SOUTH LONDON HEALTHCARE NHS TRUST
TRUST BOARD MEETING IN PUBLIC
WEDNESDAY 23 NOVEMBER 2011

QUESTIONS FROM THE FLOOR

The Chairman welcomed members of staff and the public to the Board meeting; a meeting held in public, not a public meeting.

Members of the public were invited to comment and/or to submit questions on any subject pertaining to items for discussion and/or decision relevant to the Trust Board Agenda. Officers would endeavour to capture questions submitted verbally within the records of the meeting. A record of questions and answers provided at the meeting and subsequently in writing would be made available on the Trust website within 20 working days (*21 December 2011)*. Questions previously submitted in writing or by e-mail would receive a written response (also within 20 working days).

It was highlighted that members of the public would usually be restricted to one question each to enable as many attendees as possible to raise questions relating to items on the agenda; other questions would also be welcomed, provided that time permitted. The time available for comments or questions should not prejudice the proper and timely conduct of the Trust Board meeting in public.

The Chairman invited questions to the Board.

i Susan Sulis, Secretary, Community Care Protection Group

Q1. **Planned Closure of Orpington Hospital - Orpington Health Service Late Report to 21.11.11 SLHT Board** *(Agenda item 20 – Any Other Business)*

(a) Why was this important and contentious report:
(i) Not listed on the public agenda?
(ii) Not sent out with the agenda?
(iii) Not circulated as a 'late' paper?
(iv) To be tabled at the meeting under AOB?

(b) Why can't the Orpington Hospital site 'provide optimum care for Intermediate Care' (rehabilitation) Services'?

(c) What does 'IC requiring a community setting' mean?

(d) What are the 'service requirements to meet patients' needs' that have been established'?

(e) When did the SLHT Board approve the decision that 'the Trust will be withdrawing its' services in their current form' from the Orpington Hospital?

A. (a) We apologise that the update on progress with the Orpington Health Service Project was not included within the main agenda; it had always been our intention to do so, and its omission was an error on our part. As soon as its omission was realised, it was published and posted on to our website; this was one day after the substantive agenda was issued.

The project to make recommendations on the future of Orpington health services is being led by Bromley GP Commissioners. A public meeting held in October was attended by 120 people and a further public meeting will take place on 8 December 2011 at Crofton Halls. The details are advertised on posters and on our website at: http://www.slh.nhs.uk/?section=news&article=121.

(b),(c) The provision of intermediate care falls within the remit of local healthcare commissioners and the local authority and is part of the discussions within the Project Group. Since this particular service is not provided by South London Healthcare Trust, it would be inappropriate for us to answer this.

(d) A thorough assessment of needs, led by local GP commissioners and Orpington stakeholders groups is currently underway. The Orpington stakeholder group is led by local GP commissioners and includes representatives from this Trust in addition to the Local Authority, Bromley LINk, Staff Side, Orpington League of Friends. Recommendations have yet to be made by the Project Group, although some of the principles of the service review have established that most of the Trust's specialist outpatient services do not need to be Orpington specific and can be provided at our larger hospital sites.

(e) The Trust has regularly stated its commitment to ensuring that its estate is used to the best effect for patient services and as a stakeholder, we are committed to sharing an account of current developments with the consultation. Since the decision on A Picture of Health by the Joint Committee of Primary Care Trusts in 2008, the Board has been regularly updated of the need to resolve issues around current under-utilisation of the site. Following detailed discussions with Bromley PCT, as the local commissioners, and the Board, the Trust gave formal notice to the Director of Commissioning at NHS South East London Sector that it would be withdrawing its services from Orpington Hospital with effect from 1 April 2012.

i Peter Moore, Acting Chair, Bromley LINk

Q2 **Orpington Health Services Project Presentation** *(Agenda item 20 – Any Other Business)*

Page two, *Implications regarding an Equality Impact Analysis, the legal and financial implications* – the statement gives No as an answer to these points. LINk suggests these should read 'YES'.

Re *Strategic Context – Orpington Hospital,* second paragraph states 'the site can no longer offer optimum care for some services'. LINk would like to remind members that as the site is currently under-utilised, there is indeed space for these services; if there are new standards for Colposcopy, why have they not already been introduced and that Intermediate Care is going out for public consultation.

Re *the shortfall of income (fourth paragraph).* LINk undertands the shortfall between expenditure for Orpington of £4.6m p.a. And the income from Intermediate care given to the Shadow Health and Wellbeing Board in

September of £1.8 million is £2.8 million. Can the Board explain why there is this shortfall when the footfall for the hospital is 163,000 patients which includes 24,000 for Dermatology and 62,000 for Phlebotomy (for which SLHT receives payment).

Re *Strategic Context – Bromley Commissioners* (*first paragraph);* to improve ease of access, address inequalities. LINk believes there should be an Equality Impact Analysis, particularly with the suggested loss of the hydrotherapy pool.

On *Progress to Date* – LINk would like to know which clinicians were involved in the service review.

***Raising Awareness and Listening*; can LINk be advised regarding the number of clinicans involved in the service review and should like to point out that one-staff-side representative has attended the <u>first meeting only.</u>**

***Main themes of feedback include* – there were over forty questions raised at the public meeting in September and only thirty two have been indicated on this page.**

***Orpington Project Team;* four public participants; two from LINk, one from Community Links Bromley and one from the Orpington Hospital Patient User Group.**

A. Taking each of your points in turn:

It is likely that there would be an equality impact analysis, however, as the commissioners are leading on the project, this is a decision for them.

In a strategic context, as indicated in the response to the question earlier, the site is currently under-utilised and we are keen to resolve the uncertainty. Commissioners will take a strategic view of the needs of the local health economy. As it is currently configured, Orpington Hospital does not fit into the clinical model and conditions which were previously agreed under the former A Picture of Health Agenda. Furthermore, as indicated in the response to the earlier question, a significant proportion of the Orpington Hospital site is currently under-utilised, and it is in the public interest to agree the future use of the space.

We are developing a 'hub and spoke' model for colposcopy services, with centralised treatment at one of our main sites and a diagnostic service in within Bromley and Greenwich. Whilst we shall seek to give you a more precise answer shortly, we are naturally concerned to ensure that public money is used to the best effect.

Intermediate care is being led by commissioners. Members of Bromley LINk are part of the Project Group and will therefore be aware of options which are currently being explored.

The figures most recently produced exclude PFI costs which had been included in an earlier presentation of the figures. The income/revenue position is currently undergoing evaluation.

The provision of a hydrotherapy unit will depend upon the assessment of future health needs, which are being assessed by local GPs.

Stephanie Munn, Dermatology Consultant has been leading the review, which incorporates clinical directors and service managers from each area of specialism. She knows the Hospital and the area which it serves well, as the Dermatology service is based at Orpington Hospital.

Staff meetings and team briefings have been continuing to take place and there is a series of further engagement events planned for the next couple of weeks.

Staffside has been kept updated on the process and have been invited to all meetings. They have been involved in other meetings representing Orpington Hospital staff.

Commissioners have advised that they are in the process of responding to feedback.

i. Mr. Mott

Q3. In May of last year the Trust had a backlog of 1701 patients who had breached the 18 week RtT target. The Trust implemented a plan which they said would result in a figure of under 400 patients by October.

At the end of September the backlog stands at 1459. If my math's are correct this equates to 242 fewer patients over a period of four months which means you have reduced the backlog by approximately 15 patients per week which equates to 1 patient extra per day at each of the three hospitals.

The Trust now have yet another plan to reduce the backlog to 300 by the end of February 2012. *(Agenda item 8)*

A. Your figures are mathematically correct, although using that particular method to calculate the additional activity which has been undertaken and its effect would distort the meaning, as they do not take into account additions to the waiting list or the prevention of people being added to the backlog who have been waiting just under 18 weeks for treatment.

In other words, whilst your figures are correct in terms of the backlog, they infer that we have only treated people who are on the waiting list, whereas we have also treated an additional number of people who have been waiting for almost up to 18 weeks to avoid allowing a further backlog to increase.

ii Mr. Mott

Q4. The Trust also had several plans to reduce Pressure Ulcers and still the number has increased. We are now told of yet another plan being put into operation to bring the numbers down. *(Agenda item 6)*

This Board approves many plans which fail to achieve promised results.

What does this Board intend to do if, once again, these new plans are not successful? Will action be taken against Senior staff members who constantly fail to deliver? Or is it for the Chief Executive to take full responsibility for the failure of every plan that has so far been instigated?

A. There was an increase in the incidence of Grade II pressure ulcers last month.

We understand your frustration at the incidence of pressure sores. The entire nursing and medical team is engaged in the reduction of pressure sores. However, it needs to be understood that some cases where patients suffer from pressure sores are as a result of genuine complications and/or a combination of complex medical needs.

Our initial approach to the reduction of pressure ulcers was to tackle those that cause the most harm and pain to patients. Early this year, numerous actions were put in place. This approach has been successful. In December 2010, there were 8 incidences of Grade IV pressure sores, whereas during the corresponding period this year, there have been no reports of Grade IV pressure sores. Similarly, during this period last year, 23 Grade III pressure ulcers were reported: this year over the same period, there have been 8 incidents reported. Whilst it is recognised that there is more work to be done, we have achieved a significant reduction in the incidence of those pressure ulcers which give the most discomfort.

We now want to target the incidence of Grade II pressure sores and we shall be comparing the strategies which are used by other Trusts to see whether our methods can be improved upon. All senior nurses are engaged in seeking to improve in this area. We have invited colleagues who via the Patient Safety Campaign have managed to focus and reduce overall numbers with significant success.

The Medical Director advised that he had visited those areas of the Trust which were currently experiencing the highest level of incidents and that he was confident that there were effective policies in place both to identify patients at risk and to manage and treat cases which do occur. He confirmed that patients were reviewed daily, and that the significant reduction of Grade IV and III sores indicated that the situation was continuing to improve and that corrective action was taking effect.

i. Mr. Williams

Q5. My question to the Board relates to the decontamination of endoscopic medical equipment referred to in the Governance Committee Minutes printed in the Board papers. *(Agenda item 15)*

May I inform the Board that this problem first arose in the dying days of Bromley Hospital Trust. I was informed by Board members then that the problem was sorted and from then on the endoscopic equipment would be cleaned properly.

I wish the Board to understand that as a patient my medical problems require the use of this sort of equipment and I am very alarmed that in such a short space of time the same problem, endoscopic equipment not being cleaned properly has reared its ugly head once again.

My question to the Board is this.

Will all members of the Board give an assurance to the public and the patients that from now on, no ifs, no buts; a procedure will be put in place for the long term that the endoscopic medical equipment will be decontaminated properly, be fit for purpose and that all patients can feel safe when such medical equipment is used on them?

A. The problems at the former Bromley Hospital Trust were resolved at the time.

This Trust wants to ensure that it is delivering the highest patient standards and it is therefore keen to identify any areas of practice which may be improved upon.

Current practice has been audited and the conclusion was that while there were no concerns of patient safety, a variety of decontamination measures had developed at each of the hospital sites prior to the creation of this Trust. We are therefore developing a consistent approach across the Trust for the decontamination of equipment.

The Trust is implementing a decontamination action plan to further reinforce the existing accountability and assurance framework, the key features of which are the ongoing compilation and maintenance of a log of endoscopy equipment, further centralisation of the decontamination process for endoscopes and work to achieve external accreditation for our endoscope decontamination process by a Notified Body as a recognition of best practice in this area. The Trust has taken an interest in endoscope decontamination strategies which are being deployed elsewhere and is in the process of receiving visits from, and visiting, other NHS Trusts to discuss and share best practice. The Governance Committee will continue to receive regular updates on progress with the implementation of the decontamination action plan.

ii. Mr. Williams

Q6. The NHS Constitution states, the NHS commits to provide you with information you need to influence and scrutinise the planning and delivery of NHS services (pledge).

Being allowed just one question at Board meetings that are held every two months hardly backs the Constitution up.

Would the Board at least consider allowing members of the public more time at question time than the 25 minutes now allowed, so that we can at least feel that the NHS Constitution is not just a gimmick? ? *(Refers to agreed protocol for public question time)*

A. The agreed protocol indicates that the number of questions which may be raised during public question time may be restricted, depending upon the number of members of the public who have submitted questions and the time available.

Where time permits, the Board is, as ever happy to allow more than one question from a member of the public, and it often does.

You will see from the Board's Rolling Forward Agenda *(Agenda Item 19)*, that it is proposed to schedule 8 ordinary meetings of the Board each year. This increase in meetings will afford the public additional opportunities to raise questions related to items on the board agenda.

i. Orpington resident

Q7. As I am local to Orpington, I am interested in the presentation on the future of Orpington Hospital. *(Agenda item 20)*

I am aware of the reports nationally which state that there is a huge strain on hospital finances and that our local group of hospitals is facing a deficit.

I would like to help if I can and I have come to offer a software solution which could save the Trust money.

A. Mr. Russell, Chief Operating Officer, will discuss your ideas with you at the close of the meeting.

i Mr. Angell

Q8. Few people are turning up to the Board's meetings in public because the publicity is poor. A couple of weeks ago, notice of a Board meeting was advertised with the wrong day and the wrong date. *(Agenda notice).*

Will the Board not consider advertising meetings in the local press, as I have previously suggested?

A. Thank you for drawing this to our attention.

We need to ensure that our meetings are correctly publicised and we are looking into widening our press publicity for meetings.

ii Mr. Angell

Q9. Why have we not been given a reason for the resignation of the previous Trust Board Chairman?

Is it due to the staffing situation at the coal face? Recently, a patient at your hospital has been told by the specialist that delays in arranging a change to prescribed medication is due to only one typist being available to type the form. Is that so?

The Chairman advised that questions raised prior to the Trust Board meeting in public should relate to the items included on the agenda for discussion.

A. There was no mystery surrounding the resignation of George Jenkins as Board Chairman. The Trust's journey towards Foundation Trust status would extend beyond his tenure and he wanted to hand over at a suitable point. A statement was issued at the time, and is available on our website at: http://www.slh.nhs.uk?section=news&article=108

i Ms. Smith, member of Keep NHS Public

Q10. Can we have an update on what is happening with the arrangements for the Urgent Care Centre here at Woolwich? The provision by Grabadoc was held in high regard.

A. Responsibility for the provision of the Urgent Care Centre at Woolwich and the decision to invite and assess tenders rests with the Commissioners as opposed to the NHS Trust.

Historically, the Urgent Care Centre at Woolwich has seen fewer patients than are seen at Queen Mary's Hospital or Princess Royal University Hospital, whilst a higher number of patients have presented at the Accident and Emergency at Queen Elizabeth Hospital.

We are aware that the Commissioners assessed a number of bids for the service which were of a high standard and we are confident that Greenwich residents will benefit from the opportunity to access the same level of service as is available to residents in Bromley and Bexley.

SOUTH LONDON HEALTHCARE NHS TRUST

There will be a meeting of the Trust Board on
WEDNESDAY 25th JANUARY 2012
09.30am in the
Lecture Hall, Postgraduate Centre, Princess Royal University Hospital

John Ballard
Acting Chairman

AGENDA

SESSION TO BE HELD IN PUBLIC

0930	**1**	**QUESTIONS FROM THE FLOOR** There will be an opportunity for members of the public to ask questions.	
0955		**BREAK**	
1000	**2**	**CHAIRMAN'S OPENING REMARKS**	
1005	**3**	**APOLOGIES FOR ABSENCE**	
1010	**4**	**DECLARATION OF INTERESTS** Members to declare any interests in relation to the agenda items below	
1015	**5**	**MINUTES OF TRUST BOARD 23rd NOVEMBER 2011** To agree the minutes of the previous meeting and follow up on action points as matters arising from the minutes	**ENC A**

PATIENT SAFETY & EXPERIENCE

1020	**6**	**PATIENT SAFETY AND EXPERIENCE** – To provide a review of progress with the Trust Patient Safety Action Plan and a renewed Patient Safety Action Plan for 2012/13.	**JH** **ENC B**

PERFORMANCE

1040	**7**	**PERFORMANCE REPORT** – Including a review of access and targets	**SR** **ENC C**
1045	**8**	**FINANCE REPORT** – Financial Governance Improvement Plan – 2012/13 Business Planning update	**RC** **ENC D**
1100	**9**	**iCARE IMPLEMENTATION** – To report progress with the iCare implementation programme – To report the outcome of the NHSL stock take	**LK** **ENC E**

STRATEGIC ISSUES AND ITEMS FOR DECISION

1110 **10 CHIEF EXECUTIVES REPORT** **CS**
ENC F

- To advise of progress with Orpington Health Services
- To report on the Trust Estates Strategy – Queen Elizabeth Hospital, Woolwich, Queen Mary's Hospital, Sidcup
- For the Board to consider the Trust's Medium Term Financial Model

1130 **11 BOARD ASSURANCE FRAMEWORK** **JH**
ENC G

- To provide an update to the Trust Board of the key risks to the Trust strategic objectives

1145 **12 CLINICAL SERVICES STRATEGY** **RS**
ENC H

- To receive a presentation of the Trust Cancer Services Strategy
- To receive a briefing note and Radiotherapy

REPORTS FROM TRUST BOARD COMMITTEES

1215 **13 TRUST GOVERNANCE COMMITTEE** **GH**
To receive the minutes from meeting held on 26th September 2011. **ENC I**

1220 **14 TRUST AUDIT COMMITTEE** **JB**
To receive the minutes from meetings held on 11th November, 30th November and 8th December 2011 and a verbal report from the meeting held 12th January 2012. **ENC J**

1225 **15 TRUST FINANCE COMMITTEE** **GJ**
To receive the minutes from meetings held on 25th October 2011 and 22nd November 2011. To receive a verbal report from the meeting held on 24th January 2012. **ENC K**

1230 **16 TRUST HUMAN RESOURCES SUB COMMITTEE** **JT**
To receive the minutes from meeting held on 7th November 2011. **ENC L**

ITEMS FOR INFORMATION AND ANY OTHER BUSINESS

1235 **17 ROLLING FORWARD AGENDA** **JB**
ENC M

- To advise the Board of the rolling forward agenda for 2011 / 2012
- For Trust officers to **ADVISE** the Secretariat of items for inclusion within the rolling forward programme at the earliest possible opportunity

1240 **18 ANY OTHER BUSINESS**

1245 **19 DATE OF NEXT BOARD MEETING**
The next meeting of the Trust Board will take place on Wednesday 28th March, Rooms 2 and 3, Conference Centre, Queen Elizabeth Hospital, Woolwich,

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

A

Minutes of the public session of the South London Healthcare NHS Trust Board meeting held on
WEDNESDAY 23 NOVEMBER 2011
Held in the Conference Centre, Queen Elizabeth Hospital, Woolwich
at 10.00 a.m.

MINUTES

PRESENT	Mr. J. Ballard	Acting Chairman, SLHT
	Dr. C. Streather	Chief Executive
	Ms. G. Hart	Non Executive Director
	Ms. L. Roberts	Non Executive Director
	Ms. A. Bhatia	Acting Director of Nursing & Patient Experience
	Mr. R. Cooper	Director of Finance
	Ms. J. Hall	Deputy Chief Executive and Chief Nurse
	Mr. S. Russell	Chief Operating Officer
	Mr. R. Smith	Medical Director
	Ms S. Chandra	Greenwich Local Involvement Network (LINk)
IN ATTENDANCE	Dr. C. Botfield	Clinical Leader for Organ and Tissue Donation *(for item 102/11)*
	Ms. T. Cooper	Director of Infection Prevention and Control (*for item 104/11)*
	Mr. R. Lane	Chair, Organ and Tissue Donation Committee
	Mr. E. Langford	Consultant Cardiologist
	Ms. L. Knight	Director of Information Technology and Performance *(Items 105/11 and 106/11)*
	Mr. C. Shoben	Director of Communications
	Mr. M. Weaver	Trust Board Secretary

PRESENT IN AUDIENCE

There were approximately 15 members of staff and public present.

ACTION

098/11 APOLOGIES FOR ABSENCE

Ms J. Townsend, Non Executive Director.
Mr. J. Virdee, Non-Executive Director.

099/11 DECLARATIONS OF INTEREST

No interests were declared.

100/11 MINUTES

Minutes of the meeting held on 28 September 2011 were **AGREED** as a correct record.

101/11 MATTERS ARISING

The Committee noted the matters below which did not feature elsewhere on the agenda.

101/11 MATTERS ARISING **ACTION**

Involvement of Carers

The Acting Director of Nursing and Patient Experience confirmed that a policy for the involvement of carers in the care of patients with a learning disability was being developed.

Performance Review and Appraisal Process

The Chief Executive undertook to confirm whether the performance review and appraisal process had been incorporated within the Workforce and Organisational Development Strategy. **CE**

Counter Fraud Investigation

The Acting Chairman advised that, whilst Chair of the Trust's Audit Committee, he had been asked by the then Chairman, George Jenkins to consider with the Chief Executive whether any disciplinary action would be necessary in the light of the findings of an investigation. He had subsequently recommended that an appropriate response would be an oral warning and this action had been implemented. The Board was advised that the Audit Committee was now chaired by Gill Hart, as the NHS Audit and Governance Manual provided that the Chairman and Chief Executive of Trust Boards attend Audit Committees by invitation only.

102/11 ORGAN AND TISSUE DONATION COMMITTEE

The Committee received a presentation from Dr. Claire Botfield, Clinical Leader for Organ and Tissue Donation along with the first Annual Report of the Organ and Tissue Donation Committee for the period 1 April 2010-31 March 2011and Action Plan for subsequent activity. The following aspects, in particular were highlighted:

- The Trust had three Specialist Nurses in Organ Donation, whose priority was to develop, build and consolidate trusting relationships between the critical care staff with a view to fostering a team approach to organ and tissue donation.
- The Committee, which was established in January 2010 also had representation from the Intensive Care Unit, Accident and Emergency Department, the Chapliancy and Communications and Outreach staff. Mr. Richard Lane was the Lay Chair of the Committee.
- The United Kingdom currently had less than 50% organ donations when compared to its European neighbours, with Spain and Portugal having the greatest incidence of organ donation.
- Market research had reported that 94% of UK residents would accept a donated organ, whereas the UK currently only had 18m registered donors.
- There was a particular shortage of registered donors from black and ethnic minority communities, which reduced the opportunity for life-saving donations, particularly with regard to the population served by Queen Elizabeth Hospital.
- In October 2011, there were 7,706 patients awaiting a transplant, compared with 2,699 deceased donors in 2010/11; 3 patients died

102/11 ORGAN AND TISSUE DONATION COMMITTEE **ACTION**

each day awaiting an available transplant.

- The South London NHS Trust referral and consent rate for organ and tissue donation was higher than the national average, which was in part due to the preparedness of its staff to ensure that approaches to patients and relatives are conducted in a timely and sensitive way.

- The Organ Donation Task Force, which was established in 2006 had made a number of recommendations to enhance the availability of available organs for donation; the target was to increase donations over the next 5 years.
- Key barriers to donation had been identified as: inappropriate/insensitively timed approaches; logistical problems for the Emergency Department; the legal and ethical framework surrounding donations after circulatory death; optimisation of donor opportunities; obtaining permission of the Coroner.

The Board was advised of the following areas where it could add value to the Trust's efforts to increase organ and tissue donation:

- Endorsing and continuing to support for the Organ and Tissue Donation Committee;
- Inclusion of organ and tissue donation within the Trust's strategy;
- Ratification of the Trust's Policy on Organ and Tissue Donation;
- Introducing mandatory training in donation issues for all medical and nursing staff.

It was suggested that the donor awareness campaign should be available in different languages, focussing on the point of view of the patients and the donors to raise the profile of the ethnic community perspective. It was also suggested that focus groups should be invited to explore incentives to organ and tissue donation. At a local level, it was suggested that the potential to capture patient stories, which could be adapted into educational material should be explored, and the Director of Communications was **REQUESTED** to discuss this option with Dr. Botfield, with a view to its further development. **CE**

The Board was advised that the specialist team had attended local roadshows. The national TV advertising campaign had been frozen due to financial constraints.

The Board expressed its thanks to Dr. Botfield and the Organ and Tissue Donation team for a clear and convincing presentation and indicated that it would be delighted to support the recommendations for future activity.

The Deputy Chief Executive and Chief Nurse undertook to forward some comments on the draft Organ and Tissue Donation Policy to the Committee. **DCE/CN**

The Deputy Chief Executive and Chief Nurse and the Chief Operating Officer were **REQUESTED** to discuss appropriate support to achieve the Committee's recommendations.

103/11 PATIENT SAFETY AND EXPERIENCE **ACTION**

Ms. Bhatia, Acting Director of Nursing and Patient Experience, introduced the Patient Safety and Experience Report. The Following aspects, in particular were highlighted:

- The Hospital Standardised Mortality Ratio (HSMR) in August was 86.6, representing good performance. The Trust was continuing to perform strongly and reliably and it was anticipated that the Trust would be identified within the Dr. Foster Hospital Guide as performing particularly well in this area.
- MRSA remained within trajectory for the year.
- Whilst the incidence of C.Difficile had improved during August and September, with the controls in place at Queen Elizabeth, the Princess Royal University Hospital had seen a rise in cases and the Trust was currently over the national trajectory for this infection currently.
- Safeguarding adults referrals had increased, indicating an increased awareness amongst Trust staff. The Trust was currently focussing upon a higher level of training for senior staff in this area to build upon the increasing knowledge and awareness of this agenda.
- There had been an overall reduction in the number of complaints received from the first Quarter to the second Quarter of the year
- The Emergency Care and Specialist Services Division and Planned Care Division had made significant progress in responding to complaints.
- There had been no instances of Grade IV pressure ulcers (which cause the most harm and discomfort) this year, and the Trust had seen a 50% reduction in the occurrence of grade 3 ulcers. The Trust was now focussing upon reducing the instance of Grade II pressure ulcers.
- Figures for the second Quarter relating to falls demonstrated a 17.3% reduction compared to the figures for the first Quarter. Between July and September, the Princess Royal Hospital site had seen a 34% reduction in falls.
- There had been significant progress in delivering same sex accommodation, with the only area continuing to have breaches being the daycare unit at Queen Elizabeth.
- Progress was being made with addressing patients' concerns around discharge; the Discharge Action Group had been focussing upon patient information.
- It was reported to the last meeting that Queen Mary's Hospital had received an 'acceptable' rating for standards of cleanliness within the results of the national Patient Environment Action Team survey; this had since been amended 'good'.
- Bromley LINks has recently produced a comprehensive report into the current discharge arrangements, which are being examined by the Discharge Action Group with a view to improving performance in this area.

The Board was reminded that the Trust's mortality data was significantly better than the national average, and that following investigation of whether the Trust was discharging patients early with a view to achieving this figure, it had been shown not to be the case. The mortality figures for Queen Elizabeth Hospital had, in particular, improved since the formation of South

103/11 PATIENT SAFETY AND EXPERIENCE **ACTION**

London Healthcare Trust. The Trust was now one of the safest acute Trusts in the country.

It was remarked that Level 1 & 3 Training for staff in respect of Children's Safeguarding had continued to be rated red throughout the current financial year. The Board was advised that the rating was subject to validation of data and that the timetable to ensure that relevant staff had received adequate training would be completed within the next 3 weeks.

The Board sought to explore the reason for ongoing gaps in the risk assessment for patients at risk of veinous thrombo embolisms (vte). It was advised that the pace of conducting risk assessments for vte had not been improving as rapidly as the Trust would like, and that vte was now included on the whiteboards on the wards, with nurses working with medical staff to ensure that appropriate risk assessments were conducted. It was anticipated that the rate of risk assessment would improve further when ICare became fully operational, since patients would not be permitted to be admitted prior to confirmation that an appropriate risk assessment had been conducted.

The Board **NOTED** the actions being taken to improve performance in key areas of patient safety and experience.

104/11 INFECTION PREVENTION UPDATE REPORT

Ms. Cooper, Director of Infection Prevention and Control presented an update on current performance in respect of performance in infection prevention and control measures at the Trust. The following aspects, in particular were highlighted:

- There had been a deterioration in performance related to C.Diff during 2011/12. Whilst this was now improving, it was proving challenging to identify the reason. There had been no evidence of any common link.
- Measures to control the level of incidence included: ensuring appropriate handwashing; isolation of particular incidences; and checking for environmental cleanliness.
- Work was in place to prepare for and manage seasonal cases of influenza and norovirus; the Trust had a high rate of take-up for the 'flu vaccinations and two recent cases of norovirus at Princess Royal had been managed well;
- Mapping of evidence against compliance with the Hygiene Code continued; 6 criteria were 'green rated', and 4 were currently rated 'amber', although two of these were anticipated to turn 'green' prior to the year end. Work was continuing to improve the evidence available for all 'amber'-related criteria.

The Board commended staff on their continuing efforts to maintain the standards of infection prevention at the Trust and **NOTED** the Infection Prevention update report.

105/11 PROGRESS WITH I-CARE IMPLEMENTATION **ACTION**

Ms. Knight, I-Care Programme Director, presented an update on progress with key areas of the preparatory arrangements for the introduction of the ICare Programme, which had now entered its eighth month. The following aspects, in particular, were highlighted:

- The new IT system had been constructed and staff had been validating the build to ensure that it would be fit for purpose when it went live.
- A number of changes had been identified.
- A Data Migration Steering Group had been established to handle the data queries associated with migration of the data.
- The potential identified risks remain unchanged and are ensuring staff engagement, handling the data migration process and interfacing/integration.
- The potential impact of the 2012 Olympics was being considered in the programme planning.
- The Programme would now be promoted more widely within the Trust through a series of demonstrations and roadshows.
- The project team would continue to review the detailed programme plan with Cerner BT and Divisions to firm up the go-live dates;
- The project team were attending a system validation event at the end of November.

Responding to a question relating to how the efficiency gains could be captured and disseminated to staff, the example of vte risk assessment discussed in Minute 103/11 above was used to illustrate how the system would ensure that vte assessements took place on admission. It was recognised that the interface with staff in Accident and Emergency and staff in clinical areas would be important.

The importance of contingency planning to miminise any detrimental impacts to patient safety at cut over was emphasised, and the iCare Director undertook to report further on the contingency planning arrangements which would be in place. The Board also asked to receive further detail on how it was planned to mitigate the data migration risk which currently has a 'red' rating. It was acknowledged that all Trusts which had introduced a new IT system had experienced some level of disruption to business as usual activities and that elective capacity would need to be adjusted to take account of this. **DCE/CN**

The Board **NOTED** current progress with the ICare implementation programme and the next steps.

106/11 CERNER BUSINESS CASE BRIEFING PAPER

Ms. Knight, I-Care Programme Director introduced a report, the purpose of which was to update the Board on the Cerner Business Case approval process with NHS London and the concerns raised. The Board was advised that the Full Business Case has been subject to detailed scrutiny by NHS London (NHSL), and that issues which had been raised by NHSL were now incorporated in the final version by the Board.

NHSL had indicated, in a draft letter, that it would require enhanced performance review arrangements to be put in place to provide assurance

106/11 CERNER BUSINESS CASE BRIEFING PAPER **ACTION**

that the Trust had sufficient management resource to ensure succesful implementation of the system, whilst addressing financial turnaround and the need to improve A&E and 18 week Referral to Treatment performance. NHSL has also indicated that it would like an assurance on the mitigating actions and resources which will be in place to address the potential risks to management information reporting at go live date and beyond. To this end, NHSL has commissioned the London Programme for IT to undertake a stock take (to be funded by NSHL), in January. Ms. Knight undertook to report the outcome of the stock take to the Board.

Despite having the above concerns, the CIC had approved the full business case for Cerner, subject to:

- The Trust Board reconfirming its approval of the FBC (once amended to address NHSL issues) and agreed by the Trust during the review of the case; and
- The Trust Board being provided with a briefing paper outlining the issues raised during the course of NHSL review and responses provided by Trust management.

The Board was advised that the Full Business Case had therefore been adapted to include a section on the clinical case and cultural change, and that further financial analysis had been undertaken and was included in the appendices. None of the changes affected the Trust's preferred option. A summary of the changes was outlined in the report, and a full copy of the questions and answers which had been given was available to Board members on request.

The recommendation on page 6 of the submitted report was amended to refer to *V2* as opposed to V1.9.

The Board:

- **APPROVED** V2 of the full business case to implement a common PAS/OCR/EPR across South London Healthcare Trust;
- **AGREED** the publication of the Full Business Case on the Trust's website; **DCE/CN**
- **AGREED** that the London Programme for IT should conduct a stock take of the proposals in January 2012, the cost of which will be funded by NHSL and the outcome of which would be considered as evidence for the gateway review on 23 January 2012. **DCE/CN**

107/11 PERFORMANCE REPORT

Mr. Russell, Chief Operating Officer introduced a report which advised of the Trust's current performance in respect of the NHS Performance Framework standards and highlighted the approach which was being taken to respond to the key issues facing the Trust.

The Board was informed that the two most significant areas of risk in respect of the NHS performance framework related to performance against the 18 week referral to treatment standard and to the performance against the standard for a maximum wait of 4 hours for patients presenting at the A&E Department.

107/11 PERFORMANCE REPORT **ACTION**

The Board was advised that the Trust's accumulated backlog for Referral to Treatment in relation to admitted pathways would be reduced to a sustainable level by early February 2012 through the delivery of additional capacity. In the meantime, the Trust would maintain the achievement of 90% of specialities other than gynaecology from the end of October 2011, with the gynaecology speciality receiving additional capacity from the end of November 2011.

Surgery for bariatric patients would be excluded from the above arrangements, and whilst additional capacity had been arranged, it would be insufficient to clear the backlog: the local health cluster was discussing how to resolve what was a sector wide issue.

The risk areas for non-admitted pathways were opthalmology and oral surgery. Significant work had been undertaken to reduce the wait for non-admitted opthalmic outpatient appointments to 13 weeks, and the Trust was aiming to further reduce the first outpatient wait to 7 weeks to improve the sustainability of the position. Additional capacity for oral surgery would come from Kings, which would begin to clear the backlog with effect from the beginning of Quarter 4.

Performance against the 4 hour standard has been variable over the past year and following further analysis, the Trust was refreshing its strategy for improving performance in a way that could be sustained.

Immediate operational interventions which were being put in place to support a sustainable level of performance going forward included:

- Implementation of rapid assessments at both A&E Departments in the afternoon period
- Additional medical beds at Princess Royal Hospital
- Transfer of further elective surgery to Queen Mary's Hospital
- The use of additional surgical and medical beds at Queen Mary's Hospital
- Greater emphasis on medically fit for discharge patients through closer working with health partners
- Extended in-reach models from community services to accelerate the discharge process
- The Emergency Care Programme Board is taking ownership of the system wide issues
- An engagement programme to work with shopfloor teams to identify areas for improvement and to develop more ownership and involvement with the potential solutions.

Performance on cancer care at the Trust continued to be strong, although ways of enhancing booking capacity were currently being investigated to reduce the impact of cancellations or patient availability on short waiting time targets.

In view of the significance of the standards upon patient experience and the scale of change which would be required to achieve a consistent and sustainable performance, the Board **AGREED** to focus upon the refreshed strategy for Referral to Treatment and Accident and Emergency standards at its Informal Seminar on 21 December 2011. **COO**

108/11 FINANCE REPORT **ACTION**

Mr. Cooper, Director of Finance reported on the Trust's financial position at the end of month 7. The Trust was forecasting a deficit of £69.8m, which included overperformance at the value of £20m, income for which was currently being negotiated with the sector. The Strategic Health Authority, the Department of Health and the Trust had agreed the deficit level. The forecast excluded any additional cost or income which may be associated with Trust performance on the 18 week referral to treatment target. The Cost Improvement Programme had delivered year to date savings of £10,760k, representing a shortfall of £4,968k against against a plan of £15,728k. Pay was £3,333k favourable in the current month and £1m favourable in the year to date, mainly due to vacancies within the Womens, Childrens and Clinical Services Division and a reduced pay run rate in Emergency Care and Specialist medicine, although this was offset by the bank and agency staff usage.

High level management controls on spending on bank and agency staff were now beginning to take effect. Non pay is adverse and in the current month, with the main variances against the plan being attributable to MSSE in theatres, drugs in ECSM and WCCS and pathology consumables.

Activity to reduce cost was ongoing and regularly reviewed by the senior management team and the Trust's Finance Committee.

The Board **NOTED** the month 7 finance report and the action which was being taken to achieve cost improvements.

109/11 CHIEF EXECUTIVE'S REPORT

Dr. Streather, Chief Executive gave a report on progress in meeting the Trust objectives for the current financial year. The following positive aspects, in which the Trust could take pride were highlighted:

- Wide recognition that the Trust's standard mortality rate was one of the best in the country. The Dr. Foster report indicated that South London Healthcare Trust was one of the safer acute trusts in the country, with low infection rates and one of the lowest rates of serious incidents in maternity services. The current situation represented a great improvement to the local acute services prior to the merger of services.
- Whilst the Care Quality Commission report and the National Patients Association annual survey had revealed some areas of the country where care of the vulnerable elderly was poor, this Trust did not feature in the negative reports, which is a testimony to what was being achieved at the Trust.
- The Daily Mirror had now featured the Trust twice in positive articles, including a prominent feature on the world's 7 billionth baby a fortnight ago.
- A new maternity and women's services patient information campaign had been launched last week and had been attended by the Chief Executive of the Royal College of Midwives who had commented that the Trust had a clear commitment and vibrancy for improving its women's services. Donna Ockenden, Chief Midwife at the Trust, who developed the campaign was going to develop a similar campaign for vulnerable elderly patients.

109/11 CHIEF EXECUTIVE'S REPORT **ACTION**

- The hyper acute stroke unit was now fully operational.
- The Trust received a nomination for acute healthcare organisation of the year from the Health Services Journal, which represented a testimony to the significant progress which had been made since its formation and its continued effort to deliver strategic change in a difficult environment.

The Board **NOTED** the Chief Executive's report.

110/11 TRIPARTITE FORMAL AGREEMENT

Dr Streather, Chief Executive advised that, subsequent to the last meeting of the Trust Board, a 'Board to Board' meeting had been held with the Strategic Health Authority to discuss the Trust's journey to Foundation Trust status. In common with all non-foundation trusts, South London Healthcare Trust had signed a Tripartite Formal Agreement with the Department of Health and the Strategic Health Authority, which set out milestones which must be achieved as the Trust moved towards FT status. The following key features of the TFA were drawn to the Board's attention:

- The Trust would submit a plan at the end of December 2011 which would set out how FT status would be achieved within the next 4 years; this would include measures to address workforce, productivity and estates issues, some PFI legacy issues and the best model for delivery of non-clinical functions along with the development of firmer partnership working with commissioners to match service delivery to local health community needs. **CE**
- Staff at the Trust were keen to ensure that a local health service continued to be available to the residents of Bexley, Bromley and Greenwich. **CE**
- The TFA would be posted on to the Trust's website.
- The agreed delivery plan would be reported to the Board's meeting on 25 January 2012. **CE**

The Board **NOTED** the work which was being undertaken to underpin the Tripartite Formal Agreement, the plan for delivery of which would be submitted to its next meeting. **CE**

111/11 CLINICAL SERVICES STRATEGY

Mr. Smith, Medical Director introduced the Trust's Clinical Services Strategy which had been developed in partnership with staff, the Board and representatives of local GP consortia to ensure that the picture for the delivery of future clinical services took account of the needs of the local health economy. The following aspects of the Strategy were highlighted:

- As most vulnerable and high-risk patients were cared for within emergency care pathways, there was a need to change to a 7 day per week service, and to ensure that this resource was available in both Accident and Emergency Departments. This would ensure that the Trust met its 4 hour access targets and that patients were assessed by an appropriate specialist early in the course of their admission.
- Discharge processes would be streamlined through increasing consultant input into decisions and collaborative working with the multi-disciplinary teams within local healthcare services.

111/11 CLINICAL SERVICES STRATEGY **ACTION**

- Emergency and Planned care pathways would be separated, enabling emergency beds to be consolidated at the acute sites. Over the next 2 years Queen Mary's Hospital Sidcup would be developed into an elective surgical centre, with the clear objective of becoming a centre of excellence for planned surgery.
- Consolidation of maternity services had already delivered significant improvements; the Trust now had a higher midwife to birth ratio and the 3rd lowest ceasarean section rate in London;
- There were plans to develop cancer care services to reduce the distances which patients needed to travel to receive treatment and to take account of the high level of incidence of colorectal cancer in the South East.
- The Trust's breast cancer care service was the 3rd busiest in London in terms of patients. The Trust was planning to create a single hub at Queen Mary's Sidcup, with outpatient spokes in the 3 boroughs, which would enable complex diagnostics and in patient surgery to be undertaken locally.
- A dedicated Elderly Care Unit would be provided at Queen Elizabeth Hospital from November 2011, which would enable patients to receive dedicated specialist care.
- High quality investigation and treatment cardiology treatment was available at Queen Elizabeth for patients with heart disease; it was planned to expand this service to make extend its availablility to all boroughs served by the Trust.
- The Trust provided one of the largest opthalmology services in the country, which was extended to West Kent residents. It was planned to consolidate the hub for this service at Queen Mary's Sidcup, with outpatient spokes at the other sites, which would enable the department to be of sufficient size to provide all sub-speciality services in the field of eyecare.

Mr. Ed Langford, Consultant Cardiologist gave a presentation on the current cardiology services which were available at the Trust and which illustrated the importance of strategic planning in ensuring that specialist consultants were able to plan for future service delivery.

He outlined how cardiology services had evolved differently at the Trust's 3 hospital sites prior to its merger, due to differing borough strategies having been in place historically. For example, there was no cath lab at Queen Mary's Hospital because of the way in which a community cardiology service had developed in Bexley.

Subsequent to a service review undertaken in June, the cardiology service was looking to co-ordinate its services to maximise its productivity and to ensure that admissions for emergency pathways were aligned. Whilst safe cath labs were available at both Queen Elizabeth and Princess Royal Hospitals, due to the way in which the cardiology service had evolved historically, there was currently less activity in this field of medicine at Princess Royal Hospital, due to the availability of specialist staff and ward structure.

The Trust was now looking to build on the successful investigation and treatment service for patients with heart disease which was available at

111/11 CLINICAL SERVICES STRATEGY **ACTION**

Queen Elizabeth Hospital across its sites, taking account of the NICE angina pathway. A new CT unit was being installed at Princess Royal Hospital and the previously limited stress echo service would be increased under the leadership of a specialist which would enable physiologists and cardiologists to be trained and for the service to be roll out the service across all 3 hospitals. The tariff associated with the stress echo service was more efficient than at other units.

The Board observed that cardiology represented one of the Trust's flagship services and was keen to see it further developed. It was clear that the clinical staff understood the impact of service commissioning in planning to match supply to demand and tariff and it was observed that the Board was similarly mindful of the effect of its decisions on strategic service planning.

The Board thanked Mr. Langford for illustrating how commissioning decisions affect and impact upon planning for future delivery of services in the longer term and the importance of taking account of the bigger picture as the clinical strategy develops.

The Board **APPROVED** the Clinical Service Strategy.

112/11 PATIENT CAR PARK – QUEEN ELIZABETH HOSPITAL

Ms. Hall, Deputy Chief Executive and Chief Nurse introduced a report which outlined the case for the construction of a patient car park at Queen Elizabeth Hospital to increase the availability of parking at the site in response to patient concerns.

It was confirmed that the proposals detailed within the report had been discussed with local transport providers, who had already taken steps to enhance the availability of local bus routes to the site.

The Board:

- **NOTED** that the full year capital programme that had been approved by the Board had previously allocated a total sum of £950k for the construction of a car park at Queen Elizabeth Hospital;
- **NOTED** that the scheme would deliver a partial year effect cost improvement of £289k in 2012/13 and a full year effect cost improvement of £315k thereafter;
- **NOTED** that the full design of the new car park had been completed and that the Procurement Department had undertaken a tendering exercise to identify a construction contractor that represented best value for money for the Trust;
- **NOTED** that the Executive Management Team supported the Full Business Case which contained an assessment by the Finance Department of the full capital and revenue benefits and costs of the scheme;
- **APPROVED** the award of the contract to the construction contractor that was recommended within the Procurement Department's Tender Evaluation Report at a capital cost of £777,103.09 excluding VAT. **DCE/CN**

113/11 TRUST GOVERNANCE COMMITTEE **ACTION**

The Board was advised that, at its meeting on 26 September, 2011, the Governance Committee had been advised of plans to commence estate improvement works at Queen Elizabeth Hospital with effect from April 2012; the Committee would be considering a full action plan at its next meeting. The Committee was continuing to take an interest in the pre-employment checks which staff and contractors undergo and expected to receive a further update at its next meeting. It would also be discussing the arrangements for the implementation of the ICare system, with a particular focus upon compliance with information governance requirements at its next meeting.

The Board **RECEIVED** as a matter of record the minutes of the Trust Governance Committee held on 25 July 2011.

114/11 TRUST AUDIT COMMITTEE

The Board was advised that, at its meeting of 11 November 2011, the Audit Committee had received an excellent report outlining the Financial Governance Improvement Plan, which should be submitted to the Board to note the significant progress which is being made in this area under the leadership of Mr. Worthington, Deputy Director of Finance. **DF**

The Board had previously delegated to the Audit Committee the authority to agree the Annual Accounts for 2010/11 on behalf of the Board. Agreement was imminent. Once reached, the Trust's Annual General Meeting would be arranged.

The Board **RECEIVED** as a matter of record the minutes of the Trust Audit Committees held on 15 September 2011 and 17 October 2011.

115/11 TRUST FINANCE COMMITTEE

The Board was advised that at its meeting on 22 November 2011, the Committee had reviewed this year's financial performance to date.

The Board **RECEIVED** as a matter of record the minutes of the Finance Committees held on 23 August 2011 and 27 September 2011.

116/11 TRUST HUMAN RESOURCES SUB-COMMITTEE

The Board **RECEIVED** as a matter of record the minutes of the Human Resources Sub-Committee held on 18 August 2011.

117/11 ROLLING FORWARD AGENDA

Mr. Ballard, Acting Chairman highlighted that the forward programme included provision for two additional meetings of the Board.

Officers were requested to include the dates of planned Board meetings and designated office holders who would be presenting scheduled reports within the next iteration of the work plan.

The Board:

- **AGREED** the proposed schedule of meetings; and

117/11 ROLLING FORWARD AGENDA **ACTION**

NOTED its rollling forward agenda for 2011/12.

118/11 ANY OTHER BUSINESS

Orpington Health Services

Mr. Shoben, Director of Communications introduced a presentation which outlined progress with the development of the Orpington Health Services Project, which was being led by a project team comprising local healthcare commissioners, GPs, the London Borough of Bromley and the Trust and which included representation from Bromley LINks, staff side and Orpington League of Friends.

He apologised for late circulation of the presentation, and emphasised that the project team was keen to secure local engagement in the discussions relating to the future delivery of services, subsequent to April 2012, when the services available at Orpington Hospital would not be delivered in their current configuration. It was highlighted that the future configuration of local services was relevant to the clinical services strategy, which had been discussed elsewhere on the agenda and that in developing the options appraisal, the project team was focussing on local service needs as opposed to buildings.

The Board:

- **NOTED** progress being made with the Orpington Health Services project; and
- **AGREED** to include a report on progress within its rolling forward agenda for presentation to its next meeting on 25 January 2012. **CE**

Proposed Industrial Action, 30 November 2011

The Board was assured that the Trust was aware of the potential industrial action which was scheduled for 30 November 2011 and that, by local agreement, the Trust would be delivering essential services on that day.

Falls Management

Responding to a question from the LINKs representative relating to the figures for falls management at Princess Royal Hospital contained with the Patient Safety and Experience report, the Board was advised that a similar strategy to that which was currently in operation at Queen Elizabeth and Queen Mary's Hospitals had now been put in place and that this was proving effective at Princess Royal Hospital, where the Trust was now seeing a reduction in the level of falls which cause the most harm.

Vote of Thanks – Avey Bhatia, Acting Director of Nursing and Patient Experience

The Board expressed its appreciation to Avey Bhatia, Acting Director of Nursing and Patient Experience, who would be stepping down from membership of the Board.

118/11 ANY OTHER BUSINESS **ACTION**

Non-Executive Director

The Board was advised that Mr. J. Virdee had been appointed as a non-executive director of the Trust.

119/11 DATE OF NEXT BOARD MEETING

The Board was advised that its next meeting would take place on Wednesday, 25 January 2012 in the Lecture Hall, Postgraduate Centre, Princess Royal University Hospital.

The meeting ended at 12.40 p.m.

