Chelsea and Westminster Hospital NHS
NHS Foundation Trust

19 July 2013

Dear Colleagues,

Board of Directors Meeting (PUBLIC)
Thursday, 25 July 2013

Dear Colleagues,

Please find enclosed the Agenda and Papers for the next week's meeting which will be held at 4pm in the Hospital Boardroom.

Please note that light refreshments will be provided from 3.30pm in the Atrium area.

Yours sincerely,

Vida Djelic
Foundation Trust Secretary

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting (PUBLIC)

Location: Hospital Boardroom, Lower Ground Floor, Lift Bank C
Chair: Professor Sir Christopher Edwards
Date: Thursday, 25 July 2013 Time: 4.00pm

Agenda

Ref	Item	Lead	Time
1	**GENERAL BUSINESS**		**4.00pm**
1.1	Welcome and Apologies for Absence	CE	
1.2	Chairman's Introduction	CE	
1.3	Declaration of Interests	CE	
1.4	Draft Minutes of the Meeting of the Board of Directors held on 28 May 2013	CE	
1.5	Matters arising	CE	
1.6	Chairman's Report (oral)	CE	
1.7	Chief Executive's Report	APB	
1.8	Council of Governors Report including Membership Report	CE	
2	**PERFORMANCE**		
2.1	Finance Report Commentary – June 2013	LB	
2.2	Performance Report Commentary – June 2013	DR	
2.2.1	Access		
3	**ITEMS FOR DECISION/APPROVAL**		
	QUALITY		
3.1	Patient Experience – Patient Story (video)	TP	
3.2	Francis Report update	TP	
3.3	Assurance Committee Annual Report 2012/13	KN	
3.4	Assurance Committee Report – May & June 2013	KN	
3.5	Risk Management Strategy and Policy 2013/14*	CM	
3.6	Risk Management Annual Report 2012/13	CM	
3.7	Complaints Annual Report 2012/13	TP	
3.8	Complaints Policy and Procedure	TP	
3.9	Review of Strategic Objectives, Board Assurance Framework Report and Risk Report Q1	FH/CM	
3.10	Quality Awards*	CM	
	STRATEGY		
3.11	Strategy Update (oral)	APB	
3.12	Sustainable Development and Carbon Reduction	DR	
	WORKFORCE		
3.13	Workforce including E&D Annual Report	MG	
	GOVERNANCE		
3.14	Update on Emergency Department redevelopment	DR	
3.15	Monitor In-Year Reporting & Monitoring Report Q1	LB	
3.16	Register of Seals Report Q1*	CM	
3.17	Assurance Committee Terms of Reference*	CM	

3.18	Finance and Investment Committee Terms of Reference*	CE
3.19	Annual Members' Meeting proposal	APB
4	**ITEMS FOR INFORMATION**	
4.1	Audit Committee Minutes – 23 May 2013	JB
5	**ANY OTHER BUSINESS**	
6	**QUESTIONS FROM THE PUBLIC**	
7	**DATE OF NEXT MEETING – 31 October 2013**	
	CLOSE	**5.30pm**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	1.4/Jul/13
PAPER	Draft Minutes of the Meeting of the Board of Directors held on 28 May 2013
AUTHOR	Catherine Mooney, Director of Governance and Corporate Affairs
LEAD	Prof. Sir Christopher Edwards, Chairman
PURPOSE	To provide a record of the decisions and actions discussed at a meeting.
LINK TO OBJECTIVES	Links to strategic direction/patient experience.
RISK ISSUES	None in addition to those included in report.
FINANCIAL ISSUES	None in addition to those identified in relevant papers.
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This paper outlines a record of proceedings of the meeting of the Board of Directors on 28 May 2013.
DECISION/ ACTION	1. The meeting is asked to agree the minutes as a correct record of proceedings 2. The Chairman is asked to sign the agreed minutes

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting 28 May 2013 PUBLIC
Draft Minutes

Time: 4.00pm
Location: Chelsea and Westminster Hospital NHS Foundation Trust – Restaurant

Present

Non-Executive Directors	Prof. Sir Christopher Edwards	CE	Chairman
	Sir John Baker	JB	
	Jeremy Loyd	JL	
	Prof Richard Kitney	RK	
	Karin Norman	KN	
	Sir Geoffrey Mulcahy	GM	
Executive Directors			
	Tony Bell	TB	Chief Executive
	Lorraine Bewes	LB	Director of Finance
	Therese Davis	TD	Chief Nurse and Director of Patient Experience and Flow
	Zoe Penn	ZP	Medical Director
In attendance	Catherine Mooney	CM	Director of Governance and Corporate Affairs
	Jennifer Allan	JA	Performance Lead put in exact title

1.1 Welcome and Apologies for Absence **CE**

Apologies were received from Mark Gammage and David Radbourne.

1.2 Chairman's Introduction **CE**

Members of the public were welcomed to the meeting

1.3 Declaration of Interests **CE**

There were no declarations of interest.

1.4 Draft Minutes of the Meeting of the Board of Directors held on 25 April 2013 **CE**

Minutes of the previous meeting were approved as a true and accurate record with the following amendments:

- p.1 remove Mark Gammage from the attendance list
- p. 1 add 'TP' to the list in attendance as he attended for Therese Davis
- p.2, section 1.5 reword the 4th para to be clearer
- p.3, section 2.1, 4th para, 3rd line, change '£69m' to '£16.9m'
- p.4, 3rd para, 5th line change 'introduce' to 'introduced'
- p.6, section 6, 5th para it was agreed that the final paragraph would be reworded to say 'It was confirmed that if we were to acquire West Middlesex Hospital we would require the debt to be written off'.

1.5 Matters arising **CE**

2.2/Apr/13 Performance report
Email system
It was agreed that the status of an email system for people who cannot get through on the phone will be checked.
It was noted that an update had been circulated.

Investment of capital
It was agreed in May that we would look at the potential of investing capital in reducing waiting time would be considered. It was reported that we have made a number of investments and further detail on historic, current and future planned waiting time reductions will be provided at the next meeting.

3.1/Apr/13 Assurance Committee Report – March 2013
Mandatory training update
It was agreed that a progress report would be provided at the next meeting and this is as follows:

A strategy and action plan have been presented to the Trust Executive. The under recording of training attendance, reported to the last Assurance Committee, has been corrected and the Mandatory Training Committee has removed items from the list of required training which were considered to be beyond that required to ensure patient safety. A letter has been sent to all directors clarifying the areas of training for which their staff are responsible and this also sets out the training requirements for all topics under their control to confirm that they believe them to be appropriate.

The Executive team have requested fortnightly reports on mandatory training. A policy and procedure to link mandatory training compliance with the award of annual increments is being developed in partnership with staff side representatives. It is planned to run the system in shadow form in Autumn 2013 ready to implement in 2014 in line with the new terms and conditions of service agreed in Agenda for Change.

The Board commented that staff are not able to easily find out what mandatory training they need to do and an update on progress with this was requested. The change linked to increments cannot be done until this is in place. While we continue to emphasise that this training is mandatory this must be supported by and access to training and individual training records. **MG**

It was agreed that the appraisal form could be more explicit about mandatory training.

3.9/Apr/13 Monitor Provider Licensing Requirements
Research paper on integrated healthcare
It was noted that the report has been circulated.

1.6 Chairman's Report **CE**

The Chairman noted that he had nothing specific to report that was not covered elsewhere.

1.7 Chief Executive's Report **APB**

A number of points were highlighted. Work continues on due diligence relating to

the acquisition of West Middlesex Hospital.

Regarding 'Shaping a Healthier Future' the decision is with the Secretary of State but improvements in A&E are continuing to progress. The Secretary of State spent some time with the Trust recently.

Thanks were conveyed to the Friends, governors and the Chelsea and Westminster Healthcare Charity for support on the Open Day.

The success of the Trust in receiving awards was noted.

1.8 Council of Governors Report including the Membership Report **CE**

It was noted that it is difficult to measure but overall, the numbers at start of this year against last year are good. There is an active process in place for recruitment. The detailed analysis of age and ethnicity is for noting.

2.1 Finance Report – April 2013 **LB**

A red risk on the financial position was noted as there is a variance of more than £5m to the plan. The plan is £1.6m behind in month 1 which is due to lack of delivery of the full cost improvement programme (CIP), income and HIV drug prescribing.

Regarding the income variance there has been a slow start to the elective programme. There are two issues, both in maternity; underperforming, both NHS and private, and a pricing issue related to the method of payment. This changed last year and is now done on a pathway basis which depends on where the mother is on that pathway. This month the information was not available but can be done retrospectively.

The CIP position will be the most challenging in that the Trust is behind compared with last year. A number of initiatives to address the financial position were described. These included a programme management office (PMO) approach which is being introduced due to the lack of capacity for operational tasks which need reengineering. The PMO will help to track the delivery of the CIP programme so that timely action can be taken to mitigate any risks to delivery. There will also be further work on procurement and inventory control.

Coders will go to theatres to improve income capture in orthopaedics, as consultant input improves the quality of coding. The Medical Director and Finance Director will be working together to transfer some responsibility for coding to the Medical Director.

In response to a question regarding income generation, it was confirmed that this currently all relates to NHS work but income from non-NHS services will be addressed.

It was noted that plans need to address the next two years as savings are getting harder to achieve.

The CIP table in appendix B was clarified; it tracks the first four weeks and assesses the risks of achieving the CIP. The focus is on non NHS and back office savings. Divisions and clinical departments have been given a CIP of 7% - 8% but non-clinical back office function have CIP targets of15%. It has been recognised that efficiency and productivity are reviewed that clinical quality is not

being undertaken. A risk assessment process against each CIP has been implemented which will flag up any risk, which is then RAG rated. Any 'orange' (serious) risk will be reported to the Chief Nurse and the Medical Director who will review to ensure quality is not compromised. It was also agreed that reporting back and closing off stages of a CIP should also be reported and that quality indicators should be checked on an on-going basis.

2.2 Performance Report – April 2013 **JA**

It was noted that an amber rating will be introduced as opposed to just red and green which will not necessarily do justice to some of the performance and does not accurately identify areas to focus on.

It was noted that there had been a great deal of communication in the press re A&E. The Trust has seen a year on year increase in activity. The co-location with the Urgent Care Centre enables patients to seen by the right person at the right place. Some of the failure to process patients is related to the environment i.e. limited space. The funding position was clarified i.e. that for admissions from A&E over the 2008/09 figures, only 30% of the tariff is paid. If patients attend A&E and are not admitted there are three tariffs depending on the condition. The Trust is undertaking an audit to look at why patients are coming to A&E. GPs do not necessarily accept that the increase in attendance is due to primary care failure.

It was noted that it would be a mistake to measure us against other A&Es and we should not get too complacent about being at the top of the NHS rankings. The issue of waiting was discussed and that the approach needs to be about a decrease in waiting time but also a decrease in the stress of waiting. An account of excellent care was described at the Council of Governors meeting recently and this should be the case for all patients. Some of the measures are imposed, for example over 98% patients are seen within 4hrs. What is not clear is what % are seen within 1h and if there is any pattern. The same issue has been highlighted with the appointment time to be seen by a consultant after admission. It was noted that not all waiting is within our control, specifically for mental health patients. It is important to remember that this is about the provision of service not healthcare. The problem is the randomness of patient experience and it was noted that the Trust is doing some work with the Disney. **It was agreed that there would be a trend analysis in the next report.** **DR**

It was clarified that the MRSA in April was a contaminant. The Monitor target is 6. The learning from the root cause analysis was about ensuring regular swabs and the correct process for taking blood cultures. A great deal of work was undertaken to enforce the process but as new doctors come in to the system this not being embedded. Blood culture packs include signatures but in this case it seems to have been ignored. Training is critical. Junior doctors undertake an induction when they start and before they go to wards. However, middle grade doctors may be working for a number of weeks before they undertake training. As of last year it is mandatory that junior doctors have a period of shadowing.

The new target of 95% of VTE risk assessments was achieved in the first month.

It was queried why the longest waits were in paediatrics and it was noted that waiting time in paediatrics has been challenging. There is a mixture of factors, for example paediatric neurology is a new business and a small service with one consultant who has been on maternity leave.

The Choose and Book issue outlined on p.9 was discussed. The problem is an administration issue and performance is expected to improve in May and June. These figures are weekly so problems are picked up quickly. In response to a question about what was considered an unacceptable waiting time it was confirmed that this is two weeks for neurology and six weeks for other services. The use of Choose and Book does vary by referring PCT, for example K&C GPs use it for 60% of bookings and Hammersmith and Fulham GPs use it for 15-20%. There is some resistance by GPs because it is not easy to use. There used to be incentives for use but this has now stopped and the usage has decreased. GPs find the system very slow. The Trust is moving to a web based system which will be a significant improvement.

Waiting is a factor and in particular for medicines. It was asked whether patients could not go to a pharmacy such as Boots to get their medicines following a prescription and it was confirmed that this is being looked into. The importance of communication was highlighted and that it can be sometimes seen as a good thing, for example if patients are told they are waiting in order to see a specialist i.e. they are waiting for a better service. It was agreed that the rate of patients not attending appointments needs to be addressed.

The performance on the turnaround time for letters was commended.

3.1 Assurance Committee Report – April 2013 **KN**

A number of items were highlighted. The Trust has seen a good performance overall from external contractors. However, the Assurance Committee would like to see more of a focus on environmental sustainability and waste management which has not come to Board for some time.

The issue of Never Events was noted. There is a programme of work ensuring that controls in place and then auditing these. All the Never Events incidents have been investigated and assurance sought that preventative mechanisms are in place. It was highlighted that one of the concerns which is regarding identifying the deteriorating patient is a national priority and the new national scoring system is being implemented. There is also a maternity and paediatric early warning system

Regarding 3.7, progress is good on infection control but there is an issue about emerging drug resistance. Drug resistance from overseas patients is a particular problem because there is more drug resistance in the environment from which the patients come. It is important that we start to get an idea of the significance of this and relook at our single room strategy. Most new hospitals that are being built have 50-70% single rooms and this needs to be included in our strategy.

3.2 Update on strategy **APB**

There were no issues to report which were not covered elsewhere.

3.3 Monitor Annual Plan Sign-Off – completion of governance statement **CM**

The changes to this were outlined and in particular number 18 where concerns were expressed with the uptake in governors training. It is important that the responsibilities of the Board and governors are clear.

It was highlighted that question 19 had a choice of three answers and in view of the local authority position on funding for sexual health complete assurance

could not be given.

3.4 Monitor Annual Plan Sign-Off **APB**

It was confirmed that there had been regard to the views of the Council of Governors and that a paper on the Trust had been presented at the recent Council of Governors meeting. It was highlighted that deprivation is higher than average in Kensington and Chelsea, Hammersmith and Fulham and Westminster and this is important to recognise as the perception might be that the Trust is in a relatively affluent area.

It was noted that the Monitor Plan is in two versions, the public and private.

It was noted that the Trust will find the delivery of cost improvement plans increasingly difficult. It was noted that there is no sense of the real challenge ahead and it was agreed this will be reflected in the commentary.

It was noted that under threats on p.6 it would be changed to say lack of *written* Board succession plans.

4 ITEMS FOR INFORMATION

4.1 Audit Committee Minutes – 20 March 2013 **JB**

This was noted.

5 ANY OTHER BUSINESS

None.

6 QUESTIONS FROM THE PUBLIC

It was confirmed that CHKS is a name of the company.

It was confirmed that the decision not to proceed with the 'Shaping a Healthier Future' proposals would not affect our plans for A&E. Assurance is being sought from the commissioners that they will underwrite the cost in the absence of a decision from the Secretary of State for Health.

It was clarified that losses of payments of £44,833 were not in one month. It was reported in that month but it could relate to several months.

The point re waiting time in the outpatient department was noted and that the average waiting time is displayed when patients are waiting for blood samples to be taken.

The question re nurse productivity was part of nationwide benchmarking was raised.

The question was raised about the membership figures and losing 81 members in January did not seem to be appropriate. However, the turnover of the population in K&C was noted to be 20%.

It was confirmed that Chief Nurses in London are engaged in benchmarking and have selected their own hospitals to benchmark against.

A governor present said that in his opinion training provided by the Trust was not adequate based on the quality of the presentations and the people involved. He felt that some areas of the Trust such as procurement services and contracts were a ‘closed book’ and this type of information was not being made available so that governors own experience could be utilised. The governor was asked to put in writing where improvements could be made. However, it was highlighted that this is not an area where one would expect governors to get involved.

7 DATE OF NEXT MEETING – 25 July 2013

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	1.5/Jul/13
PAPER	Matters Arising – 28 May 2013
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Prof. Sir Christopher Edwards, Chairman
PURPOSE	To provide record of actions raised in a meeting and subsequent outcomes.
LINK TO OBJECTIVES	NA
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This paper outlines matters arising from meetings of the Board of Directors held on 28 May 2013 with subsequent actions or outcomes.
DECISION/ ACTION	The Board is asked to note the actions or outcomes reported by the respective leads.

Board of Directors Meeting, 28 May 2013

Ref	Description	Lead	Subsequent Actions/Outcomes
1.5/May/13	**Matters arising**		
	3.1/Apr/13 Assurance Committee Report – March 2013 Mandatory training update **The Board commented that staff are not able to easily find out what mandatory training they need to do and an update on progress with this was requested**.	**MG**	
2.2/May/13	**Performance Report – April 2013**		
	It was noted that not all waiting is within our control, specifically for mental health patients. It is important to remember that this is about the provision of service not healthcare. The problem is the randomness of patient experience and it was noted that the Trust is doing some work with the Disney. **It was agreed that there would be a trend analysis in the next report.**	**DR**	

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	1.7/Jul/13
PAPER	Chief Executive's Report
AUTHOR	Tony Bell, Chief Executive
LEAD	Tony Bell, Chief Executive
PURPOSE	This paper is intended to provide an update to the Board on key issues.
LINK TO OBJECTIVES	Strategy and finance is the main corporate objective to which the paper relates.
RISK ISSUES	No
FINANCIAL ISSUES	No
OTHER ISSUES	No
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This report updates the Board on a number of key developments and news items that have occurred over the last month.
DECISION/ ACTION	For information

CHIEF EXECUTIVE'S REPORT
JULY 2013

1.0 Strategy Development Update

1.1 The executive team are exploring ways to develop our strategy in order to provide more integrated care to patients in the future. One such model we are looking into is that of an accountable care organisation (ACO) which incorporates both primary (namely GPs) and secondary car partners who are jointly accountable for achieving clear quality improvements and coordinated care for patients.

1.2 Integrated our services is one of our key objectives and Sir Geoff Mulcahy has kindly agreed to be the non-executive lead in developing a vision for an ACO. We are in the early stages of building a project team to take this forward and already have strong engagement from a number of local GPs and community providers, some of whom joined us on a recent fact finding visit to Valencia where we looking at their very successful ACO.

2.0 Shaping a Healthier Future

2.1 As the Board is aware the Shaping a Healthier Future (SaHF) plans were referred to the Secretary of State for Health who has asked the Independent Reconfiguration Panel (IRP) to advise him on the response he should make. As part of this process the IRP visited the Trust's A&E and maternity departments on Friday 5th July following my attendance at an evidence giving session the previous day.

2.2 The IRP's next step will be meeting with the public and stakeholders before feeding back to the Secretary of State in September. Although there is no formal feedback from the visit at this stage, I believe the IRP were impressed with the calibre and commitment of those they met and were clearly interested in learning more about our models of care in the departments they visited.

3.0 West Middlesex Update

3.1 The Trust continues to undertake detailed due diligence into a potential partnership with West Middlesex University Hospital NHS Trust. The focus for the work programme over the summer will be to determine how the potential partnership could deliver benefits to patients and improvements in service delivery. Clinical teams have also started exploring potential synergies and this work will continue over the summer.

3.2 Once the due diligence is complete we will bring the outline business case to the Board of Directors at the end of October to determine whether to proceed to the full business case stage.

4.0 The Keogh Report

4.1 The publication of Prof Sir Bruce Keogh's review into the quality of care and treatment provided by hospital trusts with persistently high mortality rates contains learning that will apply to all trusts including Chelsea and Westminster. One such issue recently highlighted at the Assurance Committee concerns nurse staffing levels relevant to Patient Safety and Experience. Whilst I am confident that we have put measures in place to ensure that staffing levels are monitored and acted upon in a proactive manner it is important to recognise that such systems and processes are constantly reviewed and I have asked Tony Pritchard to lead this piece of work.

4.2 I have also asked the executive team to review the report in detail and identify other areas which are highlighted that the Trust should pay particular attention to and the implications for our current practices. I will then escalate details of any significant issues to the Board.

5.0 Liverpool Care Pathway

5.1 An independent review of the Liverpool Care Pathway (LCP) led by Baroness Julia Neuberger concluded that the LCP should be phased out in the next six to twelve months. The review panel reached this conclusion as a result of concerns around inappropriate use of the LCP and inadequate communication around it. They call for individualised end of life care plans to be developed to replace the LCP.

5.2 In view of the likelihood that this announcement will further reduce confidence in the LCP and following discussion with Dr Sarah Cox our palliative lead, we have decided to withdraw it from use within the Trust with immediate effect. It is vital that dying patients and their relatives continue to receive excellent care from all staff and the Trust's palliative care team will continue to support all staff in ensuring the wishes of patients are respected and individual end of life care plans are in place.

7.0 Appointments

7.1 I am delighted to announce two senior appointments both of whom will take up their posts with the Trust on 9th September.

7.2 Libby McManus has been appointed as Executive Director for Nursing and Quality. Libby is currently Chief Nurse and Director of Infection Prevention and Control at York Teaching Hospital NHS Foundation Trust and prior to that was with the NHS Modernisation Agency. For the last year Libby has provided expert advice to the Department of Health on its national improvement programme to reduce MRSA infections across England.

7.3 Susan Young has been appointed as Director of Human Resources and Organisational Development. Susan is currently performing this role at the Countess of Chester Hospital NHS Foundation Trust where she has been since 2010. Prior to this Susan held a variety of roles in the public sector including HR Director at the Department for Business, Innovation and Skills.

8.0 Patient Experience Summit

8.1 135 staff from across the hospital along with Governors and other stakeholders attended our Patient Experience Summit on 12 June 2013. The purpose of the summit was to showcase our current initiatives around improving patient experience and discuss our future plans.

8.2 The intention is to bring these together with the feedback from the Francis Report listening events run throughout June into themes and actions.

9.0 Consultant Outcome Data

9.1 To support transparency, clinical outcome data is now available to the public at individual consultant level. All information is available from the NHS Choices website with links via the Trust website with data for a limited number of surgical specialties having been uploaded. From the data published so far the indication is that all our consultants are performing to the clinical standards and outcomes expected of them with measurable data sets still to be determined for

the majority of medical specialties. This data is compiled by the relevant colleges but Zoe Penn is leading a piece of work with our performance team and IT to look at what data we already have available and to determine what will be most relevant for patients going forward.

10.0 Chairman and CEO Diary

External meetings attended by the Chairman and CEO Tony 29th May 2013 – 18th July 2013	
CEO	West Middlesex Hospital with Jacqueline Docherty
CEO	Visit to Hospital del Vinalopó - Accountable Care Organisation in Valencia
CHAIRMAN & CEO	Chair and CEO from Royal Brompton and Harefield NHS Foundation Trust
CHAIRMAN & CEO	Palace of Westminster All Party Ladies Committee Fundraising Evening
CEO	Natalie Lansdown from the Mayo Clinic
CEO	BUPA Cromwell Hospital Annual Quality Lecture - Facing the World
CEO	Children's Hospital Trust Fund Pluto Appeal Fundraising Event
CEO	Imperial College Health Partners Board
CHAIRMAN	Professor Sir Anthony J Newman Taylor from Imperial College
CHAIRMAN	Foundation Trust Network Event
CEO	Greg Hands MP with Parliamentarians from Commonwealth Countries
CEO	Arts for Life Fundraising Event
CHAIRMAN & CEO	Dinner with Chair and CEO from Royal Brompton and Harefield NHS Foundation Trust and clinicians from both trusts
CEO	McKinsey's Hospital Leadership Forum
CEO	Independent Review Panel Formal Evidence Giving Session
CEO	Shaping a Healthier Future Implementation Board
CEO	Independent Review Panel Site Visit
CEO	Dr Fergus Keating from Royal Hospital Chelsea
CHAIRMAN & CEO	25 year Club Presentations
CEO	King's Fund - Collaborative Leadership Event

Tony Bell
Chief Executive

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	1.8/Jul/13
PAPER	Council of Governors Report including the Membership Report
AUTHOR	Vida Djelic, Foundation Trust Secretary Sian Nelson, Membership Manager
LEAD	Prof. Sir Christopher Edwards, Chairman
PURPOSE	Part A – provides highlights of the Council of Governors meeting held on 23 May 2013. Part B – updates the Board on its membership numbers and engagement activities.
LINK TO OBJECTIVES	The Council of Governors Membership Sub-Committee aims to maintain membership, represent members' equality and diversity and focus on engagement activities.
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This paper highlights the most important issues discussed at the Council of Governors held on 23 May 2013 and reports on the membership numbers for the Trust.
DECISION/ ACTION	To note.

Council of Governors Report

The Trust held the Council of Governors meeting on 23 May 2013.

1. Re-appointment of the Chairman and NED

The Council of Governors agreed to an extension of Prof Sir Christopher Edwards' and Karin Norman's office for a term of one year ending on 31 October 2014. The Council of Governors also agreed to a Non-executive Director attending and providing advice to the Nomination Committee meetings.

2.0 Francis Inquiry Report

It was noted that the Trust held some listening events, to listen to front line staff. A copy of listening events dates organised for May and June was tabled. All governors were invited to attend.

3.0 Approval of the Commentary

Council of Governors endorsed the commentary for the Quality Account.

4.0 Annual Plan 2013/14

The Council of Governors noted the strategic context within which the Trust operates, the main priorities and actions underpinning the clinical strategy.

The Council noted the contents of the annual plan which was due to be signed off by the Board on 28 May 2013 and submitted to Monitor on 30 May 2013.

5.0 Council of Governors Performance Evaluation Report – response to questionnaire

The results Council of Governors Performance Evaluation Report were noted. Most of results were similar to Monitor results. The area for improvement was highlighted.

The Council of Governors was asked to consider and identify actions to be taken forward.

6.0 Open Day 11 May 2013 – feedback

Highlights from 11 May Open Day were provided.

7.0 Healthwatch Kensington and Chelsea Report

Paula Murphy, Interim Director, Healthwatch Central West London updated the governors on the recent change from the Local Involvement Network (LINk) to Healthwatch. Healthwatch is a legal entity which LINk was not and will be known as Healthwatch Central West London.

It was noted that Healthwatch will continue engagement with the Council of Governors, Council of Governors Quality Sub-Committee and the Council of Governors Membership Sub-Committee.

1.0 Membership size and movements

Table 1 below shows the size and movement of membership for the year April 2012 to end of June 2013 by cumulative totals and by membership type.

Table 1. Size and movement of membership

OVERALL MEMBERSHIP OVERVIEW	Last Year 1 Apr 12 – 31 Mar 13	Next Year (Target)	Current Situation 30 June 13
As at start	**14,858**		**15,268**
New Members	1,811		392
Members leaving or changing constituency	1,401		222
TOTAL	**15,268**		**15,438**
PUBLIC MEMBERSHIP OVERVIEW	**Last Year 1 Apr 12 – 31 Mar 13**	**Next Year (Estimate)**	**Current Situation 30 June 13**
As at start	**5,942**		**5,850**
New Members	225		71
Members leaving or changing constituency	317		122
TOTAL	**5,850**		**5,799**
PATIENT MEMBERSHIP	**Last Year 1 Apr 12 – 31 Mar 13**	**Next Year (Estimate)**	**Current Situation 30 June 13**
As at start	**5,685**		**5,994**
New Members	573		320
Members leaving or changing constituency	264		95
TOTAL	**5,994**		**6,219**
STAFF MEMBERSHIP	**Last Year 1 Apr 12 – 31 Mar 13**	**Next Year (Estimate)**	**Current Situation 30 June 13**
As at start	**3,231**		**3,424**
New Members	1,013		1
Members leaving or changing constituency	820		5
TOTAL	**3,424**		**3,420**

2.0 Membership Joiners and Leavers January to April 2013

Between April and June 2013 – Quarter one (Q1), there were 392 new members and 222 members who left overall. This results in a surplus of 170 new members. Membership numbers are broken down (below) to reflect patient, public and staff membership representation.

2.1 Public Membership

Table 2 below shows public membership joiners and leaves between January and June 2013. From April to June 2013 (Q1), there were 71 members of the public who joined and 122 who left membership.

Month	Jan	Feb	March	April	May	June
Joiners	3	3	11	3	57	11
Leavers	3	3	7	104	7	11

Table 2. Public Membership joiners and leavers January to June 2013

2.2 Patient Membership

Table 3 below shows patient membership joiners and leavers between January 2013 and June 2013. From April to June 2013 (Q1), there were 320 patients who joined as members whilst 95 left patient membership.

Month	Jan	Feb	March	April	May	June
Joiners	2	2	1	7	298	15
Leavers	81	4	9	87	8	0

Table 3. Patient membership joiners and leavers January to April 2013

2.3. Staff Membership

Total staff membership at the end of Quarter one (Q1) is 3, 420.

3. Public Membership Ethnicity

Figure 1 shows public membership ethnicity. At the end of Quarter 1, 2013/14, the highest proportion of ethnicity is within the white category, and the lowest representation remains in the 'mixed' group.

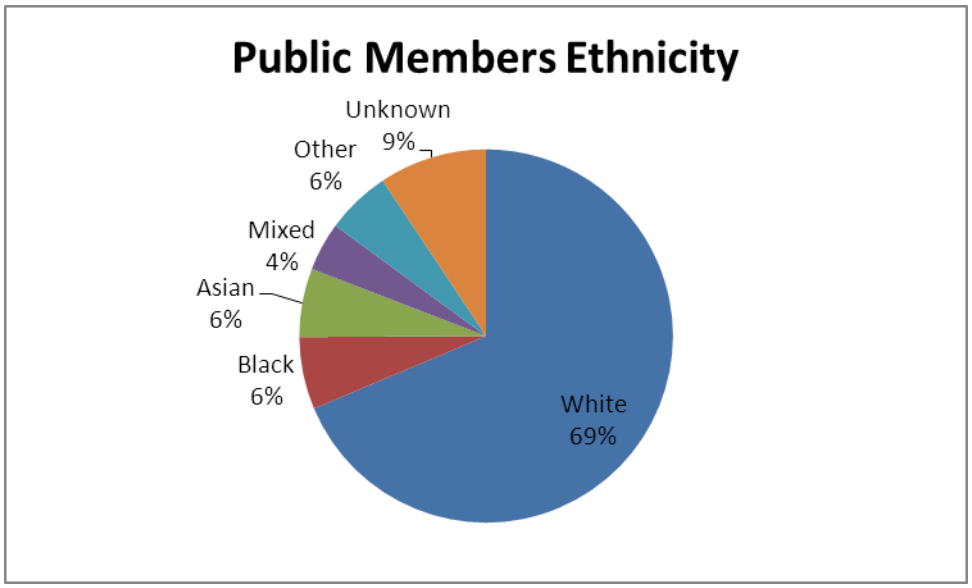
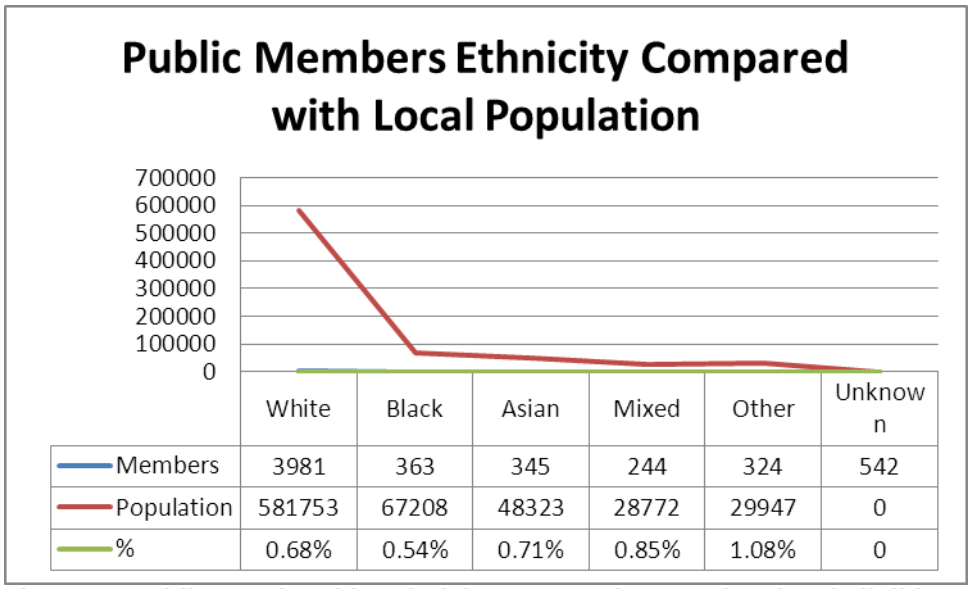


Figure 1. Public Membership Ethnicity end of June 2013 (Q1 2013/14)

3.1. Public Membership Ethnicity – comparison against local eligible population

Figure 2 shows the public membership comparison against the local eligible population. Here representation is highest in the Mixed population, followed by the Asian population and lowest in the Black population.



	White	Black	Asian	Mixed	Other	Unknown
Members	3981	363	345	244	324	542
Population	581753	67208	48323	28772	29947	0
%	0.68%	0.54%	0.71%	0.85%	1.08%	0

Figure 2. Public Membership Ethnicity - comparison against local eligible population. End of June 2013 (Q1 2013/14).

4.0 Public Membership Age

Figure 3 shows a profile of public membership by age. Public membership representation peaks at age group 40-49 years whereas the lowest age group is those within the 16-19 age group.

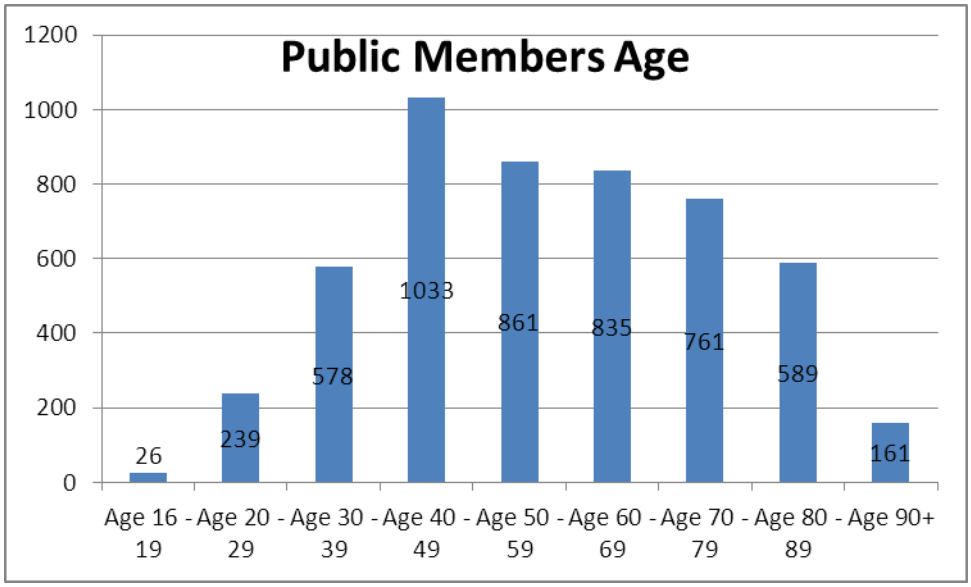
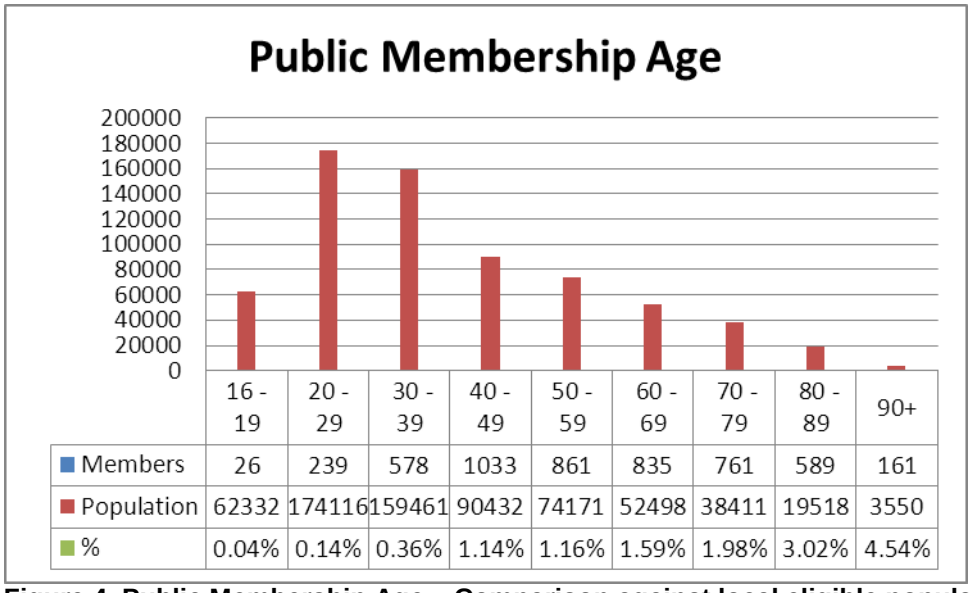


Figure 3. Public Membership Age

4.1 Public Membership Age – Comparison against local eligible population

Figure 4 shows the public membership profile in comparison to the local eligible population. The representation rises from 40 years and peaks in the 80-89 and 90+ year group.



	16 - 19	20 - 29	30 - 39	40 - 49	50 - 59	60 - 69	70 - 79	80 - 89	90+
Members	26	239	578	1033	861	835	761	589	161
Population	62332	174116	159461	90432	74171	52498	38411	19518	3550
%	0.04%	0.14%	0.36%	1.14%	1.16%	1.59%	1.98%	3.02%	4.54%

Figure 4. Public Membership Age – Comparison against local eligible population

5.0 Public Membership - Socio-economic grouping

Figure 5 below shows public membership by socio-economic groups. At end of June 2013 (Q1 2013/14) the highest representation remains in the ABC1 category* followed by category E*. There is no representation in the other categories.

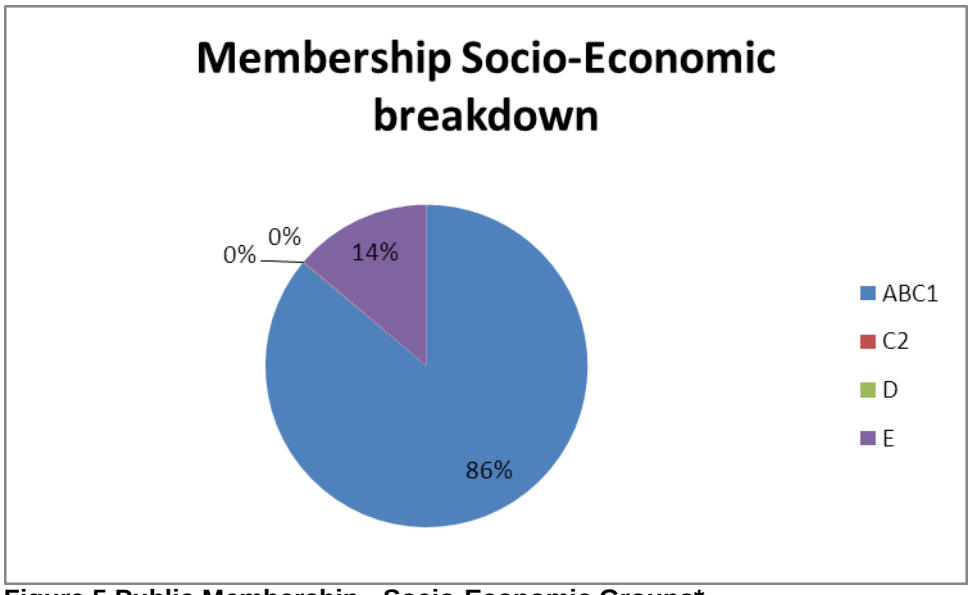


Figure 5 Public Membership - Socio-Economic Groups*

*Social economic grade: A-upper middle class (higher managerial, administrative or professional occupation, B-middle class (intermediate managerial, administrative or professional occupation), C1-lower middle class (supervisory or clerical, junior managerial, administrative or professional occupation), C2-skilled working class (skilled manual workers), D-working class (semi and unskilled manual workers) and E-those at the lowest level of sustenance (state pensioners or widows (no other earner), casual or lowest grade workers).

6.0 Membership Recruitment

During quarter one (Q1) 2013/14 there was a total of 392 new members and 222 members who left. This results in a surplus of 170 new members. This was achieved by a combination of recruitment activities from the Governors who recruited at Open Day and 'Meet a Governor' session and a recruitment campaign outsourced to Capita recruitment services.
A data cleanse is performed each quarter by Capita recruitment before member mailing which removes those not at the same address or who have been registered deceased. In addition Capita is notified monthly for requests of members' removal from the database

6.1. The Membership Development Sub-Committee of the Council of Governors develops and reviews the Membership recruitment strategy. Recruitment activity is focused on both maintaining our membership numbers whilst also enabling a diverse and representative membership.

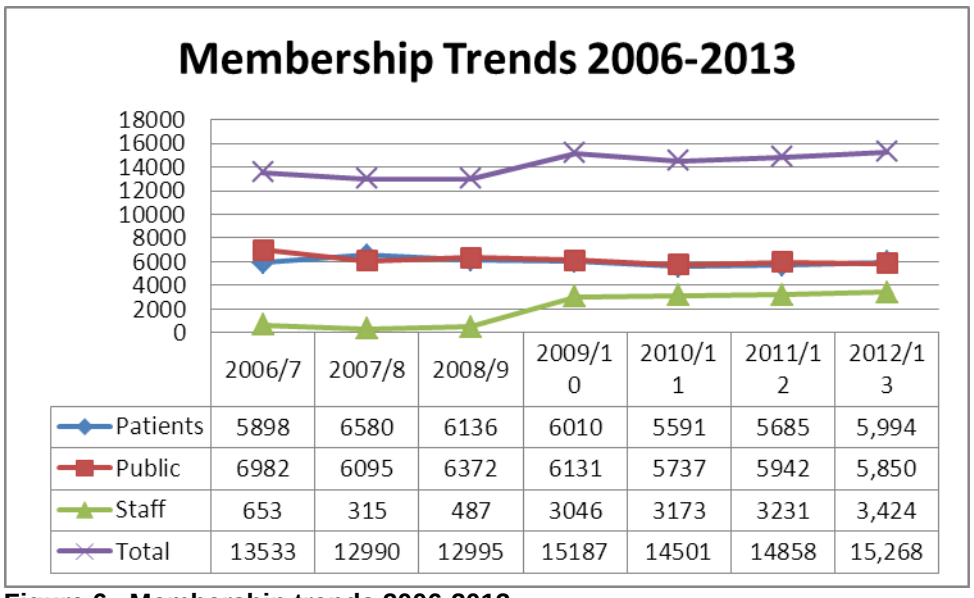
6.3. Governors continue to host 'Meet a Governor' session at the Ground floor Information Zone. Patients, public, staff and members have the opportunity to meet a Governor to discuss issues important to them. This is publicised on the Trust website, and a banner positioned at the hospital's main entrance.

