12	**92,710**	**136,273**	**83,793**	**2,117**	**-**		**39,132**	**367,188**
	Revenue Budget 2012/13								

Organisation	Barking, Havering & Redbridge Hospitals NHS Trust
Org Code	RF4
Org type	TRUST

Operating Plan Forms - 2011/12 Financial Plan

SHA	Commisioner	Sub Code	Maincode 01 2011/12 Full Year Plan £000s	Maincode 14 2012/13 Full Year Plan £000s
Q36	Brent PCT	5K5	0	
Q36	Harrow PCT	5K6	0	
Q36	Hammersmith and Fulham PCT	5H1	0	
Q36	Kensington and Chelsea PCT	5LA	0	
Q36	Westminster PCT	5LC	0	
Q36	Hounslow PCT	5HY	0	
Q36	Hillingdon PCT	5AT	0	
Q36	Ealing PCT	5HX	0	
Q36	Barnet PCT	5A9	0	
Q36	Camden PCT	5K7	0	
Q36	Enfield PCT	5C1	0	
Q36	Islington PCT	5K8	0	
Q36	Haringey PCT	5C9	0	
Q36	Barking and Dagenham PCT	5C2	92,710	
Q36	Havering PCT	5A4	136,273	
Q36	Redbridge PCT	5NA	83,793	
Q36	Waltham Forest PCT	5NC	2,117	
Q36	Croydon PCT	5K9	0	
Q36	Kingston PCT	5A5	0	
Q36	Richmond and Twickenham PCT	5M6	0	
Q36	Sutton and Merton PCT	5M7	0	
Q36	Wandsworth PCT	5LG	0	
Q36	City and Hackney PCT	5C3	279	
Q36	Newham PCT	5C5	4,371	
Q36	Tower Hamlets PCT	5C4	526	
Q36	Bexley PCT	TAK	0	
Q36	Bromley PCT	5A7	0	
Q36	Greenwich PCT	5A8	0	
Q36	Lambeth PCT	5LD	0	
Q36	Lewisham PCT	5LF	0	
Q36	Southwark PCT	5LE	0	
Q30	Other PCT's in Q30			
Q31	Other PCT's in Q31			
Q32	Other PCT's in Q32			
Q33	Other PCT's in Q33			
Q34	Other PCT's in Q34			
Q35	Other PCT's in Q35		47,119	
Q37	Other PCT's in Q37			
Q38	Other PCT's in Q38			
Q39	Other PCT's in Q39			
Total PCT income			367,188	0

SLA Rec Value	367,188
Variance	0

Please explain any variance here.

Organisation	Barking, Havering & Redbridge Hospitals NHS Trust
Org Code	RF4
Org type	TRUST

PLEASE COMPLETE:	
	£000's
TOTAL GROSS QIPPS	**28,634**
INVESTMENT	
TOTAL NET QIPP BEFORE RISK ADJUSTMENT	**28,634**
TOTAL RISK ADJUSTMENT	
NET QIPP TOTAL AFTER RISK ADJUSTMENT	**28,634**

2011/12 Initial Plans **KEY REVENUE DATA**	**Sub Code**	**Maincode 01** **Full Year Plan** **£000s**	**Maincode 02** **Full Year Plan** **£000s**	**Maincode 03** **Full Year Plan** **£000s**	**Maincode 04** **Full Year Plan** **£000s**	**Maincode 05** **Total Savings** **£000s**	**SIGN**
PCT own generated savings split between:	**100**						+
- Cash Releasing	**120**					**0**	+
- Efficiency/Expenditure Avoidance	**130**					**0**	+
Savings expected from NHS Trusts	**140**					**0**	+
Savings expected from Foundation Trusts	**150**					**0**	+
Total	**160**	**0**	**0**	**0**	**0**	**0**	

Please ensure QIPP's included here do not include income generation schemes. All monthly phased QIPPs should be net, risk adjusted figures.

QIPPS	**>90%** **Low Risk** **£000s**	**75%-90%** **Medium Risk** **£000s**	**<75%** **High Risk** **£000s**	**GROSS** **2011/12 Full Year Plan** **£000s**	**NET** **2011/12 Full Year Plan** **£000s**	**Maincode 02** **April** **£000s**	**Maincode 03** **May** **£000s**	**Maincode 04** **June** **£000s**	**Maincode 05** **July** **£000s**	**Maincode 06** **August** **£000s**	**Maincode 07** **September** **£000s**	**Maincode 08** **October** **£000s**	**Maincode 09** **November** **£000s**	**Maincode 10** **December** **£000s**	**Maincode 11** **January** **£000s**	**Maincode 12** **February** **£000s**	**Maincode 13** **March** **£000s**	**Full year effect** **£000s**
Unidenttified QIPPS			2,522	2,522	2,522	0	0	38	97	97	268	337	337	337	337	337	337	2,522
Long term conditions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Urgent care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
End of life care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Planned care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Learning disabilities	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Maternity and newborn	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Right care – Patient decision support	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Medicines use, clinical procurement, prescribing	800	845	350	1,995	1,995	58	58	64	114	114	224	227	227	227	227	227	227	1,995
Prevention	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Back office	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non-clinical procurement	503	623	0	1,126	1,126	42	87	87	87	97	104	104	104	104	104	104	104	1,126
Clinical support rationalisation -exc pathalogy	774	300	0	1,074	1,074	54	54	62	100	100	100	100	100	100	100	100	100	1,074
Supporting staff productivity	6,480	7,403	263	14,146	14,146	667	667	802	959	965	1,369	1,386	1,466	1,466	1,466	1,466	1,466	14,146
Child Health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Staying Healthy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other demand management	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Right care – Enhanced recovery	0	5,606	0	5,606	5,606	345	480	480	603	603	603	463	463	367	367	367	463	5,606
Right care – Thresholds and decommissioning	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Safe care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Community support services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Estates	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Primary care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pathalogy	873	292	1,000	2,165	2,165	0	0	0	97	222	264	264	264	264	264	264	264	2,165
Total	**9,430**	**15,069**	**4,134**	**28,634**	**28,634**	**1,166**	**1,346**	**1,534**	**2,059**	**2,200**	**2,933**	**2,880**	**2,960**	**2,865**	**2,865**	**2,865**	**2,960**	**28,634**

QIPPS	**>90%** **Low Risk** **£000s**	**75%-90%** **Medium Risk** **£000s**	**<75%** **High Risk** **£000s**	**GROSS** **2011/12 Full Year Plan** **£000s**	**NET** **2011/12 Full Year Plan** **£000s**	**Maincode 02** **April** **£000s**	**Maincode 03** **May** **£000s**	**Maincode 04** **June** **£000s**	**Maincode 05** **July** **£000s**	**Maincode 06** **August** **£000s**	**Maincode 07** **September** **£000s**	**Maincode 08** **October** **£000s**	**Maincode 09** **November** **£000s**	**Maincode 10** **December** **£000s**	**Maincode 11** **January** **£000s**	**Maincode 12** **February** **£000s**	**Maincode 13** **March** **£000s**	**Full year effect** **£000s**
Recurrent QIPP schemes	9,430	12,719	4,134	26,284	26,284	1,053	1,234	1,421	1,946	2,087	2,678	2,625	2,705	2,610	2,610	2,610	2,705	26,284
Non Recurrent QIPP Schemes	0	2,350	0	2,350	2,350	113	113	113	113	113	255	255	255	255	255	255	255	2,350
Total	**9,430**	**15,069**	**4,134**	**28,634**	**28,634**	**1,166**	**1,346**	**1,534**	**2,059**	**2,200**	**2,933**	**2,880**	**2,960**	**2,865**	**2,865**	**2,865**	**2,960**	**28,634**

QIPPS	**>90%** **Low Risk** **£000s**	**75%-90%** **Medium Risk** **£000s**	**<75%** **High Risk** **£000s**	**Maincode 02** **April** **£000s**	**Maincode 03** **May** **£000s**	**Maincode 04** **June** **£000s**	**Maincode 05** **July** **£000s**	**Maincode 06** **August** **£000s**	**Maincode 07** **September** **£000s**	**Maincode 08** **October** **£000s**	**Maincode 09** **November** **£000s**	**Maincode 10** **December** **£000s**	**Maincode 11** **January** **£000s**	**Maincode 12** **February** **£000s**	**Maincode 13** **March** **£000s**	
10/11 QIPP expected additional Full Year Effect of Savings*				300	300	300	300	300	300	300	300	300	300	300	300	+
11/12 QIPP				1,166	1,346	1,534	2,059	2,200	2,933	2,880	2,960	2,865	2,865	2,865	2,960	+
Total				**1,465**	**1,646**	**1,833**	**2,358**	**2,500**	**3,233**	**3,180**	**3,260**	**3,164**	**3,164**	**3,164**	**3,260**	+
Monthly Phasing				#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	+
Quarterly Phasing					#REF!			#REF!			#REF!			#REF!		

* This should be the figure used in your Resource and Apps submission to achieve the underlying position for 10/11

Barking, Havering & Redbridge Hospitals NHS Trust
RF4
TRUST

ROCR/OR/0190/002

NEW RESOURCES & APPLICATIONS	Sub Code	Maincode 01 2011-12 Full Year Plan £000s	SIGN
Opening Baseline income	100	405,725	+
Underlying position at 1st April			
Forecast surplus/(deficit) (-) previous year	110	(34,271)	+/-
Non-recurrent commitments in previous year only	120	1,391	+
Non-recurrent benefits for previous year only	130	(8,001)	-
FYE recurrent costs not included as next years investments	140	(4,202)	-
FYE recurrent savings not included as next years efficiency/service change benefits	150	3,595	+
Adjusted Underlying position at 1st April:	160	(41,488)	+/-
Income Changes :			
Gross inflationary uplift	170	10,800	+/-
Volume uplift	180	(600)	+/-
Expected CQUIN income	190	1,200	+
Efficiency	200	(17,280)	-
Education & Training	210		+/-
R&D	220		+/-
PbR flexibility (to be agreed with SHA in advance)	230		+/-
Other non recurrent changes	240	8,065	+/-
Total income changes for the year	250	2,185	+/-
TOTAL RESOURCES AVAILABLE IN YEAR	260	(39,303)	+/-
Expenditure changes :			
Pay inflation	270	3,024	+/-
Prices inflation	280	9,859	+/-
Drugs inflation	290	2,802	+/-
Volume changes	300	(1,566)	+/-
Education and training	310		+/-
R&D	320		+/-
QIPP	330	(28,634)	-
Impairments	340	(5,318)	+/-
Contingency	350		
Other	360	3,809	+/-
Quality & Reform			
Improving Cleanliness and Healthcare Acquired Infections (including Matrons)	370		+/-
Pay reform and legislation	380		+/-
Staff security	390		+/-
Other	400		+/-
TOTAL CHANGES TO APPLICATIONS IN YEAR	410	(16,024)	+/-

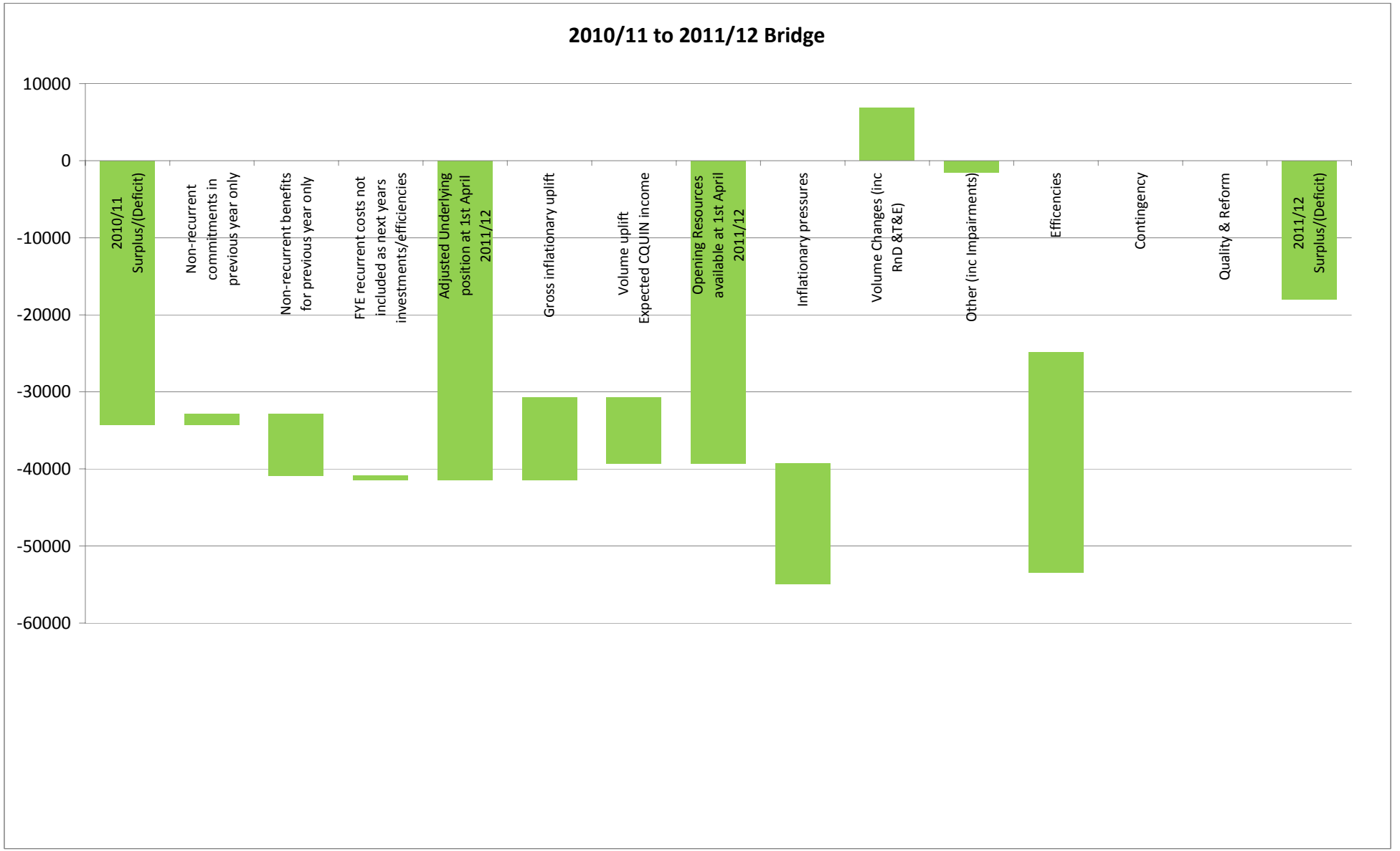
FROM QIPPS TAB

Resources Less Applications	420	(23,279)	+/-
Retained Surplus/(Deficit) for year	430	(23,279)	+/-

In-Year Position	440	10,992	+/-

Memorandum Item			
If subcode 420 shows a deficit how much of deficit relates to impairments	450	5,318	+/-

2010/11 Surplus/(Deficit)	**(34,271)**	%
Non-recurrent commitments in previous year only	**1,391**	0.3%
Non-recurrent benefits for previous year only	**(8,001)**	-2.0%
FYE recurrent costs not included as next years investments/efficiencies	**(607)**	-0.1%
Adjusted Underlying position at 1st April 2011/12	(41,488)	-10.2%
Gross inflationary uplift	10,800	2.7%
Volume uplift Expected CQUIN income	(8,615)	-2.1%
Opening Resources available at 1st April 2011/12	(39,303)	-9.7%
Inflationary pressures	(15,685)	-3.9%
Volume Changes (inc RnD &T&E)	6,884	1.7%
Other (inc Impairments)	1,509	0.4%
Efficencies	28,634	7.1%
Contingency	0	0.0%
Quality & Reform	0	0.0%
	21,342	5.3%
2011/12 Surplus/(Deficit)	**(17,961)**	-4.4%


2010/11 to 2011/12 Bridge
10000
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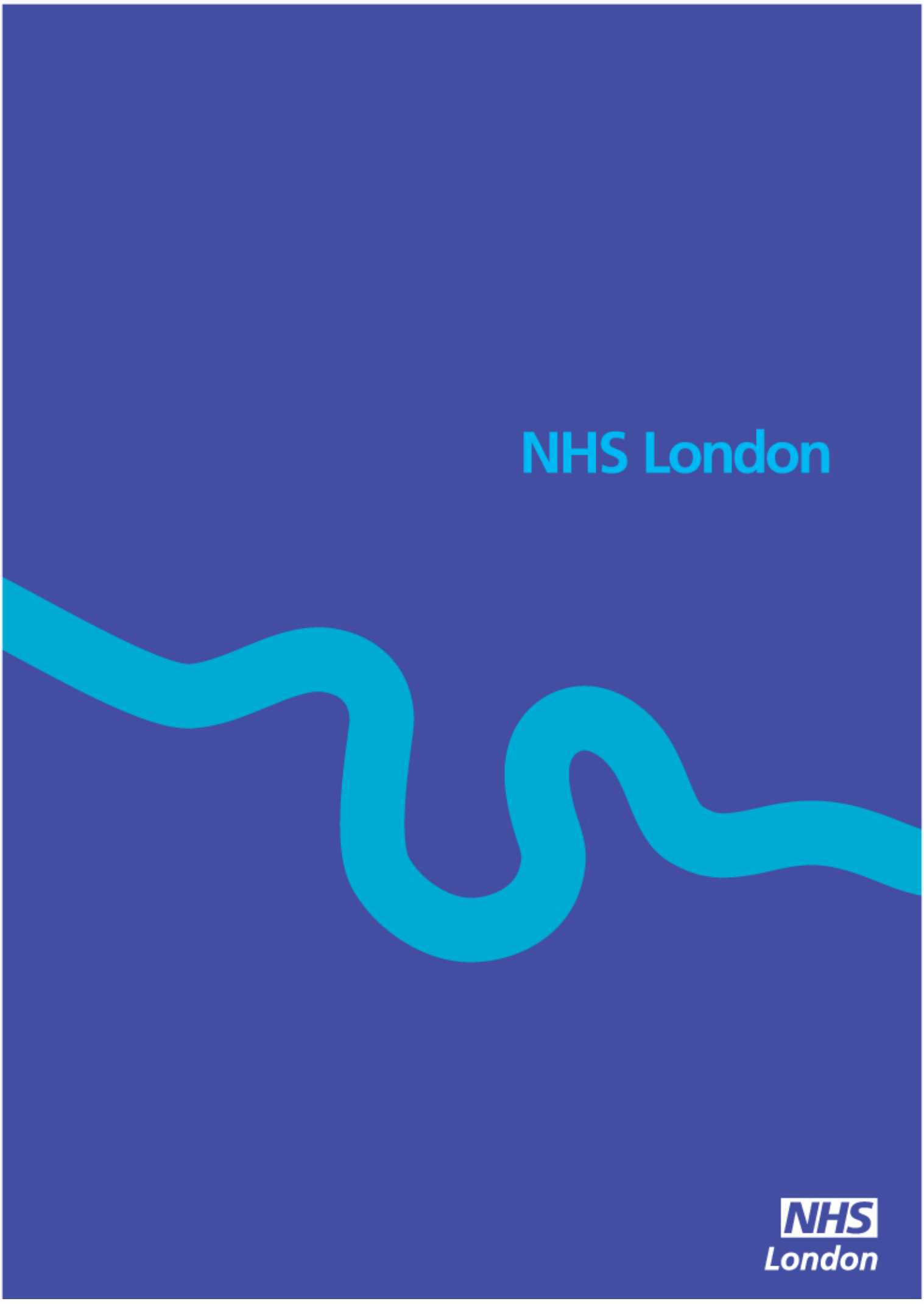
-60000
2010/11 Surplus/(Deficit)
Non-recurrent commitments in previous year only
Non-recurrent benefits for previous year only
FYE recurrent costs not included as next years investments/efficiencies
Adjusted Underlying position at 1st April 2011/12
Gross inflationary uplift
Volume uplift Expected CQUIN income
Opening Resources available at 1st April 2011/12
Inflationary pressures
Volume Changes (inc RnD &T&E)
Other (inc Impairments)
Efficencies
Contingency
Quality & Reform
2011/12 Surplus/(Deficit)


NHS London
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London

Key contacts at Trust (name, telephone number, email address)			
Name	**Title**	**Telephone**	**Email**
Executive Lead: **Finance: Alan Davies** **Workforce:**	Deputy Director of Finance	01708 435346	Alan.davies@bhrhospitals.nhs.uk

SECTION 1: STRATEGIC OVERVIEW

Provider Landscape and timescale to end state as a result of implementation of Commissioners Intentions. Where do you expect to be at the end of 2010/11 and 2011/12.

Please include a note on expected movements in activity, services and expenditure

Although the activity plan for 2011/12 has yet to be agreed, the current version of the plan shows a shift of 42,000 outpatient attendances to a Polysystem setting and a de-commissioning of 10,000 further attendances. Reductions have also been proposed by Commissioners for elective and daycase activity which are broadly related to the decommissioning of Procedures of Limited Clinical Effectiveness (POLCE) and the shift of certain procedures into the Independent Sector Treatment Centre (ISTC), most notably in the specialties of Pain and Gastroenterology.

Commissioners have signalled their intention to commission a polyclinic on the hospital site of both Queen's and King George Hospitals. The current thinking at NHS Redbridge around the service at KGH (the Seven Kings Polyclinic) is that there will not be a secondary care presence within the facility, however BHRUT has submitted an Expression of Interest in response to the tender advertisement recently issued by NHS Havering in respect of the Queen's Polyclinic (which also incorporates an Urgent Care Centre). Although both of these facilities were due to become operational during 2011/12, the tender process for the Queen's Polyclinic is currently "on hold" pending NHS Havering undertaking further GP engagement and feedback and as such it is not currently known when this facility will become operational.

BHRUT gave notice on the following services in 2010/11 and will continue to review the profitability and viability of services during 2011/12:

- Wheelchair service;
- Orthotics.

The Trust is to de-commission its Chronic Fatigue Service due to the retirement of the lead Consultant. This service is currently provided on an Exceptional Treatment basis for both inpatients and outpatients and the inpatient service is not supported by local Commissioners.

On 21st March 2011 the Trust will centralise the symptomatic Breast Surgery service onto the King George Hospital (KGH) site and Vascular Surgery onto the Queen's Hospital site. This is in line with the direction of travel under Health4NEL whereby KGH becomes a "cold" site and the Trust's vision that "King George is a modern local hospital providing excellent acute and rehabilitation services to meet the needs of the residents of Redbridge and Barking with a first class planned care centre serving our whole catchment area. Queen's is a premier acute hospital providing complex care and specialist services for the population of Outer North East

London and Essex. Queen's is also the local hospital for the residents of Havering, Dagenham and Brentwood."

In addition, there are a number of other service changes already planned/being implemented by BHRUT that fit with Health4NEL and fit with the Trust's strategic direction. These are:

- Changes to Paediatrics at King George Hospital so only short stay patients are admitted to that unit;
- Creation of a new Endoscopy unit at King George Hospital on a vacant ward;
- Conversion of a vacant ward to become a Renal unit;
- Consolidation of ortho-geriatric rehabilitation services at King George Hospital;
- Creation of co–located midwife led unit at Queens.

The Trust is in the process of completing business cases to develop a co-located midwife-led Unit at Queen's Hospital and the closure of the KGH A&E department between 8pm and 8am during Q2/3 of 2011/12. This is in anticipation of the Independent Review Panel (IRP) supporting the Health4NEL outcomes.

Adjacent to King George Hospital is an Independent Sector Treatment Centre (ISTC) (currently operated by Care UK) consisting of 5 theatres, 24 inpatient and 24 day beds. The contract is due to be re-tendered as the current contract term comes to an end in December 2011. BHRUT will express an interest in providing that service – either solely or in a partnership with a private provider.

BHRUT recognises the opportunity that will be afforded by the ISTC tender that will take place in 2011 to potentially increase income and improve overall operative efficiency on the KGH site should the Trust be successful in winning the tender. However , it is also mindful that Commissioners have identified a £2,512,000 savings target (Scheme 16 in Quality, Innovation, Productivity and Prevention in ONEL: Strategic Commissioning Intentions 2011-2015) in relation to the tender itself so the anticipated surplus associated with undertaking such elective activity will be less than at enjoyed by the present provider.

The future of this facility has to be explicitly considered in the strategic options for BHRUT as it impacts on the overall service configuration regardless of its ownership.

Furthermore, in light of the Health4NEL outcome, work is underway to look at the reconfiguration of services required to allow all non-elective, urgent services to be provided at Queen's Hospital and the majority of elective/planned activity on the King George Hospital site.

What productivity improvements are expected by 2011/12 and 2012/13?

The Trust has identified 14 key work streams for 2011/12 which have been divided into Strategic, Performance and CIP schemes:

Strategic:

1. 24/7 Hospital
2. Maternity changes (co located unit etc)
3. KGH A&E night closure and emergency surgical take
4. ISTC bid and Theatres productivity
5. Reducing LoS and ward closure programme
6. FT Trajectory
7. Service Line Reporting and Service Reviews

Performance

8. Emergency care
9. Clinical Quality Improvements (CQC, HSMR, satisfaction etc

CIP

10. Outsourcing
11. Managerial tier reduction and other staffing reductions
12. Key Staff recruitment
13. Control of premium rate staff expenditure
14. Radical review of Outpatient costs/hours of operation etc

Although some of these schemes are more focussed on qualitative improvements, it is expected that there will be productivity improvements, particularly with regard to the Outpatient function and Length of Stay.

Progress against each of these workstreams will be monitored via the Trust's Strategy or Productivity, Efficiency and Quality (PEQ) Board.

What impact are the productivity improvements envisaged to have on the workforce, including the impact on workforce utilisation?

The Trust's Clinical Divisions are currently in the process of developing Workforce Plans in relation to the key workstreams described above which will detail any workforce changes as a result of the anticipated productivity improvements.

What impact are the productivity improvements envisaged to have on asset utilisation?

In the course of 2011/12, the Trust is aiming to facilitate the closure of 96 beds within 2011/12 through reduced length of stay, improved DTOC performance and the increased provision of ambulatory care services.

In addition, the Trust clearly wishes to ensure optimum utilisation of all its facilities and as such as part of the worksteams noted above the utilisation and productivity of Theatres and Outpatient are being focussed on.

There is the potential for theatre utilisation at BHRUT to be dramatically increased principally through four changes:

1. Extending the operating day – principally through moving to three session day operating. Currently only about a quarter (at most) of all BHRUT surgeons have scheduled three session operating sessions. Most theatres operate on core hours of approximately 9am -5pm;
2. Extend elective operating to weekends - most weekend elective operating takes place as additional sessions where staff are being paid at premium rates;
3. Ensure theatre sessions start and end on time and that there are sufficient patients to be operated on during those times - many sessions start late, end early, or finish late (which can cause other sessions to start late);
4. Ensuring that there are sufficient beds for elective patients to go into following their operation.

SECTION 2: PERFORMANCE

Please describe your interaction with your Sector Acute Commissioning Unit

The Trust currently has a fortnightly formal meeting with representatives of the Outer North East London Acute Commissioning Unit (ONEL ACU) which alternates between a contract performance meeting which is also attended by PCT Directors of Finance and Commissioning and an operational meeting at which the quality agenda is taken forward. The latter meeting includes Public Health and Nursing representation from the PCTs, Stroke, Cardiac and Vascular, Network representation and members of the Trust's senior management team including the Executive Directors of Nursing and Delivery and Director of Clinical Governance. It is intended that changes will be made to these meetings in order to ensure a more joined-up approach in terms of quality and finance and also to ensure that clinicians and GPs have greater involvement. The Sector are currently drafting a proposal which it intends to share with the Trust in early April 2011.

A sub group comprising performance, information and finance representatives from the ONEL ACU, PCTs and Trust meet regularly to discuss and agree issues relating to the technical implementation of PbR.

In addition to the above formal meetings, the Trust has regular fora with the ONEL ACU and Commissioners in relation to both emergency care and planned care.

Are all operational targets forecast to be met? If not, which ones are unlikely to be met, is there an action plan in place and what is the timescale for achievement?

For the first time since November 2010 the Trust has achieved above 95% for the all-type standard. Type 1 performance has been consistently below the 95% standard since August 2010 but has improved to 94.19% (Trust-wide performance) for the last week in February 2011. However, the key performance risk for the Trust remains A&E performance and specifically the performance in terms of Type 1 attendances which is the group of patients where the majority of breaches occur. There is no doubt that improvement of emergency care is a major challenge for BHRUT and this remains the main clinical priority.

The Trust agreed an Emergency Care Strategy for Change in early 2010/11 of which Phase 1 which focussed on the establishment of an Acute Elderly Unit (AEU), an Emergency Medicine Decision Unit (EMDU) and the Virtual Ward/Ambulatory Care Centre has now been completed. In September 2010, following a review of the emergency care performance, the Emergency Taskforce changed its focus to concentrate on 7 work streams as follows:

- Capacity and Flow – Simple Discharges
- Capacity and Flow – Complex Discharges
- A&E Flow and resilience
- Admission Avoidance
- Ambulance Turnround
- Demand Management
- Compstat

In January 2011 the national Emergency Care Intensive Support Team visited the Trust and offered support in three areas.

