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

Wednesday 23rd February 2011 at 08:30 – 12:00

AGENDA

No.	*Item*	*Attachment*	
1.	**Chairman's welcome and introduction**		MC
2.	**Apologies for absence**		
	Jo Farrar – Finance Director		
	David Bridger – Dylan Jones to take minutes		
3.	**Declaration of interests regarding items on the agenda**		
4.	**Minutes of the meetings held on 26/01/2011**	10/119	MC
	and matters arising not covered elsewhere on the agenda.		
5.	**Chairman's Report:**		MC
	Monitor Board to Board		
6.	**Chief Executive's Report:**		
	Retirement of senior clinical staff		
7.	**Strategy and Policy** Homerton Strategic Position *******		
	7.1 Community Health Services	10/120	NH/TF
	7.2 Strategic Changes: Implications for the Homerton	10/121	NH
	7.3 Health and Social Care Act Analysis	10/122	JC
8.	**Quality and Safety**		
	8.1 Patient Experience and Quality Report and SUI report ***	10/123	CS
	8.2 Learning Disability Standards	10/124	CS

8.3 10/125	Infection Control Q3 Report	AC

9. Corporate Governance

9.1 10/126	Response to Consultation on amendments to the Compliance Framework for 2011-12	CS
9.2	NED re-appointments (verbal)	NH

10. Business Planning & Performance Management (Assistant Finance Director to attend)

10.1 10/127	Finance and Performance Report Month 10	FI/TF
10.2 10/128	2011/12 Financial Outlook	FI
10.3 10/129	2011/12 QIPP Position ***	TF

11. Human Resources Governance

11.1	Counter Fraud investigation (verbal) ***	CS
11.2	AAC Ratification	CC

12. Any Other Business

*** Reserved Business

To be followed by a meeting of Remuneration Committee (Secretary Cheryl Clements)

Dates of forthcoming meetings

Board of Directors - Wednesday 30th March 2011

Joint Board of Directors Council of Governors – Thursday 19th May 2011 5:30pm

Meeting of the Board of Directors
Wednesday 26th January 2011

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

1.0 Chairman's Welcome and Introduction

Michael Cassidy, Chairman, opened the meeting.

2.0 Apologies for absence

None

3.0 Declaration of interests regarding items on the agenda

None

4.0 Minutes of the previous meetings held on 15/12/2010 and matters arising

The minutes of the previous Board of Directors meeting and joint meeting with the Board of NHS City and Hackney were agreed.

5.0 Chairman's Report

Michael Cassidy provided the Board with feedback from the recent Council of Governors meeting. The recent government proposals regarding the changing role of Governors were discussed. Further detail is awaited regarding the increased Governor role and the training and development needs that will need to be met with the Board of Directors responsible for ensuring that training is provided. He also explained that consideration needs to be given to how the joint meetings between Directors and Governors are planned in future. Two options were considered one to have the joint meetings immediately after the Board of Directors meetings or to improve attendance at the scheduled joint meetings held in the evenings. The second option was considered the preferred choice with timetabled presentations from Non-Executive Directors at each meeting.

6.0 Chief Executive's Report

Nancy Hallett, Chief Executive notified the Board that they will be provided with a paper at the next meeting detailing the implications of the proposed new Health and Social Care Bill 2011.

She was pleased to announce that the Trust had received formal notification from the International Olympic Committee (IOC) that the Olympic logo can be used by the Trust and that a plaque from the IOC will be displayed in the main entrance.

7.0 Strategy and Policy***

7.1 Transfer and Integration of Community Health Services

This item was discussed under reserved business.

7.2 Hospital Services Review

This item was discussed under reserved business.

7.3 Strategic Changes

This item was discussed under reserved business.

Quality and Safety

8.1 Patient Experience, Quality Report and SUI Report***

This item was discussed under reserved business.

8.2 Care Quality Commission (CQC) Maternity Survey

Charlie Sheldon, Chief Nurse and Director of Governance presented the results of the CQC maternity survey. Overall the Trust had scored "about the same" as other Trusts in all categories. An action plan is being developed to address areas where the Trust did not perform well such as post natal care in hospital and baby feeding. The Trust has agreed to commission its own maternity survey for 2011 in order to measure improvements following implementation of the action plan. The Board noted the report.

Corporate Governance

9.1 Board Assurance Framework Q3 2010/11

Charlie Sheldon, presented the Q3 board assurance framework (BAF). Following review by the Executive team this had been presented to the Risk Committee for formal review. He asked the Board to note the change with regard to the CQUIN targets for this year particularly with regard to Venous Thromboembolism. The Trust is planning to provide a "shadow" BAF for CHS. The board noted the report.

9.2 Monitor Quarter 3 Return

Jo Farrar, Director of Finance presented the Board with the Monitor Quarter 3 Governance return. He reported that the Trust has declared a finance rating of 3 and was therefore able to sign declaration one for Finance. With regard to Governance the Trust will need to declare a rating of amber-green and therefore declaration two should be signed. This is due to the Trust having a total of 7 MRSA bacteraemias to date. Charlie Sheldon tabled a paper outlining additional information being provided to Monitor in respect of the MRSA target. He provided the Board with a summary of the action being taken to reduce the risk of MRSA bacteraemias. The Board confirmed the declarations.

9.3 Declaration of Interests

Jo Farrar explained that the Trust's Standing Orders require the Board Directors to declare any 'relevant and material' interests to the Board of Directors each year. Additionally the Board were asked to declare relevant interests related to the enlarged organisation. Declaration forms for 2011/12 would be completed and signed at the end of the meeting.

9.4 Monitor Consultation on 2011/12 Compliance Framework

Jo Farrar provided the Board with a summary of the proposed changes to the Compliance Framework for 2011/12. These were:

- Requirements to self certify against the quality governance framework;
- Triggers and scope of governance reviews;
- Consequences of failing to submit or misrepresenting data;
- Inclusion of priorities from the operating framework;
- Incorporation of CQC judgments and NHSLA performance;
- Provision of community services and associated service specific indicators;

- Refinement of PFI and finance lease liabilities ; and
- Regulatory consequences of a financial risk rating of 2

The Board noted the contents of the consultation.

Business Planning & Performance Management

10.1. Finance and Performance Report Month 9

Jo Farrar presented the Board with the financial position for M9 and explained that the Trust was broadly in line with the plan. Activity levels and income continued above plan, although December saw a planned seasonal reduction in outpatient and elective work. The policy for non-payment of readmissions also took effect from 1st December, resulting in an estimated £125k loss of income for the month. Further risks to the year-end income position include a potential fine for breach of mixed sex accommodation rules, and a potential shortfall against the planned CQUIN income target. Pressure remains on clinical expenditure budgets across both pay and non pay categories, and work with budget holders to contain these will intensify during Q4.

Mixed Sex Accommodation

Charlie Sheldon provided the Board with a summary of issues raised regarding the implementation of mixed sex accommodation requirements. The original national instructions from the Chief Nursing Officer were clear with regard to ward areas but unclear with regard to areas such as day surgery and endoscopy, these limitations were acknowledged. Recent guidance published in December 2010 means that the same requirements for ward areas must now be applied to day surgery and endoscopy with the only exceptions being ITU. The trust has been reviewed by NHS London who had indicated we had complied with the national guidance up until the change in December. The Trust has now put plans in place in day surgery and endoscopy to ensure compliance with the revised guidance by April this year.

The Trust has received a letter from the sector performance team stating that it believed the Trust to be in breach of the guidance for the whole of the financial year to date and was imposing a fine with a gross value of £4m which after an 'investment' discount was revised to £2.5m.The Trust has disputed this and written to the sector explaining its position and application of the guidance. The Trust has received a response to its letter from the sector indicating they do not agree The Trust believes that the sector has not followed guidance regarding the notification process (performance notices) and data for previous quarters has already been signed off. The Trust is seeking advice on this matter and a further response to the sector is required. The board will be updated on this matter as further information is available.

The organisation remains on track against the majority of key national access targets. HSMR figures have improved from the previous month where we were below the threshold. The Trust has had a further MRSA case in the month which has resulted in exceeding Monitor's de minimus limit. Monitor has been informed of this development and details have been provided under item 9.2. The Trust has also experienced a number of implementation issues related to a new version of the discharge summary form, although steps have been taken to ensure that this will not adversely impact on our income recovery for the month.

The Board noted the report.

10.2. Business Planning and QIPP 2011/12

This item was discussed under reserved business.

10.3. Staff Restructuring

This item was discussed under reserved business.

Human Resources

11.1 Staff Survey

The Board noted the contents of the 2010 Staff Survey.

11.2 Honorary Professorial Appointments

Dr John Coakley was pleased to inform the Board that Dr Graham Bothamley, Dr David Watson and Prof. Roy Homberg had been given honorary titles as professors with Queen Mary University of London and Dr Narendra Aladangady had been given the title of Honorary Reader.

11.3 AAC Ratification

None

12.0 Minutes of the Risk Committee and Audit Committee

The Board noted the content of the Risk and Audit Committee minutes from December 2010.

13.0 Any Other Business

Charlie Sheldon informed the Board that a proposal regarding a new approach to NED appraisal had been drafted and that this will aim to involve Governors.

BOARD OF DIRECTORS

Meeting date: 23rd February 2011 **Agenda Item: 7.1**
Paper: 10-120

Title:	Community Health Services Update

Summary:	The CHS Update paper: ○ Provides an update on Monitor assessment process ○ Provides an update on NHS London Stage 2 approval process ○ Outlines key programme milestones ○ Summarises key outstanding issues ○ Integration Risks (Risk register attached)

Action:	The Board is asked to note the contents of the update paper , including outstanding issues and the risk register

Prepared by:	Sallie Rumbold, Programme Director
presented by:	Tracey Fletcher, Chief Operating Officer

Compliance:	Regulatory

COMMUNITY HEALTH SERVICES – UPDATE PAPER

BOARD OF DIRECTORS

WEDNESDAY 23rd FEBRUARY 2011

1. INTRODUCTION

This paper provides an update on the status of the transfer of NHS City and Hackney's Community Health Services (CHS) to the Homerton.

This paper provides a summary of:

- Progress with Monitor Assessment Process
- Progress with NHS London Stage 2 Approval Process
- Integration Programme Milestones
- Outstanding Issues
- Application of Investment Adjustment to the Financial Risk Rating 2010/11

2. Monitor Assessment Process

The Board to Board meeting with Monitor took place on 8th February. During this meeting further assurances were requested regarding the 2011/12 QIPP programme. Additional meetings with the Monitor assessment team were held the following day and further detail related to the QIPP programme submitted to Monitor. Feedback so far suggests that the assessment team gained sufficient assurances from the Trust regarding the QIPP programme both in terms of detailed savings plans, progress and governance arrangements. We understand informally that the assessment team will be recommending to Monitor's Board that that the transaction should go ahead. Our transaction application is expected to be reviewed at Monitor's Board meeting on 24th February and formal communication of the decision is expected soon after this.

3. NHS London Stage 2 Approval

Informally we understand that Stage 2 approval has been granted by NHS London pending our response to a minor information request regarding CHS income and expenditure position. Formal notification of approval is awaited but is expected to be received before the end of February 2011.

4. Integration Programme Milestones

The programme remains on track for C&H Community Health Services to transfer to the Homerton on 1st April 2011. The following documents are requirements of the transaction process and will need to be completed and signed off prior to the transfer date.

4.1 Business Transfer Agreement (BTA)

The last remaining issues are being worked through and include agreeing the detailed lists contained in the various schedules within the BTA. The staff transfer list is also a key item required as a component of the BTA and a number of other issues such as a final reconciliation to ensure funding for all posts (including vacancies) transfers with a clear audit trail. We are working to achieve final sign off by the end of February 2011 and are currently on track to achieve this.

4.2 SLAs

The ICT and Estates and Facilities SLAs are near completion and expected to be signed off by the end of February 2011.

4.3 Community Services Contract

Contract documentation has now been received and a series of negotiation meetings have been set through to the end of March. The PCT are aiming for sign off by the end of February but as documentation was not received until last week this timescale is thought likely to slip into the end of March 2011. The contract documentation, schedules and embedded documents are complex and are likely to require considerable time to discuss, amend and agree. In particular the proposed performance indicators, KPI's and CQUIN targets will require further discussion and negotiation with C&H PCT Commissioners who are currently taking the lead commissioner role. A joint approach to the negotiations has been agreed with CHS which is essential to the success of the contracting process but creates its own challenges as it is taking place during a time of considerable change for CHS teams and during a critical stage in the integration programme itself.

5. Key Outstanding Issues

The integration team are now focusing on the practical tasks required pre transfer to ensure the transfer of CHS happens safely on the 1st April 2011. This 'go-live' planning is happening in conjunction with CHS colleagues. The following is a summary of key issues outstanding although currently it is anticipated that these will all be resolved prior to 1st April.

5.1 Electronic Staff Record (ESR) Upload & Staff Transfer List

The details of all CHS staff transferring must be transferred from the City & Hackney ESR system to the Homerton ESR system. This work will be carried out by the NE London Pay Consortium. The ESR upload is vital to ensure that staff can be paid by Homerton from 1st April. The information that transfers includes staff details, pay scale and pay point, budget and ESR position. For this upload to start a complete and fully reconciled list of staff transferring has to be received. To date a final list has not been received for C&H PCT.

The reconciliation process is being led by the Workforce Team at C&H PCT and involves detailed checking and sign off by CHS senior managers, operational

teams, HR and finance. The process is complex and has taken longer than the C&H/CHS teams had originally anticipated.

The delayed staff transfer list is now a significant go-live issue and as such has been escalated to CEO level. We currently expect the list to be received by the end of 18th February and anticipate that work can start on ESR on 19th February. Provided that this deadline is achieved essential work will be completed in ESR in time for the transfer date.

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5.2 TUPE Consultation

The TUPE consultation for CHS staff commenced on 5th December 2010 and is due to conclude on 5th March 2011. Regular meetings are taking place as part of this process and the Homerton workforce teams are actively involved. There is no indication at present of any concerns that could delay the process.

5.3 Staff Manual, Induction & Training

A number of key CHS staff will require training in readiness for the transfer date. Training is currently being planned for two half days in March and will include training on use of the iProc system for ordering, datix training for electronic recording and management review of risk incidents and financial and budgetary sign off processes. This is likely to only involve a small number of senior managers from CHS in the first instance. Training will be cascaded to other staff on an ongoing basis after 1st April.

A staff manual is being produced which will be issued to CHS staff towards the end of March. This manual will provide information on processes and policies and where to find and obtain help and information. The manual will be provided electronically although some paper copies will also be provided for staff with limited access to computers. The aim is for the manual to provide links to the various policies and procedures which will be held on the intranet. A go-live planning event for CHS staff is planned for 28th February to launch the staff manual.

5.4 IT & Telephone Systems

The Homerton and C&H PCT computer networks have now been technically linked which allows CHS staff to access the Homerton intranet. This is the first step in a more complex plan to ensure smooth access to essential IT and information systems and also Homerton email for all staff whether working on a CHS site or at the Homerton. It is planned that all CHS staff transferring to Homerton will move to a Homerton email account. A plan is also being developed for telecoms which will ensure that phonebooks are shared and that when patients or staff call either CHS or Homerton services the phone system appears seamless although in practice will remain technically separate.

6.0 Risks

The integration risk register is reviewed at least monthly at each internal project board meeting. The most recent review took place on 7th February by the executive team. Key risks are being actively managed by the programme and executive teams. The updated integration risk register is attached for information.

7.0 Application for an Investment Adjustment to the Financial Risk Rating 2010/11

The Compliance Framework sets out the option for Foundation Trusts to apply for an investment adjustment to their financial risk rating following a major investment. This is in place to ensure that Foundation Trusts are not dis-incentivised to consider major transactions due to the short-term negative impact that the costs of such a transaction has on its financial risk rating and its ability to continue to deliver high quality services.

Monitor have recently published further guidance on the process and will consider each application on a case by case basis.

The Trust therefore plans to submit an application to Monitor for an investment adjustment in its Quarter 4 return for 2010/11. The application will set out all the one-off costs incurred during the financial year as a direct result of the integration with Community Health Services (circa £0.9m) and provide evidence that they meet the following criteria:

- costs relate to a major investment
- costs are limited to the impact of the transaction
- costs are short term and time limited

It should be noted that any adjustment will not be applied to the liquidity metric in the financial risk rating calculation.

The Board are asked to note the intention to apply for an investment adjustment to the financial risk rating.

Tracey Fletcher
Chief Operating Officer

Sallie Rumbold
Programme Director

Fiona I'Anson
Assistant Director Finance

16th February 2011

BOARD OF DIRECTORS
CONFIDENTIAL ***

Meeting date: 23rd February 2011 **Agenda Item: 7.2**
Paper: 10-121

Title:	**Strategic Changes: Implications for the Homerton**

Summary	A number of externally driven changes are occurring that could have a significant impact on the Homerton. These are listed in the attached paper.

Action:	The Board is asked to consider the Strategic Changes and develop its response to them.

Prepared by:	**Nancy Hallett, Chief Executive**
Presented by:	**Nancy Hallett, Chief Executive**

Compliance	Terms of Authorisation Condition 1 Principal purpose

STRICTLY CONFIDENTIAL
Board of Directors
Wednesday 23rd February 2011
Agenda item 7.2

Strategic Changes: Implications for the Homerton

Introduction
This paper sets out a number of external developments which stand to impact on the Homerton.

Commissioning Clusters
In line with Department of Health directions, the three Inner North East London PCTs (Newham, Tower Hamlets and City & Hackney) are integrating to form the East London Commissioning Alliance (ELCA). Alwen Williams has been appointed as the chief executive of ELCA and is now the accountable officer for all three PCTs. The ELCA management structure has been issued and director appointments made. It is understood that the managerial functions of C&H PCT will transfer to ELCA this week.

The ELCA chair appointment is planned for 1st March; there will be nine additional NEDs, three from each locality.

ELCA is designed to operate for the period up to April 2013, the point at which GP commissioning will be fully operational. SHAs cease to exist from April 2012. The prime function of the PCT cluster organisations is to support the development of GP commissioning. In the meantime they will be responsible for commissioning both hospital and community services. In this regard they must ensure a balanced financial position across the health economy and the maintenance of quality and performance standards.

My sense is that ELCA will want to develop a constructive relationship with the Homerton. The main source of any challenge to the relationship will come for the economic constraints we collectively face.

GP consortia – application for Pathfinder status
Two GP consortia are emerging in Hackney; ELIC (c. 200,000 population) and KLEAR (c.50,000). Both are applying for Pathfinder Status which, if supported, will allow them to operate as shadow commissioning units under the auspices of ELCA from this April.

The Hackney GPs continue to express support for the Homerton. As above though they will operate in financially constrained times. We cannot assume we will be 'looked after'.

They Hackney GPs are voicing nervousness about the potential impact of the BLT/Newham/WX merger for the future of the Homerton, and indeed for the provision of health care in north east London.

BLT/Newham/Whipps Cross proposed merger
The boards of Whipps Cross, Newham and BLT trusts have stated their intention to merge to form, in the first instance, a new NHS trust and subsequently an NHS foundation trust (in advance of the April 2014 deadline). Our understanding is that NHS London will formally consider the matter on 22nd February and an announcement on next steps is expected subsequent to this. We understand that trusts, SHAs and Department of Health must reach agreement by 31st March, at the latest, on FT plans.

The ethos and business model for the new trust has not yet been shared with us. However assuming that it does come to fruition it creates a huge (largest in the country) and potentially powerful institution on our doorstep.

I am being questioned by a range of interested parties about this development and the move away from the previous plan of a Homerton/Newham/WX merger. I continue to express my personal view that merger with other hospital(s) with a similar service base and population has the potential to offer strategic, financial and clinical benefit for the Homerton and that we remain open to consideration on the matter, but that in the meantime our plans are to develop the integrated hospital community services for Hackney.

Market development
Whilst our concentration may be on these big structural changes it is important that we remain alert to some of the other changes taking place. The Any Willing Provider policy is designed to facilitate entry of appropriately qualified providers into the market. Commercials sector companies are actively gearing up for this.