6.4. The Patient Advice and Information Service support membership promotion. Visitors to the PALS office, when appropriate are offered a membership application form. Application forms are sent with patient response letters and the team will continue to actively promote membership.

6.5. The Communications team concentrate on Membership engagement and a plan for membership events has been agreed for 2013/14.

6.6. Membership recruitment campaigns are planned for 2013/14 – the first took place in May 2013, including Open Day and we exceeded the aim to recruit 300 new members (total 355). It is important to recruit throughout the year to ensure membership numbers are maintained. We aim to recruit 900 new members throughout 2013/14.

6.7. Figure 6 shows the trends in Trust membership from 2006-2013.



	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13
Patients	5898	6580	6136	6010	5591	5685	5,994
Public	6982	6095	6372	6131	5737	5942	5,850
Staff	653	315	487	3046	3173	3231	3,424
Total	13533	12990	12995	15187	14501	14858	15,268

Figure 6. Membership trends 2006-2013

7. Recruitment Campaigns

7.1. Recruitment campaigns are scheduled for four times throughout 2013 with an aim of 900 new members to counteract those members that leave membership.

7.2. The first event completed was week of May 7th – this included Open Day on 11th May 2013. The recruitment event aimed to gain 300 new members, promote Open Day and the Governor Elections.

8.0 Developing a Representative Membership

8.1. Analysis of the membership database by age, gender and ethnicity ensures we work towards representative memberships within the communities we serve.

8.2. To create equal representation, It is recognised that membership recruitment should focus on recruitment and engagement with Black, Ethnic and Minority groups. Our recruitment strategy will continue to focus on activities which can encourage wider representation within our membership.

8.3. Table 3.1 highlights that although trust membership figures are higher in the white category; ethnic groups are more balanced when compared to the local eligible population.

8.4. We will now explore further options to recruit from local community groups as a part of our strategy to develop a representative membership. All membership engagement activities during 2013 will be promoted to local BME groups.

9.0 Summary

9.1. The hospital gained Foundation Trust status in 2006 and at year end 2006/07 totalled 13, 533 members. Membership numbers peaked in 2009 when staff members' status changed from 'opt in' to 'opt out'.

9.2. We need to continue our focus on recruitment to maintain our membership numbers whilst also seeking a representative membership. Beyond this, we have introduced initiatives such as 'Medicine for members' to actively encourage the engagement of members in the work of our hospital.

10. Membership Recruitment 2013/14

The below table summarises key recruitment events scheduled for 2013/14

Month	Event	Total Recruited	Report	Funds Approved
May 2013	Members Recruitment Campaign Promotion for Open Day May 2013 And Governor Elections	300 members Achieved	Q1 2013/14	£2,340
September 2013	Members Recruitment Campaign and promotion of the Annual Members Meeting (within the hospital)	Aim – 150 members	Q2 2013/14	£1170
October 2013	Members Recruitment Campaign and promotion of Governor Elections (Inc. within the community)	Aim – 150 members	Q3 2013/14	£1170
TBC	Aim - 300 members Focus on BME groups		Q4 2013/14	£2, 340

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	2.1/Jul/13
PAPER	Finance Report Month 3 – June 2013
AUTHOR	Carol McLaughlin, Financial Controller
LEAD	Rakesh Patel, Director of Finance
PURPOSE	To report the financial performance for June 2013.
LINK TO OBJECTIVES	Ensure Financial and Environmental Sustainability Deliver 'Fit for the Future' programme
RISK ISSUES	Risk of Trust not delivering financial plan. Risk Rating: Impact 5 – Loss of more than £5m. Likelihood 3 – Possible Total Rating **Red**
FINANCIAL ISSUES	The Trust reported a surplus of £0.9m in June, which was £0.2m ahead of plan. In month however, there was £1.0m of donated income (planned), resulting in an underlying deficit of £0.1m for June. The Trust had an EBITDA of 6.1% against an EBITDA plan of 5.8%. The year to date position is a deficit of £0.1m, which is an adverse variance against plan of £1.5m; with an EBITDA of 5.5% against a planned EBITDA of 7.3%. The key issues in the Month 3 year to date position are un-achieved CIPs (£1.5m) and income adverse variances in private patients (£0.4m) and other clinical income categories (£0.4m). The CIP target for 2013/14 is £18.7m, which includes a brought-forward un-identified CIP from 2012/13 totalling £1.8m. Schemes totalling £16.7m have been identified for 2013/14 to date, which represents 89% identification and 32% classified as achieved. However, the risk adjusted assessment at Month 3 is that CIPs are on track for 72% delivery or £13.4m at year end. The forecast position is for a surplus of £2.0m, against a plan of £9.0m, which is an adverse variance of £7.0m. The EBITDA forecast is 6.5% (£22.5m) against a plan of 8.4% (£29.5m), an adverse variance of 1.9% (£7.0m).

	Due to the current adverse forecast position, largely driven by CIP under-achievement, a full trust-wide recovery plan process has been initiated. The executive has asked each Division/Directorate to present back a plan to forecast a year end break-even position. This review will include tighter controls on bank and agency expenditure, stopping any planned un-essential investments (within reserves), bringing forward back-office CIPs and also assessing what centralised support is required to help facilitate recovery plans. Recovery plans are being formulated this week and an update will be presented at the FIC on 18th July. The timescale is to have the recovery plans operationalised for the end of August 2013. The Financial Risk Rating (FRR) YTD for Month 3 is a 3, which is in line with the planned 3 rating for the first quarter. However it should be noted that the actual FRR rating is a 2.85 rounding up to a 3, rather than the planned 3.45 which would round down to a 3, the key issue being the YTD deficit position which is causing the EBITDA margin, Net Return after Financing and I&E surplus margin metrics to be lower than planned. The Continuity of Services Rating (COSR) is also a 3 which is in line with the plan under the new ratings calculation proposed in Monitor's consultation.
OTHER ISSUES	
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	**<u>Income and Expenditure</u>** The Trust had a surplus of £0.9m in June, which was £0.2m ahead of plan, with an EBITDA of £1.9m, 6.1% against a plan of 5.8%. The year to date position however is a deficit of £0.1m (£1.5m adverse against plan), with an EBITDA of £4.8m, 5.5% against a plan of 7.3%. Within both the in-month and year to date position is £1m of donated income in respect of the Paediatric Robot. The key variances in Month 3 are an over-performance in NHS Clinical contract income of £0.6m, driven mainly by excluded drugs income for HIV ARVs (£1.0m), and a reduction in prior-year income (£0.4m) following agreement on 2012/13 outstanding items, which is offset by a release of provisions. Private Patient income was under-plan (£0.2m) across most private specialties. Within expenditure the pay position is adversely affected by £0.4m un-achieved CIPs within directorate budgets, therefore the underlying pay position is an underspend of £0.1m for June. The CIP under-achievement is the key driver in the overall trust financial position. Within non-pay, HIV excluded drugs (£1.0m) are overspent although offset by excluded drugs income and thus not impacting on the Trust's net position. The key NHS clinical contract activity and income variances are set out in the table below.

NHS Clinical Contract Income Variances £000										
Point of Delivery	**Specialty**	**Annual Plan**	**In Month Variance**	**YTD Variance**	**In month % Income Variance**	**In month % Activity Variance**	**YTD % Income Variance**	**YTD % Activity Variance**	**Forecast Outturn Variance**	**Forec % Inc Varia**
Elective	T&O	7,792	-124	-63	-20%	-24%	-4%	-13%	-876	
	Plastics & Hand Surgery	4,784	-68	-28	-15%	-5%	-2%	12%	64	
	HIV	2,346	-62	-68	-33%	-33%	-12%	-25%	-51	
	Bariatric Surgery	1,829	-57	-55	-38%	-40%	-14%	-22%	-477	
	Endoscopy	4,166	-6	81	-2%	-4%	8%	6%	426	
	General Medicine/ Care of the Elderly	490	74	113	192%	1%	95%	-2%	441	
	Paediatric Dentistry	2,215	44	149	27%	20%	29%	21%	653	
	Burns Care	1,223	96	166	122%	98%	61%	61%	537	
	Elective other	22,676	76	101	4%	-16%	2%	-6%	587	
Elective Total		**47,521**	**-29**	**395**	**-1%**	**-10%**	**4%**	**-1%**	**1,303**	
Non Elective	HIV	2,423	-77	-159	-39%	-23%	-26%	-21%	-644	
	Plastics & Hand Surgery	2,460	-70	-116	-35%	-42%	-19%	-27%	-469	
	Paediatric Orthopaedics	792	-38	-124	-59%	-57%	-63%	-62%	-495	
	General Surgery	4,087	-15	-68	-4%	-7%	-7%	-1%	-287	
	General Medicine/ Care of the Elderly	20,448	30	3	2%	-8%	0%	0%	-365	
	Obstetrics	15,571	169	39	13%	16%	1%	2%	147	
	Emergency Care Metrics	-4,843	409	641	101%	N/A	53%	N/A	1,599	
	Non-Elective Threshold 30% marginal rate	-2,700	44	125	20%	N/A	19%	N/A	494	
	Non Elective Other	18,345	-21	13	-1%	-10%	0%	-6%	14	
Non Elective Total		**56,583**	**432**	**354**	**8%**	**2%**	**2%**	**-5%**	**-7**	
Outpatients firsts	Dermatology	669	-11	-23	-19%	-20%	-14%	-13%	-91	
	GUM	15,856	17	43	1%	2%	1%	1%	168	
	Paediatric Medicine	1,146	-26	-31	-28%	-39%	-11%	-23%	-134	
	Obstetrics	11,711	82	73	8%	77%	2%	2%	291	
	Metrics (Internally Generated Referrals)	-1,620	241	275	179%	N/A	68%	N/A	1,100	
	Outpatients other	14,894	-68	32	-6%	-1%	1%	5%	-11	
Outpatients - first attendances Total		**42,656**	**235**	**368**	**-1%**	**2%**	**1%**	**2%**	**1,324**	
Outpatients follow ups (incl diagnostic imaging, virtual clinics & procedures)	Paediatric Ophthalmology	802	-57	-112	-65%	-40%	-53%	-33%	-423	
	Gastroenterology	758	-28	-78	-38%	10%	-35%	12%	-192	
	Obstetrics	493	-26	-116	-99%	-102%	-99%	-138%	-491	
	Paediatric Dentistry	1,452	20	64	19%	15%	19%	16%	281	
	Burns Care	1,180	29	89	31%	28%	30%	30%	347	
	GUM	3,997	73	98	24%	24%	10%	11%	422	
	Diagnostic Imaging	4,648	-302	-467	-170%	N/A	-85%	N/A	-985	
	Outpatients other	32,464	27	154	12%	5%	8%	5%	308	
Outpatients follow up attendances Total		**45,794**	**-264**	**-369**	**0%**	**-1%**	**-1%**	**-1%**	**-732**	
Other	Accident & Emergency	6,387	8	-74	2%	1%	-5%	-5%	-86	
	Urgent Care Centre	5,147	14	28	3%	3%	2%	2%	71	
	ACU	1,168	19	27	19%	N/A	9%	N/A	104	
	Burns Critical Care	2,540	-19	-96	-9%	-15%	-15%	-13%	-393	
	Adult Critical Care	4,511	16	-101	4%	-3%	-9%	-14%	-101	
	NICU & SCBU	9,511	17	8	2%	10%	0%	5%	63	
	Paediatric HDU	2,503	279	113	136%	136%	18%	18%	462	
	Excluded Devices	1,412	-38	53	-21%	N/A	13%	N/A	574	
	Excluded Drugs	52,031	713	900	7%	N/A	7%	N/A	968	
	Chemotherapy	1,072	-64	-185	-73%	N/A	-69%	N/A	-673	
	U-code provisions	0	-147	-320	N/A	N/A	N/A	N/A	-320	
	Other	14,337	-62	-41	-7%	N/A	1%	N/A	-68	
Other Total		**100,621**	**736**	**312**	**7%**	**-6%**	**-3%**	**-3%**	**601**	
Sub Total		**293,176**	**1,110**	**1,061**	**1%**	**-3%**	**0%**	**0%**	**2,489**	
	Prior Year Income	0	-407	-407					-407	
	Change in WIP	0	36	140					140	
	Directorate Savings Target	658	-112	-191					-658	
	Cross Border Activity - to non NHS income	-186	3	30					127	
Grand Total		**293,648**	**630**	**633**					**1,691**	

Elective inpatient activity and income was slightly behind plan in month 3, but continued to be £0.4m ahead of plan for the year to date. There was an underperformance in June in Trauma and Orthopaedics of £0.1m due to consultant annual leave. Other specialties such as Paediatric Dentistry and Burns care continued to over-perform in month 3. Elective income is forecast to continue to over-perform for the rest of 2013/14. Non-elective inpatients overall reported a favourable variance against plan of £0.4m in June, which is primarily driven by low emergency care activity resulting in a benefit on the emergency care metrics due to a lower rate of emergency admissions from A&E and reduction in excess bed days in the first 3 months of 2013/14. Obstetrics inpatients were ahead of plan in June, which has

	recovered the year to date position. Outpatient new and follow-up attendances are on plan in month 3 and for the year to date, with an over-recovery on new activity and under-performance on follow ups. Obstetric ante-natal pathways improved slightly in June, with a higher number of new antenatal pathways than previous months. There has been continued over-performance in GUM attendances, with one week in June having a record number of attendances. The Trust reported a benefit of £0.3m year to date on the internally generated referrals metric, however is still above the agreed target, with the ratio of internally generated referrals to GP referrals at 0.94 compared to a commissioner target of 0.89. Unbundled diagnostic imaging was £0.5m behind plan for the year to date due to scans requested prior to 2013/14, which were funded as part of the outpatient attendance tariffs in the prior year. This is a planning issue due to the change in national tariff for 2013/14, but is expected to be non-recurrent for the first 3 months of the year only. NHS Clinical Contract Income relating to other points of delivery was £0.7m ahead of plan in June and £0.3m year to date, driven by over-performance in excluded HIV anti-retroviral drugs, which is offset by expenditure. There was also an over-performance in Paediatric HDU of £0.3m in June due to an adjustment for errors in data recording for the year to date, which have been identified by the directorate. This has now brought the year to date position for Paediatric HDU back ahead of plan by £0.1m. There was a £0.4m adverse variance in prior year income due to the final agreements made with NWL PCTs for 2012/13 data challenges and PPwT. The Trust is finalising contract documentation with North West London CCGs (local acute services) and NHS England (specialised services and directly commissioned services). The Trust has reached agreement to a reduced CQUIN rate on pass-through items with NHS England, although there remains a small dispute on the proposed 0.1% top slice of CQUIN money to fund Operational Delivery Networks. Discussions are on-going with Local Authorities in North West London regarding contracting for Sexual Health services. There is a risk to the Trust's income relating to CQUIN, as local authorities are advising that they do not wish to fund CQUIN on GUM services and there is Department of Health guidance advising that this is non-mandatory for local authorities. The Trust is disputing this as it is part of the overall funding for sexual health services that should have transferred from PCTs. All other income categories (excluding NHS Clinical Contract Income) are under-achieved by £0.1m in month 3 and £0.5m under-achieved year to date in total. The main driving factors within this are under-performance on private income (£0.4m YTD), which includes PMU being 46 deliveries behind plan in Q1, as well as adult Private Patients, ACU and overseas also being behind plan. Other NHS Clinical income is £0.2m behind plan to month 3, largely driven by under-performance in community contracts in Dermatology and Gynae. Other non-NHS Clinical revenue is £0.2m behind plan to month 3, due to RTA income being down and under-performance against amenity bed income plans. It should be noted that £1m of donated income in respect of the Paediatric Robot was accounted for in month 3 (as planned). Whilst this is part of the

planned surplus for the Trust this year, it doesn't contribute to the EBITDA performance.

Pay is overspent in month 3 by £0.3m with the main contributing factor being the un-achieved CIP plan (that reports into 'other pay contracted'); adjusting for CIPs the pay position was under-spent in month (£0.1m). Year to date the pay adverse position of £1.2m includes CIP slippage of £1.5m, thus highlighting an under-lying underspend of £0.3m. Other points of note in the pay position include a deterioration over the last 12 months in the proportion of nursing costs that are made up of B&A staff groups; and also that total nursing agency costs are steadily increasing after reductions in 2012/13 costs when compared to 2011/12 expenditure levels.

The non-pay position shows an overspend of £0.1m in month 3 and an overspend of £0.5m year to date. The main contributor to the in-month and year to date position are high levels of HIV ARV drug spend (with a year to date correction of classification from tariff drugs in June); however this overspend (£0.9m) is fully offset by excluded drug income and is thus not impacting on the bottom line financial position. Other key elements in the non-pay position include the release of £0.6m of prior year provisions in month 3; year to date pressures in consultancy spend (largely offsetting a number of vacancies); and pressures in clinical supplies budgets, although the actual trend of expenditure is on line with the previous two years.

The CIP target for 2013/14 totals £18.7m when including the £1.8m brought forward un-achieved CIP from 2012/13. Of the total £18.7m target, schemes totalling £16.7m have been identified (89%) for 2013/14 to date, with £6.1m (32%) classified as achieved. Divisions and corporate departments have been requested to have achievement of 70% by the end of July and to be 100% achieved by the end of Jan 2014. CIP achievement is the largest risk in the financial position.

Forecast

The current forecast for the Trust is a £7.0m adverse variance against plan (£2.0m forecast actual surplus against £9.0m planned surplus). A full Trust-wide recovery plan process has been started to review all divisional recovery plans for the remainder of the year. The recovery plans will outline actions required to forecast a breakeven position, timescales, operational leads and financial value of each mitigating recovery plan scheme. These schemes must outline any potential impact on quality and efficiency, as well as any other risks involved within their implementation.

In addition to working through the detailed recovery plans, the delivery of CQUIN targets, achievement of commissioner metrics, agreement of contracting arrangements (including pricing and CQUIN for GUM) and delivery of the activity plan will all also be reviewed.

Overall Financial Risk Rating (FRR) and Continuity of Services Risk Rating (COSR)

The FRR ratings for the YTD position at Month 3 are shown below:

Financial Metric	M3 YTD				
	Plan	Actual	Actual FRR	Weighting	Pla
EBITDA margin %	7.4%	5.6%	3	25%	3
EBITDA , % plan achieved	100.2%	76.1%	3	10%	5
Net Return after Financing	0.3%	-1.2%	2	20%	3
I&E surplus margin net of div.	1.5%	-0.1%	2	20%	3
Liquidity days	37	34	4	25%	4
Financial Risk Rating	**3**	**3**	**3**	**100%**	**3**

The weighted average FRR for Month 3 is 2.85 which rounds up to a 3, whereas the planned FRR was 3.45, therefore the actual result for Q1 is a low 3. The main areas of under performance against the planned FRR are the EBITDA % of plan achieved, where actual achievement was 76.1% of plan (compared to the planned 100% achievement), and the I&E surplus margin and Net Return after Financing metrics, which were both planned at a 3 but the actual performance is a 2. The underperformance on all three of these metrics is due to the YTD deficit position.

The COSR rating for the YTD position at Month 3 is shown below:

COSR Rating	Weighting	M3 Actual	M3 Plan
Debt Service Cover	50%	2	2
Liquidity	50%	4	4
Total Rating		**3**	**3**

Whilst the actual COSR rating is in line with plan at a 3, the Debt Service Cover actual metric works out at -1.25%, which is the absolute minimum threshold for a 2 rating on this metric. This is a function of the deficit position causing the revenue available for debt service to be lower than planned. If this metric drops to a 1, the overall COSR rating would then become a 2.

Prudential Borrowing Limit (PBL)/Loans

The prudential borrowing limit and prudential borrowing code are no longer in force effective from 1st April 2013.

The Trust has two signed loan agreements in place that have not been drawn down, purchase of Doughty House (£20m) and SAHF development (£6m). The Trust made a planned loan repayment of £1.8m against the £29m Netherton Grove loan in June, together with associated interest of £0.4m.

It is intended to put forward a new £10m loan application to the Foundation Trust Financing Facility shortly in relation to the Emergency Department Expansion business case, in order to allow the Trust to accelerate the capital build ahead of the timescale to implement SaHF in 2017/18.

Capital

The capital expenditure forecast of £43.0m is reported at month 3 against a capital plan of £49.9m. The reduction of 14% in planned capex is within three building projects: Emergency department expansion (£2.59m is identified to move to 2014/15), Doughty House (£3.1m will move to 2014/15) and the conversion of Rainsford Mowlem ward (capex of £2.4m total; £1.1m in 2013/14). These budgets were phased to Q3 & Q4 plan and therefore do not impact on the YTD position.

Year to date spend is £3.9m against plan of £3.7m of which £1.3m has been spent in Month 3. The Trust is reporting capex ahead of Monitor plan by 3% in Q1. This variance is within Monitor's financial variance indicator for capex, which has come down from 25% variance in 2012/13 to 15% in 2013/14.

Capital spend year to date (see table below) continues to be predominantly against projects agreed in the prior financial year. 45% of YTD spend (£1.7m) has been incurred on Medical and Non-Medical equipment primarily on the replacement of monitors across the Trust and the purchase of new scopes in the Radiology and Fluoroscopy Departments. Spend on building projects to date totals £1.3m and has been incurred on the Flooring Replacement Programme (£0.2m), various projects maintenance programme to maintain Site Condition B (£0.3m) and £0.2m for Paediatric Ward/Burns. IT Expenditure has been mainly on LastWord Development, Electronic Document Management (EDM), and PICIS Upgrade.

Asset Category	YTD Budget (£'m)	YTD Actual (£'m)	YTD Var (£'m)	YTD Var (%)	2013/14 Budget (£'m)	2013/14 Forecast (£'m)	Forecast Var (£'m)	Forecast Var (%)	C
Buildings	0.987	1.298	-0.311	-32%	34.565	27.750	6.815	20%	
Chief Executive Contingency	0.000	0.000	0.000	0%	0.200	0.200	0.000	0%	
IT	0.743	0.829	-0.086	-12%	8.938	8.938	0.000	0%	
Medical Equipment	1.878	1.574	0.304	16%	4.911	4.934	-0.023	0%	
Non Medical Equipment	0.134	0.162	-0.027	-20%	1.267	1.244	0.023	2%	
Grand Total	**3.742**	**3.862**	**-0.120**	**-3%**	**49.881**	**43.066**	**6.815**	**14%**	

Cash Flow

The cash position as at 31st May 2013 is £27.2m which is £11m below plan. The key issues driving the adverse variance against plan are the following:

- The I&E deficit of £1.4m against plan YTD.
- Capital expenditure is £2.5m higher than plan YTD – comprising a small capex overspend of £0.12m as outlined above plus a decrease in capital payables of £1.8m YTD (compared to a planned increase of £0.5m).
- Trade receivables are approx. £6m higher than plan at Q1 (explained in more detail below).

	• Trade and other payables are below plan by approx. £1.1m (the majority of which relates to accrued expenditure). Within trade receivables, the key movement is in NHS receivables which have increased by £3.4m in month. Approx. £2.7m of Q1 invoices that were billed to CCGs have not yet been paid, due to the fact that many CCGs have part paid invoices to an agreed level pending final agreement of the contract. There is also £3m of income not yet invoiced for NHS England accrued in the M3 position. This is largely due to the transfer of services between CCGs for specialised services (now hosted by NHS England), where the final contract with NHS England had not been agreed therefore neither the CCGs nor NHS England have been willing to pay for these services to date. This has now been resolved as the value of the transferring activity has been agreed and this income has been billed in July, therefore will be actively chased for collection. It is anticipated that this is a short term issue which will be resolved once final contract values are agreed with commissioners (expected to be by the end of July). In addition to this, the cash position has also been affected by the set up issues relating to moving GUM commissioning from PCTs to Local Authorities. Those Local Authorities who have been invoiced for 13-14 activity (£3.5m) have not yet paid, and the Trust has not yet billed for Month 3 activity (£1.7m). This situation has been escalated to the Director of Finance and currently represents a risk to the Trust's forward cash position. The forecast cash position at Month 12 is currently estimated at £31.4m, approx. £5m below plan, the key driver being the forecast I&E deficit. **Investments** With effect from 1st April the Department of Health changed the methodology for calculating the Trust's annual dividend payment (which is calculated as 3.5% of average net relevant assets excluding cash held in government bank accounts) to exclude cash held in government bank accounts calculated on a daily average rather than the average of the opening and closing position. This is a disincentive to place funds on deposit commercially; however deposits within National Loans Fund are not affected. As at 30th June the Trust had £13m invested with the National Loans Fund for a period of 14 days, maturing on 5th July. This will generate interest of approx. £2k at an interest rate of 0.39%.
DECISION/ ACTION	The Board is asked to note the financial position for June 2013.

APPENDIX B

Financial Overview as at 30th June 2013 (Month 3)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Financial Performance

Financial Position (£000's)

	Full Year Plan	Plan to Date	Actual to Date	Mth 3 YTD Var	Mth 2 YTD Var	Forecast
Income	(349,000)	(86,023)	(86,148)	124	(446)	(349,728)
Expenditure	316,016	78,658	80,341	(1,683)	(1,236)	323,747
EBITDA for FRR excl Donations/Grants for Assets	29,531	6,365	4,806	(1,559)	(1,681)	22,528
EBITDA % for FRR excl Donations/Grants for Assets	8.5%	7.5%	5.6%	-1.8%	-2.9%	6.5%
Surplus/(Deficit) from Operations before Depreciation	**32,984**	**7,365**	**5,806**	**(1,559)**	**(1,681)**	**25,981**
Interest	829	212	211	1	2	823
Depreciation	12,907	3,242	3,138	104	69	12,907
Other Finance costs	0	(0)	0	(0)	(0)	0
PDC Dividends	10,241	2,559	2,559	0	0	10,236
Retained Surplus/(Deficit) excl impairments	**9,007**	**1,352**	**(101)**	**(1,453)**	**(1,610)**	**2,015**
Impairments	0	0	0	0	0	0
Retained Surplus/(Deficit) incl impairments	**9,007**	**1,352**	**(101)**	**(1,453)**	**(1,610)**	**2,015**

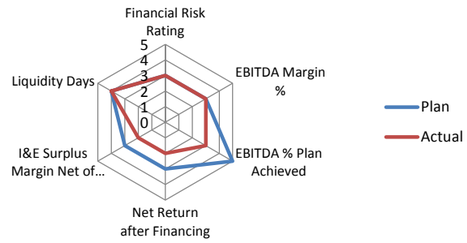
Comments

Risk Assessment
Impact 5 (Loss of more than £5m), Likelihood 3 (Possible); Internal> **Red**

The month 3 position is a deficit of £0.1m (EBITDA of 5.6%), which is an adverse variance of £1.5m against plan.

I&E Deficit (£1.5m); includes the following material items;
- Over-performance in NHS Clinical contract income (including excluded drug income)
- Private Patient income under-plan (£0.4m predominantly within Overseas, PMU & ACU)
- Pay position adversely affected by £1.5m unachieved CIPs
- Drugs expenditure (£0.9m) overspent, although largely offset by excluded drugs income

Risk Rating (year to date)

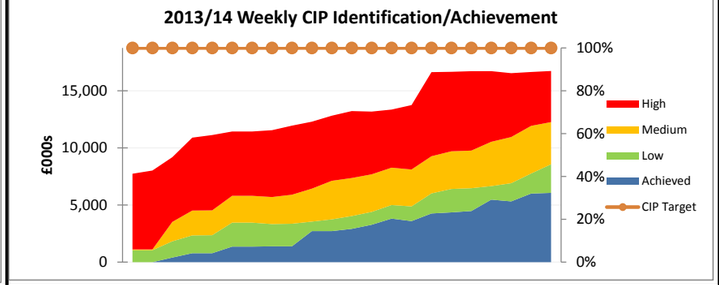


Comments

The FRR YTD for Month 3 is a 3, in line with the planned 3 rating for the first quarter. However the actual rating is a 2.85 rounding up to a 3, rather than the planned 3.45. The key issue is the YTD deficit position which is causing the EBITDA margin, Net Return after Financing and I&E surplus margin metrics to be lower than planned. The COSR rating is a 3

The COSR rating YTD is a 3 against a planned 3.

Cost Improvement Programme



Comments

CIPs 13/14
The CIP target for 13/14 is £18.7m (£16.9m for 13/14 + £1.8m b/f from 12/13).
Schemes totalling £16.7m have been identified towards the 2013/14 target.
This £16.7m represents 89% identification and includes 32% achievement.

Trajectory
It was proposed that all Divisions should have identified 100% of CIP schemes by 31st May.
It is then proposed that the following achievement trajectories to be met:
70% achieved by 31st July 2013
75% achieved by 31st Aug 2013
(Followed by a further detailed trajectory of 100% achievement by 31st Jan 2014).

NHS Clinical Income (£000)

Division	Directorate	Point of Delivery	Activity Plan	Activity Actual	Activity Variance	Price Plan	Price Actual	Price Variance
CLINICAL SUPPORT	DIAGNOSTICS	Elective	1,669	1,768	99	1,035	1,116	80
		Non Elective	5	8	3	20	19	-1
		Other	15,713	11,835	-3,878	577	495	-81
		Outpatients	7,188	7,413	224	633	650	17
	DIAGNOSTICS Total		**24,575**	**21,023**	**-3,552**	**2,265**	**2,280**	**15**
	PERI-OPERATIVE THEATRES & ANAESTHETICS	Elective	2	2	-0	13	7	-6
		Non Elective	65	49	-16	71	91	20
		Other	773	663	-110	1,125	1,023	-101
		Outpatients	89	82	-7	8	7	-1
	PERI-OPERATIVE THEATRES & ANAESTHETICS Total		**929**	**796**	**-133**	**1,217**	**1,129**	**-88**
	THERAPIES	Other	10,760	7,525	-3,235	382	293	-89
		Outpatients	10,509	11,588	1,079	577	632	54
	THERAPIES Total		**21,269**	**19,113**	**-2,156**	**959**	**925**	**-35**
CLINICAL SUPPORT Total			**46,772**	**40,932**	**-5,841**	**4,441**	**4,333**	**-107**
MEDICINE AND SURGERY	MEDICINE	A&E	28,408	28,222	-186	2,860	2,817	-43
		Elective	1,166	1,294	128	700	886	186
		Non Elective	5,049	4,829	-220	5,662	5,542	-120
		Other	382	161	-221	198	41	-157
		Outpatients	19,381	20,634	1,252	2,927	2,903	-24
	MEDICINE Total		**54,387**	**55,140**	**753**	**12,347**	**12,189**	**-158**
	SURGERY	Elective	2,921	3,238	317	5,319	5,461	142
		Non Elective	1,755	1,590	-165	3,254	3,089	-165
		Other	680	546	-134	861	829	-32
		Outpatients	25,516	27,034	1,518	3,111	3,101	-10
	SURGERY Total		**30,873**	**32,408**	**1,535**	**12,546**	**12,481**	**-65**
MEDICINE AND SURGERY Total			**85,260**	**87,547**	**2,288**	**24,893**	**24,670**	**-223**
OTHER	OTHER	Elective	**0**	**0**	**0**	**-54**	**0**	**54**
		Non Elective	0	0	0	-1,211	-570	641
		Other	186,302	186,121	-181	3,572	3,816	244
		Outpatients	2,540	3,338	797	-707	-435	272
	OTHER Total		**188,842**	**189,459**	**617**	**1,601**	**2,811**	**1,210**
OTHER Total			**188,842**	**189,459**	**617**	**1,601**	**2,811**	**1,210**
WNS/CYPS/HIV/SH/Dem	CHILDREN'S AND YOUNG PEOPLE'S SERVICES	Elective	1,967	2,015	48	2,512	2,531	20
		Non Elective	1,588	1,423	-165	2,015	1,914	-101
		Other	3,768	3,948	180	3,622	3,628	6
		Outpatients	13,414	12,790	-623	2,506	2,258	-248
	CHILDREN'S AND YOUNG PEOPLE'S SERVICES Total		**20,736**	**20,176**	**-560**	**10,654**	**10,331**	**-324**
	HIV/SEXUAL HEALTH AND DERMATOLOGY	Elective	2,150	1,680	-470	874	758	-115
		Non Elective	209	302	93	634	469	-165
		Other	-1,449	74	1,523	47	16	-32
		Outpatients	36,913	38,148	1,236	18,901	19,745	843
	HIV/SEXUAL HEALTH AND DERMATOLOGY Total		**37,823**	**40,204**	**2,382**	**20,456**	**20,988**	**532**
	WOMEN'S AND NEONATAL SERVICES	Elective	641	650	9	828	862	34
		Non Elective	3,766	3,619	-147	4,163	4,284	121
		Other	37	4	-33	334	272	-62
		Outpatients	8,961	8,847	-114	4,238	4,117	-120
	WOMEN'S AND NEONATAL SERVICES Total		**13,405**	**13,120**	**-284**	**9,562**	**9,535**	**-27**
WNS/CYPS/HIV/SH/Dem Total			**71,963**	**73,501**	**1,537**	**40,673**	**40,854**	**181**
Grand Total			**392,838**	**391,439**	**-1,399**	**71,607**	**72,668**	**1,061**

Comments

The table above summarises the NHS Clinical Income position for Directorates/Divisions and POD for month 3 of 2013-14

Key Financial Issues

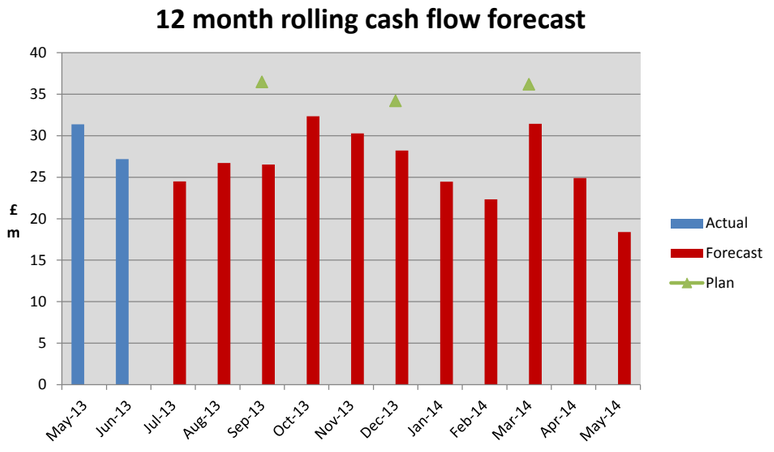
Key Issues
- CIP 13/14 identification and achievement
- including fye's of 12/13 (b/f)

- Recovery plans to improve the forecast to the
- planned surplus

- GUM Public Health commissioning & payment
- Impact of Francis Report; including QIA on CIPs
- Delivery of the Trust's activity plan
- Achievement of new commissioner metrics
- Achievement of CQUIN targets for 2013/14

Future Developments
- Strategic developments e.g. West Midd, SaHF
- West Middx at the Strategic Outline Case stage
- Operationalising the capital plan
- ED capital redevelopment

Cash Flow



Comments

The cash position as at Month 3 is £27.2m, £11m below plan. The key issues driving the adverse variance are the YTD I&E deficit, together with trade receivables being above plan and trade and other payables being below plan. The key issue within trade receivables is the increase in NHS receivables of £3.4m in month - this relates to i) Issues with agreeing the activity to be transferred between CCGs and NHS England, resulting in CCGs part paying Q1 invoices until contracts are signed and ii) Issues with the transfer of GUM commissioning from PCTs to Local Authorites. Both issues have been escalated and the cash position is expected to improve going forward.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	2.2/Jul/13
PAPER	Performance Report – June 2013
AUTHOR	Jen Allan, Head of Performance Improvement
LEAD	David Radbourne, Chief Operating Officer
PURPOSE	The purpose of this report is to the summarise high level Trust performance, highlight risk issues and identify key actions going forward for June 2013.
OBJECTIVES	This paper reports progress on a number of key performance areas which support delivery of the Trust's overarching aims.
RISK ISSUES	Overall performance in June remains stable with all Monitor indicators met for the month. Two cases of MRSA have been identified YTD although there were no cases in June. Contract negotiations continue with North West London CCGs on acute services, with NHS England for specialised services, and with Local Authorities for sexual health services. Negotiations have moved forward on the acute contract and specialised services contract but have been more problematic for sexual health due to the lack of consistency in commissioning approaches by individual Local Authorities.
FINANCIAL ISSUES /OTHER ISSUES	None.
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	The Trust is compliant with all Monitor indicators and continues to meet the 98% target for A&E and all RTT and Cancer access targets. A draft CQUIN compliance report for Q1 is presented with overall good performance although there are some challenges on Dementia and on GP Real Time information. These will have a renewed focus into Q2. Within clinical effectiveness, there are a number of indicators needing focus to meet the high standards set and the Chief Nurse and Deputy Chief Nurse will be leading improvement in these areas. Within Maternity the caesarean section rate remains high both elective and non-elective

	and the department have undertaken a new communication campaign around maternal choice caesarean section. An exciting new project has started on reducing pressure ulcers – we have named this POP (Pushing Off the Pressure). The initial focus is in AAU with a proactive MDT team working on a number of initiatives with the ultimate objective being no hospital acquired pressure ulcers. The Outpatient Transformation Project continues to focus on key measures of outpatient experience and efficiency and action is being taken on the level of hospital cancellations of outpatient appointments. Improvement can be seen in the DNA rate and work will also continue on this. In addition the McKinsey / Disney Programme of Improving Patient Experience commenced in July and is working with the dermatology outpatients team. The aim of this programme is to deliver a high quality experience that exceeds patient expectations. A more detailed focus report on Access is provided this month reporting on the reductions in waiting times achieved for key specialties.
DECISION/ ACTION	The Trust Board is asked to note this report.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Corporate Performance Report

Performance to 30th June 2013

At a Glance Performance – June 2013

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Patient Safety

- Hospital acquired VTE
- Safety Thermometer – Harm free score
- MRSA Bacteraemia
- Mortality - SHMI
- Never Events

Clinical Effectiveness

- A&E Total Time (< 4 Hours)
- Time to theatre for urgent surgery (NCEPOD recommendations)
- VTE Assessment
- Dementia Screening
- Emergency readmissions within 30 Days
- Caesarean Section rate

Patient Experience

- Choose And Book Slot Issues
- Hospital Initiated Cancellation rate - Outpatients
- RTT Incomplete pathways <18wks
- Cancer Two week wait
- Friends and Family Net Promoter score
- Complaints – Turnaround time

Access & Efficiency

- DNA Rate
- Theatre Booking Conversion Rate
- OP Letter Turnaround < 7 Days
- Discharge summaries <24 hours
- EBITDA
- CIP Achievement

Workforce

- Sickness rate
- Turnover rate
- Appraisal completion rate
- Vacancy rate
- Average time to recruitment

Contents

1. Trust Headlines
2. Performance Domains:
   - Patient Safety
   - Clinical Effectiveness
   - Patient Experience
   - Access and Efficiency
   - Finance Balanced Scorecard
   - Workforce
3. *Monthly Focus:*
   - *Access – Deep Dive*

About this report

The Board Performance Report has been refreshed to provide a clearer view of our performance across four domains of high quality care: Patient Safety, Clinical Effectiveness & Maternity, Patient Experience, & Access and Efficiency. Two organisational domains of Workforce and Finance are also addressed.

Each month, an overall view of the Trust's performance is presented on page 2 based on key indicators for each domain. Within the report, relevant KPIs for each domain are reported in a dashboard format, and areas of concern or improvement highlighted.

An Amber rating has been introduced to help us differentiate better between areas that are close to meeting the required standard, and those which need significant work. Further to this we are able to highlight where there has been a significant improvement or decline more effectively.

To aid clarity of performance change over time, further analysis in the form of graphs on key indicators has been included.

CQUIN quality improvement schemes 2013/14

A summary of performance against our CQUIN schemes for Q1 2013/14 is presented below. Achievement is good with some delivery against the Dementia and GP Real Time Information schemes. Plans are in place to address these areas. Overall, we predict that £428k CQUIN payment will be due against a total potential value of £431k, which equates to 99% achievement.

CQUIN	Description	Q1 performance	Comments / Risk issues	Q1 Value	Q1 Value Achieved
Friends and Family Test	Roll out further; increase response rate; remain in top quartile in Staff Survey FFT question	Fully achieved		£15,514	£15,514
Safety Thermometer	Submit full data; reduce incidence of newly acquired pressure ulcers	Fully achieved		£21,719	£21,719
Dementia	Identify, assess and refer patients at risk of Dementia; named clinical lead; support carers	Partially achieved	Identification, assessment and referral for support of patients at risk of dementia at 91% compliance overall	£29,476	£27,800
VTE	VTE risk assessment and root cause analysis	Fully achieved		£23,270	£23,270
Supporting care out of hospital	Enhanced use of admission avoidance schemes; improvement of acute flow; implementation of the Emergency Care Pathway; addressing frequent A&E attenders	TBC	CQUIN not yet well defined although work is actively ongoing on the Emergency Care Pathway and related initiatives	£155,135	£155,135
GP Real Time Information	Notification of A&E/UCC attendance; emergency admission; PDD; Discharge Summary and Outpatient clinic letter within appropriate timescales Development of new electronic channels of communication with GPs	Partially achieved	Technical issue led to partial compliance on notification of A&E/UCC attendance - now resolved Q2 compliance depends on GP IT leads active engagement	£62,054	£60,813
Secondary Care Quality Standards	Reduce LoS for elective total hip replacements; Increase consultant cover on Labour Ward	Fully achieved		£62,054	£62,054
Near Patient Testing	Development of protocols and transfer of patients into community clinics for ongoing management of certain conditions	Fully achieved	Q2 compliance requires significant input from GPs	£62,054	£62,054
			Total	**£431,276**	**£428,360**

Performance Headlines

Positives:

- The Trust continues to deliver excellent performance against Access and RTT standards. Performance throughout Q1 remained over the threshold for all indicators and a programme of best practice work is in progress to ensure sustainable processes are in place.
- Performance on Infection Control also improved in June with no further cases of MRSA and continued zero incidence of Cdiff.

Areas for focus:

- Our Caesarean Section rate continues to be well above target. Actions are under way within Maternity to address this, including a letter for patients explaining we cannot offer maternal choice caesarean sections
- Emergency care pathway work in support of Shaping a Healthier Future is under way to address a number of areas of clinical effectiveness such as improving Length of Stay, consultant assessment and discharge planning
- The POP (Pushing Off the Pressure) project has been started with the support of McKinseys with a focus on having zero pressure ulcers in the Trust. To achieve real focus. Grade 4 ulcers will be considered a Never Event.

Monitor Compliance

The trust has maintained compliance against the key monitor indicators for June.

