Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting

Boardroom, Chelsea and Westminster Hospital, 369 Fulham Road, London SW10
Chair: Juggy Pandit
Date: 19th May 2006
Time: 2:00pm

Agenda

1. GENERAL BUSINESS	**2.00pm**
1.1 Welcome to the Members of the Public	**JP**
1.2 Apologies for Absence	**JP**
1.3 Declarations of Interest	**JP**
1.4 Minutes of the Previous Meeting held on 4th May 2006	**JP**
2. ITEMS FOR DECISION/APPROVAL	**2.15pm**
2.1 Risk Management Strategy and Policy	**CM**
2.2 Performance Management Strategy	**LB**
2.3 Risk and Performance Management Certification	**CM**
2.4 Submission Update Timetable	**HL**
2.5 Financial Model	**LB**
2.6 Capacity Plan	**LB**
7. QUESTIONS FROM THE MEMBERS OF THE PUBLIC	**4.45pm**
8. ANY OTHER BUSINESS	
9. DATE OF THE NEXT MEETING	
1st June 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, 19th May 2006

AGENDA ITEM NO.	1.4/May/2/06
PAPER	Draft minutes of the Previous Meeting held on April 6th 2006
AUTHOR	Fleur Hansen, Foundation Trust Lead Contact Number: 020 8846 6716
SUMMARY	This paper outlines key issues for the attention of the Trust Board.
BOARD ACTION	To agree the minutes as a correct record.

DRAFT
Trust Board Meeting, 4th May 2006
Minutes

Present:

Non-Executive Directors:	Juggy Pandit (JG) (chairman) Marilyn Frampton (MFr) Richard Kitney (RK) Karin Norman (KN)
Executive Directors:	Heather Lawrence (HL), Chief Executive Mike Anderson (MA), Medical Director Lorraine Bewes (LB), Director of Finance and Information Edward Donald (ED), Director of Operations Maxine Foster (MFo), Director of Human Resources Alex Geddes (AG), Director of IM&T Elliot Howard-Jones, (EHJ), Interim Director of Strategy and Service Development Andrew MacCallum (AMC), Director of Nursing Catherine Mooney (CM), Director of Governance
In Attendance:	Fleur Hansen (FH), Foundation Trust Lead Marianne Loynes, Monitor Tania Sang, Monitor Rona McKay (RMK), Emergency Planning Lead (for item 5.1)

1. GENERAL BUSINESS

1.2 Apologies for Absence

Apologies were recorded from Andrew Havery and Charles Wilson.

The chairman also welcomed Prof Richard Kitney from Imperial College to the Board as academic non-executive director.

1.3 Declarations of Interest

No conflicts of interest were declared.

1.4 Minutes of the Previous Meeting held 6th April 2006

There were a number of spelling/grammatical corrections:

- p. 1: Cathy Mooney should be Director not Director-Elect (CM)
- p. 5, first paragraph, final line: should be completed not complete (CM)
- p. 5, 2.3.2, issue 2: KN asked for more clarification on what cash releasing efficiency is. MFr also asked what generics refers to – LB clarified that it is inflation, not generic drugs.
- p. 1, final paragraph: the final minutes are the 'province' of the chairman not the 'providence' (MFr)
- p. 6, second paragraph: AMC asked that it be noted that he said AfC was an evaluation of people's current jobs, not being paid the correct amount for their position.
- p. 8, 4.1, fourth paragraph: KN asked that it be noted that she was referring to the differing amounts of detail across directorates, rather than suggesting that more work needed to be done solely in the Medicine Directorate.
- p. 2, final line of section 1.4: this sentence should read that that the

'minutes were agreed as a true and accurate record subject to the changes above'. (CM)

HL asked the Board to note that in future the minutes will be sent out for review prior to the rest of the Trust Board papers. This had not been possible this month due to FH being on annual leave.

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

1.5 Matters Arising

5.1/Aug/05 Child Protection Quarterly Report
MA informed the Board that the Healthcare Commission would be in touch with the Trust if required and therefore this matter could be removed.

1.6/Mar/06 Connecting for Health
AG informed the Board that a number of meetings with Connecting for Health (CfH) and GE had been held and that the Trust was still awaiting further information from GE. AG will report back to the Board at the next meeting.

2.2/Feb/06 Delayed Discharges
Information on this has been included in the April Performance Report.

3.1/Mar/06 Corporate Plan
This has been tabled for later in the meeting.

1.7/Apr/06 Members' Council
AMC updated the Board that a Members' Council Induction Pack was being drawn up and that the content should be finalised next week. JP suggested that the draft pack be tabled at the extraordinary Board meeting on May 9th.
Action: Members' Council Induction Pack to be presented to the May 9th extraordinary Board meeting. **AMC**

2.3.1 /Apr/06 Generator Upgrade
ED informed the Board that the generators had passed their most recent all day test and that that the Trust was working with Haden to.take over full responsibility for them

2.3.1/Apr/06 Lift Expenditure
ED informed the Board that this matter would be taken to the June Facilities Assurance Committee which would then report back to the following Trust Board.
Action: Report on Lift Expenditure to be brought to the July Trust Board. **ED**

2.3.2/Apr/06 AfC for Contracted Services
This has been tabled for Part B of the meeting.

5.1/Apr/06 Outpatient Prescribing
An audit of length of prescribing in the Outpatients Department will be presented to the next General Matters meeting.
Action: Report on length of outpatient prescribing to be brought to the next General Matters meeting on June 13th. **ED**

2.2/Apr/06 Bank and Agency Costs
This will be addressed under the Finance Report.

2.2/Apr/06 Performance Report
The amendments were made to the Performance Report.

1.6 Chief Executive's Report

Service Level Agreement Update
HL asked the Board to note that the SLA with our host PCT, Kensington and Chelsea, had been agreed for the first time in April. The Board extended its congratulations to Lorraine Bewes and her team on negotiating the agreement in record time.

Performance
HL asked the Board to also note the excellent achievement in meeting all core performance targets in March.

External Audit
HL informed the Board that the Audit Commission is proposing the extend the appointment of Deloitte as the Trust external auditors for another year until the end of 2006/07. HL enquired as to whether the Audit Committee would need to clear this first – it was recorded that they did not. Therefore it was agreed that Deloitte should be appointed for a further one year term.

Corporate Plan Update
HL informed the Board of the new three corporate objectives:

- Excellence in teaching;
- Customer services; and
- Equality and Diversity.

JP suggested that it may also be beneficial to include a corporate objective focusing on cost management, particulary understanding the relationship between activity and cost.

Standards for Better Health Declaration
HL informed the Board that the final declaration had been submitted today and CM added that the Overview and Scrutiny Committee comments had been received and that their commentary had been added to the submission. (I think CM said that some of their comments were factually wrong and this had been pointed out. Please check with her)

Senior Appointments
HL informed the Board that interviews are currently underway for the Deputy CEO and Director of Strategy positions and that it was hoped that the Deputy CEO position could be decided before the end of the week.

A New Ambition for Old Age
HL asked the Board to be aware of new DoH guidance for old age. HL highlighted that this is not hugely new for the Trust as it already has many of the measures it suggests, and the appropriate staff, in place.

At this point AMC asked the Board to note that the Trust had been shortlisted for two National Patient's Association awards. They are for Privacy & Dignity Innovation, Helen Brown and the Rev Steven Smith for the Charter for Privacy and Dignity and for the Most Promising Innovation of the Year, Rosalind Wallis for her Introduction to Bardex IC Cathether.

1.7 NHS Foundation Trust Application

HL asked the Board to note the attached timetable of key dates in the Foundation Trust application process. In particular the extraordinary Board meetings scheduled for May 9th and 10th which will focus on the financial plan and SDS respectively. The meeting on May 10th would also address Board competencies with Jennie Hill in attendance to lead this discussion. The Board was also asked to note the Board seminars on May 9th, 10th and 19th which would address the final documents for submission due in on May 22nd.

HL also highlighted that a mock Board to Board had been arranged for June 7th with the

NWLSHA and that another is intended to be arranged for June 20th in the lead up to the Board to Board with Monitor on July 5th.

HL informed the Board that the meeting held with Monitor on May 3rd addressing the constitution, governance arrangements, consultation process and the membership strategy had gone well. Some addition documentation would be required and JP and MFr would be working with CM and AMC to ensure that these are submitted.

At this point HL asked the Board to inform her of any areas that they would specifically like to cover in the lead up the authorisation.

HL highlighted progress with the SDS – Directors are currently updating their respective sections and appropriate areas (such as the risk matrix) will be discussed at Trust Board seminars.