Accreditation requirements
We are seeing increasing specification of service specific standards. These focus on both outcome and input measures. For more specialised acute services, the input measures may be more of a challenge to the Homerton than the outcome ones. Where outcomes measures exist we generally fare well. Input measures tend to relate to volumes and size and as a stand alone organisation we are potentially disadvantaged.

Summary
There are a number of strategic changes taking place, each with potential risks and opportunities for us. The Homerton may well be able to progress as a stand alone integrated care organisation but we need to be wise to the risks we face and develop mitigation plans. At a financially difficult time, investment in business development/marketing functions must be considered. Our relations with key external partners must also be actively attended to.

It remains my personal opinion that merger with another hospital, if the circumstances were right, would offer the Homerton and through this the people of Hackney the most secure future.

The Board must reflect on the situation it now faces and consider the moves required to ensure a sound future.

Nancy Hallett
February 2011

BOARD OF DIRECTORS

Meeting date: 23rd February 2011 **Agenda Item: 7.3**
Paper: 10-122

Title:	Health and Social Care Act Analysis

Summary	The attached paper sets out a brief review of the salient points contained in the Health & Social Care Bill currently passing through Parliament. There are two attachments, the first a summary of the implications prepared by Bevan Brittan LLP which applies to the whole NHS, the second a larger document prepared by the Foundation Trust Network outlining the implications for Foundation Trusts.

Action:	The Board is asked to note the contents and their implications for this Trust.

Prepared & Presented by:	**Dr John Coakley, Medical Director**

Compliance	Terms of Authorisation - Condition 1 Principal purpose

The Health and Social Care Bill has been published and reflects the White Paper and the response to the consultations.

- Commissioning will be transferred to GP commissioning consortia and the National Commissioning Board from 2013, and PCTs will be abolished.
- SHAs will be abolished.
- Providers will get some freedoms but the NHS trust model will be abolished from 2014 so all providers will be Foundation Trusts or from the independent sector. There will be an open market to any willing provider.
- Public health goes to the local authorities subject to a degree of central supervision.
- The Secretary of State loses powers of direction over the NHS and the role becomes focused on public health.
- Monitor will lose its supervisory role over FTs but gain a new role as economic regulator with powers and duties to ensure continuity of supply of services.
- The duty of quality becomes strengthened.
- There will be abolition of central control.
- Public involvement will be increased.
- Health and Wellbeing Boards will be set up under local authority control.

These are substantial changes to the NHS and will challenge many currently existing arrangements.

There are a number of concerns, perhaps best articulated by the Consultants Committee of the British Medical Association. These are:

- Competition based on price will detract from quality
- Commissioning will only work with the involvement of all expert clinicians
- National terms and conditions of service underpin a national health service
- The NHS should not be a market place
- Measuring quality rather than targets is good

While there seems to be nothing in the Bill explicitly suggesting that all of these changes will be introduced, there is concern from all the unions and many professional bodies that they may be. The principal concerns relate to the market in healthcare and competition based on price not quality.

The Board may wish to discuss any or all of these matters, or those contained in the attached papers.

John Coakley
February 2010

Health and Social Care Bill

24/01/11

So now we have it! The Health and Social Care Bill has at last been published – and whilst it largely reflects the White Paper and the response to the consultations, there are some important shifts in emphasis.

There are no changes to the core architecture set out in the earlier papers:

Commissioning will be transferred to GP commissioning consortia and the National Commissioning Board from 2013, and PCTs will be abolished

SHAs will be abolished

Providers will get some freedoms but the NHS trust model will be abolished from 2014 so all providers will be Foundation Trusts or from the independent sector

Public health goes to the local authorities subject to a degree of central supervision

The Secretary of State loses powers of direction over the NHS (but see below)

Monitor will lose its supervisory role over FTs but gain a new role as economic regulator with powers and duties to ensure continuity of supply of services

The Secretary of State's role becomes focused on public health

The duty of quality becomes strengthened.

However, as with any substantial piece of legislation – about the same size as the NHS Act 2006 – there is a lot hidden in the detail. We will be producing a series of detailed analyses of the different themes in the Bill and, more importantly, identifying what is not in the Bill.

By way of some headlines:

Abolition of central control?

Although the Secretary of State gives up the power to direct health service bodies, the new system is very much a rulesbased system and the Secretary of State makes the rules. For example, the Secretary of State has the power to make regulations requiring the Commissioning Board or consortia to make treatments or services available, how decisions are to be made, and what must be provided for in contracts. The latter point suggests that we may see contracts regulations for secondary care that mimic the current arrangements for primary care where the GMS and PMS contracts regulations impose quite a tight hold over the form and content of the contracts.

What does disappear is the power to tell individual providers that unless they do something or desist from it, a direction or requirement will be imposed on them. There are of course also default powers for the Secretary of State to step in the event of failure by the Commissioning Board; in turn the Commissioning Board has powers to intervene where a commissioning consortium is failing or has failed or where it is satisfied that there is a significant risk that it will do so. The inclusion of future risk is perhaps evidence of Treasury concern over the financial management of consortia.

Public involvement – no decision about me without me

Despite the rhetoric over recent months, there are some significant shifts in the extent of public accountability and control over the decisions in the NHS. The absence of any public or non executive role in the consortia has remained a gap, but two important changes appear to try to limit the role of patients and public in the health service change.

Firstly, according to the consultation response, the powers of Overview and Scrutiny Committees to refer changes to the Secretary of State is to be limited to only those services designated by the consortia for the purpose of ensuring continuity of service through the exercise of Monitor's new powers (see below).

Perhaps more puzzling is the subtle shift in language over the duty of public involvement. Rather than just making the GP consortia subject to s.242 of the 2006 Act, the Bill imposes a freestanding duty in similar terms, but subject to the threshold that the proposals would have 'a significant impact' on the services delivered to individuals or the range of services. What is more puzzling is that the providers are left under s.242 without the threshold. It is unclear how this fits with the NHS Constitution, which of course the commissioning consortia must have regard to.

An open market?

The changes in the role of Monitor are significant although they will be phased over a period of time as it will retain its current role of approving (or not) FT applications until 2014, and its supervisory role through the accountability framework for up to two years beyond that for some FTs.

Monitor's new role as economic regulator will be an interesting exercise in balancing between the promotion of competition and duties to ensure continuity of services where these have been designated by Monitor on the application of the relevant commissioner, and indeed more widely having regard to the need for access to services more generally in its price setting function. Monitor will become a parallel enforcer of much of competition law including Articles 101 and 102 of the European Treaty, at least as regards providers. The relationship between commissioners and European law is left vague in the Bill, with a power to make regulations controlling this and requiring best practice, and a power for Monitor to investigate complaints. The consultation response indicated that this would be a reserve power, but it seems unlikely that it will remain so for long, and even if it does the expectation is that the courts will fill the gap and require best practice where tenders are carried out, and potentially to require tendering. Long term friendly relationships between commissioners and providers are unlikely to survive in the new regime.

Monitor will also have a licensing role for all NHS providers, through which standard or special conditions will apply. These are likely to include obligations to pay fees, and to contribute to the fund for special administration of providers of designated services. There will be obligations in respect of the supply of information to Monitor and to notify the OFT if a merger is proposed.

The key messages from this are that the health sector is expected to become fully subject to competition law, and the scope for competition both between existing providers and with new entrants into the market will substantially increase. The theory is that this will improve the quality of services and make them more efficient; it may also in the short term increase transactional costs and create instability in the system. Any willing provider models may also undermine competition unless there is clear separation between referrers into the service and the providers.

Provider changes

The well flagged changes to the FT regime of the removal of controls on borrowing and private income duly appear in the Bill and will be largely welcomed by the FT movement; what may be more of a challenge is the change to the regime of supervision. Whilst CQC remains in place as the regulator on quality, in place of Monitor, FTs will be supervised only by their governors. The Government has recognised the need for support for governors in relation to this, and has provided for a duty on the FT to ensure that the governors have the relevant skills and knowledge. Monitor is given the power to set up an advisory panel to consider on the application of a majority of the governors whether the FT is acting in breach of its constitution or an obligation under the 2006 Act as amended.

This, in part at least, answers the point about how governors are to be funded to carry out the type of review and in consideration of concerns about the Trust currently carried out by Monitor. However it remains to be seen how far the committee in fact merely carries on the role of monitor but with an advisory rather than decision making character, or whether in fact it takes a narrow view of its remit. The FTs will be required to pay Monitor fees in respect of this – again is this a level playing field as there is no equivalent for non FTs who may be competing for the same work?

Directors' positions are changed little – merely the addition of an explicit duty to act so as to maximise the benefits to members and the public. The omission of any reference to patients is striking, as is the focus on the individual organisation. This is in contrast to the duty of cooperation on all NHS bodies in s.72 of the 2006 Act which remains.

Whether this is consistent with a level playing field for all providers remains to be seen.
The seemingly unending saga of the insolvency regime for FTs is given a new proposed solution, with broadly speaking the imposition of normal insolvency law and the removal of the option of de-authorisation. This creates risks for organisations of failure which will be a challenge and also for directors who potentially face greater risks through the sanctions available in insolvency against directors including potentially money claims for wrongful trading.

Health and Wellbeing Boards

In addition to the responsibilities for public health, local authorities will now be required to establish Health and Wellbeing Boards which will have responsibility for encouraging integration of health and social care commissioning, and to encourage s.75 arrangements. Indeed the health and wellbeing strategy which the Board will be responsible for developing on behalf of the authority and the relevant commissioners has to consider explicitly whether s.75 may improve the way in which services are delivered.
The role of the Health and Wellbeing Board in carrying out functions of the local authority and the commissioning consortia is a bit odd in governance terms. If this means, in effect, delegation without accountability, it is difficult to see that it will have buy in, particularly from the consortia who have limited representation on the Board. Equally the funding arrangements for the Board are unclear, and although expressly constituted as a committee of the local authority (which with potentially only one elected member is a little unusual) it is difficult to see that the local authorities in their present financial shape will want to invest heavily in this.
There are many other areas in the Bill which invite comment and we will be covering these in coming weeks, as the Bill makes its way through Parliament.

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FTN briefing

Health and social care bill 2011

Introduction

1. The government published the Health and Social Care Bill 2011 on Wednesday 19 January; it has received its first reading. The Bill is necessarily legalistic in its framing and serves to amend previous Health Acts. We expect the explanatory notes for the Bill to be published within the week, which will give greater clarity on the meaning of the Bill's provisions. The Command Paper published in December also outlined the legislative intent in an accessible way.

FTN briefings and lobbying work

2. The FTN is working on briefings for MPs and parliamentarians to take forward lobbying on the Bill as it goes through parliament. You can track the progress of the Bill through parliament here.
3. In addition to planned parliamentary work, we continue to work very closely with officials in the DH who have been responsible for drafting the bill and regulations. This will be important for establishing the operational detail of the architecture.
4. In this regard, we had an extremely useful meeting between FTN members and officials from Monitor, the DH and the Co-operation and Competition Panel on 19 January, agreeing to work closely together to develop workable regulatory guidance for the new system which commands provider confidence.

Extent of secondary legislation

5. A Memorandum for the House of Lords Delegated Powers and Regulatory Reform Committee has been prepared by DH which outlines the extent to which it is proposed that secondary legislation is used to implement the Act, and how that will be effected, which members may find of interest.

Navigating the Bill

6. The Bill is divided into 12 parts; the most relevant to NHS foundation trusts are:
a. Part 1 – The health service (including NHSCB and consortia) (Clauses 1 – 45)
b. Part 3 – economic regulation and Monitor (Clauses 51 – 135)
c. Part 4 – NHS Foundation Trusts (Clauses 136 – 165)
7. Part 5 covers local government and Health Watch; part 8, NICE; part 9 – provisions around information and the information centre; part 11 (c.264-5) outlines the duties of Monitor and CQC to co-operate.
8. The schedules, of which there are 22, provide more detail on the various component parts of the proposed architecture. The most relevant to FTs will include Schedule 1 regarding the NHSCB; Schedule 2 on commissioning consortia and Schedule 7 – Monitor.
9. In the remainder of this document, we highlight to members the clauses pertaining to the major issues that we have identified in our analysis of the White Paper, Command Paper and the Bill to date and offer initial comment.

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FT Governance and freedoms

Governance

10. Provisions in respect of FT governors, Directors, Members, accounting, meetings and voting are outlined in clauses 136 to 143. The key provisions are set out below.

Governors

11. The bill includes changing the name of the board of governors to the council of governors, and deleting the requirement to appoint a PCT representative to the council of governors.
12. It also enables any organisation specified in the in the constitution to appoint one or more governors. This should help FTs strengthen their council and is a change the FTN has supported.
13. Governors are given a duty to hold non-executives individually and collectively to account for the board's performance and to represent the interests of FT members and

the public. Governors can also require one or more directors to attend a meeting to provide information on the directors' performance of their duties, and annual reports must include information on any occasions where this power has been exercised.
14. FTs will also have a duty to ensure that governors have the skills and knowledge they need to carry out their role. The FTN is developing a programme to support this.
Directors
15. The bill adds specific duties for directors including severally and collective to promote the success of the corporation to maximise benefit to members and the public, to avoid direct and indirect conflicts of interest, and not to accept benefits from third parties. Directors must declare direct and indirect interests.
16. Also boards of directors will have to give governors a copy of the agenda for the board of directors meeting prior to it taking place, and minutes as soon as practicable after the meeting.
Members and voting
17. On members the bill requires that an FT's membership is broadly representative of the population it serves. There will be requirement to hold an annual meeting of members (which will be open to the public) to receive the annual report, accounts and auditor's report. The annual report must include information on the FTs' pay policy and procedures, and work of the remuneration committee. FTs must publish directors' remuneration and expenses, as well as governors' expenses, in the annual report. At least one director must present the report to the annual meeting.
18. There is a new power for the Secretary of State to make regulations on voting arrangements by the council of governors, covering mergers and significant transactions (see below).
FT authorisation
19. Clause 144 essentially paves the way for an all FT public provider sector. It tidies up references to authorisation to be consistent with Monitor's new role covering the health industry rather than FTs alone – i.e. operation is not contingent on authorised status. Clause 165 repeals the provisions for FT authorisation.
Constitutional amendments and Governor Advisory Panel
20. Clauses146 and 147 make provision for constitutional amendments and a panel to advise governors. At least half of the council of governors and half of the board of directors must vote to approve any changes. The membership of the FT must confirm
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any changes to the constitution where they relate to the powers of governors (this is set out in clause 142).
21. The bill gives Monitor the power to establish a panel for advising governors. Governors will be able to refer questions to the panel as to whether the trust has failed to act in accordance with its constitution. A question can only be referred if more than half of the council of governors approve the referral. The FTN has questioned the establishment of the panel, and will continue to seek clarity on how it will operate.
Finances
22. Clause 148 establishes greater freedom to borrow, in line with previously notified proposals for an operationally independent banking function; the Secretary of State will be required to report on the activities undertaken in this regard. While the FTN identified the need for this function in its response to the White Paper, we will be seeking reassurance during the passage of the bill that independence is properly built in to any arrangement progressed.
23. This clause also removes borrowing limits.
Private patient income cap
24. Functions, including the straight removal of the private patient income cap and significant transactions are provided for in c.149 -52. As members will know, this reflects FTN lobbying for the removal of the cap over the last six years. We will seek to ensure that this proposal is protected as it makes its way through Parliament.
Significant transactions
25. There will be a new provision for a majority (over 50%) of the FT Council of Governors to approve significant transactions, though the determination of significant will be specified

by FTs' own constitutions; interestingly FTs may choose not to constitutionally describe what is significant and we are seeking clarity on what this means in practice.

Mergers and acquisitions

26. Clauses 153 – 7 give more details on mergers, acquisitions, separations and dissolutions. A governor-majority in each FT taking part is required to proceed with integrations (again 50%).

27. The FTN has lobbied for merger activity to be easier and the proposed legislation enables this; we have already put the case to officials and the Secretary of State that in addition to legislative barriers being removed, political will needs to support provider reconfiguration for it to be successful. We continue work with officials on the operative detail.

The failure regime and the end of NHS trusts

28. The failure regime is provided for in clauses 158 -63. De-authorisation is to be repealed. The new failure regime will be triggered if "the regulator is satisfied that an NHS foundation trust is, or is likely to become, unable to pay its debts".

29. The regulator may make an order authorising the appointment of a trust special administrator to exercise the functions of the governors, chairman and directors of the trust.

30. Clause 164 outlines the arrangements to apply repealing the 2006 Act provisions regarding NHS trust status. It states clearly on the face of the bill that the abolition of NHS trusts will come into force on 1 April 2014, which the FTN has strongly supported.

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Economic Regulation and Monitor

31. The duties of new Monitor are outlined in Part 3, beginning at clause 51.

Chapter 1 – Monitor

• Establishes the main duty of Monitor, to exercise its functions to protect and promote healthcare service users interests by promoting competition where appropriate and by regulating if necessary.

• Monitor is required to have regard to healthcare demand, economic and efficient provision, safety, continuous improvement, access, training, research and investment.

• Monitor must avoid conflict of interest between its role as interim Foundation Trust Regulator and its new duties. Monitor is required to publish reports on the resolution of such conflicts.

• Monitor must have regard to principles of best regulatory practice and publish regular statements on ensuring it does not impose or maintain unnecessary burdens.

• Additionally Monitor has a duty to carry out impact assessments and consultations on many of its actions (excluding competition functions and market reviews).

32. The Impact Assessment which accompanies the Bill includes cost estimates for Monitor and its functions. The annual running cost of new Monitor is estimated at £72m which is based on them having about 500 staff plus costs (this is about five times current staff numbers). There is an estimate of annual cash call on risk pool of £21m to £57m per provider failure depending on number of designated services (they estimate an average of £26m).

33. Chapter 2 – Competition

• Monitor will have concurrent powers with the OFT under the Competition Act 1998 and the Enterprise Act 2002.

• The Bill flags that the NHSCB and consortia will have requirements imposed on them relating to good practice procurement, patient choice and promoting competition. These regulations are not set out here and the FTN will be keen to ensure that they sufficient to prevent anti–competitive behaviours such as inappropriate self supply.

• Monitor will be given the power to investigate any complaints regarding these regulations and declare that an arrangement was "ineffective" and compel commissioners to remedy a failure or even for a service to be re-tendered.

• The Enterprise Act will now cover NHS foundation trust mergers. This will mean they are generally subject to the agreement of the OFT and Competition Commission rather than the Secretary of State.

• The Competition Commission will carry out a review of the provision of NHS healthcare and can make recommendations to Monitor, the NHSCB or the Secretary of State.

34. Chapter 3 – Designated Services

• Commissioners will apply to Monitor for the designation of services. The criterion that they are to use is if removing the service (without available alternatives) would have a significant adverse impact on patients' health now or in future. They will have to consult local authorities, local health watch and the provider of the service.
• Providers have the ability to appeal against designation and commissioners are required to review designations at least once every 10 years.
• The NHSCB will have to ensure commissioners agree on designations and if they can not it will determine the decision itself.
• The FTN will be seeking clarity over the designation of protected services, particularly how services can be un-designated. Our reading of the Bill clauses 69-73 suggests that designation will not have a set time frame (which has pros and cons) - once something is designated then it remains so until reviewed or appealed by

commissioner unless the provider appeals within 28 days – there is potentially insufficient flexibility here for provider-led reconfiguration.

35. Chapter 4 – Licensing

• Sets out the requirement for NHS health care providers to be licensed.
• The criteria for licenses and the grant of licenses are set by Monitor, who will also hold and publish the register of licensed providers.
• Monitor will determine the conditions within the license which will be part standard conditions and part special conditions with the consent of the applicant.
• Special conditions can be applied for a range of reasons relating to price, choice, competition and other responsibilities of Monitor.
• The conditions could include
  - Fees to Monitor
  - 'risk pool' requirements
  - Notifications of mergers to the OFT (FTs and NHS trusts only and for a 5 year period only)
  - Information requirements
  - Requirements to use the national tariff and other payment rules
  - Notice of intention to cease provision of designated services (and powers for Monitor to compel them to continue providing this service)
  - Use or disposal of assets used in the provision of designated services
  - Investment in relation to designated services.
• Monitor has powers to modify standard license conditions but providers are able to object and if a sufficient (undetermined) proportion object then the modifications can be blocked. Monitor can then refer the matter to the Competition Commission.
• Monitor has the power to impose discretionary requirements on breaches of the license, including the ability to fine up to 10% of organisation turnover. Monitor will set out in further guidance how and when it will impose such requirements.
• Monitor maintains the power to designate foundation trusts and maintain a compliance regime for a period of two years after the start of licensing (the sunset clause anticipated, so that newly authorised FTs have a degree of oversight and stability in transition). The Secretary of State has the power however to extend this period.