KPI Name	Target	YTD	Jun-13
Clostridium difficile cases	<13	0	0
MRSA objective	6	2	0
All cancers: 31-day wait from diagnosis to treatment	> 96%	97.40%	100.00%
All cancers: 31-day wait for second or subsequent treatment Surgery	> 94%	No treatments	No treatments
All cancers: 31-day wait for second or subsequent treatment anti cancer drug treatments	> 98%	No treatments	No treatments
All cancers:62-day wait for first treatment from urgent GP referral to treatment	> 85%	86.70%	87.70%
All cancers:62-day wait for first treatment from consultant screening referral	> 90%	100.00%	100.00%
Cancer: Two Week Wait from referral to date first seen comprising all cancers	> 93%	95.50%	96.40%
Referral to treatment waiting times < 18 Weeks - Admitted	> 90%	90.64%	91.71%
Referral to treatment waiting times < 18 Weeks - Non-Admitted	> 95%	97.54%	98.73%
Referral to treatment waiting times < 18 Weeks - Incomplete Pathways	> 92%	93.56%	93.91%
A&E: Total time in A&E < 4hrs	> 98%	98.60%	98.70%
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability		Compliant	Compliant

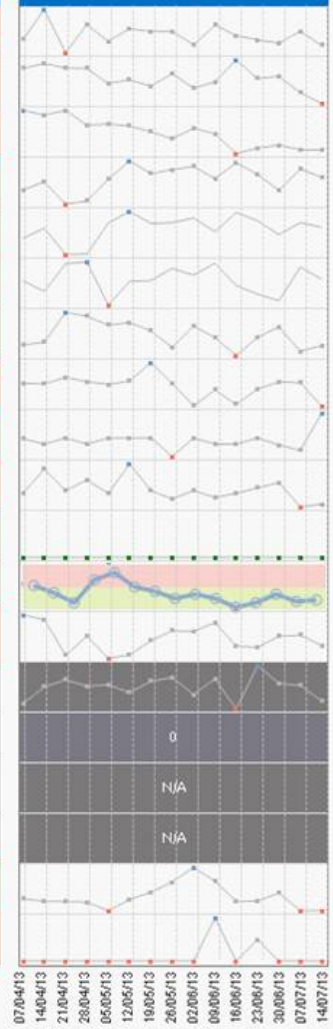
Trust Headlines – Weekly Performance Focus

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Weekly Local Indicators Dashboard

Key performance indicators across a range of domains are reviewed weekly, using this dashboard format. There is scope for divisional focus and weekly trends can be assessed. Indicators currently being monitored reflect current priorities and are adjusted in response to new challenges.

	Trust Level Last Three Weeks			Trust YTD	Trust YTD Weekly Trends	Medicine & Surgery Last Three Weeks			Women's & Childrens Last Three Weeks			Clinical Support Last Three Weeks		
WeekEnding	14/07/2013	07/07/2013	30/06/2013			14/07/2013	07/07/2013	30/06/2013	14/07/2013	07/07/2013	30/06/2013	14/07/2013	07/07/2013	30/06/2013
VTE Assessment (Target: > 95.00%)	94.2%	95.3%	94.4%	95.0%		94.5%	94.0%	91.4%	93.5%	96.1%	96.7%	95.0%	98.1%	99.4%
Discharge Summaries Sent < 24 hours (Target: < 80%)	74.8%	76.7%	79.6%	79.3%		73.4%	75.3%	72.7%	69.2%	71.9%	83.4%	95.2%	94.4%	95.8%
OP Letters Sent < 7 Working Days (Target: > 90%)	N/A	83.7%	84.6%	87.4%		N/A	85.3%	87.0%	N/A	84.1%	82.9%	N/A	93.9%	89.0%
A8E waiting times (Target: > 98%)	98.7%	98.9%	98.2%	98.6%		98.7%	98.9%	98.2%	N/A	N/A	N/A	N/A	N/A	N/A
Adult A8E Waiting Times	98.4%	98.7%	98.1%	98.4%		98.4%	98.7%	98.1%	N/A	N/A	N/A	N/A	N/A	N/A
Paed A8E Waiting Times	99.2%	99.6%	98.6%	99.2%		96.3%	97.0%	95.9%	N/A	N/A	N/A	N/A	N/A	N/A
A8E: Left without being been (Target: < 5%)	3.7%	3.4%	4.4%	4.1%		3.7%	3.4%	4.4%	N/A	N/A	N/A	N/A	N/A	N/A
A8E: Unplanned Re-attendances (Target: < 5%)	4.86%	5.91%	5.96%	5.74%		4.86%	5.91%	5.96%	N/A	N/A	N/A	N/A	N/A	N/A
A8E: Initial Assessment (Target: < 15)	00:17	00:11	00:11	00:13		00:17	00:11	00:11	N/A	N/A	N/A	N/A	N/A	N/A
A8E Time to Treatment (Target: < 60)	00:57	00:56	01:05	01:02		00:57	00:56	01:05	N/A	N/A	N/A	N/A	N/A	N/A
12 Hour Trolley Waits	0	0	0	0		0	0	0	0	0	0	0	0	0
DNA Rate (Target < 11.1%)	10.1%	10.1%	10.7%	10.6%		12.1%	11.6%	12.2%	9.5%	10.4%	9.8%	7.2%	6.7%	9.5%
First to Follow-up ratio (Target: < 1.5)	1.80	1.90	1.89	1.86		1.93	2.01	2.06	1.45	1.64	1.40	N/A	N/A	N/A
Non-Elective Admissions - (Target N/A)	672	716	722	10660		316	297	302	352	414	413	4	5	7
Red or Black (Level 4 or 5) alert days (Target NA)	0	0	0	0		0	0	0	0	0	0	0	0	0
RTT Incomplete	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
RTT 52 Wk waits	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
On the day cancelled operations (non clinical) % total elective admissions (Target: < 0.8)	0.00%	0.00%	0.30%	0.22%		0.00%	0.00%	0.00%	0.00%	0.00%	0.93%	0.00%	0.00%	0.00%
On the day cancellations not rebooked within 28 days (Target: = 0)	0	0	0	3		0	0	0	0	0	0	0	0	0



Trust Headlines – SAHF / Emergency Care

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Emergency Care Pathway Dashboard

The Emergency Care Pathway Programme is a key programme of work with commissioners to deliver a step change in out of hospital care and the use of urgent and emergency care. It is part of our CQUIN and contractual metrics as well as supporting our CIP programme and strategic development towards Shaping A Healthier Future (SAHF) implementation. The Dashboard has been developed to pull together key indicators which will enable us to track progress against the objectives. Working with partners across the local health economy we will also be pulling together an integrated dashboard including out of hospital and community services.

Under development

Month/Year	Jun-13	May-13	Apr-13	YTD
A&E waiting times (Target: > 98%)	98.70%	98.90%	98.10%	98.60%
GP notification of an A&E-UCC attendance < 24 hours (Target: = 90%)	79.70%	38.70%	97.80%	71.80%
Reducing emergency admissions (A&E Conversion Rates) (Target: = 24%)	14.40%	15.40%	16.00%	15.30%
12 Hour consultant assessment - AAU Admissions (Target: = 90%)	51.80%	35.90%	49.00%	45.20%
Fractured Neck of Femur - Time to Theatre < 36 hrs for Medically Fit Patients (Target: = 100%)	88.90%	90.00%	87.50%	88.90%
Completion of Predicted Discharge Date (Target: =)	7.4%	12.2%	12.4%	10.70%
Level of Outliers (Target: = TBC)	Under development			
Bed Occupancy (Target: = TBC)				
GP notification of discharge planning within 48 hours for patients >75 (Target: > 75%)	48.60%	46.20%	58.50%	51.50%
Accuracy of Predicted Discharge Date (Target: =)	18.60%	16.90%	20.0%	18.5%
Discharges between 8am and 11am (%) (Target: =)	6.00%	6.40%	5.60%	6.00%
Discharge Summaries Sent < 24 hours (Target: = 80%)	79.30%	78.80%	81.60%	79.90%
Emergency Re-Admissions within 30 days (adult and paed) (Target: = 3%)	3.40%	3.19%	3.22%	3.27%

Under development

Shaping A Healthier Future Programme

The emergency care dashboard is to be used as a precursor to the upcoming SAHF quality metrics dashboard. During the recent programme board, it was agreed that NWL and constituent organisations track metrics during the process of SAHF mobilisation. The above dashboard will be developed to meet this requirement for Chelsea and Westminster Hospital

Patient Safety

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Sub Domain	Month/Year	Jun-13	May-13	Apr-13	YTD
Harm	Confirmed Incidents of Hospital Associated VTE (Target: = 0.83)	1*	2	2 *	5*
	Inpatient falls per 1000 Inpatient bed-days (Target: < 3.00)	1.99	1.67	3.06	2.24
	Incidence - Newly Acquired Pressure Ulcers Grade 2 (Target: <1)	4	16	8	28
	Incidence - Newly Acquired Pressure Ulcers Grade 3 and 4 (Target: <3)	8	2	2	12
	Safety Thermometer - Newly Acquired Pressure Ulcers Grade 3 and 4 (Target: < 4)	4	8	4	16
	Safety Thermometer - Harm score (Target: > 90%)	95.20%	93.90%	94.40%	94.50%
HCAI	Clostridium difficile infections (Target: < 1.1)	0	0	0	0
	MRSA Bacteraemia (Target: < 0.5)	0	1	1	2
	Hand Hygiene Compliance (trajectory) (Target: > 90%)	97.60%	96.40%	96.70%	96.90%
	Screening all elective in-patients for MRSA (Target: > 95%)	95.12%	93.50%	88.50%	93.10%
	Screening Emergency patients for MRSA (Target: > 95%)	96.48%	98.60%	99.40%	97.87%
Incidents	Rate of pt. safety incidents resulting in severe harm / death per 100 admissions (Target: =0)	0	0	0	0
	Never Events (Target: = 0)	0	0	0	0
Pathways	Stroke: Time spent on a stroke unit (Target: > 80%)	100.00%	100.00%	100.00%	100.00%
	Proportion of people with higher risk TIA who are scanned and treated within 24 hours. (Target: > 75%)	100.00%	83.30%	71.40%	82.40%
	Fractured Neck of Femur - Time to Theatre < 36 hrs for Medically Fit Patients (Target: = 100%)	88.90%	90.00%	87.50%	88.90%
Mortality	Mortality (HSMR) (2 months in arrears) (trajectory) (Target: < 71)			63.9	63.9
	Mortality SHMI (Target: < 77)	Latest data – 78.00 (Jan 12 to Dec 12)			

Hospital associated preventable VTE – 2 cases of preventable VTE were reported in May. One patient had an acute infection and was relatively immobile, they were identified to be at high risk of VTE. The VTE risk assessment was incomplete with not all risk factors identified. Thromboprophylaxis was indicated on discharge, however this was not prescribed. 5 days after admission, a hospital associated PE was diagnosed. The second patient was admitted with chronic renal failure secondary to hydronephrosis caused by stent obstruction. The patient was identified to be at high risk of VTE (>4 risk factors) and was prescribed thromboprophylaxis. However 5 doses of the prescribed thromboprophylaxis were not administered before the DVT diagnosis was made during the patient's admission.

April and June have outstanding RCA's to be completed, to determine whether these incidents were preventable.

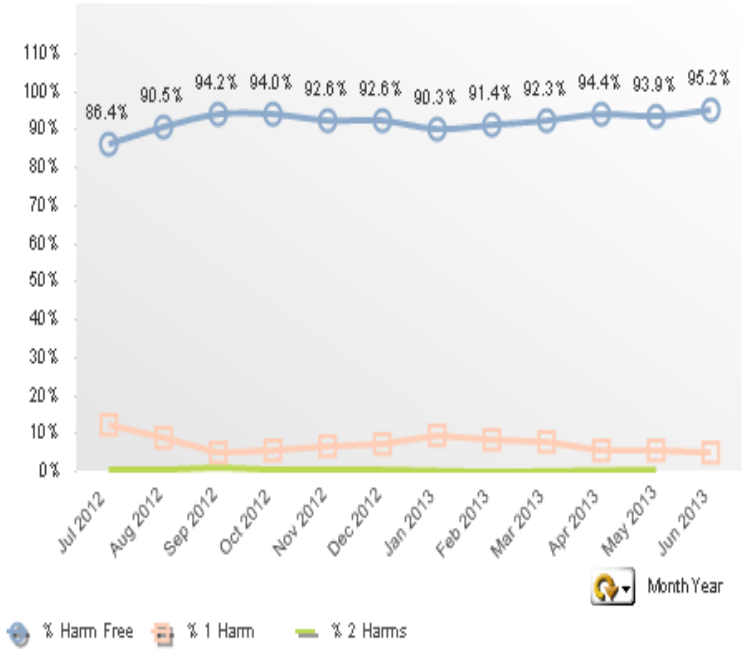
Inpatient falls – The reduction in the falls rate is a result of the continued focus of the Trust Preventing Harm Group which reviews all falls and implements mitigating actions

MRSA Bacteraemia – To date there have been 2 cases of MRSA; following the analysis of these cases; greater focus on prevention measures to minimise exposure have been addressed.

FNOF – One patient failed to reach theatre within the target time of 36hrs. This was due to a delay in a pre operative ECHO examination. Upon examination of the patient, a provisional report was given to the Ortho FY1 which needed verification by the Cardiology physiologist. By this time there were two emergency cases: ectopic pregnancies; and the on call anaesthetist decided that the patient's operation should not be done out of hours. Unfortunately the May performance has declined from 100% to 90% due to the exclusion in error of a patient who refused treatment but was medically fit.

Elective MRSA screening rate - The divisional teams and infection control are working together to maintain the achievement of the 95% target. This has two focuses – 1, the validating of data to incorporate those patients who are screened by GP's and those who have been incorrectly admitted as elective patients and 2, ensuring all elective patients are being screened within 3 months of admission. The work is being monitored by the Infection Control Committee.

Patient Safety – Focus on Harm



Division Name	Number of Harms	% Divisional Patients	Pats.
CLINICAL SUPPORT	No Harms	91.84%	45
	1 harm	6.12%	3
	2 harms	2.04%	1
MEDICINE AND SURGERY	No Harms	89.71%	2302
	1 harm	9.78%	251
	2 harms	0.47%	12
	3 harms	0.04%	1
WOMEN'S, NEONATOLOGY, CHILDREN'S AND YOUNG PEOPLE'S, HIV, SEXUAL HEALTH AND DERMATOLOGY	No Harms	98.35%	1189
	1 harm	1.65%	20
Total			**3819**

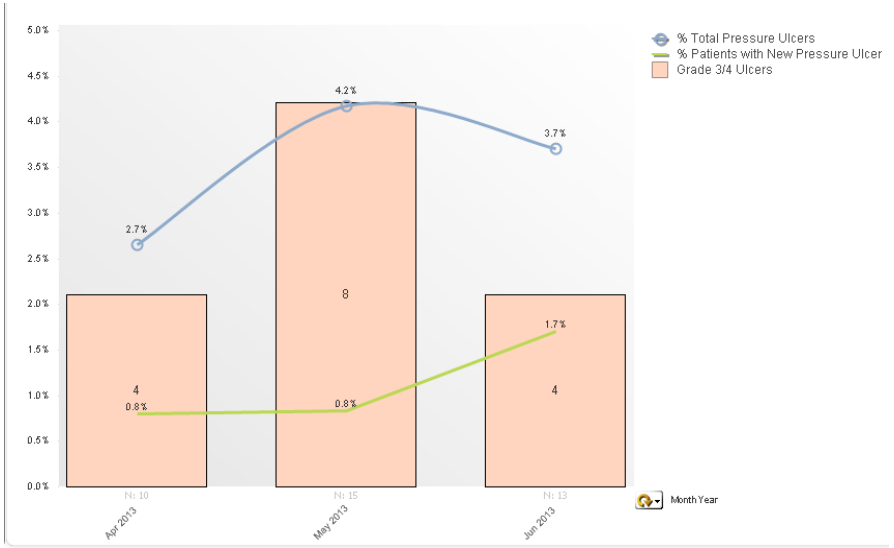
The safety thermometer tool, provides a snapshot of harm from pressure ulcers, urinary catheter infections, falls and venous thromboembolism. These four harms were selected as the focus by the Department of Health's QIPP Safe Care programme because they are common, and because there is a clinical consensus that they are largely preventable through appropriate patient care. The concept of Harm Free Care was designed to bring focus to the patient's overall experience.

During quarter one, the percentage of harm free care patients experienced has steadily been over 90% across these audits. June's performance of 95.2% is above the national average of 92.8%.

There were no falls with harm recorded in the June audit against a national percentage of 0.9% in June 2013 and 1.1% in June 2012.

Pressure Ulcer Prevention – An exciting new project has started where the Trust is working with McKinsey on reducing pressure ulcers campaign – we have named this POP (Pushing Off the Pressure). The initial focus is in AAU with a proactive MDT team working on a number of initiatives with the ultimate objective being no hospital acquired pressure ulcers. As the work develops, communication will be disseminated to inform the trust of progress.

The Trust continues to work hard both internally and with our community-based partners to reduce pressure ulcers . Work is currently being undertaken to understand the variation in performance in Q1 for pressure ulcer incidence. Standing panels have been established to review practice, learn where we could improve and share best practice. A key theme emerging is device related pressure ulcers, for example, oxygen tubing over the ear - we are taking some work forward to look at alternative devices. Another theme is patient compliance. In order to try and improve this, a patient information leaflet is being developed to support informed decision making by patients and carers.



Clinical Effectiveness

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Sub Domain	Month/Year	Jun-13	May-13	Apr-13	YTD
A&E	A&E Time to Treatment (Target: < 60)	01:01	01:03	01:05	01:03
	A&E waiting times (Target: > 98%)	98.70%	98.90%	98.10%	98.60%
	A&E: Unplanned Re-attendances (Target: < 5%)	5.55%	5.79%	6.08%	5.81%
	LAS arrival to handover more than 60mins (KPI 3) (Target: = 0)	0	0	0	0
Admitted Care	Day case rate Relative risk (Target: < 100)	103.7	98.8	101.4	100.3
	Elective length of stay relative risk (Target: < 100)	128.6	123.9	124.6	125.7
	Emergency Re-Admissions within 30 days (adult and paed) (Target: < 2.8%)	3.40%	3.19%	3.22%	3.27%
	Non-Elective length of stay relative risk (Target: < 100)	91.3	100.3	106.1	85.8
Best Practice	Time to theatre for urgent surgery (NCEPOD recommendations) (Target: > 95%)		95.70%	95.30%	95.50%
	Central line continuing care—compliance with Care bundles (Target: > 90%)	100.00%	100.00%	91.70%	98.10%
	Peripheral line continuing care—compliance with Care bundles (Target: > 90%)		87.00%	82.70%	85.00%
	Urinary catheters continuing care—compliance with Care bundles (Target: > 90%)	97.00%	89.90%	98.50%	95.10%
	% Patients Nutritionally screened on admission (Target: > 90%)	93.40%	92.50%	92.60%	92.80%
	% Patients in longer than a week who are nutritionally re-screened (Target: > 90%)	68.20%	77.00%	78.20%	74.40%
	Access to healthcare for people with a learning disability (Target: = 100%)	100%	100%	100%	100%
Best Practice CQUIN	VTE Assessment (Target: > 95%)	94.80%	95.00%	95.40%	95.10%
	Dementia Screening Diagnostic Assessment (Target: > 90%)	76.80%	74.80%	80.70%	77.90%
	Appropriate referral Dementia specialist diagnosis (Target: > 90%)	Q1 performance – 86%			86%
	12 Hour consultant assessment – Acute Admissions (Target: > 90%)	51.70%	35.90%	49.00%	45.20%

Unplanned re-attendances – The unplanned re-attendances within 7 days quality indicator has proved challenging for the Emergency Department since the standards were introduced. It has been discovered recently, that there may be concerns on the data quality. A manual audit was performed by one of the paeds consultants who discovered that in 1 month there had been approx. 160 unplanned re-attendances, however, approx. 60-70 of these were in fact planned but had been recorded incorrectly. At present the system , is not able to differentiate between planned and unplanned attendances when the planned patient does not present a hard copy of their reminder card. Work is currently underway to action this by the end of Q2.

Length of stay – Q1 performance shows us above target length of stay . The top three specialties with higher than expected length of stay YTD are T&O, Gynaecology and General Surgery. The surgical transformation project is on going with a focus on elective long stayers. As the trust moves to nurse led discharge, it is anticipated that we will gain larger efficiencies in bed occupancy and readmission rates. Across the trust, there is renewed focus on predicted date of discharge (PDD) planning, most notably through the implementation of online reporting of PDD for operational use.

Peripheral line care – A short life Intravenous Access Care Bundle Group is being set up with the purpose of achieving a minimum of 90% compliance with the vascular access care bundles across all divisions. It will meet every two weeks and will last 6 months. Upon closure of the group, care bundle scores will have been consistently above target for 3 months. This group will be a sub group of the Infection Prevention and Control Committee where it will report on progress on a monthly basis.

Nutritional re-screening – the Trust is performing well on nutritional screening of patients on admission, however re screening rates remain challenged. Fully completed rescreening = 68%. (below 90% target - this relates to 27 patients not re-screened in total 58/85). There are 3 areas with low compliance although 2 have significantly improved since the previous month. Area for focus is Edgar Horne who have recently undergone a refurbishment which was felt to contribute towards the low rescreening of patients, due to the lack of the electronic kitchen board prompting screening. The team have now returned to their permanent location and the expectation is that the rescreening will improve.

Dementia Screening diagnostic assessment – The Trust did not achieve the 90% target for dementia screening. Both the Acute assessment unit and the emergency observation unit underperformed significantly, with only 76.2% and 72.7% of patients screened respectively. Akin to last month, the importance of dementia screening has been cascaded; in addition, a dementia column has been added to the new patient list on LastWord. This will enable all staff to see which patients require the assessment in real time.

12 hour consultant assessment AAU – Compliance with this indicator is below the target level of 90% and falls well short of compliance with Adult Emergency Care Standards. This indicator is no longer a CQUIN target but continues to be an important quality metric and work will be undertaken with the acute teams to understand whether this is a recording issue with consultant assessment not being captured on Lastword, or represents more systematic issues.

Clinical Effectiveness - Maternity

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Indicator		Goal	Measure	Jun-13	May-13	Apr-13		YTD
NHS Deliveries	Benchmarked to 5184 per annum	420 per month	NHS	422	424	402		1248
Private Deliveries	Benchmarked to 840 per annum	72 per month	PMU	56	61	52		170
Trust Deliveries	Total Maternities (Mother)	492	Trust	478	485	454		1418
Births	Total NHS Births (infants)		NHS	436	431	409		1276
	Home births	6 mth (1.5%)		5	6	6		17
Norm. Vaginal Deliveries	SVD (Normal Vaginal Delivery)			190	196	185		572
	Maintain normal SVD rate	52%	SVD Rate	45.0%	46.2%	46.0%		
C- Section	Total C/S rate overall	<27%	reduce by 1%.	38.2%	38.4%	31.3%		
	Emergency C Sections		No. of patients	79	94	64		237
			%	18.7%	22.2%	15.9%		
	Elective C Sections		No. of patients	82	69	62		213
			%	19.4%	16.3%	15.4%		
Assisted Deliveries	Ventouse, Forceps Kiwi	10-15% (SD)	No. of patients	71	65	91		227
			%	16.8%	15.3%	22.6%		
PP Haemorrhage	Blood loss >4000mls		No. of patients	2	1	0		3
	Blood loss >2000mls	>10	PPH>2L	10	3	4		17
Perineum	3rd/4th degree tears	<5% (RCOG)		3	8	4		12
	Shoulder Dystocia			4	5	9		18
Stillbirths	Number of Stillbirths			1	3	2		6
	Maternity 12 week access	95%		95.3%	94.8%	91.0%		
Maternal Morbidity	Maternal Death		Incident Form		0	0		0
	ITU Admissions in Obstetrics	In 2 mths < 6	Patients		1	0		1
Serious Incidents	Serious Incidents (Orange Incidents)	0	Incidence	4	3	1		8
VTE	Assessments	90%		98.1%	97.0%	98.0%		
Trust Level Indicators	Breastfeeding initiation rate	90%		90.0%	91.5%	91.0%		
	Women smoking at time of delivery	<10%		4.7%	2.4%	2.5%		
	Turnaround times for letters	90%	< 5 days	73.4%	96.4%	94.5%		
	DSUMs completed in 24hrs	100%		97.1%	93.1%	96.9%		
	Discharge summaries sent in 24hrs	80%		82.8%	81.8%	86.5%		

Maternity performance has decreased in a number of areas, particularly post partum haemorrhage, spontaneous vaginal deliveries and caesarean sections. Work is on going to reduce the overall caesarean section rate; with the most recent consultant led review leading to the following actions:

1. Audit the women who had a caesarean for breech presentation to determine if they were offered or attempted alternatives
2. Further analysis of Robson group 4 to identify trends or lessons learnt
3. Increase review of the emergency caesarean sections by Consultants especially those women in Robson 2 group.
4. Consider a stronger position in relation to maternal choice and preference (running counter to the preservation of maternal choice)

Additionally, since June, a breech clinic has been implemented to assist in reducing the caesarean section rate.

An information letter has been developed and reviewed with the commissioners' Clinical Quality Group, explaining to women who are seeking a maternal choice CS that we are unable to offer this service. The letter has been trialled in antenatal clinic and well received so will be rolled out further

There are plans in place to increase activity and the number of deliveries (NHS and private); through business to business referrals, alongside development of the Midwifery Led Unit.

Relative to assisted deliveries; our performance is higher than the national average. A performance plan, will be in place during Q2 to understand the key drivers of the assisted delivery rate.

Patient Experience

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Sub Domain	Month/Year	Jun-13	May-13	Apr-13	YTD
Complaints	Complaints (Type 1, 2 and 3) - Communication (Target: NA)	17	24	23	64
	Complaints (Type 1, 2 and 3) - Discharge (Target: NA)	3	1	3	7
	Complaints (Type 1, 2 and 3) - Attitude / Behaviour (Target: NA)	14	19	16	49
	Complaints Re-opened (Target: < 5%)	N/A	2.40%	0.00%	2.40%
	Complaints upheld by the Ombudsman (Target: = 0)	0	0	0	0
	Formal complaints responded in 25 working days (Target: > 90%)	N/A	82.00%	82.00%	82.00%
	Total Formal Complaints (Target: NA)	N/A	34	33	67
Cancellations	Hospital cancellations \ reschedules of outpatient appointments % of total attendances (Target: < 8%)	18.20%	15.60%	17.00%	16.90%
Friends and Family Test	Friends & Family Test - Local +ve score (Trust) (Target: > 90%)	94.00%	96.00%	92.00%	95%
	Friends & Family Test - Net promoter score (Target: > 13)	16	15	13	15
	Friends & Family Test - response rate (Target: > 15%)	24.00%	22.00%	20.00%	22.04%
	Breach of Same Sex Accommodation (Target: = 0)	0	0	0	0

Formal Complaints response rate within 25 days – 82.00% of formal complaints were responded to and resolved by the Directorates within 25 days (complaints received in May are the latest available figures), this falls below the Trust target to respond to 90% within 25 days. Performance was 81.82% in April and 82.35% in May, which shows a slight improvement; overall there were 67 type 2 complaints received and 12 breaches across April and May.

The Complaints team continues to work with the divisions to achieve the required turnaround time for responses, most notably through weekly meetings with each of the divisions to review their complaints and ensure everyone is aware of the timeframes. The complaints team provides weekly logs for each division, alongside quarterly reports for the divisions outlining their performance and any themes identified by complaints.

A weekly report is sent to and discussed at Trust Execs, this details the new complaints received but also highlights any overdue complaints that week. The Divisional Directors are required to provide an update against any outstanding complaints and to ensure that these are followed up. In addition, there is now a weekly meeting with the Director of Nursing, the Head of Governance, and senior members of the Divisions to discuss type 3 complaints and Incidents.

Hospital Initiated Cancellations – The HIC rate is high and is a combination of late notice cancellation of outpatient sessions (> 6 weeks notice) repeated cancellation of patients and a reduction in the number of patients booked onto clinics. Ophthalmology, Dermatology and General Surgery are specialties with consistently high HIC rates.

The McKinseys / Disney Programme of Improving Patient Experience commenced in July and is working with the dermatology outpatients team. The first high impact change identified by the team was to change the wording of the OPD letters in Dermatology to help set realistic expectations on waiting times and also direct patients to the kiosks outside the department for check in. We have mocked up two versions and asked 30 patients which they prefer. There was a clear choice and we are now working with EPR to make and test the change within a week.

Friends and family test – Since April 2013, the friends and family response rate has continuously been above target with June performance reporting the highest response rate of 24% and a net score of 16. Ahead of the October 2013 official start date; maternity services will become early implementers of the Friends and family test. FFT is a CQUIN and the trust must attain a minimum response rate of 15%.

Access and Efficiency

Sub Domain	Month/Year	Jun-13	May-13	Apr-13	YTD
RTT	18 week referral to treatment times Admitted Patients (Target: > 90%)	91.71%	90.10%	90.10%	90.58%
	18 week referral to treatment times Non Admitted Patients (Target: > 95%)	98.73%	97.70%	97.00%	97.30%
	18 week RTT incomplete pathways (Target: > 92%)	93.94%	93.40%	93.30%	93.59%
	RTT Incomplete 52 Wk Patients @ Month End (Target: = 0)	0	1	1	2
OP	Choose and Book slot issues (Target: < 2.0%)	1.90%	1.60%	3.80%	2.40%
Cancer	Cancer urgent referral Consultant to treatment waiting times (62 Days) (Target: > 90%)	100.00%	100.00%	100.00%	100.00%
	Cancer urgent referral GP to treatment waiting times (62 Days) (Target: > 85%)	86.70%	88.50%	87.50%	87.70%
	Cancer diagnosis to treatment waiting times - Subsequent Surgery (Target: > 94%)	No Pts	No Pts	No Pts	No Pts
	Cancer diagnosis to treatment waiting times - Subsequent Medicine (Target: > 98%)	No Pts	No Pts	No Pts	No Pts
	Cancer urgent referral to first outpatient appointment waiting times (2WW) (Target: > 93%)	96.40%	94.20%	96.00%	95.50%
	Cancer diagnosis to treatment waiting times - 31 Days (Target: > 96%)	100.00%	97.10%	96.30%	97.40%
Referrals	Number of referrals (Target: = NA)	12443	13958	14428	40829
OP/ IP Waits	Average week wait for new outpatient appointment (Target: = NA)	7.07	6.99	6.94	TBC
	Average week wait for new inpatient appointment (Target: = NA)	7.47	7.60	7.62	TBC

RTT Incomplete 52 week patients: The Trust reported a small number of long waiting patients in Q1, which related to process improvement and validation work to improve the management of incomplete RTT pathways. This work is now complete and all long waiting patients have been dealt with. The performance and divisional teams are actively engaged with both commissioners and with best practice guidance to ensure that robust pathway management continues going forward.

Choose and Book Slot Issues – The Trust has achieved a significant reduction in CAB slot issues during 2012/13 and following the increase in April; we have maintained performance below 2%.

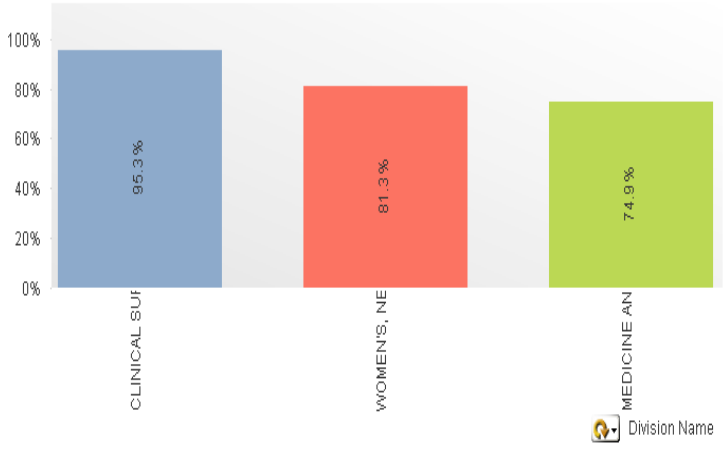
The appointments team will continue to work with specialties to highlight problem areas and release additional capacity.

FURTHER INFORMATION ON THE WORK UNDERWAY TO IMPROVE WAITING TIMES FOR OUR SERVICES IS PROVIDED IN THE FOCUS REPORT

Access and Efficiency

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Sub Domain	Month/Year	Jun-13	May-13	Apr-13	YTD
Admitted	Delayed transfers - Patients affected (Target: < 0)	Under development			N/A
	No urgent op cancelled twice (Target: < 0)	0	0	0	0
	On the day cancellations not rebooked within 28 days (Target: = 0)	0	0	0	0
	Theatre booking conversion rate (Target: > 80%)	88.20%	87.20%	88.00%	87.80%
	Theatre Active Time - % Total of Staffed Time (Target: > 70%)	73.30%	68.90%	75.80%	70.00%
DQ	Coding Levels complete - 7 days from month end (Target: > 95%)	90.80%	93.00%	93.70%	93.50%
GP Real time	GP notification of an A&E-UCC attendance < 24 hours (Target: > 90%)	79.70%	38.70%	97.80%	71.8%
	GP notification of an emergency admission < 24 hours (Target: > 90%)	95.90%	96.10%	96.10%	96.00%
	GP notification of discharge planning within 48 hours for patients >75 (Target: > 75%)	48.60%	46.20%	58.50%	51.50%
	Discharge Summaries Sent < 24 hours (Target: > 80%)	79.30%	78.80%	81.60%	79.90%
	OP Letters Sent < 7 Working Days (Target: > 90%)	88.50%	93.00%	93.00%	91.50%
OP	DNA Rate (Target: < 11%)	10.10%	11.00%	11.00%	10.70%



Discharge Summary Q1

Q1 performance shows that each division is sending over 70%, of their discharge summaries within the target time. More work needs to be done, to move from the amber threshold and back into the target time as was achieved in April this year.

A&E/UCC attendance notification - The Trust only sent 38.7% of notifications within 24 hours in May. This was due to an error in the interface between the data warehouse and the interface engine for UCC patients only (i.e. the problem related to data from Adastra), where the notification of attendance was not electronically sent for all of May (with the exception of 1st May). The error has now been fixed but the date and time of all notifications sent is the date of the fix in early June. This has very significantly affected the Quarter 1 performance although it should not recur.

Discharge planning notifications for patients >75 – the Trust only sent notification of the planned date of discharge (PDD) for emergency admissions of elderly patients in half of cases in Q1. Improving the completion of and accuracy of PDDs will be a key focus on the Emergency Care Pathway project.

DNA Rates - Reducing DNA rates has been widely promoted trust wide with a myriad of initiatives. Most recent action plans in place include super user training to establish expert users with increased knowledge of the access policy; in addition to 1:1 training with all staff in the Appointments Office. A weekly DNA focus meeting has been established where rates by speciality are analysed and target areas are brought forward for extra examination and opportunities for improvement. Patient demographics and profiles are discussed alongside the quantitative figures, so the rate of non attendance within specific groups can be addressed and communication to patient groups can be enhanced further.

Largest variances from DNA Target (June 2013)

Speciality	Target DNA %	DNA Rate	DNAs	Expected DNAs	DNA reduction required
Trust level	**11.08%**	**10.14%**	**4147**	**4531**	384
BARIATRIC SURGERY	**10.75%**	**20.66%**	**119**	**62**	-57
OBSTETRICS	**9.70%**	**11.19%**	**377**	**327**	-50
PAIN MANAGEMENT	**10.50%**	**16.44%**	**107**	**68**	-39
OPHTHALMOLOGY	**11.70%**	**13.94%**	**211**	**177**	-34
ECG	**3.25%**	**5.45%**	**64**	**38**	-26
GENERAL SURGERY	**10.75%**	**13.36%**	**122**	**98**	-24
DERMATOLOGY WPCT	**10.65%**	**16.38%**	**58**	**38**	-20
GYNAECOLOGY WPCT	**9.30%**	**19.21%**	**34**	**16**	-18
ORTHODONTICS	**10.60%**	**15.30%**	**54**	**37**	-17
ANTICOAGULANT SERVICE	**8.05%**	**10.56%**	**64**	**49**	-15
GASTROENTEROLOGY	**14.50%**	**16.04%**	**128**	**116**	-12
NEUROLOGY	**13.70%**	**15.73%**	**73**	**64**	-9

Sub Domain	Month/Year	Jun-13	May-13	Apr-13	YTD
HR	Agency Staff % (Target Q1: < 3.65%)	4.80%	4.50%	5.10%	4.80%
	Average Recruitment Time (Target Q1: < 70)	61	67	65	64
	Vacancy Rate (Target Q1: < 8%)	7.98%	7.89%	7.59%	7.82%
	Appraisal completion rate (Target Q1: > 84%)	83.00%	80.00%	81.00%	82.00%
	Sickness Rate (Target Q1: < 3.68%)	3.03%	3.27%	3.31%	3.21%
	Turnover Rate (Target Q1: < 13.5%)	14.80%	14.70%	14.41%	14.64%
	Mandatory Training (Target Q1:>73%)	75.00%	73.00%	73.00%	74.00%
	Staff Engagement (Target Q1: >4*)	4.07	4.00	4.22	4.10

*Source 2012 NHS Staff Survey (weighed data)

Areas for focus

Bank & Agency Usage – The Trust showed an increase in Bank and Agency usage for June, up by 83.48 WTE on June 2012, with both bank and Agency registering an increase on the previous year. Nursing remains the largest cohort of Agency staff at nearly 8.7% of the Nursing workforce. Agency usage is being reviewed actively by Human resources and senior managers to identify actions needed to reduce the use of Agency staff. Staffbank recruitment campaigns are planned for the remainder of the year to increase our pool of available temporary workers.

Turnover – In June the Trust staff in post position stood at 2978.17 WTE (whole time equivalents) with the substantively employed workforce increasing by 50.93 WTE (1.74%) since June 2012. Unplanned turnover (i.e. resignations) stood at 14.80% for the month, with all Divisions registering an increase against last year. This trend in increasing turnover has continued since Q4 2012/13. The most commonly stated reasons for leaving are due to promotion or relocation. Human Resources has refreshed its exit interview process to help us understand the reasons for this increased turnover better.

Appraisals
The trust made progress towards it's target of 84% of staff; having received an appraisal within the last 12 months. Fortnightly reporting of over due appraisals began in June, to support further improvement in advance of the staff survey being published in September.

Positives

Vacancies – The Trust's vacancy rates are calculated using the budgeted WTE (based on reconciliations with the Finance department), and the WTE of staff inpost at the end of the month. This represents the 'total vacancy' position. The full Trust vacancy rate for June 2013 was 7.98%, a decrease of 0.61% on the previous year. Although the overall position shows an improvement on last year, the vacancy rates for the Women, Children and Sexual Health Division, as well as the Nursing & Midwifery staffgroup across the Trust showed an increase on the previous year. The average time to recruit continued to remain within target for June at 61 days.

A truer measure of vacancies is those posts being actively recruited to, based on the WTE of posts being advertised through NHS jobs throughout June 2013. The active vacancy rate is currently 2.55%, which is below target for the month and year.

Sickness Absence – The Trust's sickness absence rate in June 2013 was 3.03% (3.21% ytd) which was lower than June 2012 (3.82%). The sickness target for the year has been set at 3.6% and the QIPP project begun in 2012 is continuing in 2013/4 to support this reduction. HR is currently reviewing the issue of non-reporting and will be implementing changes to improve compliance.

Employee Engagement - The Trust commenced its pilot of local staff surveys in April 2013. In June, staff in Therapies, Chief Nurse and the West London Centre for Sexual Health As a proxy for staff engagement we will be measuring staff willingness to recommend the Trust either as a place for friends or relatives to receive treatment ('Friends and Family' test) or as a place to work. On a Likert scale of 1-5, where 5 is the most positive; the overall score for staff willingness to recommend the Trust was 4.07 in the June surveys, with a YTD measure of 4.10. This compares favourably with a score of 3.87 in the 2012 NHS Staff Survey.

Health and Safety – Mandatory Training

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Training compliance against trust wide health and safety policies.

Sub Domain	Divisional Performance – June 2013	Medicine and Surgery	Women's Services and Children	Clinical Support		Trust Level
Health and Safety	Fire Training	63.00%	63.00%	70.00%		65.00%
	Moving and handling	59.00%	68.00%	74.00%		67.00%
	Health and Safety	58.00%	69.00%	72.00%		66.00%
	Harassment	80.00%	79.00%	83.00%		79.00%
	Information governance	67.00%	64.00%	72.00%		69.00%

This slide illustrates some key performance indicators for health and safety mandatory training. The targets for achievement of training are set as a trajectory which will be increased as performance improves.

Other KPIs have been agreed and are in development and these will look at a wide range of health and safety activities in addition to training e.g. completion of COSHH risk assessments, falls risk assessments. Lone working risk assessments and spot checks.

Rag Ratings	
<50%	
<> 51 and 73	
>73	

Finance Balanced Scorecard

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Financial Performance

Financial Position (£000's)

	Full Year Plan	Plan to Date	Actual to Date	Mth 3 YTD Var	Mth 2 YTD Var	Forecast
Income	(349,000)	(86,023)	(86,148)	124	(446)	(349,728)
Expenditure	316,016	78,658	80,341	(1,683)	(1,236)	323,747
EBITDA for FRR excl Donations/Grants for Assets	29,531	6,365	4,806	(1,559)	(1,681)	22,528
EBITDA % for FRR excl Donations/Grants for Assets	8.5%	7.5%	5.6%	-1.8%	-2.9%	6.5%
Surplus/(Deficit) from Operations before Depreciation	**32,984**	**7,365**	**5,806**	**(1,559)**	**(1,681)**	**25,981**
Interest	829	212	211	1	2	823
Depreciation	12,907	3,242	3,138	104	69	12,907
Other Finance costs	0	(0)	0	(0)	(0)	0
PDC Dividends	10,241	2,559	2,559	0	0	10,236
Retained Surplus/(Deficit) excl impairments	**9,007**	**1,352**	**(101)**	**(1,453)**	**(1,610)**	**2,015**
Impairments	0	0	0	0	0	0
Retained Surplus/(Deficit) incl impairments	**9,007**	**1,352**	**(101)**	**(1,453)**	**(1,610)**	**2,015**

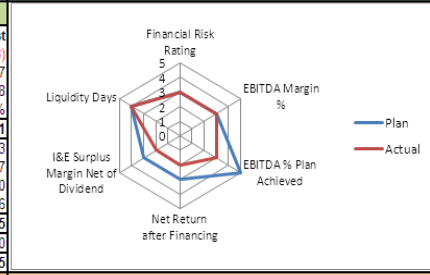
Comments

Risk Assessment
Impact 5 (Loss of more than £5m), Likelihood 3 (Possible); Internal> Red

The month 3 position is a deficit of £0.1m (EBITDA of 5.6%), which is an adverse variance of £1.5m against plan.

I&E Deficit (£1.5m); includes the following material items:
- Over-performance in NHS Clinical contract income (including excluded drug income)
- Private Patient income under-plan (£0.4m predominantly within Overseas, PMU & ACU)
- Pay position adversely affected by £1.5m unachieved CIPs
- Drugs expenditure (£0.9m) overspent, although largely offset by excluded drugs income

Risk Rating (year to date)

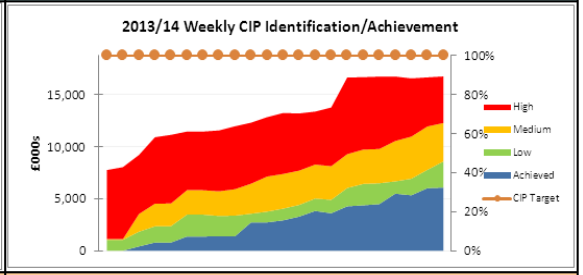


Comments

The FRR YTD for Month 3 is a 3, in line with the planned 3 rating for the first quarter. However the actual rating is a 2.85 rounding up to a 3, rather than the planned 3.45. The key issue is the YTD deficit position which is causing the EBITDA margin, Net Return after Financing and I&E surplus margin metrics to be lower than planned.

