MEETING OF THE
BOARD OF DIRECTORS

AGENDA

Wednesday 28th September 2011

Trust Offices Meeting Room

Homerton University Hospital NHS
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS OF HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

Wednesday 28th September 2011 at 08:30 – 12:00

St Leonards Hospital

AGENDA

No.	*Item*		*Attachment*
1.	**Chairman's welcome and introduction**	MC	
2.	**Introduction to discussion with Chief Executive, NHS East London and City*** **	NH/JF	11/70
3.	**08:45 - Discussion with Alwen Williams, Chief Executive, NHS East London and City*** **	NH	
4.	**Apologies for absence**		
5.	**Declaration of interests regarding items on the agenda**		
6.	**Minutes of the meetings held on 27/07/2011 and matters arising not covered elsewhere on the agenda.**	MC	11/71
7.	**Chairman's Report** Annual Members Meeting Non-Executive Director Appointments Governor Appointments	MC	
8.	**Chief Executive's Report:** Resignation of Director of Environment Response to recent civil unrest ESR Incident	NH	
9.	**Quality and Safety**		
	9.1 Infection Control Q1 Report	CS	11/72

9.2	Patient Experience, Quality and Serious Incident Report	CS	11/73
9.3	Self Certification for Quality Governance	CS	11/74

10. Corporate Governance

10.1	Monitor Feedback on Annual Plan	JF	11/75
10.2	Homerton Q1 2011-12 Monitoring Results Notification	JF	11/76
10.3	Appointment of External Auditors	JF	11/77

11. Business Planning & Performance Management

11.1	Finance and Performance Report Month 05	JF/TF	11/78
11.2	Olympic Planning Update (verbal)	TF	
11.3	EPR Contract Update (verbal) ***	TF	

12. Strategy and Policy

12.1	Board Response to Sector Developments (verbal)	NH	

13. Human Resources Governance

13.1	AAC Ratification	CC	
13.2	Workforce Investigatory Matters (verbal)	CC	
13.3	Workforce Related Risk Update***	CC	11/79

14. Committee Reports

14.1	Risk Committee 15th September	DS	11/80

15. Any Other Business

*** Reserved Business

To be followed by a tour of Community Services at St Leonards including Foot Health, Wheelchair Services and Mary Seacole Nursing Home.

Dates of forthcoming meetings

Board of Directors - Wednesday 26th October 2011

Joint Council of Governors and Board of Directors – Thursday 26th January 2012 (17:30)

Homerton University Hospital NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Meeting date: 28th September 2011

Agenda Item: 6
Paper: 11-71

Title:	**Minutes of the meetings held 27th July 2011**

Summary	This document records the items discussed at the Board of Directors meeting held on 27th July 2011.

Action:	The Board are asked to approve the minutes as an accurate record of the matters arising

Prepared by:	**Sallie Rumbold, Programme Director CHS Integration**
Presented by:	**Michael Cassidy, Chairman**

Compliance:	Terms of Authorisation - Condition 5 - Governance

Homerton University Hospital NHS
NHS Foundation Trust

Meeting of the Board of Directors
Wednesday 27th July 2011

Present:	Michael Cassidy	Chairman
	Nancy Hallett	Chief Executive
	Cheryl Clements	Director of Workforce and Education
	Andrew Panniker	Director of Environment
	Charlie Sheldon	Chief Nurse & Director of Governance
	Tracey Fletcher	Chief Operating Officer
	Dr John Coakley	Medical Director
	Eric Sorensen	Non-Executive Director
	Imelda Redmond	Non-Executive Director
	David Stewart	Non-Executive Director
	Professor Michael Keith	Non-Executive Director
	Stephen Hay	Non-Executive Director
	Professor Chris Griffiths	Non-Executive Director
Minutes:	Sallie Rumbold	Programme Director CHS Integration

1.0 Welcome and Introduction

Michael Cassidy, Chairman, opened the meeting

2.0 Apologies for absence

Jo Farrar, Finance Director

3.0 Declaration of interests regarding items on the agenda

None

4.0 Minutes of the previous meeting held on 29/06/2011 and matters arising

The minutes of the previous Board of Directors were agreed with the following amendment. Imelda Redmond had given apologies for the June meeting

5.0 Chairman's Report

None

6.0 Chief Executive's Report

Nancy Hallett briefed the board on the quality and risk issues currently in the media related to Stepping Hill Hospital and the recent documentary on maternity services in London.

The Board was informed that Andrew Panniker, Director of Environment would be leaving the Trust to take up a post at The Royal Free Hospital after 10 years working at the Homerton. The post would be advertised in September and interim cover arrangements put in place to support the current building programme.

Ms Hallett also informed the Board that Professor Kate Costeloe would be formally retiring from her NHS practitioner role this week. Professor Costeloe will retain an ongoing academic contract with the medical college over the next 2 years. The Board also heard that Dr Christine Blanshard, Associate Medical Director would be leaving the Trust at the end of August, to take up a post as Medical Director at Salisbury Hospital.

Ms Hallett updated the Board on the recent evening meeting with GPs which had been very successful and well attended. A number of hospital consultants had also attended and the main focus had been discussions related to long term conditions and emergency care. Tracey Fletcher, Chief Operating Officer explained that a structure would be put in place to support improved communication between the Trust and GPs particularly those outside of City & Hackney who were increasingly referring to the Homerton.

The Board heard that the September Board meeting would be held on the St Leonard's site and would provide an opportunity for Board members to visit community services on site and also the Mary Seacole Nursing Home. A formal letter had been sent to NHS East London & City to highlight the potential safety and reputational risks related to the state of repair of buildings and lack of security on the St Leonard's site.

An update on the management restructure was provided under reserved business.

7.0 Quality and Safety

7.1 Mandatory and Statutory Training Plan

Cheryl Clements, Director of Workforce and Education presented a paper which explained the current issues with mandatory and statutory training and outlined opportunities and options for addressing these issues. Compliance levels for statutory and mandatory training remain low despite some recent improvements. A recent internal audit by KPMG gave a limited assurance rating and highlighted six main areas requiring action. Action plans were now in place to improve compliance rates and to specifically address the issues within the audit report. The Board discussed the reasons for difficulty with data capture, the significance of low compliance rates, the actions in progress and the potential risks and consequences of low compliance with reported statutory and mandatory training as well as the actions being taken to improve both reporting and attendance. The Board will receive regular updates on progress against action plans.

7.2 Patient Experience, Quality and SI Report

Charlie Sheldon presented a report showing the Trust's performance against a range of quality and patient experience indicators as well as updates on specific actions and projects. The SUI report was appended. The Board heard how work to improve response times to complaints is ongoing. Mr Sheldon explained that where possible indicators were being used which included comparisons against other Trusts or against national guidance. Incidents reported were above 250 per month which is a positive measure against guidance from the NPSA. Falls data had been compared against seven similar trusts and 5 had been found to have higher levels than Homerton. Mr Sheldon explained that the mandatory national outpatient survey is currently underway and halfway through the collection period the Trust has a response rate of 26% which is very positive at this stage. The inpatient survey will be issued in September and will invite participation from the August inpatient cohort. The hospital standardized mortality rate (HSMR) indicates that the Homerton is not an outlier in terms of mortality rates. An SUI review process is in place with NHS East London & City and is working well. Professor Griffiths requested that dates for actions completed be included in the SUI

report. The Board heard about the work of the Patient Safety Committee chaired by Charlie Sheldon and also the process for 48 hour meetings which take place when a serious incident occurs.

7.3 Safeguarding Children Annual Report

Charlie Sheldon presented the Annual Safeguarding Report for the Homerton and also the final Safeguarding Children Report from the pre April 2011 community health services. In future years the reports will be presented as one document. The Board heard that from 1st April 2011 the safeguarding children structures and processes within the integrated organization have been under review and a plan put in place to integrate acute and community health teams and their separate safeguarding children activities. The key objectives for 2011/12 are to integrate the acute and community safeguarding teams, to have an integrated child protection training programme, to produce an integrated child protection policy with updates reflecting the recent changes as a result of the Munro review, to produce an integrated child protection supervision policy and to implement supervision for hospital staff involved in safeguarding children.

Mr Sheldon explained about the designated and named doctor roles and the plans in place to continue with a named doctor for community and also a named doctor for acute services. The designated doctor, Dr Anne Nesbitt would be retiring at the end of August. Dr Nesbitt has considerable experience in this field and her departure will leave a significant gap in expertise which will need to be filled. The Trust would be working with NHS East London & City to support recruitment to this post as the designated role formally sits within commissioning but has historically been provided from within community health services as a provider. Michael Cassidy, Chairman reiterated the importance of safeguarding posts being protected from funding reductions. Professor Michael Keith asked about CQC and OFSTED inspections related to safeguarding. Charlie Sheldon informed the Board that Hackney is due an unannounced OFSTED safeguarding inspection at any time now which will include acute and community health services as well as all related services within the local authority. The CQC attend these inspections alongside the OFSTED inspectors and the Board will be kept informed.

7.4 Infection Control Annual Report

Vicky Longstaff, Acting Director of Infection Prevention and Control attended the meeting to present the Infection Control Annual Report 2010/11. Although the Trust breached its MRSA target in 2010/11 with 7 attributable bacteraemias the Board heard that there had been no new MRSA bacteraemias in quarter 4 of 10/11 which suggested that the remedial measures put in place in actions plans have been effective. . These measures were now becoming embedded as routine practice. The Trust had 10 attributable Clostridium *difficile* infections against a target of 52 for 2010/11. All 10 cases were reported as serious incidents and investigated accordingly. Ms Longstaff summarized the contents of the report which included the infection control arrangements in place during 2010/11, cleaning services arrangements, HCAI statistics and progress with audit and education programmes. The infection control report will be made available to the public on the Trust internet in accordance with the requirements of the Health and Social Care Act.

7.5 Self Certification for Quality Governance

The Board is required to make a declaration to Monitor at the end of Quarter 2. Charlie Sheldon presented the report which summarized key actions needing to take place prior to the September declaration. The Board noted the KPMG 2011/12 Internal Interim

Audit Report on Quality Governance which is an assessment by KPMG of Trust compliance against Monitors Quality Governance Framework (July 2010). Mr Sheldon explained that the Governance team would be developing a system for the Board to continuously assess performance against the Quality Governance Framework which will be aligned to the CQC compliance framework and the Board Assurance Framework. The Board discussed how the frameworks and quality outcomes all fit together. The Board noted the importance of the new divisions embedding quality assurance within their structures and processes.

7.6 Annual Risk Performance Report

Charlie Sheldon presented the Annual Risk Performance Report which provided a summary to Board of the information held on the Trust's risk register for the period January 2010 to January 2011, including new and closed risks. Future recommendations include updating the register to include risks from finance and the continuation of risk management training for staff. The Risk Management Strategy will be revised to reflect the process needed to ensure risks are reviewed at the correct level within the organization.

8.0 Corporate Governance

8.1 Board Assurance Framework 2011/12 Q1

Charlie Sheldon presented the Board Assurance Framework 2011/12 for Quarter 1. The Board noted and agreed the contents of the Board Assurance Framework and discussed the review processes in place currently. The Executive Team review the Board Assurance Framework on a monthly basis and changes are then presented to Board.

8.2 Draft Agenda Annual Members Meeting 15th September 2011

The Board noted the date of the next meeting and discussed the draft agenda. The Board discussed the model constitution and also the skills development programme for Governors. Charlie Sheldon reported that a booklet had now been produced to help potential and current Governors prepare adequately for their role.

8.3 Constitutional Review

Charlie Sheldon provided a verbal update on the constitutional review.

8.4 Q1 2011/12 Submission to Monitor

Nancy Hallett presented the papers setting out the three declarations the Trust is proposing to make to Monitor in relation to governance, finance and quality. The Board confirmed the proposed Q1 declarations.

8.5 Nominations Committee Terms of Reference

Charlie Sheldon presented the proposed terms of reference for the Nominations Committee of the Council of Governors. The Board approved the Terms of Reference subject to final approval by the Council of Governors at their next meeting.

8.6 Tender Process Update***

9.0 Business Planning & Performance Management

9.1 Finance and Performance Report Month 3

Fiona I'Anson, Deputy Director of Finance attended the meeting to present the Month 3 Finance and Performance Report. Ms I'Anson reported that activity and income levels were above plan in June across a range of specialties. The Trusts surplus for the three

months to June was ahead of plan by 955k. The 2011/12 acute contract sign off with NHS East London and City was now imminent and agreement had been reached on the local interpretation of the readmission policy. The Trust is currently on track to meet all Monitor performance targets for quarter 1. Community health services indicators remain developmental.