36. Chapter 5 – Pricing

• Monitor will determine the currencies, price setting method and prices (or maximum price). It will set out the rules around local variation.
• Monitor will have the power to set different prices for designated services. These must be agreed in advance with the Commissioning Board.
• They will then be subject to a consultation period of 28 days in which organisations can object to the methodology but not the actual price. If a sufficient proportion

object then Monitor will have to review the tariff or refer the matter to the Competition Commission. Providers and commissioners will be able to appeal. They will consider whether Monitor has not had proper regard to the matters set out in exercising its duty, has made factual errors or is wrong in law. It appears that the Competition Commission may in some circumstances can itself make adjustments to the methodology of tariff setting (section 109 part 5) and the FTN will be seeking clarity on this matter.

• For designated services local commissioners and providers can agree a price different from the tariff if it would otherwise be uneconomic for the provider to supply this service to the NHS. This must be agreed by Monitor.

• Additionally a provider themselves can apply to Monitor for such a price adjustment, even without commissioner agreement. If Monitor makes such an adjustment then the commissioner **or** the National Commissioning Board can apply to have the service de-designated.

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37. Chapter 6 – Insolvency and Special Administration

• Sets out the applicability of insolvency laws to NHS foundation trusts (Insolvency Act 1986).

• Monitor will be able to apply for a health special administrator order for the court to appoint an administrator to continue providing designated services until the organisation is rescued or the service is transferred.

• The regulations governing the health special administrator and the special administration regime are yet to be fully set out.

38. Chapter 7 – Financial assistance in health special administration cases

• Monitor is required to establish mechanisms for providing financial assistance for special administration. This might be either

a) Mechanisms for raising money (e.g. risk pool), or

b) Mechanisms for ensuring providers arrange insurance facilities

• Monitor may make grants or loans if it is satisfied it is necessary to enable the continued provision of designated services or secure a viable long term business and there are no alternative funding sources.

• Monitor will be able to require commissioners to pay charges to support the continuing provision of designated services. This will be determined by future regulations set by the Secretary of State and is not confirmed in the bill.

• Monitor will definitely have the power to set a levy on providers in order to fund the risk pool. This will be reviewed each year and can be varied by provider, including being zero. The Secretary of State can impose a maximum amount that Monitor can raise from levies and charges.

• Monitor will have to periodically consult on their methodology for setting and collecting the levy and if it makes any changes. As usual if a sufficient number object the matter can be referred to the Competition Commission.

• The Secretary of State can provide financial assistance to Monitor if for some reason the established fund/mechanism is not sufficient.

Commissioning

NHS Commissioning Board and Commissioning Consortia

39. There are no changes to the overall function of the NHSCB since the Command Paper (Part 1 clause 5) and no changes to general functions of GP consortia – the latter will have commissioning responsibility for the physical and mental health services and services for the prevention, diagnosis and treatment of people who are provided with primary medical services (except in prescribed circumstances) or who have a ‘prescribed connection’ with the consortium’s area. It is important to note that there is as yet no definition of ‘prescribed connection’. (Part 1 clauses 6, 9, 10)

40. The Secretary of State can require the NHSCB to commission prescribed dental services, services for the armed forces, services for people who are detailed and any other services prescribed by the Secretary of State – i.e. where SoS thinks it would be more appropriate for the NHSCB rather than the consortia to do so, taking into account how many people require the service, the cost of providing the service, the number of

providers able to provide the service and financial implications for consortia (Part 1 Section 11).

NHSCB

41. General duties of NHSCB (Part 1 clause 19) include:

- To be effective and efficient
- To improve quality of services
- To promote autonomy

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- To reduce inequalities and promote patient involvement
- To obtain appropriate advice
- To promote innovation
- To promote research
- To encourage integrated working

Consortia

42. Applications to become a commissioning consortium must be made to the NHSCB including proposed constitution, accountable officer and other specified information. Consortia may make applications for variation, for mergers and for dissolution. Property and staff may be transferred in these cases (clause 21, amending Part 1 Chapter A2 Section 14A-14J of the 2006 NHS Act). As previously notified, the FTN will be working to ensure that the accountability mechanisms are sufficient to command members' confidence. The duties of consortia are outlined, which include duties:

- To be effective and efficient;
- To improve quality of services, including primary medical services;
- To reduce inequalities and promote patient involvement;
- To obtain appropriate advice.

43. Consortia in their commissioning arrangements must involve patients to whom those services being commissioned would be provided either through consultation, by providing information or through other means.

44. Consortia must not exceed their financial allocations (and through directions, the NHSCB can determine what can and cannot be counted under as part of the allocations to consortia and also what expenditure and use of resources can and cannot be counted), Note – all of the above relating to consortia may be a requirement under Regulations. (clause 23, amending Part 1 Chapter A2 Section 223I of the 2006 Act).

45. Regulations may impose requirements on the NHSCB and consortia that they adhere to good procurement practice, protect and promote the right to patient choice and promote competition in the provision of services.

46. Regulations may impose specific requirements relating to tenders and conflicts between commissioning and provision of services.

47. Regulations may give Monitor the power to investigate complaints that the NHSCB or consortia have failed to meet the requirements under Regulations. Monitor's power would only be exercisable where it considers that the complainant has sufficient interest in the matter to which the complaint relates.

48. Monitor will have the power to declare provision arrangement ineffective/void and to direct the NHSCB or consortia to put the provision of the service out to tender. Monitor may only do this where the NHSCB or consortia have failed to meet the requirements under Regulation and where the failure is 'sufficiently serious'. Note – 'sufficiently serious' is not defined.

49. Monitor may be able to direct the NHSCB or consortia to put in place measures to prevent failures to comply with requirements, to remedy failures so that it becomes compliant with the requirements, not to exercise prescribed functions in relation to provision of services, to vary or withdraw tenders, to vary arrangements made for provision of services made as a result of putting a service out to tender. Failures to comply with requirements are actionable. However, Regulations may provide for a specified defence for action and prevent action.

FTN, 20 January 2011

BOARD OF DIRECTORS

Meeting date: 23rd February 2011 **Agenda Item: 8.1**
Paper: 10-123

Title:	**Patient Experience and Quality Report**

Summary	The attached paper shows the Trusts 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:	The Board is asked to note the report.

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

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

Paper attached separately

BOARD OF DIRECTORS

Meeting date: 23rd February 2011 **Agenda Item: 8.2**
Paper: 10-124

Title:	**Meeting the Care Quality Commission, Monitor and Department of Health requirements for Learning Disabilities.**

Summary	The following paper outlines the work to date on learning disabilities standards this year. The HUH is on track to achieve the standards required this year.

Action:	To note the report

Prepared by:	**Jenny Negus, Deputy Chief Nurse**
Presented by:	**Charlie Sheldon, Chief Nurse**

Compliance	*Care Quality Commission, Monitor and Department of Health requirements for Learning Disabilities.*

Meeting the Care Quality Commission, Monitor and Department of Health Requirements for Learning Disabilities.

1. Introduction

This paper provides an update on the Trusts current position in meeting required standards for the provision of accessible, safe, effective and quality care to patients with learning disabilities.

2. Background

For CQC 2010 registration Homerton completed the required section relating to "Access to healthcare for people with a learning disability". Whilst we could state that we have mechanisms in place in response to the questions posed the Trust was not at that point in time in a strong position with regards to flagging individuals, audit of protocols or training on learning disability awareness. Whilst this indicator was not a part of the scored assessment for 2009 / 2010 CQC registration there was a need to ensure compliance by April 2011.

The specific indicators are as follows:

- Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?
- Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: treatment options (including health promotion); complaints procedures, and appointments?
- Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities, including the provision of information regarding learning disabilities, relevant legislation and carer's rights?
- Does the trust have protocols in place to routinely include training on learning disabilities in their staff development and/or induction programmes for all staff?
- Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers within Trust Boards, local groups and other relevant forums?
- Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?

In addition to CQC registration all health and social care partnerships were required in 2009 / 10 to undertake a self assessment against a range of criteria. Homerton participated as a member of the Learning Disabilities (LD) partnership and an overarching City & Hackney action plan developed. This has been continuing over the past year and the re-assessment is due, being led by the LD Partnership Board, on which there is Homerton representation.

In March 2009 the Parliamentary and Health Service Ombudsman and Local Government Ombudsman published 'Six Lives: The provision of public services to people with learning disabilities', and investigation into the deaths of six people with learning disabilities who were in the care of the NHS. Six Lives included a series of recommendations of which the most relevant to Homerton is:

That all NHS and social care organisations should review urgently the effectiveness of the systems they have in place to enable them to understand and plan to meet the full range of needs

of people with learning disabilities in their areas; and the capacity and capability of the services they provide and / or commission for their local populations to meet the additional and often complex needs of people with learning disabilities; and should report accordingly to those responsible for the governance of the organisation within 12 months of the publication of this report.
NHS London in September 2010 produced 'Benchmark of Best Practice; Healthcare for Vulnerable People' a toolkit to measure effectiveness and address issues of concerns.

3. Progress

Homerton participated in the 2009 / 2010 borough self assessment and the subsequent development and ongoing implementation of the partnership action plan. A Trust Learning Disabilities Working Group (LDWG) was convened in July 2010 with membership from across the divisions and community LD services and an action plan developed. Meetings have been held monthly and some significant progress made. Achievements include:

- A 'Health passport' called 'The Purple Book' has been developed across Homerton LD, dementia & carers work that is being launched February with initial funding support from Department of Health.

- Close links have been developed with Trust safeguarding adults; dementia and carers work where there are considerable similarities.

- A parent of an LD child who had complained about the standards of care has become a member of the LDWG and is proving to be an extremely valuable member.

- A pathway mapping workshop has held with delegates from all possible access points in both elective and emergency care at Homerton, LD services and Department of Health. From this work a set of clear standards are being finalized and the pathways thought the Trust identified and mapped.

- A sticker and EPR system agreed for flagging patients known to have LD; aim is to have EPR solution but to use sticker as back up option if not available in time.

- The partnership Performance and Self Assessment Framework is in the process of being reviewed. This includes a range of indicators some of which relate to acute care. Every sector has been RAG rated against the indicators.

4. Performance against Monitor requirements:

Requirement	January Position	Risk of not completing by April 2011
Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?	**Amber**	Low – work on track. Purple Book launch February, close work with community LD services for flagging patients. Working group using national dementia strategy approach to developing pathway. Requirement to identify LD concerns needs to be addressed through agreeing a trigger question, for example; 'Do you consider yourself to have a disability?' Next steps dependent upon the answer will be identified within the pathway. Will need

		medical staff sign up.
Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: treatment options (including health promotion); complaints procedures, and appointments?	**Amber**	Low – interim solution of overarching statement identifying where accessible information can be obtained or assistance provided will be produced as our current information is being reviewed.
Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities, including the provision of information regarding learning disabilities, relevant legislation and carer's rights?	**Green**	Excellent carers work undertaken highlighted as best practice example; including development of Carers Rules, Carers page within The Purple Book and promoting carers as 'expert partners' as opposed to simply visitors or family.
Does the trust have protocols in place to routinely include training on learning disabilities in their staff development and/or induction programmes for all staff?	**Green**	Included in induction training since July 2010. Working group are developing wider training strategy.
Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers within Trust Boards, local groups and other relevant forums?	**Green**	Parent of LD adolescent is member of LD working group, two carers forums held in autumn of 2010 with 25 attendees at both.
Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	**Green**	LD policy in development which will include audit. Prospective audit included in roll out of The Purple Book.

5. Areas for Improvement

Identification of significant gaps in recording LD activity on EPR; primarily because patients present with a clinical condition and LD, if known is not being routinely added as a chronic condition. There are also a wide range of coding options and subsections.

- Consider using a single code.
- Once pathways mapped and health passport is in use we will have the alert / flagging system that will act as a prompt.
- Ensure need for diagnosed LD to be entered as a chronic condition entry to be made explicit in EPR training.

Differences in coding across primary & secondary care, along with challenges understanding community caseloads that have interfaced with Homerton has caused significant difficulties in understanding how many patients with LD attend or have attended Homerton; therefore flagging needs is extremely difficult.

- Can we consider a single code across primary & secondary care so we can track and monitor?
- GP's are allegedly 'not keen / willing' to release details of which patients of theirs that have LD are also known to Homerton. (LES data).
- C&H LD team 'unable' to track through their caseloads to identify which patients of theirs that have LD are also known to Homerton.

The Independent Mental Capacity Advocates (IMCA) have reported that Homerton has relatively low referral rates for MCA and Deprivation of Liberty concerns. Homerton has not been represented on the borough MCA Leads group until January 2011 and although mental capacity is covered in corporate induction there is concern that the importance of this is not fully recognised across the Trust. A meeting is scheduled with MCA expert to review our processes.

6. Conclusion

If work continues on track and the medium risks are addressed there is a high level of confidence that by April 2011, as required, the Trust will meet the requirements set out in section 2. Key areas of concern include where the Trust is reliant upon other agencies for information.

Jenny Negus
Deputy Chief Nurse
February 2011

BOARD OF DIRECTORS

Meeting date: **23rd February 2011**

Agenda Item: 8.3
Paper: 10-125

Title:	**DIPC Quarterly Report (Q3)**

Summary:	This paper provides a summary of infection prevention and control issues during the third quarter of 2010/11.

Action:	The Board is asked to note the attached report

Prepared & presented by:	**Dr Alleyna Claxton, Microbiology Consultant and Director of Infection Prevention & Control (DIPC)** **Charlie Sheldon, Chief Nurse and Director of Governance**

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

HOMERTON UNIVERSITY HOSPITAL

DIPC QUARTERLY REPORT

Quarter 3 2010/2011
(Oct-Dec 2010)

- Dr Alleyna Claxton

Table of Contents

Executive Summary: Quarter 3 10/11 (Oct-Dec 2010)

a) MRSA bacteraemias Quarter 3 10/11 and summary of Trust position:

- The 2010-2011 Department of Health 'MRSA Objective' target for the Trust is 4 Homerton-attributable (Post-48h) MRSA bacteraemias.
- The 2010-2011 Monitor target for the Trust is 6 Homerton-attributable (Post-48h) MRSA bacteraemias.
- By the end of January 2011 there have been 7 Homerton-attributable MRSA bacteraemias. The Trust has breeched its Department of Health target and its Monitor targets.
- **In Quarter 3 of 2010/2011 there were 2 Homerton-attributable MRSA bacteraemias. Both cases were probable contaminants in complex patients who were difficult to obtain a blood culture sample from whilst maintaining an 'aseptic field' and both samples were clinically appropriate. Therefore, there have been no clinically significant MRSA bacteraemias since August 2010 i.e. for the last 5 months.**
- **There is no epidemiological evidence of clustering of cases of MRSA bacteraemias in time or place. From a person-based risk factor/likely source analysis, there have been 3 IV line-related MRSA bacteraemias (2 adult, 1 neonatal), 3 probable contaminants and 1 case of osteomyelitis (in a patient admitted coincidentally for an unrelated condition).**
- By the end of January 2011 there have been 7 Homerton-attributable MRSA bacteraemias. The Trust has breeched its Department of Health target and its Monitor targets.
- The major risks to the Trust for the MRSA bacteraemias theoretically continue to be surrounding peripheral & central line management and blood culture contamination. However, a significant number of actions have been taken to reduce these risks as far as possible (see appendix 2).
- For full details of the MRSA bacteraemia case analysis and risk reduction actions to date, please see appendix 2. This MRSA bacteraemia 2010/11 summary has been presented to the January 2011 ICC and shared across the 'health economy' with the PCT, NHS London & Monitor and forms part of the Trust's presentation at the February 2011 meeting with SACU.
- The Homerton Communications team, DIPC & Chief Nurse have agreed on a design for the 'Bug awareness' signage campaign and the logistics of placing signs in the grounds of the Trust clearly visible on entry from the front and back entrance of the site are being finalised.

b) MRSA bacteraemia and CDI Objectives 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.

c) Hygiene Code Compliance – Q3 10/11 update:

- 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 Hygiene Code compliance using the Klarient Hygiene code self-assessment tool.

d) Quarterly HCAI mandatory surveillance – Q3 10/11 update:

i) MRSA bacteraemias – Q3 10/11 update:

- Trust-attributable MRSA bacteraemias – Quarter 3 10/11: 2

- PCT-attributable MRSA bacteraemias – Quarter 3 10/11: 1
- Root causes from SUI reports:
    - Likely Blood culture contaminant (Edith Cavell)
    - Likely Blood culture contaminant (ITU)
- MRSA DH bacteraemia target 10/11: 4
- MRSA Monitor bacteraemia target 10/11: 6
- {Total Trust-attributable MRSA bacteraemia cases 10/11(to 31/01/11): 7}

ii) Clostridium difficile infections (CDI):

- Trust-attributable CDIs – Quarter 3 10/11: 1
- PCT-attributable CDIs – Quarter 3 10/11: 0
- 10/11 target: 52 Trust-attributable cases
- {Total Trust-attributable CDI cases 10/11 (to 31/01/11): 8}

iii) GRE bacteraemias – Quarter 3 10/11: 3 (no targets set)

iv) 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 c. 6 months after the time period for which the data is collected.
- On the 25/08/2010 the Trust received a letter from Health Protection Agency Surgical Site Infection Surveillance Unit advising of higher rates of infection in TKR (compared with the average SSI infection rate for that procedure in England) in the last four periods. As expected, a second letter with identical advice was received on 29/11/10.
- In the time period of the previous review (June-Sep 2010), there had been 1 THR SSI out of 12 operations, giving a rate of 8.6% THR SSI against a national average of 0.63% (2009/2010 SSIS HPA data) and 0 TKR SSIs out of 31 operations, giving a rate of 0% against a national average of 0.54% (2009/2010 SSIS HPA data). The small number of operations at the Trust means that a single case of SSI leads to a large variation in the Trusts SSI rates. Given that these rates are publically available on the HPA website; this has the potential for prospective patients to misinterpret the risk of orthopaedic SSIs at the Trust.
- The single THR SSI had already been reviewed as part of Mr Khan's audit to the ICC in October 2010.
- The changes recommended in Mr Khan's audit have now been implemented (single-use iodophur impregnated drapes & gowns in Theatres and 'island-style' dressings for all patients).
- All THR & TKR SSI data will continue to be reviewed on a quarterly basis at the ICC.

e) <u>Incidents/SIIs/outbreaks/ non-MRSA SUIs – Q3 10/11 update:</u>

- There was no incidents in Q3 10/11
- There was one TB-related SII in Q3 10/11
- There were 2 clusters/outbreak in Q3 10/11 – MR-Acinetobacter (ITU) and RSV (NICU).
- There were no non-MRSA SUIs in Q3 10/11.

f) <u>IPC audit programme – Q3 10/11 update:</u>

i. The ICNA audit programme:
    - on track and all 6 audits performed in Q3 10/11 have been completed and action plans developed and re-audit dates set.

ii. HII monitoring:

- Includes: IV line ongoing care, urinary catheter ongoing care, IV cannula insertion, hand hygiene & MRSA screening.
- By this criterion the HII scores are 'red' for IV cannula insertion in CWSH & DSO (69% & 50% respectively) and for MRSA screening in GEM (70%).
- HII monitoring results are discussed at the Quality Improvement Committee, Matron's Monitoring Group and at ward level so that local action plans can be drawn up and implemented.

iii. Trust-wide audits:
- Follow up of MRSA Positive Patients identified in Pre-admissions Screening Programme audit
- IV lines prevalence audit
- Antimicrobial prescribing compliance audit
- Blood culture contamination audit

g) Matron's Monitoring Group – Q3 10/11 update:

- MMG meetings continue every other month.
- Updates on HII audit score action plans and other IPC issues are discussed and good practice is shared.

h) IPC education programme – Q3 10/11 update:

- IPC annual update training has now been completed by 67.5% of Trust staff.

i) IPC balanced scorecard – Q3 10/11 update :
- The IPC balanced scorecard data for Q3 10/11 is available as a separate excel spreadsheet as detailed in Appendix 3.

j) IPC risk register – Q3 10/11 update:

- The following risks remain on the IPC Risk Register after review of the current rating scores at the ICC in January 2011:
    - IPC annual update training (rating: 8) – this remains the most challenging risk. The date for review of this risk has been changed to the May 2011 ICC meeting as data for Q3 2010/11 is not available in time for the January 2011 ICC meeting.
    - 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
- After discussion at the January 2011 ICC, it was decided that the new risk of the reduced staffing resource of the IPC team due to 2 members of the team being on maternity for 9-12 months will be added to the risk register.

k) Cleaning services – Q3 10/11 update:

- No issues of concern have been identified in Q3 10/11.

l) Estates and Facilities – Q3 10/11 update:

- Ventilation report - The Trust does not currently have any fully compliant negative pressure side rooms due to a change in the requirements of the new HTM. The ICC discussed the risks and benefits of losing one side room on Lamb ward in order to be able to build a fully compliant negative pressure side room with a lobby area and it was decided that the risk of the Trust not

having suitable facilities for e.g. possible MDR-TB cases or Lassa fever was greater than that of the loss of a side room facility. Andrew Panniker has been requested to liaise with GEM to scope the costings of this project.

