Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting

Boardroom, Chelsea and Westminster Hospital, 369 Fulham Road, London SW10
Chair: Juggy Pandit
Date: 7th September 2006
Time: 2:00pm

Agenda

1. GENERAL BUSINESS	**2.00pm**
1.1 Welcome to the Members of the Public	**JP**
1.2 Apologies for Absence	**JP**
1.3 Declarations of Interest	**JP**
1.4 Minutes of the Previous Meetings held on 3rd August 2006 (attached)	**JP**
1.5 Matters Arising (attached)	**JP**
1.6 Chief Executive's Report (incorporating the Foundation Trust Update) (attached)	**HL**
2. PERFORMANCE	**2.30pm**
2.1 Finance Report, Month 4 (attached)	**LB**
2.2 Performance Report, Month 4 (attached)	**LB**
2.3 Annual Audit Letter (attached)	**LB**
3. ITEMS FOR DECISION/APPROVAL	**3.00pm**
3.1 Private Patients Report (attached)	**LB**
4. ITEMS FOR ASSURANCE	
5. ITEMS FOR NOTING	**3.15pm**
5.1 Control of Infection Annual Report (attached)	**AMC**
6. ITEMS FOR INFORMATION	**3.35pm**
6.1 Minutes of the Clinical Governance Assurance Committee held 23rd May (attached)	**MFr**
6.2 Minutes of the Remuneration Committee held 3rd August 2006 (attached)	**JP**
6.3 Minutes of the Facilities Assurance Committee held 21st June 2006 (attached)	**CW**
7. QUESTIONS FROM THE MEMBERS OF THE PUBLIC	**3.45pm**
8. ANY OTHER BUSINESS	
9. DATE OF THE NEXT MEETING	
5th October 2006	
10. CONFIDENTIAL BUSINESS	

To resolve that the public be now excluded from the meeting, because publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be concluded in the second part of the agenda.

Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting, 7th September 2006

AGENDA ITEM NO.	1.4/Sept/06
PAPER	Draft minutes of the Previous Meeting held on 3rd August 2006.
AUTHOR	Fleur Hansen, Foundation Trust Lead Contact Number: 020 8846 6716
SUMMARY	This paper outlines key issues for the attention of the Trust Board.
BOARD ACTION	To agree the minutes as a correct record.

Chelsea and Westminster Healthcare NHS
NHS Trust

DRAFT
Trust Board Meeting, 3rd August 2006
Minutes

Present:

Non-Executive Directors:	Juggy Pandit (JP) (chairman) Marilyn Frampton (MFr) Karin Norman (KN) Charles Wilson (CW)
Executive Directors:	Mike Anderson (MA), Medical Director Lorraine Bewes (LB), Director of Finance and Information Maxine Foster (MFo), Director of Human Resources Alex Geddes (AG), Director of IM&T Catherine Mooney (CM), Director of Governance and Corporate Affairs
In Attendance:	Sharon Terry (ST), Assistant Director of Nursing (for Andrew MacCallum) Nicola Hunt (NH), General Manager – Medicine (for item 3.1) Matthew Akid (Head of Communications) (for item 4.1) Fleur Hansen (FH), Foundation Trust Lead

1. GENERAL BUSINESS

1.2 Apologies for Absence

Apologies for absence were recorded from Heather Lawrence, Andrew Havery, Richard Kitney, Edward Donald and Andrew MacCallum. Sharon Terry attended in Andrew MacCallum's absence.

1.3 Declarations of Interest

No conflicts of interest were declared.

1.4 Minutes of the Previous Meetings held 6th July 2006.

The following amendment was made to the minutes:

- p.5, first paragraph, final sentence: The sentence now reads as follows: There was a discussion whether the membership matched the patient profile and AMC reported that 30% of patient data was coded as 'other' and therefore it was difficult to make a comparison. The action that followed was deleted.

Subject to the change listed above, the minutes were agreed as a true and accurate record.

1.5 Matters Arising

5.2/May/06 Contracted Services
Facilities Assurance Committee to report to the September Board meeting on the performance of Haden.

2.3/May/06 Independent Valuation
This item is listed on the main agenda.

4.2.1/May/06 Staff Survey
The comparison on harassment and bullying with other trusts has been included in the Workforce Report which would be presented later in the meeting.

2.1/Jun/06 Private Patients
The report of Private Patients will be brought to the September/October Board meeting.

2.1/Jul/06 Finance Report
1. The updated CIP position was forwarded to Monitor.

2. A policy to reduce elderly length of stay in medicine would be discussed as part of the Medicine Directorate Savings Plan.

3. The Medicine Directorate Savings Plan would be presented later in the meeting.

4. MFo informed the Board that pay levels for midwives recruited from overseas whilst under induction had been reviewed. As the midwives are registered when recruited, it would not be appropriate to pay them less than the full amount whilst under induction. ST added that the induction did not involve re-training, it was a cultural integration which allowed the foreign midwives to shadow another member of staff to learn the way midwives practice in the Trust. MFo said in future when a decision is taken to recruit from overseas the additional costs of induction should be factored into the business case.

5. Further savings proposals have been added to the Finance Report.

6/7. MFo informed the Board that work had been undertaken to identify positions that could only be filled by agency staff. MFo said that RMNs roles would continue to need to be filled by agency staff as the Trust did not employ bank RMNs. In addition, locums, therapists and some finance and IM&T positions would need to be filled by agency as such specialist staff were not available through bank. Also there is a shortage of bank medical secretaries meaning that positions may need to be filled by agency staff. MFo said that only these positions listed would be eligible to be filled by agency staff and these and any positions outside these would require executive director sign off to be filled by agency staff. LB commented that the agency spend had come down in July.

1.4/Jul/06 Performance Report
1. LB informed the Board that the 48 hour target in GUM was being tracked and the internal plan was to achieve 60% by September. Further work was being undertaken to turn this into a profile.

2. CM commented that in AMC's absence, she had investigated the coding issue that he had raised at the last Trust Board meeting. The issue concerned the use of the ethnic code 'other' for an unusually high proportion of members (AMC mentioned 30%) listed on the Trust membership database. CM said that she had spoken with the Campaign Company regarding this and they have found that for the latest membership figures, the percentage classed as 'other' was in fact 3.5% whilst 'not specified' was 9.4%. As these appeared not to be significant figures, CM said that she would follow this up with AMC once he returned from annual leave.
Action: CM to follow up ethnic coding issue for Trust membership with AMC. (Response: Minutes should have read there was a discussion whether the membership matched the patient profile and AMC reported that 30% of patient data was coded as other and therefore it was difficult to make a comparison.) **CM/AMC**

2.3/Jul/06 Acute Hospitals Portfolio
AG informed the Board that the procedure coding issue in LastWord had now being resolved. He said that LastWord now has a facility for this and staff were being trained to use it.

3.1/Jul/06 Board Memorandum
NEDs were circulated the mitigations and chairman's action was taken to sign off the Memorandum.

3.1.1/Jul/06 Board Statement
Chairman's action was taken to sign off the Board Statement.

5.1/Jul/06 Child Protection Annual Report
CM informed the Board that the child protection issues did not feature on the Risk Register but that the head of Clinical Governance was to meet with the designated doctor for child protection to discuss which issues needed to be added.

5.3/Jul/06 Integrated Governance Update
JP informed the Board that he had met with CM and FH to discuss the annual business cycle and the structure of Board papers. JP suggested that a Board seminar be held on this in October.

1.6 Chief Executive's Report

In the absence of the chief executive JP briefly summarised the key issues raised in the report. JP highlighted the appointment of David Nicholson as chief executive of the NHS and the replacement of PPI Forums with Local Involvement Networks (LINks). The Board discussed the academic merger between St Mary's and Hammersmith Trusts and it was noted that when their strategy and services had been decided on, then the effects on the Trust could be determined. JP commented that the likely effect will be on the Trust's research but it was noted that the consultation process was yet to begin and that this would allow the Trust the opportunity to comment. It was decided to address this in the future.

Action: Effects of STM/HHNT academic merger to be addressed at a future Board meeting. **HL**

JP then updated the Board on the Trust's Foundation Trust application. JP said that the Monitor had deferred the application because of the Trust's inherited debt and their concern for our short term cash position. Monitor are concerned that the £7.8m loan from the FT Financing Facility (FTFF) has not been formally approved and consequently a risk remains that it may not be secured. Monitor also expressed concern regarding the Trust's significant CIP requirement and the fact that the Trust was off target by £500k at the end of June. JP noted that Monitor have been very supportive and they commended the Trust on its good work. They have also undertaken to work with the Trust in lobbying the DoH and have suggested asking the DoH if the PDC repayment can be re-profiled over a number of years.

JP informed the Board that the next Monitor Board meeting was not until September 28th so the first possible date for authorisation would be October 1st. JP said that he was optimistic that the Trust would be authorised on this date and commented that this delay could be positive if it provided the Trust with more flexibility for its repayments. LB added this was the first time the FTFF had been asked to approve a loan before licensing and as this may also be an issue for other Trusts in the future, that Monitor will work with us to find a solution.

2. PERFORMANCE

2.1 Finance Report, June 2006

LB informed the Board that the Trust was behind plan by £528k at the end of month 3 and that this was driven by pressures in pay and the savings plan. However this was a significant improvement on month 2 with a turnaround of £721k mainly due to directorates identifying additional CIPs. Also as a result of the last month's Board meeting, restrictions in agency use and non pay have been introduced to further

recover the position and the Medicine Directorate was delivering its interim report on its recovery plan later in the meeting.

LB highlighted a new risk on HIV day case income due to the classification of day case activity in the contract at a significantly higher level than there is. The directorate is reviewing the classification of activity between day case and outpatients to ensure it recorded accurately however the size of the gap means it is unlikely that re-classification will close it completely. The impact would be £1.5m of which 500k could potentially be recovered through renegotiating the baseline contract with the HIV Consortium. A £1m loss would still allow the Trust to meet a surplus of £2.4m though as it would be within the forecast. LB will write to the Consortium to request an in year change and the coding in this area will also be looked at closely.

The cash position for June was slightly ahead of forecast at £10.3m. LB said that a paper will be brought to the next Board meeting detailing how much of this cash improvement is permanent and how much is due to more timely collection.

Action: 1. Write to HIV Consortium to rebase the contract **LB**
2. Paper on cash position to be brought to the September 7th meeting. **LB**

LB asked the Board to note that the improvement in cash position was not due to stretching creditors and that the Trust was achieving a Better Payment Practice Code (BPPC) target of 92%.

2.2 Performance Report, June 2006

LB directed attention to page six of the report which detailed the Trust's performance against the 2005/06 Healthcare Commission targets. The Trust fully met all the existing national targets but had an overall rating of only 'fair' for the new national targets. Of these, a 'weak' performance rating was seen for the 48-hour access to GUM clinics indicator and 'fair' ratings in the experience of patients and emergency bed days indicators. As the Trust had an excellent rating in the majority of new targets, CM suggested that some explanation would be required from Nicolas Cabon as to the logic behind the overall rating of 'fair'. It was agreed that the methodology for the ratings would be circulated to the Board.
Action: Circulate methodology for the performance ratings to the Board. **LB**

JP asked if these targets would contribute to the Trust's performance rating – LB responded that they would along with the HCC Improvement Reviews. This was in part reflected in the dashboard with access to GUM clinics, thrombolysis and data quality on ethnic group all rated red although the latter of these had made significant improvement.

Regarding activity, outpatients was down as expected (1% on new patients and 3% on follow up) but elective inpatient activity was 16% ahead of plan. Emergency activity though was below plan by 9% but maternity deliveries were 43% of plan. A&E attendances were generally on plan but not as expected with paediatrics performing below plan and adults above it. LB said that there were still issues around length of stay and day case particularly emergency and that the Director of Operations had requested recovery plans from general managers.
Action: Update on length of stay recovery plans to be included in the next Performance Report. **ED/LB**

There was then some discussion on the PCT-led triage service. MA explained that this service would involve patients being triaged in A&E (at the cost of £5 per patient) but then follow up would be provided in the community through GPs and clinics.

3. ITEMS FOR DECISION/APPROVAL

3.1 Medicine Recovery Plan – Interim Report

LB briefly explained that the Medicine Recovery Plan had resulted from discussions at last month's Board meeting and that this was the interim findings – the completed Plan will be presented to the Trust Board in November. The report highlights the immediate actions to be taken to improve on the straight line forecast overspend of £1.487m at the end of month 3. A number of short term actions have been taken to improve the position resulting in the deficit being revised down to £471k. The actions taken were as follow:

- Bank and Agency quota controls for all staff groups (medical, nursing, administration and clerical) £83k;
- Non-pay freeze of non-essential items £25k;
- Removal of £153k income target (e.g. re-charge for consultants who have retired)
- Level 1 beds funded at £54k p.y.e. (£94k f.y.e.);
- Endoscopy allocation of £465k to forecast out-turn pending sign-off of final ZBB;
- Budget transfers for Discharge Team and TB nurse, net benefit to the Directorate of £60k due to unfunded posts;
- Drugs procurement benefit of £132k p.y.e.; and
- Outpatient follow-up prescribing reduction of £28k, p.y.e.

LB asked the Board to note that this was a work in progress and that a rebasing exercise would be carried out to determine the base line for their activity plan. NH added that there would be a full assessment of the effects of Payment by Results (PbR) so that all winners and losers can be identified and that a zero based budgeting exercise would allow the directorate to fully allocate costs. CW requested that the Board be updated monthly as part of the Finance Report on the progress of the recovery plan.
Action: Include monthly update on Medicine Recovery Plan in Finance Report. **LB**

The Board approved the Interim Report of the Medicine Recovery Plan.

3.2 Agency Staffing Spend – Oral Update

The Board had already discussed the restrictions in agency staffing under matters arising. MFo added that for the last two weeks there had been a 15% reduction in agency spend week on week and the expenditure matched levels from 2003/04. MFo said that the next piece of work would be focused on consolidating contracts as the agency contracts were based on cost and volume and as the volume of usage was decreasing, the cost may need to be renegotiated. MFo added that the number of different agencies being used may be reduced. The Board noted the solid improvement in position.

3.3 Working Capital Facility

LB explained to the Board that this paper was being presented to seek approval to open an RBS account in preparation for FT authorisation.
There was then some discussion on the terms offered by RBS. LB explained that KPMG had advised that the Trust seek a facility greater than 364 days so the terms offered were £18m for 12 months and then £12m for a further 6 months. LB said that a facility of £12m would provide the Trust with sufficient headroom but that £18m was sought to maintain the Trust's risk rating. The fees would be 0.10% for £6m and 0.13% for £12m with a non-utilisation fee of 0.5%. KN questioned whether the non-utilisation fee was appropriate – LB said that she would follow this up outside the meeting.
Action: RBS to be consulted on non-utilisation fee. **LB**

JP suggested that whilst the Board authorise the opening of the RBS account, that the figures be revisited at the September 7th Board meeting, prior to a possible October 1st

authorisation.

The Board authorised the setting up of an RBS bank account.

3.4 Independent Valuation

LB informed the Board that this paper reported on the results of the independent valuation undertaken by Montagu Evans earlier in the year in anticipation of becoming a Foundation Trust. The last valuation was undertaken by the District Valuer at the 1st of April 2005. The Montagu Evans valuation at 1st April 2006 was £28m less. LB said this could be the result of one of two things – either there was a difference in the pricing estimate compared with the previous valuation or there has been a significant physical deterioration in assets. The former was confirmed by Montagu Evans as they have confirmed that the estate is in good repair and the Directors are not aware of any physical damage.

This is supported by the fact that Montagu Evans said that the estate has a remaining useful asset life is 42 years as opposed to 28 years as suggested by the District Valuer. This was in part due to the District Valuer under appreciating the flexibility of the building. The impact of the revaluation is a current reduction of approximately £900k in depreciation (which had been included in the savings programme) and by £700k in 2007/08. LB informed the Board that if the Trust becomes an FT, it will be able to use the higher asset life as per the independent valuation, otherwise it must remain with District Valuer's view of the asset lift. As an FT the Trust will no longer be required to index annually but instead will need to take an independent valuation every five years and review it at least every 3 years.

The Board approved the adoption of the independent valuation if licensed as a Foundation Trust but it would still need to address the frequency of indexations. JP suggested that this valuation be reflected in the management accounts only, not the statutory accounts.

4. ITEMS FOR ASSURANCE

4.1 Draft Annual Report

The Board had reviewed the draft Annual Report and a couple of amendments were suggested:

- As Prof. Kitney did not commence his NED role until May 2006, Prof. Darzi should be listed at the academic NED in the report. (LB)
- Amanda Pritchard's role was mostly as acting Director of Strategy and Service Development in 2005/06 and she was yet to take up post as Deputy CE and the report needed to reflect this. (LB)
- Mention needed to be made of Jenny Hill and Prof. Ara Darzi departure and Karin, Prof. Kitney, Amanda and CM's arrival in the chairman's report and on the corporate governance pages. (JP)
- Under the chief executive's report, CIPs should be £11m not £10m as stated. (LB)
- The NHS standard BPPC under the summary financial statements is 95% not 90% as mentioned. (LB)

Matthew Akid noted these amendments and the Board thanked him, George Vasilopoulos and the other contributors to the Annual Report.

5. ITEMS FOR NOTING

5.1.1 Complaints Annual Report

ST informed the Board that the top three complaint subjects were aspects of clinical

care or treatment (143 complaints), attitude or behaviour of staff (134) and aspects of the appointment system (61). The second of these should be reduced by the setting up of the customer care training and appointments systems complaints should be reduced through improved access namely through Choose & Book. The largest of complaints received were in Women's and Children's (59) with the majority of these being in maternity. ST said that HL had requested a breakdown of these complaints.

Action: Breakdown of complaints in Women's and Children's Directorate to be forwarded to HL. **AMC/ST**

LB suggested that it may be more useful to track complaints by area rather than by speciality. ST said that a score card for wards was being produced which should identify key areas of complaint. MA commented that complaints may be used more formally in medical staff appraisals. MA said that he would also like to identify medical staff that consistently arise during complaints.

CM enquired as to how the actions that result from complaints are agreed and implemented. ST responded that there was a tracking system in place but that it may not be as robust as necessary and that further work needed to be undertaken to ensure that actions that apply Trust-wide are communicated.

Action: 1. Publicising changes in practice as a result of complaints to be followed up with the Head of Communications. **CM**

2. Review of systems ensuring actions recommended as a result of complaints are implemented. **AMC**

5.1.2 PALS Annual Report

ST informed the Board that there had been a marginal increase in the number of PALS enquiries in 2005/06 – 32 more than the previous year but that there had been a decrease in the number of comment cards received. ST said that a campaign was now running to raise awareness of the commend care scheme. ST also highlighted the number of positive comments that had been received through PALS – 206. ST commented that positive or useful feedback can sometimes be treated as a complaint but that a suggestions box was now being trialled in PALS. CW commented that the pie graph on page five did not correspond with the figures on the bottom of page four.

Action: Pie graph figures on page five of the PALS Report to be corrected. **AMC/ST**

KN suggested that more year-on-year trend data should be added to the reports.

Action: Year-on-year trend data to be added to the PALS and Complaints Report. **AMC/ST**

At this point the Board extended its congratulations to Sharon Terry on her new appointment as Director of Nursing at the Royal Cornwall Hospitals NHS Trust.

5.2 Workforce Report – Q1 2006/07

MFo informed the Board that the key focus for the quarter has been to control staffing costs and improve productivity to support the Trust's financial balance. A key aspect of this was restricting bank and agency spend which was down £200k on Q1 last year and reducing bank rates could save a further £800k. Vacancies have risen but this will reduce in August once the figures are calculated using the new budget and significant savings had been made through the increased use of e-recruitment and the electronic staff record project. MFo also informed the Board that by the end of June, 76.8% of staff had moved to their Agenda for Change salary and that less people were on pay protection.

KN suggested that it would be useful if long term sickness was tracked and that target lines be added to the graphs in the report. ST suggested that other staff groups be included in the graphs not just nursing and midwifery.

Action: The changes noted above to be made to the Workforce Report. **MFo**

JP noted that the percentage of staff experiencing harassment from patients or relatives was fairly high compared to other London trusts at 37% with the average being 24%. It was noted that this was a historical issue and it was decided that more work needed to be done on this.

Action: Further work to be undertaken on high percentage of staff experiencing harassment from patients or relatives. **CM/MFo**

6. ITEMS FOR INFORMATION

6.1 Minutes of Audit Committee meeting held 4th July 2006.

LB noted that Andrew Havery had given a verbal update on this meeting had been given at the July 6th Board meeting. The Board noted the minutes.

7. QUESTIONS FROM MEMBERS OF THE PUBLIC

The was a request from a member of the public that the Confidential Agenda be made available to the public. JP said that the Trust would determine if this was possible and if so then it would be made available.

Action: Determine if Confidential Agenda can be made available to public. **CM/FH**

8. ANY OTHER BUSINESS

9. DATE OF THE NEXT MEETING

The next meeting is scheduled for 7th September 2006.

10. CONFIDENTIAL BUSINESS

The Chairman proposed and the Trust Board resolved that the public be now excluded from the meeting because publicity would be prejudicial to the public interest by reason of the confidential nature of the business concluded in the second part of the agenda.

Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting, 7th September 2006

AGENDA ITEM NO.	1.5/Sept/06
PAPER	Matters Arising
AUTHOR	Fleur Hansen, Foundation Trust Lead Contact Number: 020 8846 6716
SUMMARY	This paper lists matters arising from previous meeting(s) and the action taken/to be taken.
BOARD ACTION	The Board is asked to note the matters arising and update where appropriate.

Matters Arising from Previous Meetings

Reference	Item	Action
5.2/May/06	CONTRACTED SERVICES Facilities Assurance Committee to report to the September Board meeting on the performance of Haden.	ED
2.1/Jun/06	PRIVATE PATIENTS Private Patient Report for September/October Board meeting.	LB
5.3/Jul/06	INTEGRATED GOVERNANCE UPDATE Papers on the annual business cycle and committee structure to be brought to the September Board meeting.	CM
1.4/Jul/06	PERFORMANCE REPORT CM to follow up ethnic coding issue for Trust membership with AMC.	CM/AMC
1.6/Aug/06	CHIEF EXECUTIVE'S REPORT Effects of STM/HHNT academic merger to be addressed at a future Board meeting.	HL
2.1/Aug/06	FINANCE REPORT 1. Write to HIV Consortium to rebase the contract. 2. Paper on cash position to be brought to the September 7th meeting.	LB LB
2.2/Aug/06	PERFORMANCE REPORT Circulate methodology for the HCC performance ratings to the Board. Update on length of stay recovery plans to be included in the next Performance Report.	LB LB
3.1/Aug/06	MEDICINE RECOVERY PLAN Include monthly update on Medicine Recovery Plan in Finance Report.	LB
3.3/Aug/06	WORKING CAPITAL FACILITY RBS to be consulted on non-utilisation fee.	LB
5.1.1/Aug/06	COMPLAINTS ANNUAL REPORT Breakdown of complaints in Women's and Children's Directorate to be forwarded to HL. 1. Publicising changes in practice as a result of complaints to be followed up with the Head of Communications. 2. Review of systems ensuring actions recommended as a result of	AMC CM AMC

	complaints are implemented.	
5.1.2/Aug/06	PALS ANNUAL REPORT Pie graph figures on page five of the PALS Report to be corrected. Year-on-year trend data to be added to the PALS and Complaints Report.	AMC AMC
5.2/Aug/06	WORKFORCE REPORT The following changes to be made to the workforce report: • target lines to be added to graphs; • long term sickness to be tracked; and • other staff groups to be added to the graphs. Further work to be undertaken on high percentage of staff experiencing harassment from patients or relatives.	MFo MFo
7/Aug/06	CONFIDENTIAL AGENDA Determine if Confidential Agenda can be made available to public.	CM/FH

Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting, 7th September 2006

AGENDA ITEM NO.	1.6/Sept/06
PAPER	Chief Executive's Report
AUTHOR	Heather Lawrence Contact Number: 020 8846 6711
SUMMARY	This paper outlines key issues for the attention of the Trust Board.
BOARD ACTION	To note the report.

Chelsea and Westminster Healthcare NHS
NHS Trust

CHIEF EXECUTIVE'S REPORT – AUGUST 2006

Foundation Trust Authorisation

Monitor anticipate taking a paper to their Board on September 28th with a view to licensing on October 1st subject to confirmation of a £12m loan from the Foundation Trust Financing Facility, update on brokerage arrangements for the DoH and month 4/5 position and how the revised financial target may impact on the Trust.

Revised Financial Target

I attach a letter from Julie Dent, Managing Director of the SHA for NW London in response to David Nicholson's letter of August 10th. To summarise, the carried forward surplus of £2.2m has been retained. We have been set a new surplus of £2.3m or one percent and our MPET (Multi Professional Education and Training) funding has been reduced by £1m.

The combined impact of these changes require a 6% saving on revenue however at this stage in the year this has a significantly greater impact. CEOs of teaching hospitals have written to collectively dispute this arbitrary MPET change. With regard to the additional one percent surplus requirement I have written (see attached) to advise that this is not achievable in year and that we will continue to achieve our statutory obligations. The change in MPET impacts adversely on cash. At this stage we have not taken these into financial assumptions and in addition the K&C PCT have indicated that they may wish to defer non-urgent patient treatment in the last quarter of the year by circa £500k. This has not been taken into our financial position reported at Month 4 either.

Customer Services Training Update

The steering group recently met with Steve Harris from Energize. The plan is to train 150 customer services leaders and identify 25 champions by November 2006 and for all staff to have completed customer services training by Christmas 2006.

Annual Health Check – Diagnostic Services

The results of this 2005/06 Acute Hospital Portfolio review of Diagnostic Services were published on the 22nd of August. The Trust's overall assessment was 'fair' with an average score of 2.967 across the three areas assessed – Experience of Service Users, Quality and Efficiency and Management. This is below the national average of 3.053 with the Trust scoring above average in Experience of Service Users with the lower scores in the other two areas mainly centred around pathology.

Hammersmith Hospitals, to whom pathology is outsourced, scored exactly the same as the Trust for the questions on this service. The Trust is currently reviewing the service offered at Hammersmith and how best to provide an excellent pathology service.

Senior Staff Appointments

As you are no doubt aware, Sharon Terry has recently left the Trust to take up post as Director of Nursing at the Royal Cornwall NHS Trust.

Heather Lawrence, 24th August 2006

Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting, 7th September 2006

AGENDA ITEM NO.	2.1 /Sep/06
PAPER	Financial Report – July 2006
LEAD EXECUTIVE	Lorraine Bewes, Director of Finance and Information Contact Number: 020 8846 6713
AUTHOR	Jon Bell, Deputy Director of Finance Contact Number: 020 8846 6713
SUMMARY	The reported Trust financial performance against budget for the year to Month 4 is a favourable variance of £0.062m. This represents a surplus of income over expenditure of £0.849m year to date against a target surplus of £0.787m. This is a significant improvement on the financial position reported at Month 3. The forecast for the year at the time of reporting is to deliver the planned surplus of £2.36m. Key highlights for the Board to note include: • Front line directorates have contained the overspends experienced in the first three months and achieved an underspend of £0.095m in July. • The income position has deteriorated against plan due to a reduction in the estimated level of HIV daycases and changes in activity levels and casemix. • Mitigating the income loss is the release of some of the provisions set aside for doubtful debt in 2005/06 relating to income that has since been collected. • All savings plans have been identified in full and achievement to date is £0.238m or 7% behind plan. There are a number of risks to delivering the forecast surplus and these are listed below: • K&C PCT have indicated that they intend to not pay for any non-urgent activity in the final quarter of the year. The income loss has recently been estimated at £0.5m but is not reflected in the current forecast. • Since completing the Month 4 position, the DoH have announced significant cuts to Training and Education Levies. This would reduce income by £1.1m and this in not currently reflected in the forecast. The loss of this income will carry forward into FT status if the cuts are upheld. • In addition, the SHA are proposing to remove the 2005/06 surplus carry forward showing in the Trust's income but still require a 1% surplus. The Trust is resisting this additional surplus, particularly as the notification of this change in policy has come half way through the year. As an FT the Trust would be required to deliver this surplus prorata to the number of months as an NHS Trust. The Chief Executive has written to the SHA outlining our serious concerns regarding both of the above proposals. The cash position for the Trust has continued to show a strong performance and is £1.35m ahead of plan. The Trust achieved a cumulative BPPC of 91.8% in July.
BOARD ACTION	The Board is asked to note the financial position at Month 4.

Finance Report - September 2006
Financial Position – July 2006

Summary Income & Expenditure (Form F1)

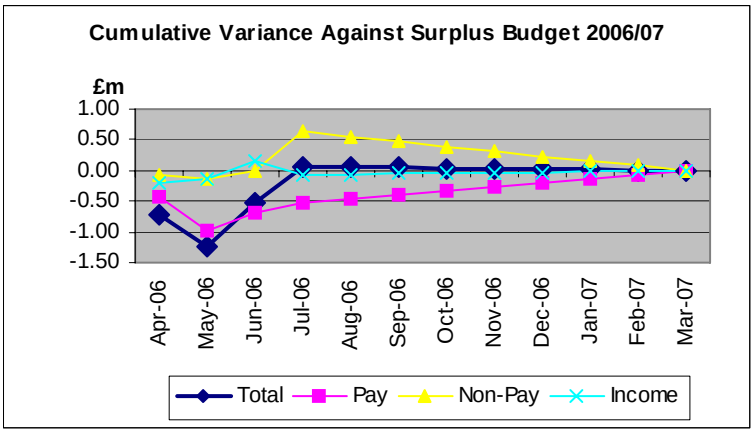
1. The Trust's budget is set to achieve a surplus of £2.360m in 2006/07 which is approximately 1% of income.

2. Within this position the total savings required are £11.073m, comprising £9.412m of a new target set this year and £1.661m of unachieved target brought forward from last year. Savings targets are phased into the position to reflect the profile of planned schemes. In total 100% of savings are achieved or planned. Year to date there is slippage of £0.238m (7%) against planned schemes. Further details on savings plans are given in Paragraph 37.

3. The income plan reflects the agreed capacity plan at April 2006. Negotiations have progressed well with PCTs and 57/123 contracts are now agreed including Kensington and Chelsea PCT SLA. Agreed contracts account for 94% of total contract value. The principles agreed with our host PCT were rolled out to all London PCTs in accordance with the London Commissioning framework. See paragraph 11.

4. The HIV SLA has now been agreed. A new risk to HIV income was identified last month relating to potential HIV day case activity; further explanation is provided in paragraph 43.

5. The overall financial position after four months is a favourable variance against budget of **£0.062m** which is driven primarily by the pay and savings positions**.** However, this is a **favourable** movement in the month of **£0.590m**, which shows significant recovery from the Month 3 position on both pay and non pay. In addition restrictions on agency and non-pay continue to further recover the position, as does the impact of the Medicine Directorate recovery plan, which was reported in detail to the Board last month. The graph below shows the cumulative variance to date and the trajectory required for the remainder of the year to achieve a zero variance against budget and consequently a £2.4m I&E surplus at the year end.



6. The overall pay position at Month 4 is an **overspend** of **£0.537m** (2.2%), which is a **favourable** movement in the month of **£0.157m** (2.6%). This includes unidentified pay savings targets of £0.376m year to date but a **surplus** on Pay savings against budget in the month by **£0.272m** because significant savings were removed from budgets in Month 4.

7. Non pay including Reserves and Capital Charges is favourable year to date by £0.633m which is favourable movement in the month of £0.642m. There are no non pay savings targets within the year to date position.

8. The income position, including interest receivable, is £0.034m favourable year to date, an adverse movement against budget in the month of £0.209m. The PCT SLA income position reflects actual activity for the first quarter extrapolated to four months.

Variance Analysis – Year to Date and In Month

9. The overall position for the Trust is a favourable variance of **£0.062m** at Month 4, a favourable movement in the month of **£0.590m**. The high-level summary of this position is as follows:

	Month 3	Month 4	Movement in the Month
	£'m	£'m	£'m
Income			
SaFF Baseline	0.123	-0.333	-0.456
Non-Contract Activity	0.000	0.000	0.000
Private Patient Services	-0.066	0.076	0.142
Other	0.030	0.112	0.082
Interest Receivable	0.089	0.111	0.022
Expenditure			
Pay	-0.693	-0.537	0.157
Non Pay pressures	-0.031	0.602	0.633
Reserves and Capital Charges	0.020	0.032	0.010
Total	**-0.528**	**0.062**	**0.590**

Income and SaFF update

10. The overall year to date income position is **£0.034m** adverse against budget, taking into account a favourable position on interest receivable (£0.111m), Private Patients (£0.076m) and Other Income (£0.112m). This is offset by an adverse position on contract income of £0.333m. (Form F2B(ii)).

11. 57 PCT SLAs have now been agreed representing 94% of the total value of SLAs. This is summarised in the table below.

	No of SLAs	SLA value agreed /Offer £m	Variance £m
Agreed	57	177.668	-0.430
Offers received not agreed	5	3.698	-0.050
No offer received	60	6.570	0
Overseas (reciprocal)	1	1.957	0
Total	123	189.893	-0.480

12. Private Patient income, including ACU, is favourable against budget by £0.076m. Within this position ACU income is favourable against target by £0.138m which is offset by an adverse position on both Private Patients Unit (£0.063m) and Private Maternity (£0.031m).

13. As reported above SaFF Income is based on an extrapolation of activity for the first quarter. The net over/under performance excluding NICU Consortium and HIV is £0.033m adverse against target year to date.

14. The NICU Consortium contract has not been signed because the Trust disputed the offer of consolidating last year's overperformance into the contract baseline at only 50% marginal rate (last year it was paid at 70%) and paying this year's overperformance at 50%. The Consortium have increased their offer to 70% and negotiations are continuing to achieve a fair risk share that adequately reimburses the Trust for costs incurred. The budget for NICU Consortium income is based on last year's outturn plus additional activity anticipated this year, a budget increase of

£0.412m. NICU Consortium income in the position for the first three months reflects over performance at 70% marginal rate resulting in a £0.098m adverse variance against budget.

Expenditure Update

15. The overall expenditure position is favourable against budget by **£0.097m** (0.1%) year to date and favourable against budget by **£0.799m** (4%) in the month.

16. Pay budgets are adverse against budget year to date by **£0.537m** (1.2%) however in the month pay budgets were favourable by **£0.157m** (1.3%) (**Form F2D**). The largest elem ent of the year to date adverse position is unachieved savings target of £0.376m, an increase in £0.023m in the month. The annual savings target remaining against Unidentified Savings includes savings planned to be achieved later in the financial year that will subsequently be removed from expenditure budgets, for example, the Executive led ward rostering savings which are expected to deliver from October onwards.

17. The remaining adverse pay variances in the month are within Medical Staff (£0.090m) and Allied Healthcare Professionals (£0.015m), both of which are lower that last month's overspends. Spend of £4.465m on bank and agency excluding medical locums is 10% lower than the year to date spend at Month 4 last year.

18. Existing staffing budgets, e.g. nursing and new Agenda for Change (AFC) bands, continue to change as staff are paid under new AFC terms and conditions. There are 1,790 staff now paid under AFC terms and conditions and a further 366 staff who have not yet moved to AFC terms and conditions.

19. Non-pay including capital charges is favourable against budget **£0.633m** year to date which is a favourable movement in the month of £0.642m (7%) (**From F2E**). The month position is a reversal of trend as a result of two significant favourable movements in the month and lower spend on Non Pay lines that were overspending for the first quarter of the year. The significant favourable variances are as follows:

    - following extensive credit control on old outstanding debt that was subsequently recovered it has been possible to release bad debt provision of £0.357m in the month;
    - within Other Expenditure is £0.339m budget released from Reserves into the year to date position as planned. Note that the planned release of Reserves to Central will continue throughout the year.

20. The remaining non pay lines include a number of offsetting variances however Medical and Surgical Equipment and Consumables is favourable against budget in the month by £0.041m which is the first time this year it has not overspent. There is a £0.100m adverse variance against budget on the Pathology SLA with Hammersmith Hospitals (HHT). This reflects the inclusion in the position of invoices received this month for the first quarter which are significantly greater than last year. Discussions at Director level are taking place with HHT to explore provision and costs of the service. Further commentary is in the directorate reports below.

<u>Directorate Positions (Forms F3A and F3B)</u>

21. The following directorates are those directorates where the position is a year to date overspend at Month 4 or there are significant over or underspends within the position.

22. **Medicine & A&E –** The Medicine & A&E Directorate is £0.470m adverse against budget at Month 4, an adverse movement of £0.079m in the month. The wards are £0.126m overspent to Month 4, of which £0.122m of the overspend occurred in Months 2 & 3. A&E is overspent by £0.043m, of which £0.028m of A&E housekeeper costs relate to 05/06. The ward costs relate to Level 1 and Registered Mental Health (RMN) nursing costs. All ward bank pay costs were breakeven in the month which shows that the bank and agency quotas set are being adhered to. Generally non pay costs are down across the Directorate due to stock controls. The Directorate forecast is £0.471m adverse against budget for the year.

23. **Anaesthetics & Imaging-** The financial position for the Imaging & Anaesthetics Directorate for the four months to 31st July 2006 is a cumulative overspend against budget of £0.099m, a positive movement of £0.063m in month.

24. The key issues to note at Month 4 are that the Anaesthetics position has continued to deteriorate, showing an overspend of £0.023m in month relating primarily to the continuing pressure on the paediatric anaesthetic rota due to the absence of two consultants together with sickness and maternity leave cover. However, this overspend has been mitigated by the fact that the Radiology pay position improved by £0.043m in month, relating primarily to careful management of the Radiographer vacancy position. In addition to this, there was a reduced level of spend against non-pay budgets across the Directorate particularly in ITU and Theatres, which is linked to the implementation of a non-pay quota for non-stock requisitions that has been in place since mid July. The Treatment Centre also saw a reduced level of overspend across both pay and non-pay budgets, which again shows that the strict quota system for pay and non-pay is beginning to impact on the financial position in a positive way.

25. As a result of the improvement in the Month 4 position, the Directorate forecast has been improved to a projected overspend of £0.111m. The key assumptions within the forecast calculation are that the Anaesthetics pressure will essentially continue at the current trend for the remainder of the financial year, whilst all other areas of overspending will be brought back to budget by means of strict quotas. In addition the Radiology pay budget is forecast to underspend substantially throughout the remainder of the financial year albeit at a lower rate from October onwards to account for recruitment into Radiographer posts.

26. **Surgery** – The financial position for the Surgery Directorate for the four months to 31st July 2006 is a cumulative overspend against budget of £0.258m, representing an adverse movement in month of £0.018m. This is a significant reduction on the overspending trend of on average £0.080m per month over the previous three months.

27. The key issues to note at Month 4 are that pay budgets underspent by £0.024m across the Directorate in terms of both medical and nursing pay, due to the strict implementation of the bank and agency quota across all budget areas. The non-pay position was an overspend against budgets of £0.046m, of which the majority related to a pressure on General Surgery MSSE. On investigation this included relatively high expenditure on Gastric Bands and associated items, together with increased expenditure on Urology consumables which is linked to the St Mary's urology activity which transferred to the Treatment Centre in April 2005. In addition to this the Prosthetics budget in T&O overspent by £0.022m in July, which represents a reduction in the trend of expenditure seen in 2005-2006 (the year to date overspend at Month 4 is £0.119m compared to £0.158m for the same period last year).

28. As a result of the improvement in the position at Month 4, the Directorate forecast has been revised to a projected overspend of £0.187m at year-end. This forecast is based on the assumption that the Month 4 trend of expenditure on pay will continue to the end of the year, i.e. the bank and agency and medical locum quotas will continue to reduce expenditure during the next 8 months. In terms of non-pay, the assumption has been made that all Wards and Outpatient departments will be able to break-even or underspend against non-pay whereas there will still be a pressure against the General Surgery, T&O and Plastics non-pay budgets linked to activity levels, although every effort will be made to contain this and reduce it where possible using non-pay quotas.

29. **Women & Children's Directorate-** The Month 4 position for the Women and Children's Directorate shows an overspend of £0.308m, with an in-month underspend of £0.084m. The key issues are as follows. Gynae continues to perform well against budget. Maternity was favourable against budget overall for the second successive month, and is now £0.096m favourable year to date. This is the result of high costs in the first two months for staff recruitment and now due to activity over-performance; with a current forecast of 4,400 deliveries, against the target of 4,250, impacting on the maternity pay position. NICU continued to overspend, in the main due to year to date over-performance and the Consortium baseline contract offer being at marginal rates from 05/06. Discussions are on-going to address this situation and an improved position has been forecast to year end. Medical staffing across the directorate continues to create cost pressures, although at a reduced rate in July, due to the funding of a Paediatric SpR and Consultant Seniority increments, as well as the impact of a Locum pay quota. Paediatric Wards pay is underspent in month, helped by the revised bank and agency quota. Private Maternity and Paediatric

Community also underspent in month. The current forecast year end position for W&C is an adverse position of £0.175m.

30. **HIV/GUM Directorate-** The financial position for the HIV/GUM Directorate at the end of Month 4 is an adverse variance of £0.017m, which represents an in-month under-spend of £0.046m. A one off non-pay charge of £0.020m in Month 1 has pushed the period end position into deficit. In addition to the normal savings target of 2.5%, the Directorate has a carried forward recurrently unmet savings targets of £0.400m from 2005-06. However, the Directorate continue to work up plans to be able to meet this target and stay within budget for the year. The forecast is to break even.

31. The Directorate has carefully reviewed all inpatient and outpatient activity over quarter 1 to understand the impact of earlier overestimates of inpatient day case activity within Kobler Day Care. The Chief Executive has also written to the Consortium to request a rebasing of the original plan.

32. **Private Patients** – The Month 4 position shows an under recovery against income target of £0.063m and an overspend against expenditure budget of £0.115m, a combined adverse variance of £0.178m. PP income continues to improve throughout the year, from a poor start in April, which saw a very low level of activity. However, while Month 4 was the best month seen this year, the service manager reports that Month 5 bookings are poor and this has been reflected in the forecast. This contrasts sharply with performance last year, when August was a good month in terms of income generated. The assumption in the forecast is that PP will see better performance from September. Taking this into account, and whilst the unit continues to deal with underlying cost pressures which are being investigated, the forecast has been pushed out to an overall adverse position of £0.392m at year end.

33. **Overseas Income**- Overseas income is currently showing a Month 4 positive variance of £0.029m against a year-to-date income target of £0.239m.

34. **Facilities-** The Facilities Directorate was £0.005m over spent as at Month 4 with an in month deficit of £0.002m, due to minor over spends. Electricity costs from Scottish & Southern Energy have been forecasted with a 2006-07 full year spend of £1.922m. This represents an increase of 36% on the total electricity expenditure of 2005-06. Actual electricity costs for April – Jun are in line with the forecast. Gas costs from ENI have been forecasted with a 2006-07 full year spend of £1.222m. This represents an increase of 48% on the total gas expenditure of 2005-06. Actual gas costs are £0.186m below forecast. This is mainly due to the new chillers being electrical instead of steam powered and the seasonally high temperatures reducing consumption levels. Both contracts have been reviewed via PASA. The ENI flexible contract for Gas has been extended until June 2007 and the Southern Electric contract has also been extended until October 2007. Haden contract is expected to be reviewed and uplifted in line with BEAMA. ISS contract uplift is currently being reviewed. The Directorate is forecasting a year end deficit of £0.012m. The Facilities Directorate had a 06/07 savings target of £0.343m. The Directorate has planned savings of £0.578m in 06/07 and therefore the Directorate has over-achieved the initial savings target by £0.235m with all savings schemes identified.

35. **Management Executive-** The Management Executive directorate was £0.214m under spent as at Month 4 with an in month surplus of £0.095m. The year to date surplus can be attributed to an under spend on the pay budget and an overachievement on the income targets. The income target has been overachieved by £0.109m YTD which is entirely due to additional income generated from interest receivable. There is also a vacancy level of 63 WTE's across the corporate directorates which has resulted in a £0.256m YTD under spend on the pay budget. The EPR department has 10 WTE vacancies resulting in a £0.08m saving YTD. However this saving is partly offset by the use of agency and bank staff as cover for the vacant posts. These budget surpluses are partially mitigated by a deficit on the non pay budget of £0.150m with the main spends being on the recruitment process and IT related costs. The Management Executive Directorate had a 2006/07 savings target of £0.903m, in addition to the £0.154m recurrent savings target from 2005/06 giving a total in year savings target of £1.057m. As at Month 4, the Management Executive directorate had allocated recurrent savings of £1.052m leaving a remaining savings target of £0.005m which is expected to be met following further review. The Directorate is forecasting a year end surplus of £0.180m.

36. **Assisted Conception Unit (Form F3B) –** The Month 4 position in ACU shows an underspend of £0.094m and an in month underspend of £0.036m. Activity and income again over-performed in July; with further amounts of the year end provision for known disputed invoices released; and also after a number of credit notes had been processed. Overall the Unit continues to perform well above its current activity plan. Pay expenditure is now overspent year to date by £0.010m, due to some in-month one-off expenditure items; whilst non-pay expenditure is overspent by £0.034m at Month 4, mainly as a result of an overspend against Drugs, due to the high levels of activity. The current forecast year end position is a favourable variance of £0.117m.

Savings Target (Form F5A and F5B)

37. As previously reported the 2006/07 savings target required to achieve the budget plan is £9.412m. The unachieved recurrent savings brought forward from last year are £1.661m, which added to the 2006/07 target gives a total savings target of £11.073m to achieve this year. Savings schemes are identified in full for 2006/07 totalling £11.073m. Some of the savings plans will begin delivering savings later in the year therefore the targets are phased in directorates or the central position to reflect this. **Form F5A** shows the target and total savings already achieved or planned.

38. **Form F5B** details each individual savings scheme that is planned or achieved and provides a risk rating for those not achieved. This is summarised in the first table showing an overall total by risk rating and in the second table below showing the savings total by directorate/department. In total £9.652m (87%) of schemes are achieved.

Achieved/Risk rating	**£'m**	**%**
Achieved	9.652	87%
Low	0.036	0.3%
Medium	1.034	9%
High	0.351	3%
Total	**11.073**	**100%**

Directorate/ Service Area	Accountability	2005/06 B/F target	New Target 2006/07	Total Target 2006/07	Total Savings Planned/ Achieved	Outstanding target to Achieve
		£'m	£'m	£'m	£'m	£'m
Frontline Directorate						
Imaging & Anaesthetics	Kate Hall	-	-0.602	-0.602	0.602	-
HIV/GUM	Debbie Richards	-0.400	-0.284	-0.684	0.724	0.040
Medicine & A&E	Nicola Hunt	-0.226	-1.259	-1.485	0.920	-0.565
Surgery	Kate Hall	-	-0.449	-0.449	0.492	0.043
Womens & Children's	Sherryn Elsworth	-	-0.727	-0.727	0.762	0.035
Subtotal Frontline Directorates		**-0.626**	**-3.321**	**-3.947**	**3.500**	**-0.447**
Pharmacy	Karen Robertson	-	-0.088	-0.088	0.088	-
Physiotherapy & Occ Therapy	Douline Schoeman	-0.031	-0.098	-0.129	0.160	0.031
Dietetics	Helen Stracey	-0.014	-0.015	-0.029	0.025	-0.004
Subtotal Clinical Support		**-0.045**	**-0.201**	**-0.246**	**0.273**	**0.027**
Chief Executive	Heather Lawrence	-	-0.028	-0.028	0.028	-
Governance & Corporate Affairs	Cathy Mooney	-0.019	-0.081	-0.100	0.100	0.000
Nursing	Andrew MacCallum	-0.005	-0.142	-0.147	0.147	0.000
Human Resources	Maxine Foster	-0.026	-0.126	-0.152	0.136	-0.016
Finance	Lorraine Bewes	-	-0.259	-0.259	0.313	0.054
IM&T & EPR	Alex Geddes	-0.099	-0.261	-0.360	0.360	-
Occupational Health	Stella Sawyer	-	-0.006	-0.006	0.006	-
Subtotal Management Exec		**-0.149**	**-0.903**	**-1.052**	**1.090**	**0.038**
Facilities	Helen Elkington	-	-0.343	-0.343	0.578	0.235
Private Patients	Edward Donald	-	-	-	-	-
ACU	Sherryn Elsworth	-	-	-	-	-
Post Graduate Centre	Kevin Shotlift	-	-	-	-	-
Projects	Edward Donald	-	-0.021	-0.021	0.021	-0.000
Simulation Centre	Andrew MacCallum	-	-	-	-	-
Service Level Agreements	Edward Donald	-	-0.210	-0.210	0.125	-0.085
Subtotal Other Directorates		**-**	**-0.574**	**-0.574**	**0.724**	**0.150**
Total All Directorates		**-0.820**	**-4.999**	**-5.819**	**5.586**	**-0.233**
Central Targets						
Capital Charges	Lorraine Bewes	-1.000	-0.700	-1.700	1.907	0.207
Procurement Savings	Lorraine Bewes	-	-0.500	-0.500	0.273	-0.227
Staff Rostering	Edward Donald	-	-0.500	-0.500	0.592	0.092
Bank and Agency Rates	Maxine Foster	-	-0.500	-0.500	0.344	-0.156
Ward Stock Management	Edward Donald	-	-0.200	-0.200	-	-0.200
HCD Income	Lorraine Bewes	-	-0.513	-0.513	0.444	-0.069
GUM Overperformance	Lorraine Bewes	-	-0.500	-0.500	0.487	-0.013
Other	Lorraine Bewes	0.159	-0.100	0.059	0.300	0.359
Director's Valuation	Lorraine Bewes	-	-0.500	-0.500	0.740	0.240
High Cost Drugs	Lorraine Bewes	-	-0.400	-0.400	0.400	-
Total Central Budgets		**-0.841**	**-4.413**	**-5.254**	**5.487**	**0.233**
Total		**-1.661**	**-9.412**	**-11.073**	**11.073**	**0.000**

39. **Form F5C** shows the phasing of savings achieved by directorate by month for this financial year- as reported above £9.652m has been achieved in total. This includes both recurrent and non recurrent schemes.

40. **Form F5D** shows savings achieved for the first four months against the planned profile of savings for the first four months. This shows a shortfall in savings of £0.238m (7%) against plan. These savings that have not been achieved are contributing to an adverse year to date variance in the Trust I&E position and are therefore already reflected in the overall adverse variance against budget and within the Trust's forecast outturn reported below. The slippage is in Frontline Directorates (£0.085m), GUM over performance income (£0.079m), Provider SLAs (£0.033m) and delayed introduction of new bank rates by one month (£0.038m).

Year End Forecast

41. In mid August (and after closure of the Month 4 position), the Trust was advised by London SHA of two material reductions to funding streams that would have an adverse impact on the Trust's forecast: reversal of reimbursement of the Trust's £2.204m surplus achieved last year with an expectation that a 1% surplus will still be delivered and a reduction in medical and non medical training income of approximately £1m. In addition, K&C PCT have advised the Trust that in the final quarter it may not contract for non-urgent activity; this would have an adverse impact on the Trust's outturn by approximately £0.5m. The Chief Executive has written to the SHA expressing our serious concerns regarding these proposed changes to income and targets this late in the year. The forecast reported at this time does not reflect any of the above and therefore this represents risks to the achievement of the forecast.

42. The full year forecast therefore remains a zero variance against the original plan of a £2.36m surplus. The forecast is based on an extrapolation of the year to date outturn adjusted for actions being undertaken by General Managers to recover overspends. In addition to the income losses described in paragraph 41, the risks remain the same as reported last month: firstly the ability to recover overspends in Pay and Non Pay via bank and agency quotas and restrictions on Non Pay ordering and secondly, the achievement of savings schemes scheduled to deliver later this financial year, for example, staff rostering and bank rates projects. Risks are discussed in greater detail below.

43. The SaFF income forecast is based on an extrapolation of the activity for first three months of the year and then adjusted down for the potential loss of income on the HIV contract relating to Day Case activity. This risk has arisen following the transfer of day case activity to payment by results from this financial year. The actual day case activity for the first three months is significantly less than the estimated level extracted from the block contract and set up as Day Case. The HIV/GUM Directorate is reviewing the classification of activity between Day Case and Outpatients to ensure it recorded accurately however the size of the gap means it is unlikely that re-classifications will close it completely. The forecast assumes there is a loss of income against contract of circa £0.776m. The Chief Executive has written to the Consortium to request an in year change to the baseline contract.

44. Schedule F3A shows the forecast by directorate and this is summarised below:

Directorate/ Service Area	Accountability	Full Year Forecast at July 06				
		Income	Pay	Non pay	Total	Change in Forecast
Central Income		£'m	£'m	£'m	£'m	£'m
SaFF income	Lorraine Bewes	-1.925	-	-	**-1.925**	**-0.865**
Central Non SaFF income	Lorraine Bewes	-	-	-	**-**	**-**
Total Central Income		**-1.925**	**-**	**-**	**-1.925**	**-0.865**
Frontline Directorate						
Imaging & Anaesthetics	Kate Hall	0.091	-0.047	-0.155	**-0.111**	**0.036**
HIV/GUM	Debbie Richards	0.342	-0.449	0.107	**-**	**-**
Medicine & A&E	Nicola Hunt	0.156	-1.246	0.619	**-0.471**	**-**
Surgery	Kate Hall	0.028	0.167	-0.382	**-0.187**	**0.037**
Womens & Children's	Sherryn Elsworth	0.092	-0.076	-0.191	**-0.175**	**0.028**
Subtotal Frontline Directorates		**0.709**	**-1.651**	**-0.002**	**-0.944**	**0.101**
Pharmacy	Karen Robertson	-0.040	0.147	0.038	**0.145**	**-**
Physiotherapy & Occ Therapy	Douline Schoeman	-0.005	-0.003	0.021	**0.013**	**0.013**
Dietetics	Helen Stracey	-0.011	-	-0.001	**-0.012**	**-0.012**
Regional Pharmacy	Susan Sanders	-	-	-	**-**	**-**
Subtotal Clinical Support		**-0.056**	**0.144**	**0.058**	**0.146**	**0.001**
Chief Executive	Heather Lawrence	0.026	0.037	0.003	**0.066**	**0.024**
Governance & Corporate Affairs	Cathy Mooney	-0.001	0.063	-0.012	**0.050**	**-0.009**
Nursing	Andrew MacCallum	-0.012	0.077	-0.010	**0.055**	**0.017**
Human Resources	Maxine Foster	-0.023	0.027	0.005	**0.009**	**-0.012**
Finance	Lorraine Bewes	0.178	-0.115	-0.062	**0.001**	**0.001**
IC&T & EPR	Alex Geddes	-0.002	0.086	-0.062	**0.022**	**0.020**
Occupational Health	Stella Sawyer	-0.030	0.008	-0.001	**-0.023**	**-0.012**
Subtotal Management Exec		**0.136**	**0.183**	**-0.139**	**0.180**	**0.029**
Facilities Management	Helen Elkington	0.097	-0.014	-0.095	**-0.012**	**-0.004**
Operation Management	Edward Donald	-	0.012	-0.004	**0.008**	**0.007**
Research & Development	Mervyn Maze	-	-	-	**-**	**-**
Private Patients	Edward Donald	-0.111	-0.118	-0.163	**-0.392**	**-0.116**
Overseas	Edward Donald	0.059	-	-0.030	**0.029**	**0.029**
ACU	Sherryn Elsworth	0.251	-0.031	-0.103	**0.117**	**0.025**
Post Graduate Centre	Kevin Shotlift	-	-	-	**-**	**-**
Projects	Edward Donald	0.020	-0.002	0.020	**0.038**	**0.038**
Simulation Centre	Andrew MacCallum	-	-	-	**-**	**-**
Service Level Agreements	Edward Donald	-	-	-	**-**	**-**
Subtotal Other Directorates		**0.316**	**-0.153**	**-0.375**	**-0.212**	**-0.021**
Total All Directorates		**1.105**	**-1.477**	**-0.458**	**-0.830**	**0.110**
Central Budgets						
Capital Charges	Lorraine Bewes	-	-	-	**-**	**-**
Central Budgets	Lorraine Bewes	-	-	2.256	**2.256**	**1.246**
Reserves	Lorraine Bewes	-	-	0.499	**0.499**	**-0.491**
Total Central Budgets		**-**	**-**	**2.755**	**2.755**	**0.755**
Favouable/ -Adverse Variance		**-0.820**	**-1.477**	**2.297**	**-**	**-**

45. The deterioration in the SaFF income forecast is mainly as a result of including a reduction to Market Forces Factor income of £0.6m. This is due to the difference between MFF currently received which is based on the 2004/05 outturn position and the MFF forecast based on the 2006/07 capacity plan. It will be possible to re-forecast the full year MFF income later in the year using 2006/07 actual activity however at this stage the reduction assumed in the forecast reflects the capacity plan (as assumed in the Foundation Trust model).

46. The central position is a forecast favourable variance against budget of £2.256m due to release of funds from Reserves following a review of Reserves created during 2006/07 budgeting setting and and excess savings above certain targets (as reported above in sections 37 to 40). Planned reserves release reported within the Reserves position last month are now within Central (£0.339m) as they have been released to the year to date position.

47. The overall improvement to the central position is mainly as a result of release of provisions for bad debts of £0.967m, of which £0.300m was released to the year to date position in Month 4. This provision is from old debt that has been recently recovered following sustained credit control in recent months.

48. The favourable central position is offsetting the adverse variance on SaFF income and frontline directorates.

Risks

49. The risks which will need to be managed in order to achieve the target surplus are as follows:

- **HIV Drugs** – the commissioning arrangements for HIV drugs have changed this year and the Trust will now be reimbursed at an average price per patient for ARV drugs. In previous years, the Trust was reimbursed for all drug costs after the agreed 1.5% risk share. The Directorate will need to manage costs within the average price otherwise any overspends will stay with the Trust.

- **HIV Day case activity**- as reported above in Paragraph 43, there is a risk that HIV income will be significantly lower than contract due to the classification of day case activity in the contract at a higher level than there is. In addition, the contract was agreed at a lower figure than initially proposed on the understanding that K&C PCT would retain £0.485m of funds ring-fenced for Trust HIV activity. These funds have been fully assumed in the Trust's income position however receipt of the income is yet to be agreed with K&C PCT.

- **Achievement of Savings**– the delivery of the full savings plan of £11.1m recurrently is crucial to achieving the required surplus.

- **MPET Income Reductions** – proposals to reduce levy income by £1.1m notified to the Trust in August has not been accepted by the Trust and are not reflected in the current position.

- **Loss of Surplus Carry Forward –** the current forecast of a £2.3m surplus assumes that the Trust will receive the full £2.2m surplus carry forward from 2005/06 under Resource Accounting and Budgeting (RAB) rules. The SHA are now proposing to keep all RAB adjustments central which would reduce our income by £2.2m. They are also suggesting that the Trust should mitigate this loss through additional savings and therefore still deliver a 1% surplus. The Trust does not accept this additional savings target and has written to the SHA outlining our objections. The position reported at July does not include either of these adjustments proposed by the SHA.

Budget Assumptions

50. Reserves (**Form F4A**) retained centrally at Month 4 total £15.035m. During the month net expenditure budgets of £1.936m were distributed to directorates/departments. The main distributions are shown below:

- **Specific Expenditure Reserves**: Urology funding to A&I (£0.049m), Reserves released centrally per the forecast (£0.339m), FT Costs (£0.025m), W&C WLI monies (£0.032m)

- **Contingency:** Removal of remaining Cheyne income budget from W&C directorate (£0.120m),

- **Pay Uplifts**: Consultants local Clinical Excellence Awards (£0.209m), Inflation uplift on all staff paid under Agenda for Change terms and conditions from Month 4 (£0.124m)

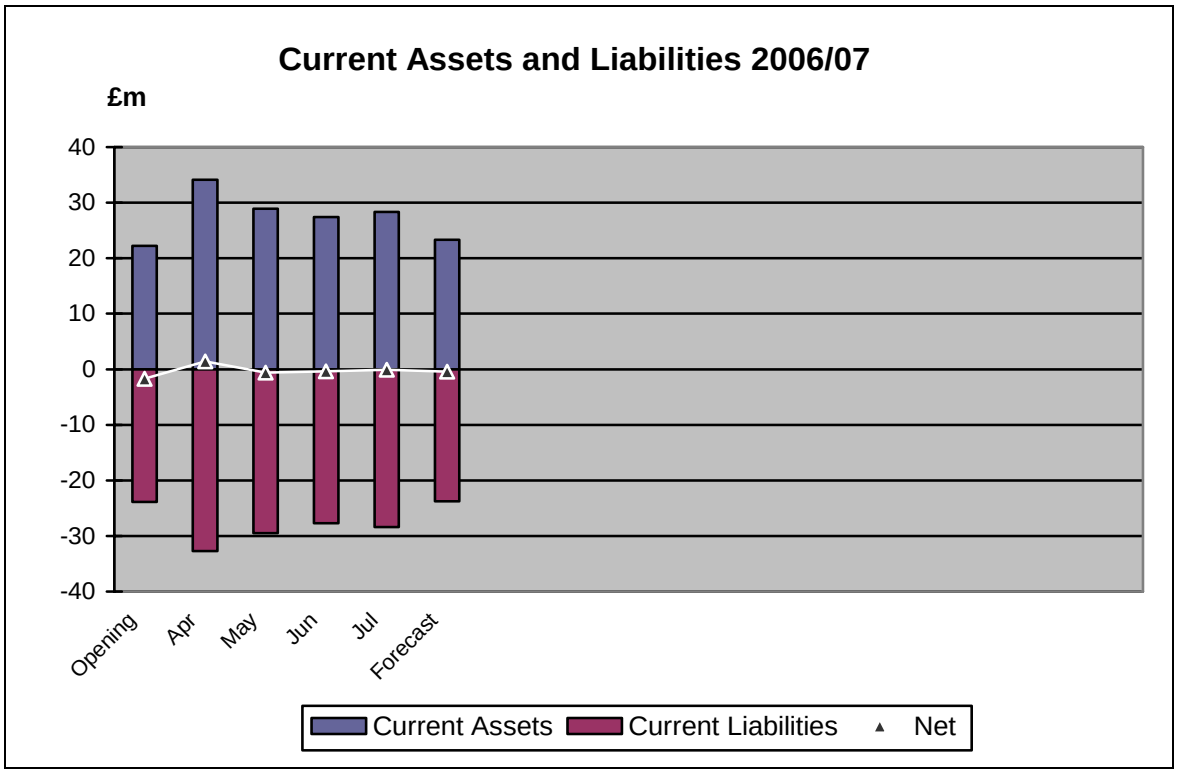
- **Non pay Uplifts:** Provider SLAs uplift 3 (£0.108m)
- **Agenda for Change:** Incremental funding for staff who moved to AFC terms and conditions in Month 4 (£0.410m)
- **Working Time Directive:** F Grade Nurse Practitioners (£0.045m) and Surgical SPR funding (0.065m)
- **Consultant Contracts:** Consultant seniority payments in W&C Directorate (£0.030m)

Balance Sheet: Key Highlights (Forms F6, F7, F8, F9, F10, F11)

Working capital

51. The movement in net current assets has remained level for the third month running at £0.238m for July-06 signifying the continuing efforts in recent months to implement a robust and efficient management of the Trust's working capital. This equilibrium was achieved mainly by the fact that general increase in current assets, driven by this month's cash balances, was counterbalanced by a fairly equal rise in current liabilities.

