

TRUST BOARD MEETING
Tuesday, 29 January 2008 at 11.00 a.m.
Board Room, Trust Headquarters
Queen's Hospital
A G E N D A

1. Apologies for Absence
2. Minutes of the meeting held on 18 December 2007 (Attachment A)
3. Matters Arising
4. **STRATEGY:**
 - 4.1 Terms of Reference for Strategy & Service Improvement Board (JG) (Attachment B)
5. **CLINICAL SERVICES:**
 - 5.1 Maternity Services – External Review. Progress against Action Plan, including Midwifery Business Case (DW-H/CD/PK) (Attachment C)
 - 5.2 Infection Control Annual Report (YD) (Attachment D)
6. **FINANCE AND OPERATIONS:**
 - 6.1 Finance Report for period ending 31 December 2007(TS) (Attachment E)
 - 6.2 Performance Report – December 2007 (YD/JG) (Attachment F)
 - 6.3 Turnaround Report for period ending 25 January 2008 (TS/SH) (Attachment G)
 - 6.4 Draft Terms of Reference for Finance Committee (TS) (Attachment H)
7. Any Other Business

Date of Next Meeting: The next public meeting will be held on Tuesday, 25 March 2008 at 11.00 a.m. in the Lecture Theatre, James Fawcett Education Centre, King George Hospital.

8. Questions from the Public
9. **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 HOSPITALS NHS TRUST

Minutes of the Meeting of the Trust Board held on the 18 December 2007 in the Board Room, Queen's Hospital

Present:	Dr Eric Nath	Chairman
	Mr John Goulston	Interim Chief Executive
	Ms Renata Drinkwater	Non-Executive Director
	Dr Yasmin Drabu	Medical Director
	Mr Mark Hicks	Non-Executive Director
	Mrs Barbara Liggins	Non-Executive Director
	Dr Faiz Noor	Non-Executive Director
	Mr Trevor Smith	Director of Finance
	Mr Paul Stone	Director of Human Resources
	Prof Dickon Weir-Hughes	Director of Nursing

In Attendance: Mrs Susan Williams Executive Assistant

2007/138 APOLOGIES FOR ABSENCE

Mr John Griffin, Non-Executive Director.

2007/139 MINUTES OF THE MEETING HELD ON 27 NOVEMBER 2007

The minutes of the meeting were noted as a true record.

2007/140 MATTERS ARISING

No matter arising.

2007/141 HEALTHCARE FOR LONDON

The document to be considered by the Board had been prepared as a joint consultation by the 31 PCTs in London and a PAN London Overview & Scrutiny Committee formed by the Local Authorities in London. A PAN Patient & Public Involvement Advisory Group had also been informed of the consultation document. Mr Goulston informed the Board that roadshows in each Local Authority were being arranged and copies of documents were being sent to libraries and GP surgeries. The document spelt out the case for change in terms of trying to improve healthcare for Londoners and was a ten-year vision, principally across a range of areas covering birth to death. It was up to individuals and groups to respond to the consultation document, which could also be accessed on line (www.healthcareforlondon.nhs.uk). MORI had been commissioned by NHS London to consolidate all the responses and PCTs would, along with NHS London, issue the final report. PCTs would then decide whether any material changes needed to be made locally to services and if so would enter into consultation locally from the Summer of 2008.

The consultation would run until 7 March 2008 and at the Board meeting in January and the Seminar in February the Board would consider and sign off the Trust's collective response. Obviously, anyone wishing to respond as an individual could do so. It was confirmed that a Steering Group from the Trust's local PPI Advisory Group had been set up and they would be holding consultation meetings.

Ms Drinkwater indicated to the Board that from her attendance at the Non-Executive Forums relating to the Out of Hospital Care in North East London, she had concerns regarding how this was going to be funded and also had issues with the assumptions of how people would receive care in the future.

The Board discussed how best to disseminate this document across the Trust in terms of getting feedback and decided that it should be circulated to the Joint Staff Committee, Senior Medical Staff Committee, the Medical Assurance Board and the Nursing Board and would be posted on the intr@net for all employees. The Executive Directors would ensure that this document was discussed at all directorate meetings in January 2008.

Comments should be sent back to Mr Goulston's office for collation.

There were two challenges facing hospital providers; getting one's house in order, effective provision of services, which was a major challenge for BHRT with turnaround; be innovative with different models of care to provide the opportunity to grow. The Trust needed to be pro-active and have a clear strategy on how it was going to work through this. The Business Plan being prepared by Mr Smith would help to inform the Board and this would be ready by mid January, with the final version completed by the end of February 2008. Mr Goulston confirmed that by the end of March 2009, the Trust would need a ten-year long term Integrated Business Plan, which would take into account agreed local changes from the Healthcare for London report.

The Board noted the consultation document and agreed to hold further discussions at the Trust Board meeting in January 2008 and the Seminar in February 2008, in order to sign off the Trust's collective response.

Action: Executive Directors 29.1.08

2007/142 SERVICE RECONFIGURATION IN OUTER NE LONDON

The Board discussed the recommendations contained in the report, which included the 'Fit for the Future' programme, the Outer North East London health economy, Care outside Hospital, Acute Hospitals, Healthcare for London and King George Hospital. The Board agreed with the recommendation for the 'Fit for the Future' programme to be brought to a close. As far as the Outer North East London health economy and Acute Hospitals were concerned, it was noted that changes to improve services could be made, provided these did not involve any material changes. The Care outside Hospital work is being taken forward by the local Primary Care Trusts, led by Ms Heather O'Meara of Redbridge PCT. This will look at care pathways in detail and the Trust's clinicians will be involved with this work.

The Chairman confirmed to the Board that no decisions had been made regarding King George Hospital and in fact no definition had yet been agreed on what constituted a modern local hospital. This was a new consultation, not the option previously proposed by the 'Fit for the Future' programme and would be a much more bottom up approach to help the Trust establish its services from a clinical perspective across the two hospitals. Mr Hicks commented that this provided the Trust with the opportunity to provide the best services in the most effective way and put the spotlight back on the Trust to get the basics right. Dr Drabu raised the fact that public health issues were not included and this point needed to be made, as it would impact on the population that the Trust served.

It was agreed that the Board would consider this paper and the updated draft strategic vision document for Care outside Hospital in Outer North East London received by Ms Drinkwater and would send comments back to Mr Goulston's office by the end of this week. Mrs Williams would circulate the updated paper to all Board members.

The Board endorsed the recommendations and agreed that a response would be sent to the Project Director, Ms Ann Smart, with comments from the Trust, by the end of the calendar year.

**Action: John Goulston 31.12.07
Sue Williams 18.12.07**

2007/143 NHS NEXT STAGE REVIEW – INVITATION TO SUBMIT POLICY IDEAS

Mr Goulston confirmed to the Board that Professor Lord Darzi's interim national report had been issued and he was looking to finalise this in June 2008. The key barriers and enablers under the seven themes were discussed and Mr Goulston asked for comments to be fed back to him by 7 January 2008, in order for him to prepare a response to Lord Darzi by 11 January 2008. The Chairman encouraged the Board to take the opportunity to provide their input and to ensure that these papers reached all relevant members of the Trust, in order for them to feed back their comments too.

The Board noted the letter.

**Action: All Board Members 31.12.07
John Goulston 11.1.08**

2007/144 AUDIT COMMITTEE MATTERS

Mr Smith presented to the Board a number of matters considered and agreed at the Audit Committee meeting in November and recommended these to the Board for approval:-

- Revised Audit Committee Terms of Reference
- Audit Committee Annual Plan
- Interim Scheme of Delegation
- Current Assurance Framework

Both the Annual Plan and the Interim Scheme of Delegation had been shared with the Internal and External Auditors. The Annual Plan was the introduction of a workplan of key activities for the Audit Committee covering the next 18 months. Mr Smith confirmed that the Committee would provide an interim report on its activities during the year and an Annual Report to the Board. Mr Smith also confirmed that the Assurance Framework was now being reshaped in line with the new Corporate Objectives and further discussions would take place on this during the Seminar to follow this Board meeting. A review of the Assurance Framework would be reported back to the Board in January 2008.

The Board agreed that it was important that the right arrangements were in place for budget holders to follow the process and to be very clear on their responsibility and accountability.

The Trust Board agreed the report and approved the Terms of Reference and the Annual Plan. The Board also agreed the Interim Scheme of Delegation in principle and for Mr Smith to consult with some of his Executive Director colleagues regarding possible amendments flagged up at the meeting. Mr Smith would make these changes and issue the scheme.

Action: Trevor Smith 29.1.08

2007/145 NEW CONSULTANT APPOINTMENTS SINCE JANUARY 2007

Mr Stone circulated a more up to date paper for Consultant appointments and leavers from April 2007 to date. Mr Hicks asked that other senior posts should also be advised to the Board and it was agreed that people reporting into Executive Directors would be included on the updates to be made to the Board at every meeting. Following a proposal by Dr Noor, it was agreed that these updates would also show where people had been recruited from and where they were going to.

The Trust Board noted the paper circulated.

2007/146 ANY OTHER BUSINESS

The Chairman informed the Board that he had received formal confirmation from the Appointments Commission regarding Mr Mark Hicks reappointment to the Board for a further four years and the Board congratulated Mr Hicks.

The Chairman also confirmed to the Board that the Trust would be advertising the post of Chief Executive and the post to replace Sue Barnett in the New Year. As indicated in the structure discussed at the Seminar in November, it was proposed that Sue Barnett's replacement would be for a Director of Planning & Performance and not a Director of Operations. The Chairman asked the Board to consider the roles and responsibilities of the last post holder and asked them to consider, as a Board, how the Trust would cover these responsibilities with the new role. A discussion took place regarding the loss of the Director of Operations post, as concerns were expressed that this post had been introduced by the previous Chief Executive because it was felt necessary in order to manage such a large organisation. The Chairman also asked the Board to consider the Job Descriptions handed to them at the meeting and let Mr Stone know before the Christmas break if they had any additions or comments to make. As far as the Chief Executive post was concerned, the Chairman would also be consulting with NHS London.

The Trust Board meetings for 2008 were circulated to the Board and all members noted the change in starting time (11.00 a.m. instead of 10.00 a.m.). This later start would allow time for any sub committees of the Board to meet prior to the meeting. The Board was asked to consider the date of the

Annual General Meeting in 2008 and the 24 June and the 29 July 2008 were proposed. Mr Smith would review the timetable for the finalisation of the Accounts and the date would be agreed at the next Board meeting in January.

**Action: All Board Members 24.12.07
Trevor Smith 29 .1.08**

Meeting closed at 11.05 a.m.

The next meeting of the Barking, Havering and Redbridge Hospitals NHS Trust Board will take place on Tuesday, 29 January 2008 at 11.00 a.m. in the Board Room, Trust Headquarters, Queen's Hospital, Romford.

BARKING, HAVERING AND REDBRIDGE HOSPITALS NHS TRUST

EXECUTIVE SUMMARY

1. Subject: Terms of Reference for the BHRT Strategy & Service Improvement Board.

2. Summary: Following the Trust Board's approval to the establishment of the BHRT Strategy & Service Improvement Board, the first meeting took place on the 9 January 2008, at which the attached Terms of Reference were agreed.

3. Action: The Trust Board is asked to endorse the Terms of Reference for the BHRT Strategy & Service Improvement Board.

4. Linkage to Corporate Aims: In order to monitor the achievement of the Trust's Corporate Objectives, drive the implementation of the Trust's Service Improvement Programme and the development of its Strategy.

5. Resource Implications: N/A

6. Author:

John Goulston
Interim Chief Executive

Dated: 18 January 2008

BHRT Strategy & Service Improvement Board

TERMS OF REFERENCE

1. Constitution

The Strategy & Service Improvement Board will be the Trust's Executive Board, accountable to the Trust Board.

2. Membership

The membership of the Strategy & Service Improvement Board will be as follows:

- Chief Executive
- Executive Directors
- Associate Medical Directors
- Associate Nursing Directors
- Director of Midwifery
- Operational Directors
- Director of ICT
- Head of Turnaround

The membership would be reviewed on completion of the UCL (H) support to clinical leadership work, as this will clarify the way forward on accountability for our clinical services.

3. Purpose and Accountability

The Trust Board, at its 27 November 2007 meeting, approved the Trust's Corporate Objectives and BHRT Service Improvement Strategy and Leadership Programme. In order to drive forward with the implementation of this paper (as previously circulated), at its seminar on 18 December, the Trust Board also approved the establishment of the BHRT Strategy & Service Improvement Board to drive the implementation of the Trust's Service Improvement Programme and the development of our Strategy. This would in effect be the Trust's Executive Board and it will be accountable to the Trust Board.

The Medical Assurance Board, Nursing & Midwifery Board and the IT Executive Programme Board will be accountable to the Strategy & Service Improvement Board. Chart 1 illustrates the proposed accountability arrangements.

4. Role and responsibility of the BHRT Strategy & Service Improvement Board

Table 1 summarises the role and responsibility of the BHRT Strategy & Service Improvement Board. Table 1 should be read in conjunction with the Corporate Objectives, Service Improvement Strategy and Leadership Programme (as previously circulated). Overall, the responsibility of the BHRT Strategy and Service Improvement Board (S&SIB) is to monitor the achievement of the Corporate Objectives on behalf of the Trust Board and to monitor and review cross cutting themes between the Service Improvement Programme and Turnaround.

Role and Responsibility of the Strategy & Service Improvement Board	
1.	Monitor the achievement of the BHRT Service Improvement Programme across the following 5 areas: <ul style="list-style-type: none"> a. Corporate Governance b. Clinical Performance c. Financial Performance d. Operational Performance e. Infrastructure
2.	Oversee the establishment and then implementation of the BHRT Strategy and Leadership Programme. This includes the development and deployment of the enabling strategies. In summary the S&SIB will monitor the development of of the programme across following areas; <ul style="list-style-type: none"> a. Overall Strategy b. Enabling Strategies c. Leadership d. Partnerships e. Foundation Status

Table 1

Tables 2 and 3 provide the overall contents of the Service Improvement and Strategy and Leadership Programmes. These schedules detail the Senior Responsible Officers (SRO) who will be accountable for delivering on the work streams within the programmes. The SROs will present progress reports against the Service Improvement action plans and the development of the Strategy and Leadership Programme.

The Chief Executive will provide a monthly overall progress report to the Trust Board based on tables 2 and 3.

5. Communication

Action points of the meeting will be recorded and circulated to senior leaders of the organisation, the Joint Staff Committee and the Senior Medical Staff Committee.

6. Meetings

The BHRT Strategy & Service Improvement Board will initially meet on a weekly basis, alternating between Queen's and KGH. The focus of the meeting will alternate between the Service Improvement Programme and Strategy and Leadership, so that each of these two elements for the delivery of our Corporate Objectives are reviewed on a fortnightly basis.

7. Agenda and Action Points

The agenda will be prepared by the Interim Chief Executive and will be circulated no later than one day prior to the meeting.

The Strategy & Service Improvement Board will be serviced by the Executive Assistant, with the action points produced and circulated within two days.

8. Date/Originator

This document was produced by the Interim Chief Executive and approved by the Strategy & Service Improvement Board on 9 January 2008 and the Trust Board on the 29 January 2008.

Chart 1

Governance – Trust Board Sub Committees as at 1 January 2008

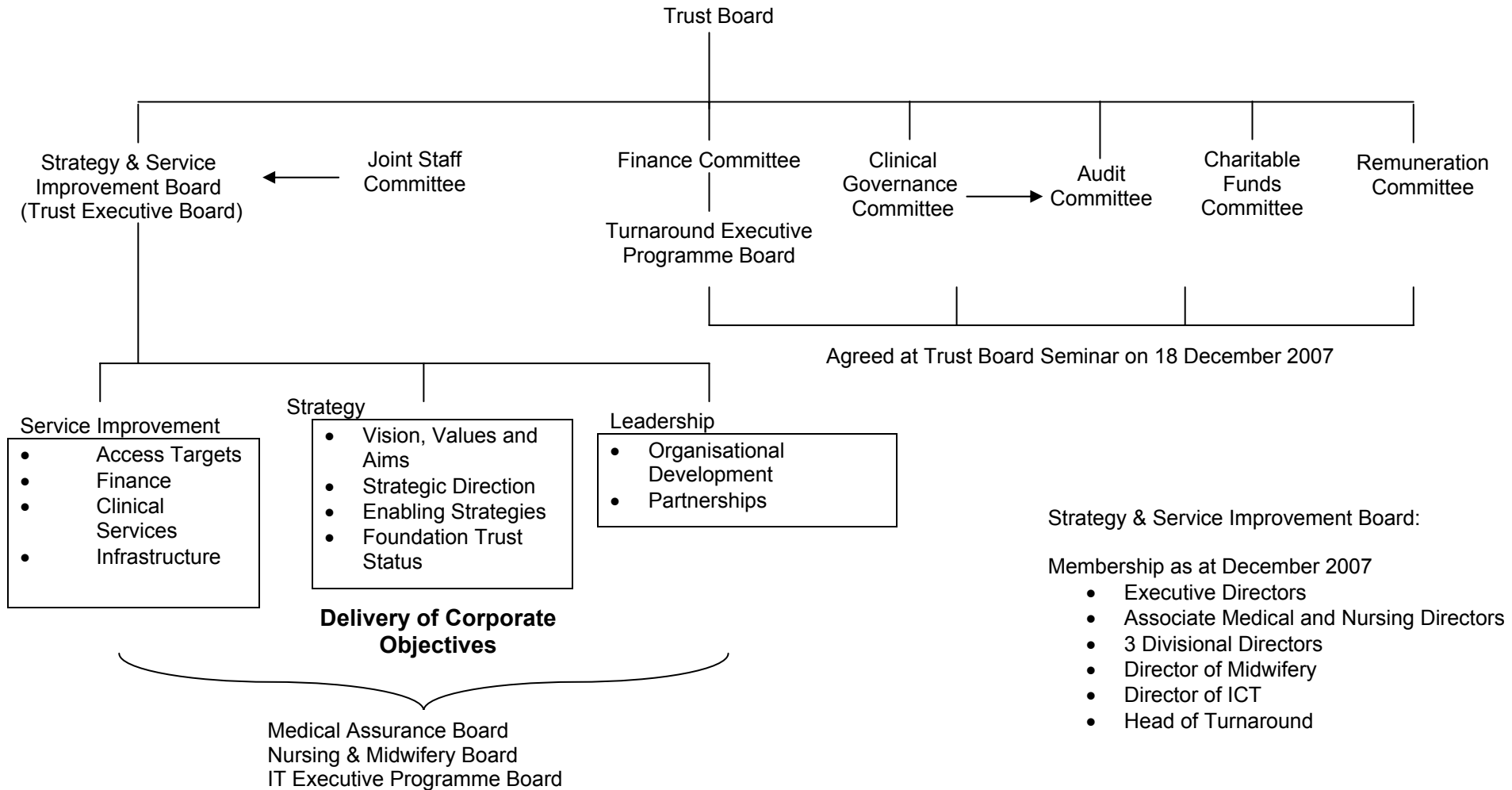


Table 2

BHRT SERVICE IMPROVEMENT PROGRAMME

	SRO	RAG Status		Action Plan Status	Milestones		Target	KPIs
		Programme	Service		07/08	08/09		
1. Governance	EN/JG							
2. Overall Performance	JG							
2.1. A&E	DoN, Em (DW-H)							
2.2. Infection Control	MD (YD)							
2.3. 18 Weeks	DoO EI (EM)							
3. Finance	DoF (TS)							
4. Clinical								
4.1. Maternity	DoN (DW-H)							
4.2. Gynaecology	DoN (DW-H)							
4.3. Trauma	MD (YD)							
4.4. Orthopaedics	MD (YD)							
4.5. Child Protection & Vulnerable Adults	DoN (DW-H)							
4.6. Stroke	DoN (DW-H)							
4.7. Diagnostics	MD (YD)							
5. Infrastructure	TBC							
5.1. Information & Choose & Book	DoN (DW-H)							
5.2. ICT	DoN (DW-H)							
5.3. PFI Contract / Facilities	DoF (TS)							
5.4. Estates	DoF (TS)							

Key – Senior Responsible Officer (SRO); Red, Amber, Green status (RAG rating); Key Performance Indicators (KPIs) Chairman, Eric Nath (EN); Interim Chief Executive, John Goulston (JG)

Table 3 **BHRT STRATEGY AND LEADERSHIP PROGRAMME**

	SRO	Process for drafting	Timescales
1. Strategy			
1.1. Vision and Trust Objectives	EN/JG		
1.2 Clinical Services	MS/AA		
1.3 Clinical Support Services	SS		
1.4 Education	DW-H		
1.5 Innovation/Research	YD		
Link to 'Fit for the Future'/Out of Hospital/Alberti Report			
2. Enabling Strategies			
2.1 Service Transformation	SH		
2.2 Finance	TS		
2.3 Capacity Planning	TS		
2.4 Workforce	PS		
2.5 Organisational Development	PS		
2.6 ICT	DW-H		
2.7 Estates	TS		
2.8 Communications	PS		
3. Leadership	JG		
3.1 Culture/Behaviours/Values			
3.2 Clinical Networks			
3.3 Accountability			
4. Partnerships	EN/JG		
4.1 Reputation			
4.2 Community/Public Engagement			
5. Foundation Status	JG/TS		

BARKING, HAVERING AND REDBRIDGE HOSPITALS NHS TRUST

EXECUTIVE SUMMARY

1. **Subject:** Maternity Services – External review.
Progress against action plan

2. **Summary:** Following an external review of maternity services at the beginning of 2007, an Executive steering group, chaired by the Director of Midwifery, was established to oversee the development and implementation of an action plan to address the recommendations. Whilst a key issue related to midwifery numbers remains, progress has been made against a significant proportion of the action plan. Attached is a summary report and a table of completed actions to date. Also, for reference, is the original action plan.

