Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting

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

Agenda

1. GENERAL BUSINESS	**2.00pm**
1.1 Welcome to the Members of the Public	**JG**
1.2 Apologies for Absence	**JG**
1.3 Declarations of Interest	**JG**
1.4 Minutes of the Previous Meeting held on 2nd February 2006 (attached)	**JG**
1.5 Matters Arising (attached)	**JG**
1.6 Chief Executive's Report (attached)	**HL**
1.7 NHS Foundation Trust Application (attached)	**HL**
1.8 NHS Foundation Trust Application – Cash Risk Update (to follow)	**LB**
2. PERFORMANCE	**3.00pm**
2.1 Finance Report, January 2006 (attached)	**LB**
2.2 Performance Report, January 2006 (attached)	**LB**
3. ITEMS FOR DECISION/APPROVAL	**3.30pm**
3.1 Corporate Plan – for discussion (attached)	**EHJ**
4. ITEMS FOR ASSURANCE	**4.00pm**
4.1 Information and Data Quality Policy (attached)	**AG**
5. ITEMS FOR NOTING	**4.15pm**
5.1 Governance Update	**VR**
5.1.1 Assurance Framework (attached)	**VR**
5.1.2 Proposed Core Standards Declaration (attached)	**VR**
6. ITEMS FOR INFORMATION	**4.45pm**
7. QUESTIONS FROM THE MEMBERS OF THE PUBLIC	**4.45pm**
8. ANY OTHER BUSINESS	
9. DATE OF THE NEXT MEETING	
6th April 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, 2nd March 2006

AGENDA ITEM NO.	1.5/Mar/06
PAPER	Matters Arising
AUTHOR	Sue Perrin/Fleur Hansen 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 this report.

Matters Arising from Previous Meetings

Reference	Item	Action
5.1/Aug/05	CHILD PROTECTION QUARTERLY REPORT Confirmation that letter has been sent on behalf of Trust Board to Healthcare Commission setting out concerns regarding Capio Nightingale House.	MA
3.2/Dec/05	MEMORANDUM OF UNDERSTANDING WITH THE ROYAL BROMPTON Legal advice to be obtained and discussions with Royal Brompton to be taken forward.	HL/Agenda item
3.3/Dec/05	SUB-COMMITTEE TERMS OF REFERENCE Discussion between Chairs of Audit, Clinical Governance Assurance Committee and Facilities Assurance Committee.	MF/AH/CW
1.5.1/Jan/06	BUSINESS CONTINUITY RISK Paper to be brought to Trust Board via Information Management and Technology Committee.	AG
2.3/Jan/06	INFORMATION AND DATA QUALITY POLICY To be discussed at the Information and Management Technology Committee and brought back.	AG/Agenda item
5.1/Jan/06	INFLUENZA PANDEMIC CONTINGENCY PLANNING Trust Board to be informed of the risks and how these might be mitigated.	AMacC/Agenda item
6.2/Jan/06	RISK MANAGEMENT MINUTES Advice on whether minutes should be received by the Trust Board.	Dir of Governance
2.2/Feb/06	PERFORMANCE Report on delayed discharges to be included.	LB
2.3/Feb/06	WORKFORCE REPORT Agenda for Change – cash assumptions to be shared with Trust Board. Ethnicity/disciplinary hearings ratio to be included in future.	LB MB

Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting, 2nd March 2006

AGENDA ITEM NO.	1.6/Mar/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.

CHIEF EXECUTIVE'S REPORT – FEBRUARY 2006

SENIOR STAFF

As you will have noted, Sue Perrin has now left the Trust. For the purposes of the Trust Board, Fleur Hansen will be taking the minutes and organising the papers. The rest of Sue's responsibilities have been distributed accordingly.

In addition, a new General Manager for HIV and GUM, Debbie Edwards, has been recruited.

We have also made progress in recruiting an academic non-executive director. A nomination has been sent to the Appointments Commission and the chairman for consideration.

FINANCE AND PERFORMANCE

The Finance Report details progress concerning the HIV Consortium as discussed at last month's meeting. We are now at the arbitration stage. If we lose then we will not achieve our surplus, however in agreement with the SHA we have not altered our current position pending a decision.

Regarding performance, there are a couple of main areas for concern. In February, A&E saw a high level of non-predicted admissions in both adults and children's resulting in difficulties reaching the 98% target. The trust will need to be at 98.4%. Edward Donald has drawn up a plan to address this.

There may be issues concerning urology cancer wait times. These are being reviewed and will be reported to the Trust Board when complete.

CANCER PEER REVIEW

The trust, as part of the West London Cancer Network, underwent Peer Review on the 9th and 10th of February. Initial indications are that we did very well with the reviewers highlighting our patient-focused service and well-defined diagnostic pathways. Also we were the first London trust to fully meet the very tough Intrathecal Chemotherapy measures. There was though concern in a couple of areas, namely nursing support for upper GI and gynae as well as the need to develop further the multidisciplinary teams and complexities around haematology.

RAVENSCOURT

Early this year McKinsey was commissioned by the SHA to undertake a review into the future of the Ravenscourt Park Hospital. The review concluded in part that there should be transfer of elective orthopaedic work to Ravenscourt and it suggested the transfer would be approximately 377 cases from our trust. In comparison to other trusts, we would have a disproportionate shift of 25% of our case, compared to an average of around 11% for other trusts.

I have drafted a response to the CEO of the SHA detailing this, along with a list of other detrimental effects such a transfer would have. Such a shift would make it very difficult to deliver a consultant-led trauma service as well as presenting challenges around patient choice and our strong position in training in orthopaedics. In addition, not all orthopaedic work is currently carried out in the sector and I feel that the SHA should address this issue before suggesting a transfer of service. In our SDS we did consider the transfer of orthopaedic work as a risk. We may need to revisit this dependent on the SHA response.

CONNECTING FOR HEALTH

The Trust commenced using the Indirect Booking Service within Choose and Book and has over 4 months received 165 referrals. The service is now being rolled out to all specialities, to be completed by the end of March 2006. This enables General Practitioners to refer patients electronically and patients will have the opportunity of booking their appointments on the day the referral is made.

The fully integrated version of Choose and Book that will enable Direct Booking to be implemented is now planned to commence 30th June 2006. GEHealthcare have committed to make Lastword compliant with the National Spine however the following steps are required in order for this to happen:

- NHS number to be greater than 95% for acceptance into testing environment (or robust policies and procedure to ensure this standard is met)
- Securing time with BTs Test Rig, which tests the messaging between Lastword and the CRS Spine
- Sandpit testing with Connecting for Health (end to end testing)
- Work groups for commissioning; training; operational workflows and technical issues are in the process of being set up

The testing timetable is crucial in order to confirm the project plan and go live date for Direct Booking. This has been raised with the NWL Strategic Health Authority and GEHealthcare are currently negotiating this with BT. The inability to go live on schedule may have an impact on Chelsea & Westminster being selected as a provider of choice for 07/08.

STANDARDS FOR BETTER HEALTH AND ASSURANCE FRAMEWORK

The Trust is currently preparing itself for its final declaration against the standards in April 2006. All standards are being reviewed and updated by appropriate staff. A timetable of progress will be noted later in the meeting. The six-monthly assessment of the Assurance Framework is also being undertaken and Lorraine will also be noted under the governance update.

Heather Lawrence
Chief Executive
22nd February 2006

Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting, 2nd March 2006

AGENDA ITEM NO.	1.7/Mar/06
PAPER	Foundation Trust Application
LEAD DIRECTOR **AUTHOR**	Heather Lawrence, Chief Executive Contact Number: 020 8846 6711 Fleur Hansen, Foundation Trust Project Lead Contact Number: 020 8846 6716
SUMMARY	This paper outlines key issues for the attention of the Trust Board.
BOARD ACTION	1. To note the report. 2. To discuss names of possible Foundation Trust.

Chelsea and Westminster Healthcare NHS
NHS Trust

FOUNDATION TRUST APPLICATION

TIMETABLE

A draft project plan has now been drawn up which incorporates all submissions required as well as key points in the timeline towards authorisation. At the time of writing Group 6 is still yet to be given firm dates from Monitor but we are currently working to a timeframe based around that of Group 5. The next major date is assumed though to be at the end of April when the financial models and Schedule of Services will be submitted. Fleur will update all concerned as soon as there is further news from Monitor.

FINANCE AND SDS

The finance team are currently working to resolve the cash risk issue mentioned at the last meeting – Lorriane will update on this. The Long Term Financial Projections and the Working Capital Review models are to be submitted at the end of April – these are currently being worked on and Nigel Turner, a consultant with specialist experience in taking trusts through the application process who has been brought in to help with this.

The newly published PbR tariffs will impact on the SDS and therefore this is also being updated in conjunction with the financial remodelling. This also needs to feed into our corporate planning.

GOVERNANCE

All governance requirements necessary to reach Foundation Trust status have been incorporated into the timetable and we are currently working through these to determine what measures will need to be taken to meet them. In addition to the seminar today, we shall organise a couple of other sessions to prepare the Board to ensure that they are fully competent in the necessary areas.

MEMBERSHIP AND ELECTION

Membership currently stands at around 7000 members who are eligible to vote in the forthcoming election. Initial indications from the Campaign Company indicate that there is a good mix across age and ethnicity groups.

The election for members of the Membership Council shall take place between March 2nd and 21st via a postal ballot system. There has been a good response to the nomination round and in particular a strong participation rate amongst staff. Two sessions have been arranged to allow members to meet the candidates – a lunch and an evening session on March 9th.

NAME OF POSSIBLE FOUNDATION TRUST

There has been some initial discussion around what the trust should be named if the application to Monitor is successful and Chelsea and Westminster becomes a Foundation Trust. Anecdotal evidence indicates that most Foundation Trusts have chosen to drop the Department of Health required 'Healthcare' from their title and replace it with 'Hospital(s)'. This is also a move generally supported by public opinion as it more specifically reflects the true business of the trust. Obviously this would only come in to official use on the application for Foundation status being successful but it is important from a communications perspective for the trust to decide at this stage whether it would prefer to be recognised as the Chelsea and Westminster Hospital NHS Foundation Trust or the Chelsea and Westminster Healthcare NHS Foundation Trust. We would ask the Board to consider this.

Fleur Hansen
Foundation Trust Lead
22nd February 2006

Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting, March 2006

AGENDA ITEM NO.	2.2/Mar/06
PAPER	Financial Report – January 2006
SUMMARY	The overall income and expenditure position for the ten months to January 2006 is a surplus against budget of £1.122m, a reduction of £1.003m on the position at Month 9. The forecast position for the year-end remains at a surplus of **£2.1m**. There was a small deterioration in the directorate in-year positions. With the exception of Surgery and A&I, the in-month Directorate positions were in-line with expectations. The main movement in the in month position is on SaFF income and is due to a provision against the overperformance on elective activity. A recent arbitration decision in the sector has confirmed that PCTs will not have to pay for non-urgent activity treated sooner than 5 month (±2 weeks) in the last 5 months of the year. The impact of this decision on the Trusts income position is a loss of £0.774m for the full year. However, the forecast out-turn has not deteriorated as the loss has been mitigated by a release of reserves that are no longer required in 2005/06 and the benefit from the Wandsworth arbitration decision. There are a number of risks that are not in the forecast position and the two significant risks include: • A net risk of between £1.6m and £3.1m arising from a proposal by the HIV consortium to not pay for any overperformance in 2005/06. This proposed unilateral change in the risk sharing policy, very late in the financial year, is not accepted by the Trust and the Trust is seeking support from the SHA to resolve this as quickly as possible. If the Consortium's proposal is upheld, the out-turn will deteriorate by a minimum of £1.6m without any possibility of mitigating this with savings elsewhere. An arbitration meeting has been arranged for the 9th March. • During the Month 9 agreement of balances exercise, a significant level of outstanding debt has been registered as disputed. The Trust believes that there is an adequate level of provision against these disputes but until they are resolved, there is a risk that the provision is not sufficient. Due to a delay in payments for SIFT and MADEL in January, the cumulative cash position against plan moved out by £1.090m. This has been rectified in February and the cash position against plan is expected to be significantly better in February. The Credit Control function has been strengthened to ensure that outstanding debtors are rigorously chased to improve cash collection for the remainder of the year.
AUTHOR	Lorraine Bewes, Director of Finance and Information: Telephone: 020 8846 6713
BOARD ACTION	The Board is asked to note the financial position at Month 10.

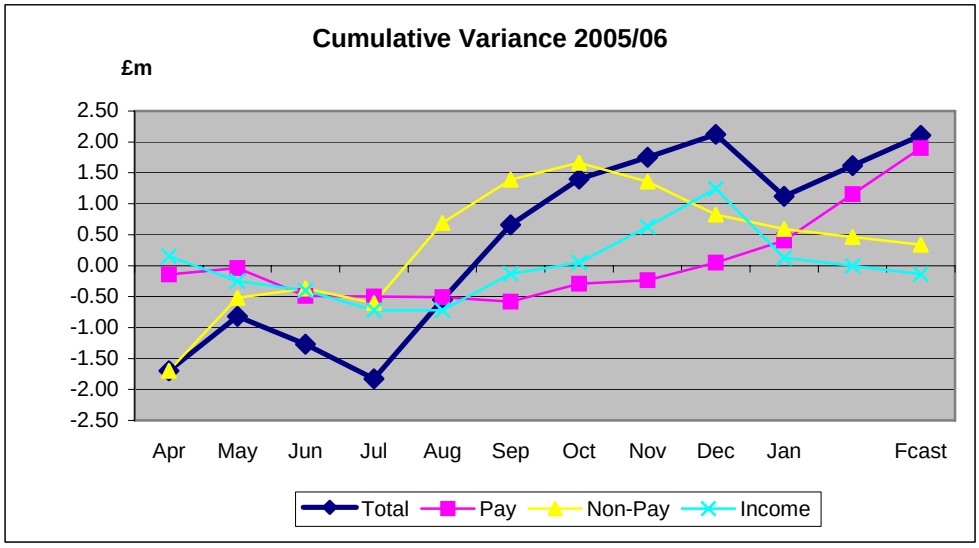
Chelsea and Westminster Healthcare NHS

NHS Trust

Finance Report
March 2006
Financial Position – Jan 2006

Summary Income & Expenditure (Form F1)

1. The overall financial position after ten months is a surplus of **£1.123m**. The Graph below shows the trend in the cumulative variance against budget to the end of December with the forecast year-end position of a £2.1m surplus.



2. The overall pay position at Month 10 is an over spend of **£0.405m** (0.4%). The in-month position is a favourable variance of £0.350m.

3. Non pay including Reserves and Depreciation is under spent by **£0.590m** (0.7%), an adverse movement in month of £0.235m. There is a significant adverse movement in the month on clinical consumables within Anaesthetics and Imaging (£200k) due to increased purchasing however investigation by the directorate has shown that this increased level of spend is not expected to continue. Further information is provided in the directorate report in paragraph 20. There is a large overspend in Facilities non pay in the month as expected, resulting from gas and electricity costs (£105k above budget in the month) in addition to increases in the comprehensive maintenance costs from Haden, which was already anticipated in the Facilities forecast. Other key pressures included the unachieved depreciation savings target (£0.884m) and overspending on clinical consumables and prostheses. These overspends are offset by an underspend on the drugs budget (£0.540m).

4. The income position, including interest receivable, is **£0.127m** favourable (0.1%) which is an adverse movement in the month of £1.118m. SaFF Contract Income is £0.958m overspent in the month, mainly as a result of a new year to date provision against PCT overperformance for patients treated in advance of target waiting times (0.644m in the month). On 22nd February the Trust received verbal notification of the Wandsworth arbitration decision which results in release of provisions totalling £0.369m full year. This is reflected in the forecast and the provisions will be released in the year to date position next month.

5. The HIV Consortium has written to the Trust advising that overperformance will not be paid this year. The Trust does not accept this change in risk management policy, issued after the arbitration on the 2005/06 contract had been held, and has written to the Consortium rejecting this change. The total income at risk from this policy change is approximately £1.6m and this is not in the current reported out-turn. Further information is provided in the risk section at paragraph 37.

6. The Trust is forecasting a year-end surplus of **£2.105m** which remains unchanged from recent months. However there are a number of changes within this position. The largest deterioration is the creation of a provision against elective overperformance as reported above (£0.774m full year). This is offset by the release of the Wandsworth PCT provision (£0.358m) and an increase in the Management Executive and Clinical Support underspends (£0.211m) and reserves released because the funds are no longer required this financial year (£0.384m).

Variance Analysis – Year to Date and In Month

7. The overall position for the Trust is a favourable variance of **£1.122m** which is an adverse movement of **£1.003m** in Month 10. The high-level summary of this position is as follows:

	Year to M9	Year to M10	Movement in month
	£'m	£'m	£'m
Income			
SaFF Baseline	1.192	0.234	-0.958
Non-Contract Activity	0.064	-0.071	-0.135
Private Patient Services	-0.227	-0.140	0.087
Other	0.319	0.204	-0.115
Interest Receivable	-0.033	-0.022	0.011
Expenditure			
Pay	0.051	0.405	0.354
Non Pay pressures	-1.358	-1.957	-0.599
Reserves and Capital Charges	2.117	2.469	0.352
Total	**2.125**	**1.122**	**-1.003**

Income and SaFF update

8. The overall YTD income position is **£0.127m** favourable taking into account an adverse position on interest receivable of £0.022m. Within this position Private Patient income, including ACU, is adverse against budget by £0.140m, a favourable movement in the month of £0.086m due to income in the month being higher than trend within the Private Patient Unit and ACU, offset by a reduction in Private Maternity income in January.

9. SaFF Income is reporting a deterioration of £0.958m in the month which has reduced the year to date position to a surplus of £0.234m. SaFF income is based on an extrapolation of the costed activity up to month 9, after taking consideration of the seasonal down-turn in activity during December. (**Form F2B(ii)**). The deterioration in the month is largely due to the provision on elective overperformance as reported above.

10. The contract with the HIV Consortium has not been signed yet as the Consortium has sought to change the policy on risk share, post arbitration on the 2005/06 contract. (See paragraph 37 for details on this risk)

11. The arbitration hearing for Wandsworth PCT has now been held with a mixed outcome for the Trust. However since the full financial risk in the arbitration had been provided for the outcome allows a release of provisions no longer required (£0.358m full year). This is not reflected in the year to date position as the outcome of the arbitration was only known after the Month 10 position had been finalised. It is however in the forecast and has contributed towards mitigating the deterioration in the elective overperformance, allowing the Trust to maintain a £2.1m forecast out-turn. This will be reflected in the year to date position next month. The conclusion of the arbitration clears the way for signing off the SLA for 2005/06.

12. Non-Contract Activity at Month 10 is showing an adverse variance of £0.071m, an adverse movement from Month 9 of £0.135m. The activity relating to patients from countries with a

reciprocal agreement has risen by over 100% in comparison to last year's activity. All this activity is billed to K&C PCT. K&C are seeking to share the risk of this overperformance with the Trust by agreeing a marginal rate for overperformance above the funding levels K&C have received. In anticipation of a possible agreement on risk share, a provision has been included for a reduction in the tariff to 67% for overperformance. Any concession on the marginal rates for overseas activity will be subject to resolution of all outstanding main SLA and HIV over-performance issues.

13. The table below shows the latest status of progress to sign-off of SLA contracts.

	No of SLAs	**SLA value agreed /Offer £m**	Variance £m
Agreed	119	121,831	(2.41)
Offers received not agreed	1	14,151	(0.59)
Offers received not agreed- HIV	1	37,581	0.08
No offer received	0	0	0
Overseas (reciprocal)	1	943	(0.43)
Total	123	174,509	(3.35)

Expenditure Update

14. The expenditure position is **£0.996m** favourable at Month 10, a favourable movement of £0.116m in the month. This position includes a further month's worth of the deficit payback reversal (£0.286m in the month) and the release of AFC funding (£0.125m in the month).

15. Pay budgets are **£0.405m** favourable (**Form F2D**) which is a favourable movement in the month of £0.350m. The favourable in month position, which is similar to last month, reflects underspends in frontline directorates (£0.235m) further commentary on this is within the directorate reports. Management Executive and Clinical Support have continued the year to date trend with significant pay underspends. These underspends are not expected to continue next year.

16. Existing staffing budgets, e.g. Nursing and new Agenda for Change bands, continue to change as staff are paid under new AFC terms and conditions. At the end of January, 663 existing staff have been assimilated and paid under AFC and 127 new staff have been appointed directly into vacant posts under AFC terms and conditions. Based on analysis of the awards given to-date and an estimate of future awards, the reserves set aside to fund AFC are considered adequate.

17. Non-pay is reporting a **£0.591m** under spend year-to-date (**From F2E**), which is an adverse movement in the month of £0.235m. The benefit from both the deficit payback and AFC funding is shown under non-pay. Highlights within non-pay are:

- Provider to provider service level agreements are significantly overspent (Form F2F), £0.066m in the month and £0.592m year to date. This is predominantly the Pathology SLA which is £0.061m overspent in the month and £0.613m year to date relating to over performance.

- Within central budgets there is an overall favourable position on non pay in the month of £0.342m. There is £0.486m within the forecast (£0.405m year to date) for the full year cost of the HIV drugs risk share within the central non pay position.

- Drugs are under spent by £0.540m YTD which was a favourable movement of £0.057m in the Month.

- Depreciation is reporting an adverse variance of **£0.923m** YTD in line with previous months.

- Patients appliances/prosthesis (£0.687m overspend YTD) and MSSE (£0.756m overspend YTD) continue to be the non-pay categories with the highest overspends.

Directorate Positions (Forms F3A and F3B)

18. Surgery, Management Executive and Clinical Support are on track to meet their year-end forecasts and there is minimal risk in their forecast out-turn.

19. The following directorates are those directorates where the forecast out-turn position is either a significant overspend or where there is a medium to high risk of under achieving their forecast out-turn.

20. **Imaging & Anaesthetics-** The Month 10 position for the Imaging & Anaesthetics Directorate is an overspend of £0.318m, which represents an adverse movement of £0.087m compared to the previous month's position. There are two key reasons for this deterioration in the position, one being the requirement to cover an additional 10 anaesthetic consultant sessions per week as reported in the December financial report, and the other being unexpectedly high expenditure on MSSE in Theatres, TSSU, ITU, Radiology and the Treatment Centre during January. This has been investigated and appears to be due to stocking up in certain areas, plus the impact of invoices relating to pre-Christmas orders being processed in the ledger in January.

21. The Directorate's forecast has changed this month from a projected underspend of £0.040m to a projected overspend of £0.050m. The reasons for this change relate partly to the issues described above and partly to the fact that the Directorate has been managing the new Urology activity transferred from St Mary's NHS Trust within a certain envelope of funding and there have been some unforeseen pressures on this funding. These pressures relate partly to the high cost of hiring laser equipment and partly to the need to carry out Waiting List Initiative sessions in Urology for certain consultants. In addition, the Directorate committed to manage the 2nd Burns ITU bed within the envelope of funding available from the National Burns Care Group and also achieve significant savings within this funding. There was always a level of risk attached to this due to the difficulty of forecasting the dependency of patients and the level of throughput through the two Burns ITU beds. Due to the high occupancy during December and January the saving achieved has been reduced.

22. **HIV/GUM –** the main risk to the forecast out-turn position relates to the stance that the Consortium are taking regarding payment for overperformance in the year. The risk ranges from £1.6m to £3.1m and is not reflected in the Trust position. Further details are provided at paragraph 37.

23. **Medicine & A&E –** The Medicine & A&E Directorate is £0.493m overspent at Month 10, which represents a negative movement of £0.057m compared to Month 9. The directorate is forecasting a year end overspend of £0.770m, which represents a positive movement of £0.020m compared to the Month 9 forecast. There was significant improvement in the ward position this month. Overspends in Adele Dixon and Frances Burdett are a result of the opening of the 6 closed beds on each ward due to Norovirus pressures on other wards. Underspending on drugs continues to underpin the financial position of the Directorate, with the forecast for drugs underspending rising to £0.630m this financial year.

24. **Women & Children's Directorate** – The Women and Children's Directorate has an underspend of £0.213m at Month 10. The large in month movement (£0.361m favourable) is the result of non-consortium NICU overperformance income being transferred to the NICU budget from Central SaFF income. The outturn forecast for W&C has been adjusted accordingly and now shows an underspend of £0.344m, which is a favourable change of £0.373m compared to Month 9.

25. **Private Patients** – At Month 10 the net position of the unit was a negative variance of £0.378m, a £0.054m positive movement on Month 9. The variance is made up of income under-recovery of £0.013m and overspends of £0.365m. The Trust continues to promote the Unit to consultants with a view to maximising second list and treatment centre income. The Unit continues to work on the measures flagged up in recent reports to reduce expenditure, some relating to improvements in efficiency and others which will curb expenditure in the Unit not directly relating to Private Patients activity. The forecast for the Unit remains a £0.396m deficit for the year.

26. Overseas income is now reported separately from Private Patients. The forecast is for Overseas income to under-recover by £0.020m at the financial year end. This incorporates estimated specific bad debts of £0.065m.

27. **Assisted Conception Unit (Form F3B) –** The year to date position within ACU at Month 10 shows an overspend of £0.161m. This is an in-month underspend of £0.046m. In January a large proportion of the previously un-billed ACU activity has now been passed to Finance for billing and has contributed to the in month positive variance. Activity in month continued on trend, with cycles down against plan, whilst 'other' activities within the Unit continued to perform well. Overall the

income budget is £0.032m under-achieving against target, year to date, whilst the forecast position is a £0.040m surplus, once all the un-billed work has been processed. Pay costs are overspent year to date, due to staff absence covered by Locum staff. Non-pay is also overspent year to date, in part due to bulk buying in the early part of the financial year. At year end the ACU is currently forecast to overspend by £0.104m.

Savings Target (Form F5A and F5B)

28. **Form F5A** shows the savings target by Directorate and reports those savings that have been identified by directorates and removed from specific expenditure budgets. A total of £2.762m has been removed from budgets at Month 9. There has been no change to the position reported last month.

29. **Form F5B** shows savings that have been removed from budget plus all further savings schemes in progress. At this stage a further £1.053m of schemes have been proposed. In summary a total of £3.815m has been achieved or planned against a target of £4.958m, leaving a shortfall of £1.143m. This is no change to the shortfall remaining at Month 9.

Total Savings

Risk	**£'m**
Achieved	2.762
Low	0.409
Medium	0.418
High	0.226
Not identified	1.143
Total	**4.958**

30. The £4.958m savings target is a recurrent target, of which £2.97m has been identified recurrently leaving a balance of £1.99m to find. The table below shows the split by directorate.

Recurrent Savings Planned

Directorate	**Recurrent Target £'m**	**Recurrent Planned £'m**	**Outstanding Recurrent £'m**
A&I	570	497	73
Surgery	436	508	-72
W&Cs	681	681	0
Medicine	569	340	229
HIV	700	340	360
Facilities	284	211	73
Pharmacy	82	82	0
Physio & OT	93	62	31
Dietetics	14	0	14
Man Exec	436	248	188
Capital Charges	1,093	0	1093
Total	**4,958**	**2,969**	**1,989**

31. Directorates are currently focussing on converting the non-recurrent elements of 2005/06 savings into recurrent savings for 2006/07 and beyond and also identifying new schemes for the 2006/07 recurrent savings target. Directorates have been asked to look for a minimum of 2.5% savings for next year however this is provisional target until the new tariff, activity projections and expenditure pressures are applied to budget forecasts for 2006/07. At the time of reporting, the National Tariff has been withdrawn and this has delayed finalising the overall savings target for the Trust.

Year End Forecast

32. The full year forecast is a surplus of **£2.105m,** no change on the forecast at Month 9. Within this position there are a number of offsetting changes, the largest of which are reported above in paragraph 6.

33. There is considerable uncertainty around what PCTs will pay in relation to SLA activity. The income reported is net of provisions for anticipated demand management reductions in the last quarter of the year; operation of a cap on the ratio of follow-up to new outpatient attendances and removal of some activity likely due to data quality issues. Two other specific provisions include:

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

	Full Year Forecast at January				Movement from December
	Income	Pay	Non pay	Total	
	£000's	£000's	£000's	£000's	£000's
SaFF Income	279	0	0	**279**	**-740**
Other Central Income	-336	0	0	**-336**	**0**
Imaging & Anaesthetics	-4	410	-456	**-50**	**-90**
HIV/GUM	500	-298	-79	**123**	**34**
Medicine & A&E	-108	-761	99	**-770**	**20**
Surgery	-1	673	-623	**49**	**0**
Women & Children's	134	60	149	**343**	**372**
Clinical Support	-7	216	98	**307**	**74**
Facilities	113	-110	-548	**-545**	**2**
Man Exec	102	863	-153	**812**	**137**
Private Patients & ACU	73	-256	-336	**-519**	**12**
Service Level Agreements	0	0	-634	**-634**	**0**
Other Departments	-20	51	-23	**8**	**25**
Depreciation	0	0	-1,000	**-1000**	**0**
Central	-861	1054	3,845	**4038**	**154**
Total	**-136**	**1902**	**339**	**2,105**	**0**

35. The Trust has been set a control total to achieve a £2.1m surplus towards the NWL sector deficit and is currently forecasting to achieve this. However, the Board should note that while the forecast is realistic there are a number of risks that could deteriorate the actual out-turn, most notably the recent notification from the HIV Consortium that it will not pay overperformance. The risks are discussed in detail below.

Risks

36. There are four main areas of risk that could impact on the financial forecast reported in this report and these are set out below:

37. **HIV overperformance –** the HIV consortium are attempting to change their policy regarding payment for overperformance in 2005/06 which, if successful, would result in a net deterioration of between £1.6m and £3.1m in the forecast out-turn. An arbitration hearing on this issue has been scheduled for the 9th March. If the arbitration goes against the Trust, then the Trust have indicated to the SHA that we will not be able to meet the control total.

38. **Savings Plan Delivery -** The current forecast assumes that the Directorates will deliver the majority of their allocated savings target through recurrent and non-recurrent savings including reductions in bank and agency spend. There is £0.226m of high risk assumptions in the savings plan, predominately around the assumption of additional NICU activity resulting from the opening

of the Combined Care Unit. This activity is not within the control of the Trust and therefore high-risk in nature.

39. **Demand Management –** the current forecast income position has made a number of assumptions around reductions in outpatient activity due to the demand management initiatives being implemented by local PCTs. The PCTs are also proposing to impose a cap on the ratio of New to Follow-Up and not paying for any follow-ups that exceed this cap. There is a medium risk that estimates of activity reductions assumed within the forecast could prove to be understated.

40. **Provisions for doubtful debt** – The month 9 agreement of balances exercise will be completed during February. To date, a total of £7.6m of outstanding invoices have been disputed by PCTs. Of this figure, £2m relates to K&C PCT and it is expected that negotiations at FD level will reduce this dispute to £1m. Against the balance of £6.6m, provisions and reserves of £6.3m have been set aside, however there is a risk that further disputes will arise that have not yet been notified, particularly in relation to over-performance.

Budget Assumptions

41. There were a number of reserves distributed in Month 10 and the most significant items are detailed below.

42. **Agenda for Change** - Recurrent funding of £0.015m was distributed from the Agenda for Change (AFC) Reserve to fund increased costs for the additional 11 members of staff who assimilated onto AFC terms and conditions in the month and also 24 new members of staff appointed directly onto AFC terms and conditions.

43. £0.350m was distributed from Reserves to SaFF income to update PCT budgets to equal the contract values for the five contracts signed in 2006.

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

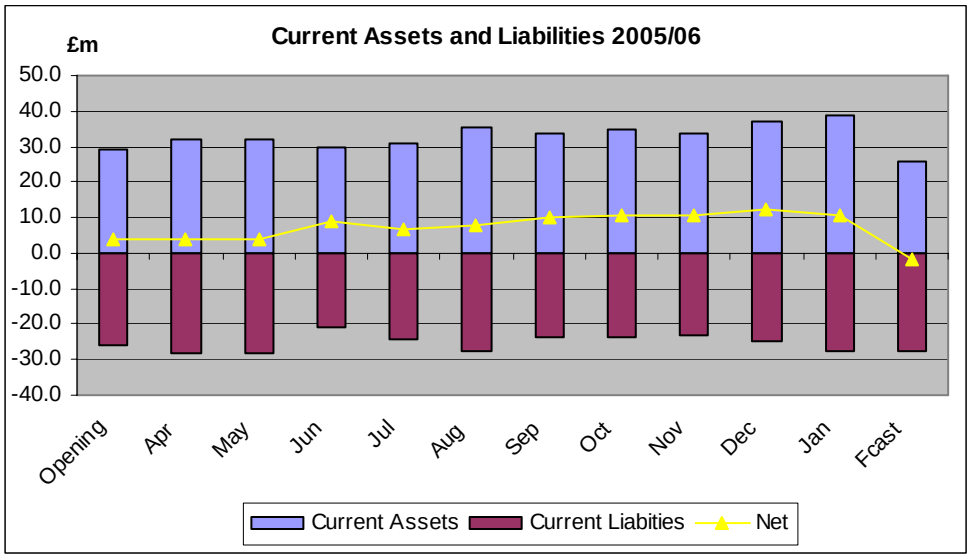
Working capital

44. Total current assets and liabilities have increased by £1.554m and £3.064 respectively. This is mainly due to the reduction of debtor receipts and a reduction in creditor payments. Consequently net current assets have gone down £1.510m.

45. At 31 January 2006, the Trust debtor days based on balance sheet values were 44 compared to 39 achieved at 31 December. The year end target is 33 days.

46. The Trust was taking on average 50 days to pay creditors in January 2006 compared to 43 days in December 2005. The year end target is 55 days. In order to achieve this target, a list of creditors has been compiled which identifies potential creditors whose payment terms will be stretched in March 2006.

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



Debtors (Form F7)

48. There has been an upward movement in the overall debt position in January with total debt increasing by 11.2% to £21.599m. Two large invoices raised during January have not been paid. Over 30 days debt has decreased by 17% or £1.499m whilst over 90 days have decreased by 0.7% or £0.069m.

49. The Hammersmith Hospitals debt has increased marginally to £2.5m from £2.3m at the end of January 2006.

50. The level of debt with Kensington and Chelsea PCT has increased by £0.492m. The outstanding debt relates to current billing and should be cleared in January 2006. The debt consists of £0.575m out of area treatment, £0.119m high cost drugs, £0.497m over-performance, £0.511m NPFIT and £0.651 GUM. The NPFIT and the GUM invoice have now been paid in February. Discussions are underway at FD level to reach agreement on the outstanding debts.

51. Increase in debt to the North West London SHA/North West London WDC of £1.929m was due to late billing. Payment was received in first week of February.

52. Increase in debt with Wandsworth PCT is for over performance billing and salary recharges. Over performance invoices for 2004/05 totalling £0.350m relate to the recent arbitration and will be dealt with in accordance with the arbitration decision. The increase in month is due to unpaid invoices for January.

53. Over 90 days debt with Watford and Three Rivers PCT relates to disputed over performance charges raised at year end. They have confirmed that will be making a payment of £0.250m as per the month 9 agreement of balances process.

54. £0.371m of the amounts outstanding for Imperial College London is for facilities charges for the period April to September. This has now been authorised for payment expected in February.

55. The amount of debt with Private Patients has increased by 9.3% to £1.185m compared to £1.084m last month. There has also been an increase in the value of Overseas Debt by 1.8%.

Creditors (FormF8)

56. The total value of creditors at the end of January has increased by 30.82% to £14.599m and most of this increase relates to ISS Mediclean Ltd, Gilead Sciences Ltd, Mawdsleys and Haden. The value of invoices >30 days is up 159.9%.

57. The level of debt with Hammersmith Hospitals has reduced by £1.058m or 18.6% from £5.6m to £4.6m.

58. The BPPC performance has increased with 76.87%in number and 70.69% by value of invoices paid within 30 days in January 06. The cumulative results are 75.96% in number and 67.10% by value of invoices paid within 30 days. Last year the cumulative results were 70.93% in number and 68.20% by value paid within 30 days.

Cash Flow Forecast (Form F9A and F9B)

59. Cumulative cash movements to 31 December 2005 are shown on Form 9B. This reveals that cash increased £5.947m compared to the £8.985m forecast. The result is a year to date shortfall of actual cumulative cash movement against plan of £3.038m hence, the cumulative cash movement has worsened by £1.090m due to lower than forecast receipts for January 2006. The reason for the shortfall was a delay in receipts for SIFT and MADEL of £1.7m. This has been rectified and payment was received in February.

60. We are now factoring a payment of £8.783m (a negative EFL) on top of the £4.411m dividend payment on the 16th of March in our cash-flow forecast.

61. The cash forecast assumes that the balance of our cash requirement will be met mainly from planned slippage in creditor payments in February and March 2006 totalling £3.24m of which £1.04m is revenue and £2.2m capital and an improvement in our debtor receipts of £6m over the same period.

62. The Credit Control department has been strengthened to deliver the significant increase in cash collection required to meet the year-end cash requirements.

Capital Expenditure (Form F10A and F10B)

63. A review of capital spend is currently underway. It is expected that there will be slippage on the capital programme this year and the scale of the slippage is currently being assessed. Once this is known, the Finance Director will consider the options for carrying this forward in discussion with the SHA.

Lorraine Bewes
Director of Finance and Information
23rd February 2006

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

FINANCE REPORTS

January 06

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

CONSOLIDATED INCOME & EXPENDITURE SUMMARY

TRUST WIDE

FORM F1
January 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	(14,273)	(13,315)	(958)	(150,872)	(151,106)	234	(164,789)	(180,391)	(180,657)	266
Non-Contract Activity	(199)	(64)	(135)	(1,993)	(1,921)	(71)	0	(2,391)	(2,391)	0
Private Patients	(617)	(704)	86	(6,102)	(5,961)	(140)	(6,742)	(7,336)	(7,401)	65
Other Income	(3,209)	(3,094)	(115)	(32,742)	(32,946)	204	(35,536)	(39,189)	(38,722)	(467)
Donated Depreciation Income	(21)	(13)	(8)	(207)	(129)	(77)	(286)	(248)	(248)	0
TOTAL INCOME	**(18,319)**	**(17,189)**	**(1,130)**	**(191,915)**	**(192,063)**	**149**	**(207,353)**	**(229,555)**	**(229,419)**	**(136)**
EXPENDITURE			**0**							
Pay	10,307	8,786	1,520	99,181	85,804	13,376	109,662	119,266	103,007	16,259
Bank , Agency & Locum	106	1,276	(1,170)	1,013	13,984	(12,971)	1,334	1,253	15,611	(14,357)
Sub-total Pay	**10,413**	**10,062**	**350**	**100,193**	**99,788**	**405**	**110,996**	**120,519**	**118,617**	**1,902**
Non Pay	7,028	7,623	(595)	69,290	71,245	(1,955)	70,880	82,560	81,221	1,339
Sub-Total Non Pay	**7,028**	**7,623**	**(595)**	**69,290**	**71,245**	**(1,955)**	**70,880**	**82,560**	**81,221**	**1,339**
Reserves	125	(29)	154	500	9	491	10,004	6,470	6,470	0
Deficit Reversal/Surplus Brought Forward	286	0	286	2,860	0	2,860	0	3,431	3,431	0
Depreciation	645	733	(88)	6,446	7,330	(884)	6,890	7,735	8,735	(1,000)
Donated Depreciation	21	13	8	207	129	77	286	248	248	0
TOTAL EXPENDITURE	**18,517**	**18,402**	**115**	**179,496**	**178,501**	**995**	**199,055**	**220,964**	**218,723**	**2,241**
OPERATING SURPLUS	**(199)**	**(1,214)**	**(1,015)**	**12,418**	**13,562**	**1,143**	**8,298**	**8,591**	**10,696**	**2,105**
Profit/Loss on Disposal of Fixed Assets	0	0	0	0	0	0	0	0	0	0
SURPLUS BEFORE DIVIDENDS	**(199)**	**(1,214)**	**(1,015)**	**12,418**	**13,562**	**1,143**	**8,298**	**8,591**	**10,696**	**2,105**
Interest Receivable	(19)	(31)	12	(192)	(170)	(22)	0	(230)	(230)	0
Dividends	735	735	(0)	7,351	7,351	(0)	8,298	8,821	8,821	0
SURPLUS / (DEFICIT)	**(914)**	**(1,918)**	**(1,003)**	**5,259**	**6,381**	**1,122**	**0**	**0**	**2,105**	**2,105**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

FORM F2B(i)
December 05

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	Status
North West London Sector:					
KENSINGTON AND CHELSEA PCT	36,288,512	35,780,774	Y	-507,738	Contract agreed & HoA signed
WESTMINSTER PCT	17,260,411	17,080,389	Y	-180,022	Difference relates to urology figure change & dermatology activity reduction
HAMMERSMITH AND FULHAM PCT	21,772,287	21,497,552	y	-274,735	Demand reduction not included in current offer
EALING PCT	2,455,652	2,441,000	Y	-14,652	Additional £180k for Dental given not shown here
HOUNSLOW PCT	4,341,080	4,280,684	Y	-60,396	Offer based on 04/05 plan not outturn
HILLINGDON PCT	505,983	407,000	Y	-98,983	04/05 plan not outturn also includes 5% CIP as activity reduction
BRENT PCT	1,587,130	1,440,353	Y	-146,777	Not buying outturn
HARROW PCT	595,574	546,678	Y	-48,896	Demand reduction
South West London Sector					
WANDSWORTH PCT	14,720,252	14,151,218	N	-569,034	Arbitration still pending -Scheduled for 27th or 30th Jan
RICHMOND AND TWICKENHAM PCT	2,798,265	2,773,291	Y	-24,974	Purcashing plan not outturn
KINGSTON PCT	549,422	556,591	Y	7,169	
CROYDON PCT	648,500	653,387	Y	4,887	
SUTTON AND MERTON PCT	1,052,670	1,035,390	Y	-17,280	
North Central London Sector					
BARNET PCT	461,302	421,000	Y	-40,302	
HARINGEY PCT	335,517	194,026	Y	-141,491	Offer on 04/05 plan not outurn & further reductions requested
ENFIELD PCT	189,561	183,007	Y	-6,554	
ISLINGTON PCT	326,112	330,432	Y	4,320	
CAMDEN PCT	734,000	721,001	Y	-12,999	Contract agreed & HoA to be signed shortly
South East London Sector					
GREENWICH PCT	299,291	255,842	Y	-43,449	Burns outstanding issue
BEXLEY PCT	90,158	87,574	Y	-2,584	
BROMLEY PCT	262,544	258,848	Y	-3,696	
SOUTHWARK PCT	617,637	589,680	Y	-27,957	Not buying outturn
LEWISHAM PCT	676,871	544,135	Y	-132,736	Not buying outturn
LAMBETH PCT	1,523,091	1,514,564	Y	-8,527	Not buying outturn
North East London Sector:					
BARKING AND DAGENHAM PCT	112,452	112,622	Y	170	
HAVERING PCT	112,448	112,610	Y	162	
TOWER HAMLETS PCT	167,993	167,992	Y	-1	
CITY AND HACKNEY PCT	208,198	208,198	Y	0	
NEWHAM PCT	274,343	274,334	Y	-9	
Other Major Non - London:					
REDBRIDGE PCT	168,792	172,807	Y	4,015	
WALTHAM FOREST PCT	186,004	192,800	Y	6,796	
EAST ELMBRIDGE AND MID SURREY PCT	809,901	785,563	Y	-24,338	Activity reductions
EAST SURREY PCT	131,857	102,364	Y	-29,493	Activity reductions
BLACKWATER VALLEY AND HART PCT	471,636	467,287	Y	-4,349	
GUILDFORD AND WAVERLEY PCT	244,998	228,589	Y	-16,409	Activity reductions
NORTH SURREY PCT	813,193	756,530	Y	-56,663	Activity reductions
WOKING PCT	561,573	548,579	Y	-12,994	Activity reductions
HERTFORDSHIRE PCT's(8)	1,091,534	944,030	Y	-147,504	Not buying out turn
EAST & WEST KENT PCTS (9)	794,238	622,855	Y	-171,383	Correction of pricing mistake
BERKSHIRE PCT's (6)	472,244	480,214	Y	7,970	Contract agreed & HoA signed
EAST SUSSEX PCT's (5)	302,136	303,867	Y	1,731	
WEST SUSSEX PCT's (5)	371,983	339,654	Y	-32,329	Activity reductions
HAMPSHIRE PCT's(6)	251,526	251,905	Y	379	
BEDFORDSHIRE PCT's(3)	226,697	206,294	Y	-20,403	Activity reductions
NORTH ESSEX PCT's (8)	218,088	209,661	Y	-8,427	
SOUTH ESSEX PCT's (5)	219,751	178,238	Y	-41,513	PbR stage 2 discrepancy
OXFORDSHIRE PCT's (5)	196,214	116,129	Y	-80,085	NICU to a cost per case contract at full local tariff
DORSET PCT's (5)	86,144	86,144	Y	0	
NORTHAMPTONSHIRE PCT' (3)	63,668	48,611	Y	-15,057	Removal of HRG's from plan
LINCOLNSHIRE PCT's (3)	45,715	46,381	Y	666	
BUCKINGHAMSHIRE PCT's(4)	239,642	248,085	Y	8,443	Contract agreed & HoA signed
DEVON PCT's (4)	24,591	24,628	Y	37	
BRISTOL PCT's(3)		20,900	Y	20,900	
Specialised Services Consortia					
NICU CONSORTIUM	2,650,411	2,597,604	Y	-52,807	Improved offer being discussed to reflect additional cot and improved marginal rate
HIV CONSORTIUM(KC)	37,502,554	37,580,680	N	78,126	Risk share agreements & cost improvement issues
HIV CONSORTIUM(OUT OF LONDON)	4,188,290	4,216,060	Y	27,770	
GUM KC	7,821,459	7,810,664	Y	-10,795	
GUM H & F	2,990,000	2,988,000	Y	-2,000	Will be agreed along with H & F main contract
Other					
Non Contracted activity (NCA)	1,015,039	1,015,039	Y		OATS element to be billed in year to PCT directly
OVS	1,374,000	940,666	Y	-433,334	Based on current K & C offer
K & C HCA's Funding	1,358,000	1,358,000	Y		
Total Contract Income	**177,859,134**	**174,509,000**		**-3,350,134**	

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SERVICE AGREEMENT VALUE SUMMARY

Responsibility: Finance Director

FORM F2B(ii)
January 06

PCT	Revised FY Budget at Month 10 £000's	Revised Target at Month 10 £000's	Actual at Month 10 £000's	Variance at Month 10 £000's
Contract and Over/Underperformance				
North West London Sector:				
Kensington & Chelsea	(37,139)	(30,949)	(30,743)	(206)
Westminster	(17,080)	(14,234)	(14,147)	(87)
Hammersmith & Fulham	(22,570)	(18,808)	(18,675)	(133)
Ealing	(2,621)	(2,184)	(2,053)	(131)
Hounslow	(4,281)	(3,567)	(3,583)	16
Hillingdon	(407)	(339)	(403)	64
Brent	(1,440)	(1,200)	(1,059)	(141)
Harrow	(547)	(456)	(462)	6
South West London Sector				
Wandsworth	(14,784)	(12,320)	(12,015)	(305)
Richmond & Twickenham	(2,773)	(2,311)	(2,353)	42
Kingston	(557)	(464)	(483)	19
Croydon	(653)	(544)	(519)	(26)
Sutton & Merton	(1,035)	(863)	(890)	27
North Central London Sector				
Barnet	(421)	(351)	(376)	25
Haringey	(194)	(162)	(335)	173
Enfield	(183)	(152)	(187)	35
Islington	(330)	(275)	(291)	16
Camden	(721)	(601)	(524)	(76)
South East London Sector				
Greenwich	(300)	(250)	(185)	(65)
Bexley	(88)	(73)	(65)	(8)
Bromley	(259)	(216)	(207)	(9)
Southwark	(590)	(491)	(528)	36
Lewisham	(544)	(453)	(432)	(21)
Lambeth	(1,514)	(1,262)	(1,306)	44
North East London Sector:				
Barking & Dagenham	(113)	(94)	(142)	48
Havering	(113)	(94)	(85)	(9)
Tower Hamlets	(168)	(140)	(184)	44
City & Hackney	(208)	(173)	(215)	42
Redbridge	(173)	(144)	(134)	(10)
Waltham Forest	(193)	(161)	(217)	57
Other Major Non - London:				
North Surrey	(757)	(631)	(662)	32
East Elmbridge and Mid Surrey	(786)	(655)	(724)	69
Woking	(549)	(457)	(642)	185
Blackwater Valley and Hart	(467)	(389)	(391)	2
Newham	(274)	(229)	(190)	(38)
Guildford and Waverley	(229)	(190)	(195)	4
Watford and Three Rivers	(329)	(274)	(272)	(2)
East Surrey	(102)	(85)	(82)	(3)
All Other PCTs	(3,970)	(3,309)	(3,653)	344
High Cost Drugs				
High Cost Drugs Exclusions Billed	(400)	(344)	(463)	119
Specialised Services Consortia				
NICU Consortium				
Hillingdon	(1,872)	(1,490)	(1,545)	55
Haringey	(54)	(45)	(45)	0
Bexley	(319)	(266)	(266)	0
Croydon	(614)	(511)	(511)	0
Tower Hamlets	(47)	(39)	(39)	0
Brent PCT	(80)	(67)	(67)	0
All Other PCTs	(168)	(140)	(140)	0
HIV Consortium & Overperformance				
Kensington & Chelsea	(38,890)	(32,794)	(32,794)	0
Out of London PCTs	(4,244)	(3,183)	(3,160)	(23)
GUM				0
Kensington & Chelsea	(7,821)	(6,517)	(6,518)	0
Hammersmith & Fulham	(2,988)	(2,490)	(2,490)	0
Other				
London Patient Choice (Receiving)	0	0	0	0
Cost per Case	0	0	0	0
Other income from PCTs	0	0	0	0
Prior Year Deficit Reversal and Surplus Carry Forward	(3,432)	(3,432)	(3,432)	0
Balance on 9D Codes	0	0	(27)	27
Balance on 9A Codes	0	0	0	0
Total Contract Income	**(180,391)**	**(150,872)**	**(151,105)**	**234**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SERVICE AGREEMENT ACTIVITY SUMMARY - BY PCT