AMC informed the Board that membership currently stands at 10,619. The membership drive in the hospital itself was currently slowing down and that the focus would shift to telephone canvassing in order to reach the target of 14,000. The number of staff members is 698 which roughly equates to one in three – this is relatively low but work is being done around induction etc to increase this number.

AMC highlighted that there had also been a good level of feedback from the elections and the aim was to receive a feedback form from every candidate. AMC mentioned that the Members' Council induction pack was being worked on and that this would be presented to the next Trust Board meeting.

2. PERFORMANCE

2.1 Finance Report, March 2006

JP extended the Board's congratulations to the Trust in achieving an overall position for the twelve months to March 2006 that was not only in line with expectations but was also in surplus.

LB laid out the highlights of the report:

- All statutory financial duties had been achieved.
- The Trust had not only broken even but has made a surplus.
- Lived within cash and capital budget limits.
- Underspent on capital by 3.5%.

LB informed the Board that the only potential risk related to the provision for disputed debt but that she was confident that this would not be an issue.

LB asked the Board to note item 27 of the report concerning the nursing bank and agency spend analysis. The increase in hours amounted to a 7.4% change from 2004/05 to 2005/06 but the average cost per hour had in fact been reduced by 1.5%. After accounting for a 3.225% increase in pay rates, the real change in average cost per hour would be a reduction of 4.7%. This reduction had been achieved due to the shift from agency to bank usage. In addition LB informed the Board that although vacancies remained static, there was still scope for improvement in bank and agency spend.

KN enquired as to what was happening to the bank and agency recruitment rate. MFo informed her that through the Capacity Plan, HR were attempting to flex between temporary workers and create a balance between agency and permanent staff. MFo noted also that bank and agency staffing was now a positive issue – the balance had been achieved and they now provided enhanced flexibility in the workforce.

JP enquired as to the ratio of bank to agency staff – MFo said that it was around 80/20.

Whilst the Trust would seek to employ more bank staff in some cases agencies would pay for training etc making agency staff more cost efficient. MFo also said that the Trust was considering phasing out special rates for bank and agency nursing staff which would also help efficiency and help make them more cost effective on weekends and bank holidays. AMC suggested that bank staff were the Trust's internal flexible workforce but also warned of potential rostering issues. ED noted that software tools were available to deal with these issues.

JP enquired as to why, under item 24, private patients had made a contribution less than planned? Was this due to the pricing being too low? ED replied that pricing is routinely checked against other Trusts and providers and that Chelsea & Westminster is in line with other organisations. JP asked then was the issue around costs to which HL highlighted the ongoing nurse rostering issue. JP asked that this issue be revisited.
Action: Private Patient Pricing be further analysed.

LB continued on to talk about the sustainability of the cash surplus. She said that a planning improvement was being made to debtor control and that should have a significant effect. JP noted that given that cash was a significant issue for the initial Foundation Trust application, that the cash surplus was a very good achievement.

2.2 Performance Report, March 2006

LB asked the Board to note that all key access targets had been achieved. There were two Healthcare Commission targets coded red though – Ethnic Coding and Delayed Transfers but both of these were being graded against the top band so there had been an achievement in part. The Rapid Access Chest Pain Clinic (RACPC) was in danger of not achieving but A&E Trolley Waits were getting there.

LB said that the Ethnic Coding issue was being addressed through the Data Quality Group and that the Trust was looking to employ a system of separating out patients that refused to disclose their ethnic origin.

HL enquired as to the affect of the July 7 bombings on cancelled operations – LB responded that the if this was excluded the rate would drop from 6.4% to under 5%. KN enquired as to how this can be improved on further – MA suggested further analysis needed to be undertaken as to why medical staff were unavailable.

2.3 Savings Plan 2006/07

LB informed the Board that the cost improvement target for 2006/07 was £10.6m of which £1.7m was carried over from last year. This would require a cost efficiency target of 2.5% for directorates. LB noted that concentration would be required to complete Trust wide initiatives of which most were directed at pay items such as productive rostering. LB also asked the Board to note that a corporate contribution of £60,000 would be required.

JP enquired as to the possible contribution from real estate revaluation – LB responded that an independent evaluation was being undertaken and that an update on delivery would be brought to the next Board meeting. (Could you check this with LB)
Action: Update of Capital Plan phasing to be delivered to the next Board. **LB**

JP enquired as to what assumptions had been made regarding I Lastword – the EPR system. AG said that the current contract is the annual fee plus additional costs but that the cost should be lower than last year's figure of £930,000. AG informed the Board that there would be no additional cost if the Trust stuck with the Connecting for Health software but otherwise, they would need to negotiate with GE.

CM commented that it was difficult to gather what the impact would be for directorates and that perhaps a risk assessment should be done. HL noted that the impact of cost

reduction was addressed through the risks facing the directorates. HL also noted that savings plans still need to be completed for HIV/GUM and the Medicine directorates. ED responded that HIV/GUM would meet the plan whilst Medicine still had a deficit challenge but was improving and would achieve the plan in the end. KN suggested that it would be useful to track changes and consolidate the corporate service indicator in one area.

Action: The above changes be made to the Savings Plan. **LB**

3. ITEMS FOR DECISION/APPROVAL

3.1 Consultant Appointments

The Board approved the following consultant appointments:

Consultant Physician and Gastroenterologist: Dr Marcus Harbord
Consultant for John Hunter Clinic: Dr Sarah Day

HL asked the Board to note that the first appointment is a replacement post.

3.2 Corporate Plan

JP highlighted once again that there should be an objective around management of costs effectively. HL noted that there was still a need to insert the financials into the plan but that the objectives had been subject to Smart and Swot analysis. There are still some issues around a couple of objectives and these have been highlighted in grey in the plan. EHJ responded that progress is being made in linking back with directives and whilst four or five were not obviously measurable, they would stay in the plan as important organisational goals. Suggestions were made for measurement tools – for example the Sole (??) system that students use for measuring teaching.

There was also discussion around the audience for the Corporate Plan and HL asked the Board to note that this is the Trust's business plan and not directed at a public audience. CM suggested looking at which objectives from last year had been achieved – this would be useful in formulating this year's.

It was decided that further Swot and Smart analysis was needed to sure up the objectives and to allow them to be measured. It was decided that the amended version with the financial activity added would be brought to the next Board after being cleared by the executive director.

Exec. Dir.

KN felt that the plan should be written so that it was easily comprehensible to the lay reader. After discussion it was felt that the plan was a working document for the management of the Trust but a version for the public should also be prepared

Action: Executives to quantify objectives where possible and undertake Swot and Smart analysis and report back to Monday Execs meeting.

3.3 SDS Risk Grading

JP summarised the discussion at the pre-Board Seminar which was focused on the SDS risk grading. It was decided that there would be a reassessment of HIV funding and that this along with Payment by Results, CIP, burns, demand management and patient choice were the main issues.

LB noted that the risks had now been agreed and that the risk matrix used for scoring had been reviewed. Adverse risks and opportunities had been identified and a hierarchy had been formed to determine which risks would feature in the base case. It was decided that the Board would look again at this at the Board Seminar on May 10th once HIV had been reassessed.

Action: HIV to be reassessed and scenarios be returned to the Board Seminar on May 10th. **LB**

4. ITEMS FOR ASSURANCE

4.1 CNST Report

CM informed the Board that there had been a change in legislation which would require the Trust to make annual periodic payments to the Clinical Negligence Scheme for Trusts (CNST) rather than fixed payments. In light of this HL had asked for a paper to assess the value of CNST.

CM asked the Board to note that CNST gives the Trust insurance as well as assurance in managing claims and that if we opted out, the costs could potentially be much higher. HL noted the high incidence of brain damage claims being brought against the trust in the Women's & Children's Directorate. CM added that this had risen across the Trust and it was suggested that a report be brought back to the next Board meeting.

Action: Report on increasing incidence of brain damage claims brought to the next Trust Board meeting. **CM**

There was then discussion around director's liability if the Trust were to reach Foundation status. JP suggested that external insurance needs to be considered and that an assessment on this should be brought to the next Board.

Action: Report on whether external insurance will be required as a Foundation Trust for the next Board meeting. **CM**

The Board confirmed the value of the CNST scheme and agreed that it was in favour of continuing with it.

4.1 Workforce Report

4.2.1 Staff Survey Action Plan and Board Assurance

MFo reported on the results of the 2005 National Staff Survey and noted that significant improvements had been made on last year's survey. There were some inconsistencies relating to work/life balance and working extra hours but overall the report was very positive. Wards and departments and their areas for improvement have been addressed in the action plan.

JP enquired as to where the Trust stood in relation to other Trust's regarding Harassment and Bullying – MFo said that this information would be added to the report. MFo informed the Board that going forward, it would be important to fully utilise appraisals so that staff know what their key deliverables are.