Action Tracker for the Trust Board in Public session of the South London Healthcare NHS Trust Board meeting held 23 November 2011

Agenda Item	Agreed Action	Minute Ref.	Date item to be reported	Responsible Officer
101/11 Matters Arising	**Performance Review and Appraisal Process** To confirm whether the performance review and appraisal process had been incorporated within the Workforce and Organisational Development Strategy.	Draft minute 101/11	OPEN	Chief Executive
102/11 Organ and Tissue Donation	**Organ and Tissue Donation Committee** To explore the possibility of focusing upon an example of organ/tissue donation within a patient story. To forward comments on the draft organ and tissue donation policy to the Organ and Tissue Donation Committee and to discuss the appropriate means of supporting that committee's recommendations	Draft minute 102/11	OPEN	Chief Operating Officer/ Deputy Chief Executive and Chief Nurse
106/11 Cerner Business Case	**Cerner Business Case Briefing Paper** To report the outcome of the NHSL stock take to the next meeting of the Board. To publish the Full Business Case for the implementation of the Cerner Programme on the website.	Draft minute 106/11	25 January 2012	Deputy Chief Executive and Chief Nurse
107/11 Performance Report	**Referral to Treatment Time** To focus upon the refreshed strategy for Referral to Treatment time at the next meeting of the Informal Seminar.	Draft Minute 107//11	21 December 2011	Chief Operating Officer
110/11 Tripartite Formal Agreement	**Tripartite Formal Agreement** To publish the TFA on the Trust's website. To submit a report advising of progress to the Board's next meeting.	Draft minute 110/11	25 January 2012	Chief Executive

Agenda Item	Agreed Action	Minute Ref.	Date item to be reported	Responsible Officer
114/11 Trust Audit Committee	**Financial Governance Improvement Plan/Rolling Forward Agenda** To submit the Financial Governance Improvement Plan to the Board's next meeting.	Draft Minute 114/11	25 January 2012	Director of Finance
117/11 Rolling Forward Agenda	**Rolling Forward Agenda** To include dates of planned Board meetings and officers who would be presenting scheduled reports within the workplan.	Draft Minute 117/11	25 January 2012	Deputy Chief Executive and Chief Nurse
118/11 Any Other Business	**Orpington Health Services** To submit a report on progress with the project to the Board's next meeting.	Draft Minutes 118/11	25 January 2012	Chief Executive

ENC B

SOUTH LONDON HEALTHCARE NHS TRUST

Subject	Patient Safety and Experience Report
Report by	Avey Bhatia, Deputy Chief Nurse
Author	Avey Bhatia, Deputy Chief Nurse
Accountable Executive Director	Jennie Hall, Deputy Chief Executive and Chief Nurse

TRUST OBJECTIVE

Our Patients	**X**
Financial Viability	
Leadership and Workforce	
High Quality Clinical Care	**X**
Healthcare Acquired Infections	**X**
National and Local Priorities	**X**
Service and Facilities fit for the future	**X**

GLOSSARY

Abbreviation	**In Full**
SI	Serious Incident
HSMR	Hospital Standardised Mortality Ratio
PIs	Patient Incidents
NHSL	NHS London
VTE	Venous Thrombus-Embolism
ECSM	Emergency Care and Specialist Medicine
CQUIN	Commissioning for Quality and Innovation
PRUH	Princess Royal University Hospital
QEH	Queen Elizabeth Hospital
QMS	Queen Mary's Sidcup
LINks	Local Involvement Networks
WCSS	Women's Children & Support Services
HSE	Health and Safety Executive
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
H&S	Health and Safety

WRITTEN REPORT (provided in addition to cover sheet) Yes

POWERPOINT PRESENTATION No

ENC B

SOUTH LONDON HEALTHCARE NHS TRUST

PURPOSE OF THE REPORT

The Trust Board are requested to note and understand the Trust's position against key patient safety and quality indicators. The report has been revised to ensure the Board receive key information on the priority areas over the next 6 – 12 months

SUMMARY OF KEY ISSUES

- MRSA remains within trajectory for the year with 3 cases year to date.
- The position on C difficile has deteriorated again since October and the Trust remains over national trajectory for this infection at present. A review by NHSL has endorsed the control plan implemented and made recommendations for additional actions that need to be taken, with a focus on prescribing.
- The HSMR in October was 82.6, indicating 33 fewer deaths than expected and continuing the positive trend.
- 9 SIs were reported across all Divisions for November and December. The report now details all patient safety incidents and details those that have resulted in major or catastrophic harm.
- There have been no grade 4 ulcers for a 12 month period and there has been a 50% reduction in grade 3 ulcers.
- The Dr Foster Relative Risk report on hospital pressure ulcers shows that SLHT's position is below the national average. The national average is set at 100 and SLHT's position is 88.3.
- The Q3 VTE audit showed that 58% of patients had a risk assessment for VTE on admission which, added to the low-risk cohort means 70% of patients are risked on admission for VTE.
- For the last 4 months although the numbers of falls has not reduced, there has been a reduction in the number of falls resulting in major harm. 1 fall has resulted in major harm over the last 4 months.
- Significant progress has been made in delivering SSA, the area that continues to have the most significant breaches is the daycare unit at QEH. There were 31 breaches for the Trust in December.
- The Trust has seen a significant improvement with a reduction in the number of open complaints across ECSM and Planned Care.
- In February we shall be contacting some patients (random sample) after discharge from hospital to ask them some questions relating specifically to their experience of discharge hospital. This is a pilot and is being supported through the discharge action group.
- Compliance with level 3 training for children's safeguarding remains under review. There are a number of actions being taken to improve this position which are detailed in the main body of the report.
- The Trust-wide H&S internal audit campaign commenced in early November 2011 in accordance with the guidelines set down by the HSE.
- HSE is satisfied that appropriate remedial action has been taken in the Trust regarding the National Inspection Programme – Preventing Dermatitis in the NHS and this has now been formally closed.

ENC B

SOUTH LONDON HEALTHCARE NHS TRUST

SUMMARY OF KEY RISKS

Non compliance with the Care Quality Commission's Essential Standards of Quality and Safety

RECOMMENDATION / DECISION REQUIRED

To Board are asked to note the key actions being to improve performance in key areas of patient safety and experience.

IMPLICATIONS

Are there any implications for Care Quality Commission Registration?	YES
Is an Equality Impact Analysis Required?	NO
Are there any legal Implications arising from this item?	NO
Are there any Financial implications arising from this item?	NO

Patient Safety and Patient Experience Report
Trust Board

25 January 2011

South London Healthcare NHS Trust
Patient Safety and Patient Experience Report

Patient Safety Improvement Priorities 2011/12

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

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

Patient Experience Improvement Priorities 2011/12

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

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

The delivery of these improvement priorities requires support and involvement of the key stakeholders.

South London Healthcare NHS
NHS Trust

Patient Safety and Patient Experience Indicators - Executive Summary

Board Action

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

Infection Prevention

MRSA bacteraemia remains within trajectory for the year, with 3 cases to date. The position on C.difficile has deteriorated again since October, and the Trust remains over trajectory for this infection. A review by NHS London has endorsed the control plan implemented, and made recommendations for additional actions that need to be taken, with a focus on prescribing. These actions are currently being put into place.

Patient Incidents and Serious Incidents(SIs)

9 SIs were reported across all Divisions for the months of November and December. No Sis were reported related to Pressure Ulcers Or Falls. There were no Never Events reported during this period. The report now includes the Trust position in relation to the reporting of all Patient Safety Incidents. Assurance has been received from the NPSA that since the implementation of the integrated risk management system, the Trust has moved from bottom quartile to midline reporting.

HSMR

The HSMR for October 2011 was 82.6, indicating 33 fewer deaths than expected and continuing the positive trend. The HSMR was below 100 on all sites. No 'red bell' alerts were notified.

Hospital Acquired Pressure Ulcers

The Dr Foster report shows the relative risk of pressure ulcers for patients at NHS Hospitals nationally at the point of discharge. Although this methodology is different to how we record our position internally it provides us with a comparison against other hospitals nationally using the same methodology.

The average is set at 100 and SLHT'S position is below average at 88.3. It is reassuring to acknowledge that the actions taken over the last 18 months have ensured that the risk to our patients is lower than the national average whilst continuing to remain focussed in improving our position further.

From April 2011, there has been an overall 30% reduction in the number of hospital acquired pressure ulcers, compared to the same period in 2010. In addition, there has been a 50% reduction in hospital acquired Grade 3 pressure ulcers & NO Grade 4 hospital acquired pressure ulcers since January 2011.

Falls

Ongoing validation demonstrates that for the last 4 months there has been only 1 incident of major harm. The incidences of medium harm remains static at 15 for November and December. Work continues on falls prevention and the Safety Express Agenda which will focus on levels of harm.

VTE Prevention

Q3 audit showed 58% of patients had a risk assessment for VTE on admission which, added to the low-risk cohort means 70% of patients are risk assessed on admission. Patient safety incident data from Dr Foster for cases of pulmonary embolism or DVT following surgery indicated 61 observed cases against 76 expected cases indicating a low relative risk in the Trust of post-operative PE or DVT.

Complaints

There has been a significant improvement in the last three months with a reduction in the amount of open complaints across both ECSM and Planned Care Divisions. This has resulted in an improvement in response times in those Divisions. Womens, Childrens and Support Services Division continue to deliver complaints responses to a high standard.

All Divisions are required to provide action plans to illustrate 'Learning from Complaints' to improve the Patient Experience and this is the next area which will be concentrated on to assist in reducing the numbers of complaints received by the Trust.

Single Sex Accommodation

There has been continued focus on the day surgery unit on the QE site where over the last few months of last year there has been some fluctuation in the numbers of mixed-sex breaches. There has however been an improvement in performance in December 2011 which is very positive and it is hoped that the team will be able to sustain and improve upon this position on the unit for subsequent months of this year.

Food and Nutrition

A Trust Wide Catering Review was completed in 2011. The purpose of the review was to identify the current status of the catering provision across all 3-hospital sites and highlight any opportunities to improve the quality and choice to patients. There are some key recommendations from this review that are been taken forward in the Trust- more detail in the main report.

A food tasting event was held in November 2011 which was attended by representatives from key stakeholders including Bromley LINk and Age UK. A pilot of the new menu has commenced in January 2012 for a month on a small sample of wards. The pilot will involve greater engagement of the catering hostesses in presenting menus to patients which will help to ensure that patients receive the right food, at the right time and in the right place.

Patient Experience Indicator

As part of the CQUIN for patient experience there are 5 key questions that relate to improving overall responsiveness to the personal needs of patients. We are going to introduce some discharge telephone interviews with patients to help us to have a better understanding of the total experience of patients relating to their discharge from hospital. There will be a pilot of this questionnaire on the 2nd February 2012.

A Discharge Action group was established in 2011 in response to the reports from Bromley and Greenwich LINks on discharge from hospital. This group has been focussing on the development of key documents that will provide patients and next of kin with important information about their discharge.

Safeguarding Children

Level 3 Children's safeguarding training currently shows 46% compliance. The framework for training changed last year with the required hours increasing for level 3. For level 3 (applicable to staff working in high risk areas) the requirement is 12-16 hours of training over a year period.

There are a number of issues that are currently impacting on our ability to provide an accurate position and action is being taken to address these.

The availability of training is not an issues but releasing staff and low attendance are areas that are being addressed. This work is being lead by a one of the named doctors for children's safeguarding supported by the lead nurse and training department.

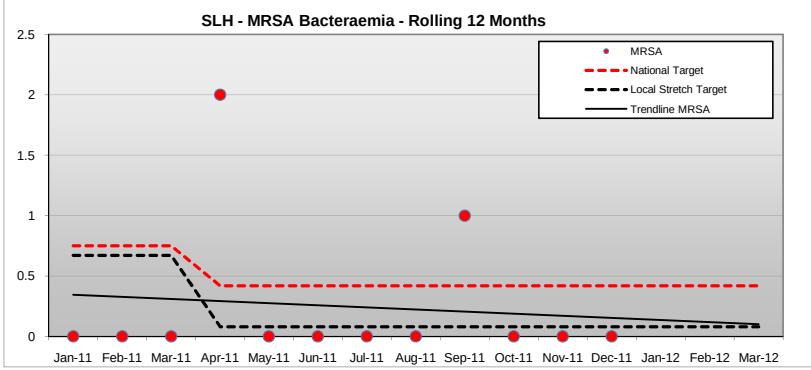
Health and Safety

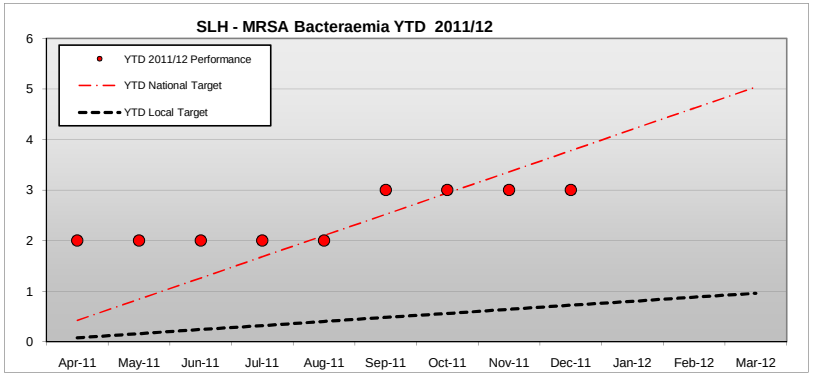
The Trust-wide H&S Internal Audit campaign commenced in early November 2011 in accordance with the guidelines as set down by the HSE. Additionally, this process allows for the promulgation of an inspection format that includes an action plan that can be outlined with responsibilities and will provide a record of outstanding actions having been completed where necessary. This is also in keeping with the Townsend Turner recommendations which continues to gain momentum towards it's completion. HSE is satisfied that appropriate remedial action has been taken in the Trust regarding the National Inspection Programme: Preventing Dermatitis in the NHS and this case has now been formally closed.

Healthcare Associated Infection - MRSA Bacteraemia

National Priority - **(PS1)** To ensure the incidence of MRSA Bacteraemia does not exceed 5
Supports Compliance with CQC Outcome 8

Indicator	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	2011/12 Forecast
MRSA (Number)	0	0	0	2	0	0	0	0	1	0	0	0				
National Target	0.75	0.75	0.75	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42	0.42	
Local Stretch Target	0.67	0.67	0.67	0.08	0.08	0.08	0.08	0.08	0.08	0.08	0.08	0.08	0.08	0.08	0.08	
YTD 2011/12				2	2	2	2	2	3	3	3	3				<1
YTD National Target	7.5	8.3	9.0	0.4	0.8	1.3	1.7	2.1	2.5	2.9	3.4	3.8	4.2	4.6	5.0	<5
YTD Local Target	6.7	7.4	8.0	0.1	0.2	0.2	0.3	0.4	0.5	0.6	0.6	0.7	0.8	0.9	1.0	<1





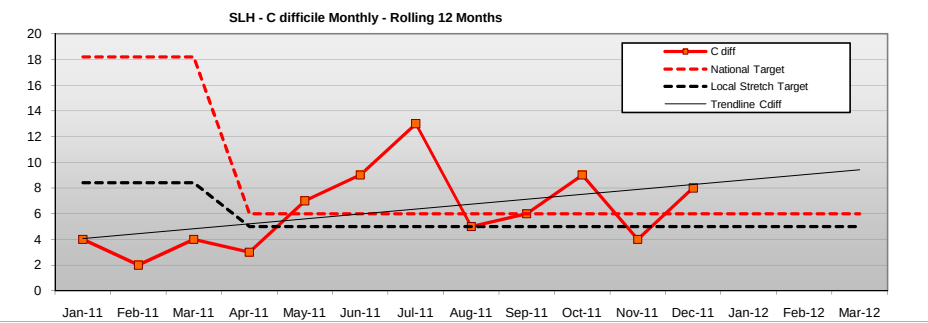
Analysis

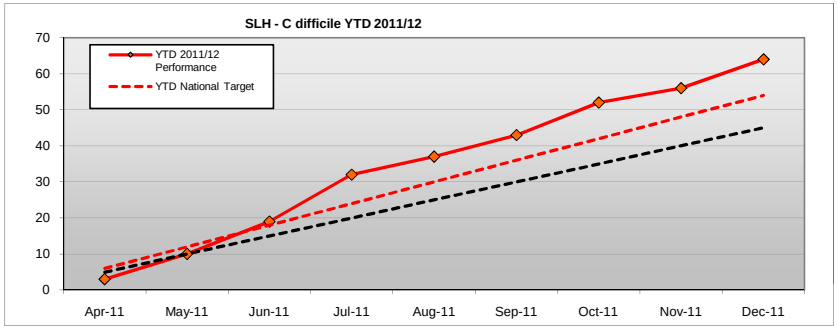
There has been no further case of Trust-acquired MRSA bacteraemia since the case in September (detail reported previously to Trust Board). The EC&SM division is implementing the learning from the root cause analyses of cases, and the Trust aspires to have no more cases this year.

Healthcare Associated Infection - C. difficile

National Priority - **(PS2)** To ensure the incidence of C.difficile does not exceed 71
Local Stretch Target - To ensure the incidence of C.difficile does not exceed 60
Supports Compliance with CQC Outcome 8

Indicator	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	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	2011/12 Forecast
(Number	7	5	6	6	4	2	4	3	7	9	13	5	6	9	4	8				<60
Target	18.2	18.2	18.2	18.2	18	18	18	6	6	6	6	6	6	6	6	6	6	6	6	<71
Stretch Target	8.4	8.4	8.4	8.4	8	8	8	5	5	5	5	5	5	5	5	5	5	5	5	<60
2011/12								3	10	19	32	37	43	52	56	64				
National Target	109.2	127.4	145.6	163.8	182	200	218	6	12	18	24	30	36	42	48	54	60	66	72	
Local	50.4	58.8	67.2	75.6	84	92	101	5	10	15	20	25	30	35	40	45	50	55	60	





Analysis

The deteriorating trend in the number of Clostridium difficile cases reported to Trust Board in the last report was brought under control in August and September, but has subsequently deteriorated again with above trajectory numbers in October and December 2011.

Focussed action on hand hygiene, cleanliness and isolation continued, and a recent NHS London review has endorsed the actions taken to date and reinforced that these must continue. The report recommended further actions with a specific focus on antimicrobial prescribing, and work is underway to implement additional action on this issue, led by the divisions.

The Trust remains in breach of the national target trajectory, with a year-to-date performance at the end of December of 64 cases, against a target trajectory of no more than 45 cases. Focussed action will continue, with the Trust continuing to strive to reverse this trend.

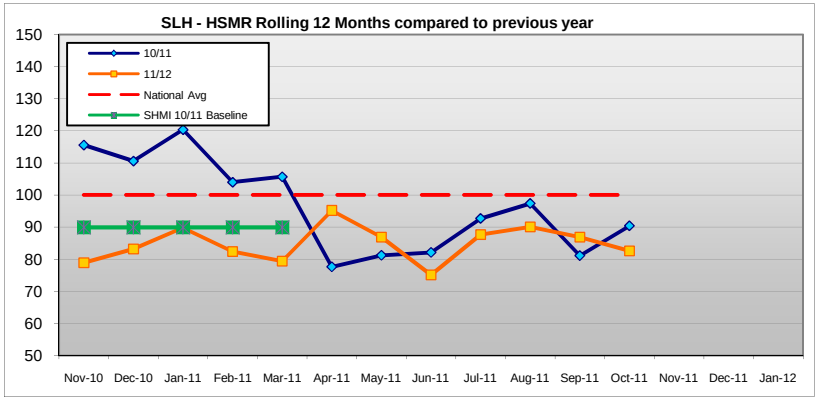
South London Healthcare NHS
NHS Trust

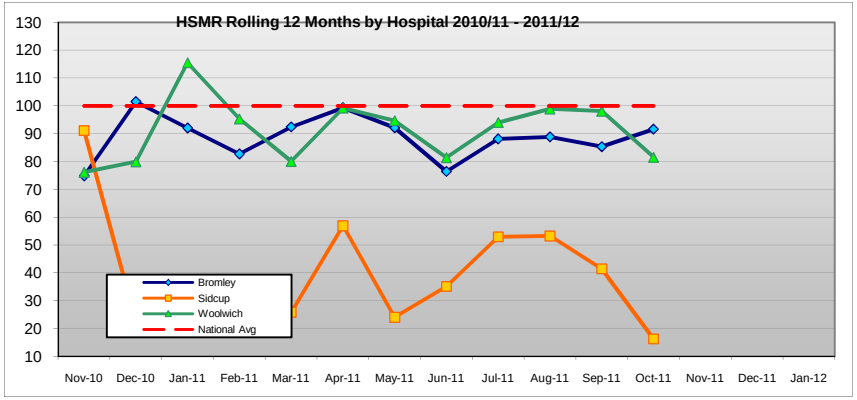
Hospital Standardised Mortality Rate

Local Priority - **(CE9)** To ensure the HSMR remains below the expected rate based on a national average of 100 incorporating adjustments for local population characteristics
Supports Compliance with CQC Outcome 4

The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a provider. The observed number of deaths is the total number of patient admissions to th e hospital which resulted in a death either in-hospital or within 30 days post discharge from the hospital

Indicator	Nov-10	Dec-10	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
HSMR 11/12	78.9	83.2	89.8	82.4	79.4	95.2	86.9	75.1	87.7	90.1	86.9	82.6			
HSMR 10/11	115.6	110.6	120.4	104	105.7	77.6	81.2	82.1	92.7	97.4	81.1	90.4			
SHMI 10/11 Baseline	89.94	89.94	89.94	89.94	89.94										
National Avg	100	100	100	100	100	100	100	100	100	100	100	100			
Bromley	74.8	101.5	92	82.7	92.4	99.3	92.1	76.4	88.1	88.8	85.3	91.6			
Sidcup	91.1	22.3	23.2	34.6	25.8	56.9	24	35.1	52.9	53.2	41.4	16.2			
Woolwich	76.1	79.9	115.5	95.3	80	99.2	94.7	81.4	94	98.9	98.1	81.5			





Analysis

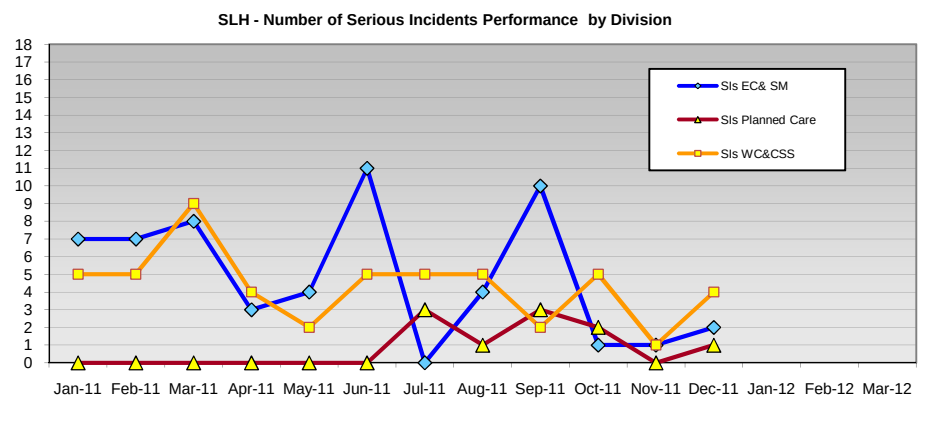
The HSMR for October 2011 was 82.6, indicating 33 fewer deaths than expected and continuing the positive trend. The HSMR was below 100 on all sites. No 'red bell' alerts were notified.

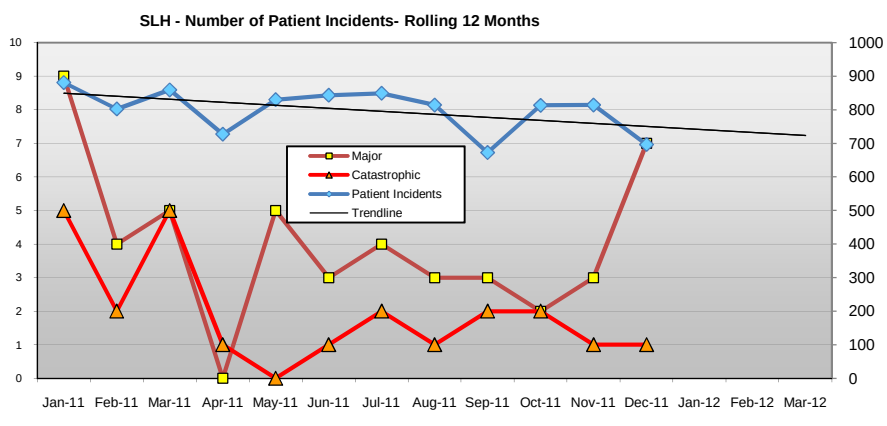
South London Healthcare NHS Trust

Patient Incidents and Serious Incidents (SIs)

NHS Trusts are required to have effective processes and policies in place to support its staff to report incidents that occur to patients, this includes incidents deemed to be Serious Incident and that lessons are learnt from the review and analysis of reported incidents

Indicator	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	YTD
SIs EC& SM	7	7	8	3	4	11	0	4	10	1	1	2				36
SIs Planned Care	0	0	0	0	0	0	3	1	3	2	0	1				10
SIs WC&CSS	5	5	9	4	2	5	5	5	2	5	1	4				33
Patient Incidents	881	802	859	727	830	843	849	814	672	813	814	696				
Major	9	4	5	0	5	3	4	3	3	2	3	7				
Catastrophic	5	2	5	1	0	1	2	1	2	2	1	1				





Analysis

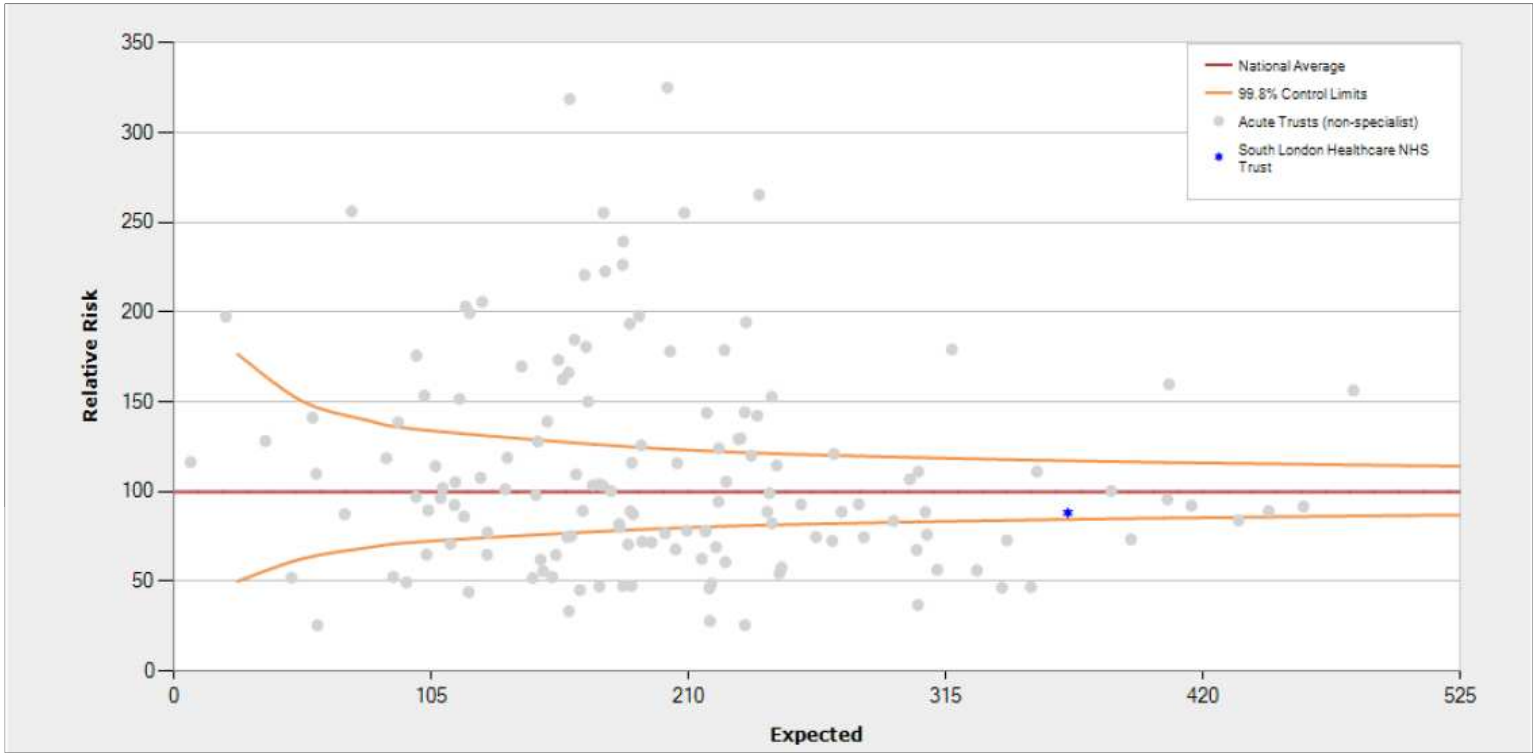
Reporting figures for SIs for November and December 2011 remain low in ECSM compared to numbers reported earlier in the year. Those reported in ECSM were both due to LAS breaches on the PRU site. Within WCCSS, 3 of the SIs were due to the admission of women to ITU, 2 unexpected post delivery admission and 1 following planned surgery. There were no hospital acquired pressure ulcers reported during this period as an SI, nor where there any SIs reported that related to serious harm occurring following a fall.

In respect of reported Patient Safety Incidents, over the last 9 months, these have averaged at 785 incidents per month, and in the last report published by the NPSA, SLHT was deemed to have moved from the bottom quartile to mid line in terms of incidents reported when compared to similar organisations. Of those incidents deemed to be major occurring between April - Dec, approximately 33%, relate to Slips, trips and Falls, 13% relate to pressure ulcers, and 13% in relation to infection prevention issues. In those deemed to be catastrophic, eight have been reported as Serious Incidents. 8 of those considered to be catastrophic relate to WCCSS. Caution should be exercised when reviewing the data for November / December as some of these incidents remain under review.

South London Healthcare NHS Trust

Relative Risk - Pressure Ulcer

Analysis of relative risk for pressure ulcers nationally. Average is set at 100%



Analysis

The above graph is produced by Dr Foster and shows the relative risk of pressure ulcers for patients at NHS Hospitals nationally at the point of discharge. Although this methodology is different to how we record our position internally it provides us with a comparison against other hospitals nationally using the same methodology.

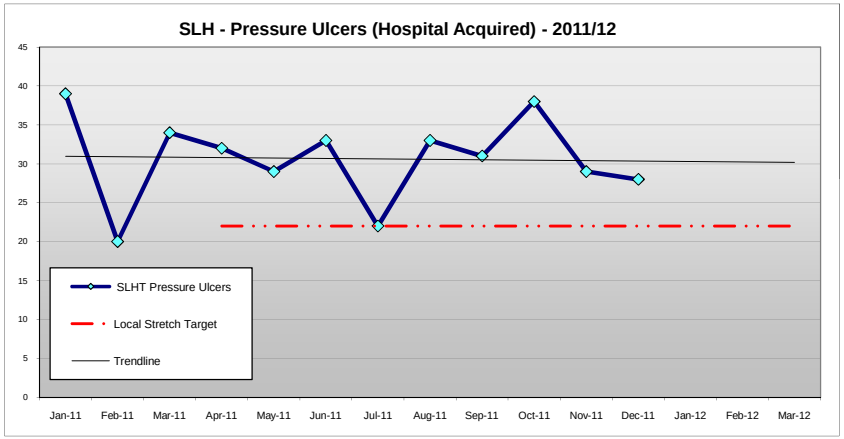
The average is set at 100 and SLHT'S position is below average at 88.3. It is reassuring to acknowledge that the actions taken over the last 18 months have ensured that the risk to our patients is lower than the national average whilst continuing to remain focussed in improving our position further.

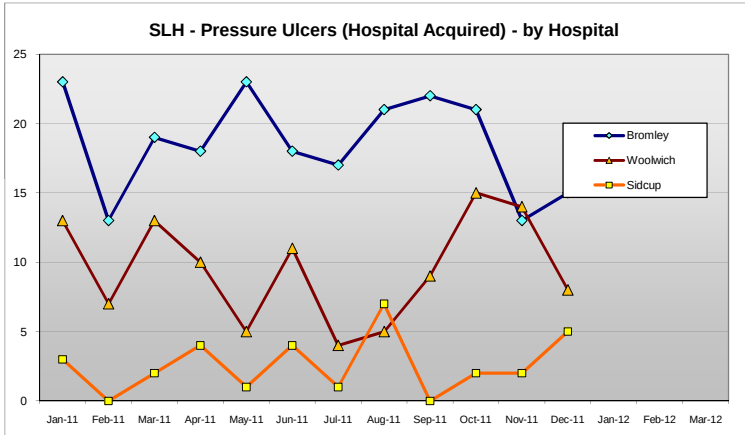
South London Healthcare NHS
NHS Trust

Pressure Ulcers (Hospital Acquired)

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

Indicator	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	2011/12 Forecast
SLHT Pressure Ulcers (Hospital Acquired)	39	20	34	32	29	33	22	33	31	38	29	28				<300
Grade II				30	29	33	22	28	31	37	29	28				
Grade III				2	0	0	0	5	0	1	0	0				
Grade IV				0	0	0	0	0	0	0	0	0				
Local Stretch Target				22	22	22	22	22	22	22	22	22	22	22	22	<264
Bromley	23	13	19	18	23	18	17	21	22	21	13	15				
Sidcup	3	0	2	4	1	4	1	7	0	2	2	5				
Woolwich	13	7	13	10	5	11	4	5	9	15	14	8				
YTD	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec				YTD
YTD 2010/11	431	451	485	52	104	141	186	230	285	328	361	392				485
YTD 2011/12				32	61	94	116	149	180	218	247	275				





Analysis

From April 2011, there has been an overall 30% reduction in the number of hospital acquired pressure ulcers, compared to the same period in 2010. In addition, there has been a 50% reduction in hospital acquired Grade 3 pressure ulcers & NO Grade 4 hospital acquired pressure ulcers since January 2011. Whilst there is good progress, work continues in striving to reduce the number of hospital acquired Grade 2 pressure ulcers. This work includes:

- Snapshot review of patients notes who have developed hospital acquired Grade 2 ulcers, to ascertain any additional information
- Robust education programme continues - sessions now including nutrition
- Education for HCA's, & AHP's (physiotherapist's, & OT's) now being organised & delivered
- Trainer tracker module being devised to allow on-line access for all health care professional

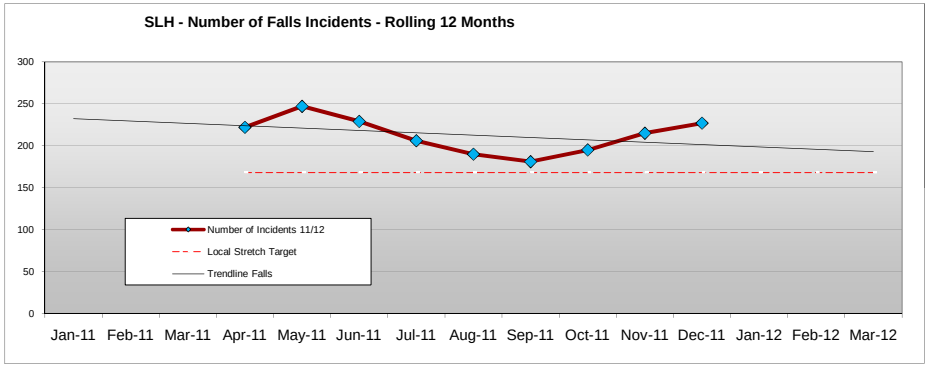
South London Healthcare NHS
NHS Trust

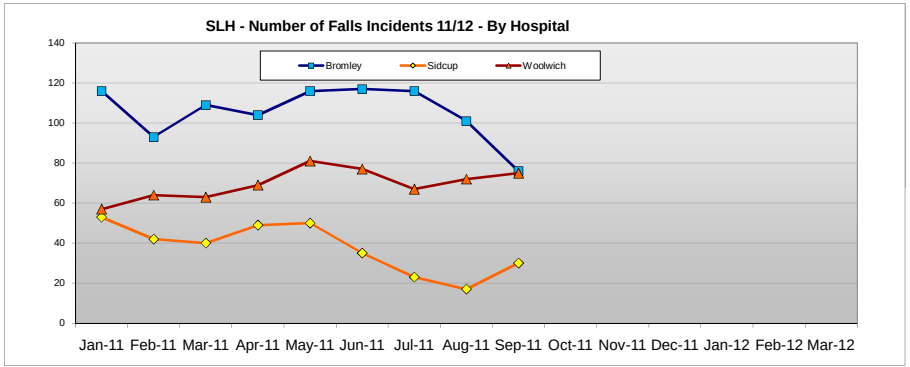
Falls Management

Trust aim is to reduce harm caused to patients by falling

Moderate - the fall resulted in harm that was likely to require outpatient treatment, admission to hospital, surgery or a longer stay in hospital. Severe - permanent harm, such as brain damage or

Indicator	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	2011/12 Forecast
Number of Incidents 11/12				222	247	229	206	190	181	195	215	227				
YTD 11/12				222	469	698	904	1094	1275	1470	1685	1912				2018
Local Stretch Target 11/12				168	168	168	168	168	168	168	168	168	168	168	168	2018
Moderate				20	12	8	6	6	7	5	5	10				
Severe				0	4	2	2	1	0	0	0	1				
Death				0	0	0	0	1	0	0	0	0				
Bromley	116	93	109	104	116	117	116	101	76	94	107	102				
Sidcup	53	42	40	49	50	35	23	17	30	20	24	28				
Woolwich	57	64	63	69	81	77	67	72	75	81	84	97				





Analysis

Ongoing validation demonstrates that for the last 4 months there has been only 1 incident of major harm. The incidences of medium harm remains static at 15 for November and December (previously 12 for Sept and October). For December, the PRUH and QE had an equal number of falls which is not reflected in the data as Bromley data includes Orpington Hospital. Further in depth analysis and work is also required on the QE site with regards to the the slight increase in falls over the last few months as there does not appear to be one specific influencing factor although admission rates in AMU have been higher over the past 2 months. .

A Falls audit undertaken in October within the medical division showed that 91% of patients had a risk assessment completed and a score category recorded which is extremely encouraging. Raising awareness around preventative actions continues and remains a priority.

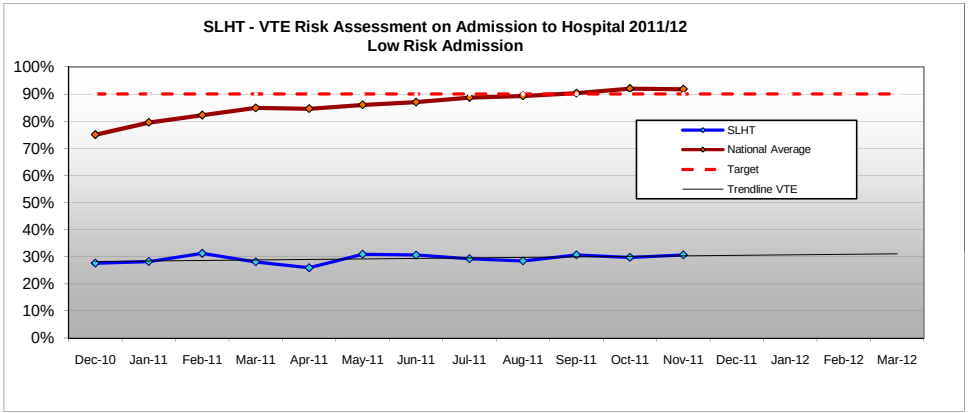
The Falls Link nurse group will have their first study day at the end of January and will help take forward some of the recommendations from the audit along with the launch of the Safety Express

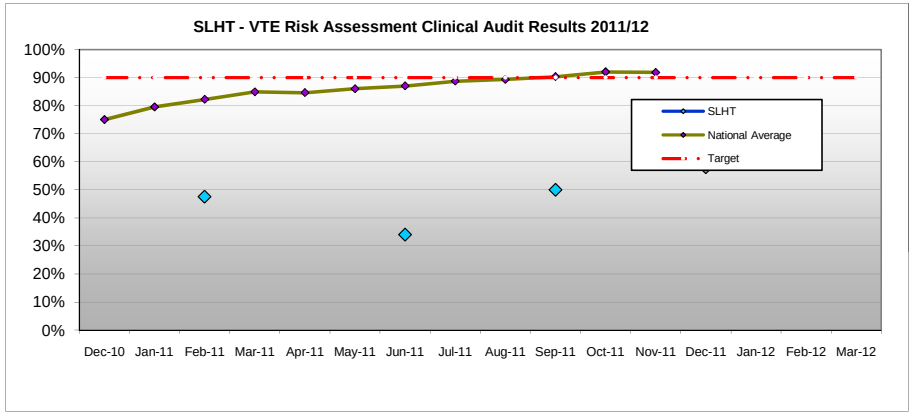
South London Healthcare NHS Trust

VTE Risk Assessment

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

Indicator	Dec-10	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	YTD
Low risk admissions	28%	28%	31%	28%	26%	31%	31%	29%	28%	31%	30%	31%					
VTE clinical audit results			48%				34%			50%			58%				
National Average	75%	80%	82%	85%	85%	86%	87%	89%	89%	90%	92%	92%					86%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%





Analysis

Q3 audit showed 58% of patients had a risk assessment for VTE on admission. A further increase from Q2, which, added to the low-risk cohort, means 70% of patients are risk assessed on admission. There is significant variation between wards and departments and ward performance on the Q2 and Q3 audits has been disseminated and will be monitored weekly as the UNIFY data becomes available.

Patient safety incident data from Dr. Foster for cases of pulmonary embolism or DVT following surgery indicated 61 observed cases against 76 expected cases indicating a low relative risk in the Trust of post-operative PE or DVT.

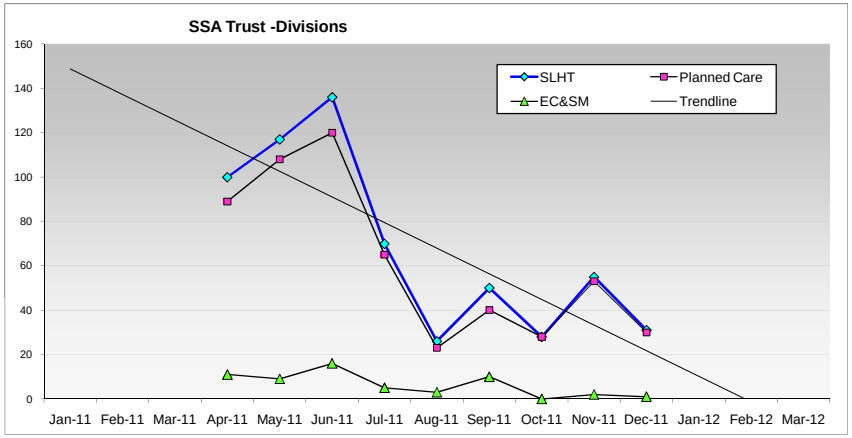
VTE risk assessment data has been collected by clinical coders from 19th December and a more accurate report on UNIFY will be available for January.

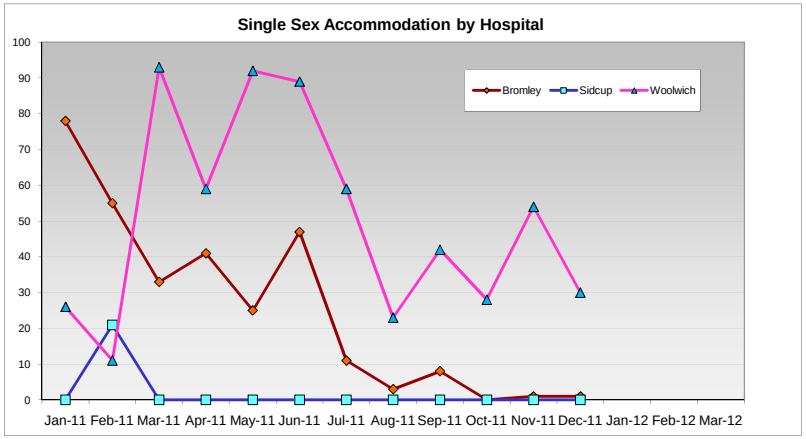
South London Healthcare NHS
NHS Trust

Same Sex Accommodation

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

Non-clinical Breaches:	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
SLHT				100	117	136	70	26	50	28	55	31			
Planned Care				89	108	120	65	23	40	28	53	30			
EC&SM				11	9	16	5	3	10	0	2	1			
Bromley	78	55	33	41	25	47	11	3	8	0	1	1			
Sidcup	0	21	0	0	0	0	0	0	0	0	0	0			
Woolwich	26	11	93	59	92	89	59	23	42	28	54	30			





Analysis

The above figures identify the numbers of patients on each site who have experienced a mixed- sex breach where there are no clinical justifications. For the month of November there were 55 mixed- sex breaches for the Trust. Of those breaches there were 54 on the QE site; 53 of these were in the day surgery unit and 1 was in the critical care unit. There was 1 mixed-sex breach on the PRUH site; which was in the critical care unit. In December 2011 there were a total of 31 mixed- sex breaches in the Trust. Of those, 30 were on the QE site in the day surgery unit and 1 was on the PRUH site in the critical care unit. There have been no mixed- sex breaches on the QM site for both months.

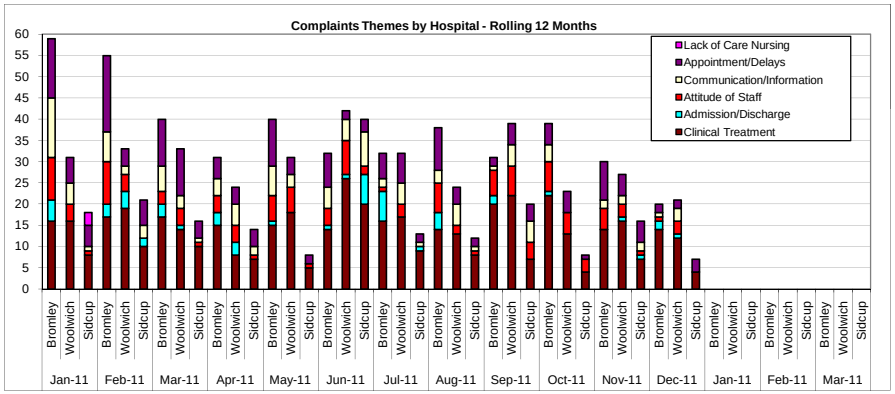
There has been continued focus on the day surgery unit at the QE site where there has been some fluctuation in the numbers of mixed- sex breaches; however it is positive to note some improvement in performance for the month of December 2011. There is absolute commitment from the senior team to maintain and improve upon this position in the unit.

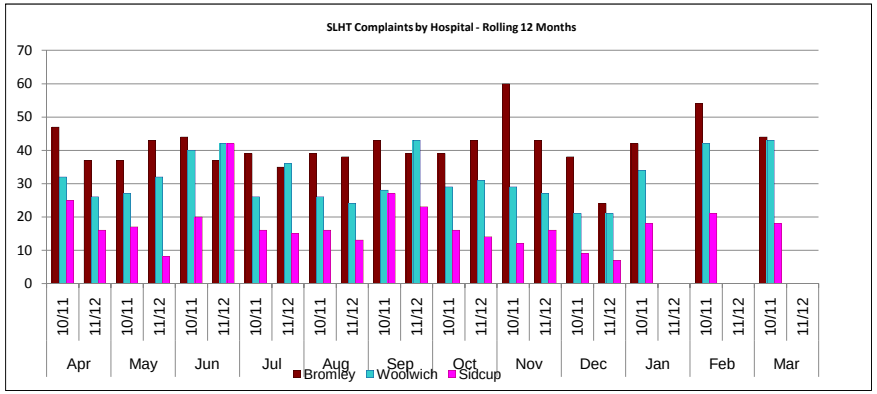
It is important to note that the endoscopy units on the PRUH and the QE sites have continued to ensure that there are no mixed- sex breaches. This has required significant flexibility and support from both teams to sustain this position which is commendable.

Complaints

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

Indicator	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	YTD 11/12
SLHT	94	117	105	79	83	121	86	75	105	88	86	52				775
Bromley	42	54	44	37	43	37	35	38	39	43	43	24				339
Clinical Treatment	16	17	17	15	15	14	16	14	20	22	14	14				144
Admission/Discharge	5	3	3	3	1	1	7	4	2	1	0	2				21
Attitude of Staff	10	10	3	4	6	4	1	7	6	7	5	1				41
Communication/Information	4	6	6	4	7	5	2	3	1	4	2	1				29
Appointment/Delays	4	18	11	5	11	8	6	10	2	5	9	2				58
Woolwich	34	42	43	26	32	42	36	24	43	31	27	21				282
Clinical Treatment	16	19	14	8	18	26	17	13	22	13	16	12				145
Admission/Discharge	0	4	1	3	0	1	0	0	0	0	1	1				6
Attitude of Staff	4	4	4	4	6	8	3	2	7	5	3	3				41
Communication/Information	5	2	3	5	3	5	5	5	5	0	2	3				33
Appointment/Delays	6	4	11	4	4	2	7	4	5	5	5	2				38
Sidcup	18	21	18	16	8	42	15	13	23	14	16	7				154
Clinical Treatment	8	10	10	7	5	20	9	8	7	4	7	4				71
Admission/Discharge	0	2	0	0	0	7	1	0	0	0	1	0				9
Attitude of Staff	1	0	1	1	1	2	0	1	4	3	3	0				15
Communication/Information	1	3	1	2	0	8	1	1	5	0	2	0				19
Appointment/Delays	5	6	4	4	2	3	2	2	4	1	5	3				26
Lack of Care Nursing	3	0	0	0	0	0	0	0	0	0	0	0				0





Analysis

The numbers of complaints received in December across all sites has reduced. The numbers of open complaints in the Planned Care and ECSM Divisions have also been reduced over the last four months and the Planned Care Division are hitting the trajectory set for reducing the numbers of open complaints and responding in a timely manner. There has also been a very considerably improvement in the ECSM Division response times. Womens, Childrens and Support Services Davison continue to provide consistent responses with a quick turn round.

