Barking, Havering and Redbridge University Hospitals NHS Trust

TRUST BOARD MEETING
Wednesday, 1 May 2013 at 1.00 pm
Board Room, Trust Headquarters
Queen's Hospital

A G E N D A

1. Apologies for Absence

2. Minutes of the Part I and Extraordinary meetings held on 6 March and 3 April 2013 (Attachment A) (Attachment B)

3. Matters Arising and Actions

4. ***GOVERNANCE:***
   - 4.1 Board Assurance Framework (FP-C) (Attachment C)
   - 4.2 Integrated Cancer System – London Cancer Memorandum of Agreement: April 2013 – March 2014 (AD) (Attachment D)

5. ***QUALITY AND PATIENT STANDARDS***
   - 5.1 BHRUT Emergency Pathway (DH) (Attachment E)
   - 5.2 Quality & Patient Standards Performance Report – March 2013 (NM/Executive Directors) (Attachment F)
   - 5.3 National Inpatient Survey 2012 (FP-C) (Attachment G)
   - 5.4 Francis Report Update (FP-C) (Attachment H)

6. ***FINANCE, WORKFORCE AND ACTIVITY***
   - 6.1 Going Concern – Briefing Note (DG) (Attachment I)
   - 6.2 Single Operating Model – February 2013 (NM) (Attachment J)
   - 6.3 Finance Report 2013/14 (DG) (Attachment K)
   - 6.4 Finance Report – Month 12 (March) 2012/13 / Draft Annual Accounts 2011/12 (DG) (Attachment L)
   - 6.5 Report from Workforce Committee and Key Performance Indicators – March 2013 (DH) (Attachment M)

7. ***COMMITTEE REPORTS***
   - 7.1 Report from Quality & Safety Committee (CW) (Attachment N)
   - 7.2 Report from Trust Executive Committee (AD) (Attachment O)
   - 7.3 Report from Audit Committee (WL) (Attachment P)
   - 7.4 Report from Finance & Investment Committee (KM) (Attachment Q)

8. ***INFORMATION***
   Matters for Noting:
   - 8.1 Chairman's Report (Attachment R)
   - 8.2 Chief Executive's Report (Attachment S)

9. Any Other Business

   Date of Next Meeting: The next public meeting will be held on Wednesday, 3 July 2013 at 1.00 p.m. in the Board Room, Trust Headquarters, Queen's Hospital

10. Questions from the Public

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

BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST

Minutes of the Part I Trust Board Meeting held on the 6 March 2013 in the Board Room, Trust Headquarters, Queen's Hospital

Present:	Sir Peter Dixon	Chairman
	Mrs Averil Dongworth	Chief Executive
	Dr Maureen Dalziel	Associate Non-Executive Director
	Ms Flo Panel-Coates	Director of Nursing
	Dr Mike Gill	Medical Director
	Dame Prof Donna Kinnair	Director of Governance & Special Projects
	Mr William Langley	Non-Executive Director
	Mr Keith Mahoney	Non-Executive Director
	Prof Anthony Warrens	Non-Executive Director
	Mr David Gilburt	Interim Director of Finance
	Mrs Dorothy Hosein	Chief Operating Officer
	Mr Neill Moloney	Director of Planning & Performance
In Attendance:	Mrs Sue Williams	Executive Assistant/Trust Board Secretary

2012/094 APOLOGIES FOR ABSENCE

Ms Caroline Wright, Non-Executive Director and Mr Michael White, Non-Executive Director.

2012/095 MINUTES OF THE PART I MEETING HELD ON 9 JANUARY 2013

The minutes of the Part I meeting held on the 9 January 2013 were noted as a true record and signed by the Chairman.

2012/096 MATTERS ARISING AND ACTIONS

2012/081: Prof Kinnair confirmed that she had devised a reporting mechanism for when the Trust was adrift from trajectory/delivery and had circulated a Risk Action Plan and Assurance Report to be used for exception reporting. Following feedback on the format, she would ensure that this was embedded in the organisation and be implemented from the 1 April 2013. The Board agreed that there should be an audit on its use three months after implementation.

Action: Donna Kinnair June 2013

2012/083: It was confirmed that the Trust was able to use text messaging for children's outpatient appointments and was currently rolling out text messaging to the specialties in the organisation.

2012/097 CARE QUALITY COMMISSION REPORTS (MATERNITY SERVICES AND EMERGENCY DEPARTMENT AT QUEEN'S HOSPITAL)

Mrs Hosein informed the Board that following the unannounced Care Quality Commission (CQC) visits to Maternity and the Emergency Department during November and December 2012, the Trust was compliant in Maternity, but non-compliant with respect to the Emergency Department. She informed the Board that a Risk Summit had been held on the 7 February and following this event, the Trust had put together an Emergency Care Pathway Workplan.

Mr Langley commented that going forward the Trust should still keep a high level oversight on the performance in Maternity Services and should still receive updates on a regular basis, in order to provide assurance to the members that it remained compliant. The Board agreed that the Trust's reporting was not adequate around assurance in many areas and needed a radical overview as to how members were provided with this assurance. A high level Dashboard would enable the Board members to drill down and see what was going on, as this was not in place at the moment. The Chairman and Prof Kinnair had discussed some key performance indicators that could be used, so Board members could judge performance across a whole range of areas, not just Maternity.

Following Dr Dalziel's comment around the timescale for implementation of this Dashboard, it was noted that this would take three months to put in place and a proposed format would be prepared and brought back to the Board for ratification before implementation.

The Trust Board noted the outline of the Care Quality Commission findings.

Action: Donna Kinnair 1.5.13

2012/098 EMERGENCY CARE RISK SUMMIT 7 FEBRUARY 2013 – LETTER FROM MEDICAL DIRECTOR, NHS LONDON

The Chief Executive informed the Board that the Trust had attended an A&E Risk Summit, along with representatives from NHS London, the NHS Trust Development Authority and the Care Quality Commission, chaired by the Medical Director of NHS London. The letter included the feedback on the Trust's Action Plan presented at the Risk Summit. Work was now underway to engage with the wider local health economy, including Clinical Commissioning Groups, Local Authorities and the London Ambulance Service (LAS) to formulate a Workplan to address the weaknesses identified by the Care Quality Commission and to deliver the sustained improvement required in emergency care. The Workplan had to be agreed, with performance metrics and milestones, and in place by the 15 March. The NHS TDA would then monitor the Plan and hold the Trust to account for delivery. As set out in the letter, the Trust had received notification that the Expert Panel understood the challenges the Trust was facing in relation to recruitment and retention in the Emergency Department (ED) and was well sighted on the difficulty of recruiting ED Consultants. The original Plan had not emphasised the importance of governance/ assurance, but the Executive Team would make sure that this was covered in the revised Workplan.

The Director of Nursing was leading on providing guidance to the ED nursing staff, so they understood the model of care that was expected. A further Clinical Fellows Programme had received support and UCL Partners were looking to bring forward the next Programme, in order for the Trust to recruit and respond with a very quick implementation.

The physical layout of the ED had been recognised as one of the difficulties to operating the Department and the Executive Team was working up a short and medium term strategy to address this, ahead of the long term strategy when the changes would be made with the closure of the ED at King George Hospital. The Trust had been working closely with the LAS and they had agreed to position one of their members of staff in Queen's ED, in order to assess the operational issues. The Trust very much appreciated the support from its partners and the Independent Expert Panel, who had provided excellent challenge to the Trust's Plan.

The Chairman asked for reassurance from the Chief Executive and her Executive Team that the Workplan would be agreed and in place to meet the 15 March deadline. The Chief Executive confirmed that most of the elements were already in place. Mrs Hosein informed the Board that there was much more clinical ownership and engagement now and all the Clinical Directors were signed up to working with her to deliver the Workplan.

The Trust Board noted the comments received from NHS London, the Commissioning Board, the NHS Trust Development Authority and the Care Quality Commission. All comments were now being addressed through the Emergency Care Pathway Improvement Plan.

Action: Averil Dongworth/Executive Directors 15.3.13

2012/099 4-HOUR ACCESS IMPROVEMENT PLAN

A copy of the Emergency Care Pathway Summit update on the Workplan was tabled at the meeting, as the Chief Operating Officer wanted to provide the Board members with the most up to date position on the key deliverables and actions during February and the planned actions for March. The Board reviewed in detail all the key deliverables for February, particularly those that were rag rated 'red'. The Board acknowledged that there were a lot of 'reds' and members were not assured that the Trust was monitoring and delivering what it had agreed to do. In relation to delayed transfers of care (DTOC's), the Trust had 1/1.5 wards full

of this cohort of patients' at any one time. The Chief Executive had raised this issue at the recent Integrated Care Coalition meeting and was discussing this with the Cluster Chief Executive, as it was important to gain the Commissioner's engagement in the Trust's Plan in relation to DTOCs. The Trust had not yet had sight of its partners' Plans and what was being delivered in the community, but in the interim was making spot purchase arrangements for the DTOC's within its control and challenging the relevant Local Authorities.

Mr Langley raised concerns around appropriate communication with patients, in order to ensure that they were aware of what to expect whilst a patient in the ED and the Director of Nursing confirmed that she would address this with the ED staff. She informed the Board members that the Trust would welcome the introduction of a patient leaflet and this would be considered as part of the actions from the Patient Survey.

Prof Warrens was concerned to see that the ratings on the Plan were not consistent and this had been talked about quite a lot and had been held up as 'real major progress'. It was obviously not as embedded in practice within the organisation, as the Board had been led to understand. Dr Dalziel referred back to the presentation by the Clinical Directors at the Business Planning sessions recently and raised the point that the other Directorates did not see the 4-hour access performance as their problem, they saw it as the ED Directorate's problem and she had been disappointed not to see something presented by each Clinical Director that they were going to do to help improve the position. The Board agreed with Dr Dalziel that the Trust could not make the step change required unless everyone saw it as one of their problems too.

The Chief Executive informed the Board that over the last few days she had been encouraged by the support from the Clinical Directors in terms of sense checking the Plan and owning it, as well as contributing other proposals that they needed to be doing to support it operationally. The possibility of restricting elective activity, in common with other Trusts, was discussed. Dr Gill informed the Board that seven day working underpinned everything and all Clinical Directors had an objective to support this and run their specialty services on a seven day basis. This included having specialists around on a Saturday and Sunday and patients being able to go straight to a specialty, rather than waiting in the ED.

Mr Mahoney raised the importance of the whole system working together, as outlined in Dr Mitchell's letter. The Chief Executive confirmed that the Chief Executive of the Cluster was working to set a process in train to address this and ensure sustainability going forward.

The Chairman informed the Board that he had asked Mr Mahoney to keep a watchful eye on the work around seven day working, in order to provide more insight at Board level and contribute some of his experience and expertise in this area. The Board thanked Mr Mahoney for agreeing to take this task on.

The Trust Board noted the update.

2012/100 CARE QUALITY COMMISSION ACCIDENT & EMERGENCY DEPARTMENT SURVEY 2012

The Board agreed that the content of the Survey was hugely disappointing, with no improvements of note and in many areas worse scores. It was agreed by all members that the attitude of staff needed to be addressed and the Chief Operating Officer confirmed that as part of the Organisational Development Strategy, the Trust was setting up 'listening groups' in this Department. There was also the work the Director of Nursing was doing in the ED in relation to patient experience. It was agreed that when dealing with an underperforming Department, you had to take exceptional measures and attack it on many different 'fronts'. It was agreed that there was a lot of work do to ensure the work around the Care Quality Commission was being embedded from the bottom up and the unacceptable behaviour in the Department, by certain individuals, was being challenged and appropriate disciplinary action taken when people operated outside of acceptable principles, behaviours and standards.

It was agreed that there was a problem with the leadership in the ED. The Board agreed that it was really distressing and very worrying that the Trust had been scored the lowest Trust Nationally. It was a chronic problem that the Trust had had for a long time and it was proposed that the organisation should bring in role models, as examples of first class care, from other Trusts, or arrange for some Trust staff to go and

work in an ED where there was evidence of good clinical care. Everything the organisation did had to be focused around patients, and the Trust had to be better than others, in order to rebuild its reputation.

Dr Dalziel had agreed, like Mr Mahoney on seven day working, to go through the Survey with the Team in much greater detail and to provide her input regarding the medical issues and how these could be addressed. The fundamentals, like getting 'pride' back into the organisation and staff being fully aware of what was expected of them, was so important and current performance could not continue.

The Trust Board noted the content of the report.

2012/101 MATERNITY SERVICES UPDATE, INCLUDING SIGN OFF OF KING GEORGE HOSPITAL MATERNITY SERVICES MOVE TO QUEEN'S HOSPITAL

The Chief Operating Officer circulated an updated paper at the meeting, which included the actions required by the Board. The Board was pleased to note that there was a patient safety plan in place, if women turned up at King George Hospital and the Director of Governance would be monitoring this closely. The Midwifery Led Unit was performing well and the Trust was receiving a lot of compliments from patients who were full of praise. All members of the Board agreed that their thanks should be passed on to everyone involved, but they must remain cognisant of the organisation's requirement to ensure it stayed on top of performance.

The Finance Department was tracking the movement of staff from one site to another in relation to the budgets going forward, the planned reductions in births and how this would affect the Trust's income streams.

The Trust Board noted the recommendations of the Gateway Review process and the letter of recommendation by NHS London to the Secretary of State for Health. The Board approved the closure and transfer of inpatient services from King George Hospital to Queen's Hospital, with a final closure to deliveries at King George on 20 March 2013. It was noted that antenatal clinics remained unchanged.

The Trust Board noted the progress, actions and recommendations from the Commissioners and NHS London to proceed to approve the transfer of inpatient maternity services to Queen's Hospital site from King George commencing on the 19 March 2013 and noted that its decision was subject to the formal NELC Board's ratification at their Board meeting on the 7 March 2013.

2012/102 QUALITY & PATIENT STANDARDS PERFORMANCE REPORT – JANUARY 2013

The Board agreed that they did not find the current format of the Dashboard helpful; the organisation needed a Dashboard that was clearer and picked up on the important key areas.

Mr Moloney informed the Board that it had been 127 days since the last MRSA blood stream isolate and the Trust was ahead of trajectory for the year. Following the work undertaken in the Complaints Department during January, the February data was providing assurance that there had been a substantial improvement, as 92% of complaints had been completed within the timescales agreed. No complaint responses had been extended, unless approved by the Director of Nursing, or her deputy. If the Trust was in risk of breaching a deadline, complainants were being contacted before they chased; this position had been sustained since the first week in February. There had been some difficulties in the Directorates and in Central Complaints, but these issues had now been resolved. Media attention around the Care Quality Commission had generated a lot of old complaints; 27 out of the 33 received in January were closed 6-9 months ago. It was noted that 15/20% of complaint responses did not answer the questions raised in the original complaint letter very well, but a system had now been put in place so they were checked before being sent. The Department was spending more time meeting with complainants, particularly where a complaint related to when a relative had died.

The total number of open complaints had reduced by 10% and Ms Panel-Coates confirmed that the Department was working closely with the Directorates to enable the organisation to learn from what people were complaining about. She also confirmed that some of the controls had been taken back into the Central Complaints Department, rather than with the Directorates and work was now underway to do more

with the Managers and clinical staff around conducting a good investigation and putting together good written responses, so the organisation could build a sustainable process going forward.

The Chairman raised the issue of the six patients that had fallen and sustained severe harm in January and indicated that he would want adequate review and more scrutiny of these cases before they were reported to the Board. A lot of work was being undertaken by the Trust to reduce falls in totality with the older population; additional assessments were being completed, additional training, ensuring correct footwear was being worn and the Trust had put up signs warning patients not to go anywhere on their own if they needed assistance. A review of any changes in medication was also being undertaken as part of the risk assessment. Ms Panel-Coates also confirmed that the Trust was liaising with the Nursing Homes to see if BHRUT was missing anything in their assessments that they may have learned, or had experience of, while the Trust worked to make the improvements set out in the National Plan.

The Board noted that the Department of Health had now released new guidance for calculating the Friends and Family Test (FFT) score for both ward and Trust level reporting. The FFT results would be calculated using underlying 'Net Promoter Score' methodology. It had been changed three or four times in the last few months, which had made things very difficult and had in fact changed since this Board report had been finalised. As of February, 73% of patients were recommending the Trust's services to friends and family; January was 77%. The Board agreed that they needed a comparator included when reporting this kind of Trust data in the future.

Mr Langley raised the issue of MRSA screening and the fact that screens were inadequate, or incorrect information was not getting processed, and there had also been incidences of screens not arriving at the laboratory. As this blockage had been identified, he questioned what was being done about it. Mr Moloney would take this away and get back to the Board. It was agreed that this should be part of the review of all the papers, so the Board had something that was 'fit for purpose' and was prepared on the basis of providing useful information.

The number of patients readmitted as an emergency within thirty days of a non-elective stay increased in December. The implementation of the community treatment team only took place in January, so it was too soon to report a reduction in readmissions, as a result of this initiative, but it was agreed that with the reducing number of readmissions, it would be good for the organisation to monitor this going forward, as they affected the Trust's income.

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

Action: Neill Moloney 1.5.13

2012/103 STAFF SURVEY 2012

Mrs Hosein informed the Board that the 2012 Staff Survey had been conducted with a 39% response rate and the Board noted the summary of the findings, which had been presented at the Workforce Committee meeting in February. The Board noted the negative findings and where there had been a statistically significant change since the 2011 Survey, when compared Nationally. Some of the key areas, included hand washing materials always available, witnessing potentially harmful errors, near misses or incidents, experiencing harassment, bullying or abuse from patients, relatives, public and staff and work pressure. The Board also noted the top and bottom five ranking scores, when compared to other Acute Trusts. The Trust proposed to triangulate the results from this Staff Survey, with the Patient Survey results, in order to identify any themes, or trends, for action to be taken and improvements incorporated into the Organisational Development Strategy. The Board asked that the Workforce Committee review this in detail, in order to provide assurance to the Board members that these key areas were being addressed. The Board also agreed that it was now important to drill down into the organisation and undertake further analyses on pockets of the Trust where there appeared to be conflicting results, when considering some of the comments made. Mr Mark Smith, Head of Workforce, was working with the Directorates to provide action plans for their areas.

The Trust Board noted the Survey.

2012/104 SINGLE OPERATING MODEL – DECEMBER 2012

The Trust Board noted the Single Operating Model for December 2012, which had been submitted to the NHS Trust Development Authority (NHS TDA). Mr Moloney informed the Board that he had recently had discussions with NHS London regarding revised timescales going into the next financial year and these would be incorporated into future submissions, following agreement by the Board to the new timeframes. He also confirmed that there was an expectation that the format would be changed going into the next financial year.

The Trust Board noted the Self-Certification Return for December 2012.

2012/105 FINANCE REPORT – MONTH 10 (JANUARY) 2012/13

Mr Gilburt presented the Finance Report for the period up to the end of January 2013 and confirmed that the report had been discussed in detail at the Finance Committee meeting on the 26 February 2013. He informed the Board that for the first time, the Trust had recorded a surplus in the month of January. A Council Tax refund and a reduction in depreciation charges had helped improve the underlying position which, without these benefits, would otherwise have recorded a £2.2m deficit. The year to date position at month 10 showed a cumulative deficit of £34.2m, but the Trust was on target to deliver the control total of £39.7m deficit. Mr Gilburt informed the Board that he expected February to be a poor month, with the reduction in elective work and it was therefore too early to predict the end of year position.

The Cost Improvement Programme (CIP) position was moving along; it should deliver a minimum of £18m and enable the Trust to meet the control total. There were some big ticket schemes that were required to be delivered by the year end and he confirmed that these were coming in.

Mr Gilburt confirmed that the Trust was maintaining the controls and keeping the pressure on Managers to ensure they delivered what they had said they would deliver, in order to meet the control total. Mr Mahoney noted that this position was encouraging, and although there was a lot to do in the last couple of months, the attention to detail that had been achieved to-date indicated that the Trust could deliver good results if it applied itself.

The organisation was making good progress with setting the budgets for the new financial year, albeit there were some issues on the level of income from the Commissioners. Mr Gilburt informed the Board that negotiations were ongoing with the Commissioners regarding next year's contract and they were making good progress with these discussions. There was not a huge difference on the money, but still some clauses and detail to be agreed in other areas. Mr Gilburt also confirmed that the Trust had already got sign-off on two thirds of the CIPs for the next financial year; balance of schemes in development should be signed-off at the Trust Executive Committee (TEC) on the 19th of this month, along with next year's budgets. It was Mr Gilburt's aim to get the 2013/14 budget signed off before the next Trust Board meeting in early April, on the assumption that the Trust was able to gain agreement with the Commissioners on next year's contract. It was agreed that the Non-Executive Directors would be invited to attend the TEC on the 19 March, in order to provide them with a greater understanding of the budgets to be agreed, prior to them being presented at the next Finance Committee meeting on the 27 March, where they would be discussed in much greater detail.

Mr Mahoney took over the Chairmanship of the meeting for a short time to enable the Chairman to take an urgent telephone call.

If the Income and Expenditure Budgets for 2013/14 were approved before the next Trust Board meeting, it was agreed that they would then be ratified at the Trust Board meeting scheduled for the 3 April 2013.

The Trust Board approved the report and noted the actions to mitigate risk in achieving the control total deficit of £39.7m.

2012/106 WORKFORCE KEY PERFORMANCE INDICATORS – JANUARY 2013

The Chief Operating Officer presented the Workforce Key Performance Indicators for January in the new format and asked members of the Board to feedback to her with any comments they might have on this.

The new format had been discussed in detail at the recent Workforce Committee meeting and it was noted that the Workforce Information Reporting Engine Database (WIRED) would bring all reporting systems together. There had been an increase in sickness in month, but she informed the Board that a new Sickness Policy had been launched, which tightened up areas of the previous Policy and a Probationary Policy had also been introduced into the organisation. The staff appraisal rate had increased in month to 73.9%, against a target of 80% and it was agreed that staff had to have an appraisal in order to move on to their next salary increment point/higher banding and all Directorates had been asked to ensure that everyone had a date set for their appraisal.

It was noted that mandatory training was low in certain areas and the organisation was looking at e-learning packages within the IT infrastructure as a key enabler to make improvements in this area. The Chief Information Officer was assisting with moving at pace on this, in order to implement as soon as possible.

Dr Dalziel raised the issue of the 'red' rating on Stability for Pathology, Anaesthetics and Women's Services and questioned whether this was significant and why were a lot of people leaving in these areas. It was confirmed that the leavers in Women's Services were planned, Anaesthetics had a large number of vacancies, but there was a plan to address this, and as far as Pathology was concerned, Mrs Hosein would get back to the Board on this area, as she was not aware of the reasons why. There was a lot of resource allocated to bring people into the Trust and then losing them would suggest a management problem and a risk to the Trust. She agreed to take this away for HR to review this statistic and discuss with Managers, to see why people were leaving so shortly after their appointment, as the Trust needed to understand all of this.

The Trust Board noted the report.

Action: Dorothy Hosein 1.5.13

2012/107 BARKING HAVERING & REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST REVISED STANDING ORDERS

The Board noted that the current Trust Standing Orders were out of date and Prof Kinnair had revised them following the publication of the new Health & Social Care Act. Prof Kinnair advised the members that following a previous discussion around the Sealing of Documents, the Standing Orders Section 9 had been amended to reflect that in the future one Trust Executive Director and one Non-Executive Director would be present to seal documents. It was agreed that Prof Kinnair would review the Standing Orders again and to ensure they were consistent throughout. Both Executive Directors and Non-Executive Directors were members of the Board and reference to Officers and Non Officers was not helpful. There was also reference to Strategic Health Authorities, which were no longer in place. Prof Kinnair would make all the changes discussed.

The Trust Board approved the revised Standing Orders/delegation of powers.

Action: Donna Kinnair 1.5.13

2012/108 ESCALATION REPORT FROM QUALITY & SAFETY COMMITTEE

The Chairman and Prof Kinnair had discussed the development of a one page report that informed the Board of the work the Quality & Safety Committee was, and was not, undertaking/monitoring. It was agreed that the paper presented for this meeting was not sufficient for the Board members to gain assurance around governance issues, or for keeping them up to date on issues that required escalation to the Board. These reports should be owned and presented by the Chair of the Committees reporting into the Trust Board.

The Board noted that the Trust had recently achieved fifty out of fifty for the Risk Management Standards Level 1 Review and agreed that the organisation should be looking to move up to Level II and then Level III, as set out in the Trust's Long Term Financial Model (LTFM).

The Trust Board noted the successful RMS assessment result.

2012/109 ESCALATION REPORT FROM TRUST EXECUTIVE COMMITTEE

The Trust Board noted the Escalation Report from the Trust Executive Committee.

2012/110 MATTERS FOR NOTING:
CHAIRMAN'S REPORT

The Board members challenged the Executive Team to see what could be learnt from the Francis Enquiry Report and to be absolutely clear that they were taking, or would very shortly be taking, all reasonable steps to ensure that this systemic failure did not happen at BHRUT. It was agreed that the Executive Team would report back to the Trust Board in one month's time. The Trust had a duty and responsibility to ensure that everyone looked at the Report. The Executive Team would take on board the important aspects of delivering an organisational culture, which delivered high quality care, and incorporate this into the Organisational Development Programme currently underway.

The Trust had to be resolute about what it stood for, e.g. *'the best possible care for its patients at all times'*.

The Chairman's Report would also be distributed to all staff in the organisation.

Action: Executive Team 3.4.13

2012/111 CHIEF EXECUTIVE'S REPORT

The Trust Board noted the report.

2012/112 MINUTES OF THE QUALITY & SAFETY COMMITTEE MEETING HELD ON 22 JANUARY 2013

The Trust Board noted the minutes of the Quality & Safety Committee meeting held on the 22 January 2013.

2012/113 ANY OTHER BUSINESS
BOARD ASSURANCE FRAMEWORK – HIGH LEVEL STRATEGIC RISKS AGAINST STRATEGIC OBJECTIVES

This agenda item had been tabled for the Part II (Closed Session) Trust Board meeting, but the Chairman asked for it to be discussed in the public forum.

The paper presented by Prof Kinnair described the Executive Directors' view of the risks against the Trust's strategic objectives and identified the Executive Risk Owner; this would be used to populate the Board Assurance Framework. All Board members were asked to feedback if they felt there were any omissions in the strategic risks. The organisation needed to identify controls and have assurance in place, correlating with exception reporting, so the Board was aware of all the actions being taken. The Board needed to be provided with clear objectives, in order to be sighted on the real risks and how the Trust described a risk. Dr Dalziel felt that they looked like targets, rather than risks, and this did not provide her with assurance, as they had not been incorporated into this from a patient care point of view.

The Trust was aware that it had problems with staffing, equipment etc and these should be included, as staffing was a big strategic risk. Dr Dalziel also raised the point that she would like to see if there were standard National protocols, e.g. (WHO), used by other Trusts, and if so, the Trust should be using them too.

Following feedback received, Prof Kinnair would amend the key risks, relate these back to the Corporate Objectives and then hold further discussions with the Board so the members could decide and be sighted on the real risks it was facing.

Action: Donna Kinnair 1.5.13

Meeting closed at 3.15 p.m.

The next meeting of the Barking, Havering and Redbridge University Hospitals NHS Trust Board will take place on Wednesday, 1 May 2013 in the Board Room, Trust Headquarters, Queen's Hospital.

Barking, Havering and Redbridge University Hospitals NHS Trust

TRUST BOARD MEETING

Actions from Minutes of Part I meeting held on 6 March 2013
in the Board Room, Trust Headquarters, Queen's Hospital

Agenda Item		Action	Deadline Date	Date Completed/ Update/ Agenda Item
2012/096 (2012/081Matters Arising and Actions)	Organise an Audit in three months time regarding Risk Action Plan and Assurance Report to be used for exception reporting.	DK	June 2013	
2012/097 (Care Quality Commission Reports)	Produce a high level Dashboard and bring back to the Board for ratification before implementation.	DK	1.5.13	
2012/098 (Emergency Care Risk Summit – 7 February 2013)	Ensure Workplan in place by the 15 March.	AD/Exec Dirs	15.3.13	15.3.13
2012/102 (Quality & Patient Standards Performance Report – January 2013)	Provide more information on the incidences of MRSA screens not arriving at the laboratory.	NM	1.5.13	
2012/106 (Workforce Key Performance Indicators – January 2013)	Provide more information on the 'red' rating on Stability of Workforce in Pathology Directorate.	DH	1.5.13	
2012/107 (BHRUT Revised Standing Orders)	Make all the changes discussed at the meeting.	DK	1.5.13	
2012/110 (Matters for Noting – Chairman's Report)	Provide update on Francis Enquiry Report, to ensure all reasonable steps had been taken to ensure this systemic failure did not happen at BHRUT. Take on board the important aspects of delivering an organisational culture, which	Exec Team	3.4.13	

Agenda Item		Action	Deadline Date	Date Completed/ Update/ Agenda Item
	delivered high quality care, and incorporate this into the Organisational Development Programme currently underway.			
2012/113 (AOB: Board Assurance Framework – high level strategic risks against strategic objectives)	Amend the key risks, relate these back to the Corporate Objectives and organise further discussions with the Board on this item.	DK	1.5.13	
	Chairman …….. Date ……..			

Barking, Havering and Redbridge NHS
University Hospitals
NHS Trust

TRUST BOARD MEETING

6 March 2013
Board Room, Trust Headquarters, Queen's Hospital

Points and Questions raised by members of the Public
at the above Trust Board meeting

Question/Comments:	Response/Action:
Mrs Elaine Clark raised the issue of checks being undertaken in the Emergency Department overnight.	Flo Panel-Coates responded to Mrs Clark and confirmed that checks were undertaken during the night. She would make sure that these were recorded in the patients notes and that the nurses on duty noted who had taken responsibility for doing these.
Was the usual handover meeting at 12.30 p.m. in MAU scheduled seven days a week?	Dr Gill confirmed that it was not currently seven days a week, as the Trust had not yet implemented seven day working, but once the reconfiguration had taken place there would be a handover meeting on a Saturday and Sunday (only Monday to Friday at the moment). This should be in place around June this year.
Mrs Clark had received a call from a patient with diabetes, who was very upset that when attending the hospital 3-4 weeks ago, for a different medical problem, their blood sugar levels had indicated that they were very high, but the patient was sent home with no attention to this issue, as no one was available in the department to address a diabetic condition. Patient told to go back and see GP and Mrs Clark arranged this within a few days.	The Trust asked Mrs Clark to provide all the details around this patient to the Director of Nursing, so a full investigation could be undertaken.

BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST

Minutes of the Extraordinary Part I Trust Board Meeting held on the 3 April 2013 in the Board Room, Trust Headquarters, Queen's Hospital

Present:	Sir Peter Dixon	Chairman
	Mrs Averil Dongworth	Chief Executive
	Dr Maureen Dalziel	Non-Executive Director
	Dr Mike Gill	Medical Director
	Mr David Gilburt	Interim Director of Finance
	Mrs Dorothy Hosein	Chief Operating Officer
	Mr William Langley	Non-Executive Director
	Mr Keith Mahoney	Non-Executive Director
	Mr Neill Moloney	Director of Planning & Performance
	Ms Flo Panel-Coates	Director of Nursing
	Prof Anthony Warrens	Non-Executive Director
	Mr Michael White	Non-Executive Director
In Attendance:	Ms Helen Rees	Personal Assistant to the Executive Offices
	Mr Alan Davies	Deputy Director of Finance

2013/001 APOLOGIES FOR ABSENCE

Ms Caroline Wright, Non-Executive Director

2013/002 2013/14 BUDGET

DG advised the Board that there had been lengthy discussions with the Commissioner, but the Trust was yet to reach an agreement. DG advised the Board that there was a meeting scheduled for 5th April and anticipated agreement being reached. DG asked the Board to approve the Budget, subject to this agreement. DG reported that the Terms and Conditions of the contract carried fines if breaches occurred and an update to the Board would be provided once agreement had been reached on the Contract.

DG reported that DM and DO had yet to sign their budgets, however these had been signed by their Associate Directors. CD's need to provide reasoning for extra funding in relation to 7-day working plans, which once agreed would be an additional cost pressure.

DG reiterated the importance of maintaining a prudent approach. The CIP would be budgeted at £20 million, with planning in place for an additional £2.5 m. DG reported there was also a further £5m contingency provision in the 2013/14 Budget Setting.

DG advised the Board that an additional contingency of £2.5 m had been set aside should the Trust fail to achieve the Commissioner's CQUIN targets. The Havering shortfall would be refused as activity has sharply increased however DG advised the Board that provisions have been made in the budget in the event that the refusal was overturned. The final Contract agreement proposed would be reviewed at the half year stage in order to revise the position of the Trust. Executives to feedback on the Budget.

DG reported that an application had been made for a Temporary Borrowing Limit(TBL) from the Department of Health, but this would only last until July. DH asked for assurance that there would be no extra charges on requesting the TBL and commented whether this application was common practice. DG advised that it was not unheard of to request the TBL. It was the concerns over the Contract being delayed in sign off that had prompted this course of action. DG

requested the Board approve the budget proposals, subject to agreement of conflicts with the Commissioners.

KM highlighted to the Board that there were uncertainties throughout the new income contracts. DH commended the process and stated that the CD's should be confident and take comfort in the plan. DG advised the Board that the Finance Department were working with Estates to develop proposals for further measures to break even in March 2015, or produce a surplus, in order to comply with Foundation Trust guidelines. AD had made it clear to the Directorates that targets would be registered and they should work to deliver their CIP targets.

PD questions the funding increments and other Agenda for Change costs. ADa reported that the number of staff this would affect lower band but assured the Board that control would be placed on the A4C pay increments. AD agreed and commented regarding the appraisal increment controls.

WL asked the Board what the response had been regarding the confidence in objective setting. DH assured the Board that this was the year of delivery and people would be held to account. AD advised the Board that DH was near completion of managerial objectives and would be setting the pace with long term objectives – (rolling 3 month objective settings)

PMO: PD requested DG give assurance to the Board that they could extract the deliverable objectives by the Trust. DG advised that Ernst and Young had largely been funded by the PCT's and had been taken into account when producing the Budgets. DG reported to the Board that Ernst and Young had been retained during April, whilst PMO posts were being recruited to. DG advised that David Fox had been moved into the PMO office and they were now in the process of recruiting internally and externally to fill the gaps in the PMO agreed structure.

Board agreed to sign off budget showing a £17 million deficit for 2013/14 but at no extra risks proposed by the CCG's and the conditions should be reviewed during the year. NM raised the question around the penalties that the Trust would incur if the targets that were set by the CCG's were not met. DG advised that no agreement had been reached with the Commissioners and once agreement has been reached this will be reported to the Board.

2013/003 4 HOUR ACCESS IMPROVEMENT PLAN UPDATE:

DH gave the Board assurance that the project plans, including timescales and governance arrangements are continuing to strengthen week on week.

AD and DH assured the Board that the workstreams meant that managers were being held to account and there was a consistency in the approach to the plan by the Directorates.
DG was nominated to Chair the Emergency Care Programme Board meetings in the future.

DH reported to the Board that there were currently 35 ED posts being advertised on NHS Jobs and this was a clear indication that there would be problems trying to recruit personnel to the ED vacancies as there was wide competition. DH advised the Board that the Trust would need to be creative in the approach to the recruitment of the ED vacancies. In the interim DH advised the Board that we are working towards fixed-term staff to be in post by July, in order to bridge gaps in the ED workforce.

MDa reported to the Board that after walking around the ED on two recent occasions, there was a noticeable change in the staff. MDa reported to the Board that there had been an increase in breaches and she was concerned in the last two weeks the Trust was heading towards a critical level. Members were in agreement that there was a lack of senior decision making and a lack of clinical and nursing leadership and there were times when the Bed Managers were busy and couldn't be contacted. MDa reported that there was a lack of clinical skill mix, which was delaying diagnosis at the point of admittance. The Board agreed that there was a need to look at the clinical skill mix within the ED.

PD urged members to enforce a more rapid approach as the changes were not being made quick enough and it was taking too long to resolve issues. MG felt that it was important that the Board recognised the progress that had been made. MG reported that the reconfiguration of Sky A ward for the Care of the Elderly(CoE) patients was now functioning and this was now preventing elderly patients getting lost in the system and remaining in MAU which meant that there was an improvement in bed flow. MG reported that there was now a CoE Consultant that was in ED to redirect the elderly patients appropriately. MG also advised that there may be a need to configure an additional Acute Assessment Ward. The Trust had also recently recruited a CoE Consultant as part of the workplan and this was making a difference, but agreed that this was not enough. MDa felt that there were additional challenges being faced in ED by other departments not contributing to the turnaround of the department. DH reported that the SAU, UCC and the GP Referral Unit were now functioning assisting with the pressures in the ED. It was reported that the NTDA had voiced concerns that BHRUT were not holding system to account. The Board agreed that there was a fundamental requirement to have everyone in the room delivering and focusing on the targets and to agree a united plan of action.

PD reiterated that there was concern that the Trust had yet to grasp the solution and urged a tighter focus.

AD reported to the Board that Derek Hicks, Clinical Director of ED had resigned and the Trust would be going out to advert and recruiting a new CD to take over on the 1st May 2013.

2013/004 FOR INFORMATION:
QUALITY & PATIENT STANDARDS PERFORMANCE REPORT – FEBRUARY 2013

KM highlighted that the Cancer Targets producing lowest number of treatments and questioned whether this was due to capacity issues. NM confirmed that the lack of capacity had been the contributing factor and could have been avoided if escalation had been made at earlier.

MW commented that discussions at the IPEG surrounding patient experiences were of concern. FP-C reported that there were concerns collecting data from the ED, currently 7% returns, but needed to be 15%. FP-C advised the Board that they were looking elsewhere for other Trust's initiatives, however FP-C highlighted to the Board that the Trust was one of the leading organisations in collecting data. FP-C reported to the Board that there had been a meeting with Havering Links regarding a plan to address this and they were very supportive.

2013/005 FOR INFORMATION: FINANCE REPORT MONTH 11 (FEBRUARY) 2012/13

DG reported to the Board that the budget had gone to the Finance Committee and there was a provisional £39.5 million forecast deficit with around £100,000 margin of error.

DG advised the Board that the Trust had undershot the External Financing Limit (EFL), due to a last minute change to the Capital Control Total. To achieve EFL the Trust would have had to go overdrawn. This measure would leave £4 million in the bank well within the EFL.

PD felt that DG provided a satisfactory explanation in the prudent approach to assist moving the Trust forward financially.

2013/006 ANY OTHER BUSINESS

No further business.

Meeting closed at 2.15p.m.

Next meeting 1st May 2013 at 1pm

Barking, Havering and Redbridge NHS
University Hospitals
NHS Trust

STRICTLY PRIVATE AND CONFIDENTIAL
TRUST BOARD MEETING

Actions from Minutes of Part I meeting held on 3 April 2013
in the Board Room, Trust Headquarters, Queen's Hospital

Agenda Item		Action	Deadline Date	Date Completed/Update/ Agenda Item
2013/003 (4 Hour Access Improvement Plan Update)	DH to review skill mix in ED. Agree a 'United Plan of Action' for ED pathway	DH DH	01/05/13 01/05/13	
	Chairman …… Date ……..			

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Board Assurance Framework – 2012/13 Quarter 4	Trust Board
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
1. Introduction. The Board Assurance Framework for the fourth quarter of 2012/13 is attached for review by the Trust Board.. The purpose of the BAF is for the risks which impact on the Trust's strategic & principal objectives to be assessed and current controls reviewed to provide assurance to the Board that mitigating actions are undertaken to reduce the impact and risk level. **2. 2012/13 Quarter 4 Risks.** All of the risks described have been reviewed within the month and all corporate risks threatening achievement of the Trust objectives have been reviewed with executive leads. The BAF has been reviewed and discussed by the Audit Committee at the meeting on 18th April 2013; issues raised have either been amended of fed back to the identified risk lead for action. There is in place a monthly review and management of the action plans that have been developed to mitigate all of the extreme and high risks. This BAF now completes the risk reporting cycle for the period 2012/13. The draft Annual Governance Statement has been completed based on the key risks identified in the BAF over the year and the Internal Auditors findings of Adequate Assurance for both the BAF and the Review of the Effectiveness of Risk Management and Internal Control. **3. 2013/14 Risk Identification.** The Executive team have considered the potential high level risks which could prevent the Trust from achieving its agreed objectives. The paper found at Appendix 2 contains details of the high level risks identified, which when agreed will be incorporated into the Board Assurance Framework, to ensure that the Board are kept fully informed. Executive leads have been identified for each risk. The Trust Board is asked to discuss and consider the revised high level risks, request amendments as necessary prior to sign off following consultation. **4. Proposed New BAF Format.** Following a range of discussions with Executive and Non-Executive Directors and our Trust Auditors a new style format for the BAF has been devised for consultation. This was presented to the April TEC for feedback initially prior seeking the views and approval of Trust Board members. Appendix 3 provides the Trust Board with an example of the proposed lay out using an existing risk on the BAF. It is proposed that a new format is identified to be in use from Q1 2013.	**x TEC ……..** **□ STRATEGY……..…** **□ FINANCE ……..……** **x AUDIT …….** **□ QUALITY & SAFETY ……..……...……** **□ WORKFORCE ……..** **□ CHARITABLE FUNDS ……...…** **x TRUST BOARD ……..** **□ REMUNERATION ……....** **□ OTHER ……..……** (please specify)

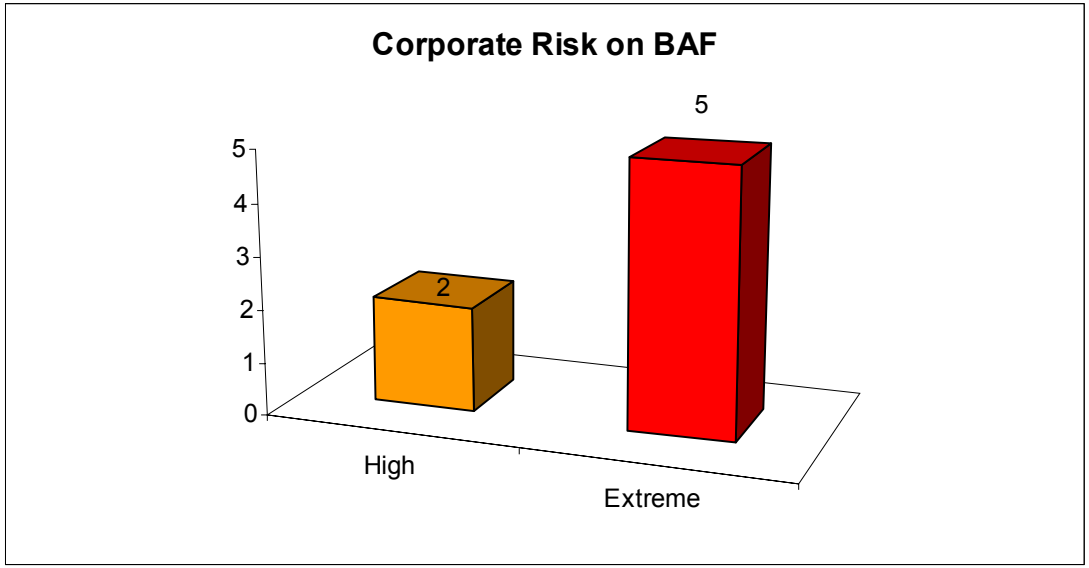
2. DECISION REQUIRED:	**CATEGORY:**
1. For noting. **2**. The Trust Board are asked to agree closure of the Quarter 4 BAF. **3**. The Trust Board are asked to consult on and agree the high level risks. 4. The Trust Board are asked to consider and agree the new format.	□ **NATIONAL TARGET** □ **RMS** □ **CQC REGISTRATION** □ **HEALTH & SAFETY** **X ASSURANCE FRAMEWORK** □ **CQUIN/TARGET FROM COMMISSIONERS** □ **CORPORATE OBJECTIVE** **……....** □ **OTHER ……..** (please specify)
	AUTHOR/PRESENTER : Flo Panel-Coates
	DATE: 19th April 2013
3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
4. DELIVERABLES	
Trust key objectives.	
5. KEY PERFORMANCE INDICATORS	
As detailed in the BAF.	
AGREED AT _____ MEETING **OR** **REFERRED TO: _____**	**DATE: _____** **DATE: _____**
REVIEW DATE (if applicable) _____	

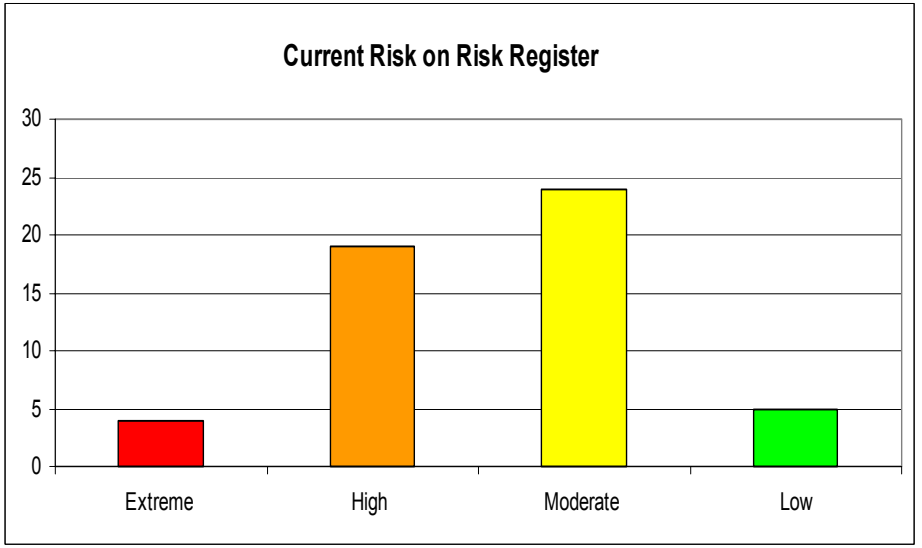
Barking, Havering and Redbridge University Hospitals NHS Trust

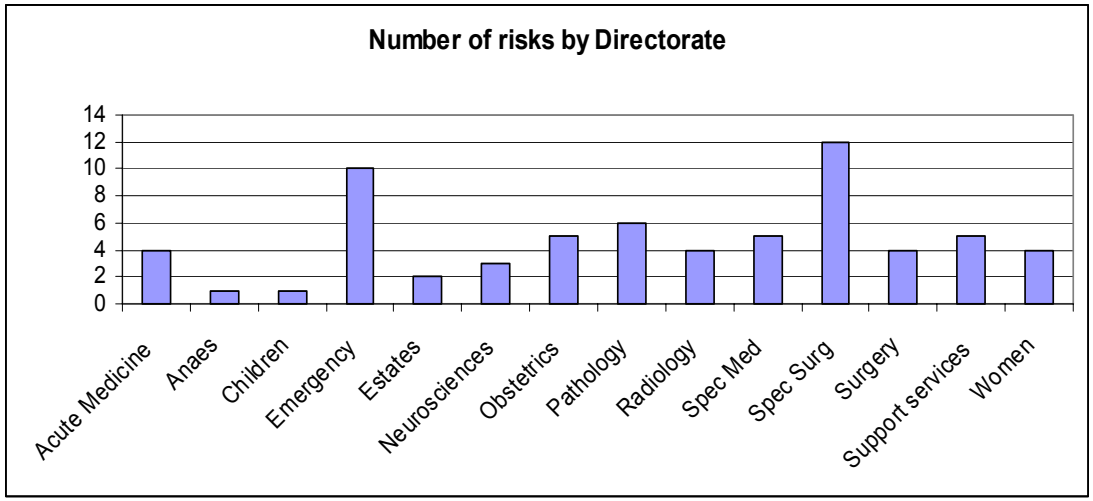
BOARD ASSURANCE FRAMEWORK 2012

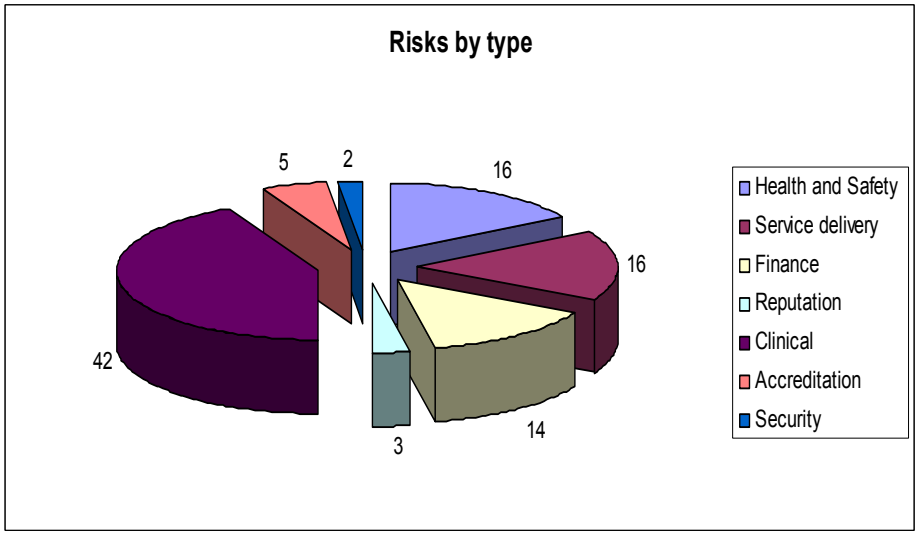
4th Quarter: January to March 2013

BHRUT RISK TREND ANALYSIS FOR 2007- 2012









Risks on the BAF: The BAF only reflects residual risks after controls / assurance have been agreed. Currently there are 4 Extreme risks.

New Risk on the Corporate Risk Register
Trust Reference: 358
Area: Neurosciences
Risk: Replacement Vidotelemetry EEG System - Will impact on the delivery of waiting times and poor reliability stops Trust from offering service to external users and loss of potential revenue.
No spare parts available for system, now 10 years old.
Loss of test data.
Controls: Application for funds to Capital Planning Group - risk managed locally by assessment

Trust Reference: 359
Area: Neurosciences
Risk: Low staffing levels increases reduces service quality
Controls: Proactive management of patients's dependency level by Matron

Trust Reference: 353
Area: Neurosciences
Risk: Stealth Machine
Controls: Application for funds to Capital Planning Group risk managed locally by assessment

Directorates
The Directorates that are not reflected currently on BAF have risks that are controlled within their own Directorate and mirrored on their locals risk registers. All risks are renewed regularly.

The Directorates are increasingly building their local risk management by a continuous process which is demanding awareness and proactive action. The drivers are to base each risk on reducing the likelihood and consequences of adverse impacts on agreed objectives and on increasing the opportunities for improvement.
This requires infusing risk management into organisational culture and everyday business operations including planning, reporting and governance.

