Barking, Havering and Redbridge NHS
University Hospitals
NHS Trust

TRUST BOARD MEETING
Wednesday, 2 November 2011 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 7 September 2011 (Attachment A)

3. Matters Arising and Actions

4. Committee References

5. ***GOVERNANCE:***
   - 5.1 Care Quality Commission Investigation Report on Queen's and King George Hospitals (AD) (Attachment B)
   - 5.2 Care Quality Commission Action Plan Update (PS) (Attachment C)

6. ***QUALITY AND PATIENT STANDARDS***
   - 6.1 Quality & Patient Standards Performance Report – September 2011 (NM/DCW/RMcA) (Attachment D)
   - 6.2 Emergency Care Report on August 2011 Performance (MO-M) (Attachment E)
   - 6.3 BHRUT Pressure Surge Plan 2011/12 (MO-M) (Attachment F)
   - 6.4 Maternity Update – September 2011 (DCW) (Attachment G)
   - 6.5 Quality & Safety Committee Escalation Report (PS) (Attachment H)

7. ***FINANCE, WORKFORCE AND ACTIVITY***
   - 7.1 Finance Report – Month 6 (September) 2011/12 (DIW) (Attachment I)
   - 7.2 Tripartite Formal Agreement (RR) (Attachment J)
   - 7.3 Workforce Key Performance Indicators - September (RMcA) (Attachment K)
   - 7.4 Activity Report – September 2011 (NM) (Attachment L)
   - 7.5 Workforce Committee Escalation Report (RMcA) (Attachment M)

8. ***INFORMATION***
   Matters for Noting:
   - 8.1 Interim Chair and Chief Executive's Report (Attachment N)
   - 8.2 Research & Development Annual Report (Attachment O)
   - 8.3 Medicines Management Annual Report 2010/11 (Attachment P)
   - 8.4 Minutes of the Quality & Safety Committee meeting held on The 9 August 2011 (Attachment Q)
   - 8.5 Minutes of the Strategic Partnership Board meeting held on The 15 March 2011 (Attachment R)
   - 8.6 Minutes of the Charitable Funds Committee meeting held on The 21 June 2011 (Attachment S)
   - 8.7 Draft Agenda for January 2012 Trust Board Meeting (Attachment T)

9. Any Other Business

   Date of Next Meeting: The next public meeting will be held on Wednesday, 11 January 2012 at 1.00 p.m. in the Board Room, Trust Headquarters, Queen's Hospital

10. Questions from the Public

11. 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 UNIVERSITY HOSPITALS NHS TRUST

Minutes of the Part I Trust Board Meeting held on the 7 September 2011
In the Board Room, Trust Headquarters, Queen's Hospital

Present:	Mr Edwin Doyle	Interim Chair
	Mr Stephen Burgess	Medical Director
	Mr William Langley	Non-Executive Director
	Mr Keith Mahoney	Non-Executive Director
	Mrs Ruth McAll	Director of Human Resources & OD
	Mr Robert Royce	Director of Strategy
	Ms Deborah Wheeler	Director of Nursing
	Mr George Wood	Non-Executive Director / Vice Chair
	Mr David Wragg	Director of Finance
	Ms Caroline Wright	Non-Executive Director
In Attendance:	Mrs Carol Drummond	Divisional Director, Women & Children's Division
	Ms Shelagh Smith	Divisional Manager, Medicine Division
	Ms Imogen Shillito	Director of Communications
	Mrs Christine Robinson	Accreditation Manager (Minutes)

2011/043 APOLOGIES FOR ABSENCE
Apologies were noted for Mrs Averil Dongworth, Chief Executive; Neill Moloney, Director of Planning & Performance; Professor Anthony Warrens, Non-Executive Director and Michael White, Non-Executive Director.

2011/044 MINUTES OF THE PART I MEETING HELD ON THE 6 JULY 2011
The minutes of the meeting were agreed as a true record and signed by the Interim Chair.

2011/045 MATTERS ARISING AND ACTIONS
There were no additional matters arising and the following outstanding actions were discussed.

Item 2011/014: An activity report was included as an agenda item; therefore this item was discharged.

Item 2011/23: Ms Wheeler confirmed the requested update on agenda item 2011/008 had been circulated. Mr Royce advised that the Capital Programme for 2011/12 had been finalised and was going to the next Finance & Programme Management Committee. This item was discharged.

Item 2011/025: Mrs McAll explained that the Annual Leave policy had been revised to take account of the impact of staff absences due to the Olympics and the revision was due for approval by the Workforce Committee. This item was discharged.

Item 2011/027: Ms Wright confirmed that the two Warning Notices regarding maternity had been circulated to the new Non Executive Directors. The action relating to the CQC communication plan had also been completed by Ms Shillito. This item was discharged.

Item 2011/029: In the absence of Mrs Dongworth, this item was deferred to the next meeting.
Action: Averil Dongworth 2.11.11

Item 2011/031: Mr Burgess confirmed that the Royal London has an Outpatient Chronic Fatigue Service structured in the same way as the Trust proposes and it was confirmed that the communications engagement plan had been implemented. This item was discharged.

Item 2011/032: Ms Smith was able to advise that the discussions concerning staff appraisal rates had taken place. The Interim Chair requested sight of the appraisal figures for the next meeting of the Board.

Action: Averil Dongworth 2.11.11

Item 2011/033: The Board were advised that a paper on Workforce has been prepared and is going to the Audit Committee meeting tomorrow. This element was discharged.

Mrs McAll advised that staff surveys and HR key performance indicators are discussed at the Workforce Committee and had been included in the HR report to the Board. Mr Mahoney confirmed the issues would be discussed further at the Workforce Committee to challenge whether the survey was reflective of what happens within the Trust. This element was therefore to remain outstanding with a further report to the next Trust Board. Ms Shillito advised that proactive work was underway for the forthcoming staff survey which will involved a larger sample group this year.

Action: Keith Mahoney 2.11.11

Item 2011/034: The Board noted that a paper on each QIPP workstream would be discussed at the October seminar meeting. An agenda item covering the Project Management Office staffing was included in Part II of the meeting. This item was therefore discharged.

2011/046 QUALITY & PATIENT STANDARDS PERFORMANCE REPORT - JULY 2011

Ms Wheeler updated the Board on the highlights from Mr Moloney's report.

There had been no MRSA bacteraemias in August and this had brought the Trust back on trajectory; there had been no MRSA bacteraemias for 134 days. Further work was continuing to audit compliance with MRSA screening. Mr Langley queried the robustness of the mitigating actions and it was explained that the new automated system of auditing MRSA screening will allow for greater interrogation of the data.

The monthly target for Venous Thromboembolism (VTE) risk assessments was exceeded with a score this month of 91.45%. The information was based on audited data that informs the central return.

There had been 4 same sex breaches in July which all occurred within the High Dependency Unit and were due to delays in transfer of patients who had been stepped down to level 1 (general) care. This is a significant reduction from the May and June figures. The improvement results from improved patient flow through the Trust, including A&E, which has improved capacity. Mrs Wheeler was able to advise that the August data, just received, was also showing 4 breaches and confirmed that work was continuing to reach zero.

This month there had been nine Serious Incidents. Ms Wheeler advised that root cause analysis investigations are being completed on all Grade 3 and 4 pressure ulcer incidents that require reporting to NHS London. Seven of the serious incidents relate to the Women's & Children's Division, all of which relate to obstetric reporting triggers. A review of maternity serious incidents has been carried out and recommendations made to improve processes within the department to ensure timely investigation and action planning.

The Board learnt there had been a small deterioration in the elective and non-elective readmissions, although at the present time the reasons for this are unclear. Ms Smith explained that the Division is looking at the readmissions for non-elective patients as a priority and working with the Community to

develop pathways for patients with long term conditions such as dementia and chronic obstructive pulmonary disease (COPD) with the aim of helping them manage their conditions without admitting them.

Delayed transfers of care (DTOC) had improved from 5.55% in June to 4.15% in July. The year to date performance is 4.08% against the National target of 3.50%.

Ms Wheeler advised that the number of complaints was increasing with 93 received in July; an increase of 9%. Detailed work is underway to analyse the issues and identify where improvements can be made. The roll out of complaints management to the Divisions has started with the Women's & Children's Division and the roll out will continue to the other Divisions. Members discussed the management of complaint backlog cases and noted that contact with all complainants was by update letters, but proposals to ensure cases are prioritised and the complainant telephoned as suggested by Mr Langley were being considered. Mrs Wheeler explained that the speed of implementation was largely dependent on the resource issues within the complaints team and the extent of the backlog. It was agreed that a report and plan of action should be brought to the next Trust Board that provides a framework, with deadlines, for this work to be carried out.

Action: Deborah Wheeler 2.11.11

It was reported that the Deputy Director of Nursing, Liz Wright, has taken over the remit for the real time surveys recording patient experiences at the Trust. Currently there appears to be low levels of awareness of the survey on the wards and plans are underway to re-launch the process once the issues with the software are resolved and an update was required for the next formal Board. Mr Mahoney praised the 'comment book' he had seen during a ward visit, pointing out that it provided good feedback that staff found useful and which documented high levels of patient satisfaction with their care.

Action: Deborah Wheeler 2.11.11

The Board noted there had been deterioration in the first to follow up ratio for outpatient appointments and Mr Royce advised that the Trust will soon be able to send an automated 'reminder' text message, generated from the patient administration system (PAS) for outpatients and those patients booked for elective surgery. This was warmly welcomed and Mr Royce was asked to ensure there was appropriate publicity and to update the Board at the next meeting when the process would be going 'live'.

Action: Rob Royce 2.11.11

There has been a significant reduction in the number of diagnostic breaches reported in July.

Ms Smith advised that length of stays (LOS) are coming down in medicine and for non-elective patients in July and August, dropping to 6 days and below. Work is currently underway to ensure a robust plan to cope with winter pressures is in place and this will be accommodated by realignment of bed capacity between Queen's and King George Hospital. Mr Langley requested a further breakdown of the data to reflect DTOCs that were the responsibility of external agencies as opposed to those due to clinical reasons that were managed internally. Ms Smith confirmed that could be done and would be shown in the next report.

Action: Shelagh Smith 2.11.11

There had been low cervical screening performance in May but successive months had seen an increase in performance which, if maintained, will meet the target.

Mrs Drummond reported that she was in discussion with the GP Commissioners to encourage early booking for maternity patients. In addition, women are now given an appointment at 10 weeks rather than 12 weeks to improve performance and facilitate greater patient safety and improved outcomes.

Freedom of Information response rates dropped to 75% in June as a result of reduced performance from some Divisions. Where such delays are encountered an escalation process is in place and being implemented.

Mrs McAll provided a brief update on the two HR indicators: more work was being carried out with the Divisions to improve appraisal rates and a further push to release staff to attend life support training was required, although the uptake for the training is higher than last year.

The report was noted by the Board.

2011/047 EMERGENCY CARE REPORT ON JULY 2011 PERFORMANCE

The Trust has achieved 98.54% at King George Hospital and 95.1% at Queen's Hospital against the target of 95% for Type 1 attendance. This was achieved through the improved A&E processes where patients are Rapidly Assessed and Treated (RATted). The RATing process is planned to be extended to longer hours and at weekends to generate further improvements. A night flow coordinator has also been piloted at Queen's and has significantly contributed to the improved performance and will become a permanent role.

Ms Smith highlighted that three of the quality indicators had been met at King George Hospital and two at Queen's; the Trust is required to publish this data and it has, since August, been placed on the Trust's website with suitable commentary.

Ambulance handovers have greatly improved and the improvement plan has been recognised by London Ambulance Service as best practice and, following assessment by the Intensive Support Team, has been put forward as an exemplar to other Trusts. The Trust is now reported as having the least number of black breaches out of all London acute Trusts for July. It was suggested that these improvements would be more easily understood if the graphs showed month-on-month improvements. Ms Smith was asked to take this request for changes to the presentation of the data up with Mr Maloney to facilitate an update for the forthcoming Board to Board meeting.

Action: Shelagh Smith 2.11.11

Ms Wright praised the improvements in ambulance handovers and asked if there were any lessons learnt that could be applied elsewhere. Ms Smith felt that it was staff on the 'shop floor' that understood the problems and had the most to contribute to finding solutions. The Interim Chair asked for the Board's thanks to be shared with the team.

It was agreed that the next Board Meeting should review the Winter Surge Plan proposals that should be clear about what elements were Trust responsibilities and which sat with others. Ms Smith advised that she was leading the internal planning meetings that are already well underway; with the sector plans led by ONEL.

Action: Magda Smith 2.11.11

2011/048 MATERNITY SERVICES UPDATE – JULY 2011 MONTHLY REPORT

Mrs Drummond presented the key areas from the report highlighting that 82% of women were triaged in July against the target of 98%; this is an improvement on the 19% recorded for June. A new Matron has been appointed to the labour ward with an immediate objective to develop a contingency plan for dealing with peaks in demand.

The time to see an obstetrician for high risk women in July was 88% which again is a significant improvement from June's performance of 39%. The August data shows this has improved further to 90-

92% compliance against the 98% target. As with triage data, an IT solution is being explored to replace the current paper based process and improve data capture.

Correlation between the Trust's local guidelines for caesarean deliveries and the National guidance was poor and in order to improve performance, the local guidance is being improved. Mrs Drummond reported that anaesthetic cover can be problematic and a plan, developed in partnership with the anaesthetic department, giving three options will be discussed by the Executive Team on the 20th September. It was confirmed that the Escalation Policy was working satisfactorily and that reports show the number of vacant maternity beds. It was also noted there were a small number of other guidelines requiring update. Mr Royce requested a separation of the LSCS data to show the length of time for each of the separate Grades. Mrs Drummond confirmed that information is now being collected and will be incorporated into the August report but that the reports are being seen by the Commissioners and because there is still some variability in performance the assurance rating remains 'red'; this scoring will remain until there is sustained improvement.

The Board were concerned that the Commissioners have not defined how long a period of sustained improvement was required before the red could be downgraded to amber and this would be raised with them at the next meeting. The Interim Chair pointed out that it was important for the Trust to set its own deadlines and that Ms Wright should be included in any such discussions. Mrs Drummond confirmed a meeting had been set for next week.

Action: Carol Drummond / Deborah Wheeler 2.11.11

Mrs Drummond advised that recruitment is continuing and from November there will be a pull away from agency staff to those employed by the In House Bank.

The review by Anne Douse from NHS London has produced a number of recommendations on the way maternity governance can be improved and these will be taken forward. There is a clear plan for the Associate Head of Midwifery for Governance and Quality to address the complaints backlog and complete the outstanding Serious Incident reports. Themes from complaints are around staff attitude and poor communication and an external company is currently undertaking an 'observation' survey to identify any leadership or individual factors that can be addressed.

The maternity mandatory training programme has been updated and a training needs analysis is taking place to identify each midwife's training requirements. It is anticipated that the review will be completed by the end of September.

The Trust Board were advised that a plan is in place and work has commenced on developing a home birth team with the expectation that this will be in place by the end of the year. Mr Langley queried whether such a team made financial sense and was informed that it did as long as it was underpinned by a robust risk assessment of the women. She explained that the team would consist of 8-10 midwives that will also cover antenatal care. During later discussions it was pointed out that the home birth team would be developed from within the existing resources and not from new recruits.

A cautionary note was introduced by Ms Shillito who stated that the Local Involvement Networks (LINks) are holding a public meeting next week and will be presenting the patient experiences of maternity care they have been collating; these are likely to be seen by the public as evidence of the overall quality of the service. Havering LINk has however provided an 'Enter & View' report which is more positive. Ms Shillito stressed the need for us to demonstrate the improvements we have made in order to improve public confidence. Visits to the Maternity Department by members of local Scrutiny Committees are planned for late September.

The report was noted by the Board.

2011/049 INFECTION PREVENTION AND CONTROL ANNUAL REPORT 2010/2011

The report was presented for information by Ms Wheeler who explained it was a statutory requirement. The report highlights a number of improvements such as the root cause analysis of MRSA bacteraemias and Clostridium difficile deaths, the introduction of ward based outbreak management training and raised staff awareness and reporting of potential outbreaks that has provided the foundation for further work in 2011/2012. Ms Wheeler explained there is continuous emphasis on improving hygiene standards and this is demonstrable through the Visible Leadership audits.

The report was noted by the Board.

2011/050 QUALITY & SAFETY COMMITTEE ESCALATION REPORT

Mr Burgess pointed out that a number of the issues highlighted for escalation from the Quality & Safety Committee had been discussed, or were due to be discussed, as separate agenda items. He proposed that the escalation report would be more useful in alerting members to issues that required close scrutiny if it was included earlier in the agenda. The Interim Chair agreed that an item entitled 'Committee References' should in future follow 'Matters Arising'.

Action: Sue Williams 2.11.11

The report was noted by the Board.

2011/051 FINANCE REPORT – MONTH 4 (JULY) 2011/12

Mr Wragg presented the Finance Report and reported there was a £21.4m deficit in the year to date, with a full year forecast outturn of £57m, against a controlled target of £40m. The figures were based on a conservative assumption of £7m over-performance so far. Mr Wragg advised that the PCTs were strongly challenging the Trust on non-elective over-performance and, although already agreed by QIPP efficiency saving, a hard stance is being adopted by the PCTs that feel the Trust is keeping beds open that do not need to be. The Trust is continuing discussions with the PCTs and will keep the Board updated. Ms Smith provided details of an HRG audit of non-elective admissions that is taking place, the results of which will feed into the Trust's response to the PCTs. Ms Wheeler also pointed out that for a while A&E was being run as a ward, due to bed shortages, that meant patients were seen and discharged from the department without being admitted, and are therefore an unseen group of patients. The Board heard that the level of patient readmissions and A&E attendances are rising but that this pattern seems to be replicated in Whipps Cross Hospital's data.

Mr Wragg confirmed the Trust was working on admission avoidance and reducing lengths of stay but the schemes were not particularly successful. Mr Burgess added that ambulatory care pathways were also being developed but the PCTs do not wish to pay any more than last year.

Clinical income actual shows a favourable £3.5m from adverse variance in Divisional incomes, with the Central Income variance against the profiled part of the £361 Annual Plan

There is £4.2m adverse expenditure for pay, primarily across Medicine, Women's & Children's and Surgical Divisions relating to expenditure of £3.7m, in month, for temporary medical and qualified nursing staff.

Mr Wragg reported there was a CIP shortfall of £2.7m, year to date, which is compounded by cost pressures arising from the additional activity. He explained that ONEL has a QIPP joint plan for reducing our activity down to £7.3m that will save £1.6m in expenditure which if successful will allow the PCTs to claim £1.6m back from NHS London. Mr Wragg further advised there was a £15.7m shortfall against

controlled total with potential mitigation against this of £15.4m. Stretch targets are being discussed with Divisions.

The ISTC has not been assumed to be successful but if the bid is successful will deliver £1.4m. Other potential savings will rely on achievement of CQUIN targets and the targeting of readmissions. Mr Wragg concluded that a number of the schemes carry significant risks including readmissions and marketing and there was extreme pressure to pay bills.

The Board noted the report and decided that in order to allow more time to consider strategies to address the serious financial situation it would be referred to the Finance & Programme Management Committee.

Action: George Wood

2011/052 WORKFORCE KEY PERFORMANCE INDICATORS – JULY 2011

Mrs McAll began by apologising for an error in the Surgical Division section where the Emergency Division's data had been accidently transcribed into the data for Surgical Division's usage of the In House Bank which should show approximately 198-200 bookings.

The report includes fuller detail on recruitment and agency usage and highlights that sickness absence is currently over 5% against the target of 4.2%. Occupational Health have been running workshops for managers and offering case reviews of the 125 staff referrals for sickness.

In the last 12 months the Trust has recruited 210 wte staff, but still had a vacancy of 575 posts equivalent to 10% of the workforce. Our staff turnover at 12% is also slightly higher than the London average of 11.65%. In answer to a question from Mr Langley, Mrs McAll advised there was no obvious reason for the increase in sickness absences. She also advised there was a plan in place to fill the staffing gaps albeit recognising some recruitment was proving extremely difficult but confirming there was clarity around where the vacancy/recruitment hotspots were in the Trust.

The number of employment relation cases has drops from 74 to 52 in July with the most common reasons being disciplinary procedures or a review of the staff member's abilities.

Mrs McAll advised there was further information on workforce in the Confidential Part II meeting.

The report was noted by the Board.

2011/053 ACTIVITY REPORT – AUGUST 2011

In the absence of the author or Mr Moloney the report was reviewed by the Board on the assumption that the figures included Essex patients as well as ONEL patients. Ms Wright felt the report highlighted the need for a clear marketing strategy. Mr Wood confirmed that discussions had been going on at a Divisional level and with Brentwood Community Hospital but currently within the Trust there was no definitive marketing team.

Concern was raised about the downward trajectory of Outpatient referrals but without other intelligence it was not possible to identify where these patients might be going. Mr Burgess said he had spoken to the Commissioners and proposed that GPs may be referring patients to Whipps Cross Hospital whose appointment times are one month less than our own.

Mr Royce explained that a partial solution may be in hand with the introduction of a new outpatient template for clinics which should ensure new appointments are seen in clinics, thus increasing outcomes

and improving wait times and theatre activity with the resultant changes becoming apparent from next month. He cautioned however, that it needs good marketing in order to increase referrals.

It was agreed that marketing should be on the next Strategy Board with clear information on what marketing is currently taking place.

The Board noted the report.

2011/054 CARE QUALITY COMMISSION ACTION PLAN UPDATE

Mr Burgess presented the CQC action plan for addressing the warning notices for A&E and staffing that was sent to the CQC by their deadline of the 22nd August. The action plan was formatted using the approved template used previously for the maternity warning notices and included two further action plans: the emergency access action plan and the pneumonia action plan. To date there had not been any response from the CQC but it was likely their response would not be forthcoming until the current review was completed.

The Interim Chair was happy with the layout of the action plan but questioned whether the named senior responsible officers (SRO) had sufficient capacity to deliver and it was explained that the SRO was supported by other members of their staff and Ms Wheeler provided an example stating the items assigned to the Assistant Director of Nursing were largely covered by the Visible Leadership programme.

It was generally felt that the pneumonia action plan needed to be put into the correct format and should be brought up to date as there were inconsistencies in the dates and timings and actions.

Action: Magda Smith 2.11.11

Mr Burgess went on to advise that the CQC Trustwide on-site investigation was completed on the 23rd August but the original plan for a draft report had been revised so that a final report only would be available in mid-October. He also explained that the IRP report was also unlikeky to be received until after the CQC findings have been looked at by the Secretary of State and NHS London.

2011/055 BOARD ASSURANCE FRAMEWORK – QUARTER 1 (APRIL-JUNE) 2011/12

The Quarter 1 Board Assurance Framework (BAF) was presented by Mr Burgess who explained that it had been discussed at TEC where it was agreed the extreme red risks, which each have an action plan, would be escalated to the Board. It was pointed out that the grading for foundation trust status was incorrect and should be showing as red. Similarly, the grading for partnership working was also incorrect based on the previous discussions about PCT unwillingness to fund our over-activity. It was agreed that Mrs Wheeler would discuss the partnership grading with Mrs Dongworth to ensure the correct grading was shown in future.

Action: Deborah Wheeler 2.11.11

There was consensus that all the items on the 'quick glance' section (pg.2) required a narrative within the report to justify its grading. Ms Wright although felt that the BAF would benefit from clear deadline against which progress could be monitored, this suggestion was generally accepted.

Mr Royce was not aware of the patient records issues in maternity that were showing as high orange as these were not included in the capital programme and it was recommended that he have a separate discussion with Mrs Drummond.

Mr Burgess agreed to take these comments on board for the next iteration.

Action: Stephen Burgess 2.11.11

The report was noted by the Board.

2011/056 INTERIM CHAIR AND CHIEF EXECUTIVE'S REPORT

The report was submitted for information and the members were offered the opportunity to ask questions of the Interim Chair. No questions were raised.

The Interim Chair asked for the Board's congratulations to be extended to Mr Aklak Choudhury, Respiratory Consultant and Associate Divisional Director for Medicine for being shortlisted as a finalist in the 'Best use of IT to promote patient safety' category for his work on the electronic handover system.

Action: Averil Dongworth 2.11.11

The report was noted by the Board.

2011/057 CANCER SERVICES MANAGEMENT BOARD ANNUAL REPORT

The report, presented for information, was felt to demonstrate that Cancer Services has performed well, but nationally could do better. Mr Wood felt there were too many items with missed deadlines with no explanation of why or what actions were taking place to address the failing therefore it was not possible to identify risks. Mr Burgess explained the report was for 2010/11 and that the National cancer survey is currently being redone. Mr Burgess agreed to take the queries back to Cancer Services and would request an update of the action plan for the next Quality & Safety Committee.

Action: Stephen Burgess 2.11.11

2011/058 MINUTES OF THE QUALITY & SAFETY COMMITTEE MEETING HELD ON THE 14TH JUNE

The Part I minutes of the Quality & Safety Committee were noted by the Board.

2011/059 DRAFT AGENDA FOR NOVEMBER TRUST BOARD AND ROLLING PROGRAMME FOR 2011

No amendments or additions were put forward for either document.

2011/060 ANY OTHER BUSINESS

The Interim Chair advised that he had been in discussion with the Chair of ONEL about reciprocal arrangements at Board meetings for Non-Executive Directors. This was agreed and Ms Wright would be our representative and her contact details would be passed through to the ONEL Chairman.

Action: Sue Williams

The meeting closed at 4.45 p.m.

The next meeting of the Barking, Havering & Redbridge University Hospitals NHS Trust Board will take place on Wednesday 2 November 2011 at 1.00 p.m. in the Board Room, Trust Headquarters, Queen's Hospital.

Investigation report

Barking Havering and Redbridge University Hospitals NHS Trust

Queen's Hospital
King George Hospital

October 2011

About this report

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. The main objective of the Commission in performing its functions is to protect and promote the health, safety and welfare of people who use health and social care services. The Commission has the power to conduct an investigation into the provision of NHS care under s48(1)(2)(a) of the Health and Social Care Act 2008. It does so where there is evidence of a significant problem that affects a whole care economy.

This report is on the findings of an investigation carried out by CQC at Barking, Havering and Redbridge University Hospitals NHS Trust. It focuses mainly on the quality and safety of care provided at King George Hospital and Queen's Hospital.

This report should be read in conjunction with the review of compliance reports published by CQC in June 2010, October 2010, March 2011 and April 2011 and available on our website. These provide further details of the trust's performance in meeting the essential standards of quality and safety detailed in section 20 of the Health and Social Care Act 2008.

Two of the outcomes on which we collected evidence (Outcome 6: Cooperating with other providers and Outcome 7: Safeguarding people from abuse) will be published after the publication of this main report, as we are still collating evidence on these issues.

This is to ensure that we can publish this report as quickly as possible, so that prompt action can be taken by the trust and its NHS partners to improve the quality and safety of services delivered to patients.

Contents

Executive Summary

The trust had a history of poor performance under the previous regulatory framework. It has long-standing and escalating debts (in 2005-2006 this was just under £16m; by 2009-2010 it was close to £117m). There have been numerous changes at executive level.

At the time of CQC registration, the trust had a high number of 'conditions' placed upon it to require improvements in care. A series of unannounced inspections in 2010-2011 resulted in some of these being lifted, but also resulted in warning notices being issued to the trust (in March, June and July 2011) on staffing levels and maternity care.

CQC saw some evidence of improvements being made in response to these notices, but the trust's overall capacity to respond to the extent and level of CQC's concerns is in question. Throughout this period, we continued to receive information about poor quality care from patients and the public.

The investigation

CQC's judgement was that continuing to tackle poor performance at the trust on a case-by-case basis was not going to address deep-seated issues around the quality of care. As a result, CQC took the decision to launch a full investigation into the quality of care provided by Barking, Havering and Redbridge University Hospitals NHS Trust at Queen's Hospital and King George Hospital.

The investigation was announced on 29 June 2011. A team of CQC inspectors and external expert advisors – including experts in maternity, accident and emergency, and nursing care – began the investigation on 4 July 2011.

The investigation was designed to assess the systems and procedures the trust has in place to ensure that people are protected against the risk of inappropriate care and treatment. The team focused on three care pathways – maternity, elective vascular surgery, and emergency care, and examined the trust's governance and management systems.

Evidence gathering took place from July to September. Both main hospital sites were inspected, during which we spoke to patients about their experiences and observed care being delivered. We interviewed more than 200 hospital staff in private, and spoke to staff from 13 different stakeholders. We received further information from more than 100 people who had used the trust's service, through interviews and written submissions. MPs and local councillors submitted their views and the views of those they represent.

Our key findings

Despite some signs of improvement in recent months, patients remain at risk of poor care in this trust, particularly in maternity services. We have identified

ongoing concerns in emergency care and in radiology. Widespread improvement is needed in patients' experiences; patient flows; the management of complaints; staff recruitment; and governance.

Long-standing concerns in maternity services have progressively worsened. The most significant problems were identified at Queen's Hospital during our investigation, although elements of poor care were present across both sites. These include poor clinical care, a service operating in isolation, abusive behaviour by some staff to patients and to their colleagues, a lack of learning from maternal deaths and incidents, and a lack of leadership from senior management. The attitudes of some midwives continue to cause concern among patients and staff.

Accident and emergency services at Queen's Hospital have struggled to meet the four-hour target for admission. A tipping point was reached last winter when the quality of services began to collapse. There have been some improvements in 2011 which the trust needs to consolidate to reduce the risk of poor care happening again.

Concerns were identified in other clinical delivery areas, including in the day case surgical unit and interventional radiology, with delays having an impact on treatment and care. An external review of interventional radiology in June 2011 gave the service an amber rating. Evidence from staff gathered during our investigation supported these concerns.

We have a number of present concerns about the safety and suitability of premises at Queen's Hospital, supported by accounts given by staff and patients during our investigation. It can be difficult to navigate and signage is poor; some wards and clinical departments do not have natural light, and there are line of sight problems in the emergency department and general wards. There is a lack of waiting space in the urgent care centre and poor facilities in the theatre recovery unit for patients who are cared for in that facility for up to 23 hours.

The design of the emergency department at Queen's Hospital also contributed to problems with equipment which staff raised during our investigation; some equipment cannot easily be shared between different areas. Disposable equipment in some clinical areas tended to run out.

There has been a gradual reduction in the number of permanent staff employed though staffing establishments have risen, with staff acknowledging that senior managers have had to focus on the trust's debt. Many vacancies have been filled by agency, locum or bank staff with an impact on the quality of care. Data from June and July showed significant vacancy rates in some staff groups. Staff told us that the trust has recently taken positive action to recruit more permanent staff, particularly midwives and nursing staff in the emergency department. Concerns remain regarding the number of medical vacancies.

Trust governance systems are reported as weak and corporate governance is underdeveloped. Governance systems have recently changed, but lines of communication in the new structure are unclear and there is a risk of duplication or issues being missed. The trust was reliant on external reviews to identify issues, and while it held extensive performance information, this was not used to drive change. There was a lack of learning from incidents, with investigations identifying recurring themes.

The trust's response to complaints has been very poor for a number of years, with a high number of complaints received each year and frequent breaches in timing and quality of response. The level of distress caused by poor complaint handling was, in some cases, reported to be as bad as the poor care experienced in the first place. The trust is seeking to put this right, but this was raised by stakeholders (particularly MPs and local councillors) as one of their biggest causes of concern apart from quality of care.

There is past and current evidence of poor leadership from some managers and a culture among some staff of poor attitude and a lack of care for patients, especially in maternity. There is recent evidence that this is beginning to change due to the efforts of the new chief executive, the director of nursing and medical director.

We identified a lack of cohesion across the trust. Divisions do not work together effectively to improve the quality of patient experience. This is particularly stark in the flow of patients out of the emergency department.

Capacity is a current and future challenge, particularly at Queen's Hospital. Efficiency gains that were supposed to happen have not come about. There was a universal view that too many women now attend Queen's for maternity care and that it cannot cope.

The problems highlighted around accident and emergency last winter were in part due to capacity, in part to poor care flows, and also due to interim management arrangements that prevented permanent staff from contributing views that could have improved care. Ownership of problems has since returned to permanent staff and some improvements in quality (e.g. a rapid assessment and treatment service for major cases) have been seen. The durability of these will be tested over the winter months.

During our investigation, we did receive information from patients who were happy with the quality of care they experienced. This was acknowledged by stakeholder groups (although the latter did raise ongoing concerns about quality, particularly in maternity services).

Almost without exception, members of staff were positive about the impact the new chief executive is having at the trust. They have embraced the chief executive's inclusive style and believe, for the first time in many years, that there is a real opportunity for positive change.

What needs to be done?

CQC has set out a range of recommendations the trust must fulfil. CQC will monitor implementation, but the trust needs the support of organisations in the local health economy, including NHS London and commissioners. The significant changes that are needed, in particular on capacity, are likely to challenge both clinical flows and trust finances.

Many leaders and managers in the trust have been overwhelmed with day to day difficulties and need support to turn the trust around. CQC believes this support must take the form of working with the chief executive and other leaders and staff at the trust, rather than seeking to impose change.

The area of greatest concern remains maternity services. Improvements must be made in a short time frame to ensure the immediate safety of women using services, while medium and long-term answers must be found to capacity problems.

The trust must prepare for the challenges the winter will pose to emergency care. Patient flows through the organisation need to improve. The organisation must function as a whole and services must not operate in isolation.

Detailed Findings

Respecting and involving people

The trust has had poor results from national patient surveys, particularly about dignity and respect. The trust has systems in place to capture the views of patients, but it is not clear that these have been used effectively to improve the quality of services. New electronic systems collect patients' experiences at Queen's Hospital; initial results support the national surveys that identified variations in the quality of patients' experience.

There is evidence that some women were not treated with dignity or respect in maternity services at Queen's Hospital. Both staff and patients raised concerns over the attitude of some midwives. The trust receives a high number of complaints about the quality of patients' experience in maternity services especially with regard to poor staff attitude.

Patients also experienced a lack of dignity and respect in the emergency department during the winter of 2010-2011 for example patients were waiting for many hours to be treated or admitted to hospital. Concerns were identified in the day case surgery unit, where patients often stayed for up to 23 hours in facilities that compromises their dignity and respect.

Care and welfare of people

There is evidence that there is some improvement to the quality of care in emergency services. However, historically the emergency department at Queen's Hospital has had difficulty in meeting the four-hour target to admit patients and despite improvement in the last four months there are still challenges to over come to ensure the flow of patients is effective.

There were concerns regarding poor quality care in maternity services especially at Queen's Hospital, for example some women in labour did not receive epidural pain relief as quickly as they should; one woman recently having to wait nearly two and a half hours. There were concerns in other clinical delivery areas, including the day case surgical unit and interventional radiology; for example delays in reporting radiological examinations that impact on treatment and patient care in the trust. There were concerns over discharge arrangements, for example delays in providing discharge medication in a timely fashion.

Although most of the information received from patients and relatives outlined poor experiences for patients, we did receive evidence where patients and their relatives had received good quality care.

Cleanliness and infection control

There is a well-resourced infection prevention team that carries out audits, reports to the trust's board and provides education for staff. There were some concerns about the number of patients developing *Clostridium difficile*

infections at the trust but fewer concerns about *methicillin resistant staphylococcus aureus* (MRSA) infections. Wards and departments that we visited were generally clean and we saw staff maintaining their hand hygiene.

We had some concerns about the storage of intravenous fluids on wards, and the cleanliness of public toilets in the emergency department at Queen's Hospital. The infection prevention team worked effectively to resolve another issue we raised ensuring patients were screened for MRSA before being admitted to hospital.

Management of medicines

We had concerns about the recording of administrating medicines to patients, and the timely provision of medication when patients are discharged from hospital. We also had concerns about access to adequate pain relief for women in labour and on some general wards. There is some evidence of audit and feedback, though the pharmacy newsletter sharing this information has only recently been published. There is evidence of changes to practice as a result of audit, and of a culture that supports the reporting of medication errors in the emergency department and corresponding learning by staff.

Safety and suitability of premises

There are a number of concerns at Queen's Hospital with regard to premises. The hospital is circular in design, and it can be difficult to navigate the ground and first floor as wards and departments are set out in an outer and inner circle configuration. Signage is often poor especially on the ground and first floors. Some wards and clinical departments on the ground and first floor do not have access to natural light and this provides a poor environment for patients and staff. There are line of sight problems in the emergency department and on general wards, where due to the nature of the design some patients cannot be observed easily. There is a lack of appropriate waiting space in the urgent care centre, and poor facilities for patients who have to stay for up to 23 hours in the theatre recovery unit.

No such problems were identified at King George Hospital.

Safety, availability and suitability of equipment

Access to equipment was generally satisfactory, at King George Hospital. At Queen's Hospital we had concerns over the availability of medical devices such as monitors and pumps. Staff in the emergency department raised particular concerns over access to medical devices and other equipment, though this is in part due to the nature of the design of the department where equipment cannot be easily shared between different sections for example 'majors' and 'minors' (areas of an emergency department that treat patients that have differing severities of illness or trauma). Managers said that concerns about access to equipment had always been voiced by staff at Queen's Hospital since it opened in 2006, and suggested that this was partly due to the complexity of patients' conditions. Not all staff voiced concerns;

those in the intensive care unit told us that access to medical devices was good.

Staffing and supporting workers

There has been high usage of temporary and locum staff, and staff acknowledged that the focus of the senior managers has been the financial debt of the organisation. Many of the vacancies have been filled on a daily or short term basis by agency, locum or bank staff. This is reported to have had an impact on the quality of care. The trust has recently employed a number of nurses and midwives in areas such as emergency care and maternity, but we still have concerns about the numbers of medical staff, therapists and other support staff.

The trust has not carried out skill mix reviews nor needs analysis in any systematic fashion or acted on those reviews that have been undertaken. There are examples where the trust did not utilise staff appropriately according to their clinical skills. For example midwives who have been trained to undertake the first postnatal mother and baby checks not utilising these skills. There are also examples where the trust may not have been getting the best value for money in terms of *Agenda for Change* grading with some groups of staff. There is a need to make better use of unqualified support staff, and to ensure that more support staff are used in a variety of clinical specialities.

The trust has been dealing with high numbers of poorly performing staff, the numbers of which have been increasing year on year and are higher than comparable trusts. The trust has processes in place to support managers, however many staff articulated that they believe there is a lack of support for managers to deal with these performance concerns, and a perception that, poorly performing staff not being dealt with effectively.

The trust is a university hospital and has formal links with educational establishments. There are well-developed systems for education and training in place, and staff have access to these with some exceptions. Where there are vacancies in staff groups permanent staff have difficulty accessing mandatory and professional development. We had concerns about adequate supervision of midwives and training grade medical staff. Appraisal is one area that staff did not raise concerns about, and this is reflected in the national staff survey.

Assessing and monitoring the quality of service provision

The trust's governance systems are reported as weak and do not provide assurance which would allow the board to fully manage the task of leading the organisation. Evidence regarding the governance reporting structures do not include all the committees operated by the trust, and lines of accountability are unclear. There was a risk of duplication and limited evidence of communication between groups. There was an underdeveloped corporate governance system in place. The trust was reliant on external reviews and

inspections to identify issues rather than through its own internal monitoring systems and the trust has been slow to implement changes and drive improvement.

The trust held extensive performance information, which was not being used effectively to drive change. There was a risk that the trust board were overloaded with information due to the number of committees and external reviews. There was a lack of learning from incidents, with investigations into serious untoward events identifying similar contributory factors to those found in previous incidents.

Complaints

The trust's response to complaints has been very poor. The trust received a high number of complaints each year as compared to trusts of its size and has a high number of complaints currently with the Parliamentary and Health Service Ombudsman. The trust frequently breached its own guidance on the timeliness of responses and its responses were often simply a record of the treatment an individual received with no response to the actual complaints raised. The trust has recognised this and is making changes to its complaints process to ensure ownership at a local level.

Records

The quality of records that we looked at were generally in line with established standards, but we did see some patient records and assessments that had not been completed fully. There were difficulties regarding the retrieval of patient records resulting in multiple temporary records for the same person being created and risks of records being mixed up. There are a number of different electronic patient information systems, which do not necessarily link to each other or the hospitals main patient administration system.

Maternity services have their own records system and clear links were not made with other hospital records. There were problems with maternity records being lost and misplaced and poor completion of maternal assessments.

Leadership

There have been a number of changes at executive level at the trust in recent years. The trust has focussed on reducing its financial deficit, and at the same time the quality of care has suffered. There is evidence of poor leadership from some managers and a culture amongst some staff of poor attitude and a lack of care for patients, especially in maternity services. There is also evidence amongst the staff that this culture is beginning to change and that the new chief executive, the director of nursing and the medical director are seen to be working well together. Staff believe that the chief executive is listening to them and are encouraged that their voices are being heard.

Capacity

There are challenges for the trust in terms of capacity at Queen's Hospital. There has been a gradual transfer of services from King George Hospital to Queen's Hospital, but the efficiency gains that were supposed to occur at Queen's Hospital have not come about.

The majority of maternity services are now provided at Queen's Hospital. Staff, stakeholders, patients, and evidence from external reviews all indicate that too many women now attend Queen's Hospital for their maternity care, and that the trust cannot cope with the level of activity.

The trust has had difficulty in ensuring that patients are admitted from the emergency department in less than four hours particularly at Queen's Hospital since it opened in 2006. There has been a traditional approach to how patients are managed and move through the department, and a lack of staff and poor inter-divisional working that has further restricted the flow of patients. For example once a decision to admit a patient has been made, some clinical specialities, require a junior member of the medical team to re assess the patient in the emergency department rather than the patient simply being transferred to that speciality.

The emergency department reached its tipping point last winter when the quality of service began to collapse. This was partly due to the fact that emergency services were not part of the medicine division, and due to interim management arrangements that had been put in place at that time. Staff told us that changes had been made to the systems and processes in the emergency department on a daily basis with no regard to or inclusion of staff in the department. One staff told us that if *'you didn't agree with the interims you were moved aside'*.

When the current chief executive started at the trust, the interim management arrangements were changed and the emergency department brought back into the medicine division. Ownership of problems returned to the staff in the department. Since then there have been improvements in the quality of the emergency service, for example the department has introduced a rapid assessment and treatment service for patients brought in to the 'majors' stream, which ensures that patients are treated more quickly.

Recommendations for the trust

As a result of this investigation, we have 73 separate recommendations that the trust must fulfil. They are set out at the end of each relevant chapter in this report. There are two strategic recommendations set out below. Because of the concerns identified in maternity services, the recommendations that the trust must fulfil in that service are also set out below.

The trust will need to develop an action plan that ensures it will implement substantive change and improve the quality of patient experience across the organisation. The Care Quality Commission will monitor the implementation of this action plan via its local compliance team.

The trust has a number of urgent problems to solve and to do so effectively will require the support of organisations in the local health economy to achieve this including its commissioners and NHS London. The correct support is required to allow staff to retain ownership of the problems that exist in the trust, and develop the solutions that are required to deliver high quality services.

However, many of the leaders and managers who are required to lead the cultural and organisational change programmes have been so overwhelmed by the day to day operational difficulties that they have not been able to work strategically. Therefore the support required will be to ‘work with’ the staff to turn the trust around and not ‘do to’ the staff to turn the trust around.

The trust has a large and challenging agenda ahead of it. It needs to ensure that it has in place managers and leaders who can lead and support the cultural change that is required.

The area of greatest concern remains maternity services; poor service culture remains in pockets, staff shortages, an isolation from the rest of the organisation and weak governance systems. Improvements need to be achieved in a short time frame to ensure the immediate safety of women using its services, whilst developing long term solutions.

The trust needs to ensure that it can cope with the upcoming winter pressures in its emergency departments and ensure the flow of patients through the whole organisation is efficient. To do this staff must ensure that they think creatively about how services can be delivered, and not just through traditional models of health care delivery. The organisation must function as a whole entity and not as appears in isolated competitive divisions and departments. The trust needs to consider how it uses all its current capacity to allow high quality patient services to be delivered across all trust sites.

The trust needs to ensure that it has monitoring systems to avoid further tipping points in other clinical services. For example there are concerns in radiology; these need to be dealt with promptly and the quality of service improved to ensure that the risk of serious untoward incidents occurring is

reduced. The trust needs to ensure that the experience of patients in areas such as day case surgery is improved.

In addition there is a need to lead the staff of the organisation on a journey of cultural change. The cultural change programme is required so that those staff who undoubtedly endeavour to provide a high quality service, are not let down by their colleagues and that patients can feel confident that problems are dealt with. The change programme should include robust, fair and transparent processes to deal with cases where individuals have dealt with patients and their colleagues inappropriately.

The trust need to assure themselves that those services that were not included in the pathways for this investigation are also safe and that the quality of patient care and experience can be assured. Again this can be achieved with appropriate external support.

Strategic Recommendations

- The trust in conjunction with NHS London should seek appropriate external expertise to support a programme of organisational change and service improvement.

- The trust in conjunction with its commissioners and other partners should identify and implement plans to secure a long term solution to reduce over capacity at Queen's Hospital.

Recommendations for the trust for maternity services

The trust must:

- In conjunction with its commissioners and other partners identify and implement immediate solutions to deliver safe maternity services at the trust especially at Queen's Hospital whilst developing plans to secure a long term solution.

- Ensure that it configures its maternity services wards and departments appropriately to improve the quality of antenatal and postnatal care at Queen's Hospital.

- Ensure that there are suitable numbers of midwives to provide one to one care for all women during established labour.

- Ensure that learning from incidents in maternity services takes place to reduce the risk to women of unsafe care.

- It takes appropriate steps to ensure that all women can receive adequate pain relief when they require it.

- Further improve the maternity triage process with the introduction of regular monitoring and learning to ensure that services improve for all mothers.

- Take appropriate action to ensure that babies are not transferred to the neonatal care unit unnecessarily.

- Ensure it utilises all staff and systems effectively to improve the discharge process.

- Undertake a skill mix review in its maternity services for example *Birth Rate Plus*.

- Continue with its recruitment plans in maternity services to ensure that it has suitable numbers of qualified staff across all service delivery departments.

- Review the clarity of its reporting processes with regard to CTG training in maternity services.

- Increase the level of training on the interpretation of CTG's so that all staff have undertaken this.

- Increase the number of supervisors of midwives as a matter of priority to improve the quality of supervision, and reduce the burden on those currently in post.

- Improve the quality of record keeping and records management in maternity services.

- Assure itself that it has the right managers and leaders in maternity services to deliver high quality safe services for women.

Background to the investigation

The trust

Barking, Havering and Redbridge University Hospitals NHS Trust (the trust) serves a population of around 700,000 in outer north east London. It operates across two main sites at Queen's Hospital in Romford which opened in 2006 and King George Hospital at Ilford which opened in 1993.

The trust provides services to people across three local authority areas; Havering, Redbridge, and Barking and Dagenham and general and emergency services to the population of west Essex with some specialist services to all of Essex, e.g. neurosurgery. The three areas have different demographic backgrounds. Havering has a population of around 232,000 with low levels of deprivation, Redbridge has around 264,000 people with average levels of deprivation, and Barking and Dagenham has around 172,000 with high levels of deprivation.

Queen's Hospital at Romford sits within Havering local authority and so is the main hospital for that population, while King George Hospital is located at Ilford and mainly serves the population within the areas of Redbridge and Barking and Dagenham.

There are two other locations registered to the trust, Barking Community Hospital and Victoria Hospital.

Previous performance

The trust has performed poorly for a number of years with regard to NHS regulation. Over the course of the previous regulatory framework (the Annual Health Check), the trust was rated 'weak' on both quality of care and use of resources in the year 2008-2009.

The trust has had long-standing financial debt and concerns over the quality of care. In 2005-2006 its cumulative debt was just under £16m; by 2009-2010 this had risen to just under £117m.

There have been numerous changes at executive level in recent years, and a new chief executive started February 2011. There is an interim chair, and a substantive post is currently being advertised. The director of nursing has been in post for 18 months. A new medical director started in May 2011; prior to this since from November 2009 the post was covered by non permanent appointments.

CQC regulatory action to date

CQC registered the trust in April 2010 under the new regulatory system under the Health and Social Care Act 2008. We placed eight conditions on its registration, one of the highest numbers for NHS trusts in England.

During 2010-2011 we carried out a number of inspections to review whether the trust had made sufficient improvements against these conditions. We noted some improvements and lifted seven of the conditions. One remains in place, with regard to having sufficient numbers of staff in maternity services.

It was during this ongoing monitoring of the trust's compliance with the essential standards of quality and safety, that we identified further concerns particularly in the trust's maternity and emergency services, and specifically at Queen's Hospital. There had been 5 maternal deaths in the 18 months before we began the investigation two of which were in 2011, and we received numerous concerns from patients, members of the public and other stakeholders.

Acting on this information, we issued warning notices to the trust in March 2011 in respect of staffing levels and concerns about maternity care. We issued a further warning notice in June 2011 in respect of emergency care.

We issued a further warning notice in July 2011 concerning staffing levels in the trust's general wards.

We conducted further compliance inspections in September 2011 to review what progress the trust had taken regarding the final condition it had place on its registration in 2010.

After the warning notices were issued the trust began to improve some areas where concerns had been raised for example it employed more permanent staff.

However despite the warning notices being served we continued to identify concerns at the trust, and we continued to receive information and reports of poor quality care from patients and the public. In light of this we took the decision to carry out a formal investigation of the trust.

How we carried out this investigation

We began the investigation on 4 July 2011. The inspection team consisted of CQC staff and external expert advisors.

The terms of reference are reproduced in Appendix A.

Out aim was to assess the systems and procedures that the trust has in place to ensure that people are protected against the risk of inappropriate or unsafe care and treatment.

To do this we looked at three particular pathways of care; maternity care, elective care and emergency care. We also examined the trust's governance and management systems.

We reviewed data supplied by the trust. We visited both main hospital sites. During the site visits we talked with patients, and observed care being delivered; and carried out over 200 private interviews with members of staff. We interviewed staff from 13 different stakeholders.

We held a number of private interviews with patients and members of the public at locations across Ilford, Romford and Barking as well as receiving written submissions. In total we received information from over 100 people who had experience of the trust's services.

Main findings of the investigation

Respecting and involving people (Outcome 1)

The trust has poor results from national patient surveys, and whilst it has systems and processes in place to capture patient experiences, it is not clear from the data supplied by the trust that the evidence is being used to effectively improve the quality of care and to allow patients to know what has changed. Patients and relatives told us that on many occasions they didn't feel that they were involved in decisions about their care, and this is supported by survey information.

From a review of information supplied by the trust, we saw evidence that it has a number of committees or groups that examine patient experience and include patient representatives. While these groups appear to discuss a large range of areas that affect patient experience it is unclear, from the information provided, how these groups actually affect changes in outcomes for people who use services. Similarly in response to the poor national survey results the trust has devised a number of actions to address areas such as information provision. Many of these actions involve reviewing and enhancing existing practices, but from the information provided it is not clear what effect these have had on outcomes for people who use services.

The trust has a patient experience strategy in place for the years 2010-2013 which includes 10 aims (areas). These include improving communication, fundamentals of care, patient and public involvement and end of life care. However, the trust performed poorly in both national patient surveys conducted during 2010 with the trust scoring in the worst 20% of organisations in England for 40 (out of 77) questions in the 2010 inpatient survey and 18 (out of 19) questions in the 2010 maternity survey. We were told that previously staff were not aware of these patient surveys, nor were they being made aware that the trust was performing so poorly. Although progress has been made this lack of communication was also expressed to us by staff. The main areas of problems highlighted by these survey results were:

1. Communication with patients and information provision
2. Involvement of patients and carers in decisions about care
3. Patient choice
4. Respect and dignity
5. Confidence and trust in staff

The director of nursing at the trust has introduced a visible leadership programme to begin to address some of the concerns raised in surveys and complaints. Audits have been undertaken which demonstrate some improvements in discharge planning, privacy and dignity and pain management; with audits taking place as part of a rolling programme. However as this is a recent introduction insufficient data was available to allow for confidence in the effectiveness of the outcomes. One member of staff told us

'Visible Leadership happens on a Thursday afternoon 2 to 4pm, every two weeks. It focuses on patient experience. (They) discuss what staff want to talk about and (she) feels they are good meetings.

In addition to locally arranged visible leadership meetings, trust wide visible leadership events take place weekly.

In January 2011 the trust introduced electronic patient surveys which can be accessed by patients on wards through hand-held touch-screen devices. There are also a number of kiosks around the hospital in public areas including the accident and emergency and outpatient departments that patients, relatives or visitors can access to provide feedback. Currently this system is only in place at Queen's Hospital, though we were told that there are plans to introduce it at King George Hospital. For inpatients that have been discharged there is also a link to the surveys via the homepage on the trust's website. Results from the first 6 months since this system was introduced show that the medical division scores below the trust average across the 11 question areas; while the surgical division scores equal to or above the trust average in all 11 question areas.

The outcomes from over 600 people who have utilised the public kiosk at Queen's Hospital in the emergency department were reported. The results were mixed; nearly 50% of patients waited over an hour to speak with a nurse or doctor, and whilst 52% of patients answered positively about being involved in decisions about their care, 40% did not. In addition to this, 35% of patients felt they were not treated with dignity and respect, and nearly 50% felt that not enough was done to control their pain.

The trust has also introduced an hourly vital signs check so that basic observations such as blood pressure and pulse can be checked as required and staff check the condition of their patients. When talking with staff whilst they were aware of this initiative some emergency department nursing staff at Queen's Hospital told us that in practice they do not do these checks as they do not have enough time.

During our site visits in July and August 2011, we observed and spoke to patients across a variety of general wards, the medical admissions unit, intensive and high dependency units and the emergency department. We saw and patients told us that staff took the privacy of patients seriously. We observed the majority of curtained bays or bed spaces were displaying do not enter signs and when staff were wishing to enter these spaces they would check with the patient first. We observed staff speaking to patients with respect.

However, the experience of patients in the emergency department during the winter of 2010-2011 was not good. Of the information we received from patients fifteen were in relation to poor care in the emergency department, only two identified good patient experiences in the emergency department. The main complaint has been in relation to a lack of basic nursing care and privacy and dignity being maintained, and many instances where patients

were being kept in the emergency department for several hours, where patients and/ or their relatives were not provided with information and were not aware of what was happening to them.

Staff attitude towards some women in maternity services has been poor. We received information from over thirty individuals who had experienced what they considered to be poor quality care. The theme of these concerns range from women routinely being ignored and their description of their labour being dismissed by staff; being left alone for long periods of time whilst in labour, being spoken to rudely by staff and not receiving adequate pain relief. One woman was denied assistance with her hygiene needs despite asking for help on numerous occasions. Another woman told us that she was told that she needed to hurry up and give birth as the midwife's shift finished at 7am. Another woman told us that she had presented to the maternity triage at Queen's Hospital after her waters had broken; she suspected that there was meconium in her waters; she was in a lot of pain and required pain relief. On telling the midwife this, the midwife ignored the woman concerned, turned to her colleague and said *'and she thinks it hurts now'*.

This attitude was not only directed at women in labour; information was provided to CQC regarding the experience of the husband of a woman on the antenatal ward at Queen's Hospital. The woman's husband was concerned over his wife's condition but stated that staff ignored his pleas for help with tragic consequences for his wife and their unborn baby.

At Queen's Hospital when women are discharged following the birth of their child but prior to leaving the hospital they are sent to a discharge lounge. We were told that women are given postnatal advice such as breast feeding, and baby checks are carried out. Women told us that they felt there was little privacy in the discharge lounge and that they were often kept waiting there a long time. During the site visit we heard one women ask how long they would be there to which the midwife responded that she didn't know.

It is not only people who use services who have articulated problems with the attitude of staff; around 25 staff that we interviewed from maternity services indicated that they have witnessed examples of poor attitude and rude behaviour between midwives and medical staff and women in their care. In data supplied by the trust the attitude of midwifery staff was also one of the most common causes of complaints. Staff described to us a culture of abuse that has been a consistent problem for many years but has not been dealt with effectively by senior managers. For example one staff member stated that a colleague

> *'shouted and argued with me on the ward, in front of staff, visitors and patients because I had refused to do a job she was allocated to do. When I approached supervisory members of staff regarding this, their attitude was flippant and they said they were already aware of previous issues regarding this member of staff'*.

There was some evidence that the recently recruited staff from overseas were having a positive effect on staff attitude, but midwifery services is still receiving complaints about the attitude of some staff.

During the winter of 2010-2011, the antenatal ward at Queen's Hospital was moved some considerable distance from the labour ward and postnatal ward. This has resulted in a number of women giving birth in the antenatal ward, or being transferred whilst in labour to the labour ward which requires that they are transported through public corridors whilst in labour and in distress. Clinical staff told us that there was a lack of consultation with them regarding this move, which they did not agree with. We were told that the trust is now considering relocating the antenatal ward again to endeavour to reduce these situations from occurring.

We were told by staff and observed that for some patients undergoing day case procedures there are often not enough beds, and some patients end up staying in the theatre recovery area for up to 23 hours. We observed that toilet facilities are inappropriate and the area does not have any natural light. The female toilet does not have a hand rail and is not suitable for people that use wheelchairs. The toilet is located in the area of the recovery unit where people who have just had surgery are cared for. Women using the toilet have to walk through this area so compromising their privacy and the privacy of those patients from theatre. The male toilet facilities are located on a corridor between the theatre rooms and the recovery unit and similarly are not suitable for people that use wheelchairs. If a patient wishes to have a shower then women need to go to the gynaecology ward on the same floor as the theatre recovery, but men need to go upstairs to another ward, which does not support the dignity and privacy needs of patients.

Recommendations for the trust

The trust must:

- Ensure that it acts on the outcomes of its own and national patient surveys and demonstrate that improvements to the quality of the patient experience across the trust are made.

- Enhance its existing systems for involving patients in the development of services to ensure that the patient's voice is an integral part of every division, ward and department engagement strategy.

- Make sure that proactive and mandatory training and education regarding dignity, respect and tolerance is delivered to all staff.

Care and welfare of people (Outcome 4)

CQC received nearly 90 submissions from patients and relatives outlining examples of poor care. The majority were from patients who had experienced care at Queen's Hospital, though some were from King George Hospital. We did receive some positive feedback from patients who had experienced care at both of the hospitals and MP's and local councillors also noted that whilst they received many complaints about the quality of care from their constituents, they also acknowledged that many people do receive good care at the trust. The terms of reference for this investigation identified three pathways to follow to explore the quality of care. The remainder of this section examines the quality of care given to people within those pathways, as well as other issues that were identified.

Maternity

Trust data raised some concerns over quality indicators. There are a high number of caesarean sections being performed at the trust (though this is not unique when compared with other trusts in London). The trust's target for less than 22.5% of births by caesarean section was not being met from January to June 2011, and was red rated for four of these months. This was also an issue in 2010 and was highlighted in several internal meetings.

In addition to the high number of caesarean sections being performed, they are not all being carried out in a timely manner; especially grade two sections (urgently requiring caesarean section within 30 minutes due to concern for the mother or baby's wellbeing). The trust's maternity performance report for the week commencing 4 July 2011 contained an audit of 17 sets of records for women who had had caesarean sections. The results indicated that 75% of women classified as grade one (urgently requiring caesarean section within 30 minutes due to immediate threat to the mother or baby's life) had their caesarean section within the recommended time. Only, 18% of women classified as grade two and 50% of women classified as grade three (requiring caesarean section within 75 minutes) had their caesarean section within the recommended time. The following weeks report (11 July 2011) containing an audit of 18 sets of notes showed that four out of five grade one sections were performed within 30 minutes (the fifth case was only delayed by a further three minutes), however only 20% of grade two sections were carried out within the recommended time. Two out of three grade three sections were delayed; one woman waited almost three hours, and the second waited for almost four.

One to one care of women in established labour was found to be a key area of risk by an external review in early 2011. According to the trust's data, one to one care was not consistently given at Queen's Hospital between February and June 2011, and its target for over 95% of women to receive this was not met. However improvement is being made; 95% of women received one to one care in June, compared with 89% in February 2011.

Recent audits of patient records have found variability in the time taken for women to receive pain relief. Generally it has been found that pethidine is given within the trust's target of 15 minutes, however this is not the case for the administration of an epidural. The most recent audit provided by the trust (July 2011) showed that 6 out of 13 women did not receive an epidural within the trust's target of 30 minutes. One woman waited almost two and a half hours. Patients' records from two weeks in June were also audited by the trust. In the first week only 1 out of 13 women did not receive the epidural within 30 minutes, but in the second week 4 out of 8 did not receive it in the required time. The main reason for this was the anaesthetist being busy in theatre.

One woman who contacted CQC told us that she had waited many hours for an epidural and felt that she was simply ignored by staff until her husband raised his concerns. She told us that when an anaesthetist did arrive an epidural was sited, which the woman believes was incorrect as she gained no pain relief from the epidural and had leg spasms. We were told that

> *'I begged hospital staff for 4 hours for the epidural to be correctly sited; I was ignored; my husband kept looking for the anaesthetist. He finally found him having a joke with a nurse. When the anaesthetist entered the delivery room he was with a female consultant, he was laughing and joking with her. I told him to please stop laughing as I found nothing funny; he then corrected my epidural. I had endured around 10 hours of excruciating labour'*.

During the course of the investigation we received many personal accounts from women detailing poor experience about their care in maternity services, the majority at Queen's Hospital which are not appropriate to publish. These examples include women being ignored by midwifery staff, being sent home from triage inappropriately, and traumatic experiences whilst giving birth including a lack of analgesia.

Another indicator of quality is the time taken to transfer a mother and her baby from the labour ward after delivery of the baby. An internal audit in March 2011 showed a minimum interval of 1h30m and maximum of 19h35m at Queen's Hospital. The reasons for the delays included no postnatal beds, staff caring for other patients, and delays in suturing. Long waiting times for transfer have been discussed in several internal meetings. Some improvement was seen in April 2011, which as noted in a trust internal meeting, coincided with the introduction of a new staffing template and supernumerary bed coordinators. However, the trust's average waiting times are still approximately double the national average (4-5 hours at the trust and 2 hours nationally).

At Queen's Hospital, historically there have been numerous problems with the trust's triage systems. Understaffing and long waits for review, inadequate telephone advice and lack of privacy have been cited at internal meetings, and triage has also often featured in complaints received by the trust.

One woman's experience was not good; despite timing her contractions at two minutes apart, the midwife in triage informed the women that she was not in labour and would have to go home.

> '*I was shocked that the midwife was not one bit sympathetic towards me and the agony I was in, instead she was patronising.*' The women then made her way to the car park at Queen's Hospital with her husband but noticed that people were staring at her; *'Once we got to the ticket machine two nurses ran over to us with a wheel chair and asked where I was going and why. My husband explained to her what the situation was and she turned around and said I could not leave the hospital as I was bleeding…and (needed) to sit in the wheel chair. I looked down and saw lots of blood on my trousers.'*

The woman was taken to the emergency department and subsequently to the labour ward where she gave birth to her baby.

In April 2011, a new system was introduced. The service is now midwife led and available all day. Staff indicated to us that they believed that this had improved access to maternity services for women. Recent data has indicated that the waiting time target for 98% of women to be assessed within 15 minutes is not consistently being met. Data from the week commencing 4 July 2011 showed that on average only 78% of women were seen within the target time. A recent serious untoward incident (SUI) report noted a two hour wait in triage for one woman.

There have also been concerns reported internally and by staff over the admission of babies with a low body temperature to the neonatal care unit (NNCU). In early 2010 it was reported that babies with a low body temperature were being admitted to NNCU from the labour ward and in particular from the operating theatres. The issue was resolved after some months by increased training; however it was mentioned again at an internal maternity risk management meeting in May 2011.

Emergency care

Concerns over the quality of care in the emergency department, especially at Queen's Hospital were raised. Concerns raised by patients and relatives were in relation to waiting times and the quality of care provided especially during the winter of 2010-2011. People told us that they had extremely long waits in the emergency department and often experienced poor care. One person told us that they had been asking staff for assistance for their relative with mouth care for four and a half hours, only to be told that the staff were busy.

Queen's Hospital has had difficulty achieving the 4 hour maximum wait to admit patients since its opening in 2006. Concerns were raised with regard to the poor flow of patients and long waiting times in an external review in 2008. In bed management reports in 2009, these difficulties still existed, the report noted that

> *'Since opening, in 2007, Queens Hospital has had difficulty reaching the NHS four hour waiting time standard for emergency cases. It has significant financial and staffing problems and is currently being supported in a turn around plan by the Department of Health'.* In particular there were problems noted over weekend working; *'This weekend situation should score as at least 'extreme-major' if not 'extreme-catastrophic' in terms of the potential impact on reputation and adverse publicity. It is also not a one off event and would score at least as 'possible' if not 'likely' to occur again'.*

These concerns continue to be identified in minutes from the emergency department meeting in September 2010, noting that

> *'Patients as a rule should be ideally seen in chronological order and what sort of case it is, however now any patient who is deemed to pass the four hour wait is left to concentrate on not breaching the next one. Overall the department sometimes looks like a medical ward with nurses and docs tied up with incredible pressure on bed managers'*.

Although waiting times have improved in recent months, there are still examples of waiting times being excessively long, and not always for clinical reasons. One patient whose records we reviewed at the beginning of August 2011 did not receive a diagnosis until they had been in the emergency department for six hours. This was during the night (when trust data indicates that the number of patients attending the emergency department is lower). We checked the records and spoke to staff and could not find any reason for the delay.

There are concerns regarding the care for pregnant women who present or who are taken by ambulance to King George Hospital. There is a perception amongst some staff that ambulance protocols do not include not taking high risk pregnant women to King George Hospital, however protocols changed in November 2010 to ensure that ambulance staff take all high risk pregnant women to Queen's Hospital. We were also told that if a woman is in the mid to late stages of pregnancy the emergency department would send her straight up to maternity services with no assessment or treatment in the emergency department. We were given a number of examples of women who were brought to the maternity department without any initial assessment, including one woman who was brought to the maternity unit with swine flu which took maternity staff over 3 hours to stabilise her condition before transferring her to the intensive care unit.

Some improvements have been noted in the emergency department at Queen's Hospital. The department has introduced a rapid assessment team (RAT) initiative within the 'majors' stream where a team, led by a senior clinician, quickly assesses all 'majors' patients soon after their admission to the department. This initiative along with improved flow through the medical admissions unit has resulted in some improvements. Staff at King George Hospital stated that they are also considering introducing this approach once workforce issues have been addressed. The resuscitation areas in both

hospitals were seen as examples of good practice where patients appear to be cared for in a sequential, standardised and seamless manner. Staff emphasised that they have observed improvements in the emergency department over the last six months for example improvements as to how trauma patients are managed.

We visited the emergency department at Queen's Hospital on a number of occasions, and on one such visit we undertook a spot check on compliance with one trust policy related to the insertion of intravenous cannulae. Unfortunately, none of the patients in the 'majors' stream had all of the mandatory documentation completed, nor were any of the cannulae signed and dated by the attending clinician as per policy. One of the senior staff said she wasn't surprised as there weren't any consequences for those staff who failed to comply with trust policies and procedures. Another member of staff stated that this may also be a reflection of the current middle grade medical workforce that is neither permanent, nor compliant with trust policies. This is a concern and a clinical risk, as it would be very difficult to retrospectively address procedural problems with staff related to technique or other compliance issues if they do not sign the cannulae and complete the necessary documentation.

Radiology

We reviewed radiology services as part of the elective care pathway, and identified a number of concerns. Patients admitted for an angiography (a test examining a patient's cardiovascular system) need to stay in hospital overnight after their procedure. These patients are often admitted directly through the short stay surgical unit. This unit does not have overnight beds and these patients often require overnight beds. This can result in patients staying for up to 23 hours in the theatre recovery area. The staff on the short stay surgical unit have to contact the vascular wards to try and find a bed for the patient after their procedure. If the vascular wards are full the patient stays overnight in the theatre recovery area; this happens several times a week. Even though the admissions are planned there are still not always beds available.

We were told that staff on the wards are required to prepare patients for radiological procedures but this does not always happen. For example, on the morning of our visit a patient who should have been nil by mouth had just been given their breakfast. When radiology staff asked the ward nurse why this had happened no reasons could be given; we were told this happened regularly and goes unreported. Clearer pathways are being developed, along with a programme of staff re-education, but despite protocols being in place, they are not being followed in practice.

Minutes of the August 2010 vascular consultant meetings raises issues regarding interventional radiology service. It was stated that the service does not meet the level of care as set out in regional guidance. Further concerns were raised in an external review in January 2011 regarding staffing levels and capacity of the service, and a further external review in June 2011 gave

the service an amber rating regarding the availability of interventional radiology services being available on site at all times.

We were told that the radiological department is not fully compliant with a National Patient Safety Agency (NPSA) alert issued in 2007 concerning the need to ensure that radiology imaging results are communicated and acted on. The trust was alerted to the fact that they were non compliant with this in 2010 following a reminder from the NPSA and they discovered that this had not been addressed. We were told that the risk posed by non-compliance with the alert from 2007 is on the trust's risk register, and the trust hopes to be able to procure an electronic information system to address the alert fully in 2013-2014. In the interim, the trust has introduced a protocol for flagging incidental findings, in particular cancer.

There are difficulties in reporting some radiological tests for example chest x-rays. Overall the trust has one of the longest reporting times for all radiological tests in the London area, but there are some exceptions, including some of the quickest reporting times for certain radiological tests performed on patients from the emergency department. We were told that there have been significant levels of non-reporting, for example with chest x-rays. We were told

> *'some chest x-rays go unreported and these could have a positive result. This has been documented as having happened several times where someone has had a chest mass and it has worsened before being picked up by a later scan. This has resulted in poorer outcomes for patients'*.

Data from July 2011 indicates that during the period from January 2010 to December 2010 only 44% of the backlog of chest x-rays were reported on. During January 2011 to July 2011 this had risen to 80% of the backlog of chest x-rays being reported on.

We received information that in September 2011 a 'never event' occurred (events that are so serious that they should never occur) during which a wrong site procedure took place in interventional radiology. The trust has raised this as a serious untoward incident and has already undertaken an internal review.

Discharge

There were concerns raised about the discharge process within the trust, with a reported lack of consistency in applying discharge processes or recording decisions regarding the discharge of patients. There have been a number of personnel changes within the bed management and discharge teams, which has led to confusion over leadership and management of the teams. There have been a number of patients whose discharge had been delayed, in one case by 78 days as they were awaiting a bed in a community hospital. This was predominantly at Queen's Hospital.

We were told that one of the delays in discharge is due to lack of to take away medication (TTA), at Queen's Hospital. Patients should be sent home with all of their TTA medication. The pharmacy will dispense within one hour for urgent TTA's and four hours for a non urgent TTA, and that doctors are requested to write the TTA 24 hours before discharge. The ward pharmacists identify patients due for discharge and request that TTA's are written by a doctor. However, doctors do not always write TTA's 24 hours before discharge. This causes significant delays and the departure lounge often has a number of patients who have been discharged, but are waiting for their prescriptions. For example on the 19 July 2011, five of the seven people in the discharge lounge had not had their TTA's requested until after they arrived in the discharge lounge. Patients sometimes leave without their medications and either have to go back to hospital or send someone on their behalf, on occasions the medications are simply not collected at all. Staff informed us that they have reported this issue, but they are not aware of anything that has been done to improve the situation.

There are 2 electronic bed management and discharge systems in place, and neither is apparently fully utilised. The two systems are not linked. One of the systems provides a record of the pathway that a patient is on and assists in discharge planning. It provides information on a patients stay in the hospital, what clinical care they are receiving, and when referrals have been made to various staff as part of the discharge process. It can then provide a theoretical figure for the number of people likely to be discharged on any given day, but this can vary dramatically to the number actually discharged. For example on one of the days that we were at the trust the system indicated that there were 72 proposed discharges; however when we followed this up the following day there had only been 29 discharges. The system was introduced two years ago, but staff were not initially trained how to use it. A new drive has begun to get staff to use it since the new chief executive has been in post.

The second system is a live web based system that should track a patient through their hospital stay and provide a 'live' picture of the number of beds in the trust. However this is not utilised by many wards, and those that do, do so not to maintain a 'live' bed state for the trust, but because it links into the hospitals patient administration system (PAS) so that information can added to the PAS system indirectly.

There is a community discharge team that works within the trust and supports patients being discharged from the hospital. They have links with the hospital discharge team, though no one we interviewed from the hospital discharge team told us about them. The community discharge team take referrals from staff via another electronic system, but told us that around 50% of the referrals did not meet the criteria for referral to the community discharge team. We were told that nothing has been done to reduce this level of inappropriate referrals or to provide hospital ward staff with training to assist with the discharge process. We were also informed that the local authorities differ slightly in the community services that they provide which impacts on the ability for patients to be discharged, with a lack of neurological rehabilitation the biggest concern for that majority of staff we spoke to.

Surgery

Vascular services were transferred to Queen's Hospital in March 2011. We did not receive any major concerns from patients or relatives regarding vascular surgery, though we did receive a number of complaints about care in other surgical specialities.

However whilst following the elective surgical pathway some concerns were identified regarding the quality of care patients experience in the day surgery unit and how this is planned.

Patients coming for routine gynaecological surgery are consented at a pre-admission appointment or in the outpatient department. In contrast we were told that most general surgery patients are not consented beforehand. The patients arrive on the unit at 07.00 and are consented by the consultant that morning. We were told that this has resulted in some patients refusing their consent or asking for more time to think about the procedure.

For example, there were two patients on the day we visited who were not sure they wanted to go ahead with the procedure after the consultant explained it and wanted time to think. We also reviewed a set of patient's notes; the consent form did not cover the risks associated with general anaesthetic, and in this instant the patient was asthmatic and there was no evidence of a discussion of the risks this may pose to the patient. For patients who take anticoagulation medication (drugs that slow down the blood clotting process), they are told to stop taking this medication prior to surgery. However blood tests to check how quickly the patient's blood clots are not done until their arrival on the unit. Although the results take less than two hours patients have to wait for the results before being able to have surgery. Sometimes their operation is cancelled or staff have to reorganise the operating list to accommodate the wait for these blood test results.

Further issues with day case surgery were also identified. We were told that there are occasions when patients requiring gynaecological procedures are added to the emergency surgery list at the end of the day, for surgery the following morning. These patients are often requiring surgery due to a miscarriage of their pregnancy. The patients are added to the day surgery list at 18.00 the day before, but day surgery staff do not know about the numbers of patients until 07.00 the following day when they see the days operating lists. At this point the unit is already full with planned admissions, so a number of the patients requiring a gynaecological procedure are required to wait in the units lounge until a bed becomes available. Many of these patients complain about waiting in a crowded waiting room for long periods of time, and staff told us that they are subject to verbal abuse by patients *'on an almost daily basis'*.

Other experiences

Although we followed three specific pathways we were informed of a variety of other experiences by patients and/ or their relatives. It is important to note that

a number of these were positive. For example those people that commented on their experiences in oncology were positive about their experiences of care, for example

> *'Since the beginning of March my wife has been under the excellent care of Dr XXX and has just completed six intravenous chemotherapy treatments and four intrathecal treatments. Her care by Dr XXX and Dr XXX has been beyond anything we could have imagined and the…Trust should be thankful that they have such competent, professional and caring specialists on their staff*'.

Also people provided us with examples of good quality care in cardiology.

However the majority of information we received from patients was to outline experiences of poor quality. We recognise that the respondents were a self selected group and that it is common for people to respond to feedback requests with concerns more often than compliments.

Whilst the majority were in relation to maternity care and emergency care other examples were in orthopaedics, medicine and surgery. For example the relative of one patient told us that despite their relative having a broken hip nursing staff on two occasions attended alone to place their relative on a bed pan, one of the nurses rolling their eyes and walking off when the relative told them that their relative has a broken hip. Another relative told us that their husband was not assisted for over a week to have a shower despite her husband wanting to have one. We were told that it took persistent requests for staff to take her husband to have a shower.

Recommendations for the trust

The trust must:

Emergency Department

- Develop its strategy and work for improving flow of emergency/ urgent patients. This strategy needs to have the engagement of all clinicians and managers as a key component.

- Develop a culture where everyone feels empowered to challenge episodes of variable or poor practice, including regular monitoring of practice and feedback and learning opportunities for staff.

- Ensure that all staff, both permanent and temporary, follow hospital policy and procedures.

Radiology

- Develop its planning and bed management processes to ensure all patients are cared for in appropriate facilities.

- Put in place clear protocols for the management of interventional radiology patients with audit and improvement cycles to ensure standards are attained and maintained.

- Ensure that it fully implements the 2007 NPSA alert regarding radiology imaging results being communicated and acted on as a matter of urgency.

Discharge

- Develop its discharge and bed management teams and processes to ensure that they are interlinked and that patient flow is managed effectively from the point of entry to the point of discharge.

- Ensure that clear guidance outlining the expectations of all staff is produced and enforced so that the prescribing and dispensing of 'to take away' medication is managed effectively and patient discharges are not delayed. The trust needs to ensure that it monitors adherence with policy, guidance and audit and takes any appropriate action to support staff to deliver a high quality service.

- Review and rationalise the discharge and bed management information systems to ensure that the most effective and accurate system is fully utilised.

Surgery

- Develop its day case surgery service to ensure that appropriate patient flow is maintained including effective pre operative assessment.

- Improve standards of care for obstetric patients who undergo minor surgical procedures.

Cooperating with other providers (Outcome 6)

We are still collating evidence about Outcome 6: Co-operating with other providers.

We will be reporting on this after the publication of the main report. This is to ensure that we can publish this report as quickly as possible, so that action can be taken by the trust and its NHS partners to improve the quality and safety of services delivered to patients.

Safeguarding people from abuse (Outcome 7)

We are still collating evidence about Outcome 7: Safeguarding people from abuse.

We will be reporting on this outcome after the publication of this main report. This is to ensure that we can publish this report as quickly as possible, so that prompt action can be taken by the trust and its NHS partners to improve the quality and safety of services delivered to patients.

Cleanliness and infection control (Outcome 8)

The trust has been subject to three separate inspections under a previous regulatory regime regarding the prevention of healthcare acquired infections. These took place during 2009 and 2010. Improvements were identified in five different areas in the 2009 report including requiring a programme of audit, ensuring the environment is kept clean and that effective arrangements are in place for the decontamination of instruments and other equipment. A follow up visit in February 2010 identified that some areas of concern from the previous visit had not been rectified. A final visit in March 2010 identified that all concerns had been rectified.

The trust has in place a board level lead for infection prevention and control. There is a well established infection prevention team in place. There is an infection control committee. There was evidence that infection prevention audits are in place, for example commode cleaning audits in ward areas and in the emergency department and hand hygiene audits. There is reporting to the board regarding infection prevention and control and the infection prevention and control staff are currently developing a link into the main reporting dashboard. Training is provided to staff and a programme of winter preparation is in place.

The number of patients with hospital acquired MRSA infections is generally lower compared to the number of patients with Clostridium difficile infections. There was a sudden peak of hospital acquired MRSA infections in December 2010 with 3 confirmed cases, but this has been stable since. The number of Clostridium difficile infections peaked between September and October 2010, but fell sharply by the end of October 2010. Following a slight increase, the number of Clostridium difficile infections appears to have stabilised, but the trust is still higher than average when compared to other trusts.

During the site visit we observed a wide range of clinical areas and spoke with staff about the cleanliness of clinical areas. In general clinical areas were clean and staff indicated that they were able to access domestic staff when required. We saw alcohol disinfectant gels at the end of beds and in the entrance to wards. We also observed signs around the hospitals advising visitors of the need for good hand hygiene. We did identify some examples of poor practice with boxes of equipment and intravenous fluids stored on storage room floors. We also identified a potential problem where patients who have attended the emergency department with orthopaedic conditions and need to return for procedures in the day surgical unit are not screened for MRSA. We raised this with the infection prevention team and they reacted promptly putting in place a process to ensure that these patients are screened appropriately.

Some concerns were raised by patients over cleanliness, especially the public toilets in the emergency department at Queen's Hospital. Staff raised concerns over audit of infection prevention in maternity, with some staff indicating that no audit takes place and others indicating that staff in maternity use their own audit tools that are separate from the rest of the trust.

Another issue identified is that many of the female medical staff especially in the emergency department wear small handbags when treating patients. This was also identified by a woman who told us that a midwife had worn her handbag all the time while delivering her baby, and may increase the risk of cross infection.

Recommendations for the trust

The trust must:

- Ensure that all equipment and disposable products are stored appropriately.

- Ensure that all public toilets are kept clean especially in areas of high usage.

- Ensure that maternity audit processes are integrated with the rest of the trust.

- Ensure that staff are not posing an increased risk to patients from cross infection. The trust should take any necessary steps to ensure that staff can store personal property as necessary.

Management of medicines (Outcome 9)

Concerns were identified with the management of medicines. These concerns were largely in relation to take away drugs as outlined previously in this report. Other concerns were identified in relation to pain relief for women in labour also outlined earlier in this report.

Patients raised concerns with us over the availability of pain relief on general wards, but the majority of patient concern was with regard to the availability of to take away (TTA) drugs.

Staff told us that the pharmacy department undertake audits of medication prescribing and administration for example an audit of antibiotic usage and an audit against the NPSA alert on insulin has been completed. The results of audits and projects are presented via the safer medication practice group and clinical governance group. We were also told of some of the changes to practice that have occurred including changes to paediatric drug charts, and changes to the oral syringe policy.

During our site visits to both Queen's Hospital and King George Hospital we observed examples of medication errors. In the medical admissions unit at Queen's Hospital 3 out of 4 charts we looked at had errors, including evidence that drugs had not been signed for, or administered at the wrong times. We also noted that oxygen was not being prescribed for patients; we raised this with staff who confirmed this was the case.

We spoke with staff about reporting drug errors, and whilst staff were aware of the process to do this, not all staff told us that they receive feedback following the reporting of medication errors, though we did see evidence of the analysis of drug errors reported in the newly developed newsletter from the pharmacy department.

Staff in the emergency department told us of an open culture with regard to medication errors where staff were provided with additional support to learn from errors rather than a blame culture existing.

Recommendations for the trust

The trust must:

- Reinforce its policy on medication prescribing, dispensing and administration, ensuring that all staff are aware of their roles and responsibilities.

- Ensure that the results of learning from medication errors is widely publicised across all services in the organisation.

Safety and suitability of premises (Outcome 10)

There are a variety of issues concerning the premises specifically at Queen's Hospital. The hospital was opened in 2006 following the closure of two local hospitals. There is a confusing layout especially on the ground and first floors. The hospital is of a circular design with inner and outer rings. This makes it more difficult for people to get their bearings. In comparison we did not find the same concerns regarding the safety and suitability of premises at King George Hospital.

Sign posts on the ground and first floors at Queen's Hospital are confusing and often point in opposite directions. There are numerous additional locally made signs stuck to the main hospital signs to assist visitors and patients to find the area they are looking for but these are in various shapes and forms which can be hard to read and add to the confusing nature of the main signs. The number of ward moves hasn't assisted this as additional temporary signs are also added when wards move location. Whilst walking around the hospital we observed numerous times people asking for directions as they were unable to establish how to exit the building, and in some cases the staff they asked were also unable to direct them. We did note the presence of an information desk which is large and easy to access in the atrium and leaflets to provide further guidance.

The paediatric waiting area at Queen's Hospital offers no line of sight to observe children in the waiting area. We were told this has caused problems in the past when sick children cannot be readily observed. The trust is aware of this and told us that they are beginning to plan alterations to improve this.

Poor line of sight is also a problem for staff with patients who are on trolleys waiting for x-rays in the emergency department at Queen's Hospital. Currently patients wait in the corridor next to the x-ray department but this is outside the main part of the emergency department and there is no one to observe these patients apart from administration staff. While on the site visit at Queen's Hospital we observed an elderly lady who spent 25 minutes alone outside the x-ray room. She had been assessed as requiring observations and these were not undertaken. The trust told us they were aware of these problems and are planning to employ a nursing assistant to observe these patients. In addition to this we were also told that the x-ray room in the emergency department was never designed as such, (we were told it had originally been planned as a discharge lounge), and so there is limited space to get trolleys in and out of the room. For ambulatory patients there are no changing rooms, so staff have to exit the x-ray room to allow patients to get undressed before their x-ray.

Also in the emergency department, patients who attend the urgent care centre have little space to wait, and on the majority of days which we attended Queen's Hospital patients and visitors were seen sitting on the floor, and on the window ledge. Staff also told us that there are insufficient toilets for the public in the emergency department, and that blind spots in the middle of the

majors section of the emergency department means that not all patients can be observed by staff in that section.

There are a number of wards and departments that have no windows and therefore no access to natural light at Queen's Hospital; both staff and patients complained about this and the impact it has on them.

Whilst the general wards on higher floors had access to natural light the circular design of the wards meant that lines of sight can be poor. Staff told us it was difficult to observe the patients all the time especially at night when fewer staff were present.

As outlined in the section on the care and welfare of people who use services, for patients who stay for up to 23 hours in the surgical theatre recovery space, toilet facilities are inappropriate and the areas does not have any natural light. The female toilet does not have a hand rail and is not suitable for people that use wheelchairs. The toilet is located in the area of the recovery unit where people who have just had surgery are cared for. Women using the toilet have to walk through this area so compromising their privacy and the privacy of those patients from theatre.

The male toilet facilities are located on a corridor between the theatre rooms and the recovery unit. All of the rooms on this corridor were found to be unlocked, so could be directly accessed by men using the toilet facilities. The security of the premises is therefore at risk.

The shower facilities were difficult to access for people having just undergone surgical procedures. The women had to go to another ward on the same floor and the men had to use the facilities on another floor. Staff told us that most of the men are discharged without a shower due to the location of the showers.

Recommendations for the trust

The trust must:

- Review the directional signage at Queen's Hospital. The trust should ensure that it seeks the input of patients, relatives, visitors and staff, to ensure that any new signage meets the needs of its populations.

- Review the emergency department paediatric facilities at Queen's Hospital in line with the standards outlined in *Services for children in Emergency Department's* document and then develop an appropriate strategy involving both the emergency and paediatric departments.

- Finalise and implement plans to improve x-ray facilities and ensure that patients waiting for x-rays in the emergency department are appropriately cared for.

- Ensure that appropriate waiting facilities are available for patients and relatives in the urgent care centre.

- Explore options and take action to improve access to natural light and ventilation in all clinical areas that currently do not have windows at Queen's Hospital.

- Review and take any necessary action in all inpatient areas to ensure that there are clear lines of sight so that patients can be observed at all times.

- Develop appropriate facilities to ensure the day case surgical patients are cared for in appropriate environments at Queen's Hospital.

Safety, availability and suitability of equipment (Outcome 11)

Access to equipment was generally satisfactory, though there were differences across the two sites. At King George Hospital staff did not articulate any specific concerns with access to equipment for example fluid pumps or monitoring equipment or disposable equipment. At Queen's Hospital, staff in the emergency department indicated that they often did not have enough of the correct equipment in the right locations. This is partly due to the design of the emergency department where the different parts e.g. majors and minors are not located immediately next to one another making utilisation of equipment more difficult. Under the contracting arrangements put in place when Queen's Hospital was built utilising the private finance initiative scheme, medical devices at Queen's Hospital are supplied as part of this contract.