Tracey Fletcher, Chief Operating Officer reported on the current position against the new A&E standards during July. Only one indicator had been missed during the past week. Ms Fletcher explained that the cancer target was at risk for July due to the unusually low number of patients this month. The Board would be kept updated. Ms Fletcher also reported on progress against childhood immunization targets which are low across the Borough of Hackney. Community health services such as health visiting and school nursing services contribute to this target along with primary care and public health. Hackney has one of the lowest immunization rates in London and as such the Board will be kept updated on progress against the Borough wide action plan. Quarter 1 performance will be reported at the September board meeting.

9.2 2011/12 QIPP Position***

This item was discussed under reserved business.

9.3 EPR Contract Position***

This item was discussed under reserved business.

10.0 Strategy and Policy

10.1 Update Position

Ms Hallett provided the Board with a verbal update on strategic issues affecting Trusts across North East London currently.

11.0 Human Resources Governance

11.1 AAC Ratification

Cheryl Clements, Director of Workforce & Education reported on recent interviews for a Radiology Consultant post where references are awaited.

11.2 Workforce Investigatory Matters***

This item was discussed under reserved business.

11.3 Workforce Related Risks Update***

This item was discussed under reserved business.

12.0 Any Other Business

The Non Executive Directors received statutory risk management training following the meeting.

Homerton University Hospital NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Meeting date: 28th September 2011 **Agenda Item: 8.1**
Paper: 11-72

Title:	**DIPC Quarterly Report (Q1)**

Summary:	This paper provides a summary of infection prevention and control issues during the first quarter of 2011/12.

Action:	The Board is asked to note the attached report

Prepared by:	**Vicki Longstaff, Infection Control Nurse Consultant/Deputy Director of Infection Prevention and Control**
Presented by:	**Charlie Sheldon, Chief Nurse & Director of Governance**

Compliance:	*The Hygiene Code and Core standards C4a, C4c, C21*

HOMERTON UNIVERSITY HOSPITAL

DIPC QUARTERLY REPORT

Quarter 1 2011/2012
(April-June 2011)

Vickie Longstaff

Table of Contents

1 Executive Summary: Quarter 1 11/12 (April - June 11)

a) MRSA bacteraemia and CDI Objectives 11/12

- The Homerton-attributable MRSA bacteraemia Objective for 11/12 is 3 Homerton-attributable cases.
- The Homerton-attributable CDI Objective for 11/12 is 12 Homerton-attributable cases.

b) Code of Practice Compliance – Q1 11/12:

- The HCAI task group continues to meet on a quarterly basis and review the Trust's progress in populating a complete evidence base of documentation demonstrating Code of Practice compliance using the Klarient Hygiene code self-assessment tool.

c) Quarterly HCAI mandatory surveillance – Q1 11/12:

i) MRSA bacteraemias – Q1 11/12 update:

- Trust-attributable MRSA bacteraemias – Quarter 1 11/12: 0
- PCT-attributable MRSA bacteraemias – Quarter 1 11/12: 0
- Root causes from SI reports: N/A
- MRSA DH bacteraemia target 10/11: 4
- {Total Trust-attributable MRSA bacteraemia cases 10/11: 7}

ii) Clostridium difficile infections (CDI) – Q1 11/12:

- Trust-attributable CDIs – Quarter 1 11/12: 2
- PCT-attributable CDIs – Quarter 1 11/12: 1
- {Total Trust-attributable CDI cases 10/11: 10}

iii) GRE bacteraemias – Quarter 1 11/12: 1 (no targets set)

iv) MSSA bacteraemia – Quarter 1 11/12:6 (no target set)

v) E.coli bacteraemia – Quarter 1 11/12: 21 (no target set)

vi) Surgical Site Infections (THR & TKR):

- SSI data is collected on Total Hip Replacements (THR) and Total Knee Replacements (TKR) as part of the national SSI Surveillance programme. The summary data, with national comparisons, is available 6 months after the time period for which the data is collected.
- In the quarter Jan - Mar 2011 there were no cases of SSI in TKR. There has been 1 SSI in THR. The SSI rate for the last 4 quarters for THR is high at 5.6% compared to all hospitals rates of 1-1.5%. The single infection episode was a THR revision, the patient had an ASA score of 3, aged between 71-80 years, had a deep incision infection and MSSA was isolated.

d) Incidents and outbreaks– Q1 11/12:

- There was an outbreak of diarrhoea and vomiting on Lamb ward due to Norovirus in April
- There was a cluster of Rifampicin resistant MRSA in SCBU in May.

e) IPC audit programme – Q1 11/12 update:

i. The ICNA audit programme:
There are 19 department/ward audits planned for the year. For 2011/2012 quarter 1 no audits have been completed. Over the next quarter the audit programme will be on track with 10 audits planned and to be completed by the new Community ICN and an additional person

ii. HII monitoring – Q1 11/12::
- Includes: IV line ongoing care, urinary catheter ongoing care, IV cannula insertion, & hand hygiene.
- The HII scores for each division were 90% or over for Quarter 1 2011/2012.
- HII monitoring results are discussed at the Matron's Monitoring Group and at ward level so that local action plans can be drawn up and implemented.

iii. Trust-wide audits – Q1 11/12::
- Sharps bin audit
- Blood culture contamination
- Surgical antibiotic prophylaxis

f) Matron's Monitoring Group – Q1 11/12:

- The main focus of the MMG over the past quarter continues to be the HII monitoring and cleanliness. Methods to improve compliance with HII actions have been discussed and shared. This is ongoing work to ensure that the high standards are maintained. Monitoring against the National Standards of Cleanliness continues with input from nursing staff at all levels. Cleanliness standards are improving and any areas of lower scores are escalated immediately. DSO has been some additional work on MRSA screening compliance to ensure that all patients who require one are screened prior to admission.
- The MMG has also been reviewing some new products available and as a result the Trust is purchasing some infection control screens for use on open wards when patients require infection control precautions.

g) IPC education programme – Q1 11/12:

IPC annual update training has been completed by 59.2% of Trust staff. The mandatory training programme for all staff is being reviewed to ensure training is accessible to all. The Infection prevention and Control update leaflet will be going out to all staff in September and October via payslips.

h) IPC balanced scorecard – Q1 11/12 :

The IPC balanced scorecard data for Q1 11/12 is available as a separate excel spreadsheet as detailed in Appendix 2.

i) IPC risk register – Q1 11/12:

- The following risks are on the IPC Risk Register
    - Risk of legionella (rating 16) – policy reviewed and updated
    - IPC annual update training (rating: 8) – this remains a challenge although some changes are being made to the mandatory training programme
    - MRSA bacteraemia objective breach (rating 9) – control measures remain in place
    - C.difficile objective breach (rating 9) – control measures in place
    - Elective emergency surgical mix-(rating 10) – this will remain on the register with control measures in place as there are no plans to segregate elective and emergency surgical cases
    - Compliance with all aspects of the Hygiene Code (rating: 4) – to be reviewed at October 2011 ICC
    - Hand washing facilities (rating: 6). - To remain on risk register as the majority of areas did not have sinks located directly in bays (although this will be addressed as part of the refurbishment programme) – to be reviewed at October 2011 ICC
    - Reduced staffing resources in the ICT (rating 6) – this will be reviewed at each ICC meeting to ensure adequate service cover

j) Cleaning services – Q1 11/12:

No issues of concern have been identified in Q1 11/12.

k) Estates and Facilities – Q1 11/12:

Water and Legionella:
The Environment report to the ICC continued to RAG rate the requirement for cold water <20°C and hot water >50°C as 'red' – The Energy Centre design is looking at reducing water storage capacity and using the space as a development area for the installation of de-centralised boiler equipment Absorption chillers are also being considered which will use that waste heat from the CHP UNIT, this cooling may be considered as a cooling medium for the incoming water supplies
Continued pseudomonas testing, chlorination and monitoring. Samples are now being taken on a monthly basis. At present we are working on the limit of acceptability as being 10cfu/100ml for Pseudomonas as recommended previously by the HPU. There are presently no guide lines in this country.

Decontamination:
All decontamination audits compliant.

Ventilation
The July 2011 Environment report to the ICC RAG rated the theatre air changes as 'amber' due to low air change rates in some theatres. Work is planned for July to improve the air flow which should increase the number of air changes per hour in the theatres suites. Planned maintenance programme for theatres is being arranged.

l) Employee Health – Q1 11/12:

Immunity register
High risk areas - Last quarter was 94.79% slightly increased to 94.91%.

Moderate risk areas - The last quarter was 70.72% and slight increase to 71.53%

Exposure prone procedure register
The total number of EPP compliant staff is 98.17% which is a further improvement from the last quarter.

Needle stick/blood splash
There were a total of 28 injuries in the previous quarter against 20 this quarter. May 2011 showed the lowest number of incidents reported since December 2008. Unfortunately this was not sustained and the figure is up again for June. 14 of the incidents involved doctors or medical students, and of this group venepuncture appears to be the highest cause for incidents, and it is hoped that this will improve with the introduction of safe needles.

The ICT and EHMS continue to work together to implement safe needles within the Trust in order to try to reduce the number of needle stick incidents reported within the Trust.
Training has been arranged with SARSTEDT® to do ward-based training sessions on using the safe venepuncture needless.
The new policy for managing Inoculation Injuries continues to be worked on, and DOSH is now involved in the process of reviewing the PEP risk assessment, as DOSH consultants will replace EHMS in giving PEP.

m) Community health services update

The CHS Infection Control Nurse (ICN) left the Trust in July and the post has been appointed into. The Community ICN is based with Acute Services ICNs and all reactive calls are dealt with in the same manner. The audit plan for 2011/12 has been developed. There is also a piece of work going on with the estates and facilities team in relation to the clinical environment. The ICT is going on site visits with the E&F team to assess and evaluate the appropriateness of the environment.

n) IPC policies endorsed by the ICC – Q1 11/12 :

The Managing water quality in hot and cold water distribution systems and Staff health surveillance policy
were endorsed at the July 2011 ICC:

o) Other IPC issues – Q1 11/12::

- One infection control nurse and the Infection control doctor/DIPC are on maternity leave until 2012.
- Mandatory surveillance and reporting of *E.coli* bacteraemias to the HPA enhanced Surveillance website started on the 1st of June 2011.
- The Trust will be participating in the 4th National PPS on Healthcare Associated Infections (HAI) and 1st National PPS on antimicrobial use (AU) quality indicators in September /October 2011.

2 MRSA bacteraemia and CDI Objectives for 2011/12

- The Homerton-attributable MRSA bacteraemia Objective for 11/12 is 3 Homerton-attributable cases.
- The Homerton-attributable CDI Objective for 11/12 is 12 Homerton-attributable cases.

3 Code of Practice compliance

a) The HCAI task group continues to meet on a quarterly basis and review the Trust's progress in populating a complete evidence base of documentation demonstrating Code of Practice compliance using the Klarient Hygiene code self-assessment tool.
b) The Code of Practice for prevention and control of infections has been updated and now contains 10 criteria (previously 9).
c) The compliance with evidence for acute and community services is assessed on the Klarient self assessment tool and presented to the ICC.
d) This is an ongoing piece of work and used to ensure evidence for compliance is available. Criteria 1-5 were completed in the June meeting and 6-10 will be completed at the September meeting.

4 Quarterly HCAI Surveillance Summary: Q1 11/12

4.1 MRSA bacteraemia – Q1 11/12

- The 2011-2012 MRSA objective/target for the Trust is 3 Homerton-attributable (Post-48h) MRSA bacteraemias.
- All Trust-attributable (post-48h) MRSA bacteraemias are automatically Serious Incidents and all non-attributable (pre-48h) MRSA bacteraemias have a Root Cause Analyses performed regardless of clinical outcome.
- In Quarter 1 of 2011/2012 there were no Homerton-attributable MRSA bacteraemias. The last Homerton attributable MRSA bacteraemia was December 2010.
- In Quarter 1 of 2011/2012 there were no non-attributable MRSA bacteraemias. The last non Homerton attributable MRSA bacteraemia was November 2010.

2010/2011 Q1	2010/2011 Q2	2010/2011 Q3	2010/2011 Q4	2011/2012 Q1
3 Homerton attributable 1 Pre 48 hour	2 Homerton attributable	2 Homerton attributable 1 Pre-48 hour	Nil to date	Nil to date

4.2 Trust-attributable MRSA bacteraemia Serious Incident report summaries:
There are no MRSA bacteraemia SI report summaries this quarter.

4.3 Clostridium difficile infection (CDI) – Q1 11/12

- The 2011-2012 C.difficile objective/target for the Trust is 12 Homerton-attributable cases (defined as all *C. difficile* toxin positive stool sample from patients admitted to the Trust, except those collected during the first 3 days of admission.)
- All CDI have a Root Cause Analyses performed regardless of clinical outcome.
- In Q1 11/12 there have been 2 Trust-attributable case of CDI.