RISKS DETAILS

PRINCIPAL RISK *What could prevent the objective being achieved* **Risk no, Date on Risk Register & Risk Scoring:**	**KEY EXISTING CONTROLS** *What controls/systems are in place to assist in securing delivery of objective and managing principle risks?*	**CQC REF:**	**RESIDUAL RISK**	**ASSURANCES ON CONTROLS & IMPACT** *Where we gain evidence that our controls/systems, on which we are placing reliance, are effective? The impact following assurances.*	**PROGRESS AGAINST RISKS/ ACTION PLAN UPDATE** *What Actions are undertaken to mitigate the actual risks?*	**GAPS IN ASSURANCE** *Where we are failing to gain evidence that our controls / systems, on which we place reliance, are effective*	**GAPS IN CONTROL** *Where are we failing to put controls / systems in place? Where are we failing in making them effective?*	**LEAD**
Principal Objective: To ensure that the patient safety agenda is fully established in all areas of the Trust								
Risk No 87: The emergency care patients will not receive better /safer care due to serious inability to manage demand and provide safe care and enable patients to enter inpatient bed or be discharged appropriately and also the ability to manage external demand, delay to implement the whole system. **Date on Register:** 01.04.2009 **Rating Scoring:** Impact:4 x Likelihood:4 = 16 **Area:** Emergency Care **Trust Objective:** To deliver 95% of patients seen in 4 hours **Impact on:** **Patient:** Patient safety **Staff:** increase stress levels, workforce development and recruitment **Stakeholder:** Confidence is compromised **Trust:** Viability of the Trust **Details updated**: 01.02.2013 There has been no major change	Constantly monitored by TEC Paper presented to Trust Board which addresses processes in place to reduce length of stay – Jonah programme will assist in this issue. Emergency Care Programme superseded by RESET programme approved by Trust Board	4 9 6 16	Extreme Risk	(RESET) Rapid End to End Sustainable Emergency Transformation Steering Group and Programme Board in place. Transformation Reports to TEC and Trust Board This risk is cross referenced to the BHRUT CQC related development plan and the references are G4 5 6. 7 10 11 12 18 53 54	Maintain improved resilience within the A&E systems and throughput to the MAU There are 4 work -streams: • Emergency care • EMAU • Medicine • Care of the Elderly Work-streams plans are led by Consultants Emergency Care action plan is currently being audited for effectiveness. RATing area upgraded and opened for business Visit by CQC undertaken in December 2012, report published	The focus is on Emergency Care and Medicine and doesn't include other speciality - these can impact on Emergency Departments waiting times and bed occupancy	Failure to improve against the 95% compliance within the four hour standard Manpower resources to maintain systems Whilst improvement in trajectory is moving upward the day to day stability is variable resulting in increased number of breaches often during or immediately after the weekend Financial implication for the Directorate in delivering the programme.	Claire Dixon (GM) / Dr Derek Hicks Clinical Director

PRINCIPAL RISK *What could prevent the objective being achieved* **Risk no, Date on Risk Register & Risk Scoring:**	**KEY EXISTING CONTROLS** *What controls/systems are in place to assist in securing delivery of objective and managing principle risks?*	**CQC REF:**	**RESIDUAL RISK**	**ASSURANCES ON CONTROLS & IMPACT** *Where we gain evidence that our controls/systems, on which we are placing reliance, are effective? The impact following assurances.*	**PROGRESS AGAINST RISKS/ ACTION PLAN UPDATE** *What Actions are undertaken to mitigate the actual risks?*	**GAPS IN ASSURANCE** *Where we are failing to gain evidence that our controls / systems, on which we place reliance, are effective*	**GAPS IN CONTROL** *Where are we failing to put controls / systems in place? Where are we failing in making them effective?*	**LEAD**
Risk No: 339 **Risks:** Patient complaints not being adequately responded to within agreed timescales and Failure to resolve patient complaints leading to Ombudsman investigations with critical findings **Date on Register:** 22.03.2012 **Rating Scoring:** Severity4 x Likelihood:3 = 12 **Area:** Trust **Impact on:** **Trust**: Reputation **Patient**: Patient experience and confidence in the care and delivery compromised **Staff:** Morale lowered **Details updated:** 05.04.2013	All complaints logged on safeguard database. Weekly tracker reports showing due date Weekly performance meetings with directorates when not achieving the targets All complaint responses signed by an executive director or chief executive Director level review and sign-off of all complaints responses. Member of complaints team responsible for managing all Ombudsman enquiries Thematic reviews emerging to improve learning which is disseminated Trust-wide	19	High Risk	Monthly reporting to Trust Executive Committee and Trust Board of response times and number of complaints that are overdue Weekly complaints report, showing dates responses are due. Objectives set for directorates to respond to complaints. Weekly performance meetings with clinical directorates . This risk is cross referenced to the BHRUT CQC related development plan and the references are G46, 47, 48, 49	Additional staff to support investigation of complaints and drafting responses Improving performance in responding to complaints For February 2013 – Directorates and the Trust overall hit the 80% target for response rates Lowest number of open complaints for the year 95% of acknowledgements in 3 days	None identified following review	None identified following review	Flo Panel-Coates, Director of Nursing/Victoria Wallen, Head of Complaints
Principal Objective: To ensure the patient safety agenda is fully established in all areas of the Trust – Nursing								

PRINCIPAL RISK *What could prevent the objective being achieved* **Risk no, Date on Risk Register & Risk Scoring:**	**KEY EXISTING CONTROLS** *What controls/systems are in place to assist in securing delivery of objective and managing principle risks?*	**CQC REF:**	**RESIDUAL RISK**	**ASSURANCES ON CONTROLS & IMPACT** *Where we gain evidence that our controls/systems, on which we are placing reliance, are effective? The impact following assurances.*	**PROGRESS AGAINST RISKS/ ACTION PLAN UPDATE** *What Actions are undertaken to mitigate the actual risks?*	**GAPS IN ASSURANCE** *Where we are failing to gain evidence that our controls / systems, on which we place reliance, are effective*	**GAPS IN CONTROL** *Where are we failing to put controls / systems in place? Where are we failing in making them effective?*	**LEAD**
Risks No 251: Failure to protect our patients against Health Care Associated Infections (HCAI's) Limit set at 7 for MRSA Bacteraemia and 59 for C.difficile **Date on Register:** 25.01.2010 **Rating Scoring:** Impact:4 x Likelihood:4 = 16 **Area:** Trust **Impact on:** **Patient**: Poor patient outcomes **Staff:** Risk to Trust reputation affecting staff morale **Trust:** In year financial risk of every C.difficile cases over the limit and on ability for Trust to reach FT status **Details updated:** 04.04.2013	Decolonisation therapy for known positive patients. Patients known to be previously positive are flagged on PAS. Detailed RCA of all bacteraemia led by DIPC. Daily reporting on MRSA bacteraemia numbers and C.difficile CQC supporting actions have been completed Re-launching hand hygiene awareness training through mandatory programmes and recorded on ESR All clinical staff are being taught and assessed on aseptic non-touch technique to be completed by 31.12.2012 Full review of all C difficile case to date to be undertaken to determine key themes on causation. Action to be completed by mid Nov. for review by DIPC From 1st December 2012 all patients to be admitted will have MRSA screens Microbiology laboratory staff to commence weekend processing of MRSA screens by 22.12.2012	8 16	Extreme Risk	RCA summary action sheets highlights key non compliances, screening of patients, appropriate decontamination of positive patients, documentation of such and the practice of blood culture taking. Training implementation of policies is actively reviewed. **Internal** –Internal Audit, Infection Prevention Control Committee **External** – CQC, Weekly reporting of non-trust apportioned and trust apportioned MRSA/mssa/E.Coli and Clostridium difficile to our commissioners	Infection Prevention and Control Strategy and Action Plan October 2012 – March 2014. (Updated Jan 17th 2013.) The Trust Board will receive reports from the Quality and Safety Committee via the Infection Prevention & Control Committee dashboard providing assurance on the systems and processes in place to monitor HCAI's	MRSA trajectory target breached for 2012, (8 incidents) C.difficile - 59 or exceeding this target. The Trust has 65 cases as at the end of March 2013 for the financial year 2012-13	improving clinical leadership and ownership of infection prevention and control the following are themes that must be addressed: Blood culture contamination Blood cultures not being drawn on admission and then drawn after 48 hours in hospital Insufficient MRSA screening Application of biomass reducing/ decolonising strategies. Insertion and care of vascular access devices. Urinary Tract Catheterisation Laboratory validation of data Flagging patients known to be MRSA colonised Soft-Tissue Care C. difficile Faecal samples being tested for C. difficile toxin (CDT) on patients with loose stools from laxative use and no reasons for suspecting C. difficile infection. Faecal samples not being sent from A&E /Admissions units on patients with loose stools	Ian Hosein, Director of Infection Control

PRINCIPAL RISK *What could prevent the objective being achieved* **Risk no, Date on Risk Register & Risk Scoring:**	KEY EXISTING CONTROLS *What controls/systems are in place to assist in securing delivery of objective and managing principle risks?*	CQC REF:	RESIDUAL RISK	ASSURANCES ON CONTROLS & IMPACT *Where we gain evidence that our controls/systems, on which we are placing reliance, are effective? The impact following assurances.*	PROGRESS AGAINST RISKS/ ACTION PLAN UPDATE *What Actions are undertaken to mitigate the actual risks?*	GAPS IN ASSURANCE *Where we are failing to gain evidence that our controls / systems, on which we place reliance, are effective*	GAPS IN CONTROL *Where are we failing to put controls / systems in place? Where are we failing in making them effective?*	LEAD
Principal Objective: To ensure a robust IM&T infrastructure to an improve our care and service delivery								
Risk No 340: Post contract of current PAS system there would be no PAS because the current PAS is provided by McKesson and this contract terminates April 1st, 2014. This is a national contract awarded via CFH (to operate in the UK). On this date the PAS will become "read only" and unavailable as a "live" PAS. This would compromise service delivery unless another system is procured timely. **Date on Register:**13.04.2012 **Rating Scoring:**Impact:4 x Likelihood: 3 = 12 **Area:** Trust **Impact on:** **Patient**: Poor patient outcome **Staff:** increased stress levels **Trust:** major impact on service delivery including disruption to service **Details updated:** 05.04.2013	Business case is going to the Trust Board for sign off and NHS London for approval and funding Received Trust board approval for replacement of PAS with the additional functionality of order communications.	11 21	High Risk	None identified during review	The Trust must plan to procure and deploy a new PAS. This procurement process is at an advanced stage Awaiting on NHS London for ratification and financial approval Business case and funding approved by NHS London Update 28/1/13 Contract awarded to preferred supplier on 24/1/13 Proposed implementation dates are August for Order Communications and November for PAS. Update 5th April 2013 Although awarded, the contract remains unsigned due to significant clarification and amendments required; it is anticipated that this will be concluded and signed by 30th April. This has not delayed the implementation timescale to date, as the Trust and system supplier have made an advanced service agreement to allow work to commence. The timescale for Order Communications has been aligned to the PAS timescale due to excessive effort and cost required to implement in August	None identified during review	Reliant upon the timeliness of the approval process. The timeline is very tight, a typical PAS implementation is 12 - 18 months 19.6.2012: none identified to date	Steve Huddleston – Chief Information Officer

PRINCIPAL RISK *What could prevent the objective being achieved* **Risk no, Date on Risk Register & Risk Scoring:**	KEY EXISTING CONTROLS *What controls/systems are in place to assist in securing delivery of objective and managing principle risks?*	CQC REF:	RESIDUAL RISK	ASSURANCES ON CONTROLS & IMPACT *Where we gain evidence that our controls/systems, on which we are placing reliance, are effective? The impact following assurances.*	PROGRESS AGAINST RISKS/ ACTION PLAN UPDATE *What Actions are undertaken to mitigate the actual risks?*	GAPS IN ASSURANCE *Where we are failing to gain evidence that our controls / systems, on which we place reliance, are effective*	GAPS IN CONTROL *Where are we failing to put controls / systems in place? Where are we failing in making them effective?*	LEAD
Strategic Objective 4: Services Are Rated Positively By Patients. Families & All Stakeholders								
Principal Objective: To embed a reputation of being a high performing Trust with the best outcomes for patients with all external stakeholder & the media								
Risk No: 258 Reputational damage may occur when there is insufficient evidence of quality of care improvements, thereby damaging patient and public confidence, user experience and create service difficulties for example from recruitment problems or poor staff morale **Date on Register:** 23.02.2011 **Rating Scoring:** Impact:4 x Likelihood:4 = 16 **Area**: Trust-wide **Impact on:** **Patients:** increased anxiety, potential service impact from recruitment difficulties **Staff:** staff morale and motivation **Trust:** damage to reputation **Details updated:** 05.04.2013	Quality improvement programme, led by the Director of Nursing and Medical Director, supported by the clinical directorates Delivery of the comprehensive improvement plan following the CQC recommendations, with PMO support Trust wide audit by directorate of CQC standards compliance, identified weakness to form part of prioritised action plan to be reviewed by the Quality and Safety Committee Communications work to promote awareness of quality improvements across the Trust, particularly against the CQC recommendations and in relation to concerns about maternity, and to strengthen relations with stakeholders	16	Extreme Red	Quality and Safety Committee reviewing quality assurance and delivery monthly. Audit quarterly patient experience reports Escalation of reputational risks, and new weekly communications update to ensure all of Board and Executive are briefed on these. CQC progress report on the Trust's progress published in June 2012 and inspection reports published following compliance visits. CQC compliance report recognising maternity improvement in January 2013	CQC Action plan provides the knowledge of key issues and concerns liable to affect reputation. Organisational development strategy in preparation. Whistle blowing policy is being widely promoted and proposed addition of lay channel for staff feedback. Monthly staff engagement meetings. Drive to strengthen the relationship between all stakeholders and the Trust, including monthly stakeholder written briefing and regular meetings with the senior Trust team. CQC report on maternity (January 13) noted significant improvements	Evidence for reputation rebuilding, particularly focusing on Emergency department performance, improved patient experience, complaints handling, finance. Resourcing of expanded programmes of staff and community engagement.	None identified following review	Imogen Shillito, Director of Comms
Strategic Objective 5 – To Ensure BHRUT is Financially Secure								
Principal Objective: The CIP be delivered fully to the agreed timescales without affecting the quality of care adversely								

PRINCIPAL RISK *What could prevent the objective being achieved* **Risk no, Date on Risk Register & Risk Scoring:**	KEY EXISTING CONTROLS *What controls/systems are in place to assist in securing delivery of objective and managing principle risks?*	CQC REF:	RESIDUAL RISK	ASSURANCES ON CONTROLS & IMPACT *Where we gain evidence that our controls/systems, on which we are placing reliance, are effective? The impact following assurances.*	PROGRESS AGAINST RISKS/ ACTION PLAN UPDATE *What Actions are undertaken to mitigate the actual risks?*	GAPS IN ASSURANCE *Where we are failing to gain evidence that our controls / systems, on which we place reliance, are effective*	GAPS IN CONTROL *Where are we failing to put controls / systems in place? Where are we failing in making them effective?*	LEAD
Risk No: 292 Clinical Directorates will not achieve financial target and CIP deliveries **Previous descriptor:** Trust would not achieve financial balance **Date on Register:** 15.06.2011 **Rating Scoring:** Severity:5 x Likelihood:5 = 25 **Area:** All Clinical **Impact on:** **Patient**: Poor patient outcome **Staff:** none **Trust:** The Trust sustaining progressive measures **Details updated** ; 14.01.2013 Planning / budgeting for 2013/14 underway, with first draft plan due to TDA by 25 Jan, including update to LTFM	- Trust has prepared Clinical Strategy and Long-Term Financial Model (with support from EY) - reviewed at October Trust Board. Model shows Trust reducing but not eliminating deficit by 2017/18, although further options are now being reviewed. - PMO with support from EY is developing CIP plans for 2013/14 and ensuring full year benefit from existing schemes meets 2012/13 target - Updated Clinical Strategy & LTFM considered at December Trust Board, including further actions to deliver surplus position by 2016/17. Supported by Commissioners and TDA. Key assumptions rolled in to Business Planning / Budget Setting processes for 2013/14	4 16	Extreme Red	- Review of Clinical Strategy, LTFM, CIP/Transformation programme by Transformation Board, Finance Committee, Trust Board, NHS London and Commissioners. Ongoing review at LTFM meetings with Commissioners & TDA, including agreement on key assumptions	Ongoing work to finalise clinical strategy and LTFM and CIP plan for 2013 /14 14.1.12 Planning / budgeting for 2013/14 underway, with first draft plan due to TDA by 25 Jan, including update to LTFM	- Further options to be fully developed to demonstrate financial viability in the longer term - Full year CIP programme yet to be fully developed	None identified following review	David Gilburt Finance Director / Alan Davies Deputy Director of Finance
Principal Objective: Meet our in-year financial targets (including net I&E surplus, liquidity, productivity)								

PRINCIPAL RISK *What could prevent the objective being achieved* **Risk no, Date on Risk Register & Risk Scoring:**	**KEY EXISTING CONTROLS** *What controls/systems are in place to assist in securing delivery of objective and managing principle risks?*	**CQC REF:**	**RESIDUAL RISK**	**ASSURANCES ON CONTROLS & IMPACT** *Where we gain evidence that our controls/systems, on which we are placing reliance, are effective? The impact following assurances.*	**PROGRESS AGAINST RISKS/ ACTION PLAN UPDATE** *What Actions are undertaken to mitigate the actual risks?*	**GAPS IN ASSURANCE** *Where we are failing to gain evidence that our controls / systems, on which we place reliance, are effective*	**GAPS IN CONTROL** *Where are we failing to put controls / systems in place? Where are we failing in making them effective?*	**LEAD**
Risk no: 104 Failure in financial management and budgetary control including expenditure restrictions, leading to reputational damage. **Date on Register:** 18.01.2008 **Rating Scoring**: Impact 4 x Likelihood:4 = 16 **Area:** Trust **Impact on:** **Patient:** Cash shortfalls may lead to suppliers suspending deliveries **Staff:** Cash shortfalls may lead to delays in payroll **Trust:** Financial Risks **Details updated** 14.1.2013 Ongoing controls as above. Emphasis at weekly CIP Accountability meetings on closing down outstanding red & amber risk	- Monthly budget statements, Business Unit financial reports, Trust financial reports - Monthly Business Unit performance review meetings (including CIP) to review key financial risks & agree mitigating actions. - Budget training provided to budget holders (April-June) - CIP governance arrangements – Work-stream Accountability review meetings; weekly pay controls; weekly vacancy controls; Transformation Board. - Non-pay expenditure and capital expenditure restrictions in place - Same controls in place as above, including weekly CIP Accountability meetings and CIP Work stream meetings - Increased emphasis on delivery of red-rated CIP schemes (£4.3m at M7) as well as additional £2m stretch to CIP forecast - Transition Board 12 December considering additional plans to improve in year CIP forecast position	4 6 16	Extreme	- Internal Audit of Financial Management arrangements - limited assurance given - Budget setting training being delivered during December, aimed to improve engagement with budget holders and greater ownership of budgets & CIPs	- Actions have been agreed through monthly Business Unit performance review meetings to address adverse variances, including CIP - Actions being progressed via CIP Accountability meetings with work-stream leads to implement further savings - Further discussions with budget holders to resolve outstanding budget ownership issues - Ongoing discussions with commissioners regarding transitional funding Agreement now reached with commissioners on payments for over-performance at full tariff, which mitigates CIP gap of £5m 14.1.13 Ongoing controls as above. Emphasis at weekly CIP Accountability meetings on closing down outstanding red & amber risk	- Ownership of budgets by budget holders remains a key issue, as identified by the Internal Audit report. - Significant risk of c. £13m in achieving I&E control total of £40m, primarily related to high risk CIPs £6.3m, unidentified CIP £5.4m and transitional funding risk of £4.3m - Ownership of budgets addressed via Budget Setting training during December - Red-rated CIP reduced to £4.3m at M7 - Transitional funding risk offset by agreement by commissioners to fund over-performance at full tariff	Mitigation plan being drawn up but at significant risk CIP non-delivery by issue	David Gilburt Finance Director / Alan Davies Deputy Director of Finance

RISK DESCRIPTORS

OBJECTIVE	MAJOR High Orange = 9-12 score	CATASTROPHIC Extreme Reds = 15-25 score	OBJECTIVE	MAJOR High Orange = 9-12 score	CATASTROPHIC Extreme Reds = 15-25 score
SAFE, HIGH QUALITY EFFECTIVE CARE:	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients	**CREATING AND SUSTAINING PURPOSEFUL PARTNERSHIPS**	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment
EFFICIENT ECONOMIC USE OF RESOURCES:	Uncertain delivery of key objective /Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time Non-compliance with national 10–25 per cent over project budget Schedule slippage / Key objectives not met	Non-delivery of key objective/ Loss of >1 per cent of budget Claim(s) >£1 million Failure to meet specification/ slippage Loss of contract / payment by results Incident leading >25 per cent over project budget Schedule slippage /Key objectives not met	**DELIVERY AGAINST BHRUT PRIORITIES AND OBJECTIVES:** **STRONG RESPECTED AND CREDIBLE LEADERSHIP**	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report National media coverage with <3 days service well below reasonable public expectation	Multiple breeches in statutory duty / Prosecution Complete systems change required Zero performance rating Severely critical report National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
PROVIDE A FIRST CLASS EDUCATIONAL EXPERIENCE AND A EFFECTIVE AND VALUED WORKFORCE	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff or Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis			

TABLE: RISK SCORING = SEVERITY X LIKELIHOOD (S X L)

SEVERITY SCORE ↓	LIKELIHOOD SCORE →				
	1	2	3	4	5
	RARE Can't believe the risk will ever happen	**UNLIKELY** Do not expect the risk to happen but it is possible	**POSSIBLE** The event may occur occasionally	**LIKELY** The event will probably occur but is not a persistent issue	**ALMOST CERTAIN** The event will undoubtedly occur, possibly frequently
5 CATASTROPHIC - Death or major disaster / loss; loss of >£1million including litigation settlement. Loss of ability to achieve/maintain financial stability of BHRUT	**5**	**10**	**15**	**20**	**25**
4 MAJOR - Significant / permanent harm Major financial loss (£100K - £1 million) Including litigation settlement.	**4**	**8**	**12**	**16**	**20**
3 MODERATE - Hospitalised or medium term injury Major financial loss (£20K to £100K) including litigation settlement.	**3**	**6**	**9**	**12**	**15**
2 MINOR - More than 3 days off sick due to injury moderate financial loss (£1K to 20K);	**2**	**4**	**6**	**8**	**10**
1 NEGLIGIBLE - No obvious injury or harm Minimal financial loss (<£1,000);	**1**	**2**	**3**	**4**	**5**

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

RAG STATUS	RISK SCORE	LEVEL OF RISK	RISK MANAGEMENT
	1 - 3	Low risk	Normal risks which can be managed by local and routine procedures
	4 - 6	Moderate risk	Risks requiring assessment, action planning and monitoring is allocated to Directorates /Specialities
	8 - 12	High risk (BAF 9-12 only)	Risks requiring urgent executive management team action linked with Action Plan
	15 – 25	Extreme risk (BAF)	Risks requiring immediate action by Lead Director and recommendations by Trust Board./ Audit Committee

BOARD ASSURANCE FRAMEWORK ELEMENTS

STEP1 KEY PILLARS OF THE BAF	APPLICATION TO THE BAF
Principal Objectives	Those strategic and directorate level principal objectives crucial to the Board's overall goals
Principal Risks	Risks threatening the achievement of principal objectives
Key Controls	Control (s) to manage one or more principal risks
Assurances on Controls	Confidence, based on sufficient evidence, that internal controls are in place, operating effectively and objectives are being achieved .
STEP2	**Regular Board reports, Directorates escalation and recognition of Principal Risks as well as summary reports from the Audit Committee identify:**
Gaps in Assurance	Failure to gain sufficient evidence that policies/ procedures, practices or organisational resources / structures on which reliance is placed are operating effectively Trust-wide.
Gaps in Control	Failure to put controls / systems in place to mitigate the risks adequately and effectively.
STEP 3	**Action plan generated from the Gaps**
Board Assurance Action Plan	An action plan approved by the board to improve its key controls to manage its principal risks, and gain assurances where required and mitigate the gaps in assurance.

CARE

QUALITY COMMISSION: Regulations and Outcome Guide

Regulation 17	**Outcome 1:**	**Respecting and involving people who use services**
Regulation 18	**Outcome 2:**	**Consent to care and treatment**

Regulation 9	**Outcome 4:**	**Care and welfare of people who use services**
Regulation 14	**Outcome 5:**	**Meeting nutritional needs**
Regulation 24	**Outcome 6:**	**Co-operating with other providers**
Regulation 11	**Outcome 7:**	**Safeguarding people who use services from abuse**
Regulation 12	**Outcome 8:**	**Cleanliness and infection control**
Regulation 13	**Outcome 9:**	**Management of medicines**
Regulation 15	**Outcome 10:**	**Safety and suitability of premises**
Regulation 16	**Outcome 11:**	**Safety, availability and suitability of equipment**
Regulation 21	**Outcome 12:**	**Requirements relating to workers**
Regulation 22	**Outcome 13:**	**Staffing**
Regulation 23	**Outcome 14:**	**Supporting workers**
Regulation 10	**Outcome 16:**	**Assessing and monitoring the quality of services**
Regulation 19	**Outcome 17:**	**Complaints**
Regulation 20	**Outcome 21:**	**Records**

Appendix 2

Board Assurance Framework

High Level Strategic Risks with potential to threaten the achievement of the Strategic Objectives.

The following high levels risks have been identified for incorporation into the Board Assurance Framework, to ensure that the Board are informed of high level risks

Corporate Objective: To deliver safe and effective care

- Failure to achieve the 4 hour access target for Emergency Department
- Failure to improve mortality rates SHMI to be consistently below 90
- Failure to protect our patients against hospital associated infections, MRSA, C-difficle, Norovirus
- Failure to reduce the numbers of falls resulting in severe harm or death
- Failure to reduce the incidences of hospital acquired grade 3 or grade 4 pressure ulcers
- Failure in prescribing, administration, dispensing and storage of medication
- Failure to provide appropriate care for patients with learning disabilities

Corporate Objective: To ensure that the Trust achieves financial control

- Failure to meet financial targets and CIP deliveries
- Uncertainty over income levels from Commissioners
- Failure to deliver services
- Unforeseen expenditure

Corporate Objective: To deliver Operational Excellence

- Failure to achieve the 18 week targets in specific specialities
- Failure to achieve 2 week cancer targets (62 days)
- Failure to achieve contract quality information requirements (CQUIN)

Corporate Objective: Services rated positively by all stakeholders

- Not achieving a positive rating on the Friend and Family Test
- Failure to respond to patient complaints within an agreed timescale
- Failure to resolve patient's complaints leading to Ombudsman investigations with critical findings
- Failure to achieve a positive rating by CQC
- Failure to be positively rated by Commissioners, Local Authority and Media
- Failure/Breakdown in Partnership working

Corporate Objective: Staff engagement in the success of the Trust

- Staff not aware of what the Trust needs to demonstrate to be successful
- Failure to achieve 100% of staff having personal objectives set
- Failure to achieve 100% of staff having annual appraisal
- Increase in numbers sickness and absence rates
- Failure to achieve a positive rating in staff survey

Corporate objective; providing a first class educational experience for all staff and ensuring that its workforce is appropriately skilled

- Failure to ensure that workforce is appropriately skilled
- Failure of staff to attend appropriate training sessions
- Poor outcomes from the GMC with regards to student surveys
- Poor educational experience with regards to junior doctors
- Inability of the Trust to recruit suitable staff appropriate for the service
- Inability of the Trust to retain suitable staff

Barking, Havering and Redbridge University Hospitals NHS Trust

BOARD ASSURANCE FRAMEWORK 2012 – Example

4th Quarter: January to March 2013

CORPORATE OBJECTIVE	1. Deliver safe and effective care	Control gaps status	Assurance gaps status	Actions plan progress
Sub Objective	1.c **To ensure a robust IM&T infrastructure to an improve our care and service delivery**			

PRINCIPAL RISKS Description of risk	Current risk	KEY CONTROLS What is already in place to manage the risk?	ASSURANCES ON CONTROLS What evidence can be used to demonstrate to the Board that the controls are working?	CONTROL GAPS What should be in place to manage the risk but is not?	ASSURANCE GAPS What should be in place to demonstrate that controls are working, but not currently in place?	Target Risk	Status change
Risk: Post contract of current PAS system there would be no PAS because the current PAS is provided by McKesson and this contract terminates April 1st, 2014. This is a national contract awarded via CFH (to operate in the UK). On this date the PAS will become "read only" and unavailable as a "live" PAS. This would compromise service delivery unless another system is procured timely. **Co-ordinating Director:** Chief Information Officer	 **12** L4 X S3	Business case is going to the Trust Board for sign off and NHS London for approval and funding Received Trust board approval for replacement of PAS with the additional functionality of order communications.	None identified during review	Reliant upon the timeline of the approval process. The timeline is very tight, a typical PAS implementation is 12 - 18 months 19.6.2012: none identified to date Update 28/1/13 Contract awarded to preferred supplier on 24/1/13 Proposed implementation dates are August for Order Communications and November for PAS.	None identified following review	 **6** L2 X S3	

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Integrated Cancer System – London Cancer Memorandum of Agreement April 2013 – March 2014	Trust Board – Part II
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
The London Cancer Memorandum of Agreement April 2013 – March 2014 was discussed in detail at the Trust Board Development Session on the 3 April 2013. Members agreed that due to the timeframe involved, the Chief Executive could sign and return the Agreement and endorsement of this sign off would be noted at the Trust Board Meeting on the 1 May 2013.	□ **TEC** ……..….. □ **STRATEGY**……. □ **FINANCE** ……..…… □ **AUDIT** ……..….. □ **QUALITY & SAFETY** ……..……..…… □ **WORKFORCE** □ **CHARITABLE FUNDS** ……..….. □ **TRUST BOARD** ……..…… □ **REMUNERATION** ……..….. □ **OTHER** ……..…….. (please specify)
2. DECISION REQUIRED:	**CATEGORY:**
The Trust Board is asked to endorse the signing off of the London Cancer Memorandum of Agreement April 2013 – March 2014.	□ **NATIONAL TARGET** □ **CNST** □ **CQC REGISTRATION** □ **HEALTH & SAFETY** □ **ASSURANCE FRAMEWORK** □ **CQUIN/TARGET FROM COMMISSIONERS** □ **CORPORATE OBJECTIVE** ……..….. □ **OTHER** …….. (please specify)
	AUTHOR/PRESENTER: Averil Dongworth, Chief Executive
	DATE: 18 April 2013
AGREED AT __Trust Board Development Session_	**DATE: __3 April 2013_____** **DATE: _____**
REVIEW DATE (if applicable) **____N/A_____**	

Integrated Cancer System - *London Cancer*

Memorandum of Agreement: April 2013-March 2014

Introduction

This document updates and replaces *London Cancer's* previous Memorandum of Agreement, which covered the period from April 2012 to March 2013.

It restates the previous commitment of each of the signatories and *London Cancer* to deliver better cancer related outcomes and experience for our patients and local communities by working in partnership.

This Memorandum of Agreement incorporates the significant progress made together since July 2011 to develop effective governance and reporting frameworks, and the work undertaken since *London Cancer* was officially established in April 2012 to build a platform from which to deliver our collective vision.

To this end, the signatories are now agreeing to enter into this updated Memorandum of Agreement, which runs from April 2013 to March 2014. This Memorandum of Agreement may be superseded during this timeframe if more detailed proposals are approved and agreed to be implemented.

London Cancer

London Cancer is an Integrated Cancer System for North Central and North East London and West Essex. It brings together providers from across the health community, academia and the voluntary sector to drive step change improvements in outcomes and experience for the cancer patients and populations we serve. Together the following provider organisations working with UCLPartners have to date led the co-creation of *London Cancer*:

•Barnet and Chase Farm Hospitals NHS Trust •Barts Health NHS Trust •Barking, Havering and Redbridge University Hospitals NHS Trust •Great Ormond Street Hospital for Children NHS Foundation Trust •Homerton University Hospital NHS Foundation Trust •Moorfields Eye Hospital NHS Foundation Trust •North Middlesex University Hospital NHS Trust •Princess Alexandra Hospital NHS Trust •Royal Free London NHS Foundation Trust •Royal National Orthopaedic Hospital NHS Trust •University College London Hospitals NHS Foundation Trust •Whittington Health

London Cancer is committed to working with its partners across the health community, academia and the voluntary sector in North Central and North East London and West Essex to deliver, by 2015, the following priority measures:

- Improved one year survival for patients within *London Cancer***;
- Improvement in patients self-reported experience of the care they receive; and

- Increased participation in clinical trials to 33% of all patients.

**** used as a proxy measure for patients being diagnosed earlier in the course of their cancer

Accountability, reporting and governance

London Cancer will continue to focus on transformation which can only be achieved through partnership, not on the business-as-usual improvements which will be driven by individual providers. This focus will enable *London Cancer* to drive change with its partners at pace and scale. To ensure there is clarity for stakeholders and that we avoid duplication of effort, we will continue to clarify carefully responsibilities.

All parts of the system will be responsible for driving forward leadership skills and behaviours that deliver an integrated partnership around patients and local populations. Furthermore, all parts of the system will work together to align objectives and priorities within the wider climate of multiple and sometimes competing pressures.

Working with the signatories below, *London Cancer* has developed core governance processes, which were approved in principle by the signatories to the original Memorandum of Agreement. These were set out in proposals from the *London Cancer* governance working group dated 17 October 2011.

At the centre of these proposals is the appointment of an independent skills-based Board to lead *London Cancer*. This Board met for the first time in February 2012 and, meets on a monthly basis.

From April 2013 through to March 2014 processes for agreeing and implementing responsibilities, reporting and governance processes and procedures will continue to be developed and reported along the lines of those already agreed in principle. These proposals will be consulted on and, in due course, be submitted for approval by the Trust Boards which are signatories to the Memorandum of Agreement.

The current structures within *London Cancer* and its key external relationships are set out at Appendix 1.

***London Cancer* Board**

The membership of the *London Cancer* Board will continue to be agreed by Trust Chief Executives who are members of the UCLP Executive Group. The primary purpose of the *London Cancer* Board is to provide skills-based leadership for *London Cancer* that is independent of the provider and other institutions. The full terms of reference are detailed in Appendix 2.

London Cancer's Board will work closely with a range of stakeholders including in particular the signatories below and the Joint Development Group. This latter group is the forum for discussions between *London Cancer* and the commissioners for our system. It is chaired by the Chief Executive of the North East London Cluster on behalf of North East and North Central London's commissioners, and will continue through the NHS North and East London Commissioning Support Unit. The stated purposes of this group are to:

- Ensure that there is a common understanding and agreement across providers and commissioners regarding the priority changes in cancer care;
- Agree *London Cancer's* Service Plan to implement the agreed Model of Care[1] for Cancer in London; and
- Identify those service changes that require action by providers and commissioners and then to agree respective actions.

It is recognised by the signatories to this document that the Joint Development Group has an important role to play in ensuring that system level commissioning objectives and requirements are taken into account and, as appropriate, incorporated within the overall plans and objectives of *London Cancer*.

***Cancer Pathway* Boards**

Cancer pathway boards are in place for each major cancer type, with a competitively appointed senior clinical leader. The boards have representation from all relevant providers, users, primary care and public health. They have taken over the responsibilities of the previous network site-specific groups of NCL and NEL Cancer Networks but with additional executive responsibility as below. Cancer pathway boards are accountable to the *London Cancer* Board and:

- Lead the co-design, implementation and management of adherence to integrated care pathways, including implementation of Model of Care recommendations appropriate to the pathway;
- Offer pathway-specific advice to commissioners;
- Build relations across the pathway, including public health and public/ patient engagement;
- Identify best practice and support its roll out; and
- Undertake governance roles for partners around peer review and Multidisciplinary Teams (MDTs).

Provider Trusts, which are signatories to the Memorandum of Agreement, will continue inter alia to be:

- Accountable to commissioners for meeting national and local quality standards at local sites e.g., waiting times, patient-experience, complaints, incidents, and peer review including MDTs;
- Responsible for day-to-day operational management of cancer care, including supporting implementation of relevant recommendations emanating from *London Cancer* Pathway Boards, and responsible financial management of cancer services;
- Responsible for contract negotiation and review with commissioners;

[1] Commissioning Support for London, *A Model of Care for Cancer Services*, 2010

- Responsible for comprehensive, accurate capture of a common data set (including staging) and feeding this to a system-wide database for provision to Thames Cancer Registry, national audits, etc.; and
- Responsible for regulatory compliance.

Members and Stakeholders Council
A combined UCLPartners and NCEL Local Education and Training Board (LETB) members and stakeholders council will be the forum where *London Cancer* will present to our population. This will operate on the principles of openness and transparency. As a minimum, *London Cancer* will ensure compliance with the requirements within the Health and Social Care Act 2012 around patient involvement and public accountability.

Mutual responsibilities

Each of the signatories below recognises:

- The obligations that each provider organisation, UCLPartners and *London Cancer*, and their Boards have to patients, regulators, commissioners, governors, members and staff;
- The objectives of *London Cancer* (as set out in this Memorandum of Agreement);
- The crucial and central interests of patients; and
- The interests of commissioners.

Each of the signatories to the Memorandum of Agreement also recognises that to deliver the objectives of *London Cancer* will require co-operation and collaboration between providers and other partners across the pathway.

This will necessitate different ways of working and will be in the form of:

- Sharing reliable, complete and timely information with Cancer Pathway Boards and the *London Cancer* Board;
- Engaging fully and co-operating with other parts of the pathway;
- Investing in appropriate equipment;
- Engaging in MDTs in the right manner;
- Co-operating and collaborating in key clinical appointments; and
- Reduced waiting times, improving the quality of patient experience and delivering superior outcomes.

It is accepted that where these behaviours can't be evidenced, the capacity and capability of a signatory to the Memorandum of Agreement to contribute effectively to the delivery of the objectives of *London Cancer* may be in doubt.

In such circumstances, and where the clinically evidence based shortfall is not satisfactorily rectified, it is recognised that the *London Cancer* Board may recommend sanction. Following discussion with commissioners, this may result in a decision to decommission services or the removal of a provider from *London Cancer*.

London Cancer further agrees to:

- Keep information which is shared with it confidential as appropriate;
- Report to each of the organisations impacted at the earliest opportunity any matter which may risk an organisation and its reputation;
- To act only on clinical evidence, and only then once a full impact analysis has been undertaken and shared;
- Seek to consult and include wider representation wherever possible; and
- To act in a manner independent of all organisations within *London Cancer*.

Tim Peachey, Interim CEO
BARNET AND CHASE FARM HOSPITALS NHS TRUST
Signature.....

Julie Lowe, CEO
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST
Signature.....

Peter Morris, CEO
BARTS HEALTH NHS TRUST
Signature.....

Yi Mien Koh, CEO
WHITTINGTON HEALTH
Signature.....

Averil Dongworth, CEO
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST
Signature..... .....
.....

Melanie Walker, CEO
PRINCESS ALEXANDRA HOSPITAL NHS TRUST
Signature.....

Jan Filochowski, CEO
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST
Signature.....

David Sloman, CEO
ROYAL FREE LONDON NHS FOUNDATION TRUST
Signature.....

Tracey Fletcher, CEO
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST
Signature.....

Rob Hurd, CEO
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST
Signature.....

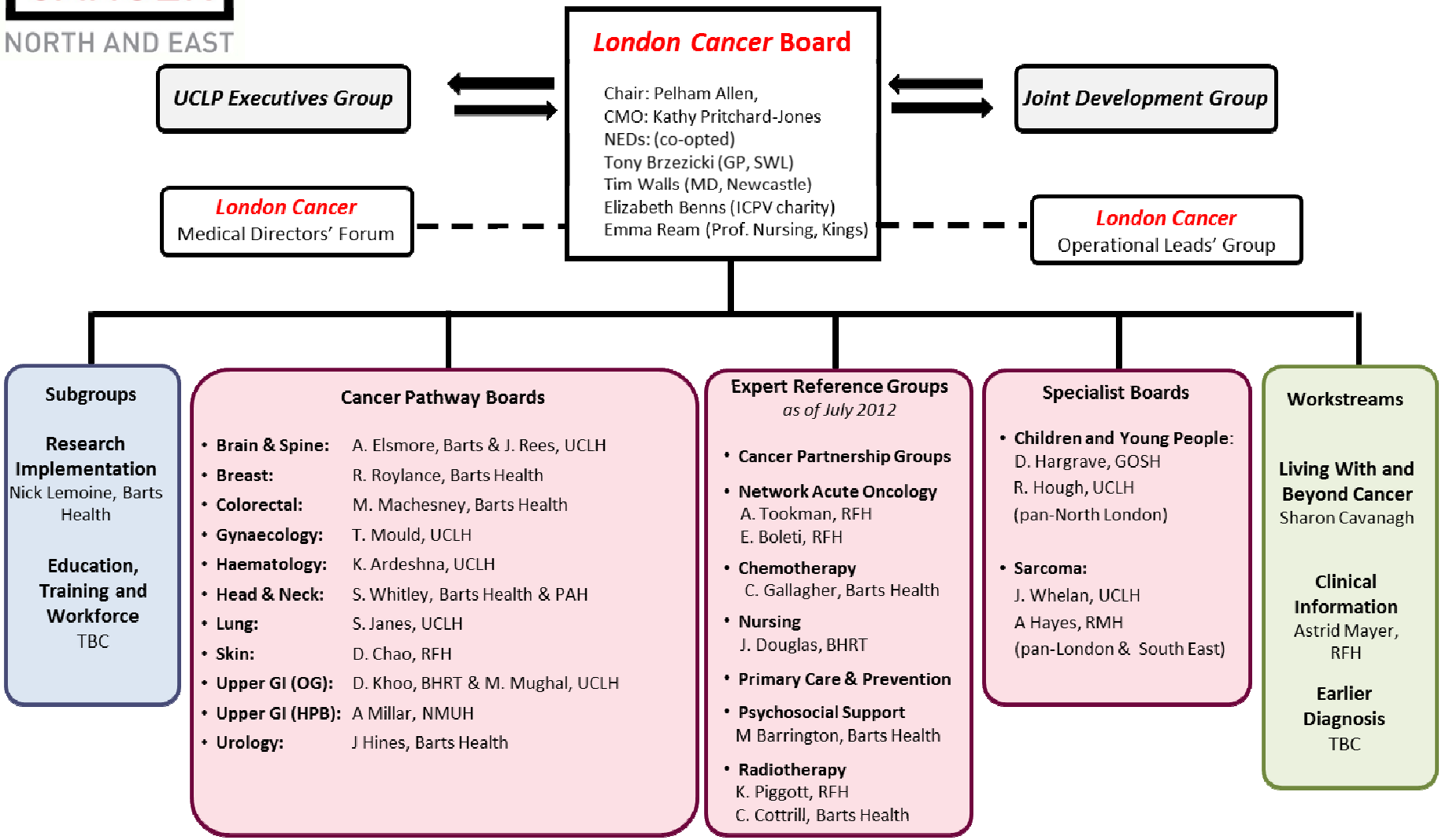
John Pelly, CEO
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST
Signature.....

Sir Robert Naylor, CEO
UNIVERSITY COLLEGE HOSPITALS NHS FOUNDATION TRUST
Signature.....

David Fish, MD
UCLPARTNERS
Signature.....

Kathy Pritchard-Jones, CMO
LONDON CANCER
Signature.....

LONDON CANCER
NORTH AND EAST



Appendix 2: *London Cancer* Board: Terms of Reference

London Cancer is an Integrated Cancer System for North Central & North East London and West Essex. It brings together providers from across the health community, academia and the voluntary sector to drive step change improvements in outcomes and experience for the cancer patients and populations we serve.

Together the following provider organisations working with UCLPartners have to date led the co-creation of *London Cancer*:

•Barnet and Chase Farm Hospitals NHS Trust •Barts and the London NHS Trust •Barking, Havering and Redbridge University Hospitals NHS Trust •Great Ormond Street Hospital for Children NHS Trust •Homerton University Hospital NHS Foundation Trust •Moorfields Eye Hospital NHS Foundation Trust •Newham University Hospital NHS Trust •North Middlesex University Hospital NHS Trust •Princess Alexandra Hospital NHS Trust •Royal Free Hampstead NHS Trust •Royal National Orthopaedic Hospital NHS Trust •University College London Hospitals NHS Foundation Trust •Whipps Cross University Hospital NHS Trust •Whittington Health

Note: subsequent to the approval of the Terms of Reference on 28 February 2012, the following events have occurred:

- *With effect from 1 March 2012, Great Ormond Street Hospital for Children NHS Trust has been awarded foundation trust status and is now Great Ormond Street Hospital for Children NHS Foundation Trust;*
- *With effect from 1 April 2012, Royal Free Hampstead NHS Trust has been awarded foundation trust status and is now Royal Free Hampstead NHS Foundation Trust; and*
- *With effect from 1 April 2012, Barts and the London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust merged to form Barts Health NHS Trust.*

London Cancer – mission and aims:

London Cancer's mission is to improve survival from cancer and experience of care for its patients and local communities. We aim to achieve this by leading a radical redesign of how cancer services are delivered across a population of nearly 4 million people in North Central and North East London and West Essex. This will be driven by all provider Trusts in *London Cancer* taking collective responsibility for the quality and outcomes of integrated care pathways, working in partnership with patients, primary care, commissioners, public health and the voluntary sector. Our ambition is to create a new model of cancer care for the NHS that empowers patients, facilitates equitable access to best practice and innovation and increases value for the health economy. We aim to support our staff to be leaders in cancer care – locally, nationally and globally. Ultimately, *London Cancer* aims to create a "virtual comprehensive cancer centre" serving the whole population of North Central and North East London, that comprises all of its partner organisations and is recognised globally for the excellence of its patient care and outcomes, education, training and research.

As partners we have developed *London Cancer* through engagement efforts reaching over 1000 staff, patients, carers, primary care and the voluntary sector, with the vision to:

- Be *patient-focused* through listening, communication, involvement, information, education, choice, and personalisation. Patient need and the patient journey will be the organising framework for care

- *Optimise care along a co-ordinated pathway* through earlier diagnosis, excellent treatment for all, local treatment where appropriate, compassionate aftercare and empowering/supporting patient self-management

- *Embed research* for personalised care, equitable access to trials, the discovery of new treatments and evaluating new ways of working together with patients

- *Increase value* through superior outcomes for patients per pound invested; continual improvement over time against our previous performance

The current priority measures are, by 2015, to:

1. Improve one year survival for patients within *London Cancer***,
2. Improve patients self-reported experience of the care they receive
3. Increase participation in clinical trials to 33% of all patients.

**** used as a proxy measure for patients being diagnosed earlier in the course of their cancer

London Cancer Board - purpose:

The primary purpose of the London Cancer Board is to provide skills-based leadership for *London Cancer* that is independent of the partner institutions, to ensure the successful delivery of *London Cancer's* mission and goals, including:

- Setting and directing *London Cancer's* overall strategy

- Driving innovation, change and shaping new models of cancer care

- Securing behaviours and commitment from partners and participants along cancer pathways which are consistent with the overall goals of *London Cancer*

- Agreeing national and international benchmarks against which to measure and promote improved performance and changed models of cancer care

- Making evidence-based, clinically led and deliverable recommendations to commissioners of cancer care across North Central and North East London
- Influencing and informing the development of national strategies for value based healthcare in the NHS

- Horizon scanning to provide advance notice of new and emerging cancer technologies and practices that might require evaluation, consideration of clinical and cost impacts, or modification of clinical guidance prior to launch in the NHS

The *London Cancer* Board will work with Cancer Pathway Boards, subgroups and work-streams, to ensure that on an ongoing and continuous basis, *London Cancer* takes steps to drive improvements and new models in cancer care for patients and its population.

Key responsibilities:

- To set, update and direct delivery of the overall strategy for *London Cancer* (including consideration and challenge of Pathway Board, key subgroup and work-stream plans)
- To prioritise consideration of potential cancer pathway changes taking into account and balancing:
    - likely impact on outcomes, patient experience and meaningful patient voice within the relevant cancer pathway
    - overall impact of change within and beyond cancer services
    - healthcare value, reflecting both cost and quality
    - potential resulting impact for treatments and commissioning of services other than cancer (e.g.: funding, location and sustainability of other services and organisations, use of healthcare resources, impact on ancillary services, equipment and other operating capacity)
- To consider and challenge recommendations from Cancer Pathway Boards and subgroups or work-streams (including evidence, impacts and mitigations)
- To make specific recommendations on behalf of *London Cancer* to commissioners for potential changes to cancer services and pathways
- To hold providers of cancer care accountable on an ongoing basis for their behaviours and commitment to the delivery of the overall goals of *London Cancer*
- To maintain an ongoing focus on the needs of local cancer patients and the population, ensuring *London Cancer* is constantly innovating and embedding its work in evidence to improve outcomes for patients and healthcare value
- To report recommendations and progress to UCLP Executive Group
- To review on a periodic basis a defined set of pathway metrics / outcome measures and agree any remedial steps as required (including the potential for exclusion of a partner from *London Cancer*)
- To require and review bench-marking (national and international) of evidence to demonstrate progress against agreed goals and the effectiveness or otherwise of changed models of cancer care
- To review, oversee the consultation on and update outcome focused compliance measures for cancer services
- To work in partnership with commissioners to develop and agree effective incentives (including to ensure GP engagement) designed to promote and support improvements in cancer services
- To oversee *London Cancer's* influencing and communication strategy (including publication of information and data) including, but not limited to, the development of national strategies for value based healthcare in the NHS

- Horizon scanning to provide advance notice of selected new and emerging technologies and practices that might require evaluation, consideration of clinical and cost impacts, or modification of clinical guidance prior to launch in the NHS
- To ensure effective engagement with and involvement of stakeholders on an ongoing basis
- To approve appointments of Cancer Pathway Directors
- To receive notification of membership of Cancer Pathway Boards to ensure proper representation
- To consider on an ad hoc basis solutions to specific and significant cancer-related challenges
- To ensure that momentum is maintained in the pace of work of *London Cancer*, and ensure that good and proper process does not delay progress in achieving the desired outcomes

Membership (and skills):

- The Board will include an independent Non-executive Chair
- The Chief Medical Officer, which will be an executive role, will be on the Board
- The Board will in addition have 6 independent Non-executive Directors, who will with the Chair and the Chief Medical Officer bring together the following skills and knowledge:
    - Cancer pathways and quality outcomes
    - Leadership of service transformation
    - Workforce development across partners
    - Strategy and financial governance
    - Clinical expertise in cancer
    - Patient and population focus
    - Public health priorities for cancer
    - Commissioning and value based healthcare
    - Primary care

Authority:

- To make recommendations and then agree with commissioners the appropriate incentives and any sanctions necessary to drive the prioritised recommendations from Cancer Pathway Boards on behalf of *London Cancer*
- To report recommendations to UCLP Executive Group
- To receive recommendations from Cancer Pathway Boards, subgroups and work-streams
- To commission further review, analysis or information gathering as necessary to support recommendations
- To recommend appointments to London Cancer Board (subject to the approval of UCLP Executive Group)
- To approve:
    - Changes in cancer metrics and outcome measures at the system level
    - Publications and other public announcements on behalf of *London Cancer*

- Appointment of Cancer Pathway Directors

Appointments to London Cancer Board:

- Initial appointments to be made by UCLP Executive Group
- Subsequent appointments to be made by *London Cancer* Board and approved by UCLP Executive Group

Support:

- Board support / administration through a *London Cancer* Board Secretary
- Communications support
- Cancer Pathway Boards
- Subgroups and work-streams

Meeting frequency:

Monthly

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
BHRUT Emergency Pathway Work Stream and Master Plan Structure	Trust Board
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
Bring the board up to date with Trust plans to deliver the national target of seeing and treating 95% of the patients in A&E within 4 hours of their arrival in the department. The report includes a revised reporting and accountability structure, a master plan update with existing project work streams, work stream KPI's and graphs showing the performance against the 95% target by site	□ **TRUST BOARD 1/5/2013**
2. DECISION REQUIRED:	**CATEGORY:**
The board is requested to note the content of this report, with a more up to date position report from the Executive directors to follow on 30th April	□ **NATIONAL TARGET** □ **ASSURANCE FRAMEWORK**
	AUTHOR/PRESENTER: David Gilburt
	DATE: 23/04/2013
3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
Proposed Contract for 2013/2014 is likely to include financial penalties if targets are not achieved	
4. DELIVERABLES	
Deliver the agreed trajectory towards achieving the 95% target.	
5. KEY PERFORMANCE INDICATORS	
A Series of metrics are being developed which are described in this report	
AGREED AT _____ MEETING **OR** **REFERRED TO: _____**	**DATE: _____** **DATE: _____**
REVIEW DATE (if applicable) _____	

BHRUT Emergency Pathway

Work Stream and Master Plan Structure

23rd April 2013

Contents

Introduction: Delivering the 4 Hour Target in A&E

- **Introduction**

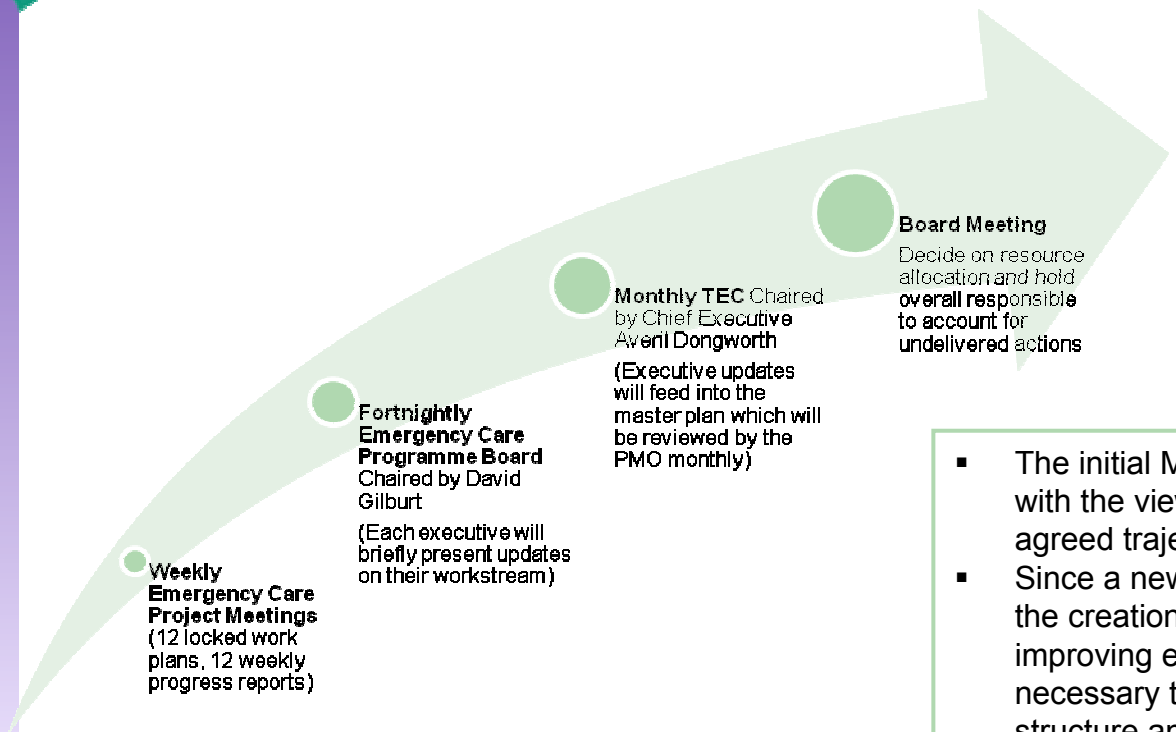
- The purpose of this report is to bring the Board up to date with the Trust plans to deliver the national target of seeing and treating 95% of the patients in A&E within 4 hours of their arrival in the department.