- Legionella & Water supplies - The January 2011 Environment report to the ICC RAG rated the Legionella and water supplies testing and sampling as 'amber'.The pseudomonas colonisation in water sample continues, particularly in the SCBU/NICU. The external expert (Dr Suzanne Surman-Lee) who assessed the Trust control for water quality has commented that new guidance will be published soon and the recommended levels of Pseudomonas will be zero. Her assessment included a complete review of the controls in place and actions taken to date for Legionella and Pseudomonas control. The written report is still pending but recommendations are likely to include the removal of the sensor taps (because they require TMVs (thermostatic mixer valves) to function) from the NICU/SCBU and TMV-containing taps from ITU. In systems where Pseudomonas is present, the use of sensor taps and TMVs makes it very difficult to reduce/eliminate the colonisation of the system. Removal of the sensor taps incorporating the TMV would reduce risk of pseudomonas colonisation in water supply. The ICC agreed that the risk and implications of babies acquiring Pseudomonal infection or bacteraemia on the unit was greater than the requirement for sensor taps and TMVs in order to reduce the risk of scald injuries. It was noted the HSE recommended using TMVs due to risk of scalding but as the sinks on these units are used purely by staff and visitors and no patients this risk could be managed. Risk management/Health and Safety to be involved in deciding which risk register the risk of scalding should be placed on when the sensor taps/TMV-containing taps are removed and whether any alternative measures to reduce scalding risk are appropriate.
- The Legionella policy will be reviewed with the recommendations from the external expert report when received and is due to be presented to the ICC at the next meeting in May 2011.

m) <u>Employee Health – Q3 10/11 update:</u>

- The draft 'Management of Occupational Needlestick and other Occupational Contamination Incidents' policy was discussed at the January ICC. This policy has been in draft form for several months beyond its review date and needs to be endorsed and taken to the Policy Group as soon as possible. It was agreed that the DIPC would review the policy and make suggestions regarding clarification of the new instructions for rapid source patient testing and liaise with the EHMS lead in order to send out a 2nd draft of the policy for comment as quickly as possible. Given the 2nd draft requires no major changes the DIPC, as Chair of the ICC, will endorse the policy by Chair's Action so that it can be sent to the February 2011 Policy Group for ratification.
- There were three staff contract tracing incidents in Q3 10/11 related to exposure to: Group C meningitis, TB and Measles/Rubella.
- Measles, rubella, chickenpox and tuberculosis screening update:
  High-risk areas are now 94.4% immune and work continues to screen and immunise the remainder. Work continues to target the medium-risk areas with 66.7% of staff known to be immune.
- Exposure Prone Procedure Register:
  The total number of EPP compliant staff is 96.9%. The remainder of those that are outstanding are those staff where an identified validated sample is required or a hepatitis C screening test is required in line with the 2002 guidelines.
- Needlestick injuries:
  There have been a total of 28 injuries for the last quarter (16 injuries in the previous quarter).
  A paper on the business case for 'safer needle' devices is being presented by one of the ICNs to the February Health & Safety Committee.
- EHMS has led a very successful Trust seasonal Flu vaccination campaign with a total of 53.1% of staff being vaccinated. This is double the national average of 26.1% and the Trust has been praised by local DPHs as an example of good practice both in our uptake rates and the collection of our data.

n) <u>IPC policies endorsed by the ICC – Q3 10/11 update :</u>

The following policies were endorsed at the January 2011 ICC:

- Infection Control Operational policy (including the ICC ToR)
- Outbreak policy
- Multi-resistant Gram Negatives policy
- Surgical Site Infections policy
- Single Use Medical Devices policy (Single use symbol added)
- IV line policy (additional instructions for Paediatrics)
- Surveillance & Incident Reporting policy
- TB policy (statement added in response to SII action point)
- Environment & Isolation Room Cleaning policy (updated with new disinfectant)

o) <u>Other IPC issues – Q3 10/11 update:</u>

- During Dr Claxton's maternity leave, Ms Vickie Longstaff, the ICNC & Deputy DIPC will act up as the DIPC with the support of the Chief Nurse. Dr Medina Ahmed will act as Dr Claxton's locum as Microbiology Consultant and Infection Control Doctor with the support of Dr Daniel Krahé, the Departmental Lead Microbiology Consultant. The DIPC & IPC team Annual programme 2011/12 can be found in Appendix 4. Whilst the IPC team will endeavor to complete the programme, it should be noted that the reduced IPC team workforce issues due to maternity leave will mean that the programme will need quarterly review at the ICC to re-evaluate progress against service needs for that quarter. Additional staff from outside the team e.g. bank nurses, other staff on secondement will be required in order for the audit programme to be completed. The Chief Nurse is aware of these issues and is in discussion with the ICNC to address them.
- It is expected that, as of the 31st March 2011, the IPC team will assume responsibility for CHS infection prevention & control. The ICNC is part of the Trust-wide team of specialist leads scoping the requirements of this additional remit.
- The new mandatory Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia surveillance has started as of January 2011 and all Trusts are required to return data on a monthly basis to the HPA enhanced Surveillance website. There are currently no objectives or targets set except the requirement to return the data. It is expected that there will be a new mandatory requirement to return monthly data on *E.coli* bacteraemias to the HPA enhanced Surveillance website as of April 2011. There is currently no reason to expect that any objectives or targets will be set in the near future except the requirement to return the data.
- In accordance with Trust practice the ICC, with the advice of David Bridger, are sending out a web-based performance review to all members of the ICC to ensure that the ICC is fit for purpose.
- Work has finally been completed to incorporate the MRSA & CDI status of patients automatically into the patient electronic discharge summary.

MRSA bacteraemias 10/11 (to date) – summary of Trust position

- The 2010-2011 Department of Health 'MRSA Objective' target for the Trust is 4 Homerton-attributable (Post-48h) MRSA bacteraemias.
- The 2010-2011 Monitor target for the Trust is 6 Homerton-attributable (Post-48h) MRSA bacteraemias.
- By the end of January 2011 there have been 7 Homerton-attributable MRSA bacteraemias. The Trust has breeched its Department of Health target and its Monitor targets.
- **In Quarter 3 of 2010/2011 there were 2 Homerton-attributable MRSA bacteraemias. Both cases were probable contaminants in complex patients who were difficult to obtain a blood culture sample from whilst maintaining an 'aseptic field' and both samples were clinically appropriate. Therefore, there have been no clinically significant MRSA bacteraemias since August 2010 i.e. for the last 5 months.**
- **There is no epidemiological evidence of clustering of cases of MRSA bacteraemias in time or place. From a person-based risk factor/likely source analysis, there have been 3 IV line-related MRSA bacteraemias (2 adult, 1 neonatal), 3 probable contaminants and 1 case of osteomyelitis (in a patient admitted coincidentally for an unrelated condition).**
- The major risks to the Trust for the MRSA bacteraemias theoretically continue to be surrounding peripheral & central line management and blood culture contamination. However, a significant number of actions have been taken to reduce these risks as far as possible (see appendix 2).
- For full details of the MRSA bacteraemia case analysis and risk reduction actions to date, please see appendix 2. This MRSA bacteraemia 2010/11 summary has been presented to the January 2011 ICC and shared across the 'health economy' with the PCT, NHS London & Monitor and forms part of the Trust's presentation at the February 2011 meeting with SACU.
- The Homerton Communications team, DIPC & Chief Nurse have agreed on a design for the 'Bug awareness' signage campaign and the logistics of placing signs in the grounds of the Trust clearly visible on entry from the front and back entrance of the site are being finalised.

MRSA bacteraemia and CDI Objectives for 2011/12

- The new Homerton-attributable MRSA and CDI Objectives for 2011/12 have been announced.
- 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.

Hygiene Code 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 Hygiene Code compliance using the Klarient Hygiene code self-assessment tool.
b) The Hygiene code has been updated and now contains 10 criteria (previously 9). This reflects a sub-division of one of the previous criteria rather than any additional requirements.
c) The 2 outstanding issues are the bed management policy which is currently in progress and the mandatory training of the junior medical staff who work at the Trust for longer than 12 months which Dr Coakley, Cheryl Clements and Charlie Sheldon are addressing.

MRSA bacteraemias and SUI/SII reports – Q3 10/11 overview

d) The 2010-2011 Department of Health 'MRSA Objective' target for the Trust is **4** Homerton-attributable (Post-48h) MRSA bacteraemias.
e) The 2010-2011 Monitor target for the Trust is **6** Homerton-attributable (Post-48h) MRSA bacteraemias.
f) All Trust-attributable (post-48h) MRSA bacteraemias are automatically SUIs and all PCT-attributable (pre-48h) MRSA bacteraemias are automatically SIIs regardless of clinical outcome.
g) In Quarter 3 of 2010/2011 there were 2 Homerton-attributable MRSA bacteraemias.
h) In Quarter 3 of 2010/2011 there was 1 PCT-attributable MRSA bacteraemias.

- Summary of Trust-attributable MRSA bacteraemias for FY 10/11 to date:

Patient	Date of admission	Date and place of blood culture	Comments/source
OG	20/02/2010	06/04/2010 Lloyd	Known to be MRSA positive. Central line infection
SD	06/03/2010	22/04/2010 Lamb	Known to be MRSA positive. Probable chest infection or contaminant
RS	07/06/2010	18/06/2010 Edith Cavell	History of MRSA on previous admissions Chronic osteomyelitis
PK	15/06/2010	14/07/2010 Halley	Hospital acquired colonisation Hickman line infection
BM	03/08/2010	11/08/2010 NICU	Hospital acquired colonisation Peripheral IV cannula site infection
EW	**08/10/2010**	**19/10/2010 Edith Cavell**	**Known to be MRSA positive Probable contaminant No evidence of deep seated MRSA infection at post-mortem**
VY	**14/10/2010**	**14/12/2010 ITU**	**Hospital acquired colonisation Probable contaminant**

- Summary of PCT-attributable MRSA bacteraemias for FY 10/11 to date:

Patient	Date of admission	Date and place of blood culture	Comments/source
VVG	23/04/10	24/04/10 Templar	No previous MRSA screening results Panton-Valentine leukocidin toxin +ve Casaerian-section wound infection
BL	**18/11/10**	**19/11/10 ACU**	No previous MRSA screening results **Diabetic foot ulcer +/-osteomyelitis or spondylodiscitis**

Trust-attributable MRSA bacteraemia SUI report summaries:

a) MRSA Bacteraemia – Edith Cavell (October)

The patient was admitted to the Homerton in 2009 and on an MRSA admission screen identified as MRSA positive. On the 08/10/2010 she was admitted via A&E with GI bleed and malaena to ACU.
PMH: IHD, AT, HTN, IDDM, TIA, breast Ca, left mastectomy, obesity and diverticular disease. She was then transferred to ITU. The MRSA admission screen was positive and she was started on decolonisation protocol. On the 17/10/2010 she was transferred to Lamb ward and on the 18/10/2010 to Edith Cavell. A blood culture was taken on the 19/10/2010 from her foot and the result was confirmed MRSA on the 21/10/2010. The patient was started on appropriate antibiotic treatment. The source of bacteraemia is difficult to determine and could be from a contaminated blood culture due to poor venous access or from a deep seated source not identified. On the 30/10/10 the patient had a cardiac arrest and died. Death certificate 1a) MOF 1b) MRSA septicaemia, 1c) IHD. However a subsequent postmortem did not reveal any evidence of deep-seated MRSA –related infection therefore a contaminated blood culture is the most likely source.

The source of the bacteraemia is most likely to be a possible contaminant due to difficulty of IV access.

Recommendations:

1. All staff inserting IV lines to ensure that all IV line insertion is documented in the patient's notes and lines are reviewed.
2. The importance of documenting IV line insertion to be reinforced with medical staff.
3. The importance of using the blood culture taking packs to be reinforced with medical staff.

All actions completed and SUI closed by PSC.

b) MRSA Bacteraemia – ITU (December)

The patient was admitted to ACU via A&E with acute pancreatitis on the 14/10/2010 and then transferred straight to ITU. On the 15/10/2010 he had 2 cardiac arrests and was intubated. A CT scan showed cerebral oedema. On the 25/10/2010 he had a tracheostomy. On the 31/10/2010 a groin swab was MRSA positive. On the 14/12/2010 a blood culture was taken and was positive for

MRSA, Klebsiella and Coagulase Negative Staphylococcus (CoNS). On the 16/12/2010 he was transferred to Edith Cavell ward.
on the 14/08/2010.

The source of the bacteraemia is probably a contaminated blood culture.

SUI to be presented to February PSC

Clostridium difficile infection (CDI) – Q3 10/11

- The HUH target for the financial year 10/11 is **52** hospital-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.)
- In Q3 10/11 we have had 1 Trust-attributable case of CDI.

- Summary of Trust-attributable CDI cases FY 09/10 to date:

Month	Number of Trust-attributable CDI cases	Root cause of CDI	Outcome
April 10	0	N/A	N/A
May 10	2	?End stage prostate cancer	RIP- CDI Pt II of death certificate
		?Antibiotic use prior to admission by GP	RIP - CDI Pt II of death certificate
June 10	2	End stage cancer	RIP
		?appropriate multiple antibiotic use or clinically not CDI	RIP - CDI Pt II of death certificate
July 10	0	N/A	N/A
Aug 10	2	Inappropriate use of ciprofloxacin	Discharged to Nursing Home
		?clinically not CDI	On RNRU
Sep 10	1	Appropriate antibiotic use	RIP - CDI Pt II of death certificate
Oct 10	0	N/A	N/A
Nov 10	0	N/A	N/A
Dec 10	1	Appropriate antibiotic use	Discharged home

Trust-attributable CDI SII report summaries:

a) Halley ward (December)

Patient admitted from nursing home and had a left hip hemiarthroplasty on 13/12/10. Antibiotic therapy was prescribed as prophylaxis for the L hip hemiarthroplasty. The antibiotics were compliant with the antibiotic prescribing policy.

Patient started having diarrhoeal stools on 16/12/10 but was not isolated. Patient was transferred to a sideroom in Priestley ward, commenced on stool precautions and was successfully treated with Metronidazole 400 mg TDS. Patient was discharged on 24/12/2010.

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 nor had any recent hospital admissions.

Antibiotic therapy was prescribed as prophylaxis for the L hip hemiarthroplasty performed on 13/12/2010. The antibiotics were compliant with the antibiotic prescribing policy.

Recommendations:
A discussion to be arranged between the infection control team and Halley ward manager to discuss the case and lessons to be learned from the event.

Actions completed and SII presented to the January 2010 PSC.

Glycopeptide Resistant Enterococci (GRE) bacteraemias – Q3 10/11

- There were 3 cases 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.

Surgical Site Infection (SSI) update

- 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 c. 6 months after the time period for which the data is collected.
- On the 25/08/2010 the Trust received a letter from Health Protection Agency Surgical Site Infection Surveillance Unit advising of higher rates of infection in TKR (compared with the average SSI infection rate for that procedure in England) in the last four periods. As expected, a second letter with identical advice was received on 29/11/10.
- In the time period of the previous review (June-Sep 2010), there had been 1 THR SSI out of 12 operations, giving a rate of 8.6% THR SSI against a national average of 0.63% (2009/2010 SSIS HPA data) and 0 TKR SSIs out of 31 operations, giving a rate of 0% against a national average of 0.54% (2009/2010 SSIS HPA data). The small number of operations at the Trust means that a single case of SSI leads to a large variation in the Trusts SSI rates. Given that these rates are publically available on the HPA website, this has the potential for prospective patients to misinterpret the risk of orthopaedic SSIs at the Trust.
- The single THR SSI had already been reviewed as part of Mr Khan's audit to the ICC in October 2010.
- The changes recommended in Mr Khan's audit have now been implemented (single-use iodophur impregnated drapes & gowns in Theatres and 'island-style' dressings for all patients).
- All THR & TKR SSI data will continue to be reviewed on a quarterly basis at the ICC.

Incidents, SIIs Outbreaks and non-MRSA SUIs: Q3 10/11

Incidents: Q3 10/11

- There were no IPC incidents in Q3 10/11.

SIIs: Q3 10/11

a) Smear Positive TB on Cardiology ward (November)

In 2002 the patient was diagnosed with TB and treated. From the 11/05/2010 – 21/10/2010 she had four admissions to the Homerton presenting with cough and shortness of breath, she was treated with nebulisers and/or antibiotics. On each occasion a chest x-ray showed changes due to tuberculosis, these were noted, but reported as showing no significant changes. The patient was admitted on the 22/10/2010 with shortness of breath and presumed ST segment elevation myocardial infarction (STEMI). On the 23/10/2010 she had right basal consolidation and was started on appropriate antibiotic treatment for a presumed Lower respiratory tract infection (LRTI) and hospital acquired pneumonia (HAP).
On the 02/11/2010 her case was discussed with microbiology as there was little improvement. Microbiology advised various investigations including sputum for acid fast bacilli (AFB – sputum test for TB) and side room isolation. Sputum was sent and the result on the 04/11/2010 was AAFB +ve, this was confirmed as Mycobacterium tuberculosis (MTB) (with no Rifampacin resistance markers) on the 09/11/2010 by the reference laboratory.

Root Cause
The patient should have been isolated and sputum sent for AAFB when the upper lobe fibrosis on the chest x-ray was noted. The radiology report should indicate that active disease cannot be ruled by chest x-ray where appropriate.

Recommendations

- All patients with upper lobe fibrosis on their chest x-ray and relevant clinical symptoms should have sputum sent for AAFBs and be isolated in a side room at least until results are known.
- Revise the Trust guideline on the management of patients with TB to include guidance on patients with previous TB and those with upper lobe fibrosis.
- All x-rays that show possible old TB to contain a standard comment on need for clinical input to assess disease activity.

Presented to PSC as an SII and action plan in progress.

Outbreaks: Q3 10/11

- There was 2 IPC cluster/outbreaks in Q3 10/11.

a) MR Acinetobacter on ITU (Nov/Dec)

In November a patient was transferred from another hospital with multi-resistant Acinetobacter. In November and December there were 3 cases of ITU-acquired Acinetobacter with various sensitivity patterns. All isolates have been sent to the HPA reference laboratory for typing. There have been no new cases since the 19th December 2010.

b) Respiratory Syncitial Virus on the SCBU/NICU (December)

There were a total of 5 neonates with confirmed RSV in SCBU in December. All babies were in the same room on the SCBU. All babies isolated, environmental cleaning increased and infection control precautions put in place. There were no further cases and all babies recovered.

Non-MRSA SUIs: Q3 10/11:

- There were no non-MRSA SUIs in Q3 10/11.