3. **Action:** The Trust Board are asked to recognise the progress to date and to discuss the options described in the business case for a further increase to the midwifery establishment.

4. **Linkage to Corporate Aims:** Improving clinical services.

5. **Resource Implications:** £1.4 million.

6. **Author:** Carol Drummond, Director of Midwifery/GM Neonates and Gynaecology.

Date: 18.01.08

MATERNITY BRIEFING PAPER

AIM

The purpose of this paper is to provide an update on the progress against the maternity action plan developed as a result of the external review in April 2007.

Background

During April 2007 an external review was conducted by the Royal College of Obstetricians and Gynaecologists, accompanied by an external Head of Midwifery as well as a member of the National Clinical Governance Support Team. The report was released to the Trust during July 2007 with a series of recommendations designed to guide the department and the Trust in the development of its 3 year strategy.

Prior to the review the maternity department presented a 5 year strategy to the Trust Board for taking the service forward with the accompanying workforce plan. This strategy was accepted and the plan commenced in April 2007, with uplift in the funded establishment for midwifery, medical and support worker numbers.

Summary of recommendations from External review

The recommendations fell under the following headings:

- The capacity and organisation of the current maternity services between the 2 sites.
- To review workforce numbers across nursing, midwifery and medical establishments and develop a workforce plan within a 3 year strategy to increase numbers to those nationally recommended.
- To implement Information technology systems to support the department with data collection and clinical audit.
- To work with local commissioners to review how services are commissioned.
- To strengthen the medical, midwifery and strategic leadership, clarifying lines of accountability and responsibility within the organisational structure.
- To achieve compliance for all staff for mandatory and statutory training.
- To develop a robust clinical governance framework, which monitors and rectifies risks identified and achieves Clinical Negligence Scheme for Trusts (CNST) level 2.
- To improve the communication both within and outside of the department with all the relevant stakeholders.
- To develop a mechanism for providing the Trust Board with reassurance of progress against the action plan by the establishment of performance indicators.

Progress made

1. The organisation of workload to improve capacity of units to provide maternity care.

Discussions have taken place within the midwifery and consultant teams about the organisation of maternity care between the 2 sites. These discussions will now hopefully inform the work related to the Local hospital project facilitated by NHS London and it is anticipated that members of the department will work as part of the women's and children's project group.

The flow of Gynaecology patients has been reviewed and a dedicated ward area has been identified to accommodate these and the Early Pregnancy unit. Maternity Day assessment facilities at Queens have been improved and the unit now functions during the week days, office hours with plans in place to increase the opening hours to 0800 – 2000 hours during the week and Saturday mornings.

2. Workforce review.

This year the Trust has a new format for business and service planning. Using the designated proformas the team within maternity have developed a 3 year service plan, incorporating the workforce requirements. Of course this is dependent on securing the appropriate funding streams to support the increasing revenue requirements.

Medical

2 additional consultant obstetricians have been appointed into substantive posts.

The work has now been completed to re-band the junior medical posts to 1a and a business case is being presented on the 23rd January 2008 to the Service and Strategy improvement Board to make the case for an increase in the funded establishment of middle grade doctors, which is facilitated by the re-banding of the posts.

During 2008 the National recommendation, based on a report by the Royal College of Obstetricians and Gynaecologists, is that units of the size of Queens should have 24 hour presence from a consultant obstetrician. King George's need, in the current configuration, would continue to be 40 hours of cover for the labour ward. To achieve this recommendation within the current service configuration a further 6 wte consultant obstetricians are required.

Midwifery

Following conversion of bank and agency funding an establishment was created for the appointment of RGNs to cover the theatre work and release midwives. Unfortunately it has not been possible to recruit to these posts so the funding has been converted back into midwifery posts giving a funded establishment which provides a ratio of 1: 40 midwives to women. The department are currently recruiting to these posts and it is hoped that this would have been completed by the 23rd January.

However further funding is required to increase the midwifery establishment by a further 50.00 wte midwives and thus achieve the 1:33 ratio. Negotiations are ongoing with the PCT commissioners regarding this matter and how the income for maternity is derived between that activity which is PBR and that which is not. The sum of 750K had been identified but to date this has not been released. This would improve the ratio to 1:37. Once agreement has been reached a rolling programme for recruitment will be implemented and it is hoped that the funded establishment would be completely in place by the end of 08/09. A midwifery business case has been developed and agreed in principle by the Trust's executive team. In addition a business case has been prepared for the PCTs detailing how the additional midwives will be utilised to improve services within both the hospital and community settings, whilst at the same time implementing recommendations from the National reports and Enquiries. The calculations are based on projected deliveries for 07/08 of 9,600.

Maternity support workers are proving difficult to recruit despite the funding. The plan is to convert some of these vacancies to nursery nurse posts to work on the postnatal wards caring for babies and supporting breastfeeding women.

The midwifery management and band7 team has been restructured. This process has enabled the department to develop some key specialist posts to support the implementation of the main national recommendations. The posts include the antenatal screening co coordinator and a lead midwife for mental health. It has also defined the team leader roles in each area to hopefully encourage ownership of the clinical areas at the ward and team levels, thus increasing clinical leadership. Not all posts were recruited to and these posts will now go out to national advert at the beginning of February 2008. As well as attracting new people to the organisation it will also provide an opportunity for internal staff to achieve promotion. Although not all staff were successful they were all successfully redeployed into alternative posts and no redundancies have occurred.

Administrative

Administrative roles are vital to release clinical staff from non clinical duties and are essential as part of the day to day functioning of the department. Additional administrative support has been provided to key roles by using temporary staff. An administrative structure has been proposed and will be consulted upon once the financial implications have been resolved.

Other Disciplines associated with maternity.

Originally, the department did not have the capacity to meet the demand for pregnancy scans due to insufficient sonography time. Adverts have been put out for additional sonographers, but these posts, historically have been difficult to recruit to. The midwifery restructure provided the opportunity to increase the number of sessions undertaken by the midwife sonographer's already in post to relieve this problem.

As part of the process involved in the development of service plans and allied business cases for each department it has been agreed to put forward the case for 2 further neonatologists.

Finally the department has developed a case for the reintroduction of the OSCAR service. This relates to the antenatal screening programme for Downs and this particular system provides the screening and results using a one stop approach and reducing the number of times a woman needs to attend the hospital for antenatal clinic. Having resolved the ultra-sonography component, there is a requirement for a wte biochemist.

3. Information technology

Over the last few months a multidisciplinary group has been established to oversee the implementation of the maternity system which has been procured by the Trust. The maternity system is on target to live by the end of March 2008. The team are currently in the process of training the staff on how to use the system. At the present time the system will only accommodate the activity which is hospital based, however it is hoped that it will be rolled out into the community very soon. With full implementation of this system it will mean that the department will be able to collate data more efficiently for local and national audits as well as maintaining accurate account of activity.

The electronic training package for the interpretation of CTGs (the trace that is produced when monitoring the unborn baby's heartbeat), is in the process of being purchased and this will be able to be accessed both within the hospital settings as well as by individual members of staff via the internet at home.

A business case has been submitted for the capital funding required for the purchase of a centralised system for CTG monitoring.

4. Commissioning of maternity service

Meetings have occurred as part of the co commissioning group, incorporating members of the maternity team to discuss the core services to be commissioned by the main PCTs. The income for maternity falls into two areas. There is that activity, such as the deliveries, which is part of the PBR process and then there is the activity, predominantly undertaken by the community based midwives, which is part of the block contract agreement. The Trust are currently negotiating with the PCTs as to the value of both these streams of activity and an audit to validate the activity is currently being undertaken. In principle all are agreed on the need to achieve the 1:33 ratio. Further support is being given to the department by the Turnaround team.

A great deal of work has been undertaken by the administrative teams to ensure activity is captured on PAS and coded correctly.

5. Strategic and Clinical leadership

The lines of accountability for the Director of Midwifery were reviewed and changed so that she reported to the Executive Director for Operations. In recent time this person has left the Trust and for the interim, the Director of

Midwifery reports to the Executive Director of Nursing. The Director of Midwifery is also a member of the Strategy and Service Improvement Board, which has been newly formed, chaired by the Chief Executive.

Within maternity the recent midwifery restructure has clarified reporting lines for staff and given more accountability for leading services forward to the senior posts. The structure composes of 3 main areas; Operational, Public Health and Clinical Governance. All 3 areas have a defined lead who reports directly then to the Director of Midwifery.

Over the coming year the plan is to provide a development programme for the band 7s to increase their knowledge and understanding in relation to management and leadership and to support them in taking forward individual projects.

The new appointments for Obstetrics has seen the development of consultant obstetricians with special areas of interest such as mental health and antenatal care.

The maternity department have reorganised their meeting structures so that there is a clearly defined reporting mechanism within the department.

On the 4th February there is a planned away day for the consultants and the senior midwifery management team to define further the direction of travel and identify individual roles and responsibilities. This session will be facilitated by the National Clinical Governance Support team.

6. Mandatory and statutory training

During September and October 2007, weekly workshops were held for staff were held for CTG training. In addition these sessions are incorporated into the Obstetrics skills and drills training and staff are encouraged to attend the weekly near miss meetings where individual cases are discussed. This has seen a compliance of over 80% of staff from both midwifery and medical groups having attended at least 2 of these sessions in the last year.

To support the learning and aid the consistent approach for the interpretation of CTGs, a sticker has been implemented for the documentation.

Staff are now mainly rostered to attend the training that has been deemed as mandatory and those that attend in their own time are either paid or given the time back. However it has to be recognised that this is difficult to maintain when staffing is critical, especially in recent times when in keeping with other clinical specialities sickness has escalated.

A training programme for 2008 has been developed which incorporates most requirements into 3 days with an additional 4th day to include the 2nd CTG session. The programme has also been supported by the Trusts resuscitation and manual handling teams, thus allowing staff to complete most of their training needs over a year in an organised way. The plan is that staff will be

rostered for these days, thus removing the onus from the individual member of staff.

In January 2008, 4 members of the multidisciplinary team, including an obstetrician, midwives and an anaesthetist are attending the PROMPT course to learn how to run successful multidisciplinary skills and drills training within the department.

7. A robust clinical governance framework, which monitors and rectifies risks identified and achieves Clinical Negligence Scheme for Trusts (CNST) level 2

The new midwifery management structure has already identified, defined a component of the structure for Clinical Governance. Prior to this there was a clinical risk midwife, who was responsible for the monitoring the clinical incidents, via the IR1 system, but also the coordination of the work required for CNST. Given the size of the department in comparison to other Trusts, this was felt not to be sustainable. Whilst there remains a midwife for clinical risk, they are part of a clinical governance team, incorporating the Practice development midwife, clinical skills facilitators and lecturer practitioner. This report to the clinical governance manager, which is a new post.

The department has redefined the Maternity Risk Management group, which is multidisciplinary and meets on a monthly basis, chaired by the Director of Midwifery. This group not only reviews clinical incidents on an individual basis, but also reviews trends via the quarterly report. It is also has responsibility for ensuring National Enquiries are reviewed and recommendations taken forward and ratifying local guidelines policies, ensuring NICE guidance is incorporated.

The Director of Midwifery and Clinical Governance manager are members of the clinical risk and governance groups with the wider Trust.

On a weekly basis the Director of Midwifery, Clinical risk midwife, Clinical Governance manager, Lead Obstetrician, Clinical Risk lead for obstetrics, Clinical Director, Associate Director of Midwifery and Contact Supervisor of midwives meet to review new cases, ongoing investigations and recommendations.

The department submitted evidence to apply for CNST level 2. Unfortunately this was not successful and the department will be assessed for level 1 on the 25th January 2008. It is hoped that the department will achieve higher scores than the last time, enabling a stronger position for future application for CNST level 2.

A balanced score card has been implemented, identifying key performance indicators. These are monitored on a monthly basis and the number of SUIs have reduced.

8. Communication strategy

There is an executive steering group to oversee the implementation of the action plan developed following the external review. As part of this process, the Director of Nursing has been identified as the executive lead and meets with the group on a fortnightly basis.

Within the department there is a process known as 'message of the week' which is sent out each week and read at the beginning of each shift for the entire week. It is also sent to the medical teams. The purpose of the message is to disseminate information to all staff within maternity, highlighting risk as well as changes.

The Maternity Services Liaison Committee has been re established in partnership with the PCT and is chaired by a Non Executive member of the Havering PCT Board. It is the main forum for engaging the users of the service with the providers.

Summary

Positive steps have been taken to improve many of the systems and process within the maternity unit, which have contributed to the improvement in the standards of care. However there is still significant work to be done, which can only be taken forward once the staffing levels for midwifery have been improved. It has to be recognised that there is still a significant level of clinical risk related to midwifery numbers. In recent times these have been compounded by sickness and an inability to secure bank and agency midwives to fill shifts where needed.

Prepared by:

Carol Drummond, Director of Midwifery, January 2008

MATERNITY – EXTERNAL REVIEW

ACTION PLAN UPDATED SEPTEMBER 2007

Prepared by:

Carol Drummond, Director of Midwifery/GM for Neonates, Chineze Otigbah, Lead Consultant Obstetrician and Prem Kollipara, Clinical Director for Women’s Services. The action plan aims to address all the individual recommendations within the RCOG report. The Department will invite the RCOG to conduct a follow up review in April 08 to verify progress against this plan.

Objective	Expected outcome	Assurance	Actions required	Target date lead	External review reference
1) To review the organisation of workload to improve capacity of units to provide maternity care	To have a maternity service where the capacity meets the demands and the configuration reflects both high and low risk models of care. To have a written proposal outlining the clinical options as part of the ‘Fit for the Future’ framework.	No of times escalation policy used. Reduction in AN admissions. Co located MLU in place. Dedicated and functioning Gyane area. Women in active labour are cared for in the appropriate place.	Revisit the configuration of services between the 2 sites and incorporate proposed service model within 3 year strategy for maternity services, incorporating a co located MLU at Queens an d/or KGH. Develop proposal from multidisciplinary team describing the possible options for ‘Fit for the Future’ Reorganise DAU to one site at Queens and operate 8-8 7 days a week. Review Gynae services and develop plan to implement a dedicated Gynae ward and relocation of EPAU/Gynae emergencies. Review referral pathways between specialties, where joint clinics do not exist.	CD/PK End Sept 07 CD/PK End Sept 07 CD End Dec 07 ED/TO End Sept 07 CO/PK March 08	7.1.2, 7.1.3, 7.1.4, 7.1.5, 7.1.6, 7.2.7, 7.2.8, 7.6.4, 7.7.6, 7.12.8, 7.15.6, 7.15.9.
2) To review Workforce across all disciplines	To meet the recommendations within the external review re staffing numbers. To have the workforce that is able to respond to the demands on the	Reduction in serious clinical incidents. MW:Woman ratio is 1:33. Consultant numbers support RCOG recs. Theatre and HDU	To fund 2 additional Consultant Obstetrician posts, asap and recruit. To recruit to posts secured by additional funding, ie 17 midwives, 3 RGNs and 20 MCAs. Convert B&A funding to substantive posts, to support increase in RGNs to cover theatre and HDU 24/7.	Out to recruit. Recruiting Now. Completed, recruiting.	7.2.1, 7.2.3, 7.2.4, 7.2.8 7.2.10, 7.4.1, 7.5.1, 7.5.3, 7.5.5, 7.6.2, 7.7.1, 7.7.2, 7.7.11, 7.12.7

	service, both in numbers and skills.	staffed by RGNs. 3 Neonatologists in post. 1:1 care in labour achieved in 75% of cases. Specialist posts recruited. LW Co ordinators supervisory.	Convert vacant band 7 posts to band 6. Provide Consultant cover for LWs as per CNST requirements and RCOG guidance. Increase funded establishment for 2 further neonatologists. Review medical banding and convert 1a posts to support workforce increase. Identify funding and recruit AN screening co ordinator Review service strategy, incorporating workforce plan and develop 3 year proposal, commencing April 07. Review Skill mix and develop other roles to release midwifery time. Increase consultant numbers for obstetrics by a further 4wte. Increase number of sonographers to meet the demand of the service, incorporate into 3 year strategy. Define minimum staffing levels for a safe service for both units. Review number of trainee grade against future projections. Appoint to Clinical lead midwife post for Queens LW, secondment until substantive in post. Develop specialist post for mental health within midwifery restructure. Move department towards a ration of midwives of 1:33	Completed. Completed. End Sept 07 MA PK End Dec 07 CD, Oct 07 CD/PK End Sept 07 A/A A/A A/A Completed CD End Dec 07 CD March 2010	
3) To develop a robust information technology system and administrative structure to support	To have a maternity system in place which supports the collection of data and clinical audit. To have in place IT	Maternity system in place. Ability to run enquiries electronically to	To develop project team to co ordinate the implementation of the maternity IT system, incorporating design of system, datasets and training, involving HR where required. Implement maternity IT system.	CO/CE Completed Jan 08	7.2.6, 7.2.11, 7.3.1, 7.3.2, 7.3.6,.7.12.7, 7.12.9

maternity	systems which support the clinical functioning and development of the unit.	match national and local data collection requirements. To have administrative posts in all places required.	Complete and submit business case to secure funds for the implementation of a centralised system for CTGs. Develop robust databases to capture information to support audit. Identify funding to install K2 for CTG training. Install K2 CTG training. Establish working group to review antenatal pathways, systems and processes. Review the administrative structure to support midwifery, ie LW 24/7 ward clerk, clerical support to lead roles. Undertake a process mapping exercise in all clinical areas to identify where efficiencies can be implemented.	CD/CO Oct 07 CE Jan 08 Completed RH, Nov 07 CO/CE In place CE Oct 07 CE Dec 07	
4) To review commissioning of maternity services	To establish a commissioning plan to meet the needs of local maternity services.	Local costs in line with National tariffs. All activity recorded and paid for. Financial balance. Funding supports overall action plan.	Establish working party comprising of DOM, Trust and PCT commissioning leads to agree how services for maternity will be commissioned, in line with Maternity Matters. To undertake a 'bottom up' costing exercise to understand the true cost of current service and underpin the development of services for the future. As part of the 3 year strategy define clearly service requirements based on predicted population growth. To ensure all activity captured and correctly coded to secure funding via PBR.	In Place CD End Nov 07 CD/PK End Sept 07 CD Ongoing	7.1.2, 7.2.1, 7.2.2, 7.4.1, 7.4.2, 7.12.7
5) To develop workforce structure which enables maternity reduce clinical risk and improve leadership	To have strong clinical leadership both midwifery and medical.	Completion of restructure. Completion of leadership programmes.	To staff obstetric theatres and HDU with RGNs, once recruitment completed, including band 7 RGN team leader. Review and implement new structure for Midwifery management and band 7 layer of midwives, incorporating consultant midwife posts. Clarify roles and responsibilities of specific team members, eg shift co ordinators for LW.	CD End Dec 07 CD End Dec 07 End Dec 07	7.2.1, 7.2.5, 7.2.9, 7.2.10, 7.5.2, 7.5.3, 7.5.4, 7.5.7, 7.7.3, 7.8.3, 7.10.4, 7.10.5, 7.10.6, 7.10.7, 7.10.8, 7.10.9,

			Review job plans for consultants to release more time for clinical supervision and teaching. Maintain active recruitment to fill new posts and keep vacancies to a minimum. Recruit 2 midwives to undertake the SOM course.	PK End Dec 07 CD Ongoing CH Jan 08	7.10.11.
6) To review organisational structure to clarify reporting lines for senior posts and provide a more strategic level of leadership	To have an organisational structure for women and children which demonstrates clear lines of accountability and responsibility through to the Trust Board.	Organisational charts.	Develop Executive steering group to oversee implementation of action plan, with an identified Exec lead to support department. Clarify lines of reporting and accountability for the Director of midwifery and reflect this in the organisational chart. Review Trust Divisional structure, in relation to women and children. Develop a management structure which integrates the 2 units. Review senior medical management roles in line with any changes to Divisional structure.	DWH In place Execs Completed Execs March 08 CD End Dec 07 YD March 08	7.5.2, 7.8.1, 7.8.2, 7.8.3, 7.8.4, 7.8.8, 7.10.1, 7.10.2, 7.10.3
7) To develop a robust training and development programme for the multidisciplinary team within Maternity	To achieve compliance for all staff for mandatory and statutory training.	75% of staff receive CTG training biannual. 90% of staff attend skills and drills annually. All staff receive CPR training annually. Fire and manual handling training received annually. 100% compliance for appraisals. 100% of new staff	To roster midwives for key training eg CTG, Skills & drills. To implement training strategy, identifying all mandatory and statutory training as rostered. To develop training database which includes the multidisciplinary team Implement additional CTG training days. Incorporate Midwifery onto wider education for a, within Trust. Develop a competency framework for all training grade doctors. To implement IT methods of training ie K2 To recruit 2 seconded posts for clinical skills	CD In place CD March 08 MD Oct 07 CO. completed CD Completed PK/CO Completed RH, Nov 07 CD	7.5.5, 7.5.6, 7.7.5, 7.11.6, 7.11.1, 7.11.2, 7.11.7, 7.11.3, 7.11.4, 7.11.5, 7.11.8, 7.15.3,

		complete induction programme. Band 7s completed development programme within 3 year strategy.	facilitators. Develop a programme to support the enhancement of management and leadership skills eg band 7 To implement appraisal system in line with ESR and the KSF framework for midwifery and ensure medical appraisals are competency linked. Ensure induction process for all new starters is adhered to. Ensure protected time for consultants with education responsibilities.	Nov 07 CD Jan 08 CD/PK March 08 CD In place PK Dec 07	
8) To enable maternity Risk Management system to meet professional and national standards e.g. CNST	To have a robust clinical governance framework which monitors and rectifies risks identified.	Reduction in avoidable serious clinical incidents. Achievement of CNST level 2 Implementation of the recommendations from external review.	To strengthen the clinical governance structure with the review of the midwifery management structure. To continue with process for monitoring the IR1 forms. To develop a meeting structure which responds in a more timely fashion to SUIs and reviews on a regular basis the incidents within a multidisciplinary forum. Role out the record keeping programme. Undertake multidisciplinary audit of documentation within the department. Maintain the risk register and record or progress against recommendations. Review National recommendations and benchmark department against these. Conduct risk assessments as part of any service changes. Ensure maternity represented at Trust Clinical Governance groups. Establish a more formal maternity risk management group. Implement system for cascading information re risk to all staff.	CD Dec 07 On going CD/PK Completed ER SOMs Sept 07 CD On going CD/SC Oct 07 All Ongoing CD Completed CD Completed CD/ER Completed	7.9.1, 7.9.2, 7.9.3, 7.7.4, 7.8.5, 7.12.1, 7.12.3, 7.12.4, 7.12.5, 7.12.6, 7.12.2, 7.15.12, 7.15.10, 7.15.11, 7.15.4