- **Included with this report:**

- Revised reporting and accountability structure
- Master Plan update with existing project work stream
- Work stream performance metrics
- King George Emergency Department Performance against target
- Queens Hospital Emergency Department Performance against target

- The Board received a report in March which set out plans to improve performance in A&E as measured by the 4 hour target. The plan set out a series of actions designed to improve performance against the target. Much progress has been made in achieving the individual elements of the plan and performance has improved particularly at KGH. However, the scale of the challenge at Queens Hospital has been far greater than expected and performance has not improved as anticipated.
- The Executive Team is currently updating the plan to learn from the experience of the plan submitted in March. This report sets out the measures being introduced including revisiting and strengthening ten work streams designed to support the improvements in performance.
- A **fortnightly Emergency Care Programme Board** chaired by the Interim Director of Finance will review performance and escalate issues that are not delivering as planned. The Programme Board will report to the Trust Executive Team and Trust Board on a monthly basis.
- **Each of the work streams is sponsored by an Executive Director** responsible for signing off the plans and ensuring delivery. These work streams are currently being finalised and an up to date position on the work streams will be reported to the Board on 1st May 2013
- The latest position on the CQC report will also be reported to the Board
- The Board is requested to note the content of this report and to receive a more up to date position report from Executive Directors on 1st May 2013

Proposed Reporting and Accountability Structure



- The initial March/April master update was written with the view that the trust would be at the agreed trajectory by the end of April.
- Since a new trajectory has been agreed and with the creation of 12 work streams which support improving emergency care at BHRUT it is necessary to refresh the current governance structure and master plan to take these work streams into account.
- Whilst the overall look and feel of the master update will in large remain the same, headings will evolve to represent all 12 work streams working towards improving emergency care at BHRUT.

BHRUT Master Plan Update with existing Project Work Streams

	Master Plan Headings	Incorporated Work Streams	Project Lead	Executive Lead
1	**Improving patient experience in the ED** -Patient experience and Safety	Improving Patient Experience	Sam Elden Lee	Flo Panel Coates
2	**Patient Inflows & the UCC**	Improving the UCC	Pat McNulty	Dorothy Hosein
3	**Improving the ED Work Force** -Workforce and Recruitment	Improving Staff Morale ED Consultant Recruitment	Claire Dixon Trisha Quashie- Boney	Mark Smith
4	**Improving The ED Operations** - Improving ED Operations - Improving Paeds ED	Improving the ED Improving Paediatric ED	Claire Dixon Pat McNulty	Dorothy Hosein
5	**Enhancing Assessment Capability and Capacity** -SAU -MAU GP Unit -Ambulatory Care -Frail Elderly	MAU GP Unit Ambulatory Care Frail Elderly	Barri M Jones Davey Yeung Jane Hustler	Dorothy Hosein
6	**Seven Day Working** -Service Redesign -Recruitment	7 Day Working	David Bays	Mike Gill
7	**Wards** -Leadership -Discharge Management	Care Planning and Discharge	Caroline Moore	Flo Panel Coates
8	**Performance Management** -Metrics and Monitoring			Neil Moloney
9	**Space Reconfiguration**	Estates	Sophie Murphy	Jackie Nugent
10	**Governance**	Programme Board	Gulsen Yenidogan	David Gilburt

Work Stream Performance Metrics (1,2)

Work stream Name	Date of Full Impact	Targets	Overall Project Owner	Exec Sponsor	Project status	Suggested KPI's	KPI Status	Lockable Work plan received?	Progress Sheet received?
Improving Patient Experience		Improve the quality of care and patient experience delivered within the ED	Sam Elden Lee	Flo Panel Coates	Amber	No. of Patient survey's completed, Spot check of comfort round compliance, Nursing staff that have signed off on Customer Care Competencies	Red		Yes
Improving the UCC	05/07/2013	50% patients of Appropriate patients streamed to UCC, 12% Appropriate patients navigated to local community, 0 UCC Breaches	Pat McNulty	Dorothy Hosein	Amber	Percentage of patients streamed to the UCC, Percentage of patients navigated to the community, Number of UCC Breaches	Red		Yes
Improving Staff Morale		Improve the staff experience and morale for all ED staff, improve staff retention, recruitment and reduce turnover rates	Claire Dixon	Mark Smith	Amber	Staff turnover to show joiners/leavers, Appraisals in the last 12 months, Staff survey completion and results	Red		Yes
ED Consultant Recruitment			Trisha Quashie-Boney	Mark Smith	Amber				No
Improving the Emergency Department		Improve quality of care delivered within ED, improve performance delivering national quality indicator targets	Claire Dixon	Dorothy Hosein	Amber	Number of breaches (showing breakdown of reasons), Time to first assessment, Specialty responses longer than 30 mins, Audit spot checks	Red		Yes
Improving Paediatric ED			Pat McNulty	Dorothy Hosein	Amber	Number clinical pathways, response times for children's surgical specialties, ED attendances through SSPAU.			No
MAU GP Unit	01/09/2013	Improve flow of patients through the department, Improve Patient Care	Barri M Jones	Dorothy Hosein	Amber	Number of patients going through the unit separated by outcome (discharged, admitted), Number of patients going through the unit separated by referral source, No of patients staying more than 48 hours (RC analysis on ALL patients that stayed > 48 hrs)	Red		Yes

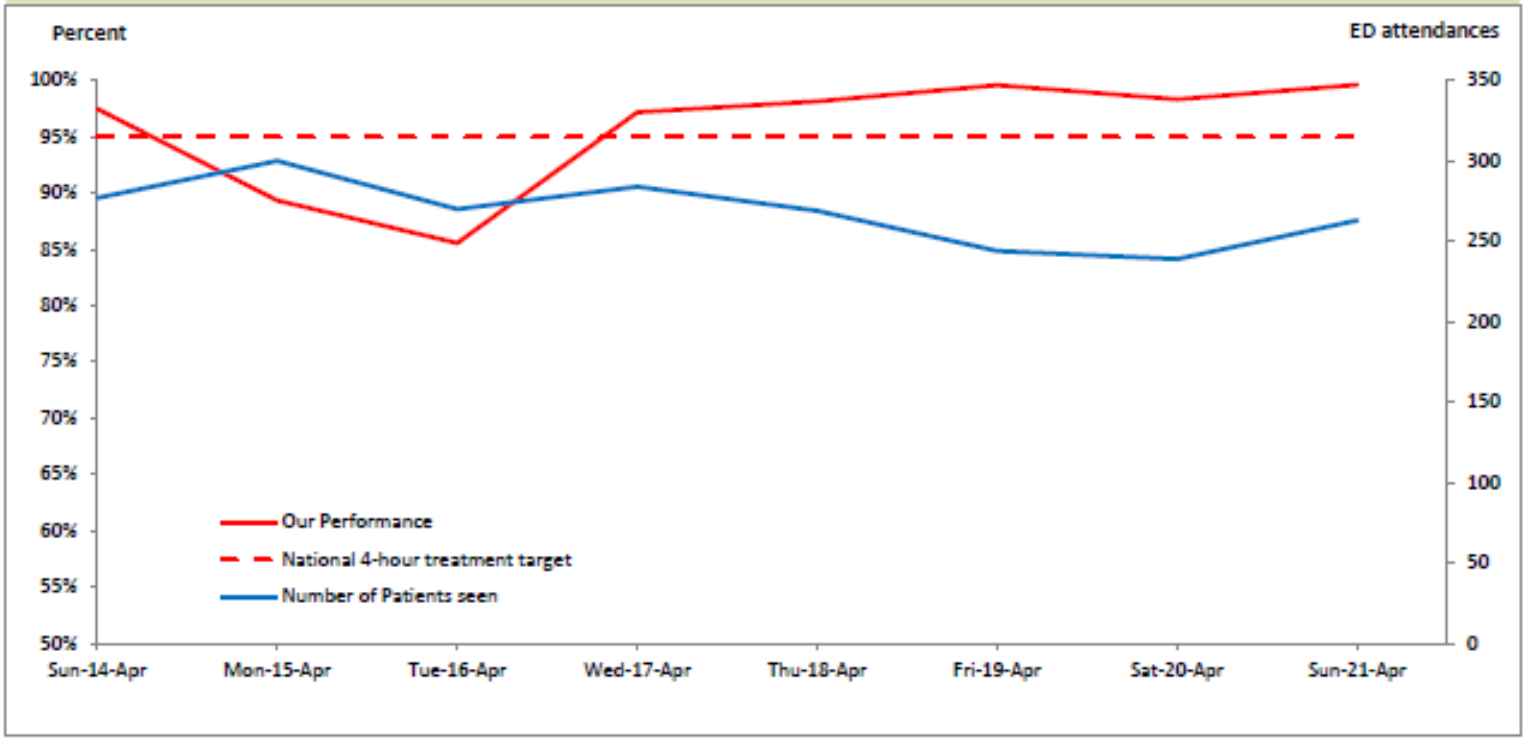
Work Stream Performance Metrics (2,2)

Work stream Name	Date of Full Impact	Targets	Overall Project Owner	Exec Sponsor	Project status	Suggested KPI's	KPI Status	Lockable Work plan received ?	Progress Sheet received ?
Ambulatory Care	July 2013	Increase Number of patients treated in ambulatory care, increase direct referrals to from PC & CC, increase current pathways	Davy Yeung	Dorothy Hosein	Amber	Patients Treated in Ambulatory Care, Direct referrals from PC, No of pathways agreed and documented	Red		Yes
Frail Elderly	01/08/2013		Ayo Ahonkai/Jane Hustler	Dorothy Hosein	Amber	Average LOS for Short stay elderly ward, no of frail elderly admissions, number of re admissions within 30 days	Red		Yes
7 Day Working		Medical NEL LOS at Average, Medical bed flow supports ED demand	Jane Hustler	Mike Gill	Amber				Yes
Care Planning and Discharge			Caroline Moore	Flo Panel Coates	Amber	Re-admission rates, % discharges on day planned, consultant attendance at morning board rounds.			Yes
Estates			Sophie Murphy	Jackie Nugent	Amber				No

KGH ED Weekly Performance 14th April – 21st April

KGH ED performance varied between 86% and 100% over the period of 14th to 21st April 2013

Over the last week* at King George's Hospital we received 1,569 patients in the Emergency Departments, of which 1,511 patients (96.3%) were treated within 4 Hours.

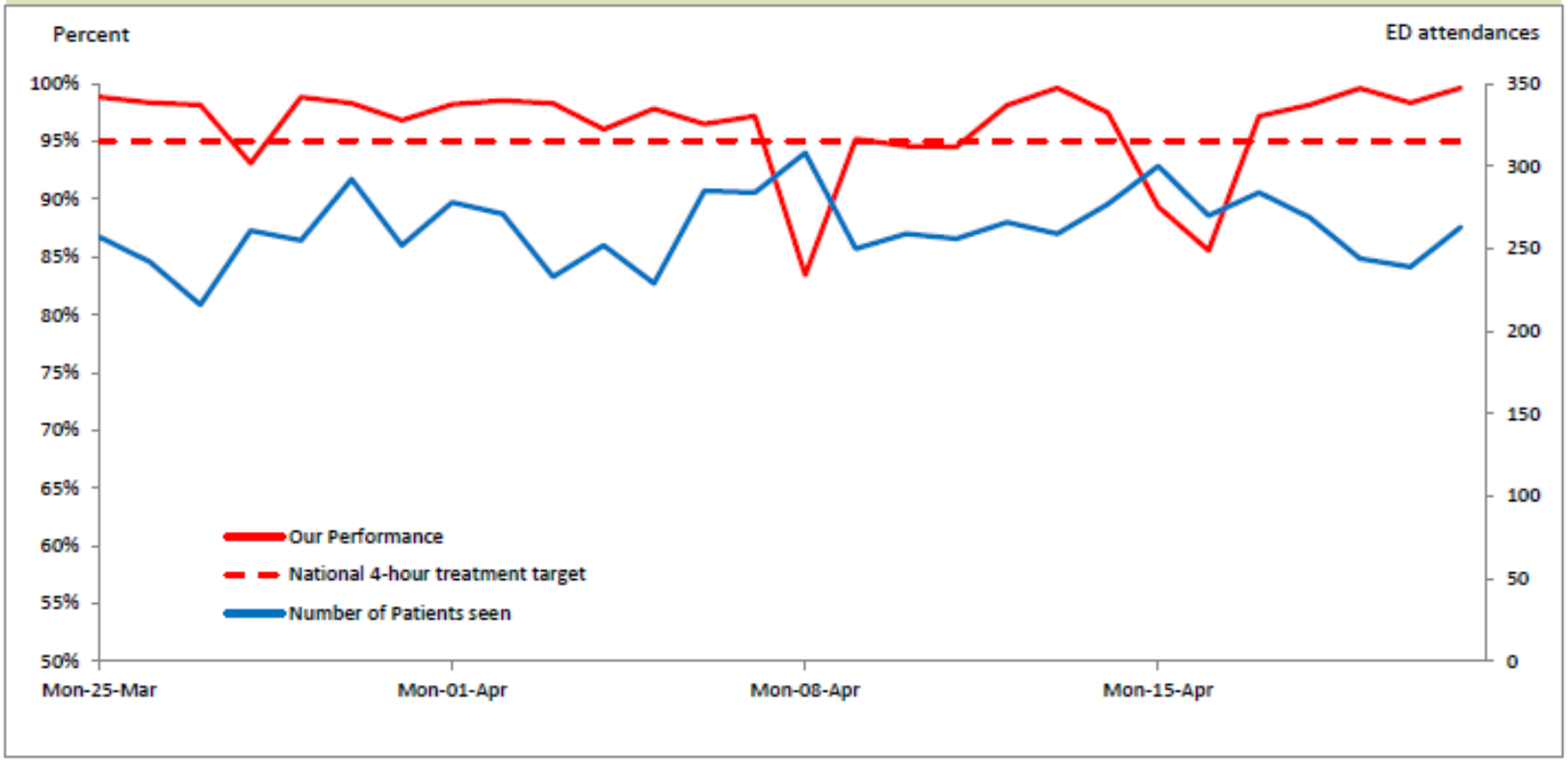


* The week of 16th to 21st April 2013

King George Monthly ED Performance 25th March- 21st April

KGH ED performance varied between 83% and 100% over the period of 25th March to 21st April 2013

Over the last month* at King George's Hospital we received 7,351 patients in the Emergency Departments, of which 7,066 patients (96.1%) were treated within 4 Hours.

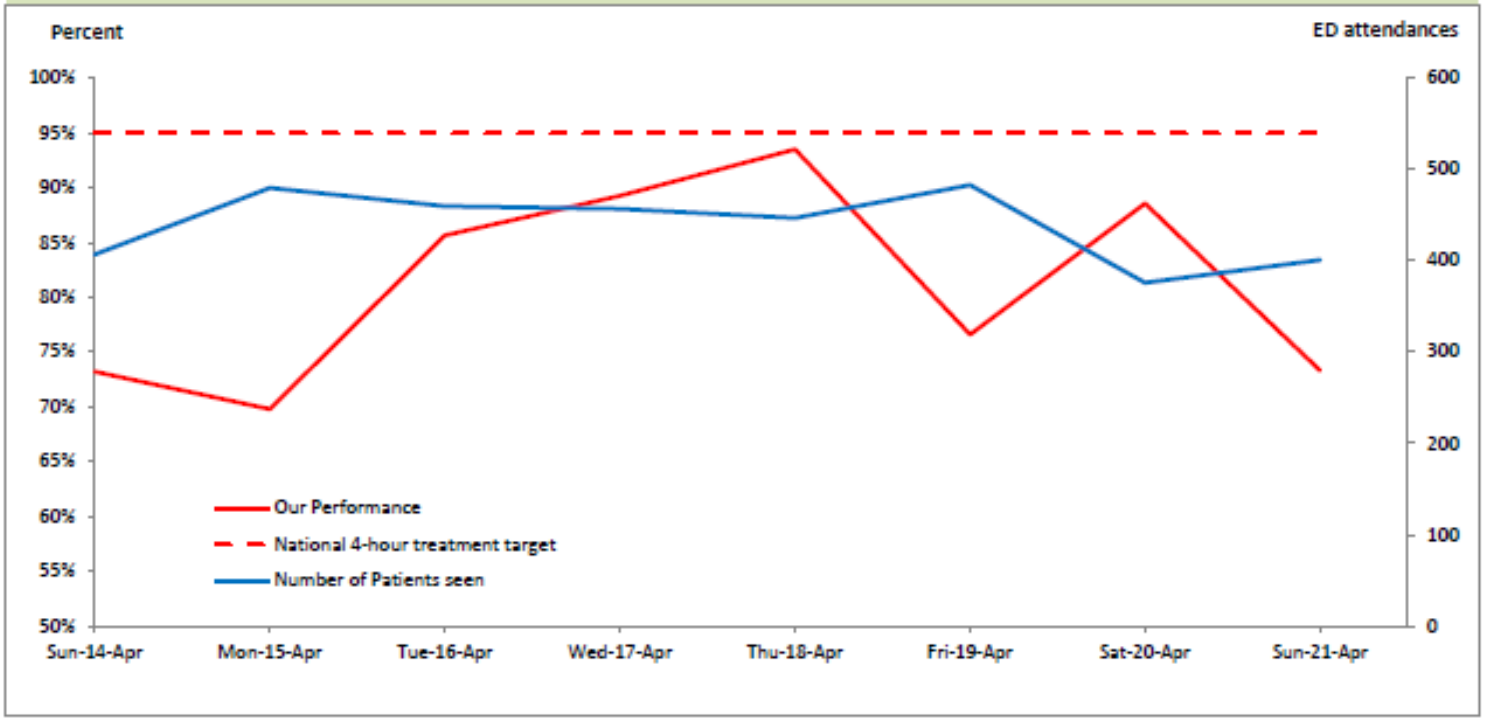


* The month of 25th March to 21st April 2013

QH ED Weekly Performance 14th April – 21st April

QH ED performance varied between 70% and 94% over the period of 14th to 21st April 2013

Over the last week* at Queen's Hospital we received 2,624 patients in the Emergency Departments, of which 2,217 patients (84.5%) were treated within 4 Hours.

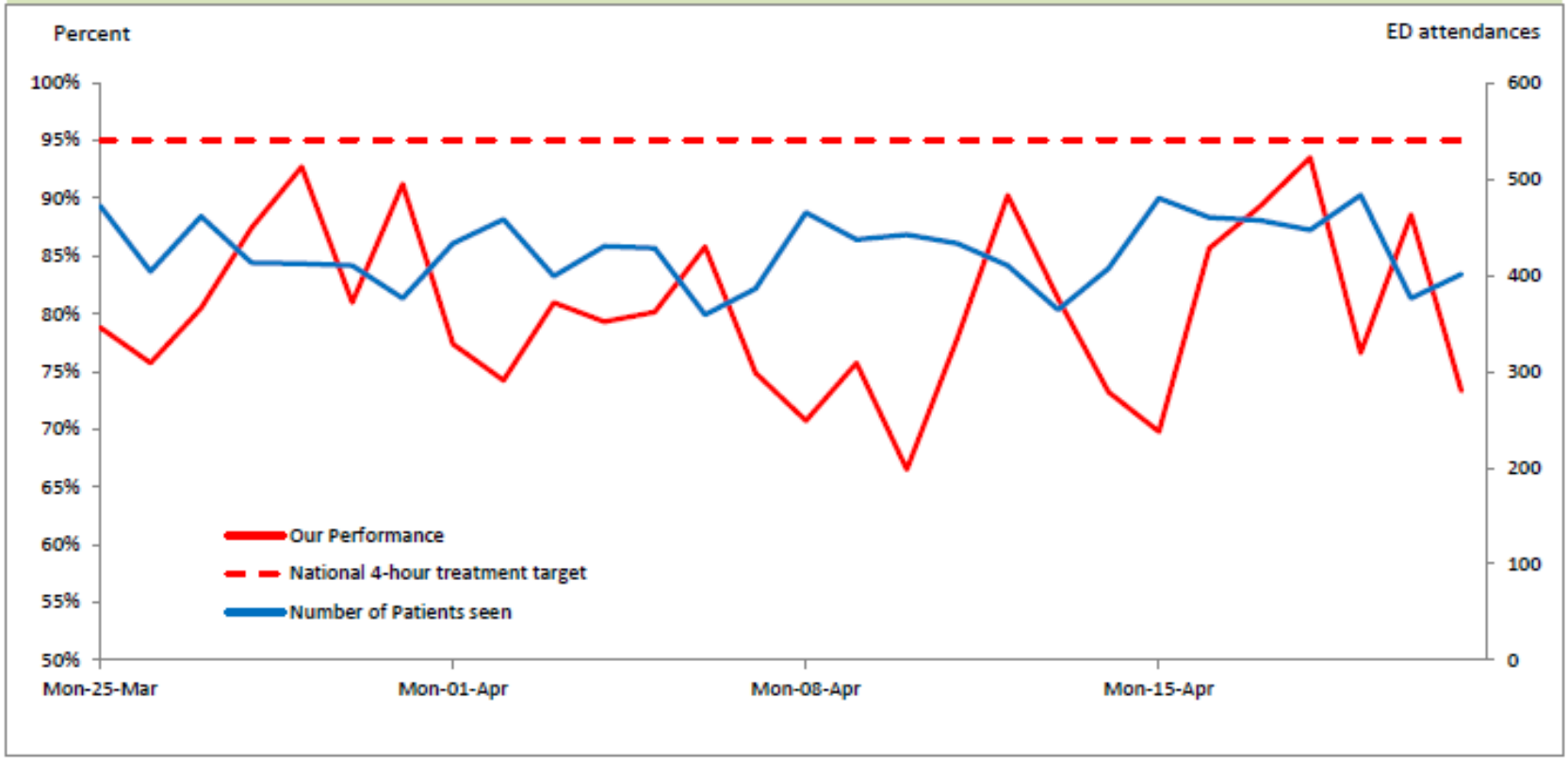


* The week of 16th to 21st April 2013

QH ED Monthly Performance 25th March – 21st April

QH ED performance was below the National Target over the period of 25th March to 21st April 2013

Over the last month* at Queen's Hospital we received 11,903 patients in the Emergency Departments, of which 9,553 patients (80.3%) were treated within 4 Hours.



* The month of 25th March to 21st April 2013

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Quality and Patient Standards Performance Report – March 2013	**Trust Board**
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
The Quality and Patient Standards Performance Report provides an analysis of performance against trust-wide and national targets for the following domains: • Patient Safety and Quality • Performance • Workforce • Productivity • Finance A number of additional indicators have been included following a review of the Dashboard by the Patient Safety and Quality Committee The following areas where monthly performance is of concern discussed within the report • **SHMI** • **Maternal deaths** • **MRSA** • **Clostridium difficile toxin-positive stools** • **MRSA Screening – elective and emergency** • **Dementia assessments** • **%Patients assessed as risk free** • **Grade 4 pressure ulcers** • **Number of falls resulting is serious harm** • **Elective Re-admissions <30 days** • **Non-elective Re-admissions <30 days** • **% patients completing a discharge survey** • **Same sex breaches** • **RTT - delivery in all specialties** • **Cancer targets** • **Emergency Department Targets** • **Workforce targets** • **Length of Stay (LoS) – non elective** • **% Patients Discharged Between 6 am and 11am** • **Goal Directed Fluid Therapy for Emergency Abdominal Patients** • **DNA Rates** This report includes the key actions that are being undertaken to bring performance back in line within target.	□ **PEQ**……..…… □ **STRATEGY**…….…… □ **FINANCE** ……..…… □ **AUDIT** ……..……..….. □ **CLINICAL GOVERNANCE** ……..……..…… □ **CHARITABLE FUNDS** ……..….. ☑ **TRUST BOARD – April 2013** □ **REMUNERATION** ……..….. □ **OTHER** ……..…… (please specify)

2. DECISION REQUIRED:	CATEGORY:
The Trust Board is asked to note the content of the report and support the actions to bring the performance back in line with trajectory/target.	☑ **NATIONAL TARGET** □ **CNST** □ **CQC REGISTRATION** □ **HEALTH & SAFETY** □ **ASSURANCE FRAMEWORK** ☑ **CQUIN/TARGET FROM COMMISSIONERS** □ **CORPORATE OBJECTIVE ……....** □ **OTHER ……..** (please specify)
	AUTHOR: Claire Burns, Head of Planning, Commissioning and Information **PRESENTER:** Neill Moloney, Director of Delivery
	DATE: April 2013

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

4. DELIVERABLES
The delivery of the Trust wide objectives.

5. KEY PERFORMANCE INDICATORS
Please see attached Trust Performance Dashboard.

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

Performance Report
March 2013
Performance Indicators - Exception Report

1. Introduction

This report provides the Board with an overview of mitigating actions identified by the Business Units to improve performance such that it brings it back into line with target. Finance and Human Resources performance are subject to separate reports to the Trust Board.

2. Patient Safety and Quality

SHMI – A deeper review of the current SHMI data has been completed and there are three elements which require deep dive review, these are deaths associated with pneumonia, septicaemia and some cancers. The review of cancer deaths is underway and the other two elements are commencing in May. The increased level of deaths associated with acute myocardial infarction has already been audited and the excess found to be related to a paucity of clinical information in the notes by which to code co-morbidities. It has been agreed that all deaths will be discussed with a consultant before completion of the death certificate in order to ensure that appropriate information is recorded.

Each Clinical Director and team is now able to review their data with the aid of CHKS data which will provide any early warning of outlier status. This is part of each Directorate dashboard reported to the Quality and Safety Committee. Progress to seven day working which includes improved seven day critical care outreach, better availability of specialist consultant support and bed reconfiguration is planned over the summer and will further improve our quality and safety and thus SHMI.

Maternal death rate (rolling 12months) - There was a maternal death in March as a result of a pregnancy induced heart condition (Cardio-myopathy). The woman booked late at 24 weeks for her pregnancy as she was an entrant from another country, and therefore treated as high risk. Patient treated appropriately; referred to a cardiologist, transferred to ITU in January 2013 stabilised and transferred to the Brompton CCU, ITU where the baby was delivered. The patient had complete heart failure and died at Harefield hospital in March 2013.

MRSA bloodstream isolates
In March there was an MRSA bloodstream isolate **(**BSI) this was the ninth case for the trust. A full root cause analysis was undertaken and an action plan is in place. During 2012-2013 the Trust was over trajectory by two cases. There is a zero tolerance for 2013-2014.

This case was in fact a blood culture contaminant, the junior medical staff member who took the blood culture had joined the trust outside of the usually start dates and had missed ANTT training. This gap is being addressed with the training department.

The key elements of the Infection Control Strategy & Action Plan to be tackled in 2013/14 are:

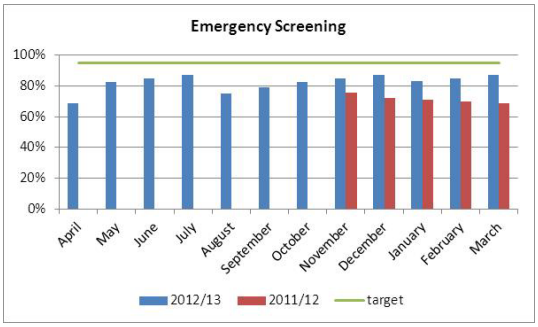
- Improving clinical leadership and ownership of infection prevention and control. The Clinical Directors will be provided with much more information on directorate performance against key parameters e.g. hand hygiene and they will be expected to lead improvements
- Utilising the data from the analyses of blood cultures for MRSA taken in 2012 and 2011, the following are themes are to be addressed:
    - Blood culture contamination

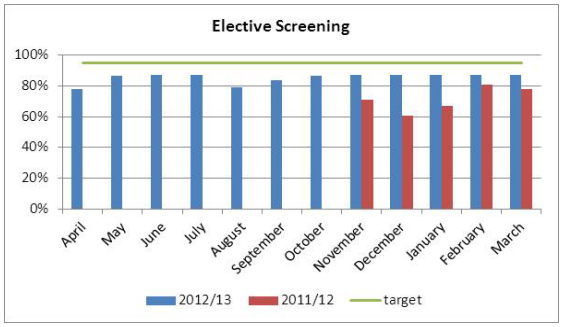
- Blood cultures not being drawn on admission and then drawn after 48 hours in hospital
- Insufficient MRSA screening
- Application of biomass reducing/ decolonising strategies.
- Insertion and care of vascular access devices.
- Urinary Tract Catheterisation
- Laboratory validation of data
- Flagging patients known to be MRSA colonised
- Soft-Tissue Care.

Clostridium difficile toxin-positive stools - In March there were three cases of hospital-acquired clostridium difficile toxin-positive stools (2 within the surgical directorate and one within specialist medicine). The trust completed 2012-2013 over trajectory by six (65 against a target of 59).The trust target for 2013-2014 is no more than 40.

In order to reduce the number of inappropriate faecal samples being taken the Director of Infection Prevention and Control has re-enforced to all clinical staff, via e-mail, when faecal samples should be sent for investigation.

MRSA Elective and emergency screening - A task and finish group established by the Chief Operating Officer with membership including an Associate Director of Operations (ADO),



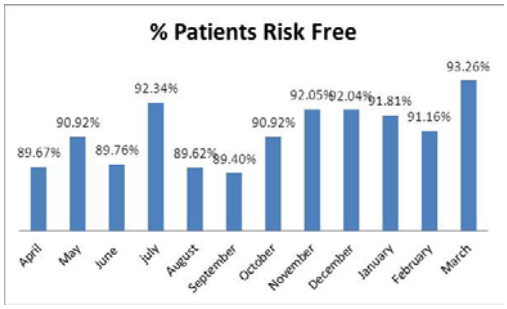


Information Lead and Infection Prevention & Control Lead is currently addressing the need for rapid feedback of information on MRSA screening to all wards in order to drive improvement in MRSA screening. It is expected that this work will be completed by the end of April 2013.

Dementia assessments – The introduction of the new Dementia Pathway pilot has introduced a new form to simplify the data collection. This has been supported by a focused drive by all departments to improve patient screening for dementia. This has resulted in a significant improvement in the % of patients having a mental test score from February (64%) to March (74%). Across the Trust there have also been various 'ad hoc' mechanisms in place to manage the screening process which has lacked a systematic approach leading to poor performance. The new pathway will significantly help to improve this.

% Patients assessed as risk free –This indicator measures the % of patients free from four harms:

- Venous Thromboembolism
- Catheter associated urinary tract infections
- Falls resulting in harm
- Category 3 and 4 pressure ulcers



The March data shows an increase in the trust overall position and the highest score to date of 93.26%. Improvements were noted in 15 of the 51 clinical areas and 24 areas maintained their previous achievement. 33 of the 51 areas achieved over 95%. The Women

and Children's directorates achieved above 95% across all areas, with areas achieving less than 95% being spread across the remaining directorates. Acute medicine has the largest number of areas achieving less than 95%.

Falls and pressure ulcers remain the key issues affecting the achievement of the target and the trust remains focussed on reducing these. Monthly monitoring continues across all wards and departments. Learning is being shared across the nursing team through the Energising for Excellence group and the Nursing, Midwifery & Allied Health Professionals Steering Group.

Pressure Ulcers (Grade 4) - In March 2013 there were two grade-3 hospital acquired pressure ulcers reported as serious incidents and one grade-4 pressure ulcer; these were all at Queen's Hospital. The three root cause analysis (RCA) investigations have been completed. Two of the incidents concerned the same ward (Sahara B).

All of these RCA's have been presented to the Pressure Ulcer Review Panel and all were found to have been avoidable. In all cases ward staff had failed to follow the Trust protocol regarding prevention and management of pressure ulcers and the SKIN Pathway had not been adhered to. The panel challenged the staff presenting the investigations and discussed areas within investigation that were causes for concern. Staff were asked to give details of current practice on the ward and strategies for addressing these issues were agreed and added to the action plan, if they had not already been included. The matron responsible for the ward area is held responsible for ensuring that the action plan is implemented and amalgamating the evidence to show progress.

A round table meeting was held for Sahara B ward concerning the two incidents in their area, which included the grade-4 pressure ulcer. Following this meeting an action plan was put in place which is being closely monitored by the ward matron who is working with the senior sister to ensure that avoidable pressure ulcers do not occur in the future. The tissue viability team have been involved with further teaching of ward staff and will monitor referrals from the ward closely. Where problems are identified these will be immediately brought to the attention of the ward's senior sister and matron.

The Trust action plan for the prevention and management of pressure ulcers is being implemented and the tissue viability team are actively working to reduce hospital acquired pressure ulcers across the Trust.

Number of falls resulting in serious harm – There has been an increase in the total number of falls reported, from 167 in February to 173 in March. The number of falls that have resulted in serious harm to the patients during March was four, the same number reported in both January and February 2013. Investigations into the falls are underway in line with the trust's Serious Incident Policy. An application to the local Clinical Commissioning Group has been made for the de-escalation of one of the four falls as, upon investigation by the Trust, this no longer classifies as a Serious Incident (SI). Following an SI investigation an action plan has been agreed for the ward and monitored by the falls SI panel. Recurring incident themes are added to the trust wide action plan.

The Trust-wide action plan has prioritised the following, which were identified during the root cause analysis (RCA):

- Reviewing the falls risk assessment and pathway. The aim is to simplify both tools to aid completion and consider how medication review and fluctuating/overnight confusion can be incorporated earlier in the risk assessment process.
- Further review of the closed RCA action plans for the period January - February 2013 in order to ensure that actions identified in the original RCA action plans have been completed within the agreed timescales, and where necessary appropriate performance management has been undertaken.

- All new RCA investigations are being reviewed by the Falls SI Panel. The purpose of the meeting is to review the findings of the RCA, hold clinical staff to account, identify any lessons learnt, and drive the closure of the RCA action plans.

% Patients completing a discharge survey – Adult inpatients **-** During March a total of 1,921 surveys were received from adult inpatients and maternity. Unfortunately, even though the number surveys received during March had increased, so had the number of discharges resulting in coverage of 44%. The friends and family test (FFT) score was 33 and positive recommendations were 87%. In February a total of 1635 adult inpatients and maternity surveys were received compared with 3938 discharges, providing coverage was 40%. The FFT score was 39 and positive recommendations were 85%. Further investigation shows the drop of survey coverage during March was largely due to the increase in patient discharges. However, absences within the patient experience team exacerbated the issue with weekly reporting not being made available to ward staff. Arrangements have since been put in place to ensure wards will continue to be provided with weekly results detailing the number of survey forms submitted against discharges. Ward sisters of those wards identified as scoring under the 50% coverage target will be required to attend with their matron the monthly divisional performance meeting to explain their action plan for meeting the coverage target.

Increasing FFT and positive recommendations - Posters have been displayed in ward areas to highlight the top three responses received from patient surveys. The bottom three responses are also detailed together with an explanation on how the ward plans to address this. This will positively encourage discussion of surveys results by ward nursing staff and raise awareness of the improvements needed in each areas with regards to patient experience.
The patient experience work stream is currently under review by the Director of Nursing. Two band 6 patient experience facilitators are in the process of being recruited to provide assistance to the wards and departments helping them to identify their issues and supporting their action plans for improvements. Initial results demonstrate that BHRUT is uploading the most patient experience responses to UNIFY2 within the London area. Once national data is available, the Trust will be able to compare its results with to others in the cluster.

A&E Patient Experience Surveys **-** During March 440 patient experience surveys were received, providing 3% coverage. The FFT score was 15 and positive recommendations were 77%.This is a reduction on the February data when 873 A&E patient experience surveys were received, providing a total of 7% coverage. A&E has now been provided with extra staffing resource to ensure that the coverage is increased. The expected coverage target for this area is 15%. There is an A&E improving the patient experience plan which focuses on improving the survey coverage, scores and feedback. The National Patient Champion is working with A&E staff to increase positive recommendations.

Single sex breaches - There were 14 single sex breaches for the month of March 2013. Twelve of the breaches occurred in the General ITU Department at Queen's Hospital and two breaches occurred in the General ITU Department at King George's Hospital. All of the breaches occurred due to delays in the transfer out of patients who had been 'stepped down' to general care. This was due to constraints on the availability of suitable beds for step down due to patient flow delays across the organisation. A Root Cause Analysis is completed on all patients, and the reason for the breach is fully explained to the patient.

The Trust has been asked to re-commence reporting the single sex breaches which occur in ITU and HDU.

3. Performance

Referral to treatment (RTT), delivery in all specialties – The trust continues to work with commissioners to develop a plan to clear the patients on the 18 week backlog list. Clearing this list would support specialties in delivering the target at specialty level.

Cancer targets – The Trust under-achieved the 62-day target for February at 83.4%; year to date we are still achieving the target at 85.41%.The poor performance is mainly due to low number of treatments being completed in breast and gynaecology. Although the trust has little control over these, because they are usually the patients that are referred into the Trust via pathways other than the '2 week wait' pathway (these are mostly in breast and gynaecology), we are trying to influence performance through:

- Going out to GPs and providing an education programme
- Working with GPs and others on early diagnosis initiatives.

Other breaches that occurred were in breast (1 breach), lung (3 breaches), lower GI (3 breaches), and gynaecology (0.5 breaches). These breaches occurred mainly due to slow pathways where appointments and tests within specialties are usually at the end of the 2 week window. The Service is trying to escalate and encourage bookings to take place much earlier, ideally at the beginning of the 2 weeks, which may mean overbooking clinics. The Service are working with specialties to enable this preferably with 'hot' slots to accommodate, if possible. There were some breaches due to complex pathways and patients who were difficult to diagnose. The 15% tolerance allows for this and it is the other pathways that the Service needs to focus on to ensure that the tolerance is for the appropriate pathways.

A breakdown of the breaches is circulated to the general managers (GMs) and service managers (SMs) for the relevant tumour sites so that they can identify with the multi-disciplinary team (MDT) where the delays are early in the patient pathway. Delays should be escalating to the appropriate ADO and CD; however there is evidence that this has not always the case and will be remedied for the future. Therefore the weekly trajectory sent to the Executives and information department will now be more widely circulated so all Directorates can see what action needs to be taken to improve the cancer wait time (CWT) for their specialties.

Each of these specialties has been asked to submit an action plan, signed off by their ADO and CD for improving their performance for March and going forward into the new financial year. There will also be a trust action plan to ensure that pathology and radiology are supporting the pathways for the MDTs. Pathology now highlight where specimens are not flagged as 2ww samples and this will be fed back to the MDTs, GMs and SMs. .

Four hour wait in A&E – The Trust failed to meet the 95% standard in March 2013 however a slight improvement of performance from 82.51% in February to 86.41% in March. There was significant pressure on bed flow throughout March 2013 despite a number of initiatives being implemented in February including:

- the development of a GP receiving area on MAU
- the introduction of GP RATing
- focus on patient flow within the emergency department (ED) department.

These initiatives remain and the service are further developing the models and embedding new pathways in practice to improve patient flow within the department.

From April 2013 new initiatives have been added to the improvement programme:

- an improved portering system to ensure patients are transferred from the department without delay
- a consultant led 'time and motion study' of RATing to ensure the working environment is efficient and enables a faster throughput of patients
- the introduction of a Symphony navigator which will strength the clinical and leadership roles of the overall in-charge nurse and the board nurse.

The department has welcomed input from an experienced Director of Nursing for Emergency Care who is helping the team to identify further improvements to the operational working of the department.

% Patients seen by speciality team within < 30 minutes of request – In March 27.38% of patients were seen by the specialty within 30 minutes following referral at KGH an upward trajectory since January. For QH 10.48% of patients were reviewed with 30 minutes. The slight decrease in performance is disappointing given a range of initiatives which commenced in February. A review is being undertaken of the data collection process to ensure that there is accurate reporting against this measure.

4. Workforce

Staff turnover - Turnover levels of staff in post have increased to 12.9% in March from 12.3% in February. Several divisions (Corporate, Emergency Care and Women) demonstrate a particularly high volume of leavers in March. Further investigation identified that 16 of the 25.8 leavers identified in the corporate division are student midwives completing their training programme and 3 clinical fellows completing the clinical leadership programme. The Womens BU also has an abnormally high volume of retirees (6fte) in month which has also had an impact on their monthly turnover rates.
Annualised turnover rates identify "hotspots" in:

- Emergency Care 27.4%
- Women 16.3%
- Corporate 16.3%

Turnover within all divisions will continue to be reviewed via performance meetings with new data available from January 2013 to demonstrate where high turnover is also exacerbated by low stability i.e. proportion of leavers in month with less than 12 months service.

Divisions are supported by HR managers to identify underlying drivers of high turnover and assist with developing strategies to improve stability and ensure the vacancy factor is manageable.

Sickness absence – The overall level of sickness absence has continued to decrease for the fourth consecutive month with a 0.5 % overall reduction most notably driven by a 0.4% reduction in long term sickness absence. Sickness absence remains high on the HR agenda with a newly revised sickness absence policy and improved reporting capability. eRostering continues to improve the accuracy of data capture and reporting capability with all clinical areas is now live and interfaced to ESR. Those areas that currently use a manual sickness return procedure are monitored closely by the HR department to ensure prompt and accurate submission.

The fully revised Sickness Absence policy to support the on-going management of sickness absence is now live and has been received well within the organisation. The comprehensive communications strategy applied to ensure managers were aware of the key changes included formal seminar format briefing sessions which were attended by 89 line managers and receive positive feedback.
Key changes within the policy include:

- Revised Bradford score trigger
- Reduction in monitoring periods
- Reduction in paid phased return to work entitlement
- Clarified and simplified management process

Appraisals (rolling 12mnts) –. Appraisal rates have continued to increase steadily over the last quarter with a further increase of 2.2% in March. The current appraisal compliance rate across the Trust is 77.4%.
Performance figures across the Clinical Directorates for March are:

- Diagnostic & Specialist medicine and Neurosciences 77.8%
- Emergency & Acute Medicine 66%
- Surgical Services 85.4%
- Women, Children & Support Services 82.5%
- Corporate Directorate 46.5%

Corporate areas have increased from 42.6% in February to 46.5% in March however the corporate division still remain very much below target. There is no one area within the corporate directorate that can be identified as a specific outlier. There are many single post holders within Corporate who, due to management restructures, are waiting on new objectives to be set and an

appraisal undertaken by their new line manager. On review of the corporate areas, there are planned dates in place for outstanding appraisals. An appraisal lead has not yet been identified in each Directorate but will be in advance of the update and re-launch of the trust's appraisal policy originally planned for February although now to be included in the organisational development strategy plan. All corporate leads will be sent a list of their staff with the reminder for appraisal to be completed.

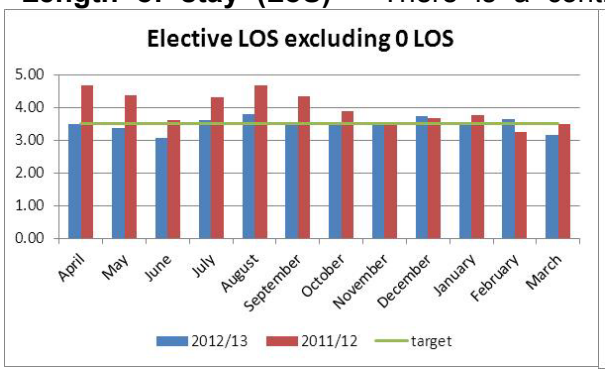
Basic life support training (BLS) - Resuscitation training compliance for the period 1st April 2012 – 31st March 2014 stands at 73.89%. This represents a total of 1024 BHRUT staff who are non-compliant with mandatory resuscitation training. There has been a minimal increase in compliance of 0.53% from the previous report (March '13) but has reduced the projected overall compliance rate for the end of June 2013 to 78.32%, a reduction of 1.47% on the last report based on bookings already made. March bookings appear to be reduced over the previous month, possibly due to the late winter bed pressures in the clinical areas preventing the release of staff for training.

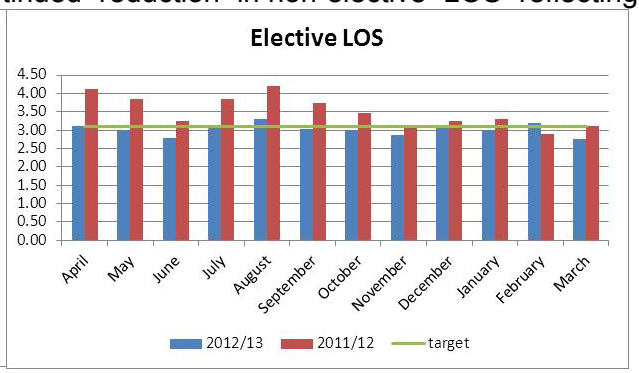
Actions undertaken to improve performance include:

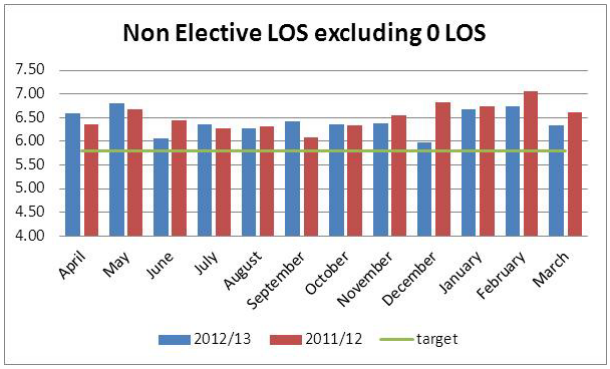
- Monthly compliance reports continue to be sent to the business units to highlight those staff that still need to book onto training as well as outlining actual and projected compliance rates.

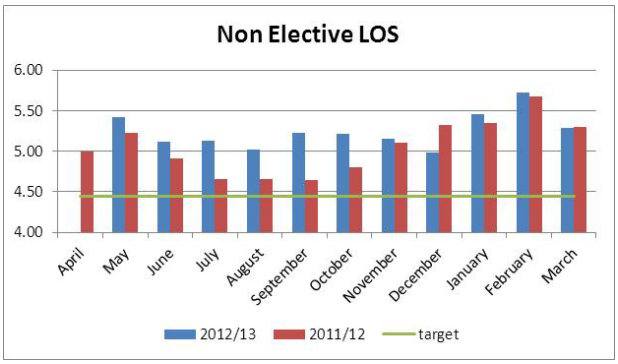
Productivity

Length of stay (LoS) – There is a continued reduction in non-elective LOS reflecting the









continued work streams focusing on acute assessment, frail elderly and ward discharge planning. In March the frail elderly liaison service was enhanced and winter monies utilised to provide a seven day service. Embedding this service is one of the on-going emergency care work streams. In addition Sky ward was reorganised to become a short stay elderly care assessment ward with a target LOS of 4-5 days. Currently a reduction from 9 to 7.5 days has been achieved.

The GP unit has been maintained as an assessment area however usage is varied and work is being undertaken to ensure that there is effective usage via A&E. Further work is required on increasing ambulatory pathways and ensuring these are effectively communicated to GP's.

% Patients discharged between 6am and 11am - Discharges before 11am have deteriorated slightly from 2.7 to 2.1%. Consistency of senior decision makers at ward board rounds has been an issue with high levels of annual leave during this period. The medical division has introduced a daily monitoring system and the clinical leads have been directed to ensure that they have robust plans in place for all periods of leave.