52. The graph below shows the movement in current assets and liabilities.



Debtors (Form F7)

53. Overall debt has decreased by £0.451m at the end of July 2006. All NHS debtors regardless of balances are being targeted to recover all collectable debts and identify those which can no longer be pursued.

54. North West London SHA debtors balance of £0.616 falls within 30 days old with the exception of an old disputed invoice for £0.001m overdue by more than 90 days. The current debt is mainly made up of two invoices; £0.358m for the LPE & T Core SLA and £0.200m for MADEL Pension SLA raised at the end of July. Settlement of these invoices is however expected to occur early in August.

55. Hounslow PCT and Adur Arun & Worthing PCT balances are due to 2006-07 Over performance invoice for £0.183m and £0.084m, respectively, billed at the end of July.

Creditors (FormF8)

56. There has been an increase in trade creditors by £1.245m (12.5%) from June 2006.

    The Hammersmith Hospitals account represents 45.8% of total creditors in July 2006 compared to 44.1% in June. There is a continuous concerted effort to clear this large account, which has a long history of queries, with the oldest invoices being targeted as priority for clearance. Further progress is expected as both Director's of Finance of the Hammersmith Hospitals and Chelsea & Westminster Healthcare NHS Trust have agreed to resolve the majority of all outstanding issues. A total of about £3.900m has been resolved and released for payment in August-06.

57. A cumulative BPPC target of 91.8% was achieved in July 2006 compared to 91.9% in June 2006 for invoices paid within 30 days and a target of 83.4% was achieved for the value of invoices paid within 30 days compared to 84.7% in June 2006.

Cash Flow Forecast (Form F9A&B)

58. Cash balance at the end of July 2006 shows a net movement upwards of £1.451m driven by an increase of £2.722m in the Trust's net operating cash flow in July 2006. The cumulative movement in cash to date is £11.117m up £1.350m against July's forecast of £9.767m.

59. The cash flow forecast has been revised to account for the deferment and reduction of the Trust's PDC repayment at the end of March 2007, which had an original forecast value of £8.374m and to be repaid in August-06 upon achieving Foundation Trust status. The drawdown dates for the forecast Foundation Trust Financing Facility (£7.794m) has also been timetabled for October-06 (£4.816m), January-07 (£2.571m) and March-07 (£0.407m).

Capital Expenditure (Form F10)

60. The expenditure to date column represents current activity levels against each sub division. The values at the end of July-06 of £1.926m against a planned spend of £8.345m represents 23% of the current capital programme – 2006-07.

61. The level of expenditure against planned spend is picking up as a number of projects have passed the tendering stages with requisition orders materialising close to the end of July 2006. This level should further increase in the remaining months to the year end.

62. The overall capital program is showing an under spend of £0.114m against our capital funding of £8.459m.

Provision for Debtors (F11)

63. Provision for irrecoverable debts shows a reduction of £0.579m from last month's of £8.538m of which £0.367m relates to the release of unused NHS credit notes provision and £0.212m utilised NHS credit notes and Private Patient's bad debt provision. The provision as at July 2006 represents 54% of our total debtors of £14.873m.

64. The value of debtors over 90 days is £9.375m (63% of total debtors) of which the total provision is created against. The provision, therefore, as a whole forms on average 85% of debtors over 90 days old.

65. The current level of provisions is approximately £7.959m which can be sub divided into NHS Debtors (Credit Notes) Provision £6.805m, Private Patients Overseas patients provision £0.689m and Other Non NHS debtors provisions £0.465m.

66. Provision for the aged debts is based on 100% of our debtors overdue by 361+ days, 90% of debtors overdue by 181 - 360 days and 31% of debtors overdue by 91-180 days.

Lorraine Bewes
Director of Finance and Information
30th August 2006

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

FINANCE REPORTS

July 06

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

CONSOLIDATED INCOME & EXPENDITURE SUMMARY

TRUST WIDE

FORM F1
July 06

Responsibility: Finance Director

	THIS MONTH			YEAR TO DATE			FULL YEAR			
							ORIGINAL	FULL YEAR	FORECAST	
	BUDGET	ACTUAL	VARIANCE	BUDGET	ACTUAL	VARIANCE	PLAN	BUDGET	ACTUAL	VARIANCE
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
INCOME										
Contract Income SaFF	(13,834)	(13,378)	(456)	(55,206)	(54,872)	(333)	(163,114)	(165,581)	(163,656)	(1,925)
Non-Contract Activity	0	0	0	0	0	0	(1,971)	0	0	0
Private Patients	(637)	(779)	142	(2,592)	(2,667)	76	(6,367)	(7,775)	(7,943)	168
Other Income	(6,062)	(6,144)	82	(24,503)	(24,615)	112	(64,650)	(67,651)	(68,087)	436
Donated Depreciation Income	(13)	(13)	0	(52)	(52)	0	(248)	(156)	(156)	0
TOTAL INCOME	**(20,546)**	**(20,314)**	**(232)**	**(82,352)**	**(82,206)**	**(146)**	**(236,350)**	**(241,163)**	**(239,842)**	**(1,321)**
EXPENDITURE			**0**							
Pay	11,583	10,257	1,326	43,266	38,685	4,581	130,925	127,706	110,024	17,682
Bank , Agency & Locum	31	1,200	(1,169)	110	5,228	(5,118)	980	216	19,298	(19,082)
Sub-total Pay	**11,614**	**11,457**	**157**	**43,377**	**43,913**	**(537)**	**131,905**	**127,923**	**129,323**	**(1,400)**
Non Pay	7,566	6,933	633	32,185	31,583	602	81,142	92,709	90,988	1,721
Sub-Total Non Pay	**7,566**	**6,933**	**633**	**32,185**	**31,583**	**602**	**81,142**	**92,709**	**90,988**	**1,721**
Reserves	(48)	0	(49)	0	1	(1)	0	0	(499)	499
Deficit Reversal/Surplus Brought Forward	0	0	0	0	0	0	0	0	0	0
Depreciation	524	466	58	2,837	2,804	33	11,259	8,511	8,511	0
Donated Depreciation	13	13	(0)	52	52	(0)	248	156	156	0
TOTAL EXPENDITURE	**19,668**	**18,869**	**799**	**78,450**	**78,354**	**97**	**224,554**	**229,298**	**228,478**	**820**
OPERATING SURPLUS	**878**	**1,445**	**567**	**3,902**	**3,853**	**(49)**	**11,796**	**11,865**	**11,364**	**(501)**
Profit/Loss on Disposal of Fixed Assets	0	0	0	0	0	0	0	0	0	0
SURPLUS BEFORE DIVIDENDS	**878**	**1,445**	**567**	**3,902**	**3,853**	**(49)**	**11,796**	**11,865**	**11,364**	**(501)**
Interest Receivable	(27)	(49)	22	(107)	(218)	111	(230)	(161)	(662)	501
Dividends	715	716	(0)	3,222	3,222	(0)	9,666	9,666	9,666	0
SURPLUS / (DEFICIT)	**189**	**779**	**590**	**787**	**849**	**62**	**2,360**	**2,360**	**2,360**	**0**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

FORM F2B(i)

May 06

SERVICE AGREEMENT VALUE SUMMARY

Responsibility: Finance Director

PCT	Original Annual Budget £000's	Agreed / latest Offer	Contract agreed Y/N	Variance on offer /agreed only
North West London Sector:				
KENSINGTON AND CHELSEA PCT	36,612,000	37,618,000	Y	1,006,000
WESTMINSTER PCT	15,119,000	14,702,251	Y	-416,749
HAMMERSMITH AND FULHAM PCT	20,034,800	20,217,039	Y	182,239
EALING PCT	3,063,000	2,702,506	Y	-360,494
HOUNSLOW PCT	3,445,000	3,719,603	Y	274,603
HILLINGDON PCT	518,000	486,000	Y	-32,000
BRENT PCT	1,489,000	1,468,501	Y	-20,499
HARROW PCT	507,000	444,000	N	-63,000
South West London Sector				
WANDSWORTH PCT	14,142,803	13,521,273	Y	-621,530
RICHMOND AND TWICKENHAM PCT	2,455,000	2,269,000	Y	-186,000
KINGSTON PCT	441,000	429,490	Y	-11,510
CROYDON PCT	552,000		N	-552,000
SUTTON AND MERTON PCT	850,000	800,000	Y	-50,000
North Central London Sector				
BARNET PCT	406,000	407,021	Y	1,021
HARINGEY PCT	271,000		N	-271,000
ENFIELD PCT	195,000	184,915	Y	-10,085
ISLINGTON PCT	410,000	331,289	Y	-78,711
CAMDEN PCT	576,000	565,000	Y	-11,000
South East London Sector				
GREENWICH PCT	136,000	135,144	Y	-856
BEXLEY PCT	86,000		N	-86,000
BROMLEY PCT	210,000	202,890	Y	-7,110
SOUTHWARK PCT	485,000	466,570	Y	-18,430
LEWISHAM PCT	292,000	285,450	Y	-6,550
LAMBETH PCT	1,362,000	1,331,604	Y	-30,396
North East London Sector:				
BARKING AND DAGENHAM PCT	160,000	121,528	Y	-38,472
HAVERING PCT	77,000		N	-77,000
TOWER HAMLETS PCT	215,000	203,000	Y	-12,000
CITY AND HACKNEY PCT	225,000		N	-225,000
NEWHAM PCT	285,000	246,775	Y	-38,225
Other Major Non - London:				
REDBRIDGE PCT	127,000		N	-127,000
WALTHAM FOREST PCT	218,000		N	-218,000
EAST ELMBRIDGE AND MID SURREY PCT	816,000		N	-816,000
EAST SURREY PCT	65,000		N	-65,000
BLACKWATER VALLEY AND HART PCT	465,000		N	-465,000
GUILDFORD AND WAVERLEY PCT	364,000		N	-364,000
NORTH SURREY PCT	625,000		N	-625,000
WOKING PCT	561,000		N	-561,000
HERTFORDSHIRE PCT's(8)	675,000	675,000	Y	0
WEST KENT PCTS (4)	249,000	246,431	Y	-2,569
EAST KENT PCTS (9)	667,000		N	-667,000
BERKSHIRE PCT's (6)	508,000	508,000	Y	0
EAST SUSSEX PCT's (5)	341,000	331,827	Y	-9,173
WEST SUSSEX PCT's (5)	225,000	241,218	Y	16,218
HAMPSHIRE PCT's(6)	129,000		N	-129,000
BEDFORDSHIRE PCT's(3)	220,000	190,000	N	-30,000
NORTH ESSEX PCT's (8)	276,000		N	-276,000
SOUTH ESSEX PCT's (5)	232,000		N	-232,000
OXFORDSHIRE PCT's (5)	71,000		N	-71,000
DORSET PCT's (5)	76,000		N	-76,000
NORTHAMPTONSHIRE PCT' (3)	144,000		N	-144,000
LINCOLNSHIRE PCT's (3)	62,000		N	-62,000
BUCKINGHAMSHIRE PCT's(4)	339,000	302,070	Y	-36,930
DEVON PCT's (4)	44,000		N	-44,000
BRISTOL PCT's(3)	6,000		N	-6,000
Specialised Services Consortia				
NICU CONSORTIUM	2,971,000	3,011,252	N	40,252
HIV CONSORTIUM(KC)	43,649,800	43,570,638	Y	-79,162
Other				
Non Contracted activity (NCA)	1,957,000	1,957,000	Y	0
REVALUATION	230,000		N	-230,000
OTHER	181,000		N	-181,000
Market forces Factor	29,210,000	29,210,000	Y	0
Total Contract Income	**190,323,403**	**183,102,285**	**0**	**-7,221,118**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SERVICE AGREEMENT VALUE SUMMARY

Responsibility: Finance Director

FORM F2B(ii)
July 06

PCT	Revised FY Budget at Month 4 £000's	Revised Target at Month 4 £000's	Actual at Month 4 £000's	Variance at Month 4 £000's
Contract and Over/Underperformance				
North West London Sector:				
Kensington & Chelsea	(37,866)	(12,622)	(12,299)	(323)
Westminster	(14,997)	(4,999)	(5,116)	117
Hammersmith & Fulham	(21,030)	(7,010)	(6,891)	(119)
Ealing	(2,703)	(901)	(1,054)	154
Hounslow	(3,720)	(1,240)	(1,485)	245
Hillingdon	(515)	(172)	(153)	(18)
Brent	(1,472)	(491)	(547)	56
Harrow	(495)	(165)	(146)	(19)
South West London Sector				
Wandsworth	(13,730)	(4,577)	(4,455)	(122)
Richmond & Twickenham	(2,408)	(803)	(860)	57
Kingston	(437)	(146)	(130)	(16)
Croydon	(539)	(180)	(180)	0
Sutton & Merton	(837)	(279)	(294)	15
North Central London Sector				
Barnet	(407)	(136)	(131)	(4)
Haringey	(269)	(90)	(116)	26
Enfield	(199)	(66)	(52)	(14)
Islington	(428)	(143)	(104)	(39)
Camden	(566)	(189)	(197)	9
South East London Sector				
Greenwich	(135)	(45)	(83)	38
Bexley	(85)	(28)	(24)	(4)
Bromley	(203)	(68)	(97)	29
Southwark	(472)	(157)	(156)	(1)
Lewisham	(285)	(95)	(85)	(10)
Lambeth	(1,357)	(452)	(398)	(55)
North East London Sector:				
Barking & Dagenham	(151)	(50)	(64)	14
Havering	(75)	(25)	(30)	5
Tower Hamlets	(214)	(71)	(65)	(6)
City & Hackney	(228)	(76)	(74)	(2)
Redbridge	(129)	(43)	(59)	16
Waltham Forest	(210)	(70)	(60)	(10)
Other Major Non - London:				
North Surrey	(616)	(205)	(214)	9
East Elmbridge and Mid Surrey	(816)	(272)	(231)	(41)
Woking	(555)	(185)	(138)	(47)
Blackwater Valley and Hart	(460)	(153)	(181)	27
Newham	(282)	(94)	(72)	(22)
Guildford and Waverley	(361)	(120)	(115)	(5)
Watford and Three Rivers	(194)	(65)	(69)	4
East Surrey	(63)	(21)	(35)	14
All Other PCTs	(4,592)	(1,531)	(1,522)	(9)
High Cost Drugs				
High Cost Drugs Exclusions Billed	0	0	0	0
Specialised Services Consortia				
NICU Consortium				
Hillingdon	(516)	(172)	(539)	367
Haringey	0	0	(18)	18
Bexley	0	0	(106)	106
Croydon	0	0	(205)	205
Tower Hamlets	0	0	(16)	16
Brent PCT	0	0	0	0
All Other PCTs	(2,971)	(990)	(193)	(797)
HIV Consortium & Overperformance				
Kensington & Chelsea	(39,615)	(13,205)	(12,712)	(493)
Out of London PCTs	(4,032)	(1,344)	(1,551)	207
GUM				0
Kensington & Chelsea	0	0	0	0
Hammersmith & Fulham	0	0	0	0
Other				
London Patient Choice (Receiving)	0	0	0	0
Non Contract Activity	(1,463)	(488)	(454)	(34)
Non Contract Activity Overseas/Cross Border	(508)	(169)	(305)	136
Revenue Incentive Payment	(171)	(171)	(171)	0
Prior year	0	0	(3)	3
Other income from PCTs	0	0	0	0
Prior Year Deficit Reversal and Surplus Carry Forward	(2,204)	(633)	(633)	0
Balance on 9D Codes	0	0	0	0
Balance on 9A Codes	0	0	0	0
Total Contract Income	**(165,581)**	**(55,206)**	**(54,885)**	**(320)**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SERVICE AGREEMENT ACTIVITY SUMMARY - BY PCT

Responsibility: Finance Director

FORM F2B(iii)
July 06

	ACTIVITY TARGET TO JULY 06									ACTIVITY ACTUAL TO JULY 06									ACTIVITY VARIANCE TO JULY 06									
	DC+DA	EL	EL XBD	NON-ELEC	NON-ELEC- XBD	NON-ELEC-SS	OPFA	OPFUP	Other	DC+DA	EL	EL XBD	NON-ELEC	NON-ELEC- XBD	NON-ELEC-SS	OPFA	OPFUP	Other	DC+DA	EL	EL XBD	NON-ELEC	NON-ELEC-XBD	NON-ELEC-SS	OPFA	OPFUP	Other	TOTAL
North West London Sector:																											
KENSINGTON & CHELSEA	1,725	487	359	2,482	1,370	117	6,605	17,406	38,898	2,037	540	271	2,742	1,410	176	6,412	16,615	38,785	312	53	88	260	40	59	193	791	113	**460**
WESTMINSTER	1,064	383	315	985	679	43	3,130	8,177	18,366	1,270	383	195	1,087	566	63	3,085	9,067	16,092	206	0	120	102	113	20	45	890	2,274	**1,334**
HAMMERSMITH & FULHAM	1,111	396	277	1,930	776	76	4,482	9,613	18,654	1,165	364	117	2,373	645	116	4,193	9,725	22,415	54	32	160	443	131	40	289	112	3,761	**3,797**
EALING	225	96	31	246	65	8	611	1,336	2,471	286	124	57	222	97	8	585	1,812	2,555	61	28	26	24	32	0	26	476	85	**659**
HOUNSLOW	308	115	64	243	176	9	626	1,389	3,499	394	113	69	255	390	11	619	1,774	3,333	86	2	5	12	214	2	7	385	166	**529**
HILLINGDON	27	24	4	34	4	4	69	171	271	26	22	8	25	2	1	64	258	272	1	2	4	9	2	3	5	87	1	**70**
BRENT	101	51	17	113	108	9	217	540	819	137	65	13	94	58	2	237	954	819	36	14	4	19	50	7	20	414	0	**403**
HARROW	23	12	2	56	23	1	56	112	221	13	10	8	31	3	1	51	145	221	10	2	6	25	20	0	1	33	0	**16**
SOUTH WEST LONDON SECTOR																												
WANDSWORTH	665	244	161	1,781	1,021	65	2,856	7,156	9,081	853	283	110	2,171	1,183	120	2,834	7,961	9,097	188	39	51	390	162	55	22	805	16	**1,583**
RICHMOND & TWICKENHAM	146	54	20	281	61	14	401	1,771	1,690	221	60	5	406	151	10	551	1,604	1,693	75	6	15	125	90	4	150	167	3	**263**
KINGSTON	27	18	16	31	8	1	70	194	307	20	17	12	38	27	3	71	265	305	7	1	4	7	19	2	1	71	2	**87**
CROYDON	24	22	9	42	4	2	69	214	368	44	9	0	43	14	4	62	277	367	20	13	9	1	10	2	7	63	1	**65**
SUTTON & MERTON	48	27	1	70	23	5	186	458	253	72	15	5	127	20	2	157	542	261	24	12	4	57	3	3	29	84	8	**131**
NORTH CENTRAL LONDON SECTOR																												
BARNET	22	12	30	35	3	1	69	190	234	28	11	0	65	37	2	40	223	229	6	1	30	30	34	1	29	33	4	**41**
HARINGEY	25	5	2	33	2	1	50	126	192	28	16	0	38	17	1	50	172	189	3	11	2	5	15	0	0	46	4	**73**
ENFIELD	6	8	1	18	3	0	28	86	134	18	5	0	8	0	1	26	98	135	12	3	1	10	3	1	2	12	1	**6**
ISLINGTON	14	12	0	22	5	2	43	141	316	13	8	0	17	8	2	56	234	315	1	4	0	5	3	0	13	93	0	**99**
CAMDEN	30	22	26	35	21	3	88	240	405	22	8	0	47	7	4	70	309	405	8	14	26	12	14	1	18	69	0	**2**
SOUTH EAST LONDON SECTOR																												
GREENWICH	4	5	1	10	7	0	36	102	186	4	6	4	15	40	1	24	142	185	0	1	3	5	33	1	12	40	1	**68**
BEXLEY	1	2	5	5	12	-	17	47	63	2	4	15	4	0	-	12	66	63	1	2	10	1	12	-	5	19	0	**15**
BROMLEY	18	9	10	16	6	0	28	89	2	10	10	1	22	10	3	37	125	3	8	1	9	6	4	3	8	36	1	**42**
SOUTHWARK	23	16	14	46	13	1	99	265	543	12	13	2	48	3	6	107	352	543	11	3	12	2	10	5	8	87	1	**67**
LEWISHAM	12	9	11	24	20	2	61	186	299	5	7	0	13	3	1	56	171	297	7	2	11	11	17	1	5	15	3	**71**
LAMBETH	144	30	24	123	132	13	232	597	1,362	68	45	7	96	56	9	286	788	1,366	76	15	17	27	76	4	54	191	4	**65**
NORTH EAST LONDON SECTOR:																												
BARKING & DAGENHAM	3	5	1	11	6	0	20	62	72	2	7	0	13	35	-	9	58	73	1	2	1	2	9	0	11	4	0	**4**
HAVERING	4	5	5	13	1	1	16	41	66	4	3	1	4	2	1	7	55	65	0	2	4	9	1	0	9	14	1	**10**
TOWER HAMLETS	34	5	-	29	31	1	28	107	207	14	6	0	35	2	1	27	125	207	20	1	-	6	29	0	1	18	1	**26**
CITY & HACKNEY	9	7	3	28	6	1	45	98	206	5	10	0	30	83	1	45	157	209	4	3	3	2	77	0	0	59	3	**139**
REDBRIDGE	8	4	1	28	1	0	23	71	110	17	1	0	12	19	1	25	105	108	9	3	1	16	18	1	2	34	2	**42**
WALTHAM FOREST	9	7	19	32	10	1	27	110	138	15	5	0	13	4	1	22	111	136	6	2	19	19	6	0	5	1	2	**45**
OTHER MAJOR NON - LONDON:																												
NORTH SURREY	56	26	28	37	9	5	41	143	268	66	34	32	31	1	-	46	235	269	10	8	4	6	8	5	5	92	1	**102**
EAST ELM & MID SURREY	108	44	142	44	12	2	86	266	345	44	41	14	44	16	-	71	308	346	64	3	128	0	4	2	15	42	1	**166**
WOKING	46	23	32	42	28	1	66	158	219	48	13	0	19	3	-	62	184	219	2	10	32	23	25	1	4	26	1	**66**
BLACKWATER VALLEY	34	16	5	30	3	2	71	177	212	32	13	0	60	15	2	72	165	211	2	3	5	30	12	0	1	12	1	**20**
NEWHAM PCT	11	8	8	23	9	1	41	105	184	7	6	10	18	2	-	34	134	186	4	2	2	5	7	1	7	29	2	**6**
GUILDFORD & WAVERLEY	16	8	1	30	3	2	33	92	162	20	9	0	29	6	-	31	134	161	4	1	1	1	3	2	2	42	1	**43**
WATFORD & THREE RIVERS	12	8	4	15	-	0	24	59	101	6	7	0	7	0	1	31	83	100	6	1	4	8	-	1	7	24	1	**10**
EAST SURREY	4	3	2	3	1	0	12	45	41	8	7	0	1	0	1	14	48	41	4	4	2	2	1	1	2	3	0	**7**
ALL OTHER 'S	174	145	113	405	160	8	437	1,355	3,297	201	133	281	449	252	9	435	1,605	2,090	27	12	168	44	92	1	2	250	1,207	**639**
NICU CONSORTIUM	-	-	-	1,365	-	-	-	-	-	-	-	-	1,517	-	-	-	-	-	-	-	-	**152**	-	-	-	-	-	**152**
TOTAL CONTRACT ACTIVITY	**6,321**	**2,371**	**1,765**	**10,798**	**4,824**	**402**	**21,095**	**53,495**	**104,259**	**7,237**	**2,433**	**1,237**	**12,269**	**5,167**	**565**	**20,616**	**57,186**	**104,367**	**916**	**62**	**528**	**1,471**	**343**	**163**	**479**	**3,691**	**109**	**5,748**
HIV/GUM & Well babies	813	34	93	167	232	-	13,931	4,882	-	294	98	280	1,766	374	39	15,231	14,923	-	519	64	187	1,599	142	39	1,300	10,041	-	12,853
TOTAL ALL ACTIVITY	**7,133**	**2,405**	**1,858**	**10,965**	**5,056**	**402**	**35,026**	**58,377**	**104,259**	**7,531**	**2,531**	**1,517**	**14,035**	**5,541**	**604**	**35,847**	**72,109**	**104,367**	**398**	**126**	**341**	**3,070**	**485**	**202**	**821**	**13,732**	**109**	**18,601**

Total activity		**225,481**		**244,082**

Key

DC + DA	Daycase & Day Attenders
EL	Elective
EL XBD	Elective Excess bed days
NON ELEC	Non Elective
NON ELEC-XBD	Non Elective-Excess bed days
NON ELEC-SS	Non Elective- Short stay
OPFA	Outpatients first attendance
OPFUP	Outpatients follow up attendance

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SERVICE AGREEMENT ACTIVITY SUMMARY - BY SPECIA

Responsibility: Finance Directo

FORM F2B(iv)
July 06

	ACTIVITY TARGET TO JULY 0									ACTIVITY ACTUAL TO JULY 0									ACTIVITY VARIANCE TO JULY 0									
	DC+DA	EL	EL XBD	NON-ELEC	NON-ELEC-XBD	NON-ELEC-SS	OPFA	OPFUP	Other	DC+DA	EL	EL XBD	NON-ELEC	NON-ELEC-XBD	NON-ELEC-SS	OPFA	OPFUP	Other	DC+DA	EL	EL XBD	NON-ELEC	NON-ELEC-XBD	NON-ELEC-SS	OPFA	OPFUP	Other	TOTAL
SURGERY and A&E																												
ANAESTHETICS	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
BURNS	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
GENERAL SURGERY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
OPHTHALMOLOGY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
ORAL SURGERY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PAIN MANAGEMENT	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PALLIATIVE MEDICIN	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PLASTIC SURGERY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
T & O	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
UROLOGY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Sub-Total Surgery & A&E	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
WOMEN & CHILDREN																												
GYNAECOLOGY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
NICU (Note this is a Cot Day	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
OBSTETRICS	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PAED CRANIO	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PAED DENTISTRY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PAED ENT	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PAED GASTRO	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PAED NEUROLOGY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PAEDI OPTHALMOLOGY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PAEDIATRIC SURGERY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
PAEDIATRICS	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
SPECIAL CARE BABIES	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Sub-Total Women & Children	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
MEDICINE & A&E																												
A & E	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
CARDIOLOGY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
CLINICAL HAEM	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
DERMATOLOGY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
ELDERLY MED	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
ENDOCRINOLOGY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
ENDOSCOPY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
GASTRO	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
GENERAL MEDICINE	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
MEDICAL ONCOLOGY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
NEUROLOGY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
RESPIRATORY MED	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
RHEUMATOLOGY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Subtotal Medicine & A&E	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
OTHER	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
TOTAL CONTRACT ACTIVITY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
WELL BABIES	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
HIV	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
GUM	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
TOTAL ALL ACTIVITY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Total [illegible] [illegible] [illegible]

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SUMMARY SALARIES AND WAGES

Responsibility:

TRUST WIDE

FORM F2D
July 06

	Full Year Budget £000s	THIS MONTH				YEAR TO DATE			
		Budget £000s	Actuals £000s	Variance £000s	Variance % £000s	Budget £000s	Actual £000s	Variance £000s	Variance % £000s
MEDICAL									
Senior Medical	22,006	1,896	1,926	(30)	-1.58%	7,382	7,391	(10)	-0.13%
Junior Medical	18,551	1,550	1,405	144	9.31%	6,187	5,742	444	7.18%
Other Medical & Dental	13	(491)	(492)	1	-0.22%	4	0	4	100.00%
Medical Locum	(0)	0	206	(206)		0	763	(763)	
Medical sub total	**40,570**	**2,954**	**3,044**	**(90)**	**-3.06%**	**13,573**	**13,897**	**(324)**	**-2.39%**
AGENDA FOR CHANGE									
Agenda for Change Bands 1-4	379	62	(0)	63	100.65%	253	(2)	255	100.97%
Agenda for Change Bands 5-9	0	0	(3)	3	13704.00%	0	(51)	51	51302.00%
Agenda for Change sub total	**379**	**62**	**(4)**	**66**	**106.11%**	**253**	**(54)**	**307**	**121.21%**
NURSING & MIDWIFERY									
Trained Nursing	44,099	3,380	2,680	700	20.71%	14,754	11,995	2,758	18.70%
Untrained Nursing	4,303	373	303	70	18.77%	1,449	1,275	174	12.02%
Health Care Assistants	174	9	8	1	9.82%	65	22	43	66.11%
Bank Nursing & Midwifery	58	7	610	(603)		28	2,616	(2,588)	
Agency Nursing & Midwifery	22	2	43	(41)		7	554	(547)	
Nursing & Midwifery sub total	**48,655**	**3,771**	**3,644**	**127**	**3.36%**	**16,303**	**16,463**	**(160)**	**-0.98%**
AHPs									
Dieticians	121	(2)	(6)	4	-215.16%	47	36	11	23.29%
Radiographers	491	25	(11)	36	143.51%	164	43	121	73.66%
Therapists	621	29	43	(14)	-47.69%	181	263	(82)	-45.16%
AHPs AFC	5,137	495	502	(8)	-1.53%	1,704	1,765	(61)	-3.58%
Agency/Locums (AHPs)	1	0	34	(34)		0	138	(137)	
PTA - sub totals	**6,371**	**547**	**562**	**(15)**	**-2.77%**	**2,096**	**2,245**	**(149)**	**-7.09%**
OTHER									
Pharmacists	2,520	205	152	53	25.70%	831	718	113	13.58%
Scientific & Professional AFC	507	93	144	(52)	-55.64%	156	149	8	4.83%
Healthcare Scientists AFC	2,255	(23)	(78)	55	-238.03%	738	831	(93)	-12.65%
Chaplains	0	0	0	0	0.00%	0	0	0	0.00%
All Other	5,977	2,270	2,232	38	1.68%	2,868	2,739	129	4.49%
Other sub	**11,258**	**2,544**	**2,450**	**94**	**3.70%**	**4,593**	**4,437**	**156**	**3.39%**
ADMIN									
Admin & Clerical	15,918	1,332	1,005	327	24.57%	5,297	4,228	1,069	20.18%
Bank Admin & Clerical	96	18	238	(220)		61	924	(862)	
Agency Admin & Clerical	40	3	69	(65)		13	233	(220)	
Senior Managers & Trust Board	6,781	405	448	(43)	-10.70%	1,563	1,541	23	1.44%
Agency Other	0	0	0	0		0	0	0	
Admin - sub total	**22,835**	**1,758**	**1,760**	**(1)**	**-0.08%**	**6,935**	**6,926**	**9**	**0.13%**
Payroll	**130,069**	**11,637**	**11,457**	**180**	**1.55%**	**43,752**	**43,913**	**(161)**	**-0.37%**
Unidentified Savings	(2,146)	(23)	0	(23)		(376)	0	(376)	
PAY TOTAL	**127,923**	**11,614**	**11,457**	**157**	**1.35%**	**43,377**	**43,913**	**(537)**	**-1.24%**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SUMMARY NON PAY EXPENDITURE

TRUST WIDE

FORM F2E
July 06

Responsibility:

NON PAY EXPENDITURE	Full Year Budget £000s	THIS MONTH				YEAR TO DATE			
		This Months Budget £000s	This Months Actuals £000s	This Months Variance £000s	This Months Variance % £000s	Year to Date Budget £000s	Year to Date Actual £000s	Year to Date Variance £000s	Year to Date Variance % £000s
DRUGS (incl HIV/GUM) & MEDICAL GASES	32,897	2,670	2,631	39	1%	11,483	11,321	162	1%
MEDICAL & SURGICAL EQUIPMENT & DRESSINGS	6,478	554	513	41	7%	2,217	2,524	-307	-14%
X-RAY FILM, EQUIP & MATERIALS	1,476	123	147	-24	-19%	492	432	60	12%
LABORATORY EQUIP & MATERIALS	260	15	34	-19	-127%	87	118	-31	-36.12%
PATIENT APPLIANCES / PROTHESES	1,553	131	152	-21	-16%	518	738	-221	-42.59%
BLOOD PRODUCTS	1,164	97	84	13	13%	388	338	50	12.79%
PATHOLOGY SERVICES	6,811	789	893	-104	-13%	2,476	2,457	19	0.76%
OTHER TESTS	535	45	36	8	19%	178	145	34	18.91%
SERVICE LEVEL AGREEMENT	3,504	-484	-492	8	-2%	1,168	1,293	-125	-10.69%
CONTRACT SERVICES			0			0	0		
Contract Catering	2,005	167	163	4	2%	668	670	-1	-0.21%
Domestics	2,247	187	179	9	5%	749	757	-8	-1.01%
Portering	943	81	75	6	7%	324	314	10	3.06%
Carparking	14	1	6	-5	-442%	5	14	-10	-204.61%
Laundry Contract	770	64	95	-31	-48%	257	307	-50	-19.38%
Change control Levy, CCNs	75	6	22	-15	-247%	25	-20	45	179.18%
Carillion Management Charge	909	76	83	-7	-9%	303	330	-27	-9.03%
Total Bed Management Contract / Lease	169	14	28	-14	-103%	56	61	-5	-8.67%
IT Services	0	0	0	0	0%	0	0	0	0.00%
Other External Contracts	1,214	101	108	-7	-7%	405	453	-49	-12.04%
PROVISIONS & OTHER CATERING	2	0	16	-16	-7613%	1	51	-50	-6118.69%
LAUNDRY, LINEN, UNIFORMS & CLOTHING	86	7	7	-0	-1%	29	41	-12	-41.96%
CLEANING EQUIPMENT	0	0	0	0	0%	0	0	0	0.00%
LEGAL FEES	3,553	312	337	-26	-8%	1,184	1,168	17	1.40%
PRINTING, STATIONERY & POSTAGE	839	70	75	-5	-7%	283	287	-3	-1.18%
TELEPHONES	619	52	64	-13	-25%	206	219	-12	-6.05%
TRAVEL, SUBSISTENCE & REMOVALS	185	15	23	-7	-48%	62	94	-32	-52.08%
TRANSPORT	1,060	88	63	26	29%	353	428	-75	-21.15%
ADVERTISING & PUBLICITY	368	36	14	21	60%	124	92	32	25.91%
TRAINING	666	66	41	25	38%	247	160	87	35.21%
ENERGY & WATER	3,477	290	221	69	24%	1,052	812	240	22.85%
FURNITURE, FITTINGS & OFFICE EQIPMENT	242	20	11	10	47%	81	55	26	32.23%
IT EQUIPMENT & SUPPLIES	1,662	129	75	54	42%	595	587	8	1.42%
RENT & RATES	2,008	167	238	-71	-42%	669	649	20	2.97%
ESTATES MAINTENANCE	2,069	172	230	-57	-33%	690	800	-110	-16.01%
CONSULTANCY	854	71	109	-37	-52%	365	450	-85	-23.29%
WARD BUDGETS	0	0	0	0	0%	0	0	0	0.00%
BAD DEBT PROVISION	0	0	-357	357	0%	0	-337	337	0.00%
OTHER EXPENDITURE	11,965	1,426	1,010	416	29%	4,442	3,778	664	14.95%
FACILITIES /THEATRE RECHARGES	22	2	0	2	100%	7	-0	7	100.01%
CIP NON PAY SAVINGS	10	5	0	5	100%	-3	0	-3	100.00%
Non Pay	**92,709**	**7,566**	**6,933**	**633**	**8%**	**32,185**	**31,583**	**602**	**1.87%**
Depreciation	8,411	466	466	0	0%	2,804	2,804	0	0.00%
CIP Depreciation Savings	99	58	0	58	100%	33	0	33	100.00%
Donated Depreciation	156	13	13	-0	0%	52	52	-0	-0.01%
DIVIDENDS PAYABLE	9,666	715	716	-0	0%	3,222	3,222	-0	0.00%
Deficit Reversal/Surplus Brought Forward	0	0	0	0	0%	0	0	0	0.00%
Reserves	0	-48	0	-49	100%	0	1	-1	-5089.29%
TOTAL NON PAY	**111,042**	**8,770**	**8,127**	**642**	**7%**	**38,296**	**37,662**	**633**	**1.65%**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SERVICE LEVEL AGREEMENTS EXPENDITURE

Responsibility: Edward Donald

FORM F2F
July 06

Account	Service Level Agreement	Budget Holder	Full Year Budget £000	THIS MONTH				YEAR TO DATE			
				This Months Budget £000	This Months Actuals £000	This Months Variance £000	This Months Variance %	Year to Date Budget £000	Year to Date Actual £000	Year to Date Variance £000	Year to Date Variance %
3A040	BLOOD PRODUCTS		0	0	20	(20)	0.0%	0	(8)	8	0.0%
3A250	NATIONAL BLOOD SERVICE CONTRAC		1,164	97	63	34	35.1%	388	351	37	9.5%
3C010	PRINTING & STATIONARY (INC. CO		0	0	0	0	0.0%	0	0	0	0.0%
3C060	TELECOMMUNICATIONS SLA		0	0	0	0	0.0%	0	0	0	0.0%
3D160	COMPUTER HARDWARE PURCHASES		0	0	0	0	0.0%	0	0	0	0.0%
3D250	RENT & ACCOMMODATION SERVICEWS		369	31	103	(72)	-232.3%	123	103	20	16.3%
3H030	MISCELLANEOUS		0	0	0	0	0.0%	0	0	0	0.0%
3H120	HOSPITALITY		0	0	(44)	44	0.0%	0	0	0	0.0%
3H200	SOCIAL SERVICES		144	12	(10)	22	183.3%	48	97	(49)	-102.1%
3H210	MEDICAL ILLUSTRATION		332	28	67	(39)	-139.3%	111	111	0	0.0%
3H220	A/V SERVICES		0	0	0	0	0.0%	0	0	0	0.0%
3J010	NATIONAL AMBULANCE		0	0	(22)	22	0.0%	0	0	0	0.0%
3J030	PATHOLOGY SLA (HHT)		6,729	781	873	(92)	-11.8%	2,435	2,404	31	1.3%
3J040	CARDIOLOGY SLA (RBH)		367	31	44	(13)	-41.9%	122	136	(14)	-11.5%
3J050	INFORMATION SYSTEMS SLA		0	0	0	0	0.0%	0	0	0	0.0%
3J060	CLINICAL ENGINEERING SLA		519	43	54	(11)	-25.6%	173	173	0	0.0%
3J070	EEG SLA		0	0	0	0	0.0%	0	0	0	0.0%
3J080	MEDICAL PHYSICS SLA		31	3	(8)	11	366.7%	10	12	(2)	-20.0%
3J090	PSYCHOLOGY SLA		0	0	0	0	0.0%	0	0	0	0.0%
3J110	CLINICAL HAEMATOLOGY SLA		0	0	0	0	0.0%	0	0	0	0.0%
3J120	OBSTETRICS COVER		0	0	0	0	0.0%	0	0	0	0.0%
3J130	RADIATION PHYSICS SLA		24	2	(12)	14	700.0%	8	47	(39)	-487.5%
3J140	CVP UNIT SLA		0	0	0	0	0.0%	0	0	0	0.0%
3J150	GUM CLINIC OVERHEADS		0	0	0	0	0.0%	0	0	0	0.0%
3J160	PAEDIATRICS/CDC OVERGEADS		0	0	0	0	0.0%	0	0	0	0.0%
3J180	SPEECH THERAPY		183	15	66	(51)	-340.0%	61	122	(61)	-100.0%
3J190	VICTORIA SHC SLA		0	0	(29)	29	0.0%	0	0	0	0.0%
3J200	EXTERNAL TESTS		0	0	(1)	1	0.0%	0	(5)	5	0.0%
3J210	PHARMACY SLA (HHT)		0	0	0	0	0.0%	0	0	0	0.0%
3J500	SERVICES NHS BODIES SUBCONTRAC		0	0	0	0	0.0%	0	0	0	0.0%
3J510	PLASTICS OUTREACH SLA		0	0	(4)	4	0.0%	0	4	(4)	0.0%
3J520	BURNS OUTREACH SLA		0	0	(34)	34	0.0%	0	0	0	0.0%
3J530	PAEDIATRIC ENT SLA		0	0	0	0	0.0%	0	0	0	0.0%
9B011	PROVIDER TO PROVIDER INCOME- BROMPTON		(205)	(17)	(77)	60	-352.9%	(68)	(68)	0	0.0%
9B012	PROVIDER TO PROVIDER INCOME- MARSDEN		(94)	(8)	52	(60)	750.0%	(31)	(31)	0	0.0%
VF010	SLAs SAVINGS TARGET 2005/06		0	0	0	0		0	0	0	
Vf042	SLAs SAVINGS TARGET 2006/07		(185)	(15)	0	(15)		(62)	0	(62)	
	TOTAL ALL SLAs		**9,378**	**1,003**	**1,101**	**(98)**	**-9.8%**	**3,318**	**3,448**	**(130)**	**-3.9%**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

TRUST WIDE SUMMARY BY DIRECTORATE

Responsibility: Finance Director

FORM F3A
July 06

Directorate/ Service Area	Accountability	Annual Budget					In Month Variance					YTD Variance					Full Year Forecast at July 06			
		Income	Pay	Savings	Non pay	Total	Income	Pay	Savings	Non Pay	Total	Income	Pay	Savings	Non Pay	Total	Income	Pay	Non pay	Total
Central Income		£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
SaFF income	Lorraine Bewes	(164,252)	0	0	0	(164,252)	(442)	0	0	(35)	(476)	(195)	0	0	(139)	(333)	(1,925)	0	0	(1,925)
Central Non SaFF income	Lorraine Bewes	(55,668)	0	0	0	(55,668)	7	0	0	0	7	(25)	0	0	0	(25)	0	0	0	0
Total Central Income		(219,920)	0	0	0	(219,920)	(435)	0	0	(35)	(470)	(220)	0	0	(139)	(359)	(1,925)	0	0	(1,925)
Frontline Directorate																				
Imaging & Anaesthetics	Kate Hall	(494)	20,727	0	5,299	25,532	4	14	(0)	45	63	12	(70)	(0)	(41)	(99)	91	(47)	(155)	(111)
HIV/GUM	Debbie Richards	(1,101)	11,142	(301)	26,168	35,908	17	69	(18)	(22)	46	114	(24)	(133)	27	(17)	342	(449)	107	0
Medicine & A&E	Nicola Hunt	(711)	22,685	(819)	6,649	27,804	1	(28)	(71)	20	(79)	7	(262)	(249)	34	(470)	156	(1,169)	542	(471)
Surgery	Kate Hall	(339)	14,362	0	4,106	18,129	4	8	16	(46)	(18)	9	(42)	(0)	(225)	(258)	28	167	(382)	(187)
Womens & Children's	Sherryn Elsworth	(3,976)	30,899	(64)	4,341	31,200	15	(9)	(5)	83	84	(130)	(316)	(21)	159	(308)	92	(76)	(191)	(175)
Subtotal Frontline Directorates		(6,620)	99,815	(1,185)	46,563	138,572	40	55	(79)	80	95	13	(715)	(404)	(45)	(1,151)	709	(1,574)	(79)	(944)
Pharmacy	Karen Robertson	(769)	4,105	0	351	3,687	(3)	12	0	(8)	1	(12)	59	0	8	56	(40)	147	38	145
Physiotherapy & Occ Therapy	Douline Schoeman	(200)	3,962	0	139	3,901	(1)	15	(0)	5	19	(12)	(50)	(0)	8	(54)	(5)	(3)	21	13
Dietetics	Helen Stracey	(25)	604	0	25	604	(1)	0	0	2	1	(4)	3	0	(0)	(2)	(11)	0	(1)	(12)
Regional Pharmacy	Susan Sanders	(59)	39	0	21	0	(20)	13	0	7	0	(20)	13	0	7	0	0	0	0	0
Subtotal Clinical Support		(1,053)	8,709	0	537	8,192	(25)	40	0	6	21	(47)	25	0	23	0	(56)	144	58	146
Chief Executive	Heather Lawrence	(1,740)	2,983	0	293	1,536	10	15	0	(5)	21	22	35	0	(13)	45	26	37	3	66
Governance & Corporate Affairs	Cathy Mooney	(3)	744	0	3,504	4,244	(0)	17	0	(20)	(3)	(1)	55	0	(15)	39	(1)	63	(12)	50
Nursing	Andrew MacCallum	(920)	2,197	0	215	1,492	10	22	0	4	35	8	84	0	(4)	87	(12)	77	(10)	55
Human Resources	Maxine Foster	(104)	1,503	0	164	1,562	(5)	1	15	4	15	(23)	23	0	17	17	(23)	27	5	9
Finance	Lorraine Bewes	(768)	3,364	0	693	3,289	22	(14)	0	(4)	4	119	(54)	0	(51)	13	178	(115)	(62)	1
IC&T & EPR	Alex Geddes	(78)	1,733	0	1,572	3,227	(1)	18	0	10	27	(2)	110	0	(75)	32	(2)	86	(62)	22
Occupational Health	Stella Sawyer	(173)	348	(5)	55	224	(2)	1	(0)	(1)	(3)	(14)	5	(2)	(9)	(19)	(30)	8	(1)	(23)
Subtotal Management Exec		(3,786)	12,872	(5)	6,495	15,576	34	58	15	(12)	95	109	258	(2)	(150)	214	136	183	(139)	180
Facilities Management	Helen Elkington	(2,696)	240	0	17,017	14,562	52	1	(0)	(55)	(2)	1	(17)	(0)	11	(5)	97	(14)	(95)	(12)
Operation Management	Edward Donald	0	759	0	7	766	0	4	0	(0)	3	0	16	0	1	17	0	12	(4)	8
Research & Development	Mervyn Maze	0	0	0	0	0	10	(10)	0	0	0	10	(10)	0	(0)	0	0	0	0	0
Private Patients	Edward Donald	(3,698)	988	0	481	(2,229)	35	(16)	0	(41)	(21)	(63)	(46)	0	(70)	(178)	(111)	(118)	(163)	(392)
Overseas	Edward Donald	(718)	0	0	0	(718)	45	0	0	(10)	34	59	0	0	(30)	29	59	0	(30)	29
ACU	Sherryn Elsworth	(1,256)	735	0	440	(81)	58	(11)	0	(12)	36	138	(10)	0	(34)	94	251	(31)	(103)	117
Post Graduate Centre	Kevin Shotlift	0	92	0	132	224	0	1	0	3	4	(3)	5	0	0	2	0	0	0	0
Projects	Edward Donald	(345)	1,125	0	128	907	1	(0)	0	10	11	10	10	0	7	28	20	(2)	20	38
Simulation Centre	Andrew MacCallum	(293)	259	0	37	4	(4)	2	0	2	0	(22)	31	0	7	15	0	0	0	0
Service Level Agreements	Edward Donald	(299)	0	(185)	9,861	9,378	(0)	7	(15)	(91)	(98)	(0)	0	(65)	(65)	(130)	0	0	0	0
Subtotal Other Directorates		(9,304)	4,199	(185)	28,104	22,814	197	(21)	(15)	(194)	(34)	131	(21)	(65)	(172)	(127)	316	(153)	(375)	(212)
Total All Directorates		(20,763)	125,594	(1,375)	81,698	185,154	245	132	(79)	(120)	178	206	(453)	(470)	(345)	(1,063)	1,105	(1,400)	(535)	(830)
Central Budgets																				
Capital Charges	Lorraine Bewes	(156)	0	0	18,233	18,077	0	0	(0)	0	0	0	0	(0)	(0)	(0)	0	0	0	0
Central Budgets	Lorraine Bewes	(1,120)	433	(661)	642	(706)	(20)	47	120	734	881	(20)	292	125	1,086	1,483			2,256	2,256
Reserves	Lorraine Bewes	635	4,042	0	10,358	15,035	0	0	0	0	0	0	0	0	0	0			499	499
Total Central Budgets		(641)	4,474	(661)	29,234	32,406	(20)	47	120	734	881	(20)	292	125	1,086	1,483	0	0	2,755	2,755
Net Deficit(-)/Surplus(+)		(241,324)	130,069	(2,036)	110,932	(2,360)	(209)	179	40	580	590	(34)	(161)	(345)	602	62	(820)	(1,400)	2,220	0

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

ACU Summary

FORM F3B
July 06

	IN MONTH PLAN ACTIVITY	IN MONTH ACTUAL ACTIVITY	IN MONTH VARIANCE ACTIVITY	YTD PLAN ACTIVITY	YTD ACTUAL ACTIVITY	YTD VARIANCE ACTIVITY	ANNUAL PLAN ACTIVITY	YE FORECAST ACTIVITY	VARIANCE TO PLAN ACTIVITY
Activity Cycles per year									
IVF	15	21	6	60	73	13	180	201	21
ICSI	10	16	6	40	48	8	120	132	12
Sub total self fund cycles	**25**	**37**	**12**	**100**	**121**	**21**	**300**	**333**	**33**
IUI (procedure)	30	35	5	120	162	42	360	446	86

	IN MONTH PLAN £000	IN MONTH ACTUAL £000	IN MONTH VARIANCE £000	YTD PLAN £000	YTD ACTUAL £000	YTD VARIANCE £000	ANNUAL PLAN £000	YE FORECAST £000	VARIANCE TO PLAN £000
Income									
IVF	(35)	(51)	16	(139)	(165)	26	(418)	(492)	74
ICSI	(28)	(45)	17	(112)	(142)	30	(336)	(400)	64
Sub total self fund cycles	**(63)**	**(96)**	**33**	**(251)**	**(307)**	**56**	**(754)**	**(892)**	**138**
IUI	(18)	(32)	14	(73)	(114)	41	(219)	(270)	51
Consultations	(2)	(6)	4	(10)	(15)	6	(29)	(36)	7
Drugs income	(18)	(20)	2	(71)	(93)	22	(212)	(254)	42
Other	(3)	(9)	6	(14)	(28)	15	(42)	(54)	13
Income sub total	**(105)**	**(163)**	**58**	**(419)**	**(557)**	**138**	**(1,256)**	**(1,507)**	**251**
Pay	62	73	(11)	244	254	(10)	735	766	(31)
Non pay	37	48	(12)	147	181	(34)	440	543	(103)
Surplus/ Deficit	**(6)**	**(42)**	**36**	**(28)**	**(122)**	**94**	**(81)**	**(198)**	**117**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SUMMARY OF RESERVES MOVEMENTS

Responsibility: Finance Director

FORM 4A
July 06

Reserve	Code	Revised Opening Balance 01/04/06	Distributed 2006/07					Closing Ledger balance 2006/07	Committed 2006/07	Uncomm-itted 2006/07	Uncomm-itted 2007/08
			Month 1	Month 2	Month 3	Month 4	Total				
		£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Specific Expenditure Reserves	3X010	16,775	(3,266)	(1,064)	(2,101)	(559)	(6,990)	9,785	7,795	1,990	0
Pay Inflation	3X060	3,228		(739)	(1,244)	(333)	(2,316)	912	912	0	0
Non Pay	3X070	7,124	(1,456)	(2,768)	(320)	(118)	(4,662)	2,462	3,155	(693)	0
Contingency	3X080	41	(15)	(19)	18	(164)	(180)	(139)	692	(831)	0
Deficit Payback	3X195	2,360		(2,360)		0	(2,360)	0		0	0
Agenda for Change Reserve	3X250	2,903	(435)	(642)		(410)	(1,487)	1,416	1,376	40	0
EWTD Reserve	3X260	543		(126)	(80)	(107)	(313)	230	230	0	0
Consultant Contract Reserve	3X290	198				(30)	(30)	168	168	(0)	0
Additional Savings	3X490	0			193	(193)	0	0	7	(7)	0
Drugs Reserve	3X510	0		158	(37)	0	121	121	121	0	0
Ringfenced Funding	3X680	0	(555)	(20)	677	(22)	80	80	80	(0)	0
		0									
		33,173	(5,728)	(7,580)	(2,894)	(1,936)	(18,138)	15,035	14,536	499	0

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

TRUST WIDE SAVINGS ACHIEVED BY DIRECTORATE

Responsibility: Finance Director

FORM F5A
July 06

Directorate/ Service Area	Accountability	2005/06 B/F target	New Target 2006/07	Total Target 2006/07	Savings Planned/ Achieved							Outstanding target to Achieve
					Process Redesign	Corporate Functions	Other Workforce Costs	Procurement Savings	Other	Income	Total	
		£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Central Income												
SaFF income	Lorraine Bewes										0	0
Central Non SaFF income	Lorraine Bewes										0	0
Total Central Income		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Frontline Directorate												
Imaging & Anaesthetics	Kate Hall	0	(602)	(602)	232	0	291	79	0	0	602	0
HIV/GUM	Debbie Richards	(400)	(284)	(684)	23	0	39	271	220	170	723	39
Medicine & A&E	Nicola Hunt	(226)	(1,259)	(1,485)	747	0	49	0	106	18	920	(565)
Surgery	Kate Hall	0	(449)	(449)	371	0	43	78	0	0	492	43
Womens & Children's	Sherryn Elsworth	0	(727)	(727)	711	0	35	0	16	0	762	35
Subtotal Frontline Directorates		**(626)**	**(3,321)**	**(3,947)**	**2,084**	**0**	**457**	**428**	**342**	**188**	**3,499**	**(448)**
Pharmacy	Karen Robertson		(88)	(88)	0	0	67	13	0	8	88	0
Physiotherapy & Occ Therapy	Douline Schoeman	(31)	(98)	(129)	0	0	131	13	0	15	160	31
Dietetics	Helen Stracey	(14)	(15)	(29)	20	0	0	5	0	0	25	(4)
Subtotal Clinical Support		**(45)**	**(201)**	**(246)**	**20**	**0**	**198**	**31**	**0**	**23**	**273**	**27**
Chief Executive	Heather Lawrence		(28)	(28)	0	0	0	0	28	0	28	0
Governance & Corporate Affairs	Cathy Mooney	(19)	(81)	(100)	0	100	0	0	0	0	100	0
Nursing	Andrew MacCallum	(5)	(142)	(147)	0	125	0	22	0	0	147	0
Human Resources	Maxine Foster	(26)	(126)	(152)	0	15	80	41	0	0	136	(16)
Finance	Lorraine Bewes		(259)	(259)	0	96	17	35	0	165	313	54
IM&T & EPR	Alex Geddes	(99)	(261)	(360)	0	139	0	151	0	70	360	0
Occupational Health	Stella Sawyer		(6)	(6)	0	6	0	0	0	0	6	0
Subtotal Management Exec		**(149)**	**(903)**	**(1,052)**	**0**	**481**	**97**	**249**	**28**	**235**	**1,090**	**38**
Facilities	Helen Elkington		(343)	(343)	0	0	0	398	0	180	578	235
Private Patients	Edward Donald		0	0	0	0	0	0	0	0	0	0
ACU	Sherryn Elsworth		0	0	0	0	0	0	0	0	0	0
Post Graduate Centre	Kevin Shotlift		0	0	0	0	0	0	0	0	0	0
Projects	Edward Donald		(21)	(21)	0	0	0	21	0	0	21	(0)
Simulation Centre	Andrew MacCallum		0	0	0	0	0	0	0	0	0	0
Service Level Agreements	Edward Donald		(210)	(210)	0	0	0	125	0	0	125	(85)
Subtotal Other Directorates		**0**	**(574)**	**(574)**	**0**	**0**	**0**	**544**	**0**	**180**	**724**	**150**
Total All Directorates		**(820)**	**(4,999)**	**(5,819)**	**2,104**	**481**	**752**	**1,251**	**370**	**626**	**5,585**	**(234)**
Central Targets												
Capital Charges	Lorraine Bewes	(1,000)	(700)	(1,700)	0	0	0	0	1,907	0	1,907	207
Procurement Savings	Lorraine Bewes		(500)	(500)	0	0	0	273	0	0	273	(227)
Staff Rostering	Edward Donald		(500)	(500)	592	0	0	0	0	0	592	92
Bank and Agency Rates	Maxine Foster		(500)	(500)	0	0	344	0	0	0	344	(156)
Ward Stock Management	Edward Donald		(200)	(200)	0	0	0	0	0	0	0	(200)
HCD Income	Lorraine Bewes		(513)	(513)	0	0	0	0	0	444	444	(69)
GUM Overperformance	Lorraine Bewes		(500)	(500)	0	0	0	0	0	487	487	(13)
Other	Lorraine Bewes	159	(100)	59	0	0	0	300	0	0	300	359
Director's Valuation	Lorraine Bewes		(500)	(500)	0	0	0	0	740	0	740	240
High Cost Drugs	Lorraine Bewes		(400)	(400)	0	0	0	0	0	400	400	0
Total Central Budgets		**(841)**	**(4,413)**	**(5,254)**	**592**	**0**	**344**	**573**	**2,647**	**1,331**	**5,487**	**233**
Net Deficit(-)/Surplus(+)		**(1,661)**	**(9,412)**	**(11,073)**	**2,696**	**481**	**1,096**	**1,825**	**3,016**	**1,957**	**11,072**	**(1)**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST
TRUST WIDE SAVINGS DETAIL INCLUDING PLANS IN DEVELOPMENT
Responsibility: Finance Director

FORM F5B
July 06

Directorate/ Service Area	Accountability	Risk	Total Savings Target	Savings Planned/Achieved							Outst-anding Target
				Process Redesign	Corporate Functions	Other Workforce Costs	Procurement Savings	Other	Income	Total Savings	
			£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Frontline Directorate											
Imaging & Anaesthetics	Kate Hall		(602)								(602)
Capacity plan 04-05		Achieved				291				291	291
Critical Care 1 % savings		Achieved		3						3	3
IMPACT secondment		Achieved		12						12	12
ITU 1% savings		Achieved		22			13			35	35
ITU bed closure		Achieved		46						46	46
Radiology 1% savings		Achieved		43			25			68	68
Theatres 1% savings		Achieved		45			1			46	46
Theatres skill mix		Achieved		41						41	41
Treatment Centre 1% savings		Achieved		20			5			25	25
TSSU 1% savings		Achieved					7			7	7
Urology Non-Pay		Achieved					28			28	28
			(602)	232	0	291	79	0	0	602	0
HIV/GUM	Debbie Richards		(684)								(684)
Contribution from Chlamydia initiative		Achieved							10	10	10
Skill Mix saving - Charing Cross		Achieved		6						6	6
Skill Mix saving - The Ward		Achieved		17						17	17
Viral Load Testing Tender		Achieved					211			211	211
VAT Saving on Home delivery of Drugs		Achieved					40			40	40
VAT Saving on Home delivery of Drugs		Medium					20			20	20
Development Funding		Achieved						155		155	155
New Income targets		Achieved							95	95	95
New Income targets		Medium							66	66	66
Travel Costs		Medium						15		15	15
Non recurring underpends		Medium						50		50	50
Band 6 Saving		Achieved				39				39	39
			(684)	23	0	39	271	220	171	724	40
Medicine & A&E	Nicola Hunt		(1,485)								(1,485)
A&E Floating Locum		High		41						41	41
Close Ward		Achieved		673						673	673
Medicine Floating Locum		High		33						33	33
Sleep Studies		Medium							18	18	18
Thalium Scans		Medium						70		70	70
Rental Of Adele Dixon		Low						36		36	36
Consultant Savings		Medium				25				25	25
Band 2 Nurse		Achieved				24				24	24
			(1,485)	747	0	49	0	106	18	920	(565)
Surgery	Kate Hall		(449)								(449)
Burn- Unit		Achieved					25			25	25
Close Surgical Beds		Achieved		260			45			305	305
Management saving		Achieved					8			8	8
Plastic Medical Staff		Achieved		73						73	73
Restructuring of Admin Support		Achieved		38						38	38
Band 5 and 0.4 A&C 3		Achieved				43				43	43
			(449)	371	0	43	78	0	0	492	43
Womens & Children's	Sherryn Elsworth		(727)								(727)
Staff Savings - Gynae		Achieved		95						95	95
Closing Bay on Annie Zunz at weekends-staff & Non pay		Achieved		58						58	58
Closing Bay on Annie Zunz at weekends-catering		Medium		2						2	2
Additional Colposcopy/Hysteroscopy Income		Medium		67						67	67
Staff Savings - Mgmt		Achieved		20						20	20
Staff Savings - Maternity		Achieved		123						123	123
Skill Mix Savings - NICU		Achieved		34						34	34
Staff Savings - Paed Community		Achieved		65						65	65
Staff Savings - Paeds		Achieved		109						109	109
Closing Jupiter Wards at weekends		Achieved		73						73	73
Closing Jupiter Wards at weekends- catering		Medium		3						3	3
Paediatric Dental Recharge		Achieved						16		16	16
Staff Savings - Women's Medical		Achieved		26						26	26
SHO Rota Change		Achieved		37						37	37
Band 5		Achieved				35				35	35
			(727)	711	0	35	0	16	0	762	35
Subtotal Frontline Directorates			**(3,947)**	**2,084**	**0**	**457**	**428**	**342**	**189**	**3,500**	**(447)**
Pharmacy	Karen Robertson		(88)							0	(88)
0.4 WTE MTO2 reduction		Achieved				12				12	12
A&C 4 1WTE (band3)		Achieved				25				25	25
Books		Achieved					8			8	8
Hammersmith Miscrobiology Income		Achieved							8	8	8
MSSE		Achieved					5			5	5