Action: Comparison with other Trust for Harassment and Bullying be added to the report. **MFo**

4.2.2 Workforce Ethnicity Report 2005/06

MFo asked the Board to note that this report provides information about the Trust's workforce and potential workforce by ethnicity for the following areas:

- Recruitment
- Training
- Promotion
- Employee Relations
- Joiners & Leavers

MFo asked the Board to note that we are required to publish this report under the Race Relations Act and particularly we are required to look in regards to our local area. JP suggested that it would be useful for further analysis by staff group to be done.

MFo said that the results would be presented at the next Ethnicity & Diversity Group meeting and that the report had also been taken to the Joint Trade Unions Group

meeting.

4.3 Inpatient Survey

AMC informed the Board that for the 2005 Inpatient Survey, 850 questionnaires had been sent to recent patients to which there was a response rate of 48.4%. The report showed that the Trust performed significantly better than the average for six questions and significantly worse for one. In comparison to the 2004 survey, the Trust performed significantly better for nine questions and did not perform significantly worse for any which is an excellent result.

The report then goes on to recommend five key actions which should drive patient satisfaction even higher. Of these, the communication of the survey results is already underway and ward-based reports are being developed. MA noted that targeting patients ward by ward should help improve the results which are average in comparison to other Trusts.

The action plan was approved by the Board.

5. ITEMS FOR NOTING

5.1 Influenza Update

AMC asked the Board to note that the paper was authored by Rona McKay, Emergency Planning Lead and not himself as suggested on the coversheet.

AMC informed the Board that the paper highlights the main points of the Draft Influenza Pandemic Plan. As the potential impact of a pandemic changes daily, all Trusts are required to ensure that they have adequate provision. The Trust has incorporated a possible pandemic as part of the major incident plan which can function for a one day or over a number of months. The suspected impact on the Trust would be an additional 5000 emergency attendances, 3,500 extra admissions and 600 deaths.

RMK highlighted one of the key tools of the plan was the use of action cards for different areas/departments of the Trust such as HR, A&E and Communications. RMK said that the Plan would be updated frequently as and when new guidance is received from the centre. LB noted that a pandemic had been accounted for in finance and the scenario had been modelled in the SDS.

AG enquired as to the impact on staff which RMK said would be significant based on q 25% clinical attack rate. Anti-virals would be provided to infected staff and MFo informed the Board that a pro forma was being tested to identify key staff and also key family carers. MFo also said that bank staff who would be willing to work were being identified as well as contacting recently retired staff. RMK noted that the Trust is a key leader in pandemic planning with five staff members being on the NWL steering group which is the leading for the country.

5.2 Minutes of the Facilities Assurance Committee meeting 2nd March, 2006

ED asked the Board to note the minutes. It was a noted on the cover sheet that any queries should be forwarded Helen Elkington, not any amendments as stated.

JP asked for an update on the relationship with Haden. ED informed the Board that Haden had brought in their head office which has put much needed systems and processes in place however there was still significant improvement to be made. LB asked where the Trust stands contractually – ED said the contract expires next January. LB suggested a timeline should be put in place for improvement and it was decided that the Facilities Assurance Committee should come back with a recommendation for the Trust Board at the September meeting.

Action: Facilities Assurance Committee to report to the September Trust **ED**

Board on the performance of Haden.

5.3 Minutes of the Clinical Governance Assurance meeting 28th March, 2006

CM asked the Board to note the minutes. CM suggested that minutes should be approved by their relevant committee before being presented to the Trust Board. JP responded that this would result in very long delays as the committees generally only met bi-monthly. JP suggested that the chairman and lead director for each committee be charged with informing the Trust Board of any significant changes to the minutes.

6. ITEMS FOR INFORMATION

There were no items under this heading.

7. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from the public.

8. ANY OTHER BUSINESS

There was no other business.

9. DATE OF THE NEXT MEETING

The next meeting is scheduled for 1st June 2006.

10. CONFIDENTIAL BUSINESS

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

Trust Board Meeting, 19th May 2006

AGENDA ITEM NO.	2.1/May/2/06
PAPER	Chelsea and Westminster Healthcare NHS Trust Risk Management Strategy and Policy
LEAD DIRECTOR	Jane Cartwright, Pippa Roberts, Vivia Richards
AUTHOR	Catherine Mooney, Director of Governance and Corporate Affairs
SUMMARY	This document has been circulated to, and has been updated following receipt of extensive comments from the following groups: • Operational Risk Management Committee (June 2005) • Executive Management Group for Clinical Governance (July and November 2005) • Clinical Governance Assurance Committee (May 2005, November 2005, March 2006) • Trust Board (July and October 2005) • Several circulations to Trust staff via the intranet and via team meetings
BOARD ACTION	The Trust Board is asked to approve this Risk Management Strategy and Policy.

Chelsea and Westminster Healthcare NHS
NHS Trust

Risk Management Strategy and Policy

Version	2.8; May 2006
Date of publication	June 2005
Date for review	September 2006
To be read in conjunction with the following Trust policies	• Standing Financial Instructions • Risk Management Procedures (Responding to, Reporting and Investigating Incidents, Risk Scoring Matrix and Risk Register, SUI Reporting Policy) • Raising Concerns (Whistleblowing) Policy • Health and Safety Policy • Major Incident Policy • Flu Pandemic Contingency Plan
Approving Committee	Trust Board
Date Approved	
Executive Responsible for the Policy	Director of Governance and Corporate Affairs

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1 Introduction

The Chelsea and Westminster NHS Trust is committed to a strategy which minimises risks of harm to people, services and the Trust through a comprehensive system of internal control and the delivery of high standards of care.

Our vision is to deliver safe care which will be of the highest quality for our local population and those using our specialist services. It will be provided in a modern way by multi-disciplinary teams working in an excellent environment, supported by state of the art technology and world class academic research.

Risk is the inevitable accompaniment to any human activity. The responsibility to minimise risk is an essential element in the corporate management of any complex organisation.

The Trust recognises the importance of continuing to promote a culture of openness within a learning environment where risk management is everyone's concern. Risk management is an integral part of everyone's responsibilities and not just that of any one individual or department. It is the responsibility of all staff to practice safely and to participate in the assessment, reporting and management of risk.

What is risk management? 'Risk management' is the term applied to the use of a logical and systematic method of identifying, analysing, evaluating, controlling, monitoring and communicating risks associated with any activity, process or function necessary to the achievement of the organisation's objectives. It can also be described as a method of minimising loss and maximising opportunity. Risk management is a continuous process and at Chelsea and Westminster Healthcare Trust it aims to influence behaviour and develop an organisational culture within which risks are promptly recognised and addressed.

Developing an Open & Fair Culture. Studies have shown that the best way of reducing adverse events is to target the underlying system failures, rather than to take action against individual members of staff. Healthcare organisations need to confront two myths that still persist:

- **The perfection myth:** that if people work hard enough they will not make any errors.

- **The punishment myth:** that if we punish people when they make errors they will make fewer of them.

Neither of these statements is true. What will achieve a reduction in adverse events and an increase in safety for users and staff is an approach which focuses on system failures and root causes within an open and fair culture. ('*Seven Steps to Patient Safety: Guide for NHS Staff*', National Patient Safety Agency 2003)

2 Definitions

Incidents include: adverse incidents/events, accidents, near misses, complaints and claims.

An adverse incident can be defined as any unexpected or untoward event experienced by patients, visitors, staff or the organisation, which has had or could have had a detrimental effect. This includes events related to clinical and non-clinical working practices.

An accident is any unplanned and uncontrolled event that has caused injury, ill health, harm to persons, damage or loss to equipment.

A ‘near miss’ is when the impact has been prevented: any incident that had the potential to cause harm but was prevented. (National Patient Safety Agency (NPSA) definition)

A ‘no harm’ incident is when the impact is not prevented: any incident that ran to completion but no harm occurred. (NPSA definition)

A ‘patient safety incident’ is any unintended or unexpected incident that could have or did lead to harm for one or more patients (based upon NPSA definition). This is often described in the NHS as a clinical incident.

A ‘significant risk’ is one which on the Risk Matrix has been scored 20 or above.

3 Scope of the Strategy & Policy

The ‘Risk Management Strategy & Policy’ relates to risk in all areas of the Trust’s activities, e.g. clinical, health and safety, IT, financial, performance and estates.

The Strategy & Policy applies to all staff employed within the Trust on a permanent, temporary, contract or volunteer basis. All staff are expected to be aware of the Strategy & Policy, understand their responsibilities in relation to managing risk and follow the guidance contained in the Trust procedure ‘Risk Management Procedure: A Practical Guide for Undertaking Risk Assessment and Managing Incidents’.

Managers at all levels will seek to ensure that risk management is a fundamental part of the total approach to quality and corporate and clinical governance.