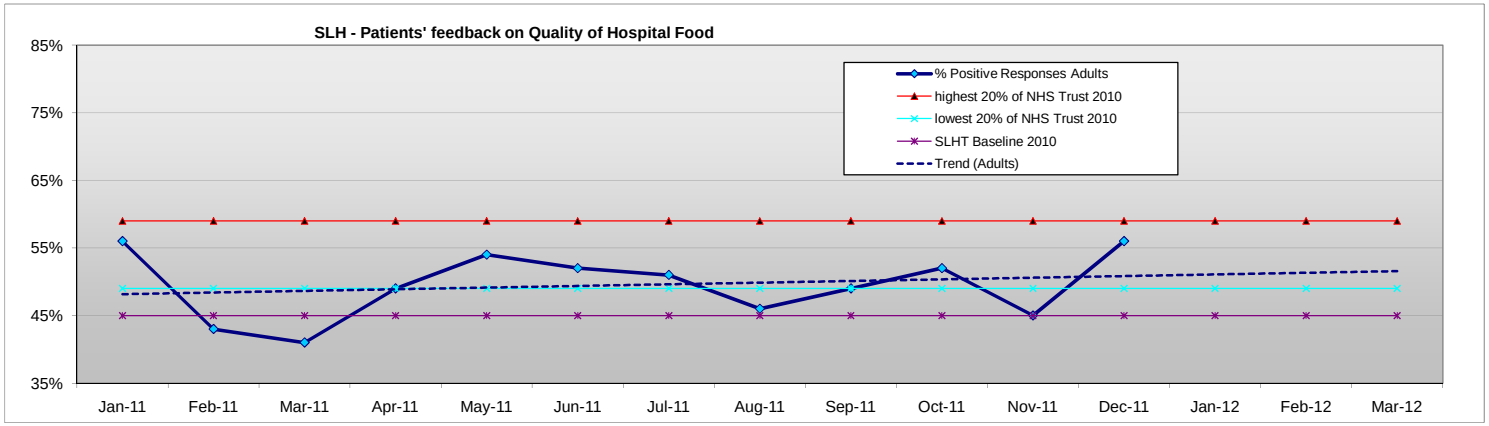
All Divisions are working towards providing appropriate and effective action planning where appropriate to learn from complaints and improve the Patient Experience. Complaints information is included in the Divisional Clinical Governance Reports at which time complaints analysis and information is reviewed.

South London Healthcare NHS
NHS Trust

Hospital Food & Nutrition

Ensure quality and choice of food for patients

Indicator	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
Number of Responses (Adults)	63	9	61	28	138	152	144	129	186	113	55	51			
How would you rate the hospital food?	56%	43%	41%	49%	54%	52%	51%	46%	49%	52%	45%	56%			



Analysis

In response to the question 'How would you rate the hospital food' there were 55 responses for November 2011 and 51 for the month of December 2011 as part of the results from the Trust inpatient survey. The level of positive feedback from these respondents was 46% for November and 56% for December. There has been a gradual reduction in the total number of responses for the inpatient survey which we hope to resolve by the introduction of a new system of real time patient feedback in April 2012.

A Trust Wide Catering Review was completed in 2011. The purpose of the review was to identify the current status of the catering provision across all 3-hospital sites and highlight any opportunities to improve the quality and choice to patients. Consultations with the Trust Food and Nutrition steering group and the PEAT team highlighted a number of areas where improvements could be made which include:

- a review of the levels of production and the quantity of meals delivered to the wards to ensure all the patients receive a full choice of menu items at the point of service
- to provide a more efficient process for supplying special dietary requirements to meet individual's specific needs
- to consider the introduction of a standard menu throughout the Trust

A food tasting event was held in November 2011 which was attended by representatives from key stakeholders including Bromley LINk and Age UK. The aim of the event was to introduce the attendees to a variety of meals that may be suitable for a future menu and to make a comparison between regenerated chilled and frozen products. The output of the tasting event will be implemented in the new menu to be introduced in 2012. A pilot of the new menu that will include a baked potato, salad and sandwich option as well as the hot food menu has commenced in January for a month on a small sample of wards. The pilot will involve greater engagement of the catering hostesses in presenting menus to patients which will ensure that patients receive the right food, at the right time and in the right place. Surveys will be undertaken before, during and after the pilot to evaluate patient's opinion of the quality of their food. The output of the pilots will be collated and reported back to the Food & Nutrition Group and will formulate the final Food & Nutrition Policy.

We continue to work closely with Lynda Stimson from Bromley LINk and Age UK in a programme of mystery shopper exercises. Working with Lynda we are hoping to roll this initiative out to all sites of the Trust this year.

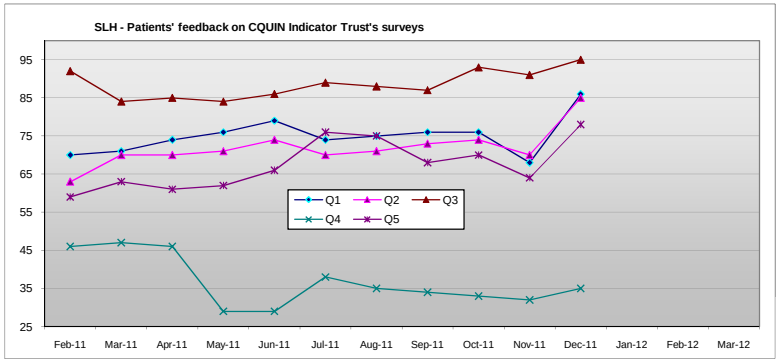
South London Healthcare NHS Trust

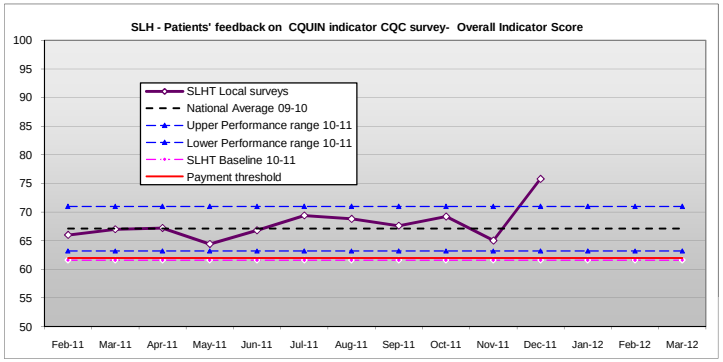
Improving responsiveness to personal needs of patients: CQUIN indicator

Monitoring and improving payment based CQUIN indicator for patient experience that focuses on responsiveness to the personal needs of patients

Best performing 20% of Trust
Intermediate 60% of Trusts
Worst performing 20% of Trust

Indicator	Target	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	2010/11 SLHT Baseline CQC
Number of Responses (Adults)		98	119	136	138	152	144	129	186	113	55	51				380
Q1. Were you involved as much as you wanted to be in decisions about your care and treatment?	≥74	70	71	74	76	79	74	75	76	76	68	86				66
Q2. Did you find someone on the hospital staff to talk to about your worries and fears?	≥64	63	70	70	71	74	70	71	73	74	70	85				57
Q3. Were you given enough privacy when discussing your condition or treatment?	≥84	92	84	85	84	86	89	88	87	93	91	95				79
Q4. Did a member of staff tell you about medication side effects to watch for when you went home?	≥52	46	47	46	29	29	38	35	34	33	32	35				37
Q5. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	≥81	59	63	61	62	66	76	75	68	70	64	78				67
Overall SLHT Indicator Score (Local surveys)	≥71	66	67	67	64	67	69	69	68	69	65	76				61





Analysis

As part of the CQUIN for patient experience there are 5 key questions that relate to improving overall responsiveness to the personal needs of patients as shown above. The results shown above are from the Trust internal patient survey compared with the baseline of the Trust results from the 2010 National Inpatient survey. For the month of November 2011, 55 patients responded to the 5 questions and 51 Patients responded in December 2011.

As already identified in the food section of this report, there has been a gradual reduction in the total number of responses for the inpatient survey which we hope to resolve by the introduction of a new system of real time patient feedback in April 2012. The responses have continued to be consistent however as in previous board reports the results identify a need for improvement on two key questions as follows: “Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?” And “Did a member of staff tell you about medication side effects to watch for when you went home?”

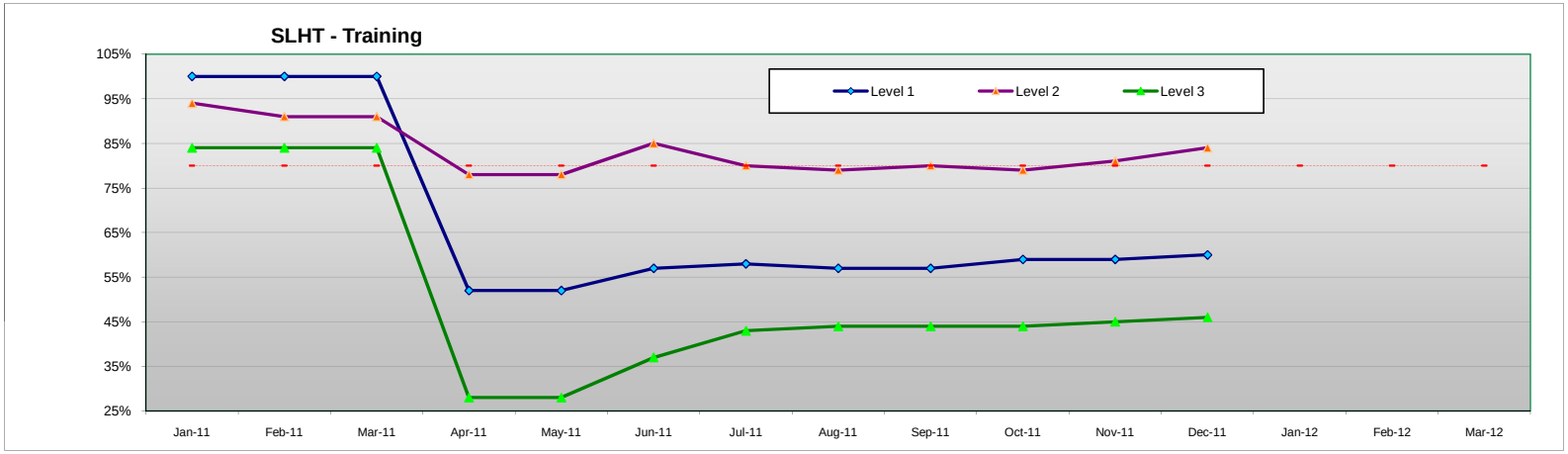
To address this we are going to introduce some discharge telephone interviews with patients following discharge from hospital using some of the questions that are currently part of the Trust inpatient survey. We are conducting a pilot on the 2nd February 2012 with the support of the Patient experience team and Trust wide volunteers. A Discharge Action group was established in 2011 in response to the reports from Bromley and Greenwich LINks on discharge from hospital. Through this group, work is progressing on agreeing the content of key documentation that will provide patients and next of kin with the required level of information needed in preparation for discharge from Hospital. This will provide clear guidance to patients regarding who they should contact if they are worried about their condition and also specific advice relating to their medication. The membership of the Discharge Action group includes members of

South London Healthcare NHS
NHS Trust

Children's Safeguarding

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

Indicator	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
Supervision for safeguarding staff	63%	63%	63%	63%	63%	63%	100%	100%	100%	100%	100%	100%			
SLHT Training: Level 1	100%	100%	100%	52%	52%	57%	58%	57%	57%	59%	59%	60%			
Level 2	94%	91%	91%	78%	78%	85%	80%	79%	80%	79%	81%	84%			
Level 3	84%	84%	84%	28%	28%	37%	43%	44%	44%	44%	45%	46%			
Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%



Analysis

Level 3 Children's safeguarding training currently shows 46% compliance. The framework for training changed last year with the required hours increasing for level 3. For level 3 (applicable to staff working in high risk areas) the requirement is 12-16 hours of training over a year period. There are a number of issues that are currently impacting on our ability to provide an accurate position and action is being taken to address these.

The issues affecting compliance and actions being taken are as follows:

•The database currently being used is not sufficiently sophisticated to collect number of hours completed. At present individuals are only recorded as being fully compliant if 16 hours have been completed within the last 3 years. A new methodology that is sensitive to the requirements is being agreed.
•Work is underway to determine for each individual who requires level 3 training how many hours they are outstanding to achieve compliance.
•Work continues to correct the mismatch in training figures between the service areas and the training department.
•Individuals who have had 12 hours training over the last 3 years need to be recorded as compliant which is not currently the case.

The availability of training is not an issues but releasing staff and low attendance are areas that are being addressed. This work is being lead by a one of the named doctors for children's safeguarding supported by the lead nurse and training department.

South London Healthcare NHS
NHS Trust

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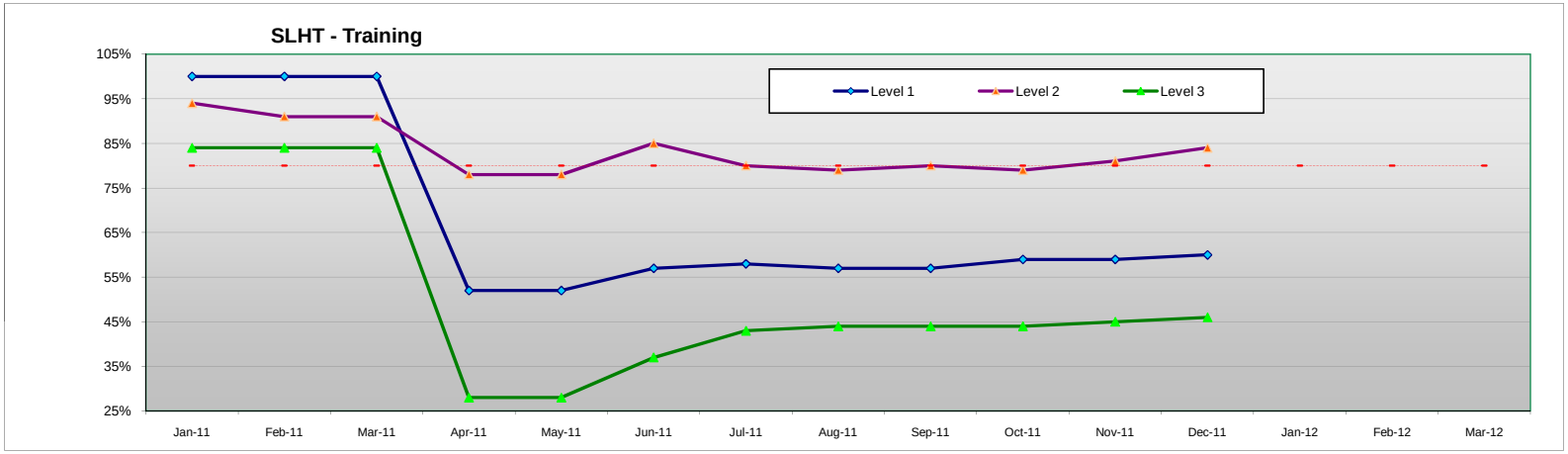
SLHT Training: Level 1	100%	100%	100%	52%	52%	57%	58%	57%	57%	59%	59%	60%			
Level 2	94%	91%	91%	78%	78%	85%	80%	79%	80%	79%	81%	84%			
Level 3	84%	84%	84%	28%	28%	37%	43%	44%	44%	44%	45%	46%			
Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%



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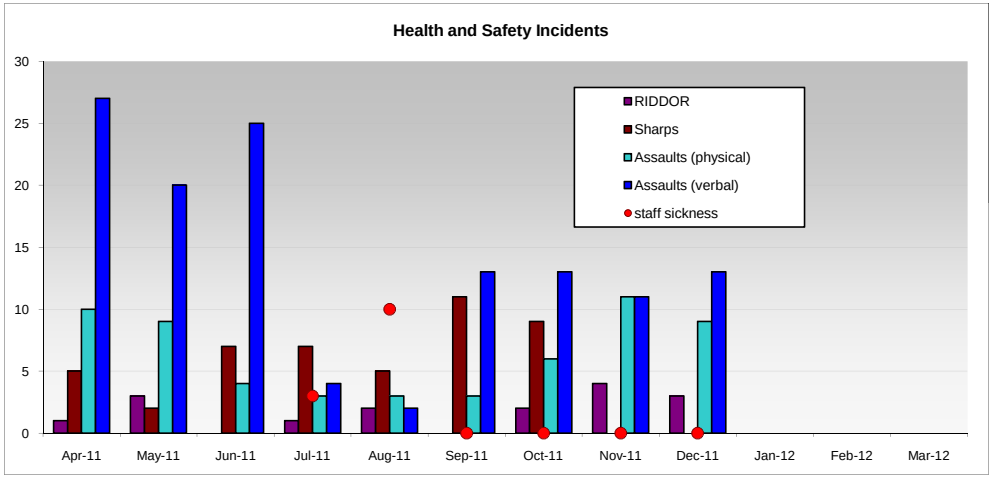
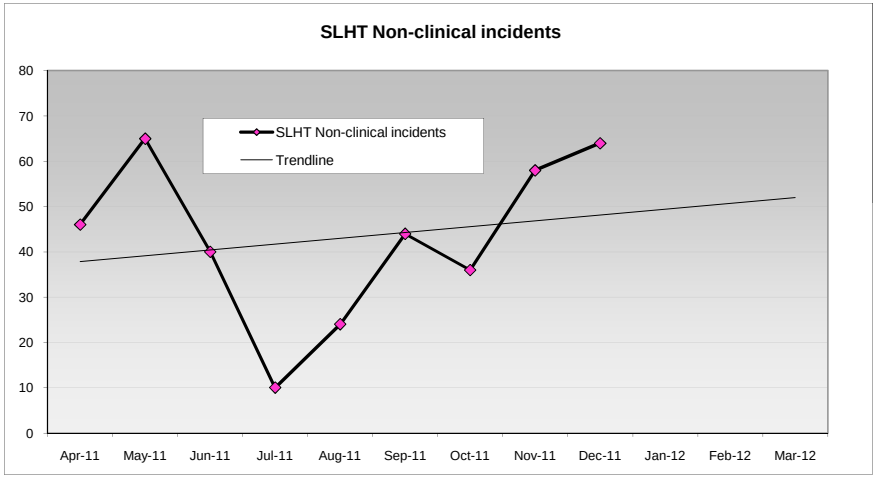
South London Healthcare NHS
NHS Trust

Health and Safety - Non Clinical Incidents

Non clinical incidents. Health and Safety incidents (slips, trips, falls, spills, splashes)
The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR), place a legal duty
to report work-related deaths, major injuries or over-three-day injuries, work related diseases, and dangerous occurrences (near miss accidents).

Indicator	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Total SLHT Non-clinical incidents	46	65	40	10	24	44	36	58	64			
YTD 11-12	46	111	151	161	185	229	265	323	387			
RIDDOR	1	3	0	1	2	0	2	4	3			
RIDDOR related staff sickness absence (days)				3	10	0	0	0	0			
Sharps	8	4	5	2	7	7	5	11	9			
Assaults (physical)	10	9	4	3	3	3	6	11	9			
Assaults (verbal)	27	20	25	4	2	13	13	11	13			





Analysis

The Trust-wide H&S Internal Audit campaign commenced in early November 2011 in accordance with the guidelines as set down by the HSE. Additionally, this process allows for the promulgation of an inspection format that includes an action plan that can be outlined with responsibilities and will provide a record of outstanding actions having been completed where necessary. This is also in keeping with the Townsend Turner recommendations which continues to gain momentum towards it's completion. HSE is satisfied that appropriate remedial action has been taken in the Trust regarding the National Inspection Programme: Preventing Dermatitis in the NHS and this case has now been formally closed.

ENC B

SOUTH LONDON HEALTHCARE NHS TRUST

Subject	Patient Safety Action Plan 2012/13
Report by	Jennie Hall, Deputy Chief Executive / Chief Nurse
Author	Dominic Ford, Assistant Director of Governance
Accountable Executive Director	Jennie Hall, Deputy Chief Executive / Chief Nurse

TRUST OBJECTIVE

Our Patients	**X**
Financial Viability	**X**
Leadership and Workforce	**X**
High Quality Clinical Care	**X**
Healthcare Acquired Infections	**X**
National and Local Priorities	**X**
Service and Facilities fit for the future	**X**

GLOSSARY

Abbreviation	**In Full**
SI	Serious Incident
HSMR	Hospital Standardised Mortality Ratio
PIs	Patient Incidents
NHSL	NHS London
VTE	Venous Thrombus-Embolism
ECSM	Emergency Care and Specialist Medicine
CQUIN	Commissioning for Quality and Innovation
PRUH	Princess Royal University Hospital
QEH	Queen Elizabeth Hospital
QMS	Queen Mary's Sidcup
LINks	Local Involvement Networks
WCSS	Women's Children & Support Services
HSE	Health and Safety Executive
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
H&S	Health and Safety

WRITTEN REPORT (provided in addition to cover sheet) Yes

POWERPOINT PRESENTATION No

ENC B

SOUTH LONDON HEALTHCARE NHS TRUST

PURPOSE OF THE REPORT

To provide a review of progress with the Trust Patient Safety Action Plan and a renewed Patient Safety Action Plan for 2012/13.

SUMMARY OF KEY ISSUES

Trust has seen sustained improvements in mortality and harm since 2009/10. A new target is being set to save 500 lives by December 2013 as measured by actual vs. expected deaths

SUMMARY OF KEY RISKS

Key patient safety risks are referred to in the Board Assurance Framework and include VTE, hospital acquired pressure ulcers and the C difficile position.

RECOMMENDATION / DECISION REQUIRED

To **REVIEW** and **APPROVE** the Patient Safety Action Plan

IMPLICATIONS

Are there any implications for Care Quality Commission Registration?	YES
Is an Equality Impact Analysis Required?	NO
Are there any legal Implications arising from this item?	NO
Are there any Financial implications arising from this item?	NO

Trust Board

25th January 2012

Patient Safety Action Plan

1. Background

1.1 The Trust Patient Safety Action Plan, which was developed in 2009, focused on a number of priorities, with the target of a measurable reduction in avoidable patient harm:

- Infection prevention
- Falls
- Pressure ulcers
- Deteriorating patients
- WHO surgical checklist
- VTE

1.2 The Trust Board *Patient Safety and Experience report* has enabled ongoing scrutiny of progress with the Patient Safety Action Plan, complemented by the monitoring of the Clinical Governance and Infection Prevention Committees.

2. Measuring progress

2.1 Internal and external assurance provides objective evidence of progress in the Trust patient safety profile.

Harm

2.2 Sustained progress can also be demonstrated in harm to patients.

2.3 Pressure ulcers have reduced from 40 per month in 2010/11 to 30 per month in 2011/12, with no grade 4 pressure ulcers in 2011/12.

2.4 Similarly the number of falls has reduced by 15% in 2011/12 while the number of falls resulting in major harm has fallen even more sharply.

Mortality

2.5 A sustained improvement in absolute and relative mortality has been observed which may be attributed to service redesign, senior clinical involvement in decision-making and systematic scrutiny of mortality among other factors. In the Dr. Foster Hospital Guide (2011) the Trust was one of only 7 Trusts whose mortality rates was *lower than expected* for 3 of the 4 mortality categories in the Guide.

2.6 This equated to 377 fewer deaths than expected in the period from April 2010 to present.

Table 1: Dr. Foster Hospital Guide (2011)

Deteriorating patients

2.7 A Trust Vital Signs strategy was developed and approved by the Trust Clinical Governance Committee in March 2011, and implemented in May 2011. It provides a standardised approach to the monitoring of and response to acutely unwell patients. An ongoing clinical audit is monitoring progress with Patient at Risk (PAR) scoring and observation. The most recent audit found PAR scoring at 91% (10% higher than the agreed KPI).

2.8 The Trust *Hospital at Night* strategy has similarly enhanced the safety of the hospitals at night.

WHO Surgical Checklist

2.9 A Never Event concerning wrong-site surgery occurred in July 2010. Investigation found shortcomings in the application of the WHO surgical checklist. A standardised check list and approach has since been implemented across the Trust and will shortly be audited.

Venous thromboembolism

2.10 While progress in documenting VTE risk assessment has been slower than desirable, data from the Dr. Foster *patient safety indicators* indicates that the Trust has fewer than expected incidents of post-operative pulmonary embolism or deep vein thrombosis. Clinical audit data also provides assurance that prophylaxis is appropriate in 95% of cases.

3. Conclusion

3.1 While much has been achieved since the Patient Safety Action Plan was initially developed, it is timely to refresh the plan with a new objective – *Saving 500 lives by December 2013.* This will be measured by the number of actual vs. expected deaths in this period.

3.2 The action plan also includes critical new initiatives around *Hospital at Night,* and the care of patients with dementia.

3.3 It should also be considered alongside the Clinical Services Strategy.

Recommendation: the Board is asked to consider and approve the Patient Safety Action Plan

Dominic Ford
Assistant Director of Governance

Avey Bhatia
Deputy Chief Nurse

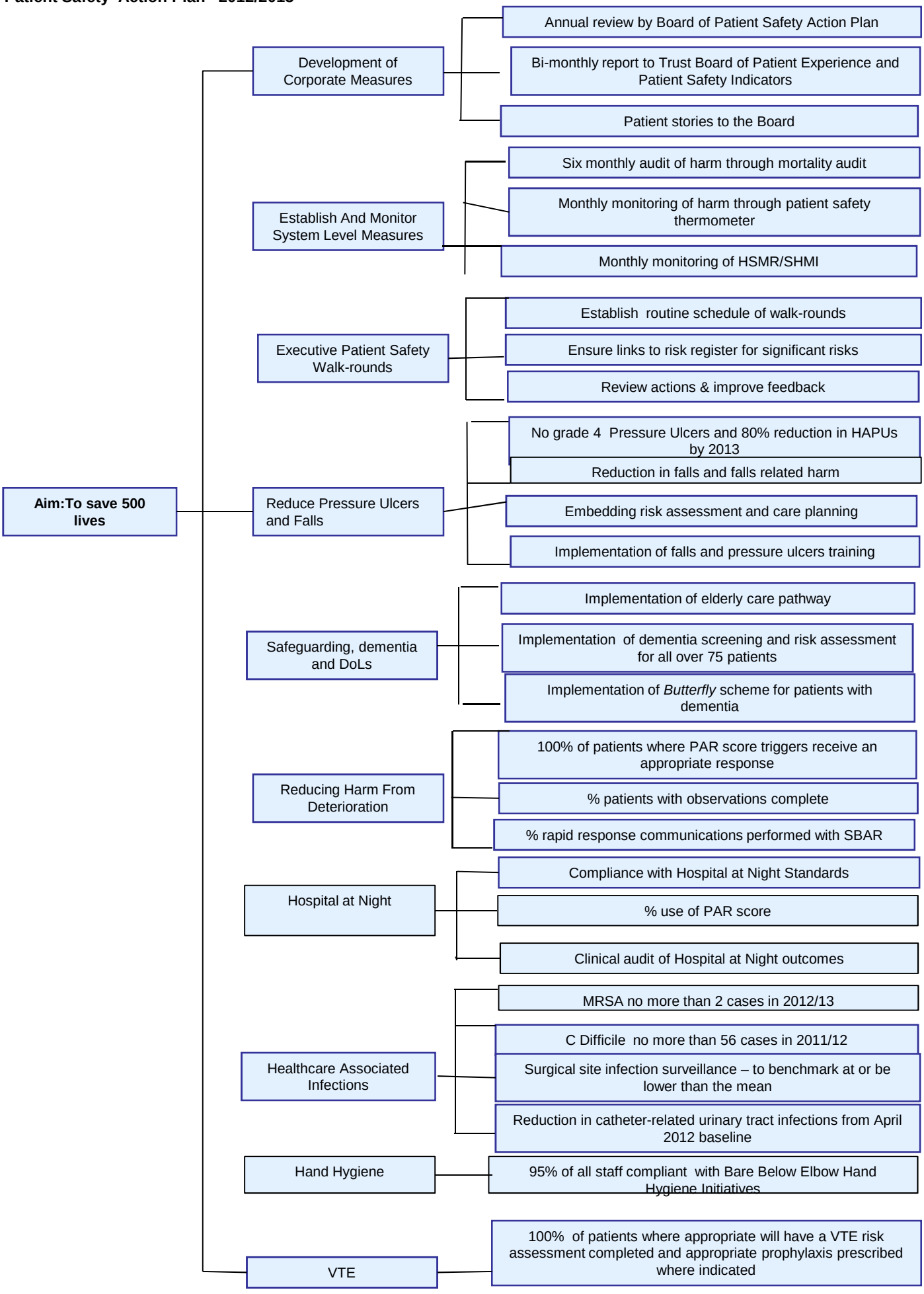
Tracey Cooper
Director of Infection, Prevention and Control

Angela Keating
Head of Patient Safety

January 2012

South London Healthcare NHS
NHS Trust

Patient Safety Action Plan 2012/2013



Patient Safety Action Plan

Overall objective: to save 500 lives by December 2013

- **Note detailed individual plans underpin this high-level plan**

Objectives	Outcome/measure/reporting	Project Lead/Support	Review Date	Actions
Development of Corporate Measures				
Board to review and sign off Action Plan	Documented in Trust Board minutes	Deputy Chief Executive/Chief Nurse	January 2012	The Board regularly reviews patient safety indicators through the Patient Safety and Experience Board report
Patient stories to the Board	Documented in Trust Board minutes	Deputy Chief Executive/Chief Nurse	Ongoing	Continue to use patient stories at Trust Board and in routine patient safety reports
Establish and monitor explicit system level measures				
Reducing avoidable mortality: Undertake a Trust-wide analysis of mortality reviewing 20 case notes on each site every 6 months using the 3x2 matrix & GTT	Track avoidable mortality through mortality audit reports	Head of Clinical Audit & Effectiveness	6 monthly	Continue to undertake every 6 months and report to Trust Clinical Governance Committee
Collect monthly data on patient harm using the NHS Safety thermometer	Number of harm events per 1000 bed days	Head of Patient Safety	Monthly from April 2012	Agree process for collecting and reporting safety thermometer data
Monthly monitoring of Hospital standardised Mortality rates (HSMR) and Summary Hospital Mortality Indicator (SHMI)	Dr Foster alerts monitored through the Clinical Governance Committee	Medical Director/Patient Safety Lead	Monthly review	Continue to review HSMR and mortality alerts monthly and undertake review as required

Healthcare Associated Infections (HCAI)	The number of cases of *Clostridium difficile* diarrhoea The number of cases of MRSA bacteraemia	DIPC	Monthly review	Reduce cases of MRSA & Clostridium difficile in line with 2012/13 trajectories
Pressure Ulcer Prevention	The number of pressure ulcers developed in hospital	Deputy Chief Nurse		Trajectory agreed to reduce pressure ulcers by 80% by April 2013
Falls prevention	The number of in-patient falls per 1000 bed days; and falls by severity of harm	Deputy Chief Nurse	Bi-monthly	Reduce numbers of falls and falls-related harm
Executive Patient Safety Walk-rounds				
Continue Leadership Patient Safety Walk-rounds	Number of walk-rounds completed	Head of Patient Safety	Bi-monthly	Agree schedule of Patient Safety Walk-rounds
Ensure a robust feed-back process is in place	Number of actions identified and completed	Head of Patient Safety	Bi-monthly	Review and strengthen the process for feeding back to staff
The Reduction of Hospital Acquired Pressure Ulcers				
Continued implementation of the pressure ulcer action plan. Focus on development of the wound link nurse role, meeting staff educational needs and comprehensive timely risk assessment and provision of pressure relieving equipment.	Number of hospital acquired pressure ulcers. Relative risk reported by Dr Foster	Deputy Chief Nurse	Monthly review	Monthly strategic and site based meeting to review progress against action plan
Falls Management				
Develop & implement a plan for falls prevention training	% of appropriate staff who have received training in falls management in the last 12 months	High Impact Action Delivery Lead	September 2012	Within 18 months 95% of appropriate staff will have received training in falls management in the last 12 months

Patients who need an in depth assessment and plan of care	% of patients who after a fall have appropriate observations documented	High Impact Action Delivery Lead	September 2012	Within 12 months all patients who experience a fall will have all the physiological observations and injury checklists recorded immediately after the fall
Review of educational & training needs - 4 basic assessments and safety for all patients	90% of patients will receive the 'four basics' by April 2012.	High Impact Action Delivery Lead	September 2012	The 4 basics 1) Ask patients on admission if they have fallen recently 2) Avoid unnecessary hypnotic and sedative medications 3) Ensure patients have appropriate footwear 4) Ensure call bells are within reach
Reducing Harm From Deterioration				
Continue implementation of standardised observations charts across the 3 sites	% of patients with observations complete	Lead Nurse- Critical Care Outreach Team	July 2012	Graded response strategy and escalation protocol incorporated in Vital signs strategy and implementation
Ongoing monitoring of graded response strategy	% of patients that triggered who received an appropriate response	Lead Nurse- Critical Care Outreach Team	July 2012	As above
Ongoing implementation of escalation protocol	%of patients that triggered who received an appropriate response	Lead Nurse- Critical Care Outreach Team	July 2012	As above
A communication tool should be used for all patients to escalate concern between team members. Examples of widely used tools include SBAR and RSVP	% rapid response communications performed with SBAR	Lead Nurse- Critical Care Outreach Team	July 2012	Implementation of SBAR template Situation Background Assessment Recommendation (SBAR)

Hospital at Night				
Hospital at Night is a clinically driven and patient focused change program. To enhance patient safety and outcomes and supports medical training and service delivery. SLHT to ensure all Hospital at Night standards are being met	Bleep filter, use of PAR score and graded response and clinical outcomes through Audit Lead:	Lead Nurse- Critical Care Outreach Team	September 2012	Continue to embed and review Hospital at Night scheme and report to Trust CG
Healthcare Associated Infections				
Further reductions in MRSA bacteraemia numbers to no more than 2 in 2012/13	The number of cases of Trust acquired MRSA bacteraemia	Director of Infection Prevention and Control	September 2012	Detailed action plan to reduce HCAI's reviewed routinely at Infection Prevention Committee
Further reductions in *Clostridium difficile* numbers to no more than 56 cases in 2012-13	The number of cases of Trust acquired *Clostridium difficile* diarrhoea	Director of Infection Prevention and Control	September 2012	As above
Hand hygiene initiatives - all wards are participating in Hand Hygiene Practice audits & staff comply with Bare Below the elbows to minimise/reduce the risk of HCAI to patients	95% compliance by staff as a minimum by year end	Director of Infection Prevention and Control	September 2012	Quarterly audit of hand hygiene compliance in clinical areas will demonstrate sustained improvements.
Surgical site infection surveillance minimise/reduce the risk of HCAI to patients by continued compliance with hygiene code	Benchmark at or lower than the mean (50th percentile) in all surveillance where comparative national data is available by end of year	Director of Infection Prevention and Control	September 2012	Mandatory surveillance of orthopaedic Surgical Site Infection (SSI) has been completed for a minimum of one quarter as required by the DH.
Reduce catheter-associated UTI from April 2012 baseline.	Percentage and numerical reduction from April 2012 baseline.	Director of Infection Prevention and Control	September 2012	Review of baseline Safety Thermometer data on CA-UTI. Targeted actions put into place

Venous Thrombo-embolism (VTE)				
VTE is a significant patient safety issue. Post-mortem studies suggest that only 1-2 in every 10 fatal pulmonary emboli is diagnosed. This gives the potential to save thousands of lives nationally each year	% of all adult in-patients who have a VTE risk assessment on admission using the national tool	VTE Lead, Consultant Haematologist	Monthly	Risk assessment tool implemented in all Divisions. Routine data collection in place. Audit for appropriate thrombo-prophylaxis planned for February 2012
Safeguarding adults and children				
Protecting adults and children from preventable harm by early detection and intervention is every staff member's responsibility	% of staff trained at the required level SLHTs referral rate (safeguarding alerts / Serious Case Reviews)	Deputy Chief Nurse	Monthly	Delivery of the safeguarding training strategies to ensure compliance at all levels Annual adult plan for children's safeguarding
Roll out Butterfly Campaign in to increase staff awareness and skills in caring for patients with Dementia	% of all patients aged 75 and over who have been screened following admission % of all patients aged 75 and over, who have been screened as at risk of dementia, who have had a dementia risk assessment within 72 hours of admission % wards that have implemented the *Butterfly* scheme % of all patients aged 75 and over, identified as at risk of having dementia who are referred for specialist diagnosis % of staff who have received MCA & DoLs training	Deputy Chief Nurse	Monthly	Implementation of screening and risk assessment tool for dementia. Implementation of *Butterfly* scheme for patients with dementia.

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SOUTH LONDON HEALTHCARE NHS TRUST

Subject	Trust performance report
Report by	Steve Russell, Chief Operating Officer
Author	Steve Russell, Chief Operating Officer
Executive Director	Steve Russell, Chief Operating Officer

TRUST OBJECTIVE

Our Patients	**x**
Financial Viability	**x**
Leadership and Workforce	
High Quality Clinical Care	**x**
Healthcare Acquired Infections	
National and Local Priorities	**x**
Service and Facilities fit for the future	**x**

WRITTEN REPORT (provided in addition to cover sheet) Yes

POWERPOINT PRESENTATION No

PURPOSE OF THE REPORT / PRESENTATION

To confirm the Trust's current performance in respect of the NHS Performance Framework standards and to highlight the key issues facing the Trust and the approach being taken

SOUTH LONDON HEALTHCARE NHS TRUST

SUMMARY OF KEY ISSUES

The two most significant access issues for the Trust remain Referral to treatment and Emergency Access. Underperformance against these standards represents the greatest driver of the Underperforming rating under the DH Performance Framework. These are summarised below.

The NHS Operating Framework has been published for 2012/13 and the Trust has undertaken a gap analysis against the requirements Operating Framework. This has highlighted areas of high, medium and low risk. This analysis is part of the basis for business planning within the Trust and the annual plan for the Trust will set out actions to address these areas. This will be presented to the Board at its next meeting.

Referral to treatment standards

Summary

At the end of November confirmed performance continued to be below the 90% and 95% standards for admitted patients and non-admitted patients. Further detail is provided below.

Over 52 week waits

Following a validation exercise Trust confirmed that there are 38 patients (excluding Bariatrics) who remained on an open pathway after 1 year. 29 patients were scheduled for treatment in December and January and 9 patients were awaiting a clinical decision following diagnostics.

Bariatrics remains a health economy wide issue and a sustainable solution is not yet in place. The 3 PCT's are due to confirm how they wish to manage the waiting list for this group of patients, and there is a further discussion scheduled at the Cluster's Clinical Strategy Group on 19th January 2012.

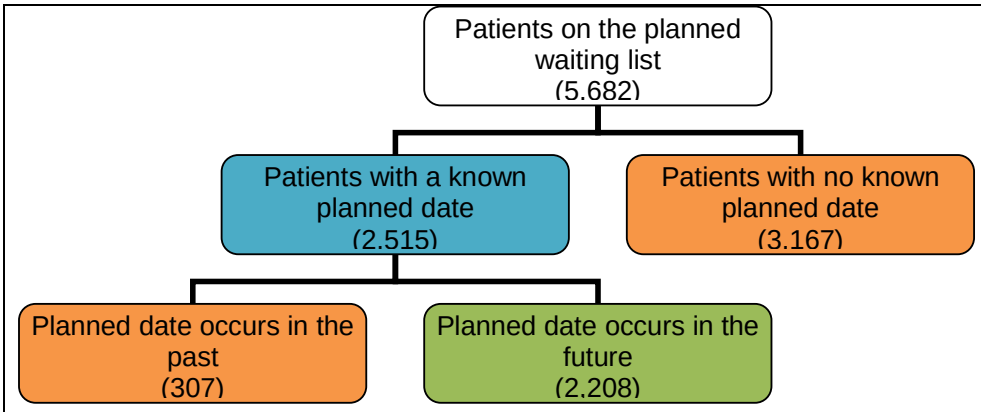
Diagnostics

The Trust has at the end of December reduced the number of people waiting over 6 weeks for diagnostics to 10. This represents a significant achievement and work is now focused on reducing patients who wait more than 6 weeks "in-month". The key risk in diagnostics remains Endoscopy capacity which becomes a greater risk due to the bowel cancer awareness programme which is due to start in January 2012. It is estimated that demand could rise by 18%. SLH has been working with the Cancer Network and Commissioners to ensure that capacity is in place to meet this demand, though this remains work in progress.

Planned waiting lists

The Trust has confirmed its compliance with the DH guidance on planned waiting lists, and has put in place systems to bring the management of the planned waiting list into the same processes as exist for the main waiting list. A summary of the position is shown below

SOUTH LONDON HEALTHCARE NHS TRUST



The Trust is validating the information where the planned date is unknown or where it occurs in the past. This will form part of the performance report in the future.

Admitted Pathways

The performance is below the 90% standard, and is an understood position that arises as a consequence of the Trust's work to remove the "backlog" of patients who are waiting over 18 weeks. In order for admitted performance to improve the backlog needs to be reduced to sustainable levels.

A comprehensive set of proposals have been agreed with Commissioners which aim to deliver admitted performance at 76% in January, just below 90% in February and just above 90% in March. The drop in performance in January represents the treatment of a number of patients who have already waited over 18 weeks.

Whilst the end of November position did not show a reduction in the backlog this represents the timing of the actions that have been taken. The backlog currently stands (week ending 8th January 2012) at 980. This rose over the Christmas period from a position of 928 due to the lower number of working days during the period.

The 95th centile remains high due to the treatment of patients who have already waited for a period over 18 weeks.

The key risks are:

- The clearance of the Orthopaedic backlog, and to a lesser extend the Gynaecology complex cases.
- The demand for Endoscopy
- Bariatric Surgery capacity

Non-admitted pathways

As previously reported the two risk areas for non-admitted are ophthalmology and oral surgery. The 95th centile wait for non-admitted patients is driven by the waits in Opthalmology.

The non-admitted backlog has reduced to 2,247, and a plan has now been agreed to reduce the Opthalmology backlog.

Diagnostics

The Trust will have cleared the 6 week backlog by the end of December, the key issue being Endoscopy capacity where demand continues to represent a significant pressure and risk to this standard. This risk is likely to increase as a consequence of the Bowel Cancer Screening awareness campaign and the Trust is discussing contingency plans with the Sector.

Governance of the 18 weeks standard is being strengthened both internally with a weekly Programme Board, refreshed information and the Trust is meeting with NHS South East London fortnightly to provide assurance on progress.

Cancelled operations

The number of cancelled operations that have not been rescheduled within 28 days has risen in October and November. The flexibility has been constrained as part of the Trust's focus on ensuring patients who have waited for treatment are receiving it, and that capacity is appropriately used. However, this requires additional action to be taken to ensure that this standard is met where patients operations are cancelled.

Performance against the 4 hour standard

Performance in December was 88.2% representing a drop in performance from November. This has resulted in a Quarter 3 position of 90.3%.

The drivers of this performance are different at QEH where the major issue is bed availability for the admitted pathway and at PRUH where the main issue is Emergency Department Capacity, though some improvement in the admitted pathway is still required.

The Trust has now agreed a series of actions to improve performance in both areas with Commissioners and the Urgent Care Network across Bexley, Bromley and Greenwich. The key schemes are summarised below. These interventions have been based on the analysis that was presented to the Board Seminar.

QEH

- Development of ambulatory care
- Additional community based services to expedite discharge
- Senior nursing and therapy cover at weekends to improve discharge rates

SOUTH LONDON HEALTHCARE NHS TRUST

PRUH

- Additional majors capacity through the reorganisation of the site and creation of a new sub-acute area
- Separating ambulatory patients from ambulance patients.
- Additional senior medical presence into the evening
- The development of a third medical team to allow a sub-acute group of patients to be seen in a non-bed based setting earlier in their presentation to hospital.
- Senior nursing and therapy cover at weekends to improve discharge rates, supported by PACE.

The impact and sustainability of these schemes will be measured and reported through the Urgent Care Networks and to Commissioners.

Cancer performance

Whilst performance against the standards remains strong overall, the Trust is reviewing performance in tumour specific pathways to ensure the standards are consistently met at specialty level. This will be shown in future performance reports to the Board.

SUMMARY OF KEY RISKS

Patient experience
Reputation with and confidence of key stakeholders
Requirement to meet TFA milestones in respect of service performance
Financial penalties
Continued pressures in respect of demand

RECOMMENDATION / DECISION REQUIRED

That the performance report is noted, and that an assessment of the Operating Framework in the context of business planning for 2012/13 is considered by the Board, building on the information presented to the Board Seminar in December.

IMPLICATIONS

Are there any implications for Care Quality Commission Registration?	No
Is an Equality Impact Analysis Required?	No
Are there any legal Implications arising from this item?	No
Are there any Financial implications arising from this item?	Yes

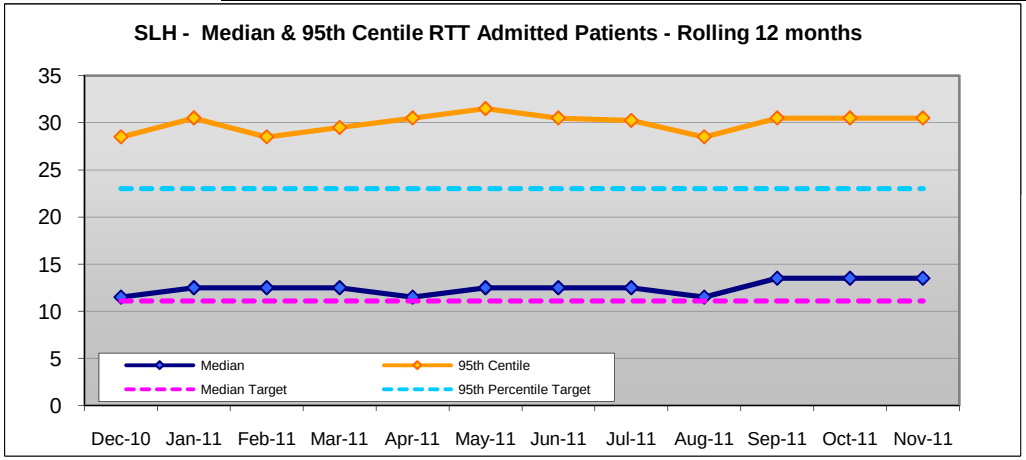
Monthly Service Performance Report: Level 1 - Trust Board

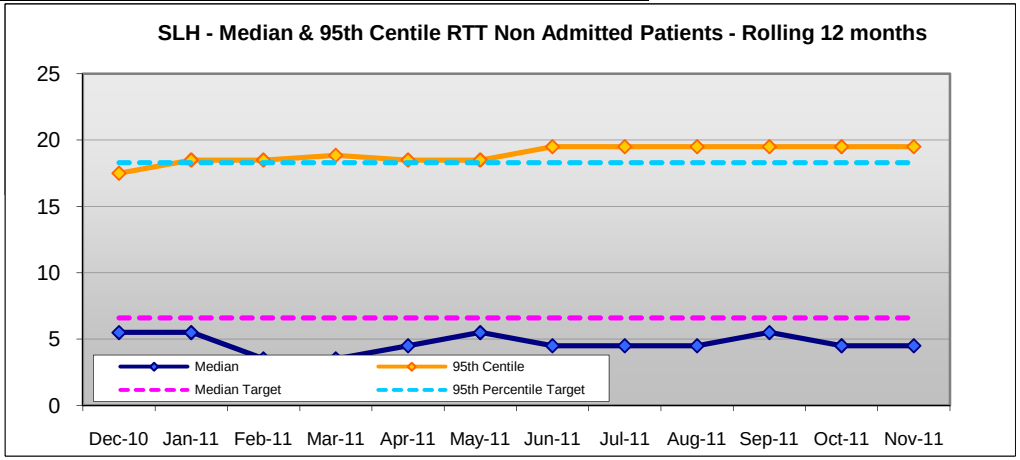
Month 9, December 2011/12

Referral to Treatment - Median & 95th Centile Waiting Times for Patients

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

Indicator	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11
Admitted - Median	11.5	12.5	12.5	12.5	11.5	12.5	12.5	12.5	11.5	13.5	13.5	13.5
Target	11.1	11.1	11.1	11.1	11.1	11.1	11.1	11.1	11.1	11.1	11.1	11.1
95th Centile	28.5	30.5	28.5	29.5	30.5	31.5	30.5	30.3	28.5	30.5	30.5	30.5
Target	23	23	23	23	23	23	23	23	23	23	23	23
Non Admitted - Median	5.5	5.5	3.5	3.5	4.5	5.5	4.5	4.5	4.5	5.5	4.5	4.5
Target	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6	6.6
95th Centile	17.5	18.5	18.5	18.9	18.5	18.5	19.5	19.5	19.5	19.5	19.5	19.5
Target	18.3	18.3	18.3	18.3	18.3	18.3	18.3	18.3	18.3	18.3	18.3	18.3





Analysis

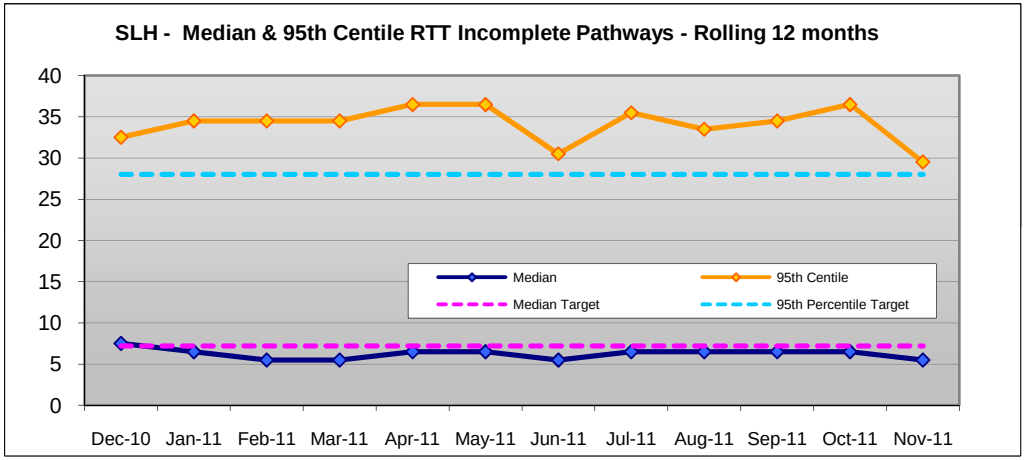
The admitted median and 95th centile performance remained unchanged at 13.5 weeks (target 11.1) and 30.5 weeks (target 23) respectively in November. The non admitted median of 4.5 weeks in November continues to be better than the target of 6.6 weeks, while the 95th centile of 19.5 weeks is worse than the target of 18.3 weeks. The actions detailed elsewhere in this report to improve admitted and non admitted performance will also improve performance to be within the median and 95th centile thresholds.