Access to disposable equipment at Queen's Hospital could be difficult. In a number of interviews staff reported that they would often run out of equipment before the end of the week. When we asked what they would do about this some staff simply said it was the responsibility of the manager, and did not recognise any responsibility that they may have to ensure that disposable equipment is available, such attitudes are unacceptable.

Staff at Queen's Hospital told us that they had problems accessing equipment such as fluid pumps and monitors. This was because as patients were transferred between wards, equipment wasn't returned and staff spent time searching for equipment to ensure that their ward had enough.

Senior staff told us that a lack of equipment had always been a problem at Queen's Hospital, though they believe this is partly due to the acuity of patients increasing and requiring more equipment due to the complexity of their conditions.

The trust has indicated that there are systems in place to audit the availability of equipment. Although staff articulated their concerns to CQC the trust has not received any requests from the divisions for further equipment and stated that staff do not appear to be following the correct process for ensuing they have sufficient equipment.

Another issue raised related to access to sufficient stationery. We were told by a number of staff from different clinical areas that they often ran out of stationery and paper specifically, and their orders for additional stock would be refused.

However not all staff indicated that there were problems accessing equipment. Staff in the intensive care unit at Queen's Hospital were happy that disposable equipment is readily available and when monitors are faulty the supply company are quick to attend and the problems are resolved quickly.

Some staff raised concerns over availability of therapy equipment such as wheel chairs; we were told it could take anything from two weeks to four months to get a wheel chair especially if a larger wheel chair was required. Some concern was also raised about access to equipment from the community for patients being discharged with differences being experienced between the different local authorities.

Recommendations for the trust

The trust must:

- Review the availability of medical devices in clinical areas to ensure that appropriate levels of equipment are available for the acuity of patients that it receives at Queen's Hospital. Further revalidation of the review needs to take place following any changes to service provision.

- Ensure that systems are in place in all clinical areas so that sufficient disposable equipment is available.

- Develop as part of its cultural change programme people's sense of responsibility to take positive action to ensure that clinical areas are suitably equipped to provide safe patient care.

Staffing (Outcome 13)

From the data supplied by the trust an accurate figure for the number of vacancies could not be established. The vacancy totals and funded establishment calculated across different staff groups and divisions from the documents provided by the trust did not match. This meant that it was not possible to conclusively determine the number of vacancies. Furthermore CQC was told that there had been no systematic skill mix reviews or needs analysis that would assist the trust to determine an appropriate funded establishment level.

What was clear from the documents was that the trust has too few permanent staff compared to its funded establishments. This is shown by the high usage of temporary staff and the numerous recruitment drives being conducted. For example in the emergency division over the time period August 2010 to March 2011 over 50% of the division's pay bill was spent on agency and bank staff. The trust is implementing new systems to enable it to more clearly identify where vacancies exist. All posts at the trust are now individually numbered so when they fall vacant it will be easier to identify them and thus recruit to them.

Vacancy problems also appear to be significant in the other divisions. In addition to high levels of vacancies staff turn over and sickness rates have all at various times been high. The trusts overall sickness levels for 2010-2011 although still higher than the NHS average are now only 0.13% above where as they were 1.06% above in 2008-2009. Although the majority of problems as a consequence of a lack of staff are focussed on Queen's Hospital, we were also told that recruitment at King George Hospital is difficult. We were told that this is due to the uncertainty surrounding the hospital and its future. This does cause problems at King George Hospital where areas that are staffed to their funded establishments lose staff to other wards at the hospital.

A lack of registered nursing and midwifery staff is also highlighted by the fact that the trust has the lowest ratio of nurses to beds of all London acute trusts. The main areas of recruitment difficulty for the trust appear to have been around midwives and middle grade doctors although problems recruiting consultants and nursing staff in general have also been noted. These difficulties have led to the trust increasingly pursuing international recruitment.

Given the impact on quality of care due to a lack of staff the trust's workforce strategy for the years 2010-2013 worryingly includes the statement

> *"To achieve its cost reduction plan the Trust anticipates that the headcount will need to reduce by circa 850 FTE (including temporary staff) during the period 2010 to 2015"*.

The document goes on to suggest that the reduction in staff numbers will be achievable due to the increase in community provision. However as outlined within this report throughput of patients continues to rise especially at Queen's Hospital. The trust has stated that these proposals were based on the models being proposed within the *Health for North East London* consultation and that

the workforce strategy will be subject to revision once the final decision regarding the consultation is made.

Lack of staff is not just a problem in maternity services and the emergency department; a breakdown of nurse staffing levels in the surgical division provided by the trust for June 2011 showed the vacancy rate amongst qualified and unqualified nursing staff was running at 18%, and individually between wards varied from 1% to 34%. The same is seen with medical vacancies across the trust. Information on the current position in the emergency department in July 2011 indicated that there was a vacancy rate of 31% for consultant medical staff, and further vacancies across a range of medical positions especially those identified as staff grade doctors.

Despite the high level of medical vacancies in the emergency department and the long standing difficulty in recruiting medical staff, when we spoke to senior staff in the emergency department their vision for the service, was restricted to a 24 hour consultant led service. Some thought had been given to utilising other staff groups, but the vision of utilising other staff groups to deliver care was limited. There are a small number of emergency nurse practitioners (ENP) who might work more autonomously for those patients attending with minor injuries and illnesses. However, ENP's have historically been pulled from their work to undertake traditional nursing roles when there is insufficient flow (that is patients are not being transferred to wards or discharged from the emergency unit quickly) to attend the needs of patients awaiting admission to hospital. This reduces the clinical exposure of the ENP group who may never gain the confidence in treating a wider range of clinical presentations. We were told that when this occurred after Queen's Hospital opened in 2006 a proportion of ENP's left as they were dissatisfied with their roles. A meaningful workforce review or staffing plan cannot be undertaken until an overall emergency department strategy has been developed. Some of the perceived need for extra staff may not be required once a more structured pathway is introduced and working styles are changed.

From discussions with staff and the review of evidence, it is clear that the trust has been taking positive action recently to recruit permanent staff. Since the new chief executive has been in post weekly rolling adverts have been stopped and more targeted recruitment plans have been put in place. Evidence seen from the three clinical specialities under review and from talking to staff indicates that the trust is beginning to take proactive action, and staff indicated that the newly recruited staff are beginning to have a positive impact at the trust. For example the emergency department at Queen's Hospital has been able to meet the four hour target to admit patients with greater regularity since the recruitment of more permanent staff.

Although the trust has begun to recruit staff to fill vacancies the next step is to ensure that staff are deployed effectively and their skills used appropriately. One concern raised with us was the lack of paediatricians to carry out post natal checks and the impact this was having on discharges from the maternity units. However we were also told that a number of midwives are trained to undertake specific post natal checks but are not utilised.

We were also told that there is variation in expectation and role between staff on the same *Agenda For Change* band. For example there are 20 band 8b nurses working in bed and site management and 5 band 8b nurses working in the emergency department. Whilst these roles may be entirely appropriate the trust is currently unable to establish whether these roles are functioning effectively or indeed need to function at this level as no skill mix or needs analysis has taken place.

There have been longstanding problems with staffing in obstetrics and midwifery. There has been a programme of overseas recruitment in midwifery and a large number of midwives have been recruited. We were told that whilst this is beginning to have a positive impact, a knock on effect of this is often a poorer skill mix, as many of the new staff are newly qualified midwives who need greater supervision.

Obstetric cover was identified as a problem by the trust, and was included in the risk register as recently as December 2010. In 2007 a report by the Royal College of Obstetricians and Gynaecologists recommended that there should be 24 hour obstetric cover due to the size of the unit at Queen's Hospital. The follow up review in 2008 found that this level of cover had not been implemented and in 2011 a further external review found that while there was 98 hours a week of cover (the trust being only one of two in the London region to achieve this level), this was still 70 hours short of the recommendations made four years earlier. Staff also indicated that the lack of middle grade doctors in obstetrics continued to have a detrimental impact on the effective delivery of obstetric services.

There are concerns over the lack of anaesthetic cover which is a long standing issue; the trust's level 2 assessment for the clinical negligence scheme for trust's (CNST) in 2009 found that the trust was non-compliant in the standard related to staffing levels of obstetric anaesthetists and their assistants. The risk of harm due to insufficient anaesthetic cover in maternity was on the unit's risk register in June 2010. Discussions about extending hours of consultant anaesthetic cover continue to take place. A recently agreed action plan does require that there should be a consultant anaesthetist present on Queen's Hospital labour ward from 08:00 to 20:00 Monday to Friday and on-call at other times. There has been a delay in implementing this, and the proposal is currently being consulted on. As noted previously, the trust is aware that women are not always receiving epidural pain relief in a timely fashion due to a lack of anaesthetic cover.

We were told for example that there are currently problems with the number of interventional radiologists, with an establishment of six, there are five in post, but with one interventional radiologist on maternity leave and another on long term sick leave, the trust has had to seek support from other organisations in the London area. There are also concerns over the lack of paediatric nurses in the emergency department. Another group of staff where there appears to be too few, are porters. Staff across both sites commented that this integral role often has too few staff in post, and that accessing them can be difficult.

This group of staff are not directly employed by the trust but are provided by an external company as part of the contractual arrangements put in place when the new Queen's Hospital was built.

We were also told of vacancy problems with allied health professionals. The trust is aware of this and has taken steps to recruit allied health professional staff. A recent bid for a vascular physiotherapist and assistant has been made as an audit completed by the therapists demonstrated the clinical effectiveness of extra therapy input into the vascular pathway.

We were told that additional therapy staff were employed in elderly care during the last year as there were too few staff. However this meant that an over spend of £0.5m occurred as the original plans for Queen's Hospital included the closure of a number of medical wards which had not all occurred.

We were told that there are only two speech and language therapists for Queen's Hospital, though they are provided by another NHS trust, and the trust now realise that as capacity has not reduced that a staffing increase of around 50% is required in this department.

A large number of staff raised concerns over poor support from human resources for example a lack of support and/ or training for managers to assist them in dealing with staff performance management or disciplinary hearings. There is also the perception amongst staff of a reluctance to discipline poor performing staff and dismiss them where appropriate; because the pressure of high vacancies meant that there was reluctance to use disciplinary procedures. We were told that if performance measures were commenced against staff they would often take a grievance out against the manager which would then take considerable time to be concluded. This is not an unfamiliar claim but should not detract from its relevance.

The trust has provided evidence that there has been an increasing number of staff suspended over the last three years, and that it has been dealing with a comparatively high number of formal procedures against staff compared with other trusts. The trust has also indicated that is provides a variety of training for managers, and has introduced a probationary period for some staff recruited from overseas to ensure they are able to perform competently in their roles. We were also told that since the new chief executive has been in post a number of nursing, midwifery and medical staff have been suspended.

Some staff and stakeholders raised concerns over whistle blowing at the trust. We were told by one staff member in midwifery that they have not raised their concerns over skill mix in maternity services as they believed that they would be victimised. The staff member told us that she was aware of other colleagues who had raised concerns and this had happened to them. We were also told by a stakeholder of concerns that had been raised with them in 2010 by a member of staff in a department at Queen's Hospital, and that they became aware from this individual that the trust was attempting to discipline staff as a result of the whistle blowing.

Concerns were also raised regarding mechanisms to link complaints made about clinicians with their overall performance. We were given a number of examples where complaints had been made about clinicians either internally or externally, which had not been linked in any formal way with HR processes when such linkage would have been appropriate. For example we were told of a clinician who was performing diagnostic tests that were outside local and National Institute of Health and Clinical Excellence (NICE) guidance. Two colleagues had managed to raise their concerns, but were frustrated that it was difficult to raise issues such as this and as far as they knew no resolution to the problem had been achieved. Whilst the trust has outlined how complaints made in this way are handled it was apparent that this did not work effectively in all instances

Recommendations for the trust

The trust must:

- Continue to review its human resource information systems and ensure that accurate data is available for the entire organisation, so that a clear and comprehensive understanding of vacancies can be established.

- Continue to review its workforce strategy to ensure that it meets the needs of the organisation and reflects the reality of service delivery.

- Undertake systematic skill mix and staffing needs analysis to ensure that they have the right staff with the right skills at the right locations and that trust is receiving value for money.

- Continue to recruit appropriate permanent staff to ensure that it reduces its reliance on agency and locum staff improving the quality of care, and have in place effective retention strategies.

- Develop and improve the human resources support for the divisions so that managers can take effective action against staff where there are performance concerns.

- Explore and develop strategies for delivering services with different staff groups so that reliance on difficult to recruit staff groups is reduced.

- Support a skills escalation programme in the emergency department that seeks to develop nurses who have already successfully completed an emergency nurse practitioner or advanced clinical practitioner course and reduce reliance on them undertaking traditional nursing duties due to shortages of staff.

- Ensure that its whistle blowing systems and processes allow staff a route to raise concerns early so that quick action can be taken and staff feel empowered to raise concerns.

Supporting workers (Outcome 14)

The trust is a university hospital and as such has links with a number of education establishments. There is a large well structured education and training department, led by the director of human resources, and is an integrated structure between nursing, medicine and allied health professionals. Structurally, beneath the director of human resources there is a director of education and a director of medical education, and a number of other education and training posts in the clinical directorates and within specialist departments that help to deliver education and training across the trust.

There is an education board that has representation from staff at different levels of the organisation. There are a variety of sub committees under the education board, whose role is to understand the training needs analysis of staff and ensure that it is commissioned appropriately. The sub groups have representation from all directorates and allied health professionals. The same approach is applied to medical education, where a variety of sub groups cover undergraduate, post graduate and consultant level education all report into the education board. The trust produces an annual education and learning report and the most recent report to March 2011 outlines the successes and areas for improvement across the trust.

There is a generic study leave policy which staff can access, and the trust have a variety of education centres and was successful in attracting funding to open a simulation training centre in 2011. A variety of training opportunities are provided for staff internally, and there are links with the trust staff bank to ensure that bank staff have access to appropriate induction training.

There were mixed views from staff on access to mandatory training; the majority of staff indicated that they had received mandatory training, while others indicated that such opportunities were not available to them. We heard that this usually correlated with staff vacancy problems.

Data from the trust, though focusing on the three clinical pathways that form part of this investigation indicate that whilst many staff do received mandatory training some do not. For example only 61% of staff in the surgical division have received mandatory training for moving and handling people.

The majority of staff we spoke told us that they had access to training. The greatest difficulty was time, and this was especially so in areas that had staff vacancies. For example, allied health professionals raised concerns about access and this tended to correlate to a lack of staff. The same issue was seen in areas such as the emergency department and maternity. We were also made aware that maternity services have operated in isolation regarding education and training from the rest of the trust. We were told that the education and training division were not involved in the recruitment of midwives from overseas despite the obviously large impact this would have on education for these new staff. We were also told that senior managers were offering midwives the opportunity to undertake master's level education;

but that this did not meet the trust's study leave policy and was therefore inequitable to other staff in the trust.

As a university hospital trust there is large number of medical training posts with a total of 366 whole time equivalent (WTE) training posts at the trust during 2010-2011 ranging from foundation year 1 doctor's through to specialist training posts. As part of their information submission the trust provided CQC with a range of visit reports from the deanery and speciality schools, the results from the most recent postgraduate medical education and training board (PMETB) survey of junior doctor's experience at the trust, and the trust's responses to recommendations and requirements made by the schools/deanery visits. In addition to this we interviewed a range of medical staff from across the trust, and spoke with stakeholders.

In the surveys, the trainees expressed concerns that high workload and work intensity was a potential risk to patient safety with this being particularly evident in anaesthesia and emergency medicine (the medical admissions unit and acute medicine especially). These workload pressures are being caused by vacancy and recruitment difficulties at the trust resulting in trainees being used to deliver activity at a detriment to their training experience.

There were also problems raised with the hospital at night system where

> *'concerns were raised about paediatrics, with a responsibility for crash calls and neonatal nights from day one, especially as the rota is shared with more senior staff'.*

There were also a number of positive aspects identified with 18 out of 24 foundation year one doctors at Queen's Hospital and all foundation year one doctors at King George Hospital saying they would recommend the programme. Amongst the foundation year two staff all but one at Queen's Hospital and all at King George Hospital would recommend the programme although the medical admissions unit was noted by both groups as being particularly difficult. The deanery annual quality liaison visit also praised the handover arrangements, the trust level induction, the recently introduced "learning opportunities" database, and the increased presence of consultants at speciality training committees.

A more recent external review outlines the problems at the trust, but also recognises that

> *'whilst there remain problems with training in some departments important changes in PGME…(post graduate medical education)… has taken place in others and there is a change programme in place that is likely to produce further significant improvements'.*

Some concerns were raised within obstetrics and gynaecology and in anaesthetics, where concerns were found that *'several consultants were not interested in teaching'*, and staff grades who acted as a '*buffer between*

trainees and consultants out of hours' with the perception that several (consultants) '*are unwilling to help trainees in acute situations'.*

This is in line with the outcome of a number of interviews CQC undertook and is outlined within this report.

The above information correlates with the views of medical staff who we interviewed, the majority of whom felt that although workload could be high there were reasonably good opportunities for education and learning. Where we found less positive responses was within obstetrics where we were told a lack of middle grade staff reduced the number of learning opportunities for trainees.

Two other concerns were raised with us regarding training in maternity services. Firstly, a series of skills and drills training has been introduced to help train all maternity staff and forms part of the clinical negligence scheme for trust's (CNST) requirements. However we were told that this has been arranged for a Saturday and medical staff were not consulted on its introduction. This has meant that not all medical staff are attending the training that by its very nature needs to be multidisciplinary and is a requirement of the CNST standards. It is unclear why this time was chose or what action had been taken to encourage attendance.

The second concern was over training to try and deal with the long standing problems over the incorrect interpretation of cardiotocography (CTG) readings (a method for recording fetal heartbeat and uterine contractions during labour). This has been an area of concern since at least 2007, and contributed to a number of serious untoward incidents in 2010-2011. By June 2011 only 65% of midwives were up to date with their CTG training. We were told that 100% of doctors were up to date; this is what was reported on the performance dash board. However, we were also given evidence from July 2011 that showed many consultants had never logged on to the computer system to undertake their training, which we were told was the only way of undertaking the training, and of those that had logged on, a number had not completed the training. It is therefore unclear how the performance dashboard information was verified.

Supervision is a problem in some areas of the trust. There is an ongoing issue with a lack of supervisors of midwives. A review carried out in 2007 by the Royal College of Obstetricians and Gynaecologists found that the ratio of supervisors to midwives was 1:23 despite a nationally agreed standard of 1:15. The review reported that day to day supervision (especially in the labour ward) needed to improve. Some junior midwives and doctors were very inexperienced and likely to need closer support. The issue was unresolved at the time of their 2008 follow-up review. Another external review in 2011 however found that the ratio was 1:26 and stated that it would improve to 1:20 by May 2011. However, this does not appear to be borne out by the trust's data, which shows a ratio of 1:24 from February to June 2011. One midwife told us

'there are some very good supervisors but they carry the rest of the team. I don't think anyone values them. They cannot challenge management. Supervisors are also fearful to challenge midwives, especially those who have been here a long time'.

We were also told that many supervisors were also working in their own time to ensure that supervision was being provided to all midwives.

Concern with supervision is not limited to midwives; inadequate supervision of medical staff has also been raised on numerous occasions in internal meetings, and two recent SUI reports cited inadequate supervision of junior doctors as a contributing causal factor. Concerns about lack of supervision have been raised at maternity risk management meetings, supervisors of midwives meetings, and the obstetrics and gynaecology board (concerns that major obstetrics procedures are being carried out by registrars unsupervised).

The majority of clinical directorates are not meeting the trust's target of 100% of staff having had an appraisal. However there are a number of divisions that have attained over 80% of their staff having had an appraisal, and data from the emergency department at King George Hospital indicated that around 95% of staff had received an appraisal. During interviews with staff a lack of appraisal was not raised with us as a major concern. Data from the national staff surveys also indicates that whilst there are many concerns raised by staff, one area that has seen improvement is with regard to staff receiving an appraisal.

Recommendations for the trust

The trust must:

- Continue to develop and deliver training for staff to support the development of quality services, seeking alternative solutions where staff have difficulty accessing training due to staffing constraints.

- Ensure that appropriate supervision is provided to medical staff and that more junior medical are not left without appropriate support especially at weekends and at night.

Assessing and monitoring the quality of service provision (Outcome 16)

Governance systems in the trust do not appear to offer sufficient assurance to the board that they are effective. There is a lack of linkage between clinical directorates and the board and there is a lack of learning from incidents. There have been numerous changes at executive level, and in the last financial year we were told that of £1m savings at a corporate level, £145,000 were from the governance department alone. This has directly impacted on the number of staff who work within that department and the department's ability to function throughout the organisation in effectively embedding systems and good practice.

There has been a focus on finance at the trust in recent years, whilst this is understandable given the trust's financial difficulties the lack of focus on quality and patient care is not. We were told that at board level there was previously a lack of challenge by non executive directors. We were told that this is beginning to improve with the new non executive directors, but there appears to be inequality with non executive workload with some non executives involved in a large number of committees and others not. There is also an underdeveloped corporate governance structure that further impedes the functioning of the board and trust and again limits assurance.

The trust has in place governance structures in terms of staff. There are a range of staff that work corporately including the clinical governance director, risk manager, legal services manager, and clinical governance facilitators. Each division then has a clinical governance lead and some divisions also have audit leads.

However, from the information supplied by the trust a number of concerns were identified.

Since June 2011 the trust's governance reporting structure has changed. The quality and safety committee (QSC, previously the clinical governance committee (CGC)) and the audit committee (AC) are directly accountable to the trust board. From the evidence submitted by the trust ten sub-committees feed into the QSC, including the safeguarding committees, the clinical risk management committee and the nursing and midwifery board. The only group to feed into the AC is the statutory safety committee. The AC also monitors the board assurance framework and risk register.

However from the evidence submitted by the trust lines of communication are unclear; there is a risk of duplication or of issues being missed. The clinical governance reporting structure for June 2011 indicates that there are 13 committees or boards that report (directly or indirectly) to the trust board. However, there are others, such as the productivity efficiency and quality board (PEQ), education board and 'implementation groups' which are not included in the structure (although the *'Education and Learning Directorate Annual Report'* indicates that the education board reports through the quality

and safety committee) and so it is not clear who they report to. For example according to the clinical audit process flowchart, divisions provide assurance of compliance to the clinical audit committee (CAC), which in turn reports to the audit committee (AC). The structure then indicates that the AC then reports to clinical governance and on to the trust board. However, according to the clinical governance reporting structure, the CAC directly feeds into the QSC not the AC. The trust is beginning to address these concerns and began implementing a new structure during the investigation. In July a new trust executive committee began and replaced a number of other committees that were previously in place, for example the productivity, efficiency and quality board.

The purpose of the quality and safety committee is to make recommendations to the board in relation to trust objectives and developing strategies and plans. The terms of reference state that the committee is responsible for ensuring the board assurance framework is core to identifying and managing the organisational risks. However, according to the clinical governance reporting structure (June 2011), the board assurance framework and risk register inform the audit committee. Since January 2011 and the development of a performance dashboard, the meetings of the QSC have become more focused on risk. Each division provides updates on identified risks at both the QSC and AC. Whilst, it is on a rotational basis at the AC there is a potential for the same issues to be discussed and actions already agreed elsewhere to be duplicated or made redundant. Overall, there appear to be overlapping remits and a lack of cohesion.

This complex system was highlighted by one incident we were told of, where a statutory stakeholder had requested information on an incident in maternity but received a response that indicated the incident had not occurred (when in fact it had). When we followed this up we were told that the response had been as such because the incident was still caught up in the trust's reporting systems and hadn't reached the respondent before they replied. This was compounded by the fact the staff spoken to in the women's and children's division regarding the incident were not aware of it either.

The trust has been slow to implement changes and drive improvement. This can be attributed to the variation in the effectiveness and quality of its committees. The Quality Account for 2010-2011 outlines the trust's current situation with CQC, what it believes it has done well and what it has not done so well. The problem areas highlighted are surgical, emergency and women and children; all have a reliance on temporary medical and nursing staff, amongst other issues. The same 3 areas are the focus of the trust's priorities for 2011-2012. The Quality Account demonstrates that trust management has an overall understanding of the key issues; however some issues were identified a year previously yet improvements have been slow.

The May 2011 governance briefing produced following the quality and safety board meeting, stated that there was a failure across the trust to close the audit loop by producing and implementing action plans. No action had been

taken by the women and children's board despite the number of outstanding audits highlighted at the January and March 2011 board meeting.

The notes for the women and children's board are brief and appear to be more of a 'message board'; issues are listed, but no actions or deadlines are documented. In April 2010 the women and children's division presented at the audit committee, summarising the actions taken over the past year. The risks identified in this presentation were also identified by CQC in early 2011, so despite the presence of an action plan, improvements had not been made and positive outcomes could not be evidenced.

The notes for the emergency board paint a similar picture. In October 2010 new incident reporting books were *'being chased'* and this was still the status in March 2011. Incidents and complaints are regularly discussed and it is acknowledged that the number of complaints has been *'creeping up'*. However, there are no actions listed in the minutes and results of investigations do not appear to be shared with the board. In the October 2010 meeting concerns were raised about which drugs anaesthetists were using when they came to resuscitation area in the emergency department. It was not until March 2011 that it was agreed it needed to be included on the risk register. In February 2011 the emergency division provided an update at the audit committee. The minutes imply that members of the audit committee were frustrated by the presentation as it gave a lot of information, but the presenters were *'asked several times what was the department doing to off-set the risks'*.

The trust collects a lot of performance information, but this is not presently used effectively to drive change. Based on the evidence reviewed, the trust has extensive data from external reviews, national and local audits as well as action plans from governance groups and independent work streams. An external board review report however, states that whilst the organisation is *'data-rich'* it is '*light on meaningful information'.* The quality and effectiveness of the committees vary, as does the information they feed upwards and there is a potential for management to be overloaded with information. The QSC discuss numerous documents submitted prior to meetings, and an external review found that information was often too long and lacked systematic follow-up of issues and recording of outcomes.

The trust board itself commented in May 2010 that the trust appears to be, *'dependent on external reviews and visits, rather than its own internal quality system'.* In February 2011 the QSC highlighted that the trust needs to examine how findings from external reviews are being captured. Furthermore, it is slow to respond to external findings. At the safeguarding adults meeting in June 2010 it was reported that the findings from an external review that took place in 2009 had only just been shared with the trust board. The minutes acknowledge that the trust had not been proactive in following this up.

Whilst CQC has been provided with a range of evidence that specialities and directorates undertake audit and discuss risk and incidents, hold multidisciplinary team meetings and discuss mortality and morbidity, there is

evidence that lessons are not learnt and that some staff do not understand incident reporting. For example while tracking one patient we discovered that there had been complications following an interventional radiological procedure. This had resulted in the person bleeding profusely and had required the insertion of a central line (a catheter which is placed into a large vein in the neck, chest or groin. It is used to administer medication or fluids, obtain blood tests and directly obtain cardiovascular measurements such as the central venous pressures). The insertion of the central line caused a pneumothorax (a collection of air or gas between the chest wall and lung), but none of this was reported as a clinical incident. The majority of staff we spoke to told us that they document any incidents that occur but that they do not hear of any actions or feedback once these forms have been passed on to the risk management team.

There is a lack of learning and sharing across the organisation. We were told that following the death of a mother and her baby at the trust in 2011 only the staff from the antenatal ward were involved in learning from the event as this is where the incident occurred. Staff from other wards in maternity services expressed frustration to CQC that they were not actively involved in this learning to ensure that these tragic events were not repeated. The independent investigation into another death in maternity services at Queen's Hospital more recently identified concerns and issues that have been raised else where in this report including, poor communication, an on call consultant that did not attend the hospital, lack of anaesthetic involvement, poor documentation and lack of recognition of the seriousness of the woman's condition. Many of the staff we interviewed told us that they did not get feedback from reported incidents and that they believed that there was a lack of learning at the trust.

Recommendations for the trust

The trust must:

- Ensure that it has adequate systems of governance to promote high quality care for patients and to deal with concerns about performance in an effective and timely manner.

- Develop a system of governance that offers it accurate and real time information that translates into an effective assurance process.

- Carry out a comprehensive review of all corporate and clinical governance systems across the organisation to ensure that effective and streamlined systems and reporting structures are in place to provide robust assurance to the board.

- Ensure that it has systems in place that allow effective sharing and learning across the whole organisation.

- Ensure that the incident reporting system for the whole trust is operating effectively and all staff are learning from incidents rather than simply reporting incidents.

- Ensure that it has appropriate levels of staff in place to allow its governance systems to function effectively and that these staff are embedding appropriate systems in clinical services.

Complaints (Outcome 17)

The trust's ability to deal with and respond to complaints was described to CQC as *'awful'*. In fact the level of distress it caused to some patients and relatives who spoke to CQC was as bad as the poor care experiences they were complaining about in the first place.

Certainly the majority of stakeholders and especially MP's and local councillors condemned the complaints process and this was one of their biggest complaints about the trust apart from the quality of care.

The trust frequently misses its own targets for timeliness in response. Some patients and relatives wait weeks simply for an acknowledgement of their complaint. Others told CQC that they simply hadn't received any response. The poor timeliness of responses is compounded by a process that simply does not answer the complainant's questions and in many cases leaves the complainant with more questions. This is partly due to many of the responses seen by CQC simply providing an overview of the care someone received which from the complainant's perspective does not match their recollection of events and does not answer the concerns they raised.

The trust received 665 complaints in the year 2010-2011, this places them in the top ten most complained about trusts in England. There are a high number currently being investigated by the Parliamentary and Health Service Ombudsman. The investigation reports from the Ombudsman highlight a number of recurring themes, including the complaints process being inadequate, poor initial investigation by the trust, lack of communication between staff, the patient and relatives, staff failing to spot warning signs of deterioration in patients and acting quickly enough, and a lack of learning by the trust.

A number of these themes are also identified in the serious untoward investigations following recent deaths in maternity services. Indeed data submitted to CQC regarding maternity services indicated that the target for the number of complaints received in the unit is less than four per month, but ten were received in February 2011 and 14 in both April and May 2011. In addition to this we were told that as obstetric records are not tracked on the same system as the rest of the trust it is often difficult to locate these records especially when answering high risk complaints or legal requests for information.

The trust has a high number of contacts with its patient advice and liaison service (PALs), and has seen a rise in the number of complaints this year (2011-2012). We were told that the reason for the increase in complaints this year was that a decision was taken in the previous year to reclassify certain complaints under a new category. This category was 'PALs serious'; and the complaint was then dealt with by the PALs team. We were told that the reason for doing this was to be able to report a drop in the number of complaints that the trust received as issues dealt with by the PALs team were not classified in the same way. We have been told that when changes to the complaints team

were made last year, and responsibility for complaints changed to another individual this practice was stopped immediately. A report highlighting this concern along with the need to have an open and accessible process for dealing with the outcomes of Ombudsman's investigations has been shared with the board.

Stakeholders and complainants alike both state that the trust's approach to complaints management is defensive, and obfuscating. This was supported by staff who indicated that time is often spent collecting data and information for people to be able to *'cover their backs'*, rather than being used objectively to focus on improving services. There is some reporting to the board on the number of complaints, but we were told that trend analysis does not take place due to a lack of staff working in the governance department.

The trust has recently undertaken a review of its complaints processes. In its review the trust recognises that its complaint processes are poor and that during 2010-2011 it only responded to 64% of complaints within 30 working days where as the target was 80%. The trust also recognises that there is no effective trend analysis or learning from complaints, which is a common theme throughout the evidence gathered. The trust outlines in its review how it intends to improve its complaints handling. There is a staged process to place complaints management back into the clinical directorates, and for corporate services to handle the overall management of the complaints process to ensure time frames are met. The trust has also restructured its response templates to try and ensure that they are more effective in answering the complainants concerns. These changes are being put in place at present; however we were told by a variety of patients, relatives and stakeholders that the problems outlined above are still occurring. Some stakeholders did indicate that they had seen some improvement in the last three to four months but this is clearly not yet systematically embedded in the organisation.

Recommendations for the trust

The trust must:

- Continue to develop and improve its complaints handling systems to ensure that complaints are responded to fully and in a timely manner.

- Develop and support staff to ensure that open transparent investigations take place, that complainants are involved as necessary and that culturally complaints are seen as opportunities to learn and improve the quality of care.

- Ensure that any staff identified in a complaint are involved in resolving the complaint and the resulting learning but where there is a complaint about an individual there is appropriate separation of the investigation from the individual.

- Develop its reporting mechanisms to ensure that the board are fully informed of all complaints, that detailed trend analysis takes place and that the board can assure itself that learning is taking place, and repetition of themes is reduced.

Records (Outcome 21)

During the course of the investigation we spoke to a number of staff regarding record keeping, as well as reviewing case notes and tracking patients across the trust at both hospital sites.

The quality of records that we looked at was generally in line with established standards. However, there were a number of examples where staff had not completed all elements of the assessment record especially in the medical admissions unit, and where discharge information was missing for patients discharged from the emergency department. There were also various omissions in records such as drug charts unsigned, missing or no risk assessments, and missing discharge information and other incomplete assessments.

Concerns were raised about the number of record systems that are in use in the trust. For example maternity services have their own tracking system for records and this does not link with the rest of the organisation. The emergency department also has its own system and staff told us that they didn't use the trust's patient administration system (PAS). We were told that this can lead to difficulties if women present in the emergency department who have recently given birth. If the patient is unable to tell the emergency staff about their condition for example they are unconscious then staff in the emergency department would not know of the recent maternal episode of care.

Another concern that was identified in a number of records reviewed was a lack of chronological ordering and case notes that were in danger of physically breaking apart. Staff also told us and we saw from some of the records we reviewed that patients can have multiple sets of records. Some patients we reviewed were on their third set of temporary records. We were told that tracking records was difficult and in some of the multiple notes we saw there were transcribing errors for data such as name and date of birth. Staff also told us that gaining access to records stored off the hospital site was difficult. It appears that this is a long standing problem at the trust and has been noted in other reports.

In addition to this we saw examples of where health record binders were being reused for different patients. We saw examples where new front sheets were simply stapled over the front cover of the records having previously been used for another patient. This could lead to the wrong notes being in the wrong file. This possibility was illustrated to us by a parent who told us that his wife had been questioned by social services staff as their baby's health records contained information that may suggest that the baby was at risk of abuse. However it transpired that the records of three babies had been mixed up and that another baby's record had been placed within the wrong records. We were told that it had taken over two weeks for the issue to be rectified, and was very distressing for the parents concerned.

Staff at King George Hospital told us that porters were now used to collect records out of core working hours. This was having an impact on the availability of porters to undertake other duties, and we were told that no information governance training had been provided for staff undertaking this role.

The poor records tracking system in maternity services results in problems in tracking down records to assist in responding to complaints or requests for copies of health records. We were also told that some maternity incidents have not been investigated as the records cannot be found. Patients and stakeholders also reiterated the difficulty in getting access to maternity records and the time the trust took to arrange this. The risk of maternity records being lost or misplaced was rated high risk on the unit's risk register in both June and December 2010 when it was noted that a new systems was being looked into. Also on the register is a historical risk that care plans are not being documented or completed. However, this was still rated as high risk on the register in December 2010. In December 2010 it was also noted that CTG recordings were '*still going missing'.* The standard of record keeping has been on the register for some time, and in December 2010 it was stated that there was no evidence that this was improving. It was noted at maternity risk management meetings between May and October 2010 that MEOWS (modified early obstetric warning score) charts were not being used in the antenatal ward. In May 2011 it was stated that maternal observations were not going immediately into the charts, meaning that trends could not be immediately identified.

Recommendations for the trust

The trust must:

- Improve its systems for records management to ensure that notes can be retrieved effectively and expediently, and reduce the risks associated with multiple sets of temporary notes and poor data handling.

- Develop integrated patient administration and information systems to ensure that where ever a patient is being treated within the trust their full healthcare history can be accessed by all staff.

Leadership

The trust has experienced frequent changes to its board. Since February 2011 there has been a new chief executive in place. Since the chief executive was appointed a medical director has been appointed following a number of years where non permanent staff have provided this function. A number of new non executive directors have also been appointed and an interim chair has been in place since 2010.

Despite the short time that the new chief executive has been in place there was almost universal praise for her. Staff commented that they felt they were being listened to and that for the first time in many years they believed that progress could be made to improve the quality of care and standing of the organisation. Staff also praised the leadership of the nurse director and medical director and noted that this triumvirate of individuals were demonstrating good leadership across the trust. Some staff were positive about working at the trust. One nurse told us that *'I'm proud to work here. I love this place and want to make it good'*. However this was often an isolated voice amongst many staff who articulated a widespread defensive, culture amongst some senior staff with poor leadership and a lack of vision.

Some staff also raised concerns about the lack of a director of operations or chief operating officer and noted that the absence of this post has had a negative impact on the trust and its ability to drive forward improvements. We were told that the lack of this role and the culture of the organisation was such that the chief executive has a large number of senior staff all directly responsible to that one individual which can risk there being a loss of focus for the chief executive; and culturally we were told that this meant that the chief executive would have individual meetings with separate executive directors and not as a whole group. Since the appointment of the current chief executive, this approach to individual executive director meetings has ceased, and a director of operations has commenced in post in October 2011. Staff commented positively on the visible leadership programme that has been introduced across the trust by the director of nursing.

External stakeholders described a culture at the organisation that is defensive, denied problems existed and not open in discussions with them. Although stakeholders that we spoke to told us specifically that when they raised concerns with the trust during the winter period of 2010-2011 with regard to accessing emergency care at the trust they were told that there were no problems in the department, evidence from the trust indicates that there was contact with stakeholders and through the media regarding the difficulties being experienced in the emergency department. Stakeholders did acknowledge the positive impression that the new chief executive was making but also felt that they needed to see sustained improvements as so much had been promised before but not delivered by previous boards of the trust.

So many of the staff we spoke to talked about an ingrained culture of blame and uncaring professionals though this was predominantly in maternity services where around 25 of the staff we interview raised concerns of this

nature. Staff also told us of a learned helplessness of many staff who did not see it was their responsibility to tackle poor practice or issues raised with them, or who had grown tired of seeing a lack of management action to tackle these problems that they no longer saw it as their issue.

The attitude of some midwives has been raised with CQC on numerous occasions. One midwife told us that she had over heard a colleague say to a woman in labour *'hurry up or I'll cut you'*. Another midwife told us that she was ashamed to work at the unit and hadn't realised how poor practice was until she observed care at another hospital. We have also outlined other examples of the unacceptable attitude of some midwives elsewhere in this report. What is of concern is that this culture in maternity services has been prevalent for a number of years.

This is compared with an example of how senior staff dealt with poor staff attitude on one surgical ward. The manager had received a number of complaints about the attitude of staff so arranged for some of the complainants to meet with all the ward staff and explain how their attitude affected the quality of their hospital admission. This was followed up with the introduction of a yellow card scheme which is used to warn staff when they are heard by colleagues behaving inappropriately to patients; this has led to improved behaviour as a consequence.

We were told that maternity services operate in isolation from the rest of the trust; in a *'silo'*, with separate bed and site managers, on call structures and clinical governance arrangements. There was some acknowledgment that signs of change had been witnessed recently for example the trust does two hourly bed checks and maternity staff now take part in this system. We were told the role of midwifery supervisors was one of frustration and lacked authority. We were told that not all supervisors performed to a high standard but that their poor performance was not being dealt with; and of management decisions being made with no involvement of other senior midwifery staff.

Staff and patients told us that poor staff attitudes are also prevalent in other clinical areas; one patient told us that whilst an inpatient at King George Hospital they listened to medical staff shout to the patient in the next bed to him *'Mr xxx your blood test was so fatty, that we could not get anything from it'.*

We were also informed of poor examples of medical leadership. One doctor we spoke to described a recent serious incident where there was a lack of support for junior medical staff following the death of a patient. We were also told that some consultants do not like to attend the hospital at weekends when they are on call, and of *'undermining behaviours by consultants'* at the trust.

There is also a lack of cohesion across the trust, with different clinical directorates and staff not working together but almost as if in competition. We were told that bed management meetings have often been combative with directorates simply not engaging to ensure the flow of patients around the trust is as effective as possible. We were told that it took a great deal of time

and effort by staff in the emergency department to change the systems for patients from the ear, nose and throat (ENT) service to receive a wound dressing change. Prior to this change, staff in the ENT service would simply send their patients to the emergency department to have their dressing changed, when this was not appropriate, and meant that staff in the emergency department were diverted away from caring for acutely ill patients. This has been resolved and the ENT has set up its own dressing clinic but was another example of directorates not working together to improve patient care.

One final issue raised by staff was over what they perceived to be poor external communications by the trust. The perception of staff is that the trust did not seem proactive in telling a more positive side to the organisation. This was also echoed by some stakeholders and patients. Whilst the trust acknowledges that staff and others may hold these views, it has provided a range of evidence to demonstrate how it endeavours to communicate the positive side to the organisation. This can be evidenced for example on the trust's website, and via its newsletter *Hospital Life* (also available on the Trust's website).

Staff also have the same perception regarding internal communications. Some staff, especially in the maternity unit were frustrated that when incidents occurred, they sometimes only heard about them through the local press and not via internal communications. Staff also felt that greater emphasis should be placed on sharing positive news internally and more actively. For example whilst some staff were aware of the various awards schemes that are in place in the trust, it was clear from staff interviews that these do not have a high profile with many. Whilst the trust acknowledges that staff may hold these views, it has provided a range of evidence to demonstrate how it endeavours to communicate with staff across the organisation. For example there is a weekly newsletter and monthly team brief as well as messages from the chief executive.

Recommendations for the trust

The trust must:

- Ensure its board assures itself that it has the right leaders and managers in place to develop the trust and improve the quality of services.

- Put a cultural change programme in place across the organisation. The programme of change needs to engage all staff so that the trust can clearly articulate what the expectations are of individual staff, what a high performing organisation feels like to work in and be clear of the penalties for staff they should not behave appropriately.

- Develop a culture of whole systems working across all divisions to reduce 'silo' working and the combative nature of bed management.

- Develop a programme of support for managers so that staff with the capability can be freed to undertake their managerial roles effectively.

- Explore how to improve its communications both internally and externally so that perceptions of poor communication can be reduced.

Capacity

Issues of capacity at the trust were not part of the initial terms of reference. However the terms of reference under section two do state that CQC does retain the right to consider *'any other matter which CQC considers arise from, or are connected with, the above matters'*.

CQC recognises that it is for the Secretary of State to agree any recommendations that are presented as part of the independent review of the configuration of services in outer north east London.

However, we were presented with a number of concerns by staff, patients, members of the public and stakeholders, and these concerns are highlighted below.

One concern that was consistently raised with us by both staff and stakeholders was that of capacity, and specifically the over utilisation of Queen's Hospital and the under utilisation of King George Hospital. We were told that the current high level of activity in maternity services at Queen's Hospital means that women are discharged too quickly and that the quality of care is often poor.

Since the opening of Queen's Hospital many services have been moved from King George Hospital. For example, vascular surgery is now only carried out at Queen's Hospital, all high risk pregnancies are managed at Queen's Hospital (which means that of around 10,000 births each year, 7500 to 8000 are at Queen's Hospital and 1500 to 2000 at King George Hospital), along with stroke services and trauma services.

Many staff at the trust and stakeholders told us of their concern about the level of activity in maternity care at Queen's Hospital. Staff told us so many women attend maternity services at Queen's Hospital that they are *'simply pushed through the system as quickly as possible'* and that is one of the reasons for the poor quality outcomes that some women are experiencing in that service. An independent review of maternity services at the trust was undertaken at the beginning of 2011, which concluded that *'Capacity at Queen's is of major concern to the review team'*. The recommendations from this review included the need to develop measures to ease the capacity at Queen's including *'an impact assessment of the changes at KGH. It should also include an updated Escalation Plan, with clear indicators relating to capping numbers at Queen's and temporary closure if required in the interests of patient safety'*. In addition to this the report made a number of other recommendations for services at Queen's Hospital including the development of the departure lounge and the improved use of telephone triage, day case assessment and an increased use of community midwives. However as has been explored in this report, whilst the trust has implemented a number of these recommendations some have not had a wholly positive effect on the quality of the maternity experience for many women.

Concern was also raised over the transfer of vascular care to Queen's Hospital in 2011. An external review carried out prior to the centralisation of services on the Queen's Hospital site highlighted concern with access to intensive care beds for major vascular surgical patients.

Similar concerns were raised with regard to emergency care and the ability of Queen's Hospital to deal with the levels of attendees at the trust. Many staff would describe the emergency department at Queen's Hospital as 'chaotic'. Since Queen's Hospital opened in 2006, the trust has had difficulty in meeting the four hourly access targets (the national target is to admit, discharge or transfer all patients within four hours of arrival at the emergency department). Staff and stakeholders both alluded to the fact that the emergency department at King George Hospital is under utilised whilst Queen's Hospital is over utilised. Some of the additional utilisation is due to the centralisation of services on the Queen's Hospital site such as vascular and neurosurgical services, as well as the trauma services; and indeed the pace of the emergency departments was very different during our site visits. Staff indicated that the design of the emergency department at Queen's Hospital didn't assist with the flow of patients and caused bottle necks which in turn led to delays in patient transfer and long waits.

There are capacity issues at Queen's Hospital emergency department as there are many examples of patients waiting for long periods of time. The systems and processes adopted within the emergency department at Queen's Hospital and King George Hospital have until recently reflected a traditional model of care delivery where patients are pushed along a pathway that can often appear uncoordinated and punctuated with a whole series of non value adding waits and queues that make little or no sense from the patient's perspective. Capacity issues elsewhere in the urgent care pathway have been shown to affect this experience, leading to poor care and unsafe working practices. This creates the cycle of shortage of cubicles, an inability to review patients, capacity bottlenecks and then the spiral of increasing delays, decreasing patient safety and variable compliance with the four hour target and the new clinical quality indicators.

Staff at the trust have begun to address the problems associated with the flow of patients through the emergency department. At Queen's Hospital a rapid assessment team (RAT) initiative within the 'majors' stream has commenced for core working hours; where a team, led by a senior clinician, quickly assesses all 'majors' patients soon after their admission to the emergency department. This initiative along with improved flow through the medical admissions unit has resulted in some improvements to the flow of patients which was also recognised by paramedics that we spoke to.

An audit of the effectiveness of the RAT system has been carried out and has shown some improvements; patients who have been assessed in this way are less likely to wait over 4 hours for admission, are referred to other specialities more quickly, and will be assessed more quickly by an emergency department clinician, though the time to treat patients does not differ much after this first assessment from those who have had a rapid assessment.

There are plans to implement the RAT system at King George Hospital once workforce issues have been addressed, and there remains a number of issues that still need to be addressed in terms of improving patient flow, including better working relations with other clinical specialities, improved discharge management and bed management and reducing processes that add built in delays to patients admissions. For example when a patient is assessed in the emergency department by an emergency department clinician and a decision to admit is made, some specialities then require a junior doctor from that speciality to undertake a further assessment of the patient rather than accepting the clinical decision of the emergency department clinician.

The three local authorities that are served by the trust raised concerns over the provision of maternity services, and where they are currently sited. The Barking and Dagenham and Redbridge local authorities both told CQC that they have expanding multicultural relatively young populations and high levels of teenage pregnancies. In contrast we were told that in Havering a third of the population is over the age of 65 and this raises different health issues for the population in that area.

Why this was raising concerns with these stakeholders was the fact that King George Hospital is geographically located for the populations of Barking and Dagenham and Redbridge, while Queen's Hospital is geographically located for people living in Havering, and yet provision for maternity services was predominantly from Queen's Hospital. What was compounding this from the stakeholder's perspective was historically poor transport links between the 2 areas (though stakeholders did note that the trust had ensured a bus stop was built outside Queen's Hospital). It should be noted that poor transport links between the two areas was also raised on numerous occasions by patients, relatives and other stakeholders. We were told that depending on where someone lived, it could take around one and a half hours to travel from the Ilford area where King George Hospital is based and where the population is growing to Romford where Queen's Hospital is based. We were told that due to higher levels of poverty in the Barking and Dagenham and Redbridge areas, people relied on public transport more and these poor links had a detrimental effect on access to health services for people.

Recommendations for the trust

The trust must:

- Improve the flow of patients not only in the emergency department, but across the whole hospital to ensure that processes that do not add value are removed and patients are seen and treated in a timely fashion.

Appendix A: Terms of reference for the investigation

1. The Care Quality Commission (CQC) has the power to conduct an investigation into the provision of NHS care under s48 (1) (2) (a) of the Health and Social Care Act 2008. The criteria under which CQC will conduct an investigation are at Appendix A of the enforcement policy. The exercise of this power would permit CQC to raise concerns with the Secretary of State for Health under the formal power under s48 (5) of the Act. CQC in this instance is relying upon the exemption Section 81(4).
2. CQC is concerned about the outcomes for patients using the services of this Trust. It will carry out an investigation into the systems and procedures that are in place to ensure that people are protected against the risk of inappropriate or unsafe care and treatment, these will include:
   a. Reviewing an emergency care pathway we will investigate the systems for admission (including emergency), internal transfer, discharge and external transfer of patients, including working in conjunction with other stakeholders.
   b. Reviewing an elective care pathway we will consider the system for admission
   c. Review the maternity services care pathway.

   The pathway investigations will identify and assess:

   - The systems for ensuring that at all times there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying out the regulated activity
   - The systems for respecting and seeking the views of people using the service and their representatives.
   - The systems for seeking the views of staff.
   - The systems for assessing and monitoring outcomes for people.
   - The systems for ensuring appropriate standards of cleanliness and hygiene and prevention, detection and control of the spread of health care associated infections.
   - The systems for ensuring equipment is properly maintained and suitable for its purpose
   - The systems in place to develop the culture of the organisation, in particular individual responsibility and whole Trust working;
   - The ability of the organisation to deliver a high quality teaching environment contingent with it's role as a teaching hospital
   - The systems in place to support management for medicine
   - Systems and processes for identifying, assessing and managing risk and their effectiveness.

- The analysis and learning across the organisation from board level down of incidents that resulted or had the potential to result in harm to people.
- The systems for service improvement by learning from adverse events, incidents, errors and near misses. This should also include using information from safeguarding concerns to identify non-compliance or risk of non-compliance and decisions made to return to compliance.
- The procedures followed in the management of abuse and the systems to monitor these.
- The overall effectiveness of governance structures (including committee structures and reporting mechanisms)
- Any other matters which CQC considers arise from, or are connected with, the matters above.

3. The investigation will involve speaking to patients, relatives and frontline staff and observing care delivered at this location. It will also involve gathering evidence through examination of records, speaking with internal and external stakeholders and requesting written statements. When appropriate CQC will work in partnership with other agencies to gather evidence, this may include the SHA and the PCT.
4. An investigation under the Act gives CQC the option to look at the provision of health care across a local system. In order to ensure that recommendations made are deliverable to enable the Trust to secure ongoing compliance against essential standards.
5. CQC may take enforcement action at any time during the investigation if there is evidence of major concerns and risks to people.
6. The Regional Director will act as the sponsor of this investigation and will use the findings to inform the ongoing monitoring of compliance. This will ensure that any evidence and recommendations made will feed into a review and the appropriate regulatory actions can be taken, this may include enforcement action if required. The investigation team will be independent of the compliance team and will therefore review the effectiveness of previous compliance actions.
7. The investigation will focus on the periods from the date of the Trust's registration under the 2008 HSCA.

   This will ensure that evidence in any improvements will be clearly identified from the date of registration.
8. The evidence gathering period including preliminary site visits, of the investigation is planned to run over a period of not more than eight weeks.
9. CQC will publish a report on the findings of the investigation, and will make recommendations as appropriate to the trust and other relevant bodies.

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Care Quality Commission – Action Plan	Trust Board
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
A&E and Staffing Attached is the updated action plan that was developed to address the A&E and staffing concerns and warning notices. The action plan was originally sent to the CQC in August 2011. The action plan highlights that progress has been, and is being, made in most areas but that there has also been a deterioration in some areas such as performance against quality indicators in the Emergency Department over the last 7 weeks and poor progress in meeting the Trust's drug 'to take away' (TTA) expectations. Mitigating actions are being taken to drive up performance in all areas. Maternity An updated maternity action plan to address the warning notice issues in March is attached. The action plan has been incorporated into a single action plan that is being delivered through the 'maternity improvement programme board'. The programme board has 4 main project areas, each driven by a number of work streams, individual work streams and cross referenced to the individual actions in the maternity action plan. The project groups have been meeting weekly, and meet with the programme board on a fortnightly basis. It shows that progress is being made.	□ **TEC** …… □ **STRATEGY**…… □ **FINANCE** …… □ **AUDIT** …… □ **QUALITY & SAFETY** …… □ **WORKFORCE** …… □ **CHARITABLE FUNDS** …… □ **TRUST BOARD** …… □ **REMUNERATION** …… □ **OTHER** …… (please specify)
2. DECISION REQUIRED:	**CATEGORY:**
The Trust Board is asked to note the content of the action plans.	□ **NATIONAL TARGET** □ **RMS** **X CQC REGISTRATION** □ **HEALTH & SAFETY** □ **ASSURANCE FRAMEWORK** □ **CQUIN/TARGET FROM COMMISSIONERS** □ **CORPORATE OBJECTIVE** …… □ **OTHER** …… (please specify)
	AUTHOR/PRESENTER: Stephen Burgess, Medical Director
	DATE: 21 October 2011
3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
Insufficient data to quantify.	
4. DELIVERABLES	
Compliance with CQC Registration	
5. KEY PERFORMANCE INDICATORS	
Compliance with CQC Registration	
AGREED AT _____ **MEETING** **OR** **REFERRED TO:** _____	**DATE:** _____ **DATE:** _____
REVIEW DATE **(if applicable)** _____	

A&E AND STAFFING ACTION PLAN

CQC Related Outcome	Aim	Objective	Action	Measureable Outcome (Evidence of success)	deadline	SRO	Milestone (Progress Check Point – Date and Measurement)	Progress Update	Evidence
1. respecting and involving people who use services	To improve staff training to enable patients to feel involved and confident in their care in A&E	QH: Staff in A&E give clear explanations to patients about why they are here and what is being done	Review content of the following staff training to ensure clarity around trust expectation to involve patients: Education - Induction - Education programme for junior doctors - Mandatory training - Nursing education programme	Improvement in patient survey for A&E Reduction in complaints with this element by 25%	31.12.11 and 3-monthly review	Magda Smith, Divisional Director for Medicine & A&E	Implementation of survey Monitoring of complaints from August 2011	Live patient survey has started in Emergency Department In Progress	

CQC Related Outcome	Aim	Objective	Action	Measureable Outcome (Evidence of success)	deadline	SRO	Milestone (Progress Check Point – Date and Measurement)	Progress Update	Evidence
1. respecting and involving people who use services	To roll out hourly rounding across the Trust on both sites to ensure we are consistentl y meeting patients' fundament al needs.	QH: Hourly rounds are performed consistently and patients' basic needs are met	• Review current practice against new information circulated at London Quality matters meeting. • Review pilot areas in August 2011 and audit practice. • Review pilot and agree way forward with Trusts documentation group. • Implement hourly rounding within all adult areas across the Trust by December 2011. • Audit practice as part of visible leadership quarterly as from January 2012 and review action needed.	Quarterly review on visible leadership in 2012 will demonstrate that all adult areas within the trust are undertaking hourly rounding in accordance with Trust policy and patients' basic needs are met.	31.7.11 31.8.11 31.8.11 31.12.11 31.4.12	Lesley Marsh Assistant director of nursing	NMB in September will have audit results presented implementation plan signed off by NMB in September 2011 all areas not already undertaking hourly rounding programme will commence implementation in November	Current practice reviewed and meets the information circulated by NHS London. Audit of practice in pilot areas ends 25th August.	Written tool Hourly rounding plan on schedule for trustwide rollout.

CQC Related Outcome	Aim	Objective	Action	Measureable Outcome (Evidence of success)	deadline	SRO	Milestone (Progress Check Point – Date and Measurement)	Progress Update	Evidence
4: care and welfare of people who use services	To reduce the number of hospital acquired pressure ulcers at category 3+4.	QH & KGH: Ensure accurate and comprehensive documentation of care of people with pressure ulcers	• Revise SKIN bundle against RCA findings and implement updated version – sent to printers in July – aim for implementation as from Sept 2011. • Train staff how to complete skin bundle via Mandatory training and on link worker programme. • Audit practice quarterly as part of visible leadership and review actions needed.	Quarterly audit will demonstrate accurate and comprehensive documentation of people with pressure ulcers.	1.9.11 Ongoing Quarterly audit	Lesley Marsh Assistant Director of Nursing	Sign off Skin bundle at NMB in June 2011 Full ward roll out September 2011 Training programme written by August 2011 Included in mandatory training from August 2011 Link worker training scheduled for August 2011. Practice audit in July and October 2011	Approved by NMB June 2011 Scheduled for roll out on return from printers Training programme written MT training commenced August 2011 Link worker programme scheduled for 30.8.11 to include skin bundle Quarterly audit in July - Trust average result is 87.53%. October audit underway.	SKIN bundle and minutes Programme MT training pack Agenda Audit tool results dashboard

CQC Related Outcome	Aim	Objective	Action	Measureable Outcome (Evidence of success)	deadline	SRO	Milestone (Progress Check Point – Date and Measurement)	Progress Update	Evidence
4: care and welfare of people who use services	Improve patient flow through A&E. Reduce waits, and ambulance trolley waits	Ensure the full and timely implementation of the Trust's Emergency Access Action Plan and monitor compliance	See Emergency Access Action Plan  Emergency Care Plan 20010623.10.xls	Progress against A&E action plan monitored at Emergency Care Programme Board.	Ongoing	Magda Smith, Divisional Director	Improved performance against 95% access target and A&E Quality Indicators	Performance against quality indicators has deteriorated over last 7 weeks. Actions being taken with new Director of Operations to improve bed flow, as major reason for reduction in performance.	

CQC Related Outcome	Aim	Objective	Action	Measureable Outcome (Evidence of success)	deadline	SRO	Milestone (Progress Check Point – Date and Measurement)	Progress Update	Evidence
	To reduce the number of poor patient discharge experiences	Improve discharge arrangements. Patients discharged at appropriate times with necessary equipment and medication	Implement discharge checklist. Operational Policy for hospital discharge: - education programme for staff - Operational policy for ambulance transport	Visible leadership audit process. All patients fully compliant with discharge checklist. TTAs prescribed 24 hrs in advance in 80% in-patient discharges (excluding acute assessment areas)	Ongoing	Caroline Moore Divisional Nurse Director	Decrease in delays to medically fit for discharge Reductions in DTOCs. Reduction in LoS	Discharge planning tool implemented. Weekly audits on ward through Visible Leadership Electronic Discharge Summary implemented to support TTA prescribing included in doctors induction. Monitoring in place. Progress poor. Consultants reminded to take responsibility for this action.	DTOCs and LOS monitored through Dashboard. TTA logs kept in Pharmacy

CQC Related Outcome	Aim	Objective	Action	Measureable Outcome (Evidence of success)	deadline	SRO	Milestone (Progress Check Point – Date and Measurement)	Progress Update	Evidence
	Improve the care of patients with pneumonia	To ensure the full and timely implementation of the Pneumonia action plan and monitor compliance.	See Pneumonia Action Plan.  PWC Pneumonia Action Plan (final) (2).	Individual as listed in Pneumonia Action Plan	As detailed in Action Plan	Magda Smith. Divisional Director	Individual as listed in Pneumonia Action Plan	Audit completed, for presentation at specialty meeting and Divisional Board. Latest data available on Dr Foster .	Dr Foster Data

CQC Related Outcome	Aim	Objective	Action	Measureable Outcome (Evidence of success)	deadline	SRO	Milestone (Progress Check Point – Date and Measurement)	Progress Update	Evidence
5: meeting nutritional needs	To improve the nutritional standard of care across the Trust so that patients do not experience significant unplanned (more than 5%) weight loss.	Patients will have timely assessment of nutritional needs and intake. Patients mealtimes will not be disturbed	• Implement the amalgamation of visible leadership and productive ward as from July 2011 with a thematic approach. • Implement "food for thought" month for July. • Audit using VL at end of July across the Trust - this will consider assessment and action taken following initial review. • Observe a mealtime using nutritional audit tool at end of July on every ward. • Monitor compliance with "food for thought" at review meeting in August • Review the following during August – protected mealtimes, food delivery and services, standard service level agreements, protected mealtimes and nutrition related policies. • Hold a RCA day in August to discuss findings and agree way forward. • Write action plan from the RCA review and continue quarterly audit.	Quarterly audit will demonstrate timely assessment of nutritional needs and intake and action taken. This will include mealtimes not being disturbed unless clinically necessary.	1.7.11 1.7.11 25.7.11 25.7.11 10.8.11 31.8.11 31.8.11 30.9.11	Lesley Marsh Assistant Director of Nursing	NMB to ratify plan in June 2011 Communication plan for food for thought month June 2011 Practice audit in July 2011 Results from mealtime observations to go to review meeting in August 2011 Protected mealtime standard reviewed Food delivery and services process reviewed	NMB ratified plan June 2011 Achieved Achieved - trust wide average is 84.05%. October audit underway Achieved Achieved In progress	NMB minutes Copies of all ward reports. Dashboard with results and audit tool. Copies of all ward reports. Meeting notes. Protected mealtimes draft agreed, NG competencies in draft format.

CQC Related Outcome	Aim	Objective	Action	Measureable Outcome (Evidence of success)	deadline	SRO	Milestone (Progress Check Point – Date and Measurement)	Progress Update	Evidence
5: meeting nutritional needs (contd.)							Standard service level agreements reviewed and approved by NMB Sept 11 Nutrition policies reviewed RCA day in August arranged Action plan written and ratified by NMB	In progress In Progress RCA day deferred – new date yet to be agreed	
9. Management of Medicines	1. Ensure all patients leave hospital with their medicines by ensuring all prescriptions are written up in advance per trust policy.	QH: There is safe administration of medicines on all wards	Review trust policy for ensuring all prescriptions are written 24 hours in advance. Communicate to all clinical leads and consultants to ensure they and they juniors are fully aware. Communicate to all pharmacists to ensure they are fully aware and identify patients in advance. Review TTA transcribing and independent prescribing polices and process to enable pharmacists to transcribe or prescribe to speed the process.	TTAs are written in advance. Reduction in complaints from patients Policy written and approved by Drug & therapeutics committee and Nursing & Midwifery board. issues		Portia Omo-Bare Chief Pharmacist	Monthly monitoring and reporting of TTAs reported to divisions Numbers of Prescriptions written or transcribed by pharmacists recorded monthly	Policy updated in October 2010	Care Custody Policy for the administration of medicines.

CQC Related Outcome	Aim	Objective	Action	Measureable Outcome (Evidence of success)	deadline	SRO	Milestone (Progress Check Point – Date and Measurement)	Progress Update	Evidence
9. Management of Medicines	2. Ensure there are processes for learning from medicine related IR1 incidents across the whole trust.		There is a group that meets monthly to review all IR1s. A monthly report will be sent to all wards and divisions. IR1s and actions taken will be reported to the safe medicine practice group where trends are viewed and incidents requiring specific actions are recommended. Incidents that relate to specific pieces of current NPSA guidance are investigated individually by the ward matron and reported back to the IR1 group. Requirement for doctors to include GMC number on all prescriptions being implemented – this will help with identifying prescribers when investigating incidents	IR1 reports sent to wards and divisions. Action plan of steps to be taken are developed and posters, training and policies produced or updated. Annual report produced showing number and types of incidents reported and action taken. Monthly newsletter published with specific section on safety Training programme has been developed and given to all nursing staff on all wards. Record of training kept by ward.	Sept 2011 On-Going Nov 2011 Sept 2011 Oct 2011 Aug 2011		Reports sent to wards and divisions. First monthly newsletter published by 31.8.11 Screensaver for GMC no. Oct 2011.		

CQC Related Outcome	Aim	Objective	Action	Measureable Outcome (Evidence of success)	deadline	SRO	Milestone (Progress Check Point – Date and Measurement)	Progress Update	Evidence
9. Management of Medicines	3. Ensure all patients leave the hospital with the correct medicine.		Undertake a training program with nurses on all wards on giving medicines to patients.	Training programme written and implementation action plan agreed Audit undertaken to review numbers of patients leaving hospital with TTAs written promptly. Complaints reduced.			Programme Written by 30.10.11.		

CQC Related Outcome	Aim	Objective	Action	Measureable Outcome (Evidence of success)	deadline	SRO	Milestone (Progress Check Point – Date and Measurement)	Progress Update	Evidence
	4. Ensure there are processes for learning from medicine related IR1 incidents across the whole trust.	KGH: there are clear processes for learning from medicines incidents	Review trust policy for ensuring all prescriptions are written 24 hours in advance. Communicate to all clinical leads and consultants to ensure they and they juniors are fully aware. Communicate to all pharmacists to ensure they are fully aware and identify patients in advance. Review TTA transcribing and independent prescribing polices and process to enable pharmacists to transcribe or prescribe to speed the process. Requirement for doctors to include GMC number on all prescriptions being implemented – this will help with identifying prescribers when investigating incidents	IR1 reports sent to wards and divisions. Action plan of steps to be taken are developed and posters, training and policies produced or updated. Annual report produced showing number and types of incidents reported and action taken. Monthly newsletter published with specific section on safety issues	Sept 2011 Oct 2011 Aug 2011	Portia Omo-Bare Chief Pharmacist	Reports sent to wards and divisions. First monthly newsletter published by 31.8.11 Screensaver for GMC no. Oct 2011.		

CQC Related Outcome	Aim	Objective	Action	Measureable Outcome (Evidence of success)	deadline	SRO	Milestone (Progress Check Point – Date and Measurement)	Progress Update	Evidence
13: Staffing	To deliver patient care	All wards will be staffed to their agreed shift numbers	Re-launch of the Trust staffing Matrix as per Bed Management Policy. Daily Action log for duty matrons to record staffing issues and actions taken. Re-launched agreed funded staffing levels for each ward.	Use of the escalation policy to manage the risk	completed	John Fletcher/ Caroline Moore/ Judith Douglas/Sue Lovell Divisional Nurses	All in place and to be monitored. Staffing levels are monitored through the bed meetings. Maternity and NICU are monitored on a daily basis by the Pathways Facilitator and the NICU matron	In place. Monitored through daily bed meetings.	

CQC Related Outcome	Aim	Objective	Action	Measureable Outcome (Evidence of success)	deadline	SRO	Milestone (Progress Check Point – Date and Measurement)	Progress Update	Evidence
21: Records	To improve compliance with the Trust's health record policies	Patient personal records are all held securely. Information can be located in them when required	Ensure all notes are stored in appropriate locations and not left in un-secure areas. Additional locking cabinets ordered for areas where access to the notes is needed out-of-hours. Review of clinical information to be undertaken. Trust lead appointed to establish working party to address this.	No notes left unsecured at any time Notes contain all relevant information for timely and appropriate decision making.	Completed TBC	Mr Stephen Burgess Medical Director	Monitoring of notes stored in areas outside of secure medical records libraries. End Aug.2011 Review of output from newly established working party. End Sept.2011	Patient personal records are all held securely Information can be located in notes when required.	Review of medical secretary areas completed to ensure notes locked in secure areas. Health Records committee established with Terms of Reference in place. Working group review completed and outcomes to be fed into the Health Records Committee.

MATERNITY ACTION PLAN

CQC Related Outcome	Aim	Objective	Action	Measureable Outcome (Evidence of success)	deadline	SRO	Milestone (Progress Check Point – Date and Measurement)	Progress Update	Evidence
13. STAFFING. 4. SAFETY OF CARE	1. To ensure appropriate numbers of staff (midwives, obstetricians, paediatricians, anaesthetists, etc) to provide safe high quality evidence based care and a choice of maternity care settings for women.	1.1 Number of midwives in post meets 1:29 ratio for midwives to births.	Develop recruitment & retention strategy for midwives, nurses and support staff, involving external recruitment agencies and internal development plans.	R&R strategy for the maternity unit approved by the Board. Midwifery staffing numbers demonstrate a net gain each month with effect from 1.6.11. The baseline for midwifery numbers in post will be taken form April 11 data. 1:29, based on in post measured against agreed trajectory on a monthly basis. Trajectory incorporated in monthly workforce proforma.	30.9.11 Revised date Dec 2011	MB	Board approval Dec 2011	The trust is currently meeting 1:33 ratio with substantive staff and achieving 1:29 ratio with agency and bank. Recruitment is ongoing.	Midwifery recruitment strategy approved at Trust Board Dec 10. Current midwifery establishment and rotas.
			Undertake exit interviews for all staff who resign and act on the findings. Findings to be incorporated into action plan.	100% of leavers have exit interviews. Reports produced following each quarterly review of exit interviews.	30.6.11	MB	Implement new structure for conducting interviews.- 30.6.11 Commence quarterly evaluation content of exit interviews.- 1.10.11.	100% leavers are offered exit interviews. Contents of all exit interviews taken are reviewed and issues arising are noted and addressed as appropriate.	Workforce proforma completed on monthly basis to include number of exit interviews completed.
			Advertise locally, nationally, internationally to recruit registered	Contract in place with recruitment companies. Recruitment schedule in	30.6.11	SL	Bi-Monthly reduction in vacancies	Agreements in place with 3 recruitment	Recruitment schedule. Workforce

			midwives on an ongoing basis. Commission recruitment companies to assist in this process	place. Copies of adverts, job descriptions, person specs. Number of midwives in post on a monthly basis as noted in workforce report trajectory to reach less than 5% vacancies by October.			against agreed target – 30.6.11	agencies: HCL, Medacs and Kate Cowig for Ireland. The trajectory for reduction in midwifery vacancies is incorporated in the monthly workforce reports.	report trajectory of net gain of midwives.
			Local recruitment open days for all groups of staff, including bank midwives and MCAs. Interviews to take place on the day	Programme of open days every 6 months Number of recruits offered posts on each day and number who actually start,	30.11.11	SL	Open day advertised – 30.9.11. Open day – 30.11.11	Open day has been postponed due to the ongoing success of recruitment of experienced midwives. A review of rolling advertising is currently underway	Advert for open day.
			Weekly Report on funded establishment: starters, leavers, staff in post, vacancies and resignations.	All metrics are improving - reduction in number of leavers, reduction in vacancies to less than 5% by October. Reduction in number of temporary staff used. Achievement of 1:29 ratio for midwives in post. Achievement of 1:1 care in labour.	16.6.11	MB	KPI proforma approved by PBE July 11. reported monthly to PBE and Trust Board	Workforce proforma developed and completed incorporating starters, leavers and sickness.	Workforce performance reports mapping performance against trajectory.
		1.2 To ensure 80:20 ratio for midwives:support staff.	Maintain Maternity Care Assistants numbers in post and recruit as required.	No vacancies longer than 3 months, mapped by individual ESR post number.	15.8.11	MB	Advertise for MCA vacancies – 20.7.11 Appoint MCAs 15.8.11 MCAs in post 30.9.11	VCP for MCA establishment included on monthly workforce proforma, which provides	Completed workforce proforma showing reduction in MCA vacancies.

								baseline.	
			Maintain Nursery Nurse numbers in post and recruit as required.	No vacancies longer than 3 months, mapped by individual ESR post number.	16.6.11	MB	Advertise Nursery Nurses – 30.6.11 Appoint NNs – 30.7.11 NN in post 15.9.11	Currently there is 1.8 wte vacancy. Establishment is currently under review	Workforce proforma showing reduction in NN vacancies.
		1.3 Number of nurses in post meets the 1:2 ratio for HDU.	To recruit nurses with appropriate level of skills and training to vacancies within HDU for maternity. Internal retention plan developed to incorporate rotational programme incorporating ITU and main theatres and professional development for HDU modules.	All metrics are improving - reduction in number of leavers, reduction in vacancies down to below 3% by September.	30.9.11	MB	Plan interview date with agency – 7.7.11 RGNs in post – 30.9.11	Readvertised in September to allow the current new starters to settle in before more new staff are incorporated. Baseline is included in the monthly workforce proforma.	Workforce proforma showing reduction in RGN vacancies
		1.4 To ensure the appropriate and robust management of staff in post to optimise staffing levels, so that staff express satisfaction with safe staffing levels and managerial response to shortfalls.	Implement trust sickness policy across all grades	- Sickness rates reduce from 5.5% to 3.5% - 100% of staff interviewed by manager on return from absence - Management plans in place for all staff on long term sick leave	30.6.11	MB	Trajectory in place for reducing sickness by all staff groups – 9.6.11 Planned audit of return to work interviews 1.8.11 Planned audit of long term sickness plans – 1.9.11	Sickness policy introduced on all wards and monitored by senior staff. Trajectory set at 0.2% reduction /month, however, September rate is 5.5.%	Workforce proforma. Audits of sickness levels, returns and management plans.
			Introduce electronic rostering in all maternity wards/departments across the Trust, to plan staffing resources aligned to activity and workload.	All staff work full contracted hours. Rosters signed off by matron 6 weeks in advance and submitted to the nurse bank for shifts	30.9.11	MB	Meet with staff side and implementa-tion group – Training of staff	Most Staff have had training. Erostring is being rolled out. Escalation	E roster currently being rolled out.

			Early identification of shifts where additional staffing needed. Agree trajectory for reduction in agency staff use. Agree trajectory for reduction in incident reports related to staffing levels, once base line established. Undertake staff survey, incorporating questions to evaluate bank staff satisfaction with booking process and set baseline.	to be filled with appropriate period of notice. Reduction in use of agency staff by 80% Reduction in incident reports where unit is short staffed. Bank staff express satisfaction with booking process.				process is in place to report any incidents arising related to staffing levels.	
			Increase staffing levels in ward areas. Set minimum staffing levels for each area, with escalation actions to be taken. Appropriate responses to staffing shortages by senior midwives in a timely manner, monitored by the HOM. Daily report eg NPSA intrapartum tool to ensure sufficient staff on a daily basis.	Staffing levels by shift increased. Staffing levels for each area signed off by band 7 and matron and known by staff in each area, with sign off by HOM, Divisional Director and Contact SOM. Escalation policy is activated appropriately. Sufficient numbers of midwives to care for women 100% of time.	12.8.11	SL	Increase in staffing levels 6.3.11 Minimum staffing levels reviewed and agreed – 23.6.11 Communicated to all staff within maternity. 30.6.11	Minimum staffing template signed off at the maternity risk management meeting on the 18.7.11. Escalation policy now implemented and reported on in weekly performance reports. Rolling programme for staff survey commenced.	Workforce paper with minutes of MRMG agreeing staffing levels. Daily staffing report. Staff survey.
			Staff questionnaire to test understanding of and satisfaction with staffing levels. Evaluate results of staff survey and include	90% of Staff report improved staffing levels in unit by October.	31.7.11	SL	Launch questionnaire – 25.7.11 Evaluate survey – 8.8.11 Report findings	Staff surveys undertaken during June. The staffing templates have been reviewed	Staff Survey results.

			recommendations into action plan.				to PBE End Aug 11	and changes made where appropriate.	
		1.5 To ensure strategy delivers appropriate medical workforce to cover BHRUT maternity services, including 168 hours of consultant obstetrician presence for Queen's labour ward.	Complete Business case as part of medical workforce strategy for maternity to achieve agreed medical cover to include, 168 hours consultant presence on Queens LW, senior cover for OAU, and maintenance of KGH LW and clinic/theatre schedules. Develop and agree implementation plan for medical workforce strategy.	Agreed business case by Trust Board in September and then presented to Commissioning Cluster by October. Agreed implementation plan.	30.9.11 Revised date Dec 2011	EO	Cost benefit analysis – 30.6.11 Business case to PBE 30.8.11	Develop case for increase in consultant workforce BY 8WTE - cost benefit analysis underway Dependant on Health for NEL report on activity	Business case approved by Trust Board. Agreed implementation plan.
			Analyse impact of IRP recommendations and Secretary of State decision on obstetric workforce model and requirements	Option appraisal in business case	30.8.11	EO	as above	As above. Dependant on timescale for publication of IRP/SoS decision	Option appraisal within business case.
		1.6 Medical cover for OAU 09:00-20:30 Monday- Friday 10 – 6 Saturday – Sunday.	Review consultant job plans and vacancies to cover OAU. Identify a consultant lead for OAU to ensure appropriate leadership and development of unit.	Women in OAU seen by obstetrician within 1 hour of arrival, following triage by midwife.	31.3.12	EO	Agree locum FTC - 16.6.11 Substantive cover for OAU in place 31.3.12	Locum in place to fill gaps Monday to Friday. Clinical Director working with obstetricians to establish a rota to cover Sat – Sun 10 – 1600hrs, by giving existing consultants additional PAs	Rotas for OAU cover. Weekly monitoring of waiting times.
		1.7 EWTD compliant rotas for junior doctors which	Establish and agree number of junior doctors required for maternity	Medical director signed off establishment. Agreed business case by	30.10.11	RH	Agreed junior establishment 30.6.11	To develop case for 3 middle grades	Compliant rotas. Education

		provide a safe level of care	services at BHRUT. Complete workforce plan and business case	Trust Board in September and then presented to Commissioning Cluster in October.			Business case agreed by 30.9.11	and incorporate within overall medical workforce strategy.	report from Deanery.
		1.8 To ensure Consultant anaesthetist presence on QH labour ward 08:00-20:00 Monday-Friday and on-call at other times. Ensure consultant for every elective LSCS in addition to consultant presence.	Joint meeting with anaesthetic and obstetric to agree level of cover. Guidelines on when to call consultant anaesthetist out of hours. Anaesthetic job plans reviewed to release PAs to LW. Benchmark level of satisfaction with availability of analgesia from CQC woman's survey and set trajectory for improvement. Audit current performance of availability of analgesia to establish benchmark and set target for improvement. Analyse incidents where delays in performing operative procedures.	Guidelines ratified and evidence staff have received and read them. 95% satisfaction for women on availability of epidural pain relief . Epidurals and other pain relief administered within 30 minutes of request. No operative delays due to lack of anaesthetic presence.	30.7.11	RO	Completion of guidelines 4.7.11 New anaesthetic rota in place – 30.6.11 Weekly audit of timeliness of analgesia commencing 20.6.11 Woman's survey – 30.9.11	Proposal developed and being consulted on with consultants. Issue escalated to Divisional Director for Surgery. Analgesia audits commenced on a weekly basis.	Guidelines and minutes ratifying. Audit and survey results.

ERS. 1. INVOLVEMENT OF WOMEN IN DECISIONS ABOUT THEIR CARE. 4. SAFETY OF CARE.	2. All staff working within maternity services are competent and capable of delivering a high quality and safe service.	2.1 Education and Supervision of midwives teams provides robust support to all maternity staff	Education strategy developed to include; Education team structure, TNA, competency frameworks & leadership programmes, Induction & preceptorship models, Integrated programme & schedule of support for new starters, students and current staff . DNA process for training. 2 Band 8a facilitators appointed and in post by the end of July. Trainee schedule documented for the year and planned training capacity approved by the NMC and LSA by end July. Agree plan for reduction in student midwifery/nursing numbers with HEIs and NMC. There is a SOM strategy that ensures all midwives have support of a SOM. Concerns over fitness to practice are dealt with proactively and in linae with LSA guidance Train MCAs in agreed relevant competencies.	Education strategy for maternity approved by the Board. Induction programme by staff group. Competency framework by staff group/band. Completed TNA for maternity services in line with NHSLA standards. Evidence of sanctions for non attendance. 95% of staff express confidence in ability to provide safe competent care. Approved training schedule signed off NMC and LSA by end of July. All MCAs/NNs are assessed as competent. 100% of midwives have an annual review. Number of SOMs supports 1:15 ratio.	30.9.11	JU	Draft strategy 15.8.11 TEC sign off 30.8.11 Full Board sign off 30.9.11. Plan for reduction of students agreed by NMC 30.7.11 TNAs completed for all MCAs and NNs 30.9.11 Training programme for MCA/NN commences 1.12.11 SOM annual reviews completed by 31.3.12 1:15 ratio for SOMs in place by 1.10.11	Induction programme for midwives has been revised and updated. All overseas midwives have an 8 week programme, supported by the education team. Evidence of programme and support days submitted to commissioners w/c 8.8.11. Standard Induction programme in place for maternity support staff. Band 6 competency framework draft out to consultation. Agreement reached 15.8.11 for reduction plan in student commissions. Review with NMC progress May 2012. TNA draft to be completed for MCAs by 1.11.11. LSA audit report received. Compliance	Education strategy approved by the Trust Board. Compliance report demonstrating attendance at training in line with TNA. Staff satisfaction survey. Training schedule. MCA/NN TNA report. LSA audit demonstrating standards met.

		2.2 Skilled & knowledgeable Doctors in post	All doctors attend: - CTG training - skills & drills training - record keeping All junior doctors have completed Annual Review of Competence Performance. Establish current baseline for compliance with training and agree trajectory for achievement of target.	95% compliance for all areas	30.9.11	SC	95% CTG training for doctors 31.7.11 Skills and drills training programme multidiscipli-nary in place – 30.9.11 and agreed trajectory for attendance by end of June. Feedback of multidiscipli-nary documentation audit/lessons learnt – 30.9.11.	All new doctors receive CTG training on induction. In place. Multidisciplinary education programme updated and commenced in September 2011.	Attendance figures at training. Documentation audit results.
		2.3 Skilled and knowledgeable midwives in post.	Complete individual training needs analysis for each midwife to inform training plans and identify gaps in skills & knowledge. All midwives to have a current PDP. All midwives attend: - mandatory training - CTG training - Skills & drills - Record keeping	Improved retention and reduced turnover . 95% of midwives have PDP 95% attend mandatory training , including CTG Agreed TNA for individual midwife	31.3.12	JU	Q1 25% of staff had PDP review Q2 50% of staff had PDP review Q3 75% Q4 100%. TNA analysis completed. 31.7.11 Mandatory training compliance 31.3.12	Appraisal data being updated on ESR and discussed at Divisional Board . New mandatory programme and data base commencing 1.9.11. TNA for midwives in place and currently being completed for all midwives. Completion for end of September. Analysis of the	TNA analysis report. Appraisal compliance. CTG training update.

								TNA's to be complete by 31/10/2011	
		2.4 Leadership development for midwives	Development programme for Band 7 midwives Recruit substantive matron for LW	All identified Band 7s attend and complete the programme, to include work based projects. Matron in post. No SUIs have poor co ordination of care or leadership as a contributory factor.	31.3.12	JU	Agree programme provider – 30.6.11 Commence programme for band 7s – July 11. Appoint matron 23.6.11	Delphi consultancy commissioned to develop this work. External support commissioned for SUI mgt and to develop new internal governance framework. Band 7 programme has been developed and has been sent for comment.	Programme outline. Report on work based projects.
		2.5 To ensure maternity services meet the requirement of 1:15 supervisors to midwives	Agree plan with LSA to increase number of SoMs through internal recruitment from 16 to 20 (based on current MW nos:) Plan for interim increase of capacity using sessional SOMs. Leadership development of supervision team in - partnership with LSA	Ratio of SoM at 1:15 Positive LSA audit.	1.10.11	HM	SOM away day 13/14.6.11 – completed. Ratio of 1:15 to be in place 1.10.11	External support received for 5 additional SoM to be in post by end October.	Update on the SOM to MW ratio. Workforce monthly returns. Action plan for Supervision.
		2.6 To ensure robust management of poor performance for all staff groups within maternity.	Review level of HR support to division. To train and support managers in the application of the policy for managing poor performance and sickness policy.	Numbers of staff subject to performance management. Length of time to resolve performance issues. Reduction of time taken to deal with by 2 weeks by end July.	1.8.11	CD	Complete training of managers 30.7.11	6 Midwives subject to formal disciplinary procedure. 1 dismissed, 1 final written warning, 1 verbal warning,	Monthly workforce return.

								3 hearings pending. Delays to 2 cases due to health issues. HR support in place to assist division with performance management and sickness reporting procedures in all areas. Band 7 and Matrons to monitor	
		2.7 To ensure all maternity staff receive a customer care training programme.	Delivery of customer care training programme Establish baseline in number of complaints about communication/attitude. BHRUT Code roll-out to all staff .	Reduction in complaints related to communication/attitude.	31.3.12	SL	Complete analysis of complaints. 30.6.11 Trajectory for reduction agreed based on baseline 4.7.11	Delphi consultancy undertaking internal observation to form baseline on attitudes. Customer care training planned, commencing with reception staff. Staff identified in complaints received so far have had customer care training. Analysis of TNA underway identify staff requiring training. Training to be extended to medical workforce	Complaints breakdown monthly. Training records.

		2.8 Lessons learnt from SUIs/ incident reporting/ complaints are fed back to all staff	Implement newsletter on a monthly basis for staff to feedback lessons learnt, discussed at ward based meetings. Include lessons learnt on mandatory training days, near miss meetings and SOM meetings. Establish baseline on the number of avoidable clinical incidents and agree target for reduction. Establish RCA training for all relevant staff.	Reduction in avoidable clinical incidents. Reduction in complaints by 50%. Improved woman satisfaction survey. 95% of staff receive feedback and training from all incidents/SIs. All SUI reports demonstrate RCA process and action plans are robust and auditable.	30.9.11	JU	Introduce newsletter – 1.7.11 Establish ward based meeting structure 30.6.11 Woman Satisfaction survey 30.9.11 Establish target for reduction in number of avoidable clinical incidents. 4.7.11	Newsletter introduced. 'Tell us what you think' Pilot commenced. Findings from the external review of governance processes to be actioned. Evidence of midwifery attendance at near miss meetings to be collated	Newsletter. Attendance list at meetings and minutes. Results of survey. Quarterly review of SUI reports.
4. SAFETY OF CARE. 1. INVOLVEMENT OF WOMEN IN DECISIONS ABOUT THEIR CARE	3. To ensure clear systems and models of care to deliver sustainable capacity and safe, effective and high quality care.	3.1 Agreed pathways of care and evidence based guideline in place and applied in practice.	All clinical guidelines are updated and database maintained. Incorporate the 'fresh eyes' approach to CTG interpretation into current guideline. Establish mechanism to updating guidelines in response to lessons learnt and audit findings. Updates on guidelines to be communicated via newsletter and meetings. Audit programme of all clinical guidelines agreed and implemented. Implement sign of sheet for when new guidelines introduced to acknowledge receipt and understood by each member of staff.	All guidelines are in date, with auditable standards defined. Audit of CTG interpretation completed and action plan in place to address any short falls.	30.8.11	DO	All guidelines updated and on intranet – 30.8.11 Agree programme of audit – 31.7.11	11 remaining guidelines are on track for review completion by end October. LSCS audits happen on a weekly basis. Fresh eyes approach now part of LW co - ordinator role.	Guidelines. Programme of audit. Monthly update on audits undertaken. Signed sheets for updated guidelines.