To achieve successful control of risk, not only is management action required, but also the active participation of all employees.

The strategy section of this document outlines the Trust’s objectives for risk management with the overall objective of protecting patients, staff and assets. The policy section outlines the roles and responsibilities of staff, structure of risk management committees, incident reporting and risk assessment requirements. Detailed guidance on how to implement the requirements of the Strategy & Policy is contained in the ‘Risk Management Procedure: A Practical Guide for Undertaking Risk Assessment and Managing Incidents’ document.

4 Communication of the Strategy and Policy

This strategy will be communicated to all staff as part of the induction programme, at mandatory updates and will be available on the intranet.

5 Strategy

5.1 Strategic Intent

The Board recognises that risk management is an integral part of good management practice and to be effective should become part of the Trust's culture. The Board is, therefore, committed to ensuring that risk management forms an integral part of its philosophy, practices and business plans rather than being viewed or practised as a separate programme, and that responsibility for implementation is accepted at all levels of the organisation.

Moreover, to achieve our corporate objectives and maintain a reputation for excellence in clinical care, as an employer and as a provider of services to the public, the Board acknowledges that the provision of appropriate training is central to the achievement of this commitment.

5.1.1 Promoting an open and fair culture - The Trust Board Position Statement

The Trust Board wishes it to be known that:

- There will be no automatic assumption that an individual is to blame for adverse incidents. Investigations will be carried out to establish all circumstances around the event in order to strengthen our systems and processes to prevent similar incidents in the future.

- It is the duty of staff to report incompetence, bad working practice, and to promote a culture of ownership, pride and professionalism.

- Members of staff are encouraged to raise concerns about their own competence and will be treated fairly. Whenever possible they will be offered the appropriate assessment, training and education.

- Any member of staff who raises genuine concerns about another individual or group of staff's competence will be listened to, taken seriously and treated fairly. Each issue will then be taken forward according to its own merit and a timely investigation will be made in accordance with the Trust's Raising Concerns (Whistle Blowing) Policy.

- Individuals or groups of staff who wish to evaluate any aspect of their own competence or working practice will be supported to do so through appropriate mechanisms, for example, through audit or other measures, in accordance with the Trust's Raising Concerns (Whistle Blowing) Policy.

5.2 Risk Management Objectives

Ensure a safe and healthy environment.

- To strive to ensure, insofar as is possible, that risks are mitigated. Avoidable accidents will be prevented and employees, patients, contractors and the public will not be exposed to any unnecessary hazards.

- To ensure that the Trust Board is aware of significant risks. This will facilitate the appropriate allocation of resources in a prioritised way, so that the Board is in a position to manage these risks and ensure that it can meet the corporate objectives.

- To comply with the Clinical Negligence Scheme for Trusts (CNST) standards, relevant risk related standards (Standards for Better Health) and all applicable Health and Safety and Environmental legislation.

- To offer counselling and support to service users and families, carers and staff involved in incidents or accidents that occur within the Trust.

- To learn lessons from incidents and share examples of good practice, both within and outside the Trust.

Ensure safe working practices.

- To train all staff to enable them to undertake clinical procedures and workplace health and safety practices.

- To consider concerns of patients, employees, suppliers, local committees and the public in establishing the Trust's risk register and action plans.

- To integrate risk management practices and procedures into all aspects of the Trust's business and clinical activities.

Communicate risk management systems and processes.

- To promote and support an open and fair culture.

- To ensure all staff have a sound working knowledge of the trust 'Risk Management Strategy & Policy' and 'Risk Management Procedure: A Practical Guide for Undertaking Risk Assessment and Managing Incidents' and use the process for risk identification, assessment, reporting and management of incidents.

- To ensure that all staff are aware of their individual responsibilities, with respect to risk management.

- To maintain regular reporting of patient safety incidents to the National Reporting and Learning System (NRLS).

6 Policy

6.1 Purpose

The purpose of the Risk Management Policy is to define the framework for managing risk as outlined in Appendix 1, and the structure of risk management related committees, as outlined in Appendix 2. The policy also outlines the roles and responsibilities of all staff and the Trust's incident reporting and risk assessment requirements.

To achieve the risk management objectives, the Trust Board recognises that there must be:

- clear and communicated arrangements with designated responsibilities for risk management,
- involvement / participation of all staff,
- integration of risk and operational management,
- a focus on problem solving and learning, rather than blame and punishment,
- a 'live' and meaningful organisational wide risk register, which includes all types of risk e.g. patient safety, financial and strategic risk,
- a robust incident reporting system,
- ongoing monitoring of actions / controls put in place to minimise the organisation's exposure to risk,
- training in risk assessment, root cause analysis and an ongoing programme to raise awareness of risk management throughout the organisation.

6.2 Responsibilities & Accountabilities

6.2.1 All staff

Risk management must be seen as everyone's responsibility and not just that of any one individual or department. It is the responsibility of all staff to practice safely and to participate in the assessment, reporting and management of risk. All staff have a responsibility to attend risk management training and ensure they understand the requirements of the Trust's risk management policies and procedures. In addition staff are responsible for fulfilling the professional requirements of their regulatory bodies.

Specific Responsibilities:

6.2.2 The Trust Board

The Trust Board is responsible for overall governance of the organisation. The Board members are responsible for reviewing and maintaining an effective system of internal control, including systems and resources for managing all types of risk.

6.2.3 Chief Executive

The Chief Executive is the accountable officer and has overall responsibility for maintaining an effective Risk Management system.

6.2.4 Non-Executive Director / Chair of Clinical Governance Assurance Committee

The Board has nominated a Non-Executive Director who will chair the Clinical Governance Assurance Committee. This committee has overarching responsibility for ensuring appropriate governance arrangements are in place for the management of all principal clinical risks.

It is the responsibility of the Chair, working with the Director of Governance and Corporate Affairs, to ensure that this committee works effectively and reports regularly to the main Trust Board. See Appendix 6 for the terms of reference of the Clinical Governance Assurance Committee.

6.2.5 Non-Executive Director / Chair of Facilities Assurance Committee

The Board has nominated a Non-Executive Director who will chair the Facilities Assurance Committee. This committee has overarching responsibility for ensuring the maintenance of a safe, clean hospital environment in which patient-focussed service standards are delivered and met.

It is the responsibility of the Chair, working with the Director of Operations, to ensure that this committee works effectively and reports regularly to the main Trust Board. See Appendix 7 for the terms of reference of the Facilities Assurance Committee.

6.2.6 Non-Executive Director / Chair of Audit Committee

The Audit Committee is authorised by the Board to investigate any activity or seek any information required, within its terms of reference. It has responsibility for effective internal control. The Audit Committee will provide the Board with a means of independent and objective review and assurance of the adequacy of Governance arrangements, financial systems and compliance with legislation and codes of conduct. See Appendix 5 for the terms of reference of the Audit Committee.

6.2.7 Board Executive Directors (general)

Executive Directors are responsible for ensuring that any preventative or remedial action that has been identified is implemented. Executive Directors also have responsibility for ensuring that staff are informed about this strategy, policy and related procedures.

6.2.8 Director of Governance and Corporate Affairs

The Director of Governance and Corporate Affairs is responsible for overseeing the systems and processes required for effective risk management. This includes management of legal affairs, corporate affairs, communications and close working with the three sub committees responsible for aspects of risk management, which are the Audit Committee, Facilities Assurance Committee and Clinical Governance Assurance Committee.

6.2.9 Medical Director and Director of Nursing

The Medical Director and the Director of Nursing also have board level responsibility for risk management relating to their professional fields. The Director of Nursing is also responsible for the Patient Affairs Team and the Infection Control Team.

6.2.10 Director of Finance

The Director of Finance is accountable for maintaining an effective system of financial control ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control, including the establishment of an effective audit function. The Director of Finance is responsible for ensuring that a programme of risk management is included in the Standard Financial Instructions. The existence, integration and evaluation of the risk elements identified within this programme will provide a basis to make a statement of the effectiveness of Internal Financial Control within the Annual Report and Accounts as required by HSG (97)17.[1]

6.2.11 Director of Human Resources

The Director of Human Resources is the Executive Director with responsibility for Human Resource issues with the Trust. The Director of Human Resources is also responsible for Occupational Health, the Moving and Handling advisors, the Training Resource Centre, including the Trust's training database.

6.2.12 Director of Operations

The Director of Operations is the Executive Director with responsibility for the day to day operation of clinical services and non-clinical support services, delivering agreed local and national performance targets. The Director of Operations provides the appropriate infrastructure to support the clinical and non-clinical activity of the hospital, ensuring optimal utilisation of resources.