The COSR rating YTD is a 3 against a planned 3.

Cost Improvement Programme



Comments

CIPs 13/14
The CIP target for 13/14 is £18.7m (£16.9m for 13/14 + £1.8m b/f from 12/13).
Schemes totalling £16.7m have been identified towards the 2013/14 target.
This £16.7m represents 89% identification and includes 32% achievement.

Trajectory
It was proposed that all Divisions should have identified 100% of CIP schemes by 31st May.
It is then proposed that the following achievement trajectories to be met:
70% achieved by 31st July 2013
75% achieved by 31st Aug 2013
(Followed by a further detailed trajectory of 100% achievement by 31st Jan 2014).

Service Line Reporting (Referenced to EBITDA) - *NB: this is month 12 2012/13*

Directorate Split (incl. some specific specialties)	Activity	Income (£000s)	Cost (£000s)	EBITDA (£000s)	EBITDA %	Surplus/Deficit (£000s)
Surgery Total	**113,874**	**58,522**	**54,062**	**4,460**	**7.6%**	**(1,333)**
Accident & Emergency - Adult	31,951	7,447	7,791	(344)	-4.6%	(960)
Medicine Other sub-total	96,501	52,112	51,821	291	0.6%	(3,789)
Medicine Total	**128,452**	**59,559**	**59,612**	**(53)**	**-0.1%**	**(4,749)**
A&E Child & Paediatric Community sub-total	2,980	571	592	(22)	-3.8%	(113)
Paediatric Medicine sub-total	25,138	15,993	14,656	1,337	8.4%	(4)
Paediatric Surgery sub-total	36,288	18,333	15,979	2,354	12.8%	575
NICU & SCBU	13,338	11,673	12,299	(626)	-5.4%	(1,320)
Paediatric HDU	1,940	2,929	1,683	1,245	42.5%	1,171
Neonatal, Children's & Young People Total	**91,441**	**52,599**	**49,077**	**3,522**	**6.7%**	**(553)**
Women's Total	**115,852**	**48,981**	**41,149**	**7,832**	**16.0%**	**4,431**
GUM	120,640	20,788	15,126	5,661	27.2%	5,054
HIV	44,813	63,046	54,160	8,887	14.1%	7,777
Dermatology	27,564	4,931	5,710	(779)	-15.8%	(1,309)
HIV, Sexual Health & Dermatology Total	**193,017**	**88,765**	**74,995**	**13,770**	**15.5%**	**11,522**
Clinical Support Total	**72,708**	**17,299**	**14,577**	**2,722**	**15.7%**	**1,620**
Private Patients & Other Total	**16,130**	**5,665**	**3,205**	**2,460**	**43.4%**	**2,105**
Total Trust	**731,474**	**331,390**	**296,678**	**34,712**	**10.5%**	**13,043**
POD Split						
Elective		22,718	24,036	(1,318)	-5.8%	(3,764)
Daycase		32,581	26,733	5,849	18.0%	3,461
Non-Elective		80,304	84,095	(3,791)	-4.7%	(11,570)
Other		41,111	41,352	(241)	-0.6%	(2,769)
Outpatients		153,181	118,891	34,290	22.4%	27,823
Outpatient Procedures		540	556	(16)	-2.9%	(24)
Community		955	1,017	(62)	-6.5%	(116)
Total Trust		**331,390**	**296,678**	**34,712**	**10.5%**	**13,043**

Comments

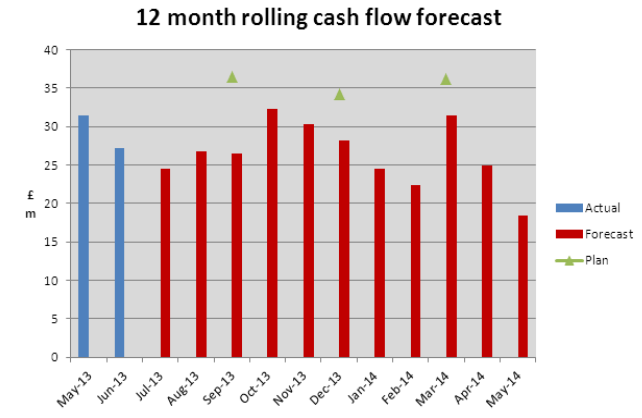
The table above summarises the SLR position for Directorates/Divisions to the end of month 12 of 2012-13. (Month 2 2013/14 SLR due this week).

Key Financial Issues

Key Issues
- **CIP 13/14 identification and achievement - including fye's of 12/13 (b/f)**
- **Recovery plans to improve the forecast to the - planned surplus**
- GUM Public Health commissioning & payment
- Impact of Francis Report; including QIA on CIPs
- Delivery of the Trust's activity plan
- Achievement of new commissioner metrics
- Achievement of CQUIN targets for 2013/14

Future Developments
- Strategic developments e.g. West Midd, SaHF
- West Middx at the Strategic Outline Case stage
- Operationalising the capital plan
- ED capital redevelopment

Cash Flow



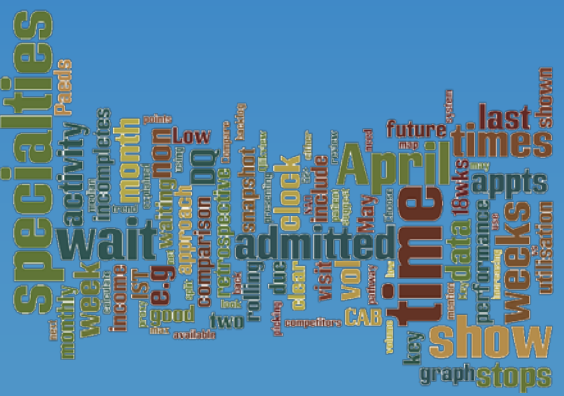
Comments

The cash position as at Month 3 is £27.2m, £11m below plan. The key issues driving the adverse variance are the YTD I&E deficit, together with trade receivables being above plan and trade and other payables being below plan. The key issue within trade receivables is the increase in NHS receivables of £3.4m in month - this relates to i) Issues with agreeing the activity to be transferred between CCGs and NHS England, resulting in CCGs part paying Q1 invoices until contracts are signed and ii) Issues with the transfer of GUM commissioning from PCTs to Local Authorites. Both issues have been escalated and the cash position is expected to improve going forward.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Access Deep Dive

Performance to 30 June 2013



This update is designed to give the Board a view of progress on reducing waiting times in key specialties across the Trust.

Trust level data is presented on referrals, activity and waiting times, with supporting information about how GPs and patients access our services (Choose and Book) and how we manage efficiency (DNA rates).

Overall, referrals to the Trust have been increasing slightly since April 2012, with a peak of 14,500 referrals received in April 2013. In this context, an increase in outpatient activity has been delivered while maintaining a broadly stable waiting time. Of note at Trust level, an increased level of elective admitted patients have been seen while also delivering a slight reduction in the waiting time for admission of approximately 5 days (now an average of 7 ½ weeks in June 2013).

The report then focuses on each specialty where we aimed to reduce waiting times through the access initiative started in September 2012. Commentary is provided on what has been delivered and future actions planned.

Good progress has been delivered in Trauma & Orthopaedics, Paediatric Dentistry, Paediatric Surgery and Urology, and in Endoscopy.

In T&O an increase in referrals has been seen, potentially reflecting a decision by commissioners to direct work towards Chelsea and Westminster from competitor trusts with long waits. Although outpatient waits have remained stable at around 8-9 weeks, a reduction of 4 weeks in the wait for elective admission has been delivered since April 2012, to under 9 weeks in June 2013.

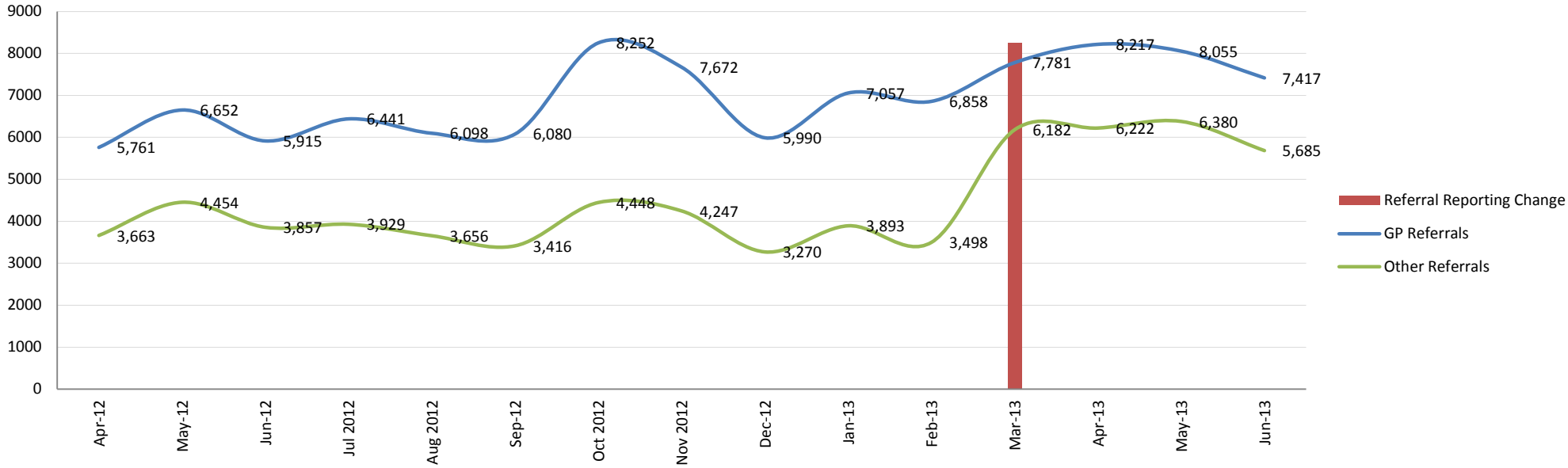
There is further work to do on a number of other specialties particularly where outpatient waits have been difficult to manage in the context of variable referral patterns, for example, Gynaecology, Dermatology and Neurology.

Elective admission waits have been significantly reduced in both Paediatric Dentistry and Surgery/Urology, through the implementation of greater efficiency in theatre utilisation. Endoscopy has delivered its target wait of 4 weeks.

What is the Demand for Services?

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Referrals to C&W by GP/Dental or Other Referral Source



Increasing demand

The number of referrals to the Trust has been increasing since April 2012 to date. However, referral numbers are quite variable and there are seasonal peaks in spring (May) and autumn (October).

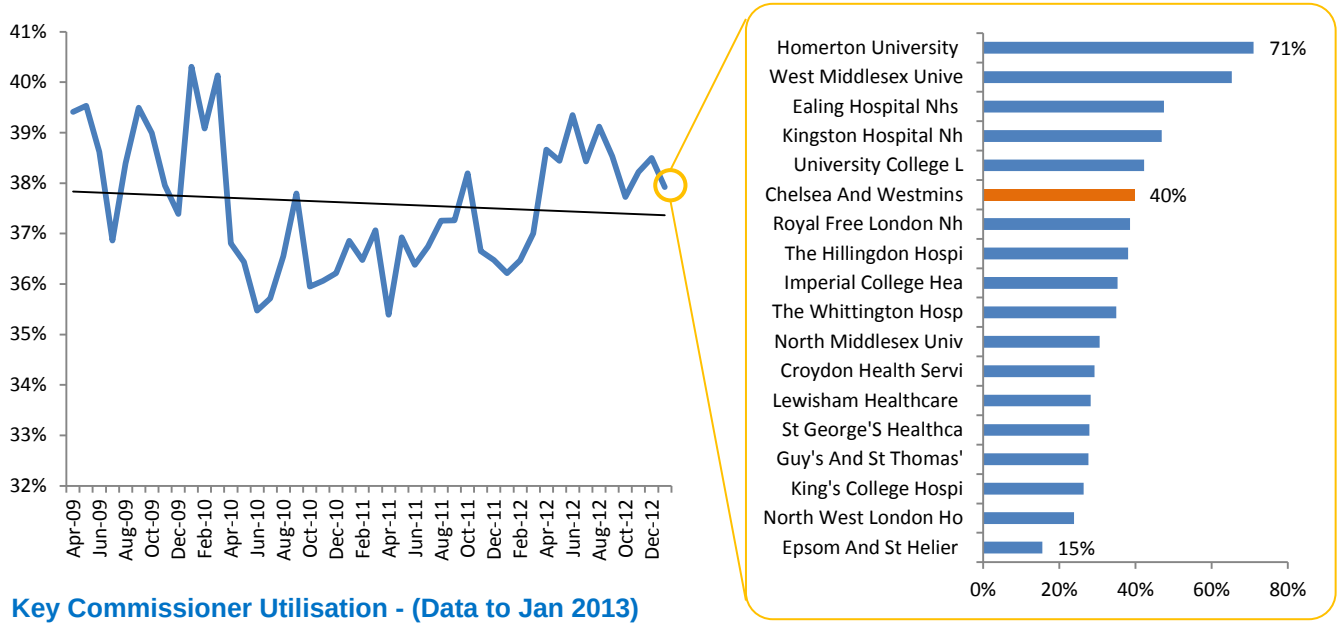
More accurate reporting

Until February 2013, the Trust's PAS system Lastword was unable to robustly record referrals received. Our referral numbers were based on a Referral database, where the 1st transaction date was used as a proxy when there was no Referral Received Date. From March 2013 onwards a fix in Lastword has enabled the Trust to use the Referral Received Date (RRD) to monitor referral numbers.
The new method of counting referrals by RRD is more accurate and the step change in non-GP (Other) referrals is likely to be explained by under-reporting up to February 2013 rather than a genuine step increase in demand.

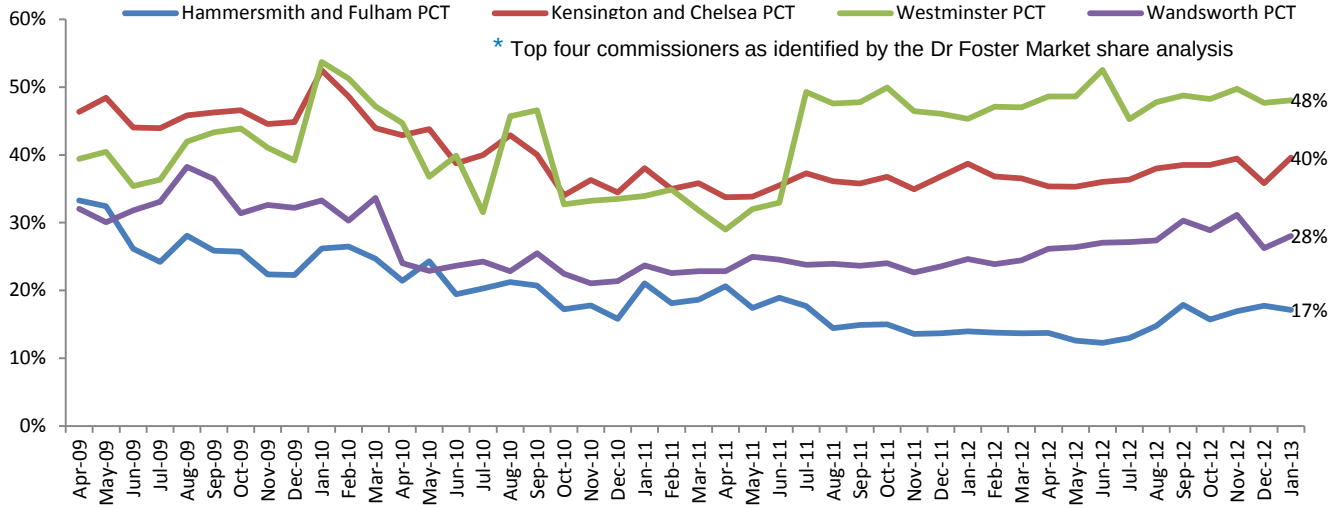
How are services accessed? - Choose and Book

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

London wide Usage of Choose and Book remains at ~38% (Data to Jan 2013)



Key Commissioner Utilisation - (Data to Jan 2013)



Data source – Chose and Book Utilisation report May - here

Choose and Book is the electronic referral and appointment booking system available to GPs in their practices and to patients over the internet. It allows GPs and patients to book new appointments directly into the hospital PAS system as well as to view information on the services we offer.

Choose and Book Utilisation

Hammersmith and Fulham (H&F) have had a consistent decrease in referrals through Choose an Book (C&B). In April 2013 H&F generated and estimated 3,937 referrals (based on the national monthly activity return) of which 816 referrals (21%) where made through C&B. Within H&F there are four practices (The Medical Centre, Dr Jefferies & Partn, Shepherds Bush Medical Centre, Fulham Cross Medical Centre and The Lilyville Surgery) that are in the lowest 95th percentile nationally.

GP Practices were historically financially incentivised to use Choose and Book and since the removal of this incentive take up of the system has not been pushed forward.

As part of contract negotiation, improving Choose and Book referral rates has been discussed with CCG commissioners. A plan is being drawn up by our GP Relationship Manager and the Appointments Office to move away from paper based referrals. The first step will be to require referrals to be made by email (and fax to email) through a single point of contact instead of paper letters. GP and CCG feedback suggests that this will be supported and accepted by the majority of referrers so is thought to be low risk. A second step to encourage GPs to use Choose and Book only is under consideration.

Slots Available to Choose and Book

For each service live on Choose and Book we make all new slots available for GPs to book . We do not ring-fence any routine capacity for booking internally.

The fact that we are at 40% utilisation is a reflection of the GP utilisation in our area rather than a lack of slots online.

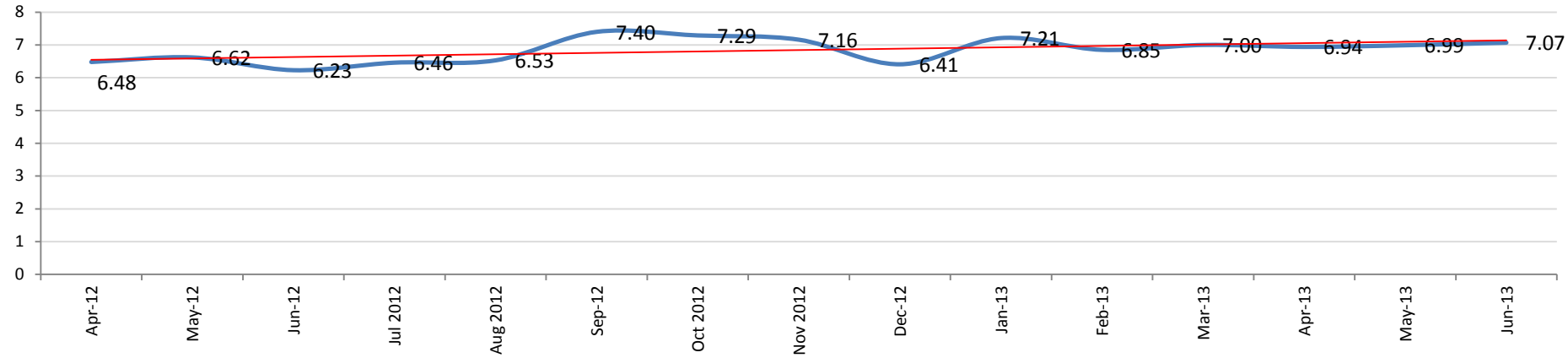
It is far more efficient for us to receive appointments through CaB rather than a paper, faxed or email referral as the patient will be registered automatically and the appointment will also be made electronically. This could save us upward of 4 or 5 minutes of administrative time per referral.

It is also a better patient experience as patients will have an opportunity to choose where they would like to be seen as well as a convenient appointment date and time.

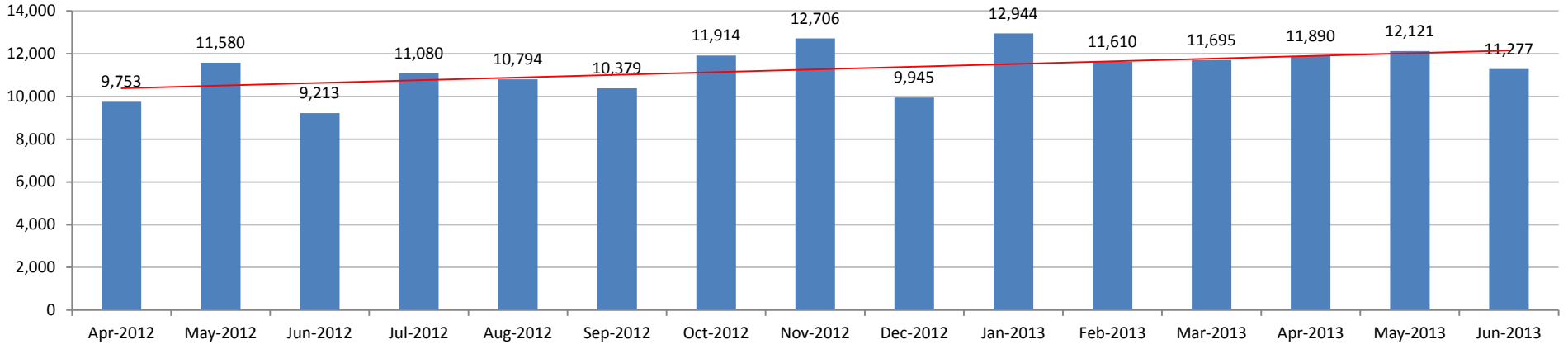
Trust Average Waiting Times for New OP Appt (Weeks)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

New OP Attendances – Average Wait (Weeks) from Referral Received Date to Attendance Date



New OP Attendances – Number of Attendances by Month



Broadly stable waiting times at Trust level, with increasing activity

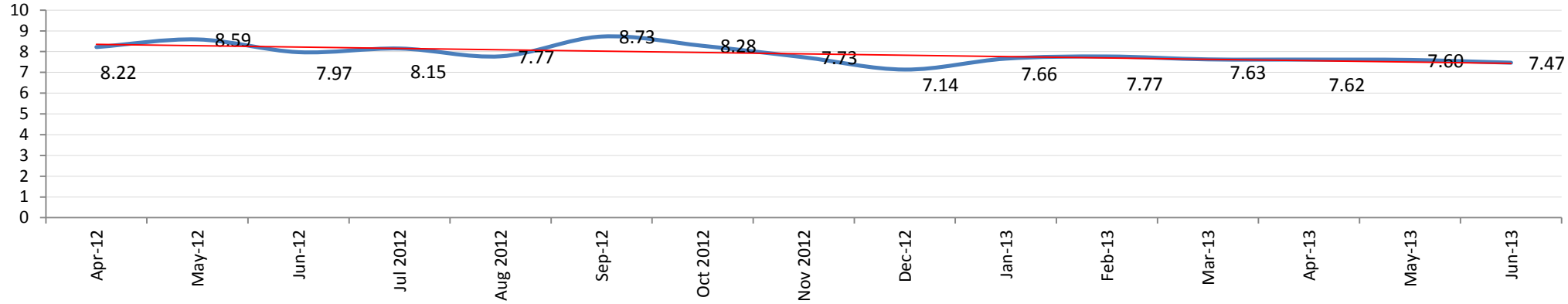
Average Waits for the Trust for a New OP Appointment have remained fairly constant since April 2012. Waiting time has been consistently at 7 weeks for the last four months.

The number of New OP Attendances for the Trust has increased from 9753 to 11277 between April 2012 and June 2013. Combined with the increase in referrals, we have delivered an increase in activity while maintaining the same waiting time.

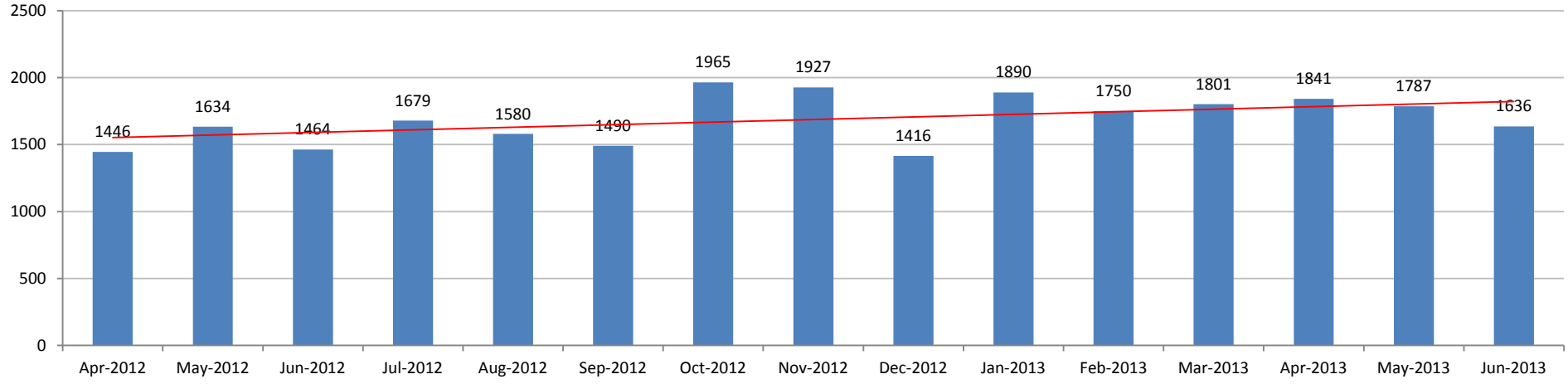
Trust Average Waiting Times for Elective Admission (Weeks)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Elective Admissions – Average Wait (Weeks) from Decision to Admit to Attendance Date (Unadjusted)



Elective Admissions – Number of Admissions by Month



Slightly decreased waiting times at Trust level, with increasing activity

Average Waits for the Trust for an elective admission from Decision to Admit (DTA) have not changed dramatically but a decrease of on average 5 days (9% decrease) has been delivered between April 2012 and June 2013. Waiting times have been fairly stable at around 7 ½ weeks over the last 6 months.

This is in the context of an increase in elective admissions over the same time period with admissions 16% higher in Q1 2013/14 (5,264) compared to Q1 2012/13 (4,544). Therefore the Trust has maintained focus on delivering a higher throughput of elective activity while improving waiting time.

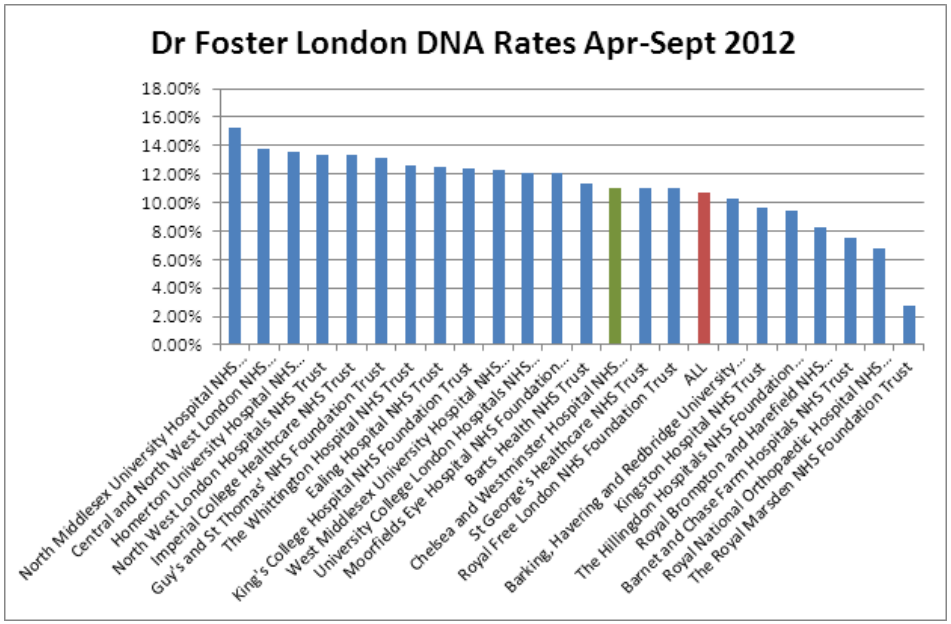
Do we use our capacity effectively? - DNAs

Trust level DNA rate year to date stands at 11.05% . The Trust performs reasonably well on DNA rates against London peers and is just slightly above the average, which is illustrated below.

Other Trusts with similar case mixes delivering better DNA performance include Kingston Hospital and Hillingdon Hospital. An improvement project has been initiated with colleagues at Hillingdon Hospital to understand whether there is best practice that could be applied to our Trust.

Daily updated DNA information is available on the Trust's online reporting system Qlikview and data quality reports relating to patients who DNA and are rebooked in breach of the Access Policy have been introduced. Operational teams are using these reports to actively manage compliance.

Hospital initiated cancellations can also be a cause of patients failing to attend appointments, if they are inconvenient or notifications go astray. The YTD hospital initiated cancellation rate is 16.9% and we aspire to reach a sustainable maximum of 8%.



London has historically had a significantly higher DNA rate than the national average and the detailed performance by specialty against London medians is shown below

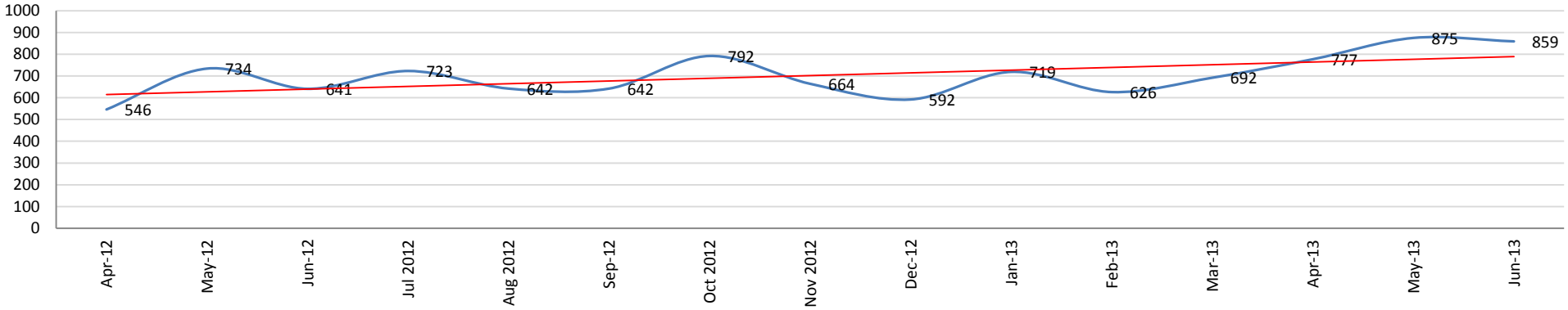
Spec	CW DNA Rate	London Average	Median DNA Rate (London Trusts)	CW - London Rank Postion	Percentile	Performance
Dermatology	14.0%	8.8%	10.7%	26		Above Target
Orthodontics	15.5%	9.8%	10.6%	12		Above Target
Pain Management	17.8%	9.3%	10.5%	20		Above Target
Anaesthetics	17.6%	10.0%	10.4%	16		Above Target
Paediatric Cardiology	19.6%	8.2%	14.9%	13		Above Target
Endocrinology	14.6%	11.0%	13.4%	17		Above Target
Vascular Surgery	13.4%	9.7%	11.7%	14		Above Target
Diabetic Medicine	16.8%	12.8%	15.3%	15		Above Target
General Surgery	11.3%	9.2%	10.8%	17		Above Target
Hepatology	17.0%	13.3%	16.7%	7		Above Target
Cardiology	12.8%	9.2%	12.2%	15		Above Target
Ophthalmology	13.0%	10.9%	11.7%	15		Above Target
Paediatric Dentistry	13.0%	11.1%	13.0%	4		Above Target
Rehabilitation	11.8%	10.4%	11.8%	7		Above Target
Gynaecology	9.5%	8.4%	9.3%	15		Above Target
Plastic Surgery	12.5%	9.9%	11.5%	12		Above Target
Physiotherapy	10.3%	11.2%	11.2%	10		Below Target
Anticoagulant Service	7.5%	7.4%	8.1%	9		Below Target
Neurology	13.1%	11.2%	13.7%	12		Below Target
Paediatric Surgery	16.2%	14.0%	17.2%	7		Below Target
Clinical Physiology	5.5%	6.4%	6.3%	2		Below Target
Rheumatology	10.7%	9.3%	12.0%	10		Below Target
Urology	10.5%	9.9%	11.5%	11		Below Target
Nephrology	11.2%	8.4%	13.0%	8		Below Target
Paediatrics	12.1%	12.0%	15.2%	10		Below Target
Trauma & Orthopae...	9.4%	8.6%	11.3%	10		Below Target
Geriatric Medicine	11.5%	11.3%	12.9%	8		Below Target
Obstetrics	7.2%	8.3%	9.7%	7		Below Target
Respiratory Medicine	13.6%	12.2%	15.9%	7		Below Target
Paediatric Trauma A...	11.1%	10.5%	14.0%	4		Below Target
Dietetics	13.2%	15.5%	16.9%	6		Below Target
General Medicine	7.4%	8.0%	9.9%	6		Below Target
Paediatric Ear Nose...	12.6%	13.3%	18.5%	3		Below Target
Clinical Haematology	6.9%	8.6%	9.7%	5		Below Target
Gastroenterology	7.8%	11.4%	14.5%	5		Below Target
Gynaecological Onco...	7.0%	9.3%	11.9%	2		Below Target
Medical Oncology	2.9%	5.8%	6.7%	3		Below Target
Paediatric Ophthalm...	12.7%	13.9%	20.8%	2		Below Target

Best Practice work undertaken

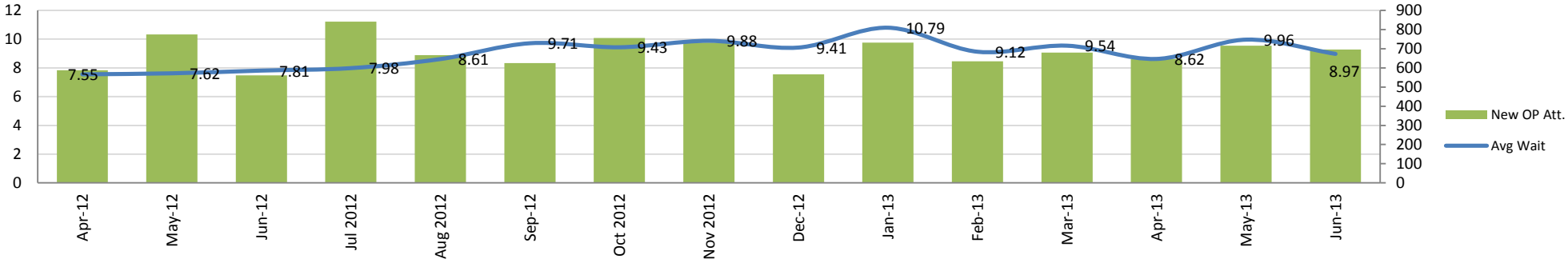
As part of improving access to services, we have undertaken a number of initiatives to improve our processes and effectiveness:

- A visit from the NHS Intensive Support Team in January 2013 to demonstrate best practice waiting list management and capacity planning tools. A follow up visit has taken place in July 2013 and a joint work package with the team is planned for September in order to support robust capacity planning for 2014/15
- We have been an early adopter of the National Audit Office Census of Elective Care Waiting Lists programme, trialling the proposed census tools and hosting a learning visit for the National Audit Office team
- We have undertaken a programme of waiting list process improvement including upgrading all our Patient Tracking Lists to online reporting and capturing all patient pathway data in the PAS system.
- Data quality reports focussing on waiting time management have been introduced including reports which enable us to identify where patients are on an incomplete referral to treatment pathway and need action.
- We have developed an online Activity vs Plan tool which shows weekly progress against our activity plan at a specialty and activity type level, enabling divisions to plan capacity and if necessary recovery plans more accurately.
- A detailed training needs analysis around waiting list and RTT pathway management has been undertaken, online training has been completely revamped and is supported by a local training and mentoring programme for administrative staff focussing on our Access Policy.

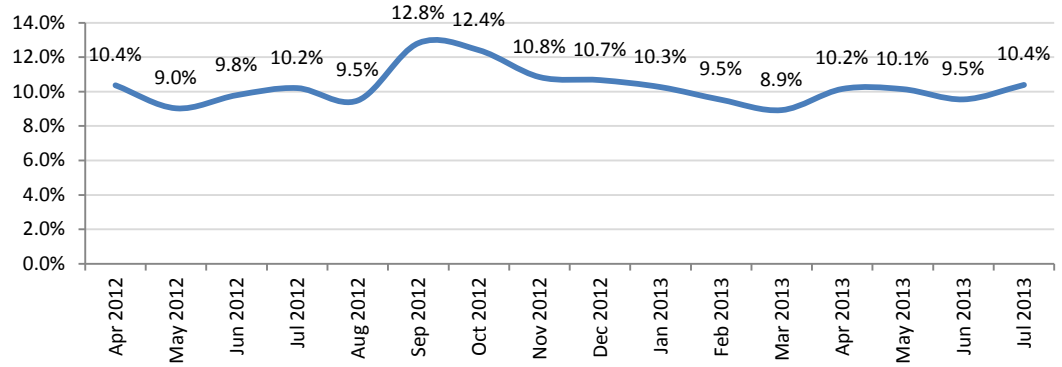
Referrals (All types)



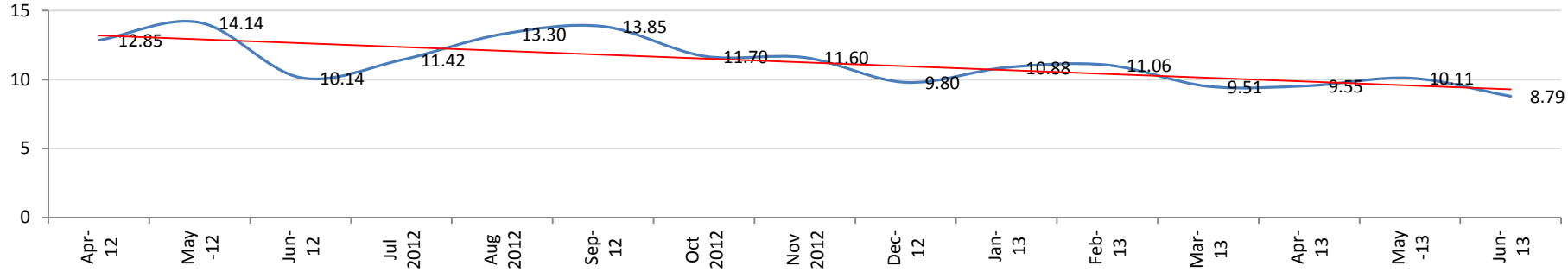
Average Wait in Weeks for New OP Appt (Referral Received to Attendance) and New OP attendances by Month



DNA Rates by Month – Against a Target of 11.3%



Average Wait in Weeks for Admission from Decision to Admit



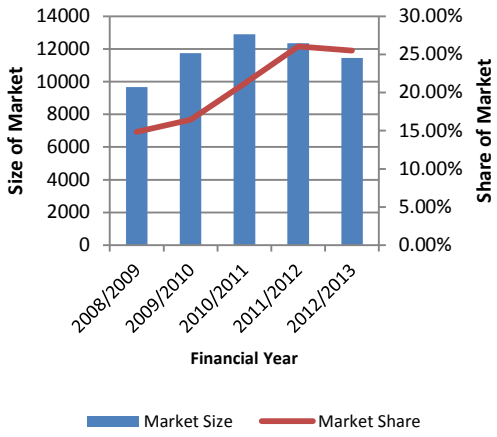
Referrals for T&O services have steadily increased with some increase in New OP activity. A key focus has been on waits for elective admission which have been reduced by 4 weeks from just under 13 weeks to just under 9 weeks, an improvement of 30%.

Market Share

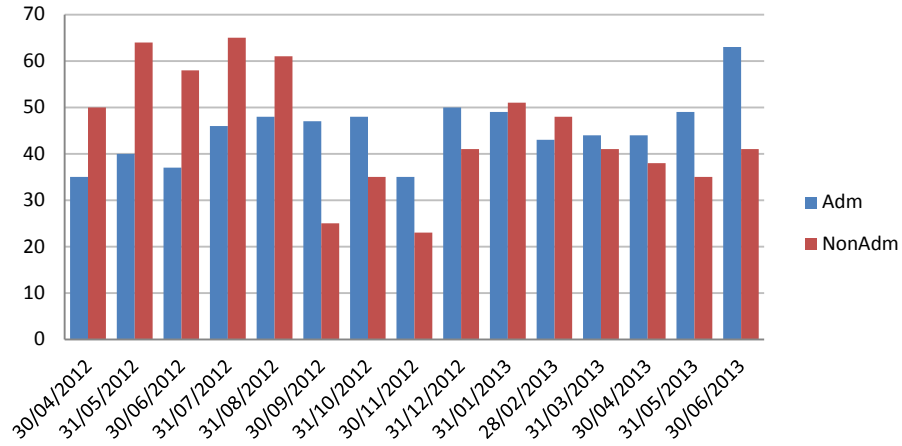
Between 2008/2009 and 2010/2011, there was a rapid increase in the size of the market of 34%. Since then, however, there has been a slow shrinking of around 4% per annum.

Noticeably C&W's share of the market increased from just under 15% to just over 25% between 2008/2009 and 2011/2012, although in the past year there has been a slight reduction in of 0.5%.

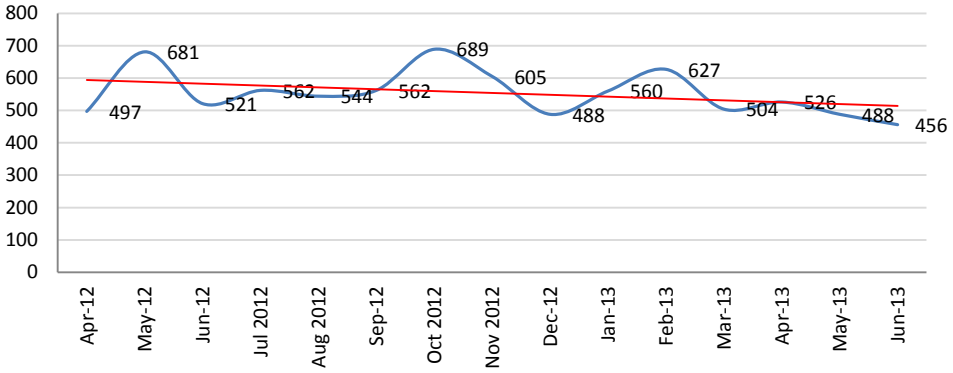
The majority of C&W's gain has been from the catchment population around Imperial College Healthcare Trust, who have seen their share of the market reduce from 39% to 26% in the past 5 years. The other major player in the market is St. George's who have maintained a market share of 18% throughout the period.