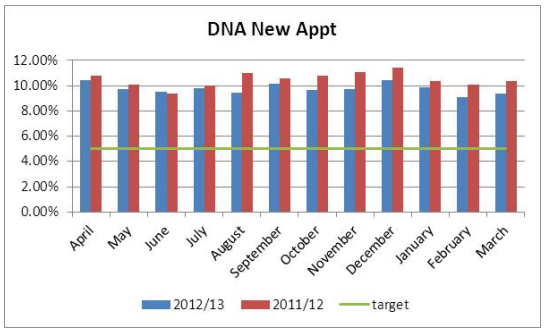
Goal directed fluid therapy (GDFT) for emergency abdominal patients – The elective target has shown a consistent improvement and is now meeting the performance target.
With regard to the emergency laparotomies the following is being undertaken to raise staff awareness:

- The Clinical Lead is contacting all of the anaesthetists who have performed emergency laparotomy cases to ascertain why the case was not indicated for the use of the Doppler.
- A trainer from the company supplying the devices is coming into the trust to attending theatres in order to raise the profile of the devices.

Analysis has shown that there may be double counting issues for repeat laparotomies which require further clarification.

Did not attend (DNA) rates for first and follow-up appointments –The Trust DNA rate for both first and follow up attendances has been fairly static in March from previous months. There has been a falling trend noted for the last 3 months.

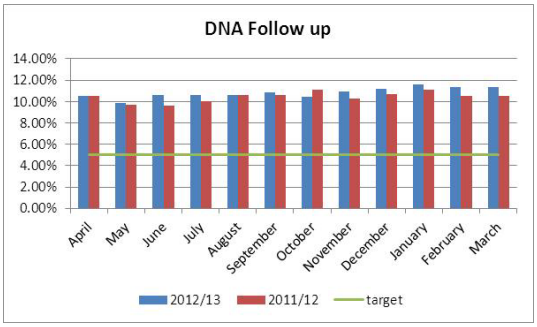
Results of the DNA audits completed in various specialties are as follows. Patients informed us that they did not attend because:



- Appointment letter not received
- Appointment rescheduled and changed so many times that patients don't know when to come
- Did not need to come – informed consultant secretary, but Trust staff didn't update PAS
- Did not come as appointment time was not suitable and patient felt well – didn't see the point of the consultation

DNA reduction initiatives in response to the above audit:

- Validation of inclusion and exclusion criteria for outpatient clinic codes linked to the Envoy messaging service – completed this month.
- Wording of the text message changed to make it less confusing – message now specifies Children's Appointment.
- Recorded message that patients were getting when they call switchboard was directing them to medical secretaries – this has been changed to redirect to the Appointments centre so that all patient cancellations are updated on PAS and slots utilised
- Appointment letter templates now have a standard paragraph on DNAs
- DNA message on TV screens in outpatient waiting areas to 'go live' next month, this is linked to the Savience Check- in Kiosks
- My Mail pilot will enable the trust to stop duplicate letters being sent out – this will help in reducing confusion. This is not yet up and running as we are still resolving problems with firewall issues.



Further work to be initiated with Associate Director of Operations (ADOs) and General Managers of specialties with high DNA rates as data analysis shows that there is a direct correlation between a high follow up ratio and DNAs. This data is available at consultant level on a monthly basis and will be shared with the relevant consultants for their opinion on why this is the case and whether telephone follow ups or giving patients an option to call and book an appointment if they need to see a consultant would help reduce DNA's.

Patient Safety and Quality

	Jan	Feb	March	Target	red
Reducing hospital mortality					
SHMI quarterly (latest July 2011/June 2012)	97.50	97.50	97.50	95.00	100.10
% emergency admitted patients review by senior clinician within 12 hours				95%	94%
% emergency admitted patients review by consultant within 12 hours				95%	94%
Maternal Death Rate per 100000 (rolling 12 m)	0.00	0.00	11.35	TBA	TBA
Serious Untoward Incidents					
Number	17	14	15		
% reported within 48Hours - quarterly	91%			50%	49%
Infection Control					
MRSA Bloodstream Isolates	9 YTD			7	
C Diff Toxic Positive Stools	65 YTD			59	44
At period end - number of days since last reported MRSA	127	155	18	52	0
At period end - number of days since last reported Cdif	6	3	9	7	0
MRSA Elective Screening	87%	88%	87%	95%	86%
MRSA Emergency Screening	83%	85%	87%	95%	86%
Complaints					
number of complaints received	91	72	70	TBA	TBA
% complaints responded to in line with agreement with patients	34.00%	93.00%	81.00%	80%	79%
Total number of complaints open	188	188	182	TBA	TBA
Number of complaints open over 90 days	33	36	27	TBA	TBA
Dementia					
% patients aged over 75 having a mental test score	68%	64%	74%	90%	89%
% patients with a mental test score of less than 8 has a dementia assessment	82%	84%	84%	90%	89%
% patients assessment as at risk of dementia referred to specialist services	96%	97%	94%	90%	85%
eligible patients screened using the patient safety thermometer tool	100%	100%	100%	100%	99%
% patients assessed as risk free	91.81%	91.16%	93.26%	95%	85.50%
% patients having a VTE risk assessment	96%	96%	95%	90%	80%
number of grade 3 pressure ulcers	3	4	2	3	4
number of grade 4 pressure ulcers	0	0	1	0	1
number of falls resulting in serious harm	4	4	2	0	0
emergency readmissions					
% patients readmitted as an emergency within 30 days of an elective stay**	3.22%	3.33%	3.65%	2.21%	2.43%
% patients readmitted as an emergency within 30 days of an emergency stay**	14.13%	13.79%	15.33%	9.38%	10.32%
** Dec-Feb data reported					
Cancer					
% new cancer patients with stage of tumour recorded at diagnosis				70%	69%
% patients who die in hospital who are on the Liverpool care pathway	36%	27%	31%	30%	29%
Patient Experience					
% patients completing a discharge survey	51%	40%	44%	50%	45%
% patients would recommend trust to friend and relatives (no longer current)	87%	85%	87%	85%	69%
Friends and family test	31	39	33	tba	tba
number of same sex breaches	10	8	14	0	0

Performance

	Jan	Feb	March	Target	red
Referral to Treatment					
% untreated waiting less than 18 weeks	92.30%	92.50%	92.10%	92%	87%
RTT admitted in 18 weeks	90.10%	92.10%	92.20%	90%	85%
RTT non-admitted in 18 weeks	98.80%	99.20%	98.90%	95%	90%
RTT not delivered in all specialties	5	8	5	0	>20
Cancer					
2 Wk. % seen all urgent refs & ref for breast	97.9%	97.2%	97.2%	93%	88%
2 Wk. GP RefTo 1st OP for susp cancer	97.8%	97.7%	97.8%	93%	88%
2 Wk GP Ref To 1st OP for breast symptoms	98.8%	94.8%	94.3%	93%	88%
31 Day 2nd Or Subs Treatment - Surgery	100.0%	100.0%	100.0%	94%	89%
31 Day 2nd Or Subs Treatment - Drug	95.2%	100.0%	100.0%	98%	93%
31 Day DTT for all cancers	98.8%	100.0%	99.4%	96%	91%
62 Day RTT From Cancer Screening*	90.9%	93.8%	100.0%	90%	85%
62 Days - treated from referral *	88.0%	86.2%	87.6%	86%	80%
62 Day RTT From Hosp Specialist*	87.5%	90.0%	100.0%	85%	80%
62 Days Urgent RTT of all cancers*	87.8%	84.3%	83.4%	85%	80%
31 Day Subs Treatment - Radiotherapy	100.0%	100.0%	100.0%	94%	89%

** fully validated data provided one month in arrears* ***Dec-Feb data reported***

A&E					
Four-Hour Maximum Wait In A&E	83.57%	82.51%	86.40%	95%	94%
Percentage of patients referred to speciality team <2hrs of registration	46.19%	49.32%	51.64%	50%	48%
Percentage of patients seen by specialty team <30min of req. (Queens)	10.24%	11.91%	10.48%	80%	50%
Percentage of patients seen by specialty team <30min of req. (KGH)	23.39%	25.23%	27.38%	80%	50%
Number of ambulance black breaches	10	7	0	0	1
screening					
Cervical Screening - Lab Results Within 2 Weeks	100%	100%	100%	98%	97%
Cervical Screening - Results Within 2 Weeks (GP to PCT)	99%	98%	99%	98%	97%
% Women who have seen a midwife within 12 wks	92%	92%	91%	90%	89%
Diagnostics					
% patients waiting over 6 weeks	0.2%	0.4%	0.3%	<1%	5.00%
workforce					
	Jan	Feb	March	Target	red
Staff Turnover (12mnt rolling from Sept)	12.23%	12.33%	12.92%	12%	13.20%
Sickness Absence	4.95%	4.92%	4.38%	3.60%	3.96%
Appraisals (12 mth rolling)	73.88%	75.19%	77.39%	80%	69%
Basic Life Support Training (12 mth rolling)	72.68%	73.36%	73.89%	80%	69%

KEY			
data not available		achieving target	
less than 10% worse than target		10% or more worse than target	

Productivity

	Jan	Feb	March	Target	Red
Inpatients					
LOS (Elective)	3.00	3.20	2.77	3.10	3.48
LOS (Non-Elective)	5.46	5.72	5.29	4.45	5.05
LOS (Elective- excluding 0 LOS)	3.52	3.63	3.15	3.50	3.92
LOS (Non- Elective-excluding 0 LOS)	6.67	6.73	6.33	5.8	6.53
% Day case rate - All	89%	89%	88%	80%	75%
DTOC	2.24	1.38	1.65	3.50%	5.00%
admissions on day of surgery	92.42%	94.59%	96.02%	85%	80%
% patients discharged between 6 am and 11 am	10.69%	10.83%	9.80%	20%	18%
Enhanced Recovery					
% patients with an ERP code entered onto the national database*	100%	100%	100%	95%	95%
% planned colorectal having GDFT*	86%	86%	88%	80%	80%
% emergency abdominal patients having GDFT*	74%	63%	61%	80%	80%

**one month in arrears*

Outpatients					
FFU Ratio	2.17	2.19	2.08	2.16	2.20
DNA First	9.90%	9.09%	9.35%	5.00%	5.50%
DNA Follow-Up	11.64%	11.38%	11.37%	5.00%	5.50%

Finance

	Jan(YTD)	Feb(YTD)	March(YTD)	Target	Red
Initial Planning	-9.4%	-9.4%	-16.3%	3%	-2%
YtoD - operating performance	-2.8%	-3.1%	-3.2%	3%	-2%
YtoD - EBITDA	-0.1%	-0.2%	0.1%	5%	1%
Forecast Op Performance	9.4%	9.4%	9.4%	3%	2%
Forecast EBITDA	0.3%	0.3%	0.3%	5%	1%
Forecast change surplus/deficit outturn	0.0%	0.0%	0.0%	5%	0%
Underlying financial position %	-9.5%	-9.5%	-9.5%	0%	-2%
EBITDA Margin %	0.0%	0.0%	0.0%	5%	1%
BPPC Value%	69.7%	70.1%	71.7%	95%	60%
BPPV Volume %	54.0%	55.6%	58.9%	95%	60%
Current Ratio	71.9%	84.8%	72.8%	100%	50%
Debtor Days	20	28	11	30	60
Credit Days	24.69	21.07	9.79	30	60
Control Total	106.1%	99.8%	98.9%	100%	100%
Performance against CIP	65.2%	67.8%	81.6%	100%	95%
Income variance against plan	103.3%	104.0%	105.1%	100%	100%

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
National Inpatient Survey - 2012	**Trust Board**
1. PURPOSE:	**REVIEWED & DATE**
Background The findings from the 2012 National Inpatient Survey for Barking, Havering and Redbridge University Hospitals NHS Trust were published by the Care Quality Commission on the 16th April 2013. The survey is part of a national survey programme carried out independently by Quality Health on behalf of the Trust. The survey asked the views of 850 adults who had stayed overnight as an inpatient during the period 31st June - 23rd July 2012. The inpatients were asked what they thought about different aspects of the care and treatment they received at Queen's and King George Hospitals. 379 completed questionnaires were returned from a sample of 850 of BHRUT patients. The final response rate for the Trust was **46%**, which is the same as the 2011 response rate. **Results** The survey of all adult inpatients involved 156 acute and specialist NHS Trusts. For each question in the survey, the individual responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. Trusts are also assigned a category to identify whether their score is 'better', 'about the same' or 'worse' than most of the Trusts that carried out the survey. Out of main ten section scores, the Trust rated worst than other Trusts in England in 6 of the 10 areas as noted below: • The Emergency/A&E Department • The Hospital and the Ward • Nurses • Care and Treatment • Leaving Hospital • Overall Views and Experiences	□ **PEQ ……..…..** □ **STRATEGY……..……** □ **FINANCE ……..……** □ **AUDIT ……..……..…..** □ **CLINICAL GOVERNANCE ……** □ **CHARITABLE FUNDS ……** □ **TRUST BOARD ……** □ **REMUNERATION ……** □ **OTHER ……**(please specify)

Out of the 60 survey questions, BHRUT has shown a statistically significant positive increase compared with the trust's 2011 results in the following areas:

- Confidence and trust in nurses treating the patient
- Nurses not talking in front of the patient as if they weren't there
- A member of staff saying something different to another one
- Hospital staff did everything they would to help control patients pain

A significant decrease is noted in the following area:

- Patients experienced a delayed discharge due to having to wait for medicines/to see a doctor/for an ambulance

The Trust's overall results were rated as 7.3. The lowest Trust score was 7.2, and the highest score was 9.0.

The full survey results are attached in Appendix 1.

Actions

The Trust has failed to make significant progress in a number of the national surveys and must try a different approach. Following a review of the enclosed at the Trust's Executive Committee it was agreed that there would be a drive to improve against the core themes identified from the Inpatient Survey, OPD Survey and Cancer Survey. This will allow a much more focused approach, using real time feedback as an indicator of success locally.

These are being incorporated into a generic action plan and monitored by the Quality & Safety Committee.

(for noting – these themes have already been incorporated into the Emergency Care Improvement Plan).

2. DECISION REQUIRED:	CATEGORY:
For discussion.	□ **NATIONAL TARGET** □ **CNST** * **CQC REGISTRATION (Outcome 7)** □ **HEALTH & SAFETY** □ **ASSURANCE FRAMEWORK** □ **CQUIN/TARGET FROM COMMISSIONERS** □ **CORPORATE OBJECTIVE ……**)
	AUTHOR: **Gary Etheridge, Deputy Director of Nursing** **PRESENTER:** **Flo Panel-Coates, Director of Nursing**
	DATE: 22 April 2013

3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:
Achievement of CQUIN targets.

4. DELIVERABLES
Improved patient experience, which will hopefully improve future National Inpatient Survey results.

5. KEY PERFORMANCE INDICATORS
Improved patient experience, which will hopefully improve future National Inpatient Survey results (compliance with CQC Essential Standards of Quality & Safety). Achievement of CQUIN targets.

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

2012 Inpatient Survey
Benchmark Reports: Q&A

This document is provided to answer some of the questions you may have on the benchmark reports, and on the underlying data. A technical guidance document is also available on the CQC website which goes into further detail on the statistical techniques used to categorise trust scores, and can be found here:
www.cqc.org.uk/Inpatientsurvey2012

Questions and Answers

The Benchmark Reports

What are the red, green and orange sections in the chart?

The coloured bars represent the full range of all trust scores, from the lowest score achieved by a trust to the highest. The orange section in the charts represents the **expected range** for a score for a trust. This is the range within which we would expect a particular trust to score if it performed 'about the same' as most other trusts in the survey. If a score falls above or below the expected range it will be in the 'better' or 'worse' category, represented by green and red areas respectively. The calculation of the expected range takes into account the number of respondents from each trust as well as the scores for all other trusts, and allows us to identify which scores we can confidently say are 'better' or 'worse' than the majority of other trusts (see the technical guidance for more details, available from: **www.cqc.org.uk/Inpatientsurvey2012** and sent to survey trust leads prior to publication).

How do I know which category my trust's score is in if the diamond representing the score appears to be on the threshold in the benchmark charts?

Text to the right of the graphs clearly states if a trust score for a particular question, or section, is 'better' or 'worse' compared with most other trusts that took part in the survey. If there is no text present, the result is 'about the same'.

How do I refer to these scores and categories when reporting on the results for my trust?

We have produced a brief guide on how to refer to the findings when disseminating the scored data. This was provided to survey leads prior to publication, and is available on request from the surveys team at: patient.survey@cqc.org.uk.

About the Scores

Why are the scores presented out of ten?

The scores are presented out of ten to emphasise that they are scores and not percentages. The scores are therefore also exactly the same as the scores that feed into indicators such as CQUIN, though divided by ten.

How are the scores calculated?

For each question in the survey, the **(standardised)** individual responses are converted into scores on a scale of 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the trust is performing. For more detailed information on the methodology, including the scores assigned to each question, please see the technical document.

About the Analysis

What is the 'expected range'?

The better / about the same / worse categories are based on a statistic called the 'expected' range that is calculated for each question for each trust. This is the range within which we would expect a particular trust to score if it performed about the same as most other trusts in the survey. The range takes into account the number of respondents from each trust as well as the distribution of scores for all other trusts, and allows us to identify which scores we can confidently say are 'better' or 'worse' than the majority of other trusts. Analysing the survey information in such a way allows for fairer conclusions to be made in terms of each trust's performance. This approach presents the findings in a way that takes account of all necessary factors, yet is presented in a simple manner.

It is the same analysis technique as applied to the risk ratings in the Quality and Risk Profiles, and is based on identifying outliers through the use of adjusted Z scores. More detail on this is available in the technical document.

Why are the percentage results for all trusts not provided?

The percentage data is provided to trusts for their own information only as it can only be used to understand the results for individual trusts.

It is not suitable to use to make comparisons between trusts because the results are not **standardisedH** meaning that differences in the profiles of respondents are not taken into account. Any differences across trusts that are shown in non-standardised data may be in part due to differences in the characteristics of respondents. We know that age, gender and route of admission are three such characteristics and so we adjust for this in the data to make fairer comparisons across trusts with differing population profiles.

A further advantage of using scored data is that it allows for all response options to be taken into account, rather than looking at just a subset of responses from the question. For example, if you look at the table below, from looking at the 'yes definitely' responses only, you would think that trust A and trust B are performing similarly. However, taking into account the other responses, it may be seen that trust B has the more positive result.

Q32: Were you involved as much as you wanted to be in decisions about your care and treatment?

	Trust A	**Trust B**
Yes definitely	59%	59%
Yes to some extent	10%	39%
No	31%	2%

Scored, standardised data is therefore considered to be the fairest way to include survey data in the Commission's regulatory activities, as well as by the Department of Health for their measures and assessments.

In the past the percentage results or scores have been used to present data in a league table form, or to identify the 'best' or 'worse' trusts. Such use would be misleading and inaccurate, as the differences have not been tested for significance.

Why is the data standardised by the age, gender and method of admission of respondents?

The reason for 'standardising' data is that we know that the views of a respondent can reflect not only their experience of NHS services, but can also relate to certain demographic characteristics, such as their age, sex and method of admission (emergency or elective). For example, older respondents tend to report more positive experiences than younger respondents, and women tend to report less positive experiences than do men. Because the mix of patients varies across trusts (for example, one trust may serve a considerably older population than another), this could potentially lead to the results for a trust appearing better or worse than they would if they had a slightly different profile of patients. To account for this we 'standardise' the data. Standardising data adjusts for these differences and enables the results for trusts with different population profiles to be compared more fairly than could be achieved using non-standardised data.

Why are there no confidence intervals surrounding the score?

As the 'expected range' calculation takes into account the number of respondents at each trust who answer a question, as well as the scores for all other trusts, it is not necessary to present confidence intervals around each score.

Understanding the Data

Why do most trusts appear to be performing 'about the same'?

The expected range is a conservative statistic. It accounts for the possibility that there is variation across trusts for other reasons, aside from differences in trust performance. There may be significant variation between trusts due to certain factors that are not within the trusts' control. The technique used takes this into account, and so if a trust is found to be performing 'better' or 'worse' compared with most other trusts that took part in the survey, you can be really very confident that this is the case and it is extremely unlikely to have occurred by chance.

Even though your trust may appear to be performing 'about the same' compared to most other trusts nationally, the results should still be useful to you locally, for example you may want to:

- Make comparisons to the results from previous surveys to look for questions where you have improved or declined.
- Identify particular areas you may wish to improve on ahead of the next survey
- Compare your results with those of other similar trusts.
- Look at your results by different patient groups to understand their different experiences, for example, by age, gender, ethnic group, etc.
- Undertake follow up activity with patients such as interviews, workshops or focus groups to get more in depth information into areas in which you would like to improve.

Please remember that for points 1-3 above, to do this accurately you should undertake an appropriate **significance test**.

The survey guidance manual provides more information on making use of survey data. The guidance manual is available on the NHS surveys website, please see the further information section.

Why does the number of trusts performing 'better' or 'worse' at each question vary?

It is important to be aware that the ranges of performance on different questions varies and this has an influence on how much a trust needs to differ from the average by, in order to be considered 'better' or 'worse' than the average. This means that the number of trusts to perform 'better' or 'worse' at each question will vary.

Is the lowest scoring trust the worst trust in the country, for each question? And likewise the highest scoring trust the best?

If a trust is in the 'better' or 'worst' category this mean that they are performing either better or worse compared with *most other trusts* that took part in the survey. However, a trust is not necessarily *the best*, or *the wors*t, and this could not be determined without undertaking an appropriate significance test.

If you took the scores and ordered them by size, you would most likely find that the highest and lowest ones would change if you ran the survey again. This is because the scores are estimates – we have only had questionnaires from some patients who had an inpatient stay during the sampling period, not all patients. If another sample of patients were surveyed, and you put the scores in order again, you would find that there would probably be a different trust at the top and at the bottom. By analysing the data the way we have, we can say which trusts are likely to always be above average and those that will always be below average, so they should be looked at as a group, rather than in order of scores. This is the fairest way to present the data as it means that individual trusts are not pulled out as the very 'best' or very 'worst', when that may not be the case and it may be that if all patients were surveyed, different trusts would be shown to be the very 'best' or 'worst'.

The score for one of my questions has gone up but is categorised as 'about the same' yet last year we were 'better'?

When looking at scores within a trust over time, it is important to be aware that they are relative to the performance of other trusts. If, for example, a trust was 'better' for one question, then 'about the same' the following year, it may not indicate an actual decrease in the performance of the trust, but instead may be due to an improvement in many other trusts' scores, leaving the trust to appear more 'average'. Hence it is more useful to look at actual changes in scores year to year.

We are categorised as 'about the same' for a question yet a trust with a slightly lower score than us is categorised as 'better'. Why is this?

The 'expected range' calculation takes into account the number of respondents from each trust as well as the distribution of scores for all other trusts, and allows us to identify which scores we can confidently say are 'better' or 'worse' than the majority of other trusts. As set out above the expected range is a conservative statistic: it accounts for the possibility that there is variation across trusts for other reasons, aside from differences in trust performance. There may be significant variation between trusts due to certain factors that are not within the trusts' control. The technique used takes this into account. It is likely that your trust came out as 'about the same' because your trust had fewer respondents to the question which creates a greater degree of uncertainty around the result. The trust with the lower score would likely have had more respondents to the question, and so their expected range would have been narrower.

How do I calculate an overall score for my trust?

It is also important to remember that there is no overall indicator or figure for 'patient user experience', so it is not accurate to say that a trust is the 'best in the country' or 'best in the region' *overall*. Adding up the number of 'better' and 'worse' categories to find out which trust did better or worse overall is misleading: we do not provide a single overall rating for each NHS trust as this would be too simplistic. The survey assesses a number of different aspects of patient experience (such as the hospital and ward, doctors, nurses, your care and treatment etc.) and trust performance varies across these different aspects.
This means that it is not possible to compare the trusts overall. It is better to look at the trusts that are similar to yours, or particular trusts against which you want to compare yourself, and see how they perform across the particular aspects that are of interest to you.

Why do the results and / or number of respondents provided by CQC differ from those provided to me by our approved contractor?

CQC do not see the reports provided to you by your approved contractor and therefore cannot comment on these. You should raise any queries directly with your approved contractor. However, likely reasons for any discrepancies are:

The approved contractor may have cleaned the data differently to CQC. In particular, CQC remove respondents from the base of a question that do not analyse the performance of a trust - we refer to these as 'non specific responses', such as 'don't know or can't remember'. A guide to data cleaning is available at: **http://www.nhssurveys.org/Filestore//Inpatient_2012/IP12_DataCleaningGuidance_AJS_v2.pdf**

Trust level data published by CQC has been 'standardised' by age, gender and method of admission to enable fairer comparisons between the results of trusts which may have different population profiles. Approved Contractors may not have done this or may have applied a different standardisation. To be able to standardise the data, information is needed on age, gender and method of admission, if any of these pieces of information is missing, or not able to be determined, the respondent must be dropped from the analysis as it is not possible to apply a weight.

CQC analyses trust level data by scoring (and standardising) the responses to each question. Each response option that evaluates performance is scored on a scale of 0-10. Approved Contractors may have analysed and / or scored the data in a different way.

The Approved Contractor will not be able to make comparisons against all trusts that took part in the survey, only against those that commissioned them. Therefore any 'national' results they publish will not be based on all trusts and any thresholds they calculate may be different.

Comparing Results

Why is statistical significance relevant?

Survey scores are estimates – we have only received questionnaires from some patients who had an inpatient stay during the sampling period, not all patients, as some choose not to respond. If another sample of patients were surveyed, you may find the results would change slightly. This is why it is important to test results for statistical significance.

A statistically significant difference means that the change in the results is very unlikely to have occurred by chance. Without significance testing you cannot be sure that a difference between two results would still be different if you repeated the survey again. If a result is not significant then you cannot be sure of its accuracy. If a significant difference is present then it is likely that it is a true difference, and if the survey was repeated again that you would see the same outcome.

How can I make comparisons to previous years survey data, or to other trusts?

The purpose of the expected range is to arrive at a judgement of a how a trust is performing compared with all other trusts that took part in the survey. To use the data in another way: to make comparisons to scores achieved in previous surveys, or between trusts, you will need to undertake an appropriate statistical test to ensure that any change is statistically significant. A statistically significant change means that you can be very confident that the change is real and not due to chance.

The benchmark report for each trust includes a comparison to the 2011 survey scores and indicates whether the change is statistically significant. However, to compare back to earlier surveys (where possible) you would need to undertake a similar significance test.

For advice on making accurate comparisons you may like to speak to someone within your trust with statistical expertise, or your approved contractor (if used) should be able to advise on this. The guidance documents issued with previous benchmark reports included some advice on using confidence intervals to check for statistically significant differences across scores, see for example section four in the following document: **http://www.nhssurveys.org/Filestore/documents/IP10_Guide_to_benchmark_reports.pdf**

Which trusts are performing best / worst?

We have compiled a list of all trusts that performed ‘better’ or ‘worse’ when comparing data across all trusts, for each scored question in the survey which is available from the surveys team on request upon publication. This can be used to at a glance identify which trusts are in each group, rather than searching through each individual trust page or benchmark report. Please note the ‘interpretation’ information at the beginning of the document, which explains how the information should be most appropriately reported.

Why can’t I sort the scores for all trusts and rank the trusts in order of performance?

It is not appropriate to sort the scores:

1) Firstly, due to the analysis technique applied, where the number of respondents is taken into account, it is possible that one trust may score higher than another - though the higher scoring trust is classed as ‘about the same’ and the second, lower scoring, trust is put into the ‘better’ category. This may occur if the second trust has a considerably larger number of respondents, as it will be assumed that their score is more reliable, and hence more likely always to be high.

2) Secondly, the statistical technique does not measure how different individual trust scores are from one another (whether statistically significant), and so it would be too simple to attempt to sort by scores alone, without running more analysis on the data. The banding technique used is helpful in identifying which trusts are likely always to be in the ‘better’, ‘worse’, or ‘about the same’ category, no matter how many surveys are sent out.

Can I see results for my local hospital / ward / site?

The survey data is presented at trust level only. At present we are unable to provide data for individual hospitals for several reasons. Some sites may have too few patients to achieve sufficient numbers of respondents (we set the cut off limit of 30 respondents per organisation). Given that the survey is used by the Department of Health and others to measure trends over time, we are currently unable to change the sampling to accommodate this, without affecting the comparability across years. However, trusts are able to increase their sample size to enable this at a local level. Advice on how to do this is in the survey guidance manual.

Further information

The full national results are on the CQC website, together with an A to Z list to view the results for each trust (alongside the technical document outlining the methodology and the scoring applied to each question):
www.cqc.org.uk/Inpatientsurvey2012

The results for the adult inpatient surveys from 2002 to 2011 can be found at:
www.nhssurveys.org/surveys/292

Full details of the methodology of the survey can be found at: **www.nhssurveys.org/**

More information on the programme of NHS patient surveys is available at:
www.cqc.org.uk/public/reports-surveys-and-reviews/surveys

More information on Quality and Risk Profiles (QRP) can be found at:
www.cqc.org.uk/organisations-we-regulate/registered-services/quality-and-risk-profiles-qrps

Further Questions

If you have any further questions please contact the surveys team at CQC: **patient.survey@cqc.org.uk**

CQC Surveys team
April 2013

Patient survey report 2012

Survey of adult inpatients 2012

Barking, Havering and Redbridge University Hospitals NHS Trust

The national survey of adult inpatients in the NHS 2012 was designed, developed and co-ordinated by the Co-ordination Centre for the NHS Patient Survey Programme at Picker Institute Europe.

Making patients' views count

National NHS patient survey programme
Survey of adult inpatients 2012

The Care Quality Commission

The Care Quality Commission is the independent regulator of health care and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act.

Whether services are provided by the NHS, local authorities or by private or voluntary organisations, we make sure that people get better care. This is because we:

- Focus on quality and act swiftly to eliminate poor quality care, and
- Make sure care is centred on people's needs and protects their rights.

Survey of adult inpatients 2012

To improve the quality of services that the NHS delivers, it is important to understand what patients think about their care and treatment. One way of doing this is by asking patients who have recently used their local health services to tell us about their experiences.

The results of surveys are mainly for NHS trusts to use in order to help them improve their performance. CQC includes data from this survey in the Quality and Risk Profile (QRP) for each provider. The QRP contributes to our assessment of providers' compliance with the essential standards of quality and safety set by the Government. The Department of Health will also use the results for performance assessment, improvement and regulatory purposes.

The tenth survey of adult inpatients involved 156 acute and specialist NHS trusts. We received responses from just over 64,500 patients, which is a response rate of 51%. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Trusts were given the choice of sampling from June, July or August 2012. Trusts counted back from the last day of their chosen month, including every consecutive discharge, until they had selected 850 patients (or, for a small number of specialist trusts who could not reach the required sample size, until they had reached 1st January 2012). Fieldwork took place between September 2012 and January 2013.

Similar surveys of adult inpatients were also carried out in 2002 and from 2004 to 2011. They are part of a wider programme of NHS patient surveys, which cover a range of topics including mental health services and Accident & Emergency (A&E) services. To find out more about our programme and for the results from previous surveys, please see the links contained in the further information section.

Interpreting the report

This report shows how a trust scored for each question in the survey, compared with the range of results from all other trusts that took part. It is designed to help understand the performance of individual trusts, and to identify areas for improvement.

A 'section' score is also provided, labelled S1-S10 in the 'section scores' on page 5. The scores for each question are grouped according to the sections of the questionnaire, for example, 'the hospital and ward,' 'doctors and nurses' and so forth.

This report shows the same data as published on the CQC website (www.cqc.org.uk/surveys/inpatient). The CQC website displays the data in a more simplified way, identifying whether a trust performed 'better,' 'worse' or 'about the same' as the majority of other trusts for each question and section.

Standardisation

Trusts have differing profiles of patients. For example, one trust may have more male inpatients than another. This can potentially affect the results because people tend to answer questions in

different ways, depending on certain characteristics. For example, older respondents tend to report more positive experiences than younger respondents, and women tend to report less positive experiences than men. This could potentially lead to a trust's results appearing better or worse than if they had a slightly different profile of patients.

To account for this, we 'standardise' the data. Results have been standardised by the age, sex and method of admission (emergency or elective) of respondents to ensure that no trust will appear better or worse than another because of its respondent profile. This helps to ensure that each trust's age-sex-admission type profile reflects the national age-sex-admission type distribution (based on all of the respondents to the survey). It therefore enables a more accurate comparison of results from trusts with different profiles of patients. In most cases this will not have a large impact on trust results; it does, however, make comparisons between trusts as fair as possible.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the trust is performing.

It is not appropriate to score all questions in the questionnaire as not all of the questions assess the trusts in any way, for example, they may be descriptive questions such as Q1 asking respondents if their inpatient stay was planned in advance or an emergency; or they may be 'routing questions' designed to filter out respondents to whom following questions do not apply. An example of a routing question would be Q41 "During your stay in hospital, did you have an operation or procedure?"

Graphs

The graphs in this report display the range of scores achieved by all trusts taking part in the survey, from the lowest score achieved (left hand side) to the highest score achieved (right hand side). The black diamond shows the score for your trust.

The graph is divided into three sections:

- If your trust's score lies in the orange section of the graph, its result is 'about the same' as most other trusts in the survey
- If your trust's score lies in the red section of the graph, its result is 'worse' compared with most other trusts in the survey
- If your trust's score lies in the green section of the graph, its result is 'better' compared with most other trusts in the survey.

The text to the right of the graph clearly states whether the score for your trust is 'better' or 'worse' compared with most other trusts in the survey.

The categories described above are based on a statistic called the 'expected range' which is uniquely calculated for each trust for each question. This is the range within which we would expect a trust to score if it performed 'about the same' as most other trusts in the survey. The range takes into account the number of respondents from each trust as well as the scores for all other trusts. This means that where a trust is performing 'better' or 'worse' than the majority of other trusts, it is very unlikely to have occurred by chance. A technical document providing more detail about the methodology and the scoring applied to each question is available on the CQC website (see further information section).

In some cases there will be no red and/or no green area in the graph. This happens when the expected range for your trust is so broad it encompasses either the highest possible score (no green section) or the lowest possible score (no red section).

Please note that if fewer than 30 respondents have answered a question, no score will be displayed for this question (or the corresponding section). This is because the uncertainty around the result is too great.

Tables

At the end of the report you will find tables containing the data used to create the graphs and background information about the patients that responded.

Scores from last year's survey are also displayed. The column called 'change from 2011' uses arrows to indicate whether the score for this year shows a statistically significant increase (up arrow), a statistically significant decrease (down arrow) or has shown no statistically significant change (no arrow) compared with 2011. (Significance is tested using a two-sample t-test.)

A statistically significant difference means that the change in the results is very unlikely to have occurred by chance. Where a result for 2011 is not shown, this is because the question was either new this year, or the question wording and/or the response categories have been changed. It is therefore not possible to compare the results as we do not know if any change is caused by alterations in the survey instrument, or variation in a trust's performance. Comparisons are also not able to be shown if your trust has merged with other trusts since the 2011 survey. Please note that comparative data is not shown for sections as the questions contained in each section can change year on year.

Notes on specific questions

Please note that a variety of acute trusts take part in this survey and not all questions are applicable to every trust. The section below details modifications to certain questions, in some cases this will apply to all trusts, in other cases only to applicable trusts.

All trusts

Q51 and Q52: The information collected by Q51 "On the day you left hospital, was your discharge delayed for any reason?" and Q52 "What was the main reason for the delay?" are presented together to show whether a patient's discharge was delayed by reasons attributable to the hospital. The combined question in this report is labelled as Q52 and is worded as: "Discharge delayed due to wait for medicines/to see doctor/for ambulance."

Q53: Information from Q51 and Q52 has been used to score Q53 "How long was the delay?" This assesses the length of a delay to discharge for reasons attributable to the hospital.

Q11 and Q13: The information collected by Q11 "When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?" and Q13 "After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?" are presented together to show whether the patient has ever shared a sleeping area with patients of the opposite sex. The combined question is numbered in this report as Q11 and has been reworded as "Did you ever share a sleeping area with patients of the opposite sex?"

Please note that the information based on Q11 cannot be compared to similar information collected from surveys prior to 2006. This is due to a change in the questions' wording and because the results for 2006 onwards have excluded patients who have stayed in a critical care area, which almost always accommodates patients of both sexes.

Trusts with female patients only

Q11, Q13 and Q14: If your trust offers services to women only, a trust score for Q11 "Did you ever share a sleeping area with patients of the opposite sex?" and Q14 "While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?" is not shown.

Trusts with no A&E Department

Q3 and Q4 (The Emergency/A&E Department): The results to these questions are not shown for trusts that do not have an A&E Department.

Further information

The full national results are on the CQC website, together with an A to Z list to view the results for each trust (alongside the technical document outlining the methodology and the scoring applied to each question):
www.cqc.org.uk/Inpatientsurvey2012

The results for the adult inpatient surveys from 2002 to 2011 can be found at: www.nhssurveys.org/surveys/292

Full details of the methodology of the survey can be found at: www.nhssurveys.org/surveys/647

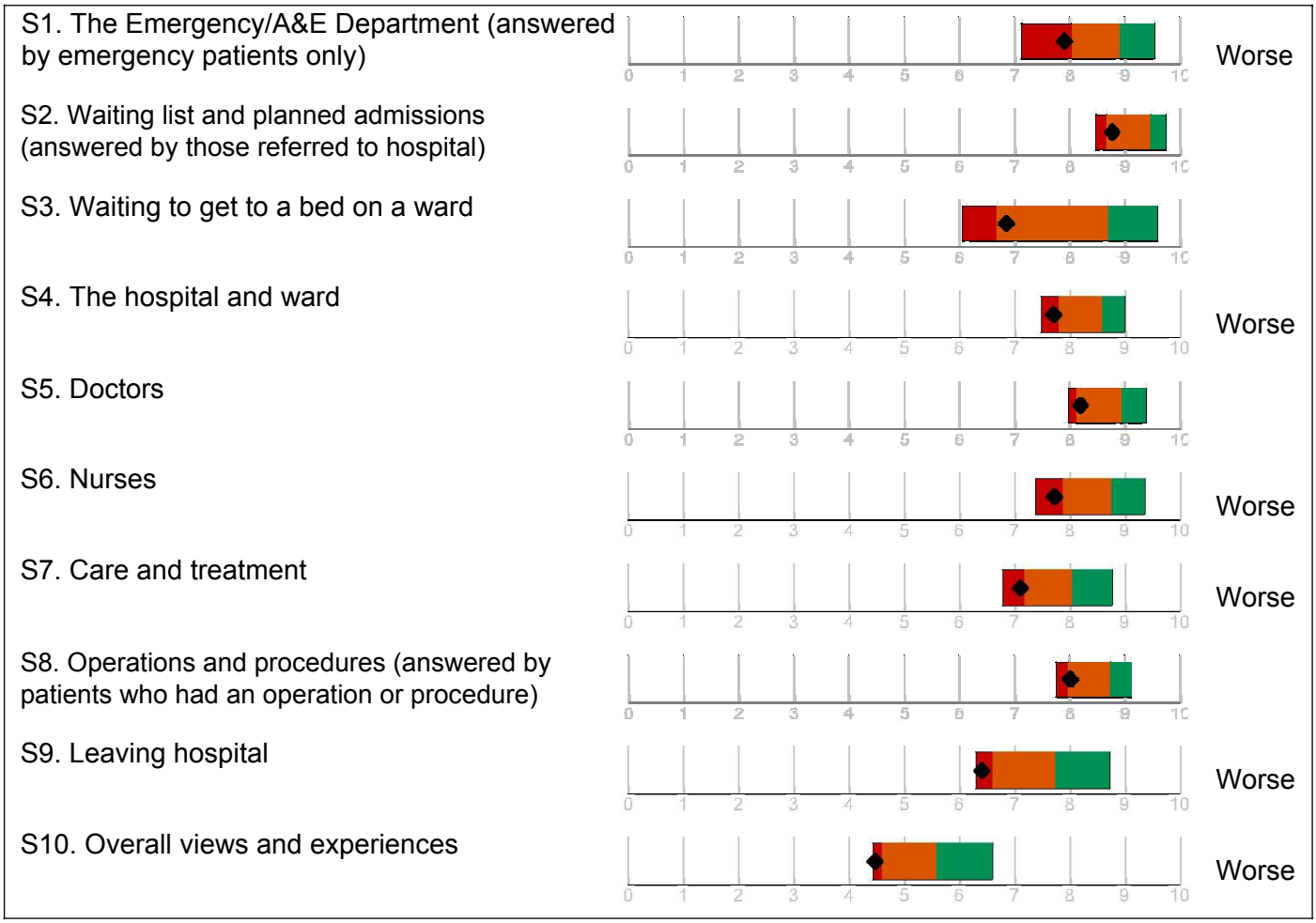
More information on the programme of NHS patient surveys is available at: www.cqc.org.uk/public/reports-surveys-and-reviews/surveys

More information on Quality and Risk Profiles (QRP) can be found at: www.cqc.org.uk/organisations-we-regulate/registered-services/quality-and-risk-profiles-qrps

Survey of adult inpatients 2012

Barking, Havering and Redbridge University Hospitals NHS Trust

Section scores



Best performing trusts

About the same

Worst performing trusts

◆ Only displayed when this trust is better/worse than 'Better/Worse' most other trusts

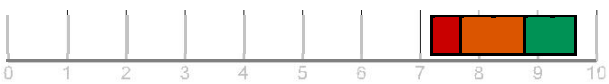
◆ This trust's score (NB: Not shown where there are fewer than 30 respondents)

Survey of adult inpatients 2012

Barking, Havering and Redbridge University Hospitals NHS Trust

The Emergency/A&E Department (answered by emergency patients only)

Q3. While you were in the A&E Department, how much information about your condition or treatment was given to you?



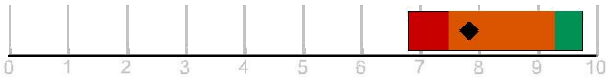
Worse

Q4. Were you given enough privacy when being examined or treated in the A&E Department?

Worse

Waiting list and planned admissions (answered by those referred to hospital)

Q6. How do you feel about the length of time you were on the waiting list?



Q7. Was your admission date changed by the hospital?

Q8. Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?

Waiting to get to a bed on a ward

Q9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

Best performing trusts

About the same

Worst performing trusts

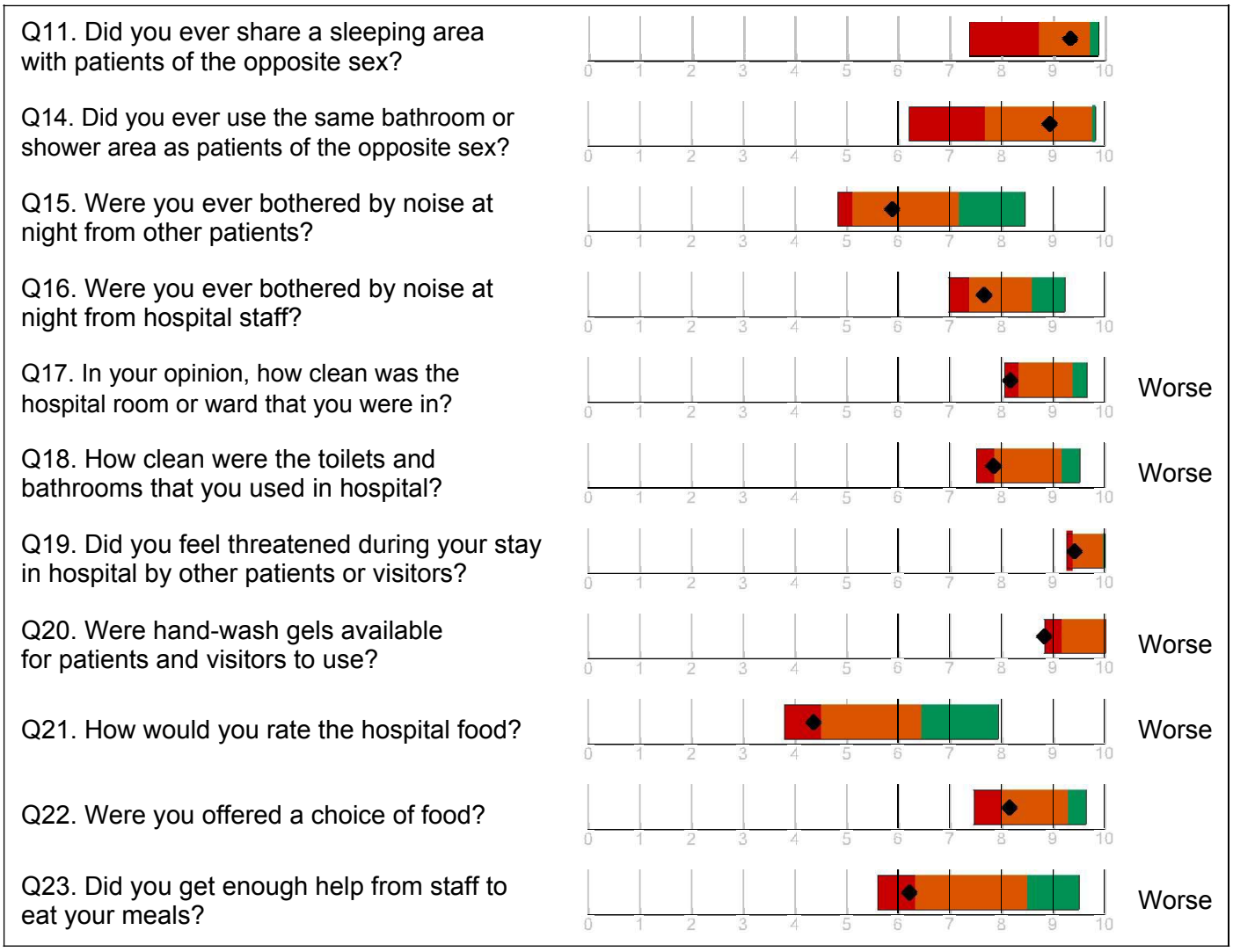
◆ Only displayed when this trust is better/worse than 'Better/Worse' most other trusts

◆ This trust's score (NB: Not shown where there are fewer than 30 respondents)

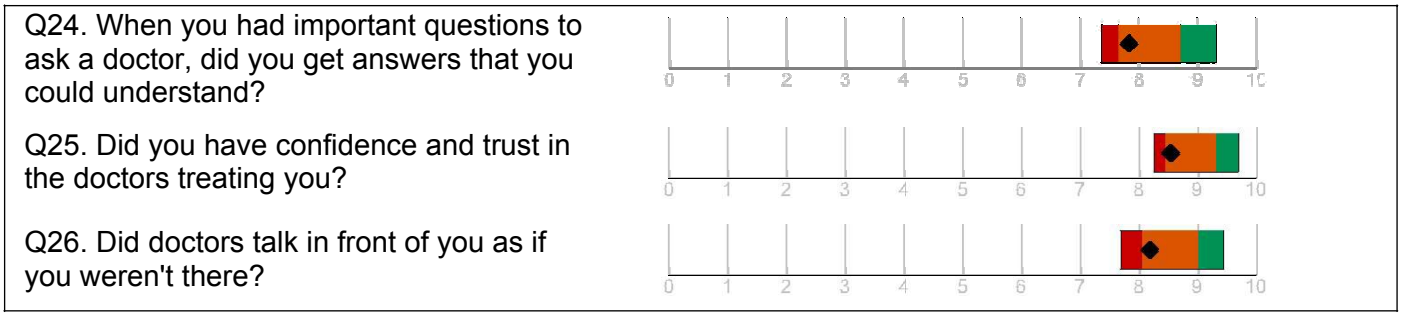
Survey of adult inpatients 2012

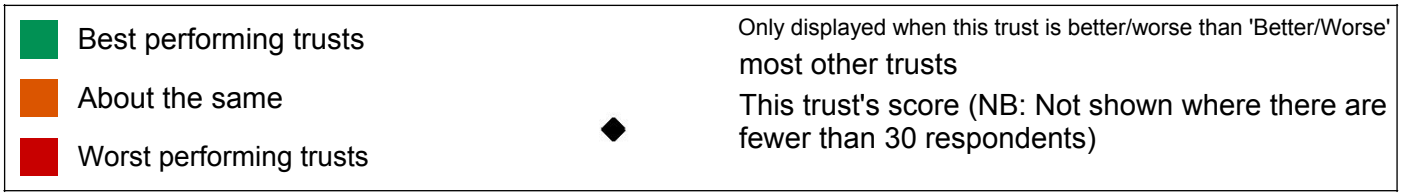
Barking, Havering and Redbridge University Hospitals NHS Trust

The hospital and ward



Doctors



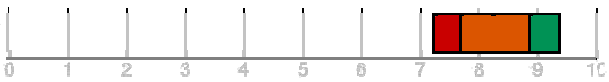


Survey of adult inpatients 2012

Barking, Havering and Redbridge University Hospitals NHS Trust

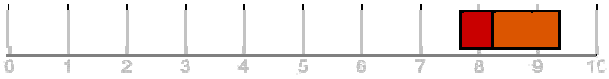
Nurses

Q27. When you had important questions to ask a nurse, did you get answers that you could understand?



Worse

Q28. Did you have confidence and trust in the nurses treating you?



Worse

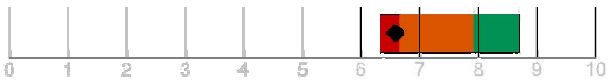
Q29. Did nurses talk in front of you as if you weren't there?

Q30. In your opinion, were there enough nurses on duty to care for you in hospital?

Care and treatment

Q31. Did a member of staff say one thing and another say something different?

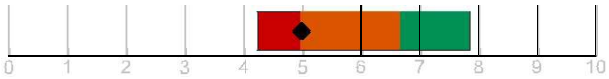
Q32. Were you involved as much as you wanted to be in decisions about your care and treatment?



Worse

Q33. How much information about your condition or treatment was given to you?

Q34. Did you find someone on the hospital staff to talk to about your worries and fears?



Q35. Do you feel you got enough emotional support from hospital staff during your stay?

Q36. Were you given enough privacy when discussing your condition or treatment?

Q37. Were you given enough privacy when being examined or treated?

Worse

Q39. Do you think the hospital staff did everything they could to help control your pain?

Q40. After you used the call button, how long did it usually take before you got help?

Best performing trusts

About the same

Worst performing trusts

◆ most other trusts

◆ This trust's score (NB: Not shown where there are fewer than 30 respondents)

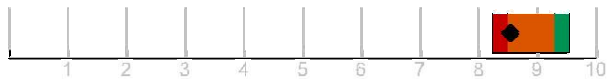
Only displayed when this trust is better/worse than 'Better/Worse'

Survey of adult inpatients 2012

Barking, Havering and Redbridge University Hospitals NHS Trust

Operations and procedures (answered by patients who had an operation or procedure)

Q42. Did a member of staff explain the risks and benefits of the operation or procedure?

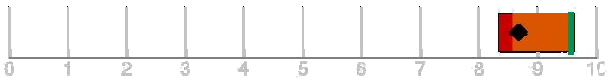


Q43. Did a member of staff explain what would be done during the operation or procedure?

Q44. Did a member of staff answer your questions about the operation or procedure?

Q45. Were you told how you could expect to feel after you had the operation or procedure?

Q47. Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?



Q48. Afterwards, did a member of staff explain how the operation or procedure had gone?