		3.2 Early access to midwife booking	Work with ONEL maternity commissioner to develop antenatal referral pathway. Risk assessment in place to direct women into appropriate pathway of care. Review antenatal booking guideline with the intention to aim for booking by 10 weeks. Work with GPs to ensure referrals are sent in a timely fashion to meet target. Develop plans to improve how hard to reach groups are engaged early in pregnancy.	90% of women to be booked by 12+6 weeks 100% antenatal risk assessment, incorporating full social and healthcare needs assessment, completed.	31.3.12	KH	Antenatal pathway review complete – 30.9.11 Revised antenatal booking guideline – 31.7.11 Audit of antenatal risk assessment 31.10.11	Process for booking an antenatal appointment under review. Appointments now being given to support booking by 10 weeks gestation. Risk assessments are in place and review of RI to be presented to the antenatal forum end Oct	Antenatal pathway updated version. Audit results. Monthly scorecard review of 12 weeks and 6 days.
		3.3 Develop model of care for low risk women, including home birth, water birth, MLU, working with user involvement	Establish working group to develop the model/pathway with joint staff and MSLC membership. Appoint consultant midwife for normal birth To introduce routine offer to all women around choice of place of birth to include home birth and/or water birth. To complete Co-located MLU business case. To produce written information to women to describe and explain choice, backed up by face to face explanation by community midwife and via antenatal education sessions. To increase availability of antenatal education	MSLC reps are able to describe their involvement in developing models of care. Midwife led care pathway implemented. Pathway agreed by maternity risk management group as well as Quality and safety committee. Home births increased from 1% to 3% by 31.3.12 Waterbirths increased from 0% to 1% by 31.3.12 Consultant midwife in post by 30.9.11 Woman's survey demonstrates 75% offered a choice by end of March 2012.	31.3.12	JU	Monthly trajectory for home birth 0.2% increase. Trajectory for water birth 0.1% increase per month. Interview for consultant midwife – 1.7.11 Establishment of additional antenatal workshops Woman's survey	Consultant midwives appointed. Programme of work started to develop MLU by June 2012. Antenatal workshops established. Education classes implemented to support home birth	Monthly scorecard detailing homebirths and waterbirths. Offer letter to Consultant midwife. Written information for women signed off by MSLC. Programme of antenatal education workshops. Results of woman's survey

			classes.	Number of antenatal workshops/programmes available.					
		3.4 Robust management of demand within unit and escalation of concerns	Supernumerary B7 co-ordinates bed capacity on LW. Bed manager post implemented. Implement daily unit status meeting management process. Escalation/divert policy fully embedded and unit status recorded on CMS. Audit of timeliness of transfer of women from antenatal ward to LW. Identify actions to improve transfer of antenatal women to LW and implement. Clear guidelines on responsibilities of shift leaders. Implement mechanism for monthly forecasting of deliveries based on bookings.	No women in established labour outside LW. Number of times escalation/divert policy activated. 1:1 care in labour. No: of women booking monthly. Forecast of deliveries.	30.6.11	SL	Daily unit status meeting established – 24.6.6.11 Weekly audit re escalation policy use. 27.6.11 Monthly forecast – 30.6.11	Capacity mgt via the capping plan since 29th September as agreed with ONEL and NHSL.	Weekly audit of unit status. CMS status. Results of 1:1 care in labour. No: of women booking monthly. monthly Forecast for deliveries. Weekly performance report.
		3.5 To improve the triage of women when contacting/arriving within triage itself.	To agree pathway for triaging women in maternity. To implement telephone triage system. To implement clinical triage in unit. Conduct full review of triage system including telephone triage.	All women triaged within 15 minutes of arrival.	30.6.11	BN	Telephone triage system in place-21.3.11 Clinical triage in place – 21.3.11 Audit waiting times 23.6.11. Audit telephone triage 1.10.11	New triage system in place. Target monitored on a weekly basis and reported in weekly Maternity Performance Report	Audit of triage waiting times. Triage pathway.
		3.6 To ensure all women requiring an Emergency LSCS are operated on	To implement pathway for emergency LSCS. To implement process for ongoing audit of	100% of women within timescales for LSCS by grade	30.6.11	CB	Pathway implemented – completed. Re instate	Weekly audit in place for emergency LSCS and	Weekly results of audit of emergency

		within appropriate timescale for grade of LSCS.	emergency LSCS. To improve capacity/resource to ensure timeliness of LSCS. Plans to be developed in line with recommendations from ongoing audit.				ongoing LSCS audit – 30.6.11	reported as part of the weekly performance report.	LSCS.
		3.7 To ensure there is an appropriate, written pathway for women having a for elective LSCS.	To establish a new reception area for women arriving for elective LSCS on day of operation. To agree plan and business case to move elective LSCS into main theatres, including recovery of women. Business case to include full option appraisal and risks associated with plan. To update written information for women having an elective LSCS. Audit compliance with pathway.	New reception area in place. Business case agreed. 100% women undergoing elective LSCS follow pathway.	30.11.11 Depend-ent on IRP	RH	Business case prepared. 30.7.11 Business case presented to PBE 31.8.11 Business case approved by Trust Board By March 2012	Business case being prepared. Pathways in place. Women currently being diverted to Homerton for Elective C-Sections until December 2012. Monitoring of acceptance vs refusal underway.	Approved business case. Written information. Audit results.
		3.8 To ensure appropriate pathways for women having Induction of labour.	To implement a staggered approach to admission of Inductions of labour on daily basis. Agree pathways for IOLs for postmature and high risk pregnancies. Fully implement model for IOL in outpatient setting, for women women who meet low risk, post dates criteria. Update written information for women related to IOL in partnership with MSLC. Audit compliance with	Number of IOLs per day. Number of outpatient IOLs. Audit of IOLs ,demonstrating appropriateness of setting and any delays. Audit of woman's satisfaction in relation to information and explanations given.	30.10.11	DO	Establishment of staggered approach to IOL. 30.7.11 Pathways in place for postmature and high risk – 30.7.11 Outpatient model in place – 30.10.11	Pathway for IOL approved by maternity risk group. New process will include staggering IOLs, to commence by end of October 2011. Creation of audit to ensure compliance to pathway to be	Weekly figures for IOLs. Audit results. Women's satisfaction survey.

			pathway. Ensure all staff are able to give informed consent for IOL.					completed by 31/12/2011	
		3.9 To ensure high quality, effective and efficient care to women during the postnatal period in both hospital and community settings, through the development and implantation of clinical pathways.	To implement a multidisciplinary system between paediatrics and midwifery to undertake discharge examination of babies. To continue with yearly education commissions to increase the number of midwives qualified to perform discharge checks for babies. To implement a clear discharge process for women from LW, incorporating; Discharge within 6 hours of delivery. Create a short stay postnatal stay facility. To bed in daily postnatal group education session. To update the written information to women on discharge . To maximise the number of Postnatal clinics, utilising the role of the MCA in community. Establish number of postnatal clinics in place and agree target for increase by Borough. Audit delay in discharge of women from postnatal ward and respond to findings.	25% increase number of midwives qualified to perform neonatal discharge examinations. LOS reduced for postnatal women by HRG by 0.2 days. 80% of women attending postnatal talk before leaving hospital. Number of postnatal clinics in operation by Borough. Improved feedback from women re discharge process in survey.	30.9.11	SA	Postnatal discharge process in place – 30.7.11 Short stay postnatal area established - 30.7.11 Written information updated – 30.9.11 Woman's survey	Utilising community settings for post natal clinics. Discharge Jonah rolled out on post natal ward. Discharge coordinator to start in October to ensure discharge within 6 hours of delivery. Tracking process to be devised to monitor success	Results of woman's survey. Number of midwives qualified to undertake newborn checks. Number of postnatal clinics by area. Audit results.

		3.10 To ensure women receive 1:1 care in established labour.	Linked to 1.1 see above. Linked to point 3.4 see above. Undertake a monthly observational audit to establish compliance with 1:1 care (observed for 7 days recording levels of care every 2 hours for each 24 hours) Incorporate into woman's satisfaction survey.	98% compliance with 1:1 care in labour. 80% of women report satisfaction with 1:1 midwifery care during labour.	31.3.12	SL	1% Monthly increase towards 98% 1:1 care in labour, by December. Woman's survey 30.9.11 Woman's survey 31.3.12	Aug audit: Queens – 98% KGH – 100% September – 100% across both sites.	Monthly audits for 1:1 care in labour. Results of woman's survey.
		3.11 Increase home birth rate to 3%	Linked to point 3.3 see above. Develop integrated model of community/hospital midwifery care, utilising team and caseloading models. Offer choice of place of birth to all women.	3% home births by 31.3.12 Women report increased continuity of care.	31.3.12	KH	Agree plan to implement new model of community midwifery care, April 2012.	Community consultation completed. Homebirth team being introduced by December.	Monthly audit of homebirth rates. Woman's survey.
11. EQUIPMENT	4. To ensure appropriate levels of equipment in working order within all areas providing maternity care.	4.1 All equipment is available and ready for use.	Implement and agree with staff equipment requirements and then log/inventory for each clinical area. Order equipment if required. Establish have ''safe to fly" checklists completed on every shift. Establish benchmark for staff satisfaction with level of equipment in each area. Faulty equipment is returned to clinical area in an agreed timescale.	Inventory of equipment signed off by band 7 for each area. 100% with safe to fly checks. Staff survey results demonstrate 90% staff satisfied with equipment availability. Audit of times for repairs.	27.3.11	SL	Completed inventories in each area. 23.6.11 Monthly audits for compliance.	Inventories in place for Coral and postnatal ward. Checklists now in place for Labour Ward for equipment currently in place – absolute inventory under review Staff survey in all areas conducted to assess staff perception of equipment levels.	Equipment inventories. Monthly safe to fly audits. Staff survey results.

21. PATIENT RECORDS	5. To ensure maternity records are maintained in a secure and confidential manner.	5.1 Provide secure and confidential storage of all patient records	Lockable notes trolleys in place. Train all staff in their responsibilities related to care of confidential information.	Trolley in place. 95% staff trained in information governance.	31.5.11	SL	Notes trolleys in place on postnatal and antenatal ward. 50% of staff trained in information governance by end of Month 6, remainder by 31.3.12	New notes trolleys in place and adherence to note security monitored.	Training records. Spot checks staff understanding.
1. INVOLVEMENT OF WOMEN IN DECISIONS ABOUT THEIR CARE.	6. To ensure a good consistent experience for all women, which demonstrates they are respected and involved in the planning of care and services.	6.1 To ensure women are involved in the improvement of maternity services within BHRUT.	Review and agree with MSLC clinical representatives for committee. Develop programme of work in partnership with MSLC. Involve MSLC member in interview panels for senior midwifery staff. Bi annual survey of women to assess satisfaction, using Quality health. Continue with 'walking the patch', to gain feedback from women in all clinical areas. Implement welcome packs for each clinical area. Introduce name badges and insist staff wear them, to assist women with identifying name and designation of members of staff.	Attendance of clinical members at MSLC meetings. Members of MSLC express satisfaction with level of involvement and response from the Trust when planning services. Woman's survey results.	30.9.11	JU	Agree clinical and user membership with MSLC – 23.6.11 Agree MSLC programme of work for 11/12 – 30.6.11 Woman's survey	Member ship of MSLC and TORs agreed. Walking the patch continues on a 6 weekly basis. Collaborative work moving forward with MSLC and LINKs. Postnatal ward survey introduced.	TORs for MSLC. Programme of work for MSLC. Woman's survey result. User representative feedback reports.
		6.2 To ensure complaints are handled in a timely and appropriate manner, which	To agree mechanism for dealing with complaints, to improve quality of responses and turnaround times.	Monthly response rates to complaints. Reduction in reports of dissatisfaction with responses.	30.6.11	SL	Mechanism in place – 30.6.11	Complaint response rate has improved slightly – tracking system	Monthly response rate to complaints.

		addresses concerns raised and treats the woman and her family with respect.	Identify members of team who require training on how to deal with complaints. Involve staff in complaints meetings.					in place Further monitoring and staff training on handling and responding to complaints.	
		6.3 To ensure bereaved families are dealt with in a respectful manner and care is individualised.	Review the current arrangement for care post delivery for women following the loss of their baby and identify alternative locations away from labour ward. Reorganise rooms on labour ward to create quieter environment for bereaved women.	Number of women transferred to setting outside labour ward for postnatal care. Decrease in number of complaints by bereaved women related to location of room post delivery.	31.8.11	BN	Side room allocated on antenatal as alternative venue.	Side rooms available on antenatal ward for women following bereavement. Alternative location of bereavement room on labour ward being explored. Care pathway is under development for women +6 weeks	% women transferred to antenatal ward %complaints by theme.

1. INVOLVEMENT OF WOMEN IN DECISOINS ABOUT THEIR CARE. 4 SAFETY OF CARE	7. To ensure women are provided with evidence based care in relation to breastfeeding and are then supported in their decision.	7.1 To improve advise and support given to women in relation to breastfeeding and increase the initiation of breastfeeding at delivery by	To gain Trust Board sign off for sector breastfeeding strategy. Implement breastfeeding workshops during antenatal period. Agree programme of actions to move Trust towards BFI status. Implement improved facilities to support women on the postnatal wards with breastfeeding. Remove wide range of freely available pre prepared formula feeds. Establish milk kitchens on postnatal wards. Develop new written information for women choosing to breastfeed. Linked to 2.3	Breastfeeding strategy. No: of breastfeeding antenatal workshops in place. Agreed plan for achieving BFI status. Breastfeeding initiation rates. % of women still breastfeeding at 6 weeks.	30.10.11	LI	Agreed breastfeeding strategy – 30.10.11 Agreed plan to achieve BFI – 30.8.11	Breastfeeding workshops for women introduced. Formula feeds removed from ward areas and milk kitchens established. Letters to women introduced to explain changes. Breasfeeding strategy signed off by the PCT's. Action plan drafted to achieve BFI status	Times and venues for breastfeeding workshops. Results of woman's survey Monthly breastfeeding initiation rates and breastfeeding rates at 6 weeks postnatal. Expenditure on pre prepared formula feed.

KEY

SL	Sue Lovell	Head of Midwifery/Divisional Nurse
EO	Edward Osei	Clinical Director Women
RH	Richard Howard	Divisional Medical Director
JU	Jane Urben	Associate Head of Midwifery – Governance and Quality
SC	Seema Charkravati	Consultant Obstetrician
HM	Helen Mansfield	Contact Supervisor of Midwives
SA	Sabah Abdin	Matron Queens
DO	Dele Olunronshola	Consultant Obstetrician/LW lead
CO	Chineze Otigbah	Lead Obstetrician
BN	Bernie Nipper	Acting Matron LW Queens
KH	Kim Hurn	Matron KGH/Community
CD	Carol Drummond	Divisional Director
CB	Celia Burrell	Consultant Obstetrician
LI	Lorraine Imber	Infant feeding co ordinator.

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Quality and Patient Standards Performance Report – September 2011	**Trust Board**
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
The Quality and Patient Standards Performance Report provides an analysis of performance against trust-wide and national targets for the following domains: • Quality and Strategy • Operational Performance • Financial Performance • Human Resource Performance The following areas where performance is of concern for the month and/or for the year are discussed within the report: • MRSA • Venous Thromboembolism Risk Assessment • Single Sex Breeches • Emergency re-admissions <30 days • Delayed transfers of care (DTOC) • Complaints • Patient Experience • Outpatient DNA rates and First to Follow-up Ratio • Diagnostic Breaches • Length of stay • Cancer Targets • % Women Seen by Midwife within 12 Weeks and 6 Days • Freedom of Information • Accident and Emergency • Referral to Treatment (RTT) • Appraisal Training • Basic Life Support Training This report includes the key actions that are being undertaken to bring performance back in line within target.	□ **PEQ**……..…… □ **STRATEGY**…….…… □ **FINANCE** ……..…… □ **AUDIT** ……..……..… □ **CLINICAL GOVERNANCE** ……..……...…… □ **CHARITABLE FUNDS** ……..… ☑ **TRUST BOARD – October 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: Neill Moloney, Director of Delivery **PRESENTER:** Neill Moloney, Director of Delivery
	DATE: October 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 Trust Performance Dashboard.

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

Barking, Havering and Redbridge University Hospitals NHS Trust

Trust Performance Dashboard - August 2011

QUALITY AND SAFETY
Trust
Cancer, Diagnostics and Therapeutics
Medicine
Surgical
Womens and Children

OPERATIONAL PERFORMANCE
Trust
Cancer, Diagnostics and Therapeutics
Medicine
Surgical
Womens and Children

FINANCIAL PERFORMANCE
Trust
Cancer, Diagnostics and Therapeutics
Medicine
Surgical
Womens and Children

WORKFORCE PERFORMANCE
Trust
Cancer, Diagnostics and Therapeutics
Medicine
Surgical
Womens and Children

Barking, Havering and Redbridge University Hospitals NHS Trust

Trust Performance Dashboard - September 2011

		Quality and Safety				
Wgt	**No**	**Indicator**	**Target 11-12**	**Actual Mth**	**Mnth Move**	**YTD Status**
4	10	MRSA HAI	3	1	▲	4
4	11	C Difficile HAI	41	6	▲	27
4	12	MRSA Screening - Elective	100%		▼	72%
4	13	MRSA Screening - Emergency	100%		▼	83%
4	15	% Adult VTE Risk Assessed	90%	94.0%	▲	85.94%
4	95	No Diagnostic waits over 6 weeks	0	31	▼	213
2	16	No of Same Sex Breaches	0	8	▲	113
4	14	Hospital Standardised Mortality Ratio Relative Risk (YTD)**	100			95.6
	19	Mortality % (elective)	n/a	0.19%	▲	0.10%
	20	Mortality % (non -elective)	n/a	2.91%	▲	2.77%
	21	SUIs as % of incidents reported	n/a	8.21%	▲	2.66%
	22	Incident Rate per 100 admissions	n/a	2.34%	▼	5.89%
4	112	Emergency Readmissions <30 days - Elective * - with PBR exclusions	2.21%	2.79%	▼	2.94%
4	113	Emergency Readmissions <30 days - Non elective* - with PBR exclusions	9.38%	13.01%	▼	13.08%
4	25	90% stroke unit	80%	95.74%	▼	93.62%
4	26	% high risk of stroke TIA <24hours	60%	80.00%	▼	83.58%
4	27	Delayed transfers of care	3.50%	4.38%	▲	4.07%
4	28	Elective Admissions on Day of Surgery*	80%	79.51%	▼	82.32%
2	17	Complaint numbers (excluding enquiries) ***	225	76	▼	495
2	18	Complaints responded to within 30 working days*	80%	11.0%	▼	23%
		PATIENT EXPERIENCE				
4	29	Satisfied with level of care received	80%	61.00%	▼	63.0%
4	30	Treated with dignity and respect	80%	67.00%	▼	68.0%
4	31	Confidence and trust in doctors	80%	71.00%	▼	72.0%
4	32	Confidence and trust in nurse/midwives	80%	66.00%	▼	68.0%

KEY
***- One Month in Arrears**
**** - Two Months in Arrears**
***** Target is year to date**

Barking, Havering and Redbridge University Hospitals NHS Trust

Trust Performance Dashboard -September 2011

DoH Performance Framework To date
Standards and Vital Signs
User Experience (National Survey)
Finance
Registration

		Operational Performance				
Wgt	No	Indicator	Target 11-12	Actual Mth	Mnth Move	YTD Status
4	40	FFU Ratio	2.13	2.35	▲	2.25
2	41	DNA First	9.70%	10.66%	▼	10.30%
2	42	DNA Follow-Up	10.30%	10.59%	▼	10.16%
4	43	LOS (Elective)	3.6	3.74	▼	3.81
4	44	LOS (Non-Elective)	5.4	4.66	▲	4.85
4	94	LOS (Elective- excluding 0 LOS)	4.0	4.35	▼	4.31
4	96	LOS (Non- Elective-excluding 0 LOS)	5.8	6.11	▼	6.37
	45	Emerg Adm for Long Term Conditions				
	46	No' of Low Value Procedures				
2	47	% Daycase rate - All	75%	87.1%	▼	87.62%
4	48	% Women who have seen a midwife within 12 wks	90%	75.0%	▼	78.0%
2	49	Cervical Screening - Lab Results Within 2 Weeks*	98%	100.0%	►	100.0%
1	50	Cervical Screening - Results Within 2 Weeks (GP to PCT)*	98%	99.9%	▼	96.9%
	51	Number of FOI requests received	318	35	▲	201
1	52	% FOI Requests responded to within 20 working days*	100%	75.0%	▼	83.7%
4	60	62 Days - treated from referral	86%	83.9%	▼	89.70%
4	61	2 Wk % seen all urgent refs & ref for breast	93%	97.2%	▼	99%
4	62	2 Wk GP RefTo 1st OP for susp cancer	93%	96.7%	▼	99%
4	63	2 Wk GP Ref To 1st OP for breast symptoms	93%	100.0%	►	100%
4	64	31 Day 2nd Or Subs Treatment - Surgery	94%	95.7%	▼	99%
4	65	31 Day 2nd Or Subs Treatment - Drug	98%	100.0%	►	100%
4	66	31 Day DTT for all cancers	96%	97.9%	▼	99.36%
4	67	62 Day RTT From Cancer Screening	90%	92.3%	▼	92.35%
4	68	62 Day RTT From Hosp Specialist	85%	100.0%	▲	90.53%
4	69	62 Days Urgent RTT of all cancers	85%	82.3%	▼	89.20%
4	70	31 Day Subs Treatment - Radiotherapy	94%	93.3%	▼	99%
		A&E				
4	71	KGH - Unplanned Re-attendance Rate - reattendances within 7 days	5%	6.5%	►	6.80%
4	72	KGH - Total Time in Department - 95th Percentile (mins)	240	240	▲	240
4	73	KGH - Left Department Without Being Seen	5%	3.3%	▲	3.60%
4	74	KGH -Time to initial assessment - 95th Percentile (mins)	15	12	▲	8
4	75	KGH -Time to Treatment - Median(mins)	60	80	▲	74
	76	Ambulatory Care - DVT *	n/a	11.5%	►	16.98%
	77	KGH - Consultant Sign Off				
	78	KGH - Service Experience				
4	98	QH - Unplanned Re-attendance Rate - reattendances within 7 days	5%	6.8%	▼	7.40%

Barking, Havering and Redbridge University Hospitals NHS Trust

Trust Performance Dashboard -September 2011

DoH Performance Framework To date
Standards and Vital Signs
User Experience (National Survey)
Finance
Registration

		Operational Performance				
Wgt	**No**	**Indicator**	**Target 11-12**	**Actual Mth**	**Mnth Move**	**YTD Status**
4	99	QH -Total Time in Department - 95th Percentile (mins)	240	360	▲	352
4	100	QH - Left Department Without Being Seen	5%	4.5%	▲	4.80%
4	101	QH -Time to initial assessment - 95th Percentile (mins)	15	49	▲	47
4	105	QH -Time to Treatment - Median(mins)	60	77	▲	54
	102	Ambulatory Care - Cellulitis *	n/a	34.2%	►	42.38%
	103	QH -Consultant Sign Off				
	104	QH -Service Experience				
4	79	Data quality indicators - % records invalid	5%			Performance Under Review
4	80	Difference in number of A&E Attendances reported on A&E HES	90% -110%	100.0%	▼	100.0%
4	81	Four-Hour Maximum Wait In A&E (types 1&2)	95%	92.68%	▼	92.68%
4	91	Four-Hour Maximum Wait In A&E (types 1 - Queens)	95%	89.75%	▼	89.40%
4	92	Four-Hour Maximum Wait In A&E (types 1 - KGH)	95%	97.22%	▼	96.48%
4	82	RTT Admitted - 95th Percentile	23	18.0	▼	
4	83	RTT Non-Admitted - 95th Percentile	18.3	14.4	▲	
4	84	RTT Incomplete - 95th Percentile	28	25.6	▲	
	85	Number waiting on an incomplete RTT pathway	tba	5948	▲	
2	86	RTT Admitted - Median	11.1	6.3	▲	
2	87	RTT Non-Admitted - Median	6.6	4.9	▲	
2	88	RTT Incomplete - Median	7.2	11.3	▲	
4	89	RTT admitted - 90% in 18 weeks	90%	95.1	▲	
4	90	RTT non-admitted - 95% in 18 weeks	95%	99.1	▼	

* Ambulatory Care data is quarterly. Previous complete quarter's figures will be reported in the monthly column
The YTD position is the actual YTD figure up to the current reporting month

Barking, Havering and Redbridge University Hospitals NHS Trust

Trust Performance Dashboard - September 2011

DoH Performance Framework Quarter 4
Standards and Vital Signs
User Experience
Finance
Registration

Financial Performance

Wgt	No	Indicator	Target 11-12	Actual Mth	Mnth Move	YTD Status
4	B1	Initial Planning	3%			-10.30%
4	B2	YtoD - operating performance	3%			-8.00%
4	B3	YtoD - EBITDA	5%			-3.00%
4	B4	Forecast Op Performance	3%			9.90%
4	B5	Forecast EBITDA	5%			0.00%
4	B6	Forecast change surplus/deficit outturn	5%			0.10%
4	B7	Underlying financial position %	0%			-9.50%
	B8	EBITDA Margin %	5%			0.00%
4	B9	BPPC Value%	95%			60.60%
4	C1	BPPV Volume %	95%			44.20%
4	C2	Current Ratio	100%			43.60%
4	C3	Debtor Days	30			21
4	C4	Credit Days	30			68
4	C5	Control Total	99.5%			120.80%
4	C6	Performance against CIP	100%			55.90%
4	C7	Income variance against plan	100%			104.30%
		Activity against Actual Performance				
4	E1	Outpatients - Activity	100.00%	96.8%	▼	107.0%
4	E2	Outpatients - Financial	100.00%	92.9%	▼	105.0%
4	E3	A&E - Activity	100.00%	142.4%	▲	126.0%
4	E4	A&E - Financial	100.00%	133.3%	▲	119.0%
4	E5	Day Cases - Activity	100.00%	94.6%	▼	110.0%
4	E6	Day Cases - Financial	100.00%	116.7%	▼	143.0%
4	E7	Inpatient - Elective Activity	100.00%	88.7%	▼	98.0%
4	E8	Inpatient - Elective Financial	100.00%	76.5%	▼	95.0%
4	E9	Inpatient - Non Elective Activity	100.00%	120.6%	▲	119.0%
4	F1	Inpatient - Non Elective Financial	100.00%	104.4%	▼	113.0%

Workforce Performance

Wgt	No	Indicator	Target 11-12	Actual Mth	Mnt Move	YTD Status*
2	A1	Staff Turnover	12%	12.4%	▲	10.7%
2	A2	Sickness Absence	3.60%	4.8%	▼	4.5%
4	A4	Appraisals (12 mth rolling)	100%			76.0%
4	A5	Basic Life Support Training (12 mth rolling)	100%			69.0%

*YTD status - annualised

Performance Report
September 2011
Performance Indicators - Exception Report

1. Introduction

This year's national performance measures have not been separated out from the Trust's local performance measures as in previous years. In 2011/12 the dashboard displays four domains; Quality and Strategy, Operational Performance, Financial Performance and Workforce Performance. The performance of each of these domains contributes to the overall Trust RAG rating however when the Finance domain is rated 'red' the Trust's rating will automatically be considered 'red'.

This report provides the Board with an explanation for those performance measures which failed to meet the agreed target. Commentaries are provided by Senior Managers for those quality or operational indicators which did not meet either the Trust's monthly or year to date (YTD) performance thresholds. There is no trust target for Serious Untoward Incidents therefore a performance statement will be included in this report each month in the quality and strategy section of the report. Finance and Human Resources performance are subject to separate reports to the Trust Board, since June 2011 where either the staff appraisal or basic life support training did not achieve the performance target a commentary has been included in the exception report.

2. Performance Indicators

The following Trust quality and strategy and operational year to date (YTD) performance measure were met; clostridium difficile, mortality, stroke, elective admissions on day of surgery, % daycase rate, DNA follow-ups, non-elective length of stay, cancer YTD targets, cervical screening, KGH – three of the five new A&E standards and Queens – two of the five new A&E standards.

3. Quality and Safety Performance Indicators

For 2011/12 the focus is on those areas where performance measures, either monthly or YTD, have not been achieved.

MEASURE	MITIGATING ACTIONS
MRSA YTD Performance – 4 cases Target in reporting period– 3 cases	The occurrence of an MRSA bacteraemia in a surgical patient takes the Trust YTD total to 4. A root cause analysis (RCA) is being undertaken and the action plan is awaited. Although the Trust has not exceeded the annual target, this target must still be seen as fragile, as historically we have tended to see more cases in the winter months. Clostridium difficile continues within acceptable limits. The infection prevention and control team

MEASURE	MITIGATING ACTIONS
	continue to review each case and highlight non-conformity with policy with the relevant teams. Failure to isolate patients within 2 hours of onset continues to be the main problem identified, especially at times of high bed pressures from emergency admissions. There is a clear difference between King George and Queens with only 15% of cases so far this year at King George. The Trust may be seeing the start of the winter Norovirus season. After a quiet summer, we have had 2 wards closed in the last 2 weeks at Queens due to outbreaks of diarrhoea and vomiting. The first ward reopened after 5 days, no definitive cause was found, and investigations on the latest outbreak are still in process
Venous Thromboembolism (VTE) Risk Assessment YTD Performance – 85.94% Target – 90%	The improvement in the audit results has been maintained during September. This has been due mainly to the continued ward visits by two haematology teams. The Service has also been meeting to discuss the PAS upgrade to version 21.1. It has been determined that the uploading of the risk assessment data onto PAS will be at ward level and ward staff training is expected soon to be implemented
Diagnostic Breaches YTD Performance – 149 Target - 0	There have been 27 breaches in month, of these breaches 23 were within Radiology. As demonstrated last month, changes within the Paediatric service led to a number of MRI breaches due to availability of Paediatric beds and anaesthetists. The backlog of these paediatric cases have been cleared during September and plans are now in place to ensure that no further breaches occur. This will be regularly reviewed to ensure that there are no changes to referral patterns or capacity. The final number of breaches may change once validation is completed.
Single Sex Breaches YTD Performance – 113 Target – 0	There were 8 single sex breaches for the month of September. These occurred within the Coronary Care Unit (2) and High Dependency Unit (6) at Queens and were due to delays in the transfer out of patients who had been 'stepped down' to general care. There were constraints on the availability of suitable beds for step down due to patient flow delays. However, it should be noted that there has been a marked improvement in the second quarter performance when compared to the first quarter of 2011-12. The reasons for this were highlighted in the last Board report and the Deputy Director of Nursing continues to monitor the step down process through regular reporting.
Serious Incidents (SI)	This month the number of reported SI's reduced from 27 to 22. These are split between Women & Children Division (8) and pressure ulcer reports (11). There has been one 'never' event reported in this time period in interventional radiology. The outcome for the patient was satisfactory. There has been an external assessor appointed to carry out the investigation and changes to processes occurred immediately with further action being taken following the' round table'.
Elective and Non-elective Re-admissions <30 days	Elective and non-elective readmissions <30 days for 2011-12 is now reported on the Board Report with exclusions applied. Elective readmissions for July (2.97%) reported in the July Board Report

MEASURE	MITIGATING ACTIONS
(Note: Re-admissions rates are reported one month in arrears) Elective YTD Performance– 2.94% Elective Target – 2.21% Emergency YTD Performance –13.08% Emergency Target – 9.38%	has improved this month to 2.94%. Non-elective readmissions for July have slightly decreased from 13.21% to 13.01% for this month.. The YTD performance for elective readmissions has improved by 0.05% and the emergency performance has decreased by 0.02% The Readmissions Group has recognised the potential breadth of this project and a recent readmissions summit within the Medicine & Emergency Division has put in place four work streams which are: 1. Patient Redirection 2. Patient Information 3. Follow Through on Discharge These will be monitored by the Project Management Office (PMO) but will also be closely linked to the CIP work stream to ensure financial as well as operational delivery. There are gains to be had in preventing elective patients readmitting as non-elective (NEL) readmissions and therefore the focus of the Group is across Divisions. One of the workstreams will focus on establishing 'hot' clinics for patients that require an urgent outpatient attendance thus preventing an admission and also reviewing which patients could appropriately be managed in a planned elective pathway. Hot clinics should achieve a reduction in readmissions in addition to attracting an outpatient tariff.
Delayed Transfers of Care (DTOC) YTD Performance –4.07% Target – 3.50%	The month of September has seen a slight increase in DTOCs to 4.38 % with a YTD figure of 4.07% There remains an issue with obtaining general rehabilitation and stroke rehabilitation beds, specifically for patients that need more intense levels of nursing care where they may require hoist or slow stream rehabilitation, particularly for Havering residents. Work continues on the Jonah discharge planning tool with our social care partners. Training in the application is expected to be completed and equipment provided by the end of the month. Work streams on readmission avoidance have identified care pathway processes which require further interrogation to improve discharge process and reduce length of stay.
Number of Complaints and Complaints Responded to Within 30 days *(Note: Complaints responded to are reported two months in arrears)* Complaint Numbers YTD Performance – 495	There were 76 new complaints received by the Trust in September, a reduction from the July & August peaks of ninety one each month. The Women & Children Division maintained their August reduction in new complaints, receiving 18 during the month. Complaints about care in the Medicine Division reduced significantly from 38 in August to 14 in September. Conversely, the surgical Division received an increased number, up to 35 from 27 in August. The timeliness of responses to complaints (within 30 working days of receipt) continues to be poor.

MEASURE	MITIGATING ACTIONS
Target – 150 Complaint responses YTD Performance – 23% Target – 80%	The completed position for July was 21%, a reduction of 8% on the June performance. At the end of September, 11% of the complaints received in August had been replied on time. The overall Trust performance masks significant variation between the response rates of the Divisions: In July, CDT achieved 43%; Medicine achieved 21%; Surgery achieved 38% and Women & Children achieved 3%. Initial monitoring of the age profile of open complaints has begun. At the end of September the Trust had 262 initial complaints open under investigation. Of those, 163 (62%) had been with the Trust for more than 30 days, and 70 (27%) were over three months old, with the longest outstanding received in February 2011. Progress with addressing this backlog will continue to be reported in future reports
Patient Experience YTD Performance – Q1 -63% Q2 –68% Q3 –72% Q4 –68% Target for all questions – 80%	There has been a small but significant increase in the use of the patient real time feedback system during September mainly via the hospital kiosks and online. The use of the hand held devices has been limited, with 24 having been rolled out to clinical areas at Queens's Hospital to date. The process of reconfiguring the hand held devices for use at King Georges is proving problematic but this issue has been expedited to the Director of Nursing and the Quality and Strategy Board. The patient survey communication campaign detailed in the last Board report is currently being undertaken. As in previous months results should be viewed with caution due to the low response rate.

4. Operational Performance Indicators

For 2011/12 the focus is on those areas where performance measures, either monthly or YTD, have not been achieved.

MEASURE	MITIGATING ACTIONS
Outpatient First to Follow-up Ratio and DNA Rate FFU Ratio YTD Performance – 2.25 Target –2.13	There was deterioration in the first to follow-up ratio from 2.23 in August to 2.35 in September. There was a small improvement in the DNA rates for both first and follow-up appointments in September but these are still significantly adrift of the target rates. New appointments rates decreased from 10.96% in August to 10.66% in September and follow-ups from 10.62% to 10.59%. The revised clinic cancellation policy has come into effect but it is anticipated that the improvement from this will start to be felt towards the end of October and into November.

DNA First YTD Performance – 10.30% Target – 9.70%	There has been a delay in the implementation of the partial booking service as other strands of the out-patient work-stream are completed. It is still planned for pilots to take place in Rheumatology and Orthopaedics, and an action plan is being finalised for all specialities to be partially booking by March 2012. It is expected that DNA's will reduce as appointments will not be booked so far in advance that patients forget, or the appointment is no longer required as the patient's condition has improved. Further discussions have taken place to investigate the possibility of re-instating the text messaging service and a plan to deal with two-way messaging is being prepared in anticipation of its introduction. Outpatient clinics are currently being re-profiled with the aim of improving the outpatient first to follow up ratio. The outpatient team will have completed the agreed changes by mid-October. It is anticipated that there will be a significant improvement in first to follow-up ratios by December once these changes are implemented. The delay in seeing the effects of the re-profiling changes is due to the average polling ranges of many specialties, with patients waiting on average 9 weeks for a first appointment. Work to reduce this waiting time for a first appointment is also underway, which should again have positive impacts on both the DNA and first to follow-up ratios.
Length of Stay (LoS) Elective LOS YTD Performance – 3.81 Target – 3.6 Elective LOS – excluding 0 days YTD Performance – 4.31 Target – 4.0 Non Elective LOS – excluding 0 days YTD Performance – 6.37 Target – 5.8	In general the overall non elective length of stay (NEL LoS) for September has remained similar to August at 4.66 days. There has been a decrease in elective LoS from 4.20 days to 3.74 days. Medicine NEL LoS decreased from 6.04 days in August to 5.78 days which is back to the continued reduction that we had seen since June 2011. Discharge Jonah has been rolled out to the remaining wards and also into Maternity. The actions around Discharge Jonah are expected to improve LoS still further. The Medicine and Surgery Divisions are now working together to understand the implications from the reduction in LoS to enable re-alignment of the bed capacity. This reduction in length of stay will prevent the use of additional contingency beds over the winter. The roll out of the ambulatory care project is now underway and is being clinically led by Dr. Aklak Choudhury, supported by the BHRUT Project and Programme Management Office (PMO). The first five pathways will be implemented in October. The delay has been due to a number of reasons including space for Ambulatory Care, which is now resolved, and the approval of the pathways through the relevant Trust committees, which again is now resolved. Dr. Deaner has been leading on 5 day Consultant ward rounds with the Division. However having met with the Consultant body it was thought that to implement this change at this stage with an acute take on both hospital sites would require significant investment. Therefore there is now a revised plan

	which is reviewing assessment facilities to enable all patients to have a consultant review within 12 hours of admission. The full details of this proposal will be reviewed and monitored through the PMO.
% Women Seen by Midwife within 12 Weeks and 6 Days YTD Performance – 78% Target – 90%	The target is for 90% of women to be seen within 12 weeks and 6 days by a midwife. This month the Trust achieved 75%. The main reasons for not meeting this target is the delay in the patient journey where the local women tend to attend the GP clinics later in their pregnancy and in many cases a delay from GPs in making the referral. The issue has been discussed with the Commissioners as it is a joint national target and will again be discussed with the GP commissioning Clinical Forum. Once a referral is made for a women in this category the trust midwifery team is able to give an appointment very quickly, on average 90% of patients are given an appointment within the required timeframe. There is an ongoing risk assessment as part of the antenatal booking process to ensure that antenatal clinics are not used for unnecessary appointments. This ensures slots are available for early booking with midwives.
Freedom of Information (FOI) – requests responded to within 20 working days YTD Performance – 83.73% Target -100%	Despite receiving a similar number of requests in both July 2011 (33) and August 2011 (32), the overall response rate has declined to 75.00% from last month's 90.91%. This is as a result of a continued low response rate for the Human Resources Department and the Medical Division, and a significant reduction in the Women and Children Division. As the Medical Division's response required assistance from an alternative department, it has highlighted the need to ensure requests are transferred to alternative departments in a timely manner. Having met with the Human Resources FOI co-ordinator, it was identified that other high priority work had delayed the processing of requests within this area. With this work now concluded the Department is committed to resolving the outstanding requests, and is on target for an improved performance rate for September 2011. The new Divisional Director of Women and Children has undertaken to resolve the outstanding FOI requests, and to date there has been an improved performance rate for requests received in September 2011.
Cancer Performance 62 urgent treatment all cancers Performance – 82.3% Target - 85% 31 day subsequent treatment – radiotherapy Performance – 93.3%	The year to date performance for all cancer measures were met in September. However this month's 62-day 'referral from GP' and 'all cancers' performance underachieved as a result of a lower than usual number of treatments being recorded; due to the number of breaches recorded this has brought the in-month performance down. Since the report was run two of the breaches have been removed, at least three more treatments have been recorded and there are potentially four more treatments once histologies have been received.

Target -94% 62 day referral from GP Performance – 83.9% Target - 86%	There has been a higher than usual number of breaches in September and detailed analysis is currently underway to understand why and also to understand why the number of treatments recorded in September is considerably less than in previous months. The 31-day subsequent radiotherapy treatments measure is under performing as there are still a number of treatments to add to the system. The current staffing levels only allows retrospective data entry; with the appointment of a replacement member of staff within radiotherapy this data collection will become prospective and will give a better weekly update on the Trust's actual performance.
Accident and Emergency Targets - See table in mitigating actions column	Against a target of 95% for Type 1 attendance (the target on which we are currently measured) the Trust achieved an overall figure of 92.95%, with King George Hospital (KGH) performing at 97.22% and Queen's Hospital (QH) at 90.62% for September 2011. QH performed below the standard which was due to two key areas: • poor flow • lack of permanent ED medical staff Despite the overall poor performance the improved ED processes continue within the department but are frequently put at risk due to the skill mix of medical staff within the department. There is now a revised recruitment strategy in place that will go to the Workforce Committee An extension of the RATing facilities and operational hours is on the agenda for TEC alongside evidence of the improvement in time to initial assessment and ambulance handover when this process is in place. The next step is to improve the time to treatment target within 60 minutes and this will improve with the embedding of the specialist response times to the ED. This is a key workstream that was agreed at the recent Senior Leaders event and is supported by the Medical Director. Although the QH performance dropped below 95% for Type 1 attenders, there is still an improvement compared to September 2010 when QH was performing at 84.33%. It should be noted that KGH consistently performs above the 95% Type 1 standard. The performance against the new A&E quality indicators for the month of September are set out in the table below:

Measure	Target	KGH	QH
Unplanned re-attendance – reattendances within 7 days	5%	6.5% (6.5%)	6.8% (7.8%)
Left Department Without Being Seen	5%	3.30% (2.7%)	4.5% (4.1%)
Total Time in Department - 95th Percentile	240mins	240mins (239mins)	360mins (240mins)
Time to initial assessment - 95th Percentile	15mins	12mins (1min)	49mins (38 mins)
Time to Treatment – Median	60mins	1hr 20mins (1hr 5mins)	1hr 17mins (1hr 9mins)

Figures in brackets are the August 2011 figures

The 95% Type 1 access target links closely to the Quality Indicators performance. KGH is consistently green for 3 of the 5 standards and QH in September failed to meet two of the indicators. The expectation from NHS London is that we meet the 95% Type 1 standard and 2 of the Quality Indicators one of which must be a 'time' indicator. The actions described in this report for medical recruitment and flow to improve the Type 1 standard will also improve these indicators. In order to get the further gains on the KGH site i.e. RATing, recording and triage processes are being implemented there.

Achievement against the improvement actions is monitored by a dashboard developed for the plan, with reports against progress from the SRO of each project, reviewed at the fortnightly Emergency Care Programme Board. Decisions made on next steps and/or remedial action where appropriate.

Referral to Treatment

RTT – incomplete median
Monthly Performance - 11.3 weeks
Target – 7.2 weeks

The Trust continues to achieve each of the referral to treatment targets with the exception of the incomplete median.

The performance of this measure will show some improvement following validation. Data analysis is being undertaken to explore the possibility that further incomplete pathways could be included in the monthly data returns. This could have a positive impact on the median target

5. Human Resources Performance Indicators

For 2011/12 commentaries will be provided where either the appraisal or basic life support training indicators fail to reach their monthly target. The Quality Care Commission (CQC) last year placed specific conditions on the Trust. These two HR indicators, as well as a number of others, were used by the CQC to monitor Trust performance. CQC conditions were lifted at the end of last financial year.

MEASURE	MITIGATING ACTIONS
Appraisal Training YTD Performance – 76.72% Target – 100%	Despite improving slightly in August the overall appraisal rate for the Trust has reduced this month to 76.03%. Line managers continue to be reminded of their appraisal responsibilities and the HR Advisors continue to table the rates at individual Divisional Top Team's. Further communications will be issued by HR and actions plans have been requested from Divisions in order to attempt to redeem the situation and prevent further slippage as we go into the winter season. Appraisals for the In House Bank Flexible Workers are underway using the new appraisal cards issued in August. Medicine has shown a significant performance improvement in month, increasing their appraisal compliance rate by 9.92% to 82.17%. Conversely, and despite having an action plan to redeem the situation in August, the Emergency Division shows a further reduction with their rate decreasing by 5.99% to 66.42%. They now have 149 staff requiring an appraisal. The other Divisions have all reduced their rates very slightly this month
Basic Life Support Training YTD Performance – 69.04% Target – 100%	The YTD performance stands this month at 69.04% a reduction from 72.62% the previous month. This figure reflects only those who have completed resuscitation training during the stated period and does not take into account those who have booked to attend training before the year end. Uptake on advertised resuscitation training sessions has been very good and attendance at sessions remains steady. Dedicated training sessions have been run for several specialities with further dates planned in the coming weeks. An Advanced Paediatric Life Support (APLS) course is being run at King George Hospital, in conjunction with the Accident & Emergency Department at Queens during November 2011.

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Emergency Care Report on August 2011 performance	**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 ▪ Informs the board of the current performance against the new emergency care standards ▪ Provides an update on the work included in the Emergency Care Programme and actions taken within the last month to improve performance	□ **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 improved performance resulting from significant progress against the Emergency Care Programme.	☑ **NATIONAL TARGET** □ **CNST** □ **CQC REGISTRATION** □ **HEALTH & SAFETY** □ **ASSURANCE FRAMEWORK** □ **CQUIN/TARGET FROM COMMISSIONERS** ☑ **CORPORATE OBJECTIVE** ……..……..…... □ **OTHER** …….. (please specify)
	AUTHOR: Shelagh Smith, Divisional Manager, Medicine & Emergency **PRESENTER:** Shelagh Smith, Divisional Manager, Medicine & Emergency
	DATE: 19th October 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)** _____	

Barking, Havering and Redbridge University Hospitals NHS Trust

Barking and Havering University Hospitals NHS Trust

Emergency Care Programme

Trust Executive Committee Report on September 2011 Progress and Performance

October 2011

1.0 Introduction

This report has been produced for the information of the Trust Executive Committee. Its purpose is to reassure the Trust Executives of progress against project plans and performance indicators, and provide the projects under the Emergency Care Programme banner with a point of escalation for key risks and issues.

2.0 Key messages to TEC

There has been significant activity during the period defining the projects, identifying owners and setting up the Governance arrangements in order to facilitate the projects being delivered in a controlled environment. This approach provides reassurance to the Trust Executives that progress is being made towards achieving the end benefits of the initiatives.

The performance against the indicators in sections 3 to 5 below provides a clear indication of the progress made during the month of August.

3.0 Performance against First Attendance

3.1 Performance in September 2011

Against a target of 95% for Type 1 attendance (the target on which we are currently measured) the Trust achieved an overall figure of 92.95%, with King George Hospital (KGH) performing at 97.22% and Queen's Hospital (QH) at 90.62% for September 2011. QH performed below the standard which was due to two key areas:

- poor flow
- lack of permanent ED medical staff

3.2 Activity impacting performance

Despite the overall poor performance the improved ED processes continue within the department but are frequently put at risk due to the skill mix of medical staff within the department – usually overnight where it is difficult to get consistent Locum staff. Following a 'line by line' review of every medical posts within the ED there is now a revised strategy for recruitment. This will be presented at the workforce committee and has been agreed by the department, HR and Finance. It demonstrates an action to recruit to each post with a timescale for delivery for each post.

An extension of the RATing facilities and operational hours is on the agenda for TEC alongside evidence of the improvement in time to initial assessment and ambulance handover when this process is in place.

The next step is to improve the time to treatment target within 60 minutes and this will improve with the embedding of the specialist response times to the ED. This is a key workstream that was agreed at the recent Senior Leaders event and is supported by the Medical Director.

Although the QH performance dropped below 95% for Type 1 attenders, there is still an improvement compared to September 2010 when QH was performing at 84.33%.

It should be noted that KGH consistently performs above the 95% Type 1 standard.

3.3 Reduction in LoS

In general the overall non elective length of stay (NEL LoS) for September has remained similar to August at 4.66 days. There has been a decrease in elective LoS from 4.21 days to 3.74 days. Medicine NEL LoS decreased from 6.02 days in August to 5.78 days which is back to the continued reduction that we had seen since June 2011. Actions to reduce LoS are described under section 5 of this report.

3.4 DTOC

The table below demonstrates the Breakdown of external/internal responsibility by Borough

DAILY ALLOCATION OF 'Next Action' RESPONSIBILITY
(Based on latest update in Master Delays File at close of play

		1% Target	Thu 13-Oct	Fri 14-Oct	Mon 17-Oct	Tue 18-Oct	Wed 19-Oct
Havering	SS	3	9	5	2	4	3
	Trust	0	9	5	8	6	5
	PCT	3	8	10	9	11	9
	Shared	0	4	8	6	6	5
B&D	SS	2	5	5	1	2	1
	Trust	0	4	2	5	3	3
	PCT	2	2	5	4	8	7
	Shared	0	1	2	4	4	4
Redbridge	SS	1	3	1	2	3	3
	Trust	0	1	2	2	0	0
	PCT	2	2	4	3	8	9
	Shared	0	2	1	1	2	2
Essex	SS	1	2	1	1	1	1
	Trust	0	0	1	1	1	1
	PCT	2	2	1	0	0	0
	Shared	0	0	0	0	0	0
Other	SS	0	1	0	0	0	1
	Trust	0	0	1	2	2	2
	PCT	0	1	1	1	1	1
	Shared	0	0	0	0	0	0
			56	**55**	**52**	**62**	**57**
	%		**4.67%**	**4.58%**	**4.33%**	**5.17%**	**4.75%**
					Rolling 5 day average		**4.70%**

4.0 Performance against A&E Quality Indicators

4.1 Performance in September 2011

The performance against the new A&E quality indicators for the month of September are set out in the table below:

Measure	*Target*	*KGH*	*QH*
Unplanned re-attendance (re-attendances within 7 days)	***5%***	***6.5% (6.5%)***	***6.8% (7.8%)***
Left Department Without Being Seen	***5%***	***3.3% (2.7%)***	***4.5% (4.1%)***
Total Time in Department	***240mins***	***240mins***	***360mins***

(95th Percentile)		*(239mins)*	*(240mins)*
Time to initial assessment (95th Percentile)	*15mins*	*12min (1mins)*	*49mins (38mins)*
Time to Treatment (Median)	*60mins*	*1hr 20mins (1hr 5mins*	*1hr 17mins (1hr 9mins*

Figures in brackets are the August 2011 figures

4.2 Delivering against the A&E Quality Indicators

The above information on the indicators with explanation is now published monthly on the BHRUT website.

The 95% Type 1 access target links closely to the Quality Indicators performance. KGH is consistently green for 3 of the 5 standards and QH in September failed to meet two of the indicators. The expectation from NHS London is that we meet the 95% Type 1 standard and 2 of the Quality Indicators one of which must be a 'time' indicator. The actions described in this report for medical recruitment and flow to improve the Type 1 standard will also improve these indicators. In order to get the further gains on the KGH site i.e. RATing, recording and triage processes are being implemented there.

Achievement against the improvement actions is monitored by a dashboard developed for the plan, with reports against progress from the SRO of each project, reviewed at the fortnightly Emergency Care Programme Board. Decisions made on next steps and/or remedial action where appropriate.

4.3 Ambulance Handover

There are four KPIs which we are now monitored against:

KP 1: Patient handover should be achieved within 15 minutes from arrival, 85% of the time.
KPI 2: Patient Handover should be achieved within 30mins from arrival 95% of the time.
KPI 3: Any patient handover which takes 60 minutes or more must be reported and investigated by the hospital trust as a Serious Incident (SI).
KPI 4: All Acute trusts to ensure patient handover times are recorded via the "Patient Handover Button" on the Hospital-Based Alert and Handover (web-based) System for 90% of all hospital turnarounds in any calendar month during2011/12.

The table below shows BHRUT performance compared to Whipps Cross and London overall.

	SEPTEMBER 2011 PERFORMANCE AS REPORTED USING HAS DATA			
	KPI 1	KPI 2	KPI 4	
Hospital	% within 15 mins	% within 30 mins	HAS Data Completeness	No. HAS Records
King George`s Ilford	79.0%	98.6%	81.4%	281
Queens Hospital, Romford	57.4%	95.5%	83.2%	605
Whipps Cross	89.8%	99.6%	85.8%	482
LONDON˚	79.7%	97.9%	67.8%	

BHRUT performance

KPI 1 - BHRUT have submitted a trajectory to ONEL to meet KPI 1 by the end of December 2011 which includes extension of the RATing process
KPI 2 - BHRUT is now meeting this target
KPI 3 - Queens had 4 black ambulance breaches which were reported and investigated as SIs (one of the lowest in London)
KPI 4 - ONEL is conducting an audit of BHRUT data compared to LAS data.

5.0 Bed availability

5.1 Discharge Jonah

Discharge Jonah has been rolled out to the remaining wards and also into Maternity. The actions around Discharge Jonah are expected to improve LoS still further, however there now needs to be accountability and a performance framework around its use. This will involve ownership of the process by ward teams, ensuring data is robust and accurate and that there are clear actions taken based on the information available in Jonah, There is also focus being given to the bed managers use of Jonah to manage flow on an operational basis. This extends the ability for more disciplines to use the information to plan their work according to PDDs.

Divisional Managers are expected to ensure that all of their areas are using Jonah fully and that staff members are held accountable for ensuring that it is being used to effectively manage a timely, safe discharge for the patients.

5.2 Ambulatory Care

The roll out of the Ambulatory Care project, clinically led by Dr. Aklak Choudhury and supported by the BHRUT Project and Programme Management Office (PMO), has been significantly delayed mainly due to two main reasons:

- space availability for the Ambulatory Care service (now resolved as a space has been confirmed with logistic plans for the move to be presented to the Emergency Care Board by the next meeting on Thursday, 20 October);
- approval of the pathways and backup documentation through the relevant Trust committees (again now resolved as the first four pathways have been approved by the Drugs & Therapeutics Committee and Patient Information Group and we're awaiting feedback on approval through the EBPC via chairman's action).

The first four pathways (respiratory pathways: Pneumothorax, Pneumonia, Pulmonary Embolism, Pleural Effusion) will "going live" as soon as the move into the agreed Ambulatory Care space has been successfully effected.

5.3 "Improvement in Patient Flow project" (previously "5 day a week consultant ward rounds")

The proposed model of consultant of the week for the specialty wards has been revised following discussions with the Divisional Director. Due to a large specialty bed base and number of consultants the model was not feasible when compared to implementation in other organisations. This was compounded by the experience in other organisations where the scheme has been stopped. Whilst the model remains a positive stepping stone to 7 day working in line with recommendations from the recent intensive support team visit, the concentration of the project will now be on three main workstreams:

- consolidating the consultant cover over 7 days per week within the assessment area;
- elderly care input to A&E assessment; and
- consolidating the use of Jonah and daily board rounds on the specialty areas.

5.4 Readmissions

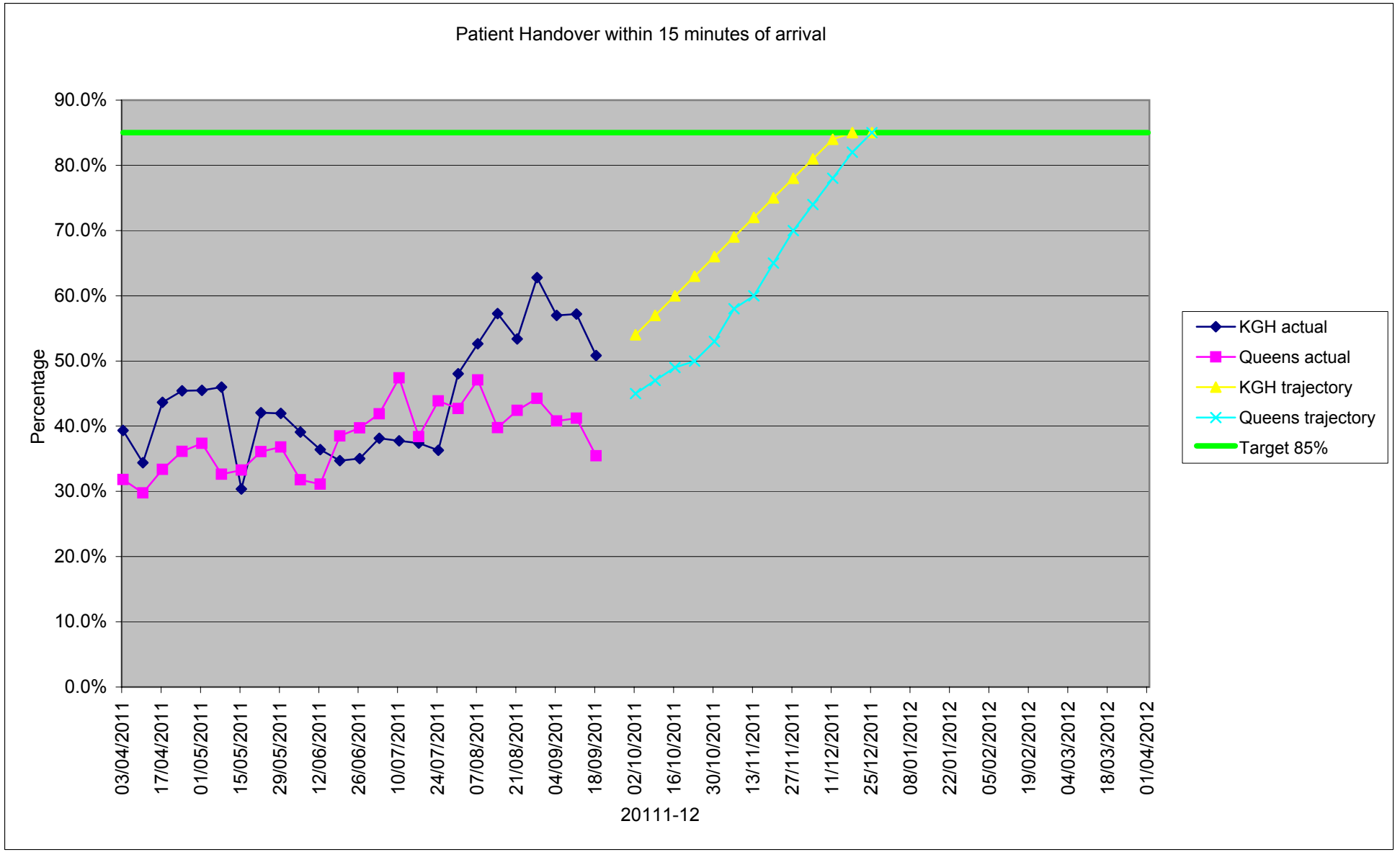
A successful Readmissions Summit was held on 5 October, with a total of 19 attendees. 4 work streams were identified for which robust action plans are being developed:

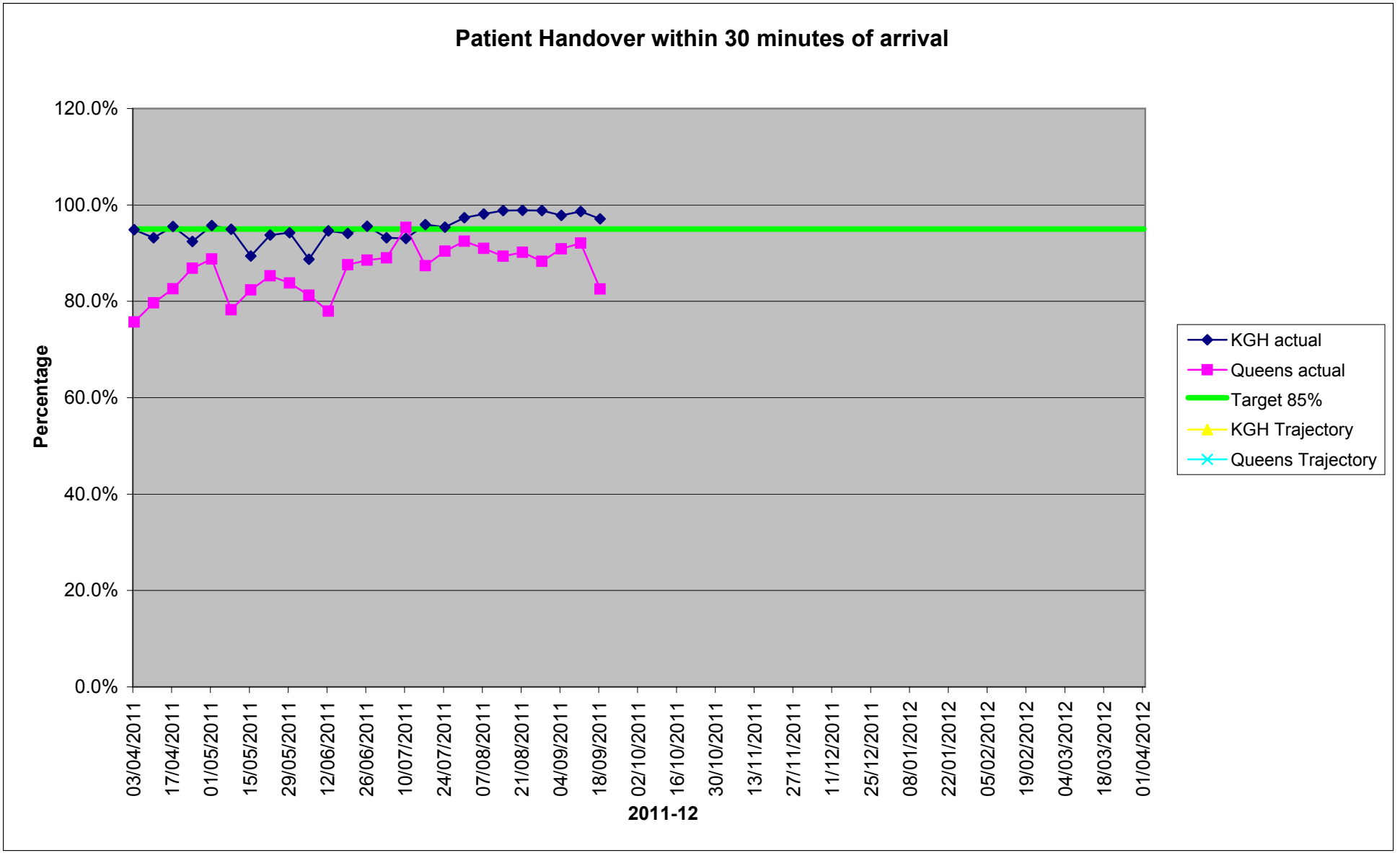
- Redirection of Patients;
- Patient Information;
- Follow-through on Discharge;
- Auditing, Monitoring and Review (which includes all initiatives / deliverables that do not necessarily fall into one of the other 3 work streams).

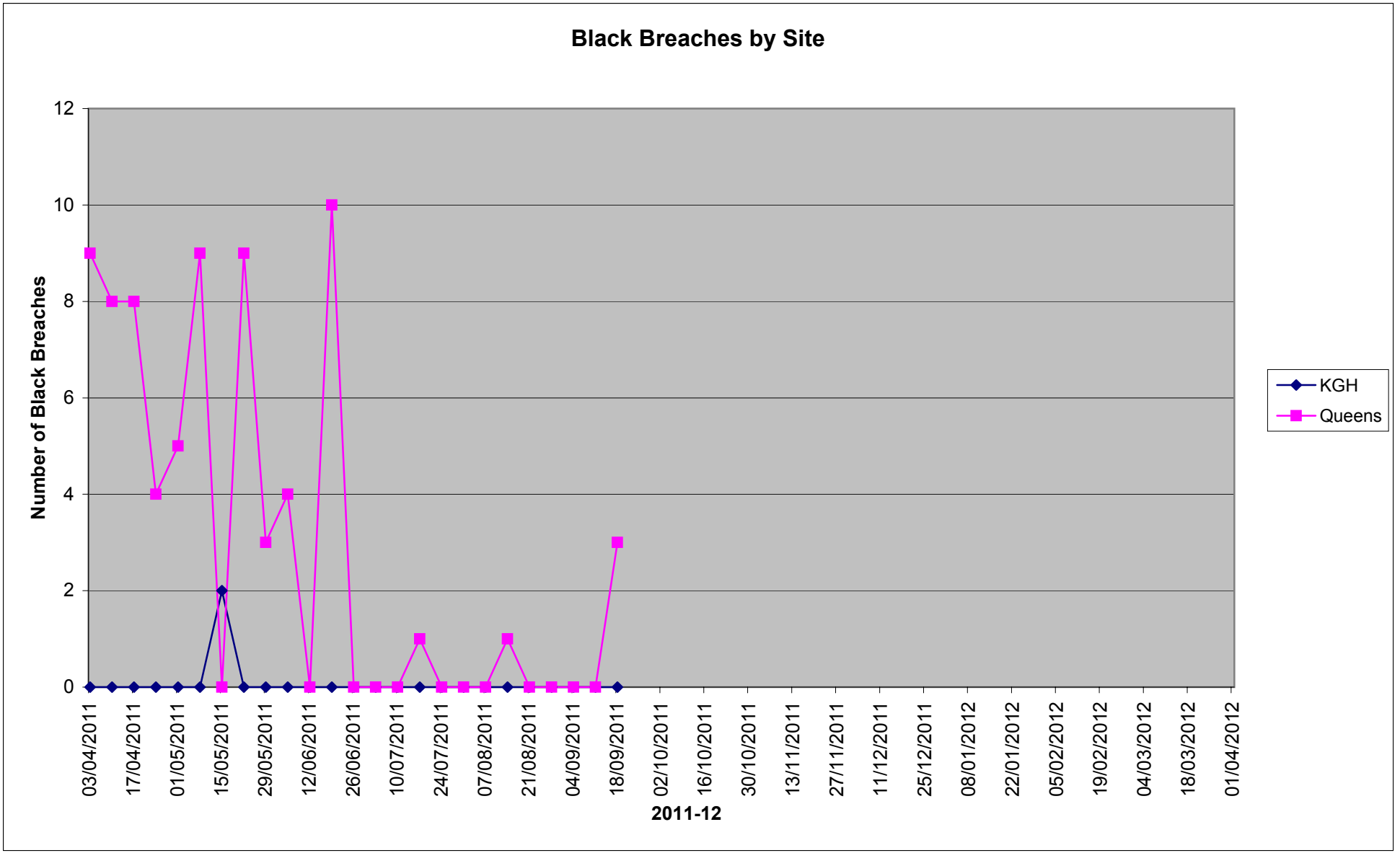
A two-pronged approach is necessary and is being followed to tackle the high readmissions rate:

- Retrospectively / reactively through the sharing of frequent flier data for the Integrated Case Management Projects across the boroughs; and
- Prospectively / proactively through the implementation of the action plans linked to the work streams identified at the readmissions summit.

Close ties are being forged between the Trust, Barking and Dagenham, and Redbridge with regard to Integrated Case Management of patients with long-term conditions and information sharing agreements are in the process of being developed.


Patient Handover within 15 minutes of arrival
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Percentage
03/04/2011
17/04/2011
01/05/2011
15/05/2011
29/05/2011
12/06/2011
26/06/2011
10/07/2011
24/07/2011
07/08/2011
21/08/2011
04/09/2011
18/09/2011
02/10/2011
16/10/2011
30/10/2011
13/11/2011
27/11/2011
11/12/2011
25/12/2011
08/01/2012
22/01/2012
05/02/2012
19/02/2012
04/03/2012
18/03/2012
01/04/2012
20111-12
KGH actual
Queens actual
KGH trajectory
Queens trajectory
Target 85%


Patient Handover within 30 minutes of arrival
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
Percentage
03/04/2011
17/04/2011
01/05/2011
15/05/2011
29/05/2011
12/06/2011
26/06/2011
10/07/2011
24/07/2011
07/08/2011
21/08/2011
04/09/2011
18/09/2011
02/10/2011
16/10/2011
30/10/2011
13/11/2011
27/11/2011
11/12/2011
25/12/2011
08/01/2012
22/01/2012
05/02/2012
19/02/2012
04/03/2012
18/03/2012
01/04/2012
2011-12
KGH actual
Queens actual
Target 85%
KGH Trajectory
Queens Trajectory


Black Breaches by Site
Number of Black Breaches
12
10
8
6
4
2
0
03/04/2011
17/04/2011
01/05/2011
15/05/2011
29/05/2011
12/06/2011
26/06/2011
10/07/2011
24/07/2011
07/08/2011
21/08/2011
04/09/2011
18/09/2011
02/10/2011
16/10/2011
30/10/2011
13/11/2011
27/11/2011
11/12/2011
25/12/2011
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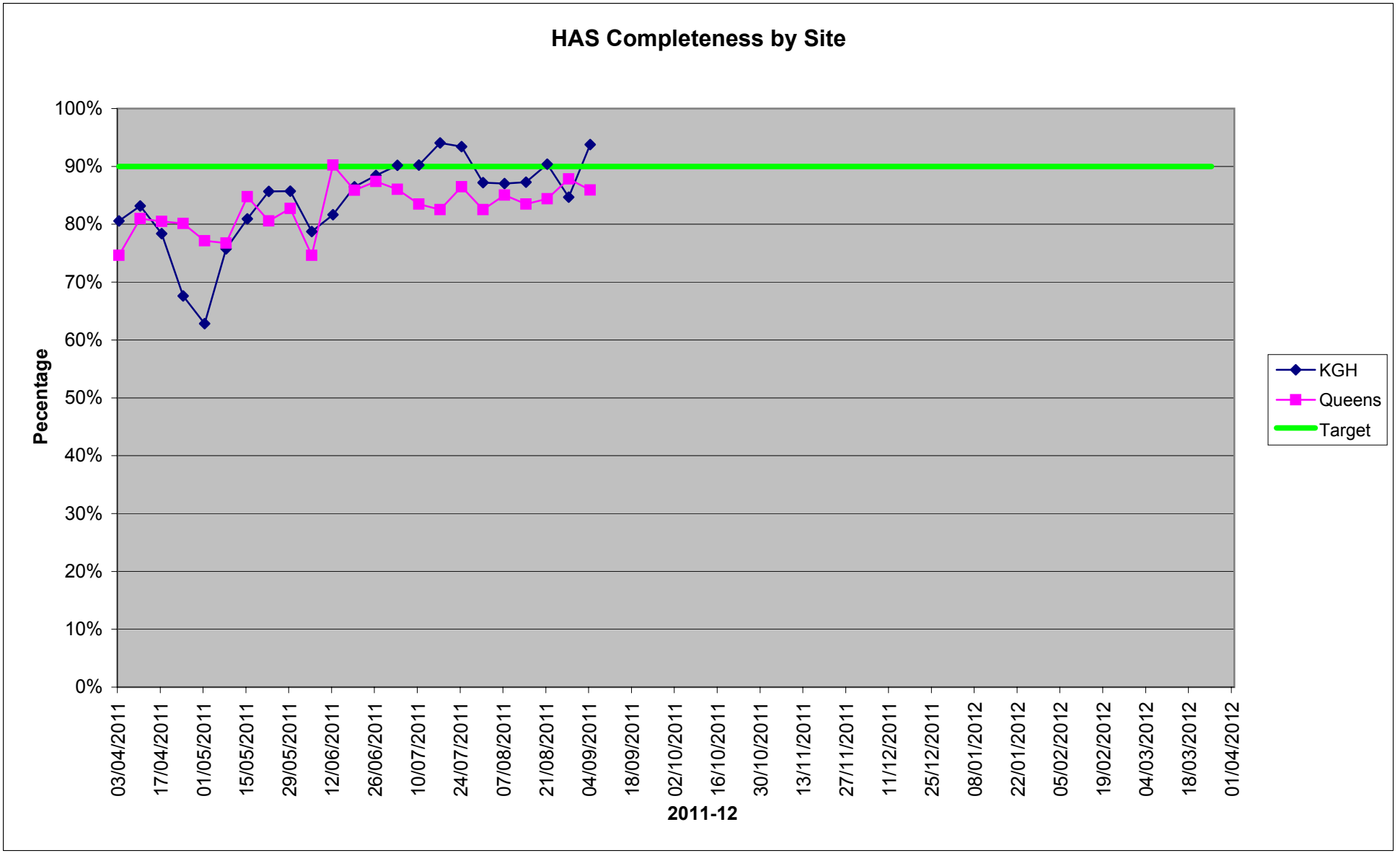
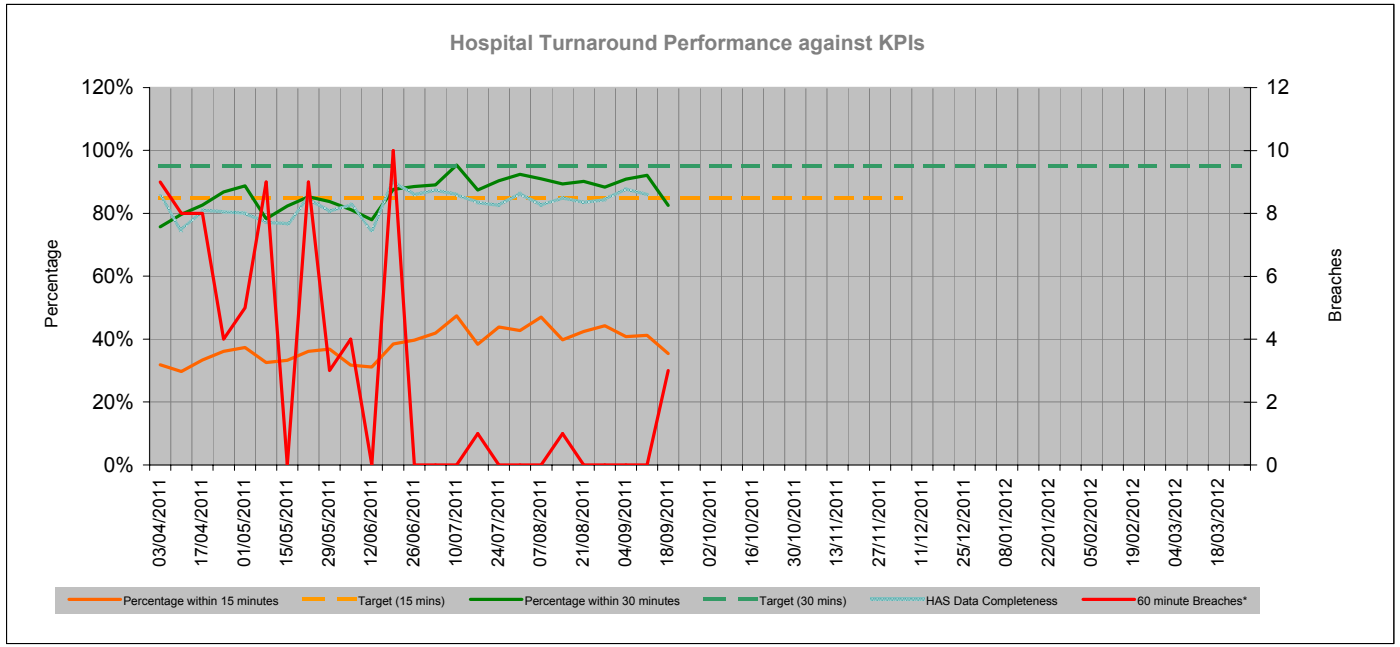
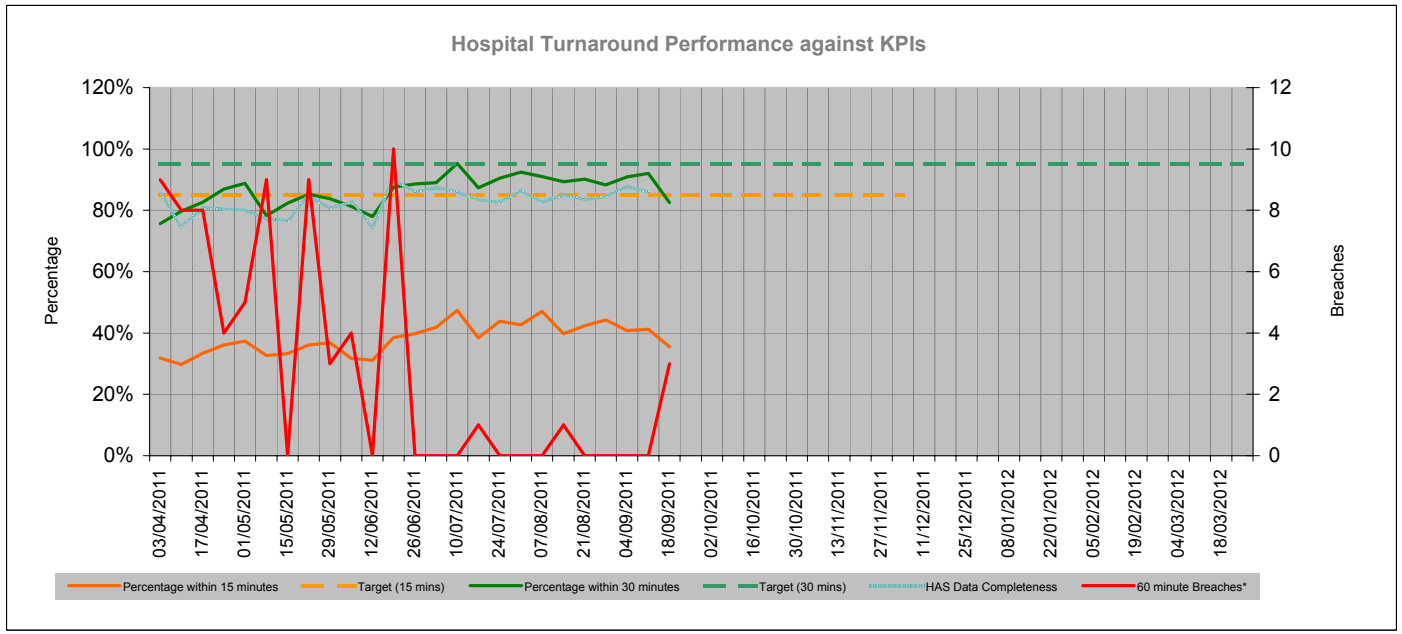
18/03/2012
01/04/2012
2011-12
KGH
Queens


HAS Completeness by Site
Pecentage
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
03/04/2011
17/04/2011
01/05/2011
15/05/2011
29/05/2011
12/06/2011
26/06/2011
10/07/2011
24/07/2011
07/08/2011
21/08/2011
04/09/2011
18/09/2011
02/10/2011
16/10/2011
30/10/2011
13/11/2011
27/11/2011
11/12/2011
25/12/2011
08/01/2012
22/01/2012
05/02/2012
19/02/2012
04/03/2012
18/03/2012
01/04/2012
2011-12
KGH
Queens
Target

KGH - GRAPHS FROM LAS



Queens - GRAPHS FROM LAS



Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
BHRUT Pressure Surge Plan 2011.12	**Trust Board**
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
The Pressure Surge Plan is to provide assurance to the Trust and external partners on its preparedness to take appropriate action when our services come under unusual pressure.	□ **PEQ**……..…… □ **STRATEGY**…….……. □ **FINANCE** ……..…… □ **AUDIT** ……..……..…. □ **CLINICAL GOVERNANCE** ……..……..……..…… □ **CHARITABLE FUNDS** ……..…….. ☑ **TRUST BOARD** □ **REMUNERATION** ……..……. □ **OTHER** ……..…… (please specify)
2. DECISION REQUIRED:	**CATEGORY:**
The Trust Board is to sign off the plan as it stands and note that the Trust has been required to submit this to ONEL for a risk assessment. It is currently 'red' for the following reasons: • lack of contingency capacity • previous poor performance during winter • recruitment issues for ED medical staff	□ **NATIONAL TARGET** □ **CNST** □ **CQC REGISTRATION** □ **HEALTH & SAFETY** ☑ **ASSURANCE FRAMEWORK** □ **CQUIN/TARGET FROM COMMISSIONERS** □ **CORPORATE OBJECTIVE** …….. □ **OTHER** …….. (please specify)
	AUTHOR: Shelagh Smith, Divisional Manager, Medicine & Emergency **PRESENTER:**
	DATE: 19th October 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)** _____	

BARKING, HAVERING & REDBRIDGE NHS UNIVERSITY TRUST

2011/2012 Pressure Surge Plan

Version 1

Barking, Havering and Redbridge University Hospitals NHS Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

THIS DOCUMENT IS VERSION 1	Approved By: Date:	Review Frequency: Annually First Review Date: January 2012
Responsible Officer: Director of Planning and Delivery	Applicable to all Clinical areas: Yes	

Glossary

Activity	Process or set of processes undertaken by an organisation (or on its behalf) that produces or supports one or more products or services NOTE Examples of such processes include accounts, call centre, IT, manufacture, distribution.
Business Continuity	Strategic and tactical capability of the organisation to plan for and respond to incidents and business disruptions in order to continue business operations at an acceptable pre-defined level
Business Continuity Plan (BCP)	Documented collection of procedures and information that is developed, compiled and maintained in readiness for use in an incident to enable an organisation to continue to deliver its critical activities at an acceptable pre-defined level
Disruption	Event, whether anticipated (e.g. a labour strike or hurricane) or unanticipated (e.g. a blackout or earthquake), which causes an unplanned, negative deviation from the expected delivery of products or services according to the organisation's objectives
Emergency Planning	Development and maintenance of agreed procedures to prevent, reduce, control, mitigate and take other actions in the event of a civil emergency
HDU	High Dependency Unit
Impact	Evaluated consequence of a particular outcome
ITU	Intensive Therapy Unit
Likelihood	Chance of something happening, whether defined, measured or estimated objectively or subjectively, or in terms of general descriptors (such as rare, unlikely, likely, almost certain), frequencies or mathematical probabilities NOTE 1 Likelihood can be expressed qualitatively or quantitatively. NOTE 2 The word "probability" can be used instead of "likelihood" in some non-English languages that have no direct equivalent. Because "probability" is often interpreted more formally in English as a mathematical term, "likelihood" is used throughout this Standard with the intention that it is given the same broad interpretation as "probability".
NICU	Neonatal Intensive Care Unit
Organisation	Group of people and facilities with an arrangement of responsibilities, authorities and relationships EXAMPLE Company, corporation, firm, enterprise, institution, charity, sole trader or association, or parts or combinations thereof.

	NOTE 1 The arrangement is generally orderly. NOTE 2 An organisation can be public or private. [BS EN ISO 9000:2005]
Pandemic Flu (H1N1)	H1N1 is an illness caused by a new influenza A virus which has seen sufficient cases world-wide that the World Health Organization declared the situation a pandemic on 11th June 2009.
PICU	Paediatric Intensive Care Unit
Recovery	Process of returning to "business as usual"
Risk	Something that might happen and its effect(s) on the achievement of objectives
Risk Assessment	Overall process of risk identification, analysis and evaluation
Risk Management	Structured development and application of management culture, policy, procedures and practices to the tasks of identifying, analysing, evaluating, and controlling responding to risk
Stakeholders	Those with a vested interest in an organisation's achievements NOTE This is a wide-ranging term that includes, but is not limited to, internal and "outsourced" employees, customers, suppliers, partners, employees, distributors, investors, insurers, shareholders, owners, government and regulators.
Trigger	An event/status which will instigate some sort of action.
Winter Resilience	The measures undertaken to ensure that "business as usual" is able to continue through the peak demands for non-elective activity which occur predictably during the winter months.

Contents

Pressure Surge Plan 2010/11

1 Introduction

This operational plan provides a structure for the Trust to respond to pressure surge. It outlines how management, command and control structures, clinical response and support services all combine to deliver a response based on the principles of 'doing the most of the most' at any given time. Departmental staff should read this overarching document with their individual operational and action plans which can be found in the Business Continuity plan.

2 Scope of the Plan

This plan provides the framework for planning, preparation response to the pressure surges in Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT). It does NOT replace existing emergency plans (e.g. Major Incident Plan, Business Continuity Plan etc) or cover seasonal influenza outbreaks. It is to be used as a supplement to generic emergency plans, providing additional information and guidance specific to preparing for and managing pressure surges.

- Manage the increased demands for specialist beds;
- Maintain essential services;
- Provide a clear escalation process for increased demand and/or staff shortages during this period;
- Reduce morbidity and mortality from influenza illness amongst patients and staff;
- Provide timely, authoritative and up to date information to professionals, the public and the media.

2.1 Time Period

This plan aims to ensure that services are continued and performance standards met during the period 1st October 2011 to 31st March 2012.

Experience of previous years shows that there can be a significant drop in performance against the emergency care standards during October and although the main winter months of concern are December, January and February, mid-December and the weeks post the New Year are the times that present the most challenges to delivering services.

2.2 Aims of the Plan

The basic aim is to ensure service continuity and that performance standards are met, which specifically mean that:

- Contingency bed capacity is identified at KGH and QH that can be opened in response to significant and sustained surges in activity;

- there is sufficient bed capacity available, including ITU/HDU/paediatric beds, single rooms;
- sufficient bed, nursing home and other capacity is available in the community to ensure that patients who do not need acute care are not occupying acute beds, thereby facilitating the acute Trust in meeting performance standards;
- there are effective, practical plans to ensure that there are sufficient staff with the necessary skills available. This is to anticipate that staff may be absent from work due to illness or unable to travel to work due to adverse weather;

2.3 Duties and responsibilities for this plan

12.1.7 Responsible Director/s

The Director of Operations is the responsible Executive Director for Emergency Planning and is ultimately responsible for this Operational Policy.

12.1.7 Review and Maintenance of the policy

The Emergency Planning Officer is responsible for maintaining and reviewing this policy.

12.1.7 Training the plan

Due to the timing of the publication of the plan, focused training of key individuals will be needed; this will include bronze, silver and gold on-call managers and will be carried out by Director of Operations. For the wider Trust employees training and familiarisation with the plan is the responsibility of individual department leads.

3 About Us

Barking, Havering and Redbridge University Hospitals NHS Trust is one of the largest Acute Trusts in the country and the biggest provider of acute healthcare services in outer North East London, serving a local population of circa 750,000. General healthcare and Cancer services are also provided to South West Essex, with specialist Neurosciences services being provided to the whole of Essex, a population base of some 2.1 million. BHRUT gained Hyper Acute Stroke Unit (HASU) status during April 2010. There are 12 HASU beds and 30 Stroke Unit (SU) beds available at the KGH site. Thrombolysis and TIA services have also been established at Queen's Hospital.

Details of the Trust's inpatient capacity are provided at Appendix 1

4 Background and What We Should Expect

From the experience of winter 2009/2010 when the Trust experienced exceptionally high demand in terms of non-elective care and A&E attendances post the New Year period which led to a shortfall in bed capacity, it will be imperative that sufficient capacity is available to avoid a recurrence of this problem and to maintain performance against the 4 hour standard. The plans must ensure appropriate response to infection control issues, such as seasonal Norovirus.

As part of the Length of Stay (LoS) Programme and remodelling some 2 wards have been closed at BHRUT. All treatment rooms at Queens Hospital have also been closed and no longer in use as per CQC guidelines and contingency beds at KGH are currently not in use.

Discharge Jonah implementation work which started in April this year will continue with support from QFI. This will reduce LoS still further to support surge capacity for this winter.

There are plans to review the use of Erica, Elm and Foxglove as there has been significant reduction in LoS with the intention of closing 1 ward in preparation for winter.