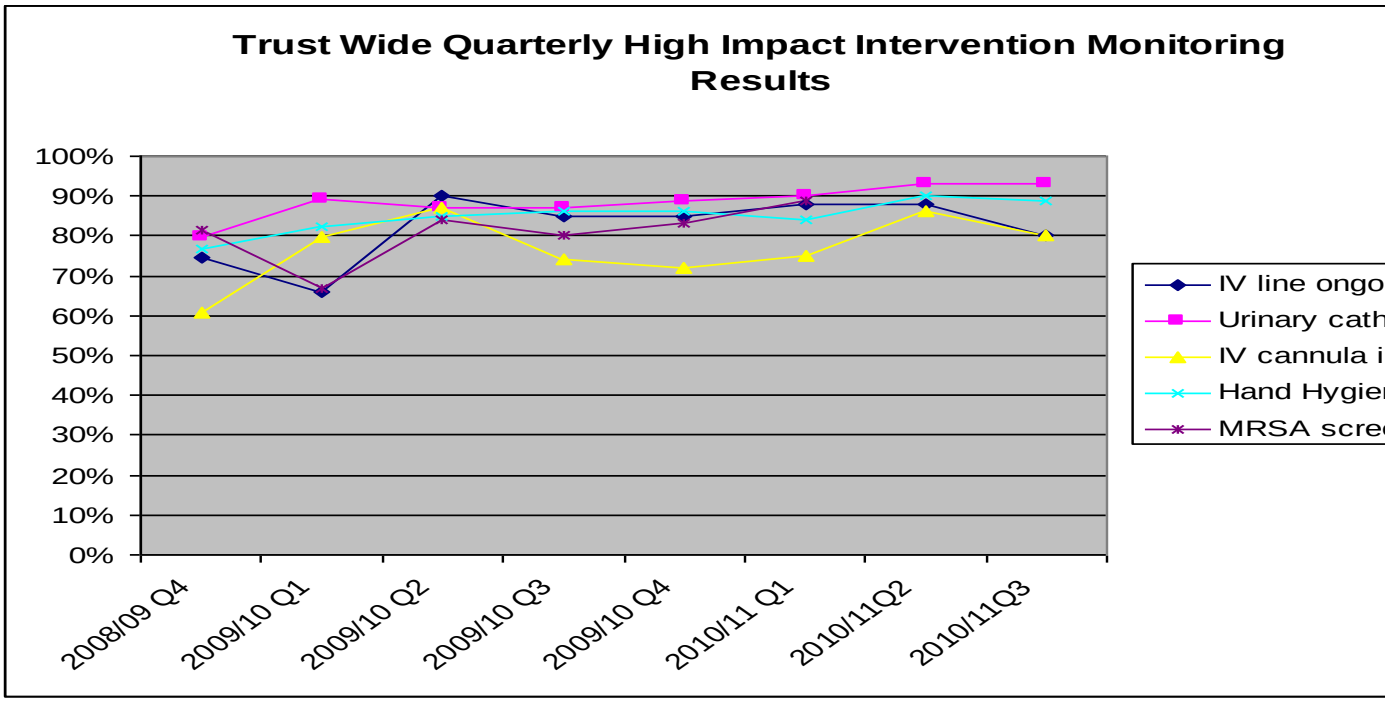
IPC audit programme 2010/2011: Q3 10/11 update

Infection Control Nurses Association Audit Programme 2010/2011

There are 30 department/ward audits planned for the year.
For 2010/2011 quarter 3, six audits were planned and all have been completed (Starlight, Templar, Bryning, MDU, Surgical Centre & Halley). All audits are on a tracker showing compliance scores and action plan progress. All of the action plans and tracker are discussed at Matron Monitoring Group.
The Infection Prevention Society and DH have reviewed the ICNA audit tool currently used and have launched a set of Infection Prevention and Control Quality Improvement Tools. These will be assessed and used as appropriate in the 2011/2012 audit programme.

High Impact Intervention (HII) audits: Q3 10/11 update

- 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 3.Collection of hand hygiene data is due to 'go live' on the 1st February 2011.
- A summary of the HII monitoring results is detailed in the graph below:



- The Trust target for Quarter 3 10/11 was for HII scores of above 95%.
- By this criterion the HII scores are 'red' for IV cannula insertion in CWSH & DSO (69% & 50% respectively) and for MRSA screening in GEM (70%).
- HII monitoring results are discussed at the Quality Improvement Committee, 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 3.

Trust Wide Audit Programme 2010/2011

Summary table of Trust wide audit programme:

Audit and planned date	Audit team/data collectors
CVC audit - April 2010	ICT (Completed)
Audit of Follow up of MRSA Positive Patients identified in Pre-admissions Screening Programme- April 2010	ICT (Completed)
Antimicrobial prescribing - June 2010	ICT/Pharmacy (Completed)
Sharps Audit - July 2010	Daniel's (Completed)
Isolation Audit - August 2010	ICT (Completed)
Antimicrobial prescribing - September 2010	ICT/Pharmacy (Completed)
Antimicrobial prescribing - December 2010	ICT/Pharmacy (Completed)
Isolation Audit - Feb 2011	ICT
Antimicrobial prescribing - March 2011	ICT/Pharmacy

Audit of Follow up of MRSA Positive Patients identified in Pre-admissions Screening Programme-

The aim of this audit to assess patient management and follow up against the standards recommended in the Trust MRSA policy. The areas audited were: the screening process; follow up of the result; who was informed; patient management and treatment. The data collection tool was developed by the Infection Control Team and used to gather data on all patients who screened positive for MRSA prior to admission for an elective procedure at the Trust from April to the end of August 2010. The data was collected retrospectively by using the infection control team data; the pre-admission clinic database and patient's medical records.
A total of 19 patients who had an MRSA screen done prior to elective surgery had an MRSA positive result from the period of April 2010 to August 2010. The turnaround time for processing of the specimens ranged from 2 to 6 days with an average of 3.5 days which shows an improvement from the previous audit where the average was 5.6 days,

Out of a total of 19 patients 13 needed to collect MRSA decolonisation protocol from Pre-admissions clinic. There was no documentation related to the collection of the decolonisation pack in 12 out of 13 cases that needed to collect the protocol. Six patients out of a total of 14 needed IV Teicoplanin added to the prophylaxis, three patients out of these 6 did receive IV Teicoplanin. Of the 8 patients admitted only 2 were isolated on admission and these 2 had decolonisation protocol prescribed immediately.

The recommendations from this audit are:

- Dispensing of pre-operative decolonisation needs to be documented and checked on admission if the patients has carried out
- Antibiotic prophylaxis requirements need to be raised with anaesthetic team
- Decolonisation protocol prescription and isolation on admission needs to be addressed
- GP being informed of MRSA positive status of the patient.

a) IV Lines Point Prevalence Audit (November)

The Homerton IV Line Care and associated infection prevalence audit was carried out to ensure that the standards of care identified in the Trust IV line policy were being performed in order to reduce the risk of IV line associated infection to patients. This is the first audit using this approach that has been performed. The prevalence of IV line associated infection was also performed using a modified version of the HCAI Prevalence Survey.

Method
A structured data collection tool and Centres for Disease Control definitions of infection were used. The data was collected by the infection control team.

Results
There were a total of 191 patients included in the audit, 61% had an IV cannula and 2% a central line insitu on the day of the audit or in the previous 7 days. Of the patients with a cannula insitu on the day of the audit (total - 63) 22% were not indicated. Insertion of peripheral cannula was documented in 59% of patients and VIP scores were recorded in 80% of cases. Documentation of insertion of Central lines was found in 2 out of the 4 cases and daily observation of the site was performed in all cases. On the day of the audit there were no patients identified who were being treated for IV device related infections.

Conclusions
The results of this audit show that there were a number of patients with IV devices who did not require them. This puts patients at increased risk of developing IV device related infections including bacteraemias and all clinical staff should take responsibility for reviewing invasive devices. The documentation of insertion of peripheral cannulas needs to improved and a general observation was that many of the patients who had insertion documented using the cannula pack labels were patients from A&E. Recording of observation of IV cannula sites using the VIP score is good at 80% but could be improved and there is currently a piece of work taking place which involves the Clinical Nurse Specialists doing 'spot checks' of this practice. This piece of work could be extended to all clinical staff and involve staff reviewing the patients they see routinely for invasive devices and checking on continued indication with clinical teams. Checking on continued indication for invasive devices is essential in order to reduce risk of infection to patients which improves patient comfort and safety.

Recommendations and action plan
Cannula insertions packs to be on ward stock top.
Documentation of insertion of IV devices (peripheral cannula and central lines) to be raised as essential with all staff who insert these devices.
Highlight with all clinical staff the importance of reviewing patients IV access and the continued requirement. This includes empowering nursing staff to review IV access and liaise with medical colleagues.
Clinical staff (such as clinical nurse specialists) to review the patients they see routinely to determine if they have IV lines (and other invasive devices) and check on the requirement. This would also include checking VIP score recording for IV lines to raise awareness with ward staff.

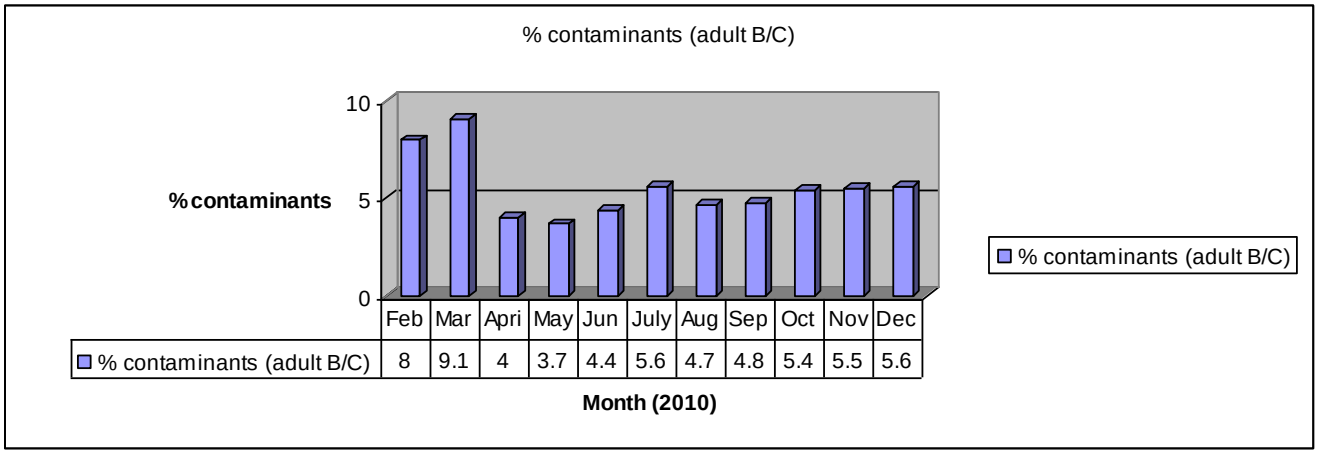
Antimicrobial prescribing compliance audit

- The December 2010 antimicrobial prescribing compliance audit was presented and discussed at the January 2011 ICC meeting.
- The ICC has agreed that Antimicrobial prescribing compliance audit frequency will be reduced from quarterly to twice yearly.
- A summary of the findings are detailed in the table below:

	Audit Dec 10	Audit Sep 10	Audit Jun 10	Audit Mar 10	Audit Dec 09	Audit Sept 09	Audit Mar 09
Total patients	**138**	**113**	**267**	**186**	**238**	**201**	**289**
Patients on antibiotics	**45 (33%)**	**31 (32%)**	**83 (31%)**	**66 (36%)**	**83 (34%)**	**77 (29%)**	**91 (32%)**
Compliance:				**85.0%**	**79.8%**	**75.3%**	**72.5%**
Compliant	**82%**	**79%**	**74%**				
Non-compliant	**12%**	**12%**	**15%**				
Off-policy	**6%**	**9%**	**11%**	**2%**			
Stop/Review	**62%**	**46.5%**	**42%**	**46.7%**	**48.4%**	**32.4%**	**43.5%**
Indication	**97%**	**93%**	**92%**	**91.6%**	**93.1%**	**95%**	**95.4%**

Blood culture contamination audit

- The measures introduced from April 2010 onwards to decrease blood culture contaminants are continuing to work and the rates remain below 6% from previous rates of 7.5- 9.1%.
- Graph of blood culture contamination rates by month:



Feedback from Matron's Monitoring Group: Q3 10/11 update

- The Matron's Monitoring Group (MMG) was formed in February 2009.
- 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 has been 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.
- Maternity: HII Q3 - Achieving 100% compliance in the last 3 reporting period. Ongoing discussion with staff to maintain 100%.
- ACU, Cardiology Unit, Lloyd and Aske ward HII Q3:

ACU have been inconsistent with returns but with appointment of a new staff nurse as infection control link practitioner this has improved. Recent scores in November have good results. Aske results have been consistently good with exception of hand hygiene which has only achieved 40% in Nov but has improved significantly at 100% in December. Cardiology ward have been inconsistent with returns. November returns are low; and this is being monitored closely by the matron. Lloyd results remain consistent. Ongoing peripheral care is rising slowly and in Nov was 67%.

- Edith Cavell and Lamb ward HII Q3:
  Lamb Ward the results are variable, the results are being completed and returned on a fortnightly basis. Results are variable scores of 75-80% for catheter care, cannulation and hand hygiene. The lowest score in the hand hygiene are from the medical teams. Dates for completion are being written in diary for permanent staff to complete. Both Junior Sisters have been allocated areas of responsibility in relation to infection control. Edith Cavell ward opened in October following a refurbishment programme. The returns received for November and December are variable with results ranging from 67% and 93%. Both ward sisters are supervisory at present.
- NICU/SCBU HII Q3:
  Mainly 100% in NICU.
  SCBU has x 1 low score-67% in November (due to high workload) Link nurses made aware of the poor result.
- Graham/RNRU/ARU/Bryning HII Q3:
  Matron ensuring all areas is feeding back their results at team meetings. This is working well on Graham and ARU all safe are aware of their HII results. Bedpan washer results not consistent will need to be reviewed
- Halley/Thomas Audley HII Q3:
  For the last quarter, both Halley and Thomas Audley have not been achieving 100% consistently across the whole spectrum of HII audit. Despite the fact that the ward sisters have been reminding their staff of the current practice, it was felt that there are certain levels of apathy among the nursing staff. On the other hand the medical team remained the biggest challenge in complying with the HII practices in clinical practice.
  Lead Nurse liaising closely with both ward sisters to address failures in compliance.

IPC education programme: Q3 10/11 update

IPC Induction training: Q3 10/11 update

- 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 DIPC does a monthly (or as required) session on this programme.

IPC annual update training: Q3 10/11 update

- By the end of the Q3 10/11 the following percentages of staff had received IPC annual update training against a Trust target of 80% by the end of the FY 10/11:

Area	Percentage of staff completing IPC annual update (%) [by end of Q3 10/11]
CWSH	60.6%
DSO	72.0%
GEM	54.8%
Workforce	85.2%
Environment	100.0%

Corporate	96.6%
Trust total	65.5%
Trust total (including contracted staff)	**67.5%**

Other IPC training: Q310/11 update

- Intravenous study day training continues to include infection control and runs on a monthly basis.
- High Impact Intervention training continues
- Infection Control Link Practitioner - Quarterly ICLP days continue
- Blood culture taking training continues in order to embed best practice.
- Aseptic Non Touch technique (ANTT) continues in order to embed best practice particularly in relation to IV line care.
- Global Infection Prevention and Control week: 17-23 October 2010, events at Homerton included hand hygiene with ATP swabs and UV light box, ANTT and IV line awareness.

IPC balanced scorecard: Q3 10/11 update

- The following KPIs for IPC (with targets) 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 3 of this report and its contents are discussed in the relevant sections of this report.

IPC Risk Register: Q3 10/11 update

- The following risks remain on the IPC Risk Register after review of the current rating scores at the ICC in January 2011:
    - IPC annual update training (rating: 8) – this remains the most challenging risk. The date for review of this risk has been changed to the May 2011 ICC meeting as data for Q3 2010/11 is not available in time for the January 2011 ICC meeting.
    - 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
- After discussion at the January 2011 ICC, it was decided that the new risk of the reduced staffing resource of the IPC team due to 2 members of the team being on maternity for 9-12 months will be added to the risk register.

Cleaning Services reports: Q3 10/11 update

- The National Standards Monitoring Tool audit quarterly results for Q3 10/11 is detailed in the table below. The scores are RAG rated ‘green’ in all areas.

By Cleaning Service	**Score (%) Q3 10/11**
CWSH	98.1
DSO	97.2
GEM	97.0
Trust	97.0
By Infection Control Risk	
Very high	97.8

High	96.4
Significant	96.2
Low	94.3

Estates and Facilities reports: Q3 10/11 update

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 interim 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 September 2010 RAG rated all areas 'green' and no major compliance-related issues were reported to the October 2010 ICC.

Ventilation planned preventative maintenance programme

- The January 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. The ICC discussed the risks and benefits of losing one side room on Lamb ward in order to be able to build a fully compliant negative pressure side room with a lobby area and it was decided that the risk of the Trust not having suitable facilities for e.g. possible MDR-TB cases or Lassa fever was greater than that of the loss of a side room facility. Andrew Panniker has been requested to liaise with GEM to scope the costings of this project.
- The January 2011 Environment report to the ICC RAG rated the theatre air changes as 'amber' due to low air change rates in some theatres. It is probable that there will need to be some planned theatre 'downtime' in order to allow the planned preventative maintenance to be completed.

Legionella and water supplies planned preventative maintenance programme

- The January 2011 Environment report to the ICC continued to RAG rate the requirement for cold water <20°C and hot water >50°C as 'red' – a discrepancy between the sample results from tap samples and sensor results has been identified and is being investigated. Work is ongoing to address this issue and Andrew Panniker is leading to reduce the ongoing risks associated with the Trust's water supplies.
- The January 2011 Environment report to the ICC RAG rated the Legionella and water supplies testing and sampling as 'amber'.The pseudomonas colonisation in water sample continues, particularly in the SCBU/NICU. The external expert (Dr Suzanne Surman-Lee) who assessed the Trust control for water quality has commented that new guidance will be published soon and the recommended levels of Pseudomonas will be zero. Her assessment included a complete review of the controls in place and actions taken to date for Legionella and Pseudomonas control. The written report is still pending but recommendations are likely to include the removal of the sensor taps (because they require TMVs (thermostatic mixer valves) to function) from the NICU/SCBU and TMV-containing taps from ITU. In systems where Pseudomonas is present, the use of sensor taps and TMVs makes it very difficult to reduce/eliminate the colonisation of the system. Removal of the sensor taps incorporating the TMV would reduce risk of pseudomonas colonisation in water supply. The ICC agreed that the risk and implications of babies acquiring Pseudomonal infection or bacteraemia on the unit was greater than the requirement for sensor taps and TMVs in order to reduce the risk of scald injuries. It was noted the HSE recommended using TMVs due to risk of

scalding but as the sinks on these units are used purely by staff and visitors and no patients this risk could be managed. Risk management/Health and Safety to be involved in deciding which risk register the risk of scalding should be placed on when the sensor taps/TMV-containing taps are removed and whether any alternative measures to reduce scalding risk are appropriate.

- The Legionella policy will be reviewed with the recommendations from the external expert report when received and is due to be presented to the ICC at the next meeting in May 2011.
- The January 2011 Environment report to the ICC RAG rated their risk assessment process, plant and equipment checks, AC plant & condenser checks and policies as 'green'.
- The January 2011 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 January 2011 Environment report to the ICC RAG rated the presence of dead legs and blind legs in the water supply system as 'red' and ongoing works are being carried out to address this issue.