Best performing trusts

About the same

Worst performing trusts

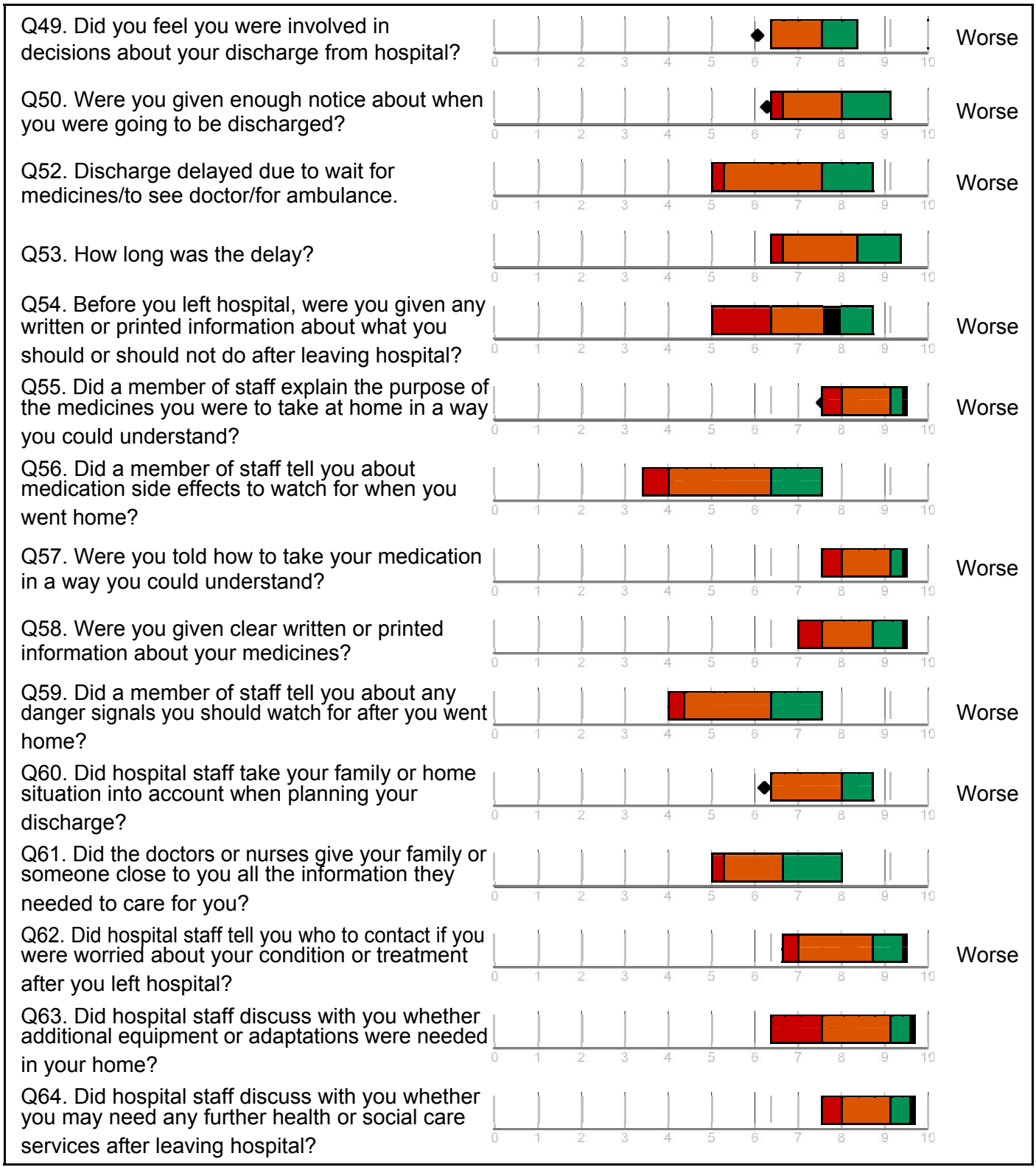
◆ Only displayed when this trust is better/worse than 'Better/Worse' most other trusts

◆ This trust's score (NB: Not shown where there are fewer than 30 respondents)

Survey of adult inpatients 2012

Barking, Havering and Redbridge University Hospitals NHS Trust

Leaving hospital



Best performing trusts

About the same

Worst performing trusts

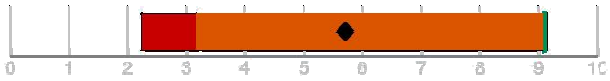
Only displayed when this trust is better/worse than 'Better/Worse' most other trusts

This trust's score (NB: Not shown where there are fewer than 30 respondents)

Survey of adult inpatients 2012

Barking, Havering and Redbridge University Hospitals NHS Trust

Q65. Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?



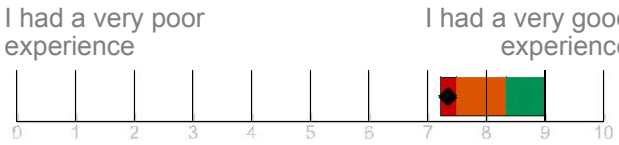
Q66. Were the letters written in a way that you could understand?

Overall views and experiences

Q67. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Worse

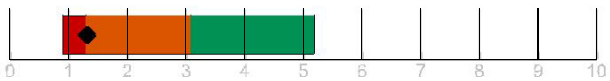
Q68. Overall...



Worse

Q69. During your hospital stay, were you ever asked to give your views on the quality of your care?

Q70. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?



Best performing trusts

About the same

Worst performing trusts

◆ Only displayed when this trust is better/worse than 'Better/Worse' most other trusts

◆ This trust's score (NB: Not shown where there are fewer than 30 respondents)

Survey of adult inpatients 2012

Barking, Havering and Redbridge University Hospitals NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2011 scores for this NHS trust	Change from 2011
The Emergency/A&E Department (answered by emergency patients only)							
S1	Section score	7.9	7.1	9.5			
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	7.7	7.1	9.6	234	7.8	
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	8.1	7.2	9.7	248	8.2	
Waiting list and planned admissions (answered by those referred to hospital)							
S2	Section score	8.8	8.5	9.7			
Q6	How do you feel about the length of time you were on the waiting list?	7.8	6.8	9.8	107	7.1	
Q7	Was your admission date changed by the hospital?	9.0	8.2	9.9	107	9.0	
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	9.5	8.7	10.0	103		
Waiting to get to a bed on a ward							
S3	Section score	6.9	6.1	9.6			
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	6.9	6.1	9.6	373	7.3	

↑ or ↓ Indicates where 2012 score is significantly higher or lower than 2011 score
(NB: No arrow reflects no statistically significant change)
Where no score is displayed, no 2011 data is available.

Survey of adult inpatients 2012

Barking, Havering and Redbridge University Hospitals NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2011 scores for this NHS trust	Change from 2011
The hospital and ward							
S4	Section score	7.7	7.5	9.0			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	9.3	7.4	9.9	301	8.8	
Q14	Did you ever use the same bathroom or shower area as patients of the opposite sex?	8.9	6.2	9.8	340	8.9	
Q15	Were you ever bothered by noise at night from other patients?	5.9	4.8	8.4	370	6.0	
Q16	Were you ever bothered by noise at night from hospital staff?	7.7	7.0	9.2	371	7.4	
Q17	In your opinion, how clean was the hospital room or ward that you were in?	8.2	8.1	9.6	374	8.3	
Q18	How clean were the toilets and bathrooms that you used in hospital?	7.8	7.5	9.5	359	7.8	
Q19	Did you feel threatened during your stay in hospital by other patients or visitors?	9.4	9.3	10.0	374	9.5	
Q20	Were hand-wash gels available for patients and visitors to use?	8.8	8.8	10.0	357	9.2	
Q21	How would you rate the hospital food?	4.4	3.8	7.9	353	4.4	
Q22	Were you offered a choice of food?	8.2	7.5	9.6	364	8.1	
Q23	Did you get enough help from staff to eat your meals?	6.2	5.6	9.5	105	5.9	
Doctors							
S5	Section score	8.2	8.0	9.4			
Q24	When you had important questions to ask a doctor, did you get answers that you could understand?	7.8	7.4	9.3	333	7.6	
Q25	Did you have confidence and trust in the doctors treating you?	8.5	8.3	9.7	372	8.3	
Q26	Did doctors talk in front of you as if you weren't there?	8.2	7.7	9.4	368	7.4	↑
Nurses							
S6	Section score	7.7	7.4	9.4			
Q27	When you had important questions to ask a nurse, did you get answers that you could understand?	7.5	7.2	9.3	321	7.0	
Q28	Did you have confidence and trust in the nurses treating you?	8.2	7.6	9.5	375	7.6	↑
Q29	Did nurses talk in front of you as if you weren't there?	8.5	7.8	9.7	375	7.8	↑
Q30	In your opinion, were there enough nurses on duty to care for you in hospital?	6.7	6.3	9.3	375	6.3	

↑ or ↓	Indicates where 2012 score is significantly higher or lower than 2011 score (NB: No arrow reflects no statistically significant change) Where no score is displayed, no 2011 data is available.

Survey of adult inpatients 2012

Barking, Havering and Redbridge University Hospitals NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2011 scores for this NHS trust	Change from 2011
Care and treatment							
S7	Section score	7.1	6.8	8.8			
Q31	Did a member of staff say one thing and another say something different?	7.8	7.4	9.4	376	7.0	↑
Q32	Were you involved as much as you wanted to be in decisions about your care and treatment?	6.6	6.3	8.7	376	6.2	
Q33	How much information about your condition or treatment was given to you?	7.5	7.0	9.4	374	7.0	
Q34	Did you find someone on the hospital staff to talk to about your worries and fears?	5.0	4.2	7.8	238	4.5	
Q35	Do you feel you got enough emotional support from hospital staff during your stay?	6.4	5.7	8.8	258	5.8	
Q36	Were you given enough privacy when discussing your condition or treatment?	8.0	7.8	9.3	367	7.8	
Q37	Were you given enough privacy when being examined or treated?	9.1	9.1	9.8	372	9.0	
Q39	Do you think the hospital staff did everything they could to help control your pain?	7.9	7.5	9.4	236	7.1	↑
Q40	After you used the call button, how long did it usually take before you got help?	5.6	5.1	7.4	228	5.6	
Operations and procedures (answered by patients who had an operation or procedure)							
S8	Section score	8.0	7.8	9.1			
Q42	Did a member of staff explain the risks and benefits of the operation or procedure?	8.5	8.2	9.5	203	8.5	
Q43	Did a member of staff explain what would be done during the operation or procedure?	8.4	7.7	9.4	200	8.1	
Q44	Did a member of staff answer your questions about the operation or procedure?	8.3	8.1	9.6	181	8.1	
Q45	Were you told how you could expect to feel after you had the operation or procedure?	7.1	6.0	8.3	206	6.4	
Q47	Did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain?	8.7	8.3	9.6	169	8.0	
Q48	Afterwards, did a member of staff explain how the operation or procedure had gone?	7.2	6.8	8.7	205	7.1	

↑ or ↓ Indicates where 2012 score is significantly higher or lower than 2011 score
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Survey of adult inpatients 2012

Barking, Havering and Redbridge University Hospitals NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2011 scores for this NHS trust	Change from 2011
Leaving hospital							
S9	Section score	6.4	6.3	8.7			
Q49	Did you feel you were involved in decisions about your discharge from hospital?	6.1	5.8	8.3	358		
Q50	Were you given enough notice about when you were going to be discharged?	6.3	6.3	9.1	371		
Q52	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	5.2	4.8	8.7	345	6.0	↓
Q53	How long was the delay?	6.7	6.2	9.3	341	7.2	
Q54	Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	5.8	4.8	8.8	352	5.6	
Q55	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	7.6	7.3	9.5	276	7.0	
Q56	Did a member of staff tell you about medication side effects to watch for when you went home?	4.0	3.4	7.5	237	3.4	
Q57	Were you told how to take your medication in a way you could understand?	7.7	7.4	9.6	233	6.9	
Q58	Were you given clear written or printed information about your medicines?	7.3	6.9	9.6	236		
Q59	Did a member of staff tell you about any danger signals you should watch for after you went home?	4.1	3.8	7.6	281	4.0	
Q60	Did hospital staff take your family or home situation into account when planning your discharge?	6.2	5.6	8.7	263		
Q61	Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	5.6	4.8	7.9	262	5.2	
Q62	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	6.8	6.6	9.5	324	6.6	
Q63	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	7.8	6.1	9.8	135		
Q64	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	7.9	7.3	9.7	207		
Q65	Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?	5.7	2.2	9.1	332	5.5	
Q66	Were the letters written in a way that you could understand?	8.2	7.2	9.4	187	8.2	

↑ or ↓	Indicates where 2012 score is significantly higher or lower than 2011 score (NB: No arrow reflects no statistically significant change)
	Where no score is displayed, no 2011 data is available.

Survey of adult inpatients 2012

Barking, Havering and Redbridge University Hospitals NHS Trust

		Scores for this NHS trust	Lowest trust score achieved	Highest trust score achieved	Number of respondents (this trust)	2011 scores for this NHS trust	Change from 2011
Overall views and experiences							
S10	Section score	4.5	4.4	6.6			
Q67	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	8.3	8.2	9.7	368	8.0	
Q68	Overall...	7.3	7.2	9.0	360		
Q69	During your hospital stay, were you ever asked to give your views on the quality of your care?	0.9	0.5	3.4	345	0.7	
Q70	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	1.3	0.9	5.2	315		

↑ or ↓ Indicates where 2012 score is significantly higher or lower than 2011 score
(NB: No arrow reflects no statistically significant change)
Where no score is displayed, no 2011 data is available.

Survey of adult inpatients 2012
Barking, Havering and Redbridge University Hospitals NHS Trust

Background information

The sample	This trust	All trusts
Number of respondents	379	64505
Response Rate (percentage)	46	51

Demographic characteristics	This trust	All trusts
Gender (percentage)	(%)	(%)
Male	41	46
Female	59	54
Age group (percentage)	(%)	(%)
Aged 16-35	9	7
Aged 36-50	8	13
Aged 51-65	20	25
Aged 66 and older	63	55
Ethnic group (percentage)	(%)	(%)
White	81	90
Multiple ethnic group	1	1
Asian or Asian British	8	3
Black or Black British	3	1
Arab or other ethnic group	0	0
Not known	8	5
Religion (percentage)	(%)	(%)
No religion	10	14
Buddhist	0	0
Christian	76	79
Hindu	2	1
Jewish	3	1
Muslim	4	2
Sikh	1	1
Other religion	1	1
Prefer not to say	2	2
Sexual orientation (percentage)	(%)	(%)
Heterosexual/straight	94	94
Gay/lesbian	0	1
Bisexual	0	0
Other	0	1
Prefer not to say	6	4

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
The Francis report into Mid Staffordshire NHS Foundation Trust. April update	Trust Board
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
The attached paper reminds the trust board of the key issues identified following the Francis report, the key themes the trust is focusing on and an update against these themes.	✓**TEC** …….. □ **STRATEGY**……. □ **FINANCE** …….. □ **AUDIT** …….. ✓ **QUALITY & SAFETY** ……..……..…… □ **WORKFORCE** □ **CHARITABLE FUNDS** ……..… □ **TRUST BOARD** …….. □ **REMUNERATION** …….. □ **OTHER** …….. (please specify)
2. DECISION REQUIRED	**CATEGORY:**
For information	□ **NATIONAL TARGET** □ **CNST** ✓ **CQC REGISTRATION** □ **HEALTH & SAFETY** □ **ASSURANCE FRAMEWORK** □ **CQUIN/TARGET FROM COMMISSIONERS** ✓ **CORPORATE OBJECTIVE** …….. □ **OTHER** …….. (please specify)
	AUTHOR/PRESENTER: Flo Panel-Coates
	DATE: 22 April 2013.
3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
4. DELIVERABLES	
To ensure there is a comprehensive and coordinated approach to the integration of the findings from the Francis report into clinical practice at BHRUT.	
5. KEY PERFORMANCE INDICATORS	
Patient Experience Quality Outcomes Risk and Safety Workforce Mortality Infection Prevention and Control measures and others incorporated into the clinical directorate and corporate performance metrics.	
AGREED AT _____ **MEETING** **OR** **REFERRED TO:** _____	**DATE:** _____ **DATE:** _____
REVIEW DATE **(if applicable)** _____	

Barking, Havering and Redbridge NHS
University Hospitals
NHS Trust

Update on the Francis Report into Care Failures

Background
The independent inquiry led by Robert Francis has made important recommendations about how the NHS can protect patients from poor care, following the failings at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2008. Failings included patients found left in their own excrement, thirsty and in pain, high death rates and ineffective management and leadership.

The failings identified have seriously damaged public trust in the NHS, in healthcare professionals and the systems that are supposed to protect patients.

There are important recommendations about how the care of patients, and management of the NHS can be improved, and how we can prevent such failures in the future. All NHS staff have been asked to read the findings, discuss with colleagues, and put forward ideas and suggestions for how we can improve as an organisation.

What happened at Mid Staffs?
The inquiry heard evidence about a range of shocking failings in the care provided to patients over a period of four years. The negative aspects of culture in the system were identified as including:

- A lack of openness to criticism
- A lack of consideration for patients
- Defensiveness
- Looking inwards, not outwards
- Secrecy
- Misplaced assumptions about the judgments and actions of others
- An acceptance of poor standards
- A failure to put the patient first in everything that is done.

The inquiry heard evidence that while Mid Staffs provided some shocking care, the circumstances that led to their failings were not unique. Pockets of poor care exist across the NHS.

To achieve the necessary changes, Mr Francis concluded there was a need for re-emphasis of what is truly important:

- Emphasis on and commitment to common values throughout the system by all within it
- Readily accessible fundamental standards and means of compliance
- No tolerance of non-compliance and the rigorous policing of fundamental standards
- Openness, transparency and candour in all the system's business
- Strong leadership in nursing and other professional values
- Strong support for leadership roles
- A level playing field for accountability
- Information accessible and useable by all allowing effective comparison of performance by individuals, services and organisations.

Learning the lessons within BHRUT
All staff from direct care givers to Trust Board members have been asked to read the key recommendations, reflect on the findings and consider what action each of us can take to prevent such care failings in our own Trust in the future. Listening events engaging with staff were held on 25th February at Queen's and 26th February at King George, some of the enclosed actions included in this paper are as a direct result of feedback from staff.

Governance Warning Themes from Mid Staffs
The completion of a timeline of key warning signs from August 2011 to March 2009 resulted in the Francis Report making the following statement:

"Chronological analysis showed that for many years there were numerous causes for concern about the Trust's standard of service, governance, finances and staffing. These concerns taken cumulatively, and in some cases individually, had implications in relation to patient safety and the Trust's ability to deliver a minimum acceptable standard. Known serious concerns were not addressed effectively." (Francis Report Feb 2013 Chapter 1)

The key themes included:

- Failure of Regulation – non-compliance with the Regulatory Quality Standards, concerns raised in Peer Review, high level of concern around individual services, high HSMR.
- Failure to use clinical data and information to improve patient safety
- Professional staff complaints were ignored by management in a drive to achieve Foundation Trust status and Cost Improvement Programme savings
- Staff completely disempowered
- Lack of accountability on every level

Moving Forward and update
The Inquiry concluded with 290 recommendations for the NHS, its Regulators and Government. The trust made a decision to focus on the key areas identified and use patient and staff outcomes as the measures for success. This approach has also been supported by the UCLP Medical Director and Director of Nursing groups, who met in March to agree four initiatives to focus across the partnership for improvements.

The initiatives are:

1. Understanding and measuring what matters to patients (i): developing a "Ward Health Check"
2. Understanding what matters to patients (ii): developing the "UCLP Promise"
3. Understanding and acting on what matters to staff
4. Developing ward sister training and accreditation.

These are being scoped at present but will be incorporated into the three areas the trust is focusing on following the analysis completed in February.
These recommendations are summarised into the following three areas:

- **Understand the quality of care we provide.**
- **Report problems (including the Duty of Candour)**
- **Place patients at the heart of all we do**

These were discussed at the Quality and Safety Committee, Clinical Quality Review Meeting (with our commissioners) and the executive team meeting. It was agree that ensuring these simple steps are taken, will continue the development pathway already started in many areas to achieve the high performing culture to which we aspire.

1. Understand the quality of care we provide.
The signs of care failings are visible in all sorts of data to which we have access. Each clinical area needs to take ownership of the data, understand what it is telling us and take action to address problem areas. In addition board to ward transparency and review of the quality of care provided relating to the performance indicators collected such as,

- Complaints: looking at the narrative as well as the numbers and using them to influence and improve the quality of care we provide.
- Monthly Safety Thermometer

- Monthly completion of the new ward to board reporting via the Quality Effectiveness and Safety Trigger Tool (QUESTT)
- Patient surveys and feeding back this information to enable improvements to care delivery
- Staff surveys and examining why staff would not recommend to services to their family or friends.
- Serious incidents and other harm incidents
- Mortality data and other data on clinical outcomes
- Comments about the Trust's services and hospitals on NHS Choices (Reviews of **KGH** and reviews of **Queen's**).
- Observing care and speaking to patients and relatives.
- Clinical leadership and role modelling
- Being open and transparent
- Patient Stories

Action update - all of the above are included in the revised Directorate Clinical Governance meeting template.
To support the triangulation of data and ensure appropriate scrutiny occurs at all levels of the organisation, a revised dashboard is being developed at the request of the Quality and Safety Committee and as part of the Integrated Performance Framework review. This will be reviewed at the May Quality and Safety Committee meeting.
The priorities within our 2013/4 Quality Account will be much more focused on improving outcomes for patients rather than process actions.
A new 'learning lessons group' will be established, as discussed at the Q&SC to ensure that quality and performance data including audit, clinical outcomes, patient and staff surveys, complaints and incidents are interpreted in a meaningful way and used to influence and develop excellence in clinical practice with front line clinical staff.

2. Report problems.
Staff must report all incidents as a professional obligation and the Incident Reporting Policy identifies that failure to report a known incident could result in disciplinary action. Making it easy for staff to ask questions, raise issues and make suggestions on care improvements. Promoting the policy on reporting concerns: **Speak up for a Healthy Trust.** Staff are encouraged to raise concerns with their line manager, union representative, HR or more senior manager, non-executive director. If their concerns are not listened to locally then there is the NHS whistle blowing helpline or a regulator.

Action update – the Trust has launched a campaign to ensure all staff are aware of what to do and confident that the issues they raise will be considered favourably.

This is reinforcing that everyone has a responsibility to report their concerns relating to patient care, everyone has a voice and uses the following;

Verbalise
penness and transparency
Interests of patients come first
Confidentiality for staff will always be maintained when reporting concerns
Excellence in care at BHRUT

Following the agreement at the Trust Executive Committee and Support from the Joint Staff Committee, we will be piloting a Guardian Service for 6 months, to support our existing management teams and policies such as '**Speak up for a Healthy Trust'** to encourage staff to report any issues affecting patient care.
The pilot is using an independent Patient Champion to facilitate monthly concerns surgeries where staff can raise their concerns. This is supported by a clear governance process and a communications plan.

In addition we have set up an email address **Concerns@BHRhospital.nhs.uk** where staff can send concerns and will shortly be advertising the mobile contact where voice and text messages can be left.

More work is required to:

Develop a **culture** where all staff have a responsibility for high quality care and feel comfortable reporting any concerns or issues.

2.1 Duty of Candour – the Trust must take ensure that patients (or their lawfully entitled personal representatives) where any death or serious harm has been *or may have been caused* to a patient by an act or omission of the organisation or its staff. The patient (or their personal representative in the event of death) should then be informed of the incident as soon as is reasonably practicable, be given full disclosure of the circumstances and be offered appropriate support, *whether or not the patient has asked for this information.* (Recommendation no.174, Vol III p 1494).

The Trust must also take care that any statement made to a regulator, Commissioner or in public records on its performance must be completely truthful and not misleading by omission (Recommendations 176, 177 and 250).

Action update.
As advised the Duty of Candour has been shared with all staff.
This includes the Executive Directors, Clinical directors and other key staff, with an explanation of what is expected.
The question of open and honest disclosure is checked as part of the serious incident panel review and via part 2 of the RCA incident reviews at the Quality and Safety Committee.
"Being Open" is part of the Trust policy but increased training and awareness is required to support staff in what is often a difficult conversation.

3. Place patients at the heart of all we do.

Ensure patients are the first priority in all that the NHS does. Patients must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.
Current cultures within the NHS often ignore poor care rather than highlight it by promoting an open, transparent and rewarding culture of flagging poor care. Leadership across all disciplines within healthcare is paramount to accept responsibility for patient care and role model the exemplar practice we expect all patients including our own family and friends should receive.

Action update - The work started through the Organisational Development Programme will continue to champion the improvements required in behaviours to impact on the culture of the organisation.
The Trust Boards vision, Values and Mission have been agreed. The word Pride to support the Trust's focus on behaviours has also been approved with more work being done to agree the actions and measures against each of the behaviours.
The Quality Impact Assessment process has also been agreed to ensure any service changes as a result of our Clinical Improvement Programme are scrutinised to ensure no negative impact on patients.
To Support and develop leadership within the Trust, the next group of staff have been identified for the BHRUT Leadership Development Programme that starts in May (last year was called the clinical fellows programme). Fifty one doctors, nurses and managers will be working on important patient improvement projects and developing together.

Monitoring and Evidence Gathering

The trust Board has requested that all work related to the recommendations from the Francis Report be monitored through the Quality and Safety Committee and reported to the Trust Board at least every 3 months.

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Going Concern – Briefing Note	**Trust Board**
1. KEY ISSUES:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
Further to the agenda item and discussion at the March Finance Committee regarding the Going Concern assumption for Annual Accounts purposes, this report sets out a draft Note to the Accounts. Although the Directors consider the Trust to be a Going Concern there are material uncertainties in reaching that conclusion, which will need careful management going forward and which need disclosure in the Accounts, by way of an 'Emphasis of Matter' Note. An outline of the wording has been suggested by the External Auditors, KPMG, and based on this, together with a review of similar Notes from three other Trusts in the 2011/12 Accounts, a proposed wording for BHRUT is set out in the report, in relation to risks such as Cashflow, CIP, Income and medium-term service reconfiguration The Audit Committee is requested to agree / amend the Emphasis of Matter – Going Concern Note.	**X TEC…16/4/13…….. X FINANCE …30/4/13** X **AUDIT …18/4/13… XTRUST BOARD …1/5/13…** **CATEGORY:** □ **NATIONAL TARGET** □ **CNST** □ **STANDARDS FOR BETTER HEALTH** □ **ASSURANCE FRAMEWORK** □ **TARGET FROM COMMISSIONERS** ☑ **CORPORATE OBJECTIVE** To achieve financial security for the Trust, with reduced costs, improved productivity and collecting income due □ **OTHER ……..** (please specify) **AUTHOR/PRESENTER:** Alan Davies, Deputy Director of Finance / David Gilburt, Director of Finance **DATE: 9th April 2013**
2. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
To ensure the financial sustainability of the Trust	
3. ALTERNATIVES CONSIDERED/REASONS FOR REJECTION:	
Without this assurance the Trust will fall under the Unsustainable Provider regime	
4. DELIVERABLES:	
Financial sustainability	
5. EVIDENCE :	
As detailed in report	
6. RECOMMENDATION/ACTION REQUIRED:	
The Trust Board is requested to agree the proposed wording for the Note to the Annual Accounts regarding Emphasis of Matter – Going Concern.	
AGREED AT _____ MEETING, OR **REFERRED TO: _____**	**DATE: _____** **DATE: _____**
REVIEW DATE _____ **(if applicable)**	

Emphasis of Matter - Going Concern

1. Introduction

Further to the agenda item and discussion at the March Finance Committee regarding the Going Concern assumption for Annual accounts purposes, this report sets out the draft Note to the Accounts. What is proposed is an Emphasis of Matter Note regarding the Going Concern assumption, i.e. although the Directors consider the Trust to be a Going Concern there are material uncertainties in reaching that conclusion, which will need careful management going forward.

An outline of the wording has been suggested by the External Auditors, KPMG, and based on this, together with a review of similar Notes from three other Trusts in the 2011/12 Accounts, the proposed wording for BHRUT is set out below.

The Audit Committee is requested to agree / amend the Emphasis of Matter – Going Concern Note.

2. BHRUT – Draft Note for 2012/13

***Suggested outline narrative from KPMG*:**
Having considered the position of the Trust, the Directors of the Trust do consider the Trust to be a going concern. However, in reaching this conclusion, the Directors have identified matters which need careful management and represent material uncertainty to that position:

- Commissioner income
- Other income
- CIP Performance
- Medium term redesign of service and cost reduction
- Capital maintenance, spend and disposal
- Nature of cash support and conditions for its receipt
- Any other matters which cause Directors concerns on future assumptions.

***Proposed BHRUT narrative*:**
Having considered the position of the Trust, the Directors do consider the Trust to be a going concern.

The Trust has developed a Clinical Strategy and Long Term Financial Model (LTFM), which show how the Trust will move towards financial and clinical sustainability. These have been developed in partnership with both the local commissioners and the SHA/Trust Development Authority, both of which have been party to the key underlying assumptions.

The Trust has shown significant financial improvement, with a reduction of £10.4m to the in-year deficit, from £49.9m in 2011/12 to £39.5m in 2012/13. It is planning to reduce the deficit further in 2013/14 to £17.3m, including the benefit from £16m of new recurrent funding for PFI costs. The Trust will be required to meet certain criteria before it can access this funding (including sustainable achievement of A&E access target).

The latest version of the LTFM shows the Trust returning to financial surplus in 2016/17, primarily through a combination of operational efficiency savings in excess of tariff

assumptions and further savings from service reconfiguration. However, the Trust is actively reviewing options for accelerating the savings from reconfiguration, with a view to breaking-even or generating a small surplus in 2014/15. These plans are likely to require further additional external capital funding, which will need to be agreed with the TDA & Department of Health. The Trust expects to update the LTFM as a result of this review by the end of April 2013.

The updated financial plan for 2013/14 was submitted to the TDA on 5th April, and assumes that as in previous years the £17.3m deficit will be supported by additional Public Dividend Capital. This will be contingent on the TDA approving a business case prepared by the Trust, including the refresh of the LTFM referred to above.

Although contract income values and terms and conditions have been broadly agreed with local commissioners, there remains a relatively marginal gap of c.£2m to resolve. Agreement has been reached with the London Specialist Commissioning Group on contract values, although contracts have yet to be actually signed off.

The Trust has prepared a detailed cashflow for 2013/14, based on assumptions within the financial plan, and will continue to report its cash position monthly to the Finance Committee and Trust Board, with rolling 12 month forecasts produced on a weekly basis for internal review. Key assumptions for 2013/14 are:

- Receipt of £25m temporary borrowing in April, or payment of SLA values by commissioners, prior to the quarterly PFI payment and monthly payroll in April. Both were actually received in April.
- Receipt of £17m Public Dividend Capital to fund the in year deficit by the end of Q1.

The Trust is planning for an in year Cost Improvement Programme (CIP) of £20m (5% of operational budgets). The majority of this is supported with detailed project plans, with the remainder due to be completed before the end of April 2013. On a longer-term basis, the Trust is planning for CIPs in excess of 5% per annum over the following four years 2014/15 to 2017/18, per the LTFM assumptions, and is looking to accelerate the savings from future years in to 2014/15, as referred to above.

In reaching its going concern conclusion, the Directors have therefore highlighted the following matters, referred to above, which will need careful management and which represent material uncertainty to that position:

- Delivery of the Trust's CIP of £20m for 2013/14
- PDC cash support for the I&E deficit of £17m in the first quarter of 2013/14
- Payment of the £16m PFI funding support
- Final agreement of commissioner contracts and agreement to pay SLA values
- Conclusion of short to medium-term plans for service reconfiguration, with agreement of associated capital funding and acceleration of savings in to 2014/15

3. Extracts from other Trusts/FTs Annual Accounts 2011/12

a. Heatherwood & Wexham Park FT

Auditor's Opinion
Emphasis of matter: going concern
In forming our opinion on the financial statements, which is not qualified, we have considered the adequacy of the disclosure made in Note 1 to the financial statements concerning the ability of the Trust to continue as a going concern.

The Trust incurred a deficit of £13.9 million during the year ended 31 March 2012 and will require a significant injection of Public Dividend Capital in 2012-13. These conditions, along with the other matters explained in Note 1 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt on the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

Ref p.119 of Annual Report & Accounts

Relevant Extract from Note 1:
Judgements, Estimates and Assumptions
In applying the Trust's accounting policies management are required to make judgements, estimates and assumptions concerning the carrying amounts of assets and liabilities that are not readily apparent from other sources. Estimates and assumptions are based on historical experience and any other factors that are deemed relevant. Actual results may differ from these estimates and are continually reviewed to ensure validity remains appropriate. These revisions are recognised in the period in which they occur or the current and future periods, as appropriate.

No estimates and assumptions concerning the future at the end of the reporting period where significant risk exists of a material adjustment to the carrying amounts have been made.

For the year ended 31 March 2012 the Trust has an income and expenditure position of £13.9m deficit and an EBITDA of £5.2m deficit.

The Directors of the Trust have prepared cash flow projections for a period in excess of one year from the date of approval of these financial statements. The cash projections make assumptions in respect of trading performance and market conditions to an extent which the Directors consider to be reasonable, based on the information that is available to them at the time of approval of these financial statements. Notably this includes:

- Delivery of the 2012-13 planned cost improvement plan totalling £17.3m. The Trust will deliver a total of £66m of recurrent cost improvements over the 5 year period from 2012-13 in order to offset an anticipated annual cost improvement efficiency assumption of 4% annually, to cover 1% of internal cost pressures annually and to make inroads into the structural deficit each year.

- Receipt of an additional PDC cash injection of £15m in quarter 1 of 2012-13 (the Trust received a PDC cash injection of £4m on 26 March 2012).

- The full drawn £8m revolving credit facility with the Foundation Trust Financing Facility is repaid during April 2012 when the current facility expires. After 6 April 2012 the Trust will not have access to such a facility.

- Both Berkshire East Pct and Buckinghamshire Pct to make SLA payments on the 1st of each month from April 2012.

- Assumed patient activity continuing at planned levels and is paid for by commissioning bodies at the new tariff

- Control over necessary captial and revenue expenditure.

- A £12.5 million capital expenditure programme in 2012-13 has been developed to manage essential issues and support cost improvement delivery in that and later years. This level of continuing investment will not be sufficient to clear the full extent of the backlog maintenance in the 5 year period but some inroads will be made.

In delivering these plans:

- The Trust will progressively reduce its annual deficit from £13.9m in 2011-12 over the five year period to March 2017.
- The Trust will be illiquid from June 2012 onwards and this will have reached £30m by 2016-17.
- Normalisation of working capital and capital expenditure will not be possible.

The Board continues to monitor its monthly and future cash position and, in addition, the Directors will develop the detail of its longer-term cash flows in light of developments and share this with the Board. In particular, the Trust is engaged in negotiations with the Department of Health for long term funding based on a plan supported by the lead commissioner, the local SHA and Monitor.

After making enquiries and considering the uncertainties described above, the Directors have a reasonable expectation that the Trust will secure adequate resources to continue in operational existence for the foreseeable future and continue to adopt the going concern basis in preparing the Annual Report and Accounts.

There are, however, significant challenges in finalising and successfully delivering the planned financial turnaround and funding solution and the directors have concluded that the combination of these circumstances represents a material uncertainty that casts significant doubt upon the Trust's ability to continue as a going concern, and therefore, the Trust may be unable to continue realising its assets and discharging its liabilities in the normal course of business.

b. Peterborough and Stamford FT

Auditor's Opinion

Emphasis of matter - going concern

In forming our opinion, which is not qualified, we have considered the adequacy of the disclosure made in note 1.2 of the financial statements, concerning the ability of the Trust to continue as a going concern. The Directors of the Trust have prepared cash flow projections for a period in excess of one year from the date of approval of these financial statements, however there are material uncertainties to the achievement of this projection, as set out in note 1.2. This includes the assumption that the Department of Health will continue to provide funding to the Trust. The Department of Health has indicated that it is reasonable to assume

that they will provide funding when required, however the quantum and timing of funds has not been agreed. In addition, the cash flow projections assume savings targets will be achieved and detailed plans to deliver these targets are still being developed by management.

These matters, along with other matters, explained in note 1.2 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt on the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

Note 1.2 Going Concern Statement

International Accounting Standard (IAS) 1 requires management to assess, as part of the accounts preparation process the Trust's ability to continue as a going concern. The financial statements should be prepared on a going concern basis unless management intends or has no alternative but, to apply to the Secretary of State for the Trust's dissolution without the transfer of its services to another entity.

Peterborough and Stamford Hospitals NHS Foundation Trust Board have carefully considered the principle of 'Going Concern' and the Directors have concluded that the combination of the circumstances outlined below represents a material uncertainty that casts significant doubt upon the Trust's ability to continue as a going concern and that, therefore the Trust may be unable to continue realising its assets and discharging its liabilities in the normal course of business. This is also set out in the Annual Governance Statement. Nevertheless after making enquiries, and considering the uncertainties described in the following paragraphs, the Directors have a reasonable expectation that the Trust will have access to adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

During 2011/12

Following on from the uncertainties and concerns raised in the 2010/11 Going Concern statement, the actual position as at 31 March 2012 was:

• Monitor governance risk rating of red (lowest level of assurance) due to the significant breach of the Trust's Terms of Authorisation notified on 11 October 2011 in terms of three conditions: condition 2 to exercise its functions effectively, efficiently and economically (linked to a financial risk rating of 1 and liquidity concerns); condition 5 its governance duty (linked to effective planning, reporting and board challenge); condition 12 to remain a going concern (linked to the development of a credible turnaround plan).

• Monitor financial risk rating (FRR) of 1 (lowest level of assurance).

• Financial deficit for the 2011/12 financial year of £45.8m.

• The Trust's performance and the progress being made in developing longer term plans have been reviewed by Monitor since November 2011 at monthly meetings.

• The Trust had identified an additional funding requirement for 2011/12 within its plans and accordingly during February and March the Trust received £41.2m of Public Dividend Capital (PDC) from the Department of Health (DoH). This funding ensured that the Trust could continue to meet its liabilities during 2011/12 as and when they fell due. The PDC was classified as a temporary advance pending completion of a wider review of the Trust's longer term plans. No repayment date has been specified.

• Prior to that point, the Trust's main Commissioners had been supportive of the in year liquidity challenges by bringing forward contract payments and therefore delaying the need for additional funding until towards the end of the financial year.

• During the year the Trust has also improved a number of areas of financial governance :
- Introducing weekly rolling 13 week cash forecasts incorporating a detailed variance analysis
- Improving the quality of information provided in the monthly finance report
- Improving the planning processes
- Introducing a Finance and Investment sub-committee of the Board
- Introducing a fortnightly board-level cash flow meeting to provide assurances on the position and processes being followed

• The Trust no longer has a Working Capital Facility (short term overdraft), the facility was withdrawn when Monitor found the Trust to be in significant breach of its Terms of Authorisation in November 2011. The Trust had not used the Facility throughout the year so were not exposed to overdue debt risk;
• During the 2011/12 financial year several key Board posts were occupied on a temporary basis, new appointments have now been made to these posts to strengthen the Trust's management team :
- Mr Christopher Preston, Finance Director with effect from 20th June 2011;
- Mr Angus Maitland, Chief Operating Officer with effect from 1st April 2012;
- Dr Peter Reading, Interim Chief Executive Officer with effect from 29th February 2012;

Looking forward
The current economic outlook for all NHS organisations is challenging and funding to the acute sector is likely to be further squeezed over the next few years. In response to that outlook, the Board has defined three strategic aims :

Doing the very best inside our hospitals
Continuing to improve the quality of care; continuing to deliver to operational performance standards; improving patient pathways; engaging clinicians more directly in the running of the hospital; developing our people to provide the highest standards of care; improving the governance processes within the Trust.

Getting value for money from our hospitals
Driving efficiency improvements; working with the health system to review the use of estates across Peterborough; working with commissioners to increase the use of the Trust's healthcare facilities; working with the DoH to make the Trust's Private Finance Initiative (PFI) scheme affordable.

Making the most of our hospitals
Improving patient experience; enhancing relationships with related clinical organisations; developing longer term commissioning plans; continuing to be transparent and open with patients, staff and the public; working hard with stakeholder organisations to improve the services provided at the hospital. The Trust is working with Monitor and other stakeholders to develop plans that return it to financial balance. These plans will incorporate a significant internal efficiency improvement challenge (which, in order to reduce the Trust's deficit, will need to exceed the
proposed annual efficiency targets that are imposed each year through reductions to national tariffs); increasing the financial contribution from the clinical services provided through dialogue with commissioners and other providers; the introduction of new services; a solution to the affordability of the Trust's PFI scheme.

In the current financial year, the Trust plans identify the requirement for significant additional external funding from the Department of Health. This requirement has been acknowledged by both Monitor and the DoH. Whilst arrangements are put in place for that external funding, the Trust's main Commissioners have again supported the Trust's short term liquidity position by agreeing to advance contract payments from later in the financial year.

The healthcare contracts with these Commissioners are agreed and signed for 2012/13.

In October 2011, Health Secretary Andrew Lansley announced that the Department of Health would provide ongoing support to a small number of NHS organisations with historic Private Finance Initiative (PFI) arrangements that were unable to demonstrate the necessary long-term financial viability. To meet the criteria for such support, a shortlist of affected Trusts would need to demonstrate that they had met four key tests:
- The problems they face should be exceptional and beyond those faced by other organisations;
- They must be able to show that the problems they face are historic and that they have a clear plan to manage their resources in the future;
- They must show that they are delivering high levels of annual productivity savings;
- They must deliver clinically viable, high quality services, including delivering low waiting times and other performance measures.

This process will be designed to provide assurance to patients and taxpayers that any additional funding will be absolutely necessary to make the relevant organisations financially sustainable. Following initial work by the DoH, in February 2012 seven Trusts who may need financial support were identified and Peterborough and Stamford Hospitals NHS Foundation Trust was one of the seven trusts identified.

Risks
The Trust has also identified some significant risks to cash flows during the next 12 months :
• Delivery of a challenging internal cost reduction programme, both in terms of timing and overall size;
• Lower than expected payments from commissioners / delays in receiving payments;
• Additional unexpected spending requirements (that exceed the contingency incorporated within the Trust's budget);
• Delay in the receipt of external funding from the DoH;
• Lack of co-operation and support from the Trust's commissioners and other key stakeholders.

Summary
During the next twelve months, the Trust plans identify the requirement for significant additional external funding from the Department of Health which is estimated to be circa £60 million dependant on the outcome of the risks outlined above. After making enquiries and considering the uncertainties, the Directors have a reasonable expectation that the Trust will have access to adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

c. West Middlesex University Hospital NHS Trust

Audit Opinion
In our opinion the summary financial statement is consistent with the statutory financial statements and the Directors' Remuneration Report of West Middlesex University Hospital NHS Trust for the year ended 31 March 2012 and complies with the relevant requirements of the directions issued by the Secretary of State.

We have not considered the effects of any events between the date on which we signed our report on the statutory financial statements on 1 June 2012 and the date of this statement.

Our opinion on the statutory financial statements included an emphasis of matter paragraph because of the significant uncertainty relating to the Trust's liquidity.

Emphasis of matter – liquidity

We draw attention to the Statement of Financial Position which shows that the Trust has a £15.3 million loan from the Department of Health outstanding as at 31 March 2012. The Trust negotiated a revised repayment schedule for the loan at the beginning of 2009/10 but has subsequently not made any payments of the principal element of the loan in 2009/10, 2010/11 or 2011/12. The full value of outstanding loan is due in 2012/13 which indicates the existence of a material uncertainty which may cast significant doubt about the Trust's liquidity. Our opinion is not qualified in respect of this matter.

Extract from Trust Financial Review narrative:
Other financial issues
In 2008/09, the Trust received a loan of £17.0 million from Department of Health, of which £15.3 million remains outstanding as at the end of this year. The Trust is in discussions with North West London Challenged Trust Board (CTB) over the repayment of this loan. Assistance with the repayment will partly depend on the Trust having a fuller understanding of its long term strategy.

To this end, the Trust is actively engaging with a number of partners most notably NHS North West London on the NWL Reconfiguration Programme – "Shaping a healthier future" to develop a sustainable healthcare landscape for the population of this part of London. The conclusion of this and other work programmes will help determine the future configuration of services at this Trust.

SELF-CERTIFICATION RETURNS
Organisation Name:
BHRUT
Monitoring Period:
February 2013

NHS Trust Over-sight self certification template

Returns to XXX by the last working day of each

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

Name of Organisation:	BHRUT	Period:	February 2013

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance, in addition to providing comment with regard to any contractual issues and compliance with CQC essential standards:

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per SOM guidance)	R
Normalised YTD Financial Risk Rating (Assign number as per SOM guidance)	1

*** Please type in R, AR, AG or G and assign a number for the FRR**

Governance Declarations

Declaration 1 or declaration 2 reflects whether the Board believes the Trust is currently performing at a level compatible with FT authorisation.

Supporting detail is required where compliance cannot be confirmed.

Please complete **one** of the two declarations below. If you sign declaration 2, provide supporting detail using the form below. Signature may be either hand written or electronic, you are required to print your name.

Governance declaration 1

The Board is sufficiently assured in its ability to declare conformity with **all** of the Clinical Quality, Finance and Governance elements of the Board Statements.

Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		
Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		

Governance declaration 2

At the current time, the board is yet to gain sufficient assurance to declare conformity with all of the Clinical Quality, Finance and Governance elements of the Board Statements.

Signed by :		Print Name :	Sir Peter Dixon
on behalf of the Trust Board	Acting in capacity as:		Chairman
Signed by :		Print Name :	Averil Dongworth
on behalf of the Trust Board			Chief Executive

If Declaration 2 has been signed:

For each target/standard, where the board is declaring insufficient assurance please state the reason for being unable to sign the declaration, and explain briefly what steps are being taken to resolve the issue. Please provide an appropriate level of detail.

Target/Standard:	**4. The trust will maintain a FRR ≥ 3 over the next 12 months.**
The Issue :	**Trust is trading at a deficit.**
Action :	**LTFM sets out plan to reduce deficit**

Target/Standard:	**5. The trust shall at all times remain a going concern.**
The Issue :	**Trust is trading at a deficit.**
Action :	**LTFM sets out plan to reduce deficit**

Target/Standard:	**11. Plans in place to ensure ongoing compliance with all existing targets.**
The Issue :	**MRSA Target exceeded, A&E 4 Hour Access Target**
Action :	**Action plans agreed to improve performance**

Target/Standard:	**12. Achieved a minimum of Level 2 of the IG Toolkit.**
The Issue :	**A number of areas rated as level 1 in 2012/13 assessment**
Action :	**Action plans in place for all areas level 1 in 2013/14**

Target/Standard:	
The Issue :	
Action :	

Board Statements

BHRUT
February 2013

For each statement, the Board is asked to confirm the following:

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SOM's Oversight Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	Yes
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	Yes
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	Yes
	For FINANCE, that:	**Response**
4	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.	No
5	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	No
	For GOVERNANCE, that:	**Response**
6	The board will ensure that the trust at all times has regard to the NHS Constitution.	Yes
7	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner	Yes
8	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of occurrence and the plans for mitigation of these risks.	Yes
9	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	Yes
10	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	Yes
11	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the Governance Risk Rating; and a commitment to comply with all commissioned targets going forward.	No
12	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	No
13	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies, and that any elections to the shadow board of governors are held in accordance with the election rules.	Yes
14	The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	Yes
15	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual plan; and the management structure in place is adequate to deliver the annual plan.	Yes

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO		**Averil Dongworth**	
Chair		**Sir Peter Dixon**	

QUALITY

Information to inform discussion meeting

BHRUT

Insert Performance in Month

	Criteria	Unit	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Board Action
1	SHMI - latest data	Score	97.5								97.5	97.5	95.0	94.0	
2	Venous Thromboembolism (VTE) Screening	%	91	94	94	93	94	94	95	96	95	93	96	96	
3a	Elective MRSA Screening	%	78	78	78	74	78	79	74	86	86	86	87	88	
3b	Non Elective MRSA Screening	%	69	69	74	83	77	75	79	78	81	81	83	85	
4	Single Sex Accommodation Breaches	Number	30	30	21	10	12	19	13	13	3	10	10	8	Figures amending following discussion on how this should be reported. All breaches relate to patients waiting step down from ITU
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	270	216	105	91	68	46	35	34	32	32	37	35	
6	"Never Events" occurring in month	Number	0	0	0	0	0	0	0	0	1	1	0	0	
7	CQC Conditions or Warning Notices	Number	2	2	2	2	2	2	2	2	2	2	1	1	Following the inspections in November and December the warning notice for Maternity has been removed. The warning notice for A&E remains and a proposed condition is being agreed with the CQC.
8	Open Central Alert System (CAS) Alerts	Number	0	0	0	0	0	0	0	0	0	0	0	0	
9	RED rated areas on your maternity dashboard?	Number	5	8	10	9	7	5	5	12	8	5	7	4	S.I's and Governance - there were 2 post partum haemorrhages. A full review of the care showed there were no care management issues and the care was noted to be of a high standard WHO – covered separately LSCS. A clinical review identified that the high LSCS rate occurs at KGH. With KGH closing in March 2013 and the availability of senior doctors in the labour ward at Queens it is expected that this will be addressed. With KGH closing in March the vacancy rate for the Trust will reduce with remaining staff at KGH moving to Queen's
10	Falls resulting in severe injury or death	Number	3	3	3	2	2	2	2	2	1	1	4	4	Actions agreed to reduce falls can be summarised as follows: Invest in a Falls Lead Review the Falls Risk Assessment and Falls Pathway to simplify both tools to focus on the priorities identified through the root cause analysis of incidents. Increase scrutiny and support shared learning through a Falls review panel and senior nursing forum review Learn from national falls reduction work regarding the use of information, the environment advice and equipment.
11	Grade 3 or 4 pressure ulcers	Number	5	5	4	6	5	2	2	3	3	3	3	4	All grade 3 pressure ulcers. Actions being implemented include: Introduce a rapid review tool to be complete on day of incidence for level 2 Pressure Ulcers so that early actions can be taken to minimise the risk Increase scrutiny and support shared learning through a Pressure Ulcer review panel and senior nursing forum review To ensure key learning from the review panel provide additional training focussed on the findings of the review panel.
12	100% compliance with WHO surgical checklist	Y/N	yes			yes	no	yes	yes	yes	no	no	no	no	Compliant in main theatres and day theatres. Maternity compliance is 100% for elective procedures and 78% for emergencies. Maternity are reporting 100% compliance in March 2013.
13	Formal complaints received	Number	128	101	98	85	100	85	67	105	81	65	91	72	
14	Agency as a % of Employee Benefit Expenditure	%		5.3	6.5	4.7	5.3	4.8	4.65	4.56	6.2	5.5	5.15	5.6	
15	Sickness absence rate	%	4.41	4.29	4.51	4	4.59	4.68	4.88	5.07	5.3	5.7	4.95	4.92	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%													

FINANCIAL RISK RATING

BHRUT

			Risk Ratings					Insert the Score (1-5) Achieved for each Criteria Per Month				
								Reported Position		Normalised Position*		
Criteria	Indicator	Weight	5	4	3	2	1	Year to Date	Forecast Outturn	Year to Date	Forecast Outturn	Board Action
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	1	1	1	1	EBITDA margin -0.2%. Trust is trading at a large deficit
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	1	5	1	5	Trust is trading at a deficit. Forecast Outturn is per Plan , hence the score of 5 on FOT
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	1	1	1	1	EBITDA margin -0.2%. Trust is trading at a large deficit
	I&E surplus margin %	20%	3	2	1	-2	<-2	1	1	1	1	I&E surplus margin is -17.0% Trust is trading at a deficit
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	1	1	1	1	Trust current liabilities exceeds current assets causing score of 1
Weighted Average		**100%**						**1.0**	**1.4**	**1.0**	**1.4**	
Overriding rules								1	1	1	1	
Overall rating								**1**	**1**	**1**	**1**	Two or more financial criteria at "1"

Overriding Rules :

Max Rating	Rule					
3	Plan not submitted on time	No				
3	Plan not submitted complete and correct	No				
2	PDC dividend not paid in full	No				
2	Unplanned breach of PBC	No				
2	One Financial Criterion at "1"					
3	One Financial Criterion at "2"					
1	Two Financial Criteria at "1"		1	1	1	1
2	Two Financial Criteria at "2"					

* Trust should detail the normalising adjustments made to calculate this rating within the comments box.