Directorate/ Service Area	Accountability	Risk	Total Savings Target	Savings Planned/Achieved							Outst-anding Target
				Process Redesign	Corporate Functions	Other Workforce Costs	Procurement Savings	Other	Income	Total Savings	
			£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
MT04 Uncovered maternity leave		Achieved				5				5	5
Staff pay 0.3 E grade leave vacant		Achieved				15				15	15
Technical staff		Achieved				10				10	10
			(88)	0	0	67	13	0	8	88	0
Physiotherapy & Occ Therapy	Douline Schoeman		(129)							0	(129)
Income savings		Achieved							15	15	15
Non-pay Savings		Achieved				22	13			35	35
Staff Savings		Achieved				83				83	83
Band 4		Achieved				26				26	26
			(129)	0	0	131	13	0	15	160	31
Dietetics	Helen Stracey		(29)							0	(29)
Non-pay Savings		Achieved					5			5	5
Staff Savings		Achieved		20						20	20
			(29)	20	0	0	5	0	0	25	(4)
Subtotal Clinical Support			**(246)**	**20**	**0**	**198**	**31**	**0**	**23**	**273**	**27**
Chief Executive	Heather Lawrence	Achieved	(28)					28		28	0
Governance & Corporate Affairs	Catherine Mooney		(100)							0	(100)
Clinical Gov Coordinator 1.0 post		Achieved			45					45	45
Clinical Gov Support Officer 1.0 post		Achieved			29					29	29
Consultancy		Achieved			9					9	9
Legal fees		Achieved			18					18	18
			(100)	0	100	0	0	0	0	100	0
Nursing	Andrew MacCallum		(147)							0	(147)
Computer Hardware		Achieved					14			14	14
Staff budget review		Achieved			7					7	7
Lead Nurse Practice & Prof Dev 1.0 WTE		Achieved			47					47	47
Practice Education Facilitator 0.5 WTE		Achieved			48					48	48
Printing & Stationary		Achieved					8			8	8
Vacant Grade 5 post 1.0		Achieved			24					24	24
			(147)	0	125	0	22	0	0	147	0
Human Resources	Maxine Foster		(152)							0	(152)
Consultancy		Achieved				35				35	35
Snr Workforce Info Analyst post		Achieved			15					15	15
Miscellanous Training		Achieved					5			5	5
Play Scheme		Achieved					10			10	10
Reduce Bank opening hours (cost savings)		Achieved				45				45	45
Reduction in Advertising costs		Achieved					17			17	17
Staff recruitment		Achieved					10			10	10
			(152)	0	15	80	41	0	0	136	(16)
Finance	Lorraine Bewes		(259)							0	(259)
Charities Salary Recharges		Achieved							59	59	59
Arrears Charities Salary Recharges		Achieved							15	15	15
Bank Charges		Achieved					5			5	5
Bank Weekly to Monthly Paid		Achieved				17				17	17
CD-rom service reduction		Achieved					12			12	12
Cancellation OFA Software		Achieved					4			4	4
Capitalisation of Capital Accountant (100%)		Achieved			32					32	32
Creditors currrent vacant post		Achieved			24					24	24
Other savings		Achieved			16					16	16
Pharmacy to GL Interface		Achieved			25					25	25
Staff recruitment - use e-recruit		Achieved					14			14	14
Interest Receivable Target		Achieved							91	91	91
			(259)	0	96	17	35	0	165	313	54
IM&T & EPR	Alex Geddes		(360)							0	(360)
Budget for IBM contract		Achieved					68			68	68
IDX		Achieved			134					134	134
Ing Lease for 209 PC's (CHEW01)		Achieved					36			36	36
Lease Cars		Achieved					3			3	3
Legal Fees		Achieved			5					5	5
EPR Savings		Achieved							70	70	70
Software Licences		Achieved					9			9	9
Telephone calls		Achieved					10			10	10
Training		Achieved					22			22	22
Various Leases		Achieved					3			3	3
			(360)	0	139	0	151	0	70	360	(0)
Occupational Health	Stella Sawyer		(6)							0	(6)
Counselling		Medium			6					6	6
			(6)	0	6	0	0	0	0	6	0
Subtotal Management Exec			**(1,052)**	**0**	**481**	**97**	**249**	**28**	**235**	**1,090**	**38**
Facilities	Helen Elkington		(343)							0	(343)

Directorate/ Service Area	Accountability	Risk	Total Savings Target	Savings Planned/Achieved							Outst-anding Target
				Process Redesign	Corporate Functions	Other Workforce Costs	Procurement Savings	Other	Income	Total Savings	
			£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Carparking		Achieved							180	180	180
Franking Machine Mail		Achieved					42			42	42
Interpretation		Achieved					20			20	20
ISS contract terms re: Bed Making		Achieved					24			24	24
ISS Francis Burdette Ward Cleaning		Achieved					44			44	44
ISS General Areas Cleaning		Achieved					18			18	18
ISS Reception Staffing		Achieved					16			16	16
ISS Ward Cleaning		Achieved					34			34	34
LAS contract		Achieved					200			200	200
			(343)	0	0	0	398	0	180	578	235
Projects	Edward Donald		(21)							0	(21)
Sewage & Water		Achieved					2			2	2
Telephone Calls		Achieved					19			19	19
			(21)	0	0	0	21	0	0	21	(0)
Service Level Agreements	Edward Donald		(210)							0	(210)
Pathology Savings		Medium					100			100	100
Viral Load Testing Tender		Achieved					25			25	25
			(210)	0	0	0	125	0	0	125	(85)
											0
Subtotal Other Directorates			**(574)**	**0**	**0**	**0**	**544**	**0**	**180**	**724**	**150**
Total All Directorates			**(5,819)**	**2,104**	**481**	**752**	**1,251**	**370**	**627**	**5,586**	**(233)**
Central Budgets											
Capital Charges	Lorraine Bewes	Achieved	(1,700)					1,907		1,907	207
Procurement Savings	Lorraine Bewes	Achieved	(500)				273			273	(227)
Staff Rostering	Edward Donald	Medium	(500)	592						592	92
Bank and Agency Rates	Maxine Foster	Achieved	(500)			306				306	(194)
Bank and Agency Rates	Maxine Foster	High				38				38	38
Ward Stock Management	Edward Donald	Medium	(200)							0	(200)
HCD Income	Lorraine Bewes	Achieved	(513)						444	444	(69)
GUM Overperformance	Lorraine Bewes	Achieved	(500)						248	248	(252)
GUM Overperformance	Lorraine Bewes	High							239	239	239
Other	Lorraine Bewes	Achieved	59				300			300	359
Director's Valuation	Lorraine Bewes	Achieved	(500)					740		740	240
High Cost Drugs	Lorraine Bewes	Achieved	(400)						400	400	0
			(5,254)	592	0	344	573	2,647	1,331	5,487	233
Total Central Budgets			**(5,254)**	**592**	**0**	**344**	**573**	**2,647**	**1,331**	**5,487**	**233**
Net Deficit(-)/Surplus(+)			**(11,073)**	**2,696**	**481**	**1,096**	**1,825**	**3,016**	**1,958**	**11,073**	**0**

Achieved		1,958	475	1,033	1,705	2,845	1,635	9,652	87%
Low		0	0	0	0	36	0	36	0%
Medium		664	6	25	120	135	84	1,034	9%
High		74	0	38	0	0	239	351	3%
Total		2,696	481	1,096	1,825	3,016	1,958	11,073	100%

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

TRUST WIDE SAVINGS ACHIEVED BY DIRECTORATE

Responsibility: Finance Director

FORM FC
July 06

Directorate/ Service Area	Accountability	2005/06 B/F target	New Target 2006/07	Total Target 2006/07	Total Savings Planned/ Achieved	Outstanding target to Achieve	Phasing 2006/07 of Savings Achieved												Total
							Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	
		£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Central Income																			
SaFF income	Lorraine Bewes				0	0													
Central Non SaFF income	Lorraine Bewes				0	0													
Total Central Income		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Frontline Directorate																			
Imaging & Anaesthetics	Kate Hall	0	(602)	(602)	602	0	53	53	53	49	49	49	49	49	49	49	49	49	602
HIV/GUM	Debbie Richards	(400)	(284)	(684)	723	39	27	27	49	49	50	50	52	53	53	53	54	54	571
Medicine & A&E	Nicola Hunt	(226)	(1,259)	(1,485)	920	(565)	0	63	63	63	63	63	63	63	63	63	63	63	696
Surgery	Kate Hall	0	(449)	(449)	492	43	20	20	76	42	42	42	42	42	42	42	42	42	492
Womens & Children's	Sherryn Elsworth	0	(727)	(727)	762	35	48	53	49	58	62	62	62	62	62	59	58	58	692
Subtotal Frontline Directorates		**(626)**	**(3,321)**	**(3,947)**	**3,499**	**(448)**	**148**	**216**	**291**	**261**	**266**	**266**	**268**	**269**	**269**	**267**	**266**	**266**	**3,053**
Pharmacy	Karen Robertson	0	(88)	(88)	88	0	7	7	7	7	7	7	7	7	7	7	7	7	88
Physiotherapy & Occ Therapy	Douline Schoeman	(31)	(98)	(129)	160	31	24	24	23	11	14	12	9	9	9	9	9	8	160
Dietetics	Helen Stracey	(14)	(15)	(29)	25	(4)	0	0	0	0	0	3	3	3	3	3	3	3	25
Subtotal Clinical Support		**(45)**	**(201)**	**(246)**	**273**	**27**	**31**	**31**	**30**	**19**	**22**	**22**	**20**	**20**	**20**	**20**	**20**	**19**	**273**
Chief Executive	Heather Lawrence	0	(28)	(28)	28	0	2	2	2	2	2	2	2	2	2	2	2	2	28
Governance & Corporate Affairs	Cathy Mooney	(19)	(81)	(100)	100	0	8	8	8	8	8	8	8	8	8	8	8	8	100
Nursing	Andrew MacCallum	(5)	(142)	(147)	147	0	11	11	13	13	13	13	13	13	13	13	13	13	147
Human Resources	Maxine Foster	(26)	(126)	(152)	136	(16)	8	12	12	12	12	12	12	12	12	12	12	12	136
Finance	Lorraine Bewes	0	(259)	(259)	313	54	23	23	23	25	28	28	28	28	28	28	28	28	313
IM&T & EPR	Alex Geddes	(99)	(261)	(360)	360	0	30	30	30	30	30	30	30	30	30	30	30	30	360
Occupational Health	Stella Sawyer	0	(6)	(6)	6	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Subtotal Management Exec		**(149)**	**(903)**	**(1,052)**	**1,090**	**38**	**82**	**86**	**87**	**89**	**92**	**92**	**93**	**93**	**93**	**93**	**93**	**93**	**1,084**
Facilities	Helen Elkington	0	(343)	(343)	578	235	48	48	48	48	48	48	48	48	48	48	48	48	578
Private Patients	Edward Donald	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ACU	Sherryn Elsworth	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Post Graduate Centre	Kevin Shotlift	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Projects	Edward Donald	0	(21)	(21)	21	(0)	2	2	2	2	2	2	2	2	2	2	2	2	21
Simulation Centre	Andrew MacCallum	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Service Level Agreements	Edward Donald	0	(210)	(210)	125	(85)	0	0	3	3	3	3	3	3	3	3	3	3	25
Subtotal Other Directorates		**0**	**(574)**	**(574)**	**724**	**150**	**50**	**50**	**52**	**52**	**52**	**52**	**52**	**52**	**52**	**52**	**52**	**52**	**624**
Total All Directorates		**(820)**	**(4,999)**	**(5,819)**	**5,585**	**(234)**	**311**	**383**	**460**	**422**	**432**	**433**	**433**	**434**	**434**	**432**	**430**	**430**	**5,033**
Central Targets																			0
Capital Charges	Lorraine Bewes	(1,000)	(700)	(1,700)	1,907	207	159	159	159	159	159	159	159	159	159	159	159	159	1,907
Procurement Savings	Lorraine Bewes	0	(500)	(500)	273	(227)	23	23	23	23	23	23	23	23	23	23	23	23	273
Staff Rostering	Edward Donald	0	(500)	(500)	592	92	0	0	0	0	0	0	0	0	0	0	0	0	0
Bank and Agency Rates	Maxine Foster	0	(500)	(500)	344	(156)	0	0	0	0	38	38	38	38	38	38	38	38	306
Ward Stock Management	Edward Donald	0	(200)	(200)	0	(200)	0	0	0	0	0	0	0	0	0	0	0	0	0
HCD Income	Lorraine Bewes	0	(513)	(513)	444	(69)	37	37	37	37	37	37	37	37	37	37	37	37	447
GUM Overperformance	Lorraine Bewes	0	(500)	(500)	487	(13)	0	23	23	23	23	23	23	23	23	23	23	23	248
Other	Lorraine Bewes	159	(100)	59	300	359	25	25	25	25	25	25	25	25	25	25	25	25	300
Savings to be worked up																			
Director's Valuation	Lorraine Bewes	0	(500)	(500)	740	240	62	62	62	62	62	62	62	62	62	62	62	62	741
High Cost Drugs	Lorraine Bewes	0	(400)	(400)	400	0	33	33	33	33	33	33	33	33	33	33	33	33	400
Total Central Budgets		**(841)**	**(4,413)**	**(5,254)**	**5,487**	**233**	**339**	**362**	**362**	**362**	**400**	**400**	**400**	**400**	**400**	**400**	**400**	**400**	**4,622**
Net Deficit(-)/Surplus(+)		**(1,661)**	**(9,412)**	**(11,073)**	**11,072**	**(1)**	**650**	**745**	**822**	**783**	**832**	**833**	**833**	**833**	**834**	**831**	**830**	**829**	**9,655**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

TRUST WIDE SAVINGS ACHIEVED BY DIRECTORATE

Responsibility: Finance Director

FORM F5D
July 06

Directorate/ Service Area	Accountability	Total Target 2006/07	Phasing 2006/07 Planned/Achieved					Phasing 2006/07 Achieved					Variance of M1-M4 Plan to Achieved Over/ (Under)	Var as % of Planned/ Achieved
			Month 1	Month 2	Month 3	Month 4	Total	Month 1	Month 2	Month 3	Month 4	Total		
		£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	%
Central Income														
SaFF income	Lorraine Bewes													
Central Non SaFF income	Lorraine Bewes													
Total Central Income		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Frontline Directorate														
Imaging & Anaesthetics	Kate Hall	(602)	53	53	53	49	209	53	53	53	49	209	0	
HIV/GUM	Debbie Richards	(684)	33	33	55	62	183	27	27	49	49	153	(30)	-16.5%
Medicine & A&E	Nicola Hunt	(1,485)	0	71	71	79	222	0	63	63	63	190	(32)	
Surgery	Kate Hall	(449)	20	20	76	42	157	20	20	76	42	157	0	
Womens & Children's	Sherryn Elsworth	(727)	53	59	55	63	230	48	53	49	58	207	(22)	-9.8%
Subtotal Frontline Directorates		**(3,947)**	**159**	**236**	**310**	**296**	**1,001**	**148**	**216**	**291**	**261**	**916**	**(85)**	**-8.5%**
Pharmacy	Karen Robertson	(88)	7	7	7	7	29	7	7	7	7	29	0	
Physiotherapy & Occ Therapy	Douline Schoeman	(129)	24	24	23	11	81	24	24	23	11	81	0	
Dietetics	Helen Stracey	(29)	0	0	0	0	1	0	0	0	0	1	0	
Subtotal Clinical Support		**(246)**	**31**	**31**	**30**	**19**	**112**	**31**	**31**	**30**	**19**	**112**	**0**	**0**
Chief Executive	Heather Lawrence	(28)	2	2	2	2	9	2	2	2	2	9	0	
Governance & Corporate Affairs	Cathy Mooney	(100)	8	8	8	8	33	8	8	8	8	33	0	0.0%
Nursing	Andrew MacCallum	(147)	11	11	13	13	47	11	11	13	13	47	0	0.0%
Human Resources	Maxine Foster	(152)	8	12	12	12	43	8	12	12	12	43	0	0.0%
Finance	Lorraine Bewes	(259)	23	23	23	25	92	23	23	23	25	92	0	0.0%
IM&T & EPR	Alex Geddes	(360)	30	30	30	30	119	30	30	30	30	119	0	0.0%
Occupational Health	Stella Sawyer	(6)	1	1	1	1	2	0	0	0	0	0	(2)	-100.0%
Subtotal Management Exec		**(1,052)**	**82**	**86**	**88**	**90**	**346**	**82**	**86**	**87**	**89**	**344**	**(2)**	**-0.6%**
Facilities	Helen Elkington	(343)	48	48	48	48	193	48	48	48	48	193	0	0.0%
Private Patients	Edward Donald	0	0	0	0	0	0	0	0	0	0	0	0	
ACU	Sherryn Elsworth	0	0	0	0	0	0	0	0	0	0	0	0	
Post Graduate Centre	Kevin Shotlift	0	0	0	0	0	0	0	0	0	0	0	0	
Projects	Edward Donald	(21)	2	2	2	2	7	2	2	2	2	7	0	
Simulation Centre	Andrew MacCallum	0	0	0	0	0	0	0	0	0	0	0	0	
Service Level Agreements	Edward Donald	(210)	8	8	11	11	38	0	0	3	3	5	(33)	-87.0%
Subtotal Other Directorates		**(574)**	**58**	**58**	**61**	**61**	**238**	**50**	**50**	**52**	**52**	**205**	**(33)**	**-14.0%**
Total All Directorates		**(5,819)**	**331**	**411**	**489**	**465**	**1,697**	**311**	**383**	**460**	**422**	**1,576**	**(120)**	**-7.1%**
Central Targets							0					0	0	
Capital Charges	Lorraine Bewes	(1,700)	159	159	159	159	636	159	159	159	159	636	0	
Procurement Savings	Lorraine Bewes	(500)	23	23	23	23	91	23	23	23	23	91	0	
Staff Rostering	Edward Donald	(500)	0	0	0	0	0	0	0	0	0	0	0	
Bank and Agency Rates	Maxine Foster	(500)	0	0	0	38	38	0	0	0	0	0	(38)	
Ward Stock Management	Edward Donald	(200)	0	0	0	0	0	0	0	0	0	0	0	
HCD Income	Lorraine Bewes	(513)	37	37	37	37	149	37	37	37	37	149	0	
GUM Overperformance	Lorraine Bewes	(500)	20	42	42	42	147	0	23	23	23	68	(79)	-53.9%
Other	Lorraine Bewes	59	25	25	25	25	100	25	25	25	25	100	0	0.0%
Savings to be worked up							0					0	0	
Director's Valuation	Lorraine Bewes	(500)	62	62	62	62	247	62	62	62	62	247	0	
High Cost Drugs	Lorraine Bewes	(400)	33	33	33	33	133	33	33	33	33	133	0	
Total Central Budgets		**(5,254)**	**359**	**381**	**381**	**420**	**1,541**	**339**	**362**	**362**	**362**	**1,424**	**(117)**	**-7.6%**
Net Deficit(-)/Surplus(+)		**(11,073)**	**690**	**793**	**870**	**885**	**3,237**	**650**	**745**	**822**	**783**	**3,000**	**(238)**	**-7.3%**
3/12ths of Outstanding Target							**(0)**						**(0)**	**100.0%**
Total							**3,237**						**(238)**	**-7.3%**

Chelsea & Westminster Healthcare NHS Trust

FORM F6

July 06

BALANCE SHEET

Responsibility: Finance Director

	OPENING BALANCE £000	LAST MONTH ACTUAL £000	THIS MONTH ACTUAL £000	YEAR END FORECAST £000
INTANGIBLE FIXED:	0	0	0	0
TANGIBLE FIXED ASSETS :				
Land	46,725	46,725	46,725	49,395
Buildings	208,922	206,962	206,623	228,338
Plant & Equipment	12,347	11,930	11,790	16,165
RELEVANT FIXED ASSETS :	**267,994**	**265,617**	**265,138**	**293,898**
Under Construction	11,924	12,500	13,267	6,414
TOTAL FIXED ASSETS :	**279,918**	**278,117**	**278,405**	**300,312**
CURRENT ASSETS :				
Stocks & Work In Progress	5,237	4,968	5,642	5,545
Trade Debtors	18,490	15,328	14,877	13,229
Provision for Irrecoverable Debt	(8,850)	(8,538)	(7,959)	(5,314)
Accruals and Prepayments	2,938	3,638	2,786	1,298
Other Debtors	4,372	1,613	1,176	1,698
Cash at Bank & in Hand	678	10,344	11,795	6,865
Short - term Investment	0	0	0	0
TOTAL CURRENT ASSETS :	**22,865**	**27,353**	**28,316**	**23,321**
CURRENT LIABILITIES :				
Tax and social security costs	(2,836)	(3,127)	(2,994)	(3,146)
Dividends Payable	0	(2,417)	(3,223)	0
Trade Creditors	(11,302)	(9,949)	(11,194)	(12,557)
Accruals and deferred income	(8,545)	(10,109)	(9,277)	(4,393)
Other Creditors	(1,816)	(2,115)	(1,754)	(3,673)
TOTAL CURRENT LIABILITIES :	**(24,499)**	**(27,717)**	**(28,441)**	**(23,769)**
NET CURRENT ASSETS / (LIABILITIES)	**(1,634)**	**(364)**	**(126)**	**(448)**
Creditors over one year	(969)	(969)	(969)	(2,192)
Provisions for liabilities and Charges	(4,554)	(3,992)	(3,751)	(432)
TOTAL ASSET EMPLOYED	**272,761**	**272,792**	**273,559**	**297,240**
CAPITAL & RESERVES				
Public Dividend Capital	168,981	168,981	168,981	163,746
Loans	0	0	0	7,794
TOTAL CAPITAL DEBT	**168,981**	**168,981**	**168,981**	**171,540**
RESERVES				
Revaluation Reserve	97,085	97,085	97,085	116,509
Donation Reserve	7,194	7,155	7,143	7,330
Other Reserve	0	0	0	0
Income & Expenditure Reserve / (Deficit)	(499)	(429)	350	1,861
TOTAL RESERVE	**103,780**	**103,811**	**104,578**	**125,700**
TOTAL CAPITAL AND RESERVES	**272,761**	**272,792**	**273,559**	**297,240**

Chelsea & Westminster Healthcare NHS Trust

FORM F7

July 06

Age Debtor Analysis

Responsibility: Finance Director

July	%Age	Total	Days 0-30	Days 31-90	Days 91+
The Hammersmith Hospitals NHS Trust	**14.48%**	790,776	41,076	28,898.16	720,802
North West London Strategic Health Authority	**6.65%**	616,148	615,148	0	1,000
Hammersmith And Fulham Primary Care Trust	**3.95%**	503,172	0	0	503,172
Royal Brompton & Harefield NHS Trust	**2.76%**	451,928	123,533	14,094.46	314,301
Hounslow PCT	**2.53%**	448,815	184,704	58,192.00	205,919
Adur, Arun And Worthing PCT	**2.25%**	440,609	84,363	0.0	356,246
Southend-On-Sea PCT	**2.16%**	416,917	39,320	6,821.48	370,776
Westminster PCT	**2.10%**	415,512	170,995	4,911.82	239,605
Brent, Kensington C & W Mental Health Trust	**2.00%**	413,639	0	0	413,639
Western Sussex PCT	**1.98%**	397,830	0	0	397,830
Sub Total	**40.86%**	**4,895,347**	**1,259,138**	**112,918**	**3,523,291**
Other Debtors	**59.14%**	9,981,847	2,456,409	622,311	6,903,126
	100%	**14,877,193**	**3,715,547**	**735,229**	**10,426,417**
% of total		**100.0%**	**25.0%**	**4.9%**	**70.1%**
Increase/(decrease) on last month		**-451,057**	**1,038,874**	**-3,153,205**	**1,663,274**
% Increase/(decrease)on previous month		**-2.9%**	**38.8%**	**-81.1%**	**19.0%**

Analysis of Private Patients Debtors

Outstanding as at 31 July 2006		1,651,093.59	612,313	348,422	690,358
% of total		**100.0%**	**37.1%**	**21.1%**	**41.8%**
Increase/(decrease) on last month		127,951	-110,035	39,752	198,233
% Increase/(decrease)on previous month		8.4%	-15.2%	12.9%	40.3%

Analysis of Overseas Visitors Debtors

Outstanding as at 31 July 2006		1,317,795	81,871	31,124	1,204,800
		100.0%	**6.2%**	**2.4%**	**91.4%**
Increase/(decrease) on last month		58,068	-8,439	31,124	35,383
% Increase/(decrease)on previous month		4.6%	-9.3%	0.0%	3.0%

June	%Age	Total	Days 0-30	Days 31-90	Days 91+
Kensington & Chelsea PCT	**19.25%**	1,109,034	4,984	712,307	391,743
Westminster PCT	**3.24%**	734,192	685,552	18,876	29,763
Hammersmith and Fulham PCT	**2.79%**	731,769	307,326	81,108	343,335
The Hammersmith Hospitals NHS Trust	**2.78%**	710,690	0	23,196	687,494
Royal Brompton and Harefield NHS Trust	**2.52%**	506,202	55,153	276,840	174,209
Brent KCW Mental Health Trust	**2.46%**	413,639	0	0	413,639
Western Sussex PCT	**2.41%**	397,830	0	0	397,830
Southend on Sea PCT	**2.30%**	390,150	18,571	24,607	346,971
Adur Arun and Worthing PCT	**2.00%**	356,246	0	64,550	291,695
Hounslow PCT	**1.96%**	294,911	88,992	69,510	136,409
Sub Total	**41.71%**	**5,644,663**	**1,160,579**	**1,270,994**	**3,213,090**
Other Debtors	**58.29%**	9,683,587	1,516,094	2,617,440	5,550,053
	100%	**15,328,251**	**2,676,673**	**3,888,435**	**8,763,143**
		100.0%	**17.5%**	**25.4%**	**57.2%**
Analysis of Private Patients Debtors					
Outstanding as at 30 June 2006		1,523,143	722,348	308,670	492,125
% of total		**100.0%**	**47.4%**	**20.3%**	**32.3%**
Analysis of Overseas Visitors Debtors					
Outstanding as at 30 June 2006		1,259,726	90,309	0	1,169,417
% of total		**100.0%**	**7.2%**	**0.0%**	**92.8%**

	%age	TOTAL	0 - 30	Days 30 - 90	OVER 90
Opening Balance April 2006-2007	**100.00%**	**18,427,343**	**7,426,985**	**1,205,330**	**9,795,027**
Age Analysis %		**100.0%**	**40.3%**	**6.5%**	**53.2%**

Customer Movement - Top 10	**£**
The Hammersmith Hospitals NHS Trust	80,085
North West London Strategic Health Authority	616,148
Hammersmith And Fulham Primary Care Trust	-228,597
Royal Brompton & Harefield NHS Trust	-54,274
Hounslow PCT	153,904
Adur, Arun And Worthing PCT	84,363
Southend-On-Sea PCT	26,767
Westminster PCT	-318,680
Brent, Kensington C & W Mental Health Trust	0
Western Sussex PCT	0
Total	**359,717**

Chelsea & Westminster Healthcare NHS Trust
Age Creditors Analysis Report & Better Payment Practice Code Month Ended 31 July 2006

FORM F8A
July 06

Responsibility: Finance Director

	CURRENT MONTH: July	**%age of Total Car's**	**TOTAL**	**Days 0 - 30**	**Days 30 - 90**	**Days OVER 90**
	Top 10 Creditor Balances		**£**	**£**	**£**	**£**
1	HAMMERSMITH HOSPITALS NHS TRU	45.82%	5,129,416	2,684,973	1,339,613	1,104,830
2	HOUNSLOW PRIMARY CARE TRUST..	4.54%	508,302	0	0	508,302
3	IMPERIAL COLLEGE	4.12%	460,991	211,787	16,132	233,072
4	GILEAD SCIENCES LTD.	3.75%	419,996	419,996	0	0
5	BRISTOL-MYERS SQUIBB PHARMACE	2.96%	331,170	331,191	-21	0
6	MAWDSLEY BROOKS & CO LTD	2.34%	262,203	262,203	0	0
7	HADEN BUILDING MANAGEMENT LTD	2.33%	260,342	219,814	9,161	31,367
8	WANDSWORTH PRIMARY CARE TRUST	2.16%	241,555	55,373	506	185,676
9	ST MARYS HOSPITAL NHS TRUST	2.05%	229,513	88,404	15,743	125,366
10	ROYAL BROMPTON & HAREFIELD NH	1.54%	172,417	43,324	587	128,506
	Sub Total	**71.61%**	**8,015,905**	**4,317,066**	**1,381,721**	**2,317,118**
	Others Creditors	28.39%	3,177,656	2,433,955	416,681	327,019
	TOTAL	**100.00%**	**11,193,561**	**6,751,021**	**1,798,402**	**2,644,138**
	% of total		**100.00%**	**60.31%**	**16.07%**	**23.62%**
	Incease/decrease on last month		**1,244,722**	**2,899,033**	**-754,949**	**-899,362**
	% increase /decrease on last month		**12.51%**	**75.26%**	**-29.57%**	**-25.38%**

	PREVIOUS MONTH : June Accruals	**%age of Total Cr's**	**TOTAL**	**Days 0 - 30**	**Days 30 - 90**	**Days OVER 90**
	Top 10 Creditor Balances		**£**	**£**	**£**	**£**
1	HAMMERSMITH HOSPITALS NHS TRU	44.15%	4,392,546	857,480	1,563,060	1,972,006
2	ISS MEDICLEAN LTD.	8.37%	832,541	758,044	54,124	20,373
3	IDX SYSTEMS UK LIMITED	5.45%	542,263	0	0	542,263
4	HOUNSLOW PRIMARY CARE TRUST..	5.11%	508,302	0	508,302	0
5	IMPERIAL COLLEGE	3.63%	361,491	120,971	14,896	225,624
6	NHS LITIGATION AUTHORITY	3.42%	339,961	339,961	0	0
7	HADEN BUILDING MANAGEMENT LTD	2.74%	272,439	209,607	12,088	50,744
8	WANDSWORTH PRIMARY CARE TRUST	2.43%	241,555	55,373	52,048	134,134
9	ST MARYS HOSPITAL NHS TRUST	1.71%	169,771	28,662	30,184	110,925
10	ROYAL BROMPTON & HAREFIELD NH	1.60%	159,224	30,719	7,242	121,264
	Sub Total	**78.60%**	**7,820,094**	**2,400,817**	**2,241,945**	**3,177,332**
	Others Creditors	21.40%	2,128,745	1,451,171	311,406	366,168
	TOTAL	**100.00%**	**9,948,840**	**3,851,988**	**2,553,351**	**3,543,500**
	Percentage of No. of days / Total Creditors		**100.00%**	**38.72%**	**25.66%**	**35.62%**

	Opening Balance April 2006 - 2007		11,302,033	5,430,889	507,928	5,363,215
		%age	***100.00%***	***48.05%***	***4.49%***	***47.45%***

Movement from Previous Month

	Supplier	**£**
1	HAMMERSMITH HOSPITALS NHS TRU	736,870.19
2	HOUNSLOW PRIMARY CARE TRUST..	0.00
3	IMPERIAL COLLEGE	99,499.52
4	GILEAD SCIENCES LTD.	419,995.80
5	BRISTOL-MYERS SQUIBB PHARMACE	331,170.33
6	MAWDSLEY BROOKS & CO LTD	262,203.25
7	HADEN BUILDING MANAGEMENT LTD	(12,097.35)
8	WANDSWORTH PRIMARY CARE TRUST	0.00
9	ST MARYS HOSPITAL NHS TRUST	59,742.27
10	ROYAL BROMPTON & HAREFIELD NH	13,192.69
	Total	**1,910,576.70**

BETTER PAYMENT PRACTICE CODE - INVOICES PAID WITHIN 30 DAYS

	This month				**Cummulative**		**Prior year**
	VALUE	**NUMBER**	**%age (Value)**	**%age (No)**	**%age (Value)**	**%age (No)**	**%age (No)**
April	£6,122,327	4,043	91.97%	91.84%	91.97%	91.84%	79.83%
May	£6,501,739	4,064	92.34%	90.63%	92.16%	91.23%	77.50%
June	£8,988,152	5,310	76.07%	93.01%	84.71%	91.93%	89.09%
July	£6,099,298	3,757	78.97%	91.57%	83.37%	91.85%	88.16%

Chelsea & Westminster Healthcare NHS Trust

Age Creditors Analysis Report & Better Payment Pra **Month Ended 31 July 2006**

FORM F8B
July 06

Responsibility: Finance Director

	CURRENT MONTH: July	%age of Total Cr's	TOTAL	Days 0 - 30	Days 30 - 90	Days OVER 90
	Top 8 NHS Balances & 2 Non Nhs Bal		£	£	£	£
1	HAMMERSMITH HOSPITALS NHS TRU	45.82%	5,129,416	2,684,973	1,339,613	1,104,830
2	HOUNSLOW PRIMARY CARE TRUST..	4.54%	508,302	0	0	508,302
3	IMPERIAL COLLEGE	4.12%	460,991	211,787	16,132	233,072
4	WANDSWORTH PRIMARY CARE TRUST	2.16%	241,555	55,373	506	185,676
5	ST MARYS HOSPITAL NHS TRUST	2.05%	229,513	88,404	15,743	125,366
6	ROYAL BROMPTON & HAREFIELD NH	1.54%	172,417	43,324	587	128,506
7	CNWL MENTAL HEALTH NHS TRUST	1.35%	150,915	77,472	0	73,443
8	ISS MEDICLEAN LTD.	1.25%	140,355	90,320	50,035	0
9	NHS LOGISTICS AUTHORITY	1.10%	123,622	123,622	0	0
10	KENSINGTON AND CHELSEA PCT	0.96%	107,732	103,832	3,900	0
	Sub Total	**64.90%**	**7,264,818**	**3,479,107**	**1,426,516**	**2,359,194**
	Others Creditors	35.10%	3,928,743	3,271,914	371,886	284,944
	TOTAL	**100.00%**	**11,193,561**	**6,751,021**	**1,798,402**	**2,644,138**
	Percentage of No. of days / Total Creditors		**100.00%**	**60.31%**	**16.07%**	**23.62%**

	PREVIOUS MONTH : June	%age of Total Cr's	TOTAL	Days 0 - 30	Days 30 - 90	Days OVER 90
	Top 8 NHS Balances & 2 Non Nhs Bal		£	£	£	£
1	HAMMERSMITH HOSPITALS NHS TRU	44.15%	4,392,546	857,480	1,563,060	1,972,006
2	ISS MEDICLEAN LTD.	8.37%	832,541	758,044	54,124	20,373
3	HOUNSLOW PRIMARY CARE TRUST..	5.11%	508,302	0	508,302	0
4	IMPERIAL COLLEGE	3.63%	361,491	120,971	14,896	225,624
5	NHS LITIGATION AUTHORITY	3.42%	339,961	339,961	0	0
6	WANDSWORTH PRIMARY CARE TRUST	2.43%	241,555	55,373	52,048	134,134
7	ST MARYS HOSPITAL NHS TRUST	1.71%	169,771	28,662	30,184	110,925
8	ROYAL BROMPTON & HAREFIELD NH	1.60%	159,224	30,719	7,242	121,264
9	LONDON AMBULANCE SERVICE NHS	1.02%	101,432	98,521	1,262	1,649
10	SOUTHEND PCT	0.96%	95,494	0	0	95,494
	Sub Total	**72.39%**	**7,202,319**	**2,289,731**	**2,231,118**	**2,681,469**
	Others Creditors	27.61%	2,746,521	1,562,257	322,233	862,031
	TOTAL	**100.00%**	**9,948,840**	**3,851,988**	**2,553,351**	**3,543,500**
	Percentage of No. of days / Total Creditors		**100.00%**	**38.72%**	**25.66%**	**35.62%**

	Opening Balance April 2006 - 2007		11,302,033	5,430,889	507,928	5,363,215
		%age	**100.00%**	**48.05%**	**4.49%**	**47.45%**

Movement from Previous Month

	Supplier	£
1	HAMMERSMITH HOSPITALS NHS TRU	736,870.19
2	HOUNSLOW PRIMARY CARE TRUST..	0.00
3	IMPERIAL COLLEGE	99,499.52
4	WANDSWORTH PRIMARY CARE TRUST	0.00
5	ST MARYS HOSPITAL NHS TRUST	59,742.27
6	ROYAL BROMPTON & HAREFIELD NH	13,192.69
7	CNWL MENTAL HEALTH NHS TRUST	150,914.50
8	ISS MEDICLEAN LTD.	(692,186.28)
9	NHS LOGISTICS AUTHORITY	123,622.36
10	KENSINGTON AND CHELSEA PCT	107,731.58

Chelsea and Wesminster Healthcare NHS Trust
Cash Flow Statement

FORM F9A
July 06

Responsibility: Finance Director

£ 000	1 Actual Apr-06	2 Actual May-06	3 Actual Jun-06	4 Actual Jul-06	5 Forecast Aug-06	6 Forecast Sep-06	7 Forecast Oct-06	8 Forecast Nov-06	9 Forecast Dec-06	10 Forecast Jan-07	11 Forecast Feb-07	12 Forecast Mar-07	Actual YTD	Forecast Total Mar-07
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Total Operating Surplus/(Deficit)	2,196	(1,537)	1,750	1,445	1,026	1,224	950	950	950	900	889	621	3,854	11,364
Depreciation and Amortisation	838	746	792	466	708	708	708	709	709	709	709	709	2,842	8,511
Transfer from the donated asset reserve	(20)	(6)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(52)	(156)
(Increase)/Decrease in Stocks	639	133	(504)	24	24	24	24	24	24	24	24	(718)	292	(256)
(Increase)/Decrease in Debtors	(237)	3,316	1,215	1,162	1,384	755	587	300	768	(584)	(582)	(1,618)	5,456	6,466
Increase/(Decrease) in Creditors	8,830	(4,394)	(2,648)	(82)	(3,220)	(288)	(313)	(464)	(465)	(566)	(416)	3,520	1,706	(506)
Increase/(Decrease) in Provisions	(85)	73	(553)	(241)	(388)	(388)	(388)	(388)	(388)	(388)	(2)	(1,057)	(806)	(4,193)
OPERATING ACTIVITIES														
Net cash inflow(outflow) from operating activities	**12,161**	**(1,669)**	**39**	**2,761**	**(479)**	**2,022**	**1,555**	**1,118**	**1,585**	**82**	**609**	**1,444**	**13,292**	**21,230**
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:														
Interest received	55	51	60	35	55	35	45	45	60	60	60	39	201	600
Interest paid	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest element of finance leases	0	0	0	0	0	0	0	0	0	0	0	(80)	0	(80)
Net cash inflow/(outflow) from returns on investments and servicing of finance	**55**	**51**	**60**	**35**	**55**	**35**	**45**	**45**	**60**	**60**	**60**	**(41)**	**201**	**520**
CAPITAL EXPENDITURE														
Payments to acquire tangible fixed assets	0	(104)	(927)	(1,345)	(585)	(748)	(890)	(469)	(779)	(854)	(970)	(747)	(2,376)	(8,418)
Donations	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash inflow (outflow) from capital expenditure	**0**	**(104)**	**(927)**	**(1,345)**	**(585)**	**(748)**	**(890)**	**(469)**	**(779)**	**(854)**	**(970)**	**(747)**	**(2,376)**	**(8,418)**
DIVIDENDS PAID	0	0	0	0	0	(4,833)	0	0	0	0	0	(4,833)	0	(9,666)
Net cash inflow/(outflow) before management of liquid resources and financing	**12,216**	**(1,722)**	**(828)**	**1,451**	**(1,009)**	**(3,524)**	**710**	**694**	**866**	**(712)**	**(301)**	**(4,177)**	**11,117**	**3,666**
MANAGEMENT OF LIQUID RESOURCES	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash inflow (outflow) from management of liquid resources	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Net cash inflow (outflow) before financing	**12,216**	**(1,722)**	**(828)**	**1,451**	**(1,009)**	**(3,524)**	**710**	**694**	**866**	**(712)**	**(301)**	**(4,177)**	**11,117**	**3,666**
FINANCING														
Public dividend capital received	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Public dividend capital repaid	0	0	0	0	0	0	0	0	0	0	0	(6,235)	0	(6,235)
Department of Health -PACS - Brokerage	0	0	0	0	0	0	0	0	0	0	0	1,000	0	1,000
Capital element of finance lease rental payments	0	0	0	0	0	0	0	0	0	0	0	(38)	0	(38)
Foundation Trust Financing Facility	0	0	0	0	0	0	4,816	0	0	2,571	0	407	0	7,794
Brokerage payments and receipts	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Net cash inflow (outflow) from financing	**0**	**0**	**0**	**0**	**0**	**0**	**4,816**	**0**	**0**	**2,571**	**0**	**(4,866)**	**0**	**2,521**
Increase (decrease) in cash	**12,216**	**(1,722)**	**(828)**	**1,451**	**(1,009)**	**(3,524)**	**5,526**	**694**	**866**	**1,859**	**(301)**	**(9,043)**	**11,117**	**6,187**
Opening Cash Balance	**678**	**12,894**	**11,172**	**10,344**	**11,795**	**10,786**	**7,263**	**12,789**	**13,483**	**14,349**	**16,209**	**15,908**	**678**	**678**
Cash Balance at the end of the period	**12,894**	**11,172**	**10,344**	**11,795**	**10,786**	**7,263**	**12,789**	**13,483**	**14,349**	**16,209**	**15,908**	**6,865**	**11,795**	**6,865**

Chelsea & Westminster Healthcare NHS Trust
ANALYSIS OF CASH FUNDS MOVEMENT
Responsibility: Finance Director

FORM F9B
July 06

NORMAL ACTIVITIES	April	May	June	July	August	September	October	November	December	January	February	March	**TOTAL**
	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
RECEIPTS	29,493	17,449	21,427	22,545	22,769	20,356	21,700	20,829	20,829	20,829	20,829	24,946	264,001
PAYMENTS	(17,277)	(19,171)	(22,255)	(21,094)	(23,778)	(23,880)	(20,990)	(20,135)	(19,973)	(21,541)	(21,130)	(29,123)	(260,347)
NET MOVEMENT	12,216	(1,722)	(828)	1,451	(1,009)	(3,524)	710	694	856	(712)	(301)	(4,177)	3,654
Cumulative	12,216	10,494	9,666	11,117	10,108	6,584	7,294	7,988	8,844	8,132	7,831	3,654	
FUNDING / BROKERAGE	0	0	0	0	0	0	4,816	0	0	2,571	0	(4,866)	0
NET MOVEMENT	0	0	0	0	0	0	4,816	0	0	2,571	0	(4,866)	0
Cumulative	0	0	0	0	0	0	4,816	4,816	4,816	7,387	7,387	2,521	
TOTAL FUND MOVEMENT	12,216	(1,722)	(828)	1,451	(1,009)	(3,524)	5,526	694	856	1,859	(301)	(9,043)	3,654
Cumulative	12,216	10,494	9,666	11,117	10,108	6,584	12,110	12,804	13,660	15,519	15,218	6,175	

SUMMARY OF CUMULATIVE MOVEMENTS	April	May	June	July	August	September	October	November	December	January	February	March	
NORMAL ACTIVITIES													
Forecast	3,123	8,737	9,635	9,767	10,108	6,584	7,294	7,988	8,844	8,132	7,831	3,654	
Actual	12,216	10,494	9,666	11,117	0	0	0	0	0	0	0	0	
FUNDING / BROKERAGE													
Forecast	0	0	0	0	0	0	4,816	4,816	4,816	7,387	7,387	2,521	
Actual	0	0	0	0	0	0	0	0	0	0	0	0	
COMBINED													
Forecast	3,123	8,737	9,635	9,767	10,108	6,584	12,110	12,804	13,660	15,519	15,218	6,175	
Actual	12,216	10,494	9,666	11,117	0	0	0	0	0	0	0	0	

Chelsea & Westminster Healthcare NHS Trust
CAPITAL PROGRAMME 2006/07 - SPEND and FORECAST OUT-TURN
Responsibility: Finance Director

FORM F10
July 06

	Planned Spend 2006/2007	Expenditure to date	Forecast Out-turn	(Over)/Under Spend
	£000	£000	£000	£000
SUMMARY				
A. SCHEMES CARRIED FORWARD FROM 05/06	936.0	612.0	936.0	324.0
B. APPROVED SCHEMES MORE THAN ONE YEAR	2,353.0	376.0	2,353.0	1,977.0
C. BACK LOG MAINTENANCE	740.0	192.0	740.0	548.0
D. ENVIRONMENTAL	220.0	10.0	220.0	210.0
E. DEVELOPMENT WORKS	452.0	71.0	452.0	381.0
F. SPECIAL PROJECT	1,370.0	28.0	1,370.0	1,342.0
G. IT EQUIPMENT	834.0	503.0	834.0	331.0
H. MEDICAL EQUIPMENT	1,338.0	6.0	1,338.0	1,332.0
J. CONTINGENCY	102.0	-	102.0	102.0
K. DONATED	-	25.0	-	(25.0)
L. OTHERS	-	103.0	-	(103.0)
		-		-
CAPITAL PROGRAMME TOTAL	**8,345.0**	**1,926.0**	**8,345.0**	**6,419.0**

FUNDING			
CAPITAL RESOURCE LIMIT - FUNDING RECEIVED			
BLOCK ALLOCATION	7,999.0		
CARRIED FORWARD	1,373.0		
BROKERAGE REVERSAL 05/06	(4,393.0)		
OLD CAPITAL BROKERAGE CONVERTED TO PERMANENT PDC	3,480.0		
TOTAL CRL	**8,459.0**		**-**

DONATED			
DONATED	-	-	-

DONATED FUNDING	**-**
TOTAL FUNDING	**8,459.0**
PROGRAMME (OVER)/UNDER SPEND	**114.0**

Chelsea & Westminster Healthcare NHS Trust

Provision for Aged Debtors

Responsibility: Finance Director

FORM F11
July 06

Customer	Amount	% of Total Debtors	Current	Overdue by 1-30 Days	Overdue by 31-60 Days	Overdue by 61-90 Days	Overdue by 91-180 Days	Overdue by 181-360 Days	Overdue by 361+ Days	Provisions
NHS Bodies	10,697,563	71.91%	3,068,629	66,604	0	793,111	1,463,094	949,841	4,356,283	(6,805,188)
NHS Other	29,347	0.20%	8,656	630	1,786	1,150	2,690	1,035	13,400	
Private Patients - Self Funding	348,051	2.34%	209,903	44,667	22,567	(913)	52,486	19,342	0	
Private Patients - Insurance Companies	1,004,713	6.75%	274,201	171,562	69,108	63,979	168,520	84,512	172,830	
Private Patients - Maternity	218,330	1.47%	107,186	34,682	(5,940)	(14,711)	(36,623)	29,848	103,887	
Private Patients - ACU	77,349	0.52%	20,193	4,272	7,044	3,595	34,676	1,030	6,540	
Private Patients - Overseas	1,317,795	8.86%	81,871	11,179	19,945	0	39,632	135,541	1,029,627	(689,107)
Private Patients - Doctors & Consultants	2,650	0.02%	830	150	310	430	640	290	0	
Default	26,128	0.18%	13,828	86	569	759	0	1,694	9,192	
Other General Trading Organisations	1,151,338	7.74%	91,931	63,989	124,869	146,033	124,454	104,966	495,096	(465,063)
Private Patients - PCT	3,930	0.03%	3,930	0	0	0	0	0	0	
Grand Total:	**14,877,193**	**100.00%**	**3,881,159**	**397,821**	**240,258**	**993,434**	**1,849,568**	**1,328,100**	**6,186,854**	**(7,959,358)**

Provisions Cover	0	577,214	1,195,290	6,186,854	**7,959,358**
% of Provision Cover	**0.00%**	**31.21%**	**90.00%**	**100.00%**	**0.00**

Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting, 7th September 2006

AGENDA ITEM NO.	2.2 /Sep/06
PAPER	Performance Report
LEAD EXECUTIVE	Lorraine Bewes – Director of Finance and Information
AUTHOR	Nick Cabon – Head of Performance and Information Contact Number: 020 8237 2426
SUMMARY	The purpose of this report is to provide information about the Trust's performance for the period ending 31st July 2006.
BOARD ACTION	The Trust Board is asked to note and discuss the report and actions.

Chelsea and Westminster Healthcare NHS

NHS Trust

PERFORMANCE REPORT FOR THE PERIOD APRIL - JULY 2006

1. PURPOSE

The purpose of this report is to provide information about the Trust's performance from April to July 2006. The Trust Board is asked to note the report and conclusions.

2. DEVELOPMENT OF PERFORMANCE REPORT

The development of the report continues with the inclusion this month of SLA performance monitoring information. The reports show performance against target for the main points of delivery, and is presented by directorate and for each of our main commissioners. Due to a time lag in reporting the SLA reports the Performance Report only includes SLA information up to month 3.

3. SUMMARY

The report comprises of the following components:

- **Board Dashboard – pg 5**
- **Existing and New External Indicators Summary – pg 6**
- **Internal Indicators Summary – pg 7**
- **Analysis of Breaches of Targets – p13**
- **Activity Summary – pgs 14 & 15**
- **HR Summary – pgs 20 & 21**
- **Efficiency and Resources Summary – pgs 16 to 19**
- **SLA Performance Summary – pgs 21 to 25**

The dashboard highlights the Trust position against key Healthcare Commission targets and internal indicators.

The summary report of existing and new core targets sets out further comments and detail including performance last month, year to date and a banding given comparing performance to the latest target or threshold. There are four possible outcomes for the targets – the indicator is deemed to be Fully Met, Almost Met, Partly Met or Not Met. The internal indicators summary is set out in exactly the same way.

Analysis of breaches of targets provides details on where the Trust is not expected to meet the external performance indicators, for this month's report there are breaches in four areas.

The activity summary shows the levels of activity of the Trust compared with the same period last year and also against the year-to-date plan.

The efficiency and use of resources summary shows how the Trust is performing against targets that were derived from the capacity plan, Dr Foster national averages, CHKS benchmarks or the average Trust performance for the previous year. The sources of the targets are indicated on each table.

The HR summary shows key workforce information in relation to numbers of staff, bank and agency usage, sickness and turnover rates.

The SLA performance summary shows the year-to-date income and activity performance against commissioning plan.

4. EXTERNAL HEALTHCARE COMMISSION TARGETS – pages 5 & 6, 8 to 13

The Trust is on schedule to fully meet eleven of the existing targets and four of the new targets; however there are three areas that are forecast to underachieve. These targets relate to Thrombolysis, 48 hour access to GUM clinics and MRSA. The Trust's performance is rated as amber for the indicators of Financial Management and Data Quality on Ethnic Group.

a. THROMBOLYSIS

There have been 5 eligible patients so far this year, in the majority of cases the ambulance journey time was very long and consequently the patients did not receive thrombolytic treatment within one hour. In the past the Healthcare Commission has not assessed trusts that have fewer than 20 cases in the year against this indicator. This applies to Trust's having 2 consecutive eligible years of data, therefore if the Trust had greater than 20 eligible patients this year we would need to have the same next year in order to be assessed.

b. 48 HOUR ACCESS TO GUM CLINICS

The assessment of this indicator is based on the quarterly audits carried out by the Health Protection Agency. The year-to-date performance is based on the audit that was carried out in May. The NHS target for this year is to achieve 60% by November 2006 and 80% by the end of the financial year. The HIV/GUM directorate has a plan to achieve 60% by the end of August and to be near to 80% by November.

c. ETHNIC CATEGORY CODING

Significant improvement has been made in this area in the past few months, and the Trust is very close to its target of 95%. The importance of recording all of the patients' demographic details correctly will continue to be a focus of attention for the Data Quality Group, and further plans will be devised to achieve the few percentage points that are required to meet the target.

d. MRSA

There were 4 cases of MRSA in the Trust in July. These bring the total for the year up to 10, and we are now 25% above the trajectory. The Trust can only afford to have 13 further cases in the final 8 months of the year.

e. FINANCIAL MANAGEMENT

An in month improvement of £588k was made during July, therefore the year to date position stands at a £62k surplus variance from plan.

5. INTERNAL INDICATORS – page 7

The Trust is on track to achieve all of the internal indicators with the exception of Deaths following Selected Non-Elective Surgical Procedures. There have been 10 deaths so far this year, and the performance rate to date is 1.36% compared with a target of 1%. Details of each death have been sent to the relevant directorate for investigation.

6. ACTIVITY SUMMARY – pages 14 & 15

The total number of referrals has increased year to date compared with last year. GP referrals are currently 12% higher than referrals in the first four months of last year, and Other referrals are 11% higher. These figures are derived from the QM08 outpatient waiting time report. The accuracy of this report has been questioned and is still being investigated.

New outpatient attendances year-to-date are lower than the plan for the period. Follow up attendances are significantly lower then last year and are 2% below plan. This reflects the Trust's work in reducing the new to follow up rate in accordance with the capacity plan and suggestions from PCTs.

Elective inpatient activity is 23% greater than plan and 7.5% higher than the corresponding period last year. The predicted rise in day case spells has been seen with an additional 5% growth on plan.

The anticipated rise in emergency spells has not been seen. Year-to-date activity was 13% lower than plan. However non-elective spells have increased significantly on the same period last year and are 22% higher than plan and 29% higher than in the first 4 months of 2005/6. Of this increase the number of maternity delivery spells was 50% greater than expected in the plan.

A&E attendances were 5% higher than the same period last year and 1% higher than the plan for the first 4 months of 2006/7.

7. EFFICIENCY AND RESOURCES – pages 16 to 19

The Trust's new to follow-up rate for outpatients is currently 1:1.91. This is slightly better than the target set in the capacity plan. However, despite achieving the targets in July the year-to-date rates for the Surgery and W&C directorates are significantly above the respective target. The plan for each PCT has been set at specialty level. Therefore, income will be at risk if we do not achieve the individual specialty target – we may not be allowed to offset good performance in one specialty against missing the target for a different specialty.

The average elective length of stay is below the target set for the Trust. However, every directorate is above the plan for average non-elective length of stay. The Medicine directorate currently has an average that is 15% higher than the target, and the Surgery directorate is 12% higher than the plan.

The Trust's day case rate has been below the plan each month so far this year. In July the average was 66.6%, and the year-to-date rate is 69.7%. This is compared with a target of 73%. The rate has deteriorated each month this year. In order to meet the target for the year the Trust would need to achieve an average of 74.1% for the final 8 months.

The percentage of elective inpatients admitted on the day of surgery is 13% higher than in 2005/6, and the average pre-operative length of stay continues to fall. The average in June was 0.78 days which is 0.3 days better than last year's average.

Clinical coding is a concern for the organisation. A significant backlog of coding has developed due to a high rate of sick leave during June and July. The Trust has an action plan to achieve 100% coding in time for the Quarter 1 freeze date (mid-September). The Trust is also concerned with the depth of coding. We are currently recording an average of 2 diagnosis codes for each episode. The Trust's target of 2.25 codes per episode is based on the benchmarking information from CHKS. Improving the depth of coding will also contribute to the Trust's SLA performance. Clinical Directors have been asked to arrange for relevant clinicians to meet with the Clinical Coding department to devise processes and discuss issues that will help improve the depth of coding.

8. HR INDICATORS – pages 20 & 21

The Trust employed more staff in July 2006 than in the corresponding month last year. The greatest increases were in Anaesthetics and Imaging and Women and Children. These directorates saw increases of 8% and 9% respectively.
The vacancy rate was 13.9% in the first 4 months of this year. That is 1% lower than last year. There has been a 9% increase in staff bank usage, but this has been offset by a 37% reduction in agency staff. The sum of the bank and agency usage is 6.4% lower than for the corresponding period in 2005/6.

9. SLA PERFORMANCE – pages 21 to 25

The Trust's SLA income is ahead of plan by £123k after the first quarter. This is mainly due to outpatient and non-elective activity being ahead of plan.

Elective inpatient performance is over 2% below plan. Of the local commissioners only Hammersmith and Fulham PCT are below plan, but the performance for the more distant PCTs is also poor. At a directorate level, the problem lies with the Surgery, Anaesthetics and Imaging and Women and Children directorates.

The deficit in day case income is entirely due to the HIV Consortium and the HIV/GUM directorate. Collectively, the rest of the Trust would be 14.4% above plan at month 3.

The Trust is ahead of plan for non-elective activity, but each of the local PCTs is in deficit. The surplus in this area is mainly due to the HIV Consortium. Only the HIV/GUM and Women and Children directorates are currently ahead of plan.

10. CONCLUSION

Performance improved slightly in July compared with the previous month. The Trust has made progress in recovering its financial position, and is on track to achieve nearly all of the existing national targets.

SLA performance is going well, but there are still some areas where we are below the plan so need to focus our attention. This may be helped by the actions to improve the depth of our clinical coding.

The Trust needs to turn around the trend in day case rate, and reductions in average non-elective length of stay need to be made in all directorates.

Nick Cabon
Head of Performance and Information
23rd August 2006

Dashboard of Indicators to July 06

	Indicator Name	Expected Performance	Trend
Exisiting Indicators	All cancers: two week wait		⇔
	Cancer patients waiting 31 days from decision to treat to first treatment		⇔
	Cancer patients waiting 62 days from GP referral to first treatment		⇔
	Cancelled operations		⇑
	Financial management		⇑
	Outpatient and elective (inpatient and daycase) booking		⇔
	Delayed transfers of care		⇔
	Elective patients waiting longer than the standard		⇔
	Outpatients waiting longer than the standard		⇔
	Thrombolysis		⇔
	Total time in A&E: four hours or less		⇔
	Waiting times for rapid access chest pain clinic		⇔
New Indicators	Access to GUM Clinics		⇑
	Data quality on ethnic group		⇑
	Emergency Bed Days		⇑
	Infant Health - Data Completeness		⇔
	MRSA		⇓
	Participation in Audits (MINAP)		⇔
	Waiting times for MRI or CT scans		⇑
Other Indicators	Clinical risk management		⇔
	Hospital Cleanliness		⇔
	Better Hospital Foods		⇓
	4 hour wait for emergency admission via A&E (trolley waits)		⇔
	Deaths following selected elective surgical procedures		⇔
	Emergency readmissions following discharge (adults)		⇔
	Emergency readmissions following discharge for fractured hip		⇔
	Information governance toolkit		⇔
	Patient complaints		⇔
	Workforce		⇔

Key	
The Trust is on track to meet this target	
The Trust is slightly off track towards this target	
It does not seem likely that the Trust will meet this target.	
It is not possible to accurately assess performance in this area.	
Performance in this indicator is improving.	⇑
There is no significant change in performance in this indicator.	⇔
Performance in this indicator is getting worse.	⇓

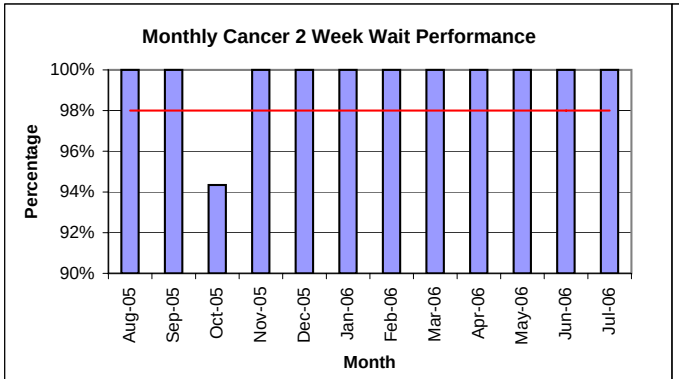
Existing and New Targets

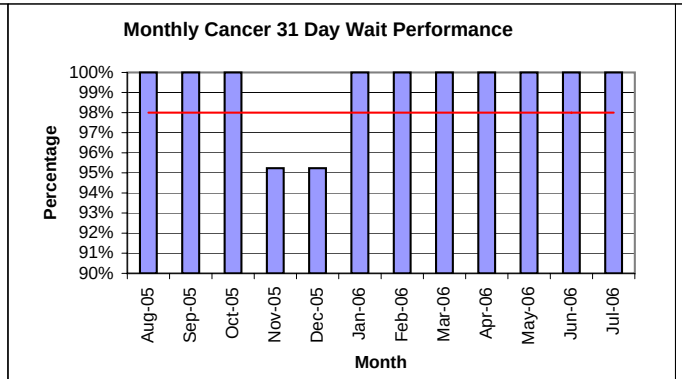
	Name	Performance Last Month	YTD Performance	Target/Likely Threshold	Predicted Banding	Comments/Actions
Exisiting Targets	All cancers: two week wait	100%	100%	98%	Fully Met	There have not been any breaches of these standards this year.
	Cancer patients waiting 31 days from decision to treat to first treatment	100%	100%	98%	Fully Met	
	Cancer patients waiting 62 days from GP referral to first treatment	100%	100%	95%	Fully Met	
	Cancelled operations	0.32%	0.46%	0.50%	Fully Met	If current activity levels continue the Trust has a tolerance of 116 cancellations for the year and therefore cannot afford to cancel more than 74 during the final 8 months of the year.
	Cancelled operations not readmitted within 28 days	0.00%	0.00%	0.50%	Fully Met	There have not been any breaches of the standard this year.
	Financial management	M3 £526 k deficit	M4 £62 k surplus	£2.4 million surplus	Almost Met	The Trust's performance for 05/06 in this area will be based on the Auditor's Local Evaluation which will be carried out later in the year. The year-to-date deficit is a significant concern.
	Outpatient and elective (inpatient and daycase) full and partial booking	Outpatient = 100%; Elective = 100%	Outpatient = 100%; Elective = 100%	100%	Fully Met	The Trust has achieved 100% booking for each month this year.
	Delayed transfers of care	2.8%	2.0%	3.5%	Fully Met	The threshold for this inidcator has been published at 3.5%, and therefore the trust is on track to meet this indicator.
	Elective patients waiting longer than the standard (Target of 6 months for 2006-07)	0.00%	0.00%	0.03%	Fully Met	There have not been any breaches of the standard this year.
	Outpatients waiting longer than the standard (Target of 13 weeks wait 2006-07)	0.00%	0.01%	0.03%	Fully Met	There was 1 breach of the standard in May 2006.
	Thrombolysis - 60 minute call to needle time	No eligible patients during July	0%, 0/5 ytd	68%	**Not Met**	Assessment of this indicator consists of a) improvement between 2005/06 and 2006/07 and b) performance in 2006/07. As the Trust was below the eligibilty level in 2005/06 it is likely the Trust would not be assessed on this indicator this year.
	Total time in A&E: four hours or less	98.18%	98.39%	98.00%	Fully Met	The trust has achieved the 98% target each month this year.
	Waiting times for rapid access chest pain clinic	100%	100%	99%	Fully Met	There have not been any breaches of the standard this year.
New Targets	48 hour Access to GUM Clinics	49%	49%	60%	Partly Met	The data for this indicator is derived from quarterly audits carried out by the HPA. This data relates to the audit carried out in May, the next audit is due to be carried out in August.
	Data quality on ethnic group	92% (Jun 06)	91%	95%	Almost Met	The data for this indicator was not available at the time of producing this report, therefore the figure relates to June 2006. Performance in this area was below the required level in 2005/6.
	Emergency Bed Days	-3.6%	-3.6%	Reduction	Fully Met	This indicator is based on performance in 2004/5 and 2005/6.
	Infant Health - Data Completeness	98.67%	99.20%	TBA		This was a new indicator in 2005/6. It is difficult to predict a target for this indicator until the 2005/6 indicator thresholds are published.
	MRSA (% of cases against trajectory)	0% = 4 cases	75% = 10 cases	100% = 8 cases	**Not Met**	There were 4 MRSA cases during July. The Trust is off course by 2 cases to meet this target.
	Participation in Audits (MINAP)	100%	100%	90%	Fully Met	The Trust continues to meet this target.
	Waiting times for MRI or CT scans (percentage of patients waiting under 13 weeks)	MRI=100%, CT=100%, Overall=100%	MRI=98.57%, CT=100%, Overall=98.87%	TBA		The 2005/06 target was 26 weeks a new target has yet to be published, we expect the target to be 13 weeks this year.