2010/2011 Q1	2010/2011 Q2	2010/2011 Q3	2010/2011 Q4	2011/2012 Q1
4 Homerton attributable 4 Pre 48 hour	3 Homerton attributable 0 Pre 48 hour	1 Homerton attributable 0 Pre-48 hour	2 Homerton attributable 0 Pre-48 hour	2 Homerton attributable 1 Pre-48 hour

- Summary of Trust-attributable CDI cases:

Date of admission	Date and place of specimen	Comments/Sources
03/03/2011	18/04/2011 Edith Cavell	The prescribed antibiotics and PPI could have contributed to the development of C.difficile associated diarrhoea but both were indicated.
14/05/2011	17/06/2011 Lloyd	Re-occurrence of infection.

4.4 Trust-attributable CDI RCA report summaries:

a) Edith Cavell (April

Patient admitted to hospital on 03/03/2011 via A&E following a fall from home. Patient had been unwell for 2 days with abdominal pain, vomiting and diarrhoea. Impression was sepsis due to possible flare up of ulcerative colitis, intra-abdominal sepsis or urosepsis. Patient had a diagnosis of listeria in the blood culture on the 07/03/2011 and was treated with a course of IV Amoxicillin and Gentamicin for 21 days with total antibiotic requirement of 6 weeks. Patient started having type 7 stools on 25/03/2011, stool chart was commenced. Patient had Type 7 x 1 stool on 16/04 and 17/04. Stool sample sent on 18/04/2011 was C. difficile positive. Metronidazole started on 19/04/2011 with successful results and the patient recovered. All practices were in line with Trust policy and procedures.

The acquisition of C. *difficile* is difficult to determine as the patient had not been exposed to any patients with C. *difficile* and/or diarrhoea at the Homerton.

The prescribed antibiotics and PPI could have contributed to the development of C.difficile associated diarrhoea but both were indicated.

Recommendations:

All practices were in line with Trust policies and procedures and no recommendations were identified.

Presented to Patient Safety Committee.

b) Lloyd (June)

The patient was previously admitted to hospital on the 03/03/2011 with lethargy, diarrhoea and dark stool, an OGD showed healing ulcer, gastric erosions and mild duodenitis. The patient was commenced on PPI for treatment of duodenal ulcer. The patient had been having diarrhoea since admission and on the 07/03/2011 a stool specimen was sent and the result confirmed C. difficile, she was treated with Metronidazole with successful results. The patient recovered and was subsequently discharged on 23/03/2011. A full RCA was completed for this episode.

Patient was re-admitted on 14/05/2011 with a history of twice daily dark diarrhoea. A stool sample was sent on 15/05/2011 and the result was C. difficile

positive. The patient was on iron tablets and Lansoprazole 30 mg BD for duodenal ulcer. The patient was treated with Vancomycin 125 mg QDS for 14 days and was reviewed by Microbiology. All practices since admission were in line with Trust policy and procedures. The patient responded well to treatment, the diarrhoea resolved, was de-isolated and all precautions discontinued.
The patient started having loose stools again on 07/06/2011 with increased frequency (Type 6 stools x 3) on 08/06/2011. Patient was isolated on stool precautions into a side room, stool chart commenced and was prescribed Metronidazole orally for 10 days on 07/06/2011 but this did not improve patient's diarrhoea so it was changed to Vancomycin on 16/06/2011. On the 17/06/2011 a stool sample was sent and the result came back C. difficile positive. The patient is now on a tapering dose of Vancomycin and is responding well to treatment and being closely reviewed by Microbiology.
The reason for the C. difficile associated diarrhoea was probable recurrence as the patient was at high risk (risk of a recurrence following the first recurrence is 45-60%). The use of high dose PPI could have contributed to this.

Recommendations
All patients with current or past C.difficile infection to be seen on the weekly infection control and microbiology ward rounds until discharge even if asymptomatic and treatment plans shared with microbiology team so everyone is aware of treatment plans.
C. difficile protocol and policy to be used for treatment and follow up of patient with C.difficile infection, where the treatment protocol is not followed rationale to be documented.
Junior microbiology staff to discuss management of all patients with C.difficile infection with microbiology consultant.
On- call microbiologist to validate and authorise results over a weekend.
Presented to Patient Safety Committee

4.5 Glycopeptide Resistant Enterococci (GRE) bacteraemias – Q1 11/12

- There was 1 case of GRE bacteraemia in this quarter.
- There are currently no targets/objectives set regarding GRE bacteraemias apart from the requirement to report them to the HPA Enhanced Surveillance website on a quarterly basis.

4.6 Surgical Site Infection (SSI) update – Q1 11/12

- SSI data is collected on Total Hip Replacements (THR) and Total Knee Replacements (TKR) as part of the national SSI Surveillance programme. The summary data, with national comparisons, is available 6 months after the time period for which the data is collected.
- All THR & TKR SSI data will continue to be reviewed on a quarterly basis at the ICC.
- In the quarter Jan - Mar 2011 there were no cases of SSI in TKR. There has been 1 SSI in THR. The SSI rate for the last 4 quarters for THR is high at 5.6% compared to all hospitals rates of 1-1.5%. The single infection episode was a THR revision, the patient had an ASA score of 3, aged between 71-80 years, had a deep incision infection and MSSA was isolated.

4.7 MSSA Bacteraemia – Q1 11/12

Mandatory surveillance of MSSA bacteraemia started in January 2011. No objective has been set.

Apr-11	**Total 1 (pre 48 hr)**	
	CEA- pre 48 hr	Porta-Cath
May-11	**Total 2 (1 pre 48 hr, 1 post 48 hr)**	
	A&E - pre 48 hr	Soft tissue infection
	SCBU - hospital acquired	line infection
Jun-11	**Total 3 (2 pre 48 hr, 1 post 48 hr)**	
	D/Suite – pre 48 hr	wound infection
	E/Cavell - hosp. acquired	infected haematoma
	A&E - pre 48 hr	cellulitis

4.8 E.coli Bacteraemia – Q1 11/12

Mandatory surveillance of E.coli bacteraemia started in June 2011. No objective has been set.

Apr-11	Total 4 (3 pre 48hr, 1 post 48hr)	Source
	ACU -1 pre 48 hr	urosepsis
	A&E - 2 pre 48 hr	uti, cholecystitis
	Graham - 1 post 48 hr	
May-11	**Total 12 (6 post 48hr, 6 pre 48hr)**	
	A&E - 5 pre 48 hr	pyelonephritis, 3 urosepsis, Cholecystitis
	ACU - 1 pre 48 hr	urosepsis
	SCBU/NICU -2 post 48 hr	neonatal sepsis
	ARU - 2 post 48 hr	subdural abcess, urosepsis
	Graham - 1 post 48 hr	urosepsis
	Lamb -1 post 48 hr	urosepsis
Jun-11	**Total 5 (pre 48 hr)**	
	ACU - 3 pre 48 hr	uti
	A&E - 2 pre 48 hr	urosepsis

5 Incidents and Outbreaks: Q1 11/12

Diarrhoea and Vomitting – Aske ward (April 2011)

There were a total of 15 patients (fulfilling case definition) with diarrhoea and/or vomiting, 6 confirmed Norovirus and 2 negative. During the outbreak, 9 members of staff reported symptoms and went off sick. The ward was closed from the 02/04/2011 – 15/04/2011.

Rifampicin resistant MRSA – SCBU (May 2011)

Routine weekly screening identified 2 babies on SCBU with Rifampicin and Flucloxacillin resistant MRSA (colonised) which appeared to be acquired on the unit. The babies were isolated and the rooms deep cleaned. The isolates were sent to the reference laboratory for typing and confirmed that they were both a rare Berlin clone which is associated with hospital and community acquisition. Both isolates were identical therefore indicating cross infection. The babies have since been discharged and there have been no further cases on the unit.

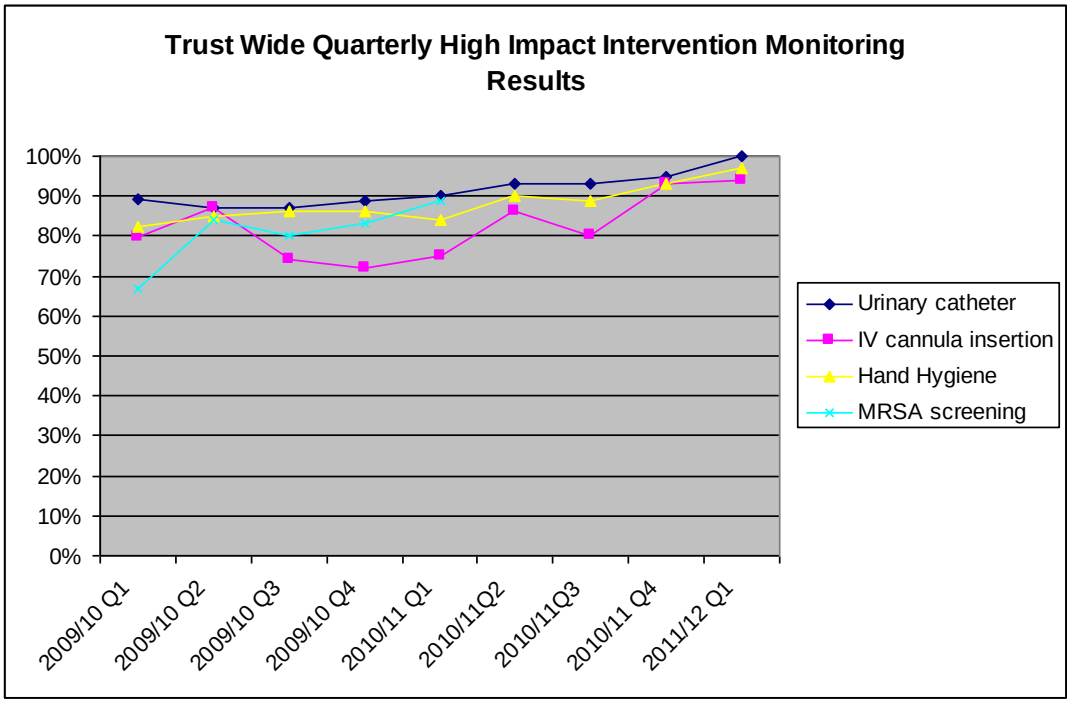
6 IPC audit programme 2011/2012: Q1 11/12 update

6.1 Infection Control Nurses Association Audit Programme 2011/2012

There are 19 department/ward audits planned for the year. For 2011/2012 quarter 1 no audits have been completed. Over the next quarter the audit programme will be on track with 10 audits planned and to be completed by the new Community ICN and an additional person.

6.2 High Impact Intervention (HII) audits: Q1 11/12

- Work continues with ward and departments collecting their data monthly via the Infection Prevention Audit System. Detailed results for each ward and intervention are sent to wards and departments and are available on the intranet or directly from IPAS. For divisional results see the IPC balanced score card in Appendix 2.
- A summary of the HII monitoring results is detailed in the graph below:



- The HII scores for each division were 90% or over for Quarter 1 2011/2012.
- HII monitoring results are discussed at the Matron's Monitoring Group and at ward level so that local action plans can be drawn up and implemented.
- Further details of HII scores by Directorate are available in the IPC Balanced Scorecard in Appendix 2.

6.3 Trust Wide Audit Programme 2011/2012

6.3.1 Summary table of Trust wide audit programme:

Audit and planned date	Audit team/data collectors	Action plan progress
Antimicrobial prescribing - June 2011	ICT/Pharmacy	Audit completed, report pending and to be presented to Oct ICC.
Sharps Audit - July 2011	Daniels	Audit and actions completed
Isolation Audit - October 2011	ICT	
IV Lines Point Prevalence Audit - November 2011	ICT	

Antimicrobial prescribing - December 2011	ICT/Pharmacy	

6.3.2 Surgical antibiotic prophylaxis (April 2011)

The antibiotic prophylaxis given at induction was recorded in main Theatres for a week to assess current practice and compliance with HUH antibiotic policy. A data collection form was distributed each morning to theatre staff to give to Anaesthetists and patient's medical notes were consulted were the recording was incomplete. All patients in surgical lists for main Theatres each day of the week were entered in the audit. A total of 61 patients were reviewed. Overall non-compliance was 11%, found mainly in general surgery. In 5% of patients there was no data recorded in the forms and notes were not accessible at the time of the audit completion so they fell into the Unknown category. There has been a considerable improvement in compliance since the review of surgical prophylaxis policy and training programme.

	G. surgery	Orthopaedics	Obs & Gynae	Urology	Breast	**OVERALL**
June 2009	23%	66%	33%	33%	--------	20.6%
March 2011	71%	85%	90%	100%	100%	84%

6.3.3 Sharps bin audit (July 2011)

Twenty two (22) Wards/Departments were visited during the audit by the sharps bin company and ninety sharps containers were sighted. (Less than previous years due to ward refurbish and building work). The audit found zero (0) sharps containers with protruding sharps, zero (0) that were not properly assembled, and five(5) that were more than three quarters full, (staff were advised to only fill to the line).