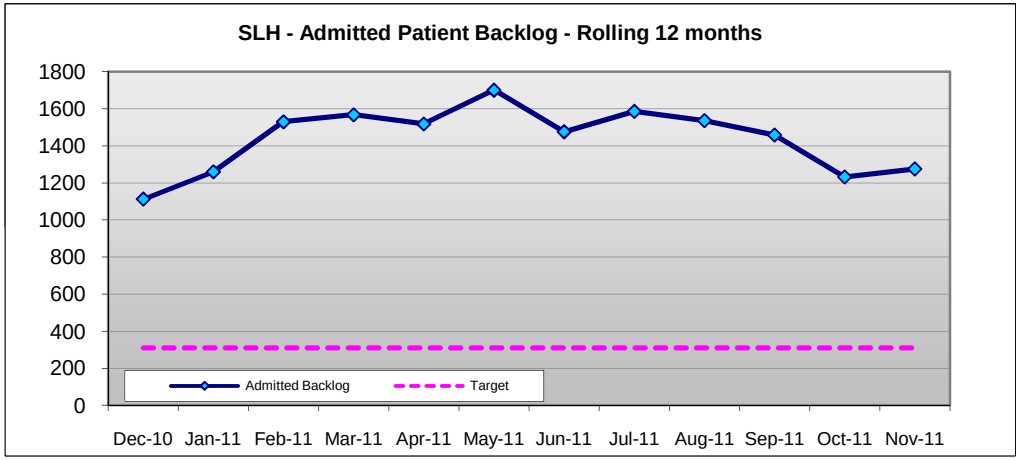
Lead - Steve Russell Chief Operating Officer

Referral to Treatment - Admitted Backlog & Waiting Times for Incomplete Pathways

Backlog of patients waiting for admitted treatment compared to trajectory.
(A20/A21) Median and 95th Centile for incomplete referral to treatment pathways.
Supports Compliance with CQC Outcome 4

Indicator	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11
Median	7.5	6.5	5.5	5.5	6.5	6.5	5.5	6.5	6.5	6.5	6.5	5.5
Target	7.2	7.2	7.2	7.2	7.2	7.2	7.2	7.2	7.2	7.2	7.2	7.2
95th Centile	32.5	34.5	34.5	34.5	36.5	36.5	30.5	35.5	33.5	34.5	36.5	29.5
Target	28	28	28	28	28	28	28	28	28	28	28	28
	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11
Admitted Backlog	1112	1260	1530	1568	1518	1701	1476	1586	1536	1459	1232	1275
Target	310	310	310	310	310	310	310	310	310	310	310	310





Analysis

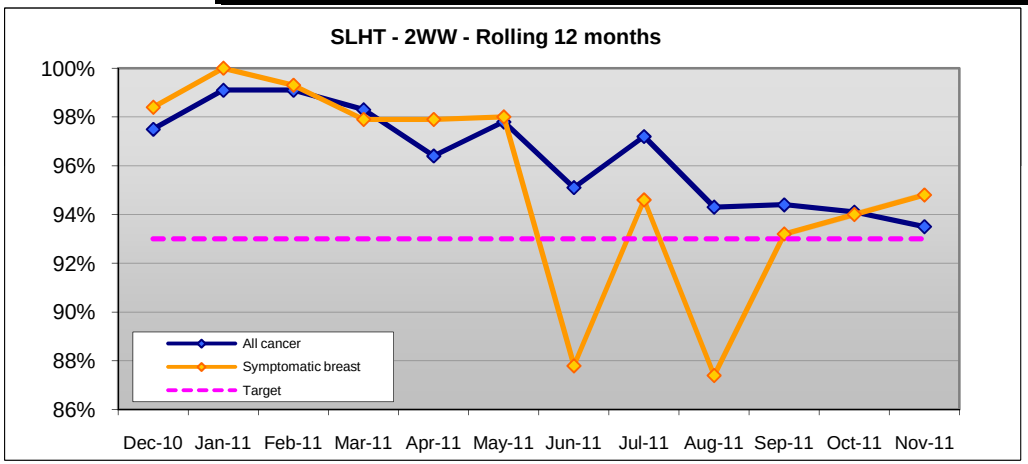
The plans to improve admitted performance are expected to reduce the backlog from 1275 at the end of November to 350 by the end of March 2012. The plan to reduce outpatient waiting times to seven weeks for all specialties except Ophthalmology and to reduce diagnostic waiting times to below six weeks will reduce the number of patients added to the inpatient waiting lists after twelve weeks and allow this position to be sustained.

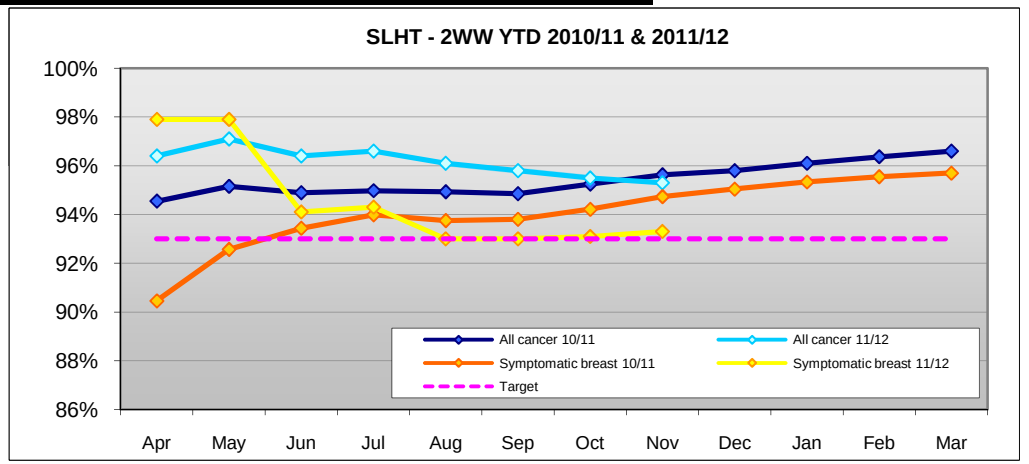
Lead - Steve Russell Chief Operating Officer

Cancer - Two Week Outpatient Wait

National Priority - **(C1)** 93% of Urgent Cancer Outpatient referrals to be seen within two weeks.
(C2) 93% of Urgent Cancer Outpatient referrals for patients with breast symptoms to be seen within two weeks.
Supports Compliance with CQC Outcome 4

Indicator	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11
All Cancer	97.5%	99.1%	99.1%	98.3%	96.4%	97.8%	95.1%	97.2%	94.3%	94.4%	94.1%	93.5%
Symptomatic Breast	98.4%	100%	99.3%	97.9%	97.9%	98.0%	87.8%	94.6%	87.4%	93.2%	94.0%	94.8%
Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
All Cancer YTD 10/11	94.5%	95.2%	94.9%	95.0%	94.9%	94.8%	95.2%	95.6%	95.8%	96.1%	96.4%	96.6%
YTD 11/12	96.4%	97.1%	96.4%	96.6%	96.1%	95.8%	95.5%	95.3%				
Symptomatic Breast YTD 10/11	90.5%	92.6%	93.4%	94.0%	93.8%	93.8%	94.2%	94.7%	95.0%	95.3%	95.6%	95.7%
YTD 11/12	97.9%	97.9%	94.1%	94.3%	93.0%	93.0%	93.1%	93.3%				
Target	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%





Analysis

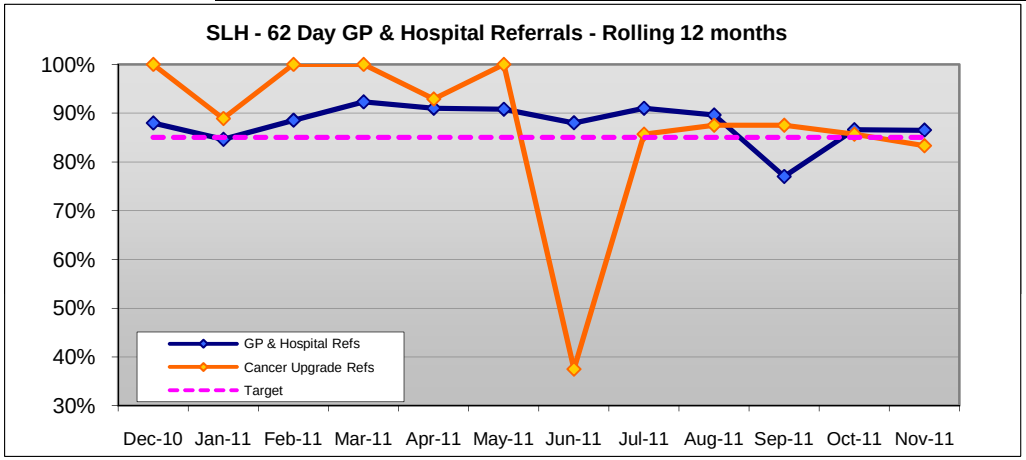
2WW performance in October was 93.5% and symptomatic breast 94.8%, both better than the target of 93%. This provides a year to date position for all cancers of 95.3% and 93.3% for symptomatic breast.

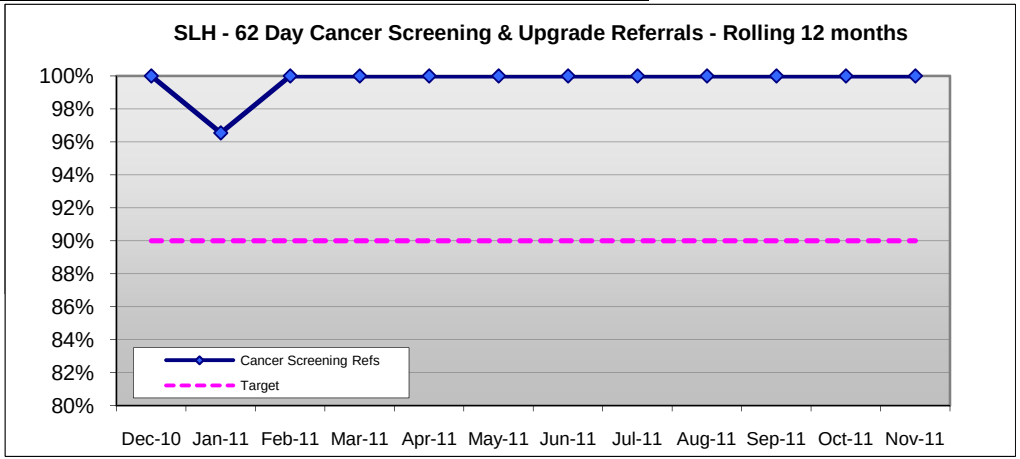
Lead - Steve Russell Chief Operating Officer

Cancer - 62 Days for Referral to Treatment

National Priority - **(C8)** 85% of Urgent GP referrals and patients referred by a hospital specialist where cancer is diagnosed, receieve first definitive treatment within 62 days of referral.
(C9) 90% of patients referred by an NHS cancer screening service receive first definitive treatment within 62 days of referral.

Indicator	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11
GP & Hospital Refs	88.0%	84.6%	88.5%	92.3%	91.0%	90.8%	88.0%	91.0%	89.6%	77.0%	86.6%	86.5%
Cancer Upgrade Refs	100%	88.9%	100%	100%	92.9%	100.0%	37.5%	85.7%	87.5%	87.5%	85.7%	83.3%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Cancer Screening Refs	100%	96.6%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%





Analysis

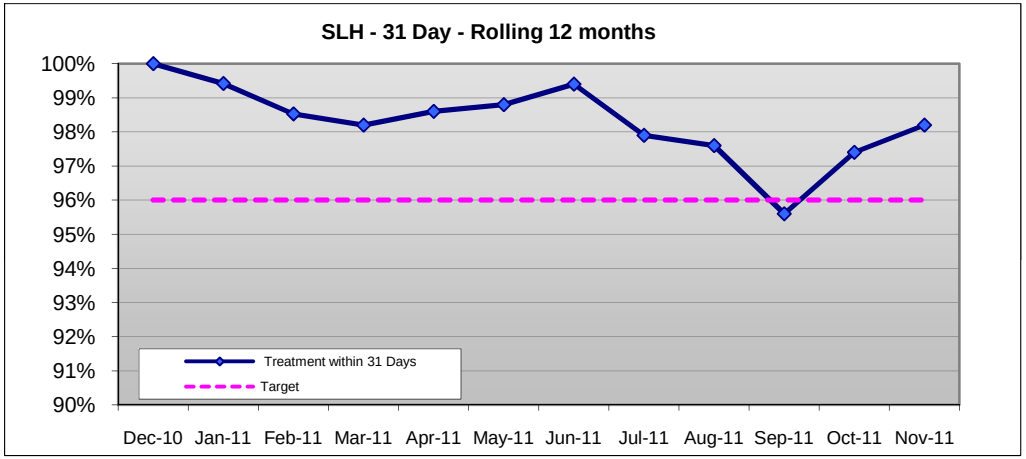
Performance exceeded the threshold for two of the three 62 day cancer targets with performance of 86.5% (target 85%) for GP and hospital referrals and 100% (target 90%) for cancer screening referrals. Performance for cancer upgrades was slightly below the threshold of 85%. In November activity for this target was unusually low with only 4 patients commencing treatment. For one patient there was a delay in commencing treatment due to the patient being on holiday and the planned procedure having to be changed.

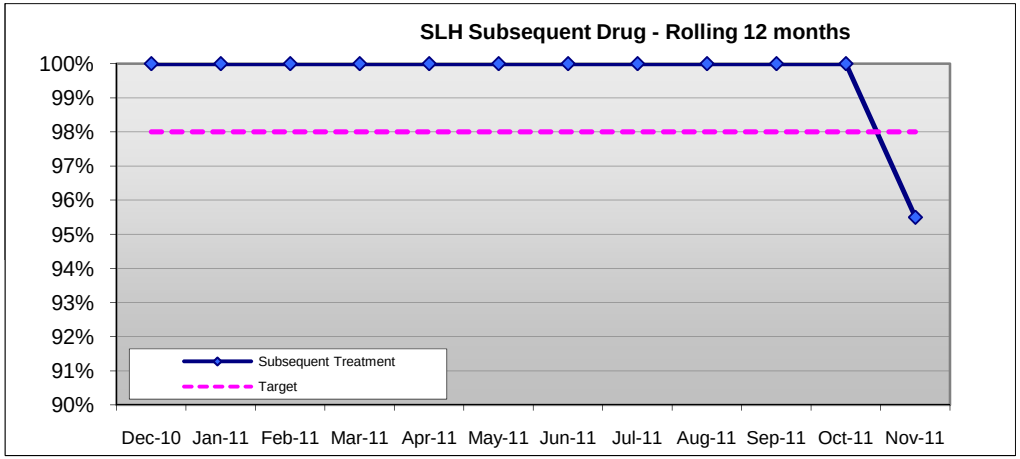
Lead - Steve Russell Chief Operating Officer

Cancer - 31 Days from Diagnosis to Treatment

National Priority - **(C3)** 96% of cancer patients to be treated within 31 days of diagnosis.
(C4) 98% of patients requiring subsequent drug treatment to be treated within 31 days.
Supports Compliance with CQC Outcome 4.

Indicator	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11
Treatment within 31 days of diagnosis	100%	99.4%	98.5%	98.2%	98.6%	98.8%	99.4%	97.9%	97.6%	95.6%	97.4%	98.2%
Target	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%
Subsequent drug treatment required	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95.5%
Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%





Analysis

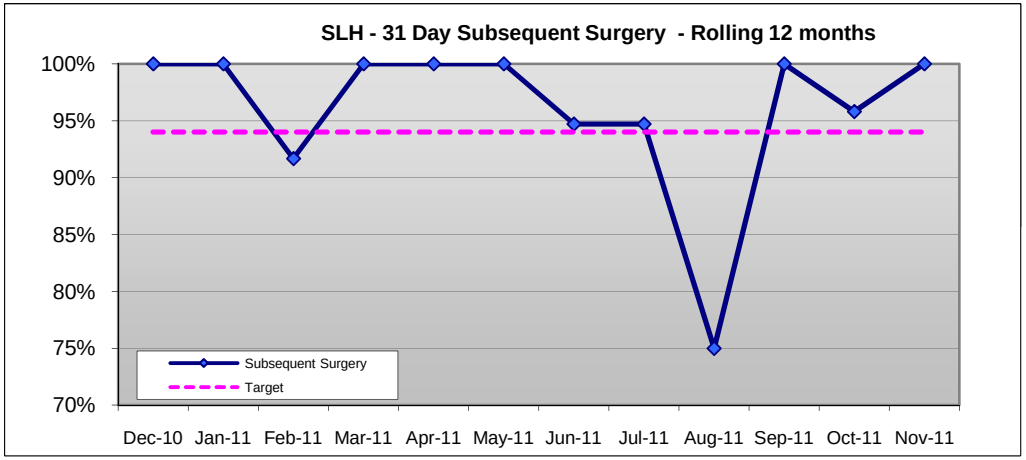
Performance against the cancer 31 day diagnosis to treatment target in November was 98.2% which is above the target of 96%. Performance against the target for subsequent drug treatment at 95.5% was slightly below the target of 98%. Normally performance against this target is 100%. The volume of patients treated is small and one patient waited longer than 31 days for subsequent drug treatment for clinical reasons.

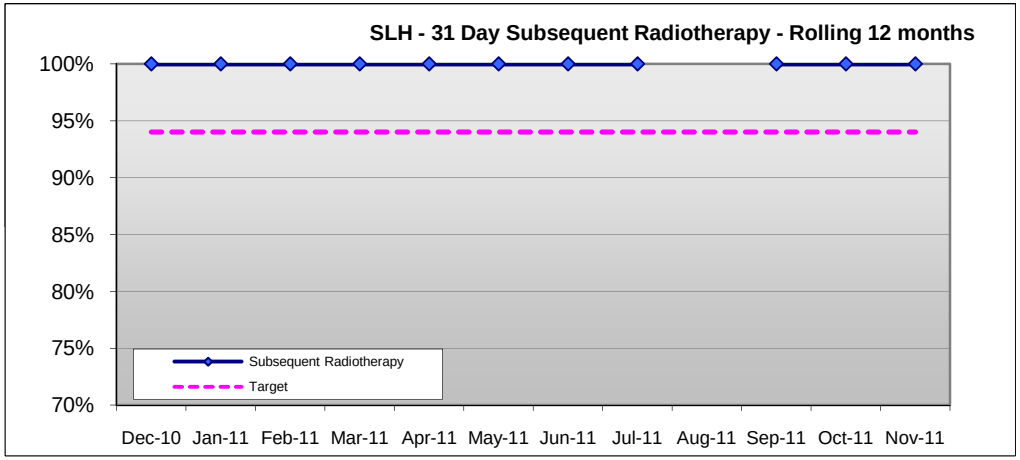
Lead - Steve Russell Chief Operating Officer

Cancer - 31 Days from Diagnosis to Treatment

National Priority - **(C5)** 94% of cancer patients requiring subsequent surgery to be treated within 31 days.
(C6) 94% of patients requiring subsequent radiotherapy to be treated within 31 days.
Supports Compliance with CQC Outcome 4.

Indicator	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11
Subsequent Surgery required	100%	100%	91.7%	100%	100%	100%	94.7%	94.7%	75.0%	100%	96%	100%
Target	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%
Subsequent Radiotherapy or all other treatment	100%	100%	100%	100%	100%	100%	100%	100%	no activity	100%	100%	100%
Target	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%





Analysis

Performance in November for both targets continues to exceed the threshold of 94%.

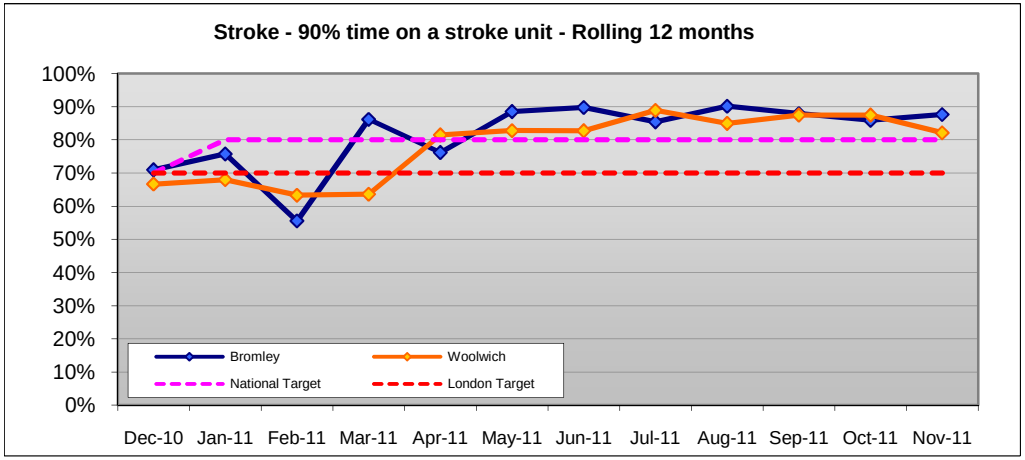
Lead - Steve Russell Chief Operating Officer

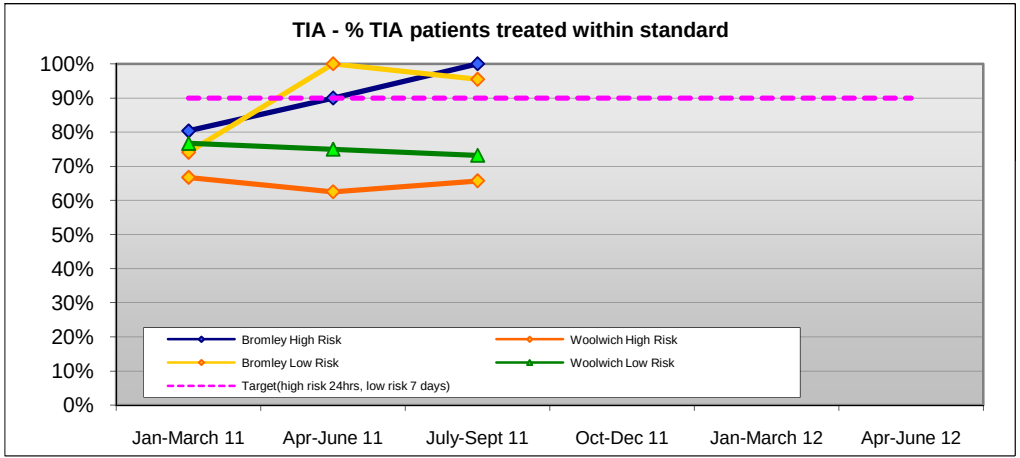
Stroke Services - Time on a Stroke Unit and TIA Service

National Priority - **(CE2)** 80% of stroke patients to spend more than 90% of their stay in hospital on a stroke unit.
(CE3) 90% of high risk TIA patients to be treated within 24 hours. 90% of low risk TIA patients to be treated within 7 days.
Supports Compliance with CQC Outcome 4.

Indicator	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11
Bromley 90% time	71.0%	75.8%	55.6%	86.2%	76.2%	88.6%	89.8%	85.5%	90.2%	88.0%	85.9%	87.7%
Woolwich 90% time	66.7%	68.0%	63.3%	63.6%	81.5%	82.8%	82.8%	88.9%	85.0%	87.5%	87.5%	82.1%
National Target	70%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
London Target	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%

	Jan-March 11	Apr-June 11	July-Sept 11	Oct-Dec 11	Jan-March 12	Apr-June 12
Bromley High Risk	80.4%	90%	100%			
Bromley Low Risk	74.1%	100%	95.5%			
Woolwich High Risk	66.7%	62.5%	65.7%			
Woolwich Low Risk	76.7%	75.0%	73.2%			
Target	90%	90%	90%	90%	90%	90%





Analysis

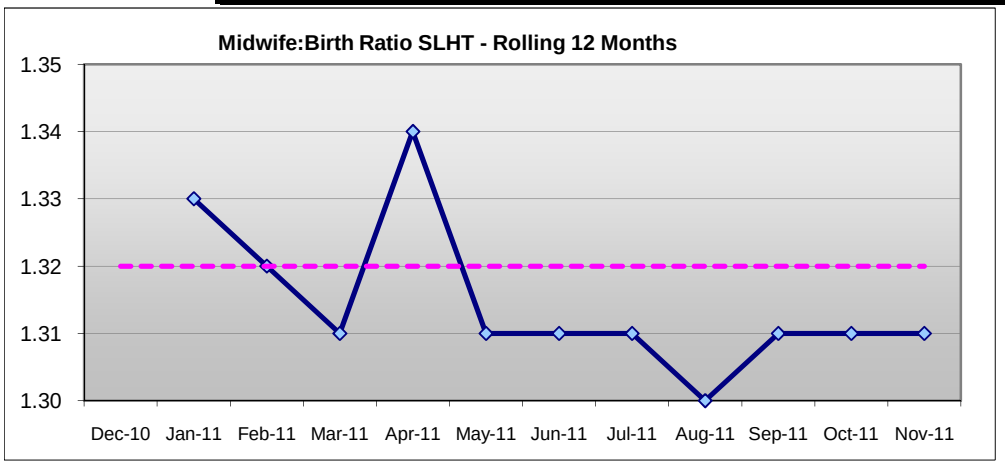
This month shows continued achievement on both sites of the 80% target for patients with a diagnosis of stoke spending more than 90% of their time in a stroke unit. TIA performance is monitored quarterly and the indicator has been changed to show performance against the London stroke network standards of 24 hours for high risk and 7 days for low risk referrals from first contact with a health care professional. This is more representative of performance as it covers all TIA patients and not just those treated in an outpatient setting. The standard is 90% for both indicators and this is being achieved at Bromley. Performance at Woolwich in quarters 1 and 2 was below 90% and an action plan is being implemented to address this which includes a redesigned patient pathway, improvements to the referral process and better data capture. Quarter 3 TIA performance will be reported next month.

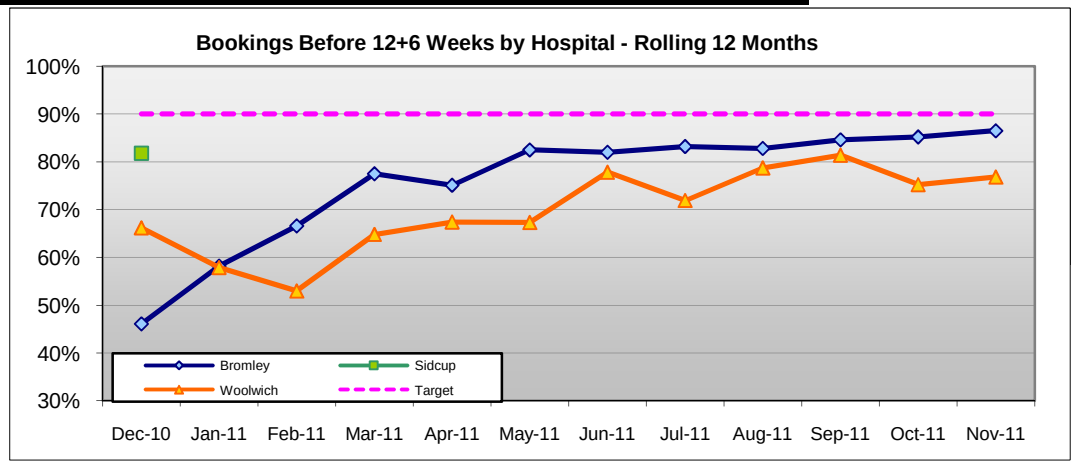
Lead - Steve Russell Chief Operating Officer

Maternity & Midwifery Services

Local Priority - **(CE23)** to reduce the midwife:birth ratio to 1:32
Local Priority - **(A27)** 90% of women to have seen a midwife for assessment by 12 weeks and 6 days of pregnancy
Supports Compliance with CQC Outcome 13 (CE23) and 4 (A27)

Indicator	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	2011/12 Forecast
Midwife:Birth - SLHT		1.33	1.32	1.31	1.34	1.31	1.31	1.31	1.30	1.31	1.31	1.31	
Target	1.32	1.32	1.32	1.32	1.32	1.32	1.32	1.32	1.32	1.32	1.32	1.32	
12+6wks - Bromley	46.1%	58.2%	66.6%	77.5%	75.1%	82.5%	82.0%	83.2%	82.8%	84.6%	85.2%	86.5%	
12+6wks - Sidcup	81.8%												
12+6wks - Woolwich	66.2%	57.9%	53.0%	64.8%	67.4%	67.3%	77.8%	71.9%	78.7%	81.4%	75.2%	76.8%	
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	





Analysis

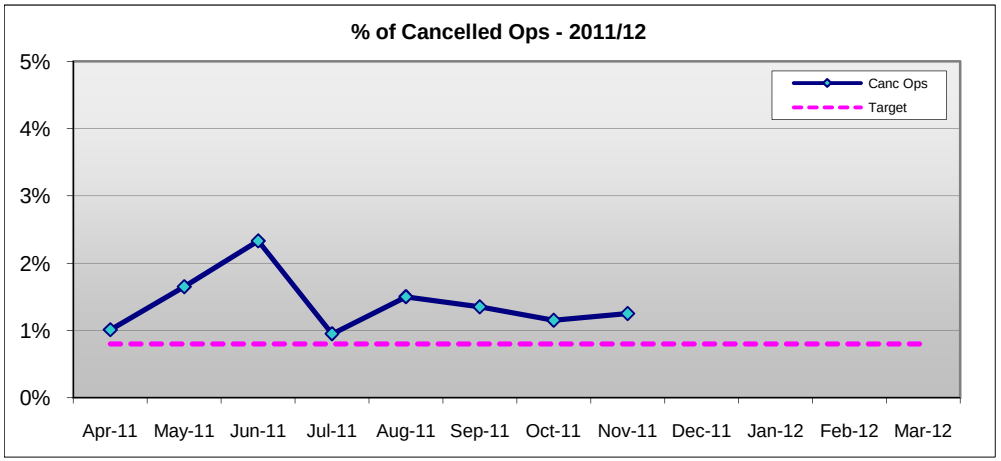
The booking of women at 12+6 weeks is a joint target between Primary care and SLHT. It is more challenging in Greenwich Borough due to the diversity, migration and movement of the population. Of the women referred to SLHT for booking before 13 weeks we see over 85%. A task group with members from GBU, Primary care and SLHT are working collaboratively and introducing electronic/speed booking from GP's to improve the process of referral, a dedicated phone line for women to make their appointments and changes to the booking process in order to make access and data collection easier for all. These are but a few of the schemes in the process of implementation. Performance against the midwife to birth ratio target of 1:32 is being achieved on a consistent basis.

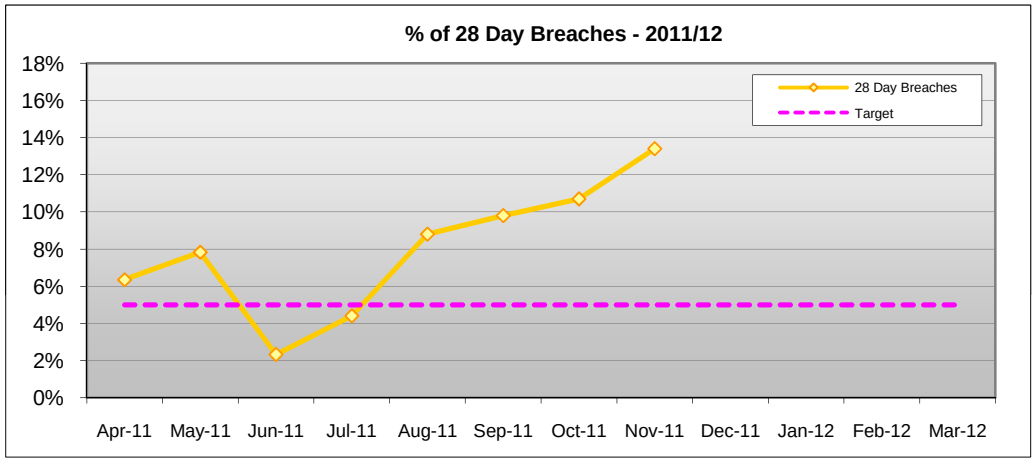
Lead - Steve Russell Chief Operating Officer

Cancelled Ops

Local Priority - **(A6 & A7)** % of cancelled operations on or after planned admission date.
% of elective cancellations not treated within 28 days.
Supports Compliance with CQC Outcome 4.

Indicator	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	2011/12 Forecast
Cancelled Ops	1.0%	1.7%	2.3%	1.0%	1.5%	1.4%	1.2%	1.3%					
Target	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	
28 Day Breaches	6.4%	7.8%	2.3%	4.4%	8.8%	9.8%	10.7%	13.4%					
Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	





Analysis

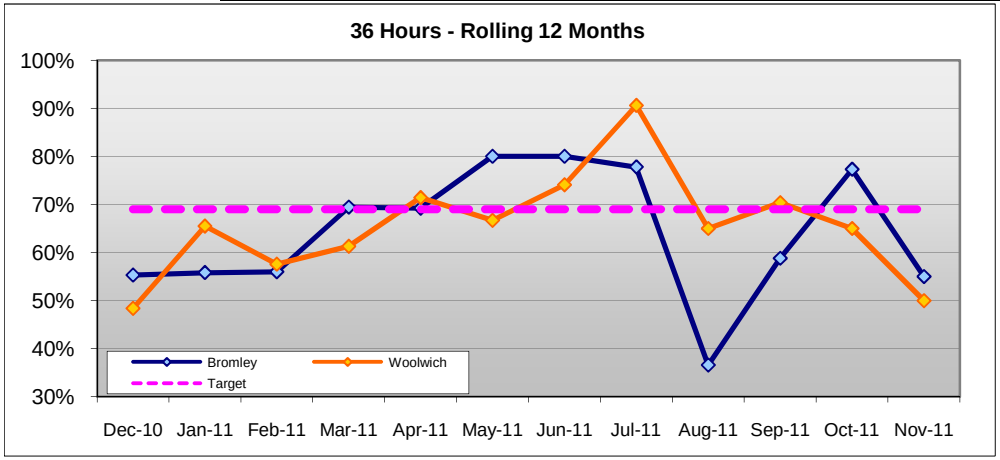
If a patients operation is cancelled on or after the planned admission date by the trust for non clinical reasons, the patient should be admitted for treatment within 28 days. The national target is that 95% of patients cancelled on or after their planned admission date for non clinical reasons are admitted for treatment within 28 days. Action to reduce breaches of the 28 day standard is being taken through a workstream of the theatre productivity group. The ring fencing of elective beds at Woolwich and plans to move elective activity to Sidcup should reduce the number of cancellations by seperating elective and emergency activity. Root cause analysis of the reasons for non clinical cancellations is taking place weekly within the theatre productivity group with the aim of reducing these types of cancellations.

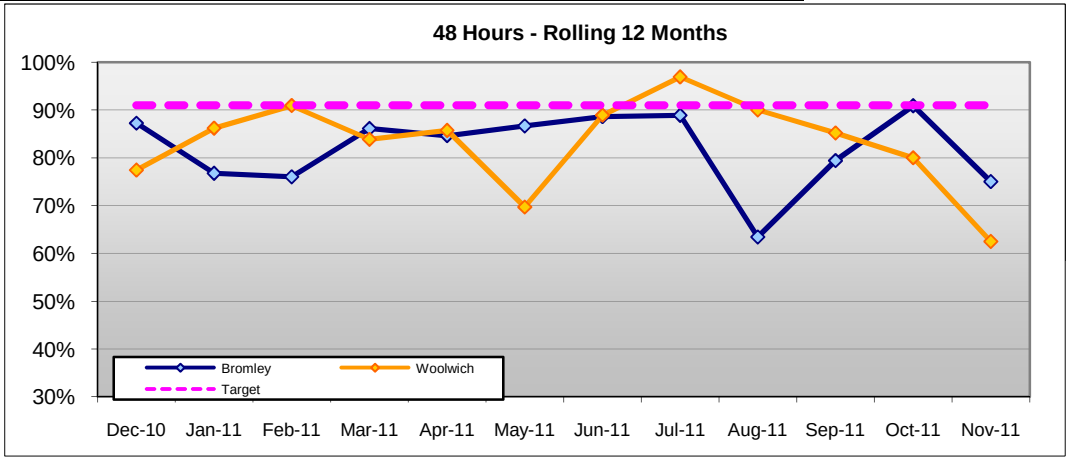
Lead - Steve Russell Chief Operating Officer

Fractured Neck of Femur

Local Priority - **(CE13 & CE14)** To reduce time to surgery within 36 and 48 hours and equal or exceed national top quartile performance.
Supports Compliance with CQC Outcome 4.

Indicator	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	2011/12 Forecast
Bromley 36hrs	55.3%	55.8%	56.0%	69.4%	69.2%	80.0%	80.0%	77.8%	36.6%	58.8%	77.3%	55.0%	
Woolwich 36hrs	48.4%	65.5%	57.6%	61.3%	71.4%	66.7%	74.1%	90.6%	65.0%	70.4%	65.0%	50.0%	
Target	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	69%	
Bromley 48hrs	87.2%	76.7%	76.0%	86.1%	84.6%	86.7%	88.6%	88.9%	63.4%	79.4%	90.9%	75.0%	
Woolwich 48hrs	77.4%	86.2%	90.9%	83.9%	85.7%	69.7%	88.9%	96.9%	90.0%	85.2%	80.0%	62.5%	
Target	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	





Analysis

In November time to surgery has been affected by a higher than usual volume of patients and also more complex patients resulting in the target set at the top 25% of trusts nationally not being achieved. Work is ongoing to improve the fractured neck of femur pathway and to increase trauma theatre capacity.

Lead - Steve Russell Chief Operating Officer

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

South London Healthcare NHS Trust

Trust Performance on NHS Performance Framework

The NHS Performance Framework measures quarterly performance against the 4 domains of Finance, Intergrated Performance Measures, User Experience and CQC Registration. It is the mechanism by which SLHT's performance will be judged by external stakeholders and links closely to SLHT's internal priorities.

Performance Domain	Quarter 2 2010/11 Actual		Quarter 3 2010/11 Actual		Quarter 4 2010/11 Actual		Quarter 1 2011/12 Actual		Quarter 2 2011/12 Actual	
	Score	Category	Score	Category	Score	Category	Score	Category	Score	Category
Finance	-	Under Performing	-	Under Performing	-	Challenged	-	Challenged	-	Challenged
Quality: Integrated Performance Measures	2.89	Performing	2.89	Performing	2.82	Performing	2.02	Under Performing	1.67	Under Performing
Quality: User Experience	2	Performance Under Review	2	Performance Under Review	1	Under Performing	1	Under Performing	1	Under Performing
Quality: Registration	-	Performing	-	Performing	-	Performing	-	Performing	-	Performing
Quality of Service: Overall	-	Performing	-	Performing	-	Performance Under Review	-	Under Performing	-	Under Performing

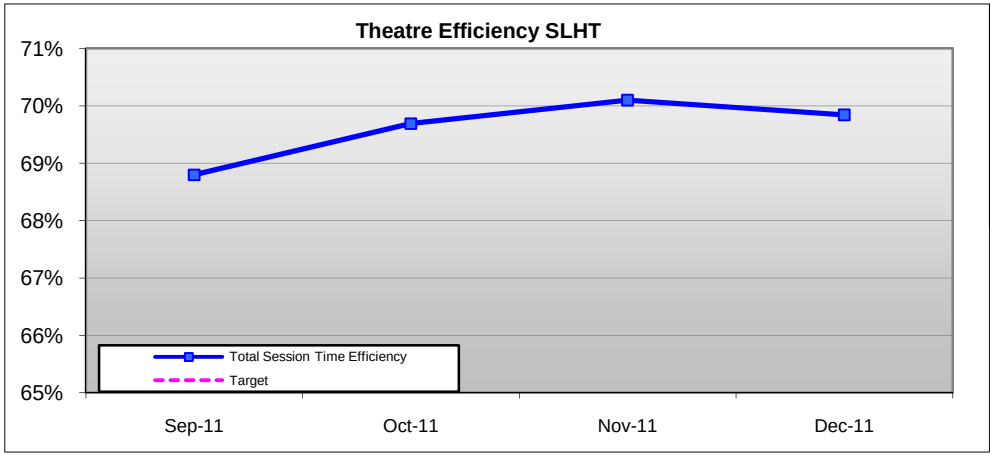
Analysis

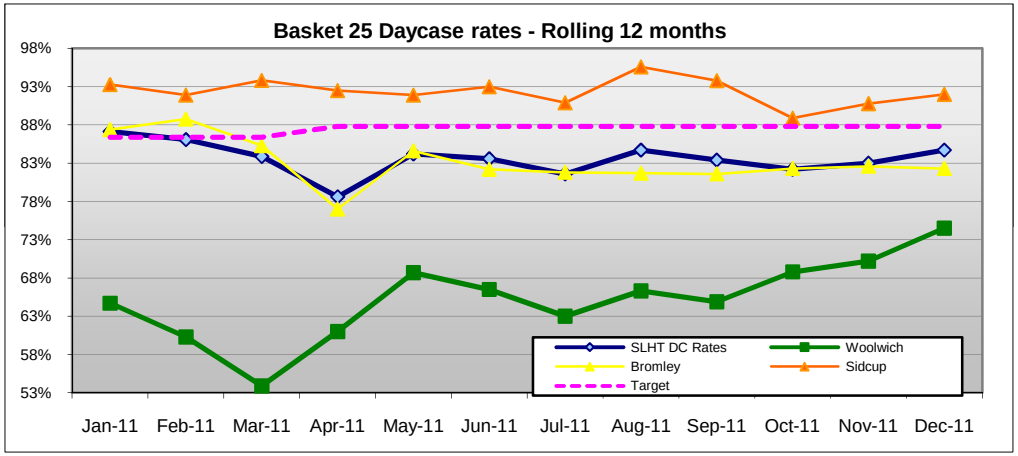
The results of the 2011/12 quarter 2 NHS Performance Framework have been published by the Department of Health. SLHT remains 'challenged' on finance along with 6 other acute trusts in England. For the second consecutive quarter the overall quality of services score remains 'underperforming' and this is because performance against the integrated performance measures continues to be 'underperforming' and user experience remains 'underperforming'. Performance against the integrated performance measures dropped from 2.02 in quarter 1 to 1.67 in quarter 2 and remains well below the performing threshold of 2.4. Performance for user experience and CQC registration is covered in the Patient Safety and Experience report. The next page of this report details performance against the Integrated Performance Measures for quarter 2 2011/12.

Efficiency Overview - Theatre Efficiency & Daycase Rates

Local Priority - **(E5)** to improve the Daycase rate of 25 procedures (identifed nationally) to the best 25% in England
Local Priority - **(E4)** to improve Theatre Efficiency to 90% to get maximum use of and value from Trust assests
Supports Compliance with CQC Outcome 4

Indicator	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11
Total Session Time Efficiency				71.2%	69.0%	68.5%	69.7%	68.3%	68.8%	69.7%	70.1%	69.8%
Target												
SLHT DC Rates	87.2%	86.1%	83.9%	78.6%	84.2%	83.6%	81.6%	84.7%	83.4%	82.2%	83.0%	84.7%
Woolwich	64.7%	60.3%	53.9%	61.0%	68.7%	66.5%	63.0%	66.3%	64.9%	68.8%	70.2%	74.5%
Bromley	87.4%	88.8%	85.3%	77.0%	84.6%	82.2%	81.8%	81.7%	81.6%	82.3%	82.6%	82.3%
Sidcup	93.3%	91.9%	93.8%	92.5%	91.9%	93.0%	90.9%	95.6%	93.8%	88.9%	90.8%	92.0%
Target	86.4%	86.4%	86.4%	87.8%	87.8%	87.8%	87.8%	87.8%	87.8%	87.8%	87.8%	87.8%





Analysis

A new theatre productivity tool has been launched, which allows drill-down to drive improvement at specialty and consultant level. The tool uses a revised definition for session time efficiency and the chart above has been refreshed using data from the new tool. This new definition excludes overrun time from time used, making it a more challenging indicator than most calculations nationally. Total session time efficiency was 69.8% in December. Daycases rates are calculated for a 'basket' of 25 procedures that are defined nationally and allows comparison with other Trusts. Of those procedures that could have been carried out as daycases, SLHT carried out 84.7% (Amber) of them in this way in October 2011.

Lead - Steve Russell Chief Operating Officer

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

South London Healthcare NHS
NHS Trust

Trust Performance on Integrated Performance Measures

The Integrated Performance Measures are the domain of the quarterly NHS Performance Framework Assessment and the table below shows the outcome for quarters 1 and 2 2011/12.

Integrated Performance Measure	Weight	Threshold	Quarter 1 2011/12			Quarter 2 2011/12		
			Actual	Score	Weighted Score	Actual	Score	Weighted Score
ED 4 hour emergency access	1	95%	93.0%	0	0	95.4%	3	3
ED CQIs - data completeness	0	90-110%	129.1%	0	0	120.5%	0	0
ED CQIs - data quality	0	various		0	0		0	0
ED CQIs - performance	2	various		0	0		0	0
Cancelled operations - readmitted <28 days	1	5%	4.9%	3	3	8.1%	2	2
MRSA	1	<=plan		3	3		3	3
Clostridium Difficile	1	<=plan		2	2		0	0
RTT - admitted 95th percentile	0.5	<=23	30.7	0	0	29.8	0	0
RTT - non-admitted 95th percentile	0.5	<18.3	19.0	0	0	19.5	0	0
RTT - incomplete 95th percentile	0.5	<=28	30.2	2	1	35	2	1
RTT - admitted 90% in 18 weeks	0.75	90%	75.7%	0	0	74.3%	0	0
RTT - non-admitted 95% in 18 weeks	0.75	95%	94.3%	2	1.5	93.5%	2	1.5
Cancer 2 week GP referral to 1st outpatient	0.5	93%	96.4%	3	1.5	95.3%	3	1.5
Cancer 2 week GP referral to 1st outpatient - breast	0.5	93%	94.1%	3	1.5	91.9%	2	1
Cancer 31 day wait for second or subsequent treatment surgery	0.25	94%	98.3%	3	0.75	96.4%	3	0.75
Cancer 31 day wait for second or subsequent treatment drug	0.25	98%	100%	3	0.75	100%	3	0.75
Cancer 31 day wait diagnosis to treatment all cancers	0.25	96%	99.0%	3	0.75	97%	3	0.75
Cancer 31 day wait for second or subsequent treatment radiotherapy	0.25	94%						
Cancer 62 day wait from referral from screening service to treatment	0.5	90%	100%	3	1.5	100%	3	1.5
Cancer 62 day wait from urgent GP referral to treatment all cancers	0.5	85%	90.1%	3	1.5	85.7%	3	1.5
Stroke patients spending >90% of admission on a stroke unit	1	60%	40.6%	2	2	40.6%	2	0
Delayed transfers of care	1	3.5%	2.6%	3	3	1.8%	3	3
Total	14				23.75			21.25
Overall score (weighted score/weighting)	36				2.02			1.67

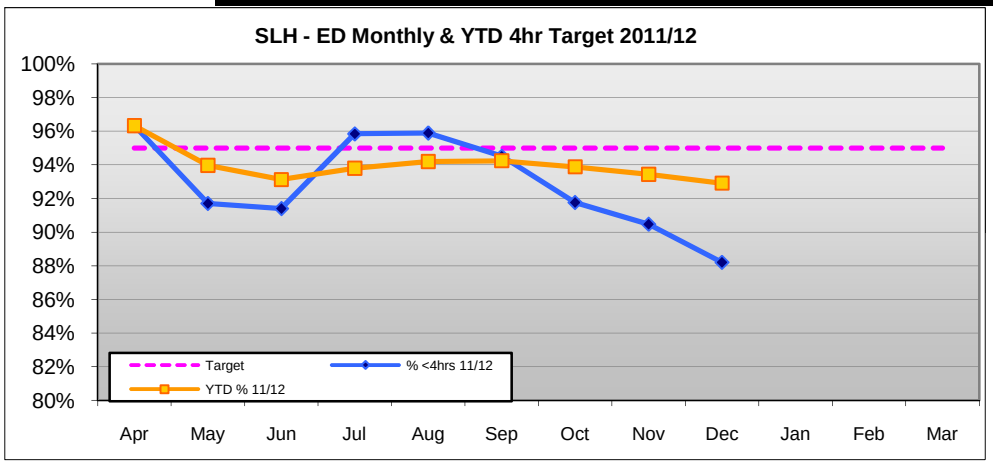
Analysis

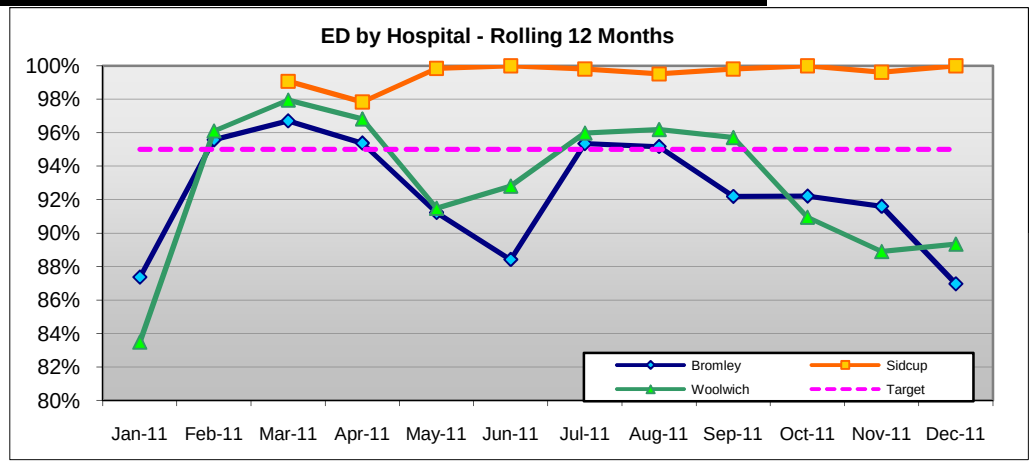
The overall score for quarter 2 was 1.67, this represents performance of underperforming and is slightly worse than performance in quarter 1. The ED emergency access target was achieved in quarter 2 but this was offset by a drop in performance for Clostridium difficile, cancelled operations and one of the cancer targets. The overall score continues to be materially affected by underperformance against the Emergency Department CQI's and Referral to Treatment performance measures. Details of current performance and the actions being taken to improve performance are covered in other sections of this report.