FINANCIAL RISK TRIGGERS

BHRUT

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

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Jun-12	Qtr to Sep-12	Qtr to Dec-12	Jan-13	Feb-13	Mar-13	Qtr to Mar-13	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	No	No	No	No	No			Forecast to achieve control total in 2012-13
2	Quarterly self-certification by trust that the normalised financial risk rating (FRR) may be less than 3 in the next 12 months	Yes	Yes	Yes	Yes	Yes			Driven by deficit position both planned and actual
3	Working capital facility (WCF) agreement includes default clause	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
4	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	No	No	No	No			Taken from AR ledger, after application of bad debt provision. Debtors > 90 days account for 8% of total debt;, but only 3% after provision. Overseas patients forms a particular risk.
5	Creditors > 90 days past due account for more than 5% of total creditor balances	Yes	Yes	Yes	Yes	Yes			Taken from AP ledger, creditors over 90 days form 25% of total creditors. Heavily influenced by cash-flow consequences of running a deficit, plus planning for PFI payments.
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No			
7	Interim Finance Director in place over more than one quarter end	No	No	Yes	Yes	Yes			Interim Finance Director in place
8	Quarter end cash balance <10 days of operating expenses	Yes	No	No	No	No			End of year cash balance determined by Trust EFL. Quarter date cash balances usually higher preparing for PFI payment. In Feb 13 cash reflected 14 days operating expenses excl impairments
9	Capital expenditure < 75% of plan for the year to date	Yes	Yes	Yes	Yes	Yes			2011/12 and 2012/13 capital expenditure plans accommodated for large scale Health for NEL restructuring
10	Yet to identify two years of detailed CIP schemes			No	No	No			CIPs identified for two years

GOVERNANCE RISK RATINGS

See 'Notes' for further detail of each of the below indicators

						BHRUT							
						Insert YES, NO or N/A (as appropriate)							
						Historic Data			Current Data				
Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Qtr to Jun-12	Qtr to Sep-12	Qtr to Dec-12	Jan-13	Feb-13	Mar-13	Qtr to Mar-13	Board Action
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	N/a	N/a	N/a	N/a	N/a			
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		N/a	N/a	N/a	N/a	N/a			
			Patients dying at home / care home	50%		n/a	N/a	N/a	N/a	N/a			
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a			
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a			
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes	Yes			This indicator will deteriorate when work is undertaken to reduce the number of patients on the waiting list waiting over 18 ww. Detailed plans for delivering this performance by specialty are being considered by commissioners
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes	Yes			
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	Yes	Yes	Yes	Yes	Yes			
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	No	No	Yes	Yes	Yes			
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising :	Surgery	94%	1.0	Yes	Yes	Yes	Yes	Yes			
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	Yes	Yes	Yes			
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes			
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes			
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	No	No	No	No	No			Improvement plan agreed at risk summit and being implemented
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a	N/a			
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a			

GOVERNANCE RISK RATINGS

See 'Notes' for further detail of each of the below indicators

BHRUT

Insert YES, NO or N/A (as appropriate)

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Jun-12	Historic Data: Qtr to Sep-12	Historic Data: Qtr to Dec-12	Current Data: Jan-13	Current Data: Feb-13	Current Data: Mar-13	Current Data: Qtr to Mar-13	Board Action
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	**1.0**	N/a	N/a	N/a	N/a				
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	**0.5**	N/a	N/a	N/a	N/a				
	3j	Category A call – emergency response within 8 minutes	Red 1	80%	**0.5**	N/a	N/a	N/a	N/a				
			Red 2	75%	**0.5**	N/a	N/a	N/a	N/a				
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	**1.0**	n/a	N/a	N/a	N/a				
	4a	Clostridium Difficile	Is the Trust below the de minimus	*12*	**1.0**	No	No	No	No	No			bacteria in the gut. To reduce the risk of C Diff there will be a daily review of all patients on antibiotics. This will be led by medical staff supported by nursing staff and pharmacists. Isolation precautions including physical isolation is a cornerstone of the approach to CDI containment. The Trust will improve the knowledge and skills for prevention, management and containment on all wards along the lines of the successful approach to norovirus Proper hand washing has been shown to be the most cost-effective method for the prevention and control of HCAIs. Compliance with hand hygiene will be
			Is the Trust below the YTD ceiling	*54*		No	No	No	No	No			
			Is the Trust below the de minimus	*6*		Yes	No	No	No	No			In order to reduce blood culture contamination the following actions are being taken :

GOVERNANCE RISK RATINGS

See 'Notes' for further detail of each of the below indicators

						BHRUT							
						Insert YES, NO or N/A (as appropriate)							
						Historic Data			Current Data				
Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Qtr to Jun-12	Qtr to Sep-12	Qtr to Dec-12	Jan-13	Feb-13	Mar-13	Qtr to Mar-13	Board Action
Safety	4b	MRSA	Is the Trust below the YTD ceiling	6	1.0	No	No	No	No	No			To eliminate blood culture contamination decontamination materials will be bundled into blood culture sets. The Trust will screen all patients to be admitted for MRSA to ensure that screening is undertaken more consistently. The application of biomass reducing/ decolonising strategies an example being the use of wash by patients prior to an elective admission reduces colonisation. The Trust will ensure that these strategies are used consistently To ensure the correct approach to drawing blood cultures all staff who undertake insertion or care of an invasive device will undergo Aseptic Non-Touch Technique Training
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	**2.0**	No	No	No	No	No			
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	**4.0**	Yes	Yes	Yes	Yes	Yes			Improvement plan and trajectory agreed and being implemented
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	**2.0**	No	No	No	No	No			
			TOTAL			**6.5**	**7.5**	**7.0**	**7.0**	**7.0**	**0.0**	**0.0**	
						R	R	R	R	R	G	G	

RAG RATING :

GREEN	**= Score less than 1**
AMBER/GREEN	**= Score greater than or equal to 1, but less than 2**
AMBER / RED	**= Score greater than or equal to 2, but less than 4**
RED	**= Score greater than or equal to 4**

	Overriding Rules - Nature and Duration of Override at SHA's Discretion										
i)	Meeting the MRSA Objective	Greater than six cases in the year to date, and breaches the cumulative year-to-date trajectory for three successive quarters	Yes	Yes	Yes	Yes	Yes			The Trust had been 155 days without a case of MRSA at the end of Feb 13
ii)	Meeting the C-Diff Objective	Greater than 12 cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters	Yes	Yes	Yes	Yes	Yes			

GOVERNANCE RISK RATINGS

See 'Notes' for further detail of each of the below indicators

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	BHRUT Insert YES, NO or N/A (as appropriate) Historic Data Qtr to Jun-12	Qtr to Sep-12	Qtr to Dec-12	Current Data Jan-13	Feb-13	Mar-13	Qtr to Mar-13	Board Action
			Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency.										as above
	iii)	RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter The non-admitted patients 18 weeks waiting time measure for a third successive quarter The incomplete pathway 18 weeks waiting time measure for a third successive quarter			No	No	No	No	No			
	iv)	A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.			Yes	Yes	Yes	Yes	Yes			
	v)	Cancer Wait Times	Breaches either: the 31-day cancer waiting time target for a third successive quarter the 62-day cancer waiting time target for a third successive quarter			No	No	No	No	No			
	vi)	Ambulance Response Times	Breaches: the category A 8-minute response time target for a third successive quarter the category A 19-minute response time target for a third successive quarter either Red 1 or Red 2 targets for a third successive quarter			N/a	N/a	N/a					
	vii)	Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter			N/a	N/a	N/a					
	viii)	Any other Indicator weighted 1.0	Breaches the indicator for three successive quarters.			No	No	No	No	No			
			Adjusted Governance Risk Rating			**6.5**	**7.5**	**7.0**	**7.0**	**7.0**	**0.0**	**0.0**	
						R	R	R	R	R	G	G	

CONTRACTUAL DATA

Information to inform discussion meeting

BHRUT

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

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Jun-12	Qtr to Sep-12	Qtr to Dec-12	Jan-13	Feb-13	Mar-13	Qtr to Mar-13	
1	Are the prior year contracts* closed?	Yes	yes	Yes	Yes	yes			
2	Are all current year contracts* agreed and signed?	Yes	yes	Yes	Yes	yes			
3	Has the Trust received income support outside of the NHS standard contract e.g. transformational support?	Yes	yes	Yes	Yes	yes			
4	Are both the NHS Trust and commissioner fulfilling the terms of the contract?	No	no	No	No	no			Covered in sections on C Diff and A&E
5	Are there any disputes over the terms of the contract?	No	no	No	No	no			
6	Might the dispute require third party intervention or arbitration?	No	no	No	No	no			
7	Are the parties already in arbitration?	Yes	no	No	No	no			
8	Have any performance notices been issued?	No	no	No	No	no			
9	Have any penalties been applied?	No	no	No	No	no			

*All contracts which represent more than 25% of the Trust's operating revenue.

TFA Progress

Apr-13

<INSERT TRUST NAME HERE>

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Performance	Board Action
1	AA - TFA governance agreed by Trust / Cluster / SHA	Aug-12	Fully achieved in time	
2	AA - Trust Transformation Programme Plan developed	Sep-12	Fully achieved but late	Presented to the Trust Board in November.
3	AA - Transformation plan approved by Board	Oct-12	Fully achieved but late	Transformation plan developed for 2013/14
4	AA - All Trust Board and Executive Director positions filled	Oct-12	Fully achieved in time	
5	AA - OD plan agreed with deliverables/milestones	Dec-12	Fully achieved but late	OD plan agreed with trust Board in February
6	AA - Quality Governance self assessment agreed by Trust Board	Jan-13	Not fully achieved	Assessment initiatied and expected to be completed in June 2013
7	AA - BGAF self assessment agreed by Trust Board	Jan-13	Not fully achieved	Assessment initiatied and expected to be completed in June 2013
8	AA - Formal review of Transformation Programme	Jan-13	Fully achieved in time	2013/14 plan developed
9	AA - Workforce strategy/education/training plan approved	May-13	On track to deliver	Head of HR taking the lead on this development
10	AA - A&E target achieved at KGH	Aug-12	Fully achieved in time	KGH met 95% target in June 2012. This was sustained until December 2012
11	AA - A&E target achieved at Queen's	Oct-12	Not fully achieved	Remedial Action Plan agreed at risk summit and in process of being implemented. Detailed updates on progress against this plan routinely presented to Trust Board.
12	AA - Quality Improvement Strategy approved by Trust Board	Jan-13	Not fully achieved	Draft strategy will be completed in March and reviewed at Trust Executive Committee in April. Final comments will be incorporated in to the paper for submission to the Trust Board.
13	AA - March 2012 CQC compliance actions addressed	Dec-12	Not fully achieved	The strategic actions following the March 2012 report have now been incorporporated as business as usual.
14	AA - 12/13 monthly CIP plan re-profiled	Sep-12	Fully achieved in time	Completed in August 2012
15	AA - Plan to deliver £23m Recurrent CIP by Mar 13 agreed by Trust Board	Oct-12	Fully achieved in time	Plan to deliver £23m recurrent savings agreed at Trust Board. Mitigating action in place to ensure delivery of recurrent savings.
16	AA - Plan to deliver additional in year non recurrent CIP to deliver 12/13 control total agreed by Trust Board	Oct-12	Fully achieved in time	Plan to deliver in-year non-recurrent CIP agreed at finance committee and Trust Board.
17	AA - 2012/13 £23.2m CIP target delivered	Oct-12	Not fully achieved	Provisional outturn position £18.9m at Month 12
18	AA - 2012/13 Plan deficit no greater than £39.7m	Apr-13	On track to deliver	
19	AA - 5 year Trust productivity programme developed	Sep-12	Fully achieved in time	Baseline LTFM with 5 yr productivity programme complete with report to Trust Board
20	AA - LTFM base case assumptions and options to bridge gap agreed by commissioners	Oct-12	Not fully achieved	Baseline LTFM complete. Refresh to be completed following agreement of SLA for 2013/14
21	AA - SHA review 5 year Trust productivity programme and LTFM baseline and options to bridge gap	Oct-12	Fully achieved but late	Baseline LTFM complete. Refresh to be completed following agreement of SLA for 2013/14
22	AA - Clinical & Financial Viability Plan approved by Trust Board	Dec-12	Fully achieved in time	Draft LTFM agreed by Trust Board requires update to take account of CCG QIPP
23	AA - OBC (inc commissioner support) approved by Trust Board	Feb-13	Not fully achieved	Process for completion of OBC agreed with NTDA and local commissioners in Acute Reconfiguration Group Meeting.
24	AA - SHA approval of OBC at CIC	Feb-13	Not fully achieved	Process for completion of OBC agreed with NTDA and local commissioners in Acute Reconfiguration Group Meeting.
25	AA - FBC approved by Trust Board			Date for FBC to be confirmed
26	AA - SHA approval of FBC			Date for FBC to be confirmed
27	AA - BHR transition plan for closure KGH maternity (intrapartum care)	Oct-12	Fully achieved in time	Final gateway review completed. NELC Board and BHRUT Board approve closure of KGH maternity unit.
28	AA - BHR system readiness assurance gateway	Feb-12	Fully achieved in time	See above
29	AA - BHR birth numbers < 8000 per annum (@660 pcm)	Feb-13	Fully achieved in time	
30	AA - KGH maternity closed	Mar-13	On track to deliver	KGH unit closed on 17 March 2013.
31				
32				
33				
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40				

Notes

Ref	Indicator	Details
Thresholds	The SHA will not utilise a general rounding principle when considering compliance with these targets and standards, e.g. a performance of 94.5% will be considered as failing to achieve a 95% target. However, exceptional cases may be considered on an individual basis, taking into account issues such as low activity or thresholds that have little or no tolerance against the target, e.g. those set between 99-100%.	
1a	Data Completeness: Community Services	Data completeness levels for trusts commissioned to provide community services, using Community Information Data Set (CIDS) definitions, to consist of: - Referral to treatment times – consultant-led treatment in hospitals and Allied Healthcare Professional-led treatments in the community; - Community treatment activity – referrals; and - Community treatment activity – care contact activity. While failure against any threshold will score 1.0, the overall impact will be capped at 1.0. Failure of the same measure for three quarters will result in a red-rating. **Numerator:** all data in the denominator actually captured by the trust electronically (not solely CIDS-specified systems). **Denominator:** all activity data required by CIDS.
1b	Data Completeness Community Services (further data):	The inclusion of this data collection in addition to Monitor's indicators (until the Compliance Framework is changed) is in order for the SHA to track the Trust's action plan to produce such data. This data excludes a weighting, and therefore does not currently impact on the Trust's governance risk rating.
1c	Mental Health MDS	Patient identity data completeness metrics (from MHMDS) to consist of: - NHS number; - Date of birth; - Postcode (normal residence); - Current gender; - Registered General Medical Practice organisation code; and - Commissioner organisation code. **Numerator:** count of valid entries for each data item above. (For details of how data items are classified as VALID please refer to the data quality constructions available on the Information Centre's website: www.ic.nhs.uk/services/mhmds/dq) **Denominator:** total number of entries
1d	Mental Health: CPA	**Outcomes for patients on Care Programme Approach:** • Employment status: **Numerator:** the number of adults in the denominator whose employment status is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting, in a financial year. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Accommodation status: **Numerator:** the number of adults in the denominator whose accommodation status (i.e. settled or non-settled accommodation) is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Having a Health of the Nation Outcome Scales (HoNOS) assessment in the past 12 months: **Numerator:** The number of adults in the denominator who have had at least one HoNOS assessment in the past 12 months. **Denominator:** The total number of adults who have received secondary mental health services and who were on the CPA during the reference period.
2a-c	RTT	Performance is measured on an aggregate (rather than specialty) basis and trusts are required to meet the threshold on a monthly basis. Consequently, any failure in one month is considered to be a quarterly failure. Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process. Will apply to consultant-led admitted, non-admitted and incomplete pathways provided. While failure against any threshold will score 1.0, the overall impact will be capped at 2.0. The measures apply to acute patients whether in an acute or community setting. Where a trust with existing acute facilities acquires a community hospital, performance will be assessed on a combined basis. The SHA will take account of breaches of the referral to treatment target in 2011/12 when considering consecutive failures of the referral to treatment target in 2012/13. For example, if a trust fails the 2011/12 admitted patients target at quarter 4 and the 2012/13 admitted patients target in quarters 1 and 2, it will be considered to have breached for three quarters in a row.
2d	Learning Disabilities: Access to healthcare	Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (DH, 2008): a) Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? b) Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: - treatment options; - complaints procedures; and - appointments? c) Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? d) Does the trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? e) Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers? f) Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? Note: trust boards are required to certify that their trusts meet requirements a) to f) above at the annual plan stage and in each month. Failure to do so will result in the application of the service performance score for this indicator.
3a	Cancer: 31 day wait	31-day wait: measured from cancer treatment period start date to treatment start date. Failure against any threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter.. Will apply to any community providers providing the specific cancer treatment pathways
3b	Cancer: 62 day wait	62-day wait: measured from day of receipt of referral to treatment start date. This includes referrals from screening service and other consultants. Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. National guidance states that for patients referred from one provider to another, breaches of this target are automatically shared and treated on a 50:50 basis. These breaches may be reallocated in full back to the referring organisation(s) provided the SHA receive evidence of written agreement to do so between the relevant providers (signed by both Chief Executives) in place at the time the trust makes its monthly declaration to the SHA. In the absence of any locally-agreed contractual arrangements, the SHA encourages trusts to work with other providers to reach a local system-wide agreement on the allocation of cancer target breaches to ensure that patients are treated in a timely manner. Once an agreement of this nature has been reached, the SHA will consider applying the terms of the agreement to trusts party to the arrangement.
3c	Cancer	Measured from decision to treat to first definitive treatment. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways.
3d	Cancer	Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners and any primary care professional).Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation

Notes

Ref	Indicator	Details
3e	A&E	Waiting time is assessed on a site basis: no activity from off-site partner organisations should be included. The 4-hour waiting time indicator will apply to minor injury units/walk in centres.
3f	Mental	7-day follow up: **Numerator**: the number of people under adult mental illness specialties on CPA who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. **Denominator:** the total number of people under adult mental illness specialties on CPA who were discharged from psychiatric inpatient care. All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemptions from both the numerator and the denominator of the indicator include: - patients who die within seven days of discharge; - where legal precedence has forced the removal of a patient from the country; or - patients discharged to another NHS psychiatric inpatient ward. For 12 month review (from Mental Health Minimum Data Set): **Numerator:** the number of adults in the denominator who have had at least one formal review in the last 12 months. **Denominator:** the total number of adults who have received secondary mental health services during the reporting period (month) who had spent at least 12 months on CPA (by the end of the reporting period OR when their time on CPA ended). For full details of the changes to the CPA process, please see the implementation guidance Refocusing the Care Programme Approach on the
3g	Mental Health: DTOC	**Numerator:** the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed during the month. For example, one patient delayed for five days counts as five. **Denominator:** the total number of occupied bed days (consultant-led and non-consultant-led) during the month. Delayed transfers of care attributable to social care services are included.
3h	Mental Health: I/P and CRHT	This indicator applies only to admissions to the foundation trust's mental health psychiatric inpatient care. The following cases can be excluded: - planned admissions for psychiatric care from specialist units; - internal transfers of service users between wards in a trust and transfers from other trusts; - patients recalled on Community Treatment Orders; or - patients on leave under Section 17 of the Mental Health Act 1983. The indicator applies to users of working age (16-65) only, unless otherwise contracted. An admission has been gate-kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission. For full details of the features of gate-keeping, please see Guidance Statement on Fidelity and Best Practice for Crisis Services on the Department of Health's website. As set out in this guidance, the crisis resolution home treatment team should: a) provide a mobile 24 hour, seven days a week response to requests for assessments; b) be actively involved in all requests for admission: for the avoidance of doubt, 'actively involved' requires face-to-face contact unless it can be demonstrated that face-to-face contact was not appropriate or possible. For each case where face-to-face contact is deemed inappropriate, a declaration that the face-to-face contact was not the most appropriate action from a clinical perspective will be required; c) be notified of all pending Mental Health Act assessments; d) be assessing all these cases before admission happens; and e) be central to the decision making process in conjunction with the rest of the multidisciplinary team.
3i	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
3j-k	Ambulance Cat A	For patients with immediately life-threatening conditions. The Operating Framework for 2012-13 requires all Ambulance Trusts to reach 75 per cent of urgent cases, Category A patients, within 8 minutes. From 1 June 2012, Category A cases will be split into Red 1 and Red 2 calls: • Red 1 calls are patients who are suffering cardiac arrest, are unconscious or who have stopped breathing. • Red 2 calls are serious cases, but are not ones where up to 60 additional seconds will affect a patient's outcome, for example diabetic episodes and fits. Ambulance Trusts will be required to improve their performance to show they can reach 80 per cent of Red 1 calls within 8 minutes by April 2013.
4a	C.Diff	Will apply to any inpatient facility with a centrally set C. difficile objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Both avoidable and unavoidable cases of C. difficile will be taken into account for regulatory purposes. Where there is no objective (i.e. if a mental health trust without a C. difficile objective acquires a community provider without an allocated C. difficile objective) we will not apply a C. difficile score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of C. difficile is set at 12. However, Monitor may consider scoring cases of <12 if the Health Protection Agency indicates multiple outbreaks. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation. If the Health Protection Agency indicates that the C. difficile target is exceeded due to multiple outbreaks, while still below the de minimis, the SHA may apply a score.
4b	MRSA	Will apply to any inpatient facility with a centrally set MRSA objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Those trusts that are not in the best performing quartile for MRSA should deliver performance that is at least in line with the MRSA objective target figures calculated for them by the Department of Health. We expect those trusts without a centrally calculated MRSA objective as a result of being in the best performing quartile to agree an MRSA target for 2012/13 that at least maintains existing performance. Where there is no objective (i.e. if a mental health trust without an MRSA objective acquires a community provider without an allocated MRSA objective) we will not apply an MRSA score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of MRSA is set at 6. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Finance Report 2013/14	Trust Board
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
The purpose of this report is to provide an update on the contract negotiations with commissioners for 2013/14, and a progress report on the Trust savings plan for the year A further update of the latest position will be provided at the meeting on 1 May	□ **TEC** ……..….. □ **STRATEGY**……. □ **FINANCE** ……..…… □ **AUDIT** ……..….. □ **QUALITY & SAFETY** ……..……..…….. □ **WORKFORCE** □ **CHARITABLE FUNDS** ……..….. **X TRUST BOARD** ……**1/5/13**……. □ **REMUNERATION** ……..….. □ **OTHER** ……..…… (please specify)
2. DECISION REQUIRED:	**CATEGORY:**
The Board is asked to note: The current position on contract negotiation with Commissioners and The progress made in further developing savings plans	□ **NATIONAL TARGET** □ **CNST** □ **CQC REGISTRATION** □ **HEALTH & SAFETY** □ **ASSURANCE FRAMEWORK** □ **CQUIN/TARGET FROM COMMISSIONERS** □ **CORPORATE OBJECTIVE** ……..….. □ **OTHER** …….. (please specify)
	AUTHOR/PRESENTER: David Gilburt
	DATE: 24th April 2013
3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
4. DELIVERABLES	
A successful our come is required to deliver the Trust financial plan	
5. KEY PERFORMANCE INDICATORS	
Reduce the financial deficit from £39.5m in 2012/13 to £17m in 2013/14	
AGREED AT _____ **MEETING** **OR** **REFERRED TO:** _____	**DATE:** _____ **DATE:** _____
REVIEW DATE (if applicable) _____	

Finance Report 2013/14

The purpose of this report is to provide an update on the contract negotiations with commissioners for 2013/14, and a progress report on the Trust savings plan for the year.

Contract negotiations

Contract negotiations are not progressing as quickly as had been envisaged. When budgets were provisionally approved by the Board the approval was subject to a satisfactory solution of the contract negotiations which were expected to be concluded during the first few days of April. At the time of writing (24th April) no contracts have been agreed. The position with key contracts is as follows:

1. There has been progress over the last few days with **Specialist Commissioning** and we are hopeful that we will have a draft heads of terms for the £56m contract this week. We are now told Specialist Commissioners are undertaking a triangulation exercise which requires our local commissioners to sign off the baseline and this is holding up agreement. When the offer is available it will be shared with CDs and Executive colleagues to ensure there are no surprises in the T&Cs which at the moment appear to be satisfactory.

2. We have contact with the **National Commission Board** with whom we expect a contract for circa £6m. Discussions are at an early stage and it seems that unlike London Specialist Commissioners, who are commissioning for the whole of England, breast screening and secondary dental services will be commissioned on a local area basis. Further clarification is being sought.

3. After a good start with our **local commissioners**, negotiations seem to have stalled due to an "Affordability Gap" When we met with CCG colleagues on 8th April we believed this to be around £1.8m. We have subsequently received an offer to halve the gap in order to come to a reduced baseline but we are still awaiting the terms and conditions that would accompany such a settlement. We are awaiting Local Commissioners proposal today (24th April 2013) .

   There is a real danger that local commissioners may yet slip into the arbitration process but it would be really disappointing in view of the huge amount of goodwill and progress made up to the end of March. We are scheduled to meet again Thursday 25th. Averil has asked to meet with Conor Burke her opposite number at the local CCGs before we have our monthly meet with the **TDA Friday 26th**. We continue to try to find a sensible way forward but I am not hopeful we will conclude the process whilst material shifts are being made to previously agreed numbers.

The TDA have indicated that contracts not agreed by 30Th April will by default go into an arbitration process. We will continue to press local commissioners to make progress and find an acceptable solution without the need for external arbitration.

Update on Savings Plans for 2013/14

The Programme Management Office (PMO) is taking over the coordination work to ensure plans are properly developed, signed off by the appropriate clinicians and managers and implemented effectively. Until now these tasks have been performed by a project team from EY but for 2013/14 onwards the Trust is putting its own team in place.

The Programme Management Office now has an agreed establishment allowing the trust to recruit an experienced team to lead the savings and reconfiguration work. The transition to a Trust team is well underway and actions include:

- Interim appointments have been made to deliver the roles and responsibilities of the PMO from May 2013.
- The permanent recruitment of the PMO roles is in progress. Job descriptions have been designed to meet the needs of the Trust and provide a focussed range of skills and expertise.

The CIP Programme for 2013/14 is now well advanced with lead clinicians and managers identified for major schemes and a process for sign off of each plan (Mandates) developed. The budget for 2013/14 envisages some £20m of savings schemes being delivered in year and to date:

- The CIP programme currently includes £15.8m of mandated schemes and a further £4.75m in development.
- All Directorates (clinical and non clinical) are working towards a deadline of 24/04/13 for outstanding mandates to be submitted and uploaded to the tracker.

These plans will have an impact on our workforce as we plan to become less dependent on temporary staffing and more efficient in the care we provide. The budgets allow for the trust to invest more funds in priority areas such as wards and the Emergency Department but overall

- Agency reduction strategies have been agreed by the 11 Clinical Directorates
- An overall reduction of 196 posts/equivalent spend is planned for the 2013/14 programme

Weekly accountability meetings are held with those delivering these plans and regular reports on progress will be made to the Trust Executive Team and Finance Committee and an overview of progress will be presented regularly to each Board meeting.

David Gilburt
Interim Director of Finance

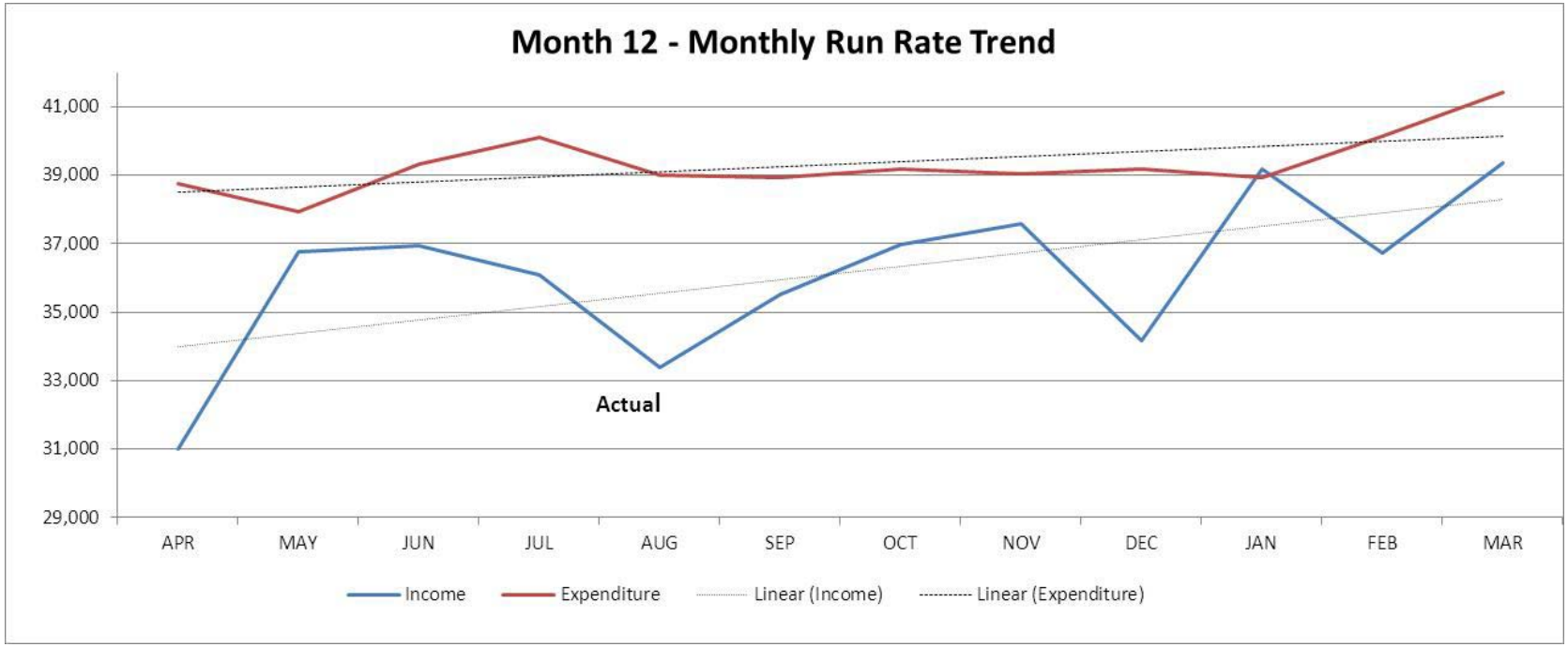
Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Finance Report – Month 12 (March) 2012/13	**Trust Board**
1. KEY ISSUES:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
• The March in- month position showed a recorded deficit of £1.1m, which is £1.5m favourable to original budget. • The Trust met its control total deficit of £39.7m deficit, with a final out-turn of £39.5m • The CIP position shows full year delivery of £18.9m, against a full year target of £23.1m, a shortfall of £4.3m for the year, but in excess of the minimum level of £18m, required to achieve the control total. A number of schemes related to year-end adjustments were delivered in line with expectations • The full-year income position is £438.4m, a favourable variance of £22.4m against budget and an increase of £21.2m (5.0%) over 2011/12. The final position has been agreed with all the main Commissioners. • The operating expenditure position was £477.8m, an adverse variance of £21.6m, of which £4.3m is related to the CIP shortfall, with the balance primarily related the cost of over-performance. This represents an increase of £10.2m over 2011/12, an increase of 2.2% • The year on year Trust financial performance therefore shows a very marked improvement of £11.7m at EBITDA level and £10.4m in terms of the bottom line position. • Pay costs represent 67% of income this year compared to 71% last year, whilst non-pay costs are at 32% of income, unchanged from last year. • The combination of continued strong cost control, improved income generation and the delivery of the CIP target have ensured that the Trust has met its overall financial target for the year.	□ **S&SIB** ……□ **EPB**…..…….. **X FINANCE** ……**30/4/13**□ **AUDIT** ……..….. □ **CLINICAL GOVERNANCE** ……..…..….. □ **CHARITABLE FUNDS** …… ☑**TRUST BOARD** …… □ **REMUNERATION** …… □ **OTHER** ……(please specify) **CATEGORY:** □ **NATIONAL TARGET** □ **CNST** □ **STANDARDS FOR BETTER HEALTH** □ **ASSURANCE FRAMEWORK** □ **TARGET FROM COMMISSIONERS** ☑ **CORPORATE OBJECTIVE** To achieve financial security for the Trust, with reduced costs, improved productivity and collecting income due □ **OTHER** …….. (please specify) **AUTHOR/PRESENTER:** Alan Davies, Deputy Director of Finance / David Gilburt, Director of Finance **DATE:** • The draft Annual Accounts were submitted to the Department of Health by the deadline of 22nd April and the primary financial statements from the Accounts are appended to this report. The audit of the Accounts is underway and final audited Accounts will be presented to the Board for approval at its meeting on 5th June.

2. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
Set out under key issues	
3. ALTERNATIVES CONSIDERED/REASONS FOR REJECTION:	
N/A	
4. DELIVERABLES:	
N/A	
5. EVIDENCE :	
N/A	
6. RECOMMENDATION/ACTION REQUIRED:	
The Trust Board is asked to approve the report and note that the Trust has achieved the control total deficit of £39.7m.	
AGREED AT _____ MEETING, OR **REFERRED TO: _____**	**DATE: _____** **DATE: _____**
REVIEW DATE _____ **(if applicable)**	

1. EXECUTIVE SUMMARY



Trust I&E Summary (+ve variances = favourable, -ve = adverse)

2012/13 In Month (£'000)				2012/13 Year to date (£'000)			2011/12 YTD	2012/13 Annual Budget	2012/13 Forecast at M11 (£'000)		
Actual £'000	Var £'000	Var %		Actual £'000	Var £'000	Var %	Actual £'000	£'000	Forecast	Var to Forecast £000	Var %
(44,132)	7,081	19.1%	Income	(438,450)	22,377	5.4%	(417,286)	(416,073)	(433,687)	(4,763)	1.1%
			Expenditure								
24,870	607	2.4%	- Pay	294,315	379	0.1%	290,883	294,695	294,102	213	0.1%
17,050	(6,278)	(58.3%)	- Non-pay	142,524	(11,299)	-8.6%	136,570	131,224	136,418	6,105	4.3%
	(582)	100.0%	- QIPP/Cost Reduction		(10,350)	100.0%		(10,350)	(3,036)	3,036	
	531	100.0%	- Contract adjmt. & reserves		(1,142)	100.0%		(1,142)	5,493	(5,493)	
(2,212)	**1,360**	**(159.5%)**	**EBITDA**	**(1,611)**	**(35)**	**2.1%**	**10,167**	**(1,646)**	**(709)**	**(902)**	
			ITDA								
1,202	6	0.5%	- Depreciation	13,993	501	3.5%	14,033	14,494	13,952	42	0.3%
208	147	41.4%	- Capital Dividends	3,283	980	23.0%	3,613	4,263	3,327	(44)	(1.3%)
128	(128)		- Unwinding of Discounts	128	(128)						
1,841	88	4.6%	- Net Interest	23,636	186	0.8%	23,027	23,822	23,736	(100)	(0.4%)
1,166	**1,473**	**55.8%**	**Net position**	**39,429**	**1,504**	**3.7%**	**50,840**	**40,933**	**40,306**	**(1,005)**	**(2.5%)**
(1,717)	(1,011)		Impairments	27,220	(29,225)		(1,133)	(2,005)	28,937		
(551)	**462**	**(521.7%)**	**Net position**	**66,648**	**(27,720)**	**-71.2%**	**49,707**	**38,928**	**69,243**	**(1,005)**	**(1.5%)**
1,717	1,011		Add back - Impairment	(27,220)	29,225		1,133	2,005	(28,937)	1,717	
(63)	69	1285.9%	IFRS reversed	64	(1,266)	105.3%	(882)	(1,202)	(759)	823	
1,103	**1,542**		**Net against control**	**39,493**	**238**	**0.6%**	**49,958**	**39,731**	**39,547**	**(54)**	**(0.1%)**

In Month and YTD Performance

The Increase in income and expenditure in the last two months of the year is primarily due to non-recurrent winter pressures costs of £2.8m, matched by ring-fenced non-recurrent funding by commissioners.

Income

There was an over- performance of £7.1m in the month, with a year to date over-performance of £22.4m. The reported position reflects the performance agreed with all commissioners and a forecast of £340k for Non contract activity income yet to be billed. This increase was partly the result of the release of provisions (£1.6m) against disputes and challenges from commissioners, which were no longer needed as an out-turn has been agreed with all main commissioners, and the winter pressures revenue support of £2.1m, to match against expenditure incurred in the month, and £2.5m of restructuring funding.

Pay expenditure

The monthly payroll costs of £24.9m are £607k less than budget. Cost over runs on **Medical Staff** in Anaesthetics (£90k), Neurosciences (£55k) and Radiology (£45k) are partially offset by savings in **Scientific, Therapeutic & Technical staff** in Radiology (£278k), and by savings in **Nursing staff** in Anaesthetics (£88k) and Womens (£178k)

The YTD pay cost is £294.3.4m, giving a budget underspend of £379k. The main areas of overspend relate to **Medical Staffing** in Anaesthetics (£642k), Radiology (£598k) and Specialist Surgery (£382k), being offset by savings in **Admin & Management** of £1,326 across most areas, but most notably Corporate (£700k), Women's and Children's (£309k) and Emergency Care.(£110k).

Non-pay expenditure

Non-pay expenditure exceeded budget by £6.0m in the month. The overrun predominately relates to a £1.2m variance on **Drug**s (a CIP budget reduction for drugs of £0.9m in Specialist Medicine, and overspend in drugs charges in Womens of £0.3m), and £4.1m on **Other Non-Pay**, made up of the creation of a number of provisions (£1.5m for Goods Received Not Invoiced , £1.4m for RTA income, £0.3m for disputed NHS charges), Consultancy Fees in Director of Nursing £0.4m and in Head of Estates £0.1m.

The full year non-pay over spend of £11.0m against budget is the result of the items detailed above, plus the creation of an redundancy provision in Month 11 of £1.8m, a restructuring provision of £3.7m for planned service changes in 2013-14, and other activity-driven overspends in drugs . This has been partially offset by a tax rebate of £3.7m.

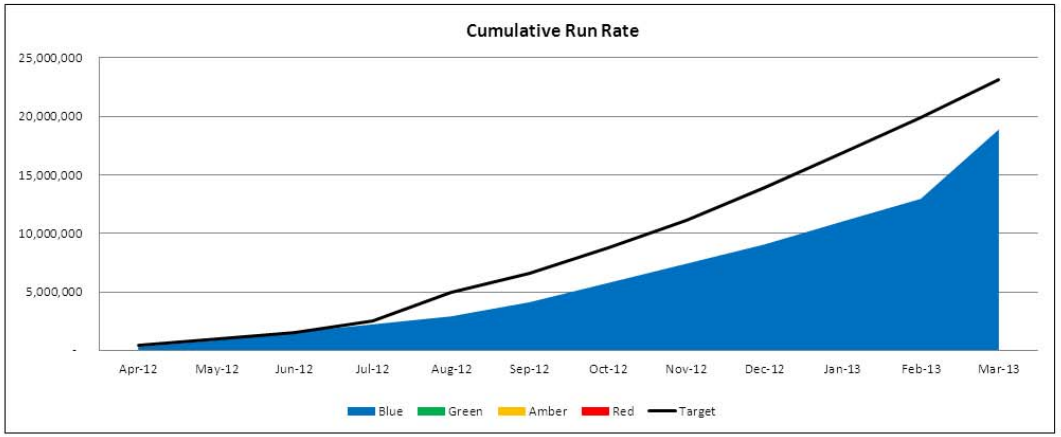
EBITDA

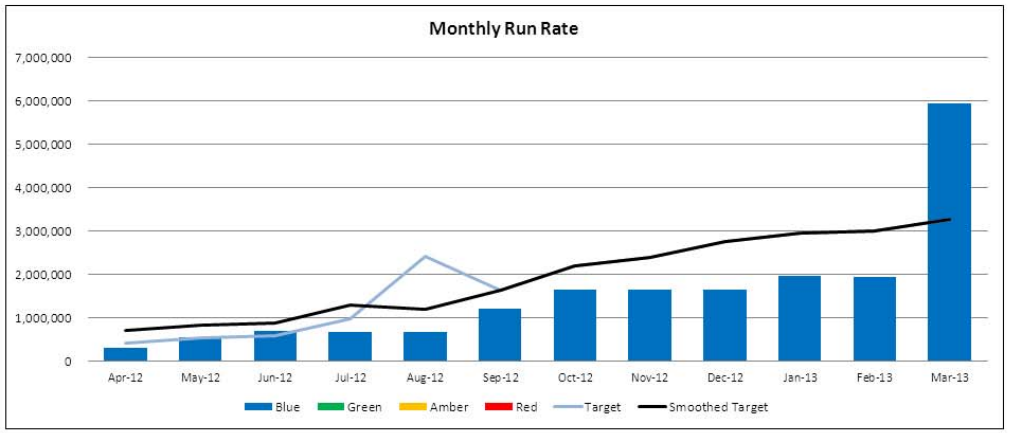
Earnings before Interest, Tax, Depreciation and Amortisation (EBITDA) were £2,212k positive in the month, and £1,611k positive YTD. The YTD EBITDA is in line with plan, and has improved by £11.8m compared with the same period last year.

Net deficit

The net deficit for the year is £39.5m as forecast, which is £0.2m better than the control total agreed with NHS London

CIP





CIP

- Overall CIP delivery for Month 12 was £5.9m in month and £18.9m YTD, above the forecast out-turn of £18.1m as at Month 11, and exceeding the total required to meet the Trust overall target.

Financial risk rating (per Monitor criteria)

Criteria	Indicator	Weight	Risk Ratings 5	4	3	2	1	Reported Position: Year to Date	Reported Position: Forecast Outturn	Normalised Position*: Year to Date	Normalised Position*: Forecast Outturn	Comments where target not achieved
Underlying performance	EBITDA margin %	25%	11	9	5	1	<1	1	1	1	1	Driven by planned and actual deficit
Achievement of plan	EBITDA achieved %	10%	100	85	70	50	<50	1	5	1	5	5 awarded as FOT equals Plan
Financial efficiency	Net return after financing %	20%	>3	2	-0.5	-5	<-5	1	1	1	1	Driven by planned and actual deficit
	I&E surplus margin %	20%	3	2	1	-2	<-2	1	1	1	1	Driven by planned and actual deficit
Liquidity	Liquid ratio days	25%	60	25	15	10	<10	1	1	1	1	Driven by financial position
Weighted Average		100%						1.0	1.4	1.0	1.4	
Overriding rules								1	1	1	1	
Overall rating								1	1	1	1	

KPIs

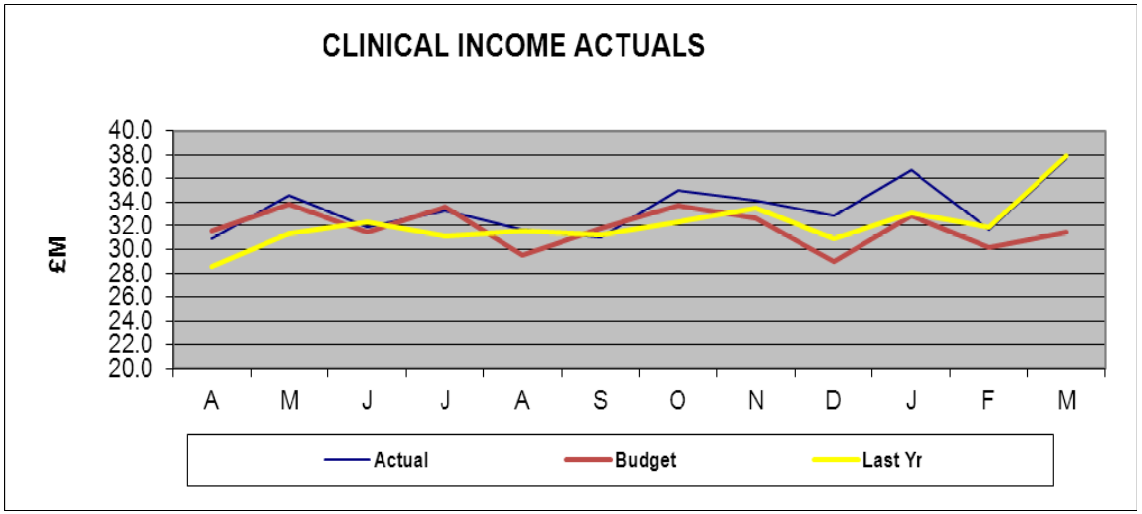
		Mar 13 Act Score	Mar 13 Bud Score
Initial Planning	Planned Outturn as a % of turnover	-16.3%	-16.3%
YtoD - operating performance	Ytd Operating surplus/Forecast Income %	-3.2%	-3.1%
YtoD - EBITDA	Ytd EBITDA/Ytd Income %	0.1%	0.3%
Forecast Op Performance	Forecast (Surp) or Def/Forecast income %	-9.4%	-16.3%
Forecast EBITDA : DH Risk score	Forecast EBITDA/Forecast Income %	0.3%	0.3%
Forecast change surplus/deficit outturn	Rate of change in Forecast %	0.0%	0.0%
Underlying financial position %	Underlying Forecast (Surp) or Def/Forecast underlying income %	-9.4%	-16.3%
EBITDA Margin %	Underlying Forecast EBITDA/Forecast underlying income %	0.3%	0.3%
BPPC Value%	Ytd % of value paid within target	71.7%	95.0%
BPPV Volume %	Ytd % of volume paid within target	58.9%	95.0%
Current Ratio	Current assets/current liabilities	0.73	
Debtor Days	Debtors represents x days income	11	
Credit Days	creditors represents x days expenditure	10	
Control Total variance to date %	Actual Variance / Budgeted (def) surp to date	-1.8%	0.0%
Performance against CIP (Variance) %	Actual CIP/Budgeted CIP to date	81.6%	100.0%
Income variance against plan %	Actual Income/Planned Income to date	105.1%	100.0%

Trust I&E summary by Division/Directorate:

2012/13 Budget			2012/13 In Month			2012/13 In Month			2012/13 Year to date (£'000)			2011/12	2011/12	2011/12	2012/13	2012/13 Forecast (£'000)		
In month	YTD	Annual	Actual £'000	Var £'000	Var %	Actual £'000	Variance WTE		Actual £'000	Var £'000	Var %	Ave Actual WTE	Ave Actual £'000	YTD Actual £'000	Budget £'000	Actual £'000	Var £'000	Var %
(34,277)	(384,459)	(384,459)	(35,617)	1,340	3.91%			Central Income	(393,220)	8,761	2.28%		(32,119)	(385,425)	(384,459)	(393,569)	9,110	2.37%
								Surgical Services Division										
3,537	42,505	42,505	3,966	(429)	-12.14%	669.37	-8.13	Anaesthetics	45,186	(2,681)	-6.31%	613.40	3,507	42,089	42,505	45,128	(2,623)	-6.17%
1,286	15,615	15,615	767	519	40.37%	221.40	2.60	Specialist Surgery	14,881	734	4.70%	250.26	1,340	16,082	15,615	15,326	289	1.85%
1,469	16,844	16,844	1,471	(2)	-0.12%	332.25	-10.48	Surgery	17,250	(406)	-2.41%	384.78	1,624	19,493	16,844	17,258	(414)	-2.46%
6,292	74,964	74,964	6,204	88	1.40%	1,223.02	-16.01	Total	77,317	(2,353)	-3.14%	1,248.44	6,471	77,664	74,964	77,711	(2,747)	-3.66%
								Emergency Care, Gen Med & Neurosciences										
4,267	50,903	50,903	4,811	(544)	-12.74%	1,128.68	-63.41	Medicine	50,996	(92)	-0.18%	1,033.10	3,829	45,953	50,903	50,276	627	1.23%
1,838	21,383	21,383	1,930	(92)	-5.00%	345.97	13.28	Emergency Care	22,077	(694)	-3.24%	583.37	2,573	30,880	21,383	21,939	(555)	-2.60%
793	8,807	8,807	565	228	28.77%	171.13	4.37	Therapies	8,585	223	2.53%	180.31	754	9,045	8,807	8,702	105	1.20%
1,099	13,510	13,510	1,003	96	8.73%	231.73	2.00	Neurosciences	13,929	(419)	-3.10%	230.86	1,136	13,629	13,510	14,179	(668)	-4.95%
7,998	94,604	94,604	8,310	(312)	-3.89%	1,877.51	-43.76	Total	95,586	(982)	-1.04%	2,027.64	8,292	99,506	94,604	95,095	(491)	-0.52%
								Women's, Children & Support Services										
1,212	14,164	14,164	1,201	11	0.89%	270.56	-12.89	Children	13,959	205	1.45%	263.71	1,188	14,257	14,164	13,916	247	1.75%
794	10,189	10,189	883	(89)	-11.20%	372.46	-3.86	Support Services	10,394	(204)	-2.01%	382.87	887	10,645	10,189	10,371	(181)	-1.78%
3,005	34,937	34,937	2,731	274	9.12%	612.65	51.31	Women	34,979	(42)	-0.12%	678.97	3,124	37,493	34,937	35,416	(479)	-1.37%
5,011	59,290	59,290	4,815	196	3.91%	1,255.67	34.56	Total	59,332	(42)	-0.07%	1,325.55	5,199	62,395	59,290	59,703	(413)	-0.70%
								Diagnostics & Specialist Medicine										
1,843	20,835	20,835	2,095	(252)	-13.66%	278.77	-0.94	Pathology	21,610	(775)	-3.72%	284.06	1,777	21,329	20,835	21,171	(336)	-1.61%
1,824	19,202	19,202	1,401	423	23.19%	305.37	-14.29	Radiology	19,397	(195)	-1.02%	287.38	1,543	18,521	19,202	19,603	(402)	-2.09%
2,423	30,499	30,499	2,494	(71)	-2.93%	400.14	3.76	Specialist Medicine	30,425	74	0.24%	425.17	2,687	32,248	30,499	30,405	93	0.31%
6,090	70,535	70,535	5,990	100	1.64%	984.28	-11.47	Total	71,432	(897)	-1.27%	996.61	6,007	72,099	70,535	71,180	(645)	-0.91%
7,818	89,523	89,523	6,751	1,067	13.64%	805.73	91.51	Corporate	85,837	3,686	4.12%	728.52	6,777	81,322	89,523	86,147	3,377	3.77%
(1,068)	4,458	4,458	(3,547)	2,479	232.14%	6,146.21	54.83	- Sub-total	(3,715)	8,173	183.32%	6,326.76	627	7,561	4,458	(3,732)	8,190	183.71%
20	279	279	1,462	(1,442)	-7286.05%			Central adjustment including provisions & red CIP	2,245	(1,966)	-705.55%		134	2,757	279	572	(293)	-105.32%
197	(6,373)	(6,373)		197	100.00%			Contract QIPP adjmt. & res		(6,373)					(6,373)	2,464	(8,837)	-138.66%
1,208	14,494	14,494	1,202	6	0.50%			Depreciation	13,993	501	3.45%		1,169	14,033	14,494	13,952	542	3.74%
2,283	28,075	28,075	2,049	234	10.25%			PDC & Net Interest	26,905	1,170	4.17%		2,209	26,508	28,075	27,050	1,025	3.65%
2,639	40,933	40,933	1,166	1,473	55.82%			Total	39,429	1,504	3.68%	6,326.76	4,139	50,859	40,933	40,306	627	1.72%
	(2,005)	(2,005)	(1,717)	(1,011)				Impairments	27,220	(29,225)				(1,151)	(2,005)	28,937		
2,639	38,928	38,928	(551)	462	17.52%			Net position	66,648	(27,720)	-71.21%	6,326.76	4,139	49,708	38,928	69,243	627	0.96%

- Central income over-performance is net of £8.6m income devolved to Business Units. The gross over-performance is therefore £17.2m.
- Surgical Services overspending primarily driven by £1.4m CIP shortfall, Medical staffing £0.6m and Clinical supplies expenditure (£1.3m), partially offset by devolved income (£1.3m)
- Emergency Care, Gen Med & Neurosciences out-turn is overspent due to CIP failure in Emergency Care (£0.4m), Non-Pay in Emergency Care (£0.2m) and Non-Pay costs Neurosciences (£0.2m)
- Women's, Children & Support Services have out-turned in line with budget, and below forecast.
- Diagnostics & Specialist Medicine overspend rimarily related to CIP shortfall £0.9m.
- Corporate under-spending primarily from non-recurrent income (£1.5m), estates (£1.0m), Management & Admin Pay (£0.7m), and Nursing (£0.4m)

2. CLINICAL INCOME



In Month			Year to date	
Actual	**Var**		**Actual**	**Var**
(7,637)	901	Medicine	(90,198)	8,245
(2,011)	108	Anaesthetics	(22,215)	(162)
(2,000)	9	Children	(23,687)	(368)
(2,393)	25	Emergency Care	(28,095)	(427)
(2,258)	(122)	Neurosciences	(27,045)	(1,806)
(813)	(1)	Pathology	(10,044)	126
(735)	129	Radiology	(8,980)	1,444
(3,517)	875	Specialist Medicine	(36,183)	4,046
(3,596)	269	Specialist Surgery	(43,926)	3,368
(3,608)	85	Surgery	(43,477)	606
(4,228)	46	Women	(50,628)	(104)
(4,948)	3,946	Corp	(17,058)	4,908
(37,746)	**6,269**	**Total**	**(401,536)**	**19,877**
		Devolved Income	8,626	(8,626)

Key points:

- In line with guidance from the SHA, the Trust and Commissioners' have agreed a monthly profile plan based on Commissioners' QIPP schemes; as such the Budget has been re-profiled to reflect this change.
- There was an over- performance of £6.3m in the month, with a full year over-performance of £19.9m. The reported position reflects the performance agreed with all commissioners and a forecast of £340k for Non contract activity income yet to be billed.
- There continues to be a higher than normal level of un-coded activity, however with a year -end agreement in place for all contracts the risk around the un-coded activity remains with non-contract activity and the potential risk to the Trust in the next financial year, should the un-coded activity levels remain the same.
- In month the East of England Contract has seen a favourable movement due to the Trust's achievement of 75% of CQUIN.
- The favourable movement in the Inner North East London contract mainly relates to the £4.3m support paid through City and Hackney. The actual INEL performance agreed for the year was Break-even.
- The activity table below compares current year YTD activity with the same period last year. A&E activity has grown by 3% year on year, but this is primarily due to the full-year effect of the Queen's UCC, which was taken on by BHRUT in August 2011.
- There is a growth of 3% in Day cases year on year as a result of the achievement of the 18 weeks targets, coupled with the Trust undertaking work that went to the ISTC last year. The Trust is also seeing a large increase in endoscopic work as a result of the expansion of bowel screening programmes.
- Non Elective activity has declined by 3% year on year Trust wide. However, B&D and Havering CCGs activity continues to increase year on year and this is putting considerable pressure on our finances as tariff is paid at 30% marginal rate. The reclassification of paediatric zero length of stay patients to a paediatric assessment unit is also responsible for a third of this reduction.
- Prior months' actual income came in at £1.5m less than accrued. The YTD position has been adjusted for this movement.
- The tables show the proportion of income over-performance that has been devolved to Clinical Directorates, £8.6m. A total of £9.2m has been built in to budgets for 2013/14
- The full year outturn includes SHA approved funding for winter pressures of £2.8m. The trust has put in place specific work streams which will alleviate pressures in A&E. The funding is to pay for additional expenditure on staff and non-pay and has not resulted in additional activity.
- The out-turn also includes £2.5m funding for restructuring at the Trust.