			Establish action plan for achieving CNST 2 and implement. Review guidelines and update according to recommendations from investigations.	CD/PK Jan 08 RH Oct 07	
9. To establish a robust communication strategy to disseminate information in relation to action plan and service changes.	All stakeholders are kept informed of service changes and developments for maternity.	User feedback. Staff surveys.	Specialty Board revamp to cover wider multidisciplinary team. Establish Executive link. Establish internal weekly bulletin. Establish forum with PCTs. Reinstate the MSLC. Work with Trust Communication manager to ensure media enquiries dealt with in a robust and timely manner. To identify Non Exec to lead on maternity.	PK/CD Completed DWH Completed CD completed CD Completed CE In place CD DWH	7.1.3, 7.8.6, 7.8.7, 7.8.9, 7.13.1, 7.13.2, 7.15.1
10. To strengthen and the leadership of the medical workforce and its contribution to service development.	To have a collaborative approach between medical and midwifery teams in moving the service forward.	Appraisal of consultants. Job plans.	To review which consultants undertake obstetric duties and for which unit, taking age into consideration. Clarify the roles and responsibilities of the consultant on for Labour ward. Establish work groups which are multidisciplinary.	PK End Dec 07 CO End Oct 07 PK/CD Completed	7.7.5, 7.7.6, 7.7.7, 7.7.8, 7.7.10, 7.8.8
11. To establish a system for monitoring the performance of the maternity service	To provide Trust and partner organisations with robust information that demonstrates comparable performance with national benchmarks.	Balanced score card completion.	Develop a balanced score care identifying specific clinical and performance indicators. Review EMLSCS on a daily basis.	CD Completed CO Completed	7.14.1, 7.14.2, 7.14.3, 7.14.4.

Completed Actions

Action R	Action	Lead	Date Signed off as completed	Comments	Evidence Collected
1.4	Review Gynae services and develop plan to implement a dedicated Gynae ward and relocation of EPAU/Gynae emergencies	TO / JD	7th November 2007	Services now consolidated on Cornflour B	Not Appropriate
2.1	To fund 2 additional Consultant Obstetrician posts, asap and recruit.	PJK	17th October 2007	3 new consultant new to post / due to start which includes the replacement of Mr Cochrane (retired)	Not Appropriate
2.3	Convert B&A funding to substantive posts, to support increase in RGNs to cover theatre and HDU 24/7.	CD	17th October 2007	Linked with action 2.2. 19 applicants - which is enough to provide the cover	Not Appropriate
2.4	Convert vacant band 7 posts to band 6.	CD	17th October 2007	Linked with action 2.2	Not Appropriate
2.5	Provide Consultant cover for LWs as per CNST requirements and RCOG guidance.		17th October 2007		Not Appropriate
2.15	Appoint to Clinical lead midwife post for Queens LW, secondment until substantive in post.	CD	17th October 2007	In post	Not Appropriate
3.1	To develop project team to coordinate the implementation of the maternity IT system, incorporating design of system, datasets and training, involving HR where required.	CMO / CE	17th October 2007	Project team insitu - include midwives working clinically	Meeting notes - to be put in evidence file

3.5	Identify funding to install K2 for CTG training.		17th October 2007	Sue Lovell put in cost installation to take place	
3.7	Establish working group to review antenatal pathways, systems and processes.	CMO / CE	17th October 2007	Group meeting on 6 weekly basis, systematic review of pathways and processes taking place	Ongoing evidence for file
4.1	Establish working party comprising of DOM, Trust and PCT commissioning leads to agree how services for maternity will be commissioned, in line with Maternity Matters.	CD	17th October 2007	In place	Evidence still needed for the file
6.1	Develop Executive steering group to oversee implementation of action plan, with an identified Exec lead to support department.	DWH	17th October 2007	Group up and running	Yes
6.2	Clarify lines of reporting and accountability for the Director of midwifery and reflect this in the organisational chart.	Execs	17th October 2007	DoM reports to D of Operations for managerial issues and Exec D of Nursing for professional issues	
7.3	To develop training database which includes the multidisciplinary team	Maura Deegan	17th October 2007	Database up and running	Evidence required for file
7.4	Implement additional CTG training days.	CMO	17th October 2007		
7.5	To integrate aspects midwifery training/education with the Trust education department.	CD	17th October 2007		

7.6	Develop a competency framework for all training grade doctors.	PJK	17th October 2007		Copy of framework required for evidence
7.11	Ensure induction process for all new starters is adhered to.	CD	17th October 2007		Evidence is required for file
8.3	To develop a meeting structure which responds in a more timely fashion to SUIs and reviews on a regular basis the incidents within a multidisciplinary forum.	CD /ER	7th November 2007	There is a weekly meeting where actions are looked at from individual investigations and closing the loop on cases. There is also now a more timely response to urgent cases	Evidence required for file
8.7	Review National recommendations and benchmark department against these.	CD	21st November	To be taken to the clinical governance speciality board	Report required for the file
8.8	Conduct risk assessments as part of any service changes.	All	17th October 2007	Authors of risk assessment to present at Maternity Risk Meetings	Yes
8.9	Ensure maternity represented at Trust Clinical Governance groups.	CD	17th October 2007	Ongoing	
8.10	Establish a more formal maternity risk management group.	CD	17th October 2007	Ongoing	
8.11	Implement system for cascading information re risk to all staff.	CD / ER	17th October 2007	Ongoing - Through newsletter, message of the week and Maternity Risk Strategy	Yes

8.13	Review guidelines and update according to recommendations from investigations	RH	17th October 2007	Have been signed off by risk management group	
9.1	Specialty Board revamp to cover wider multidisciplinary team.	CD/PJK	17th October 2007	Group meeting once a month and now includes representation from neonates and anaesthetics	TOR required for evidence
9.2	Establish Executive link.	DWH	17th October 2007		Not Appropriate
9.3	Establish internal weekly bulletin.	CD	17th October 2007		Examples for evidence file
9.4	Establish forum with PCTs.	CD	17th October 2007		TOR required for evidence
9.5	Reinstate the MSLC.	CD	17th October 2007	Hosted by Havering PCT on behalf of the other 3 PCTs. Meeting held bimonthly	TOR required for evidence
11.1	Develop a balanced score care identifying specific clinical and performance indicators.	CD	21st November		Need copy for the evidence file

BUSINESS CASE PROFORMA

Business Case Title:	Expansion of midwifery staffing establishment
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Department:	Maternity
General Manager:	Sue Lovell
Clinical Director:	Premilla Kollipara

Pathway for Business Case

 Complete Y, N or N/A in Boxes

Date

Initiation Stage

1) Statement of case discussed and endorsed by Directorate Team	<input type="text" value="y"/>	03/12 /2007
2) Executive Director Sponsorship Gained	<input type="text" value="y"/>	21/ 11 /2007

Development Stage

3) Business case and financial appendices completed?	<input type="text"/>	/ /20
a) Finance Manager Consulted	<input type="text"/>	/ /20
b) Capital cost analysis (If Capital requirement applicable)	<input type="text" value="n/a"/>	/ /20
c) Estates and Facilities Dept Consulted	<input type="text" value="n/a"/>	/ /20
d) Diagnostics & Medical Equipment Consulted	<input type="text" value="n/a"/>	/ /20
e) Contents checked by Finance Team	<input type="text"/>	/ /20
f) Executive Director Sponsor Sign-Off	<input type="text" value="y"/>	/ /20

Review Stage

4) Endorsed by Operations Board	<input type="text"/>	/ /20
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Approval Stage

5) Approval received in line with scheme of delegated authority	<input type="text"/>	/ /20
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Section 1: Summary of Business Case

1.1 Objectives of the Investment

Define the objectives of the investment

The aim of the business case is to increase the midwifery establishment to reduce the midwife to woman ratio from 1:40 to the recommended 1:33. This recommendation is based on national workforce objectives and backed by an external review conducted at the beginning of 2007 by the Royal College of Obstetricians and Gynaecologists, following a series of Serious Untoward Incidents within the local Maternity services.

Recently a sum of £750K has been agreed in principle by the PCTs, but to date not released. If this is released the number of additional midwives this would provide is approximately 18wte and takes the department to a ratio of 1:36.6. To move to the 1:33 ratio an additional 37 wte would be required, based on this year's projected deliveries of 9800.

The prime objective to be achieved by increasing the number of midwives as described above is to reduce clinical risk and create a more flexible system which can respond to changes required whilst still maintaining safety.

The issues related to clinical risk and the correlation to staffing levels were highlighted in the External review undertaken at the beginning of 2007 and borne by the department's 'weak' rating in the Health care Commission preliminary report.

NB ratios are calculated on funded not in post.

1.2 Scope of the Business Case

Define the scope of the business case including all the services/functions affected by the business case.

The increase to the midwifery staffing establishment and subsequent recruitment would enable the department to secure the staffing levels for both hospital and community based services. In turn this would enable the maternity service to achieve the following objectives;

- 1- Would reduce risk associated with labour care in relation to poor delivery outcomes and the ratio of 1 midwife to 1 woman in active labour,
- 2- Improve access to booking with a midwife directly and thus the efficiency of the antenatal care pathway.
- 3- Develop real options for choice for women locally, eg homebirths, co located midwifery led unit and progression towards a stand alone birthing facility.
- 4- Midwifery teams based in children centres as part of the multidisciplinary primary health care team
- 5- Antenatal education incorporated as standard part of community based care.
- 6- Reliance on the community based midwives to fill staffing gaps within the hospital would be the exception as opposed to the norm.
- 7- Development of a more integrated approach to midwifery between hospital and community enabling the development and maintenance of clinical skills to support above models of care.
- 8- Ability of department to release staff to attend training and thus improve knowledge and skills, reducing risk.
- 9- Improve the quality of care in the postnatal period, in particular advice and support given to breastfeeding women.

10-Enable the department to ready itself for any reconfiguration of services in the future.

1.3 Context of Current Service

Provide brief details of current service, for example, turnover, number of patients, service configuration.

Maternity services span both the acute and primary health care settings. BHRT is the largest provider of maternity services within London, with deliveries occurring on 2 sites, Queens and King George. Queens is supported by a level 2 Neonatal Intensive Care Unit and delivers the higher risk women, whilst King George is supported by a level 1 Special Care Baby Unit and caters for the lower risk obstetric cases. The gestational cut off point for King George is 37 weeks of pregnancy. The combined projected delivery rate for 07/08 is 9,800. However, given the proximity of other acute services and the organisation of PCT boundaries, the Trust provides antenatal and postnatal care within the community setting to approximately 13000 women per annum. Those that do not deliver at BHRT, receive their care from neighbouring units. The main sources of referrals are from Barking and Dagenham, Havering and Redbridge. There are a small amount of referrals from Brentwood.

Service level agreements for maternity were last reviewed in 04/05, however since that time significant changes have occurred in how the services are provided, as well as the number of deliveries.

The majority of a woman's antenatal care will be provided by the community based midwifery team. The locations of these clinics vary between primary care and hospital settings. However, due to the demographic and cultural diversity of the local population a significant number of women also need to be referred to an obstetrician at some point during their pregnancy. Their care then becomes shared between the obstetrician and the midwife, with the former being the lead professional.

Over 98% of women currently deliver within one of the 2 hospitals, with only a small proportion opting for a home birth. The average length of stay, following delivery is comparable across the sector at around 1.35 days, incorporating all types of deliveries.

On returning home a woman will receive approximately 3 postnatal contacts with the community midwife. The first of these is in the woman's home with the remainder being provider at home or in a clinic setting, depending on the health and well being of the mother and baby.

The maternity service for BHRT has undergone significant scrutiny following a number of maternal deaths and stillbirths related to misinterpretation of the baby's heart beat during labour. This, as already alluded to, has culminated in an external review and following the receipt of the report an extensive action plan has been developed, monitored by an internal Executive steering group and presented to the Trust Board, as well as Commissioning teams. Regular updates are also provided the NHS London for assurance that work against the plan is progressing.

Income streams for maternity are via 2 main sources. There is that attributed to PBR, which incorporates all hospital based deliveries and obstetric led outpatient episodes, the later being predominantly during the antenatal period in either clinic or day assessment settings. The income received for delivery also covers the cost of the postnatal care provided in the

hospital for the mum and baby, where the later remains well. However the majority of the antenatal care is in fact provided by the midwives based in the community. If a woman is low risk she does not require an obstetrician in name and can be cared for by the midwife as the lead professional for the entirety of her antenatal period. Even if a woman has an obstetrician as her lead professional she will still be seen by a community midwife for a significant proportion of her care. The pathway of care that is followed is in accordance with the N.I.C.E. antenatal care guidance, which for a low risk woman results in approximately 7-9 follow up visits, depending on if it is her first baby or not. Obviously there are women who are at higher risk clinically and/or socially and these may require more contact. This element of antenatal care by the community midwives is not part of PBR funding but needs to be part of a locally agreed pricing contract. Within BHRT there are a number of women, particularly from the Redbridge area, that although they receive their antenatal care from us and postnatal care on returning home they actually deliver at a neighbouring Trust. The same mechanism has to be negotiated for funding the postnatal care at home or in community clinics, which again does not come under PBR.

1.4 Key Assumptions of Business case

State the underlying assumptions concerning activity levels, other influencing factors.

It is assumed that based on the current rate of increasing delivery numbers and the growth identified within the GLA statistics, that there will be a 4% increase in deliveries on an annual basis mapped forward to 2010. This increases the deliveries from 9800 (07/08) to 10500 by 2010. This assumes the current configuration of services between, BHRT and Whipps Cross. Likewise the number of women booking and receiving antenatal care will also increase.

If there is a change in the configuration of maternity services, with King George becoming a midwife led unit as well as well as the development of another stand alone birthing centre then the number of deliveries occurring at Queens would increase. The financial flows related to PBR would follow the woman, however the activity and income attached to locally agreed block contracts would need to be reviewed.

To reiterate this business case also assumes that the previously agreed 750K additional funding from the PCTs, in principle has been assumed. If this is not released then this would need to be added to the final title.

Section 2: Options Appraisal

2.1 List of Options

Option 1) Do Nothing

Option 2) Increase the funded establishment for midwifery to achieve the 1:33 ratio of midwife to women. This option is not dependent on the configuration of services.

Option 3) Cap deliveries to bring the number of women delivering low enough, so that the ratio of 1:33 can be achieved from within the current funded establishment.

2.2 Specify the Evaluation Criteria

How are the alternative options evaluated?

Financial

- 1) Financial Impact/Affordability
- 2) Availability of Capital

Strategic / Qualitative (please specify)

- 1) Meets Strategic Requirement
- 2) Key Stakeholder support – e.g. Commissioners, Department
- 3) Patient & Public Involvement
- 4) Interdependencies with other services
- 5) Other

Management of Change

- 1) Workforce
- 2) Equality & diversity
- 3) Communication/consultation

Risk factors

- 1) Demand & Activity Risk
- 2) Risk of Project Overrun
- 3) Risk to Services
- 4) Financial Risks to costs & savings
- 5) Impact on other services
- 6) Other

2.3 Options Details

OPTION 1 – Do Nothing

(i) This option would mean that there would be no changes to the current establishment of midwifery numbers and there would continue to be a requirement to use B&A to maintain minimum staffing levels as required, within the current configuration of services.

(ii) Key assumptions specific to option

You should record the key assumptions affecting this option – level of service required, nature of service delivery, growth assumptions, timing, revenue streams etc.

This assumes the status quo from the delivery of the current service and the presumed growth as detailed previously. However it also assumes a growing level of clinical risk and the inability to deliver on the recommendations within the clinical governance review.

iii) Implications of the “Do Nothing” option

Financial

- No further increase in revenue for midwifery staffing.
- Current rate of spend on B&A would continue
- Potential to not achieve higher levels of CNST and thus the reduced premium.

Strategic/ Qualitative

- Inability to secure community midwifery services
- Inability to take forward recommendations within the external review action plan.
- Will remain a weak in the HCC ratings.
- In ability to take forward objectives stated in 1.2.
- Inability to reconfigure services safely within the wider Health Care Economy’s strategic plan

Management of change.

- No increase in workforce numbers
- Continued reliance on B&A.
- Maintains status quo.
- Would establish an environment of constantly having to put in emergency measures to safeguard and reduce risk.

Risk Factors

- Activity and demand on capacity will continue to rise.
- Clinical risk and litigation will increase.
- Retention of staff will become more difficult and morale reduced further.
- Lack of staffing will mean that there will be times when the unit will not be able to deal with the demand and women will be diverted elsewhere, increasing the clinical risk.
- Will not be able to secure the community services, developing a more robust homebirth and antenatal education service.
- Inability to provide 1:1 care in active labour.
- Developing and maintaining the skills of the workforce will be jeopardised.

OPTION 2 -

(i) Description of option

To increase the funded establishment of midwives to move the department towards a ratio of 1:33 midwife to women. Currently there is a plan for a further 750k from the PCTs, this would provide an additional 18 midwives and improve take the ratio to 1:36.6. Assuming this funding is released a further investment is needed to appoint 37 wte midwives to achieve the ratio of 1:33.

Given that it is difficult to recruit and support during orientation large groups of staff, the plan is to undertake a rolling programme of recruitment on a quarterly basis, incorporating groups of 20 midwives at a time. This would mean that the financial impact would be phased in over 08/09, with the full impact being realised in 09/10

(ii) Key assumptions specific to option

You should record the key assumptions affecting this option – level of service required, nature of service delivery, growth assumptions, timing, revenue streams etc.

This assumes that the configuration of the service will stay the same. The calculations are based on the projected delivery numbers for 07/08 of 9800 and do not at this point take into consideration the suggested 4% annual increase in activity. Irrespective of the configuration of the service the number of deliveries are the dictating factor for calculating the midwife: woman ratio.

It is also assumed in this option that that the revenue associated with the non PBR activity, ie community, will be resolved through negotiations with the PCT.

iii) Implications of Option 2.

Financial.

- There will be a requirement for a phased in increase to the revenue funding for midwifery.
- If negotiations are successful with the PCTs this funding should be secured through some PBR, due to improved recording, but predominantly an uplift in the local agreed block contracts.
- Ability to secure higher levels of CNST and release of funding through reduced premiums for the Trust.

Strategic/ Qualitative

- This supports the department in being able to safely staff the acute areas eradicating the reliance on community staffing to 'prop' up the service.
- This will allow the service to develop maternity care in line with National and local recommendations, incorporating choice for women and antenatal education.
- Allow the department to improve their HCC rating (currently rated at Weak).
- Enable service to develop in line with the objectives outlined in 1.2.

Management of change.

- A robust recruitment and induction programme would be implemented to cope with the employment of groups of midwives. This would also aid retention of staff.
- No consultation would be needed for additional recruitment, but consultation would be required for significant service change.

- The unit's 'message of the week' would be used to keep staff up to date with the progress of recruitment.
- New ways of working could be explored once more staffing was available to provide the flexibility for change.

Risk Factors

- Increase in funding required, within a period of turnaround.
- Once services are more secure and maternity able to offer a complete service, which is competitive with neighbouring Trusts, there could be a further increase in deliveries over that projected.
- Employing significant amounts of staff at the same time, presents challenges relating to ensuring that staff are supported and orientated appropriately.

OPTION 3 -

(i) Description of option

To reduce the number of deliveries occurring within the Trust, by capping, until the activity is such that the current establishment of midwives is at a ratio of 1:33. This option does not require additional funding for midwifery posts, but does lose income related to deliveries and PBR.

(ii) Key assumptions specific to option

You should record the key assumptions affecting this option – level of service required, nature of service delivery, growth assumptions, timing, revenue streams etc.