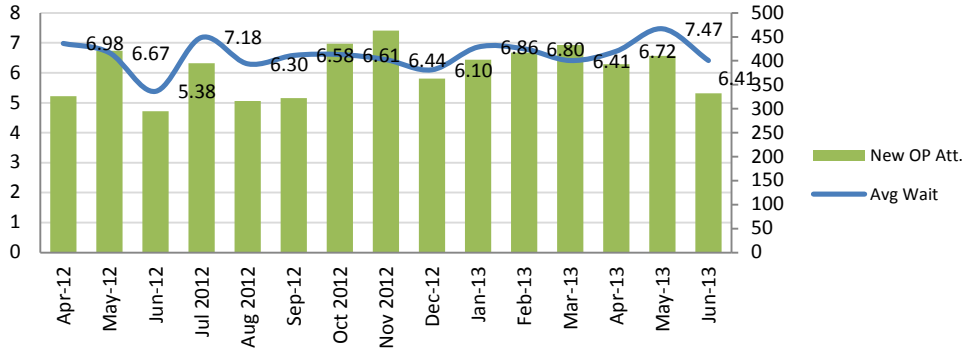
Patients Waiting Over 18 Weeks by Month (Admitted and Non Admitted)



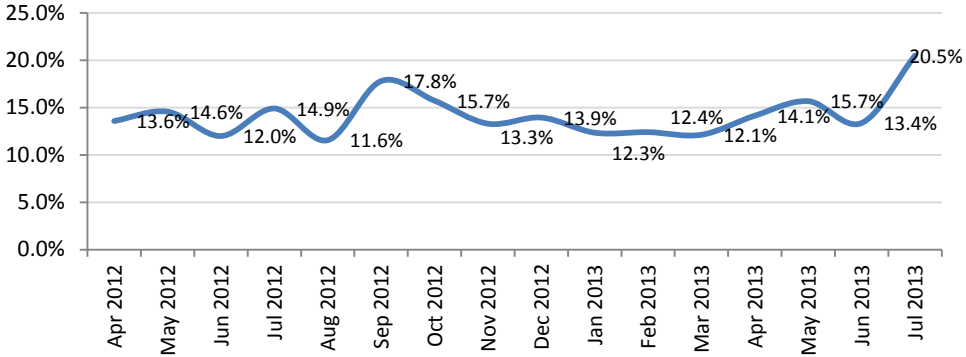
Referrals (all types)



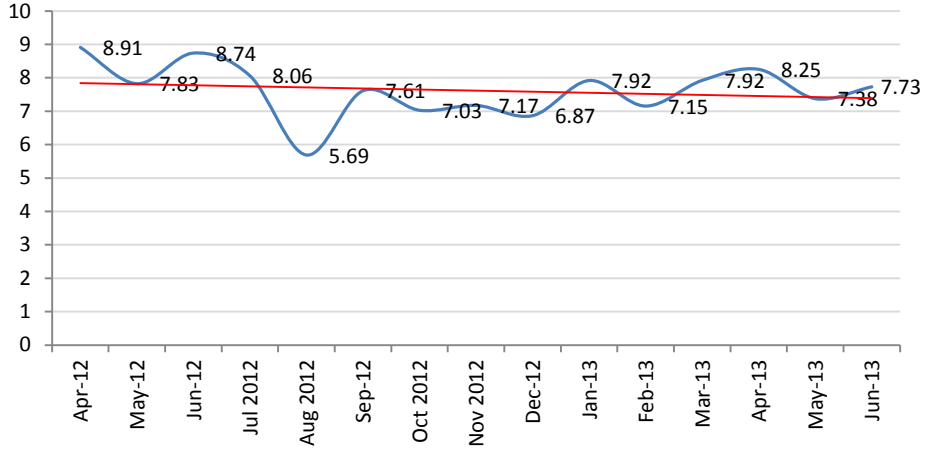
Average Wait in Weeks for New OP Appt (Referral Received to Attendance) and New OP attendances by Month



DNA Rates against a Target of 10.8%



Average Wait in Weeks for Elective Admission. Decision to Admit to Admission Date

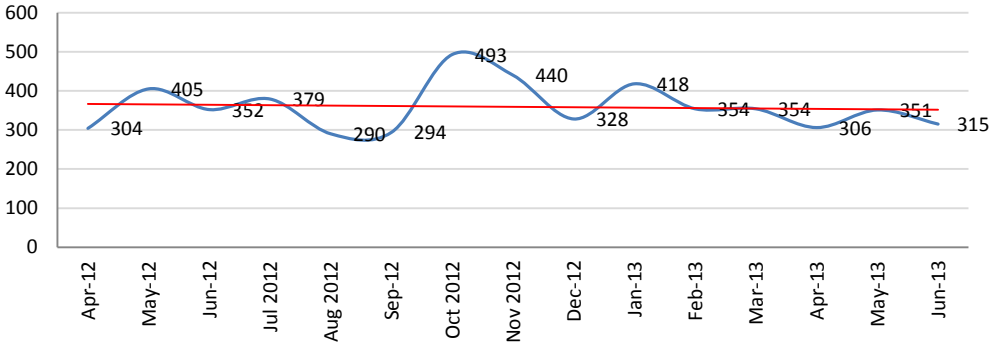


- Waits for a New OP Appointment have remained fairly static over the last 14 months, with referrals broadly static. There is the opportunity to improve DNA rates in this service and there is an outpatient service transformation project in place which incorporates DNA reduction
- Referrals have decreased largely due to PPwT (where some procedures are no longer purchased by Commissioners). This does present opportunities in terms of private patients however (self-pay market, e.g. varicose veins, hernias etc.)
- Wait for an admission has decreased by 1 week between April 12 and June 13

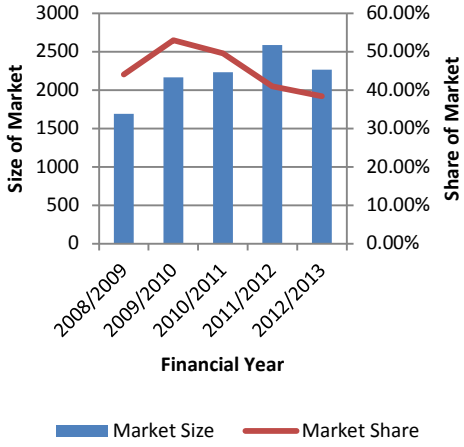
PAIN MANAGEMENT

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Referrals (all types)



Market Share

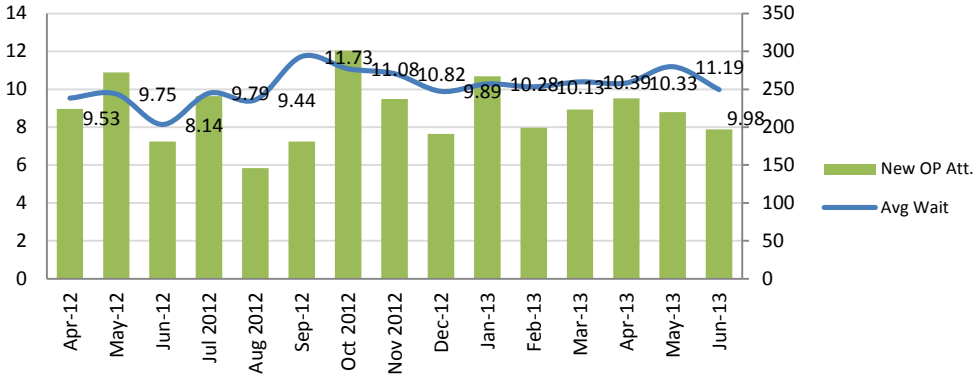


The market for Pain Management had seen steady growth for four years, peaking in 2011/2012. However, the market contracted by 12% during 2012/2013, which could be as a result of commissioner restrictions on outpatient pain management programmes.

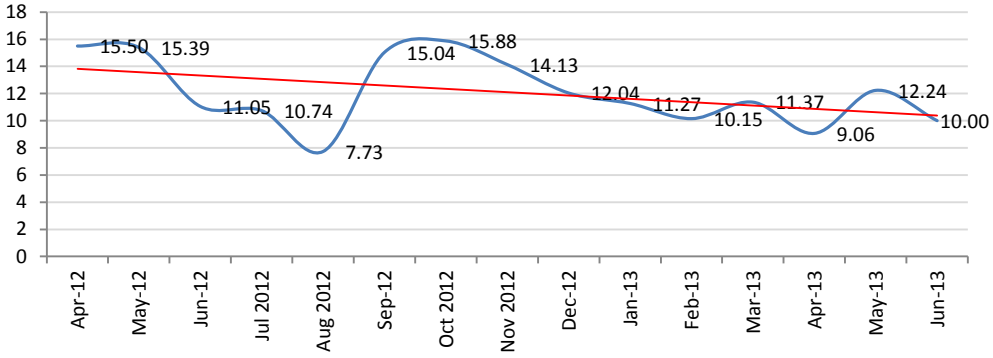
Although C&W have lost market share in the past few years (as has the other local provider, Imperial) this does seem to have slowed down in the past year with only a 2% reduction rather than the 9% seen the year before.

There does seem to be more fragmentation in the market, with St. George's and other providers seeing their market share increase.

Average Wait in Weeks for New OP Appt (Referral Received to Attendance) and New OP attendances by Month

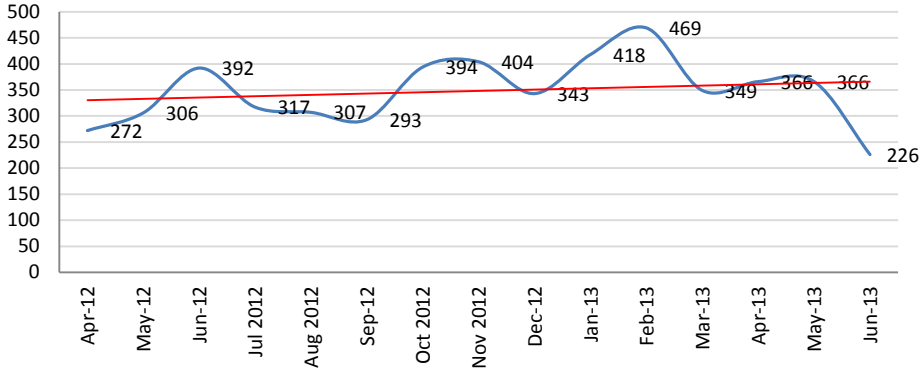


Average Wait in Weeks for Admission from Decision to Admit

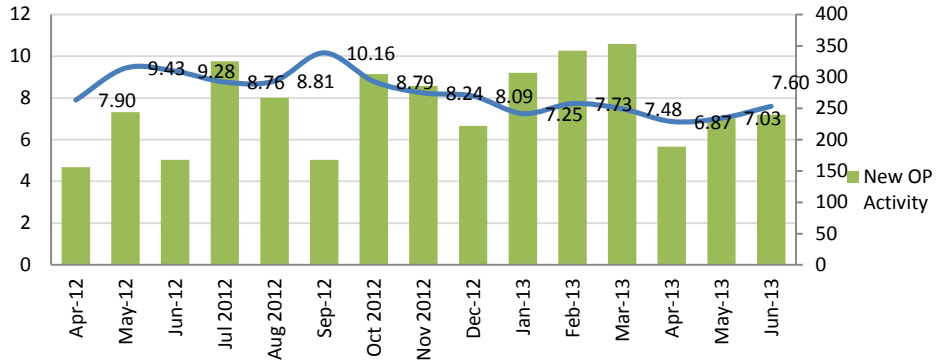


- Wait for a New OP appointment has remained fairly consistent since April 2012
- IP Waits have reduced by 5.5 weeks

Referrals (all types)



Average Wait in Weeks for New OP Appt (Referral Received to Attendance) and New OP attendances by Month

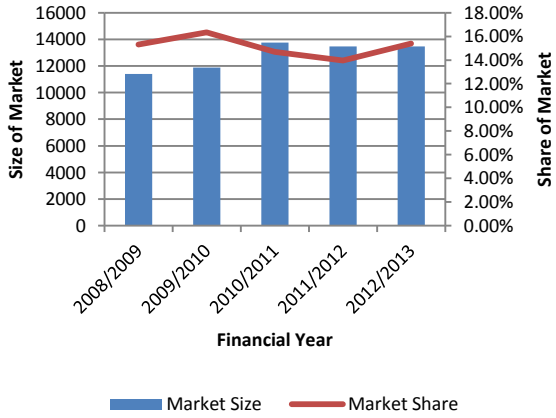


Market Share

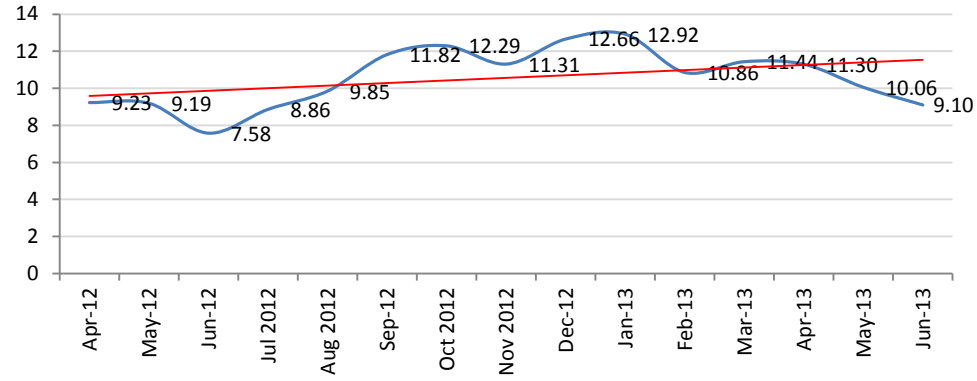
Although there was a step-change in the size of the market between 2009/2010 and 2010/2011, for the past 3 years the market has remained stable at around 13500 referrals.

During this time, C&W's market share has also relatively stable at around 15%. The other two major providers in the market are Imperial and Moorfields.

Moorfields has increased its share by 2% but Imperial has lost market share of around 7%. This appears to have been taken up by the other smaller providers, who have grown their combined market share by 5%.

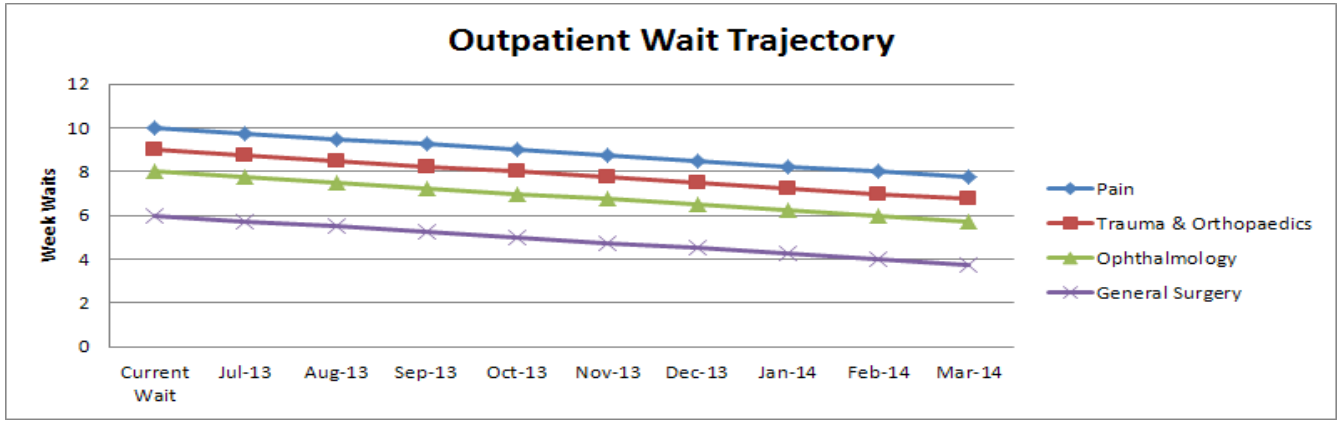


Average Wait in Weeks from Decision to Admit to Admission Date

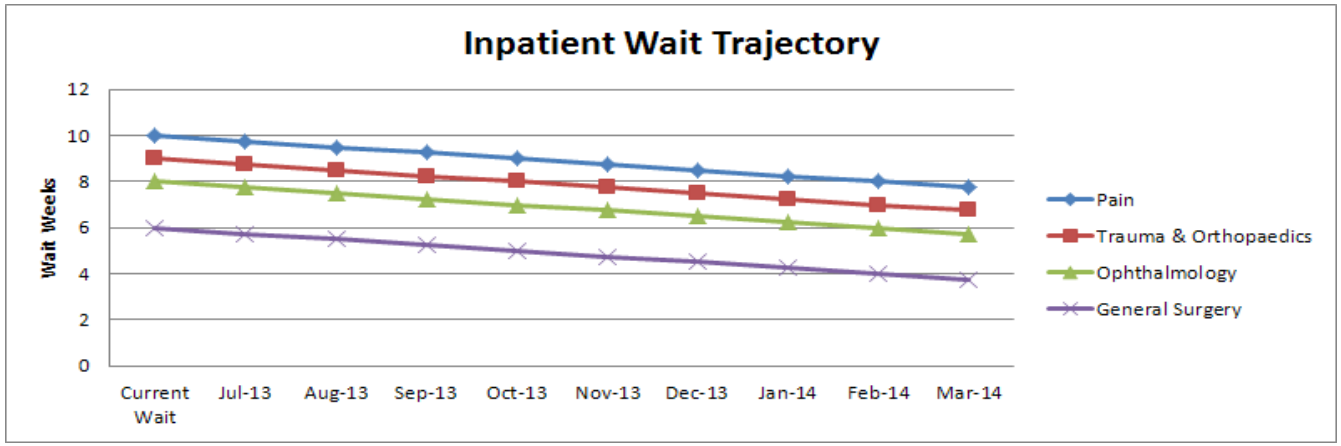


- Referral numbers show some variation between Sept 12 to Feb13 but have remained steady since March 2013.
- New OP Activity seems to vary from month to month. Wait for a New OP appointment increased following increasing referrals through 2012 but has since reduced down to around 7 weeks
- IP Waits have seen an increase between April and December 2012 , which has since reduced to a similar level to April 2012.
- This specialty is under-going some focussed work to examine its productivity and efficiency, which in turn will help to reduce waiting times / improve access. There is significant potential to grow the market share in this profitable specialty.

Surgery - Access Initiative Plans



Specialty	Current Wait	Target Wait
Pain	10	8
Trauma & Orthopaedics	9	7
Ophthalmology	8	6
General Surgery	6	4



Specialty	Current Wait	Target Wait
Pain	10	8
Trauma & Orthopaedics	9	7
Ophthalmology	9	7
General Surgery	8	6

How will we deliver the access improvement?

This will be achieved with a combination of extra clinics/lists to reduce any backlog in the system but also through better practice and process that will see efficiency and process improve to reduce areas like DNA rate and late cancellations

There are a number of initiatives in place through the Surgical Transformation programme, including improving the use of the Surgical Admissions Lounge, improving the layout and flow in Treatment Centre, and piloting a list utilisation predictor tool with the surgeons

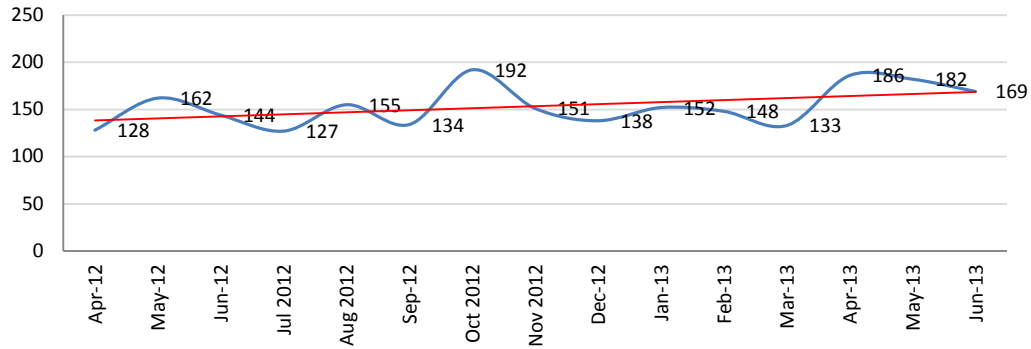
How will this impact EBITDA?

The aim is that, over time, better waiting times and improved access would trigger a potential switch in market share and referrals. This will see the services grow and increase profitability / EBITDA.

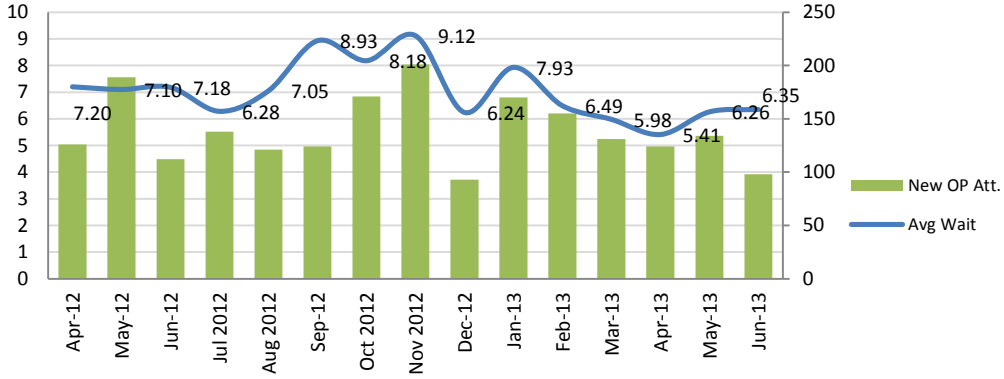
PAEDIATRIC SURGERY + UROLOGY Page 1

Chelsea and Westminster Hospital NHS Foundation Trust

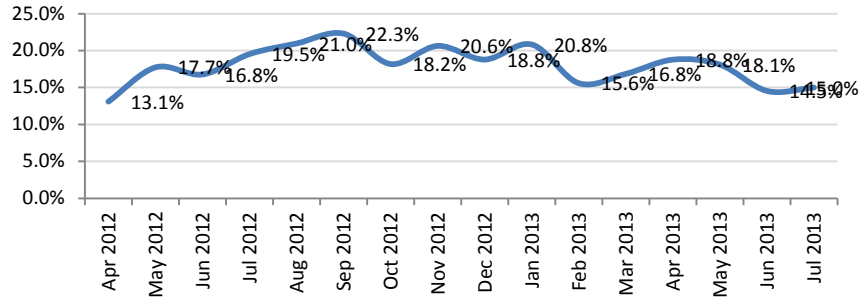
Referrals (all types)



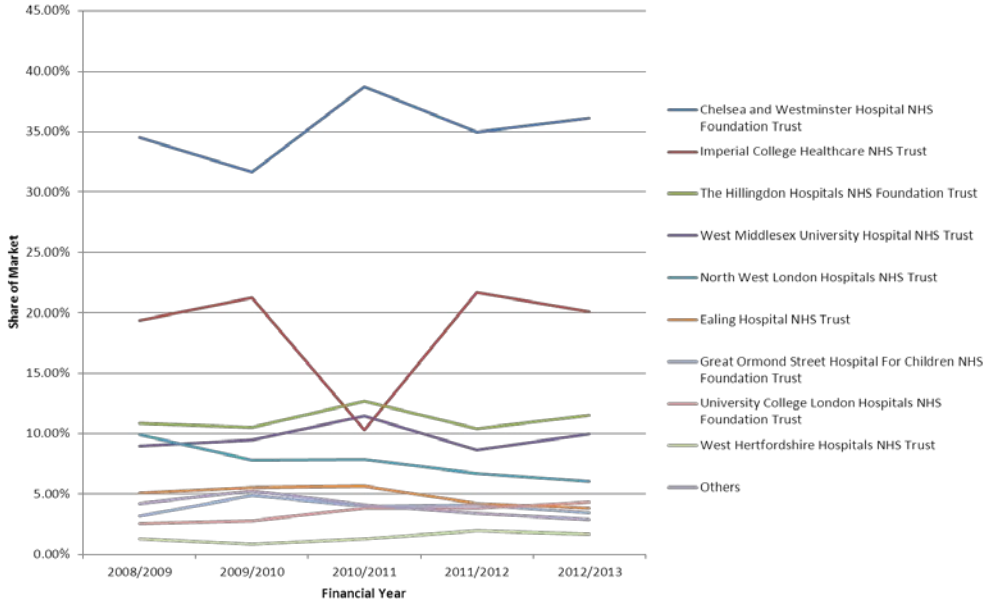
Average Wait in Weeks for New OP Appt (Referral Received to Attendance) and New OP attendances by Month



DNA Rates against a Target of 17.2%



Paediatric Surgery/Urology - OP Market Share - North West London PCTs



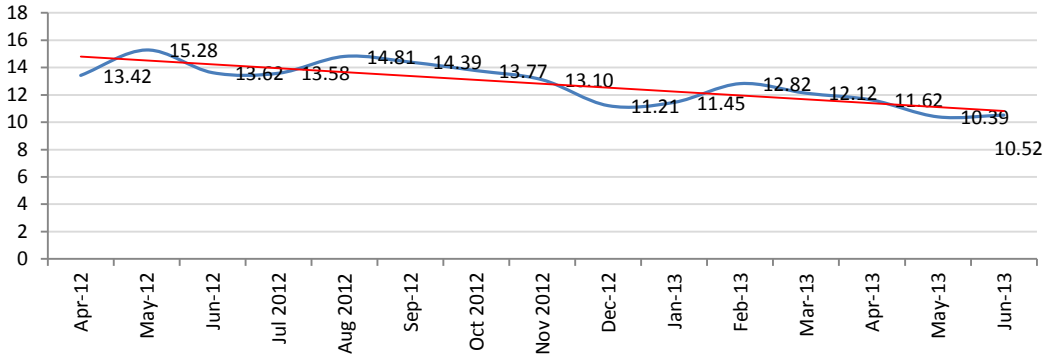
Activity and Waits

- High % of DNA for Surgery and Urology combined, consistently above the target
- New OP Activity has been decreasing since January 2013
- Average waits for a New OP Appointment have reduced by just under 1 week.

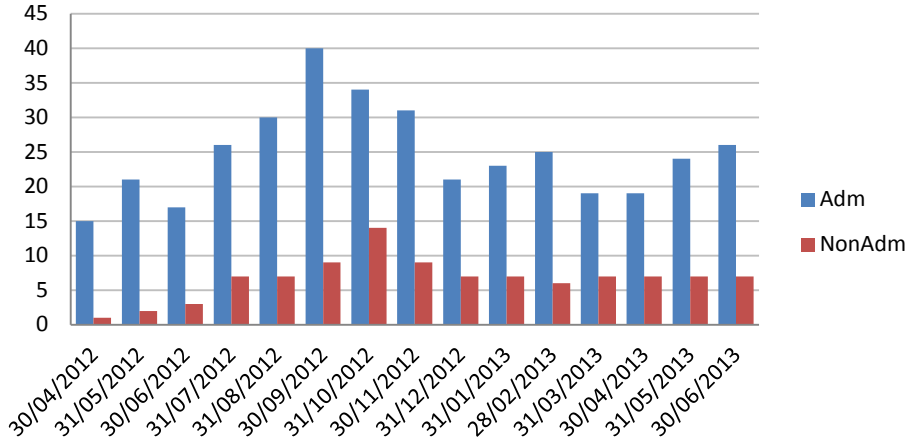
Market Share

- The NWL market has witnessed over 11% growth in the past 5 years. However, it appears to have stabilised in the last year
- There was a clear surge in activity at C&W following designation, although again this has stabilised in the past couple of years
- Despite this, C&W's market share has seen significant fluctuation with the share swapping with Imperial. Given the geographical proximity of the two providers, this may indicate that capacity issues at either provider adversely affect the market share
- The non-NWL providers are attracting activity from the periphery of the sector as they are the geographically closest providers. C&W provide clinicians/outreach clinics at Imperial, West Middlesex, Hillingdon

Average Wait in Weeks for Admission from Decision to Admit



Patients Waiting Over 18 Weeks by Month (Admitted and Non Admitted)



Progress To Date

The referrals data illustrates that there is variable demand, which is challenging to manage with static capacity and particularly with the impact of the on-call rota within the service which impacts outpatient clinics. Nevertheless, waits for first outpatient appointment have reduced to around 6 weeks, and we plan to further reduce these to consistently deliver a 5-6 week wait.

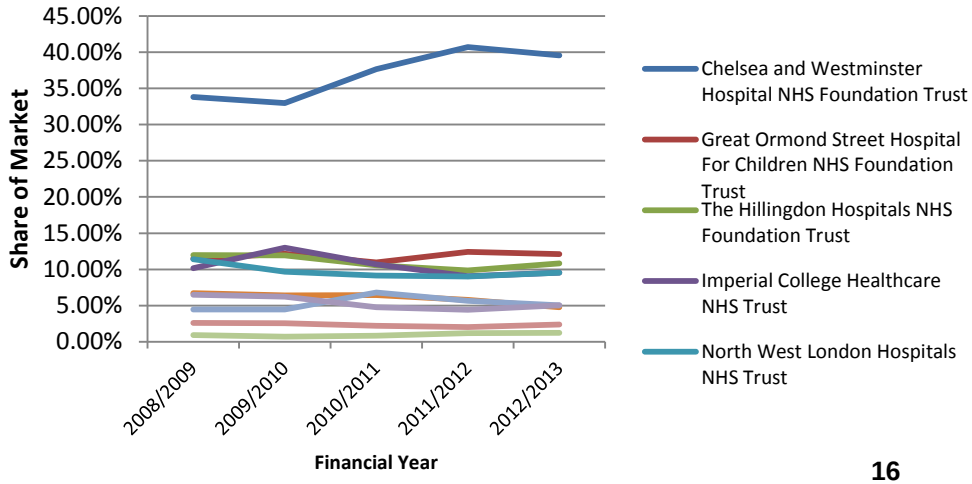
The DNA rate is still unacceptably high, and this is being targeted for review and reduction

The wait for admission has reduced significantly by 3 weeks (from 13 ½ to 10 ½ weeks). This is as a result of dual lists being run in theatre, and pre-admissions telephone calls which have reduced DNAs and cancellations on the day due to sickness . The aim is to further reduce waits to 8 weeks, and a new Consultant Urologist is currently being recruited to support this.

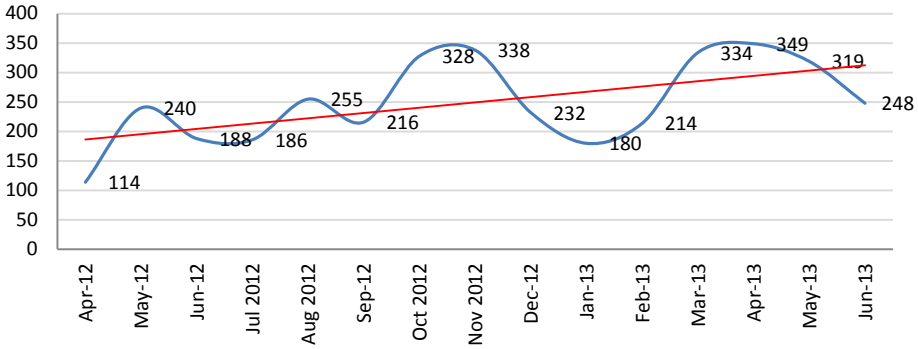
Market Share

- Between 2008 and 2012, the inpatient market saw steady growth of 5%. In the last year, however, this increase to a 10% growth rate
- C&W has experienced a 39% growth in admissions since designation. In terms of market share, this represents an 8% increase in share
- Of concern, however, may be the reduction in market share of 1% in the past year. This seems mainly to have gone to Hillingdon and Northwick Park hospitals.
- Further analysis is being undertaken on this data to ensure it is well understood as there are complexities in the way these specialties are reported to Dr Foster

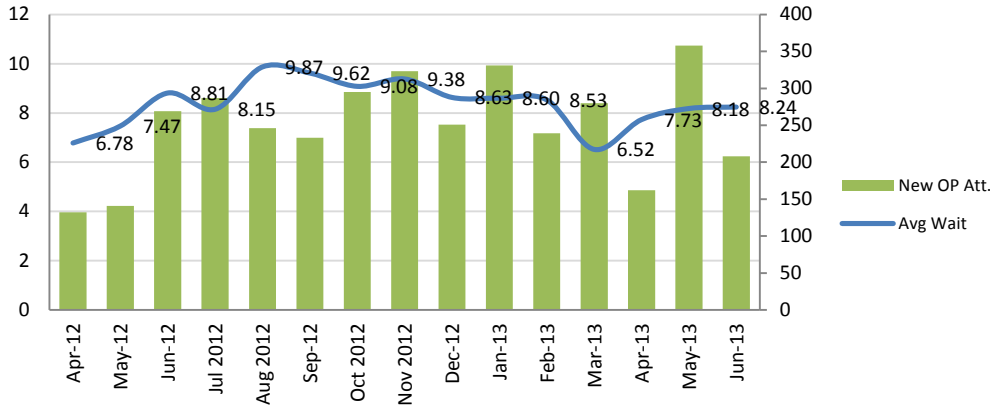
Paediatric Surgery/Urology - IP Market Share - North West London PCTs



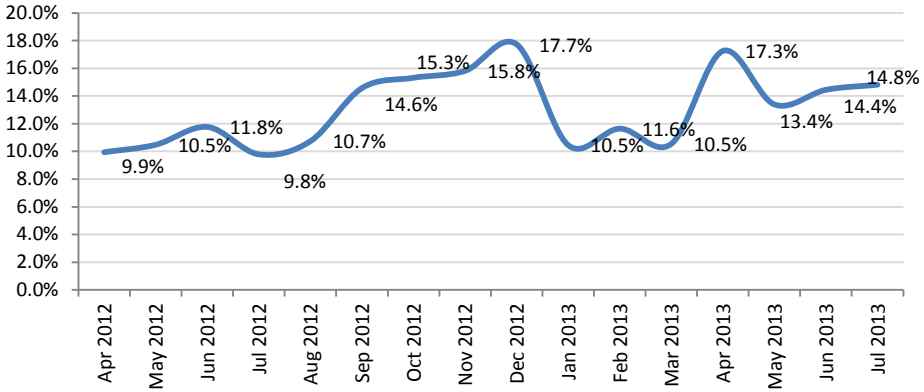
Referrals (all types)



Average Wait in Weeks for New OP Appt (Referral Received to Attendance) and New OP attendances by Month



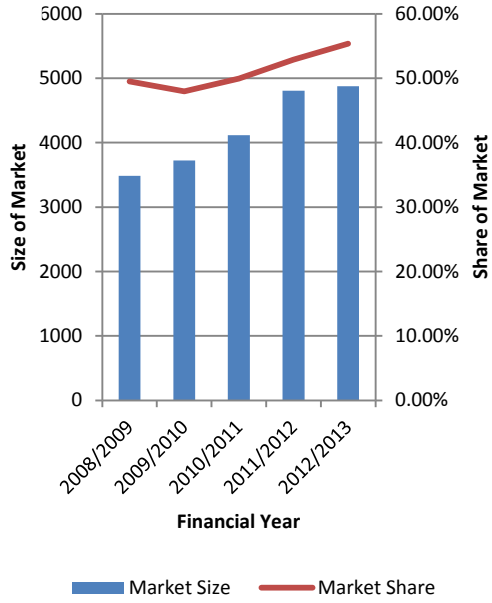
DNA Rates against a Target of 13.0%



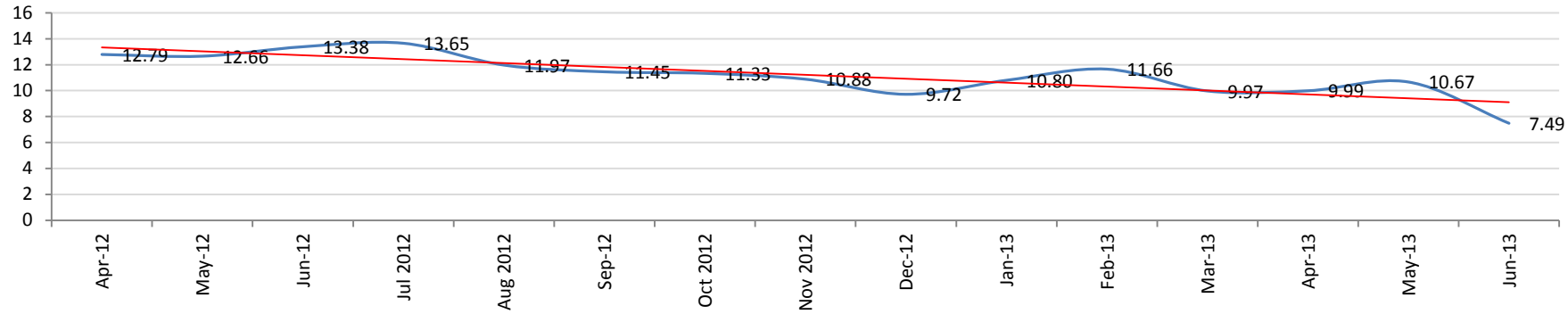
Market Share

The market for Paediatric Dentistry has grown by 40% in the last five years. In the past year, there has only been growth of 1.5% but ,due to the nature of the data, rather than reflecting a slowing in demand, this could actually be due to limitations in capacity.

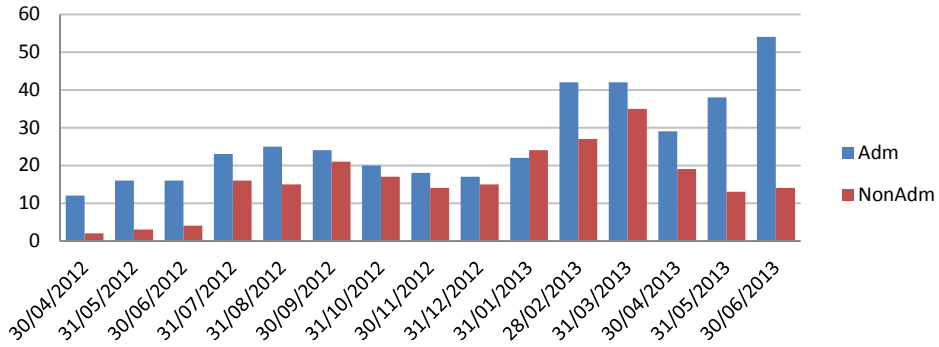
C&W is the principal provider of these services and its market share continues to grow year on year, despite recurrent issues with waiting times.



Average Wait in Weeks for Admission from Decision to Admit



Patients Waiting Over 18 Weeks by Month (Admitted and Non Admitted)



The referrals data indicates that dental referrals are increasing, but are also subject to seasonal demand, which is challenging to manage. There are significant public health issues regarding children's oral hygiene which contribute to the increasing demand for dental services.
These patients require acute dental care in a hospital setting, over and above the levels provided by community dentists. C&W are the only acute provider in NW London, and therefore have no existing competitors nor any support in managing capacity.

Progress To Date

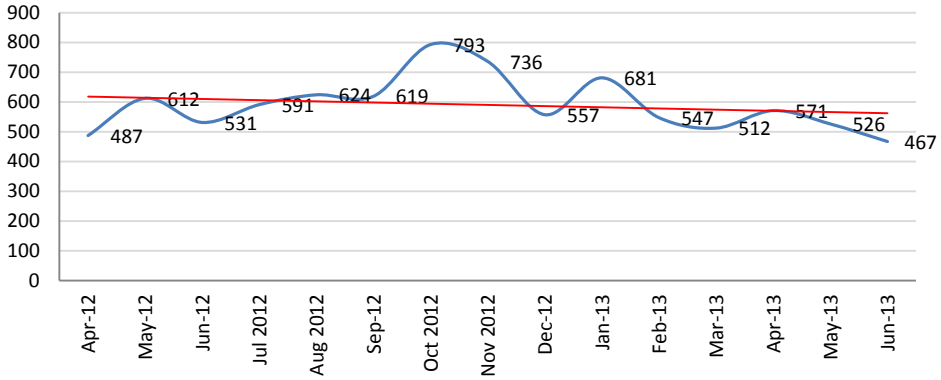
- Waiting times for outpatient appointments have increased slightly, as there has been a focus on reducing very long inpatient waiting times
- The DNA rate remains unacceptably high, and a review is required to target and reduce this (clinics are overbooked to compensate) and this should result in improvement in outpatient waits. DNAs are also high for admission, and the Service Improvement team have undertaken a pilot of calling patients the day before surgery and are assessing the impact on DNA rates.
- Additional weekly Saturday dental dual lists have been running all year, and the inpatient wait continues to reduce, with a significant reduction over the last year from a peak of over 13 weeks to around 10 weeks currently.
- Two WTE dentists are starting August 13. This will enable waiting times to be further reduced, with an aim to sustain waits at or below 6 weeks for outpatients and 10 weeks for inpatients.

There are a number of HR issues currently being addressed within the department, which pose a risk to delivery.