Income by POD

In Month			Year to date	
Actual	Var		Actual	Var
(1,799)	92	AandE	(21,100)	556
(77)	3	Ambulatory Care	(956)	54
(173)	(11)	Breast Screening	(2,132)	(109)
(199)	(17)	Challenge Trust Board	(2,548)	(52)
(655)	277	CQUIN	(6,888)	2,352
(2,449)	168	Critical Care	(27,303)	449
(2,772)	154	Daycases	(34,232)	2,247
(1,539)	676	Devices & Drugs	(12,411)	1,780
(1,294)	59	Direct Access	(15,981)	932
(1,902)	(16)	Elective	(23,487)	18
(355)	0	HIV Contract	(4,264)	0
(38)	(7)	ISTC Contract	(445)	(95)
(11,517)	697	Non Elective	(133,992)	3,535
(2,573)	125	OP First Attendances	(31,783)	1,777
(2,779)	202	OP Follow Ups	(34,318)	2,742
(530)	95	OP Procedures	(6,540)	1,230
(2,873)	1,400	Other	(22,285)	4,606
(305)	24	Patient Transport Services	(3,660)	294
(351)	34	Radiotherapy	(4,086)	225
468	28	Readmissions	5,511	442
(506)	43	Regular Day Attenders	(5,888)	255
1,424	(1,663)	Road Traffic Accidents	(808)	(2,056)
(4,300)	3,942	Transitional Funding	(4,300)	0
(654)	(36)	XBD	(7,641)	(1,304)
(37,746)	**6,269**	**Total**	**(401,536)**	**19,877**
		Devolved Income	8,626	(8,626)

Activity

POD Group	2011-12	2012-13	Var	% Change
AandE	205,108	218,923	13,815	3%
Ambulatory Care	3,156	3,239	83	1%
Breast Screening	22,037	21,539	(498)	-1%
Critical Care	26,484	27,674	1,190	2%
Daycases	42,565	45,354	2,789	3%
Direct Access	4,934,332	4,906,124	(28,208)	0%
Elective	7,903	7,759	(144)	-1%
Non Elective	78,293	73,761	(4,532)	-3%
OP First Attendar	174,373	175,013	640	0%
OP Follow Ups	404,120	392,234	(11,886)	-1%
OP Procedures	32,137	38,977	6,840	10%
Other	84,312	80,454	(3,858)	-2%
Radiotherapy	18,116	20,963	2,847	7%
Regular Day Atte	14,200	14,594	394	1%
XBD	39,510	28,971	(10,539)	-15%
Total	**6,086,646**	**6,055,580**	**(31,066)**	

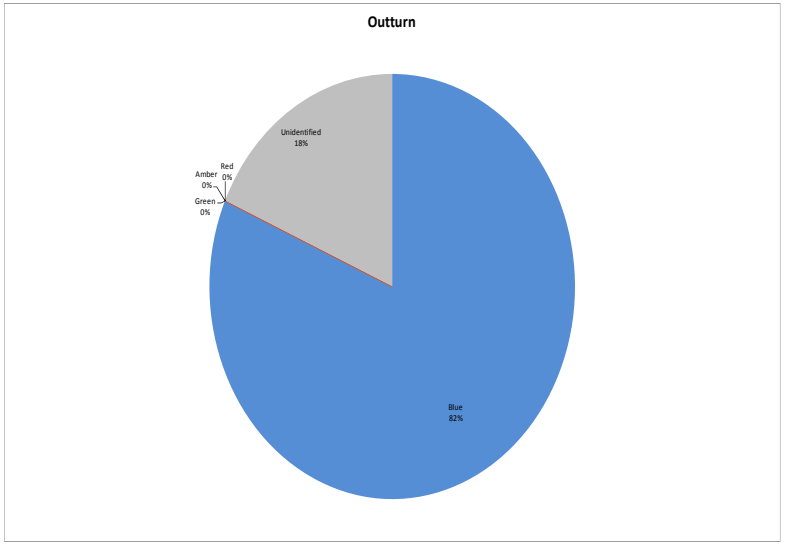
Cluster Performance

Cluster Performance

In Month			Year to date	
Actual	**Var**		**Actual**	**Var**
(25,214)	(865)	Outer North East London	(330,028)	13,800
(4,847)	4,370	Inner North East London	(10,071)	4,300
(1,327)	378	London Specialist Commissioning	(12,090)	707
(4,844)	1,683	East Of England Specialist Commissioning	(38,441)	95
(341)	5	Non Contract Activity	(4,011)	(200)
(76)	13	North Central London	(783)	20
(1,096)	683	Trust	(6,110)	1,155
(37,746)	**6,269**	**Total**	**(401,536)**	**19,877**
		Devolved Income	8,626	(8,626)

3. COST IMPROVEMENT PROGRAMME

Workstream	No of Schemes	Blue	Green	Amber	Red	Unidentified	EXECUTIVE LEAD	WORKSTREAM LEAD
Corporate	44	3,625,173	0	0	0	-2,666,323	Donna Kinnair	TBC
Diagnostics	52	924,155	0	0	0	1,001,077	Nick Hulme	Liz Lyon
Medicines Managemen	27	2,261,125	0	0	0	-664,244	David Gilburt	Portia Omo-Bare
Estates	24	2,175,304	0	0	0	-967,224	David Gilburt	Jackie Nugent
Length of Stay	14	2,050,356	0	0	0	556,688	Dorothy Hosein	Shelagh Smith
Non-pay	27	1,290,936	0	0	0	-123,389	David Gilburt	Linda Kruse
Outpatients	15	279,558	0	0	0	769,489	Dorothy Hosein	Arshiya Khan
Theatres	21	535,796	0	0	0	1,002,170	Nick Hulme	Eileen Moore
Workforce - A&C	53	829,771	0	0	0	235,382	Nick Hulme	Clare O'Toole
Workforce - AHP	32	965,377	0	0	0	256,352	Flo Panel-Coastes	Nick Hulme
Workforce - Medical	54	1,607,815	0	0	0	3,102,114	Dr Mike Gill	Mr Stephen Burgess
Workforce - Nursing	33	2,351,700	0	0	0	1,754,841	Flo Panel-Coastes	Judith Douglas
Totals	**396**	**18,897,067**	**0**	**0**	**0**	**4,256,933**		



Commentary

The outturn as at Month 11 is £18.9.m, which is an £800k increase from the Month 11 forecast position of £18.1m

The in-month performance was £5.9m, compared with an average run-rate of £1.2m as at month 11

The material movements in the actual out-turn compared to the forecast at month 11 are:

Central	***£250k –stock management***
Corporate	***(£474k) – rates rebate***
Specialist Medicine	***£432k – pharmacy efficiencies***
Womens	***£575k – Midwifery Temp staff and rota management***

Workstream	Full Year Performance					Forecast Month 11		
	Plan £	Outturn £	Outturn %	Variance £	Variance %	Outturn £	Variance M12 v M11 £	Variance M12 v M11 %
Corporate	1,338,652	3,625,173	271%	2,286,521	171%	3,375,173	250,000	11%
Diagnostics	1,922,522	924,155	48%	-998,366	(52%)	924,155	0	0%
Medicines Management	1,606,525	2,261,125	141%	654,601	41%	1,829,125	432,000	66%
Estates	1,001,764	2,175,304	217%	1,173,540	117%	2,649,320	-474,016	-40%
Length of Stay	2,535,139	2,050,356	81%	-484,783	(19%)	2,050,356	0	0%
Non-pay	1,308,633	1,290,936	99%	-17,697	(1%)	1,290,936	0	0%
Outpatients	1,176,930	279,558	24%	-897,372	(76%)	279,558	0	0%
Theatres	1,598,558	535,796	34%	-1,062,762	(66%)	526,676	9,120	-1%
Workforce - A&C	1,123,278	829,771	74%	-293,507	(26%)	829,771	0	0%
Workforce - AHP	1,388,501	965,377	70%	-423,125	(30%)	965,377	0	0%
Workforce - Medical	4,198,726	1,607,815	38%	-2,590,911	(62%)	1,607,815	0	0%
Workforce - Nursing	3,954,772	2,351,700	59%	-1,603,072	(41%)	1,776,700	575,000	-36%
Totals	**23,154,000**	**18,897,067**	**82%**	**-4,256,933**	**-18%**	**18,104,963**	**792,104**	**-19%**

- *£5.9m delivered in the final month of the year, including £1.6m of year-end schemes (annual leave £750k and stock adjustments £900k)*
- *Includes £1.8m of other schemes which delivered in the final month, as planned £650k for Midwifery, and £800k Pharmacy*

	In Month (£)				Year To Date (£)				Run Rates		Full Year
Directorate	Plan	Actual	Variance	% Var	Plan	Actual	Variance	% Var	YTD	YTG	Effect
Anaesthetics	335,101	105,247	(229,854)	(69%)	2,104,000	659,956	(1,444,044)	(69%)	54,996		1,239,468
Central	856,398	2,095,032	1,238,635	145%	5,823,000	4,888,953	(934,048)	(16%)	407,413		4,897,153
Children	64,526	80,844	16,318	25%	735,000	797,026	62,026	8%	66,419		889,414
Corporate	249,286	1,124,388	875,101	351%	2,042,000	2,997,694	955,694	47%	249,808		2,086,108
Emergency Care	185,559	86,189	(99,370)	(54%)	1,111,000	694,483	(416,517)	(37%)	57,874		894,832
Medicine	411,565	249,152	(162,413)	(39%)	2,542,000	2,071,975	(470,025)	(18%)	172,665		2,784,002
Neurosciences	91,982	52,354	(39,628)	(43%)	686,000	547,095	(138,905)	(20%)	45,591		672,932
Pathology	141,940	84,137	(57,803)	(41%)	1,073,000	515,749	(557,251)	(52%)	42,979		1,021,465
Radiology	123,310	68,963	(54,348)	(44%)	910,000	461,210	(448,790)	(49%)	38,434		717,981
Specialist Medicine	297,877	968,576	670,698	225%	2,011,000	2,140,004	129,004	6%	178,334		2,038,909
Specialist Surgery	83,912	74,189	(9,723)	(12%)	872,000	749,416	(122,584)	(14%)	62,451		777,468
Support Services	97,449	125,224	27,775	29%	527,000	165,556	(361,444)	(69%)	13,796		198,000
Surgery	108,255	77,681	(30,574)	(28%)	839,000	617,025	(221,975)	(26%)	51,419		840,571
Women	225,179	748,302	523,123	232%	1,879,000	1,590,927	(288,073)	(15%)	132,577		1,979,708
Totals	**3,272,340**	**5,940,277**	**2,667,937**	**82%**	**23,154,000**	**18,897,067**	**(4,256,933)**	**(18%)**	**1,225,617**	**4,623,173**	**21,038,010**

4. BALANCE SHEET

(£m)	Current Period Mar-13	Previous Period Feb-13	Last Yr End Mar-12
Non-current assets	**£358.3**	£357.2	£387.5
Current assets			
Inventories	**£5.9**	£5.0	£5.8
Trade and other receivables	**£22.7**	£45.9	£35.6
Cash and cash equivalents	**£4.5**	£19.3	£4.2
	£33.2	£70.3	£45.6
Current liabilities			
Trade and other payables	**(£28.1)**	(£69.3)	(£46.3)
PFI \ Borrowings	**(£6.7)**	(£6.5)	(£6.0)
Provisions	**(£1.9)**	(£2.1)	(£1.8)
Net current assets/(liabilities)	**(£3.5)**	**(£7.6)**	(£8.4)
Non-current liabilities:			
PFI \ Borrowings	**(£254.9)**	(£254.9)	(£258.7)
Trade and other payables	**(£4.7)**	(£4.7)	(£4.9)
Provisions	**(£8.9)**	(£5.1)	(£3.2)
Total assets employed	**£86.3**	£85.0	£112.2
Financed by taxpayers' equity:			
Public dividend capital	**£405.4**	£405.4	£365.7
Retained Earnings - P&L	**(£329.9)**	(£331.0)	(£263.8)
Retained Earnings - Donated Assets	**-**	-	-
Revaluation reserve	**£10.9**	£10.6	£10.3
Donated asset reserve	**£0.0**	£0.0	-
Total taxpayers' equity	**£86.3**	£85.0	£112.2

KPIs	Current Period Mar-13	Prior Period Feb-13	Last Yr End Mar-12
Average Debtors days	**11**	**28**	21
Debtors >90 days (£'000s)	**£5,149**	**£589**	£592
Debtors >180 days (£'000s)	**£509**	**£378**	£1,536
Debtors >365 days (£'000s)	**£1,223**	**£1,229**	£2,825
Total Bad Debt Provision (£'000s)	**£2,169**	**£1,590**	£1,926
>365 days provided (£'000s)	**£993**	**£958**	£1,293
Average creditor days	**10**	**21**	58
Current ratio	**73%**	**85%**	84%
Better payment practice code performance:			
- Non-NHS			
- Volume - paid on time	**6,765**	**4,093**	2,773
- Volume - % paid on time	**83.35%**	**70.33%**	27.96%
- Value - paid on time (£'000s)	**£17,863**	**£7,901**	£5,150
- Value - % paid on time	**86.51%**	**78.21%**	35.85%
- NHS			
- Volume - paid on time	**234**	**150**	316
- Volume - % paid on time	**80.14%**	**62.76%**	34.39%
- Value - paid on time (£'000s)	**£1,902**	**£1,039**	£1,630
- Value - % paid on time	**72.35%**	**78.08%**	30.52%

Key points:

- Trade and other receivables reduced by £23.7m in March as the local PCT's paid outstanding debt including £19.7m over performance.
- The Trade and other payables reduced by £41.2m in March as over performance and winter pressure cash was received to enable creditors to be reduced .
- Provisions increased by £3.8m in March which includes a restructuring provision of £3.7m for 2013/14 for the changes in Maternity and planned ward closures.

Key points:

- Debtors>90days (£000s) increased by £4,560k in March, which included a £2.5m over performance invoice for over performance which has since been paid. More detail is provided in the debtors report.
- Better payment practice code performance for Non NHS organisations improved in volume by 13% with 83% of volume paid on time.

5. CAPITAL AND CASHFLOW

Summary Cashflow - Year to date	£000's
Operating Deficit	(40,785)
Interest Paid	(24,461)
PDC Dividend Paid	(3,498)
Interest received	718
Impairments	28,732
Transfers	-
Net I&E deficit (cash impact)	**(39,294)**
Depreciation and Amortisation	13,993
Movements in working balances:	
Decrease in Inventories	(114)
Increase in Trade and Other Receivables	15,736
Increase in Trade and Other Payables	(15,435)
Decrease in Provisions	2,937
- sub-total	(22,177)
Capital expenditure	(12,842)
Revenue Rental Income	1,659
Net cashflow before financing	(33,360)
Capital Element of Finance Leases and PFI	(6,171)
Loans repaid	-
Public Dividend Capital Received	39,700
Net Increase/(Decrease) in Cash and Cash Equivalents	**168**
Opening cash balance	4,343
Closing cash balance	4,512

Capital Programme Summary	Original Plan	YTD Spend	Total Forecast To Spend 31-03-13
Internally Funded Schemes			
Medical Equipment	2,325	1,886	1,886
Medical Equipment - KGH MRI	851	811	811
IT - Hardware	1,230	1,246	1,246
IT - Software	62	170	170
Other Plant & Machinery	500	500	500
Estates	3,625	2,621	2,621
Revenue to Capital other		0	0
sub-Total	**8,593**	**7,234**	**7,234**
Externally Funded Assets			
Digital Mammography	1,548	998	998
Pathology	5,094	660	660
SAN	714	873	873
MLU	1,526	1,353	1,353
SCBU	1,050	213	213
Access Funded Assets	261	51	51
PAS Replacement	10,000	297	297
Improving Birthing Environments	0	0	0
sub-Total	**20,193**	**4,445**	**4,445**
Trust Variation Enquiries	**2,966**	**3,128**	**3,128**
Unallocated		**(18)**	**(18)**
Total Trust - Funded	**2,966**	**14,789**	**14,789**
Subject to External Approval & Funding			
Cardiac Cath Lab	1,700	5	5
CT Scanners	1,149		
A&E Reconfiguration	3,000	0	0
sub-Total	**5,849**	**5**	**5**
Total Capital Plan to Date	**8,815**	**14,794**	**14,794**
Assets to be Considered via Charitable Funds			
Da Vinci Robot	2,400		
Rapid Arc	0	467	467
Radiotherapy Innovation Fund	0	462	462
	2,400	929	929
Grand Total	**11,215**	**15,723**	**15,723**

Key points:

- The closing cash position was £4,512. An under shoot of the EFL by £4.8m due to slippage with externally funded capital schemes where the Trust was not able to draw down EFL till 2013/14.

Key points:

- At the end of March 2013, the 2012-13 Capital Program reported a year end actual outturn of £15.7m, representing a £981k shortfall against the February 2013 planned forecast and an undershoot of £2.5m against the Capital Resource Limit (CRL), which is carried forward to 2013/14. The commencement of the Improving Birthing Environment project £181k has also been delayed as a result of the inability of the company to deliver ordered Draeger Billimeters items until the end of April 2013. Also The Remtec Chairs, ordered as part of this project, are still waiting to be delivered.
- A key reason for the movement away from forecast has also been the de capitalisation of the MISL/A&E Document scanning project. A decision of accelerated depreciation was effected on the capital spend to date, accounting for £181k write off in 2013 alone.
- Two schemes related to Estates, Roof Repairs £80k and Health and Safety £40k, could not be started as planned due to unfavourable weather conditions and logistical delays respectively
- It is also worth mentioning that the plan to capitalise revenue expenditure items totalling £500k was not implemented

6. ANNUAL ACCOUNTS

- The draft Annual Accounts (including Remuneration report) were submitted to the Department of Health by the deadline of 12pm on 22nd April.
- The Trust also submitted its draft Governance Statement, Board assurance Framework, Risk Register and Head of Internal Audit Opinion
- The Accounts showed a final deficit of £39,492k, adjusted for impairments and IFRS, in line with the Month 12 position reported above.
- The four primary financial statements are appended below:
    - The Statement of Comprehensive Income (more commonly referred to as the Income and Expenditure Account)
    - Statement of Financial Position (or Balance Sheet)
    - Statement of Changes in Taxpayers' Equity
    - Statement of Cashflows
- Also appended to the report is Note 43, regarding the Trust's performance against its key financial targets. In summary, the Trust's performance was as follows:

Financial Duty	Description	Outcome
Breakeven duty	To breakeven between income and expenditure, on a rolling three year basis (five by exception)	Failed
Capital Cost Absorption Rate	To achieve a return of 3.5% on net assets, payable as Public Dividend Capital Dividend	Achieved
External Financing Limit	To not exceed the EFL set by the Department of Health	Achieved
Capital Resource Limit	To not exceed the CRL set by the Department of Health	Achieved

- A full set of audited Accounts including Notes, will be presented to the Audit Committee and Trust Board on 5th June for approval.

Statement of Comprehensive Income for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Gross employee benefits	10.1	**(297,028)**	(291,010)
Other costs	8	**(180,926)**	(151,148)
Revenue from patient care activities	5	**409,173**	388,459
Other Operating revenue	6	**29,181**	30,662
Operating surplus/(deficit)		**(39,600)**	(23,038)
Investment revenue	12	**718**	754
Other gains and (losses)	13	**0**	35
Finance costs	14	**(24,482)**	(23,800)
Surplus/(deficit) for the financial year		**(63,364)**	(46,049)
Public dividend capital dividends payable		**(3,283)**	(3,613)
Retained surplus/(deficit) for the year		**(66,647)**	(49,662)

Other Comprehensive Income	2012-13 £000	2011-12 £000
Impairments and reversals	**(168)**	0
Net gain/(loss) on revaluation of property, plant & equipment	**1,508**	422
Net gain/(loss) on revaluation of intangibles	**0**	0
Net gain/(loss) on revaluation of financial assets	**0**	0
Movements in Other Reserves eg. Non NHS Pensions Scheme	**0**	0
Net gain/(loss) on available for sale financial assets	**0**	35
Net Gain / (loss) on Assets Held for Sale	**0**	0
Net actuarial gain/(loss) on pension schemes	**0**	0
Reclassification Adjustments		
On disposal of available for sale financial assets	**0**	0
Total comprehensive income for the year*	**(65,307)**	(49,205)

* This sums the rows above and the surplus / (deficit) for the year before adjustments for PDC dividend and absorption accounting

Financial performance for the year

Retained surplus/(deficit) for the year	**(66,647)**	(49,662)
Prior period adjustment to correct errors	**0**	0
IFRIC 12 adjustment	**810**	53
Impairments	**27,219**	(180)
Adjustments from donated asset/gov't grant reserve elimination	**874**	124
Adjustment re Absorption accounting	**0**	0
Adjusted retained surplus/(deficit)	**(39,492)**	(49,665)

PDC dividend: balance receivable/(payable) at 31 March 2013	**245**
PDC dividend: balance receivable/(payable) at 1 April 2012	**29**

The notes on pages 5 to 46 form part of this account.

Statement of Financial Position as at 31 March 2013

	NOTE	31 March 2013 £000s	31 March 2012 £000s
Non-current assets:			
Property, plant and equipment	15	**341,563**	365,635
Intangible assets	16	**1,992**	2,760
Investment property	18	**0**	0
Other financial assets	24	**0**	0
Trade and other receivables	22.1	**14,084**	19,076
Total non-current assets		**357,639**	387,471
Current assets:			
Inventories	21	**5,867**	5,818
Trade and other receivables	22.1	**23,583**	35,588
Other financial assets	24	**0**	0
Other current assets	25	**0**	0
Cash and cash equivalents	26	**4,512**	4,343
Total current assets		**33,962**	45,750
Non-current assets held for sale	27	**690**	0
Total current assets		**34,652**	45,750
Total assets		**392,291**	433,220
Current liabilities			
Trade and other payables	28	**(28,607)**	(43,691)
Other liabilities	29	**0**	0
Provisions	35	**(6,714)**	(2,710)
Borrowings	30	**(6,454)**	(5,977)
Other financial liabilities	31	**0**	0
Working capital loan from Department	30	**0**	0
Capital loan from Department	30	**0**	0
Total current liabilities		**(41,775)**	(52,378)
Non-current assets plus/less net current assets/liabilities		**350,516**	380,842
Non-current liabilities			
Trade and other payables	28	**(4,703)**	(4,916)
Other Liabilities	31	**0**	0
Provisions	35	**(4,074)**	(5,014)
Borrowings	31	**(255,154)**	(258,720)
Other financial liabilities	30	**0**	0
Working capital loan from Department	30	**0**	0
Capital loan from Department	30	**0**	0
Total non-current liabilities		**(263,931)**	(268,650)
Total Assets Employed:		**86,585**	112,192
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital		**405,375**	365,675
Retained earnings		**(329,657)**	(263,787)
Revaluation reserve		**10,867**	10,304
Other reserves		**0**	0
Total Taxpayers' Equity:		**86,585**	112,192

The financial statements on pages 5 to 46 were approved by the Board on [date] and signed on its behalf by

Chief Executive: Date:

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2013

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2012	**365,675**	**(263,787)**	**10,304**	**0**	**112,192**
Changes in taxpayers' equity for 2012-13					
Retained surplus/(deficit) for the year	0	(66,647)	0	0	**(66,647)**
Net gain / (loss) on revaluation of property, plant, equipment	0	0	1,508	0	**1,508**
Net gain / (loss) on revaluation of intangible assets	0	0	0	0	**0**
Net gain / (loss) on revaluation of financial assets	0	0	0	0	**0**
Net gain / (loss) on revaluation of assets held for sale	0	0	0	0	**0**
Impairments and reversals	0	0	(168)	0	**(168)**
Movements in other reserves	0	0	0	0	**0**
Transfers between reserves	0	777	(777)	0	**0**
Release of reserves to Statement of Comprehensive Income	0	0	0	0	**0**
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0	**0**
Transfers between Revaluation Reserve & Retained Earnings in respect of assets transferred under absorption	0	0	0	0	**0**
On Disposal of Available for Sale financial Assets	0	0	0	0	**0**
Reserves eliminated on dissolution	0	0	0	0	**0**
Originating capital for Trust established in year	0	0	0	0	**0**
New PDC Received	39,700	0	0	0	**39,700**
PDC Repaid In Year	0	0	0	0	**0**
PDC Written Off	0	0	0	0	**0**
Transferred to NHS Foundation Trust	0	0	0	0	**0**
Other Movements in PDC In Year	0	0	0	0	**0**
Net Actuarial Gain/(Loss) on Pension	0	0	0	0	**0**
Net recognised revenue/(expense) for the year	**39,700**	**(65,870)**	**563**	**0**	**(25,607)**
Balance at 31 March 2013	**405,375**	**(329,657)**	**10,867**	**0**	**86,585**
Balance at 1 April 2011	**307,275**	**(215,571)**	**11,328**	**0**	**103,032**
Changes in taxpayers' equity for the year ended 31 March 2012					
Retained surplus/(deficit) for the year	0	(49,662)	0	0	(49,662)
Net gain / (loss) on revaluation of property, plant, equipment	0	0	422	0	422
Net gain / (loss) on revaluation of intangible assets	0	0	0	0	0
Net gain / (loss) on revaluation of financial assets	0	0	0	0	0
Net gain / (loss) on revaluation of assets held for sale	0	0	0	0	0
Impairments and reversals	0	0	0	0	0
Movements in other reserves	0	0	0	0	0
Transfers between reserves	0	1,446	(1,446)	0	0
Release of reserves to Statement of Comprehensive Income	0	0	0	0	0
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0	0
On Disposal of Available for Sale financial Assets	0	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0	0
Originating capital for Trust established in year	0	0	0	0	0
New PDC Received	58,400	0	0	0	58,400
PDC Repaid In Year	0	0	0	0	0
PDC Written Off	0	0	0	0	0
Transferred to NHS Foundation Trust	0	0	0	0	0
Other Movements in PDC In Year	0	0	0	0	0
Net Actuarial Gain/(Loss) on Pension	0	0	0	0	0
Net recognised revenue/(expense) for the year	58,400	(48,216)	(1,024)	0	9,160
Balance at 31 March 2012	**365,675**	**(263,787)**	**10,304**	**0**	**112,192**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED
31 March 2013

	2012-13	2011-12
	£000s	£000s
Cash Flows from Operating Activities		
Operating Surplus/Deficit	**(39,600)**	(23,038)
Depreciation and Amortisation	**13,995**	14,033
Impairments and Reversals	**27,219**	(1,133)
Other Gains / (Losses) on foreign exchange	**0**	0
Donated Assets received credited to revenue but non-cash	**(493)**	(213)
Government Granted Assets received credited to revenue but non-cash	**0**	0
Interest Paid	**(23,839)**	(23,721)
Dividend (Paid) / Refunded	**(3,498)**	(3,735)
Release of PFI/deferred credit	**0**	0
(Increase)/Decrease in Inventories	**(49)**	1,170
(Increase)/Decrease in Trade and Other Receivables	**16,724**	(1,425)
(Increase)/Decrease in Other Current Assets	**0**	0
Increase/(Decrease) in Trade and Other Payables	**(15,124)**	(5,555)
(Increase)/Decrease in Other Current Liabilities	**0**	0
Provisions Utilised	**(2,421)**	(762)
Increase/(Decrease) in Provisions	**5,357**	1,519
Net Cash Inflow/(Outflow) from Operating Activities	**(21,729)**	(42,860)
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest Received	**718**	754
(Payments) for Property, Plant and Equipment	**(12,349)**	(9,251)
(Payments) for Intangible Assets	**0**	0
(Payments) for Investments with DH	**0**	0
(Payments) for Other Financial Assets	**0**	0
(Payments) for Financial Assets (LIFT)	**0**	0
Proceeds of disposal of assets held for sale (PPE)	**0**	100
Proceeds of disposal of assets held for sale (Intangible)	**0**	0
Proceeds from Disposal of Investment with DH	**0**	0
Proceeds from Disposal of Other Financial Assets	**0**	0
Proceeds from the disposal of Financial Assets (LIFT)	**0**	0
Loans Made in Respect of LIFT	**0**	0
Loans Repaid in Respect of LIFT	**0**	0
Rental Revenue	**0**	0
Net Cash Inflow/(Outflow) from Investing Activities	**(11,631)**	(8,397)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(33,360)**	(51,257)
CASH FLOWS FROM FINANCING ACTIVITIES		
Public Dividend Capital Received	**39,700**	58,400
Public Dividend Capital Repaid	**0**	0
Loans received from DH - New Capital Investment Loans	**0**	0
Loans received from DH - New Revenue Support Loans	**0**	0
Other Loans Received	**0**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal	**0**	0
Loans repaid to DH -Revenue Support Loans	**0**	0
Other Loans Repaid	**0**	0
Cash transferred to NHS Foundation Trusts	**0**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(6,171)**	(5,636)
Capital grants and other capital receipts	**0**	6
Net Cash Inflow/(Outflow) from Financing Activities	**33,529**	52,770
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**169**	1,513
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**4,343**	2,830
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies	**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	**4,512**	4,343

43. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

43.1 Breakeven performance	2005-06 £000s	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s
Turnover	334,815	351,780	345,451	378,400	397,456	407,107	419,121	**438,354**
Retained surplus/(deficit) for the year	(16,009)	(16,844)	(35,621)	(35,674)	(56,243)	(25,436)	(49,662)	**(66,647)**
Adjustment for:								
Timing/non-cash impacting distortions:								
Use of pre - 1.4.97 surpluses [FDL(97)24 Agreements]	0	0	0	0	0	0	0	**0**
2006/07 PPA (relating to 1997/98 to 2005/06)	0	0	0	0	0	0	0	**0**
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0	0	0	0	0	0	**0**
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0	0	0	0	0	**0**
Adjustments for Impairments	0	0	0	9,460	31,862	(8,670)	(1,133)	**27,219**
Adjustments for impact of policy change re donated/government grants assets	0	0	0	0	0	0	(124)	**(874)**
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*	0	0	0	0	2,100	1,120	1,006	**810**
Adsorption Accounting Adjustment	0	0	0	0	0	0	0	**0**
Other agreed adjustments	0	0	0	0	0	0	0	**0**
Break-even in-year position	**(16,009)**	**(16,844)**	**(35,621)**	**(26,214)**	**(22,281)**	**(32,986)**	**(49,913)**	**(39,492)**
Break-even cumulative position	**(15,989)**	**(32,833)**	**(68,454)**	**(94,668)**	**(116,949)**	**(149,935)**	**(199,848)**	**(239,340)**

*

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

The Trust's recovery plan, aims to achieve break-even in 2015.

If anticipated financial year of recovery is more than two years state the period agreed with SHA

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %
Materiality test (I.e. is it equal to or less than 0.5%):								
Break-even in-year position as a percentage of turnover	-4.78	-4.79	-10.31	-6.93	-5.61	-8.10	-11.91	**-9.01**
Break-even cumulative position as a percentage of turnover	-4.78	-9.33	-19.82	-25.02	-29.42	-36.83	-47.68	**-54.60**

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

43.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

43.3 External financing

The trust is given an external financing limit which it is permitted to undershoot.

	£000s	**2012-13 £000s**	2011-12 £000s
External financing limit		**41,297**	56,307
Cash flow financing	**33,360**	**0**	51,257
Finance leases taken out in the year	**3,082**	**0**	4,905
Other capital receipts	**0**	**0**	(6)
External financing requirement		**36,442**	56,156
Undershoot/(overshoot)		**4,855**	151

With no signed contract in place at 31st March 2013 with the local Clinical Commissioning Groups and therefore due to the uncertainty over cash flow in the new financial year the Trust had to take a prudent position on cash at the year end. It is a regulatory duty not to exceed our External Finance Limit (EFL) at the year end and normal practice is to deplete the bank account at the end of March to get close to the EFL. Recent changes made to the EFL by the DH would mean the Trust would effectively have to empty the account to get near to this target. Because the uncertainty about the flow of funds had not been resolved it was decided to hold a contingency of circa £4.8m in the bank account at the year-end which meant the Trust "undershot" the EFL on 31 March 2013 by this amount.

43.4 Capital resource limit

The trust is given a capital resource limit which it is not permitted to exceed.

	2012-13 £000s	2011-12 £000s
Gross capital expenditure	**15,724**	15,516
Less: book value of assets disposed of	**0**	(65)
Less: capital grants	**(462)**	0
Less: donations towards the acquisition of non-current assets	**(493)**	(213)
Charge against the capital resource limit	**14,769**	15,238
Capital resource limit	**17,305**	16,572
(Over)/underspend against the capital resource limit	**2,536**	1,334

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Report from Workforce Committee and Workforce Key Performance Indicators	Trust Board
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
The following update is twofold, the first part is a report on the key issues discussed and reviewed at the Workforce Committee meeting held on 15th April 2013. The second is the workforce key performance indicators for the Trust. The report adopts a revised format from previous months and on-going iterations of the report will incorporate an improved content and presentation following re commendations and feedback received through the Workforce Committee.	□ **TEC** ……..….. □ **STRATEGY**……..….. □ **FINANCE** ……..…… □ **AUDIT** ……..……..….. - **QUALITY & SAFETY** ……..……..……..…… □ **WORKFORCE** □ **CHARITABLE FUNDS** ……..……..….. ✓ **TRUST BOARD - 01 May 2013** □ **REMUNERATION** ……..……..…... □ **OTHER** ……..……..…… (please specify)
2. DECISION REQUIRED	**CATEGORY:**
The Board is requested to note the enclosed and comment on the style and content of the new reporting format from the Workforce Committee.	✓**NATIONAL TARGET** ✓ **CNST** ✓ **CQC REGISTRATION** ✓ **HEALTH & SAFETY** ✓ **ASSURANCE FRAMEWORK** ✓**CQUIN/TARGET FROM COMMISSIONERS** ✓ **CORPORATE OBJECTIVE** ……..…... □ **OTHER** ……..…….. (please specify)
	AUTHOR/PRESENTER: Mark Smith
	DATE: 23 April 2013
3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
Ensuring appropriate workforce in place to deliver service requirements. Failure to meet key quality and CQUIN indicators will result in financial penalties.	
4. DELIVERABLES	
Against key performance indicators attached.	
5. KEY PERFORMANCE INDICATORS	
Contained within the attached report	
AGREED AT _____ **MEETING** **OR** **REFERRED TO:** _____	**DATE:** _____ **DATE:** _____
REVIEW DATE **(if applicable)** _____	

Barking, Havering and Redbridge NHS
University Hospitals
NHS Trust

REPORT TO: **Trust Board**

REPORT FROM: **William Langley, Non-Executive Director**

DATE: **1 May 2013**

SUBJECT: **Workforce Committee Report (Part 1)**

1. Purpose

The Workforce Committee meets monthly and is chaired by a non-executive Director. It is a sub committee of the Trust Board

The remit of the Workforce Committee is to present key performance indicators and share results on workforce changes for assurance prior to submission to TEC and Trust Board. The Workforce Committee monitors the progress of the workforce plan including OD and Education.

Workforce Plan and OD Strategy	Confirmation was given that the high level workforce plan using the six step methodology has been shared with Commissioners and the development of the workforce plan is on track for a draft to be presented at the next committee in May. The progress of the Organisational Development Plan supports this work and Pulse surveys rolled out by business units during the summer will test the engagement of the staff and indicate the success of the plan.
DBS formerly known as CRB	The Workforce Committee approved the commencement of a project to check all 1,215 substantive staff who were employed prior to 2009 and who would have been eligible for a DBS check under the new regulations. The project will take approximately ten months with priority given to medical and nursing staff.
Recruitment	The Committee received a report detailing planned efficiencies achieved through a new software package that will provide clearer reporting and more efficient collection of references, for example, to free up skilled recruitment advisors to concentrate on more complex activities. TRAC, will support the HR objective to reduce recruitment lead times by a minimum of five days, the business case for the TRAC system was approved by the committee.
Payroll	The committee was informed that the current provider's contract expires in June 2013 and a tender has been undertaken to choose the next provider. The HR team have worked with the London procurement team under a framework and recommended McKesson remain for a further three years. The Workforce Committee noted the recommendations and, after questioning, the recommendation was passed to TEC for subsequent final approval.
Education	The Workforce Committee was apprised of the plans for e-learning to achieve Mandatory and Statutory training compliance and a learning package from a NHS Trust currently undertaking e-learning. The committee was also informed of the purchase of a system called Wired that will provide a more transparent and effective way of viewing progress of compliance.
Workforce Key Performance Indicators	The Committee noted the KPIs presented and questioned the actions described to address rag rated indicators in the red. In particular, the Corporate Directorate was to provide more granular detail on compliance at the next committee. The KPI for sickness and absence demonstrate a drop of a further percentage point reflecting the positive steps the Trust is taking in managing absenteeism. Recruitment and stability factors were noted as the level of vacancy remains high at circa 500 wte Trust wide with bank and agency usage correspondingly high.

Reports for noting	Medical Job Planning, with six individuals with booked appointments with the Chief Executive due to non-compliance. Auto Enrolment successfully being set in place and communicated out to all staff. The estimated £250k additional payroll costs will be discussed at the next Workforce Committee when the number of staff remaining opted out can be confirmed. The staff survey is being triangulated with the patient satisfaction survey and, in particular, the Workforce Committee was asked to approve the creation of two staff and patient improvement posts to take forward the key points around the family friendly test. The IHB fill rate has risen to 81% despite an increase in bookings for March occurring. The comparative fill rates for IHB pan London is 83% currently and the Workforce Committee received assurance that plans to increase fill are in place. The Workforce and Education risk register is currently being validated and the Workforce Committee agreed a report in May would be received.
Action required by the Board	The Board is requested to note the enclosed and comment on the style and content of the new reporting format from the Workforce Committee.

BHRUT - HR Workforce KPI Report for March 2013

Barking, Havering and Redbridge NHS University Hospitals NHS Trust

				Diagnostics, Specialist Medicine and Neurosciences					Emergency & Acute Med		Surgical Services			Women, Children & Support Services					
		Target	Corporate	Neurosciences	Pathology	Radiology	Specialist Medicine	Therapies	Acute Medicine	Emergency Care	Anaesthetics	Specialist Surgery	Surgery	Children	Support Services	Women	Overall (reporting month)	Overall (previous month)	Trend
Funded Establishment (FTE)			600.7	231.8	276.5	289.1	402.9	175.8	1054.8	333.2	661.2	223.9	321.8	256.0	368.6	641.7	**5838.0**	**5856.8**	↓
SIP (FTE)			499.7	194.5	266.2	277.2	387.2	156.2	953.7	277.9	597.6	202.6	297.8	229.2	341.4	565.3	**5246.3**	**5287.2**	↓
Vacancy Rate (FTE)			101.0	37.4	10.3	11.9	15.7	19.6	101.1	55.3	63.7	21.3	24.0	26.8	27.2	76.5	**591.8**	**569.6**	↑
Vacancy Factor (%)		8%	16.8%	16.1%	3.7%	4.1%	3.9%	11.1%	9.6%	16.6%	9.6%	9.5%	7.4%	10.5%	7.4%	11.9%	**10.1%**	**9.7%**	↑
Starters (FTE)			1.0	0.0	0.0	0.0	2.4	3.0	8.0	3.0	2.0	0.0	0.0	4.6	0.0	2.0	**26.0**	**24.0**	↑
Leavers (FTE)			25.8	0.0	3.2	2.0	3.0	3.0	9.5	11.9	2.0	3.8	2.5	3.2	3.9	9.0	**82.7**	**52.8**	↑
Turnover (annualised %)		11%	16.3%	14.4%	9.4%	5.6%	11.1%	13.6%	12.4%	27.4%	8.3%	13.4%	10.7%	15.2%	9.6%	16.3%	**12.9%**	**12.3%**	↑
Stability (% leavers in month with less than 12 months service)		25%	19.2%	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%	41.7%	0.0%	25.0%	0.0%	20.0%	0.0%	0.0%	**25.5%**	**20.4%**	↑
Sickness Absence Long Term (%)		2%	3.0%	0.6%	2.6%	2.0%	2.6%	1.7%	2.4%	1.0%	2.3%	1.7%	0.7%	3.1%	2.7%	3.2%	**2.3%**	**2.7%**	↓
Sickness Absence Short Term (%)		2%	1.1%	3.2%	2.3%	1.5%	2.8%	2.5%	2.0%	1.6%	2.7%	1.8%	2.1%	2.0%	2.6%	1.9%	**2.1%**	**2.2%**	↓
Overall Sickness Absence (%)		4%	4.1%	3.7%	4.9%	3.5%	5.3%	4.1%	4.4%	2.6%	5.0%	3.5%	2.7%	5.1%	5.3%	5.2%	**4.4%**	**4.9%**	↓
Bank/Agency Use (FTE)	BANK		33.9	39.0	3.1	23.2	9.9	3.52	159.7	34.7	67.7	11.1	26.0	27.6	26.7	60.2	**526.4**	**437.8**	↑
	AGCY		16.1	2.6	9.2	8.9	15.8	10.76	26.9	35.6	12.7	6.5	11.1	11.9	1.0	3.6	**172.7**	**151.3**	↑
Bank/Agency Spend (£)	BANK		117,838	129,199	10,906	136,498	31,597	9,918	527,143	149,705	398,980	81,629	96,295	112,582	60,624	222,160	**2,085,074**	**1,725,113**	↑
	AGCY		112,738	17,346	37,357	105,943	105,185	68,673	226,213	372,154	103,793	72,978	75,270	81,960	2,939	21,046	**1,403,595**	**1,219,429**	↑
IHB Fill Rate			83.9%	80.2%	82.3%	96.7%	81.1%	93.0%	78.9%	81.5%	92.1%	82.6%	81.5%	85.2%	91.0%	88.1%	**84.5%**		
Paybill Budget (£)			3,104,813	995,491	1,165,974	1,632,121	1,621,348	684,031	4,207,817	1,761,066	2,895,525	1,168,952	1,473,203	1,186,548	859,306	2,721,080	**25,477,275**	**24,573,682**	
% Paybill Budget spent on Bank & Agency staff (%)	BANK	11%	3.8%	13.0%	0.9%	8.4%	1.9%	1.4%	12.5%	8.5%	13.8%	7.0%	6.5%	9.5%	7.1%	8.2%	**8.2%**	**7.0%**	↑
	AGCY		3.6%	1.7%	3.2%	6.5%	6.5%	10.0%	5.4%	21.1%	3.6%	6.2%	5.1%	6.9%	0.3%	0.8%	**5.5%**	**5.0%**	
Number of Suspensions			1	1	0	0	0	0	1	0	2	0	0	2	0	0	**7**	**7**	
Number of Appeals/ET Cases etc.			2	0	1	0	4	0	1	0	0	0	1	1	0	1	**11**		
Appraisals (%)		80%	46.5%	81.2%	76.9%	79.8%	73.3%	77.7%	84.8%	47.2%	85.9%	85.0%	85.2%	78.8%	85.2%	83.4%	**77.4%**	**75.1%**	↑
Resus (%)		80%	66.0%	72.9%	89.5%	73.3%	74.3%	83.5%	69.1%	71.5%	74.1%	69.2%	69.2%	81.7%	64.7%	83.6%	**73.9%**	**73.4%**	↑

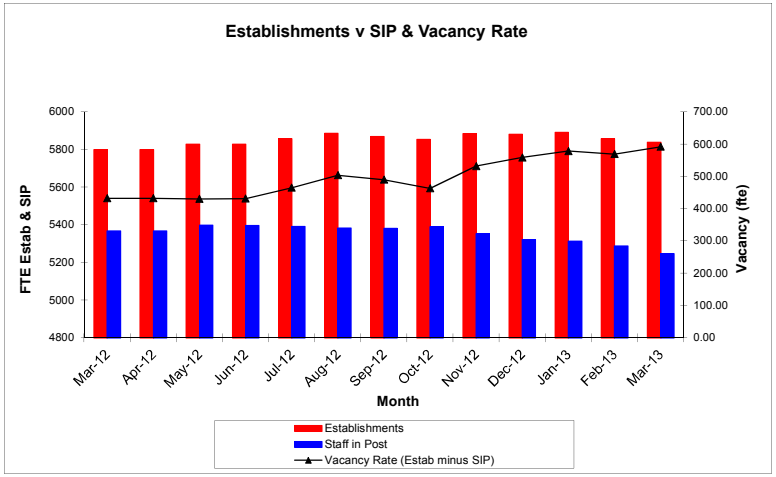
Data Sources:

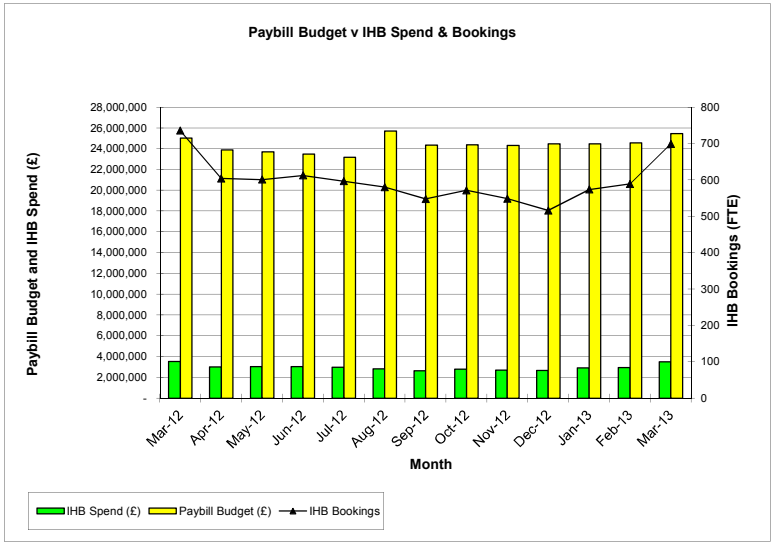
Funded Establishments & Paybill Budget data from Finance Dept.

Bank & Agency Data from StaffBank systems

All other data from Electronic Staff Records system (HR and Payroll database)

BHRUT - Trust Overall Staff Levels and Suporting Narrative





Diagnostics & Specialist Medicine Narrative

The vacancy rate for Therapies is 11.1%. A recruitment plan is in place to address this.

The percentage of paybill spend for bank and agency remains high in therapies due to ongoing agency usage to cover vacancies and capacity. The recruitment plan will also address this.

The percentage of paybill spend for bank and agency in Radiology still remains high.. An ongoing recruitment programme to appoint Sonographers in currently in place to address this.

For Neurosciences the high vacancy factor of 16.1% and turnover rate of 14.4% mostly relates to basic grade doctors in the Stroke team as the retention rate for this grade of doctors in the stroke teams low.