Employee Health Report: Q3 10/11 update

- The draft 'Management of Occupational Needlestick and other Occupational Contamination Incidents' policy was discussed at the January ICC. This policy has been in draft form for several months beyond its review date and needs to be endorsed and taken to the Policy Group as soon as possible. It was agreed that the DIPC would review the policy and make suggestions regarding clarification of the new instructions for rapid source patient testing and liaise with the EHMS lead in order to send out a 2nd draft of the policy for comment as quickly as possible. Given the 2nd draft requires no major changes the DIPC, as Chair of the ICC, will endorse the policy by Chair's Action so that it can be sent to the February 2011 Policy Group for ratification.
- There were three staff contract tracing incidents in Q3 10/11 related to exposure to: Group C meningitis, TB and Measles/Rubella.
- Measles, rubella, chickenpox and tuberculosis screening update:
  High-risk areas are now 94.4% immune and work continues to screen and immunise the remainder. Work continues to target the medium-risk areas with 66.7% of staff known to be immune.
- Exposure Prone Procedure Register:
  The total number of EPP compliant staff is 96.9%. The remainder of those that are outstanding are those staff where an identified validated sample is required or a hepatitis C screening test is required in line with the 2002 guidelines.
- Needlestick injuries:
  There have been a total of 28 injuries for the last quarter (16 injuries in the previous quarter).
  A paper on the business case for 'safer needle' devices is being presented by one of the ICNs to the February Health & Safety Committee.
- EHMS has led a very successful Trust seasonal Flu vaccination campaign with a total of 53.1% of staff being vaccinated. This is double the national average of 26.1% and the Trust has been praised by local DPHs as an example of good practice both in our uptake rates and the collection of our data.

Staff Group	Tot. No.	31.12.10	31.12.10
All Doctors	404	292	72.30%
Nurses/Midwives	758	303	40%
AHPS	241	172	71.40%
Support to Clinical staff	644	307	47.70%
Others	253	148	58.40%
OVERALL TOTAL	2300	1222	53.10%

Policies endorsed by the ICC

The following policies were endorsed at the January 2011 ICC:

- Infection Control Operational policy (including the ICC ToR)
- Outbreak policy
- Multi-resistant Gram Negatives policy
- Surgical Site Infections policy
- Single Use Medical Devices policy (Single use symbol added)
- IV line policy (additional instructions for Paediatrics)
- Surveillance & Incident Reporting policy
- TB policy (statement added in response to SII action point)
- Environment & Isolation Room Cleaning policy (updated with new disinfectant)

Other Infection Prevention & Control issues

- During Dr Claxton's maternity leave, Ms Vickie Longstaff, the ICNC & Deputy DIPC will act up as the DIPC with the support of the Chief Nurse. Dr Medina Ahmed will act as Dr Claxton's locum as Microbiology Consultant and Infection Control Doctor with the support of Dr Daniel Krahé, the Departmental Lead Microbiology Consultant.
- The DIPC & IPC team Annual programme 2011/12 can be found in Appendix 4. Whilst the IPC team will endeavor to complete the programme, it should be noted that the reduced IPC team workforce issues due to maternity leave will mean that the programme will need quarterly review at the ICC to re-evaluate progress against service needs for that quarter. Additional staff from outside the team e.g. bank nurses, other staff on secondement will ne required in order for the audit programme to be completed. The Chief Nurse is aware of these issues and is in discussion with the ICNC to address them.
- It is expected that, as of the 31st March 2011, the IPC team will assume responsibility for CHS infection prevention & control. The ICNC is part of the Trust-wide team of specialist leads scoping the requirements of this additional remit.
- The new mandatory Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia surveillance has started as of January 2011 and all Trusts are required to return data on a monthly basis to the HPA enhanced Surveillance website. There are currently no objectives or targets set except the requirement to return the data.
- It is expected that there will be a new mandatory requirement to return monthly data on *E.coli* bacteraemias to the HPA enhanced Surveillance website as of April 2011. There is currently no reason to expect that any objectives or targets will be set in the near future except the requirement to return the data.
- In accordance with Trust practice the ICC, with the advice of David Bridger, are sending out a web-based performance review to all members of the ICC to ensure that the ICC is fit for purpose.
- Work has finally been completed to incorporate the MRSA & CDI status of patients automatically into the patient electronic discharge summary.

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

Appendix 2 - MRSA Bacteraemia Summary Report 2010-11 (to date)

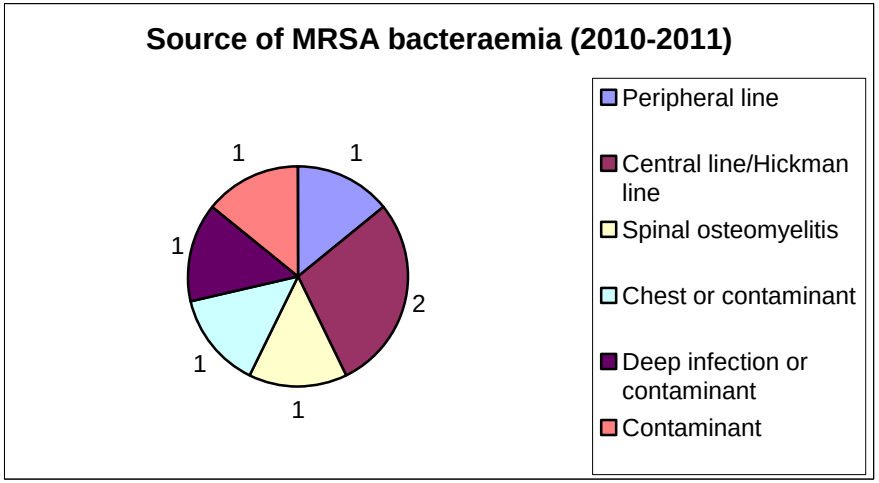
1. Summary of MRSA bacteraemias FY 2010-2011 (to date)

Table 1: Summary of all MRSA bacteraemias by quarter

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

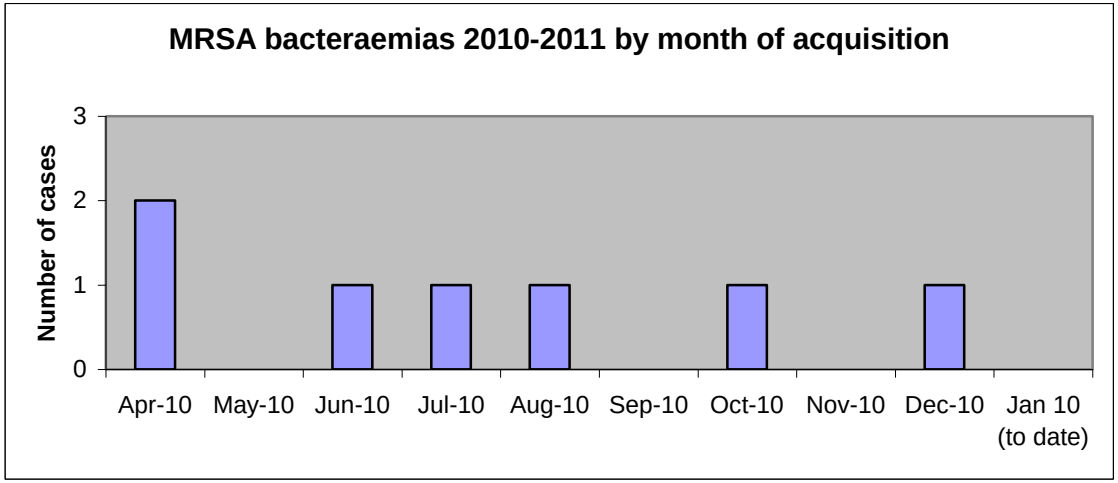
As demonstrated in the figures below, with the exception of 3 IV line-associated cases, there is no other significant clustering of cases of MRSA bacteraemia by source of infection, time or ward. As described in the section below on completed and ongoing Trust-wide actions to decrease risks, detailed action plans have been drawn up in response to every MRSA bacteraemia root cause analysis (RCAs) and implemented to reduce the risks of both adult and neonatal IV line-related infections and also blood culture contaminants. There have been no MRSA bacteraemias likely to be from clinical sources since August 2010.
The 2 Pre-48 hour MRSA bacteraemia RCAs were shared with the community Infection Prevention and Control Team and neither demonstrated any common themes that required collaboration between the community and acute Infection Prevention and Control Teams.

Figure 1: Summary of Trust-attributable MRSA bacteraemias by source of infection



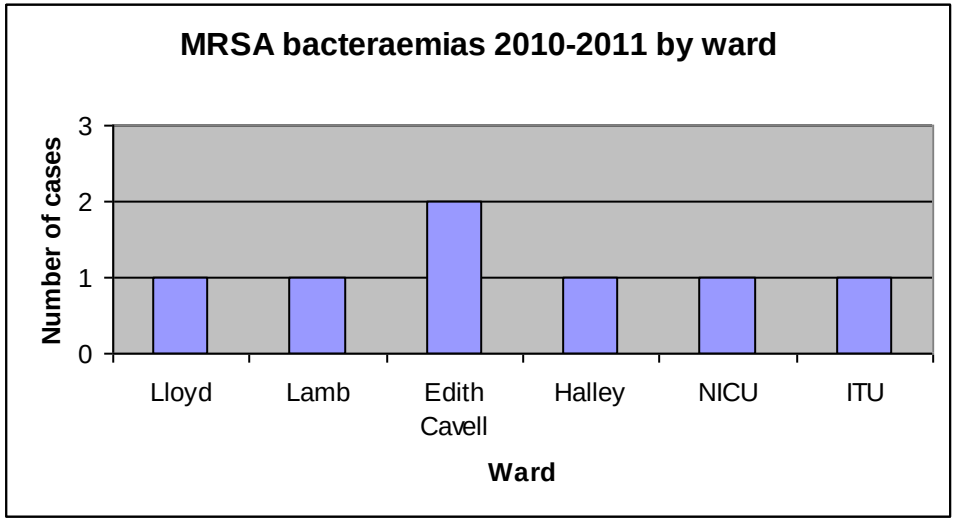
There were a total of 3 line-related infections leading to MRSA bacteraemia. Otherwise, with the exception of possible blood culture contamination, there is no clustering of MRSA bacteraemia sources.

Figure 2: Summary of Trust-attributable MRSA bacteraemias by month:



There is no significant clustering of MRSA bacteraemias by month. The 2 cases in April had different sources and were on different wards.

Figure 3: Summary of Trust-attributable MRSA bacteraemias by location:



There is no significant clustering of MRSA bacteraemias by ward. The 2 cases on Edith Cavell ward had unrelated diagnoses and no risk factors in common.

2. Homerton-attributable MRSA bacteraemias: summary of cases

Patient	Date of admission	Date and place of blood culture	Source/ comments
OG	20/02/2010	06/04/2010 Lloyd	Known to be MRSA positive. Central line related
SD	06/03/2010	22/04/2010 Lamb	Known to be MRSA positive. Probable chest or contaminant
RS	07/06/2010	18/06/2010 Edith Cavell	History of MRSA on previous admissions Chronic osteomyelitis (co-incidental diagnosis during admission for unrelated illness)
PK	15/06/2010	14/07/2010 Halley	Hospital acquired colonisation Hickman line infection
BM	03/08/2010	11/08/2010 NICU	Hospital acquired colonisation Peripheral IV cannula site infection
EW	08/10/2010	19/10/2010 Edith Cavell	Known to be MRSA positive Possible deep seated infection or contaminant (subsequent post-mortem did not reveal any evidence of deep-seated MRSA-related infection)
VY	14/10/2010	14/12/2010 ITU	Hospital acquired colonisation Probable contaminant

3. Pre 48 hour MRSA bacteraemias: summary of cases

Patient	Date of admission	Date and place of blood culture	Source/ comments
VVG	23/04/2010	24/04/2010 ITU	No history of MRSA colonisation PVL toxin positive community strain Surgical wound infection (post C-section)
BL	18/11/2010	19/11/2010 ACU	No history of MRSA colonisation No history of previous hospital admission to Trust Spondylodiscitis and/or osteomyelitis secondary to infected diabetic foot ulcer

4. Trust wide actions to decrease risks to date (completed and ongoing)

a) General risk reduction measures:

- All MRSA bacteraemias reported as SUIs to the Patient Safety Committee – July 2009
- Introduction of MRSA Universal emergency admission screening – Jan 2010
- Monitoring of compliance with screening carried out by information team and sent to divisions for actions – April 2010
- ANTT training pack and blue ANNT trays purchased – February 2010.
- Update of ANTT policy – April 2010
- Trust wide roll out of ANTT training and blue trays Trust wide – May 2010, training also ongoing

b) IV line care risk reduction measures:

- High impact intervention monitoring of ongoing IV line care – February 2009.
- Review of IV line policy – 2009 and 2010.
- Introduction of 2% chlorhexidine and 70% alcohol for skin prep prior to IV line insertion – 2009.
- New IV line VIP record sheet for cannula – May 2010
- CVC policy audit – April 2010.
- Peripheral cannula packs introduced – July 2010
- CVC insertion packs and insertion documentation check sheets introduced – April 2010
- Clinical Nurse Specialists enrolled in auditing IV line care – October 2010
- Hickman line training developed– August 2010
- Hickman line policy developed – October 2010
- IV Line care Point Prevalence Audit – November 2010

c) Blood culture contamination risk reduction measures:

- New blood culture taking policy – April 2010.
- Blood culture taking procedure reviewed and blood culture taking packs implemented with training programme and training film on the intranet and YouTube – May 2010.

5. MRSA Bacteraemia (01/04/2010 – to 31/12/2010): RCA/SUI Summaries

At this Trust, all MRSA bacteraemias are declared as SUIs regardless of clinical outcome. A full SUI report is completed according to Trust policy which includes a full RCA and action plan. The SUI report is taken to the monthly Patient Safety Committee and is not signed off until all actions are completed. The SUI report summaries and action plans also form part of the quarterly Infection Prevention and Control team report to the Infection Control Committee and the quarterly DIPC report to the Board of Directors.

Patient	Date of admission	Date and place of blood culture	Place acquired	SUI/RCA investigation Findings	Action plan status
OG	19/02/10	06/04/10 Lloyd	Homerton	OG was admitted on the 19/02/2010 with painful sickle cell crises. He was known to be MRSA positive since the 01/04/2009. He required IV fluids and IV antibiotics for re-current Klebsiella pneumonia and bacteraemia. Peripheral access became difficult therefore the patient had central lines inserted for IV access. On the 06/04/2010 a blood culture was taken and was positive for MRSA. **Root cause** The patient became colonised with MRSA at the beginning of 2009. The acquisition of the MRSA is difficult to determine in relation to potential exposure and admission dates however the sensitivity pattern suggests a hospital strain. The source of the MRSA bacteraemia was an internal jugular central line required for IV medications. The patient had very difficult IV access and required IV medications for a number of weeks. **Recommendations** Ensure that all staff inserting central lines are aware of the higher infection risk with a femoral site and the need to document the rationale for using the femoral site. This is to be included in all central line/IV training. Check on supply of central lines and ensure that clinical areas requiring access to lines to have suitable supplies. Ensure that all staff inserting central lines are aware of the higher infection risk with more lumens and the need to document the rationale for using a quad or triple lumen. This is to be included in all central line/IV training. Theatres need to stock 2% chlorhexidine / 70% alcohol Chloraprep	Completed and closed by PSC

				which is the recommended skin prep for CVC insertion. Ward staff to ensure that MRSA admission screens are taken in the first 24 hours of admission. (admitted 19/02/2010, screened on the 23/02/2010) Clinical staff to ensure that if a patient has had a recent positive swab in the last 6 months and has not any subsequent negative screens patients should be started on MRSA protocol following the admission screen. The feasibility and resource implications for a formal process or group/staff to review and refer patients with poor IV access who require longer term (greater than 1 week) IV therapy.	
SD	06/03/10	22/04/10 Lamb	Homerton	SD was admitted on the 06/03/2010 with an infective exacerbation of COPD. The patient has had several previous admissions and was known to have been MRSA positive since 2007. The patient received antibiotic treatment for a ?chest infection. On assessment by Speech and Language Therapy was found to be at risk of aspiration so was put nil by mouth and started on NG feeds and had multiple NG tube insertions. On the 12/04/2010 he was started on supervised puree oral intake and continued with NG feeding. On the 22/04/2010 he reported feeling unwell and his temperature was found to be 37.7°C. A blood culture was taken and was positive for MRSA. **Root Cause** The patient acquired MRSA in ITU in 2007 and remained colonised since with sputum specimens positive for MRSA in January 2009 and on admission for this episode. The source of the MRSA bacteraemia was likely to be either: Contaminant (pseudobacteraemia) – although the chest was the clinical source of the patient's infection and the relevant sputum culture grew both Pseudomonas and MRSA, his WCC and CRP had already significantly decreased after starting Tazocin on 23/04/10 (an antibiotic which will cover Pseudomonas but not MRSA) but before starting Vancomycin on 25/04/10. Chest (possibly due to aspiration following being started on puree diet) – although there was a significant improvement in clinical markers of infection before starting antibiotic therapy which covered MRSA, the patient continued to improve after the addition of	Completed and closed by PSC

				Vancomycin therefore it is impossible to be certain about the contribution of the MRSA to the patient's chest infection and therefore as to the significance of the bacteraemia. However, given the comments above on his clinical parameters it is more likely that the Pseudomonas was the pathogen causing the patient's chest infection and clinical illness and the MRSA was only colonising the patient's sputum. **Recommendations** Site and technique for blood culture taking to be documented. This recommendation has already been raised in another SUI and interim guidance has already been sent out to all doctors and implementation of blood culture packs is taking place in May 2010.	
RS	07/06/2010	18/06/2010 Edith Cavell	Homerton	Patient was admitted to Aske ward on 07/06/10 from OPD for further investigation of deranged LFTs/weight loss/anaemia. Patient was known to have chronic back pain and T12 collapse. Patient was already known to be MRSA colonised from admission swabs taken on previous inpatient stay in April 2010. CT scan on 08/06/10 revealed biliary obstruction at ampulla of Vater ?impacted stone – ERCP recommended and patient referred to Gastro team for review and ERCP. Patient reviewed by Gastro team on 09/06/10 – ERCP initially scheduled for 25/06/10 then brought forward to 18/06/10. MRSA screening swabs from this admission positive on 11/06/08 and result telephoned to ward by ICNs on 11/06/10 and documented in notes on 14/06/10. MRSA decolonisation protocol started on 15/06/10 although full protocol not given on 16 & 17/06/10. Patient transferred to Edith Cavell ward on 17/06/10. Patient pyrexial at 21:30 on 17/06/10 and reviewed by on-call doctor at 01:20 on 18/06/10 – blood cultures taken and MRSA grown (preliminary gram stain results from blood cultures 19/06/10; presumptive MRSA 20/06/10; confirmed MRSA 21/06/10). ERCP performed on the afternoon of 18/06/10 under Teicoplanin cover (stat dose) and purulent bile retrieved. Blood culture results telephoned by on call Micro SpRs on 19/06 & 20/06 and patient started on treatment course of IV Teicoplanin on 20/06/10. Subsequent investigation of possible sources of MRSA 'seeding' revealed a T11-12 & L5-S1 discitis. **Root cause** The most likely root cause for this patient's MRSA bacteraemia is a chronic spinal discitis. The most likely source of entry is via broken	Completed and closed by PSC

				skin through the sacral sore, peripheral cannula or at previous invasive device sites given history of multiple hospital admissions at several Trusts. The MRSA bacteraemia is most likely to be secondary to a chronic spinal osteomyelitis and his admission was for a different complaint (he needed an ERCP for an impacted gallstone) – he is likely to have been spiking intermittent fevers due to his osteomyelitis for several months and one fever spike happened to be in hospital and therefore a blood culture was taken. He acquired his initial MRSA colonisation at another Trust and, as far as we can see, although his longstanding sacral sore is the most likely portal of entry it has been appropriately & well cared for in the community. In relation to practices to prevent this MRSA bacteraemia there are no recommendations to be made as it was due to a chronic spinal discitis. Some issues were highlighted which did not contribute to this case and these have been included in the lessons learnt and addressed or noted as ongoing work.	
PK	16/06/2010	14/07/2010 Halley	Homerton	The patient (PK) was admitted via A&E with a strangulating and obstructed parastomal hernia She was admitted to Priestley and then transferred to Halley. She had surgery on 16/06/2010 for laparotomy + small bowel resection + reversal of stoma. The patient had difficult IV access requiring a central line on the 22/06/2010. She required admission to ITU on 2 occasions, she was on non-invasive ventilation on the first admission and intubated and ventilated on the second (22/06/2010-25/06/2010 and 27/06/2010 – 06/07/2010). On the 27/06/2010 she returned to theatre for washout of faecal peritonitis. On the 06/07/2010 she was transferred from ITU to Halley. She required long term IV access for TPN and bloods and on the 08/07/2010 had a Hickman line inserted in theatres. On the 11/07/2010 MRSA screening swabs were taken on Halley ward and these were positive from the groin and throat. On the 14/07/2010 a blood culture was taken and this was confirmed as MRSA on the 16/07/2010. The patient was started on appropriate antibiotic treatment on the 15/07/2010. The patient acquired MRSA colonisation at the Homerton, identified in swabs taken on the 11/07/2010 on Halley ward. The patient had	Completed and closed by PSC