- The development of a rapid assessment and treatment model for the Emergency Department at Queens Hospital;

- The development of a Trust-wide emergency ambulatory care strategy and implementation plan;
- The implementation of new internal professional standards that support patient flow across the acute Trust.

It is clear that there are a number of critical factors in achieving improvements in clinical care across the organisation and enabling BHRUT to achieve success as measured by the Emergency Care standard:

- Organisational culture;
- A&E department engagement and internal/external working relationships;
- Championship of the new Emergency Care Quality Standards;
- Ownership of the Emergency Care Quality Standards by clinical staff, external to the A&E department, within the organisation;
- Realistic plans for clinical redesign of the patient pathway enabling a reduction in the bed capacity, supporting a challenging financial target.

Within this there are a number of key operational challenges:

- Recruitment and retention of an appropriate clinical workforce (medical, nursing and others) particularly in A&E and acute areas to deliver care;
- Development of Emergency Ambulatory Care to deliver across all 49 clinical conditions identified;
- Improving bed flow – planning discharge at the point of admission, case management of complex patients;
- Integration of Medical and Surgical Assessment facilities together with A&E;
- Urgent Care centre – development and management of the QH UCC from April 2011;
- Changes in the management of emergency/urgent GP referrals;
- Development of clinical pathways for single condition admissions;
- Successful implementation of Jonah as a management support tool;
- Integration with community services.

The Emergency Care Strategy for Change outlined key work streams for improving the emergency care clinical pathway for patients admitted to BHRUT. The Trust is cognisant that to be successful in achieving the new Emergency Care Standards it is imperative that that the process of clinical redesign continues and as such it has been proposed that a new workstream for Clinical Redesign is developed to lead the clinical redesign and this will be led by the Divisional Director for Medicine.

This workstream will focus on key areas of service redesign intended to reduce the reliance on the Trust's bed capacity. Key areas of focus will be the development of the ambulatory care pathways that seek alternatives to admitting patients to hospital and reduce the length of time that patients spend in hospital. This will also include a review of the pathways for patients that are likely to require regular admission to hospital if no alternative is available.

The two key areas of performance improvement which have been seen since during 2011 are the number of patients discharged before midday and the number of patients in hospital for longer than 20 days. To support the delivery and improvement in the number of patients discharged by midday a revised approach to managing these discharges has been proposed which utilises the predicted date of discharge to identify patients that are due for discharge in the next 2-3 days. Matrons will ensure that ward managers have plans in place to discharge these patients as early as possible on the day of discharge. Any issues that would prevent a patient from being discharged during the morning should be highlighted and resolved by the ward managers in advance of the date of discharge. Data will be held centrally on these patients enabling a clear set of priorities to be made available for those staff that will support

these beds becoming available early in the morning e.g. medical review, transport, porters, pharmacy etc. A review of the information systems to support this accountability framework is currently under way.

To support the delivery of a reduction in the number of patients in hospital that have stayed longer than 20 days, the Trust has been working hard to ensure that the data on the information system "Jonah" is up to date and the operational teams are now working through on a patient by patient basis to identify the delays to discharge. During the first week of operation this reduced the number of patients in delay from 186 to 129. A new implementation plan to support the further roll-out of Jonah, supported by additional training, is currently being developed.

Referral to Treatment

The Trust has continued to achieve the RTT week performance standards for admitted and non-admitted patients, however is currently not achieving the median waiting time standard for incomplete pathways. Performance is a median wait of 12.4 weeks compared to the national target of 7.2 weeks.

A validation exercise has been initiated to ensure that accuracy of the patients with an incomplete pathway. It is expected, however, that many of the patients on this list would need to be treated before the end of March 2011 in order to reduce the waiting times and deliver the target before the end of March 2011. The Acute Commissioning Unit (ACU) have instructed the Trust not to increase activity levels in 2010/11 in order to achieve the median wait standard for incomplete pathways. The impact of achievement of this target in 2011/12 has been submitted to the ACU for inclusion in the 2011/12 activity plan.

SECTION 3 FINANCIAL PLANNING

Clinical Revenue

	2010/11 Plan £'000'	2010/11 Forecast Outturn £'000'	2011/12 Plan £'000'	2012/13 Plan £'000'
PbR - Elective	51,472	54,951	49,194	
PbR - Non-Elective	130,683	133,509	133,485	
PbR - A&E	17,577	18,844	17,269	
PbR - Outpatient	58,599	64,488	64,302	
PbR - Other	10,730	9,549	9,999	
Non-PbR: critical care	23,207	23,237	24,511	
Non-PbR: mental health				
Non-PbR: community care				
Non-PbR: other	62,109	62,257	60,470	
Excluded drugs & devices	6,267	6,978	13,233	
Non Contract Activity				
LSCG				
NCG				
Tranisitional funding				
Total	360,644	373,813	372,463	

Commentary on clinical revenue

Please explain the significant changes in clinical revenue including:

Tariff/price changes:

The table below shows the bridge of the 2011/12 central income position from the 2010/11 forecast outturn, which shows a broadly static position year on year.

	£ml	
Month 9 FCOT	374.60	
Year end Settlement	-1.80	Impact of change to FCOT to M11 incl. PCT year end settlement
Sub-total	372.8	
Challenged Trust Board	-3.20	Non-recurrent in 2010/11
Risk pool change	2.00	Reduction from £5m to £3m
Chemo & High Cost drugs	6.90	Arbitration case for baseline funding of chemotherapy and growth
ISTC	1.60	Anticipated repatriation of activity from Dec 2010
Other activity:		
Direct Access Physio (Redbridge)	-0.70	Transfer of service
EL DC & OP demand management	-4.70	In line with PCT Plans
Midwifery births	0.50	Growth per H4NEL assumptions
18 week RTT	2.00	Growth required to meet target
UCC	-0.80	
Wheelchairs	-0.50	Transfer of service

Other price changes:		
Grays Court	-0.50	
A&E tariff	-0.60	
Ambulatory Care	0.60	
CQUIN increase	1.20	
Critical care tariff	0.70	
Day case to out-patients	-0.60	
NEL tariff	4.00	
Polyclinics	-0.60	
PPNCO	-0.30	
Readmissions	-6.20	
SCBU price	1.00	
Other	-2.20	
	372.4	
Change	(0.4)	
Represented by:		
- non-recurrent / FYE adjustments	(1.2)	CTB funding & risk pool changes
- activity changes	(2.6)	Incl. ISTC, RTT less demand management
- price changes	3.4	Incl. Drugs £6.9m,

In addition to the above, the Trust is planning for £2m growth from marketing of services to outside the local area.

Market Forces Factor:

There is no gain on MFF due to capping at 10/11 level. Difference of £4m between cap and true MFF.

Investments/Divestments :

Key disinvestment is implementation of PCT demand management plans for elective in-patient day case and out-patient activity. The plan also assumes transfer of Redbridge Therapies and Wheelchairs to alternative providers, although the Trust may potentially bid for these services as part of the tender process.

Transitional funding: **CQUIN and Other:**

The Trust is planning for 50% achievement of CQUIN targets & income (£2.2m). There is no transitional funding arrangement in place, although the Trust is applying a £3m risk pool discount to its SLA with the ONEL PCTs.

Other revenue				
£000's	Plan 2010/11	Forecast 2010/11	Plan 2011/12	Plan 2012/13
Research and Development	1,332	1,009	1,009	
Education and training	5,304	5,242	5,070	
Transitional PFI	0	0	0	
Other	27,412	25,878	27,407	
TOTAL	34,048	32,129	33,486	

Commentary on other revenue

Please explain the significant changes in other revenue

Expenditure

Please explain the significant changes in expenditure

Operating Expenses are forecast to reduce by £9.7m overall, although excluding impairment, this reduces to £4.4m. This movement primarily comprises a combination of FYE costs from 2010/11, additional generic and local cost pressures in 2011/12 offset by the 2011/12 QIPP/CIP. The bridge reconciliation below provides further detail.

Overall Position

£000's	Plan 2010/11	Forecast 2010/11	Plan 2011/12	Plan 2012/13
Revenue from Patient Care activities	360,644	373,813	376,932	
Other operating revenue	35,384	31,480	29,207	
Operating expenses	(392,908)	(416,266)	(406,593)	
Operating Surplus/(deficit)	**3,120**	**(10,973)**	**(454)**	
Other gains and losses			0	
Investment Revenue	1,009	802	804	
Finance Costs	(20,791)	(21,214)	(20,787)	
PDC dividends payable	(3,216)	(3,033)	(3,033)	
Retained surplus/(deficit)	**(19,878)**	**(34,418)**	**(23,470)**	
Impairments included		0	0	
IFRS impact included	442	442	191	
Retained surplus/(deficit) excluded impairments and IFRS	**(19436)**	**(33,976)**	**(23,279)**	
Contingency included	0	0	(4,000)	
Impairments included in Operating Expenses			5,318	

The Plan for 2012/13 is currently under review.

Commentary on overall position

Please provide an explanation of your overall financial position including sections on:

Medium term Financial Strategy and historic debt

The Trust will have accumulated a deficit (as measured against the breakeven duty) of c.£150m over the six years ending 2010/11. During this time the Trust has received £140m of temporary PDC funding to mitigate the cash impact of the deficit:

£'000	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Turnover	334,815	351,780	345,451	378,400	397,456	405,725
Deficit	(16,009)	(16,844)	(35,621)	(35,674)	(56,243)	(34,418)
Adjmt for impairments	-	-	-	9,460	31,862	0
Adjmt for IFRS impact on PFI	-	-	-	-	2,100	442
Break-even in year position	(16,009)	(16,844)	(35,621)	(26,214)	(22,281)	(33,976)
Break-even cumulative position	**(15,989)**	**(32,833)**	**(68,454)**	**(94,668)**	**(116,949)**	**(150,925)**
Temporary PDC received		**46,000**	**35,750**	**23,300**	**5,000**	**30,000**
- cumulative		**46,000**	**81,750**	**105,050**	**110,050**	**140,050**

Over the same period, the underlying deficit increased significantly during the three years to 2007/8, since when it has steadily reduced to a forecast of £27m in 2010/11:

Over the period since 2006/07 the RCI has also gradually improved:

Financial Year	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**2009/10**
RCI	95	107	102	102	100

(£m)	2004/05 Actual	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Actual	2009/10 Actual	2010/11 Forecast
Reported deficit	**0.0**	**(16.0)**	**(16.8)**	**(35.6)**	**(35.7)**	**(56.2)**	**(34.4)**
Non-recurrent expenditure:							
- Redundancy costs			4.5	1.0	0.3	0.0	1.5
- Land sale debtor impairment					3.0		
Non-recurrent income:							
- PFI transitional support		(2.0)		(4.0)	(2.7)	(1.4)	0.0
- ISTC transitional support				(3.8)	(2.3)	0.0	0.0
- HCA milestone payment						(2.6)	
- PCT risk pool support		(5.0)				(8.0)	5.0
- Other		(2.1)					
Timing differences:							
- Outsourcing invoices					(1.1)	1.1	
- Accruals & provisions releases				7.9	(8.6)		
Profit on asset disposal		0.0	(19.7)	(12.9)			
Fixed Asset Impairments	(12.6)	0.0	1.8	2.2	9.5	31.9	0.0
Impact of IFRS						2.9	0.4
Normalised deficit	**(12.6)**	**(25.1)**	**(30.2)**	**(45.2)**	**(37.6)**	**(32.3)**	**(27.5)**

Key factors contributing to the underlying deficit include:

- Opening of a new **PFI** funded hospital at Romford (Queen's) in December 2006, with a Unitary Payment of £47m (including Soft FM and MES (Managed Equipment Service);
- High usage of temporary staff (at premium rates), with a projected expenditure of £40m for 2010/11, c17% of pay costs;
- Historical under-achievement of Cost Improvement targets, most significantly in 20007/8, when only 5% of the target was achieved;
- Relatively high levels of length of in-patient stays, compared to benchmark comparators
- Lost income contribution from the transfer of elective activity to the ISTC at the King George's Hospital site in January 2007
- Relatively low levels of non-PbR income and non-clinical income (training and education and R&D)
- ONEL is closest to capitation in London therefore the level of funding per head of population is less than in

other areas

- Funding for Market Forces the furthest from target in London

The Trust's medium-term financial strategy is therefore designed to address the causes of the underlying deficit, improve productivity and efficiency and rationalise future capacity in response to the PCTs' demand management strategy. The Key Strategic Workstreams are described in section 1. above, but specific CIP initiatives include:

- Significant reduction in temporary staffing levels, through reduction in capacity (beds, theatres, out-patients), improved recruitment strategy and improved staff productivity (e.g. sickness management)
- Improvements in productivity from length of stay, A&E and Theatre / out-patient throughput
- Improvement in medical staff productivity, via tighter job planning
- Outsourcing of support service functions e.g. Pathology
- Review / reduction in management costs
- Increased income contribution from repatriation of patient activity from other providers e.g. ISTC, BLT, WX, Essex
- Addressing under-pricing of non-PbR services (e.g. high cost drugs), or decommissioning loss-making services
- Consolidation / centralisation of services e.g. A&E, Maternity, Paediatrics
- Maximising value for money from PFI contract (Trust is first pilot in Treasury review of PFI contracts)

The Trust is aiming to deliver a surplus position in 2012/13, but in addition to a further 4% tariff CIP (c£17m), this would require a further dramatic improvement in the Trust's underlying position of c£30m, which would be extremely challenging. A more realistic assessment at this stage is that surplus is unlikely until 2013/14.

Bridge between 2010/11 and 2011/12

The bridge can be summarised as follows:

	£'000	£'000	
Month 9 FCOT per detailed bridge model		-31451	
Adjustments to M9 forecast:			
- PCT income (reduced EL activity / year end settlement)		-1,800	
- Demand management schemes in Surgical Division		-897	
- Reduction in redundancy forecast		1809	
- eduction in central recovery schemes forecast		-1450	
- Other		-482	
Revised M11 FCOT incl. IFRS		-34271	Incl. IFRS impact of £442k
Non-recurrent commitments in previous year			
Redundancies		1391	
Non-recurrent benefits in previous year			
Central recovery schemes	-2700		
Less: repeat N/R balance sheet reversals	1000		
			Shown as N/R here - FYE built in to 2011/12
Ward closure programme	-2700		CIP
Midwifery underspending	-1993		
Divisional recovery schemes	-1014		
Other adjustment to M9 forecast	482		
Other (net)	-1076		
		-8001	

FYE recurrent costs not included as next years investments

- Ward staffing levels (CQC)	-2076		
- Local cost pressures	-2126		
		-4202	
FYE recurrent savings not included as next years efficiency/service change benefits		3595	
Adjusted Underlying position at 1st April:		**-41488**	
Income Changes :			
Gross inflationary uplift		10800	2.5% per tariff
Volume uplift:			
- Net volume changes	-2600		Demand management partially mitigated by ISTC & RTT
- Marketing strategy	2000		
		-600	
Expected CQUIN income		1200	Increase over 2010/11
Efficiency		-17280	-4% per tariff
Other income changes			
- Challenged Trust Board funding (N/R)	-3243		
- Change in Risk pool support	2000		
- Chemotherapy & High Cost drugs	6900		
- Income generation / CIPs	637		
- Other aggregated price changes	1771		
		8065	
Total income changes for the year		**2185**	
TOTAL RESOURCES AVAILABLE IN YEAR		**-39303**	
Expenditure changes 2011/12 :			
Pay inflation:			
- Incremental drift		3024	
Prices inflation:			
- VAT increase	1341		
- Contractual uplifts incl. PFI	4457		
- Other non-pay @ 2.5%	1662		
- Other generic pressures	2399		CNST, MRSA screening
		9859	
Drugs inflation / cost pressures		2802	
Volume changes		-1566	
QIPP/CIP:			
- Scale-back 2010/11 overspending	-6595		
- 2011/12 CIP targets	-20550		
- Management of local cost pressures	-2126		
	-29271		
- Less income related CIPs (shown above)	637		
		-28634	
Impairments		-5318	Following revaluation of buildings
Other:			
- IFRS	-191		
- Contingency	4000		
		3809	
Total expenditure changes for the year		**-16024**	
Resources Less Applications		**-23279**	
Incl IFRS		-23470	
Note:			

1. Other aggregated price changes for the year:		
Gross inflationary uplift	10800	
Efficiency	-17280	
	-6480	
Actual price changes	-4700	Excl. chemo/HC drugs
Difference	1780	
2. CQUIN		
Aggregated price changes	-3500	
Including CQUIN change	1200	
Net other changes	-4700	

Contingency

A contingency of £4m (c1%) has been provided for in the 2011/12 plan

The impact of IFRS

There is a marginal adverse impact of £191k from IFRIC12 on the 2011/12 Plan position

Key Assumptions included within the plan

Key assumptions are

- Activity Plan is based on baseline 10/11 activity +/- waiting list growth (baseline agreed with PCTs), less 5% reduction in out-patient follow-up activity and £4.7m of elective demand management plans by PCTs. As mitigation, the Trust is assuming £1.6m income growth from repatriation of ISTC activity and £2m from 18 week RTT activity, plus a further £2m growth from marketing of services outside the local area, or from repatriation of activity from providers out of area..
- Zero pay uplift assumed, in line with national assumptions, although incremental drift (c.£3m) is included
- Non-pay inflation of 2.5% assumed, except PFI and other contractual commitments where RPI is assumed
- See risk section below for key assumptions on:
    - CIPs
    - Reduction in baseline overspending & other cost pressures
    - nPbR pricing

Key risks included within the plan

Explanation of the risk	High/ Medium/ Low risk	Mitigating actions
Cost Improvement Programme £28.6m	Medium	Finance Committee and PEQ Board to monitor development and implementation of Programme Risk assessment (see template for further detail): High £4.1m Medium £15.1m Low £9.4m
PCT Pricing: High Cost Drugs £6.9m	High	Trust has submitted an arbitration case to address under-funding of chemotherapy and high cost drugs excluded from PbR

Difference in activity assumptions with PCTs £11.4m	Medium	Trust has differing assumptions to PCTs in respect of: • A&E shift of activity to UCC £0.9m • Non-elective demand management £3.7m • Polyclinic activity & price £1.2m • Day case to out-patient settings £2.3m • Ambulatory care impact on NEL activity £1.4m • RTT activity £2m
ISTC activity £1.0m	Medium	The Trust is assuming that it will capture ISTC activity for the last 4 months of the financial year (£1m contribution). The Trust will be developing a marketing strategy / tender submission
Marketing of services £2m	Medium	Trust to develop and implement marketing strategy (see above)
Aggregate risks c. £49.9m		

CQUINS

Describe what your commissioners have contracted for in relation to CQUINS

Although the CQUIN schemes for 2011/12 have yet to be formally agreed with Commissioners, in addition to the nationally mandated CQUINs for VTE risk assessment and responsiveness to personal needs of patients, the following six schemes currently under discussion for local CQUINs are:

- Pressure ulcer reduction
- Reducing falls in frail elderly
- Reduce catheter related UTIs
- Enhanced Recovery Programmes for 8 surgical procedures
- Reducing out of ITU cardiac arrest
- To increase the number of patients assessed by a Consultant within 12 hours of emergency admissions

Cost Improvement Programme (expenditure savings only)

Please provide detail narrative to support your CIP's to include risk rating (gross values vs. risk weighted values included within the plan), Full Year Effects, recurrent vs. non recurrent and the level of unidentified CIP's.

The table below sets out the Trusts Cost Improvement Programme for 2011/12.

The additional FIMs template (attached) provides a breakdown of the 2011/12 QIPP/CIP by national QIPP category. The breakdown by key Trust workstream is as follows:

Key Workstream	SRO	£'000
ISTC bid and Theatres productivity	RR	1,657
Reducing LOS and ward closure programme	NM	5,606
Service Line Reporting and Service Reviews	DIW	500
Outsourcing	DIW	1,274
Managerial tier reduction and other staffing reductions	RMcA	6,052
Key Staff recruitment	RMcA	300
Control of premium rate staff expenditure	DIW	5,262
Outpatient Operations	RR	947
Local CIP	DM's	5,150
Unidentified		**2,522**
Total		**29,271**

The analysis by individual CIP schemes is as follows, with a low/medium/high risk assessment:

(£'000)	Total	Low	Med	High
Outpatient productivity	947	947	0	0
Length of stay / Ward closures	5,606	0	5,606	0
Pathology Outsourcing/Efficiency	2,165	873	292	1,000
KGH A&E night closure	0	0	0	0
Other outsourcing / shared services	274	274	0	0
Collaboration with other Trusts	0	0	0	0
Theatre productivity	1,657	1,657	0	0
Ward productivity	0	0	0	0
Pharmacy productivity	1,045	0	845	200
Medical staffing productivity	6,013	1,531	4,219	263
Senior Nurse staffing	1,342	33	1,309	0
Procurement automation	43	0	43	0
Procurement - other	1,230	500	580	150
A&E	0	0	0	0
Estates	503	503	0	0
Pay increments	0	0	0	0
IT	40	40	0	0
Decommission loss making services	500	0	500	0
Care pathways (see below for QIPP headings)	0	0	0	0
KGH elective activity	0	0	0	0
PFI renegotiation	0	0	0	0
Management Structure	3,222	2,647	575	0
Key Recruitment	300	0	300	0
Staff Absence	0	0	0	0
Other automation opportunities	74	24	50	0
Divisional CIP	1,788	863	924	0
To be identified	**2,522**	**0**	**0**	**2,522**
Total	**29,271**	**9,893**	**15,243**	**4,134**

The key priority now is for SROs/project leads to complete the detailed project and implementation plans for each scheme and ensure delivery.

SLA Triangulation

Please provide additional narrative to support your triangulation data in the operating plan spreadsheets including explanation and resolution of remaining variances.

See key risks above

Demand management schemes (amount notified by commissioners, have they been included within your plans, how realistic are they, timing of implementation, how are you expecting to manage their impact etc.)

Note: must be scheme specific with clear explanation of implementation, activity reductions and expected benefits

£4.7m elective in-patient , day case and out-patient demand management plans have nbeen assessed by the Trust as being realistic and have been included in the Trust's income assumptions.

The Trust is not persuaded by the robustness of the PCTs' non-elective demand management plans (£3.7m) and therefore not included them in the Plan

Capital investment and disposal (including sources of funding)

.

£000	Plan 2010/11	Forecast 2010/11	Plan 2011/12
Depreciation			13.0
Less: PFI capital lease repayment			(5.5)
PDC funding c/f (KGH polyclinic)			0.9
Asset sales			0.0
External funding - H4NEL schemes - Other major schemes e.g. PAS			10.0 5.0
Total Capital Investment			**23.4**

The Trust is limited to depreciation less the capital element of the PFI lease payment (net £7.5m), in terms of internally generated cash to fund the capital programme. It is therefore seeking external funding (via additional PDC capital) to fund other major schemes, including reconfiguration schemes associated with Health4NEL (e.g. maternity and A&E) and other major schemes, e.g. PAS reconfiguration, Procurement Automation and Network Upgrade.

Key risks and opportunities not included in the financial plans

Key risks not included in the plan with mitigating actions

None specifically. A contingency of £4m has been provided in the financial plan

Key opportunities not included in the plan with mitigating actions

Further detailed review of internal and generic cost pressures

Could you provide an explanation of the impact of up to a 10% downside funding scenario?

To follow

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Workforce Key Performance Indicators	Trust Board
1. KEY ISSUES:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**

- The dashboard demonstrates that Trust-wide the workforce has grown by 183.25 FTE's over the past 12 months
- However, starters & leavers analysis for the same period shows that the workforce should in fact have grown by 221.08 FTE's - highlighting a discrepancy of 37.83 FTE's. The 3 causative factors of this difference remain:

1. If new starters commence employment or leave after the payroll cut off date (midmonth) they will not be entered or removed onto/off ESR until month end – therefore they will not appear on the staff in post report generated from ESR until the following month.
2. Staff who increase or decrease their hours will affect the reported FTE's in post but not the starters and leavers
3. Timliness of managers completing and submitting the appropriate forms to HR - for entering onto ESR.

- Overall, despite the evident peaks and troughs both the starters and leavers measures are down slightly on the same period 12 months ago by 18.78 and 3.5 FTE's respectively. Indicating a more stable workforce and reduced workforce movement in the wider economy
- This is reflected in the Trust-wide workforce turnover graph where it is evident that staff turnover has reduced by 2.2% in the past 12 months - falling from 13.3% to 11.1% respectively. This continues to be 0.9% below the NHS average and trust target of 12%.
- However, learning from the recent A&E experience this could be a smoke screen of underlying issues, therefore, as part of the current Divisional workforce planning process and performance monitoring of workforce KPI's the Head of Workforce Planning drilled down into the turnover data at:

1. Divisonal Level
2.Cost centre & Staff group

- Areas which have been defined as 'HOTSPOTS' - i.e. where turnover either by the cost centre itself or a staff group within it are elevated above 14%, creating a 'revolving door' of vacancies and a constant requirement to bridge the gap with bank or agency staff.

☐ **S&SIB ……..** ☐ **EPB ……..……**

☐ **FINANCE ……** ☐ **AUDIT ……..…**

☐ **CLINICAL GOVERNANCE ……..…..……**

☐ **CHARITABLE FUNDS ……...…**

√ **TRUST BOARD March 2011**

☐ **REMUNERATION ……...**

☐ **OTHER ……** (please specify)

CATEGORY:

☐ **NATIONAL TARGET** ☐ **CNST**

☐ **STANDARDS FOR BETTER HEALTH**

☐ **HEALTH & SAFETY**

☐ **ASSURANCE FRAMEWORK**

☐ **TARGET FROM COMMISSIONERS**

☐ **CORPORATE OBJECTIVE ……..**

……..

☐ **OTHER ……** (please specify)

AUTHOR/PRESENTER:

Author – Linda Baker – Head of workforce Planning

Presenter – Ruth MCall – Director of Workforce

DATE:

- Clearly much lower turnover rates in the remaining cost centres within the Divisions are diluting the hotspot areas rates - creating an illusion that the workforce is stable across the board.
- Many of the areas with high turnover rates in 2010 - relate to specialist services e.g. A&E, Paediatrics, MAU, CCU, etc
- As part of the workforce planning, CIP and budget setting processes Divisions have been charged with undertaking a line by line review of their existing establishments and vacancies. They have then been asked to produce a revised vacancy list by staff group and a recruitment plan for the next 12 months- also factoring in their current and predicted turnover rates
- There is a continual cycle of recruitment both medical and non-medical with only moderate workforce staff in post growth which suggests we are recruiting just to maintain status quo and also indicates possible retention issues in some areas - highlighted in the turnover reports earlier.
- October, November December and January saw a continual rise in sickness absence rates , increasing by 1.53% from 3.73% in September to 5.26% in January, demonstrating an estimated increase in our sickness absence costs by £213,967 over the period. From January to February the sickness absence rate has reduced back by 0.75% to 4.51%.
- Again as part of the workforce planning process Division's have been provided with detailed data relating to absence stats by staff groups within the Division - this is in addition to the monthly workforce KPI data they receive which outlines their rates - by month, by rolling 12 months and by specialty.
- A 2 year analysis of month on month sickness absence trends has been undertaken and despite the evident peaks and troughs - demonstrated by the blue trend line, the overall tend is that sickness absence rates have reduced since March 2009 - data indicates this is c1.16% overall.
- Despite the evident variance in July and the downward trend since August 2010 the overall trend for Bank & agency spend has continued to rise over the past 12 months. Despite the +/- fluctuations, compared to the same period in 2009 the Trust is spending an extra c£245,674 per month on temporary staff.
- From September 2010 to January 2011 the month on month Bank & agency spend reduced - falling by £905,776 over the 5 months
- However, February's data demonstrates an increase in temporary staff spend of £150,550 over the month or 0.48% extra of the pay bill.

2. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:

None

3. ALTERNATIVES CONSIDERED/REASONS FOR REJECTION:	
N/A	
4. DELIVERABLES:	
Continuous measurement and monitoring of workforce performance against NHS and local agreed targets	
5. EVIDENCE :	
ESR data IView Data NHSIE data	
6. RECOMMENDATION/ACTION REQUIRED:	
No action for information only	
AGREED AT _____ MEETING **OR** **REFERRED TO: _____**	**DATE: _____** **DATE: _____**
REVIEW DATE _____ **(if applicable)**	

TRUST - WORKFORCE KEY PERFORMANCE INDICATORS - FEBRUARY 2011

Barking, Havering and Redbridge NHS University Hospitals NHS Trust

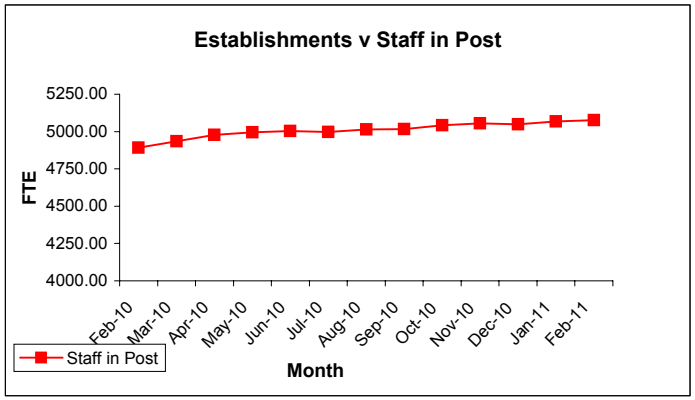
Indicator	Target	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11
Staff In Post		4892.72	4934.81	4976.80	4993.91	5003.75	4998.01	5013.64	5015.97	5041.69	5055.96	5048.64	5067.50	5075.97
Starters *1		57.95	92.32	76.22	55.85	53.51	36.09	53.00	61.74	50.77	54.37	25.36	61.09	38.17
Leavers *1		32.26	47.13	35.89	39.34	36.88	24.78	65.31	46.36	37.91	32.76	32.50	36.28	27.96
Turnover (Annualised) *1	12.0%	13.2	13.3	13.3	12.2	11.4	11.3	11.5	11.8	12.0%	10.9%	11.3%	11.2%	11.1%
Trust Sickness Absence % for month	3.6%	5.16	4.94	4.75	4.48	4.81	4.45	4.07	3.73	4.06	4.41	4.83	5.26	4.51
Trust Sickness Absence Rolling 12 Month Period	3.6%	5.53	5.47	5.46	5.54	5.52	4.77	4.67	4.55	4.49	4.49	4.52	4.58	4.53
Trust Estimated Cost of Sickness Absence (Month) *2		£445,386	£475,528	£468,056	£471,424	£475,920	£439,139	£506,637	£442,607	£516,051	£542,212	£599,608	£656,574	£534,500
Paybill Budget		£22,139,362	£22,746,975	£22,831,718	£22,545,966	£23,283,650	£22,178,669	£22,275,433	£22,332,464	£22,079,274	£22,318,004	£22,078,804	£21,864,418	£22,163,900
Paybill		£21,914,349	£21,728,819	£22,836,821	£23,475,596	£23,240,531	£22,977,291	£23,849,384	£23,624,550	£23,960,015	£23,441,035	£23,418,239	£23,464,872	£23,262,763
Bank/Agency Spend		£3,129,396	£3,357,153	£3,392,816	£3,734,873	£3,725,269	£2,875,803	£4,130,296	£4,048,638	£3,948,964	£3,452,504	£3,370,796	£3,224,520	£3,375,070
% Paybill Budget spent on bank & Agency staff		14.13%	14.76%	14.86%	16.57%	16.00%	12.97%	18.54%	18.13%	17.89%	15.47%	15.27%	14.75%	15.23%
IHB FTE Bookings							632.81	654.68	678.60	669.04	610.13	591.49	634.39	608.99
IHB FTE Worked							532.61	529.67	564.66	571.76	525.15	492.14	528.61	508.18
IHB FTE Worked as a % of Substantive SIP							10.66%	10.56%	11.26%	11.34%	10.39%	9.75%	10.43%	10.01%
Appraisals	90.0%	34.8%	36.3%	35.8%	36.7%	38.0%	44.3%	54.8%	60.0%	72.7%	85.3%	94.7%	93.1%	87.95%

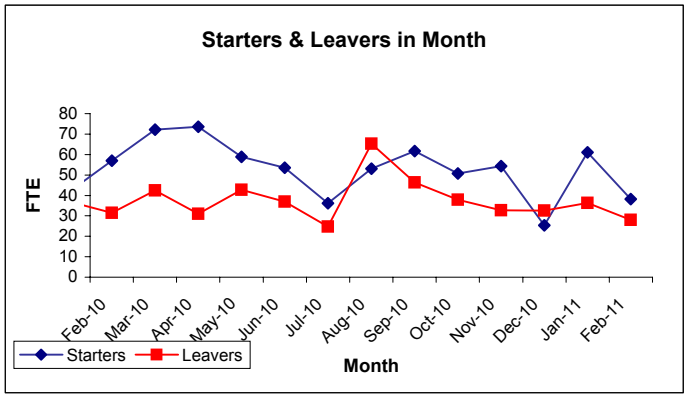
*1 Starters, Leavers & Turnover figures excludes junior doctors on rotation

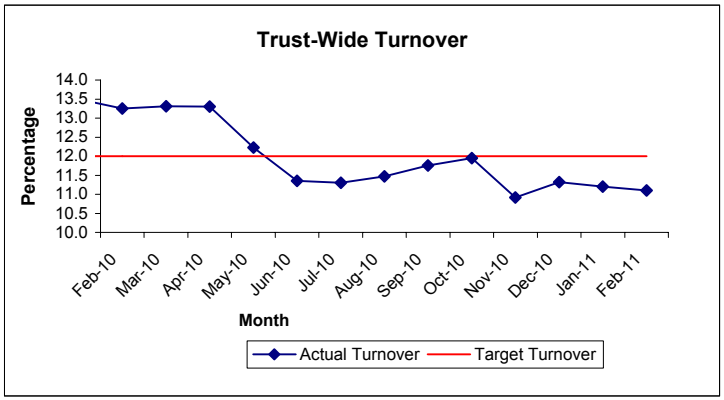
*2 Estimated cost of sickness absence is calculated by ESR and from August 2010 includes on-costs, i.e. Employers Pension and NI costs

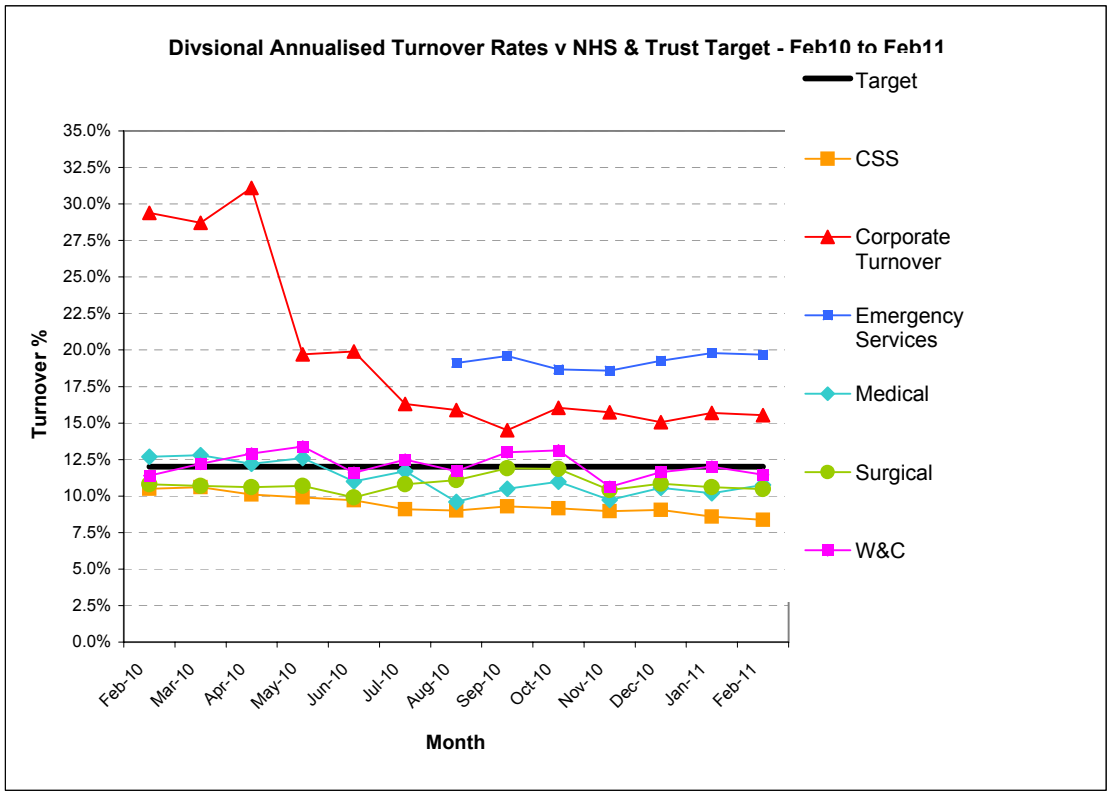
TRUST - WORKFORCE KEY PERFORMANCE INDICATORS - FEBRUARY 2011

Barking, Havering and Redbridge University Hospitals NHS Trust









• The dashboard demonstrates that Trust-wide the workforce has grown by 183.25 FTE's over the past 12 months

• However, starters & leavers analysis for the same period shows that the workforce should in fact have grown by 221.08 FTE's - highlighting a discrepancy of 37.83 FTE's. The 3 causative factors of this difference remain:

1. If new starters commence employment or leave after the payroll cut off date (midmonth) they will not be entered or removed onto/off ESR until month end – therefore they will not appear on the staff in post report generated from ESR until the following month.
2. Staff who increase or decrease their hours will affect the reported FTE's in post but not the starters and leavers
3.Timliness of managers completing and submitting the appropriate forms to HR - for entering onto ESR.

• Peaks and troughs in the numbers of starters & leavers are explained by the numerous bulk recruitment campaigns - both medical and non medical which have taken place over the year, in addition to the trainee doctor change over in August - which also impacts upon the number of leavers in the same month.

• Overall, despite the evident peaks and troughs both the starters and leavers measures are down slightly on the same period 12 months ago by 18.78 and 3.5 FTE's respectively. Indicating a more stable workforce and reduced workforce movement in the wider economy

• This is reflected in the Trust-wide workforce turnover graph where it is evident that staff turnover has reduced by 2.2% in the past 12 months - falling from 13.3% to 11.1% respectively. This continues to be 0.9% below the NHS average and trust target of 12%.

• However, learning from the recent A&E experience this could be a smoke screen of underlying issues, therefore, as part of the current Divisional workforce planning process and performance monitoring of workforce KPI's the Head of Workforce Planning drilled down into the turnover data at:

1. Divisonal Level - which indicated that at this level only the Corporate & Emergency Services Divisions had a higher than NHS average and Trust target turnover rate - across the rolling 12 month period. The Corporate peak of 31% in April 2010 incorporates the TUPE' ing of the sterile and laundry services staff in April 09 - whereas from May onwards these staff were excluded from the rolling 12 month calculations. Emergency Services has had a consistently high turnover rate which has been deconstructed and presented at both the Board and Workforce Committee - an update will be provided at cost centre and staff group level on the next pages, in addition to a recruitment progress report.

Barking, Havering and Redbridge NHS University Hospitals NHS Trust

2010 HOTSPOT Turnover			Admin, Clerical & Maintenance	Medical - Career Grades	Other Qualified Nurses	Unq Nurses & Patient-care SWkrs	Allied Health Professionals (PAMs)	Professional , Technical & Scientific	Overall Total
CSS DIVISION									
E30308	Oncology	Anti-Coagulant Unit			33.33%				22.22%
E30311	Oncology	Radiotherapy	20.00%				24.00%		23.33%
E30315	Oncology	Cancer Admin Services	16.67%						16.67%
E30851	Pathology	KGH Pathology General	40.00%						40.00%
E30857	Pathology	HW Haematology						18.18%	18.18%
E30872	Pathology	QH Mortuary						20.00%	20.00%
E30817	Pharmacy	Pharmacy Dept						15.20%	14.50%
OVERALL CSS TURNOVER BY HOTSPOT STAFF GROUP & COST CENTRE			17.60%		33.30%	0.00%	24.00%	15.70%	17.20%
MEDICAL DIVISION			**2010 Turnover**						
E30035	Medical - Medicine	QH Medical Assessment Unit			40.00%	23.08%			31.03%
E30705	Medical - Cardiology	QH CCU (Sky C)			29.41%				29.41%
E30744	Medical - Medicine	QH Sunrise Ward A	0.00%		18.75%	11.11%			15.38%
OVERALL TURNOVER BY HOTSPOT STAFF GROUP & DIVISION			0.00%	0.00%	29.10%	18.10%	0.00%	0.00%	25.00%
SURGICAL DIVISION			**2010 Turnover**						
E30070	Day Surgery	QH Adult Day Unit	100.00%			100.00%			17.39%
E30071	Day Surgery	KGH Adult Day Care Unit		0.00%	100.00%				15.38%
E30736	ENT	QH Mandarin Ward A	0.00%		18.75%	10.00%			14.29%
E30732	General Surgery	QH Ocean Ward A	0.00%		26.67%	23.08%			24.14%
E30733	General Surgery	QH Ocean Ward B			11.11%				22.22%
E30480	ISTC	I.S.T.C.	0.00%		20.00%				25.00%
E30050	Management	KGH Management		0.00%					40.00%
E30012	Neurology	KGH Beech Ward			7.69%	33.33%			18.18%
E30734	Neurology	QH Sahara Ward A		0.00%					22.22%
E30735	Neurosciences	QH Sahara Ward B			16.67%	7.69%			16.22%
E30743	Neurosciences	QH Harvest Ward B			18.18%	0.00%			16.00%
E31025	Neurosciences	ME Scheme	0.00%						28.57%
E30443	Ophthalmology	Optical Services		0.00%					15.38%
E30730	Orthopaedics	QH Amber Ward A	0.00%		15.38%	30.00%			20.83%
E30731	Orthopaedics	QH Amber Ward B			25.00%	20.00%			22.22%
E31052	Orthopaedics	Orthopaedic Pre-Admissions	0.00%		50.00%				40.00%
E30080	Pain Management	Acute Pain Service			20.00%				20.00%
OVERALL TURNOVER BY HOTSPOT STAFF GROUP & DIVISION			60.00%	3.00%	17.30%	27.60%	16.67%	1.54%	19.70%
EMERGENCY DIVISION			**2010 Turnover**						
E30023	Emergency - A&E & Acute Assessment	KGH A & E Nursing			29.30%				29.30%
E30842	Emergency - A&E & Acute Assessment	Accident & Emergency			29.50%				29.50%
DIVISION					29.50%				29.50%
W&C DIVISION			**2010 Turnover**						
E30263	Midwifery	Unit Midwives	0.00%		10.32%	8.33%	15.71%		11.24%
E30265	Midwifery	Maternity Administration	20.00%						20.00%
E30272	Midwifery	Ante-Natal Clinic	30.77%		10.53%		12.50%		17.50%
E31120	Paeds	QH Tropical Lagoon	50.00%			35.29%	33.33%	0.00%	33.33%
E31124	Paeds	KGH Clover Ward	0.00%			21.05%	50.00%		24.00%
E30201	Sexual Health	Sydenham/Queen's HIV/GUM	17.39%	33.33%		10.71%	28.57%	0.00%	16.67%
DIVISION			17.70%	33.30%	10.34%	18.40%	18.90%	0.00%	15.10%

2.Cost centre & Staff group- In order to help inform the workforce planning process and facilitate discussions and challenges with divisions around why their temporary staffing use remains consistently high, 2010 turnover rates by cost centre and staff groups within has been measured for each Division. The table to the left demonstrates the areas defined as 'HOTSPOTS' - i.e. where turnover either by the cost centre itself or a staff group within it are elevated above 14%, creating a 'revolving door' of vacancies and a constant requirement to bridge the gap with bank or agency staff.

- Clearly much lower turnover rates in the remaining cost centres within the Divisions are diluting the hotspot areas rates - creating an illusion that the workforce is stable across the board.
- Many of the areas with high turnover rates in 2010 - relate to specialist services e.g. A&E, Paediatrics, MAU, CCU, etc. Further compounding the problem is the issue that most of these areas are also difficult to recruit to, making it more likely that if there are significant or continuous numbers of vacancies - only a few new starters can be recruited at any one time.
- In addition, high levels of activity, high turnover rates and vacancy gaps continuously being bridged by temporary staff - who likely are not as committed to our Organisation or our patients, places inadvertent pressure upon our own substantive staff. Staff begin to feel undervalued and morale drops, stress and sickness absence increase and staff leave - creating a revolving door of vacancies.
- As with A&E Registered Nursing and HCA & support worker turnover rates are high within the hotspot areas - expected as proportionally these groups have the most number of staff within them .However, further analysis within this staff group by nurse band has commenced, to begin to further drill down into the turnover rates and help facilitate solutions to close the gap - see below and over next page. This is work that is ongoing.

Medical Divsion - MAU Queen's site both at Registered Nurse (40%) and HCA (23%) level - overall QH MAU turnover 31%

Hotspots

Band 5 Registered nurses @ 14.55% (2.55% above Trust target) – 4 leavers over the year – calculation further exacerbated by the consistent number of vacancies in the area (turnover calculation uses SIP- if recruited to establishment of 35.05 FTE's – turnover rate would be lower)
Band 3 un-registered staff (HCA's) @ 66.67% - only 2.0 FTE's within this staff group with 1 leaver in 2010

QH Medical Assessment Unit	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7
SIP Jan 2010	22	2	0	28	23	3
SIP Dec 2010	24	1	0	27	19	4
Average	23	2	0	28	21	4
Leavers	2	1	0	4	2	0
Turnover	8.70%	66.67%	0.00%	14.55%	9.52%	0.00%

Medical Division - QH CCU – Sky C – Qualified Nursing turnover 29.5% = overall Nursing turnover due to Registered nurse only workforce

Hotspots:

Band 5 Registered nurses @ 71.43% (59.43% above Trust target) – 5 leavers over the year – which exacerbates the situation as leavers used in calculation. (If recruited to establishment of 10.29 FTE's – turnover rate would be lower)

QH Sky Ward C (CCU)	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7
SIP Jan 2010	0	0	0	8	7	4
SIP Dec 2010	0	0	0	6	7	4
Average	0	0	0	7	7	4
Leavers	0	0	0	5	0	0
Turnover	0.00%	0.00%	0.00%	71.43%	0.00%	0.00%

TRUST - WORKFORCE KEY PERFORMANCE INDICATORS -
FEBRUARY 2011

Barking, Havering and Redbridge NHS University Hospitals NHS Trust

Medical Division - QH Sunrise ward A – Registered Nursing turnover = 19% overall Sunrise ward A turnover 15.8%
Hotspots:
Band 5 Registered nurses @ 27.27%% (15.27% above Trust target) – 3 leavers over the year

QH Sunrise Ward A - Turnover for 2010				
	Band 2	Band 5	Band 6	Band 7
Jan-10	11	11	3	1
Dec-10	11	11	3	1
Average	11	11	3	1
Leavers	1	3	0	0
Turnover	9.09%	27.27%	0.00%	0.00%

Emergency Division - QH A&E - Registered Nursing turnover 29.50%
Hotspots:
Band 5 Registered nurses @ 52.05% (40.05% above Trust target) - 19 leavers over the year.
Band 8a Registered nurses @ 37.50% - 3 leavers over the year

QH - A&E Registered Nursing Turnover 2010				
	Band 5	Band 6	Band 7	Band 8a
SIP Jan 2010	42	28	12	10
SIP Dec 2010	31	27	13	6
Average	37	28	13	8
Leavers	19	2	1	3
Turnover	52.05%	7.27%	8.00%	37.50%

Emergency Division - KGH A&E - Registered Nursing turnover 29.30%
Hotspots:
Band 5 Registered nurses @ 46.81% (34.81% above Trust target) - 11 leavers over the year.
Band 6 Registered nurses @ 17.14% - 3 leavers over the year
Band 8a Registered Nurses @ 50% - 1 leaver over the year

KGH A&E Registered Nursing Turnover 2010				
	Band 5	Band 6	Band 7	Band 8a
SIP Jan 2010	25	16	11	3
SIP Dec 2010	22	19	12	1
Average	24	18	12	2
Leavers	11	3	1	1
Turnover	46.81%	17.14%	8.70%	50.00%

W&C Divsion - Unit Midwives- Overall turnover rate @ 11.24% in itself not high but required further analysis when midwifery includes community as well as unit. overall Midwifery 2010 annualised turnover rate = 7.72%.
Hotspots:
Relates to unregistered nurses & support workers @15.71%. More in-depth analysis (below) shows that this specifically relates to band 2's.
Band 7 Midwives @20.41% due to 5 leavers over the year – which haven't been replaced- assumption they are carrying these vacancies due to difficulties in recruiting

Unit Midwives 2010 Turnover						
	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7
SIP Jan 2010	56	0	7	2	135	27
SIP Dec 2010	63	0	7	4	141	22
Average	60	0	7	3	138	25
Leavers	11	0	0	0	12	5
Turnover	18.49%	0.00%	0.00%	0.00%	8.70%	20.41%

W&C - QH Tropical lagoon Paediatrics – overall turnover 33.33% High rates across A&C @ 50%, Registered nurses @ 35.29% and unregistered nurses and support workers at 33.3% - concerns that turnover is high across all staff groups.

More in-depth analysis of Registered nursing and HCA & support worker turnover (below) – identifies this relates to band 3 un-registered nurses @ 200% - although this is purely due to the fact there was only 1 person in post – who then left and wasn't replaced. Registered nurses band 5's - @ 40% - 5 staff left over the year and band 6's @14.29% - 1 leaver over the year who hasn't been replaced.

QH Tropical Lagoon 2010 Nursing Turnover						
	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7
SIP Jan 2010	6	1	0	12	8	1
SIP Dec 2010	6	0	0	13	6	0
Average	6	1	0	13	7	1
Leavers	0	1	0	5	1	0
Turnover	0.00%	200.00%	0.00%	40.00%	14.29%	0.00%

W&C KGH Clover ward – paediatrics - overall turnover 24% High rates across Registered nurses @ 21.06% and unregistered nurses and support workers at 50% - concerns that turnover is high across both staff groups.

More in-depth analysis of Registered nursing and HCA & support worker turnover (below) – identifies this relates to band 2 un-registered nurses @ 33.3% - this is due to the fact there was only a very small number of staff in this group = 3 with 1 leaver over the year. Registered nurses band 5's - @ 19.35% - 3 staff left over the year, band 6's @ 20% - 1 leaver over the year who hasn't been replaced, and band 7's @ 100% - 1 leaver over the year who has been replaced.

KGH Clover Ward 2010 Nursing Turnover						
	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7
SIP Jan 2010	3	0	0	16	6	1
SIP Dec 2010	3	0	0	15	4	1
Average	3	0	0	16	5	1
Leavers	1	0	0	3	1	1
Turnover	33.33%	0.00%	0.00%	19.35%	20.00%	100.00%

- It is important to note that there may be perfectly justifiable reasons why nursing turnover in these areas is so high - for example:
1. the overall number in the band group may be very low and with 1 or 2 leavers over the year this will give a very high turnover rate.
2. Vacancies may not have been recruited to - either intentionally, to contribute to CIP programmes such as the ward closures or skill mix changes or unintentionally as there are difficulties in recruiting.
- Divisonal Nurses have been encouraged to view the data and explain the reasons why rates are so high.
- Where difficulties in recruiting have been identified in areas such as A&E, midwifery and MAU - alternative solutions have been sought.
- A cross Divisonal recruitment strategy group is set to commence at the end March - with input from HR - workforce planning and recruitment as well as the IHB and divisional nurses.
- The intention is to identify and implement strategies to get the appropriate staff with the right skills into post as soon as viable.

Vacancies

• The True number of vacancies across all staff groups across the Trust still cannot easily be clarified as obtaining this data is a manual exercise- therefore there is still uncertainty around whether we are bridging the gap between funded establishments and Staff In Post or just maintaining a status quo.
• As part of the workforce planning, CIP and budget setting processes Divisions have been charged with undertaking a line by line review of their existing establishments and vacancies. They have then been asked to produce a revised vacancy list by staff group and a recruitment plan for the next 12 months- also factoring in their current and predicted turnover rates. These plans will be presented by the Divisions to the workforce committee on the 28th March 2011and will contribute to the completion of the Trust operating plan - also due month end.
•Nurse vacancies are currently manually collated by the Divisonal Nurses on a monthly basis and reported to the N&MW Board. HR have been made aware of the medical & surgical divisions current status - outlined to the right.
•The medical Division's remaining registered nurse vacancies represent a c7.9% vacancy gap and Surgical c15%. the main area within the surgical division with outstanding vacancies relates to ITU - where there are currently 27 band 5 FTE's unfilled.

Medical division Nursing Vacancies as at 28th February 2011-(inc A&E)

Band	Number of FTE's waiting to start in post	Number of Vacancies Remaining
5	61.00	19.22
6	5.00	15.40
7	0.00	9.15
2	19.30	8.77

Surgical division Nursing Vacancies as at 28th February 2011

Band	Number of FTE's waiting to start in post	Number of Vacancies Remaining
5	40.00	63.64
6	0.00	19.98
7	0.00	5.70
2	19.30	39.08

Recruitment

Non- Medical Recruitment broken down by staff groups with projected start dates

	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Totals
Nurses	45	28	14.85	3	0	**90.85**
Midwives	10	8	0	0	0	**18**
HCA(Unqual)	9	20	7	2	0	**38**
Senior Manager	0	1	0	0	1	**2**
Admin and Clerical	4	12	27	0	0	**43**
AHP	10	8	6.69	6.28	0	**30.97**
Additional Clinical Services	6	9	12.8	0	0	**27.8**
Additional Professional Scienific & Tech	0	3	1	1.4	0	**5.4**
Healthcare Scientist	0	0	0	0	0	**0**
Student Midwives	13	0	0	0	0	**13**
Nursey Nurses	8	1	0	0	0	**9**
Total	**105**	**90**	**69.34**	**12.68**	**1**	**278.02**

Medical Recruitment in process	
Commenced in post	7
Awaiting JD	4
At VCP	7
Out to advert	15
Awaiting interview	22
Awaiting start date	15
On Hold	12
Total	**82**

Medical Recruitment almost complete	Mar-11	Apr-11	May-11	Total
Consultants with projected start dates	1	1	1	**3**
All other grades with projected start dates	4	1	1	**6**
Total	**5**	**2**	**2**	**9**

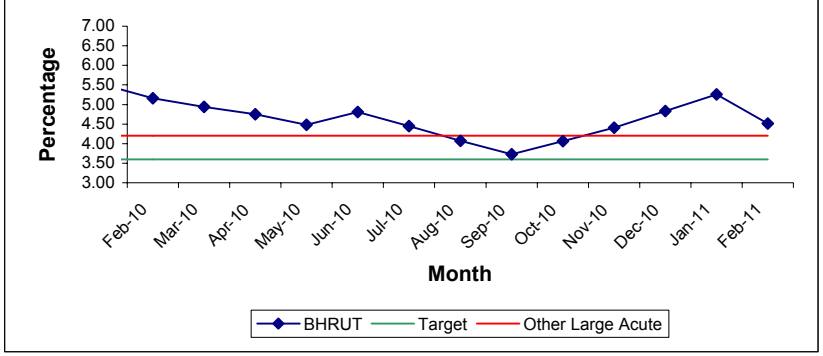
•The table above demonstrates there is a continual cycle of recruitment both medical and non-medical with only moderate workforce staff in post growth which suggests we are recruiting just to maintain status quo and also indicates possible retention issues in some areas - highlighted in the turnover reports earlier..
• Several bulk recruitment campaigns including the overseas A&E and midwifery focussed campaigns via recruitment agencies are underway, in particlular the table above highlights the Portugese and Irish band 5 nurses coming into post in March and April. The Midwifery Italian campaign will be factored into the next dashboard report. Open days, focussed advertising and university targeting have successfully served to reduce the number of vacancies within nursing, midwifery and ODP's however, this remains an ongoing process due to high turnover and difficulties in recruiting to areas such as A&E, theatres, midwives & NICU
• The A&C vacancy freeze has now been lifted - due to the high number of vacancies within CSS in particular which were being covered by bank and agency staff. .
• Medical recruitment - Overseas and targetted recruitment for difficult to recruit to areas such as Paediatrics, A&E and orthopaedics have returned results in filling long term vacancies in Paediatrics, which has enabled the re-configuration plan to be delivered November 2010 and Trauma and Orthopaedics in the delivery of the Orthogeriatric care pathway and in the implementation of the A&E Workforce plan
• A constant review of our Medical recruitment strategies has seen the introduction and launch of the International Graduate Placements. A Policy initially launched Nov 2009, has been most effective in A&E and the re launch for career progression for overseas doctors up to Specialty doctor posts, has seen the development of the A&E university linked training academy being led by consultants within universities overseas January 2011.

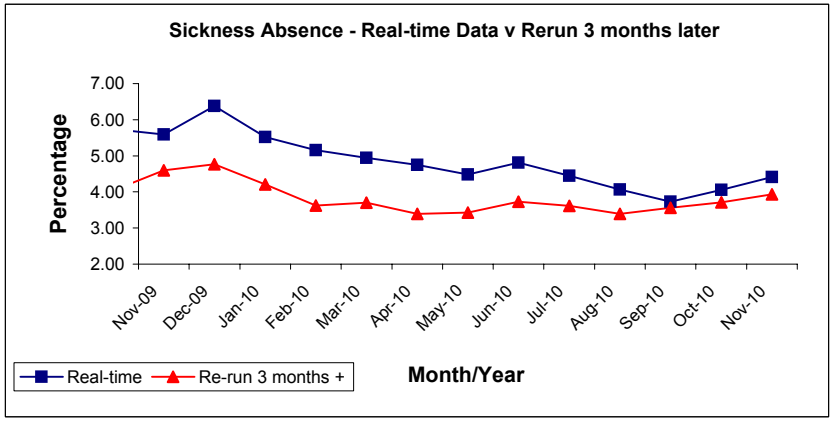
TRUST - WORKFORCE KEY PERFORMANCE INDICATORS - FEBRUARY 2011

Barking, Havering and Redbridge NHS University Hospitals NHS Trust

Real-Time Sickness Absence

• October, November, December and January saw a continual rise in sickness absence rates , increasing by 1.53% from 3.73% in September to 5.26% in January, demonstrating an estimated increase in our sickness absence costs by £213,967 over the period. From January to February the sickness absence rate has reduced back by 0.75% to 4.51%. BHRUT's benchmarked





period. From January to February the sickness absence rate has reduced back by 0.75% to 4.51%. BHRUT's benchmarked position shows us as sitting 0.31% above the average of all other large acute Trusts, and above the revised in-house target by 0.91%.