Responsibility: Finance Director

FORM F2B(iii)

January 06

	ACTIVITY TARGET TO JANUARY 06								ACTIVITY ACTUAL TO JANUARY 06								ACTIVITY VARIANCE TO JANUARY 06								
	DC+DA	EL	EL XBD	NON-ELEC	NON-ELEC- XBD	NON-ELEC-SS	OPFA	OPFUP	DC+DA	EL	EL XBD	NON-ELEC	NON-ELEC- XBD	NON-ELEC-SS	OPFA	OPFUP	DC+DA	EL	EL XBD	NON-ELEC	NON-ELEC- XBD	NON-ELEC-SS	OPFA	OPFUP	TOTAL
North West London Sector:																									
KENSINGTON & CHELSEA	4,561	1,360	986	5,606	3,788	345	4,529	37,012	4,311	1,169	897	6,044	3,424	524	5,803	44,541	-250	-191	-90	439	-363	179	1,274	7,530	**8,528**
WESTMINSTER	2,322	1,085	1,013	2,518	2,214	140	2,515	21,545	2,660	940	787	2,457	1,698	201	2,643	23,826	338	-145	-226	-61	-516	61	128	2,281	**1,860**
HAMMERSMITH & FULHAM	2,518	879	813	4,734	3,048	235	4,197	25,500	2,778	968	693	4,752	1,941	346	4,858	26,836	260	89	-119	18	-1,106	111	661	1,336	**1,249**
EALING	513	204	204	515	320	35	528	4,203	563	233	77	606	162	31	611	4,312	50	30	-128	91	-158	-4	83	110	**73**
HOUNSLOW	582	227	201	693	155	40	686	5,076	771	279	160	596	441	38	663	4,772	189	52	-41	-97	286	-2	-23	-304	**61**
HILLINGDON	58	28	26	58	37	5	64	93	67	60	11	81	9	14	114	754	9	33	-15	24	-28	9	51	662	**745**
BRENT	368	136	282	331	284	13	293	2,028	252	124	43	278	271	38	309	1,948	-115	-11	-238	-53	-13	24	16	-80	**-471**
HARROW	47	43	33	101	36	3	85	479	61	31	7	137	57	3	77	409	14	-11	-27	35	20	1	-9	-70	**-46**
SOUTH WEST LONDON SECTOR																	-	-	-	-	-	-	-	-	**-**
WANDSWORTH	1,558	587	569	4,494	3,805	175	3,082	17,414	1,662	593	402	4,380	2,553	293	2,837	19,911	104	6	-167	-114	-1,252	118	-246	2,497	**949**
RICHMOND & TWICKENHAM	340	133	86	704	225	25	567	4,020	401	143	58	751	143	60	554	4,222	61	11	-28	47	-82	35	-12	202	**234**
KINGSTON	54	33	25	95	69	10	155	760	67	46	40	76	19	4	152	726	13	13	15	-19	-50	-6	-3	-34	**-71**
CROYDON	86	79	18	74	104	3	132	855	60	57	23	102	11	9	131	830	-26	-22	6	28	-93	6	-0	-25	**-126**
SUTTON & MERTON	100	33	23	162	131	13	242	1,442	119	64	3	172	58	22	284	1,408	19	32	-20	11	-73	9	43	-34	**-14**
NORTH CENTRAL LONDON SECTOR																	-	-	-	-	-	-	-	-	**-**
BARNET	55	28	7	54	24	8	95	600	54	29	76	86	7	4	117	631	1	1	69	32	-17	3	21	31	**133**
HARINGEY	22	10	5	43	18	12	58	318	64	12	6	81	6	2	74	449	43	2	1	38	-12	9	16	131	**208**
ENFIELD	25	15	-	28	3	8	47	306	16	21	3	43	7	1	57	323	-9	6	3	16	4	-6	10	17	**41**
ISLINGTON	37	14	1	83	24	3	86	469	34	29	1	73	13	6	80	490	-2	15	-0	-9	10	-3	-6	21	**11**
CAMDEN	58	81	35	159	88	15	149	805	74	54	66	86	53	11	153	841	17	-26	31	-73	-34	-4	4	36	**-50**
SOUTH EAST LONDON SECTOR																	-	-	-	-	-	-	-	-	**-**
GREENWICH	23	20	8	30	18	3	66	389	11	13	2	23	18	1	69	336	11	-7	-5	-7	0	-1	3	-53	**-82**
BEXLEY	8	11	6	9	95	-	31	154	3	4	12	11	29	-	36	181	-4	-6	6	2	-66	-	5	27	**-36**
BROMLEY	31	18	45	59	3	3	56	308	44	27	24	36	14	2	51	358	13	9	-21	-23	12	-0	-5	50	**35**
SOUTHWARK	44	38	63	58	29	8	135	869	58	38	36	110	33	4	184	922	14	-1	-28	53	4	4	49	53	**141**
LEWISHAM	33	19	1	48	17	8	104	519	30	23	27	59	49	6	121	556	-3	4	26	11	32	-3	17	37	**121**
LAMBETH	194	88	116	213	103	50	398	2,191	360	76	59	297	331	46	377	2,217	166	-12	-57	84	229	-4	-22	25	**409**
NORTH EAST LONDON SECTOR:																	-	-	-	-	-	-	-	-	**-**
BARKING & DAGENHAM	5	9	-	13	-	3	20	189	7	9	3	89	14	1	31	178	2	0	3	76	14	-1	11	-11	**94**
HAVERING	18	14	15	18	9	3	26	159	9	12	13	33	2	3	27	138	-9	-2	-2	16	-7	1	0	-21	**-22**
TOWER HAMLETS	20	12	1	30	60	-	44	275	84	13	0	98	78	3	50	377	64	2	-1	68	18	3	6	102	**262**
CITY & HACKNEY	23	18	4	30	9	-	61	289	22	17	7	69	14	3	86	369	-0	-1	3	39	6	3	25	80	**155**
REDBRIDGE	23	16	6	19	1	5	43	245	21	10	2	70	3	2	37	268	-1	-6	-4	51	2	-3	-6	23	**56**
WALTHAM FOREST	16	22	6	29	10	5	40	278	23	18	47	81	24	3	50	346	8	-4	41	52	14	-2	10	68	**187**
OTHER MAJOR NON - LONDON:																	-	-	-	-	-	-	-	-	**-**
NORTH SURREY	134	39	17	93	21	15	79	609	140	64	69	90	22	21	78	614	6	25	52	-2	1	6	-2	6	**92**
EAST ELM & MID SURREY	273	73	92	73	39	13	127	803	271	102	356	109	29	11	173	829	2	29	264	36	-10	1	47	26	**389**
WOKING	133	-	-	53	-	10	46	506	114	58	79	104	71	3	82	490	-18	58	79	52	71	-7	36	-16	**255**
BLACKWATER VALLEY	83	40	16	80	16	13	36	501	86	39	13	73	8	7	81	509	3	-1	-3	-7	8	-6	45	8	**31**
NEWHAM PCT	31	35	15	76	14	5	51	330	28	20	20	46	23	4	69	416	-3	-15	-5	-31	10	-1	18	86	**69**
GUILDFORD & WAVERLEY	59	-	-	79	15	18	38	495	41	19	3	73	8	7	49	368	-18	19	-3	-5	-7	-11	11	-127	**-136**
WATFORD & THREE RIVERS	30	25	5	28	121	-	37	205	29	21	11	37	0	2	50	221	-1	-3	-6	-9	121	-2	-13	-16	**-79**
EAST SURREY	10	8	1	8	11	3	18	120	11	8	6	8	3	1	19	126	1	-0	-5	-0	-8	-1	-1	-6	**-3**
ALL OTHER 'S	540	387	274	1,012	270	48	695	4,235	436	367	282	1,262	401	36	826	4,230	-104	-20	-8	-251	-131	-12	-131	-5	**-380**
TOTAL CONTRACT ACTIVITY	**15,028**	**5,860**	**5,015**	**22,500**	**15,229**	**1,295**	**19,662**	**136,590**	**15,844**	**5,811**	**4,423**	**23,578**	**12,050**	**1,777**	**22,063**	**151,274**	**816**	**-49**	**-592**	**-1,077**	**-3,179**	**482**	**2,401**	**14,684**	**15,640**
HIV/GUM & Well babies	21	91	-	4,332	-	-	11,389	36,976	9	116	130	3,707	1,068	178	10,997	45,712	**-12**	**-24**	**-130**	**-625**	**-1,068**	**-178**	**-393**	**-8,736**	**-9,106**
TOTAL ALL ACTIVITY	**15,049**	**5,952**	**5,015**	**26,832**	**15,229**	**1,295**	**31,052**	**173,566**	**15,853**	**5,927**	**4,553**	**27,284**	**13,118**	**1,954**	**33,060**	**196,987**	**804**	**-25**	**-462**	**-452**	**-2,111**	**659**	**2,008**	**23,421**	**24,747**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

FORM F2B(iv)

January 06

SERVICE AGREEMENT ACTIVITY SUMMARY - BY SPECIALTY

Responsibility: Finance Director

	ACTIVITY TARGET TO JANUARY 06								ACTIVITY ACTUAL TO JANUARY 06								ACTIVITY VARIANCE TO JANUARY 06								
	DC+DA	EL	EL XBD	NON-ELEC	NON-ELEC- XBD	NON-ELEC-SS	OPFA	OPFUP	DC+DA	EL	EL XBD	NON-ELEC	NON-ELEC-XBD	NON-ELEC-SS	OPFA	OPFUP	DC+DA	EL	EL XBD	NON-ELEC	NON-ELEC- XBD	NON-ELEC-SS	OPFA	OPFUP	TOTAL
SURGERY and A&I																									
ANAESTHETICS	0	247	0	1,757	0	12	0	0	0	313	0	2,006	0	22	0	0	0	67	0	248	0	11	0	0	326
BURNS	29	54	39	307	295	29	1,467	3,953	8	110	76	270	327	30	1,524	4,564	(21)	56	37	(37)	31	1	57	611	735
CRANIO SURGERY	5	10	1	31	0	2	8	36	7	26	28	17	38	0	3	32	2	15	27	(14)	38	(2)	(4)	(4)	58
GENERAL SURGERY	486	815	494	965	804	172	1,049	7,206	341	824	584	956	523	122	940	5,696	(145)	9	91	(10)	(281)	(49)	(109)	(1,510)	(2,004)
OPHTHALMOLOGY	675	30	12	3	0	0	868	10,368	540	38	22	3	3	0	810	8,549	(135)	8	10	1	3	0	(58)	(1,820)	(1,990)
ORAL SURGERY	65	3	1	6	0	0	32	1,718	11	0	0	0	0	0	18	1,524	(54)	(3)	(1)	(6)	0	0	(14)	(193)	(272)
PAIN MANAGEMENT	257	19	30	2	0	0	417	1,149	223	44	11	1	0	0	352	1,550	(34)	25	(19)	(1)	0	0	(64)	401	309
PALLIATIVE MEDICINE	33	19	121	13	55	3	15	187	40	27	161	12	0	0	26	206	8	8	40	(0)	(55)	(3)	11	18	26
PLASTIC SURGERY	1,074	647	405	1,370	400	184	349	7,654	1,009	810	390	1,432	453	197	579	7,256	(65)	163	(15)	63	53	13	230	(398)	44
T & O	627	780	630	800	1,507	108	3,698	14,073	454	737	449	776	902	87	2,428	10,659	(173)	(43)	(181)	(25)	(605)	(21)	(1,270)	(3,414)	(5,731)
UROLOGY	728	1,018	85	186	118	13	498	4,006	958	522	187	223	44	32	411	4,928	230	(496)	102	37	(73)	19	(87)	922	654
Sub-Total Surgery & A&I	**3,979**	**3,642**	**1,817**	**5,440**	**3,179**	**522**	**8,400**	**50,349**	**3,591**	**3,451**	**1,908**	**5,696**	**2,291**	**490**	**7,091**	**44,963**	**(388)**	**(191)**	**91**	**256**	**(888)**	**(32)**	**(1,308)**	**(5,386)**	**(7,846)**
WOMEN & CHILDREN																									
GYNAECOLOGY	789	863	498	805	274	17	1,782	6,459	659	820	416	907	201	72	4,691	8,614	(130)	(43)	(82)	101	(73)	56	2,909	2,156	4,894
NICU (Note this is a Cot Day)	0	0	0	377	0	0	1	876	0	1	0	774	0	8	7	831	0	1	0	398	0	8	6	(45)	368
OBSTETRICS	0	14	8	5,065	3,139	0	2,469	11,070	1	9	2	5,226	2,256	311	610	18,558	1	(5)	(6)	161	(884)	311	(1,859)	7,488	5,206
PAED CRANIO	85	36	17	4	0	0	147	785	60	11	22	2	0	0	129	383	(25)	(25)	5	(2)	0	0	(18)	(401)	(467)
PAED DENTISTRY	209	16	1	5	0	0	58	1,037	667	18	2	1	0	0	79	1,994	458	2	1	(4)	0	0	21	957	1,435
PAED ENT	113	150	9	13	3	2	241	551	124	284	3	11	2	0	252	768	12	135	(5)	(1)	(0)	(2)	11	217	366
PAED GASTRO	144	179	343	48	201	15	137	1,451	220	217	300	86	556	13	231	1,750	76	38	(43)	38	354	(2)	94	299	854
PAED NEUROLOGY	39	31	15	9	26	3	40	181	39	21	3	3	29	0	41	198	0	(10)	(12)	0	3	(3)	1	17	(3)
PAEDI OPTHALMOLOGY	16	2	0	0	0	0	0	0	19	3	0	0	0	0	143	911	3	1	0	0	0	0	143	911	1,059
PAED PLASTIC SURG	149	45	7	147	9	10	3	130	169	76	50	144	2	7	8	129	20	31	43	(3)	(7)	(3)	5	(1)	86
PAEDIATRIC SURGERY	516	300	350	591	384	48	337	1,720	580	349	154	630	247	52	1,681	4,601	64	49	(196)	39	(137)	4	1,344	2,881	4,048
PAEDIATRICS	127	54	93	2,099	588	77	1,374	5,267	163	62	46	2,270	459	134	967	5,386	37	8	(47)	171	(129)	58	(408)	119	(191)
SPECIAL CARE BABIES	0	0	0	3,683	0	0	0	0	0	0	0	3,290	0	0	0	0	0	0	0	(393)	0	0	0	0	(393)
Sub-Total Women & Children	**2,186**	**1,690**	**1,340**	**12,844**	**4,624**	**171**	**6,587**	**29,526**	**2,701**	**1,871**	**999**	**13,350**	**3,751**	**598**	**8,839**	**44,123**	**515**	**182**	**(342)**	**506**	**(873)**	**427**	**2,251**	**14,598**	**17,264**
MEDICINE & A&E																									
A & E	269	3	3	80	0	10	584	77	241	9	29	61	13	16	1,367	172	(28)	6	26	(18)	13	6	783	96	882
CARDIOLOGY	14	10	125	81	515	3	900	8,488	56	7	2	73	360	4	1,299	10,063	41	(4)	(122)	(7)	(155)	2	399	1,575	1,729
CLINICAL HAEM	893	19	19	37	10	3	265	6,180	908	6	9	11	91	0	202	8,720	15	(13)	(10)	(26)	81	(3)	(63)	2,540	2,522
DERMATOLOGY	2,323	28	54	47	50	3	457	12,887	2,719	18	28	49	44	6	614	13,064	396	(11)	(26)	2	(6)	3	158	177	693
ELDERLY MED	54	44	61	875	1,750	116	118	1,793	61	59	111	933	1,693	156	117	1,690	7	15	50	58	(57)	40	(2)	(103)	9
ENDOCRINOLOGY	74	3	0	14	15	0	396	6,651	134	7	13	12	183	0	391	6,491	60	4	13	(2)	168	0	(5)	(160)	79
ENDOSCOPY	3,213	88	312	125	503	4	0	0	3,250	59	192	82	172	28	0	0	38	(29)	(120)	(42)	(331)	24	0	0	(462)
GASTRO	312	54	83	142	278	14	443	5,640	264	57	189	181	351	14	447	5,068	(48)	3	106	39	73	0	4	(572)	(395)
GENERAL MEDICINE	272	99	430	2,391	3,877	395	74	1,902	306	113	444	2,657	2,534	403	113	1,899	33	15	14	266	(1,343)	8	39	(3)	(970)
MEDICAL ONCOLOGY	585	81	348	28	133	5	93	1,425	524	52	119	24	17	1	62	1,227	(60)	(29)	(229)	(4)	(116)	(4)	(31)	(198)	(671)
NEUROLOGY	230	60	236	30	106	3	248	3,807	370	50	219	20	61	6	279	3,237	140	(10)	(17)	(10)	(45)	3	31	(570)	(478)
RESPIRATORY MED	129	20	119	333	184	48	335	2,185	181	27	28	357	412	46	346	2,083	52	7	(91)	24	228	(3)	11	(101)	127
RHEUMATOLOGY	495	20	69	23	5	0	154	3,249	538	27	133	61	74	9	252	3,551	43	6	64	39	69	9	98	302	630
Subtotal Medicine & A&E	**8,863**	**529**	**1,858**	**4,205**	**7,426**	**603**	**4,067**	**54,284**	**9,552**	**489**	**1,517**	**4,522**	**6,008**	**688**	**5,489**	**57,266**	**690**	**(40)**	**(342)**	**317**	**(1,418)**	**85**	**1,422**	**2,982**	**3,696**
OTHER	1	0	0	11	0	0	609	2,432	0	0	0	10	0	1	644	4,922	(1)	0	0	(1)	0	1	36	2,491	2,525
TOTAL CONTRACT ACTIVITY	**15,028**	**5,860**	**5,015**	**22,500**	**15,229**	**1,295**	**19,662**	**136,590**	**15,844**	**5,811**	**4,423**	**23,578**	**12,050**	**1,777**	**22,063**	**151,274**	**816**	**(49)**	**(592)**	**1,077**	**(3,179)**	**482**	**2,401**	**14,684**	**15,640**
WELL BABIES	0	6	0	4,018	0	0	0	0	2	8	3	3,327	752	104	0	0	2	2	3	(691)	752	104	0	0	173
HIV	21	85	0	313	0	0	961	21,047	7	108	127	380	316	73	1,079	23,502	(14)	23	127	67	316	73	118	2,456	3,166
GUM	0	0	0	1	0	0	10,429	15,929	0	0	0	0	0	0	9,918	22,210	0	0	0	(1)	0	0	(511)	6,281	5,768
TOTAL ALL ACTIVITY	**15,049**	**5,952**	**5,015**	**26,832**	**15,229**	**1,295**	**31,052**	**173,566**	**15,853**	**5,927**	**4,553**	**27,284**	**13,118**	**1,954**	**33,060**	**196,987**	**804**	**(25)**	**(462)**	**452**	**(2,111)**	**659**	**2,008**	**23,421**	**24,747**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SUMMARY SALARIES AND WAGES

Responsibility:

TRUST WIDE

FORM F2D
January 06

	Full Year	THIS MONTH				YEAR TO DATE			
	Budget £000s	Budget £000s	Actuals £000s	Variance £000s	Variance % £000s	Budget £000s	Actual £000s	Variance £000s	Variance % £000s
MEDICAL									
Senior Medical	21,398	1,793	1,825	(31)	-1.75%	17,819	17,661	159	0.89%
Junior Medical	18,124	1,519	1,339	180	11.83%	15,086	13,475	1,611	10.68%
Other Medical & Dental	13	1	0	1	100.00%	11	7	3	31.19%
Medical Locum	12	(0)	200	(200)		12	1,902	(1,891)	
Medical sub total	**39,547**	**3,313**	**3,363**	**(50)**	**-1.52%**	**32,928**	**33,045**	**(118)**	**-0.36%**
AGENDA FOR CHANGE									
Agenda for Change Bands 1-4	(8)	(2)	(0)	(2)	88.15%	(4)	1	(5)	130.46%
Agenda for Change Bands 5-9	(38)	(10)	13	(22)	231.13%	(18)	11	(29)	160.13%
Agenda for Change sub total	**(45)**	**(12)**	**12**	**(24)**	**207.57%**	**(22)**	**12**	**(34)**	**155.03%**
NURSING & MIDWIFERY									
Trained Nursing	30,148	2,015	1,460	555	27.54%	25,590	19,430	6,160	24.07%
Untrained Nursing	2,407	174	186	(12)	-6.75%	2,035	1,959	76	3.72%
Health Care Assistants	730	59	20	39	65.81%	612	258	355	57.89%
Bank Nursing & Midwifery	307	33	592	(560)		197	6,518	(6,321)	
Agenda for Change Bands 1-4	1,491	193	133	59		1,188	923	265	
Agenda for Change Bands 5-9	12,948	1,629	1,344	285		10,288	8,966	1,323	
Agency Nursing & Midwifery	230	16	211	(195)		197	2,056	(1,858)	
Nursing & Midwifery sub total	**48,262**	**4,118**	**3,947**	**171**	**4.16%**	**40,109**	**40,110**	**(1)**	**0.00%**
PAMS									
Dieticians	216	18	17	1	6.34%	181	180	1	0.55%
Radiographers	1,437	123	103	20	16.52%	1,191	1,097	95	7.94%
Therapists	2,038	77	166	(89)	-115.70%	1,698	1,664	34	2.00%
Agenda for Change Bands 1-4	26	2	1	1		22	1	21	
Agenda for Change Bands 5-9	1,942	291	221	70		1,618	1,616	2	
All Other	3,710	313	302	11	3.55%	3,077	2,701	376	12.23%
Agency/Locums (PAMS)	25	2	36	(34)		21	398	(376)	
PTA - sub totals	**9,394**	**825**	**844**	**(19)**	**-2.27%**	**7,808**	**7,655**	**152**	**1.95%**
OTHER									
Pharmacists	2,179	182	173	9	4.94%	1,815	1,745	70	3.86%
Agenda for Change Bands 1-4	94	9	14	(5)		77	57	20	
Agenda for Change Bands 5-9	854	100	64	36		695	224	471	
Chaplains	0	(0)	0	(0)	100.00%	0	0	(0)	-45.90%
Other sub	**3,128**	**291**	**251**	**40**	**13.59%**	**2,587**	**2,025**	**561**	**21.70%**
ADMIN									
Admin & Clerical	14,037	1,060	818	242	22.84%	11,861	9,088	2,773	23.38%
Bank Admin & Clerical	134	8	189	(181)		118	2,499	(2,381)	
Agency Admin & Clerical	545	48	45	3		467	610	(143)	
Senior Managers & Trust Board	4,508	324	307	17	5.25%	3,800	3,315	486	12.78%
Agenda for Change Bands 1-4	1,527	268	217	52		1,146	1,076	70	
Agenda for Change Bands 5-9	555	109	68	41		460	353	106	
Agency Other	0	0	0	0		0	0	0	
Admin - sub total	**21,307**	**1,817**	**1,644**	**173**	**9.53%**	**17,853**	**16,940**	**913**	**5.11%**
Payroll	**121,592**	**10,354**	**10,062**	**291**	**2.81%**	**101,262**	**99,788**	**1,473**	**1.46%**
Unidentified Savings	(1,073)	59	0	59		(1,068)	0	(1,068)	
PAY TOTAL	**120,519**	**10,413**	**10,062**	**350**	**3.37%**	**100,193**	**99,788**	**405**	**0.40%**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SUMMARY NON PAY EXPENDITURE

TRUST WIDE

FORM F2E
January 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	33,999	3,045	2,988	57	2%	28,719	28,179	540	2%
MEDICAL & SURGICAL EQUIPMENT & DRESSINGS	6,669	575	757	-182	-32%	5,553	6,309	-756	-14%
X-RAY FILM, EQUIP & MATERIALS	1,476	123	144	-21	-17%	1,230	1,301	-71	-6%
LABORATORY EQUIP & MATERIALS	260	22	50	-28	-131%	217	376	-159	-73.39%
PATIENT APPLIANCES / PROTHESES	1,595	133	246	-114	-85%	1,329	2,016	-687	-51.66%
BLOOD PRODUCTS	1,164	97	89	8	8%	970	922	49	5.01%
PATHOLOGY SERVICES	6,805	572	648	-76	-13%	5,666	6,391	-725	-12.79%
OTHER TESTS	535	45	36	9	19%	446	396	50	11.24%
SERVICE LEVEL AGREEMENT	3,530	284	327	-43	-15%	2,962	2,879	83	2.81%
CONTRACT SERVICES			0			0	0		
Contract Catering	2,005	167	175	-8	-5%	1,671	1,734	-63	-3.80%
Domestics	2,343	195	195	-0	0%	1,952	1,962	-9	-0.48%
Portering	971	112	82	31	27%	809	796	14	1.69%
Carparking	14	1	1	-0	-3%	12	-25	36	310.19%
Laundry Contract	797	66	63	3	5%	664	660	4	0.55%
Change control Levy, CCNs	75	6	-40	46	735%	62	47	15	24.54%
Carillion Management Charge	925	77	82	-5	-6%	771	794	-23	-3.04%
Total Bed Management Contract / Lease	176	15	14	0	3%	147	113	34	23.24%
IT Services	0	0	0	0	0%	0	0	0	0.00%
Other External Contracts	1,256	102	114	-12	-12%	1,053	1,195	-142	-13.49%
PROVISIONS & OTHER CATERING	2	0	18	-18	-8512%	2	112	-110	-5351.85%
LAUNDRY, LINEN, UNIFORMS & CLOTHING	94	8	8	-0	-5%	79	97	-18	-22.98%
CLEANING EQUIPMENT	0	0	0	0	0%	0	0	0	0.00%
LEGAL FEES	3,493	291	282	9	3%	2,911	2,943	-32	-1.09%
PRINTING, STATIONERY & POSTAGE	920	77	40	37	48%	767	697	70	9.16%
TELEPHONES	650	54	51	3	6%	542	536	6	1.13%
TRAVEL, SUBSISTENCE & REMOVALS	209	19	31	-12	-61%	176	198	-22	-12.36%
TRANSPORT	1,260	105	136	-31	-29%	1,050	1,136	-86	-8.18%
ADVERTISING & PUBLICITY	443	37	16	21	57%	369	342	27	7.19%
TRAINING	779	70	45	24	35%	667	403	264	39.58%
ENERGY & WATER	1,955	163	265	-102	-62%	1,629	1,919	-290	-17.79%
FURNITURE, FITTINGS & OFFICE EQIPMENT	243	20	21	-1	-6%	203	153	50	24.45%
IT EQUIPMENT & SUPPLIES	1,799	160	145	15	9%	1,509	1,619	-110	-7.28%
RENT & RATES	1,895	158	150	8	5%	1,579	1,601	-22	-1.37%
ESTATES MAINTENANCE	2,069	172	280	-108	-63%	1,724	1,934	-210	-12.19%
CONSULTANCY	1,058	86	74	12	14%	896	948	-52	-5.84%
WARD BUDGETS	0	0	0	0	0%	0	0	0	0.00%
BAD DEBT PROVISION	0	0	67	-67	0%	0	71	-71	0.00%
OTHER EXPENDITURE	823	-32	23	-55	172%	687	242	445	64.76%
FACILITIES /THEATRE RECHARGES	22	2	-1	3	154%	19	12	7	36.78%
CIP NON PAY SAVINGS	0	0	0	0	0%	0	0	0	0.00%
Non Pay	**82,560**	**7,028**	**7,622**	**-594**	**-8%**	**69,290**	**71,245**	**-1,955**	**-2.82%**
Depreciation	7,687	641	733	-92	-14%	6,406	7,330	-923	-14.41%
CIP Depreciation Savings	48	4	0	4	100%	40	0	40	100.00%
Donated Depreciation	248	21	13	8	37%	207	129	77	37.41%
DIVIDENDS PAYABLE	8,821	735	735	-0	0%	7,351	7,351	-0	0.00%
Deficit Reversal/Surplus Brought Forward	0	0	0	0	0%	0	0	0	0.00%
Reserves	9,902	411	-29	440	107%	3,360	7	3,353	99.78%
TOTAL NON PAY	**109,265**	**8,840**	**9,074**	**-235**	**-3%**	**86,654**	**86,062**	**591**	**0.68%**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SERVICE LEVEL AGREEMENTS EXPENDITURE

Responsibility: Edward Donald

FORM F2F
January 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	0	0	0.0%	0	19	(19)	0.0%
3A250	NATIONAL BLOOD SERVICE CONTRAC		1,164	97	89	8	8.2%	970	893	77	7.9%
3C010	PRINTING & STATIONARY (INC. CO		0	0	0	0	0.0%	0	0	0	0.0%
3C060	TELECOMMUNICATIONS SLA		0	0	(5)	5	0.0%	0	37	(37)	0.0%
3D160	COMPUTER HARDWARE PURCHASES		0	0	0	0	0.0%	0	0	0	0.0%
3D250	RENT & ACCOMMODATION SERVICEWS		369	31	32	(1)	-3.2%	308	321	(13)	-4.2%
3H030	MISCELLANEOUS		0	0	0	0	0.0%	0	0	0	0.0%
3H120	HOSPITALITY		0	0	0	0	0.0%	0	0	0	0.0%
3H200	SOCIAL SERVICES		144	12	9	3	25.0%	120	92	28	23.3%
3H210	MEDICAL ILLUSTRATION		332	28	27	1	3.6%	277	269	8	2.9%
3H220	A/V SERVICES		0	0	0	0	0.0%	0	0	0	0.0%
3J010	NATIONAL AMBULANCE		0	0	0	0	0.0%	0	0	0	0.0%
3J030	PATHOLOGY SLA (HHT)		6,719	560	624	(64)	-11.4%	5,600	6,215	(615)	-11.0%
3J040	CARDIOLOGY SLA (RBH)		375	31	31	0	0.0%	312	312	0	0.0%
3J050	INFORMATION SYSTEMS SLA		0	0	9	(9)	0.0%	0	0	0	0.0%
3J060	CLINICAL ENGINEERING SLA		519	43	43	0	0.0%	433	432	1	0.2%
3J070	EEG SLA		0	0	0	0	0.0%	0	0	0	0.0%
3J080	MEDICAL PHYSICS SLA		31	3	7	(4)	-133.3%	26	66	(40)	-153.8%
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	10	(8)	-400.0%	20	29	(9)	-45.0%
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	12	3	20.0%	152	125	27	17.8%
3J190	VICTORIA SHC SLA		0	0	0	0	0.0%	0	0	0	0.0%
3J200	EXTERNAL TESTS		0	0	0	0	0.0%	0	0	0	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	0	0	0.0%	0	0	0	0.0%
3J520	BURNS OUTREACH SLA		0	0	0	0	0.0%	0	0	0	0.0%
3J530	PAEDIATRIC ENT SLA		0	0	2	(2)	0.0%	0	2	(2)	0.0%
9B011	PROVIDER TO PROVIDER INCOME- BROMPTON		(200)	(17)	(17)	0	0.0%	(167)	(167)	0	0.0%
9B012	PROVIDER TO PROVIDER INCOME- MARSDEN		(90)	(8)	(8)	0	0.0%	(75)	(76)	1	-1.3%
VF010	SLAs SAVINGS TARGET		0	0	0	0		0	0	0	
	TOTAL ALL SLAs		**9,570**	**797**	**865**	**(68)**	**-8.5%**	**7,976**	**8,569**	**(593)**	**-7.4%**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

TRUST WIDE SUMMARY BY DIRECTORATE

Responsibility: Finance Director

FORM F3A
January 06

Directorate/ Service Area	Accountability	Annual Budget				In Month Variance				YTD Variance				Full Year Forecast at Dec-05				
		Income	Pay	Non pay	Total	Income	Pay	Non Pay	Total	Income	Pay	Non Pay	Total	Income	Pay	Non pay	Total	Move't
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
SaFF income	Lorraine Bewes	(181,233)	0	0	(181,233)	(1,053)	0	(373)	(1,426)	45	0	(373)	(328)	279	0	0	279	(740)
Central Non SaFF income	Lorraine Bewes	(28,954)	0	0	(28,954)	(16)	0	0	(16)	(259)	0	0	(259)	(336)	0	0	(336)	0
Total Central Income		(210,187)	0	0	(210,187)	(1,069)	0	(373)	(1,442)	(214)	0	(373)	(587)	(57)	0	0	(57)	(740)
Frontline Directorate																		
Imaging & Anaesthetics	Kate Hall	(480)	20,842	5,338	25,700	(15)	128	(200)	(87)	(24)	68	(363)	(318)	(4)	410	(456)	(50)	(90)
HIV/GUM	Claire James	(723)	10,262	27,700	37,239	20	19	5	44	348	(206)	(85)	57	500	(298)	(79)	123	34
Medicine & A&E	Nicola Hunt	(841)	22,568	6,470	28,197	(32)	16	(41)	(57)	(73)	(564)	144	(493)	(108)	(761)	99	(770)	20
Surgery	Kate Hall	(424)	14,657	4,454	18,687	(1)	40	(104)	(65)	3	446	(511)	(62)	(1)	673	(623)	49	0
Womens & Children's	Sherryn Elsworth	(3,804)	29,586	4,244	30,026	(87)	32	415	361	151	(42)	104	213	134	60	149	343	372
Subtotal Frontline Directorates		(6,272)	97,916	48,206	139,850	(114)	235	74	195	405	(298)	(710)	(604)	521	84	(910)	(305)	336
Pharmacy	Karen Robertson	(772)	3,919	396	3,544	(61)	69	28	35	16	81	52	149	14	79	47	140	45
Physiotherapy & Occ Therapy	Douline Schoeman	(178)	3,794	174	3,790	(2)	15	13	26	(12)	101	40	130	(14)	101	49	136	28
Dietetics	Helen Stracey	(24)	582	30	588	(1)	3	0	3	(6)	30	1	25	(7)	36	2	31	1
Regional Pharmacy	Susan Sanders	(59)	39	33	12	(5)	3	2	1	(49)	32	27	10	0	0	0	0	0
Subtotal Clinical Support		(1,032)	8,334	633	7,934	(68)	90	44	65	(51)	244	120	314	(7)	216	98	307	74
Chief Executive	Heather Lawrence	(84)	1,051	181	1,148	0	17	5	23	9	53	31	93	11	58	47	116	21
Governance & Corporate Affairs	Vivia Richards	(3)	721	3,530	4,248	(0)	21	4	25	(1)	193	(9)	183	(1)	205	(16)	188	18
Nursing	Andrew MacCallum	(875)	2,387	308	1,820	(1)	11	7	16	(3)	96	29	123	(8)	78	29	99	15
Human Resources	Maxine Foster	(104)	1,751	349	1,995	0	7	4	11	13	85	89	187	12	82	88	182	68
Finance	Lorraine Bewes	(421)	3,342	693	3,614	0	17	(10)	7	20	82	(90)	12	14	70	(81)	3	2
IC&T & EPR	Alex Geddes	(518)	1,578	1,862	2,922	(1)	23	2	25	(2)	295	(82)	210	87	349	(218)	218	11
Occupational Health	Stella Sawyer	(169)	332	61	223	(1)	2	(2)	0	(10)	18	3	10	(13)	21	(2)	6	2
Subtotal Management Exec		(2,175)	11,163	6,983	15,971	(2)	99	11	107	26	821	(30)	817	102	863	(153)	812	137
Facilities	Helen Elkington	(2,465)	143	15,851	13,529	(4)	(10)	(118)	(131)	73	(109)	(310)	(346)	113	(110)	(548)	(545)	2
Research & Development	Mervyn Maze	(3)	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Private Patients	Elizabeth Ogunoye	(3,520)	919	481	(2,120)	53	(11)	12	54	(24)	(195)	(159)	(378)	(17)	(209)	(170)	(396)	1
Overseas	Elizabeth Ogunoye	(690)	0	0	(690)	23	0	(65)	(42)	48	0	(65)	(17)	50	0	(70)	(20)	(5)
ACU	Sherryn Elsworth	(1,204)	697	440	(67)	62	(7)	(9)	46	(32)	(47)	(81)	(161)	40	(47)	(96)	(103)	16
Post Graduate Centre	Kevin Shotlift	0	89	132	221	0	2	(2)	(0)	24	13	25	61	0	16	20	36	23
Projects	Helen Elkington	(493)	985	154	646	2	(1)	(1)	(0)	20	(11)	(16)	(7)	24	(20)	(15)	(11)	1
Simulation Centre	Andrew MacCallum	(287)	274	51	38	(6)	5	3	2	(50)	58	(12)	(4)	(44)	55	(28)	(17)	1
Service Level Agreements	Edward Donald	(290)	0	9,861	9,571	1	0	(68)	(66)	1	0	(593)	(592)	0	0	(634)	(634)	0
Subtotal Other Directorates		(8,951)	3,106	26,974	21,129	132	(23)	(248)	(139)	60	(291)	(1,212)	(1,444)	166	(315)	(1,541)	(1,690)	39
Total All Directorates		(18,431)	120,519	82,796	184,884	(53)	401	(119)	229	440	475	(1,832)	(917)	782	848	(2,506)	(876)	586
Central Budgets																		
Capital Charges	Lorraine Bewes	(248)	0	16,756	16,508	(8)	0	(85)	(92)	(77)	0	(846)	(923)	0	0	(1,000)	(1,000)	0
Central Budgets	Lorraine Bewes	(919)	0	(188)	(1,107)	12	(51)	342	303	(22)	(70)	3,641	3,549	(861)	1,054	3,845	4,038	154
Reserves	Lorraine Bewes	0	0	9,901	9,901	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Central Budgets		(1,167)	0	26,470	25,303	4	(51)	258	211	(99)	(70)	2,795	2,626	(861)	1,054	2,845	3,038	154
Net Deficit(-)/Surplus(+)		(229,785)	120,519	109,265	(0)	(1,118)	350	(235)	(1,003)	127	405	591	1,122	(136)	1,902	339	2,105	(0)

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

ACU Summary

FORM F3B
January 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	3	(12)	138	96	(42)	168	126	(42)
ICSI	10	8	(2)	92	79	(13)	112	99	(13)
Sub total self fund cycles	**25**	**11**	**(14)**	**230**	**175**	**(55)**	**280**	**225**	**(55)**
IUI (procedure)	30	28	(2)	300	285	(15)	360	345	(15)

	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	(33)	(8)	(25)	(298)	(221)	(77)	(363)	(286)	(77)
ICSI	(27)	(23)	(4)	(245)	(210)	(35)	(299)	(264)	(35)
Sub total self fund cycles	**(60)**	**(31)**	**(29)**	**(543)**	**(431)**	**(112)**	**(662)**	**(550)**	**(112)**
IUI	(20)	(18)	(2)	(195)	(163)	(32)	(234)	(202)	(32)
Consultations	(4)	(3)	(1)	(33)	(28)	(5)	(40)	(35)	(5)
Drugs income	(18)	(13)	(5)	(168)	(152)	(16)	(204)	(188)	(16)
Other	(6)	(104)	98	(53)	(187)	134	(64)	(270)	206
Income sub total	**(106)**	**(168)**	**62**	**(992)**	**(960)**	**(32)**	**(1,204)**	**(1,244)**	**40**
Pay	58	65	(7)	581	629	(47)	697	744	(47)
Non pay	37	46	(9)	366	448	(81)	440	536	(96)
Surplus/ Deficit	**(11)**	**(57)**	**46**	**(44)**	**117**	**(161)**	**(67)**	**36**	**(104)**

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

SUMMARY OF RESERVES MOVEMENTS

Responsibility: Finance Director

FORM 4A
January 06

Reserve	Code	Opening Ledger Balance 01/04/05	Distributed 05/06										Closing Ledger balance 2005/06	Committed 2005/06	Uncomm-itted 2005/06	Uncomm-itted 2006/07
			Month 1 & 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	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	£000's	£000's	£000's
Specific Expenditure Reserves	3X010	7,804	(4,066)	(1,471)	(541)	(558)	(351)	(690)	(73)	455	(319)	(7,614)	189	(868)	(679)	(1,688)
Other Income Inflation Target	3X020	1,700	0	(149)	(883)	50	(594)	(322)	252		(350)	(1,995)	(295)	0	(295)	(296)
Income	3X050	2,259	0	(664)	(193)					(770)		(1,627)	632	0	632	632
Pay Inflation	3X060	4,504	(1,213)	0	(2,609)	(329)						(4,151)	354	(33)	320	(38)
Non Pay	3X070	2,633	(694)	0	(1,273)	93	(294)					(2,168)	465	(142)	323	0
Contingency	3X080	730	(222)	(230)	454		(159)	(14)	(28)			(198)	532	(375)	157	512
Cost Improvement Programme	3X190	(1,022)	213	500	0							713	(309)	0	(309)	(309)
Deficit Payback	3X195	4,802	(4,665)	(138)	0	3,432						(1,371)	3,431	0	3,431	(1)
Agenda for Change Reserve	3X250	3,798	615	(19)	279	(61)	(167)	(236)	(193)	(210)	(64)	(56)	3,741	(3,012)	730	0
EWTD Reserve	3X260	826	(145)	(215)	255	(137)		(25)	(37)			(304)	522	(93)	429	355
Pensions Indexation	3X270	250	0	0								0	250	0	250	0
CNST Reserve	3X280	674	(669)	0								(669)	5	0	5	5
Consultant Contract Reserve	3X290	636	(49)	0	(300)	(17)	(12)					(377)	259	(159)	100	0
LDP - Emergency Care	3X410	141	0	0								0	141	0	141	0
NICE Drugs	3X510	1,553	(1,656)	39								(1,618)	(65)	0	(65)	(65)
Capital Charges	3X600	1,675	0	(1,675)								(1,675)	0	0	0	0
Ringfenced Funding	3X680	512	(89)	(23)	302	(10)	103	(65)	(90)	(64)	(48)	16	527	(527)	0	0
Generics	3X700	(1,140)	0	491	173							664	(476)	476	(0)	512
		32,334	(12,639)	(3,555)	(4,335)	2,463	(1,474)	(1,352)	(168)	(589)	(781)	(22,431)	9,903	(4,734)	5,169	(382)

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST
TRUST WIDE SAVINGS ACHIEVED BY DIRECTORATE
Responsibility: Finance Director

FORM FSA
January 06

Directorate/ Service Area	Accountability	Original Target 2.5% Note 1	Savings Achieved									Outstanding target to Achieve
			Procure-ment Initiatives	Nursing Skill Mix Review	IMPACT Projects	Depreciation Savings	Dell PC Leases	Returning Drugs Initiatives	LAS Contract Reduction	Other	Total Savings Achieved	
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	(570)		83						341	424	(146)
HIV/GUM	Paul Walsh	(700)		300						400	700	0
Medicine & A&E	Nicola Hunt	(569)		109	47					42	196	(370)
Surgery	Kate Hall	(436)								192	192	(244)
Womens & Children's	Sherryn Elsworth	(681)		71						610	681	0
Subtotal Frontline Directorates		(2,956)	0	563	47	0	0	0	0	1,586	2,196	(760)
Pharmacy	Karen Robertson	(82)									0	(82)
Physiotherapy & Occ Therapy	Douline Schoeman	(93)								93	93	0
Dietetics	Helen Stracey	(14)								14	14	0
Regional Pharmacy	Susan Sanders	0									0	0
Subtotal Clinical Support		(189)	0	0	0	0	0	0	0	107	107	(82)
Chief Executive	Heather Lawrence	0									0	0
Governance & Corporate Affairs	Susan Burnett	(19)									0	(19)
Nursing	Andrew MacCallum	(39)									0	(39)
Human Resources	Maxine Foster	(36)								10	10	(26)
Finance	Lorraine Bewes	(78)								78	78	0
IM&T & EPR	Alex Geddes	(259)					160				160	(99)
Occupational Health	Stella Sawyer	(5)									0	(5)
Subtotal Management Exec		(436)	0	0	0	0	160	0	0	88	248	(188)
Facilities	Edward Donald	(284)							60	151	211	(73)
Private Patients	Paul Walsh	0									0	0
ACU	Sherryn Elsworth	0									0	0
Post Graduate Centre	Kevin Shotlift	0									0	0
Projects	Edward Donald	0									0	0
Simulation Centre	Paul White	0									0	0
Service Level Agreements	Edward Donald	0									0	0
Subtotal Other Directorates		(284)	0	0	0	0	0	0	60	151	211	(73)
Total All Directorates		(3,865)	0	563	47	0	160	0	60	1,932	2,762	(1,103)
Central Budgets												
Capital Charges	Lorraine Bewes	(1,093)									0	(1,093)
Central Budgets	Lorraine Bewes										0	0
Reserves	Lorraine Bewes										0	0
Total Central Budgets		(1,093)	0	0	0	0	0	0	0	0	0	(1,093)
Net Deficit(-)/Surplus(+)		(4,958)	0	563	47	0	160	0	60	1,932	2,762	(2,196)

Note 1- Target calculated after funding of brought forward savings. CNST and Drugs budgets excluded from calculation of 2.5%

CHELSEA & WESTMINSTER HEALTHCARE NHS TRUST

TRUST WIDE SAVINGS DETAIL INCLUDING PLANS IN DEVELOPMENT

FORM F5B
January 06

Responsibility: Finance Director

Directorate/ Service Area	Accountability	Risk	Savings Target (From Form F5(A))	Total Savings Including Those Under Development									Outstanding Target
				Procurement Initiatives	Nursing Skill Mix Review	IMPACT Projects	Depreciation Savings	Dell PC Leases	Returning Drugs Initiatives	LAS Contract Reduction	Other	Total Savings	
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		(570)										(570)
Nursing Skill Mix Review		Achieved			54							54	54
Radiology		Low									100	100	100
GM post in A&I		Achieved									19	19	19
2nd Burns on call ITU bed		Achieved									200	200	200
Bed closed in ITU		High									46	46	46
MTO 3 post in Anaesthetics		Achieved									15	15	15
G grade post in Theatres		Achieved			29							29	29
Perioperative Nurse Practitioner		Achieved									17	17	17
Anaesthetics Practitioner Project Management Funding		Achieved									10	10	10
Critical Care G Grade part year effect		Achieved									31	31	31
Maintenance Saving		Achieved									20	20	20
Miscellaneous Saving		Achieved									29	29	29
			(570)	0	83	0	0	0	0	0	487	570	0
HIV/GUM	Paul Walsh		(700)										(700)
Nursing Skill Mix Review		Achieved			300							300	300
Non-Recurring Savings CX Clinic		Achieved									308	308	308
Non-Recurrent Pay Slippage		Achieved									10	10	10
Other Savings		Achieved									82	82	82
			(700)	0	300	0	0	0	0	0	400	700	0
Medicine & A&E	Nicola Hunt		(569)										(569)
Nursing Skill Mix Review		Achieved			71							71	71
12-14 bed reduction (6 immediately)		Achieved				47						47	47
12-14 bed reduction		High				105						105	105
Floating SpR locum		Low									15	15	15
A&E Skill Mix		Achieved			38							38	38
Consultant Pay Savings		Achieved									43	43	43
Sleep studies		-										0	0
			(569)	0	109	152	0	0	0	0	58	319	(250)
Surgery	Kate Hall		(436)										(436)
Management pay budget savings		Achieved									108	108	108
SK Skin Bank pye facilities		Achieved									84	84	84
Close 10 surgical beds		Medium									100	100	100
Nursing Skill Mix Review (Outpatients)		Low			24							24	24
Plastics SPR Banding savings		Medium									120	120	120
			(436)	0	24	0	0	0	0	0	412	436	0
Womens & Children's	Sherryn Elsworth		(681)										(681)
Nursing Skill Mix		Achieved			71							71	71
NICU HDU Income		Achieved									177	177	177
Delayed Recruitment		Achieved									433	433	433
			(681)	0	71	0	0	0	0	0	610	681	0
Subtotal Frontline Directorates			**(2,956)**	**0**	**587**	**152**	**0**	**0**	**0**	**0**	**1,967**	**2,706**	**(250)**