Emergency Care - Total time in ED 4 hours or less

National Priority - **(A26)** 95% of patients to spend 4 hours or less in ED
Supports Compliance with CQC Outcome 4

Indicator	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2011/12 Forecast
<4hrs (%) 2011/12	96.3%	91.7%	91.4%	95.8%	95.9%	94.5%	91.8%	90.5%	88.2%				
YTD (%)	96.3%	94.0%	93.1%	93.8%	94.2%	94.2%	93.9%	93.4%	92.9%				
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	
SLHT Quarter (%)	93.1%			95.4%			90.3%						
	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	
Bromley (%)	87.4%	95.6%	96.7%	95.4%	91.2%	88.4%	95.3%	95.2%	92.2%	92.2%	91.6%	87.0%	
Sidcup (%)			99.1%	97.8%	99.8%	100%	100%	100%	99.8%	100%	99.6%	100%	
Woolwich (%)	83.5%	96.1%	98.0%	96.8%	91.5%	92.8%	96.0%	96.2%	95.7%	91.0%	88.9%	89.3%	





Analysis

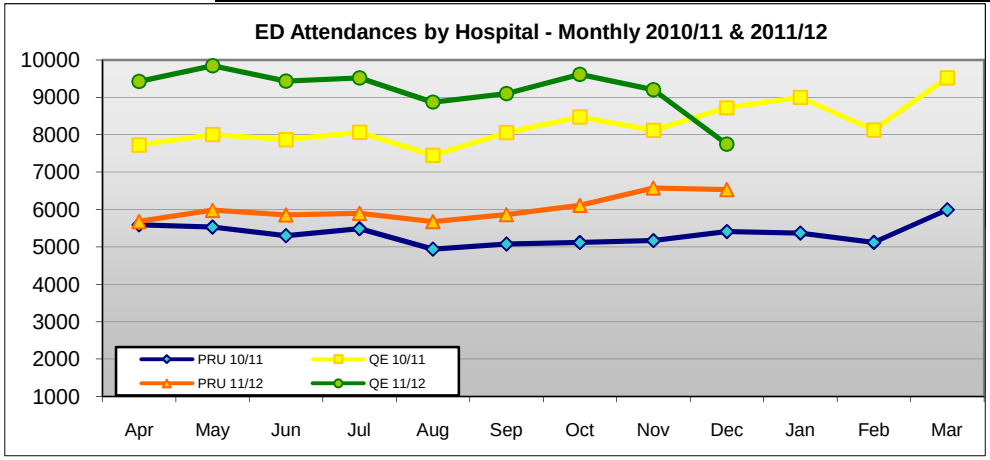
Performance of all Emergency Departments directly managed by SLHT against the 4 hour emergency access standard for December 2011 at trust aggregate level was 88.2%. Performance is assessed quarterly by the Department of Health against a national trajectory of 95% and performance for quarter 3 is 90.3%. Performance at Bromley and Woolwich remains below 95% due to long waits for first assessment caused by high volumes, surges of activity and lack of beds. Action is being urgently taken to address immediate and underlying issues on both sites with the objective of improving performance to above 95% by March. Full details are provided elsewhere in this report.

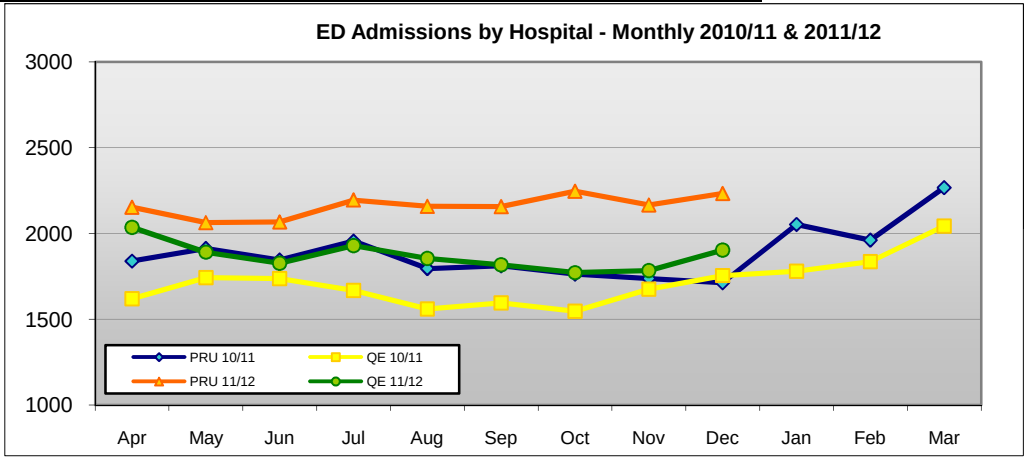
Lead - Steve Russell Chief Operating Officer

Emergency Care - Attendances & Admissions

National Priority - Number of Type 1 Attendaces and Emergency Admissions
Supports Compliance with CQC Outcome 4

Indicator	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2011/12 Forecast
PRU 2010/11	5588	5530	5298	5485	4939	5076	5116	5167	5411	5371	5122	5993	
QE 2010/11	7722	8005	7868	8062	7449	8053	8472	8116	8719	8994	8122	9516	
PRU 2011/12	5680	5980	5857	5900	5677	5865	6111	6578	6534				
QE 2011/12	9427	9845	9435	9520	8872	9100	9610	9200	7746				
PRU 2010/11	1839	1913	1845	1955	1796	1812	1764	1738	1713	2053	1961	2267	
QE 2010/11	1620	1743	1737	1668	1560	1596	1547	1676	1755	1780	1836	2043	
PRU 2011/12	2153	2063	2067	2195	2158	2156	2246	2166	2233				
QE 2011/12	2036	1891	1827	1929	1855	1817	1772	1784	1903				





Analysis

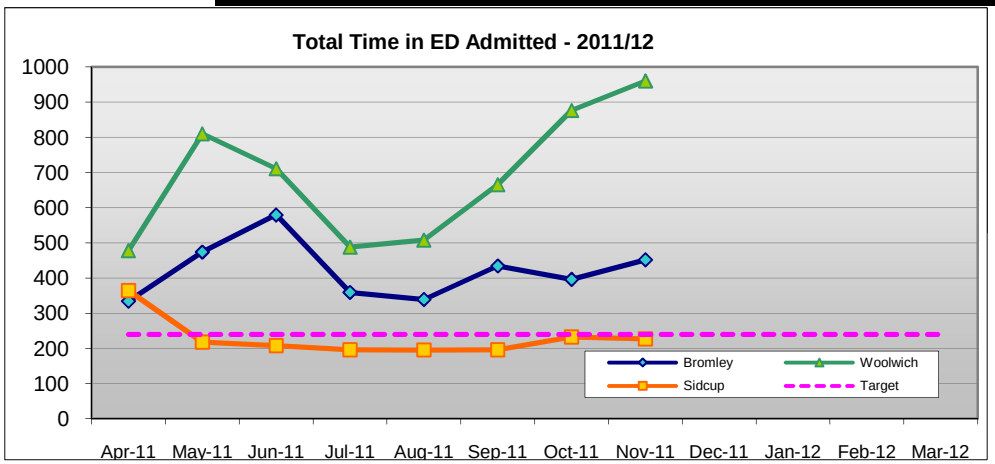
This page shows emergency department type 1 attendances and emergency admissions at the QEH and PRU from April 2010 to December 2011. Emergency department attendances increased on both sites from November 2010 to March 2011 following the closure of the emergency department at QMS in November 2010. Since March 2011 emergency department attendances have been stable, however there has been a further increase of circa 1000 attendances per month at the PRU from August 2011. Emergency admissions show a similar pattern with continuing increases at the PRU causing significant pressure on the acute sites. Extra unfunded beds have been brought into the system to try to ease the pressure on the main sites.

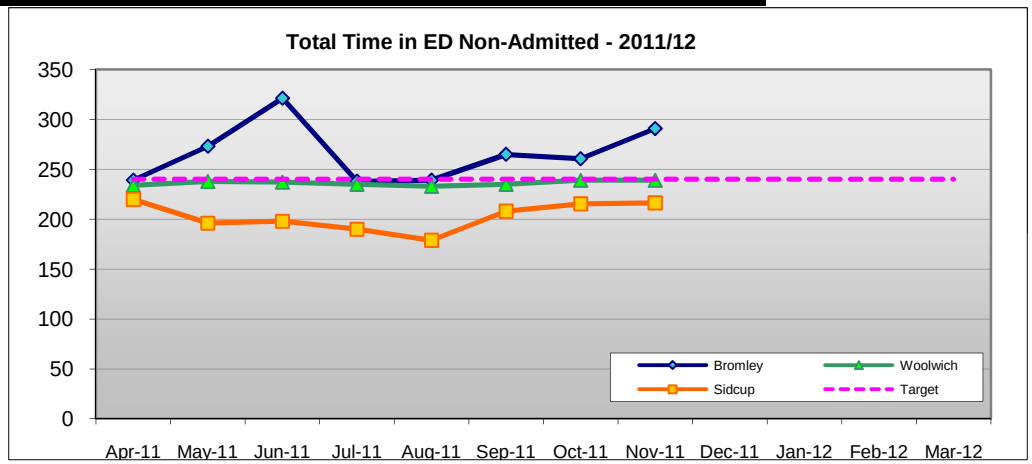
Lead - Steve Russell Chief Operating Officer

Emergency Care - Total Time In ED (Admitted & Non-Admitted)

National Priority - 95th Percentile time in the Emergency Department for admitted and non admitted patients should not exceed 240 minutes.
Supports Compliance with CQC Outcome 4

Indicator	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	2011/12 Forecast
Bromley	334.0	474.0	579.6	359.2	339.0	434.1	396.0	452.0					
Woolwich	478.0	809.7	710.7	487.8	507.6	665.5	876.2	960.5					
Sidcup (CYPAU)	364.0	217.9	208.0	196.1	195.5	195.8	232.4	227.1					
Admitted Target	240	240	240	240	240	240	240	240	240	240	240	240	
Bromley	239.0	273.0	321.2	238.0	239.0	264.9	260.6	290.8					
Woolwich	234.0	238.0	237.2	235.0	233.0	235.0	239.0	239.0					
Sidcup (CYPAU)	219.9	196.0	198.0	189.9	178.8	208.0	215.4	216.3					
Non admitted Target	240	240	240	240	240	240	240	240	240	240	240	240	





Analysis

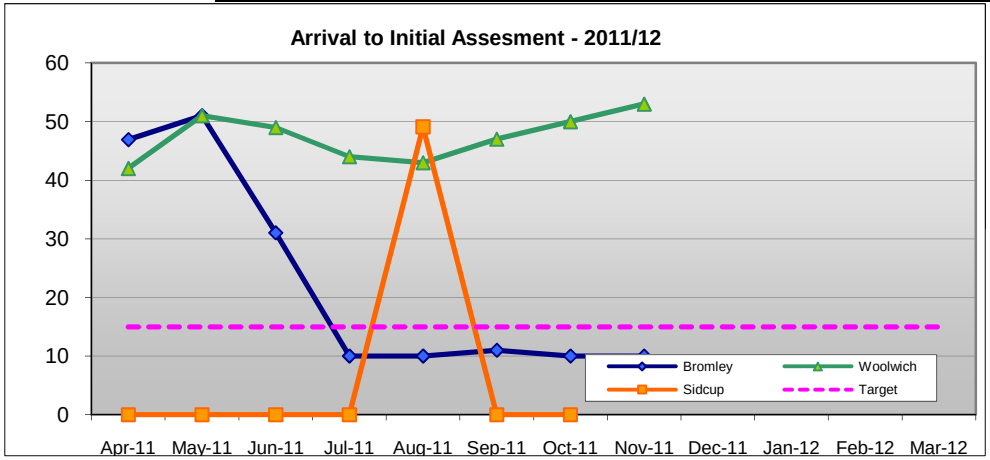
This indicator is similar to the 4 hour emergency access target and shows the 95th centile time in department for admitted and non admitted patients seperately compared to a threshold of 240 minutes (4 hours). The non admitted time in department was less than 240 minutes for all sites in November apart from Bromley (due to long waits for assessment), while the admitted time in department exceeded 240 minutes for all sites except the CYPAU due to long waits for first assessment and bed availability. Admitted performance at Woolwich is worse than the England average while Bromley continues to do better than the England average. Details of the actions being taken to improve performance are provided elsewhere in this report.

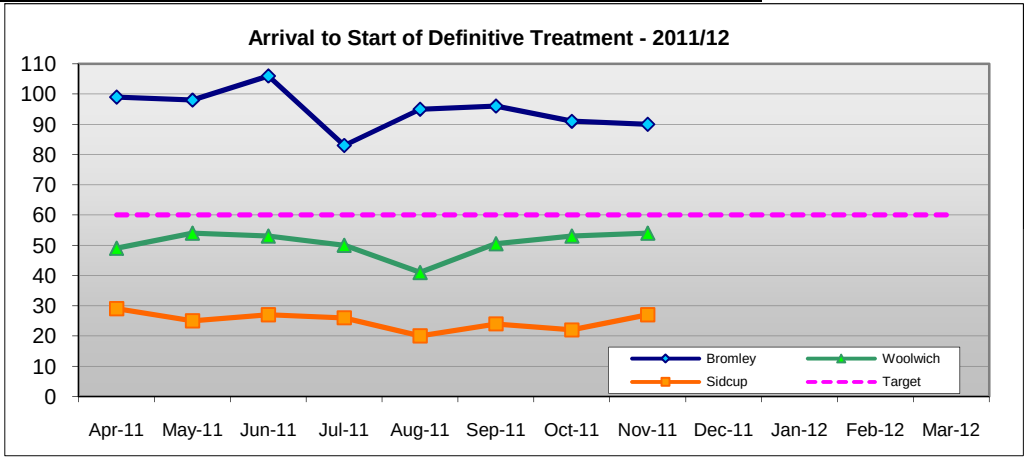
Lead - Steve Russell Chief Operating Officer

Emergency Care - Arrival to Assesment & Arrival to Treatment Times

National Priority - 95th Percentile time from arrival to intial assessment for ambulance arrivals should not exceed 15 minutes.
Median time for arrival to treatment for all patients should not exceed 60 minutes.

Indicator	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	2011/12 Forecast
Bromley	46.9	51.0	31.0	10.0	10.0	11.0	10.0	10.0					
Woolwich	42.0	51.0	49.0	44.0	43.0	47.0	50.0	53.0					
Sidcup (CYPAU)	0.0	0.0	0.0	0.0	49.1	0.0	0.0	0.0					
Assesment Target	15	15	15	15	15	15	15	15	15	15	15	15	
Bromley	99.0	98.0	106.0	83.0	95.0	96.0	91.0	90.0					
Woolwich	49.0	54.0	53.0	50.0	41.0	50.5	53.0	54.0					
Sidcup (CYPAU)	29.0	25.0	27.0	26.0	20.0	24	22	27					
Treatment Target	60	60	60	60	60	60	60	60	60	60	60	60	





Analysis

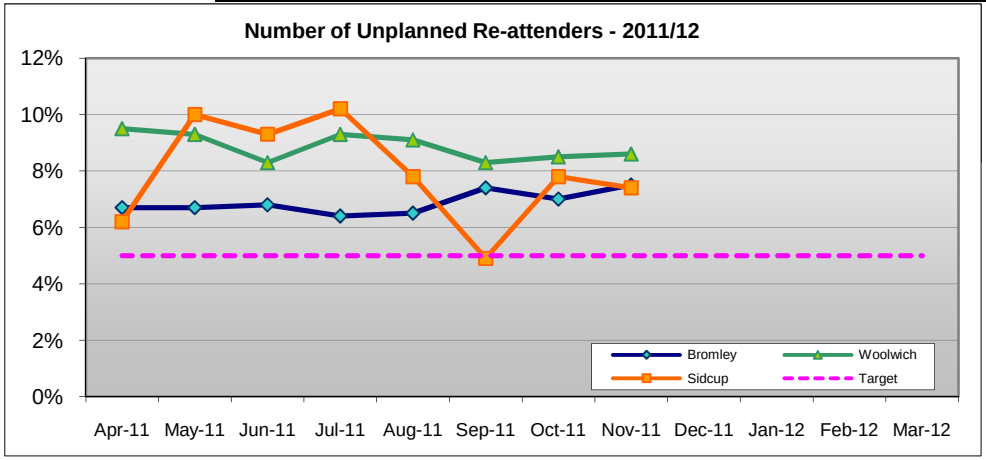
These indicators cover the 95th centile time from arrival to initial assessment for patients arriving by ambulance against a benchmark of 15 minutes and the median time from arrival to treatment for all patients against a benchmark of 60 minutes. The time to initial assessment at Bromley is consistently within 15 minutes following an initiative to improve the patient pathway and address data quality issues. The data for Woolwich indicates performance worse than the benchmark and a validation process has been implemented from December to ensure the correct time is captured electronically. The time to treatment at Woolwich and the CYPAU is consistently below the benchmark while for Bromley shows performance worse than the benchmark. At Bromley an action plan has been developed to address the issues and a rapid assessment team of a senior doctor, nurse and assistant at peak times has been introduced to reduce the time and develop early treatment plans.

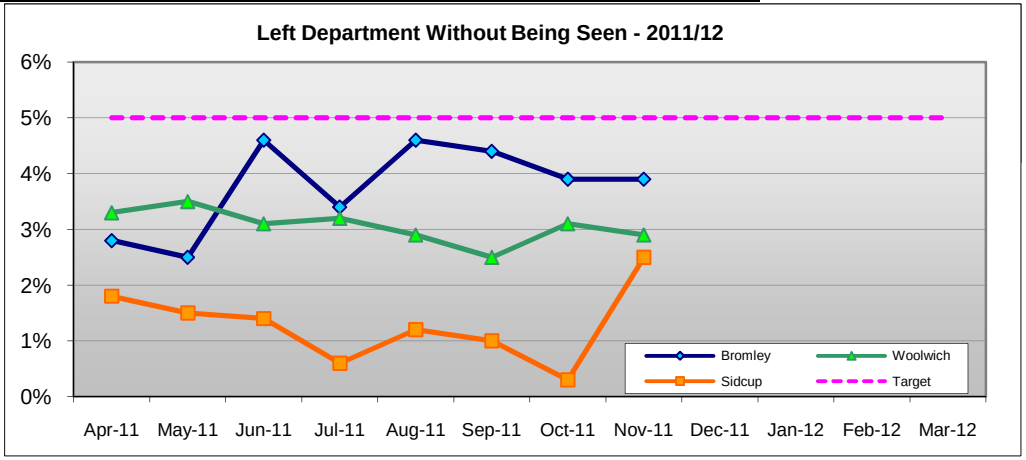
Lead - Steve Russell Chief Operating Officer

Emergency Care - Unplanned Re-attendances & Left Without Being Seen

National Priority - <5% of patients to make an unplanned reattendance at ED within 7 days of original attendance.
<5% of patients to leave A&E without being seen.

Indicator	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	2011/12 Forecast
Bromley	6.7%	6.7%	6.8%	6.4%	6.5%	7.4%	7.0%	7.5%					
Woolwich	9.5%	9.3%	8.3%	9.3%	9.1%	8.3%	8.5%	8.6%					
Sidcup (CYPAU)	6.2%	10.0%	9.3%	10.2%	7.8%	4.9%	7.8%	7.4%					
Unplanned re-attenders Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	
Bromley	2.8%	2.5%	4.6%	3.4%	4.6%	4.4%	3.9%	3.9%					
Woolwich	3.3%	3.5%	3.1%	3.2%	2.9%	2.5%	3.1%	2.9%					
Sidcup (CYPAU)	1.8%	1.5%	1.4%	0.6%	1.2%	1.0%	0.3%	2.5%					
Left without being seen Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	





Analysis

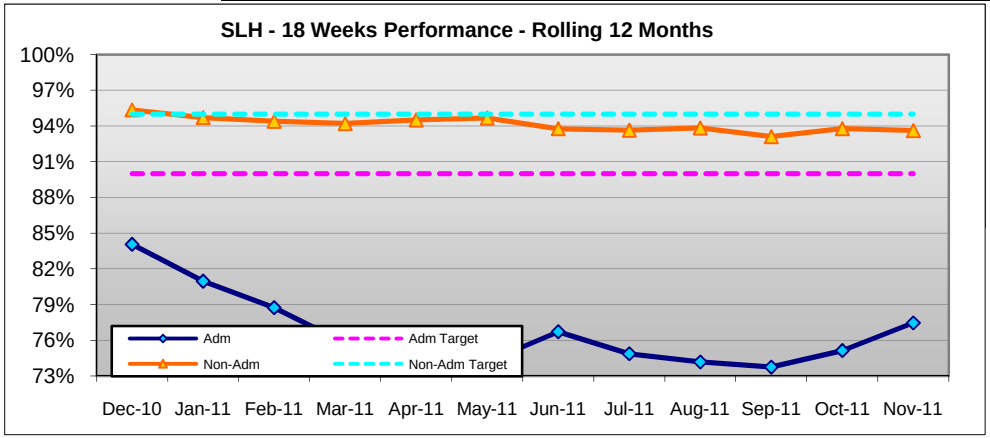
These indicators look at the percentage of patients making an unplanned reattendance at the Emergency Department within 7 days of the original attendance and the percentage of patients who leave the Emergency Department without being seen by a clinical decision maker, both measured against a benchmark of 5%. Performance for patients leaving without being seen has been consistently below the threshold since April. The DH have changed the definition in November for the reattendance indicator from patients recorded as a reattendance to now include all patients reattending within 7 days regardless of the reason. Performance has been recalculated back to April on the new basis and shows performance on all three sites worse than the unchanged threshold of 5% for reattenders, although it is broadly consistent with the national performance of 7.4% for June. This is a recent change and work is in hand to understand the data and develop an action plan to improve performance.

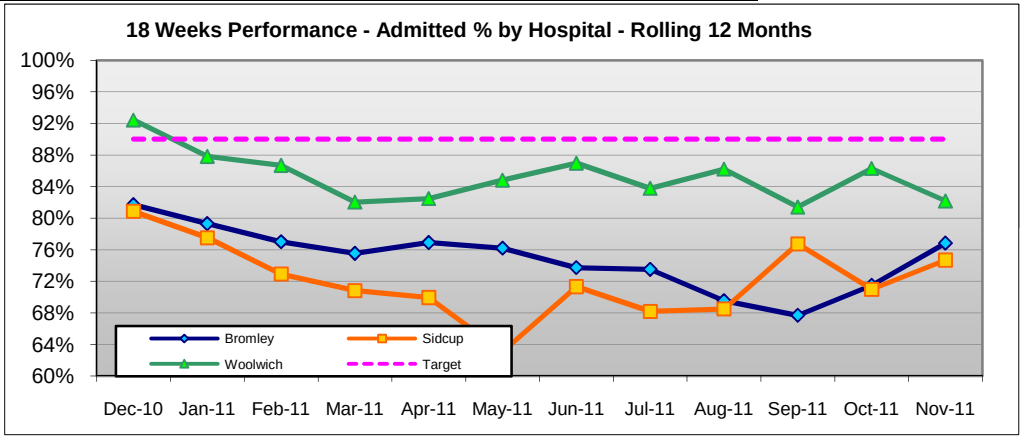
Lead - Steve Russell Chief Operating Officer

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

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

Indicator	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	2011/12 Forecast
Admitted (%)	84.1%	81.0%	78.7%	75.8%	76.4%	74.2%	76.7%	74.9%	74.2%	73.8%	75.1%	77.5%	<90%
Bromley	81.7%	79.3%	77.0%	75.5%	76.9%	76.2%	73.7%	73.5%	69.5%	67.7%	71.5%	76.8%	
Sidcup	80.9%	77.5%	72.9%	70.8%	69.9%	63.1%	71.3%	68.2%	68.5%	76.7%	71.0%	74.7%	
Woolwich	92.4%	87.8%	86.7%	82.0%	82.5%	84.8%	87.0%	83.8%	86.2%	81.4%	86.3%	82.2%	
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	
Non-Admitted (%)	95.4%	94.7%	94.4%	94.2%	94.5%	94.7%	93.8%	93.6%	93.8%	93.1%	93.8%	93.6%	>95%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	





Analysis

Admitted performance of 77.5% in November is the highest since February 2011 but remains below the threshold of 90%. This is due to ongoing action to clear the admitted backlog. The admitted performance standard will be achieved and sustained for all specialties except Orthopaedics and bariatric surgery from the end of January and is expected to be achieved for all specialties from the end of March 2012.

Non admitted performance of 93.6% remains below the 95% threshold. This is largely due to capacity issues in Ophthalmology and Oral Surgery. Additional capacity has been put in place and the non admitted standard will be achieved from the end of January. To ensure performance is sustained plans are in place to reduce outpatient waiting times to a maximum of 7 weeks in all specialties except Ophthalmology (10 weeks) from February 2012.

Full details of the plans to improve and sustain admitted and non admitted RTT performance are provided elsewhere in this report.

Lead - Steve Russell Chief Operating Officer

South London Healthcare

Report to Trust Board (Public)

Month 9

25 January 2012

Agenda

- Trust Financial Plan

- Month 9 Financial Summary

Consolidated Plan by Type

Financial Year 2011/12

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Annual
	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
Income	33,754	34,332	34,043	34,103	34,786	34,705	35,008	34,486	33,405	34,219	33,420	34,864	411,126
Pay	(24,811)	(24,687)	(25,656)	(24,788)	(25,249)	(24,872)	(25,038)	(24,944)	(24,688)	(24,811)	(24,841)	(24,798)	(299,183)
Non-Pay	(12,421)	(11,450)	(12,015)	(11,411)	(10,817)	(11,190)	(12,374)	(11,017)	(11,270)	(11,078)	(11,076)	(11,079)	(137,198)
Operating Expenses	(37,233)	(36,137)	(37,670)	(36,199)	(36,066)	(36,062)	(37,412)	(35,961)	(35,958)	(35,889)	(35,917)	(35,877)	(436,380)
EBIDTA	**(3,478)**	**(1,805)**	**(3,627)**	**(2,095)**	**(1,280)**	**(1,357)**	**(2,404)**	**(1,475)**	**(2,553)**	**(1,670)**	**(2,497)**	**(1,013)**	**(25,254)**
Depreciation	(1,303)	(1,384)	(1,344)	(1,299)	(1,341)	(1,347)	(1,353)	(1,364)	(1,369)	(1,396)	(1,396)	(1,401)	(16,298)
PDC Dividend	(708)	(708)	(708)	(708)	(708)	(708)	(708)	(708)	(708)	(708)	(708)	(708)	(8,494)
Interest	(1,634)	(2,586)	(2,110)	(2,110)	(2,110)	(2,110)	(2,110)	(2,110)	(2,110)	(2,110)	(2,110)	(2,110)	(25,323)
Central Reserves	0	0	1,128	376	376	376	1,166	487	487	487	487	198	5,569
Net Loss (IFRS)	**(7,124)**	**(6,483)**	**(6,661)**	**(5,836)**	**(5,063)**	**(5,146)**	**(5,409)**	**(5,170)**	**(6,253)**	**(5,397)**	**(6,224)**	**(5,034)**	**(69,800)**
IFRS	385	385	385	385	385	385	385	385	385	385	385	385	4,620
Net Loss (Pre-IFRS)	**(6,739)**	**(6,098)**	**(6,276)**	**(5,451)**	**(4,678)**	**(4,761)**	**(5,024)**	**(4,785)**	**(5,868)**	**(5,012)**	**(5,839)**	**(4,649)**	**(65,180)**

Agenda

- Executive Summary

- Month 9 Financial Summary

Consolidated Profit & Loss (Month 9) - Plan

	Month 9 (December)			Year to Date			Annual			Notes
	Actual £000	Budget £000	Variance £000	Actual £000	Budget £000	Variance £000	Budget £000	Forecast £000	Variance £000	
TOTAL INCOME	34,994	33,405	1,589	321,725	308,624	13,101	411,126	441,436	30,310	*(d)*
Pay	(24,230)	(24,688)	458	(222,638)	(224,733)	2,095	(299,183)	(298,014)	1,169	*(e)*
Non-Pay (excl. Depreciation)	(13,015)	(11,270)	(1,745)	(116,501)	(103,965)	(12,536)	(137,198)	(157,695)	(20,497)	*(f)*
TOTAL OPERATING EXPENDITURE	(37,245)	(35,958)	(1,287)	(339,139)	(328,698)	(10,441)	(436,380)	(455,709)	(19,329)	
EBITDA	**(2,251)**	**(2,553)**	**302**	**(17,414)**	**(20,074)**	**2,659**	**(25,254)**	**(14,273)**	**10,981**	
% of Income	**-6.4%**	**-7.6%**		**-5.4%**	**-6.5%**					
Central Reserves	0	487	(487)	0	4,397	(4,397)	5,569	(6,802)	(12,371)	
Depreciation	434	(1,369)	1,804	(10,236)	(12,105)	1,870	(16,298)	(13,721)	2,577	
Finance Charges	(3,155)	(2,818)	(337)	(26,107)	(25,363)	(744)	(33,817)	(35,004)	(1,187)	*(g)*
	(2,720)	(3,700)	980	(36,343)	(33,071)	(3,272)	(44,546)	(55,527)	(10,981)	
NET LOSS	**(4,972)**	**(6,253)**	**1,281**	**(53,759)**	**(53,145)**	**(614)**	**(69,800)**	**(69,800)**	**(0)**	*(a) & (b)*

Notes

a) The Trust YTD deficit for month 9 is £53,759K against a budget of £53,145K. This is £614K worse than plan.

b) The current Trust forecast is £69.8M against a plan of £69.8M. This forecast includes £25.6M of over performance on contract income. The above forecast also includes £2.4M for the outsourcing of orthopaedics and bariatric patients, £2.4M cost included in the Planned Care forecast and £2.4M included in Central Income. The risks to this forecast are the payment for the RTT backlog and over performance (£25.6M rather than £20.4M an increase of £5.2M based on current activity levels). The reserves forecast includes further funding for RTT part of the 2011/12 access initiatives from NHS London and MARS.

c) The CIP Programme has delivered YTD savings to month 9 of £14.8M against a plan of £21.5M, a shortfall of £6.6M. The forecast for the Trust CIP Programme is showing a shortfall of £9.1M by year end.

d) The Trust activity and income plan was not agreed as part of the contracting negotiations therefore the budget has been phased in 12ths. The actual position at month 9 reflects over performance of £15.3M, 9/12ths of the agreed over performance of £20.4M. The over performance income is offset by the YTD income shortfall of £3.6M.

e) Pay is £458K favourable in month and £2M favourable YTD. This is mainly due to the pay under spend in WCCS offset by the Theatres overspend in Planned Care.

f) Non Pay is £1.7M adverse in month and £12.5M adverse YTD. The main variances are Drugs £2.4M, MSSE £4M, Pathology Consumables £525K, Electricity £310K and Unidentified CIP £5.3M.

g) Depreciation charges are £1.8M favourable in month, £1.8M YTD. A YTD adjustment has been made in month to reflect the depreciation based on current live assets in RAM.

Consolidated Profit & Loss (Month 9)

In Month Trading Position Month 9 (December)

	Central Income	Planned Care	ECSM	WCCS	Corporate Services	Financial Charges	Total
	£000s	£000s	£000s	£000s	£000s	£000s	**£000s**
Actual	32,837	(8,806)	(10,102)	(7,689)	(8,491)	(2,720)	**(4,972)**
Budget	31,534	(8,128)	(9,885)	(7,888)	(8,186)	(3,700)	**(6,253)**
Variance	**1,303**	**(678)**	**(217)**	**199**	**(305)**	**980**	**1,281**

Year to Date Trading Position Month 9 (December)

	Central Income	Planned Care	ECSM	WCCS	Corporate Services	Financial Charges	Total
	£000s	£000s	£000s	£000s	£000s	£000s	**£000s**
Actual	304,436	(82,142)	(91,598)	(71,679)	(76,432)	(36,343)	**(53,759)**
Budget	293,454	(76,591)	(88,999)	(72,642)	(75,296)	(33,071)	**(53,145)**
Variance	**10,982**	**(5,551)**	**(2,599)**	**962**	**(1,136)**	**(3,272)**	**(614)**

Trend Analysis

	Central Income	Planned Care	ECSM	WCCS	Corporate Services	Financial Charges	Total
Month 1 Actual	32,195	(8,794)	(10,079)	(8,318)	(9,154)	(3,727)	(7,878)
Month 2 Actual	32,832	(9,257)	(10,247)	(7,915)	(7,739)	(4,684)	(7,009)
Month 3 Actual	32,749	(9,282)	(10,515)	(8,054)	(8,556)	(4,215)	(7,873)
Month 4 Actual	32,822	(9,140)	(10,182)	(8,093)	(8,680)	(4,162)	(7,435)
Month 5 Actual	31,147	(9,122)	(10,364)	(7,686)	(8,527)	(4,198)	(8,749)
Month 6 Actual	42,676	(8,955)	(9,986)	(7,985)	(8,249)	(4,197)	3,304
Month 7 Actual	32,684	(9,187)	(10,015)	(8,070)	(8,689)	(4,314)	(7,592)
Month 8 Actual	34,496	(9,599)	(10,110)	(7,869)	(8,347)	(4,125)	(5,555)
Month 9 Actual	32,837	(8,806)	(10,102)	(7,689)	(8,491)	(2,720)	(4,972)
Movement	**(1,659)**	**793**	**8**	**180**	**(145)**	**1,405**	583
YTD	**304,436**	**(82,142)**	**(91,598)**	**(71,679)**	**(76,432)**	**(36,343)**	**(53,759)**

Notes

- The central income run rate has decreased by £1.8M this is primarily driven by the volume of activity. The Lewisham sla has also been transferred to Planned Care in month on a YTD basis.
- Planned Care has seen a reduction in run rate of £793K month on month. £232K relates to the catch up in month 8 for junior doctors rebanding mainly in trauma and orthopaedics. The Lewisham sla has also been transferred from central income in month £447K. A reduction in Theatres and Surgery 1 agency cost has also occurred in month (£169K) this is due to the closure of Theatres over the Christmas period.
- WCCS has also seen a reduction in run rate by £180K. This relates to lower Pathology consumable spend of £120K month on month.
- Corporate Services has had an increase in run rate month on month by £145K. This is relating to agency costs and higher GP rotational doctors cost.
- Financial Charges has decreased month on month by £1.4M. This is due to the YTD adjustment posted for depreciation.

Financial Governance Improvement Plan

1. Introduction

1.1 The Trust faces a range of financial governance issues that must be systematically and sustainably resolved. The Financial Governance Improvement Plan (FGIP) was approved by the EMT in July to address this. Funding of £300,000 was subsequently agreed to support its implementation. An update will be given to each Audit Committee meeting.

2. Updates to the plan

2.1 The overall objective of the plan is to bring the Trusts financial process to a standard of "Adequate" under the Auditors Local Evaluation framework – on the assumption that the processes will remain in place once established and excluding consideration of the deficit.

2.2 Since the last update to the Board the following amendments have been made to the plan:

Item	Action
Integrated Business Plan Chapter Six by March 2012	In light of changes to the Trust's Tripartite Formal Agreement (TFA) and the production of the Long Term Financial Plan this is no longer required.
Integrated Business Plan Chapter Seven by March 2012	In light of changes to the Trust's Tripartite Formal Agreement (TFA) and the production of the Long Term Financial Plan this is no longer required
Historic Due Diligence Preparation by March 2012	In light of changes to the Trust's Tripartite Formal Agreement (TFA) and the production of the Long Term Financial Plan this is no longer required

3. Progress

3.1 The following are monitoring information is used to regularly update the Audit Committee of its progress:

- Key Performance Indicator Dashboard (Appendix 1 attached for Board Info)
- Overall programme plan (Appendix 2 attached for Board Info)
- Basic process status
- Finance reporting KPIs
- Finance staff KPIs

- Risk Register

4. Exception report

4.1 The following table identifies any items that are not completed / are at risk along with the reason, mitigation and revised completion date

Item	Issue / Mitigation	Revised date
Finance Directorate PDRs	All senior staff have had a PDR within the time frame set, however some more junior staff have not yet had theirs. X% of Department have had PDR, target of 95% should be achievable by close of Jan 12	Jan12
Finance Performance Management Framework	The COO has proposed and integrated finance and performance management framework and has shared this with Divisional Directors. This needs to be taken through the EMT in January and included as the performance management framework in the 2012/13 Business Plan.	Jan 12
Basic Finance Governance Improvements – Phase 1	This has been graded as at risk due to the impact of the time taken to achieve 2010/11 accounts sign off. Key issues are • General process improvements are in some cases behind where they are planned to be at this point. The month 9 soft close of the accounts will be used to ensure critical aspects are brought back on track. • Asset register - the Trust response to the final audit testing allowed the 2010/11 accounts to be signed off as free from material error. On-going work is required to deliver data quality improvements to ensure that the error rate revealed by audit testing for 2011/12 accounts is not material. Given the length of time taken complete the 2010/11 exercise additional	March 12

	resources have been authorised to assist in data quality improvements. A revised verification approach is being implemented using the Trusts maintenance records.	
21012/13 Contract Sign Off	Graded as at risk because no plan in place between SLHT and Commissioners that demonstrates how sign off will be achieved by 31st March. Urgent action is required through the Contracting Board to address this.	Jan 12
Charities review	Charities review has not been started yet due to delay in finalising the external support for this element of the programme.	Jan 12

5. Risks

5.1 There is increased risk to the delivery of the plan due to turnover / long term sickness issues in the senior finance team A mitigation plan is in place top address these issues. As noted above further resource mitigation has been put in place in respect of the fixed asset register.

6. Conclusion

6.1 Overall good progress being made on the plan, although at present the Trust can only have limited assurance on a range of financial governance issues. The assurance status will begin to improve over the next few months as the actions in the plan begin to take effect.

SLH Financial Governance - Performance Summary — Dec-11

Statutory Duties Forecast	RAG Status	Trend
Income and Expenditure - In year	Fail	⟺
Income and Expenditure - Cumulative	Fail	⇩
Capital Resource Limit	Pass	⟺
External Finance Limit	Pass	⟺
Return on Capital Employed	Pass	⟺
Public Payment Practice Forecast	**Fail**	⟺
Monitor Risk Rating Forecast		
Achievement of Plan	Intervention	⟺
Underlying Performance	Intervention	⟺
Financial Efficiency	Intervention	⟺
Liquidity	Intervention	⟺
Overall	**Intervention**	⟺
DH Performance Management Framework Forecast		
Initial Plan - Outturn	Under Perf	⟺
YTD - operating performance	Under Perf	⟺
YTD - EBITDA	Under Perf	⟺
Forecast - Operating Perf	Under Perf	⟺
Forecast - EBITDA	Under Perf	⟺
Forecast - Change	Performing	⟺
Underlying - Operating %	Under Perf	⟺
Underlying - EBITDA %	Under Perf	⟺
BPP - Value	Under Perf	⟺
BPP - Volume	Under Perf	⟺
Bal Sheet - Current Ratio	Under Perf	⟺
Receivable Days	Under Perf	⟺
Payable Days	Under Perf	⟺
Overall	**Under Perf**	⟺
Finance staff KPIs	**Risk**	⇧
Finance Budget KPIs	On track	⟺
11/12 Counter Fraud Plan	At Risk	⇧

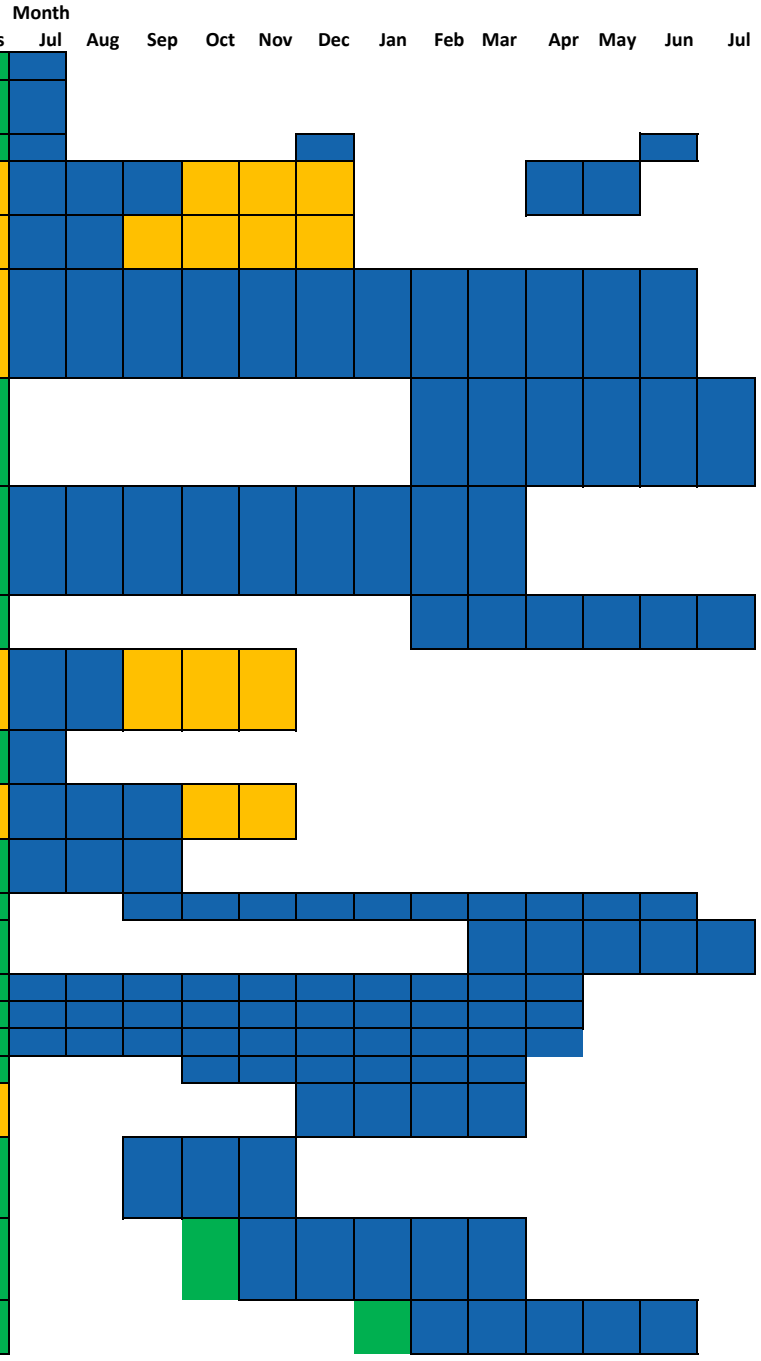
	RAG Status
2010/11 Statutory Accounts Opinion Forecast	
True and fair view	Unqualified
Value for money	Qualified
2011/12 Statutory Accounts Opinion Forecast	
True and fair view	Unqualified
Value for money	Qualified
2011/12 Head of Internal Audit	"Reasonable"
Basic Process Assurance Current	**No Assurance**
Auditors Local Evaluation	
Financial reporting	Weak
Financial standing	Weak
Financial management	Weak
Internal control	Weak
Value for money	Weak
Overall	**Weak**
Financial Governance Improvement Plan Status	
Forecast by end of March	On track
Financial reporting quality	**Action Rqd**
Audit recommendations implemented	
10/11 External Audit	At Risk
10/11 Internal - Grade 1	At Risk
10/11 Internal - Grade 2	At Risk
10/11 Internal - Grade 3	At Risk
11/12 Internal Audit Plan	At Risk
11/12 Internal Audit Reports	
Full Assurance	0
Significant Assurance	0
Reasonable / Limited	0

SLH Finance Governance Improvement Plan (V3 9th Jan 12)- Programme Monitoring

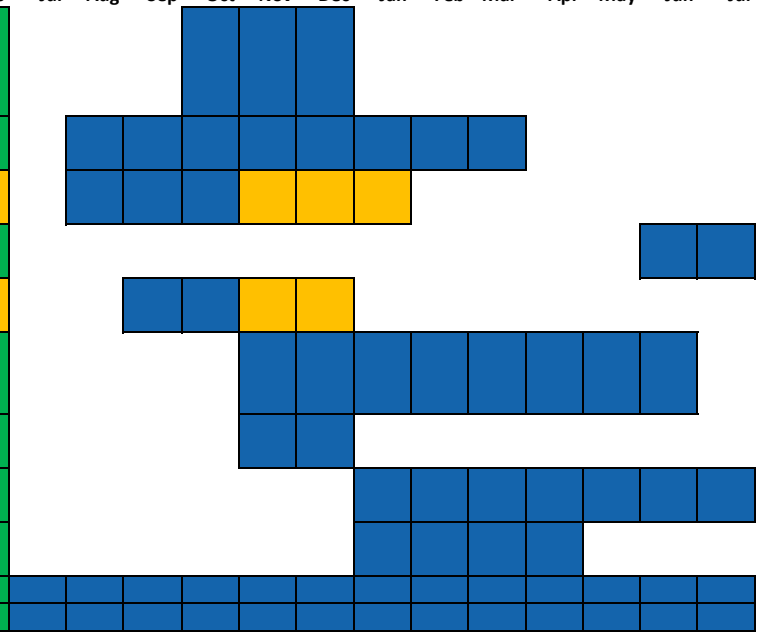
Appendix 2

Appendix 2

Project		Objective / KPI	Who	Finance Objective	Status
1	Establish Programme	Programme plan established	RC	Fin Gov	Done
2	Finance Function Vision / Strategy	Finance Department Development agreed by RC	RC	Develop	Done
3	Finance Time Outs	Two time outs held per year	RC	Develop	On track
4	Finance Function PDRs / Objective Setting	95% PDRs completed by end Sept, 95% 2012/2013 completed by end of May 2012	SW/JH	Develop	At Risk
5	Implement SLH Performance Management Framework	Documented framework agreed by EMT by end of August	RC	Fin Gov	At Risk
6	Basic Finance Governance Improvements - Phase 1	All basic processes are rated Green by Feb 2011, Standard required by ALE Level 2 achieved by June 2012 (excluding consideration of the deficit)	CT	Fin Gov	At Risk
7	Basic Finance Governance Improvements - Phase 2	All basic processes are Green through 2012/2013,Standard required by ALE Level 2 achieved by June 2013 (excluding consideration of the deficit)	CT	Fin Gov	On track
8	Financial Position Monitoring - 2011/12	All internal / external monitoring produced on time and quality, Review reporting requirements, reduce transactions, bring forward report deadline to 5th day.	SS	Fin Gov	On track
9	Financial Position Monitoring - 2012/13	All internal / external monitoring produced on time and quality	SS	Fin Gov	On track
10	2010/2011 Accounts Sign Off	Unqualified True and Fair view , signed off by 15th September (achieved end November)	CT	Fin Gov	Done
11	2010/2011 Reference Costs	No material errors in quantum of cost of activity or cost	MW	Info	Done
12	2011/2012 Contract Sign Off	Contract signed in accordance with PBR guidance and Standard Contract guidance	JH	Fin Gov	Done
13	Response to NHS London (SaFE) work(MTFP)	Work up repsonse for 28th Sept meeting based on high level MTFP	SW	LTFM	Done
14	Service Line Reporting Development	Sustainable SLR in place by Q1 12/13	MW	Info	On track
15	Service Line Management Development	Deliverable approach to SLM agreed by EMT by end of Q2 12/13	MW	Fin Gov	On track
16	Information Improvements	KPIs as per information improvement plan	JH	Info	On track
17	PBR Improvements	KPIs as per PBR improvement plan	JH	Info	On track
18	Procurement Improvements	KPIs as per procurement improvement plan	CT	Fin Gov	On track
19	2012/2013 Business Plan	Board signs business plan off in March 12	SW	Fin Gov	On track
20	2012/2013 Contract	2012/2013 Contract agreed by 31st March 2012	JH	Fin Gov	At Risk
21	2012/2013 Budget Setting Process Review (Inc Capital)	Budget setting process review signed off by EMT end of November. Full standardisation, 25% transaction processing reduction.	SS	Fin Gov	Done
22	2012/2013 Budget Setting (Inc Capital)	Budget agreed by the Board before 31st March 2012, complies with agreed quality standards.	SS	Fin Gov	On track
23	2012/2013 FIMs Plans	FIMs plans produced on time, complies with agreed quality standards	CT	Fin Gov	On track



Project		Objective / KPI	Who	Objective	Status
23a	Long Term Financial Plan	Produce a LTFM incorporating latest CIP position and strategic options for QMS site. This to support further meeting with NHS London re FT at end Dec.	MW	LTFM	Done
24	Tender Internal Audit	Service in place following tender by 1st April 2012	CT	Fin Gov	On track
25	Charities Review	Externally assured review of charities completed by 31st October.	CT	Fin Gov	At Risk
26	Finance Function Capability / Capacity Review re FT	Externally assured capability and capacity review concluded by 31st July 2012	SW	Develop	On track
27	2011/2012 Accounts Planning	Credible "ALE Level 4" accounts plan agreed by RC and reported to audit committee	CT	Fin Gov	Done
28	2011/2012 Accounts Process	Accounts and Annual report produced in accordance with plan, submit early, only trifling errors, no adjustments	CT	Fin Gov	On track
29	2011/2012 Reference Costs Planning	Plan to produce reference costs agreed by RC, clear link to SLR process established	MW	Info	On track
30	2011/2012 Reference Costs Process	Reference costs submitted on time with no requirement to resubmit due to errors.	MW	Info	On track
31	Integrated Board Performance Reporting (Finance El)	Finance elements of 2012/2013 agreed and available	SS	Fin Gov	On track
35	Finance staff development	KPIs as per finance staff development plan	SS	Develop	On track
36	SBS Improvement plan	KPIs as per SBS Improvement Plan	CT/SS	Fin Gov	On track



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SOUTH LONDON HEALTHCARE NHS TRUST

Subject	Progress with the iCare implementation programme
Report by	Lorraine Knight, iCare Programme Director
Author	Colin Fassnidge, Head of PMO; Lorraine Knight, iCare Programme Director
Executive Director	Jennie Hall, Deputy Chief Executive / Chief Nurse

TRUST OBJECTIVE

Our Patients	**x**
Financial Viability	
Leadership and Workforce	
High Quality Clinical Care	**x**
Healthcare Acquired Infections	
National and Local Priorities	
Service and Facilities fit for the future	**x**

GLOSSARY

Abbreviation	**In Full**
A&E	Accident and Emergency
CIC	Capital Investment Committee (NHS London)
DCW	Data Collection Worksheet
DDM	Design Decision Matrix
FSW	Future State Workflow
ICT	Information & Communication Technology
IPWL	Inpatient Waiting List
LPfIT	London Programme for IT
MPI	Master Patient Index
MRN	Medical Record Number
PAS	Patient Administration System
PRU	Princess Royal University Hospital
QEH	Queen Elizabeth Hospital
QMS	Queen Mary's Sidcup Hospital
RTT	Referral to Treatment
SLHT	South London Healthcare NHS Trust
TL1	Trial Load 1
TIE	Trust Integration Engine
RFC	Request For Change

WRITTEN REPORT (provided in addition to cover sheet) Yes

POWERPOINT PRESENTATION No

Title	
Number of Slides	

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SOUTH LONDON HEALTHCARE NHS TRUST

PURPOSE OF THE REPORT / PRESENTATION

To provide a progress report to the Trust board on the iCare Programme Implementation

SUMMARY OF KEY ISSUES

The report provides an update on the key areas of the programme, describing some of the challenges being faced, the actions being taken to address them and the next steps in the programme.