One (1) sharps containers were sited on a windowsill or at an unsuitable height or place, staff were advised to have them bracketed if possible or remove them from public areas. A few areas required wall or trolley brackets and this was discussed with the staff and will be provided with these.

All staff understood that the label on the sharps bin was to be completed at assembly as four (4) units were unlabelled through out the hospital.

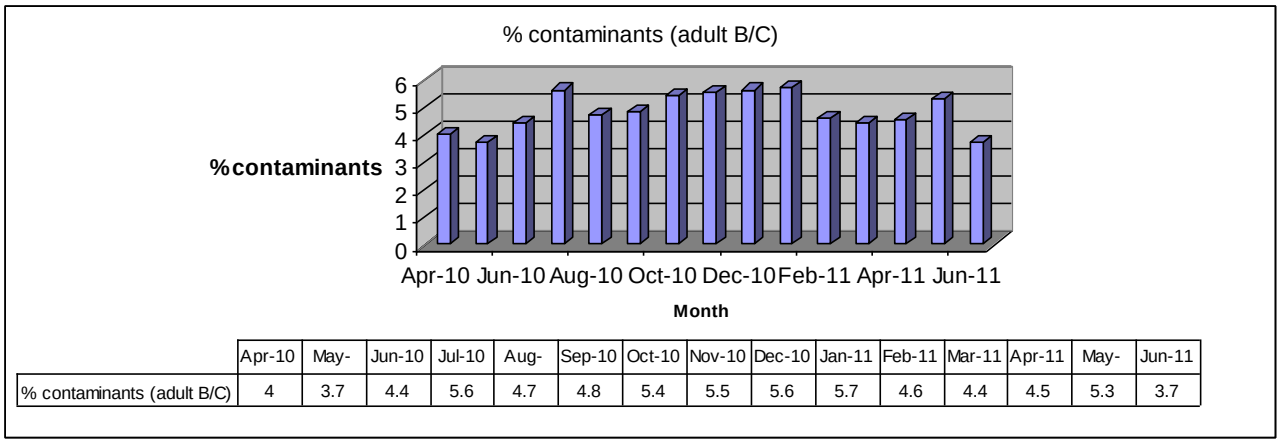
One (1) sharps container had significant inappropriate non sharp contents. Staff were advised not to put packaging or non sharp items in sharps containers.

Small sharps containers and trays were available to take to the bedside.

6.3.4 Blood culture contamination audit

- The measures introduced from April 2010 onwards to decrease blood culture contaminants are continuing to work and the rates remain low at 3.7% for June from previous rates of 7.5- 9.1%.

- Blood culture contamination rates are reviewed on a quarterly basis as part of the IPC team report to the ICC.
- The blood culture policy has been reviewed and paediatrics added. The monitoring of contaminants for paediatric blood cultures will start.



	Apr-10	May-	Jun-10	Jul-10	Aug-	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-	Jun-11
% contaminants (adult B/C)	4	3.7	4.4	5.6	4.7	4.8	5.4	5.5	5.6	5.7	4.6	4.4	4.5	5.3	3.7

7 Feedback from Matron's Monitoring Group: Q1 11/12 update

- The purpose of the MMG is to review and ensure progress on the Infection Control audit programme and action plans at divisional and directorate level. The MMG reports to the ICC.
- Attendance at the MMG remains good and there has been feedback from the Matrons on ward level responses to HIIs and other IPC issues. The MMG functions as an important forum for sharing good practice.
- The main focus of the MMG over the past quarter continues to be the HII monitoring and cleanliness. Methods to improve compliance with HII actions have been discussed and shared. This is ongoing work to ensure that the high standards are maintained. Monitoring against the National Standards of Cleanliness continues with input from nursing staff at all levels. Cleanliness standards are improving and any areas of lower scores are escalated immediately. DSO has been some additional work on MRSA screening compliance to ensure that all patients who require one are screened prior to admission.
- The MMG has also been reviewing some new products available and as a result the Trust is purchasing some infection control screens for use on open wards when patients require infection control precautions.

8 IPC education programme: Q1 11/12 update

8.1 <u>IPC Induction training: Q1 11/12</u>

- All staff attend the Trust induction and the ICT continues to do fortnightly sessions on this programme. IPC training is also part of the junior medical staff induction arranged by medical staffing and the ICT does sessions on this programme covering practices such as Aseptic technique and blood culture taking.

8.2 IPC annual update training: Q1 11/12

- By the end of the Q1 11/12 the following percentages of staff had received IPC annual update training:

Area	Percentage of staff completing IPC annual update (%) [by end of Q1 11/12]
CWSH	51.3%
DSO	59.0%
GEM	49.2%
Workforce	90.1%
Environment	97.7%
Corporate	81.2%
Trust total	57.2%
Trust total (including contracted staff)	59.2%

The Infection prevention and Control update leaflet will be going out to all staff in September and October via payslips.

8.3 Other IPC training: Q1 11/12

- Intravenous and urinary catherterisation study day training continues to include infection control and runs on a monthly basis.
- Student nurse training
- Infection Control Link Practitioner – reduced to every 4 months
- Aseptic Non Touch technique (ANTT) continues as part of all infection control and invasive device/procedure training in order to embed best practice particularly in relation to IV line care.

9 IPC balanced scorecard: Q1 11/12 update

- The following KPIs for IPC have been included: DH indicators, SUIs, alert organism trigger events, Cleaning National Standards Monitoring Tool (by Area and infection risk), Outbreaks, Audits completed, IPC training completed (by area).
- The IPC Balanced Scorecard is available in Appendix 2 of this report and its contents are discussed in the relevant sections of this report.

10 IPC Risk Register: Q1 11/12 update

- The following risks remain on the IPC Risk Register after review of the current rating scores at the ICC in July 2011:
    - Risk of legionella (rating 16) – policy reviewed and updated
    - IPC annual update training (rating: 8) – this remains a challenge although some changes are being made to the mandatory training programme
    - MRSA bacteraemia objective breach (rating 9) – control measures remain in place
    - C.difficile objective breach (rating 9) – control measures in place

- Elective emergency surgical mix-(rating 10) – this will remain on the register with control measures in place as there are no plans to segregate elective and emergency surgical cases
- Compliance with all aspects of the Hygiene Code (rating: 4) – to be reviewed at October 2011 ICC
- Handwashing facilities (rating: 6). - To remain on risk register as the majority of areas did not have sinks located directly in bays (although this will be addressed as part of the refurbishment programme) – to be reviewed at October 2011 ICC
- Reduced staffing resources in the ICT (rating 6) – this will be reviewed at each ICC meeting to ensure adequate service cover

11 Cleaning Services reports: Q1 11/12 update

- The National Standards Monitoring Tool audit quarterly results for Q1 11/12 is detailed in the table below. The scores are RAG rated 'green' in all areas.

By Cleaning Service	**Score (%) Q1 11/12**
CWSH	98.0%
DSO	96.9%
GEM	97.0%
Trust	97.0%
By Infection Control Risk	
Very high	97.8%
High	96.6%
Significant	97.3%
Low	87.3%

12 Estates and Facilities reports: Q1 11/12 update

12.1 Decontamination Monitoring Group

- The Decontamination Monitoring Group was set up in January 2009 and is Chaired by Andrew Panniker and advised by Martin Williams, the Trust's decontamination manager.
- The decontamination manager has developed a Decontamination KPI quarterly audit covering the endoscopy department, operating theatre, outpatients department and sterile services department and wards.
- The Decontamination KPI quarterly report performed in July 2011 RAG rated all areas green and no major compliance-related issues were reported to the ICC.

12.2 Ventilation planned preventative maintenance programme

- The July 2011 Environment report to the ICC RAG rated the enhanced ventilation/negative pressure rooms as amber due to ongoing issues over air change rates and pressure profiles. Work is continuing to address the issues raised.

- The Trust does not currently have any fully compliant negative pressure side rooms due to a change in the requirements of the new HTM. This work will not go forward at present.
- The July 2011 Environment report to the ICC RAG rated the theatre air changes as 'amber' due to low air change rates in some theatres. Work is planned for July to improve the air flow which should increase the number of air changes per hour in the theatres suites. Planned maintenance programme for theatres has been arranged for July/August.

12.3 Legionella and water supplies planned preventative maintenance programme

- The Environment report to the ICC continued to RAG rate the requirement for cold water <20°C and hot water >50°C as 'red' –. Options of cooling incoming mains being investigated by framework engineering consultants; reduced stored water volumes being considered Problems experienced with pressure drops when tank levels lowered due to mains water isolation external to site. Reasons for high sensor readings continue to be investigated and remedial action taken when required. The Energy Centre design is looking at reducing water storage capacity and using the space as a development area for the installation of de-centralised boiler equipment Absorption chillers are also being considered which will use that waste heat from the CHP UNIT, this cooling may be considered as a cooling medium for the incoming water supplies
- Continued pseudomonas testing, chlorination and monitoring. Samples are now being taken on a monthly basis. At present we are working on the limit of acceptability as being 10cfu/100ml for Pseudomonas as recommended previously by the HPU. There are presently no guide lines in this country. Discussions are ongoing into supplying filters for taps in two locations in SCBU and NICU, these filters are to combat the problems of pseudomonas and will allow the water to be used to bathe the babies within this area. The ITU shower room had also had positive pseudomonas results. The possibility of the shower being removed is being explored.
- The Environment report to the ICC RAG rated their risk assessment process, plant and equipment checks, AC plant & condenser checks and policies as 'green'.
- The Environment report to the ICC RAG rated the flushing of little used outlets, shower head water sample results and flow rates & pressures as 'amber' and ongoing works and monitoring are being carried out to address this issue.
- The Environment report to the ICC RAG rated the presence of dead legs and blind legs in the water supply system as 'amber' and ongoing works are being carried out to address this issue.

13 Employee Health Report: Q1 11/12 update

- Immunity register
  High risk areas - Last quarter was 94.79% slightly increased to 94.91%.
  Moderate risk areas - The last quarter was 70.72% and slight increase to 71.53%

- Exposure prone procedure register
  The total number of EPP compliant staff is 98.17% which is a further improvement from the last quarter.

- Needle stick/blood splash
  There were a total of 28 injuries in the previous quarter against 20 this quarter. May 2011 showed the lowest number of incidents reported since December 2008. Unfortunately this was not sustained and the figure is up again for June. 14 of the incidents involved doctors or medical students, and of this group venepuncture appears to be the highest cause for incidents, and it is hoped that this will improve with the introduction of safe needles.

  The ICT and EHMS continue to work together to implement safe needles within the Trust in order to try to reduce the number of needle stick incidents reported within the Trust.
  Training has been arranged with SARSTEDT® to do ward-based training sessions on using the safe venepuncture needless.
  The new policy for managing Inoculation Injuries continues to be worked on, and DOSH is now involved in the process of reviewing the PEP risk assessment, as DOSH consultants will replace EHMS in giving PEP.

14 Community health services

The CHS Infection Control Nurse (ICN) left the Trust in July and the post has been appointed into and new ICN is currently on orientation. The Community ICN is based with Acute Services ICNs and all reactive calls are dealt with in the same manner. The audit plan for 2011/12 has been developed and the following departments audited. There is also a piece of work going on with the estates and facilities team in relation to the clinical environment. The ICT is going on site visits with the E&F team to assess and evaluate the appropriateness of the environment.

location	**Date of audit**	**comments**
Linden centre	21st April 2011	Audit report completed
Milton garden	27th April 2011	Audit report completed.
Chyps plus, the house, lower Clapton	5th May2011	Audit report completed.
Ivy centre	25th May 2011	Audit report completed.
Hackney Ark	2nd June 2011	Audit report completed.
Foot health - St. Leonards	6th June 2011	Audit report completed.
Wheelchair	10th June 2011	Audit report completed.
PUCC	16th June 2011	Audit report completed
ACRT	17th June 2011	Audit report completed
Locomotor - Well street	17th June 2011	Audit report completed
Sexual health clinic - Lower Clapton	20th June 2011	Audit report completed

15 Policies endorsed by the ICC

The Managing water quality in hot and cold water distribution systems and Staff health surveillance policy
were endorsed at the July 2011 ICC:

16 Other Infection Prevention & Control issues

- One infection control nurse and the Infection control doctor/DIPC are on maternity leave until 2012.
- Mandatory surveillance and reporting of *E.coli* bacteraemias to the HPA enhanced Surveillance website started on the 1st of June 2011.
- The Trust will be participating in the 4th National PPS on Healthcare Associated Infections (HAI)
  and 1st National PPS on antimicrobial use (AU) quality indicators in September /October 2011.