Directorate/ Service Area	Accountability	Risk	Savings Target (From Form F5(A))	Total Savings Including Those Under Development									Outstanding Target
				Procurement Initiatives	Nursing Skill Mix Review	IMPACT Projects	Depreciation Savings	Dell PC Leases	Returning Drugs Initiatives	LAS Contract Reduction	Other	Total Savings	
Pharmacy	Karen Robertson		(82)									0	(82)
Prescription income		Low									20	20	20
PCT Income		Low									5	5	5
Charitable Funds Micro-HHNT		Low									10	10	10
Purchasing/ reclaims		Low									40	40	40
BKCW non-SLA		Low									7	7	7
			(82)	0	0	0	0	0	0	0	82	82	0
Physiotherapy & Occ Therapy	Douline Schoeman		(93)									0	(93)
Delayed recruitment		Achieved									93	93	93
			(93)	0	0	0	0	0	0	0	93	93	0
Dietetics	Helen Stracey	Achieved	(14)								14	14	0
Regional Pharmacy	Susan Sanders		0									0	0
Subtotal Clinical Support			**(189)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**189**	**189**	**0**
Chief Executive	Heather Lawrence		0									0	0
Governance & Corporate Affairs	Susan Burnett	Low	(19)								19	19	0
Nursing	Andrew MacCallum	Low	(39)								39	39	0
Human Resources	Maxine Foster	Low	(26)								26	26	0
Human Resources	Maxine Foster	Achieved	(10)								10	10	0
Finance	Lorraine Bewes	Achieved	(78)								78	78	0
IM&T & EPR	Alex Geddes	Achieved	(160)					160				160	0
IM&T & EPR Other Savings	Alex Geddes	Low	(99)								99	99	0
Occupational Health	Stella Sawyer	Low	(5)								5	5	0
Subtotal Management Exec			**(436)**	**0**	**0**	**0**	**0**	**160**	**0**	**0**	**276**	**436**	**0**
Facilities	Helen Elkington		(284)									0	(284)
LAS/Taxis		Achieved								60		60	60
Telecoms		Achieved									25	25	25
Car Parking		Achieved									76	76	76
Consultancy reduction		Achieved									25	25	25
Climate Control Levy		Achieved									25	25	25
Rates appeal		High									50	50	50
Interpretation		High									25	25	25
			(284)	0	0	0	0	0	0	60	226	286	2
Private Patients	Paul Walsh		0									0	0
ACU	Sherryn Elsworth		0									0	0
Post Graduate Centre	Kevin Shotlift		0									0	0
Projects	Helen Elkington		0									0	0
Simulation Centre	Paul White		0									0	0
Service Level Agreements	Edward Donald		0									0	0
Viral load testing													0
Subtotal Other Directorates			**(284)**	**0**	**0**	**0**	**0**	**0**	**0**	**60**	**226**	**286**	**2**
Total All Directorates			**(3,865)**	**0**	**587**	**152**	**0**	**160**	**0**	**60**	**2,658**	**3,617**	**(248)**
Central Budgets													
Capital Charges	Lorraine Bewes		(1,093)									0	(1,093)
Central Budgets	Lorraine Bewes											0	0
Procurement Savings	Vince Pross	Medium		100								100	100
PODs	Karen Robertson											0	0
Drug returns	Karen Robertson	Medium							98			98	98
			0	100	0	0	0	0	98	0	0	198	198
Reserves	Lorraine Bewes											0	0
Total Central Budgets			**(1,093)**	**100**	**0**	**0**	**0**	**0**	**98**	**0**	**0**	**198**	**(895)**
Net Deficit(-)/Surplus(+)			**(4,958)**	**100**	**587**	**152**	**0**	**160**	**98**	**60**	**2,658**	**3,815**	**(1,143)**

Chelsea & Westminster Healthcare NHS Trust

FORM F6

January 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	44,500	46,739	46,739	46,739
Buildings	208,590	206,842	206,235	215,279
Plant & Equipment	9,416	8,425	8,286	14,473
RELEVANT FIXED ASSETS :	**262,506**	**262,006**	**261,260**	**276,491**
Under Construction	7,136	14,798	15,095	1,571
TOTAL FIXED ASSETS :	**269,642**	**276,804**	**276,355**	**278,062**
CURRENT ASSETS :				
Stocks & Work In Progress	4,147	3,540	4,234	3,597
Trade Debtors	16,583	19,139	21,416	14,895
Provision for Irrecoverable Debt	-5,520	-4,199	-4,264	-4,370
Accruals and Prepayments	12,974	9,816	8,602	10,862
Other Debtors	444	2,049	1,952	361
Cash at Bank & in Hand	620	6,607	6,567	683
Short - term Investment	0	0	0	0
TOTAL CURRENT ASSETS :	**29,248**	**36,953**	**38,507**	**26,028**
CURRENT LIABILITIES :				
Tax and Social Security	(3,700)	(3,894)	(3,940)	(6,732)
Dividends Payable	0	(2,205)	(2,940)	0
Trade Creditors	(12,223)	(9,345)	(14,598)	(15,431)
Accruals and Prepayments	(5,969)	(6,504)	(3,546)	(5,294)
Other Creditors	(1,727)	(2,698)	(2,687)	(2,074)
TOTAL CURRENT LIABILITIES :	**(23,619)**	**(24,647)**	**(27,711)**	**(29,531)**
NET CURRENT ASSETS / (LIABILITIES)	**5,629**	**12,306**	**10,796**	**(3,503)**
Creditors over one year	(996)	(996)	(996)	(996)
Provisions for liabilities and Charges	(2,518)	(2,079)	(2,044)	(2,122)
TOTAL ASSET EMPLOYED	**271,757**	**286,034**	**284,111**	**271,441**
CAPITAL & RESERVES				
Public Dividend Capital	177,764	177,764	177,764	168,981
Loans	0	0	0	0
TOTAL CAPITAL DEBT	**177,764**	**177,764**	**177,764**	**168,981**
RESERVES				
Revaluation Reserve	90,811	97,099	97,099	96,714
Donation Reserve	5,885	5,583	5,570	6,344
Other Reserve				
Income & Expenditure Reserve / (Deficit)	(2,703)	5,589	3,678	(598)
TOTAL RESERVE	**93,993**	**108,271**	**106,348**	**102,460**
TOTAL CAPITAL AND RESERVES	**271,757**	**286,034**	**284,111**	**271,441**

Chelsea & Westminster Healthcare NHS Trust

FORM F7

Age Debtor Analysis

January 06

Responsibility: Finance Director

January	%Age	Total	Days 0-30	Days 31-90	Days 91+
Kensington & Chelsea PCT	**11.90%**	2,570,480	1,771,567	778,437	20,476
The Hammersmith Hospitals NHS Trust	**11.68%**	2,522,268	327,683	943,805	1,250,781
North West London SHA	**6.20%**	1,339,548	1,360,284	0	-20,737
Wandsworth PCT	**3.45%**	744,604	265,949	69,962	408,693
North West London WDC	**3.09%**	667,172	645,436	0	21,736
Southend on Sea PCT	**2.24%**	483,734	56,042	114,499	313,194
Adur Arun & Worthing PCT	**2.09%**	450,784	93,216	79,740	277,828
Watford and Three Rivers PCT	**1.95%**	421,280	-145,424	152,916	413,788
Brent KCW Mental Health Trust	**1.92%**	413,640	0	0	413,640
Imperial College London	**1.91%**	412,814	2,514	374,750	35,550
Sub Total	**46.42%**	**10,026,325**	**4,377,268**	**2,514,108**	**3,134,949**
Other Debtrors	**53.58%**	11,573,144	2,950,493	2,122,735	6,499,915
Total	**100%**	21,599,468	7,327,761	4,636,843	9,634,864
% of total		**100.0%**	**33.93%**	**21.47%**	**44.61%**
Increase/decrease on last month		**2,175,304**	**-1,499,390**	**3,743,787**	**-69,093**
% Increase/(decrease)on previous month		**11.2%**	**-17.0%**	**419.2%**	**-0.7%**

Analysis of Private Patients Debtors

Outstanding as at 31 January 2005		1,184,951	569,367	148,124	467,460
% of total		**100.0%**	**48.0%**	**12.5%**	**39.4%**
Increase/decrease on last month		100,613	145,241	-122,977	78,349
% Increase/(decrease)on previous month		9.3%	34.2%	-45.4%	20.1%

Analysis of Overseas Visitors Debtors

Outstanding as at 31 January 2005		1,208,296	33,581	51,396	1,123,319
% of total		**100.0%**	**2.8%**	**4.3%**	**93.0%**
Increase/decrease on last month		21,318	8,864	-14,786	27,240
% Increase/(decrease)on previous month		1.8%	35.9%	-22.3%	2.5%

November	%Age	Total	Days 0-30	Days 31-90	Days 91+
The Hammersmith Hospitals NHS Trust	**12.06%**	2,341,854	288,499	826,376	1,226,980
Kensington & Chelsea PCT	**10.70%**	2,078,579	2,079,276	-14,149	13,452
Wandsworth PCT	**3.27%**	635,030	203,687	22,650	408,693
Watford and Three Rivers PCT	**3.10%**	602,394	152,739	-39,309	488,964
Imperial College London	**2.45%**	476,388	371,543	7,084	97,761
Adur Arun & Worthing PCT	**2.37%**	460,502	156,135	-16,361	320,728
Southend on Sea PCT	**2.33%**	452,473	158,162	-46,656	340,966
Brent Kensington C & W Mental Health Trust	**2.13%**	413,640	0	0	413,640
Western Sussex PCT	**2.05%**	397,830	0	0	397,830
Hillingdon PCT	**1.86%**	362,076	191,474	6,250	164,352
Sub Total	**42.32%**	**8,220,767**	**3,601,515**	**745,886**	**3,873,366**
Other Debtrors	**57.68%**	11,203,397	5,225,637	147,170	5,830,590
Total	**100%**	19,424,164	8,827,152	893,056	9,703,957
		100%	**32.80%**	**10.82%**	**56.39%**
Analysis of Private Patients Debtors					
Outstanding as at 31 October 2005		**1,084,338**	**424,125**	**271,101**	**389,112**
% of total		**100.0%**	**39.1%**	**25.0%**	**35.9%**
Analysis of Overseas Visitors Debtors					
Outstanding as at 31 October 2005		**1,186,978**	**24,716**	**66,183**	**1,096,079**
% of total		**100.0%**	**2.1%**	**5.6%**	**92.3%**

	%age	TOTAL	0 - 30	Days 30 - 90	OVER 90
Opening Balance April 2004-2005	**100.00%**	**17,378,760**	**8,446,128**	**285,892**	**8,646,739**
Age Analysis %		**100.00%**	**48.60%**	**1.65%**	**49.75%**

Customer Movement - Top 10	**£**
Kensington & Chelsea PCT	491,901
The Hammersmith Hospitals NHS Trust	180,413
North West London SHA	1,332,981
Wandsworth PCT	109,574
North West London WDC	595,886
Southend on Sea PCT	31,261
Adur Arun & Worthing PCT	-9,718
Watford and Three Rivers PCT	-181,115
Brent KCW Mental Health Trust	0
Imperial College London	-63,574
Total	2,487,610

Chelsea & Westminster Healthcare NHS Trust
Age Creditors Analysis Report & Better Payment Practice Code

FORM F8A
January 06

Responsibility: Finance Director

	CURRENT MONTH	**%age of Total Car's**	**TOTAL**	**Days 0 - 30**	**Days 30 - 90**	**Days OVER 90**
	Top 10 Creditor Balances		**£**	**£**	**£**	**£**
1	HAMMERSMITH HOSPITALS NHS TRU	31.66%	4,622,537	156,622	1,037,847	3,428,068
2	ISS MEDICLEAN LTD.	5.27%	769,446	762,315	3,765	3,366
3	GILEAD SCIENCES LTD.	4.99%	728,956	728,956	0	0
4	NHS LITIGATION AUTHORITY	4.22%	616,495	0	616,495	0
5	MAWDSLEYS	4.01%	585,240	584,212	1,250	-222
6	NHS BLOOD AND TRANSPLANT	3.44%	501,537	155,066	184,887	161,584
7	HADEN BUILDING MANAGEMENT LTD	2.84%	414,442	334,761	42,678	37,004
8	IMPERIAL COLLEGE	2.78%	405,891	30,399	49,999	325,493
9	BRISTOL-MYERS SQUIBB PHARMACE	2.53%	369,460	369,460	0	0
10	NHS LOGISTICS AUTHORITY	1.89%	275,514	275,514	0	0
	Sub Total	63.63%	9,289,518	3,397,304	1,936,921	3,955,293
	Others Creditors	36.37%	5,309,401	3,479,287	574,156	1,255,958
	TOTAL	100.00%	14,598,919	6,876,592	2,511,077	5,211,251
	% of total		**100.00%**	**47.10%**	**17.20%**	**35.70%**
	Incease/decrease on last month		**3,439,172**	**4,230,841**	**-435,579**	**-356,090**
	% increase /decrease on last month		**30.82%**	**159.91%**	**-14.78%**	**-6.40%**

	PREVIOUS MONTH : December	**%age of Total Cr's**	**TOTAL**	**Days 0 - 30**	**Days 30 - 90**	**Days OVER 90**
	Top 10 Creditor Balances		**£**	**£**	**£**	**£**
1	HAMMERSMITH HOSPITALS NHS TRU	50.90%	5,680,839	90,607	1,480,493	4,109,739
2	NHS LITIGATION AUTHORITY	5.52%	616,495	0	616,495	0
3	IMPERIAL COLLEGE	5.47%	610,235	243,410	91,602	275,222
4	NHS BLOOD AND TRANSPLANT	4.12%	460,064	162,666	202,128	95,271
5	RICHMOND&TWICKENHAM PCT	2.38%	265,705	0	0	265,705
6	MAWDSLEYS	2.15%	239,514	239,736	-222	0
7	BRISTOL-MYERS SQUIBB PHARMACE	2.06%	230,338	230,338	0	0
8	NHS LOGISTICS AUTHORITY	1.50%	167,828	167,828	0	0
9	ABBOTT LABORATORIES LTD	1.49%	166,294	166,257	37	0
10	INTERSPACE LTD	1.33%	148,704	0	0	148,704
	Sub Total	76.94%	8,586,016	1,300,842	2,390,533	4,894,641
	Others Creditors	23.06%	2,573,731	1,344,909	556,123	672,700
	TOTAL	100.00%	11,159,748	2,645,751	2,946,656	5,567,341
	Percentage of No. of days / Total Creditors		***100.00%***	***23.71%***	***26.40%***	***49.89%***

	Opening Balance April 2005 - 2006		12,222,784	8,159,674	992,944	3,070,166
		%age	***100.00%***	***66.76%***	***8.12%***	***25.12%***

Movement from Previous Month

	Supplier	**£**
1	HAMMERSMITH HOSPITALS NHS TRU	-1,058,302
2	ISS MEDICLEAN LTD.	769,446
3	GILEAD SCIENCES LTD.	728,956
4	NHS LITIGATION AUTHORITY	0
5	MAWDSLEYS	345,726
6	NHS BLOOD AND TRANSPLANT	41,473
7	HADEN BUILDING MANAGEMENT LTD	414,442
8	IMPERIAL COLLEGE	-204,344
9	BRISTOL-MYERS SQUIBB PHARMACE	139,122
10	NHS LOGISTICS AUTHORITY	107,686
	Total	1,284,205

BETTER PAYMENT PRACTICE CODE - INVOICES PAID WITHIN 30 DAYS

	This month				**Cumulative**		**Pior year**
	VALUE	**NUMBER**	**%age (Value)**	**%age (No)**	**%age (Value)**	**%age (No)**	**%age (No)**
April	£5,534,623	3,673	79.09%	81.69%	79.09%	81.69%	84.01%
May	£6,204,915	3,195	78.00%	78.00%	78.25%	80.15%	83.95%
June	£6,785,311	4,216	86.96%	89.74%	83.55%	81.23%	79.66%
July	£5,220,672	3,896	78.54%	88.38%	80.62%	84.75%	76.72%
August	£3,776,265	3,292	82.40%	88.78%	80.86%	85.45%	70.10%
September	£2,049,386	2,107	33.43%	73.54%	73.62%	84.04%	65.76%
October	£3,504,461	3,415	39.42%	59.43%	67.42%	79.33%	67.15%
November	£4,134,379	2,979	53.56%	58.72%	65.54%	76.35%	69.27%
December	£5,956,630	2,570	76.46%	71.17%	66.87%	75.88%	70.24%
January	£2,906,653	2,453	70.69%	76.87%	67.10%	75.96%	70.93%
February							
March							

Chelsea & Westminster Healthcare NHS Trust
Age Creditors Analysis Report & Better Payment Practice Code

FORM F8B
January 06

Responsibility: Finance Director

	CURRENT MONTH	%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	31.66%	4,622,537	156,622	1,037,847	3,428,068
2	ISS MEDICLEAN LTD.	5.27%	769,446	762,315	3,765	3,366
3	NHS LITIGATION AUTHORITY	4.22%	616,495	0	616,495	0
4	NHS BLOOD AND TRANSPLANT	3.44%	501,537	155,066	184,887	161,584
5	IMPERIAL COLLEGE	2.78%	405,891	30,399	49,999	325,493
6	NHS LOGISTICS AUTHORITY	1.89%	275,514	275,514	0	0
7	RICHMOND&TWICKENHAM PCT	1.82%	265,705	0	0	265,705
8	WANDSWORTH PRIMARY CARE TRUST	1.18%	172,795	36,326	42,784	93,686
9	ROYAL BROMPTON & HAREFIELD NH	1.15%	167,421	72,837	7,882	86,703
10	ST MARYS HOSPITAL NHS TRUST	0.98%	143,558	60,975	22,064	60,519
	Sub Total	54.39%	7,940,900	1,550,054	1,965,722	4,425,124
	Others Creditors	45.61%	6,658,020	5,326,538	545,354	786,127
	TOTAL	100.00%	14,598,919	6,876,592	2,511,077	5,211,251
	Percentage of No. of days / Total Creditors		***100.00%***	***47.10%***	***17.20%***	***35.70%***

	PREVIOUS MONTH : November	%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	50.90%	5,680,839	90,607	1,480,493	4,109,739
2	NHS LITIGATION AUTHORITY	5.52%	616,495	0	616,495	0
3	IMPERIAL COLLEGE	5.47%	610,235	243,410	91,602	275,222
4	NHS BLOOD AND TRANSPLANT	4.12%	460,064	162,666	202,128	95,271
5	RICHMOND&TWICKENHAM PCT	2.38%	265,705	0	0	265,705
6	NHS LOGISTICS AUTHORITY	1.50%	167,828	167,828	0	0
7	WANDSWORTH PRIMARY CARE TRUST	1.22%	136,469	0	45,119	91,350
8	ROYAL BROMPTON & HAREFIELD NH	1.12%	125,402	36,210	47,760	41,432
9	GUY'S & ST THOMAS' FOUNDATION	1.09%	121,981	43,226	6,879	71,875
10	ST MARYS HOSPITAL NHS TRUST	0.88%	98,551	32,186	11,407	54,958
	Sub Total	74.23%	8,283,568	776,133	2,501,883	5,005,552
	Others Creditors	25.77%	2,876,180	1,869,618	444,772	561,789
	TOTAL	100.00%	11,159,748	2,645,751	2,946,656	5,567,341
	Percentage of No. of days / Total Creditors		***100.00%***	***23.71%***	***26.40%***	***49.89%***

	Opening Balance April 2005 - 2006		12,222,784	8,159,674	992,944	3,070,166
		%age	***100.00%***	***66.76%***	***8.12%***	***25.12%***

Movement from Previous Month

	Supplier	£
1	HAMMERSMITH HOSPITALS NHS TRU	-1,058,302
2	ISS MEDICLEAN LTD.	769,446
3	NHS LITIGATION AUTHORITY	0
4	NHS BLOOD AND TRANSPLANT	41,473
5	IMPERIAL COLLEGE	-204,344
6	NHS LOGISTICS AUTHORITY	107,686
7	RICHMOND&TWICKENHAM PCT	0
8	WANDSWORTH PRIMARY CARE TRUST	36,326
9	ROYAL BROMPTON & HAREFIELD NH	42,020
10	ST MARYS HOSPITAL NHS TRUST	45,007

Chelsea and Wesminster Healthcare NHS Trust
Cash Flow Statement

FORM F9A
January 06

Responsibility: Finance Director

£ 000	1 Actual Apr-05	2 Actual May-05	3 Actual Jun-05	4 Actual Jul-05	5 Actual Aug-05	6 Actual Sep-05	7 Actual Oct-05	8 Actual Nov-05	9 Actual Dec-05	10 Actual Jan-06	11 Forecast Feb-06	12 Forecast Mar-06	Actual YTD	Forecast Total Mar-06
	£	£	£	£	£	£	£	£	£	£	£	£	£	£
Total Operating Surplus/(Deficit)	1,172	3,253	427	327	1,680	2,958	1,584	541	2,848	(1,226)	(1,364)	(1,365)	13,563	10,834
Depreciation and Amortisation	669	640	822	733	746	746	746	746	746	746	798	797	7,340	8,935
Transfer from the donated asset reserve	0						0		-			(248)	0	(248)
(Increase)/Decrease in Stocks	21	(1,162)	528	327	314	194	1,315	(910)	(20)	(694)	294	342	(86)	550
(Increase)/Decrease in Debtors	(1,274)	543	1,280	1,030	(6,818)	776	(1,155)	1,828	1,465	(901)	2,440	3,518	(3,225)	2,733
Increase/(Decrease) in Creditors	730	(1,058)	(2,329)	590	3,001	32	(608)	(1,656)	910	3,064	500	2,737	2,675	5,912
Increase/(Decrease) in Provisions	-	(6)	-	(5)	0	0	(373)	(33)	(22)	(34)	39	39	(474)	(396)
OPERATING ACTIVITIES														
Net cash inflow(outflow) from operating activities	**1,317**	**2,209**	**729**	**3,002**	**(1,077)**	**4,706**	**1,509**	**515**	**5,927**	**955**	**2,707**	**5,821**	**19,793**	**28,321**
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:														
Interest receivable	13	15	22	10	17	14	14	18	12	31	32	32	166	230
Interest payable	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	0	0
Net cash inflow/(outflow) from returns on investments and servicing of finance	**13**	**15**	**22**	**10**	**17**	**14**	**14**	**18**	**12**	**31**	**32**	**32**	**166**	**230**
CAPITAL EXPENDITURE														
Payments to acquire tangible fixed assets	(409)	(2,398)	(980)	(507)	(1,320)	(498)	(580)	(393)	(1,490)	(1,026)	(392)	(972)	(9,602)	(10,966)
Donations	0	0	0	0	0	0		0	0	0	0	402	0	402
Net cash inflow (outflow) from capital expenditure	**(409)**	**(2,398)**	**(980)**	**(507)**	**(1,320)**	**(498)**	**(580)**	**(393)**	**(1,490)**	**(1,026)**	**(392)**	**(570)**	**(9,602)**	**(10,564)**
DIVIDENDS PAID	0	0	0	0	0	(4,411)	0	0	0	0	0	(4,410)	(4,411)	(8,821)
Net cash inflow/(outflow) before management of liquid resources and financing	**921**	**(174)**	**(229)**	**2,505**	**(2,380)**	**(189)**	**943**	**140**	**4,449**	**(40)**	**2,347**	**873**	**5,946**	**9,166**
MANAGEMENT OF LIQUID RESOURCES														
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	**921**	**(174)**	**(229)**	**2,505**	**(2,380)**	**(189)**	**943**	**140**	**4,449**	**(40)**	**2,347**	**873**	**5,946**	**9,166**
FINANCING														
Public dividend capital received	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other capital receipts and payments (LT Debtors/creditors Governm	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Capital element of finance lease rental payments	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Brokerage payments and receipts	0	0	0	0	0	0	0	0	0	0	0	(9,103)	0	(9,103)
Net cash inflow (outflow) from financing	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(9,103)**	**0**	**(9,103)**
Increase (decrease) in cash	**921**	**(174)**	**(229)**	**2,505**	**(2,380)**	**(189)**	**943**	**140**	**4,449**	**(40)**	**2,347**	**(8,230)**	**5,946**	**63**
Opening Cash Balance	**620**	**1,541**	**1,367**	**1,138**	**3,643**	**1,263**	**1,074**	**2,017**	**2,157**	**6,606**	**6,566**	**8,913**	**620**	620
Cash Balance at the end of the period	**1,541**	**1,367**	**1,138**	**3,643**	**1,263**	**1,074**	**2,017**	**2,157**	**6,606**	**6,566**	**8,913**	**683**	**6,566**	683
05/06 CASH NET INFLOW BEFORE EFL REPAYMENT	**1,541**	**1,367**	**1,138**	**3,643**	**1,263**	**1,074**	**2,017**	**2,157**	**6,606**	**6,566**	**8,913**	**683**	**6,566**	**0**
BROKERAGE PAID BACK										0	0	0		0

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

FORM F9B
January 06

NORMAL ACTIVITIES	April	May	June	July	August	September	October	November	December	January	February	March	**TOTAL**
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
RECEIPTS	19,662	17,358	21,264	19,410	13,605	21,141	21,809	19,697	22,814	16,400			193,161
PAYMENTS	(18,741)	(17,533)	(21,492)	(16,905)	(15,985)	(21,331)	(20,866)	(19,557)	(18,364)	(16,441)			-187,214
NET MOVEMENT	921	(175)	(228)	2,505	(2,380)	(189)	943	140	4,450	(40)	0	0	5,947
Cumulative	921	746	518	3,023	643	454	1,397	1,537	5,987	5,947			
FUNDING / BROKERAGE	0	0	0	0	0	0	0	0	0				0
NET MOVEMENT	0	0	0	0	0	0	0	0	0	0	0	0	0
Cumulative	0	0	0	0	0								
TOTAL FUND MOVEMENT	921	(175)	(228)	2,505	(2,380)	(189)	943	140	4,450	(40)			5,947
Cumulative	921	746	518	3,023	643	454	1,397	1,537	5,987	5,947			

SUMMARY OF CUMULATIVE MOVEMENTS	April	May	June	July	August	September	October	November	December	January			
NORMAL ACTIVITIES													
Forecast	921	1,792	3,809	4,696	5,566	5,142	4,953	5,449	7,935	8,985			
Actual	921	746	518	3,023	643	454	1,397	1,537	5,987	5,947			
FUNDING / BROKERAGE													
Forecast	0	0	0	0	0	0	0	0	0	0			
Actual	0	0	0	0	0	0	0	0	0	0			
COMBINED													
Forecast	921	1,792	3,809	4,696	5,566	5,142	4,953	5,449	7,935	8,985			
Actual	921	746	518	3,023	643	454	1,397	1,537	5,987	5,947			
	0	1,046	3,291	1,673	4,923	4,688	3,556	3,912	1,948	3,038			

Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting, 2nd March 2006

AGENDA ITEM NO.	2.2/Mar/06
PAPER	Performance Report
AUTHOR	Nick Cabon, Head of Performance and Information / Lorraine Bewes, Director of Finance 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 January 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 TO 31 JANUARY 2006

1. PURPOSE

The purpose of this report is to provide information about the Trust's performance for the period of April 2005 to January 2006. The Trust Board is asked to note the report and conclusions.

2. NEW PERFORMANCE FRAMEWORK

The Healthcare Commission has published broad guidance of the methodology for their new performance framework. The framework is called "The Annual Health Check" and replaces the star ratings from 2005/6 onwards.

The Annual Health Check incorporates several components that are assessed in a variety of ways. The components include a Declaration of Compliance with Core Standards, results of Acute Hospital Portfolio assessments, performance against national targets, and a detailed assessment of the Trust's financial management processes.

The Healthcare Commission published the detailed constructions of the new national targets in January 2006, and the Trust has developed project plans to ensure that we achieve the best possible performance. The project plans are included in the Appendices.

3. SUMMARY

A summary report for the targets is set out in Appendix A, and the other indicators are summarised in Appendix B. Each indicator has been given a banding based on the performance during 2005/6. There are also comments associated with each indicator. There are four possible outcomes for the targets – the indicator is deemed to be Fully Met, Almost Met, Partly Met or Not Met.

The Trust is on course to meet many of the targets, but there is still some work to do in a number of areas. There are also a few concerns amongst the other indicators, particularly those relating to the staff surveys and the clinical indicators.

4. HEALTHCARE COMMISSION TARGETS

The Trust is on course to meet most of the targets, but there are five areas that should be treated as a risk at this stage. These are Cancer, Thrombolysis, Rapid Access Chest Pain Clinics, Delayed Transfers of Care and Ethnic Coding.

5. CANCER INDICATORS

The actual reporting period for this indicator starts on 1st January 2006. The level of activity in the 62 day target is very low. Consequently, each breach carries significant weight.

The achievement of the 31 day target has been helped by the re-calculation of the expected activity levels. The Trust had been categorised as a medium sized hospital and was expected to treat 600 cancer patients each year. However, following discussion with the Cancer Action Team in the Department of Health the expected number of patients has been halved.

There weren't any breaches of any of the cancer indicators in January 2006, but the Trust must maintain its focus in this area.

6. THROMBOLYSIS

The Trust has provided thrombolytic treatment within one hour to 67% of eligible patients this year. The target for this year is 68%, so we are very close to being on course. However, the Trust has historically had very few patients in this area, and there is a possibility that this indicator will not be applicable to this Trust.

7. RAPID ACCESS CHEST PAIN CLINICS

The Trust had several breaches of this standard in January, and the performance to date dropped to 98.5%. The Trust cannot afford any more breaches this year if it is to achieve the target of 99%. The Trust has a specialist nurse who manages this service, and had arranged cover with the Royal Brompton Hospital for her leave period over the Christmas and New Year period. Unfortunately, the anticipated reduction in activity over the festive period did not materialise, and demand outstripped capacity.

8. DELAYED TRANSFERS OF CARE

The number of delayed transfers of care dropped for the second month running in January. A rate of 0.4% was recorded in January. This was achieved because a large number of patients were discharged over the Christmas and New Year period, and there weren't any delayed transfers in the first half of January 2006. Throughout the whole year the Trust's rate is 2.5%.

9. ETHNIC CATEGORY CODING

The Ethnic Coding target presents a significant challenge to the organisation. Only 76.78% of patients admitted in the first three quarters of the year had a valid ethnic category code recorded against them. The Trust contacted the remaining patients during January and asked them to identify their ethnic category. Many patients responded, and their details were updated and the rate has increased to over 80%. The Trust will continue to work towards the 95% target in this area.

10. TOTAL TIME IN A&E

The Trust performance from April 2005 to January 2006 was right on the target of 98%. Unfortunately, performance during February has slipped back, and we must ensure that the target is achieved for the remainder of this year.

11. OTHER INDICATORS

The Trust has historically performed at the average in the patient surveys with some areas of excellence. The surveys this year relate to adults who were admitted and children who were treated at the Trust. The results of the adult survey show that the Trust has improved as a whole and has not got worse in any area. The children's survey will be sent out later this year.

The Trust had been ahead of the trajectory for MRSA until last month, but there were 3 cases in January 2006 which put the hospital right on target.

Performance has been good in many of the other indicators. The Trust is on target to achieve the hospital cleanliness, better hospitals food, 12 hour A&E trolley waits and the workforce indicators.

The Trust is nearly on course in a number of other indicators, including those relating to patient complaints, and 4 hour A&E trolley waits. Extra focus is required to achieve the required performance levels for these indicators.

Performance in the clinical indicators relating to readmissions was below the average in December. One in five patients who were treated for a fractured neck of femur was re-admitted within one month, and 12.38% of all patients discharged were re-admitted within the same timeframe. It is difficult to predict the

actual levels of performance in these indicators because the Trust does not have access to data relating to patients who were subsequently admitted to other trusts.

As part of the Improving Partnerships in Health project the Trust has been looking at its use of resources. The aim of the project is to apply the lessons form the 10 High Impact Changes in order to improve the patient's journey through the hospital. There have been several efficiency gains as a result of this project. The Trust's average length of stay has been consistently lower than in 2004/5, and it continued to fall in January. There has also been a significant increase in the percentage of patients being admitted on the day of their elective admission. The rate in 2004/5 was 43.35% and the rate in January 2006 was over 62%

The Trust is ahead of the activity plan in most of the areas of the service level agreements. The exceptions are elective inpatients and excess bed days. In income terms the Trust is ahead of the plan in all points of delivery except excess bed days.

12. CONCLUSION

The cancer indicators remain high risks for the Trust and must be monitored very closely. Indicators on delayed discharges and Ethnic Category coding are also of concern. The performance in the Total Time in A&E standard is just on target at the end of January, so the Trust needs to achieve over 98% each month for the rest of the year.

The Trust has devised action plans to achieve the new targets that have been published by the Healthcare Commission. These plans will be monitored over the next few months.

Nick Cabon
Head of Performance and Information
22nd February 2006

New Performance Targets
Current Status and Action Plans

Access to genito-urinary medicine (GUM) clinics

Construction:
The number of patients attending GUM services who were seen within 48 hours of contacting a service divided by the number of patients attending the GUM service.

Actions:
Nick Cabon (NC) to enquire with the Commission for Healthcare Audit and Inspection (CHAI) if a patient is offered an appointment date but declines it are we still penalised or should adjustment be made?
NC to identify which activity return provides the source data for this indicator?
Steve Bullbeck to start collecting data relating to this indicator and to send it to NC for inclusion in the performance report.

Data quality on ethnic group

Construction:
The number of Finished Consultant Episodes (FCEs) for the trust on Hospital Episode Statistics (HES) with valid 2001 census coding for ethnic category (exclusing 'not stated' and 'not known') divided by the number of FCEs for the trust on HES.

Expressed as a percentage.

Actions:
Patients who did not have a valid ethnic category code were sent letters asking them to advise us of their code. HES extract will be refreshed for Q1 to Q3 by 17th February. General Managers (GMs) to action.
The 1976 Sexually Transmitted Diseases Act gives GUM patients the right to not give correct demographics. NC has asked CHAI whether they will make such an adjustment.

Drug misusers: information, screening and referral

Construction:
Trusts are assessed based on their responses to the following questions, designed to test compliance with the requirements outlined in chapters 1, 2 and 3 of 'Models of Care' Part 2:

1) Does the trust display up to date posters and have latest edition leaflets available about drug and alcohol issues including:
a) Health promotion messages
b) Harm reduction strategies in particular overdose prevention
c) Information on where to get help.

Answer: Yes.

2) Does the trust make available to patients up to date advice and information, relating to drug misuse and specifically covering:
a. The potential psychological and physical complications of drug and alcohol misuse
b. How to safely reduce and stop the misuse of various illicit drugs and alcohol
c. How to reduce the harms associated with drug and alcohol misuse
d. How and where to access help for problems associated with drug and alcohol misuse
e. How to access appropriate, related generic services (for example, housing department, sexual health clinics etc)

Answer: We have all of this, but it needs updating. This will be completed by the end of February. Nicola Hunt (NH) to action.

3) Does the trust maintain an up to date directory of local drug service provision for clinical use within A&E and maternity services?

Answer: Yes, but needs updating. This will be completed by the end of February. NH to action

4) Does the trust have a written protocol or policy for the initial screening and referral assessment of individuals using drugs presenting to A&E and maternity services, including locally agreed (with drug action teams) referral criteria and specifically covering:
a. Identification of drug and alcohol misuse problem
b. Identification of related or co-existent problems (for example, physical, psychological, social)
c. Identification of immediate risks (for example, self-harm, harm to others, physical and/or mental health emergencies)
d. An assessment of the urgency of referral

Answer: Yes, but needs updating. This will be completed by the end of February. NH to action

5) Are there joint working protocols in place between maternity services and DAT/NHS commissioned specialist drug treatment and care services?

Answer: Yes

Actions:
NH to provide evidence of the Trust's compliance in this area.

Emergency bed days

Construction:
The actual number of emergency bed days in financial year 2004/2005 minus the actual number of emergency bed days in financial year 2003/2004 divided by the actual number of emergency bed days in financial year 2003/2004.

Performance will be based on improvement between 2003/2004 and 2004/2005.

Actions:
NC has contacted CHAI to query the use of an indicator based on 2004/5 improvement in the 2005/6 assessment.
CHAI have confirmed that bed days resulting from maternity activity or transfers from other providers will be excluded from the analysis.

Infant health: data completeness

Construction

Numerator 1
The number of new mothers known to have initiated breastfeeding plus the number of new mothers known NOT to have initiated breastfeeding

Denominator 1
The number of maternities

Numerator 2
The number of women known to be smokers at the time of delivery plus the number of women known NOT to be smokers at the time of delivery.

Denominator 2
The number of maternities.

Overall Indicator:
A composite indicator reflecting the completeness of returned data on smoking in pregnancy and breastfeeding initiation.

Actions:
CHAI have advised us that this indicator covers the whole of this financial year – they had previously stated that it was based on a snapshot as of 31st March 2006.
Margaret Cronin has started to collect data relating to this indicator and has passed it to NC for inclusion in the performance report.

Obesity: identification and management in secondary care

Construction:
Trusts are assessed based on their responses to the following question:

As at March 31st 2006, does the trust have in place a management process for the identification and onward referral of adult inpatients (where clinically appropriate) with a body mass index of over 30, or over 27 with co-morbidity, to weight advice and management services (including specialist services), either within or outside of the trust? Yes/No

Action:
NC to convene a mmeting with all interested parties to ensure that the required process can be devised and implemented.

Participation in audits

Construction:
This indicator will be scored on a three point scale (0 - 2), scoring one point for answering 'Yes' and zero for 'No' to the questions listed below.

This indicator will assess the completeness of MINAP data and will measure:

a) whether a trust has greater than 90% completion for the 11 key fields in patients with an admission diagnosis of definite myocardial infarction, and

b) whether a trust took part in the annual (2005) MINAP data validation exercise.

Action:
NC to meet with Andrea Feegrade to confirm that the quality of the data that was submitted to MINAP was over 90% and that the Trust took part in the MINAP audit. By the end of February 2006.

Processes in place to ensure compliance with National Institute for Health and Clinical Excellence (NICE) guidelines on the treatment and management of self harm in emergency departments.

Construction:
Trusts will be assessed on the processes, systems and protocols they have in place to meet key requirements set out in NICE guideline 16, 'Self harm, the short term physical and

psychological management and secondary prevention of self harm in primary and secondary care, the assessment and initial management of self harm by ambulance services.'

The assessment will be carried out using a new data collection, including questions designed to test compliance with the following elements of the NICE guidelines:

1) That clinicians working in emergency departments have been trained in the use of mental health triage systems, ensuring that all patients who self harm have an assessment of their suicide risk using a validated system (ref 1.4.1.4)
Answer: Yes

2) That people who self harm are provided with clear and understandable information about the care process, both verbally and as written material in a language they understand (ref 1.4.2.2)
Answer: Yes

3) That children's and young people's triage nurses have been trained in the assessment and early management of mental health problems and, in particular, in the assessment and early management of children and young people who have self harmed (ref 1.9.1.2)
Answer: Yes

4) That the emergency department has worked in partnership with local ambulance and mental health trusts to develop locally agreed protocols for ambulance staff to consider alternative care pathways to emergency departments for people who have self harmed, where this is appropriate and does not increase the risks to the service user (ref 1.3.1.4)
Answer: Yes

5) All people who have self harmed should be offered a preliminary psychosocial assessment at triage or at the initial assessment following an act of self harm. Assessment should determine a person's mental capacity, their willingness to remain for further (psychosocial) assessment, their level of distress and the possible presence of mental illness (ref 1.4.1.5)
Answer: Yes

Actions:
NH to provide evidence of the Trust's compliance in this area.

Smoke-free NHS, recording of smoking status and reducing smoking

Construction:
Trusts will be assessed on their progress towards becoming smoke free by the end of 2006, in line with the process described in 'Guidance for smokefree hospital trusts'. Trusts that have yet to become smoke-free will be expected to demonstrate that they have robust and realistic plans to do so.

Trusts will be asked:

As at March 31st 2006, can the trust demonstrate that it has a smoke free policy in place, in line with 'Choosing health' and 'Guidance for smoke free hospital trusts' Yes/No

Note:
Smoke free means that smoking is not permitted anywhere within hospital buildings. No exceptions will be made for staff or visitors. For long stay mental health patients in an acute psychiatric state or terminally ill patients exceptions may be made on a case-by-case basis. However, no blanket exceptions will be allowed for particular categories of patients.

Answer: The policy has been approved, and there are no exceptions.

Part 2 Recording smoking status in adult inpatients

Trusts will be asked:

As at March 31st 2006, does the trust routinely record the smoking status of all adult inpatients? Yes/No

Answer: Yes, we do routinely ask patients their smoking status.

Action:
Louise Galloway and Sue Greenland to confirm.

Part 3 Reducing smoking in adult inpatients

Trusts will be asked:

As at March 31st 2006, can the trust demonstrate that it has in place an agreed management process for the provision of advice and onward referral of adult inpatients who smoke to NHS Stop Smoking services, either within or outside of the trust? Yes/No

Answer: We don't know of such a process of referral to stop smoking services.

Action:
New process to be developed – whoever records the smoking status also offers leaflets and onward referral. GMs to action.
NC to contact PCTs to ask for copies of leaflets and to identify who the stop smoking services are.

Trust Board Performance Dashboard - January 2006

Healthcare Commission Targets

Cancer	Improving	Ethnic Coding	No Change
A&E	Improving	Delayed Transfers	Improving
Elective Waits	No Change	MRSA	Getting worse
Outpatient Waits	No Change	RACPC	Getting worse
Bookings	Improving	CNST	Improving
Cancelled Operations	Improving	Thrombolysis	Improving

On track for most targets, but some significant areas of concern.

Operational Indicators and Targets

Hospital Cleanliness	Improving	Patient Complaints	Improving
A&E Trolley Waits	Improving	Hospital Food	Getting Worse
Clinical Indicators		Nurse Hours per Patient Day	Getting Worse
Information Governance	No Change	Average LoS	Improving
Day of Surg Admission	Improving		

Few areas of weakness. Significant improvement has been made in many of the operational targets (such as average LoS and Day of Surgery Admission.

Workforce Indicators - Currently under Development

Staff Surveys	Vaccancy Rate
Bank Spend	Agency Spend
Sickness Rate	

Service Level Agreement Performance

	Activity	Income
Daycase	3.07%	4.11%
Elective	-1.63%	1.17%
Elective Excess Bed Days	-12.09%	-11.16%
Regular Day Admissions	30.91%	17.23%
Non-Elective	7.70%	4.67%
Non-Elective Excess Bed Days	-20.83%	-8.08%
1st Outpatients	5.61%	1.79%
Follow Up Outpatients	10.92%	4.83%
Total	**6.68%**	**2.60%**

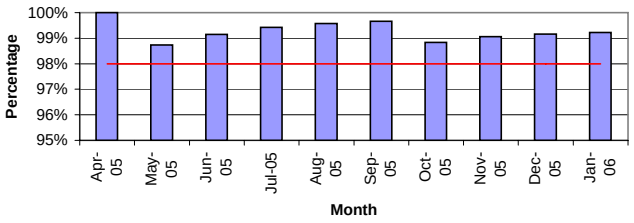
Overall performance is ahead of plan in both activity and income.