6.2.13 Director of Information Communications and Technology

The Director of Information Communications and Technology is the Executive Director with responsibility for information technology and information governance in the Trust.

6.2.14 Clinical Directors & General Managers, Chief Pharmacist and Head of Therapies

Clinical Directors, General Managers, Chief Pharmacist and Head of Therapies are responsible for service provision and for risk management within their respective directorate, ensuring that governance structures are in place and operating effectively to identify and manage risks, and implement learning throughout the service. They are also responsible for ensuring that risk register updates are received in a timely and complete fashion and that, with Directorate Risk Leads, training and information is cascaded throughout the directorate management structure.

6.2.15 Consultants, Heads of Departments, and Clinical Nurse Leads

Consultants, Heads of Departments, and Clinical Nurse Leads are responsible for ensuring that all necessary risk assessments are undertaken within the directorate or department and that appropriate control measures are implemented and monitored. They must ensure that employees at all levels are made aware of the risks within their

[1] Chelsea and Westminster Healthcare NHS Trust Standing Financial Instructions, version 3, September 2005

work environment and of their personal responsibilities. They are also responsible for providing the necessary information and access to training to enable staff to work safely.

In order to support the above named officers in their roles, the following staff work together and have designated Trust-wide risk management responsibilities:

6.2.16 Head of Clinical Governance

The Head of Clinical Governance is responsible for leading the implementation of all aspects of the Trust's Clinical Governance Strategy and has responsibility for the corporate risk register and incident review register. The Head of Clinical Governance is also responsible for the Clinical Governance Support Team, which includes the risk managers.

6.2.17 Risk Managers

The risk managers are responsible for maintaining and developing the Incident Reporting system, maintaining the risk register, delivering training and education on risk management issues to staff, and providing advice and updates to staff on risk management issues. They also support the directorate risk leads in their risk management responsibilities.

6.2.18 Health & Safety Consultant

The Health & Safety Consultant acts on behalf of the Director of Operations in fulfilling the Trust's statutory health, safety and fire responsibilities, through implementation of the Trust's 'Health and Safety Policy' and operational procedures for health, safety and fire audit and risk assessment.

6.2.19 Patient Affairs Manager

The Patient Affairs Manager is responsible for ensuring that a speedy and effective response is made to all patient/user complaints, comments and suggestions regarding the service provision of the Trust, minimising the risk of complaints being referred for independent review and taking action or making recommendations arising from complaints where appropriate.

6.2.20 Head of Legal Services

The Head of Legal Services is responsible for the provision of legal advice and services to the Trust, relating to healthcare and for handling clinical negligence and personal injury claims against the Trust. and advising the Chief Executive and all staff on any work related issues, which have legal implications.

6.2.21 Occupational Health Manager

The Occupational Health Manager will provide expert advice and support to the organisation in relation to the assessing whether staff are fit to work, ongoing health surveillance, staff support and follow up of staff accidents and injuries.

6.2.22 Infection Control

The Infection Control Nurses are responsible for training staff on all aspects of infection control and for monitoring and auditing areas of risk. They are also involved with practice development aspects of infection control and surveillance.

The Director of Infection Control and Prevention is responsible for advising the Chief Executive and Board on matters relating to infection control and prevention in line with national policy.

6.2.23 Moving and Handling Advisers

The Moving and Handling Advisers are responsible for training and education on moving and handling, and prevention of injuries and back care, in accordance with manual handling legislation and professional codes of practice.

6.2.24 Training Resource Centre (TRC)

The TRC is responsible for co-ordinating training for staff. This includes co-ordinating the corporate induction programme which includes risk management.

6.2.25 Directorate Risk Leads

Directorate Risk Leads direct and co-ordinate the risk management agenda in the directorate on behalf of the General Managers and Clinical Directors. They ensure that annual comprehensive risk reviews and risk assessments are undertaken, that action plans are formulated and reviewed at least annually, and together with the Clinical Director and General Manager, training and information is cascaded through the directorate management structure to all staff.

6.3 Identification and escalation of risk

Risks may be identified in a variety of ways, either proactively, such as formal risk assessments or reactively such as through incidents, complaints and claims. Orange and red risks (currently 12 and above when graded using the Trust risk matrix) are entered into the centrally managed risk register and then monitored by the risk managers.

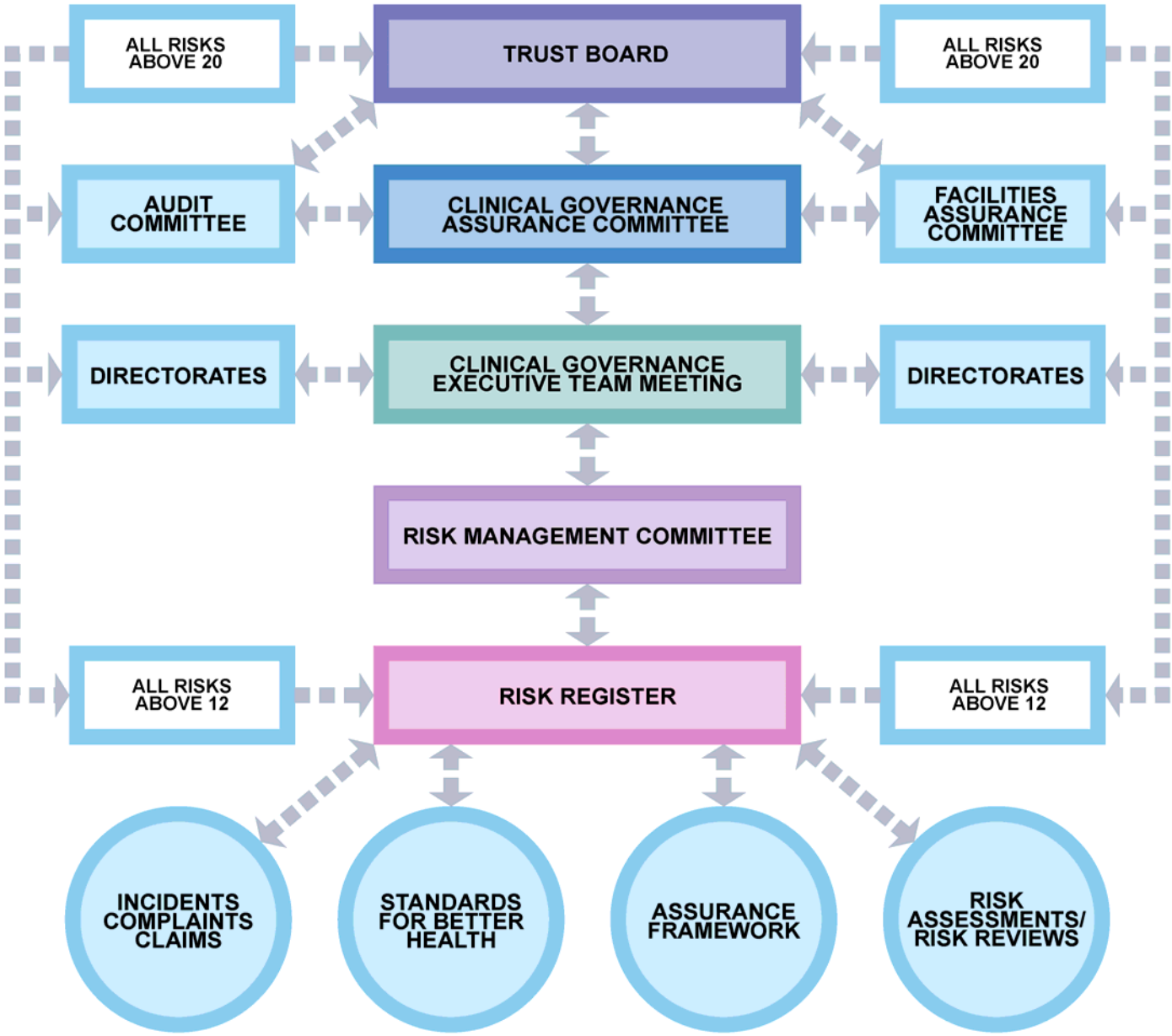
Risks may be managed locally and reported to the Operational Risk Management Committee for review. See appendix 3 for the Operational Risk Management Committee. Appendix 4 outlines the sub-committees which report to the Operational Risk Management Committee and other related committees.

Risks which have an organisation wide or resource implication will be escalated to the Trust Executive Management Meeting for Clinical Governance.

Progress on risk mitigation is monitored by the relevant sub committees of the Board as outlined in section 6.2. Risks that score 20 or above on the risk register or areas where progress with risk mitigation in relation to significant risks has been limited will be escalated to the Board quarterly. Risks scoring 20 or above will automatically be reported to the Board at their time of entry onto the risk register. The overall identification and escalation process for the management of risk is described in Appendix 1.