17 Appendix 1 - Glossary of terms

Bacteraemia	blood stream infection; blood poisoning
CDI	*Clostridium difficile* infection
CQC	Care Quality Commission
DIPC	Director of Infection Prevention & Control
GRE	Glycopeptide Resistant Enterococci
HCAI	Healthcare Associated Infections; 'any infection by any infectious agent acquired as a consequence of a person's treatment by the NHS or which is acquired by a healthcare worker in the course of their NHS duties'
HCW	Healthcare Worker
HII	*Saving Lives* High Impact Interventions
HIPPI	Homerton Influenza In-house Planning Group
HPU	Health Protection Unit; 'Public Health'
ICC	Infection Control Committee
ICD	Infection Control Doctor
ICN(C)	Infection Control Nurse (Consultant)
ICT	Infection Control Team
IV line	Intravenous line
IPC	Infection Prevention and Control
MRGNR	The term 'multi-resistant gram negative rods' (MRGNR) covers the laboratory finding of GNRs resistant to gentamicin and a 3rd generation cephalosporin. These include both those GNRs who are multi-resistant due to the production of extended spectrum ß-lactamases (ESBL-producers) e.g. multi-resistant *E. coli*, multi-resistant *Klebsiella* and those GNRs who are multi-resistant due to other resistance mechanisms e.g. multi-resistant *Acinetobacter*
MRSA	Meticillin Resistant *Staphylococcus aureus*
NPSA	National Patient Safety Agency
PCT	City & Hackney Primary Care Trust
RCA	Root Cause Analysis
SCBU	Special Care Baby Unit
SUI	Serious Untoward Incident
VZV	varicella zoster virus, the causative agent of chickenpox and shingles

Homerton University Hospital NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Meeting date: 28th September 2011

Agenda Item: 8.2
Paper: 11-73

Title:	**Patient Experience and Quality Report**

Summary:	The attached paper shows the Trust's performance against a range of quality and patient experience indicators as well as updates on specific actions and projects. The SUI report is appended.

Action:	To note the report

Prepared by:	**Melanie Mavers, Head of Clinical Quality**
Presented by:	**Charlie Sheldon, Chief Nurse and Director of Governance**

Compliance	*CQC Essential Standards of quality and safety* *NHSLA Standards*

Homerton University Hospital NHS
NHS Foundation Trust

Monthly Patient Experience, Quality and Serious Incident Report September2011

(Reporting period July 2011)

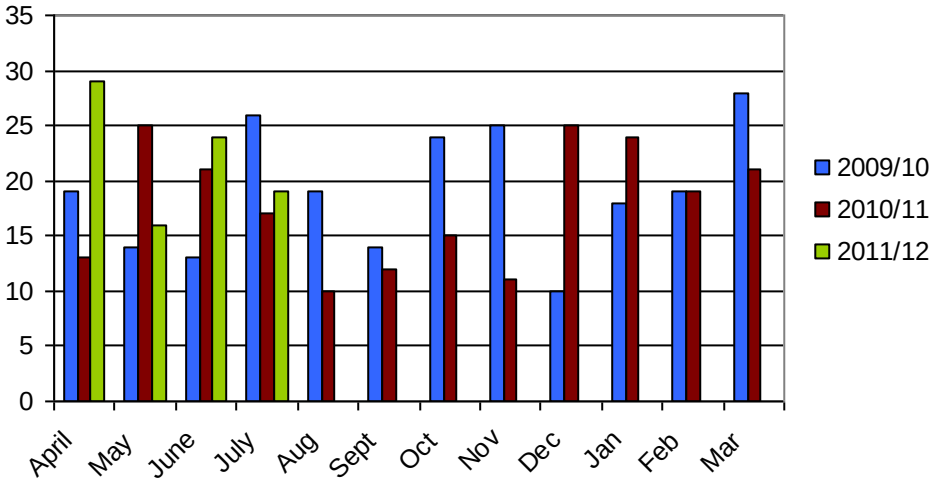
1. Introduction

The following information shows the Homerton University Hospital performance against a range of quality and patient experience indicators.

2. Complaints

Complaints in June and July – 43 formal complaints were received in June and July.

Figure 1: Formal complaints by Month

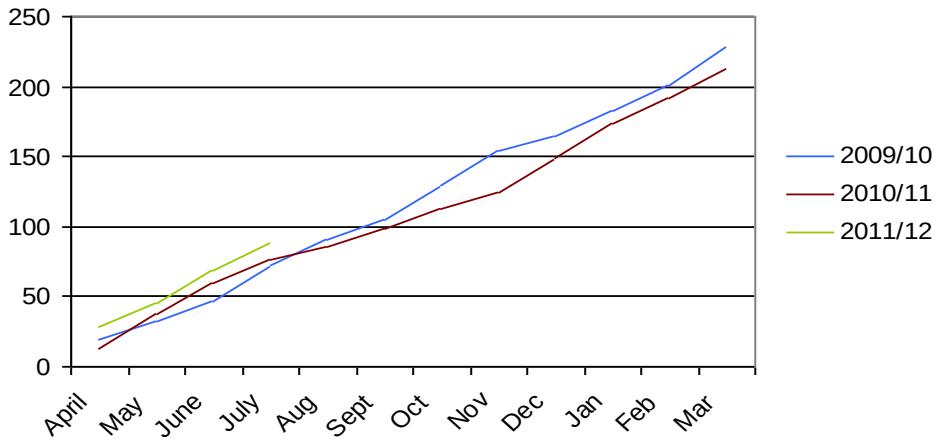


A breakdown of complaints by division from April to July 2011 is provided in Table 1.

Table 1: Complaints by division in April to July 2011

	April	May	June	July	Total
Community Health Services	2	1	3	1	7
Children Women and Sexual Health Division	4	5	6	4	19
Diagnostic, Surgery and Outpatients Division	13	5	7	7	32
Directorate of the Environment	0	0	1	1	2
General and Emergency Medicine Division	8	5	7	6	26
Totals:	27	16	24	19	86

Figure 2: Cumulative totals of formal complaints



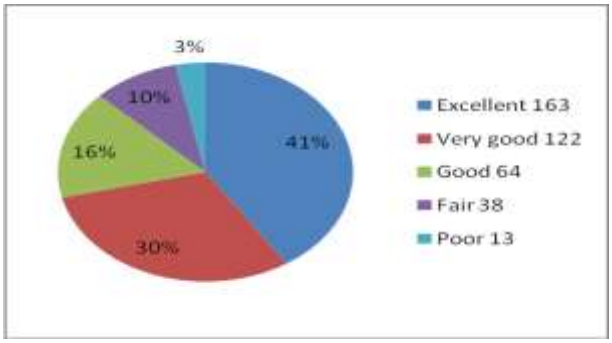
In June 2011 87.5% % of complaints received were responded to in 25 days in July the figure was 100%.

3. Patient experience Tracker data for June and July 2011

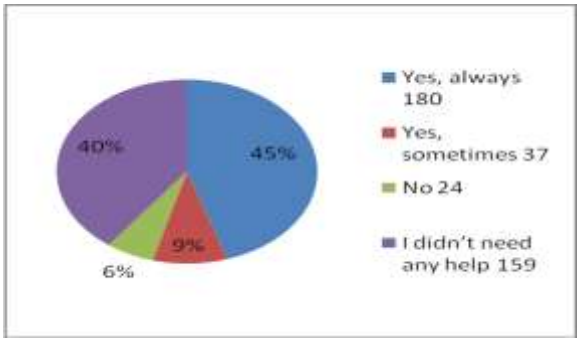
Patients completed the surveys during June/July 2011 Against the 5 ward questions the results are:

Figure 3: PET responses to the five ward questions during June and July 2011 (response rate from 400 patients)

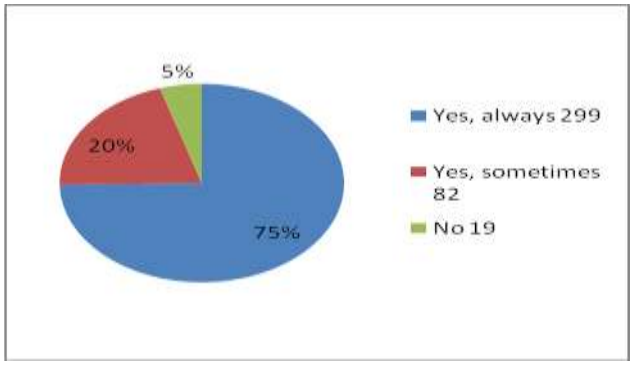
Overall how would you rate the care you received?



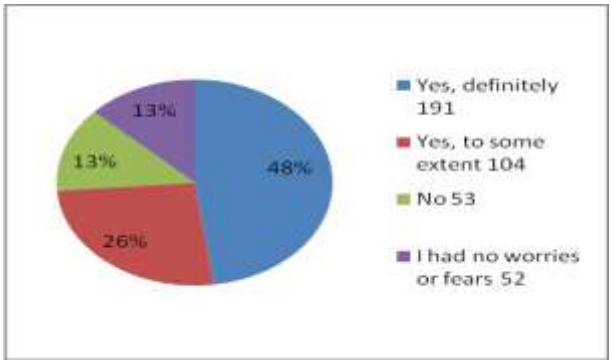
Did you get enough help from staff to eat your meals?



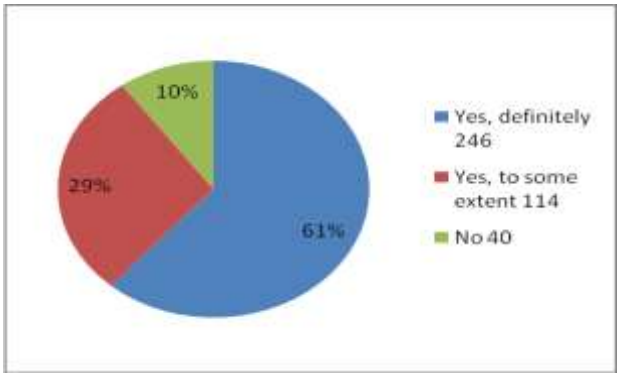
Did you have confidence and trust in the nurses treating you?



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



Were you involved as much as you wanted to be in decisions about your care?

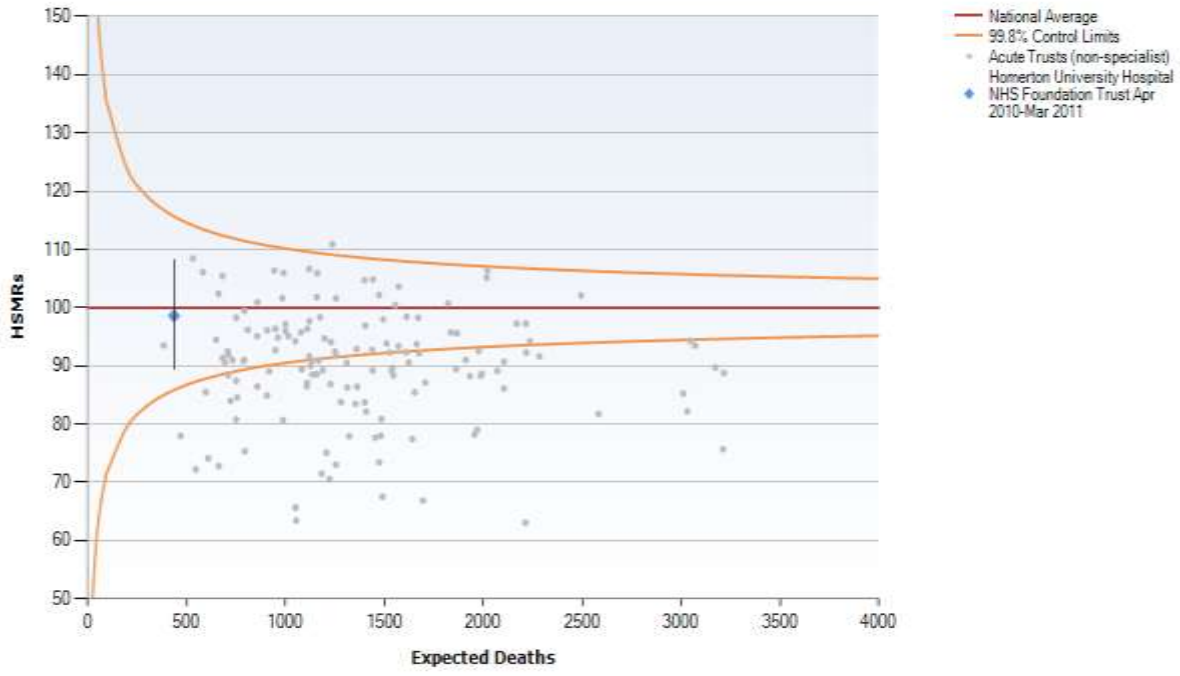


4. Hospital Standardised Mortality Rate (HSMR)

HSMR is calculated by Dr Foster the figure below shows the Trusts HSMR April 10 to March 11 in relation to other acute Trusts

Figure 4: Hospital Standardised Mortality Rate Apr 2010-Mar 2011

The background points show the most recent rolling 12-month HSMR for each acute non-specialist trust in England.