Emergency, Gen Med & Neuro Narrative

Paybill on Bank & Agency staff reflects the continued reliance on temporary staff. The highest proportion of this spend is attributable to the M&D agency staff and reflects the current vacancy factor within the BU currently at 16.6%.

There is an increase in the retention of staff in Acute Medicine with a stability rate of 0.0% down from 9.1% in previous month however the vacancy rates remain high in Emergency Care which also has more leavers with a stability rate of 41.7% an increase from 33.3% in previous month.

Surgical Services Narrative

The percentage spent on Bank and Agency in Anaesthetics is 1.2% higher this month at 17.4%. As previously reported temporary staffing usage with the Anaesthetics is proportionate to the volume of activity and vacancy factor. This additional activity although income generating has had a large impact on medical and nursing costs. Within ITU as well the high volumes of patients has resulted in higher staffing costs. The percentage spent on Bank and Agency is also higher than average in Specialist Surgery this month. This is due partly to the difficulty recruiting to doctor's posts and partly due to the need to cover consultant sickness and increase in activity in Max Fac. Agency usage has also increased due to leavers in Audiology and in Opthalmology.

All three business units achieved their targets this month for appraisal compliance.

Women, Children & Support Services Narrative

The Women's BU currently has a higher than average vacancy factor of 11.9% with the highest proportion of vacancies relating to midwives. This is however expected to reduce by 11 fte's following the disestablishment of recently TUPE'd posts and the division is also holding posts vacant given the reducing volume of activity.

The higher than expected turnover rate in Women's is also driven by the TUPE transfer of a number of community midwives to Bart's Health.

Diagnostics & Spec Med Actions

Recruitment plan is currently in place to address high vacancy rate and agency/bank spend in Therapies.

The retention of basic grade doctors in Stroke services is being addressed through ongoing recruitment activities.

Emergency, Gen Med & Neuro Actions

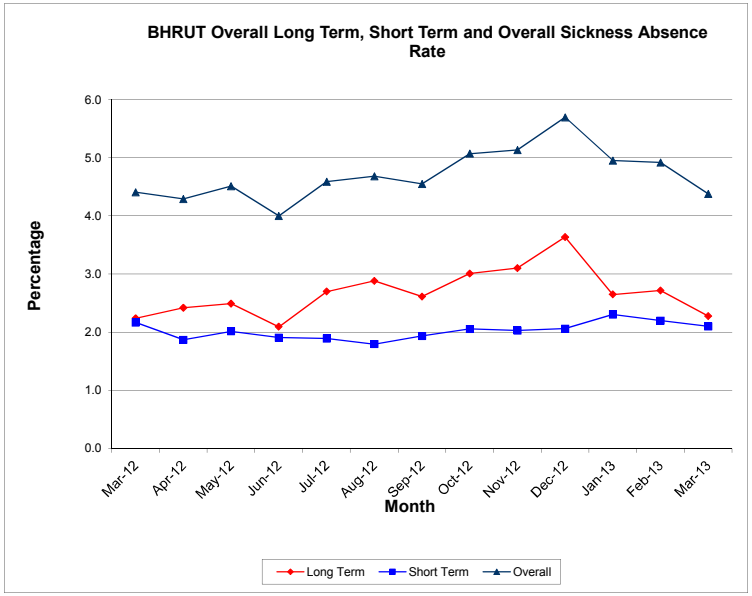
An investigation into turnover in the Emergency dept. is ongoing as this remains high at 27.4%. The recruitment difficulties, high sickness and dependence on temporary staff is likely to drive high turnover and the current workforce planning exercise aims to identify long term solutions to these problems including a retention plan which looks at implementing staff development e.g. multi-speciality recruitment/working. This is also being addressed through ongoing recruitment activity and sickness management.

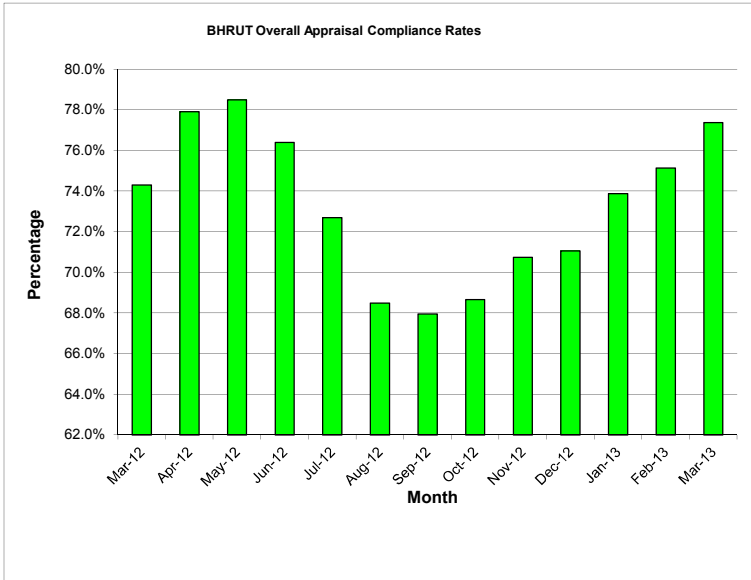
There is ongoing recruitment drive to fill Consultant vacancies in the Emergency department through international recruitment and 2 agencies have been engaged for this. There is a current recruitment activity for 16 middle grade doctors, 6 Locum Consultants, 5 basic grades and 2 Band 7 N&M staff with a rolling advert for all staff grades to enable continuous recruitment into vacancies. The recruitment plan will help to achieve improvement in the business unit through a significant reduction in the use of bank and Agency spend

Surgical Services Actions

An active recruitment drive for doctors and qualified nurses in the Surgery Directorate is to be undertaken.

BHRUT - Trust Overall Sickness Absence and Temporary Staff





Diagnostics & Specialist Medicine Narrative

Sickness reporting has improved. There were seven members of staff who had actually returned from sickness and therefore incorrectly recorded, compared to twelve staff last month.

Long term sickness for Pathology has reduced from 3.2% to 2.6%. This is mainly due to the fact a number of records of open ended sickness were closed. In addition eight staff are now been managed under the LT informal stage of the policy.

Long term sickness for Specialist Medicine has reduced from 3.3% to 2.6%. Three staff are now been managed under the LT procedure of the sickness policy, One member of staff is due to move to the formal stage of the policy in early April following an OH assessment. Short term sickness for Specialist Medicine for Specialist Medicine has increased from 2.4% to 2.8%, however, three staff are now been managed under the ST sickness procedure.

Long term sickness for Radiology has reduced from 2.5% to 2%. Four staff are been managed under the LT procedure of the sickness policy; one at the formal stage and three at the informal stage.

Short term sickness for Therapies has increased from 2.3% to 2.5%, however, six staff are now been managed under the formal ST sickness procedure.

Emergency, Gen Med & Neuro Narrative

Overall sickness absence in the business unit is reduced significantly from 4.2% to 2.6% in Emergency Care and from 5.4% to 4.4% in Acute Medicine. Sickness absence rate in Neuroscience has increased from 2.9% to 3.7% with ongoing management of the identified cases.
Sickness in this area is constantly reviewed with the General Managers with specific emphasis on managing short and long term absence under the sickness absence policy. Increased HR support is being provided to the line managers responsible for day to day absence management.

Surgical Services Narrative

There are no sickness hotspots in the Surgical directorate this month. However all 3 business units overall sickness percentage increased this month. All 3 business units saw an slight increase in their short-term sickness rate but had a reduction in their long term sickness .

Anaesthetics long-term sickness reduced by 0.3% however short-term sickness was worse by 0.1% this month.

Short-term sickness increased by 0.5% in Specialist Surgery from last month. There was however a slight improvement in long-term sickness by 0.5% since February.

Surgery saw an improvement in the long-term sickness percentage of 0.5%, however short-term sickness was worse by 0.7%.

Women, Children & Support Narrative

Good progress has been made in reducing absence in Support Services with a reduction from 9.4% in December 2012 to the current figure of 5.3%. Further work remains to be done in Support Services and in Women's and Children's, particularly in respect of long term sickness absence, where figures remain unacceptably high.

Diagnostics & Spec Med Actions

Action plan in place to ensure compliance in reporting and closure of open ended sickness recording. Examples to be continued to be highlighted to managers.
In total 18 staff on LT sickness are currently been managed under the policy. However, there are a further 16 staff who require managing and action plans will be developed for each of these staff.
In line with the release of the revised Sickness Absence Policy, for a review of staff with high levels of short term sickness to be conducted across the Directorate and action plans to be developed

Emergency, Gen Med & Neuro Actions

17 long Term absence cases identified and 16 currently being managed under the informal process and 10 cases due to progress to the formal stage. 1 is a potential redeployment.
48 short term sickness cases identified. 5 have progressed to formal monitoring 12 are being monitored informally and are due to proceed to formal monitoring. Support is being provided on remaining cases.
Action plan in place to ensure continued compliance in reporting through line manager responsibility for accurate reporting and management in line with the sickness absence policy. Training on the new policy has been delivered to equip line managers in the BU. Further guidance will also be issued to support active management of sickness absence cases.

Surgical Services Actions

Action plans have been developed to monitor and ensure accurate and timely absence reporting continues to be reviewed. The emphasis this month will be on tackling short-term sickness.

HRM and HRA delivered a series of sickness absence training sessions. These update managers on the new sickness policy and provided advice for tackling sickness absence in their areas. New guidance on sickness management is also shortly due to be released. it is intended to provide a source of advice to help those responsible for attendance management.

Women, Children & Support Actions

Action to be taken locally to manage long term sickness absentees with support from Occupational Health.

BHRUT - Corporate Update

Sickness Absence

The overall level of sickness absence has continued to decrease for the forth consecutive month with a 0.5 % overall reduction most notably driven by a 0.4% reducton in Long Term sickness absence. Sickness absence remians high on the HR agenda with a newly revised sickness absence policy and improved reportign capability. eRostering continues to improve the accuracy of data capture and reporting capability with all clinical areas now live and interfaced to ESR. Those areas that currently use a manual sickness return procedure are monitored closely by the HR department to ensure prompt and accurate submission.

The fully revised Sickness Absence policy to support the ongoing management of sickness absence is now live and has been recieved well withint he organisation. The comprehensive communications strategy applied to ensure managers were aware of the key changes inlcuded formal seminar format briefing sessions which which were attended by 89 line managers and receive positive feedback.

Key changes within the policy include:
- Revised Bradford score trigger
- Reduction in monitoring periods
- Reduction in paid phased return to work entitlement
- Clarified and simplified management process

Appraisals

Appraisal rates have continued to increase steadily over the last quarter with a further increase of 2.3% in March. The current appraisal compliance rate across the Trust is 77.4%.

Performance figures across the Clinical Directorates for the month of March are:

Diagnostic & Specialist medicine and Neurosciences 77.8%
Emergency & Acute Medicine 66%
Surgical Services 85.4%
Women, Children & Support Services 82.5%
Corporate Directorate 46.5%

Corporate areas have increased from 42.6% in February to 46.5% in March however, corporate still remain very much below target. There is no one area within the corporate directorate that can be identified as a specific outlier. There are many single post holders within Corporate who, due to management restructures, are waiting on new objectives to be set and an appraisal done by their new line manager. On review of the corporate areas, there are planned dates in place for outstanding appraisals

An appraisal lead has not yet been identified in each Directorate but will be in advance of the update and re-launch of the trust's appraisal policy originally planned for February although now to be included in the OD strategy plan.

All Corporate Leads will be sent a list of their staff with the reminder for appraisal to be completed.

Auto Enrolment

The rules for work based pensions have changed and with effect from the 1st April 2013 the Trust is required to have in place an alternative pension provision available for staff ineligible to join the NHS Superannuation pension scheme. Agreement has been obtained through TEC to engage NEST as the supporting scheme as this offers maximum flexibility for the Trust and is also the most cost effective. The forecast cost of Auto enrolment via NEST scheme for previously ineligible staff estimated at £1700 per month. There is also a potential for increased expenditure under NHS pension scheme for "opt in" of current "opted out" staff which carries a maximum potential exposure of £250k per month. Although the risk is unquantifiable at present as there is no benchmark data from other NHS Trust's to suggest the likely increase in NHSPS uptake.

Although this remains an unquantifiable risk there is a strong likelihood that the circumstances prompting staff to opt out prior to auto enrolment will remain unchanged after the 1st April and therefore it may be assumed that a large proportion of employees are likely to re-opt out lessening the financial impact.

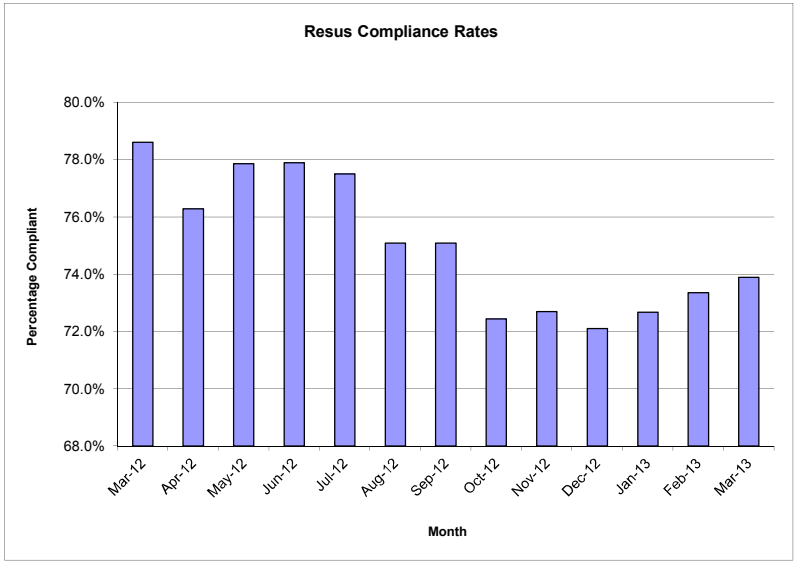
Communication to all staff and stakeholders will commence throughout March with the first pension contributions deducted under autoenrolement from April pay period.

To be included in next Month's report - a breakdown of all Corporate areas to show key performance indicators for each of those areas.

BHRUT - Education Update

Statutory and Mandatatory Training Monitoring as at 31st March 2013

		Reporting Period - Compliance Rate								
Course Name	Frequency	28-Feb-11	30-Jun-11	30-Sep-11	31-Dec-11	31-Mar-12	30-Jun-12	30-Sep-12	31-Dec-12	31-Mar-13
Conflict Resolution	3 yearly							11.61%	12.91%	16.51%
Equality, Diversity & Human Rights	3 yearly							55.92%	54.42%	52.84%
Fire Training	Annual	39.49%	36.33%	28.63%	33.57%	21.63%	35.10%	45.46%	45.58%	45.16%
Health & Safety	Annual							41.31%	47.65%	72.50%
Infection Control	Annual							41.61%	49.16%	51.41%
Information Governance	Annual	36.22%	36.92%	37.98%	17.43%	21.45%	21.35%	28.23%	31.50%	38.55%
Manual Handling (Loads)	2 yearly	18.76%	20.37%	22.77%	33.00%	39.54%	33.53%	38.28%	52.37%	54.81%
Manual Handling (People - Refresher)	2 yearly	63.50%	68.83%	69.22%	85.12%	73.84%	76.19%	71.16%	73.89%	76.07%
Manual Handling (People + Loads)	Once	46.60%	41.62%	40.90%	40.55%	40.77%	65.95%	63.80%	65.08%	53.57%
Resuscitation	Annual	89.72%	78.42%	69.04%	72.15%	78.61%	77.89%	75.09%	72.11%	73.89%
Safeguarding Adults	3 Yearly							65.84%	68.09%	70.05%
Safeguarding Children Level 1	3 yearly	62.61%	70.50%	56.61%	67.79%	69.72%	71.15%	71.12%	73.27%	73.74%
Safeguarding Children Level 2	3 yearly	26.87%	37.50%	10.76%	53.25%	58.29%	30.08%	42.93%	50.14%	72.29%
Safeguarding Children Level 3	3 Yearly	54.49%	50.97%	34.78%	67.68%	80.82%	72.14%	71.29%	73.20%	75.08%



Education & Learning Narrative

Training release and therefore compliance continues to be a challenge; this has consequences for external accreditation and internal governance.

Uptake remains consistent, with significant improvements in Manual Handling of Loads.

Further improvements are anticipated with regard to Safeguarding Children Level 2 as more staff attends the mandatory programmes.

Conflict resolution refresher training has been commenced

Uptake on advertised resuscitation training sessions to date remains good. Non-attendance rates are being monitored closely & absences continue to be escalated to the appropriate managers.

WIRED

The Trust is in the process of purchasing WIRED (Workforce Information Reporting Engine Database). WIRED is a web-based tool that will enable us to export data from ESR to quickly produce a wide range of high quality compliance reports.

Individuals will be able to view and manage their own statutory and mandatory training compliance. WIRED reports will be instantly available to all managers via the Intranet.

Because of the amount of resource required to implement this tool, it will be a phased implementation and we will be focusing on high profile statutory/mandatory compliance data first, i.e. Resus, Safeguarding and Manual Handling. All other statutory and mandatory compliance reports will follow as soon as practicable.

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Report from Quality and Safety Committee (part 1)	Trust Board
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
The following update is to report the key issues discussed and reviewed at the Quality and Safety Committee meeting 16 April 2013.	□ **TEC** …….. □ **STRATEGY**…… □ **FINANCE** …….. □ **AUDIT** …….. ✓ **QUALITY & SAFETY** ……..……..…… □ **WORKFORCE** □ **CHARITABLE FUNDS** ……..… □ **TRUST BOARD** …… □ **REMUNERATION** …….. □ **OTHER** …….. (please specify)
2. DECISION REQUIRED	**CATEGORY:**
The Board is requested to note the enclosed and comment on the style and content of the new reporting format from the Q&SC.	✓**NATIONAL TARGET** ✓ **CNST** ✓ **CQC REGISTRATION** ✓ **HEALTH & SAFETY** ✓ **ASSURANCE FRAMEWORK** ✓**CQUIN/TARGET FROM COMMISSIONERS** ✓ **CORPORATE OBJECTIVE** …….. □ **OTHER** …….. (please specify)
	AUTHOR/PRESENTER: Flo Panel-Coates
	DATE: 22 April 2013.
3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
Failure to meet key quality and CQUIN indicators will result in a financial penalties.	
4. DELIVERABLES	
Against key performance indicators as below.	
5. KEY PERFORMANCE INDICATORS	
Patient Experience Quality Outcomes Risk and Safety Workforce Mortality Infection Prevention and Control measures and others incorporated into the clinical directorate and corporate performance metrics.	
AGREED AT _____ **MEETING** **OR** **REFERRED TO:** _____	**DATE:** _____ **DATE:** _____
REVIEW DATE **(if applicable)** _____	

Barking, Havering and Redbridge NHS
University Hospitals
NHS Trust

REPORT TO: **Trust Board**

REPORT FROM: **Caroline Wright, Non Executive Director**

DATE: **1 May 2013**

SUBJECT: **Quality and Safety Committee Report (Part 1)**

Feeder Committees	The minutes of each of the feeder groups/committees were noted. It was agreed that in the future each feeder group would send a formal report. Noting the key issues, areas for action and/or escalation. The detailed IP&CC report was noted.
Quality Dashboard	The dashboard and narratives were reviewed. The improvements in the narrative, whole hospital and directorates was noted. Challenges were made regarding areas of none compliance.
Directorate Presentations	The committee received detailed presentations from the CD for Acute Medicine and the CD for Paediatrics. They each presented their progress, key challenges and areas of focus fro 2013/4.
Quality Accounts	Progress against the priorities set in 2012 were noted and supported. It was agreed that for the new priorities in 2013/4, greater focus must be on delivering improved outcomes for patients.
Information Governance	The chair of the Information Governance Committee attended the meeting. Poor compliance against the IG toolkit was reported with a request for greater trust engagement with training and the introduction of a new e-learning system from May as part of the ongoing solution to improve compliance.
Mortality presentation	A presentation was made by the deputy medical director providing an overview of the CHKS programme, monthly data submissions and the findings of the review of any outlying areas. There was nothing concerning to note at this time.
QUESTT	A presentation was given to share the new Quality, Effectiveness and safety Trigger Tool implemented in the trust. The findings will be incorporated into the revised dashboards in the next 3 months.
Reports for noting	The following papers were noted Safeguarding Adults Quarter 4 report Falls report Complaints briefing paper
Action required by the Board	The Board is requested to note the enclosed and comment on the style and content of the new reporting format from the Q&SC.

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Report from the Trust Executive Committee	**Trust Board**
1. PURPOSE:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
A summary of issues discussed at the March 2013 Trust Executive meeting.	□ TEC …….. □ STRATEGY…… □ FINANCE …….. □ AUDIT …….. □ QUALITY & SAFETY ……..……...…… □ WORKFORCE □ CHARITABLE FUNDS ……...… □ TRUST BOARD ……✓……. □ REMUNERATION ……... □ OTHER …….. (please specify)
2. DECISION REQUIRED:	**CATEGORY:**
For information	□ NATIONAL TARGET □ CNST □ CQC REGISTRATION □ HEALTH & SAFETY □ ASSURANCE FRAMEWORK □ CQUIN/TARGET FROM COMMISSIONERS □ CORPORATE OBJECTIVE ……... □ OTHER …….. (please specify)
	AUTHOR/PRESENTER: Averil Dongworth
	DATE: 22 April 2013
3. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:	
n/a	
4. DELIVERABLES	
5. KEY PERFORMANCE INDICATORS	
AGREED AT _____ MEETING **OR** **REFERRED TO: _____**	**DATE: _____** **DATE: _____**
REVIEW DATE (if applicable) _____	

Key items from the Trust Executive Committee meeting 19 March 2013

Emergency Care Pathway
The TEC discussed and reviewed a number of areas relating to the performance of the emergency care pathway and plans to improve, including seven day working.

Data was showing improvements in the use of the Surgical Assessment Unit, which is now receiving direct referrals from GPs. The importance of keeping flow open and ensuring that assessment areas were kept clear was emphasised.

The TEC noted that there were significant outliers on the wards and that the patient length of stay and discharge management were suffering due to gaps in staffing, currently filled by temporary staff which needed to be filled by substantive staff. The importance of nurse leaders accompanying the consultants on ward rounds was emphasised, which would lead to improved communications.

The care of the elderly work plan was now showing evidence of positive functionality. It was reported that Sky A would now become a short stay ward for elderly patients to improve patient flow and bed availability. GP beds needed to be kept open and flowing and that the plan needed to change existing mindsets to maximise results

Work was progressing on the seven day workplan, which would incorporate the financial model and length of stay targets. It was noted that everyone's input aws needed and that the plan needed to be approved by the Board before implementation, including a risk assessment on the impact on services. It was noted that there was a need to ascertain where there was a need for seven day working and where this was not appropriate, and need for supportive services, such as pharmacy and discharge teams. The importance of integrating these plans into budget setting was also emphasised. A project board led by David Gilburt would report to the TEC.

There was evidence of an increase in the percentage of emergency department patients completing the survey on discharge, from 3% to 7%, although a substantial way to go to achieve the target of a 15% return rate. The TEC was advised that systems such as comfort rounds, are now beginning to be properly embedded.

Mondays continue to be problematic with high flows of patients attending the ED, but the Trust is continuing to work with LAS partners to tackle the issue. The interface plan from the Trust's partners was felt to be weak, especially the Ambulatory Plan and the Community Plan, which were not tackling the problem. It was felt that the plans were not looking at change in the long-term, nor at cultural change. Havering needed to open services at the weekend as the GP practices were full, which lead to poor decisions being made and directing patients to the ED. The benefit to the extended opening hours on a weekend would be felt by the Trust and the local services. There was also a need to target action and response with nursing homes, using recently collected data. Follow up is to be made with commissioners.

It was reported that LAS were using the UCC increasingly and that the Hurley group was settling in well. There was more work to be done within the UCC especially with streaming. Some patients had declined redirection into the UCC but this had not been captured, and more data is being collected. A briefing note is in preparation following an external visit to Rochdale UCC. Rochdale had a generous allocation of GP Beds and DH project team were to look at the feedback and incorporate findings into the Trust's own UCC service. The Trust had had discussions with commissioners on the UCC target, but there was an issue with the appropriate groups of patients, which they would continue to work on.

A recruitment drive for the ED was agreed as a priority, and additional resource from the HR department had been allocated to assist with this. It was reported to members that the Trust had appointed a Middle Grade and a Locum to substantive posts, and a Consultant in ED Paediatrics had recently been appointed.

All members were reminded that it was the responsibility of every member of staff to have their own action plan to take ownership and their input was crucial to the delivery of the overall Trust performance.

Month 11 Finance Report and draft budget proposals 2013-4
Members were informed that the Trust would hit the control total, which was encouraging. Everything was being done to deliver the CIP target and assured members that £18 million in savings was expected to be delivered. The agreement not to carry over annual leave had produced a £1.5m benefit. However, members agreed that measures should be put in place to ensure that annual leave was spread throughout the year and did not put pressure on the operation of the Trust during March, as had happened this year. All members were reminded that there was still urgency for all areas to deliver their savings targets and to keep focused on delivering the year-end target.

Contract negotiations were progressing well with commissioners, with the initial baseline contract projected on the 2012-3 forecast and a £8m QIPP saving on this baseline. There would be a higher focus on 'payment by results' with payment for the work the Trust delivered rather than as a block contract. It was important to ensure that the Trust also maintained quality of service. The CQUIN target would hold back £10 million and would pay providing the set target was reached. There were risks and contract penalties for poor performance, for example ED waiting times.

All the cost savings schemes for the year ahead had now been rated. The CIP is now more advanced than 12 months ago and the PMO are bringing the proposals together with £40 million of schemes to be delivered and £11.7 million of schemes in process of development, which were due to be signed off by early April 2013. Work with the PMO is on-going to ensure delivery of £22.5 million in savings for the current year.

Money has been set aside in the Budget for inflation and increments however this had been taken into account. There was a need to be prudent and gain confidence in the CIP and CQUIN targets. The Budget sign-off was subject to the signing-off of cost pressures.

The projected deficit for 2013/14 was £17 million, for 2014/15 £5.7 million. The Trust would need to bring forward reconfiguration plans to break even in 2014/15.

Quality & Patient Standards Performance Report
A further case of MRSA had been reported in March, breaching the Trust's annual target. The Trust had already breached the annual target for C diff and more work was required to ensure no further cases were reported. Further work was needed to ensure all patients were screened for MRSA prior to admission or at an emergency attendance. There needed to be further work to identify if exclusions could apply in certain areas. There was a particular need to improve reporting of MRSA screening in the ED or in MAU.

Other issues raised were complaints, completion of the mental test and falls. During January, there had been an increase in old complaints coming into the Trust, and this had led to the 90 day increase.

Workforce Key Performance Indicators
There had been a 1% reduction in sickness during February, as well as a reduction in exclusions (from 12 to 7). Pension Auto-Enrolment scheduled to take place in April 2013 would affect 1,300

employees of which 90% were NHS and 10% other staff. Communications had gone out Trust-wide advising the workforce of this change. While staff were able to opt out of the scheme, the Trust were unable to promote opting out of the auto-enrolment and would face potential fines.

There was still much work to do to reach 100% of all staff achieving Statutory and Mandatory compliance. There were plans to introduce a programme called WIRED, where individuals could view and managed their own training and compliance. Another benefit was that training would be transferable and could pull through existing data from the Trust's ESR system. It was reported that the Trust was now in the process of purchasing the system and training demonstrations would begin in the coming weeks.

There was to be a 1% increase in staff salaries who were employed under the Agenda for Change contract. Newly qualified nursing staff, who previously would have previously received two increments as part of their Preceptorship, would now receive one and this would provide a £40,000 saving to the Trust.

18 Week Plan
Concerns were raised with regard to the 18 week referral to treatment times and that the Trust may not be able to sustain its current performance. A validation exercise was to be conducted, to consider options for each specialty and explore methods of getting more work through existing capacity. CDs were asked to submit business cases to take this forward.

Integrated Cancer System - London Cancer
A meeting to discuss the London Cancer Agreement would be held with Anglia Ruskin Partnership which would discuss the proposals to develop a virtual organisation and strengthen the Trust's services through this alliance, and this would provide an input to the London Cancer Network, in order to highlight what could be provided.

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Report from Audit Committee	**Trust Board**

1. KEY ISSUES:

- The following report summarises the key issues raised at the Audit Committee meeting on 22nd April 2013
- Under matters arising an update was provided on the implementation of the Automated Inventory System in Queen's Operating Theatres
- The Q4 BAF was presented (also on the Trust Board Agenda), with the following noted:
  - The format has been reviewed and simplified and will be presented to TEC on 16th April for agreement
  - Four risks were added or re-instated
  - The financial risks will be reviewed in light of the final outturn for 2012/13 and the Plan for 2013/14
- An update on progress against the CQC action plans was presented, in particular work to progress the Emergency Care action plan. The CIO informed the Committee that he has commissioned a review of data recording in A&E.
- The CIO gave an update on the PAS implementation project. The project is rated as 'Green'. Key points to note were; the contract with the supplier is awaiting sign-off (target end April); the Project Board has been fully established; the project is on track for 30th November 'go-live'. Some of the key risks were noted e.g. information for billing & it was agreed to note these formally in the risk register. It was noted that the A&E system Symphony is not part of the upgrade, but will be subject to a separate business case. It was agreed that a regular update would continue to be provided at Audit and Finance & Investment Committee.
- A draft note to the Accounts regarding the Going Concern concept was agreed (also on the Trust Board agenda). This set out the key assumptions under-pinning the going concern assumption, but also the key risks that will need to be managed going forward, including agreement of PFI funding and Public Dividend Capital to support the deficit

REVIEWED BY (BOARD/COMMITTEE) and DATE:

□ **S&SIB** ……□ **EPB**…..……..
□ **FINANCE** ……□ **AUDIT** ……..…..
□ **CLINICAL GOVERNANCE** ……..…....
□ **CHARITABLE FUNDS** ……
☑**TRUST BOARD** ……
□ **REMUNERATION** ……
□ **OTHER** ……(please specify)

CATEGORY:

□ **NATIONAL TARGET** □ **CNST**
□ **STANDARDS FOR BETTER HEALTH**
□ **ASSURANCE FRAMEWORK**
□ **TARGET FROM COMMISSIONERS**
☑ **CORPORATE OBJECTIVE** To achieve financial security for the Trust, with reduced costs, improved productivity and collecting income due

□ **OTHER** …….. (please specify)

AUTHOR/PRESENTER:

Alan Davies, Deputy Director of Finance / William Langley, Non-executive Director & Chair of Audit Committee

DATE:

- The new Internal Auditors (RSM Tenon, led by new CIA Tim Merritt) set out its work programme for 2013/14. Tim stressed the importance of rigorous follow-up of the recommendations carried-forward from Parkhill's work in 2012/13, which would also be regularly reported to the Chief Executive and TEC. The importance of testing the assurances provided in the BAF was highlighted and RSM plan to undertake a regular deep dive in to the CQC action plans. A review of SLR is planned for Q3, allowing time for the system to bed in during the first half of the year.
- RSM also set out its Counter-fraud strategy and work programme. A policy on Anti Fraud and Bribery was approved.
- The audit and counter-fraud handover from Parkhill to RSM Tenon is progressing, but there is still some information to be passed on.

in 2013/14. The Note will need to be updated in light of recent developments, but the Committee were satisfied with the content.

- External Audit gave its progress report. Work on the interim audit had been completed, which indicated that the Trust is making good progress in Accounts preparation. Department of Health advice regarding implementing the recommendations of the HMT review of tax arrangements was discussed, including arrangements for off-payroll engagements as well as arrangements for Auto-enrolment of staff in to workplace pension schemes. It was also noted that Charitable Funds will need to be consolidated in to the Trust Accounts from 2013/14, under existing arrangements.

- Internal Audit (Parkhill) gave its Annual Report, including Head of Internal Audit opinion on internal controls. The overall opinion was for limited assurance on the effectiveness of internal controls, primarily in relation to Audit reports conducted earlier in the financial year on budgetary control, billing, Theatres stock, e-rostering and Saviance. It was noted that considerable progress had been made to address the weaknesses identified, including;

    - Strengthening of CIP reporting and governance arrangements
    - Strengthening of the budgetary control process including improved engagement and sign-off of budgets with clinical directorates
    - Improved billing arrangements
    - Implementation of new Theatres automated stores system to improve security and control
    - Improved IM&T project management arrangements

  It was noted that some work of the Internal Auditors had yet to be completed and the CIA agreed to provide this information to the DoF and provide a final version of the Annual Report. This was subsequently received on 19th April.

- Parkill also presented its Annual Report on Counter Fraud. It was noted that a case relating to Radiology required handover to RSM Tenon. It was also noted that the report needed to be amended to show the change in LCFS during the year.

- The Annual Security Management report was presented by the Trust's Local Security Management Specialist, Sarah Jenkins. It was noted that Sarah has transferred to the Trust from Parkhill, under TUPE arrangements.

- The Losses, Compensations and Write-offs report was received. It was noted that the provision for bad debts relating to claims recovered by the Compensation Recovery Unit under the NHS Injury Recovery Scheme had been increased by £1.4m, due to the increasing level of bad debts. It was agreed to seek more information from the CRU as to the reasons for the increase and the steps that they are taking to recover the debts. RSM Tenon agreed to review the situation with their other Trust clients. Overseas Visitors' debts of £182k were agreed for write-off.

- The SFI Waivers report was received. RSM Tenon commented that the number of waivers was high, based on its experience from elsewhere and it was agreed to review this. DG highlighted the waiver approval exceeded his formal delegated limit and that this need a practical solution.

2. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:

N/A

3. ALTERNATIVES CONSIDERED/REASONS FOR REJECTION:

N/A

4. DELIVERABLES:

N/A	
5. EVIDENCE :	
N/A	
6. RECOMMENDATION/ACTION REQUIRED:	
The Trust Board is request to note this report	
AGREED AT _____ MEETING, OR **REFERRED TO: _____**	**DATE: _____** **DATE: _____**
REVIEW DATE _____ **(if applicable)**	

Barking, Havering and Redbridge University Hospitals NHS Trust

EXECUTIVE SUMMARY

TITLE:	BOARD/GROUP/COMMITTEE:
Report from Finance & Investment Committee - 27th March 2013	**Trust Board**
1. KEY ISSUES:	**REVIEWED BY (BOARD/COMMITTEE) and DATE:**
1. The following report summarises the key issues raised at the Finance and Investment Committee meeting on 27th March 2013. The Chair of the FIC and the Director of Finance will also provide a verbal update on the key points from the FIC meeting of 30th April, the day before the Trust Board ***2.*** Under matters arising the following was noted: 3. Options to create a centralised maternity leave budget would be reviewed and presented to the next meeting 4. An update on the Pathology project was provided by NM. It was agreed to proceed to open procurement for the pathology equipment. A new project manager is now in place. It was agreed to bring back to the FIC the proposal from Barts Health for centralisation of Microbiology. ***5.*** The external auditors (KPMG) presented on the Going Concern issues relating to the 2012/13 audit of Accounts. It was agreed that the Trust would prepare a Note to the Accounts described as Emphasis of Matter – Going Concern, setting out the reasons for the Going Concern ***6.*** assumption, but also the material risks and uncertainties that would need careful management going forward (NB draft Note on Trust Board agenda) ***7.*** The Month 11 Finance Report was noted, which showed a year to date deficit of £37.6m, was	□ **S&SIB** ……□ **EPB**…..…….. □ **FINANCE** ……□ **AUDIT** ……..….. □ **CLINICAL GOVERNANCE** ……..….... □ **CHARITABLE FUNDS** …….. ☑**TRUST BOARD** …… □ **REMUNERATION** …… □ **OTHER** ……(please specify) **CATEGORY:** □ **NATIONAL TARGET** □ **CNST** □ **STANDARDS FOR BETTER HEALTH** □ **ASSURANCE FRAMEWORK** □ **TARGET FROM COMMISSIONERS** ☑ **CORPORATE OBJECTIVE** To achieve financial security for the Trust, with reduced costs, improved productivity and collecting income due □ **OTHER** …….. (please specify) **AUTHOR/PRESENTER:** Alan Davies, Deputy Director of Finance / Keith Mahoney, Non-Executive Director & Chair of Finance & Investment Committee **DATE:**

£0.4m adverse to budget, and with a forecast outturn deficit of £39.5m, within the Trust's control total deficit of £39.7m. The CIP position showed YTD delivery of £13.5m, with a forecast of £18.1m, against the target of £23.1m, but in line with the minimum level required to meet the overall control total. The contribution from income over-performance of £20m, net of additional marginal costs, has more than offset the CIP shortfall. In relation to income, it was agreed to bring back to the FIC an update on the level of uncoded activity along with continuous coding improvement to the next meeting. With regard to CIP, it was noted that there would be a significant increase in delivery in Month 12, including a number of non-recurrent savings, which would be highlighted in future reports. It was noted that the CIP plan for 13/14 showed a 'flatter' CIP monthly profile, with most recurrent savings implemented by May/June.

8. The draft 2013/14 budgets were presented for agreement, with an overall reduced I&E deficit of £17m. The bridge from the 2013/14 control total deficit was presented, with the most significant changes relating to:

- PFI support £16m
- Recurrent income –over-performance £15.2m
- Inflationary pressures / contingencies £16.9m
- Activity cost pressures of £9.2m and other local cost pressures of £5.4m
- CIP of £20mThe Trust

9. It was noted that although good progress had been made, contracts with commissioners had yet to be signed-off and the key risks including potential contract penalties were noted.

10. The process for agreeing cost pressure funding was described, with priority given to those that contributed to key Trust priorities (e.g. Emergency Care targets and 7 Day working) or were unavoidable due to external factors.

11. The budgets were agreed, subject to satisfactory outcome of the contract discussions with commissioners, with approval recommended to the Trust Board on 3rd April.

12. The cashlow report was received and it was noted that £16.7m PDC capital had been received in February, as the second tranche of funding to meet the I&E deficit of £39.7m. Payment for PCT over-performance of £19.6m and winter pressures £2.8m was received in March. The Trust had applied for a Temporary Borrowing Limit of £25m, given uncertainty about SLA payments by commissioner in April (subsequently received in April, together with CCG payment)

13. The aged debtors report was noted. Actions were agreed for outstanding overdue debtors.

14. The aged creditors report was noted.

15. The Radiology Directorate gave a presentation on its financial position and performance. Discussion centred around control of requests for scans, recruitment of staff and high cost devices. It was agreed that progress was being achieved, although there was still work to be done if the Directorate was to meet its budgetary targets for 2013/14.

16. An update on the Capital programme was provided. NM described the work to strengthen project management arrangements going forward, to mitigate against the risk of slippage. The outline plan for 2013/14 was presented, total £29.2m, including externally funded schemes. The process for agreeing priority schemes in 2013/14 was described.

2. FINANCIAL IMPLICATIONS/IMPACT ON CURRENT FORECAST:

N/A

3. ALTERNATIVES CONSIDERED/REASONS FOR REJECTION:

N/A

4. DELIVERABLES:

N/A

5. EVIDENCE :	
N/A	
6. RECOMMENDATION/ACTION REQUIRED:	
The Trust Board is requested to note this report and to approve the revised Finance & Investment Committee Terms of Reference.	
AGREED AT _____ MEETING, OR **REFERRED TO: _____**	**DATE: _____** **DATE: _____**
REVIEW DATE _____ **(if applicable)**	

TERMS OF REFERENCE

Name of Committee / Group / Board

FINANCE & INVESTMENT COMMITTEE (FIC)

Constitution

The Finance Committee is constituted as a standing committee of the Trust Board. Its constitution and terms of reference shall be as set out below, subject to amendment at future Trust Board meetings.

The Committee is authorised by the Trust Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

Membership

Membership will be:

- Trust Board Chair
- Three Non Executive Directors
- Chief Executive
- Director of Finance (Executive Director Lead)
- Director of Planning and Performance
- Chief Operating Officer (or nominated representative)
- Deputy Director of Finance

All other members of the Trust Board may attend or be requested to attend; all Board members will receive papers. The Committee may invite other Trust staff to attend its meetings as appropriate.

Purpose

The Finance Committee shall conduct objective Board-level review of financial policy, planning and performance of the Trust including its Cost Improvement Programme.

Terms of Reference

Financial Policy, Planning and Performance:

- To consider the Trust's financial strategy, in relation to both revenue and capital.
- To consider the Trust's annual financial plans and targets including the strategic investment programme.
- To review the annual budget, before submission to the Trust Board.
- To consider the Trust's financial performance in terms of income, expenditure, cost improvement and turnaround programmes
- To review the annual Capital Budget and Annual Capital Programme.
- To commission and receive the results of in-depth reviews of key financial issues affecting the Trust.
- To consider and review any financial issues regarding contracts both within the NHS and with the private sector (e.g. contract with Catalyst) including their agreement and monitoring.
- To consider and agree the Trust's Treasury Management Policy and monitor performance
- To receive and consider, as appropriate, reports on "commercial" activities of the Trust.

Other duties

- To monitor and make recommendations on as necessary on the adequacy and effectiveness of the Trust's performance reporting.
- To make arrangements, as necessary, to ensure that all Trust Board members maintain an appropriate level of knowledge and understanding of key financial issues affecting the Trust.
- To examine any other matter referred to the Committee by the Trust Board.
- To review performance indicators relevant to the remit of the Committee.

Communication

The minutes of all meetings shall be formally recorded and submitted, together with recommendations where appropriate, to the Trust Board part 2. The Chair of the Committee shall draw to the attention of the Trust Board any issues that affect the financial standing of the Trust.

Meetings

Meetings shall be held monthly (except August).

- **Two Non-Executive Directors (including the Chair of the Committee)**
- **Executive Lead (or nominated Executive representative)**

The above will be considered sufficient for a quorum

Agenda and Minutes

The Finance Committee will be administered by the PA to the Director of Finance.

Review

The ToR will be review bi-annually (or sooner if required)

February 2013

Barking, Havering and Redbridge University Hospitals NHS Trust

Chairman's Report

1. NTDA meeting:

A meeting for Chairs and Chief Executives of all non-FT's under the aegis of the new Development Authority is taking place on the 30th April and I shall report verbally on any matters of particular interest. I have to say that I am encouraged by the initial stance of the NTDA on commissioning and their apparent willingness to challenge unreasonable requirements.

2. London Cancer:

We have a meeting at Romford with Pelham Allen, who is the Chair of London Cancer and Jane Stevens, BHRUT Clinical Director for Specialist Medicine, who has now met with Kathy Pritchard-Jones, the Medical Director. Again I shall report verbally. It is important that we engage fully with London Cancer and I am delighted that Mr Khoo is leading their work on upper GI cancers. Obviously, he has to take a non-partisan position in their discussions, but his appointment does recognise the significance of our activity in this area.

3. Smoking and litter:

I have asked that we have larger non-smoking signs and I would encourage all colleagues to continue to ask smokers politely to use the shelters, rather than cluster around entrances. I do think that matters have improved and I am also delighted that our revised arrangements for clearing litter are having an impact. My thanks to Jackie Nugent for her efforts.

4. Never Events:

We have now had three surgical never events in the past few months, fortunately without major harm to patients, and I remain concerned that the Trust's approach is inadequate. It is simply not good enough for individuals, including senior clinical colleagues, to shrug their shoulders and accept that "these things happen".

Everyone has a part to play in insisting on the highest standards and excuses are simply not acceptable.

April 2013

Barking, Havering and Redbridge University Hospitals NHS Trust

REPORT TO: Trust Board

REPORT FROM: Chief Executive

DATE: 16 April 2013

SUBJECT: CHIEF EXECUTIVE'S REPORT

FOR: Information

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1. INTRODUCTION

This report contains a summary of:

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

2. RECOMMENDATION

The Board is asked to note this report.

3. ACTIONS TAKEN UNDER EMERGENCY POWERS

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

4. EXECUTIVE DECISIONS

The Trust Executive Committee has been meeting on a monthly basis and have reviewed and inputted into several reports prior to their submission to the Trust Board, such as the Board Assurance Framework, Single Operating Model (February 2013), National Inpatient Survey 2012 and the BHRUT Emergency Pathway.

5. NATIONAL ISSUES/NEWS:

Building a culture of compassionate care – the Friends and Family Test:
Seeking and acting on patient feedback is key to improving the quality of healthcare services and putting patients at the centre of everything we do. From 1 April 2013 all patients in acute inpatient hospital wards and A&E departments across the country are being offered the opportunity to complete a Friends and Family Test (FFT). The test supports the 6Cs of 'Compassionate Care' – the three year vision and strategy for nursing, midwifery and care staff.
For more information, go to: http://cno.dh.gov.uk/2013/02/27/building-a-culture-of-compassionate-care-the-friends-and-family-test-2/

The 15 Steps Challenge – new Toolkits released:
The NHS Institute for Innovation and Improvement (NHSII) has released two new toolkits for the 15 steps challenge. The series includes toolkits for clinic and outpatient settings and children and young people's inpatient services. The challenge encourages patients and staff to work together to identify improvements to improve patient experience and increase confidence.
Link: www.institute.nhs.uk/productives/15StepsChallenge

Delivering the National maternal, newborn and infant clinical outcome review programme:
MBRRACE-UK has been commissioned to deliver the National maternal, newborn and infant clinical outcome review programme. Participation is mandatory and a requirement for quality accounts. Data collection of eligible deaths from 1 January 2013 commenced in early March.
Link: https://www.npeu.ox.ac.uk/mbrrace-uk

Hunt calls for action to save more lives:
Improvements in the fight against the five big causes of death, including new plans to tackle cardiovascular diseases, could save 30,000 lives by 2020, Jeremy Hunt announced in March this year. The call to action outlines his ambition to cut avoidable deaths from the five major causes – cancer, heart, stroke, respiratory and liver disease – and to make England among the best in Europe.
For further information, go to: http://mediacentre.dh.gov.uk/2013/03/05/hunt-calls-for-action-to-save-more-lives/

Measuring and monitoring clinical quality:
A conference, taking place in Manchester on the 21 May 2013, will provide an essential update on measuring and monitoring quality in the new health system including; implementing the recommendations for quality metrics from the Francis Inquiry. The conference will feature presentations from the NHS Commissioning Board, Care Quality Commission, WHO, NICE and the Health and Social Care Information Centre.
Link: http://www.healthcareconferencesuk.co.uk/quality-in-the-new-health-system-conference-quality-surveillance-group

Be clear on Cancer – plans for 2013/14:
A joint letter from the Department of Health, the NHS Commissioning Board and Public Health England outlines provisional plans for the Be Clear on Cancer campaigns in 2013/14 and provides an update on the latest campaign results. The 2013/14 programme will begin with a National lung cancer symptoms awareness campaign in July 2013, with a further National campaign planned in Autumn 2013 and two Regional campaigns in early 2014.
For further information, go to: http://www.dh.gov.uk/health/2013/03/bcc-plans

Accelerating the release of public sector land:
A letter from Dr Daniel Poulter, Parliamentary Under Secretary of State for Health, informed the NHS of the incentives to accelerate the disposal of surplus land in the NHS. This included details of the investment and acquisitions funds announced in the Autumn Statement and operational support to facilitate disposals.
Link: http://www.dh.gov.uk/health/2013/03/public-land-funding-support/

Complaints about NHS service provision from 1 April 2013:
Currently, a complaint about service provision may be made to either the provider of NHS funded care, or the PCT that commissioned the service. From April 2013, a complaint can now be made either to the provider, the NHS Commissioning Board, or the local CCG (whichever body commissioned the service in question).
Link:
http://www.nhs.uk/choiceintheNHS/Rightsandpledges/complaints/Pages/NHScomplaints.aspx

Introducing 6Cs Live! :
A letter from the Chief Nursing Officer for England explained the launch of 6CsLive! She expressed the desire to build on the strong foundations of Energise for Excellence and take the values, philosophy, learning and momentum into the 'Compassion in Practice' strategy and vision.
Link: http://www.commissioningboard.nhs.uk/wp-content/uploads/2013/03/6c-live-letter.pdf

Investigating, resolving and learning from complaints:
A conference on Wednesday, 3 July 2013 in London will focus on implementing the Francis Inquiry recommendations and the learning from the Prime Minister's review of hospital complaints. Chaired by Chris Bostock, Head of Complaints Policy at the Department of Health, the conference will look at how this learning can be put into practice at a local level.
Link: http://www.healthcareconferencesuk.co.uk/nhs-complaints-handling-investigtion-training

Delivering a seven day health service:
Following growing evidence of a need for routine health services to be available seven days a week, a conference was held in London during April focused on improving care, safety, outcomes and productivity throughout the week. It featured a presentation from the NHS Commissioning Board and was chaired by Dr Nick Bishop, Senior Medical Advisor at the Care Quality Commission.

Government publishes initial response to the Mid Staffordshire NHS Public Inquiry Report and revised NHS Constitution:
The Department of Health has published its initial response to the recommendations of the Mid Staffordshire NHS Foundation Trust Public Inquiry. 'Patients First and Foremost' sets out an initial response, on behalf of the health and care system as a whole. It details key actions to make sure patients are 'the first and foremost consideration of the system and everyone who works in it' and to restore the NHS to its core values.

It sets out a collective commitment and a five point plan of action to eradicate harm and aspire to excellence, focused on:

- Preventing problems
- Detecting problems quickly
- Taking action promptly
- Ensuring robust accountability
- Ensuring staff are trained and motivated

You can read 'Patients First and Foremost' at https://www.gov.uk/government/publications/government-initial-response-to-the-mid-staffs-report

A revised NHS Constitution was also published on the 26 March: https:www.gov.uk/government/publications/the-nhs-constitution-for-england

The NHS Constitution was revised following a public consultation. It also incorporates some changes based on the recommendations made by Robert Francis QC in his inquiry. An updated handbook to the NHS Constitution and the Government's response to the public consultation were also published in late March.

Extension of the Information Commissioner's powers to issue assessment notices:
On 25 March 2013, the Ministry of Justice published a consultation paper proposing to extend the powers of the Information Commissioner to carry out compulsory assessments of NHS bodies' compliance with the Data Protection Act 1998 and its data protection principles. The Information Commissioner's proposals are based on his view that there is strong evidence of significant and widespread data protection compliance concerns in the health sector.
Link: https://consult.justice.gov.uk/digital-communications/ico-assessment-notices

Safeguarding children and adults – revised guidance:
The Department for Education has published revised inter-agency statutory guidance, Working Together to Safeguard Children. To complement it, the NHS Commissioning Board has published its Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework. This updates interim advice on arrangements for children's and adult safeguarding issued last September.
Links:
http://www.education.gov.uk/childrenandyoungpeople/safeguardingchildren/protection/a00210235/consultation
http://www.commmissioningboard.nhs.uk/wp-content/uploads/2013/03/safeguarding-vulnerable-people.pdf

LOCAL NEWS:
NHS Sustainability Day Award:
BHRUT has been awarded this year's NHS Sustainability Day Award for best Carbon Reduction Initiative and also Best Overall Initiative, sponsored by British Gas, for the wide range of initiatives undertaken as part of this year's NHS Sustainability Day.

It was felt that the breadth of the coverage, from energy reduction, to travel, to waste, water and behavioural change, was a fantastic example of what can be achieved and rang through the very essence of Sustainability Day – to be involved and make measurable changes that can be sustained in the long term. It is fantastic that the Trust is placing sustainability high on the agenda and I thank all members of staff for participating so actively in this year's event. Congratulations to everyone for this excellent achievement, particularly with our very demanding challenges in the ED.