Appendix 1

MANAGEMENT OF RISK
AT CHELSEA AND WESTMINSTER HEALTHCARE NHS TRUST

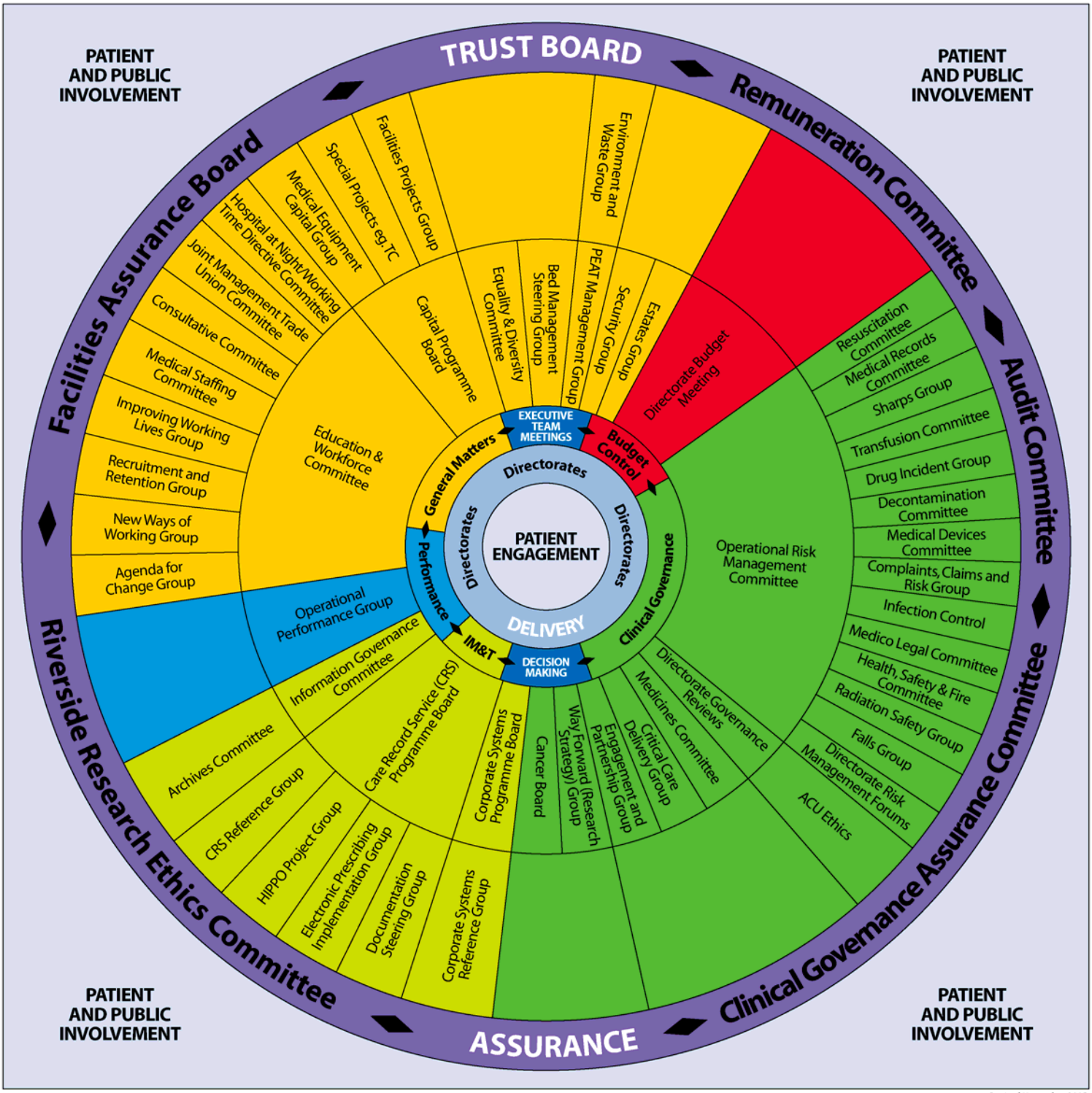


All serious and significant incidents are immediately escalated to the Chief Executive. These are reviewed and acted upon without delay.

Appendix 2

Chelsea & Westminster Governance Structure

How the Trust Board Receives Governance Assurance



Revised November 2005

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

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

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

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

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

INFORMATION FLOW

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

Appendix 3

Operational Risk Management Committee
Membership & Terms of Reference

Reports to: Executive Team Meeting for Clinical Governance

Meeting: Monthly – Appropriate papers to be distributed one week prior to meeting

Openness: Agenda, papers and minutes to be published on the intranet by the secretary of the committee.

Membership

- Director for Governance and Corporate Affairs (Chair)
- Head of Clinical Governance
- Risk Leads from each Service
- Risk Managers
- Head of Legal Services
- Patient Affairs Manager
- Health and Safety Officer
- Occupational Health Manager
- IT Representative
- Assistant Director of Finance

Terms of Reference:

a) To consider trends in incident reports and take decisions regarding appropriate steps required to reduce re-occurrence.

b) To oversee the planning and implementation of new controls introduced.

c) To receive reports following internal or external incident reviews ('orange' and 'red' incidents), monitor corrective action and ensure that learning is shared across the organisation by utilising directorate and department dissemination structures.

d) To review the 'orange' and 'red' incident log to provide assurance that reviews are occurring in a timely manner and that all recommendations are completed.

e) To review the Trust's risk register, monitor the management of high grade risks (12 and above) and escalate risks which have an organisation wide or resource implication to the Trust Executive Team Meeting for Governance.

f) To note all Safety Alert Broadcasts Service alerts (SABS) and monitor any action required until compliance is achieved action plans. The alerts may include medical device, NPSA alerts, safety alerts and estates related alerts.

g) To monitor the progress against the Clinical Negligence Schemes for Trusts (CNST) and Risk Pooling Schemes for Trust (RPST) action plans.

h) To receive progress reports from the following Risk Management subcommittees according to a predetermined schedule:

    - Drug incident Group
    - Decontamination committee

- Medical devices committee
- Complaints, claims and risk group
- Infection control committee
- Sharps committee
- Medico-legal committee
- Radiation safety group
- Falls group
- Environment & waste committee
- Directorate risk management committees
- Security group

Regular updates from the Health and Safety Committee. This committee reports directly into the Management Executive Committee but all risks will be monitored using the risk management systems and therefore will be monitored by the risk management committee.

Roles and Responsibilities

Members of the Risk Management Committee

As a member of the Risk Management Committee it must be remembered that you are an individual representing your directorate / department. Committee members are expected to:

- Actively participate in discussions pertaining to risk ensuring that solutions and action plans have multidisciplinary perspectives and have considered the impact across all of the directorates and departments.

- Disseminate the minutes from this meeting within your directorate and inform the directorate policy board and specialty meetings of issues discussed.

- Share the learning gained from directorate and corporate incident reviews within their directorate to ensure that organisational learning occurs.

- Communicate to the Risk Management Committee risk issues and solutions discussed in the directorate meetings to support organisational learning.

- Present to the Risk Management Committee directorate/departmental progress with reducing directorate/departmental risks.

- Discuss and liaise within the directorate or departments any local actions required as part of the CNST and RPST action plans.

Appendix 4

Committees Related to the Operational Risk Management Committee

Management Executive for Clinical Governance	-	Reviews progress with all aspects of the clinical governance agenda and makes decisions regarding strategies and work streams.
Audit Committee		Reviews the establishment and maintenance of an effective system of internal control and risk management.
Health and Safety Committee		Oversees Health and Safety in the Trust and monitors the implementation of the Health and Safety Executive Action plan.

Sub-Committees Responsible for Specific Risk Management Areas Delegated by the Operational Risk Management Committee

Maternity Risk Management Committee		Reviews risk management in maternity, including trends and the progress against the CNST action plan.
Sharps Group	-	Reviews sharp injuries and discuss strategies for reducing injuries.
Drug Incident Group	-	Reviews medicines incidents and discuss strategies for reducing drug errors. Monitors medicine related CNST requirements.
Decontamination Committee	-	Develops Trust wide decontamination standards and strategies for meeting HTM compliance.
Medical Devices Committee	-	Develops Trust wide standards for all medical devices purchased and strategies for reducing the risks associated with medical devices. Monitors the education programme for all staff using medical devices. Monitors medical device related CNST requirements.
Infection Control Committee	-	Reviews all aspects of infection control that are required for statutory purposes and protect all staff patients and third parties standards. Monitors compliance with infection with infection control policy.
Medico Legal Committee	-	Reviews Trust litigation with the clinical directorates. Reviews all emerging trends/themes from reported claims and serious incident.
Radiation Safety Group	-	Develops Trust wide radiation safety standards and strategies for meeting radiation safety compliance.
Falls Group	-	Reviews all falls that occur within the Trust and develops strategies for the reduction of falls.
Security Group	-	Reviews security incidents and risk assessments for verbal, physical assault and security issues.