Key

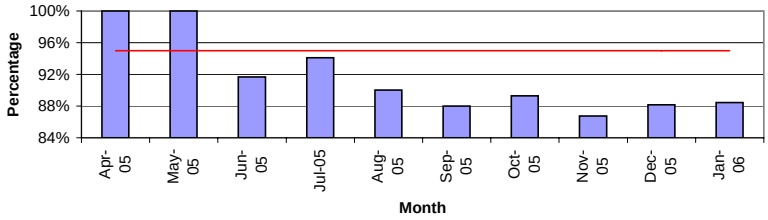
	The Trust is on track to meet this target
	The Trust is slightly off track towards this target
	It does not seem likely that the Trust will meet this t
	It is not possible to accurately assess performance

Graphs relating to New and Existing Targets

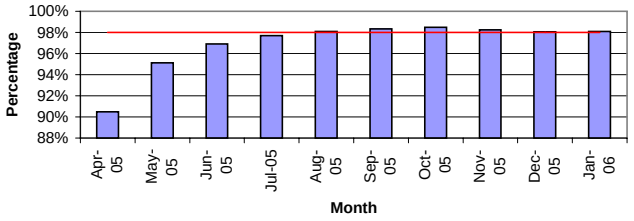
Cumulative Cancer 2 Week Wait Performance



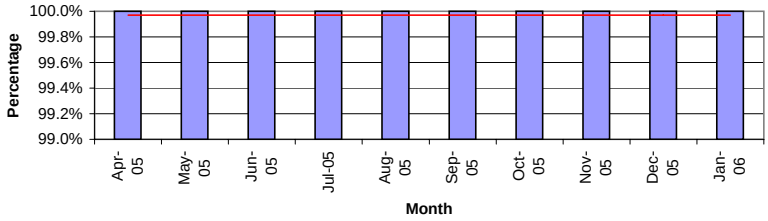
Cumulative Cancer 62 Day Wait Performance



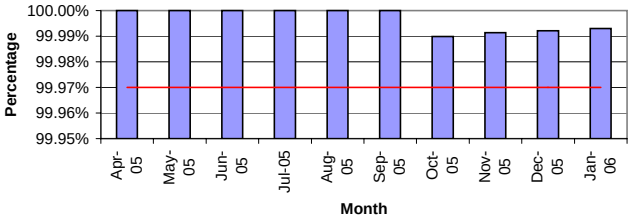
Cumulative Cancer 31 Day Wait Performance



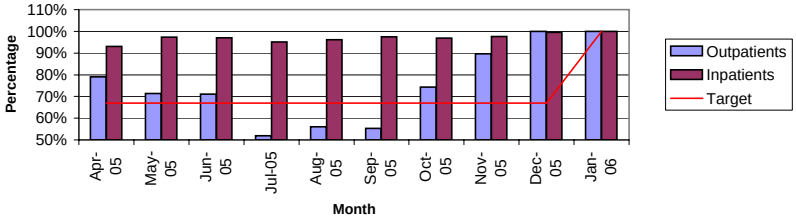
Cumulative Elective Inpatient Wait Performance



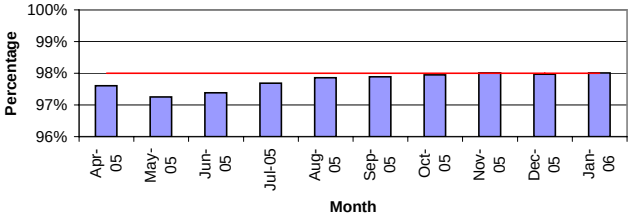
Cumulative Outpatient Wait Performance



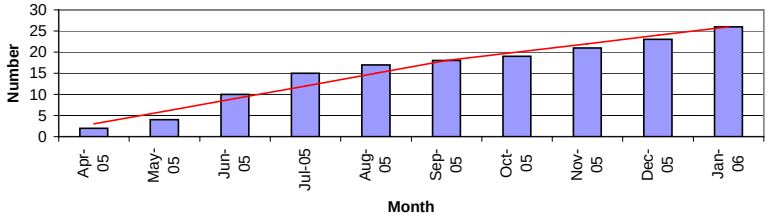
Monthly Booking Indicator Performance



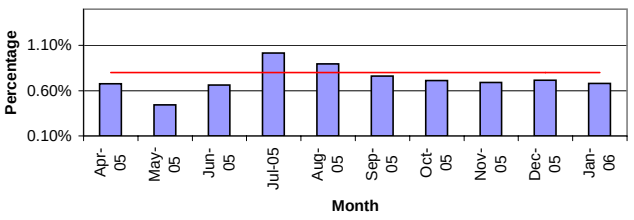
Cumulative Total Time in A&E Performance



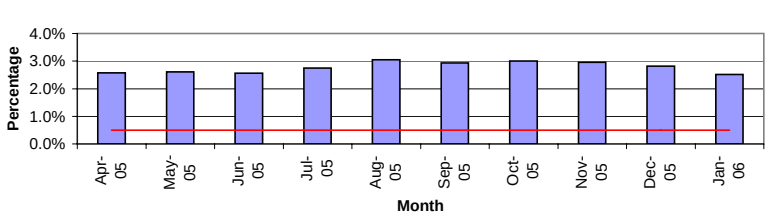
Cumulative MRSA Performance



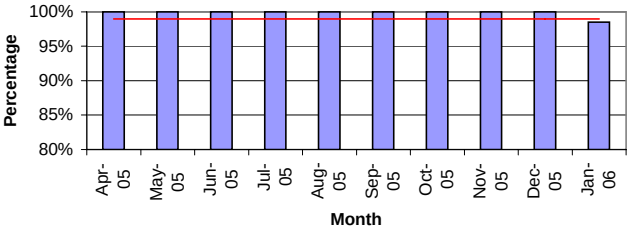
Cumulative Cancelled Operations Performance



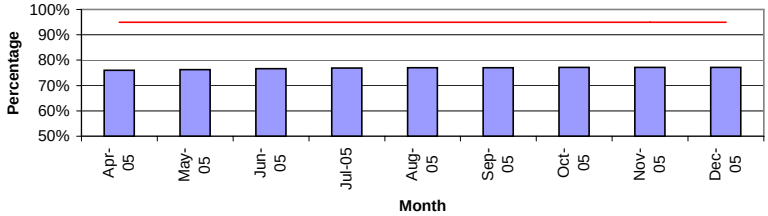
Cumulative Delayed Transfers of Care Performance



Cumulative Waiting Time for RACPC Performance

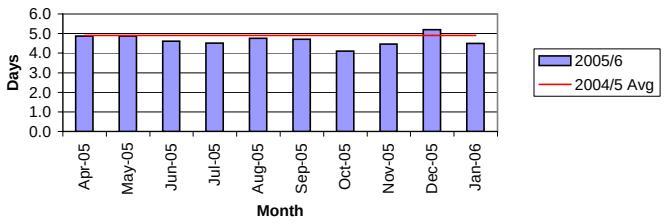


Cumulative Inpatient Ethnic Coding Performance

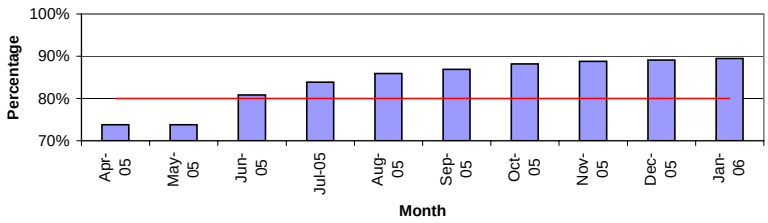


Graphs relating to Operational Targets

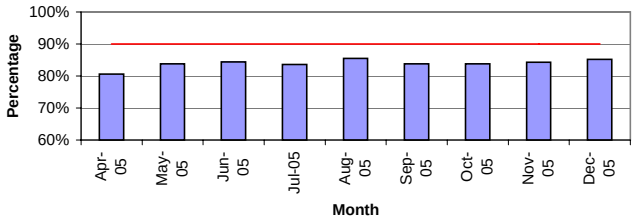
Average Length of Stay



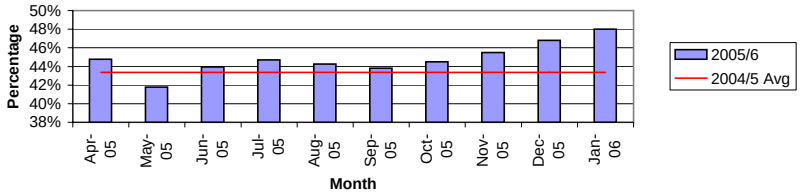
Cumulative Hospital Cleanliness Performance



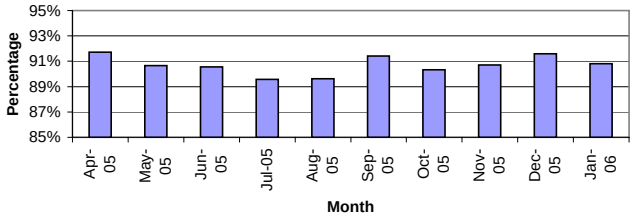
Cumulative Patient Complaints Performance



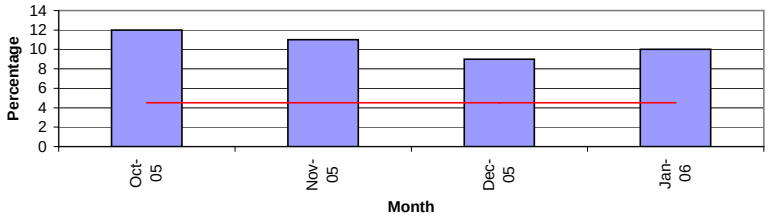
Cumulative Elective Admissions on Day of Surgery



Cumulative Bed Occupancy



Nurse Hours per Patient Day



(Data Quality still to be validated in this area)

Service Level Agreement Performance

Activity				
	Plan	**Actual**	**Variance**	**% Variance**
Daycase	12692	13081	389	3.1%
Elective	#REF!	#REF!	#REF!	#REF!
Elec Excess Bed Days	#REF!	#REF!	#REF!	#REF!
Regular Day Admissions	2337	3059	722	30.9%
Non-Elective	#REF!	#REF!	#REF!	#REF!
Non-Elec Excess Bed Days	#REF!	#REF!	#REF!	#REF!
1st Outpatients	49624	52410	2786	5.6%
Follow Up Outpatients	136633	151550	14917	10.9%
Total	**#REF!**	**#REF!**	**#REF!**	**#REF!**

Excludes Well Babies and HIV/GUM

Income				
	Plan	**Actual**	**Variance**	**% Variance**
Daycase	£ 8,325,480	£ 8,668,008	£ 342,528	4.1%
Elective	#REF!	£ 8,532,910	#REF!	#REF!
Elec Excess Bed Days	#REF!	£ 875,620	#REF!	#REF!
Regular Day Admissions	£ 284,438	£ 333,449	£ 49,010	17.2%
Non-Elective	#REF!	£ 43,145,738	#REF!	#REF!
Non-Elec Excess Bed Days	#REF!	£ 4,213,331	#REF!	#REF!
1st Outpatients	£ 10,583,597	£ 10,773,483	£ 189,886	1.8%
Follow Up Outpatients	£ 15,142,838	£ 15,874,735	£ 731,897	4.8%
Block	£ 20,439,878	£ 20,439,878	-£ 151,111	-0.7%
Total	**£ 110,001,040**	**£ 112,857,153**	**£ 2,856,114**	**2.6%**

Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting, 2nd March 2006

AGENDA ITEM NO.	3.1/Mar/06
PAPER	Corporate Planning update
AUTHOR	Elliot Howard-Jones Contact Number: 020 8846 6823
SUMMARY	This purpose of this report is to update the Board on the progress of the Corporate Plan for 2006/07.
BOARD ACTION	The Board is asked to discuss this paper.

Corporate Planning Round: 2006/07

Progress update

Introduction

The corporate planning process is integral to the plan to deliver the levels of activity specified in the capacity plan, which is a key component of the Service Development Strategy.

The capacity identified in the plan incorporates the moves towards national averages in provision of care, including benchmarked new to follow up ratios in outpatients.

The levels of activity identified in the capacity plan must be delivered net of the Cost Improvement Programme of the Trust, identified by costing the activity identified at National Tariff.

The Corporate Plan will specify the processes by which these changes are achieved, and allow monitoring of progress throughout the year.

Components of the Corporate Planning Process

In addition to the assumptions of the capacity plan, the process must take into account the requirements of previously submitted plans to Monitor, targets specified by the Healthcare Commission, and improvements the Trust needs to make to maintain its competitive advantage.

These requirements are outlined below.

Service Development Strategy

The key document for the 2006/07 plan is the Service Development Strategy (SDS). A significant amount of work was put into this plan, and it forms the basis of our application for Foundation Trust status, and the feedback from Monitor on this plan has been acceptable.

I have highlighted for directorates the key deliverables from this plan for 2006/07.

2005/6 Corporate Plan

An important part of the process this year is to link to the 2005/6 Corporate

Plan. The first part of this highlights successes in the plan, and key achievements of the last year. The second element assesses plans contained within the plan for relevance to the SDS, and updates those plans for which there is still a continued relevance, and discontinues plans which no longer match the direction of travel of the SDS.

Quality, Reputation and Patient Choice

It is essential to build in plans for how we are perceived as an organisation. Patient choice is now an important part of the NHS landscape, and we need to ensure that we maintain our status as provider of choice with our GPs and patients. This has a number of facets:

- Quality – there is clearly a high focus on the clinical quality of the services that we provide, as well as the cleanliness of the building – we can build on our reputation through the acquisition of CNST level 3
- Patient choice – understand what matters to patients when choosing this hospital, and become more patient focused in our approach
- Public involvement – the Members Council of the Foundation Trust will have a key role as our link to the community, and developing that relationship will be key to our success as a Foundation Trust
- Strategic partnerships with other organisations – we will need to continue to develop relationships with our key PCTs over the coming year, and work with them on their growing public health and prevention focus. Vertical integration of services, particularly around the long term conditions work will also be essential.
- Staff attitudes – we need to mobilise the positive attitude of staff, both to the public and to the organisation to achieve these changes
- Communication – Directorates will need to have a plan for improving the quality and reliability of communication with both patients and GPs, both in regular correspondence and improving access to information about us as an organisation.

Annual Health Check

The annual health check is the system for assessing the performance of healthcare organisations in England. It is designed to give the public a more accurate picture of local NHS healthcare organisations, whilst reducing overlap and duplication in the regulation of healthcare providers, as inspections, audits and reviews are focused where they are most valuable.

The new system looks at a much broader range of issues in the assessments, and Directorates will need to have plans to continue to meet existing targets, with particular focus on targets which may be difficult to achieve in 2006/07, and those targets that are new next year.

A summary of requirements for the annual health check has been circulated to Directorates as part of the process.

Capacity Planning

A summary of the capacity plan that has been built to support Foundation Trust planning for 2006-07 onwards has been circulated to all Directorates. Directorates are planning on the basis of delivering this level of activity over the next financial year and financial plans will also reflect this.

The capacity plan includes moves towards National Benchmarks for service delivery, and the assumption is that activity will be delivered through improvements in efficiency. Where the capacity plan assumes increases in activity beyond the level achievable through efficiency gains then directorates are required to submit a business case for any additional investments.

The capacity plan also shows those areas where a reduction in activity is expected. Where this is the case, the directorates cash releasing savings plans are required to include reductions in cost associated with reducing levels of activity. In some cases it will be necessary to consider radical service restructuring to deliver the additional savings.

Benefits Realisation

For any new developments, there will have to be quantified costs and benefits. Any developments must therefore be linked to the benefits they bring, in activity, financial and quality terms. Directorates will ensure that activity is there to cover any development, and that new developments are covered by the expected income received under Payment by Results, and that this is built on reasonable expectations of PCT affordability.

The directorates are also required to make sure that service redesign is factored into the planning process, and that quantifiable savings are made from this redesign.

How does the process fit in with the FT process?

The Corporate Plan is not required for the authorisation process to become a Foundation Trust, but is used annually by Monitor as a tool to regulate the Trust.

We will be required to submit an annual plan, which will include a three year strategic outlook, financial projections, a membership report and will include verification that Board has considered these issues. Throughout the year, Monitor will require us to submit monitoring reports and risk analysis information against this plan, and this will be a key part of their regulatory and compliance framework.

The budget setting process

The budgets for 2006-07 will be set in accordance with the capacity planning assumptions and service developments set out in the SDS with appropriate mechanisms to manage any risk arising from contracting with PCTs at a lower activity level than the capacity plan and the impact of the new operating framework.

Work carried out during the PbR rebasing exercise suggested that the Trust may gain income under the national tariff however, this was calculated using the "interim" tariff and before the tariff deflator was applied. Once the tariff has been re-issued, it will be possible to calculate the actual income the Trust will receive for delivering the activity in the capacity plan and to confirm the savings target for directorates. Until then, directorates have been asked to assume a minimum of 2.5% savings target for 2006-07.

Overview of the process

Guidance has been issued to directorates as outlined above to aid with the production of their plans. It is important that there is wide consultation within the directorates about the plans submitted, not only as buy-in to the plan is important, but also as observations from the front line may give key indications of what may make a real difference to perceptions of patients who use the hospital.

In line with this, all staff in the Trust have been invited to Business Planning seminars on key topics within the plan, and within that have been given opportunities to input with their perceptions of the service, and how this may help us to achieve improvements in service delivery and financial viability in the coming year.

The directorates are currently working on their plans for the coming year, with the aim of completing a first draft of each directorate plan by 17th March. This will allow time to refine the plans in time for the Board Meeting at the beginning of April.

Conclusion

The Board are asked to note the contents of this update, and to comment on future direction and progress to date.

Elliot Howard-Jones
Interim Director of Strategy and Service Development
22nd February 2006

Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting, 2nd March 2006

AGENDA ITEM NO.	4.1/Mar/06
PAPER	Information and Data Quality Policy
AUTHOR	Nick Cabon, Head of Performance and Information Lorraine Bewes, Director of Finance and Information Contact Number: 020 8846 6713
SUMMARY	This policy sets out a clear framework for increasing and maintaining high levels of data and information quality within Chelsea and Westminster Healthcare NHS Trust.
BOARD ACTION	To approve the policy.

Chelsea and Westminster Healthcare NHS
NHS Trust

Information and Data Quality Policy

Release: Version 1.6

Date: December 2005

Author: Jason Cockerton

Ownership: Data Quality Group

Document History

This document was formerly the Information Quality Policy; it has undergone extensive revision.

Document location

Hardcopy of this document is only valid on the day it was printed.
When approved the source of this document will be found on the Trust intranet.

Revision History

Date of this revision: December 2005
Date of next revision: December 2006

Revision Date	Previous version number	Previous Revision Date	Summary of Changes	Changes Marked
December 2005	Draft 2	n/a	Extensive revision to content and format, no real elements or previous version left. Version number format change from integers to decimals.	No

Approvals
This document has the following approvals.

Name	Title	Date of Approval	Version
Nick Cabon	Head of Performance and Information	14/12/05	Draft 1.3
Data Quality Group	Chair	20/12/05	Draft 1.4
Information Governance Steering Group	Director of Finance and Information, Director of IM&T	27/01/06	Draft 1.5
Trust Board or Audit Committee	Chair		v1.6

Distribution
This document has been distributed to:

Name	Date of Issue	Version
IM&T Steering Group		v1.6
All Employees at Chelsea and Westminster Healthcare Trust via the Trust Intranet		
Finance and Information Department, EPR Team and all Clinical Directorates via Hardcopy		

This Policy is applicable to all employees at Chelsea and Westminster Healthcare NHS Trust

Contents

Section 1: Introduction

Back to Contents

The aim of this document is to set out a clear policy framework for increasing and maintaining high levels of data and information quality within Chelsea and Westminster Healthcare NHS Trust. This policy reflects the Trust's commitment to raising data quality standards for the collection and reporting of information for operational, performance and billing purposes. High quality data enables the Trust to accurately process and report its levels of activity information for Payment by Results (PbR), which in turn increases its effectiveness in providing higher quality care to patients.

Section 2: Policy Statement

Back to Contents

The Board of Chelsea and Westminster Healthcare NHS Trust directs that Information Quality Assurance (IQA) shall be given a high priority in the operation of the hospital and care delivery.

The Trust Board recognises that requirements for information quality differ according to the required currency and accuracy of the data concerned. For this reason, the Board seeks to establish an information quality system with the fundamental objective of satisfying and maintaining prescribed standards of quality and integrity of information used in scheduling, delivering and transferring responsibility for health care within the Trust and with our care partners across care settings.

Information quality must operate across all our activities. We will need to ensure that delivery of quality information is designed into current and future activities. We need to ensure that in decommissioning activities we do not destabilise information services to patients, significant others and our staff delivering health care.

The Trust is making available adequate funds, facilities, staff and resources to implement and maintain this policy.

Information Quality is the concern of us all and the Board has designated the Head of Information and Performance to be responsible for Information Quality Management and to organise and supervise attaining level 3 in the Trusts Information Quality Assurance as measured by the Information Governance Toolkit.

The principles set out in this policy are applicable to any information system owned, used or managed by the Trust, whether they use paper, computer or other media (film, tape etc.). However the focus will be on the LastWord Electronic Patient Record (EPR) system and any other clinical computer systems from which the Commissioning Data Set (CDS) and performance information is extracted.

This policy defines roles and responsibilities and establishes the routes to be followed in improving, maintaining and monitoring data and information quality and will be made available on the Trust's Intranet.

The principal owner of this policy is the Data Quality Group, the terms of reference of which can be seen in appendix A. The policy will be reviewed annually or sooner if required, to ensure the policy always reflects the latest local and national guidance.

Section 3: Information Quality Assurance Standards

Back to contents

Information Quality Assurance is an initiative within Information Governance. The Trust's Information Governance is assessed annually via the Information Governance Toolkit and forms part of the Annual Health Check which replaces the Star Ratings as the national performance indicator.

This policy is written to abide by the following IQA requirements (follow links for full guidance):

Req.	Information Governance level 3 Description
301	The Trust has allocated responsibility for Information Quality Assurance appropriately within the Trust, including corporate responsibility at Board level, and these are reflected in all relevant job descriptions. Individuals are actively engaged in initiatives to monitor and improve Information Quality, and are held accountable for the success of these.
802	The Trust has documented procedures that are available in all locations to cover the capture and recording of patient information, and which are reviewed and kept up-to-date.
804	The Trust has written procedures for reviewing and validating all waiting lists to ensure that lists do not include patients who are no longer awaiting admission or appointment; these are agreed by the Trust Board (or delegated sub-committee), and there is a process of audit of the effectiveness of these procedures.
911	The Trust has comprehensive procedures in place to ensure that there is no adverse impact on information quality when new services are provided, or where changes within the system are made, and compliance with these is monitored and enforced.
2802	The Trust has audit trails on key systems which link individual data items to individual input staff and these are regularly used to follow up data quality issues.
4300	The Trust has key patient based systems incorporating NHS standard definitions and values, which have validation programmes, that conform to NHS Standards built in. These are kept up-to-date, and maintained so that they cannot be switched off or overridden by operational staff. There is regular audit of the output of validation programmes to ensure that errors are identified and acted upon.
4301	The Trust has procedures to check a NHS Number using the validation algorithm on receipt or where the Number has been input manually and to validate NHS Numbers that fail the algorithm or are without a "01" status indicator. Compliance with these procedures is monitored, and this is formalised in at least one individual's job description.
5800	There are processes for monitoring data collection activities to ensure procedures are followed, including sample checking to ensure events have not been missed, and these are carried out regularly in every area.
5801	The Trust local documentation does reference national data standards, and there are effective arrangements for updating this as national data standards develop. The effectiveness of these arrangements is monitored.
6001	The Trust has submitted its Patient Care Datasets to ClearNET on a monthly basis and has remained within the required national quarterly deadlines on all the last four quarters.

Req.	Information Governance level 3 Description
6300	The Trust uses external data quality reports to monitor data quality and produces regular reports which are submitted to the Trust Board (or delegated sub-committee) and feed into action plans for improvement. These action plans are signed off by the Trust Board (or delegated sub-committee) and appropriately resourced.
6301	The Trust has agreed timescales for the correction of errors and omissions identified by validation and internal queries, and these are consistently met.
6302	The Trust staff routinely check information about patients with the source, and corrections are routinely made to all appropriate patient records, and compliance with this is monitored.
6303	The Trust analyses trends in information over time, and, where appropriate, corrects information before official submission of data or returns. These duties are included formally in appropriate job descriptions.
7302	The Trust has established procedures for the regular audit of clinical coding, and within the last twelve months has had an external clinical coding audit based on the requirements and standards within the 'Data Quality Audit Framework for Coded Clinical Data' and undertaken by staff registered on the national approved list of clinical coding auditors. The overall % accuracy score was greater than or equal to the levels indicated in the guidance document.
7303	The Trust has documented procedures and has a regular audit cycle to check the accuracy of patient data and the audit covers all key data items identified in the guidance document. The results of the audits are reported as part of the Trust's data quality reviews to the Trust Board, and the accuracy checks form part of the Information Governance Policy and are reflected in the terms of reference of an Information Quality monitoring group.
7306	The Trust has completed the Completeness and Validity check for each data group as detailed in the guidance document, and has achieved the standard required for attainment level 3 on all three data groups.
7310	The Trust does involve clinical staff in validating information derived from the recording of clinical activity. There is a steering group (or senior individual) within the Trust with responsibility for monitoring the effectiveness of this process.
8800	The Trust has (or accesses) a formal targeted programme for all staff involved in the collection and management of patient related data on all key systems and this is maintained and its effectiveness routinely audited.
8802	The Trust uses training programmes for clinical coders that are comprehensive and cover all relevant clinical coding using national standard training materials, and staff are offered refresher and update training at minimum every two years.

Section 4: Responsibilities

Back to Contents

The Director of IM&T is the executive lead for Information Governance and is a member of the Information Governance Steering Group which the Data Quality Group feeds into. The Director of Finance and Information has board level responsibility for data quality and is a member of the Information Governance Steering Group.

The individual General Managers supported by the person responsible for performance management are responsible for the quality of the data captured within their directorates, and have responsibility to:

- Develop and implement data capture procedures
- Determine and resolve causes of poor data quality
- Determine the training needs in respect of data capture of their staff

The Head of Booking and Choice supported by their deputy has responsibility for:

- Maintaining the Access policy and procedures
- Determining and resolving causes of poor data quality
- Determining the training needs of their staff in respect of data capture

The Head of Pharmacy has responsibility for:

- Determining and resolving causes of poor data quality
- Drug expenditure

The Data Warehouse Manager supported by the Information & Systems Project Analyst has responsibility for:

- The development and maintenance of data warehouse procedures
- The population of the Commissioning Data Set (CDS) on a monthly basis.
- Investigation & resolution of any discrepancies highlighted by the Information Departments reconciliations.
- Ensuring the Commissioning Data Set is submitted to ClearNET, and in future Secondary user Service (SUS), within the required monthly and quarterly deadlines.

The Head of Performance and Information, supported by the Information Governance Officer has overall responsibility for:

- The Trust's adherence to IQA standards
- Setting up and supporting the Data Quality Group
- Developing and implementing the Data and Information Quality Policy
- Internal performance monitoring of data quality

The Head of Performance and Information, supported by the Information Department is responsible for:

- Internal Performance monitoring of information quality
- Producing the Service Level Agreement (SLA) data warehouse activity extract on a monthly basis.
- Determining and resolving causes of poor information quality
- The reconciliation of the monthly CDS extract against the SLA data warehouse activity extract.
- The reconciliation of the statutory returns against recorded activity within the data warehouse.
- Ensuring statutory returns are submitted to the Department of Health within the required deadlines.
- Determining the training needs in respect of information reporting of the information Department staff.

The Data Protection Act requires that personal information relating to an individual is accurate and up to date. Therefore it is a contractual obligation of members of the Trust including staff, contractors and suppliers to ensure that data where possible is captured accurately.

Appendix A

Data Quality Group

Terms of Reference

The key role of the Data Quality Group is to co-ordinate all data quality activities into a trust wide framework that will aim to:

- Ensure core work is carried out to improve the quality of data collected.
- Implement a programme of monitoring and improvement.
- Provide timely, valid and complete data for population of the Commissioning Data Set (CDS) and for Payment by Results (PbR).
- Meet National Requirements:
    - Performance Indicators/Annual Health Check
    - Statutory Returns and Data Sets
    - Data Protection Act

Responsibilities:

- Identify key targets and associated areas for improvement.
- Develop and implement a strategic action plan to meet these targets.
- Identify resource implications in respect of the action plan and develop proposals to support any shortfalls.
- Develop an Information and Data Quality Policy for the Trust incorporating an accountability framework detailing roles and responsibilities and defining the principles of data ownership.
- Ensure that where appropriate detailed trust wide policies and procedures are in place in respect of data collection.

Accountability:

The Data Quality Group is a working group accountable to the Information Governance Steering Group that is chaired by the Caldicott Guardian and meets at a minimum once a month.

Membership:

The Data Quality Group to be composed of the following people:

Director of Finance and Information	Lorraine Bewes
or Director of IM&T by rotation	Alex Geddes
Head of Performance & Information	Nick Cabon
Information Governance Officer	Jason Cockerton
Senior Clinical Coder	Jo Newman
Data Warehouse Systems Manager	Sharon Thompson
EPR Analyst	Mary Coplestone-Boughey
Head or Deputy of Booking and Choice	Debbie Ensor-Dean/Mike Delahunty
Directorate Acting/General Managers	Kate Hall
or nominated deputies	Sherryn Elsworth
	Claire James
	Nicola Hunt
Directorate Performance Managers	Darren Duffield
	Louise Galloway
Deputy Nursing Director	Sharon Terry
Deputy Director of Finance	Jon Bell
Medical Records Manager	Symeon Bagias
Outpatients supervisor	Liz Barnshaw
Nursing EPR Co-ordinator	Post empty deputy to be nominated
Director of Operations	Edward Donald
Radiology Manager	Alan Kaye
Head of Therapy Services	Douline Schumann
Head of Pharmacy	Karen Robertson
Endoscopy Manager	Charlotte Carne
Lead Ward Clerks	
Lead Outpatient Clerk/Supervisor	
Impact Lead	Catherine Andrews

Glossary

IQA	Information Quality Assurance
CDS	Commissioning Data Set
PbR	Payment by Results
SLA	Service Level Agreement
IM&T	Information Management & Technology
SUS	Secondary Users Service
NHS	National Health Service

Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting, 2nd March 2006

AGENDA ITEM N°	5.1.1/Mar/06
PAPER	Assurance Framework
AUTHOR	Vivia Richards, Head of Clinical Governance
SUMMARY	The Trust is continually expanding its capacity to create desirable outcomes, where challenging priorities are considered, where innovative aspiration is encouraged, and where teams continually striving to deliver the corporate objectives together. The Assurance Framework allows the Trust to identify risks which might hinder delivery of the corporate objectives. By managing the gap between the corporate objectives and reality, recognising structural tensions (gaps in assurances) and other constraints, and our own capacity (or lack of it) with regard to them, the Trust can effectively manage and work toward limiting risks in order to better achieve its corporate objectives. The Assurance Framework was reviewed by the Trust Board in April 2005 and August 2005, and relevant sub committees of the Board in year. This update is in line with the scheduled 6 month review, intended to provide the board with evidence based assurances on the way in which the organisation is managed at a strategic level. The Trust Board is asked to note the updates to the Assurance Framework. Positive assurances against identified risks linked to each corporate objective along risk mitigation updates, reported by Executive Leads, provides evidence that the Trust is managing the risks relating to the corporate plan effectively. Risks have been re-graded the light of additional information provided by Executive Leads.
ACTION	The Board is asked to consider each report and confirm that sufficient assurance has been given to enable Board members to sign the declaration. It is recommended that the printed submission, which will include commentaries received from our partners, is signed by members of the Board and posted to the Healthcare Commission.

Assurance Framework Update Report
Trust Board 2nd March 2006

A/F Ref No	Principle Risk	Risk Mitigation Update	Initial Risk	Rescored Risk	Lead
1.2.2	IT infrastructure may not capture the diagnostic wait information in Statistical Process Control (SPC) format (mean is currently used as indicator for waits)	The diagnostic wait times have been investigated. For imaging the system has been set up using Enterprise Scheduling. Because of the way processes have been established the request is not recorded until the patient presents. As a result the time from request to result is not available. Further work is being undertaken to resolve this difficulty. When times can be calsulated it will be possible for the mean and standard deviation to be calculated as required by the SPC technique.	20	12	AG
1.5.2	Information systems do not support identification of patients and monitoring of patient journey	Patients can be identified by patient number, surname and other data. The ADT Log provides history of contact with care in the Trust.	20	0	AG
2.3.5	Information technology systems do not support audit programmes eg Cancer audits	A number of cancer logs have been developed for MDT support.	15	4	AG
2.4.2	The Trust wide training database will not provide the information and follow up needed for mandatory training	This has been developed and is subject to changing requirements.	16	4	AG
3.1.4	Website not utilised as a medium for feedback	Feedback is on the WWW Trust Home Page as is Foundation Trust Membership.	9	0	AG
4.1.2	Risk that all staff are not familiar with scope and extent of information governance	A set of web training has been created and will be published by FY end. EPR training has been strengthened to cover information governance and data quality. Information governance is a topic area in the Intranet.	6	6	AG
4.1.3	Information not required for clinical care is collected without explicit patient consent	The patient is informed of use of information and can explicitly refuse its use although this has a serious effect on treatment. If non pseudoanonymised data is to be used for purposes other that patient care the patient is informed and policies exist on this.	8	0	AG
4.2.1	Inability of Connecting for Health to engage with the Trust in realistic timescales	This risk is outside the control of the Trust. The risks are being managed through GE who have subsumed IDX, CCA, CfH and the KCW Care Community on a weekly and more frequent basis by a wide range of staff including Executive Directors.	16	16	AG
4.2.2	Lack of clear timeline for adoption	As for 4.2.1 with which this should be merged.	16	16	AG
4.3.1	Suppliers of legacy systems are unable to deliver additional functionality	In September 2005, the Trust implemented LastWord Step Release 4.5.3 with added functionality in prescribing, maternity, document management, Dictation and Inbox. The PICIS Theatre Management System is in parallel running with the Theatreman system that it will replace and is working with TSSU's instrument tray tracking system. Agreement has been reached on piloting a bed management system in mid-2006. The PACS project is underway and is rationalising the commercial arrangements for procurement. A project has started to obtain National Spine compliance by GE and to implement full Choose and Book	12	3	AG
4.3.2	Risk that internal systems will not survive until the care record service is available	See 4.3.1	9	3	AG

Assurance Framework Update Report
Trust Board 2nd March 2006

A/F Ref No	Principle Risk	Risk Mitigation Update	Initial Risk	Rescored Risk	Lead
4.5.2	Lack of IT solutions to support agenda	See 4.3.1	20	3	AG
4.7.2	Trust website newly developed and service information not current	A great deal of effort has been made to ensure currency and keep the site in line with Trust initiatives - see www.chelwest.nhs.uk.	15	3	AG
5.6.3	Database will not function fully and capture information required	The training database is in use and functions as originally specified.	20	0	AG
7.4.3	Risk that IT systems will not capture information required and that focus will be placed on easy to collect data areas rather than areas of poor performance	There is a specific programme to ensure that data is fit for purpose and all areas of the Trust are treated equally. The data warehouse is used for clinical and corporate modelling.	20	3	AG
1.1.1	Lack of awareness and understanding of 'Essence of Care' priorities	Essence of Care steering group established, EofC key topic at each quarterly staff working conference, reports on EofC carried in Trust News, 'champions' identified for documentation, nutrition and privacy and dignity.	3	2	AMacC
1.1.2	Lack of action taken to address areas of concern highlighted in the patient feedback national patient surveys	Action plans agreed and implemented with the Emergency Department and Out Patients Department reflecting key finding from the national patient surveys.	8	4	AMacC
1.11.3	Clinicians may not change practice to support objective	Monitoring of Estimated Date of Discharge implemented in January 2006. Dr Foster database available to clinicians.	12	7	AMacC
1.8.1	Significant isolated MRSA outbreak would dramatically affect infection rates	All MRSA bacteraemia are reported and investigated and untoward incidents and improvement actions agreed between IC team and clinical area.	9		AMacC
1.8.2	Failure to improve infection practices relating to long lines and cannulas	Plan of audit and training established in respect to lines and cannulas overseen by the IC team and IC committee	6	5	AMacC
1.9.2	Failure to recruit Nurse Consultant and nurse specialist post for older people	Consultant taking up post in April 2006-02-22	6	2	AMacC
2.1.1	Systems and processes may be inadequate to deliver the agenda		9		AMacC
2.1.3	Capacity owing to a growing agenda and an inability to recruit to clinical governance team members and directorate leads		8		AMacC
2.4.4	Medical device training will not be sufficient in terms of amount and availability at a multi professional level	CNST level 2 achieved which assesses medical device training. Training database established.	20	10	AMacC
2.4.5	The provision of patient information is inadequate in terms of amount and content	Information on medical conditions now available on Patient Line system, Director of Communications and PPI Coordinator appointed Feb 2006.	20	15	AMacC
3.1.1	Actions from 1000 good ideas may not be followed through or communicated fully to users and staff	Action form 1000 Good Ideas reviewed and reported to Board and communicated through Trust News.	6	0	AMacC
3.1.2	Lack of regular engagement with foundation status membership could result in disengagement	Plans to 'refresh' Shadow Membership initiated in 2005. Shadow Membership was invited to AGM Open Day, to participate in EofC and Patient Accelerating Change workshops. All members have received a Membership Pack.	6	1	AMacC

Assurance Framework Update Report
Trust Board 2nd March 2006

A/F Ref No	Principle Risk	Risk Mitigation Update	Initial Risk	Rescored Risk	Lead
3.1.3	Links with PPI forum are currently not well established	Quarterly meeting with CE and Chairman established.	9	7	AMacC
3.1.5	Actions from complaints and comments cards not incorporated into directorate plans	Engagement and Partnership group established information and guidance given to Directorates at the start of business planning.	6	3	AMacC
3.1.6	Failure to implement key actions in the Trust's Patient and public engagement strategy	Engagement and Partnership steering group established, PPI coordinator appointed.	3	2	AMacC
4.7.4	Lack of contact with our shadow foundation members	Plans to 'refresh' Shadow Membership initiated in 2005. Shadow Membership was invited to AGM Open Day, to participate in EofC and Patient Accelerating Change workshops. All members have received a Membership Pack.	5	1	AMacC
1.11.1	Diagnostic waits will not deliver a fast enough service	see update relating to 1.2.3.	H12		ED
1.11.2	Inadequate access to intermediate care and rehabilitation.	Increased provision of community rehabilitation services. Pressure remains in relation neurological and frail elderly intermediate care services. Maintained last years delayed discharge improvement at 2.5%. Development of Ellesmere House will increase by 5 the PCT/ social services funded places, available from 2007/08.	H12		ED
1.2.3	Diagnostic waits will not support the target	MRI and CT currently meet the maximum 26 week wait with performance tracked through the monthly Performance report. Pathology SLA to be developed and signed-off with HHT by April 2006, with turnaround times included. Physiological measurement tests provided by other Trusts (e.g. lung function) to be reviewed during 2006/07 with turn-around times included in SLAs that support the stepped reduction towards an 18 week maximum wait.	12		ED
1.2.4	Choose and Book service not available or too many patients choose Chelsea and Westminster Hospital (C&W)	Project plan, benefits realisation and timetable to be developed by March 2006 to deliver Full Booking at C&W, aiming for implementation by September 2006. Capacity will be increased where further efficiency gains not possible to accommodate additional referrals. If demand rises to a level where maximum waits are not maintained, C&W will be removed from the GPs Choice list until the backlog of activity is cleared.	8		ED
1.2.5	Insufficient bed/theatre capacity at C&W to deliver 18 weeks	Capacity plan of bed/theatre etc. Efficiency improvement programme. Ask Nick Cabon re tracking. Which group - Pisces about to go live. Demand work with PCT to reduce demand through out of hours primary care. GM Bed Days: Long term conditions, changing models. Stepped care into primary care. Re-inforced by PBR	12		ED

Assurance Framework Update Report
Trust Board 2nd March 2006

A/F Ref No	Principle Risk	Risk Mitigation Update	Initial Risk	Rescored Risk	Lead
1.3.3	Continuing increase in demand for A&E services	A&E attendances are projected to increase from 91,000 in 2004/05 to 95,000 in 2005/06 with the most significant increase in paediatrics.In paediatrics GPs have been notified that the department will no longer undertake routine phlebotomy requests from GPs and these will be returned or re-directed to paediatric outpatients as clinically indicated. Also, paediatric A&E review slots have been reduced from 6 to 2 per day with all other patients discharged back to the care of their GP. K&C PCT planning to make better use of under-utilised capacity at Worlds End and continue to consider plans for primary care facility in/ adjacent to A&E. Capacity Plan 2005/06 to 2009/10 projects an increase rather than a decrease in emergency admissions which means the 5% reduction in bed days will need to be achieved by further reductions in l.o.s. and development of Long Term Conditions and Frequent Fliers programme in partnership with local PCTs.	20		ED
1.3.5	Insufficient bed capacity to admit A&E waiters	As identified in the Capacity Plan 2005/06 to 2009/10 bed capacity available to support emergency care admissions overall, with bed base flexed as identified through the daily bed management meeting(s).99% of patients are admitted within 4 hours currently.	4		ED
1.4.1	Lack of scheduled day surgery theatre capacity – adult and paediatrics	Day surgery capacity exists with the development of the treatment centre to increase rates of day surgery for adults and in paediatrics by converting existing inpatient lists. Major focus of work for surgical directorates to improve from 55% currently to the national average of 70%, with action plans to be developed for delivery of 2006/07 rates required by capacity plan. Performance currently tracked through IMPACT programme.	16		ED
1.5.1	Lack of manpower – multidisciplinary team (MDT) co-ordinators to routinely collect data and service improvement manager to reduce unnecessary bottlenecks and variation	MDT co-ordinator and Service Improvement posts funded and recruited to with no vacancies. Cancer data routinely collected and uploaded onto cancer waits PTL and national database by co-ordinators. Need to review other data sources (e.g. waiting lists) to confirm that all patients identified with cancer are discussed at MDT, adding them to the PTL where this is not the case. Review of last 10 patients completed by Service Improvement Manager with action plans to be agreed with each MDT by end of March 2006.	16		ED
1.5.2	Information systems do not support identification of patients and monitoring of patient journey	PTL now established to track patient journey prospectively. Need to review other data sources (e.g. waiting lists) to confirm that all patients identified with cancer are discussed at MDT, adding them to the PTL where this is not the case.	20		ED

Assurance Framework Update Report
Trust Board 2nd March 2006

A/F Ref No	Principle Risk	Risk Mitigation Update	Initial Risk	Rescored Risk	Lead
1.5.3	Access to diagnostic services will not be fast enough to meet the target wait	All patients fast-tracked through diagnostic services provided at C&W, currently access to TURP is key diagnostic bottleneck which is being reviewed and action plan agreed by mid-March 2006.Turnaround times for histopathology agreed with HHT, with escalation by Cancer Services Manager where notified.	20		ED
1.5.4	Bottlenecks at partner hospitals	Bottlenecks in Urology for access to robotic surgery at SMH. Joint meeting w/c 27 February 2006 to resolve. No other bottlenecks identified at other partner hospitals to date.	20		ED
1.7.1	Lastword and GP systems will not support Choose and Book	GE Healthcare have committed to make Lastword compliant with version 1 of Choose and Book Full Booking Service. Key risk to implementation by September 2006 is BT and Connecting for Health testing, which the Trust is in negotiation to deliver during March 2006. GP systems are technically compliant with Indirect Booking Service. Roll-out of Full Booking Service to all GPs by March 2007 to support 90% of all referrals via GP Direct Booking.	20		ED
1.7.2	GPs will not comply with Indirect Booking System	Department of Health £100k incentive for PCTs to deliver Direct Booking by December 2006. PCTs to incentivise GPs via the flexibilities afforded by the GP contract.	8		ED
1.7.3	Theatre scheduling system does not meet service needs	PICIS implemented to service user specification.	1		ED
1.8.3	Failure to maintain cleaning standards to PEAT assessment level or above	PEAT inspection completed and rating of Acceptable/ Good will be achieved for 2005/06. Joint monthly audits with ISS-M consistently scored at 90% pre-rectification for the whole hospital.	1		ED
1.9.1	Inability to deliver because of Lack of investment in NSF targets	Annual NSF Reports to be signed off by Trust Eexecutive Clinical Governance to monitor progress. Annual updates scheduled for October to December 2006.	8		ED
2.2.1	Missing notes can mean that knowledge of patient pathways is not available	Majority of all patient records are logged on lastword. Medical records tracking policy and updated SLA agreed with each directorate to ensure local ownership of roles and responsibilities. Missing records policy and database implemented and monitored with feedback to directorates in relation to performance standards. This will be backed up by a Trust wide missing notes audit to check that notes tracked out to departments/ individuals reconcile. Temporary folders established where patient records cannot be traced with clear procedure for ammalgamation once original records located.	4		ED

Assurance Framework Update Report
Trust Board 2nd March 2006

A/F Ref No	Principle Risk	Risk Mitigation Update	Initial Risk	Rescored Risk	Lead
4.1.1	Notes not always available for clinic or theatre	Continuous mitigation process. Medical Records library now only contains 2 years worth of records in line with the Medical Records policy.Integrity check will be completed 3 March 2006 to ensure all records in order and no mis-files. Medical Records staff also have responsibility for maintaing these standards for allocated areas of the library. Directorates now search for missing records 3 days in advance of appointment/ admission in line with Missing records policy.	9		ED
4.6.1	Lack of training in Security/ Health & Safety	Training courses established via Training Resource Centre	9		ED
4.6.2	Lack of safety audits	Health and Safety and Security audits included in annual comprehensive risk reviews with results fed back to directorates and health and safety Committee.	9		ED
4.8.1	Pathology SLA does not allow the service provided to be monitored within a measured performance and quality framework	Pathology to be based on an SLA (rather than shared service) model, aiming for completion by April 2006 with HHT. Viral Load in process of being competitively tendered, with legally binding contract established with successful bidder.	20		ED
4.8.2	Pathology services are not modernised in line with clinical services	This will be included as a key requirement of the Pathology SLA/ contract.	20		ED
4.9.2	Capacity of projects team to deliver projects	Projects manpower based on capital programme rather than fixed establishment. Funded by 12% fees included in all capital business cases, in line with indistry average.	1		ED
5.1.1	Equality and Diversity (E&D) inadequately resourced – staff time and space	A decision needs to be taken to fund a substantive appointment if the Equality and Diversity Programme is to be taken forward in a sustainable way.	12		ED
5.1.2	Inadequate consultation with internal and external groups means Trust may be unaware of key work streams needed to implement E&D for all staff groups	Staff groups established along with feedback from the staff survey which identifies ethnic profile. FT membership will also be used as a means of ensuring adequate consultation.	8		ED
5.1.4	Failure to change behaviours of key staff members	Included as a key competency in every AfC job description with link to Knowledge and Skills Framework.	12		ED
6.2.1	Lack of clinical ownership and agreement of service models	Service models agreed within HIV directorate as part of business planning process with development of Sexual health Strategy in 2006/07 that will be used as basis for agreeing sector wide service model with PCTs and the SHA.	8		ED
6.2.2	Shift in commissioning strategy	Increased risk in relation to HIV consortium approach. 48 hour target for Sexual Health has reinforced requirement to purchase sexual health capacity.	8		ED

Assurance Framework Update Report
Trust Board 2nd March 2006

A/F Ref No	Principle Risk	Risk Mitigation Update	Initial Risk	Rescored Risk	Lead
6.3.3	Lack of infrastructure to support existing service (e.g. Paediatric A&E space, PACU development)	Mini PACU development completed on Saturn ward increasing day case capacity from 5 to 10 trolley spaces, releasing ward capacity for additional elective and emergency activity. Fracture clinic available 1700 to 2200 for additional paediatric A&E capacity. Both represent short-term solutions pending startegic review of specialiost paediatric services.	6		ED
7.5.1	Lack of strategy and business plans for private patients and lack of organisational agreement on which services to grow	Self financing business case for the appointment of a General Manager in Private Practice developed and awaiting decision.	16		ED
7.5.2	Lack of commitment to/ownership of private patients in the Trust	Self financing business case for the appointment of a General Manager in Private Practice developed and awaiting decision.	12		ED
7.5.3	Lack of organisational agreement on which services to grow	Self financing business case for the appointment of a General Manager in Private Practice developed and awaiting decision.	12		ED
7.5.4	Lack of incentive to grow business for stakeholders	Self financing business case for the appointment of a General Manager in Private Practice developed and awaiting decision.	9		ED
1.10.1	Lack of awareness of IMPACT and associated high impact changes	Delete	6	3	EH-J
1.10.2	Trust does not make IMPACT a priority	Delete	9	3	EH-J
1.10.3	Risk that behaviours may not support delivery of IMPACT	Unchanged	12	12	EH-J
1.3.2	Chronic disease management service models and integrated care pathways fail to deliver target reductions in length of stay and admissions	Internal plans to reduce emergency LOS.	12	12	EH-J
5.5.1	Vision not articulated and shared and therefore not delivered	Maxine	12	12	EH-J
6.1.1	Failure to identify all specialist services	Unchanged	3	3	EH-J
6.1.2	Lack of support and process for engaging London Specialised Commissioning Group, SHA, PCTs or NSCAG	Unchanged	12	12	EH-J
6.4.1	Failure to provide adequate space, staffing and critical care capacity	Unchanged	20	20	EH-J
6.4.2	Designation process is unclear therefore difficult to achieve	Unchanged	9	9	EH-J
3.3.1	Further delay of Paddington Campus	No longer relevant: Initial risk related to Paddington Campus.	16	0	HL
3.3.2	Different priorities for different organisations in the sector		12		HL
3.3.3	Lack of engagement from one or more organisations		6		HL
6.3.1	Paddington Campus development and alignment of St Mary's and Hammersmith Hospital drives transfer of specialist paediatrics away from C&W	No longer relevant: Initial risk related to Paddington Campus.	12	0	HL

Assurance Framework Update Report
Trust Board 2nd March 2006

A/F Ref No	Principle Risk	Risk Mitigation Update	Initial Risk	Rescored Risk	Lead
6.3.2	Uncertainty about future of paediatrics in West London leads to drift of expertise away from C&W	No longer relevant: Initial risk related to Paddington Campus.	12	0	HL
1.2.1	PCTs may not prioritise funding to deliver 18 week target	This risk will impact on SLAs for 2006/07 to 2008/09 which are being negotiated now. The Trust SLA strategy is to set out the 3 year plan to meet 18 weeks and agree stepped trajectory and associated investment with PCTs. A key risk to delivering the 18 week maximum journey time will be funding MRI and CT waits as the additional diagnostic capacity is unlikely to be funded through activity growth. The Trust will negotiate direct access diagnostics SLAs from block to cost and volume to mitigate this. Review risk at 31.03.06 when SLA 06/07 negotiations completed.	U25	U25	LB
1.2.1	Primary Care Trusts (PCTs) may not prioritise funding to deliver this target		25		LB
1.2.1	Primary Care Trusts (PCTs) may not prioritise funding to deliver this target		25		LB
1.3.1	Potential lack of investment by primary care in intermediate and continuing care beds	Check ED	U20		LB
1.3.4	Disinvestment in mental health services by PCT may lead to increased waits and clinical incidents or security risks.	Check ED	U20		LB
1.3.4	Disinvestment in mental health services by PCT may lead to increased waits and clinical incidents or security risks		20		LB
3.3.4	Lack of funding/financial flexibility to support delivery of objective: collaborate with healthcare community to plan & provide complementary & cost effective services & support delivery of sector wide priorities & improve sector performance.	Regular feedback from SHA Chief Executives' Forum is in place. Trust is planning for control total surplus of £2.1m to support sector financial position although HIV income risk may make this unachievable. Trust in correspondence with SHA over sector approach to supporting Ravenscourt Park.	H12	H12	LB
4.4.1	Loss of economies of scale through lack of best procurement practice	Procurement Director in place and procurement strategy documented. To be approved by Executive.	H9	L4	LB
4.4.1	Loss of economies of scale through lack of best procurement practice		16		LB
4.4.2	Failure to follow tendering procedures required by SFIs	Procurement Director in place and procurement strategy documented. To be approved by Executive. Contract management system in development. Purchasing handbook available for managers on intranet	U20	U12	LB
4.4.2	Failure to follow tendering procedures required by standing financial instructions(SFIs)		9		LB