SUMMARY OF KEY RISKS

The current programme risks are listed at the end of this report

RECOMMENDATION / DECISION REQUIRED

The Board is asked to note the progress made by the programme, the risks going forward and the next steps

IMPLICATIONS

Are there any implications for Care Quality Commission Registration?	No
Is an Equality Impact Analysis Required?	No
Are there any legal Implications arising from this item?	No
Are there any Financial implications arising from this item?	No

REVIEW

Trust Committee	**Date**
Executive Management	17th January 2012

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SOUTH LONDON HEALTHCARE NHS TRUST

Subject: **iCare Implementation Programme**

Report from: **Lorraine Knight iCare Programme Director**

Date: **12 January 2012**

Purpose:	The purpose of this report is to provide an iCare Programme update

1. Introduction

The Trust successfully completed the labour-intensive task of finalising the system documentation in time for Cerner to build and demonstrate our solution at the System Validation event during week commencing 21st November. At this event, the Trust 'super-users' received in-depth demonstrations of the solution and gained hands-on experience of using the system in a safe, non-operational environment. A key element of this process was for these key Trust staff to request any changes to the build that they considered would improve the final solution. Immediately following System Validation, a significant number of Requests For Change (RFC's) were raised and test scripts and Future State Workflows were revised to support these. To give the maximum amount of time to prepare for system testing a decision was made to move the completion of the Configure stage from January into February and to start system testing on 3rd January rather than before Christmas. This has not created additional programme risk or jeopardised the proposed go-live dates

2. Progress to Date

The Programme comprises multiple projects and workstreams of which the following areas, although not exclusive, are critical to its ultimate success. A high level programme plan is shown at the end of this report. The dates may vary as the Programme progresses and should therefore be regarded as indicative at this point in time. There is work in progress to refine the scope of the go-live as part of the Configure Gateway deliverables and to further develop the draft cut-over plan which details the actions required to prepare for the transition at go-live and beyond. This is work in progress and requires more detail to be added**.**

2.1 Data Collection

The Trust teams have now successfully completed the definition of the baseline data required to allow Cerner to build our solution. As a result of the RFC's raised during and after the System Validation event in November, each of these areas had to be revisited to ensure alignment with these RFC's. This will be carried out in two stages allowing Cerner to build the changes required to support System Testing 1 (January 3rd – 24th) and System Testing 2 (January 27th – February 24th) respectively.

2.2 Data Migration

The Data Migration project remains on the programme critical path but good progress has been made over the last two months. Avoca, our third-party data migration specialist, carried out further data health-checks on the legacy Trust data. This is an iterative process where each extract reveals an ever decreasing number of issues requiring resolution. Although

there are some minor data quality issues still to be addressed at QMS and the PRU, the health check work is complete. The first data migration trial (TL1) of PRU and QMS data is due to take place on 8th February. This will give an indication of the data quality, time required to upload trust data and the amount of potential downtime at go-live which may lead to a revision of the go-live scope. These timings will be further revised at subsequent trial loads. Following each trial load there will be a number of data quality issues which will need to be resolved and the migrated data will be subject to testing to ensure that it is fit for purpose. The Data Migration Test Strategy and Test Plan have now been written and are out for review by the Data Migration Steering Group and Cerner.

2.3 Interfacing/Integration

The Trust went live with a new integration engine (Ensemble) on 17th January. The messages types required to be passed between Cerner Millennium and all Trust departmental systems via the Trust Interface Engine (TIE) have now been fully defined. High-level future state workflows (FSW's) have also been defined and are now being further refined in order to allow the interface design work to proceed. Draft design documents have been produced for Pathology and Radiology but further work is required. Design documents for the remaining system interfaces are also being progressed. Once these documents have been approved, the interface development work can begin. This will be undertaken by Ascribe, a third-party specialist supplier which has previous experience of working on the existing Trust interfaces. The first draft of the integration test strategy has been produced which, when approved, will detail how the interfaces will be tested as part of the overall integration testing activity scheduled for March and April 2012.

2.4 Testing

Cerner successfully carried out the unit testing of our system build prior to the System Validation event at the end of November 2011. Following this event, the Trust teams created the test scripts required to test the different workflows. This proved to be a lengthy process and in order to give the maximum amount of time to ensure that test scripts were robust System Testing was moved from December to early January 2012. This work is currently underway and is progressing well. One issue that has been encountered is the variety of PC build standards which have evolved over time. Each PC must conform to a defined build state to support the smartcard access to the system. This is currently being addressed by the ICT team. This re-scheduling of System Testing can be accommodated within the programme plan without impacting the proposed go-live dates.

2.5 Clinical Transformation

Clinical transformation continues to support the delivery of the programme. A benefits working group has been set up with divisional representation to ensure initial work stream benefits are aligned to corporate objectives. Key performance indicators have been agreed and baseline data has been captured for local and national benefits where relevant.

3. Risks

The Programme Risk Register documents risks at both the programme level (i.e. those risks which, should they materialise, could jeopardise the success of the programme) and the project level (i.e. risks to the constituent projects which, should they materialise, could impact the particular project but without impacting the ultimate success of the programme). The current Programme-level risks are listed as an Annex to this document. Although the Data Migration project is making good progress, it remains on the critical path for the Programme and the reduced testing time between trial loads presents the top risk to the programme.

4. NHSL Assurance Process

LPfIT representatives have now started work on the assurance process on behalf of NHSL. This process is expected to last 4 weeks. This review will contribute to the Configure Gateway Process. Recommendations will be made which will enable the Trust to strengthen its plans prior to going into integration testing and then onto go-live. The scope of the review is listed below.

- Data migration approach, particularly for the current waiting list;
- Results from testing (system validation) particularly in relation to the solution design for the 18 week pathway;
- Data warehouse design and approach to support 18 week reporting;
- Approach to transitioning to the Cerner 18 week solution from the current approach;
- Reporting strategy and plans for testing.

At the time of writing the Trust has not had formal notification of unconditional approval for the business case which is now published. A copy of the November Board minute has been sent to NHSL as requested.

5. Next Steps

5.1 Preparing for Trial Load 1 (scheduled for February 8th)

5.2 Continuing preparation for the Configure Gateway review at the end of February, refining cut-over plan and go-live scope

5.3 Complete the System Testing activities (scheduled to complete February 24th)

5.4 Carry out preparatory work for Integration Testing (first round of testing scheduled to commence February 27th)

5.5 Start of training conversion preparation

The Board is asked to note the progress of the programme, the risks going forward and the next steps.

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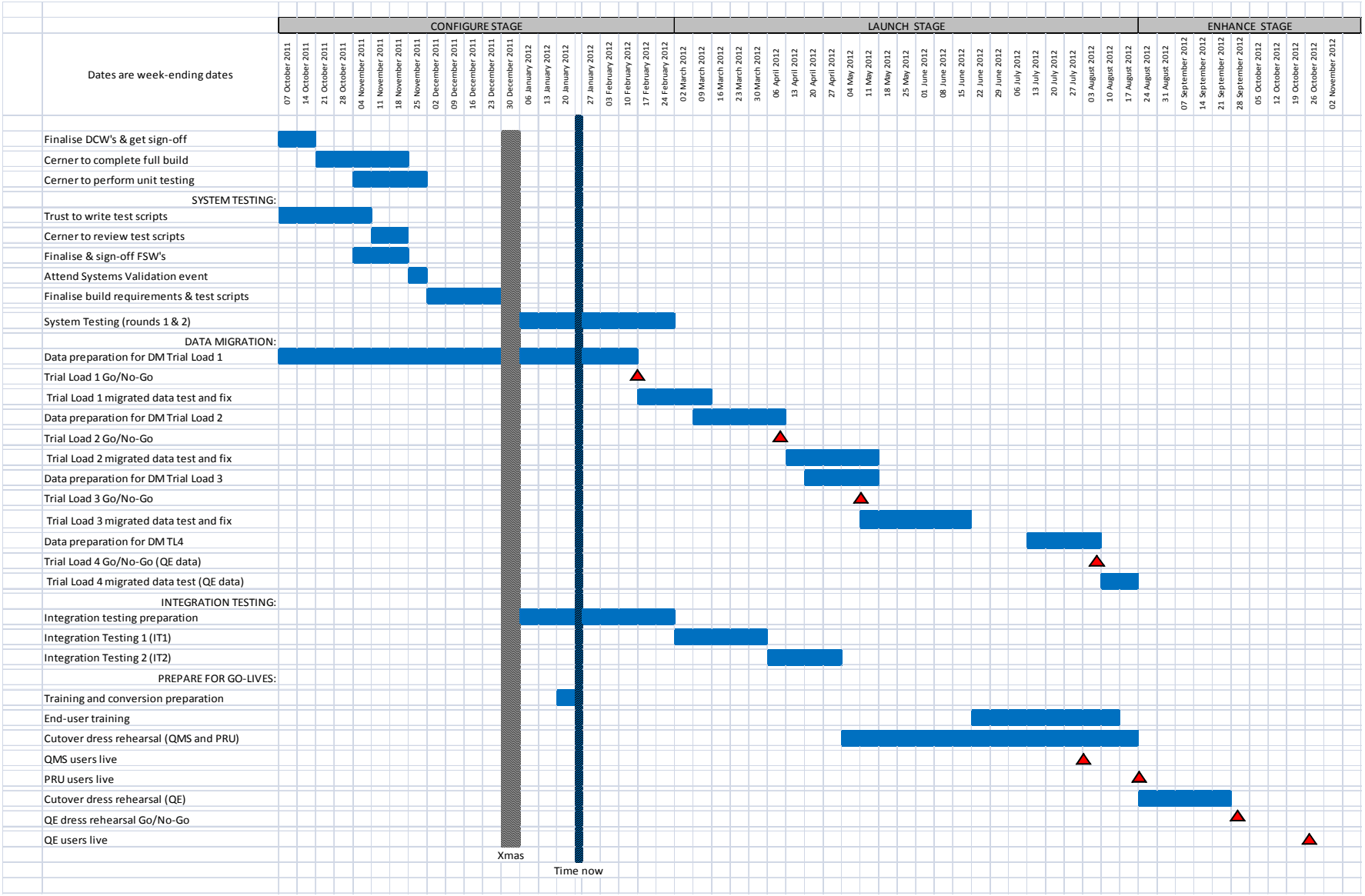
SOUTH LONDON HEALTHCARE NHS TRUST



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SOUTH LONDON HEALTHCARE NHS TRUST

					Last update:		17 January 2012		Risk Rating				Residual Risk							
Risk ID number	Raised by	Date raised	Project/Workstream /Programme	Accountable Risk Manager	Action Owner	Site	Risk Cause	RISK DESCRIPTION	Consequence	Likelihood	RAG GRADE	EXISTING CONTROLS/COUNTER MEASURES	Consequence	Likelihood	RAG GRADE	ACTIONS NEEDED TO IMPROVE CONTROLS (with date of update)	Proximity Date	Review Date	LEAD DIRECTOR	Date closed
RG0109	Laura Edwards	17 August 2011	Programme	Sharon Walker	Sharon Walker	All	The timeframe for the data migration	Because of the delays encountered within the data migration project, the testing time between trial loads has been reduced in order to maintain the programme timescales. This creates the risk of having reduced data quality at go-live.	5	4	20	Replanning testing to incorporate an Integrated testing plan, building scripts, then allocating sufficient resource to run and complete 'fit for purpose' tests in shortened timeframe. Possible requirement for evening and weekend working during TL tests.	5	3	15	17/1/12 - Testing strategy and plan developed. Tobe approved by iCare programme Team in January 2012. Testing time and resource to be detailed and arranged. Laura to draft strategy and discuss with Luke. The Testing Strategy has now been completed and Sharon will discuss with Luke and send to the DM Steering Group for approval 20.12.11.		17 January 2012		
RG0121	D Bhadare	01 August 2011	Programme	D Bhadare	Project Managers	All	Infrastructure	In key areas and where there is high usage, there is a risk that devices will not be available and accessible where/when they are needed for timely data entry.	3	4	12	Make better use of existing kit. There is a provision for equipment in the Programme Business Case capital budget and in the ICT annual capital budget for equipment refresh.	3	3	9	17/1/12 - Devices group set up to define requirements. Bulk hardware purchase in February 2012. Early roll-out of devices. Hardware Gap Analysis template issued on Nov 2011 for workstations, label printers and bar code readers.		17 January 2012		
RG0011	Graham Lee	May 2011	Programme	Shelagh Kirkman-Wood	Wanda Crook	All	Office and Training space	Due to Estates rationalisation, there is a risk that Trust will not be able to provide sufficient office space and Training facilities to support the Programme.	3	4	12	Estates plan to factor in programme requirements.	3	3	9	17/1/12 - Use of flexible training methods, including access to training domain from wards and departments. Accommodation requirements plan drafted. Flexibility in approach and use of training rooms across sites and use of hotdesking. Buy in training pods to increase capacity. 8/12 BW to identify training accommodation plans by 9/12 for inclusion in training plan which is gateway deliverable.		17 January 2012		

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SOUTH LONDON HEALTHCARE NHS TRUST

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Risk ID number	Raised by	Date raised	Project/Workstream /Programme	Accountable Risk Manager	Action Owner	Site	Risk Cause	RISK DESCRIPTION	Consequence	Likelihood	RAG GRADE	EXISTING CONTROLS/COUNTER MEASURES	Consequence	Likelihood	RAG GRADE	ACTIONS NEEDED TO IMPROVE CONTROLS (with date of update)	Proximity Date	Review Date	LEAD DIRECTOR	Date closed
RG0110	B Garden	11 August 2011	Programme	B Garden	B Garden	All	Functionality	SLHT's integration strategy requires that pathology results for GP tests are sent to Millennium. To achieve this the trust plan to send a patient registration message (ADT Inbound) to Millennium on receipt of the order. This requires approval from LPfIT which has not yet been obtained. LPfIT have stated that there are concerns around information governance and sending demographic data to a Spine connected system (Millennium). Approval is required before the Integration Scope can be finalised. The risk is that Results for some GP tests will not be available in Millennium.	4	4	16	Functionality in existence only at QEW and requires manual checking on whether it is registered in McKesson, followed by manual data entry if not registered.	3	3	9	17/1/12 - GP results can be obtained from the Pathology system. Activity to determine most cost effective solution to be performed during Jan 2012.		17 January 2012		
RG0138	Brian Garden	29 October 2011	Programme	B Garden	B Garden	All	Departmental Systems replacement strategy	If the lack of clarity around which departmental system interfaces will be required is not resolved, there is a risk that the interfaces will not be ready for Integration Testing 1 or retesting or Integration Testing 2.	4	4	16	The interfaces have been categorised in terms of the certainty of contracts being in place with Ascribe, who will be developing the interfaces.	3	3	9	17/1/12 - Ascribe have been contracted to build all required interfaces as per an agreed plan by 5 March 2012.		17 January 2012		
RG0147	Dil Bhadare	07 December 2011	Programme	Dil Bhadare	Dil Bhadare	All	Hardware delivery	Due to procurement controls and warning from manufacturers about parts from Asia affected by natural disasters risk to receiving hardware on time	3	3	9	Working closely with procurement and suppliers. Notification setup for known delivery risks.	3	3	9	17/1/12 - Early identification of requirements Work on long lead times for placing orders and commitment from suppliers of goods availability		17 January 2012		

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SOUTH LONDON HEALTHCARE NHS TRUST

					Last update:		17 January 2012		Risk Rating				Residual Risk							
Risk ID number	Raised by	Date raised	Project/Workstream /Programme	Accountable Risk Manager	Action Owner	Site	Risk Cause	RISK DESCRIPTION	Consequence	Likelihood	RAG GRADE	EXISTING CONTROLS/COUNTER MEASURES	Consequence	Likelihood	RAG GRADE	ACTIONS NEEDED TO IMPROVE CONTROLS (with date of update)	Proximity Date	Review Date	LEAD DIRECTOR	Date closed
RG0001	Graham Lee	May 2011	Programme	I Bailey	Valerie Swaby	All	Lack of engagement	Non availability of key resources to provide input to analysis, design, testing and support rollout. Without this input, there is a risk that adoption of the Cerner Millennium solution by staff will meet with some resistance.	5	3	15	17/1/12 - The programme's transformational team is assisting with engagement activities. Engage with Stakeholder Group to devise strategy to improve engagement with Trust staff.	4	2	8	17/1/12 - iCare roadshow held with considerable interest from staff. Increase in the number of Drs attending DR compared with SR. Clinical Champions and Super Users identifed at SLHT with roles and resonsibilities scoped out. Clinical engagement sessions held with input from Drs. Drs engaged in DCW process and in some instances signing off designs.		17 January 2012		
RG0009	Graham Lee	May 2011	Programme	Luke Wiles	Luke Wiles	All	Build	Local build output may not be as expected due to the complexity of links between the DCW (Data Collection Worksheets) and DDM (Design Decision Matrix)	4	3	12	Ensure DCW's are accuaretely complied, validated and kept up to date. Validate build based on DCWs. Unit testing of DCW builds included in Test Strategy.	4	2	8	17/1/12 - RFC process in place. Worked well for ST1; now addressing ST2. DCW's, FSW's and DDM's are being signed off by the Divisions. Any further changes will be via formal change control. Detailed test plan with test scripts are being produced. 08/12 DCW's, FSW's and DDM's signed off. Test scripts written. RFC process working well. Cerner to complete build ready for ST1 (3/1/2012).		17 January 2012		
RG0013	Graham Lee	May 2011	Programme	Shelagh Kirkman-Wood	Luke Wiles	All	System Performance	Performance and Volume testing is not included in scope of Phase 1.It is not practical or economically viable for SLHT to undertake this testing. There is a large uplift in users from QMS to SLHT wide and a risk that degradation in system performance will have an operational impact.	4	3	12	Performance at QMS site subject to SLA. Centralised testing by BT/LPfIT has been undertaken and report received assessing scalability.	4	2	8	Close Monitoring of performance as deployment progresses.		17 January 2012		

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SOUTH LONDON HEALTHCARE NHS TRUST

					Last update:		17 January 2012		Risk Rating				Residual Risk							
Risk ID number	Raised by	Date raised	Project/Workstream /Programme	Accountable Risk Manager	Action Owner	Site	Risk Cause	RISK DESCRIPTION	Consequence	Likelihood	RAG GRADE	EXISTING CONTROLS/COUNTER MEASURES	Consequence	Likelihood	RAG GRADE	ACTIONS NEEDED TO IMPROVE CONTROLS (with date of update)	Proximity Date	Review Date	LEAD DIRECTOR	Date closed
RG0120	D Bhadare	21 July 2011	Programme	D Bhadare	D Bhadare	All	Infrastructure	Unless the trust technical team understand the message flows and Cerner printing solution, there is a risk that the network design will not be able to be agreed. This is vital to assure connectivity for printing and messaging.	4	3	12	Technical workshop with BT and Cerner booked for 7 Sept 2011 to address these issues.	4	2	8	17/1/12 - Detailed meeting on printing to be held with Cerner on 18/1/12. Workshop held with BT/Cerner on 6 Oct 2011. Further session planned in Dec 2011 to review documentation and network mapping diagram.		17 January 2012		
RG0149	Lorraine Knight	07 December 2011	Programme	Lorraine Knight	Chris Jennings	All	Reporting	Unless NHS London receive adequate assurance that RTT and Activity Reporting will not be adversely affected at go-live, there is a risk that NHS London temporarily halts the programme.	4	3	12	LPfIT team working with Trust staff on Reporting and RTT.	4	2	8	17/1/12 - Take action on any recommendations from the review. Monitor through the Programme Team.		17 January 2012		
RG0106	Shelagh Kirkman-Wood	05 August 2011	Programme	Shelagh Kirkman-Wood	Wanda Crook	All	Resources/Financial	Procurement process for trainers has not yet started. This introduces the risk of a delay to the training programme.	5	3	15	17/1/12 - Tender specification under construction. ITT sent out by Procurement in December 2011.	3	2	6	17/1/12 - Two week turnaround time given to suppliers. Tender evaluation meeting to be held on 23/1/12. Plan to award tender by February 2012.		17 January 2012		
RG0094	Tracy Ross	28 July 2011	Programme	D Bhadare	Project Managers	All	Infrastructure	Lack of available space to accommodate additional hardware for clinical areas that are short of devices.	3	3	9	Hardware locations to be identified and requirements escalated to Dil Bhadare.	3	2	6	Review the potential for using movable trolleys or smaller footprint devices. Workstreams leads to identify areas with space issues on the Hardware Gap Analysis		17 January 2012		

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SOUTH LONDON HEALTHCARE NHS TRUST

					Last update:		17 January 2012		Risk Rating				Residual Risk							
Risk ID number	Raised by	Date raised	Project/Workstream /Programme	Accountable Risk Manager	Action Owner	Site	Risk Cause	RISK DESCRIPTION	Consequence	Likelihood	RAG GRADE	EXISTING CONTROLS/COUNTER MEASURES	Consequence	Likelihood	RAG GRADE	ACTIONS NEEDED TO IMPROVE CONTROLS (with date of update)	Proximity Date	Review Date	LEAD DIRECTOR	Date closed
RG0119	D Bhadare	27 July 2011	Programme	D Bhadare	D Bhadare	All	Resourcing	Without sufficient technical resources for the infrastructure Work stream, there is a risk of delays to the overall Implementation Programme. This Workstream requires significant technical resources to support the infrastructure and manage the devices to ensure it meets Cerner/BT specifications.	4	4	16	Full time Cerner Technical resource appointed from Agency. IT undergraduate Work placement.	3	2	6	17/1/12 - Three Cerner Technical resources required from Feb 2012 to end Dec 2012. Take to VCG. Cerner Technical resource appointed from Sept 2011 to March 2012.		17 January 2012		
RG0134	Laura Edwards	12 October 2011	Programme	Sharon Walker	Sharon Walker	All	Data Migration	Uncertainty around data migration scope has put the delivery schedule of the archive solution at risk.	3	3	9	The issues are being resolved through the Data Migration Steering and Design Authority Groups.	3	2	6	17/1/12 - Scope of the Archive solution discussed at the DM Steering Grou p on 13.12.11 .		17 January 2012		
RG0137	Laura Edwards	01 September 2011	Programme	Sharon Walker	Sharon Walker	All	Data Migration	Current Testing Strategy excludes DM testing. If this is not addressed, the programme testing schedule will be compromised.	4	3	12	Testing strategy and plan under development.	3	2	6	17/1/12 - Take to Programme Team for approval, ensuring early identification of resources. Present the Testing Strategy and Testing plan to the DM Steering Group 20.12.11.		17 January 2012		

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SOUTH LONDON HEALTHCARE NHS TRUST

					Last update:		17 January 2012		Risk Rating				Residual Risk							
Risk ID number	Raised by	Date raised	Project/Workstream /Programme	Accountable Risk Manager	Action Owner	Site	Risk Cause	RISK DESCRIPTION	Consequence	Likelihood	RAG GRADE	EXISTING CONTROLS/COUNTER MEASURES	Consequence	Likelihood	RAG GRADE	ACTIONS NEEDED TO IMPROVE CONTROLS (with date of update)	Proximity Date	Review Date	LEAD DIRECTOR	Date closed
RG0005	John Hampson	29 June 2011	Programme	Lorraine Knight	Lorraine Knight	All	Financial	NHS London have not yet signed the Cerner upgrade programme Business Case. Until such time as this is signed (scheduled for July 2011), the programme is proceeding at Risk.	4	3	12	NHS London has posed a series of questions to be answered prior to approval of Programme Business Case. Trust response has been produced, signed by SLHT CEO and submitted to NHS London.	3	1	3	17/1/12 - Review of Reporting and RTT by LPfIT underway. NHSL Capital Investment Committee approved the Business case on 13 October and have documented their conditions in the acceptance letter. Trust has sent its response to NHSL. Agreement by Trust Board to publish response on Trust web site. Trust has agreed to a stocktake by NHSL on Reporting.		17 January 2012		
RG0113	Valerie Swaby	September 2011	Programme	Valerie Swaby	Valerie Swaby	All	Corporate Enabler	Delay in identifying and realising benefits for each workstream ahead of gateway reviews	3	2	6	Set up mothly Benefits Working Group wih representaion from operational teams and Project Managers. Establish mechanism for monitoring progress with KPI's	3	1	3	17/1/12 - Continue to monitor progress across all sites. Staff attended initial Benefits Working Group at QE. Benefits reviewed and mapped onto benefits tracker, KPI' s established, identified operational owners and developed benefits trajectory graph to map progress.		17 January 2012		

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SOUTH LONDON HEALTHCARE NHS TRUST

Subject	Chief Executive's Report
Report by	Dr Chris Streather, Chief Executive
Author	Dr Chris Streather, Chief Executive
Executive Director	Dr Chris Streather, Chief Executive

TRUST OBJECTIVE

Our Patients	**x**
Financial Viability	**x**
Leadership and Workforce	**X**
High Quality Clinical Care	**X**
Healthcare Acquired Infections	**X**
National and Local Priorities	**x**
Service and Facilities fit for the future	**x**

GLOSSARY

Abbreviation	In Full
CEO	Chief Executive Officer
IRP	Independent Review Panel

WRITTEN REPORT (provided in addition to cover sheet) Yes

POWERPOINT PRESENTATION No

PURPOSE OF THE REPORT / PRESENTATION

To inform the Board of the following items

- Recommendations to the Board on the future use of Orpington Hospital and services in Orpington.
- A report on the Trust Estates Strategy – Queen Elizabeth Hospital, Woolwich, Queen Mary's Hospital, Sidcup
- The Trusts Medium Term Financial Model

SUMMARY OF KEY ISSUES

As set out in the report.

SOUTH LONDON HEALTHCARE NHS TRUST

SUMMARY OF KEY RISKS

- The report contains recommendations from the Orpington Project Group on the future of services in Orpington following an engagement with services users and clinicians

RECOMMENDATION / DECISION REQUIRED

Board is **ASKED** to

1. **APPROVE** the delegation of powers to the Chair and Chief Executive to agree to content and scope of the consultation.

2. It is recommended the Board:

   a. **NOTES** progress with the potential rationalisation opportunities for each of the Trust's main sites (Paragraphs 4 to 10);
   b. **APPROVES** designation of the rear of the Queen Mary's Sidcup site as surplus to the Trust's requirements (Paragraph 6);
   c. **APPROVES** the issuing of marketing packs for Frognal & Training Centre to an appropriate timetable (Paragraph 6).

3. For the Board to **CONSIDER** the Trust's Medium Term Financial Model

IMPLICATIONS

Are there any implications for Care Quality Commission Registration?	Yes
Is an Equality Impact Analysis Required?	Yes[1]
Are there any legal Implications arising from this item?	No
Are there any Financial implications arising from this item?	Yes

1. Equality Impact Analysis for Orpington Hospital Project has been done as part of needs assessment

SOUTH LONDON HEALTHCARE NHS TRUST

1.0 Update on Orpington Hospital Project

16th January 2012

1.1 The Trust Board received an update in November 2011 on this project. The Board will recall Orpington Hospital and the necessary services to meet local needs has been an unresolved issue since "A Picture of Health' which left around half the building as unused once elective care moved off-site. Resolution for Orpington Hospital was one of the stipulations from Independent Review Panel (IRP) feedback. SLHT has served notice to Commissioners that it will not provide services at Orpington Hospital in their current configuration after April 2012.

1.2 This short paper is intended to give SLHT board an update on the progress of the Orpington Health Services project and seek delegation to enable consultation to begin before the March Board should this be necessary on the changes that are under consideration.

2.0 Progress

2.1 Orpington Project Team has been established including the full range of Stakeholders (5 members of public drawn from voluntary sector LINK patient groups and League of Friends), GPs, Staff side, SLHT Clinicians and public health.

2.2 The group covers both the Commissioner and Hospital ownership issues (SLHT) and have:

- Undertaken a needs assessment
- Identified the services required to meet needs
- Calculated the space requirement to deliver care
- Established an option appraisal on the best site to deliver the new model of care and are currently completing the financials.

2.3 The proposed new services bring together Practices and the essential community and diagnostic services to support Primary Care in a preventative model supporting the out of hospital care agenda.

2.4 Most of the outpatient services currently delivered in Orpington Hospital are to be transferred to Princess Royal University Hospital – 2.6 miles away

2.5 A health and well being facility is to be developed and the option appraisal is considering if this should be delivered;

- In the current hospital.
- Rebuilt in a smaller footprint on a portion of the site.
- Located on the Orpington High Street or other off-site local location.

2.6 The option appraisal seeks to conclude on 16th January, provide further information for consultation and provide data to inform any future business case. All options

require investment of capital to offer the modern healing environment. The business case will need to address how capital could be obtained to fund any redevelopment off or on site.

2.7 The subject of consultation would be on the services being provided, rather than the facility in which they will eventually be provided. So the focus of consultation will be;

- Increased preventative and health improvement activity with diagnostic support
- Premises improvements and relocation for several GP Practices
- Future locations and access for Hydrotherapy
- Potential to bring alongside community physiotherapy, mammography, mental health support and other enabling services
- Location for the hub of SLHT dermatology service
- Dispersal of some services such as phlebotomy and warfarin over time to increase very local access for patients
- Transfer of outpatients from Orpington hospital to the PRUH
- It is to be noted there is a parallel consultation issue affecting the only inpatient beds on site (the intermediate care beds)

2.8 Looking at the proposed changes and latest legal, it maybe that the nature of the change to services is not substantial[1] in the terms of section 242 (1B) of the National Health Service Act 2006, and so is not subject to a formal public consultation. However, we believe that any proposals will be enhanced, improved and more responsive to patients if we undertake some consultation process and we intend to do this and consult with the Overview and Scrutiny committee about its nature.

3.0 Engagement

3.1 There has been an extensive engagement approach to date involving two public meetings (>100 attendees each time), local drop in sessions, staff meetings, attendance at groups, published information on the website and stakeholders fully participating throughout. Individual meetings with all affected Councillors have been offered with many taking these up and valuing the opportunity. Meetings have been held with all key portfolio Councillors, the Bromley Council Leader and MP twice during the engagement phase.

4.0 Key issues raised

4.1 Our engagement work and ongoing project meetings have brought a number of issues to the forefront that we hope to address in the next stage of the project. These include:

- Transport/parking
- Hydrotherapy pool

[1] Regulation 4 of the OSC Regulations provides that where a “local NHS body…has under consideration any proposal for a substantial development of the health service in the area of a local authority, or for a substantial variation in the provision of such service, it shall consult the overview and scrutiny committee of that authority”.

- Wanting to see increased maternity and other hospital services to fill the vacant space
- Patient experience
- Proceeds of any sale
- Intermediate care
- Nursery facility

5.0 Current timelines

- Complete option appraisal mid January
- Public Consultation February 2012
- Agree changes May 2012
- Likely new service over 18 months

6.0 Risks

6.1 Securing the capital to facilitate alternative solutions

6.2 Ensuring viable alternatives to the current configuration so the present under utilisation of the Orpington Hospital site continues or increases.

6.3 One of the key risks should the options appraisal and subsequent consultation suggests a move off the current hospital site, is public concern at perceived loss of services and a hospital. We aim to mitigate this risk in a series of ways:

- Clear communication throughout the consultation period with regard to the retention of current services and the addition of new health services to the area – albeit delivered in alternative locations
- Ongoing engagement with patient groups, local politicians and key stakeholders to ensure that messaging is clear

7.0 Next steps

7.1 Completion of option appraisal with recommendations
7.2 Decision on the nature and length of consultation and consultation plan
7.3 Launch of consultation with support of Local Clinical Commissioning Committee and SLHT Board
7.4 Attendance at Health Subcommittee of the London Borough of Bromley Overview and scrutiny committee on 16th February 2012 and delivery of remainder of consultation plan.

8.0 Decision Required

8.1 Due to the timelines involved in the project and the timing of meetings of the relevant committees named above, we are seeking approval from The Trust Board for delegated powers to the Chair and Chief Executive to agree to content and scope of the consultation.

SOUTH LONDON HEALTHCARE NHS TRUST

9.0 Trust's Estate Strategy Programme.

9.1 RECOMMENDATION

It is recommended that Trust Board:

a. **NOTES** progress with the potential rationalisation opportunities for each of the Trust's main sites (Paragraphs 4 to 10);
b. **APPROVES** designation of the rear of the Queen Mary's Sidcup site as surplus to the Trust's requirements (Paragraph 6);
c. **APPROVES** the issuing of marketing packs for Frognal & Training Centre to an appropriate timetable (Paragraph 6).

9.2 BACKGROUND

The Trust undertook a full briefing to NHS London in December on its Estates Strategy Programme, with the aim of ensuring that the SHA is aware of the range and complexity of the issues the Trust is handling as it strives to derive maximum benefit and value from its Estate, land and buildings.

9.3 Queen Mary's Sidcup (QMS)

At QMS, the Trust is working with the Local Planning Authority (LPA) to develop a Master Plan for the site. The Master Plan will aim to set out a sustainable vision for clinical services on the site, which will be developed in concert with other health partners and providers. The Trust and its external property and design advisors have already met twice with the LPA team, and the Trust is currently developing proposals for the relative heights, masses and scales of current and potential future buildings on the site. This will help to inform planning considerations regarding how the former Kent Women's Wing and surrounding land can both realise a benefit to the Trust and align with local needs and requirements.

The Frognal & Training Centre will be fully vacated at the end of January 2012, and a new facility is currently under construction – the Hockendon Training Centre – which will provide high quality clinical and other training accommodation. It is confirmed that reductions in utilities and rates from closing the building have already been captured as Cost Improvements for FY 2012/13. The area beyond the Frognal & Training Centre is used for car parking, and plans are already in hand to reduce the Trust's car parking footprint in that area and to consolidate parking provision elsewhere on the site.

There have been a number of expressions of interest regarding the Frognal & Training Centre from organisations that would potentially be suitable tenants and neighbours on the QMS site. In order to formally explore the opportunities that exist, Trust Board is asked to APPROVE declaration of the rear of the site (as shown on the QMS Development Control Plan at Annex A) as surplus to the Trust's

requirements, and to APPROVE the issuing of marketing packs for Frognal & Training Centre to an appropriate timetable.

It is emphasised that declaration of the area as surplus does not carry with it an approval to dispose of any land or buildings, or to establish tenancy arrangements with any external company or other entity. Instead it is confirmed that the potential disposal of any assets, or the granting of any leases or licences, will be a matter that will be reserved to Trust Board for consideration.

9.4 Queen Elizabeth Hospital (QEH)

On the QEH site, work will shortly commence on the new 198 space patient car park, the Full Business Case for which Trust Board recently approved, and for which the procurement process has successfully been completed. The new car park will make a significant contribution to mitigating the parking pressures that currently exist on the site, and the fact that the Local Planning Authority granted planning permission for the scheme reflects their strong support for the hospital and the quality of the patient experience there.

In parallel, work has commenced to convert the lowest two floors of St Nicholas' Tower into Trust office accommodation. This in particular will enable administrative staff to be transferred out of Ranken and Brook Houses on the site, which currently not efficiently utilised as regards occupancy.

9.5 Orpington Hospital

For Orpington Hospital, a Project Board that is being led by the Bromley Commissioners' Business Support Unit has led and successfully completed a Clinical Needs Analysis of the health issues that exist within the locality, together with a high level specification of the amount of floor space that each clinical service requires. Two public engagement events have been held to seek the views of local people about the range of services that should be provided locally, and those events have been very well supported.

1. Executive Summary

This document sets out the response to the key question regarding viability posed at the 28th September Board to Board with the Strategic Health Authority. The primary focus of the document is to answer the question do we have a credible and deliverable plan to achieve financial balance, and therefore Foundation Status, over a five year time frame? There is a secondary question about the organisation's, and the local health economy's, ability to deliver that plan.

The task to deliver this is substantial, given the size of financial difficulty we inherited, and still face, despite a track record of delivery of significant cost reductions of £70.72 million in the period 2009 to 2011 and a further programme of £22.63million (5.26%) in 2011/12. The overall anticipated position for 3 years (2009-11) a cost reduction of £93.36 million equivalent to 7.08% during this period.

Our mission to deliver a constant improvement in quality, access and financial performance, requires further significant development of leadership capacity, and is in the face of some well known historic obstacles and a distinctly challenging local political environment. However, some confidence can be derived from the substantial progress made on quality and the delivery of strategic change in this environment.

The document has been set out in the format of an Integrated Business Plan for a number of logical reasons. It must be noted that the document portrays the position as understood by the Trust Board in December 2011. The question addressed within the document is fundamentally concerning viability, and the journey to Foundation Status, and this format allows easy comparison with a conventional Foundation trust (FT) application. In addition, and given the size of the task we are facing there is a logic to using this document as a template/platform from which we will develop further more comprehensive versions as we advance along the pathway.

However, the paper differs in detail from a conventional Integrated Business Plan (IBP). There is a much stronger emphasis on the purely financial issues, sections six and seven of a conventional IBP. There, naturally given the magnitude of the undertaking is also a stronger emphasis on risks and their mitigation.

Some sections are short in order to emphasize on the key question, but will be left in to support the further iterations of our more comprehensive piece of work. There will be some exceptions to this. Within the delivery sections there is quite a long section on culture and our organisational development strategy. It is well known that twenty five percent of FT applications fall short on the basis of inadequate Board development, and we want to highlight our awareness of this issue, and our high level of preparedness to deal with the risk.

As described above it is obvious that a clear path to financial balance is the primary question. This does have to be delivered in the context of a continued consistent improvement in the quality of patient care, and in an environment where we are consistently delivering timely care against national access targets. In addition this has to occur in an environment where we have a long term strategy that is appropriately future proofed.

The creation of South London Healthcare NHS Trust has led to a measurable and well evidenced improvement in quality. Notably, but not exclusively, in emergency care, reflected in an HSMR of 90, maternity, where are services from a low baseline have become amongst the best in London, and in stroke care.

This has been delivered in pressing financial circumstances, alongside large scale service change, moving from three to two hot sites.

At the end of this document we append our Clinical Service Strategy (Appendix A); in essence the fundamental objective of the strategy to continue to improve the quality of fundamental inpatient secondary care and its productivity, and to pick up measured opportunities in high end secondary care to reflect our 850,000 population base and local skills, using the Hyper acute Stroke Unit as a model example. Throughout this strategy there is a commitment to being open about metrics to evidence improvement.

Notwithstanding this the key to the organisation's survival is to deliver a succession of financial improvements.

The table below presents the net outcome of the downside modeling and associated mitigations contained within the document.

Forecast I&E 2012/13 to 2016/17 Base Case v Downside	12/13 £m	13/14 £m	14/15 £m	15/16 £m	16/17 £m
Base Case Surplus / (Deficit)	(58.8)	(41.7)	(35.0)	(30.5)	(30.5)
Downside Case (Deficit) after mitigation	(73.8)	(51.1)	(51.7)	(45.7)	(40.2)

The document also identifies cost improvements over the life of the plan as follows:

CIPs by year	12/13	13/14	14/15	15/16	16/17	Total
Value £m	29.9	25.0	25.0	18.8	14.0	**112.7**
Value %	6.0%	5.2%	5.1%	3.8%	2.9%	**4.6%**

Key points to note from the tables:

- The base case deficit of £30.5million excludes predicted PFI funding of £21million which would therefore reduce this deficit down to £9.5million. This funding is included in the downsize case after mitigation.
- The CIP programme is clearly a very challenging target and is £29m greater than the estimate of what national efficiency requirements will be over the period. A full description of our proposed CIPs plan is detailed in Section 7.4.
- The tables above highlights that, in the event of all of the downside scenarios occurring together, the Trust will not be able to achieve to the trajectory in the base case and would continue to have a major deficit and therefore would not achieve a risk rating of 3 against FT criteria by 2016/17.
- The implementation of Service Line reporting by March 2012 will provide an opportunity to both gain greater understanding of service profitability and to drive productivity and efficiency across the Trust.

Within the key areas of financial focus for SLHT the first two of these are entirely within our own gift. Principally a substantial improvement in productivity across the Board, delivered over the next 18 months. We have spent the last three months developing this in detail, and this will entail a reduction in headcount of 695 staff, some of which has already begun with the launch this month of a Mutually Agreed Resignation Scheme (MARS). The comprehensive plan, and its implementation is included in appendix B, and represents a saving of >£30m recurrently.

The second of these is a comprehensive estates rationalization plan, (appendix C) to this document. As can be seen later in the body of this document, our downside case includes a mitigation approach that reduces our footprint from three to two large sites, and some of the risks, and implementation challenges of this approach are described in the appropriate sections. Of key note the financial benefit of moving from the QMS site is offset by a number of factors including the complex political landscape, consultation, anticipated risk on elective activity and non recurrent workforce costs.

The remaining issues, including excess PFI costs, need to be part of Health Economy or National solutions. However we have a clear understanding that we need to deliver our component quickly, and without a negative impact on quality and access to be the beneficiaries of wider solutions.

There is a genuine difficulty with the arithmetic of our mitigation against a full blown downside case. There are a number of approaches to this. Firstly as well as taking seriously the most radical estates solution, and assuming the negative effect on income can be managed, we have seriously explored a whole sale approach to outsourcing of corporate, but maybe some middle and front office functions. Again the paper describing this approach is included as an appendix D, and some conservative assumptions about gains from this are included in our mitigation. We are preparing a business case to explore this formally and test the market to be agreed at our January 2012 Board.

There is also a conundrum about the apparent gap between our income and our reference costs. An increase in income from commissioners over and above the SAFE analysis assumptions is not a practical solution, and there has been a step change in the quality of partnership working recently, which may allow a measured capacity and demand response to this issue. There may be some utility in some independent analysis of how this gap has arisen, if only to enable the partnership working that will be an essential feature of any solution.

Finally there is an important message that some clarity about the future, though conditional on delivery, helps to create a stable platform from which to deliver the productivity and estates savings that are necessary, whether or not there is a credible route to Foundation Status

Next Steps:

The focus is clear for the Trust in relation to next steps.

- Delivery of the Productivity and efficiency improvements with implementation of the workforce productivity programme commencing in January 2012, focus on sustainable performance delivery to achieve improvements in theatre productivity and length of stay. Pace of delivery ambitious for 2011/12 reflecting ability for the SLHT management team to proceed quickly.

- Delivery of the Estates rationalisation programme to include resolution of the Orpington Site by April 2012.

- Deliver with partners the work programme in planning a sustainable future for the BBG Health Economy. The Programme "The Big Think" will require strong clinical engagement from all disciplines, with focus on long term conditions such as Elderly Care, Cardiology and Diabetes. These partners include Kings Health Partners, Oxleas, Primary care and local authorities.