To achieve the accepted ratio of 1:33 midwives to women within the current funded establishment, the number of deliveries would need to be reduced by 1154 deliveries per annum. This option assumes that the 750K recently agreed in principle with the PCTs would be released.

Whilst the income associated with the block contract would be retained as community activity would remain unaltered, the income related to PBR, ie deliveries would be reduced.

Neighbouring units are also struggling with delivery numbers and midwifery establishments, but it would be assumed in this option that the deliveries would be accommodated within the wider health economy.

iii) Implications of option 3.

Financial

- Although no increase in the funded establishment, there will be a loss of income associated with the 1154 deliveries, without a reciprocal loss in revenue cost.
- Potential for increase litigation costs when women are transferred elsewhere for delivery.
- Achievement of the 1:33 ratio will enable the service to work towards higher levels of CNST with the accompanying reduction in premium costs.

Strategic/ Qualitative

- Would enable the department to secure current services and deliver the objectives outlined in 1.2
- The reputation of the Trust's maternity services would be tainted and the HCC rating would potentially remain weak due to women's choice for place of delivery.
- It would be dependent on gaining the support of the PCTs and Overview and Scrutiny Committee.
- Would require negotiation with neighbouring Trusts to meet the extra demand on their current capacity.

Management of Change.

- There would be no increase in workforce numbers.
- With improvement in the staffing levels there would be an ability to work in new ways and develop services and consultation would be required as appropriate.
- Recruitment is undertaken adhering to Equality and Diversity guidance.

Risk Factors.

- Reduction in PBR activity with loss of income.
- Women will turn up for deliveries irrespective of capping and thus the outcome will not be realised.
- Clinical risk reduced for those delivering within Trust but increased if asked to deliver elsewhere.
- Increase on service demand for neighbouring units.
- HCC rating will not be improved due to women's surveys.
- The Trust's reputation with the Public would remain poor.

Section 3: Evaluation and Recommendation

3.1 Financial Evaluation

3.1.1 Summary of Revenue Requirements – (Taken from Financial Appendices & to be completed by Finance Manager)

SUMMARY REVENUE IMPACT for all options	Do Nothing Option 1	Option 2	Option 3	Option 4
Financial Year 2010/11	£000	£000	£000	£000
Income	0	0	0	0
Direct costs: Pay	0	1,672,722	0	0
Direct costs: Non pay	0	5,000	0	0
Overheads and indirect costs	0	0	0	0
Capital charges	0	0	0	0
Total	0	1,677,722	0	0
<i>Net impact on Trust revenue a/c compared to 2005/06</i>	0	1,677,722	0	0
OPTION RANK				

3.1.2 Summary of Capital Requirements – (Taken from Financial Appendices)

CAPITAL COST and FUNDING	Do Nothing Option 1 £000 incl VAT	Option 2 £000 incl VAT	Option 3 £000 incl VAT	Option 4 £000 incl VAT
Building works incl VAT		0	0	0
Medical equipment incl VAT		0	0	0
IT equipment incl VAT		0	0	0
Total capital cost incl VAT		0	0	0
Funding received to date				
Other funding - specify				
Total funding received to date		0	0	0
Capital funding required to meet cost of option		0	0	0
OPTION RANK				

3.1.1. Summary of Financial Evaluation

State briefly the evaluation of revenue and capital requirements and the conclusion of the analysis above

Option 1

There is no additional Financial investment required. However this may weaken the opportunity of success at higher levels of CNST and accompanying reduction in premiums.

Option 2

Basing the calculations at mid point of a band 6 there would be an increase in financial investment of **£1,678k**.

There are no capital costs associated.

Option 3

Although there is no increase in funding required the loss of income through PBR activity is approximately **£1,280,000**.

NB

All of these options assume receipt of the 750K

3.2 Strategic and Qualitative Evaluation

Scoring system 1-5, with 1 being good and 5 being high risk.

Strategic and Qualitative Factors		Option 1	Option 2	Option 3
1	Strategic Fit - local - national	5	1	4
2	Key stakeholder support	5	1	5
3	Patient & Public Involvement	5	1	5
4	Positive impact/interdependencies on other services internally	3	1	5
5	Total	18	4	19

3.2.1. Summary of Evaluation

Option 2 provides the best in terms of meeting local and National drivers, without increasing risk for the local population as well as the wider Health Economy.

Option 1 maintains the current status which has already been described and reviewed as unsustainable as well as Clinically unsafe.

Option 3, whilst this achieves the goal of 1:33, there would be a greater strain on neighbouring units as well as reducing the choice and increasing the risk for the local population, by not providing locally based services.

3.3 Management of Change Impact Assessment

What is the scale of change related to each option?

Does each option rely on recruitment and how easy will this be?

Are there impacts for staff in terms of training?

Have Equality & Diversity impacts been fully assessed?

Using the 0-5 with 0 being good and 5 being high risk

Workforce	Option 1	Option 2	Option 3	Option 4
Ease of recruitment (if applicable)	na	3	na	
Training or development required	5	1	1	
Equality & Diversity				
Access to services*	4	1	5	
Impact on staff*	4	0	3	
Impact on patients/carers*	4	0	5	
Communication/Consultation				
Scale of communication about the development required	3	2	5	

- *If any of these scores 3 or greater, please complete an Equality Impact Assessment*

Conclusion of Change Impact Assessment

This has been assessed in terms of the negative impact against each of the highlighted criteria.

Option 1, whilst it would see the status quo, it has already been demonstrated that this is not acceptable. The recent user survey used as part of the data source would not improve and therefore this would impact significantly on the HCC rating for maternity. It would remain difficult to have a robust training and development programme to address the issues highlighted by the clinical risk.

Option 2 takes on board all the recommendation from the Clinical Governance and National perspective and would meet the requirements of the local population.

Option 3, whilst potentially meeting the criteria as stated for option 2, requires negotiations with PCTs and local Public Involvement groups to accept the need to cap deliveries and for women to be transferred elsewhere creating a lottery system for maternity care within the already stretched Maternity for the Health Economy.

3.4 Risk Evaluation

What are the potential risks to the project and the savings?

How will these risks be managed / minimised?

What is the impact on Trust corporate governance and controls assurance objectives?

How sensitive are the key financial indicators to changes in cost?

Score 1-5 as above

Risks	Option 1	Option 2	Option 3	Option 4
1 Demand & Activity Risk	4	1	5	
2 Risk of Project Overrun	na	na	na	
3 Risk to Services	5	1	5	
4 Financial Risks to costs & savings	5	3	5	
5 Negative impact on other services	3	1	4	
Total	17	6	19	

3.4.1. Summary of Risk Evaluation

Option 2 provides the least risk overall for the organisation, the local population and the wider Health Economy.

Option 1 and 3 maintain a level of unacceptable risk both clinically and financially. These 2 options would not see the quality or the reputation of the maternity services within BHRT improving. Also there would be the inability to meet the requirements of the External review and improve the ratings with the HCC.

3.5 Summary of Option Appraisal & Recommended Option

State clearly why the preferred option scores more highly against the evaluation criteria than the other options.

This case would recommend option 2 as the proposed way forward. The rationale is that it is the only one which meets the recommendations of the National and local policies, as well as though made within the recent external review. It also supports the ability of the Trust to meet the expectations of the local community as well as the PCTs for the delivery of maternity services.

Risk is categorised by clinical, financial and HCC or similar ratings. Option 1 and 3 carry significant clinical risk, which has to be the main driver to any decision made.

Section 4: Performance Monitoring

Who is responsible for delivering the savings/additional income?

When will the savings/additional income be realised?

How will the realisation of the savings/additional income be demonstrated?

How will service quality be affected?

Benefits	Progress Measurement	Service Markers*
1		
2		
3		
4		
5		

**How success will be monitored, e.g. waiting times and/or turnaround times reduced, additional activity undertaken and income generated.*

There is a balanced score card attached demonstrating the performance indicators that are and will continue to be used to monitor progress against the targets set.

Section 5: Key Project Milestones

The timetable should cover the period from completion of the Project Initiation Document (PID) following approval of the business case to full benefits realisation (i.e. when all savings realised) and include key project milestones.

Milestone	Timescale	Responsible
Initiation		
Development		
Approval		
Implementation		
Post Implementation review		

Supporting Papers & Appendices

List here if required.

1)Balanced scorecard.

2)External Review Action Plan

BUSINESS CASE CHECKLIST *(Please check boxes X)*

PATHWAY FOR BUSINESS CASE COMPLETED

Section 1) Summary of Business Case

1.1 Does the Business Case have clear objectives?

Has the type of Business Case been determined?

1.) Service Development

Meet waiting list target

Meet quality standards

Meet increasing demand

2.) Generate Revenue Savings

Improve efficiency - cost reduction

Improve efficiency - increase throughput

Have all opportunities to reduce costs/increase income been explored?

1.2 Does the Business Case have a clear scope?

The range of patients and treatment settings have been identified e.g. elective, emergency, OP etc

Are all locations of service affected?

Which other services affected?

Section 2) Options Appraisal

2.1 Have all feasible options been identified?

Are there reasons for excluding outwardly feasible options?

Options Checklist: -

Scale of investment required

Use of Technology

Outsourcing

Purchase v Lease

Process Redesign

Skill Mix Changes

2.2 The Options Evaluation Criteria are clearly stated?

Have financial, strategic and qualitative criteria been included e.g.

Revenue and Capital Cost

Service Quality Impact

Ease of implementation

Service Reputation

Risks identified, commissioner support

Impact on other services

2.3 Has each option been considered in terms of the following: -

- i) The details of each option have been clearly documented?
- ii) All assumptions have been stated

Section 3 Evaluation & Recommendation

3.1 Financial Evaluation

Financial Appendices completed
 Costing information is complete

- Income streams evaluated*
- Capital Charges included*
- Maintenance included*
- Support Services (Diagnostics and facilities Costs)*
- Training implications*
- Set Up Costs - Double Running costs*

Capital requirements summarised

3.2 Strategic and Qualitative Evaluation completed

3.3 Management of Change Impact completed

3.4 Risk Evaluation completed

3.5 The Business Case has a clear recommendation

All Criteria assessed

Section 4 Performance Monitoring

Are performance measures fully stated?

Section 5 Key Project Milestones

Are milestones fully completed?

Reviewed by: -

Date

BARKING, HAVERING AND REDBRIDGE HOSPITALS NHS TRUST

EXECUTIVE SUMMARY

1. Subject: Infection Control Annual Report

2. Summary:

The attached draft Annual Report summarises the infection control activity within the Trust for the period April 2006 – March 2007. It provides detail on the infection control arrangements in place and progress against key programmes to minimise the spread of infection. The document provides an overview of the surveillance data for health care acquired infections and what measures are in place to ensure staff are adequately trained.

The document is required to meet CNST and S4BH evidence and has been compiled retrospectively against a background of the move to Queen's Hospital and with an Infection Control Team that has been understaffed for a considerable time. The resulting pressures on the remaining Infection Control Team to maintain operational practice and meet the Trust's infection control targets hindered compilation of this report earlier as would normally be expected.

3. Action:

The Board is asked to note this draft version on the premise that the final details will be included and a further copy circulated to them when completed.

4. Linkage to Corporate Aims:

Patient safety is an underpinning principle for the Trust, and infection control therefore must remain a high priority.

5. Resource Implications:

Not identified.

6. Author:

Dr Yasmin Drabu
Medical Director

Date: 23rd January 2008

INFECTION CONTROL ANNUAL REPORT APRIL 2006 – MARCH 2007

Dr Lindsey Bain
Infection Control Doctor

Sheila O'Mahony
Head of Infection Control

Content

		Page
1.0	EXECUTIVE SUMMARY – OVERVIEW OF INFECTION CONTROL ACTIVITIES IN THE TRUST	4
	1.1 Organisation	4
	1.2 Activities	4
	1.3 Infection Control Action Plan for the Year	4
	1.4 Progress in <i>Winning Ways</i>	4
2.0	DESCRIPTION OF INFECTION CONTROL ARRANGEMENTS	4
	2.1 Infection Control Team	4
	2.2 Infection Control Committee	5
	2.3 Reporting line to the Trust Board	5
	2.4 Links to Drugs and Therapeutic Committee	5
	2.5 Links to Clinical Governance / Risk Management / Patient Safety .	6
3.0	DIPC REPORT TO THE TRUST BOARD – SUMMARY	6
4.0	BUDGET ALLOCATION TO INFECTION CONTROL ACTIVITIES.....	7
	4.1 Outbreak Funding	7
	4.2 Support (IT)	7
	4.3 Training	7
5.0	HCAI STATISTICS	7
	5.1 Results of Mandatory Reporting	8
	5.1.1 MRSA Bacteraemia	8
	5.1.2 GRE Bacteraemia	8
	5.1.3 Clostridium difficile	9
	5.1.4 Orthopaedic surgical site infection	9
	5.2 Trends in HCAI statistics	9
	5.3 Untoward incidents including Outbreaks	9
6.0	HAND HYGIENE AND ASEPTIC PROTOCOLS	10
	6.1 Implementation of ‘ <i>cleanyourhands</i> ’ Campaign	10
	6.1.1 Timing	10
	6.1.2 Coverage in Trust	10
	6.1.3 Future Plans	10
	6.2 Application of aseptic no-touch clinical protocols	10
	6.3 IV catheters	10
	6.4 Urinary Catheters	10

		Page
7.0	DECONTAMINATION	11
	7.1 Arrangements	11
	7.2 Audit	11
	7.3 Incidents / failures investigated	11
8.0	CLEANING SERVICES	11
	8.1 Management arrangements (in house and/or contracted out)	11
	8.2 Monitoring arrangements	11
	8.3 PEAT / Patient Forum inspection results	11
	8.4 User satisfaction measures	12
9.0	AUDIT	12
	9.1 Extent of audit programme undertaken by the ICT	12
	9.2 Peripheral Line Audit	12
	9.3 Adoption of ICNA audit tool or alternative	12
	9.4 Antibiotic prescribing (report from Antimicrobial Pharmacist)	13
	9.5 Changes and benefits as a result of audit	14
10.0	TRAINING ACTIVITIES	14
	10.1 Induction for all staff	14
	10.2 Infection Control Passport	14
	10.3 Infection Control Link Nurses	15

Appendices

Appendix 1	Infection Control Team organisational chart	16
Appendix 2	MRSA Action Plan	17
Appendix 3	Clostridium Difficile Action Plan	23

1.0 EXECUTIVE SUMMARY – OVERVIEW OF INFECTION CONTROL ACTIVITIES IN THE TRUST

1.1 Organisation

See Infection Control Team organisation chart at Appendix 1

1.2 Activities

The team were understaffed both in nursing and administrative for part of the year so reactive work has been the priority. Other attention and focus were devoted to main aspects of the action plans for the year. Vacancies will be advertised when approved.

1.3 Infection Control Action Plan for the Year

Progress to date has been successful in some areas but many of the actions are to be carried over to ensure continuity and compliance. After a visit from the Department of Health Improvement Programme Review Team in December 06 the ICT have made more robust action plans for management of MRSA (Appendix 2) and Clostridium difficile (Appendix 3).

Work had already been progressing on reducing inappropriate use of antibiotics-targeting clinical areas with high rates of MRSA bacteraemias – standardising the MRSA decontamination protocol – updating of patient visitor information leaflets – junior doctor training.

1.4 Progress in *Winning Ways*

Following implementation of *Winning Ways*, and subsequent publication of *Saving Lives*, which is the working framework to support a number of High Impact Interventions to further reduce Health Care Associated Infections (HCAI's) the ICT are developing plans around Intravenous, central venous catheter, and urinary catheter care and practice.

2.0 DESCRIPTION OF INFECTION CONTROL ARRANGEMENTS

As required by the Clinical Negligence Scheme for Trusts, BHRT has an appropriately constituted Infection Control Team that is supported by timely and effective microbiological services with advice available on a 24-hr basis. The Trust's Director of Infection Prevention and Control is the Medical Director, Dr Yasmin Drabu.

2.1 Infection Control Team

Dr Lindsey Bain is the Trust's Infection Control Doctor (ICD) who works with 4 other consultant microbiologists on a rotational basis across the trust. She has 2 sessions a week for IC related issues and development of policies.

The Head of Infection Control, Sheila O'Mahony, has responsibility for managing the Infection Control Team (ICT) that is made up as shown in Appendix 1.

The ICT continue to work with local infection control teams and community colleagues in the management of infection control issues. MRSA Bacteraemia Root Cause Analyses (RCA) have been undertaken since January 2007. It is the intention of the Infection Control Team to report these RCAs to the appropriate Primary Care Trusts as they occur. The Trust is investigating all MRSA bacteraemias. Those identified as being community acquired will be followed up by the relevant PCT.

2.2 Infection Control Committee

The Infection Control Committee (ICC) terms of reference states that the Committee should meet at least three times a year. During the past year the dates of the meeting were the 2nd May, 20th June and the 14th November 2006 and March 2007, with Dr Lindsey Bain as Chair.

Membership of the Committee is broad with senior representatives from each major specialty. However, during 2006/7 attendance at the meetings by medical staff continued to be poor and a review of membership was carried out. Neighbouring PCTs, the Health Protection Agency and public health colleagues from Redbridge continue to support the Committee.

The minutes of the ICC meetings are available on the Trust's Intranet for all staff to view.

2.3 Reporting line to the Trust Board

The Infection Control Committee reports directly to the Clinical Governance Committee that meets quarterly and which has delegated responsibility from the Trust Board for monitoring governance issues including infection control. The Chair of the Clinical Governance Committee is a Non Executive Director who reports, on an exception basis, to the Trust Board.

The Medical Director includes in her regular clinical governance reports to Trust Board any infection control issues the Trust Board should be aware of, or where decisions need to be made. The report includes the clinical governance clinical indicators that provides the latest data on infection control, septicaemia and PEAT inspection scores enabling the Board to monitor the Trust's trends in performance compared to national data.

The importance of the comprehensive reporting of infection control discussions at Trust Board meetings to the accreditation process have been reinforced by the Medical Director. The minutes from the Trust Board meetings and copies of the clinical indicators are available on the Trust's Intr@net.

2.4 Links to Drugs & Therapeutic Committee

The Drugs and Therapeutic Committee's terms of reference stipulate that they shall report to the Trust Management Board after each meeting in the form of minutes. The Committee submit a bi-annual report to the Medical Director, that includes recommendations made in respect of items considered and the next 6-months work

plan. The Committee also submits an annual report to the Trust Board that outlines the work of the Committee during the previous year.

2.5 Links to Clinical Governance / Risk Management / Patient Safety

The Infection Control Committee's remit includes identifying and supporting the implementation of governance accreditation standards such as the Clinical Negligence Scheme for Trusts (CNST), the Healthcare Commission's 'Annual Health Check' and participating and monitoring the outcome of external infection control related service reviews.

Following the Trust's Level 2 CNST Assessment in February 2006, a report has subsequently been received highlighting their recommendation that greater evidence needs to be provided for the next review that consultants and specialist registrars receive hand hygiene training and that a programme of annual infection control training for all key staff should be implemented.

The Infection Control Team are responsible for monitoring and implementing strategies to take forward national initiatives to combat healthcare acquired infections and to work with managerial, clinical and nursing colleagues to reduce risks. The Team will now carry out an annual corporate infection control risk assessment to tie together and provide a holistic view of the infection control risks identified through the individual department's and directorate's risk assessments. The combined infection control priorities identified will be fed into the Trust's Risk Register and extreme and high risks included in the Assurance Framework.

During the past year the Infection Control Policy has been completely revised to ensure it meets external accreditation needs and is a more useful tool for staff. Other infection control policies include the Surveillance Policy, the Policy and Guidelines for the Safe Handling and Disposal of Sharps. Work has already taken place to revise a number of infection control protocols and guidance documents, but an extensive piece of work is ongoing to combine this into a comprehensive procedural document that takes account of current best practice and is user-friendly.

3.0 DIPC REPORT TO THE TRUST BOARD – SUMMARY

- 3.1 A monthly report showing the number and frequency of MRSA and Clostridium cases is prepared by Dr Bain for the Trust Board to inform them of current trends.
- 3.2 Implementation of the annual Infection Control Action Plan is discussed with the DIPC and ICT, and progress reported to Trust Board monthly
- 3.3 Any incidents or infection control issues occurring outside of Trust Board meetings, but requiring Trust Board notification, are discussed and actions as appropriate through the DIPC.
- 3.4 As part of SUI reporting process, any infection control outbreaks are notified to the Trust Board immediately and further discussed at monthly meetings. More information on outbreaks is contained within Section 5.3.

4.0 BUDGET ALLOCATION TO INFECTION CONTROL ACTIVITIES

Detailed below is the budget allocation for the Infection Control Team, including ICD team organisational Structure (as shown in Appendix 1).

Staff Group	Amount
Medical	£127k
Nursing	£310k
Scientific	Nil
Administrative	£32k

4.1 Outbreak Funding

The Finance Director has confirmed in a memorandum dated the 9.11.2005 that any reasonable costs associated with an outbreak of infection will be funded from the Trust's contingency reserves. Indicative budgets would need to be discussed and agreed at an executive level.

During the last year, no money has been drawn against this allocation.

4.2 Support (IT etc.)

The ICT do not have specific personnel for IT support but this has been raised to the executive team to improve the way the systems ICT currently use are delivering the required information.

4.3 Training

Funding for ICT training is available from the NHS London budget, the Trust's Strategic Health Authority that facilitates access to courses provided by London Southbank University. Any specific Infection Control conferences are funded from the local budget.