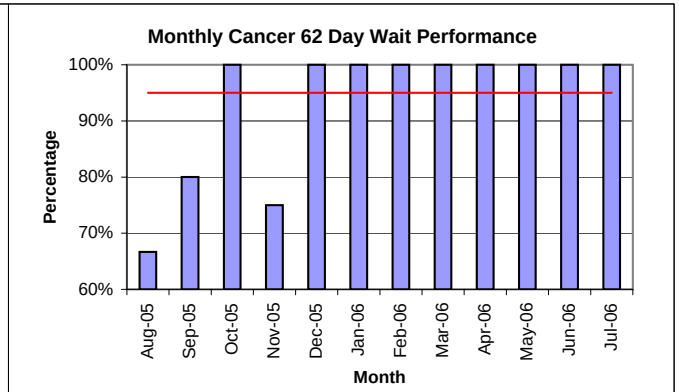
Other Indicators

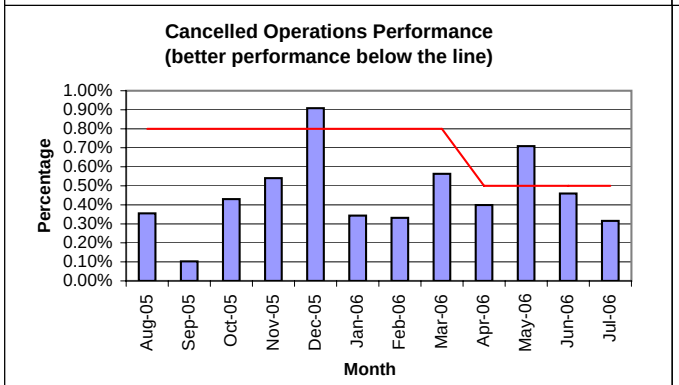
Name	Performance Last Month	YTD Performance	Target /Likely Threshold	Predicted Banding	Comments/Actions
Clinical risk management	CNST Level 2	CNST Level 2		Fully Met	The Trust achieved CNST Level 2 in January 2006.
Hospital cleanliness	92%	93%	60%	Fully Met	The Trust continues to perform well against this indicator.
Better Hospital Food	82%	90%	60%	Fully Met	The Trust continues to perform well against this indicator.
4 hour wait for emergency admission via A&E (trolley waits)	99.47%	99.09%	99.00%	Fully Met	The threshold to achieve the top band for this indicator in 2004/5 was 99%.
12 hour wait for emergency admission via A&E (trolley waits)	100%	100%	100%	Fully Met	There have not been any breaches of this standard so far this year.
Deaths following selected non-elective surgical procedures	0.78%	1.36%	1.00%	Almost Met	There was 1 death during July 2006, beinging the total to 10 year to date.
Emergency readmissions following discharge (adults)	12.32%	10.61%	11.40%	Fully Met	The Targets for these indicators are based on the expected performance derived from the Dr Foster toolkit.
Emergency readmissions following discharge for fractured hip	6.67%	3.61%	8.6%	Fully Met	
Information governance toolkit	85% (2005/06)	85%	70%	Fully Met	This indicator is assessed annually and is next due to be updated for year ending March 2006/07.
Patient complaints	89% (June 06)	93%	90%	Fully Met	Performance in June dipped slightly however the ytd position continues to meet the target.
Workforce indicator	IWL - Practice Plus; Junior Doctors Hours = 100%; Sickness Absence Rate = 3.55% to Jun 06				Data relating to HR indicators is not available until the end of the following month. The figures relate to June 2006.

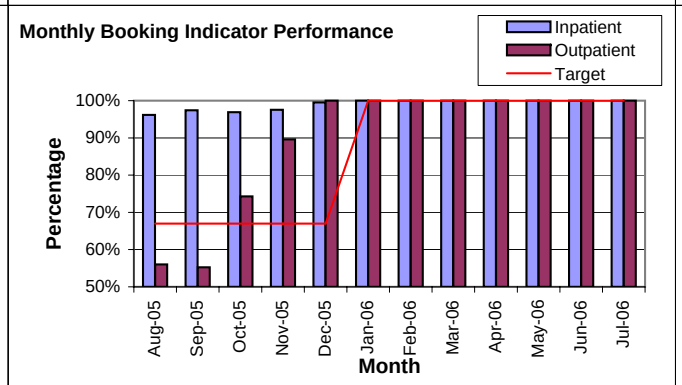
Indicator Graphs

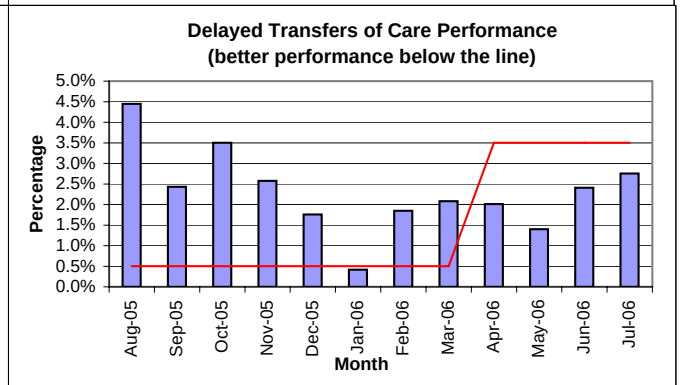


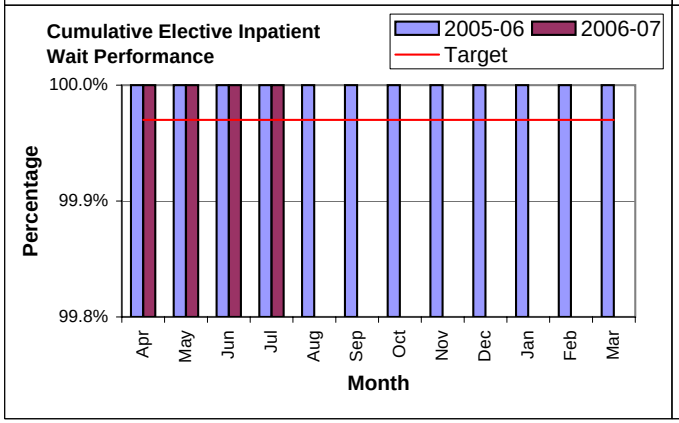


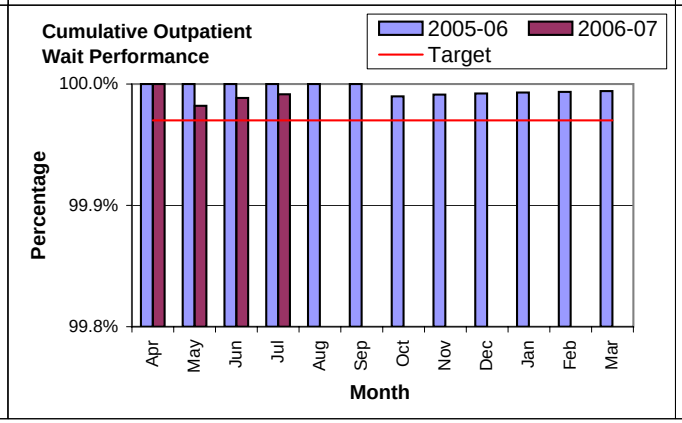


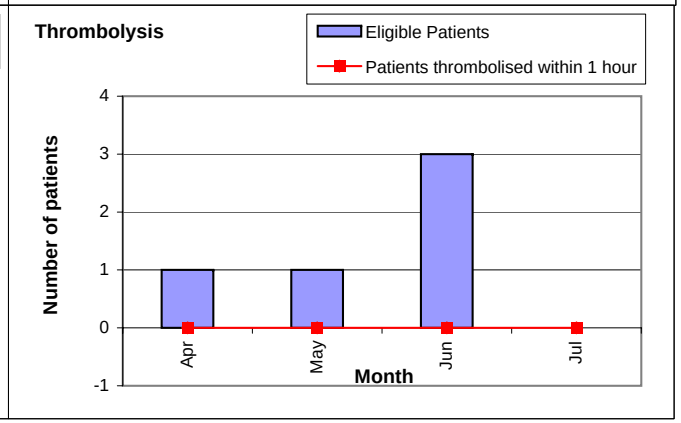






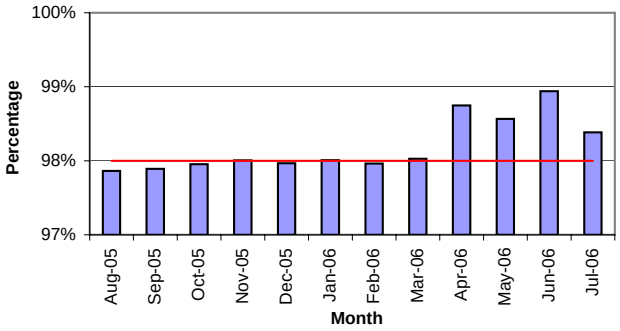




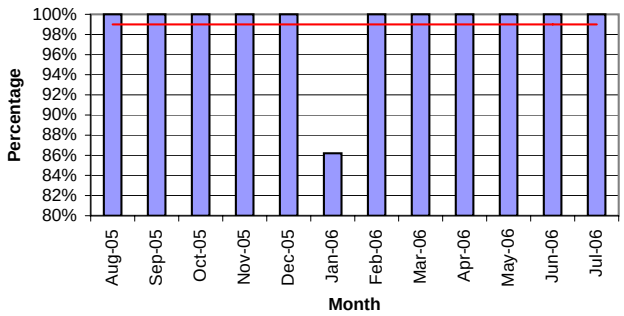


Indicator Graphs

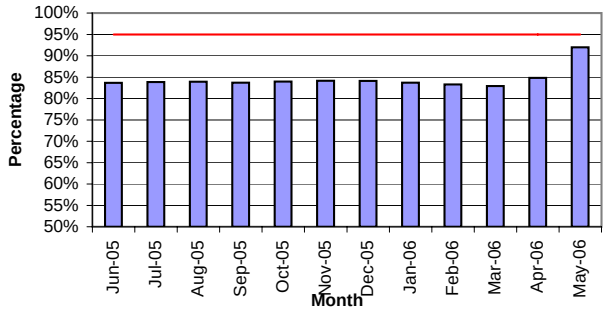
Cumulative Total Time in A&E Performance



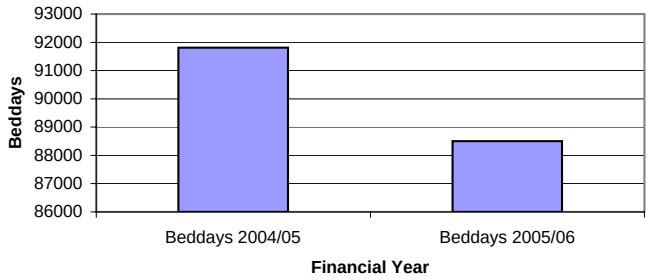
Waiting Time for RACPC Performance



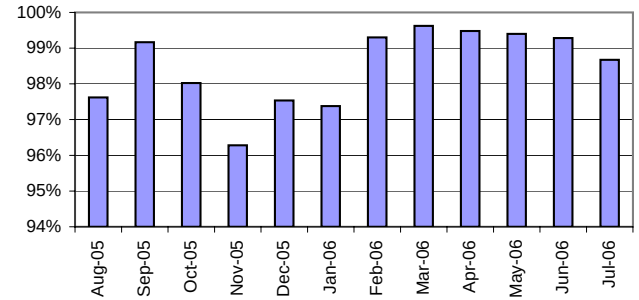
Inpatient Ethnic Coding Performance



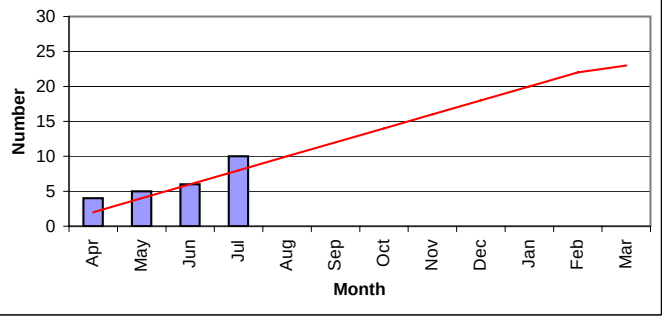
Emergency Bed Days
(a reduction in beddays shows better performance)



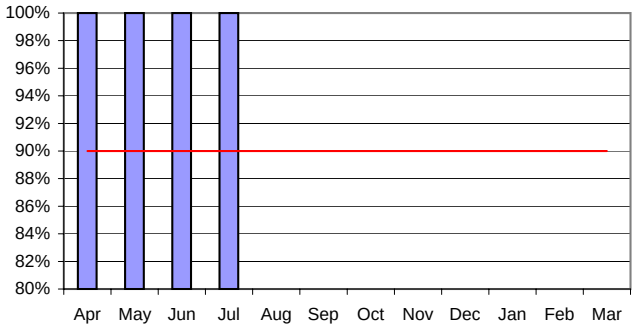
Infant Health Data Completeness



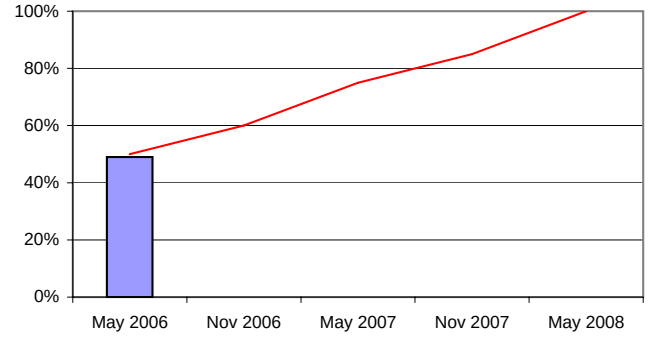
Cumulative MRSA Performance
(better perfrormance below the line)



MINAP Entries

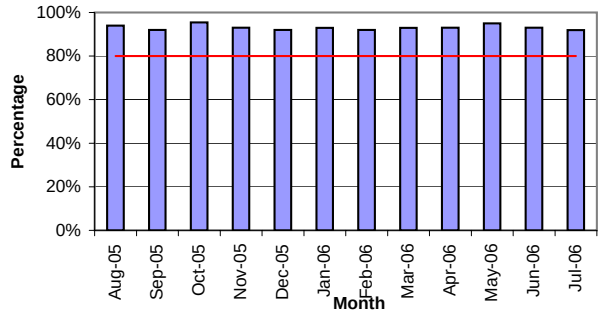


48 hour access to GUM clinics trajectory

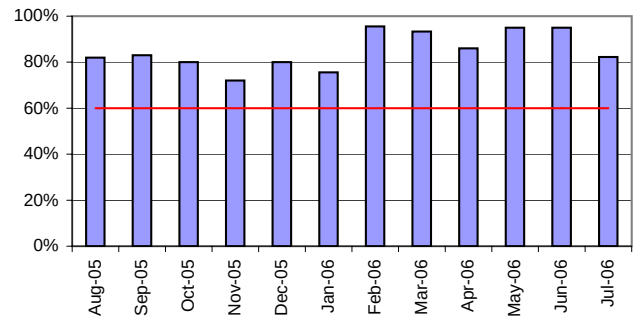


Indicator Graphs

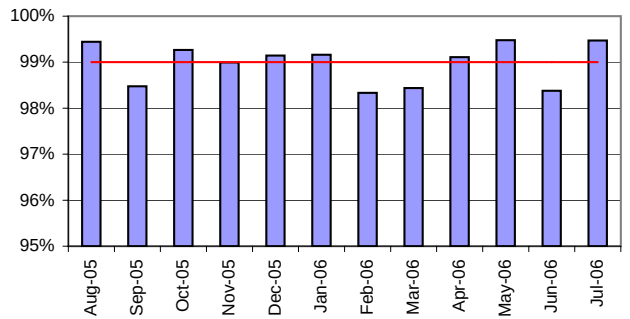
Hospital Cleanliness Performance



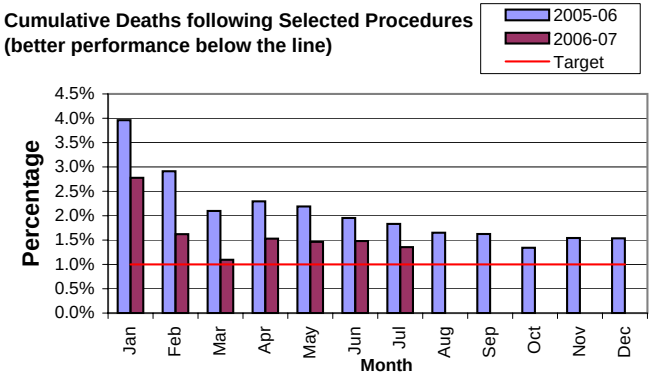
Better Hospital Food



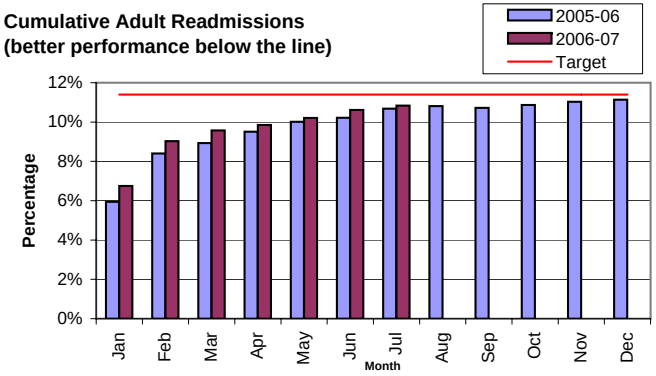
Four hour trolley waits



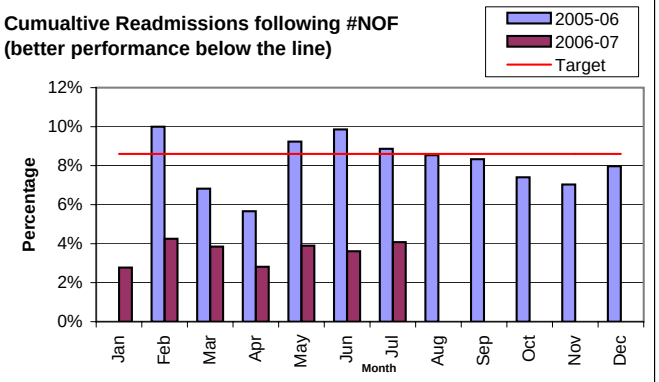
Cumulative Deaths following Selected Procedures (better performance below the line)



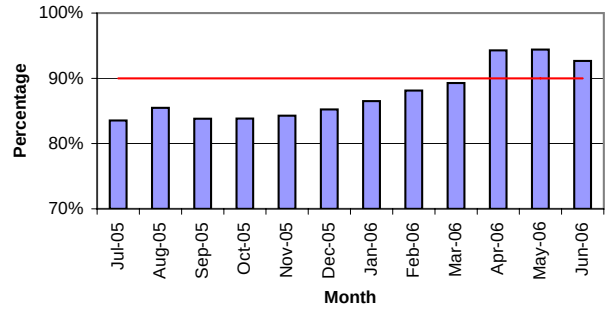
Cumulative Adult Readmissions (better performance below the line)



Cumualtive Readmissions following #NOF (better performance below the line)



Cumulative Patient Complaints Performance

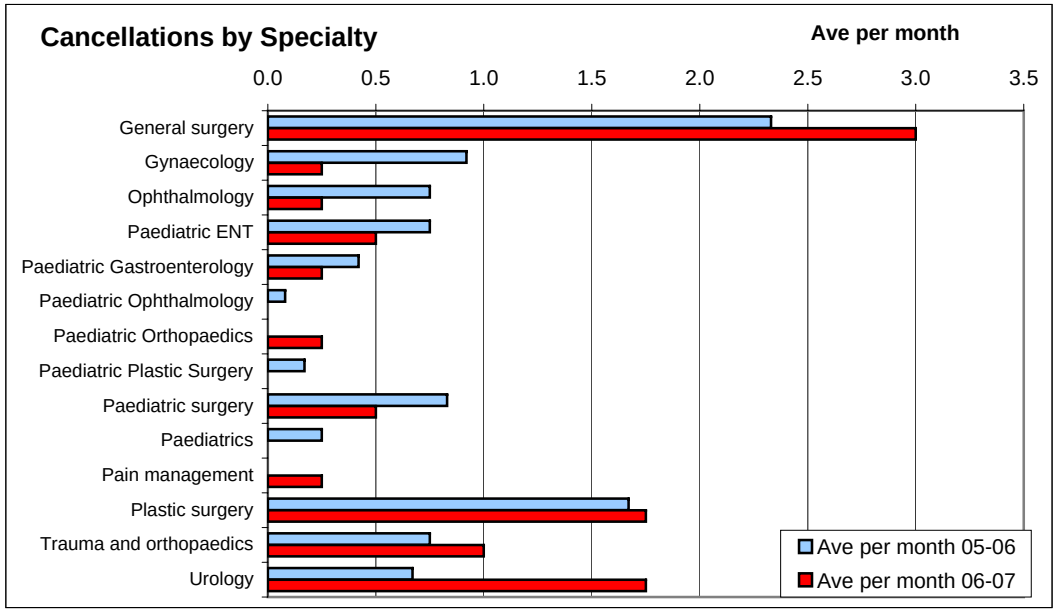


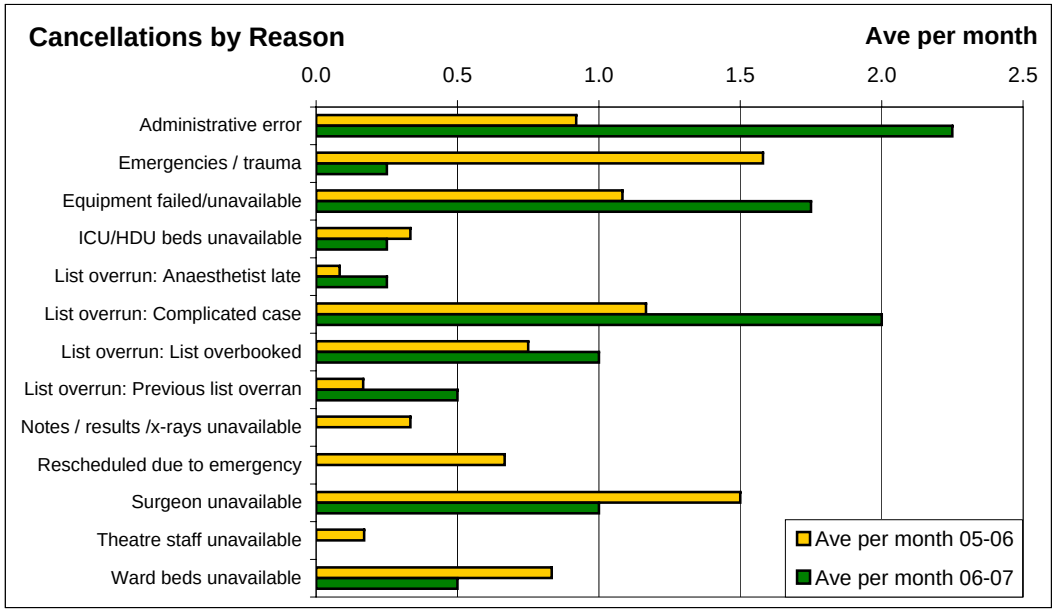
Cancelled Operations 2006-07

Cancelled Operations - Summary		
	2005 - 2006	2006 - 2007
Total Cancellations	1237	463
Reportable Cancellations	115	39
% of Activity	0.51%	0.46%
Average per week	2.2	2.3
Tolerance		113
Remaining cancellations to stay within tolerance		74
Ave. cancellations per week to stay within tolerance		2.1

Cancelled Operations - By Specialty		
Specialty	Ave per month 05-06	Ave per month 06-07
General surgery	2.3	3.0
Gynaecology	0.9	0.3
Ophthalmology	0.8	0.3
Paediatric ENT	0.8	0.5
Paediatric Gastroenterology	0.4	0.3
Paediatric Ophthalmology	0.1	0.0
Paediatric Orthopaedics	0.0	0.3
Paediatric Plastic Surgery	0.2	0.0
Paediatric surgery	0.8	0.5
Paediatrics	0.3	0.0
Pain management	0.0	0.3
Plastic surgery	1.7	1.8
Trauma and orthopaedics	0.8	1.0
Urology	0.7	1.8
TOTAL	**9.6**	**9.8**

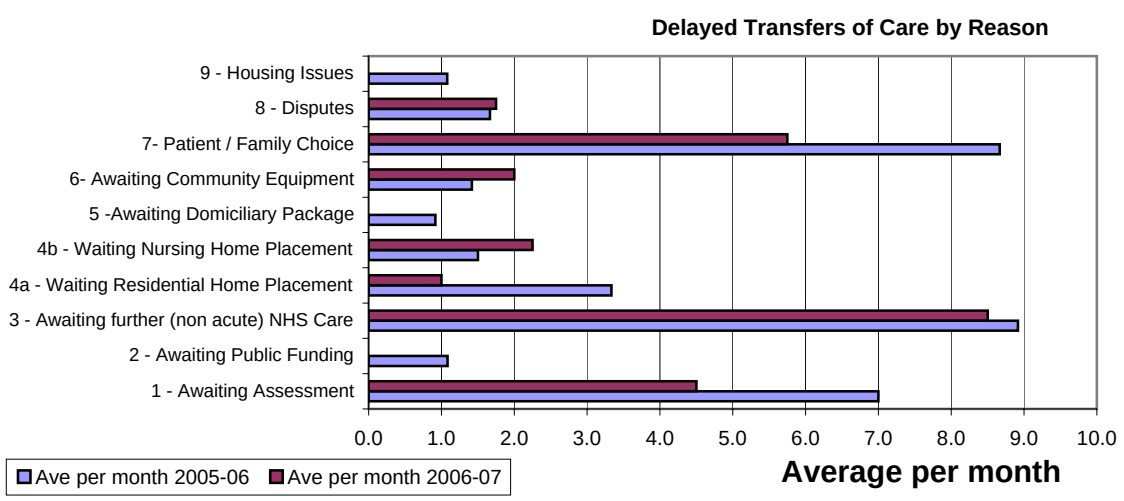
Cancelled Operations - By Reason		
Reason (Use pick list)	Ave per month 05-06	Ave per month 06-07
Administrative error	0.9	2.3
Emergencies / trauma	1.6	0.3
Equipment failed/unavailable	1.1	1.8
ICU/HDU beds unavailable	0.3	0.3
List overrun: Anaesthetist late	0.1	0.3
List overrun: Complicated case	1.2	2.0
List overrun: List overbooked	0.8	1.0
List overrun: Previous list overran	0.2	0.5
Notes / results /x-rays unavailable	0.3	0.0
Rescheduled due to emergency	0.7	0.0
Surgeon unavailable	1.5	1.0
Theatre staff unavailable	0.2	0.0
Ward beds unavailable	0.8	0.5
TOTAL	**9.6**	**9.8**



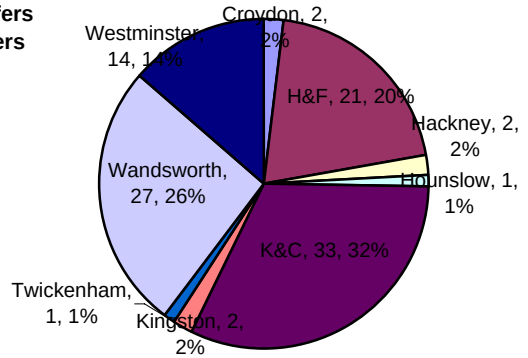


Delayed Transfers of Care 2006-07

Summary	2006-07	2005-06
Number of Delayed Transfers	103	442
Beddays used from Delayed Transfers	550	2372
Total Beds Occupied (from weekly sitrep)	4141	17247
% of Total Beds Occupied	2.49%	2.56%
Average per month	25.8	35.8
Annual Tolerance	604	
Remaining Tolerance	501	
Remaining Tolerance per month	62.6	



Delayed Transfers by PCT (numbers & percentage)



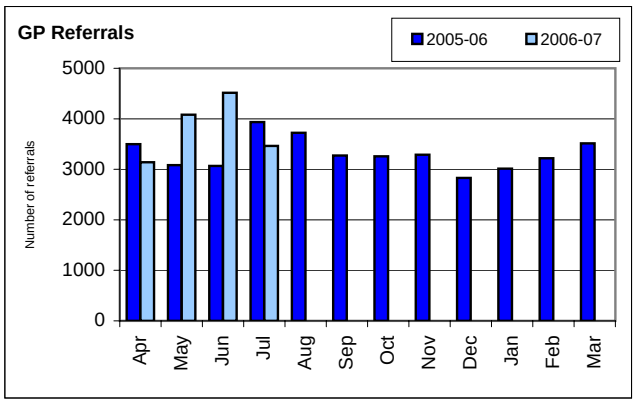
Specialty	Total
Dermatology	2
Elderly Medicine Acute	28
Gastro	6
Gastro HIV	1
General Medicine	26
General Surgery	2
Medical Oncology	1
Palliative Medicine	1
Respiratory	2
T&O	5
Grand Total	**74**

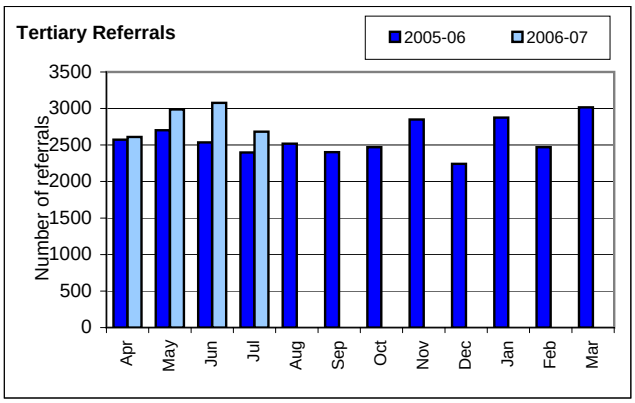
PCT	REASON	Number of Patients	Sum of Bed Days
H&F	1 - Awaiting Assessment	4	19
	3 - Awaiting further (non acute) NHS Care	5	24
	4b - Waiting Nursing Home Placement	3	21
	7- Patient / Family Choice	7	41
	4a - Waiting Residential Home Placement	1	2
	6- Awaiting Community Equipment	1	4
H&F Total		**21**	**111**
Hounslow	7- Patient / Family Choice	1	4
Hounslow Total		**1**	**4**
K&C	1 - Awaiting Assessment	5	18
	3 - Awaiting further (non acute) NHS Care	10	44
	4b - Waiting Nursing Home Placement	5	28
	7- Patient / Family Choice	11	63
	8 - Disputes	2	14
K&C Total		**33**	**167**
Twickenham	3 - Awaiting further (non acute) NHS Care	1	2
Twickenham Total		**1**	**2**
Wandsworth	1 - Awaiting Assessment	3	14
	3 - Awaiting further (non acute) NHS Care	13	79
	4b - Waiting Nursing Home Placement	1	1
	7- Patient / Family Choice	3	17
	6- Awaiting Community Equipment	7	39
Wandsworth Total		**27**	**150**
Westminster	1 - Awaiting Assessment	3	12
	3 - Awaiting further (non acute) NHS Care	3	16
	4a - Waiting Residential Home Placement	3	20
	8 - Disputes	5	35
Westminster Total		**14**	**83**
Kingston	3 - Awaiting further (non acute) NHS Care	2	9
Kingston Total		**2**	**9**
Hackney	1 - Awaiting Assessment	2	10
Hackney Total		**2**	**10**
Croydon	1 - Awaiting Assessment	1	7
	7- Patient / Family Choice	1	7
Croydon Total		**2**	**14**
Grand Total		**103**	**550**

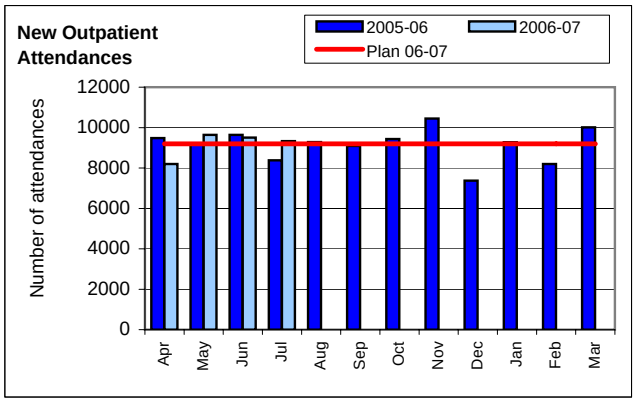
Breaches of the Thrombolysis Target	
Month	**Breach Reason**
Apr-06	1 patient CtoN >60min (long Call to Hospital time = 46min)
May-06	1 patient CtoN >60min. Call to needle time 98 minutes, ambulance took 63 minutes to arrive at the hospital
Jun-06	3 patients CtoN >60 min (1 patient call to hospital time 76 mins, comment from LAS "difficult entry to patient's housing block", 1 patient call to hospital time 64 mins, 1 patient door to needle time 39 mins due to delays in the process.)

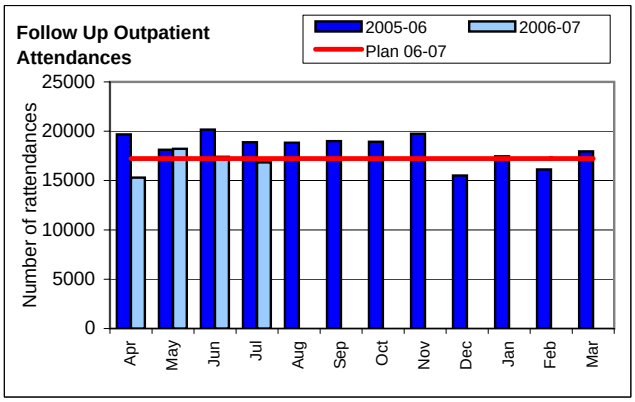
Breaches of the Outpatient Waiting Time Target	
Month	**Breach Reason**
May-06	Dermatology patient - referral letter was misfiled after prioritisation and not added to the pend list. The incident is to be reviewed through the serious untoward incident process.

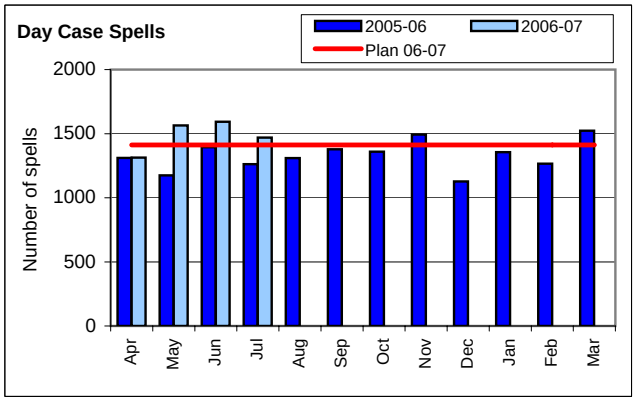
Activity Graphs

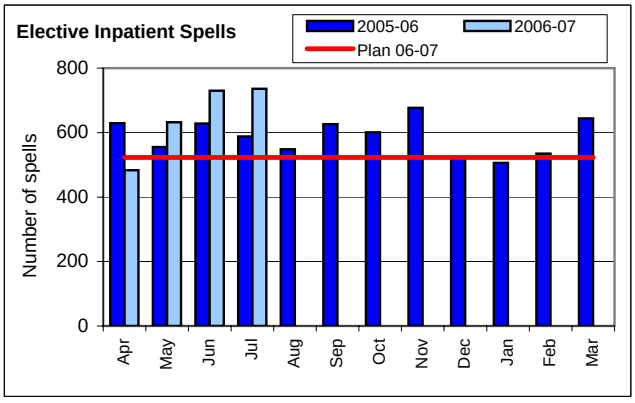


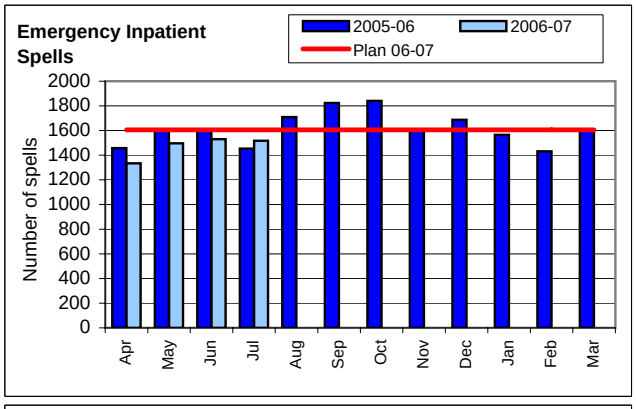


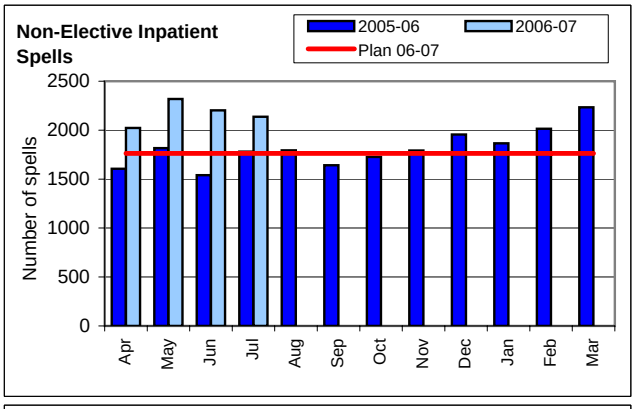


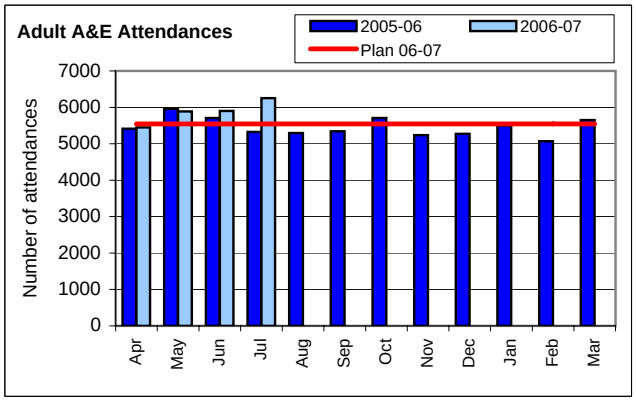


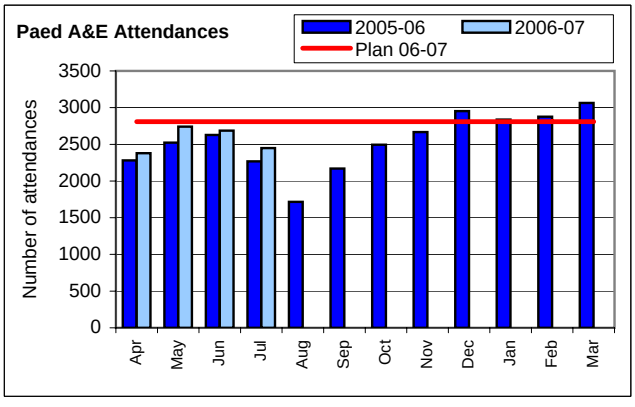












Activity Report - July 06

GP Referrals

Data to be validated

Directorate	Actual Jul 05	Actual Jul 06	Actual M1-M4 2005/06	Actual M1-M4 2006/07	Capacity Plan M1-M4 2006/07	Variance on plan
A & I	43	64	213	241	190	27%
HIV	2	4	6	17	10	76%
GUM	2	1	3	14	15	-9%
MEDICINE	1321	1090	4941	5085	4755	7%
SURGERY	678	740	2933	3490	2906	20%
W & C	1889	1564	5485	6353	5357	19%
TRUST	**3935**	**3463**	**13581**	**15200**	**13233**	**15%**

Other Referrals

Data to be validated

Directorate	Actual Jul 05	Actual Jul 06	Actual M1-M4 2005/06	Actual M1-M4 2006/07	Capacity Plan M1-M4 2006/07	Variance on plan
A & I	74	38	225	234	243	-4%
HIV	113	129	366	447	389	15%
GUM	58	285	225	1460	464	215%
MEDICINE	558	399	2000	1791	2013	-11%
SURGERY	639	792	2852	3046	2986	2%
W & C	956	1040	4540	4381	4255	3%
TRUST	**2398**	**2683**	**10208**	**11359**	**10350**	**10%**

1st Outpatient Attendances

Directorate	Actual Jul 05	Actual Jul 06	Actual M1-M4 2005/06	Actual M1-M4 2006/07	Capacity Plan M1-M4 2006/07	Variance on plan
A & I	55	73	302	305	282	8%
HIV	255	332	1129	1558	1275	22%
GUM	3306	3795	13948	14815	14948	-1%
MEDICINE	1621	1717	6659	6690	6554	2%
SURGERY	1146	1445	5574	5310	5459	-3%
W & C	1999	1971	9075	7996	8266	-3%
TRUST	**8382**	**9333**	**36687**	**36674**	**36784**	**-0%**

Follow-Up Outpatient Attendnances

Directorate	Actual Jul 05	Actual Jul 06	Actual M1-M4 2005/06	Actual M1-M4 2006/07	Capacity Plan M1-M4 2006/07	Variance on plan
A & I	198	154	729	690	732	-6%
HIV	2917	2127	10559	7724	10944	-29%
GUM	1243	1287	5199	5073	5267	-4%
MEDICINE	5946	5323	24058	20676	20445	1%
SURGERY	4144	3892	17546	15892	14697	8%
W & C	4435	4049	18761	17690	16842	5%
TRUST	**18883**	**16832**	**76852**	**67745**	**68927**	**-2%**

Elective Inpatient Spells

Change in Medicine figures being investigated

Directorate	Actual Jul 05	Actual Jul 06	Actual M1-M4 2005/06	Actual M1-M4 2006/07	Capacity Plan M1-M4 2006/07	Variance on plan
A & I	17	20	69	111	152	-27%
HIV	7	27	33	99	41	141%
GUM	0	0	0	0	47	-100%
MEDICINE	48	165	201	384	156	146%
SURGERY	307	325	1321	1280	1042	23%
W & C	209	199	776	707	655	8%
TRUST	**588**	**736**	**2400**	**2581**	**2093**	**23%**

Day Case Spells

Directorate	Actual Jul 05	Actual Jul 06	Actual M1-M4 2005/06	Actual M1-M4 2006/07	Capacity Plan M1-M4 2006/07	Variance on plan
A & I	11	32	104	136	106	28%
HIV	1	84	3	257	3	8467%
GUM	0	0	0	0	2	-100%
MEDICINE	717	725	2841	2900	2784	4%
SURGERY	275	353	1235	1457	1564	-7%
W & C	258	276	959	1190	1189	0%
TRUST	**1262**	**1470**	**5142**	**5940**	**5648**	**5%**

Emergency Inpatient Spells

Directorate	Actual Jul 05	Actual Jul 06	Actual M1-M4 2005/06	Actual M1-M4 2006/07	Capacity Plan M1-M4 2006/07	Variance on plan
A & I	14	160	442	483	796	-39%
HIV	30	76	160	273	382	-29%
GUM	0	0	0	0	193	-100%
MEDICINE	517	515	2011	1998	2068	-3%
SURGERY	469	377	1738	1472	1612	-9%
W & C	423	389	1759	1652	1718	-4%
TRUST	**1453**	**1517**	**6110**	**5878**	**6769**	**-13%**

Non-Elective Inpatient Spells

Directorate	Actual Jul 05	Actual Jul 06	Actual M1-M4 2005/06	Actual M1-M4 2006/07	Capacity Plan M1-M4 2006/07	Variance on plan
A & I	51	18	91	25	41	-39%
GUM	1	3	12	14	20	-30%
GUM	0	0	0	0	0	
MEDICINE	2	2	15	11	11	0%
SURGERY	11	7	33	18	19	-5%
W & C	890	1299	3487	4855	3898	25%
NICU & SCBU	825	808	3104	3759	3129	20%
TRUST	**1780**	**2137**	**6742**	**8682**	**7118**	**22%**

A&E Attendances

Department	Actual Jul 05	Actual Jul 06	Actual M1-M4 2005/06	Actual M1-M4 2006/07	Capacity Plan M1-M4 2006/07	Variance on plan
Adult A&E	5327	6252	22411	23491	22178	6%
Paed A&E	2267	2449	9698	10257	11230	-9%
Total A&E	**7594**	**8701**	**32109**	**33748**	**33408**	**1%**

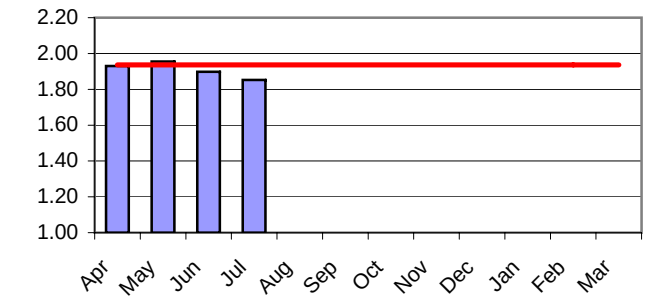
Deliveries

Directorate	Actual Jul 05	Actual Jul 06	Actual M1-M4 2005/06	Actual M1-M4 2006/07	Capacity Plan M1-M4 2006/07	Variance on plan
Deliveries	319	378	1312	1482	1417	5%
Spells	521	881	1941	3233	2155	50%

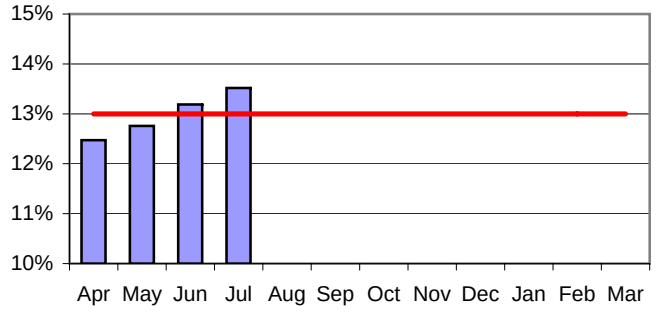
Efficiency Indicator Trends 2006-07

Better performance below the line unless indicated

New to Follow up Rate

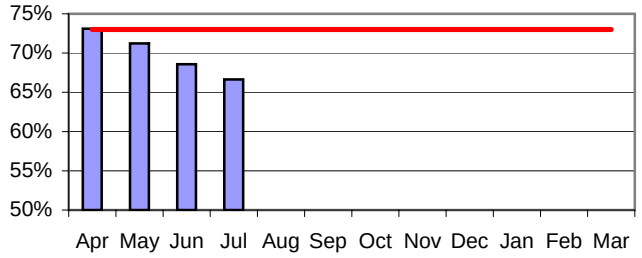


OP DNA Rate

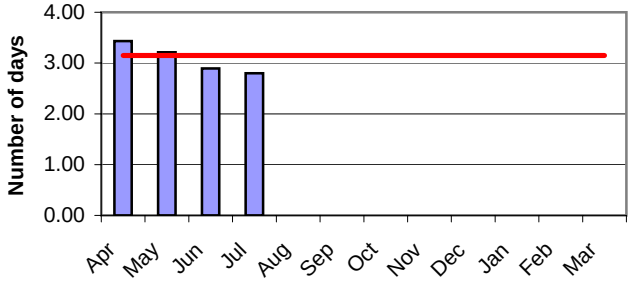


Day Case Rate

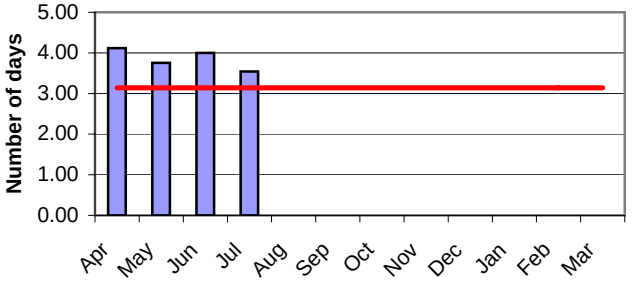
(better performance above the line)



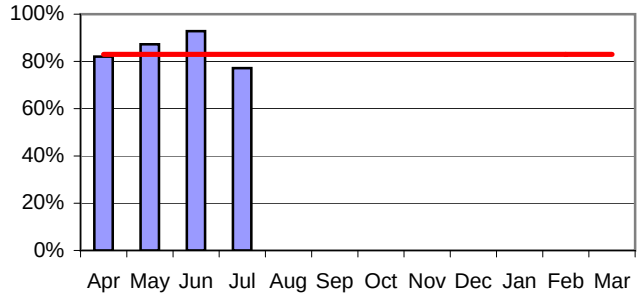
Elective Inpatient Length of Stay



Non-Elective Inpatient Length of Stay

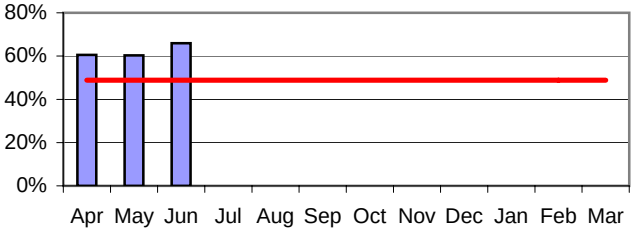


Bed Occupancy Rate

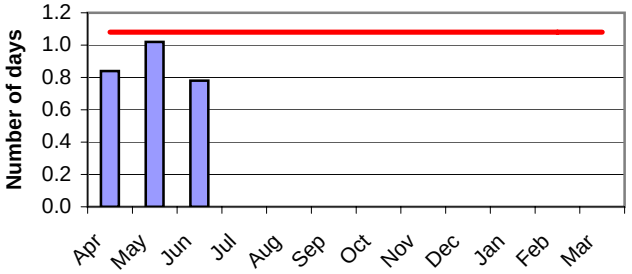


Elective Inpatients Admitted on Day of Surgery

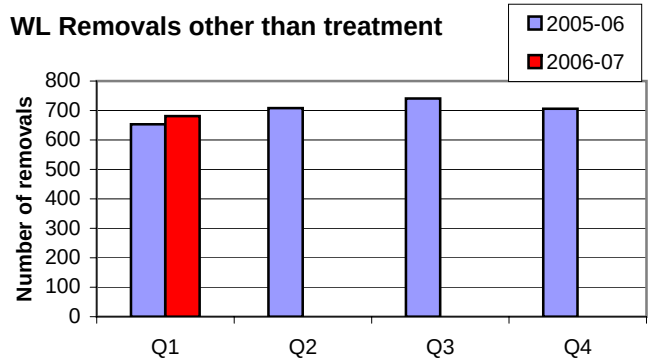
(better performance above the line)

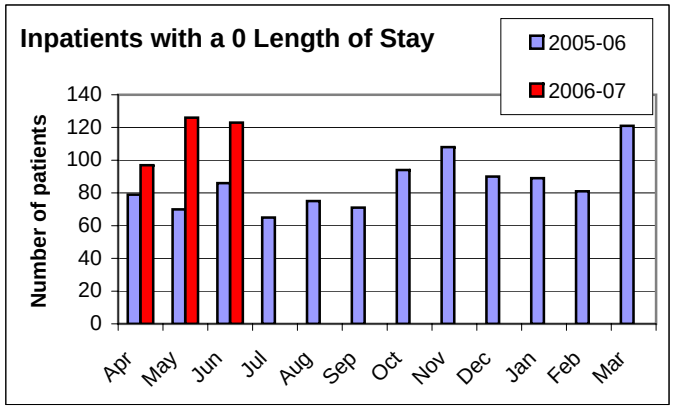


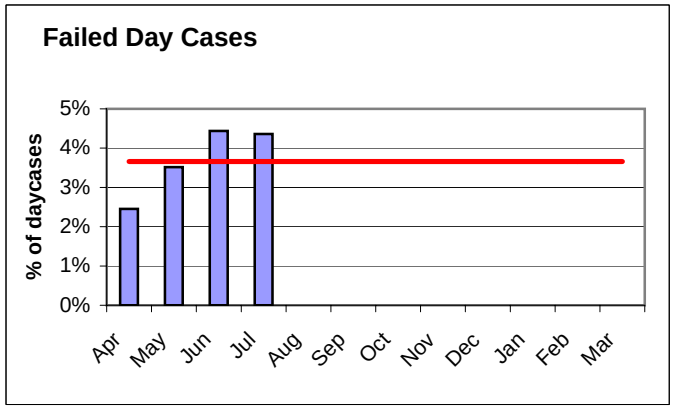
Average Pre-operative Length of Stay

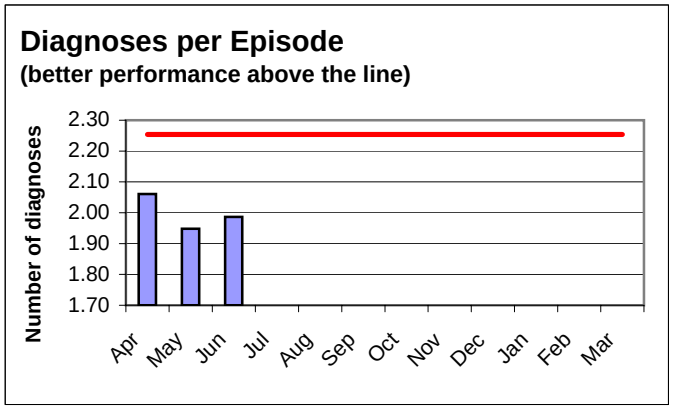


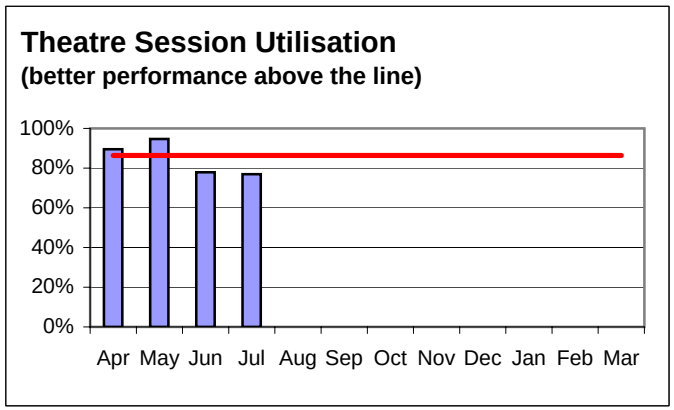
WL Removals other than treatment

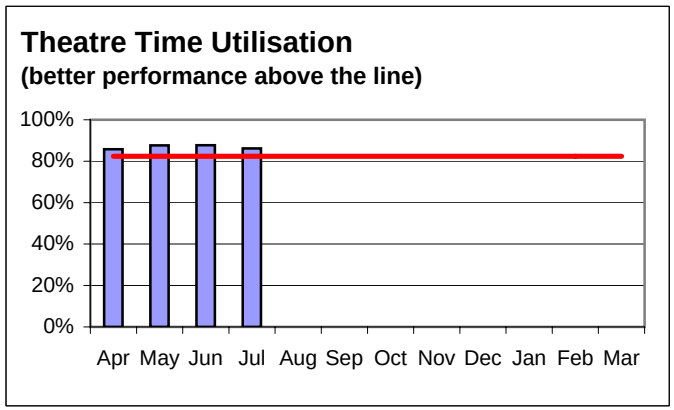


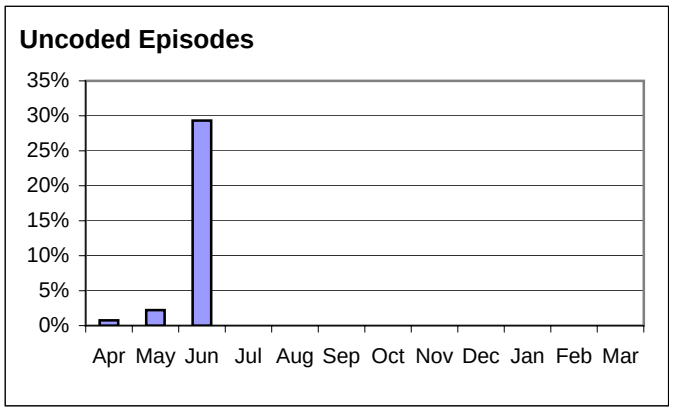

Inpatients with a 0 Length of Stay
2005-06
2006-07
Number of patients
140
120
100
80
60
40
20
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

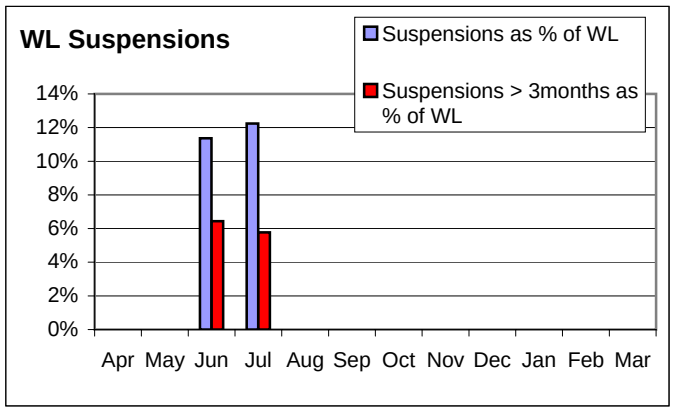

Failed Day Cases
% of daycases
5%
4%
3%
2%
1%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar


Diagnoses per Episode
(better performance above the line)
Number of diagnoses
2.30
2.20
2.10
2.00
1.90
1.80
1.70
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar


Theatre Session Utilisation
(better performance above the line)
100%
80%
60%
40%
20%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar


Theatre Time Utilisation
(better performance above the line)
100%
80%
60%
40%
20%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar


Uncoded Episodes
35%
30%
25%
20%
15%
10%
5%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar


WL Suspensions
Suspensions as % of WL
Suspensions > 3months as % of WL
14%
12%
10%
8%
6%
4%
2%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

Trust Board Efficiency Report - July 2006

Figures in Red show variance against target or average

New to Follow-up Outpatient Rate			
Directorate	Jul-06	Year-to-Date	Target (Capacity Plan)
A&I	2.11	2.26	2.60
HIV / GUM	0.83	0.78	1.00
MEDICINE	3.10	3.09	3.41
SURGERY	2.69	2.99	2.69
W&C	2.05	2.21	2.04
TRUST	**1.85**	**1.91**	**1.94**

Outpatient DNA Rate			
Directorate	Jul-06	Year-to-Date	Target (Average 2005-06)
A&I	18.1%	14.2%	16.0%
HIV / GUM	Data unavailable at this time		
MEDICINE	12.9%	13.3%	13.1%
SURGERY	13.9%	13.4%	14.3%
W&C	13.7%	12.4%	13.3%
TRUST	**13.5%**	**13.0%**	**13.2%**

Average Elective Inpatient Length of Stay			
Directorate	Jul-06	Year-to-Date	Target (Capacity Plan)
A&I	1.38	3.30	1.38
HIV / GUM	7.92	5.71	3.61
MEDICINE	5.34	7.03	5.96
SURGERY	2.73	2.90	3.36
W&C	1.74	2.10	2.62
TRUST	**2.80**	**3.06**	**3.15**

Average Non-Elective Inpatient Length of Stay			
Directorate	Jul-06	Year-to-Date	Target (Capacity Plan)
A&I	6.00	6.70	1.05
HIV / GUM	4.35	5.06	4.92
MEDICINE	7.75	8.46	7.38
SURGERY	5.45	5.24	4.67
W&C	1.97	2.11	2.04
TRUST	**3.54**	**3.85**	**3.14**

Day Case Rate			
Directorate	Jul-06	Year-to-Date	Target (Capacity Plan)
A&I	61.5%	55.1%	79.7%
HIV / GUM	75.7%	72.2%	5.4%
MEDICINE	81.5%	88.3%	91.5%
SURGERY	52.1%	53.2%	60.0%
W&C	58.1%	62.7%	64.6%
TRUST	**66.6%**	**69.7%**	**73.0%**

% of Elective Inpatients Admitted on the Day of Surgery			
Directorate	Jun-06	Year-to-Date	2005-06 average per month
A&I	0%	50%	77%
HIV / GUM	50%	18%	9%
MEDICINE	62%	56%	43%
SURGERY	62%	58%	48%
W&C	74%	74%	50%
TRUST	**66%**	**62%**	**49%**

Average Elective Inpatient Pre-Operative Length of Stay			
Directorate	Jun-06	Year-to-Date	2005-06 average per month
A&I	0.00	4.00	1.55
HIV / GUM	2.00	3.79	2.27
MEDICINE	1.38	2.11	3.12
SURGERY	0.86	0.91	0.93
W&C	0.52	0.50	1.17
TRUST	**0.78**	**0.89**	**1.08**

Un-coded Episodes		
Directorate	Jun-06	Year-to-Date
A&I	68%	29%
HIV / GUM	64%	41%
MEDICINE	24%	10%
SURGERY	10%	4%
W&C	41%	15%
TRUST	**29%**	**12%**

Average Number of Diagnoses Per Episode			
Directorate	Jun-06	Year-to-Date	Target (CHKS Peer)
A&I	3.11	3.06	3.44
HIV / GUM	2.55	3.90	4.47
MEDICINE	2.20	2.24	2.61
SURGERY	1.82	1.81	2.07
W&C	1.76	1.73	1.91
TRUST	**1.99**	**2.00**	**2.25**

NB - Coding figures have a 1 month time lag

Midnight Bed Occupancy Rate			
Directorate	Jul-06	Year-to-Date	Target
HIV / GUM	81.6%	77.3%	159%
MEDICINE	78.9%	91.2%	85%
SURGERY A&I	79.6%	86.2%	82%
W&C	72.7%	78.1%	79%
TRUST	**77.1%**	**84.8%**	**81%**

Failed Day Cases			
Directorate	Jul-06	Year-to-Date	2005-06 average per month
A&I	5.9%	4.2%	7.5%
HIV / GUM	14.3%	12.6%	25.0%
MEDICINE	1.4%	1.5%	1.8%
SURGERY	6.9%	6.0%	5.6%
W&C	5.2%	4.1%	4.9%
TRUST	**4.4%**	**3.7%**	**3.7%**

Elective Inpatients with 0 days Length of Stay			
Directorate	Jun-06	Year-to-Date Average per month	2005-06 average per month
A&I	0	0	3
HIV / GUM	0	1	1
MEDICINE	12	12	12
SURGERY	68	64	42
W&C	43	39	28
TRUST	**123**	**115**	**86**

Note - data excludes uncoded spells

Waiting List Suspensions			
Directorate	Jul-06	% of WL Jul-06	% of WL last month
A&I	7	4%	4%
SURGERY	327	14%	12%
W&C	116	10%	10%
TRUST	450	12%	11%

Waiting List Suspensions > 3 Months			
Directorate	Jul-06	% of suspensions	% of suspensions last month
A&I	4	57%	57%
SURGERY	152	46%	58%
W&C	56	48%	53%
TRUST	212	47%	57%

Figures exclude activity related to Pre-operative Assessment.