• In line with national , regional and local requirements to improve workforce productivity and efficiency we have reviewed and revised our sickness absence target to 3.60% and as discussed in previous workforce dashboards and focus reports the workforce information team now re-run sickness absence reports 3 months retrospectively in order to ensure that all absence data has been entered onto ESR and our view of actual sickness rates is a true picture which also brings us in line with the IView methodology for the data warehouse..

• Undertaking this exercise previously has demonstrated a difference of between -1 & -2% in our reported sickness absence rates, which has been shown to be accurate and consistent.

• The sickness absence reports continues to be re-run with a 3 month lag in addition to the 'real time reports' in order to ensure data quality & consistency is being maintained. The graph above shows that the reported 'real time' sickness absence rates for November 2010 was 4.41%..Having re-run the report 3 months later the reported rate for the same month as 3.93% - a gap of 0.48%.

•Managers/supervisors still need to be more timely in completing their weekly absence returns, despite monthly monitoring and 'chasing' by HR compliance remains c50% for real time reporting.

• Divisions are advised of their managers/supervisors compliance rates in completing their absence returns - on a monthly basis, via the divisional workforce KPI reports

• Due to the identified difference in the reported sickness absence rates the workforce dashboards continue to contain a comparison graph to monitor sickness absence rates both in real-time and in retrospect (rerun data). This graph will run to the same standards as IView and as such it will always be 3 months in arrears to ensure data has been inputted

• The HR workforce information department provide monthly analyses & perspective of sickness absence for the Trust overall and each of the 5 Divisions. In-depth information & Bradford scores are provided to managers through the HR advisors who are then tackling sickness absence by:

1. Continuous monitoring of absence data with the Divisional Managers
2.. HR Advisors then hold 1 to 1 meetings with General/Service Managers and Matrons to review their data
3.. Training in the procedure on Sickness Absence Management was been rolled out by the HR Advisor with sessions being run across the Divisions

• Work has been undertaken in relation to Medical staffing absence reporting/recording - medical staffing co-ordinators have absorbed this work and data is recorded onto ESR

Sickness Absence % By Division and Staff Group for the period January to December 2010

	Admin, Clerical & Maintenance	Medical - Career Grades	Medical - Training Grades	Midwives	Other Qualified Nurses	Unq Nurses & Patient-care SWkrs	Allied Health Professionals (PAMs)	Professional, Technical & Scientific	Ancillary & Non-patient-care SWkrs	Total
Clinical Support	4.86%	1.38%	0.00%		4.44%	6.02%	5.22%	4.58%		4.70%
Corporate	4.15%	0.00%	0.00%		4.62%	1.78%		4.02%	9.12%	4.04%
Emergency **	4.59%	0.98%	0.92%		4.40%	2.82%		5.69%		3.72%
Medical	4.26%	3.03%	0.41%		4.33%	8.01%	2.38%	4.06%		4.43%
Surgical	5.66%	1.12%	0.57%		4.53%	5.45%	12.89%	4.40%		3.79%
Women & Children	7.37%	0.93%	1.17%	7.70%	6.47%	10.20%		7.43%		6.54%
Trust Total	4.81%	1.50%	0.61%	7.70%	4.69%	6.68%	5.42%	4.55%	9.12%	4.60%

** Emergency was reported separately from August 2010 - prior to this it was included within Medical Division

• Again as part of the workforce planning process Division's have been provided with detailed data relating to absence stats by staff groups within the Division - this is in addition to the monthly workforce KPI data they receive which outlines their rates - by month, by rolling 12 months and by specialty.

CSS As a division CSS has demonstrated an overall improvement of 0.8% over the year Month on month sickness absence rates also demonstrate the division is consistently above the Trust sickness absence rate.

CSS Hotspots – Rolling 12 month sickness absence rates in the un-registered nurses and patient care support workers and AHP groups remain high @ 6.02% and 5.22% - respectively - over the 12 months. Highlighting areas for further targeting and improvement

Medical Division As a division medicine has demonstrated an overall improvement of 1.36% over the year and is currently 0.4% below the Trust rolling 12 month rate but 0.83% above the revised Trust target of 3.6%

Medicine Hotspots

Unregistered nurses & patient care Support workers (HCA's & support workers) – Rolling 12 month sickness absence rate @ 8.01%, 3.18% above current Trust rolling 12 month rate of 4.83% and 3.58% above Divisional rolling 12 month rate.

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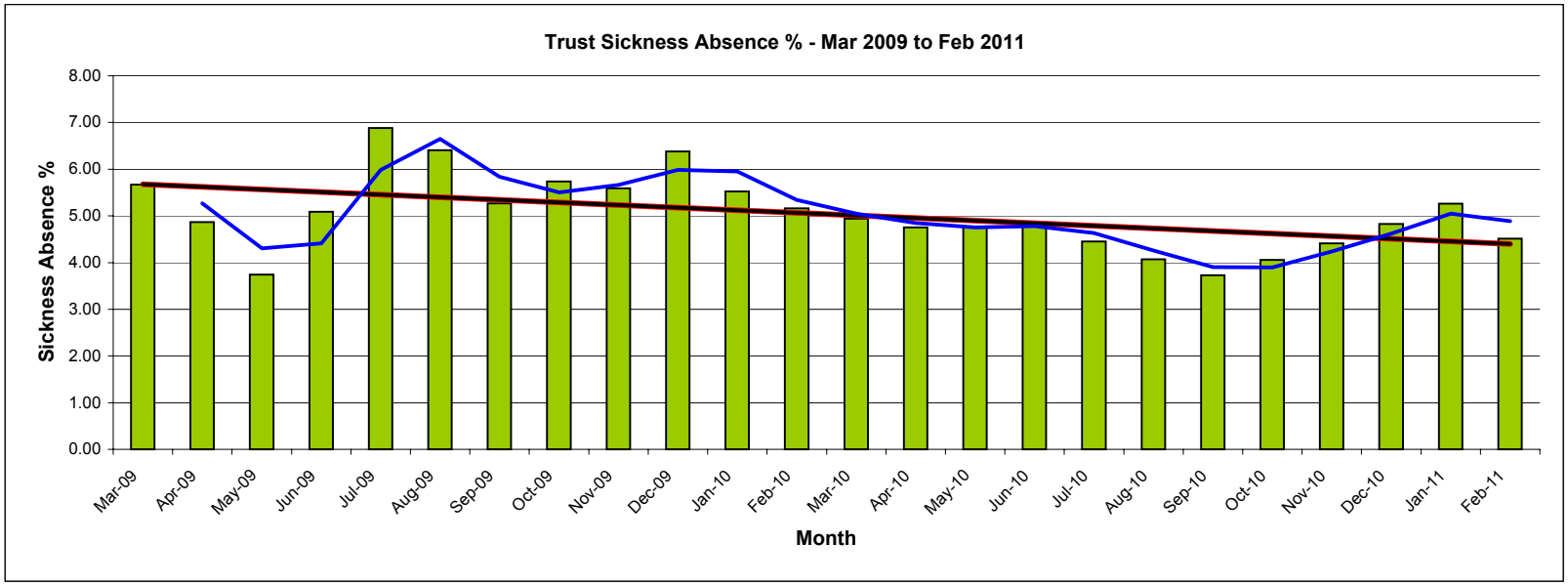
Surgical Division As a division surgery has demonstrated an overall improvement of 1.21% over the year and is currently 0.77% below the Trust rolling 12 month sickness absence rate but 0.21% above the revised Trust target of 3.6%

Surgery Hotspots

Surgery Hotspots
Admin & Clerical - Rolling 12 month sickness absence rate @5.66% - 0.85% and 1.85% above the current Trust and Division rolling 12 month rates – respectively. Unregistered nurses & patient care Support workers (HCA's & support workers) – Rolling 12 month sickness absence rate @ 5.45% - although this is 1.23% below the current Trust rolling 12 month rate of 6.68% for the same staff group. AHP's @ 12.89% - 7.47% above the current Trust rolling 12 month rate of 5.42% for the same staff group
W&C Division - As a Division Women's & Childrens rolling sickness absence rate has run fairly consistently between 6.5% and 7.25% - 2.5% to 3% above the Trust and target rates of 3.6% - they also demonstrate an increase in their rolling 12 month sickness absence rate, increasing by 0.39% over the period.
W&C Hotspots
Specialities with highest sickness absence rates over the year relate to NICU/SCBU @2.8% at its lowest (for 1 month only) up to 15.03% at its highest, Midwifery which hasn't dropped below 7.62% over the year and sexual Health. Highest sickness absence rates are within the A&C staff group@ 7.71%, Midwives @7.7%, Registered nurses @ 6.47%, Un-registered nurses @ 10.2% and Professional scientific and technical staff @ 7.43%. This demonstrates significant areas of improvements are required across all staff groups and some specialities.
Emergency services As a division emergency has demonstrated an overall decline of 2.62% in their sickness absence rate over the 7 months since splitting out from Medicine and is currently 0.78% above the Trust rolling 12 month sickness absence rate and 1.76% above the revised Trust target of 3.6%.
Emergency Services Hotspots
Moderate improvements across A&C and Registered Nurses is required , however Professional scientific and technical staff @ 5.69% should be the key focus area to target

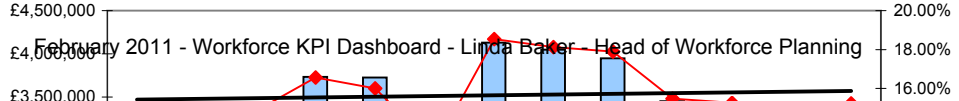


• A 2 year analysis of month on month sickness absence trends has been undertaken and despite the evident peaks and troughs - demonstrated by the blue trend line, the overall tend is that sickness absence rates have reduced since March 2009 - data indicates this is c1.16% overall.

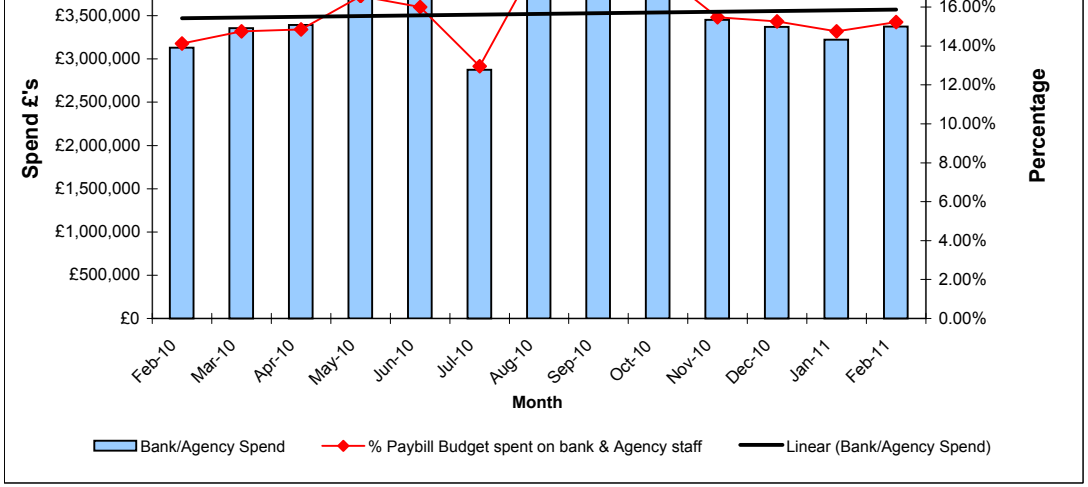
TRUST - WORKFORCE KEY PERFORMANCE INDICATORS - FEBRUARY 2011

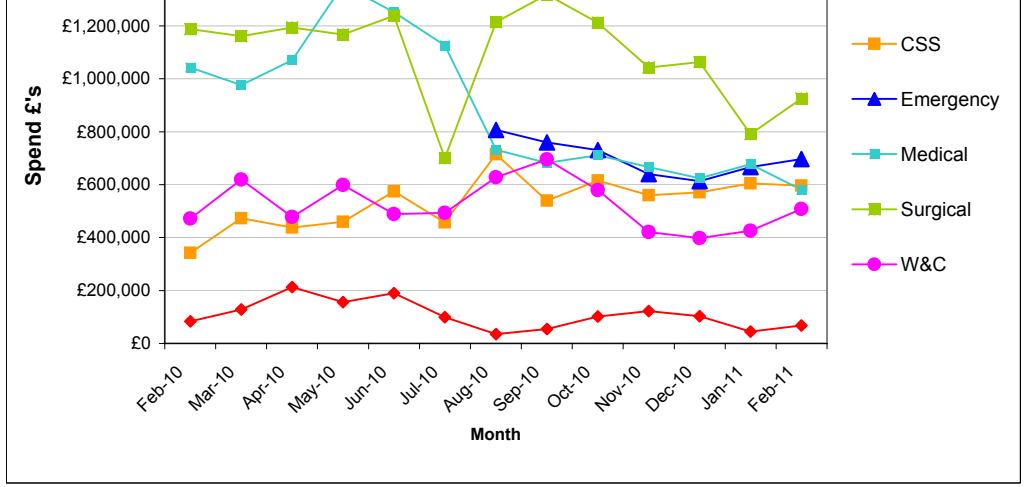
Barking, Havering and Redbridge NHS University Hospitals NHS Trust

Trust-wide Month on Month Bank/Agency Spend v Overall Percentage of Pay bill
Budget spent on bank/agency (data provided by finance)



Divisional month on month contribution (£'s) to overall Trust Bank/Agency Spend (£'s) (data provided by finance)

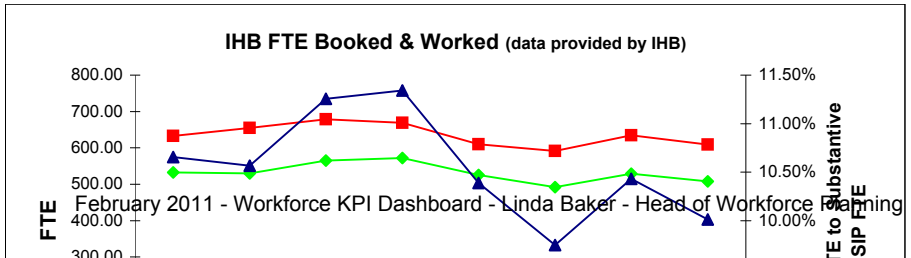


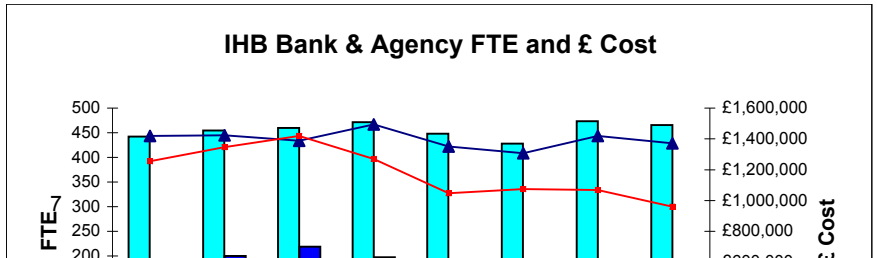


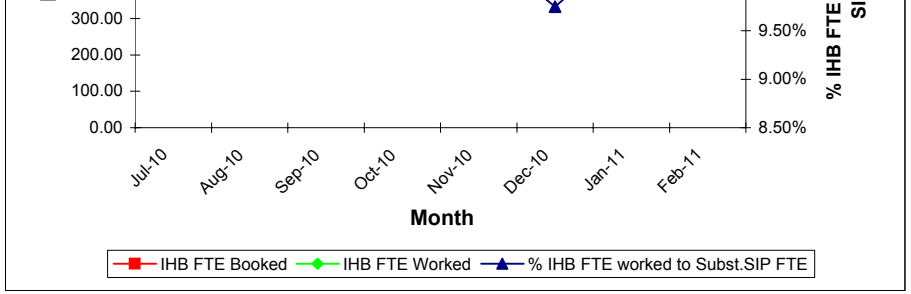
• Despite the evident variance in July and the downward trend since August 2010 the overall trend for Bank & agency spend has continued to rise over the past 12 months. Despite the +/- fluctuations, compared to the same period in 2009 the Trust is spending an extra c£245,674 per month on temporary staff.
• August 2010 saw the largest spend on bank & agency over a month at £4,130,298
• From September 2010 to January 2011 the month on month Bank & agency spend reduced - falling by £905,776 over the 5 months
• However, February's data demonstrates an increase in temporary staff spend of £150,550 over the month or 0.48% extra of the pay bill.
• Surgical consistently demonstrates the highest month on month bank & agency spend - they also saw the largest spend increase from January to February - rising by £134,392 or a further 2.08% of their pay bill budget over the month
• A reduction in the Trust's reliance upon temporary staff - both medical, dental, nursing and A&C remains a Trust priority. The current overall workforce plan includes a workforce reduction plan for Admin & Clerical posts which commenced with stopping agency booking of these grades.
•.
• However, as a proportion of their overall pay bill budget the emergency division (introduced mid 2010) - consistently spends the highest percentage (%) of its pay bill budget on bank & agency staff - now with over 50%
• A proportion of the difficulties in recruiting continue to relate to national difficulties in specific staff groups e.g. Middle grade training doctors, Midwives and nursing roles related to specialist areas such as ICU, Theatres & A&E causing staffing shortages and high use of temporary staff. Divisions are actively considering new ways of working, 'growing our own' - development of existing staff and new roles to support the ongoing recruitment difficulties in these areas. However, consideration needs to be given that lead times in terms of education commissioning to 'grow our own' as an alternative will mean that this aspect of workforce planning will take 18 months to 2 years before the Trust see's the benefit
• For areas such as A&E where 'vacancy & turnover hotspots' are a real issue and significantly contribute to temporary staff spend discussions at the workforce committee have focussed on mitigating actions to address the gap such as recruitment strategies, notably whether Divisions should be able to over-recruit and to what level, where high levels of turnover and poor staff retention have been identified and implemented.
.
• Despite the development of an in-house bank, investment into funded establishments over the year , generally a more stable workforce than 2009 and turnover reducing significantly our bank and agency spend continues to rise. Workforce KPI's must be integrated into the Divisional performance meetings in order to facilitate improved Divisional accountability & responsibility for workforce related performance and enable formal challenges, discussions and actions to be brought to the table.
•Further work will be undertaken by the in house bank in relation to understanding why the has the highest temporary staff spend through breaking it down in to specialities to prepare more concentrated and targeted workforce plans which will identify 'intelligent true' reasons for reliance of temporary staff.

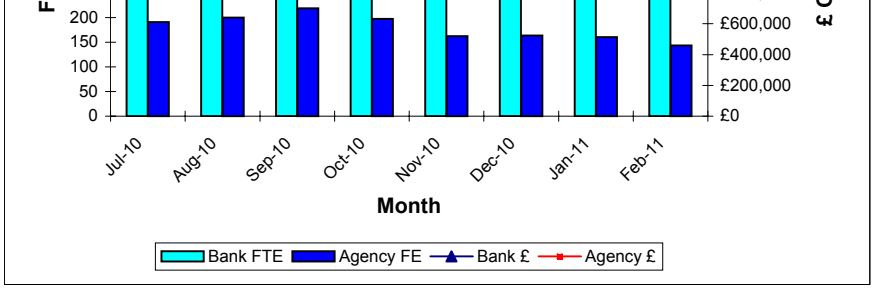
TRUST - WORKFORCE KEY PERFORMANCE INDICATORS - FEBRUARY 2011

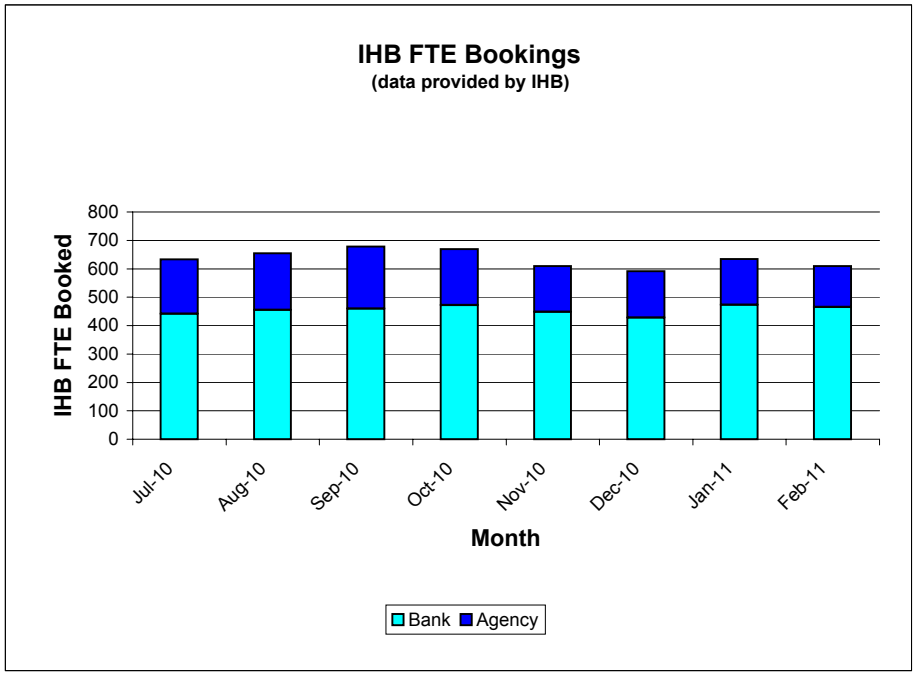
Barking, Havering and Redbridge NHS University Hospitals NHS Trust

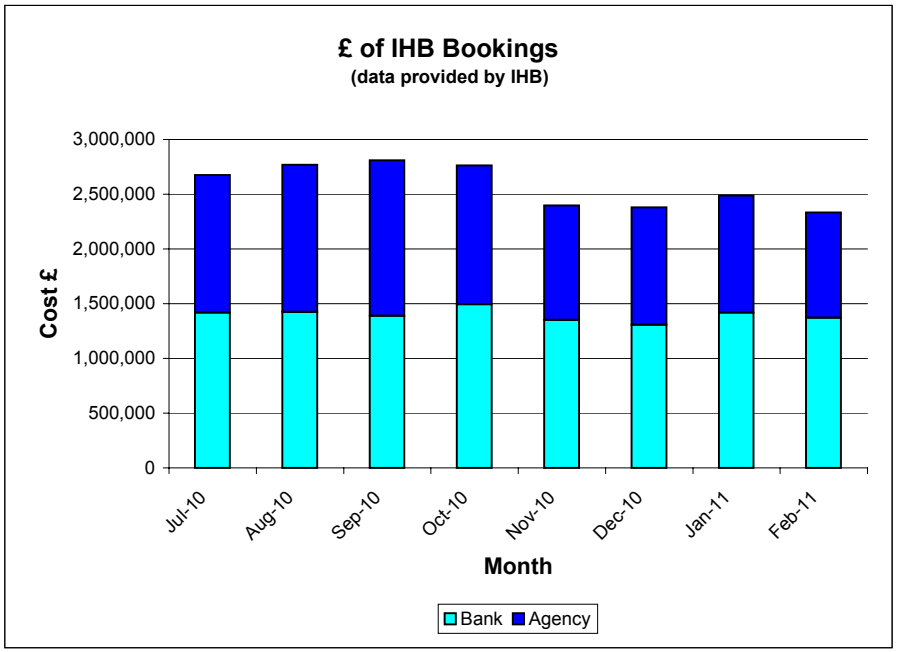








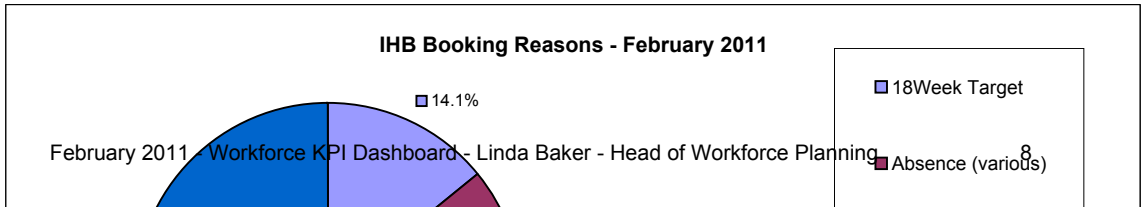


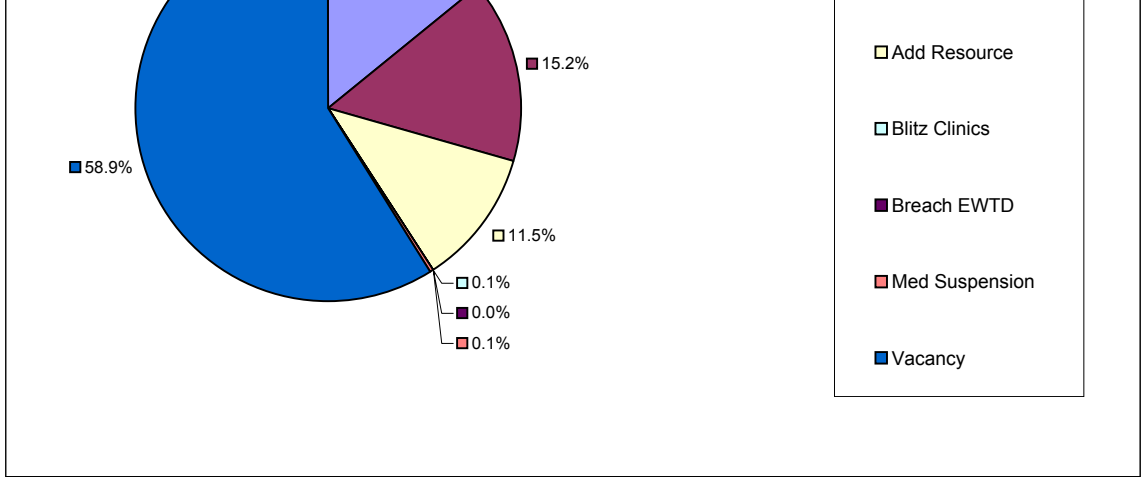


• Despite the overall temporary staff spend increasing in February, the overall number of Bank and Agency FTE's - worked decreased by 20.43 over the month, and the overall number of IHB FTE's booked also reduced by 25.4 FTE's over the same period. Initial thoughts would be that we are using more expensive agency staff, however, agency bookings costs and the number of agency FTE's for the month February fell by £108,783 and 16.97 FTE's respectively. This suggests that accrued invoices may have gone through the ledger during the month - distorting the picture and therefore misaligning with the IHB reported data.

TRUST - WORKFORCE KEY PERFORMANCE INDICATORS - FEBRUARY 2011

Barking, Havering and Redbridge University Hospitals NHS Trust




15.2%
58.9%
11.5%
0.1%
0.0%
0.1%
Add Resource
Blitz Clinics
Breach EWTD
Med Suspension
Vacancy

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Finance Report – February 2011	

1. KEY ISSUES:

The overall I&E position to the end of February showed a net deficit of £33.3m, which represented an £14.1m adverse variance against the profiled plan to date and exceeds the Annual Plan control total deficit of £19.9m. In month there was a deficit of £2.0m against a plan of £1.5m, giving an adverse variance of £0.5m in the month.

The adverse movement in month is brought about primarily by unidentified CIP target of £0.8m. Both pay and non-pay budgets showed reduced in month overspends of £0.2m respectively (i.e. £0.4m in aggregate), although these benefited from non-recurrent items; pay from a £0.7m reversal of agency accruals relating to earlier in the financial year and non-pay from specific accrual reversals and retrospective utilities rebates of £0.4m in total. These adverse variances were mitigated by under spending from uncommitted reserves and central budgets of £0.7m. Income overall over performed, by £0.3m in the month, with central income over-performing by £0.6m.

For the year to date the main components of the £14.7m adverse variance are; shortfall on unvired (i.e. unidentified) CIP of £8.0m, pay overspending of £9.2m and non-pay overspending of £9.8m, each partly attributable to activity over-performance, and exacerbated by associated CIP shortfall resulting from failure of PCT Demand Management plans and the consequent temporary staffing costs incurred at premium rates. The other major factor is continued overall use of temporary staffing and CIP slippage (aside from demand management), notably Length of Stay. These are only partly offset by an income over-performance of £10.6m to date and a net under spending on reserves and other central items of £2.3m.

The overall forecast outturn is for a deficit of £34.2m, which is a slight improvement from the Month 10 forecast of £34.4m. Some additional reductions in agency expenditure have been identified, notably in Medical and Clinical Support Divisions, but these have been largely offset by increased numbers of agency midwives

REVIEWED BY (BOARD/COMMITTEE) and DATE:

☐ **S&SIB** ……☐ **EPB**……..

☐ **FINANCE** ……☐ **AUDIT** ……..

☐ **CLINICAL GOVERNANCE** ……..