Assurance Framework Update Report
Trust Board 2nd March 2006

A/F Ref No	Principle Risk	Risk Mitigation Update	Initial Risk	Rescored Risk	Lead
4.5.1	Lack of senior capacity to work on the development agenda for the finance service.	Trust finance and information functions have been assessed in the light of Early Lessons of PbR and FT requirements. Cost pressure bid will be assessed as part of setting Budget 06/07.	H9	M6	LB
4.5.1	Lack of senior capacity to work on the development agenda for the finance service		20		LB
4.9.1	Lack of clarity for all Trust regarding process for building project and equipment		9		LB
7.2.1	Budgets not consistent with planned activity leading to cost pressures.	Budgets signed off with Budget Holders	M6	M4	LB
7.2.2	Budget holders unclear about activity targets leading to cost pressures.	Budgets signed off with Budget Holders.	M6	M4	LB
7.2.3	Failure to control bank and agency costs.	Regular SLA meetings to agree managed approach Bank and agency quotas introduced. Weekly establishment panel in place. All requests for agency for G grade (A4C 7) and above can only be signed off by General Manager/Clinical Director and Exec Director countersignature.	U12	M6	LB
7.2.4	Lines of financial accountability unclear	Regular SLA meetings to agree managed approach Finance reports state management accountability clearly. DoF escalates to CEO where budget responsibility unclear.	M6	L2	LB
7.2.5	Staff unaware of financial responsibilities and duties.	Budgetary control objectives/SFIs clearly stated and communicated. Budget responsibility clearly set out in KSF competencies and in job descriptions. Ongoing training programme for budget holders through Learning Resource Centre.	M4	L4	LB
7.2.6	Failure to report accurately or promptly to budget holders and relevant third parties	Budget position reported within 11 working days currently. Plans in place to reduce this to 5 working days from April 06. Finance support for Medicine and HIV has been under-resourced and this will be addressed through separating Finance Manager posts for Medicine and HIV to line up with General Manager accountability.	H9	M6	LB

Assurance Framework Update Report
Trust Board 2nd March 2006

A/F Ref No	Principle Risk	Risk Mitigation Update	Initial Risk	Rescored Risk	Lead
7.2.7	Local PCTs facing financial deficit will seek to withdraw funds via reduced activity and challenge to prices and trust unable to reduce costs commensurately SLAs have specific risk share agreements Joint working with other acute trusts	Signed SLAs are in place for all North West London PCTs with clear risk share arrangements. PCTs have withdrawn funds in 05/06 via reduced activity but the financial effects have been provided for and the Trust is forecasting to achieve statutory financial balance at M10. HIV Consortium has sought to withdraw funds via suspension of risk share in M9 and non payment of over-performance which would reduce income by £1.6m but should not compromise statutory break-even. Trust will seek arbitration on this decision. For 2006/07, Trust has planned for withdrawal of outpatient activity but needs to revisit elective assumptions as PCTs may resist paying for routines more quickly than 5 months maximum	U25	U20	LB
7.2.8	Lack of effective link between SLAs and financial management systems – failure to cover costs through price and risk share arrangements SLAs have specific risk share agreements Joint working with other acute trusts	Clear risk share arrangements have been agreed for 05/06 SLAs	U12	M6	LB
7.3.1	Inherent uncertainty of the form and timing for Payment by Results (PBR) which may mean we are unable to plan resourcing adequately	Tariff for 2006/07 published at the end of January and Trust is remodelling the implications for its financial plan for the April Trust Board. Trust still expects to be a gainer under PbR as planned. Trust has anticipated some aspects of the changes e.g. tariff deflator but differential tariff for emergency spells needs to be modelled. Review risk again at end March 06.	U25	U15	LB
7.3.2	Services may be operating above tariff.	Overall the Trust is operating below tariff as it has an RCI of 97. Finance has assessed which services are gainers and losers under the tariff and are working with directorates to develop plans to mitigate. Trust is developing refined patient level procedure costing through ComboCC to inform and refine reference costs. These will be used to challenge tariffs where these are anomalous.	U25	U15	LB
7.3.3	Capacity within each directorate to research and fully understand the impact of PBR is constrained.	Trust has purchased and is rolling out training to all directorates for Dr Foster benchmarking products which will highlight potential areas for efficiency savings eg daycase rates and length of stay. Finance has plan to reduce reporting period to 5 days to allow finance managers more time each month to support financial planning and forecasting including PbR risk mitigation.	U25	U16	LB
7.3.4	Impact of activity and demand reductions is expected to increase under PbR	Activity reports are now available on HIPPO. Need to develop more proactive usage within the Trust by directorates and escalation of key issues through Performance Board.	U25	U15	LB

Assurance Framework Update Report
Trust Board 2nd March 2006

A/F Ref No	Principle Risk	Risk Mitigation Update	Initial Risk	Rescored Risk	Lead
7.3.5	Coding systems and process fail to capture activity accurately and time for billing	Data Quality Group has been established which is actively addressing coding systems and processes.	U25	U12	LB
7.4.1	Capacity of Head of Performance and General Managers may not enable a performance management framework to be delivered.	Staffing structure has been reviewed and post of performance analyst being recruited to.	U16	U16	LB
7.4.2	Performance framework timetable and reporting process is not embedded and a lack of understanding and awareness of Trust objectives.	Corporate Planning process has set out corporate objectives clearly for business planning. Performance targets for 05/06 were published in January 06 which have introduced new priorities for acute Trusts.	H12	H12	LB
1.11.3	Clinicians may not change practice to support objective	A number of initiatives have been introduced over the past year in order to meet length of stay targets. These initiatives include priorities driven by the IMPACT agenda, such as ensuring that on admission, patients are assigned a predicted date of discharge at the first opportunity by the medical/surgical teams - this should be within 24 hrs. In addition to this, Dr Foster clinical benchmarking software facilitates comparison of this Trust's performance with other hospitals and then the interrogation of local data. Targetted training is underway.	12	6	MA
1.4.2	Poor clinical outcomes or adverse incidents	Gaps in assurance and control relate to pre-operative assessment, in that a proportion of elective adult patients (surgical and gynaecology) are pre-assessed. Patients not pre-assessed are at risk of unanticipated adverse events leading to poor clinical outcomes.	2	2	MA
1.4.3	Benchmarking performance Clinical leads	Local directorate or specialty-specific clinical indicators are being develped in order to benchmark local clinical indicators. Dr Foster clinical benchmarking software is in use across the Trust. A programme of training is underway.	9	2	MA
2.2.2	Clinicians unaware of national guidance	National Guidance is reviewed monthly at the Trust Executive for Clinical Governance. In addition to this, there is a system of cascading information from the Medical Director to relevant clinical, service directors or heads of departments such as therapies or pharmacy.	9	0	MA
2.3.1	Audit does not occur in all specialties therefore performance vs standards is not known	Trust wide audit lead appointed. Each directorate has a nominated audit lead. Annual audit programme agreed, which includes the mandatory corportate audits such as documentation and resuscitation. Space contraints limit the ability to recruit suitable clinical governance coordinators to support directorates.	10	6	MA

Assurance Framework Update Report
Trust Board 2nd March 2006

A/F Ref No	Principle Risk	Risk Mitigation Update	Initial Risk	Rescored Risk	Lead
5.6.2	Difficult to change behaviour - staff have been allowed to say too busy in past	Induction programme updated. Records of attendance to induction kept on Training Database. Reporting tool purchased to enable exception reports. Training Database administrator appointed.	16	2	MA
2.4.2	The Trust wide training database will not provide the information and follow up needed for mandatory training	Administrator appointed. Trained key trainers. Trained other staff to ensure follow-up/reporting. Crystal Reporting Tool purchased, enabling report extraction.	16	9	MF
3.2.1	Partnership agreement with staff to promote their involvement in planning and decision making' (Standards for Better Health, Domain: Governance) Failure to agree on terms of involvement	Positive working relationship with staff side, as evidence by JMTUC minutes. Staff involvement in corporate descision making. Establishment and promotion of staff support groups, such as BME and Gay and Lesbian groups. Partnership agreement to be formalised as part of Foundation Trust and HR Strategy. This may be evidenced by the Trust Employee members of the FT.	8	4	MF
3.2.2	Staff do not want to be engaged	see update relating to 3.2.1	8	4	MF
3.2.3	Lack of ownership of the agenda	see update relating to 3.2.1	10	8	MF
5.1.3	Lack of available E&D training	Regular Equality and Diversity training now takes place. An annual programme is in place. New 'RES' scheme adopted. Quarterly reports to Board on Ethnicity of workforce. Attendance records placed on training database. Still need to secure recruitment resources to employ equality and diversity manager/advisor.	10	8	MF
5.2.1	Risk that the HR and payroll systems and staff will not have the capacity to deliver agenda for change to timetable	HR/Payroll systems have capacity to deliver 100%. Assimilation of staff for A&C. Space found for staff to work, computers provided, project methodology adopted.	9	4	MF
5.2.2	Risk of breach in data protection because inadequate facilities for staff record storage	Filing cabinets/locked storage (link to 2.4.2 IT solution resolved).	15	2	MF
5.3.1	Risk that behaviours will not change because junior staff want to stay and learn (breaching EWTD)	Action taken to address problems with rotas by HR and General Managers/Clinical Directors. Diary cards completed twice a year for ministerial returns. Compliance with EWTD for 2004 achieved. Performance monitoring via ministerial return/diary cards.	9	2	MF
5.3.2	Risk that behaviours will not change because A&E targets seen as more important than European working time directive (EWTD)	Compliance with EWTD for 2004 achieved. Performance monitoring via ministerial return/diary cards.	9	2	MF
5.3.3	Rotas shared with other Trusts may not comply	Problem with shared rota with other Trust now resolved.	9	2	MF

Assurance Framework Update Report
Trust Board 2nd March 2006

A/F Ref No	Principle Risk	Risk Mitigation Update	Initial Risk	Rescored Risk	Lead
5.3.4	EWTD: Attention focussed on medics - all staff groups must comply.	Gaps in assurance reduced: Nursing staff asked to confirm total working hours if additional bank shifts are requested as overtime. Rota'd working hours of the nursing team ensures that nursing staff are not allocated hours in breach of the EWTD.	9	4	MF
5.3.5	Consultancy support has no space to be based	Desk space now provided for EWTD Lead	9	1	MF
5.4.1	Lack of awareness of and evidence to support progress against Improving Working Lives (IWL) standards	IWL Practice Plus Achieved April 2005	4	0	MF
5.4.2	IWL Self assessment over optimistic	IWL Practice Plus Achieved April 2005	6	0	MF
5.6.1	Failure to deliver induction owing to lack of resources and disparate nature of induction across staff groups	Induction programme updated. Records of attendance to induction kept on Training Database. Reporting tool purchased to enable exception reports. Training Database administrator appointed.	12	2	MF
2.5.1	Priorities of Imperial for research may not align with service strategy and Imperial may move research base away from the Trust site	Professor in Acute Medicine appointed, commences March 2006. There is significant input from clinicians from the Trust, particularly the HIV/GUM Directorate, in National research initiatives, which inform the local agenda. The Trust conitnues to collaborate with the Imperial College School of Medicine's around research strategy and the agreement and development of research priorities.	12	6	MM
2.5.2	St Stephens Aids Trust (SSAT) fail to sustain adequate level of research	The Medical Director is a member of the St Stephen's Aids Trust (observer), as agreed within an agreed Memorandum of understanding. Level of research (and funding) has been maintained.	12	3	MM
2.5.3	Impact of EU directive for clinical trials will result in reduced number of trials	The number of research trials reduced immediately following the application of the EU directive. As other countries had adopted these limitations, clinical trials have stabilised. Critics of the new regulations have raised the notion that the problem is compounded by the fact that the UK appears to be more fastidious than other parts of Europe in adopting and adhering to EUCTD guidelines.	9	6	MM
2.5.4	Failure of Trust to recognise the importance of multiprofessional research development	In order to further strengthen multi-professional research, an Assistant Director of Nursing with a special interest in research and education was appointed in 2005.	12	6	MM
1.6.1	Inadequate space exists to deliver the level of service needed to meet target	(Paul Walsh - S Barton: No GM/AGM insufficient support)	8		PW
1.6.2	Current inability to provide 7 day services	(Paul Walsh - S Barton: No GM/AGM insufficient support)	5		PW
1.6.3	There is currently a lack of definition of this target	(Paul Walsh - S Barton: No GM/AGM insufficient support)	5		PW

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
1	1.1	Make 'personal care' a priority for service delivery in the Trust (links to Standards for Better Health, Domain - Patient Focus)	1.1.1	Lack of awareness and understanding of 'Essence of Care' priorities	Essence of Care Steering Group Nursing and Midwifery Strategy	Report on progress against plan to Clinical Governance Executive Report on progress against agreed action to Trust Board Quarterly patient involvement report to Patients Forum	Essence of Care steering group established, EofC key topic at each quarterly staff working conference, reports on EofC carried in Trust News, 'champions' identified for documentation, nutrition and privacy and dignity.	First Essence of Care progress report to go to Clinical Governance Executive in May	No assurance received to date	M3	L2	AMacC
2	1.1	Make 'personal care' a priority for service delivery in the Trust (links to Standards for Better Health, Domain - Patient Focus)	1.1.2	Lack of action taken to address areas of concern highlighted in the patient feedback national patient surveys	Patent and Public Engagement Steering Group	Quarterly complaint reports	Report to Board on Patient survey results(annual) with progress reports against action plans Action plans agreed and implemented with the Emergency Department and Out Patients Department reflecting key finding from the national patient surveys.	Directorate level action plans	Lack of assurance received to date on areas of improvement	H8	L4	AMacC
42	1.10	Implement relevant Modernisation Agency high impact changes (links to Standards for Better Health, Domain - Clinical and cost effective care)	1.10.1	Lack of awareness of IMPACT and associated high impact changes	IMPACT project team IMPACT launch event and Trust News articles	Progress reports to Performance Board and IMPACT Board	Controls being established currently	IMPACT Board and Project Plan (to be established in April)	Assurance mechanisms to be established	M6	L3	AP
43	1.10	Implement relevant Modernisation Agency high impact changes (links to Standards for Better Health, Domain - Clinical and cost effective care)	1.10.2	Trust does not make IMPACT a priority	IMPACT project team IMPACT part of Corporate Plan	Progress reports to Performance Board and IMPACT Board	Controls being established currently	IMPACT Board and Project Plan (to be established in April)	Assurance mechanisms to be established	H9	L3	AP

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
44	1.10	Implement relevant Modernisation Agency high impact changes (links to Standards for Better Health, Domain - Clinical and cost effective care)	1.10.3	Risk that behaviours may not support delivery of IMPACT	IMPACT project team IMPACT part of Corporate Plan	Progress reports to Performance Board and IMPACT Board	Controls being established currently	IMPACT Board and Project Plan (to be established in April)	Assurance mechanisms to be established	H12	H12	AP
45	1.11	Achieve an average length of stay equal to or better than the national average in 2005/6 (links to Standards for Better Health, Domain - Clinical and cost effective care)	1.11.1	Diagnostic waits will not deliver a fast enough service	Monitoring of waiting times for cancer Monitoring of waiting times for radiology IMPACT implementation	Cancer waiting times reported to Performance Board report Radiology waiting times reported to Performance Board Length of stay data reported to Performance and IMPACT Boards	CHKS length of stay information shows the trust compares favourably with other teaching hospitals in London North West London SHA has not identified C&W as a major performance concern in relation to length of stay see update relating to 1.2.3.	No automatic waiting time monitoring for diagnostics, cancer and pathology Timely information on national upper quartile performance in relation to length of stay Access to real time LOS data to consultant level	Timely data is needed	H12	H12	ED
46	1.11	Achieve an average length of stay equal to or better than the national average in 2005/6 (links to Standards for Better Health, Domain - Clinical and cost effective care)	1.11.2	Inadequate access to intermediate care and rehabilitation.	Monthly discharge team report	Delays in access to intermediate care and rehabilitation reported to Performance Board Length of stay data reported to Performance and IMPACT Boards	CHKS length of stay information shows the trust compares favourably with other teaching hospitals in London North West London SHA has not identified C&W as a major performance concern in relation to length of stay Increased provision of community rehabilitation services. Pressure remains in relation neurological and frail elderly intermediate care services. Maintained last years delayed discharge improvement at 2.5%. Development of Ellesmere House will increase by 5% the PCT/ social services funded places, available from 2007/08.	Access to intermediate care Timely information on national upper quartile performance in relation to length of stay Access to real time LOS data to consultant level	Timely data is needed No assurance from partner organisations concerning adequate intermediate bed access	H12	H9	ED

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
47	1.11	Achieve an average length of stay equal to or better than the national average in 2005/6 (links to Standards for Better Health, Domain - Clinical and cost effective care)	1.11.3	Clinicians may not change practice to support objective	Expanded short stay and ring fenced beds IMPACT implementation	Length of stay data reported to Performance and IMPACT Boards	CHKS length of stay information shows the trust compares favourably with other teaching hospitals in London North West London SHA has not identified C&W as a major performance concern in relation to length of stay Monitoring of Estimated Date of Discharge implemented in January 2006. Dr Foster database available to clinicians. A number of initiatives have been introduced over the past year in order to meet length of stay targets. These initiatives include priorities driven by the IMPACT agenda, such as ensuring that on admission, patients are assigned a predicted date of discharge at the first opportunity by the medical/surgical teams - this should be within 24 hrs. In addition to this, Dr Foster clinical benchmarking software facilitates comparison of this Trust's performance with other hospitals and then the interrogation of local data. Targetted training is underway.	Timely information on national upper quartile performance in relation to length of stay Access to real time LOS data to consultant level	Timely data is needed	H12	M6	MA / AMacC

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
3	1.2	For elective care : to deliver the 18 week maximum journey time by 2008 (links to Standards for Better Health, Domain– Accessible and responsive care)	1.2.1	Primary Care Trusts (PCTs) may not prioritise funding to deliver this target	Service Level Agreements (SLAs) Local Delivery Plans IMPACT Modernisation Agency 10 High Impact Changes	Signed SLAs presented to the Board SLA reports to Trust Board and Performance Board identifying differences between SLAs and activity Performance review with NWL SHA and national IPH leads	Partial assurance is available for 1.2.1, 1.2.3, 1.2.4 This risk will impact on SLAs for 2006/07 to 2008/09 which are being negotiated now. The Trust SLA strategy is to set out the 3 year plan to meet 18 weeks and agree stepped trajectory and associated investment with PCTs. A key risk to delivering the 18 week maximum journey time will be funding MRI and CT waits as the additional diagnostic capacity is unlikely to be funded through activity growth. The Trust will negotiate direct access diagnostics SLAs from block to cost and volume to mitigate this. Review risk at 31.03.06 when SLA 06/07 negotiations completed.	Capacity plan 2005/06 to 2007/08 that identifies stepped activity(demand management) increases to reach 18 weeks Tracking progress in relation to 18 week waits Tracking clinical support service and diagnostic waits Project plan for key diagnostic departments to improve productivity and access times	Insufficient and monitoring of capacity, demand and variation analysis at all levels in the trust	U25	U25	LB

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
5	1.2	For elective care : to deliver the 18 week maximum journey time by 2008 (links to Standards for Better Health, Domain– Accessible and responsive care)	1.2.2	IT infrastructure may not capture the diagnostic wait information in Statistical Process Control (SPC) format (mean is currently used as indicator for waits)	IMPACT Modernisation Agency 10 High Impact Changes		The diagnostic wait times have been investigated. For imaging the system has been set up using Enterprise Scheduling. Because of the way processes have been established the request is not recorded until the patient presents. As a result the time from request to result is not available. Further work is being undertaken to resolve this difficulty. When times can be calsulated it will be possible for the mean and standard deviation to be calculated as required by the SPC technique.	Capacity plan 2005/06 to 2007/08 that identifies stepped activity(demand management) increases to reach 18 weeks Tracking progress in relation to 18 week waits Tracking clinical support service and diagnostic waits Ability to use SPC linked to Lastword, enabling variation to be tracked in real time Project plan for key diagnostic departments to improve productivity and access times Audit patients journey by specialty to assure correct bottlenecks identified	Insufficient and monitoring of capacity, demand and variation analysis at all levels in the trust No assurance that the IT system can currently deliver appropriate waiting time information	U20	H12	AG

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
7	1.2	For elective care : to deliver the 18 week maximum journey time by 2008 (links to Standards for Better Health, Domain– Accessible and responsive care)	1.2.3	Diagnostic waits will not support the target	IMPACT Modernisation Agency 10 High Impact Changes	Performance review with NWL SHA and national IPH leads	Partial assurance is available for 1.2.1, 1.2.3, 1.2.4 MRI and CT currently meet the maximum 26 week wait with performance tracked through the monthly Performance report. Pathology SLA to be developed and signed-off with HHT by April 2006, with turnaround times included. Physiological measurement tests provided by other Trusts (e.g. lung function) to be reviewed during 2006/07 with turn-around times included in SLAs that support the stepped reduction towards an 18 week maximum wait.	Capacity plan 2005/06 to 2007/08 that identifies stepped activity(demand management) increases to reach 18 weeks Tracking progress in relation to 18 week waits Tracking clinical support service and diagnostic waits Ability to use SPC linked to Lastword, enabling variation to be tracked in real time Project plan for key diagnostic departments to improve productivity and access times Audit patients journey by specialty to assure correct bottlenecks identified Partnership working eg with Hammersmith for Lung function tests	Insufficient and monitoring of capacity, demand and variation analysis at all levels in the trust	U12	H9	ED

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
10	1.2	For elective care : to deliver the 18 week maximum journey time by 2008 (links to Standards for Better Health, Domain– Accessible and responsive care)	1.2.4	Choose and Book service not available or too many patients choose Chelsea and Westminster Hospital (C&W)	IMPACT Modernisation Agency 10 High Impact Changes NWL Booking and Implementation Strategy CWH Booking Implementation plan	Performance review with NWL SHA and national IPH leads Local community reviews Key milestones and % patients booked monitored through Steering Group with assurance reports to Performance and Trust Board NWL SHA/K&C PCT Performance review	Partial assurance is available for 1.2.1, 1.2.3, 1.2.4 Project plan, benefits realisation and timetable to be developed by March 2006 to deliver Full Booking at C&W, aiming for implementation by September 2006. Capacity will be increased where further efficiency gains not possible to accommodate additional referrals. If demand rises to a level where maximum waits are not maintained, C&W will be removed from the GPs Choice list until the backlog of activity is cleared.	Capacity plan 2005/06 to 2007/08 that identifies stepped activity(demand management) increases to reach 18 weeks Tracking progress in relation to 18 week waits Tracking clinical support service and diagnostic waits Project plan for key diagnostic departments to improve productivity and access times Audit patients journey by specialty to assure correct bottlenecks identified	Insufficient and monitoring of capacity, demand and variation analysis at all levels in the trust No assurance that 1.2.4 will be delivered	U20	H8	ED

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
12	1.2	For elective care : to deliver the 18 week maximum journey time by 2008 (links to Standards for Better Health, Domain– Accessible and responsive care)	1.2.5	Insufficient bed/theatre capacity at C&W to deliver 18 weeks	IMPACT Modernisation Agency 10 High Impact Changes CWH Capacity Plan	NWL SHA/K&C PCT Performance reviews NAO benchmark reports Capacity plan monthly report to Performance Board	Capacity plan of bed/theatre etc. Efficiency improvement programme. Ask Nick Cabon re tracking. Which group - Pisces about to go live. Demand work with PCT to reduce demand through out of hours primary care. GM Bed Days: Long term conditions, changing models. Stepped care into primary care. Re-inforced by PBR	Capacity plan 2005/06 to 2007/08 that identifies stepped activity(demand management) increases to reach 18 weeks Tracking progress in relation to 18 week waits Tracking clinical support service and diagnostic waits Project plan for key diagnostic departments to improve productivity and access times Delivery of PISCES and full booking software in line with implementation plan timetable Annual increase in emergency activity reducing available elective bed base and theatre capacity	Insufficient and monitoring of capacity, demand and variation analysis at all levels in the trust	H12	H9	ED

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
15	1.3	For emergency care: to deliver a 5% reduction in bed days by 2008 and a maximum 4 hour period in Accident and Emergency for 98% of patients (links to Standards for Better Health, Domain– Accessible and responsive care)	1.3.1	Potential lack of investment by primary care in intermediate and continuing care beds	Planning for the Commissioning of Long Term Care for Older People in the Royal Borough of Kensington and Chelsea Joint Health Partnership Board Joint Clinical Executive Group	Weekly delayed discharge report to clinical directorates and monthly to Performance Board, identifying gaps in local capacity NWL SHA/K&C PCT Performance Reviews	See 1.3.3 An increase in community based services has maintained '[delayed discharge' performance in line with last year's trend, with a significant improvement in performance during January 2006. Access to neurological and frail elderly intermediate care remains an issue.	Clear identification of all patients (not just delayed discharges) who are medically fit for discharge Sufficient community or home based capacity for patients to be discharged to once medically fit Alternative funded borough or hospital based solutions Joint strategy and implementation with PCTs and social services	Incomplete assurance or no assurance of action to address exception reports	U20	U12	LB
17	1.3	For emergency care: to deliver a 5% reduction in bed days by 2008 and a maximum 4 hour period in Accident and Emergency for 98% of patients (links to Standards for Better Health, Domain– Accessible and responsive care)	1.3.2	Chronic disease management service models and integrated care pathways fail to deliver target reductions in length of stay and admissions	Joint Health Partnership Board Joint Clinical Executive Group PCT Demand Management Initiatives identified in Service Level Agreements Demand Management checklist for each PCT by initiative as an annexe to the SLA SLA review meetings NWL SHA Pricing Policy and Procedure	NWL SHA/K&C PCT Performance Reviews SLA report at General Matters and Trust Board Activity, A&E and bed day reduction reports to Trust Board	Internal plans to reduce emergency LOS.	Lack of primary or community based input to nursing and residential care homes Identification of frequent fliers and capacity of community case managers Demand management initiatives not currently based on solid business and evidence base Inability to control emergency attendances and admissions	Incomplete assurance or no assurance of action to address exception reports	H12	H12	AP

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
19	1.3	For emergency care: to deliver a 5% reduction in bed days by 2008 and a maximum 4 hour period in Accident and Emergency for 98% of patients (links to Standards for Better Health, Domain– Accessible and responsive care)	1.3.3	Continuing increase in demand for A&E services	A&E activity monitored Daily performance monitoring	NWL SHA/K&C PCT Performance Reviews Activity, A&E and bed day reduction reports to Trust Board Monitoring target monthly at Performance and Trust Board as a Key Performance Indicator SITREP return Weekly breach reports	Star ratings - A/E waits show evidence of ability to deliver but this is not without unsustainable pressures A&E attendances are projected to increase from 91,000 in 2004/05 to 95,000 in 2005/06 with the most significant increase in paediatrics.In paediatrics GPs have been notified that the department will no longer undertake routine phlebotomy requests from GPs and these will be returned or re-directed to paediatric outpatients as clinically indicated. Also, paediatric A&E review slots have been reduced from 6 to 2 per day with all other patients discharged back to the care of their GP. K&C PCT planning to make better use of under-utilised capacity at Worlds End and continue to consider plans for primary care facility in/ adjacent to A&E. Capacity Plan 2005/06 to 2009/10 projects an increase rather than a decrease in emergency admissions which means the 5% reduction in bed days will need to be achieved by further reductions in l.o.s. and development of Long Term Conditions and Frequent Fliers programme in partnership with local PCTs	Inability to control emergency attendances and admissions	Incomplete assurance or no assurance of action to address exception reports	U20	U15	ED

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
20	1.3	For emergency care: to deliver a 5% reduction in bed days by 2008 and a maximum 4 hour period in Accident and Emergency for 98% of patients (links to Standards for Better Health, Domain– Accessible and responsive care)	1.3.4	Disinvestment in mental health services by PCT may lead to increased waits and clinical incidents or security risks		NWL SHA/K&C PCT Performance Reviews	The PCT has continued its investment of the Central North West London Mental Health Trust (CNWL) liaison psychiatry team at previous levels of service provision (Mon-Fri 0900 to 1700). Existing policies and protocols for the safe management of mental health patients continue to be used by clinical teams across the Trust. Out of hours, long waits continue to be an issue for patients attending A&E and the Trusts clinical teams. Despite discussion (including at SHA level) this remains unresolved without investment in an expanded Liaison Psychiatry service or direct access to ward facilities at CNWL and other Mental Health Trusts.	Mental Health investment	Incomplete assurance or no assurance of action to address exception reports	U20	U12	LB
21	1.3	For emergency care: to deliver a 5% reduction in bed days by 2008 and a maximum 4 hour period in Accident and Emergency for 98% of patients (links to Standards for Better Health, Domain– Accessible and responsive care)	1.3.5	Insufficient bed capacity to admit A&E waiters	Escalation Procedure	NWL SHA/K&C PCT Performance Reviews Bed occupancy rates	Star ratings - A/E waits show evidence of ability to deliver but this is not without unsustainable pressures As identified in the Capacity Plan 2005/06 to 2009/10 bed capacity available to support emergency care admissions overall, with bed base flexed as identified through the daily bed management meeting(s).99% of patients are admitted within 4 hours currently.	Bed capacity Lack of community based services lead to patients choosing to use A&E services as a one-stop approach to non-acute health needs Detailed understanding of primary care and Out of Hours (OOH) services to redirect patients Inability to refuse access for GP heralded or LAS patients out of area	Incomplete assurance or no assurance of action to address exception reports	H4	M3	ED

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
23	1.4	1.4 For ambulatory care: to increase the % of elective day case activity to a Trust average of 79% in 2005/6 (links to Standards for Better Health, Domain– Accessible and responsive care)	1.4.1	Lack of scheduled day surgery theatre capacity – adult and paediatrics	10 High Impact Changes Treatment Centre - used for day and short stay procedures Clinical champions identified (anaesthetic and surgical by specialty) to drive objective forward, through TC Clinical reference Board(	Performance in relation to basket of 25 procedures and peer group reported at Performance Board Monthly activity reports routinely circulated to Directorates Ring fenced elective short stay beds	Day surgery capacity exists with the development of the treatment centre to increase rates of day surgery for adults and in paediatrics by converting existing inpatient lists. Major focus of work for surgical directorates to improve from 55% currently to the national average of 70%, with action plans to be developed for delivery of 2006/07 rates required by capacity plan. Performance currently tracked through IMPACT programme.	Implementation plan for treatment centre with key milestones tracking delivery Funded project plan for implementation of PISCIS Increased Medical Day Unit capacity Timely information on national upper quartile performance in relation to day surgery rates Audit and quality assurance programme needed for TC via Clinical reference Board	Key performance indicators have not been fully developed nor are they adequately reviewed down to desired level	M3	M3	ED
25	1.4	1.4 For ambulatory care: to increase the % of elective day case activity to a Trust average of 79% in 2005/6 (links to Standards for Better Health, Domain– Accessible and responsive care)	1.4.2	Poor clinical outcomes or adverse incidents	Routine pre-op assessment for all elective patients	Directorate clinical governance report incidents reported through risk management system	Controls deemed to be satisfactory and shown to be operating effectively in relation to 1.4.2 Gaps in assurance and control relate to pre-operative assessment, in that a proportion of elective adult patients (surgical and gynaecology) are pre-assessed. Patients not pre-assessed are at risk of unanticipated adverse events leading to poor clinical outcomes.	Increased Medical Day Unit capacity Audit and quality assurance programme needed for TC via Clinical reference Board Policy and procedures to deliver infection free environment	Local key performance clinical indicators have not been fully developed nor are they adequately reviewed down to desired level	M2	L3	MA
26	1.4	1.4 For ambulatory care: to increase the % of elective day case activity to a Trust average of 79% in 2005/6 (links to Standards for Better Health, Domain– Accessible and responsive care)	1.4.3	Benchmarking performance Clinical leads			Local directorate or specialty-specific clinical indicators are being develped in order to benchmark local clinical indicators. Dr Foster clinical benchmarking software is in use across the Trust. A programme of training is underway.	Increased Medical Day Unit capacity Progress reports incl consultant level analysis from Clinical Reference Board to Modernisation Board Link change in practice to IPR	Local key performance clinical indicators have not been fully developed nor are they adequately reviewed down to desired level	H9	L3	MA

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
27	1.5	For cancer care: to deliver the 31 day maximum wait from diagnosis to treatment and 62 day maximum wait form referral to treatment(links to Standards for Better Health, Domain– Accessible and responsive care)	1.5.1	Lack of manpower – multidisciplinary team (MDT) co-ordinators to routinely collect data and service improvement manager to reduce unnecessary bottlenecks and variation	SLA contract income	Quality assurance by Head of Performance National cancer database returns reported at Performance and Trust Board NWL SHA/ K&C PCT Performance Review meetings	Cancer waits within target for 2004/5 MDT co-ordinator and Service Improvement posts funded and recruited to with no vacancies. Cancer data routinely collected and uploaded onto cancer waits PTL and national database by co-ordinators. Need to review other data sources (e.g. waiting lists) to confirm that all patients identified with cancer are discussed at MDT, adding them to the PTL where this is not the case. Review of last 10 patients completed by Service Improvement Manager with action plans to be agreed with each MDT by end of March 2006.	3 additional posts needed - MDT co-ordinators in Dermatology and Urology and full-time service improvement manager Lack of histopathology and radiology input to MDT meetings	No assurance currently available regarding the ability to meet this target in 2005/6 Waiting times for endoscopy, bronchoscopy and radiology	U20	M6	ED
28	1.5	For cancer care: to deliver the 31 day maximum wait from diagnosis to treatment and 62 day maximum wait form referral to treatment(links to Standards for Better Health, Domain– Accessible and responsive care)	1.5.2	Information systems do not support identification of patients and monitoring of patient journey	Lastword clinical logs Contingency plan developed for manual collection of data to be entered onto spreadsheet, including mandatory data fields	Progress reports to EPR and Cancer Boards	Cancer waits within target for 2004/5. Patients can be identified by patient number, surname and other data. The ADT Log provides history of contact with care in the Trust. PTL now established to track patient journey prospectively. Need to review other data sources (e.g. waiting lists) to confirm that all patients identified with cancer are discussed at MDT, adding them to the PTL where this is not the case.	Inability to capture data automatically using IT systems		U20	0	AG

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
29	1.5	For cancer care: to deliver the 31 day maximum wait from diagnosis to treatment and 62 day maximum wait form referral to treatment(links to Standards for Better Health, Domain– Accessible and responsive care)	1.5.3	Access to diagnostic services will not be fast enough to meet the target wait	Cancer Waits Action Plan		Cancer waits within target for 2004/5 All patients fast-tracked through diagnostic services provided at C&W, currently access to TURP is key diagnostic bottleneck which is being reviewed and action plan agreed by mid-March 2006.Turnaround times for histopathology agreed with HHT, with escalation by Cancer Services Manager where notified.	Ability to upload data automatically from partner hospitals Pathology waiting/ turnaround times not available	Waiting times for endoscopy, bronchoscopy and radiology	U12	M6	ED
30	1.5	For cancer care: to deliver the 31 day maximum wait from diagnosis to treatment and 62 day maximum wait form referral to treatment(links to Standards for Better Health, Domain– Accessible and responsive care)	1.5.4	Bottlenecks at partner hospitals	Cancer Waits Action Plan		Cancer waits within target for 2004/5 Bottlenecks in Urology for access to robotic surgery at SMH. Joint meeting w/c 27 February 2006 to resolve. No other bottlenecks identified at other partner hospitals to date.	Lack of equipped MDT video facilities	Limited assurance currently available regarding the ability to meet this target in 2005/6 Waiting times for endoscopy, bronchoscopy and radiology	U16	H12	ED
31	1.6	For sexual health: to guarantee access to services within 48 hours(links to Standards for Better Health, Domain– Accessible and responsive care)	1.6.1	Inadequate space exists to deliver the level of service needed to meet target	Business case for JHC expansion Developing network and increasing outreach Introduction of booking system and walk in clinics	Approval of business case at Trust Board	Walk in triage indicates that symptomatic patients will be treated that day	Monitoring system needs to be developed	No assurance currently available for 1.61,1.6.2,1.6.3	H8		PW
32	1.6	For sexual health: to guarantee access to services within 48 hours(links to Standards for Better Health, Domain– Accessible and responsive care)	1.6.2	Current inability to provide 7 day services		Approval of business case at Trust Board	Walk in triage indicates that symptomatic patients will be treated that day	Monitoring system needs to be developed Investment needed for clinics to open at weekend and evenings	No assurance currently available for 1.61,1.6.2,1.6.3	H5		PW

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
33	1.6	For sexual health: to guarantee access to services within 48 hours(links to Standards for Better Health, Domain– Accessible and responsive care)	1.6.3	There is currently a lack of definition of this target		Approval of business case at Trust Board	Walk in triage indicates that symptomatic patients will be treated that day	Monitoring system needs to be developed Definition needed regarding difference between screening and chronic clinics PCTs commissioning strategy must change to meet 48 hour target in their LDP	No assurance currently available for 1.61,1.6.2,1.6.3	H5		PW
34	1.7	Ensure that all first outpatient appointments, day case and elective inpatient operations are fully booked(links to Standards for Better Health, Domain– Accessible and responsive care)	1.7.1	Lastword and GP systems will not support Choose and Book	Trust and PCT leads for Booking and for Choose and Book Booking and Choice Board Care Records Service Programme Board	Booking figures reported at Performance and Trust Board	Booking targets to date have been achieved GE Healthcare have committed to make Lastword compliant with version 1 of Choose and Book Full Booking Service. Key risk to implementation by September 2006 is BT and Connecting for Health testing, which the Trust is in negotiation to deliver during March 2006. GP systems are technically compliant with Indirect Booking Service. Roll-out of Full Booking Service to all GPs by March 2007 to support 90% of all referrals via GP Direct Booking.	Cross sector implementation plan for the Indirect Booking System (planned for 2005)	Working toward full implementation of Choose and Book at C&W	U20	H12	ED
35	1.7	Ensure that all first outpatient appointments, day case and elective inpatient operations are fully booked(links to Standards for Better Health, Domain– Accessible and responsive care)	1.7.2	GPs will not comply with Indirect Booking System	Trust and PCT leads for Booking and for Choose and Book Booking and Choice Board	Booking figures reported at Performance and Trust Board	Booking targets to date have been achieved Department of Health £100k incentive for PCTs to deliver Direct Booking by December 2006. PCTs to incentivise GPs via the flexibilities afforded by the GP contract.	Cross sector implementation plan for the Indirect Booking System (planned for 2005) Choice directory of services linked to full booking systems		H8	H8	ED

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
36	1.7	Ensure that all first outpatient appointments, day case and elective inpatient operations are fully booked(links to Standards for Better Health, Domain– Accessible and responsive care)	1.7.3	Theatre scheduling system does not meet service needs	Trust and PCT leads for Booking and for Choose and Book Booking and Choice Board Care Records Service Programme Board	Booking figures reported at Performance and Trust Board	Booking targets to date have been achieved PICIS implemented to service user specification.		No detailed plan for procurement and implementation of a new Theatre Scheduling System(	H8	L1	ED
37	1.8	Reduce hospital acquired infection rates each year, particularly MRSA (Links to Standards for Better Health, Domain - Safety and care environment and amenities)	1.8.1	Significant isolated MRSA outbreak would dramatically affect infection rates	Infection control committee Infection control policy New elective patient screening process	Monitoring of MRSA rates	MRSA rates reported to Performance Board All MRSA bacteraemia are reported and investigated and untoward incidents and improvement actions agreed between IC team and clinical area.	Process for immediate communication of infection outbreaks Additional bed management support to increase management infection risk All staff have understanding of the national standards Training for designated staff		H9	0	AMacC
38	1.8	Reduce hospital acquired infection rates each year, particularly MRSA (Links to Standards for Better Health, Domain - Safety and care environment and amenities)	1.8.2	Failure to improve infection practices relating to long lines and cannulas	Infection control committee Infection control policy		Plan of audit and training established in respect to lines and cannulas overseen by the IC team and IC committee	Process for immediate communication of infection outbreaks All staff have understanding of the national standards Training for designated staff	Detailed infection rate performance indicators to be developed	M6	H5	AMacC

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
39	1.8	Reduce hospital acquired infection rates each year, particularly MRSA (Links to Standards for Better Health, Domain - Safety and care environment and amenities)	1.8.3	Failure to maintain cleaning standards to PEAT assessment level or above	Infection control committee Infection control policy Contract specification and Abatement Schedules Key Performance Indicator PEAT score	Key Performance Indicators and audit schedules based on national standards reported to PEAT management group and Facilities Assurance Board Quarterly PEAT inspections, with results fed back to directorates, PEAT Management Group	Monthly KPIs and quarterly PEAT results operating effectively PEAT inspection completed and rating of Acceptable/ Good will be achieved for 2005/06. Joint monthly audits with ISS-M consistently scored at 90% pre-rectification for the whole hospital.	Roll out of joint audit programme to lead staff at ward and department level Establishment of Facilities Assurance Board All staff have understanding of the national standards Training for designated staff		U12	L1	ED
40	1.9	Deliver the targets established in the National Service Frameworks (links to Standards for Better Health, Domain - Clinical and cost effective care)	1.9.1	Inability to deliver because of Lack of investment in NSF targets	Directorate NSF group	Results of Royal College of Physicians audits feedback to trust Executive for clinical governance and Performance Board	Local assessment against milestones Annual NSF Reports to be signed off by Trust Eexecutive Clinical Governance to monitor progress. Annual updates scheduled for October to December 2006.	Investment NSF progress reports needed at Trust Exec	No corporate assurance that milestones are being delivered NSF reports to Trust Board via the Governance Committee Relevant balance score card elements presented at Performance Board and Trust Board	H12	H8	ED
41	1.9	Deliver the targets established in the National Service Frameworks (links to Standards for Better Health, Domain - Clinical and cost effective care)	1.9.2	Failure to recruit Nurse Consultant and nurse specialist post for older people	Directorate NSF group Recruitment process	Results of Royal College of Physicians audits feedback to trust Executive for clinical governance and Performance Board	Consultant taking up post in April 2006-02-22	Shortage of suitably qualified nurses available NSF progress reports needed at Trust Exec	NSF reports to Trust Board Relevant balance score card elements presented at Performance Board and Trust Board	M6	L2	AMacC

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
48	2.1	Embed the Trust clinical governance structures, systems and processes in 2005/6 (Standards for Better Health, Domain- Governance and safety)	2.1.1	Systems and processes may be inadequate to deliver the agenda	Risk management policies and procedures Incident reporting system Risk management committee Trust wide and Maternity specific Clinical Governance Development Plan (CGDP) Quarterly clinical governance and risk management reports Clinical Governance half days Increased risk management training Complaints reports Comprehensive risk review Incident review register Risk register 1000 good ideas	Exception reporting for CGDP monthly at Trust Executive for Clinical Governance (TE for CG) Quarterly risk report presented to Risk Management Committee (RMC) and TE for CG Risk register reviewed at Risk Management Committee and Clinical Governance Assurance Committee to assure progress Compliance with complaint targets monitored at performance board monthly	Many actions from the CGDP are delivered Annual General Meeting attracted 200+ service users Numbers of incident forms are increasing There is evidence that steps have been taken to mitigate risks in the risk register Complaints figures are reported monthly at performance board Actions arising from incident reviews are being closed	Actions to mitigate areas of CGDP highlighted but not always followed through on time Lack of familiarity with the new systems introduced Systems are new and will need to evolve and adapt following experience of use Risk management policies need review and simplification		H9	L2	Dir of Gov/ AMacC
50	2.1	Embed the Trust clinical governance structures, systems and processes in 2005/6 (Standards for Better Health, Domain- Governance and safety)	2.1.2	Lack of ownership of the agenda (including risk management) which may be seen as something to do on top of everything else			Trust-wide commitment enabled the delivery of CNST Level 2 against both the General and Maternity standards	Lack of specific clinical governance responsibilities written into job descriptions and objectives for key managers Staff at all levels need to be held to account for their areas of responsibility in relation to the agenda Lack of understanding of the broader governance agenda	Variable of assurance in relation to 2.1.2 and 2.1.3 currently	U16	M6	Execs

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
52	2.1	Embed the Trust clinical governance structures, systems and processes in 2005/6 (Standards for Better Health, Domain- Governance and safety)	2.1.3	Capacity owing to a growing agenda and an inability to recruit to clinical governance team members and directorate leads	Budget in place for staffing structure			Job descriptions need to be written which encourage recruitment and meet agenda for change requirements Lack of permanent established support for user involvement agenda	Lack of assurance in relation to 2.1.2 and 2.1.3 currently	H8	M6	Dir of Gov/ AMacC
53	2.2	Comply with National Guidelines, where appropriate, or provide an acceptable rationale for non compliance(links to Standards for Better Health, Domain - Clinical and cost effective care)	2.2.1	Missing notes can mean that knowledge of patient pathways is not available	Medical records policy Case note tracking system Record pull rate audits	Clinic pull rates monitored Case notes audits	Majority of all patient records are logged on lastword. Medical records tracking policy and updated SLA agreed with each directorate to ensure local ownership of roles and responsibilities. Missing records policy and database implemented and monitored with feedback to directorates in relation to performance standards. This will be backed up by a Trust wide missing notes audit to check that notes tracked out to departments/ individuals reconcile. Temporary folders established where patient records cannot be traced with clear procedure for ammalgamation once original records located.	Tracking system is inadequate or not used properly - notes are frequently not available at the latest location they are tracked to	Insufficient assurances received corporately upon the effectiveness of the case note tracking and pull rates in clinics	16	L4	ED
54	2.2	Comply with National Guidelines, where appropriate, or provide an acceptable rationale for non compliance(links to Standards for Better Health, Domain - Clinical and cost effective care)	2.2.2	Clinicians unaware of national guidance	NICE guidance dissemination system Confidential enquiry dissemination system	CE report and CGDP exception report at TE for CG	National Guidance is reviewed monthly at the Trust Executive for Clinical Governance. In addition to this, there is a system of cascading information from the Medical Director to relevant clinical, service directors or heads of departments such as therapies or pharmacy.	Other guidance published by Royal colleges Delays in compliance or lack of declaration when non compliance occurs	Assurance that guidance is complied with is collected, however evidence of compliance through indicated audit is not effective for all areas or practice	H9	L3	MA

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
55	2.2	Comply with National Guidelines, where appropriate, or provide an acceptable rationale for non compliance(links to Standards for Better Health, Domain - Clinical and cost effective care)	2.2.3	Risk of litigation if the trust does not declare non compliance and accept it formally at executive level				Delays in compliance or lack of declaration when non compliance occurs		H4	0	Dir of Gov
56	2.3	Develop clinical audit programmes that reflect national and local priorities and use information derived from them to improve clinical services (links to Standards for Better Health, Domain - Clinical and cost effective care)	2.3.1	Audit does not occur in all specialties therefore performance vs standards is not known	Audit leads in each directorate Clinical Governance coordinator posts budgeted for Clinical audit data base	Named clinicians are in place in each directorate Annual audit report as part of CG annual report presented to Trust Board	Named clinicians for each directorate publicised on intranet Trust wide audit lead appointed. Each directorate has a nominated audit lead. Annual audit programme agreed, which includes the mandatory corportate audits such as documentation and resuscitation. Space contraints limit the ability to recruit suitable clinical governance coordinators to support directorates.	Lack of audit plan for 2004/5 No Trust wide audit lead No audit guidance for annual audit plans Inability to recruit suitable staff to Clinical Governance posts Use of clinical audit database is not widespread	Insufficient assurance is received upon the audit work undertaken	U10	U10	MA

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
57	2.3	Develop clinical audit programmes that reflect national and local priorities and use information derived from them to improve clinical services (links to Standards for Better Health, Domain - Clinical and cost effective care)	2.3.2	Specialties do not participate in national audits to specified deadlines which can result in a failure to achieve star ratings	Audit leads in each directorate Clinical Governance coordinator posts budgeted for Clinical audit data base	Named clinicians are in place in each directorate Annual audit report as part of CG annual report presented to Trust Board	Named clinicians for each directorate publicised on intranet	Lack of audit plan for 2004/5 No Trust wide audit lead No audit guidance for annual audit plans No timetable for national audits Inability to recruit suitable staff to Clinical Governance posts Use of clinical audit database is not widespread	Insufficient assurance is received upon the audit work undertaken	U20	H8	Dir of Gov
58	2.3	Develop clinical audit programmes that reflect national and local priorities and use information derived from them to improve clinical services (links to Standards for Better Health, Domain - Clinical and cost effective care)	2.3.3	Specialties fail to include relevant national and corporate priorities in identifying local audits e.g. NICE, complaints	Audit leads in each directorate Clinical Governance coordinator posts budgeted for Clinical audit data base	Named clinicians are in place in each directorate Annual audit report as part of CG annual report presented to Trust Board	Named clinicians for each directorate publicised on intranet	Lack of audit plan for 2004/5 No Trust wide audit lead No audit guidance for annual audit plans No timetable for national audits Inability to recruit suitable staff to Clinical Governance posts Use of clinical audit database is not widespread	Insufficient assurance is received upon the audit work undertaken	H10	L2	Dir of Gov