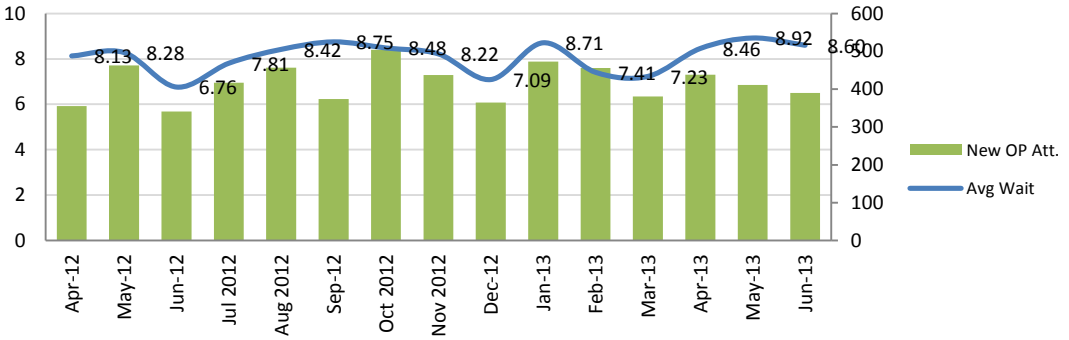
DERMATOLOGY SPECIALITIES - OP

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

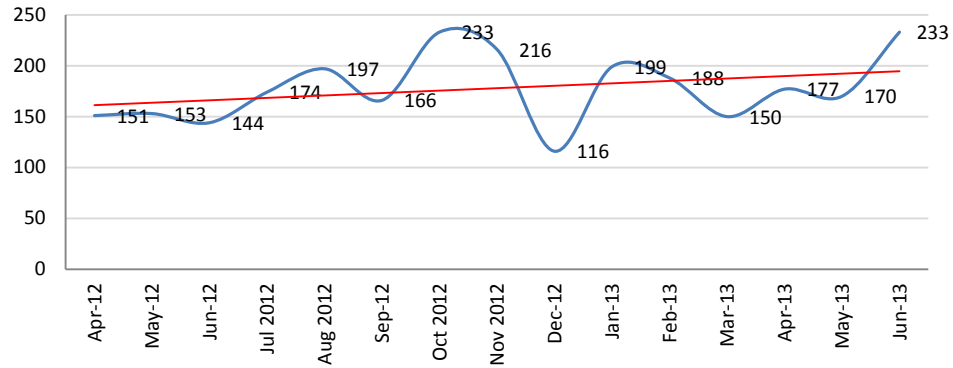
DERMATOLOGY - All Referrals to Trust



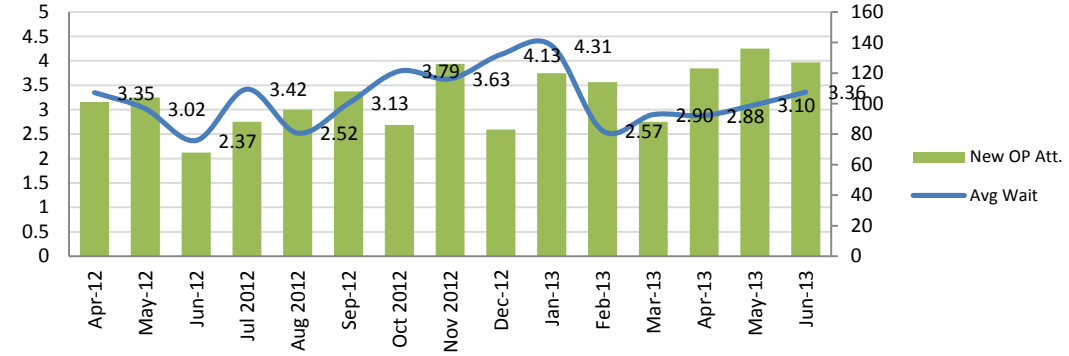
DERMATOLOGY Average Wait in Weeks for New OP Appt (Referral Received to Attendance) against New attendances by Month



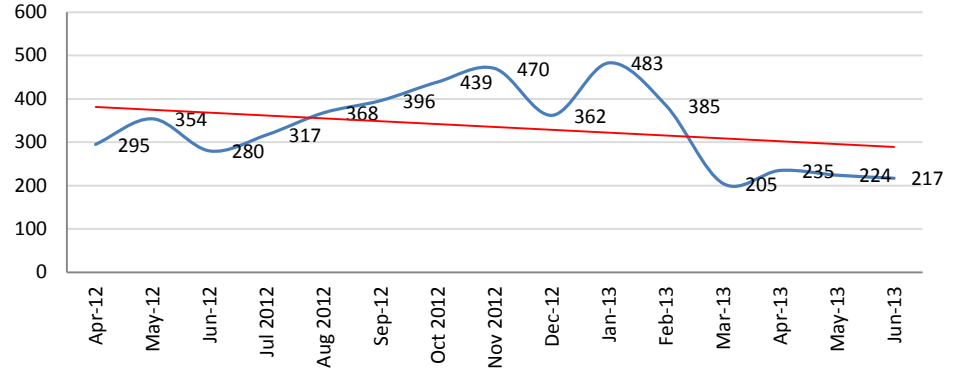
DERMATOLOGY KCPCT - All Referrals to Trust



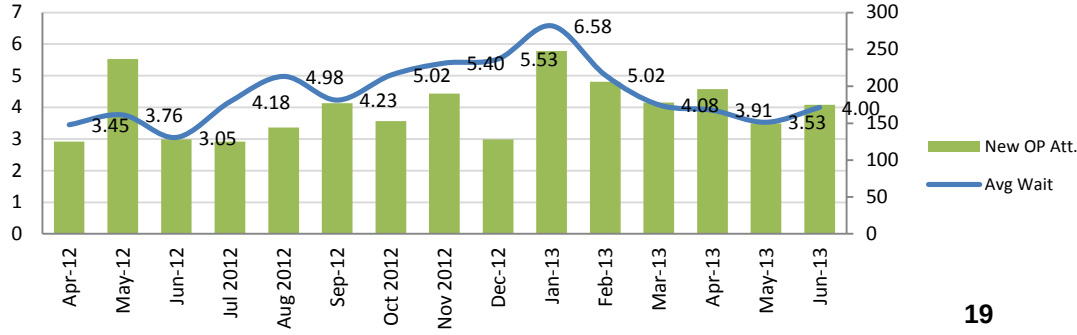
DERMATOLOGY KCPCT Average Wait in Weeks for New OP Appt (Referral Received to Attendance) against New attendances by Month



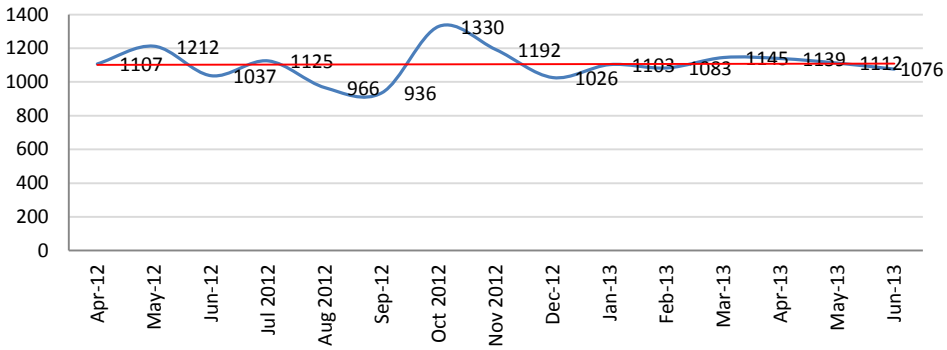
DERMATOLOGY WPCT - All Referrals to Trust



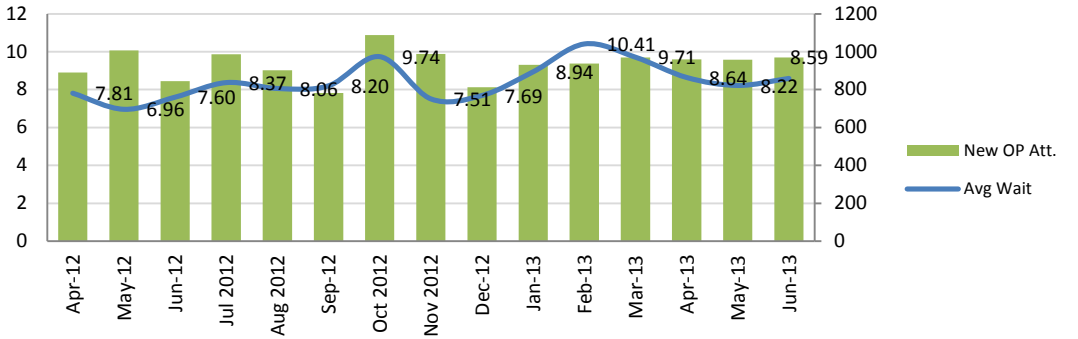
DERMATOLOGY WPCT Average Wait in Weeks for New OP Appt (Referral Received to Attendance) against New attendances by Month



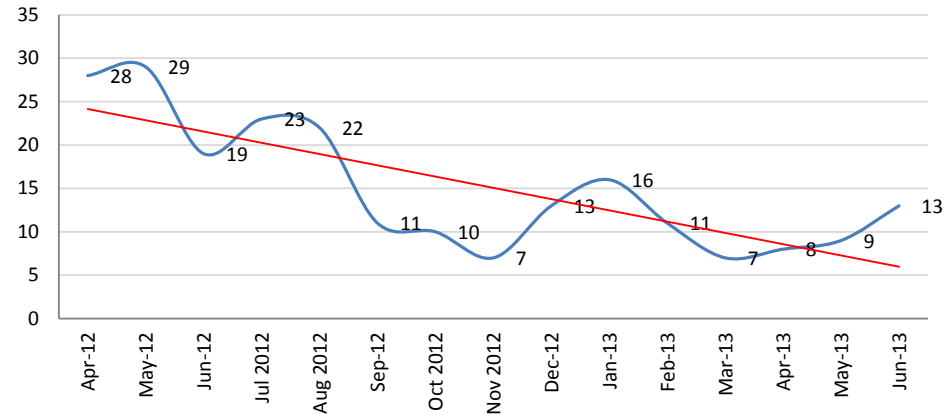
GYNAECOLOGY - All Referrals to Trust



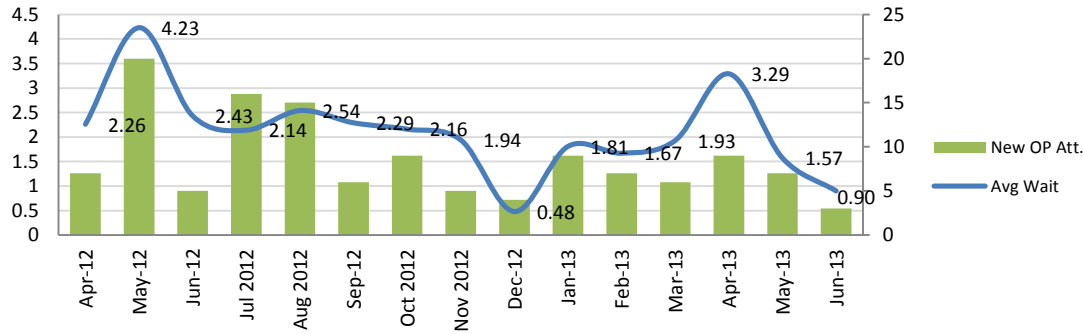
GYNAECOLOGY Average Wait in Weeks for New OP Appt (Referral Received to Attendance) against New attendances by Month



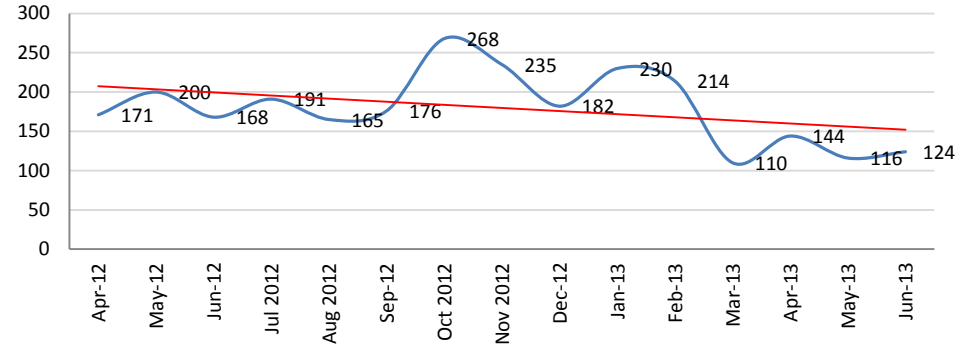
GYNAECOLOGY RTPCT - All Referrals to Trust



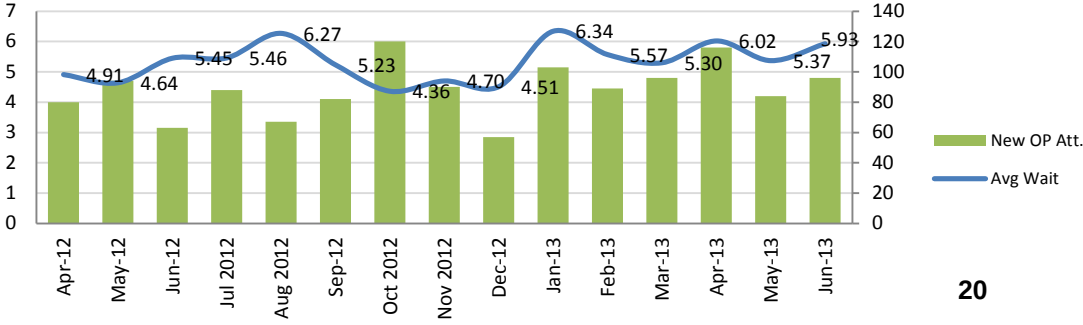
GYNAECOLOGY RTPCT Average Wait in Weeks for New OP Appt (Referral Received to Attendance) against New attendances by Month



GYNAECOLOGY WPCT - All Referrals to Trust



GYNAECOLOGY WPCT Average Wait in Weeks for New OP Appt (Referral Received to Attendance) against New attendances by Month



GYNAE and DERMATOLOGY – Access Initiative Update

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Achieved to date - Gynaecology

- Prospective view of clinic slots to maximise utilisation
- New patient pathway for ACU to reduce waits for IVF cycles

Actions outstanding - Gynaecology

- Gynae OP has variation between sub-specialities, longest waits currently for fertility, menopause & psychosexual clinics.
- Aim to increase utilisation of community clinics where waits currently well below average 1-5 weeks.
- Aim to bring all gynaecology sub-specialties under 7 weeks by April 2014
- Additional gynaecology capacity from virtual telephone results clinics in Q3. This will also eliminate unnecessary follow up visits.

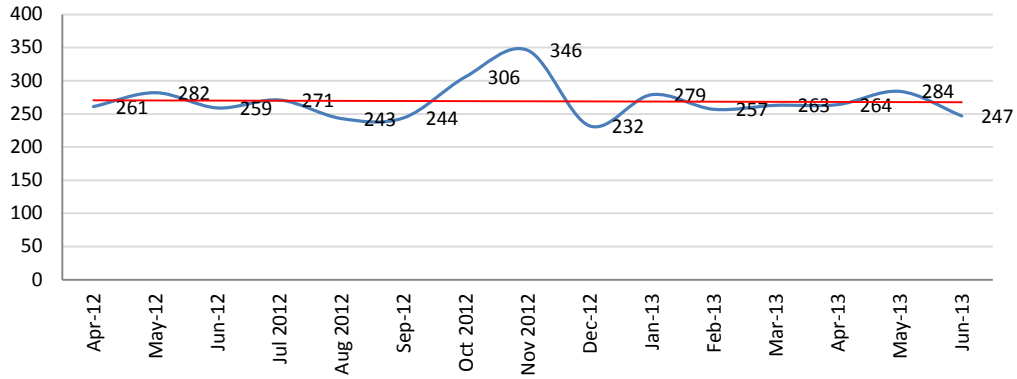
Achieved to date - Dermatology

- Prospective view of clinic slots to maximise utilisation
- Embedding of the Tuesday evening clinics. These have been a big success and continue on a substantive basis. It is also easier to get staff to do extra clinics in the evening because they often have extra commitments on weekday day times
- It should be noted that the service consistently achieves cancer 2 week waits for new outpatients

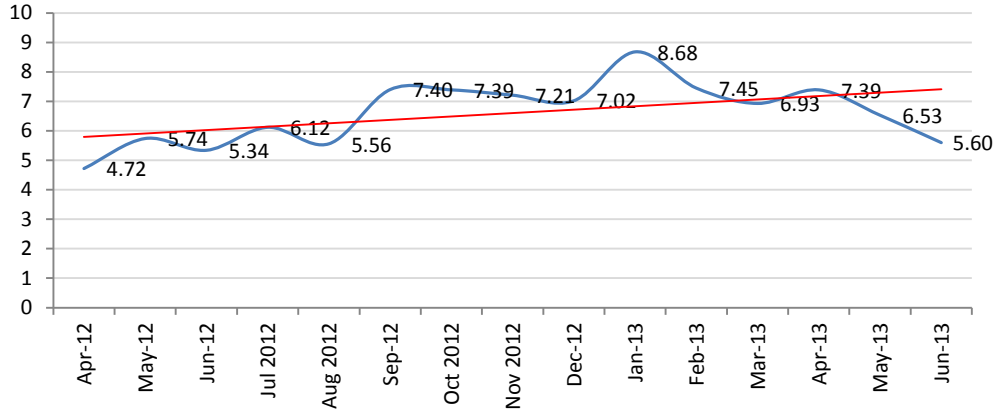
Actions outstanding – Dermatology

- The Department has recently remodelled all templates as well as the SpR rota so we should have an extra monthly capacity of 137 slots once the changes to the PAS system have been completed
- We are also looking to employ an additional junior doctor for which there is available funding from vacant Consultant sessions; this individual will focus on general clinics and community clinics to improve our waiting times. We hope to advertise in August.
- Aim to have the wait for the service down to under 5 weeks by the end of 2013.

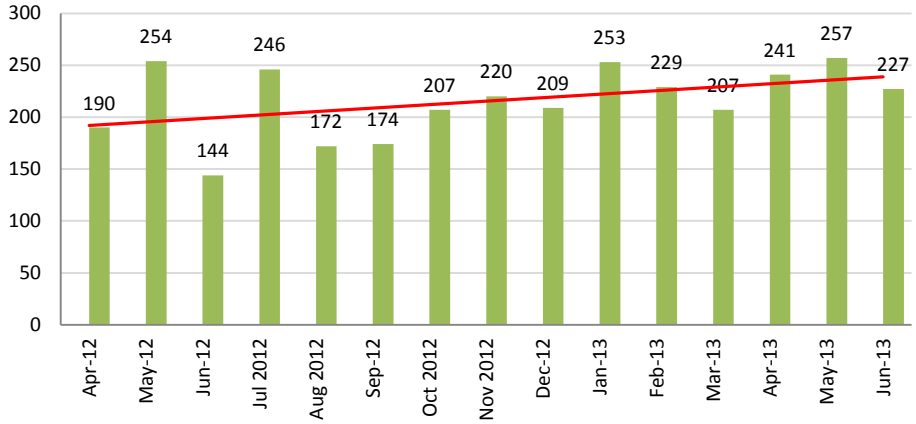
Referrals (all types)



Average Wait in Weeks for New OP Appt (Referral Received to Attendance)



New OP Attendances by Month



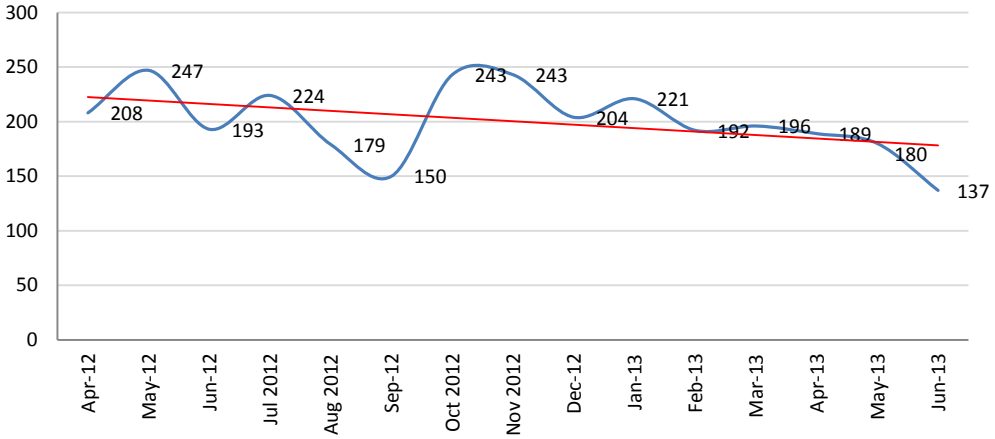
Progress to date

Waits have climbed very slightly in the past 18 months whereas referrals have remained static, however slightly more outpatient activity has been seen suggesting that clinic utilisation has been improved.

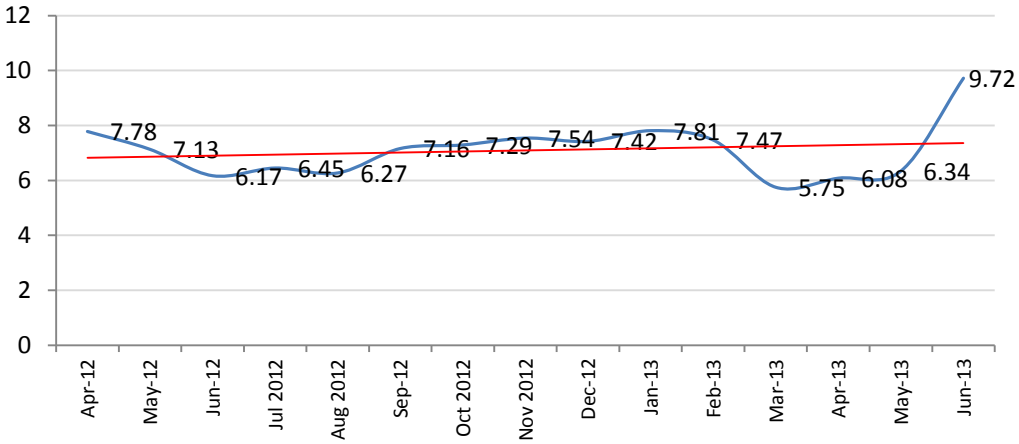
A robust demand and capacity exercise is underway, and results will allow for the gradual reduction of OP waits of 2-3 weeks to a target of 4-6 weeks – current waits are quite competitive already – this work has already led to a gradual reduction in Q1 of 13/14

Market share has remained static at approximately 6% of London market - a marketing strategy of the service is to take place in Q2 and Q3.

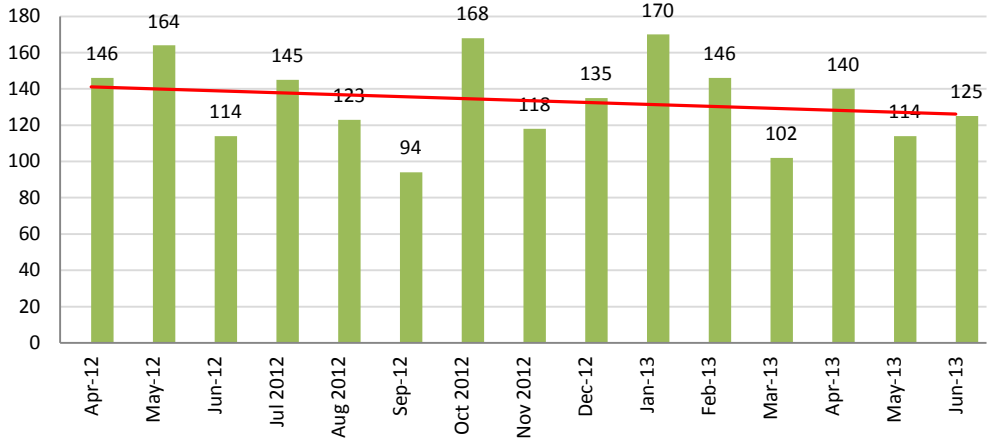
Referrals (all types)



Average Wait in Weeks for New OP Appt (Referral Received to Attendance)



New OP Attendances by Month



Progress to date

Referrals have seen a very slight decline in recent months with waits static at 5-6 weeks (June 2013 outlier value).

Capacity review has determined consultants are seeing too many patients in their clinics and a lack of follow up capacity

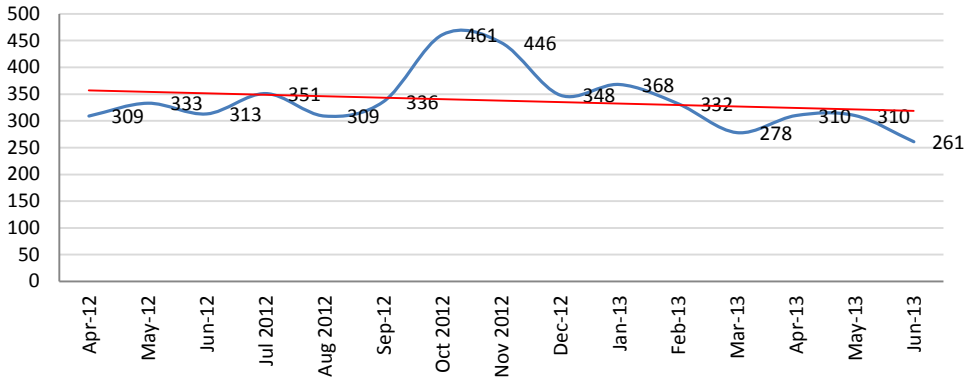
Outpatient templates have been re-set and additional capacity has been secured (short term 1 month) locum consultant

Discussions are on-going with the Divisional management team to draft a business case requesting funding for a new substantive consultant post with likely links with RBH and ICHNT (Neurosciences). The aim is to have this in place for 2014/15

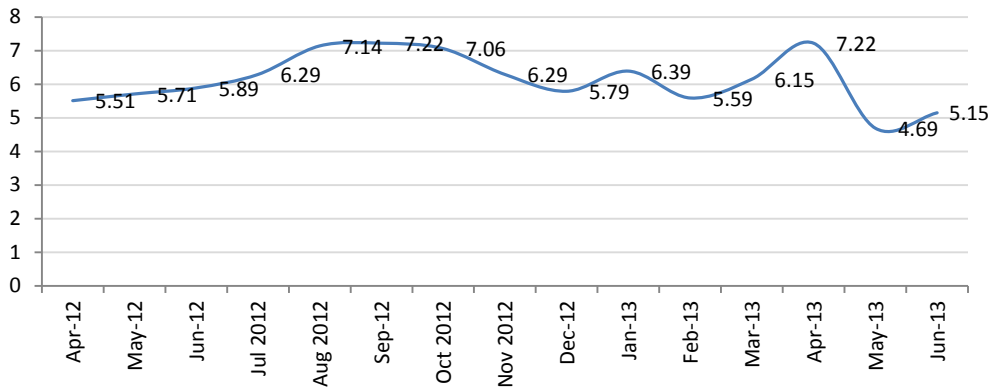
GASTROENTEROLOGY

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

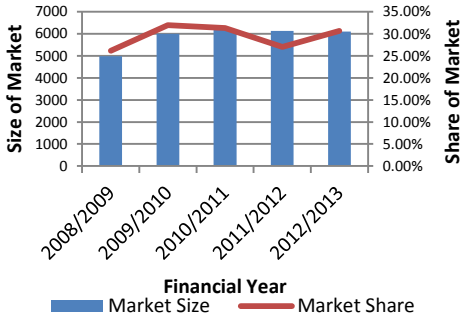
Referrals (all types)



Average Wait in Weeks for New OP Appt (Referral Received to Attendance)



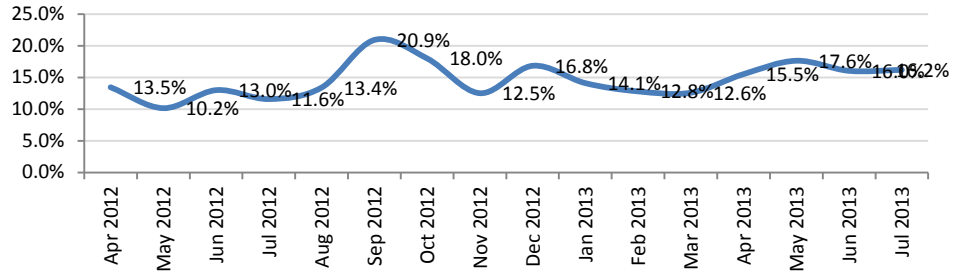
Market Share



The market for Gastroenterology has remained surprisingly stable in the last four years at around 6000 referrals and whilst there has been some fluctuation in market share, C&W have largely maintained a 30% share of the market.

Our nearest competitor is Imperial who also have a 30% share of the market. St. George's share is only 15%.

DNA Rates against a Target of 10.7%



Progress to date

Since Aug-12, the average wait for a New OP Appointment has decreased from 7.14 weeks to 5.15 in Jun 2013 , although the average wait spiked in April 2013.

Gastro has seen a slight reduction in referrals in recent months with OP waits static. An area of concern is the high % of DNAs. This is likely to be related to the high rate of rescheduling which takes place in Gastro OP, which has been largely due to some medical staffing issues, including a shortage of middle grade posts. This issue is being addressed with the aim to provide a more stable service and clinic timetable.

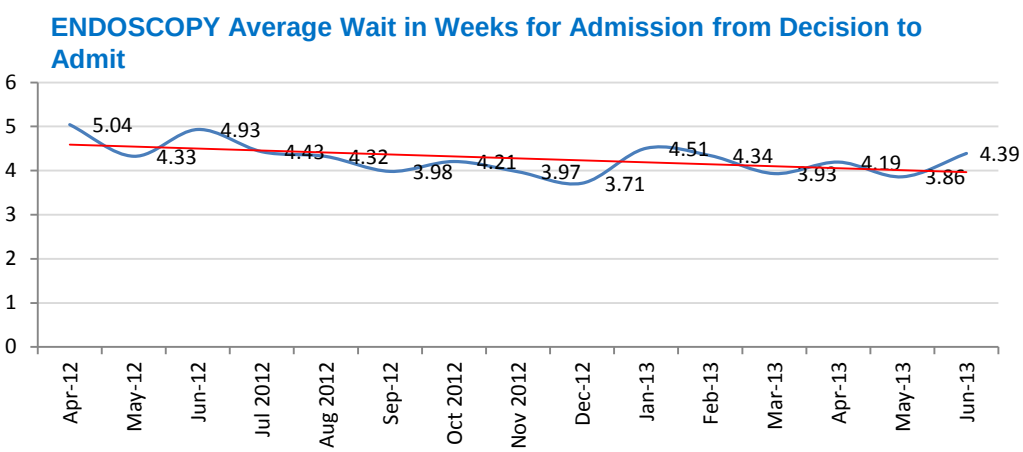
A new junior service manager has been appointed to provide dedicated admin support to the Gastro team which is the largest of all medical specialties. This role will better coordinate the middle grade rota to ensure clinics are better covered (as well as ward cover and Endoscopy).

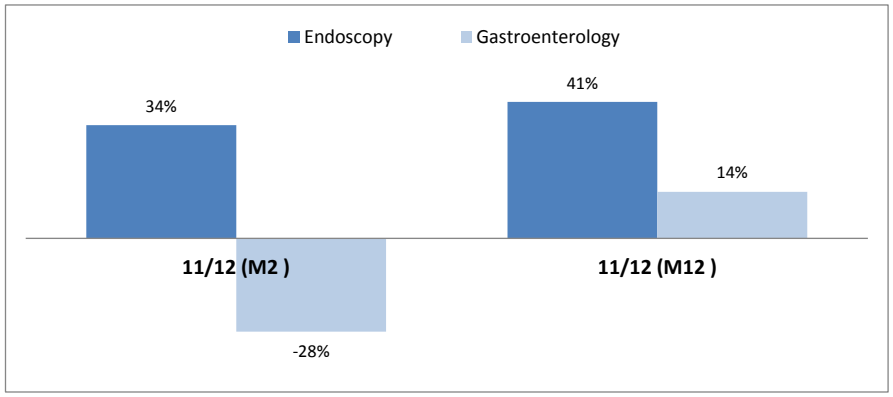
Additional consultant sessions were secured via 13/14 HQP to make the former consultant post who departed (formally a 6 session post) a full time post – plans are in place to appoint into this post on a locum basis with a view to substantive.

Additional capacity has been created. The clinical teams have agreed to perform additional patient facing and virtual clinics which will provide additional capacity throughout July and August.

Endoscopy Daycase – Access Initiative Plans

Chelsea and Westminster Hospital NHS
NHS Foundation Trust





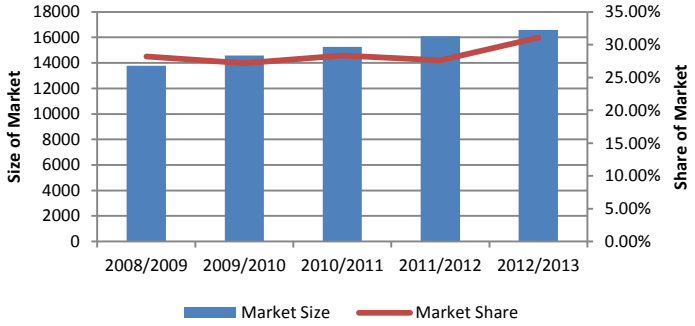
Waiting Times for Endoscopy

- As part of HQP for 2013/14 a decision was taken to aim to reduce the waiting time for endoscopy from around 6 weeks down to 4 weeks.
- This was felt to be achievable in the new Endoscopy unit which opened at the end of Q4 2012/13; this provided an increase in departmental, daytime capacity of 50% initially and 100% at the end of Q1 2013/14 (i.e. stepped increase from 2 to 4 procedure rooms)
- Total capacity actually only increased by around 30% as prior to the new unit opening the department operated evening, weekend and TC lists in order to meet demand.
- As may be seen in the previous slide; the waiting time for all endoscopy is now down to 4 weeks. A report is currently being developed via Qlikview to monitor wait times on a daily basis

Impact on EBITDA

- The EBITDA position in endoscopy has been very healthy for some time. However, the position for Gastroenterology was artificially poor as this reflected all payments (additional WLI at a premium) and so it was decided to rebase the position for the new financial year. This makes direct comparison or trend analysis more difficult but the positions are shown in chart 2.

Market Share



The market for Endoscopy has seen steady growth for the past 5 years of around 3% per annum. Throughout most of the period C&W maintained a market share of around 26% but in the past year this has increased markedly to over 31%.

Our other main competitors, Imperial and St. George's have seen a reduction in their market share in the past year.

Conclusion

Good progress has been achieved in delivering more activity, while maintaining stable waiting times. However, there is a need for a renewed focus on demand and capacity and a greater understanding of the impact of our access initiatives on EBITDA and the financial position. The key question is whether we are delivering better access, and increasing our activity and market share, in specialties which support our strategic objectives and deliver financial sustainability. This work will be taken forward in partnership with the Divisions and Finance and supported by the development of a suite of planning tools such as online waiting time, activity, capacity planning and SLR information.

Next Steps

- Confirm improvement tracking mechanism for key specialties
- Roll out suite of online planning tools and develop online EBITDA and SLR tools
- Monitor progress against agreed trajectories for access improvement, on a quarterly basis

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.2/Jul/13
PAPER	Francis Inquiry Report update on progress
AUTHOR	Cathy Mooney, Director of Governance and Corporate Affairs
LEAD	Tony Pritchard, Acting Director of Nursing
PURPOSE	To update the Boar don the process for responding to Francis Inquiry Report.
LINK TO OBJECTIVES	Quality and Safety
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This summaries actions that have been taken and are in development to respond to the Francis Inquiry Report. The Council of Governors was advised at the meeting in May 2013 that as a result of the Francis Inquiry Report the Trust arranged listening events during April to June to listen to our frontline staff. The listening events were run by the Executive Directors initially and then by other managers in the organisation. Governors were invited to attend. Following the listening events, themes are being collated and linked back to the recommendations where appropriate. However, the recommendations are far reaching and affect all staff in the organisation including directors and governors and many aspects of care e.g. how we handle complaints,

	the need to be open and honest and the duty of candour. All the recommendations for provider organisations are being reviewed to plan how we address them and an action plan is in development. Some recommendations are being addressed nationally and some have already been considered e.g. being explicit about openness and honesty in the risk policy and revising the whistleblowing policy. The next steps are for the action plan to be presented to the Quality Committee and Trust Executive in August. A response detailing how the Trust is responding to the Francis Inquiry report and the action taken will be agreed by the Board of Directors and the Council of Governors in September. In the meantime work will be undertaken with the governors to reflect on their role changes as a result of the Francis Inquiry Report.
DECISION/ ACTION	For information.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.3/Jul/12
PAPER	Assurance Committee Annual Report 2012/13 Summary
AUTHOR	Catherine Mooney, Director of Governance and Corporate Affairs
LEAD	Karin Norman, Non-executive Director
PURPOSE	The paper is to advise the Board of the areas under discussion by the Assurance Committee in the year 2012/13 including assurance that appropriate actions have been taken or are in progress. This report is the same as the report to the public Board with the exception of item 3.2 which is not included in the public Board version.
LINK TO OBJECTIVES	Patient and Staff Safety
RISK ISSUES	None other than those identified in the paper.
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This paper is brief summary of the discussions and summaries from the Assurance Committee over the year 2012/13 i.e. up until March 13. A more detailed version is available in the supplementary papers.

DECISION/ ACTION	The Board is asked to note the report and confirm that the Assurance Committee provides an effective assurance process.

Summary Annual Report to the Board from the Assurance Committee
April 2012 to March 2013

1. Introduction

This report contains a summary of the key issues that have been discussed over the period April 2012 to March 2013 by the Assurance Committee. This report is presented to the Board as part of seeking confirmation that the Assurance Committee fulfils its function of assuring the Board on matters within its remit.

The Board receives a copy of the minutes of the Assurance Committee and in addition a monthly summary report which indicates levels of assurance. This summary is based on the reports to the Board and is a summary of a fuller report that is available in the supplementary papers. .

2. Background

The Assurance Committee is responsible for assuring on a wide range of issues, including quality on behalf of the Board. It receives reports from the Quality Committee, Facilities Committee, Health and Safety Committee and Risk Management Committee.

3 Key issues

3.1 Health & Safety

The Assurance Committee began to receive reports directly from the Health and Safety Committee in June 2012.

Areas that have been discussed include staff training (in particular for fire), the challenges of ensuring staff are trained and the actions taken to improve uptake and necessary culture change. Extensive work relating to Control of Substances Hazardous to Health (COSHH) assessments was reported, including progress on identifying department representatives and relevant training. There was also a focus on risk assessments for lone working where progress in ensuring they were done has been slow.

Level of compliance for mandatory health and safety training increased from less than 50% to 56% over the reporting period but rapid and significant progress needs to be made. The Committee has underscored the need for executive prioritisation of H&S matters and a different, effective approach to mandatory training to start to show meaningful results.

Despite some needed progress in H&S in the last 12 months in terms of quality and ownership, the Committee remained concerned that progress is slow and the need for a culture change was emphasised.

3.2 Never events – assurance

The Committee has focused on actions being put in place to prevent never events and how robust these controls are (assurances). One particular example is that of retained vaginal swabs where the Committee has considered in detail what processes are in place to prevent swabs being retained and how we know they are working which has involved regular audits.

Of the other 25 Never Event categories, each of these has also been reviewed, looking at systems and processes in place to prevent them happening. For some of these the Trust is confident that there are good systems in place and for some the systems and processes are still being evaluated.

The Assurance Committee is assured that processes in place to reduce the risks of Never Events occurring are being systematically reviewed and will continue to receive reports on progress.

3.3 Mandatory Training

Developments over the year include a small improvement in the rates of mandatory training and a revised approach to training e.g. annual updates for all staff which means that the bulk of training can now be done in one day, the introduction of Qlikview, which will allow access to managers to check staff training against requirements for that staff member, and the range of methods for training (taught sessions, update dates and e-learning, which is available from home). Further developments discussed include weekend training and how to increase the perception of the quality of mandatory training and the importance of it.

Concerns identified included the slow progress overall and in particular low compliance of medical staff with Health and Safety and moving and handling training, access, and tracking of on line induction. Sanctions were discussed.

Training rates were noted to be 63% in the final report for the year against a target of 80% for 2012/13.

The Assurance Committee remains concerned about the slow progress with mandatory training which has not reached acceptable levels despite efforts over the last 5 years.

3.4 Facilities Report

The Committee received two reports in the year relating to the Facilities and Estates services. Areas of concern were discussed but there was noted to be nothing of significance, and in October 2012 the report indicated that there was a good service from the contractors and that the services were being adequately monitored.

The Assurance Committee was assured on the monitoring and performance of the external contractors and sub groups reporting to the Facilities Committee.

3.5 Top concerns

Committee members were asked to consider their top 5 concerns and subsequently to that it has become a regular item on the agenda for the Director of Nursing and Medical Director to report. Top concerns include mandatory training, Never Events, Health & Safety – culture, ownership, assurance; patient experience – improved consistency in satisfaction, values – embedding at all levels, staff appraisals – effective, meaningful and regular, failure to recognise and escalate deteriorating patients, meeting the acute care standards and having 24 hour consultant presence, delayed follow up of outpatient appointments e.g. patients needing to be seen in 4 weeks being seen in 3-4 months, pressure ulcers and administrative processes around appointments which can lead to delayed results.

This new agenda item was felt to be meaningful in highlighting potential areas of concern, particularly with regard to patient safety and clinical

operations. The Assurance Committee will continue to focus on the top concerns of the Director of Nursing and Medical Director.

4. Annual Reports and updates in year
The Trust received a number of annual reports and updates throughout the year. These as follows (including the main points of assurance)

4.1 Infection Control Annual Report 11/12 and Q2 Report Jan 2013
Targets for next year are increasingly challenging as C&W has one of the lowest rates in the UK. There is zero tolerance for MRSA and the target for *C. difficile* will decrease.

Performance has been consistently good and processes are robust. The committee has subsequently asked the team to start to highlight any matters of long-term strategic significance to inform board planning moving forward.

4.2 Risk Management Annual Report 2011/12 and Q1 and Q2 reports 2012/13
These reports contain information on risks, incidents, both trend information and serious incident reviews. Key achievements in 2011/12 included attaining NHLSA risk management standards level 2 in December 2011, achievement of the falls related CQUIN, the introduction of new online training for nursing and medical staff in clinical record keeping and clinical audit, and revised online training module for risk and incident management.

The Assurance Committee discussed the reports and no areas of significant concern were raised.

4.3 Maternity Risk Management Report 2011/12 and Q1 report 12/13
These reports contain information on risks, incidents, both trend information and serious incident reviews in maternity. Key achievements included a significant reduction in the caesarean section rate (26%, which is the national average).

The Assurance Committee discussed the reports and no areas of significant concern were raised for 1011/12.

4.4 Medicines Management Annual Report 2011-2012
This report outlines the activity relating to medicines management throughout the year.

The Assurance Committee discussed the reports and no areas of significant concern were raised.

4.5 Safeguarding Children Annual Report 2011/12 and 6 monthly report 2012/13
The main points noted by the Committee included the outcomes of external visits which were good and confirmation that the method of flagging children with safeguarding issues was effective and fit for purpose.

The Assurance Committee was assured that there are no children safeguarding issues of concern.

4.6 Safeguarding Adults Annual Report 2011/12 and Q1-Q3 2012/13 Report
The main points noted by the Committee included that similar numbers of allegations against the Trust were made in 2010/11 and 2011/12 but there was an increase in allegations from 18% to 22% for the same period last year and the use of a flagging system to denote people with learning difficulties

The Assurance Committee was assured that there are no adult safeguarding issues of concern .

4.7 Annual Workforce Report
The report did not raise any areas of concern unique to this organisation. A source of some concern is the over representation of BME staff involved in employee relations (disciplinary procedures). This is seen across the NHS and is therefore to be addressed nationally. An internal and external mediation service is available as well as training relating to bullying and harassment etc. in order to try to resolve issues before they escalate.

The Assurance Committee noted the concerns relating to BME staff and employee relations but otherwise noted no major concerns regarding the workforce report for 2011/12.

4.8 Complaints and Concerns Annual Report Summary 2011 – 2012 and Q2 2012/13 report
A summary of the Complaints and Concerns Annual Report was noted. This was subsequently presented to the Board. The Q2 report noted that the number of complaints was above national average and in particular complaints relating to attitude. Most complaints are from inpatients, and are about medical, nursing and support staff. Processes have been put in place to increase the amount of direct contact with complainants soon after the complaint is received to try and ameliorate communication. It was noted that turnaround time for complaints continues to be unsatisfactory.

The Assurance Committee noted the main issues in the reports.

4.9 Annual Claims Report 2011/12
The report was presented in November 2012. Although the number of claims has gone down, the number varies yearly.

The Assurance Committee noted no concerns raised from the claims report.

5. Audits
A number of audits were considered by the Trust as follows (further details are available in the supplementary report)

5.1 Audit of Discussion between Clinician and Patient relating to consent
This audit demonstrated that there was 100% compliance with the documentation of a general discussion between clinician and patient as part of the consent process.
However the risks of anaesthesia were not documented on 50% of the anaesthetic forms and the importance of doing so has been reinforced to staff.