☐ **CHARITABLE FUNDS** ……

☑ **TRUST BOARD** ……

☐ **REMUNERATION** ……

☐ **OTHER** ……(please specify)

CATEGORY:

☐ **NATIONAL TARGET** ☐ **CNST**

☐ **STANDARDS FOR BETTER HEALTH**

☐ **ASSURANCE FRAMEWORK**

☐ **TARGET FROM COMMISSIONERS**

☑ **CORPORATE OBJECTIVE** To monitor the Trust's progress in achieving its financial turnaround, achieving control targets and meeting its statutory financial duties going forward.

☐ **OTHER** …….. (please specify)

AUTHOR/PRESENTER:

Alan Davies, Deputy Director of Finance / David Wragg, Director of Finance

DATE:

17 March 2011

(in response to CQC report).	
2. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
Set out under key issues	
3. ALTERNATIVES CONSIDERED/REASONS FOR REJECTION:	
N/A	
4. DELIVERABLES:	
N/A	
5. EVIDENCE :	
N/A	
6. RECOMMENDATION/ACTION REQUIRED:	
The Board is asked to note this report.	
AGREED AT _____ MEETING **OR** **REFERRED TO: _____**	**DATE: _____** **DATE: _____**
REVIEW DATE **_____** **(if applicable)**	

Finance Report for 11 Months Ended 28th February 2011

1. Financial Summary

Annual Budget £'000	I&E Description	Bdgt WTE	Actual WTE	Var WTE	M11 Bdgt £'000	M11 Actual £'000	M11 Var £'000	YTD Bdgt £'000	YTD Actual £'000	YTD Var £'000
	Income									
(395,925)	**Total Income**				**(33,120)**	**(33,390)**	**270 (F)**	**(362,570)**	**(373,206)**	**10,636 (F)**
	Pay Expenditure									
76,126	Medical Staff	897	917	-20	6,313	6,451	(138) A	69,813	78,393	(8,581) A
40,378	Scientific, Therap & Technical	941	925	15	3,363	3,536	(173) A	37,014	37,808	(794) A
87,474	Nursing & Midwifery - Qual.	1943	2221	-278	7,201	7,404	(202) A	80,453	80,992	(538) A
18,782	Nursing & Midwifery - Unqual.	745	842	-97	1,554	1,558	(4) A	17,225	17,456	(231) A
8,402	Ancillary Staff	331	331	0	702	673	29 (F)	7,700	7,526	174 (F)
38,442	Management & Admin Staff	1142	1090	52	3,225	2,971	254 (F)	35,526	34,802	724 (F)
269,604	**Pay Total**	**5998**	**6326**	**-329**	**22,358**	**22,592**	**(234) A**	**247,730**	**256,976**	**(9,246) A**
	Non Pay Expenditure									
25,238	Drugs				2,095	2,319	(224) A	23,063	25,864	(2,801) A
27,061	Clinical Supplies & Appliances				2,226	2,356	(130) A	24,836	27,294	(2,458) A
15,529	General Supplies & Services				1,285	1,440	(155) A	14,244	15,596	(1,351) A
15,565	Premises & Fixed Plant				1,354	960	393 (F)	14,206	14,268	(62) A
33,316	Other Non Pay				2,765	2,855	(90) A	30,568	33,682	(3,114) A
116,710	**Non Pay Total**				**9,725**	**9,931**	**(206) A**	**106,917**	**116,703**	**(9,787) A**
	Unidentified CIP									
(5,244)	CIP Target Pay				(549)	-	(549) A	(4,699)	-	(4,699) A
(3,412)	CIP Target Non Pay				(230)	-	(230) A	(3,307)	-	(3,307) A
(8,656)	**CIP Target Total**				**(779)**	**-**	**(779) A**	**(8,006)**	**-**	**(8,006) A**
2,502	**Reserves**				**379**	**(7)**	**386 (F)**	**2,457**	**(96)**	**2,553 (F)**
(15,764)	**EBITDA**				**(1,438)**	**(875)**	**(563) A**	**(13,472)**	**378**	**(13,850) A**
12,644	Depreciation				1,054	1,009	44 (F)	11,590	11,879	(288) A
-	F Asset Impairements				-	-	-	-	25	(25) A
3,216	Capital Dividends				268	248	20 (F)	2,948	2,785	163 (F)
19,782	Net Interest				1,649	1,521	128 (F)	18,134	18,101	32 (F)
-	Unwinding of Discounts				-	108	(108) A	-	108	(108) A
19,878	**Net (Deficit)/Surplus**	**5998**	**6326**	**-329**	**1,533**	**2,012**	**(479) A**	**19,200**	**33,276**	**(14,076) A**

The overall income and expenditure position for the Trust at Month Ten showed a cumulative deficit of £33.3m, £14.1m adverse against Plan. In the month, there was a deficit of £2.0m, £0.5m adverse against Plan.

Central income continued to over perform in the month, but to a lesser degree than earlier in the financial year, with a larger mix of non-elective activity compared to elective, with non-elective work attracting only 30% of tariff, in respective of activity above the 2008/09 threshold. Pay saw a further overspending in the month of £0.2m, which is below the previous monthly run rate of £0.9m, although this is primarily due to a reversal of £0.7m agency staff accruals relating to Months 1 to 9 of the financial year (this is part of the planned year end release of accruals from the balance sheet). Non-pay also saw an overspending of £0.2m, but again benefited from a non-recurrent accrual reversal of £0.2m (in respect old disputed invoices from the Trust's previous photocopier supplier) and £0.2m gas rebate. Therefore there was an underlying overspending of £0.6m on non-pay, compared with a prior monthly run rate overspending of £0.9m. The overspendings on both pay and non-pay are largely linked to ongoing activity pressures and failed CIP, particularly Length of Stay, and continued high levels of temporary staffing.

There was a shortfall against CIP target of £0.8m in the month, in respect of unidentified schemes, although this was partially offset by uncommitted reserves of £0.4m and a net underspending of £0.1m from non-operating budgets, i.e. depreciation, PFI interest and PDC Dividend.

2. Income

This section reports on the Trust income position, primarily in relation to PCT contract income. Income performance is an important element of the monthly performance review meetings with the clinical divisions and forms part of the overall assessment of financial performance of each division.

The following table summarises the overall Trust income position: For Central Income this has been represented against a re-phased plan (equal twelfths).

Income Type	Annual £ Plan	£ FOT	£ FOT Var	Monthly £ Actual	Monthly £ Var	YTD £ Actual	£ Var
	£000k	£000k	£000k	£000k	£000k	£000k	£000k
PbR	269,061	280,161	11,100	23,180	758	258,136	11,497
Non PbR	91,540	92,356	816	7,700	72	85,382	1,471
Central Income	**360,601**	**372,517**	**11,916**	**30,880**	**830**	**343,518**	**12,967**
Other Income	43			31	31	866	823
Divisional Income	35,281			2,610	(460)	28,717	(3,259)
Trust Income	**395,924**			**33,522**	**402**	**373,101**	**10,531**
Prior Period Adj	0					0	0
Trust Income	**395,924**					**373,101**	**10,531**

The overall position shows a £10.5m favourable variance year to date, including a £12.97m favourable variance on central income (still referred to as 'central' income here, to distinguish from other income that has always formed part of the Divisional budgets). The forecast outturn position is based on an extrapolation of the months 1 to 11 year to date position (net of provisions) through to month 12. There is a total of £2m provided for in the forecast.

Income by Point of Delivery

Income by point of delivery is as follows:

POD	Annual £ Plan	£ FOT	£ FOT Var	Monthly £ Actual	Monthly £ Var	YTD £ Actual	£ Var	Var
	£000k	£000k	£000k	£000k	£000k	£000k	£000k	%
A&E	17,577	18,759	1,182	1,560	95	17,199	1,087	-6.75%
Critical Care	23,207	24,129	922	2,288	354	21,856	582	-2.74%
DC & EL	51,425	52,675	1,250	3,825	(460)	49,300	2,160	-4.58%
NEL	128,970	132,332	3,362	11,259	512	121,073	2,851	-2.41%
XBD	10,730	12,008	1,278	1,188	294	10,820	984	-10.01%
Direct Access	14,081	15,072	991	1,175	2	13,897	989	-7.66%
OP 1sts	29,175	32,282	3,106	2,494	63	29,788	3,044	-11.38%
OP Follow Ups	34,960	35,271	311	2,728	(185)	32,543	496	-1.55%
OP Procedures	3,936	5,102	1,166	383	55	4,719	1,111	-30.79%
Other	46,540	44,887	(1,653)	3,980	102	42,324	(337)	0.79%
Total	**360,601**	**372,517**	**11,916**	**30,880**	**830**	**343,518**	**12,967**	**-3.92%**

Day case and In-patient Elective activity over performed by 590 spells over the plan, giving a £2.2m over-performance year to date, although it should be noted there was under-performance of £0.5m in the month. Conversely, non-elective income saw an over-performance of £0.5m in the month (£2.9m year to date). Due to the PbR rule that any non-elective activity above 2008/09 baseline can only be charged at 30% of full tariff, the Trust has effectively 'lost' £2.6m as a result of this.

Outpatient activity has not seen the reductions required by the Outer North East London PCTs (ONEL). Therefore outpatient activity is over performing in total by £4.6m at month 11 (7.4%).

Finally a provision against almost all excess bed day over performance has been made as PCT's will impose KPI penalties against length of stay reductions not achieved. Also provisions against the London Ambulance and Length of Stay targets have been made against the income position in anticipation of PCT fines being imposed.

Income by Division

Income performance by Division is as follows:

Division	Annual £ Plan	£ FOT	£ FOT Var	Monthly £ Actual	Monthly £ Var	YTD £ Actual	£ Var
	£000k	£000k	£000k	£000k	£000k	£000k	£000k
A&E	23,082	25,222	2,140	2,069	146	23,230	2,072
Corp	12,142	8,649	(3,493)	540	(472)	8,380	(2,749)
CSS	35,017	35,965	948	2,872	(47)	33,205	1,106
Medicine	90,746	91,704	958	8,099	537	83,907	723
Surgery	124,758	134,695	9,937	10,873	476	124,690	10,328
W&C	74,856	76,281	1,425	6,428	190	70,105	1,488
Total	**360,601**	**372,517**	**11,916**	**30,880**	**830**	**343,518**	**12,967**

The main area of over performance at month 11 is in the surgical directorate. As most of the PCT outpatient reduction plans focused on the surgical areas, their aim to decommission activity of 70,000 attendances in year does not appear to have worked in the first 11 months of this year. The plan is profiled on working days for outpatients. The YTD over-performance in A&E includes c.£1m income that is attributable to the Medical Division but is yet to be agreed as a change.

Non PbR Income

Non PbR Income includes other income not strictly related to healthcare income. Road traffic Accident Income and ISTC income is valued here as well as Non clinical income as part of the main SLA contracts.

Other Divisional Income

The main components of other divisional income are doctor and nurse training income, overseas and private patients, pharmacy production and SLA's, car parking charges, patient transport, building rental and the plastics contract.

3. Revenue Expenditure

Pay – (£0.2m) adverse in month and (£9.2m) Adverse YTD. Overall there was a £234k overspending in the month, but this was net of a £670k reversal of agency staff accruals related to Months 1 to 9 this financial year. Most of this reversal related to Medical staff (£396k) and Qualified Nursing (£190k). The large majority of the pay overspend to date relates to Medical Staffing, primarily driven by high agency premia and additional sessional rate payments.

The table below shows the expenditure and variance against budget for each staff group:

Staff Type	Budget WTE	Actual WTE	Var. WTE	M11% of WTE	M11 Budget £000	M11 Actual £000	M11 Var £000	M11 % of Spend	YTD Budget £000	YTD Actual £000	YTD Var £000	YTD % on spend
Mdical Staff	897	917	(20) A	(2%) A	6,313	6,451	(138) A	(2%) A	69,813	78,393	(8,581) A	(12%) A
Scientific, Therap & Techniccal	941	925	15 F	2% F	3,363	3,536	(173) A	(5%) A	37,014	37,808	(794) A	(2%) A
Nursing & Midwifery - Qual.	1,943	2,221	(278) A	(14%) A	7,201	7,404	(202) A	(3%) A	80,453	80,992	(538) A	(1%) A
Nursing & Midwifery - Unqal.	745	842	(97) A	(13%) A	1,554	1,558	(4) A	(0%) A	17,225	17,456	(231) A	(1%) A
Ancillary Staff	331	331	() A	(0%) A	702	673	29 F	4% F	7,700	7,526	174 F	2% F
Management & Admin Staff	1,142	1,090	52 F	5% F	3,225	2,971	254 F	8% F	35,526	34,802	724 F	2% F
Total	**5,998**	**6,326**	**(329) A**	(5%) A	**22,358**	**22,592**	**(234) A**	(1%) A	**247,730**	**256,976**	**(9,246) A**	(4%) A

Below shows a sub analysis breakdown of the major overspending staffing groups by source of staffing with the %showing the proportion of each as a total of that staff group.

Staff Type	Bdgt WTE	Actual WTE	Var WTE	M11 % of WTE	M11 Bdgt £'000	M11 Actual £'000	M11 Var £'000	M11 % of Spend	YTD Bdgt £'000	YTD Actual £'000	YTD Var £'000	YTD % of Spend
Medical Staff												
Permanent	901	767	133 F	84%	6,461	5,634	827 F	87%	71,039	62,788	8,250 F	80%
Bank	(12)	90	(102) A	10%	(155)	518	(673) A	8%	(1,497)	7,174	(8,671) A	9%
Agency	8	60	(51) A	6%	7	695	(688) A	5%	271	8,827	(8,556) A	11%
Scientific, Therap & Technical												
Permanent	939	859	80 F	93%	3,346	3,139	207 F	88%	36,893	34,132	2,762 F	90%
Bank	-	-	-		(0)	22	(22) A	1%	(0)	56	(56) A	
Agency	2	67	(65) A	7%	17	375	(358) A	11%	121	3,620	(3,499) A	10%
Nursing & Midwifery - Qual.												
Permanent	1	1,877	252 F	85%	7,651	6,385	1,266 F	86%	83,831	68,307	15,523 F	84%
Bank	(61)	268	(329) A	12%	(112)	705	(817) A	7%	31	7,343	(7,312) A	9%
Agency	(124)	77	(201) A	3%	(344)	497	(841) A	7%	(3,476)	5,525	(9,001) A	7%

Medical Staff continues to overspend in each of the clinical Divisions, totalling (£0.1m adverse in month – net of £0.4m agency accrual reversal) and (£8.6m) adverse YTD:

The table below shows the Divisional breakdown.

Division	M11 Actual £'000	M11 Var £'000	YTD Actual £'000	YTD Var £'000
Medical	1,362	27 F	15,977	(791)A
Emergency	676	(142)A	7,619	(1,569)A
Surgical	2,864	(268)A	33,485	(4,758)A
Women & Children	1,090	(116)A	11,863	(959)A
Clinical Support	799	(46)A	8,995	(791)A
Corporate	55	13F	734	7F
Central (accrual reversal in month)	(396)	396F	(280)	280F

Much of the Surgical Division overspend is derived from additional activity above contract plan, often delivered through agency staff employed at premium rates. It therefore also represents the largest contributing factor toward failed CIP within the Division. PCT Demand management schemes still do not appear to have been effective in many areas. The main specialties with over performance and correlating overspends are within ENT, T&O and Neurosciences, often related to 18 week pressures. The overspending in A&E is largely due to the reliance on temporary staff at premium rates, due to the national shortage of staffing and the inability to fill posts permanently. Women and Children is largely related to Paediatric pressures and sickness/absence.

At a corporate level there have been a number of actions that are being implemented to mitigate the position. These are:

- Caps on medical agency rates paid
- Negotiations with medical agencies to recruit fixed term locums for the Trust, for a negotiated placement fee, and thus avoid extremely high agency staff rates
- Agreement to pay additional consultant PA sessions at standard rates and conversion of non-clinical to clinical sessions
- Review of consultant job plans
- Specific A&E Workforce Recruitment Plan
- Implementation of tighter controls / restrictions

Nursing significantly overspent in the month (£206k – net of £190k agency accrual reversal) taking the YTD position to (£769k) adverse.

Nursing spend continues to be impacted by the additional bed pressures and opened wards against failed LOS/Ward closure CIP. This is also affecting the ability of the organisation to run at planned CQC levels without ongoing significant temporary staffing. The year to date overspend is less than expected due to the inability to fill all the requested shifts. This is born out by the fact that recent increases in Permanent staffing has led to an increase in overall pay rather than a like for like reduction, or better, in Temporary Staffing expenditure.

Scientific, Therapeutic & Technical Staff are over spent (£173k) in month and (£794k) YTD. This is mostly within Radiology, Neuro and Therapies, from additional activity and high reliance on temporary staffing.

The table below shows the divisional Pay split and the Trust Wide split of expenditure between permanent and temporary staff groups.

Division	Bdgt WTE	Actual WTE	Var WTE	M11 % of WTE	M11 Bdgt £'000	M11 Actual £'000	M11 Var £'000	M11 var % of Budget	YTD Bdgt £'000	YTD Actual £'000	YTD Var £'000	YTD Var % of Budget
Medical	958	1,144	**(187) A**	**(20%) A**	3,766	3,782	**(15) A**	**(0%) A**	41,350	42,266	**(916) A**	**(2%) A**
Emergency	322	410	**(88) A**	**(27%) A**	1,352	1,823	**(472) A**	**(35%) A**	15,715	19,532	**(3,817) A**	**(24%) A**
Surgical	1,424	1,566	**(141) A**	**(10%) A**	6,067	6,379	**(312) A**	**(5%) A**	67,495	71,485	**(3,990) A**	**(6%) A**
Women & Children	909	906	**3 F**	**0% F**	3,379	3,550	**(172) A**	**(5%) A**	37,622	38,742	**(1,119) A**	**(3%) A**
Clinical Support	1,532	1,521	**11 F**	**1% F**	5,272	5,368	**(96) A**	**(2%) A**	57,981	58,954	**(973) A**	**(2%) A**
Corporate	853	779	**74 F**	**9% F**	2,522	2,360	**163 F**	**6% F**	27,567	26,534	**1,034 F**	**4% F**
Central Income & Expenditure	0	0	-		-	(671)	671 F		-	(536)	536 F	
TRUST TOTAL	**5,998**	**6,326**	**(329) A**	**(0)**	**22,358**	**22,592**	**(234) A**	**(1%) A**	**247,730**	**256,976**	**(9,246) A**	**(4%) A**

Trust Wide

Permanent	6,185	5,439	747 F	86%	23,018	19,888	3,130 F	88%	253,096	218,231	34,865 F	85%
Bank	-74	669	(743) A	11%	(276)	1,710	(1,986) A	8%	(1,599)	19,680	(21,280) A	8%
Agency	-114	219	(333) A	3%	(384)	1,665	(2,049) A	7%	(3,766)	19,601	(23,367) A	8%
Other (primarily agency reversal)	0	0	-		-	(671)	671 F		-	(536)	536 F	
TRUST TOTAL	**5,998**	**6,326**	**(329) A**	**(0)**	**22,358**	**22,592**	**(234) A**	**(1%) A**	**247,730**	**256,976**	**(9,246) A**	**(4%) A**

It can be seen that the most significant pay cost pressure is within Emergency, driven primarily by the high use of agency and associated premium costs, particularly of Medical Staff. Surgery is also high in absolute terms and both are discussed above.

Non Pay – (£0.2m) adverse in month and (£9.8m) adverse YTD.

Annual Budget £'000	I&E Description	M11 Bdgt £'000	M11 Actual £'000	M11 Var £'000	M11 % of Spend	YTD Bdgt £'000	YTD Actual £'000	YTD Var £'000	YTD % of Spend
25,319	Drugs	2,095	2,319	(224) A	-11%	23,063	25,864	(2,801) A	-12%
27,061	Clinical Supplies & Appliances	2,226	2,356	(130) A	-6%	24,836	27,294	(2,458) A	-10%
15,529	General Supplies & Services	1,285	1,440	(155) A	-12%	14,244	15,596	(1,351) A	-9%
15,565	Premises & Fixed Plant	1,354	960	393 F	29%	14,206	14,268	(62) A	0%
33,300	Other Non Pay	2,765	2,855	(90) A	-3%	30,568	33,682	(3,114) A	-10%
116,774	TOTAL	9,725	9,931	(206) A	-2%	106,917	116,703	(9,787) A	-9%
	Major Other Non Pay Variances								
307	*Course Fees*	*26*	*61*	*(35) A*	*-139%*	*281*	*362*	*(81) A*	*-29%*
1,795	*External Consultancy Fees*	*149*	*61*	*88 F*	*59%*	*1,679*	*1,950*	*(271) A*	*-16%*
2,221	*Hcare Srv Rec Other NHS*	*181*	*235*	*(54) A*	*-30%*	*2,040*	*2,264*	*(223) A*	*-11%*
387	*Legal / Prof Fees*	*32*	*7*	*25 F*	*78%*	*355*	*540*	*(185) A*	*-52%*
14,594	*Miscellaneous Expenditure*	*1,211*	*1,208*	*(4) A*	*0%*	*13,383*	*13,486*	*(103) A*	*-1%*
280	*Commercial Sector (incl. outsourcing)*	*23*	*19*	*4 F*	*16%*	*256*	*1,020*	*(764) A*	*-298%*
1,358	*SrvcsRecd-Other NHS*	*113*	*137*	*(24) A*	*-21%*	*1,245*	*1,334*	*(89) A*	*-7%*
688	*IntRcg Recd Estates*	*57*	*60*	*(3) A*	*-6%*	*630*	*657*	*(27) A*	*-4%*
-	*Interpreting services*	-	*0*	*() A*		-	*55*	*(55) A*	

Drugs and Clinical Supplies continue to be the major areas of Non Pay over spend year to date.

- Drugs overspends are mostly within areas of over performance and growth areas that involve high cost drugs, including Oncology (£744k) and Rheumatology (£739k), but also in areas like Endoscopy (£307k), which is primarily activity driven. Pharmacy (£509k) Adv YTD, is mostly due to FP10s prescribing; Sexual Health (predominantly HIV) accounts for (£118k) adverse YTD. There is also CIP failure of £441k YTD within Medicine and Surgery.

- Clinical Supplies & Appliances are predominantly overspent due to: Medical & Surgical Equipment, mostly in Surgery through: Theatres largely prosthesis and patient appliances, accounts for (£1,052k) Adv YTD; Neurosciences (£302k) Adv YTD; Midwifery (£425k) adv YTD, and Radiology (£333k) Adv YTD. Most of these are impacted by additional activity above plan and in instances high product costs.

- General Supplies & Services are (£155k Adv in month and(£1,351k) Adv YTD. Although there is an overspend in Theatres (£207k) Adv YTD due to activity, most of this is in Corporate areas and relates to Staff Recruitment, managed print and dual running in Procurement and Patient Transport. The latter being due to often late and unplanned nature of discharges, requiring expensive short notice out of hours ambulance transport.

- Premises and fixed plant £393k Fav in month, primarily relates to the reversal a gas rebate of £220k and reversal of photocopier contract charges of £180k, from the previous supplier which had been in dispute, but are now resolved

- Other Non Pay – The adverse variance YTD is mostly attributable to: Redundancy provisions (£1.3m); Commercial Sector Outsourcing (£0.8m) Adv YTD, mostly in Surgery (ENT) and Radiology, but with some in Pathology and Midwifery; Legal & Professional Fees totalling (£0.2m) Adv YTD which has come down significantly; and External Consultancy Fees (£0.3m) Adverse YTD which has seen a run rate reduction in HR and Clinical Governance. The majority of External Consultancy Fees are attached to a number of various project work and temporary management solutions in A&E and LOS Project.

4. Divisional Summary

Annual Budget £'000	Division	Budget WTE	Actual WTE	Var WTE	M11 Budget £'000	M11 Actual £'000	M11 Var £'000	YTD Budget £'000	YTD Actual £'000	YTD Var £'000
45,078	Medical	959	1,144	(186) A	3,758	3,869	(112) A	41,486	44,230	(2,744) A
17,775	Emergency	322	410	(88) A	1,409	1,970	(561) A	16,367	21,077	(4,711) A
85,668	Surgical	1,424	1,566	(141) A	7,047	7,781	(734) A	78,671	87,815	(9,145) A
43,077	Women & Children	909	906	3 F	3,472	3,890	(419) A	39,613	42,109	(2,496) A
75,844	Clinical Support	1,532	1,521	11 F	6,242	7,018	(777) A	69,602	77,469	(7,866) A
74,896	Corporate	853	779	74 F	6,307	5,780	527 F	68,926	70,693	(1,767) A
(322,460)	Central Income & Expenditure	0	0	-	(26,701)	(28,298)	1,597 F	(295,465)	(310,118)	14,653 F
19,878	**Total**	**5,999**	**6,326**	**(327) A**	**1,533**	**2,012**	**(479) A**	**19,200**	**33,276**	**(14,076) A**

MEDICINE:

Medical	Month Budget £000	Month Actual £000	Month Variance £000	YTD Budget £000	YTD Actual £000	YTD Variance £000
Income	(469)	(565)	96	(5,104)	(5,178)	75
Pay	3,766	3,782	(15)	41,350	42,266	(916)
Non Pay	558	653	(95)	6,368	7,142	(774)
CIP / Turnaround Target	(97)	-	(97)	(1,128)	-	(1,128)
Total	**3,758**	**3,870**	(111)	**41,486**	**44,230**	(2,744)

Income
£96k in month favourable position reflects BLT/Renal Dialysis SLA £104k and Junior Doctors Training £28k recovery exceeding unachieved CIP target of £(33)k. Year to date favourable position of £75k reflects income from Renal Dialysis Unit 104k, Realignment of Junior Doctors income £167k, Erica/Japonica DTOC income of £118k exceeding unachieved CIP pressure £(393)k.

Pay

Medical staff £(27)k in-month adverse movement due to temporary staff CIP £(62)k only being partially met by favourable rates negotiated for agency cover and booking reduction. Year to date £(791)k deficit reflects £(688)k unachieved CIP £(64)k AAU secondment and £(153)k Endoscopy Blitz payments.

Nursing Staff £(51)k in-month adverse movement is driven by Ward closure slippage £(69)k and Endoscopy Blitz payments £(29)k against Specialty Nurse vacancies £47k. Year to date £(164)k adverse reflects unutilised CQC resources and specialty vacancies being short of the £(864)k Ward Closure slippage and Endoscopy Blitz £(282)k

Non-Pay

Drugs £(57)k in month adverse movement mainly due to Drug Management CIP slippage £(39)k and net adverse movement through Specialty prescribing £(21)k (incl. High cost drugs). Year to date £(450)k deficit reflects effect of CIP slippage £(266)k against Specialty and high cost prescribing £(184)k.

Clinical Supplies & Services £(23)k adverse movement as a result of Length of Stay reduction CIP failure £(10)k and Pacemaker procurement £(10)k. Year to date £(240)k deficit reflects Pacemaker activity pressure £(86)k, White Cell Apheresis £(20)k and Ward procurement £(134)k.

CIP

Unallocated Gap (£97k) (Adverse). Current month being adverse impact of Local CIP target through refinancing of Cardiology Nurse Vacancies £(16)k, CQC Ward closure £(30)k resource due to closure slippage, balance from control total stretch £(22)k and PEQ CIP gap £(30)k. Year to date deficit is (£1,128k).

EMERGENCY:

Emergency	Month Budget £000	Month Actual £000	Month Variance £000	YTD Budget £000	YTD Actual £000	YTD Variance £000
Income	(65)	(65)	0	(713)	(722)	8
Pay	1,352	1,823	(472)	15,715	19,532	(3,817)
Non Pay	191	211	(20)	2,131	2,267	(136)
CIP / Turnaround Target	(70)	-	(70)	(766)	-	(766)
Total	**1,408**	**1,969**	**(562)**	**16,367**	**21,077**	**(4,711)**

Income:
In month break-even. Year to date £8k favourable position being over-recovery through Local Authority DTOC fines against under recovery of Junior Doctors Training income £(32)k.

Pay:
Medical staff £(142)k adverse movement being continuing recruitment and Deanery deployment pressures resulting in failure of the Temporary Staff CIP £(68)k and additional resource utilisation supporting activity pressures.£(74)k. Year to date £(1,569)k deficit being £(750)k unachieved CIP and £(819)k Temporary staff bookings/premiums.

Nursing Staff £(270)k reflects Admission avoidance and EDMU CIP slippage through staggered implementation and unrealised bed opportunity £(223)k, Bed & Site team CIP failure £(30)k. Year to date £(1,865)k deficit mainly reflects Admission/EDMU £(1,574)k and Bed & Site £(394)k CIP failures.

Management & Clerical £(58)k in-month deficit relates to unfunded Director and Divisional Manager Agency cover. Year to date £(376)k deficit reflects current.

Non - Pay:

General Supplies & Services £(13)k adverse position due to Doctor Recruitment fees. Year to date £(42)k deficit being Doctor recruitment fees totalling £(80)k.

CIP

Unallocated Gap (£70k) (Adverse). Current month being adverse impact of Local CIP target through refinancing of A&E Nurse Vacancies £(33)k, balance from control total stretch £(17)k and PEQ CIP gap £(22)k. Year to date deficit is (£766k).