				been potentially exposed to MRSA on ITU and Halley ward. The sensitivity pattern of the ITU patient MRSA is different from PK and therefore the MRSA was not acquired on ITU. The sensitivity pattern of the patient in side room 1 on Halley is the same as PK and therefore the MRSA was likely to be acquired through cross-infection from that patient. **Root cause** The source of the bacteraemia is a Hickman line site infection. In addition to the clinical signs of infection which prompted the taking of the blood culture, pus was observed in the Hickman line track on removal of the Hickman line and MRSA was also isolated from a sample of the pus. The patient acquired MRSA colonisation at the Homerton, identified in swabs taken on the 11/07/2010 on Halley ward. The patient had been potentially exposed to MRSA on ITU and Halley ward. The sensitivity pattern of the ITU patient MRSA is different from PK and therefore not acquired on ITU. The sensitivity pattern of the patient in side room 1 on Halley is the same as PK and therefore the MRSA was likely to be acquired through cross-infection from that patient on Halley ward. **Recommendations** Protocol and guidance to be developed for insertion and care of tunnelled central lines. Training on the above to developed and delivered to staff caring for patients with tunnelled central lines Halley ward to ensure that all staff are aware of the requirement for screening patients transferred to them from other wards Reminder to be sent to all doctors about use of blood culture packs.	
TM	03/08/2010	11/08/2010 NICU	Homerton	Mother admitted to templar ward on the 30/07/2010 with abdominal pain. MRSA screen taken on admission as had previous in-patient episodes. Nose, throat and perineum swabs negative. Twin pregnancy. On the 03/08/20120 at 27+5 by Twins born by emergency LSCS due to APH and placenta previa. Both twins admitted to the NICU. Twin 2 was screened for MRSA on admission	Completed and closed by PSC

				and then 1 week later and both results for nose, throat and perineum were negative. On the 11/08/2010 the baby developed swelling on the right arm at an IV cannula site, this developed into a cellulitis. The cannula was removed, the baby was started on antibiotics and blood cultures were taken. On the 12/08/2010 there was erythema, tenderness and swelling present. The plastic surgeons from RLH were asked to review the baby and recommended transfer to the RLH for debridement and washout. The baby was transferred on the 12/08/2010. The blood culture result was confirmed as MRSA on the 14/08/2010. The source of the bacteraemia is the peripheral IV line. **Root cause(s)** 1/ Acquisition of MRSA on the NICU through cross infection. 2/ IV line associated infection resulting in bacteraemia possibly due to no clear guidance on insertion, review and ongoing care procedures **Recommendations** There should be clear Isolation procedures for babies on NICU in incubators. There should be IV line insertion, review and ongoing care procedures which are included in all local staff induction. There should be a system for documenting VIP scores when babies are not receiving continuous infusions The NICU Infection prevention and Control group to be resurrected.	
EW	08/10/2010	19/10/2010 Edith Cavell	Homerton	The patient was admitted to the Homerton in 2009 and on an MRSA admission screen identified as MRSA positive. On the 08/10/2010 she was admitted via A&E with GI bleed and malaena to ACU. PMH: IHD, AT, HTN, IDDM, TIA, breast Ca, left mastectomy, obesity and diverticular disease. She was then transferred to ITU. The MRSA admission screen was positive and she was started on decolonisation protocol. On the 17/10/2010 she was transferred to Lamb ward and on the 18/10/2010 to Edith Cavell. A blood culture was taken on the 19/10/2010 from her foot and the result was confirmed MRSA on the 21/10/2010. The patient was started on appropriate antibiotic treatment. The source of bacteraemia is difficult to determine and could be from a contaminated blood culture due to poor venous access or from a deep seated source not identified. On the 30/10/10 the patient had a cardiac arrest and died.	Completed and closed by PSC

				Death certificate 1a) MOF, 1b) MRSA septicaemia, 1c) IHD **Root cause** The source of the bacteraemia is unclear. Possible contaminant due to difficulty of IV access or deep seated infection. It is therefore difficult to identify an exact root cause. **Recommendations** All staff inserting IV lines to ensure that all IV line insertion is documented in the patient's notes and lines are reviewed. The importance of documenting IV line insertion to be reinforced with medical staff. The importance of using the blood culture taking packs to be reinforced with medical staff.	
VY	14/10/2010	14/12/2010 ITU	Homerton	The patient was admitted to ACU via A&E with acute pancreatitis on the 14/10/2010 and then transferred straight to ITU. On the 15/10/2010 he had 2 cardiac arrests and was intubated. A CT scan showed cerebral oedema. On the 25/10/2010 he had a tracheostomy. On the 31/10/2010 a groin swab was MRSA positive. On the 14/12/2010 a blood culture was taken and was positive for MRSA, Klebsiella and Coagulase Negative Staph (CoNS). On the 16/12/2010 he was transferred to Edith Cavell ward. **Root cause** The source of the bacteraemia is probably a contaminated blood culture due to the correct procedure not being followed.	Open – action plan in progress
VVG	23/04/2010	24/04/2010 ITU	Pre-48 hour	The patient was previously admitted to the Homerton from the 17th to 21st April as a transfer from Newham for an emergency C/S (as her baby needed a SCBU cot and we were the only local centre with a cot available). The MRSA screening policy was not followed and she was not screened on admission so we do not know her MRSA status on admission. She had previously been an inpatient at Newham from the 20th-22nd March 2010 and 15th-17th April 2010. She was admitted to the Homerton via A&E on 23/04/2010 and the blood culture was taken on 24/04/2010 and is therefore 'pre-48h/PCT-attributable' - the patient was septic secondary to a post-	RCA and action plan shared with PCT

				caesarian section abdominal collection. **Root causes** The bacteraemia is secondary to a C-section wound. It is unclear as to the acquisition of the MRSA as the patient was not screened on admission to the Homerton. It is an unusual strain of MRSA which we have sent to the reference lab in Colindale for further testing - it is only resistant to meticillin on disc testing and sensitive to all other antibiotics we routinely test vs. MRSA in the lab (our usual pattern for MRSA is resistance to meticillin, erythromycin & ciprofloxacin as a minimum). Confirmation from HPA that the isolate was PVL MRSA. **Recommendations** Templar ward to ensure that all patients who fulfill the MRSA screening criteria are screened on admission or when a decision to do a C-section is made.	
BL	18/11/2010	19/11/2010 ACU	Pre 48 hour	The patient was admitted to the Homerton on the 18/11/2010 via A&E onto ACU at approx 18.00. A blood culture was taken on the 19/11/2010 in ACU and was MRSA positive. The patient had admission screening swabs taken from nose throat and perineum on the 19/11/2010 at 03.00 and the nose swab was positive. **Root cause** The source of the bacteraemia is likely to be from a spondylodiscitis (reported on MRI) and/or osteomyelitis from the diabetic foot ulcer. **Recommendations** Community infection control nurses to investigate diabetic foot ulcer management.	RCA and action plan shared with PCT

Appendix 3 – IPC Balanced ScoreCard 10/11: Q3

Please see separate accompanying excel spreadsheet for the IPC BSC.

Appendix 4 - DIPC and ICT Annual Programme 2011-2012

During 2011-2012 both Dr Claxton (Infection Control Doctor & DIPC) and Ms Martinez Garcia (Infection Control Nurse) will be on maternity leave therefore the annual programme below reflects the changes in IPC team resources and may be subject to change during 2011-2012 in light of quarterly review at the ICC

Objective	Actions	Leads	Timescale
ICT PRIORITY OBJECTIVES			
• Ensure Trust is compliant with Care Quality Commission (CQC) registration criteria	• Review all 10 criteria of The Health and Social Care Act (2008) at quarterly HCAI task group meetings and ensure that all criteria are met • Ensure that progress on the ICT annual plan is reported quarterly to the ICC (via ICT quarterly report) and Trust Board (via DIPC quarterly report)	• Chief Nurse • DIPC • IPC team	Quarterly review at HCAI task group meetings Quarterly review at ICC meetings Quarterly review by Board of Directors via DIPC quarterly report
• Ensure Trust has measures in place to minimise the risk of MRSA bacteraemias and *C.difficile* infections	• Continue to review clinical practices in response to RCA findings and audit results • Continue to report findings and progress against MRSA bacteraemia and *C.difficile* infections action plans to ICC via IPC quarterly reports and Board via DIP quarterly reports and to monthly Patient Safety Committee meetings and share across the health economy as required	• Chief Nurse • DIPC • IPC team	Ongoing during 2011-2012 Quarterly review at ICC meetings Quarterly review by Board of Directors via DIPC quarterly report
• Ensure the City & Hackney Community Health Service (CHS) Infection Prevention and Control Service is safely incorporated	• Ensure all CHS training and audit programs are developed and in place and reported to the ICC on a quarterly basis • Ensure all IPC	• Chief Nurse • ICNC	Ongoing during 2011-2012

into the current Trust IPC team	policies incorporate acute and community service requirements • Ensure community level IPC reactive service is responsive to local needs		
• Continue to enhance IPC as an integral part of governance and patient safety throughout the organisation	• Continue to sit on Trust's Quality Improvement Committee and Patient Safety Committees and other relevant committees when necessary	• DIPC • IPC team	Ongoing during 2011-2012
• Continue to embed evidence based practice for central and peripheral line care	• Provide ongoing training and support for staff on the implementation of the IV line policy • Monitor practice via the High Impact Intervention programme and feedback results	• IPC team • IPC team	Ongoing during 2011-2012 Ongoing during 2011-2012
• Continue to embed evidence based practice for blood culture taking	• Provide training and support for staff on the implementation of the Blood Culture taking policy • Monitor practice and feedback results on contamination rates via quarterly IPC team report to ICC	• IP C team • IP C team	Ongoing during 2011-2012 Quarterly review at ICC meetings
• Review infection prevention and control initiatives that require additional financial resources to inform the annual budget setting process at Divisional level	• Review IPC practice and initiatives and priorities those which will have the greatest impact on reducing HCAI and improve patient safety • Present the above to the ICC and include in the relevant DIPC report	• IPC team • DIPC	• September 2011 • September 2011
ICT ONGOING OBJECTIVES			
• Review of IPC policies	• Review all IPC policies due for revision and update • IPC policies due for revision and update in 2011-2012:	• IP C team	• All IPC policies revised and updated on 3-year rolling basis

	1. Management of C.difficile 2. Management of meningococcal meningitis 3. Safe handling of body fluid spills 4. Management of GRE 5. Control of VHF 6. Infection Control Operating Policy 7. Standard Infection control precautions 8. Infection control involvement with Estates and Facilities projects		• All IPC policies due for revision & update in 2011-2012 to be completed by March 2012
• Audits i) IPC policy compliance ii) ICNA audits iii) HII audits iv) Antibiotic prescribing	• Ensure that key findings and recommendations from IPC audits and progress on IPC audit programmes are reported to the ICC via the ICT quarterly report and Trust Board via the DIPC quarterly report for action	• IPC team	• Quarterly review at ICC (via ICT quarterly report)
• Maintain awareness of hand hygiene	• Continue to monitor hand hygiene compliance as part of the IPC audit programme	• IPC team	• Ongoing during 2011-2012
• Education	• Continue to provide induction lecture for all new staff; annual IPC updates for all staff; junior doctors teaching; Infection Control/IV/urinary catheterisation study days • Ensure that proportion of Trust staff receiving annual IPC training are reported to the ICC via the IPC Balanced Scorecard and Trust Board via the DIPC quarterly report for action • Continue to develop	• IPC team	• Ongoing during 2011-2012

	education programme for IPC link practitioners with continued Trust commitment to 3 protected study days/year		
• Surveillance & Reports i) 'alert organism' ii) 'alert condition' iii) Incidents/RCAs/SUIs iv) Enhanced orthopaedic surgical site surveillance v) Provision of comparative data to clinicians on HCAIs vi) Key indicators to Trust Board/PCT vii) Quarterly ICT reports to ICC viii) Quarterly IPC Balanced Scorecard ix) Monthly HPA Enhanced Surveillance website reports (MRSA BSI, CDI, MSSA currently and *E.coli* may be required)	• Continue to identify and respond promptly to all incidents and clusters/outbreaks of infection in the hospital • Continue to update & disseminate MRSA bacteraemia/colonisation and C.diff infection data to all doctors and lead nurses on a monthly basis • Use findings from incidents/RCAs/SUIs to inform practice development priorities • Continue to return all mandatory reports promptly • Ensure that key findings and recommendations from surveillance data and incidents are reported to the ICC via the ICT quarterly report and Trust Board via the DIPC quarterly report for action	• IPC team	• Ongoing during 2011-2012
• Communication	• Ensure there are robust systems of communication in place between the ICT and all Trust staff via: email updates; monthly infection control newsletter; up-to-date ICT policies on intranet • Ensure there are	• IPC team	• Ongoing during 2011-2012

	robust systems of communication in place between the ICT and Public and patients via: patient information leaflets; prompt response to all Freedom of Information and other enquiries through the Communications and Information Governance departments		
• Cleanliness & Decontamination issues	• ICT members to continue to sit on and contribute expert advice to the Decontamination Monitoring Group; Cleaning Service Review Group • Facilitate the reporting of cleanliness scores to the ICC via the IPC Balanced Score • Advise the Trust Lead for Decontamination (Andrew Panniker) on decontamination issues both at the regular Decontamination Monitoring Group meetings and on an ad hoc basis	• IPC team	• Ongoing during 2011-2012

Audit programme 2011/2012

Audit and planned date	**Audit team/data collectors**
Antimicrobial prescribing - June 2011	ICT/Pharmacy
Sharps Audit - July 2011	Daniels
Antimicrobial prescribing - September 2011	ICT/Pharmacy
Isolation Audit - October 2011	ICT
IV Lines Point Prevalence Audit - November 2011	ICT
Antimicrobial prescribing - December 2011	ICT/Pharmacy

Antimicrobial prescribing - March 2012	ICT/Pharmacy
Summary of changes from 2010/2011	
Isolation audit reduced to annual rather that twice per year	
CVC (was twice yearly) audit integrated with IV lines point prevalence audit, reduced to annual	
MRSA pre-admission screening audit (was twice yearly) - not performed	
CR - UTI point prevalence audit in 10/11 one off audit	

ICNA Department Audits
RNRU
Mary Seacole Nursing Home
Rehab Unit
Aske
ACU
ITU
Graham
Lloyd
A&E
Priestley
Cardiology
Starlight
Templar
Halley
Thomas Audley
CEA
Lamb
Delivery Suite
NICU
Edith Cavell
Removed (reduced from 31 to 20
Surgical centre
Theatres
DSU
Colposcopy
DOSH
Bryning/MDU
Fertility Unit
ANC
Out-patients

BOARD OF DIRECTORS

Meeting date: 23rd February 2011 **Agenda Item: 9.1**
Paper: 10-126

Title:	Monitor Consultation on Compliance Framework 2011/12

Summary:	Monitor are consulting on the Compliance Framework for 2011/12. Trusts are invited to respond to the consultation questions on the form provided. The deadline for submission of a response is 25th February 2011. A draft response has been prepared for the Board to consider.

Action:	The Board is asked to note the consultation document and questions and to approve the draft response

Prepared by:	Sallie Rumbold, Programme Director
presented by:	Charlie Sheldon, Chief Nurse and Director of Governance

Compliance:	Regulatory

Homerton University Hospital NHS
NHS Foundation Trust

Board of Directors
23rd February 2011

Proposed Response to Monitor Consultation – Compliance Framework 2011/12

	Consultation Question	Type of Change Proposed	Homerton Response
Quality governance, complaints and SUI's			
Q1	Do you agree with the proposed requirements for self certification with regard to quality governance, including the change in frequency	Submission annually and in quarterly returns	Yes
Q2	Do you agree with the proposed wording of the self certification	Wording changes	Yes
Q3	Do you agree with the proposal to allow an alternative self certification until Sept 2011	Where boards unable to self certify to make an alternative declaration – Sept 11 allows time to put governance arrangements in place. After Sept 11 Monitor requires the un-amended certificate and may explore reasons for inability to provide self certificate	Yes
Governance Reviews			
Q4	Do you agree that Monitor should be able to require governance reviews to address: i) quality of plan ii)quality self certification concerns	Clarifies scope and trigger for reviews	Yes
Accuracy of Reporting			
Q5	Do you agree that failure to provide accurate and timely information represents a potentially serious governance failure, and Monitor should reflect this in its regulatory regime?	Would be assessed on case by case basis and serious poor reporting accuracy could result in escalation for significant breach	Yes
Q6	Do you agree Monitor should respond to any such failure on a case by case basis ,with the option to escalate a FT in order to determine whether it was in significant breach where poor data quality is a factor?		Yes
Governance Indicators – Referral to treatment times			
Q7	Do you agree with the proposed inclusion of referral to treatment times in Monitors Compliance Framework? If so do you agree with the proposed: ○ targets and definitions	See page 9 Introduces to the compliance framework the RTT target as in Operating Framework + thresholds and risk rating	Yes

	Consultation Question	Type of Change Proposed	Homerton Response
	○ thresholds ○ weightings (or scores) for the purpose of the governance risk ratings and ○ monitoring periods	No thresholds for incomplete pathways	
A&E Quality Indicators			
Q8	Do you agree with the proposed inclusion of national A&E quality indicators in Monitors compliance regime? If so do you agree with the proposed: ○ targets and definitions ○ thresholds ○ weighting (or scores) for the purpose of the governance risk ratings ○ monitoring periods and ○ application of our existing escalation approach	See page 9 and 10 Introduces the 5 A&E quality indicators + thresholds and risk rating and describes escalation criteria	Yes as brings in line with operating framework – however this is a risk in terms of recording and reporting for the Trust. An action plan is in development. We are currently shadow monitoring to assess impact.
Stroke Indicator			
Q9	Do you agree with the proposed introduction of a stroke indicator in Monitors compliance framework pending discussion on definition and threshold? If so do you agree with the proposed: ○ weighting for the purpose of the governance risk rating, and; ○ monitoring period	Proposes a stroke indicator - TBC	Yes – but indicator still TBC
Other governance indicators (if you disagree please give suggestions/comments)			
Q10	Do you agree with the proposed removal of MRSA screening as a governance indicator from the Compliance Framework?	MRSA screening removed	Yes
Q11	Do you agree with the proposed removal of category B response times as a governance indicator from the Compliance Framework?	No longer in operating framework	Yes
Q12	Do you agree with the proposed removal of the 60 minute/68% thrombolysis target as a governance indicator from the Compliance Framework?	No longer in operating framework	Yes – no longer in operating framework
Q13	Do you agree that the healthcare standards and other measures in Appendix 1 represent a reasonable set of indicators for service performance as part of the overall governance of a FT?	Definition of quality standards and good practice	Yes
CQC Registration Concerns			
Q14	Do you agree that formal CQC actions in responses to failures or risks of failures to comply with registration requirements should be reflected in our governance risk rating?		Yes
Q15	Do you agree with the proposed scoring by which Monitor will incorporate this actions in our	Page 13 and 14	Yes