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SOUTH LONDON HEALTHCARE NHS TRUST

Subject	Board Assurance Framework
Report by	Jennie Hall, Deputy Chief Executive / Chief Nurse
Author	Dominic Ford, Assistant Director of Governance
Executive Director	Jennie Hall, Deputy Chief Executive / Chief Nurse

TRUST OBJECTIVE

Our Patients	**x**
Financial Viability	**x**
Leadership and Workforce	**x**
High Quality Clinical Care	**x**
Healthcare Acquired Infections	**x**
National and Local Priorities	**x**
Service and Facilities fit for the future	**x**

GLOSSARY

Abbreviation	In Full

WRITTEN REPORT (provided in addition to cover sheet) Yes

POWERPOINT PRESENTATION No

PURPOSE OF THE REPORT / PRESENTATION

To provide an update to the Trust Board of the key risks to the Trust strategic objectives

SUMMARY OF KEY ISSUES

Key finance, performance, workforce, infection prevention, patient safety and experience and estate risks are described in the attached document

SUMMARY OF KEY RISKS

Attached

RECOMMENDATION / DECISION REQUIRED

To review the Board Assurance Framework

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SOUTH LONDON HEALTHCARE NHS TRUST

IMPLICATIONS

Are there any implications for Care Quality Commission Registration?	Yes
Is an Equality Impact Analysis Required?	No
Are there any legal Implications arising from this item?	No
Are there any Financial implications arising from this item?	As described

REVIEW

Trust Committee	**Date**
Trust Board	25th January 2012

REF.	TRUST OBJECTIVE	PRINCIPAL RISKS	Initial risk rating			EXISTING CONTROLS	Current risk			ACTIONS NEEDED TO IMPROVE CONTROLS	Review Date	ASSURANCE (EXISTING ASSURANCE / GAPS &/OR RECOMMENDED ASSURANCE)	LEAD DIRECTOR	CQC OUTCOME
			Consequence	Likelihood	RAG GRADE		Consequence	Likelihood	RAG GRADE					
Corporate Objective One: Our patients														
We will put patients at the centre of everything that we do. We will ensure that all patients experience care that is safe, maintains their dignity, treats them with respect and leads to agreed outcomes.														
1.1	Patient safety	Continued occurrence of hospital acquired pressure ulcers	3	4	12	Pressure ulcer policy; education and training programme; wound care link nurses; risk assessments; specialist advice; bed contract; specialist equipment;	3	3	9	HCA training; training tracker for PU care and ulcer grading; heel boots trial	monthly	Monthly data analysis; performance scorecards reporting to Board, EMT, divisions and wards; Dr Foster data	Deputy Chief Nurse	4
Corporate Objective Two: Financial Viability														
We will develop and commence implementation of a strategy to achieve and sustain financial viability in readiness for a future foundation trust application, ensuring that our services are provided within available financial resources and that we get paid for the services we provide.														
2.1	Financial viability	Income and expenditure position: Risk that Trust will not receive income required; non-delivery of cost improvement programmes; and inadequate cost control	5	5	25	Financial plan agreed with NHS London in June 2011 Forecast £69.8m deficit. No Board approved business plan or budget for 2011/12.	5	4	20	Use the budgets that support the plan agreed with NHS London to enable monitoring and control; Ensure a robust process to enable the Board to sign off the business plan and budget for 2012/13; Develop and implement a sustainable approach to service line reporting;	weekly	Monthly financial reporting; performance reviews	Finance Director	26
2.2	Financial viability	Cash position: Trust is dependent on cash support from Department of Health to continue to operate; with risks to continued payment of creditors	5	5	25	Cash business case accepted by NHS London; Cash rolling 13 week forecast; Cash management procedures	5	2	10	Reduce / eliminate the deficit	monthly	Monthly financial reporting; performance reviews	Finance Director	26

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			Consequence	Likelihood	RAG GRADE		Consequence	Likelihood	RAG GRADE					
2.3	Financial viability	Financial statutory duties: Risk that Trust will not be able to meet its statutory financial duties including: capital resourcing limit; external financing limit; return on capital	5	5	25	Capital Management Board, Capital Finance Reports	5	2	10	Clear programme planning to clarify accountabilities. Ensure key elements of the plan are approved by Trust committees. Use organisational performance management arrangements to deal with any issues	weekly	Monthly financial reporting; performance reviews	Finance Director	26
2.4	Financial viability	Financial processes: Risk of non-compliance with standing financial instructions; sign-off of annual accounts	5	5	25	Standing Financial Instructions, Finance Procedures, Financial Governance Improvement Plan	5	2	10	Implement Financial Governance Improvement Plan. Ensure robust programme planning and management in place through Senior Finance Team meeting. Identify any capacity gaps and fill	weekly	Monthly financial reporting; performance reviews	Finance Director	26

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			Consequence	Likelihood	RAG GRADE		Consequence	Likelihood	RAG GRADE					
Corporate Objective Three: Leadership and workforce														
We will provide positive leadership and effective management and engagement of staff at all levels and in all disciplines in the transition to the new organisation to ensure a safe and supportive working environment. We will develop a workforce that is increasingly sensitive to the needs of patients, exploits every opportunity to improve its productivity without sacrificing quality of care, and is proactive and flexible in its approach to service change.														
3.1	Leadership and workforce	Staffing Levels may be compromised as a conqequence of Workforce Transformation Programme with impact on patient safety and service delivery	4	3	12	Executive sponsors and work-stream leads for all work-streams; evaluation and risk assessment processes for disestablishment of posts; organisational change framework; job planning processes; communication and engagement processes	4	3	12	Clinical assurance panel established to test potential safety and quality impact; formal consultation on proposals; KPIs for each work-stream	monthly	PWC benchmarking of staffing levels with comparator organisations; CQC QE and PRUH inspection reports; Patient perception of staffing levels (CQC IP survey); Audit Commission reports on medical and nurse	Chief Nurse/Deputy Chief Executive	13
3.2	Leadership and workforce	Staffing satisfaction	4	3	12	Staff Satisfaction action plan in place. Implementation of Trust values. Implementation of OD strategy, staff support initiatives through organisational change programme, staff awards and a range of communication tools, including emails, open forums, Trust magazine.	4	3	12	Further actions to improve satisfaction - Work shadowing event undertaken, follow-up meeting arranged for participants. Further embedding of Trust values. Pilots launched for on-line staff satisfaction survey. Well-being events planned linked to Olympics. Staff awards process in place.	monthly	National Staff Survey, workforce KPIs, HR Sub committee reports.	Director of HR & OD	14

REF.	TRUST OBJECTIVE	PRINCIPAL RISKS	Initial risk rating			EXISTING CONTROLS	Current risk			ACTIONS NEEDED TO IMPROVE CONTROLS	Review Date	ASSURANCE (EXISTING ASSURANCE / GAPS &/OR RECOMMENDED ASSURANCE)	LEAD DIRECTOR	CQC OUTCOME
			Consequence	Likelihood	RAG GRADE		Consequence	Likelihood	RAG GRADE					
3.3	Leadership and workforce	Levels of statutory and mandatory training are insufficient to meet Trust requirements	4	4	16	L&OD action plan in place. Monthly face to face updates held on all sites. E-learnong modules available to all staff. Bespoke training offered as required. Piloting social learning platform including statutory and mandatory modules. Implementation of passport scheme for junior doctors. Monthly reporting of compliance. Quarterly reporting of non-compliant individuals.	4	4	16	Increase number and frequency of bite-sized face to face sessions. Support managers to enable their staff to complete training. Support staff not IT confident to start e-learning. Divisions to develop local action plans to improve compliance. Hold managers to account for non-compliance in area.	monthlyy	Learning & OD KPIs	Director of HR & OD	14
3.4	Leadership and workforce	Clinical Engagement	4	3	12	Medical Director's engagement programme, High performing team development available, multi-professional leadership development, coaching and mentoring through London Deanery	4	2	8	Work with clinicians on a number of organisational development interventions which will include job planning, revalidation, appraisals and objective setting. There is a requirement for Clinical Directors to develop their leadership skills. There is a 2-monthly development programme for Clinical leaders including management and leadership priorities. 360 degree appraisal reviews are available using the new Leadership Framework.	monthly	National Staff Survey, workforce KPI's, HR sub-committee reports, Job planning outcomes, service delivery performance and appraisal feedback.	Medical Director	14

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			Consequence	Likelihood	RAG GRADE		Consequence	Likelihood	RAG GRADE					
	Leadership and workforce	Appraisal rates	3	4	12	Divisional targets and action plans. Appraisee and appraiser training. Monthly reporting through performance reviews.	3	3	9	Appraisal cycle aligned with business planning cycle. Managers held to account for appraisals in their area with penalities for non-compliance.	monthly	Learning & OD KPIs	Director of HR & OD	14
3.5	Health and Safety	Failure to comply with critical health and safety and fire safety reports	4	3	12	Health and safety and fire safety policies and procedures, training, risk assessments, advisers and governance structure	3	3	9	Training to enable suitable and sufficient health and safety risk assessments are undertaken, together with health and safety audits	monthly	H&S KPIs. Incident reports. Fire risk assessments. H&S audits and risk assessments. HSE occupational dermatitis review	Chief Nurse/Deputy Chief Executive	10, 11
Corporate Objective Four: High Quality Clinical Care														
We will deliver, high quality clinical care through the application of best clinical practice and by ensuring that the principles of clinical governance underpin our organisation's culture, our systems and the working practices of our clinical teams and clinical services.														
4.1	Patient safety	Limited application and/or documentation of risk assessment for Venous Thromboembolism reduces mitigation of avoidable morbidity and mortality	3	4	12	VTE prevention policy implemented; risk assessment documentation in place across Divisions supported by training and awareness-raising and reinforced by clinical audits, ward rounds, matron rounds etc	3	3	9	High impact nurses working on VTE to reinforce practice. Drug chart includes VTE risk assessment. More frequent performance data will shortly be available	monthly	Q3 audit indicated 58% compliance (70% overall). Gap in assurance due to absence of routine data collection now resolved.	Medical Director	4

REF.	TRUST OBJECTIVE	PRINCIPAL RISKS	Initial risk rating			EXISTING CONTROLS	Current risk			ACTIONS NEEDED TO IMPROVE CONTROLS	Review Date	ASSURANCE (EXISTING ASSURANCE / GAPS &/OR RECOMMENDED ASSURANCE)	LEAD DIRECTOR	CQC OUTCOME
			Consequence	Likelihood	RAG GRADE		Consequence	Likelihood	RAG GRADE					
4.2	High quality clinical care	Emergency Care Pathway at QE/PRUH - Issues relating to capacity and patient flow as temporary service closures are finalised and as new models of care are embedded.	4	5	20	Service sustainability changes are now complete. Rehabilitation and medically fit areas are now open and operating at QMS and have an length of stay of In a average of 5 days. Focussed effort on timely discharge of patients ongoing and continued working with community partners to expedite safe and timely discharge of patients. Actions implemenrted through performance improvement group.	4	3	12	Continued improvement of the pathway for elderly patients to reduce their length of stay. Continued improvement to the discharge processes. Review of utilisation of capacity across the Division for all aspects of care to ensure capacity meets demand.	weekly	Performance scorecards and data collected. Daily performance reviews and weekly Performance Improvement group.	Divisional Director of Operations	4

REF.	TRUST OBJECTIVE	PRINCIPAL RISKS	Initial risk rating			EXISTING CONTROLS	Current risk			ACTIONS NEEDED TO IMPROVE CONTROLS	Review Date	ASSURANCE (EXISTING ASSURANCE / GAPS &/OR RECOMMENDED ASSURANCE)	LEAD DIRECTOR	CQC OUTCOME
			Consequence	Likelihood	RAG GRADE		Consequence	Likelihood	RAG GRADE					
Corporate Objective Five: Healthcare Acquired Infections														
5.1	Reducing infections	**Legionella risk and Water System Management and Control**: Risk of cases of legionella infection related to the Trust due to legionella in water systems and failure to implement adequate assessment of risk and suitable control measures. Risk of action against the Trust from the HSE, and also non compliance with Hygiene Code. Several areas within the Trust have repeatedly high legionella counts on testing despite control measures. (Dec 2009)	5	4	20	Need for significant improvement to assurance framework on legionella identified as a result of review of recent legionella SUI at QEH. Action plan in place for this, monitored by Director of Estates and Facilities and Legionella Action Group.	5	2	10	Implementation of most actions in action plan achieved - some slippage of deadlines noted but work progressing. Identification of any weaknesses in assurance evidence via this process, and subsequent action to address any gaps to be put into place. Establishment of robust assurance review process as per action plan, including legionella dashboard is in place, with majority of dashboard evidence now available. Further work identified to ensure full assurance.	Bi-Monthly - last reviewed 9th Jan 2012	Additional gaps in corporate understanding identifed via assurance 'challenge and confirm' review process. Actions put into place to provide complete picture of Legionella management arrangements trustwide, population of dashboard continues in order to achieve this.	Director of Estates and Facilities	8

REF.	TRUST OBJECTIVE	PRINCIPAL RISKS	Initial risk rating			EXISTING CONTROLS	Current risk			ACTIONS NEEDED TO IMPROVE CONTROLS	Review Date	ASSURANCE (EXISTING ASSURANCE / GAPS &/OR RECOMMENDED ASSURANCE)	LEAD DIRECTOR	CQC OUTCOME
			Consequence	Likelihood	RAG GRADE		Consequence	Likelihood	RAG GRADE					
5.2	Reducing infections	**Decontamination and Monitoring of Endoscopes and Associated Devices:** The main endoscopy units are managed by the Division of Planned Care. Endoscopes and their accessories are used and decontaminated across other units and services within the Trust in addition to this. There is a need to set up a trustwide system to ensure common standard setting and co-ordination of action to prevent these items posing a risk of infection.	3	4	12	Main endoscopy units have processes and systems in place to ensure safe decontamination of endoscopes. Estates Dept has commissioned trust-wide survey of medical devices and decontamination processes in use. This will identify endoscopes and accessories in use elsewhere. Operational Lead for Decontamination currently developing proposal for trustwide system to ensure common standard setting. Planned Care Division have nominated a lead for endoscope decontamination, to help drive standardisation across the main endoscopy units.	3	4	12	Focussed review of decontamination practices across all areas by Infection Prevention & Trust Decontamination Advisor commenced June 2011, with initial priority review of areas decontaminating high and medium risk items. This has identified areas of non-compliance relating to endoscope decontamination - action plans put in place by Planned Care Division. Further work in progress with Planned Care Division to develop consistent policy and standards across main endoscopy units and to ensure scopes used in outlying areas are decontaminated to the agreed standard. Strategy for endoscope decontamination approved by the trust, and implementation plan under development.	Bi-Monthly - last reviewed 9th Jan 2012	Assurance strong in relation to main endoscopy units. Limited assurance in relation to other areas presently.	Operational Lead for Decontamination, on behalf of Director of Estates and Facilities (Trust Decontamination Lead)	

REF.	TRUST OBJECTIVE	PRINCIPAL RISKS	Initial risk rating			EXISTING CONTROLS	Current risk			ACTIONS NEEDED TO IMPROVE CONTROLS	Review Date	ASSURANCE (EXISTING ASSURANCE / GAPS &/OR RECOMMENDED ASSURANCE)	LEAD DIRECTOR	CQC OUTCOME
			Consequence	Likelihood	RAG GRADE		Consequence	Likelihood	RAG GRADE					
5.3	Reducing infections	**Clostridium difficile infection:** The number of cases of Clostridium difficile has increased, resulting in potentially increased harm to patients, the Trust failing to meet its national C.diff objective for 2011-12, resulting in reputational damage and a possible fine.	4	5	20	A focussed action plan is in place. The Trust received a peer review visit from NHS London on 21st December 2011, which endorsed the actions already taken, and made recommendations for further action, with a major focus on antimicrobial prescribing and strong clinical leadership .	4	5	20	Divisions are taking action in response to the report, supported by corporate teams. An new action plan is under development, with actions being implemented to address the issues highlighted in the report.	Bi-monthly	NHSL report provided positive assurance about actions in place. New action plan, with focus on prescribing to be monitored by Infection Prevention Committee.	DIPC	8
Corporate Objective Six: National and Local Priorities														
We will demonstrate that the Trust is providing high quality cost effective services through achieving the national priorities highlighted in the Operating Framework and through the achievement of a high level of performance in the measures included within the Annual Health Check (or Care Quality Commission equivalent), including the Auditor's Local Evaluation Assessments.														
6.1	National targets	Backlog of patients on admitted and non-admitted pathways waiting over 18 weeks	5	4	20	Daily scrunity of booked cases; outsourcing orthopaedics, bariatrics, gynae & endoscopy. Validation of open pathways reducing non admitted and 95th centile; Additional theatre sessions; recruitment of theatre staff	5	3	15	Increased theatre capacity;outsourcing; workforce recruitment and retention	weekly	Daily reporting;weekly program board for performance monitoring and forward look	Divisional Director	4

REF.	TRUST OBJECTIVE	PRINCIPAL RISKS	Initial risk rating			EXISTING CONTROLS	Current risk			ACTIONS NEEDED TO IMPROVE CONTROLS	Review Date	ASSURANCE (EXISTING ASSURANCE / GAPS &/OR RECOMMENDED ASSURANCE)	LEAD DIRECTOR	CQC OUTCOME
			Consequence	Likelihood	RAG GRADE		Consequence	Likelihood	RAG GRADE					
6.2	National targets	Delivery of A&E performance targets as service reconfigurations/service plans embed.	5	5	25	Work streams in place all with active action plans to deliver sustained improvement, overseen by Performance Improvement Group. New models of working in place in both Emergency Departments, and workforce plans in place.	5	3	15	Implement changes through work streams, improved community capacity availability to reduce number of patients waiting for placement. Continue to improve and streamline discharge processes	Weekly	Performance scorecards and data collected. Daily performance reviews and weekly Performance Improvement group	Divisional Director of Operations	4
6.3	Compliance	Non-compliance with CQC registration standards leading to possible enforcement action	5	3	15	Action plans developed in response to planned and maternity review with identified leads and timescales for completion of actions	5	2	10	Improvement report submitted following QEH responsive review (full compliance). PRUH responsive review report pending. QMS and maternity reviews pending	monthly	Internal and external assurance identified within Provider Compliance Assessments	Chief Nurse/Deputy Chief Executive	All
Corporate Objective Seven: Services and facilities fit for the future														
We will work closely with partners in primary and social care to develop new and improved services to benefit our local population, with particular emphasis on the quality of care within improved patient pathways. We will ensure that our buildings, equipment and infrastructure are fit for purpose and capable of accommodating service change.														
7.1	Services and facilities fit for the future	Failure to maintain theatres in accordance with the HTMs and PPM schedules	4	4	20	Theatres Maintenance Dashboard	4	3	12	Deliver against targets	Jan-12		Director of Estates and Facilities	10
7.2	Services and facilities fit for the future	Failure to maintain QEH patient areas in accordance with the HTMs and PPM schedules	4	4	20	QEH PEAT Maintenance Dashboard	4	3	12	Deliver against targets	Jan-12		Director of Estates and Facilities	10

REF.	TRUST OBJECTIVE	PRINCIPAL RISKS	Initial risk rating			EXISTING CONTROLS	Current risk			ACTIONS NEEDED TO IMPROVE CONTROLS	Review Date	ASSURANCE (EXISTING ASSURANCE / GAPS &/OR RECOMMENDED ASSURANCE)	LEAD DIRECTOR	CQC OUTCOME
			Consequence	Likelihood	RAG GRADE		Consequence	Likelihood	RAG GRADE					
7.3	Services and facilities fit for the future	Only a small percentage of 'Nil Returns' relating to underused water outlets are being received by Estates.	5	4	20	Global e-mail reminder is sent monthly. JL to follow up with Nursing leads and ensure monitoring system of returns is in place	5	3	15	System for monitoring returns and process for reporting to be reviewed by the Water Mangagement Group	Jan-12		Director of Estates and Facilities	10
7.4	Services and facilities fit for the future	Lack of Compliance of QEH site with HTMs	5	4	20	Forensic audit of HTM compliance of QEH site has been undertaken and a full action plan is being prepared by the PFI partner.	5	4	20	PFI Partner to prepare action plan	Jan-12		Director of Estates and Facilities	10
7.5	Cerner	Inability to meet timelines for iCare deployment due to the scale and complexity of the programme leading to delayed go live and disruption to business as usual activities with associated financial risk	3	5	**15**	Robust programme plan in place agreed with Cerner BT & LPfIT. Multi professional programme team monitoring weekly. Project leads all have active project plans to deliver against agreed timelines.	3	4	**12**	Weekly progress checks and reports from data migration and interfacing suppliers. Sytem tersting plan in place to start 3/1/12. Checkpoint and gateway reviews undertaken with multi professional sign off. Additional LPfIT assurance process starting January 2012.	Weekly	Weekly programme report and project highlight reports.Trust and programm board reports. Monitoring through iCare Programme Board. iCare Programme Implementation Team.	iCare Programme Director	21

ENC H

SOUTH LONDON HEALTHCARE NHS TRUST

Subject	Briefing Note Radiotherapy Procurement 18th January 2012
Report by	Mr Roger Smith, Medical Director
Author	Mr Roger Smith, Medical Director
Executive Director	Mr Roger Smith, Medical Director

TRUST OBJECTIVE

Our Patients	**x**
Financial Viability	
Leadership and Workforce	
High Quality Clinical Care	**x**
Healthcare Acquired Infections	
National and Local Priorities	
Service and Facilities fit for the future	**x**

GLOSSARY

Abbreviation	**In Full**
OSEL	Outer South East London
SLHT	South London Healthcare NHS Trust
GST	The Guy's and St Thomas' NHS Foundation Trust
Q & A	Question and Answer
ITT	Invitation to Tender

WRITTEN REPORT (provided in addition to cover sheet) Yes

POWERPOINT PRESENTATION No

PURPOSE OF THE REPORT / PRESENTATION

To inform the Board of progress regarding the provision of radiotherapy services to the population of OSEL at SLHT

SUMMARY OF KEY ISSUES

As per the paper

ENC H

SOUTH LONDON HEALTHCARE NHS TRUST

RECOMMENDATION / DECISION REQUIRED

For the Board to **NOTE** the progress made.

IMPLICATIONS

Are there any implications for Care Quality Commission Registration?	No
Is an Equality Impact Analysis Required?	As per the report
Are there any legal Implications arising from this item?	No
Are there any Financial implications arising from this item?	No

ENC H

SOUTH LONDON HEALTHCARE NHS TRUST

Briefing Note: Radiotherapy Procurement 18th January 2012

1.0 Background

1.1 This briefing note follows previous strategic discussions regarding the provision of radiotherapy services to the population of OSEL at SLHT. The high-level draft timeline proposed at the launch of the second phase of the ITT on 16th January is set out below, for your information.

1.2 This procurement seeks to develop a satellite radiotherapy centre which will hopefully open at the end of 2013 to treat suitable local patients having radical treatment for breast, lung, prostate and colorectal cancers, and for palliative care.

2.0 The Process

2.1 The Guy's and St Thomas' NHS Foundation Trust (GST) led procurement process has been underway for some months. A Pre-Qualification Questionnaire was developed and issued in July from which an initial short list was developed. The procurement process then advanced to the first phase of the invitation to tender, which has now been completed, with the second phase having just commenced. SLHT continues to work in partnership with GST to advance this work

ITT Phase 1	• Series of confidential meetings with each bidder • Aim to provide clarity on requirements and help to iterate specific bidder plans • Helps the Trusts develop the final requirement documentation	Complete
ITT Phase 2	Instructions for Best and Final Offers issues	13 January 2012
	Q & A session on Best And Final Offer document	16 January 2012
	Best and Final Offers due	20 February 2012
Award and Contract	Interview Panel/Presentations	w/c 27 February 2012
	Preferred Tenderer Identified	early March 2012
	Contract discussions	March 2012
	Contract award	Post Trusts Board Meetings April 2012

SOUTH LONDON HEALTHCARE NHS TRUST

2.2 These timescales have evolved since the initial schedule was developed with the competitive dialogue process having been extended to address some of the issues that arose. However, it remains the intent that a recommendation will be sent to the SLHT Boards in March. Please note that these timelines are provisional and may be subject to revision, dependent on the requirements of the procurement process.

2.3 The original procurement plan aimed to have the satellite radiotherapy unit open in mid 2013, however, after engaging with the potential partners, a date as close as possible to the end of December 2013 is being sought.

3.0 In conclusion

3.1 Progress is being made with this programme and we are hopeful that this will lead to a good result for local people, and all parties involved.

3.2 SLHT needs to continue to engage fully with the process to facilitate the programme through to successful completion.

Mr Roger Smith

Medical Director

19th January 2012

MINUTES
of the
South London Healthcare NHS Trust
GOVERNANCE COMMITTEE
meeting held on
MONDAY 26 SEPTEMBER 2011
At 9.00 a.m.
in the Boardroom
Princess University Hospital

MINUTES

PRESENT	Ms. G. Hart	Non Executive Director (Chair)
	Mr. J. Ballard	Non Executive Director
	Ms. A. Bhatia	Acting Director of Nursing
	Ms. J. Hall	Acting Chief Operating Officer
	Mr. R. Smith	Medical Director
IN ATTENDANCE	Ms. A. Cosens	Asst. Trust Board Secretary (Minutes)
	Mr. D. Ford	Assistant Director of Governance
	Mr. J. Pearce	Director of Estates and Facilities
	Mr. M. Weaver	Trust Board Secretary

GC73/11 **APOLOGIES FOR ABSENCE** **ACTION**

Ms. J. Townsend, Non Executive Director, Ms. T. Cooper, Director of Infection Control, Ms. L. Knight, Director of Information Technology and Ms. L. McKenzie, Director of Human Resources and Organisational Development.

GC74/11 **MINUTES**

The minutes of the meeting held on 25 July 2011 were **AGREED** as a correct record.

GC75/11 **ACTION POINTS AND MATTERS ARISING NOT ON THE AGENDA**

Integrated Governance Arrangements

The Committee was advised that the Divisional Directors' Group had been incorporated within the integrated governance structure. Comments on Standing Financial Instructions were awaited.

Management of Medical Equipment – Update

Mr. Pearce advised that a report detailing progress with addressing the issues identified by the Internal Audit review would be submitted to the Committee's next meeting.

ACTION POINTS AND MATTERS ARISING NOT ON THE AGENDA | **ACTION**

Information Governance

Mr. Weaver advised that he would be discussing with the Finance Department whether a review of the Trust's Corporate Records could be included within the Annual Internal Audit Plan or whether a business case should be prepared for a stand alone piece of work. The Committee indicated a strong preference for the proposed work to be included within the existing Internal Audit Plan, on the basis that staff capacity to undertake the work associated with the review would be limited.

The Committee **AGREED** that the Internal Auditors should be requested to include a review of corporate records within their workplan. **MW/CT**

GC76/11 GOVERNANCE COMMITTEE TERMS OF REFERENCE

The Committee was invited to review and comment upon its Terms of Reference.

The following comments were made:

- Reporting arrangements to the Governance Committee should include the Statutory Mandatory Compliance Committee
- Membership of the Committee should include the Director of Estates and Facilities as an attendee
- Approval of an Annual Governance Committee workplan should be included within the Committee's purpose
- The quorum of the Committee should be altered to include 2 Non-Executive Directors, with at least one of the Non-Executive Directors present to include the Chair or Deputy Chair of the Committee.

The Committee **APPROVED** the Terms of Reference of the Governance Committee (as amended above). **MW**

GC77/11 LOCUM MEDICAL STAFFING

Subsequent to media coverage of a case involving the employment of an inappropriately qualified locum doctor (at another NHS Trust), which had led to catastrophic results, the Committee had been invited to seek an assurance that the locum medical staff employed by South London Healthcare NHS Trust undergo appropriate checks to ensure that they are adequately qualified and registered to practice in within the areas in which they are employed.

The Committee was advised that the processes associated with the recruitment of bank locum staff is the same as that which applies to the process for a substantive appointment. Namely, applicants are required to submit a CV prior to their being interviewed and prior to

LOCUM MEDICAL STAFFING **ACTION**

confirmation of appointment, pre-employment checks carried out include two written references, Occupational Health Clearance, inspection of 3 forms of identification, which includes passport, immigration status cleared through the Home Office, General Medical Council registration check and Criminal Records Bureau clearance. In terms of the engagement of agency locum staff, CVs are forwarded to the relevant manager for approval, along with details of the charge rate for the doctor. If approved, the agency completes an agency worker check list (which includes professional registration checks, mandatory training, proof of identity, specialist qualifications, occupational health clearance and the date of the last CRB check, prior to their assignment). The Committee was further advised that the Trust seeks uses PASA agencies, which have a robust governance profile, wherever possible, although it was acknowledged that a vulnerability exists where other agencies are used.

The Committee sought additional assurance on the Safeguarding Children checks which are applied to locum staff, particularly where staff are to be employed in paediatric, maternity or accident and emergency units and asked officers to provide further detail on the measures which are taken to verify safeguarding children's training in relation to locum staff, including the evidence which locum and bank staff are required to provide, indicating who has responsibility for checking the relevant documentation.

The Committee emphasised that a written assurance that relevant employment checks had been made prior to engaging locum staff, including their immigration status, on the basis that the Trust bore full liability for its employees and patients. It recommended that a policy for the employment of locum staff should be developed and it was agreed to refer this to the Clinical Governance Committee for further consideration and development. **RS**

The Committee further recommended that contractors and sub-contractors should be subject to enhanced pre-employment checks to maintain the safety of patients, staff and the Trust's reputation. **LM**

The Committee:

- **NOTED** the pre-employment checks which apply to the recruitment of locum bank and agency staff;
- **REQUESTED** to receive further information on the verification of safeguarding children's training which is applied to locum staff; **RS/LM**
- **RECOMMENDED** that all locum staff employed in maternity units, paediatric wards and accident and emergency units **RS/LM**

LOCUM MEDICAL STAFFING **ACTION**

- should provide evidence of having had an enhanced level of safeguarding children training; **RS**
- **REQUESTED** the Clinical Governance Committee to develop a written policy on the employment of locum staff;
- **RECOMMENDED** that contractors and sub-contractors should be subject to enhanced pre-employment safeguarding checks. **LM**

GC78/11 CARBON REDUCTION AND SUSTAINABILITY PLAN

The Committee received a tabled report and energy dashboard, the purpose of which was to illustrate how the Trust would be meeting its obligations under the Carbon Reduction Energy Efficiency Scheme.

Mr. Pearce advised of the following actions in connection with the carbon reduction commitment :

- Registration of the Trust, which was submitted ahead of the deadline
- Submission of the CRC Annual Report on 26 July 2011, which included the Trust's energy consumption for the previous year
- Compilation of a CRC evidence pack is underway;
- An Energy Committee, which is meeting every two weeks to monitor energy consumption and the CRC implications.

The Committee was advised that specific schemes associated with the Trust's CRC obligations include rationalisation of Building Management Systems to synchronise them with department timings and temperature requirements, the introduction of low energy and movement/daylight operating sensors and a review of the car parking lighting strategy and night surveys of the site to reduce unnecessary illumination. The Committee was advised that the current year's cost improvement programme included provision for energy reduction valuing £260k.

The Committee discussed other initiatives which could be included within the CRC reduction programme. The following was suggested:

- It was noted that the car parks at the QMS (including the area around the Education Centre and the Kent Women's' Wing) and PRUH sites currently remain lit throughout the night, and that there may be scope for reducing some of the illumination in these particular areas
- Reminding staff to turn off their computers, as opposed to leaving them on standby;
- The introduction of low energy light bulbs
- Opportunities for solar powered heating.

The Committee **ASKED** to receive a detailed action plan, with named accountability and timescales for their delivery at its next meeting. **JP**

GC79/11 QUEEN ELIZABETH HOSPITAL ENVIRONMENTAL WORKS **ACTION**

Mr. Pearce introduced a tabled report which advised of progress in planning the PEAT works programme for Queen Elizabeth Hospital. It was highlighted that planned improvement works would now be undertaken on a ward basis and that this will be achieved through releasing a decant ward at Queen Elizabeth Hospital by 1 April 2012, which will enable the improvement work to be undertaken on a ward by ward basis. It is estimated that the improvement works to each ward will take approximately three weeks and that the work would therefore be completed within two years. It was noted that the plan would, however, be subject to achieving a vacant ward of 35 beds. The Committee suggested that officers consider the inclusion of a contingency to utilise the QMS site for a decant ward to ensure that the necessary improvements are undertaken.

The Committee **REQUESTED** the submission of a detailed work programme illustrating the steps associated with the environmental improvements works to Queen Elizabeth Hospital with effect from 1 April 2012 to its next meeting, including a timetable for their completion. **JP**

GC80/11 SAFETY AND SECURITY MANAGEMENT REPORT

Ms. Hall introduced a report advising of progress which is being made with Health, Fire, Safety and Security and Emergency Planning by the Trust. The following aspects, in particular, were highlighted:

- An inspection by the Health and Safety Executive during August had found that policies and procedures relating to dermatitis (a key area of focus for the inspection) were in place, however further action to extend non-latex options and to reduce the potential for skin irritation had been recommended, in addition to a documented system for the reporting of injuries, diseases and dangerous occurrences (including occupational dermatitis). The Trust would be required to report the action taken to remedy issues identified by 16 January 2012.
- Following an audit by the London Fire and Civil Defence Authority (LFCDA) at Kennedy House in June, which had resulted in an enforcement notice, it remained the intention to vacate the building by 14 November 2011;
- Following an audit by the LFCDA at Queen Mary's Hospital, the Chief Executive had been informed of risk and safety issues which had arisen through the use of Kent Women's Wing for the storage of medical records. The Trust was required to rectify outstanding fire safety issues by 14 January 2012.
- An arson incident at Princess Royal University Hospital on 11 July 2011 was subject to an ongoing investigation by the Metropolitan

SAFETY AND SECURITY MANAGEMENT REPORT

ACTION

- Policy, the LFCDA and a Trust-commissioned Serious Untoward Incident report;
- A period of civil unrest during August had led to occasions where Trust legacy and satellite sites had been locked down as a precautionary measure. Whilst no untoward incidents on hospital premises had occurred, the issue had presented some areas for consideration within the Trust's emergency planning procedures
- A report outlining the arrangements for planning for the London 2012 Olympics would be submitted to the Trust Board on 28 September 2011.

The Committee noted that works to ensure compliance with the fire improvement notice for Kennedy House would be required in the event that the Trust would not be in a position to vacate the building by 14 November 2011.

The Committee was advised that the medical records which are currently stored at Thistlebrook House would be located to another building and that a business case for Thistlebrook House is being finalised for consideration.

The Committee sought an assurance that there would be no recurrence the incident at Kent Women's Wing which had led to an immediate Fire Risk Assessment being conducted by the London Fire Board. The importance of compliance with inspection reports was emphasised and the Committee was advised that the LFCDA would share its findings with the Care Quality Commission.

The Committee noted that NHS Protect had emphasised the importance of ensuring that Trusts completed enhanced CRB checks, including immigration status for staff, particularly with regard to agency and locum staff. It had also been suggested that staff should receive training in recognizing bogus documents. Officers undertook to provide an update on progress to the Committee's next meeting, including where accountability for verifying documentation within the trust lies. It was suggested that PFI/contractual staff should be subject to a similar process.

The Committee **NOTED**

- The update on safety and security management;
- That compliance with the Fire Safety Notice which had been served on Kennedy House would be required in the event that the building was not vacated by 14 November 2011
- That a report on progress with undertaking CRB checks, including where accountability for verifying documentation within the Trust lies, would be submitted to the Committee's **JP**

LM

- next meeting.

ACTION

GC81/11 CLINICAL AUDIT ANNUAL REPORT 2010/11

Mr. Ford introduced a report which summarised clinical audit activity across the Trust for the Financial Year 2010/11 and recommended action to correlate with the Trust's 3-year Clinical Audit Strategy objectives 2011/12.

In remarking on the progress which had been made in embedding audit processes into practice, the Committee observed that a number of audits were being undertaken which were not registered on an audit programme. The Committee recognised the need to monitor the outcomes arising from local audit programmes, to ensure that action plans were developed which would contribute towards improvements in quality of care.

It was highlighted that a strengthening of the audit processes to ensure that clinical audit leads to improve in practice is a priority for 2011/12 and that the Governance team would be meeting with lead clinicians to discuss the key areas of focus in October. The Committee suggested that it would assist monitoring if a consistent approach to presentation, including RAG ratings were adopted.

Officers undertook to provide a summary of where clinical audits have been completed to the Committee's next meeting.

The Committee **REQUESTED** to receive a completed summary of the clinical audit programme at its next meeting.

DF

GC82/11 QUARTER I THEMED REPORT

Mr. Ford introduced the themed Quarter I Report, which focussed upon trends in incidents, complaints and claims. The following trends had been identified:

- The amount of patient safety incidents stabilised, with the Trust now featuring at the median of incident reporting when compared to other large acute trusts; however further work needs to be done to reduce slips, trips and falls, particularly Princess Royal Hospital, where reported incidents are higher;
- Complaints during the first quarter have reduced from a peak in the final quarter of 2010/11. The Planned Care Division has received a higher than average number of complaints, often relating to the organisation of care. To address complaints relating to cancelled operations, the Planned Care Division is working towards a dedicated elective surgery centre at QMS.

- A high level of CNST claims relating to Queen Elizabeth Hospital is attributable to a historic time lag in their coming forward. The profile for the current year indicates an improvement.

The Committee suggested that greater use should be made of a red sticker system to identify patients at risk of falls.

The Committee **NOTED** the quarter 1 themed report.

GC83/11 CARE QUALITY COMMISSION COMPLIANCE REPORT

Ms. Hall introduced a report which advised of the current status of compliance with Care Quality Commission registration requirements. The following key risks to compliance with registration standards were highlighted:

- Meeting referral to treatment times;
- Single sex accommodation;
- Fire safety (Whilst no red or amber risks had been identified by the CQC in its Quality and Risk Profile, the LFCDA has recently served enforcement notices at QMS and Kennedy House)
- Management of medical devices (the Committee would be receiving a report on progress with addressing actions arising from the Internal Review at its next meeting),
- Statutory and mandatory training
- Confidentiality breaches (A number of Serious Incidents have been reported to the Information Commissioner, which could lead to action against the Trust).

The CQC had undertaken a responsive review at Queen Elizabeth Hospital on 18 August, which had focused upon those areas which had been found to be non-compliant in September 2010. Further responsive reviews at Queen Mary's Hospital and Princess Royal University Hospital were expected shortly. A draft report was pending at the time of the Committee, however verbal feedback had not indicated any major concerns.

The Committee noted that the Information Governance Committee would be undertaking a campaign to raise staff awareness of the importance of maintaining confidentiality. The Committee was advised that a register of staff that have data-encrypted sticks for use on Trust business is maintained and that remote access on central services is limited. It was recommended that the Information Governance Committee should be requested to address and progress issues related to compliance with Trust/NHS Information Governance policy, which should include consideration of management of the access to information needs of locum staff.

The Committee also noted that information governance would be a

cornerstone of the implementation of the ICare system and requested to

CARE QUALITY COMMISSION COMPLIANCE REPORT **ACTION**

receive an update on progress with ICare at its next meeting.

The Committee requested to receive an action plan at its next meeting to capture how the issues which had been identified within the patient survey would be addressed.

The Committee;

- **NOTED** the current status of compliance with the CQC registration requirements;
- **REQUESTED** that issues related to compliance with the Trust's/NHS Information Governance Policy be referred to the Information Governance Committee which should monitor progress and consider the optimum way of managing the access to information needs of locum staff; **DF**
- **REQUESTED** to receive an update on the implementation of the ICare system at its next meeting; **LK**
- **REQUESTED** to receive an action plan at its next meeting to capture how the issues which had been identified within the patient survey would be addressed. **DF**

GC84/11 ENDOSCOPE DECONTAMINATION STRATEGY

Ms. Bhatia introduced a report which set out proposals and recommendations for the future strategy of endoscopes across the Trust, in response to issues raised by the Infection Prevention Committee in July 2011.

A review of endoscopy equipment and endoscope decontamination procedures had been commissioned to assess the processes which were in place across the Trust's sites. The review had identified that the following key issues:

- There is currently no identified lead or specialist advisor with overall responsibility for managing the decontamination of endoscopes;
- There is currently no trustwide policy for the decontamination of endoscopes, meaning that units have a variety of local policies and procedures and no minimum Trust standard of practice has been set;
- Current governance arrangements for the decontamination of endoscopes are fragmented.

As a result of the review, a number of recommendations to ensure that patient safety was maintained and to provide sufficient assurance to the Trust Board that the arrangements for the decontamination of endoscopes

were proposed, with a timescale for implementation of 18 – 24 months.

ENDOSCOPE DECONTAMINATION STRATEGY **ACTION**

The Committee was of the view that the timescale to address the issues identified by the review was too lengthy in terms of the potential risk to patient safety and statutory compliance, and it requested the Infection Prevention Committee to develop an action plan to address each of the review's recommendations within a shorter timeframe. It was noted that leadership and management of the decontamination process had been identified as an issue, and it therefore recommended that the action plan should include specify the accountability and timescale for ensuring that progress was made and the structure within which the decontamination framework will operate. The Committee also recommended that the future strategy for endoscopes should include an examination of the opportunities to streamline practices for the purchasing or leasing of endoscopes.

The Committee:

- **NOTED** the key issues identified by the review of the current arrangements for endoscopy decontamination and the recommendations for improvement; **TC**
- **RECOMMENDED** that the timescale for the work associated with the achievement of achieve external accreditation should be reduced from 18 – 24 months; **TC**
- **RECOMMENDED** that the Infection Prevention Committee should be requested to develop an action plan to address each of the recommendations, which should specify the accountability and timescale for ensuring that progress is made;
- **REQUESTED** to receive an update on the compilation of an endoscope asset list at its next meeting. **TC**

GC85/11 ESTATES STATUTORY AND MANDATORY COMPLIANCE COMMITTEE TERMS OF REFERENCE

Mr. Pearce invited the Committee to consider and comment upon the Terms of Reference of the Estates Statutory and Mandatory Compliance Committee, a new Committee, the objective of which was to oversee statutory compliance with the maintenance and development of the estate.

The Committee made the following comments and suggestions;

- The objectives should include the Carbon Reduction and Sustainability Plan
- Staff membership of the Committee should be widened to promote challenge and objectivity;
- The Terms of Reference should clarify how the Committee will

link/report to other bodies, to ensure that there is no scope for

ESTATES STATUTORY AND MANDATORY COMPLIANCE COMMITTEE TERMS OF REFERENCE **ACTION**

- duplication or confusion over responsibility.

The Committee:

- **NOTED** that an Estates Statutory and Mandatory Compliance Committee had been formed;
- **REQUESTED** to receive revised Terms of Reference at its next meeting, taking about of the above comments and suggestions.

GC86/11 TRUST BOARD ROLLING FORWARD AGENDA

The Committee **NOTED** the Trust Board rolling forward agenda for 2011/12.

GC87/11 INTERNAL CONTROL ISSUES

No internal control issues were identified.

ITEMS FOR INFORMATION

GC88/11 GOVERNANCE SUB-COMMITTEES

The minutes of the following Sub-Committees were received:

- Clinical Governance Committee 8 June 2011
- Executive Health and Safety Committee 7 July 2011
- Infection Prevention Committee 15 July 2011.

GC89/11 ANY OTHER BUSINESS

There were no other items of business.

GC90/11 DATE OF NEXT MEETING

Monday 28 November 2011, Princess Royal University Hospital, 9.00 a.m.

The meeting ended at 11.10 a.m.

SOUTH LONDON HEALTHCARE NHS TRUST
TRUST BOARD AUDIT COMMITTEE
Wednesday 30 November 2011
Held in the Committee Room, Queen Mary's Hospital
at 4.00 p.m.
MINUTES

PRESENT

Ms. G. Hart	Non Executive Director (Chair – in the chair from item 91/11) *(By conference call)*
Ms. L. Roberts	Non Executive Director *(By conference call)*
Ms. J. Townsend	Non Executive Director *(By conference call)* (In the Chair up to item 90/11)

IN ATTENDANCE

Mr. J. Ballard	Acting Chairman, South London Healthcare Trust
Mr. R. Cooper	Director of Finance *(By conference call)*
Ms. A. Cosens	Assistant Trust Board Secretary (Minutes)
Mr. N. Beth	Audit Manager, Audit Commission
Mr. P. Johnstone	Engagement Lead, Audit Commission
Dr. C. Streather	Chief Executive
Ms. E. Trace	Head of Financial Control
Ms. C. Trevena	Associate Director of Finance
Mr. S. Worthington	Deputy Director of Finance

88/11 APPOINTMENT OF TEMPORARY CHAIR FOR THE MEETING **ACTION**

It was proposed, seconded and **AGREED** that Jackie Townsend take the chair for the commencement of the meeting.

89/11 APOLOGIES FOR ABSENCE

No apologies for absence were submitted.

90/11 ANNUAL GOVERNANCE REPORT

Mr. Johnstone introduced the draft Annual Governance Report (AGR) 2010/11, the audit now being substantially complete following the review of the Trust's fixed assets register and the Trust's detailed evaluation of the Property, Plant and Equipment errors which had been identified to date. The external auditors were now in a position to issue an unqualified audit opinion, subject to receipt of the Trust's Letter of Representation, a draft of which was included elsewhere on the agenda. The following aspects, in particular, were drawn to the Committee's attention:

- Whilst the Trust had made significant progress with the review of its fixed asset register, there remains substantial work to be done to develop and maintain a sustainable record of its assets.

- As reported to the Committee's meeting of 17 October 2011, *(minute 72/11 refers),* the audit opinion on the Trust's arrangements to secure value for money did not differ to that which had been reported previously and in relation to the year ending 31 March 2011. The District Auditor would be giving an adverse opinion on the arrangements which had been in place to secure economy, efficiency and effectiveness in the use of resources.

91/11 ANNUAL GOVERNANCE REPORT **ACTION**

- Whilst the draft opinion which had been considered at the Committee's meeting of 17 October 2011 had indicated that the external auditors had seen little evidence of Board level scrutiny of the cost effectiveness of existing activities, there had since been clear evidence provided by the Trust of extensive Non-Executive Director involvement in other areas via other fora.

(At this point in the proceedings (4.15 p.m.), Gill Hart (Chair) in the Chair).

- To improve the effectiveness of the Trust's system of internal control, the annual governance report recommends a strengthening of the role of internal audit to ensure that it provides the Trust's Board with an accurate level of assurance on which could be relied in the future; the annual audit had revealed several significant control weaknesses within material systems, despite the Trust having been given reasonable assurance by internal audit on the robustness and effectiveness of those systems. The AGR therefore recommends a review of the criteria used to determine the overall assurance levels given by internal audit in relation to material systems and that the timetable for the internal audit plan should be adhered to. The external auditors had met with the Trust's internal auditors to discuss this issue.

- Those charged with governance would be required to provide a reason for non-adjustment of any of the non-trivial unadjusted misstatements within the financial statements which were listed within the final Letter of Representation in Appendix 3.

- Whilst the Trust did not have a medium term financial plan in place during 2010/11, it was recognised that work was underway to produce a 4-year financial plan.

It was acknowledged that the process associated with the finalisation of the Trust's accounts for the previous year had taken longer than anticipated. The Committee was advised that the Executive Management Team would be reviewing lessons learned. The Committee was reminded that a report on progress with the implementation of issues identified within the Financial Governance Improvement Plan, would be submitted to the its next meeting on 8 December 2011. The Committee:

- **NOTED** the updated Annual Governance report;
- **NOTED** the adjustments to the financial statements set out within the report;
- **NOTED** the requirement to approve the letter of representation on behalf of the Trust prior to the issue of audit opinion and conclusion;
- **NOTED** the proposed action plan, to which the Trust would be required to prepare a response.

92/11 ANNUAL ACCOUNTS PRESENTATION **ACTION**

Mr. Worthington, Deputy Director of Finance presented the Trust's Accounts 2010/11, and a summary which was contained within an analytical review. The following points, in particular, were highlighted:

- A Statement of Annual Income and Expenditure would be included within the Trust's Annual Report 2010/11, which would be presented at the Trust's Annual General Meeting;
- The presentation of the Trust's operating position did not include adjustments associated with IFRS accounting principles, on the basis that this had no cash impact;
- Income from the Primary Care Trust had reduced from the previous year;
- Revenue income had reduced from the previous year;
- Expenditure had reduced from the previous year;
- The Trust is currently indicating poor performance on the Better Payment Practice Code due to its current cash position, which means that it is currently incurring additional cost and not achieving value for money from its contract with SBS.

The Committee:

- **APPROVED** the Annual Statement of Accounts.

93/11 2010/11 LETTER OF REPRESENTATION

Mr. Worthington, Deputy Director of Finance introduced a report which illustrated evidence which would be submitted in support of the Trust's Management Letter of Representation in response to the AGR *(minute 91/11 above refers).* The Committee was advised that the issue of an unqualified audit opinion would be subject to satisfactory representation. It was confirmed that all issues raised within the AGR had been addressed within the Management Letter.

The Committee was advised that a report would be submitted to the next meeting of the Trust Board advising that South London Healthcare Trust had received appropriate assurances from NHS London that it would continue to be a going concern during the current financial year. **DF**

The Committee was reminded that Trust Board meeting of 28 September 2011 *(minute 93/11 refers)* had delegated authority to the Audit Committee and the Chief Executive to finalise the Trust's accounts. It was **AGREED** to make reference to this within the Management Letter of Representation. **DF**

Under the authority delegated to it by the Trust Board, the Committee:

- **APPROVED** the Management Letter of Representation.

94/11 DATES OF FORTHCOMING MEETINGS

The Committee was advised of the following dates of forthcoming meetings:

94/11 DATES OF FORTHCOMING MEETINGS **ACTION**

- Thursday 8 December 2011 at 9.00 a.m., Queen Elizabeth Conference Centre
- Thursday 12 January 2011 at 9.00 a.m., Committee Room, Queen Mary's Hospital Sidcup.

95/11 ANY OTHER BUSINESS

Annual General Meeting

The Committee was advised that the Trust was planning to hold its Annual General Meeting, at which its Annual Report 2010/11 would be presented on Wednesday 21 December 2011 at 7.30 p.m.

South London Healthcare Annual Report 2010/11

Mr. Johnstone, Engagement Head, Audit Commission advised the committee the Trust would need to agree and adopt the Trust Annual Report for 2010/11.

On behalf of the Trust Board, the Committee **AGREED** to adopt the contents of the Trust Board Annual Report 2010/11.

The meeting ended at 4.50 p.m.

SOUTH LONDON HEALTHCARE NHS TRUST
TRUST BOARD AUDIT COMMITTEE
Friday 11 November 2011
Held in the Board Room, Princess Royal Hospital
at 9.00 a.m.

MINUTES

PRESENT

Ms. G. Hart	Non Executive Director (Chair)
Ms. J. Townsend	Non Executive Director

IN ATTENDANCE

Ms. A. Cosens	Assistant Trust Board Secretary (Minutes)
Mr. D. Hariram	Deputy Director of Human Resources
Mr. M. Hughes	Assistant Director of Audit, LAC
Mr. P. Johnstone	Engagement Lead, Audit Commission
Ms. C. Purton	Counter Fraud Manager
Mr. A. Shah	Audit Manager, London Audit Consortium (LAC)
Mr. S. Worthington	Deputy Director of Finance

75/11 APOLOGIES FOR ABSENCE

There were no apologies for absence from members of the Committee.

76/11 MINUTES

The minutes of the meeting held on 17 October 2011 were **AGREED** as a correct record.

77/11 ACTION LOG

The Committee **NOTED** the following actions which did not feature elsewhere on its agenda:

Final Counter Fraud Report *(Minute 48/11 refers)*

- Internal Audit had been asked to examine a sample of other projects to identify whether internal and statutory processes are being followed correctly.
- The Governance Committee would be monitoring the action which was being taken to ensure staff were aware of their duty to adhere to the Information Governance Policy
- Local Counter Fraud Service had followed upon the issues which had been identified as requiring clarification and confidential notes of that meeting were tabled for the Committee's information
- EMT had considered a report which clearly set out the requirement to ensure that staff receive appropriate training in the application, monitoring and compliance with Financial Standing Orders. The Financial Governance Improvement Plan (FGIP) has taken account of the need to ensure wider staff training in this regard
- The procurement workstream within the FGIP has incorporated a review of the procurement process for items with a planned shelf life and ensuring value for money; this

77/11 ACTION LOG **ACTION**

- workstream is not yet completed. Mr. Worthington undertook to advise the Committee of the timescale for its completion. It was **AGREED** to invite the Head of Procurement to attend the next meeting of the Committee. The Committee suggested that the review of procurement procedures should consider whether there was scope to reduce the number of eligible signatories who could sign waivers. Mr. Hughes advised the Committee that the *Oracle* system, if used effectively could alert where a forthcoming procurement exercise was necessary. **DDF**
- EMT had been reminded of the requirement within Standing Financial Orders to ensure that Tender Waivers are brought before the Audit Committee to comply with governance procedures.
- Previous EMT minutes have been reviewed to ascertain whether there were any references to the process associated with the awarding of the contract. Although the requirement to outsource was noted at a meeting, there was no decision recorded by EMT. The Committee emphasised that decisions should be taken in accordance with the governance process going forward and recorded appropriately.

Internal Audit Progress Report

- Monthly reconciliation is being produced for review by the Head of Financial Control.
- A sample of journal entries is being monitored to review whether the additional controls are being followed and will be reported to the next Audit Committee.

78/11 SOUTH LONDON HEALTHCARE FINANCIAL FOCUS

Financial Governance Improvement Plan – Update

Mr. Worthington introduced a detailed report which advised of progress with implementing the FGIP. It was highlighted that the plan is currently in draft and that a final version would be presented to the Committee's meeting on 8 December 2011. **DDF**

The Committee emphasised that the Trust needed to have a basic accountability system in place by the end of December as part of its agreement under the Transitional Formal Agreement, the contract for which was due to be signed early the following week, and that this should include a plan to address the issues associated with the Trust's journey to Foundation Trust status over the next year. Mr. Worthington undertook to bring a plan back to the Committee's next meeting.

The Committee noted that the 2010/11 Statutory Accounts Forecast for both the previous year and the current year indicated areas which may be qualified. Mr. Johnstone advised that the Trust's financial status was the biggest influencing factor in this.

78/11 SOUTH LONDON HEALTHCARE FINANCIAL FOCUS **ACTION**

Financial Governance Improvement Plan - Update

The Committee noted that the Trust's Charitable Funds Policy was indicating an area of particular strength.

It was highlighted that the Trust needed to have a regular Financial Report for submission to the Board to enable the Board to review whether value for money was being achieved and to hold officers to account.

Mr. Worthington undertook to bring a report to the Committee's next meeting to address those areas of performance which were currently indicated as being "amber". **DDF**

Tender Waivers

In the reviewing the tender waivers, the Committee made the following comments:

- Whether the timescales associated with the planning for the HASU genuinely precluded the conduct of a tendering exercise – the Committee sought an assurance that in future, the timescales associated with statutory tendering procedures would be brought within the business planning process.
- Whether a lack of suitable expertise had represented a genuine reason for requiring a tender waiver in certain instances.
- The Committee suggested that suitable challenge of the tender waiver process should be discussed by the Governance Committee. **DDF**
- The Committee recommended that future reports should include the cumulative value of waivers.