Under extreme pressure, plans for other clinical areas in the Trust maybe revised, as a last resort for further in-patient capacity to be created. However, this will only be done following a risk assessment made by the Director of Nursing of the situation and the final decision made by the Director of Operations.

It is also anticipated that there will be additional community capacity provision in line with community bed modelling led by Outer North East London Acute Commissioning Unit.

This will provide extra beds across the Sector that will enable the Trust to ensure that it can continue to provide an acute inpatient service to those patients that require it within the available bed capacity in the acute Trust. To up-date in line with community plans.

Use of ISTC and HCA

The Trust will discuss with Care UK and HCA the possibility to use any inpatient facility that may be available at the ISTC at KGH and Harley St on level 4 QH. Access to ISTC beds will help maintain the elective flow of patients. This has been successfully used in the past for patients undergoing breast procedures.

4.1 What can we expect this winter?

We have undertaken extensive capacity modelling to account for the coming winter based on the lessons learnt from previous years.

5 Business Continuity Planning

The Trust's Business Continuity Plan (BCP) was approved by the Trust Board in September 2008 and was subsequently tested during the bad weather and snowfall experienced in 2010. This plan is now being reviewed for winter 2011/12 as part of overall emergency planning albeit the Trust is working towards the national standard BS25999.

The BCP document provides a general overview of Business Continuity Planning together with actions to be undertaken by individual services. As part of the planning process for pressure surge, individual departments have re-visited their departmental BCPs and can be found on the Trusts Intranet (submitted separately for this plan)

6 BHRUT Winter Resilience Model

The Trust position, i.e. the impact of ED attendances and bed capacity issues on the Trust is measured at four levels Green, Amber, Red and SIE (black).
(Appendix 2: detail in bed policy)

6.1 Figure One- Trust Levels of response

STATUS				
Abulance turnaround times	No ambulance queing	No ambulance queing and/or	Ambulance queing	Ambulance queing
	RAT cubicles 2, 3, 4 & 5 available	RAT cubicles 2, 3, 4 & 5 NOT available		No Resus capacity
MAU	>5 Empty beds	< 5 Empty beds and/or	0 Empty beds and/or	0 Empty beds and no beds coming up
		Non-medical outliers	>5 Non medical outliers	
SAU	>3 beds	< 3 beds	0 beds	0 beds
EPAU	>2 beds	< 2 beds	0 beds	0 beds
ITU	>1 bed	0 beds but ITU step-down	0 beds and no step-down	0 beds and no step-down
GP Unit	Open		Closed	Closed
Total Beds (med/surg/assessment)	> 20 beds	10-20 beds	< 10 beds	0 beds
Paediatric Beds	> 5 beds	> 2 beds	< 2 beds	0 beds
	Actions Required	Action Required	Action Required	Action Required
	No Actions Required	Activate Internal Actions in all departments	Activate Trust Internal & External Actions	Activate Trust Internal & External Actions

6.2 Action Card for each department

(Appendix 2: Action Cards)

6.3 Deferring or curtailing service

During the pressure surge at SIE status or request of director of delivery services may need to be curtailed or differed to support other emergency activity.

7 Reporting Arrangements

7.1 Daily Pressure Surge SitRep

SitRep to be up-dated as per NHS London Guidance when available. As in previous years the Trust will also have to complete a Winter Resilience SitRep on a daily basis.

7.2 Monthly SitRep

In addition, to the above SitReps, the Trust also has to submit a more detailed SitRep each month submitted on the 5th working day of the month following the reporting period.

8 Organisational Management Structure

The Trust's existing management structure is attached at Appendix 3.

On a day to day basis it is essential that the Trust is able to respond to any potential, or real, service disruptions and as such an on-call system is in operation which consists of three levels of escalation to provide support for the organisaton, its staff and patients either out of normal office hours and when during office hours there is an untoward situation to be managed, such as extreme bed pressures.

8.1 Command and Control Structure

The Trust uses a three tier command and control system for all incidents and this reflects the strategic, tactical and operational areas and personnel. They reflect the Gold, Silver and Bronze terminology used by external agencies.

- Bronze Control - Matrons, Bed Management and Discharge Planning;
- Silver Control – General Managers who are on-site between 9am – 5pm during hours on weekdays when on call and attend at all Bed Meetings. Silver Level managers must be available immediately by telephone and able to attend the sites in the event of an incident or at the request of Gold Level. Silver on-call is for a 24 hour period;
- Gold Control - This rota consists of very senior managers and Executive directors. Gold on-call is for a 7-day period.

  In hours, the Gold command will be assumed by the director of delivery. In his absence, Gold command will revert to executive director on-call.

The need for a phased, proportionate but adequate management response to the threat of service disruption has led to the creation of arrangements to provide up to 24/7 on site management support to the Trust.

The Trust must be able to respond appropriately to any challenges posed as a result of pressure surges.

We have established a structure to support the response internally and enable consistent and timely communication with other agencies. The Director of delivery and the GM Silver on-call are responsible for leading the response and advising the Executive Team and Board.

Please note, the CEO retains ultimate 'Gold' level authority, responsibility and accountability at all times. Anyone else performing the role of Gold Executive is doing so on behalf of the CEO.

Proposed Meeting Schedule for Trust Status
All meetings held in the Operations Room at Queens Hospital

Trust Status		Team	Bed Meetings	Detail in section:
Green	Business as usual with strategic overview and operational trouble shooting and planning focus		Regular bed meetings 9.30am 12.30pm 15.30pm 17.30pm (On-call) Actions cards completed for each department	
Amber	Business as usual with a focused response team and operational trouble shooting and planning focus		Regular bed meetings 9.30am 12.30pm 15.30pm 17.30pm (On-call) Actions cards completed for each department	
Red	All actions completed as per action cards		Regular bed meetings 9.30am 12.30pm 15.30pm 17.30pm (On-call) Actions cards completed for each department	
SIE	Full command and control is in place 24/ 7		8.30am 12.30 (or earlier if req) 15.30 17.30 Chair: Director of delivery, in his absence the	

			Executive on-call Actions cards completed for each department	

Note: There are no bed meetings scheduled for the weekends, this is replaced by a teleconference call chaired by the bed manager at Queens Hospital at 11.00am on sat/sun and BH.

8.2 Summary of Roles during SIE

8.2.1 Executive on-call – Gold command

The Chief Executive retains ultimate 'Gold' level authority, responsibility and accountability at all times. Anyone else performing the role of Gold Command is doing so on behalf of the Chief Executive.

Gold Command
Leader: Director of Delivery on behalf of Chief Executive (or On Call Executive Director out of hours)
Responsibility ➢ Make decisions at the onset ➢ Focal point for the management of the incident ➢ Manage all communications ➢ Ensuring resources are evenly distributed across the Trust ➢ Responsible for business continuity ➢ Recovery Planning ➢ Declare organisation stand down
This is the focal command point for the management of the incident. All communications and issues will be handled by the team. The team consists of senior management, nursing and medical staff.

8.2.2 GM on-call – Silver command

The Silver group, chaired by the Silver commander, manage the organisational response to the incident. They are the decision making group and as such sanction changes in operational practice with referral to Gold as required.

Silver Command
Leader : General Manager on call
Membership: ➢ Clinical Site Manager ➢ Matrons ➢ Bed Management Team ➢ Divisional managers ➢ Divisional directors ➢ General managers ➢ Communications

Reporting Lines ➢ Gold Command
Responsibilities ➢ Collation of activity ➢ Providing the Gold Command with SIT reports ➢ Redeployment of staff ➢ Liaison between wards and departments ➢ Documenting which services have been cancelled ➢ Advice Gold Command of Incident Stand down in A&E ➢ Advice Gold Command of incident stand down in the rest of the hospital

8.2.3 Bronze Command – Operational Team

Bronze Command
Leader : A&E Consultant, Senior Nurse Overall in Charge (OIC) A&E, Critical Care Lead, Critical Care Matron, Paediatric Lead, Paediatric Matron, Maternity Matron and Physician of the Day
Membership: ➢ Key action card holders within A&E
Reporting Lines: ➢ Silver Command
Responsibility ➢ Triage incoming casualties ➢ Ensure appropriate documentation is maintained ➢ Organise staffing requirements to meet the demands of the incident ➢ Advise Silver command of Incident Stand down

Bed Meetings

The briefing group consists of:

Bed and site managers

GM bed/site and discharge

Divisional Nurse for clinical support services

Discharge Team manager

On-call GM

A&E representative

Infection control representative (when appropriate)

Duty matron

Medical matrons

Surgical matron

Paediatric matron

Divisional manager or representative

The bed manager will take on the role of overall Commander on a day-to-day basis and as such be the link between Silver and the operational level. They are responsible for operationalising the decisions of Gold and Silver. Only one member of the management team in each Patient Flow need attended briefings but the Doctor, Manager and Nurse are all responsible for cascading information.

The bed and site team of senior nurses have a significant role in supporting command and control. They will work directly within the command and control structure with a key aim of transferring knowledge to the team. If team members begin to go off sick, and command and control is in place, the rota will be recast to provide cover out of hours and at weekends.

After every SIE incident we are required to perform a review. For this reason and for good governance, it is imperative that contemporaneous notes are kept of decisions made not only by Gold and Silver controls but also within clinical care.

Key principles:

- Normal operational responsibilities prevail and should be used to manage the Trust where ever possible
- The focus is on mitigation and the maintenance of business as usual
- It is the responsibility of the Winter Resilience Group who meet weekly on a Friday to scan the horizon and prepare for sudden escalation and movement to the next stage of management control
- Clear roles and responsibly are essential

9 Working with Partners

9.2 Borough and PCTs

Our partners have been requested to submit plans to compliment our structure and response. Details of these plans will be made available to us by ONEL and referenced in the ONEL plan.

9.3 London Ambulance Service

Emergency Department Capacity Management NHS London policy and NHS London Pressure Surge Guidance 2011-12: Appendix 4

9.4 NHS London

As the SHA, NHS London has a key role to provide overview and scrutiny of preparedness and response. During any response to extreme pressure surge NHS London have a key role in coordinating the Health response across the capital.

NHS London's other key role is to act as a conduit to disseminate best practice.

10 Performance Management

This plan assumes that current performance management standards and targets will remain in place throughout periods of pressure surge and the Trust will strive to maintain performance in all areas throughout this period.

11 Management of Cases

11.2 Capacity

11.1.2 Critical Care

The definition of admission to a level 3 or ITU bed is a patient with two or more organ failure and/or requiring advanced respiratory support and for level 2 or HDU bed is a patient with single organ failure.

For the purposes of this plan, paediatrics are described as those younger than 16 years and 16 to 18 year olds if they are vulnerable or have special requirements.

The existing Critical Care capacity across the Trust sites is as shown in the table below:

ITU/HDU	Neuro ITU/HDU	CCU
28	12	14

Table 2: Existing critical care capacity

Currently the Trust is able to 'flex its critical care capacity by accommodating ITU or HDU patients in theatre recovery with suitably qualified staff.

A total of 21 ITU and 18 HDU beds would give a potential 39 ITU beds if HDU beds were flexed to ITU levels. This level would be available if all Neurosurgical critical care beds are included in the "pool" of general critical care bed capacity. This plan proposes to ring fence 6 neurosurgical critical care beds for neuro emergency patients, leaving 6 beds to be incorporated into the general 'pool'.

By utilising the Recovery areas within Theatres at both Queen's and King George Hospitals, the following additional critical care beds could be opened

I ITU bed in the main unit at QH
2 HDU and 1 ITU in recovery at QH or 2 ITU or 4 HDU
2 HDU or 1 ITU at KGH.

11.1.3 Elective and Emergency Inpatient Capacity

The requirement to meet the 18 week Referral to Treatment (RTT) standard (on a specialty basis) means that elective activity must continue throughout the winter period, as far as possible. Much elective surgery does not require an inpatient bed. However, if the emergency care 4 hour standard is at risk at certain times during the winter period, then elective surgery that requires inpatient beds will be kept under review and operations will be cancelled if considered appropriate and, at all times in accordance with the Trust's escalation plan. This will only apply if additional surgical capacity is full i.e. overnight recovery at Queen's Hospital, possibility of using the day unit overnight at Queen's Hospital, use of ADCU at KGH.

The Trust has modelled the bed capacity that it is anticipated will be required over the winter period of 2011/12. This assumes no change to current LoS. However the Trust is working on plans to reduce LoS which will then negate the need to open further bed capacity. Appendix 1

11.1.4 Elective Work

The elective workload will be reviewed on a regular basis during times of increased demand with TCIs only being cancelled as a last resort due to the impact on both patient experience and maintenance of the waiting time standards.

All surgical General Managers, in collaboration with their Clinical Directors/Leads and Admissions Officers, will be responsible for agreeing the cancellation process based on patient need and taking into consideration waiting time (breach dates) of previously cancelled patients.

An emergency Theatre service will be in operation at all times to ensure that, as a minimum, cancer patients (on a 31/62 day pathway) and those requiring life and limb surgery.

Should the hospital be experiencing extreme bed pressures, elective inpatient admissions will be progressively cancelled according to clinical urgency, following consultation with the Clinical Director for the area and relevant Consultant Team(s). Day case (planned same day) activity, by its very nature, will continue unaffected unless it proves necessary to use the staff in these areas to support more urgent elective activity elsewhere within the Trust. However, the Trust will aim to maintain day case activity as much as is possible over this period.

Every effort will be made, by the appropriate clinical and management team, to give patients sufficient notice prior to cancellation of an elective surgical procedure. In hours this will be done by the Bed Management team. In order to achieve the access targets, BHRUT is required to achieve a position whereby a maximum of 0.8% of elective patients can be cancelled on the day due to non-clinical reasons and as such, the intention will be to plan for any necessary cancellations on the day prior to surgery. These patients will then need to be re-dated within 28 days and would form part of the priority treatment groups.

Whilst, under normal circumstances, cancellations to elective lists within surgery do not occur, at times of severe capacity issues discussion will take place with the appropriate General Manager and Clinical Director to prioritise possible cancellations. The Bed Management Team will ensure any cancellations are

recorded and the information passed to the Admission Team to follow up the next working day.

In order to ensure that discharges are maximised escalation protocols have been developed and are implemented according to the pressures that the hospitals are experiencing.

11.1.5 Contingency (external) Capacity

To be updated from external partners plans

11.1.6 Delayed Transfers of Care (DTOCs)

One of the key elements for ensuring efficient patient flows throughout the Hospital and therefore in turn, maximising capacity, will be the minimisation of DTOC patients occupying acute beds. Work is already ongoing with regard to improving discharges through appropriate community facilities, the aim is to reduce DTOC to 1%. The following initiatives have been put in place:

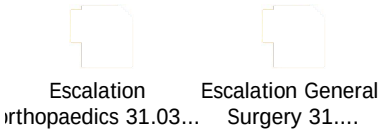
- Daily conference calls from October 2011 agreed with bed managers at the community and acute hospitals and discharge facilitators.
- Conference calls with ONEL, scope to increase to daily conference calls when on SIE with support/decision making at executive level.
- Daily reviews with Havering, B&D, Redbridge & Essex identifying rehab bed needs, with appropriate escalation process in place.
- Actions are being taken by the nursing teams to ensure that we eliminate all hospital delays. Appropriate escalation processes are in place for all hospital delays.
- Full training programme delivered to all wards across both sites to support the above.
- Daily KPIs developed against Trust 1% target.
- Winter surge modelling tools developed from the daily reviews with PCTs.

11.1.7 Paediatric Winter bed capacity

Included in in patient bed modelling Appendix 1. Further work to be submitted

11.1.8 Trauma and Orthopaedics

The establishment of the virtual ward and ambulatory care units will further enhance the management of patients with less traumatic injuries from their home environment. Stable patient will become a planned trauma admission that will have their procedure undertaken in a trauma list at QH or be redirected into a free elective slot at KGH. These patients will not require access to an inpatient bed and can be managed through the day units and recovery facilities.
Theatres and anaesthetics plan respond to trauma demands within a 24 hour period. Theatres will ‘flex up’ the number of theatre sessions required weekdays and weekends to ensure delays are minimal.
The introduction of the orthogeriatric pathway is expected to enhance the care and shorten length of stay for those patients undergoing trauma procedures.
Use of the Recovery area, Surgical beds, Virtual ward and Dhalia ward at KGH are identified as areas to use once orthopaedic pressures exceed their bed base.



11.1.9 Identification of 'core' clinical activity in response to severely reduced staff capacity

Under certain conditions staff may need to be redeployed in order to ensure the continuation of core emergency and urgent services.

The HR department will hold a list of all registered staff who are not working in front-line roles that can potentially be redeployed to cover periods of increased demand or staff shortage in clinical areas. As a result of the departmental BCPs, a matrix of essential staffing levels has also been completed so that non-clinical staff can also be identified to provide support. Additionally in periods of extreme pressure caused by increased staff absence the Trust will consider cancellation of annual/study leave with discretion, in order that patient services can continue unabated.

11.2 Admission Assessment/Triage

At present patients are streamed at the front door of the A&E department to the Urgent Care Centre and the Trust would expect this to continue. Triage of patients will continue unchanged. For patients brought in by ambulance, Consultants will be applying the rapid assessment and triage assessment service at the front door to facilitate improved processes for direct specialty referrals.

The Consultant-led Admissions Unit will also provide input on early patient management for 12 hours a day, 7 days per week.

11.3 Preventing Admissions

11.3.2 Nursing and Residential Homes

PCTs as part of their winter resilience planning will ensure that patients are seen and assessed in nursing/residential homes by appropriate practitioners in order to manage any unnecessary admissions to secondary care.

Update PCT Info:
PCTs are also providing training for nursing home staff and as pressures mount will ensure a review of all residential home residents.

It is critical that PCTs have appropriate rapid response services to manage either acute care or palliative care of any residents for whom secondary care intervention is unlikely to benefit.

Other actions currently being undertaken by the Trust to both increase discharges and prevent admissions include:

- EDMU
- Ambulatory Care

- Weekend Bed meetings at 11.00am;
- Increasing the seniority of the individual undertaking A&E triage;
- Direct GP admissions to the Medical and Surgical Assessment Units;
- Winter directory of services (needs to be developed-PCT)
- Increase UCC hours
- Setting a target number of discharges per ward per day (to be owned by the Clinical Lead and Senior Sister)
- A GP Advice Line staffed by Consultants;
- Daily Consultant ward rounds on all bank holidays and in particular over the Christmas and New Year period for the medical specialties;

12 Impact on Services

Managing the demand and capacity 'surge planning' across BHRUT is an essential part of the response to pressure surge. The principle of surge management is that as demand for services increases, BHRUT would respond firstly by increasing capacity, secondly by diverting capacity to essential services by closing other non-essential services, and lastly by prioritising patients access to essential services.

Services within each Division have all completed surge plans which will enable them to react to increasing demands, plans are now being cross referenced in order to indentify the potential impacts on other services within the Trust. Part of the surge planning process includes planning by each division to redeploy staff to priority services, in the event of staff shortages and the closure of non essential services. During a 'pressure surge' the intention is to maintain normal services as far as is reasonably possible however, the unique nature of the challenges presented by emergency situations such as inclement weather or a pandemic flu outbreak and the unknown aspects of their duration may inevitably require a reduction in some services and redeployment of staff and resources to other areas.

The role of the HR department at BHRT leading up to and during a 'pressure surge' will be to provide an effective and viable response to the exceptional circumstances through supporting service delivery operations, providing employee based information to those responsible for the management of services and to also provide guidance and advice on the legal and policy frameworks in place regarding the employment of staff and the interpretation of these when such pressures/surges occur.

Escalation plans, both at the Trust and PCTs, have been reviewed and revised post the experience of Winter xxx in order to ensure that responses are effective and actions taken in a timely manner. For the Trust, this has resulted in the development of a single escalation process which is to be used in all situations (with the exception of a major incident). This plan contains trigger points in terms of beds, isolation facilities, ambulance turnaround, A&E and staffing for the Trust to move from green status through amber and red to Serious Internal Event (SIE) and documents the actions to be taken in response to the triggers at each stage.

In order to gauge potential impacts upon workforce 'supply during the 'pressure' months of October 2011 through to March 2012, part of the 'surge planning' process

has included a review of the sickness absence rates across the Trust from September 2010 to end January 2011. In order to identify the exact impact of the H1N1 flu pandemic on overall absence, absences associated with Flu have been extrapolated separately, in addition this is directly compared to the same period in 2010/11 – Graph 1.

During a 'pressure surge', daily meetings with key individuals will establish how and where excess patients will be placed and how departments, such as A&E, will cope with large numbers of self-referred patients or patients who present via their GP and walk-in centres. Staffing and other operational issues will also be reviewed at these meetings. This will be co-ordinated through the Command and Control structure.

12.1 Staffing

The purpose of this section is to provide guidance regarding BHRUT procedures for managing staff in the event of a 'pressure surge'. This guidance has also been developed to help the HR department to provide an effective and viable response to such surges whilst supporting the Service Delivery operations as and when appropriate.

The Trust will seek to operate within its existing employment policies and principles whilst dealing with a pressure surge situation. In an emergency there may be a necessity to reallocate and redeploy staff. Consultation has taken place with staff side at the Joint Staff Committee (JSC) regarding the principles outlined within this plan and the required response to workforce issues during a pressure surge. This may include asking staff to undertake duties outside their normal professional area should staffing levels reach the agreed trigger points. Additional staff may also be required, sourced from a pool of bank staff, retirees, and volunteers.

Current job descriptions and employment contracts allow some flexibility in the ability to allocate existing staff other tasks or work, whereas permanent or very long term redeployment would require consultation under the staff affected by change policy.

In the event of a pressure surge occurring, due consideration must be given to the fact that there maybe a higher degree of absenteeism amongst health service employees at a time when the service could be facing unprecedented demand. Dependant on the scenario staff may be absent due to:

- Exceptional Sickness circumstances - e.g Norovirus outbreak, seasonal flu
- School closures
- Travel problems due to inclement weather, fuel shortages or advice from external agencies not to undertake any non-essential travel

This guidance aims to ensure that mechanisms are in place in order to ensure the maximised availability, utilisation and deployment of our workforce during a period of potential major staff shortages coupled with potential major surge in demand.

12.1.2 Redeployment/Re-allocation of Staff

In order to address a 'pressure surge' it will be necessary to take pragmatic decisions to sustain services. As such the Trust reserves the right to redeploy staff as the need arises. This could be to a different role, function, or locality. Staff may also be

requested to work different hours from those in their contract of employment. Supported by the HR and workforce data from ESR, Operational services will need to make daily decisions regarding prioritisation of services and redeployment of staff.

The following arrangements would only apply in an emergency situation during the 'pressure surge' should workforce numbers reach the critical trigger point:

In an emergency where staff may need to be redeployed or work may need to be reallocated, managers will assess:

Whether it is necessary for staff to report to their normal place of work and whether there is a need to redeploy staff or reallocate work. In deciding this managers will, wherever possible:

- Direct staff to sites which are convenient
- Allocate staff work with which they are familiar - it is recognised that it is more effective for staff to work in areas, both in terms of locality and duties, that they are familiar with and this will be, where possible, the first course of action taken.
- The location of staff, their access to public/private transport, any reasonable constraints on their flexibility, as appropriate.

In considering redeployment, managers will take account of:

- Any known/stated restriction on work that could safely be undertaken by an individual on health grounds. This may include, for example, pregnancy and in the case of communicable infection, whether the individual had received any appropriate vaccination.
- Any training or professional qualification that would be a prerequisite to carrying out certain duties safely
- Any other circumstance that may make working unreasonably unsafe, for example, severe staff shortages.
- Any official communication from bodies with emergency powers by law, for example, advising against travel/other activity in all/some circumstances. The Trust will provide advice to staff on interpreting such communications. For example, essential workers would normally be expected to travel to work if there were advice to refrain from non-essential travel

As part of the normal course of employment staff would be consulted with regard to re-locating to other areas of the Trust to meet service demands.

During a 'pressure surge', the Trust's priority will be to maintain consistent patient care , a sustained decrease in staffing levels may trigger the need to consider re-locating non-critical business staff to support clinical areas.

Where it is considered that patient care is being compromised and it is deemed necessary to ask non-critical staff to support clinical services this will be done in full consultation with staff.

It is understood that staff that are currently outside of the clinical setting may want to assist within a clinical service, but feel they do not have the capability to undertake this role. In these circumstances on-the-job training/mentoring and support will be provided by clinical staff or a role that utilises an individual's existing skills will be identified, this will be done in conjunction with the education department.

In relation to redeployment/reallocation of work, if staff refuse without good reason to follow a management request that is reasonable in the circumstances, this may lead to disciplinary action being taken, in accordance with the Disciplinary Policy, Rules & Procedure

The following list provides examples of offences which are normally regarded as gross misconduct and therefore could warrant dismissal without previous warning and without notice (summary dismissal).

- Theft
- Fraud
- Assault/threatening behaviour
- Malicious damage to Trust property or that of a patient, fellow employee or a member of the public on Trust premises
- Corruption - receipt of money, goods or favours in respect of services rendered
- Breach of Health & Safety Rules
- Breach of Statutory Requirements
- Failure to carry out instructions reasonably given by recognised and authorised senior managers or supervisors.

Appendix 5 Disciplinary Policy, Rules and Procedure (Sept 2008) – page 18
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Such action may be stayed until the end of the emergency or until resources allow te matter to be dealt with.

12.1.3 Roles and Responsibilities

12.1.4 Human Resources:

The HR department will take a lead on the provision of employee based information – emergency contact details, to those responsible for the management of services during a pressure surge.

They will also provide guidance and advice on the legal and policy frameworks in place regarding the employment of staff and the interpretation of these during such a scenario.

HR will:

- Ensure that, as required, the HR Department becomes fully integrated in the Trust Command and Control Structure;

- Maintain a flexible approach to succession planning for staff who are absent during a pressure surge
- Access Electronic Staff Records used to record and track staff sickness absence;
- Access and supply workforce information – emergency contact details;
- Liaise with nominated lead managers, either present or available, to discuss redeployment options and other sources of staffing;
- Ensure:
    - Prompt recruitment practices so that new staff can commence as soon as possible; and
    - Specialist HR advice including the Working Time Regulations;
    - Liaison with Occupational Health regarding fitness for work and Staff Support and Chaplaincy teams to direct staff to appropriate sources of support;
- Facilitate the arrangement of accommodation, food and beverages, and toiletries to staff working long hours, with priority being given to those providing direct patient care;
- Assist in making decisions to suspend annual leave and non-statutory training;
- Assist in making decisions regarding assisted transport to work, using public transport, loaned vehicles or taxis;
- Monitor HR issues reported during the daily 'Battle Rhythm' briefings and take necessary action(s);
- Manage & report the staffing absence situation – reporting frequency and data-set yet to be agreed

12.1.5 Divisions and Departments:

- Identify clinical areas that could be temporarily suspended, therefore possibly freeing employees for potential deployment elsewhere;
- Communicate individuals available for redeployment;
- Work collaboratively with other Divisions;
- Ensure smooth handovers for employees who are filling in for colleagues in unfamiliar roles;
- Facilitate flexible working or home working as necessary;
- Provide required information on HR issues during the daily pressure surge "Battle Rhythm" briefings;
- Complete a daily staffing absence situation report for collation and escalation.

12.1.6 Workforce Data

HR will take a weekly extract of staff's emergency contact details and staff group from the Electronic Staff Record (ESR). This will be password protected and placed upon the winter resilience drive in order to support Executives/ managers in being able to contact staff for their availability should the need arise.

The emergency contact list and the data within will be updated on the winter resilience drive – weekly, by HR

In accordance with the Data Protection Act and the Trust Information Governance Policy, staff can be reassured that this information is being used only for emergency planning purposes and not for any other reason

It is essential that all staff ensure that they follow the correct notification procedure for any changes to their personal details in order to ensure that the Trust holds the correct contact details for all staff.

12.1.7 Working Hours

Part time staff will be invited to increase their contractual hours for a specified period of time, however, will not be obliged to do so.

Staff on other flexible working arrangements may be asked to temporarily alter these arrangements in response to the emergency situation, if it is reasonable for them to do so. However, flexible working solutions may also enable as many staff to continue working as possible. This may include home working, childcare schemes/facilities, staff accommodation, and special travel arrangements (e.g. car pools). HR and managers will therefore continue to promote and agree flexible working options where possible – See Flexible working policy – appendix 5

In normal circumstances, no staff should be asked to work in excess of 48 hours per week, nor without appropriate rest breaks and to take annual leave. In an emergency situation, it will be important to ensure that staff continue to receive appropriate rest breaks or compensatory rest and that they are not asked to work more than 48 hours on average over a 17-week reference period, in accordance with the Working Time Regulations (WTR). If a member of staff however wishes to work beyond the 48 hours they must complete a WTR opt out form – which is available form the HR department – copy in appendix 5

Annual leave requests may need to be more tightly controlled and staff may not be able to take leave at the exact times they request, depending on service needs. However, staff will remain entitled to take their annual leave allocation and must take at least four weeks' leave during the leave year, in accordance with WTR.

It will be important for both staff and managers to monitor working time and ensure that excessive working time without appropriate rest does not occur as this could adversely affect staff health and therefore their ability to remain at work to support colleagues and the running of services.

12.1.8 Managing Absence

Any staff who are feeling unwell during the emergency situation be asked to report as off sick under the normal Trust procedure .

Staff will be expected to continue following the existing reporting procedures in accordance with the sickness absence, special leave policies and annual and sick leave policy for medical staff (Appendix 5)

No member of staff will be required to attend work if they are not fit enough to do so safely. Managers may seek Occupational Health advice regarding the fitness of staff and making adjustments to enable the early, safe return of staff where appropriate.

The normal procedure for managing sickness should be followed in line with the Trust sickness absence policy and procedure however local discretion should be used when dealing with episodes of absence due to emergency situation as this will need to managed on an individual basis depending on the circumstances.

Procedure for reporting and certifying absence (Trust sickness absence policy (2009) and annual and sick leave policy for Medical staff (appendix 5)

First day of absence

The employee must telephone either their line manager or (if previously advised by the line manager) a nominated person as soon as possible, once they know they will be absent from work.

Medical staff will report their absence to the medical staffing coordinators on the day of absence, who will enter the information onto the HealthRoster system.

This telephone call will be one full shift in advance, but must be no later than 1 hour after the employee is due to be at work. Only in exceptional circumstances may someone else call on behalf of the employee.

The employee must give an indication of the cause of the absence and how long it is expected to last.

Sending text messages or leaving voicemail messages is not an acceptable means of informing managers of absence. The employee must actually speak with them or their nominated person. If for any reason a message is left or text received, the manager will contact the employee at home to confirm the circumstances regarding their sickness absence.

Failure to notify absence within 1 hour of the scheduled start time will result in absence being counted as ”unpaid absence without permission” and the employee will be subject to disciplinary action unless there are exceptional circumstances. (eg road traffic accident, emergency admission to hospital)

The line manager is responsible for ensuring that the period of absence is reported on the electronic weekly absence return.

The existing Trust process will remain the same and managers/supervisors must submit their completed absence return to McKesson within the timeframe specified. McKesson will continue to input all absence data into ESR in order to allow the workforce Information team to run and analyse weekly absence reports as required.

Medical certification

Failure to submit the appropriate medical certificate within the required timeframe will result in non payment of occupational sick pay or statutory sick pay.

12.1.9 Special Leave

In certain circumstances – such as the closure of schools it is expected that there will be an increase in requests from staff for Special Leave, for the care for dependant(s)

If a member of staff requests special leave during a pressure surge then the special leave policy (2003) will apply then this should be requested in writing to their line manager as indicated within Policy. If the individual is unable to put the request in writing prior to commencing their leave then it can be completed on their return (Appendix 5).

All staff have a responsibility to attend work particularly when there are staff shortages due to a pressure surge. Whilst there are instances where this will not be possible managers will assess each special leave request on a case by case basis and acceptance of the request is at manager's discretion. Therefore all staff will be asked to explore all possible avenues before requesting special leave.

Where staff request special leave then Managers will be required to inform HR. This is to ensure that BHR is able to report daily on absence levels to assist in the redeployment of staff.

The professional codes that apply to registered NHS staff make clear that staff have a responsibility to provide care to those in need. Whilst staff do not have the right to refuse to attend work unless there is a clear health and safety risk, the Trust needs to acknowledge the level of anxiety that a pressure surge is likely to generate and seek to work with staff to reassure them

Staff who are not ill themselves, but have carer responsibilities, will be given a combination of paid and/or unpaid leave or annual leave, at managers discretion, as per the Special Leave Policy.

12.1.10 Annual Leave

The procedure for requesting annual leave will remain unchanged as laid out in the Trusts Annual Leave policy 2004 and the annual & sick leave policy for medical staff (appendix 5).

It is anticipated that individual departments shall have an approval process or local operational policy, which makes explicit the minimum standards by which staff may book and take paid annual leave.
Managers approving annual leave will ensure service needs are met and will normally set standards for the maximum number of staff who may be absent from work on annual leave at any one time.

12.1.11 Cancellation of Annual Leave

Other than in exceptional circumstances, following approval of an employee's application to take annual leave, approval will not normally be withdrawn. However, Barking, Havering and Redbridge Hospitals NHS Trust reserves the right to withdraw such approval should circumstances so warrant. Withdrawal of approval must be

communicated to the affected employee in accordance with the provisions set out in paragraph 5.4.2 of the policy. Compensation for losses resulting from such a decision would be considered.
Appendix 5 Annual Leave policy (2004) page 5

Based on the level of the pressure surge, arrangements for the restriction and/or postponement of both planned and ad hoc annual leave will need to be determined. Requests for leave should be considered on their merits at the time as it is important, in balancing needs, to allow staff to recuperate from the pressures of working during the emergency period.

All annual leave is subject to operational needs and demands therefore a specific policy is not deemed necessary; however, appropriate communications briefings will be issued to remind staff of such contingency arrangements. Therefore, as at any other time, a manager may accept or decline this leave in accordance with service or staffing demands.

In extreme circumstances the decision may be made at Director level to cancel all non-essential annual/study leave. Financial commitments and disruption to personal circumstances will be taken into consideration.

Requests for annual leave taken at short notice due to family circumstances or emergencies would have to be considered and authorised as quickly as possible by managers.

Following a pressure surge there may be a large amount of staff that have had their annual leave cancelled or have been unable to take annual leave. Due to being unable to predict the impact and the effect such a surge will have on BHR, a decision will be made following a surge situation to determine if there is a need to carry more than the 5 days annual leave over to the next annual leave year. This will be agreed by the Director of HR following an assessment of the situation.

12.1.12 Study Leave / Training

It would be expected that all study leave would be put on hold until after the crisis is over. All staff would be needed to work, dependant on the cause of the pressure surge colleges etc may be closed and staff would be expected to report for duty.

All training courses except those required for supporting and training redeployed staff, volunteers or reserves, should cease until the clearance is given and the pressure surge is declared over. Staff in the training department can be redeployed if there is insufficient work in the Training and Development department.

12.1.13 Recruitment Process & CRB Checks

HR will provide a truncated process to enable fast turnaround of applications into new starters. This will involve utilising verbal offers and reference checks and they will undertake this on behalf of managers. However this can not be the case with CRB checks. Managers therefore, must not allow unaccompanied new starters to be unsupervised with any patient until given the clearance from HR. This is not negotiable. All contractual documentation will be provided from HR following the start date of the new employee and will be in accordance with legal requirements.

The Trust would need to assess the risk of using staff that have not been cleared; full clearance could be postponed until after the pressure surge is over.

12.1.14 Staff Support

To enable staff to continue working, it will be important to ensure they are appropriately supported during and after an emergency. This may be in the form of trauma counselling, Occupational Health or support groups set up by other agencies. Managers will also play a key role in identifying concerns, supporting their staff and ensuring their health, safety and well-being at work.

12.1.15 Retirees

HR are able to identify all retirees who have retired in the last year. Retirees who have left the Trust in the previous 12 months will be contacted by their previous manager to see if they would like to be entered on an emergency register of staff. All staff who have retired more than six months ago will be health screened and CRB checked again.. If professional registration or training has lapsed, retirees will not be asked to undertake duties for which either would be a requirement. Retirees would be engaged as bank workers on the same rates of pay as in operation for the Trust In House Bank.

12.1.16 Volunteers

Those already on the volunteer register may be called upon in an emergency. New volunteers will need to be health and CRB screened with appropriate references being taken up. Volunteers' competence, qualifications and skills will also need to be assessed by way of an application form, skills audit and/or interview/test. Volunteers are normally deemed to be helping out rather than fulfilling a discrete role and are therefore not usually paid. If a particular role is being filled, they will be subject to the recruitment procedures in operation at the time for bank workers and paid accordingly.

12.1.17 Indemnity and litigation

The Trust cannot prevent patients from pursuing legal options but should reassure staff that they will provide support in such circumstances. Discussions have taken place with the NHS Litigation Authority at a national level concerning indemnity insurance issues. The Authority has indicated that it does not believe there would be a substantially greater risk of successful legal challenges to the NHS in scenarios that may arise during an emergency situation. The authority has confirmed the following:

The Individual:

- NHS staff will be covered by existing indemnity insurance arrangements during a pandemic and staff will be covered by the Trust's employer's insurance. This will apply even if staff are working on a different site or seconded to a different employer;

- Temporary staff will also be covered, provided that there is a clear contractual relationship with an employer. Volunteers should have an honorary contract;
- The NHS Litigation Authority does not believe that there is a substantially greater risk of employers or employees being sued as a result of actions taken during a pressure surge as long as a healthcare professional was able to show an appropriate degree of reasonableness in their actions;
- Reasonable steps should be taken to maintain records, as would happen normally, but the courts will take into account the emergency nature of the context when making judgments;
- Where staff or students are working outside their normal role they need to continue to work within their scope of competence and receive adequate training and supervision.

The Trust:

- The Trust must also be aware of its responsibility to make adequate provision for health and safety during the pandemic;
- The Trust will take every care to deploy staff to the most suitable area of need to match their skills.

12.1.18 Increasing Workforce Capacity

12.1.19 In-house bank- Temporary staff

12.1.20 A Flexible Workforce

Planning preparation includes consideration of additional flexibility/capacity which could be generated through variation to shift patterns e.g. longer hours, extra hours, staggered shift arrangements.

The implications of the Working Time Regulations must be borne in mind and appropriate risk assessment carried out by the responsible manager. Staff will be approached at an early stage to identify willingness to “opt out” of the 48 hour/week working limit for the duration of the pressure surge only.

12.1.21 Medical staff

A staged approach to contingency management will be implemented for this group. The first stage of the process if medical staffing becomes an issue will be to take advantage of the EWTD opt out in order to keep optimum services functioning. A list of all medical staff who have chosen to opt out for the period relating to the flu pandemic has been compiled and formulated into a ‘pool’ of medical staff which can be drawn upon should the need arise.

Should the situation worsen non-essential services will be reduced according to the contingency plans defined within this overall plan and available staff will be redeployed. Fair allocation and H&S requirements of the workforce will be maintained as far as possible using HealthRoster which is currently being used to manage all junior doctors’ rotas.

Should a national temporary derogation of the WTD be instated the trust in the first instance would attempt to remain within the local opt out parameters, whilst maintaining a sensible cap on the number of hours.

12.1.22 Doctor's In Training

EWTD rotas within the Trust remain compliant but it is vital to point out that due to a national shortage of middle grade training doctors rotas in areas such as A&E, Trauma, Paediatrics and medicine are in precarious position. In response an overseas task force has been initiated which has an aggressive recruitment campaign which envisages filling vacant posts by December, this in turn will generate spare capacity of available doctors.

The shortfall of doctors due to absence has been considered within the Trusts current medical staffing recruitment strategy. The Trust started the new intake with a significant shortfall in the placement of training doctors, largely due to national shortages, and partly down to the rotations we are offering to the deanery. This has resulted in an aggressive overseas recruitment campaign targeting Europe and Australia/New Zealand/Asia, this campaign commenced on 14th September 2009 and has been optimistically filling vacant posts in A&E and T&O with plans to fill in Paediatrics and Medicine by the end of the year. The campaign will continue to progress through out the winter months to increase the availability of floater doctors and increase of bank pool of doctors.

We are also revisiting our Clinical Attachments policy to bring in attachments for a period of 3 months on completion of a sponsored attachment they will undertake locum work for the Trust for the next 3 months..

12.1.23 Graduate Healthcare Professionals

Newly qualified staff, who have not yet secured employment, may be offered temporary contracts, during a pressure surge. However, if nurses, for example, have not yet gained registration, they may only be employed as Healthcare Assistants, until registration is received.

12.1.24 Escalation of Non-adherence to Plan

Failure to comply with centralised sickness and absence reporting will be escalated through line managers to Divisional Directors, and disciplinary action may result Trust policies - Managing Poor Performance (2005) & The Disciplinary policy, rules and procedure (2008) Appendix 5

Excessive levels of sickness absence/maternity leave/vacancies, which cannot be covered by the use Bank/agency staff, may result in staffing levels which do not allow the normal number of beds to be open. This is particularly relevant when the Trust is trying to prepare different pressure surge scenarios of an unknown origin and duration. The Trust will be innovative in maintaining bed capacity by redistributing nurses and other resources throughout the organisation and Appendix X identifies the process that should be followed when identifying areas that may be at risk due to reduced staffing levels.

12.1.25 Joint Staff Committee

In order to ensure staff engagement and support, the Trust's Joint Staff Committee (JSC) has been kept fully briefed on the arrangements being made within the Trust to tackle the challenges posed during pressure surges. ,

A copy of the meeting minutes held on the 18th August where these topics have been discussed can be supplied.

12.2 Communications

The Trust's Communications Team will:

- Adopt processes detailed in "Communications Out of Hours" and "Dealing with Press Enquiries" attached at Appendix 6;
- All members of Communications Team to work remotely when required, utilising the out of hours dial-up technology already implemented;
- Facilities in place for a media centre at Queen's and KGH, with a Communications Representative liaising with Gold Command, as per the Trust's Major Incident Plan;
- Provide the media with updates on a regular basis, keeping them well informed;
- Spokespeople to be clinical staff whenever possible. In other cases the Medical Director, or if not available, the Director of Nursing;
- Put arrangements in place for pre-determined messages that can be given automatically to those telephoning the hospital at times of winter pressure;
- Keep the Communications Team at NHS London, ONEL and local PCTs informed and prepare joint statements in liaison with partner organisations and local stakeholders if required;
- Utilise established links with local papers, radio and stakeholders to issue messages to the public, as and when required.

The Trust's communication Team is currently working with PCT communications teams to promote Choose Well messages to prevent patients attending A&E unnecessarily, where other services could be accessed instead.

12.2.1 Communication with staff and media

The Trust's Communications Plan is as detailed below. The out of ours policy is attached in appendix 6

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Type	Description	Activities
Internal communications	Updating Divisions/Directorates regarding the latest developments on winter resilience and the impact on their work.	Internal communications will be discussed at each bed management meeting. All attendees would be required to communicate issues/actions to their respective Divisions/Directorates. A cascade process will be implemented for those services that are expected to have a substantial impact and representatives at a daily whole health economy meeting/teleconference call will

		disseminate appropriate information to their teams. Internal communications will be sent out following a daily whole health economy meeting/teleconference call via an agreed communication cascade pathway. Membership of meeting/teleconference calls will consist of agreed 'core' members. Weekly e-communications to all staff from Communications Department and staff briefings organised daily/weekly when required. Utilise existing communication links with NHS London Communications Department and keep them fully informed, preparing joint statements when required in liaison with partner organisations and local stakeholders. Additional communications to be prepared via the Infection Control Team. Update the Trust website and Intranet with key messages on a regular basis. Remote access in place for members of the communications team.

Type	Description	Activities
External Communications	Communication with all Commissioners and Local Stakeholders. Communication with local media. Status of services in the local area which may be under pressure during winter. Direct contact with patients and answering	If a system wide event takes place, which requires all Commissioners and Local Stakeholders to receive a communication, this will be distributed by the local Lead Commissioner, working with the PCT Communication Teams and the BHRUT communications team on the production of content. For confidentiality NHS net email addresses would be considered. Proactive communications prepared where we seek to engage with partners in the media and elsewhere, in order to communicate with the public. Remote access in place for members of the communications team. Provide the media with updates on a regular basis, keeping them well informed. Utilise established links with local papers, television and radio to issue messages to the public as and when required. Planned messages released through the Trust website and local press/radio stations. Facilities in place for a media centre at Queen's and King George Hospitals, with a communications representative liaising with Gold Command, as per the Trust's Major Incident Plan. Spokespeople available (to be clinical staff whenever possible - in the case of Pandemic Flu, the Flu Director. In other cases, the Medical Director, or if not available, the Director of Nursing.)

	questions through a local telephone line. Keep local MPs informed and involved.	Work with the existing Patient Advice and Liaison Service (PALS) to disseminate information to callers as required from briefing provided by Communications Department. Additional capacity for existing PALS service to be considered, if required. Helpline facilities also available if required. MP briefings to be prepared, regularly updated and distributed.

12.3 Clinical Support

12.3.1 Diagnostics

12.3.2 Radiology

Has contingency and business continuity plans which contain the detailed action to be taken with increased demand for radiological tests and decreasing staff levels as staff are affected and sickness rises on a sliding scale to from 0% to 50% loss of staff of all grades across all specialities (Radiographers, Radiologists, Nurses, Radiographic Helpers and Clerical staff).

These plans outline the action that will be taken by the Radiology Department depending on the surge in pressure and the percentage of staff absent on a particular shift.

The actions include:

- Restricting annual leave and study leave;
- Stop imaging non-urgent radiological requests by suspending non-urgent work for GP and Out-patient referrals;
- Offering overtime to necessary staff;
- Maximising use of flexible contracted staff;
- Consider cross-site working by re-deploying site specific staff, to ensure all areas are covered by qualified staff;
- Prioritising work for in-patients and theatres and A&E referrals;
- Utilise weekend and/or evening staff (on-call) to provide the necessary level of cover;
- Eventually considering consolidating core work on one site and have only essential Imaging on the other site;
- Cancelling annual leave and study leave;
- Ultimately reducing Radiological service to a core essential service akin to the on-call (out of hours emergency service).

All other local hospitals and Radiology Departments would be in a similar situation and would be unable to accept referrals from us, as we would not be able to accept from them.

12.3.3 Pathology

Has contingency and business continuity plans for pressure surges which detail the action to be taken with increased demand for tests and decreasing staff levels. These plans include:

- Restricting annual/study leave;
- Stop processing non-urgent screening work;
- Prioritising work by suspending non-urgent work;
- Additional weekend and/or evening work;
- Suspending phlebotomy service;
- Consolidating core work on one site;

- Cancelling annual leave;
- Ultimately reducing to a core service akin to the out of hours emergency level.

The details of each laboratory's plans are available separately.

Chain of Command
Pathology is headed by a General Manager supported by 6 service managers (Head Biomedical Scientists) managing specialised workforces in:

- Biochemistry;
- Haematology and Blood Transfusion and Phlebotomy (QH and KGH separately);
- Histology;
- Cytology;
- Microbiology.

Together with an IM&T Manager, Quality Manager and Lead Blood Transfusion Practitioner.

In prolonged absence of the General Manager, the Head Biomedical Scientist for Haematology, Blood Transfusion and Phlebotomy at Queen's Hospital would formally deputise. In her absence this would pass to other HBSs depending on the situation in their services at the time.

12.3.4 Pharmacy

Actions to be taken by the Pharmacy service are detailed in the Pharmacy Business Continuity Plan which covers all services provided.

On-call services and weekend/late evening services will be provided and a list has been developed of previous BHRUT staff (retired etc) who could be called upon and of part-time staff who could increase their hours.

Those services which could be reduced or stopped in order to maximise services to core/acute areas have been identified.

In addition, arrangements have been made with locum agencies to provide qualified staff should this be necessary.

12.3.5 Infection Control

The provision for single/en suite rooms across King George and Queen's Hospitals is adequate to accommodate patients requiring isolation.

The facilities include 6 negative pressure rooms
KGH:

- Foxglove ward x 1
- Gentian ward x 1

Queen's Hospital:

- Ocean B ward x 2

- Medical assessment unit x 2

Consideration must be given to other respiratory cases in particular Tuberculosis (TB) specifically Multi Drug Resistant Tuberculosis (MRDTB) patients as well as patients with other highly transmissible infections. MDRTB patients MUST be nursed in a negative pressure room. Policies detailing efficient management throughout the winter period are as follows: Outbreak Management Policy- Hand Hygiene Policy and the Isolation Policy(Appendix 7)

Also available are the priority lists for isolation in A&E MAU's ITU's wards and paediatrics. (Appendix 7)

During Outbreaks of Infection the IPCT will advise bed managers what on call services they will provide at weekends and bank holidays. Consultant Microbioligists cover both sites 24/7

12.3.6 Mortuary Capacity

The mortuaries have ample capacity, however in the event of overwhelming body numbers the Trust has contracts in place with Undertakers to increase capacity. If this capacity is exceeded the Trust would rent or purchase approved temporary body storage units however it is unlikely that this would be necessary as community facilities have been arranged to ensure that there is sufficient storage available.

There are 6 staff across two mortuaries - one mortuary can function with a minimum of 2 staff.

The Trust would not anticipate other local Trusts accepting bodies from us, as in cases of extreme pressure we would not be able to accept from them.

12.4 Non-Clinical Support

12.4.1 Accommodation

Staff accommodation is available at both KGH and Queen's Hospital:

KGH – London & Quadrant

- Bed Capacity 294;
- Bed availability at present 35;
- On Call Rooms 8;
- Quiet Room Accommodation on Management Corridor 5.

Queen's Hospital – Swan Housing

- Capacity 369 properties
- Bed availability at present 229
- On Call Rooms – Trust to look at parity with KGH
- Quiet Room Accommodation on hospital site 12 each with 2 full recliners

The Accommodation Manager will arrange for keys to be made available to staff should they not be able to commute to and from work as normal due to winter pressures/pandemic flu (H1N1). Keys will be held by Security on each site and authority for release of keys to

members of staff should be given by the General Manager of the service. All keys will need to be signed for and noted on the key log.

In addition to this, the Trust is investigating the cost of holding a number of rooms for emergency use on both sites.

In the coming days/weeks a list of local hotels (to both sites) is to be compiled as well as a listing of local letting agents. (Specify in plan)

12.4.2 Linen

Increased demand for Linen Services will be managed through current practices of review and monitoring of stock levels (inclusive of Buffer Stock) daily. Additional supplies of stock would be ordered and received from our Contracted provider. Access to additional buffer stock "Out of Hours" is already in place on both the main hospital sites. Cross-site sharing of stock items is also facilitated where needs are identified.

Contract Monitoring Officers would revert to a "hands on" approach for the duration of short-term increased absence and staggered shifts could also be considered/implemented if necessary.

In extreme circumstances with national shortages of linen, stock needs would have to be prioritised for packing and delivery on a clinical/ward based priority.

Close partnership working with Portering staff (FM contract provider) would ensure delivery in priority order (needs basis) to clinical area's and enable portering staff to deliver linen to wards/clinical areas on the Queen's Hospital site allowing experienced Linen staff to remain processing and packing of stock for onward delivery to the clinical areas/wards.

12.4.3 Food

The Trust's catering services are provided by Sodexo who have confirmed that they have received assurance from all Suppliers that contingency plans are in place, so that deliveries will not be affected. Sodexo will not be 'stockpiling' food items and have confirmed that they would revert to a simplified menu, should the need arise.

12.4.4 Procurement

NHS Supply Chain (NHSSC) has already put contingency plans in operation with their Suppliers and the Trust has its own stock. There is a rolling stock of 7-10 days on all consumables from NHSSC. We also have other consolidated Suppliers on whom we can call. With regard to Non Stock, orders would be prioritised and all staff would multi skill including senior managers becoming operational.

12.4.5 Transport

Any staff shortages are covered with overtime and/or agency staffing. In the event of staff shortages, services would be prioritised and we have a contingency arrangement with our external contracted services. Transport services will continue to run until such times as road conditions become unsafe for driving.

12.4.6 Chaplaincy

The Chaplaincy Team work across site and include currently 2.0 WTE with an additional full time member due to join the team in October 2009. They work with an extensive bank of chaplains and volunteers and undertake on call duties on a rotational basis. Their role would be pastoral as well as spiritual in the support of patients, relatives as well as staff within their capacity to counsel in all circumstances including bereavement. Their rotation to on call would be extended to include the bank chaplains over this extended period of time with

remuneration accordingly. They would also see patients and staff from other faiths and advise/counsel or seek advice e.g. Muslim chaplains for instance from nearby Trusts such as Newham for specific information.

12.4.7 Counselling

The Pastoral care team provide a counselling service that is generic and not specifically related to solely spiritual care (as specified above). As such they become involved proactively within maternity settings for baby deaths as well as Intensive Care and general ward patients.

The Bereavement service currently constitutes 3 administrative staff who cover cross site services and have support from other staff trained the administration of death certification and provision of information for relatives concerning registration.

There is a Registrar based at Queen's Hospital affiliated with the service.

In addition, the Maternity service has two part-time Counsellors who work with women and their families following events such as a still birth. These staff could be used within the Maternity service for a wider role during the Pandemic if this is necessary.

13 Reporting Lines

Regular updates are provided to PEQ which constitutes the Trust's Executive Board by both the Director of Delivery. The Trust Board are also fully on board with Surge planning and will formally sign off this plan at its September meeting.

The Trust, as a first line responder, has a responsibility under the Civil Contingencies Act 2004 and is required to ensure that its Emergency Plans are maintained and up to date. To this end the Trust has produced Service Continuity Plans which will ensure that its core services are delivered during any emergency.

14 Triggers to Activate the Plan

As detailed within the Corporate Adult Bed Management Policy and the Escalation Policy.

15 Response Team Roles and Responsibilities

As detailed within the Corporate Adult Bed Management Policy and the Escalation Policy (Appendix 1)

16 Stand Down Phase and Recovery

As demand for services subsides the level of alert will be stood down through the stages of SIE status through to Green status in accordance with the Corporate Adult Bed Management Policy.

As part of the response it may have been necessary to cancel elective activity. As a result TCIs and outpatient clinics should be re-instated as soon as possible following the event. However, liaison with the Theatre Manager should be undertaken to establish if any theatres are to be out of general use as a result of the need to increase critical care capacity.

TCIs should be discussed with the General Managers and Clinicians, to ensure that re-instated patients can be accommodated on proposed theatre lists and where necessary, the availability of ITU and HDU beds.

The departmental BCPs identify critical and non critical services. During an event and the immediate aftermath, it is reasonable for non critical services to be temporarily stopped so that resources can be re-allocated to the more critical areas. However these functions cannot be suspended indefinitely and any suspension will have consequences during the recovery phase.

Services should be discontinued in a priority order with the most important business service being discontinued last. The recovery order will, in the main, be a reversal of the Service Priority order.

The departmental BCPs highlight the most and least critical functions for each area.

17 Audit and Review Process

With any incident or event that requires the Capacity Surge Plan to be enacted there will be a requirement for post event enquiry, (whether public or private). It is imperative that comprehensive notes are made to ensure that a record is kept of:

- Actions taken;
- Decisions made;
- Events that occurred;

A complete audit trail of all decisions made/actions taken (meeting minutes, correspondence copies etc) should be kept which should focus on the three areas above. All paperwork generated from the activities should be held centrally and once complete passed to the Safety and Emergency Planning Manager.

18 Debrief

When the organisation/department has recovered and all areas returned to normality, a debrief should be held by Director of Delivery for the Capacity Surge effort.

The Debrief should focus on:

- Which areas went well;
- Which areas could be improved and how they could be improved;
- Lessons learnt.

18.2 Review

This plan will be reviewed on an annual basis or every time a significant change has occurred within the Divisions necessitating a substantial change to the plan. The plan will be reviewed and signed off by the PEQ board.

19 Appendices

19.1 Appendix 1 Trust's inpatient capacity

2011.12 BHRUT bed requirement.xlsx

19.2 Appendix 2 BHRUT Bed Policy and Action Cards

Bed Management Policy - 041209.pdf

BEDS - Green Action Cards.pdf

BEDS - Amber Action Cards.pdf

BEDS - Red Action Cards.pdf

BEDS - SIE Action Cards.pdf

19.4 Appendix 3 Management structure

BHRUT\Corporate Structure April 2011.p

19.5 Appendix 4 LAS/NHS London pressure Surge Plan

2011.12 Emergency Department Capacity

NHS London Pressure Surge Mana

19.6 Appendix 5 HR Policies

policyannualandsickmedical.pdf

policyannualleave.pdf

policydisciplinary.pdf

policyflex.pdf

19.7 Appendix 6 Communications Out of Hours and Dealing with Press Enquiries

smocpress.pdf

protocolcommsoncall.pdf

19.8 Appendix 7 Infection Control Policies

STANDARD ISOLATION PRECAUTI

Priority List For Isolation for patients

Precautions - Priority List for Isolation in Pa

Precautions - Priority List for Isolation in IT

precautions - priority list for isolation.doc

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Maternity Update – September 2011	Trust Board
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
The purpose of this report is to provide the Trust Board with an update on the monthly performance for maternity services. The key areas to note are: • Following CQC visit in September a plan has been agreed with ONEL to cap the number of daily deliveries on both sites at BHRUT from 29th September. At Queen's the rate is capped at 20 births per day and at KGH at 7 births per day. Overall the escalation process is well implemented and in general it is acknowledged that this system works better at BHRUT than other trusts. • Activity had been variable during September and the escalation process was initiated 9 times before the capping of births action plan was implemented. • Average of 81% women were seen by a midwife in triage within 15 minutes in September which is almost the same as for August (82%) • 74% women in September were seen by a doctor in the OAU within an hour as compared to 71% seen within the hour. • Time taken to be seen in OOH OAU was not well documented especially in the last week of September due to the escalation process applied that resulted in a lot of administration time take to divert and record diverted activity. • LSCS performance for the timeliness to perform emergency LSCS was 74%. This is a much improved performance as compared to previous months.	□ **PBE** …….. □ **STRATEGY**…….. □ **FINANCE** …… □ **AUDIT** …… □ **QUALITY & STRATEGY** ……..…… □ **CHARITABLE FUNDS** ……..… □ **TRUST BOARD** …….. □ **REMUNERATION** …….. □ **OTHER** …….. (please specify)
2. DECISION REQUIRED:	**CATEGORY:**
The Board are asked to note the content of the report.	□ **NATIONAL TARGET** □ **RMS** □ **CQC REGISTRATION** □ **HEALTH & SAFETY** □ **ASSURANCE FRAMEWORK** □ **CQUIN/TARGET FROM COMMISSIONERS** □ **CORPORATE OBJECTIVE** …….. □ **OTHER** …….. (please specify)
	AUTHOR/PRESENTER: A Khan **Presenter: D Wheeler**
	DATE: 19th October 2011

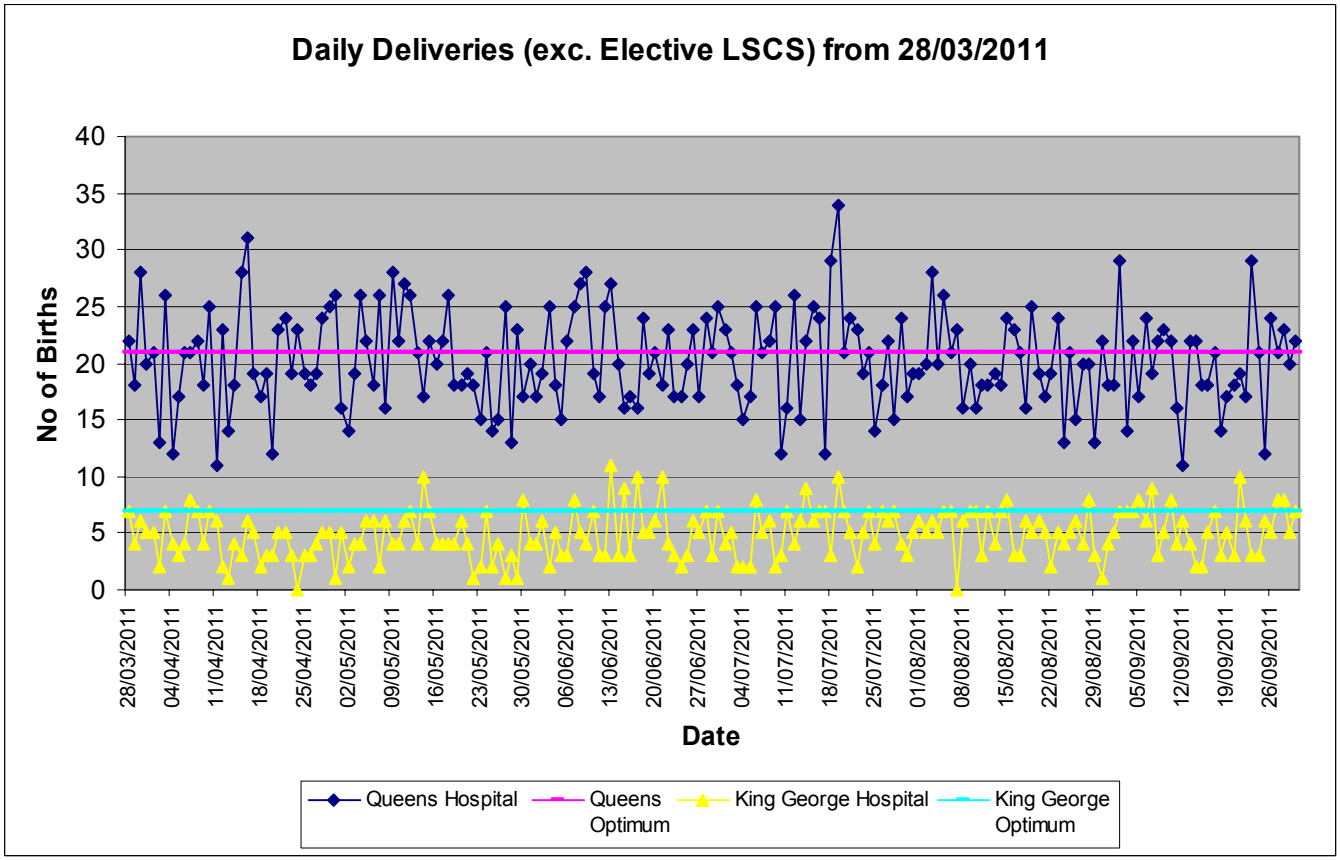
3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
N/A	
4. DELIVERABLES	
Maternity Improvement plan.	
5. KEY PERFORMANCE INDICATORS	
98% of women seen within 15 minutes of arrival within Triage 98% of women seen within an hour of referral to an obstetrician within the obstetric assessment unit. All emergency LSCS performed within the graded time allocated.	
AGREED AT _____ MEETING **OR** **REFERRED TO: _____**	**DATE: _____** **DATE: _____**
REVIEW DATE (if applicable) _____	

Maternity Services Monthly Performance Report

Aim

The purpose of this report is to summarise the progress made in the month of September against the maternity service improvement plan and the KPIs agreed with the commissioning team within ONEL.

1.0 Daily Activity (excluding elective LSCS)



2.0 Escalations

Following the maternity improvement plan and the CQC visit last week a plan has been agreed with ONEL to cap the number of daily deliveries on both sites from Thursday 29th September. At Queens the rate is capped at 20 births per day and at KGH at 7 births per day. When deliveries reach 15 at Queen's and 5 at KGH the units will be on RED and will start diverting women first to KGH if the woman is low risk and then if the limit is reached at KGH, to units in the surrounding area.

As a result of this plan and to ensure there is a robust audit trail of data, the escalation plan has been updated and daily activity sheets have been implemented

September 2011	Red days	Amber Days	Green Days	Escalations
	7	8	15	7

Site	Date	Status	Time From	Time To	Diverts in Place	Diverts to	Reason for Escalation	Mitigation
KGH	02/09/2011	Amber	12.30	15.30	no	n/a	Labour bed capacity - KGH only had one bed available	All women referred to Queens during this period
QH	06/09/2011	Amber	4.00	6.00	no	n/a	Reduced labour ward capacity due to number of delivered women and postnatal bed availability	Delivered women were moved to non labour beds and postnatal capacity was made on the antenatal ward.
KGH	09/09/2011	Amber	12.30	3.30	no	n/a	Labour bed capacity - KGH had no delivery bed available for a short period of time.	Delivered women were moved to non labour beds to ensure labour bed capacity.
KGH	18/09/2011	Amber	10:00	16:00	no	n/a	Staffing issues	Agency staff recruited to cover vacant shifts - then returned to Green Status
KGH	21/09/2011	Red			no	n/a	Labour bed capacity - KGH had no delivery bed available for a short time.	Delivered women were moved to non labour beds to ensure labour bed capacity. Oncall maternity manager contacted
QH	22/09/2011	Amber	8.00	11.30	Yes	KGH	No beds on the LW and there were 4 deliveries in quick succession. Waiting for transfer of women to PN	All low risk women diverted to KGH as beds available there. No patients were actually diverted to KGH
QH	23/09/2011	Amber	8.00	12.00	Yes	KGH	No beds available on the labour ward	All low risk women diverted to KGH as beds available there. No patients were eventually diverted to KGH - no adverse outcomes
KGH	26/09/2011	RED	08:20	09:15	No	N/A	Bed capacity	Via triage as per trust policy
KGH	28/09/2011	AMBER	09:15	01:30	No	N/A	Bed capacity	Via triage as per trust policy
KGH	29/09/2011	RED	02:30	20:15	Yes	ONEL providers	As per capping agreed with ONEL	Part of the assurance framework agreed with ONEL
QH	30/09/2011	RED	07.05	12.00	Yes	ONEL providers	As per capping agreed with ONEL	Part of the assurance framework agreed with ONEL
KGH	30/09/2011	RED	09:30	11:00	Yes	ONEL providers	As per capping agreed with ONEL	Part of the assurance framework agreed with ONEL
QH	01/10/2011	RED	22.45	12.00	Yes	ONEL providers	As per capping agreed with ONEL	Part of the assurance framework agreed with ONEL
KGH	01/10/2011	RED	08:00	22:15	Yes	ONEL providers	As per capping agreed with ONEL	Part of the assurance framework agreed with ONEL

3.0 Triage

The agreed standard is that 98% of women will be seen by a midwife within 15 minutes of arrival at triage.

Graph 3.1

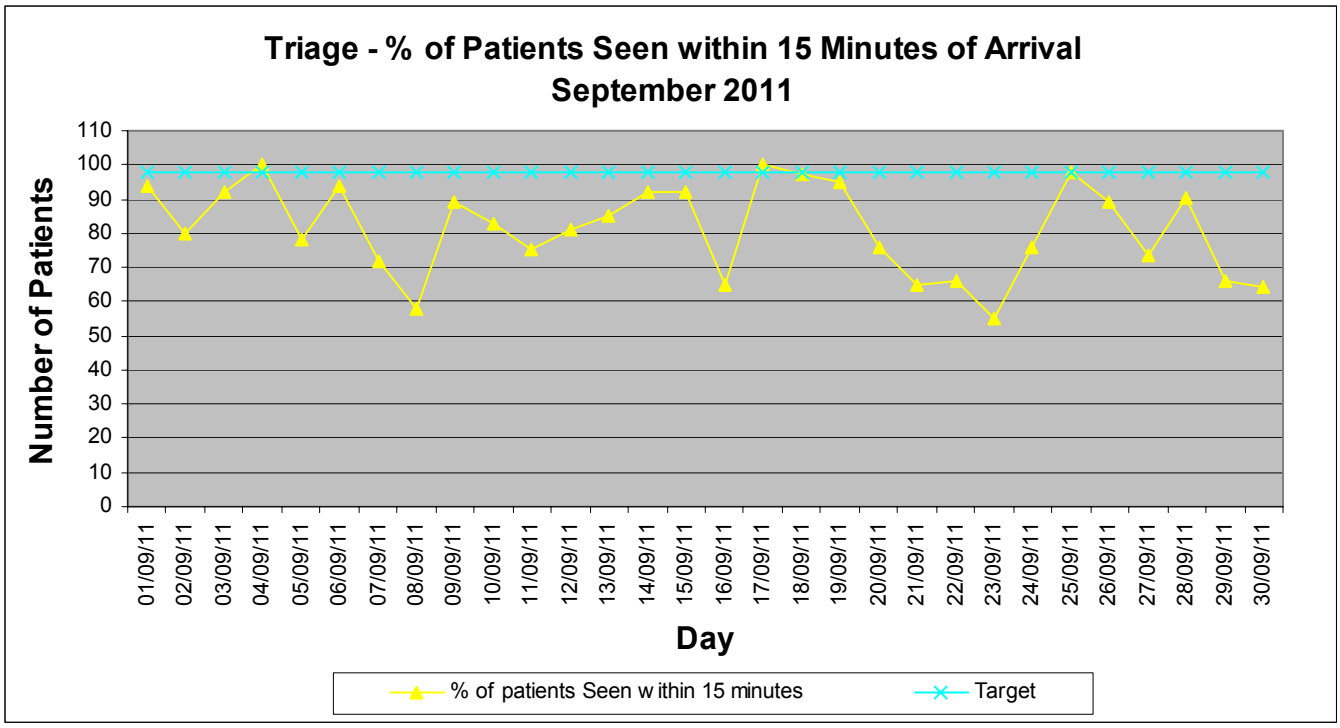


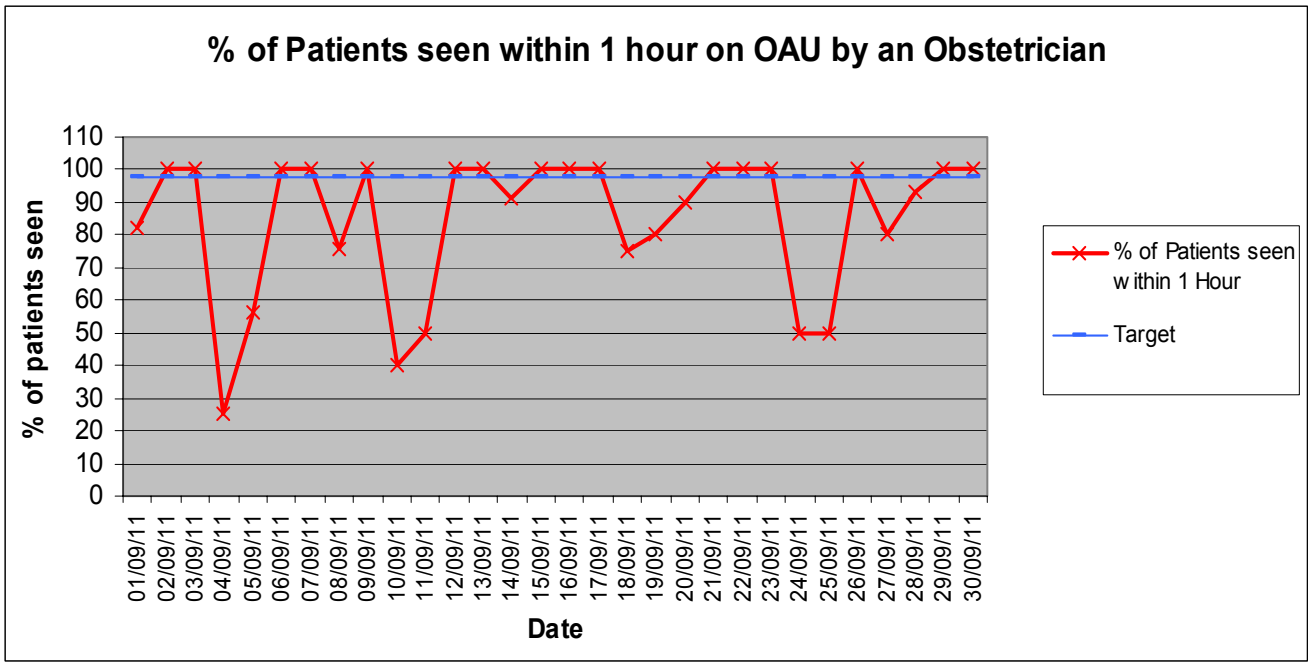
Table 3.1

Issue identified	Action to be taken
Multiple attendances at one time and both triage rooms in use. Staffing capacity to deal with peaks.	New Matron for Labour Ward commenced at the end of August and will be reviewing capacity vs demand for triage. As part of the plan a realistic assessment will be made in terms of the feasibility of the 98% target and clarity on the risks associated with longer waits and their mitigation.
One woman waited over 1 hr 25 mins. Although unit was busy there is no reason documented as to why she waited this long. The rest of the women arrived at times of high activity.	Labour Ward Matron is implementing plan to ensure flow is kept going during times of high activity. OAU and triage staff now rostered as one team so there is a seamless flexibility to move staff to the area most busy and to ensure rapid flow from triage to OAU.
There were some issues with non-	Staff have been made aware of the process for

recording of when women were seen week commencing 26/09/11 within triage. There is no clear reason documented for the woman delayed for 1 hour 40 mins. Other breaches of the 15 min assessment time were at times of high activity.	escalating breaches.

4.0 OAU Activity

It has been agreed that 98% of women should be seen within 1 hour of arrival to the Obstetric Assessment Unit (OAU).



Issue identified	Action to be taken
The longest wait to see an obstetrician was 3 hours and 58 minutes. This was related to the difficulty with covering both Labour Ward and OAU with one obstetric team, which has continued to be an issue in this area during out of hours.	There was a clear plan to deploy a more junior member of the medical team to the OAU, who then liaised directly with the consultant to agree the appropriate management plan for the woman. There was no adverse clinical outcome as a result of this long wait.

5.0 Out of Hours OAU Activity

Graph 5.1

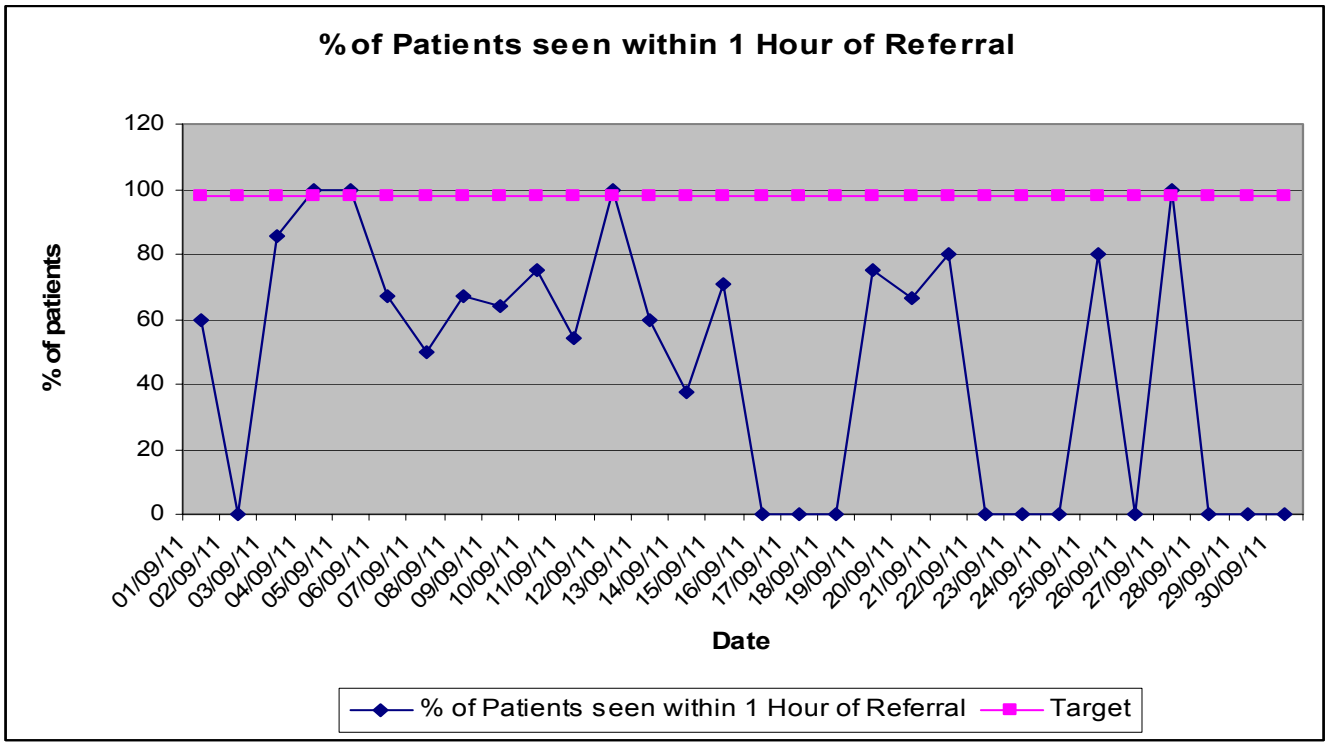


Table 5.1

Issue identified	Action to be taken
Poor documentation for out of hours obstetric assessment activity. It is extremely difficult to understand the activity type, decisions made and referrals. Ongoing constraints re consultant presence out of hours.	The new Labour Ward Matron is identifying staff to work in out of hours OAU, who will be appropriately briefed and able to accurately record essential activity through the unit. The expected date of completion has slipped from 30th September due to the recent instigation of the capping exercise at the trust. Workforce review for obstetrics is part of the maternity PMO and will be oversee by the clinical director and the divisional director.
Due to previous poor recording within this unit, unable to determine if referrals to obstetrician was not necessary or just not documented correctly	Action plan being developed by matron for area to include daily check of record keeping of activity. Reason for any delay to be clearly documented with actions taken to escalate breaches

6.0 Effective treatment and management of risk

Systems are in place to ensure women do not give birth outside of the labour ward environment. There were no inappropriate deliveries outside of the labour ward for the month of July.

6.1 Analgesia audit.

On a weekly basis, as part of visible leadership, an audit is undertaken to monitor the amount of time women are having to wait for their analgesia. The agreed standard is:

- If a woman requests pethidine she should receive this within 15 minutes of the request.
- If a woman request an epidural she should receive this within 30 minutes of request.

		Pethidine		
Week Commencing	**No of Requests**	**<15 mins**	**15-30 mins**	**>30 mins**
05/09/11	4	4	0	0
12/09/11	1	1	0	0
19/09/11	11	11	0	0
26/09/11	10	10	0	0
Total	**26**	**26**	**0**	**0**

		Epidural	
Week Commencing	**No of Requests**	**15-30 mins**	**>30 mins**
05/09/11	6	5	1
12/09/11	5	5	0
19/09/11	5	5	0
26/09/11	5	4	1
Total	**21**	**19**	**2**

6.2 Serious Untoward Incidents reported:

1. A mother suffered an intrapartum cardiac arrest and a perimortem caesarean section was performed. The patient was resuscitated and admitted to the Intensive Care Unit. Both mother and baby survived.
2. Incident related to a breach of confidentiality following the wrong baby notes being sent through the post to a mother, following her discharge home. The incident was bought to the Trust's attention by the family.
3. 3 SUIs related to unplanned admission of women to the ITU. 2 of these were due to a massive obstetric haemorrhage and 1 was suspected septic shock.
4. Unexpected admission to the Neonatal Intensive care unit 40+11 weeks ventilated transferred to Great Ormond Street Hospital (Date of incident 26/09/2011). No update on condition of baby.
5. Intrapartum stillbirth. Term baby. Significant care issues. Investigation in progress, parents have been kept informed and are fully involved in the investigation.

7.0 Caesarean Deliveries including elective activity

7.1 Emergency Caesarean Sections

When a decision is made to perform an emergency LSCS, the timing for this is dictated by the acuity of each case which is graded from 1-4.

Grade 1

Caesarean section is considered as urgent and has an immediate threat to the life of the woman and foetus. To be performed within 30 minutes.

Grade 2

Caesarean section is considered urgent with maternal or foetal compromise which is not immediately life threatening. To be performed within 30 minutes

Grade 3

Caesarean section is an emergency with no maternal or foetal compromise, but requires early delivery. To be performed within 75 minutes.

Grade 4

Caesarean section is classified as an elective caesarean at a time to suit the parents and the maternity teams.

Queens Hospital

Out of the 88 Emergency LSCS which were performed at Queens Hospital, a total of 83 sets (94%) of notes were audited by the consultant body. This is a much improved performance compared to last month when only 50% of the notes were audited

Grade 1: 30 out of the 34 (88%) Grade 1 Emergency LSCS met the target time of delivery within 30 minutes.
Grade 2: 24 out of the 31 (77%) Grade 2 Emergency LSCS met the target time of delivery within 30 minutes.
Grade 3: 8 out of the 14 (57%) Grade 3 Emergency LSCS met the target time of delivery within 30 minutes
Grade 4: 1 grade 4 was performed. No time scale was allocated.

King Georges Hospital

There were 14 emergency C sections at the KGH.100% of the notes were audited.

Grade 1: 100% hit the target time of delivery within 30 minutes
Grade 2: 100% hit the target time of delivery within 30 minutes
Grade 3: None recorded.

Top 3 reasons for delays like the previous month were:
1. Anaesthetist cover
2. Theatre capacity
3. Delayed consent (by mother)

Issue identified	Action to be taken
As above	The clinical director has been asked to discuss these delays with the consultant team and agree actions to minimise these delays.

Balanced Scorecard: **The balanced scorecard is attached as Appendix 1**

Attendance at the MDT Maternity Risk Management meeting was poor in September. The issue is being actively addressed with a complete review of the maternity governance systems. October meeting has already seen a much better attendance and participation by all teams.

Work continues with the review and updating of guidelines and pathways. Regular project group meetings are held to ensure work is progressed well to deliver on time. Good progress has been noted in October with 4 pathways /guidelines coming to the Maternity Risk Management Committee.

There were 7 SUIs during September. Details are included in the main body of the report.

There were 15 complaints in September. The overall theme is the same as in previous months i.e. staff attitude and lack of clear communication. An external company has been engaged to support the department develop a 'customer training programme'.

The ability of the team to perform emergency caesarean sections within the graded time during September was on average 74%, when combining all the grades.

As part of the action plan agreed with ONEL the trust will get 5 Supervisors of Midwives to support the trust in securing the 1 supervisor to 15 midwives ratio.

Workforce report

Recruitment

Currently in the recruitment processes are:

- 28 midwives
- 2 consultant midwife commenced one on 26th October and the other on 3rd October 2011
- 2 theatre nurses due to start, the band 5 in October and the band 7 in November
- The HDU lead commenced on the 10th October 2011

New starters in September

There were 5 midwives that started in September on the induction programme.
One of the midwives moved to the education department and became a clinical skills facilitator.

Adverts

Following the adverts and interview on 23rd September 2011, there were 2 band 7 co-ordinators appointed, one substantive and one on a six month contract with support to develop into this role. The advert for the HDU nurses is being completed and sent to VCP.

Leavers

There were 3 leavers this month:

- 1 Irish midwife left as she wanted to return to her own country.
- 1 due to high workload and pressure
- 1 who did not complete the induction programme and was unhappy from commencement with the trust

Maintaining the 1:29 midwife to birth ratio

Within the wards the staffing is done on a monthly basis and temporary staff are booked for the vacant shifts. Every day this is reviewed and amended. As a temporary measure and to reduce the clinical risk we have line bookings with agencies, as this allows the midwives to take ownership and responsibility for working within the trust. We are continually reviewing the line booking to ensure a good level of service.