Appendix 5

Audit Committee

Terms of Reference

This Board sub Committee assures the Trust Board that probity and professional judgement is exercised in all financial matters. It is authorised by the Trust Board to seek relevant professional advice and to secure attendance of relevant parties at its meetings.

It will:

- Review the establishment and maintenance of effective systems of internal control and risk management including fraud and corruption in conjunction with the Clinical Governance Assurance Committee and Facilities Assurance Committee
- Review the adequacy of IT controls and the ability of IT to support the hospital
- Assure the Board on completeness and compliance of required disclosure statements and policies
- Review the Trust's annual financial statements and assure the Board on compliance
- Assure the Board on judgements and adjustments relating to annual financial statements.
- Assure the Board on the appropriateness and effectiveness of the internal audit service, its fees, findings and co-ordination with external audit
- Assure the Board on the appropriateness, effectiveness and co-ordination of external auditors, their reviews and the Trust's management response and outcomes.

Key Relationships: Some shared membership and agenda items with Clinical Governance Assurance Committee and Facilities Assurance Committee.

Membership: Non Executive Chair and two Non Executive Directors. A quorum is 2 members.

In Attendance: Chief Executive, Director of Finance, Director of Information, Communication and Technology, Director of Governance and Corporate Affairs, Head of Internal Audit , External Audit Representatives and a Counter Fraud representative

Frequency of Meetings: Quarterly, aligned with Trust Board and Clinical Governance Assurance Committee and additionally if requested by auditors.

Forward Plan of Work: In liaison with the Clinical Governance Assurance Committee and the Facilities Assurance Committee.

Appendix 6

Clinical Governance Assurance Committee

Terms of Reference

This Trust Board sub Committee will assure the Trust Board that probity, quality assurance, quality improvement and patient and staff safety are central components of all Trust activity.

It will:

- Monitor the strategic direction of clinical governance activity in the Trust
- Assure the Trust Board that the Trust systems of internal controls are appropriate and maintained accurately taking into account best practice
- Hold the Clinical Governance Executive Committee to account to deliver accurate and informative up to date internal controls
- Assure the Trust Board that the clinical aspects of key organisational risks are being appropriately identified and managed.
- Assure the Trust Board that the Terms of Reference, functions, roles and responsibilities of the Trust Clinical Governance Committees are clearly defined and aligned.

Key Relationships: Some shared membership with Audit Committee and shared items.

Membership: Non Executive Chair, Non Executive Member, Chief Executive, All Executive Directors and the Head of Clinical Governance.

Frequency of Meetings: Quarterly to be aligned with Audit and Facilities Assurance Board

Forward Plan of Work: The forward plan of work is planned in conjunction with the Audit Committee and the Facility Assurance Committee.

Agreed by Trust Clinical Governance Assurance Committee November 2005

Appendix 7

Facilities Assurance Committee

Terms of Reference

This Trust Board sub Committee assures the Trust Board on the maintenance of a safe, clean hospital environment in which PEAT (Patient Environment Action Team) patient focused service standards are delivered and met through its contract management arrangements.

This sub committee monitors capital investment decisions and internal controls relating to facilities. It will:

- Set and agree the strategic direction of Facilities services at the Trust;
- Agree the Key Performance Indicators for contract monitoring and monitor feedback on the contract performance of ISS Mediclean and Haden Building Management;
- Agree the key risks involved in the delivery of a safe, secure patient and staff environment;
- Identify the capital investment required to assure a safe and secure environment and make recommendations to the Capital Review and Trust Boards;
- Receive feedback from the PEAT Inspection Team on the standard of facilities services and the patient environment, agree action plans for improvement;
- Communicate progress to the Trust Board on the delivery of an excellent Facilities Management service and make recommendations;
- Support a staff recognition scheme for outstanding performance of individuals and teams;
- Provide assurance to the Trust Board on relevant risks and controls.

Key Relationships: Some shared membership with audit and shared agenda items. Close working with Patient/User Group.

Membership: Non Executive Chair, Chief Executive, Director of Operations, Deputy Director of Finance and Information, Director of Nursing, Assistant Director of Nursing, Director of Infection Control, Director Human Resources, General Manager Facilities, *As required* - Patient Representative(s), General Manager ISS Mediclean, Director ISS Mediclean, Account Manager Haden Building Services, Director Haden Building Services

Frequency of Meetings: Quarterly with an annual meeting in public.

Forward Plan of Work: Is developed in line with the Trust's strategy and capital development

Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting, 19th May 2006

AGENDA ITEM NO.	2.2/May/2/06
PAPER	Performance Management Strategy
LEAD DIRECTOR	Lorraine Bewes, Director of Finance and Information Contact Number: 020 8846 6713
AUTHOR	Nicolas Cabon, Head of Performance and Information Contact Number: 020 8237 2426
SUMMARY	This Strategy has been drawn up as a requirement on the Foundation Trust authorisation process.
BOARD ACTION	Please forward any amendments to this document to Fleur Hansen prior to the meeting. The Trust Board is asked to approve this Performance Management Strategy.

Chelsea and Westminster Healthcare NHS Trust
Performance Management Strategy 2006/7 to 2010/11

Introduction

This document will set out the Trust's Performance Management Strategy from 2006/7 to 2010/11. The new challenges that are presented by the Payment by Results funding mechanism, the delivery of the 18 week target and the move towards Foundation Trust status will require a new approach to management of performance throughout the organisation. The development of the performance process will be supported by the new performance framework. The various roles and responsibilities will be outlined along with timescales for implementation.

Background Information

The Trust's Performance Report reflects the national performance indicators that have been monitored by the Healthcare Commission (CHAI).

An acute NHS trust is a multi-faceted organisation, and the performance indicators that are published by CHAI do reflect performance in a large number of areas. However, the performance indicators do not provide a comprehensive assessment of the business and efficiency metrics that the Trust needs to deliver in order to successfully operate in a commercial Foundation Trust environment.

In 2005/6 CHAI changed the performance ratings methodology. The star ratings were replaced by the Annual Health Check. Many of the old star ratings indicators are replicated in the new system, but there is also a more sophisticated assessment of financial management and the views of the local PCTs are also taken into account.

The introduction of Payment by Results has introduced new challenges. The organisation will have to have a grasp of its productivity and its procedure costs verses the national tariff and be able to link the activity and financial performance of each service if it is to be successful as a Foundation Trust.

Performance in the NHS

Performance in the NHS has traditionally focused on the measures imposed from above. The government has defined the priorities for hospitals and these have been reflected in the star ratings. Trusts have put a great deal of effort in achieving the key targets in the performance ratings, and slightly less resource would have been channelled towards the balanced scorecard indicators.

The new Annual Health Check is being introduced over the course of two or three years. One of the criticisms of the old star ratings system was that it was not always appropriate for all trusts – one size did not always fit. Within the new methodology there will be a slightly more local focus to the indicators. PCTs and trusts will be able to select

additional indicators that reflect particular challenges that are relevant to their local area and both organizations will be assessed against these indicators.

As the hospital becomes a Foundation Trust this approach will change. The new organisation will have to develop a broader view of performance. The hospital will be operating in a commercial environment and the Foundation Trust Board will need analysis of demand for the services and its competitive position, throughput and other efficiencies, information relating to the Trust's workforce, and also income generation and progress towards meeting the patient choice objectives. These are in addition to continuing to monitor the indicators defined by the centre. In order to produce such a broad view of performance the Trust will need to develop a board report that provides succinct and dynamic indicators. Initially, the Trust will develop a model similar to the "Intelligent Board" proposed by Dr Foster.

The Trust's Aim for Performance

The Trust's aim is to deliver the best possible care by making efficient use of all resources and meeting the specific demands of the patients. Various indicators will be developed to inform progress towards this aim. However, it is also necessary for the Trust to adopt a new approach. The Trust needs to develop a framework for the Directorates to take ownership of performance issues rather than the Trust having a top-down approach.

The Trust will continue to monitor performance against the national targets, and in due course will also report progress against the local targets agreed with the PCTs. However, the Directorates will also set their own targets relating to efficiency indicators in line with the Service Development Strategy, and these will be aggregated to derive the Trust's targets.

The plans for the development of a new performance framework have been discussed in the executive meetings in 2005. This framework will provide the support necessary for the directorates to achieve the various targets. The framework will be developed in 2006/7.