Elective Waiting List Removals other than Treatment			
Directorate	**Q1 06-07**	**Year-to-Date**	**2005-06 average per quarter**
A&I	4	4	6
HIV / GUM	0	0	0
MEDICINE	1	1	0
SURGERY	441	441	451
W&C	235	235	245
TRUST	**681**	**681**	**702**

Inpatient Theatre Session Utilisation (Session used as % of forecast)			
Directorate	**Jul-06**	**Year-to-Date**	**2005-06**
Treatment Centre Surgery	95.0%	94.3%	91.3%
Treatment Centre W&C	84.0%	94.7%	89.1%
Main/Paed Theatres Surgery	77.8%	85.8%	89.0%
Main/Paed Theatres W&C	97.4%	97.6%	96.1%
TRUST	**76.9%**	**91.8%**	**91.3%**

Inpatient Theatre Time Utilisation (Session used as % of forecast)			
Directorate	**Jul-06**	**Year-to-Date**	**2005-06**
Treatment Centre Surgery	77.1%	78.7%	80.3%
Treatment Centre W&C	76.7%	78.6%	80.7%
Main/Paed Theatres Surgery	92.5%	93.2%	92.1%
Main/Paed Theatres W&C	97.7%	94.2%	90.8%
TRUST	**86.2%**	**86.9%**	**87.1%**

NB - Data relates to all of June 06 except the treatment centre which is up until 14th June.
Women & Children's includes obstetrics, Surgery/A&I includes Burns and Hand Theatres

Theatre Late Starts			
Directorate	**Jul-06**	**Year-to-Date**	**Target Rate**
A&I			
HIV / GUM			
MEDICINE			
SURGERY			
W&C			
TRUST			

Theatre Overruns			
Directorate	**Jul-06**	**Year-to-Date**	**Target Rate**
A&I			
HIV / GUM			
MEDICINE			
SURGERY			
W&C			
TRUST			

Theatre Underruns			
Directorate	**Jul-06**	**Year-to-Date**	**Target Rate**
A&I			
HIV / GUM			
MEDICINE			
SURGERY			
W&C			
TRUST			

Theatre Cases per List			
Directorate	**Jul-06**	**Year-to-Date**	**Target Rate**
A&I			
HIV / GUM			
MEDICINE			
SURGERY			
W&C			
TRUST			

Percentage of Missing Notes (Outpatients)			
Directorate	**Jul-06**	**Year-to-Date**	**Target Rate**
A&I			
HIV / GUM			
MEDICINE			
SURGERY			
W&C			
TRUST			

Percentage of Missing Notes (Elective Admissions)			
Directorate	**Jul-06**	**Year-to-Date**	**Target Rate**
A&I			
HIV / GUM			
MEDICINE			
SURGERY			
W&C			
TRUST			

Outliers			
Directorate	**Jul-06**	**Year-to-Date**	**Target Rate**
A&I			
HIV / GUM			
MEDICINE			
SURGERY			
W&C			
TRUST			

Critical Care Transfers			
Directorate	**Jul-06**	**Year-to-Date**	**Target Rate**
A&I			
HIV / GUM			
MEDICINE			
SURGERY			
W&C			
TRUST			

Data Quality - Missing Items			
Directorate	**Jul-06**	**Year-to-Date**	**Target Rate**
A&I			
HIV / GUM			
MEDICINE			
SURGERY			
W&C			
TRUST			

% of Elective Patients who had a Pre-Op Assessment			
Directorate	**Jun-06**	**Year-to-Date**	**2005-06 average per month**
A&I			
HIV / GUM			
MEDICINE			
SURGERY			
W&C			
TRUST			

Figures exclude activity related to Pre-operative Assessment.

HR Report

	Headcount			WTEs		
Directorate	**Jul-05**	**Jul-06**	**Variance**	**Jul-05**	**Jul-06**	**Variance**
A&I	390	421	31	363.5	392.5	29.0
HIV/GUM	236	235	-1	215.4	215.6	0.2
MEDICINE	493	481	-12	448.9	438.0	-11.0
SURGERY	283	276	-7	270.4	263.7	-6.7
W&C	586	640	54	515.6	569.5	53.9
CLINICAL SUPPORT	223	241	18	210.0	225.0	14.9
PRIVATE PATIENTS	46	42	-4	43.0	38.1	-4.9
MGT EXEC	252	252	0	241.1	242.0	0.9
Trust	**2509**	**2588**	**79**	**2307.9**	**2384.1**	**76.2**

Bank Staff (WTEs)

Directorate	**Jul-05**	**Jul-06**	**Variance**	**Ave M1-M4 2005/06**	**Ave M1-M4 2006/07**	**Variance**
A&I	44.1	36.4	-7.7	42.8	44.6	1.8
HIV/GUM	26.9	22.0	-4.9	22.0	22.4	0.4
MEDICINE	83.6	77.1	-6.6	80.1	71.8	-8.3
SURGERY	32.9	40.0	7.1	29.8	39.2	9.4
W&C	103.0	109.4	6.4	91.5	104.2	12.7
CLINICAL SUPPORT	11.6	9.3	-2.2	7.2	8.8	1.6
PRIVATE PATIENTS	5.6	6.8	1.2	5.8	6.8	1.0
MGT EXEC	56.4	46.6	-9.8	52.4	43.1	-9.2
Trust	**364.1**	**347.5**	**-16.6**	**331.5**	**340.9**	**9.4**

Agency Staff (WTEs)

Directorate	**Jul-05**	**Jul-06**	**Variance**	**Ave M1-M4 2005/06**	**Ave M1-M4 2006/07**	**Variance**
A&I	22.3	3.8	-18.5	21.7	4.8	-16.9
HIV/GUM	4.6	0.9	-3.7	3.7	2.0	-1.7
MEDICINE	19.1	12.5	-6.7	22.7	17.1	-5.6
SURGERY	9.8	3.5	-6.3	9.5	10.3	0.9
W&C	28.2	6.2	-22.0	28.4	18.4	-10.0
CLINICAL SUPPORT	4.2	1.0	-3.1	2.3	1.1	-1.2
PRIVATE PATIENTS	0.3	0.0	-0.3	0.6	0.4	-0.2
MGT EXEC	11.3	10.3	-1.0	11.5	9.3	-2.3
Trust	**99.8**	**38.1**	**-61.6**	**100.4**	**63.4**	**-37.0**

Planned Staff Turnover (%)

Directorate	**Jul-05**	**Jul-06**	**Variance**	**Ave M1-M4 2005/06**	**Ave M1-M4 2006/07**	**Variance**
A&I	1.8	0.7	-1.1	1.4	1.1	-0.3
HIV/GUM	0.8	0.4	-0.4	0.3	0.4	0.1
MEDICINE	0.4	0.4	0.0	0.5	0.4	-0.1
SURGERY	0.4	2.6	2.2	0.9	1.1	0.2
W&C	0.0	0.2	0.2	0.3	0.4	0.0
CLINICAL SUPPORT	2.5	2.9	0.4	0.7	0.7	0.0
PRIVATE PATIENTS	0.0	0.0	0.0	0.0	0.0	0.0
MGT EXEC	0.4	0.0	-0.4	0.3	0.0	-0.3
Trust	**6.2**	**7.2**	**0.9**	**4.5**	**4.1**	**-0.5**

Unplanned Staff Turnover (%)

Directorate	**Jul-05**	**Jul-06**	**Variance**	**Ave M1-M4 2005/06**	**Ave M1-M4 2006/07**	**Variance**
A&I	0.8	0.7	-0.0	1.0	0.6	-0.4
HIV/GUM	0.8	2.1	1.3	0.8	1.5	0.6
MEDICINE	2.0	1.5	-0.6	1.3	1.4	0.2
SURGERY	0.7	0.7	0.0	0.6	0.5	-0.1
W&C	1.7	0.6	-1.1	1.0	0.8	-0.3
CLINICAL SUPPORT	1.6	2.5	0.9	1.7	1.6	-0.1
PRIVATE PATIENTS	0.0	2.2	2.2	0.0	0.6	0.6
MGT EXEC	0.8	0.8	-0.0	1.2	1.4	0.1
Trust	**8.4**	**11.1**	**2.7**	**7.7**	**8.4**	**0.7**

Vacancy Rate (%)

Directorate	**Jul-05**	**Jul-06**	**Variance**	**Ave M1-M4 2005/06**	**Ave M1-M4 2006/07**	**Variance**
A&I	14.8	9.1	-5.7	14.2	10.2	-4.0
HIV/GUM	12.6	18.4	5.8	11.5	17.5	6.1
MEDICINE	12.2	15.7	3.5	12.2	14.4	2.1
SURGERY	14.5	17.6	3.0	13.5	18.0	4.4
W&C	18.4	11.7	-6.8	16.3	12.3	-4.0
CLINICAL SUPPORT	16.4	10.5	-5.9	17.6	10.0	-7.6
PRIVATE PATIENTS	10.0	19.1	9.1	7.5	15.3	7.8
MGT EXEC	18.5	18.2	-0.3	21.5	17.9	-3.6
Trust	**15.4**	**14.1**	**-1.3**	**14.9**	**13.9**	**-1.0**

2006/07 data based on establishement for 05/06 as 06/07 budget not ready yet

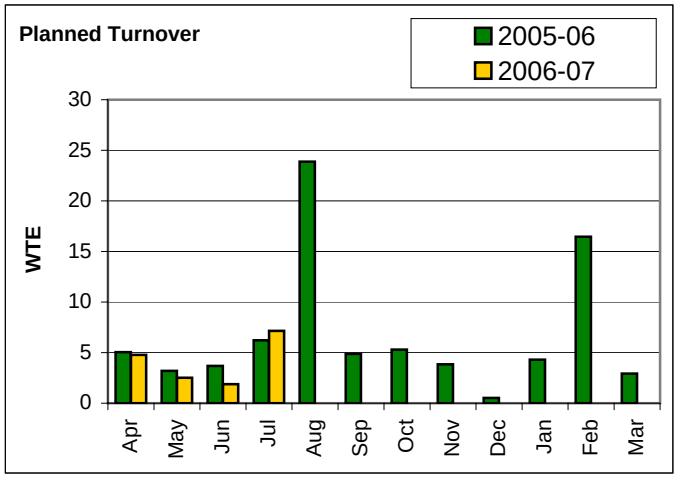
Sick Leave (%)

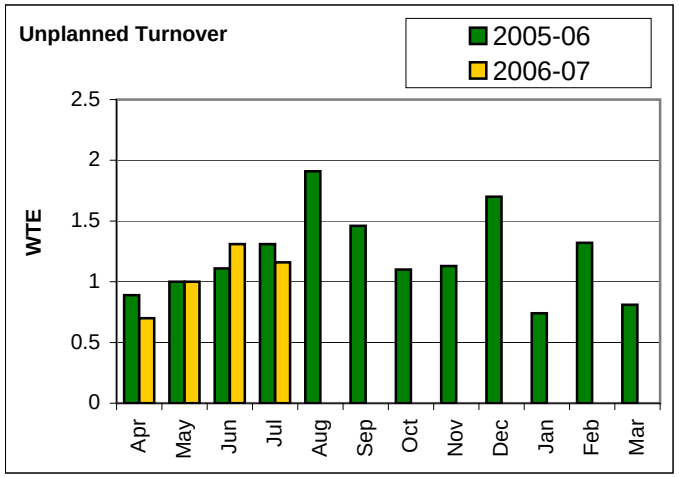
Directorate	**Jun-05**	**Jun-06**	**Variance**	**Ave M1-M3 2005/06**	**Ave M1-M3 2006/07**	**Variance**
A&I	1.8	3.9	2.1	2.5	3.5	1.0
HIV/GUM	3.6	3.8	0.2	3.6	4.0	0.4
MEDICINE	4.0	3.3	-0.6	3.5	3.4	-0.1
SURGERY	4.4	3.1	-1.3	3.5	3.6	0.1
W&C	3.0	5.0	2.0	3.8	4.3	0.5
CLINICAL SUPPORT	2.5	2.3	-0.2	2.5	2.3	-0.2
PRIVATE PATIENTS	3.4	2.8	-0.6	1.4	3.0	1.6
MGT EXEC	3.1	2.5	-0.6	2.5	3.4	0.9
Trust	**3.2**	**3.7**	**0.5**	**3.2**	**3.6**	**0.4**

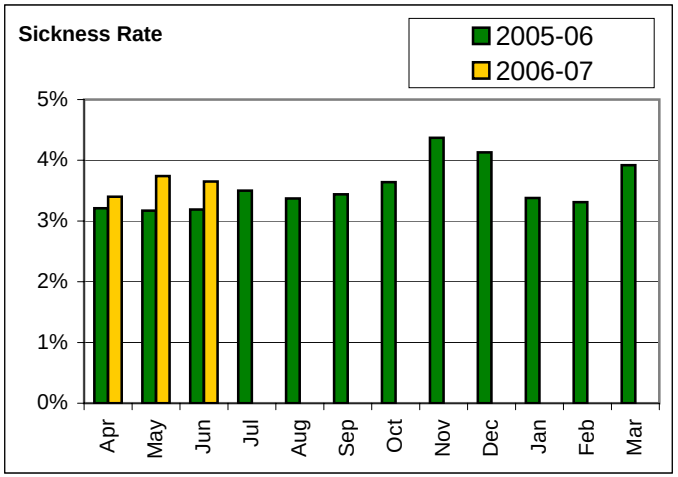
Sickness figures are available from the 16th of the month

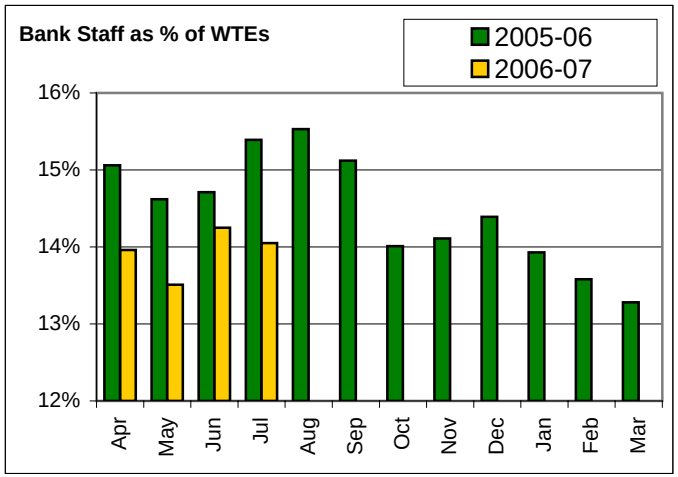
2006/07 figures exclude staff on no pay that left the monthly paycycle

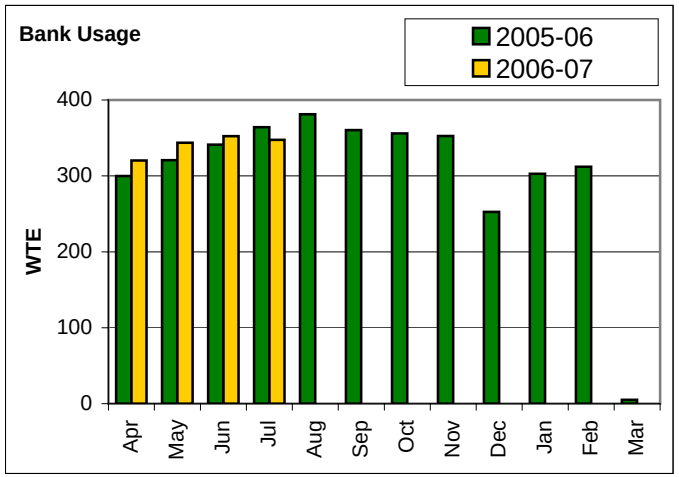
HR Graphs

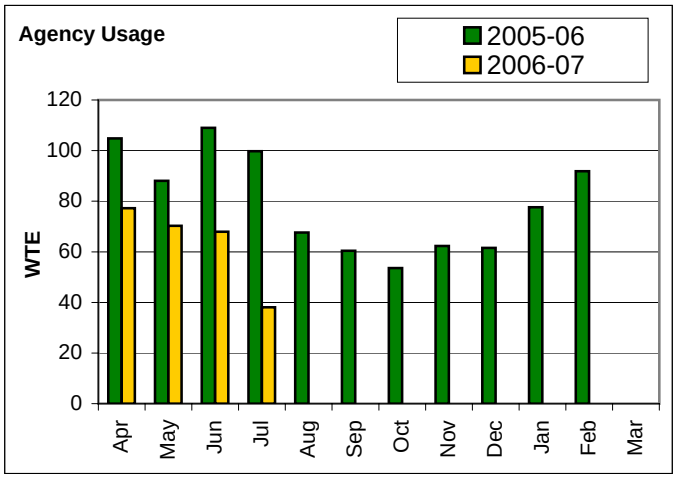

Planned Turnover
2005-06
2006-07
WTE
30
25
20
15
10
5
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Unplanned Turnover
2005-06
2006-07
WTE
2.5
2
1.5
1
0.5
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Sickness Rate
2005-06
2006-07
5%
4%
3%
2%
1%
0%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Bank Staff as % of WTEs
2005-06
2006-07
16%
15%
14%
13%
12%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Bank Usage
2005-06
2006-07
WTE
400
300
200
100
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Agency Usage
2005-06
2006-07
WTE
120
100
80
60
40
20
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

SLA Performance Report by Directorate- June 06 (Qtr1)

1st Outpatient Attendances									
Directorate	Actual Jun 05	Actual Jun 06	Plan Jun 06	Actual M1-M3 2005/06	Actual M1-M3 2006/07	Plan M1-M3 2006/07	Actual M1-M3 2006/07 £'s	Plan M1-M3 2006/07 £'s	Variance against plan to M3 £'s
A & I	69	75	71	247	228	212	41,866	40,031	1,835
HIV/GUM	7634	8066	7563	22158	23263	22689	1,561,859	1,483,321	78,538
MEDICINE	1749	1681	1580	5038	4733	4739	1,014,978	925,093	89,885
SURGERY	1559	1370	1371	4428	3941	4114	586,792	620,134	-33,342
W & C	2292	2109	2196	7076	6181	6587	952,785	1,006,910	-54,125
THERAPIES		36	41	0	81	122	4,759	7,774	-3,015
TRUST	**13303**	**13337**	**12821**	**38947**	**38427**	**38463**	**4,163,039**	**4,083,263**	**79,776**

Follow-Up Outpatient Attendances									
Directorate	Actual Jun 05	Actual Jun 06	Plan Jun 06	Actual M1-M3 2005/06	Actual M1-M3 2006/07	Plan M1-M3 2006/07	Actual M1-M3 2006/07 £'s	Plan M1-M3 2006/07 £'s	Variance against plan to M3 £'s
A & I	179	172	183	531	536	549	47,499	48,235	-736
HIV / GUM	4345	3248	3086	11598	9537	9257	297,356	289,266	8,090
MEDICINE	6186	5510	4984	18112	15999	14953	1,461,127	1,318,840	142,287
SURGERY	4569	4026	3631	13402	11856	10893	796,005	741,533	54,472
W & C	4885	4241	4310	14326	13415	12929	1,115,431	1,043,090	72,341
THERAPIES	0	63	46	0	192	139	12,015	9,240	2,775
TRUST	**20164**	**17260**	**16240**	**57969**	**51535**	**48720**	**3,729,433**	**3,450,204**	**279,229**

Elective Inpatient Spells									
Directorate	Actual Jun 05	Actual Jun 06	Plan Jun 06	Actual M1-M3 2005/06	Actual M1-M3 2006/07	Plan M1-M3 2006/07	Actual M1-M3 2006/07 £'s	Plan M1-M3 2006/07 £'s	Variance against plan to M3 £'s
A & I	20	15	37	51	46	112	152,336	163,773	-11,437
HIV / GUM	8	29	12	22	76	35	47,547	1,980	45,567
MEDICINE	44	144	49	137	219	147	273,474	197,006	76,468
SURGERY	363	353	316	1010	953	948	1,625,920	1,747,976	-122,056
W & C	189	194	192	567	519	575	720,548	768,775	-48,227
TRUST	**624**	**735**	**606**	**1787**	**1813**	**1817**	**2,819,825**	**2,879,510**	**-59,685**

Elective Excess Bed days									
Directorate	Actual Jun 05	Actual Jun 06	Plan Jun 06	Actual M1-M3 2005/06	Actual M1-M3 2006/07	Plan M1-M3 2006/07	Actual M1-M3 2006/07 £'s	Plan M1-M3 2006/07 £'s	Variance against plan to M3 £'s
A & I		4	31		13	93	10,458	9,705	753
HIV / GUM		82	23		136	70	33,699	29,339	4,360
MEDICINE		11	152		172	455	31,219	86,460	-55,241
SURGERY		107	171		399	512	84,434	105,645	-21,211
W & C		90	103		368	308	109,627	78,614	31,013
TRUST	**0**	**294**	**479**	**0**	**1088**	**1438**	**269,437**	**309,763**	**-40,326**

Day Case Spells									
Directorate	Actual Jun 05	Actual Jun 06	Plan Jun 06	Actual M1-M3 2005/06	Actual M1-M3 2006/07	Plan M1-M3 2006/07	Actual M1-M3 2006/07 £'s	Plan M1-M3 2006/07 £'s	Variance against plan to M3 £'s
A & I	31	37	26	91	104	78	56,790	47,836	8,954
HIV / GUM	1	59	200	2	125	600	76,064	586,315	-510,251
MEDICINE	721	790	684	1979	2170	2052	1,409,961	1,320,974	88,987
SURGERY	346	401	330	962	1100	991	936,827	749,858	186,969
W & C	248	310	271	697	919	813	793,503	675,987	117,516
TRUST	**1347**	**1597**	**1511**	**3731**	**4418**	**4534**	**3,273,145**	**3,380,970**	**-107,825**

SLA Performance Report by Directorate- June 06 (Qtr1)

Non-Elective Inpatient Spells									
Directorate	Actual Jun 05	Actual Jun 06	Plan Jun 06	Actual M1-M3 2005/06	Actual M1-M3 2006/07	Plan M1-M3 2006/07	Actual M1-M3 2006/07 £'s	Plan M1-M3 2006/07 £'s	Variance against plan to M3 £'s
A & I	180	179	208	467	462	624	959,201	1,075,064	-115,863
HIV / GUM	46	75	42	135	196	126	463,625	325,064	138,561
MEDICINE	502	585	512	1463	1483	1535	2,814,525	3,156,950	-342,425
SURGERY	432	403	401	1281	1085	1202	2,362,991	2,455,386	-92,395
W & C	1950	2220	1718	6174	6561	5154	4,851,064	4,363,610	487,454
TRUST	**3110**	**3462**	**2880**	**9520**	**9787**	**8641**	**11,451,406**	**11,376,074**	**75,332**

Non Elective Excess Bed days									
Directorate	Actual Jun 05	Actual Jun 06	Plan Jun 06	Actual M1-M3 2005/06	Actual M1-M3 2006/07	Plan M1-M3 2006/07	Actual M1-M3 2006/07 £'s	Plan M1-M3 2006/07 £'s	Variance against plan to M3 £'s
A & I		0	10		93	30	24,456	0	24,456
HIV / GUM		27	58		204	174	38,173	46,961	-8,788
MEDICINE		478	601		1658	1802	281,827	311,037	-29,210
SURGERY		135	225		476	676	101,189	147,328	-46,139
W & C		160	379		1365	1137	378,710	315,826	62,884
TRUST	**0**	**800**	**1273**	**0**	**3796**	**3819**	**824,355**	**821,152**	**3,203**

A&E Attendances									
	Actual Jun 05	Actual Jun 06	Plan Jun 06	Actual M1-M3 2005/06	Actual M1-M3 2006/07	Plan M1-M3 2006/07	Actual M1-M3 2006/07 £'s	Plan M1-M3 2006/07 £'s	Variance against plan to M3 £'s
Adult A&E		5920	5865	17084	15732	17596	1,202,715	1,316,882	-114,166
Paed A&E		2687	2635	7431	7048	7906	537,755	589,047	-51,292
Observation Ward		246	209		650	626	151,980	144,480	7,500
Total A&E	**0**	**8853**	**8709**	**24515**	**23430**	**26128**	**1,892,450**	**2,050,408**	**-157,958**

Other									
	Actual Jun 05	Actual Jun 06	Plan Jun 06	Actual M1-M3 2005/06	Actual M1-M3 2006/07	Plan M1-M3 2006/07	Actual M1-M3 2006/07 £'s	Plan M1-M3 2006/07 £'s	Variance against plan to M3 £'s
Direct Access		17433	17433		52696	52300	790,413	785,434	4,979
Drugs		0	0		0	0	604,662	633,037	-28,375
MFF		0	0		0	0	0	0	0
MFF HIV							239,750	239,750	0
Other		586	389		1746	1168	1,753,084	1,678,435	74,650
HIV (Outpatients & Drugs)							9,684,000	9,684,000	0
Total	**-**	**18,019**	**17,823**	**-**	**54,442**	**53,468**	**13,071,910**	**13,020,656**	**51,253**

Summary									
	Actual Jun 05	Actual Jun 06	Plan Jun 06	Actual M1-M3 2005/06	Actual M1-M3 2006/07	Plan M1-M3 2006/07	Plan £'s	Actual £'s	Variance £'s
Total		**71,952**	**67,479**	**153,925**	**209,149**	**202,432**	**41,372,000**	**41,495,000**	**123,000**

SLA Performance Report by PCT - June 06 (Qtr1)

All Referrals			
PCT	Actual M1-M3 2006/07	Plan M1-M3 2006/07	Variance
TRUST	**20413**	**15404**	5009

1st Outpatient Attendances						
PCT	Actual M1-M3 2006/07	Plan M1-M3 2006/07	Variance	Actual M1-M3 2006/07 £'s	Plan M1-M3 2006/07 £'s	Variance against plan to M3 £'s
KENSINGTON & CHELSEA	12507	12496	11	1,833,940	1,823,151	10,789
HIV CONSORTIA	12246	11516	730			
HAMMERSMITH & FULHAM	6339	6265	74	932,962	921,257	11,705
WESTMINSTER	2278	2347	-69	364,236	363,445	791
WANDSWORTH	2052	2142	-90	310,055	318,684	-8,629
OTHER	3005	3697	-692	721,846	656,726	65,120
TRUST	**38427**	**38463**	**-36**	**4,163,039**	**4,083,263**	**79,776**

Follow-Up Outpatient Attendances						
PCT	Actual M1-M3 2006/07	Plan M1-M3 2006/07	Variance	Actual M1-M3 2006/07 £'s	Plan M1-M3 2006/07 £'s	Variance against plan to M3 £'s
KENSINGTON & CHELSEA	15056	15699	-643	1,141,103	1,186,830	-45,727
HIV CONSORTIA	7642	5596	2046			
HAMMERSMITH & FULHAM	8425	8226	199	670,828	644,053	26,775
WESTMINSTER	6730	6133	597	513,237	467,229	46,008
WANDSWORTH	5853	5367	486	431,609	396,061	35,548
OTHER	7829	7699	130	972,656	756,031	216,625
TRUST	**51535**	**48720**	**2815**	**3,729,433**	**3,450,204**	**279,229**

Elective Inpatient Spells						
PCT	Actual M1-M3 2006/07	Plan M1-M3 2006/07	Variance	Actual M1-M3 2006/07 £'s	Plan M1-M3 2006/07 £'s	Variance against plan to M3 £'s
KENSINGTON & CHELSEA	376	365	11	581,233	556,829	24,404
HIV CONSORTIA	76	35	41	45,900	-	45,900
HAMMERSMITH & FULHAM	236	297	-61	350,383	439,924	-89,541
WESTMINSTER	283	288	-5	456,754	427,187	29,567
WANDSWORTH	189	183	6	321,980	303,372	18,608
OTHER	653	649	4	1,063,575	1,152,198	-88,623
TRUST	**1813**	**1817**	**-4**	**2,819,825**	**2,879,510**	**-59,685**

Elective Excess Bed days						
PCT	Actual M1-M3 2006/07	Plan M1-M3 2006/07	Variance	Actual M1-M3 2006/07 £'s	Plan M1-M3 2006/07 £'s	Variance against plan to M3 £'s
KENSINGTON & CHELSEA	184	269	-85	38,675	52,470	-13,795
HIV CONSORTIA	136	70	66	33,699	29,339	4,360
HAMMERSMITH & FULHAM	57	208	-151	12,613	44,424	-31,811
WESTMINSTER	161	236	-75	32,806	48,283	-15,477
WANDSWORTH	65	121	-56	12,775	25,130	-12,355
OTHER	485	534	-49	138,869	110,117	28,752
TRUST	**1088**	**1438**	**-350**	**269,437**	**309,763**	**-40,326**

Day Case Spells						
PCT	Actual M1-M3 2006/07	Plan M1-M3 2006/07	Variance	Actual M1-M3 2006/07 £'s	Plan M1-M3 2006/07 £'s	Variance against plan to M3 £'s
KENSINGTON & CHELSEA	1187	1106	81	803,761	716,359	87,402
HIV CONSORTIA	118	635	-517	71,614	581,865	-510,251
HAMMERSMITH & FULHAM	662	638	24	479,397	450,905	28,492
WESTMINSTER	787	689	98	568,511	465,227	103,284
WANDSWORTH	415	374	41	283,791	238,929	44,862
OTHER	1249	1092	157	1,066,071	927,685	138,386
TRUST	**4418**	**4534**	**-116**	**3,273,145**	**3,380,970**	**-107,825**

SLA Performance Report by PCT - June 06 (Qtr1)

Non-Elective Inpatient Spells						
PCT	**Actual M1-M3 2006/07**	**Plan M1-M3 2006/07**	**Variance**	**Actual M1-M3 2006/07 £'s**	**Plan M1-M3 2006/07 £'s**	**Variance against plan to M3 £'s**
KENSINGTON & CHELSEA	2047	1949	98	2,731,352	2,837,059	-105,707
HIV CONSORTIA	187	126	61	449,499	310,938	138,561
HAMMERSMITH & FULHAM	1911	1504	407	1,760,140	1,782,094	-21,954
WESTMINSTER	958	771	187	1,035,169	1,058,554	-23,385
WANDSWORTH	1484	1384	100	1,630,935	1,808,011	-177,076
OTHER	3200	2907	293	3,844,311	3,579,418	264,893
TRUST	**9787**	**8641**	**1146**	**11,451,406**	**11,376,074**	**75,332**

Non Elective Excess Bed days						
PCT	**Actual M1-M3 2006/07**	**Plan M1-M3 2006/07**	**Variance**	**Actual M1-M3 2006/07 £'s**	**Plan M1-M3 2006/07 £'s**	**Variance against plan to M3 £'s**
KENSINGTON & CHELSEA	963	1027	-64	189,313	214,959	-25,646
HIV CONSORTIA	204	174	30	38,173	46,961	-8,788
HAMMERSMITH & FULHAM	525	582	-57	123,405	123,331	74
WESTMINSTER	471	509	-38	98,617	99,843	-1,226
WANDSWORTH	770	766	4	152,259	148,189	4,070
OTHER	863	761	102	222,588	187,869	34,719
TRUST	**3796**	**3819**	**-23**	**824,355**	**821,152**	**3,203**

A&E Attendances						
PCT	**Actual M1-M3 2006/07**	**Plan M1-M3 2006/07**	**Variance**	**Actual M1-M3 2006/07 £'s**	**Plan M1-M3 2006/07 £'s**	**Variance against plan to M3 £'s**
KENSINGTON & CHELSEA	10516	12765	-2249	781,335	937,091	-155,756
HIV CONSORTIA	0	0	0			
HAMMERSMITH & FULHAM	7170	6961	209	395,979	378,498	17,481
WESTMINSTER	4148	4002	146	518,041	501,133	16,908
WANDSWORTH	112	111	1	22,848	22,593	255
OTHER	1484	2289	-805	174,247	211,093	-36,846
Total A&E	**23430**	**26128**	**-2698**	**1,892,450**	**2,050,408**	**-157,958**

Other						
PCT	**Actual M1-M3 2006/07**	**Plan M1-M3 2006/07**	**Variance**	**Actual M1-M3 2006/07 £'s**	**Plan M1-M3 2006/07 £'s**	**Variance against plan to M3 £'s**
KENSINGTON & CHELSEA	17643	17492	151	1,123,349	1,083,302	40,047
HIV CONSORTIA	0	0	0	37,960	37,960	
HAMMERSMITH & FULHAM	9344	9293	51	254,927	269,774	-14,847
WESTMINSTER	7239	7239	0	249,644	236,161	13,483
WANDSWORTH	6904	6824	80	174,863	156,531	18,332
OTHER	13312	12620	692	11,231,167	11,236,928	-5,761
Total	**54,442**	**53,468**	**974**	**13,071,910**	**13,020,656**	**51,254**

Summary						
	Actual M1-M3 2006/07	**Plan M1-M3 2006/07**	**Variance**	**Plan £'s**	**Actual £'s**	**Variance £'s**
Total	**209,149**	**202,432**	**6,717**	**41,495,000**	**41,372,000**	**123,000**

Scoring methodology for existing national targets for 2005/2006

(Updated May 11th 2006 to include a worked example)

As the annual health check is a new system, the Healthcare Commission reserves the right to modify its scoring methods in light of experience. Any changes made would be transparent and intended to promote fairness in the results of the assessment. Rule changes would either apply across all health care organisation types, or might be specific to a particular health care organisation type.

This document describes how the Healthcare Commission will calculate scores for performance relating to existing national targets for each NHS organisation. Assessment of performance against the existing national targets is one component of the 'Quality' element of the Healthcare Commission's 2005/2006 annual health check and covers the targets published by the Department of Health in *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/2006 – 2007/2008.* The existing national targets assess whether levels of service set through the 2003-2006 planning round are being maintained and are considered to be the basics of what organisations should be doing. Accordingly, the existing national targets carry a heavy weight in the derivation of the overall 'Quality' score.

This document includes the following details:

1. *outline of the existing national targets scoring methodology*
2. *key principles of scoring existing national targets*
3. *allocation table for acute & specialist Trusts*
4. *allocation table for primary care trusts (PCTs)*
5. *allocation table for ambulance trusts*
6. *allocation table for mental health trusts*
7. *allocation table for PCTs that also provide mental health services*
8. *allocation table for combined trusts, which provide acute, ambulance and mental health services*

Appendix 1:	*Full list of existing national targets*
Appendices (2-5):	*Full lists of applicable existing national targets and relevant performance indicators by organisation types*
Appendix 6:	*Scoring methodology for existing national targets – worked example*

1. Outline of the existing national targets scoring methodology

The scores for each existing national target are aggregated into one overall score, which then contributes to the overall 'Quality' element of the annual health check. Existing national targets are scored on the following four-grade scale:

'Fully met'

'Almost met'

'Partly met'

'Not met'

The following four trust types are assessed against the existing national targets – acute and specialist, mental health, ambulance, and primary care trust (PCT). Each trust is assessed within its own group by a set of performance indicators, specifically designed to measure the existing national targets that apply to it. Combined trusts (PCTs that provide mental health services and the Isle of Wight Healthcare NHS Trust, which provides acute, ambulance and mental health services) are assessed on

the performance indicators that apply to them from each relevant organisation type set.

In total, there are 21 separate existing national targets as set out by the Department of Health (see Appendix 1). In the 2005/2006 annual health check, the Healthcare Commission is using 26 different performance indicators to measure performance against the existing national targets. Therefore, some existing national targets are measured by one performance indicator and others are measured by two (see Fig. 1 below).

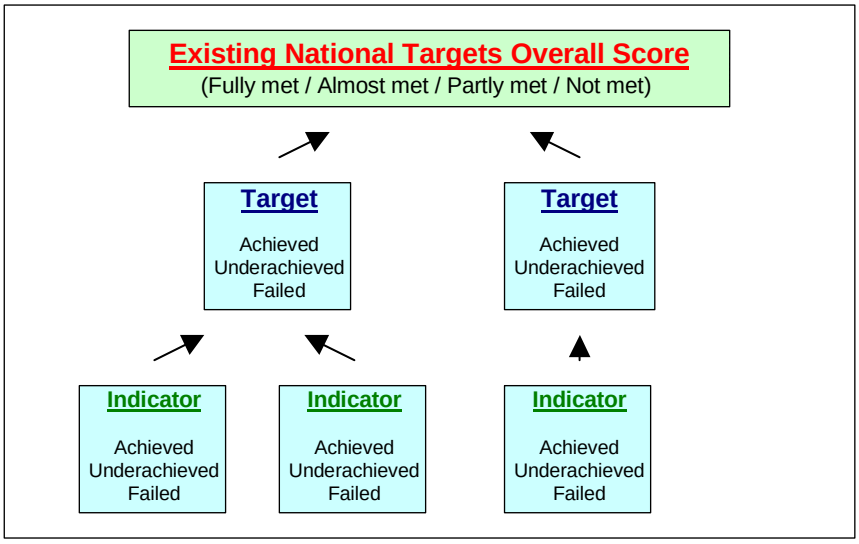


Fig 1. Illustration of existing national targets scoring methodology

Not all existing national targets apply to all trusts. The number of applicable existing national targets varies by health care organisation type and may vary between trusts of the same organisation type, depending on the services they provide. Trusts will only be assessed against the targets and indicators that are applicable to them within their relevant set(s) of indicators. For example, if an acute trust does not have an accident and emergency (A&E) department, the performance indicator '*Total time in A&E: four hours or less*' will not apply.

See Appendices 2 to 5 for full lists of existing national targets and relevant performance indicators by organisation types.

2. Key principles of scoring existing national targets

The following key principles underpin the existing national targets scoring methodology:

i. Scores for 'Fully met', 'Almost met, 'Partly met' and 'Not met' for existing national targets are based on cumulative scores from all the individual existing national targets.

ii. All individual existing national targets are equally weighted.

iii. Where there is more than one performance indicator used to assess an existing national target, then all performance indicators within the target are equally weighted.

iv. Performance relating to each performance indicator is assessed as '**achieved**', '**underachieved**' or '**failed**'. This is based on expected levels of performance using two defined thresholds; the first threshold distinguishes between 'achieved' and 'underachieved', the second distinguishes between 'underachieved' and 'failed'.

v. Performance relating to each existing national target is also assessed as '**achieved**', '**underachieved**' or '**failed**'. Where only one performance indicator is used to assess an existing national target, the individual target score will mirror the performance indicator score (i.e. underachieving the performance indicator results in underachieving the relevant target). Where there are two performance indicators used to assess an existing national target, the individual target is scored as follows:

Scoring performance on an existing national target, which is assessed using two performance indicators	
Indicator outcomes	**Individual target score**
Achieved & Achieved	**Achieved**
Achieved & Underachieved	**Underachieved**
Underachieved & Underachieved	**Underachieved**
Achieved & Failed	**Failed**
Failed & Underachieved	**Failed**
Failed & Failed	**Failed**

vi. For each individual existing national target, a trust is allocated points in relation to its performance level using the following rules:

Achieved target: 3 points
Underachieved target: 2 points
Failed target: 0 points

Therefore, a trust that fails one target fails to score 3 available points. This is equivalent to the number of available points not scored if a trust underachieves three targets. This reflects the severity of failing to meet a target.

vii. The overall scores of 'Fully met', 'Almost met', 'Partly met' and 'Not met' on existing national targets are calculated by comparing the number of points scored with the maximum number of points available to the trust. Please refer to sections 3 to 7 for full details of the required points to score 'Fully met', 'Almost met', 'Partly met' and 'Not met' for acute and specialist, primary care, ambulance and mental health trusts respectively.

viii. Trusts are only assessed against the indicators/targets that are applicable to them. Indicators or targets that are not applicable are not included in the calculation of overall score for existing national targets.

ix. If an indicator is applicable to a trust but data are not available (through no fault of the trust), the indicator is deemed not applicable with regards to the overall scoring of existing national targets.

x. Trusts that submit incomplete data, or miss the published deadline for data submission, will be awarded the lowest score available for the relevant indicator(s).

xi. If a trust has low activity, such that there is not sufficient data to adequately assess them against an indicator, the indicator is deemed not applicable with regards to the overall scoring of existing national targets.

3. Allocation table for acute and specialist trusts

Acute and specialist trusts have up to 12 existing national targets that apply for scoring, which are measured by 13 performance indicators. For 11 of the targets, one indicator is used to assess the target. For one target, two indicators are used to assess the target. See Appendix 2 for a full list of the existing national targets and relevant performance indicators applicable to acute and specialist trusts.

The number of targets applicable to acute and specialist trusts may vary and this is reflected in the methodology to derive the existing national targets overall score. Table 1 below shows the number of points required to score 'Fully met', 'Almost met', 'Partly met' or 'Not met' depending on the number of targets that apply.

Table 1. Acute & specialist trusts – existing national targets overall scoring allocation table

Number of targets that apply	Maximum points available	Fully met	Almost met	Partly met	Not met
12	*36*	>=33	>=30	>=27	<27
11	*33*	>=30	>=27	>=24	<24
10	*30*	>=27	>=24	>=21	<21
9	*27*	>=25	>=22	>=19	<19
8	*24*	>=22	>=20	>=17	<17
7	*21*	>=19	>=17	>=15	<15
6	*18*	>=17	>=15	>=13	<13
5	*15*	>=14	>=12	>=11	<11
4	*12*	>=11	>=10	>=9	<9
3	*9*	>=9	>=8	>=7	<7

Therefore, when all **12** existing national targets apply to an acute or specialist trust, scoring is as follows:

Fully met >=33 out of 36 points
(i.e. tolerance for one failed target only or three underachieved targets only)

Almost met >=30 out of 36 points
(i.e. tolerance for two failed targets only or six underachieved targets only etc)

Partly met >=27 out of 36 points
(i.e. tolerance for three failed targets only or nine underachieved targets only etc)

Not met <27 out of 36 points
(i.e. greater than three failed targets or greater than nine underachieved targets etc)

Scoring methodology for new national targets for 2005/2006

(Updated May 11th 2006 to include scoring allocation tables by organisation type and a worked example)

As the annual health check is a new system, the Healthcare Commission reserves the right to modify its scoring methods in light of experience. Any changes made would be transparent and intended to promote fairness in the results of the assessment. Rule changes would either apply across all health care organisation types, or might be specific to a particular health care organisation type.

This document describes how the Healthcare Commission will calculate scores for performance relating to new national targets for each NHS organisation. Assessment of performance against the new national targets is one component of the 'Quality' element of the Healthcare Commission's 2005/2006 annual health check and covers the targets published by the Department of Health in *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/2006 – 2007/2008.* New national targets are considered to cover what trusts are required to do to demonstrate they are developing and sustaining improvement. Consequently, new national targets carry weight in promoting the overall 'Quality' score to 'Excellent' or 'Good' but carry no weight in limiting the overall 'Quality' score to 'Weak'.

This document includes the following details:

1. *outline of the new national targets scoring methodology*
2. *key principles of scoring new national targets*
3. *allocation table for acute & specialist Trusts*
4. *allocation table for primary care trusts (PCTs)*
5. *allocation table for ambulance trusts*
6. *allocation table for mental health trusts*
7. *allocation table for PCTs that also provide mental health services*
8. *allocation table for combined trusts, which provide acute, ambulance and mental health services*

Appendix 1:	*Scoring rules for a new national target where there are two or more performance indicators used to assess the target*
Appendices (2-6):	*Full lists of applicable new national targets and relevant performance indicators by organisation types*
Appendix 7:	*Scoring methodology for new national targets – worked example*

1. Outline of the new national targets scoring methodology

The scores for each new national target are aggregated into one overall score, which then contributes to the overall 'Quality' element of the annual health check. New national targets are scored on the following four-grade scale:

'Excellent'

'Good'

'Fair'

'Weak'

The following five trust types are assessed against the new national targets – acute and specialist, mental health, ambulance, learning disability, and primary care trust

(PCT). Each trust is assessed within its own group by a set of performance indicators, specifically designed to measure the new national targets that apply to it. Combined trusts (PCTs that provide mental health services and the Isle of Wight Healthcare NHS Trust, which provides acute, ambulance and mental health services) are assessed on the performance indicators that apply to them from each relevant organisation type set.

In the 2005/2006 annual health check, the Healthcare Commission is using 41 different performance indicators to measure performance against the new national targets. Some new national targets are measured by one performance indicator and others are measured by more than one (see Fig. 1 below).

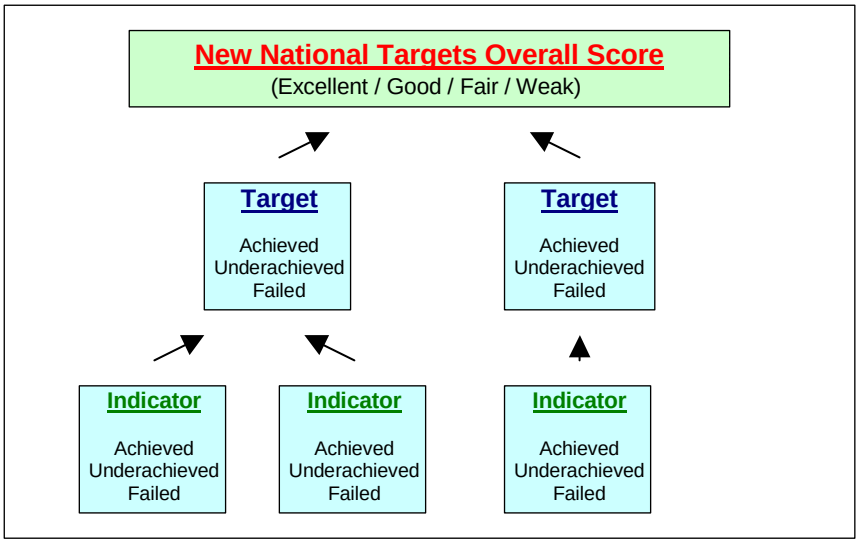


Fig 1. Illustration of new national targets scoring methodology

Not all new national targets apply to all trusts. The number of applicable new national targets varies by health care organisation type and may vary between trusts of the same organisation type, depending on the services they provide. Trusts will only be assessed against the targets and indicators that are applicable to them within their relevant set(s) of indicators. For example, if a mental health trust does not provide older people mental health services, the performance indicator '*CMHT integration (older people)*' will not apply.

See Appendices 2 to 6 for full lists of new national targets and relevant performance indicators by organisation types.

2. Key principles of scoring new national targets

The following key principles underpin the new national targets scoring methodology:

i. Scores for ‘Excellent, ‘Good, ‘Fair and ‘Weak for new national targets are based on cumulative scores from all the individual new national targets.

ii. All individual new national targets are equally weighted.

iii. Where there is more than one performance indicator used to assess a new national target, then all performance indicators within the target are equally weighted.

iv. Performance relating to each performance indicator is assessed as ‘**achieved**’, ‘**underachieved**’ or ‘**failed**’. This is based on expected levels of performance using two defined thresholds; the first threshold distinguishes between ‘achieved’ and ‘underachieved’, the second distinguishes between ‘underachieved’ and ‘failed’.

v. Performance relating to each new national target is also assessed as ‘**achieved**’, ‘**underachieved**’ or ‘**failed**’. Where only one performance indicator is used to assess a new national target, the individual target score will mirror the performance indicator score (i.e. underachieving the performance indicator results in underachieving the relevant target). Rules for scoring a target where there are two or more performance indicators used to assess the target are detailed in Appendix 1.

vi. For each individual new national target, a trust is allocated points in relation to its performance level using the following rules:

Achieved target:	3 points
Underachieved target:	2 points
Failed target:	0 points

Therefore, a trust that fails one target fails to score 3 available points. This is equivalent to the number of available points not scored if a trust underachieves three targets. This reflects the severity of failing to meet a target.

vii. Overall scores of ‘Excellent’, ’Good’, ‘Fair’ and ‘Weak’ on new national targets are calculated by comparing the number of points scored with the maximum number of points available to the trust. Please refer to sections 3 to 8 for full details of the required points to score ‘Excellent’, ’Good’, ‘Fair’ and ‘Weak’ for acute and specialist, primary care, ambulance, mental health and learning disability trusts respectively.

viii. Trusts are only assessed against the indicators/targets that are applicable to them. Indicators or targets that are not applicable are not included in the calculation of overall score for new national targets.

ix. If an indicator is applicable to a trust but data are not available (through no fault of the trust), the indicator is deemed not applicable with regards to the overall scoring of new national targets.

x. Trusts that submit incomplete data, or miss the published deadline for data submission, will be awarded the lowest score available for the relevant indicator(s).

xi. If a trust has low activity, such that there is not sufficient data to adequately assess them against an indicator, the indicator is deemed not applicable with regards to the overall scoring of new national targets.

xii. If an indicator is constructed such that actual performance is assessed against planned performance and a trust has not planned any performance in 2005/2006, the indicator is deemed not applicable with regards to the overall scoring of new national targets.

3. Allocation table for acute and specialist trusts

Acute and specialist trusts have up to 11 new national targets that apply for scoring, which are measured by 12 performance indicators. For 10 of the targets, one indicator is used to assess the target. For one target, two indicators are used to assess the target. See Appendix 2 for a full list of the new national targets and relevant performance indicators applicable to acute and specialist trusts.

The number of targets applicable to acute and specialist trusts may vary and this is reflected in the methodology to derive the new national targets overall score. Table 1 below shows the number of points required to score 'Excellent', 'Good', 'Fair' or 'Weak' depending on the number of targets that apply.

Table 1. Acute & Specialist Trusts – new national targets overall scoring allocation table

Number of targets that apply	Maximum Points Available	Excellent	Good	Fair	Weak
11	*33*	>=31	>=28	>=25	<25
10	*30*	>=28	>=25	>=22	<22
9	*27*	>=26	>=23	>=20	<20
8	*24*	>=23	>=20	>=18	<18
7	*21*	>=20	>=18	>=16	<16
6	*18*	>=17	>=15	>=14	<14
5	*15*	>=14	>=13	>=11	<11
4	*12*	=12	>=10	>=9	<9

Therefore, when all **11** new national targets apply to an acute or specialist trust, scoring is as follows:

Excellent >=31 out of 33 points
(i.e. tolerance for two underachieved targets only)

Good >=28 out of 33 points
(i.e. tolerance for one failed target and two underachieved targets only or five underachieved targets only etc)

Fair >=25 out of 33 points
(i.e. tolerance for two failed targets and two underachieved targets only or eight underachieved targets only etc)

Weak <25 out of 33 points
(i.e. greater than two failed targets and two underachieved targets or greater than eight underachieved targets etc)

APPENDIX 1

Length of stay recovery plans

Medicine

Patients admitted on a Friday stay 1 day longer than patients admitted on other days during the week. To address this, the consultants and junior doctors on acute take have agreed to move from a 1 day weekend take to a 3 day week-end take which will cover Friday, Saturday and Sunday. This will enable the active treatment of these patients and evidence nationally shows that this will reduce length of stay, with the proper diagnostic and therapeutic support.

The junior doctor's rota has also been changed to achieve 3 doctors on a rota for the Medical Admissions Unit (MAU), along with a locum consultant (cost neutral). This will have the effect of speeding up treatment, transfer or discharge from the MAU and reducing overall length of stay.

All patients in hospital longer than 15 days are actively reviewed by the patient's multi-disciplinary team with escalation to the directorate team and the Director of Nursing/ Operations to resolve unnecessary delays in relation to intermediate care access and patient choice.

The directorate will also be piloting delivery of IV antibiotic therapy at home rather than admission to hospital, which currently requires a stay of 5-7 days for treatment.

In partnership with K&C PCT, 'frequent fliers' are being identified for management at home by community matrons. This is at an early stage of development, with case review of 5 patients identified for this approach.

Surgery

Good progress has been made in relation to Day of Surgical Admission rates which are at an average of 85% across the directorate in August 2006.

Work is ongoing in relation to fractured NOF which has moved from 21 days to a 14 day length of stay. A rehabilitation at home business case is being developed which has the potential to significantly reduce length of stay to 5 days for the acute phase.

Day case rates are planned to improve in the second half of the year with the move of some General Surgery main theatre lists to the treatment centre in September. Coding issues in Urology will also have a positive impact on the day case rate.

Edward Donald
Director of Operations

Trust Board Meeting, 7th September 2006

AGENDA ITEM NO.	2.3/Sep/06
PAPER	Annual Audit Letter
AUTHOR	Mark Craigen – Audit Manager – Deloitte
LEAD EXECUTIVE	Lorraine Bewes, Director of Finance and Information Contact Number: 020 8846 6713
SUMMARY	This paper concludes the annual audit of the 2005/06 accounts of the Trust.
ACTION	The Board is asked to note this paper.

Chelsea & Westminster Healthcare NHS Trust

Management letter

on the 2005/06 Audit

16 August 2006

Deloitte.

Contents

Deloitte.

Executive summary

Introduction	We have pleasure in setting out in this document our detailed management letter to Chelsea & Westminster Healthcare NHS Trust for the year ended 31 March 2006. As you will be aware, we discussed the status of our audit and any significant matters arising at the Audit Committee meeting on 4 July 2006. This report includes further detail of matters that have arisen from our audit for the year ended 31 March 2006. This summary is not intended to be exhaustive but highlights the most significant matters that have come to our attention. It should, therefore, be read in conjunction with the report and the appendices thereto.
Recommendations	We have identified the following matters which are discussed further below along with our recommendations to management: Financial audit recommendations • Fixed asset verification and tracking; and • Segregation of duties. IT related recommendations • Oracle Account Management; • Network and Application Authentication Configuration; • Password Expiry: Oracle; • Notification of Oracle Leavers; • Business Continuity and Disaster Recovery Planning; and • Backup Tape Storage. We have also included an update on the status of recommendations that were made in the prior year.

1. Accounting and internal control systems

Whilst we did not identify any material weaknesses in the financial control environment of the Trust, we have noted below a number of control observations, which have been discussed with management. We remind you that our audit was not designed to provide assurance as to the overall effectiveness of the controls operating within the Trust.

Fixed asset verification and tracking
It was noted during our testing that fixed assets are not tagged for identification process, which means that management are unable to efficiently track assets that move around the Trust or verify that all assets are still being utilised within the Trust.

Recommendation	Management Response
We recommend that the Trust labels all assets with a unique asset number such that each individual asset can be identified and checked against the fixed asset register. This will enable management to more efficiently reconcile the fixed asset register and ultimately the financial statements of the Trust to the actual assets that are held and used by the Trust.	All medical equipment currently has an asset control number assigned on the day of its commissioning by our Clinical Engineering department. This process will be reviewed to ensure that it is rolled across the Trust. The capital accountant will liaise with the Clinical Engineering department to look into the possibility of adopting this control number as the asset's number and the asset register will be updated accordingly. **Timeframe:** December 2006 **Owner:** Mansoor Zaman – Financial Controller

1. Accounting and internal control systems (continued)

Segregation of duties
It was noted during our testing that the manual calculation of occupational sick pay due to an individual is not reviewed or reperformed by a second individual. This is a specific example of a lack of segregation of duties, which may offer a potential risk of inaccuracy in calculating balances that ultimately feed into the financial statements of the Trust.

Recommendation	Management Response
We recommend that management review the arrangements for this specific example as well as being aware of other instances where a lack of segregation of duties.	There is a resource issue in the payroll department; a recent benchmarking exercise with four other organisations underlined the need for two extra staff. Once the additional resources are recruited we should be able to perform the additional checks. **Timeframe:** September 2006 **Owner:** Andy Christie – Payroll Manager

2. IT related recommendations

Oracle account management
We identified that three generic accounts remained active within the Oracle environment with system administrator privileges. We also identified seven system accounts that have not been used during the last 15 months.

Recommendation	Management Response
Management should consider the following actions: - All generic accounts should be replaced by accounts which are associated with named individuals; - All generic accounts which are no longer in use should be end dated; - Procedures should be implemented to control the creation of temporary/system accounts to ensure that they are set up with unique IDs and end-dated as appropriate; and - Periodic reviews should be performed to ensure that account management procedures are appropriately adhered to.	The generic account which has system administrator privileges and is associated with a group of individuals is assigned to Patech Solutions Ltd who provide our third party application and database support. It is not considered feasible or desirable to create and associate generic accounts with the required privileges to individual members of their support department. Oracle Financials requires a number of generic accounts to be in place and active in order for the system to be able to function. These should not be associated with individuals. However, a review will be carried out of all the active generic accounts to ascertain whether any are not required and therefore can be disabled. The review will be completed in one month. Any temporary accounts created are set up with unique ids and are regularly reviewed and end dated as required. There are agreed procedures already in place for this. The recommendation for periodic reviews performed by management is accepted and will be implemented in one month. **Timeframe:** September 2006 **Owner:** Alan Vine, Oracle Administrator

2. IT related recommendations (continued)

Network and application authentication configuration

Network

We noted that password parameter settings are configured as follows on the main Windows domain:

- Minimum password length = 5 characters;
- Password expiry = 0 days;
- Account lockout = not enabled; and
- Threshold = not enabled (unlimited attempts at password guessing).

Oracle

We identified that the following parameters are not currently enabled within the environment:

- SIGNON_PASSWORD_FAILURE_LIMIT (SIGNON_PASSWORD_FAILURE_LIMIT specifies the number of failed password attempts that are permitted before an account is locked. By default, this is not set, indicating that an infinite number of attempts are permitted).

Inappropriate authentication controls increases the risk of unauthorised access to systems resources. This could result in system downtime and financial loss.

Recommendation

On **network** password controls, we recommend that password authentication parameters be strengthened as follows:

- Minimum password length = 8 characters;
- Password expiry = 60 days;
- Account lockout = enabled; and
- Threshold = 3 attempts.

On **Oracle**, the password failure limit should be set to three attempts.

Management Response

Network:

All the recommended password controls are accepted except for password complexity. The controls will be implemented by the end of July 2006.