This indicates that the Trust death rate from April 10 to March 11 was within acceptable limits for our population based on Dr Fosters methodology.

5. Incident reporting

For June and July 2011, 576 clinical incidents were reported in the Trust. This is maintaining the trend of reporting above 250 clinical incidents per month as seen in the last quarter (Fig 5).

Figure 5: Monthly reported incidents

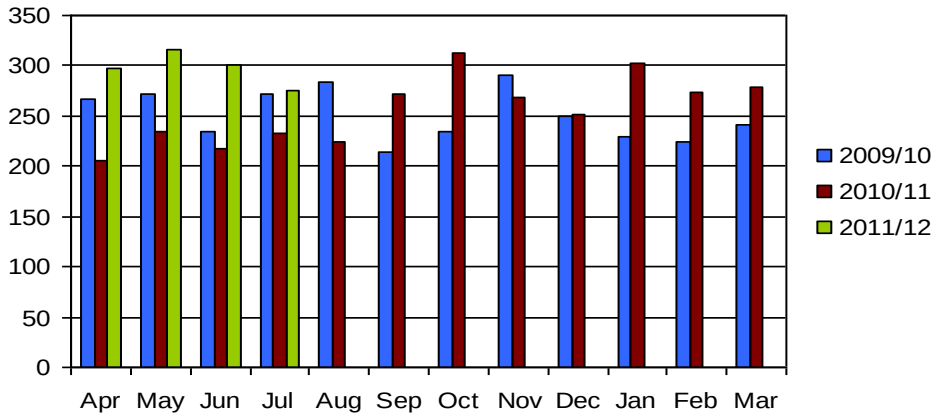


Figure 6: Cumulative Incidents Trust

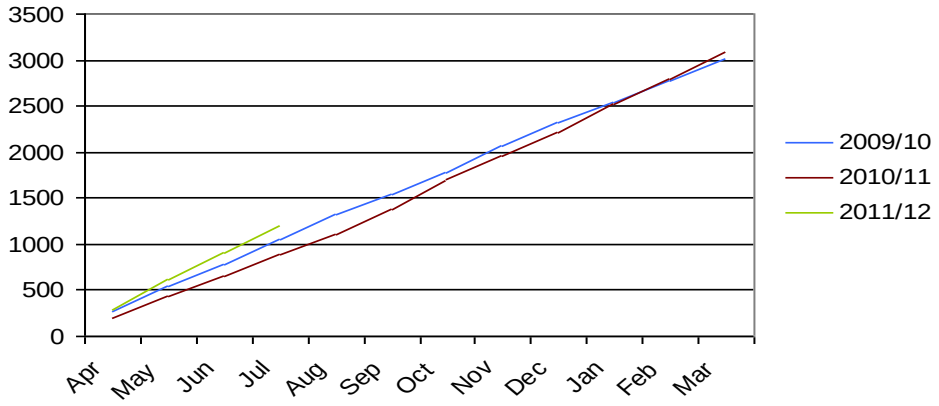
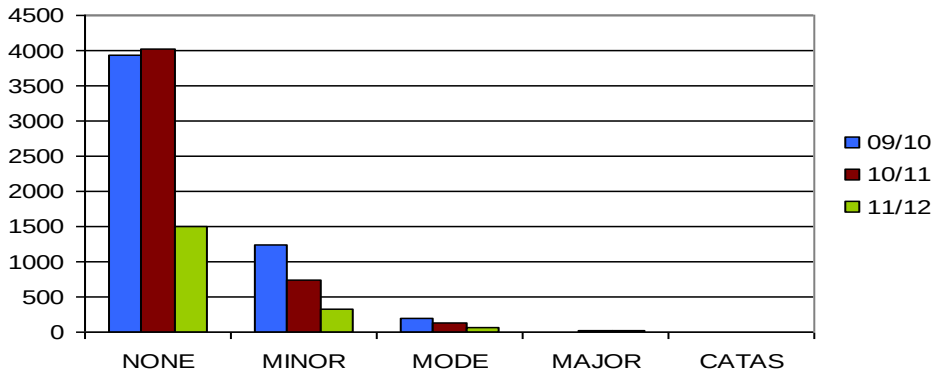


Figure 7: Incidents by severity



6. National Patient Safety Agency (NPSA) National Reporting and Learning system (NRLS) Organisational Safety Report October 2010 to March 2011. (Report published 13th September 2011)

The NPSA release six monthly data reports to compare similar size organisations in terms of clinical incident reporting. The most recent report covers October 2010 to March 2011.

During this time the Homerton reported 1,833 clinical incidents equivalent to 7.61 incidents per 100 admissions. This is a slight increase from the same time period last year when our rate was 7.2 per 100 admissions and indicates the improving safety culture within the Trust.

There are 28 acute Trusts in our peer group; the highest reporting Trust reported 10.38 incidents per 100 admissions. Homerton remains in the top reporting quartile. Homerton's rate of 7.61 incidents is the highest of the 5 acute Trusts in east London the lowest being 2.14 incidents per 100 admissions.

Timeliness of reporting

Homerton is the second most timely reporter of incidents to the NRLS in the peer group, with a median time of 15 days. This is due to ensuring that an upload is sent at least weekly. We are in joint third place in terms of timeliness of reporting in London.

Percentage of incidents causing no harm

Our percentage of reported incidents where there was no harm to the patient was 83.2% this is the fifth best in the group and above the group average of 66.8%. We have maintained this level of no harm incidents since the same reporting period last year.

There were no patients recorded as having died as a direct result of a clinical incident between October 2010 to March 2011

Top reported incident

The most commonly reported incidents were patient accidents (generally falls). Homerton reported 22.8% of its incidents as patient accidents this is the fifth lowest percentage within the group. Organisations falls incidents as a percentage of their total reports ranged from 19% to 49.1%.

The second highest reported incident category at Homerton was "Treatment/procedure" this was 22.3% of our total incidents. This is in the top three of the peer group.

Medication incidents

Only 10% of our reported incidents were related to medication, this seems to be a static figure, we are in the middle of the peer group.

Recommendations

- Review incidents categorised "treatment/procedure" to establish any trends within the category, implement actions as appropriate.
- Publicise Trust reporting rate per 100 incidents to staff and encourage further reporting in line with Quality Account priorities.
- Review rate of medication incident reporting by location and target training in those areas.

7. Serious Incidents (SI)

This data was correct on the 7th September 2011.

From April 2011, we have reported 18 Serious Incidents (SIs). One of these occurred in 2010 but was reported this year when it came to light following a patient's complaint.

Table 1 shows the category of SIs reported.

Table 1: categories of reported SIs

	Total Incidents
Pressure Ulcers	7
Never Events	3
Pregnancy and Peri-natal (Labour / Delivery) Incident	3
Diagnosis Incident	1
Infection Control	1
Slips / Trips / Falls Unanticipated	1
Treatment Incident	1
Violence / Harassment / Aggression / Assault Incident	1
Totals:	18

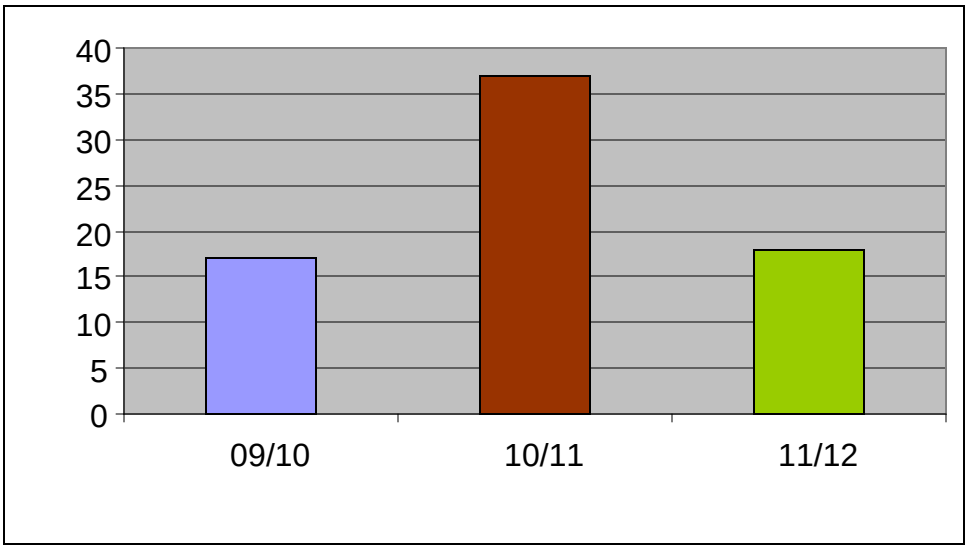
The breakdown of SIs by Division is shown in Table 2:

Table 2: SIs reported by division since April 2011

	Total Incidents
Community Health Services	2
Children Women and Sexual Health Division	4
Diagnostic, Surgery and Outpatients Division	4
General and Emergency Medicine Division	8
Totals:	18

- In context, these SIs account for 1.1% of all reported clinical incidents in the Trust to date.
- From April 2010 to March 2011, there were 37 SIs reported, and this represented 1% of all incidents reported in this period.
- Figure 1 shows a comparison of all SIs reported over the previous three financial years.

Figure 1: Total SI reported in each financial year



The increase in reporting year on year is likely to be associated with the raised profile of incident reporting in the Trust. The introduction of the “24 hour meeting” format in June 2010, where potentially serious incidents are reviewed quickly using a standard agenda to decide the most appropriate course of action including the required level of investigation, will also have had an effect on reporting rates.

Table 2 shows all current reported SIs.

- Once all the recommendations from an SI report have been implemented, the incident is shaded in light grey in Table 2
- Of note this months is the increase in reported pressure ulcers grade 3 and above. These required to be reported as SIs. Common elements have come to light during these investigations which include:
    - Lack of consistency carrying out risk assessments (Waterlow score)
    - Inconsistent documentation
    - Varied use of wound care dressings.

  A learning event has been arranged in October to aggregate and share the learning from all investigations into pressure ulcers and develop a Trust wide action plan. Patient Safety Week this year (September 12th to 18th) focus was on what individual staff can do to improve patient safety. The Trust used this focus to concentrate on actions staff can take to prevent pressure ulcers whilst patients are in our care.

8. Medication Incidents

Figure 9: Cumulative medication incidents

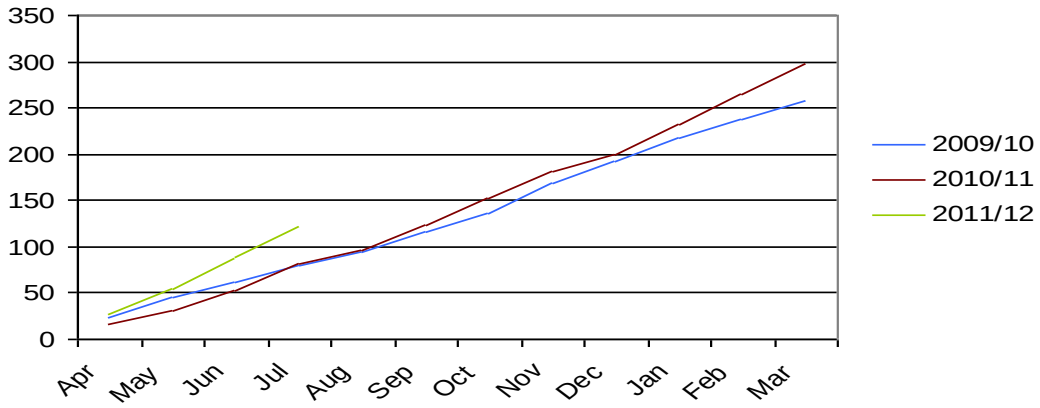


Figure 10: Medication incidents by month (Trust)