% of bank and agency

The % of bank and agency currently used within this month is:

- 6% agency
- 7% bank
-

Medical recruitment

1 consultant is due to start on 1.11.2011

Vacancies

We are fully established with junior doctors and have no vacancies

Appendix 1

Barking, Havering and Redbridge University Hospitals NHS Trust		Target			Q4 10/11			Q1 11/12			Q2 11/12			Q3 11/12			Q4 11/12		
		On Target	Of Concern	Action Required	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Organisation	MSLC Meeting MDT Attendance	80%	79.99% - 50.01%	50%	60%	Not held	50%	Not held	Not held	80%	Not held	Not held	Not held						
	Maternity Risk management meeting MDT Attendance	80%	79.99% 50.01%	50%	55.30%	20%	18%	18%	21%	80%	80%	75.00%	31.57%						
	Serious Incident group - MDT Attendance	80%	79.99% - 50.01%	50%	55-66%			66%	81%	42%	66%	22.80%	44.52%						
	Labour Ward Forum - MDT Attendance	80%	79.99% - 50.01%	50%		70%	70%	50%	50%	50%	80%	80%	75%						
	Number of guidelines over due for review	5		10	41	41	41	41	41	28	23	11	11						
	Moderate Untoward Incidents	4			1	2	2	2	2	1	0	2	1						
	SUIs	0	1	2	4	1	2 +1	3	3	3	10	5	7						
	Improved patient satisfaction								NR	NR	NR	NR	NR						
	Complaints	<4/mnth	N/A	>6/mnth	17 + 3 pals	8+2 Pals	17	14	14	17	16	11	15						
Activity	Births Benchmarked to 9800 for 10/11	817	818 - 899	900	813	762	821	777	830	840	843	832	820						
	Births in acute Queens LW setting target for Q3 11/12	<720	721 - 800	>800	667	623	684	647	695	664	676	677	654						
	Births taking place at KGH	<208	209 - 250	>250	129	123	133	116	135	154	167	155	166						
	Midwife led births -	TBC	TBC	TBC					NR	NR	NR	NR	NR						
	Homebirths	3%	2%- 2.9%	<2%	2%	2.80%	0.85%	1.80%	1%	0.20%	1.67%	0.84%	1.20%						
	No: of women booked - in total (WXH)				1102	1077	1166	1025	1191 (69)	1148	970 (89)	1068	989						
	No: of women booked before 12 weeks and 6 days	90%	89.99% - 75.01%	<75%		89%	76%	77%	78%	79.00%	80%	78%	75%						
	No: in utero transfers				0	0	0	0	0	0	0	0	0						
	No: ex utero transfers				0	0	0	0	0	0	0	0	0						
	% of normal births	>60%	59.99% - 40.01%	<40%	65%	61.50%	60.10%	62.40%	58%	61%	64.50%	63.80%	66%						
	%instrumental vaginal births	12%	12.01% - 14.99%	15%	12.70%	12.00%	11.30%	13.20%	16%	11.10%	11%	13.50%	11.50%						
	Total % C section (planned and unplanned)	<22.5%	23% - 25%	<25%	22.30%	26.5%	27%	23.90%	26%	26.00%	24.30%	21.80%	21.70%						
	Emergecny LSC undertaken within graded time	100%	95%	90%	NR	NR	NR	NR	NR	NR	53%	91%	74%						
	% of Spontaneous Vaginal delivery with episiotomy								6%	2%	4%								
	% of women who receive pharmocological pain releif within 30 minutes	100%			NR	NR	NR	NR	NR	NR	NR	77%	98%						
	% Induction of labour				14.90%	14.96%	15%	16.85%	18%	15%	17%	21.80%	15%						
	% of women seen within 1 hour for a medical opinion in obstetric assessment unit.	>98%	97.99%- 75%	<74.99%	NR	NR	NR	NR	NR	39%	88%	91%	92%						
	% of women seen within 15 minutes of arrival within triage	>98%	97.99% - 75%	<74.99%	NR	NR	NR	NR	NR	63%	82%	82%	81%						
	Implementation of escalation process							0	2	2	5	5	9						
Workforce	weekly hours of consultant presence	98 hrs Q 40 hrs K		<98 hrs Q <40 hrs K	98 hrs Q 40 hrs K	98 hrs Q 40 hrs K	98 hrs Q 40 hrs K	98 hrs Q 40 hrs K	98hr Q 40hr K	98hr Q 40hr K	98hr Q 40hr K	98hr Q 40hr K	98hr Q 40hr K						
	Midwife to birth ratio - funded	01:29	1:30 - 1:32	01:33	01:29.6	01:29.6	01:29.6	01:29.6	01:29	01:29	01:29	01:29	01:29						
	Number of midwifery vacancies (excl B&A usage)	<3%	4% - 7%	>8%	16%	16%	19%	19%	19%	17%	16.30%	16.42%	16.25%						
	Staff sickness	<3.5%	3.6% - 4.9%	>5%	8.76%	6.87%	6.53%	4.29%	5.50%	4.85%	5.43%	5.92	5.70%						
	Supervisor to midwife ratio	01:15	15.01 - 19.99	01:20	01:27	01:24	01:24	01:24	01:24	01:24	01:24	01:22	01:22						
	1:1 care	>95%	95% - 75.01%	<75%		89%	92% Q 100% KG	94% Q 100% KG	92%Q 100%	95% Q 100%	97% Q 100% KG	98% Q 100% KG	98% Q 100% KG						
	Attendance at Training - mandatory.	>80%	79.99% - 75.01%	<75%					under review	under review	under review	under review	under review						
	No: of midwives up to date with CTG training.								65%	65%	65%		75%						
	No of Doctors trained in CTG iinterpretation	100%							100%	100%	100%		100%						
Maternal Morbidty	Eclampsia	0	N/A	1		0	0	0	0	0	0	0	0						
	ITU Admissions for obstetrics	1	N/A	2	2	0	0	0	1	2	2	2	2						
	Major Postpartum haemorrhage (2000) (4,000)	0	N/A	1	3	(2) (1)	0	2(4)	3 (1)	1	0	0	1						
	Postpartum hysterectomy	0	N/A	1	0	0	0	0	1	0	0	0	0						
Neonatal morbidity	Meconium aspiration	1	N/A	2	4	2	2		1	3	2	3	2						
	Cases of HIE Grade 2 and 3	0	N/A	1	0	0	0		0	2	0	0	0						
	Unplanned admission to NICU at term longer than 24 hours requiring ventilation	1	N/A	2	14	8	11	11	12	0	3	3	0						
Mortality	Maternal deaths	0	N/A	1	1	0	0	1	0	0	1	0	0						
	Number of Intrapartum stillbirths	0	N/A	1	0-1NND	0	1	1	0	0	1	1	0-1 NND						
	Number of inuterine deaths over 24 weeks	3	4	5	5	7	5	8	6	5	5+ 1 feto	0	3						
Risk Monitoring	failed instrumental	0	N/A	1					1	0	0	0	2						
	Shoulder dystocia with brachial plexus damage	0	N/A	1	0 (5SD)	0(7 SD)	0(10)	0(14)	0	0	0	0	13						
	3rd/4th degree tears	1.50%	1.51% - 2.49	2.50%	1.10%	1.70%	1.09%	2.31%	1.60%	2.20%	1.30%	1.44%	1.68%						
	No of women delivering iunavoidabley outised the LW environment	0	1	2				0	0	0	0	0	0						
	resuscitaire audits	>75%	74.99%- 70.01%	<70%		89%	96.55%	100%	100%	100%	100%	98.5% Q 100% KGH	100% Q 100% KGH						

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Quality & Safety Committee (QSC) Escalation Report	Trust Board (Part I)
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
The QSC members feel that the latest Dr Foster statistics should be escalated to Trust Board as it demonstrates the improvements that are continuing to be made. The re-based position at the end of July showed the Trust as an outlier with the HSMR of 105; an improvement on the March re-based figure of 108.5, and a significant improvement on the November 2010 position of 115. A report on the new data to be released will be included in the Trust Board agenda to provide information on the data that will shortly be published.	□ **TEC** ……..….. □ **STRATEGY**……..…… □ **FINANCE** ……..…… □ **AUDIT** ……..…… **X QUALITY & SAFETY** ……**25.10.11**…….…….. □ **WORKFORCE** ……..… □ **CHARITABLE FUNDS** ……..… □ **TRUST BOARD** ……..… □ **REMUNERATION** ……..….. □ **OTHER** ……..…… (please specify)
2. DECISION REQUIRED:	**CATEGORY:**
The Board is asked to note the improvement.	□ **NATIONAL TARGET** □ **RMS** □ **CQC REGISTRATION** □ **HEALTH & SAFETY** □ **ASSURANCE FRAMEWORK** □ **CQUIN/TARGET FROM COMMISSIONERS** □ **CORPORATE OBJECTIVE** ……..….. □ **OTHER** …….. (please specify)
	AUTHOR/PRESENTER: Mr Edwin Doyle, QSC Chair
	DATE: 10 October 2010
3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
N/A	
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

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Finance Report – Month Six (September) 2011/12	**Trust Board**

1. KEY ISSUES:

- The **YTD I&E** position at M06 is a **£32.9m deficit**, before £5.3m impairment reversals and £27.6m after. Against plan to date the **adverse variance** is **£5.7m**. The Key variances to date being:
  - **Income** is **£8.2m** favourable net of (£1.0m) adverse variance in Divisional income. It should be noted however that the favourable income variance to date is partly driven by the relatively low income plan for August, which generates c.£3.3m of the variance.
  - **Pay** is **(£10.8m)** adverse. This is primarily across W&Cs, Surgery and to a lesser degree Medicine and a relatively small adverse position in CDT and unallocated CIP. Temporary staffing spend is £3.3m in month, down against recent months and YTD average but partially offset by the increased substantive staff spend to achieve this.
  - **Non Pay** is **(£2.6m)** adverse, with the main variances coming from other non-pay (£2.3m), including bad debt provisions (£0.7m), PFI (£0.4m) and outsourcing (£0.3m).
- The I&E position for **Month of September** was **£4.3m deficit**, with a **£3.0m adverse variance** against budget, primarily driven by pay (£2.6m) adverse and non-pay (£0.6m) adverse, with a marginal over-performance of £0.2m on income.
- **CIP** – **£14.7m forecast shortfall** in CIP against the £28m plan, of which £3.7m represents red-rated schemes and a further 3.3m unidentified schemes.
- The opening FOT at M6 is a £58.7m deficit, excluding impairments, but before mitigating actions, a shortfall of £17.7m from control total and which represents a deterioration of £0.9m from last month's FOT. Potential mitigation against this of £11.2m has been identified, although £3.2m of this is assessed as high risk (i.e. £8m net mitigation likely), giving a net forecast deficit of £50.7m.
- The Trust has been largely successful in Q1 arbitration with the ONEL PCTs (see Section 2.), although following this, the Trust has agreed to modify its income forecast, primarily with respect to non-elective activity and maternity (the latter linked to CQC restrictions), the net result of which worsens the **bottom line forecast** by £0.5m, to **£51.2m**.
- After taking account of IFRS impact of £1.2m, the headline forecast agreed with NHS London and the Department of Health is a **deficit of £50m**, against a control total (excluding IFRS) of £39.8, a **shortfall of £11.2m**.

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:

2. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:

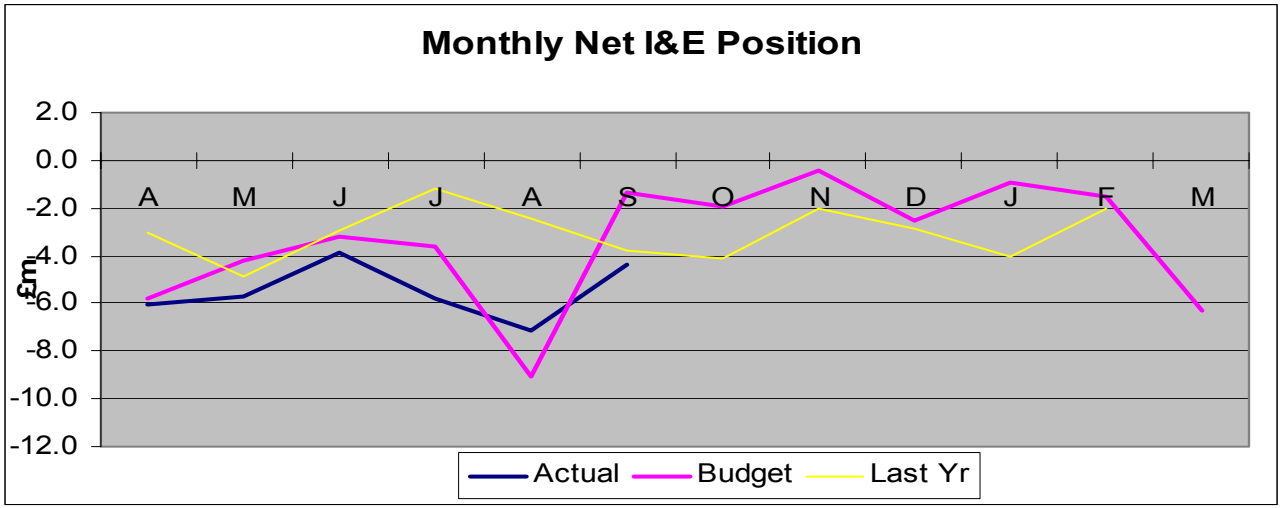
Set out under key issues

3. ALTERNATIVES CONSIDERED/REASONS FOR REJECTION:

N/A

4. DELIVERABLES:	
N/A	
5. EVIDENCE :	
N/A	
6. RECOMMENDATION/ACTION REQUIRED:	
AGREED AT _____ MEETING, OR **REFERRED TO: _____**	**DATE: _____** **DATE: _____**
REVIEW DATE _____ **(if applicable)**	

1. EXECUTIVE SUMMARY



Trust Income & Expenditure

In Month Actual	In Month Var		Year to date Actual	Year to date Var	Annual Budget	Forecast Actual	Forecast Var	2010/11 Actual
(33,949)	176	Income inc. Divisional	(198,584)	8,224	(396,491)	(405,412)	8,921	(407,107)
		PCT QIPP - NEL Demand Mgt & Maternity				4,200	(4,200)	
		Expenditure						
24,012	(2,619)	- Pay	144,367	(10,801)	270,420	290,534	(20,114)	281,042
10,911	(611)	- Non-pay	66,699	(3,125)	125,908	132,641	(6,733)	123,346
		PCT QUIPP related Marginal Cost Reduction. (£2.6m NEL / £1m Mat)				(3,600)	3,600	
		Mitigation				(11,200)	11,200	
974	**(3,054)**	**EBITDA**	**12,482**	**(5,701)**	**(163)**	**7,163**	**(7,326)**	**(2,719)**
		ITDA						
1,176	(14)	- Depreciation	7,003	(12)	14,176	14,065	111	13,120
324	6	- Capital Dividends	1,943	34	3,955	3,887	68	3,368
1,867	42	- Net Interest	11,488	10	22,997	22,973	24	20,337
4,342	**(3,021)**	**Net position**	**32,917**	**(5,668)**	**40,965**	**48,088**	**(7,123)**	**34,106**
		Impairments	(5,318)		(5,318)	(5,318)		(8,670)
4,342	**(3,021)**	**Net position**	**27,599**	**(5,668)**	**35,647**	**42,770**	**(7,123)**	**25,436**
	(367)	Memorandum Control Adj for PCT QIPP		(2,200)	(4,400)		(4,400)	
4,342	**(3,387)**	**Net position**	**27,599**	**(7,868)**	**31,247**	**42,770**	**(11,523)**	

Divisional Performance

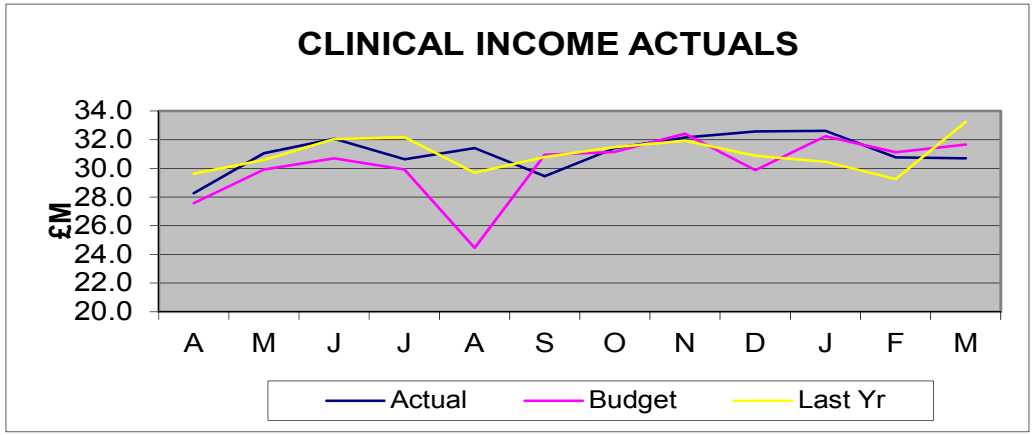
In Month Actual	In Month Var		Year to date Actual	Year to date Var	Annual Budget	Forecast Actual	Forecast Var	2010/11 Actual
(30,990)	(133)	**Central Income**	(182,812)	8,959	(363,377)	(373,041)	9,664	(372,099)
		PCT QIPP - NEL Demand Mgt & Maternity				4,200	(4,200)	
		Clinical Divisions:						
6,048	(619)	- Medical	36,755	(3,074)	68,343	74,905	(6,562)	70,609
8,041	(647)	- Surgical	48,520	(2,446)	90,229	96,033	(5,803)	95,382
4,296	(605)	- Women & Children	26,008	(3,546)	44,474	50,786	(6,312)	46,300
6,796	(373)	- CDT	42,123	(1,338)	78,679	82,595	(3,915)	83,646
6,944	(193)	- Corporate	41,169	(2,207)	77,768	80,083	(2,315)	76,177
32,125	**(2,436)**	**- Sub-total Divisions**	**194,574**	**(12,611)**	**359,493**	**384,401**	**(24,908)**	**372,114**
		PCT QUIPP related Marginal Cost Reduction. (£2.6m NEL / £1m Mat)				(3,600)	3,600	
		Mitigation				(11,200)	11,200	
32,125	**(2,436)**	**- Rev Sub-total Divisions**	**194,574**	**(12,611)**	**359,493**	**369,601**	**(10,108)**	**372,114**
(153)	(535)	Finance adjmts	764	(1,359)	(2,657)	551	(3,207)	(2,019)
	50	Reserves		(689)	6,473	5,944	529	
1,168	(14)	Depreciation	7,003	(12)	14,081	13,974	108	13,025
2,191	47	Non-operating	13,431	45	26,952	26,860	92	23,085
4,342	**(3,021)**	**Total**	**32,962**	**(5,667)**	**40,965**	**48,088**	**(7,123)**	34,106
		Impairments	(5,318)		(5,318)	(5,318)		(8,670)
4,342	**(3,021)**	**Net position**	**27,644**	**(5,667)**	**35,647**	**42,770**	**(7,123)**	25,436
	(367)	Memorandum Control Adj for PCT QIPP		(2,200)	(4,400)		(4,400)	
4,342	**(3,387)**	**Net position**	**27,644**	**(7,867)**	31,247	**42,770**	**(11,523)**	

The following table summarises the forecast outturn position, taking in to account:

- The 'opening' forecast, following review of Divisional financial positions
- Potential and likely mitigation (details are set out in the CIP section 5.)
- Adjustments to the income forecast, taking in to revised assumptions following the outcome of arbitration on 19 October (see Section 2. for details)
- Exclusion of the technical impact of International Financial Reporting Standards (IFRS) on PFI costs (these are excluded from the the control total set by the SHA)

(£'000)	FCOT	Control	Variance
Forecast outturn deficit before mitigation, net of impairment reversal	53,369	35,647	-17,722
Impairment	5,318	5,318	0
Gross forecast deficit	58,687	40,965	-17,722
Mitigation (see Section 5. for detail)	-11,211		11,211
- less risk (25%)	2,804		-2,804
- PFI Hard FM AfC risk	400		-400
	50,680	40,965	-9,715
Adjustments to FCOT following arbitration (see Section 2. for detail)	536		-536
	51,216	40,965	-10,251
Less technical impact of IFRS	-1,228	-1,165	63
Forecast excluding IFRS impact	49,988	39,800	-10,188

2. CLINICAL INCOME



Income by POD

In Month			Year to date		Forecast	
Actual	Var		Actual	Var	Actual	Var
(1,438)	(339)	AandE	(9,557)	571	(20,041)	1,342
(1,526)	(427)	Critical Care	(12,126)	208	(23,903)	66
(4,357)	(92)	DC & EL	(26,142)	4,192	(52,285)	5,674
(10,604)	460	NEL	(66,180)	4,300	(139,634)	9,126
(810)	58	XBD	(4,933)	432	(10,350)	857
(1,275)	(159)	Direct Access	(7,777)	544	(15,424)	176
(2,572)	(389)	OP First Attendances	(15,309)	129	(30,654)	(1,153)
(2,996)	(182)	OP Follow Ups	(17,773)	1,364	(35,604)	1,320
(437)	(300)	OP Procedures	(2,619)	(1,368)	(5,238)	(2,983)
(3,459)	(484)	Other	(20,577)	(1,392)	(40,118)	(4,831)
(29,474)	**(1,853)**	**Total**	**(182,994)**	**8,979**	**(373,252)**	**9,595**

Divisional Performance

In Month			Year to date		Forecast	
Actual	Var		Actual	Var	Actual	Var
(3,014)	(214)	CDT	(18,200)	967	(36,490)	709
(8,604)	(406)	Medical	(54,537)	797	(113,959)	976
(11,592)	(511)	Surgical	(70,773)	2,339	(142,681)	(1,808)
(6,031)	(267)	Women & Children	(38,242)	1,970	(78,641)	3,343
(29,241)	**(1,399)**	**- Sub-total**	**(181,751)**	**6,073**	**(371,771)**	**3,220**
(233)	(454)	Corporate	(1,243)	(1,882)	(1,481)	(3,725)
0	841	PCT QIPP	0	4,788	0	10,100
(29,474)	**(1,852)**	**Net position**	**(182,994)**	**8,979**	**(373,252)**	**9,595**

Key points:

- There was an over-performance of £1.8m in month, increasing the year to date over-performance to £8.9m. The forecast outturn over-performance is £9.6m, against the annual contract Plan of £363m. Month 6 actuals are based on an extrapolation of the Month 5 actual billed data
- The majority of the over-performance to date continues to be generated by Non Elective activity, with over-performance of £0.4m in month, £4.3m year to date and a forecast outturn of £9.1m.
- It should be noted that Non Elective income lost, due to activity breaching the threshold above which the 30% marginal tariff is charged, is £3.5m year to date with a forecast of £7.8m for the full year.
- Outpatient income is now slightly over performing compared to last month's slight under performance
- A&E activity is over-performing by £0.6 (6.3%) year to date; the impact of the transfer of activity to the Queens UCC in M4 is currently being reviewed. UCC activity is currently being counted as A&E activity and as such contributes to the A&E over-performance.
- The year to date and forecast outturn position is net of £3.3m and £7.3m provisions respectively, in relation to anticipated PCT challenges or recording issues, for; radiotherapy non-elective threshold, ITU & obstetrics non-elective.
- The Divisional performance analysis table is compared with the original Trust plan (£371m), which is the basis on which the Divisional expenditure budgets have been set and is in line with capacity plans. The £10.1m QIPP/PCT demand management is shown on a separate line.
- All Divisions show over-performance to date, although the forecast assumes a tailing off of the Surgical Division over-performance, where a prudent assumption has been made that increased income target for ISTC activity later in the year will not be met.
- The shortfall in Corporate is primarily represented by the £4m Marketing target (£1.9m year to date)

The following table shows performance by POD, excluding the £10.1m PCT QIPP schemes:

In Month			Year to date		Forecast	
Actual	Var		Actual	Var	Actual	Var
(1,438)	(339)	AandE	(9,557)	571	(20,041)	1,342
(1,526)	(427)	Critical Care	(12,126)	208	(23,903)	66
(4,357)	(450)	DC & EL	(26,142)	2,005	(52,285)	1,061
(10,604)	34	NEL	(66,180)	1,699	(139,634)	3,639
(810)	58	XBD	(4,933)	432	(10,350)	857
(1,275)	(159)	Direct Access	(7,777)	544	(15,424)	176
(2,572)	(389)	OP First Attendances	(15,309)	129	(30,654)	(1,153)
(2,996)	(182)	OP Follow Ups	(17,773)	1,364	(35,604)	1,320
(437)	(300)	OP Procedures	(2,619)	(1,368)	(5,238)	(2,983)
(3,459)	(484)	Other	(20,577)	(1,392)	(40,118)	(4,832)
(29,474)	**(2,638)**	**Total**	**(182,994)**	**4,191**	**(373,252)**	**(507)**

Budget profiling

The original profile of the income plan assumed a significant reduction in elective activity during August, on the assumption that there would be a significant reduction in Theatre capacity (primarily for maintenance work). The actual reduction in elective activity & income in August did not occur to anywhere near the level anticipated and therefore the over-performance reported against profiled plan for August is somewhat misleading. A more appropriate profiling of the Plan is given below, with the elective plan profiled on an even-twelfths basis, which re-profiles £3.3m of the Plan in to the second half of the year;

Divisional Performance – Revised profile

	Year to date		Original
	Actual	Var	Var
Corporate	(1,243)	(1,882)	(1,882)
CDT	(18,200)	418	967
Medical	(54,537)	327	797
Surgical	(70,773)	453	2,339
Women & Children	(38,242)	1,549	1,970
Total	**(182,994)**	**866**	**4,191**

Income by POD – Revised profile

	Revised - YTD			Original
	Revised Budget	Actual	Var	Var
AandE	(8,986)	(9,557)	571	571
Critical Care	(11,918)	(12,126)	208	208
DC & EL	(26,416)	(26,142)	(274)	2,005
XBD	(4,501)	(4,933)	432	1,699
NEL	(61,880)	(66,180)	4,300	432
Direct Access	(7,624)	(7,777)	153	544
OP First Attendances	(15,904)	(15,309)	(594)	129
OP Follow Ups	(17,142)	(17,773)	631	1,364
OP Procedures	(2,416)	(2,619)	204	(1,368)
Other	(25,297)	(20,531)	(4,764)	(1,392)
Total	**(182,084)**	**(182,948)**	**866**	**4,191**

Arbitration

The Trust was notified of the outcome of Q1 arbitration by NHS London on 19 October, in relation to a number of areas under dispute with ONEL PCTs. The Trust was successful in all but one of the areas, as follows:

Issue	**£'000 Q1 value**	**Rationale for decision**
Found in favour of Trust:		
1. Re-admissions from ambulatory care	187	Original activity in ambulatory care deemed not to be an admission, therefore activity not seen as *re*-admitted activity
2. Non-PbR costs for related re-admissions	100	PCT missed deadline for challenge (however Panel agreed with principle, therefore risk of £0.3m for Qs 2-4)
3. Non-PbR costs for unrelated re-admissions	296	PCT missed deadline for challenge (however Panel agreed with principle, therefore risk of £1.0m for Qs 2-4). The Panel also found that the assumption agreed by ONEL and the Trust that a systematic 15% of re-admissions are unrelated is contra to PbR guidance and should be based on actual re-admissions, that are *clearly & unambiguously unrelated and material* and relates to a small *number of high cost re-admissions*. The Trust will need to undertake further work in collaboration with ONEL to agree this activity.
4. Day cases without a procedure	90	The Panel found against the ONEL view that day cases where no procedure has taken place cannot be coded as day cases: there are a wide range of day case HRGs with no procedure code. However, the Panel advised that the Trust must facilitate a transparent review of coding of this activity.
5. First to follow-up out-patients	117	KPI agreements on first to follow up out-patient ratios have not been agreed between the Trust and ONEL and also based on past precedent the Panel found in favour of the Trust.
6. Non-elective admissions – over-performance	2100	The Panel found no satisfactory reason or evidence why this activity should not be billed.
Total for Trust	**3,182**	96% of total value of issues
Found in favour of ONEL:		
Well babies	105	Trust change in coding practice notified towards end of 2010/11 – Commissioners require at least 6 months notice
Total of issues	**3,287**	

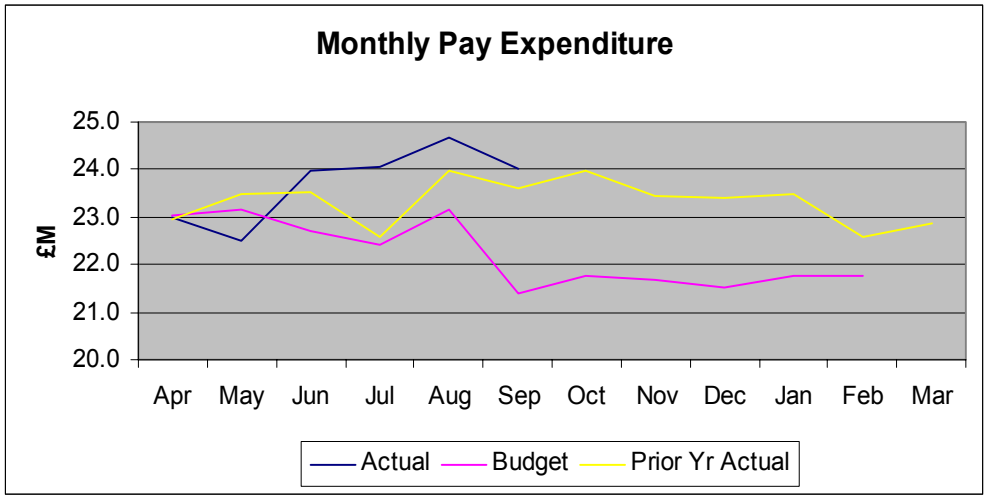
The Trust and ONEL were jointly levied an arbitration fee of £80k by the SHA, with £67k levied against ONEL, based on the proportion of issues lost (by number).

Following the arbitration decision, the Trust has agreed with ONEL to reflect the following income assumptions in its forecast, although this still falls £3.5m short of ONEL demand management assumptions:

(£'000)	Income	Cost reduction	
Phototherapy	177	0	
OP contract over-performance removed	905	300	Activity over-performance reduced to contract. Assumed 30% marginal cost reduction.
OP to day case	500	0	Price
NEL reduce over-performance to overall 3.4% growth	2145	2145	Activity. Assumption is that over-performance reduces to a level at 3.4% growth over 2010/11 & that income comes out at 30% tariff & expenditure at 30% marginal cost (against 100% tariff)
Unwell babies	420	0	Coding / price
Re-admissions nPbR costs	300	0	Price
Re-admissions - unrelated	1034	200	Price (assumes there will be £200k mitigation through either income or cost reduction)
	5481	**2645**	
Less reductions already provided for in original M6 position	-3400	0	
	2081	**2645**	
Reductions in maternity activity	**2100**	**1000**	Reduction in birth and caesarean activity following CQC inspection, enabling some reduction in agency midwife expenditure
	4,181	**3,645**	
Cost reduction	**(3,645)**		
Net impact on bottom line forecast (adverse)	**(536)**		

The Trust will not accept the income reductions in relation to activity, unless there is a real reduction in activity (otherwise PbR rules should apply).

3. PAY EXPENDITURE



Key points:

- Pay continued to overspend, £7.2m YTD, primarily medical staff (£3.3 m) and Nursing/Midwifery (£3.8m). This is additional to a £3.6m shortfall against unallocated CIP target and reserves (i.e. overall £10.8m overspending)
- The medical staff overspending primarily related to Surgical Division £1.4m of which £0.8m is CIP shortfall, Medicine £0.9m mostly CIP efficiency shortfall and agency staffing, Paediatrics £0.5m – agency, and Radiology £0.4m
- Whilst permanent staffing costs have increased, total Pay has reduced slightly against previous monthly average £0.06m. The net reduction is borne from a larger decrease in temporary staffing and specifically agency by £0.24m. However this does not appear to be from the 2 areas of mass recruitment A&E and Midwifery both of which continue to see increases against previous trend pay, albeit midwifery has seen a reduction against the previous 2 months.
- % of total pay for temporary staffing has therefore improved and is now at 13.6% in month and 14.4% YTD. Of this, agency is 5.8% and 6.7% respectively.

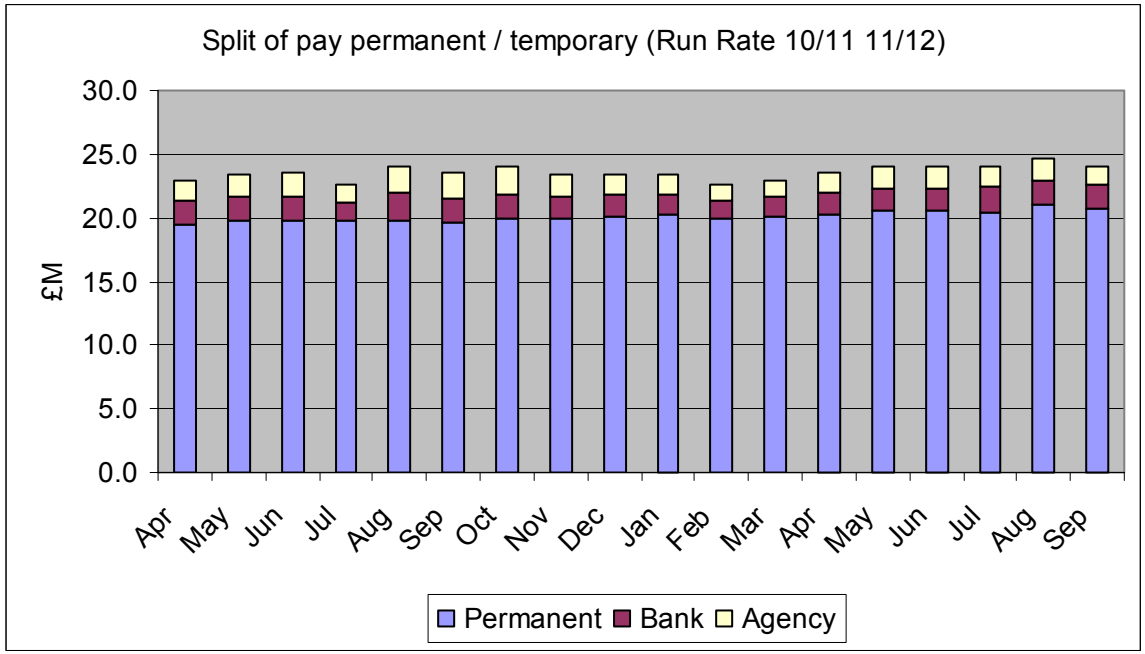
Expenditure By Pay Group

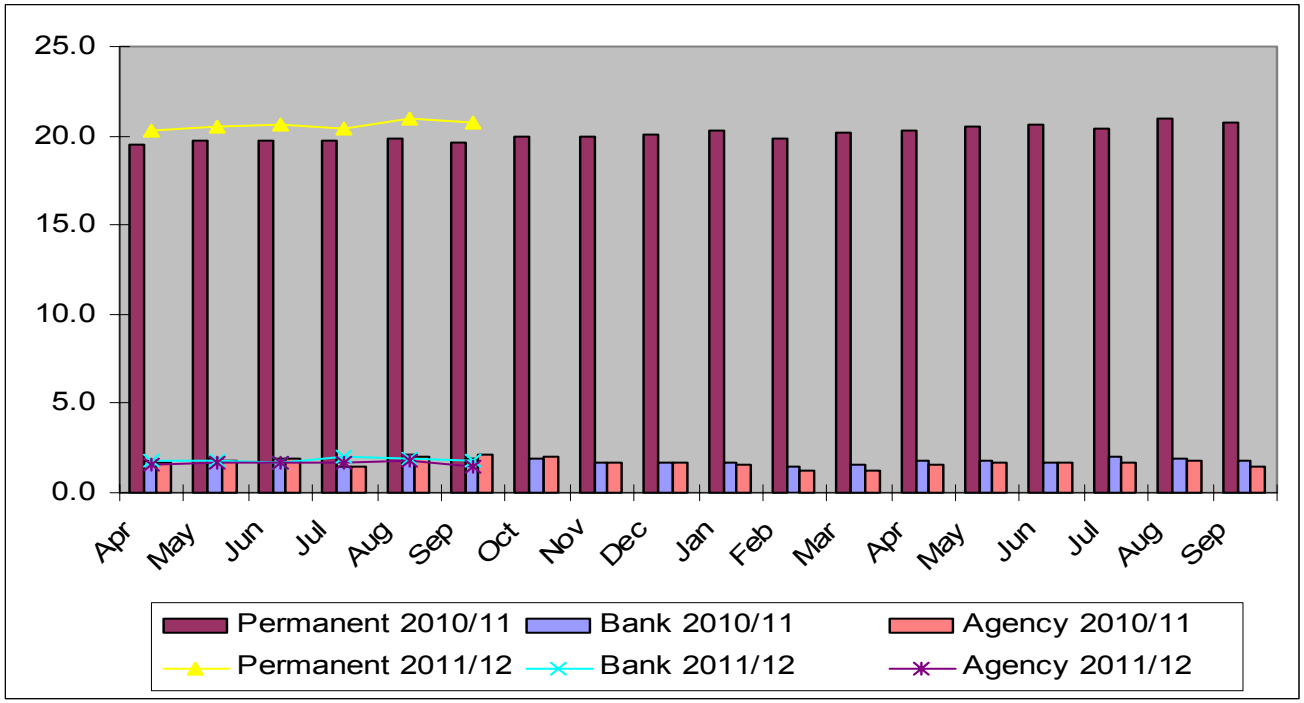
In Month (£'000)			Year to date (£'000)	
Actual	Var		Actual	Var
7,299	(783)	Medical	43,522	(3,337)
7,864	(582)	Nursing - Qualified	47,314	(2,634)
1,657	(182)	Nursing - Unqualified	10,119	(1,156)
3,286	28	ST&T	20,399	(178)
3,110	(62)	Management & Admibn	18,388	(32)
796	(1)	Ancillary	4,626	102
24,012	**(1,581)**	**Total**	**144,367**	**(7,236)**

Pay Expenditure by Division

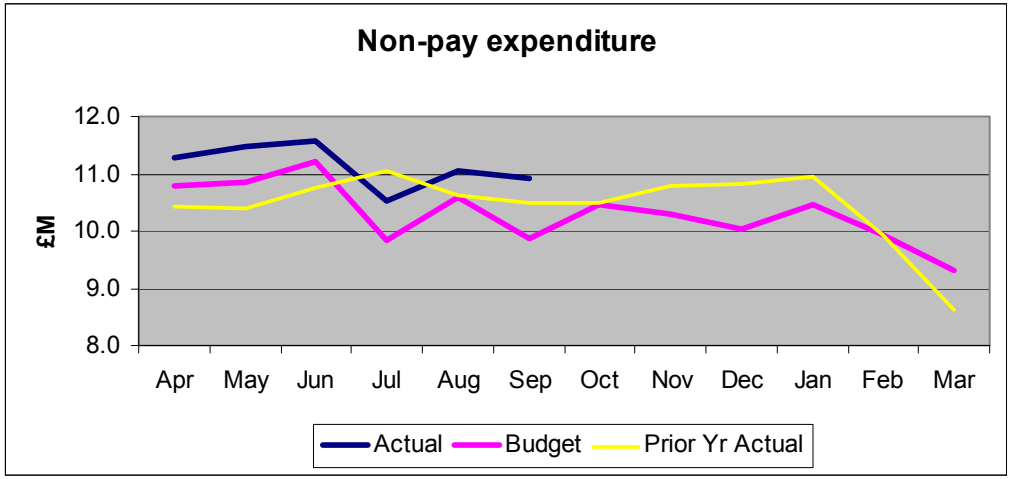
In Month (£'000)			Year to date (£'000)	
Actual	Var		Actual	Var
5,786	(266)	Medical	34,647	(1,445)
6,514	(555)	Surgical	39,284	(2,251)
3,938	(448)	Women & Children	23,486	(2,580)
5,311	(78)	CDT	32,240	(631)
21,550	**(1,348)**	**- Sub-total**	**129,657**	**(6,907)**
2,463	(233)	Corporate	14,709	(329)
24,012	**(1,581)**	**Net position**	**144,367**	**(7,236)**

PAY EXPENDITURE (Contd.)





4. NON-PAY EXPENDITURE



Key points:

- The overall non-pay overspending increasedby £1.0m, to £3.3m, from (£250k) on gas cost pressures, (£144k) on Drugs – largely within Pharmacy and Rheumatology.
- There was also (£0.4m) against Other non-pay, relating to CIP target shortfall, in relation to expected benefits from system generated accruals for purchasing and temporary staff booking systems, which have to be fully validated

YTD

- The most significant overspend YTD is on other non-pay (£2.3m), primarily on bad debt provisions (£680k), PFI (£434k), Outsourcing and external tests (£447k), Corporate consultancy fees (£223k) and (£140k) compromise agreements.
- Drugs (£262k) mostly Pharmacy, Rheumatology and CIP slippage
- General Supplies is mostly Patient Transport and to a lesser extent postage & carriage.
- Premises and Fixed Plant is mostly Computer Maintenance, Electricity and Photocopier rental.

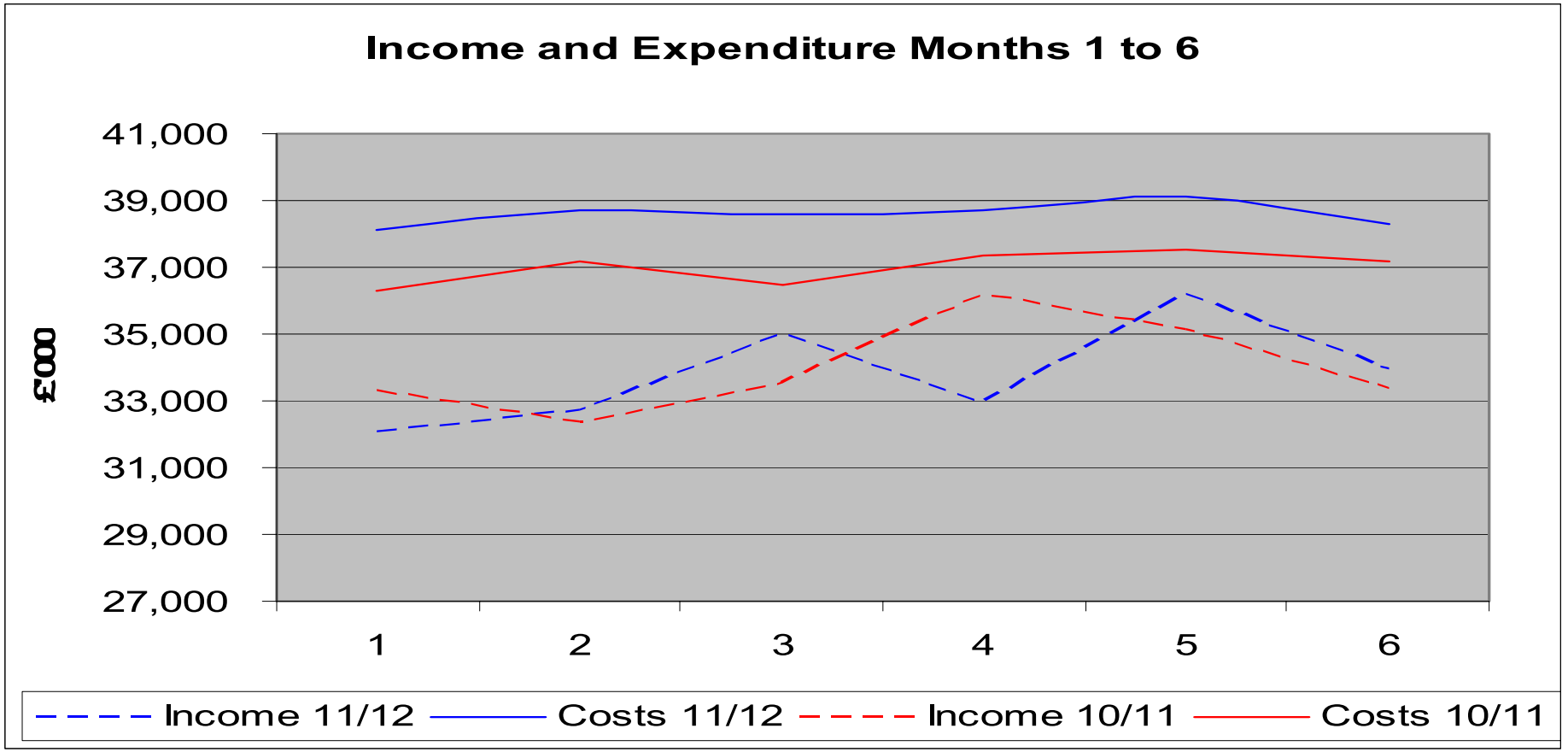
Expenditure By Non Pay Category

In Month (£'000)			Year to date (£'000)	
Actual	Var		Actual	Var
2,394	(144)	Drugs	14,747	(262)
2,406	118	Clinical supplies & services	15,361	(1)
1,406	2	General supplies & services	9,091	(163)
1,885	(446)	Premises & fixed plant	9,210	(560)
2,814	(554)	Other	18,293	(2,320)
		PFI		
10,904	**(1,024)**	**Total**	**66,702**	**(3,306)**

Non Pay Expenditure By Division

In Month (£'000)			Year to date (£'000)	
Actual	Var		Actual	Var
767	34	Medical	5,155	(121)
1,927	(30)	Surgical	11,562	197
623	(59)	Women & Children	4,021	(578)
2,150	(131)	CDT	13,557	(575)
5,467	**(187)**	**- Sub-total**	**34,295**	**(1,077)**
5,490	(472)	Corporate	31,238	(1,084)
(46)	(371)	Central Income & Finance Adj	1,167	(1,142)
10,911	**(1,030)**	**Net position**	**66,699**	**(3,303)**

Comparison to 2010/11



- The graph above compares the monthly profile of income and expenditure to Month 6 between this year 2011/12 and last year 2010/11.
- It can be seen that expenditure follows a fairly consistent pattern, with each month in 2011/12 c.£1.58m (4.3%) above 2010/11. The main drivers of this are increases in Nursing & Midwifery costs (+£0.70m/month, 7.9% - mainly driven by the FYE of increased ward establishments and midwifery numbers/agency) and non-pay (+£0.53m/month, 5.1% - partly driven by inflation, VAT FYE increase and specific cost pressures e.g. CNST)
- The income profile above is based on the reported *ledger* position, whereas the clinical income profile shown in section 2. reflects the costed actual *activity,* thereby adjusting for the in month income estimate normally applied

Reconciliation of Forecast Outturn

The table below provides a broad reconciliation between a straight-line projection of the year to date position and the forecast outturn, before and after mitigation:

(£m)	Income	Expend	Net	Note
M6 YTD	198.6	231.5	-32.9	
Straight line extrapolation of M6	397.2	463.0	-65.8	
FCOT before mitigation	405.0	463.8	-58.8	
Run rate improvement already assumed in FCOT	7.8	0.8	7.0	1,2
Further mitigation assumed to meet FCOT	3.2	-5.2	8.4	3
Other risk		0.4	-0.4	4
Revised QIPP / maternity assumptions	-4.2	-3.7	-0.5	
Total run rate improvement assumed to meet FCOT	6.8	-7.7	14.5	

Notes

1. Income improvement primarily from £1.7m additional UCC and Redbridge Physio income from M5 and from increased rate of elective work in second half of year
2. Expenditure movement comprises £3.9m increase in CIP run rate, but offset by additional costs from UCC/Redbridge Physio of c.£1.6m and c.£3m other costs (including cost of increased elective activity)
3. See CIP section for further detail
4. AfC claim from Hard FM provider

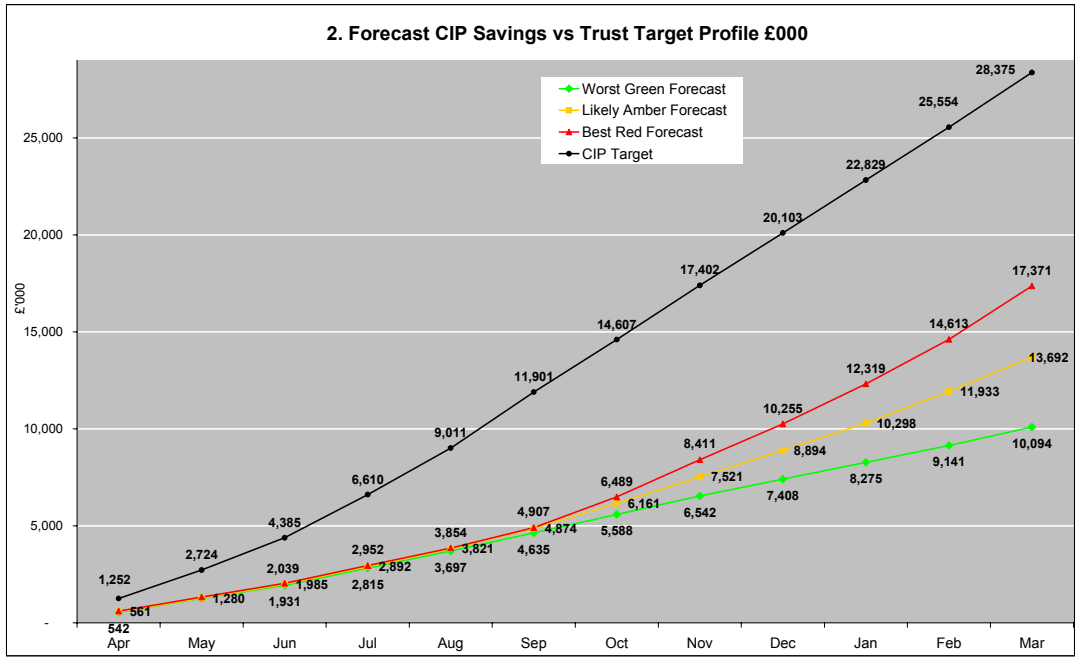
5. CIP and QIPP Programme Summary

Trust Wide Forecast Overview up to and including 30th September 2011

1. Annual Savings Forecast (part year and full year effect).

		Apr 11 £'000	May 11 £'000	Jun 11 £'000	Jul 11 £'000	Aug 11 £'000	Sep 11 £'000	Oct 11 £'000	Nov 11 £'000	Dec 11 £'000	Jan 12 £'000	Feb 12 £'000	Mar 12 £'000	Total PYE £'000	2012/13 FYE £'000	
IN MONTH	Target	1,252	1,472	1,661	2,225	2,401	2,889	2,706	2,796	2,701	2,726	2,726	2,820	28,375		
	Implemented	518	678	645	788	804	838	845	845	758	758	758	845	9,082	*11,530*	
	Variance from Trust target	*-733*	*-794*	*-1,016*	*-1,437*	*-1,597*	*-2,051*	*-1,861*	*-1,951*	*-1,943*	*-1,968*	*-1,968*	*-1,975*	*-19,293*		
	Cumulative Target	1,252	2,724	4,385	6,610	9,011	11,901	14,607	17,402	20,103	22,829	25,554	28,375	28,375		This is the original CIP target
GREEN Schemes	**Actual /** forecast Savings	542	1,257	1,931	2,815	3,697	4,635	5,588	6,542	7,408	8,275	9,141	10,094	10,094	*12,844*	This forecast includes only green schemes
AMBER Schemes	**Actual /** forecast Savings	18	23	54	77	124	239	573	979	1,486	2,024	2,792	3,598	3,598	*5,693*	This forecast includes only amber schemes
RED Schemes	**Actual /** forecast Savings	43	47	53	60	33	33	328	890	1,362	2,021	2,680	3,678	3,678	*9,079*	This forecast includes only red schemes
BEST CASE Forecast	**Cumulative Target**	1,252	2,724	4,385	6,610	9,011	11,901	14,607	17,402	20,103	22,829	25,554	28,375	28,375		
	Actual / forecast Savings	604	1,327	2,039	2,952	3,854	4,907	6,489	8,411	10,255	12,319	14,613	17,371	17,371	*27,615*	This forecast includes all green, amber & red schemes
	Variance from Trust target	*-648*	*-1,397*	*-2,346*	*-3,658*	*-5,157*	*-6,994*	*-8,117*	*-8,991*	*-9,848*	*-10,509*	*-10,941*	*-11,004*	*-11,004*		
LIKELY CASE Forecast	**Cumulative Target**	1,252	2,724	4,385	6,610	9,011	11,901	14,607	17,402	20,103	22,829	25,554	28,375	28,375		
	Actual / forecast Savings	561	1,280	1,985	2,892	3,821	4,874	6,161	7,521	8,894	10,298	11,933	13,692	13,692	*18,536*	This forecast includes all green, amber & red schemes
	Variance from Trust target	*-691*	*-1,444*	*-2,400*	*-3,718*	*-5,190*	*-7,027*	*-8,445*	*-9,881*	*-11,209*	*-12,530*	*-13,621*	*-14,683*	*-14,683*		
WORST CASE Forecast	**Cumulative Target**	1,252	2,724	4,385	6,610	9,011	11,901	14,607	17,402	20,103	22,829	25,554	28,375	28,375		
	Actual / forecast Savings	542	1,257	1,931	2,815	3,697	4,635	5,588	6,542	7,408	8,275	9,141	10,094	10,094	*12,844*	This forecast includes only green schemes
	Variance from Trust target	*-709*	*-1,467*	*-2,453*	*-3,795*	*-5,315*	*-7,266*	*-9,018*	*-10,861*	*-12,695*	*-14,554*	*-16,413*	*-18,280*	*-18,280*		

2. Forecast CIP Savings vs Trust Target Profile £000



CIP Monthly Headlines September 2011

Monthly Financial Narrative

- Overall Change since August
  - Worst case -£500k
  - Likely case -£200k
  - Best case -£1,900k
- Schemes implemented PYE now stands at £9.1M with a FYE of £11.5M
- Further Green Schemes to be implemented £1.0M
- Worst Case shows delivery of £10.1M, likely case£13.7M and a Best case of £17.4M

Scheme Narrative

- **Length of stay** – No change.
- **Outpatients** – Implementaiton of revised profiles now in palce and work being undertaken to assess proactive reduction of waiting times across a number of specialties in response. DNA levels to be targeted through message texting pilot to go live in November.
- **Recruitment & Temporary staffing** – 173 WTE posts filled since accelration plans commenced, including 93 WTE in September. Reduction in temporary staff run rate to be expected to continue, although current level of overspending unlikely to result in significant increase to CIP deliery.
- **Readmissions** – Red rated scheme financial evaluation reduced from £2m target to £900k follwoing review of actions in place to address the scheme

Key Mitigation Actions

- Review of bed capacity
- Strict restrictions on non-pay expenditure
- Anlysis of CQUIN delivery against current budget

Definitions

Trust target: The efficiency required to meet the CIP plan.

Savings plan: Original savings potential (local estimate of savings to allow performance management of project)

Savings actual / forecast: In month / cumulative actual savings and forecast savings for future periods.

PYE: Part Year Effect: Benefit of saving in current financial year.

FYE: Full Year Effect: Benefit of saving running for full 12 months.

Risk Ratings for Projects

GREEN
Initiative is delivering on plan and to the full value.

AMBER
Initiative is off trajectory or there are risks to delivery but assured that recovery/mitigation plans are adequate. May also be used if scheme has been actioned but it is achieving less than 90% of the cash value.

RED
Initiative is off trajectory and/or a significant risk to delivery and not sufficiently assured that recovery/mitigation plans in place. There is a 50% or greater risk of non delivery.

Divisional Summary By Workstream

(all figures in £'000)

		Annual Statement						In Month Statement			Ytd Statement		
Division	Key Worsktream	11-12 Targets	Green	Amber	Red	11-12 F-cast	11-12 Variance	In Mth Target	In Mth Delivery	In Mth Variance	Ytd Target	Sum of Ytd	Ytd Variance
Medicine & Emergency Care	Reducing LOS and ward closure programme	3,908	1,725	-	1,040	2,765	(1,143)	443	182	(261)	2,339	959	(1,381)
	Outpatient Operations	158	-	-	66	66	(92)	13	-	(13)	79	-	(79)
	Control of premium rate staff expenditure	1,200	-	302	516	818	(382)	233	32	(201)	800	32	(768)
	Managerial tier reduction and other staffing r	376	276	49	-	325	(51)	31	21	(10)	193	152	(41)
	Local CIP	946	55	231	339	625	(322)	81	24	(57)	463	176	(287)
	Unidentified	2,610				-	(2,610)	287	-	(287)	891	-	(891)
	Readmissions		-	-	933	933	933		-	-		-	-
Medicine & Emergency Care Total		9,199	2,056	582	2,893	5,531	(3,668)	1,087	258	(829)	4,765	1,319	(3,446)
Surgical	Reducing LOS and ward closure programme	1,485	412	243	-	655	(830)	135	43	(92)	675	152	(523)
	Outpatient Operations	450	-	-	-	-	(450)	38	-	(38)	225	-	(225)
	ISTC bid and Theatres productivity	1,357	-	-	-	-	(1,357)	113	-	(113)	679	-	(679)
	Control of premium rate staff expenditure	763	-	86	50	136	(627)	109	-	(109)	109	-	(109)
	Managerial tier reduction and other staffing r	525	-	56	-	56	(469)	74	-	(74)	80	-	(80)
	Service Line Reporting and Service Reviews	500	-	-	-	-	(500)	71	-	(71)	71	-	(71)
	Local CIP	3,823	3,431	150	-	3,581	(242)	323	291	(31)	1,886	1,684	(203)
	Unidentified	265	-	-	-	-	(265)	-	-	-	-	-	-
Surgical Total		9,167	3,843	535	50	4,428	(4,738)	863	335	(528)	3,726	1,836	(1,890)
Women & Children	Managerial tier reduction and other staffing r	614	323	-	-	323	(291)	51	18	(33)	307	216	(91)
	Local CIP	759	252	181	-	433	(327)	51	13	(38)	242	80	(163)
	Unidentified	334	-	-	-	-	(334)	43	-	(43)	77	-	(77)
Women & Children Total		1,707	575	181	-	755	(952)	145	31	(114)	626	296	(331)
Cancer, Diagnostics & Therapeutic	Outpatient Operations	340	339	-	-	339	(1)	28	28	(0)	170	170	(0)
	Collaborative Working & Outsourcing	1,561	561	-	-	561	(1,000)	174	51	(122)	520	253	(267)
	Control of premium rate staff expenditure	1,133	394	121	67	582	(552)	84	44	(40)	328	131	(196)
	Key Staff recruitment	486	404	28	-	432	(53)	40	27	(13)	247	137	(109)
	Managerial tier reduction and other staffing r	865	359	170	220	749	(117)	43	33	(10)	208	163	(45)
	Local CIP	2,118	1,334	809	48	2,192	74	247	191	(56)	544	438	(106)
	Unidentified	157				-	(157)	34	-	(34)	(47)	-	47
Cancer, Diagnostics & Therapeutic Total		6,659	3,392	1,128	335	4,854	(1,805)	650	374	(276)	1,969	1,292	(677)
Corporate	Reducing LOS and ward closure programme	211	211	-	-	211	-	25	25	-	99	99	-
	Local CIP	1,431	18	1,173	400	1,591	159	119	30	(90)	716	65	(650)
Corporate Total		1,642	229	1,173	400	1,801	159	144	54	(90)	815	164	(650)
Grand Total		28,375	10,094	3,598	3,678	17,371	(11,004)	2,889	1,053	(1,837)	11,901	4,907	(6,994)

Total Summary By Workstream

(all figures in £'000)		Annual Statement						In Month Statement			Ytd Statement		
Key Worsktream	Division	11-12 Targets	Green	Amber	Red	11-12 F-cast	11-12 Variance	In Mth Target	In Mth Delivery	In Mth Variance	Ytd Target	Sum of Ytd	Ytd Variance
Reducing LOS and ward closure programme		5,604	2,348	243	1,040	3,631	(1,973)	603	250	(353)	3,113	1,210	(1,903)
Outpatient Operations		948	339	-	66	405	(543)	79	28	(51)	474	170	(304)
ISTC bid and Theatres productivity		1,357	-	-	-	-	(1,357)	113	-	(113)	679	-	(679)
Collaborative Working & Outsourcing		1,561	561	-	-	561	(1,000)	174	51	(122)	520	253	(267)
Control of premium rate staff expenditure		3,096	394	508	633	1,535	(1,560)	427	76	(351)	1,236	163	(1,073)
Key Staff recruitment		486	404	28	-	432	(53)	40	27	(13)	247	137	(109)
Managerial tier reduction and other staffing reductions		2,380	958	275	220	1,453	(927)	199	71	(128)	789	532	(257)
Service Line Reporting and Service Reviews		500	-	-	-	-	(500)	71	-	(71)	71	-	(71)
Local CIP		9,077	5,090	2,544	787	8,421	(657)	821	549	(272)	3,851	2,442	(1,409)
Unidentified		3,366	-	-	-	-	(3,366)	363	-	(363)	921	-	(921)
Readmissions			-	-	933	933	933		-	-		-	-
Grand Total		28,375	10,094	3,598	3,678	17,371	(11,004)	2,889	1,053	(1,837)	11,901	4,907	(6,994)

Detailed Mitigating Opportunities

The CIP register records schemes and opportunities risk rated according to the level of development, stage of implementation and level of financial integrity. Red rated schemes, along with other opportunities are excluded from the overall Trust forecast as they lack sufficient planning integrity, or are yet to have fully quantified plans confirmed.

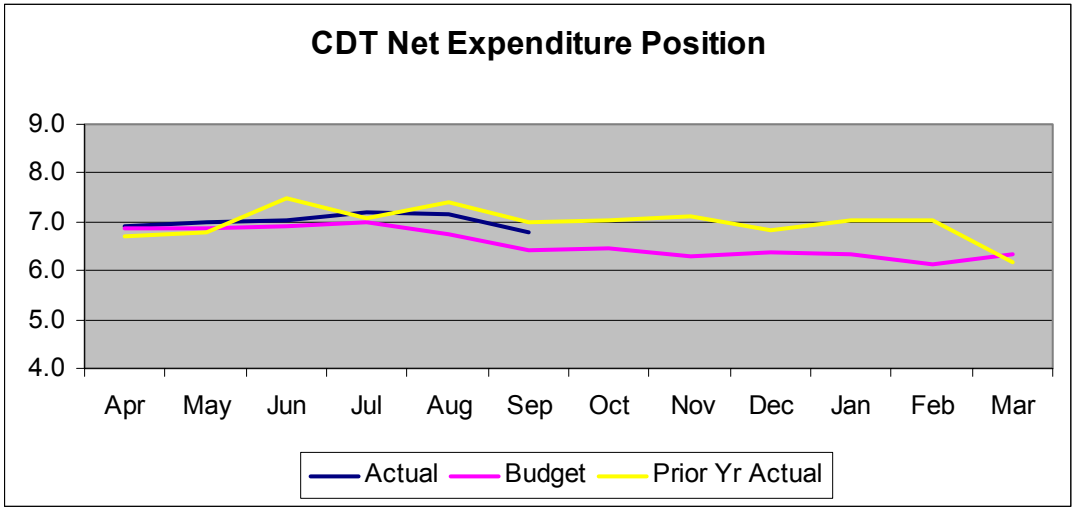
A further £18m in opportunities have been identified and are listed to the left, although the overall likely maximum delivery has been estimated at £11m,

		Notes	M6 Estimate - best case	M6 estimate - likely
Medical Staffing				
Bud - £81m, YTD Var - (£2.5m)				
Consultant Job Planning Efficiency	All	Meal break deductions not allowed for in job plans	400	0
	All	Currently standardised allocation for 1 PA unpredictable on-call/emergency. Needs to be evidence based and benchmarked	100	50
	All		75	35
		Number of SPA's without specific evidence as to how used	75	35
			75	35
Recruitment	Medicine	£600k Red rated within emergency. Plans not fullay spec'd at 13/9/11	680	340
	Surgery	£690k less £220k estimate for recruitment fees	490	490
	W&C	Recruitment activity reducing current run rate overspending	200	200
	CDT	Detailed response not received at 13/9/11	648	648
			0	
Capactity Reductions	Medicine	Retention of existing capacity but with increased productivity expectations will deliver income earlier but plans required to reduce overall theatre and outpatient capacity. Propose that all specialties look to reduce outpatient capcity by 10% from December.	105	105
	All	Outpatient project prgressing well. Mitigations are in excess of £1m already in CIP plans. Determination required to deliver and overcome organisational inertia	414	414
	Surgery	Theatre project prgressing with clear set of actions.	361	180
			3,623	**2,532**
Nursing				
Bud - £107m, YTD Var - (£3.0m)				
Rotas	All	Elimination of inefficient rostering through full compliance of roster policy	150	150
	All	Current establishment based on nurses per bed instead of nurses per bed day. Target 5% ward based reduction, but no plan/project yet established	500	0
Recruitment	Surgery		250	125
	W&C	Recruitment activity reducing current run rate overspending. £200k allowance for recruitment fees. Division will still be running at £90k per month over budget	450	225
			0	
Bed Capacity Reductions	Medicine	KGH Medical Ward to close in October 2011, surgical ward to close part year. One further ward required to be closed to achieve financial target, in Line with Safe review of opportunity. Cost reductions need to be tied to improved readmissions avoidance - non-elective currently overperforming but will be at marginal or no tariff.	2,216	1100
	Surgery		400	200
			3,966	**1,800**
ST&T				
Bud - £40m, YTD Var - (£0.2m)				
Recruitment	CDT		326	326
Staff Expenditure Controls				
Bed Capacity Reduction	CDT	Associated targeted savings in support services. 13% ST&T assessment in line with SaFE	229	115
			555	**441**

		Notes	M6 Estimate - best case	M6 estimate - likely
Management & Admin				
Bud - £30m, Var - £0.0m				
Temporary Staff Restrictions				
Management Restructure	CDT	Based on proposed reorganisation not yet gone to consultation	320	100
			320	**100**
Non-Pay				
Supplies and Procurement		Further restrictions on supplies expenditure and more aggressive management of consumables usage in excess of divisional plans. Subject to further planning and validation.	250	250
Bud - £48m				
Var - £0.3m				
Drugs			0	
Medicines Management	All	Further agreed controls on prescribing	150	150
Estates				
Suspension of Non-Critical Capital Plans	All	Reduction in associated non-capital expenditure, and identification of capitalisable assets in I&E. Requires sufficient CRL headroom to be established.		
Balance Sheet Review				
Opportunities not included in forecast	All	Overall value reduced, as £1m now apportioned to capitalisation		
			280	150
Transport		Mitigation of additional M6 charges		
			680	**550**
Divisional CIP's	Medicine		339	339
	Surgery		796	796
	W&C		305	305
	CDT		48	48
	Corporate			
			1,488	**1488**
Income				
Readmissions	Medicine	**Total Readmissions reduction provision in budget - £6.5m** Currently Red rated - on CIP target but outside of Trust forecast. Accurate targets still not prepared - action plans to reduce levels still a work in progress.	2,000	0
CQUINS	All	Achieve 75% of total CQUIN target. Requires leads for each target and full accountabilty	1,100	550
QIPP	All	Associated Marginal Costs associated with PCT QIPP plans. Detail to support PCT initiatives is extremely limited, but evidence of reduced elective inpatient and outpatient referral activity.	1,570	0
Marketing	All	No detailed marketing plan	1,000	0
ISTC - Cessation of	Surgery	Net gain - income value of referral work - £1.7m, need to ensure associated additional costs do not exceed £700k		
ISTC - Successful T	Surgery	Net gain through Quarter 1. Full Financial model being prepared as part of tender submission, so actual valu still subject to verification.	1,400	1400
Coding Audit	All	Further Benefit from 11/12, subject to contract review and full audit	750	750
SLA - Audit of all 3r	All	Estimate subject to full sudit	250	250
Reduction in Low C	All	Identified from SLR system. Estimate subject to detailed analsyis and project plan	250	250
CTB income to fund	Conultancy /	Programme Management costs	1,100	1100
			9,420	**4,300**
Total			**18,672**	**11,211**

6. Divisional Summaries

Cancer, Diagnostic & Therapeutics



Performance by I&E category:

In Month			Year to date		Forecast	
Actual	Var		Actual	Var	Actual	Var
(665)	51	Income	(3,674)	207	(7,485)	332
5,311	(78)	Pay expenditure	32,240	(631)	63,706	(1,419)
2,150	(131)	Non-pay expenditure	13,557	(575)	26,348	(1,181)
	(214)	Unallocated CIP		(339)		(1,622)
6,796	**(373)**	Net position	**42,123**	**(1,338)**	**82,570**	**(3,890)**

Performance by Specialty:

In Month			Year to date	
Actual	Var		Actual	Var
77	(256)	Clinical Services Mgt	460	(455)
217	8	Healthcare Records	1,305	47
339	10	Medical Secretaries	2,063	31
1,362	74	Oncology	8,578	118
323		Outpatients	1,950	(6)
1,698	(2)	Pathology	10,854	(225)
517	(42)	Pharmacy	3,403	13
1,553	(185)	Radiology	9,081	(846)
709	19	Therapies	4,429	(15)
6,796	**(373)**	**Net position**	**42,123**	**(1,338)**

CDT Key Variance Narrative.

- **Income**
  - **Income £ 111 k (F)**. In month favourable variance being IFR/ICDF drugs income growth £94k, HCA inter-divisional income £44k (negated by increase in non pay cost), Blood products £12k being partially mitigated by under-performance of in HCA drug income £ (29) k and Pharmacy Commercial Operations £(11)k.

    Year to date £157k (F) being ICDF/IFR growth £343k mitigated by under performance in HCA drug income £ (196) k and Pharmacy commercial operations £ (59) k.

- **Staffing**
  - **Medical staff £(191)k (A)** being Radiologists £(167)k including £(40)k retrospective bookings.

    Year to date over spend £ (296) k (A) being Radiologists as above.
  - **Nursing staff £ (12) k (A)**. In month overspend being unallocated CIP target for outpatient productivity which is largely covered by non-recurrent Management & Clerical vacancies.

    Year to date over spend being £ (75) k being reflection of CIP target.
  - **Scientific Therapeutic and Technical staff £(93)k (A)** In-month adverse movement being delivery of high cost Radiology Polyclinic support and Radiographer CIP slippage £(60)k, Pathology agency premium and sickness cover £(55)k, Retrospective therapy agency bookings(19k) mitigated by vacancies in Pharmacy Department £34k.

    Year to date £(269)k (A) being Radiographer Polyclinic and CIP slippage £(196)k, Pathology £(105)k, Therapy agency premiums £(59)k mitigated by vacancies in Pharmacy £66k.
  - **Management and Admin £7k (F).** In month favourable position reflects vacancies in Outpatient to support productivity improvement £9k and vacancies in Healthcare records £12k.

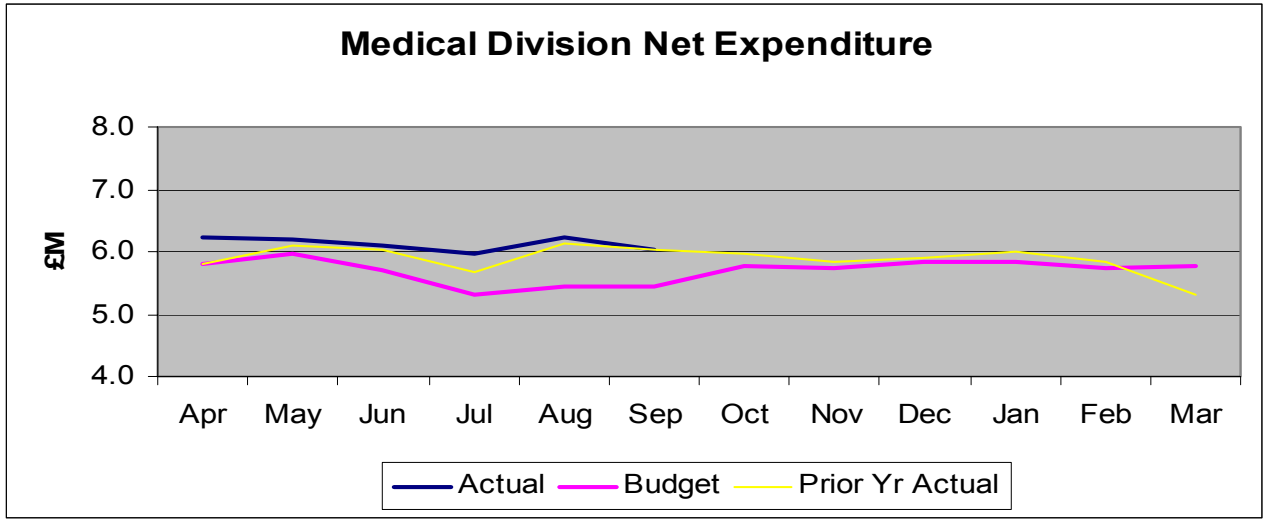
    Year to date under spend £87k being Medical Secretariat £27k, Outpatients £60k and Healthcare Records £43k non-recurrently supporting CIP targets.

- **Non-Pay**
  - **Drugs £ (10) k (A)**. In month over spend being nuclear medicine coding issues (£12)k

    Year to date £(121)k(A) being cancer prescribing £(68)k and Radiology coding issues (43)k.
  - **Clinical Supplies & Services £(43)k (A)** In month overspend being Coiling and related high cost consumables £(23)k, growth of CT injection procurement £(21)k, Pathology reagents £(23)k.

    Year to date £ (77) k (A) relates to Coiling £(108)k, Pathology reagents £(23)k mitigated by Kenwood Garden contract £42k
  - **Other Non-Pay £(75)k (A**). In month overspend being CIP slippage on procurement program £(28)k and HCA inter-divisional cross charges to (49)k (off set by income).
    Year to date £(244)k is Radiology out sourcing £(45)k, Pathology Sent Away Services £(55)k, CIP slippage on procurement programme £(56)k and HCA inter-divisional cross charges £84K (off set by income).

Medicine & Emergency



Performance by I&E category:

In Month			Year to date		Forecast	
Actual	Var		Actual	Var	Actual	Var
(505)	(26)	Income	(3,047)	(178)	(6,004)	(409)
5,786	(266)	Pay expenditure	34,647	(1,445)	70,549	(2,526)
767	34	Non-pay expenditure	5,155	(121)	10,361	(413)
	(360)	Unallocated CIP		(1,329)		(3,214)
6,048	**(619)**	Net position	**36,755**	**(3,074)**	**74,905**	**(6,562)**

Performance by Specialty:

In Month			Year to date	
Actual	Var		Actual	Var
1,666	172	A+E & Acute Assessment	9,817	492
252	(24)	Bed & Site Management	1,493	(117)
563	(12)	Cardiology	3,264	55
184	44	Care of the Elderly	1,163	171
1	(469)	Emergency Management	1	(1,561)
584	6	Endoscopy	3,651	(88)
2,243	(34)	General Medicine	13,792	(513)
196	(307)	Medical Management	1,309	(1,424)
10	(26)	Renal	58	(151)
348	31	Respiratory	2,207	61
6,048	**(619)**	**Net position**	**36,755**	**(3,074)**

Medicine & Emergency Key Variance Narrative.

- **Income**
  - **Income £(26)k (A)**. CIP slippage on KGH Renal Dialysis accommodation £(21)k, where this value has yet to be agreed, Queens renal accommodation (£5)k as accommodation value is in dispute. Opportunity which is now managed by the Estate's Team. There is also an ongoing under-recovery of Junior Doctor Training monies £(18)k.

    Year to date £(178)k (A). Renal Dialysis £(154)k accommodation lease and Junior Doctor Training £(67)k.
- **Staffing**
  - **Medical staff £(179)k (A)**. In month deficit due to CIP slippage on ED Medical Staff recruitment £(180)k and Outpatient productivity £(15)k being further compounded by temporary staff bookings in respect of Vacancies, UCC, high sick leave, additional ward cover and Endoscopy out of hour sessions £(44)k with partial mitigation through cancellation of historical Agency bookings £60k.

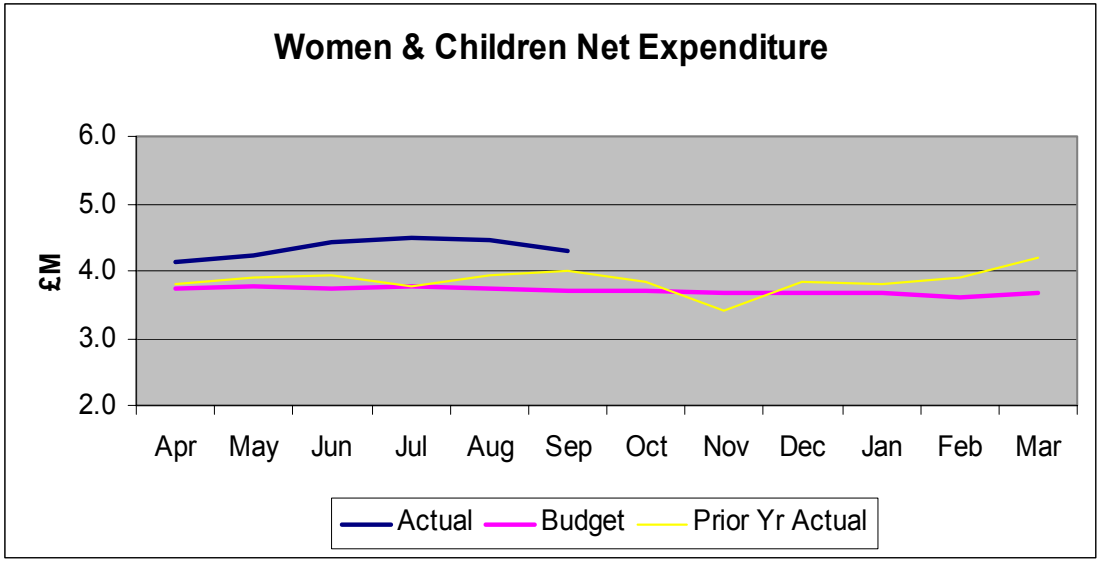
    Year to date £(908)k (A). CIP Premium rate slippage £(701)k through delayed Emergency recruitment, Outpatient productivity CIP Slippage £(80)k and premium rate cover £(127)k
  - **Nursing Staff £(100)k (A)**. In-month adverse movement through Ward closure CIP slippage £(180)k as all length of stay opportunities being absorbed by NEL over-performance which although financed at 30% tariff is not reported at Divisional level. Although Out of hour pressures remain in delivery of Endoscopy waiting times £(17)k these have been resourced by ongoing Emergency Departmental Vacancies totalling £106k.

    Year to date £(583)k (A). Due to Ward CIP slippage of £(864)k, Endoscopy sessions £(107)k against Divisional Vacancies £388k
- **Non-Pay**
  - **Clinical Supplies £68k(F)**. In month favourable position has been achieved through downturn in Endoscopy Consumable procurement £38k and Maintenance pre-payment adjustment £20k from timing only (Non recurrent).

    Year to date £43k (F). Endoscopy £59k, Angiography £28k and Emergency Department £48k Consumables against Ward closure slippage £(72)k.
- **Cost Improvement Programme**
  - **Unallocated Gap £(360)k (A)**. Current month deficit reflects the Divisional gap £(360)k.

    Year to date £(1,319)k (A). Reflects Divisional Gap £(1,319)k

Women & Children's



Performance by Specialty:

In Month			Year to date	
Actual	Var		Actual	Var
659	(34)	Gynaecology	4,073	(314)
1,941	(298)	Midwifery	11,540	(1,692)
335	(30)	NICU / SCBU	1,969	(148)
835	(121)	Paediatrics	5,193	(956)
493	(1)	Sexual Health	3,065	(82)
33	(121)	W&C Management	167	(345)
4,296	**(605)**	**Net position**	**26,008**	**(3,546)**

Performance by I&E category:

In Month			Year to date		Forecast	
Actual	Var		Actual	Var	Actual	Var
(265)	(22)	Income	(1,499)	(220)	(3,034)	(404)
3,938	(448)	Pay expenditure	23,486	(2,580)	46,107	(4,370)
623	(59)	Non-pay expenditure	4,021	(578)	7,763	(913)
	(76)	Unallocated CIP		(168)	(50)	(625)
4,296	**(605)**	Net position	**26,008**	**(3,546)**	**50,786**	**(6,312)**

Womens & Childrens Key Variance Narrative:

- **Income – Under-achieved by (£22k) for the month of September, (£220k) Year to Date.**
  - The adverse variance in month is made up of many smaller variances with the largest being lack of overseas patients income in Gynaecology and SCBU. £8k in SCBU is due to the posts funded externally and the target is still not removed.

- **Pay – Over-spent by (£448k) for the month of September, (£2.6M) Year to Date.**
  - **Medical staff is over-spent by (£77k) in month and (£568k) ytd.** Paediatric medical pay continues to drive the overspend in this category reporting (£65k) in month and (£462k) ytd. This is however, an improvement on last month and is expected to continue to come down as more permanent staff come into post. The reasons for the reduction in spend this month has been the junior doctors rotation and new permanent staff starting in the month.

  - **Nursing & Midwifery pay is over-spent by (£310k) in month and (£1.8m) ytd.** Midwifery continues to drive this position reporting (£249k in month) as they continue to use temporary staff in their attempts to achieve the 1:29 birth ratio. There is double running of agency staff with new permanent staff to allow the new recruits to become compliant. This level of spend is anticipated to continue until end of November when it will reduce month on month until it levels off in the new calendar year as permanent staff are recruited. It should be noted that the Specialty has not received additional budget for the additional 10 Midwives above the current budgeted establishment to reflect the number of births at the 1:29 ratio as agreed in the past. Paediatrics is over-spent by (£40k) in month due to continued use of temporary staff to cover vacancies, long term sickness and maternity leave.

    Year to date variance is (£1.8M). Midwifery (£1.3M), Paediatrics (£282k) and NICU is (£94k).

- **Non Pay – is over-spent by (£59k) in the month of September and (£578k) Year to Date.**
  - **Clinical Supplies & Appliances is over-spent by (£27k) in month**. (£19k) of the over-spent is due to unfound Divisional Cost Improvement Programme which is aligned to the Consumables work stream. (£3k) in NICU and (£3k) in Paediatrics is related to Resus stock.
    Year to date deficit is (£247K). Failed Cost Improvements (£114k) & Medical & Surgical Equipment in Midwifery (£57k) & Gynaecology (£68k).

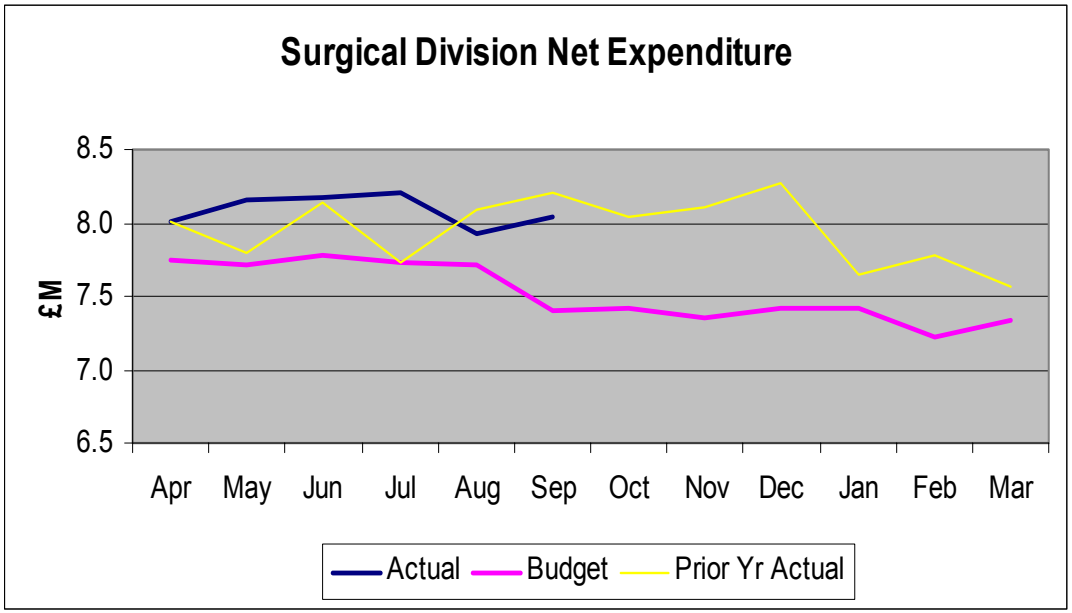
  - **General Supplies and Services is over-spent by (£23k).** Midwifery specialty continues to drive spend in this category reporting an in month adverse variance of (£26k). Recruitment costs of overseas midwives have attributed mainly to this variance and more costs associated with this recruitment are expected in future periods.
    Year to date deficit is (£122k) of which (£123k) relates to Midwifery.

  - **Other Non pay is over-spent by (£17k).** (£6k) in Gynaecology is due to Imaging charges. (£6k) in Midwifery are due to compensation Ex Gratia payments. (£7k) is due to External consultancy fees charges which are not funded in Paediatrics. External consultancy fees will not continue month on month.

    Year to date deficit is (£133k), of which (£87k) relates to Paediatrics. (£121k) to Midwifery, (£23k) to Gynaecology and (£66k) to Sexual Health.

- **Cost Improvement Programme – under-achieved by (£76k) for the month of September, (£168k) Year to Date.**
  - This represents the balance of the Cost Improvement Programme gap detailed below that currently does not have a plan.

Surgical:



Performance by I&E category:

In Month			Year to date		Forecast	
Actual	Var		Actual	Var	Actual	Var
(401)	37	Income	(2,326)	(142)	(4,531)	(200)
6,514	(555)	Pay expenditure	39,284	(2,251)	78,127	(5,336)
1,927	(30)	Non-pay expenditure	11,562	197	23,021	252
	(98)	Unallocated CIP		(250)	(585)	(520)
8,041	**(647)**	Net position	**48,520**	**(2,446)**	**96,033**	**(5,803)**

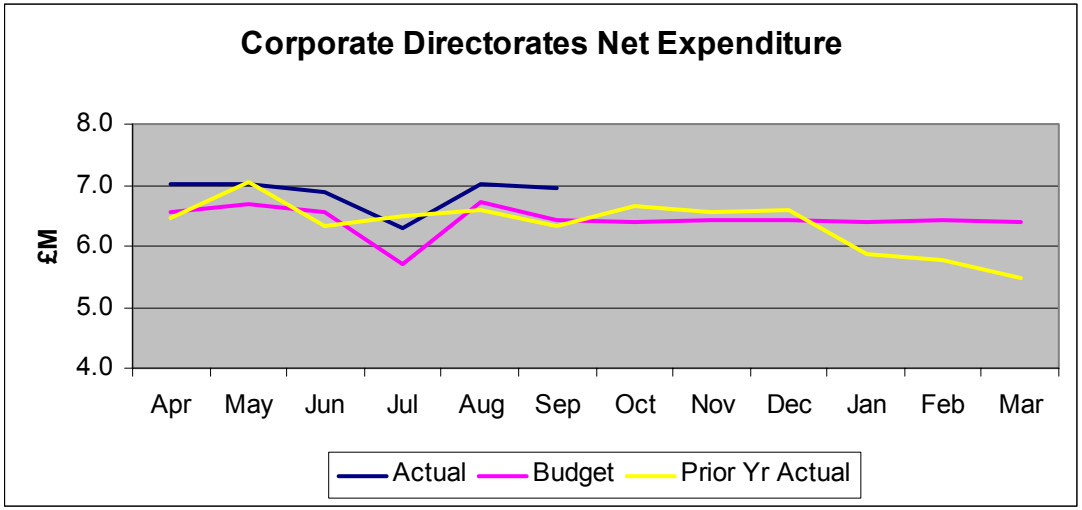
Performance by Specialty:

In Month			Year to date	
Actual	Var		Actual	Var
37	4	Admissions	223	20
965	(21)	Anaesthetics	5,780	(248)
645	(10)	Critical Care	3,938	22
138	5	Day Surgery	819	41
62	(2)	Dermatology	381	(20)
317	2	Ear, Nose & Throat	1,782	133
848	12	General Surgery	5,334	(177)
84	(24)	MaxFax	346	10
360	(45)	Neurology	2,110	(130)
999	(1)	Neurosciences	6,182	(304)
354	(42)	Ophthalmology	2,024	(141)
35	2	Orthodontics	216	10
731	36	Orthopaedics	4,601	(4)
19	3	Pain Management	154	(24)
566	(82)	Rheumatology	3,189	(129)
114	(444)	Surgical Management	824	(1,312)
1,445	(84)	Theatres	8,469	(241)
320	46	Urology	2,150	47
8,041	**(647)**	**Net position**	**48,520**	**(2,446)**

Surgery Key Variance Narrative.

- **Income – Over-achieved by £37k for the month of September, (£142k) Under-achieved Year to Date.**
    - Non NHS Overseas Income over-achieved by £37k in the month and due to the nature of these patients it is not anticipated to continue at this level month on month. Junior Doctors Revenue was only £2k under-achieved due to a catch up of Flexible Trainee Income relating to prior periods therefore going forward the Junior Doctors Income will revert to being a cost pressure as the number of doctors from the Deanery are less than last year so income is reduced against the outturn income target.
    - Of the YTD (£142k) under-achievement (£141k) year to date can be attributed to the CFS Service which has now ceased inpatient referrals.
- **Pay – Over-spent by (£555k) for the month of September, (£2.3m) Year to Date.**
    - **Medical staff over-spent by (£328k)**. Two thirds of this was due to failed Cost Improvement Programme (£219k) that relate to Medical Staff. Individual schemes can be seen in section 4. The specialties with the largest over-spends were Anaesthetics (£58k) due to agency premiums spent on middle grades, Neurosciences/Stroke (£40k) which was related to Junior grade agency costs.
    - The year to date Medical Staffing is (£1.4m) over-spend which relates to CIP slippage (£830k), Neurosciences (£234k), General Surgery (£134k) and Anaesthetics (£227k).
    - **Qualified Nursing Staff over-spent by (£208k).** Failed Cost Improvement Programme of (£249k) for the schemes relating to Theatres efficiency, Surgical Ward closure programme and the general 1% saving around nursing which haven't come to fruition during the month. Most wards have under-spent against budget with the exception of Critical Care which over-spent by (£24k) in month due to high cost agency spend.
    - Nursing and Midwifery Qualified year to date over-spend is (£1.0m) of which (£1.1m) is missed CIP plan although all specialties apart from Ophthalmology and Critical Care are under-spending year to date. It should be noted that no local CIP target has been allocated directly to the ward's budget unlike all other cost centre areas.
- **Non Pay – Over-spent by (£30k) for the month of September, under-spent £198k Year to Date.**
    - **Drugs** drive the non pay position in the month over-spent by **(£75k)**, (£67k) of this relates to Rheumatology whilst Ophthalmology over-spent by (£34k) whilst there was also a £17k CIP shortfall. Anaesthetics under-spent in month by £35k. Additional budget for ARMD is expected next month.
    - Consumables continue to over-spend in Theatres but this is offset by numerous small under-spends in all other layers of Non Pay expenditure.
    - **Year to date Non Pay under-spends by £198k**, £83k relates to Clinical Supplies, £61k to Other Non Pay, £51k to General Supplies, £26k to Premises & Fixed Plant whilst the Drugs position is (£23k) over-spent year to date.
- **Local Cost Improvement Programme – Under achieved by (£98k) for the month of September, (£250k) Year to Date.**
    - Of the local CIP schemes contributions by specialty are as follows Anaesthetics £111k, Urology £37k, Admissions £8k & ENT £6k.