Oracle:

The recommendation to set the password failure limit on Oracle to three attempts is accepted. This will be implemented by the end of July 2006.

Timeframe: July 2006

Owner: Alan Vine, Oracle Administrator & Bill Gordon, Director of ICT

2. IT related recommendations (continued)

Password Expiry: Oracle

We identified that 13 Oracle user accounts did not have an enforced password expiry, nor have the accounts been end-dated. Of these accounts, 11 system accounts and 2 were user accounts.

Recommendation	Management Response
All accounts should have passwords that expire, especially where users have higher privileged access. The list of password expiry rules should be reviewed by management to confirm that they are in line with current best practices. In addition, procedures should be implemented to ensure that all new user requests have a password expiry time specified, and periodic reviews of this procedure should be undertaken.	All user accounts have a password expiry time set to 30 days. The two user accounts identified as not having a password expiry time set have been corrected. We believe that the generic accounts required to be in place for the functioning of the system should not have password expiry set. There are no accounts in existence which have a password lifespan determined by the number of accesses rather than a time interval. Written procedures are already in place to ensure that all new user accounts have a password expiry time limit of 30 days specified. The recommendation for management to perform periodic reviews of the password expiry settings is accepted and will be implemented in one month. A report of the findings of the review will be sent to Finance. **Timeframe:** July 2006 **Owner:** Alan Vine, Oracle Administrator

2. IT related recommendations (continued)

Notification of Oracle leavers
We noted that the Oracle system administrator does not always receive information about leavers. This means that accounts and profiles could potentially be left active on Oracle Financials subsequent to the owner leaving the organisation. These accounts could be accessed by malicious users, causing system downtime and financial loss.

Recommendation	Management Response
We recommend that management implement a formal procedure to ensure that the Oracle system administrator receives timely information regarding leavers. This will enable appropriate and timely user removal from the Oracle application.	This recommendation is accepted. The procedures for the notification of leavers will be reviewed. In order to more effectively identify permanent and Bank sourced staff leaving the Trust, procedures will be put in place to receive a copy of the leavers report from the HR system. Temporary staff will in future have an end date set when their user account is created in order that the member of staff has to make contact for the account to be re-activated. Senior Finance management will be reminded again of the importance of providing timely notification to the Systems Manager of any Oracle users, both permanent and temporary staff, who leave the employment of the Trust so that their accounts can be disabled as soon as possible following the date of leaving. The recommendation will be implemented in one month. **Timeframe:** July 2006 **Owner:** Alan Vine, Oracle Administrator

2. IT related recommendations (continued)

Business Continuity and Disaster Recovery Planning
Although a formalised Disaster Recovery Plan (DRP) and Business Continuity Plan (BCP) is in place, it was identified that regular plan testing is not carried out. Without adequate and comprehensive testing of the DRP and BCP, management cannot be assured that key data processing and business activities will not be disrupted for a prolonged period of time in the event of a disaster. This could result in significant unforeseen and unexercised problems as well as increased disaster-related expenses.

Recommendation	Management Response
We recommend management consider testing the business continuity and disaster recovery plans at least annually and that the plans be updated to reflect the results of such tests. The tests should involve all critical staff. Any issues and queries that arise during the tests should be documented and an appropriate plan for resolution developed. These arrangements should be agreed by senior management, formally documented, and circulated to staff as necessary.	The Disaster Recovery Plan is being reviewed. The review is expected to be completed by the end of March 2007. The recommendation for consideration to be given to testing of the plans and updating where necessary is accepted. **Timeframe:** March 2007 **Owner:** Bill Gordon, Director of ICT

2. IT related recommendations (continued)

Backup tape storage
During our review it was identified that backup tapes are stored onsite. It is noted that tapes are stored within a fireproof safe, some distance from the main server and DR rooms. Backup tapes stored onsite, rather than at an appropriate storage site may: - Not be retrievable in an emergency or disaster situation; and - Not be subject to appropriate environmental or physical security controls while stored. In the event of a disaster scenario or other event where the entire site became inaccessible, backup tapes would be irretrievable and business critical information may be unavailable for restoration on a timely basis. This would then affect the ability of the business to continue effectively as essential data would not be available.

Recommendation	Management Response
We recommend that management assess the business criticality of data stored on the backup tapes and give consideration to storing tapes at a remote, off-site location with appropriate physical security and environmental controls on a daily basis to minimise the risk of data unavailability and loss.	Back up tapes are currently stored in the fireproof safe in the St Stephen's building. The procedure for off-site storage is currently being reviewed. The review is expected to be completed by the end of March 2007. **Timeframe:** March 2007 **Owner:** Bill Gordon, Director of ICT

3. Prior year update

Prior Year Issue	Status		
	Completed	Ongoing	Outstanding
Windows 2000 Security **2006 update:** Password controls have now been strengthened to include history and complexity; however, password expiry and length issues have been re-raised above.		✓	
Attack and Penetration Testing **2006 update:** This has now been performed by an independent 3rd party.	✓		

4. Responsibility statement

While our report includes suggestions for improving accounting procedures, internal controls and other aspects of your business arising out of our audit, we emphasise that our consideration of Chelsea & Westminster Healthcare NHS Trust's system of internal financial control was conducted solely for the purpose of our audit having regard to our responsibilities under Auditing Standards. We make these suggestions in the context of our audit but they do not in any way modify our audit opinion which relates to the financial statements as a whole. Equally, we would need to perform a more extensive study if you wanted us to make a comprehensive review for weaknesses in existing systems and present detailed recommendations to improve them.

We view this report as part of our service to you for use as Directors for corporate governance purposes and it is to you alone that we owe a responsibility for its contents. We accept no duty, responsibility or liability to any other person as the report has not been prepared, and is not intended, for any other purpose. In the event that a third party asks to see this report, please ask for our consent before releasing it.

Deloitte & Touche LLP.

Deloitte & Touche LLP
Chartered Accountants

St Albans

16 August 2006

Contact:	
Roger Miles – Partner	Tel: 01727 839000
Mark Craigen – Senior Manager	Fax: 01727 831111

Trust Board Meeting, 7th September 2006

AGENDA ITEM NO.	3.1/Sept/06
PAPER	Private Patients Report
AUTHOR	Heather Lawrence, Chief Executive Contact Number: 020 8846 6711
SUMMARY	This paper provides the Trust Board with an update on Private Patient (PP) Income in year and addresses the rules under the NHS FT regime with respect for PP Income and our scope to increase PP Income.
BOARD ACTION	The Trust Board is asked to agree to the proposed shift in income targets between services and to the further exploring of alternatives to achieve growth in private maternity for which there is a clear market that is reliable in the long term as a source of income.

PRIVATE PATIENTS UPDATE – AUGUST 2006

Introduction

There are two elements to this report:-

1. Private income assumptions 06/07.

2. Rules re private income for NHS Foundation Trusts and the capacity to expand our Private Patient Income.

This paper provides the Trust Board with an update on Private Patient (PP) Income in year and addresses the rules under the NHS FT regime with respect for PP Income and our scope to increase PP Income.

1. Private Patient Income in year

There are three main elements to PP Income:-

- Adult (Chelsea Wing)
- Maternity (Kensington Wing)
- ACU

The budget for the Chelsea Wing is set up to achieve a 60% contribution and the Kensington Wing 45%. ACU was not set up to make a contribution. Our external advice would suggest that 60% is set too high and is not achievable. The budget for the Chelsea and Kensington Wings are set to have budget (Income) Expenditure (Pay and Non Pay) and Contribution.

At month 4 the Chelsea Wing is predicted to have a negative income variance of £110k at year end and an overspend on pay of £117k and non-pay of £164k making an overall variance to plan of -£391k. The Kensington Wing is predicted to have a £27k improvement in the predicted out turn position. ACU for the first time is predicted to make a surplus of £117k. The Surgical Directorate is controlling expenditure in the Chelsea Wing. The total annual private patient income is predicted to be £7,083,056m.

2. Rules re Private Patient Income under the FT regime.

The statutory instrument on Foundation Hospital Trust Income is capped at the financial year 02/03 Private Patient level inflated as a % of total patient income, therefore growth is restricted to the percentage growth of NHS income.

Our current cap is £7,100,000 m. When the PbR clawback is reversed in 2008/9 then our cap will be £7,400,000m. This leaves us with little room for growth at this stage.

The obstetricians have identified a market for expanding the private maternity service and we have identified £500k in the capital programme to expand the unit from 6 beds to 10 beds.

The Way Forward

It is proposed that the contribution is redistributed between the Chelsea Wing and the Kensington Wing and the income target for the Chelsea Wing reduced, and the income target redistributed to the Kensington Wing. In addition in 08/09 the additional income allowance of £400k is given to the Kensington Wing.

We need to look into the concept of 'chambers' and to see if one of the areas could be retained but provided by an external contractor to explore if there is a legal way to increase our PP income.

Monitor regulates PP Income as a percentage of income rigorously.

The Trust Board is asked to agree to the proposed shift in income targets between services and to the further exploring of alternatives to achieve growth in private maternity for which there is a clear market that is reliable in the long term as a source of income.

Heather Lawrence
24th August 2006

Trust Board Meeting, 7th September 2006

AGENDA ITEM NO.	5.1/Sept/06
PAPER	Director of Infection Prevention and Control(DIPC) and Infection Control Team Annual Report 2005/06 - Summary
AUTHOR	Roz Wallis, Senior Infection Control Nurse Contact Number: 020 8746 8266
LEAD EXECUTIVE	Andrew MacCallum, Director of Nursing Contact Number: 020 8846 6721
SUMMARY	This paper provides a summary of the Annual Report which outlines the performance and service developments of the DIPC and the Infection Control team between April 2005 and March 2006. *Note: The full version of the report is also attached for information.*
ACTION	The Board is asked to note the report and to approve the work programme for the forthcoming year which is detailed on page 33-35 of the Annual Report.

SUMMARY OF DIPC / INFECTION CONTROL TEAM ANNUAL REPORT 2005-2006

The Infection Control Team (ICT) has continued to work effectively this year, responding to the challenges of Healthcare Associated Infections (HAI) and implementing the Department of Health (DH) recommendations contained in the various documents released over the last few years

This year's Annual Report highlights the measures taken by the ICT in their endeavour to reduce the burden of HAIs in all clinical settings.

Under the Mandatory Surveillance System, we reported 28 cases of MRSA bacteraemia for this year, a 40% reduction from the previous year and we were commended by the DH for being one of the top 20 improved Trusts. Also our C. difficile rate has decreased by 34% (131 in 2005 down to 86 in 2006).

Infection control education continued to be a priority with lectures, demonstrations and practical training provided to nurses, doctors, medical students and other healthcare workers, totalling about 1800 individuals.

This year we held our 5th annual Hand Hygiene Awareness Week, with a series of lectures, posters and entertainment events aiming at highlighting the importance of hand hygiene. This week remains the Trust's biggest annual event and was attended by over 1000 staff.

In July 2005 the Infection Control Link Professionals (ICLP) commenced their duties after training. They conducted monthly Hand Hygiene compliance audits, using a standard tool. The results were then fed back to the Directorates.

Also in July 2005, our Trust was the chosen pilot and launch site for the Royal College of Nursing "Wipe it Out" campaign, focusing on improving basic Infection Control standards now used by the Patient Environment Action Team (PEAT).

We were the first Trust to introduce, in May 2005, the innovative silver alloy urinary catheter to decrease urinary tract infection.

There were no Serious Untoward Incidents (SUI) relating to Infection Control this year, but there were 10 incidents/clusters mainly diarrhoea and vomiting with a prolonged Norovirus infection period affecting a large number of patient and staff.

We continued to monitor antibiotic resistant organisms such as MRSA and Gram negative bacteria with the aim of identifying patients carrying the organism and preventing their spread. This monitoring coupled with prudent antibiotic usage, point prevalence studies and local antibiotic guidelines enabled us to improve the control of these resistant organisms.

Lastly, the full report presents the ICT's implementation of the 2005-2006 programme as well as the 2006-2007 programme which includes the Trust's MRSA reduction trajectory, the training and development of the ICLPs, the focusing on IV line care and improving Clinicians IT access to their own Infection Control data

As in previous years, we will work closely with all our colleagues in the Trust whose cooperation is of paramount importance to decrease HAIs in our hospital.

Healthcare Associated Infection Statistics

All NHS Trusts now report the below healthcare acquired infections to the DH:

- MRSA bacteraemia
- GRE bacteraemia
- *Clostridium difficile*
- Orthopaedic surgical site infection
- Serious Untoward Incidents and Outbreaks

Mandatory MRSA Bacteraemia Reporting

Since October 2005 the Trust has reported MRSA bacteraemias via an enhanced national online reporting database which is managed by the Health Protection Agency.

Our annual MRSA target for April 2006-March 2007 is 23 MRSA bacteraemias. Between April 2005-March 2006 we had 28 which was two below the set target of 30. This represented a 40% reduction in our MRSA rates in comparison with the previous year (n=47). As a result the DH have cited us as one of the top 20 hospitals which have demonstrated improvements in our rates.

Between April 2005-March 2006 MRSA bacteraemias occurred mostly in Intensive Care (n=10), Medicine (n=8) and Surgery (n=6). A small proportion also occurred in Accident and Emergency (A&E) (n=2). Most have been IV line related, occurring in unwell patients with central lines in place.

Table 1 shows that the Chelsea and Westminster Hospital have the second lowest rates of the London Acute Teaching Hospitals over the last reporting period of the year between October 2005 and March 2006.

Table 1. MRSA Bacteraemia rates of London Acute Teaching Hospitals October 2005 - March 2006

London Acute Teaching Hospital Trusts	MRSA bacteraemia rates per 10,000 bed days
St Georges	1.37
Chelsea and Westminster	**1.43**
Guys and St Thomas's	1.70
Bart's & The London	1.75
Hammersmith Hospitals	2.29
University College London	2.39
Royal Free Hampstead	3.17
St Mary's	3.79
Kings College	4.05

Figure 1 shows that we have the seventh lowest MRSA bacteraemia rates nationally in the Acute Teaching Hospitals category.

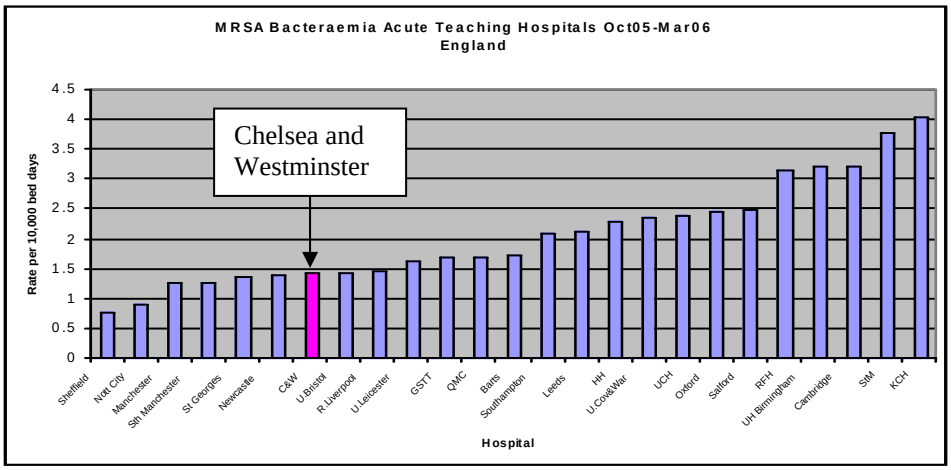


Figure 1 MRSA Bacteraemia rates of Acute Teaching Hospitals October 2005 - March 2006 for England

Glycopeptide Resistant Enterococci

Enterocooci are common gut flora. Glycopeptide-resistant enterococci (GRE) are enterococci that have developed resistance to glyopeptide antibiotics such as Vancomycin. Infections caused by GRE mainly occur in hospital patients who are very unwell although they can be acquired in the community.

Between April 2005 - March 2006 we had two Vancomycin resistant enterococci (VRE) bacteraemias. (HDU and David Erskine Ward.) VRE is rare at the Chelsea and Westminster Healthcare NHS Trust partly because there are no inpatient haematology or renal units where Vancomycin is frequently prescribed. It may also reflect a strict antibiotic prescribing policy and effective isolation policy.

Figure 2 shows that we have the 3rd lowest VRE bacteraemia rates in the Acute Teaching Hospitals in England between October 2004 - September 2005 (latest data available).

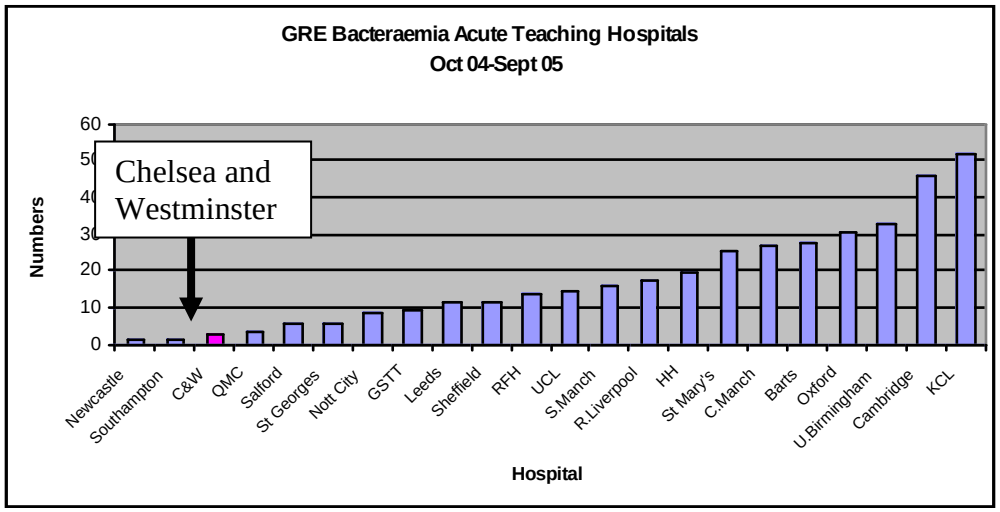


Figure 2 Glycopeptide Resistant Enterococci Bacteraemia Rates in Acute Teaching Hospital in England October 2004 – September 2005

Clostridium difficile **Toxin (CDT) rates**

This is the second year of mandatory reporting of CDT in patients over the age of 65 years to the Department of Health. *Clostridium difficile* is a type of bacteria found in the gut that can cause diarrhoea if it overgrows. It produces a toxin that can cause a spectrum of symptoms from mild antibiotic-associated diarrhoea to very severe colitis. It is able to persist in the environment for months and therefore poses an infection control risk in healthcare facilities. Patients over 65years, in hospital, who have previously received antibiotics, are most at risk of developing *C.difficile* diarrhoea. It can be controlled by good antibiotic prescribing, isolation precautions and high standards of cleaning.

In total there were 86 new CDTs >65 years age (and a further eight < 65 years). It reflects the Health Protection Agency's data which demonstrates that the vast majority of CDTs occur in the >65yrs age group. Most occurred in medical patients which is likely to reflects antibiotic use. This represents a 38% reduction in our CDT rate in comparison to the previous year.

Figure 3 shows Chelsea and Westminster Hospital rank the seventh best in the Acute Teaching Hospitals in England. Rates are calculated per 1000 bed days to enable comparisons to be made across hospitals.

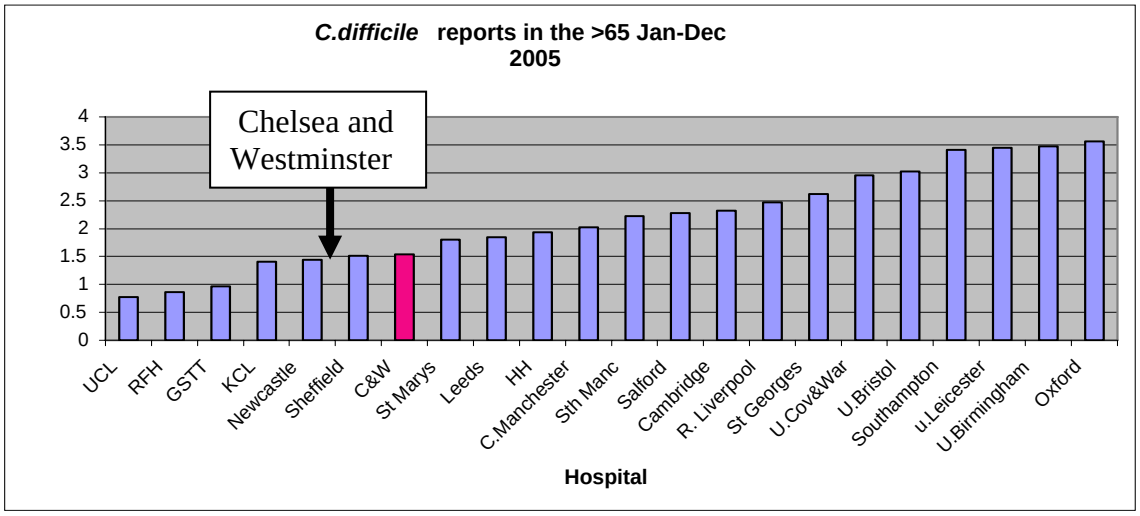


Figure 3. ***Clostridium difficile*** **Toxin rates for Acute Teaching Hospitals in England January – December 2005**

Orthopaedic Surgical Site Infection Surveillance (SSI)

All patients undergoing total hip replacements (THR); total knee replacements (TKR); hip hemi-arthroplasties (Hip-hemi) are monitored for SSI using nationally set criteria. Data is collated by the Infection Control Practitioner in collaboration with the orthopaedic team. It is then entered onto a national SSI online database.

Table 2 shows that out of 464 procedures (THR, TKR, Hip-hemi) between April 2005-March2006 we had 6 infections, which is an overall OSSI rate of 1.3%. Table 2 also

shows that our THR and TKR infection rate is lower in comparison to the national average. The hip-hemi rate is only slightly higher than the national average. However caution should be exercised when interpreting this data because these are very small numbers and therefore if there were an additional one or two cases it would result in a dramatic rise in our rates and ranking. Also the national average is based largely on data collated in the HPA voluntary surveillance scheme which may not be representative of national trends.

Table 2. Orthopaedic Surgical Site Infections local and national data

	THR C&W 2005-2006	THR All Hospitals	TKR C&W 2005-2006	TKR All Hospitals	Hip Hemi C&W 2005-2006	Hip Hemi All Hospitals
No of Operations	216	86690	187	75228	61	27461
No of SSIs	2	1435	1	709	3	1205
% Infected	0.9	1.7	0.5	0.9	4.9	4.4

Outbreaks

Between December 2005 and March 2006 there were 10 outbreaks of diarrhoea and vomiting. This is the most prolonged outbreak season in the history of the hospital. It reflects a large and prolonged Norovirus outbreak in the local communities. In total 189 people were affected, 35 of whom were staff. Nine outbreaks occurred in medical wards. Norovirus was confirmed as the causative organism in six of the outbreaks and was presumed to play a part in four other wards. CDT was also found in four of these wards.

It is likely that some of the 10 were new outbreaks introduced by different visitors, patients or staff who initially became infected in the community. It is also likely that some of the outbreaks occurred due to cross infection by staff working between different clinical areas. In addition the pressure to open beds in affected wards may also have contributed to the perpetuation of the outbreaks by not keeping the affected wards closed for long enough to allow the outbreaks to subside.

Winning Ways

Table 3 summarises the ICT activities between April 2005-March 2006 which are aimed at improving compliance with *Winning Ways.*

Table 3. Winning Ways Action Plan – progress to date

	Winning Ways Action Area	Areas on which to focus:	Actioned by:	Progress to date
1	Active Surveillance and Investigation	Mandatory surveillance of: a) bloodstream infections b) *Clostridium difficile* c) Surgical site infections d) Serious incidents associated with infection	ICT/CE	Monthly reporting by ICT/CE to DH/HPA Data presented quarterly to the Infection Control Committee There have been SUIs in 2005-2006.

		e) Infections after discharge		
2	Reducing the Infection Risk from use of Catheters, Tubes, Cannulae, Instruments and Other Devices	a) Urinary Catheters b) IV peripheral lines c) IV feeding lines d) Central lines e) Respiratory Care f) Decontamination of Instruments and Other Devices	ICLPs ICT Decontamination Lead	• Introduction of silver alloy urinary catheters • Catheter audit • Specific training for ICLPs on reducing infection risks from invasive devices. • Monthly IV line audit • New IV line documentation chart • Standardisation of peripheral dressings • Education on IV line access including use of Bionectors and Octopuses • Introduction of Daniels IV line tray to provide clean mobile field for IV administration/ peripheral cannulation and point of use sharps disposal • In ICU for CVP line insertion: • -Use of large dressing pack with large sterile field and sterile gown • -Chlorhexidine disc on insertion site • Hand Hygiene Awareness Week (HHAW) 2005 programme focused on reducing infection risks from invasive devices.
3	Reducing Reservoirs of Infection	Optimise use of side-rooms Plan toward more isolation facilities ICT to be involved at every stage of planning for new building/ renovations/ maintenance work All plans to purchase new furniture to be assessed by ICT	ICT DoO Facilities	• Closer liaison between ICT and bed managers • Started pre-op MRSA screening of elective surgical patients, March 2005 • Introduced single swab MRSA screening • Turning offices, changing rooms, store rooms back into side-rooms on wards (all were originally designed as side-rooms) • Close liaison between Facilities, Projects Team and ICT re furniture, new builds, refurbishments. • HHAW annual infection control lecture for Estates, Projects Team, Facilities
4	High Standards of Hygiene in Clinical Practice	Hand Hygiene (HH) Aseptic Technique Universal Precautions Infection Control included in all PDPs and taught to all on induction All staff properly immunised if not already immune. To include: hepatitis B, TB, influenza and chickenpox.	ICLPs ICT OH HR Corporate Nursing	• Monthly audits of HH by ICLPs. Results reported to Infection Control Committee & Risk Management Committee and NMAC. • ICLPs trained re HH, aseptic technique and universal precautions • HHAW2005 programme focused on Aseptic Technique and HH. • Joined *cleanyourhands* Campaign in July 2005 • Joined *Wipe it Out* Campaign also in July 2005 • Bed-side alcohol gels introduced in August 2005 • More than 1800 staff received Infection Control training between April 2005-March 2006. All sessions included HH training
5	Prudent Use of Antibiotics	Close monitoring of antibiotic prescribing and compliance with local national policy	DIPC Pharmacist	Antibiotic prescribing behaviour monitored daily and audited annually by Pharmacy led by Microbiology Pharmacist in liaison with Consultant Microbiologist

6	Management and Organisation	a) Introduction of DIPC role b) Chief Exec reports to DH quarterly mandatory information on MRSA, CDT, GRE, SUI c) ICT Annual Report presented to Trust Board d) To be actioned also by SHA and DH	CE DIPC SHA DH	Dr Berge Azadian appointed as DIPC, January 2003
7	Research and Development	To be actioned by DH	DH	To be action by DH

For further details see the full DIPC / Infection Control Team Annual Report April 2005-March 2006.

Chelsea and Westminster Healthcare NHS
NHS Trust

Director of Infection Prevention and Control (DIPC) and Infection Control Team (ICT)

ANNUAL REPORT

April 2005 – March 2006

Chelsea and Westminster Healthcare NHS

NHS Trust

Title:	Director of Infection Prevention and Control (DIPC) and Infection Control Team (ICT) Annual Report to the Trust Board (April 2005 - March 2006)
Executive Summary:	The attached report outlines the performance and service developments of the Infection Control Team between April 2005 and March 2006
Key Issues for Discussion:	Review of service delivery and pressures in terms of: • Infection Control Activity • Mandatory Surveillance Reporting • Responding to outbreaks • Surveillance and audit • Staffing
Authors:	Roz Wallis, Senior Infection Control Nurse
Acknowledgements:	Kerryn Money, Service Administrator Shona Perkins, Infection Control Nurse Dr Berge Azadian, Consultant Microbiologist, D.I.P.C. Olga Sleigh, Decontamination Lead Dr. Kieran Hand, Microbiology Pharmacist Tony Lawes, Project Manager Catherine Horne, ISS General Manager Stella Sawyer, Occupational Health Manager Georgina Dumler, IT System Support Leader Maria Lee, Corporate Nursing Team Co-ordinator Rosamunde Wood, Post-Graduate Centre Manager
Date Paper Produced:	August 2006

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EXECUTIVE SUMMARY

The Infection Control Team (ICT) has continued to work effectively this year, responding to the challenges of Healthcare Associated Infections (HAI) and implementing the Department of Health (DH) recommendations contained in the various documents released over the last few years

This year's Annual Report highlights the measures taken by the ICT in their endeavour to reduce the burden of HAIs in all clinical settings.

Under the Mandatory Surveillance System, we reported 28 cases of MRSA bacteraemia for this year, a 40% reduction from the previous year and we were commended by the DH for being one of the top 20 improved Trusts. Also our C. difficile rate has decreased by 34% (131 in 2005 down to 86 in 2006).

Infection control education continued to be a priority with lectures, demonstrations and practical training provided to nurses, doctors, medical students and other healthcare workers, totalling about 1800 individuals.

This year we held our 5th annual Hand Hygiene Awareness Week, with a series of lectures, posters and entertainment events aiming at highlighting the importance of hand hygiene. This week remains the Trust's biggest annual event and was attended by over 1000 staff.

In July 2005 the Infection Control Link Professionals (ICLP) commenced their duties after training (see Appendix 9 for role and responsibilities). They conducted monthly Hand Hygiene compliance audits, using a standard tool. The results were then fed back to the Directorates.

Also in July 2005, our Trust was the chosen pilot and launch site for the Royal College of Nursing "Wipe it Out" campaign, focusing on improving basic Infection Control standards now used by the Patient Environment Action Team (PEAT).

We were the first Trust to introduce, in May 2005, the innovative silver alloy urinary catheter to decrease urinary tract infection.

There were no Serious Untoward Incidents (SUI) relating to Infection Control this year, but there were 10 incidents/clusters mainly diarrhoea and vomiting with a prolonged Norovirus infection period affecting a large number of patient and staff.

We continued to monitor antibiotic resistant organisms such as MRSA and Gram negative bacteria with the aim of identifying patients carrying the organism and preventing their spread. This monitoring coupled with prudent antibiotic usage, point prevalence studies and local antibiotic guidelines enabled us to improve the control of these resistant organisms. This approach is outlined in the Microbiology Pharmacist report on page 12, Table 3.

Lastly, this report presents the ICT's implementation of the 2005-2006 programme (Table 8) as well as the 2006-2007 programme (Table 9) which includes the Trust's MRSA reduction trajectory, the training and development of the ICLPs, the focusing on IV line care and improving Clinicians IT access to their own Infection Control data

As in previous years, we will work closely with all our colleagues in the Trust whose cooperation is of paramount importance to decrease HAIs in our hospital

BERGE AZADIAN
DIRECTOR OF INFECTION PREVENTION AND CONTROL

Director of Infection Prevention (DIPC) & Infection Control Team (ICT)
Annual Report
April 2005-March (inc) 2006

1. Description of Infection Control Arrangements

1.1 Infection Control Team

The Infection Control Team at the end of the financial year were:

Dr. Berge Azadian (BA)	Director of Infection Prevention and Control Infection Control Doctor Consultant Microbiologist
Ms. Roz Wallis (RW)	Senior Infection Control Nurse
Ms. Shona Perkins (SP)	Infection Control Sister
Ms. Linda Whetren (LW)	Infection Control Practitioner
Dr. Kieran Hand (KH)	Microbiology Pharmacist
Ms. Susan Maye (SM)	Service Administrator

In November 2005 Linda Whetren joined the team as the Infection Control Practitioner. This role was created in January 2005 to enable the Trust to provide data for the Department of Health (DH) mandatory orthopaedic surgical site surveillance scheme. Linda came to us from Tayside NHS Board in Scotland where she worked as a Health Protection Agency Nurse which had a public health focus including infection control in the community.

1.2 The Role of the Infection Control Team (ICT)

The role of the ICT is to implement the annual programme and policies and to make clinical decisions about the prevention and control of infection on a twenty-four hour basis. The ICT provides advice to all grades of staff regarding the management of infected patients and on reducing the risk of infection in hospitals. The functions of the team include:

- The identification and control of outbreaks, in collaboration with the Consultant in Communicable Disease Control (CCDC) and an outbreak control group, as appropriate.
- Education of all hospital staff on infection control procedures and hand hygiene.
- Preparation of policy documents in liaison with relevant staff.
- Formulation of an annual programme of work including surveillance of infection.
- Implementation of this programme in liaison with other hospital staff and provision of regular progress reports to the Trust Chief Executive (CE) of important incidents, actions taken as well as surveillance and audit results. These reports are discussed at each quarterly Infection Control Committee (ICC) meeting before being sent to the CE.

- Provision of an annual report to the CE following discussion at the ICC meeting on the results of the programme, indicating achievements and highlighting any matters of concern.
- Liaison with the Occupational Health Service (OHS) on relevant staff issues.
- Liaison with clinical teams on development of standards, audit and research.
- The programme provides for the production and review of policies, staff education, surveillance of infection, monitoring of hospital hygiene and a variety of other matters. It does not all need to be undertaken by the ICT, but the ICT must be involved.

1.3 Communication within the ICT

Good communication within the ICT continues:

- Daily liaison between the microbiology laboratory and the Infection Control Nurses occurs with regard to reporting of antibiotic resistant bacteria or other alert organisms.
- The ICT formally meets on a weekly basis to discuss specimen results of concern and other infection control issues.
- The DIPC informally meets with the Chief Executive on a weekly basis.
- The senior ICN meets monthly and as required with the Assistant Nurse Director to discuss infection control issues within the Trust.

1.4 Infection Control Committee

The functions of the committee are:

- Advise and support the ICT.
- Draw the attention of the CE, either through the ICT or directly, to any serious problems or hazards relating to infection control.
- Consider reports on infection and infection control problems.
- Discuss and endorse a plan for the management of infection outbreaks in the hospital and monitor its implementation.
- Discuss and endorse the hospital response to major outbreaks of infection in the community (the Major Incident [Outbreaks] Plan) and monitor its implementation.
- Discuss and endorse the annual infection prevention and control programme, which will be submitted for approval to the CE, review the progress of the programme, assist in its implementation and review the results.
- Advise on the most effective use of resources available for implementation of the programme and for contingency requirements.
- Advise on and approve infection control policies before their submission for the CE's approval, and review their implementation.
- Promote and facilitate the education of all grades of hospital staff in infection control procedures and hand hygiene.
- Promote communication between the different disciplines in the hospital. The ICC minutes should be widely circulated and made accessible to senior medical and nursing staff and appropriate committees.

See Appendix 1 for Infection Control Committee Terms of Reference.
See Appendix 2 for Infection Control Committee members.

1.5 Reporting Lines to the Trust / Links to Clinical Governance/Risk Management/Patient Safety

Clear lines of accountability are in place throughout the Trust defining the relationship between the Infection Control Committee, Risk Management Committee, Clinical Governance, and the Trust Board. (see Appendix 3 for Clinical Governance Wheel).

1.6 Links to Prescribing and Formulary Committee

There are excellent links with the Formulary Committee and Pharmacy:

- **6**The antibiotic pharmacist (post funded jointly by Microbiology and Pharmacy) liaises closely with the Consultant Microbiologist/DIPC and is a member of the Infection Control Committee.
- **62**Consultant Microbiologist/ DIPC is a member of the Medicines Committee.
- **63**Consultant Microbiologist/DIPC receives a daily automated electronic report from Pharmacy of restricted antibiotic use in the Trust.
- **64**Any unusual antibiotic prescribing is brought to the attention of the Consultant Microbiologist/DIPC or microbiology registrars by the antibiotic pharmacist on a daily basis so that antibiotic prescribing is well monitored.

2. DIPC reports to the Trust Board – summary

The Chief Medical Officer's report *Winning Ways* required all NHS organisations to appoint a Director of Infection Prevention and Control (DIPC) who would be a senior officer with responsibility to:

- Oversee control of infection control policies and their implementation
- Be responsible for the Infection Control Team
- Report directly to the Chief Executive and Board
- Challenge inappropriate hygiene practice and antibiotic prescribing
- Assess the impact of all plans/policies on infection control
- Be a member of the Clinical Governance and Patient Safety teams/structures
- Produce an annual report

Our DIPC, Dr Berge Azadian, reports to the Trust Board on an annual basis to present the ICT/DIPC Annual Report. The report is structured to comply with DH DIPC Annual Report guidelines (Appendix 4)

3. Budget allocation

We currently have funding for:

- 1 Consultant microbiologist (3 Programmed Activities)
- 1 'I' grade ICN (now Band 8c)- wte
- 1 'G' grade ICN (now Band 7) – wte
- 1 'G' grade ICP (now Band 7) – wte
- 1 part-time A&C grade 4 Service Administrator – 18hrs a week. Budget held by the Medical Directorate because the role is shared with the TB Nurse Service.

We have a non-pay budget of £700 per annum for stationary which has not increased over the last 12 years. The named signatory for the Infection Control budget is Roz Wallis.

Funding for training is provided by the Corporate Nursing Team Post Registered Nurse Training Budget.

4. Infection Control Team activities between April 2005 - March 2006

4.1 Membership of Committees

The Infection Control Team members continue to be integrally involved in Trust activities. Below are the regular committee meetings that we attend:

Infection Control Committee	BA/RW/SP/LW
Decontamination Committee	RW/BA
Health and Safety Committee	RW
Sharps Committee	RW/SP
PEAT	RW
Waste Management Group	RW
Medical Devices Committee	RW
NMAC	RW
Risk Management Committee	BA/RW
Antibiotic Steering Group	BA/RW/SP
ICU Clinical Governance Meeting	RW
Document Steering Committee	RW
Discharge Planning Committee	RW
Good Clinical Practice Committee	RW/SP
Facilities Assurance Board	BA/RW
North West London Decontamination Project	BA
Clinical Reference Group	BA

4.2 Education

Education continued to be a priority in 2005-2006. The infection control strategy and was aimed at all disciplines and grades of staff. In total 1887 members of staff received infection control training from all professions and grades.

Figure 1 demonstrates that nurses, doctors and medical students have proportionally been the main focus of infection control education. But a significant range of all other staff have also received training. The ‘other ‘category includes all other healthcare professionals, administrators, managers, soft and hard services staff. The ‘not spec’ category did not specify their professional title on the evaluation/attendance forms.

This data was taken from the Trust Training database, the Post-Graduate Centre and the Corporate Nursing Team. It is worth noting that it is likely that there is under-reporting of attendance due to human error. Nevertheless Figure 1 demonstrates the extent of training and diversity of staff groups that the ICT teach.

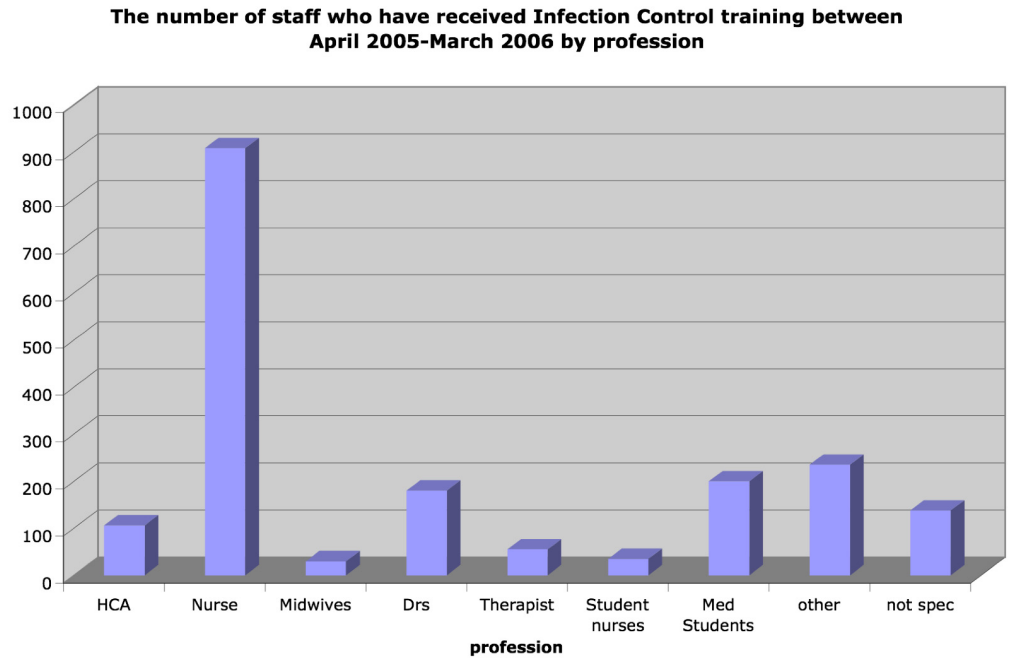


Figure 1. The number of staff who have received Infection Control training between 1 April 2005 and 31 March 2006, by profession

Regular teaching sessions included:

- Corporate Induction for all new employees (excluding doctors) to the Trust (monthly).
- Nurses Induction (monthly)
- Pre-Registration House Officers (PRHO) Induction (every six months)
- Senior House Officers (SHO) Induction (every six months)
- New Specialist Registrars and Consultants Induction (monthly)
- Student Nurses Induction (per intake)
- Nurses Annual Update (monthly)
- Healthcare Assistants Update (monthly)
- IV Administration Study Day (monthly)
- Intensive Care Foundation Course (every six months)
- Medical Students (every six months)
- Infection Control Link Professionals four courses, each four days long
- Infection Control Link Professionals monthly meetings
- Quarterly Seasonal Conferences

All teaching sessions include education/discussion about hand hygiene.

In addition to the regular teaching sessions, the ICT provided various *ad hoc* teaching sessions for all staff groups. Most Infection Control teaching sessions are included in the list in Appendix 5.

4.3 Clinical Negligence Scheme for Trusts (CNST)

CNST assessors assessed the Trust in February 2005, awarding us Level 2. CNST criteria are integral to the ICT annual programme. The ICT continue to work towards achieving Level 3 at the next assessment in 2007.

4.4 Hand Hygiene

The Chelsea and Westminster Healthcare NHS Trust takes hand hygiene very seriously because good practice can significantly reduce hospital acquired infection rates. The ICT encourage staff ownership of hand hygiene at all levels by including in all teaching sessions in the Trust together with the annual Hand Hygiene Awareness Week (see below) aimed at all staff.

4.4.1 Hand Hygiene Awareness Week, April 2005

This was a high profile week of events aimed at increasing Chelsea and Westminster hospital staff awareness of the importance of Hand Hygiene (HH). It is our fifth annual HH awareness week, which built on the format of the event of the previous years. It remains the biggest annual event in the Trust and attracted national and local press interest.

A diverse range of tactics were used to capture staff attention, including: evolving art, circus entertainment, a barbershop quartet, professional comedians, hand massage, quizzes, and prizes. The main focus was education (see Appendix 6 for full programme). Specific staff groups were targeted using posters, emails, and the Trust News to advertise the academic seminars. Over the years staff attendance at these events has gradually increased, this year just under 1000 staff attended. We consider that this emphasises the credibility of the programme. Some managers made it mandatory to attend e.g. cleaners and caterers.

4.4.2 Alcohol Gels

The Trust now have alcohol gels throughout the Trust, in every Department, by every bed-side, in every clinical corridor and in every outpatient consulting room.

Three PASA approved alcohol gels were trialed at each bedside in nine clinical areas over three weeks in April 2005 to enable staff to choose which of the three they preferred. They chose GoJo Purell alcohol gels. These were then introduced by each bed-side in the Trust in July 2005 as part of the NPSA *cleanyourhands* campaign to enables 'point of care' hand decontamination i.e. staff can clean their hands immediately after procedures/contact with patients. Staff in A&E and Paediatrics were given small personalised bottles rather than positioning by bed-sides for patient safety reasons.

Alcohol gels are also used our operating theatres as an alternative to the usual hand antiseptics.

4.4.3 Hand Hygiene Audits

Monthly auditing of Hand Hygiene compliance was commenced in July 2005. The Infection Control Link Professionals conduct the audits which are then put on onto the intranet by the ICT. The ICLPs are taught how to audit on the ICLP course. The audit tool, devised by UHL ICT (2001) is the main hand hygiene audit tool used in the UK (Appendix 7).

Figure 2 shows the average Hand Hygiene compliance for each directorate. It shows that there is significant room for improvement. However this reflects all published research on

hand hygiene compliance which on average is about 40%. The overall Trust average Hand Hygiene compliance is 54% (See Appendix 8 for raw data.) This is a crude calculation and should only be used as an indicator. It is important to point out that few other NHS Trust have such regular and detailed and transparent information on hand hygiene compliance.

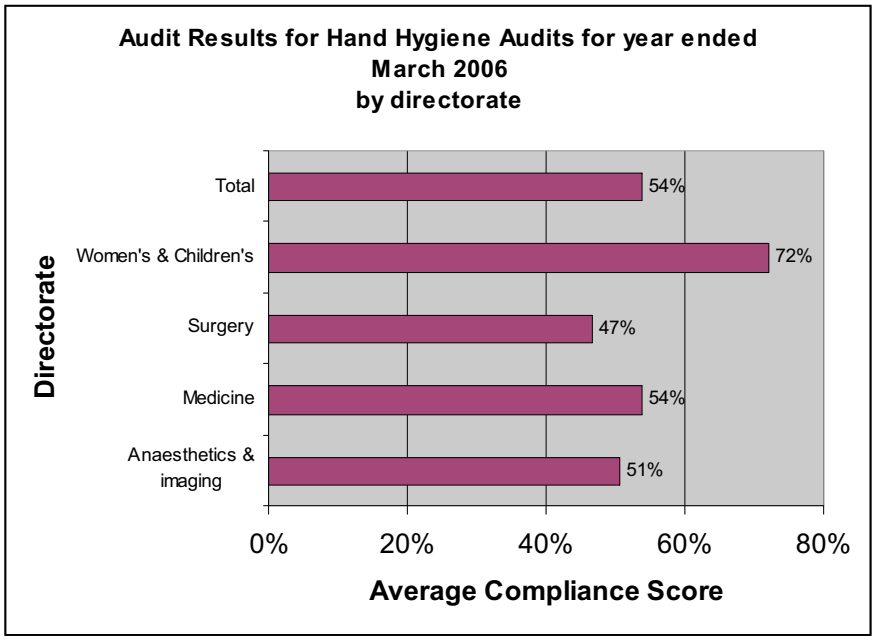


Figure 2. Audit Results for Hand Hygiene Audits for year ended March 2006, by directorate

Hand Hygiene Compliance is reported to NMAC monthly, the Infection Control Committee and the Risk Management Committee quarterly and to the Trust Board annually.

4.4.4 NPSA *cleanyourhands* Campaign (CYH)

This national campaign was launched in the Trust in July 2005.

It was commissioned by the Department of Health in 2003 and launched by the NPSA in 2004. The aim is to improve hand hygiene compliance across the NHS by reducing practical barriers. The campaign combines a number of approaches that have demonstrated significant reductions in MRSA rates in hospitals in Switzerland, USA, Australia and Oxford, England. Materials are all supplied free by the NPSA.

It involves

- Displaying and changing posters on a monthly basis.
- 'Point of care' alcohol gels (i.e. at each bed-side).
- Giving all inpatients a leaflet on admission which explains
    - the importance of hand hygiene
    - that it is okay to ask staff to clean their hands

  (Leaflets available in 26 languages from the NPSA website).

- Staff to routinely wear enamel campaign badges
- Influential staff to openly support the campaign by being identified as a role models in a poster campaign

Infection Control Link Professionals are responsible for implementing the campaign in their own clinical areas.

This national campaign will continue to be centrally founded for the next 3 years.

4.5 Infection Control Link Professionals (ICLP)

The ICLP system was commenced in July 2005. Its aim is to ensure there is one informed and influential healthcare professional in each clinical area who is responsible for implementing and monitoring the Trust's infection control priorities (i.e. priorities identified in Winning Ways 2003). See Appendix 9 for ICLP role responsibilities.

All ICLPs are initially required to complete a 4–day training course run by the Infection Control Team. As part of the course each ICLP completes a project which involves improving an aspect of infection control care in their area of practice. To date 43 ICLPs have completed the training.

Following completion of the course trained ICLPs must attend the ICLP monthly meeting. This provides a forum for conducting monthly audits, professional development and for networking with fellow ICLPs.

4.6 RCN *Wipe it Out* Campaign

The Chelsea and Westminster Hospital became the first Trust in the country to pilot the RCN *Wipe it Out* Campaign. Beverley Mallone, RCN General Secretary, attended the launch in July 2005, along with approx 400 of our nurses. The event attracted national and local media attention.

The campaign focuses on improving basic standards of Infection Control (Appendix 10). The Trust are using the A3 size Visitor poster (outside all ward areas) and the MRSA leaflets for patients and visitors. The basic standards are used as a reference point by the PEAT Committee

4.7 Training in Litigation Management in Infection Control

In August 2005 the Chelsea and Westminster Infection Control Team piloted a Legal Training workshop in collaboration with the RCN and Bevan Brittain. More than 60 senior members of staff, from executive to ward level, participated. The workshop consisted of an afternoon of taught sessions, group work and courtroom scenarios.

4.8 Pre-operative MRSA Screening for Elective Patients

In March 2005 pre-operative MRSA screening commenced for elective patients. This is managed by the Pre-Assessment Clinic. It enables identification and treatment of patients who are colonised with MRSA, and enables isolation precautions to be taken on admission to the hospital. Doing this has enabled the Surgical Directorate to set up MRSA screened wards, thus reducing the potential for MRSA cross infection. Most emergency admissions are screened on admission and weekly on Sundays.

4.9 Single Swab for MRSA Screening

The introduction of pre-operative MRSA screening significantly increased the workload of the Pre-Assessment Nurses and of the Microbiology Laboratory staff. Screening required three swabs to be taken from the nose, axilla and groin, (and any wounds). Each swab required a separate form to be generated and printed off HISS. In April 2005 we changed over to single swab screening which significantly reduced the related workload and costs for all concerned (Separate sterile swabs are indicated for wounds.)

In additional a new MRSA treatment chart was developed by the ICT for MRSA positive patients

4.10 Introduction of Silver Alloy Urinary Catheters (BARDEX IC)

In May 2005 the Infection Control Team and the Procurement and Supplies Department introduced silver alloy catheters across the Trust, replacing all pre-existing stock. Chelsea and Westminster Hospital were the first Trust in the UK to do this.

Silver alloy catheters are associated with reducing urinary tract infections. BARDEX IC is a new technology to the NHS and was approved at the highest level (Level 1) by the DH Rapid Review Panel in December 2004. It also received a favourable Cochrane review with recommendation for use in the NHS.

A Trust-wide audit of urinary catheter use in April showed that:

- more than 90% of catheters used were sizes 12Ch and 14Ch,
- less than that 1% were silicone based (i.e. the alternate product used for patients with Latex allergies)
- More than 90% were for short-term use (i.e. in situ for less than 4 weeks).

On this basis wards were only stocked with sizes 12Ch and 14Ch and a holding ward was created (Rainsford Mowlem) for all other sizes, silicon and long term catheters.

As a result of the smooth introduction of silver alloy catheters the Trust is being used as an example of innovative practice by the Innovations Department in the DH. It has also resulted in the Trust being short-listed for a prestigious Patients Association Award (named Trust representative: Roz Wallis) which has resulted in positive publicity for the Trust in the local and national press.

The change has significantly improved materials management resulting in financial savings by streamlining to the one product and significantly reducing the costs associated with ordering. Previously there could be up to 60 urinary catheters of all different sizes and manufacturers on each ward. Now there are only two boxes, therefore less wastage.

4.11 Introduction new urinary collection bag

A new urinary collection bag was introduced across the Trust to replace other urinary bags. It was introduced to reduce the risk of sharps injuries and splash injuries when taking samples (it has a needle-less sample port). It also has a very sturdy hanger to prevent it from falling off the bed frame and becoming contaminated.

4.12 Introduction of new online MSc module in Management of Infection Control

Chelsea and Westminster Hospital became the pilot site for this new course in January 2006. It was set up by Greenwich University. It provides post-graduate education in the Trust in Infection Control at Masters level. It can be done as a stand-alone module or as part of a Master of Science degree at Greenwich University. Five members of staff have completed it as a stand alone module including three senior nurses, an ISS cleaning manager and a junior doctor (SHO). Roz Wallis was a co-author and will participate in the online tutoring.

4.13 External Meeting Presentations by ICT

Table 1 shows the external presentations given by the ICT between April 2005 and March 2006:

Table 1. External presentations given by the ICT between April 2005 and March 2006

Date	Event	Presentation focus	Presenter
April 2005	Royal College of Nursing (RCN) National Congress	Hand Hygiene for the *Wipe it Out* National Campaign Launch	Roz Wallis
June 2005	London Assembly	Steering Committee on MRSA in London	Roz Wallis as representative of RCN
July 2005	Kensington and Chelsea Borough Council	Borough Steering Committee on MRSA	Dr Berge Azadian Roz Wallis
September 2005	North Middlesex Hospital Infection Control Link Nurse Conference	IV line care Hand Hygiene Awareness Week at the Chelsea and Westminster Hospital	Shona Perkins Roz Wallis
November 2005	RCN National Conference re MRSA	One acute trust's approach to reducing healthcare acquired infections	Roz Wallis Shona Perkins

4.14 Conferences, study days and courses attended by the ICT:

Table 2 shows the courses, study days, conferences attended by the ICT between April 2005-March 2006.

Table 2. Courses, study days, conferences attended by the ICT between April 2005 and March 2006

Date	Event	Attended by:	Paid for by
April 2005	Pandemic Flu, half day, Royal Free Hospital	Roz Wallis Shona Perkins	Free
September 2005	ICNA National Conference	Shona Perkins	C&W Trust
September 2005 December 2005	HPA Orthopaedic Surveillance	Shona Perkins Linda Whetren	Free
October 2005	Kingston Infection Control Study Day	Roz Wallis (guest of Kingston Hospital ICT)	Free
October 2005	Healthcare Associated Workshop: Sharing in the experience of others. National Performance Advisory Group. Milton Keynes	Roz Wallis Shona Perkins	Free
November 2005	Water Masterclass, UCH	Roz Wallis Shona Perkins	Free
December 2005	Presentation Skills Course	Linda Whetren	Internal course
January 2006	Topix Microbiology Conference	Dr Berge Azadian Roz Wallis	HHT Personal payment
February 2006	3rd National Prevalence Survey half day:instructions re how to do it	Roz Wallis	Free
February 2006	Kings Fund Leadership Course, 1 week	Roz Wallis	Free
March 2006	MRSA and Healthcare Acquired Infections: Associate Parliamentary Health Group, Houses of Commons	Roz Wallis, guest of RCN	Free
March 2006	Healthcare Associated Infection 2006 2 day Conference	Day 1 Roz Wallis Day 2 Shona Perkins Both on behalf of Dr Azadian	C&W Trust
March 2006	Communicable Diseases in 2006:Aliens and young adults	Linda Whetren	C&W Trust

4.15 Microbiology Pharmacist

Antibiotic resistant organisms present a growing threat to hospitalised patients. They have resulted from misuse of antibiotics. In response to DH guidelines (Standing Medical Advisory Committee, 1998) Chelsea & Westminster Healthcare NHS Trust Pharmacy have continued to prioritise responsible antibiotic prescribing in 2005-2006.

The microbiology pharmacist is a 0.5WTE position. Table 3 shows the activities of Kieran Hand, our Microbiology Pharmacist over the last year.

Table 3. Microbiology Pharmacist Activities between April 2005 and March (inc) 2006

Service Development

Critical Care Outreach Team

- Drafted proposal for antibiotic pharmacist input to critical care outreach team
- Drafted SWOT analysis

Out-patient Parenteral Antimicrobial Therapy

- Conducted literature search and review of evidence for OPAT
- Prepared and delivered presentation to clinical nurse leads
- Drafted proposal for out-patient parenteral antibiotic therapy
- Attended training on PICC line insertion and maintenance
- Visited OPAT nurse at St. Mary's

Selective Decontamination of the Digestive tract

- Reviewed the literature on selective decontamination of the digestive tract in ventilated patients and participated in debate with representatives from ICU and the Burns unit on proposals to adopt SDD at C&W
- Argued successfully against introduction of SDD to C&W

European Survey of Antimicrobial Consumption

- Attended preliminary meeting of ESAC sub-group on hospital antibiotic consumption to discuss benchmarking of antibiotic usage and prescribing

Management of Service

Pharmacy IT system

- Developed specifications for the following routine reports of antibiotic usage in collaboration with pharmacy systems analyst
    - Daily report of issues of alert broad spectrum antimicrobials
    - Monthly report of antibiotic issues in Defined Daily Dose format and split by directorate for feedback to prescribers
    - Monthly report of antibiotic expenditure split by directorate
    - Monthly report of alert broad spectrum antibiotic issues split by directorate as a marker of quality of prescribing

Infection control IT system – Pathogen epidemiology and antibiotic prescribing

- Attended two meetings to review Cereplex system from the US in collaboration with the Health Protection Agency
- Attended presentation by two UK providers of infection control software

Meetings

- Convened antibiotic steering group
- Attended meetings of the trust infection control committee
- Attended the Interscience Conference on Antimicrobial Agents and Chemotherapy meeting in Washington D.C. in December 2005 and presented summary notes at the respiratory journal club

Interface with primary care

- Reviewed and commented upon KCW PCT antibiotic guidelines

NorthWest London Antibiotic Pharmacists Network

- Attended quarterly meetings and submitted point prevalence and antibiotic usage data for benchmarking and quality assurance initiatives

Stock supply issues

- Managed stock shortages of Tazocin (liaison with microbiology regarding Timentin disc testing) and Meropenem
- Contributed to introduction of unlicensed tuberculin product for Mantoux testing
- Managed discontinuation of Amphocil formulation of amphotericin

Evaluation of Service

Audit activity
- Conducted hospital-wide point prevalence audit of antibiotic prescribing
- Drafted audit contract and timetable for pre-registration pharmacists (pre-regs)
- Delivered training for new audit supervisors
- Reviewed and commented upon proposals for pre-reg audits
- Supervised pre-reg audit of antibiotic usage patterns and correlation with *Clostridium difficile* and MRSA infection
- Supervised pre-reg audit of gentamicin and vancomycin therapeutic drug monitoring
- Co-supervised one pre-reg audit of antibiotic prophylaxis in surgery
- Provided advice and support on a further two pre-reg audits on the management of cellulitis on medical wards and the management of asthma by HIV physicians in the Kobler Centre

Antibiotic usage monitoring
- Prepared reports of antifungal use for Consultant Microbiologist and implemented distribution of daily reports of alert antimicrobials to Dr Azadian
- Provided Consultant Microbiologist with report of 5-year trends in antibiotic use overall and by class

Clinical Practice

Microbiology
- Accepted referrals of complex infection cases and provided advice or liaised with microbiology as required
- Responded to resident pharmacist handovers and provided education and training as required

National MRSA workshops
- Developed training material for a series of national multi-disciplinary workshops on the topic of evaluating interventions to reduce MRSA
- Delivered the pharmacy presentation at the London workshop to an audience of pharmacists, microbiologists and infection control nurses

National MRSA guideline
- Submitted a detailed response to the consultation document from the British Society for Antimicrobial Chemotherapy on the treatment of MRSA

United Kingdom Clinical Pharmacy Association
- Served as a committee member of the infection management specialist interest group
- Served as a committee member of the R&D sub-committee

Clinical Governance
- Adapted penicillin-allergy traffic light poster for use in C&W

Miscellaneous
- Contributed to pharmacy Medicines Information internal quality assurance

Education and Training
- New pharmacist inductions and new resident pharmacist training
- Medicines management technicians – teaching sessions on antibiotics and gentamicin/vancomycin monitoring
- Pre-registration pharmacists – afternoon workshop on antibiotics
- Basic grade pharmacists – two-hour lecture/workshop
- PRHOs – one-hour lecture on antibiotic prescribing during handwashing awareness week
- SHOs – one-hour lecture on antibiotic prescribing during handwashing awareness week
- Nurses and allied health professionals – infection control link professional training on antibiotics and resistance
- Plastic surgery nurses - delivered presentation on the management of infection associated with the use of leeches in plastic surgery
- Prepared presentation on C&W antibiotic control measures for infection control induction sessions for new consultants and registrars
- Completed ICLP 4 day training course
- Acted as ward tutor to basic grade pharmacists

Continuing Professional Development

- Completed MSc in Infection Management at Imperial College London (awarded distinction)
- Completed supplementary prescriber training at King's College London

Research and Development

Research

- Completed multi-centre research study to evaluate knowledge of antibiotics amongst junior pharmacists for MSc in infection management
- Presented results of MSc research to Pharmacy Department, Microbiology Department and Respiratory Team
- Presented results of MSc research as a poster at the November meeting of the UKCPA in Leeds
- Submitted antibiotic usage data in the form of Defined Daily Doses to NorthWest London collaboration for benchmarking and publication
- Contributed to research agenda for introduction of electronic prescribing

Publications

- Ardehali B, Hand K, Nduka C, Holmes A, Wood S (2005) Delayed leech-borne infection with Aeromonas hydrophilia in escharotic flap wound. Br J Plast Surg.
- Review of treatment of infections caused by multi-drug resistant bacteria - article in Pharmacy in Practice with Dr Hayley Wickens from St Mary's published in February 2006
- Review of TB treatment - article for Hospital Pharmacist published in April 2006

Guidelines and policy

- Reviewed and commented upon Central and NorthWest London Mental Health Trust antibiotic policy
- Reviewed and commented upon updates to HIV directorate antibiotic guidelines
- Drafted A&E guideline and developed algorithm for management of tetanus prone wounds
- Published algorithm for antibiotic treatment of respiratory tract infections on the Intranet
- Developed pleurodesis guideline in collaboration with pharmacy colleague
- Developed guidelines for use of antibiotics in plastic surgery and algorithm for antibiotic prescribing

MRSA pre-admission screening

- Developed prescription proformas for MRSA decolonisation protocols for use by pre-admission screening clinics

Patient Group Directions

- Reviewed A&E antibiotic PGDs and suggested revisions
- Reviewed and commented upon draft BCG vaccination PGD

Avian influenza and influenza

- Drafted pharmacy department position statement on supply of anti-viral medication in cases of suspected avian influenza
- Attended meetings with trust co-ordinator
- Attended PCT meeting
- Distributed algorithm for influenza prophylaxis and treatment
- Reviewed paediatric algorithm and commented

5. Auditing

Auditing activities have focused on hand hygiene audits (see section 6.4.3) and IV line audits both of which are conducted by the ICLPs. The IV line audit is a qualitative monitoring tool which currently does not enable quantitative feedback.