5.0 HCAI STATISTICS

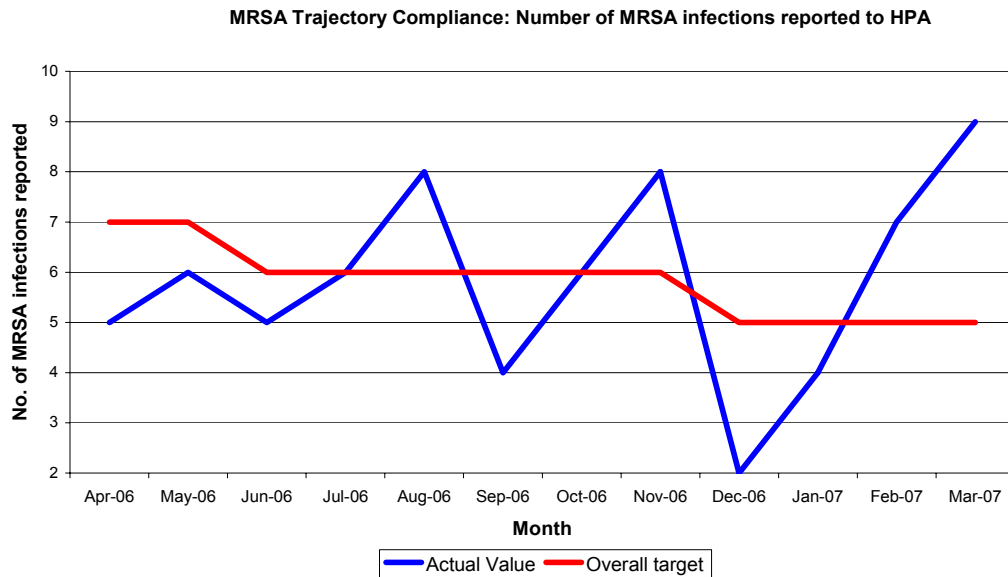
In December 2006, the Trust hosted a Department of Health MRSA/HCAI Improvement Review. A small team of reviewers and programme manager examined large quantities of evidence and interviewed a number of relevant staff with a view to understanding the Trust's current practices. The reviewers then submitted their recommendations on actions that the Trust could initiate to reduce the number of MRSA/HCAI infections.

The Trust's MRSA data figures were demonstrably below trajectory and the Trust was congratulated on its performance. They felt there were many examples of good practice and encouraging signs which the rest of the NHS can learn from. The reviewers felt the Trust had an excellent open and transparent culture of reporting, addressing infections and quality improvements which was an ideal platform to build from. They have set the Trust targets such as focusing on hot spot specialties and carrying out root cause

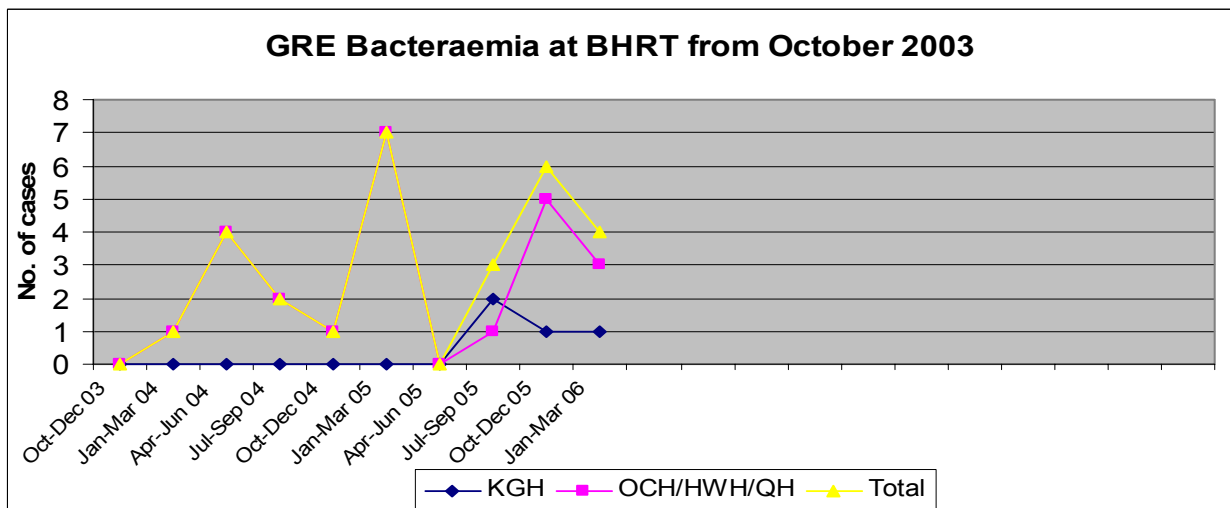
analysis routinely to identify source and cause of all MRSA bacteraemias within 24 hours. An action plan to take forward all the recommendations from the review was developed and is being actively monitored by the Infection Control Committee.

5.1 Results of Mandatory Reporting

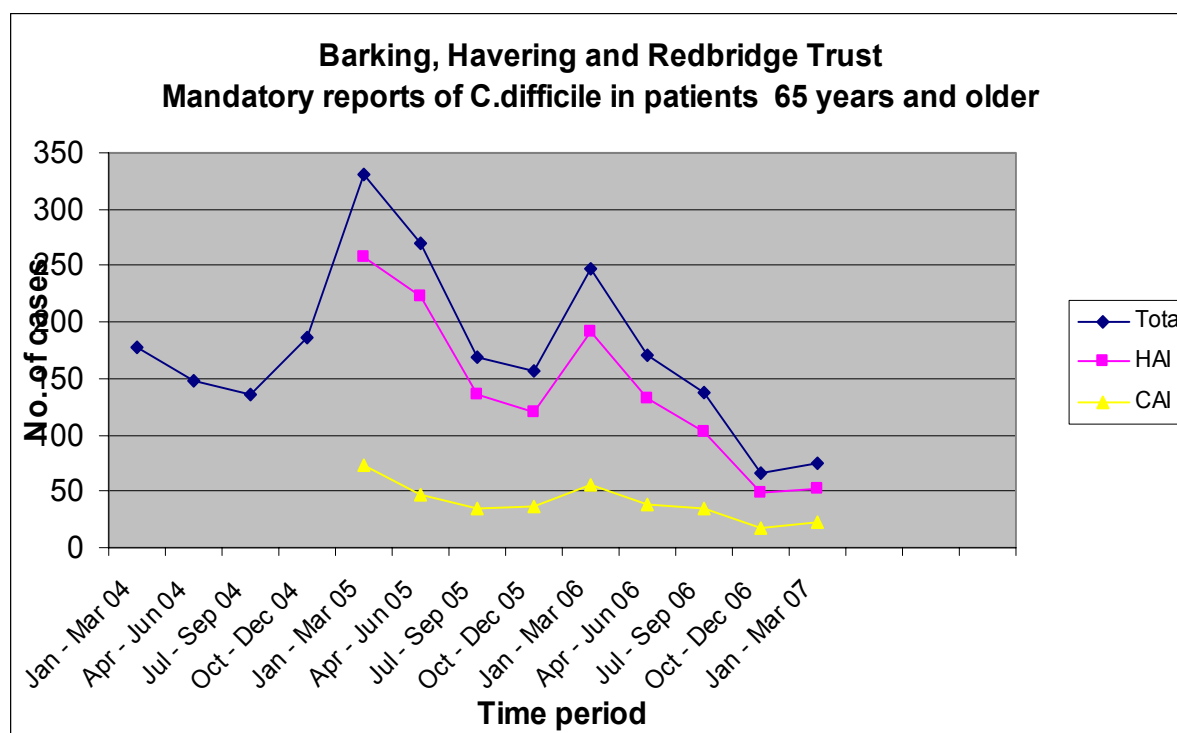
5.1.1 MRSA Bacteraemia



5.1.2 GRE Bacteraemia



5.1.3 Clostridium difficile



5.1.4 Orthopaedic surgical site infection

BHRT continues to participate in the national Surgical Site Surveillance Scheme (SSIS), however accurate reporting this year was intermittent due to operational issues, not least the planning for the move to the new Queens Hospital Site. However in January 2007 a decision was taken by the Orthopaedic Consultant Lead for Clinical Governance and the Infection Control Team to concentrate totally on surgical site infections in trauma/ emergency patients. This has been more successful and although more needs to be done on the scheme, no surgical site infections were reported. The Head of Infection Control oversees the scheme and has presented the scheme to Consultant Orthopaedic Surgeons with the ICD at clinical governance meetings.

5.2 Trends in HCAI statistics

BHRT continue to be report downward trends in statistics

5.3 Untoward incidents including Outbreaks

Outbreaks of Infection leading to closure of wards April 06-March 07

Medical wards x 17 Surgical wards x 1

10/18 wards were confirmed Norovirus by PCR genome detection. The remainder were unconfirmed.

Bed days lost were not calculated in the first part of the year but from August 06 to March 07 the lost days were calculated by the ICT using the simple formula of adding up empty beds available per day, and totalling them on reopening.

For the latter part of the year 331 bed days were lost

6.0 HAND HYGIENE AND ASEPTIC PROTOCOLS

6.1 Implementation of 'cleanyourhands' Campaign CYHC

6.1.1 Timing

The Trust has participated in the campaign since 2004 in all inpatient areas and some poster campaigns in the departments.

6.1.2 Coverage in Trust

On a monthly basis the posters are updated and the CYHC champion in each area is expected to update the posters accordingly. When Oldchurch and Harold Wood wards moved in the new PFI Queens Hospital the campaign advertising slipped backwards as the actual placement of signs was slow to progress.

6.1.3 Future Plans

The ICT anticipate continuing into year 3 of the campaign but have concerns about the poster displays in Queens hospital as posters are not permitted unless in a proper clip frame. The financial aspects have been addressed and this should be remedied very soon.

6.2 Application of aseptic no-touch clinical protocols

To be compliant with The Health Act 2006 an up to date Aseptic technique is required, this has been developed by the ICT and Nurse Consultant - Tissue Viability.

6.3 IV catheters

As part of the Saving Lives and Winning Ways documents looking at high impact interventions the ICT have prepared business cases for standardisation of IV peripheral packs and Central line packs. Further work is expected from June 2006

6.4 Urinary catheters

As above ICT have plans for Late 2007 early 2008 to undertake a review of all aspects of urinary catheterisation including the possible introduction of silver alloy coated catheters.

7.0 DECONTAMINATION

7.1 Arrangements

Currently there is not a named lead for decontamination lead but work is in progress to appoint to this post. Responsibilities for Sterile services is within the Commercial Operations directorate. The department based at King George Hospital is BSE and ISO mark accredited.

7.2 Audit

In the absence of a decontamination lead no decontamination audits have been undertaken within departments or Theatres.

7.3 Incidents/failures investigated

Only one incident involving one wet set has been reported through the system.

8.0 CLEANING SERVICES

8.1 Management arrangements (contracted out)

Cleaning services within the Trust have undergone a considerable change during the last 12 months as Oldchurch and Harold Wood Hospitals were decommissioned and the new Queen's Hospital opened in December 2006. The previous arrangements with Trust staff and Initial undertaking the day-to-day cleaning of the Trust's premises was replaced when Trust staff were TUPE'd across to Sodhexo in preparation for the opening of the new hospital. Initial now have a service level agreement (SLA) to clean King George and Barking Hospitals, with Sodhexo responsible via a similar arrangement for the cleaning of Queen's Hospital. At Queens, Sodexo - as part of the PFI agreement have a retention of employment scheme whereby cleaning staff are employed by the Trust and temporarily seconded to Sodexo. The managers of the service are directly employed by Sodexo.

8.2 Monitoring arrangements

The SLAs with both Sodexo and Initial are regularly monitored by the Corporate Development Director, through regular spot checks and routine meetings with the providers of the service and a Trust monitoring officer. The service is monitored using 9 contractual performance indicators which are collated each month. Failure to meet the agreed standards will result in penalty points being incurred, which in turn can result in financial penalties for the contractors. The Infection Control Team have a close relationship with contract services and are involved in ensuring contractor staff have adequate infection control training.

8.3 PEAT/Patient Forum inspection results

The PEAT inspections take place during January and March each year and the scores for the Trust's hospitals is shown below:

Year	Harold Wood	Oldchurch	King George	Barking	Queen's
2003	3	3	3	2	
2004	4	3	4	3	
2005	3	3	4	4	
2006	3	3	4	4	
2007			86.65%	83.89%	96.72%

Key: 1 = unacceptable, 2 = poor, 3 = acceptable, 4 = good, 5 = excellent

8.4 User satisfaction measures

There were some initial bedding down difficulties following the opening of Queen's Hospital and cleaning was amongst them. This led to criticism of cleanliness standards in some areas of the hospital that resulted in Havering's Health Scrutiny Committee identifying this as a concern in their Annual Health Check comments. The Corporate Development Director and his team have been working closely with the providers to rectify the situation and cleaning is now of a satisfactory standard.

9.0 AUDITS

9.1 Extent of audit programme undertaken by the Infection Control Team

Hand Hygiene Audits : 46

Peripheral lines Audits : 60 wards/departments across sites

Due to imminent move to Queen's the annual sharps audit did not take place. Instead Daniels provided an extensive educational programme, including accurate placement of sharps bins

9.2 Peripheral Line Audit

The peripheral line audit was undertaken to monitor compliance with usage of a sterile transparent, semi-permeable dressing for IV peripheral management, introduced to the Trust the previous year and supported by the Infection Control Team. The aim was to move towards standardisation of dressings used for IV peripheral cannula (PIVC) and to improve patient outcomes.

The aim of the audit was to:

- Monitor compliance with usage of a sterile transparent, semi-permeable dressing for IV peripheral management.
- Identify potential Infection risks associated with PIVC management.
- Identify knowledge and practice deficits

9.3 Adoption of ICNA audit tool or alternative

The Team use the ICNA audit tool. However, for the peripheral line audits an audit tool provided by 3M was modified by the Infection Control Team to include specific PIVC management issues.

9.4 Antibiotic prescribing (report from Antimicrobial Pharmacist)

The antibiotic pharmacist has had an opportunity to formulate and ensure correct implementation of the following guidelines to improve usage of antibacterials; reduce expenditure and limit resistance to antibiotics:

- ***A Guide for Treatment of Acute Infections***
Cephalosporins and broad spectrum antibiotics such as ciprofloxacin were replaced with alternative agents as it was thought that these may be a causative factor for the high incidence of c difficile
- ***Automatic Stop Policy***
A Policy was drawn up informing all Clinicians, pharmacists and other health care staff of IV antibiotics being stopped after 72 hours and all oral antibiotics for 7 days. There were exclusions in this policy for those infections, which were more severe and thus required longer-term treatment. The aim of this policy was to prevent unnecessary usage/over exposure of antibiotics which would not only lead to resistance but also increase financial expenditure
- ***Restricted antibiotics Policy***
A policy was drawn up to ensure that certain antibiotics (usually high cost drugs) were being used appropriately i.e. not being misused which can ultimately have a huge financial impact as well as lead to resistance. Letters were sent out to consultants, pharmacists, nurses and site managers informing them that these antibiotics must be used according to the guidelines and if it is to be used for any other indication not according to BHRT Antibiotic Guidelines, this must be approved by a micro consultant
- ***Surgical Prophylaxis Guidelines***
ONE dose of antibiotic is sufficient for surgical prophylaxis - three doses are very rarely required. This was agreed upon by all microbiologist and clinical leads/consultants – and then a policy was drawn up which was enforced. All cefuroxime, which was stock for many wards, was withdrawn so as to control the usage of cefuroxime.
- ***Revising BHRT Antibiotic Policy***
The guidelines were last updated in 2005. All guidance in this policy had to be revised to take into account all the changes that have occurred over the last couple of years. This was agreed upon by all microbiologists and the necessary Clinical Leads/consultants and was then formatted and placed on the intranet

AUDITS CARRIED OUT

1. Adherence to BHRT Guidelines for common Acute Infections
2. Point Prevalence Audit to Assess adherence to BHRT Antibiotic Policies (automatic stop/BHRT guidelines for Acute infections/IV usage)
3. Tazocin Audit

9.5 Changes and benefits as a result of audit

- An enhanced teaching programme developed
- Relaunch of the automatic stop antibiotic policy
- IV to oral antibiotic switch
- Further developments are planned for 07/08

10.0 TRAINING ACTIVITIES

10.1 Induction for all staff

All Trust staff, at all grades and specialties, including executive and non executive directors must participate in the Trust's Corporate Induction programme that is run every fortnight. The all-day induction programme covers a wide range of topics including staff infection control responsibilities. The Infection Control presentation introduces to new staff to the key principles of infection control practice, focusing particularly on the importance of hand hygiene to minimise cross-infection, and gives guidance on how and when to contact the Infection Control Team. There is a mechanism for following up on non-attendees.

Key staff, such as junior doctors, nurses and health care assistants/support workers are required to undergo further, more detailed, training commensurate with their role within the organisation.

All areas are required by the Trust to ensure they have a local induction programme in place for new staff, those transferring from other areas, and for locum and temporary staff. Depending on the staff member's responsibilities, the depth of the infection control information made available to them varies and at the present time is the subject of a review by the Associate Director for Education and Training.

At the moment there is no centralised electronic attendance monitoring information available from the induction programmes and all attendance registers are kept in hard copy only. The introduction of the Electronic Staff Record later in 2007 will enable the electronic collection of such data, which will greatly enhance the Team's ability to identify areas that need focused attention.

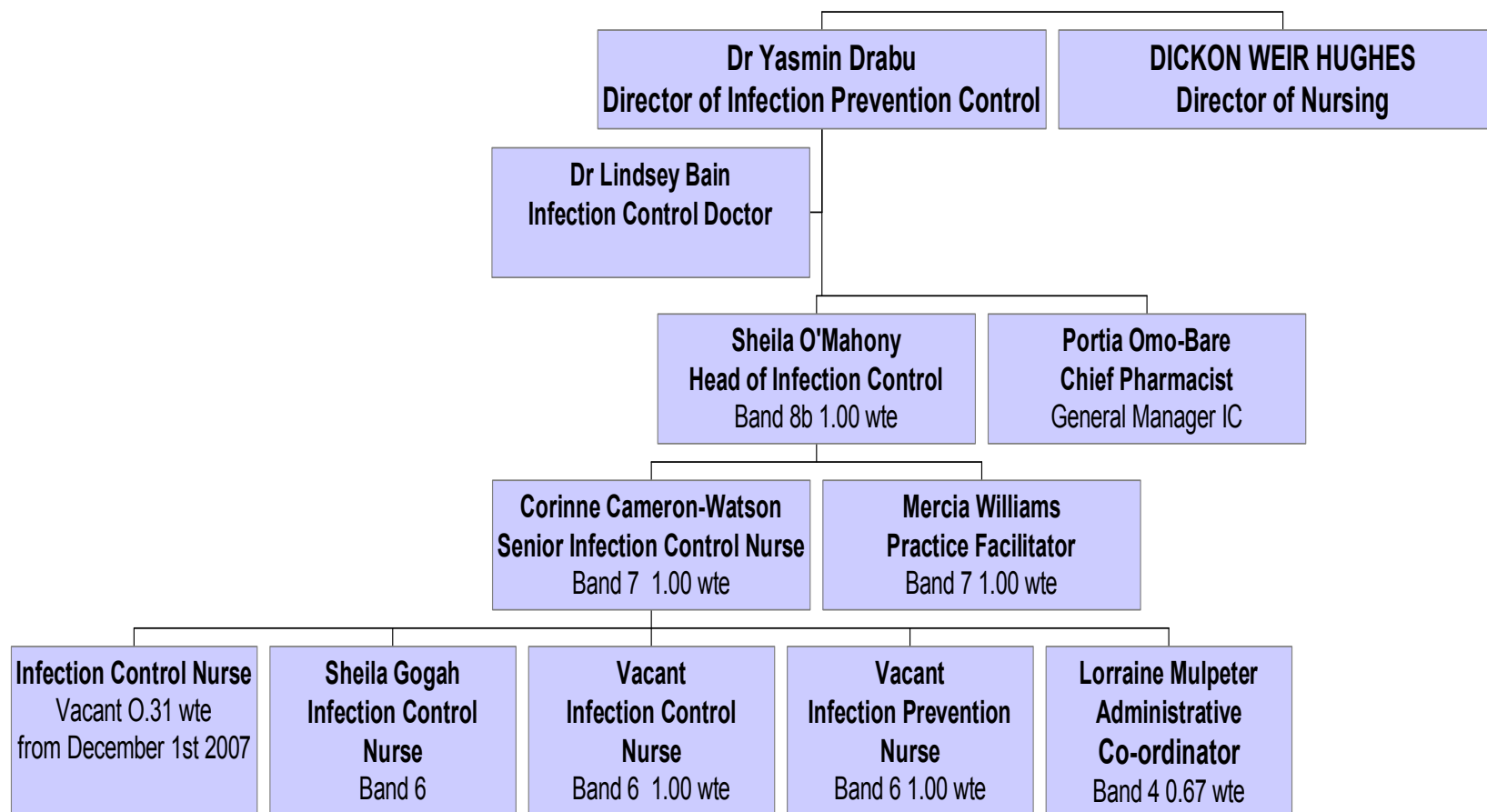
10.2 Infection control passport

The Passport was primarily designed to deal with the infection control issues related to the Isolation of *C. difficile* positive patients. Since its commencement in 2005 great success has been achieved, as 214 staff members have been trained on the passport and 100 have already been assessed of whom 9 are incomplete. The intention is to quickly develop specific infection control passports for staff groups such as junior doctors and therapists. Other passports for administrative staff and other non clinical staff are being discussed for introduction in the near future.