Corporate



Performance by Directorate:

In Month Actual	In Month Var		Year to date Actual	Year to date Var
339	(111)	Chief Executive	1,493	(282)
887	33	Director of Finance	5,123	(287)
284	45	Director of Human Resources	1,701	(348)
106	24	Director of Nursing	722	54
173	(26)	Dir. of Performance & Planning	878	111
48	(155)	Education	35	(672)
3,619	(114)	Head of Estates	21,666	(820)
996	39	Medical Director	6,126	105
(26)	26	R&D	192	(201)
517	45	Strategy & Planning	3,232	134
6,944	**(193)**	**Net position**	**41,169**	**(2,207)**

Performance by I&E category:

In Month Actual	In Month Var		Year to date Actual	Year to date Var	Forecast Actual	Forecast Var
(1,082)	255	Income	(4,780)	(684)	(10,545)	(503)
2,536	(56)	Pay expenditure	14,711	172	29,756	10
5,490	(472)	Non-pay expenditure	31,238	(1,084)	61,262	(1,008)
	80	Unallocated CIP		(611)	(436)	(768)
6,944	**(193)**	Net position	**41,169**	**(2,207)**	**80,038**	**(2,270)**

Corporate Key Variance Narrative.

- Head of Estates £(114)k in M06, primarily related to Queens variations (£85k) and specific cost pressure to be funded from reserves. YTD the major cost pressures are CIP shortfall (£398k) though there are plans to pull this back, and additional PFI costs (£442k) of which (£126k) relates to Queens variations.
- Education £(155)k in M06 and (£672k) YTD. The YTD variance primarily related to income £(518)k, although recovery is anticipated in the latter half of the year, through increases in Nursing and Medical staff training SLAs and also recovery of income from Barts and the London, as Lead Provider in NEL, in respect of costs incurred in the first half-year.
- Director of HR £45k favourable in M06 / £(348)k adverse YTD. In month movement is due to re-adjustment to expected Occupational Health target which is still (£190k) adverse YTD. The remaining is largely due to posts in HR some of which are over established but some of which will be refunded through reserves as they are substantive staff costs which can no longer be capitalised under the capital programme.
- Trust Board £(111)k M06 / £(282)k YTD mostly from Corporate External Agency/Consultancy and dual CEO costs.
- R&D £26k favourable in M06 / £(201)k adverse YTD largely as a result of CLRN funding reductions. Planning is underway to recover the full position through other funding streams by Year End.
- Director of Finance 33k Fav M06 / £(287)k Adv YTD - £(100)k YTD Compromise agreement in Turnaround, Patient Transport (£96k) from both increase usage and indexation (the latter to be funded from its specific reserve, (£61k) from increased use of audit and (£115k) on Consultancy in Turnaround. CIP shortfall (£113k) YTD from central contract review as allocation needs to be agreed.
- Strategy & Planning £45k Fav in M06 / £134k Fav YTD. The YTD position mostly on various items on Computer Maintenance.

7. OVERALL DIVISIONAL PERFORMANCE

The following table brings together the Divisional proportion of the central (PCT) income over or under performance, alongside the net expenditure position for each Division, to give an overall financial performance picture for each Division. Income performance has been adjusted to allow for notional direct marginal costs of 50%, with a further 10% for Clinical Support Services. It should be noted this does not represent a 'true SLR' position for each Division, as not all income will be directed aligned with expenditure, but nevertheless provides a high level view of the performance of each Division. Further refinement is required to calculate by Division the impact of the 30% NEL tariff and for readmissions (further update to be given at Finance Committee)

	(£'000 favourable/(adverse) variance	Note	Medical Division	Surgical Division	Womens' & Children Division	CDT Division	**Total**
A	Central Income Over / (Under) Perf. Against Plan	1	797	2,339	1,970	967	**6,074**
B	Adjustment to income performance for marginal rate		-399	-1,170	-985	124	**-2,429**
C=A+B	**Net income performance**		**399**	**1,170**	**985**	**1,091**	**3,644**
D	Net Expenditure (Over) / Under Spends £'000	2	-3,074	-2,446	-3,546	-1,338	**-10,402**
E=C+D	**Net income and expenditure performance**	**3**	**-2,676**	**-1,277**	**-2,561**	**-247**	**-6,757**
	Impact of August Plan profile on M6 over-performance	4	470	1,886	421	549	**3,326**
	M6 CIP underperformance		-3,446	-1,890	-331	-645	**-6,312**
	M5 net I&E performance		-1,095	510	-1,664	460	**-1,790**

Notes:

(1) The Divisional position represents performance against plan, ***excluding*** £10.1m (£4.2m YTD) of PCT QIPP/demand management plans, which is the basis on which Divisional budgets have been set, and is therefore the appropriate comparator for overall performance purposes

(2) Only 50% of the income over/under performance is attibuted to Clinical Divisions (as an approximation of the marginal cost impact), with 10% attributed to CDT for the impact on clinical support services

(3) Divisional over/underspending, including local Divisional income

(4) As explained in Section 2., above, this shows the impact of the lower profiled Plan for August on the year to date over-performance position

8. BALANCE SHEET

(£m)	Current period Sep-11	Current period Aug-11	Last Yr End Mar-11
Non-current assets	**£396.3**	£397.3	£388.9
Current assets			
Inventories	**£6.7**	£6.8	£7.0
Trade and other receivables	**£29.0**	£25.8	£29.7
Cash and cash equivalents	**£1.0**	£1.6	£2.8
	£36.7	£34.3	£39.5
Current liabilities			
Trade and other payables	**(£78.4)**	(£76.4)	(£48.2)
PFI \ Borrowings	**(£5.8)**	(£5.7)	(£5.3)
Provisions	**(£1.9)**	(£2.1)	(£1.8)
Net current assets/(liabilities)	**(£49.4)**	(£49.9)	(£15.8)
Non-current liabilities:			
PFI \ Borrowings	**(£257.8)**	(£258.0)	(£260.2)
Trade and other payables	**(£5.1)**	(£5.1)	(£4.9)
Provisions	**(£4.5)**	(£4.6)	(£5.0)
Total assets employed	**£79.5**	£79.7	£103.0
Financed by taxpayers' equity:			
Public dividend capital	**£307.3**	£307.3	£307.3
Retained earnings	**(£244.0)**	(£243.8)	(£216.4)
Revaluation reserve	**£15.4**	£15.4	£11.3
Donated asset reserve	**£0.8**	£0.8	£0.8
Total taxpayers' equity	**£79.5**	£79.7	£103.0

KPIs	Current period Sep-11	Prior period Aug-11	Last Yr End Mar-11
Average Debtors days	**21**	14	21
Debtors >90 days (£'000s)	**£662**	£1,118	£592
Debtors >180 days (£'000s)	**£828**	£781	£1,536
Debtors >365 days (£'000s)	**£2,329**	£2,338	£2,825
>365 days provided (£'000s)	**£1,913**	£1,912	£1,293
Average creditor days	**68**	58	58
Current ratio	**44%**	42%	71%
Better payment practice code performance:			
- Non-NHS			
- Volume - paid on time	**2,548**	2,438	2,773
- Volume - % paid on time	**41.95%**	56.49%	27.96%
- Value - paid on time (£'000s)	**£3,248**	£5,363	£5,150
- Value - % paid on time	**37.07%**	58.41%	35.85%
- NHS			
- Volume - paid on time	**105**	37	316
- Volume - % paid on time	**35.84%**	19.68%	34.39%
- Value - paid on time (£'000s)	**£346**	£494	£1,630
- Value - % paid on time	**14.11%**	21.79%	30.52%

Key points:

- The overall balance sheet position shows a reduction of £0.2m in total assets compared with August 2011, relating to the movement in retained earnings. Note this includes the £4.2m income accrual, which was made manually in the Month 5 income and expenditure position.

Key points:

- Average creditor days showed a further increase and performance against the 30 day Better Payment Practice Code a further deterioration, due to increased pressure on cash arising from the adverse I&E position

9. CAPITAL AND CASHFLOW

Summary Cashflow - Year to date	£000's
Operating Deficit	(14,772)
Interest Paid	(11,125)
PDC Dividend Paid	(2,031)
Interest received	391
Impairments	(4,520)
Transfers	(46)
Net I&E deficit (cash impact)	**(32,103)**
Depreciation and Amortisation	7,003
Movements in working balances:	
Decrease in Inventories	302
Increase in Trade and Other Receivables	(1,294)
Increase in Trade and Other Payables	30,678
Decrease in Provisions	(422)
- sub-total	4,164
Capital expenditure	(3,892)
Revenue Rental Income	611
Net cashflow before financing	883
Capital Element of Finance Leases and PFI	(2,692)
Loans repaid	(0)
Public Dividend Capital Received	-
Net Increase/(Decrease) in Cash and Cash Equivalents	**(1,809)**
Opening cash balance	2,830
Closing cash balance	1,021

Capital Expenditure (£'000)	Allocation	YTD expenditure	% of alloc spent
Medical Equipment	1,279	283	22%
IT	2,473	1,103	45%
Estates	3,983	1,936	49%
Capital TVEs	198	0	0%
Revenue to Capital	750	291	39%
Sub-total	**8,683**	**3,613**	42%
KGH Polyclinic	-	-	
(Over Committed) \ Unallocated	(216)	-	0%
Total programme (Cashflow)	**8,467**	**3,613**	43%
MES Refresh	5,500	986	18%
Major schemes:			
Maternity	2,000	-	0%
A&E	3,000	-	0%
Cardiac Lab	3,000	-	0%
CT Scanners	2,000	-	0%
PAS Procurement	2,900	-	0%
SAN Virtualisation (Server)	1,000	-	0%
Total (Balance Sheet)	**27,867**	**4,599**	17%

Cashflow - Key points:

- The year to date cash deficit arising from the I&E position stands at £32.1m, largely supported to date by SLA advances from ONEL PCTs (£24.9m), which forms part of the increase in other payables figure.
- The Department of Health has agreed to release additional cash (as Temporary Public Dividend Capital) of £45m in October, to ease the cash position & enable reduction in creditor levels and repayment of PCT advances.
- However, it should be noted that this advance does not cover the cash impact of the I&E deficit beyond the agreed control total of £41m (the £45m covers the control total and £4m cash imbalance from last year)

Capital - Key points:

- Year to date capital expenditure is £4.6m, with £1.0m of this part of the Managed Equipment refreshes
- The Trust has submitted a business case to NHS London for the SAN Virtualisation (Server) & is in the process of tendering for the new PAS System.

10. Financial Risk Rating (Using Dept of Health's risk bandings between 1.0 and 3.0 where riskier organisations score closer to 1)

The weighted financial risk score for September is 1.13, (August 1.33). The downward movement is caused by an upward revision of the forecast deficit and an upward movement in creditor days.

Financial indicators for acute & ambulance trusts : BHRUT SEPTEMBER 2011

Criteria	Metric			Weight (%)		Measure	SCORING 3	SCORING 2	SCORING 1	BHRUT Raw Score SEP 11	BHRUT Weighted Score SEP 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	-10.3%	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: YTD planned operating breakeven/ surplus/deficit - YTD actual operating breakeven or surplus / Forecast Income x 100	Formula for organisations with a YTD actual operating deficit: YTD operating deficit / Forecast Income x 100	25	20	-8.0%	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	-3.0%	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	-11.5%	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	-1.6%	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
	Rate of Change in Forecast Surplus or Deficit	(Current period forecast surplus/deficit) - (Prior period forecast surplus/deficit) / Forecast Income x 100			15	-18.2%	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.	1	0.15
Underlying Financial Position	Underlying Position %	Underlying Breakeven/Surplus/Deficit / Underlying Income x 100		10	5	-10.9%	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 i.r%	Underlying EBITDA / Underlying Income x 100			5	-2.3%	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	61%	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	2	0.05
	Better Payment Practice Code Volume %	Volume of ALL Bills paid within target / Volume of ALL Bills paid within the year x 100			2.5	44%	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	0.44	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	1	0.05
	Debtor Days	Debtors as at current period / Forecast Income x365			5	21	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	68	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
				100	100					16	1.13

*Operating Position = Retained Surplus/Breakeven/deficit less impairments

TFA document

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

Tripartite Formal Agreement between:

- Barking, Havering and Redbridge University Hospitals NHS Trust
- NHS London
- Department of Health

Introduction

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

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

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

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

Prior to signing, NHS Trust CEOs should have discussed the proposed application date with their Board to confirm support.

In addition the lead commissioner for the Trust will sign to agree support of the process and timescales set out in the agreement.

The information provided in this agreement does not replace the SHA assurance processes that underpin the development of FT applicants. The agreed actions of all SHAs will be taken over by the National Health Service Trust Development Authority (NTDA)[1] when that takes over the SHA provider development functions.

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

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

Standards required to achieve FT status

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

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

Alongside development activities being undertaken to take forward each NHS Trust to FT status by April 2014, the quality of services will be further strengthened. Achieving FT status and delivering quality services are mutually supportive. The Department of Health is improving its assessment of quality. Monitor has also been reviewing its measurement of quality in their assessment and governance risk ratings. To remove any focus from quality healthcare provision in this interim period would completely undermine the wider objectives of all NHS Trusts achieving FT status, to establish autonomous and sustainable providers best equipped and enabled to provide the best quality services for patients.

[1] NTDA previously known as the Provider Development Authority – the name change is proposed to better reflect their role with NHS Trusts only.

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

1 April 2013 subject to outcome of Board to Board on 18 October 2011 (Board to Board decision will determine route to FT)

Part 2a - Signatories to agreements

By signing this agreement the following signatories are formally confirming:

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

as covered in this agreement.

Averil Dongworth, Chief Executive Officer Barking, Havering and Redbridge University Hospitals NHS Trust	Signature  Date: 28 September 2011
Dame Ruth Carnall, DBE Chief Executive, NHS London	Signature  Date: 28 September 2011
Ian Dalton, Director General Provider Development	 Signature Date: 30 September 2011

Part 2b – Commissioner agreement

In signing, the lead commissioner for the Trust is agreeing to support the process and timescales set out in the agreement.

Heather O'Meara, Chief Executive, Outer North East London Cluster Chief Executive	Signature  Date: 28 September 2011

Part 3 – NHS Trust summary

Short summary of services provided, geographical/demographical information, main commissioners and organisation history.

Required information

Current CQC registration (and any conditions):

In April 2010 BHRUT had 8 conditions to registration imposed by the CQC, 7 of which have now been lifted.

In March 2011 the CQC imposed a Warning Notice on Maternity Services, 2 further notices in June, A&E; and Staffing and in July they also commenced a wide ranging investigation into care provided by the Trust. That report is expected in late September 2011.

Financial data

	2009/10 £000s	2010/11* £000s
Total income	397,400	407,107
EBITDA	9,600	2,800
Operating deficit**	22,309	32,986
CIP target	33,300	35,900
CIP achieved recurrent	22,400	16,400
CIP achieved non-recurrent	7,800	6,500

Source: DH FIMS

*Audited figures

**Excludes impairments/IFRS adjustments

The NHS Trust's Main Commissioners

- Havering 234,000 pop. 41% elective and 35% emergency
- Barking and Dagenham 176,000 pop. 24% elective and 27% emergency
- Redbridge 268,000 pop. 21% elective and 25% emergency
- South West Essex 388,300 pop. 8% elective and 6% emergency

Summary of PFI schemes (if material)

Queen's Hospital was constructed by Bovis Lend Lease under a £261m PFI agreement and opened in December 2006. Catalyst Lend Lease is responsible for managing its day to day upkeep, long term maintenance and soft FM services under a 36 year project agreement. A fully managed Equipment service is provided by Siemens plc healthcare division. The current Unitary payment for this facility is £47m which is inclusive of hard and soft FM services and Managed Equipment Services (MES).

Further Information

Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) is one of the largest Acute Trusts in the country and the biggest provider of acute healthcare services in Outer North East London (ONEL), serving a local population of over 750,000 from a wide range of social and ethnic groups. The Trust operates two A&E departments alongside other acute services covering all the major specialties of large district general hospitals as well as a joint Cancer Centre with Barts and The London NHS Trust and a regional Neurosciences Centre with a population base of some 2.1 million.

BHRUT operates out of the state-of-the-art Queen's Hospital (QH) Romford which was opened in December 2006 (PFI hospital) and King George Hospital (KGH) (Ilford) opened in 1993.

The Trust has 1,269 inpatient beds, of which 813 are at the QH site with the remaining at KGH. In addition, there are 132 day beds (split between QH and KGH, 84 and 48 respectively). The Trust provides a wide range of outpatient services at both its main hospital sites and satellite locations.

The Trust employed 5,655 WTE permanent staff in 2010/11 and also used 565 temporary staff.

In recent years the Trust has been designated as a Hyper Acute Stroke Centre and a Stroke Unit. It has achieved Trauma Unit status (in collaboration with the Royal London).

The projected total income for 2011/12 is £407.1m. For 2010/11 the in-year deficit was £35.0m which brought the accumulated deficit to £149.9m as at 31 March 2011.

Part 4 – Key issues to be addressed by NHS Trust

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

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

STRATEGIC AND LOCAL HEALTH ECONOMY ISSUES

In relation to service reconfiguration BHRUT is significantly impacted by the proposed Health4NEL proposals which are subject to an Independent Review Panel with resulting uncertainty on both timescales and content of any changes.

Service reconfiguration- major changes envisaged for KGH, with significant knock on impact on Queen's and estate owned by PCTs.

Integration of community services- BHRUT are actively exploring with ONEL opportunities to integrate with community services via leadership of integrated pathways.

Not clinically or financially viable in current form- relates to financial position (see below) but H4NEL also made recommendations based on appraisal of changes required within North East London to deliver long term clinical sustainability.

Local health economy sustainability issues- see comments on H4NEL above.

Contracting arrangements- history of arbitrations, especially with regard to non-PbR elements of the contract.

FINANCIAL

Current financial position- BHRUT has failed to breakeven since its creation and 2011/12 marks six years of financial imbalance and has been subject to a public interest report from External Audit. The total accumulated deficit will be c£185m by end of 2011/12. Against this figure, the London Challenge Trust Board (CTB) to date has only earmarked £84m for debt repayment. **Level of efficiencies-** Very large CIP Programme (£28.2m). Currently clinical performance generally around national average (but in 2010/11 average length of stay (LoS) generally above national average).

PFI plans and affordability- Queen's is a new PFI funded hospital (December 2006) with a unitary payment of £47m. The scale of the scheme and the payment arrangements significantly contribute to BHRUTs financial difficulties and are currently a major obstacle to ultimately achieving FT status.

Other Capital Plans and Estate Issues- H4NEL implementation requires significant capital expenditure. There are opportunities to rationalise the local health economy estate if planned across the whole economy and not looked at in isolation.
Loan Debt- see above.
Working Capital and Liquidity- BHRUT has historically had significant problems making payments within time to creditors due to its deficit position.

QUALITY AND PERFORMANCE
QIPP- there is a significant QIPP requirement as reflected in the CIP Programme and in the transfer of activity to polysystems.
Quality and clinical governance issues - The Trust received a weak rating from the Care Quality Commission (CQC) for quality of services in 2009/10 and at the time 8 conditions to registration were imposed by the CQC, 7 of which have now been lifted. However, in March 2011 the CQC imposed a warning notice on Maternity services relating to staffing, safety of care and equipment with 2 further conditions for A&E and Staffing in June. The CQC are also undertaking a wide ranging investigation into the Trust's performance.
Service performance issues- The Trust has historically struggled to maintain performance against the A&E 4 hour standard. Performance during 2010/11 and the first quarter of 2011/12 were often below profile. The Trust has recently improved and the Trust wide performance has been at 95% or better since 19 June 2011. Elective performance is satisfactory and BHRUT is currently achieving the cancer wait time's targets.

GOVERNANCE AND LEADERSHIP
A new Chief Executive Officer has been appointed and an interim Chairman is in place. In May a permanent Medical Director was appointed and all other Executive and Non Executive Director positions are in place.

Board capability and non-executive support- BHRUT successfully applied for NHSL funding to assist in Board development. The Board has a clear focus on tackling long standing performance issues and ultimately attaining FT status and has a good mix of Executives and Non-Executives of public and private enterprise backgrounds.

Part 5 – NHS Trust actions required

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

Describe what actions the Board is taking to assure themselves that they are maintaining and improving quality of care for patients.

Standard item on Trust Board Agenda. Quality and Strategy sub committee of the Trust Board established and Chaired by Edwin Doyle (BHRUT Interim Chair).

Visible Leadership Programme headed by Director of Nursing.

Regular patient surveying introduced via handheld devices.

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

Strategic and local health economy issues
Sector support for the Integrated Business Plan (IBP) and transition to FT status is predicated on the following improvements to service quality and performance:

- The removal of all conditions to registration by the CQC and any recommendations arising from the current CQC investigation.
- Delivery of the Operating Framework priorities for 2011/12 in preparation for delivery of the NHS Outcomes Framework in 2012/13 onwards. Areas requiring specific performance improvement are listed below:
  - Sustainable delivery of all A&E indicators set out in the 2011/12 Operating Framework;
  - Maintaining delivery of Cancer targets;
  - Demonstrable improvements in patient experience as measured from local and national surveys

Lead: Averil Dongworth, Chief Executive
Timescale: see milestones

Integration of community services and current financial position
The scale of the financial challenge facing BHRUT coupled with the proposed changes to North East London's service configuration makes it vital that BHRUT not only engages in a

systematic process of improving operational efficiency but also increases its income base by taking on additional elective work and pursuing integration of pathways with community services. These income opportunities are being taken forward with the ONEL Sector. A conservative view has been taken as to their contribution to the financial position in 2011/12 (not least because they will have various lead in times) but they are seen as integral to the longer term financial viability of BHRUT including making a major contribution in 2012/13 and beyond.
Leads: Neill Moloney, Director of Planning & Performance, David Wragg, Director of Finance and Robert Royce, Director of Strategy Timescale: December 2011

Financial
Current Financial Position
The size of the saving required to obtain breakeven is such that alternative/ innovative service approaches must be found to create any realistic chance of achieving a breakeven position in a reasonable timeframe. This has included the Trust responding to tender advertisements for additional activity, such as the North East London Treatment Centre contract which is out to tender (North East London Treatment Centre /Independent Sector Treatment Centre contract expires December 2011).
Lead: Robert Royce, Director of Strategy Timescale: Quarter 2 – 2011/12

CIP- BHRUT has a £28.2m CIP Programme for 2011/12. ***Lead: David Wragg, Director of Finance Timescale: By end of 2011/12***

An assessment of the financial challenges and productivity opportunities by provider, incorporating the impact of commissioner QIPP plans has been undertaken for London's acute NHS Trusts. With the analysis, as it applies to BHRUT the trust is in the process of revamping its cost improvement programme into a larger clinical productivity programme with strengthened governance arrangements. The clinical productivity programme is to be aligned with a wider review of the service configuration and use of the estate which will have implications for the FT pipeline, including the need for Capital and pump priming funding to promote rapid service change.
Lead: Averil Dongworth, Chief Executive

Other capital and estate plans
Working with the Sector to review opportunities to utilise entire local health economy estate via integrated pathways.
Lead: Averil Dongworth, Chief Executive Timescale: Quarter 4 2011/12

Quality and Performance
Service Performance
The Trust has improved performance and achieved the 95% standard since 19 June 2011 and is on course to maintain the standard though the rest of 2011/12. However, achievement of the A&E 4 hour target is still not felt to be totally robust and a series of actions are in place to support achievement of the standard on an ongoing basis.
Lead: Averil Dongworth, Chief Executive Timescale: August 2011

Quality and Clinical Governance
Trust actively working to remove <u>all</u> CQC conditions/ warning notices, to address adverse patient survey results and improve it national position on avoidable deaths.
Leads: Deborah Wheeler, Director of Nursing and Stephen Burgess, Medical Director Timescale: November 2011

Governance & Leadership
Board Development

The Trust has appointed a permanent Medical Director to support delivery of the Health4NEL service reconfigurations and is engaging in an extended process of clinical engagement to facilitate performance improvement, particularly for the emergency pathway.

The Trust is undertaking a series of Board development sessions.
Lead: Averil Dongworth, Chief Executive

Part 6 – SHA actions required

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

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

Strategic & Local Health Economy Issues
ONEL Cluster support for the BHRUT Integrated Business Plan (IBP) is predicated on the plan being consistent with delivery of the Health4NEL Strategic Business Case.

Delivery of the service changes and productivity improvements are currently not sufficient to deliver sustainable financial balance. ONEL Cluster is therefore working with the Trust to identify additional service changes to deliver financial balance that are consistent with the ONEL QIPP and can be made within procurement and competition rules with the identified opportunities including:

- Procurement process for the North East London Treatment Centre (NELTC) (contract due to end in December 2011) to provide an integrated elective offering across KGH campus including NELTC with the procurement carried out in accordance with competition rules;
- Integration of some community services providing opportunities for service efficiency and income growth.

Lead: Heather Mullin, ONEL Cluster Chief Executive – 31 December 2011

Financial
The Trust has a historic deficit of £149.9m as at the end of 2010/11, with an offset of £84m earmarked from the London Challenged Trust Board. In 2010/11 the Trust reported a deficit of £33m missing the control total by £19m. The current IBP does not demonstrate financial breakeven to the timescales required to attain FT status by April 2014.

The IBP assumes a cost improvement programme of 8% in 2011/12. The Trust will need to demonstrate ongoing delivery of the CIP for the Sector and NHSL to support the FT application. NHS London's CTB has an earmarked budget of £84m to match the historic deficit of BHRUT. The Trust has to achieve the CTB's criteria to receive the funding in full (e.g. positive run rate on income and expenditure account). The Trust's accumulated deficit (actual to date and forecast to 31/3/2012) exceeds the earmarked budget of the London CTB.
Lead: NHSL Director of Finance

The SHA is contributing to the national work on PFI and will work with the Trust in resolving the outstanding PFI issues as a result of the national financial review.
Lead: Regional Director of Provider Development

ONEL Cluster has identified strategic opportunities for commissioning intentions to support financial recovery, and these were included in the Cluster's response to the IBP in January 2011:

- Repatriation of tertiary or specialist work to BHRUT;
- Realignment of elective work across the Sector subject to procurement rules;
- Vertical integration along emergency care pathways;
- Alignment of UCC and A&E provision at QH;
- BHRUT provision of outpatient shifts to community at reduced tariff;
- Supporting the Trust to increase Category C income;
- Utilisation of KGH capacity for renal satellite unit and rehab to support acute ward closure program.

Lead- Heather Mullin, Cluster Chief Executive Timescale: 31 December 2011

Actions the Cluster will take to support improvements in service quality will be:

- The Cluster has commissioned an independent review of Maternity services to support delivery of quality improvements and Heatlh4NEL service models;
- Alignment of UCC and A&E provision at QH;
- Options for vertical integration along elective and non-elective pathways;
- Joint appointment for Community Support Programme to improve A&E performance;
- Use of contract schedules as a lever to improve service quality and performance;
- Establishing a performance framework setting out standards required for Sector support of FT status.

Lead: ONEL Medical Director/ Performance Director. CEO Timescale: To be determined

Part 7 – Supporting activities led by DH

Actions led by DH to support delivery of date in part 1 of agreement	
Strategic and local health economy issues Alternative organisational form options	☐
Financial NHS Trusts with debt	☒
Short/medium term liquidity issues	☐
Current/future PFI schemes	☒
National QIPP work streams	☐
Governance and Leadership Board development activities	☐
Other key actions to be taken (please provide detail below	☐

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

Financial
NHS Trusts with debt
The Trust's accumulated deficit (actual to date and forecast to 31/3/2012) exceeds the potential earmarked budget of the London CTB. NHSL is in discussion with DH re potential solutions.
Lead: NHSL Director of Finance & DH

A national financial review of Trusts with a PFI hospital is takingplace to gain a common understanding of any issues that might be an obstacle to passing the financial elements of the FT assessment process. Some elements contained within the TFA will be subject to the outcome of this review in enabling any issues outlined in this agreement to be resolved. This will be confirmed on a case by case as the PFI work is completed and communicated.
Lead; DH Director of Provider Delivery

Part 8 – Key milestones to achieve actions identified in parts 5 and 6 to achieve date agreed in part 1

Date	Milestone
30 June 2011	Agreement reached on BHRUT assuming reasonability for integrated elderly pathway with transfer of staffing and assets during 2011/12
30 June 2011	BHRUT achieving 95th percentile standard for all A&E departments- then sustained to year end.
30 June 2011	BHRUT achieving all Cancer targets- then sustained to year end
30 June 2011	Agreement of volumes and value of transfer of elective work from Whipps Cross and tertiary providers during 2011/12 and 2012/13
30 June 2011	Financial return at month 2 on target against plan YTD and year-end projection in control
31 July 2011	SHA financial challenges and productivity opportunities assessment
20 September	Board to Board on financial challenge and productivity opportunity
30 September 2011	Financial return at month 5 on target to meet £28.8m (including IFRS) control total
18 October 2011	Board to Board. Trust will have prepared in advance a plan for delivery of FT Trajectory that takes into account the SaFE review. The following timetable is subject to review following Board to Board on 18th October 2011. If alternative approach is required it will be decided at this time.
31 October 2011	Review and refresh of IBP and LTFM ideally informed by Independent Reconfiguration Panel decision Review of Q1 and Q2 quality, service and financial performance (including achievement and trajectory of CIPs)
30 November 2011	Financial return at month 7 on target to meet £35.6m (including IFRS) control total
30 November 2011	Application to CQC for removal of conditions
30 November 2011	Establishment of Clinical Productivity Programme – year 1 of full delivery 2012/13
July, Oct, Dec, April 2011-2013	Quarterly reviews of finance (including achievement and trajectory on CIPs (11/12); clinical productivity programme from 12/13), quality and performance, including waiting list/18 weeks actions and milestones will be undertaken with the Trust
31 December 2011	Financial return at month 8 on target to meet £28.8m (including IFRS) control total.

31 March 2012	£35.6m deficit control total for 2011/12 projected to be met
31 March 2012	No CQC conditions

The following timetable is subject to review following Board to Board on 18 October 2011

June 2012	Submit IBP & LTFM
June/ July 2012	Historical Due Diligence part one
July - October 2012	Undertake public consultation
August 2012	Safety and Quality Assurance Gateway Review
October 2012	Historical Due Diligence part two
December 2012	Final IBP & LTFM
January 2013	Board to Board meeting
February 2013	Trust Board formal approval of FT application
March 2013	SHA Board approval
April 2013	Submission of FT application to DH

Provide detail of what the milestones will achieve\solve where this is not immediately obvious. For example, Resolves underlying financial problems – explain what the issue is, the proposed solution and persons\organisations responsible for delivery.

Describe what actions\sanctions the SHA will take where a milestone is likely to be, or has been missed.

NHS London's monthly performance monitoring process will highlight challenges to FT pipeline milestones with regard to quality, service performance & finance and address these in monthly performance improvement meetings with the trust (and include the Cluster). In addition, NHSL's Provider Development Directorate will link this to a NHSL TFA tracker and where a milestone not related to in year performance is likely to be missed, the Regional Director of Provider Development will hold a review meeting with the Trust Chief Executive. Where required, these meetings will include relevant SHA Directors and be chaired by the SHA Chief Executive. These meetings may also involve the SHA Chair, the Trust Chair or a Board to Board meeting. The outcome of the milestone review meeting will be a recovery plan with escalation to DH where necessary.

Key Milestones will be reviewed every quarter, so ideally milestones may be timed to quarter ends, but not if that is going to cause new problems. The milestones agreed in the above table will be monitored by senior DH and SHA leaders until the NTDA takes over formal responsibility for this delivery. Progress against the milestones agreed will be monitored and managed at least quarterly, and more frequent where necessary as determined by the SHA (or NTDA subsequently). Where milestones are not achieved, the existing SHA escalation processes will be used to performance manage the agreement. (This responsibility will transfer to the NTDA once it is formally has the authority)

Part 9 – Key risks to delivery

The top three risks, as agreed with the ONEL Sector and joint submitted to NHS London in September 2010 are:

Risk	Mitigation including named lead	Named Lead
Insufficient Commissioner resource/ clinical activity across North East London to support three acute Foundation Trusts and the possible impact on BHRUT. Linked with this, is the financial viability of BHRUT's service configuration over the period leading up to FT submission including possible changes to Trust service portfolio	1. Ensure that the Trust maintains the 2 sites; 2 scenarios re: service reconfiguration (2 A&E and maternity units and 1 A&E and maternity unit) with the implementation building blocks in place to deliver both scenarios. Further scenarios may emerge over time. 2. Work with Commissioners to ensure whole system viability issues have been explicitly considered in determining way forward 3. Explore the opportunities to put in place an integrated health system Estates Strategy that explicitly brings together estate owned by PCT's with those of Trusts and Independent Sector. 4. Implementation of Health4NEL service models	**Robert Royce, Director of Strategy** **Neill Moloney, Director of Planning & Performance** **Robert Royce, Director of Strategy**

Failure to meet required clinical, quality and access targets. In particular that delivery of required quality and patient experience improvements occurs over a longer time period than planned such that insufficient track record on clinical outcomes and patient satisfaction rating is available for Monitor assessment	1. Senior Clinical leadership team devoted to further improving outcomes and patient experience 2011/12. 2. Revamped focus of the Clinical Governance Committee to be a quality/ outcome focused Trust Board sub committee. 3. Active assessment of systems and pathways in place by high performing Trusts with a view to rapid implementation at BHRUT. Stroke services- RCP latest stroke audit shows BHRUT stroke services in the top quartile nationally. 3 years ago the Trust was in the bottom quartile. Trauma access to theatres within 24 hours as 24% in 2008 and now stands at 80%. This illustrates the Trust's determination to radically improve services	**Stephen Burgess, Medical Director/ Deborah Wheeler, Director of Nursing** **Stephen Burgess, Medical Director/ Deborah Wheeler, Director of Nursing** **Averil Dongworth, Chief Executive**
Challenging multiple performance (quality, financial & workforce) improvements which the organisation has to manage within FT trajectory timescale	1. FT trajectory will be a standing item on Trust Board agenda with Board giving clear leadership on priorities and close scrutiny on progress via programme management reporting. Establishment of sub committees to the Trust Board covering key elements of FT trajectory e.g. HR 2. BHRUT looking to obtain early agreement to the enabling elements of its FT	**Averil Dongworth, Chief Executive**

	trajectory plan. These will need to include agreement on BHRUT management of selected acute and community pathways such as frail elderly care, an agreed health system wide Estates Strategy, resolution of DTOC issues to 1% target and a funding envelope that takes account of the service configuration that will be in place at the time of BHRUT's FT submission.	

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:**
• There is a limited Workforce KPI scorecard for presentation to the Board this month due to the work still in progress relating to the establishment control project. The workforce information team aim to complete this project by mid October , resulting in a shift of establishment control from the financial ledger to the HR ESR system. • The overall number of FTE's in post across the Trust increased by a further 26.32 FTE's on the July 2011 position and has increased by 234.55 FTE's across the 12 month period. The Trust currently has a c7.1% vacancy gap equal to 372 FTE vacancies which is still being covered by bank and agency staff, at higher cost and arguably lower quality . In order to improve quality whilst demonstrating better value for money the Trust Executive Committee has endorsed a proactive strategy to recruit to these vacancies and, following focussed recruitment campaigns this vacancy gap has reduced by c272 FTE's since April - equal to c4.5% • The number of starters has increased on previous months for the first time in four months, there were 59.29 FTE starters in August compared to 40.73 FTE's in July. The number of FTE leavers has increased for the third month in succession - rising from 35.25 FTE's June to 46.70 FTE's in August. • Starters & leavers data analysis over the same period differs from the staff in post growth for the same 3 reasons as in previous reports. 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. • Trust annualised turnover has fallen in month, reducing from 11.65% to 10.88%, this is still 1.12% below the average of other large acute Trusts.	☐ **TEC ……** ☐ **EPB ……..……** ☐ **FINANCE ……** ☐ **AUDIT ……..…** ☐ **CLINICAL GOVERNANCE ……..…..……** ☐ **CHARITABLE FUNDS ……..…** √ **TRUST BOARD October 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: 21 October 2011**

• Following low sickness absence rates from March through to June, The past two months has seen the rates rise again, increasing from 3.63% in June to 5.05% and 5.35% in July and August respectively .BHRUT's benchmarked position shows us as sitting 1.75% above the Trust target of 3.6% and 1.15% above the he average of all other large acute Trusts. . This also means that the Trust has increased its sickness absence costs by c46% since June- spending an estimated £221,350 extra per month. • Overall Trust Bank & Agency spend decreased by a further £8,399 in month, but still accounts for 16.37% of the pay bill. • Overall Trust monthly bookings of Bank & Agency have increased for the fifth month in succession, increasing by 10.62 FTE's on the July position and by 21.11 FTE's since March. • For the first time in eight months the Trust appraisal compliance rate has increased, having risen from 72.09% in July to 76.72% in August - equalling a rise of 4.63% • Resuscitation training compliance has fallen for the eighth month in succession - dropping from 77.38% in July to 72.62% in August, a reduction of 4.76%	
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)**	

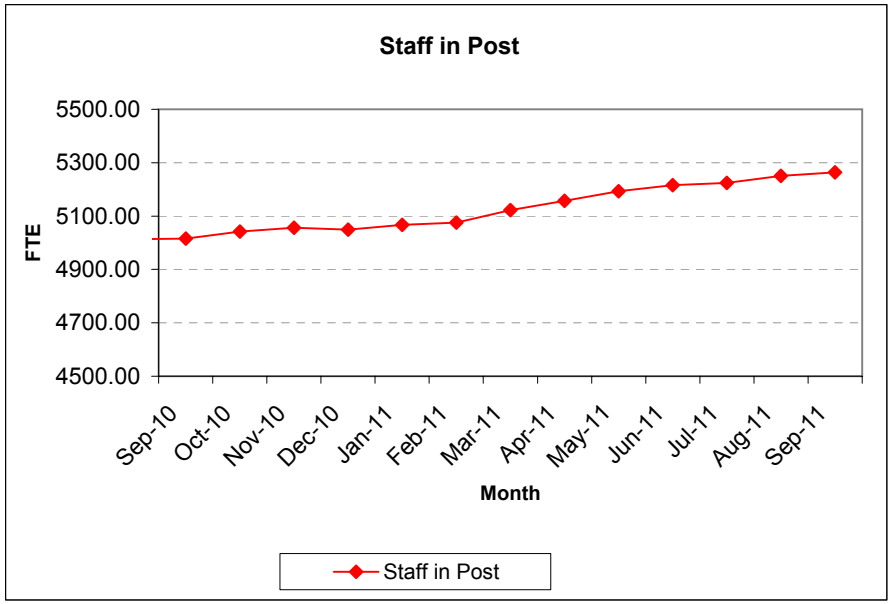
TRUST - WORKFORCE KEY PERFORMANCE INDICATORS - SEPTEMBER 2011

Barking, Havering and Redbridge University Hospitals NHS Trust

Indicator	Target	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	YTD
Staff In Post		5015.97	5041.69	5055.96	5048.64	5067.50	5075.97	5121.85	5157.15	5192.63	5215.55	5223.68	5250.52	5263.48	221.79
Starters *1		61.74	50.77	54.37	25.36	61.09	38.17	87.27	71.44	55.83	46.59	40.73	59.29	70.57	661.48
Leavers *1		46.36	37.91	32.76	32.50	36.28	27.96	50.95	37.23	32.60	35.25	44.96	46.70	49.75	464.85
Turnover (Annualised) *1	12.0%	11.8	12.0%	10.9%	11.3%	11.2%	11.1%	11.1%	11.1%	11.0%	11.0%	11.65%	10.88%	10.69%	
Vacancies (FTE's) Contracted FTE's via Finance ledger									645.10	637.22	619.19	575.80	525.14	433.36	
Trust Sickness Absence % for month	3.6%	3.73	4.06	4.41	4.83	5.26	4.51	3.78	3.40	4.82	3.63	5.05	5.35	4.80	
Trust Sickness Absence Rolling 12 Month Period	3.6%	3.73	3.90	4.07	4.26	4.46	4.47	4.37	4.25	4.31	4.24	4.32	4.40	4.49	
Trust Estimated Cost of Sickness Absence (Month) *2		£442,607	£516,051	£542,212	£599,608	£656,574	£534,500	£523,387	£414,606	£672,178	£482,909	£668,946	£704,259	£618,998	£6,934,228
Appraisals	90.0%	60.0%	72.7%	85.3%	94.7%	93.1%	87.95%	83.11%	83.06%	78.60%	72.40%	72.09%	76.72%	76.03%	
Resus	90.0%		53.6%	73.5%	93.3%	93.1%	89.72%	87.60%	85.52%	80.26%	78.42%	77.38%	72.62%	69.04%	
Paybill Budget		£22,332,464	£22,079,274	£22,318,004	£22,078,804	£21,864,418	£22,163,900	£21,604,748	£22,977,669	£22,735,275	£22,223,328	£22,030,665	£22,326,245	£21,393,649	£265,795,980
Paybill		£23,624,550	£23,960,015	£23,441,035	£23,418,239	£23,464,872	£23,262,763	£22,585,510	£23,625,127	£23,999,750	£24,005,808	£24,058,435	£24,665,197	£24,012,335	£284,499,086
Bank/Agency Spend		£4,048,638	£3,948,964	£3,452,504	£3,370,796	£3,224,520	£3,375,070	£2,662,629	£3,360,963	£3,437,137	£3,361,872	£3,662,378	£3,653,979	£3,259,189	£40,770,001
% Paybill Budget spent on bank & Agency staff		18.13%	17.89%	15.47%	15.27%	14.75%	15.23%	12.32%	14.63%	15.12%	15.13%	16.62%	16.37%	15.23%	15.34%
Overtime Spend (£)		£175,450	£179,732	£192,744	£171,410	£100,662	£137,196	£104,214	£114,580	£131,254	£93,063	£104,179	£112,130	£116,637	£1,557,801
IHB FTE Bookings		678.60	669.04	610.13	591.49	634.39	608.99	709.58	628.10	663.81	637.33	677.85	688.47	646.05	7765.23
IHB FTE Booked as a % of Substantive SIP		13.53%	13.27%	12.07%	11.72%	12.52%	12.00%	13.85%	12.18%	12.78%	12.22%	12.98%	13.11%	12.27%	12.58%

*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



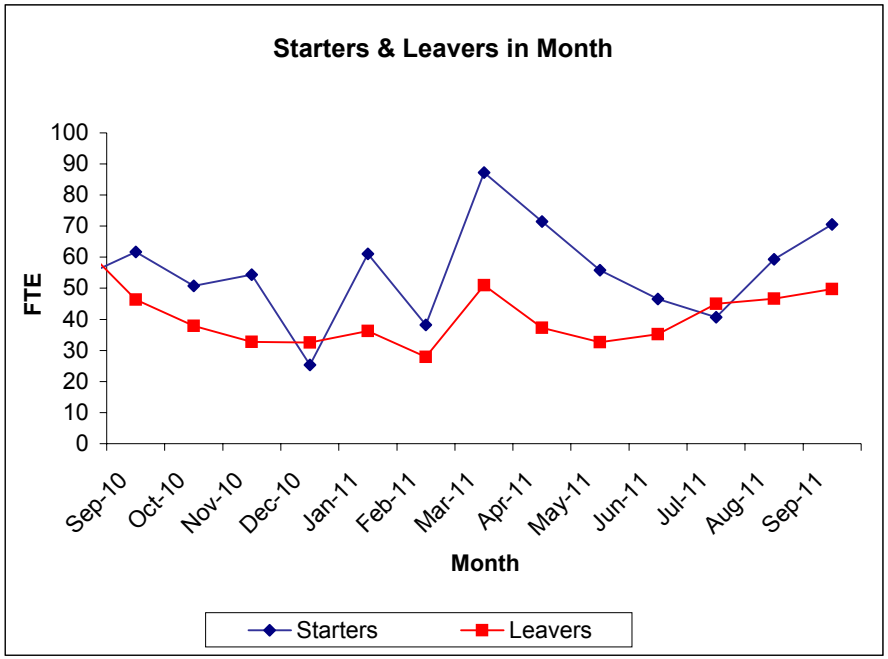


Table 1

	Admin, Clerical & Maintenance	Medical - Career Grades	Medical - Training Grades	Midwives	Other Registered Nurses	HCAs & Patient-care SWkrs	Allied Health Professionals (PAMs)	Professional, Technical & Scientific	Ancillary & Non-patient care SWkrs	Total	Growth Rate (year on year)
Jul-08	929.52	382.73	355.40	225.42	1339.25	593.30	284.06	532.26	82.37	**4724.31**	
Jul-09	980.23	394.91	382.95	231.64	1392.98	605.37	291.75	491.10	65.35	**4836.28**	**2.37%**
Jul-10	980.21	430.10	362.50	231.28	1422.43	684.57	320.34	536.59	30.00	**4998.01**	**3.34%**
Aug-11	960.70	471.24	375.36	281.04	1587.58	693.36	328.17	527.08	26.00	**5250.52**	**5.05%**
Overall Growth Rate	**3.35%**	**23.12%**	**5.62%**	**24.67%**	**18.54%**	**16.87%**	**15.53%**	**(0.97)%**	**(68.43)%**	**11.14%**	

Staff in Post (SIP)

The overall number of FTE's in post across the Trust increased by 39.8 FTE's on the July position and has increased by 221.79 FTE's across the 12 month period. A further analysis of the workforce growth by staff group over the past 3 years has been undertaken, concentrating on changes in the substantive/contracted FTE's only. Table 1 above demonstrates that the total workforce has increased by 5.05% in the past 12 months and 11.14% over the 3 year period. Most notable are the growth rates in the clinical staffing groups where medical staff - career grades, Midwives, Registered nurses, HCA's & support workers and AHP's have all seen significant increases whilst Admin and Clerical staff have only grown by 3%. There were reductions Ancillary & non-patient care support worker staff group due to TUPE 'in of services in 2009.

Starters & leavers

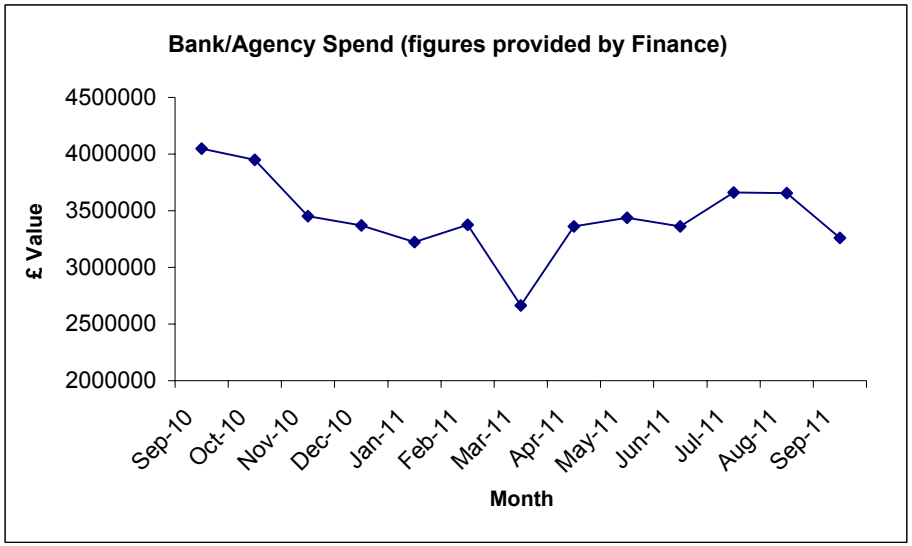
For the first time since March the number of starters increased , with a total of 129.86 FTE's starting in the Trust during August and September. There also continues to be and upward trend in the number of FTE leavers which increased from 44.96 FTE's in July to 49.75 FTE's in September. Supported by the HR Advisors, Divisions have been tasked to actively promote Exit interviews so that 'reasons for leaving' can be truly understood. Findings of this piece of work will be reported within future scorecards once the data has been analysed in a meaningful way.

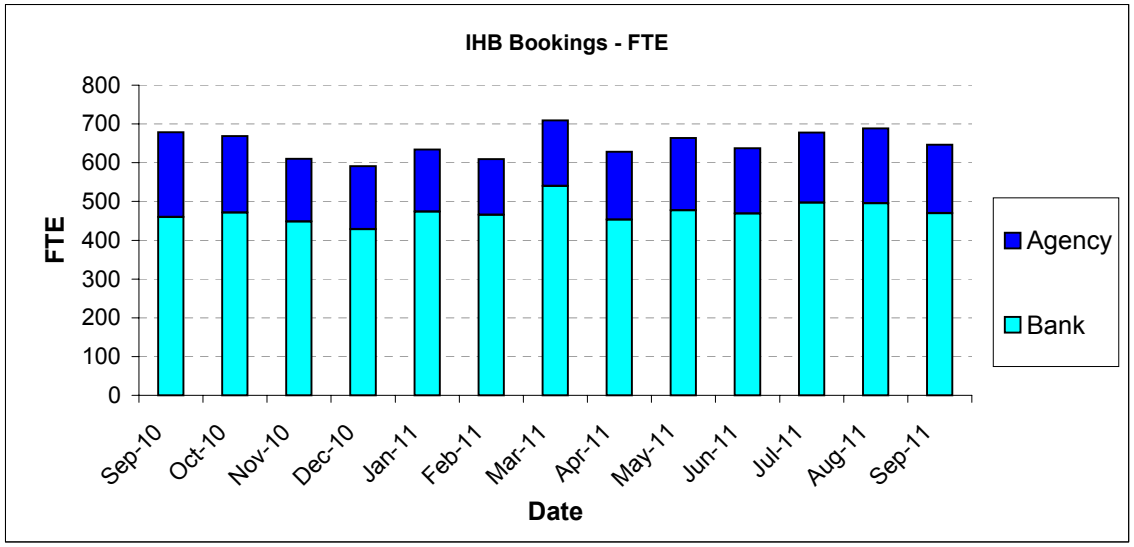
Starters & leavers data analysis over the same period differs from the staff in post growth for the same 3 reasons as in previous reports.

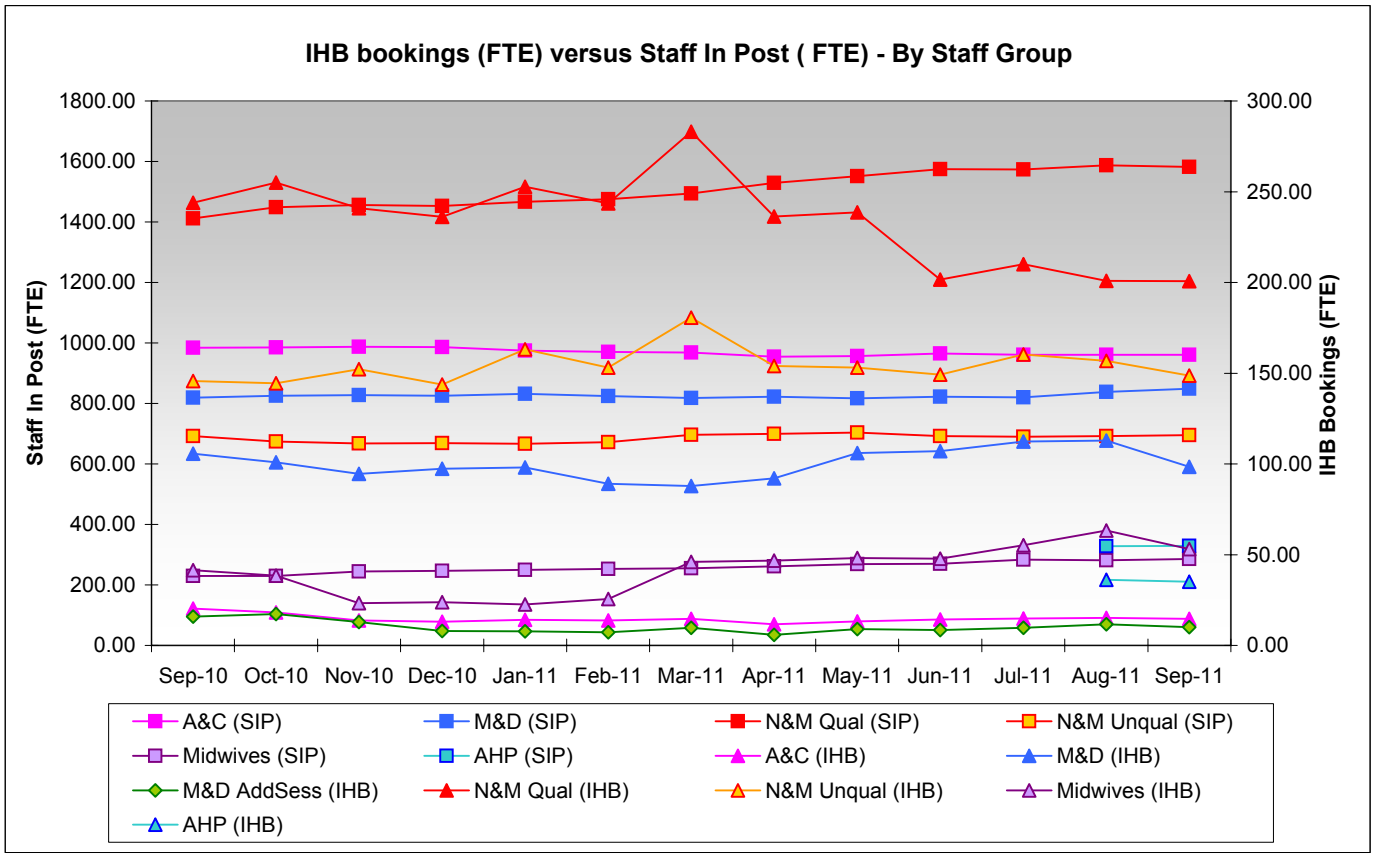
1. If new starters commence employment or leave after the payroll cut off date (midmonth) they will not be entered or removed onto/off ESR until month end – therefore they will not appear on the staff in post report generated from ESR until the following month.
2. Staff who increase or decrease their 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.

Vacancies

As at 30th September there were 433.36 contracted FTE vacancies across the Trust equalling a 7.6% vacancy gap. Vacancies are now calculated using monthly information provided by finance on Budgeted FTE's, Contracted staff in post and the variance between the 2 which equals the vacancy gap, this is then compared to live recruitment activity to provide the number of vacancies outstanding. Contracted staff in post equals the number of physical people and is therefore is a true reflection of the vacancy gaps across the Trust. This method of reporting has been agreed with Finance, in other reporting mechanisms where the term 'actual staff in post ' is used includes any overtime or excess hours worked and therefore equates to worked or paid FTE's rather than the real contracted value. When establishment control shifts to ESR the vacancy gap will be measured using budgeted versus contracted in order to give an accurate picture of the vacancy situation. Progress on the recruitment and temporary staffing projects are report separately to the Board.







Bank & Agency Spend

Overall Trust Bank & Agency spend decreased by £394,790 in month. The bank and agency spend accounts for 15.23% of the pay bill.

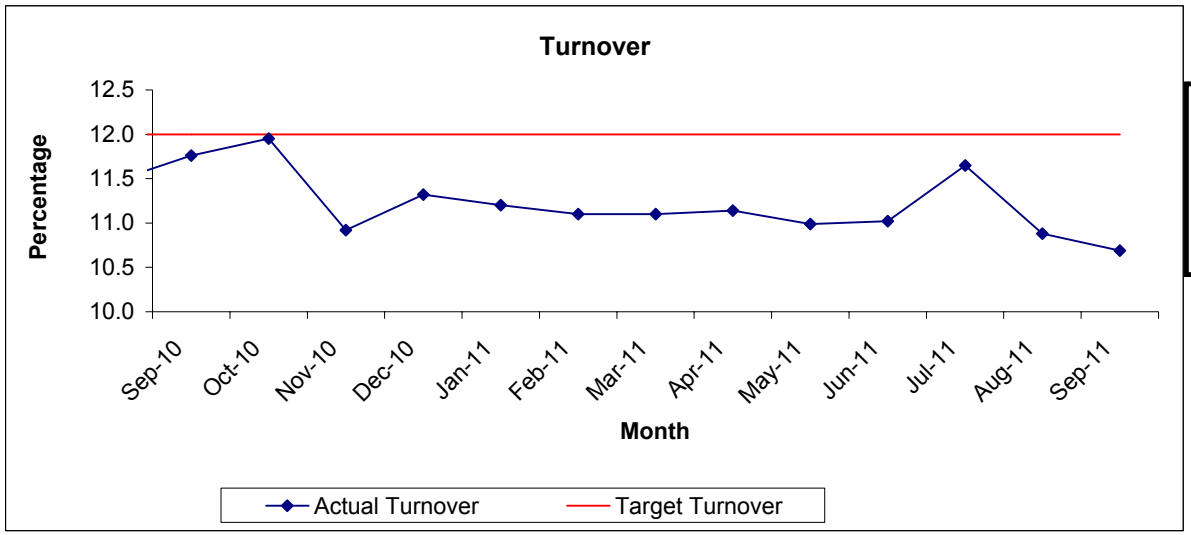
Bank & agency usage

Overall Trust bookings of Bank & Agency have decreased by 42.82 FTE's on the August position, with agency bookings decreasing by 17.16 FTE's and bank bookings decreasing by 25.26 FTE's. These reductions have been reflected in the decrease in temporary staff spend this month. Despite the midwifery workforce growing - albeit slowly, bank and agency FTE bookings dramatically increased in the period January to August with the Division using 40.82 FTE's more than at the beginning of the year. September has seen the first reduction in midwifery temporary staff use over the same period - reducing by 10.25 FTE's on the August position.. In part this is due to having to use agency midwives whilst the new over-seas recruits take part in a robust induction and orientation programme - creating a 'double running' effect and associated costs

Registered Nursing temporary staff bookings have seen the biggest reduction dropping by 82.46 FTE's since February this is expected as the number of staff in post increases. Temporary staffing usage in the Medical & Dental, staff group has also decreased in month by 14.37 FTE's.

TURNOVER

Barking, Havering and Redbridge University Hospitals NHS Trust

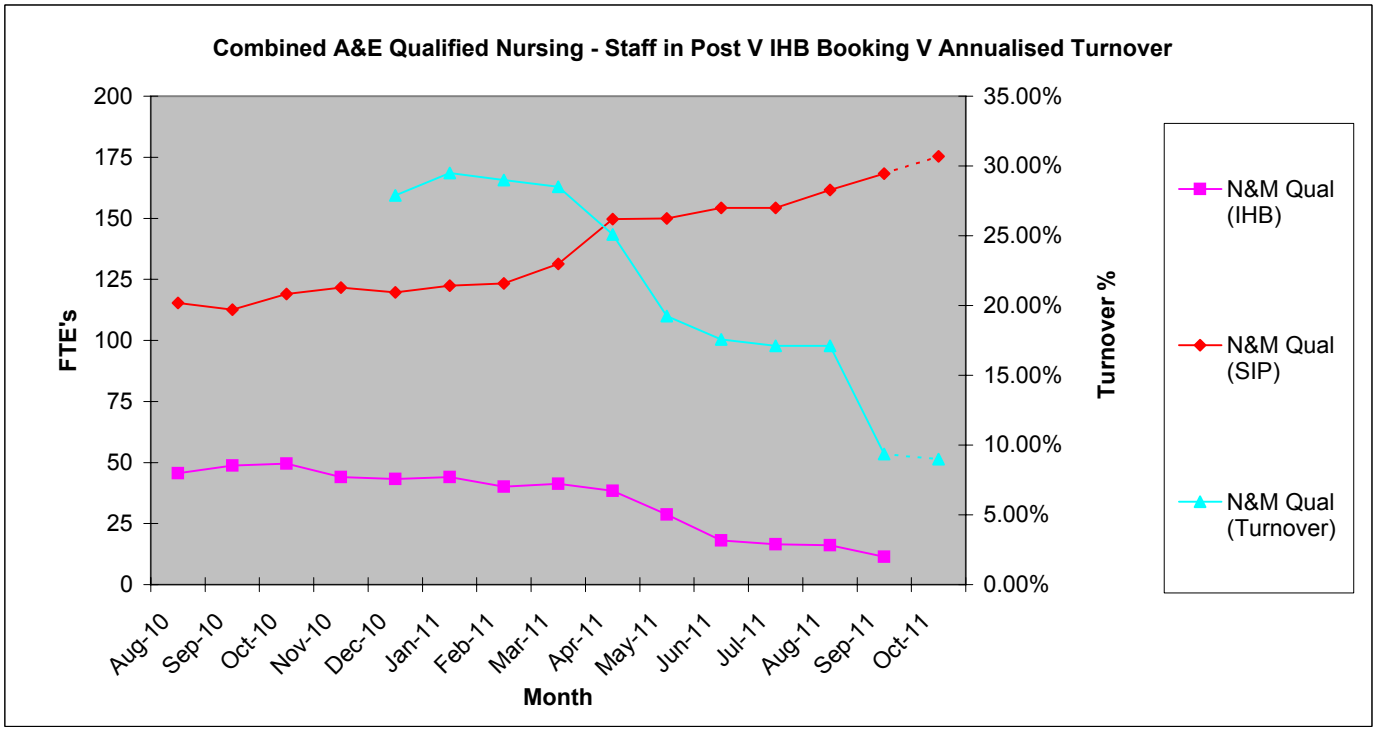


Turnover
Trust annualised turnover has fallen over the past 2 months, dropping from 11.7% in July to 10.7% in September - 1.3% below the average of other large acute Trusts.

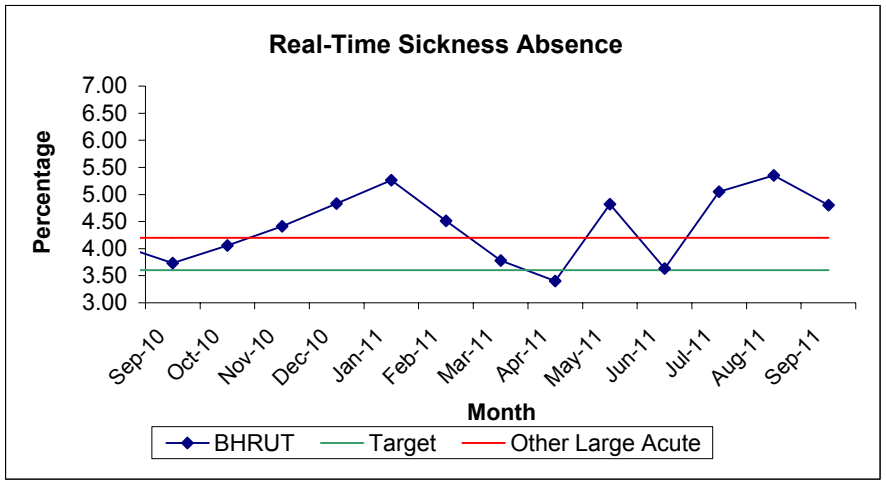
A&E Registered Nursing Turnover, recruitment and temporary staff use - Hotspot monitoring

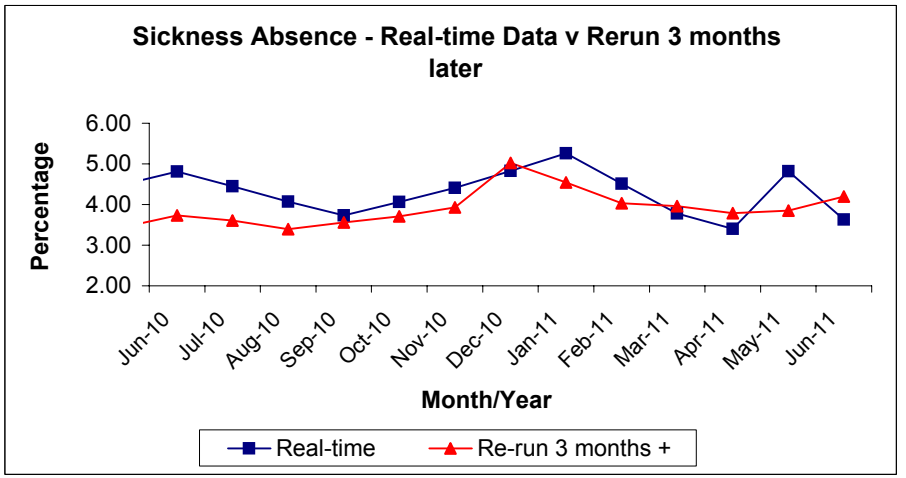
A&E detailed turnover and leavers update for monitoring purposes - The effects of the registered nurse band 5 overseas recruitment & over-recruitment strategy is demonstrated to the right - QH A&E band 5 registered nursing turnover has fallen from 50% to 15.56% since March. KGH A&E band 5 registered nursing turnover has also fallen from 44.4% to 17.02% over the same period. This means the combined rate has fallen from 47.9% to 16.06% - a 66% reduction in turnover at this level. The graph shows the number of FTE's, truonover and tempoarary staff usage for all registered nursing bands within A&E. The division must ensure that the staff recruited in this initiative are retained and delivery of their retention strategy is paramount in ensuring that turnover rates continue to fall. As anticipated within the strategy this is beginning to impact upon temporary staff spend in this area - already discussed in this scorecard.

As anticipated temporary staff usage has also significantly reduced - dropping by 29.92 FTE's since March



SICKNESS ABSENCE





Sickness Absence

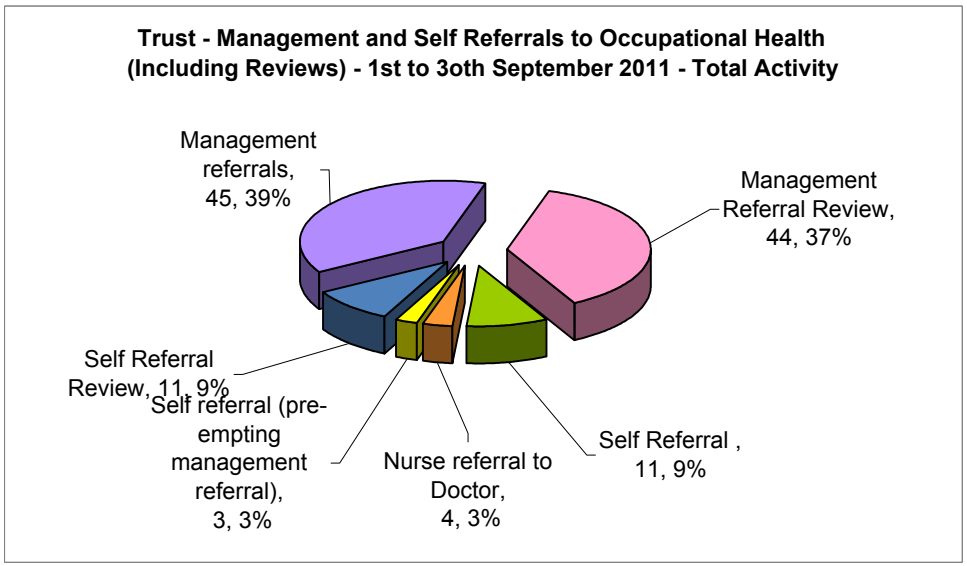
September saw reported sickness absence rates fall by 0.55% to 4.8% following a 2 month increase during July and August. .BHRUT's benchmarked position shows us as currently sitting 1.2% above the Trust target of 3.6% and 0.6% above the 4.20% average of all other large acute Trusts.

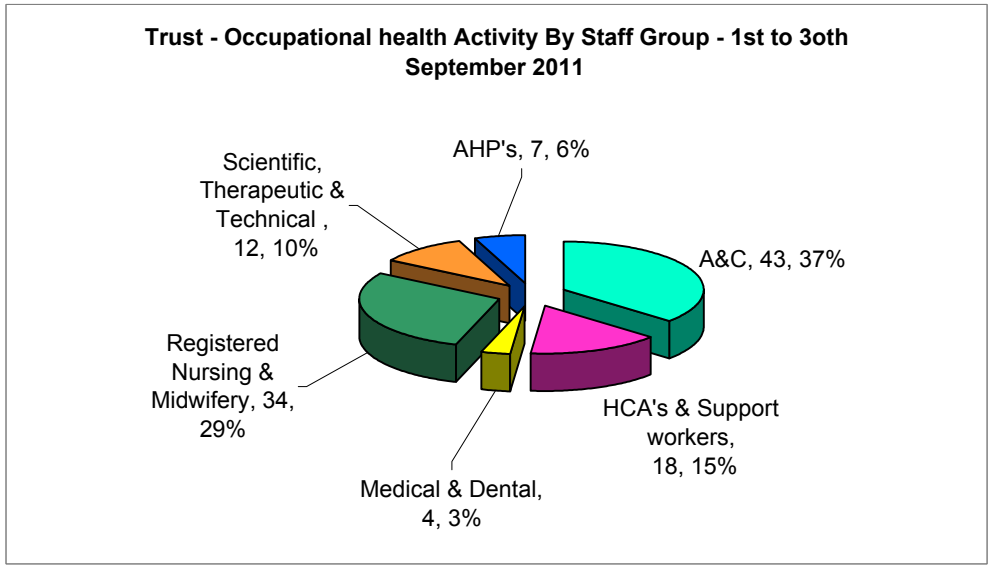
In line with national , regional and local requirements to improve workforce productivity and efficiency we have reviewed and revised our sickness absence target to 3.60% and as discussed in previous workforce dashboards and focus reports the workforce information team now re-run sickness absence reports 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 June 11 was 3.63%..Having re-run the report 3 months later the reported rate for the same month as 4.2% - a gap of 0.57%

Occupational Health Activity relating to Sickness Absence





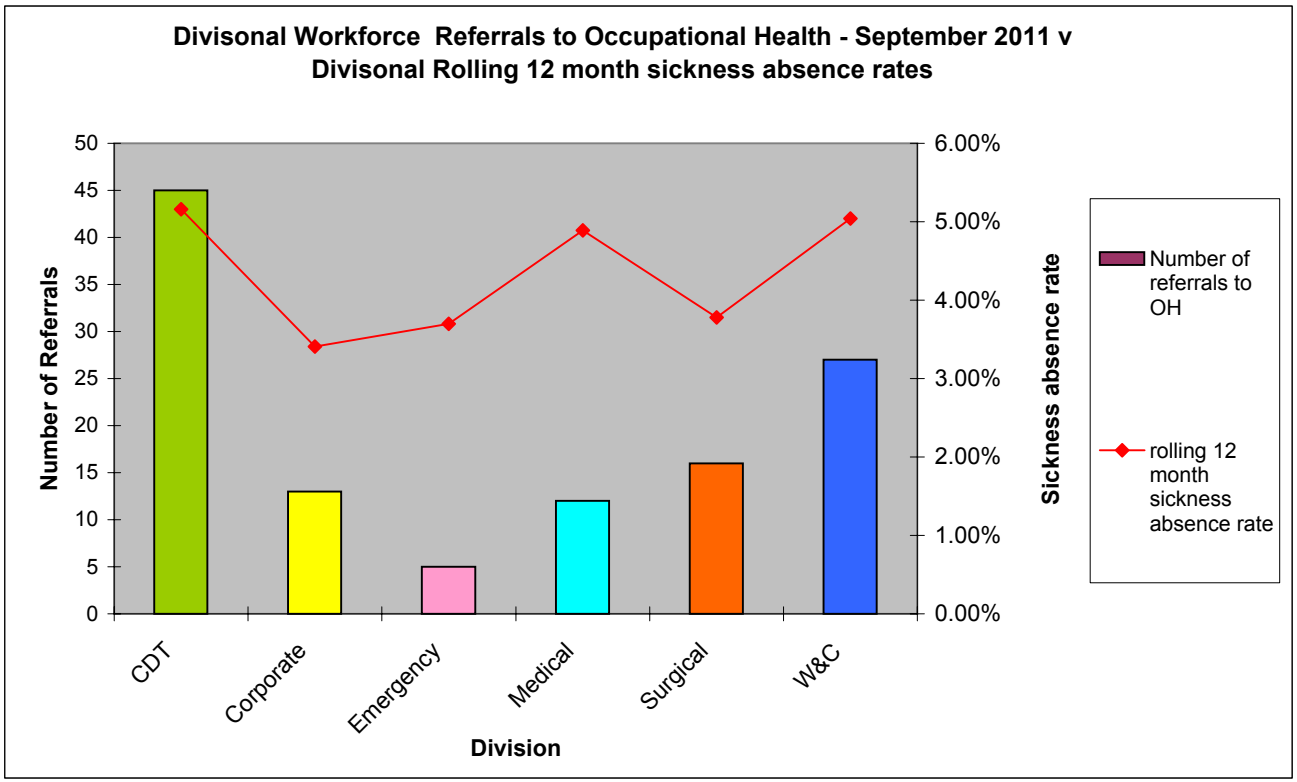
All of the referrals to OH are related to sickness absence. These are either current absence or ongoing issues with either long term or frequent short term sickness absence

Trust-wide there was a total of 118 sickness absence cases processed & handled by the occupational Health department in September 2011

Management referral & Management referral review at 39% and 37% respectively, demonstrate the highest levels of OH activity relating to the Trust. As expected as one of the largest staff groups within the Trust A&C at 37% has the highest number of referrals to the OH department, closely followed by Registered Nursing & midwifery at 29%

These high levels of related OH activity - especially management referrals correlate with the high sickness absence rates at cost centre level within the Divisions - suggesting that management are using the appropriate resources to manage sickness absence.

It has been the policy of the occupational health and wellbeing department to, where possible, decrease the amount of reviews that are carried out, unless clinically necessary. This has been strongly promoted over the past 12 months, with even more emphasis in the past 6 months, with clinical staff being instructed to answer all questions asked (in a management referral), employing a bullet point style of answer where possible. This is an attempt to give specific answers to specific questions and cut down on the 'management issues' that are increasingly forming a large part of the referral cause and reason.



Cross Referencing Divisional workforce referrals to OH against Divisional Sickness absence rates (rolling 12 months)

The graph to the left demonstrates the latest divisional rolling 12 month sickness absence rates versus then umber of referrals to occupational health for the month September. Data shows that whilst CDT is demonstrating the highest rolling 12 month sickness absence rate in the Trust at 5.16% they also demonstrate high levels of Divisionally related OH activity - 45 in month. In the main these are management referral reviews.(19 = 42%) which correlate with the high sickness absence rates across the Division suggesting that management are using the appropriate resources to formally manage sickness absence.

In comparison W&C Division continue with the second highest 12 month sickness absence rate at 5.04% and have needed to increase their number of OH referrals in recent months- this month referrals are substantive at 27s suggesting they are trying to improve the management of staff sickness absence

Employee Relations Casework

Non -Medical Staff Employee Relations Cases	Number active in Month	Target		Number more than 3 months old	Number more than 12 months old	New cases in month
Capability No UHR	4	Yet to be agreed	Of Which	1		1
Capability UHR	12			5	1	3
Grievance	9			4	2	2
Disciplinary	25			18	2	5
Bullying & Harassment	8			5	1	1
Employee Tribunals	4			1	1	

Medical Staff Employee Relations Cases	Number active in Month	Target		Number more than 3 months old	Number more than 12 months	New cases in month
Capability No UHR		Yet to be agreed	Of Which			
Capability UHR	10			8	2	
Grievance						
Disciplinary	8			5	1	
Bullying & Harassment						
Employee Tribunals	1					

Medical ER Case work -
Senior medical workforce ER casework is reviewed and managed by the medical director supported by HR Medical Personnel through a consistent Trust-wide ER framework. Medical ER cases are reported onto the ESR and reported on a monthly basis to accurately inform on the management and progress of all casework.

ESR reports:
• Grievances one case has progressed to ET, with a further submission made for unfair constructive dismissal.

• Bullying and Harassment One has progressed to a disciplinary conduct panel, case against the claimant. One case made against a consultant is being formally investigated.

• Disciplinary One disciplinary investigation last reported as resolved through informal action has now progressed to a disciplinary conduct panel. In total 3 cases scheduled for a conduct hearing October 2011.

• Capability / Behaviour Two groups of consultants referred to NCAS for behaviour assessment following reports impacting on service provision. The second group are in the process of referral for a behaviour assessment as a result of junior doctor feedback to generate facilitated action plans,

• Capability / underlying health ill health one ill health application declined progressed to dismissal. A much higher level of reporting this quarter, what is known has an estimated cost at 409k to cover

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Activity Report August 2011	**Trust Board**
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**

For the period April – September 2011 performance against plan for the Payment by Results (PbR) Points of Delivery (PODs) is summarised in the table below:

POD	Plan	Actual	Var %
A&E	76160	88615	16.35
Daycase	18413	20254	10.00
Elective	3925	3839	(2.19)
Non Elective	33460	39983	19.49
OP First Att	79974	82522	3.19
OP Follow-up	172611	196825	14.03
OP Procedure	11907	16115	35.34
Critical Care	6431	7335	14.06

As can be seen, there is significant over performance in the A&E, Day Case, Non-Elective, Outpatient Follow-up, Outpatient Procedure and critical care PODs. Outpatient First Attendances and Elective activity are broadly on plan. For the elective activity this represents a significant change where this has been shown in previous months to have been under performing. This is largely down to the phasing of the elective activity plan which assumed a significant reduction in outpatient and elective activity during August due to annual leave. The August activity was, however, not dissimilar to previous month's activity.

□ **PEQ**……..…… □ **STRATEGY**……..……..

□ **FINANCE** ……..…… □ **AUDIT** ……..……..…..

□ **CLINICAL GOVERNANCE** ……..……..……..……

□ **CHARITABLE FUNDS** ……..……..

☑ **TRUST BOARD – October 2011**

□ **REMUNERATION** ……..……..

□ **OTHER** ……..…….. (please specify)

2. DECISION REQUIRED:	CATEGORY:
The Trust Board is asked to note the content of the report.	□ **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: October 2011

3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:

4. DELIVERABLES
The delivery of the Trust wide objectives.

5. KEY PERFORMANCE INDICATORS

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

Barking, Havering and Redbridge University Hospitals NHS Trust

Activity Report October 2011

Introduction

For the period April – September 2011 performance against plan for the Payment by Results (PbR) Points of Delivery (PODs) is summarised in the table below:

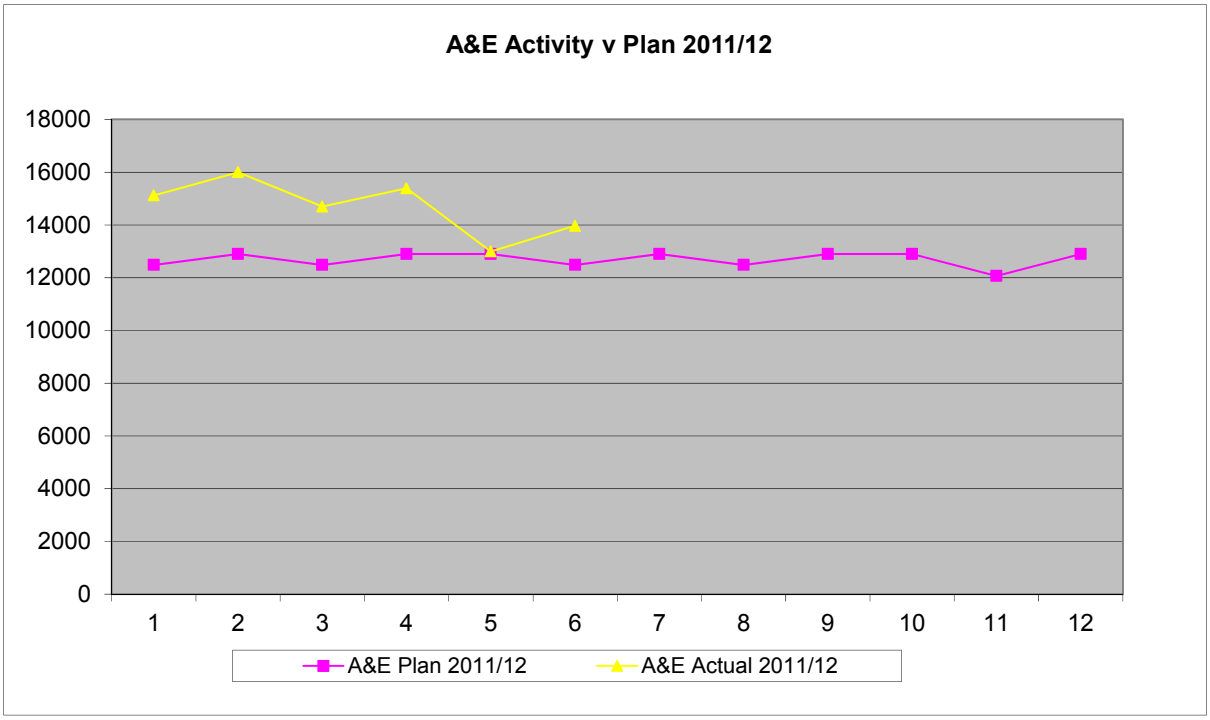
POD	Plan	Actual	Variance	Variance %
A&E	76160	88615	12455	16.35
Daycase	18413	20254	1841	10.00
Elective	3925	3839	(86)	(2.19)
Non Elective	33460	39983	6523	19.49
OP First Attendance	79974	82522	2548	3.19
OP Follow-up	172611	196825	24214	14.03
OP Procedure	11907	16115	4208	35.34
Critical Care	6431	7335	904	14.06

As can be seen, there is significant overperformance in the A&E, Day Case, Non-Elective, Outpatient Follow-up, Outpatient Procedure and critical care PODs. Outpatient First Attendances and Elective activity are broadly on plan. For the elective activity this represents a significant change where this has been shown in previous months to have been under performing. This is largely down to the phasing of the elective activity plan which assumed a significant reduction in outpatient and elective activity during August due to annual leave. The August activity was, however, not dissimilar to previous month's activity.

Each individual POD is discussed in more detail below.

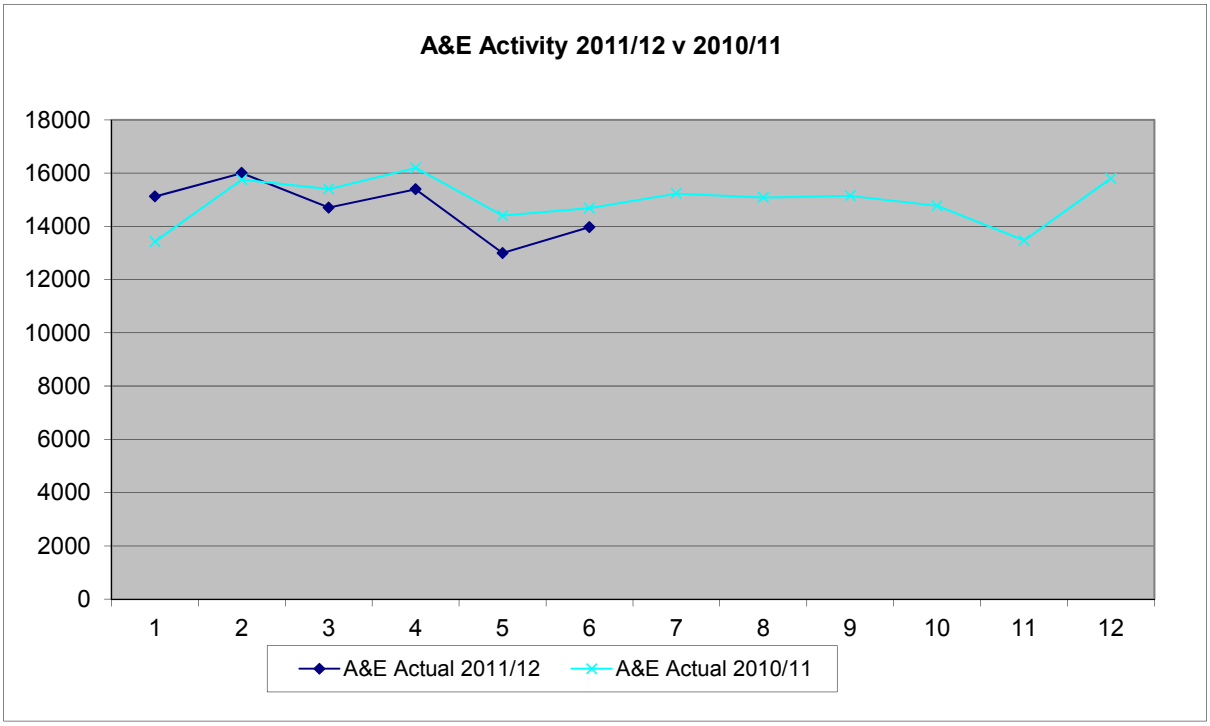
A&E

Performance against plan is showing a month on month over performance with a year to date variance of 16.35%.



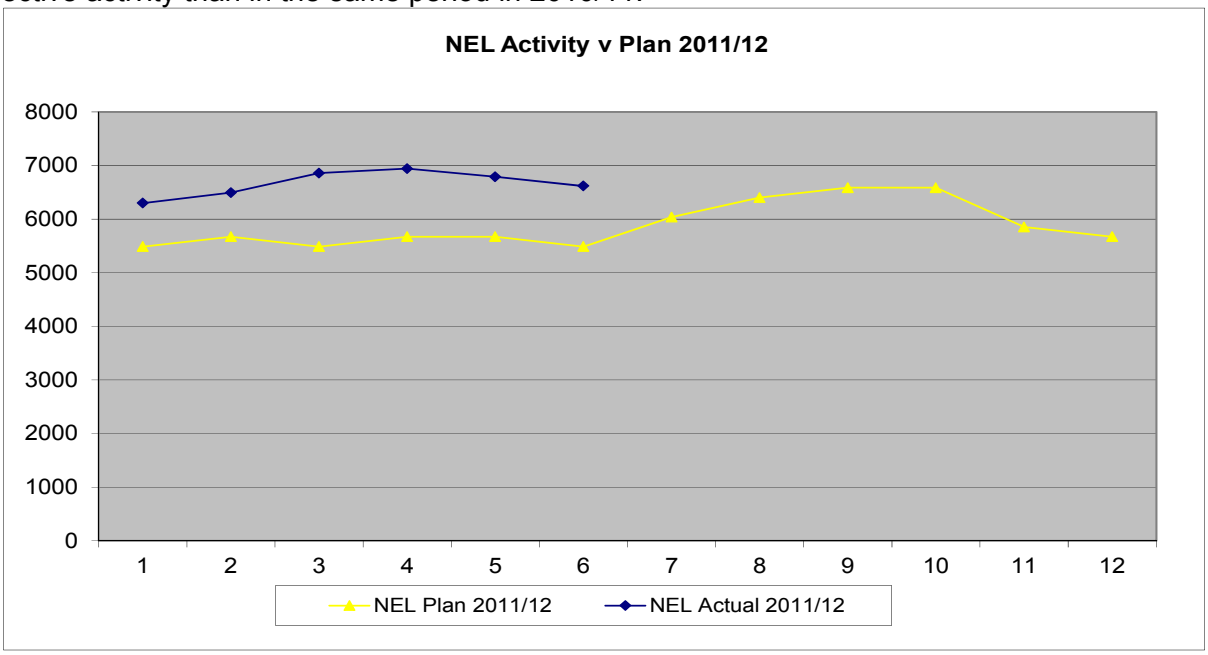
The 2011/12 activity plan was set in line with the Commissioner's expectations that a transfer of activity from A&E to Urgent Care would occur from April. Over performance in months 1-4 is reflective of the delayed transfer of the management responsibility for the Urgent Care Centre at Queen's Hospital to the Trust, which finally transferred on 1st August 2011.