The Intensive Care Unit had an infection Control Environmental audit conducted in October (using the West Midlands ICNA audit tool). Their overall score was 73%.

In August a Sharps Container audit was conducted. 322 sharps boxes were observed in 43 wards/department. Generally practice was good. One sharps container had sharps protruding from it. 10 were positioned on the floor, and 56 were not labelled by the persons who assembled them. A key recommendation was to use the trays/small sharps boxes for point of use disposal. Results were fed back to individual clinical areas, to NMAC and to the Infection Control Committee.

6. Policies

All Infection Control Policies are reviewed on an annual basis. There have been no new policies added over this time period.

7. Building Works

Infection Control advice was given on a number of building and refurbishment projects. During the Hand Hygiene Awareness Week Peter Hoffman, Clinical Scientist from the Health Protection Agency gave a dedicated presentation to our Facilities and Estates Departments, and Project Management Team (PMS) entitled Infection Control in Building & Maintenance Projects. Attendance and evaluations were very good because it was specifically tailored to answer their questions. These annual session have resulted in greater understanding of Infection Control issues in the built environment and closer liaison with the ICT.
Over this last year ICT advice was given on the following projects:

- Bed Pan Washers
- St Stephens refurbishment
- Lift Modernisation
- Cooling – permanent solution
- Security Modernisation Programme
- Boiler House Hotwell Replacement
- Regional Burns Unit
- Water Treatment
- New TB Nurse Room
- Fire, Health & Safety
- Treatment Centre

8. Decontamination

Table 4 lists the Decontamination issues that have arisen over the last year

Table 4. Decontamination issues between April 2005 and March 2006

Decontamination Initiatives 2005-2006

- Sterile Services Department has been audited by the Notified Body for compliance with the Medical Devices Directive 93/42 EEC and has successfully passed the audit third year around. This is a significant achievement for the trust and this is the highest standard that can be achieved for reprocessing medical devices in Europe and is paramount for quality and patient safety.

- The highest risk for the Trust in decontamination is reprocessing of endoscopes and it is on the Trust Risk Register.. There are five units which are undertaking endoscope reprocessing. They are: Endoscopy unit, treatment centre, ITU-main theatres, paediatric theatre (including paediatric outpatient), Kobler day care. None of the unit is complying with the MDD requirements which need to be achieved by March 2007. These areas required specially trained staff and facilities and this could be improved upon to promote patient and staff safety.

- Risk assessments have been done on each unit and information is collided to be presented to the Risk management committee in September 2007.

- Review of the local decontamination was undertaken by the Decontamination manager and as result many items which were decontaminated locally, are reprocess in the SSD (Lung function Laboratory).

- There is improvement in monitoring and validation of decontamination equipment in the Endoscope reprocessing unit, although there were problems with releasing equipment for the testing and service due to the breakage, non-conformance in TVC results.

- All problems were dealt with together with Haden, facilities and Decontamination manager

- Decontamination site was updated.

- There were a few training sessions organised for the staff involved in the decontamination of endoscopes by Pentax, Olympus and Steris.

- Sadly Decontamination Committee meetings were poorly attended by the members. Decontamination Manager attend NMAC meeting to update on development in decontamination and new legislation.

- Trust continue to participate in the collaboration of outsourcing the Sterile Services to the private contractors and Trust staff have been involved in the evaluation process. Trust Board will make the final decision in September 2006.

O.Sleigh - Decontamination manager

9. Healthcare Associated Infection Statistics

All NHS Trusts now report the below healthcare acquired infections:

- MRSA bacteraemia
- GRE bacteraemia
- *Clostridium difficile*
- Orthopaedic surgical site infection
- Serious Untoward Incidents and Outbreaks

9.1 Mandatory *Staphylococcus aureus* Bacteraemia Reporting

Since April 2001, all acute NHS Trusts in England have reported *Staphylococcus aureus*

bacteraemia rates. This includes *Staphylococcus aureus* that are meticillin*resistant (MRSA). The Health Protection Agency (HPA) collates this data and expresses them as MRSA rates per 1000 bed days to enable comparisons to be made.. Acute NHS hospital trusts are categorised according to the patient groups they provide services for. This hospital provides services for a number of different specialities. Prior to 2005 we have been a "Specialist Hospital Trust". This category has now been re-named as 'Acute Teaching Hospital Trusts'. Until 2005 MRSA rates were expressed per 1000 bed days. This has also changed to per 10,000 bed days.

*Spelling recently changed from methicillin to 'meticillin' to comply with EU drug nomenclature. ('Meticillin resistant' means the *S.aureus* is resistant to flucloxacillin, an antibiotic commonly used to treat staphylococcal infections).

Acute Teaching Hospital Trusts are likely to have higher infection rates because the patients are likely to require more invasive therapies and spend longer in hospital. These are the main risk factors for acquiring an infection in hospital.

Since October 2005 the Trust reports it's annual MRSA rate via an enhanced national online reporting database which is managed by the Health Protection Agency.

We have demonstrated a 40% reduction in our MRSA rates in comparison with the previous year. Last year we reported 47 MRSA bacteraemias out of 50,000 admissions. Between April 2005 and March 2006 we reported 28. Of these a proportion were acquired in the community: i.e. they didn't acquire it at the Chelsea and Westminster Hospital. As a result the DH have cited us as one of the top 20 hospitals which have demonstrated improvements in our rates.

What Is an MRSA Bacteraemia?

MRSA bacteraemias (bloodstream infections with MRSA) are used as a benchmark of infection control practice standards. Patients most at risk of MRSA bacteraemia are those having invasive procedures: major surgery or with intravenous lines in place (for example in ITU).
MRSA bacteraemia rates should be interpreted with caution; they may be affected by the nature and volume of specialist procedures carried out in a Trust.

Figure 3 shows the number of MRSA bacteraemias that have occurred in each directorate. Accident and Emergency (A&E) has been separated from the Medical Directorate for the purpose of demonstrating the proportion of community acquired MRSA bacteraemias that are included in our data. (Note: MSSA is Meticillin SENSITIVE *Staphylococcus Aureus*)

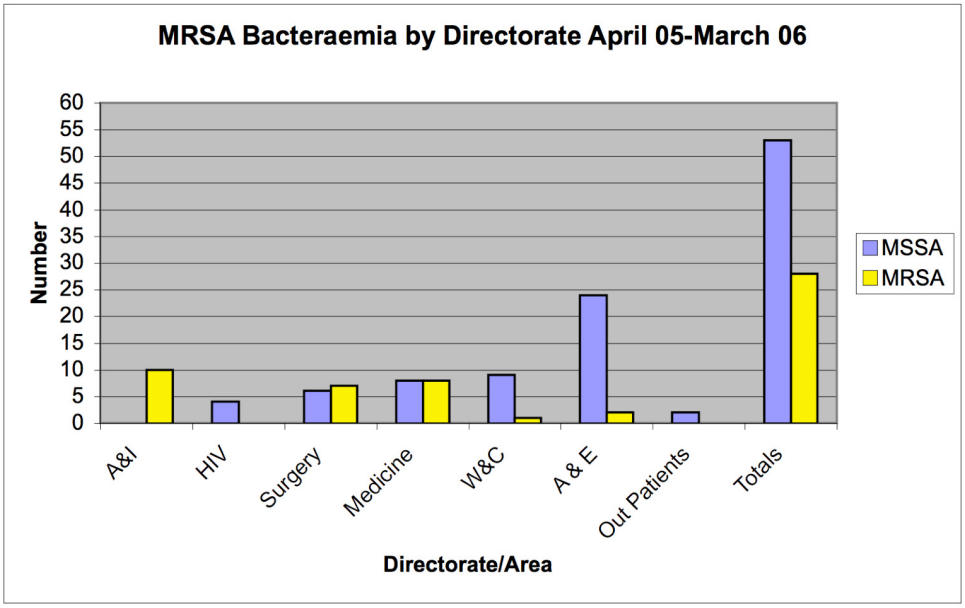


Figure 3. MRSA Bacteraemia by Directorate April 2005 – March 2006

Table 5 shows that the Chelsea and Westminster Hospital have the second lowest rates of the London Acute Teaching Hospitals over the last reporting period of the year between October 2005 and March 2006.

Table 5. MRSA Bacteraemia rates of London Acute Teaching Hospitals October 2005 - March 2006

London Acute Teaching Hospital Trusts (formerly refered to as Specialist Trusts)	MRSA bacteraemia rates per 10,000 bed days
St Georges	1.37
Chelsea and Westminster	**1.43**
Guys and St Thomas's	1.70
Bart's & The London	1.75
Hammersmith Hospitals	2.29
University College London	2.39
Royal Free Hampstead	3.17
St Mary's	3.79
Kings College	4.05

It is important to note that these are small numbers. If there were changes of just two or three bacteraemias it would result in large fluctuations in the MRSA rates and ranking which can be misleading when making comparisons on values and rates.

Figure 4 shows that we have the seventh lowest MRSA bacteraemia rates nationally in the Acute Teaching Hospitals category.

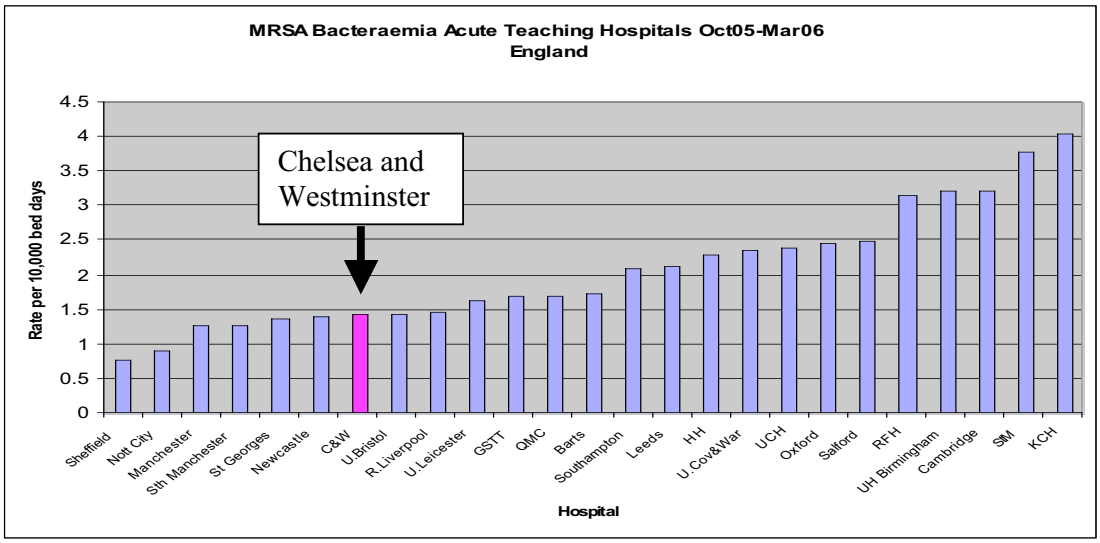
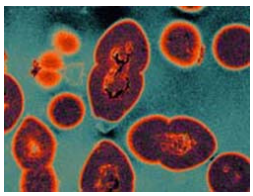


Figure 4. MRSA Bacteraemia rates of Acute Teaching Hospitals October 2005 - March 2006 for England

9.2 Glycopeptide Resistant Enterococci

It is now mandatory to report Vancomycin Resistant Enterococci (VRE) bacteraemias to the Department of Health.

Enterococci are bacteria that are commonly found in the bowel of normal healthy individuals. They can cause a range of illnesses including urinary tract infections, bacteraemia (blood stream infections) and wound infections.



During the mid-1980s enterococci with resistance to glycopeptide antibiotics such as vancomycin emerged, and have been termed glycopeptide-resistant enterococci (GRE).

Infections caused by GRE mainly occur in hospital patients who are very unwell although it can be community acquired.

Between April 2005 to March 2006 we had two VRE bacteraemias (HDU and David Erskine Ward). VRE is is rare at the Chelsea and Westminster Healthcare NHS Trust partly because there are no inpatient haematology or renal units where Vancomycin is frequently prescribed.

Figure 5 shows that we have the 3rd lowest VRE bacteraemia rates in the Acute Teaching Hospitals in England October 2004 - September 2005 (latest data available).

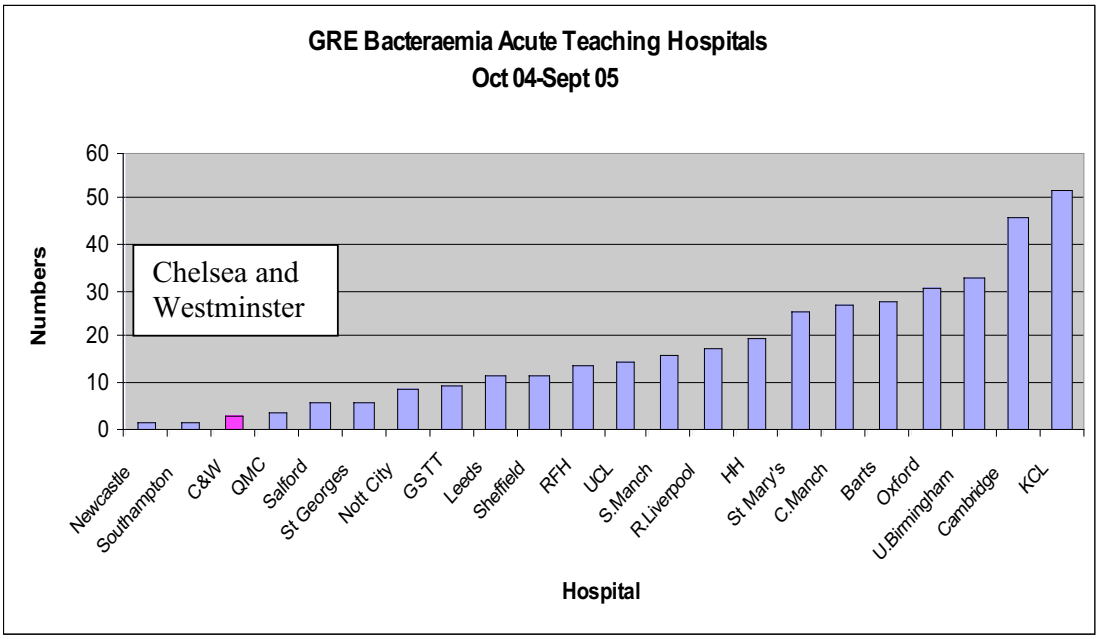


Figure 5. Glycopeptide Resistant Enterococci Bacteraemia Rates of Acute Teaching Hospitals

9.3 *Clostridium difficile* Toxin (CDT) rates

This is the second year of mandatory reporting of CDT in patients over the age of 65 years to the Department of Health.

Clostridium difficile is a type of bacteria found in the gut that can cause diarrhoea if it overgrows. It produces a toxin that can cause a spectrum of symptoms from mild antibiotic-associated diarrhoea to very severe colitis. It is able to persist in the environment for months and therefore poses an infection control risk in healthcare facilities. Patients over 65years, in hospital, who have previously received antibiotics, are most at risk of developing *C.difficile* diarrhoea. It can be controlled by good antibiotic prescribing, isolation precautions and high standards of cleaning.

Figure 6. shows the number of new CDTs identified between April 2005 and March 2006 in each directorate. It shows that most occur in medical patients which is likely to reflects antibiotic use.

In total there were 86 new CDTs >65 years and a further eight < 65 years. This reflects the Health Protection Agency's data which demonstrate that the vast majority of CDTs occur in the >65yrs age group. It also represents a 34% reduction on our rate (131 in previous year, 2004-2005).

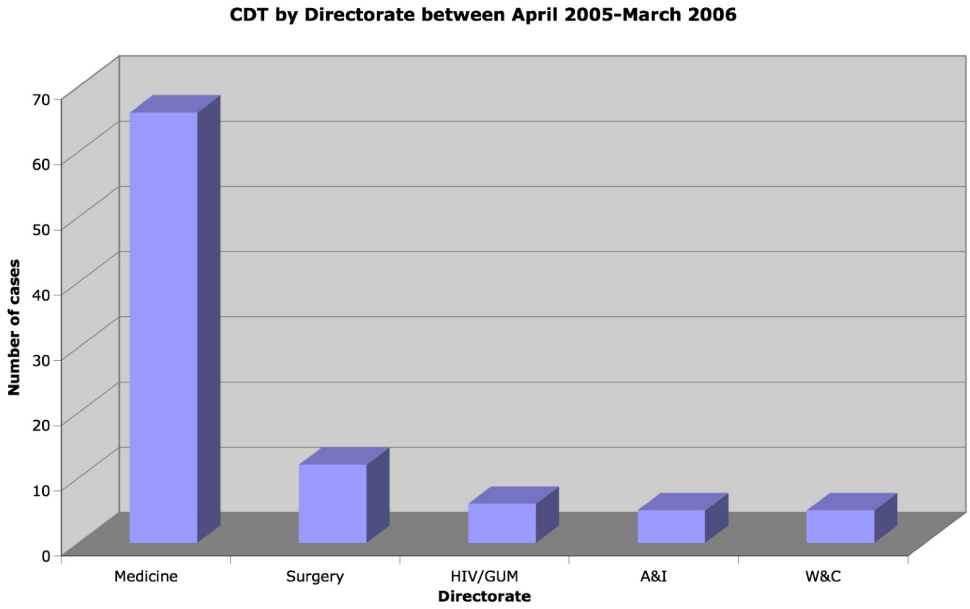


Figure 6. *Clostridium difficile* Toxin rates between April 2005 and March 2006

Figure 7 shows the CDT incidence over the last 11 years. The HPA have reported that CDT incidence has gradually risen nationally over the last few years. They attribute this to growing use of cephalosporin antibiotics. To minimise the risk of cross infection patients with diarrhoea of infective origin are prioritised for side-rooms. The ICT also conduct annual mandatory outbreak teaching every November to pre-empt the anticipated community acquired outbreaks that result in outbreaks in the hospital. Antibiotic prescribing is closely monitored by the Microbiology Pharmacist and the DIPC.

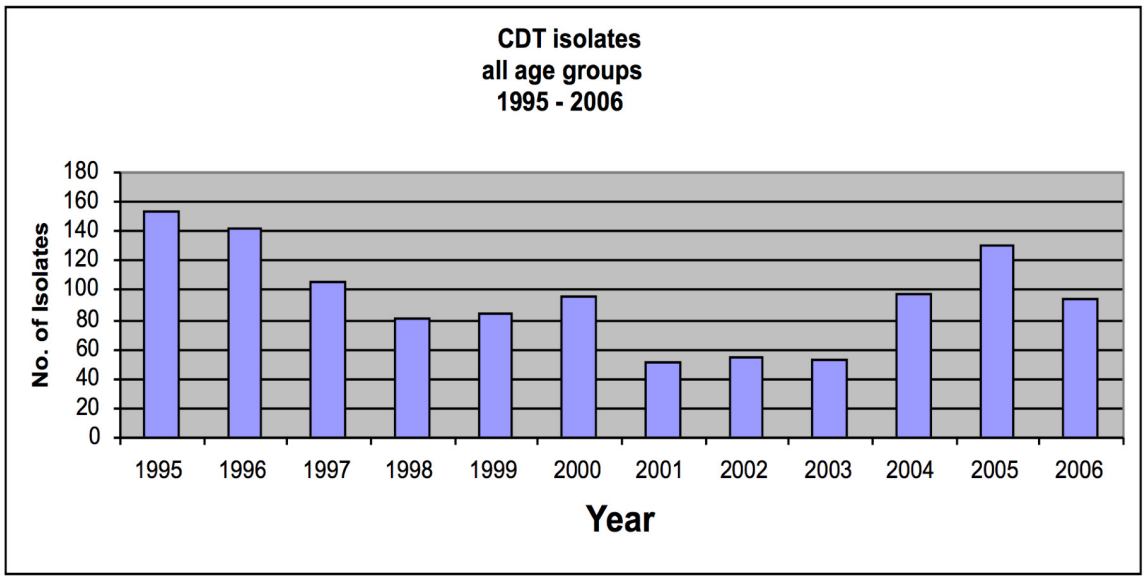


Figure 7. *Clostridium difficile* Toxin rates between 1995 and 2006

Figure 8 shows the ranking of all the Acute Teaching Hospitals in England. Chelsea and Westminster Hospital rank the seventh best in the England.

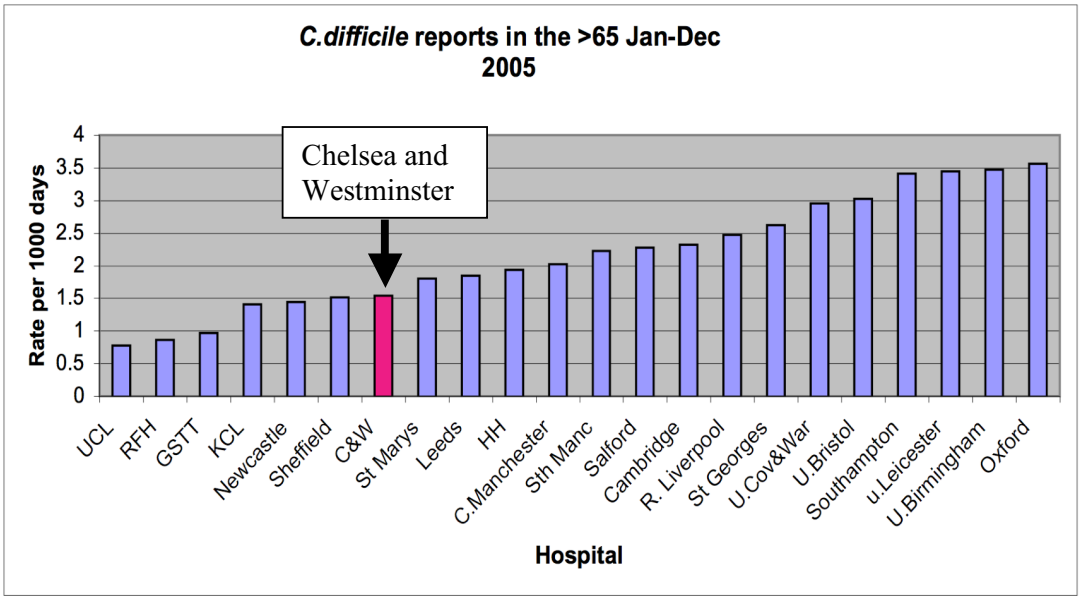


Figure 8. *Clostridium difficile* Toxin rates for Acute Teaching Hospitals in England January – December 2005

9.4 Orthopaedic surgical site infection surveillance (OSSI)

All patients undergoing total hip replacements (THR); total knee replacements (TKR); hip hemi-arthroplasties (Hip-hemi) are monitored for OSSI using nationally set criteria. Data is collated by the Infection Control Practitioner in collaboration with the orthopaedic team. It is then entered onto a national SSI online database.

Out of 464 procedures (THR, TKR, Hip-hemi) between April 2005-March2006 we had six infections, which is an overall OSSI rate of 1.3%. Table 6 also shows that our THR and TKR infection rate is lower in comparison to the national average. The hip-hemi rate is only slightly higher than the national average. However caution should be exercised when interpreting this data because these are very small numbers and therefore if there were an additional one or two cases it would result in a dramatic rise in our rates and ranking. Also the national average is based largely on data collated in the HPA voluntary surveillance scheme which may not be representative of national trends.

Table 6. Orthopaedic Surgical Site Infections local and national data

	THR C&W 2005-2006	THR All Hospitals	TKR C&W 2005-2006	TKR All Hospitals	Hip Hemi C&W 2005-2006	Hip Hemi All Hospitals
No of Operations	216	86690	187	75228	61	27461
No of SSIs	2	1435	1	709	3	1205
% Infected	0.9	1.7	0.5	0.9	4.9	4.4

9.5 Serious Untoward Incidents and Outbreaks

There were no SUIs relating to Infection Control between April 2005-March 2006. Incidents reported at the Infection Control Committee are listed in Table 7.

Table 7. Serious Untoward Incidents reported to ICC, April 2005 - March 2006

Month	Directorate	Incident	Actions Taken/Outcome
April 2005	Women and Children(W&C)	Cluster 4 children with Diarrhoea and Vomiting	• Prompt isolation by ward staff • Deep Clean • Outbreak precautions • No organism identified. All cases community acquired
April 2005	Medicine	Incident Patient with Streptomycin resistant pulmonary TB nursed without respiratory precautions in a side-room for 2-3 weeks when patient receiving inadequate treatment.	• Risk Assessment found minimal risk to staff • Occupational Health sent letters to staff.
April 2005	W&C	Exposure Chickenpox in sibling that visited NICU	• Two closest babies considered high risk of developing symptoms. • Unable to isolate in siderooms so cohorted in HDU baby in a corner for 21 days. No further known cases.
April 2005	HIV/GUM	Exposure Chickenpox. Thomas Macaulay Ward. Visiting infectious child. Child in bay for 10-15 mins. ICT found out on Day 10.	• Occ Health contact traced staff • One non-immune immunocompromised patient: isolated. No further known cases

May 2005	Surgery	Exposure Chickenpox. Member of staff worked whilst infectious on Lord Wigram Ward.	• One non-immune patient, isolated. • Occ Health contact traced staff. Isolated patient didn't develop symptoms. No further known cases.
June 2005	Medicine	Incident Endoscopy. Steris HAMO washer disinfector rinse water heavily contaminated on routine testing.	• Risk Assessment – considered low risk • Cancel patients • Training for Estates engineer by Steris • Increase maintainance contract with Elgar from twice yearly to quarterly • Instigate weekly analysis of rinse water for bacterial contamination by Endoscopy nurses • Steris to recalabrate Chessel data recorder • Elgar to replace filters and membrane • Elgar to change sample valve • Elgar to sanitise unit after works
June 2005	Anaesthetics and Imaging (A&I)	Cluster of Infection Four MRSA bacteraemias on ICU	change in practice: • Chlorhexadine disc • CVC impregnated with silver alloy • Replace alcohol wipes with alcoholic chlorhexadine (good Gram positive cover) • Use of sharps trays for IV administration • Big CVC placement pack with large sterile field & swabs on sticks • Plan towards an IV line care awareness week These interventions and heightened awareness appeared to control this cluster of infection
December 2005	Surgery	Cluster of Infection LWIG had 3 patients in the same bay with diarrhoea,	• Isolate patients • Deep clean the bay • Close bay to admissions • Monitor other patients in bay • Education focus on hand hygiene and cleaning Causative organism: *Clostridium difficile* in 2 cases

December 2005	Medicine	Incident: An infectious TB patient was admitted to ward bay and then transferred to ITU prior to positive TB result	• Incident meeting • TB Nurses contact traced • Occ Health/GP letter sent out to staff/patients considered at risk
January 2006	Medicine	Exposure: A known shingles patient admitted to a bay on WGIL, then NG, and then put into a sideroom on SMA before the ICT was informed	Follow up of patients and staff. Nil at risk Nil known subsequent chickenpox cases
January 2006	W&C	Cluster: 14 children admitted to 3 wards with diarrhoea and vomiting	Large outbreak in community at that time Ward put on high alert. Outbreak precautions taken to minimise cross infection risk. Nil subsequent hospital acquired cases Causative organisms: Norovirus and Rotovirus isolated in 2 patients – Community acquired
February 2006	Treatment Centre	Incident: Treatment Centre: The extractor in the dirty sluice between theatres four and five broke down	A risk assessment showed that airflow in theatres not affected therefore theatre list continues Extractor fan replaced the following day
February 2006	Treatment Centre	Incident: MRSA+ve result was wrongly reported by microbiology lab when in fact it was a sensitive *Staphylococcus aureus*.	Microbiology informed of error The Pre-assessment Unit were advised but had already informed the patient and organized treatment. Patient informed but did not lodge a complaint

March 2006	HIV/GUM	Incident: Legionella species isolated in water in un-used sink in St Stephens Centre	Stopped patients showering in Research floor Estates investigated the water pipes and found a number of 'deadlegs' These have been removed and the water supply has been treated with a chloride based treatment in the short term until a long term solution agreed at Board level. Further results negative to Legionella
March 2006	Medicine	Exposure: Appropriate precautions not taken with patient with Norwegian Scabies	Occ Health contact traced staff. Nil further known subsequent cases

9.5.1 Outbreaks

Between December 2005 and March 2006 there were 10 outbreaks of diarrhoea and vomiting (Appendix 11). Outbreaks continued to occur into the new financial year for a further three months. This is the most prolonged outbreak season in the history of the hospital. It reflects a large and prolonged Norovirus outbreak in the local communities.

It is likely that some of the 10 were new outbreaks introduced by different visitors, patients or staff who initially became infected in the community. It is also likely that some of the outbreaks occurred due to cross infection by staff working between different clinical areas. In addition the pressure to open beds in affected wards may also have contributed to the perpetuation of the outbreaks by not keeping the affected wards closed for long enough to allow the outbreaks to subside.

In total 189 people were affected, 35 of whom were staff. Nine outbreaks occurred in medical wards. Norovirus was confirmed as the causative organism in six of the outbreaks and was presumed to play a part in four other wards. CDT was also found in four of these wards.
The cost of the outbreaks is likely to be significant although it was not formally evaluated. A minimum of 571 bed days were lost, each costing between £100-£260. Additional expenditure would include bank and agency staff cover for symptomatic staff who would require a minimum of 3 days off sick if they worked when symptomatic. Additional linen, disposables e.g. incontinence pads, plastic aprons, gloves, pulp products, clinical waste; and the deep cleaning would all contribute to the cost.

NOTE:
Norovirus has a 70% attack rate i.e. if one person is symptomatic on a ward, 70 % of the people in that area are likely to subsequently become cross infected. The incubation period is 48 hours. Symptoms last for 24-48 hours and are not usually life threatening, although the elderly are more vulnerable to fluid imbalances. The affected person remains highly infectious for a minimum of a further 48hrs after symptoms have ceased. Therefore wards closed due to Norovirus outbreaks need to be kept closed for 48 hours after all symptoms have ceased after which the ward needs to have a thorough deep clean using a hypochlorite based product.

9.6 Local Data: Alert Organism Surveillance

As well as providing MRSA bacteraemia data for the Health Protection Agency (HPA), the ICT collate data for local use on all new MRSA isolates and other alert organisms from all sites including blood. Alert Organism Surveillance (ie local organism data collection) cannot accurately differentiate between infection and colonisation therefore both are represented in these data. It is likely however that the majority of these new isolates represent colonisation.

9.6.1 MRSA

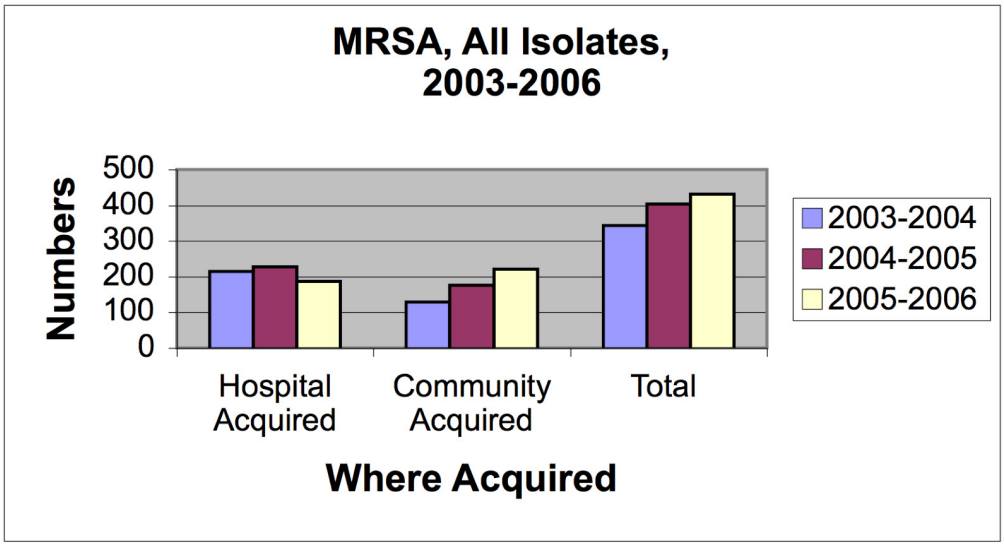


Figure 9. All MRSA Isolates, 2003-2006

Figure 9 shows that there has been:

1. a gradual rise in new MRSA isolates over the last three years
2. a reduction in hospital acquired MRSA isolates
3. an increase in community acquired MRSA

This is likely to reflect the introduction of pre-assessment MRSA screening. The more we look for MRSA, the more we will find. By identifying positive patients in advance it enables decolonisation treatment prior to admission. It also ensures that isolation precautions are taken throughout the patients stay in hospital thus reducing the risk of cross infection to other patients.

9.6.2 Resistant Gram Negative Organisms

To date, NHS Trusts have not been required to report incidence of resistant Gram-negative organisms. Locally however the ICT closely monitor it.

Figure10 shows that there were 66 new resistant Gram-negative isolates mostly in the Surgical and Medical directorates over the winter months.

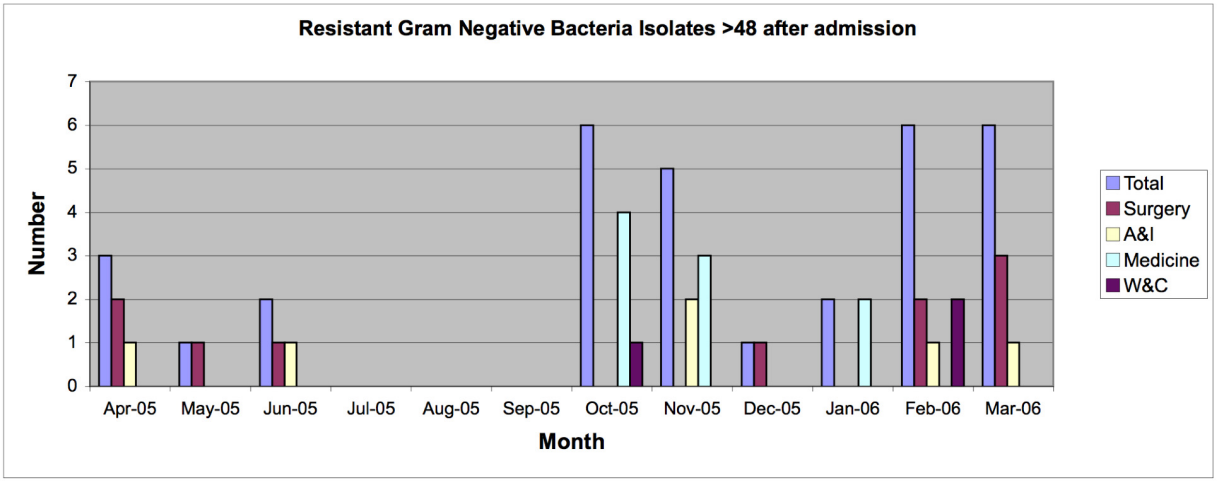


Figure 10. Resistant Gram Negative Bacteria Isolates over 48 hours after admission, April 2005 – March 2006

In previous annual reports Acinetobacter species have been the predominant resistant Gram negative organisms reported by the ICT. This year the predominant group of Gram-negative organisms identified were the ESBLs.

What is an ESBL?
ESBLs (Extended Spectrum Beta-Lactamases) are enzymes that can be produced by bacteraemia which make them resistant to cephalospirins - the most widely used antibiotics in UK hospitals. ESBLs are present in a wide range of organisms, most frequently Klebsiella and E-coli species. Since 2000 a particularly virulent strain of ESBL has emerged and caused outbreaks across the UK. They have emerged due to antibiotic use, often cause urinary tract infections and have been associated with a high mortality.

Over the last two years there have been numerous ESBL outbreaks across the country associated with a high mortality, mostly in the community. This is a new and worrying national trend which represents a threat to hospitals. To monitor this our microbiology laboratory introduced routine ESBLs testing in urine specimens in September 2005. Therefore in Figure 10 the resistant Gram negative organisms isolated thereafter were mostly ESBLs, predominantly Klebsiella species and E coli in urine specimens.

It is important to note that there has been no apparent ESBL cross infection at the Chelsea and Westminster. It is likely that all were acquired in the community.

9.6.3 Tuberculosis (TB)

Incidence of the disease in the UK is increasing, particularly in London. By far the most common site of TB (80%) is in the lungs (pulmonary). Pulmonary TB is infectious by airborne transmission. Non-infectious TB is its occurrence in other "closed" parts of the body e.g. spine, lymph nodes. Patients with closed TB do not present an infection control risk; however, these patients must be screened for pulmonary TB as a precaution.

Figure 11 shows the number of patients who were diagnosed with TB during their hospital admission between April 2005-March 2006. The HPA was notified of these (and all newly diagnosed TB patients) by the TB Nurse Service because TB is a notifiable disease. Not all required an infection control input because not all were infectious.

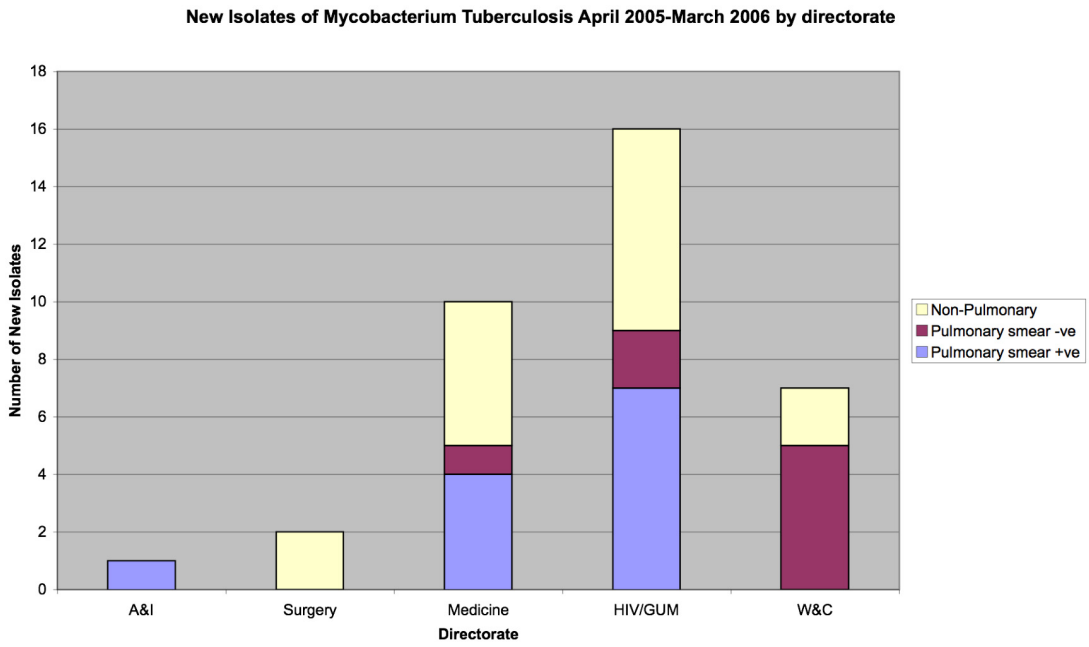


Figure 11. New Isolates of *Mycobacterium tuberculosis* in in-patients April 2005 – March 2006

The TB Nurse Service additionally treated a further 35 confirmed TB patients who were not inpatients at the time of diagnosis. These are not included in Figure 11.

HIV/GUM and the Medical directorates have most cases, partly because of the location of the negative pressure rooms. A significant proportion of these patients were also diagnosed with HIV. However the HIV/GUM Directorates rate does not accurately represent the number of HIV+ patients with TB because the negative pressure facilities are also used by medical patients.

For more information see TB Nurse Service Annual Report which will be available on the intranet from October 2006.

10. Body Fluid Exposures

Body Fluid Exposures are solely occupationally related. Under current health and safety legislation, employers have a duty of care to assess the risks to their employees and to reduce these as far as is reasonably practicable. The number of Body Fluid exposures reported to Occupational Health between April 2005 – March 2006 was 137, compared to 74 for the previous 12 months.

- Most sharp injuries occur after the use of sharps and before disposal. Many of these could be prevented by correct disposal and introduction of safer devices which make the needle safe as soon as it has been used.
- The number of staff injured who were not the original user of the item is particularly high in theatres

- Mucocutaneous exposures could be prevented by use of personal protective equipment such as face visors

The OH department held a Health and Safety Awareness event in October 2005 which included sessions on BFE prevention, (with input from the Clinical Skills Trainers and Infection Control team)
Dr MacGreevy, OH physician led a protected teaching session for SHOs on pre-test BBV counselling.

Over the next 12 months, Occupational Health will be probing the circumstances surrounding BFEs in more depth so preventative strategies may be directed at areas of concern.

The Prevention of Body Fluid Exposures Policy is awaiting ratification and includes guidance on training, personal protective equipment (e.g. eye protection) and appropriate use of sharps boxes.

A trial of safer devices is planned 2006/2007. Visible savings of implementing these devices are unlikely initially, but the direct (management) and indirect (psychological stress) costs will be reduced in the longer term as will the risk of potential claims for breaches of health and safety legislation

For more information see Appendix 12.

11. Cleaning Services

11.1 Management Arrangements

ISS Mediclean were awarded the Soft Services contract in June 2004. They are responsible for the cleaning, catering, portering, security and Helpdesk services within the Trust. They are monitored by the Soft Services Facilities Manager who is employed by the Trust.

The Trust in partnership with ISS Mediclean has been focussing on improving cleaning standards throughout the hospital. The Housekeeping Department launched a deep cleaning programme in May 2005. The works included de-cluttering as well as stripping and sealing floors, washing walls and ceilings in in-patient and out-patient areas. Also between April and November 2005, the "Abseiling Team" completed the periodic cleaning of all high access areas including internal and external glazing and lift shafts.

In addition to improving cleanliness throughout the hospital, the Trust and ISS Mediclean have been focusing on raising staff awareness and competence in control of infection as well as food hygiene. 85% of catering staff together with 80% of ward housekeepers handling food have received a modular food hygiene certificate from the Royal Institute of Public Health (RIPH). All food handlers will be trained to RIPH standards by the end of September 2006.

11.2 Monitoring Arrangements

To enhance the quality of cleaning audits completed throughout the hospital, the Trust Facilities Team and ISS Mediclean started a new training programme in June 2005. Aimed primarily at nursing staff, the programme is geared to ensuring that all staff completing cleaning audits understand both the National Standards of Cleanliness regime and the

expectations of the Trust. The overwhelming evidence shows a better understanding of cleaning standards by those involved in the auditing process. It has also raised the number of cleaning audits conducted jointly by an auditor from the Trust and from ISS Mediclean. To date there has been approximately seventy attendees to a training session.

The Trust is achieving consistent cleaning audit results of 94%. Over 86% of these audits are carried out jointly with a member of the Trust staff. These results are presented monthly at the PEAT Group and also to the Infection Control Committee each quarter.

11.3 User Satisfaction Feedback

The "Healthcare Commission" undertook an unannounced site inspection in August 2005, and the result was very positive. The Trust achieved a score of 97%. To compliment external evaluation, the Trust has been conducting "PEAT Plus" inspections which began in September 2005. This local initiative which is supported by patient representatives and nursing and housekeeping staff, means that all areas of the Trust are assessed at least once per year, with an audit of a floor completed bi-monthly. By April 2006, twenty-one areas had been inspected. Most areas audited achieved a score of (4) out of a maximum of (5) in cleanliness**.**

12. Infection Control Annual Programme

12.1 Actions Achieved between April 2005-March (inc) 2006

Table 8 is the Annual Programme for the previous year: April 2005 to March (inc) 2006. In red are the actions achieved. The remaining actions will be incorporated into the 2006-2007 Annual Programme.

Table 8. The Infection Control Team Annual Programme for the period April 2005 to March (inc) 2006

Action Number	Action	Source	Action by	Commencement Date	Achieved?
1.	Reduce MRSA bacteraemia rates to two per month to ensure MRSA rates are reduced by 60 % (from 2004) by 2008		BA/RW/SP	April 2005	40% reduction achieved over the last year. Cited by DH as one of the top 20 improvers
2.	Work towards achieving 100% compliance with the Infection Control *Controls Assurance* Standard	Controls Assurance (2001)	AM/RW/BA	Ongoing	Controls Assurance now abandoned. Last score 98.5%
3.	Facilitate the Trustwide implementation of the Trust *Winning Ways* action plan.	The NHS Improvement Plan (2004)	AM/RW/BA	Ongoing	Ongoing via the ICLPs
4.	Comply with the Core Standards for Better Health	National Standards, Local Action (2004)	AM/RW/BA	Ongoing	Ongoing

5.	Develop formal Infection Control Link Professionals (ICLP) system with dedicated training	Winning Ways (2003)	RW	July 2005	4 day ICLP course developed. 43 ICLPs trained between July 2005-April 2006
6.	Introduce monthly auditing of hand hygiene by the ICLPs in all clinical areas.	Winning Ways	RW	July 2005	Completed by ICLPs
7.	Introduce silver alloy catheters across the Trust to replace existing short term catheters	EPIC	RW	May 2005	Introduced May 2005.
8.	Audit urinary catheter care	Winning Ways	RW	December 2005	April 2005
9.	Audit Intravenous Line care in high risk areas	Winning Ways	SP	May 2005	Conducted monthly in all clinical areas by ICLPs
10.	Update the Intravenous Line Therapy policy	Winning Ways	SP	December 2005	Ongoing
11.	Introduce monthly auditing of intravenous line care in all inpatient clinical areas by ICLPs	Winning Ways	SP	July 2005	Conducted monthly in all clinical areas by ICLPs
12.	Introduce monthly audits of standard (universal) precautions by ICLPs	Winning Ways	RW	November 2005	Ongoing.
13.	Join the NPSA '*cleanyourhands'* campaign	Winning Ways	ST/RW	July 2005	July 2005 And ongoing. Managed by ICLPs
14.	Join the RCN Wipe it Out Campaign	RCN	AM/RW	July 2005	July 2005
15.	Update key policies: • IV line care/administration • Hand Hygiene • Universal Precautions • Sterilisation/ Disinfection	Controls Assurance, Winning Ways	RW/SP	September 2005 October 2005 November 2005 January 2005	
16.	Ratify the CJD policy	Controls Assurance (2001) SEAC (2003)	RW/BA	December 2005	ongoing
17.	Write new policies for: • Resistant Gram Negative Organisms • Avian Flu • West Nile Virus	Controls Assurance (2001)	RW/SP/BA	October 2006 December 2005 March 2006	

18.	Write business plan for IT surveillance system	NAO (2004) Controls Assurance (2001) Winning Ways (2003)	RW	November 2005	
19.	Write business plan for full time administration support (currently only part- time)	Controls Assurance (2001)	RW	December 2005	
20.	Revise Patient Information leaflets and extend range	Towards Cleaner Hospitals	SP	August 2005	
21.	Mandatory winter infection outbreak training for all nurses	Winning Ways	SP	November 2005	November 2005

Key to Abbreviations for Table 8 and Table 9

BA Berge Azadian
HPA Health Protection Agency
SP Shona Perkins
KH Kieran Hand
KM Kerryn Money
RW Roz Wallis
ICT Infection Control Team
AM Andrew MacCallum
ST Sharon Terry

12.2 Infection Control Annual Programme for April 2006-March (inc) 2007

Table 9 shows the Annual Programme for the coming year.

Table 9. Infection Control Team Programme for the period April 2006 - March (inc) 2007

	Implement:	**Source**	**Responsible person/s**	**Commencement date**
1	Continue to reduce MRSA bacteraemia rates to 23 by March 2007 i.e. Maximum 2 per month for 11 months. 1 month with a maximum of 1 MRSA	Standards for Better Health The NHS Improvement Plan	ICT	ongoing
2	Continue to collect other mandatory data for DH/HPA: Clostridium difficile Toxin >65yr age Glycopeptide Resistant Enterococci bacteraemias: VRE Othopaedic Surgical Site Infections	*Winning Ways*	ICT	ongoing

3	Write new policies for: • Resistant Gram Negative Organisms • Pandemic/Avian Flu • West Nile Virus	Controls Assurance (2001)	RW/SP/BA	October 2006 December 2005 March 2006
4	Introduce DH Saving Lives Programme	Saving Lives	RW	January 2007
5	Continue with the *Cleanyourhands* campaign	NPSA *Cleanyourhands* campaign	ICLPs overseen by ICNs	ongoing
6	Focus on IV line care: 1. introduce large aseptic packs for central line insertion 2. introduce Trust-wide IV line monitoring charts 3. Improve compliance with use of peripheral dressings	*Winning Ways* *Saving Lives*	SP	September 2006 August 2006 Ongoing
7	Train up 40 more ICLPs to ensure 1 per clinical area	*Winning Ways*	RW/SP/	September 2006
8	Develop ICLPs: Introduce a bespoke course for ICLPs to improve the following skills: assertiveness Facilitation Presentation Powerpoint motivational	National Audit Office *Winning Ways*	RW Learning Resource Centre	October 2006
9	Develop online London-wide policy folder	Controls Assurance *Winning Ways*	RW	February 2007
10	Full time administrative support	Controls Assurance National Audit Office	RW	March 2007
11	IT package to improve clinicians access to infection control data	ASEPTIC (DH)	RW	January 2007
12	Revise Patient Information leaflets and extend range	Towards Cleaner Hospitals	SP	Ongoing
13	Mandatory winter infection outbreak training for all nurses	*Winning Ways*	SP	November 2006
14	Ratify the CJD policy	Controls Assurance (2001) SEAC (2003)	RW/BA	Ongoing
15	Update the Intravenous Line Therapy policy	*Winning Ways*	SP	Ongoing
16	Work towards full compliance with the 10 basic standards for the *Wipe it Out* Campaign	*Wipe it Out* *Winning Ways*	ICT	Ongoing
17	Provide education sessions for Foundation Trust Members and Patients Forum Members		RW	September 2006

18	Provide Infection Control Training including Hand Hygiene to all staff on induction and in annual updates	CNST	Corporate Nursing Team Learning Resource Centre Post Graduate Centre ICT	Ongoing
19	ICT to work closely with Occupational Health Dept to manage risks associated with sharps and inoculation injuries	CNST	ICT Occupational Health Dept	
20	ICT to work closely with the Trust Decontamination Lead to manage the risks associated with maintenance and decontamination of re-useable and other medical devices/equipment	CNST	Decontaminatio n Lead ICT	

For Winning Ways Action Plan see Appendix 13.

Appendix 1

TERMS OF REFERENCE

INFECTION CONTROL COMMITTEE

FUNCTION

The Infection Control Committee (ICC) is responsible for developing policies and procedures related to infection control in the hospital and for acting as a source of expertise on matters relating to infection. The Committee advises the Chief Executive (or the Executive Committee) of the hospital, trust or district, through the Infection Control Doctor.

INFECTION CONTROL DOCTOR

The ICD is responsible for the day-to-day management of infection control in the hospital. The ICD refers to the ICC for major matters of policy development and for the management of large outbreaks according to the major outbreak policy.

CHAIRMAN

The Chairman will be the ICD for the hospital. When there is more than one ICD in the District, the Chairmanship will be agreed between the ICDs or appointed by the Chief Executive. In the absence of the ICD, the meeting will be chaired by another consultant microbiologist, the Infectious Diseases Physician or by the Consultant in Communicable Disease Control.

MEMBERSHIP OF THE INFECTION CONTROL COMMITTEE

The following will be members of the ICC:

- The Infection Control Doctor
- Other microbiologists of consultant status
- The Infectious Disease Physician (if not the ICD)
- The Senior Infection Control Nurse
- The Chief Executive or deputy
- A consultant Virologist
- The Consultant in Communicable Disease Control
- The Director of Public Health
- A consultant Physician or Surgeon
- A consultant from the Occupational Health Department
- Executive Director – Nursing
- A Committee Administrator
- Lead Nurses from all Directorates

If a member is unable to attend, a deputy should be sent.

INVITED ATTENDANCE

The following may be invited by the Chairman to attend specific items as indicated by the agenda:

- A consultant Physician or Surgeon
- A Nurse Manager
- The District Supplies Manager
- The District of Works and Maintenance
- The Catering Manager
- The Central Sterile Supplies Department (CSSD) Manager
- The Director of Pharmacy

In addition, trainees in medical microbiology or public health medicine may be invited to attend as observers.

Appendix 1

AGENDA OF THE MEETINGS

At each meeting the committee should:

- Report on the incidence and prevalence of 'alert' organisms, and novel or important infectious diseases
- Report on the occurrence and nature of any outbreaks of infection, and on incidents involving microbiological hazards (e.g. needle injuries)
- Develop and maintain policies for the promotion of good infection control standards in the hospital
- Review outbreaks of infection and advise managers on how outbreaks might be prevented
- Assist in the planning and development of services and facilities in the hospital on issues which are relevant to infection control
- Monitor and advise on specific areas of hygiene and infection control, catering, CSSD, ventilation and water services, occupational health, pharmacy, operating theatres, endoscopy etc.,
- Develop programmes for the education of staff and students about infection control practices and policies

FREQUENCY OF MEETINGS

Meetings should be held at least four times a year, with at least 2 weeks notification of the date of the meeting, and 7 days notice of the agenda. Minutes should be kept, ratified and signed.

ADMINISTRATIVE SUPPORT

The ICC will be supported by the Infection Control/TB Service Coordinator for the recording and preparation of minutes in conjunction with the Chairman, for arranging and notifying of meetings, and for distributing the minutes and agenda. The agenda will be prepared by the Chairman.

QUORUM AND VOTING

If fewer than five people attend the meeting, another should be arranged. If a vote is required on any issue, a simple majority will be required and the Chairman has a casting vote in the case of equal voting.

STATUS OF POLICY DOCUMENTS

Policy documents for hospital-wide distribution, especially those with financial implications, should be submitted to the hospital's Chief Executive for approval. Once adopted, these policies become hospital policy, and should be distributed and implemented by the relevant divisional care group or departmental management.

CIRCULATION OF MINUTES

Minutes should be sent to all members and to those who attended the meeting. In addition, copies should be sent to:

- The Chief Executive of the hospital
- Heads of departments or Directors of 'care groups'
- Divisional Managers
- The hospital's Clinical Director

EMERGENCY MEETINGS AND OUTBREAK CONTROL

The Chairman may call an emergency meeting of the Infection Control Committee at any time and all members or their alternates will be notified by telephone. Emergency meetings are arranged for the control of outbreaks of infection, when the Infection Control Team requires additional support and notification of the problem, in accordance with the Major Outbreak Policy. The Chairman will chair all emergency meetings, and is in charge of the outbreak control measures. If the outbreak has particular significance for the non-hospital community or

involves other hospitals, the CCDC or Director of Public Health may act as Chairman. In case of dispute over the management of a large outbreak, the Chief Executive will appoint a chairman.

COMMUNITY INFECTION CONTROL COMMITTEE

The Director of Public Health may wish to organise a separate committee for community issues, with community representatives such as a general practitioner, a district nurse and the Environmental Health Officer. The ICD should be invited to attend as an adviser, and to deal with issues that affect both the hospital and community. However, it may be possible to combine the functions of the Hospital and Community Infection Control Committees; it depends on the local arrangements.

Appendix 2

Chelsea and Westminster Healthcare NHS
NHS Trust

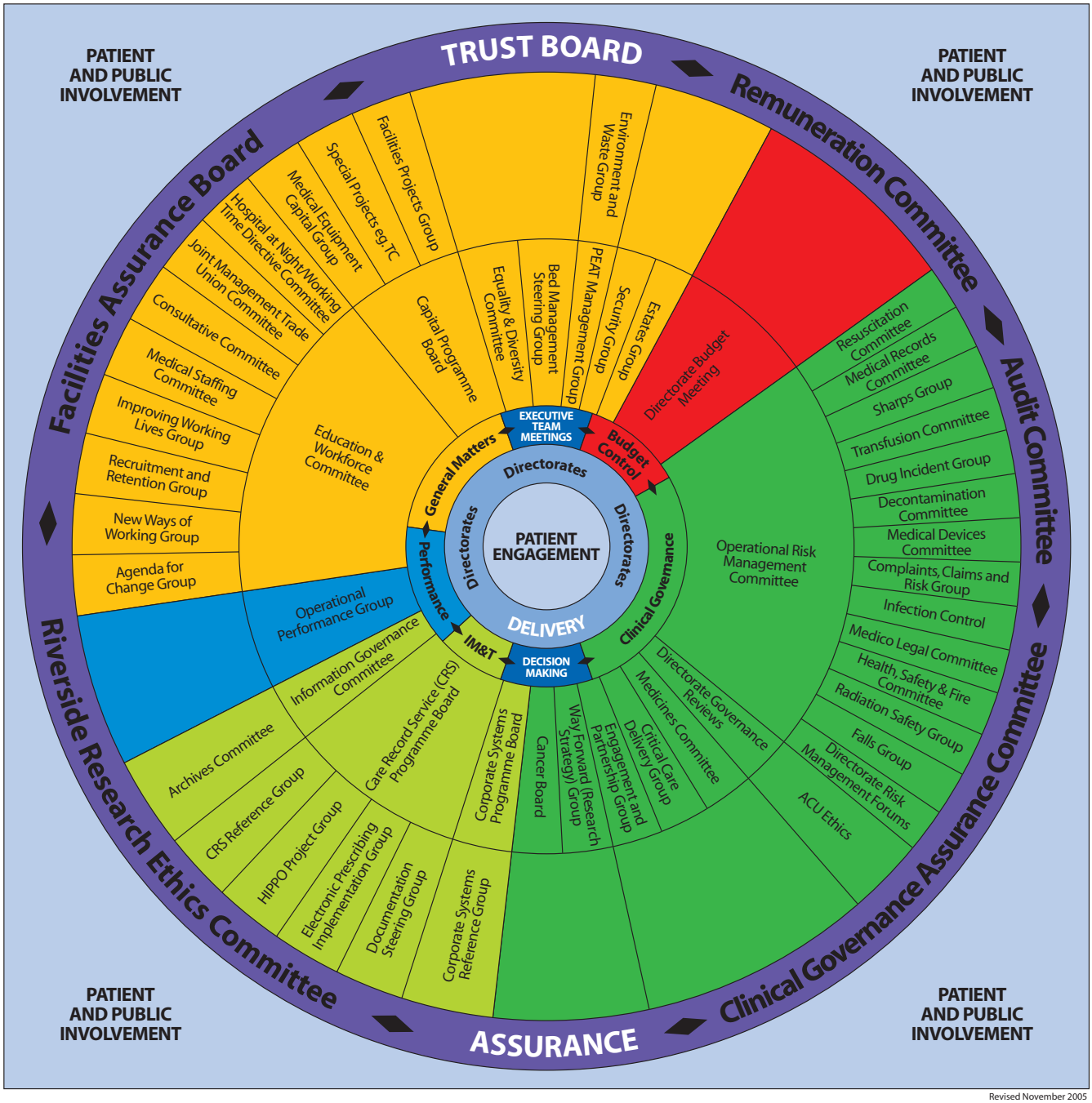
INFECTION CONTROL COMMITTEE

MEMBERS April 2005- March 2006

Dr. Berge Azadian (**Chair**)	Infection Control Doctor/Microbiologist
Roz Wallis	Senior Infection Control Nurse
Shona Perkins	Infection Control Nurse
Dr. Kieran Hand	Microbiology Pharmacist
Dr. Kai Lau	CCDC
Dr. Mark Atkins	Consultant, Virology
Dr. Catherine MacGreevy	Consultant, Occupational Health
Stella Sawyer	Manager, Occupational Health
Chris MacKie	Safety Officer
Teresa Ancliff	Clinical Risk Manager
Sheena Basnayake	Lead TB Clinical Nurse Specialist
Andrew MacCallum	Director of Nursing
Sharon Terry	Assistant Director of Nursing
Helen Elkington	Facilities Manager (Trust)
Catherine Horne	ISS General Manager
Melanie van Limborgh	Decontamination Lead/Theatres Manager
Olga Sleigh	TSSU Manager
Peter Rooney	Technical Services Manager (Haden)
Tony Lawes	Projects Manager
Jane Bruton	Clinical Lead Nurse – HIV/GUM
Dr. Simon Barton	Clinical Director – HIV/GUM
Dr. Anton Pozniak	Consultant – HIV/GUM
Dr. Neil Soni	Consultant, ICU
Jane-Marie Hamil	Clinical Lead Nurse – ICU
Dr. Nick Fauvel	Consultant, ICU
Mr. Simon Myers	Consultant, Burns and Plastics
Michelle Das	Clinical Lead Nurse, Burns
Mr. Jonathan Lavelle	Consultant, Orthopaedics
Dr. Alison Bedford-Russell	Consultant, Neonates
Dr. Enitan Ogundipe	Consultant, Neonates
Lyn Ronnie	Clinical Lead Nurse, Neonates
Dr. Mike Markiewicz	Consultant, Paediatrics
Sue Harris	Clinical Lead Nurse, Paediatrics
Dr. Michael Pelly	Consultant, Medicine
Sue Greenland/Louise Magee	Clinical Lead Nurses, Medicine
Dr. Peta Longstaff	Consultant, A&E
Rona MacKay	Clinical Lead Nurse, A&E
Paul Thomas	Clinical Lead Nurse, Surgery

Appendix 3

Chelsea & Westminster Governance Structure



Revised November 2005

The Trust has developed a committee structure, known as 'the wheel', through which it is governed and managed, from Trust Board to directorate, specialty and patient level.