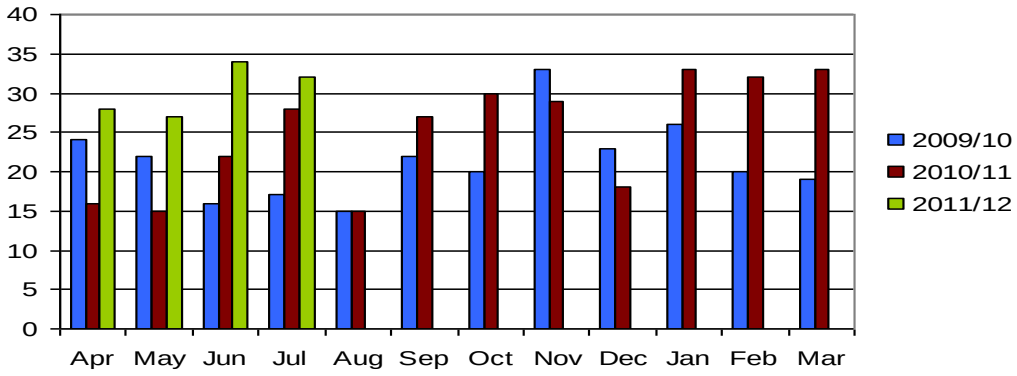
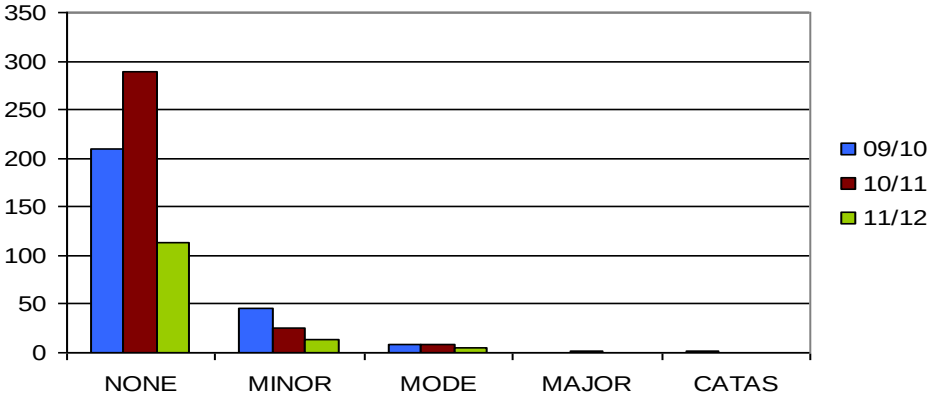
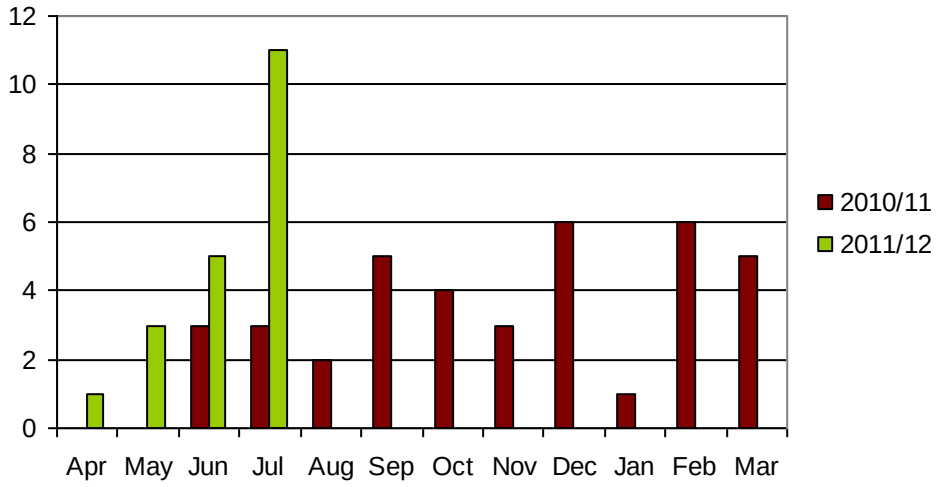


Figure 11: Medication incidents by severity



9. Pressure Ulcers

Figure 12: Hospital acquired pressure ulcers grade 2 and above



The reporting of pressure ulcers has increased in the last two months. This is partly due to increased awareness within the Trust of the necessity to report pressure ulcers grade two or above as clinical incidents. Between April and July we have reported seven grade 3 or 4 pressure ulcers as serious incidents, two in the community and five in hospital. One of these ulcers occurred last year and was detected as part of a review of audit data from the national hip fracture database.

There are a further three internal root cause analysis investigations in progress of patients admitted to hospital with pressure ulcers that deteriorated whilst they were inpatients.

Factors common to all cases will be established, a learning event has been arranged for October to share the knowledge and establish actions for the future to ensure patients being cared for in the acute Trust or in community do not develop pressure ulcers.

Pressure ulcers are reported across London and figures are collated by NHS London. Not all Trust collect the same data so comparison between Trusts can be difficult. Following discussions at the Quality Improvement Committee, the Trust has decided that all pressure ulcers regardless of the source will be reported as incidents (some Trusts do not report of ulcers sustained by patients in Intensive Care Units that are the result of endo tracheal tube placement).

A risk assessment has been carried out and this risk is on the Trust risk register as a high risk graded 12. There is a risk not only to patients but in terms of our ability to demonstrate compliance with the Care Quality Commissions essential standards of quality and safety particularly outcome four; care and welfare of service users.

A revised Trust policy on the prevention and treatment of pressure ulcers is in development and will complement existing information that is available in the current wound care manual.

10. Patient Falls

Figure 14: Patients falls by month

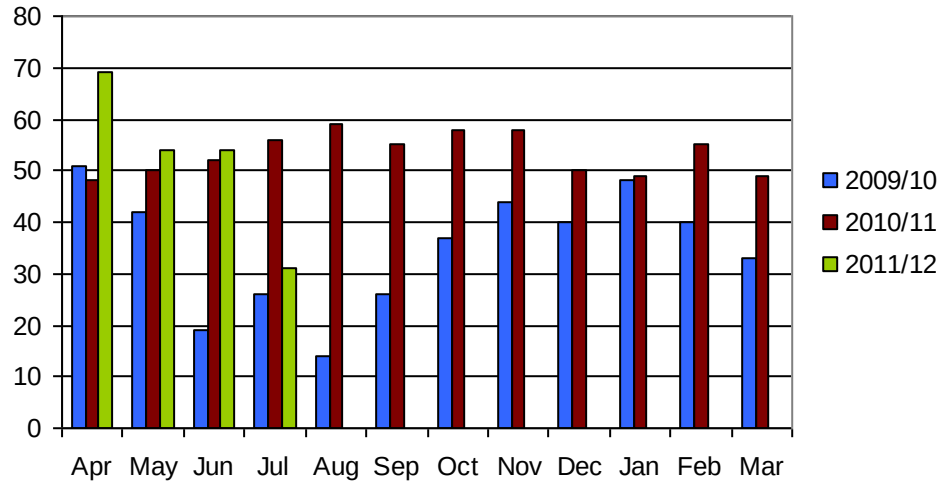
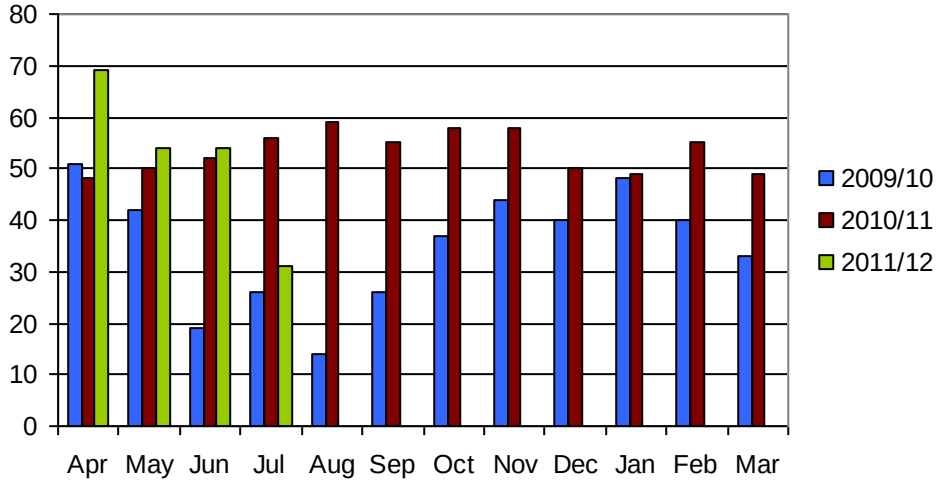


Figure 15: Severity of falls



Melanie Mavers

Head of Clinical Quality

September 2011

Homerton University Hospital NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Meeting date: 28th September 2011 **Agenda Item: 8.3**
Paper: 11-74

Title:	**Report on Quality Governance / Board Self Certification for Quality**

Summary:	The Board is required to make a self certification that: "The board is satisfied that, to the best of its knowledge and using its own processes and having had regard to Monitors *Quality Governance Framework* (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), it has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients". The Trust is required to make this declaration to Monitor at the end of Quarter 2. The Trust's internal auditors have undertaken an assessment of our compliance against the Quality Governance Framework .The report from KPMG is attached for information. Additionally, Monitor commissioned a review of publically available information on patient safety, quality of care and patient/staff experience amongst acute foundation trusts. Their findings are also attached. Based on the findings of these reports and the actions the Trust has in place to address any recommendations, we are advising the Board that they will be in a position to self-certify for Quality in the required form as part of the Monitor Q2 submission in October.

Action:	The Board are asked to note the contents of the report and the actions in place to address recommendations raised.

Prepared & presented by:	**Charlie Sheldon, Chief Nurse and Director of Governance**

Compliance	**Terms of Authorisation – Condition 1 Principal Purpose**

Self Certification for Quality
(Assessment against the Monitor Quality Governance Framework)
September 2011

1. Audit Report on Quality Governance

The Board is required to make a self certification to Monitor in relation to quality at the end of quarter 2.

That: *"The board is satisfied that, to the best of its knowledge and using its own processes and having had regard to Monitors Quality Governance Framework (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), it has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients".*

The Board will recall that, as reported at the July Board meeting, the Trust's internal auditors, KPMG have undertaken an assessment of our compliance against Monitor's Quality Governance Framework (July 2010).The final report from KPMG is attached.

The Board are asked to note that we are required to make some improvements in several key areas as outlined on pages 13 – 16. Key actions and deadlines have been identified and leads appointed.

One recommendation highlighted in a previous KPMG audit report (Data Assurance Review – Dec 2010) significantly impacts on quality governance data quality and, if not addressed, may influence our ability to make the decalration in the required form. The following actions have been implemented in response to this recommendation.

As part of the Data Assurance Framework, every indicator reported to the Board is being individually assessed to determine the level of assurance offered in terms of process of recording, checks and validation applied.

An initial high level analysis will be carried out followed by a detailed review of each indicator. The first group of indicators will be those that are nationally mandated and submitted as part of the quarterly Monitor return. The second group of indicators will be prioritised based on risks that are identified.

This process will require input from the operational leads and potentially audits carried out such that an action plan is created and recommendations for improvement identified and implemented by the Data Quality Group.

Evidence is being collated to determine which staff groups are responsible for sign off, how changes to data set definitions or guidance are applied and who the internal / external recipients are for the reporting cycle.

A detailed assessment is required of each Data Assurance Document supporting each indicator to assess whether the level of assurance the board requires is being achieved and highlight any gaps in assurance as well as residual risk for the organisation.

Any indicators that require further review and those that represent a high risk to the organisation will be followed up with operational leads as appropriate. The recommendations will be reviewed and actions agreed at the Data Quality Group and periodically reported to the Audit Committee and the Information Governance Committee.

2. Monitor Commissioned Report on Quality / Safety

Alongside this year's Annual Plan Review process Monitor commissioned Mckinsey to review publically available information on patient safety, quality of care and patient/staff experience amongst acute foundation trusts. The Board are asked to note the attached report relating to the Homerton produced by McKinsey as part of this process.

It is worth noting that some of this information is relatively old and may therefore not reflect the current position of the trust. The analysis highlighted a number of areas in which the Homerton was identified as being in the worst performing decile for acute foundation trusts in some areas:

- MRSA
- Nurse WTEs
- Confidence in nurses
- Confidence in Dr's
- Overall patient exp.
- Readmission rates - hips & knees

The Board are requested to note the following updates on each of these indicators:

1	MRSA	The HUHFT breached its target in 2010/11. YTD the HUHFT has had no MRSA bacteraemias.
2	Nurse WTEs	The board received a report on nurse staffing in March 2011 • Registered to non registered nursing numbers above the minimum advised by the Royal College of Nursing • Ward nursing establishments are slightly above the requirement for the acute patient (level 0). When each ward has more level 1a /1b patients the need for additional nurses being used increases proportionally resulting in the use of additional staff • ITU / HDU has adequate establishments to work to the Association of UK University Hospitals advised nursing numbers. • The paediatric ward is compliant with RCN guidance
3	Confidence in nurses	The board has previously considered the inpatient survey which was carried out in 2010. An action plan was implemented last year and we will receive results of survey in April 2012. Local patient feedback for both in and outpatients has improved in the last 2 years. The Trust patient experience action plan was launched at the AMM on 15th September. The nursing indicators will be launched in November 2011.
4	Confidence in Dr's	The board has previously considered the inpatient survey which was carried out in 2010. An action plan was implemented last year and we will receive results of survey in April 2012.
5	Overall patient exp.	The board has previously considered the inpatient survey which was carried out in 2010. An action plan was implemented last year and we will receive results of survey in April 2012.