10.3 Infection Control Link Nurses

Many attempts have been made to rekindle the link nurse programme but it has not been successful to date. The way forward has been discussed with the executive nurse.

Infection Control



Title: MRSA Plan
Project manager: Dr Bain

Owner: Dr Drabu

Purpose: To reduce the incidence of serious infection with MRSA at BHRT

Outcomes: Monitored by monthly MRSA bacteraemia rates

Objectives: To reduce the overall incidence of MRSA bacteraemia at BHRT and reduce avoidable hospital acquired MRSA bacteraemias to nil

Action	Start Date	Finish Date	Responsibility
Develop a programme of RCA to ascertain the cause of each MRSA bacteraemia <ul style="list-style-type: none"> Team led by Microbiologist, working with an Infection Control Nurse, nominated doctor and ward nurse Information collected centrally by L. Bain Review on a 2 weekly basis at ICT meeting 	January 2007	Ongoing	L. Bain
Develop training programme for junior doctors to address insertion & care of PIVCs <ul style="list-style-type: none"> Discuss requirements with junior doctors Draw up training programme. Liaise with Education Centres at both sites. Incorporate into ongoing training programmes for all junior doctors 	May 2007 June 2007	June 2007 Ongoing	L. Bain CCW
Second nurse to line care project <ul style="list-style-type: none"> Identify individual Arrange training Agree work plan 	April 2007 May 2007 May	May 2007 End May 2007	C. Moore S. O'Mahony

	2007		
Audit of PIVCs on wards <ul style="list-style-type: none"> Compliance with policy Audit use of VIP scores 	June 2007	August 2007	A. Moody
MRSA patients are flagged on PAS – Infection Control informed weekly. <ul style="list-style-type: none"> Ascertain if daily notification from PAS previously positive patients who are previously is possible. Ascertain if daily notification of admissions from Nursing, Residential Homes and transfers from other hospitals or Health Institutions is possible Ascertain if Infection control alert could be on PAS front sheet 	May 2007	July 2007 Completed August 2007 Not currently possible Completed July 2007	R. Elias Lead person no longer in post
Ward staff may not be aware of PAS alerts <ul style="list-style-type: none"> Training for ward clerks to recognise PAS alerts 	May 2007	July 2007	S. O'Mahony
Analysis of pre 48 hr bacteraemia <ul style="list-style-type: none"> A sample of cases to be reviewed. Information to be shared with the PCTs Further action to be considered pending findings 	April 2007	May 2007	L. Bain
Active training programme for line care etc in intensive care across all sites <ul style="list-style-type: none"> Nominated medical and nursing patient safety lead identified for each intensive care who will be responsible for this To have allocated time identified in job plan to deliver this 	May 2007	August 2007 Jitendra Garg is leading on this across both sites Audit to commence October 2007	Jitendra Garg
Agree & implement Trust wide strategy for Patient Safety. Patient safety re infection control – to be highlighted to TB every 3 months by CE <ul style="list-style-type: none"> Infection control and Patient Safety strategy to be developed by Medical Director – this would cover infection control issues Regular quarterly reports to the Trust Board 	April 2007	September 2007	Y. Drabu
MRSA targets to be reported to TB and TMB and to each directorate <ul style="list-style-type: none"> Infection control targets to be developed and agreed for each directorate, consultant and ward as part of performance framework (Proposed target is NO hospital acquired bacteraemias by September 2007) Agree report format 	May 2007	September 2007 Monthly directorate report format agreed ?have directorates been informed they have targets? Monthly data goes to TB etc via information department	Y. Drabu
Infection control responsibility identified in job description <ul style="list-style-type: none"> At present not identified in JD. 	May	July 2007	Paul Stone

<ul style="list-style-type: none"> Standard working to be agreed by HR and Infection Control – to be incorporated into JD 	2007	(Actually completed August 2007)	
Infection control responsibility identified in training and appraisal Infection Control and other statutory requirements to be identified for all staff in training and appraisal	May 2007	August 2007	Alison Crombie
Infection control lead identified with allocated time in each clinical speciality <ul style="list-style-type: none"> Medical Director and Director of Nursing to identify clear JD for clinical lead in Patient safety in each speciality, which will incorporate infection control 	May 2007	August 2007 Frame work for Infection Control Champion written 2 leads appointed so far	Y. Drabu
Ensure ICT attendance to improvement programme <ul style="list-style-type: none"> ICT to ensure that they link up with the National Improvement programmes. 	March 2007	May 2007	C.Cameron-Watson
All staff to be responsible for hand washing and hand decontamination; all consultants to use alcohol gel at ward rounds <ul style="list-style-type: none"> Set up Infection control champions in each clinical area Hand washing audit to be fed back to each ward Ensure all staff use alcohol gel – personal gel to be given to staff 	July 2007	August 2007 Ongoing	S. O'Mahony
Infection Control Link Nurses identified for each clinical area <ul style="list-style-type: none"> Link nurses to be identified for each clinical area starting with high risk areas first Link nurse training pack Training on one-one basis 	March 2007	April 2007	S. Gogah
Ongoing training for Infection Control Link Nurses <ul style="list-style-type: none"> 3 monthly update meetings 	June 2007	August 2007 Ongoing	S.Gogah
Identify Infection Control Links for other relevant areas e.g. Physiotherapy, Occupational Therapy, Estates <ul style="list-style-type: none"> Training on one-one basis 	June 2007	August 2007	S. O'Mahony J. Burr now leading
House keepers to be responsible for cleanliness <ul style="list-style-type: none"> Check responsibility identified in cleaning contract 	March 2007	May 2007	J. Burr
PALS to be trained to advocate on behalf of patients re infection control practice <ul style="list-style-type: none"> ICT to ensure PALS trained in basic infection control practices 	March 2007	June 2006	M. Williams

<ul style="list-style-type: none"> Link Nurse assigned to PALS 			
Use of PPI to monitor infection control practice on wards <ul style="list-style-type: none"> Agree a monitoring programme of patient safety issues with the PPI 	?	?	PPI Manager (to be appointed)
Work with PCTs in a programme for reducing colonised patients into hospital <ul style="list-style-type: none"> Infection control team to work with HPA and local PCT Infection control staff to agree a clear strategy re MRSA in nursing homes 	March 2007	August 2007 Progress being made but not complete. Have some dates for meetings	S. O'Mahony
Ensure all bacteraemias are coded <ul style="list-style-type: none"> Performance team to work with ICT to ensure all MRSA bacteraemias are coded correctly 	May 2007	August 2007 Partial compliance – mostly recorded as septicaemia. Need to clarify what doctors need to write in notes and how this could be coded	Teresa Miller
Use of IT to support ICT 's work <ul style="list-style-type: none"> PDA's to be given to ICT as a pilot to see if helpful in audit and surveillance 	April 2007	June 2007	L. Mulpeter
Set hand hygiene targets <ul style="list-style-type: none"> Wards to have agreed hand hygiene targets set (Target agreed at 80%) 	March 2007	September 2007	S. O'Mahony
Establish a safety culture across the Trust <ul style="list-style-type: none"> Review Trust Patient safety strategy to ensure emphasis on patient safety is established 	April 2007	September 2007 (Draft Safety Strategy out to consultation)	Y. Drabu
Establish an IV team <ul style="list-style-type: none"> High level external audit Do a business case for IV team? 	July 2007	September 2007 Likely to occur in November?	D. Weir-Hughes
Set up standardised CVC pack on all the wards <ul style="list-style-type: none"> ICT, anaesthetists and ward managers to review requirements ICT to investigate commercially available packs. Business case Launch 	March 2007	July 2007 Will not be possible to launch before December ? due to lead time required by company	C. Cameron-Watson
Set up standard PIVC pack for all wards <ul style="list-style-type: none"> Review requirements Business case Launch 	March 2007	June 2007 Actually launched July	C. Cameron-Watson
Develop Care bundle for CVC line insertion and care	March	April 2007	C. Cameron-Watson

<ul style="list-style-type: none"> ICT to visit/liaise with PAH to learn from practice there. 	2007		
Agree screening guidelines for admission and get funding from PCTs <ul style="list-style-type: none"> Infection control team to agree policy for screening Business case Commissioning to agree funding for screening 	March 2007	December 2007	L.Bain
Improve compliance with MRSA decontamination protocols	July 2007	September 2007 Work started at Queen's	L. Bailes-Barrett
Routine Octenisan washes for patients staying over 7 days in high risk wards <ul style="list-style-type: none"> Establish cost Implementation 	May 2007	August 2007 Initial meeting held, awaiting costing November – December Survey ongoing	S.Gogah
Continue with implementation of antibiotic policy <ul style="list-style-type: none"> Policy for surgical prophylaxis Continue rationalisation of antibiotic policy 	March 2007	May 2007	A. Yaneza
Audit compliance with antibiotic policies <ul style="list-style-type: none"> Surgical prophylaxis Automatic stop IV to oral switch Guidelines for common infections 	June 2007	July 2007 July 2007 July 2007 Delayed due to staff sickness, completed September 2007	S. Zaman
48 hour Antibiotic Stop Policy ; IV to oral policy <ul style="list-style-type: none"> Ensure compliance across Trust 	July 2007	August 2007 Taken to NSP&P Committee 18/9/07 & matron's meeting 25/9/07	D. Weir-Hughes Ask S. Zaman to take this on
Infection control policies related to patient movement <ul style="list-style-type: none"> Update policies 	March 2007	May 2007	S. O'Mahony
Cleaning standards lead <ul style="list-style-type: none"> To work with ICT on ensuring cleaning standards are maintained 	March 2007	June 2007 Ongoing	S. O'Mahony
Improve MRSA reporting via non mandatory field <ul style="list-style-type: none"> No longer required as will duplicate information available elsewhere 	March 2007	May 2007	L. Bain
Review urinary catheter policy	March	July 2007	C. Cameron-Watson D. Weir -Hughes

<ul style="list-style-type: none"> • Introducion of silver coated catheters 	2007	Policy approved, awaiting implementation date ?Dec 1 st Catheter still under discussion – not for current implementation	
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Key:

W	Not yet started
█	Not Applicable
G	Underway, on track
A	Slight variation to plan (up to 5 days over due)
R	Major variation to plan (6+ days over due)
B	Completed
█	Not possible to progress this further at this time

PROGRESS NOTES

6/6/2007

Ralph to assign dedicated person to work on project

Title: Clostridium Difficile Plan
Project manager: Dr Bain

Owner: Dr Drabu

Purpose: To reduce the incidence of hospital acquired C.difficile at BHRT

Outcomes: Monitored by monthly C.difficile cases

Objectives: To reduce the incidence of C.difficile at BHRT in 2007/08 by at least 20% compared with 2006/07

Action	Start Date	Finish Date	Responsibility
Ensure timely processing of specimens to minimise delays in diagnosis	Already in place	Already in place	S.Lacey
Ensure same day communication of result to ward staff and isolation of patient	Already in place	Already in place	S. O' Mahony
Managerial responsibility for isolation area at Queen's Hospital (Clementine B)	Already in place	Already in place	J. Harris
Medical responsibility for patients at Queen's hospital	Already in place	Already in place	M. Smith
Managerial responsibility for isolation area at King George's Hospital (Fern ward)	Already in place	Already in place	B. Bishop
Medical responsibility for patients at King George's hospital	Already in place	Already in place	K. Niranjana
Review antibiotic guidelines	May 2007	June 2007	A. Yaneza
Update antibiotic guidelines on intranet (delayed due to staff sickness, new target August)	May 2007	June 2007 Completed August	S. Zaman
Re-audit adherence to antibiotic guidelines (delayed due to staff sickness, new target August)	June 2007	July 2007 Completed August	S. Zaman

Implementation of 'automatic stop' policy by ward managers	July 2007	August 2007 Going to NSPP committee September	D. Weir-Hughes
Maintenance of cleaning standards at KGH	Already in place	Already in place	C. Eaton
Maintenance of cleaning standards at Queen's	Already in place	Already in place	J. McDowell
Ensure 'blitz' cleans requested according to agreed protocol	Already in place	Already in place	S. O' Mahony
Incorporate C.difficile into educational sessions (e.g. Passport) for nursing, support and PAM staff	Already in place	Already in place	M. Williams
Incorporate C.difficile into educational sessions for medical staff	May 2007	August 2007 Dates arranged	L. Bain
Update BHRT Clostridium difficile policy and operational policies for Fern and Clementine B ward.	May 2007	June 2007	S. O' Mahony
Maintenance and review of C.difficile data locally	Already in place	Already in place	L. Bain
Provision of data to HPA and DOH via MESS database and quarterly summary	Already in place	Already in place	L. Bain
Dissemination of data (monthly) to BHRT, PCTs and HPA.	Already in place	Already in place	L. Bain
Monthly report to local Governance committees (Queen's and King George's)	May 2007	June 2007	L. Bain
C.difficile targets to be reported to TB and TMB and to each directorate <ul style="list-style-type: none"> • Infection control targets to be developed and agreed for each directorate, consultant and ward as part of performance framework (Proposed target is not more than 10 hospital acquired cases per month at each hospital) • Agree report format 	May 2007	September 2007	Y. Drabu

Key:

	Not yet started
	Not Applicable
	Underway, on track
	Slight variation to plan (up to 5 days over due)
	Major variation to plan (6+ days over due)
	Completed

EXECUTIVE SUMMARY

1. Subject:

Finance Report for Period ended 31 December 2007.

2. Summary:

Q3 Financial Risk Rating	1
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Financial Risk Rating Criteria

- | | |
|--------------------------|---|
| • Underlying Performance | 1 |
| • Achievement of Plan | 1 |
| • Financial Efficiency | 1 |
| • Liquidity | 3 |

Key Financial Headlines

- Financial deficit £2.8m in the month, £26.6m year to date.
- CIP delivery forecast at £1.3m.
- Financial outturn forecast of £39.9m agreed with NHS London.
- Subsequent risk on transitional fund receipts (ISTC £3.7m) and 18 week penalty fines.

3. Actions:

The Board is asked to note this report

4. Linkage to Corporate Aims:

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

Author:

Trevor Smith
Director of Finance
20 January 2008

Barking, Havering and Redbridge Hospitals

Finance Report

December 2007

Finance Report for Period Ended 31 December 2007

1. Financial Summary

The Trust recorded a deficit of £2.8m for the month and has a £26.6m deficit for the year to date.

The forecast financial outturn deficit remains £39.9m with significant risks associated with transitional support funds and 18 week penalty fines.

A Turnaround function and process has been set up to address the underlying deficit of £50m going forward.

The Income and Expenditure Account is summarised below and detailed in Appendix 1.

Full Year Budget £000		Current Period Actual £000	Current Period Budget £000	Current Period Over/(Under) spend £000	Year To Date Actual £000
(345,948)	Total Operating Income	(28,624)	(28,904)	280	(253,661)
220,888	Pay Expenditure	19,471	17,380	2,091	178,285
131,258	Non Pay Expenditure	10,682	10,431	251	98,170
6,198	EBITDA	1,529	(1,093)	2,622	22,794
9,800	Depreciation	876	816	60	7,890
(1,698)	Non Operating Items	443	601	(158)	(4,038)
14,300	Net (Surplus)/Deficit	2,848	324	2,524	26,646

2. Income

Income was £280k under budget for the month. Year to date under recovery is a combination of aged bad debt write off's, correction to the accounting treatment of last year's income and disputes with PCTs.

3. Expenditure

3.1 Pay Expenditure

Pay costs were £2.1m over budget for the month and £12.7m overspent for the year to date.

The largest component of the year to date over spend is unachieved CIP. The CIP target to the end of December was £16.7m. Excluding the CIP and uncommitted reserves there was a £2.4m under spend against the base budgets.

The under spend is caused by a large number of substantive vacancies (800 WTE at December), less the expenditure on temporary staff (£18.4m to the end of December).

Within the month pay expenditure was broadly consistent with previous months, the only significant movement being in Nursing and Health Care Assistants which has spent £88k less than the monthly year to date average. This is explained by the closure of the final 2 wards at Barking and the opening of only 1 ward at King Georges Hospital

The table below shows the expenditure and over spend variance against budget by staff group:

Full year Budget	Staff Group	Current Period Actual	Current Period Budget	Current Period Over/(Under) spend	Year to Date Actual
£000		£000	£000	£000	£000
25,762	Admin & Clerical	1,992	2,166	(174)	18,134
69,842	Medical Staff	5,941	5,816	125	53,298
37,485	Scientific & Technical Staff	2,935	3,130	(196)	26,430
96,110	Nursing & HCA	7,903	8,009	(105)	71,922
10,236	Other	786	885	(99)	7,027
239,434	Total	19,557	20,006	(449)	176,811
6,854	Reserves	(86)	107	(193)	1,474
(25,400)	CIP target	0	(2,733)	2,733	0
220,888	Total	19,471	17,380	2,091	178,285

3.2 Non-Pay Expenditure

Non Pay costs were £0.3m over budget for the month and £1.4m overspent for the year to date.

The largest component of the year to date over spend are drugs costs, particularly in relation to Cancer, Rheumatology and HIV. Some of these costs are reimbursed by the PCTs through the SLA billing process.

Within the month the notable expenditures includes:

- An increase in Drugs, Consumables and Appliances cost, this is a combination of additional Prosthesis and Medical equipment in Theatres due to additional sessions performed to hit the 18 week target, increased drugs cost in Rheumatology and Cancer and over spends on the blood contract. There has also been some evidence of over ordering of Consumables in the run up to Christmas.
- A reduction in Premises and Fixed Plant costs due to the rateable value for Queens Hospital being confirmed at a level below that budgeted and accrual.
- An increase in other expenditure, costs include provisions for Redundancy, Employment tribunals and Consultancy.

The table below shows the expenditure and over spend (£251k) variance against budget by expenditure type:

Full year Budget	Expenditure Type	Current Period Actual	Current Period Budget	Current Period Over /(Under) spend	Year to Date Actual
£000		£000	£000	£000	£000
45,449	Drugs, Consumables and Appliances	4,368	3,796	572	36,109
1,582	General Supplies and Services	140	149	(9)	1,121
0	Non-Pay Savings Target	0	0	0	0
20,000	Premises and Fixed Plant	853	1,667	(813)	14,598
59,065	Other	5,321	4,756	565	46,343
5,162	Reserves	0	64	(64)	0
131,258	Total	10,682	10,431	251	98,170

4. Business Unit Performance

The table below shows overall performance against base budget:

Full year Budget	Business Unit	Current Period Actual	Current Period Budget	Current Period Over /(Under) spend	Year to Date Actual
£000		£000	£000	£000	£000
77,899	Elective	6,631	6,514	117	57,726
66,362	Emergency	5,350	5,444	(94)	48,406
75,370	Commercial Operations	5,644	6,384	(740)	56,436
22,400	Corporate Services	1,745	1,737	9	16,458
(335,199)	Central Income	(27,766)	(27,949)	183	(247,745)
10,160	Reserves	(86)	105	(191)	1,474
9,216	Financing	1,767	1,465	302	7,912
(25,400)	CIP	0	(2,733)	2,733	0
16,993	Maternity	1,504	1,448	55	12,727
55,329	Nursing	4,686	4,488	198	42,501
41,170	Clinical Support Services	3,372	3,421	(48)	30,752
14,300	Total	2,848	324	2,524	26,646

Note: Financing includes Capital Dividend Payable, Depreciation, Redundancy and technical accounting adjustments.

Note: The Commercial Operations under spend is the rates reduction mentioned earlier in the report.

5. Temporary Staffing

Total expenditure on temporary staff in month £2,377k, YTD £21,954k; an increase of £3,524k on this time last year. In the month expenditure on temporary staff was £2,377k, £828k more than in Dec 2006.

Month	Bank / Locum £000	Agency £000	Total £000	2006/07 Total £000
Apr	1,542	920	2,462	2,193
May	1,541	919	2,460	2,192
Jun	1,387	973	2,360	2,014
Jul	1,860	897	2,757	2,136
Aug	1,770	868	2,638	2,081
Sep	1,584	815	2,398	2,061
Oct	1,448	707	2,155	2,131
Nov	1,394	953	2,347	2,071
Dec	1,601	776	2,377	1,550
Total	14,126	7,828	21,954	18,430

The table below shows the temporary staff expenditure by staff type:

Bank/Agency	Staff Type	Nov £000s	Dec £000s	Yr to Date 2007/8 £000	2006/7 £000	Increase / (Decrease) £000
Bank/Locum	Medical Staff NHS Locum	421	507	3,852	3,669	183
Bank/Locum	NHSP Qualified Nurse	618	701	6,425	5,511	914
Bank/Locum	NHSP Unqualified	233	272	2,702	2,252	451
Bank/Locum	NHSP Admin & Clerical	121	118	1,122	968	154
Bank/Locum	NHSP Professional & Technical	1	2	20	97	(77)
Bank/Locum	NHSP Ancillary	0	1	5	8	(3)
Bank/Locum Total		1,394	1,601	14,126	12,505	1,622
		£000	£000	£000	£000	£000
Agency	Agency Medical Staff	284	199	2,520	1,638	883
Agency	Agency Nursing Staff	92	82	796	545	251
Agency	Agency Admin & Clerical	144	110	1,008	258	750
Agency	Agency Prof & Tech	239	241	2,267	2,134	132
Agency	Agency Healthcare Assistants	192	144	1,234	1,349	(115)
Agency	Agency Other	2	-	3		3
Agency Total		953	776	7,828	5,925	1,903
Trust Total		2,347	2,377	21,954	18,430	3,525

6. Cost Improvement Plans (CIPs)

Due to the failure of the Financial Recovery Plan the £25.4m CIP target is now centralised and does not sit within the operational budgets.