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
59	2.3	Develop clinical audit programmes that reflect national and local priorities and use information derived from them to improve clinical services (links to Standards for Better Health, Domain - Clinical and cost effective care)	2.3.4	Audits information is not routinely reported in line with governance arrangements	Clinical audit data base		Audit database established. Audit Lead appointed Head of Clinical Governance appointed	Use of clinical audit database is not widespread Clinical audit activity not reported at directorate clinical governance boards	Insufficient assurance is received upon the audit work undertaken	U15	L2	Dir of Gov
60	2.3	Develop clinical audit programmes that reflect national and local priorities and use information derived from them to improve clinical services (links to Standards for Better Health, Domain - Clinical and cost effective care)	2.3.5	Information technology systems do not support audit programmes eg Cancer audits	Manual systems for e.g. cancer patients		A number of cancer logs have been developed for MDT support.	Information systems do not support audit	Insufficient assurance is received upon the audit work undertaken	U15	L4	AG
61	2.4	To maintain CNST level one and achieve CNST level two (Standards for Better Health, Domain- safety	2.4.1	Lack of awareness and understanding of the importance of CNST		Achievement of CNST level two	CNST Level 2 achieved			U16	0	Dir of Gov

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
62	2.4	To maintain CNST level one and achieve CNST level two (Standards for Better Health, Domain- safety	2.4.2	The Trust wide training database will not provide the information and follow up needed for mandatory training	Training data base now collecting data	Achievement of CNST level two	Level one achievement in 2003/4 This has been developed and is subject to changing requirements. Administrator appointed. Trained key trainers. Trained other staff to ensure follow-up/reporting. Crystal Reporting Tool purchased, enabling report extraction.	Training database unable to currently follow up on mandatory training with learner and manager and resources will be needed to implement system fully	Exception reports required relating to mandatory training attendance	U16	L4	AG / MF
63	2.4	To maintain CNST level one and achieve CNST level two (Standards for Better Health, Domain- safety	2.4.3	The Trust wide incident reporting system does not map to the National patient safety reporting and Learning system to the specified deadline	Mapping training for National reporting system underway	Achievement of CNST level two	CNST Level 2 achieved			H9	0	Dir of Gov
64	2.4	To maintain CNST level one and achieve CNST level two (Standards for Better Health, Domain- safety	2.4.4	Medical device training will not be sufficient in terms of amount and availability at a multi professional level	Medical device training delivered for high risk devices to nursing staff Clinical skills business plan	Achievement of CNST level two	CNST level 2 achieved which assesses medical device training. Training database established.	Equipment library needs to be established and staffing recruited to supplement training delivery		U20	0	AMacC
65	2.4	To maintain CNST level one and achieve CNST level two (Standards for Better Health, Domain- safety	2.4.5	The provision of patient information is inadequate in terms of amount and content	National producing patient information toolkit available	Achievement of CNST level two	Level one achievement in 2003/4 Information on medical conditions now available on Patient Line system, Director of Communications and PPI Coordinator appointed Feb 2006.	Systems for development and approval of patient information need to be established Lack of focus within the Trust on patient information No identified budget for patient information	CNST level two achieved, however patient information remains variable	U20	0	AMacC / PR

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
66	2.5	Integrate clinical services and research to develop and improve patient outcomes (links to Standards for Better Health, Domain - Governance)	2.5.1	Priorities of Imperial for research may not align with service strategy and Imperial may move research base away from the Trust site	Regular meetings with Imperial Academic Dean on site University representative on Trust Board Research Governance framework	Published Imperial College School of Medicine (ICSM)academic and research strategy Research activity reports	Inclusion of research activity in clinical governance quarterly reports and Trust wide meeting report Professor in Acute Medicine appointed, commences March 2006. There is significant input from clinicians from the Trust, particularly the HIV/GUM Directorate, in National research initiatives, which inform the local agenda. The Trust conitnues to collaborate with the Imperial College School of Medicine's around research strategy and the agreement and development of research priorities.	Strategic objectives and activities of the Teaching Hospitals within the ICSM Campus may not be aligned Professor in acute medicine Integration of R&D Director into mainstream Trust governance arrangements		H12	M6	MM
67	2.5	Integrate clinical services and research to develop and improve patient outcomes (links to Standards for Better Health, Domain - Governance)	2.5.2	St Stephens Aids Trust (SSAT) fail to sustain adequate level of research	Research Governance framework Memorandum of understanding and associated legal framework in place between the Trust and SSAT	Research activity reports	The Medical Director is a member of the St Stephen's Aids Trust (observer), as agreed within an agreed Memorandum of understanding. Level of research (and funding) has been maintained.	Integration of R&D Director into mainstream Trust governance arrangements	Risk assessment required	H12	L3	MM

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
68	2.5	Integrate clinical services and research to develop and improve patient outcomes (links to Standards for Better Health, Domain - Governance)	2.5.3	Impact of EU directive for clinical trials will result in reduced number of trials	Research Governance framework	Research activity reports	The number of research trials reduced immediately following the application of the EU directive. As other countries had adopted these limitations, clinical trials have stabilised. Though demand for hosting trials has increased in some counties, this is representative of the London trend. Critics of the new regulations have raised the notion that the problem is compounded by the fact that the UK appears to be more fastidious than other parts of Europe in adopting and adhering to EUCTD guidelines.	Integration of R&D Director into mainstream Trust governance arrangements	Variation resulting from EU directive stabilised.	H9	M6	MM
69	2.5	Integrate clinical services and research to develop and improve patient outcomes (links to Standards for Better Health, Domain - Governance)	2.5.4	Failure of Trust to recognise the importance of multiprofessional research development	Research Governance framework New role for Dir. Of Nursing in Multiprofessional Education with links to Director of research	Research activity reports	Inclusion of research activity in clinical governance quarterly reports and Trust wide meeting report In order to further strengthen multi-professional research, an Assistant Director of Nursing with a special interest in research and education was appointed in 2005.	Integration of R&D Director into mainstream Trust governance arrangements	Risk assessment required	H12	M6	MM
70	3.1	Provide opportunities for users and staff to give feedback on the quality of services provided and to use feedback to improve service delivery (links to Standards for Better Health, Domain - Patient Focus)	3.1.1	Actions from 1000 good ideas may not be followed through or communicated fully to users and staff	1000 good ideas Membership names and numbers	1000 good ideas report(	Report for 1000 good ideas received monthly – shows actions completed Action form 1000 Good Ideas reviewed and reported to Board and communicated through Trust News.	Need to monitor outstanding actions from 1000 good ideas and communicate back all ideas to users and staff		M6	0	AMacC

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
71	3.1	Provide opportunities for users and staff to give feedback on the quality of services provided and to use feedback to improve service delivery (links to Standards for Better Health, Domain - Patient Focus)	3.1.2	Lack of regular engagement with foundation status membership could result in disengagement	Membership names and numbers		Plans to 'refresh' Shadow Membership initiated in 2005. Shadow Membership was invited to AGM Open Day, to participate in EofC and Patient Accelerating Change workshops. All members have received a Membership Pack.	Currently no performance indicators for status of membership e.g. numbers and attrition rates		M6	0	AMacC
72	3.1	Provide opportunities for users and staff to give feedback on the quality of services provided and to use feedback to improve service delivery (links to Standards for Better Health, Domain - Patient Focus)	3.1.3	Links with PPI forum are currently not well established	Membership names and numbers		Quarterly meeting with CE and Chairman established.	Need a quarterly report on PPI forum liaison and actions arising as a result of this link		H9	0	AMacC
73	3.1	Provide opportunities for users and staff to give feedback on the quality of services provided and to use feedback to improve service delivery (links to Standards for Better Health, Domain - Patient Focus)	3.1.4	Website not utilised as a medium for feedback			Feedback is on the WWW Trust Home Page as is Foundation Trust Membership.			H9	0	AG

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
74	3.1	Provide opportunities for users and staff to give feedback on the quality of services provided and to use feedback to improve service delivery (links to Standards for Better Health, Domain - Patient Focus)	3.1.5	Actions from complaints and comments cards not incorporated into directorate plans	Membership names and numbers Directorate clinical governance development plans	Complaints report	Engagement and Partnership group established information and guidance given to Directorates at the start of business planning.		Head of Patient Affairs should check directorate clinical governance plans for key actions arising from complaints and comment cards	M6	L3	AMacC
75	3.1	Provide opportunities for users and staff to give feedback on the quality of services provided and to use feedback to improve service delivery (links to Standards for Better Health, Domain - Patient Focus)	3.1.6	Failure to implement key actions in the Trust's Patient and public engagement strategy	Membership names and numbers Patient and Public engagement committee	Reports from PPI forum Patient Survey Complaints report	Engagement and Partnership steering group established, PPI coordinator appointed.	Patient and public engagement committee new and will take time to develop	Lack of awareness of PPI views	M3	L2	AMacC
76	3.2	Develop a partnership agreement with staff to promote their involvement in planning and decision making (Standards for Better Health, Domain- Governance)	3.2.1	Failure to agree on terms of involvement	Staff side	Staff survey	Positive working relationship with staff side, as evidence by JMTUC minutes. Staff involvement in corporate descision making. Establishment and promotion of staff support groups, such as BME and Gay and Lesbian groups. Partnership agreement to be formalised as part of Foundation Trust and HR Strategy. This may be evidenced by the Trust Employee members of the FT.	Lack of partnership agreement	Lack of assurance currently provided	H8	H8	MF

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
77	3.2	Develop a partnership agreement with staff to promote their involvement in planning and decision making (Standards for Better Health, Domain- Governance)	3.2.2	Staff do not want to be engaged		Staff survey Minutes of JMTUC	IWL self assessment signed off by chair of staff side see update relating to 3.2.1	More formal involvement strategy needed	Audit required for level staff involvement in key decisions	H8	H8	MF
78	3.2	Develop a partnership agreement with staff to promote their involvement in planning and decision making (Standards for Better Health, Domain- Governance)	3.2.3	Lack of ownership of the agenda		Staff survey	IWL self assessment signed off by chair of staff side see update relating to 3.2.1		Audit required for level staff involvement in key decisions	H8	H8	MF
79	3.3	Collaborate with Healthcare community to plan & provide complimentary & cost effective services & support delivery of sector wide priorities & improve sector performance (SBH Domain: governance, accessible & responsive care, clinical & cost effectiveness)	3.3.1	Further delay of Paddington Campus	C&W Corporate Plan SHA Chief Executives' Forum	Feedback from SHA Chief Executives' Forum	No longer relevant: Initial risk related to Paddington Campus.	No controls of timing and result of Paddington Health Campus decisions Lack of formal communication process from SHA Chief Executives' Forum		U16	0	HL

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
80	3.3	Collaborate with Healthcare community to plan & provide complimentary & cost effective services & support delivery of sector wide priorities & improve sector performance (SBH Domain: governance, accessible & responsive care, clinical & cost effectiveness)	3.3.2	Different priorities for different organisations in the sector	PCTs Local Delivery Plans Royal Borough Cabinet Business Plan Clinical Networks SHA Chief Executives' Forum	Progress reports to Trust Board on priorities identified in the Corporate Plan Feedback from Clinical Networks Feedback from SHA Chief Executives' Forum		Lack of formal communication process from Clinical Networks Lack of formal communication process from SHA Chief Executives' Forum	Further assurance to be developed in this area where possible	H12	H12	HL
81	3.3	Collaborate with Healthcare community to plan & provide complimentary & cost effective services & support delivery of sector wide priorities & improve sector performance (SBH Domain: governance, accessible & responsive care, clinical & cost effectiveness)	3.3.3	Lack of engagement from one or more organisations	Clinical Networks SLA negotiation process SHA Chief Executives' Forum	Progress reports to Trust Board on priorities identified in the Corporate Plan Feedback from Clinical Networks Feedback from SHA Chief Executives' Forum	Opportunity to comment on Westminster Council and PCTs' plans for the future Record of engagement in clinical networks Engagement with a range of partners as part of the annual health check.	Lack of formal communication process from Clinical Networks Lack of formal communication process from SHA Chief Executives' Forum	Further assurance to be developed in this area where possible	M6	L4	HL

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
82	3.3	Collaborate with Healthcare community to plan & provide complimentary & cost effective services & support delivery of sector wide priorities & improve sector performance (SBH Domain: governance, accessible & responsive care, clinical & cost effectiveness)	3.3.4	Lack of funding to support delivery	SHA Chief Executives' Forum	Reports on SLA process and finance to Trust Board and Budget Control Meeting Feedback from SHA Chief Executives' Forum	Regular feedback from SHA Chief Executives' Forum is in place. Trust is planning for control total surplus of £2.1m to support sector financial position although HIV income risk may make this unachievable. Trust in correspondence with SHA over sector approach to supporting Ravenscourt Park.	Lack of financial flexibility to respond to new pressures or fund new priorities Lack of formal communication process from SHA Chief Executives' Forum	Further assurance to be developed in this area where possible	H12	H12	LB
83	4.1	Ensure that Information Governance systems and processes are robust, support the delivery of the Trust objectives(Standards for Better Health, Domain-Governance	4.1.1	Notes not always available for clinic or theatre	Medical records policy Case note tracking system	Case note tracking audits Incident reports	Continuous mitigation process. Medical Records library now only contains 2 years worth of records in line with the Medical Records policy.Integrity check will be completed 3 March 2006 to ensure all records in order and no mis-files. Medical Records staff also have responsibility for maintaing these standards for allocated areas of the library. Directorates now search for missing records 3 days in advance of appointment/ admission in line with Missing records policy.	Key performance indicators - not fully developed nor are they fully reported	Insufficient assurances received corporately on the availability of notes	H9	H9	ED
84	4.1	Ensure that Information Governance systems and processes are robust, support the delivery of the Trust objectives(Standards for Better Health, Domain-Governance	4.1.2	Risk that all staff are not familiar with scope and extent of information governance	Training programme developed Information available on intranet	Evidencing and auditing of information governance toolkit	Exception reporting to information governance steering group A set of web training has been created and will be published by FY end. EPR training has been strengthened to cover information governance and data quality. Information governance is a topic area in the Intranet.	Training plan Exception reporting for training to highlight staff who have not taken training	No action taken on exception reports for staff who have not taken training	M6	M6	AG

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
85	4.1	Ensure that Information Governance systems and processes are robust, support the delivery of the Trust objectives(Standards for Better Health, Domain-Governance	4.1.3	Information not required for clinical care is collected without explicit patient consent			The patient is informed of use of information and can explicitly refuse its use although this has a serious effect on treatment. If non pseudoanonymised data is to be used for purposes other that patient care the patient is informed and policies exist on this.	Audit on how information handled at patient level Separate clinical IT systems from research IT systems Patient information leaflet explaining to patients how information will be used		H8	0	AG
86	4.2	Work with the National Programme for Information Technology (NPfIT) to maximise opportunities for Chelsea and Westminster (Standards for Better Health, Domain-Governance)	4.2.1	Inability of Connecting for Health to engage with the Trust in realistic timescales	KCW Care community governance structure SHA Governance and reference groups Pan London governance groups Best practice groups	Gateway review Reports from care community and SHA regarding the inclusion of C&W in NPfIT plans	This risk is outside the control of the Trust. The risks are being managed through GE who have subsumed IDX, CCA, CfH and the KCW Care Community on a weekly and more frequent basis by a wide range of staff including Executive Directors.	No feedback loop from NPfIT	Effective assurance does not exist	H16	H16	AG
87	4.2	Work with the National Programme for Information Technology (NPfIT) to maximise opportunities for Chelsea and Westminster (Standards for Better Health, Domain-Governance)	4.2.2	Lack of clear timeline for adoption		Renegotiated existing supplier contracts	As for 4.2.1 with which this should be merged.		Effective assurance does not exist	H16	H16	AG

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
88	4.3	Continue to develop internal information technology systems to support service delivery (Standards for Better Health, Domain- Governance, clinical and cost effectiveness)	4.3.1	Suppliers of legacy systems are unable to deliver additional functionality	Financial penalties Contract negotiations Change controls systems Participation in product user group	System releases Early adoption of care records service	Changes and new system releases are delivered and noted at IM&T steering group In September 2005, the Trust implemented LastWord Step Release 4.5.3 with added functionality in prescribing, maternity, document management, Dictation and Inbox. The PICIS Theatre Management System is in parallel running with the Theatreman system that it will replace and is working with TSSU's instrument tray tracking system. Agreement has been reached on piloting a bed management system in mid-2006. The PACS project is underway and is rationalising the commercial arrangements for procurement. A project has started to obtain National Spine compliance by GE and to implement full Choose and Book	Product release strategies and plans	Inability to control external suppliers	H12	L3	AG
89	4.3	Continue to develop internal information technology systems to support service delivery (Standards for Better Health, Domain- Governance, clinical and cost effectiveness)	4.3.2	Risk that internal systems will not survive until the care record service is available	Individual system assessment as candidates for decommissioning	Reports to the IM&T programme board	See 4.3.1		Need to formalise decommissioning assessments and formalise reports to the IM&T steering group	H9	L3	AG

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
90	4.4	Develop Trust procurement strategy that ensures delivery of targeted savings & ensure procurement services deliver best value for money (Standards for Better Health- domain clinical & cost effectiveness & performance assessment framework use of resources)	4.4.1	Loss of economies of scale through lack of best procurement practice	Procedures for quotations and tendering Potential suppliers vetted before contract awarded Contracting procedures Contract monitoring to identify off contract variations	Internal audit report on procurement function PASA benchmark reports	Partial assurance Procurement Director in place and procurement strategy documented. To be approved by Executive.	Documented procurement strategy Absence of vetting for smaller suppliers Lack of contract management system Post contract evaluation and reporting procedure to be implemented	Purchasing practices currently being scoped	U16	L4	LB
91	4.4	Develop Trust procurement strategy that ensures delivery of targeted savings & ensure procurement services deliver best value for money (Standards for Better Health- domain clinical & cost effectiveness & performance assessment framework use of resources)	4.4.2	Failure to follow tendering procedures required by standing financial instructions(SFIs)	Procedures for quotations and tendering Potential suppliers vetted before contract awarded Contracting procedures Contract monitoring to identify off contract variations	Internal audit report on procurement function PASA benchmark reports	Procurement Director in place and procurement strategy documented. To be approved by Executive. Contract management system in development. Purchasing handbook available for managers on intranet	Documented procurement strategy Absence of vetting for smaller suppliers Lack of contract management system Post contract evaluation and reporting procedure to be implemented	Partial assurance Purchasing practices currently being scoped	H9	L4	LB

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
92	4.5	Ensure that our financial systems and services including procurement are modernised to deliver best value for money (Standards for Better Health- domain clinical and cost effectiveness and performance assessment framework use of resources)	4.5.1	Lack of senior capacity to work on the development agenda for the finance service	Established staffing structure	None available	Trust finance and information functions have been assessed in the light of Early Lessons of PbR and FT requirements. Cost pressure bid will be assessed as part of setting Budget 06/07.		Lack of assurance in this area - need documented financial/ IT strategy	U20	U12	LB
93	4.5	Ensure that our financial systems and services including procurement are modernised to deliver best value for money (Standards for Better Health- domain clinical and cost effectiveness and performance assessment framework use of resources)	4.5.2	Lack of IT solutions to support agenda	IT strategy	None available	See 4.3.1	IT strategy needs to take account of use priorities at local level	Lack of assurance in this area - need documented financial/ IT strategy	U20	L3	AG
94	4.6	Work with our facilities partners to deliver a safe and secure environment (links to Standards for Better Health, Domain – Care environment and amenities)	4.6.1	Lack of training in Security/ Health & Safety	Senior security manager Security policy Included in mandatory training for security staff	6-monthly monitoring schedules against Minutes of Security Group Training record from database Health & Safety Committee review	Monthly contract review meetings Weekly meetings to discuss security incidents Reports for those who have had training available Clear policies and procedures developed and being implemented Training courses established via Training Resource Centre	Security Group to be established to promote best practice and monitor implementation of Security Policy Not utilising database fully to chase non attendees	Assurances not available regarding effectiveness of exception reporting for safety audits and training	H9	H9	ED

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
95	4.6	Work with our facilities partners to deliver a safe and secure environment (links to Standards for Better Health, Domain – Care environment and amenities)	4.6.2	Lack of safety audits	Safety Coordinators identified for each area Central record of assessments established	6-monthly review of safety audit Health & Safety Committee review	Clear policies and procedures developed and being implemented Health and Safety and Security audits included in annual comprehensive risk reviews with results fed back to directorates and health and safety Committee.	Staff changes mean that areas may be exposed until new leads identified	Improved assurances regarding effectiveness of exception reporting for safety audits and training	H9	L2	ED
96	4.7	Develop our Public Relations and Communication systems to enhance internal and external communications with all of our stakeholders and develop branding (Standards for Better Health, Domain- Governance)	4.7.1	Staffing structure inadequate to deliver the PR agenda	Budget in place for Head of Communications role Medic over 24/7 from Jonathan Street	Media coverage Production of trust information e.g. Trust news Production of patient information for all specialties	Monthly production of Trust news	Need staff to manage PR proactively i.e. maintain and develop internet site, produce trust news, deal with media enquiries, develop branding No system for production approval and review of patient information Communications group to be re-established	Media coverage to be sent to Trust Board members Lack of assurance available	U15	U6	Dir of Gov
97	4.7	Develop our Public Relations and Communication systems to enhance internal and external communications with all of our stakeholders and develop branding (Standards for Better Health, Domain- Governance)	4.7.2	Trust website newly developed and service information not current	Service directory written		A great deal of effort has been made to ensure currency and keep the site in line with Trust initiatives - see www.chelwest.nhs.uk.	Need staff to manage PR proactively i.e. maintain and develop internet site, produce trust news, deal with media enquiries, develop branding Communications group to be re-established	Lack of assurance available	U15	L3	AG

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
98	4.7	Develop our Public Relations and Communication systems to enhance internal and external communications with all of our stakeholders and develop branding (Standards for Better Health, Domain- Governance)	4.7.3	Team brief inadequate to deliver corporate message to all staff	Limited team brief in situ	IWL assessment		Team brief needs review Communications group to be re-established	Lack of assurance available	H10	L2	Dir of Gov
99	4.7	Develop our Public Relations and Communication systems to enhance internal and external communications with all of our stakeholders and develop branding (Standards for Better Health, Domain- Governance)	4.7.4	Lack of contact with our shadow foundation members	Membership database		Plans to 'refresh' Shadow Membership initiated in 2005. Shadow Membership was invited to AGM Open Day, to participate in EofC and Patient Accelerating Change workshops. All members have received a Membership Pack.	Regular contact with members needed Membership post vacant Communications group to be re-established	Performance indicators needed for Trust membership Limited assurance available	H5	0	AMacC
100	4.8	4.6 Deliver pathology and diagnostic services to meet clinical service needs (links to Standards for Better Health, Domain - Patient Focus and clinical and cost effectiveness)	4.8.1	Pathology SLA does not allow the service provided to be monitored within a measured performance and quality framework	Current SLA document	Exception reporting for quality and variance analysis for financial reporting	Financial information provided Pathology to be based on an SLA (rather than shared service) model, aiming for completion by April 2006 with HHT. Viral Load in process of being competitively tendered, with legally binding contract established with successful bidder.	SLA is a series of spreadsheets with rollover baseline based on outturn for previous year No quality information monitoring Pathology expertise not available in Trust Lack of devolved pathology budgets	No fully effective assurance is provided currently	U20	U16	ED

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
101	4.8	4.6 Deliver pathology and diagnostic services to meet clinical service needs (links to Standards for Better Health, Domain - Patient Focus and clinical and cost effectiveness)	4.8.2	Pathology services are not modernised in line with clinical services	Current SLA document Pathology SLA meeting	Specialty audits	This will be included as a key requirement of the Pathology SLA/ contract.	Pathology expertise not available in Trust Lack of devolved pathology budgets	No fully effective assurance is provided currently	U20	U16	ED
102	4.9	Establish a clear and robust process for developing, approving and managing capital building projects (Standards for Better Health, Domain- Governance and performance framework component use of resources)	4.9.1	Lack of clarity for all Trust regarding process for building project and equipment	Capital Programme Board Capital Medical Equipment Board Medical Devices Committee Treatment centre programme board IM&T Steering group	Capital expenditure reports to Board Post audit on capital projects	Increased clarity at executive level Forward schedule for Capital Programme committee in place and Facilities assurance committee established. Approval process for capital bids documented.	Forward schedule of meetings and process for capital bids Facilities assurance committee	Clarity across all organisation Inadequate review Post project	H9	M6	LB
103	4.9	Establish a clear and robust process for developing, approving and managing capital building projects (Standards for Better Health, Domain- Governance and performance framework component use of resources)	4.9.2	Capacity of projects team to deliver projects	Project management team	Capital expenditure reports to Board Post audit on capital projects	Increased clarity at executive level Projects manpower based on capital programme rather than fixed establishment. Funded by 12% fees included in all capital business cases, in line with indistry average.		No assurance regarding Benchmarking of project management teams	H9	L1	ED

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
104	5.1	Ensure that the equality and diversity agenda is a priority in all Trust business (Standards for Better Health, Domain-Governance)	5.1.1	Equality and Diversity (E&D) inadequately resourced – staff time and space	Executive lead for E&D E&D Steering group Temporary consultancy 2days/week until March 2005	Progress reports to E&D steering group IWL assessment	Evidence of some progress e.g. training and network report IWL self assessment scored high A decision needs to be taken to fund a substantive appointment if the Equality and Diversity Programme is to be taken forward in a sustainable way.	Lack of space No benchmarking for resources Resource for an E&D Manager has not yet been prioritised Not part of performance management framework	Variable performance monitoring undertaken IWL assessment awaiting external validation E&D quarterly and annual performance monitoring does not currently go to the Board Missing assurances upon the effectiveness of E&D policy and practices	U12	M4	ED
105	5.1	Ensure that the equality and diversity agenda is a priority in all Trust business (Standards for Better Health, Domain-Governance)	5.1.2	Inadequate consultation with internal and external groups means Trust may be unaware of key work streams needed to implement E&D for all staff groups	E&D Steering group Temporary consultancy 2days/week until March 2005	Progress reports to E&D steering group IWL assessment Ethnicity monitoring	Evidence of some progress e.g. training and network report IWL self assessment scored high Ethnicity of 99% staff known Staff groups established along with feedback from the staff survey which identifies ethnic profile. FT membership will also be used as a means of ensuring adequate consultation.	Not part of performance management framework Ethnicity of the workforce does not map the local population Lack of performance indicators	Variable performance monitoring undertaken IWL assessment awaiting external validation E&D quarterly and annual performance monitoring does not currently go to the Board Missing assurances upon the effectiveness of E&D policy and practices General lack of current knowledge of priorities for action planning	H8	M4	ED

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
107	5.1	Ensure that the equality and diversity agenda is a priority in all Trust business (Standards for Better Health, Domain- Governance)	5.1.3	Lack of available E&D training	E&D Policy in place Some E&D training	Progress reports to E&D steering group IWL assessment	Evidence of some progress e.g. training and network report IWL self assessment scored high Regular Equality and Diversity training now takes place. An annual programme is in place. New 'RES' scheme adopted. Quarterly reports to Board on Ethnicity of workforce. Attendance records placed on training database.	Not part of performance management framework Lack of performance indicators Not yet utilising database fully to chase non attendees	Variable assurances upon the effectiveness of E&D policy and practices Currently reports of staff who have not had training are not produced Need to secure recruitment resources to employ equality and diversity manager/advisor.	U10	M6	MF
109	5.1	Ensure that the equality and diversity agenda is a priority in all Trust business (Standards for Better Health, Domain- Governance)	5.1.4	Failure to change behaviours of key staff members	Some E&D training Grievance procedure Whistle blowing/ bullying and harassment policy Policy	Progress reports to E&D steering group IWL assessment Absence of claims/complaints Absence of employment tribunals Absence of grievances Feedback from staff/patient surveys	Evidence of some progress e.g. training and network report IWL self assessment scored high ITs/grievance rates no higher than comparable organisation Included as a key competency in every AfC job description with link to Knowledge and Skills Framework.	Not part of performance management framework Lack of performance indicators Lack of proactive, positive management time and attention Need diversity guidelines	Variable performance monitoring undertaken regarding E&D E&D quarterly and annual performance monitoring does not currently go to the Board Missing assurances upon the effectiveness of E&D policy and practices Do not monitor complaints/claims/ grievances for diversity issues	H12	H12	ED

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
111	5.2	Implement Agenda for Change by September 2005 (Standards for Better Health, Domain- Governance)	5.2.1	Risk that the HR and payroll systems and staff will not have the capacity to deliver agenda for change to timetable	Additional resources identified	Update on % job matched in agenda for change report to Board	% Jobs matched continues to rise HR/Payroll systems have capacity to deliver 100%. Assimilation of staff for A&C. Space found for staff to work, computers provided, project methodology adopted.	No space to place staff to undertake work Computers inadequate and cannot replace until new financial year Team learning “on job” Lack of project methodology		U9	L4	MF
112	5.2	Implement Agenda for Change by September 2005 (Standards for Better Health, Domain- Governance)	5.2.2	Risk of breach in data protection because inadequate facilities for staff record storage	Office locked overnight		Filing cabinets/locked storage (link to 2.4.2 IT solution resolved).	Need locked storage in suitable location with appropriate access- daytime access not prohibited Space strategy needed		U15	0	MF
113	5.3	5.1 Comply with the European working time directive by April 2005(Standards for Better Health, Domain- Governance)	5.3.1	Risk that behaviours will not change because junior staff want to stay and learn	Shift patterns introduced to prevent on call exceeding EWTD limit. Rotas monitored via diary cards to see exceptions to EWTD	EWTD report at Trust Board	Ministerial return completed biannually Progress against EWTD target Action taken to address problems with rotas by HR and General Managers/Clinical Directors. Diary cards completed twice a year for ministerial returns. Compliance with EWTD for 2004 achieved. Performance monitoring via ministerial return/diary cards.	Incomplete diary card returns Lack of detailed review of areas where non compliance is reported		U9	L2	MF
114	5.3	5.1 Comply with the European working time directive by April 2005(Standards for Better Health, Domain- Governance)	5.3.2	Risk that behaviours will not change because A/E targets seen as more important than European working time directive (EWTD)	Shift patterns introduced to prevent on call exceeding EWTD limit. Rotas monitored via diary cards to see exceptions to EWTD A&E rotas monitored via diary cards to see exceptions to EWTD	EWTD report at Trust Board	Ministerial return completed biannually Progress against EWTD target Compliance with EWTD for 2004 achieved. Performance monitoring via ministerial return/diary cards.	Incomplete diary card returns Lack of detailed review of A&E compliance		U9	L2	MF
115	5.3	5.1 Comply with the European working time directive by April 2005(Standards for Better Health, Domain- Governance)	5.3.3	Rotas shared with other Trusts may not comply	Rotas monitored via diary cards to see exceptions to EWTD	EWTD report at Trust Board	Ministerial return completed biannually Progress against EWTD target Problem with shared rota with other Trust now resolved.			U9	L2	MF

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
116	5.3	5.1 Comply with the European working time directive by April 2005(Standards for Better Health, Domain-Governance)	5.3.4	Attention focussed on medics - all staff groups must comply		EWTD report at Trust Board	Ministerial return completed biannually Progress against EWTD target Gaps in assurance reduced: Nursing staff asked to confirm total working hours if additional bank shifts are requested as overtime. Rota'd working hours of the nursing team ensures that nursing staff are not allocated hours in breach of the EWTD.	Do not monitor working hours of other groups of staff	Variable assurance of action to address exception reports.	U9	L4	MF
117	5.3	5.1 Comply with the European working time directive by April 2005(Standards for Better Health, Domain-Governance)	5.3.5	Consultancy support has no space to be based		EWTD report at Trust Board	Ministerial return completed biannually Progress against EWTD target Desk space now provided for EWTD Lead	Lack of space strategy and prioritisation of requirements		U9	L1	MF
118	5.4	Achieve Improving Working Lives Practice Plus accreditation by April 2006 (Standards for Better Health, Domain-Governance)	5.4.1	Lack of awareness of and evidence to support progress against Improving Working Lives (IWL) standards	Focus groups 1:1 interviews Trust news articles Management time with staff Staff side engagement and positive relationships	IWL self and external assessment	Positive self assessment Staff survey IWL Practice Plus Achieved April 2005	Cannot control what staff feel or say on the day of assessment Poor communication regarding what is good		M4	0	MF
119	5.4	Achieve Improving Working Lives Practice Plus accreditation by April 2006 (Standards for Better Health, Domain-Governance)	5.4.2	Self assessment over optimistic	Focus groups 1:1 interviews Trust news articles Management time with staff Staff side engagement and positive relationships	Staff survey result	Positive self assessment Staff survey IWL Practice Plus Achieved April 2005	Lack of independent audit of self assessment		M6	0	MF

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
120	5.5	Examine new roles and new ways of working(Standards for Better Health, Domain-Governance)	5.5.1	Vision not articulated and shared and therefore not delivered	HR strategy Appraisal and Personal development plans Education and workforce committee	Staff survey Patient survey Staff turnover Sickness absence rates	Maxine	Joined up strategies needed for service delivery	No assurances have been received on how we examine new roles and ways of working	U12	H12	AP
121	5.6	Review the content and delivery of Trust wide induction and mandatory training (Standards for Better Health, Domain-Governance)	5.6.1	Failure to deliver induction owing to lack of resources and disparate nature of induction across staff groups	Induction project group		Induction programme updated. Records of attendance to induction kept on Training Database. Reporting tool purchased to enable exception reports. Training Database administrator appointed.	Induction policy IT solution for database not fully functioning	No assurance of issue of exception reports	U12	L2	MF
122	5.6	Review the content and delivery of Trust wide induction and mandatory training (Standards for Better Health, Domain-Governance)	5.6.2	Difficult to change behaviour -staff have been allowed to say too busy in past			Induction programme updated. Records of attendance to induction kept on Training Database. Reporting tool purchased to enable exception reports. Training Database administrator appointed.		No assurance of action to address exception reports	U16	H12	MA
123	5.6	Review the content and delivery of Trust wide induction and mandatory training (Standards for Better Health, Domain-Governance)	5.6.3	Database will not function fully and capture information required	Training database	Exception reporting from training data base for mandatory induction	The training database is in use and functions as originally specified.	IT solution for database not fully functioning		U20	0	AG
124	6.1	Identify all existing specialist services and apply for formal recognition if not in place	6.1.1	Failure to identify all specialist services	SLA negotiation process identifies specialist services as contract exclusions for 2005/06 Clinical Directors and Service Directors knowledge of services	SLA monitoring process	Involvement with LSCG in relation to specific services has proved positive	No agreed list of specialist services provided at C&W		M3	L3	AP

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
125	6.1	Identify all existing specialist services and apply for formal recognition if not in place	6.1.2	Lack of support and process for engaging London Specialised Commissioning Group, SHA, PCTs or NSCAG	SLA negotiation process identifies specialist services as contract exclusions for 2005/06 Involvement in HIV Consortium	SLA monitoring process Feedback from HIV consortium	Involvement with LSCG in relation to specific services has proved positive	No specific forum for discussing specialist services except HIV Consortium	No robust assurance	H12	H12	AP
126	6.2	Develop and confirm the model of care and establish an HIV and sexual health brand within primary and secondary care services in North West London	6.2.1	Lack of clinical ownership and agreement of service models	Service strategy and business plan Multidisciplinary consultant led clinics Virtual clinics in HIV John Hunter Clinic refurbishment National HIV /sexual health strategy Medical foundation for AIDS and sexual health strategy	Exception reporting on project plans Virtual clinic has weekly and monthly audits by service director	Go live of multidisciplinary led teams Audit from virtual clinic and action taken when exceptions identified Service models agreed within HIV directorate as part of business planning process with development of Sexual health Strategy in 2006/07 that will be used as basis for agreeing sector wide service model with PCTs and the SHA.	Communications plan Business case awaiting approval	Currently no national performance reporting for HIV/GUM outpatient and inpatient activity	H8	H8	ED
127	6.2	Develop and confirm the model of care and establish an HIV and sexual health brand within primary and secondary care services in North West London	6.2.2	Shift in commissioning strategy	Service strategy and business plan London HIV consortium PCT sexual health groups National HIV /sexual health strategy Medical foundation for AIDS and sexual health strategy	Quarterly monitoring business plan objectives at directorate policy board National monitoring of policy initiatives and targets	Controls deemed to be satisfactory although policy is fluid Increased risk in relation to HIV consortium approach. 48 hour target for Sexual Health has reinforced requirement to purchase sexual health capacity.		Currently no national performance reporting for HIV/GUM outpatient and inpatient activity	H8	H8	ED
128	6.3	Build upon the reputation of excellence in paediatrics by consolidating expertise and developing academic and research opportunities	6.3.1	Paddington Campus development and alignment of St Mary's and Hammersmith Hospital drives transfer of specialist paediatrics away from C&W	Paediatric Review Group for North West London PACU development SHA Option planning group	SHA involvement	SHA commitment to involve all stakeholders Evidence of clinician involvement No longer relevant: Initial risk related to Paddington Campus.			H12	0	HL

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
129	6.3	Build upon the reputation of excellence in paediatrics by consolidating expertise and developing academic and research opportunities	6.3.2	Uncertainty about future of paediatrics in West London leads to drift of expertise away from C&W	Paediatric Review Group for North West London SHA Option planning group	SHA involvement	SHA commitment to involve all stakeholders Evidence of clinician involvement No longer relevant: Initial risk related to Paddington Campus.			H12	0	HL
130	6.3	Build upon the reputation of excellence in paediatrics by consolidating expertise and developing academic and research opportunities	6.3.3	Lack of infrastructure to support existing service (e.g. Paediatric A&E space, PACU development)	Paediatric Review Group for North West London SHA Option planning group Link with Imperial Capital Programme Board	SHA involvement	SHA commitment to involve all stakeholders Mini PACU development completed on Saturn ward increasing day case capacity from 5 to 10 trolley spaces, releasing ward capacity for additional elective and emergency activity. Fracture clinic available 1700 to 2200 for additional paediatric A&E capacity. Both represent short-term solutions pending startegic review of specialist paediatric services.	Project management skills	Political agenda outside C&W control	M6	M6	ED
131	6.4	Ensure that the Trust achieves designation as a Burn Centre	6.4.1	Failure to provide adequate space, staffing and critical care capacity	Burns strategy group Capital Programme Board Specialist commissioning group North West London critical care network	Minutes from Burns strategy group Minutes from SE England network	Draft recommendations from designation process identifies C&W as centre Specialist commissioning group funding second critical care bed	Space strategy needed	No assurance provided for space	U20	U20	AP
132	6.4	Ensure that the Trust achieves designation as a Burn Centre	6.4.2	Designation process is unclear therefore difficult to achieve	SE England network	Minutes from Burns strategy group Minutes from SE England network	Draft recommendations from designation process identifies C&W as centre		No assurance provided for space	H9	H9	AP

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
133	7.1	Develop the Trust's framework for integrated governance (Standards for Better Health, Domain-Governance)	7.1.1	Lack of awareness of corporate governance issues as the Trust moves to become a foundation hospital	Board away day in planning Executive meetings Governance wheel	Trust Board minutes Board assurance products		Executive and non executive responsibilities clarified Training for Board members Lack of DH clarity and steer at present	Annual review of Board performance required	U12	M6	Dir of Gov
134	7.1	Develop the Trust's framework for integrated governance (Standards for Better Health, Domain-Governance)	7.1.2	Risk that issues may fall between the committee structures and executive responsibilities	Standards for Better Health	Trust Board minutes Board assurance products		Board calendar Lack of DH clarity and steer at present	Annual review of Board performance required	H9	L2	Dir of Gov
135	7.2	Achieve statutory financial duties including financial balance (Standards for Better Health, Domain-Governance, clinical and cost effectiveness and performance assessment component use of resources)	7.2.1	Budgets not consistent with planned activity leading to cost pressures	Budget setting principles agreed at board level and communicated to budget holders Budget setting review meetings with Chief Exec, monthly finance reports and budget control group monitoring meetings Capacity plan to meet 6 month and 13 week maximum waits developed in consultation with General Managers to inform budget setting Monthly finance and activity monitoring Clear sector pricing and payment rules	Signed budgets at directorate level Internal audit review of budget setting process - report to audit committee External audit opinion to audit committee Signed SLAs with PCTS	Controls deemed to be satisfactory for 05/06 for 7.2.3 and 7.2.6 Budgets signed off with Budget Holders	Not all budgets signed off Management reports comparing reference costs for each specialty Training accountants not available due to resource constraint		M6	M4	LB

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
137	7.2	Achieve statutory financial duties including financial balance (Standards for Better Health, Domain-Governance, clinical and cost effectiveness and performance assessment component use of resources)	7.2.2	Budget holders unclear of activity to about activity targets leading to cost pressures	Budget setting principles agreed at board level and communicated to budget holders Budget setting review meetings with Chief Exec, monthly finance reports and budget control group monitoring meetings Capacity plan to meet 6 month and 13 week maximum waits developed in consultation with General Managers to inform budget setting Monthly finance and activity monitoring Clear sector pricing and payment rules	Signed budgets at directorate level Signed SLAs with PCTS	Controls deemed to be satisfactory for 05/06 for 7.2.3 and 7.2.6 Budgets signed off with Budget Holders.	Not all budgets signed off Management reports comparing reference costs for each specialty Training accountants not available due to resource constraint		M6	M4	LB
139	7.2	Achieve statutory financial duties including financial balance (Standards for Better Health, Domain-Governance, clinical and cost effectiveness and performance assessment component use of resources)	7.2.3	Failure to control bank and agency costs Regular SLA meetings to agree managed approach	Clear sector pricing and payment rules Prospective bank and agency booking and reporting tool Agreed establishments Recruitment and retention plans	Internal audit review of budget setting process - report to audit committee Signed SLAs with PCTS HR and finance reports Vacancy fill rates	Controls deemed to be satisfactory for 05/06 for 7.2.3 and 7.2.6 Regular SLA meetings to agree managed approach Bank and agency quotas introduced. Weekly establishment panel in place. All requests for agency for G grade (A4C 7) and above can only be signed off by General Manager/Clinical Director and Exec Director countersignature.	Management reports comparing reference costs for each specialty Training accountants not available due to resource constraint		U12	M6	LB

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
140	7.2	Achieve statutory financial duties including financial balance (Standards for Better Health, Domain-Governance, clinical and cost effectiveness and performance assessment component use of resources)	7.2.4	Lines of financial accountability unclear Regular SLA meetings to agree managed approach	Clear sector pricing and payment rules Schedule of delegation and management report structures	Signed SLAs with PCTS	Controls deemed to be satisfactory for 05/06 for 7.2.3 and 7.2.6 Regular SLA meetings to agree managed approach Finance reports state management accountability clearly. DoF escalates to CEO where budget responsibility unclear."	Management reports comparing reference costs for each specialty Training accountants not available due to resource constraint Some central budgets need to be devolved to improve accountability		M6	L2	LB
141	7.2	Achieve statutory financial duties including financial balance (Standards for Better Health, Domain-Governance, clinical and cost effectiveness and performance assessment component use of resources)	7.2.5	Staff unaware of financial responsibilities and duties	Clear sector pricing and payment rules Budgetary control objectives/SFIs clearly stated and communicated	Internal audit review of budget setting process - report to audit committee External audit opinion to audit committee Signed SLAs with PCTS	Controls deemed to be satisfactory for 05/06 for 7.2.3 and 7.2.6 Budgetary control objectives/SFIs clearly stated and communicated. Budget responsibility clearly set out in KSF competencies and in job descriptions. Ongoing training programme for budget holders through Learning Resource Centre.	Management reports comparing reference costs for each specialty Training accountants not available due to resource constraint		M4	L4	LB
142	7.2	Achieve statutory financial duties including financial balance (Standards for Better Health, Domain-Governance, clinical and cost effectiveness and performance assessment component use of resources)	7.2.6	Failure to report accurately or promptly to budget holders and relevant third parties	Clear sector pricing and payment rules	External audit opinion to audit committee Signed SLAs with PCTS	Budget position reported within 11 working days currently. Plans in place to reduce this to 5 working days from April 06. Finance support for Medicine and HIV has been under-resourced and this will be addressed through separating Finance Manager posts for Medicine and HIV to line up with General Manager accountability.	Management reports comparing reference costs for each specialty Training accountants not available due to resource constraint		H9	M6	LB

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
143	7.2	Achieve statutory financial duties including financial balance (Standards for Better Health, Domain- Governance, clinical and cost effectiveness and performance assessment component use of resources)	7.2.7	Local PCTs face financial deficit will seek to withdraw funds via reduced activity and challenge to prices and trust unable to reduce costs commensurately SLAs have specific risk share agreements Joint working with other acute trusts	Clear sector pricing and payment rules	Signed SLAs with PCTS	Signed SLAs are in place for all North West London PCTs with clear risk share arrangements. PCTs have withdrawn funds in 05/06 via reduced activity but the financial effects have been provided for and the Trust is forecasting to achieve statutory financial balance at M10. HIV Consortium has sought to withdraw funds via suspension of risk share in M9 and non payment of over-performance which would reduce income by £1.6m but should not compromise statutory break-even. Trust will seek arbitration on this decision. For 2006/07, Trust has planned for withdrawal of outpatient activity but needs to revisit elective assumptions as PCTs may resist paying for routines more quickly than 5 months maximum	Management reports comparing reference costs for each specialty Training accountants not available due to resource constraint PCT investment and SLA risk shares	No assurances received regarding income and risk shares	U25	U20	LB
144	7.2	Achieve statutory financial duties including financial balance (Standards for Better Health, Domain- Governance, clinical and cost effectiveness and performance assessment component use of resources)	7.2.8	Lack of effective link between SLAs and financial management systems- failure to cover costs through price and risk share arrangements SLAs have specific risk share agreements Joint working with other acute trusts	Clear sector pricing and payment rules	Signed SLAs with PCTS	Clear risk share arrangements have been agreed for 05/06 SLAs	Management reports comparing reference costs for each specialty Training accountants not available due to resource constraint PCT investment and SLA risk shares	No assurances received regarding income and risk shares	U12	M6	LB

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
145	7.3	Ensure that the organisation is fully prepared for changes in the funding flows under payment by results (Standards for Better Health, Domain- Governance, clinical and cost effectiveness and performance assessment component use of resources)	7.3.1	Inherent uncertainty of the form and timing for Payment by Results (PBR) which may mean we are unable to plan resourcing adequately	Trust accountant on secondment in the DH Links Into finance networks including the ATH and ILTH		Tariff for 2006/07 published at the end of January and Trust is remodelling the implications for its financial plan for the April Trust Board. Trust still expects to be a gainer under PbR as planned. Trust has anticipated some aspects of the changes e.g. tariff deflator but differential tariff for emergency spells needs to be modelled. Review risk again at end March 06.		PBR timing not known	U25	U15	LB
146	7.3	Ensure that the organisation is fully prepared for changes in the funding flows under payment by results (Standards for Better Health, Domain- Governance, clinical and cost effectiveness and performance assessment component use of resources)	7.3.2	Services may be operating above tariff		SHA monitor the benchmarking data Reference cost index is below 100	Overall the Trust is operating below tariff as it has an RCI of 97. Finance has assessed which services are gainers and losers under the tariff and are working with directorates to develop plans to mitigate. Trust is developing refined patient level procedure costing through ComboCC to inform and refine reference costs. These will be used to challenge tariffs where these are anomalous.	Elective work under ref costs critical care and emergency over Directorate involvement in benchmarking to bring cost in line with tariff Inability in some instances to reduce services in response due to political or patient choice Board level Performance report to be developed further	Effective assurance not available at this time given currently re responsiveness of Trust to PBR	U25	U15	LB

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
148	7.3	Ensure that the organisation is fully prepared for changes in the funding flows under payment by results (Standards for Better Health, Domain- Governance, clinical and cost effectiveness and performance assessment component use of resources)	7.3.3	Capacity within each directorate to research and fully understand the impact of PBR	Benchmarking of reference cost against tariff to understand drivers including benchmarking clubs CHKS and HIPPO	Activity reports to the board External audits back to case records Overview report to Trust Board and details to Finance and General Purposes Committee February 2004	Trust has purchased and is rolling out training to all directorates for Dr Foster benchmarking products which will highlight potential areas for efficiency savings eg daycase rates and length of stay. Finance has plan to reduce reporting period to 5 days to allow finance managers more time each month to support financial planning and forecasting including PbR risk mitigation.	Inability in some instances to reduce services in response due to political or patient choice	Effective assurance not available at this time given currently re responsiveness of Trust to PBR	U25	U16	LB
149	7.3	Ensure that the organisation is fully prepared for changes in the funding flows under payment by results (Standards for Better Health, Domain- Governance, clinical and cost effectiveness and performance assessment component use of resources)	7.3.4	Impact of activity and demand reductions is expected to increase under PBR	Benchmarking of reference cost against tariff to understand drivers including benchmarking clubs CHKS and HIPPO Business planning training session on PBR Monitor referrals Monitor activity	Activity reports to the board External audits back to case records Overview report to Trust Board and details to Finance and General Purposes Committee February 2004	Activity reports are now available on HIPPO. Need to develop more proactive usage within the Trust by directorates and escalation of key issues through Performance Board.		Effective assurance not available at this time given currently re responsiveness of Trust to PBR	U25	U15	LB