SURGERY:

Surgical	Month Budget £000	Month Actual £000	Month Variance £000	YTD Budget £000	YTD Actual £000	YTD Variance £000
Income	(619)	(420)	(199)	(5,872)	(4,887)	(985)
Pay	6,067	6,379	(312)	67,495	71,485	(3,990)
Non Pay	1,623	1,822	(199)	18,038	21,217	(3,179)
CIP / Turnaround Target	(23)	0	(23)	(990)	0	(990)
Total	**7,048**	**7,781**	**(733)**	**78,671**	**87,815**	**(9,144)**

Income
Failed CIP relating to Absorbing Back Surgery, HCA, Diabetic Retinopathy & Neurophysiology, partly offset by Overseas & Private patient income.

Pay
Medical staff over-spent by (£268k) Adv / (£4,8m) Adv YTD. This was also due to failed Cost Improvement Programme as the planned reduction in Medical Staffing spend has not happened to the extent as PCT plans for reducing activity via POLCE and other Demand Management Schemes have failed to materialise as the Division has continued to over-perform against activity plan

Nursing (£75k) adv / and £648k F all areas under-spend, with the exception of Neurosciences, as a result of CQC investment however Nursing overall over-spends in the month as the areas are spending closer to budget as recruitment and agency usage increases meaning that they are no longer offsetting against the Cost Improvement plans around Length of Stay and Theatres that have not been successful (£140k) Adv / (£1m) Adv.

Non Pay
Drugs (£100k) Adv / and (£980k) Adv YTD due to the high cost of guidance regimes in Rheumatology.
Clinical Supplies (£59k) Adv / and (£1,4m) Adverse YTD due to Theatre and Neuro work.
General Supplies (£48k) ADV / and (£373k) ADV YTD. Consumables in Theatre drive this position in month and YTD.

CIP
Slippage continues, mainly around the demand management schemes and medical staff which are around £280k a month. There is still £1m of unidentified savings YTD.

CLINICAL SUPPORT SERVICES:

Clinical Support	Month Budget £000	Month Actual £000	Month Variance £000	YTD Budget £000	YTD Actual £000	YTD Variance £000
Income	(660)	(554)	(106)	(7,096)	(5,371)	(1,725)
Pay	5,272	5,368	(96)	57,981	58,954	(973)
Non Pay	2,019	2,204	(185)	22,072	23,886	(1,814)
CIP / Turnaround Target	(389)	0	(389)	(3,354)	0	(3,354)
Total	**6,242**	**7,018**	**(776)**	**69,603**	**77,469**	**(7,866)**

Income
£(106)k in month adverse variance being HCA activity £(143)k and Pharmacy commercial operation £(18)k downturn against IFR/ICDF income growth £44k. Year to date £(1,726)k deficit being HCA activity £(1,345)k and Production Unit commercial operations £(496)k under performance partially off set by IFR/ICDF income growth £168k and recovery of Radiology Harold wood Polyclinic service £154k

Pay
Medical staff £(46)k adverse variance being Radiologist delivery of diagnostic waiting times £(34)k and unfunded Locum Histopathologist £(20)k. Year to date £(790)k deficit being Radiologist £(526)k and Pathologist £(283)k cover.

Scientific Therapeutic and Technical staff £(197)k in month deficit reflects Radiographer waiting time and Polyclinic support £(102)k cover plus Therapy project support to EAU £(99)k. Year to date deficit of £(858)k arising from Therapy £(606)k AEU support and premium rate of vacancy cover plus Radiographer £(788)k waiting time pressure being partially mitigated by vacancies in Pharmacy £313k, Oncology £108k and Pathology £96.

Management and Admin £123k in month favourable position reflects downturn in temporary staff bookings producing under-spends in Medical Secretariat £30k, Outpatients / Medical records Admin £50k. Year to date £489k favourable position is due to Outpatient £272k, Medical Secretary £108k, and Pathology £85k vacancies.

Non-Pay
Drugs in month £(119)k deficit created by Pharmacy FP10 £(61)k and Oncology prescribing growth through ICDF/IFR £(44)k. Year to date £(1.2)m pressure being Oncology prescribing growth £(557)k, FP10 £(356)k and Pharmacy dispensary £(151)k.

Clinical Supplies & Services break-even in month through downturn in PNS service £11k, MES savings £16k financing activity pressures in Microbiology £(13)k and Coiling Service procurement £(24)k. Year to date over spent £(224)k being Wheelchairs £118k against Coiling £(296)k and Orthotic £(35)k costs.

Other Non-Pay £(70)k in month adverse position due to Therapy ONEL SLA price increase £(57)k and Pathology outsourcing £(32)k. Year to date £(331)k adverse position reflects cost of outsourcing in Radiology £(254)k and Pathology £(118)k.

CIP
In month and year to date gap being £(389)k and £(3,354)k respectively.

WOMENS & CHILDRENS:

Women & Children	Month Budget £000	Month Actual £000	Month Variance £000	YTD Budget £000	YTD Actual £000	YTD Variance £000
Income	(353)	(256)	(97)	(3,401)	(3,305)	(96)
Pay	3,379	3,550	(171)	37,622	38,742	(1,120)
Non Pay	510	596	(86)	5,742	6,672	(930)
CIP / Turnaround Target	(65)	0	(65)	(350)	0	(350)
Total	**3,471**	**3,890**	**(419)**	**39,613**	**42,109**	**(2,496)**

Income

- The in month adverse variance of £96k and the YTD adverse position of £96k overspend is due to the CIP slippage on Income. Previously this has been offset by over achieved income on Private Patients and Overseas Patients, Out of London HIV Patients

Pay

- The in month adverse variance in month of £172k and £1119k adverse variance YTD.
- Medical staffing of £116k in month variance is mainly due to Medical staffing overspends mainly in Paediatrics mainly driven by Agency SPR and SHO costs, Maternity Cover together with high level of sickness among Medical staff especially within Consultant grades which had to be backfilled due to winter pressures therefore slipping the Paediatric Workforce cost reductions expected of £90k , there has also been a non recurrent payment for pay arrears to the Associate specialist in month of £17k, the bed base reduction expected from current 50 to 38 has not been actioned which was a part of the configuration due to severe bed pressures in month offset against under-spends in Sexual Health Medical Consultant vacant post.
- The Nursing Spend on Qualified and Non Qualified has over-spent by £55k in month and under-spend £30k YTD. Temporary staffing costs in Midwifery have increased slightly, and will increase further after the recent CQC visit (whereas the previous forecast had anticipated a reduction). Paediatrics Nursing spend was expected to be a lot lower in line with the Paediatric Taskforce Reconfiguration, which required the bed base to be reduced to 38 from the current 50 which has slipped and is expected not to deliver any savings as expected from the business case.
- There is also overspend in Management and Admin mainly in Sexual Health which is a cost pressure driven by the call centre currently offset against vacancies in Nursing.

Non Pay

- The in month adverse variance of £86k and £845k adverse variance YTD mainly on Clinical Supplies (£67k in month) which is mainly in Maternity and NICU which is activity driven and also cost pressure due to Consultancy fees for the Paediatric Workforce Review which is not funded and also slippage in non pay CIP expected not materialising so far which accounts for £20k in month and £220k YTD. Drugs under-spending in month and over-spending by £64k YTD mainly in Sexual Health mainly due to higher activity in GUM , FP and also due to Out of London HIV patients which is being offset against income for OUL patients.
- The other Non Pay overspend of £28k in month and £233k YTD is driven by External consultancy fees in Paediatrics which is not budgeted therefore a cost pressure , and higher costs on Maternity storage and specialist tests to outside bodies . There is also non recurrent spend of £10k in Paediatrics for Outreach Clinics to replace clinics due to Consultant being sick which are specialist clinics which is an additional cost pressure contributing to the overspend YTD.

CIP

- CIP/Turnaround £65k adverse in month and £350k adverse YTD

  Current month adverse is due to the gap still to be identified which is primarily to reduce the run rate which is not being fully achieved

CORPORATE

Corporate	Month Budget £000	Month Actual £000	Month Variance £000	YTD Budget £000	YTD Actual £000	YTD Variance £000
Income	(904)	(854)	(50)	(9,791)	(9,360)	431
Pay	2,522	2,360	162	27,567	26,534	(1,034)
Non Pay	4,824	4,275	549	52,566	53,519	953
CIP / Turnaround Target	(135)	0	(135)	(1,417)	0	1,417
Total	**6,307**	**5,781**	**526**	**68,925**	**70,693**	**1,767**

- ***Human Resources – £60k Favourable in month and (£444k) Adverse YTD.*** The in month favourable variance is mainly due £37k favourable income variance in Occupational Health, YTD adverse variance predominantly associated with agency cover for vacancies and Advisors, which has now been stopped, as well as nursing support in Occ Health for the flu campaign. Non Pay is (£165k) Adv YTD, mostly from External Consultancy usage and Recruitment fees but is slowing down under spending in month by £29k due to reduced Consultancy and legal fees in month.
- ***Education – £5k Favourable in month and (£126k) Adverse YTD.*** The YTD adverse variance is due to a £269k income shortfall against budget for Medical and Nurse education, which is partly offset by an under spending of £174k on student nurses. The YTD position also had the benefit of the release of deferred income carried from 09/10 ,which was no longer required .
- ***Director of Finance – £99k Favourable in month and (£1,166k) Adverse YTD***. The main overspends are related to Photocopier contracts and Stationery, in respect of slippage on the Managed Print CIP, dual contract running in Procurement and increased Patient Transport hire, largely related to short notice out of hours discharge requiring premium rate patient transport within Logistics. The YTD also includes a £274k bill for contribution to Parkhill Audit which is non recurrent and is currently under review with the Parkhill Consortium Board.
- ***Strategy & Planning (incl. IT) – (£4k) Adverse in month and (£491k) Adverse YTD.*** The YTD variance is due to under delivery of CIP of £277k and non-pay overspend of £242k, primarily due to Phone Rental, PAS Server and IT Maintenance pressures.
- ***Head of Estates – £360k Favourable in month and 377k Favourable YTD.*** The in month favourable movement is primarily related to the Gas rebate of £220k.
- ***Director of Performance & Planning – (£24k) adverse in month and (£111k) Adverse YTD.*** This is predominantly from External Consultancy relating to Length Of Stay.
- ***Director of Nursing – £5k Favourable in month and £94k Favourable YTD.*** This is due to staff vacancies being managed to achieve the CIP target and mitigating the additional cost pressure for the Deputy Director of Nursing recharge from Whipps Cross Hospital.

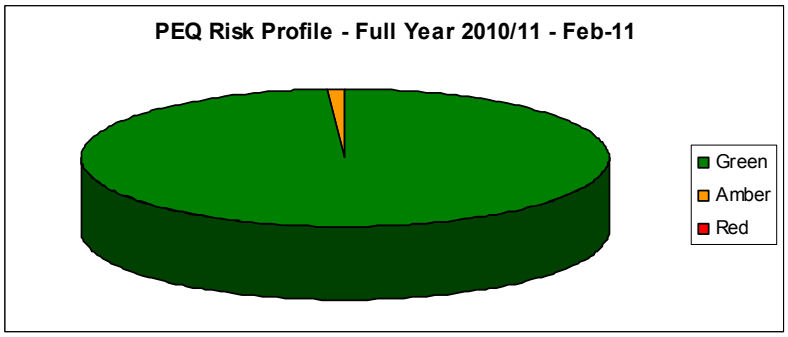
5. PEQ Programme

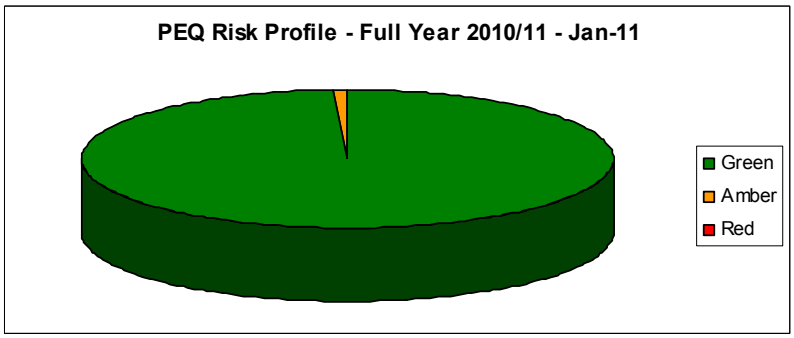
February PEQ and recovery cost reduction schemes delivered £2.8m which was in line with forecast in aggregate for the month, against a budget of £3.4m. Included in this was £670 in balance sheet review items as part of the recovery (forecast £500k in month) and an underlying £2.1m (forecast £2.3m) from identified PEQ schemes. The shortfall from identified schemes arose primarily from an increase in agency expenditure in midwifery of £100k following the warning notice from the CQC, the estates impact of wards remaining open, and shortfall in additional occupational health income. Other actions, including a continued reduction in temporary staff costs, were in line with expectations.

The current forecast for the full year remains at £22.9m. The majority of immediate cost reduction actions for March will attempt to reduce expenditure but will not deliver addition CIP.

	ADtual			Full Year	
	Plan YTD	Actual YTD	Var YTD	Budget	Forecast
P1 Bed Reconfiguration	3,490	2,240	(1,250)	4,332	2,534
P2 Surgery Efficiency	1,034	891	(143)	1,128	962
P3 Capacity Planning	1,484	346	(1,138)	1,809	347
E1 Workforce Reform	6,311	5,656	(655)	6,974	6,510
E2 Medical Staffing	1,582	815	(767)	1,738	874
E3 Temporary Staff	5,603	2,791	(2,812)	6,140	3,197
E4 Non pay	2,951	2,128	(823)	3,363	3,282
E5 Commercials	2,072	3,393	1,321	2,268	4,268
E6 Non SLA income	2,566	667	(1,899)	2,915	761
Q1 Outpatients	32	0	(32)	36	0
Q2 Patient Services	730	94	(636)	807	164
Unidentified	4,151	0	(4,151)	4,377	0
Total	**32,006**	**19,021**	**(12,985)**	**35,887**	**22,900**

PEQ schemes seeking to reduce budgeted expenditure are now in place. Remaining risk on actions for March relate to actions to deliver CIP against temporary staffing initiatives.



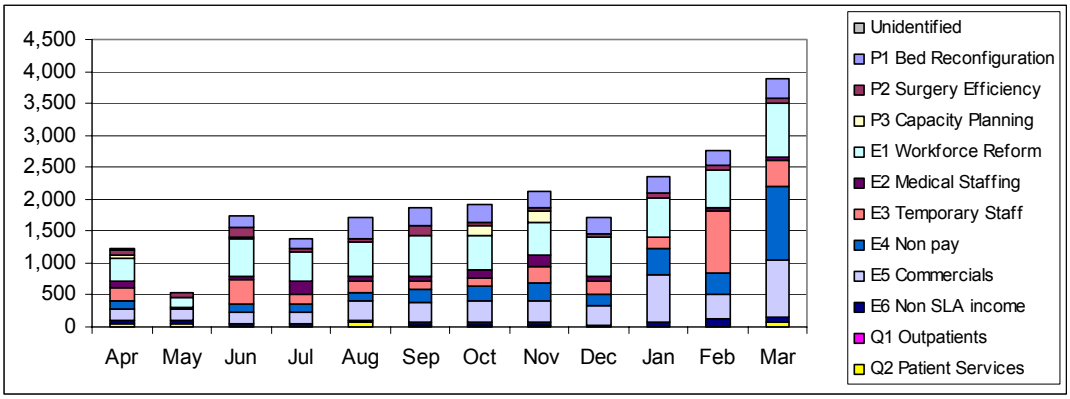


The recovery plans include actions for increased rigour around balance sheet controls, e.g. accruals for pay and non-pay, provisions and prepayments, ensuring all appropriate assets and resources are capitalised correctly, and tightening controls around stock taking and valuation for the year end. Most of these actions will have a direct outcome as at the end of March, but significant work has already been undertaken to validate and quantify these actions.

In February, a thorough review of accruals for temporary staff pay highlighted significant provisions for shifts booked more than 3 months ago but where the booking has not been paid or confirmed as worked. In doing so, the total provision has been reduced by £670k from £4.2m to £3.5m, of which £860k relates to shifts more than 3 months old. Further work is being undertaken, both centrally and by the divisions to further validate and clear down old shifts which were not worked, and to refine the provisioning methodology for these aged accruals.

Turnaround Profile

The recovery plans linked to cost improvement schemes are included in the phasing forecast below, and are still expecting to deliver short term, predominantly non-recurrent savings by the end of the year.



Divisional Summary

Medicine

Medicine division achieved in month savings of £480k which was consistent with the previous month and the February forecast. Expectations of limited bed closures are now expected in March, with Angelica ward now closed, but pressure remains on releasing further beds ahead of the end of March.

	Plan YTD	Actual YTD	Var YTD
Total Expenditure	47,934	49,019	(1,085)
CIP (By Scheme)	(4,926)	(4,789)	(137)
Unidentified CIP	(1,522)	0	(1,522)
Total	41,486	44,230	(2,744)

	Plan YTD	Actual Actual YTD	Var YTD
CIP Schemes			
P1 Bed Reconfiguration	2,348	2,275	(73)
P2 Surgery Efficiency	0	0	0
P3 Capacity Planning	366	2	(363)
E1 Workforce Reform	533	930	397
E2 Medical Staffing	445	576	131
E3 Temporary Staff	640	583	(57)
E4 Non pay	411	181	(230)
E5 Commercials	0	0	0
E6 Non SLA income	184	241	57
Q1 Outpatients	0	0	0
Q2 Patient Services	0	0	0
Unidentified	1,522	0	(1,522)
Total CIP	6,448	4,789	(1,659)

Emergency

There have been no new savings delivered in month, and minimal additional actions for the remainder of the year. The divisional management team has now been restructured, and is being managed with Medicine.

	Plan YTD	Actual YTD	Var YTD
Total Expenditure	19,213	21,337	(2,124)
CIP (By Scheme)	(1,934)	(260)	(1,675)
Unidentified CIP	(912)	0	(912)
Total	16,367	21,077	(4,710)

	Plan YTD	Actual Actual YTD	Var YTD
CIP Schemes			
P1 Bed Reconfiguration	100	0	(100)
P2 Surgery Efficiency	0	0	0
P3 Capacity Planning	950	0	(950)
E1 Workforce Reform	0	0	0
E2 Medical Staffing	0	0	0
E3 Temporary Staff	613	0	(613)
E4 Non pay	225	260	35
E5 Commercials	0	0	0
E6 Non SLA income	0	0	0
Q1 Outpatients	0	0	0
Q2 Patient Services	46	0	(46)
Unidentified	912		(912)
Total CIP	2,846	260	(2,586)

Surgery

Efforts continued to constrain additional and temporary staff expenditure which is unbudgeted. CIP delivery was in line with prior months, with no new CIP's in the month Continued pressure remains on the use of agency medical and nursing staff, including ITU and critical care.

	Plan YTD	Actual YTD	Var YTD
Total Expenditure	87,086	89,761	(2,676)
CIP (By Scheme)	(7,374)	(1,946)	(5,427)
Unidentified CIP	(1,041)	0	(1,041)
Total	78,671	87,815	(9,144)

	Plan YTD	Actual Actual YTD	Var YTD
CIP Schemes			
P1 Bed Reconfiguration	362	0	(362)
P2 Surgery Efficiency	1,036	528	(508)
P3 Capacity Planning	0	0	0
E1 Workforce Reform	1,552	1,291	(261)
E2 Medical Staffing	220	0	(220)
E3 Temporary Staff	2,984	64	(2,920)
E4 Non pay	302	14	(288)
E5 Commercials	0	0	0
E6 Non SLA income	917	50	(867)
Q1 Outpatients	0	0	0
Q2 Patient Services	0	0	0
Unidentified	1,041		(1,041)
Total CIP	8,415	1,946	(6,468)

Womens and Children

February savings forecast of £314k fell short by £90k as a result of additional agency midwives being hired to cover vacancies until substantive appointments commence later in the yearvings through the remainder of the year.

	Plan YTD	Actual YTD	Var YTD
Total Expenditure	43,205	44,149	(944)
CIP (By Scheme)	(3,223)	(2,040)	(1,183)
Unidentified CIP	(369)	0	(369)
Total	39,613	42,109	(2,496)

	Plan YTD	Actual Actual YTD	Var YTD
CIP Schemes			
P1 Bed Reconfiguration	0	0	0
P2 Surgery Efficiency	0	0	0
P3 Capacity Planning	0	311	311
E1 Workforce Reform	916	1,167	251
E2 Medical Staffing	372	126	(246)
E3 Temporary Staff	821	380	(441)
E4 Non pay	174	29	(146)
E5 Commercials	70	6	(64)
E6 Non SLA income	870	22	(848)
Q1 Outpatients	0	0	0
Q2 Patient Services	0	0	0
Unidentified	369		(369)
Total CIP	3,592	2,040	(1,552)

Clinical Support Services

Overall divisional expenditure remained stable in February, and reflects no additional CIP delivery in the month in excess to forecast. Savings continue to be from additional income from HCA, although this is significantly below targets. Overspending against budgets restrict further CIP delivery, with recovery plans seeking to reduce the overspend, primarily in therapies and radiology.

	Plan YTD	Actual YTD	Var YTD
Total Expenditure	77,826	82,879	(5,052)
CIP (By Scheme)	(5,978)	(5,410)	(568)
Unidentified CIP	(2,247)	0	(2,247)
Total	69,602	77,469	(7,867)

	Plan YTD	Actual Actual YTD	Var YTD
CIP Schemes			
P1 Bed Reconfiguration	252	0	(252)
P2 Surgery Efficiency	0	0	0
P3 Capacity Planning	171	0	(171)
E1 Workforce Reform	1,660	1,202	(458)
E2 Medical Staffing	547	4	(543)
E3 Temporary Staff	275	98	(177)
E4 Non pay	256	272	16
E5 Commercials	2,002	3,834	1,832
E6 Non SLA income	98	0	(98)
Q1 Outpatients	34	0	(34)
Q2 Patient Services	683	0	(683)
Unidentified	2,247		(2,247)
Total CIP	8,224	5,410	(2,815)

6. Forecast Outturn Position

The table below shows the evaluation of the M11 overall forecast outturn I&E position, compared with the M10 forecast.

(£'000)	Month 10 FOT Actual	Month 11 FOT Actual	Month 11 FOT Variance	Movement in FOT Month 10 to M11	Comment
Medical	48,315	48,032	2,954	-283	Renal charge -£104k; Med staff agency -£120k; Angelica closure -£50k
Emergency	22,923	22,900	5,125	-23	Destruction provision -£80k; mangt. costs -£40k; other +c£100k agency bookings
Surgical	95,474	95,593	9,899	119	Increase in Critical Care costs
Women & Children	45,558	46,048	2,971	490	Increase in agency midwives related to CQC report
Clinical Support	84,516	84,395	8,550	-121	ONEL SALT SLA reduction -£105k
sub-total	**296,786**	**296,968**	**29,499**	**182**	
Corporate	77,242	76,955	2,042	-287	Reversal of old accrual re RICOH photocopiers £180k
Sub-total	**374,028**	**373,923**	**31,541**	**-105**	
Central I&E:					
Central Income	-372,517	372,517	-11,916	0	
Depreciation	12,681	12,737	93	56	
Reserves	645	100	-2,402	-545	Previous VAT provision in forecast released to Divisional positions
Finance adjustments	-550	-185	-142	365	Increase in E'rs liability & bad debt provision
Net interest	-802	-789	220	13	
PDC Dividend	3,033	3,033	-183	0	
PFI Interest	20,675	20,525	-266	-150	
Sub-total	**37,193**	**-337,096**	**-14,596**	**-261**	
Recovery Plans	-4,250	-3,950	-3,950	300	Reduction in estimates for Hard FM and stock
Sub-total before redundancies	**32,943**	**32,877**	**12,995**	**-66**	
Redundancies	1,475	1,391	1,391	-84	
Grand Total	**34,418**	**34,268**	**14,386**	**-150**	
Recovery Plans					
Soft FM	-500	-300	-300	200	
Stock	-1,000	-850	-850	150	
Revenue to Capital	-1,250	-1,000	-1,000	250	
Balance Sheet review	-1,500	-1,800	-1,800	-300	
Total	**-4,250**	**-3,950**	**-3,950**	**300**	

Overall, the forecast is a £34.3m deficit, a marginal improvement from the M10 forecast. Within the Divisional and Corporate position, there is a marginal overall improvement with improvements in Medical, Clinical Support and Corporate mostly offset by an increase in agency midwife numbers, in response to the recent CQC investigation. A proportion of the balance sheet release has been effected in M11 (£67ok), with a further £3.2m planned in M12, including stock and capitalisation of revenue expenditure

7. Balance Sheet

A detailed balance sheet is shown below : £000

	Notes	Actual			Movements	
		Y/E Bal Mar10	Prior Mth Jan-11	Current Feb-11	Mth	YTD
Fixed Assets	1					
Intangible		3,529	2,809	**2,743**	(66)	(786)
Tangible		354,783	352,842	**352,591**	(252)	(2,192)
		358,312	**355,651**	**355,334**	**(317)**	**(2,978)**
Current Assets						
Inventories		6,033	6,344	**6,313**	(31)	280
NHS Debtors	2	22,374	27,245	**22,378**	(4,867)	4
Non NHS Trade Debtors		6,253	4,935	**4,618**	(318)	(1,635)
Provision for Irrec debts		(1,567)	(2,940)	**(3,004)**	(64)	(1,437)
Other Debtors	3	9,839	15,401	**9,517**	(5,883)	(322)
Cash in hand and at Bank	4	2,098	21,659	**21,017**	(643)	18,919
		45,030	**72,645**	**60,838**	**(11,808)**	**15,808**
Current Liabilities						
NHS Creditors	2 & 5	(10,272)	(12,965)	**(13,004)**	(40)	(2,732)
Non NHS Trade Creditors	5	(20,744)	(21,622)	**(16,409)**	5,213	4,335
Other Creditors		(1,307)	(2,702)	**(2,953)**	(251)	(1,646)
Taxes and Social Sec. Costs		(5,305)	(6,032)	**(5,869)**	162	(564)
Accruals		(13,055)	(14,848)	**(15,655)**	(807)	(2,600)
Other PFI Liabilities		(4,755)	(5,480)	**(5,480)**	-	(725)
Deferred Income		(1,258)	(25,589)	**(19,735)**	5,854	(18,477)
Temporary Loan - DH		(5,000)			-	5,000
		(61,696)	**(89,236)**	**(79,105)**	**10,131**	**(17,409)**
Net Current Assets/Liabilities		**(16,666)**	**(16,591)**	**(18,267)**	**(1,676)**	**(1,601)**
Debtors > 1 year		26,556	27,239	**27,266**	27	710
Total Assets less Liabilites		**368,202**	**366,299**	**364,334**	**(1,967)**	**(3,868)**
Creditors > 1 year						
Long term Loans-SBS		(470)	-	**-**	-	470
PFI Liabilities and Finance Leases		(263,815)	(259,948)	**(259,948)**	1	3,867
Provisions for liabilities		(7,450)	(6,439)	**(6,496)**	(57)	954
Deferred Income		(5,555)	(5,342)	**(5,342)**	-	213
Net Assets		**90,912**	**94,569**	**92,547**	**(2,022)**	**1,635**
Financed by:-						
Public Dividend Capital		271,375	306,375	**306,375**	-	35,000
Revaluation Reserve		9,547	9,527	**9,547**	19	(0)
Donated Asset Reserve		912	831	**823**	(8)	(89)
Government grant		-	-	**-**	-	-
Income & Expenditure Reserve	6	(190,922)	(222,164)	**(224,198)**	(2,034)	(33,276)
Total Taxpayers Equity		**90,912**	**94,569**	**92,547**	**(2,023)**	**1,635**

Balance Sheet Movements

The main movements in the balance sheet are as follows:

1. The year to date movement in Fixed assets consists of £11.9m depreciation for the eleven months less £8.9m of additional capital expenditure
2. A switch between NHS Debtors and Deferred Income within Creditors of £17m that reflects the advance PCT SLA payments received.

3. Other debtors have reduced by £5.9m mainly reflecting the monthly release of the quarterly PFI charge made in January.
4. Bank and Cash balances have reduced slightly in month, however, the balance still substantially reflects the receipt of the temporary PDC (£30m) in January 2011.
5. The year to date NHS and Non NHS Creditors have reduced following the receipt of the PDC loan in January. The benefits of the additional cash received in January (in addition to the PDC loan earlier in 2010/11), has been utilised by the Trust to make some significant payments to suppliers in February. The Trust has continued to experience cashflow difficulties due to the I&E deficit and also the timescale in recovering PCT contract over-performance income from 2009-10 and 2010-11 year to date, although this largely has been mitigated by the PCT SLA advances. The Trust received £30m PDC from the Department of Health in January 2011 which will be utilised to repay the PCT advance payments over the final quarter of 2010/11.
6. The Trust has a reported year to date I & E deficit of £33.3m (see detailed explanation in I & E report).

Balance Sheet KPIs

The brief table below shows Trust performance against the key Balance Sheet KPIs, also included in the financial risk rating metrics (see section 10 below for further detail).