The turnaround function is beginning to address the financial shortfall for the remainder of this year and into 2008/09 – 2010/11. The Trust continues to seek to achieve or better the revised forecast outturn of £39.9m; monthly reports will be provided to the Board as this progresses.

7. Balance Sheet

A summarised balance sheet is shown below.

	Actual			Movements	
	Dec £m	Nov £m	Mar £m	Mth £m	YTD £m
Fixed Assets	<u>231.6</u>	<u>231.7</u>	<u>249.9</u>	<u>0.1</u>	<u>18.3</u>
Current assets					
Cash at bank	15.8	18.0	0.9	(2.2)	14.9
Other	<u>47.8</u>	<u>46.2</u>	<u>54.3</u>	<u>1.6</u>	<u>(6.5)</u>
	63.6	64.2	55.2	(0.6)	8.4
Current liabilities	<u>(49.9)</u>	<u>(47.9)</u>	<u>(44.0)</u>	<u>(2.0)</u>	<u>(5.9)</u>
Net current assets	<u>13.7</u>	<u>16.3</u>	<u>11.2</u>	<u>(2.6)</u>	<u>2.5</u>
Debtors > 1 year	66.2	66.2	53.9	-	12.3
Provisions for liabilities	<u>(8.1)</u>	<u>(7.9)</u>	<u>(7.0)</u>	<u>(0.2)</u>	<u>(1.1)</u>
Net assets	<u>303.4</u>	<u>306.3</u>	<u>308.0</u>	<u>(2.9)</u>	<u>(4.6)</u>
Public dividend capital	294.0	294.0	266.8	-	(27.2)
Revaluation reserve	54.8	54.8	60.0	-	(5.2)
Donated asset reserve	1.3	1.3	1.3	-	-
I&E reserve	<u>(46.7)</u>	<u>(43.9)</u>	<u>(20.1)</u>	<u>(26.6)</u>	<u>(23.8)</u>
Tax payers equity	<u>303.4</u>	<u>306.3</u>	<u>308.0</u>	<u>(2.9)</u>	<u>(4.6)</u>

A more detailed Balance Sheet is set out in Appendix 2.

Significant progress has been made in substantiating the Balance Sheet. The Financial Controller is continuing to undertake a more detailed assessment, the outcomes of which will be fully reported to the Audit Committee and back to the Board. This will be informed by a trial closure of accounts for month 9.

7.1. Fixed assets

A summary of the opening and closing net book value (“NBV”) positions and fixed asset movements comprises:

	Total £000	Land & Build £000	Equip & Other £000	Residual Interest £000	AUC¹ £000	Donated £000
<i>1 April 2007</i>	249,871	206,739	27,500	798	13,486	1,348
Indexation	-	-	-	-	-	-
Revaluation	(5,121)	(5,121)	-	-	-	-
Impairments	(3,654)	(3,654)	-	-	-	-
Additions	4,767	-	1,079	2,131	1,558	-
Disposals	(6,362)	(6,362)	-	-	-	-
Depreciation	(7,890)	(5,974)	(1,916)	-	-	-
Transfers	-	-	-	-	-	-
<i>31 Dec 2007</i>	<u>231,612</u>	<u>185,628</u>	<u>26,663</u>	<u>2,929</u>	<u>15,043</u>	<u>1,348</u>

The transactions associated with phase two of the Oldchurch site are set out below:

	Total £000	Land £000	Build £000
<i>NBV of Old Church II</i>	15,025	4,019	11,006
Revaluation	(5,121)	2,231	(7,352)
Impairment	<u>(3,654)</u>	-	<u>(3,654)</u>
<i>NBV of disposal</i>	6,250	6,250	-
Sale proceeds	<u>18,800</u>	<u>18,800</u>	-
<i>Gross profit on disposal</i>	<u>12,250</u>	<u>12,250</u>	-

Whilst the management accounts show the gross profit position, the published accounts will show the net profit position, i.e. in accordance with DH guidance, the impairment will be netted off the profit to show a net profit of £8.596m on disposal.

¹ Assets Under Construction

A summary of the capital program, highlighting projects in excess of £100,000, is set out below:

	Forecast Outturn	YTD
	£000	£000
Carried forward projects:		
Digital hearing aids	233	233
Other	190	190
New projects:		
KGH walk-in centre	1,161	1,110
CT scanner	484	-
SBS migration	283	283
New medical records centre	152	(102)
Decommissioning OCH & HW	102	102
IT projects:		
Olympus blood tracking	613	262
IMS	252	252
Euroking (maternity)	162	40
Other IT projects	241	-
Other projects	347	266
Additional proposed projects:		
Endoscopy and pump	217	-
Centralised CTG	183	-
New chairs at KGH's OPD	100	-
Other projects	233	-
Over 'commitment'	<u>(413)</u>	<u>-</u>
	4,540	2,636
PFI residual interest	<u>2,920</u>	<u>2,131</u>
	<u>7,460</u>	<u>4,767</u>

Further detail will follow in future months.

7.2. Stocks

Stocks levels remain broadly in-line, with no significant movements.

	Actual			Movements	
	Dec	Nov	Mar	Mth	YTD
	£000	£000	£000	£000	£000
Stocks	<u>6,776</u>	<u>6,643</u>	<u>6,655</u>	<u>133</u>	<u>121</u>

7.3. Debtors due within one year

Current debtors comprise:					
	Dec	Actual		Movements	
	£000	Nov	Mar	Mth	YTD
		£000	£000	£000	£000
NHS debtors					
Rec'd on account	(7,451)	(11,400)	-	3,949	(7,451)
Other	8,847	7,126	13,628	1,721	(4,781)
Trade debtors	3,967	3,052	4,343	915	(376)
Bad debt provisions	(256)	(257)	(1,831)	1	1,575
Capital debtors	30,705	30,705	24,745	-	5,960
Other debtors	2,764	4,346	4,532	(1,582)	(1,768)
RTA ² provisions	(108)	(108)	(108)	-	-
Prepayments:					
Unitary payment	1,671	5,124	1,639	(3,453)	32
Other	<u>1,003</u>	<u>1,141</u>	<u>816</u>	<u>(138)</u>	<u>187</u>
	<u>41,142</u>	<u>39,729</u>	<u>47,764</u>	<u>1,413</u>	<u>(6,622)</u>

November's payments received on account of £11.4m represent the early drawdown of SLA income from Barking & Dagenham PCT to assist the Trust's in managing its forecast cash deficit. The reduction in December represents the allocation of the advance to December's SLA less a further £1.8m received from the PCT.

The YTD reduction in trade debtors and associated provision for bad debts relates to the write off of £1.9m in September and October.

The increase in capital debtors represents the first instalment due on the disposal of phase two of Old Church to Swan Housing Association. The debtor of £30.7m is due in March relating to the instalments due on the three property disposals.

£1.7m of the reduction in other debtors relates to the receipt of VAT recoverable on the Queens' PFI unitary payment ("UP").

The reduction in the UP prepayment represents one month's UP charge. The UP is payable quarterly in advance at the beginning of each quarter.

² Road Traffic Act Income

7.4. Debtors due after more than one year

Long term debtors comprise:					
	Dec	Actual		Movements	
	£000	Nov	Mar	Mth	YTD
		£000	£000	£000	£000
NHS debtors	1,689	1,689	1,689	-	-
Capital debtors	60,402	60,402	48,502	-	11,900
Other debtors	1,895	1,895	1,538	-	357
RTA provision	(146)	(146)	(118)	-	(28)
Prepayments	<u>2,201</u>	<u>2,201</u>	<u>2,201</u>	-	-
	<u>66,041</u>	<u>66,041</u>	<u>53,812</u>	-	<u>12,229</u>

NHS debtors comprise the back-to-back provisions associated with the funding by PCTs of a proportion of the Trust's provisions for pensions, injury benefits and public and employer's liability.

The increase in capital debtors represents the second and third instalments due on the disposal of phase two of Old Church to Swan Housing Association receivable in March 2009 and March 2010.

Other debtors represent RTA income receivable. In accordance with the NHS Finance Manual, the RTA provision represents 7.7% of the debtor. This will need to increase to 7.8% in accordance with the 2007/08 manual updates.

Prepayments represent the deferred asset on the transfer of equipment to the Siemens' managed equipment services contract. This balance will be written off over the period of the PFI contract.

7.5. Provisions for liabilities and charges

A summary of the movement on provision for liabilities and charges comprises:

	Total	Pension	Redund.	Other
	£000	£000	£000	£000
<i>At 1 April 2007</i>	7,046	5,487	565	994
Arising during the period	188	98	-	90
Utilised	(870)	(638)	(134)	(98)
Reversed unused	(29)	(11)	-	(18)
Unwinding of discounts	<u>62</u>	<u>55</u>	-	<u>7</u>
<i>At 30 September 2007</i>	6,397	4,991	431	975
Arising during the period	2,005	1,565	308	132
Utilised	(93)	-	(31)	(62)
Reversed unused	(255)	-	(255)	-
Unwinding of discounts	-	-	-	-
<i>At 31 December 2007</i>	<u>8,054</u>	<u>6,556</u>	<u>453</u>	<u>1,045</u>

Provisions for pensions relate to individuals who have been made redundant and have opted to take part of their cash settlement as enhanced pension entitlement. Along with the injury benefits provision (see below), the information for the movement on these provisions is provided quarterly in arrears by the NHS Pension Agency. The information for quarter three was received after the month has been closed.

Provisions for redundancy costs relate to those staff whose posts have been identified as being at risk and without the likelihood of redeployment, but who have not received a formal notification of redundancy. The information for these provisions is provided primarily by the human resources department.

Other provisions include provisions for costs associated with claims under employer's liability, public liability, staff injury benefit and employment tribunals. Information on the movements for employer's and public liability is provided quarterly in arrears by the NHS Litigation Authority. The information for quarter three was received after the quarter's accounts had been closed. Employment tribunal movements are provided by the human resources department.

7.6. Public dividend capital

The YTD movement on PDC comprises:

- Two draw downs of temporary PDC totalling £35.75m to fund the Trust's in-year deficit; and
- Repayment of £8.6m relating to a funds flow transaction associated with the funding for 2006/07's impairment on the equipment transferred to Siemens' managed equipment services.

The Trust has requested a further drawdown of £4.15m to fund the current forecast outturn deficit of £39.9m. In addition, the Trust is forecast to repay £25.4m in March funded by land sale receipts. Given that the Trust has temporary PDC funding of £46m brought forward from 2006/07, the forecast temporary borrowings at the end of March 2008 equates to £60.5m. It is yet be agreed by the DH that the Trust can use its capital receipts to repay its 'revenue' related loans.

As a result of a late adjustment to the 2006/07 impairment associated with the transfer to Siemens, a reverse funds flow funding of £6.0m will arise in 2008/09. A creditor for this amount was raised in the balance sheet in March 2007.

7.7. Reserves

The YTD movement on the revaluation reserve of £5.1m relates to the second of the disposal of Oldchurch, in checking:

- The downward valuation of buildings to zero, resulting in a reversal of the revaluation reserve of £7.3m; and
- An uplift in the valuation of the land by £2.2m to £6.25m

The Trust has yet to account for the indexation of fixed assets at 1 April 2007. This is dependent upon bringing the fixed asset register up to date as at

31 March 2007. A capital accountant, who moved to GOSH in February 2007, was reemployed in late December 2007. The expectation is that the register will be up-to-date by early February, with it fully updated by the end of February. Notwithstanding this, an increased depreciation charge for the year has taken account of the expected indexation.

Other adjustments that need to be made to the revaluation reserve include the transfer to the I&E reserve relating to the realisation of the revalued sums. This relates to both in-year depreciation, as well as the sale of Old Church II. Also, it has been established that the Trust has not historically accounted for the transfer from the revaluation to the I&E reserve for backlog depreciation.

No movements have yet been processed on the donated asset reserve. This will not affect the forecast deficit reported by the Trust.

A revaluation of the Barking Hospital site has been commissioned through the District Valuer as part of the site transfer to Barking and Dagenham PCT.

8. Cash Flow

A summary of the Trust cash flow during the period is set out below. A more detailed cash flow statement is provided in Appendix 3.

	Month	YTD
	£000	£000
EBITDA	(1,529)	(22,794)
Working capital movements:		
SLA advance from B&D PCT	(3,949)	11,400
Impairment funds flow receipt	-	8,587
Other	<u>3,933</u>	<u>(640)</u>
<i>Net operating cash flow</i>	(1,545)	(3,447)
Net interest	145	493
Capital:		
Capital expenditure	(772)	(6,825)
Land sale receipts	<u>-</u>	<u>972</u>
<i>Net cash flow before financing</i>	(2,172)	(8,807)
Financing:		
PDC dividends paid	-	(3,526)
PDC repaid (impairment)	-	(8,587)
Temporary PDC received	<u>-</u>	<u>35,750</u>
<i>Net movement in cash</i>	<u>(2,172)</u>	<u>14,830</u>

As a result of its operational performance, the Trust's continues to have a severe net cash outflow. In order to support the Trust's cash forecasts, the Trust received advances against future SLA payments from Barking & Dagenham PCT of £11.4m in November. This was partly utilised against the SLA due in December, and was added to by a further £1.8m advance from the PCT.

The main component of the other working capital movement relates to the utilisation of the PFI unitary payment prepayment.

The land sale receipt relates to the deposit received in April relating to the completion of phase two of the Oldchurch disposal.


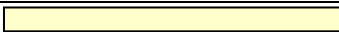

The Trust is on weekly cash-flow reporting with the London Provider Agency. As a result of advances of SLA income from Havering and Barking & Dagenham PCTs, the Trust has been able to push back the forecast cash deficit from January to the end of March. The Trust is current in negotiation with the SHA and DH to establish funding to address this deficit, including a further £4.15m to fund the forecast deficit of £39.9m.

The timing of future capital land sale receipts is being checked and confirmed with the Trust's legal advisors.

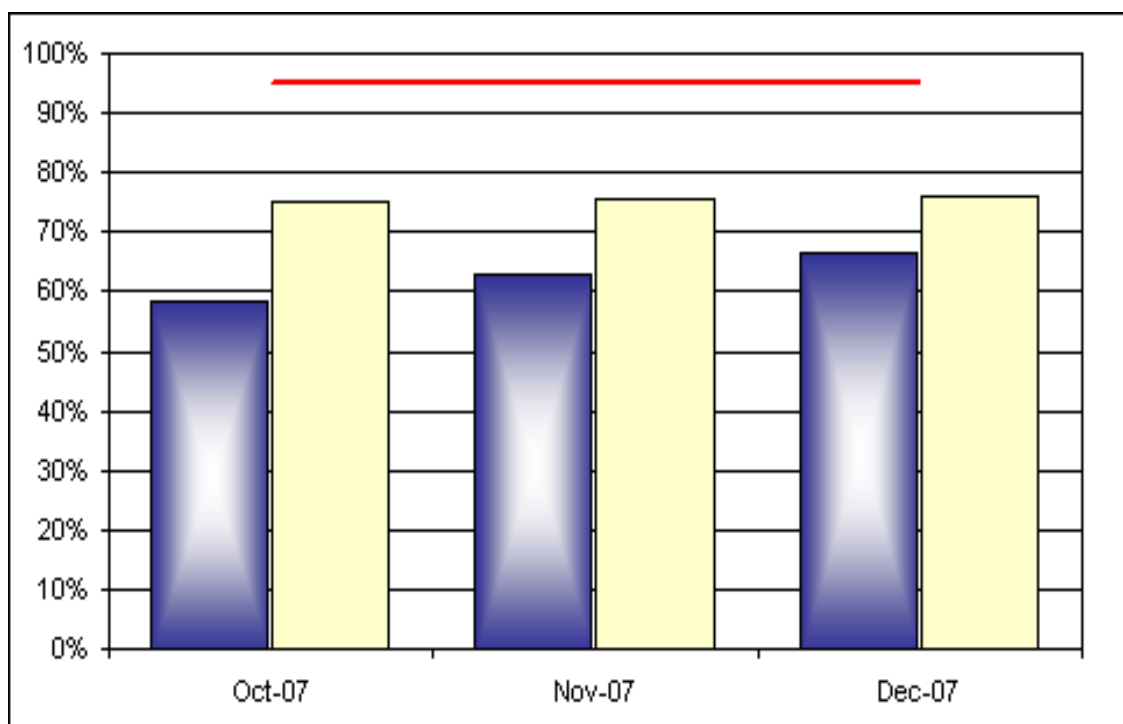
8.1. Public Sector Payment Policy (Better Payment Practice Code)

Under the better payment practice code, invoices received from trade creditors should be paid within 30 days of the receipt of goods or a valid invoice (whichever is later), unless other payment terms have been agreed.

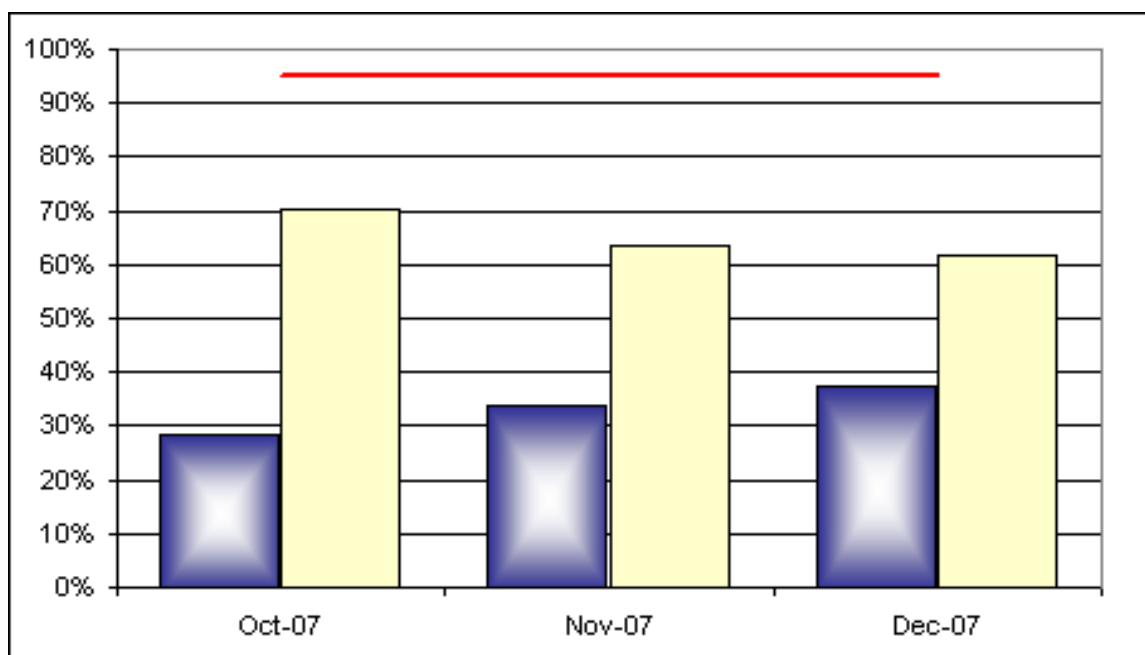
The Trusts cash position has contributed to the performance against the 95% PSPP target being extremely poor. Year to date performance is 67% (63% last month) of Non NHS debt paid and 38% (34% last month) of NHS debt paid within 30 days. The tables below show the performance for the last three months.

Key to tables	
	% of invoices paid within 30 days by volume
	% of invoices paid within 30 days by value
	Target % of invoices paid within 30 days

Non NHS Trade Suppliers by Volume and Value



NHS Trade Suppliers by Volume and Value



9. Financial Risks

The following risks could adversely affect achievement of the £39.9m outturn deficit.

Activity

- Performance; failure to deliver activity plans will mean income reductions.
- Capture, coding and classification (recording).
- Disputes on activity performance with PCTs.
- Failure to hit the 18 week target could lead to a penalty (£2.5m)

CIP's

- Forecast £1.3m from opening plan of £25.4m.
- Any improvement would clearly improve the financial out turn. Failure to achieve the latest forecast would deteriorate the position further.

Control accounts, debtor balances and accruals

- Integrity, validity.
- Recoverability of debtor balances.
- Completeness of provision / accruals for historic and current costs.

Cost Controls

- It is essential that they deliver expenditure reductions. The Trust must prevent circumvention of restrictions.

Agenda for Change appeals and claims that may be outstanding

Supply Chain provision

- Potential abortive fees if the scheme were not to proceed.

ISTC (Independent Sector Treatment Centre)

- Must ensure full cost release and recharge.
- Transitional cost funding via NHS London (£3.75m) scheduled to be received, confirmation awaited.

Medical Staff re-bandings

- Banding appeals are outstanding in some specialties. If appeals are successful then there is potential for back pay not accrued to date.

Redundancy

- There is no provision for any future redundancy costs.

ESR / Payroll

- New payroll and HR systems. Failure of payroll provider has led to a transfer of service which may have audit implications as well as financial risks. The external auditors are reviewing the situation.

SBS Systems and Processes

- Under review following implementation in April.
- Processing, structural and training issues to be addressed.