	Consultation Question	Type of Change Proposed	Homerton Response
	governance risk rating?		
Q16	Do you agree that a CQC responsive review of a trust may be reflected by an increased governance risk rating, applied on a discretionary, case by case basis, taking into account the triggers for CQC's responsive review?		Yes – sharing of information between regulators can also minimise administrative burden. We would suggest that discretion would be needed on the impact of the CQC responsive review as this type of review can cover a wide range of regulations, services and outcomes for patients and services.
NHSLA clinical negligence scheme for trusts			
Q17	Do you agree with the proposal to require NHSFT's to maintain a CNST score of at least Level 1?		Yes
Q18	Do you agree that a Trust failing to maintain at least CNST level 1 should have a score applied to its governance risk rating? If so do you think this score should be: o 2, ie a minimum amber-red rating or o 4, ie red rating and potential escalation for consideration of potential breach		Yes Amber-Red rating (not Red)
Community Services			
Q19	Do you agree with the proposed definition of effectiveness for governance risk indicators for community services?	Indicators should be representative, robust, timely and attributable	Yes
Q20	What indicators do you believe can be used to assess governance risk in community services?	Inviting suggestions as to a small number of appropriate indicators listed in Appendix 4	A small number of indicators should be selected – starting with those already routinely collected and likely to be recorded electronically within community services. We would also be concerned that some targets are PCT targets and it is difficult to apportion compliance levels to community services specifically as often shared responsibility with primary care and public health. This will require clarification and will be a nation wide issue in terms of community services. Community performance targets may also be disproportionally affected by population demographics (diversity/deprivation/age etc) which would ideally need to be considered in terms of thresholds.
Q21	Do you believe that data completeness is a more appropriate indicator of governance risk than a performance threshold for 2011/12?	The appropriateness of using a data completeness indicator rather than performance threshold	In principle agree but would depend on the type of indicator and would not necessarily provide a better indicator of governance risk. Combining both data completeness and indicators might be considered. In practical terms data accuracy is likely to be a issue for most community providers.
Financial Risk Ratings			

	Consultation Question	Type of Change Proposed	Homerton Response
PFI Projects			
Q22	Do you agree with the proposed change to how we incorporate PFI liabilities and other finance leases in our financial risk rating?	Change to calculation of Return on Assets financial risk rating	The impact of this change will be minimal to Homerton as the Trust does not have any PFI arrangements and only a small number of finance leases. The principle of the Monitor adjustment is reasonable however there must be a corresponding adjustment to scoring thresholds of the calculation which is not specified in the consultation document.
Forward financial indicators			
Q23	Do you agree to the proposed change to this indicator of forward financial risk?	Working Capital Facility: confirmation of whether this has been used in the last quarter required	This is an appropriate revision to the existing queries and would provide more useful performance measures on WCF than the current proforma.
Financial Risk Ratings of 2			
Q24	Do you agree that Monitor should consider whether any trust delivering a financial risk rating of 2 in any quarter should be considered for escalation and potential significant breach? - Do you agree that if a trust displays an unplanned financial risk ration of 2, Monitor should consider requiring a review of financial governance at the trust?	If *any* trust delivers an unplanned FRR of 2 Monitor would consider them to likely to be in significant breach of its authorisation, regardless of its liquidity position and thus potentially subject to regulatory action. For financial governance they may require a review of: - assumptions behind trust plans; - rigour of planning process degree to which deterioration in financial position was within the trust's control	Whilst a risk rating of 2 needs to be investigated in certain circumstances, a proposed approach could be for any FT to provide a detailed explanation if this occurs at the point of the quarterly submission including information on: 1) exact reason within FRR of a level 2 rating; 2) operational/financial reasons for the rating; 3) plans in place to increase rating within the next quarter if applicable. In addition if FTs are anticipating an unplanned risk rating of 2 at any point during the year Monitor should be informed

Note: this draft response has been formulated with input from City & Hackney's Community Health Services

BOARD OF DIRECTORS

Meeting date: 23rd February 2011 **Agenda Item: 10.1**
Paper: 10-127

Title:	**Month 10 Finance and performance report**

Summary:	The I&E surplus for the ten months ended 31.01.11 was £1,179k, slightly ahead of plan, by £54k. Activity levels and income continued above plan in most categories, although the estimated impact of the readmissions policy has reduced non elective income levels. The forecast year-end income position includes an expected reduction in CQUIN income, and an estimate of the impact of claims management challenges from commissioners, currently under negotiation. Pressure remains on clinical expenditure budgets across both pay and non pay categories, and measures to contain these over the remainder of the financial year are being agreed with budget holders. Performance remains on track for all key national access targets. We remain on 7 MRSA cases which means we have breached both the national and monitor thresholds. The PEP shortfall previously reported has been supplemented by our income generation over performance. Our focus over the next few months will be to ensure we meet our year end income and expenditure targets and begin to implement efficiency and productivity plans for 2011-12. We anticipate some of QIPP proposals for 2011-12 taking effect towards the end of this financial year. 75% of CQUIN indicators were met at the end of Quarter 3 although this represents only a relatively small proportion of our overall income for CQUINs. There is however a significant risk of not achieving our planned CQUIN income for year end on the basis of our revised forecasts. The balanced scorecard for CHS is in the process of being developed. A shadow draft is included with detailed explanation in associated paper.

Action:	The Board is asked to note the report.

Prepared by:	**Pete Walsh and Zaman Hussain**
Presented by:	**Fiona l'Anson, Assistant Director of Finance**

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

Paper attached seperately

BOARD OF DIRECTORS

Meeting date: 23rd February 2011 **Agenda Item: 10.2**
Paper: 10-128

Title:	**Update on 2011-12 outlook**

Summary:	This paper provides an update on the outlook for 2011/12 and in particular describes the results of the road testing of the national tariff, and progress to date with the contact negotiation round.

Action:	The board is asked to note the report.

Prepared by:	**Pete Walsh and Karl Munslow-Ong**
Presented by:	**Fiona l'Anson, Assistant Director of Finance**

Compliance	Terms of Authorisation Condition 12 Financial Viability

Homerton University Hospital NHS
NHS Foundation Trust

2011/12 OUTLOOK - UPDATE

1. Introduction

The purpose of this paper is to provide an update on the 2011/12 planning round and in particular to describe the results of the road testing of the national tariff, and progress to date with the contact negotiation round.

2. National tariff – road test results

The modelling of the 'road test' national tariff has now been completed and shows that overall PbR income will fall by 1.5% (excluding the two issues described below). This, combined with inflationary pressures of 2.5%, makes up the 4% efficiency requirement as anticipated and already included within the trust £15m gap analysis for 2011/12. The road test tariff also confirmed the £1.2m loss of MFF income as a result of the trust index being reduced, which was also included in the gap calculation.

There are currently two issues not included as part of the tariff testing:

(i) The testing excluded **A&E activity,** which is moving to a new currency (HRG4) for 11/12. EPR does not currently support the investigation fields required to generate the HRG 4 codes, and so it has not yet been possible to model the tariff for this activity. An EPR fix is being developed and is due to be implemented by the end of February, which will allow March activity to be run in the new currency. Indications from other trusts are that they have gained from the move to HRG4 in A&E, but the late application and testing of the EPR fix does represent a risk in terms of agreeing an accurate activity baseline and funding level for A&E in 2011/12.

(ii) The DH guidance on the application of the **readmissions** policy that accompanied the road test tariff requires further clarification, and also discussion with commissioners to reach agreement on exactly how this should be implemented in 2011/12. An estimate of the impact of readmissions has already been factored into the £15m gap figure, but clarification on the detailed application of the policy is required before this can be validated.

3. Contract negotiations

The contract negotiations with commissioners are progressing across three main areas:

(i) the main **acute services contract** with inner NEL London sector commissioning unit (INEL SCU). Baseline activity figures at specialty and patient category level have been agreed, based on the forecast outturn position at month 8 adjusted for expected seasonal increases in months 9 – 12. The SCU are now due to provide details of activity reductions they expect as a result of the changes described in the Commissioners Strategy Plan (CSP), and reaching agreement on the impact of these will form the next part of the negotiation. There are separate negotiations taking place around maternity services and funding, where the SCU have signalled their intention to remove significant amounts of non PbR maternity allocations and propose to put in place activity caps related to PbR activity. Commissioners have also outlined their intention to ration the availability of IVF and bariatric services. This will involve changes to eligibility criteria, although early indications are that this will not have a material impact on our planned income levels for next year.

(ii) the contract for **specialised services** with the London Specialist Commissioning Group (SCG), covering neonatal intensive care services, HIV, and neuro-rehabilitation. Proposals for these have now been received from the SCG and are under consideration. The offers are largely based on forecast outturn with some growth for expected increased activity. Prices include the 1.5% reduction as applied in the tariff. In neonatal, agreement has yet to be reached on levels of activity expected to shift from other providers to Homerton, and also on proposed marginal rates for over performance as proposed by the SCG.

(iii) the contract for **community health services** (CHS) with City & Hackney PCT. Discussions are taking place to agree detailed service specifications for these services, and the associated levels of funding that will make up the contract value for 2011/12. As in previous years the contract value will be based on block allocations, although it is expected that during 2011/12 joint work will take place with commissioners to develop activity based tariffs where appropriate. Negotiations are also taking place with LB Hackney and the Learning Trust, and current indications are that the reduction in funding on these contacts may not be as great as anticipated for 2011/12, although further reductions are expected in subsequent years.

For each contract, the basis of CQUIN targets for 2011/12 has also to be agreed.

4. Conclusion

The results of the national tariff road testing exercise produced results in line with previous estimates, although A&E and readmissions were excluded from this analysis pending availability of further information.

The contract negotiation process is ongoing, with further detail on commissioner plans around CSP changes required to enable the financial impact to be modelled and checked against current estimates.

Pete Walsh
Deputy Finance Director
16.02.11

BOARD OF DIRECTORS

Meeting date: 23rd February 2011 **Agenda Item:10.3**

Paper: 10-129

Title:	QIPP Update

Summary:	This paper summarises the QIPP Programme and the current position on savings and provides information on: o The QIPP programme structure o The reporting and governance structures o Key programme milestones and current saving schemes

Action:	The Board is asked to consider progress with the QIPP program to date and confirm its support for the proposals.

Prepared & presented by:	Tracey Fletcher, Chief Operating Officer

Compliance	Terms of Authorisation Condition 12 Financial Viability

Homerton University Hospital NHS
NHS Foundation Trust

QIPP PROGRAMME – UPDATE PAPER

BOARD OF DIRECTORS

WEDNESDAY 23rd FEBRUARY 2011

1. Introduction

The purpose of this paper is to update the Board of Directors on the format and structure of the QIPP Programme and the delivery of efficiencies against target.

2. Structure of the programme

The structure of the QIPP Programme has been established. This consists of a central team comprising of a Lead Director (COO), Associate Medical Director, Senior Manager (Dep. COO) and Project Manager. The team is based centrally within the main hospital building adjacent to DSO and GEM Divisions and the CHS Integration team. The team will retain the monitoring role of performance against the targets, provides direct input on agreed projects and supports the Clinical and Corporate Divisions in a number of their projects.

The following meeting structure has been established to ensure that necessary communication is maintained across the Trust at a time where the pace of change and decision making needs to be rapid. The following arrangements are in place:

Name or description	***Purpose of meeting***	***Attendees***	***Frequency***	***Reports to***
QIPP Team meeting	To ensure that overall monitoring and programme are on track. To identify where remedial action will need to be taken.	COO Deputy COO Associate Medical Director Link HR Manager Link Finance Manager Head of Communications (when required)	Weekly – Friday morning	QIPP Programme Board
QIPP Operational meeting	To track projects with Divisions, ensure Trust wide issues or cross Division issues are identified, enable feedback from the Divisions on operational impact and communication	COO Deputy COO Associate Medical Director General Managers Deputy Director for the Environment Link HR Manager (CHS Lead)	Weekly – Thursday morning	QIPP Programme Board
QIPP Programme Board	To be responsible for the delivery of the QIPP and general savings programme. To oversee the impact of the schemes on service provision.	CEO Executive Directors Associate Medical Director Clinical Division representatives	Monthly - Friday	Will inform the report to the Board of Directors
In addition, the progress of the QIPP Programme will be reported to the following established meetings				

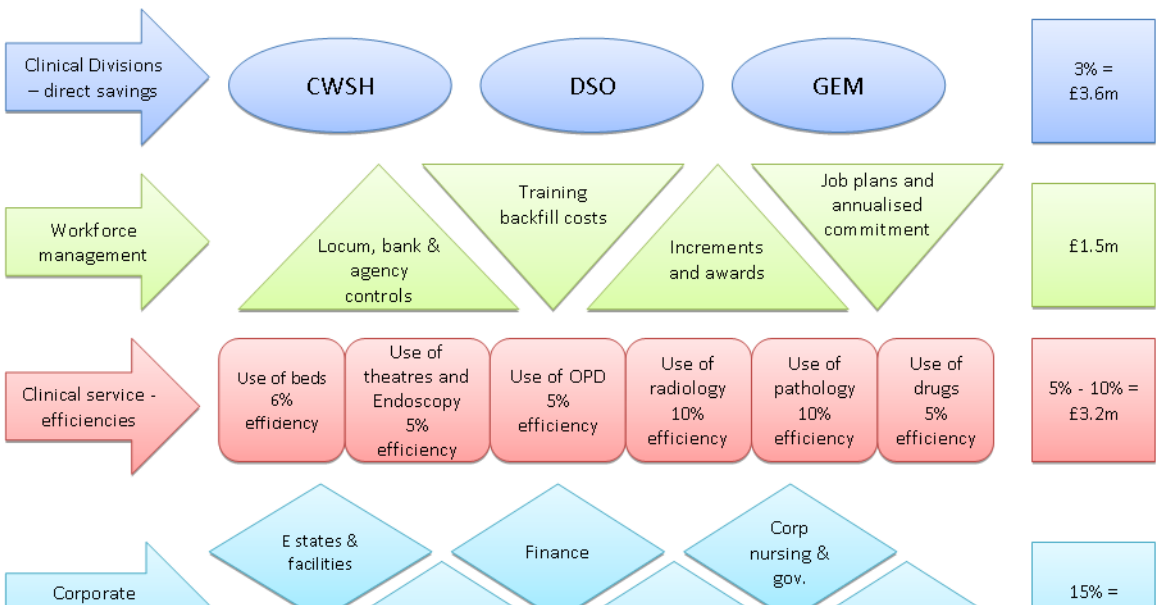
Executive Team meeting	To highlight forthcoming proposals for projects and seek approval for assessed projects to be progressed. To report on the occasions when staff may be placed at risk.	CEO Executive Team	Weekly	
Quality Board	To ensure that all projects are considered for their impact on patient safety and quality within service areas.	Chief Nurse Medical Director Clinical Division representatives Quality and Risk representatives	Every six weeks	
Board of Directors	To report on the delivery of the programme to ensure that the Trust achieves a balanced financial business plan for 2011/12.	Chair Non-executives Executive Directors	Monthly	
Clinical Board	To report on the projects proposed and to gain operational feedback, assessment and decisions where applicable	CEO Executive Team Clinical Directors General Managers	Monthly	

The management of the QIPP Programme will be a key component of the overall delivery of the Divisions and the Trust Business Plans and subsequently managed through Divisional Performance meetings into 2011/12.

3. QIPP Themes and associated targets

A model to describe the QIPP themes and targeted areas for efficiency gains has been developed and recently presented to Clinical Board. The summary slide of this is given below.

This aims to describe the programme through five themes which are distinguished by the nature of the savings that is intended to be realized but also by allocated lead responsibilities. These are local themes applicable within this organization and reflective of the resources available and focused on this work and the current management structures we have in place.



A brief description of each theme is given below:

Clinical Divisions – direct savings

The Clinical Divisions are each responsible for identifying 3% savings from their budget which has no Trust wide or cross division implications

Workforce management

The central QIPP team will co-ordinate with the Workforce Division the schemes that will be Trust wide, which will review and re-establish process and criteria to contain expenditure on staff costs

Clinical service – efficiencies

The central QIPP team will co-ordinate and be responsible for delivery against these projects. Each project will closely involve the Clinical Divisions through the most relevant individuals e.g. Clinical Directors, Lead Clinicians, whilst also keeping the General Managers fully appraised.

Beds efficiency – a paper has been developed to propose the closure of an 11 bedded ward. This has included the following consideration:

- analysis of current bed usage by speciality and seasonal variation
- modeling of the effects of reductions in length of stay to national median and upper quartile performance and use this to plan bed requirement going forward by speciality
- establishment of a multidisciplinary length of stay project group to deliver trust-wide reductions in length of stay
- creation of a operational policy for new service model

Theatres efficiency – work is ongoing to improve the efficiency within main theatres, daystay unit and endoscopy. This includes the following:

- develop demand and capacity model
- model productivity improvements (analysis against peer benchmarked against upper quartile and comparison with other similar providers)
- share and gain agreement with Clinical Directors and consultants regarding productivity improvements per list and high impact changes to deliver improved throughput
- agree as part of annualised job plan cross cover arrangements at no additional cost

- align consultant surgeon and anaesthetist job plans to meet required start and finish times
- publish and monitor routinely start and finish times

Outpatient efficiency – this work is focusing on the throughput within each clinic, affected by scheduling and DNA's.

- model improved productivity to upper quartile throughput for each clinical specialty
- agree with consultants revised OP templates
- ensuring 44 week working year
- review option to increase consultant leave notification to 8 weeks (Initial indications suggest we reschedule 35000+ appointments each year)
- develop an OP performance reporting tool (monitoring clinic and slot utilisation, DNAs, reschedules, consultant clinics)
- implement improved booking service to ensure patient have sufficient choice of appointments
- streamline processes for patients who wish to cancel / reschedule appointment

Diagnostic efficiency – there are several workstreams underway within this area focusing on the different modalities. These include the following:

- reduce internal demand for 3 key modalities by 10% (keep area of focus OP generated work) – CT, ultrasound and MRI
- reduce DNAs / cancellations for ultrasound activity
- improve MR and ultrasound productivity by 10%
- reducing or stopping repeat diagnostics
- review the out of hours model of service provision

Corporate Divisions – direct savings

The Corporate Divisions have responsibility for identifying and releasing 15% savings against their budget from the acute contract allocation.

Integration efficiencies

The Corporate Divisions and corporate management have a responsibility for delivering an additional 11% savings. This is above the expected level of efficiencies of 4% that will be required through the community services contract. This is a reflection of the efficiencies the Trust should expect to release through the opportunity to combine departments.

4. Current position – February 2011

The Trust has progressed a first wave of savings which total £4.2m. A summary of these projects, the potential impacts, the total value identified and the outstanding balance have been discussed across the organisation.

The Clinical and Corporate Divisions were given milestone targets to achieve by January 2011. The summary below reports the progress against these targets. The value of the savings given are agreed and will be removed in January (albeit in some cases the financial change will not impact until 1st April 2011).

The current total of savings that have a 'green' rating are given in the table below. This relates to the acute contract only.

		Target set	Estimated annual savings (£)	Estimated annual income (£)	Final Agreed Saving	Final Agreed Income
Clinical Divisions - Direct savings		4,007,190	2,614,500	1,803,500	2,151,500	1,098,500
Workforce management		1,800,000	1,350,000	0	0	0
Clinical services - efficiencies		3,700,000	4,658,900	0	0	0
Corporate Divisions - Direct savings		4,880,100	2,904,508	78,505	1,872,855	78,505
Integration efficiencies		420,414	165,000	0	165,000	0
	GRAND TOTAL	14,807,704	11,692,908	1,882,005	4,189,355	1,177,005

The number of posts affected is currently calculated at 31. However, there are only a small number of staff affected directly. Given the current work in progress this number will be confirmed at the Board of Directors meeting.

In addition to the £4.2m identified, schemes amounting to a further £7m (i.e. £11m in total) have been identified and undergone initial validation. At the Board meeting the database relating to the schemes will be shared with Board members.

5. Summary

The current status of the QIPP Programme can be summarized as follows:

- A model which paints a picture of the areas of focus for efficiencies and the associated targets has been presented to Clinical Board and agreed.
- The target set for a first wave of savings has been achieved although there are areas of over-performance and areas of under-performance.
- Proposals are being assessed and a project plan established for other projects, particularly those related to the theme ‘Clinical service – efficiencies’.

Tracey Fletcher
Chief Operating Officer
16th February 2011