		The PPE/PPI strategy was launched in September 2011 at the AMM.
6	Readmission rates - hips & knees	Readmission rates appear higher due to the low no. of hip and knee replacements undertaken

3. Conclusion

Based on the findings of these reports and the actions the Trust has in place to address any recommendations, we are advising the Board that they will be in a position to self-certify for Quality in the required form as part of the Monitor Q2 submission in October.

Charlie Sheldon, Chief Nurse & Director of Governance, September 2011

Homerton University Hospital NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Meeting date: 28th September 2011 **Agenda Item: 9.1**
Paper: 11- 75

Title:	**Monitor feedback on Annual Plan**

Summary:	The attached letter and report provides a summary of Monitor's assessment of our 2011 Annual Plan. Following review by Monitor the Trust has been assigned a Green risk rating for Governance and a financial risk rating score of 3 for 2011/12.

Action:	The board is asked to note the report.

Prepared & Presented by:	**Jo Farrar, Director of Finance**

Compliance:	Monitor reporting requirements.

SEE SEPERATE REPORT

Homerton University Hospital NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Meeting date: 28th September 2011 **Agenda Item: 9.2**
Paper: 11- 76

Title:	**Homerton Q1 2011-12 Monitor results notification**

Summary:	The attached letter and report provides a summary of Monitor's assessment of our 2011/12 Q1 performance. We were assigned a Green risk rating for Governance and a financial risk rating score of 4. The Trust's Q1 return indicated that the Trust's private patient income is above the Trust's cap. Monitor has stated that this does not represent a breach at this time but the level will be monitored over subsequent quarters.

Action:	The board is asked to note the report.

Prepared & Presented by:	**Jo Farrar, Director of Finance**

Compliance:	Monitor reporting requirements.

SEE SEPERATE REPORT

Homerton University Hospital NHS Foundation Trust

Board of Directors

Meeting date:	**28th September 2011**	**Agenda Item:**	**9.3**
		Paper:	**11-77**

Title:	Appointment of External Auditors

Summary	The report provides a summary to the Board of Directors on the external audit tender process. From September 2011, we have appointed Deloitte LLP to provide our external audit services.

Action:	The Board is asked to note the report

Prepared:	Fiona l'Anson - Deputy Director of Finance
Presented by:	Jo Farrar – Director of Finance

Compliance:	Terms of Authorisation: Condition 22 - Audit

EXTERNAL AUDIT TENDER SUMMARY

1 Introduction

1.1 This paper provides a summary of the external audit tender process that was completed in September 2011 with the appointment of Deloitte LLP.

2 The tender process

2.1 We invited and received bids from four suppliers under the NHS East of England Framework for Audit Services to tender for the provision of external audit services.

2.2 In order for the tender to be awarded, bids were evaluated by an advisory panel to the Governors. The panel were:

Clyde Baker (Governor)

Stephen Hay (Chair of the Audit Committee)

Eric Sorensen (Member of the Audit Committee)

Shortlisting took place on 2nd June 2011 and all four suppliers were invited to present to the panel on 30th June 2011.

2.3 Following the tender process the panel scored each bid against agreed and published criteria. Both written submissions and presentations from the bidders were taken in to account as part of the panel's evaluation.

2.4 Following the tender process the panel unanimously agreed that Deloitte LLP should be appointed as external auditors. Their high score in comparison to other bidders reflected the quality of both their written submission, their presentation on the day, and their unrivalled experience of auditing Foundation Trusts across London. The Council of Governors approved the appointment at their meeting on 28th July 2011.

3 Contract

3.1 The contract for the external audit services is effective for a three year period from 1st September 2011. The contract covers statutory external audit work on the Trust annual accounts and value for money opinion, the Quality accounts and the Charitable Fund accounts.

3.2 It should be noted that the audit of the 2010/11 Charitable Fund Accounts has not been completed, therefore the formal engagement of Deloitte LLP in this work will be concluded in October. The Charitable Fund Accounts will be considered by the Charitable Funds Committee on 26th September.

4 Conclusion

4.1 Following a comprehensive tender process, we have appointed Deloitte LLP as our external auditors. They will be presenting a draft 2011/12 work plan for the Audit Committee's consideration in September 2011.

Homerton University Hospital NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Meeting date: 28th September 2011 **Agenda Item: 10.1**
Paper: 11-78

Title:	Month 5 Financial position and performance report

Summary:

As at the end of August our reported surplus for the year to date was £2.1m, ahead of plan by £0.8m. This favourable variance primarily reflects income over performance across a number of service areas. Unlike last year, the majority of this over performance is arising from outside of Inner North East London. Expenditure (both pay and non-pay) is also above plan although to a lesser extent than income.

We are currently in the process of reviewing the financial position and potential outcomes for the full year. It is worth noting that there are a number of factors which may mean that the current level of surplus over achievement cannot be assumed for the second half of the year. The results of this review will be shared with the board in due course.

The main acute contract with INEL commissioners has now been signed.

All key performance targets, including Monitor's performance indicators, were met during the period to the end of August. A continuing area of focus for us is the level of unplanned A&E re-attendances within 7 days. However, this indicator is not part of Monitor's Compliance Framework.

Action:	The Board is asked to note the report.

Prepared by:	**Fiona l'Anson and Zaman Hussain**
Presented by:	**Jo Farrar, Director of Finance**

Compliance:	Terms of Authorisation: Condition 12 – Financial Viability Condition 6 – Healthcare Standards

SEE SEPERATE FILE

Homerton University Hospital NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Meeting date: 28th September 2011.

Agenda Item: 12.3
Paper: 11-79

Title:	**Workforce Related Risks Update*** **

Summary	This document is a brief update to inform the Board of a number of Workforce related risks. These include • Electronic Staff Records • Industrial Unrest

Action:	The Board is asked to note the content of the report.

Prepared by:	Cheryl Clements, Director of Workforce and Education
Presented by:	Cheryl Clements, Director of Workforce and Education

Compliance	CQC

RESERVED PAPER

Homerton University Hospital NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Meeting date: 28th September 2011

Agenda item: 13
Paper: 11-80

Title:	**Draft minutes of the Risk Committee held 15th September 2011**

Summary	This document records the items discussed at the Risk Committee meeting held in September 2011.

Action:	Minutes for information

Presented by:	**David Stewart, Non-Executive Director**
Prepared by:	**David Bridger, Head of Governance**

Compliance:	*NHSLA Risk Management Standards* *CQC Essential Standards for Quality and Safety*

Homerton University Hospital NHS
NHS Foundation Trust

Minutes of the Risk Committee Meeting
15th September 2011

Present:	David Stewart	Non Executive Director (Chair)
	Nancy Hallett	Chief Executive
	Charlie Sheldon	Chief Nurse & Director of Governance
	Jo Farrar	Director of Finance
	Andrew Panniker	Director of Environment
	Cheryl Clements	Director of Workforce and Education
	Melanie Mavers	Head of Clinical Quality
	Karen Gordon	Quality Improvement Manager
	Lesley Rogers	Head of Healthcare Compliance
	David Bridger	Head of Governance (Minutes)

1. Apologies for absence

Michael Cassidy	Chairman
Prof Michael Keith	Non Executive Director
John Coakley	Medical Director

2. Minutes of the previous meeting

The minutes of the previous meeting held on 16th June 2011 were approved as a true record of the meeting.

3. Matters arising

Melanie Mavers reported that training for senior managers has been delivered by presentation to Clinical Board at one of their meetings and also to the Non Executive Directors. It is anticipated that this will be timetabled to be delivered annually.

4. Litigation Settlement Report

Charlie Sheldon presented the litigation settlement report. The Trust has a total of 77 open claims formally notified to the NHSLA, 55 open clinical negligence claims and 22 personal injury claims. He reported that by division CWSH continues to have the highest number of clinical negligence claims. All claims are centrally recorded on the Trusts database and are reviewed weekly as part of the Complaints, Litigation, Incidents and PALS (CLIP) meetings. He provided details of two cases that had recently been heard at the coroners court. The committee noted the report.

5. Board Assurance Framework (BAF) 2011/12

Charlie Sheldon presented the current BAF. This has been presented to the Board of Directors in July. All BAF risks have been entered onto the Trust risk management database and are linked to the Trust risk register. Further work is required to better integrate the BAF with the risk register. The target ratings need to be identified along with target dates. It is anticipated that the BAF will be reviewed by the executive team prior to submission to the Board of Directors. The committee discussed a number of the high scoring risks and the actions in place to mitigate the risks.

6. Risk Performance Report

Melanie Mavers presented the risk performance report for May to August 2011. This is the last report reflecting the old divisional structure. She explained that the process of transfer of risks from the old structure to the new divisional structure is underway. Some CHS risks have been identified and assessed but not yet agreed. Training for CHS staff is being provided. As of August 2011 the trust has a total of 139 open risks on the risk register. The majority of the risks have been initiated by risk assessments by staff regarding concerns. Fifty four new risks have been identified including a number from GEM. 14 of the 54 have scores greater than 12. A number of these still require review by a relevant executive director. The number of risks outside of their review date has decreased significantly from 80 to 27. The committee discussed a number of the open high scoring risks. The committee noted the content of the report and approved the recommendations.

8. NHSLA Assessment Update

Melanie Mavers provided the committee with a verbal update on the NHSLA compliance. The Trust is required to be reassessed before March 2013. A reassessment date has been arranged for November 2012 which will require evidence to be gathered from November 2011. The maternity directorate is due to be assessed for level 2 compliance in October 2011. It was noted that the Monitor Compliance Framework for 2011/12 requires all Trusts to maintain level 1 compliance with NHSLA standards. The committee noted the report.

9. CQC Quality and Risk Profile Update

Lesley Rogers presented a paper summarising the findings of the latest quality and risk profile for the Trust. She provided the committee with summary of the sources of evidence used by the CQC to determine the Trust profile. Scores derived from staff and patients surveys will not change until the next survey results are available. The QRP will be used by the Trust to inform its plan with regard to provision of evidence in support of compliance with the essential standards. The committee discussed the data in the profile and particularly the negative score associated with the dignity and nutrition inspection in May. It was agreed that the trust should contact the CQC and ask for feedback regarding this score. The committee noted the report.

10. Central Alert System (CAS) Performance Report

Melanie Mavers presented a paper summarising the Trust position in relation to the dissemination and action of safety alerts received through the central alert system. She reported that the Trust had received a total of 63 alerts since 01/04/2011. The number of open alerts is 10 with none past their deadline. A total of four alerts had

been closed without full implementation of recommendations. These have been risk assessed, placed on the risk register and have plans in place to ensure compliance. The committee discussed the NPSA alert for standardising wristbands which although delayed now has actions in place to ensure this is implemented. The committee noted the content of the report.

11. Information Governance

David Bridger presented a paper setting out the Homerton's compliance with Version 9 of the Information Governance toolkit. This had been previously presented and reviewed by the Information Governance Committee in September. The Trust has in place an Information Governance Manager who is responsible for taking forward the work to ensure compliance with level two for the toolkit. The trust has a number of areas where work is required to ensure compliance at level two across all the standards. The committee requested an update report at the next meeting to provide assurance on compliance with the toolkit.

12. Workforce Performance

Cheryl Clements presented the Trust workforce report. She reported that whilst sickness remains below 4% CHS is currently an outlier with figures greater than 4% and focussed work is being carried out with CHS managers. Vacancy levels have reduced. Appraisal rates continue to be an issue across some of the divisions. CHS appraisal levels are to be established. The committee discussed the low levels of mandatory training and the strategy required to ensure levels of training improve. Training rates for infection control and child protection are expected to improve relatively quickly following implementation of actions. The committee discussed a number of workforce related risks and the plans in place to address them. These included neonatal unit vacancy rates, retirements within the environment division and ESR user notice risks. The committee noted the report.

13. Environment Committee

Andrew Panniker provided a verbal update regarding the revisions to the Environment Committee. He explained that the revised terms of reference had been drafted with the committee focussing on energy efficiency and all associated legislative compliance. The group will be chaired by the new operations directors. Accountability will continue to be to the risk committee and a report and minutes will be provided for the December risk committee meeting. The committee noted the report.

14. Minutes of the Health and Safety Committee and Quality Improvement Committee

The committee noted the contents of the minutes of the Quality Improvement Committee and Health and Safety Committee.

15. Any other business

The committee were notified that the Trust is in the process of assessing those risks to the Trust associated with the Olympic Games. An Olympic Games lead has been appointed to provide operational oversight for the Trust.

The committee briefly discussed the IT risks previously identified regarding the transfer of CHS. The committee were informed that the SLA is in place and is currently working satisfactorily.

Date of next meeting: 14th December 2011, 3pm Trust Offices meetings room.