The wheel builds upon an integrated governance model to link together individual work streams, effective monitoring, decision making, assurance, and ratification.

To do this the Trust Board must have in place systems and processes which lead, direct and control its functions in order to deliver the organisation's objectives. Collectively, these systems are called 'integrated governance'. The wheel depicts the integrated governance management and committee structures within the organisation.

This model requires leadership of the Non-Executive and Executive Directors for the delivery of integrated governance of the Trust, focussing on developing an effective Board assurance framework to ensure that risks to the Trust are being properly managed and monitored. Board assurance is outlined within an assurance framework, which sets out the risks which the Trust faces in delivering its corporate objectives, and how these are being managed. In addition to this, a risk register outlines clinical, financial and operational risks, which are being managed in the organisation.

The information flows ensure that the Trust maximises the Board capacity through streamlined reporting systems and reports, to enable efficient and effective Board decision making.

INFORMATION FLOW

Trust Board	For Information/Ratification & Strategic Decision Making
↕	
Audit Committee Remuneration Committee Clinical Governance Assurance Committee Facilities Assurance Board	Assurance
↕	
Trust Executive Meeting	Operational Decision Making
↕	
Trust Meetings	Support Structures
↕	
Directorates	Operational Delivery
↕	
Patient	

Appendix 4

DIRECTOR OF INFECTION PREVENTION AND CONTROL

The Chief Medical Officer's report *Winning Ways* required all NHS organisations to appoint a Director of Infection Prevention and Control who would be a senior officer with responsibility to:

- Oversee control of infection control policies and their implementation
- Be responsible for the Infection Control Team
- Report directly to the Chief Executive and Board
- Challenge inappropriate hygiene practice and antibiotic prescribing
- Assess the impact of all plans/policies on infection control
- Be a member of the Clinical Governance and Patient Safety teams/structures
- Produce an annual report

A suggested template for the DIPC's annual report was introduced at the first DIPC Conferences in October and has been presented at several workshop sessions since. The template that forms the rest of this document is a guide to the aspects of infection prevention and control that should be covered in the reports. Not every item will be appropriate for all NHS bodies but the framework is designed to help DIPCs to produce reports that are consistent across the NHS.

1) Executive summary - Overview of infection control activities in the Trust

- Organisation
- Activities
- Infection control Action Plan for the year
- Progress in *Winning Ways* and *Towards Cleaner Hospitals and Lower Rates of Infection*

2) Description of infection control arrangements

- Infection control team
- Infection control committee
- Reporting line to the Trust Board
- Links to Prescribing and Formulary Committee
- Links to Clinical Governance/Risk Management/Patient Safety

3) DIPC reports to the Trust Board – summary

- Number and frequency
- Annual Action Plan
- Board decisions
- Outbreak reports

4) Budget allocation to infection control activities

- Staff
  - Medical
  - Nursing
  - Scientific
  - Administrative
- Support (IT etc)
- Training

5) HCAI statistics

- Results of mandatory reporting
  - MRSA bacteraemia
  - GRE bacteraemia
  - *Clostridium difficile*
  - Orthopaedic surgical site infection
- Trends in HCAI statistics

Appendix 4

• Untoward incidents including outbreaks
• Antimicrobial resistance
• Goals identified locally

6) Hand hygiene and Aseptic protocols
• Implementation of '*cleanyourhands*'
  o Timing
  o Coverage in Trust
  o Future plans
• Application of aseptic no-touch clinical protocols
• IV catheters
• Urinary catheters
• Wounds etc

7) Decontamination
• Arrangements
• Audit
• Incidents/failures investigated

8) Cleaning services
• Management arrangements (in-house or contracted out)
• Monitoring arrangements
• Budget allocation
• Clinical responsibility
• Clinical access
• PEAT/Patient forum inspection results
• User satisfaction measures

9) Audit
• Extent of audit programme
• Reasons for audit focus
• Adoption of ICNA audit tool or alternative
• Antibiotic prescribing (report from Antimicrobial Pharmacist)
• Changes and benefits as a result of audit

10) Targets and outcomes
• For SHA performance managements
  o MRSA bacteraemia
  o *Winning Ways* and *Towards Cleaner Hospitals* implementation
• Cleaner hospitals (PEAT scores)
• Healthcare Commission self-assessment
• Local targets

11) Training activities
• Induction for all staff
• CPD for all staff
• CPD for clinical staff
• For infection control specialists
• For DIPC

Appendix 5

Infection Control Teaching sessions documented on Trust Training Database

CNT Infection Control Study Day
IC Chickenpox Teaching
IC Link Professional Course Day 1/4
IC Link Professional Course Day 2/4
IC Link Professional Course Day 3/4
IC Link Professional Course Day 4/4
ICMS Yr 2 Infection Control
ICMS Yr 3 Infection Control Workshop
OHD Infection Control - Frequently Asked Questions
CNT- Infection Control HCA Study Day
IC Leeches+association with infection risks
IC Silver Alloy Urinary Catheter
IC Alert Organisms
IC Alert Organisms and Dermatology
IC Asepsi Vs Clean Technique
IC Asian Flu epidemic.
IC Breaking the Chain - Infection in Hospial
IC Chickenpox/influenza A and Norovirus
IC Chickenpox/Parainfluenza A
IC CJD
IC Clinical Scenarios
IC CNT HCA Mandatory Update
IC CNT Nurses Update
IC Common Viruses in Healthcare Settings
IC Contractor
IC Controls Assurance and Star Rating
IC D Grade Development
IC D Grade Induction
IC Decontamination Review
IC Decontamination: The Local + National Overview
IC Diagnosing Wound Infection
IC Diarrhoea Outbreak
IC Diarrhoea Outbreak Management
IC Doctors Induction
IC E Grade Development
IC Food Hygiene Update
IC Generic Induction
IC Hand Hygiene
IC Hand Hygiene and Orthopaedic
IC Hand Hygiene for Food Handlers
IC Hand Hygiene for housekeepers (porters)
IC Hand Hygiene Roadshow
IC Hand Hygiene Trainning for Supervisors
IC Hand Hygiene Workshop
IC Handwashing
IC HHAW
IC IC Quiz
IC Improving Satandarts of Respiratory Care
IC Induction
IC Infection Control & Hand Hygiene
IC Infection Control Detectives
IC Infection Control in ICU
IC Infection Control in the Built Environment

Appendix 5

IC Infection Control in the Burns Unit
IC Infection Control in the Operating Theatre
IC Infection Control Induction
IC Infection Control Update
IC Introduction to Infection Control
IC Issues inbuilding and Maintening Projects
IC IV Infection
IC Mandatory Induction
IC Mandatory Nurses Induction
IC Mandatory Update
IC Microbiology and ITU
IC MRSA / Acinetobacter
IC MRSA Debate
IC MRSA Why all the fuss?
IC New National Decontamination Online Training
IC Orientation IC
IC Orientation Infection Control
IC Overview of Infection Control Issues in Hospital D
IC Paediatric Nurse Induction
IC Paediatric SpR Induction
IC PAMS Update
IC PAMS Update
IC Preventing HAI
IC Preventing Infections in Critically
IC Pulmonary TB
IC Radiographers IC Update
IC Resistant Organisms
IC Shadowing
IC Shadowing ICN
IC SHO Medicine
IC SpR Induction
IC SpR Induction (NICU)
IC Student Nurse Induction
IC Student Orientation
IC Support Staff Update
IC TB an Overview
IC TB An Overview
IC The new threat of TB
IC The Use and Abuse of Antibiotics for PRHOS
IC Tuberculosis
IC Use and Abuse of Antibiotics
IC VAP
IC Ventilation in Hospitals
IC View from the DOH
IC VZV
Infection Control
C&W- Infection Control Link Professionals Course
TVU - Infection Control Principles and Practice - Surgery Allocation
TVU Infection Control - Principles and Practices - Burns Allocations
IC Litigation Management in Infection Control

Infection Control Teaching Sessions not included on Trust Training Database:

Mandatory Outbreak Teaching	IV study days
PRHO and SHO Induction	Imperial College Medical Students
Corporate Induction	Quarterly Seasonal Conferences
ICLP Monthly Meetings	Intensive care foundation course

Appendix 6

HAND HYGIENE AWARENESS WEEK 2005

DATE	TIME	VENUE	EVENT	SPEAKER	SUITABLE FOR	REFRESHMENTS	BOOKING REQUIRED
Monday 11th April	9:30 – 15:00	Academic Atrium Lower Ground floor LBB	Sponsor's Exhibition String Quartet-Emanual Ensemble (12-2) Hand Reflexology Continental Breakfast Free Draw for Hamper Buffet Lunch Food Safety Stand and Video Show		All staff in C&W and PCT	Yes	No
	12.15 – 12.45 13.00 – 13.30	Post-Grad Seminar Room Lower Ground floor LBB	Decontamination. The Local and National Overview.	Olga Sleigh Decontamination Lead and TSSU	Ward Sisters Lead Nurses Budget Holders	Lunch	yes
	14:00 – 15:00	Post Grad Seminar Room Lower Ground floor LBB	" Don't count your chickens....." Examining the implications of an avian flu epidemic.	Dr Mark Atkins Consultant Virologist	A&E, Jr Drs Qualified nursing staff, midwives	Coffee and Biscuits	Yes
Tuesday 12th April	08.15 – 09.15	Theatre Coffee Room 5th floor, Main Theatres, LBC	New National Decontamination Online Training	Carl Bradley Programme Marketing Manager Intuition Ltd	Theatre Staff	Yes	no
	10.00 – 12.00	Outpatient and Inpatient areas	Hand Hygiene Roadshow	Infection Control Nurses and Link Professionals	All staff	Yes	no
	10.15 – 10.45	Post Grad Lecture Theatre Lower Ground floor LBB	Infection Control at the Chelsea & Westminster	Roz Wallis Senior Nurse Infection Control	New SpRs	No	Yes
	14.00 – 14.30 14.45 – 15.15	Westminster Admission Suite, David Evans Ward	Aseptic versus Clean Technique	Kumal Rajpaul Tissue Viability Nurse	Surgical Nurses/Midwives	Yes	No
	14.00 – 14.30 14.45 – 15.15	Edgar Horne Day Room 4th Floor LBC	TB – an overview	Leslie Ruta TB Nurse Specialist	Medical Nurses	Yes	Yes
	12:00 – 13.00	Post Grad Seminar Room LGF LBB	Use and Abuse of Antibiotics	Dr Kieran Hand Antibiotic Pharmacist & Dr Berge Azadian Consultant Microbiologist and Director of Infection Prevention and Control	SHOs (Protected time)	Yes	No
	13.00 – 14.00	Post Grad Lecture Theatre Lower Ground floor LBB	" Infection Control Issues in Building and Maintenance Projects"	Dr. Peter Hoffman Senior Clinical Scientist Health Protection Agency Introduced by Andrew MacCallam, Director of Nursing	Estates, Project Team and Facilities Staff	Lunch	Yes
Wednesday 13th April	09.15 – 09.45	Pathology Seminar Room 2nd floor LBD	Hand Hygiene Training for Supervisors	Euan MacAuslan Environmental Health Training Co-ordinator Royal Borough of Kensington and Chelsea	Supervisors: Caterers, Housekeepers, Porters, Facilities, Volunteers	Yes	Yes
	10.00 – 12.00	Outpatient and Inpatient areas	Hand Hygiene Roadshow	Infection Control Nurses and Link Professionals	All staff	Yes	no
	10.00 – 10.30	Pathology Seminar Room 2nd floor LBD	Food Hygiene Update	Euan MacAuslan Environmental Health Training Co-ordinator Royal Borough of Kensington and Chelsea	Caterers, Housekeepers, Facilities	Yes	Yes
	12.00 – 13.00	Staff Restaurant	Jazz	Tommaso Starace Trio	All staff, patients and visitors		No
	13.00 – 14.00	Staff Restaurant	Pub Quiz	Quiz Master: Hospital Radio's Quiz Wiz	All staff	No	Yes
	14.00 – 15.00	Pathology Seminar Room 2nd floor LBD	Preventing Infections in Critically Ill Patients	Dr Azadian Consultant Microbiologist	ICU, Burns Unit, Neonatal Unit	Yes	Yes
	14.15 – 15.00	Post-Grad Seminar Room Lower Ground floor LBB	Urinary Catheter Infection. The value of silver alloy in prevention	David Dawson Product Manager BARD	Nurses in Medical and Surgical Directorates, Midwives	Yes	Yes
	13.30 –14.00	Anaesthetic Library 5th floor	IV Line Infection Prevention	Shona Perkins, Infection Control Nurse	Anaesthetists	Yes	No

Appendix 6

Thursday 14th April	09.45 – 10.45	Clinical Skill Lab Lower Ground floor LBD	Update for Nurses and Midwives	Shona Perkins Infection Control Nurse	Nurses, Midwives	No	Yes
	10.00 – 12.00	Outpatient and Inpatient areas	Hand Hygiene Roadshow	Infection Control Nurses and Link Professionals	All staff	Yes	no
	13.00 – 14.00	Post-Grad Lecture Theatre	Grand Round. Reducing MRSA Bacteraemia Rates in an NHS Specialist Trust	Professor Gary French Consultant Microbiologist and Infection Control Doctor Guys and St Thomas's NHS Foundation Trust Introduced by Mike Anderson, Medical Director	Consultant Drs/ Nurses/Midwives Junior Doctors, Lead Nurses and Midwives	Yes	Lunch
	14.00 – 14.30 14.45 – 15.15	Westminster Admission Suite, David Evans Ward	TB – an overview	Breda Ward TB Nurse Specialist	Nurses Surgical Directorate	Yes	Yes
	14.00 – 14.30 14.45 – 15.15	Edgar Horne Day Room 4th Floor LBC	Aseptic versus Clean Technique	Kumal Rajpaul Tissue Viability Nurse	Nurses, Medical Directorate	Yes	No
	14.30 – 15.00	Pathology Seminar Room 2nd floor LBD	Food Hygiene Update	Euan MacAuslan Environmental Health Training Co-ordinator Royal Borough of Kensington and Chelsea	Caterers, Housekeepers, Facilities	Yes	Yes
	15.15 -15.45	Pathology Seminar Room 2nd floor LBD	Hand Hygiene Training for Supervisors	Euan MacAuslan Environmental Health Training Co-ordinator Royal Borough of Kensington and Chelsea	Caterers, Housekeepers, Facilities	Yes	Yes
	19.30 onwards	Hollywood Arms Function Room	Comedy Night	4 stand-up comedians from the London Comedy Circuit hired to entertain you			
Friday 15th April	08.45	Fry Seminar Room 5th Floor, LBD	Hand Hygiene and Orthopaedic Wound Infection Update	Claudia Cummings Infection Control Practitioner	Orthopaedic Dept	Yes	No
	10.00 – 12.00	Outpatient and Inpatient areas	Hand Hygiene Roadshow	Infection Control Nurses and Link Professionals	All staff	Yes	no
	09.45 – 12.30	The Stage 2nd floor between LBC & D	Hand Hygiene for Children Captain Custard's children's show	Jane Beckford K&C PCT Senior Nurse, Infection Control	Children form local schools and hospital school, visiting children,	No	No
	11.45	The Stage	Children's hand hygiene art competition will be judged	The Mayor			
	13.00 – 14.00	Post-Grad Lecture Theatre	The Use and Abuse of Antibiotics	Dr Kieran Hand Antibiotic Pharmacist & Dr Berge Azadian Consultant Microbiologist and Director of Infection Prevention and Control	PRHO (protected time)	Yes	No
	12.15 – 12.45	Pathology Seminar Room 2nd floor, LBD	Improving Standards of Respiratory Care	Andrea Blay Nurse Consultant – Critical Care	Medical & Surgical Nurses	Lunch	Yes
	12.30 – 13.15	Physio Gym	MRSA, Why all the fuss?	Roz Wallis Senior Nurse, Infection Control	Physios, Radiographers, Speech Therapists	Yes	Yes
	14.00 – 15.00	Post Grad Lecture Theatre	An Update from the Department of Health	Carol Fry Department of Health Nursing Officer for Infection Control Introduced by Heather Lawrence, Chief Executive	Executives, Managers, Consultant Drs/Nurses/Midwives, Lead Nurses and Lead Professions Allied to Medicine	Yes	Yes
	15.00 – 15.30	Pathology Seminar Room	'Filthy Suckers: a case study into the use of leeches and the associated infection risks'	Dr Kieran Hand Antibiotic Pharmacist	Surgical, Medical, Plastics Nurses and Junior Doctors	Yes	Yes

Appendix 7

Chelsea and Westminster Healthcare NHS
NHS Trust
Chelsea & Westminster Hospital, 369 Fulham Rd, London, SW10 9NH

HAND HYGIENE OBSERVATION TOOL

Developed by the Infection Control Team, University Hospital Lewisham (2001)

Appendix 7

Chelsea and Westminster Healthcare NHS

NHS Trust

Chelsea & Westminster Hospital, 369 Fulham Rd, London, SW10 9NH

Background

- Approximately 8% of hospitalised patients acquire an infection during their hospital stay
- It is estimated that the additional costs for each patient ranges from £1300 - £5300 and that patients remain in hospital for a further 10 days on average
- The cost to the NHS is approximately £1 billian per year
- It is estimated that hospital acquired infections (HAI) cause more that 5000 deaths each year
- It is recognised that HAI could be significantly reduced if Healthcare workers complied with hand hygiene guidance

Reference: Pratt RJ, Pellowe C, Loveday HP et al 2001 The epic Project: Developing national Evidence-based Guidelines for preventing Healthcare associated Infections Journal of Hospital Infection 47 supplement.

This tool has been developed to measure hand hygiene compliance in healthcare workers. It is based on previous work, by Pittet et al (2000) and Faulkener (Meengs et al 1994). The underlying principle is that in healthcare there are 'hand hygiene opportunities'. These are identifiable episodes when hand hygiene should take place e.g. before doing a sterile procedure, after handling body substances, before and after patient contact. The observational tool compares hand hygiene opportunities with observed hand hygiene. Compliance can be expressed as a percentage i.e.

$$\frac{\text{Observed hand hygiene}}{\text{Hand hygiene opportunities}} \times 100 = \text{compliance\%}$$

Pittet et al 2000 Effectiveness of hospital wide programme to improve compliance with hand hygiene. Lancet 356: 1307-12
Meengs et al 1994 Handwashing frequency in an emergency department. Annals of Emergency medicine 23 (6) 1307-12

Instructions

1. You can do this alone but it is better with a partner.
2. Identify and observable part of the clinical area.
3. Position yourself so that you do not cause an obstruction but can still see what is happening.
4. Observe for 20 minute periods.
5. Using the observation sheet mark a '1' for a hand hygiene opportunity and a '0' for an observation of hand hygiene actually taking place.
6. The observation sheet is just a guide so do not worry if you cant identify if the episode is high, medium or low risk, just mark it on the sheet.
7. When you have completed 20 minutes observation, do give feedback to the staff – a feedback form is included in this pack. When you give verbal feedback try to stress positive findings first and if you give negative feedback, give examples and suggestions for improvement.
8. While you are observing you may identify issues with are barriers to hand hygiene e.g. no soap, obstructed sinks – include this in your feedback.

If you find activities, which are not identified on the chart – add them and let the Infection Control Team know.

Appendix 7

Chelsea and Westminster Healthcare NHS

NHS Trust

Hand Hygiene Observation Sheet

Date: Time: Location:

	Nurses/Stn	Doctors	HCA's	Physio/ OT	Others	Score
Low risk						
Touching sterile goods						
Making clean bed						
Contact with notes, telephone etc.						
Drugs round						
Other						
Medium risk						
Stripping a non-soiled bed						
Patient contact (hand shake)						
Cleaning beds, furniture						
Setting up O_2 , Nebulizers						
Observations (TPR & BP)						
Setting up IVI, giving injections, IV,s						
Removing gloves						
Bed bath, washing patients						
Other						
High risk						
Dealing with bodily secretions						
Bedpans, commodes						
Suctioning, tracheostomy care						
Infected wound dressings						
Phlebotomy, cannulation						
Other						
Score						

Appendix 7

Chelsea and Westminster Healthcare NHS
NHS Trust
Chelsea & Westminster Hospital, 369 Fulham Rd, London, SW10 9NH

Fulkerson- Risk scale for hand hygiene opportunities

Low Risk

1. Sterile or autoclaved materials
2. Thoroughly cleaned or washed materials
3. Materials not necessarily cleaned but free from patient contact i.e. Notes, papers, telephone and nurses desk area.
4. Materials in contact with patients with little contamination risk i.e. Furniture in patient area

Medium Risk

5. Objects or materials that have been in close contact with patients but are not contaminated with patient secretions or other sources of pathogenic bacteria i.e. Relatively clean patient grown, linen, used cutlery or plates, bed rails and tops of patient tables.
6. A patient, minimal contact without touching excretions or secretions and for a limited period of time such as shaking hands, taking a pulse or a back rub.
7. Materials and inanimate objects that have been in contact with or bear patient secretions such as saliva, not known to be contaminated.

High Risk

8. A patient, directly touching areas of secretions such as mouth, nose and so forth.
9. Materials contaminated with patient urine
10. Patient urine (direct contact)
11. Materials bearing faecal soilage
12. Faecal soilage (direct contact)
13. Materials that have been in direct contact with known infected secretions or excretions
14. Secretions or excretions known to be contaminated (direct contact)
15. Infected patient sites such as infected wounds (direct contact)

Appendix 7

Chelsea and Westminster Healthcare NHS

NHS Trust

Chelsea & Westminster Hospital, 369 Fulham Rd, London, SW10 9NH

Hand Hygiene Observation Tool – Feedback Form

DATE_____ TIME_____

SITE_____

OBSERVER/S_____

SCORE (observed hand hygiene ÷ hand hygiene opportunities x 100)

SPECIFIC FEEDBACK

FEEDBACK GIVEN TO_____

Further action required

Appendix 8

Hand Hygiene Compliance Scores Raw Data

	30/04/2005	31/05/2005	30/06/2005	31/07/2005	31/08/2005	30/09/2005	31/10/2005	30/11/2005	31/12/2005	31/01/2006	28/02/2006	31/03/2006	Average
ICU/HDU				52%	54%		46%						51%
DAVID ERSKINE				67%		75%							71%
EDGAR HORNE						39%	13%	62%					38%
FRANCIS BURDETT												67%	67%
ST MARY ABBOTTS						30%	35%	34%					33%
LORD WIGRAM						50%							50%
DAVID EVANS						50%							50%
RAINSFORD MOWLEM				57%		41%	46%	77%					55%
NEONATAL ICU					76%		75%	50%					67%
CHILDRENS OUTPATIENTS'						87%							87%
Directorate	30/04/2005	31/05/2005	30/06/2005	31/07/2005	31/08/2005	30/09/2005	31/10/2005	30/11/2005	31/12/2005	31/01/2006	28/02/2006	31/03/2006	Average
Anaesthetics & imaging													51%
Medicine													54%
Surgery													47%
Women's & Children's													72%
TOTAL													54%

Appendix 9

Chelsea and Westminster Healthcare NHS
NHS Trust

INFECTION CONTROL LINK PROFESSIONAL ROLE PROFILE

AIM

To act as a resource in the clinical area and to liaise with the Infection Control Team to create an environment that will ensure the safety of patients, health care workers and visitors.

RESPONSIBILITIES

- To assist in the implementation of infection control policies, guidelines and standards at clinical level.
- To act as a communication link between the Infection Control Team and the clinical area.
- In liaison with the Infection Control Team to act as a resource person concerning infection control-related problems, e.g. isolation of patients, decontamination of equipment, etc.
- To conduct monthly hand hygiene and IV line care audits and to send to the Infection Control Team the completed audit forms.
- To complete the four day ICLP training course.
- To attend the mandatory ICLP monthly meetings.
- To meet regularly with an Infection Control Nurse.
- To conduct annual infection control audits of designated clinical environment together with an Infection Control Nurse using the Infection Control Nurses Association audit tool.
- To participate in the education of staff and patients in infection control-related matters and feedback to professional information gained at the monthly ICLP meeting to professional colleague discussions
- To bring to the attention of the Infection Control Team outbreaks of infection, or infection control-related problems in the clinical area.
- To bring to the attention of the Infection Control Team practice developments to enable sharing of good practice.
- To take every opportunity to extend and update personal knowledge of infection control and related issues.
- To act as an information resource to assist in ensuring the availability of resources to support infection control practice at clinical level.
- To participate in the structure and processes of infection control related to clinical governance.

Appendix 9

- To recognise one's own limitations of knowledge and expertise in infection control, and when to refer infection control issues to the Infection Control Team.
- To change the NPSA *cleanyourhands* campaign posters on a monthly basis.
- To ensure all new admissions receive a NPSA *cleanyourhands* campaign leaflet and be responsible for ensuring there is an adequate supply of leaflets. These can be downloaded from the *cleanyourhands* website (via Google).
- To wear the *cleanyourhands* campaign enamel badge
- To wear a name badge that includes 'Infection Control Link Professional' in the title.

ROLE CRITERIA

The post holder will be a healthcare professional with an interest in infection control. The post holder will be a relatively senior member of staff with a minimum grade of Band 6. They will have good communication skills and an ability to encourage and promote a positive environment for high standards of infection control. It is important that the person is respected by their colleagues and is assertive to enable them to introduce changes in practice in their clinical environment.

ICLP TRAINING

The post holder will be required to complete a 4 day ICLP training course. All course lectures are posted on the intranet and are available in Education and Training/Infection Control/Infection Control Link Professionals. 100% attendance is required. The post holder will then be required to attend the mandatory monthly ICLP meetings when they will perform hand hygiene and intravenous line audits. Attendance lists will be emailed to directorate managers, lead nurses, and charge nurses/sister and posted on the intranet.

A further bespoke course will be offered to ICLPs who have completed the four day ICLP course. This will focus on empowering ICLPs. The content will include assertiveness skills, facilitation skills, change management, presentation skills, how to use Powerpoint, and leadership skills. There will be an initial one day taught course followed by an online module. Presentations will be available on the intranet.

Appendix 10
Wipe it Out 10 Minimum Infection Control Standards

These are the minimum standards that the Royal College of Nursing and the Infection Control Nurses' Association believe should be accepted and mandated by Government, the relevant UK departments of health and, where applicable, all independent health care organisations.

Royal College of Nursing

April 2005

Published by the Royal College of Nursing

20 Cavendish Square,
London W1G 0RN

www.rcn.org.uk/mrsa

002 725

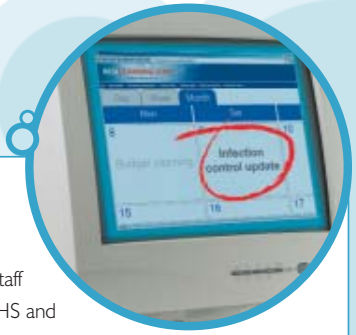
NURSINGSTANDARD Kimberly-Clark Infection Control Nurses Association www.icna.co.uk

Infection prevention and control

Minimum standards

Royal College of Nursing

wipe it out
RCN Campaign on MRSA



1. Mandatory infection control training at the time of induction for **all** health and social care staff working in both the NHS and the independent sector should be introduced across the four UK countries. An annual update, with protected study time to allow staff to attend, should be made mandatory.

2. A standardised infection prevention and control education module should be developed at a UK-wide level by an expert multi-disciplinary group and must become a compulsory component of **all** multi-professional undergraduate health care programmes.

3. Matrons, senior nurses, sisters/charge nurses or registered managers must have the mandated power, authority and necessary protected time to ensure health care establishments are clean and decontaminated in line with UK standards.

4. 24 hour cleaning teams should be introduced in all acute health care facilities and be rapidly deployable by senior nursing staff especially for high risk areas such as ICU and emergency care settings.

5. There must be sufficient provision of staff uniforms for all staff and students commensurate with the number of shifts worked and there must be provision of adequate onsite changing facilities for all staff. **All** acute health care services must provide adequate and timely laundering arrangements for staff uniforms.

6. The implementation of the ward housekeeper role should be rolled out across the UK and be supported by additional funding, rather than by changing existing nursing establishments.

7. Employers should be mandated to introduce straightforward, confidential and highly visible systems which allow patients, visitors and staff to report safely and/or challenge poor practice, incidents and mistakes involving infection control and cleanliness.

8. Clinical need and clinical advice given by infection control teams or senior clinical nurses must be paramount in determining how MRSA and other healthcare associated infectious outbreaks are managed.

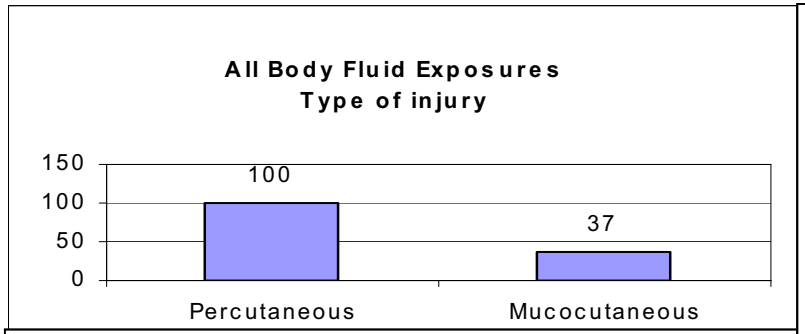
9. The Government should re-emphasise its commitment to ensuring that the ring-fenced ward environment budgets of £5000 and the associated ward manager credit cards announced by the Secretary of State for Health in 2000 are adequately resourced, delivered and extended across the whole of the UK.

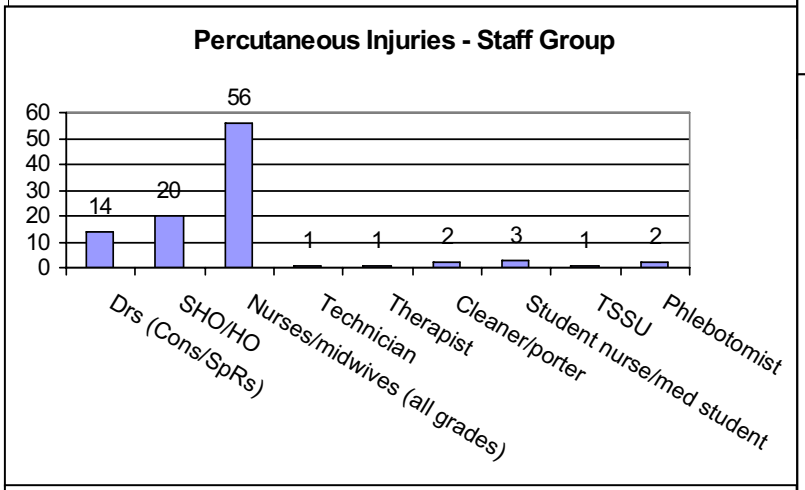
10. Employers should ensure that there are appropriate, easily accessible and widely available evidence-based infection prevention and control policies for all staff groups, and appropriate and understandable guidance for **all** patients and visitors.

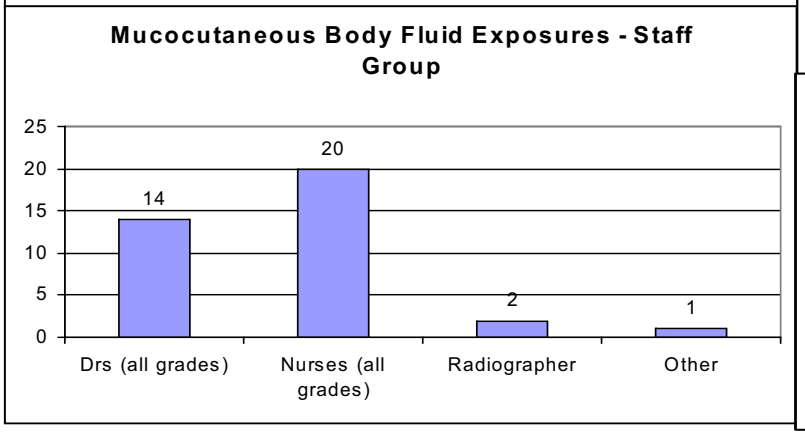
Appendix 11 Norovirus Outbreaks December 2005-March 2006

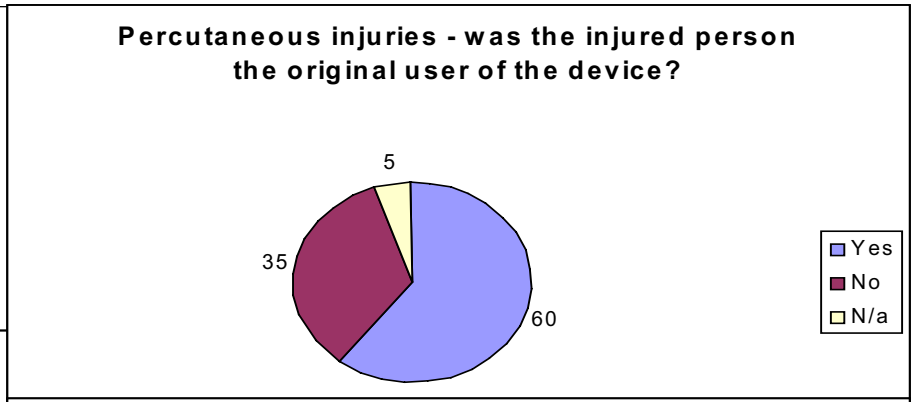
Directorate	Ward	Outbreak Start Date	Ward Reopened	No of pts & Staff affected	Bed days lost	Cost per bed	Causative Organism
W&C	Paed A&E	December 05	Not Applicable	Staff - 6	Not Applicable	Not Applicable	Presumed Community Acquired Norovirus. Nil specimens received
Medicine	Adele Dixon	01st Dec 05	7th Dec 06	Pts-7 Staff-1	6	£207 - £262	Possible Noro-virus Two patients positive for CDT
Medicine	Nell Gynne		Closed for 3 days	Pts-9 Staff-0	15	£262- £360	Presumed Noro-virus
Medicine	Edgar Horne	9th Jan 06	19th Jan 06	Pts – 15 Staff – 2	94+	£97 – £202	6 patients tested positive for Noro-virus
Medicine	Nell Gwynne	11th Jan 06	27th Jan 06	Pts – 17 Staff – 9	123+	£262- £360	4 patients tested positive for Noro-virus
Medicine	Adele Dixon	18th Jan 06	27th Jan 06	Pts – 13 Staff – 6	21+	£207 - £262	3 patients tested positive for Noro-virus 2 patients tested positive for CDT
Medicine	Edgar Horne	30th Jan 06	10th Feb 06	Pts – 18 Staff -3	112	£97 – £202	1 patient tested positive for Noro-virus 1 patient tested positive for CDT
Medicine	Nell Gwynne	4th Feb 06	15th Feb 06	Pts – 12 Staff – 5	71+	£97 – £202	Presumed Noro-virus
Medicine	David Erskine	6th Feb 06	17th Feb 06	Pts – 17 Staff – 1	70	£225.39 - £269.81	1 patient tested positive for Noro-virus 1 patient tested positive for CDT
Medicine	Marie Celeste	27th Feb 06	6th Mar 2006	Pts – 12 Staff - 2	59	£241.81	5 patients tested positive for Noro-virus
	TOTALS	Patients= 154 Overall Total 189 Staff Reported to ICT= 35					

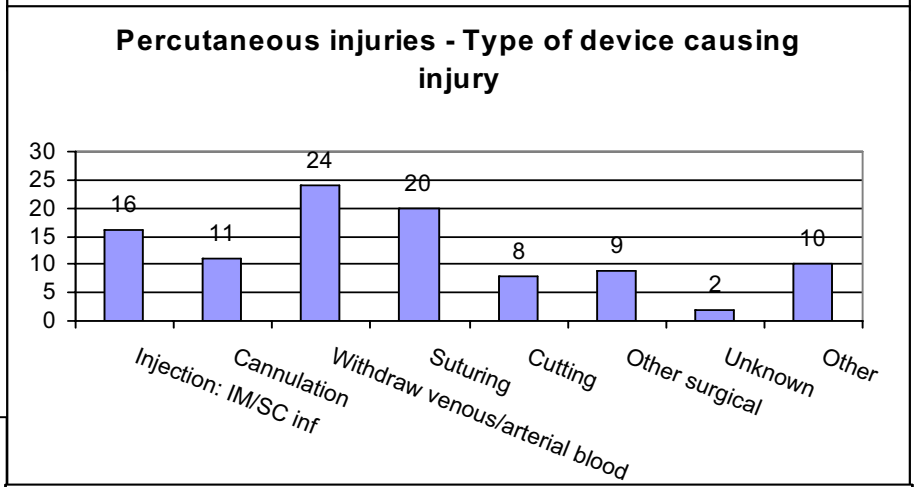
Appendix 12 Body Fluid Exposure April 2005-March 2006

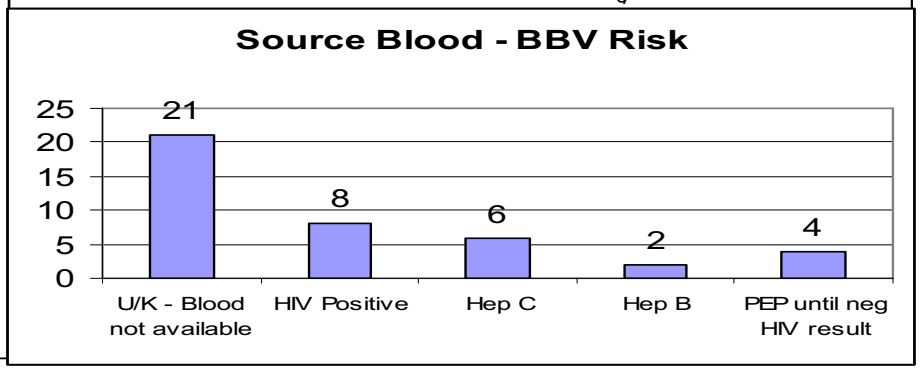












Appendix 13 Winning Ways Action Plan - Progress to Date

	Winning Ways Action Area	Areas on which to focus:	Actioned by:	Progress to date
1	Active Surveillance and Investigation	Mandatory surveillance of: a) bloodstream infections b) *Clostridium difficile* c) Surgical site infections d) Serious incidents associated with infection e) Infections after discharge	ICT/CE	Monthly reporting by ICT/CE to DH/HPA Data presented quarterly to the Infection Control Committee There have been SUIs in 2005-2006.
2	Reducing the Infection Risk from use of Catheters, Tubes, Cannulae, Instruments and Other Devices	a) Urinary Catheters b) IV peripheral lines c) IV feeding lines d) Central lines e) Respiratory Care f) Decontamination of Instruments and Other Devices	ICLPs ICT Decontamination Lead	• Introduction of silver alloy urinary catheters • Catheter audit • Specific training for ICLPs on reducing infection risks from invasive devices. • Monthly IV line audit • New IV line documentation chart • Standardisation of peripheral dressings • Education on IV line access including use of Bionectors and Octopuses • Introduction of Daniels IV line tray to provide clean mobile field for IV administration/ peripheral cannulation and point of use sharps disposal • In ICU for CVP line insertion: • -Use of large dressing pack with large sterile field and sterile gown • -Chlorhexidine disc on insertion site • Hand Hygiene Awareness Week (HHAW) 2005 programme focused on reducing infection risks from invasive devices.
3	Reducing Reservoirs of Infection	Optimise use of side-rooms Plan toward more isolation facilities ICT to be involved at every stage of planning for new building/ renovations/ maintenance work All plans to purchase new furniture to be assessed by ICT	ICT DoO Facilities	• Closer liaison between ICT and bed managers • Started pre-op MRSA screening of elective surgical patients, March 2005 • Introduced single swab MRSA screening • Turning offices, changing rooms, store rooms back into side-rooms on wards (all were originally designed as side-rooms) • Close liaison between Facilities, Projects Team and ICT re furniture, new builds, refurbishments. • HHAW annual infection control lecture for Estates, Projects Team, Facilities
4	High Standards of Hygiene in Clinical Practice	Hand Hygiene (HH) Aseptic Technique Universal Precautions Infection Control included in all PDPs and taught to all on induction All staff properly immunised if not already immune. To include: hepatitis B, TB, influenza and chickenpox.	ICLPs ICT OH HR Corporate Nursing	• Monthly audits of HH by ICLPs. Results reported to Infection Control Committee & Risk Management Committee and NMAC. • ICLPs trained re HH, aseptic technique and universal precautions • HHAW2005 programme focused on Aseptic Technique and HH. • Joined *cleanyourhands* Campaign in July 2005 • Joined *Wipe it Out* Campaign also in July 2005 • Bed-side alcohol gels introduced in August 2005 • More than 1800 staff received Infection Control training between April 2005-March 2006. All sessions included HH training
5	Prudent Use of Antibiotics	Close monitoring of antibiotic prescribing and compliance with local national policy	DIPC Pharmacist	Antibiotic prescribing behaviour monitored daily and audited annually by Pharmacy led by Microbiology Pharmacist in liaison with Consultant Microbiologist

Appendix 13 Winning Ways Action Plan - Progress to Date

6	Management and Organisation	a) Introduction of DIPC role b) Chief Exec reports to DH quarterly mandatory information on MRSA, CDT, GRE, SUI c) ICT Annual Report presented to Trust Board d) To be actioned also by SHA and DH	CE DIPC SHA DH	Dr Berge Azadian appointed as DIPC, January 2003
7	Research and Development	To be actioned by DH	DH	To be action by DH

This table summarises the ICT activities between April 2005-March 2006 which are aimed at improving compliance with *Winning Ways.*

Trust Board Meeting, 7th September 2006

AGENDA ITEM NO.	6.1/Sept/06
PAPER	Minutes of the Clinical Governance Assurance Committee meeting held 23rd May 2006.
CHAIR	Marilyn Frampton
AUTHOR	Vivia Richards, Head of Governance Contact Number: 020 8846 1156
SUMMARY	This paper outlines key issues discussed at the recent Clinical Governance Assurance Committee meeting.
BOARD ACTION	The Board is asked to note these minutes.

Clinical Governance Assurance Committee – DRAFT UNAPPROVED MINUTES

23rd May 2006

Present:
Marilyn Frampton (MFN), Non-Executive Director (Chair)
Andrew MacCallum (AMacC), Director of Nursing
Catherine Mooney (CM), Director of Governance & Corporate Affairs
Edward Donald (ED), Director of Operations
Lorraine Bewes (LB), Director of Finance
Mike Anderson (MA), Medical Director
Vivia Richards (VR), Head of Clinical Governance

In attendance:
Patricia Cediel, Guideline and Policy Coordinator (notes)
Mary Coplestone-Boughey, representing Alex Geddes
Lydia Jackson, Observer, Chair of the Chelsea and Westminster Patient and Public Involvement Forum

	Action
1.0 GENERAL BUSINESS	
1.1 Apologies For Absence Apologies were received from Heather Lawrence, Alex Geddes, and Maxine Foster.	
1.2 Conflict Of Interest There were no conflicts of interest declared in respect of items on the agenda about which members might have a pecuniary or other interest either as individuals or as members of other organisations.	
1.3 Minutes Of The Meeting Held On 28th March 2006 • AMacC clarified that Pg. 1, point 1.4.2. Patients' Forum Member should be amended to lay member from the Foundation Trust membership. The application process was briefly outlined, and noted for further discussion as part of the present agenda. LJ stated that she would like to be considered as a member of the CGAC • MFn noted that in point 2.3 (pg. 3) LD should be noted as LB The minutes of the meeting held on 28th March 2006 were then agreed as a correct record.	
1.4 Matters Arising	
1.4.1 Riverside Research Ethics Committee CM reported that she will be liaising with relevant clinicians regarding how this group fits into the Trusts Governance structure. A proposal paper will be presented to a future meeting.	CM
1.4.2 Patients' Forum Member Agenda item.	
1.4.3 Incident Review Register Mary Coplestone-Boughey reported on the interface between Lastword and CMIS, on behalf of Alex Geddes. AG is liaising with suppliers about data systems. The timescales will be reported at the Clinical Governance Trust Executive meeting.	AG
1.4.4 Minutes from Trust Executive Team for Clinical Governance Agenda item.	
1.4.5 Healthcare standards consultation	

	Action
Agenda Item.	
1.4.6 Assurance Framework Agenda item.	
1.4.7 Protect your information. CM reported that the leaflet had been completed and distributed. Matt Akid is establishing a system for patient information leaflets to ensure a consistent process throughout the trust. AMacC suggested that Julie Cooper can assist with identifying 'critical readers' who are willing to assist with the development of patient information.	
1.4.8 Relationship with Facilities Assurance Committee VR has updated the risk register to denote the type of risk against each item, e.g. financial risk, clinical risk, performance risk. VR will continue to ensure that risks are shared between committees through reporting to the Risk Management Committee and relevant operational, executive committees.	
Clinical Governance Strategic Direction CM reported that once the corporate objectives are agreed, the clinical governance strategic direction will be discussed by the Trust Executive for Clinical Governance.	CM
1.4.9 Risk Management Strategy and Policy Agenda item.	
1.4.10 Terms of reference This should be re-dated as May 2006 rather than November 2005. CM suggested developing an assessment tool to evaluate whether groups such as this committee and the other sub-committees of the Trust Board are achieving their aims. This assessment could be used in future as evidence for the Annual Health Check.	CM
2.0 GOVERNANCE	
2.1 Healthcare Standards Consultation Deadline for comments on this consultation document regarding the developmental standards is 5th June 2006. Feedback will be discussed at the next Clinical Governance Trust Executive meeting. All comments should be forwarded to CM.	All CM
2.2 Assurance Framework CM discussed a proposal for developing and monitoring the Assurance Framework for 2006/07. The purpose is to retain the positive features of the current system and to introduce a revised system of risk rating to enable more effective prioritisation of key risks. The Assurance Framework will only cover risks related to objectives; however risks may appear on both the Risk Register and Assurance Framework. MFn stated that the circulated document has assisted in clarifying the relationship between the Risk Register and the Assurance Framework.	
It is proposed that a more detailed risk rating tool is developed to make it easier to assess risks and help with validity. The process will include ensuring that risks of 16 or above are specifically agreed, as these risks require the greatest level of scrutiny for adequacy of controls and assurances.	CM
LB stated that there is a move, supported by the Standards for Better Health, towards a bottom-up approach where organisations will measure performance within their priorities and scope instead of being externally driven. LB will be	

	Action
taken this to the Audit Committee before presenting it at the CG Trust Executive Board.	
	LB

2.3 Report From Audit Committee 16 May 2006

LB reported highlights from the Audit Committee. It was acknowledged that this will be an informative report, rather than an accountability one, avoiding duplication with the information required at the Audit Committee meeting.

Issues highlighted by internal audit were discussed, particularly relating to mandatory training and the lack of available evidence of staff attendance at training sessions. Assurance was given that training is occurring within the Trust and that staff are attending mandatory training events. Internal audit will follow this up within 6 months. This is also an important risk management issue, and relates to several CNST standards.

LB reported that internal audit plans will focus on the operational rather than financial issues. Two advisory reports were provided on performance management and IT.

The auditors will be applying a framework called the Auditors Local Evaluation (ALE) for assessing areas within the Code of Audit Practice during 2005/06, covering 5 areas:

- Financial reporting
- Financial management
- Financial standing
- Internal control
- Value for money

The assessment will contribute to the Healthcare Commission's Annual Health Check, to be published in October 2006.

The Trust undertook a self-assessment, which provided an opportunity to reflect on strengths and consider weak areas of the assessment criteria. A score of 3 out of 4 was awarded, which was consistent with the external assessment.

The Value for Money audit covers A&E, treatment centre and ward staffing. There are no concerns in any of these areas. The tool considers financial and practical aspects such as skill mix. The data currently used is related to the Q1 2004/05. LB expressed concerns about the time-lag, and reported that she is exploring options to improve this.

The Audit Committee will consider one dimension of risk at each meeting. CM has reviewed the risk register to consider clinical and corporate risks and their impact on financial plans. Cash management has been identified as a barrier to become a Foundation Trust and this will be discussed further at the next Audit Committee meeting.

Following LJ's enquiry LB reported that external audit is conducted by Deloittes and internal audit by Bentley Jennison.

2.4 Report From Trust Executive Team Meetings For Clinical Governance

MA presented a summary of items discussed at the Trust Executive for Clinical Governance Team meetings held between March 2006 and May 2006.

MA drew the committee's attention to the Human Tissue Licensing Framework, which was published in 2005, and sets out a legal framework for the storage and use of tissue from the living and for the removal, storage and use of tissue and organs from the dead. The implications of this is the Trust requires a licence for the storage of skin held in the Burns Unit, and possibly for human tissue stored

within the Assisted Conception Unit. The Trust will be required to assess any requirement for a similar licence for human tissue collected for research.

The Resuscitation Committee has updated the DNAR (Do Not Attempt to Resuscitate) policy after reviewing the outcome of a DNAR audit.

Three new procedures were approved by the Trust Executive team: Permanent Pacing, Implant of Loop Recorder, and Uterine Artery Embolisation.

In response to incidents involving patients receiving joint care between the Trust and the Central and North West London Mental Health NHS Trust, three related policies are being reviewed via the Trust Executive Team.

The production of directorate-specific reports, detailing non-attendance by staff scheduled to attend mandatory training remains on the agenda at the Trust Executive Team meeting. AMacC stated that the problem of mandatory training is not only one of content but also of context as the current system is very fragmented, i.e. there are at least 5 different places through which training can be booked.

MA discussed issues relating to competency assessments for rotating medical staff, which is a risk management requirement and relates to the CNST standards. The issue of night time cover was also discussed although it was agreed that this is a different issue to competency assessments. The night time cover problem represents a clinical risk however, this is a problem across most Trusts, with no current solution due to conflicts between education (and hours of training) and provision of care.

2.5 Report From Facilities Assurance Committee

ED presented the key estates and facilities risks that have potential implications for the delivery of clinical care within the hospital. The paper clearly sets out intended mitigating or actual mitigation against each principal risk.

Risks and mitigating actions included risks of cross infection relating to decontamination processes, generator testing or uninterrupted power supply failure, incorrect or expired medical gas cylinders, and the risk of potential interruption to service as a result of steam leaks leading to a possible shutdown of the steam plant.

ED provided a comprehensive report, with rescored risk grading, detailing how these risks are being mitigated.

2.6 Lay member from a membership

Application packs have been produced and provides information regarding the role and expected responsibilities. The pack is ready for review by HL and MFn and will then be sent out in the near future. The interview panel will comprise of MFn, CM and Julie Cooper.

AMacC confirmed that a lay member is not necessarily required at all Trust committees as there are many other methods of involving the public in the scrutiny or delivery of our services.

ED stated that as principle, he would support the inclusion of a lay member at the Facilities Assurance Committee.

LJ enquired of the aim of including a lay member at this committee, VR responded that the individual(s) would provide a patient or user perspective and an additional element of external scrutiny. AMacC outlined the differences between a lay member and representatives.

	Action
Other groups where a lay member would be welcome should be considered.	
3.0 RISK MANAGEMENT	
3.1 Risk Management Strategy and Policy The Risk Management Strategy and Policy has been approved and published. In light of the approval date, the review date will be amended to May 2007, rather than September 2006 as currently stated. VR noted that this is now on the intranet.	VR
4.0 ANY OTHER BUSINESS No other business raised.	
5.0 DATE OF NEXT MEETING	
5.1 Time Of Next Meeting CM circulated a time table of future committee meetings. Meetings should, where possible, be held on Tuesdays at 1pm. The following dates were proposed: • September 26th 2006 (but see below) • November 28th 2006 • March 27th 2007 CM to confirmed dates and circulate an updated table.	CM
6.0 DATE OF NEXT MEETING 3rd October 2006 1pm	

Trust Board Meeting, 7th September 2006

AGENDA ITEM NO.	6.2/Sept/06
PAPER	Minutes of the Remuneration Committee meeting held 4th July 2006.
CHAIR	Juggy Pandit
AUTHOR	Maxine Foster, Director of Human Resources Contact Number: 020 8846 6726
SUMMARY	This paper outlines key issues discussed at the recent annual Remuneration Committee meeting.
BOARD ACTION	The Board is asked to note these minutes.

Chelsea and Westminster Healthcare NHS Trust

Minutes of the Trust Remuneration Committee held on 3rd August 2006

Present: Juggy Pandit, (chair), Charles Wilson, Karin Norman,
In attendance: Mike Anderson, Maxine Foster
Apologies: Marilyn Frampton, Andrew Havery, Heather Lawrence

1. **Minutes of the previous meeting held on 5th August 2005**
These were agreed as correct.

2. **Clinical Excellence Awards 2006**
The Committee discussed and noted the report and the number of points awarded to medical staff in 2006.

3. **Pay Awards for Trust Staff 2006**
The Committee discussed and noted the pay uplift for staff on Agenda for Change and medical staff and approved the recommended uplift for Chief Executives, Non Executive and Executive Directors.

4. Senior Staff Appointment
Deputy Chief Executive - The committee confirmed the appointment of Amanda Pritchard as Deputy Chief Executive. Amanda starts back with the Trust on 24th September 2006.

5. **Any other business**
None

Trust Board Meeting, 7th September 2006

AGENDA ITEM NO.	6.3/Sept/06
PAPER	Minutes of the Facilities Assurance Committee meeting held 21st June 2006.
CHAIR	Charles Wilson
AUTHOR	Helen Elkington, General Manager - Facilities Contact Number: 020 8237 2145
SUMMARY	This paper outlines key issues discussed at the recent Facilities Assurance Committee meeting.
BOARD ACTION	The Board is asked to note these minutes.

Chelsea and Westminster Healthcare NHS
NHS Trust

FACILITIES ASSURANCE COMMITTEE MEETING

MINUTES OF THE MEETING HELD ON WEDNESDAY 21st JUNE 2006

Present

Charles Wilson	Non-Executive Director (Chair)
Edward Donald	Director of Operations
Berge Azadian	Director of Infection Control
Maxine Foster	Director of Human Resources
Andrew MacCallum	Director of Nursing & Patient Services
Catherine Mooney	Director of Governance & Corporate Affairs
Helen Elkington	General Manager, Estates & Facilities
David Bunn	Interim Account Manager, Haden Building Services
Dave Lawrence	Regional Manager, Haden Building Services
Marc Gosling	Director London & South East, Haden Building Services
Catherine Horne	General Manager, ISS Mediclean
Denise Hollebon	Operations Director, ISS Mediclean

ITEM	MINUTE	ACTION
1.	**General Business**	
1.1	**Apologies** Sharon Terry, Deputy Director of Nursing	
1.2	The minutes of the meeting held on 2nd March 2006 were agreed as an accurate record.	
1.3	**Matters Arising from Previous Meeting**	
	Energy Campaign HE reported that the £170,000 capital bid for investment in energy saving initiatives had been approved. The work would be factored in to the capital programme.	
2.	**Assurance – General**	
2.1	**Facilities Risk Register – Top Five Risks**	
	It was noted that the Estates & Facilities Risk Register had been shared with the Clinical Governance Committee. New risks had been added to the register, primarily as a result of work completed with Pharmacy to update the Medical Gas Policy where two portering issues were identified. Work would be undertaken with the ISS portering team to put controls in place. Steam Leaks (Risk Score 8): Repairs would be undertaken in the Summer when the reliance of steam was not so great. UPS indictors (Risk Score 20): An audit had been completed to identify all UPS sockets. Planned modifications would be undertaken as part of the overall capital project which, due to the time required to isolate areas, would be phased throughout the year. In the meantime, it was noted that a programme of checking UPS batteries prior to generator tests was in place. Endoscopy washer disinfectors (Risk Score 12): It was noted this	**HE/CH**

	item would remain on the register until the Approved Person (as required by the HTM) was formally appointed.	**HE**
2.2	**HTM Compliance**	
	Outstanding items with regards formalising individual responsibilities would be completed during July. It was noted that once all responsibilities were clearly documented, structured audits would be undertaken to assess overall compliance against key HTM's. It was agreed to report back on progress with the audits to the December Committee meeting.	**HE/DB**
2.3	**Legionella Risks**	
	High water counts continued in relation to the Burns Unit kitchen. The Trust-appointed water risk assessor, Dr Tinkler had scored this as a risk factor of 6. Although a number of modifications had been made to the sinks and associated pipe work, the high counts remained. DB agreed to involve Peter Loake, Haden's water treatment specialist to agree the way forward. At the St Stephens Centre, it was noted that the redundant water tank had yet to be removed but that all other modifications to the water system were complete. Water samples would continue to be taken until clear counts were achieved. It was noted that there had been a reduction in the count, but that three clear counts were required to assume all risks had been removed.	**DB** **DB**
2.4	**Generator Failure**	
	The report of the independent review undertaken by ERA Technology Ltd was discussed. The review concluded that the generators met the present essential load requirements of the hospital. A successful handover test was completed in April 2006, with maintenance responsibility transferring to Haden Building Management. It was noted that there were some minor residual risks which would be worked through by the technical team to conclusion. The report highlighted concerns with regards future load growth and the uncertainty of peak loads. These would be monitored via tests run during peak seasonal loads. It was noted that future clinical activity expansion would be likely to require additional generator support.	**HE/DB/ Tech Team**
2.5	**Contract Performance – ISS Mediclean**	
	CH reported that monitoring outcomes against KPIs remained good. Initiatives introduced in the last quarter included: • designating a manager responsible for each floor, undertaking weekly checks and discussions with nurse leads to troubleshoot any particular issues; • reviewing the patient breakfast service which led to the introduction of a breakfast menu so that patients knew what was available to them and ensuring that toast reached those requesting it as hot as possible; • 9% of all waste was now recycled. Following briefings and waste initiatives introduced, general improvements in waste segregation were noted from up to 40% of waste in the wrong streams to	

	between 6-30% across the Trust; • all staff had been CRB checked; • security briefings had continued during the quarter with 50% of the Trust visited.	
2.6	**Contracted-Out Services HR Issues**	
	CH gave a presentation setting out the ISS Mediclean strategy for inducting staff and ensuring that the expectations and aspirations of both the company and the Trust were shared. Key points discussed were noted as follows: • all staff have an induction over a 12 week period, with reviews at the end of months one and three; • first line supervisors undertake a 6-month mandatory programme, including staff management techniques, equal opportunities, appraisals and disciplinary training; • encouraging staff to attend neighbouring colleges to improve reading, writing and language skills; • the availability of flexible employment contracts; • an NVQ in customer care has been developed for receptionists; • 61% of staff have benefited from promotion within ISS Mediclean as a whole. ED asked that both Haden and ISS Mediclean give an update to a future committee meeting setting out their approach to diversity issues, both in terms of the company strategy and actual application at C&W.	**DB/CH**
3.	**Estates & Facilities Business Plan**	
	Key objectives established for 2006/7 were noted. Progress would be shared with the Committee at future meetings	**HE**
4.	**Capital Programme 2006/7**	
	Progress against the agreed programme was noted.	
5.	**Lift Refurbishment Investment**	
	The investment of a total £2.1m in refurbishing the lifts was noted. It was agreed that when viewed against the initial independent assessment in 2002 to completely renew the lifts at a cost of £8m, the scheme had demonstrated value for money. Initial reviews of the number of faults recorded post-refurbishment were encouraging and would be monitored over the year.	**HE**
6.	**Date of Next Meeting** Thursday 7th September 2006 at 10.00 am	**All**

PART B: HADEN CONTRACT PERFORMANCE

	Contract Performance – Haden Building Management	
	Continuing under-performance with the Haden Building Management contract was discussed in detail, with the last joint audit noted as having established a 40% compliance score.	
	Each element of the joint audit was discussed, the key points of concern noted as follows:	
	1.3 Record Keeping: Concerns were expressed regarding the checking mechanisms in place to ensure that records were completed accurately and that appropriate management input was provided to verify that work had been adequately undertaken by the technicians. It was noted that the supervisors were checking documents on a weekly basis.	**DB/DL**
	Haden intended to introduce hand-held devices to enable technicians to input data directly as PPMs and other tasks were completed. The protocols for use would be available within one week, with the handhelds introduced in 3 months time.	**DL**
	2.4/5 Emergency Lighting/TMV Testing: Concerns were expressed about the level of underperformance against planned tasks. In particular it was not clear whether the follow-up work identified had been completed. Haden to clarify and to identify how future procedures would ensure that any follow-up issues were monitored to conclusion.	**DB**
	2.7 Legionella Prevention: It was noted that a recent audit completed by Dr Tinkler, the Trust-appointed water risk assessor demonstrated improvement in record keeping and the schedule of works.	
	6.1 External Grounds/Internal Plants: It was noted that a sub-contract had been let with Rentokil who started later in the month. Haden confirmed that this contract would maintain both external and internal planting areas.	
	6.2 Roof & Drain Maintenance: Little evidence existed to demonstrate what work was undertaken since the outset of the contract in terms of roof and drainage maintenance. Haden to evaluate the PPMs in order to demonstrate compliance.	**DB**
	6.5 Random Sampling of PPM Tasks: As with 2.4/5 above.	**DB**
	6.6 Five Year Electrical Testing: It was noted that no programme had been issued and that a Performance Notice had been issued to Haden for failure to complete any testing in year 1. Haden agreed to issue the programme within the week.	**DB**
	7.9 Random Reactive Work: As with 2.4/5 above.	**DB**

	Generally, it was noted that a consistent theme of poor and/or inconsistent record-keeping was an underlying issue with underperformance. It was acknowledged this is should be readily redeemable with a rapid improvement in audit scoring achieved in a short timeframe. The Haden management team committed to investing the time and resources required to turn around the contract. An in-depth review of progress would form the main agenda item of the September meeting, the expectation being that demonstrable compliance would be achieved by that time.	**DB/DL**