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
150	7.3	Ensure that the organisation is fully prepared for changes in the funding flows under payment by results (Standards for Better Health, Domain- Governance, clinical and cost effectiveness and performance assessment component use of resources)	7.3.5	Coding systems and process fail to capture activity accurately and in time for billing	GP user group Internet site to be developed New clinical coding manager Sector wide coding group Coding team restructure	Overview report to Trust Board and details to Finance and General Purposes Committee February 2004	Data Quality Group has been established which is actively addressing coding systems and processes.		Effective assurance not available at this time given currently re responsiveness of Trust to PBR	U25	U12	LB
151	7.4	Develop a performance management framework to support the delivery of Trust objectives (Standards for Better Health, Domain- Governance)	7.4.1	Capacity of Head of Performance and General Managers may not enable a performance management framework to be delivered	Review of information departments structure	Performance report focussing on star ratings External audit reviews as part of Acute Hospital Portfolios SHA review Healthcare Commission visits Spot check review	Staffing structure has been reviewed and post of performance analyst being recruited to.	Staffing structure Needs further review	Current performance delivered by paper and not HIPPO technology Not audited sufficiently and therefore gives inadequate assurance	U16	U16	LB
152	7.4	Develop a performance management framework to support the delivery of Trust objectives (Standards for Better Health, Domain- Governance)	7.4.2	Performance framework timetable and reporting process is not embedded and a lack of understanding and awareness of Trust objectives		Performance report focussing on star ratings External audit reviews as part of Acute Hospital Portfolios SHA review Healthcare Commission visits Spot check review	Performance report to Trust Board focusing on star ratings Corporate Planning process has set out corporate objectives clearly for business planning. Performance targets for 05/06 were published in January 06 which have introduced new priorities for acute Trusts.	Performance review must cover all relevant areas of performance not just areas of star ratings	Current performance delivered by paper and not HIPPO technology Not audited sufficiently and therefore gives inadequate assurance	U12	H12	LB

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
153	7.4	Develop a performance management framework to support the delivery of Trust objectives (Standards for Better Health, Domain- Governance)	7.4.3	Risk that IT systems will not capture information required and that focus will be placed on easy to collect data areas rather than areas of poor performance		Performance report focussing on star ratings External audit reviews as part of Acute Hospital Portfolios SHA review Healthcare Commission visits Spot check review	There is a specific programme to ensure that data is fit for purpose and all areas of the Trust are treated equally. The data warehouse is used for clinical and corporate modelling.	Need to design framework and work with IT in progress All algorithms supporting lastword need to be audited	Current performance delivered by paper and not HIPPO technology Not audited sufficiently and therefore gives inadequate assurance	U20	L3	AG
	7.4	Develop a performance management framework to support the delivery of Trust objectives (Standards for Better Health, Domain- Governance)	**7.4.4**	**Risk that new performance targets for 2006/07 are not included within directorate buisness plans**	Review and update of business planning templates and information within the Performance report template to reflect the new targets	Reports of performance against new and existing targets for 2006/07	New targets included in business planning templates	Monitoring system developed however not yet validated.		M3		LB
	7.4	Develop a performance management framework to support the delivery of Trust objectives (Standards for Better Health, Domain- Governance)	**7.4.5**	**Risk that data collected relating to new performance targets for 2006/07, is not robust enough to inform the organisation sufficiently.**	Review and update of information contained within the Performance report template to reflect the new targets Develop robust data indicators to ensure reliable data capture		Monthly reports updated to include new performance targets. These monthly reports are reviewed by the Executive Team		Insufficient assurances provided regarding directorate plans for measurement and improvement of each new performance indicator for 2006/07 targets Insufficient investment to produce clear information in order to signpost patients to secondary care for obesity, ethnic monitoring, access to GUM clinics, drug misuse and smoking cessation	M3		LB

Assurance Framework
February 2006

N°	C/P Ref N°	Topic	A/F Ref N°	Principal Risks	Key Controls	Assurances on Controls	Positivie Assurances	Gaps in Control	Gaps in Assurance	Initial Risk Rating	Rescored Risk Rating	Lead
154	7.5	Maximise opportunities from private patient income activity within the Trust to generate income to support NHS activity	7.5.1	Lack of strategy and business plans for private patients and lack of organisational agreement on which services to grow	Business Manager for private patients Monthly management accounts	Internal and external financial audit annually Report at Budget Control executive meeting	Report to audit committee for annual performance Self financing business case for the appointment of a General Manager in Private Practice developed and awaiting decision.	General Management input needs to increase Lack of information and business systems suitable for private practice Business and marketing plan	Insufficient assurances provided regarding these risks	H8	H8	ED
155	7.5	Maximise opportunities from private patient income activity within the Trust to generate income to support NHS activity	7.5.2	Lack of commitment to/ownership of private patients in the Trust	Business Manager for private patients	Internal and external financial audit annually Report at Budget Control executive meeting	Report to audit committee for annual performance Self financing business case for the appointment of a General Manager in Private Practice developed and awaiting decision.	General Management input needs to increase Lack of information and business systems suitable for private practice Business and marketing plan	Insufficient assurances provided regarding these risks	U12	H8	ED
156	7.5	Maximise opportunities from private patient income activity within the Trust to generate income to support NHS activity	7.5.3	Lack of organisational agreement on which services to grow	Business Manager for private patients Monthly management accounts	Internal and external financial audit annually Report at Budget Control executive meeting	Report to audit committee for annual performance Self financing business case for the appointment of a General Manager in Private Practice developed and awaiting decision.	General Management input needs to increase Lack of information and business systems suitable for private practice Business and marketing plan	Insufficient assurances provided regarding these risks	U12	H8	ED
157	7.5	Maximise opportunities from private patient income activity within the Trust to generate income to support NHS activity	7.5.4	Lack of incentive to grow business for stakeholders	Business Manager for private patients	Internal and external financial audit annually Report at Budget Control executive meeting	Report to audit committee for annual performance Self financing business case for the appointment of a General Manager in Private Practice developed and awaiting decision.	General Management input needs to increase Lack of information and business systems suitable for private practice Business and marketing plan	Insufficient assurances provided regarding these risks	H9	H9	ED

Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting, 2nd March 2006

AGENDA ITEM NO.	5.1.2/Mar/06
PAPER	Healthcare Commission – Proposed Core Standards Declaration (Board Assurance Reports)
AUTHOR	Vivia Richards, Head of Clinical Governance
SUMMARY	At the end of October 2005 the Trust submitted a draft declaration, outlining its performance against the Healthcare Commission's 24 core standards. That draft declaration was intended to form the basis of the final declaration, which must be submitted to the Healthcare Commission by mid-day on 4th May 2006. Board assurance reports for each of the 24 national standards were prepared by the Executive Directors for the October draft declaration. These reports have been updated, taking into account feedback received from the Overview and Scrutiny Committee, the Patient and Public Involvement Forum, and the Strategic Health Authority. The Executive Team would like to assure the board that the core standards have been maintained. Board members will be required to sign the final declaration to indicate whether they have received reasonable assurance that the Trust has accurately reported its compliance with the core standards. The Healthcare Commission will check the declaration against existing data held by a number of bodies about the Trust. They will then undertake selected inspections, including those Trusts for which cross-checking indicates a high risk of an undeclared lapse or conflict in core standard compliance declaration. The Trust will be scored using a system based on the degree to which we are meeting the core standards. The scale will remain the same as: fully met; partly met; not met.
ACTION	The Board is asked to consider each report and confirm that sufficient assurance has been given to enable Board members to sign the declaration. It is recommended that the printed submission, which will include commentaries received from our partners, is signed by members of the Board and posted to the Healthcare Commission.

Chelsea & Westminster Healthcare NHS Trust: Annual Health Check 2005
Paper for the Trust Board 2nd March 2006

1. Introduction

This paper describes the approach taken at Chelsea and Westminster to give the Trust Board assurance that the Trust remains complaint with the core standards described by the Healthcare Commission.

At the end of October 2005 the Trust submitted a draft declaration indicating its position against the Healthcare Commission's 24 core standards. That draft declaration will form the basis of the final declaration, which is due by 4th May 2006.

Attached is an 11-week timetable, detailing key dates and deadlines relating to the final declaration along with assurance reports for each of the 24 standards. These assurance reports have been prepared by nominated lead Directors for the area.

The Board is asked to consider the reports in order to be in a position for the declaration to be signed.

2. The Process and the Proposed Declaration

The performance framework for the NHS is driven by the Standards for Better Health, which sets out the level of quality Trusts are expected to meet or aspire to. The Board therefore needs to receive assurance reports, confirming the status of each of the core standards.

The attached assurance reports detailing whether the core standards have been maintained. These reports will be sent to our local partners: the Overview and Scrutiny Committee, Internal Audit, the Strategic Health Authority, and the Patient and Public Involvement Forum. Board members will be required to sign the final declaration to say that they have received reasonable assurance that the Trust has accurately reported its compliance with the core standards.

3. Developmental Standards

Progress is expected to be made against the developmental standards across much of the NHS as a result of the NHS Improvement Plan and the extra investment in the period to 2008. The Healthcare Commission have confirmed that Trusts will not be expected to declare their position against the developmental standards in May 2006.

The Commission have changed the information which was published on their website in December 2005, when it was realised that the consultation period relating to measurement methods for developmental standards would not provide sufficient time to include these in this year's declaration. The inspection period which we are reporting against relates to 2005/06.

Confirmation of the developmental standards will be confirmed within the next few months and we should expect to declare progress towards achieving these in next year's declaration.

4. Engaging our Partners

We are required to give our local partners the opportunity to comment on our performance against the core standards and the assurance reports have been sent to them. The timetable for this consultation is detailed within the attached paper. Their comments must be produced verbatim in the relevant sections of the declaration template. The partners include:

- The Strategic Health Authority
  A meeting has been held with the StHA to consider the declaration and further information was provided about areas of particular strength in the Trust.

- The PPI Forum
  The PPI Forum will be asked to consider the assurance reports.

- The Overview and Scrutiny Committee
  The local OSC will be preparing the commentary for the Trust.

5. Assessment Against the Declaration

The Healthcare Commission will check the declaration against existing data held by a number of bodies about the Trust. They will then undertake selected inspections including those Trusts for which cross checking indicates a high risk of an undeclared lapse in a core standard and a randomly selected group.

Each Trust will be scored using a system based on the degree to which they are meeting core standards and have action plans in place to rectify any identified significant lapses. The scale will be: fully met; almost met; partly met; not met.

If a Trust has not declared a significant lapse that is subsequently included on the declaration as a qualification, it will be weighted more heavily in the calculation of the Trust's score than will lapses that have been declared and resolved.

The overall ratings will be: excellent; good; fair; weak. These will be issued following the final declaration submission in May.

6. Internal Audit

The Trusts Internal Auditors, Bentley Jennison, have audited the process that the Trust has used to prepare the assurance reports. Their audit report was included within the draft declaration, and will be considered in our final declaration report.

7. Actions

The Board is asked to consider the updated reports and the timetable, and confirm that sufficient assurance has been given to enable Board members to sign the final declaration.

It is recommended that the declaration is signed once the commentaries have been received from our partners mid April and the Board is asked to agree a process for this to happen.

8. 11-week Timetable to Declaration Submission

Wks	Monday	Tuesday	Wednesday	Thursday	Friday	Sat/Sun
1	20th February Confirm Executive Leads for Core Standards	21st February Executive Leads to produce Board Assurance Reports	22nd February Deadline for Executive Leads – submit Board Assurance Reports to VR	23rd February Circulate Board Assurance Reports to the Trust Board (with TB papers)	24th February	25th 26th
2	27th February	28th February	1st March	2nd March Trust Board review Board Assurance Reports, which evidence intended declaration	3rd March	4th 5th
3	6th March	7th March	8th March	9th March Email draft declaration with Board Assurance Reports to OSC, PPIF and StHA	10th March Deadline for submission of the Declaration to the OSC Submit declaration to PPIF members for consideration at the meeting on 29th	11th 12th
4	13th March	14th March	15th March	16th March	17th March	18th 19th
5	20th March	21st March	22nd March	23rd March	24th March	25th 26th
6	27th March	28th March (Clinical Governance Assurance Committee)	29th March Patient and Public Involvement Forum (Andrew, Amanda and Heather attend?)	30th March	31st March Deadline for OSC and PPIF response to Trust	1st April 2nd
7	3rd April Email OSC and PPIF responses to Trust Board	4th April	5th April VR meeting with Healthcare Commission Assessment Manager	6th April Trust Board (review of proposed declaration with comments from OSC and PPIF)	7th April	8th 9th
8	10th April	11th April	12th April	13th April	14th April (Bank Holiday)	15th 16th
9	17th April (Bank Holiday)	18th April	19th April	20th April	21st April	22nd 23rd
10	24th April	25th April	26th April Deadline for submission (mid-day on 4th May). On-line submission.	27th April Print and circulate a copy of the submitted declaration to the Trust Board.	28th April	29th 30th
11	1st May (Bank Holiday)	2nd May	3rd May	4th May Trust Board review of final declaration with comments.		

Executive Lead for Each Standard

	Standard	Executive Lead
C1	Healthcare organisations protect patients through systems that: a) identify and learn from all patient safety incidents and other reportable incidents and make improvements in practice based on local and national experience and information derived from the analysis of incidents b) ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required timescales	MA
C2	Healthcare organisations protect children by following national child protection guidelines within their own activities and in their dealings with other organisations	AMac
C3	Healthcare organisations protect patients by following NICE interventional procedure guidance	MA
C4	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that: a) the risk of healthcare acquired infection to patients is reduced with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in MRSA b) all risks associated with the acquisition and use of medical devices are minimised c) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed d) medicines are handled safely and securely e) the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment	ED
C5	Healthcare organisations ensure that a) they conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care b) clinical care and treatment are carried out under supervision and leadership c) clinicians continuously update skills and techniques relevant to their clinical work d) clinicians participate in regular clinical audit and reviews of clinical services	MA
C6	Healthcare organisations cooperate with each other and social care organisations to ensure that patients individual needs are properly managed and met	AP
C7	Healthcare organisations a) apply the principles of sound clinical and corporate governance b) actively support all employees to promote openness, honesty, probity, accountability and the economic, efficient and effective use of resources c) undertake systematic risk assessment and risk management d) ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources e) challenges discrimination, promote equality and respect human rights f) meet exists performance requirements	LB C7d & f will be measured by the HC Commission through existing mechanisms

C8	Healthcare organisations support their staff through a) having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services b) organisation and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under representation of minority groups	MF
C9	Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required	AG
C10	Healthcare organisations a) undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies b) require that all employed professionals abide by relevant published codes of professional practice	MF
C11	Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare a) are appropriately recruited, trained and qualified for the work they undertake b) participate in mandatory training c) participate in further professional and occupational development commensurate with their work throughout their working lives	MF
C12	Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied	AMac
C13	Healthcare organisations have systems in place to ensure that a) staff treat patients, their relatives and carers with dignity and respect b) appropriate consent is obtained when required for all contacts with patients and for the use of any confidential patient information c) staff treat patient information confidentially, except where authorised by legislation to the contrary	AMac
C14	Healthcare organisations have systems in place to ensure that patients, their relatives and carers a) have suitable and accessible information about, and clear access to procedures to register formal complaints and feedback on the quality of serivces b) are not discriminated against when complaints are made c) are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery	AMac
C15	Where food is provided healthcare organisations have systems in place to ensure that a) patients are provided with a choice and that it is prepared safely and provides a balanced diet b) patients individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day	ED

C16	Healthcare organisations make information available to patients and the public on their services, provide patients with suitable accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during their treatment, care and aftercare	AMac
C17	The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health services	AMac
C18	Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably	AMac
C19	Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services	ED
C20	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being a) safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of their organisation b) supportive of patient privacy and confidentiality	ED
C21	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises	ED
C22	Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by a) cooperating with each other and with local authorities and other organisations b) ensuring that the local Director of Public Health's annual report informs their policies and practices c) making an appropriate and effective contribution to local partnership arrangements including local strategic partnerships and crime and disorder reduction partnerships	AP
C23	Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the national service frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections	MA
C24	Healthcare organisations protect the public by having a planned, prepared and where possible, practised response to incidents and emergency situations, which could affect the provision of normal services	AMac

Assurance Report: Healthcare Standard 1

Patient safety is enhanced by the use of healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.

Proposed declaration: compliant.

Standard 1a

1. Standard 1a: Healthcare organisations protect patients through systems that: a) identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.

2. Element:
   - There is a defined reporting process and incidents are reported regularly.
   - Reported incidents are counted, aggregated and analysed to identify patterns and trends, and periodically reported.
   - Improvements in practice are made as a result of analysis of local and national incidents.

3. Proposed declaration: Compliance

4. Evidence:
   - There is a Board approved Risk Management Strategy and Policy, which outlines the systems in place to ensure that risks which could potentially harm patients are recognised and addressed.
   - The Trust proactively uses internal and external information to improve clinical care.
   - All incidents are reported centrally, using one system – Datix, a nationally recognised database for managing incidents, near misses, complaints and claims.
   - The Clinical Governance Assurance Board is a sub Committee of the Trust Board and assures the Trust Board that probity, quality assurance, quality improvement and patient and staff safety are central components of all Trust activity.
   - The Trust reports to the National Patient Safety Agency (NPSA).
   - The Trust complies with Clinical Negligence Scheme for Trusts (CNST) 1.2.1 and 1.2.3.
   - The Trust analyses and reports on the number of incidents, categories and trends through a Quarterly Risk Management Report and a Quarterly Directorate Clinical Governance Report. These reports are in relation to professional groups, clinical areas and severity.
   - The Trust uses national findings to inform local reporting.
   - Staff are trained in the use of NPSA incident decision trees and in reporting risk.
   - The Trust can demonstrate that risks to patients have been reduced and safety improved as a result of national and local incident reporting.
   - The Trust has mechanisms for disseminating information on incidents across the organisation.
   - The Trust complies with CNST 1.2.2.

5. Where the Trust does not fully comply with the standard: n/a

6. Information available to support the evidence:

- Incident report policy available on the intranet
- Clinical Governance Meetings/Risk Management policies and procedures.
- Director of Governance and Corporate Affairs job description.
- Datix database available for review.
- Weekly Incident Reports
- Clinical Governance Assurance Committee minutes.
- Datix system NRLS reports.
- Clinical Governance Quarterly Risk Reports.
- Quarterly Governance Reports for Directorates.
- Quarterly Risk Management Report –
- Risk Management Committee minutes.
- NCEPOD/NPSA/SAB's.
- Induction Training program.
- Incident Review Register and Risk Register on Intranet SAB's website.
- Incident Review profomas on intranet.
- CNST Level 2 compliance report.

Standard 1b

1. Standard 1b:
   Healthcare organisations protect patients through systems that ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required timescales.

2. Elements:
   - Patient safety communications are regularly reviewed by appropriate individuals.
   - Patient safety communications are acted upon within stated timeframes.

3. Proposed declaration: Compliance

4. .Evidence
   - The Trust is implementing patient safety alerts.
   - There are named staff accountable for ensuring any required action is taken.
   - The Trust has mechanisms for disseminating safety alerts (SABs) across the organisation.
   - There is one route for all safety notices.
   - The Trust ensures action is taken against timescales.
   - The Trust complies with CNST 1.2.6.

5. Where the Trust does not fully comply with the standard: N/A

6. Information to support the evidence:

- SABs policy printouts
- SABs website.
- Clinical Governance/Policies and Procedures
- SABs file
- CNST Level 2 compliance report

Assurance Report – Healthcare Standard 2

1. Standard

Healthcare organisations protect children by following national child protection guidelines within their own activities and in their dealings with other organisations.

2. Elements:

- The healthcare organisation has internal systems in place to protect children
- The healthcare organisation works with all relevant partners and communities to protect children.

3. Proposed declaration: Compliance

4. Evidence:

The healthcare organisation has internal systems in place to protect children

The Trust has established systems to protect children that takes account of national guidelines and established best practice. There is a designed Board Executive lead for Child Protection (Director of Nursing) and appointed named /designated doctor and nurse. The Trust Board receives frequent reports on Child Protection arrangements within the Trust

There is 24 hours access to local child protection registers through Emergency Duty Teams (soon to be available electronically). There is 24-hour access to a clinical professional with experience in child protection via the Consultant Paediatrician on call.

Criminal Records Bureau checks are conducted for permanent staff and nursing staff on the Trust Staff Bank. The Trusts HR department complies with HSC 2002/08.

There is a comprehensive monthly program and designated budget for training in Child Protection, which is reviewed and updated regularly. Child Protection is also part of the Trusts Corporate Induction for all staff.

The healthcare organisation works with all relevant partners and communities to protect children.

The Trust has regular liaison with other health and social care agencies in respect to the protection of children. Interagency guidance on child protection has been implemented (e.g. Laming Report) and is reported on to the Trust Board frequently to ensure ongoing compliance and delivery against the guidance.

The Trust follows the London Child Protection Procedures to ensure information follows children as they across local agency boundaries. Discharge summaries and A&E attendance slips are sent to GP's, HVs and other relevant agencies. The Trusts designated doctor represents the Trust on the local child protection committees

5. Where the Trust does not fully comply with the standard: n/a

6. Information available to support the evidence:

- Trust Board Child Protection Reports
- Trust Child Protection Guidelines (on Trust Internet)
- Job Description / Job Plan for named /designated Nurse and Doctor
- Program of Child Protection Monthly Training
- Programme for Corporate Induction
- Clinical Governance Reports
- Area Child Protection Committee Minutes
- CNST Level 2 compliance report
- Child Protection training is part of the corporate programme for all staff

Assurance Report – Healthcare Standard 3

1. Standard:

Healthcare organisations protect patients by following National Institute for Clinical Excellence (NICE) interventional procedures guidance.

2. Elements:

- The healthcare organisation follows NICE interventional procedures guidance.

3. Proposed declaration: compliant

3. .Evidence

- The Trust has a policy related to new interventional procedures.
- The Directorate put forward the proposal to undertake a new interventional procedure to the Trust Executive for Clinical Governance.
- Once approved, the Medical Director ensures that the clinical professional has met appropriate external standards of training to undertake the procedure.
- The decisions made are communicated to the appropriate clinical professionals by the Clinical Director.
- Where NICE guidance does not exist, the Trust's policy details the steps to be followed (e.g. notifying NICE, making sure patients are aware of the special status of the procedures and lack of experience of its use, and making sure that clinical audit arrangements are in place.
- The Trust complies with CNST 5.1.3, 5.1.5, 5.2.2, 5.2.6 and 7.3.2.

5. Where the Trust does not fully comply with the standard: N/A

6. Information available to support the evidence:
- Trust Executive for Clinical Governance minutes.
- Trust policy for new interventional procedures
- CNST Level 2 compliance report

Assurance Report: Healthcare Standard 4

1. Standard 4: The Healthcare organisation keeps patients, staff and visitors safe by having systems that ensure that:
   a) the risk of healthcare acquired infection to patients is reduced with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in MRSA
   b) all risks associated with the acquisition and use of medical devices are minimised
   c) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed
   d) medicines are handled safely and securely
   e) the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment

2. Proposed declaration: Compliance

3. Evidence:

a) the risk of healthcare acquired infection to patients is reduced with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in MRSA

- The Trust has a Director of Infection Control and Prevention
- The Director of Nursing has executive responsibility for the Trust's PEAT initiative.
- The Trust has an Infection Control Policy
- Standards of cleanliness are monitored by the PEAT Steering Group
- Regular audit cycle, involving lead clinical staff is in place and actively monitored
- Training sessions held regularly to ensure consistent approach to standards of cleanliness and infection control training is completed at the Trust induction and with annual updates
- Clean Your Hands Campaign introduced throughout the organisation and hand-gels installed at every bed-side
- The Trust is on track to meet the year on year reduction in MRSA

b) all risks associated with the acquisition and use of medical devices are minimised

- The Medical Director has lead responsibility for the purchase of medical equipment and devices
- Medical Devices Committee meets monthly
- Bids for Equipment purchases are considered by the Trust's Capital Programme Board
- The Trust's Clinical Engineering team is accredited to ISO9001
- Medical Device Alert procedures are in place to ensure that concerns about equipment are passed on to the relevant parties, appropriate action taken and recorded
- Hospital Equipment Control System operated with annual cycle of medical equipment contracts

c) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed

- The Assistant General Manager, Surgery has responsibility as Trust Decontamination Lead
- The TSSU department is fully accredited (Medical Devices Directive 93/42 EEC and ISO 13485 2003)

d) medicines are handled safely and securely

- The Chief Pharmacist has lead responsibility for medicines issues
- The Trust has a Medicines Management Policy and Dispensary Procedures
- The Medicines Committee meets bi-monthly
- The Medication Incident Committee reviews any occurrence of medication errors

e) the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment

- The Trust has a Waste Policy, which sets out our approach to waste handling, segregation and compliance with HSE guidance. Recent changes to this guidance mean that the Policy is currently being reviewed and updated.
- There is a Trust-wide Waste & Environment Group, currently developing an action plan to take forward key areas of concern, including recycling
- Waste disposal is managed via an outsourced provider, who undertakes the following on the Trust's behalf:
    - Training of all staff who handle waste, including regular competency checks and training in infection control and the disposal of sharps
    - Carries out annual review of the waste handling risk assessments
    - Carries out due diligence checks regarding landfill use and retention of relevant licences
- All waste is tagged to ensure traceability in the event of any untoward incident

4. Where the Trust does not fully comply with the standard: n/a

5. Information available to support the evidence:

- Infection Control Policy
- Infection Control Committee Terms of Reference and minutes of meetings
- Clean Your Hands action plan
- Winning Ways Action Plan
- PEAT Steering Group Terms of Reference and minutes of meetings
- PEAT Plus audit cycle procedures
- Outcome of annual PEAT inspection
- ISS Mediclean monthly reports
- Environmental audit training pack
- Medical Devices Committee Terms of References and minutes of meetings
- Capital Programme Board Terms of Reference and minutes of meetings
- MDD/ISO Accreditation Certificates
- Full documentation of TSSU/Medical Devices operational procedures
- Medicines Management Policy
- Medicines Committee and Medication Incident Committee Terms of Reference and minutes of meetings
- Examples of Dispensary Procedures
- Pharmacy audit plan
- Waste Management Policy
- ISS Mediclean training pack and handling Procedures
- Waste management risk assessment
- Copies of waste management licences and consignment notices
- Annual infection control audit
- Waste Audit 2005
- CNST Level 2 compliance report

Assurance Report – Healthcare Standard 5

Patients achieve healthcare benefits that meet their individual needs through healthcare decisions and service, based on what assessed research evidence has shown provides effective clinical outcomes.

Proposed declaration: compliant.

Standard 5a

1. Standard 5a: Healthcare organisations ensure that they conform to National Institute for Clinical Excellence (NICE) technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care.

2. Elements:
- The healthcare organisation conforms to NICE technology appraisals, when appropriate, or provides an acceptable rationale for non-compliance.
- Nationally agreed best practice is taken into account when planning and delivering care, as appropriate.

3. Proposed declaration: compliant

4. Evidence:
- There is a decision making process for deciding whether a NICE technology appraisal is relevant to the organisation which is to be placed on the Internet.
- There has been an assessment of current local practice and potential need (including the number of patients eligible for treatment under the guidance and associated resource costs). This is done in Directorates and is on the Intranet.
- There are arrangements to identify and notify relevant staff/teams about specific NICE technology appraisals in the governance plan.
- An implementation plan for each appropriate NICE technology appraisal been developed with clearly defined leadership responsibilities and timelines and is on the Intranet.
- Compliance with NICE technology appraisals is part of the audit plans for directorates.
- There are arrangements to monitor all of the above via the Trust Executive Committee for Clinical Governance.
- There is a process for identifying and acting upon the local implications of nationally agreed best practice, particularly as defined in national service frameworks (NSF), NICE clinical guidelines, national plans and agreed national guidance on service delivery.
- The Trust has implementation plans, which set out clearly defined responsibilities, timelines, actions and the resources required to achieve broad compliance with the guidelines, recommendations.
- There is a mechanism for monitoring implementation – through the clinical governance process.
- Compliance with nationally agreed best practice is audited, and exceptions are acted upon, for example NCEPOD recommendations

5. Where the Trust does not fully comply with the standard: n/a

6. Information available to support the evidence:
- Intranet.
- Governance plan.
- Trust Executive Committee for Clinical Governance – papers and minutes
- CNST Level 2 compliance report

Standard 5b

1. Standard 5b: Healthcare organisations ensure that clinical care and treatment are carried out under supervision and leadership.

2. Elements:
- There are mechanisms in place to ensure that all staff involved in delivering clinical care and treatment receive appropriate supervision.
- Clinical leadership is supported and developed across all disciplines.

3. Proposed declaration: compliant

4. Evidence:
- There is a process in place for identifying all staff who must be supervised and a process establishing supervisors.
- There are mechanisms for identifying appropriate supervisors with sufficient seniority and training. This is included in appraisals and PDPs.
- Time is available for staff to receive regular supervision although most supervision is conducted as part of the person's job
- Supervision arrangements comply with the relevant professional standards and guidelines as evidenced by the reports from visits from professional bodies
- The adequacy and quality of supervision arrangements are monitored and reviewed through the appraisal process.
- There is a mechanism for ensuring supervision for students and trainees that complies with the requirements of their educational and/or professional body through placement visit reports from Universities. Accreditation of placements examines supervision arrangements.
- Leadership roles and responsibilities are clearly defined in job descriptions for senior clinical staff from all disciplines. This is evidenced in personal files for non-medics, and guidance notes for completion of job descriptions developed for Agenda for Change. The Knowledge and Skills Framework (KSF) outlines will also clarify further.
- Senior clinical staff have access to clinical leadership training courses including in-house training and development programmes available via the Learning Resource Centre and attendance at external training programmes.
- Clinical leaders from all disciplines have the opportunity to be involved in strategic and operational decision making via development of the corporate plan and through weekly executive team meetings (with the underpinning directorate structure in place to feed in views from across the organisation).

5. Where the Trust does not fully comply with the standard: n/a

6. Information available to support the evidence:
- Placement visit reports from Universities.
- Personal files, guidance notes for completion of job descriptions developed for Agenda for Change.
- Corporate plan and record of development process.
- Minutes of weekly executive team meetings.
- Governance wheel and Directorate structure
- CNST Level 2 compliance report

Standard 5c

1. Standard 5c: Healthcare organisations ensure that clinicians continuously update skills and techniques relevant to their clinical work.

2. Elements:

- There are mechanisms in place to identify the skills required to deliver the clinical care provided by the healthcare organisation.
- Clinical professionals from all disciplines have access to and participate in activities to update the skills and techniques relevant to their clinical work.

3. Proposed declaration: compliant

4. Evidence:

- The Trust has methods for identifying and addressing individual clinical skill gaps within the workforce, including non-permanent staff and independent contractors. The new Induction Policy required identification of skills gaps for new employees. Appraisal and now KSF outline discussions are the mechanism for regularly identifying skills gaps.
- The Trust ensures that staff working in extended roles have the appropriate clinical skills.
- The Trust has mechanisms in place to ensure clinical staff do not undertake duties outside of their skill set through supervision, the professional codes of conduct and through training and appraisal.
- The Trust has an mechanisms in place for non-consultant medical staff to ensure that they are properly supported and covered and know what procedures they can perform.
- All clinical professionals have an appraisal (including, where relevant, to meet the requirements of their professional body) and an annual performance development review that highlights skills requirements relevant to their clinical work.
- The Trust ensures rigorous appraisal is fully operational for all medical staff and it is adequate to meet the standard for revalidation.
- The Trust complies with CNST 5.1.5, 5.2.2, 5.2.6.
- The Trust ensures that all clinical professionals have access to internal and external skills updates training courses. Attendance is monitored.
- There are systems in place to enable all clinical professionals to implement guidance from professional bodies in relation to updating skills and techniques relevant to their work.
- The Trust has a mechanism for identifying resources for skills updates training courses.

5. Where the Trust does not fully comply with the standard:

6. Information available to support the evidence:
    - Appraisals and PDP's
    - Staff rota's
    - Consultant job plans
    - Training database
    - Study leave information
    - CNST Level 2 compliance report

Standard C5d

1. Standard: Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services.

2. Elements:
- Clinical professionals are involved in the system for prioritising, conducting, reporting and acting on clinical audits.
- Clinical professionals participate in reviewing the effectiveness of clinical services.

3. Proposed declaration: compliant

4. Evidence:
- The Trust has a strategy for prioritising and conducting clinical audits through the clinical audit lead.
- The Trust produces a clinical audit annual report as part of the Clinical Governance Annual Report.
- The Trust has a database of clinical audits (including completed, ongoing and planned audits) which is included in the Clinical Governance Annual Report.
- The Trust ensures that clinical professionals from all disciplines participate in clinical audit.
- The Trust ensures that clinical professionals participate in national confidential inquiries.
- The Trust supports clinical professionals to participate in national clinical audits.
- There is a mechanism for feeding back the results of clinical audits to all relevant clinical professionals via the Clinical Governance Half Days, or within appropriate directorate meetings, and the Annual Report.
- Clinical professionals are involved in planning and implementing actions resulting from clinical audit activities.
- Relevant clinical data is readily available to clinical professionals to inform reviews of clinical services through the IDX LastWord system which supports operational data and the Trust Data Warehouse which supports management and research.
- Where comparators are available, they are used to inform reviews of clinical services. There has been a Trust-wide review of clinical services through the IMPACT programme which has been informed by comparators.
- There are mechanisms for reviewing serious untoward incidents that involve relevant clinical professionals.

5. Where the Trust does not fully comply with the standard: n/a

6. Information available to support the evidence:
- 2003/04 on intranet in Clinical Governance Annual Report Clinical Governance/Annual Reports.
- On intranet in CG Annual Report Clinical Governance /Annual Reports.
- On intranet in CG Annual Report Clinical Governance /Annual Reports.
- See NCEPOD action plans.
- Clinical Governance facilitator's role in audit.
- Annual Report. Trust Exec for Clinical Governance minutes.
- EPR Audit and System Documentation.
- Papers/Minutes from the IMPACT project meetings
- Intranet/ Clinical Governance /Policies and Procedures
- CNST Level 2 compliance report.

Assurance Report – Healthcare Standard 6

1. Standard: Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.

2. Elements:

- The healthcare organisation has systems in place to ensure health and social care organisations cooperate with each other.
- The healthcare organisation works with relevant partner agencies to ensure that patients' individual needs are properly met and managed.

3. Proposed declaration: Compliant

4. Evidence:

Element 1: The healthcare organisation has systems in place to ensure health and social care organisations cooperate with each other.

- The Trust participates (at executive level) in the Joint Partnership Board, which is chaired by a local councillor and includes representatives from local PCTs, acute trusts and mental health trusts as well as the local authority. This enables the development of multi-agency strategies and plans for service delivery.
- The Trust's Joint Clinical Effectiveness Group meets monthly, and brings together senior clinicians and managers from the Trust with colleagues from local PCTs to review joint approaches to care and agree service models for the future.
- Monthly meetings are held at the Strategic Health Authority, bringing together Chief Executives from all healthcare organisations in the sector, which enables joint discussion and agreement about future developments.
- The Kensington and Chelsea Care Community exists to bring together local PCTs and acute trusts to plan (in particular) for the deployment of Information Technology to support patient care. Recent developments include the implementation of a common IT system (ProWellness) across the Care Community.
- At an operational level, numerous groups exist to ensure that services are co-ordinated across multi-agency boundaries. These include the Children's Board, the Older People's NSF Group, the Diabetes NSF Group, the Discharge Group and the Coronary Hearth Disease NSF Group; all of which include representatives from across the health and social care system. Recent developments have included the appointment of joint posts with the PCT, such as an older people's pharmacist, and the development of joint initiatives, such as the Return Home Safely Service, which is based at C&W and run jointly by two local PCTs.
- The Trust also has representation on groups that are run by other health and social care organisations, such as the Kensington and Chelsea Area Child Protection Committee.

Element 2: The healthcare organisation works with relevant partner agencies to ensure that patients' individual needs are properly met and managed.

- The trust has clear communication channels with other health and social care organisations to ensure that patient's individual needs are met. These include the forums outlined above and, on a practical level, tools such as the single assessment process, the discharge planning process (which involves the patient, family, social workers and healthcare professionals) and the child protection process.

- The trust has a number of integrated care pathways in place, which span the patient journey from admission to discharge, such as the stroke ICP and the fractured neck of femur ICP.
- The Joint Clinical Effectiveness Group is used as a forum to evaluate the effectiveness of joint working arrangements at a system and individual patient level, for example through review of tertiary referral letters.
- The trust has achieved CNST standard 7.1.1 - All specialities have in place an integrated policy that identifies and addresses the needs of the patient prior to discharge, and in preparation for, discharge from hospital.

5. Where the Trust does not fully comply with the standard:

6. Information available to support the evidence:
- Minutes, agendas and relevant papers from the meetings listed above are available for inspection.
- Examples of completed documentation e.g. ICPs are available for inspection.
- Reference to recent developments can be found in the Clinical Governance Annual Report 04/05, the Corporate Plan 05/06 and specific reports such as the Discharge Team Monthly Report.
- CNST Level 2 compliance report
- The web site can be visited: www.chelwest.nhs.uk

Assurance Report – Healthcare Standard 7

1. Standard: Healthcare organisations:

g) apply the principles of sound clinical and corporate governance
h) actively support all employees to promote openness, honesty, probity, accountability and the economic, efficient and effective use of resources
i) undertake systematic risk assessment and risk management
j) ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources
k) challenges discrimination, promote equality and respect human rights
l) meet exists performance requirements

2. Elements:

- The healthcare organisation has arrangements in place for clinical governance
- Functions, roles and responsibilities of the board and accountable committees are clearly defined
- The healthcare organisation has a corporate strategy that identifies arrangements for delivering and monitoring its objectives
- The healthcare organisation recognises and uses the principles established by the Committee on Standards in Public Life (known as the Nolan principles)
- The healthcare organisation has mechanisms in place to take informed, transparent decisions
- The healthcare organisation has an effective counter fraud framework
- The healthcare organisation ensures that financial management systems achieve economy, efficiency and effectiveness.
- The healthcare organisation supports staff to use resources efficiently, effectively and economically
- The healthcare organisation has systematic risk assessment and risk management processes in place
- The healthcare organisation challenges discrimination, promotes equality and respects human rights
- The healthcare organisation is meeting existing performance requirements

3. Proposed declaration: Compliant

4. Evidence:

Element 1: the healthcare organisation has arrangements in place for clinical governance

- The Trust's annual report includes reference to clinical governance systems.
- The Trust has a Clinical Governance Assurance Committee that reports to the Trust board and discusses clinical governance issues.
- The Trust has clinical governance plans in place
- The Trust ensures that clinical professionals are involved in decision making – the Clinical Directors, Allied Health Professional Leads, General Managers and Executive leads are members of the Trust Executive.
- The Trust undertakes regular monitoring of the quality of services for patients, service users and carers.
- Monitoring is shared with staff across the organisation through the production of directorate quarterly Clinical Governance Reports
- The Trust uses information to monitor its performance including monthly performance board reports which are presented at Trust Board and Trust Executive, performance board meetings, HIPPO, Dr Foster Real Time Monitor and Hospital Activity Tracker and

performance through the performance management framework in development includes benchmarked targets.
- The Trust uses performance indicators to identify areas for improvement or immediate action including monthly performance board reports presented to Trust Board and Trust Executive.

Element 2: Functions, roles and responsibilities of the board and accountable committees are clearly defined
- The Board is constituted and conducted according to national guidance.
- There are relevant accountable committees in place including Audit Committee, Remuneration Committee, Clinical Governance Assurance Committee and Facilities Assurance Committee.
- There is an agreed and clear statement on the respective roles, accountabilities and responsibilities of executives and non-executives in standing orders
- The board has mechanisms in place to engage corporately with partners, patients and the public.
- The board ensures accountability to the public for the Trust's performance.

Element 3: The healthcare organisation has a corporate strategy that identifies arrangements for delivering and monitoring its objectives
- There is a clear statement of the organisation's objectives that is communicated across the organisation via the Corporate Plan.
- The developmental process of the Corporate Plan creates a system to identify corporate priorities based on local and national needs and requirements.
- The Trust takes account of local and national policy and practice developments that will impact on its service throughout the developmental process of the Corporate Plan.
- The Trust has a current business plan that identifies arrangements and resources for delivering and monitoring its objectives and priorities. The Corporate Plan is updated annually.
- The business plan has been developed in consultation with relevant partners including the K&C PCT and SHA at Performance Review Meeting.
- The business plan is communicated across the organisation, to partners and the public via the Intranet, Trust Executive meetings and is publicised in Trust News.
- The Trust has arrangements in place for monitoring and managing its performance in delivering its objectives including the Corporate Plan and development of the integrated performance framework.
- The Trust has mechanisms in place to respond to the recommendations and requirements of, for example, external visits, inspections and accreditations. These are coordinated by the Clinical Governance Support Team and reported via the Trust Executive for Clinical Governance.

Element 4: The healthcare organisation recognises and uses the principles established by the Committee on Standards in Public Life (known as the Nolan principles)
- The Trust has ensured that the board and staff are aware of the Nolan principles and it was circulated to Board members in July 2005.
- The Trust has a register of interests that is regularly monitored and updated. This is held by the Head of Corporate Affairs.
- The Trust has a system in place to identify and manage situations where the Nolan principles are at risk of being compromised, including the declaration of conflict of interest which is required at the Trust Board and all Assurance Committees.

Element 5: The healthcare organisation has mechanisms in place to take informed, transparent decisions

- The board papers set out criteria, rationale and considerations on which a decision needs to be based, and the impact and consequences of the decision.
- The board ensures that it is provided with information in board papers that is directly relevant to the decisions it has to take.
- Decision making processes and final decisions are recorded and communicated in a timely manner through the team brief which takes place the morning after Trust Board meetings and by placing meeting minutes on the Intranet.

Element 6: The healthcare organisation has an effective counter fraud framework

- The Trust has a counter fraud policy in place and it is located on the Intranet.
- The Trust ensures that sufficient proactive work is undertaken to detect fraud and corruption as outlined in the Counter Fraud Plan.
- The Trust adheres to the framework and standards set by the Counter Fraud and Security Management Service.
- The Trust has identified the Director of Finance as being responsible for leading and coordinating the work of the local counter fraud service.
- The Trust has made arrangements to develop an anti-fraud culture as per the Counter Fraud Plan.
- The counter fraud policy has been disseminated throughout the organisation via payroll distribution, seminars for staff and the Intranet.

Element 7: the healthcare organisation ensures that financial management systems achieve economy, efficiency and effectiveness.

This element will be measured separately, not as part of the Trust's declaration of compliance.

Element 8: The healthcare organisation supports staff to use resources efficiently, effectively and economically

- The Trust has clearly identified budget holders and is this communicated effectively.
- There is a formal scheme of budget delegation and responsibilities are clearly documented.
- The Trust ensures that regularly updated guidance is available to all budget holders.
- Budget holders receive regular financial training and specific training on the budgetary control system and relevant financial systems. Attendance is monitored.
- Budget holders have access to relevant financial systems.
- Budget holders are able to review their budget status as required.
- Budget management forms a part of a budget holder's performance assessment.
- The Trust has systems in place to monitor budget management.

Element 9: The healthcare organisation has systematic risk assessment and risk management processes in place

- The Trust has structures and clear accountabilities with regard to risk management.
- There is a process for reporting, managing, analysing and learning from adverse incidents, in accordance with NHS guidance.
- There is a process for reporting, managing, analysing and learning from complaints and claims, in accordance with NHS guidance.
- The Trust ensures that all employees, including members of the board, clinicians, managers, bank, locum and agency staff, and, where relevant, contractors and volunteers, are provided with appropriate risk management training.
- The Trust has an assurance framework in place.
- The accounting officer has signed off the statement of internal control.

- The Trust complies with the relevant clinical negligence scheme for trusts (CNST) standards.
- The Trust complies with the risk pooling scheme for trusts (RPST)

Element 10: The healthcare organisation challenges discrimination, promotes equality and respects human rights

- The Trust complies with current equality, antidiscrimination and human rights legislation with respect to workforce and service delivery, including the Race Relations Amendment Act, the Disability Discrimination Act and the Human Rights Act.
- The Trust assesses and monitors its compliance with all equality, anti-discrimination and human rights legislation.
- The Trust has a board approved strategy that spells out how equality issues are to be addressed, including racial discrimination, faith, disability, age, gender and sexual orientation.
- The strategy has an action plan and the organisation can demonstrate progress against the plan.
- There is a board champion for human rights, discrimination and promotion of equality.
- The Trust ensures that its staff are aware of their responsibilities in relation to all equality, anti-discrimination and human rights legislation. Relevant training is provided and attendance is monitored.
- The Trust takes steps to create a culture in which the rights of different groups of staff and patients are promoted and respected. This is monitored.
- The Trust has a race equality scheme.
- The Trust reports on progress in delivering the race equality scheme to the board.
- The Trust has undertaken and published the three yearly review of the race equality scheme.
- The Trust has the two tick symbol for disability.
- The Trust has reviewed its workforce generally to assess whether it represents the local community, and identified what steps it will take to rectify any gaps.
- The Trust ensures that its policies, procedures and practices do not inadvertently discriminate against specific patient groups.
- Arrangements are in place to assess local language and communication support needs.

Element 11: The healthcare organisation is meeting existing performance requirements

National requirements are measured separately. This is not part of the Trust's declaration of compliance

5. Where the Trust does not fully comply with the standard: n/a

6. Information available to support the evidence:

These are described in the text under each element where required.

Assurance Report: Healthcare Standard 8

Standard 8a

1. Standard C8a
Healthcare organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services

2. Element
The healthcare organisation has processes in place to support staff to raise concerns over any aspect of service delivery, treatment or management.

3. Proposed Declaration: Compliance

4. Evidence
- The Trust complies with HSC 1999/1998, and has a Whistleblowing Policy in place
- The grievance policy has been updated this year in agreement with Staff Side.
- The Whistleblowing Policy details Trust assurances to staff regarding job security, retribution, harassment and victimisation in relation to those who raise concerns in good faith
- All policies are on the Intranet and staff are informed of their existence at Induction.

5. Where the Trust does not fully comply with the standard n/a

6. Information available to support evidence
- Policy on the Intranet
- Policy review files in HR Department
- Trust News Articles
- CNST Level 2 compliance report.

Standard 8b

1. Standard C8b: Organisational and personal development programmes recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups

2. Elements
- Staff participate in an annual personal development plan (PDP) and appraisal process.
- The organisation supports and involves staff in organisational and personal development programmes.
- The organisation ensures that staff from minority groups have access to organisational and personal development programmes to help address under representation in different parts of the workforce.

3. Proposed Declaration: Compliance

4. Evidence

- IWL Practice Plus Awarded April 2005
- Appraisal and PDP planning training part of annual training plan.
- Exec Directors and General Managers are responsible for ensuring all staff have a PDP.
- In time Training Database will be used to monitor access to training by job type, level, minority group.
- Diversity monitoring of the workforce takes place.

5. Where the Trust does not fully comply with the standard

6. Information available to support evidence

- IWL P Plus Letter of Confirmation of Achievement & Certificate issued.
- Appraisal and PDP policy on the Intranet
- Director of HR Workforce Information Reports
- Race Equality Scheme

Assurance Report – Healthcare Standard 9

1. Standard: Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

2. Elements:
- The healthcare organisation has systems in place to ensure that records are managed in accordance with the information governance toolkit.

3. Proposed declaration: compliant

4. Evidence:
- The healthcare organisation has assessed itself against the information governance toolkit, with reference to holding, obtaining, recording, using and sharing information. The Trust has improved from amber to green status.
- The Director of ICT assumes board level responsibility that includes performance monitoring for information governance.
- There are clear lines of accountability throughout the healthcare organisation leading to the board and these are laid out in Board Approved Strategy, Policy and Processes.
- The Trust ensures that staff are aware of information governance requirements and this is continually being improved through publicity and training in 2005/06.
- The Trust has a system to manage breaches of information governance requirements and sanctions are clearly expressed in the Trust's Governance Framework.
- The Trust complies with CNST 4.1.1 to 4.1.8, and 4.2.6.