The Trust Board will receive reports highlighting adverse performance and trend analysis in the following areas:

1. Finance and Activity plans.
2. Access and Targets
3. Efficiency and use of resources.
4. Workforce.
5. Clinical quality.
6. Strategy and progress towards strategic objectives (such as the 18 week wait).
7. Patient experience

In summary, the arrangements for reporting performance to the Board will give assurance of the following:

a) Performance measures have been defined and are being monitored
b) Reasonable targets have been identified for these measures
c) A robust system is in place for managing performance against the targets

d) Lines of reporting are in place
e) Arrangements are in place to manage and respond to adverse performance

The Trust has an intranet reporting tool called HiPPO, and this will be developed to include all of the performance reports. The content of the Performance report will be regularly reviewed. As new indicators are developed and tested, or new priorities are identified, the performance suite will be updated accordingly.

For the foreseeable future it is envisaged that the performance indicators will reflect the national priorities outlined in:

1. The NHS Improvement Plan
2. National Standards, Local Action - Standards and Planning Framework
3. Standards for Better Health

They will also support:

4. Developing service requirements and modernisation
5. The new Payment by Results funding mechanism
6. NHS Foundation Trust status

Trust Performance Process

As mentioned earlier, performance has traditionally been driven down the organisation from the top with respect to 'must do' national targets. In order to be successful in achieving our performance goals the directorates need to take more ownership in this area.

In the past the Head of Performance and Information would have presented the reports complete with comments explaining adverse performance and projections to the year end at the executive Performance meeting. The data for the reports would have been supplied by the relevant manager for the area or from appropriate internal and external activity reports.

The directorates will have a greater role to play in the process. They will be sent the data and projected year-end positions by the Performance team, and will feedback comments relating to adverse performance along with plans that have been developed to mitigate against future breaches.

The Head of Performance and Information will draw together all of the comments from the directorates to produce a summary of the key messages for discussion at the Performance Board and Trust Board. These messages will be included in the Trust Board Performance report along with the headline performance indicators.

Conclusion

Performance is an important aspect of modern healthcare management. It has a key strategic and operational role to play. Trust's have traditionally aimed to achieve the key targets and balanced scorecard indicators, and thus have been criticised for "hitting the target but missing the point".

This Trust must continue to assess performance against the national priorities in order to give the public confidence in our ability to deliver healthcare and also to help attract good quality staff. However, the Trust must also develop a new suite of measures that will give assurance that the hospital is making the most efficient and effective use of resources.

Nicholas Cabon
Head of Performance and Information

Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting, 19th May 2006

AGENDA ITEM NO.	2.3/May/2/06
PAPER	Risk and Performance Management Certification
LEAD DIRECTOR	Catherine Mooney, Director of Governance and Corporate Affairs Contact Number: 020 8237 2881
AUTHOR	Fleur Hansen, Foundation Trust Project Lead Contact Number: 020 8846 6716
SUMMARY	This paper is the proforma for self-certification by the Board for Risk and Performance Management as required by Monitor. The Board will not sign the Board Statement until July but as are required to submit the direct evidence of Risk and Performance Management on May 22nd, it is important for the Board to agree that the Trust meets the lists six requirements listed.
BOARD ACTION	The Board is asked to identify at this stage if any further evidence is required by the Board in order to sign off the six Risk and Performance Management requirements.

The Trust is required to submit on Monday 22nd May direct evidence of Risk and Performance Management processes. The direct evidence includes (but is not limited to):

- Risk Management Strategy and Policy
- Performance Management Strategy
- Statement of Internal Control for 2005/06
- Major Incident Policy
- Serious Untoward Incident Reporting Policy
- Policy And Procedure for Responding to, Reporting and Investigating Incidents
- Influenza Pandemic Contingency Plan
- Controls Assurance Standards for Risk Management, Governance and Financial Management 2004
- Auditors Local Evaluation (ALE) 2005/06
- Self Assessment for the Healthcare Standards
- CNST General and Maternity Assessment Reports
- RPST Assessment Report 2004
- A Trust Board Performance Report
- Healthcare Commission CHAI Performance Assessment
- Performance Management Reporting Procedure
- Board statement of no material change (attached)

Risk and Performance Management

The Board of Directors is required to confirm that:

- Issue and concerns raised by external audit and external assessment groups (including the RPST and CNST reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the Board is confident that there are appropriate action plans are in place to address the issues in a timely manner;
- All recommendations to the Board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned;
- The necessary planning, performance management and risk management processes are in place to deliver the Business Plan;
- A Statement of Internal Control ("SIC") is in place and the NHS foundation trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to most up to date guidance from HM Treasury;
- The Board is satisfied that plans are in place to ensure that all core national healthcare targets and standards are met going forward;
- All key risks to compliance with the Authorisation have been identified and addressed.

Chelsea and Westminster Healthcare NHS
NHS Trust

Risk and Performance Management Self-Certification

The Board of Directors of the Chelsea and Westminster Healthcare NHS Trust do hereby declare that:

There has been no material change in the Trust's Risk Management policies and processes since the assessments listed below were made.

- Risk Management Strategy and Policy
- Performance Management Strategy
- Statement of Internal Control for 2005/06
- Major Incident Policy
- Serious Untoward Incident Reporting Policy
- Policy And Procedure for Responding to, Reporting and Investigating Incidents
- Influenza Pandemic Contingency Plan
- Controls Assurance Standards for Risk Management, Governance and Financial Management 2004
- Auditors Local Evaluation (ALE) 2005/06
- Self Assessment for the Healthcare Standards
- CNST General and Maternity Assessment Reports
- RPST Assessment Report 2004
- A Trust Board Performance Report
- Healthcare Commission CHAI Performance Assessment
- Performance Management Reporting Procedure

The Board of Directors also hereby confirms that:

- Issue and concerns raised by external audit and external assessment groups (including the RPST and CNST reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the Board is confident that there are appropriate action plans are in place to address the issues in a timely manner;
- All recommendations to the Board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned;
- The necessary planning, performance management and risk management processes are in place to deliver the Business Plan;
- A Statement of Internal Control ("SIC") is in place and the NHS foundation trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to most up to date guidance from HM Treasury;
- The Board is satisfied that plans are in place to ensure that all core national healthcare targets and standards are met going forward;
- All key risks to compliance with the Authorisation have been identified and addressed.

Signed for and on behalf of the Board:

Title:
Date:
Trust

Chelsea and Westminster Healthcare NHS
NHS Trust

Trust Board Meeting, 19th May 2006

AGENDA ITEM NO.	2.4/May/2/06
PAPER	Submission Update Timetable
LEAD DIRECTOR	Heather Lawrence, Chief Executive Contact Number: 020 8846 6711
AUTHOR	Fleur Hansen, Foundation Trust Project Lead Contact Number: 020 8846 6716
SUMMARY	This paper outlines the timetable for Monitor submissions for May to July 2006.
BOARD ACTION	The Board is asked to note this report.

Chelsea and Westminster Healthcare NHS
NHS Trust

Monitor Submissions

S = Official Monitor Submission
A = Additional Information Requested by Monitor
V = Voluntary Submission

May 15th	Constitution	S
	Governance Arrangements and Rationale	S
	Membership Development and Communication Strategy	S
May 22nd	Service Development Strategy + Appendices	S
	Financial Model	S
	Workforce Strategy	V
	Board and Organisation Development	V
	Direct evidence of Risk and Performance Management: • Risk Management Strategy and Policy • Performance Management Strategy • Statement of Internal Control for 2004/05 • Major Incident Policy • Serious Untoward Incident Reporting Policy • Policy And Procedure for Responding to, Reporting and Investigating Incidents • Influenza Pandemic Contingency Plan • Controls Assurance Standards for Risk Management, Governance and Financial Management 2004 • Auditors Local Evaluation (ALE) 2005/06 • Self Assessment for the Healthcare Standards • CNST General and Maternity Assessment Reports • RPST Assessment Report 2004 • A Trust Board Performance Report • Healthcare Commission CHAI Performance Assessment • Performance Management Reporting Procedure • Board statement of no material change	A
May 26th	Amendments to minutes of Monitor meetings	A
	Additional Board submissions • Terms of reference for all Board Committees and Standing Orders • Board minutes (excluding the supporting papers) for the last 2 years • Audit Committee minutes (excluding the supporting papers) for the last year • A list of all the reports that have been completed by the Internal Auditors and External Auditors in the past two years plus Data Quality report • Do you provide shared services? If so, please could you provide a schedule of income received and any work done on the profitability of these areas • Members of each Board Committee (which NEDs and EDs sit on each committee)	A

July 1st	Schedule 2 – Schedule of Services Schedule 3 – Schedule of Services Self-certification on Governance Arrangements	S S S
July 14th	Signed Board Statement Board Memorandum	S S
July 21st	Statement of outcome of election	S