Measure	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10
Average Debtor Days (* - Incl PT advances)	25	18	* 18.00	* 6.80	* (0.75)	* (2.11)
Average Creditor Days	529	185	125	74	53	105
Current Ratio Curret Assets \ Current Liability	79%	69%	65%	60%	51%	43%

Measure	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Average Debtor Days (* - Incl PT advances)	* (3.19)	* 1.83	33	37	25	
Average Creditor Days	123	108	105	94	72	
Current Ratio Curret Assets \ Current Liability	42%	37%	58%	83%	77%	

8. Cashflow

The tables below present the Year to Date Cash flow, on an Income and Expenditure basis

Statement of Cash Flows (CF)	Apr - Jan 11 Actual	Feb 11 Actual	YTD Actual
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Surplus/(Deficit)	(£13,100)	(£231)	**(£13,331)**
Depreciation and Amortisation	£10,870	£1,009	**£11,879**
Impairments and Reversals (inc Change in Fair Value of Financial Instruments)	£289	£137	**£426**
Other gains/losses on foreign exchange	-	-	**-**
Transfer from the Donated Asset Reserve	(£81)	(£8)	**(£89)**
Transfer from the Government Grant Reserve	-	-	**-**
Interest Paid	(£20,296)	-	**(£20,296)**
Dividend Paid	(£1,764)	-	**(£1,764)**
(Increase)/Decrease in Inventories	(£311)	£31	**(£280)**
(Increase)/Decrease in Trade and Other Receivables	£12,464	(£12,668)	**(£204)**
(Increase)/Decrease in Other Current Assets	-	-	**-**
Increase/(Decrease) in Trade and Other Payables	£12,800	£11,672	**£24,472**
Increase/(Decrease) in Other Current Liabilities	-	-	**-**
Increase/(Decrease) in Provisions	(£1,013)	(£51)	**(£1,064)**
Net Cash Inflow/(Outflow) from Operating Activities	**(£142)**	**(£109)**	**(£251)**
CASH FLOWS FROM INVESTING ACTIVITIES		-	**-**
Interest received	£680	£65	**£745**
(Payments) for Property, Plant and Equipment	(£7,033)	(£692)	**(£7,725)**
Revenue Rental Income	£1,070	£94	**£1,164**
Net Cash Inflow/(Outflow)from Investing Activities	**(£5,283)**	**(£533)**	**(£5,816)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(£5,424)**	**(£642)**	**(£6,067)**
		-	**-**
CASH FLOWS FROM FINANCING ACTIVITIES		-	**-**
Public Dividend Capital Received	£30,000	-	**£30,000**
Public Dividend Capital Repaid	-	-	**-**
New Capital Investment Loans	-	-	**-**
Capital Element of Finance Leases and PFI	(£5,014)	-	**(£5,014)**
Cash transferred to NHS Foundation Trusts	-	-	**-**
Net Cash Inflow/(Outflow)from Financing	**£24,986**	**-**	**£24,986**
Net Increase/Decrease) in Cash and Cash Equivalents	**£19,561**	**(£642)**	**£18,919**
Cash (and) Cash Equivalents (and Bank Overdrafts) at the Beginning of the Financial Year	**£2,098**		**£2,098**
Effect of Exchange Rates Changes on the Balance of Cash Held in Foreign Currencies	-	-	**-**
Cash (and) Cash Equivalents (and Bank Overdrafts) at the End of the Financial Year/YTD	**£21,659**	**(£642)**	**£21,017**

The main points to note at month eleven are the decrease in NHS Debtors and increase of Creditors (Deferred Income) due to reduction advanced SLA payments referred to above (£17m Feb 11, £22m Jan 11, £30m Dec 10). Trade Creditors have decreased with the receipt of the temporary PDC (£30m) allowing some of the older outstanding invoices to be cleared, however, the severe cashflow restrictions will continue to prevent timely payment of outstanding supplier invoices.

9. Capital Programme

A summary of the capital programme spend for the month of February is shown below:

Description	Fcast Capital Resources Allocation	Program Schemes Expenditure to date	
		Trust Spend	Finance
	£'000	£'000	£'000
Capital Resources			
2009-10 B/Fwd Schemes		-	
2009-10 B/Fwd Capital Accruals		655	
2010-11 Capital Schemes	9,897	3,177	-
Revenue to Capital		1,480	
Completed Capital Schemes (Transferred)		2,249	
Trust Variation Enquiries	-	5	
PFI- MES Capitalisation- IFRS Impact	1,600	-	
Other Capital Expenditure			
Purchase of Leased Medical Equipment		161	
		(0)	
Total Capital Expenditure - as per Cashflow	**11,497**	**7,727**	**-**
PFI Purchases			
2010-11 Capital Schemes		1,872	
Total PFI Expenditure	**-**	**1,872**	**-**
Total Capital Expenditure - as per Balance Sheet	**11,497**	**8,944**	**-**

Year to Date Capital expenditure is £7.727m.

In light of the difficult cash position, the Trust's Capital Planning Group has decided to limit capital expenditure to £8.0m. The Group has assessed and re-prioritising existing and new capital schemes in order to manage within this limit. The Trust has also been asked by the SHA to limit its capital programme, including the capital element of the PFI agreement (£4.9m) to no greater than the planned depreciation of £12.5m, effectively limiting other capital expenditure to £7.6m.

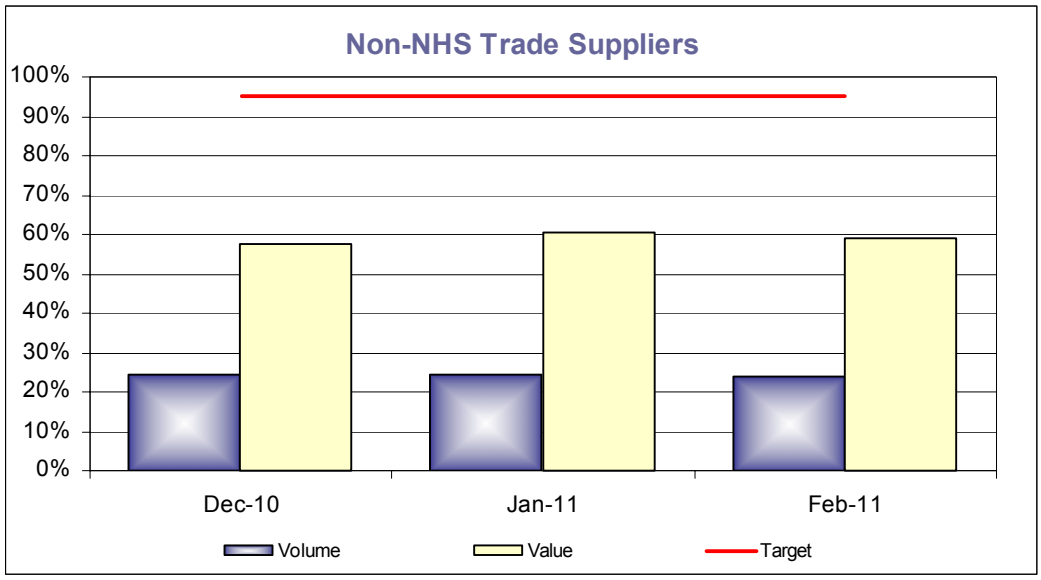
10. Better Payment Practice Code ("BPPC")

Under the better payment practice code, invoices received from trade creditors should be paid within 30 days of the receipt of goods or a valid invoice (whichever is later), unless other payment terms have been agreed. The target is to pay 95% of such sums due.

Non NHS creditor performance reduced in comparison to the previous month, with a decrease of 2% to 59% (Prior month: 61%) in value and the volume remaining practically the same at 24% (Prior month: 24%), being settled within 30 days.

Trust performance also reduced for NHS creditors with a reduction of 10% to 33% (prior month 43%) by value and the volume reducing by 4% to 32% (prior month 36%) by volume. Notwithstanding this, unapproved invoices do not appear in these figures.

Key to tables	
	% of invoices paid within 30 days by volume
	% of invoices paid within 30 days by value
	Target 95% of invoices paid within 30 days



11. Financial Risk Rating

The Department of Health has a methodology by which NHS organisations are financially risk-assessed. The assessment is prepared across a number of key areas of financial discipline, such as initial planning, year to date performance, underlying financial position, and strength of financial position. Within each key area are a number of indicators which are each given a raw risk score of between 1 and 3, where 1 denotes the highest risk and 3 denotes the lowest risk. Each key area is weighted, and an overall organisation financial risk rating is computed between 1.00 and 3.00. The best performing or least 'risky' organisations will have a weighted risk factor approaching 3.0, with organisations having the highest financial risk scoring nearer a 1.0.

BHRUT's weighted risk factor for February 2011 is 1.30, (1.40 from January 2010). The change in month is due to the change in forecast out-turn which affects the EBITDA (Earnings before Interest, Tax, Depreciation & Interest) scores. The main points to note across the five main components are:

1. **Initial planning**. The score is 1 (lowest), due to the size of the Trust's planned deficit of £19.878m (5.04% of income – threshold for a 2 being below 2%)
2. **Year to date position**. This is measured against both the Trust's bottom line position and EBITDA (year to date position, as a % of income. The Trust has a year to date bottom line deficit which is 8.9% of income, attracting a score of 1 (threshold between 1 and 2 is 2%) and an EBITDA ratio to income of -0.070%, which also attracts a score of 1. (threshold to get to 2 is +1%).
3. **Forecast Outturn**. This has 3 elements; forecast outturn for the bottom line position, forecast outturn for EBITDA, and consistency of forecasting of the bottom line position.

The Trust scores 1 on forecast outturn bottom line due to the operating deficit at 8.458% of income, 2 on EBITDA, which was 0.39% of income and 2 for forecast consistency as the movement in the forecast is insufficient to affect the risk rating.

4. **Underlying financial position.** This is measured on both bottom line, which the Trust scores 1, and EBITDA which it also scores 1.
5. **Finance Processes & Balance Sheet Efficiency.** This measures performance against 5 metrics:
    a. Volume and value (2 metrics) of invoices paid within the 30 day target. The Trust performance is 24% and 56% respectively in February, which gives a score of 1 on both (thresholds being 60%)
    b. Current ratio, i.e. current assets divided by current liabilities (an indicator of liquidity). The Trust's ratio is 0.77 (i.e. current assets are 77% of current liabilities), which gives it a score of 2 (thresholds are 0.5 and 1.0)
    c. Debtor days, i.e. the value of debtors expressed as the number of days of income. The reported February performance of 25 days scores a 3 (threshold being 30 days for a 3), but this is highly influenced by prompt payment of NHS SLA's.
    d. Creditor days, i.e. the value of creditors expressed as number of day's expenditure. The Trust's February performance is 72 days, i.e. creditors represent 72 days non-pay expenditure. This is an improvement from 94 days in January.

The detailed breakdown for February is found at appendix 1.

Appendix 1

Financial indicators for acute & ambulance trusts : BHRUT FEB 2011

Criteria	Metric			Weight (%)		Measure	SCORING 3	SCORING 2	SCORING 1	BHRUT Raw Score FEB 11	BHRUT Weighted Score FEB 11
Initial Planning	Planned Outturn as a proportion of Turnover	Formula for organisations with a planned operating breakeven or surplus: (SHA expected operating surplus or breakeven - planned operating surplus or breakeven) / Planned Income x 100	Formula for organisations with a planned operating deficit: Planned operating deficit / Planned Income x 100	5	5	-5.0%	Planned operating breakeven or surplus that is either equal to or at variance to SHA expectations by no more than 3% of income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to SHA expectations by more than 3% of planned income.	Operating deficit more than or equal to 2% of planned income	1	0.05
Year to Date	YTD Operating Performance	Formula for organisations with a YTD actual operating breakeven or surplus: (surplus/deficit - YTD actual operating) / Forecast Income x 100	Formula for organisations with a YTD actual operating deficit: YTD operating deficit / Forecast Income x 100	25	20	-8.9%	YTD operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of forecast income.	Operating deficit more than or equal to 2% of forecast income	1	0.20
	YTD EBITDA	YTD EBITDA / Actual YTD Income x 100			5	-0.1%	Year to date EBITDA equal to or greater than 5% of actual year to date income	Year to date EBITDA equal to or greater than 1% but less than 5% of year to date income	Year to date EBITDA less than 1% of actual year to date income.	1	0.05
Forecast Outturn	Forecast Operating Performance	Formula for organisations with a forecast operating breakeven or surplus: (Planned operating breakeven/ surplus/deficit - Forecast operating breakeven or surplus) / Forecast Income x100	Formula to be used for organisations with a forecast operating deficit: Forecast operating deficit / Forecast Income x100	40	20	-8.5%	Forecast operating breakeven or surplus that is either equal to or at variance to plan by no more than 3% of forecast income.	Any operating deficit less than 2% of income OR an operating surplus/breakeven that is at variance to plan by more than 3% of income.	Operating deficit more than or equal to 2% of income	1	0.20
	Forecast EBITDA	Forecast EBITDA / Forecast Income x 100			5	0.4%	Forecast EBITDA equal to or greater than 5% of forecast income.	Forecast EBITDA equal to or greater than 1% but less than 5% of forecast income.	Forecast EBITDA less than 1% of forecast income.	1	0.05
	Size of Change in Forecast Surplus or Deficit	(Current period forecast surplus/(deficit) - (Prior period forecast surplus/(deficit)) / Forecast Income x 100			15	1.1%	Still forecasting an operating surplus with a movement equal to or less than 3% of forecast income	Forecasting an operating deficit with a movement less than 2% of forecast income OR an operating surplus movement more than 3% of income.	Forecasting an operating deficit with a movement of greater than 2% of forecast income.	2	0.30
Underlying Financial Position	Underlying Position %	Underlying Breakeven/Surplus/Deficit / Underlying Income x 100		10	5	-8.1%	Underlying breakeven or Surplus	An underlying deficit that is less than 2% of underlying income.	An underlying deficit that is greater than 2% of underlying income	1	0.05
	EBITDA Margin (%)	Underlying EBITDA / Underlying Income x 100			5	0.0%	Underlying EBITDA equal to or greater than 5% of underlying income	Underlying EBITDA equal to or greater than 5% but less than 1% of underlying income	Underlying EBITDA less than 1% of underlying income	1	0.05
Finance Processes & Balance Sheet Efficiency	Better Payment Practice Code Value %	Value of ALL Bills paid within target / Value of ALL Bills paid within the year x 100		20	2.5	56%	95% or more of the value of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the value of NHS and Non NHS bills are paid within 30days	Less than 60% of the value of NHS and Non NHS bills are paid within 30 days	1	0.025
	Better Payment Practice Code Volume %	Volume of ALL Bills paid within target / Volume of ALL Bills paid within the year x 100			2.5	24%	95% or more of the volume of NHS and Non NHS bills are paid within 30days	Less than 95% but more than or equal to 60% of the volume of NHS and Non NHS bills are paid within 30days	Less than 60% of the volume of NHS and Non NHS bills are paid within 30 days	1	0.025
	Current Ratio	Current Assets / Current Liabilities			5	0.77	Current Ratio is equal to or greater than 1.	Current ratio is anything less than 1 and greater than or equal to 0.5	A current ratio of less than 0.5	2	0.10
	Debtor Days	Debtors as at current period / Forecast Income x365			5	25	Debtor days less than or equal to 30 days	Debtor days greater than 30 and less than or equal to 60 days	Debtor days greater than 60	3	0.15
	Creditor Days	Creditors as at current period / Total Expenditure x365			5	72	Creditor days less than or equal to 30	Creditor days greater than 30 and less than or equal to 60 days	Creditor days greater than 60	1	0.05
*Operating Position = Retained Surplus/Breakeven/deficit less impairments				100	100					17	1.30

Other Finance Processing KPI's		
Average Debtor days		24.25
Average Creditor days		71.97
YTD PSPP by Volume - NHS		31.79 %
YTD PSPP by Volume - Non NHS		24.29 %
PO Invoices Received in Month %		33.700%
Unallocated Cash - Volume		8.000%
Unallocated Cash - Value £'k		110
Contract Volumes - Annualised Volumes/Contract Volumes		95.114%

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Reference Costs score 2009/10	Trust Board
1. KEY ISSUES:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
The 2009/10 Reference Cost results for England have now been published. BHRUT's MFF adjusted overall index score is 100, which matches the national average. This means that overall, our costs were at the level to be expected for the volume of work we did. An organisation's reference cost index score is calculated as 100 x the actual cost divided by the "expected" (national average) cost for that volume of activity. Scores below 100 indicate better than average performance. Inpatient activity is still measured in Finished Consultant Episodes (FCEs) rather than spells for this purpose. The MFF-adjusted scores take regional cost variations into account. BHRUT's score has improved by 2 points since last year. Inpatient & daycase activity was 3.6% higher than last year, for a 3.4% real-terms increase in cost. The biggest improvement is in Non-elective inpatients, due to arise in activity. But the elective activity score has deteriorated. Our worst scores are for A&E and unbundled services, and some of the "other acute services" Looking at BHRUT's MFF-adjusted scores for each of the reporting categories: • Non-elective inpatients score has improved from 98 to 94, due to a 5.4% rise in activity • Day case & Elective inpatients score has deteriorated from 99 to 103. Day case activity has risen by 3% but elective inpatient activity is down by more than 6% since last year. These changes reflect the effects of non-elective pressures displacing elective activity. • Excess bed-days, Critical Care bed-days, Outpatients, Community midwives & Other Acute Services (OS) are all within 3% of the average (between 97 and 103). The excess bed-day score relates to the cost per day rather than the number of days incurred.	☐ **S&SIB ……..** ☐ **EPB ……..……** ☐ **FINANCE ……** ☐ **AUDIT ……..…** ☐ **CLINICAL GOVERNANCE ……..…..……** ☐ **CHARITABLE FUNDS ……..…** ☐ **TRUST BOARD ……..…** ☐ **REMUNERATION ……...** ☐ **OTHER ……** (please specify) **CATEGORY:** **X NATIONAL TARGET** ☐ **CNST** ☐ **STANDARDS FOR BETTER HEALTH** ☐ **HEALTH & SAFETY** ☐ **ASSURANCE FRAMEWORK** ☐ **TARGET FROM COMMISSIONERS** ☐ **CORPORATE OBJECTIVE ……..** **……..** ☐ **OTHER ……..** (please specify) **AUTHOR/PRESENTER:** **Tony Green/David Wragg (Director of Finance)** **DATE:**

• Our score for A&E has deteriorated compared to 2008/09. The number of A&E attendances has risen by nearly 10,000 to 187,000, whilst our costs have risen by £4.4m to £27.9m. An MFF adjusted score of 125.3 suggests that this is £5.6m too high. (This does not include Observation wards which are reported in Non-electives, not the A&E category). • Unbundled services' overall score has improved to 109. This consists of Outpatient diagnostic imaging, Rehab bed-days, Chemotherapy, Radiotherapy and high cost drugs. Our poorest scores are for Chemotherapy and for Radiotherapy. The Chemo data suffers from difficulties in matching drug costs with activity, as these are recorded in different systems. We include pharmacy on-costs & overheads but it is possible some others may report the basic drug cost only, while our activity measure may be short. Benchmarking of Radiotherapy costs had shown ours to be high, but steps taken to reduce them did not take effect until late in 2009/10. This score is expected to be much better in 2010/11. • Patient Transport Service costs are no longer reported by Acute Trusts, but by the PCTs. But that part of PTS costs relating to internal transfers has been included in our inpatient costs. • Our Community services score is almost wholly for community midwives. Our score has moved since last year due to changes in counting of activity in outreach clinics. Further analysis of our results will be undertaken. It is hoped to provide an analysis of the inpatient & daycase activity which will create an index score for each specialty, and to identify for each specialty their most significant "high & low cost" HRGs.	02 February 2011

2. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:

None

3. ALTERNATIVES CONSIDERED/REASONS FOR REJECTION:

N/A

4. DELIVERABLES:

Index score for each specialty to be derived.

5. EVIDENCE :

This paper provides evidence that BHRUT's costs are average, and have consistently improved over the period 2006/07 to 2009/10, showing that BHRUT is improving its unit costs more quickly than other NHS acute trusts.

6. RECOMMENDATION/ACTION REQUIRED:	
The Trust Board is asked to note the paper.	
AGREED AT _____ MEETING **OR** **REFERRED TO: _____**	**DATE: _____** **DATE: _____**
REVIEW DATE _____ **(if applicable)**	

Comparison of Reference Costs Index Scores for BHRUT
(National Average = 100)

Year		ELECTIVE./ DC CARE	NON-ELECTIVE INPATIENT	EXCESS BED DAYS	CRITICAL CARE SERVICES	OUTPATIENT SERVICES	OTHER ACUTE SERVICES	COMMUNITY SERVICES	Adult Critical Care	TRANSPORT	A&E	UNBUNDLED	ORGANISATION-WIDE INDEX INCLUDING EXCESS BED DAYS	ORGANISATION-WIDE INDEX EXCLUDING EXCESS BED DAYS	MARKET FORCES FACTOR	FCEs	£ Quantum
2003/04	gross	106	97	116	98	93	105	216					101	100		122169	248,136,863
	MFF adjusted	102	94	112	95	90	102	210					**97**	**97**	1.03333		
2004/05	gross	106	91	109	104	103	118	120					102	101		134491	289,242,310
	MFF adjusted	102	88	105	100	99	113	116					**98**	**98**	1.03632		
2005/06	gross	103	86	107	104	102	112	88					98	97		145942	313,202,710
	MFF adjusted	100	84	103	100	99	108	86					**95**	**94**	1.03267		
2006/07	gross	115.9	95.9	138.1	120.8	123.8	124.7	77.5	104.8			100.5	111	110		145484	326,178,256
Revised 20/12/07	MFF adjusted	112.3	92.9	133.9	117.1	120.0	120.9	75.1	101.6			97.4	**107**	**106**	1.03175		
revised basis to exclude PSSC excluded services from Quantum																	
2007/08	gross	107.3	112.4	114.2	115.3	113.1	113.3	99.4	see OAS	133.6	134.5	121.3	112	112		139163	348,210,983
	MFF adjusted	97.8	102.5	104.1	105.1	103.1	103.3	90.6	-	121.8	122.5	110.5	**102**	**102**	**1.09717**		
2008/09	gross	108.6	107.7	108.9	109.0	108.5	119.6	86.0		120.2	129.5	134.3	112	112		150824	371,760,829
	MFF adjusted	99.0	98.1	99.3	99.3	98.9	109.0	78.4		109.6	118.0	122.4	**102**	**102**	**1.09720**		
2009/10	gross	112.0	101.6	106.8	111.5	105.8	107.0	107.8	-	-	135.6	118.4	108	109		156231	390,885,767
	MFF adjusted	103.5	93.8	98.6	103.0	97.7	98.9	99.6	-	-	125.3	109.3	**100**	**100**	**1.08250**		

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
BHRUT Staff Survey	Trust Board
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
The enclosed is a summary of the Staff Survey which was published by the Care Quality Commission. The survey is a national survey and therefore BHRUT can compare our staff responses with other NHS organisations. The survey reveals that there are improvements but also areas of weaknesses within the results. It is important to ensure that staff are briefed about the results of the survey but also have a proactive role in contributing to various initiatives that will ensure there are improvements for staff working at the Trust. Therefore we intend to ensure that not only do Divisions establish a Staff Survey Action Plan for their area with contributions from staff but also this is part of a wider engagement strategy for the organisation.	□ **PEQ** ……..….. □ **STRATEGY**…… □ **FINANCE** ……..…… □ **AUDIT** ……..….. □ **CLINICAL GOVERNANCE** ……..……..…… □ **CHARITABLE FUNDS** ……..….. □ **TRUST BOARD** ……**X**…… □ **REMUNERATION** ……... □ **OTHER** ……..…… (please specify)
2. DECISION REQUIRED:	**CATEGORY:**
For noting.	□ **NATIONAL TARGET** □ **CNST** □ **CQC REGISTRATION** □ **HEALTH & SAFETY** □ **ASSURANCE FRAMEWORK** □ **CQUIN/TARGET FROM COMMISSIONERS** □ **CORPORATE OBJECTIVE** ……... □ **OTHER** …….. (please specify)
	AUTHOR/PRESENTER:
	DATE:
3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
N/A	
4. DELIVERABLES	
N/A	
5. KEY PERFORMANCE INDICATORS	
AGREED AT _____ **MEETING** **OR** **REFERRED TO:** _____	**DATE:** _____ **DATE:** _____
REVIEW DATE **(if applicable)** _____	

Staff Survey

The staff survey results have been announced and have been published by the Care Quality Commission. More details can be found through this link: http://bit.ly/staffsurveyBHRUT. All trusts have taken part in this national staff survey, and almost 306,000 staff have given their views. At BHRUT, a sample of 381 staff were surveyed and we had a response rate of 47% (in 2009 the response rate was 53%).

The survey looked at the implementation of the four Pledges in the NHS Constitution:

1. To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.
2. To provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed.
3. To provide all staff with opportunities for staff to maintain their health, well-being and safety.
4. To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

The highlights from the report are listed below:

The results revealed that we improved in the following areas over the last 12 months and were amongst the top 20% of Trusts in the country in these areas:

- *The number of staff having well structure appraisals and personal development plans showed that we were in the top 20% of all Trusts for this indicator*

- *There was a significant improvement in staff experiencing physical violence from patients, relatives or the public in the last 12 months and again we were in the top 20%*

Improvements were needed in the following areas, where the Trust's scores were in the lowest 20% of Trusts:

- *Staff experiencing physical violent from staff, work related stress, staff's intention to leave and team working*

In comparison to the last survey in 2009 this year's survey showed a better position in the following areas:

- *Staff job satisfaction*

- *Trust commitment to work life balance*

- *Support from immediate managers*

- *Fairness and effectives of incident reporting procedures*

- *Staff experiencing physical violence from patients, relatives or the public in the last 12 months has dropped*

- *Staff job satisfaction*
- *An improvement of staff receiving health and safety training in the last 12 months*

The survey showed a worsening position since the last survey in 2009 in the following areas:

- *Work pressure felt by staff*
- *Staff suffering work-related stress in last 12 months*

The survey also showed no difference from the last survey in the following categories:

- *Provide staff with clear roles, responsibilities and rewarding jobs*
- *Percentage of staff agreeing that their role made a difference to patients*
- *Percentage of staff feeling there are opportunities to develop their potential at work and have received training in the last 12 months*
- *Staff saying hand washing materials are always available*
- *Staff witnessing potentially harmful errors, near misses or incidents in last month*
- *Perceptions of effective action from employer towards violence and harassment*
- *Impact of health and well-being on ability to perform work or daily activities*
- *Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell*
- *Percentage of staff reporting good communication between senior management and staff*
- *Percentage of staff able to contribute towards improvements at work*
- *Staff intention to leave job and staff recommendation of the trust as a place to work or receive treatment*
- *Staff believing the trust provides equal opportunities for career progression or promotion*

Scores where the Trust was average compared to Trusts of a similar size

- *Staff motivation at work*
- *Percentage of staff having equality and diversity training in last 12 months*

What happens now?

Each Division will review their own areas in more depth, so they can fully understand the survey and can start taking action to make improvements. To do this each Division will engage staff to talk through the results and to develop an action plan. Staff side will be involved at both Divisional level and Trust-wide.

The action plans from each Division will be monitored through the Workforce Committee which reports directly to the Trust Board.

This is a very important piece of work for the Trust since it is vital we have all staff's engagement to improve our organisation and services. The Chief Executive, Averil Dongworth, will be taking a personal interest in this work and will be sending further details out to staff in the near future.

Appendix: The demographics of the staff who responded

Age	16-30	31-40	41-50	51+	
Number	48	94	97	132	

Men	Women	Disabled	Not disabled	White	Black and Minority ethnic
79	291	53	308	239	122

Full-time	Part-time	Manager	Non Manager	0-5 years	6-15 years
82%	18%	31%	69%	36%	44%

Nurses, midwives and nursing Assistants	42%
Medical and Dental	11%
Allied Health Professionals	12%
Scientific and Technical/Healthcare Scientists	7%
Other Groups	28%

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
External visits to the Trust	Board 29 March 2011
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
This protocol aims to create clarity on how visits by stakeholders will be agreed to and facilitated. This is expected to promote improved working relationships with stakeholders, build confidence in BHRUT services and enable appropriate scrutiny while minimising disruption to staff work and patient care.	**□ PEQ …□ STRATEGY……..** **□ FINANCE …… □ AUDIT ……..** **□ CLINICAL GOVERNANCE ……** **□ CHARITABLE FUNDS ……..** **□ TRUST BOARD ……..** **□ REMUNERATION ……...** **□ OTHER**
2. DECISION REQUIRED:	**CATEGORY:**
Board members are asked to review and decide on the suitability of this protocol.	**□ NATIONAL TARGET □ CNST** **□ CQC REGISTRATION □ HEALTH & SAFETY** **□ ASSURANCE FRAMEWORK** **□ CQUIN/TARGET FROM COMMISSIONERS** **x□ CORPORATE OBJECTIVE** **□ OTHER**
	AUTHOR/PRESENTER: Imogen Shillito, Director of Communications
	DATE: 7 March 2011
3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
None	
4. DELIVERABLES	
A protocol for communication to staff and stakeholders	
5. KEY PERFORMANCE INDICATORS	
More consistency and clarity in communications with stakeholders about visits, improved scrutiny without adverse impact on patient care and improved relations	
AGREED AT _____ MEETING **OR** **REFERRED TO: _____**	**DATE:** **_____** **DATE:** **_____**
REVIEW DATE (if applicable) _____	

Protocol on external visits to the Trust

Introduction

Given BHRUT's role in the local community, both in health care provision, as an employer and in its use of public funds, a range of stakeholders have a strong and legitimate interest in BHRUT and its work. The Trust aims to promote good working relationships with external organisations, so that they can hold BHRUT to account appropriately, represent the interests and views of their constituents and the public, build public confidence in the management and delivery of services, and support BHRUT and its staff in their work.