5. Where the Trust does not fully comply with the standard:

6. Information available to support the evidence:
- Director of ICT
- Board Approved Strategy, Policy and Processes.
- Publicity and training.
- Sanctions are clearly expressed in the Governance Framework.
- Publicised on Intranet.
- Electronic Training Courses
- Patients, public and staff leaflets
- CNST Level 2 compliance report

Assurance Report: Healthcare Standard 10

Proposed declaration overall: Compliant

Standard 10a

1. Standard C10a: Healthcare organisations undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies

2. Prompts
- All staff are appointed following the necessary employment checks detailed under Health service circular (HSC) 2002/008.
- All staff undergo appropriate Criminal Records Bureau (CRB) checks on appointment and relevant change of duty

3. Proposed Declaration: compliant

4. Evidence
- Evidence of pre-appointment checks stored on HR personal files (with the exception of CRB Disclosures, which are stored separately).
- Identity checks are carried out in accordance with the Asylum and Immigration (Amendment) Regulations 2004 New starters must present the documents listed in the Regulations.
- All new starters must be health cleared via Occupational Health
- If individuals make a voluntary move within the organisation then a further healthcare check is undertaken. However, if the individual's duties change for organisational reasons then further healthcare checks are not undertaken.
- Volunteers issued with honorary contracts and checked as part of that process.
- New staff bring their registration certificate to the HR Department no later than their first day of appointment. A secondary check on the appropriate authority's website is also made.
- During employment a monthly report of those staff whose registrations will expire during the next month is checked. The individual and managers are then contacted by the HR department and advised that the registration is due to expire and must be renewed before expiry. Websites are then checked and copies of confirmation of renewal printed off and placed on HR personal files. If registration is not renewed on time, the individual and manager are advised that the individual may not work in a post that requires registration

5. Where the Trust does not fully comply with the standard

6. Information available to support evidence
- Copies of certificates or confirmation from authority websites stored on HR personal files. Copies of letters to individuals and managers stored on HR personal files.
- Copies of appropriate documentation stored on HR personal files.
- Copies of identity documents stored on HR personal files
- Copies of occupational health clearance forms on HR personal file
- Recruitment and Selection training Course.
- Deputy HR Director responsible for implementing monitoring and reviewing the policies.
- CNST Level 2 compliance report.

Standard 10b

1. Standard C10b: Healthcare organisations require that all employed professionals abide by relevant published codes of professional practice

2. Prompts
- The healthcare organisation requires and supports staff to abide by their codes of professional practice.
- The healthcare organisation has systems in place to identify and manage staff who are not abiding by their published codes of professional practice.

3. Proposed Declaration: Compliance

4. Evidence
- A term is included in the new draft Agenda for Change contract, and will be included with the general information attached to all job descriptions.
- A Whistleblowing Policy is in place.
- Systems are in place to identify staff who are not abiding by their published codes of professional practice (e.g. appraisal, confidential reporting systems and performance monitoring)
- Systems exist to investigate concerns about staff in relation to published codes of professional practice – needs more evidence

5. Where the Trust does not fully comply with the standard n/a

6. Information available to support evidence
- Copies of contracts on HR personal files and copies of job descriptions on local personal files
- Policy on intranet

Assurance Report: Healthcare Standard 11

Standard 11a

1. Standard C11a: Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare are appropriately recruited, trained and qualified for the work they undertake

2. Elements
- The healthcare organisation has an agreed recruitment and selection process in place, which complies with relevant legislation.
- The healthcare organisation undertakes workforce planning.
- The healthcare organisation identifies the training required to enable its staff to provide all aspects of its service.

3. Proposed Declaration: Compliance

4. Evidence
- The e-recruitment system is compliant with monitoring required under legislation. International recruitment is undertaken in accordance with DoH guidance.
- The Trust's Race Equality Scheme was updated in 2005 and the Equal Opportunities Policy will be reviewed in 2005.
- The new 'Agenda for Change' terms and conditions have been equality-proofed at national level.
- References to the Disability Discrimination Act will be included in policies that are reviewed during 2005.
- A regular training course in recruitment and selection is delivered to managers.
- Workforce plans produced as part of business planning and in response to service developments like Treatment Centre.
- Workforce plans are reviewed annually as part of LDP process and Corporate Plan. The Trust participates in SHA-led planning.
- Appraisal, PDP, and KSF are the means of identifying and addressing individual skill gaps within the workforce, including non-permanent staff
- New draft study leave policy should provide a policy or statement outlining our commitment to support all staff to attend training, including:
  – cover arrangements
  – protected time
  – appropriate funding
  – evaluation of training programmes

Standard 11b

1. Standard C11b: Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in mandatory training programmes

2. Element
- All staff participate in appropriate mandatory training**.**

3. Proposed Declaration: Compliance

4. Evidence
- Mandatory training courses have been identified for all staff groups by the clinical governance and risk management groups.
- All staff are required to attend the Trust's Corporate Induction, where mandatory training is explained.
- Locum staff take an induction checklist to their area of work
- Monitoring of attendance is via the Training Database.

5. Where the Trust does not fully comply with the standard

6. Information available to support evidence
- Trust News Articles
- Training Database reports
- Corporate Induction Programme
- CNST Level 2 compliance report

Standard 11c

1. Standard C11c: Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in further professional and occupational development commensurate with their work throughout their working lives

2. Prompt
The healthcare organisation ensures that staff have the opportunity for professional and occupational development**.**

3. Proposed Declaration: Compliance

4. Evidence
- IWL Practice Plus. As a result of our validation for IWL Practice Plus status in April this year, we were awarded 6 points (maximum available) for 4 of the training and development indicators, and 5 points for the remaining two. The validation team made the following comments:
  - The Trust offers robust leadership training for staff.
  - Clear progress has been made with regard to expanding learning and development opportunities to all staff groups, in particular Administrative and Clerical staff.
  - The development of the new skills laboratory is an excellent facility, which is used to support multi-professional education.
  - Staff in focus groups stated that access to training was one of the reasons for working in the Trust.
  - There was compelling evidence of the use of PDPs throughout the Trust and plans are being implemented to incorporate the KSF.
  - There is evidence that non-professional groups are accessing NVQ training and that this is monitored by the Trust.
- There is a system in place, such as PDPs, to identify and respond to staff learning and developmental needs
- The Trust has a Study leave policy or statement outlining commitment of the organisation to support all staff to access professional and occupational development, including:
  - cover arrangements
  - protected time
  - appropriate funding

- The Trust monitors implementation of professional and occupational development via Appraisal and training database

5. Where the Trust does not fully comply with the standard:

6. Information available to support evidence: see 4 above

Assurance Report – Healthcare Standard 12

1. Standard: Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.

2. Elements:
- The healthcare organisation complies with the requirements of the Research Governance Framework for Health and Social Care (DH 2001)

3. Proposed declaration: Compliance

4. Evidence:

Where the healthcare organisation, or any of its staff, leads or participates in research, does it comply with the research governance framework?
The Trust has systems and processes in place sufficient to provide assurance that compliance against the Research Governance Framework can be demonstrated, to a level that is appropriate for the nature of active research projects and the level of risk associated with this activity.

The Trust has utilised the detailed requirements of the RGF to provide assurance that this standard is being met. Key areas where appropriate systems have recently been either newly-established or consolidated and enhanced include:
• Procedure for inquiry and investigation into scientific misconduct and fraud
• Research Approval & Registration mechanism (including integration of ethics approval process)
• Charging methodology and cost recovery mechanism for commercial sponsors
• Recruitment of Corporate Accountant (R&D) to ensure financial probity
• Enhanced co-ordinating role developed for R&D Programme Leads
• Clear allocation and division of co-sponsorship responsibilities with the trust's academic partner Imperial College
• Establishment of sponsorship and other essential agreements (including with research programme collaborators) to ensure that allocated responsibilities are not only identified but are understood and formally acknowledged – through both individual project agreements and framework agreements
• Enhanced GCP training programme and database tracking mechanism

Has the healthcare organisation considered how it might collect data to monitor its research and development activity, such as those proposed through Better metrics?
Existing audit processes have been made more rigorous and brought into line with the latest version of the RGF
Developments are underway with the R&D department's database software designers to design a series of monitoring templates. These include a project progress report and a series of self assessment templates based on examples of best practice published by the NHS Research and Development Forum, though tailored to local requirements.

These developments will enhance existing audit and monitoring processes, with an emphasis on identifying and minimizing risk to patients, staff and the organisation early on, while improving the level of service delivered to researchers as internal customers.

5. Where the Trust does not fully comply with the standard: n/a

6. Information available to support the evidence:

R&D folder in intranet; individual project files, audit and monitoring folders (electronic and hard copy) held within R&D office

Assurance Report: Healthcare Standard 13

Standard 13a

The Healthcare organisation has taken steps to ensure patients, carers and relatives are treated with dignity and respect

The patient experience is a central element of the 2005-2006 Corporate Plans in which making personal care (including privacy and dignity) a priority for service delivery is a key objective.

Mention of patient privacy and dignity is made in Trust reports, staff newsletters and information literature provide by the Trust.

The Trust has and Privacy and Dignity Champion (Hospital Chaplain) as part of the Trust's work relating to Essence of Care Benchmarking. Training workshops are being conducted over September and October 2004 focusing on the Essence of Care Privacy and Dignity Benchmark.

The Hospital was built with a multi-faith sanctuary and has an established and active multi-faith chaplaincy. The Hospitals catering facilities are able to respond to the dietary needs of individuals in respect to their religion.

The Hospitals environment is designed to meet the needs of patients and visits who have a disability. This is being reviewed in relation to the RRA (Race Relations Act), which will provide the framework for a DDA (Disability Discrimination Act) review also.

The Trust as a training programme for Diversity and Equity, which is overseen by a Trust wide Diversity and Equality Committee. In July 2005, the Trust held a Diversity and Equality staff conference. Executive Directors has all received diversity and equality training over the last year.

The Trust has an established and accessible interpreting service.

The Trust has introduced the Liverpool Care Pathway for dying patients, which addresses the specific needs of patients and their cares at the end of life.

The Healthcare organisation monitors its performance with regard to treating patients and cares with dignity and respect.

The Trust has established process for feeding back at Board, Executive and Directorate level issues that are identified through PALS, complaints and the Trust's comment scheme. Information for the National Patients Survey relating to patients privacy and dignity has also been used.

The Trust is undertaking the Essence of Care Privacy and Dignity Benchmark in October 2005.

The Trust takes seriously any breeches of privacy and dignity and respond to these by investigation and response to the person make the complaint.

Information available to Support the Evidence

- Corporate Plan
- Copies of Trust News
- Equality and Diversity Training Programme
- Minutes of the Diversity and Equality committee
- Summer Working Conference Programme
- Chaplaincy Annual Plan
- ISS contract /SLA
- Interpreting service contract/SLA
- Essence of Care Benchmarking tool
- PALS/Complaints reports
- Liverpool Care Pathway
- Childers Bereavement Service Report

Standard 13b

The health care organisation has process in place to ensure that valid consent is obtained by suitably qualified staff for all treatments, procedures or investigations

The Trust has a consent policy this is currently under review. The consent policy is available to all staff on the Trusts intranet. On induction, SPRs and grades above receive consent training. Further training and advice is provided by the Trust Legal Services Manager.

The Trust conducts an annual audit of the consent policy to ensure compliance and that only trained and qualified staff obtain consent.

The Trust has an established interpreting service.

The Trust complies with CNST 3.1.1, 3.2.2, 3.3.2.

Attachments to Support the Evidence

- Consent Policy and associated documents
- Report of annual audit 2005
- Induction training records
- CNST Level 2 compliance report.

Standard 13c

Staff treat patient information confidentially, except where authorised by legislation to the contrary

- **The health care organisation takes steps to ensure that patients have information that they can understand on the use and disclosure of confidential information.**

- **The healthcare organisation meets standards for the confidential use of patient personal information.**

The Trust has a fully compliant and comprehensive Information Governance programme managed by the Trust's Information Governance Steering Group that is a task group of the Trust's Governance Committee. The chair person is the Medical Director as Caldicott Guardian with representation across Clinical and Corporate Directorates. It provides a framework to bring together all the requirements, standards and best practice that apply to the handling of personal information to ensure:

- Compliance with the law
- Implementation of Department of Health advice and guidance;
- Planned year on year improvement;
- Assessment against NHS IG Toolkit.

The framework includes a number of information-handling requirements:

- Confidentiality Code of Practice;
- Data Protection;
- Freedom of information;
- Health Records;
- Information Governance Management;
- Information Quality Assurance;
- Information Security;
- National Programme for Information Technology.

The focus is on setting policy and standards; communicating with patients, public and staff to ensure they understand the use and disclosure of confidential information; and ensuring that the Trust has implemented the tools to achieve these standards. The goal is to help the Trust and individuals to be consistent in the way they handle personal information and to avoid duplication of effort.

The Trust has also developed Information Sharing policies and procedures in primary care, acute and mental health, social services, education and metropolitan police partnerships.

- The Trust has clear Board approved policies for ensuring that consent is obtained from every patient, where patient identifiable information is used for purposes other than the direct delivery of healthcare. In particular the Trust's Confidentiality and Data Protection Policy approved by the Board on 3rd March 2005 applies.

- The Trust provides patients with written information in a leaflet that they can understand on the confidential use and disclosure of their personal information (including access to health records).

- The Trust provides advice for patients about their rights with regard to confidential information in languages and formats relevant to the local population.

- This information is accessible by those with special communication support needs.

- The Trust complies with clinical negligence schemes for trusts (CNST) 3.1.1, 3.2.2 and 3.3.2.

- The Trust complies with national standards for use and disclosure of patient information (i.e. access to health records requests 1998, Data Protection Act 1998, Caldicott review of patient identifiable information 1997 and Confidentiality: NHS Code of Practice Department of Health 2003.

- A Caldicott assessment has taken place and the Trust meets Caldicott principles.

- The Trust monitors all non-consented disclosures.

- There are formal systems to request exemption under Section 60 of the Health and Social Care Act 2001.

- The Trust has a procedure for responding to requests for access to patient identifiable information.

- The Trust uses national guidance for safeguarding the confidentiality of patient information. The last information governance toolkit assessment was completed on 31 March 2005 and green light status was achieved.

- The Trust has policies and procedures to prevent information about patients being shared inappropriately. Information sharing agreements are in place with primary care, acute and mental health, social services, education and metropolitan police partners

- There are Trust Board approved policies that meet legal requirements including the Human rights Act, regarding the use and disclosure of confidential patient information.

- The Trust provides relevant classroom and intranet electronic training for clinical and non-clinical staff to ensure that they are aware of their responsibilities and obligations to respect patient confidentiality and attendance is monitored.

- Policies and procedures are published on the Trusts Intranet and the public is informed through the Trust Internet world wide web site.

- There are appropriate disciplinary procedures in place in the event of staff breaches of patient confidentiality. This is included in staff contracts and is also part of supplier and contractor agreements.

- The Caldicott clinical professional guardian at board level is the Trust's Medical Director.

- The Trust's Executive lead for Information Governance implementation across the Trust is the Director of ICT who is also a Trust Board member.

Attachments to support the evidence

- Confidentiality and Data Protection Policy Approved by Trust Board of 3 March 2005
- Freedom of Information Policy Approved by Trust Board of 3 March 2005
- Information Governance Policy Approved by Trust Board of 3 March 2005
- Trust Information Management and Technology Policy Approved by Trust Board on 23/11/2004
- Trust Information Management and Technology Strategy Approved by Trust Board in February 2004
- Information Quality Policy Approved by Trust Board of 3 March 2005
- Information Security Policy Approved by Trust Board of 3 March 2005
- Records Management Policy Approved by Trust Board of 3 March 2005
- What You Should Know About Information Governance: NHS Information Authority Document on Information Governance

Assurance Report – Healthcare Standard 14

1. Standard: Healthcare organisations have systems in place to ensure that patients, their relatives and carers:

   a) have suitable and accessible information about, and clear access to procedures to register formal complaints and feedback on the quality of services
   b) are not discriminated against when complaints are made
   c) are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.

2. Elements:

a): The healthcare organisation ensures that patients, relatives and carers have clear access to a formal complaints system.

The healthcare organisation provides information to ensure that patients, relatives and carers understand how to make a formal complaint.

The healthcare organisation provides opportunities for patients, relatives and carers to give feedback on the quality of services they receive.

b): The healthcare organisation ensures that patients, relatives and carers are reassured that the patient's care and treatment will not be adversely affected by having complained.

c): The healthcare organisation uses feedback from patients, relatives and carers to improve service delivery.

3. Proposed declaration: Compliant

4. Evidence:

The healthcare organisation ensures that patients, relatives and carers have clear access to a formal complaints system.

The Trust has an established formal complaints system that is clearly understood by staff. The Complaints Manager undertakes regular presentations to Trust staff. This includes the Nursing Induction Programme and Induction Programme for Specialist Registrars. The Trust complaint procedure is accessible to all staff on the Intranet.

The Patient Affairs Manager is the designated Complaint Manager responsible for dealing with complaints. She works with a team of two complaint co-ordinators who are dedicated to specific directorates.

The Trust complies with the NHS (Complaints) Regulations 2004.

The Complaints Team provides training to staff on rights of patients, relatives and carers to make complaints and how to deal with complaints at the Nursing Induction Programme, Specialist Registrar Induction Programme, Mandatory Update Programme for Nursing Staff and Staff Nurse Development Programme. Attendance is monitored by the Trust.

The Trust has a formal system to inform patients that staff have logged their complaints. On receipt of all complaints a formal acknowledgement letter is sent within two working days.

People who have language or communication support needs are adequately supported in accessing the complaints process through the use of an interpreting service, both face to face and a phone line. Hearing loops are available in our counselling rooms.

We also stock copies of 'Your Guide to the NHS' which details how to access the complaints procedure and the Health Service Ombudsman's leaflet in a range of languages and on tape.

Both the complaints team and the PALS team will provide support to those who wish to make a complaint about our services. They are available to talk through the procedure, discuss options where necessary. Complainants are also supported where necessary to write a complaint statement. All clients are offered contact details for independent advocacy. They will be given details of the Independent Complaint Advocacy Service (ICAS) or any other relevant advocacy agency. The acknowledgement letter sent to complainants gives contacts details for ICAS.

People who wish to complain can access the complaints team by a number of methods, other than by letter. Complaints can be taken over the phone or in a face to face meeting. The complaint team also have a generic 'complaints' e-mail address for receipt of e mailed complaints. Our Comment Cards have an option for making a formal complaint by this route and these can be returned to the Trust by 'Freepost.'

A feedback form is available on the Trust website.

The Patient Affairs Manager, complaints team and PALS team speak regularly to contacts at ICAS in order to maximise the support offered to complainants.

The healthcare organisation provides information to ensure that patients, relatives and carers understand how to make a formal complaint.

The PALS office provide a range of literature, which is on display, giving information about how to make a formal complaint. This includes:

'Your Guide to the NHS'
Health Service Ombudsman's leaflet
Problems with the NHS (ICAS)
Healthcare Commission leaflet – 'Unhappy with the way your complaint has been handled.'

The Trust Comment Cards outline how to make a complaint to the Trust. The comment cards are available in every patient area in the hospital, as are the PALS posters and leaflets. We are currently drafting a complaints specific leaflet.

The Trust does not currently provide our own information in a range of languages relevant to the local population. This is currently under review. We do stock copies of 'Your Guide to the NHS' which details how to access the complaints procedure and the Health Service Ombudsman's leaflet in a range of relevant languages and on tape.

The Comment Cards and PALS leaflets are in the process of being reprinted. The new print has details of ICAS. ICAS contact details are included in all complaint acknowledgement letters and all those who visit PALS and wish to make a complaint are given the relevant contact details. Information regarding ICAS and a link to website are available on the Trust website.

The healthcare organisation provides opportunities for patients, relatives and carers to give feedback on the quality of services they receive.

There are a variety of opportunities for patients, relatives and carers to comment on the quality of service they receive from the Trust. This is done through the National Patient Surveys and resulting departmental surveys. The Trust has an established Comment Card scheme. Comment Cards are widely available throughout the Trust and supplies are maintained in patient areas with the help of volunteers attached to the PALS team. These can be returned directly to the PALS office or by the 'Freepost' service. We are currently looking at expanding this scheme to ensure that there is a Comment Card box for feedback in all patient areas.

A more recent innovation has been the development of a feedback form on the Trust website. There is also a generic 'PALS' e-mail address for feeding back views to the Trust.

Feedback is received through the Patient and Public Involvement Forum and a variety of focus groups held throughout the Trust.

The Trust PALS service is promoted throughout the organisation to patients, relatives and carers. The PALS is in a high profile, very visible location on the ground floor at the front of the hospital. It is clearly identified as the PALS office. There are PALS posters and leaflets in all patient areas of the Trust.

There is information relating to PALS of the Trust website and a regular advert on the hospital radio station. An advert has recently been taken out in the hospital radio magazine.

The Trust 'Patient Guide' leaflet, which is sent to all patients prior to admission features PALS details inside the front cover. This publication also encourages patients to feedback their views via the Comment Cards.

Trust staff are aware of how to deal with patient feedback and opportunities available to service users to provide feedback. This information is included in all the Complaints/PALS training sessions. These include the Nursing Induction Programme, Specialist Registrar Induction Programme, Mandatory Update Programme for Nursing Staff and Staff Nurse Development Programme.

The Trust evaluates its methods for gaining feedback from patients, relatives and carers on its services through the recently established Engagement and Partnership Group and quarterly meetings with the Patient and Public Involvement Forum.

The healthcare organisation ensures that patients, relatives and carers are reassured that the patient's care and treatment will not be adversely affected by having complained.

The Trust complaints procedure states a commitment that complaints will not experience discrimination as a result of having made a complaint. This is included in all PALS/complaints training sessions. Service users are reassured with regard to this by a statement on our comment cards. This information is also included in the complaints leaflet currently being drafted.

Both the PALS team and the complaints team see patients, relatives and carers directly. They do not require referral by a member of staff. Clients can be seen on a drop in or appointment basis.

The Good practice toolkit for local resolution and the department of health guidance relating to the current legislations has been used to inform the trust compliant policy. The complaint teaching is based on advice provided in these documents.

The healthcare organisation uses feedback from patients, relatives and carers to improve service delivery.

The Trust monitors and analyses compliments, comments and other feedback at the end of each quarter year. An analysis of concerns is reported on the same basis. This is done through quarterly complaints and PALS reports and summarised in an annual report. This information is feedback to each directorate every quarter in the form of an overarching Clinical Governance report.

The quarterly reports are also taken to the Trust Board and provided to the Patient and Public Involvement Forum.

The quarterly reports include information relating to the numbers and types of complaints referred to the Healthcare Commission and the health Service Ombudsman.

The Trust monitors its response time to complaints to ensure it complies with national guidelines. This is closely monitored on a monthly basis. They form part of directorate's monthly performance review. The response rates are reported in the quarterly complaint reports and annually to the Department of Health through the K041 returns.

Feedback from service users is shared with staff through the clinical governance reports which are reviewed and discussed at Directorate meetings.

5. Where the Trust does not fully comply with the standard: n/a

6. Information to support the evidence: described in the evidence and supported within CNST level 2 compliance feedback report.

Assurance Report: Healthcare Standard 15

1. Standard C15: Where food is provided, healthcare organisations have systems in place to ensure that patients are provided with a choice and that it is prepared safely and provides a balanced diet

2. Elements:

- The healthcare organisation offers patients a choice of food which is in line with a balanced diet.

- The healthcare organisation ensures that patients have access to food and drink 24 hours a day

3. Proposed declaration: Compliant

4. Evidence:

- Annual PEAT assessment scored 4 (Good) for food provision and service
- Trust achieves compliance with Better Hospital Food initiative in terms of 24-hour patient service, leading chefs' dishes and snack box provision
- Menu provision includes identified healthy options, meals that meet religious and cultural requirements of the main hospital client groups and meet the clinical needs of patients
- Patients are able to influence the portion sizes of meals
- Nutritional analysis of menu cycle completed by outsourced contractor and validated by Trust Nutrition and Dietetics service
- Catering Facilities Management Group established to take forward future initiatives regarding patient and staff catering
- Monthly patient satisfaction surveys undertaken and used to inform menu choices
- Each ward has a housekeeper with responsibility for food and drink provision. Drinks are served to a minimum of seven times daily with access over 24 hours
- Annual inspection of food production unit undertaken as well as EHO visit to hospital catering department
- Fully compliant with HACCP (Assured Safe Catering) legislation and good practice with fully documented procedures and staff training in place

5. Where the Trust does not fully comply with the standard: n/a

6. Attachments to support the evidence:

- ISS Mediclean catering contract
- Catering FM Group Terms of Reference and Minutes
- Trust menu cycle
- Patient menu ordering cards
- Nutritional analysis of menu's
- ISS Mediclean monthly reports documenting monthly patient satisfaction audits
- Staff survey of restaurant services 2005
- EHO Report
- Annual independent audit of HACCP compliance
- EfM Data regarding PEAT assessment 2005

Assurance Report – Healthcare Standard 16

1. Standard: Healthcare organisations make information available to patients and the public on their services, provide patients with suitable accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during their treatment, care and aftercare.

2. Elements:
- The healthcare organisation provides suitable and accessible information on the services it provides and in languages and formats relevant to its service population and which accords with the Disability Discrimination Act 1995 and the Race Relations Act 1976 (as amended)
- The healthcare organisation provides patients and where appropriate, carers (including those with communications or language support needs) with sufficient and accessible information on the patients individual care, treatment and aftercare, taking into account the Toolkit for producing patient information, NICE information for patients and other nationally agreed guidance where available.

3. Proposed declaration: Compliant

4. Evidence:
- The Trust provides information about all its services on the public website.
- Patient information is available in a range of languages across the hospital.
- The Trust use interpreting services provided by Language Line and GRIP (a Group of Reliable Interpreters in Parkside, run by Westminster PCT).
- Recorded information is available to patients in several departments including the Treatment Centre and ICU. Sign language interpreters are available for patients when needed.
- Service users are involved in the production of patient information. In some departments (eg: maternity) service users are involved in liaison groups where patient information is reviewed. Where these groups do not exist, patients are asked to comment on the information before the leaflets are finalised for printing.
- Information is available to patients about different conditions and procedures in each department.
- The 'Toolkit for producing patient information', Department of Health 2003, is used as a guide in producing patient information in the Trust. Each leaflet has a review date to ensure the information is kept up to date and relevant.
- The PALS service is located in the centre of the foyer of the hospital. They are accessible to all patients and carers and provide a wide range of information including where to go for further help. Before admission elective patients are sent a 'Patient's Guide' specific to the hospital.
- Through the Patients Accelerating Change Programme the Trust sought feedback on the quality, availability and accessibility of the information it provides on its services
- National Institute for Clinical Excellence (NICE) information for patients is used where available

5. Where the Trust does not fully comply with the standard:

6. Attachments to support the evidence:
- A range of patient information leaflets are available for inspection.
- The PALS service can be contacted for further information on the interpreting services.
- The web site can be visited: www.chelwest.nhs.uk

Assurance Report: Healthcare Standard 17

1. Standard C17: The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.

2. Elements:

- The healthcare organisation seeks the views of patients, carers and the local community.
- The views of patients, carers and the local community are taken into account in designing, planning, delivering and improving health and healthcare services.

3. Proposed declaration: compliant

4. Evidence

- The Trust has statement of intent and policy for Engagement and Partnership with Patients and the Public. The Engagement and Partnership Group chaired by the Chairman of the Trust Board oversees the delivery of this strategy. The Executive lead is the Director of Nursing.
- The Trust has regular liaison meetings and works with the Trust's PPI Forum and the local OSC's
- There are a various mechanisms through which the Trust obtains the views of patients, relatives and carers. The Trust participates in the National Patients Surveys, resulting in departmental surveys.
- The Trust was part of the Patients Accelerating Change project and through this patients were involved in redesigning services and gave a wide range of feedback on improving communications.
- The Trust has an established PALS service, which records feedback from patients given directly to the service. The Trust PALS service is promoted throughout the organisation to patients, relatives and carers. The PALS is in a high profile, very visible location on the ground floor at the front of the hospital.
- Comment cards are widely available throughout the Trust and supplies are maintained in patient areas with the help of volunteers attached to the PALS team. These can be returned directly to the PALS office or by the 'freepost' service. We are currently looking at expanding this scheme to ensure that there is a comment card box for feedback in all patient areas.
- A more recent innovation has been the development of a feedback form on the Trust website. There is also a generic 'PALS' e mail address for feeding back views to the Trust. Feedback is also received through the Patient and Public Involvement Forum.
- In 2004, the Trust held series of focus groups attended by over 160 members of the local community to help generate ideas to improve services within the Trust. At the Trust AGM over 200 people attended with approximately 30 people attending focus group activity on the Hospitals services. Two departments with in the Hospital hold the Charter Mark.
- The Trust encourages user representation in all areas. In maternity services there are nationally recognised forums which must have user representation. These include the Maternity Services Liaison Committee - recognised in 1993 and endorsed in the Children's & Maternity Services NSF 2005 and the Labour Ward forum - linked to CNST requirements.
- Examples of other groups which we run with user representation are the breastfeeding support group and discharge planning group.

- Maternity services invite women and partners to apply to join committees and working parties on the website and through posters in the clinical areas.
- User groups also exist in the neo natal unit, intensive care and paediatrics.
- The Trust consulted widely on its application for Foundation Trust Status and feedback was used to inform the service development strategy
- Patient feedback was used as part of the work to develop the Trust's Corporate Plan.
- The Trust provides patients, carers and staff with written information on how services have been changed or improved as a result of patient and public feedback in the annual report.

5. Where the Trust does not fully comply with the standard: N/A

6. Information available to support the evidence:
- Strategy for Engagement and Partnership with Patients and the Public
- Engagement and Partnership Action Plan
- Report and action plans for 2005 National Patient Surveys
- 1000 Good Idea report
- Portfolio of departmental patient surveys

Assurance Report – Healthcare Standard 18

1. Standard: Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.

2. Elements:
- The health care organisation takes steps to ensure that all members of the population are able to access services equally.
- The healthcare organisation offers patients an equal choice in accessing services and treatments.

3. Proposed declaration: compliant

4. Evidence:
- On track to deliver Choose and Book, 6 month and 13 week maximum waits in elective surgery and outpatients.
- The Trust participates in a range of clinical networks to support the needs of patients across North West London, including cancer, vascular, plastics and HIV. The Trust also participates in local health economy groups leading work on NSFs for older people, cardiovascular disease and diabetes.
- The Trust Access Policy and Procedure has been signed-off by the SHA and Modernisation Agency as representing best practice, ensuring appointments and admission are based on clinical need and length of wait.
- The Older Peoples NSF group have reviewed the Trusts policies and procedures and did not identify any that were inadvertently discriminatory.
- A range of outreach services are run in the local community for HIV and Sexual Health services (Victoria, Westminster and Soho clinics) following an assessment of unmet need and patient feedback.
- Booking (partial and full) in outpatients, day surgery and elective surgery provides patients a choice of dates and times for their appointment or admission convenient to them.
- The Trust is one of five acute hospital healthcare organisations identified by local PCTs for patients to choose from.
- Choose and Book is being implemented through the Booking Board, which includes K&C PCT and North West London membership. The directory of services has been uploaded and is available to view via the nhs.uk health site web link. The interim booking system will be implemented prior to spine compliance being delivered by IDX.
- The current standard is 6 months elective surgery overall and 3 months for cataract surgery. Patients are offered a choice of an alternative provider where the Trust is unable to guarantee these maximum waits. The Trust also ensures that all patients cancelled on the day are offered a date within 28 days for their surgery.

5. Where the Trust does not fully comply with the standard:

6. Information available to support the evidence:
- Trust Board Performance Reports
- North West London Performance Reports
- Access Policy and Procedure
- Booking Board minutes and Action Plan
- Older peoples NSF minutes
- Network Board minutes
- K&C PCT NSF Group minutes

Assurance Report: Healthcare Standard 19

1. Standard C19: Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within the national expectations on access to services.

2. Elements:

- The healthcare organisation ensures that patients are able to access its services within nationally agreed timescales and expectations.

3. Proposed declaration: Compliance

4. Evidence:

- An Emergency Care Strategy is in place, built on the principles of 'Reforming Emergency Care', and the Modernisation Agency Bed Management and Specialist Take toolkits.
- Routine emergency care activity reports are available, identifying activity by PCT, stream (e.g. minors, majors and specialist take) and arrival/ discharge time, enabling manpower to be deployed in line with peak activity trends. A weekly breach analysis is routinely undertaken to ensure that 'bottlenecks' are identified and action taken.
- Triage followed by a medical appraisal of each patients health needs (Rapid Assessment and Treatment) by A&E team ensures length of wait relates to clinical need. This backed up by specialist take review in A&E where appropriate.
- Making better use of existing capacity through the development of a Medical Assessment and Admissions Unit (MAAU) on William Gilbert ward, an Emergency Observation Unit in adult A&E and designated bed/cubicle space on the paediatric wards for children requiring observation. Work has also started in relation to reducing length of stay from 5.4 days to 4.8 days through the IMPACT programme. The development of a daily GP service is currently being discussed with our host PCT (currently week-ends only) in recognition of the significant increase in attenders with minor injuries.
- Joint work to re-design services and develop capacity is undertaken with local PCTs through our host Kensington and Chelsea. Practical examples include the community based Walk in Centres at St.Charles Hospital and Parsons Green.
- The Trust is part of the Emergency Care network hosted by K&C PCT.
- A Trust wide action plan has been developed based on the Bed Management toolkit, with nurse led discharge being the key focus. This is being taken forward through the IMPACT programme.
- Compliance with national guidance is monitored by the Trust in relation to the 98% standard, models of care (e.g. streaming in A&E, Rapid Assessment and Treatment teams, MAAU, bed management and specialist take tool-kits).
- Daily and weekly performance reports to monitor delivery of 98% standard. Performance year to date is 98.2% (1 April to 31 January 2006). The Trust is on track to ensure no 6 month waiters by the end of December 2005. An Access policy and procedure sets out the Trusts approach to waiting list management which is based on clinical priority and length of wait as the key admission criteria.

5. Where the Trust does not fully comply with the standard: n/a

6. Information available to support the evidence:

- Trust Board Emergency Care Report (including Bed Management and Specialist Take Action Plans) – September 2004
- Monthly Trust Board Performance Report
- SITREPs
- North West London SHA Performance Reports
- Emergency Care Monitoring reports
- Weekly breach analysis
- HIPPO Information System
- Minutes of Emergency Care Network Board
- IMPACT Programme update and length of stay analysis
- Nurse Led Discharge Project Group minutes and protocol
- Emergency Care Collaborative minutes and monthly reports

Assurance Report: Healthcare Standard 20

1. **Standard C20:** Healthcare services are provided in environments which promote effective care and optimise health outcomes by being a) a safe and secure environment which protects patients, staff, visitors and their property and the physical assets of the organisation. b) Supportive of patient privacy and confidentiality.

3. **Proposed declaration**: Compliant

4. **Evidence:**

a)

- Director of Operations has lead responsibility for security
- Trust Security Management Specialist in post (Facilities Manager, Soft Services) and links with NHS Security Management Services established
- Security incident reports are reviewed in detail by the Director of Operations with agreement on required action to ensure and improve the safety of patients, visitors and the organisation security.
- The Trust has a Security Policy and linked suite of key operational procedures, including losses and compensation procedures and key control policy as a means of protecting physical assets
- High risk employee groups have been trained on basic conflict resolution, through the LRC, further groups and refresher training is ongoing
- Staff security team briefings have been rolled out for all groups, starting in August 2005.
- Trust-wide Security FM Group established to lead security initiatives across the organisation
- Revised patients Procedure for Care policy, reinforces the manner in which the Trust will deal with situations which may compromise the safety of employees.
- Sample of outsourced service providers training records reviewed on a monthly basis against the agreed KPI
- 2005 Capital Programme supports the introduction of enhanced CCTV and roll-out of improved physical security measures over a 3-year programme
- The Trust is on target to deliver the NHS Security Management Services Initiative

b)

- Essence of care standard for privacy and dignity adopted within the Trust for the care of patients, led by nursing staff
- Information Governance policies are in place and followed by the multi-disciplinary team in relation to confidentiality and data protection
- Copying letters to patients

- All construction and refurbishment schemes comply with current Health Building Notes/Health Technical Memoranda and, where possible, comply with consumerism standards

b)

- All construction and refurbishment schemes comply with current Health Building Notes/Health Technical Memoranda and, where possible, comply with consumerism standards

5. <u>Where the Trust does not fully comply with the standard</u>:

6. <u>Information available to support the evidence:</u>

- Patient Survey feedback and action plan
- Essence of Care Standards
- Copying letters to patients guidelines and audit results
- Confidentiality and data protection policy
- Freedom of Information policy
- Information Governance policy
- Information security policy
- Information governance sheet

Assurance Report: Healthcare Standard 21

1. Standard C21: Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification of clean NHS premises

2. Element: Provides care in well designed and well maintained environments, which meet the national standards for cleanliness

3. Proposed declaration: Compliance

4. Evidence:

- All construction and refurbishment schemes comply with current Health Building Notes/Health Technical Memoranda and, where possible, comply with consumerism standards

- An annual and 5-year plan of maintenance is maintained

- The Capital and FM Projects Group leads the coordination of required building schemes and maintenance cycles to ensure the premises are optimally maintained

- The Director of Nursing has executive responsibility for the Trust's PEAT initiative

- Standards of cleanliness are monitored by the PEAT Steering Group

- Regular audit cycle which adheres to the National Standards of Cleanliness in terms of frequency and elements assessed is in place and actively monitored

- Training sessions held regularly to ensure consistent approach to standards of cleanliness

- Annual programme of periodic cleaning in place to carry out structural cleaning in order to underpin work achieved through daily cleaning routines

- The Trust achieved a PEAT Score of 3 for cleanliness in 2005 and following a spot check by the HCC was rated as the third cleanest hospital in England

5. Where the Trust does not fully comply with the standard: n/a

6. Information available to support the evidence:

- Capital and FM Projects Group Terms of Reference and Minutes
- Capital Programme Board submissions
- Haden Building Services annual PPM and 5-year maintenance schedules
- PEAT Steering Group Terms of Reference and Minutes of meetings
- Trust cleaning audit cycle and escalation procedures for non-compliance
- ISS monthly reports demonstrating hospital-wide cleaning scores
- EfM Data demonstrating annual PEAT assessment score

Assurance Report: Healthcare Standard 22

1. Standard

Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by:
a) cooperating with each other and with local authorities and other organisations
b) ensuring that the local Director of Public Health's annual report informs their policy making and practices
c) making an appropriate and effective contribution to local partnership arrangements including local strategic partnerships and crime and disorder reduction partnerships

2. Elements:

- The healthcare organisation actively works with partners to improve health and reduce health inequalities.

- The healthcare organisation has a process in place for monitoring and evaluating public health partnership arrangements.

- The healthcare organisation contributes appropriately and effectively to nationally recognised and statutory partnerships, such as the local strategic partnership and the crime and disorder reduction partnership (CDRP).

- The healthcare organisation's policies and practice to improve health and reduce health inequalities are influenced by the Annual public health report (APHR).

3. Proposed declaration: compliant for an acute Trust

4. Evidence:

- The Trust's corporate plan is informed by the Public Health reports from the local PCT's and the LDP's
- The Trust participates (at executive level) in the Joint Partnership Board, which is chaired by a local councillor and includes representatives from local PCTs, acute trusts and mental health trusts as well as the local authority. This enables the development of multi-agency strategies and plans for service delivery.
- The Trust's Joint Clinical Executive brings together senior clinicians and managers from the Trust with colleagues from local PCTs to review joint approaches to care and agree service models for the future.
- Monthly meetings are held at the Strategic Health Authority, bringing together Chief Executives from all healthcare organisations in the sector, which enables joint discussion and agreement about future developments.
- The Kensington and Chelsea Care Community exists to bring together local PCTs and acute trusts to plan (in particular) for the deployment of Information Technology to support patient care. Recent developments include the implementation of a common IT system (ProWellness) across the Care Community.
- At an operational level, numerous groups exist to ensure that services are co-ordinated across multi-agency boundaries. These include the Children's Board, the Older People's NSF Group, the Diabetes NSF Group, the Discharge Group and the Coronary Hearth Disease NSF Group; all of which include representatives from across the health and social care system. Recent developments have included the appointment of joint posts with the PCT, such as an older people's pharmacist, and the development of joint initiatives, such as the Return Home Safely Service, which is based at C&W and run jointly by two local PCTs.

- The Trust also has representation on groups that are run by other health and social care organisations, such as the Kensington and Chelsea Area Child Protection Committee and the Children and Young Peoples Strategic Partnership
- The Trust is working jointly with the local PCT to develop joint plans on equality and diversity
- The Trust works in partnership with the PCT and the Hospital at Home Service to support patients discharged from the A&E Dept who need further support

5. Where the Trust does not fully comply with the standard: n/a

6. Information available to support the evidence:
- Papers are available from the meetings described in 4 above

Assurance Report – Healthcare Standard 23

1. Standard: Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the national service frameworks (NSFs) and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections

2. Elements:

- The healthcare organisation collects, develops and analyses information to understand the current and future health and healthcare needs of the local population, reflecting health inequalities
- The healthcare organisation sets priorities for disease prevention and health promotion by using information about the health and healthcare needs of the population and evidence of effectiveness
- The healthcare organisation commissions and/or provides locally appropriate evidence-based disease prevention and health promotion programmes and services to meet the requirements of the NSFs and national and local plans
- The healthcare organisation implements policies and practice to support healthy lifestyles among the workforce
- Systems are in place for monitoring, evaluating and disseminating findings in relation to disease prevention and health promotion programmes and services
- The healthcare organisation has the capacity and capability to systematically and effectively deliver their public health responsibilities

3. Proposed declaration: compliant for an acute Trust

4. Evidence:

Element: The healthcare organisation collects, develops and analyses information to understand the current and future health and healthcare needs of the local population, reflecting health inequalities

- The Trust works with local PCT's to support their work to improve public health and reduce health inequalities in their priority areas and the NSF's. The Trusts work in this area is agreed with the PCT's through the commissioning process
- The Trust's information systems are designed to collect information about the patients referred, which includes information about the person's age, gender and where they live. Data is provided to the PCT as requested to support their work on disease prevention
- The Trust fulfils our component of all relevant NSF's and works in conjunction with PCT's in relation to their work on health promotion agreed through the commissioning process
- The Trust collects required data items to support national and local initiatives for public health, in particular the data required for sexual health initiatives
- Information is shared with other relevant local organisations as requested (taking into account the Caldicot principles), such as public health observatories, the StHA and local government

Element: The healthcare organisation sets priorities for disease prevention and health promotion by using information about the health and healthcare needs of the population and evidence of effectiveness

- The Trust complies with relevant NSF's and other national plans that apply
- The Trust works with the PCT's to support their work on disease prevention and health promotion through the commissioning process. For example the Trust provides sexual health services and health promotion work in maternity services such as promoting breast feeding.

- Locally and nationally available evidence is taken into account when setting the Trust's priorities

Element: The healthcare organisation commissions and/or provides locally appropriate evidence-based disease prevention and health promotion programmes and services to meet the requirements of the NSFs and national and local plans

- The Trust provides the services commissioned by the PCT's in line with their analysis of the requirements of their local populations.

Element: The healthcare organisation implements policies and practice to support healthy lifestyles among the workforce

- The Trust provides Occupational Health services to support the staff
- The Trust provides other facilities to support healthy lifestyles such as cycle racks and smoking cessation groups

Element: Systems are in place for monitoring, evaluating and disseminating findings in relation to disease prevention and health promotion programmes and services

- The Trust works in conjunction with the PCT to support this work.

Element: The healthcare organisation has the capacity and capability to systematically and effectively deliver their public health responsibilities

- This is done in conjunction with the local PCT's

5. Where the Trust does not fully comply with the standard:

6. Information available to support the evidence:

- Occupational Health – information can be provided about the services offered.
- Minutes of meetings with PCT's
- Information relating to commissioning

Assurance Report: Healthcare Standard 24

1. Standard

Healthcare organisations protect the public by having a planned, prepared and where possible, practised response to incidents and emergency situations, which could affect the provision of normal services.

2. Elements: .

- The healthcare organisation has up to date plans to deal with major incidents and emergencies that are compliant and tested in accordance with national guidance
- The healthcare organisation works with key partner organisation in the preparation and testing go major incident plans.

3. Proposed declaration: Compliant

4. Evidence:

The healthcare organisation has up to date plans to deal with major incidents and emergencies that are compliant and tested in accordance with national guidance

- The Trust's Major Incident Plan was revised in 2005 and takes account of all relevant national guidance and established best practice.

The healthcare organisation works with key partner organisation in the preparation and testing of major incident plans.

- The Trust works with key partners in the ambulance, fire and police services in Major Incident Planning under the leadership of the Lead PCT for North West London.
- The Trust is represented at local Borough Resilience and Major Incident Planning Meetings
- The Trust has participated in training and testing exercises the most recent being a communication exercise in March 2005.
- The Trusts Major Incident policy was comprehensively tested by the Major Incident affecting the whole of London on the 7th July 2005. Following this Major Incident, a review of how the Trust Major Incident arrangements worked was conducted. The Trust also participated in the North West London Strategic Health Authority debriefing event.
- The Trust Major Incident Policy describes how key staff will be contacted and identifies who would establish Gold and Silver Control in the event of a major incident being declared, and who would assume control on arrival at the Hospital.
- The Trust has a 24-hour Emergency Department
- Training on the Trusts response to Major Incident is included in staff induction training and updates. Supplementary training is provided by the Trust Clinical Nurse Lead, Emergency Department.

5. Where the Trust does not fully comply with the standard: n/a

6. Information available to support the evidence:

- Major Incident Policy
- Untoward Incident Report – Major Incident 7th June 2005
- Training Programmes for Induction and Update
- Meeting Minutes
- Royal Borough of Kensington and Chelsea Emergency Planning Committee (this includes borough, police, transport police, London ambulance service, public health, fire service and local PCT rep)
- Chelsea and Westminster PCT Influenza planning group
- North West Thames Emergency Planning Network
- London Health Mutual Aid group (this group seeks to secure links between private sector and NHS)
- One to one meetings with regional health emergency planner
- Regular informal meetings with London Ambulance Service emergency planners
- Ad hoc emergency planning liaison meetings, usually pan London

Glossary of Acronyms

BME Black and Minority Ethnic
CCTV Closed Circuit Television
CG Clinical Governance
CNST Clinical Negligence Scheme for Trusts
CRB Criminal Records Bureau
DDA Disability Discrimination Act
DoH or DH Department of Health
EEC European Economic Community
EHO Environmental Health Officer
EPR Electronic Patient Record
FM Facilities Management
GCP Good Clinical Practice
GRIP a Group of Reliable Interpreters in Parkside
H&S Health and Safety
HACCP Hazard Analysis Critical Control Point – food safety management system
HIPPO – name of the Trusts Clinical Information System
HR Human Resources
HSC Health Service Circular
ICAS Independent Complaint Advocacy Service
ICP integrated care pathways
ICT Information, Computing and Technology
ICU Intensive Care Unit
IDX – name of computer company
ISO International Standards Organisation
ISS Mediclean – company contracted to provide facilities management to the Trust
IWL Improving Working Lives
K&C Kensington and Chelsea
KPI Key Performance Indicator
KSF The Knowledge and Skills Framework
LPD Local Delivery Plan
MAAU Medical Assessment and Admissions Unit
n/a not applicable
NCEPOD National Confidential Enquiry into Patient Outcome and Death
NICE National Institute for Clinical Excellence
NPSA National Patient Safety Agency
NSF National Service Framework
OSC Overview and Scrutiny Committee
PALS Patient Advice and Liaison Service
PCT Primary Care Trust
PDP Personal Development Plan
PEAT Patient Environment Action Team
PPI Patient and Public Involvement
R&D Research and Development
RGF Research Governance Framework (Department of Health document)
RPST risk pooling scheme for trusts
RRA Race Relations Act
SAB's Safety Alert Broadcast System (run by the Department of Health)
SITREPs Situation Reports
SLA Service Level Agreement
SPRs Specialist Registrars
StHA or SHA Strategic Health Authority
SUI Serious Untoward Incident
TBC to be confirmed
TSSU Theatre Sterile Services Unit