In accordance with the Trust's Standing Orders and Standing Financial Instructions, the Committee reviewed and **NOTED** the list of tender waivers detailed within the report, which included the tender waiver in respect of CESP which had been highlighted at the Committee's meeting of 15 September 2011 *(Minute 61/11 refers)*.

Write-Off of Bad Debts

The Committee was advised that the bad debts detailed within the report were historic.

The Committee asked whether it would be possible to identify the debts on a site basis.

The Committee **NOTED** the bad debts detailed within the paper; and

APPROVED the write-off of debt totalling £394,749.15, provision for which was include within Doubtful Debts.

The Committee **REQUESTED** officers to ensure that patients who **DDF**

78/11 SOUTH LONDON HEALTHCARE FINANCIAL FOCUS **ACTION**

Write-Off of Bad Debts

were ineligible for NHS treatment were required to pay for

treatment in advance of its receipt, with the exception of emergency treatment.

Losses and Compensation

None to report.

79/11 INTERNAL AUDIT PROGRESS REPORT

Progress Report

The Committee received a report which gave an update on the progress made in delivering the Annual Internal Audit Plan 2011/12. The following points were made:

- Those risks which were identified as having a "high" risk rating would be reviewed more closely by Internal Audit.
- Whether there was a consistent basis on which risks were recorded across divisions.
- Whether there were appropriate plans in place to address areas of high risk; it was agreed to refer this to the Governance Committee for review.
- A "limited assurance" had been issued in relation to the Network management and security review, particularly in reflection of information governance breaches. It was agreed to report on the requirements of the National Directive in respect of Information Governance at the next meeting of the Audit Committee. **DDF**

The Committee:

- **NOTED** the Internal Audit progress Report;
- **AGREED** to refer issues associated with action planning to address areas of high risk to the Governance Committee for review; **Chair/ Secretariat**
- **AGREED** to review the Information Governance National Directive. **DDF**

Outstanding Audit Recommendations – Follow Up

The Committee was advised of the status of outstanding Audit Committee recommendations for the Trust. It was remarked that there were a number of areas where implementation targets were not being met, and the Committee sought to explore whether realistic targets were being set.

It was suggested that a review of a random sample of outstanding recommendations should be undertaken. to verify what action was being taken to make progress.

The Committee **NOTED** the outstanding audit recommendations.

80/11 EXTERNAL AUDIT UPDATE

Mr. Johnstone provided a verbal update to the Committee on progress with signing off the previous year's accounts. The

80/11 EXTERNAL AUDIT UPDATE **ACTION**

auditors were currently in the process of testing the fixed asset register in order to satisfy itself as to whether a number of errors which had been identified were isolated. It was agreed that it was important to ensure that the auditors were satisfied of the accuracy of the Trust's assumptions prior to signing off the accounts.

It was **AGREED** to schedule a conference call within a couple of weeks' time to discuss progress. **Secretariat**

81/11 COUNTER FRAUD UPDATE

The Committee was advised of current local counter fraud activity. The Committee was advised of changes to the qualitative assessment process which would be implemented going forward.

The Committee **NOTED** the report.

82/11 REVIEW OF CONTRACT EXPENDITURE

The Trust **NOTED** legal advice received following LCFS Investigation 10/00700.

The Committee:

- **NOTED** that contracts which may have been entered into in breach of procurement regulations would not constitute "illegal" payments; and

- **AGREED** that the Trust must ensure that in future the correct procurement rules are followed and that the Action Plan presented to the Audit Committee must be implemented as soon as possible. **DDF**

83/11 DECLARATIONS OF INTEREST

The Committee was informed of action which is being taken remind staff of the Declaration of Interest requirements.

The Committee **NOTED:**

- that Trust staff would receive an invitation reminding them to declare any personal interests that they (or a close member of their family) may have and/or positions that they (or a close member of their family) may hold that could potentially be perceived to put them in a position to influence transactions at the Trust by the end of Quarter 3; **Secretariat**

- That the Executive Management Team would receive a report on progress at its meeting on 6 December 2011. **Secretariat**

84/11 ANNUAL GOVERNANCE PLAN 2010/11 AND STATEMENT ON INTERNAL CONTROL

The Committee received a report which outlined the arrangements for the implementation of the recommendations within the Annual Governance Report and to address issues identified within the

84/11 ANNUAL GOVERNANCE PLAN 2010/11 AND STATEMENT ON INTERNAL CONTROL **ACTION**

Statement on Internal Control.

The Committee recommended that the workforce plan should clearly include the processes which would need to be followed, and a full appraisal of the implications of any options to enable sound decisions to be taken. Officers were requested to submit the report to the Human Resources Committee. **DHR/OD** **DHR/OD**

The Committee **REQUESTED** to receive an update on payroll at its next meeting. **DF**

The Committee:

- **APPROVED** the action plan; and
- **NOTED** the officers responsible for its delivery.
- **NOTED** that the Committee would receive regular updates on progress.

85/11 AUDIT COMMITTEE WORKPLAN

The Committee received a report which detailed the items which would be included within its workplan for the forthcoming year, to ensure that the Committee would fulfil its role and adhere to the best practice outlined in the NHS Audit Committee Handbook.

The Committee **APPROVED** its workplan 2011/12. **DF**

86/11 ANY OTHER BUSINESS

<u>E-mail accounts</u>

The Committee was recommended to ensure that Non-Executive Directors had access to NHS e-mail accounts for the transaction of Trust business to adhere to best practice for Information Governance. **Secretariat**

<u>30 November</u>

To receive an update at the Governance Committee on forecast staff participation in planned industrial action. **DHR/OD**

87/11 DATES OF FORTHCOMING MEETINGS

The Committee noted that further meetings had been scheduled as follows:

- Thursday 8 December 2011 at 9.00 a.m., Rooms 1 & 2, Conference Centre, Queen Elizabeth Hospital.
- Thursday 12 January 2012 at 9.00 a.m. in the Committee Room, Queen Mary's Hospital Sidcup.

The meeting ended at 11.15 a.m.

MINUTES
of the
South London Healthcare NHS Trust
AUDIT COMMITTEE
meeting held on
THURSDAY 8 DECEMBER 2011
At 9.00 a.m.
Rooms 1 &2, Conference Centre
Queen Elizabeth Hospital

MINUTES

PRESENT	Ms. G. Hart	Non Executive Director (Chair)
	Ms. J. Townsend	Non Executive Director
IN ATTENDANCE	Mr. R. Cooper	Director of Finance
	Mr. D. Corbett	Director of Audit, LAC
	Ms. A. Cosens	Asst. Trust Board Secretary (Minutes)
	Mr. M. Hughes	Assistant Director of Audit, LAC
	Mr. P Johnstone	Engagement Lead, Audit Commission
	Ms. L, McKenzie	Director of Human Resources and Organisational Development
	Ms. C. Mode-Keefe	Procurement Manager *(for item 100/11))*
	Ms. C. Purton	Counter Fraud Manager
	Mr. A. Shah	Audit Manager, London Audit Consortium (LAC)
	Ms. C. Trevena	Associate Director of Finance

96/11 **APOLOGIES FOR ABSENCE** **ACTION**

There were no apologies submitted by members of the Committee.

97/11 **DECLARATIONS OF INTEREST**

No declarations of interest were made.

98/11 **MINUTES**

The minutes of the meetings held on 11 November 2011 and 30 November were **AGREED** as correct records.

99/11 **ACTION POINTS AND MATTERS ARISING NOT ON THE AGENDA**

The Committee **NOTED** the following actions which did not feature elsewhere on its agenda:

Write-Off of Bad Debts (*Minute 79/11 refers)*

The Committee was advised that staff seek to secure payment from non-NHS patients in advance. Where applicable, information is also shared with the United Kingdom Borders Agency. All maternity patients are treated as emergency patients, in accordance with European guidelines. From 2010 onwards, it was anticipated that the Trust would be seeking to write off bad debts associated with overseas patient as an exception.

ACTION

A report will be submitted to the meeting of Executive Management Team in January 2012 on provisions for overseas patients.

Internal Audit Report *(Minute 79/11 refers)*

The Committee was advised that consideration of plans to address areas of high risk would be included as an item on the agenda of the next Governance Committee.

It was noted that the National Directive on Information Governance had been reported to the Information Governance Committee.

100/11 FINANCIAL GOVERNANCE IMPROVEMENT PLAN

Mr. Cooper, Director of Finance introduced a report, the purpose of which was to update the Committee on progress with the implementation of the Financial Governance Improvement Plan. It was acknowledged that aspects of the Trust's performance on financial governance would be in the red zone for some time, as the Trust took steps to redress its balance. It was highlighted that the work which had been undertaken on the Trust's fixed assets register was now beginning to demonstrate an improvement.

The Committee emphasised the importance of ensuring that the staffing complement was sufficient to sustain the level of improvement. The Committee was advised that agreement had been secured to support the short term resourcing of the Improvement Plan, and that the Division was supporting a strengthening of team focus, through teambuilding and the development of robust business continuity arrangements which would stabilise the Division in the longer term. It was suggested that consideration be given to career development initiatives and succession planning. The Committee was advised that the Financial Governance Improvement Plan incorporates a Directorate Development Plan, and that the Directorate Training Policy is currently being developed. Arrangements were in place for current the Head of Financial Control, who would be leaving the Trust at the end of January 2012 to scope the resources which would be required on an ongoing basis to support the maintenance of the fixed assets register, in collaboration with the Medical Equipment Manager and the Information Technology Department.

DF

The Committee **REQUESTED** to be kept updated on progress with the Improvement Plan.

Review of Procurement Process **ACTION**

Cherie Mode-Keefe, Head of Procurement, advised of the arrangements which have been put in place to improve the strategy, governance and tactical controls to deliver cost improvements. The following key features of the Procurement Improvement Plan were drawn to the Committee's attention:

- The Procurement Department will have a new structure with effect from January 2012;
- Key Performance Indicators have been put in place;
- The procurement process has been standardised;
- The reasons for single tender waivers are challenged and officers refer back to samples of other related contracts; where a precedent is established, ways of improving purchasing arrangements are discussed with the division/department concerned;
- Monthly reporting on spending against the tender waiver values has been introduced;
- Mini-competitions will be run for contracts which are not required to be tendered, to ensure that the Trust is getting value for money;
- Purchase orders and non-purchase orders for goods and services are followed up where the relevant procedures have not been applied;
- Suppliers have been advised that the Trust will not issue payment without a valid purchase order;
- Internal Audit have commenced a review of compliance with tendering procedures;
- A training package for end-users of Standing Financial Orders has been developed.

Report on Audit of Employee Files

Subsequent to the Statement of Internal Control 2010/11, which had identified a number of inconsistencies in payroll expenditure, the Human Resources Directorate had undertaken a follow up audit to assess the currency of employee files. 80% of the files which had been tested were up to date, although a number of issues which required remedial action had been identified, which had been addressed as follows:

- To ensure that information on ID is up to date, all new joiners are required to produce documentation which accords with the Employment Checks Policy and Unique Information Management;
- The process for bank workers who join the permanent establishment are the same as those which apply to all new joiners;
- Senior authorised signatories sign timesheets and changes to hours are checked by SBS payroll against the forms.

The Human Resources Directorate had commenced an exercise to validate staffing lists with a view to the development of a single directory of the location of personal files. The Committee was advised that the assembly of the information required divisional support and that there had been a poor response rate thus far.

ACTION

The Directorate is working to a completion deadline of January 2012. In the event that the Trust decides to centralise staff personal files, it will be necessary to identify a suitable location to store the archive; It is anticipated that a business case for the introduction of a centralised model will be presented in March 2012.

The outcome of the annual internal Payroll Audit will be reported to a future meeting of the Committee; it is anticipated that the audit will be complete by the end of January 2012.

The Committee **NOTED** progress with the action plan.

101/11 ACCOUNTS CLOSEDOWN PLAN

Ms. Trevena, Associate Director of Finance introduced the detailed timetable for the delivery of the 2011/12 accounts. The Committee was advised that the timetable may be subject to change, as the Department of Health had not yet issued its timescales. It was highlighted that there would be a few days' less preparation time, due to 2012 being a leap year and the additional Bank Holiday. It was also recommended that officers take account of the siting of Easter, which could sometimes be problematic.

The Committee emphasised the importance of adherence to the timetable and Department of Health deadlines, which would be a vital component of its Foundation Trust application. Officers were requested to raise any problems encountered at an early opportunity with this Committee, the Board and the Executive Management Team, to ensure that the appropriate resources and arrangements were in place.

DF

With regards to the dates of forthcoming meetings, officers were requested to check the scheduling of the meeting of 1 June 2012.

Secretariat

The Committee **NOTED** the timetable for the closedown of the Accounts 2011/12.

102/11 TENDER WAIVERS

The Committee was advised that tender waivers would be reported to its meeting of 12 January 2012.

103/11 WRITE-OFF OF BAD DEBTS

There were no write-offs of bad debts for report to the Committee.

104/11 LOSSES AND COMPENSATION

There were no losses and compensation for report to the Committee.

105/11	**ANNUAL GOVERNANCE REPORT AND STATEMENT ON INTERNAL CONTROL ACTION PLAN 2010/11**	**ACTION**
	The Committee received a report, the purpose of which was to update it on the Annual Governance Report and Statement on Internal Control Action Plan. It was emphasised that achievement of the actions associated with the Annual Governance plan would be dependent upon the staff responding in a timely manner. The Trust **NOTED** the Annual Governance Action Plan 2010/12.	
105/11	**AUDIT COMMITTEE TERMS OF REFERENCE**	
	The Committee: - **NOTED** its current Terms of Reference; and - **REQUESTED** the Secretariat to review the Terms of Reference in the context of the current NHS Audit Committee Handbook produced by the Healthcare Financial Management Association and to represent them to its next meeting for review.	**Secretariat**
106/11	**INTERNAL AUDIT PROGRESS REPORT**	
	Mr. Shah, Acting Assistant Director of Audit, advised the Committee of the outcome of 3 reviews conducted by Internal Audit as follows: **Medical Equipment and Devices** It was reported that there had been significant improvements in the management of medical equipment and devices since the last review by Internal Audit conducted in May 2011 and that there was a reasonable assurance that appropriate controls were in place. The review had identified a need for improved monitoring and reporting of equipment at Queen Mary's Sidcup and had recommended the development of a risk register which encompassed all the risks associated with medical devices throughout the Trust. On the basis that it is intended to increase the volume of elective surgery at Queen Mary's Sidcup, officers were **REQUESTED** to report back on the action which is being taken to respond to the review's recommendations.	**DCE&CN**
	Legionella and Water Management It was reported that the review of legionella and water management had found there to be reasonable assurance, with good progress having been made in implementing action plans developed to address the risks identified by the previous review of this area. It was highlighted that the review had identified that improvements to the assurances provided by the Legionella Assurance Dashboard and to obtaining assurance in respect of properties rented and leased	

properties. A recommendation for clinical staff and managers to receive training on legionella remained outstanding from the previous audit. **ACTION**

The Committee remarked that the review had indicated that there was room for improvement, particularly in respect of operational issue and training. The Committee was advised that most of internal audit's recommendations had been implemented promptly. In respect of training, the Director of Infection Prevention was developing and e-learning module from scratch.

The Committee **NOTED** that progress on implementing the recommendations would be reported to the Governance Committee. **DCE&CN**

Network Management and Security

The review of Network Management and Security had provided a limited assurance relating to the system of internal controls, with the lack of evidence of a consistent approach across the Trust's three sites, network infrastructure, anti-virus measures and a lack of control over the potential to download data to unencrypted USB memory sticks indicating potential weaknesses.

The Committee **REQUESTED** officers to confirm the access rights to the Trust data and the arrangements for the internal promotion and dissemination of the Trust's Network and Security Safety Management Policy to staff and to report back to the Committee's next meeting on how network and security management would be incorporated into the arrangements for the implementation of the ICare system. The Committee further **REQUESTED** officers to report to its next meeting on the arrangements for addressing the recommendations arising from the review. **DP&IT**

The Committee **NOTED** the Internal Audit Progress report.

109/11 EXTERNAL AUDIT PROGRESS REPORT

Mr. Johnstone, Engagement Lead, Audit Commission advised the Committee that the Trust Annual Accounts 2010/11 had now been signed. As reported to the Committee's meeting of 30 November 2011 *(minute 90/11 refers)*, the District Auditor had given an adverse opinion on the arrangements which had been in place to secure value for money during the financial year 2010/11.

It was noted that the Trust's Annual Report and Annual Accounts would be presented to the Trust's Annual General Meeting on 21 December 2011.

An interim audit, examining the PbR requirements and incorporating interviews with the Trust Board Chairman, Chief Executive and the

Director of Finance would begin early in 2012. **ACTION**

The Chair thanked the District Auditors for their work on finalising the previous year's annual accounts.

110/11 LOCAL COUNTER FRAUD SERVICE REPORT

Ms. Purton, Local Counter Fraud Manager, advised of current local counter fraud activity.

It was reported that the Trust had maintained a level 2 rating for its Qualitative Assessment for the year 2010/11. As previously reported, there were changes to the assessment process which would be implemented going forward. The Committee remarked that there did not appear to be a consistent approach to the current assessment and rating process and it was hoped that the future arrangements, when announced, would provide greater clarity on the criteria to be met.

The Committee was advised that recent counter fraud investigations where disciplinary and or criminal sanctions had been applied would be mentioned in Trust Communications as part of the Trust's policy on the deterrence of fraud. The Local Counter Fraud Service is also working with the Trust Secretariat to review and fraudproof the Trust's processes and procedures surrounding declarations of interest. The Committee was advised that consultants who held managerial positions would be expected to comply with the Trust's Declaration of Interest Policy.

The Committee **NOTED** the report.

111/11 ANY OTHER BUSINESS

Unwanted Equipment Policy

Officers were requested to give some consideration to the development of a policy on the disposal of unwanted assets/equipment. The Director of Human Resources and Organisational Development undertook to discuss this with the Director of Estates and Facilities and PFI partners. **DHR&OD**

112/11 DATES OF NEXT MEETINGS

The Committee **NOTED** the following dates of forthcoming meetings *(all at 9.00 a.m.)*:

- Thursday 12 January 2012
- Thursday 15 March 2012
- Thursday 10 May 2012
- Thursday 31 May 2012*
- Thursday 13 September 2012
- Thursday 15 November 2012.

SOUTH LONDON HEALTHCARE NHS TRUST
FINANCE COMMITTEE MEETING
TUESDAY 22ND NOVEMBER 2011
Held in the Committee Room, Trust Headquarters, Queen Mary's Sidcup

MINUTES

PRESENT	Mr J Ballard	Acting Chairman (Chair)
	Ms J Townsend	Non Executive Director
	Mr J Virdee	Non Executive Director
	Dr C Streather	Chief Executive
	Mr R Smith	Medical Director
	Mr R Cooper	Finance Director
	Ms J Hall	Deputy Chief Executive / Chief Nurse
	Mr S Russell	Chief Operating Officer
IN ATTENDANCE	Mr M Weaver	Trust Board Secretary (Minute Taker)
	Mr A Bokari	Divisional Director, Women, Children and Support Services
	Ms M McSharry	Divisional Director, Planned Care
	Dr L Sawicka	Divisional Director, Emergency Care and Specialist Medicine
	Ms S Stenson	Associate Director of Finance (Planned Care)
	Ms M Walton	Associate Director of Finance (Emergency Care and Specialist Medicine)

STANDING ITEMS **ACTION**

069/11 APOLOGIES FOR ABSENCE

Ms G Hart	Non Executive Director
Ms L Roberts	Non Executive Director

070/11 MINUTES

Minutes of the meeting held on 25th October 2011 were **AGREED** as an accurate record. Mr Ballard welcomed Mr Virdee, Non-Executive Director to the meeting.

071/11 ACTION POINTS AND MATTERS ARISING NOT ON THE AGENDA

061/11 Oxleas Rental of Facilities

The Committee had **ASKED** the Trust to reassess the rental fee charged to Oxleas NHS Foundation Trust against the potential gains which could be made by leasing the facilities to other services. Mr Cooper had met with the Finance Director of Oxleas NHS Foundation Trust (FT) to discuss what would constitute a reasonable rental agreement. Mr Ballard asked the Trust to ensure that matters were resolved at the earliest possible time. **RC**

052/11 Pathology

The Committee had **ASKED** to receive an update on progress with developments to establish the Trust as a main Pathology hub. South London Healthcare NHS Trust (SLHT) was working towards the merger of its three laboratories. However progress with regard to the London Pathology Modernisation programme was reported to be slow. A further update would be given at the Committee's next meeting. **JH**

STANDING ITEMS **ACTION**

072/11 MONTH 7 FINANCIAL POSITION

The Trust YTD deficit for month 7 was £43,230K against a budget of £41,720K. This was £1.5M worse than plan.

The current Trust forecast was £69.8M against a plan of £69.8M. This forecast included the £20M over performance income being negotiated with Sector. The above forecast excluded any additional cost or income that might be incurred/due to the Trust to achieve the 18 week target at the end of quarter 3. For the Trust to achieve its plan of £69.8M a further £5.7M reduction in spend was required by the end of the financial year. This was a significant risk for the Trust. Expenditure on bank and agency staff needed to be rigorously controlled. Ms Townsend commented that the Trust position on non-pay expenditure was not good. Mr Cooper advised that securing improvements in year were constrained by inadequacies in the initial budget setting process for 11/12. For example Private Finance Initiative (PFI) and pharmacy costs had been underestimated. Nevertheless reductions in spend were needed.

Mr Ballard stated that the reported pay forecast made no allowance for planned reductions in bank and agency staff. Mr Virdee asked why the Trust couldn't re-set the budget. Mr Cooper stated that while it would be possible to reset the budget the resources required to do so would be better employed on reducing the number of Whole Time equivalent (WTE) staff f across the organisation through the structured programme of workforce reduction.

ITEMS FOR DISCUSSSION

073/11 TACTICAL CONTROLS UPDATE

Mr Cooper outlined action taken to reduce expenditure that included implementation of the "Ready Reckoner" and the implementation of a target reduction of spend on agency and bank staff introduced into the Divisions in August 2011. This action was beginning to demonstrate a reduction in expenditure.

Variable pay workstream

Ms Walton, Associate Director of Finance reported on action taken within the variable pay workstream. This included findings from an initial review, work undertaken since 15th November 2011 and future plans to reduce agency and bank staff.

Temporary staffing report – Corporate Services

Ms Townsend asked members of the committee to note the necessity for the Trust to move from agency to bank spend and the required target to reduce overall expenditure on pay. Ms Hall asked the committee to note that whilst the Trust would continue to exert tight control over expenditure there would need to be a change in the staffing profile to reflect the winter pressures that would begin to build over the coming weeks.

ECSM Ready Reckoner Summary

The Trust would continue to focus its attention on those areas where agency expenditure was high and build on the progress it had made over the last four months.

ITEMS FOR DISCUSSSION **ACTION**

073/11 TACTICAL CONTROLS UPDATE

ECSM Ready Reckoner Summary

Ms Walton asked the committee to note the detail reported within the Emergency Care and Specialist Medicine (ECSM) Ready Reckoner that included information replicated by Directorate and site for General Managers and Heads of Nursing for their areas. Information in this summary indicated vacancies within the Division, the Total Whole Time Equivalent (WTE) used by Bank and Agency Staffing split by the different hourly rates (i.e. Saturday enhancements, unsocial hours, Sunday/Bank holiday etc).Such data would be used to identify areas that had high usage of Unsocial WTE staff and inform action to plan rotas more efficiently

Women, Children and Support Services

Mr Bokari, Divisional Director, Women, Children and Support Services (WCSS) reported on Tactical Controls for WCSS. The Division was currently £746K favourable Year to Date (YTD) to budget. This was due to Divisional vacancies and tactical pay controls offset by an overspend on non-pay which is primarily driven by increased Pathology spend, increased drug charges to Pharmacy, lower scan charges in Radiology and non identified Cost Improvement Plans (CIPs).An important contributor to the adverse position in non-pay was a reported 25% increase in CT scans year on year and an 80% increase in CT scans ordered after 21.00 hours The Division has a vacancy factor of 38.92 WTE. The majority of this is within Specialist Children's Services (20 WTE) Speech and Language Therapy and Respite Care.

The Division's strategy was to stop using agency staff and to replace with bank staff or substantive appointments. Through monthly directorate performance reviews the Divisional Management team challenged any unfilled vacancies and reduced substantive posts. Weekly General Manager (GM) meetings focused on the Trust Ready Reckoner and action to further reduce run rates. The Division reviewed all vacancies i.e. banding, hours required before they were sent to the Trust Vacancy Control Group (VCG).The Medical Workforce had successfully removed 79.8 PA's from the current workforce. This represented 10% of the total PA's in the Division and work continued to progress plans to further reshape the workforce in line with the transformation of services.

Ms Townsend asked if the Division would continue to hold existing vacancies in order to control expenditure as the Trust would need to understand how any future recruitment would impact upon savings targets. Mr Cooper stated that the Division needed to maintain control of its expenditure and meet its targets for reductions in bank and agency spend. Mr Bokari asked the committee to note that the Trust would save money by recruiting to vacant posts currently covered by bank staff. Mr Cooper agreed but emphasised the need to ensure that any decision to fill a vacancy post was challenged by the Trust VCG. Mr Bokari asked the committee to note that the Trust would need to recruit to posts where it was demonstrated that not filing the post would present a clinical risk. Members of the committee agreed the priority for the Trust was to ensure the highest standards of quality and safety, prompt

access to services and financial balance.

ITEMS FOR DISCUSSSION **ACTION**

073/11 TACTICAL CONTROLS UPDATE

Emergency Care and Specialist Medicine

Dr Sawicka, Divisional Director, Emergency Care and Specialist Medicine (ECSM) reported on Tactical Controls for ECSM. Dr Sawicka reported there were significant levels of staff sickness in Medical Staffing. One area of significant over spend was the use of agency medical staff in Accident and Emergency Services however the Trust was in the process of recruiting to 2 posts and this would reduce agency spend.

Ms Walton asked the committee to note that the reported discrepancy between spend at the Princess Royal University Hospital (PRUH) and that at the Queen Elizabeth Hospital (QEH) was a consequence of a lower staff establishment at the PRUH than at the QEH. Ms Hall added that work to be completed shortly would identify an indicative establishment profile for the Trust at the end of December. The Trust would also need to look at medical staff rotas in ECCS to ensure than they were managed more efficiently. It had become practice for medical staff sickness to be covered by locum staff. Dr Streather asked the committee to note the progress made by the Division. However it would need to ensure there was greater control over the use of locum staff to cover staff sickness.

Dr Sawicka reported on work to review the role and banding of Clinical Nurse Specialists (CNS) in each of its specialties. Mr Cooper reiterated the need for the Division to reduce its current level of expenditure on temporary staffing. The Division would also need to maintain this control over expenditure during winter pressures. Mr Russell, Chief Operating Officer stated he would be happy to help the Trust review of medical staff rotas in ECCS.

Planned Care

Ms McSharry, Divisional Director, Planned Care reported upon the current status of tactical controls within Planned Care. The Division was running with a 12% vacancy rate within its theatres. Two theatres at QEH were closed due to Planned Preventative Maintenance (PPM) and day surgery services at the PRUH had been impacted by a recent power failure. Cost pressures included the opening of escalation wards at the PRUH and QEH that remained unfunded, a step increase in demand for Endoscopy Services and non pay expenditure rising in line with increasing activity.

Mr Cooper stated that where savings could not be made within the Division they would need to be made elsewhere within the Trust. The Trust could not continue to spend more than it was earning. Mr Ballard asked Ms McSharry if there was any further action that could be taken outside of Planned Care that would help the Division. Support with the funding of escalation wards would assist: however the cost pressure would remain within the Trust. The Trust was committed to its theatre activity in order to achieve the 18 week Referral to Treatment (RTT) Target.

ITEMS FOR DISCUSSSION **ACTION**

073/11 TACTICAL CONTROLS UPDATE

Corporate Services

Ms Hall reported upon the current status of tactical controls within Corporate Services. This included progress made in CIPs and emerging cost pressures that included staff recruited to deliver the implementation of the Cerner Millennium Patient Administration System, known as iCare. The Trust would need to ensure that the review of corporate services identified appropriate savings to set alongside those being made in Clinical Divisions.

The Committee **AGREED**.

- That Divisional run rates must not increase, and that the savings target for bank and agency costs must be delivered. Should there be any forecast increase in costs, for e.g. the two winter wards in ECSM then additional savings **MUST** be made to offset these costs.
- The COO will report compliance at the next Finance Committee meeting on December 20th 2011
- ECSM would report its plan to meet its target reduction of spend on agency and bank staff. This plan must be updated to allow for any cost increases over the winter period.
- Divisions would not make any increase in establishment without full justification and prior approval at the Executive Management Team (EMT) Vacancy Control Group (VCG).
- Planned Care would report its plan to meet its target reduction of spend on agency and bank staff. This plan would need to incorporate measures for tactical support from WCCS and ECSM
- Corporate Services would report its plan to meet its target reduction of spend on agency and bank staff. This plan would need to incorporate action to address outputs from the review of corporate services.

The Committee **AGREED**

- The Chief operating Officer would update the Executive Management Team (EMT) on the overall Tactical Controls that would deliver weekly target of £493k. This report should set out the level of contribution from each Division, and assurance that the savings will be delivered. **SR**

074/11 ANY OTHER BUSINESS

Radiotherapy Procurement

Dr Streather tabled a briefing note regarding the provision of radiotherapy services to the population of Outer South East London (OSEL) at South London Healthcare NHS Trust (SLHT). This represented a partnership between the Trust, the South East London Cancer Network and Guys and St Thomas's Foundation Trust. This included a high-level draft timetable proposed at the launch meeting held on 31st October 2011.

	ITEMS FOR DISCUSSSION	ACTION
074/11	**Radiotherapy Procurement**	
	This procurement sought to develop a satellite radiotherapy centre that would open in the summer of 2013 to treat suitable local patients having radical treatment for breast, lung, prostate and colorectal cancers, and for palliative care. Whilst timelines were subject to revision and the tendering process could be withdrawn this proposal should see a recommendation being taken to Boards for ratification in February or March 2012.	
	SLHT had been asked to produce an indicative rental cost to be posted for all the bidders to see. This process should clearly state what is included and excluded, and at this point was likely to be based on a sight as seen basis, but this might evolve as the clinical model and the understanding of people's requirements developed.	
	Dr Streather **ASKED** the committee to agree the objectives of the pricing exercise set out as follows: – To ensure that pricing did not lead to SLHT incurring net additional cost to encourage the siting of a satellite radiotherapy unit on the SLHT site – To try and ensure that the provision of radiotherapy made a positive contribution to SLHT's financial position.	
	The Committee **AGREED** the objectives of the pricing exercise and **ASKED** to receive an update on this item at the Trust Board Seminar on 21st December 2011.	**CS**
075/11	**DATE OF NEXT MEETING**	
	Tuesday 20 December 2011 at 09.00 a.m. to 11.00 a.m. in the Committee Room, Trust Headquarters, Queen Mary's Hospital Sidcup	

SOUTH LONDON HEALTHCARE NHS TRUST
FINANCE COMMITTEE MEETING
TUESDAY 25th OCTOBER 2011
Held in the Committee Room, Trust Headquarters, Queen Mary's Sidcup

MINUTES

PRESENT	Mr J Ballard	Acting Chairman (Chair)
	Ms J Townsend	Non Executive Director
	Dr C Streather	Chief Executive
	Mr R Smith	Medical Director
	Mr R Cooper	Finance Director
	Ms J Hall	Deputy Chief Executive / Chief Nurse
	Ms A Bhatia	Deputy Chief Nurse
IN ATTENDANCE	Mr M Weaver	Trust Board Secretary (Minute Taker)
	Ms L McKenzie	Director of Human Resources and Organisational Development

STANDING ITEMS **ACTION**

059/11 APOLOGIES FOR ABSENCE

Ms G Hart	Non Executive Director
Ms L Roberts	Non Executive Director

060/11 MINUTES

Minutes of the meeting held on 27th September 2011 were **AGREED** as an accurate record.

061/11 ACTION POINTS AND MATTERS ARISING NOT ON THE AGENDA

052/11 Oxleas Rental of Facilities

The Committee had **ASKED** the Trust to reassess the rental fee charged to Oxleas NHS Foundation Trust against the potential gains which could be made by leasing the facilities to other services. The Committee was informed that action to address this matter was still ongoing. **RC**

052/11 Reduction of Trust Clinical Negligence Scheme for Trusts (CNST) Contribution

The Committee had **ASKED** the Trust to seek a response to the Trust's requests to receive a formal review of the Trust's National Health Service Litigation Authority (NHSLA) contributions in respect of the provision of maternity services for 2011/12. The Committee was informed the Trust had received a £600k refund for the year 2011/2012.

052/11 Service Review of Planned Care Division and Women, Children, Cancer and Clinical Support Services

The Committee had **ASKED** to receive a report that reported recommendations arising from the service review undertaken by Ernst and Young. The Committee was informed matters arising from this review had informed a submission to the Challenge Trust Board Fund.

052/11 Pathology

The Committee had **ASKED** to receive an update on progress with developments to establish the Trust as a main Pathology hub. The Chairman **ASKED** to receive an update on this item at the next meeting. **JH**

STANDING ITEMS | **ACTION**

061/11 ACTION POINTS AND MATTERS ARISING NOT ON THE AGENDA

053/11 Month 4 Financial Summary

The Committee had **ASKED** the Trust to ensure that vacant posts had been removed from the Trust establishment prior to the calculation of savings. Ms McKenzie reported on the action being taken and asked the committee to note the Trust was seeking to calculate the level of saving based on posts being covered by bank and agency staff.

053/11 Month 5 Financial Summary

The Committee had **ASKED** the Trust to submit a detailed account of the measures put in place to reinforce the Trust savings plan that would incorporate contractual income, meeting Cost Improvement Plan (CIP) targets and reductions in spend on temporary staffing. Discussion with the Sector had made sufficient progress for it to be reasonable to assume that income would be £24m more than had been assumed previously. However the Trust could face potential fines for not achieving National Referral to Treatment (RTT) targets. It was important to ensure that the increase of £24m was a net increase in income.

The Committee **AGREED** that all members of the Finance Committee would receive a briefing on contractual income before the Trust signed the contract.

Ms Townsend advised the amount of work the Trust was doing to prove the activity it was doing needed to continue. Mr Cooper agreed and added that Clinical audit would substantiate this level of activity. | **RC**

057/11 Full Business Case (FBC) to expand theatre capacity at Queen Marys Hospital Sidcup

The Committee had **ASKED** to receive a FBC at the next meeting of the Trust Finance Committee. Ms Hall asked the committee to note that following discussion at the Executive Management Team (EMT) meeting Trust it had been decided not to proceed with the immediate proposal and an alternate proposal needed to be agreed. Alternative proposals were being considered with a view of implementing in March 2012.

062/11 MONTH 6 FINANCIAL POSITION

The Trust Year to Date (YTD) deficit for month 6 was £35,640K against a budget of £36,314K. This was £674k better than plan YTD due to the over performance of income of £11.6M, £10.6M shown in month 6. The Trust had recognised £20M of over performance income in the Trust forecast compared to month 5 due to the movement on contracting negotiations from the informal arbitration.

The CIP Programme had delivered YTD savings to Month 6 of £8,808K against a plan of £12,852K, a shortfall of £4,044K. The Trust CIP programme was currently forecasting a shortfall of £8.5m against a total plan of £30.6M. This shortfall was the consequence of an increase in non-pay costs, failure to control bank and agency expenditure in some areas. The Trust was therefore introducing further controls to improve the management of bank and agency staff. These included the requirement for Divisions to provide finance with 4 weekly staff rotas and the reiteration of rules for ordering Non Purchase Order number items.

STANDING ITEMS **ACTION**

062/11 MONTH 6 FINANCIAL POSITION

Members acknowledged the need to improve controls without disrupting clinical services. Ms Townsend stated that even though the Board scrutinised CIPs every year and was given assurance that plans would be delivered there needed to be greater individual accountability for those areas where CIPs were not delivered. The Committee **AGREED** Divisional Directors:

- Attend the Trust Board Finance Committee on 22nd November 2011 to report on what action they have taken since September 2011 to control expenditure on bank and agency staff.
- Prepare and present a 15 minute presentation that sets out the following

1. Action taken since September to control expenditure.
2. Evidence of performance against the Monthly Human Resource (HR) Key Performance Indicators (KPIs)
3. The action to be taken to achieve the agreed levels of expenditure as set out in the HR KPIs **RC**

ITEMS FOR DISCUSSSION

063/11 SERVICE REVIEW

Members of the committee **NOTED** an update on the recommendations of the Service Review undertaken by Ernst and Young would be discussed at the Trust Board Informal Seminar to be held on 26th October 2011.

064/11 WORKFORCE REVIEW

Members of the committee **NOTED** an update on the arrangements to oversee the Workforce Review and progress with its implementation would be discussed at the Trust Board Informal Seminar to be held on 26th October 2011.

065/11 BUSINESS PLANNING 2012/13

Members of the Board were asked to note and approve the process for producing a Board approved business plan for 2012/13 by 31st March 2012. Development of the 2012/13 Business Plan had included the development of corporate objectives and the approach to setting the CIP target for 2012/13. The Acting Chairman asked if Year 1 of the proposed 4 year plan would be ready for sign off by December 2011. Mr Cooper assured Mr Ballard of the action to be taken by December 2011. The Acting Chairman asked if the Strategic Health Authority (SHA) had agreed to this approach. Mr Cooper confirmed that the Trust was meeting with the SHA to inform them of the business planning process for 2011. The Trust also meets with representatives from the cluster to Quality Assure its plans before they go the SHA. The Committee :

- **AGREED** Dr Streather's proposal that Mr Roger Smith, Medical Director or Mr Ali Bokari Divisional Director, Women, Children and Support Services should attend the Health Economy Group **RS**

APPROVED the process for producing a Board approved business plan for 2012/13 by 31st March 2012.

ITEMS FOR DISCUSSSION **ACTION**

066/11 BRIDGE ANALYSIS

2011/12 Forecast Outturn compared to 2011/12 Financial Plan

Mr Cooper introduced a paper that presented the results of an analysis that had been undertaken to reconcile 2010/11 income and expenditure to 2011/12 projections in the 7th June bridge and the month five straight line forecast. The purpose of this analysis was to clarify:

- Where costs have gone up greater than plan
- Action required to directly address these overspends
- Action required to reduce costs in other areas to compensate for overspends that cannot be directly addressed
- Any learning for future budget setting / planning rounds

The main reasons why costs were higher than plan was due to non pay spending and failure to deliver the planned CIP's on pay. This indicated structural problems within the Trust's processes e.g. too many CIPs that were unlikely to be delivered.

The committee **NOTED** the findings of the report and the further work required on the overspending areas to

- Identify any technical issues (e.g. stock movements) that may be distorting the position
- Identify any additional explanation required as to why these costs are higher than identified in the June 7th Bridge
- Identify any direct mitigation of these costs
- Identify indirect mitigation for the overspends
- Learning for next year's business plan / budget setting process

067/11 ANY OTHER BUSINESS

Common PAS/OCR/EPR Implementation: Full Business Case (FBC)

Ms Hall **ASKED** the committee to note the NHS London Capital Investment Committee (CIC) approved the Trust's FBC at its meeting on 13th October 2011 subject to The Trust Board reconfirming its approval of the FBC once it had been amended to address issues raised by NHSL and agreed by the Trust and the Trust Board being provided with a briefing paper outlining the issues raised during the course of NHSL's review and responses provided by Trust management.

Draft Audit Letter

The Acting Chairman **ASKED** the committee to note the Trust Board Audit Committee had considered the Draft Audit Letter at its meeting on 17th October 2011. The Trust would need to develop a coherent explanation that addressed all the points raised within the letter. Dr Streather agreed the Trust would need to respond with a detailed action plan to address each point within the letter.

068/11 DATE OF NEXT MEETING

Tuesday 22nd November 2011, Committee Room, Trust Headquarters.

Trust Board
25 January 2012
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UNCONFIRMED
MINUTES OF HR SUB-COMMITTEE MEETING
Held on 7th November 2011
By Conference Call

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

IN ATTENDANCE:
Mr Danny Hariram, Deputy Director of HR (DH)

APOLOGIES:
None noted

		ACTION
1.	**MINUTES OF THE PREVIOUS MEETING (16 JUNE 2011)** These were agreed as an accurate record.	
2.	**MATTERS ARISING** There were no matters arising by the Committee	
3.	**POLICIES** The following policies were presented to the Committee: **3.1 Flexible Working policy** The Flexible working policy was approved by the Committee and will be reviewed after three years. **3.2 Recruitment and Retention Premia policy** The Committee approved for the draft policy. It was noted that the draft policy would now be negotiated with Staff Side, and will apply for all new R&R requests once existing notice periods have expired.	**DH**
4.	**PERSONAL FILES AND PAYROLL AUDIT UPDATE** Mrs McKenzie updated the Committee on the actions being taken following the external audit of payroll files and the internal audit undertaken in June 2011. Mrs McKenzie noted that as a result of merger and different approaches to the retention of personal files by the legacy Trusts, there was a considerable piece of work to be completed to identify and record the location of all employee personal files. Mrs McKenzie noted that the target date for completion of this work was end of January 2012. Further to this work it was noted that a business case would be developed identifying the costs of centralisation of employee personal files. Mr Hariram noted that a sample audit will be undertaken in November 2011, consisting of 50 staff files of new joiners from 1 April 2011 – 31 October 2011	

	to provide internal assurance that the new current systems meet audit requirements. Mr Hariram said that the annual external payroll audit is due to take place week beginning 14th November. The audit forms part of the Trust's Internal Audit Plan 2011/12 and has been approved by the Audit Committee. The audit will include- ➢ Assurance that all employees are paid the correct amount of time. ➢ Assurance that all new employees are correctly paid from the time they join the Trust. ➢ Assurance that all leavers are removed from the payroll on a timely basis and overpayments are promptly identified and recovered. ➢ Assurance that all payroll records are complete and accurately and variations are auctioned on a timely basis. The Committee noted the progress made in relation to this work programme.	
5.	**CRB UPDATE** Mrs McKenzie confirmed to the Committee that the directorate had met the final target date for this project and by 29th October 2011, all CRBs had been completed and sent off for checking. Mrs McKenzie described the next phase of this project and commented that the EMT would be considering whether the Trust moves to a self-declaration process for employees rather than continuing to do 3 yearly checks as part of the next phase. Mrs McKenzie noted that this decision would require amendment of the current policy and therefore would need to be presented to the HR Committee in due course. Ms Townsend suggested that a self-declaration process would need to be supported by a programme of random checks to provide a level of assurance.	**LMcK**
6.	**COST IMPRPOVEMENT PLANS (CIPs)** Ms McKenzie updated on the following HR CIPs: 6.1 Consultant Job planning: good process has been made in ensuring that all consultants have an up to date JP, and reducing cost were possible. It was noted that there was still further work to do to drive further productivity. 6.2 Occupational Health – It is expected at the end of October that the contract price will reduce by £237k. 6.3 Salary Sacrifice Scheme – It is anticipated from the new financial year this project will yield savings of approximately £90k savings. 6.4 Monthly to Weekly pay change for Bank Workers – It is anticipated that scheme will yield savings of £80k if it is agreed for implementation in 2012/13.	

7	**JOB PLANNING** Mrs McKenzie updated the Committee that through the recent job planning exercises there had been a reduction of 116 PAs. Ms Townsend asked how the outstanding job plans were progressing. Mrs McKenzie said that the divisions are continuing with these exercises and will be completed through the Medical work stream, which forms part of the workforce transformation programme.	
8.	**WORKFORCE KPIs** Ms Townsend said that further work is required to reduce Bank and Agency pay. Mrs McKenzie noted that the variable pay work stream will identify actions to be taken in order to reduce expenditure in this area. Ms Townsend noted a high level of turnover within Physiotherapy, Pharmacy and Pathology. Mr Hariram said that he would look in to this and provide an update. Mrs McKenzie noted that the Trust had made improvements in terms of meeting the required statutory and mandatory compliance standards. Discussions have taken place with the Divisions regarding the data and the Head of Learning and Organisational Development is working with them on their improvement plans. These will be monitored within the performance review framework.	**DH**
9.	**PREPARATION FOR INDUSTRIAL ACTION** Mr Hariram provided the Committee with a copy of the guidance that has been developed for Managers. Managers are currently in the process of understanding potential numbers of staff who maybe absent due to industrial action and childcare requirements. Mr Hariram said that the Trust is working through the principles that have been developed by the London Partnership committee. Mr Hariram confirmed that communications would be provided to staff and that staff would be encouraged to not participate in industrial action.	
10.	**ANY OTHER BUSINESS** No items were raised by the Committee.	
11.	**NEXT MEETING** 23rd November 2011. It was agreed that the Committee would meet again in November where the focus would be on the Workforce Transformation programme.	

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SOUTH LONDON HEALTHCARE NHS TRUST

Subject	Trust Board Rolling Forward Agenda
Report by	John Ballard, Acting Chairman
Author	Michael Weaver, Trust Board Secretary
Executive Director	Ms Jennie Hall, Deputy Chief Executive / Chief Nurse

TRUST OBJECTIVE

Our Patients	**x**
Financial Viability	**x**
Leadership and Workforce	**x**
High Quality Clinical Care	**x**
Healthcare Acquired Infections	**x**
National and Local Priorities	**x**
Service and Facilities fit for the future	**x**

GLOSSARY

Abbreviation	**In Full**
SFIs	Standing Financial Instructions
iCare	Patient healthcare Record System

WRITTEN REPORT (provided in addition to cover sheet) No

POWERPOINT PRESENTATION No

PURPOSE OF THE REPORT / PRESENTATION

To advise the Board of the rolling forward agenda for 2011 / 2012.

SUMMARY OF KEY ISSUES

At its meeting on 28th September 2011 The Board **APPROVED** the rolling forward agenda items and **REQUESTED** officers to advise the Secretariat of items for inclusion within the programme at the earliest possible opportunity. To ensure the Board has sufficient capacity to dispatch its operational oversight tasks as efficiently and thoroughly as possible it is proposed that the number of Trust Board meetings to be held in Public in 2012 will be increased from 6 to 8 meetings.

SOUTH LONDON HEALTHCARE NHS TRUST

SUMMARY OF KEY RISKS

1. The Trust does not achieve all its stated objectives for 2011/2012
2. The Trust does not have sufficient capacity to dispatch its operational oversight tasks as efficiently and thoroughly as possible

RECOMMENDATION / DECISION REQUIRED

For Trust officers to **ADVISE** the Secretariat of items for inclusion within the rolling forward programme at the earliest possible opportunity

IMPLICATIONS

Are there any implications for Care Quality Commission Registration?	No
Is an Equality Impact Analysis Required?	No
Are there any legal Implications arising from this item?	No
Are there any Financial implications arising from this item?	No

REVIEW

Trust Committee	**Date**
Executive Management	3rd January 2012

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SOUTH LONDON HEALTHCARE NHS TRUST

Trust Board rolling forward agenda as of January 2012

Date	Agenda Item	Matters for Consideration	Director
25/01/12	Finance	Update on annual planning process	RC
25/01/12	Strategy	Exception report on Key Risks	JH
25/01/12	Patient Experience	Quarterly Report on Patient Experience	JH
25/01/12	Performance	In-depth review of Access and Targets	SR
25/01/12	Strategy	Board Assurance Framework	JH
25/01/12	Patient Safety	Trust Board Safety Plan	JH
25/01/12	Finance	Financial Governance Improvement Plan	RC
25/01/12	Clinical Services Strategy	Cancer Services Strategy and Radiotherapy	RS

Date	Agenda Item	Matters for Consideration	Director
28/03/12	Finance	Agree annual plan and budget	RC
28/03/12	Strategy	Review Board Assurance Framework	JH
28/03/12	Patient Safety	Report on Infection Prevention	TC
28/03/12	Strategy	Review of Staff Survey Report / Plan	LMcK
28/03/12	Finance	Report on “Going Concern”	RC
28/03/12	Audit	Authorisation of Audit Committee to sign off Annual Report and Annual Accounts	Board
28/03/12	Clinical Services Strategy	Cancer Services Strategy and Radiotherapy	RS

Date	Agenda Item	Matters for Consideration	Director
25/04/12	Information	Report from Trust Board Audit Committee	Board
25/04/12	Information	Approve register of Seals	Board
25/04/12	Information	Approve register of Interests	Board
25/04/12	Information	Approve Changes to Standing Orders and SFIs	RC
25/04/12	Strategy	Exception report on Board Assurance Framework	JH

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SOUTH LONDON HEALTHCARE NHS TRUST

Date	Agenda Item	Matters for Consideration	Director
30/05/12	Patient Experience	Quarterly Report on Patient Experience	JH
30/05/12	Strategy	In-depth review of Access and Targets	SR
30/05/12	Strategy	Exception report on Board Assurance Framework	JH

Date	Agenda Item	Matters for Consideration	Director
25/07/12	Patient Safety	Annual Report on Infection Control	TC
25/07/12	Strategy	Annual Report on Research and Development	JH
25/07/12	Patient Safety	Report on Infection Prevention	TC

Date	Agenda Item	Matters for Consideration	Director
26/09/12	Patient Safety	Annual report on Health and Safety, Radiation Protection and Fire Safety	JH
26/09/12	Strategy	Exception report on Board Assurance Framework	JH
26/09/12	Strategy	Review Board Assurance Framework	JH

Date	Agenda Item	Matters for Consideration	Director
24/10/12	Patient Experience	Quarterly Report on Patient Experience	JH
24/10/12	Performance	In-depth review of Access and Targets	SR

Date	Agenda Item	Matters for Consideration	Director
28/11/12	Patient Safety	Report on Infection Prevention	TC
28/11/12	Finance	Sign off Annual Audit Letter	RC
28/11/12	Strategy	Review and Update Board Assurance Framework	JH