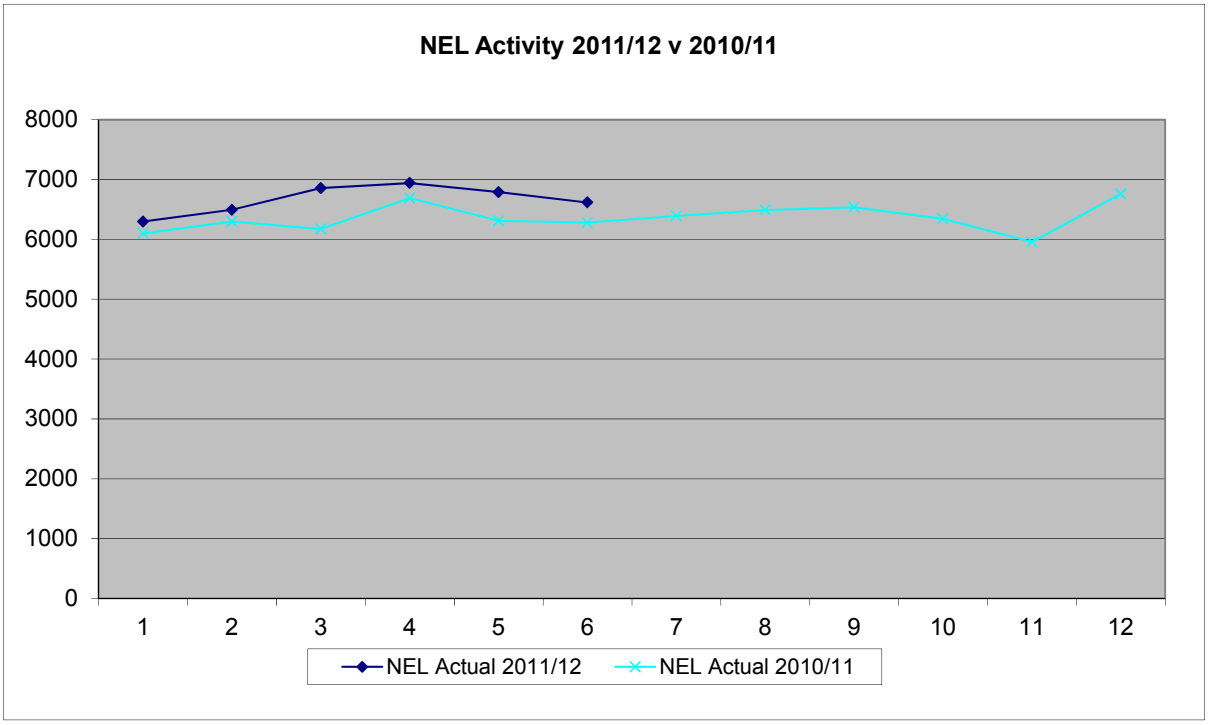
As can be seen from the graph below, the overall A&E activity undertaken by the Trust is following a similar trajectory to last year.



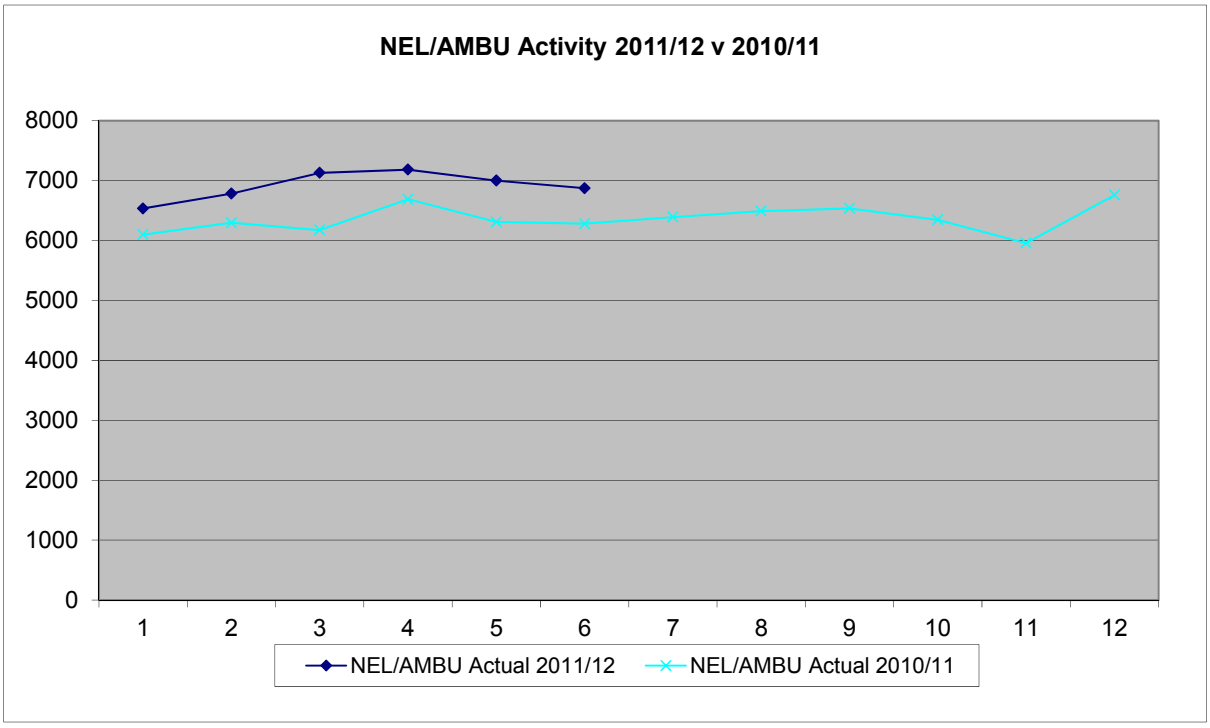
Non-Elective

Non-Elective activity is over performing significantly against the commissioned plan. However the year on year position shows that the Trust is undertaking approximately 5% more non-elective activity than in the same period in 2010/11.



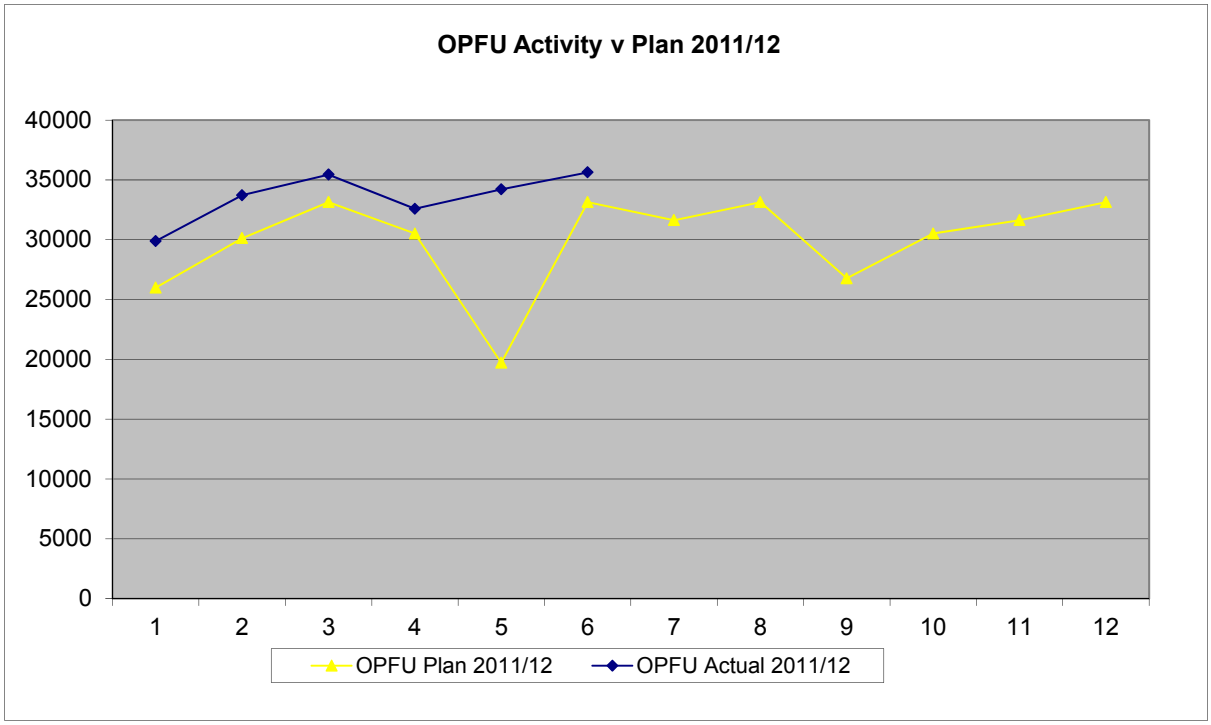


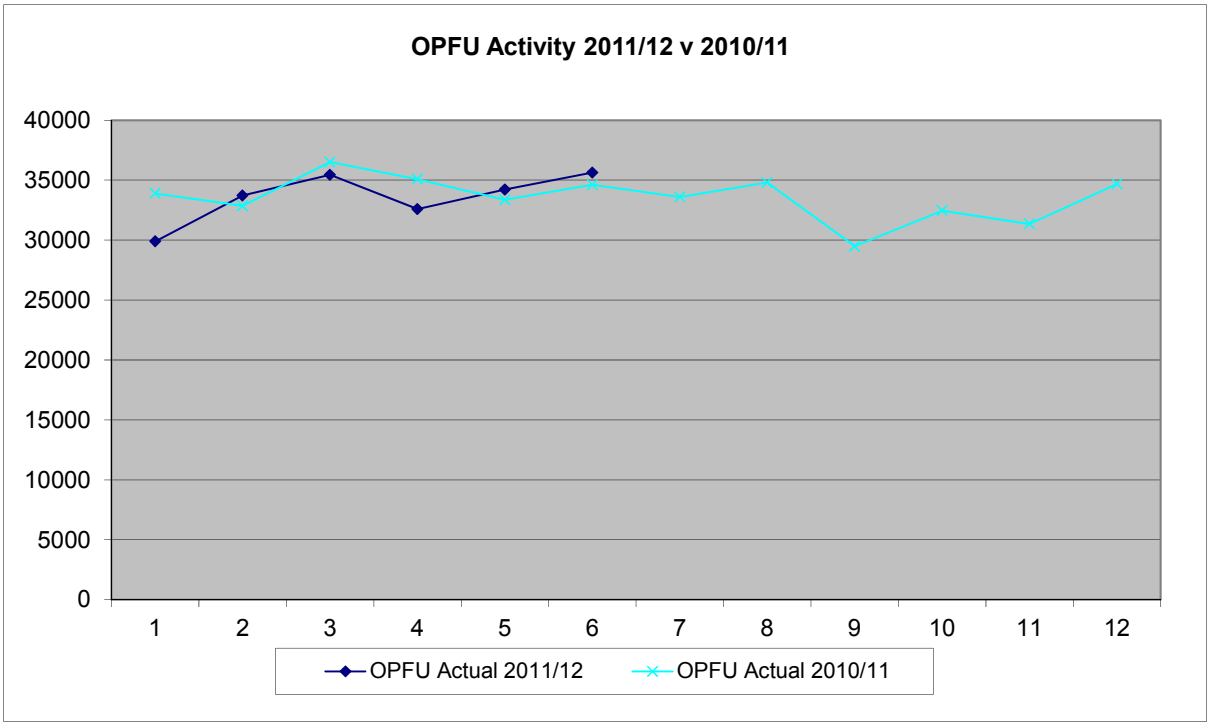
With agreement from Commissioners the Trust has implemented a new model of care during 2010/11 called Ambulatory Care. This service enables patients who would previously have been admitted non-electively to have their treatment managed without the need for an admission. If the activity that is now managed as Ambulatory Care is included with the non-elective numbers to give a like for like comparison (as these patients would previously have been managed by a non-elective admission), then the total quantum of non-elective activity is up 10% when compared to the same period in 2010/11:



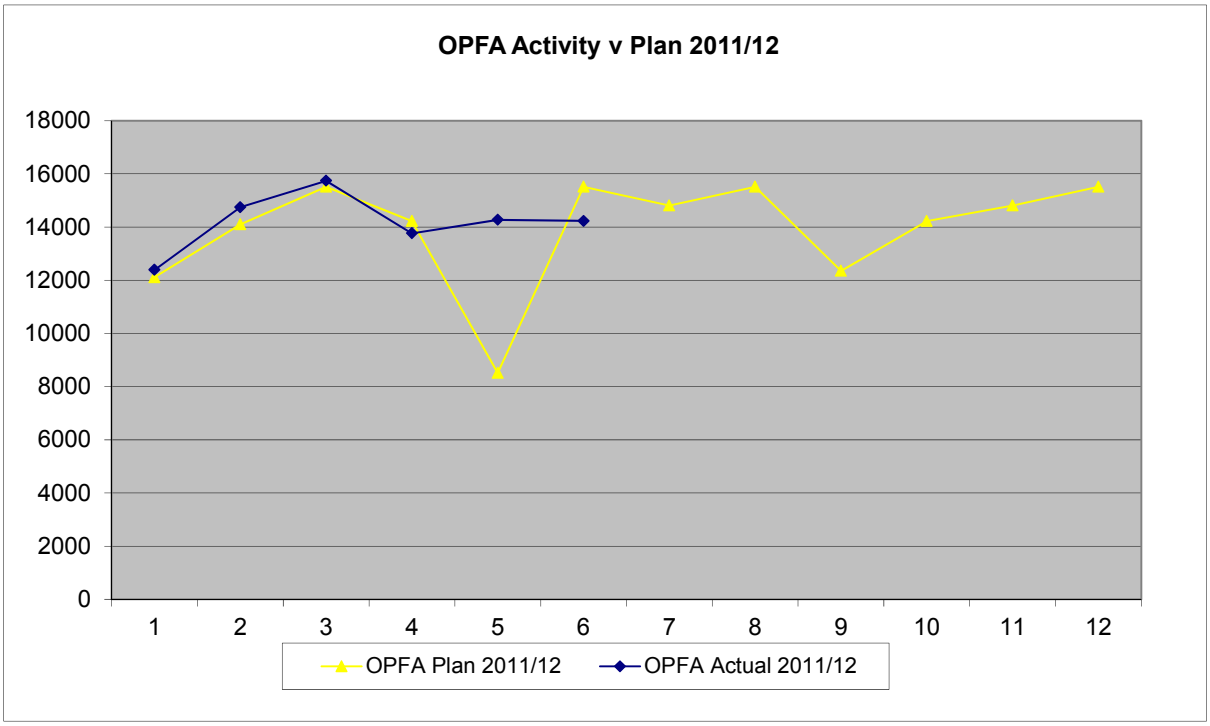
Outpatients

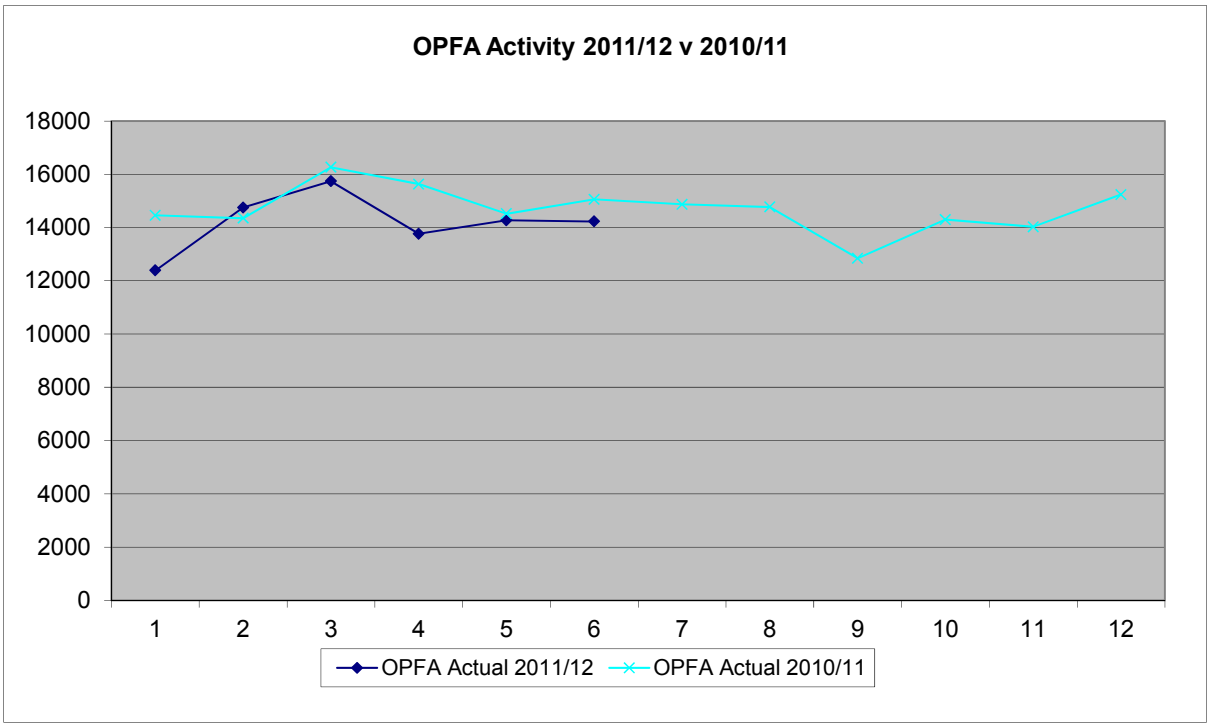
Outpatient first attendances are performing broadly in line with plan and outpatient follow-ups are significantly over plan. The work to review the clinic templates is expected to start to have an impact from October onwards.



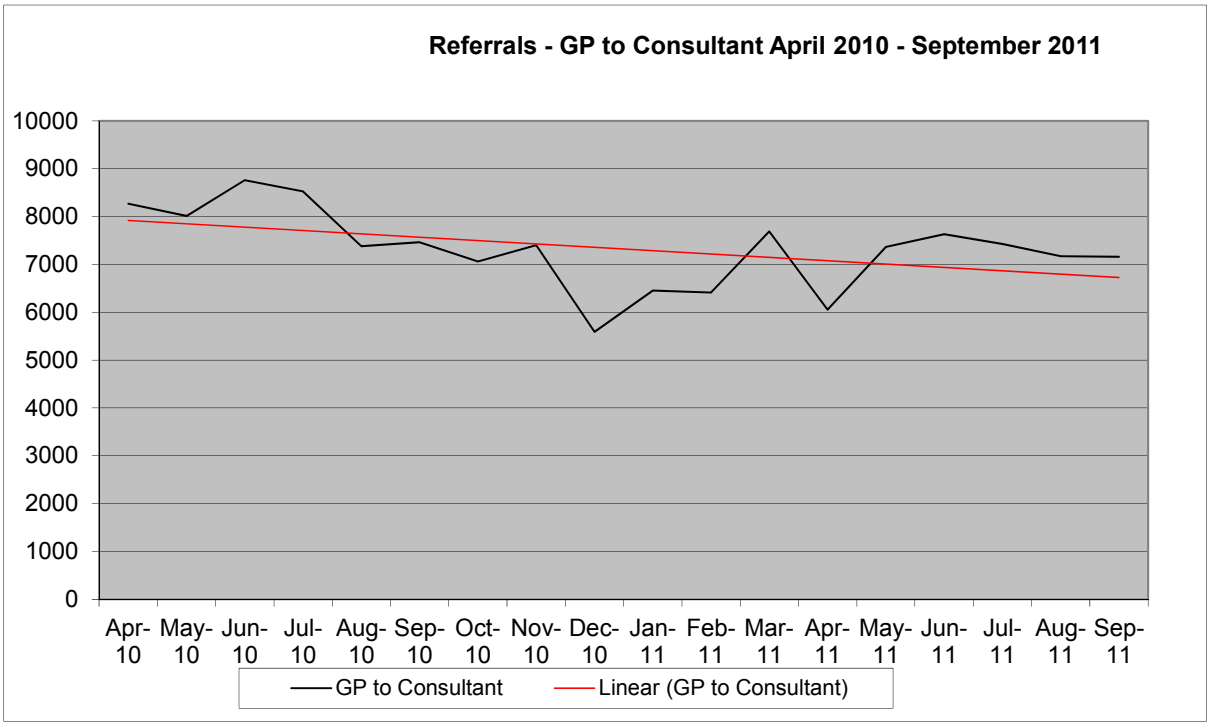


The activity plan for outpatients was set significantly lower than 2010/11 out-turn due to PCT QIPP initiatives and activity for both first attendances and follow-up attendances is lower than the same period for 2010/11:





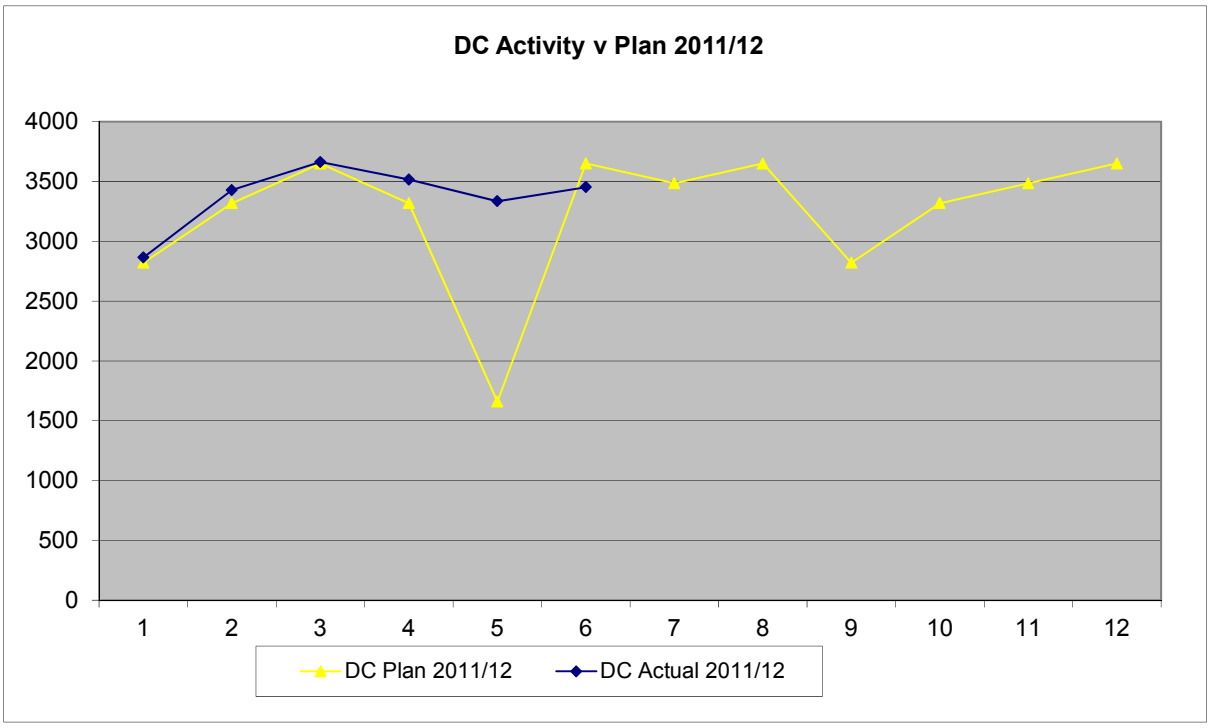
Referrals to the Trust have been falling significantly since April 2010, with the month on month referrals down 15% when compared to the same period in 2010/11, so it would be anticipated that outpatient first attendances will continue at a lower level than in 2010/11:

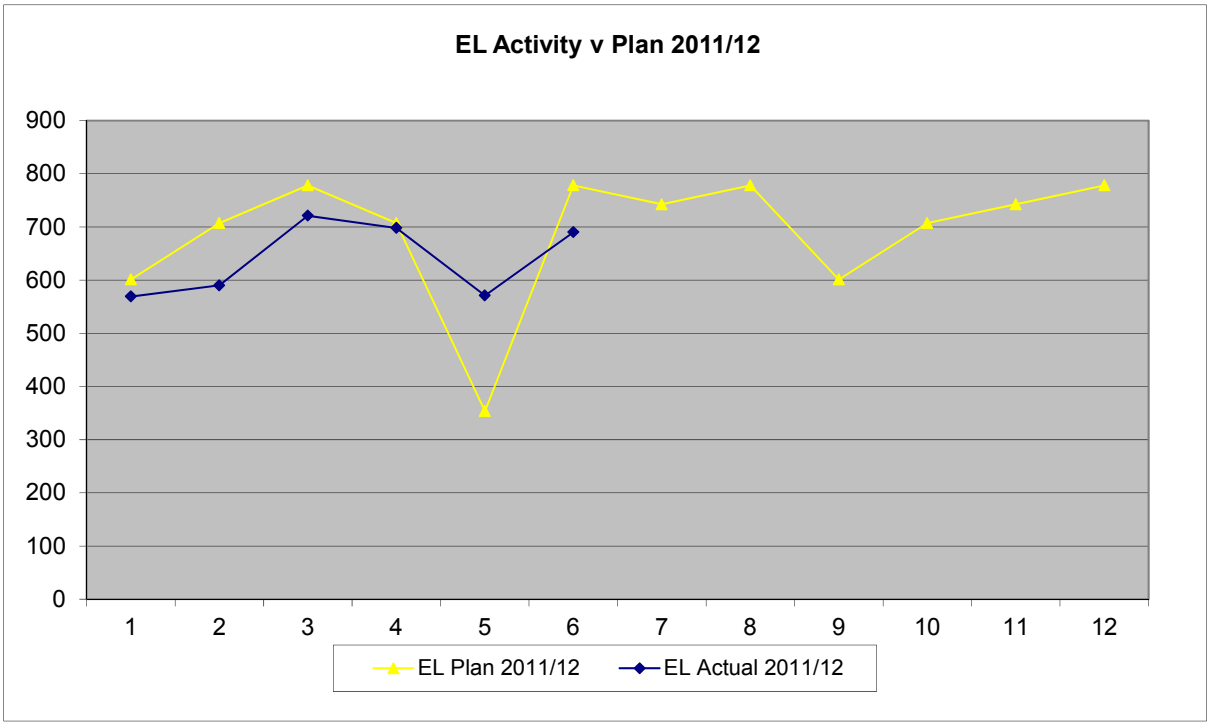


Outpatient procedures are over performing against plan and activity is broadly in line with the same period in 2010/11.

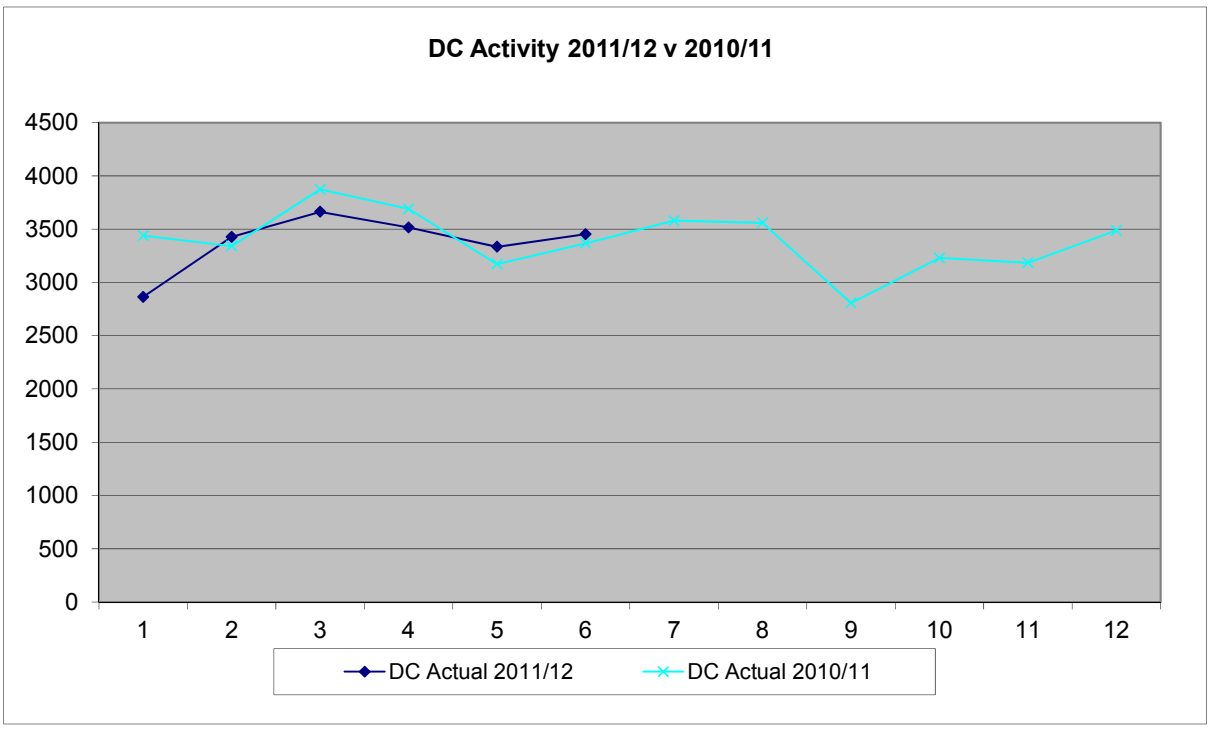
Daycase/Elective

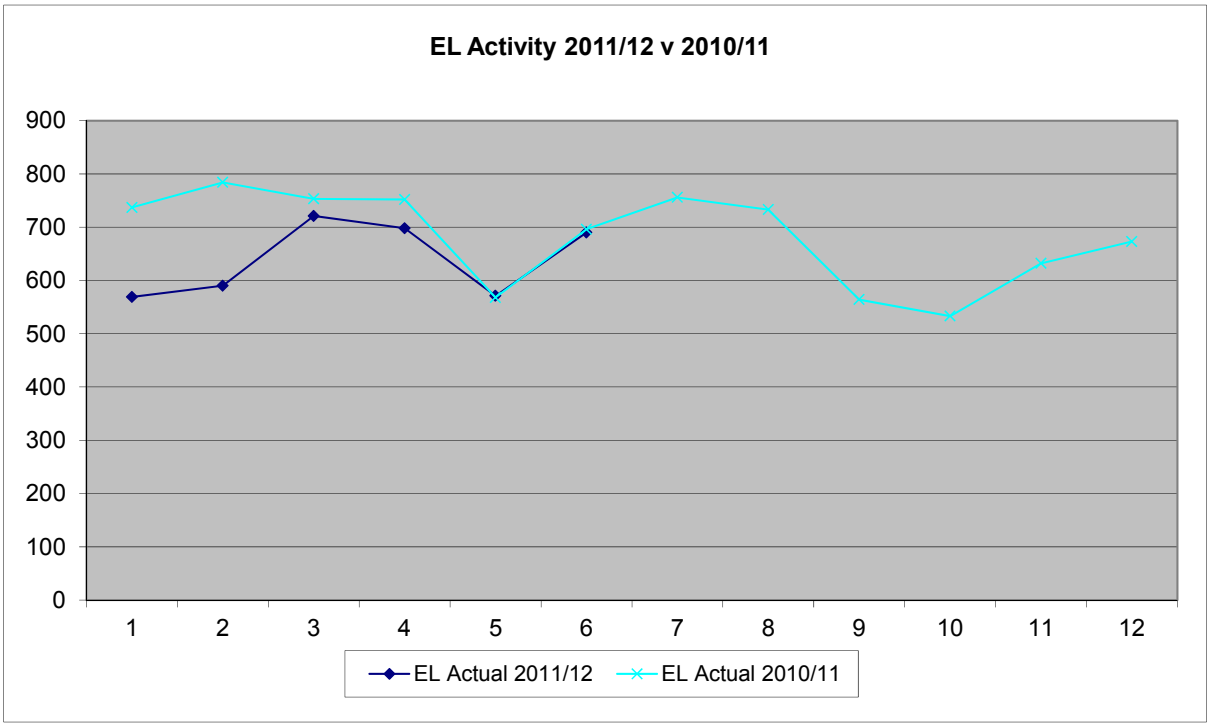
Daycase activity is approximately 10% above plan, and elective activity is performing more or less in line with plan. On the basis of the agreed activity plan phasing the expectation is that the day case over performance will not continue at this rate and the elective activity will continue to under perform the activity plan.





Due to PCT QIPP and Procedures of Limited Clinical Effectiveness (PoLCE) schemes, the plan for daycases and electives was set lower than the 2010/11 out-turn, so current activity levels are 7% and 15% below the same period for 2011/12. This is largely affected by performance in April.





Conclusion

Activity levels are either over performing or are broadly in line with plan for all PODs. When compared to the same period in 2010/11, activity in the 'emergency care' PODs (A&E, non-elective) is at a similar or higher level, however activity in the 'planned care' PODs (elective, daycase, outpatient first attendance) is at a lower level.

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Workforce Committee Escalation Report	**Trust Board**
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
The last Workforce Committee discussed two main issues - recruitment and management of temporary staff. The recruitment of staff was discussed and Divisions identified areas where recruitment was proving difficult and more innovative plans were required, such as the use of clinical fellows, fixed term contracts, etc. The retention issues were also highlighted and a review of exit interviewing information to inform managers of the reasons why people were leaving was reinforced by the Committee as essential in retaining staff. The Committee sought understanding of reasons for increased temporary spend, when overall permanent staff had increased. During these discussions it was agreed that a 5% buffer above the vacancy level was appropriate so that staff could be flexible to variations in demand. Divisions agreed to review temporary staffing usage and HR agreed to establish a working group to ensure vacancies were accurate and actively been recruited to. HR performance information was shared with the meeting and a discussion took place regarding HR KPIs. The meeting stated that the information was full and appropriate.	□ **TEC** ……..….. □ **STRATEGY**……..…… □ **FINANCE** ……..…… □ **AUDIT** ……..……..… □ **CLINICAL GOVERNANCE** ……..……..…… □ **CHARITABLE FUNDS** ……..….. □ **TRUST BOARD** ……✓……..…… □ **REMUNERATION** ……..….. □ **OTHER** ……..…… (please specify)
2. DECISION REQUIRED:	**CATEGORY:**
For noting/information.	□ **NATIONAL TARGET** □ **CNST** □ **CQC REGISTRATION** □ **HEALTH & SAFETY** □ **ASSURANCE FRAMEWORK** □ **CQUIN/TARGET FROM COMMISSIONERS** □ **CORPORATE OBJECTIVE** ……..….. □ **OTHER** …….. (please specify)
	AUTHOR/PRESENTER: Ruth McAll, Executive Director of HR and OD, BHRUT.
	DATE: 25th October 2011

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 University Hospitals NHS Trust

REPORT TO: Trust Board

REPORT FROM: Chief Executive

DATE: 19 October 2011

SUBJECT: INTERIM CHAIR & 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 Interim 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 Care Quality Commission Investigation Report, Tripartite Formal Agreement, Maternity Services Update, Emergency Care Update and Research & Development Annual Report 2010/11.

5. **NATIONAL ISSUES/NEWS**

Information Governance Assurance:
Sir David Nicholson and the Information Commissioner have written to all NHS Chief Executives to stress the importance of robust information governance. The letter points to guidance for Board members, sets out required practice for all who handle patient information and draws attention to new penalties of up to £500k for breaches.
For further information go to:
www.dh.gov.uk/health/2011/09/information-governance/

Invitation to join the NHS Supply Chain's Customer Board:
The first meeting of the NHS Supply Chain's Customer Board, chaired by Chris Sharratt, took place on 5 October 2011. The Board's purpose is to allow open and constructive communication between the NHS and NHS Supply Chain, with the aim of influencing strategy to enable greater savings to be delivered to NHS Trusts (see Local News).

The Allan Brooking NHS travel fellowship:
NHS Managers can apply for grants of up to £3,000 to pay for travel and accommodation within the UK or abroad to investigate innovative non-clinical healthcare management practices, in any discipline, that might benefit the wider NHS. Deadline for submissions 21 November 2011.
Link: www.aboveandbeyond.org.uk/brooking_fellowship.aspx

College of Emergency Medicine – Quality & Safety in Emergency Care:
The College of Emergency Medicine, in conjunction with the International Federation for Emergency Medicine, is hosting a two-day symposium on quality and safety in emergency care from 15-16 November at the British Museum in London.
Link:
www.collemergencymed.ac.uk/Development/Conferences%20and%20courses/Forthcoming%20Conferences/CEM%20IFEM%20Symposium/default.asp

NHS Support for social care: provision of support for memory services:
Following publication of the first national audit of dementia services, the Department is providing £10m of additional support to social care via PCTs for memory services. Following agreement of areas of investment and the outcomes expected, PCTs should transfer the funding to the relevant local authority.
Link: www.dh.gov.uk/health/2011/09/nhs-support-for-social-care-provision-of-support-for-memory-services/

Equality Act Specific Duties approved by Parliament:
To help public bodies perform the Public Sector Equality Duty (PSED) more effectively, regulations were approved by Parliament recently that require public bodies to publish information to demonstrate compliance

with the PSED at least annually starting by 31 January 2012 and to prepare and publish equality objectives at least every four years, starting by 6 April 2012. Earlier this year, the Equality Delivery System (EDS) was rolled out to the NHS to help it meet the PSED and the two specific duties.
Link: www.legislation.gov.uk/uksi/2011/2260/contents/made
www.homeoffice.gov.uk/equalities/equality-act/equality-duty/

Benchmarking of inpatient prescription charts:
Trusts should consider benchmarking their inpatient prescription charts against guidelines recently published by the Academy of Medical Royal Colleges.
Link: www.dh.gov.uk/health/2011/09/guidelines-for-design-of-in-patient-prescription-charts/

Publication of Organisation Patient Safety Incident Reports data:
In September this year, the National Patient Safety Agency (NPSA) published the Organisation Patient Safety Incident Reports 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/

Dismantling the NHS National Programme for IT:
The Government has announced plans to accelerate the dismantling of the NHS National Programme for IT (NPfIT) as it can no longer provide the IT support that the NHS requires. The important applications already delivered such as the Spine, N3 Network, NHSmail, Choose and Book and Picture Archiving and Communications Service will continue and new arrangements for managing them will be communicated in the Autumn.
Further information: www.dh.gov.uk/health/2011/09/update-on-dismantling-the-nhs-national-programme-for-it/

Leadership Challenge: New self-assessment tool for all staff:
All NHS staff can now take advantage of a self-assessment tool, linked to the new NHS Leadership Framework to review their leadership skills. Launched earlier this year by the Secretary of State for Health, the Leadership Framework is designed to ensure that the whole workforce can have the leadership knowledge, skills and behaviours needed to improve health and care.
Link: www.nhsleadershipframework.rightmanagement.co.uk/f-self-assessment-tool

SHA Cluster Directors Appointed and Non-Executives Appointed to new SHA Clusters:
A full list of the appointments can be found on –
http://healthandcare.dh.gov.uk/cluster-directors/

Following the introduction of the Cluster arrangements on 3 October 2011, the Appointments Commission has announced the appointments of Non-Executive Directors to the SHA Clusters.
Link: http://healthandcare.dh.gov.uk/non-executives-appointed-to-new-sha-clusters/

New Senior Responsible Officer Appointment for Health Education England (HEE):
Christine Outram has been appointed SRO for Health Education England (HEE) to develop the new organisation that will take on accountability for leadership of the education and training system by April 2013. She will combine this with her role as Managing Director of Medical Education England (MEE).
Link: www.mee.nhs.uk/latest_news_releases/sro_appointed.aspx

Implementing a duty of candour:
A consultation has been launched on implementing a duty of candour, a contractual requirement on NHS providers to be open with patients when things go wrong with their healthcare. This forms part of the Government's plans to modernise the NHS by making it more accountable and transparent.
Link: www.dh.gov.uk/health/2011/10/candour-consultation/

Signals – emerging patient safety issues:
The National Patient Safety Agency (NPSA) has published its latest set of Signals – emerging patient safety issues identified from a review of serious incidents. Topics include risk of harm from ingestion of Vernagel, risk of harm from retained guidewires, following central venous access, prevention of harm with alfacalcidol preparations and rapid deterioration in patients with Systemic Lupus Erythematosus. The NPSA would be pleased to receive comments and anonymised local investigations.
Link: www.nrls.npsa.nhs.uk/resources/type/signals

Leading Large Scale Change:
Leading large scale change provides an overview of theory, tools and approaches to delivering change at scale, pace and across organisational boundaries. This guide describes the experiences of NHS Institute's Academy for Large Scale Change. A learning programme is also available to support this guide.
Link: www.institute.nhs.uk/academy

European Antibiotic Awareness Day:
The Chief Pharmacist has written to all Trusts seeking support for European Antibiotic Awareness Day (EAAD) on 18 November 2011 and help in tackling one of the most significant threats to patient safety in Europe – the rise of antibiotic resistance. Materials promoting the responsible use of antibiotics are available on the DH website for local use.
Link: www.dh.gov.uk/health/2011/10/european-antibiotic-awareness-day-letters/

Readiness for revalidation report:
The report sets out for the first time a comprehensive snapshot of clinical governance and appraisal systems in the context of revalidation for the health sector in England at 31 March 2011. It is based on responses from designated bodies that employ or contract doctors as defined in the Responsible Officers Regulations 2010 and had a 90 percent response rate.
Link: www.revalidationsupport.co.uk/orsa_report.asp

6. **LOCAL ISSUES/NEWS**

Non-Executive Appointment on NHS Supply Chain Customer Board:
Mr Keith Mahoney, Non-Executive Director at BHRUT, has been appointed a Non-Executive Director on the NHS Supply Chain Board.

Care Quality Commission Update:
The Whole Hospital Review Investigation Report was published on the 27 October 2011. The full report is available to view on the Care Quality Commission website.
Link: http://www.cqc.org.uk/

Rewarding Excellence in Healthcare IT:
As previously advised in our September report, the EHI Awards 2011 awards ceremony took place on 6 October. The Trust is extremely proud to announce that Dr Aklak Choudhury, Respiratory Consultant and Associate Divisional Director for Medicine, won the award for the "Best Use of IT to promote patient safety" category. This award recognizes the outstanding contribution made by Dr Choudhury in the past year.

Global Corporate Challenge (GCC):
Trust staff were recently congratulated on their superb participation in the Global Corporate Challenge (GCC) - the world's largest health initiative. Our staff also won the Active Company Award – amazingly becoming fifth in the World in the 10-19 teams category!

Established in 2004, the GCC aims to combat the growing health risks associated with a sedentary lifestyle. It achieves this by challenging employees to walk over 10,000 steps per day – a proven and recommended way of reducing your overall risk of chronic diseases, including cardiovascular disease and type II diabetes.

Walking away with the Gold Award for the most active team was Bed Management 1 - the 'Bluebuddies'. The team stepped up to the challenge with a blistering step count of 17,695,878.

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Research and Development Annual Report	Trust Board
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
To update the Trust Board on the progress of the R&D office.	□ **PEQ** ……..….. □ **STRATEGY**…….……. □ **FINANCE** ……..…… □ **AUDIT** …… □ **CLINICAL GOVERNANCE** ……..……...…… □ **CHARITABLE FUNDS** ……...… □ **TRUST BOARD** ……..……. □ **REMUNERATION** ……... □ **OTHER** ……..…… (please specify)
2. DECISION REQUIRED:	**CATEGORY:**
APPROVAL of the RSS document.	□ **NATIONAL TARGET** □ **CNST** □ **CQC REGISTRATION** □ **HEALTH & SAFETY** □ **ASSURANCE FRAMEWORK** □ **CQUIN/TARGET FROM COMMISSIONERS** □ **CORPORATE OBJECTIVE** …….... **OTHER : Research and Development**
	AUTHOR/PRESENTER: Davy Yeung
	DATE:

3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:

- In the Financial Year 2010/2011, the R&D office became, for the first time, cost neutral to the Trust.
- During this Financial Year, 2011/2012, the R&D office has committed to spending £1.9 million to maintain current research activity at the Trust. This includes R&D Staff, Research Nurses, Research PA's for Consultants and payment to service departments (Pharmacy, Radiology, Pathology and Cardiology)
- The R&D office has already secured £2 million of non commercial funding to cover our costs.
- Together with our commercial and non-commercial income, we can forecast that the R&D office will remain cost neutral this financial year with any profit to be reinvested into the development of our staff, and the new Clinical Research Centre, which will allow BHRUT to host more commercial research. Ultimately, this will enhance our potential profit in the coming year.
- Currently we are planning a new project-based accounting system for the R&D office. This will grant us a more efficient and transparent financial system, as agreed with the Director of Finance.

4. DELIVERABLES

Over the past year, there have been significant changes to the R&D office in terms of structure, processes and finance.

- Restructuring the R&D office has enabled us to perform, more robustly, both research governance and research finance management.
- The R&D office established a clear and transparent communication pathway with all the service departments, ensuring that all research costs (service support costs) are covered and, in the case of commercial research,

generating revenue.

- BHRUT is now one of the top clinical trial recruiters in Central and East London; our recruitment figures for the financial year 2010/2011 were higher then those for Barts and the London NHS Trust (BLT).

Deliverables for 2011/12:

- Conceptually and practically structure R & D at BHRUT as 2 business sub-units: a. non-commercial or "not-for-profit" (but cost-neutral) research unit, delivering high quality NHS network and other non-commercial research, and meeting our obligations to the NHS research community and DoH, commensurate with our position as a large university hospital with cancer centre status; b. commercial research unit, efficiently run to maximise income for the Trust, with NHS market-rate profit margins
- The Finance committee has requested that the financial side of the partnership agreement with BLT be renegotiated, to ensure an equal finance partnership between BHRUT and BLT. David Wragg is reviewing this as part of due diligence measures entrusted upon him by the Trust Board, and will be meeting representatives from Barts to discuss this. The final recommendations on the financial relationship rests with the Director of Finance.
- To establish the new project-based accounting system.
- To establish core research policies for BHRUT; also to establish a Code of Conduct for all research-active staff, based on Good Clinical Practice (GCP) in Research and the National Research Governance Framework (and relevant EU directive and UK law) - with local application in concordance with the Trust's overall code of conduct for BHRUT staff
- To re-establish and re-invigorate the Research and Development Committee, which will report to the Quality and Safety committee on governance and safety issues, and the Finance committee on financial issues. The Chair will be the Director of R & D, who will report directly to the Medical Director (who will also be a member of the R&D committee) and the Executive Lead at Board level responsible for Research and Development
- To bring our processes inline with the national standard set by the National Institute of Health Research (NIHR).

5. KEY PERFORMANCE INDICATORS

BHRUT has not set any KPI for the R&D office. However, the NIHR has now put in place KPI to monitor performance of various Trusts.

- **Recruitment Targets**: In 2010/2011, BHRUT has doubled the number of patients recruited in to clinical trails (from 2525 to 5758), and exceeded our targets set by the NIHR Comprehensive Local Research Network (CLRN).
- **Project Approval Time**: To put BHRUT inline with the national standard, we are now being monitored on the time taken by R&D to approve projects. We are expected to approve projects within 30 working days after receipt of all relevant study documents. Currently the R&D office is struggling to meet this target. However, new standard operating procedures (SOPs) are being implemented to streamline our approval processes.
- **Increase Number of NIHR portfolio projects:** Currently we are hosting 145 active NIHR portfolio projects. This number is expected to increase significantly over the next year. In order to achieve this we will have to actively engage consultants and promote research at BHRUT, starting with our annual R&D conference in November.
- **Increase number of Commercial Projects:** Currently, only about 15% of our active research projects are commercial. With the Trust's new Clinical Research Centre (CRC), we are hoping to significantly increase the number of commercial projects we host in the immediate future. With the partnership agreement in place, we are expecting BLT to pass us more commercial research projects that are currently taking place in their Trust.

AGREED AT _____ MEETING	**DATE: _____**
OR	
REFERRED TO: _____	**DATE: _____**

REVIEW DATE (if applicable) _____

SAMPLE

Barking, Havering and Redbridge University Hospitals NHS Trust

Research & Development Annual Report

Professor Jayanta M Barua, Director of R & D

Dr Davey Yeung, R & D Manager, BHRUT

2010 / 2011

Table of Contents

Introduction

There have been many positive changes in our Research and Development Department over the last 12 months. These developments have been underscored by the improved performance and stabilisation of both infrastructure and finance management. Moreover, there is now a clear channel of communication through the Research and Development to all the service departments, and monies generated by research are being channelled transparently into these departments.

The Department of Health (DoH) has repeatedly stated the importance of research to the NHS. Over the last decade, it has published studies demonstrating how R&D undertaken within, and by, the NHS can improve both the health and wealth of the UK patient population, asserting that research investment is money well spent. Earlier this year Dame Sally Davis, Chief Medical Officer for England, Director General of Research & Development and Chief Scientific Adviser for the Department of Health & NHS, stated that research, “is even more important when resources are under pressure because it identifies ways of preventing, diagnosing and treating disease”. At the local level, involvement in research allows the Trust the opportunity to provide our patients with access to experimental treatment regimes that are 5 to 10 years in advance of current treatment, and geared towards providing effective, cost efficient care provision, which in many cases has an economic benefit to the Trust.

More importantly, patients enrolled in clinical trials today enjoy better health outcomes and often have a better experience of healthcare en route, irrespective of whether they have test or control treatments. This has specifically been seen in the cardiology research trials that take place at the Clinical Research Centre (CRC) at Queens Hospital. Taking part in research is very often an empowering experience for patients. Feedback has demonstrated that patients feel that they receive more personal care, and experience a sense of control in what can be very challenging circumstances. In addition, there is a virtuous circle for the NHS; in the short-term usage of novel and expensive cost-free trial drug treatments, and then, in the longer term, establishing more efficient treatments (i.e. both those that are more cost-effective, and those requiring less repeat visits by patients).

Performance

Recruitment / Activities

Recruiting patients into clinical trials has always been one of BHRUT's strengths, owing to our large research-amenable population. The research activities at BHRUT have increased in 2010/11 in comparison with previous years. The Central and East London Comprehensive Research Network (CEL-CLRN), of the National Institute of Health Research (NIHR), has reported that our recruitment figures have risen from 2525 to 5765 (128% increase), which make us the third highest recruiting Trust in Central and East London. There are multiple reasons why this has occurred:

- An increase in research activity at BHRUT;
- Improved patient recruitment reporting;
- Research staff and study coordinating centres have a better working understanding of the CEL-CLRN and it's requirements
- Improved communication between BHRUT and CEL-CLRN
- Increased number of observational trials.

Currently we have over 200 active research studies at BHRUT:

- 189 studies are in active recruitment;
- 61 studies are close to recruitment but in follow up
- 145 projects are NIHR portfolio projects
- 15% of our projects are commercially funded

In the Financial Year (FY) 2010/2011, BHRUT demonstrated that our current research strength lies in Cancer, Cardiology and Rheumatology. As we have a large patient population base, the R&D office has started to scope, invest and develop other areas for research activity e.g. Stroke, Neuroscience, Women & Children and Diabetes.

National Metrics

Traditionally, only the number of studies and recruitment figures affect our core funding from the National Institute of Health Research (NIHR). However, in May 2011, the Government's "Plan for Growth" announced the creation of a new NIHR Research Support Service, stating:

> *"At a local level, the Government will radically transform the incentives for efficiency in research initiation and delivery. In May, the Government will launch a framework of good practice and standard procedures called the NIHR Research Support Services to facilitate consistent local research management and greatly improve performance. NHS Trusts which adopt these standards will stop unnecessary duplication of checks. They will publish metrics regularly on their performance. They will have access to NIHR financial support for these activities. For clinical trials, the NIHR will from 2012 publish outcomes against public NIHR benchmarks, including an initial benchmark of 70 days or less*

from the time a Provider receives a valid research protocol to the time when that Provider recruits the first patient for that study."

The introduction of these benchmarks will affect future NIHR funding. Indeed, the CLRN will make this a condition of new contracts from autumn 2011 and performance will affect funding from 2013. This is an additional challenge to the R&D office and we will have to significantly improve our current performance to meet these performance targets. New Standard Operating Procedures (SOPS) and Core Research Policies are currently being developed in line with the national standards.

Research and Development Committee

The Research and Development committee was suspended in 2008. However, in light of all the many changes that need to be managed, and the challenges to be faced, the R&D committee has recently been reformed, to provide multi-disciplinary, multi-professional support and advice to the Director of R & D and his management team. The purpose of the R&D committee is:

- To advise the Director and the R&D department on key issues regarding BHRUT research strategy, governance and activity;
- To review and strengthen the decision-making process on core research strategy and policy, local processes and SOPs
- To report into the Trust's Quality and Safety Committee, and the Finance committee.

The R&D committee terms of reference (Appendix 1) have already been submitted to the Quality and Safety Committee, and meetings will commence in the third quarter of the FY 2011/12.

Research and Development Infrastructure

R&D infrastructure is critical if we are to succeed in our goal of being one of the most research-active DGH's in the country. It is essential to have adequate provision and maintenance of the infrastructure to support our research activities. In order to support and sustain our drive to increase research activity at BHRUT the following are essential:

Research Culture

It is vital for BHRUT to foster and maintain a vibrant research culture, where staff feels that a desire to engage in research is encouraged at all levels in the organisation. This will need to be supported with real resource allocations, principally financial, but also in terms of senior management input. An example of promotion of this research culture will be seen with the 2011 BHRUT Annual Research and Innovation Conference in November.

Finance

The Trust receives significant funding through a number of DoH support mechanisms, either through the CLRN or Topic Specific Research Network, to fund and support non-commercial research. It is important that transparency in the allocation and expenditure of these funds is maintained so that they may be targeted at supporting our research groups, or invested in emerging areas of national research priority. In the year 2011/2012, we have invested significant amounts in stroke, neuroscience and diabetes research. Additionally, Barts and the London NHS Trust and Queen Mary University of London (QMUL)'s Joint Clinical Research Office have given us a tremendous amount of practical help and advice in creating a transparent R&D financial accounting system.

Research Support

The R&D office has signalled its intention of enhancing the support researchers receive by building up the Clinical Research Centre (CRC). The CRC provides a range of services to consultants running clinical trial across the Trust and disciplines. Although the main focus of the CRC is to run commercial research, it is also there to support consultants doing non-commercial research. A pool of specialist Research Nurses with common generic research skills is available to provide support to new or experienced researchers.

Staffing

The R&D Department presently consists of the following staff:

- R&D Director (0.2 WTE);
- Band 8a R&D Manager (1 WTE);
- Band 6 Governance Lead (1 WTE);
- Band 5 Governance Assistant (1 WTE);
- Band 6 Finance Lead (0.5 WTE);
- Band 5 Finance Assistant (0.5WTE);
- Band 4 Departmental Secretary (0.5 WTE).

In addition to the R&D Department, the department also supports the following Clinical Research Staff:

5	x	Consultant Sessions
2	x	Clinical Research Fellow
1	x	Clinical Trial Pharmacist
1	x	Band 8 Nurse lead
6.5	x	Band 7 Research Nurse
5.5	x	Band 6 Research Nurse
3	x	Band 7 Research Assistant
5	x	Band 5 Research Assistant
1	x	Band 4 Pharmacy Technician
1	x	Band 3 Pharmacy Technician

All the posts above are funded by the Central and East CLRN, Topic Specific Research Network and income from Commercial Research, at cost-neutrality to the Trust.

Finance

For the first time in this Trust's recent history, the R&D department is completely cost-neutral to the Trust. In 2010/2011, we received:

CLRN Activity Based Funding	£538,100
Project Based Funding (Contingency fund)	£303,892
Topic Specific Network Funding	£98,000
Commercial Income	£194,105
Total	**£1,134,097**

Out of this £1.134 million income, £423,351 was carried forward to the current financial year to cover on-going cost of salaries. In this Financial Year, 2011/2012, the R&D department has committed to spend £1.9 million to maintain current research activity within the Trust. This includes funding R&D Staff, Research Nurses, Research PA's for Consultants, and payment to service departments (Pharmacy, Radiology, Pathology and Cardiology). Significant portions of this money will be provided via the CEL-CLRN and the Topic Specific Research Network:

CLRN Activity Based Funding	£ 327,000
Cancer Research Network Support	£ 435,577
Key Service Support	£ 89,299
Project Based Funding (contingency funds)	£ 662,406
Other non-commercial Funding Stream	£ 63,194
Deferred Income from 2009/2010	£ 423,351
Charity	£ 29,257
Total	**£ 2,030,084**

The figures above demonstrate that our non-commercial income covered our cost for the year 2010/2011. Bearing in mind that the Trust is not permitted by NIHR research finance support structuring to generate a profit from non-commercial research, the entire surplus generated is from commercial research alone.

The table above does not taken into account of our commercial income. Currently, around 15% of our studies are commercial. In the past year, the R&D office has improved and tightened our costing of research projects and established a system to ensure that all invoices owed to the Trust are paid on time. We are expecting this to result in significantly higher income as compared with last year. For the six months into the Financial Year 2011/2012, we have already accrued £152,080.

Together with our commercial and non-commercial income, we forecast that the R&D office will be cost-neutral in the coming financial year with a surplus that can to be reinvested into the development of our staff and the new Clinical Research Centre. This will allow BHRUT to

host more commercial research, and, ultimately, enhance our potential profit in the coming year. Currently we are planning a new project-based accounting system for the R&D office. This will enable us to a have more efficient and transparent financial system as agreed with the Director of Finance.

Research and Development in 2011/2012 and Beyond

The Challenges

As the UK struggles to recover in this post-recession period, and manages significant reductions in public sector funding, including the NHS (which will clearly impact on our ability to maintain R&D infrastructure and obtain commercial income in a more competitive environment), the drive to expand our research base will become increasingly challenging.

To ensure our survival in this tough economic climate, we must complete and solidify our partnership with the Barts and the London NHS Trust (BLT) and QMUL. For the past year, BLT/QMUL has provided us with invaluable resources in terms of research governance and accountancy. The final stages of the agreement are about to be completed, and this presents significant opportunities for the partnership to strengthen its research base.

Conceptually and practically we intend to structure R & D at BHRUT as 2 business sub-units:

- non-commercial or “not-for-profit” (but cost-neutral) research unit, delivering high quality NHS network and other non-commercial research, and meeting our obligations to the NHS research community and DoH, commensurate with our position as a large university hospital with cancer centre status
- commercial research unit, sited in the Clinical Research Centre, efficiently run to maximise income for the Trust, with NHS market-rate profit margins

The MHRA has started to undertake inspections of NHS Trusts like BHRUT, I.e., Trusts that only host clinical trials. Given the number of trials we currently host, it is likely that we will be inspected in the near future. The R&D department has started to prepare for an imminent Inspection, and this will present us with both financial and logistical challenges.

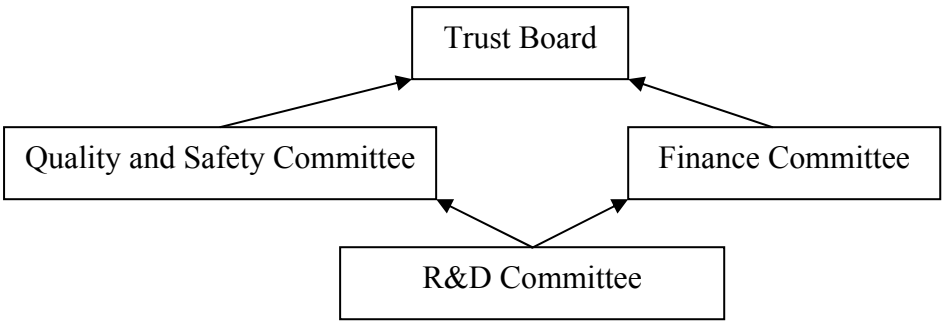
Although performance in most of our measured activities, such as the number of NIHR portfolio studies hosted and their recruitment targets, were good in 2010/11, more focus will have to be given to expanding our commercial research portfolio to increase revenue to the Trust. Thus, improving our processes to ensure that the time taken to give NHS permission to research is in line with the benchmark set in the Plans for Growth Document is essential.
Finally, in order to continue our success, we must invest in the training of our staff. The right kind of training, development and education provides a large incentive for an organisation like BHRUT. It will not only increase productivity and knowledge, but it will ensure loyalty and retention.

Barking, Havering and Redbridge Hospitals NHS
NHS Trust

BHRUT Research and Development Committee

Terms of Reference

Constitution



The Research and Development Committee will be accountable to the Trust's Quality and Safety committee for quality issues and the Trust's Finance Committee for finance issues.

Membership

Executive members:

General
R&D director (Chair)
R&D manager (Vice Chair)
Medical Director
Principal Investigators (PI) forum representative
Innovation Representative
Education Representative

Academic
QMUL/BLT representative
LSBU representative

Specialty
Chief Pharmacist
Cancer Representative
Education Representative
Radiology representative (Support Services)
Pathology Representative (Support Services)

Other
Lay member
Ad hoc and other specialty members

Corresponding Members:

Director of Finance
Director of Clinical Governance
HR Representative; Director of HR
All Divisional and Clinical Directors

Minutes of all meetings will also be sent to the CEO's office

In Attendance:

Staff from R&D office

a. Quorum

Business will only be conducted if the meeting is quorate. The committee will be quorate with one third of the voting members, including the Chair or Vice Chair being present

b. Attendance by Members

The Chair of the Committee, and the R & D manager will normally attend all meetings but when unavoidably not present will arrange deputisation. Other Committee members will be required to attend a minimum of 4 out of 6 meetings per year and in their absence (formal apologies must be sent to the R & D Office) will be able to send a Deputy.

c. Attendance by Others

Lead investigators and specialist advisors may be co-opted to attend as necessary, on an *ad hoc* basis, e.g. to present papers, but will have no vote.

Purpose

- To advise the R&D Department on key issues regarding BHRUT research strategy, governance and activity
- To advise on funding distribution of external monies.
- To advise on links and collaborations with current and potential stakeholders with the aim of continued improvement in the global research functions and activities of the Trust
- To give decision on local processes.
- To recommend papers and reports to be put forward to the Quality and Safety Committee.
- To support the Director of R & D in overseeing the conduct of all research activity at BHRUT. This will include monitoring of adherence of PI's and their teams to established international, national and BHRUT local Codes of Good Conduct and GCP in research. It will also include advising and supporting the R & D Director and Manager in the initial investigation of alleged breaches of policy, prior to any escalation where required, to the Executive Lead for research (currently the Medical Director)

- To support the R & D management team in promoting research throughout the Trust and beyond; participate and support in the annual R&D conference
- Oversee workings of R & D Research and Clinical Trial Review, Approval and Monitoring Group ("R & D Approval Group"), which will report to it

Roles and responsibilities of the BHRUT Research and Development Committee

1 To advise the Trust Board, Chief Executive, Medical Director, Senior Clinical and Administrative Service managers of the Trust and the R&D department in all matters relating to the research activity at BHRUT.
2 To promote an active research culture within the Trust and encourage the processes which aid wider participation in research
3 To provide the means for the exchange of information on R&D issues between clinical research leads, academic leads and management on research issues
4 To work as a forum for the promotion of research activities involving Trust staff and patients in liaison with other Trusts and other organisation involved in research.
5 To work with the Trust's R&D Department, BLT, QMUL and LSBU to promote funding opportunities and other services in support of research and research training.
6 To promote high quality Trust-based research activities, co-operation between researchers and development.
7 To advise the Trust R&D office and management Team on all aspects of management of the Comprehensive Local Research Network funding for R&D. To include contributing to the development of the Annual Report and to advise on the distribution of CLRN funding resource within the trust, taking responsibility for appropriate allocation.
8 To facilitate and oversee the principles of research governance as required by the framework for research governance.
9 To promote the publication and reporting of research findings and encourage the translation of research into practice
10 To promote liaison with the local NHS Research Ethics Committee
11 To promote liaison between the Universities and the NHS on research matters (Research education, Critical appraisal skills)
12 Support R&D Department in organising R&D conferences

Communication

Action points of the meeting will be recorded and circulated to all members of the committee. Minutes will be published on the Trust intranet website

Meetings

The BHRUT Research and Development Group Committee will meet on a bi - monthly basis, at Queen's. The focus of the meeting will be research strategy and management.

Agenda and Action Points

The agenda will be prepared by the R&D Manager or Co-ordinator in the absence of the Manager and will be circulated no later than three days prior to the meeting. The meetings will be serviced by the R&D administrative staff, with the action points produced and circulated within two days.

Date/Originator

This document was produced by the R&D Manager, reviewed and amended by the R & D Director and approved by the Research and Development Group on 2011 and the Quality and Strategy Committee on the XXX.

v1c

NIHR Guideline B01
R&D Operational Capability Statement

Version History

Version number	Valid from	Valid to	Date approved	Approved by	Updated by
RDOCS 001	01/01/2001	31/01/2001	01/12/2000	Trust Board	rrr

Contents

Organisation R&D Management Arrangements

Information on key contacts

Organisation Details	
Name of Organisation	Research & Development Department, Queens Hospital
R&D Lead / Director (with responsibility for reporting on R&D to the Organisation Board)	Prof Jayanta Barua
R&D Office details:	
Name:	Prof Jayanta Barua
Address:	R&D Office, Green Zone, Queens Hospital, Romford, RM7 0AG
Contact Number:	01708 435306
Contact Email:	jayanta.barua@bhrhospitals.nhs.uk
Other relevant information:	
Key Contact Details e.g. Research Governance Lead, NHS Permissions Signatory contact details	
Contact 1:	
Role:	R&D Manager
Name:	Dr Davy Yeung
Contact Number:	01708 435000 x 2151
Contact Email:	davy.yeung@bhrhospitals.nhs.uk
Contact 2:	
Role:	R&D Facilitator
Name:	Ian Laskey
Contact Number:	01708 435000 x 2204
Contact Email:	ian.laskey@bhrhospitals.nhs.uk
Contact 3:	
Role:	Contract and Finance
Name:	Victoria Darkins
Contact Number:	01708 435000 x 4956
Contact Email:	victoria.darkins@bhrhospitals.nhs.uk

Add further contacts by selecting and then **copying** the five Excel **rows** (ie whole rows) above for Contact, role, name, number and email.
Then select the **blank row** under the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
Go to top of document

Information on staffing of the R&D Office

R&D Team		
R&D Office Roles (e.g. Governance, Contracts, etc)	Whole Time Equivalent	Comments indicate if shared/joint/week days in office etc
R&D Manager	Whole Time Equivalent	Mon - Fri
Finance Administrator	Whole Time Equivalent	
CSP Coordinator	Whole Time Equivalent	Mon - Fri
R&D Secretary	0.5 wte	Tue - Thurs and alternate Fri

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
Go to top of document

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

Reporting Structures
The Research and Development Group Approval group responsible for approving studies, reports into the Research and Development Committee, chaired by the Director of Research. For Safety and Quality issues, the R&D committee report to the Quality and Safety committee and for Finance issues to the Finance Committee and then to the Trust Executive Board.

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Information on Research Networks supporting/working with the Organisation.
Information on how the Organisation works with the Comprehensive Local Research Network (CLRN), Primary Care Research Network (PCRN), Topic Specific Clinical Research Networks (TCRN).

Research Networks	
Research Network (name/location)	Role/relationship of the Research Network eg host Organisation
CLRN	Providing General Support
National Cancer Research Network	
Thames Stroke Research Network	
Medicine fo Children Research Network	
Denron	

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Information on collaborations and partnerships for research activity (e.g. Biomedical Research Centre/Unit, Other NHS Organisations, Higher Education Institutes, Industry)

Current Collaborations / Partnerships				
Organisation Name	Details of Collaboration / Partnership (eg	Contact Name	Email address	Contact Number
Barts & The London NHS Trust	Partnership	Gerry Leonard	gerry.leonard@bartsandthelondon.nhs.uk	
LSBU				

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)

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Organisation Study Capabilities

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

Types of Studies Organisation has capabilities in (please tick applicable)							
	CTIMPs (indicate Phases)	Clinical Trial of a Medical Device	Other Clinical Studies	Human Tissue: Tissue Samples Studies	Study Administering Questionnaires	Qualitative Study	OTHER
As Sponsoring Organisation			X		X	X	
As Participating Organisation	2, 3 & 4	X	X	x	X	X	
As Participant Identification Centre	2, 3 & 4	X	X	X	X	X	

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Which licences does the organisation hold which may be relevant to research?

Organisation Licences			
Licence Name Example: Human Tissue Authority Licence	Licence Details	Licence Start Date (if applicable)	Licence End Date (if applicable)
None			

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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PCT ONLY: Information on the practices which are able to conduct research

Number/notes on General Practitioner (GP) Practices

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Organisation Services

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

Clinical Service Departments					
Service Department	Specialist facilities that may be provided (eg number/type of scanners)	Contact Name within Service Department	Contact email	Contact number	Details of any internal agreement templates and other comments
Pathology		Mr Len Kemp	len.kemp@bhrhospitals.nhs.uk		
Radiology		Dr Zoltan Nagy	zoltan.nagy@bhrhospitals.nhs.uk		
Radiotherapy and Medical Physics	MUGA	Dr Seeni Naidu	seeni.naidu@bhrhospitals.nhs.uk		
Pharmacy		Mr Yousaf Razzak	yousaf.razzak@bhrhospitals.nhs.uk		
Cardiology		Ms Judith Skipper	judith.skipper@bhrhospitals.nhs.uk		

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Information on key management contacts for supporting R&D governance decisions across the organisation.

Management Support e.g. Finance, Legal Services, Archiving					
Department	Specialist services that may be provided	Contact Name within Service Department	Contact email	Contact number	Details of any internal agreement templates and other comments
Archiving		Dr Davy Yeung	davy.yeung@bhrhospitals.nhs.uk	01708 435000	
Contracts		Dr Davy Yeung	davy.yeung@bhrhospitals.nhs.uk	01708 435000	
Data management support		Dr Davy Yeung	davy.yeung@bhrhospitals.nhs.uk	01708 435000	
Finance		Dr Davy Yeung	davy.yeung@bhrhospitals.nhs.uk	01708 435000	

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Organisation R&D Interests

Information on the areas of research interest to the Organisation

Organisation R&D Areas of Interest				
Area of Interest	Details	Contact Name	Contact Email	Contact Number
Oncology	Clinical Director	Dr Jane Stevens	Jane.stevens@bhrhospitals.nhs.uk	
Hematology	Clinical Lead	Dr Claire Hemmaway	honer.kadr@bhrhospitals.nhs.uk	
Rheumatology	Clinical Lead	Prof Chakravarty	kuntal.chakravarty@bhrhospitals.nhs.uk	
Neuroscience	Clinical Director	Dr Abhijit Chaudhuri	abhijit.chaudhuri@bhrhospitals.nhs.uk	
Cardiology	Consultant	Dr Honer Kadr	honer.kadr@bhrhospitals.nhs.uk	
Critical Care	Consultant	Dr Rajesh Jain	rajesh.jain@bhrhospitals.nhs.uk	
Stroke	Director of Stroke Services	Dr Khaled Darawil	khaled.darawil@bhrhospitals.nhs.uk	

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Information on Local / National Specialty group membership within the Organisation which has been shared with the CLRN

Specialty Group Membership (Local and National)					
National / Local	Specialty Group	Specialty Area (if only specific areas within	Contact Name	Contact Email	Contact Number
None					

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Organisation R&D Planning and Investments

Planned Investment			
Area of Investment (e.g. Facilities, Training, Recruitment, Equipment etc.)	Description of Planned Investment	Value of Investment	Indicative dates
Clinical Research Centre	Builiding up a team of research nurses to run commercial research	TBC	2012
Pharmacy	Recuriting a full time Clinical Trial Pharmacist to help with Trials	£70,000	Nov-11

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Organisation R&D Standard Operating Procedures Register

Standard Operating Procedures								
SOP Ref Number	SOP Title		SOP Details			Valid from		Valid to
To Be Confirmed								

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Information on the processes used for managing Research Passports

Indicate what processes are used for managing Research Passports
The Trust follows, and is fully compliant with , the processes for managing Research Passports as outlined with the National Institute for Health Research (NIHR) document "Research in the NHS-Human Resources (HR) Good Practice Resource Pack"

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Information on the agreed Escalation Process to be used when R&D governance issues cannot be resolved through normal processes

Escalation Process
When R&D Governance issue cannot be resolved through normal processes, they will be referred frist to the Director of Research and Development, who will raise it to the Medical Director (exec lead for R&D). However, if the Medical Director can not reslove the issue, it will be raised to the Trust Exec Board.

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Planned and Actual Studies Register

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

Comments
The Trust uses the CSP RedA and ReDa databases to manage its planned and active research

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Other Information

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

Other Information (relevant to the capability of the Organisation)

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)
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Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	**BOARD/GROUP/COMMITTEE:**
Medicines Management Annual Report 2010 - 11	**Quality & Safety Committee**
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
In line with the strategy the trust board should receive an annual report from the Drugs and Therapeutics Committee on medicine management. The report provides information on the structure for medicines management during the year, key priorities and feedback on the 2009-10 action. The report also set out priorities for 2011-12. The priorities set for 11-12 were considered and proved by the Drugs and Therapeutics Committee.	**Drugs & Therapeutics Committee …..27.5.11…….** □ **FINANCE** □**AUDIT ……..…..** □ **CLINICAL GOVERNANCE** □ **CHARITABLE FUNDS** □ **TRUST BOARD** □ **REMUNERATION ……** □ **OTHER ……** (please specify)
2. DECISION REQUIRED:	**CATEGORY:**
To note the report, achievements made in 2010-11 and prioritised activities for 2011 -12. To support the on going work of the Drugs and Therapeutics Committee.	□ **NATIONAL TARGET** □ **CNST** □ **CQC REGISTRATION** □ **HEALTH & SAFETY** x□ **ASSURANCE FRAMEWORK** x□ **CQUIN/TARGET FROM COMMISSIONERS** □ **CORPORATE OBJECTIVE** □ **OTHER ……..** (please specify)
	AUTHOR/PRESENTER: **Portia Omo-Bare Chief Pharmacist** **Dr Ian Grant Divisional Director CDT**
	DATE: 27.711
3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
None	
4. DELIVERABLES	
Robust system for medicines management within the Trust, compliance with national guidance particularly around quality and safety.	
5. KEY PERFORMANCE INDICATORS	
AGREED AT _____ **MEETING OR REFERRED TO: _____**	**DATE: _____** **DATE: _____**
REVIEW DATE (if applicable) _____	

Barking, Havering and Redbridge University Hospitals NHS Trust

MEDICINES MANAGEMENT ANNUAL REPORT 2010 - 2011

'Medicine management' in hospitals encompasses the entire way that medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution that medicines make to produce informed and desired outcomes of patient care.

'A Spoonful of Sugar', Audit Commission, 2001

Portia Omo-Bare
Chief Pharmacist
June 2011

Contents Page

1.0 **Executive Summary**

1.1 This report details the current position of medicines management at Barking, Havering and Redbridge NHS trust and key achievements for the financial year ending March 2011. It encompasses much of the work which fed into the Trust's medicine management rating by the Healthcare Commission (now Care Quality Commission), a strand of Standards for Better Health. It is a requirement of NHSLA that the Trust board approves an annual report for medicines management.

1.2 The report incorporates the developments made during the year covering patient safety and patient experience.

2.0 **Strategic Context**

2.1 The administration of medicines is one of the commonest interventions made in acute hospitals and the safe and effective use of medicines is a key component of high-quality patient care. Admission rates for medicines-related adverse events run at 6.5% (with a 0.15% fatality rate) and 9% of all incidents reported to the NPSA are due to medicines. Medicines are wasted due to non-adherence by patients in around 50% of cases. Drug treatments account for about 5% of hospital costs and are frequently identified as a reason for budget overspends, so managing the resource effectively is an important component in controlling costs.

2.2. This report details the current position of medicines management at BHRUT and key developments for the financial year ending March 2011. It encompasses much of the work which fed into the trust's medicine management rating by the Healthcare Commission (now Care Quality Commission), a strand of Standards for Better Health. It is a requirement of NHSLA that the trust board approves an annual report for medicines management.

3.0 **Key Achievements for 2010-11 :**

3.1. Access

- Changes in hours and rotas, services provided at weekends were re-structured in response to increasing workload
- New antibiotic pharmacy service with the recruitment of two new antibiotic pharmacists has strengthened our team, resulting in a point-prevalence audit of all wards, increased teaching and monitoring for all pharmacists and the development of a specialist referral service
- Improving patient care by providing a bag which can be used to bring all medications the patient is taking into hospital. It is called the green bag scheme.

3.2 Quality and Safety

- Development of Key Performance Indicators for antimicrobial prescribing using findings from the antimicrobial point prevalence study and stewardship assessment. An Antimicrobial Management Code has been

developed to tackle poor prescribing. Compliance with this code will be monitored via audits with mandatory reporting to the trust Infection Control Committee and the trust Drugs and Therapeutics Committee.

3.3. Consultant Mandatory Training.

- A one day program for Consultant mandatory training was commenced in May 2010. Pharmacy provides a 1 hour slot on this program covering key medicines management issues. Four sessions have been provided to date covering issues such as Formulary and Trust application process for new drugs; role of the Drugs and Therapeutics Committee, discharge planning/prescribing (TTA's); antibiotics; Medicines Reconciliation; venous thromboembolism prevention and prescribing of intravenous immunoglobulin.

3.4 Initiation of safe prescribing training for year 5 medical students.

- The Trust is part of a collaborative programme with 6 other Trusts in North East London and London Medical Deanery to train Year 5 undergraduate medical student on safe prescribing through a 4-week programme for each cohort of students. Topics covered include how to prescribe safely, dose calculations, medicines reconciliation, practical aspects of drug administration, antibiotics and anticoagulation prescribing. There is a prescribing assessment at the end of the course.

3.5 Implementation of NPSA guidance

- All NPSA guidance has had action plans developed and been implemented within year

3.6 Crib sheet for staff on top 100 medicines

- In response to the patient survey, where it was stated that patients felt they did not receive enough information about their medicines, either during their stay or on discharge, a crib sheet of the top 100 medicines was developed for nursing, medical and pharmacy staff to use when counselling patients. The crib sheet is aimed at ensuring simple plain language is used and that consistent terminology and descriptions are used for commonly prescribed drugs.

3.7 Successful Good Manufacturing Practice Inspection by the Medicines and Healthcare products Regulatory Agency-May 2010.

4.0 **Staff Development**

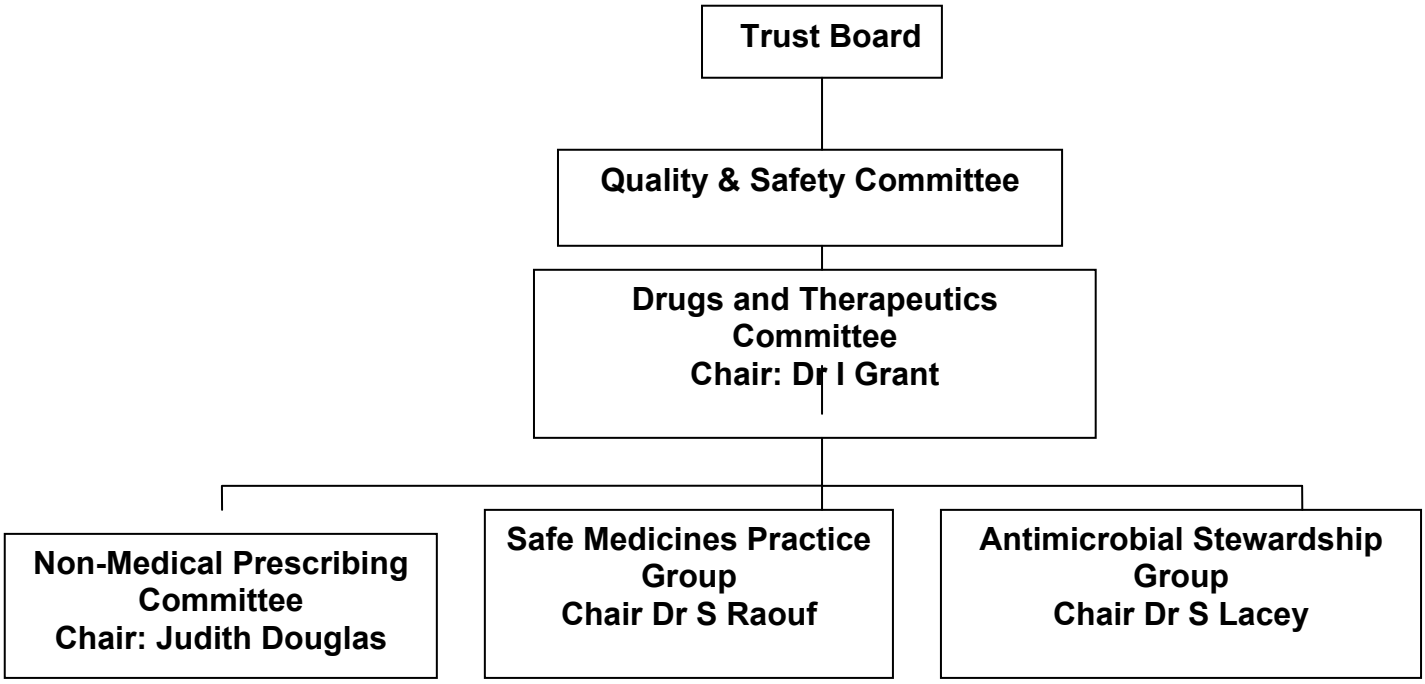
- Actively supported a project with Barts and the London NHS Trust to develop a North-East London programme for band 6 pharmacist training (General to Advanced Practice for Pharmacists (GAPP).
- Achievement of 100% staff appraisal rate for pharmacy staff.
- Ensured that all pharmacy technicians are ready to register with the General Pharmaceutical Council in line with new statutory requirements

5.0 Medicines Management Structure

5.1 Lead responsibility for medicines management at BHRUT lies with the Chief Pharmacist, who oversees activity in this area and who reports to the Trust Board through the Quality and Strategy Committee, The Trust Drugs and Therapeutics Committee, chaired by the Divisional Director for Cancer, Diagnostics and Therapies and a number of supporting multidisciplinary groups. As part of the wider governance agenda, the Divisional Director for Cancer Diagnostics and Therapeutics is the executive lead for medicines management.

5.2 Medicines management is governed through several trust committees. See below.

Medicines Management Committee Structure



6.0 Reducing Healthcare Associated Infection

6.1 Antimicrobial Stewardship

Previously, the Trust employed an Antimicrobial Pharmacist for three days a week (0.6wte). Since August 2010, two antimicrobial pharmacists have joined the trust to make a total equivalent of 2wte.

Since August 2010, the following key areas of work have been led and developed by the antimicrobial pharmacists:

6.2 Audits completed

a. Point Prevalence study

A Trust wide largest Point Prevalence study was carried out in October 2010. This was a snapshot of antimicrobial use across the trust over a period of 3 days**.**

Results

- 649 patient charts assessed across 29 of the 43 wards across BHR hospitals.
- Of the 649 patients seen, 224 patients were prescribed a total of 378 antimicrobials.
- Documentation of allergy status was excellent (99.5%).
- Documentation of nature of allergy was poor.
- Documentation of indication was poor, 7% on drug chart and 60% in medical notes.
- Documentation of duration/course length was also poor, 32% on the drug chart and 14% in the medical notes.
- Auto stop policy- 2 out of 378 antimicrobial prescription had antimicrobial sticker to alert doctor to review IV to oral and review duration of treatment.
- Of the 52 restricted antibiotics prescribed, 66.1% included documentation in the medical notes or on drug chart indicating 'Consultant microbiologist's approval'.

The Safe Medicines Practice Group, Infection Control Committee (ICC) and the Drugs and Therapeutic Committee (DTC) ratified the recommendations made based on the audit results**.**

Key actions completed

- The audit has been presented to the above groups, at the QH Grand round, KGH medical audit meeting and to all the pharmacists
- A new Trust Antimicrobial Management Code was launched on 1st June 2011. The aim of this code is to promote the prudent use of antimicrobials by compliance with the key performance indicators. These indicators include documentation of indication, duration/review date/stop date on drug charts and medical notes; the code also aims to promote awareness of IV to oral switch.
- There are now two designated drug administration sections for antimicrobials on the new drug chart. New drug chart was implemented in May 2011.
- Training sessions on antimicrobial stewardship have been initiated for pharmacists, medical students and prescribers
- The referral system for inappropriate antimicrobial prescribing to antimicrobial pharmacist has been revised.

b. Gentamicin

An audit on 19 patients on Gentamicin showed that none of the patients were given a gentamicin dose in accordance with the nomogram. Lower doses were given because of fear of toxicity and there were difficulties in interpreting the levels and using the nomogram as time dose given and time level taken not indicated. A new Adult Gentamicin Dosing and Monitoring guideline will be implemented in April 2011. This will be re-audited in July 2011

c. Omitted and delayed doses of antimicrobials

The Rapid Responses Report NPSA 2010; reducing harm from omitted and delayed medicines in hospitals stated that anti-infectives (antibacterial and anti-fungals) had the highest incidence reports, including deaths, from omitted and delayed doses.

A point prevalence audit was carried out to determine the frequency and reasons for delayed and omitted antibacterial doses within the trust (including all routes of administrations). Both hospital sites and all wards (43) were audited. All antibacterial prescriptions that required administration in the preceding 24 hours were included. Each care area (Medicine and Surgery) was audited separately.

- 822 drug charts were assessed of which 353 patients were prescribed antibacterials (42.9%).
- Of the patients prescribed antibacterials 95 patients (26.9%) had omitted antibacterial dose(s) during the total course of their treatment and of these 50 patients (52.6%) had 75 omitted doses within the preceding 24 hours
- The audit highligthed that documenation of omitted doses of antibacterials was inadequate, 44% (33/75) of the doses omitted were not documented on the drug chart (i.e administration record box was left blank). Therfore it was not possible to determine the reasons for these omissions, particularly as there was was no information recorded on the drug chart or in patients notes and when nursing/medical staff were questioned they did not know.
- Of the total amount of doses omitted in 24 hours:
    - 25.3 % (19/75) were due to unavailability of the administration route this included displacement of the cannula so IV doses of antibacterial could not be administered and NBM patients.
    - 14.6% (11/75) were due to refusal by the patient.