5.2 National Care of the Dying Audit

This is a national audit and the data for the Trust showed that this is an area that needs improvement. A team led by Richard Morgan is reviewing Trust practices and will report back to the committee following an update to the Quality Committee, due in August 2013

5.3 Audit on signing for Controlled Drug (CD) requisitions

The Committee were reassured that there is a process in place for recording and following up on CD discrepancies

5.4 Medicines storage audit

The Trust has a reasonable degree of assurance of the safe and secure handling/storage of medicines.

5.5 Medicines Policy Audit October 2012

Overall the results of the audit were positive

5.6 KPMG Audit on Patient Experience

The outcome of this was reported as 'requires improvement' but with minor recommendations. Extensive work continues on several fronts to improve performance including values work and customer service training.

6. Care Quality Commission

6.1 CQC Quality Risk Profile Update

The Assurance Committee considered the CQC QRP for March 2012, July 12 and Sept 12 on behalf of the Board. These reports look at areas where the Trust is significantly worse than expected in a wide range of areas based on nationally available data.

The Assurance Committee noted that there is an action plan in place for all areas highlighted as red. Overall, performance was noted to be strong.

6.2 CQC Standards Provider Compliance Assessments (PCAs) review of action plans

These were reviewed in November 2012.

The Assurance Committee noted any risks that were rated amber; there are no red risks in the current PCAs.

6.3 Essential Standards of Quality and Safety – monitoring at ward level

The process of transferring these standards into a practical toolkit was described and the approach to continuous assessment, feedback and action planning. This involves ward based assessments by senior teams and others, including governors, against key questions developed from the standards.

The Committee noted the report and the positive feedback from staff.

7. Other

7.1 Emergency preparedness and business continuity

The Committee received two updates during the year

The Trust Emergency preparedness and business continuity plans are up to date However two gaps were identified - the Trust does not have a current Pandemic Influenza Plan - the most recent was written in 2009, and an updated plan will be available by August 2013 – and a risk around essential items of CBRNE/HAZMAT equipment going missing.

7.2 Learning Disabilities Report
The Committee received two updates during the year which included a number of developments including an easy to read consent form available and volunteer escorts are available to accompany patients and carers during hospital visits.

The Committee was assured on the work undertaken for patients with learning disabilities and that we met the CQC standards.

7.3 Equality and Diversity update
The Committee received two updates during the year which confirmed that the Trust has met its legal responsibilities in accordance with the Equality Act 2010. An update was provided on how the Trust is progressing with implementing the NHS Equality Delivery System tool.
There is more to do in relation to feedback from the staff survey on values.

The Committee noted the progress and that bullying and harassment needs to be addressed and focus groups have flagged that staff need to be trained better to improve interaction with patients with learning disabilities.

7.4 Inpatients Survey - Analysis of London hospitals and amalgamated action plans following the Inpatients and Outpatients Survey
The Committee considered a paper which provided Trust scores for each of 10 components of the 2011 National Inpatient Survey and compared them with the scores of 6 other London teaching hospitals. The categories for which C&W has low scores (A&E, Discharge, Nurses) validate what we believe to be problem areas.

The Committee also reviewed the action plan for the outpatient and inpatient surveys.

The Committee noted concern about the inpatients survey results and was assured that action will be taken through the Patient Experience Committee.

7.5 Summary Hospital Level Mortality Indicator (SHMI) /Hospital Standardised Mortality Rate (HSMR)
The Committee discussed the SHMI and HSMR and noted that C&W was the only hospital in the country to be low on all four hospital mortality indicators reported by Dr Foster.

The Committee noted the good performance

7.6 National Reporting and Learning System (NRLS) report on incidents
In June 2012 the NRLS report was considered and an additional report comparing four reporting periods for London Acute Trusts was circulated. The Trust is in the middle quartile.

7.7 External Trustwide/Corporate External agency visits, inspections and accreditations update report
The Committee received two reports on external visits, but asked for more clarification on any risks. In October 2012 a report was presented which RAG rated progress on actions from the visits and it was agreed that further reports would include whether there were any causes for concern or recommendations highlighted as part of the visits. It was noted that the Trust

No concerns were noted but the committee asked for greater clarity on risks as a result of such inspections in future.

7.8 Complaints Policy - Annual Review
This was approved in September 2012.

7.9 Complaints, Claims and Incidents – Aggregated Q3 and Q4
This paper reported on themes from looking at complaints, claims and incidents together and actions taken and assurances in place. The areas identified as common themes include failure to follow up on results or required outpatient appointments, communication, education and training and handover.

The Assurance Committee noted the main themes and action taken.

8. Other regular reports

8.1 Report from the Trust Executive Quality Committee
The Committee considered these reports at every meeting. These included the Controlled Drugs Accountable Officer Occurrence Report and Controlled Drug Reports every quarter.

8.2 Monthly Reports on Local Quality Indicators
The Committee considered these reports at every meeting. Discussions were mainly around HSMR, SHMI and areas where performance was red and amber.

8.3 Quality priorities
Progress on quality priorities for each quarter was presented. The year end position is as described in the quality report.

9. Review of Assurance Committee Effectiveness
The effectiveness of the Assurance Committee measured against the terms of reference was considered in September 2012. Generally the Committee agreed that most aspects of the terms of reference were met but further work needed to be done in ensuring focus on the main priorities (Committee members were asked to identify these – see 7.5) and ensuring that the key issues are identified in a clear way with an assessment of assurance.

10 Action required from the Board
The Board is asked to confirm that this gives adequate information and that it is assured on the effectiveness of the Assurance Committee.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.4/Jul/13
PAPER	Assurance Committee Report to the Board – May 2013
AUTHOR	Catherine Mooney, Director of Governance and Corporate Affairs.
LEAD	Karin Norman, Non-executive Director
PURPOSE	The Assurance Committee is responsible for assuring on a wide range of issues on behalf of the Board, including quality. This report informs the Board on the issues that have been discussed and the Assurance Committee's views on the level of assurance for each issue, where this is possible. The Assurance Committee will also escalate to the Board where appropriate. The paper is for information but also to allow any directors to raise any issues or queries about the matters in the paper.
LINK TO OBJECTIVES	The Assurance Committee assures on quality. The items discussed at the meetings are relevant to the quality objectives.
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	A summary of the issues discussed at the meeting in May 2013 is attached.
DECISION/ ACTION	For information.

ASSURANCE COMMITTEE REPORT FROM MEETING MAY 2013

1. Introduction

The Assurance Committee is responsible for assuring on a wide range of issues on behalf of the Board, including quality. This report informs the Board on the issues that have been discussed at the May meeting. This paper includes the Assurance Committee's views on the level of assurance for each issue, where this is appropriate.

2. Background

The Assurance Committee receives matters to discuss or for information, from the Quality Committee, Facilities Committee, Health and Safety Committee and Risk Management Committee.

3. Items discussed at the Assurance Committee in May 2013

3.1 Health and Safety Committee Monthly Report

The Assurance Committee asked for more analysis of the information presented and specifically more of a focus on outcomes and not process. Further information on stress management was requested. It was agreed that the executive would consider a different reporting format as well as ensuring that there was absolute clarity in terms of the responsible Director's overall opinion of each area being considered.

It was noted that there were 141 management referrals to Occupational Health during the quarter, of which 12 were related to stress. The staff survey had also shown an increase in staff reporting work-related stress in the last 12 months. The Committee asked for further information to understand the situation.

The Assurance Committee did not consider there was enough information to assess assurance and an alternative approach will be considered for future meetings.

3.2 Setters Report

The report was discussed by the Assurance Committee but will be discussed in more detail at the next Assurance Committee meeting after they present their report in person.

The Assurance Committee will consider the Setters report in more detail at the next meeting with Setters in attendance.

3.4 Never Events

3.4.1 Assurance Report

It was agreed that the process was good, it was intensive and thorough and the report was clear. Progress is slow because of the level of detailed work required. Further clarification on what was meant by 'largely compliant' was requested and what the outstanding concerns were.

3.4.2 Audit of Retained Swabs in Maternity Audit

Due to the number of never events relating to retained swabs, results of the audit had been requested to be presented to the committee.

The Assurance Committee was reassured by the audit results and the training in place and that it was reported that this was taken seriously by medical staff and midwives.

3.5 Proposed changes to the Assurance Committee
The committee structures have been reviewed as to how they might work better together but it is in the early stages and further consultation is needed. It is important to determine what data we should be collating for the Trust's requirements rather than simply responding to external requirements. Individual specialties have been asked to prioritise the key 3-5 performance measures they will report on through high quality planning. Over a hundred pieces of data are collected for key performance indicators and CQUINS.

The German quality system was discussed, and it was agreed to research what data is collected in Germany and consider whether our model is the most efficient and effective.

3.6 Top Concerns from Medical Director and Nursing Director
These were reported to be pressure ulcers, early warning scores (rolling out the new system), failure to escalate and treatment of mental health patients, failure to follow up results and Infection Control.

The line of governance reporting for the Information Technology (IT) Strategy Group was highlighted as well as the need to look at how we are assured on suitability of work direction and progress.

It was agreed that Bill Gordon, Operations Director of IT, be invited to the Assurance Committee to present on IT.

3.7 Report from the Trust Executive Quality Committee for May
The size of the agenda was noted as was the need to think more strategically about this. The Quality Committee is not in a position to provide assurance on matters considered because of the size of the agenda.

It was noted that there are plans to review the committee structures.

3.8 External Visits
It was reported that the Care Quality Commission (CQC) visit in relation to the Mental Health Act compliance was very positive. The outcome of other Trust visits was noted.

The Assurance Committee noted the much clearer format for external visits and the importance of external visits as a means of assurance and also agreed that specialist areas should be reported on by specialty leads in future.

3.9 Equality and Diversity
There was a discussion regarding Equality and Diversity which sits with Human Resources, the Human Resources Business Partners link into the divisions and with the E&D training lead.

There was some discussion as to whether Equality and Diversity efforts may benefit from being located organisationally within a broader Staff Well-being initiative.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.4/Jul/13
PAPER	Assurance Committee Report to the Board – June 2013
AUTHOR	Catherine Mooney, Director of Governance and Corporate Affairs.
LEAD	Karin Norman, Non-executive Director
PURPOSE	The Assurance Committee is responsible for assuring on a wide range of issues on behalf of the Board, including quality. This report informs the Board on the issues that have been discussed and the Assurance Committee's views on the level of assurance for each issue, where this is possible. The Assurance Committee will also escalate to the Board where appropriate. The paper is for information but also to allow any directors to raise any issues or queries about the matters in the paper.
LINK TO OBJECTIVES	The Assurance Committee assures on quality. The items discussed at the meetings are relevant to the quality objectives.
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	A summary of the issues discussed at the meeting in June 2013 is attached.
DECISION/ ACTION	For information.

ASSURANCE COMMITTEE REPORT FROM MEETING JUNE 2013

1. Introduction

The Assurance Committee is responsible for assuring on a wide range of issues on behalf of the Board, including quality. This report informs the Board on the issues that have been discussed at the June meeting. This paper includes the Assurance Committee's views on the level of assurance for each issue, where this is appropriate.

2. Background

The Assurance Committee receives matters to discuss or for information, from the Quality Committee, Facilities Committee, Health and Safety Committee and Risk Management Committee.

3. Items discussed at the Assurance Committee in June 2013

3.1 Health & Safety Committee Monthly Report (includes Health & Safety Key Performance Indicators)

The report structure has been revised to include Key Performance Indicators as an alternative approach to reporting, discussed at the last meeting. These will be reported monthly through the executive dashboard.

The Committee discussed reporting to the Health and Safety Committee from the Divisions and noted the importance of Divisional Directors being accountable and health and safety being embedded.

The role of the Safety Officer was noted and the interim arrangements for health and safety until the new Director of Nursing starts which is that the Director of Governance will lead with the Chief Operating Officer being the accountable Board member.

It was noted with some concern that there was still some poor Divisional reporting, mandatory H&S training attendance remains below target with attendance to Fire Training being particularly low. Risk assessments have still not been undertaken by every Division across all policy requirements.

The Assurance Committee noted the development of KPIs as a useful way to monitor progress on health and safety but remained deeply concerned about overall progress and lack of culture change and accountability.

3.2 Setters Report and additional information

Graham Setter (GS), Managing Director, and Steve Jones (SJ) Business Development Director of Setters attended for this item. They provided an overview of their review of health and safety in the Trust and the recommendations from the HSE Improvement Notice and the St. Stephens's incident action plan. Their conclusion was that further work was needed to make improvements proactive and sustainable. They wondered whether integrating H&S with Patient Safety which is a well-established area of work for the Trust could enable us to achieve the required cultural changes needed in a relatively new area by comparison. They noted lack of clarity around management responsibility within Divisions for H&S and that while there is substantial goodwill from those leading lines of work, there was a need for further training.

These points were discussed in detail and the means to achieve a step-change in H&S culture will be considered further at the Assurance Committee.

3.3 Never Events Assurance Report
This was noted. Actions are progressing and further progress is expected next month.

3.4 Annual Risk Management Report 2013/14
This was discussed in detail and some reporting clarifications requested. The areas of work for consideration next year include integration of H&S with patient safety, clinical handover, further Training for HCAs and an overall focus on prevention

The report is on the Board agenda. The Assurance Committee were assured on process.

3.5 Annual Maternity Risk Report 2013/14
This was discussed in some detail and some changes requested. The Committee noted the extensive risk work that had been undertaken in Maternity and progress made towards a very robust system.

The report is on the Board agenda.

3.6 Assurance Committee Annual Report 2013/14
This was agreed subject to some changes and will be presented to the July Board.

The report is on the Board agenda

3.7 Top Concerns from Medical Director and Nursing Director
No new concerns were highlighted. Work on failure to escalate is being measured through the National Early Warning System (NEWS) implementation and work is ongoing with mental health issues and reducing pressure ulcers.

3.8 Report from the Trust Executive Quality Committee, June
The report was noted and in particular the successful venous thromboembolism (VTE) initiatives.

3.9 Assurance Committee Terms of Reference (tabled paper)
The ToR was approved subject to comments.

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.5/Jul/13
PAPER	Risk Management Strategy and Policy 2013/14*
AUTHOR	Cathy Mooney, Director of Governance and Corporate Affairs
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
PURPOSE	To update the Board on risk activities throughout the year including incidents
LINK TO OBJECTIVES	Links to patient and staff safety
RISK ISSUES	Included in report
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	The attached risk strategy and policy has been reviewed for 2013/14 and approved by the Risk Management Committee and by the Audit Committee.
DECISION/ ACTION	For approval by the Board

1. Introduction
The attached risk strategy and policy has been reviewed for 2013/14 and approved by the Audit Committee.

2. Background
There was a major review in 2011 in preparation for the NSH Litigation Authority (NHSLA) standards assessment in December 2011 which incorporated advice from the internal auditors KPMG based on best practice as well as the requirements for the NHSLA and further changes in 2012/13, mainly to definitions, the training section and to reflect changes to committees

3. Changes for 13/14
These are as follows:

Introduction
This contains a statement on support for the principles of openness, transparency and candour following the Francis Inquiry report and in preparation of a duty of candour.

Section 3.14 Risk categories and risk appetite
The Trust Board appetite for risk has been inserted as agreed at the last Audit Committee.

Section 4.3 Key objectives for 13/14
The general objectives have been agreed by the Medical Director, Acting Director of Nursing and the Risk Management Committee.

The health and safety objectives will be agreed at the Health and Safety Committee meeting on 23rd July and will be approved at the Board meeting in October.

Section 5.2.2
Responsibilities have been updated for established post changes, notably the new post of Chief Financial Officer and the inclusion of quality in the remit of the Director of Nursing.

Section 5.3.2 Structure for the management of risk locally
This section has been checked to ensure it reflects current arrangements – changes in committees responsible for risk will be followed up to ensure no gap in risk management within Divisions.

Section 6
Monitoring of training has been revised to ensure compliance with training policy.

Section 7.2
This has been updated to be a more robust assessment of risk being managed locally.

Appendix 1 Trust Governance Structure
This has been amended to take into account some committee reporting changes but titles of Directors have not yet been changed as these changes are not yet fully implemented. In addition there are some gaps in reporting which need to be resolved e.g. Information Technology Steering group reporting, and the committee structure for quality will be reviewed later in the year. The separation between executive and assurance functions has been made clearer by the removal of the Trust Executive line, which apparently suggested that all committees report to it, rather than signalling overall responsibility and accountability.

4. Action

The Board is asked to ratify the approval by the Audit Committee of the Risk Strategy and Policy.

Risk Management Strategy and Policy 2013/14

START DATE:	July 2013	**NEXT REVIEW:**	June 2014
COMMITTEE APPROVAL:	Trust Board **DATE:** 25th July 2013	**CHAIR'S SIGNATURE:**	
	ENDORSED BY: Audit Committee	**DATE:** 10th July 2013	
DISTRIBUTION:	Trust wide		
LOCATION:	Intranet: Trust Policies and Procedures		
RELATED DOCUMENTS:	Procedure for the management and Investigation of incidents, including Serious Untoward Incidents (SUIs) Procedure for risk assessment and the risk register. Raising Concerns (Whistleblowing) Policy Training Need Analysis and Trust Training Policy Health and Safety Policy Major Incident Policy Flu Pandemic Contingency Plan Governance Structures and Processes policy Slips, Trips & Falls Policy Fire Safety Policy COSHH Policy Display Screen Equipment Policy Moving & Handling Policy Stress Policy Management of Body Fluid Exposure Policy Prevention of Body Fluid Exposure Lone Working Policy Security Policy Management of Violence and Aggression Policy Policy for Staff Induction		
AUTHOR / FURTHER INFORMATION:	Catherine Mooney Director of Governance and Corporate Affairs		
STAKEHOLDERS INVOLVED:	Executive team		

DOCUMENT REVIEW HISTORY:

Date	Version	Responsibility	Comments
May 2006	1	Director of Governance and Corporate Affairs	Revision of document May 2006
Oct 08	1.1	Director of Governance and Corporate Affairs	Update to reflect current structure and other minor amendments.
Mar 08	2	Director of Governance and Corporate Affairs	Yearly review. Incorporates changes to governance and health and safety

May 09	3	Director of Governance and Corporate Affairs	Yearly review. Changes to objectives
July 10	4	Director of Governance and Corporate Affairs	Yearly review. Changes to objectives
Dec 10	4.1	Director of Governance and Corporate Affairs	To include recently updated terms of reference of committees.
June 11	5	Director of Governance and Corporate Affairs	Yearly review. Changes to objectives. Inclusions recommended by internal audit
Oct 11	5.1	Director of Governance and Corporate Affairs	Revision to reduce duplication and provide more clarification in some areas. Terms of reference of the reporting committees have been removed.
June 12	6	Director of Governance and Corporate Affairs	Yearly review.
June 13	7	Director of Governance and Corporate Affairs	Yearly review.
DATE EXPIRED:		June 2014	

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1. INTRODUCTION

The Trust vision is to deliver safe care of the highest quality to our patients, provided in a modern way by multi-disciplinary teams working in an excellent environment, supported by state of the art technology and high class academic research.

The Trust is committed to a strategy and policy which minimises the risks of harm to people, services and the Trust and which aims to influence behaviour and develop an organisational culture within which risks are seen as everyone's responsibility and where they are promptly recognised and addressed. The Trust also strongly supports the principles of openness, transparency and candour and requires honesty openness and truthfulness in all dealings with the patients and the public.

The purpose of this document is to outline the strategic direction for the management of risks within the Trust and to provide a framework for the continued development of the risk management processes throughout the Trust.

Approval of the Trust's strategy and policy for risk management is a matter reserved to the Board.

2. SCOPE OF THE STRATEGY AND POLICY

2.1 General

The risk management strategy and policy relates to risk in all areas of the Trust's activities, and covers risks to both staff and patients and the organisation's assets.

It 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 and policy, understand their responsibilities in relation to managing risk and follow the guidance contained in the Trust risk management procedures. These are available on the Trust intranet

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The strategy section of this document outlines the Trust's objectives for risk management with the overall objective of protecting patients, staff and assets. Key objectives for 12/13 are identified in 4.2. The policy section outlines the roles and responsibilities of staff, structure of committees overseeing risk management and risk management processes.

2.2 Health and Safety

In the context of effective corporate governance, management of health and safety risks is a key issue for the Board, who have a collective role in providing committed leadership in the continuous improvement of health and safety performance. The Board will ensure that their actions and decisions always reinforce this commitment, and that they will review the effectiveness of the health and safety management system and performance, at least annually.

The Board has a specific responsibility under the Health and Safety at Work etc Act (1974), to prepare a General Policy statement and all staff are expected to comply with this policy, as outlined in the statement. The Board has a monitoring, review and policy setting role in health and safety.

With respect to risk management and in particular, Health and Safety, the Trust is committed to delivering the following:

Strong and active leadership:

- Visible, active commitment from the board;
- Integration of good health and safety management with business decisions;
- Establishing effective 'downward' communication systems and management structures.

Staff Involvement:

- Engaging the workforce in the promotion and achievement of safe and healthy conditions;
- Effective 'upward' communication;
- Attending training.

Assessment and review:

- Identifying and managing health and safety risks
- Accessing and following competent advice
- Monitoring, reporting and reviewing performance

This is undertaken by the Health and Safety Committee which reports into the Facilities Committee and ultimately the Assurance Committee.

3. DEFINITIONS

3.1 Risk

Risk is the chance something will happen that will have an impact on the achievement of our objectives or service delivery to patients, staff or visitors. This may include damage to the reputation of the Trust, which could undermine the public's confidence in us. It is measured in the terms of consequence (impact or magnitude of the effect of the risk occurring) and likelihood (frequency or probability of the risk occurring).

3.2 Hazard

Anything with the potential to cause harm (for example, disease, electricity, chemicals, sharps, an event with business or clinical implications).

3.3 Risk management

This 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.

3.4 Risk Management Processes

The risk management process is "the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk." Australian / New Zealand Risk Standards 4360:1999

3.5 NHSLA Training Needs Analysis (TNA) Minimum Data Set 2012/13

These are key subject areas in relation to risk and incorporate aspects of training. These include the following topics:

- Health record keeping training

- Hand Hygiene Training
- Risk awareness training for senior managers
- Moving and Handling Training
- Consent Training
- Slips, Trips and Falls Training (Staff and others)
- Slips, Trips and Falls (Patients)
- Inoculation Incident Training
- Harassment and Bullying Training
- Violence and Aggression Training
- Health Record Keeping Training
- Medicines Management Training
- Transfusion Process Training
- Resuscitation Training
- Venous Thromboembolism Training
- Investigations of incidents, complaints and claims training

3.6 Controls

Policies, procedures, practices, training, behaviours or organisational structures to manage risks and achieve objectives. Examples include a written system of working e.g. counting swabs; training programmes; software e.g. the system not allowing you to do something; physical barriers e.g. locked or key pad controlled access; security levels on software systems. The strength of controls can vary e.g. a policy or procedure is a weak control and in itself it does not help as it needs to be followed.

3.7 Assurance

This can be defined as confidence, based on sufficient evidence that internal controls are in place, operating effectively and objectives or actions are being achieved. Or 'Where can we gain evidence that our controls/systems, on which we are placing reliance are effective' or simply 'how do we know that something we are told is happening is actually happening'.
Examples of assurances include external validation such as via external visits e.g. the Care Quality Commission or the NHLSA assessment or via internal audit. This is the strongest form of assurance. Internal data can be used to provide assurance such as in clinical and non clinical audits, performance reports, finance reports, surveys, and questionnaires.

Having a policy or procedure in place is a weak assurance: it demonstrates that a practice has been described but provides no assurance that it is being followed. Minutes of meetings demonstrating discussions is slight stronger as it demonstrates active input, but the real test would be observation or audit. A negative assurance is that an incident occurs, which may demonstrate that a process is not being followed.

3.8 Comprehensive Risk Review: It is a mandatory, detailed risk review of all work areas within the Trust covering both clinical related and non-clinical risk.

3.10 Acceptable risk

The Health and Safety Executive (1988) has suggested the following definitions; -

"the risk although present, is generally regarded by those who are exposed to it as not worth worrying about."

The Trust classifies risks according to a risk classification matrix, which allocates a colour to indicate the level of risk associated with a hazard (green = very low, yellow = low, orange = medium, red = high) – refer to Appendix 2.

The Trust considers a risk to be acceptable when there are adequate control measures in place and the risk has been managed as far as is considered reasonably practicable. Risks falling in the green "very low" risk category are considered "acceptable" although the Trust will still need to take action on these risks where the assessment has identified that risks can be easily minimised.

3.11 Managed risk

'A risk that society is prepared to live with in order to have certain benefits and in the confidence that the risk is being properly controlled."

The Trust regards tolerable risks as those falling within the yellow "low" risk category. (Refer to risk classification matrix – appendix 2)

3.12 Significant risk

"a risk, that requires action in the short to mid term to reduce the likelihood of harm."

The Trust uses its risk classification matrix to categorise risk ratings and regards risk which fall into the orange "medium" category as significant. These are managed as described in the 'Procedure for Risk Assessments and the Risk Register' available on the Trust intranet.

Risks that are categorised as red are unacceptable. Therefore, the activity must be stopped immediately until the risk is substantially lower. These are managed as described in the 'Procedure for Risk Assessments and the Risk Register' available on the Trust intranet.

3.13 Residual risk

The risk remaining following treatment.

3.14 Risk categories and risk appetite

The Board sets the overall risk tolerance. One of the ways it constrains overall exposure to risk is to set authority limits for managers within policies and processes under the governance structure.

Risk tolerance has been divided into the following areas, based on the current classification and definitions of risks. *Risks can have more than one category e.g. a risk may be organisational and financial and reporting on risks refers to the main categorisation.*

3.14.1 Clinical risk

Those risks, which have the ability to affect patient care and may cause harm to the patient. This covers anything related to the diagnosis, treatment and outcome of each patient. Psychological harm or distress is also included. Tolerance: Nil tolerance in respect of risks associated with patient safety including non-compliance with Child Protection and Safeguarding Adults Policies.

3.14.2 Health and safety risk

Health and safety risks include risks that affect the environment of care and risks that could cause injury or ill health to any person in connection with the

Trust's activities. This includes fire, security, environmental and health and safety issues.
Tolerance: Nil tolerance in respect of risks associated with patient and staff safety

3.14.3 Financial risk

Those risks which have the ability to affect the financial well-being of the Trust.
Tolerance: Low tolerance to financial risks to safeguard public funds.
Moderate tolerance to financial risks with potential significant benefit to the Trust – patient care, efficiency and reputation.

3.14.4 Reputational risks

Those risks which adversely affect the reputation of the Trust
Tolerance: Low tolerance to risks that affect our reputation and the confidence patients have in the organisation.

3.14.5 Strategic risk

Those risks, which have the ability to affect the development, implementation and control of agreed strategies.
Tolerance: Moderate tolerance to opportunities that might arise through the course of normal business and moderate tolerance in respect of taking well-considered risks that influence and promote positive change.

3.14.6 Performance /organisational risks

Those risks that threaten the achievement of the organisations principal objectives and the viability of the organisation.
Tolerance: Nil tolerance

4. STRATEGY

4.1 Risk Management aims

Risk management underpins and supports all activities aimed to deliver the corporate objectives which are:

To improve patient safety and clinical effectiveness
To improve the patient experience
To deliver excellence in teaching and research
To ensure financial and environment sustainability

The risk management aims are:

- To ensure that all systems of risk identification and management are integrated and that risk management is a key part of all the Trust's business and clinical activities.
- To ensure excellent systems are in place for identifying, managing and monitoring risks including escalation of risk within the organisation to the appropriate committee or the board.
- To comply with the NHS Litigation Authority Risk Management Standards and all applicable Health and Safety and Environmental legislation.
- To promote and support an open and fair culture.
- To ensure that all staff are aware of their individual responsibilities, with respect to risk management and have a sound working knowledge of the Trust procedures.

- To provide risk management training in line with the NHSLA Training Needs Analysis (TNA) Minimum Data Set, to support effective and safe working practices.
- To provide training in other key areas associated with risk management such as risk assessments and health and safety training
- To support an ongoing programme to raise awareness of risk management throughout the organisation, in particular for senior managers and all Board members.

Key Objectives for 13/14

General:

- To develop a prevention strategy to include considering foresight training, continued focus on assurance on actions implemented, continued monitoring of controls and assurances for never events, the continued use of risk assessments locally and strategically and actions linked to them and focusing audit on ensuring 'right first time' for key procedures. October 2013.

- To achieve level 3 NHSLA general risk management standards in October 2013

- To identify and then monitor appropriate timescales for investigating incidents, including panel meetings and completion of reports in order to meet commissioner targets. A baseline will be established and targets set for the year by September 2013. Achievement of the targets may require fundamental changes to the current process.

- To implement on line incident and risk reporting and a supporting risk management system (to include incidents, claims, risks, COSHH assessments and complaints/M-PALS) by March 2014.

- To continue to ensure appropriate integration of all aspects of risk into day to day operations of the Trust and in particular Health and Safety by December 2013

- To ensure appropriate application of the Quality Governance Framework to risk structures and processes by March 2014

Health and Safety objectives 2013/14 Update to be agreed at HSC on 23rd July

5. RISK MANAGEMENT POLICY

5.1 Purpose

The purpose of the risk management policy is to define the framework for managing risk and the structure of risk management related committees. The policy also outlines the roles and responsibilities of all staff and the Trust's incident reporting and risk management arrangements.

5.2 Duties

5.2.1 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.

5.2.2 The Trust Board, Directors and Sub Committees of the Board

The Trust Board is responsible for overall governance of the organisation including risk management. The Chief Executive is the accounting officer.

a) Non-Executive Director / Chair of Assurance Committee

The Assurance Committee is chaired by a non-executive director. 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.

b) Non-Executive Director / Chair of Audit Committee

The Audit Committee 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.

c) Finance and Investment Committee / Chair of Finance and Investment Committee

The Finance and Investment Committee conducts an objective review of financial and investment policy issues, on behalf of the Board.

d) Directors

All Board Directors have a collective responsibility for risk management and individually for advising the Board as necessary in areas of particular expertise. All directors are responsible for ensuring that the risk management programme is effective both in their responsible areas and using their expertise, in the organisation. They are accountable to the Chief Executive for ensuring safe and healthy working conditions and will provide appropriate support to divisional managers in order that they are able to meet their responsibilities for health and safety.

e) Chief Executive

The Chief Executive is the Accountable Officer for risk management, including health and safety. The duty to implement Health and Safety Regulations has been delegated to the Director of Nursing and Quality.

f) Medical Director and Director of Nursing and Quality

The Medical Director and Director of Nursing and Quality have board level responsibility for risk management relating to their professional fields.

The Director of Nursing and Quality is also responsible for the operational aspects of Health and Safety. This post holder chairs the Health, Safety & Fire Committee; ensures that the Health & Safety policy is reviewed annually or as appropriate;

promotes a healthy, safe environment by effective communication and coordination on matters of health and safety; ensures that health and safety is given a sufficiently high profile to maintain a culture which encourages effective health and safety management; supports the Chief Executive in relation to corporate health and safety responsibilities; and ensures that staff have access to fire safety advice as part of their induction and to a range of health and safety related training as required to undertake their roles.

g) Chief Financial Officer

The Chief Financial Officer is responsible for finance overall and in particular developing income streams outside of the NHS This post delegates operational financial risk management to the finance director

h) Director of Finance

The Director of Finance is responsible 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 Finance Director is responsible for insurance arrangements in the Trust.

i) Chief Operating Officer

The Chief Operating Officer has operational responsibility for the running of the trust, manages the directors of Information Communication and Technology, Director of Estates and Facilities and has board level responsibility for these areas. This post is also the executive lead for Information governance

j) Director of Human Resources

The Director of Human Resources is the 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, and the Training Resource Centre, including the Trust's training database, the identification of training needs, the training prospectus and monitoring attendance at mandatory training.

k) Director of Information, Communications and Technology

The Director of Information Communications and Technology is the Director with responsibility for information technology. This post holder has a key role to play in business continuity of IT systems.

l) 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 legal affairs, corporate affairs, clinical governance and close working with the board sub committees responsible for risk management, which are the Audit Committee and Assurance Committee.

m) Executive Team

This refers to the Chief Executive, and all Directors including the Divisional Medical Directors and Divisional Operations Directors.

5.2.3 Trust-wide Responsibilities

The following committees and staff have designated Trust-wide risk management responsibilities:

a) Risk Management Committee

This is chaired by the Director of Governance and Corporate Affairs and it is a cross divisional multidisciplinary committee which aims to achieve a safer service for patients through reviewing incidents and risks, safety alerts etc and through facilitating learning and changes in practice. Terms of reference are available from the Foundation Trust Secretary/Head of Corporate Governance

b) Health and Safety Committee
This is chaired by the Chief Nurse and Director of Patient Experience and Flow and its aim is to consider general policy matters relating to the health safety and related welfare of employees, contractors, visitors and members of the public, to ensure a safe working environment and to advise Chelsea & Westminster Hospital NHS Foundation Trust accordingly. The terms of reference are available from the Foundation Trust Secretary/Head of Corporate Governance

c) Head of Clinical Governance
The Head of Clinical Governance is responsible for leading the implementation of all aspects of the Trust's Clinical Governance related objectives and has responsibility for the risk register and incident review register. The Head of Clinical Governance is also responsible for the Clinical Governance Support Team, which includes risk managers and clinical governance coordinators.

d) Risk Managers
The risk managers are responsible for maintaining and developing the incident reporting system, and supporting the divisions in the management of risks and incidents on the risk register and incident database in conjunction with the divisional risk leads. They also deliver training and education on risk management issues to staff, and provide advice and updates to staff on risk management issues. They support the divisions in their overall risk management responsibilities.

e) Health & Safety Consultant
The Health and Safety consultant provides advice on general Health and Safety and monitors and advises on safety performance.

The Health and Safety Consultant has a co-ordinating role in relation to general safety issues including delivering health and safety training, review of risk assessments and audit of the Trust Safety Management System.

The duties and responsibilities are:

- on a day-to-day basis to assist the Trust in ensuring, as far as is possible, that activities comply with the necessary legislation and to advise the management on safety matters, to ensure that the Trust's procedures for caring for the health, safety and welfare of its staff and students are of the highest standard and that the health, safety and welfare of the general public is not adversely affected by the Trust's activities;
    - to act as the Fire Safety Advisor as required by the NHS Firecode to support the Fire Safety Manager;
    - to act as the secretary of the Health, Safety & Fire Committee and follow up any recommendations made;
    - to provide training and instruction of staff and students in respect of safety and fire prevention, and to keep them conscious of the problems of safety, and of their responsibility for the safety of those with whom they work;
    - to carry out audits of each department at appropriate intervals and provide a report to department managers and safety committees;
    - to obtain, where appropriate, expert advice to ensure that the safety procedures in operation are of the highest necessary standard;
    - to act directly as advisor to managers and members of staff on safety matters and, where necessary, to obtain expert advice on their behalf;
    - to liaise on behalf of the Trust with the enforcing authorities on all safety & fire issues.

f) 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.

g) 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.

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

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

j) Moving and Handling Advisors
The Moving and Handling Advisors 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.

k) Local Security Management Specialist (LSMS)
The LSMS is responsible for reviewing security related risk assessments and will provide a quarterly report to the Health, Safety & Fire Committee of any risks identified as orange or above. The LSMS will lead Trust-wide security initiatives and will provide a monthly report to the Health, Safety & Fire Committee describing security-related activities experienced in the last month. The LSMS will initiate an investigation into all security incidents or allegations of crime and will support managers in discharging their duties in relation to any incident, as well as offering support to the victims of crime. The LSMS will report all allegations of criminal activity to the Police and will ensure that incidents of physical or verbal assault are reported to NHS Protect, in line with existing national guidance.

l) Organisational Learning and Development (OLD) Department
The OLD department is responsible for co-ordinating training for staff. This includes co-ordinating the corporate induction programme which includes risk management.

5.2.4 Division

a) Divisional Medical Directors and Operations Directors, Clinical Directors & General Managers, Chief Pharmacist and Head of Therapies
Divisional Medical Directors and Divisional Operations Directors, Clinical Directors & General Managers, Chief Pharmacist and Head of Therapies are responsible for ensuring that appropriate and effective risk management processes are in place within their designated area(s) and scope of responsibility; and that all staff are made aware of the risks within their work environment and of their personal responsibilities. They will ensure that local risks are regularly reviewed in directorate/department meetings to ensure timely and systematic maintenance of the Trust risk register. They are responsible for implementing and monitoring any identified risk management control measures within their designated area(s) and scope of responsibility ensuring that they are appropriate and adequate. For risks where local control measures are considered to be inadequate, they are responsible for bringing these risks to the attention of the appropriate forum, usually the Risk Management Committee if local resolution has not been satisfactorily achieved.

b) Risk Leads

The Divisional Directors will nominate risk leads through their clinical directors. Risk leads are members of the Risk Management Committee and are responsible for disseminating information from the committee and reporting relevant matters into the committee e.g. directorate/department updates.

5.3 Risk Management Structure

The Trust governance structure is attached as appendix 1 (Trust Governance Structure). This illustrates the committee reporting structure and which committees report into the sub committees of the Board.

5.3.1 Overseeing risk

The main Board committees for overseeing risk are the Audit Committee and the Assurance Committee which report to the Board. The terms of reference are available from the Foundation Trust Secretary/Head of Corporate Governance. The Audit Committee is responsible for the systems of internal control, while the Assurance Committee focuses on assurance of safety, quality, the environment, patient and staff satisfaction and supporting systems. Minutes of the Audit Committee and Assurance Committees are available to the Board after each meeting and in addition, there is an Assurance Committee meeting summary identifying key areas. The Audit Committee and the Assurance Committee each produce an annual report of the areas that they cover.

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The main committees with operational responsibility for risk management are the Risk Management Committee and the Health Fire and Safety Committee. The terms of reference are available from the Foundation Trust Secretary/Head of Corporate Governance. The Risk Management Committee reports to the Assurance Committee for risk through a quarterly report and to the Quality Committee through a monthly summary of the main items discussed at the Risk Management Committee.

The Health and Safety Committee reports to the Facilities Committee and to the Assurance Committee.

Other groups with a risk management remit which report to the Facilities Committee include Water Management, Sustainability and Waste Groups (see appendix 1)

5.3.2 Structure for the management of risk locally

The Trust has three clinical Divisions and corporate services. The Divisions and corporate services are represented at the Quality Committee, the Risk Management Committee, and the Health and Safety Committee.

Divisional structures

The overall Divisional structures are included in each Quarterly Quality Report and are available from the Head of Clinical Governance.

Within the Divisions risks are discussed in the following forums:

Women and Children, HIV and Dermatology

- Maternity Safety Meeting
- Clinical effectiveness committees for gynaecology, neonates and paediatrics
- HIV/GUM/Dermatology Clinical Governance Board
- HIV/GUM and Dermatology Clinical Effectiveness Meetings
- Neonatal and Paediatric Services Policy and Performance Board
- Women's Services Policy and Performance Board
-

Medicine and Surgery Division

- Sister's meeting,
- Medicine and Surgery Divisional Board
- Medicine Directorate Board
- Stroke Clinical Governance Meeting
- ED Clinical Effectiveness Committee
- Speciality surgery sub directorate meetings (general surgery, ophthalmology, burns, plastics, trauma and orthopaedics)
- General Surgery & Urology sub directorate meetings
- Burns sub directorate meetings
- Trauma & Orthopaedics -sub directorate meetings
- Plastics - undertake a quarterly review of incidents and risks at clinical governance half day meeting

Clinical Support Services

- Divisional Board – Quality
- Radiology safety committee
- Pharmacy Board
- ICU Board
    - ICU Clinical Incidents
    - ICU Clinical Governance Group

Corporate services

- Estates & Facilities have a bi-weekly Directorate Board.

5.4 Risk Management Processes

The risk management process is "the systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk." Australian / New Zealand Risk Standards 4360:1999

5.4.1 Process for Assessing all Types of Risk

These are identified and assessed both in a continual systematic way throughout the organisation as well as ad hoc, using a risk matrix (appendix 2). Further details are described in the **'Procedure for Risk Assessment and the Risk Register'**

5.4.2 Authority of all managers with regard to managing risk

The authority of managers with respect to managing risk is described in the '**Procedure for Risk Assessment and the Risk Register.** In summary, risks graded red must be escalated to the Chief Executive. The responsibility for managing the risk and the implementation of action plans will be at Director level. The risk assessment and plan of action will be reviewed and monitored by the Trust Board. For risks graded orange the relevant Executive or Divisional Director is responsible for managing the risk and the implementation of action plans. The progress on risk reduction for Divisional risks is managed through the Divisional structures and processes. For corporate risks, the progress on risk reduction is managed through the Risk Management Committee or other relevant Trust Committee e.g. Capital Programme Board. For risks graded yellow and green departmental managers are authorised to manage locally.

5.4.3 Risks associated with the Trust Strategic objectives (Assurance Framework)

The Trust identifies its strategic objectives and the process for developing the Assurance Framework identifies the risks of failure to deliver these objectives, the controls and assurances in place and the gaps in control and assurance. Following this assessment, risks are graded by the appropriate lead director. Risk graded orange or red have action plans linked to the gaps in control and gaps in assurance. Risks are also identified through papers presented to the Board. The full Assurance Framework is approved by the Board and the Board then receives a

quarterly report on orange and red risks only (Q1 Q2 and Q3 only as Q4 update is linked to the revised Assurance Framework for the following year) which contains an update on the action plans and any changes to the risks. The Board also receives a report on organisational, strategic, financial and reputational risks.

5.4.4 Local processes for managing risk

Divisional Directors, Clinical Directors, Divisional nurse leads and General Managers are responsible for ensuring that local processes follow the organisational strategy and policy as follows:

- By ensuring that staff within their areas report incidents, and these are followed up according to the grade and as specified in the incident reporting procedure (available on the Trust intranet)
- By disseminating learning through appropriate divisional meetings and Clinical Governance half days
- By participating in the annual comprehensive risk review
- By reviewing the incidents, complaints, claims and risk reports in the quarterly quality report, to ensure progress on action plans and learning
- By providing reports to the Risk Management Committee in order to share issues, progress and learning

5.5 Risk Assessments, the risk register and monitoring risks

Risks are monitored according to their grade with red risks being monitored quarterly by the Board, and orange risks being monitored quarterly through the Quarterly Divisional Reports (for divisional risks) and the Risk Management Committee (corporate and Trust-wide risks). The Assurance Committee receives a report on risks every quarter. The Board, through direct review of some risks and delegation of the review of other risks, has oversight of the organisation-wide risk register. Risks will be reported externally as appropriate. See 'Procedure for Risk Assessments and the Risk Register' available on the Trust intranet for more information

5.6 Adverse Incident Reporting and Investigation

Incidents are graded using the Trust risk grading system, outlined in the **Trust Procedure for the Management and Investigation of Incidents (**available on the Trust intranet). Incidents graded red are notified to the Chief Executive within one hour of the incident being identified. Incidents graded orange are notified to the Chief Executive and other key directors within 24 hours of the incident being identified. The Chief Executive will agree the panel for red incidents, and this may include a non-executive director and external members. Orange incidents are usually subject to a directorate-led review, although in some circumstances reviews may be chaired by an executive director or non-executive director. Incidents will be reported externally as outlined in the Trust Procedure for the Management and Investigation of Incidents.