Senior Trust staff will arrange regular meetings with stakeholders and facilitate discussions with other relevant staff where requested. However, we recognise that tours of the hospitals, visits to clinical areas and discussions with frontline staff and patients provide more insight into the operation of the Trust than meetings and briefings alone. The Trust will endeavour to agree to appropriate requests, subject to guidelines to ensure that patient care is not disrupted.

This protocol aims to create clarity on how visits by stakeholders will be agreed to and facilitated.

Guidelines for visits

Stakeholder visits must recognise the vulnerability of patients and must not disrupt patient care, compromise patients' privacy or dignity, or seek to make inappropriate use of NHS facilities. The following guidelines are to safeguard this and visitors must:

- be accompanied at all times
- keep groups small and restricted to necessary staff only
- abide by infection control guidelines
- keep noise to a minimum and be unobtrusive
- inform staff on duty about what they are doing at each stage of the visit
- respect patients' right to privacy and protect their dignity
- treat patients and their visitors with courtesy and respect
- have respect for confidentiality, and not disclose any personal or sensitive information without the consent of the individual concerned or through following safeguarding procedures
- cooperate with requests from staff, patients and their families, and comply with all operational or health and safety requirements
- accept the guidance of staff on operational constraints around visiting
- refrain from political or campaigning activity while on the premises
- not to take any pictures or recordings, without the approval of the Communications Department and the consent of any patients or staff involved.
- not to bring in members of the media or any other organisations without BHRUT's prior consent.

Public bodies and their representatives are expected to abide by their own codes of conduct and principles, including for example the Nolan principles on public life.

Protocol for managing visits by specific groups of stakeholder
Stakeholders should make a formal request to visit the Trust, providing the Trust with reasonable notice (usually at least two weeks). The Trust will attempt to accommodate requests to visit specific areas, but stakeholders may need to be flexible in their requests, so that the disruption to work of the Trust can be minimised. Without notice, stakeholders (other than those authorised to make unannounced visits – see below) will not be able to visit clinical areas and are unlikely to be able to meet with staff.

1. Politicians and officials
Requests for a visit should be passed to the Chief Executive's office for response. A senior manager will be designated to lead the visit. Notes should be taken of questions or issues raised, to enable appropriate follow-up. The Trust must take steps to protect the NHS from politicisation, and this will include restrictions on political activity on site, measures to ensure there is party political balance, and restrictions on visits in the run-up to and during election campaigns.

2. Regulators
The Care Quality Commission and the Health and Safety Executive, together with a number of certain other specialist regulators have statutory responsibilities to inspect the Trust and its services, including making unannounced inspections. Inspectors should demonstrate authorisation and identity on their arrival, so that staff can ensure patients are protected from those who have not undergone checks. Staff should facilitate the work of the inspectors, and notify the Director of Clinical Governance/the Executive on call of their arrival or intention to visit.

3. Patient representatives
The Local Involvement Networks have the right to conduct 'Enter and View' visits, both with and without advanced notice. The Trust will expect LINks members to abide by their Code of Practice on visits, including demonstrating authorisation and identity before entering. Staff should notify the Director of Clinical Governance/the Executive on call of their arrival and facilitate their visit.
Members of the Trust's patient forum, the Improving Patient Experience Group (IPEG), are also encouraged to view services and the experience of patients, arranging visits through the Patient Experience team. They are expected to abide by the Code of Behaviour for IPEG members.

4. The media
The media must obtain prior permission from the Communications Department to enter the hospitals for media purposes and notify Communications on their arrival. Members of staff should report attendance of the media on site to Communications, the manager on call, and Security, if they are not accompanied by a member of the Communications team. No photography or recording is permitted on site without Communications approval and consent of any staff member of member of the public concerned.

5. Other groups and members of the general public
The Trust has to balance general interest in the work of hospitals against the need to protect patients and their privacy, and minimise disruption and distraction to the work of staff. Managers may allow such visits where it is necessary for the functioning of the Trust (for example, visits by certain suppliers), where it is in the interests of patients (for example, to familiarise them with facilities or to enable patient choice), or in the broader interests of the NHS (for example, to facilitate learning and information exchange between health organisations).

There is no formal requirement for patients and their visitors to engage with external visitors to the Trust, but they should be encouraged to share their views and experiences if they wish.

BHRUT's first concern is to protect patient care, and the needs of patients are paramount. It is important to note that there is no legal entitlement for people to remain on BHRUT sites after they have been asked to leave. Staff who have concerns about the behaviour of any external visitors should raise these immediately. Examples of concerns could be that a visit is compromising effective provision of services, the dignity or privacy of patients, or that appropriate identification and authorisation has not been shown. They should firstly ask the visitor to modify their approach, then if necessary notify a senior manager and call Security.

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
International Nurses Day 12 May 2011	**Trust Board 29 March 2011**
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
International Nurses Day is marked annually on 12 May, the anniversary of Florence Nightingale's birth. Board members will recall they were all invited to shadow a nurse in the Trust on Nurses Day 2010. There was very positive feedback from both the Board members who participated and the staff who were shadowed. Two events are planned for 2011. First, Board members are invited to join the Visible Leadership programme on Monday 9 May. Time will be spent alongside matrons and senior nurses, looking at patient care on the wards. This will also provide opportunity to talk to staff and patients. Second, a nursing conference is being planned to take place on 12 May in the Education Centre at Queen's, chaired by the Director of Nursing. The theme will be the care of older people, which is a focus of national attention following the recent Ombudsman's national report, summarising a number of cases. Invitations have gone to several national speakers to contribute to the day, and trust staff will also have the opportunity to present work they have done to improve standards of patient care. All Board members are invited to attend the conference, which will be chaired by the Director of Nursing.	□ **PEQ** …… □ **STRATEGY**…… □ **FINANCE** …… □ **AUDIT** …… □ **CLINICAL GOVERNANCE** …… □ **CHARITABLE FUNDS** …… □ **TRUST BOARD** …… □ **REMUNERATION** …… **X□ OTHER …Nursing & Midwifery Board** …… (please specify)
2. DECISION REQUIRED:	**CATEGORY:**
Board members are asked to note the two dates, and to confirm their availability for 9 May with the Director of Nursing	□ **NATIONAL TARGET** □ **CNST** □ **CQC REGISTRATION** □ **HEALTH & SAFETY** □ **ASSURANCE FRAMEWORK** □ **CQUIN/TARGET FROM COMMISSIONERS** □ **CORPORATE OBJECTIVE** …… □ **OTHER** …… (please specify)
	AUTHOR/PRESENTER: Deborah Wheeler, Executive Director of Nursing
	DATE: 18.3.11

3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
4. DELIVERABLES	
5. KEY PERFORMANCE INDICATORS	
AGREED AT _____ MEETING **OR** **REFERRED TO: _____**	**DATE: _____** **DATE: _____**
REVIEW DATE (if applicable) _____	

Barking, Havering and Redbridge NHS University Hospitals NHS Trust

Notes of the Meeting of the Strategic Partnership Board (SPB)

Monday 29th November 2010 @ 10.00am
Boardroom, Queen's Hospital

Members present:	David Wragg **(Chair)**	DW	Director of Finance BHRUHT
	George Wood	GW	Non-Executive Director BHRUHT
	John Goulston	JG	CEO - BHRUHT
	Jackie Doyle	JD	Director of Estates & NCS
	Ray Farrell	RF	Siemens – Representative
In Attendance	Tony Velupillai	TV	Catalyst - General Manager
	Lesley Seville	LS	Sodexo - Site Manager

1 **Apologies for Absence**

Simon Scrivens, Philip Cooper, Lindsey Coles,

2 **Review of notes from the previous meeting on 27th July 2010**

DW took the group through the Notes from 27th July.

Item 4 SPC meeting – DW said that at joint working meeting several issues had arisen and it was suggested that a separate meeting should be held with PC and GW especially in connection to variation costs. DW commented that the Trusts position is that we need an open on book on the risk profile.

Action: DW to update group on any outcomes from PC/GW meeting

Item 8 (Action Log) Workshop – DW reported that this had been completed. The action log would be consolidated with other actions logs and is due to be reviewed by DW and JD later today.

3 **Matters Arising**

None

4 **BeeAgile Partnership Workshop Update**

DW reported that a workshop had recently taken place, and the document attached a reasonable summary of the issues and actions from the day. DW commented that a positive element that has arisen from the event was the quality of the relationship and flexibility with Siemens, together with an overall good working relationship with Sodexo Soft FM (although there remains frustration around the pace of the market testing exercise.) DW said that the Trust has concerns with the lack of partnership working with the SPV and its funders, and also with Sodexo Hard FM. The Trust must have a clear understanding of the SPV risk profile before we can allow the terms to shift in favour of the SPV. Other concerns raised were around the differences in objectives and H4NEL issues. DW said that we will need a quick and flexible response from the SPV, together with

assurances that they will respond. TV replied that he would be happy to get the SPV engaged, and that as soon as this happens we can plan better. DW said that we would benefit from experiences from Catalyst. JG said he felt someone from Catalyst should attend the Health Campus Board Meetings. It was agreed this was a good idea and JD (who attends this meeting) would pass all relevant information to TV to enable a Catalyst representation. TV confirmed he would be happy to attend

Action: JD to pass relevant information to TV to enable Catalyst representation at the Health Campus Board

A discussion around the action points ensued. It was established there were various action logs, which raised concerns around how they would be monitored. JD said she was aware of these action logs and would be meeting with DW later today to organise a consolidated action log. JD said she would circulate the consolidated action log once it was completed. It was agreed that the log would show priority of actions and show clear time scales. The log would need to be approved by the SPB before presentation to the Finance Committee. DW said he would present the top 10 actions to the Finance Committee who will agree the key priorities for 2011/12. It was agreed that TV/JD would updated attendees at the next meeting

Action:

- **JD to circulate consolidated action log ASAP**
- **ALL to review log and approve.**
- **DW to present action log to the Finance Committee (14th December)**
- **TV/JD to update progress with action log at all future SPB meetings**
- **LF to agenda update of action log for next meeting**

5 SPC Development cost on variations update *(inc removal of DoV requirement)*

TV said that the work which has been done with Clifford Chance would be circulated on Thursday for consideration. TV confirmed he had circulated the report to DW, JD and RF

Action:

- **DW, JD & RF to review and comment to TV on Clifford Chance report**

6 Novation process Bovis lend lease/Vita lend lease *(final update)*

TV reported that this is virtually completed, however the was a slight hold up from his end from their legal department. Their legal department is generally overwhelmed with work currently which they are working through. Concerns were expressed by both DW and GW on the length of time this is taking. TV was asked whether the delay would have any repercussions. TV and JD confirmed that the delay in this would not have any repercussions as this is just a governance issue.

7 Assurance Reports

Investment Committee – RF reported that the last meeting was on 1st September 2010 and the next meeting is due to sit this week. He updated the Board on progress, however commented that generally progress is going well. Digital theatres – DW confirmed to RF this is going to carry forward to next year. JD reported that the audit of medical equipment at KGH is now complete. Issues arising regarding DoV will be discussed later today with JD and DW, JD also commented that she would like to review the TVE process to make it more efficient and less time consuming. The minutes were duly noted.

Health4NEL – DW reported that there is the decision making business case is due to be presented to the PCT's next week. The PCT's will review and their decision will be issued in a formal document (which can be made available to the Board members)

Clinical Strategy – JG said the regardless of H4NEL issues the midwife lead unit at Queens would stand. The Cather Lab and A&E are dependant on H4NEL outcomes, however there still may be some reconfiguration to these sections at a later date

New Developments – None

7 Market testing update soft FM

DW said the deadline for signing the DoV was extended by 3 months and is now due on 15th January. JD said the proposal had been reviewed by SS (who is broadly happy with the contents). JD continued that if SS confirmed his acceptance, a copy could be sent to Catalyst by close of play today. TV commented that a £1 million saving is being offered and he felt the lenders would want a benchmarking exercise to be undertaken and that considering all the documents and schedules involved, perhaps we should consider a delay in the deadline. At this point a full and frank discussion ensued regarding the process involved, delays in responses to requests, deadlines not being met, together with work already undertaken by E C Harris and Langdon (for the benchmarking). It was agreed that a meeting should take place with DW, SC and TV around delivering the 15th January deadline. JG and GW expressed concerns regarding slipped deadlines and said that the 15th January must be adhered to. JD and LS confirmed a lot of the work to finalise the DoV has already been completed so the 15th January was a realistic date. Emphasis was placed on all parties working as a partnership and giving each other reciprocal co-operation. TV said he felt he had not previously be invited into or engaged into the process. JD reassured the SPB that a lot of the work is already done and that once completed fully, this will be shared with the SPV.

Action: JD/LS/SS to keep TV updated of any information or developments with DoV and to ensure he is invited to any relevant events or meetings.

8 Soft/hard FM efficiency programme update/Trust CIP

JD confirmed that this years CIP has been fully delivered. Insurance is due in February, however this had been costed, and scheduled in.

9 Retail outlet expansion/convenience store update

TV reported that this is all part of the 11/12 programme JD reported that a feasibility study had been carried out for the convenience store project, but nothing else had progressed. This was partly due Market Testing situation. JD said that she will now be meeting with TV to present a complete proposal. With regard to the Maternity retail outlet, we are waiting for final proposal from Sodexo. GW expressed concern about the convenience store project, given all the other important project/issues that we working on. GW asked JD if we can ensure we don't get distracted and priorities projects accordingly. JD assured GW that work would be prioritised correctly.

10 Schedule of Business

DW said he will continue to pick up with TV. Soft FM and Market testing will need monitoring especially with how it works with H4NEL. JG said we need to have an escalation process on Market Testing

Action:

- **TV/DW to ensure an escalation process for Market Testing is established and monitored**
- **JD to distribute action schedule for Market Testing which clearly state timeframes and deadlines**
- **ALL to make every endeavour to ensure schedule dates are met**

11 Any other business

The meeting closed at 11.05am

Date and Time of Next Meeting

The next SPB meeting would be held on **Tuesday 15th March 2011** to commence at **10.00am** in the **Meeting room 3 at Queens Hospital**. Any apologies for absence should be sent to Laura Fingleson at laura.fingleson@bhrhospitals.nhs.uk

Dates for next 2011 – *all will commence at 10.00 for 1 hour*

Tuesday 12th July 2011 @ 10.00am, Meeting room 2, Queens Hospital
Tuesday 22nd November 2011 @ 10.00am, Meeting room 2, Queens Hospital

Strategic Partnership Board ACTION POINT LIST

Ref	Action point	Action by	Date to complete	Chased	Date
	Actions from SPB 29th November 2010				
2	DW to update group on any outcomes from PC/GW meeting	DW/GW	DONE	GW to give update at next meeting	10/1/11
4i	JD to pass relevant information to TV to enable Catalyst representation at the Health Campus Board	JD	DONE	G:\LAURA\MEETINGS Strategic Parternship	
4ii	JD to circulate consolidated action log ASAP	JD	DONE	G:\LAURA\MEETINGS Strategic Parternship	
4iii	ALL to review log and approve.	ALL	DONE		
4iv	DW to present action log to the Finance Committee	DW	DONE	To be presented to Feb FC	
4v	TV/JD to update progress with action log at all future SPB meetings	TV/JD	On going		
4vi	LF to agenda update of action log for next meeting	LF	DONE		
5i	DW, JD and RF to review and comment to TV on Clifford Chance report	DW/JD/RF	DONE		
7	JD/LS/SS to keep TV updated of any information or developments with DoV and to ensure he is invited to any relevant events or meetings.	JD/LS/ SS	On going		
10i	TV/DW to ensure an escalation process for Market Testing is established and monitored	TV/DW	On going		
10ii	JD to distribute action schedule for Market Testing which clearly state timeframes and deadlines	JD	DONE	G:\LAURA\MEETINGS Strategic Parternship	
10iii	ALL to make every endeavour to ensure schedule dates are met	ALL	On going		

Charitable Funds Committee
Minutes from meeting held on
Tuesday 7th December 2010

Attendees:	Keith Mahoney	KM	non- Executive Director, Chairman
	Deborah Wheeler	DCW	Director of Nursing
	Bill Langley	WL	Non-Executive Director
	Linda George	LG	Charitable Funds Accountant
	Jackie Doyle	JD	Director of Estates, Facilities and Capital
	Chris Stevens	CS	Head of Fund Raising

1 Apologies

David Wragg

2 Minutes of the Previous Meeting & Matters Arising

The minutes from the previous meeting held on 26th October were agreed as a correct record.

JD reported that the Bladder scanner will actually cost £11,621 and is not suitable to be put on the MES. She had approached the League of Friends for funding but has not had positive feedback. If the purchase of this scanner is going to be approved then it is likely that it will have to be funded from Charitable Funds.

JD reported that the ENT equipment will actually cost nearer to £40k. She has checked and, once again, this is not suitable for the MES. JD agreed to approach the League of Friends to investigate funding. The League of Friends will require justification that this equipment is to enhance patient welfare, as they would not fund this if it is something that is necessary within the Department and should be bought from exchequer funds.

ACTION JD

LG informed the Committee that there was an unrestricted legacy of £54k that could possibly be used to "top up" paediatric charitable funds. LG agreed to check the amount in the paediatric funds to see if there is sufficient to purchase the equipment with this funding.

ACTION LG

KM has circulated a memo regarding the split of MMMM from the BHR Charity and informed the Committee that he and CS are going to arrange a meeting in January to meet with MMMM to re-establish relationships and further clarify the situation in order to avoid a conflict of interest, with both charities collecting in the same place.

ACTION KM/CS

CS reported that the Charity Events Calendar is being prepared

The current "Bid Form" was discussed and it was felt that more guidance should be given to staff on what is required by the Charitable Funds Committee, as the quality of the information currently submitted is sometimes not sufficient enough to make a decision. CS agreed that he would review all the bids prior to their submission to the Committee, to ensure that all relevant information is included. It was felt that copies of quotes should be included when appropriate. Staff also need to be aware that bids for goods or services from the Charitable Funds should "enhance the patient experience"

ACTION CS

JD and CS agreed to review the bid form and amend as necessary.

ACTION JD/CS

3 Statement of Financial Activities and Balance Sheet for the period: 1st October – 30th November 2010

LG confirmed a total of donations received for £31k and legacies for £5k and £55k for voluntary services and equipment respectively with income from fundraising amounting to £1.5k. Total expenditure amounted to £104k being £17k for investment managers' fees, fundraiser consultant's fees and administration fees and £87k of direct charitable expenditure.

4 I&E Report as at 30th November 2010

LG provided each Committee member with a paper that identified the fund movements for the last two months.

5 Staff recognition & Rewards

A discussion was held regarding a staff recognition gift. All the options were revisited including gift vouchers, deposits for a group occasion; lunch for staff working on Christmas Day It was agreed that if this gift was going to be granted from charitable funds, it must be all inclusive for every member of staff. KM and WL agreed to have discussions with the Trust Executive Directors in order that this situation may be resolved.

ACTION KM

6 Requests for Expenditure

Concerns were expressed over the cost of the MIAD courses but assurances were given that the cost of £8,600 per course was for 20 consultants and that If anyone was unable to attend once a commitment had been made, then every effort was made to fill the place.

Application to fund and install a 52" monitor
Following discussion, it was agreed that there was a poor level of detail included in the bid. CS agreed to speak with the applicant and obtain more information before this bid can progress.

ACTION CS

Application for the purchase of Tumble Dryer for the Nursery.

JD informed the Committee that she would be happy to fund this purchase from the relevant exchequer budget.

ACTION JD

JD also informed the Committee that she would also be happy to fund the purchase of the necessary fridges for the Nursery in the same way.

ACTION JD

Application for a mammography positioning chair
This bid was discussed, it was felt that, once again, the quality of the bid was not adequate. JD agreed to investigate as to whether the chair is a new addition to the unit or a replacement. If this is a new chair, there needs to be investigation as to whether maintenance is required and if this should be purchased at the same time as the chair. LG informed the Committee that once the bid contained all the relevant details and if the purchase was approved, the Pemberton Barnes legacy would be an appropriate source of funding.

ACTION JD

Verbal request for funding for photographic paper
Request has been received from Nicole McIntosh for £2.5k to complete the project to have photographs of the relevant staff at ward entrances.
This request was approved

The Committee discussed the request for a rest room for staff in A&E at Queen's. JD informed the Committee that she had been looking into this and had located a potential space. She agreed to co ordinate a scheme and costs and will bring all the information to the next meeting in February. It was felt that KGH had a similar problem but that the problem at Queen's would be addressed first.

ACTION JD

7 Legacies

LG presented a report to the Committee updating the status of all the bequests.

The Trust has been bequeathed approximately £65k for the provision of a kidney machine by Miss Vera Pike. It has been agreed that this can be interpreted as equipment to benefit the renal unit, as this amount is not enough to buy and maintain a dialysis unit. As Queen's Hospital has a renal unit that is funded by Barts Hospital, it was agreed that it would be better to wait to spend this money as plans are underway to have a specialist renal unit in Angelica Ward at KGH, and this money would be well received for this project.

LG informed the Committee that she had received information regarding the house sale

from the Maureen Ann Fitzgerald bequest. The Trust has been asked to agree that the sale price of the house be dropped by £6k, It was felt that as BHRUT is a minority beneficiary from this bequest, the Committee were happy to take advice on the best way forward and go along with the majority opinion.

8 6 Month review of BHR Charity

CS presented his report showing that in comparison to the first 6 months of FY 09/10 (excluding legacies and investments), for the FY 10/11 is up by 20%. A growth in charitable income is predicted of circa 25% pa average over the next three years. Objectives for the post have been agreed, including mail-shots to local solicitors making them aware of this charity. It was felt that it is important now is to make staff more aware of the results of charitable fund raising and the benefits to not just patients but also staff.

9 Revised Annual report and Accounts for Approval

There have been a few amendments to the final accounts to align the way that income and expenditure is recorded with other Trusts. This means reverting to the previous counting method. It was felt that is important to be consistent with other trusts in order to benchmark progress.

The Accounts have been approved by the Director of Finance and are ready to be signed and circulated.

10 Sensory Garden Update

JD reported that expenditure has been approved for an artist impression of the Garden. The Trust is still waiting for planning permission, and this is expected some time in December. The outline communications strategy has been agreed, and it is hoped that the launch of this project can take place in January. Two tenders have been received so far, but it is expected that in all, five tenders will be received.

CS agreed to distribute the dates for the planning meetings for the garden

ACTION CS

KM informed the Committee that Marks and Spencer were happy to advertise this project and that, if the Charity wanted to fund raise at the Romford Marks & Spencer, an application would be positively viewed.

11 Any Other Business

JD presented a three year strategic plan for charitable funds, and was thanked for this excellent piece of work. It was agreed that CS will distribute electronically and Committee Members will bring any further comments to the next meeting in February in order to finalise this document.

ACTION ALL

JD requested £15k of funding for the Head of Fund Raising to access, in order to move forward with further work, including the production of leaflets, products and marketing to promote the Charity. It was agreed that £15k would be approved and CS agreed to report quarterly and update the Committee on how this money was being spent.

ACTION CS

WL informed the Committee that it may be possible to introduce a colleague of his to them in order to discuss the "branding" of the Trust Charitable Funds. It was felt that the Charitable Funds was too closely allied to the Trust and should be seen more as a separate entity. The Committee felt that this was a good idea to move in this direction and this would be a first step in getting the idea of the costs and processes involved.

ACTION WL

It was felt that there should be some terms and conditions, and a clear code of conduct, that could be issued to health promotional stands that occupy the atrium to ensure that they were not doing their own fund raising. CS said that he was not aware of this happening and that, generally, these stands were well received and a good opportunity for patients to receive information and support. CS agreed to draft a paper for discussion at the next Charitable Funds Committee in February.

ACTION CS

LG informed the Committee that the money recently given to Diabetes UK was to be used to fund some new equipment for Queen's hospital.

JD informed the Committee that she will arrange a meeting in order to progress the links between the hospital radios on the KGH and Queen's hospital sites. The possibility could also be discussed of the hospital radio joining the BHRUT charity. This was seen as an opportunity to advertise the charity.

ACTION JD

It was agreed that the dates for the Charitable Funds Committee for 2010 would take place, bi-monthly on the penultimate Tuesday starting in February and that Rensburg Sheppards would be invited to attend twice a year. One meeting should be held at KGH.

ACTION SECRETARY

Dates of Future Meetings for 2011

All meetings will take place at 9am – 10.30am

Tuesday 15th February – Emergency Services Meeting Room, Queen's Hospital
Tuesday 19th April at – Emergency Services Meeting Room, Queen's Hospital
Tuesday 21st June at – Meeting Room 3, Queen's Hospital OR Seminar Room 3 KGH
Check with KM that this date is convenient to be at KGH
Tuesday 23rd August at – Meeting Room 2, Queen's Hospital
Tuesday 18th October at – Emergency Services Meeting Room, Queen's Hospital
Tuesday 6th December at – Meeting Room 3, Queen's Hospital

Barking, Havering and Redbridge NHS
University Hospitals
NHS Trust

TRUST BOARD MEETING
Tuesday, 31 May at 1.00 pm
Board Room, Trust Headquarters
Queen's Hospital

A G E N D A

1. Apologies for Absence

2. Minutes of the meeting held on 29 March 2011 (Attachment A)

3. Matters Arising and Actions

4. ***STRATEGY:***
   - 4.1 Chairman & Chief Executive's Report (ED/AD) (Attachment B)
   - 4.2 Health4NEL Update (RR) (Attachment C)

5. ***GOVERNANCE:***
   - 5.1 Board Assurance Framework (MS) (Attachment)
   - 5.2 Care Quality Commission Action Plan Update (DCW) (Attachment)

6. ***CLINICAL:***
   - 6.1 Emergency Care Update (NM) (Attachment)
   - 6.2 HSMR Update (SB) (Attachment)
   - 6.3 Maternity Services Update (CD) (Attachment)
   - 6.4 Drugs & Therapeutic Committee Annual Report (Attachment)

7. ***QUALITY, PATIENT STANDARDS and FINANCE:***
   - 7.1 Quality and Patient Standards Performance Report – April 2011 (NM/DCW/RMcA) (Attachment)
   - 7.2 Workforce Key Performance Indicators (RMcA) (Attachment)
   - 7.3 Finance Report for period ending 30 April 2011 (DIW) (Attachment)

8. ***INFASTRUCTURE:***
   - 8.1 BHRUT's Corporate Story (IS) (Attachment)
   - 8.2 Estates Strategy (RR) (Attachment)
   - 8.3 Education & Learning Directorate Annual Report

9. ***INFORMATION***

   Matters for Noting:
   - 9.1 Declaration of Member's Interests (Attachment)
   - 9.2 Minutes of the Quality & Strategy Committee meeting held on the 2011 (Attachment)
   - 9.3 Minutes of the Strategic Partnership Board meeting held on the 2011 (Attachment)
   - 9.4 Minutes of the Charitable Funds Committee meeting held on the 2011 (Attachment)
   - 9.5 Draft Agenda for July Trust Board Meeting and Rolling Programme for 2011 (Attachment)

10. Any Other Business

Date of Next Meeting: The next public meeting will be held on Tuesday, 26 July 2011 at 1.00 p.m. in the Lecture Theatre, James Fawcett Education Centre, King George Hospital

11. Questions from the Public

12. Exclusion of the Public and Press In accordance with the Public Bodies Admission to Meetings Act), to resolve to exclude members of the public and press from the remainder of the meeting.

PART I - Trust Board Rolling Programme 2010/2011

	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
STRATEGY													
Chairman & CEO Report													
IT Strategy													
Annual Operating Plan													
Estates Strategy													
GOVERNANCE													
Board Assurance Framework													
Annual Quality Report													
Safeguarding Children Annual Report													
Clinical Governance Annual Report													
Health & Safety Annual Report													
Care Quality Commission Action Plan													
Francis Report into Mid Staffs Update													
CLINICAL													
Maternity Services Update													
Director of Infection Prevention & Control Annual Report													
Cancer Board Annual Report													
Drugs & Therapeutic Committee Annual Report													
Research & Development Annual Report													
Critical Care Business Case Update													
QUALITY, PATIENT STANDARDS and FINANCE													
Quality and Patient Standards Performance Report													
Finance Report													
Income and Expenditure Budgets													
Financial Plan and Service Level Agreements													
INFRASTRUCTURE													
Staff Survey													
Education and Learning Directorate Annual Report													
Workforce Key Performance Indicators													
INFORMATION													
Quality & Strategy Minutes													
Strategic Partnership Board Minutes													
Charitable Funds Committee													
Declaration of Members Interests													

KEY

Informal Board Seminar & Part II Meetings