Recommendations:

- The audit results will be to presented to nursing directorate – senior nurses and all nurses
- The importance of using the correct codes on the drug chart when a dose is not administered will be highlighted to nursing staff. Leaving administration sections of the drug chart blank is unacceptable. It is also important for nurses to document further explanation for omitted doses in the nursing notes

6.3 Antimicrobial Stewardship Self Assessment

Antimicrobial stewardship is in UK (Health & Social Care Act 2008) and statute. Antimicrobial stewardship self-assessment tool is a strong recommendation by the DOH. The aim of the tool is to assess the Trust against evidenced based recommendations to ensure adequate antimicrobial stewardship and subsequently add to the Trust's strategy for reducing HCAIs.

The antimicrobial stewardship self-assessment tool was completed by the Antimicrobial pharmacists, Consultant Microbiologists, Chief and Deputy Chief Pharmacists. The responses were collated and the Trust's scores from the toolkit were assessed. The following key recommendations were made:

- A formal antimicrobial stewardship committee/group, which reports to DTC and informs the Trusts Infection Control Committee, is required.
- Clinical Governance- A written audit strategy and programme is required.
- A written strategy for Education and Training is required.

- Antimicrobial stewardship core training is required in addition to the induction programme and completion of an antimicrobial stewardship competency assessment by all prescribers.

The results were presented to DTC and ICC. The recommendations were ratified by both committees, and the Trust's Chief Executive at the ICC meeting.

6.4 Training conducted

Antimicrobial stewardship training for new nurses as part of the Infection Control Passport - November 2010, February 2011 and March 2011.

Antimicrobial teaching to medical students in October 2010, December 2010 and January 2011.

Antimicrobial stewardship training - ST1 & ST2 in February 2011.

The Point prevalence audit results were presented at the medical audit meeting at KGH in January 2011, Grand round (QH) in March 2011 and Pharmacists in February 2011 at KGH and QH.

6.5 Antimicrobial guidelines and policies

A new Antimicrobial Guideline development and implementation process is now in place. The following guidelines have been updated and approved by the Drugs and Therapeutic Committee:

- Skin and Soft Tissue Infections
- Gentamicin Guidelines
- The Antimicrobial Management Code

6.6 Guidelines under review

- Gastro-Intestinal Infections
- Lower Respiratory Tract Infections
- Adult pocket Antimicrobial Guide
- Urinary Tract Infections
- Obstetrics and Gynaecology

6.7 Clostridium difficile (C.diff) Ward Round

The Antimicrobial Pharmacist conducted a pilot C. diff ward round with the Consultant Microbiologist for a period of two months. A formal independent patient review of C. diff patients by the antimicrobial Pharmacist at Queen's will be launched in May 2011. From June 2011, this will be launched at KGH.

6.8. Action plan for 2011/2012

- Launch Antimicrobial Management Code.
- PPS Audit in July 2011 and repeated in October 2011.
- Gentamicin Audit July 2011.
- Set up formal Antimicrobial Stewardship Committee.
- Write an antimicrobial audit strategy for Clinical Governance.
- Prepare an Education and Training Strategy on antimicrobial stewardship.

- Prepare an E-Learning module for FY1s on Antimicrobials.
- Set up antimicrobial stewardship core training and competency assessment for all prescribers excluding consultations who will have their antimicrobial stewardship training as part of their mandatory yearly updates.
- Set up a mandatory training for all nurses.
- Continue Antimicrobial Stewardship training for Pharmacists.
- Launch pocket size cards on antimicrobial for common infections.
- Update and review antimicrobial guidelines.

7.0 Improving safety by implementing national safety standards

The two key elements that are required by Core Standards for better Health – Standard C04d – Medicines Management are:

- Safe and secure procurement, prescribing, dispensing, preparation administration and monitoring of medicines
- Controlled Drugs are handled safely and securely in accordance with the Misuse of Drugs Act 1971.

Evidence to support the above elements is through a comprehensive set of Trust Core Policies, treatment guidelines, Standard Operational Procedures, a list of which are maintained on the pharmacy database and updated every quarter.

8. Report from the Safe Medicines Practice Group (SMPG)
(Current Chair: Dr Sherif Raouf, Consultant Oncologist)

8.1 The Safe Medicines Practice Group (SMPG) has had another challenging year with four Alerts or Rapid Response Reports (RRRs) coming from the National Patient Safety Agency (NPSA). The alerts, along with the NPSA decision to initiate the concept of 'Never Events' included actions still required in response to previous alerts.

8.2 Through ongoing incident report monitoring, the SMPG also identified and initiated work streams covering a number of other areas where the potential for further medication related incidents was predicted.

NPSA Alerts issued in 2010-2011:

8.3 **Safer administration of insulin.** The aim of this Alert is to improve patient safety by empowering patients as they take an active role in their treatment with insulin. Actions required under this guidance have been completed. Work is on going on trust wide insulin policy

8.4 **Reducing treatment dose errors with low molecular weight heparins** Prescribed doses of low molecular weight heparins (LMWHs) for the treatment of a thromboembolic event are dependent on the weight of the patient and renal function. Under dosing has an increased risk of a further thromboembolic event, while overdosing can increase the risk of bleeding. Actions required in this guidance have been completed

8.5 **Preventing fatalities from medication loading doses.**

A loading dose is an initial large dose of a medicine used to ensure a quick therapeutic response. It is usually given for a short period before therapy continues with a lower maintenance dose. The use of loading doses of medicines can be complex and error prone. Incorrect use of loading doses or subsequent maintenance regimens may lead to severe harm or death. The aim of this alert is to risk assess these medicines and ensure safe systems and polices are in place to prevent errors. Work is still ongoing to complete this guidance and date for completion is November 2011

8.6 The adult patient's passport to safer use of insulin.
The aim of this alert is to improve the safety of patients by empowering them to take an active role in their treatment with insulin. Patients will be given an information booklet and a hand held record. A steering group is being set up and led by Dr Nikookam and the date for completing this is August 2012.

NPSA Alerts from Previous Years with Actions Outstanding:

8.6 Intravenous heparin flush solutions.
Further work is required to ensure that all peripheral flushes are prescribed. We are looking to develop a trust wide process, but this has been difficult. It has been placed on the trust risk register. No errors have been reported on this to date.

NPSA Alert actions completed this year:

- Safer use of intravenous gentamicin in neonates
- Reducing harm from omitted and delayed medicines in hospital
- Reducing treatment errors with low molecular weight heparins
- Prevention of over infusion of IV fluids and medicines in neonates

9.0 Medication incidents in 2010/11

9.1 There were a total of 702 medication related incidents which shows an increase from 649 that was reported on 2009/10. The full report is at appendix 3

9.2 There were seven serious incidents: One relating to a patient given IV antibiotics that they were allergic to in A&E, even though their allergy status was known. Another incident was a patient not given thrombolysis treatment as prescribed, but a different drug in error. The patient subsequently died. This is being investigated.

9.3 The main theme for all of the Serious Incident meetings held was the failure to follow the correct process when prescribing and administering medications.

9.4 The main themes for the penicillin incidents continue to highlight the lack of checking when prescribing and administering the drug. A number of initiatives have been rolled out across the Trust this year:

- The new design drug chart

- IV Policy has been updated to incorporate new guidance from the Nursing and Midwifery Council (NMC). All IV drugs within the Trust must now be double checked.
- Allergy awareness session at all nursing mandatory updates, IV Study Day and Cooperate Induction for new nurses

9.5 The main themes from the remaining incidents continue to be the failure to follow local policy when prescribing, administering or monitoring patients following administration of medication. These themes will be reviewed by the safe medicines practice group and an action plan developed and implemented.

10. National NHS Patient Surveys 2009 – Medicines Issues

10.1 The annual inpatient survey contains four specific questions about medication use. The results for BHRUT are shown in table 1:

Question	BHRUT Score TBC	Threshold for Lowest 20% of trusts	Threshold for Highest 20% of trusts
Did hospital staff explain the purpose of the medicines you were to take home?	77	80	86
Did a member of staff tell you about medication side effects to watch for?	40	41	52
Were you told how to take your medication in a way you could understand?	76	80	86
Were you given clear written information about your medicines?	72	71	78
Did a member of staff tell you about any danger signals you should watch for?	43	46	56

10.2 The annual outpatient survey contains three specific questions about medication use:

10.3 The results show that BHRUT scores low in these areas. A key objective for 2011/12 will be to engage more closely with patients about what they expect from their drug therapy and to work with clinicians across the trust and externally to deliver this.

11. Report from the Trust Drugs and Therapeutics Committee (DTC)

Current Chair: Dr Ian Grant Divisional Director for Cancer, Diagnostics and Therapeutics
Secretary: Portia Omo-Bare Chief Pharmacist

11.1 The DTC is responsible for overseeing the safe, effective and economic use of drugs within the Trust. It is the body responsible for approving all drug policy and for monitoring the efficiency and safety of medicines management within the Trust.

Summary of activities April 2010/11

11.2. Policies agreed

1. Automatic Stop Antibiotic policy – July 2010
2. Restricted Antibiotic Policy – July 2010
3. Policy on the Reconciliation of Medicines on Admission – July 2010
4. Policy of Administration and Management of Patients on Anticoagulants – November 2010
5. Unlicensed Medicines Policy – November 2010
6. Care Custody Policy – November 2010
7. Policy for the use of Midazolam for Conscious Sedation in Adult Patients – November 2010
8. Safer Lithium Policy – November 2010
9. High Dose Morphine/Diamorphine Policy – December 2010
10. Allergies Policy – December 2010
11. Policy for the Safe Administration and Management of Patients on Anticoagulant Therapy
12. Policy for Potassium Chloride and other Strong Solutions – January 2011
13. Policy and scope of Practice for Independent Pharmacist Prescribers in an Inpatient setting – January 2011
14. Management of acute and Chronic pain in Adults – February 2011
15. Hypodermoclysis Policy – February 2011
16. Nil by Mouth and Fasting Policy – March 2011
17. Policy and scope of Practice for Independent Pharmacist Prescribers in an Inpatient setting – January 2011
Guidelines and protocols agreed
1. Guidelines for the Diagnosis and Management of Familial Hypercholesterolaemia – April 2010
2. Acute ST Elevation Myocardial Infarction (ICP) guidelines – April 2010
3. Non- ST Elevation Myocardial Infarction/Unstable Angina (ICP) – April April 2010
4. Medical Management of Miscarriage – April 2010
5. MMR Vaccination Guidelines for Post-Natal Women – May 2010
6. BHRUT Antibacterial Prophylaxis for Surgery – July 2010
7. Urinary Tract Infections (Antibiotics) – July 2010
8. Cardiology Guidelines – July 2010 a. Protocol for the Management of Atrial Fibrillation (AR) b. Atrial Fibrillation Guidelines c. Stroke Risk Stratification in Atrial Fibrilation Guidelines d. Protocol for the treatment Angina
9. Antibiotics (September 2010) a. Lower Respiratory Infections b. Guidelines for Pre-labour Rupture of the membrane at term
10. Sickle Cell Disease Guidelines (Priapism) – November 2010
11. Methotrexate Guidelines – December 2010
12. BHRUT guidelines for the Management of Post-Menopausal Osteoporosis December 2010
13. Shared Care Guidelines for Prescribing Growth Hormone for Children (Somatropin) – January 2011

14. Integrated Care Pathway for Children and Young People with Diabetic Ketoacidosis (DKS) January 2011
15. Shared Care Guidelines For Prescribing N-Acetylcysteine for The Treatment of Idiopathic Pulmonary Fibrosis
16. Thalassaemia Guidelines/Paediatric Thalassaemia Protocol – January 2011
17. Chemotherapy Protocols (11 protocols) – January 2011
18. Paediatric Anticoagulant Guidelines – February 2011
19. Guidelines on the Activity of Pharmaceutical Company Representatives – March 2011
20. Delirium Guidelines – March 2011

11.3 Drugs with conditions agreed

1. Degarelix "Firmagon®" powder for reconstitution (April 2010, Oncology – Approved for 1st dose treatment with a switch to GNRH analogue therapy. To be used in secondary care only.
2. Sodium Hyaluronate "Cystistat®" (June 2010) Urology – approved as 3rd line use
3. Zonisamide "Zonegran®" capsules (June 2010) Neurology – approved as 2nd line adjunctive therapy. Not licensed in paediatrics
4. Ulipristal Acetate "EllaOne®" tablets (June 2010) GU medicine and sexual health – approved
5. Tafluprost "Saflutan"® - May 2010 Ophthalmology – Approved only for patients with Corneal Graft
6. "NuvaRing®" Ethinylestradiol with Etonogestrel – May 2010 GU medicine and sexual health – Approved
7. Anti-D (Rh) Immunoglobulin "Rhophylac®" – (October 2010) Haematology – Approved
8. Hydroxypropyl Guar "Systane®" – (November 2010) Ophthalmology – Approved
9. N-Acetylcysteine "ACC®" 600 tabs – (December 2010) Respiratory Medicine - Approved
10. Lignoacine 4%, Adrenaline 0.1%, Tetracaine 0.5% (LAT Gel) – December 2010 Emergency Medicine – Approved (Unlicensed in the UK)
11. Pregabalin "Lyrica®" – December 2010 (Neurology, Rheumatology, Anaesthetics ,Pain Management and Palliative Care) – Approved
12. Etilefrine Hydrochloride "Effortil®" – January 2011 Urology - Approved
13. Dalteparin "Fragmin®" – March 2011 Haematology - Approved

11.4. Exception requests and issues of professional practice

Exceptional Circumstance Reports that have been approved
April 2010
Etanercept – Pyoderma Gangrenosum
Zidovudine – ATLL
Dasatinib/Nilotinib – Chronic Myeloid Leukaemia
Lucentis/Avastin – ARMD

Zidovudine – Acute T Cell Leukaemia
Exjade – Sickle Cell Disease
Exjade – Thalassaemia
Infliximab – Pemphigus Vulgaris
Rituximab – Follicular Lymphoma
May 2010
Infliximab – Recalcitrant Pemphigus Vulgaris
Exjade – Sickle Cell Disease
Azacitidine – Recurrent Myelodysplasia
Deferasirox – Sickle Cell Disease
June 2010
Rituximab – Severe Autoimmune Haemolytic Anaemia
Exjade – Sickle Cell Disease
IVIG – anti-SRP Necrotising Myopathy
Exjade – Sickle Cell Disease
July 2010
Desferal – Sickle Cell Disease
Zevalin – Follicular Lymphoma
August 2010 – September 2010
Infliximab – Intractible Hidradenitis Suppurativa
Rituximab – Wegner's Granulomatosis
Pemetrexed – Adenocarcidoma of Lung
Deferasirox/Exaje – Beta Thalassaemia major
Exjade – Sickle Cell Disease
Abatacept – Rheumatoid Arthritis
Desferal – Myelofibrosis
Infliximab – Refractory Uveitis
Dasatinib or Nilotinib – Chronic Myeloid Leukaemia
October 2010
Adalimumab – Crohn's dward disease
Campath – ATLL
RSV Vaccinations
Rituximab NMDA
November 2010
Dasatinib - Chronic Myeloid Leukaemia
Bendamustine – Follicular Lymphoma
December 2010
RSV – Heart Disease
Velcade - Amyloisosis
January 2011
Lucentis – ARMD
Erythropoetin – Myelodysplasia
Rituximab – Anaemia - Approved
Bosentan - Scleroderma
February 2011 – March 2011
Infliximab – Bilateral Chronic Uveitis
Lenograstim – Autoimmune Neutropenia

12. Report from the North-East London (NEL) Medicines Management Network
Current Chair: Dr. Martin Hamilton-Farrell, Consultant Anaesthetist, Whipps Cross University Hospital.

12.1 The NEL Medicines Management Network was formed in April 08. One of the main objectives of the network for 08/09 was to provide recommendations to lead commissioners in NEL about the commissioning of high cost drugs and managed entry of new medicines into the NEL Health Economy. The network has representation from all NEL PCTs Prescribing and Medicines Management teams and acute trusts Pharmacy Departments, PCT Commissioning, acute trust commissioning leads, chairs of local acute trust and primary care Drug and Therapeutics Committees (or their equivalent).

12.2 Summary of Activities April 2010-2011:

Drug description	Approximate Costs	Recommendations
Agreement of guidelines for use of Cytomegalovirus (CMV) drugs	HIV: £900-£1,800 per treatment course depending on which anti CMV used	The Network agreed that For HIV: to adopt the CMV management section of the NEL HIV Sector's Opportunistic Infection (OI) Guidelines For Renal patients, the Network agreed on adopting the BLT Guidelines for managing CMV. Both HIV and Renal guidelines require clarification on end points for use of CMV drugs.
Icatibant Subcutaneous injection for symptomatic treatment of acute attacks of hereditary angioedema (HAE) in adults (with C1-esterase-inhibitor deficiency)	£1,604 - £3,208 per angioedema attack	Provisional agreement for funding icatibant for individual patients. pending: a. Protocol from the BLT immunology team b. An audit after 12months on patients self-administration
The use of sequential anti TNFs after failure of 1st anti TNF (not approved by NICE. (Interim guidelines across NEL until NICE guidance published.	£9,295 - £20,142 per patient per year, depending on which anti TNF used and frequency of administration	Final agreement of all parties – NELMMN and local rheumatologists Tools – guideline and tick box form – finalised and agreed Category B –prior notification using agreed tick box form
Alitretinoin at BLT, the acute trust sought from the Network	£483.43/ month £1793.52 per av course	Consensus view that alitretinoin was within tariff and as NICE guidance imminent, costs should be covered within

clarification on tariff status of alitretinoin and source of funding for use of this drug		NICE uplift This case highlighted need to clarify how the Network addressed review process in-year new drug funding requests
Golimumab for Rheumatoid Arthritis	Not known *Other biologics used in RA priced £9,295-£20,142*	The network did not support the addition of golimumab to the existing choice of anti TNF's. If significant additional information becomes available in-year the network will review its position.
Adalimumab in active polyarticular juvenile idiopathic arthritis	£9295.52 per annum	Agreement to use within its product licence and according to NICE criteria for use of etanercept for JIA. Tick box form for etanercept in JIA would be adopted to support a category B status of adalimumab for JIA
Exjade®	£5,422- £10,808 incl per 18kg patient on 20-30mg/kg dose	The Network agreed to extended selection criteria for Exjade® to include first-line use of Exjade® in children aged 2-5 years
Golimumab for Ankylosing Spondylitis	Not known *Other biologics used in rheumatology priced £9,295-£20,142 pa*	The network did not support the addition of golimumab to the existing choice of anti TNF's for this indication. If significant additional information becomes available in-year the network will review its position.
Grazax in treatment of grass pollen induced rhinitis and conjunctivitis in adult patients	£810 per patient per year	NELMMN recommended that following appropriate patient selection and agreed shared care, patients initiated on Grazax by acute trusts could be transferred to GPs for ongoing prescribing within licensed indications.
Fingolimod and Cladribine – 1st oral agents for multiple sclerosis	Estimate of £500,000 1st year cost for BLT patients	Network concluded that as there was not sufficient published clinical evidence to commission for 2010-11 it would be reasonable to defer a decision to the 2011/12 horizon-scanning round.
Off label use of Rituximab for Hepatitis C-induced cryoglobulinemia	£4,000 -£5,000 per course	The NELMMN were unable to make a recommendation - acute trusts may consider use of individual funding requests where appropriate.
Off label use of Rituximab for ITP	Low dose regime approx. £830/course. High dose regime approx. £4872/ course	Group supported use of low dose rituximab protocol with tick box form for notification and suggested individual funding requests to PCT for use of the high dose regimen.
Liraglutide	£1,122-£1,683 per patient pa incl VAT	Liraglutide use was not recommended, pending NICE guidance.

12.3 Summary of other key activities;

- Horizon scanning list for 2010/11- agreed by the group and used to create work plan for recommendations for 2010/11.
- Fitness for Purpose Review of the network undertaken
- Operating Policy of the Network discussed and agreed
- Agreement of tick boxes for C1 esterase inhibitor and icatabant
- Agreement of 2010-11 Commissioning for High Cost Drugs Principles
- Agreement on an Ethical Framework for considering new interventions
- Set up of a Database to enable sharing across the sector, of decisions taken by the various NEL formulary groups on new drugs and other medicines issues

13 Audit and Research 2010/11

13.1 The pharmacy department is committed to supporting an extensive audit programme for medicines management. The 2010/11 annual audit programme for medicines management comprised 8?? (need to clarify) audits which met a number of regulatory requirements, specifically: e.g.

- Assuring adherence to NICE guidance.
- Income recovery for Payment by Results.
- Demonstration of adherence to Standards for Better Health core standards.
- Implementation of directives from the National Patient Safety Agency (NPSA)
- Regulatory requirements to maintain a licence to operate (Medicines and Healthcare Products Regulatory Agency)
- Locally-set Key Performance Indicators.

13.2 A key objective for 2011/12 is to ensure that all audit activity is recorded with the clinical Audit Team and contained in the trust's annual quality account.

14 FINANCIAL REPORT 2010-2011

14.1 The total spend on drugs in 2010/11 was £26,489 505 against a budget of £24,201,980 resulting in an overspend of £2,287,525. The spend on drugs which are excluded from tariff was £7,501,015

The overall increase in spend is 8.6% increase on total drug spend. National data is awaited to benchmark this growth. The year-end position is a reflection of the work undertaken across the trust and heavily supported by the Pharmacy to:

- Manage new drug introductions through DTC.
- Monitor prescribing against agreed guidance and criteria.
- Optimise drug purchasing
- Delivery on drug saving plans

15.. Drug Savings Plans 2011/12

This summary describes the framework in place to manage the drug spend and to describe the activities which generate savings and cost avoidance. The elements involved in controlling drug expenditure are:

- Drug Procurement.
- Control of entry of new drugs / formulary management
- Benchmarking.
- Local project initiatives.

Drug Procurement - Medicines contracting at BHRUT:

15.1 Commercial Medicines Unit (formerly PaSA) administered These contracts include National contracts for generic medicines, immunoglobulins, vaccines, blood clotting factors and London contracts for Intravenous and Irrigation fluids, and HIV drugs.

15.2 London Procurement Programme, Pharmacy & Medicines Management Work stream The LPP initiates a number of contracts as well as issuing advice on implementing savings and various benchmarking exercises. Contracts include branded medicines, various therapeutic tenders, Erythropoietin Stimulating Agents's, Contrast Media and Medical gases. A Homecare contract is due to be awarded this year. It ensures that all high expenditure medicines across London are tendered at least once a year.

15.3 Locally tendered contracts. Certain contracts are handled locally and are tendered in conjunction with the Trust's Purchasing department. These typically include, ingredients for Parenteral Nutrition manufacture and blood, urine and pregnancy testing strips.

15.4 Local agreements. As not all suppliers respond to the Branded tender the Trust enters into local purchasing agreements with pharmaceutical companies were that company is the sole supplier. These usually involve a commitment to a certain volume of purchase over a given period in return for a discount. The discounts are often determined by nationally agreed frameworks that ensure all trusts obtain the same discount for the same commitment.

15.5 Wholesaler discount. Many low volume low usage lines are purchased from Pharmaceutical wholesalers. For many products, the Pharmaceutical companies give the wholesaler a 12.5% to distribute their product. In return for certain volumes of business the wholesaler passes a proportion of that discount on to the Trust. We currently receive 12% from AAH, our prime wholesaler and slightly lower ones from our back up wholesalers. This is part of a LPP framework agreement.

15.6 Risk Share and Patient Access Schemes. A recent development in medicine purchasing has been the introduction of risk sharing and patient access schemes. These come in various formats; but the basic principle is that the Trust shares the risk with the Pharmaceutical manufacturer that a new, usually expensive, medicine is not effective in all given patients. A rebate or free stock is given to the Trust if a patient has not had a satisfactory outcome after an agreed period of time. This effectively

means that the Trust can reduce the cost of a medicine that is not otherwise discounted.

16. Conclusion

The past year has been challenging ensuring that all national guidance has been implemented and now further work needs to be undertaken to ensure the changes made are adhered to. \key achievements for 2010/11 were:

- Changes to services to the ward. The conventional ward pharmacy service was re-engineered to target all new admissions, whilst working in surgical, medical and admission's teams
- New antibiotic pharmacy service. The recruitment of three new antibiotic pharmacists has strengthened our team, resulting in a point-prevalence audit of all wards, increased teaching and monitoring for all pharmacists and the development of a specialist referral service
- Green bags. A joint project with our partners in primary care has led to the introduction of a Green Bag scheme so that patients coming in to hospital are reminded to bring all their medication with them

.

We look forward to ensuring that all objectives set for 2011/12 are met and that medicines management with the trust is robust and providing high quality, safe and cost effective medicines management for all patients.

Portia Omo-Bare
Chief Pharmacist

June 2011

Drug and Therapeutics Committee Action Plan 2010/11 **Appendix 1**

No	Objective	Positive outcome expected	Consequence of Failing	Likely financial implication	By When	By Whom	Outcome
1	To develop an on line data based formulary possibly web based and ensure it is kept up to date. The formulary will be consistent with national guidance such as NICE, NPSA, NSF etc.	Formulary is put on the intranet and is up to date and evidence based.	Suboptimal use of the trust resources.	The financial implications for 10/11 have already been considered and drugs budgets appropriately funded. Failure to adhere to formulary also has a negative clinical impact where inappropriate drug choices are made.	March 2011	Principal pharmacist Formulary and MI	Partially completed
2	North East London roles and responsibilities are embedded in drugs and therapeutics processes in BHRUT.	Commissioning process for drugs is robust and consistent across the sector.	Suboptimal use of the trust resources and potential for missing sector wide initiatives to reduce costs which require sector involvement e.g. therapeutic tendering.	The financial implications for 10/11 have already been Failure to adhere to formulary may impact on the trust financial oppositions.	Annual program set by sector and on going.	Chief Pharmacist	Not completed due to commission process for high cost drugs
3	Review policies and	Ensure all	Governance	Financial impact of failing	Annual on-	Chief	Completed

	procedures to ensure compliance with CNST and CQC	policies and protocols are up to date and reflect current policy and initiatives	will be compromised with failure to meet national standards	CNST or CQC	going programme	Pharmacist	
4.	Increase NMP opportunities including consultant pharmacist posts	Support the develop of NMP roles within the trust particular consultant pharmacists	Support EWTD and recruitment and retention and TTA turn around time	Inefficient use of resources will have negative financial impact on trust	Mar 2011	Principal pharmacist NMP	On going
5.	EDS	Support the roll out of electronic discharge summaries incorporating electronic prescribing	EDS will support timely trust objective to send out summaries within 48 hours of discharge.	Inefficient use of resources will have negative financial impact on trust	On going	Chief Pharmacist	On Going
6.	To review and implement all guidance from the National Patient Safety Agency. A significant amount of guidance is being brought into effect including guidance on anti coagulation, injectable medicines, oral liquid	Safe systems of operation are developed and implemented ensuring patients receive high standards of	Patients and staff will be at risk of receiving and giving inappropriate drugs. National guidance shows that mistakes in	Most policy areas being reviewed require policy and protocol changes. Some financial impact may occur where the purchasing of safer forms of injectable products are required. This has not been quantified yet.	On-going	POB	Completed

	medication, paediatric infusions and epidurals. This list is exclusive. Other guidance is also periodically announced requiring implementation.	care and healthcare professionals work in a safe environment using national standard policy.	these areas are causes of death, injury and preventable litigation.				
8	Develop annual CIP medicines management strategy linked to the trust overall business plan objectives, ensuring all staff are aware of its contents.	Clinical and cost effectiveness in all areas of medicines usage is achieved with services developments linked to trust priorities.	Lack of clarity within the trust on the role and management of medicines	Possible inappropriate use and waste of trust resources.	March 2011	Portia Omo-Bare Chief Pharmacist	Completed
7.	Financial control is maintained on prescribing budgets and the trust annual financial pprogramme implemented. Drug budgets are set at directorate level but systems are set up to support the management including clinical director,	Drug costs remain within budget allocated and the cost effective use of resources promoted. Programme identified at directorate	Will adversely impact on the Trust ability to achieve financial balance as directed in the financial recovery plan.	Possible inappropriate use and waste of trust resources.	March 2011	Portia Omo-Bare Chief Pharmacist	Partially completed

	general manager and clinical pharmacist joint management.	level.					

Portia Omo-Bare
Chief Pharmacist
May 2010

Drug and Therapeutics Committee Action Plan 2011/12 Appendix 2

No	Objective	Positive outcome expected	Consequence of Failing	Likely financial implication	By When	By Whom	Outcome
1	ONEL commissioning principles and responsibilities are embedded in drugs and therapeutics processes in BHRUT.	Commissioning process for drugs is robust and consistent across the sector.	Suboptimal use of the trust resources and potential for missing sector wide initiatives to reduce costs which require sector involvement e.g. therapeutic tendering.	Failure to adhere to principles will impact negatively on the trust financial position	Annual programme set by sector and on-going.	Chief Pharmacist	
2	To review and implement all guidance from the National Patient Safety Agency. Including never events	Safe systems of operation are developed and implemented ensuring patients receive high standards of care and healthcare	Patients and staff will be at risk of receiving and giving inappropriate drugs. National guidance shows that mistakes in these areas are causes of	Most policy areas being reviewed require policy and protocol changes. Some financial impact may occur where the purchasing of safer forms of injectable products are required. This has not been quantified yet.	On-going	Chief Pharmacist	

		professionals work in a safe environment using national standard policy.	death, injury and preventable litigation.				
3	Review policies and procedures to ensure compliance with CNST and CQC	Ensure all policies and protocols are up to date and reflect current policy and initiatives	Governance will be compromised and failure to meet national standards	Financial impact of failing CNST or CQC and	Annual on-going Programme	Chief Pharmacist	
4	Review the clinical pharmacy service to all areas to ensure national requirements on medicines reconciliation are fully met.	Services to be targeted so that all new admissions are identified and target	Failure to undertake meds rec has clinical and financial implications and puts patients and trust at risk	Financial impact	March 2012	Chief pharmacist	

5	Develop an action plan to improve the outcome of the trust on the national patient survey	Patients will be given advice on discharge and before hand explaining what the medicine are that they have been given, own to take them and what side effects may be expected.	Poor patient compliance with medication prescribed and poor outcome on the national survey in 2011/12	,may have a negative financial impact on the trust	March 2012	Chief Pharmacist	
6	Develop annual CIP medicines management strategy linked to the trust overall business plan objectives, ensuring all staff are aware of its contents.	Clinical and cost effectiveness in all areas of medicines usage is achieved with service developments linked to trust priorities.	Lack of clarity within the trust on the role and management of medicines	Possible inappropriate use and waste of trust resources.	March 2012	Portia Omo-Bare Chief Pharmacist	

7	To develop an on line data based formulary possibly web based and ensure it is kept up to date. The formulary will be consistent with national guidance such as NICE, NPSA, NSF etc.	Formulary is put on the intranet and is up to date and evidence based.	Suboptimal use of the trust resources.	The financial implications for 10/11 have already been considered and drugs budgets appropriately funded. Failure to adhere to formulary also has a negative clinical impact where inappropriate drug choices are made.	March 2012	Principal pharmacist Formulary and MI	Partially completed still on going
8	Review NMP prescribing within the trust to ensure all trained NMPs are prescribing	Support the develop of NMP roles within the trust particular consultant pharmacists	Support trust priorities on TTAs 24 hours in advance and full roll out of eDS.	Inefficient use of resources will have negative financial impact on trust	Mar 2012	Principal pharmacist NMP	On going
9	EDS	Support the full roll out of electronic discharge summaries incorporating electronic prescribing	EDS will support timely trust objective to send out summaries within 48 hours of discharge.+	Inefficient use of resources will have negative financial impact on trust	On going	Chief Pharmacist	Partially completed

Portia Omo-Bare
Chief Pharmacist
May 2011

Appendix 3

Barking, Havering and Redbridge University Hospitals NHS Trust

Medication Incidents 2010/2011

Period:	**1st April 2010 – 31st March 2011**
Source:	**Safeguard Risk Management System**
Author:	**Sharon McConkey – Patient Safety Adviser**

CONTENTS

1.0 INTRODUCTION

INTRODUCTION

Subject:

Annual report of incidents for the period 1st April 2010 – 31st March 2011.

Purpose:

To provide details of incidents reported via the IR1 reporting system. To disseminate the report to identified groups

Distribution:

This report will be circulated to the Medication Incident Review Group and the Safe Medicines Practice Group

Authors:

Risk Management Team

Date of submission:

Safe Medicines Practice Group 12th April 2011.

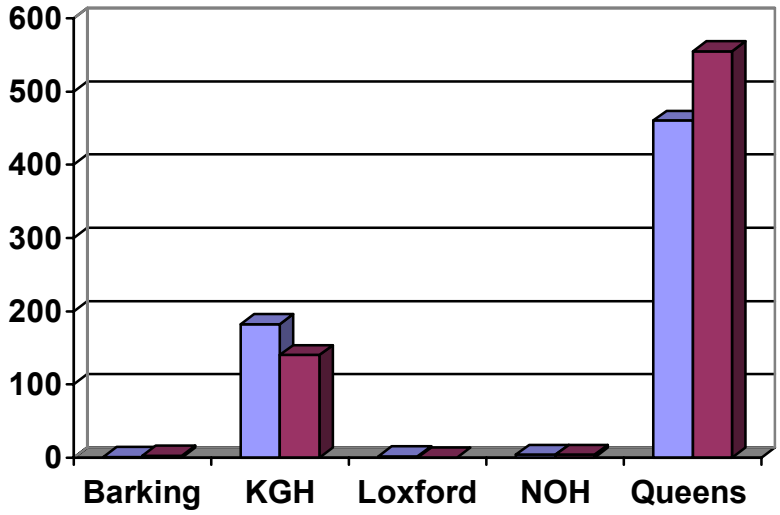
2.0 OVERVIEW OF MEDICATION INCIDENTS

Medication Incidents

Total number of reported incidents

The total number of Medication related incidents was 702 which shows an increase from 649 that was reported 2009/2010

Site of reported incident



Actual impact totals (previous year in bracket)

- **Near-miss – 107 (52)**
- **Low - 457 (393)**
- **Moderate – 131 (180)**
- **High – 6 (17)**
- **Major – 1 (2)**

Details of High/Major Incidents

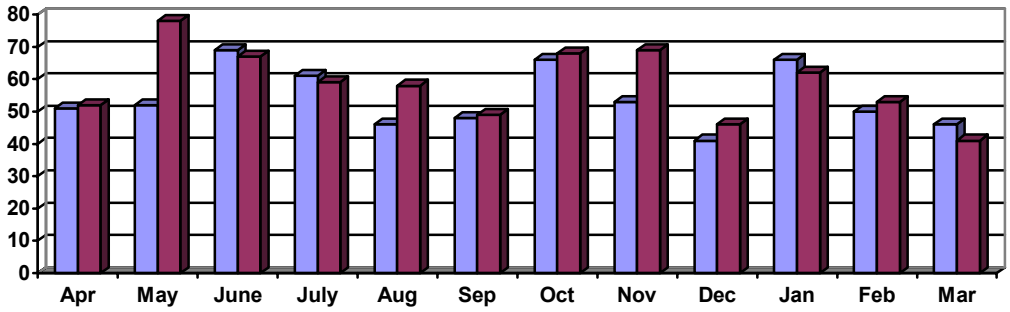
Patient admitted via A&E with increased sob she was given IV Augmentin in A&E on the front of the drug chart it stated that patient is allergic to penicillin and she also had a wrist band on that stated allergy to penicillin patient became very SOB, coughing and became distressed. Patient given adrenalin, hydrocortisone and piriton - seen by ITU doctor -medical management of anaphylaxis given	**Comments received from matron A&E I was aware that this incident had occurred and was picked up by the staff on CAU. I have stopped the nurse involved from giving any medications and he has submitted a statement. I will need to show this statement to Matron on her return from A.L . I have also discussed this error with Divisional Nurse and I anticipate that we will be reassessing this nurse on his I.V competencies and he will be working with this practice development nurse on this. This nurse has been with us for 8 years and has not made any previous drug errors to my knowledge. On the day of the incident I went down to CAU and apologised and explained to**

	the patient and family the steps we take after a drug error is made and they seemed satisfied with my response. Patient given IV Augmentin when known to be penicillin allergic -patient and family spoken to given IV adrenaline, hydrocortisone and piriton and seen by anaesthetists as a precaution - nurse involved stopped from giving and medication until statement obtained and worked through IV drug competencies with PDN - General Manager aware and will deal with Medic involved – Have spoken to patient involved since and she phoned to find out what was happening and explained procedure
In Resus for Paracetamol OD. Est weight 70k. Dose for Parvolex is 10500mg in 200ml Dextrose 5% over 15mins then 3500mgover 4 hrs then 70000mg over 16hrs. However, dose prescribed & given was 10 times less than that (i.e. 1050mg, then 350mg then 7000mg) Error discovered at 16.30 on 31/8/2010 when transferred to ITU. Dr went to A&E to check w A&E Dr & Nurse confirm dosage. Correct dose were prescribed & 1st infusion started at 17.30.	Pt had taken massive 142 tabs OD - and possibly antifreeze as well. Admitted to A&E at 08.30am and administered 2 of the 3 Parvolax (with wrong dosage) doses, by time the error was discovered at 18.00hrs - at this time, was on the 16hr infusion regime. 1/09/2010 - had metabolic acidosis & at 07.45 on 2/09/2010, RIP. Has been referred to Coroner & will be subject to Inquest. Discussed at departmental meeting SPR now moved on matron to deal with nursing side - development of tox box for resus with dedicated box for antidotes and guidance for poisoning to include chart of parvolex doses to help nurses and medical staff to double check doses(complicated doing which currently results in errors)
Decision to give PE thrombolysis in an arrested pt. I went to discuss with family Told thrombolysis given. On my return I found Reopro given not thrombolysis. This dose was given on instructions from Dr. Not prescribed. Pt given thrombolysis. Pt died.	Currently being investigated as a red incident
Pt brought in following o/d. Discussed - decided pt suitable for activated charcoal since ingestion < 1hr. Pt not prescribed charcoal and appropriate treatment was not given in appropriate time. When I saw pt 1 1/2 hrs after brought into dept no treatment had been initiated.	Doctor involved spoken to by A&E consultant. Discussed at Medication Incident review meeting held on 17th August 2010
Pt presented with evidence of TB Meningitis - possible. Case discussed with Cons on duty. Decided to give anti-TB treatment. Pharmacist on all contacted by Cons on duty but still pt received no anti-TB therapy. Following day noticed pt more unwell. Therapy started.	
Pt prescribed Diclofenac PR 75-150mg in divided doses on pm prescription - dated 15/10/10. Four 100mg doses were given on 16/10/10 - the licensed max dose 150mg/24 hrs - and a further 100mg dose on 18/10/10. This was noted 19/10/10 at approx 13.30 by the GHDU Pharmacist when the pt was on GHDU. This was reported to the HDU Dr and to the pts Cons. Cons to r/v	

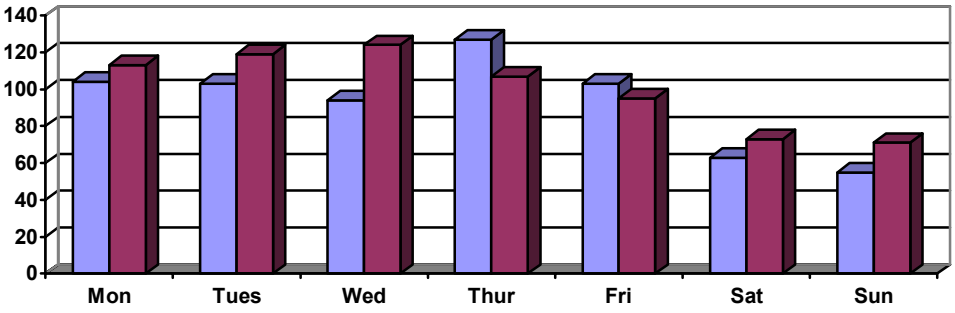
pt and to d/w renal physicians. Pt transferred to ITU 19/10.10.	
Pt in status epilepticus. No paraldehyde on ward. Took > 20 mins to get some from A&E. Insufficient amount of phenobarbitone on the ward. Took >30 mins to get meds - from NICU. A NICU s/n came with CD book in order for checks to be done.	Unfortunately not enough stock available to give prescribed amount. Meds requested from Pharmacy. Stock levels to be replenished as needed. Discussed at Paeds Incident mtg in Oct

When was the incident reported?

Month



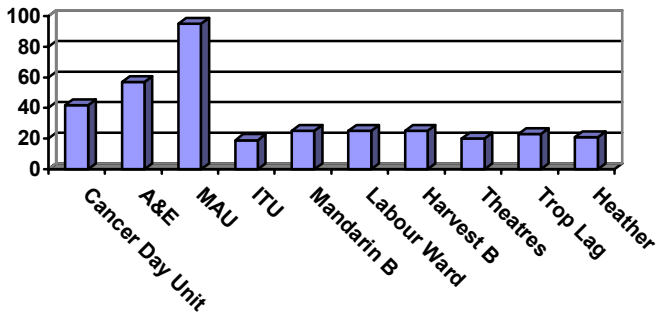
Day of the Week



Who reported incidents?

Acute Medicine	73
Acute Medicine KGH	34
Anaesthetics	43
Anaesthetics KGH	2
Cancer Services	70
Cardiology	7
Corporate Services	1
Elderly Care	27
Emergency Services	135
Emergency Services KGH	17
General Surgery	37
General Surgery KGH	26
Gynaecology	10
Neurosciences	47
Obstetrics	50
Other	9
Outpatient/Inpatient Serv	5
Paediatrics	52
Pathology	2
Pharmacy	8
Radiology	1
Specialist Surgery	14
Trauma & Orthopaedics	31
Trauma & Orthopaedics KGH	1

Top ten departments reporting

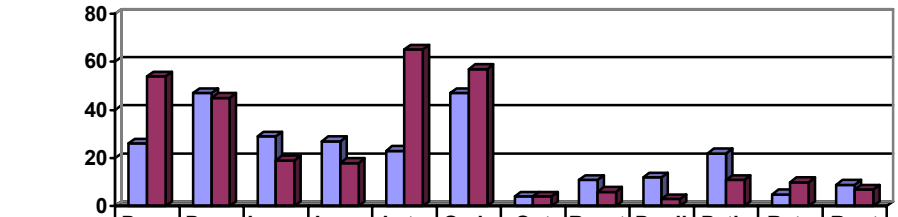


3.0 BREAKDOWN

Type of Incidents

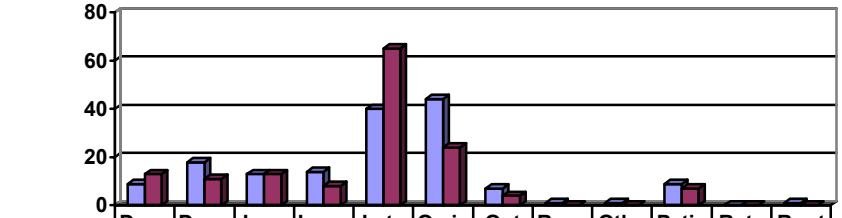
Process Error

Administration



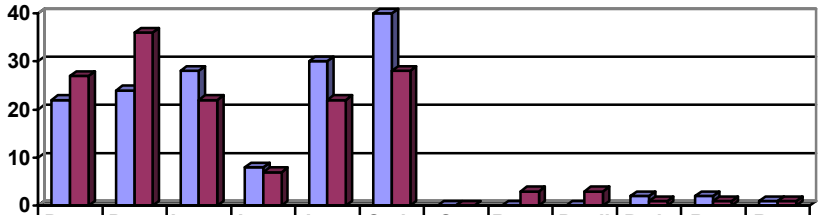
	Dose	Docu	Inapp	Incor	Late	Omis	Out	React	Dupli	Patie	Rate	Rout
2009/10	26	47	29	27	23	47	4	11	12	22	5	9
2010/11	54	45	19	18	65	57	4	6	3	11	10	7

Dispensing



	Dose	Docu	Inap	Incor	Late	Omis	Out	Reac	Othe	Patie	Rate	Rout
2009/10	9	18	13	14	40	44	7	1	1	9	0	1
2010/11	13	11	13	8	65	24	4	0	0	7	0	0

Prescribing



	Dose	Docu	Inapp	Incor	Late	Omis	Out	React	Dupli	Patie	Rate	Rout
2009/10	22	24	28	8	30	40	0	0	0	2	2	1
2010/11	27	36	22	7	22	28	0	3	3	1	1	1

4.0 FEED BACK FROM MEDICATION INCIDENT REVIEW GROUP

Trends

Medication being given to the wrong patient

Allergic patients being given penicillin etc

Barking, Havering and Redbridge NHS
University Hospitals
NHS Trust

QUALITY & SAFETY COMMITTEE

Part I

Minutes of the meeting held on Tuesday 9th August 2011 at 14.00 hrs in Board Rooms 1&2, Trust Headquarters, Queen's Hospital, Romford.

Present: Edwin Doyle, Chairman (Chair) (ED)
Averil Dongworth, Chief Executive (AD)
Caroline Wright, Non Executive Director (CW)
Magda Smith, Divisional Director – Medicine (MS)
Stephen Burgess, Medical Director (SB)
Deborah Wheeler, Director of Nursing (LW)
Tan Vandal, Acting Divisional Director – Surgery (TV)
John Fletcher, Divisional Nurse Director – Surgery (JF)
Judith Douglas, Divisional Nurse Director – Clinical Support (JD)
Pam Strange, Clinical Governance Director (PS)
Carol Drummond. Divisional Director – Women's & Children's (CD)
Ariysha Khan, Divisional Manager – Women's & Children's (AK)
Alison Crombie, Education Director (AC)
Dinesh Gupta, Assistant Chief Pharmacist – Clinical Services (DG)
Imogen Shillito, Director of Communications (IS)
Cris Robinson, Committee Coordinator (Minutes) (CR)
Elaine Clark, Patient Representative / Chair of IPEG (EC)

Apologies: John Alcolado, Director of Medical Education (JA)
Ian Grant, Divisional Director - Clinical Support (IG)
Portia Omo-Bare, Chief Pharmacist (POB)
Michael White, Non Executive Director (MW)
Prof. Anthony Warrens, Non Executive Director (AW)
Jane Moore, NE London Sector Director of Public Health (JM)

		Action
64/2011	**Apologies** The above apologies were noted.	
65/2011	**Minutes of Meeting held on 14th June 2011 (Part I)** The minutes of the previous meeting were agreed with the following amendments: Item 50/2011 – typographical error to be corrected: 'retaining' to be changed to 'retraining' Item 56/2011 – Additional text to be added to improve clarity: It was confirmed by DCW that the video from the Dispatches, Channel 4 programme is being used in our mandatory training programmes and the Care and Compassion report was used as the focus of the Trust's internal Nurses' Day event.	CR

		Action
66/2011	**Matters Arising** Rolling Programme The members were reminded by the Chairman of the need to update the rolling programme, emphasising that items such as Annual Reports should be included. The Chairman asked for the rolling programme to be a standing item on future agendas. Action Log SB advised that the work on reviewing the governance framework and Committee structures was temporarily on hold awaiting the outcome of the CQC visit and review by KPMG. Once their report was received it would provide recommendations for improving the Committees and feeder Committee structures. It was agreed that a report should be received in time to enable a report to be compiled for the October meeting. Inclusion of the CQUIN targets into the dashboard, requested at the last meeting, has not been achieved as the baseline position and targets is awaiting sign off with the Commissioners. Following a brief discussion it was agreed that individual CQUINs should be reported by the relevant Division. AD explained that these were part of the discussions to be had with ONEL and NHSL in September on the overall financial agenda. This item to remain on the action log. CD reported that the Women's & Children's dashboard needed to include KPIs for gynae and neonates. AK advised that the maternity dashboard does include their KPIs and is consistent with the Assurance Framework. The Chairman requested that the Women's & Children's full dashboard be the subject of a report at the next meeting. The members were assured that attendance at the maternity risk multi-disciplinary team meetings has improved and attendance is continuing to be monitored. This item is now discharged. Problems with the company involved in the real time surveys was explained to the Committee by DCW who confirmed that maternity was the next area where the surveys would be introduced. She was aware of the urgency of gathering views from maternity patients and would progress this as quickly as possible. This item is not discharged. JD provided a brief summary on radiology access times. However, the Committee felt that it was insufficient to provide assurances especially around the portering issue. A fuller report was requested for the next meeting in October. AD confirmed that the topic was being covered during performance reviews by other routes but agreed that the Committee needed to keep monitoring the quality aspects. CD apologised that the maternity action plan had not been submitted for review. It was noted that the Trust Board had received the action plan and that it was updated in July and would be taken to the September Trust Board meeting. The members requested it become a standing item to this Committee. TV reported that the enhanced recovery programme now has 8 pathways in place and a paper is being taken to the next Strategy Board, to be followed by implementation in all 4 areas. 2 Colorectal surgeons have been appointed and the programme is progressing very well. There was a discussion about ensuring the Trust was not hindered by the lack of skills and an explanation was given by SB on retraining techniques pointing out that not all surgeons have the right abilities to do laparoscopic surgery. The Committee were asked by TV to note that the national pilot for hip, knee, colorectal and gynae	All / Agenda Item SB CD JD/IG CD

		Action
	pathways (urology has been removed) carried out in 14 organisation has resulted, as of February, with 3 having all 4 pathways; 10 only having 1 in place and 1 with none in place. The Trust therefore should be considered as having a higher performance than others in this area. SB agreed to review whether there is a written policy around retraining expectations for doctors.	SB
	Since the enhanced recovery programme is part of ongoing business discussions AD was happy to ensure this was kept moving forward. The item was therefore discharged from the log with the exception of the feedback on policy by SB.	TV
	The Committee noted that the breast and vascular centralisation was now completed and requested an update at the October meeting as the 6-monthly report on implementation would be available.	
	PS reported that an e-mail had been sent to Davy Yeung requesting the next 6-monthly R&D report due in December includes the governance and financial information requested at the last meeting.	DCW
	The Chairman highlighted that an action point had not been noted against the 'Enter & View' report at the June meeting and DCW was asked to provide a report to the next meeting focusing on what actions were required. DCW did point out there was a query on whether the report would be received in time.	
	All other items have been discharged from the action log.	
	<u>Draft Agenda (October)</u>	
	The reports requested above to be added to the draft agenda together with any additional items from the rolling programme raised by the Divisions.	CR
	STRATEGY	
67/2011	**Divisional Quality Dashboard**	
	SB explained the revised format of the dashboard. The quality & safety and workforce sections of the Trust Board approved Performance Dashboard had been used in an effort to avoid duplication of requests to managers and to ensure consistency of reporting. The dashboard continues to contain the updates on the risks from each Division, those from feeder Committees and risks to the Trust's reputation.	
	The Chairman stressed the document remains a 'live' document that will be continually evolving and where some items would be singled out for future attention i.e. maternity. He was pleased to see the patient experience information was included but requested that we set our own internal targets. DCW agreed to put forward 'best guess' targets.	DCW
	ED felt strongly that more information was required on the views of staff as well as from Unions and Management in order to properly triangulate the data and this could be provided by the Workforce Committee with KPIs for example around the staff survey	
	The lack of supporting narrative was highlighted by AD who raised the need for a central repository for data to avoid managers being asked time and again for the same information; an issue also raised by AC who was concerned that currently there is scope for confusion. AD proposed that the data issues needed resolving with the Information Team.	PS
	SB confirmed that the Dr Foster target could be included for 'mortality % elective'.	
	CW found high level Trust data helpful but considered there was limited narrative to suggest how the risks to reputation were going to be tackled, nor was it clear what members were expected to do with the information presented. Members were reminded by ED that an executive summary was	

		Action
	expected for all items. Members were informed that as of tomorrow (10th July) no incidents of MRSA bacteraemia breaches will have occurred for 100 days. This was agreed to be an excellent achievement and the first time that had happened in the Trust. DCW also pointed out there was also an improvement in same sex breaches, with only 4 being reported in July; all in HDU. DCW raised an issue on the benchmark information, as it was not possible to have half a bacteraemia; this required review. ED asked for comments on the Divisional areas of the dashboard highlighting that he was concerned that under the finance risk section not all Divisions had included achieving their CIP as a risk. He also pointed out that not all columns have been completed, as there were some where target dates had not been included. The need to get smarter about categorisation was raised by AD who stressed the need to work with Divisions to be clear about what we need; overall it was felt that the individual sections of the dashboard did not relate properly to the Trust overview data. IS was asked to update the risks to reputation section and include strategy, plans, SROs and targets. AK confirmed that the Division's dashboard is discussed at the W&C monthly Board meetings. It was agreed that DCW and SB would take this work forward but would involve Neill Moloney and the Information Team.	IS DCW/SB
68/2011	**Medicines Management Annual Report** DG presented the 2010-11 Medicines Management Annual Report explaining that it detailed the structure of the department plus the key priorities for the current year and progress against the previous year's priorities. The report had been approved by the Drugs and Therapeutic Committee. A report to the next meeting was requested to cover the questions raised by members and which should include identified learning points: • Medication errors – clarity around the action taken when errors occur • CQC concerns are not mentioned, nor how they are going to be addressed • The provision of medical information for patients scored very poorly but the ongoing work with the Communications Team was not mentioned. • An explanation was required of why it is difficult to develop a trust wide process for carrying out i.v. heparin flushes. • An update on the gentamycin audit in July. • An explanation should be included of the management process for staff that do not attend their required training. A discussion around the recording of mandatory training ensued and AC pointed out that competencies should be picked up as part of the local induction process. The need for standardised content for annual reports was also discussed and ED confirmed that annual reports needed to be able to provide the Committee with appropriate assurances that challenges were identified and programmes were in place to address them. DCW advised that medicines were now being included as part of the Visible Leadership programme and it was agreed that a joint update report should be made available for the October meeting.	POB/SB /DCW

		Action
69/2011	**Policies for Ratification** <u>Patient Experience Policy</u> DCW advised that the policy was based on the Patient Experience Strategy and had been brought to the Committee for approval following its passage through various Committees, including the Improving Patient Experience Committee, as part of the consultation process. AC felt the document had been well consulted on. CW said she found it helpful that there was clarity around the Trust's expectations, although she would like to see specific mention of 'The Code'. She also felt that dividing the responsibility section into different stages was not helpful and suggested changing culture should warrant more than half a page. CW advised that often too much reliance was placed on electronic and written dissemination and not enough on face-to-face. EC advised that patients need documents that are easy for them to understand otherwise it is viewed as 'waffle'. The IPEG members had felt this document was understandable. AD considered that the performance management aspects need to be included in later iterations as this topic was a top corporate objective i.e. it was important to more clearly describe what happens if staff do not comply with the expectations described in the policy. This then prompted MS to question whether staff have the tools to comply particularly asking about private areas for conversations with patients. DCW explained there are a number of work streams planned to take the work forward in the Trust including that specific issue. DCW stressed that the document had been compiled to ensure that the expectations were fully woven into the staff 'day jobs' and not as an add-on. DCW agreed to take on board the comments made and to revisit the policy. It was agreed that ED would discuss the policy further with AD before it goes to Trust Board to ensure that it is absolutely right and it is received positively. It was also noted that reference should be made to the patient strategy and that the responsibilities section should start with Trust Board. Once amended the policy should be taken to Trust Board. <u>Staff Supervision Policy for the Safeguarding of Children & Young People</u> DCW highlighted that the policy needs to be put into the correct Trust format before release. The SIT visits by NHS London had cited the Trust's processes as best practice. CD felt the document was succinct but that there did need to be greater clarity that it was a trust wide document and not one aimed solely at those working with children. It was again pointed out that responsibilities should start with the Trust Board. Following a short discussion it was agreed that the Executives and Non Executive Directors should all be invited to attend corporate safeguarding children training and DCW agreed to ensure that the dates were circulated. The report was approved subject to the above requirements being completed. <u>Visiting Policy</u> CW praised the policy for being helpfully set out and clear for staff. AD pointed out that Ward Managers need to be clear about their responsibilities under this policy. An error was pointed out for correction (no 7.2). The suggestion was also put forward by CW and accepted that staff behaviour and staff responsibilities become one section and reference made	ED/AD DCW DCW DCW DCW

		Action
	to The Code. IS reported that work is ongoing in relation to patient and visitor information to ensure it conveys a positive attitude. It was also pointed out by JD that in section 7.1 reference should be made to the fact that car parking fees are waived for the close relatives of dying patients. JD was asked to send a suitable form of words to Lesley Marsh for inclusion. EC reported that IPEG had worked really hard on this document and were very pleased with it. DCW stressed that implementing the policy will not be plain sailing and they were expecting some teething difficulties. The 'go live' date was set for the 24th August, which was before the next Trust Board has the opportunity for final sign off. Beforehand there were issues to resolve such as changing signage across the Trust and raising staff awareness. DCW reported that the policy was the subject of Visible Leadership, team brief and the next Sisters' awayday. The policy was approved subject to the above requirements being completed and once revised should be taken to Trust Board.	JD DCW
	PATIENT SAFETY	
70/2011	**Mortality Report** PS reported there had been month on month improvement in the HSMR data and currently the Trust has an HSMR of 97. However, Dr Foster is expected to again rebase the baseline back to 100 and, once that is done, the Trust is likely to remain an outlier with an HSMR of 108. Continued improvements may bring this down to 107. It was reported the organisation has got smarter with its reviews of red bells and the prompt development of action plans. Peritonitis was identified by the Trust as an issue and steps taken to review the 5 patient episodes; this was done prior to Dr Foster notifying the CQC. The review by Mr Mukerjee is nearing completion and the findings suggest that no issues relate to the surgical activity but that co-morbidities of these patients had not been written up and this therefore affected the coding. AD was concerned that inaccurate coding meant the Trust did not get properly reimbursed. The Committee were asked to note that Dr Brownell was carrying out a scoping exercise with a number of Consultants with a view to driving up the quality of documentation in health records and providing accurate and timely information for coders. The group will be developing an action plan and it is anticipated this might be ready in time for the next meeting. ED felt that the distribution graph was a very useful visual aid, but noted that there was still some way to go to bring the re-based HSMR data to 100 or below. SB advised that there were new ways of reporting cancer deaths and these were excluded from the Dr Foster data. MS found the green bell on pneumonia encouraging. AV requested that the jargon used (P95.X etc.) be omitted and a clearer definition used in future. During the discussion of the report the lack of tracking of maternity records was raised as highlighted under 'other perinatal conditions'. CD explained that the issues why integration into the Trust's other health records system had not be achieved was very complex involving resources, IT elements and the fact that women carry their own health record. DCW reported that this issue had been picked up in an open LINk meeting at Redbridge but the LINk had not been able to provide any substantiating evidence for the comment.	PS

		Action
	It was agreed that a report on the maternity records issue should be brought to the next meeting.	CD
71/2011	**Care Quality Commission Update** SB presented the CQC update pointing out the details of the CQC's ongoing concerns and the warning notices for A&E and staffing; the draft action plan was included with the report as was an overview of the current trust wide visit. Page 4 of the action plan was missing from the circulated papers, and a replacement copy of the page was provided to members at the meeting. ED queried whether there had been a conversation with our Commissioners about the action plan and if not, then recommended one should take place. It was also suggested that KPIs should be included to identify the outcome measures and to enable us to demonstrated actions had been achieved. AD queried whether the submitted action plan was based on the maternity action plan format and DCW confirmed that it was. MS also confirmed that the A&E elements were being incorporated into a similarly formatted action plan with an emergency care assurance framework that will be reported weekly to ONEL and an emergency care action plan dashboard. It was agreed that the over-arching action plan and emergency care action plan should be escalated to the Trust Board for review. The Committee noted that as the deadline for submission to the CQC was the 22nd August it would need signoff by the Medical Director and Chief Executive. It would then go to the September Trust Board meeting.	SB SB/MS SB/AD
72/2011	**Ambulatory Care Expansion** MS reported that the ambulatory care pathway was being developed to take account of the national initiative to move some conditions from inpatient care to care at home. Some emergency conditions are also safe to manage at home and Dr Choudhury was leading on this work. The Department of Health has identified 50 ambulatory care medical pathways and the Trust was working to develop a robust business case for a 30 pathway ambulatory care service. DCW pointed out inaccuracies for both cellulitis and DVT which had not yet been approved by the Trust although it was noted that both were in hand. MS agreed to make corrections. MS was thanked for a clear and succinct document.	MS
73/2011	**Gynae – Progress with Emergency Walk-In** CD reported that the emergency 'walk in' for gynaecology patients is not fully established and that there were some space issues for the first line triage areas. Work was ongoing with the Surgical Division on the cases where following clinical review, patients were found not to be gynaecological cases. The Head of Midwifery is leading on this work. CD confirmed that the gynae. pathways are clear but referral onwards is a problem area still to be resolved. AK confirmed that the system is working well for early pregnancy cases. AD advised that the topic should be taken to the Emergency Board Task Force first to seek a rapid solution and requested a report back on any findings to the next meeting.	CD

		Action
PATIENT OUTCOMES		
74/2011	**Cancer Waiting Times and Faster Access to Tests** JD advised that the Trust was meeting the cancer target. The members felt that the report was in essence, a service report and not a governance paper relevant to the Committee. SB did however advise that there are waiting time issues which need to be extrapolated for the Quality & Safety Committee in future. The report was noted.	
75/2011	**MRSA Root Cause Analysis Review** DCW reported that as the Trust had missed its MRSA trajectory last year a process of root cause analysis of all cases had been introduced and the report presented was a summary of the issues identified and reported to the Infection Control Committee from those reviews. Blood culture management and junior doctor's competencies to take blood are the main areas of concern. The Chairman questioned whether there was Consultant engagement and SB advised there was engagement from some, but there was also some pockets of resistance. Escalating action plans, initially to DCW and then to AD, SB and DCW for final sign off has had a positive impact and where there is continued need actions will be taken. Suggestions such as no agency doctor to take blood samples, or more stringent training for on call doctors were put forward to mitigate the risk to patient safety. A further report on the blood culture problem was requested for the next meeting.	DCW
PATIENT EXPERIENCE		
76/2011	**Real Time Patient Survey** CW questioned whether the real time survey reports would be available for the next and subsequent Trust Board meetings; DCW confirmed they would be. Delays in the software, mentioned earlier has put the roll out a little behind but following a meeting with the company involved the issue has been resolved. She also advised that there were issues at KGH as it does not have wireless capacity and the equipment has to be incorporated into docking stations. DCW agreed to inform CW of the date for the roll out to the last ward. In answer to a question from AC it was confirmed that the questions had been compiled with the LINks and were chosen from questions included in the Patient Survey where the Trust responses had been poor. The outcome from the surveys was purely for internal use. ED felt the report would be enhanced if graphs could be used to help the identification of trends and if 'families of data' could be generated to foster a culture of competition between the wards. DCW accepted the suggestion confirming that was the direction of travel anticipated for the reports. AD congratulated DCW that the wards were getting the feedback so quickly. It was confirmed that the themes from the surveys were always covered in Team Brief and the report would be shared with Trust Board.	DCW DCW

		Action
77/2011	**Visible Leadership / Productive Ward** DCW proudly reported that the NHS Institute was looking to use the Trust as an exemplar of best practice for the work being done on Visible Leadership / Productive Ward. She confirmed that the information from the Visible Leadership audits are sent to Clinical Directors and explained that the process was not purely a nursing one but involved others in the medical team such as pharmacists, physios, nutritionist and doctors on the ward at the time. DCW stressed that we need to be clear about how we use the data and whilst the aim is to be more visible in the organisation, we need first to review the information and consider how it is utilised to the fullest effect. DCW was thanked for her report.	
78/2011	**Any Other Business** A paper showing the dates for 2012 meetings was tabled at the meeting and members asked to note them in their diaries. Members were also reminded to update the work programme	
79/2011	**Summary of Issues for Escalation to Trust Board** The Chairman summarised that the following items should be shared and/or escalated with the Trust Board: • Patient Experience Policy (once amended) • Visiting Policy (once amended) • Care Quality Commission (Emergency Care action plan when all 3 sections are completed) • Maternity Action Plan • Real Time Patient Survey	
80/2011	**Dates of Future Meetings** Meetings have been arranged at 14.00 hrs in Board Rooms 1&2 on the following dates: 11th October / 6th December	

ACTION LOG

		Responsibility
65/2011	**MINUTES OF THE MEETING HELD ON 14TH JUNE 2011 (PART I)**	
Amendments to be made in line with discussions.		CR
66/2011	**MATTERS ARISING**	
Rolling programme to be updated with reports requested for October Meeting. Rolling programme to be updated with annual reports and other items.		CR All
Committee Structure and governance framework report required for next meeting.		SB

Matters Arising (Continued)		Responsibility
Update on sign off of CQUIN targets for inclusion in Divisional Quality Dashboard		SB
W&C dashboard to be aligned to KPIs and reported to next meeting.		CD
Update on progress with the roll out of real time surveys to maternity		DCW
Quality and risk issues relating to radiology access times inc. portering – report required for next meeting.		IG
Maternity action plan to be standing item at all future meetings		CD
6-monthly progress report requested on breast and vascular centralisation for October meeting.		TV
Report on actions required following 'Enter and View' visits		DCW
67/2011	**DIVISIONAL DASHBOARD**	
'Best Guess' targets to be developed for patient experience data for Dashboard		DCW
Dr Foster target information to be included for 'mortality % elective'		PS
Risk to reputation section to be developed to include strategy, plans, SROs and targets.		IS
Meeting to be arranged, to include Neill Moloney and the Information Team, to discuss further developments of the dashboard taking on board the comments made during the discussions (see minutes)		DCW / SB
68/2011	**MEDICINES MANAGEMENT**	
A joint report to be prepared for the October meeting to address the questions raised by members and to draw out learning points. (see minutes)		POB / SB / DCW
69/2011	**POLICIES**	
Patient Experience Policy to be amended in line with the comments made by the Committee. (see minutes)		DCW
Discussion to be arranged to ensure Patient Experience Policy is absolutely right before it is shared with Trust Board		AD / ED
Staff Supervision Policy for Safeguarding Children and Young People to be amended in line with the comments made by the Committee and put into the correct Trust format before release. (see minutes)		DCW
Dates of Safeguarding Children training to be circulated to Executive and Non Executive Directors.		DCW
Visiting Policy to be amended in line with the comments made by the Committee and put into the correct format before release. (see minutes)		DCW
Wording for inclusion on the waiving of car parking fees for relatives of dying patients to be sent to Lesley Marsh for inclusion in the policy.		JD

		Responsibility
70/2011	**MORTALITY REPORT**	
Jargon to be removed from future reports and clearer explanations given.		PS
Report required at October meeting on the issues affecting the lack of tracking of maternity records		CD
71/2011	**CARE QUALITY COMMISSION**	
Conversation to be had with our Commissioners about our Action Plan to address the A&E and Staffing warning notices		SB
Sign off of final action plan before submission date of 22nd August by Chief Executive and Medical Director, prior to the September Trust Board.		SB / AD
72/2011	**AMBULATORY CARE EXPANSION**	
Cellulitus and DVT inaccuracies to be corrected		MS
73/2011	**GYNAE EMERGENCY WALK-IN**	
Referrals to surgery of non-gynae cases (following review) to be taken to Emergency Board Task Force for resolution with feedback report to next QSC.		CD
75/2011	**MRSA**	
Blood culture problem – fuller report on the issues and actions being taken is required for October meeting.		DCW
76/2011	**REAL TIME SURVEYS**	
Advise CW of anticipated date of roll out of real time surveys to the last ward.		DCW
79/2011	**ESCALATION TO TRUST BOARD**	
Issues identified to be either escalated to Trust Board following required actions or incorporated into executive summary for Trust Board to accompany minutes.		PS

Barking, Havering and Redbridge University Hospitals NHS Trust

Notes of the Meeting of the Strategic Partnership Board (SPB)
Tuesday 15th March 2011 @ 10.00am
Meeting room 3, Queen's Hospital

Members present:	David Wragg	DW	Director of Finance BHRUHT
	George Wood	GW	Non-Executive Director BHRUHT
	Averil Dongworth **(Chair)**	ADo	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
	Simon Scrivens	SS	Sodexo - Managing Director
	Philip Cooper	PC	Catalyst - SPC Representative
	Lindsey Coles	LC	Sodexo -

ADo introduced herself as the new CEO at BHRUHT to the group. The meeting commenced at 10.00am

1 **Apologies for Absence**

None

2 **Notes from the previous meeting on 29th November 2010 & Matters arising**

The notes of the last meeting were reviewed. They were duly agreed as a true record.

Matters Arising – None

3 **Action Log from BeeAgile Partnership Workshop - Update**

ADo took the group through the action log from the partnership workshop by item

Transfer of energy management to Sodexo - DW said we have now met Sodexo, with regard to soft FM, who have expressed their interest in becoming a willing partner, following Sodexo hard FM's withdrawal of their energy management proposal. PC commented that he also was in support of this, and has in fact introduced the same or similar on other projects. GW asked if we were likely to see the £600k saving this financial year. It was confirmed that this would not happen. After due discussion a deadline for completion was agreed as June 2011. GW asked if we could do sundries at the same time as VAT. JD said they are currently working on as many of these as they possibly can and are also double checking to see if there is anything else which can be picked up, but their aim would be to do the two at the same time

Action:
- **DW/PC to liaise regarding other similar projects PC has work on**
- **VAT and Sundries to be in effect and maximised by June 2011**

A discussion around ROE and TUPE commenced and it was agreed to hold several meetings regarding this outside of this meeting. DW, JD and SS would continue to work

together on this area, and ADo would contact the DoH for support if necessary.

Feasibility for Retail Pharmacy – SS has been requested to outline opportunities for retail pharmacy for consideration. ADo said a lot of work on this needs to be done off line

JD said that at the last SPB it was agreed the TV would attend the Health Campus Group; however Rob Royce (Chair of the group) was concerned as to whether the content of the meeting was appropriate. A discussion is now underway to establish which items TV should attend

Combined Telephony – There has been slow progress with this at the BHR end mostly due to IT issues, however things are now progressing and JD will discuss this further at the PEQ meeting

Action: JD to take to PEQ combined telephony system

Market Testing – although this was on the agenda later, it was agreed to discuss this now. JD advised ADo that this had been discussed several times at both Finance Committee and Trust Board. There will be a meeting later today to review a final draft of the documents to agree the wording (after due diligence). RF commented that he had not been involved in depth in this process and has on several occasions asked for the documents in track changed format for his lawyers to peruse.

Action: JD/LC to provide to RF assurances either by letter that Siemens will be in a neutral position as a result of this (i.e no better or worse off) or by providing the requested documents

Simplifying & speeding up decision making with TVE's – after a brief discussion around how other Trust do this as part of the regular contract, RF was requested to provide a letter confirming this.

DW commented that he would aim for better understanding and would like to work in partnership with the ProjectCo to manage any reputational risks. It was agreed that this was in the best interests of all parties

Behaviour changes to build better working relationships – GW commented that although this is noted on the log, it does not appear to have happened. After due discussion it was agreed that all parties need to make every endeavour to ensure things are carried out efficiently and effectively with a positive and can do attitude.

Action: JD to arrange for a monthly briefing to SPB on working relationships between all parties

This action log needs to be reviewed on a semi annual basis at further workshops

Action: JD to liaise with all parties concerned to arrange another workshop to review the action log

4 SPC Development cost on variations update *(inc removal of DoV requirement)*

This was discussed under the previous item

5 Assurance Reports

Investment Committee – RF presented the minutes from 10th January, and advised that

the last meeting was held on 10th March. RF gave a brief update including radiology issues. The minutes were duly noted.

Health4NEL – DW reported this is now in hands of the Independent Review Panel and until the outcome is published we are unable to plan any developments.

Clinical Strategy – Midwifery lead unit at Queens (subject to Board approval) needs prioritisation.

New Developments – ADo advised that we have had some warning notices from CQC so we may need to speak to our partners about a collective response to the CQC. JD said she had received a copy of the report so we have a clear idea of what needs to be done. JD reported that we are currently undertaking a full equipment audit (Trust wide) and she will share all information to RF.

6 Presentation on Catalyst Annual Accounts September 2009 & 2010

PC said that if any of the group had any questions, please let him know and they will be addressed. DW said he would like arrange a detailed explanation. After discussion it was decided that this is information the Treasury would want as well and it was agreed that DW will link in with PC and the Treasury to arrange a meeting

Action: DW to liaise with PC and the Treasury to arrange a meeting to discuss the Catalyst Accounts

7 Market testing update soft FM

This was covered under item 3

8 Soft/hard FM efficiency programme update/Trust CIP

JD confirmed the 2010/11 CIP on PFI had been delivered. Both GW and ADo offered their congratulations and said this was outstanding work. JD said this years target would be tougher; however she was confident they have a robust programme and they will deliver. ADo commented that we must ensure we work with our partners to build, improve and develop our relationships and optimise productivity.

9 Retail outlet expansion/convenience store update

JD reported she and TV had engaged a retail expert to look at opportunities at Queens. Some basic outline figures had been completed and they were now moving to the second stage to issue an outline proposal, which would be presented to PEQ. Provisional discussions had taken place with Sodexo and they are looking to deliver this project in the early part on next year.

10 Treasury/DoH PFU review of Romford PFI

DW said the Treasury had advised him that this review would be on smaller scale than previously thought. The Treasury are currently working through the financial model. DW advised that a lot of what they are looking at has already been done, particularly on soft FM and insurance. GW asked if the Treasury would be producing a report which was unique to BHRUT. DW confirmed this would be the case

11 Any other business

None

The meeting closed at 11.30am

Date and Time of Next Meeting

The next SPB meeting would be held on **Tuesday 12th July 2011** to commence at **10.00am** in the **Meeting room 2 at Queens Hospital**. Any apologies for absence should be sent to Robert Royce at robert.royce@bhrhospitals.nhs.uk

Dates for next 2011 – *all will commence at 10.00 for 1 hour*

Tuesday 22nd November 2011 @ 10.00am, Meeting room 2, Queens Hospital

Charitable Funds Committee
Minutes from meeting held on
Tuesday 21st June 2011

Attendees:	Keith Mahoney	KM	Non- Executive Director, Chairman
	David Wragg	DIW	Director of Finance
	Bill Langley	WL	Non-Executive Director
	Jackie Doyle	JD	Director of Estates
	Linda George	LG	Charitable Funds Accountant
	Chris Stevens	CS	Head of Fund Raising

1 Apologies

Deborah Wheeler

2. Investment Report – this was presented out of order as JD could not be present for the whole meeting

David Richardson (DR) presented his report and informed them that the company is now called Investec after Investec bought into the rest of the business, having already taken over Carr Sheppards Crosthwaite in 2006. The company also offer deposit account facilities.

DR began with our last quarter to March 2011 which showed reasonable results. Forecasts were up and it was felt that big events like the Tsunami and Arab Spring had little effect on the markets especially if the flow of oil remained static. Main things to note were:

- For the first time oil producers were not united
- There are more sources of energy other than oil
- There are more sources of oil.

DR stated that they intend to increase more exposure in Japan when things are settled. The portfolio is held in real assets and DR stated that it was believed that Britain will not go into a double-dip recession and the UK economy should grow by 1 to 1 ½%, but with inflation remaining.

WL asked what Investec's issue was on defensive stock. DR responded that the classic signs are that, when consumers stop spending, they do it in a specific order, with food and drink being the last to go. Switching of brands should hold the portfolio steady. DIW remarked if we should expect low growth and DR responded that a long term growth of 7% was expected. WL emphasized that, with the energy crisis, the government increasing taxes and problems with the euro, there is a lower portion of spending on credit and to be as defensive as possible. DR reminded the Committee that there was the vehicle to draw down cash to cover larger spending projects.

DR reported that, at the moment, they benchmark against WM, but that WM is only a sample and they are beginning to move into hedge funds and various other fund types, and were to devise a specific allocation to BHR in order to construct a long term strategy i.e. 50%. DIW remarked that, as a charity, care should be taken to protect the assets and it would be useful to consider various models. DR report that, as at the close of business on 20th June, the portfolio (including cash) was £2.8 million.

3. Minutes of the Previous Meeting & Matters Arising

The minutes from the previous meeting held on 19th April were agreed as a correct record.

KM updated the Committee regarding MMMM. In the event of nothing coming back from an email sent by KM regarding the draft Memorandum, it was assumed that they were happy.

KM is to meet with Averil Dongworth at the next Workforce Committee. However, Stephen Burgess is looking at Clinical Innovation and Service Improvement and wants some type of recognition put in place. With regards to the Employee and Volunteer awards, CS mentioned that the Charity had not been given recognition for these contributions. CS is to speak to Imogen Shilitto about this. WL suggested that local businesses might like to chip in

ACTION CS

The application for the TV monitor is still ongoing. It is still being decided whether the original 32" screen will give a high enough resolution or to re-apply for a computer monitor.

ACTION CS

Signage for the up-grade to the Relatives' Room at KGH as been ordered and JD is to speak with Lynne Taylor.

ACTION JD

WL will put the postal questionnaires and register to reduce the lists go on the agenda for the next Workforce Committee and update the CFC at the next meeting.

ACTION WL

KM had circulated a paper to Matthew Watson of Bedrock Radio. JD suggested that Bedrock should be asked to incorporate their charity into BHR Hospitals' Charity, but would need to sit with them again to suggest this. As our Charity is looking to fund £8k, it was felt that this would be a good opportunity to promote the Charity and vital information e.g. infection control. It was felt that Bedrock was an enthusiastic group, but WL emphasized that they would need to come to terms with the fact that they would lose some element of independence, but we should give assurance they would not lose their identity. CS to meet with them. JD suggested that the CFC should still support the public address system.

ACTION CS

CS mentioned that staff should be encouraged to ask questions about the Charity via the Link e-magazine. Funeral Directors have been approached to encourage more donations and there has been an increase in the 'in memory' donations via Just Giving. CS mentioned that Virgin is a cheaper method for on-line donations, but the level of service is not as good. WL informed the Committee that Vodafone had just launched with Just Giving, and BT has also launched their site. WL suggested that we draw up a chart and JD agreed that we compare the market. DIW suggested the possibility of incorporating the Just Giving link when sending out emails etc., but that we should integrate the link to the Charity website where the Just Giving link is readily available. WL asked whether membership of PayPal was required and the response was that it was not. JD and CS will discuss the options at their next meeting. .

ACTION JD/CS

LG informed the Committee that the treatment of profit distribution had been investigated and treatment was dependant on the original wording of donations. A response is still expected from the Charity Commission in answer to whether realised gains and investment income can be used where the benefit would reach patients and staff trust wide.

JD informed the Committee that she and DCW went through the account signature list and proposed the following amendments to reduce the schedule. Firstly to erase all current signatories and re-work the schedule as follows:

- Streamline the accounts into speciality
- A matron or General Manager for each account
- The Divisional Manager or Divisional Nurse for each account
- Any Executive for <u>any</u> account.

JD and LG to meet to discuss the required amendments and DIW suggested that the pending change around should be taken into account.

ACTION JD/LG

KM suggested that charity statements should go out with the Exchequer budgets.

David Richardson informed the Committee that all Investec's NHS customers were going through the same issues, but asked if BHR Hospitals' Charity had a policy in place that, if a donation exceeded £100 it was to go to the account designated by the donor, but anything under £100 should go into the General Purpose account. CS mentioned that the current wording on the receipt book could be a restriction.

CS explained that, depending on the length of time the Rapid Arc appeal might cover, it was hard to work out the actual costing as the final value could change. The Lavender Garden should be the Charity's first big appeal. DIW suggested a timetable is needed, but CS re-iterated that the length of time would depend on staff involvement. Interest from external sources is increasing but, internally, not much has happened. KM hoped that, once the work starts at the weekend, it will generate interest and staff will begin to see that things are getting done and build a momentum.

CS commented that we already have sponsorship for £130k for Rapid Arc and the

timescale for this appeal is currently set for the end of next year.

CS is currently in talks with KGH about their requirements i.e. Breast care. WL suggested that the Executive team should, once a year, go through the process of asking if there were any big item requirements.

WL enquired whether there was any other charity that relates to NHS activity and DIW expected that there would be one for Havering PCT, so WL asked how these can be brought together. DIW stated that, when services move, it would be more likely to be able to bring in integrated charities.

KM informed the Committee that Averil is happy to get behind the Charity, especially relating to Capital expenditure.

DIW informed the Committee and David Richardson that Linda Kruse has been asked to test the market and a PQQ would be circulated. WL offered assistance in the decision making process.

ACTION WL

CS informed the Committee that Clover Ward were deciding on the murals before ordering the recliner chairs as the colour of the murals would determine the colour of the chairs. The out-patients department funded equipment has been ordered.

CS explained that The Corporate Global Challenge has created a great deal of interest and this increase requires further funding. **Further funding of £550 was approved**.

WL informed the Committee that he would have more information regarding the Charity branding in the next week.

ACTION WL

4 Statement of Financial Activities and Balance Sheet for the period: 1st April 2011 – 31st May 2011

DIW informed the Committee that the consolidation of charitable accounts into NHS Trust accounts as now been deferred for a further two years.

The SoFA and Balance Sheet were presented to the Committee with an accompanying analysis sheet showing major sources of income and expenditure, together with details the movements on the Balance Sheet as follows:

£ 44k worth of donations
£ -10k for legacies – being over-accrued for 2010/2011

£ 29k expenditure during the period
£ 4k costs of generating income
£ 6k management and administration

Showing a net reduction in the Balance Sheet of £5k

The Committee was asked to note this report

5. Income and Expenditure Report from 1st April to 31st May 2011

The Committee was asked to note this report

6. Requests for Expenditure

Application for Air Pall Lifting Aid

DIW lead the discussion giving his support for this innovative piece of equipment substantially mitigating risks to both patients and staff administering the patients. DIW stated that, after three years, the maintenance and consumables would be placed into the Trust's budget. **The purchase was approved**.

ACTION CS

Application for Information Desk Two (Mezzanine) Phone

It was reported that this would speed up communication and reduce volunteers' and patient's time by having the means to communicate between both information desks. WL remarked that the quoted price of the phone was highly expensive and asked why dect phones could no be used. WL also suggested that the desk be moved so that spare ports could be used.__ **This request was seen as a good idea, but to be bought at the most economical price and to arrange for signage.**

ACTION CS

Application for Obstetric pelvic floor clinic anal manometer

DIW explained that staff currently send patients to Barts and the London (who they invoice) for tests. This equipment could potentially avoid both delays and expenditure and should ultimately be self-funding. The estimated costs per patient are about £60. WL asked how to avoid the dichotomy of the process increasing income and reducing outgoings. DIW suggested that it needs to have a short business case and a decision needs to be made on how to market this e.g. is there an opportunity to involve other Trusts, can a pharmaceutical company pay, how will we be assured of continued training? **To await the outcome of the business case**

ACTION CS

Application for maintenance of a second bladder scanner

CS explained to the committee that £8k has already been received from the pharmaceutical company, but they were not prepared to cover the costs of the maintenance. The Committee asked why a second one was necessary and, if not, would the pharmaceutical company be prepared to support another piece of equipment. **Can we be assured that this equipment is bought as a result of the need rather than 'nice to have'? This request was not approved at this time.**

ACTION CS

Application for Appraiser Training Course No. 5

These courses provide a kick-start for the whole revalidation process. KM asked that consultants should be made aware that this funding was paid for out of charitable funds and that, if they failed to attend without a reasonable excuse, they should repay the Charity. **The request was approved.**

ACTION LG

Application to fund MIAD Consultant Leadership & Development Courses 9 to 11

These requests have been approved in the past but, with the revision of how charitable funds are spent; the requests are now being sent as part of the agenda. WL proposed that the Committee should now receive a report on how the consultants are benefitting, the effectiveness of the training and proven results. **The request was not approved at this time, until more feedback is received.**

ACTION CS

Application for a donation to support the Arthritis Self-Help Network

KM informed the Committee that Barbara Liggins had been approached by Diane Wynne-Fitzgerald of the A.S. Network to see if the BHR Charity would make a contribution towards their work which would enable them to kick-start their self-help classes. **The request was approved in principle for a one-off donation of £500 pending further information**

ACTION KM

KM circulated a paper from Matthew Watson of Bedrock Radio

7. Capital Programme

It was agreed that this would be discussed at a later date.

8. Legacies

The Committee were asked to note the report on legacy updates. It was agreed that a further updated application should be made regarding the legacy for Renal Services and this would be sent to the solicitors for approval.

9. Fundraising Update

(i) Overview of Expenditure for the year 2010.2011

The Committee were asked to note the report which showed a comparison of expenditure for financial years 2009-2010 and 2010-2011. The Committee were pleased to see that there was an increase in the expenditure for patient welfare and

research, again benefitting patients as the research related to Rheumatology patients and patient experience questionnaires.

*** At this point both KM and DIW had further appointments and it was agreed that the following agenda items would be heard at the next committee meeting:

9 (ii) Will Organiser

10. Lavender Garden Update.

Dates of Future Meetings for 2011

All meetings will take place at 9am – 10.30am

Tuesday 23rd August at – Meeting Room 2, Queen's Hospital

Tuesday 18th October at – Catalyst Meeting Room, Queen's Hospital* **please note**

Tuesday 6th December at – Meeting Room 3, Queen's Hospital

Barking, Havering and Redbridge NHS
University Hospitals
NHS Trust

TRUST BOARD MEETING
Wednesday, 11 January 2012 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 2 November 2011 (Attachment A)

3. Matters Arising and Actions

4. Committee References

5. ***GOVERNANCE:***
   - 5.1 Board Assurance Framework (SB) (Attachment)
   - 5.2 Care Quality Commission Action Plan Update (DCW) (Attachment)
   - 5.3 Safeguarding Children Annual Report (DCW) (Attachment)

6. ***STRATEGY:***
   - 6.1 Options on Upney Lane Land Sale (RR) (Attachment)

7. ***QUALITY AND PATIENT STANDARDS***
   - 7.1 Quality & Patient Standards Performance Report – November 2011 (NM/DCW/RMcA) (Attachment)
   - 7.2 Emergency Care Update (MO-M) (Attachment)
   - 7.3 Maternity Services Update (DCW) (Attachment)
   - 7.4 Quality & Safety Committee Escalation Report (PS) (Attachment)

8. ***FINANCE, WORKFORCE AND ACTIVITY***
   - 8.1 Finance Report – Month 8 (November) 2011/12 (DIW) (Attachment)
   - 8.2 Workforce Key Performance Indicators - November (RMcA) (Attachment)
   - 8.3 Workforce Committee Escalation Report (RMcA) (Attachment)
   - 8.4 Finance & Programme Management Committee Escalation Report (DIW) (Attachment)

9. ***INFRASTRUCTURE***
   - 9.1 Trust Travel Plan (RR) (Attachment)

10. ***INFORMATION***
    Matters for Noting:
    - 10.1 Interim Chair and Chief Executive's Report (Attachment)
    - 10.2 Minutes of the Quality & Safety Committee meeting held on the 2011 (Attachment)
    - 10.3 Minutes of the Strategic Partnership Board meeting held on the 2011 (Attachment)
    - 10.4 Minutes of the Charitable Funds Committee meeting held on the 2011 (Attachment)
    - 10.5 Draft Agenda for March 2012 Trust Board Meeting (Attachment)

11. Any Other Business

DRAFT

Date of Next Meeting: The next public meeting will be held on Wednesday, 7 March 2012 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.

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