Trevor Smith
Director of Finance
20 January 2008

Income & Expenditure

December 2007

Full Year		Month			YTD		
Budget £'000		Actual £'000	Budget £'000	Variance £'000	Actual £'000	Budget £'000	Variance £'000
INCOME							
(318,158)	Protected activities	(26,104)	(26,513)	409	(234,248)	(238,618)	4,370
(3,168)	Non-protected activities	(208)	(280)	72	(2,388)	(2,330)	(58)
(24,622)	Other operating income	(2,312)	(2,111)	(201)	(17,025)	(18,505)	1,480
(345,948)		(28,624)	(28,904)	280	(253,661)	(259,453)	5,792
PAY							
219,472	NHS	17,602	17,168	434	160,176	164,469	(4,293)
1,416	Non-NHS	1,869	212	1,657	18,109	1,121	16,988
220,888		19,471	17,380	2,091	178,285	165,590	12,695
NON-PAY							
19,364	Drugs	1,667	1,610	57	15,836	14,534	1,302
28,001	Clinical Services (excl. drugs)	2,768	2,277	491	21,456	21,077	379
83,893	Other Non-Pay (excl. depreciation)	6,247	6,544	(297)	60,878	61,128	(250)
352,146		30,153	27,811	2,342	276,455	262,329	14,126
6,198		1,529	(1,093)	2,622	22,794	2,876	19,918
		EBITDA					
9,800	Depreciation	876	816	60	7,890	7,350	540
(12,554)	Profit/(loss) on disposal	-	-	-	(12,550)	(12,554)	4
-	Interest Payable	-	-	-	4	-	4
-	Interest Receivable*	(145)	-	(145)	(497)	-	(497)
150	Unwinding of Discounts	-	13	(13)	62	113	(51)
7,052	Capital dividends payable	588	588	-	5,289	5,289	-
10,646		2,848	324	2,524	22,992	3,074	19,918
		Net (surplus)/deficit					
3,654	Asset Impairment	-	-	-	3,654	3,654	-
14,300		2,848	324	2,524	26,646	6,728	19,918
		Retained (surplus)/deficit					

Balance Sheet

December 2007

March 2008		December 2007			Nov 07
Budget £'000		Actual £'000	Budget £'000	Variance £'000	Actual £'000
223,400	FIXED ASSETS	231,611	224,000	7,611	231,723
200	Cash at bank and in hand	15,780	5,200	10,580	17,950
66,000	Other current assets	47,772	66,000	(18,228)	46,226
66,200	CURRENT ASSETS	63,552	71,200	(7,648)	64,176
-	Bank overdraft/Drawdown facility	-	-	-	-
(41,600)	Other current liabilities	(49,890)	(44,400)	(5,490)	(47,889)
(41,600)	CREDITORS: due within one year	(49,890)	(44,400)	(5,490)	(47,889)
24,600	<i>Net current assets/(liabilities)</i>	13,662	26,800	(13,138)	16,287
58,400	DEBTORS: Greater than one year	66,187	89,100	(22,913)	66,187
306,400	Total assets less current liabilities	311,460	339,900	(28,440)	314,197
-	Government grants	-	-	-	-
(27,100)	Other creditors (Including Loans)	-	(56,500)	56,500	-
(27,100)	CREDITORS: due after one year	-	(56,500)	56,500	-
(3,400)	PROVISIONS for liabilities & charges	(8,054)	(3,400)	(4,654)	(7,944)
275,900	Total assets employed	303,406	280,000	23,406	306,253
(234,300)	Public dividend capital	(293,957)	(234,200)	(59,757)	(293,957)
(84,900)	Revaluation reserve	(54,827)	(84,900)	30,073	(54,827)
(1,300)	Donated asset reserve	(1,348)	(1,300)	(48)	(1,348)
44,600	Income & expenditure reserve	46,726	40,400	6,326	43,879
(275,900)	TAXPAYER'S EQUITY	(303,406)	(280,000)	(23,406)	(306,253)
(275,900)	Total funds employed	(303,406)	(280,000)	(23,406)	(306,253)

Cash Flow Statement

December 2007

Full Year		Month			YTD		
Budget		Actual	Budget	Variance	Actual	Budget	Variance
£'000		£'000	£'000	£'000	£'000	£'000	£'000
6,198	EBITDA	(1,529)	(1,093)	(436)	(22,794)	(11,561)	(11,233)
-	Transfers from reserves		-	-			-
-	Stocks	(133)	-	(133)	(121)	-	(121)
(6,300)	Debtors	(1,413)	4,693	(6,106)	12,314	2,743	9,571
5,802	Creditors	1,420	(100)	1,520	6,209	13,500	(7,291)
-	Provisions	110	-	110	945	-	945
32,700	Receipt from asset sales	-	1,000	(1,000)	972	1,900	(928)
38,400	Net operating cash flow	(1,545)	4,500	(6,045)	(2,475)	6,582	(9,057)
(8,000)	Capital expenditure	(772)	(600)	(172)	(6,825)	(5,900)	(925)
(2,800)	Net interest received/(paid)*	145	(700)	845	493	(2,100)	2,593
27,600	Net cash flow before financing	(2,172)	3,200	(5,372)	(8,807)	(1,418)	(7,389)
(9,300)	Capital dividends paid	-	-	-	(3,526)	(4,700)	1,174
-	PDC received/(repaid)	-	-	-	(20,000)	4,500	(24,500)
(19,000)	Net Loans received/(repaid)	-	-	-	47,163	6,000	41,163
(700)	Net movement in cash	(2,172)	3,200	(5,372)	14,830	4,382	10,448

EXECUTIVE SUMMARY

1.0	Subject: Performance Report – December 2007												
2.0	Introduction: This Report incorporates the material previously reported within the Performance and Clinical Governance Reports as previously agreed by the Board. It covers Standards of Patient Care, Targets and Respect and Pride – HR Workforce Data.												
3.0	<p>Summary: The Q2 risk ratings ratified from the London Provider Agency (LPA) Board for the Trust are:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: black; color: white;"> <th style="text-align: left;">RISK</th> <th style="text-align: center;">ASSESSMENT</th> <th style="text-align: left;">PROVIDER AGENCY COMMENTS</th> </tr> </thead> <tbody> <tr> <td style="vertical-align: top;">Finance</td> <td style="text-align: center; background-color: red; color: white;">1</td> <td> Agreed Q2 projection of £39.9m deficit as the basis for the plan for the remainder of this year. LPA to continue to closely monitor progress against the Trust’s action plan going forward, including implementation of its revised turnaround programme and strengthening financial systems and controls. Weekly updates of progress, including cash flow projections to continue. </td> </tr> <tr> <td style="vertical-align: top;">Governance</td> <td style="text-align: center; background-color: red; color: white;">Red</td> <td> The Trust has been rated red on Governance primarily in relation to concerns with financial controls and due to the significant issues around clinical quality and service performance. LPA recognise that the new management team has taken action to address these concerns and we would expect to see the governance rating improve when substantial progress has been achieved. Noted that progress will be closely monitored by the Board in each of the key areas (maternity, orthopaedics, blood transfusion, gynaecology, and breast screening), through the Trust’s Service Improvement Plan. As agreed at the recent review meeting, LPA to continue to closely monitor progress against these action plans and Board progress reports on an ongoing basis. The Gynaecology review is due in December and LPA expect to agree the action plan subsequently and monitor on an ongoing basis. </td> </tr> <tr> <td style="vertical-align: top;">Services Provided</td> <td style="text-align: center; background-color: yellow;">Amber</td> <td>Amber rating relates to invoice disputes with Havering PCT. Noted that the Trust is in negotiations with the PCT with respect to over performance and we would expect you to resolve negotiations locally.</td> </tr> </tbody> </table>	RISK	ASSESSMENT	PROVIDER AGENCY COMMENTS	Finance	1	Agreed Q2 projection of £39.9m deficit as the basis for the plan for the remainder of this year. LPA to continue to closely monitor progress against the Trust’s action plan going forward, including implementation of its revised turnaround programme and strengthening financial systems and controls. Weekly updates of progress, including cash flow projections to continue.	Governance	Red	The Trust has been rated red on Governance primarily in relation to concerns with financial controls and due to the significant issues around clinical quality and service performance. LPA recognise that the new management team has taken action to address these concerns and we would expect to see the governance rating improve when substantial progress has been achieved. Noted that progress will be closely monitored by the Board in each of the key areas (maternity, orthopaedics, blood transfusion, gynaecology, and breast screening), through the Trust’s Service Improvement Plan. As agreed at the recent review meeting, LPA to continue to closely monitor progress against these action plans and Board progress reports on an ongoing basis. The Gynaecology review is due in December and LPA expect to agree the action plan subsequently and monitor on an ongoing basis.	Services Provided	Amber	Amber rating relates to invoice disputes with Havering PCT. Noted that the Trust is in negotiations with the PCT with respect to over performance and we would expect you to resolve negotiations locally.
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	Quality and Safety	Amber	<p>18 weeks – The LPA notes the Trust recognises the risk in not achieving this target. LPA have received a copy of schedules on the stages of treatment in relation to the 18 week target</p> <p>A&E – Since the opening of Queens Hospital, Trust performance has remained below the national standard. Despite a number of action plans being pursued by both the Trust and local health economy performance remains poor. The Trust has identified delayed transfers of care, A&E care pathways and staffing as the principle reasons for the under performance. The Trust must forward weekly to the LPA a 7 day breach analysis report and a progress update on the action plan.</p> <p>It should be noted that the target will not be met in 2007/08</p> <p>Annual Heath Check – The Trust core standard declaration was qualified by HCC on the privacy & dignity standard, in relation to the mixed sex issue. Whilst the trust has addressed the mixed sex issues with regards to Gynaecology, mixed sex issues at KGH will require significant investment to fully resolve. The trust has agreed to closely monitor mixed sex status and escalate daily.</p>
	<p>The Q3 submission will be made to the LPA on 31st January 2008 and their revised ratings for Q3 are due to be released at the end of February 2008.</p> <p>Following the establishment of a Strategy and Service Improvement Board, the attached programme updates will be provided to Trust Board members on a monthly basis. With effect from the February Trust Board meeting, all programmes marked “red” will have an accompanying paper detailing the reason for the rating, mitigating action to be taken and next steps.</p> <p>4.0 Action: The Trust Board is asked to note this report, in particular the “red” rated areas within the Strategy and Service Improvement Board updates, which the Strategy and Service Improvement Board is monitoring required further actions.</p> <p>5.0 Linkage to Corporate Aims: To deliver the Trust’s Corporate Objectives agreed by the Trust Board at their meeting on 27th November 2007.</p> <p>6.0 Presented by: Dr Yasmin Drabu, Medical Director, John Goulston, Interim Chief Executive, and Trevor Smith, Director of Finance.</p> <p>Authors: Jacky Kutner, Ranjita Sen and Charles Wellington</p> <p>Date: 21st January 2008</p>		

1. Domain 3: Standards of Patient Care

1.1. CLINICAL AND COST EFFECTIVENESS

Mortality rates for all and non-elective cases are slightly above the two year average for the month. Emergency readmissions remain around 2% up on historic levels and have been so since the end of 2005. Previous benchmarking has indicated a similar pattern nationally.

1.2. PATIENT FOCUS

The complaint response rate for the month is down due to the impact of the Christmas break.

1.3. ACCESSIBLE AND RESPONSIVE CARE

Some data is not yet available this month. Based on a mix of this and last month's data, eight Key Performance Indicators (KPIs) are currently outside target as detailed below:

- **Trauma and Orthopaedics** - Fractured Neck of Femur Time to Theatre and Mortality. Data collection for the former has now been addressed and will commence from next month.
- **Maternity** - Midwife to Birth Ratio, Midwife Vacancies and Midwife to Supervisor ratios are currently outside target.
- **Breast Screening** - Number Screened as Percentage of Number Invited is outside target. Other indicators are now within target having previously been outside.

1.4. CARE ENVIRONMENT AND AMENITIES

A number of indicators are included for the first time. There have recently been two flooding incidents at Queen's Hospital (9th December 2007 – Endoscopy; 10th January 2008 – Biochemistry).

2. Domain 4: Targets

2.1. ELECTIVE SERVICES AND OUTPATIENTS

We have reported eight inpatient month-end breaches for December in the specialties of General Surgery, ENT, Dermatology, General Medicine and Gynaecology. Most of these breaches were due to failure in the process of "cashing up" (reconciliation and checking) of clinic outcome forms with TCI cards which was introduced some months ago.

General Managers continue to reiterate to clinic staff the importance of cashing up clinic outcomes and the process for ensuring that TCI cards for patients to be added to the waiting list are being taken to Admissions Offices and subsequently added to a waiting list on PAS. The process itself is robust, but the importance of adhering to the policy needs to be reinforced to the Admissions staff.

Some work will be undertaken shortly to identify whether the breaches reported so far can pinpoint problems with particular areas within Admissions.

2.1.1. Implications

The Trust has now reported 34 inpatient breaches in total which, based upon thresholds used to assess the Trust against this target in the 2006/07 Annual Health Check and a projection of the proportion of activity that these breaches represent, the Trust still remains in the "Underachieved" category in the target scoring. This is also based upon the assumption that further breaches are not reported throughout the year which could lead to failing this target overall.

Based upon the thresholds applied in the 2007/08 Annual Health Check ratings, if breaches exceed 0.15% of elective activity (minus planned) then we will fail this target. 34 breaches reported so far represents 0.12% of 2006/07 full year activity (elective minus planned) and so with 34 breaches we are now at a much higher risk of failing the target altogether.

2.2. EMERGENCY SERVICES

Performance for the year to date against the A&E four hour target, including attendances at primary care run urgent care centres, is 94.01%. During December, King George A&E performance reduced again and averaged 90.51% (95.3%% in November) whereas performance at Queen's Hospital A&E deteriorated further in December and averaged 80.41% (87.03% in November).

The following issues have also contributed to A&E breaches:

- Gray's Court Community facility continues to have beds closed due to staffing issues.
- The Trust continues to experience short periods of bed closures due to outbreaks of diarrhoea and vomiting.
- Sky A Ward has opened as a 30 bedded medical ward with the expectation that patients will be seen and their care plans will be more robust. This should be an improvement on the previous arrangement where CDU was being used on an ad-hoc basis.
- The Trust continues to experience severe medical staffing shortages within A&E despite trying to source locums in agencies within and outside our PASA arrangement.

Despite recent interviews where existing vacancies were filled the Trust continues to have unfilled training and Trust doctor posts. These posts are being advertised on E-rec and in the British Medical Journal (BMJ) and a selection of national recruitment agencies have been approached in an effort to fill these posts on temporary basis. Some success has been achieved with regard to nurse recruitment and new staff are starting imminently.

- At the end of December Delayed Transfers of Care (DTCs) occupied 4.1% of beds available. The threshold to achieve this target, used by the Healthcare Commission for the 2006/07 Annual Health Check rating exercise remains at 3.5%. The year to date position is 3.22%. The December increase will need to be monitored further.

See Appendices: *490-A&E 4 Hr Target* and *500-A&E Attendances*, *540-DTOC with Acute beds* and *550-DTOC*

2.2.1. Implications

A&E breaches are a key indicator of potential problems across the emergency patient pathway, both within the Trust (e.g. bed management) and in the broader health economy and its inhabitants (e.g. long term conditions management). The yearly performance target will not be met.

2.3. 18 WEEKS

Improvements are continuing in terms of the capturing of data from outpatient clinics that enable the Trust to monitor patient pathways, with a further 10% improvement over the last 4 weeks. This means that data is being captured for 80% of patients entering the outpatient setting.

A reporting tool will now be circulated that will enable the “tracking” of patients pathways for those whose waiting times are between 11-14 weeks.

A Validation Team is now in place to provide data quality checks and to “close down” patient pathways where treatments have occurred.

The Trust continues to meet weekly with PCT representatives working collaboratively to meet maximum waiting times of 2 weeks for diagnostic tests, 5 weeks for outpatient appointments and 11 weeks for a day case or inpatient procedure, all of which increases the likelihood that patients will have been referred from GP and Treated or discharged within the maximum 18 week target.

2.3.1. Implications

The following waiting times milestones have been agreed with the NHS to be achieved by the end of March 2008:

- For admitted patients, 85% to start treatment in 18 weeks or less
- For non-admitted patients, 90% to start treatment in 18 weeks or less.

2.3.2. Actions

The Performance Ream are in the process of producing two Priority Treatment Lists (PTL), one for validation and one for tracking.

The outsourcing of day case, inpatient and Endoscopy services has commenced. Patients are being offered the choice to continue their care pathway within the Trust or at an alternative provider, if clinically suitable. The requirement for outsourcing of outpatient activity for Orthopaedics is under review.

In order to improve performance, outpatient outcome compliance reports continue to be distributed within the Trust identifying particular specialty clinics where outcomes have not been captured.

See Appendices: 470-18 weeks

2.4. PATIENT FLOWS

Provisional figures for December suggest that the trust will be reporting over 60 cancellations and ten 28 day breaches.

However, over 30 of the cancellations this month were due to a flood in the Clinical Diagnostic Unit, which meant having to cancel procedures for around two days. A further problem was a breakdown of equipment in the Angiography laboratories, which has now been rectified.

Bed pressures continued in December and were the main reason behind 15 of the cancellations this month.

2.4.1. Implications

The threshold for achieving the national cancelled operations target is that cancelled operations should not exceed 0.5% of elective activity. The Trust's cancelled operations rate is currently approaching 1% of elective activity and therefore it is unlikely that this performance target will be met for 2007/08.

3. Domain 5: Respect & Pride

3.1. WORKFORCE

Targets not yet established. Data covers the following issues:

- Staff numbers
- Sickness absence
- Age profile
- Ethnic profile
- Stability – length of service

Staffing incident reports have increased from 72 in September to 120 in December, virtually all relating to staff shortages (See Domain 3 – Safety).

4. Emerging Issues

4.1. HOSPITAL ORGANISATION: SPECIALTY MIX AND MRSA

The Department of Health have published a document on investigating factors associated with Trust-level differences in MRSA rates, however these factors may have changed over time and the implications of these results for current and future policy.

This document presents an analysis of the contribution of organisational factors, such as bed occupancy rates, cleanliness and use of temporary staffing; to understand the variations in MRSA rates between different hospitals. The paper also examines how these relationships may have changed over time.

4.1.1. Actions

A copy of the paper has been forwarded to the Director of Infection Control and Prevention and the Trust's Infection Control Leads – for general information.

4.2. IMPLEMENTATION PLAN FOR REDUCING HEALTH EQUALITIES IN INFANT MORTALITY

The plan is about delivering the recommendations and themes of the Health Inequalities Infant Mortality PSA Target Review. Building on the key interventions in the review, it shows how to narrow the health inequalities gap in infant mortality by looking at current examples of good practice. The actions in this plan will contribute to meeting the target, and improving infant and child health for all disadvantaged groups.

The plan identifies the key features of effective service planning that local commissioners and providers can use to help reduce health inequalities in infant mortality. These include raising awareness of the target, encouraging ownership of the target through effective performance management and improving access to maternity care.

4.2.1. Actions

A copy of the plan has been forwarded to the Director of Midwifery and the General Manager for Maternity for consideration of the impact on their service.

EXECUTIVE SUMMARY

1.0	Subject: Turnaround Monitoring
2.0	Summary: This is the Turnaround programme monitoring report.
3.0	Action: The Trust Board is asked to note the performance monitoring for Turnaround.
4.0	Presented by: Trevor Smith, Director of Finance Author: Steve Hopkins, Head of Turnaround Date: 23 rd January 2008

EXECUTIVE SUMMARY

1.0	Subject: Finance Committee Terms of Reference
2.0	Summary: The Trust Board at its meeting on 27 th November 2007 agreed that, as part of the Governance Improvement Programme, a Finance Committee would be established to monitor progress on turnaround and financial planning performance and policy.
3.0	Action: The Trust Board is asked to approve the draft terms of reference for the Finance Committee.
4.0	Linkage to Corporate Aims: Governance and Financial Turnaround.
5.0	Author: Trevor Smith, Director of Finance Date: 23 rd January 2008

DRAFT TERMS OF REFERENCE

Name of Committee / Group / Board

FINANCE COMMITTEE

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:

- x Trust Board Chair
- x Two Non Executive Directors
- x Chief Executive
- x Director of Finance (Executive Director Lead)
- x Director of Planning and Performance

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 Turnaround Plan.

Terms of Reference

Financial Policy, Planning and Performance:

- x To consider the Trust's financial strategy, in relation to both revenue and capital.
- x To consider the Trust's annual financial plans and targets including the strategic investment programme.
- x To review the annual budget, before submission to the Trust Board.
- x To consider the Trust's financial performance in terms of income, expenditure, cost improvement and turnaround programmes
- x To review proposals for major business cases with capital or revenue costs of over £1m.
- x To commission and receive the results of in-depth reviews of key financial issues affecting the Trust.
- x 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.
- x To consider and agree the Trust's Treasury Management Policy and monitor performance
- x To receive and consider, as appropriate, reports on "commercial" activities of the Trust.

Other duties

- x To monitor and make recommendations on as necessary on the adequacy and effectiveness of the Trust's performance reporting.
- x 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.
- x To examine any other matter referred to the Committee by the Trust Board.
- x 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. 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 at least quarterly.

Agenda and Minutes

The Finance Committee will be serviced by the Personal Assistant to the Director of Finance.