Following completion of incident investigations, summaries of the investigation and recommendations are reviewed by the Director of Governance and Corporate Affairs. The report and recommendations are presented at the Risk Management Committee. They may also be presented at other committees if appropriate e.g. the Quality Committee in order to support Trust-wide learning or where the incident actions are more appropriately addressed.

The incident summary reports and recommendations are published on the intranet. A précis of the incident and the recommendations is placed on the incident review register, which tracks progress through to completion of the action. The register is updated as recommendations are achieved. Actions are reported every quarter in the Quality Report and reviewed at Divisional/Directorate Boards or other relevant meetings to ensure progress and identify any significant delays.

6. RISK AWARENESS TRAINING FOR SENIOR MANAGERS AND BOARD MEMBERS

All staff members including Non-executive Directors receive risk management awareness training as part of their induction. Participation in induction is recorded on a central learning database (OLM).

6.1 Board members risk awareness training

In addition to the Trust induction, new Board members, including Non-executive Directors receive additional risk awareness training from the Director of Governance and Corporate Affairs as part of their local induction. The Foundation Trust Secretary informs the Organisational Learning and Development Department (OLD) when training is complete.

Ongoing training is provided through relevant Board papers and seminars. All board papers have a risk section on the Board cover which notes the risk identified in the paper. Any Board members that are not able to attend Board meetings receive a copy of the minutes and presentations through the circulation of Board papers.

Monitoring:

The Foundation Trust Secretary will:

- Liaise with OLD if required (e.g. to contact NEDs) if a new Board member fails to attend corporate induction (OLD will inform the Foundation Trust Secretary as part of routine follow up if required)
- Monitor attendance according to the local induction programme for Board members and follow up if any part of the programme is not attended, by re-arranging that part of the induction.
- Check after the first 3 months, that all Board members have received their induction according to the induction programme and advise individuals and the Director of Governance and Corporate Affairs of any gaps so that corrective action may be taken.
- Follow up on the completion of local training cards if required.
- Ensure that all papers are received by all Board members even if they are unable to attend the Board meeting.

6.2 Senior managers risk awareness training

Senior managers receive risk awareness training through corporate induction. This is delivered and followed up through the ORD as described in the Trust induction and mandatory training policy.

In addition to the Trust induction, new senior staff (defined as 8a or above) receive additional risk awareness training by the Head of Clinical Governance or Risk Managers within the first three months. The Head of Clinical Governance identifies staff through the ' joiners report' provided by the Workforce Information Team.

Non attendance is followed up by the Head of Clinical Governance who will reschedule training and escalate if necessary in accordance with the Policy for Induction and Mandatory Training.

Monitoring

The Head of Clinical Governance monitors and reports on training provided on a quarterly basis. Any deficiencies identified will be recorded in the Risk Management Quarterly Report, which will be reported to the RMC. In addition monitoring is included as part of the audit of induction and mandatory training.

7. PROCESS FOR MONITORING THE EFFECTIVENESS OF THE RISK STRATEGY AND POLICY

7.1 Reporting Arrangements to the Board and High Level Committees

The monitoring of the systems of control within the Trust overall is monitored by the Audit Committee supported by internal audit, and the position expressed through the Annual Governance Statement which is approved by the Chief Executive and reported in the Trust

Annual Report. The adequacy of the Annual Governance Statement is monitored by internal audit through the Head of Internal Audit Opinion.

The reporting arrangements of committees reporting to the Board for risk (Audit Committee and Assurance Committee) are monitored annually through a review of agendas and minutes to confirm that reports are occurring to the Board as specified in the terms of reference. Where deficiencies are highlighted, action will be taken by the Foundation Trust Secretary and chair of the reporting committee. A review is also undertaken for committees reporting to the Assurance Committee and for regular reports e.g. risk management report. Where deficiencies are highlighted, action will be taken by the Head of Quality and Assurance and chair of the reporting committee.

An annual review of reports from the Divisions and reporting committees to the RMC committee is undertaken to ensure that reporting is occurring as specified in the terms of reference or annual calendar. Where deficiencies are highlighted, action will be taken by the chair of the RMC.

The main risk committees which report to the Board, the Assurance Committee, and the Audit Committee undertake an annual review of committee effectiveness. Where deficiencies are highlighted the relevant committee will develop recommendations to address them, and monitor implementation of any resulting action plans.

The Foundation Trust Secretary monitors terms of reference for Trust Committees quarterly to ensure that they meet the Trust requirements and are in date. Where deficiencies are highlighted these are addressed by the Foundation Trust Secretary, with escalation to the Director of Governance and Corporate Affairs as required.

7.2 Management of Risk Locally

An audit will be undertaken annually to determine whether the groups described in the policy as having a responsibility for risk still exist and whether risks are managed and discussed at these groups. A sample audit of agendas and minutes across the Divisions will be obtained to confirm this is the case.

7.3.1 Risk Management Awareness Training

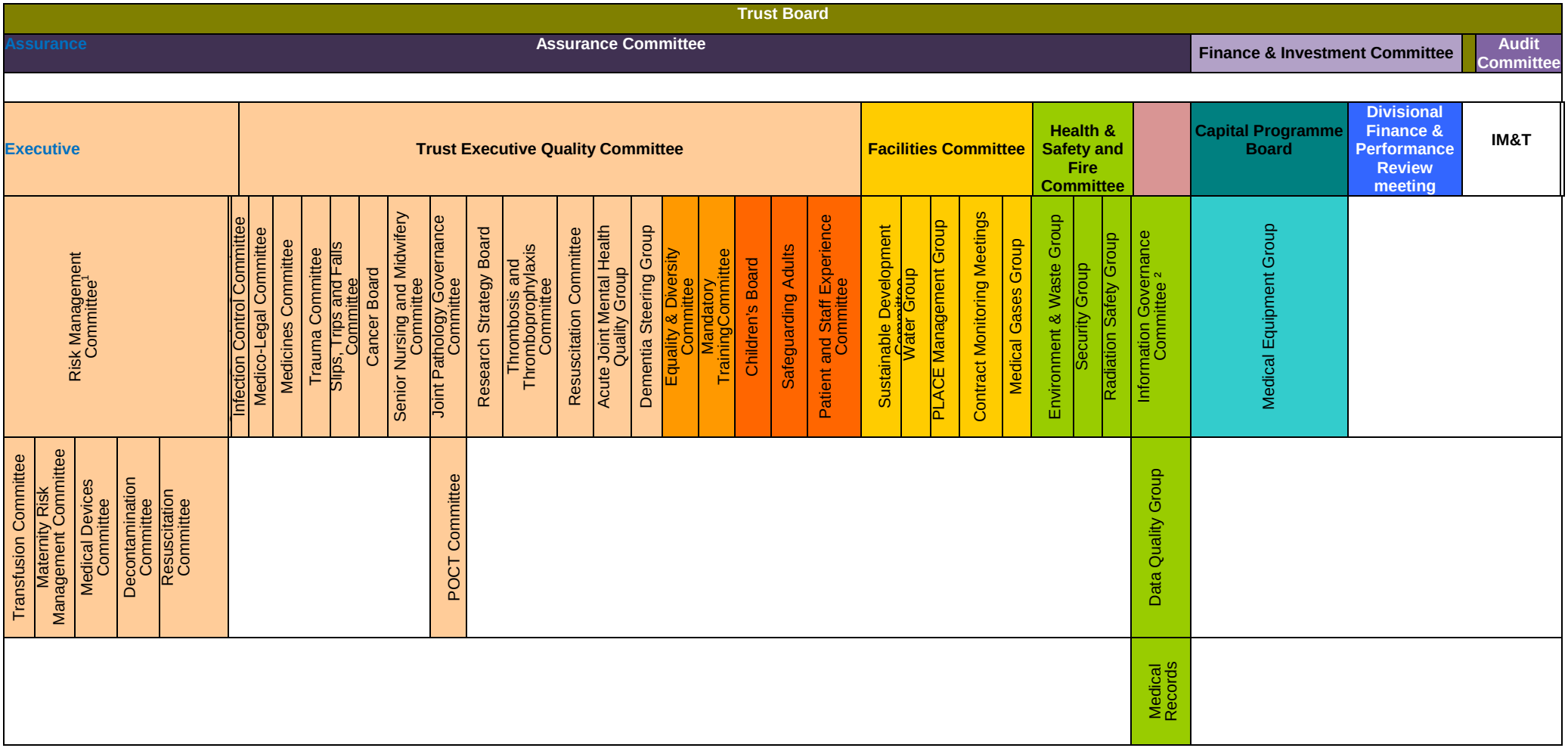
See section 6.1 and 6.2

8. DISSEMINATION

The main features of this policy and strategy are communicated to all staff as part of the induction programme, at mandatory updates and the document is available on the intranet. Other existing communication methods such as ‘Trust News’ and the Risk newsletter are used to increase general awareness of risk management issues.

Acknowledgements
The Royal National Orthopaedic hospital for risk definitions

Appendix 1 Trust Governance Structure
GOVERNANCE STRUCTURE JULY 2013



[1] Reports to both Quality Committee and Assurance Committee as relevant
[2] Reports to both IMT and Audit Committee

Appendix 2 RISK REGISTER/RISK ASSESSMENT GRADING SYSTEM

Full instructions for use are available in the 'Procedure for Risk Assessments and the Risk Register' available on the Trust intranet.

Risks are defined in terms of consequence using table 1. If several consequences are applicable, the highest score is used to determine the consequence. Likelihood is determined from the likelihood tables.

Table 1: Descriptors for Consequence/ Impact

Descriptor	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Extreme
Achievement of corporate objectives	No effect.	Minor impact on achieving one or more objectives.	Moderate impact on achieving one or more objectives.	Major adverse effect on delivery of one or more key objectives.	Will not meet one or more key objectives.
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Ongoing low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Service/ business interruption (will depend on criticality of service)	Loss/interruption more than 1-8 hour.	Loss/interruption more than 8-24hours.	Loss/interruption more than 1-7 days.	Loss/interruption more than 1 week.	Permanent loss of service or facility.
Financial	Local management tolerance level.	Loss less than £0.5M.	Loss between £0.5m and £0.999m.	Loss between £1m and £4.9m.	Loss of more than £5m.

Descriptor	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Extreme
Quality	Minor non-compliance with internal standards.	Single failure to meet internal standards or follow protocol.	Repeated failures to meet internal standards or follow protocols. Potential to affect external standards (e.g CNST, Health Care Standards). Failure to comply with IR(ME)R.	Failure to meet one or more external standards.	Affects achievement of a significant amount of external standards.
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Reputation	Rumours. No significant reflection on any individual or body. Media interest very unlikely	Damage to an individual and/or team's reputation. Some local media interest that may not go public. Local media—short term reduction in public confidence. Minor effect on staff morale.	Damage to a services reputation, or low key local media coverage. Local media—long term reduction in public confidence. Significant effect on staff morale.	Damage to an organisation's reputation with local or national media coverage. National Media less than 3 days. Major loss of confidence in organisation.	Damage to NHS reputation or national media coverage. National media more than 3 days. MP concern (questions in House). Severe loss of public confidence
Data security	Potentially serious breach. Less than 5 people affected or risk assessed as low e.g. files were encrypted.	Serious potential breach and risk assessed high eg. unencrypted clinical records lost. Up to 20 people affected.	Serious breach of confidentiality eg. up to 100 people affected.	Serious breach with either particular sensitivity eg sexual health details, or up to 1,000 people affected.	Serious breach with potential for ID theft or over 1,000 people affected.

Likelihood of exposure to this event

The likelihood of exposure to the risk is determined from table 2 by selecting from either the probability descriptors or the frequency descriptors, whichever is most accurate or appropriate

Table 2: Likelihood descriptors

	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
Probability Will it happen or not?	This is likely to occur in 1% of occasions.	This is likely to occur in 20% of occasions.	This is likely to occur in 50% of occasions.	This is likely to occur in 80% of occasions.	This is likely to occur in 90-99% of occasions.
Frequency How often might it/does it happen in a defined period	Not expected to occur for years.	Expected to occur at least annually.	Expected to occur at least monthly.	Expected to occur at least weekly.	Expected to occur at least daily.
Frequency How often might it/does it happen in general	This will probably never happen/ recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur possibly frequently

The risk matrix - table 3 is used to map consequence score with likelihood score and this combination of consequence x likelihood will provide your risk grade. For example if the

consequence is moderate (3) and the likelihood is almost certain (5), the result is Moderate (Orange).

Table 3: RISK MATRIX (RISK [R] = CONSEQUENCE [C] * LIKELIHOOD [L])

	CONSEQUENCE				
LIKELIHOOD	**1 Insignificant**	**2 Minor**	**3 Moderate**	**4 Major**	**5 Catastrophic**
1 Rare	**Green**	**Green**	**Yellow**	**Orange**	**Orange**
2 Unlikely	**Green**	**Green**	**Yellow**	**Orange**	**Red**
3 Possible	**Green**	**Yellow**	**Yellow**	**Orange**	**Red**
4 Likely	**Green**	**Yellow**	**Orange**	**Red**	**Red**
5 Almost Certain	**Yellow**	**Yellow**	**Orange**	**Red**	**Red**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.6/Jul/13
PAPER	Risk Management Annual Report 2012/13 Summary
AUTHORS	Malin Zettergren, Risk Manager Vivia Richards, Head of Clinical Governance
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
PURPOSE	• To report risk management activity during the year 2012/13 • To report on the number and type of incidents and risks arising in 2012/13 and the actions taken to manage risks or address incidents • To highlight lessons learned during 2012/13 and changes to practice as a result of incidents being reported • To summarise the risks on the register and examples of mitigation
LINK TO OBJECTIVES	Links to the Trust objectives for safety.
RISK ISSUES	None
FINANCIAL ISSUES	NA
OTHER ISSUES	NA
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	The Trust is committed to the management of risk and this is clearly demonstrated by the commitment demonstrated through risk management activities within divisions and the progress that has been made during 2012/13, however there are still areas for improvement.

	This report outlines a summary of issues identified and trends arising from incidents reported and risks highlighted and reported on the Trust Risk Register. It provides summaries of the number and types of incidents and risks, information on lessons learned and changes to practice in response to these incidents and risks. Good incident reporting and risk management practices can only be achieved through effective communication at all levels within the organisation, which is the lynchpin to the effectiveness of all risk management systems. Appendix 1 of this paper illustrates benchmarking data – incident reporting rate and results of the staff survey questions relating to incidents. The full Risk Management Annual Report 2012/13 is available in the supplementary papers and gives greater details of all issues highlighted in this report.
DECISION/ ACTION	The Board is asked to note the Risk Management Annual Report 2012/13.

RISK MANAGEMENT ANNUAL REPORT

EXECUTIVE SUMMARY 2012/13

1 Introduction

This document summarises the Risk Management Annual Report for the period April 2012 to March 2013. The full report contains the detail of the work that has continued in the Trust in 2012/13, building on previous achievements, to ensure that the management of risk is firmly established in order to ensure quality, safety and continued improvement of services provided to patients.

2 Lessons Learned and changes to practice during 2012/13

When things go wrong, or are narrowly avoided, we need to find out why it happened so that we can take steps to avoid a recurrence and make Chelsea and Westminster an even safer environment for patients and staff. Some examples of the lessons learned during 2012/13 include:

2.1 The patient locator on the Acute Assessment Unit (AAU) has been re-launched by the Lead Consultant to ensure it is being used by junior medical staff. The locator enables the clinical team to address any delays in clerking patients thereby initiating prompt and appropriate treatment.

2.2 Psychiatric Liaison staff now have access to the electronic patient record (Lastword) This improves the communication between the Psychiatric Liaison team and Trust staff in the management of patients with mental health needs.

2.3 Additional security measures were put in place with the introduction of infant tagging within the maternity service. There have been some issues with availability of the tags and additional supplies have been purchased. Additional teaching on application and removal have been initiated and a risk assessment is in place to ensure controls are in place to manage any emerging risks.

2.4 On AAU patients' pressure ulcer risk scores are now handed over with their 'early warning' score and is also documented on the handover sheet. Stickers of green, amber and red to notify staff of the level of risk are placed on the medical notes so that the entire MDT are aware of the risks and likelihood of that particular patient developing pressure ulcers.

2.5 The Infection Control Team and Nell Gwynne ward staff developed a *C.Difficile* algorithm for insertion in the bedside observations folder to help guide staff on when and when not to, take stool samples in patients with diarrhoea. Further education was also provided to ensure efficient use of the stool charts and screening tools.

2.6 Visual aids are now used in all cancer related MDTs in order to ensure that the site of any malignancy can be determined and is clear to all those attending the meeting. The diagram is then inserted in the patient's notes for future reference. Scopeguides are also routinely used during all colonoscopy procedures to reduce the risk of malignancies being missed.

2.7 In maternity a suturing proforma, which requires two signatures, was introduced as a response to serious incidents relating to retained vaginal swabs.

2.8 A 'quick prompt guide' was developed by a consultant in the Emergency Department (ED) and circulated to all staff in the department to help, in particular, junior members of the team out of hours when the ED is struggling with capacity. By including helpful hints and tips on actions to take, and when,

the aim of the guide is to prevent handover and waiting time related target breaches. The ED Escalation Policy was also updated to include clearer roles and responsibilities to aid communication.

2.9 In Dermatology a policy was developed and new processes introduced to help staff avoid the risk of overexposure of phototherapy as a response to several serious incidents. The phototherapy machine in questions has also been replaced as the timer was found to be faulty although this is not directly linked to the incident.

2.10 Although not considered surgical procedures the surgical safety checklist was introduced for all pain management related procedures, such as nerve blocks, carried out in the Treatment Centre to add extra assurance on these processes.

2.11 Following an audit relating to the management of pain in the ED, the documentation used was re-designed with a new emphasis on the importance of recording and re-evaluating a patient's pain score.

2.12 The alcohol withdrawal policy has been reviewed by an expert group to simplify the content after an incident revealed that the policy had not been followed as intended as unclear. Accessing the policy was also highlighted as an issue therefore staff are working on ensuring that the policy is easily found on the Trust intranet. The current alcohol withdrawal education provided to junior doctors is being reviewed and a withdrawal algorithm is being developed.

2.13 Following 3 incidents relating to NJ tubes becoming detached from the main tube specific training was completed in association with the company supplying the tubes. Further work is also ongoing with the suppliers to develop stickers which can be placed in the notes to identify batch numbers.

2.14 LastWord has been updated to provide triggers for neonatal staff when requesting blood products to ensure the requirements are made clear to laboratory staff. The lab standard operating procedure has also been updated as a response to an incident where an infant received non-irradiated blood contrary to their requirements.

3 Incidents

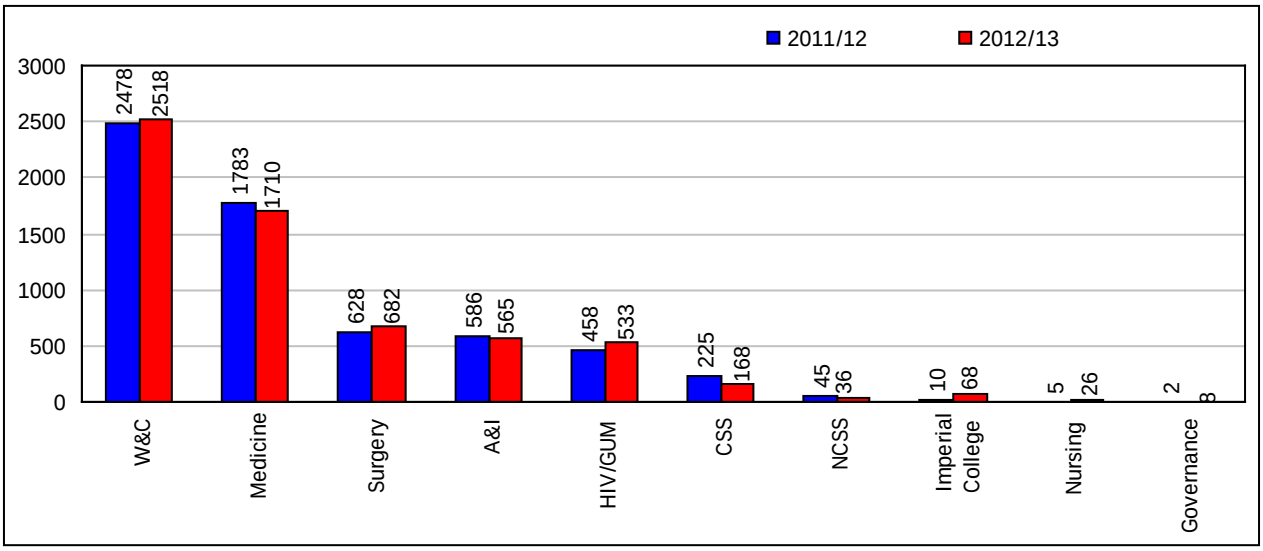
A total of **6,314** incidents took place during the 12-month period 1st April 2012 to 31st March 2013. This compares with **6,220** incidents in the previous year (2011/12), representing a **1.5% increase**.

Table 1 : Reported Incidents: Number of incidents per month, Apr 2008 – Mar 2013

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2008/09	378	535	595	460	450	446	579	773	439	525	396	528	6104
2009/10	549	490	491	457	467	515	510	471	409	516	451	503	5829
2010/11	448	467	411	542	515	603	522	537	454	478	499	465	5941
2011/12	444	497	501	498	531	528	479	523	485	594	568	572	6220
2012/13	460	521	531	560	505	426	530	597	569	555	504	556	6314

The evidence shows that teams, departments, and organisations that report more safety incidents are more willing to learn from their mistakes and to promote a culture where patient and staff safety is a high priority, therefore an increase in incident reporting is a good thing. A 'reporting culture' indicates that teams are 'risk aware' and signifies an open and healthy organisation.

Chart 1: Incidents Reported by Directorate, 2011/12 vs. 2012/13 (Clinical and non-clinical)



4 Top Five Incident Types & Risk Mitigation/Management Initiatives

The top five incidents reported were as follows:

4.1 **Blood/blood related incidents** – 782, a decrease of 12% from 888 in 2011/12

The majority of blood related incidents arise when the patient's details on the request form do not match the information on the electronic patient record, for example a mis-spelled surname or incorrect date of birth. The appointment of a Transfusion Practitioner in June 2012 and the establishment of Hospital Transfusion Leads (members of the Transfusion Committee) has resulted in an increased awareness of errors and a continuing improvement in reporting.

4.2 **Medication** – 766, an increase of 3% from 743 in the previous year

There was a trend in serious incidents relating to the administration of IV medication and the identification of over infusion as being frequent types of medication incident. An IV competency training package was further developed in 2012/13, and only relevant staff that have evidence of completion of a competency-based learning package have authority to administer IV medications; a central database of authorised staff is recorded on the MAPs system. This is also routinely checked as part of weekly nursing ward-rounds in order to spot-check injectable practices.

4.3 **Falls** – 533, a decrease of 0.5% from 562 in 2011/12

Documents to assist staff in assessing patients who are at risk of falls were further developed in 2012/13. Once patients are assessed, their care plan to prevent falls/harm is put in place. Successful initiatives in the past 18 months include the purchase and roll-out of falls alarms which are especially useful for people with cognitive problems as this increases the risk of a fall, the falls care plans have been redesigned and are available to patients and their carers along with information about falls prevention and patient wristbands for vulnerable patients which alert staff that the patient may be at particular risk of fall.

4.4 **Patient Care Related Incidents** – 522, an increase of 0.5% from 493 in 2011/12

This incident category mainly relates to instances where staff have failed to undertake required clinical observations, the management plan or where guidelines have not been followed, or where there is an absent or inadequate clinical management plan leading to a clinical incident. Early warning trigger systems have been further developed in 2012/13 to assist staff with correctly and consistently tracking and scoring a patient's

vital signs (heart rate, breathing rate, temperature and blood pressure) on a colour coded observation chart, flagging up any danger signs, and triggering a review of care.

4.5 **Delivery** – 429, an increase of 14% from 377 in 2011/12

This category relates to maternity-related incidents, and includes subcategories such as post-partum haemorrhage, unanticipated admissions to NICU, third or 4th degree tears or shoulder dystocia. These incidents are monitored on a monthly basis via a maternity dashboard and the more significant incidents are also subject to a formal investigation using a Root Cause Analysis approach. Common themes associated with unanticipated admission to NICU are the need to recognise early signs of sepsis and CTG interpretation, particularly subtle changes in the presence of infection.

5 Serious Incidents

135 incidents were graded orange during 2012/13 with no red incidents. This represents a significant increase from the previous financial year when 84 orange incidents were reported.

During this year standing panels, originally introduced within the Medicine and Surgery Directorate have been introduced within specialities of Women's, Neonatal, Paediatric and Young People, HIV/GUM and Dermatology Directorate.

One other major change relates to the NHS Commissioning arrangements, which has led to a requirement for the Trust to report an increased number of specific incident categories externally to commissioners via the Strategic Executive Information System (STEIS). The STEIS is a repository for notifying external agencies introduced by the Department of Health in 2002. Over the past 18 months there have been changes to the reporting requirements for identifying cases suitable for external reporting; this has led to a significant increase in the proportion of incidents warranting external notification and consideration as a serious incident.

The significant increase in orange incidents is largely attributable to an increase in reporting in two areas: hospital acquired pressure ulcers and also hospital acquired venous thromboembolism.

5.1 Pressure Ulcers

Pressure ulcers are a common problem for patients who have limited mobility, who sit or lie in one position for long periods of time. Due to blood flow being restricted by the pressure of body weight, the result can be severe tissue damage. They can also lead to patients needing surgery and long stays in hospital and can be potentially life-threatening. Reducing pressure ulcers is an important Trust priority; with this in mind, a 'care bundle' is being rolled out to assist staff with protecting patients from developing pressure ulcers.

5.2 Venous Thromboembolism: Assessing and Managing Associated Risks

All patients must be assessed for their risk of a VTE and, where appropriate, should receive a form of prophylaxis suitable to their personal risk and existing conditions. The Trust improved the process for identifying and investigating hospital associated VTE events in 2012/13 with the assistance of the Specialist Anticoagulation Pharmacist and working closely with the Risk Managers. Radiology reports are screened to identify new VTE diagnoses. Electronic records on the prescribing system are reviewed to determine whether the VTE diagnosis is hospital associated or not. A root cause analysis is then undertaken to determine if the VTE was preventable.

The Trust was awarded the 'Best Obstetrics Venous Thromboembolism Prevention' at the National Lifeblood VTE Awards in February 2013. Some of the changes and innovations undertaken by the team included an electronic VTE risk assessment specific for pregnant women with pop-up alerts and a training video on how to complete risk assessments, obstetric anticoagulation pocket guide covering VTE

management, improved awareness and best practice in the use of anti-embolism stockings via posters displayed in clinical areas on the measuring, application and monitoring of anti-embolism stockings, and the introduction of obstetric VTE ward rounds with summary reports circulated to the department on findings and improvements.

6 Contributory Factors

In our personal and working lives we all make mistakes in the things we do, or forget to do, but the impact of these is often non-existent, minor or merely creates inconvenience. In the hospital there is always the underlying chance that the consequences of mistakes could be significant or regrettably catastrophic. When such incidents occur it is uncommon for any single action or 'failure' to be wholly responsible. It is far more likely that a series of seemingly minor events all happen consecutively and/or concurrently so on that one day, at that one time, all the 'holes' line up and a serious incident occurs. Often, our investigations reveal that a number of factors (or failings) occur leading to the serious incident; these are referred to as contributory factors.

The most commonly occurring contributory factor identified from serious incidents during 2012/13 was communication, both written and oral. 58 out of the 135 orange incidents featured communication issues, including inappropriate communication of diagnosis/treatment and failure of communication at handover or ward round. Written documentation in the medical notes is often poor and sometimes also affects the investigation into an incident as occasionally evidence cannot be found to verify if a task was undertaken or not.

Interruptions were also cited as a contributor in 2012/13, where staff reported that they were doing several things at the same time (for example multi-tasking or being called away to attend to another patient), but failed to complete a single but important task. Inexperience with the Trust systems or lack of competence with a particular task was another commonly cited factor attributable to incidents during the reporting year.

7 Risk Register

Risks are categorised by 'risk type', indicating the type of consequence that an identified risk may have. The main source of the risk can be classified as being clinical, financial, Health and Safety, IT or performance.

At the end of March 2013, there were a total of 218 open risks on the Trust risk register, representing a 14% increase on 2011/12. 70 out of the total 218 risks relate to corporate objectives identified in the development of the Assurance Framework over the years and through papers provided to the Board. Assurance Framework risks relating to the current years' objectives and the actions taken to mitigate these risks are reported directly to the Trust Board by the Director of Governance and Corporate Affairs.

Of the open risks on the register, 32 out of the remaining 148 non-Assurance Framework risks were graded orange, and 1 was graded red. Risks are categorised by 'risk type', indicating the type of consequence that an identified risk may have, and also by the 'source of the risk', i.e. risk assessment, incident, and assurance framework for example. The open risks on the register at the end of March 2013 were categorised by type as follows:

Table 2: Open risks on the register by risk type and source

	Clinical	Financial	H&S	IT	Performance	Total
Assurance framework	15	21	5	0	29	**70**
Comprehensive risk review	2	0	1	0	0	**3**
Incident	3	1	5	1	2	**12**
Risk Assessment	57	4	59	7	6	**133**
Totals:	**77**	**26**	**70**	**8**	**37**	**218**

In 2012/13 a total of 91 new risks were opened on the register (compared to 169 the previous year) with 11 being closed during the same time period. 23 of the new risks related to the Assurance Framework.

45 out of the 91 new risks were graded orange and 1 was graded red. The red risk related to the 'Shaping a Healthier Future' consultation**.** which may have led to the closure of our emergency department had we been unsuccessful.

Table 3 : New Risks 2012/13

Directorate	VLOW	LOW	MOD	HIGH	TOTAL
Anaesthetics and Imaging Directorate	0	4	3	0	7
Clinical Support Services	6	1	3	0	10
Non Clinical Support Services	0	0	2	0	2
HIV GUM Directorate	1	3	2	0	6
Whole Hospital	1	4	2	1	8
Medical Directorate	1	1	3	0	5
Surgical Directorate	0	1	2	0	3
Women and Children Directorate	0	11	10	0	21
Governance & Corporate Affairs	0	1	1	0	2
TOTAL	9	26	29	1	65*

*26 of the new risks in 2012/13 were not assigned to a specific directorate; the majority of these were Assurance Framework risks.

Table 4: Closed Risks 2012/13

Directorate	VLOW	LOW	MOD	HIGH	TOTAL
Anaesthetics and Imaging Directorate	0	0	1	0	7
Clinical Support Services	0	0	0	0	0
Governance and Corporate Affairs	1	0	0	0	1
HIV GUM Directorate	1	1	0	0	2
Whole Hospital	1	7	2	0	10
Medical Directorate	1	2	0	0	3
Non Clinical Support Services	0	1	0	0	1
Nursing Directorate	0	0	0	0	0
Surgical Directorate	0	3	1	0	4
Women and Children Directorate	7	2	2	0	11
TOTAL	11	17	6	0	34

8 Examples of Actions Taken to Mitigate Risks on the Register

During 2012/13 a total of 66 risks were downgraded following the completion of actions to mitigate identified hazards. Actions include:

8.1 **Falls risks:** The Slips, Trips and Falls Group have been pro-active in reviewing current documentation, including the policy, updating the falls risk assessment and continuing to promote the yellow falls prevention aids (such as slippers and daily assessment charts). This year, a bespoke root cause analysis (RCA) tool for falls related incident investigations was developed. An improvement was seen in 2012/13 in not only the total number of falls but also the number of falls causing moderate or severe injury.

8.2 **Adastra IT System in the Urgent Care Centre:** Due to changes to the agreement with the license holder of the Adastra IT system, access and non-compatibility with LastWord is no longer an issue and the risk was closed in 2012/13.

8.3 **Medical Devices Procurement Process:** The Business Case forms were amended to incorporate: signature sign-off of proposals by Clinical Engineering and Clinical Skills Departments and a standard proforma/PQQ of device information required prior to approval in order to streamline the process and avoid the situation of devices being brought into the Trust without the knowledge or input of the Clinical Engineering Team.

8.4 **NICU infection control and capacity:** Number of cots reduced by 4 special care cots in October 2012 - leading to more surrounding space between cots. In addition a shower and toilet was removed to mitigate the risk of standing water and provide additional storage.

8.5 **Paediatric mental health provision:** Working with our partners, the Mental Health Admission guideline was updated and ratified to support management of these patients.

9 Never Events in 2012/13

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. An updated list of the never events list for 2012/13 was published on 18 January 2012. There are 25 national categories of "never events" on the expanded list. This includes the original eight events from previous years, some of which have been modified, and builds on the draft list published in October 2010.

In 2012/13 the Trust reported 3 incidents linked to never events, 1 related to maternity, 1 to orthopaedic surgery and 1 to Dermatology.

In 2012/13 the Trust reported 3 incidents linked to never events, 1 related to maternity, 1 to orthopaedic surgery and 1 to Dermatology.

In all cases a thorough investigation was undertaken and measures put in place to prevent re-occurrence. The Trust is systematically working through all never event categories to ensure that effective preventative measures are in place and are working.

Full reports relating to Never Events have been provided to the Board.

10 Maternity

Because of the high risk nature of the service, a separate comprehensive annual report has been produced relating to the Maternity service. The service monitors trends and emerging themes identified by incident reporting through discussion and review of monthly incident reports at the Maternity Risk Management Committee. Of the 6,314 incidents reported Trust-wide during 2012/13, 1,549 related to maternity services.

The trends in incident types reported within maternity remain unchanged in 2012/13, and are similar to trends reported during the previous year, the only difference being staffing issues replacing medication errors, which reduced significantly from 156 in 2011/12 to 89 during 2012/13.

This year two new obstetric labour ward consultants have been appointed who have taken active roles within the department's governance structure. One is the dedicated lead for risk management and together with the risk midwife, has been continuing work to strengthen existing governance frameworks and also the introduction of new systems to ensure learning and ongoing improvements in patient safety.

11. How do we compare?

See appendix 1

11 Conclusion

The Chelsea and Westminster Hospital NHS Foundation Trust is committed to the management of risk and this is clearly demonstrated by the progress that has been made during 2011/12, however there are still areas for improvement and these will be reflected in the risk management objectives for 2012/13.

To ensure that staff feel involved in the risk management process, can appreciate the benefits, and continue to report incidents, feedback mechanisms will continue to be developed during 2012/13.

All of the above requirements are to be addressed through the Trust's risk management systems. Good incident reporting and management practices can only be achieved through effective communication at all levels within the organisation, which is the lynchpin to the effectiveness of all risk management systems.

Two Reports are available upon request:

- Trust Risk Management Annual Report 2012/13
- Maternity Risk Management Annual Report 2012/13

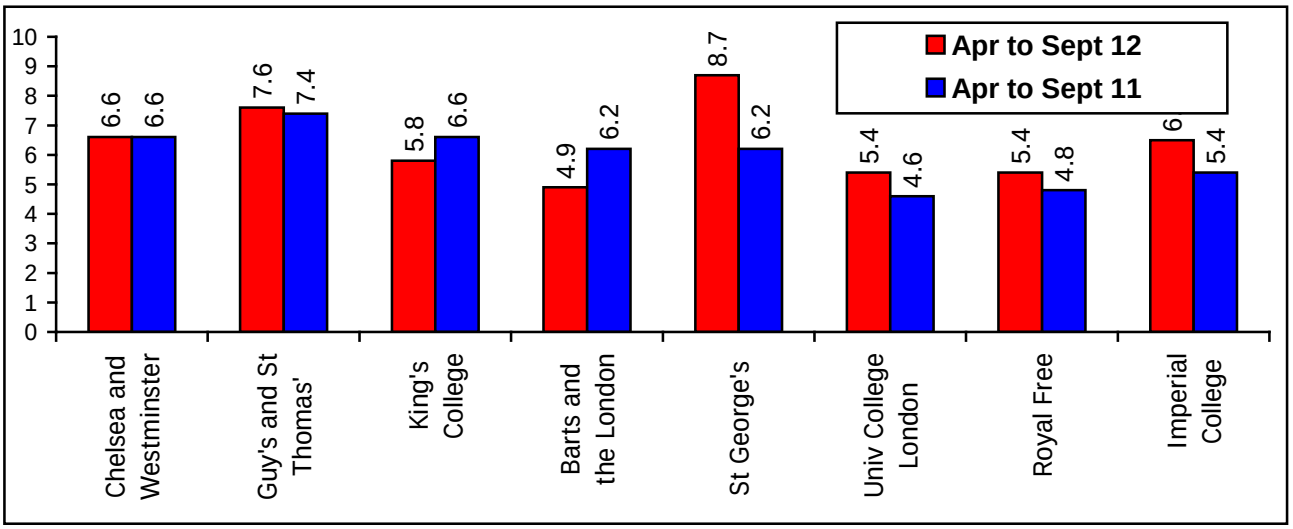
Appendix 1 How do we compare?

The following highlights the comparison data that is available

1. Comparison with our Peers – Patient Safety Incidents

A high reporting rate indicates a strong reporting and learning culture. Experience from other industries shows that as an organisation's reporting culture matures, staff become more likely to report incidents. The graph below shows the reporting rate per 100 admissions, comparing the Chelsea and Westminster Hospital with other Acute Teaching Trusts in the London Strategic Health Authority, based on incidents occurring between April - September 2010, and also April - September 2011. The reporting rate per 100 admissions at the Chelsea and Westminster Hospital was 6.6 in 2011/12, compared with an average of 6.5 reporting rate at similar Trusts. The data used for this comparison was extrapolated from the NPSA website.

Chart 4.4: Reporting rate per 100 admissions: Comparing Acute Teaching Trusts in NHS London



It is most often the case that those organisations which report more have a stronger learning culture where patient safety is a high priority – so resulting in better and more established reporting amongst all staff. The substantial increase in reporting seen at St George's is largely due to the recent introduction of an online reporting system.

Nationally – in 2012/13 - 67% of incidents were reported as no harm, and 1% as severe harm or death. However, not all organisations apply the national coding of degree of harm in a consistent way, which contributes to variations in the harm profile of each organisation. Therefore, deaths are often reported as incidents, even though it may relate to a natural course of events/the patient's illness or underlying condition.

Organisations are advised to record the actual harm to patients rather than potential degree of harm. **86%** of all incidents reported by the Trust were **no harm** incidents, well above the national average.

The source of the above comparative information is the National Patient Safety Agency (NPSA). On Friday 1 June 2012 the key functions and expertise for patient safety developed by the NPSA transferred to the NHS Commissioning Board Special Health Authority.

2. Staff survey results

The attached Appendix 1.1 is a summary of the 3 Key Findings from the most recent staff survey relating to reporting.

Table 1 shows our performance in these 3 key findings, against last year, the national average for acute trusts and our own benchmarking against other London acute trusts. You will see that we are either in the top 20% nationally or better than average for each Key Finding.

Table 2 shows the Key Findings responses broken down by staff group. Please note this data is unweighted, which will mean the totals are slightly different to the official Key Findings report

Table 3 shows the Key Findings responses broken down by Divisions. Again this data is unweighted

Table 4 shows the individual questions asked in the survey. The responses are shown against last year and the national average.

appendix 1.1

Key Finding	2012	2011	National Average**	National ranking	C&W London Ranking***
* ***KF13:*** *% of staff witnessing potentially harmful errors, near misses or incidents in last mth*	31%	36%	33%	Below (better than) average	4/22
KF14: % of staff reporting errors, near misses or incidents witnessed in the last mth	94%	97%	90%	Highest (best) 20%	7/22
KF15: Fairness and effectiveness of procedures for reporting errors, near misses or incidents (1-5 where 5 is the highest)	3.59	3.54	3.5	Highest (best) 20%	7/22

*** KF13-Lower score is better**

****National average of all acute trusts**

***** 22 London acute trusts**

Professional responses (this data is unweighted)

Key: Highest / Best Lowest / Worst

Staff Pledge 3 : Provide support & opportunities for staff health, well-being & safety	N&M (Reg)	Nursing Support	Medical & Dental	AHP	Prof & Tech (Support)	Sci & Prof	Prof & Tech (Reg)	Admin & Clerical	Senior Mgt	Trust	C&W 2012 vs National Acute Trusts
* ***KF13:*** *% of staff witnessing potentially harmful errors, near misses or incidents in last mth*	48%	19%	38%	33%	36%	31%	45%	13%	21%	34%	Below (better than) average
KF14: % of staff reporting errors, near misses or incidents witnessed in the last mth	96%	-	92%	93%	-	-	-	92%	-	94%	Highest (best) 20%
KF15: Fairness and effectiveness of procedures for reporting errors, near misses or incidents	3.70	3.66	3.59	3.53	3.91	3.73	3.54	3.45	3.55	3.64	Highest (best) 20%

Divisional responses (this data is unweighted)

Staff Pledge 3 : Provide support & opportunities for staff health, well-being & safety	Clinical Support	Women's Children & Sexual Health	Medicine & Surgery	Mgt Executive	Trust	C&W 2012 vs National Acute Trusts
* ***KF13:*** *% of staff witnessing potentially harmful errors, near misses or incidents in last mth*	31%	40%	44%	20%	34%	Below (better than) average
KF14: % of staff reporting errors, near misses or incidents witnessed in the last mth	93%	95%	96%	93%	94%	Highest (best) 20%
KF15: Fairness and effectiveness of procedures for reporting errors, near misses or incidents	3.72	3.61	3.58	3.44	3.64	Highest (best) 20%

Questions within Staff Survey	C&W 2012	Average for acute trusts	C&W 2011
% witnessing errors, near misses or incidents in the last month that could have hurt staff	21	20	24
% witnessing errors, near misses or incidents in the last month that could have hurt patients / service users	30	30	34
(If YES to Q17a or YES to Q17b): % saying the last time they witnessed an error, near miss or incident that could have hurt staff or patients/service users, either they or a colleague had reported it	96	94	N/A
My organistaion treats staff who are involved in an error, near miss or incident fairly (Strongly agree/Agree)	59	48	53
My organisation encourages us to report errors, near misses or incidents (Strongly Agree/Agree)	86	86	87
My organisation treats reports of errors, near misses or incidents confidentially (Strongly Agree/Agree)	66	64	65
My organisation blames or punishes people who are involved in errors, near misses or incidents (Strongly Agree/Agree)	12	13	10
When errors, near misses or incidents, my organisation takes action to ensure that they do not happen again (Strongly Agree/Agree)	68	61	64
We are informed about errors, near misses or incidents that happen in the organisation (Strongly Agree/Agree)	49	41	47
We are given feedback about changes made in response to reported errors, near misses and incidents (Strongly Agree/Agree)	49	41	47

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.7/Jul/13
PAPER	Complaints Annual Report 2012/13 Summary
AUTHOR	Carol Davis, Head of Patient Affairs
LEAD	Tony Pritchard, Acting Chief Nurse
PURPOSE	• To report Complaints and Patient Advice and Liaison Service (PALS) activity during the year 2011/2012. • To report on the number and type of issues and complaints received. • To present a summary of key trends in complaints and concerns raised. • To report on performance in relation to the complaints response process. • To summarise organizational change and development in response to feedback from complaints and concerns.
LINK TO OBJECTIVES	Improving the patient experience
RISK ISSUES	It is essential that issues raised from complaints and concerns are dealt with in a sensitive and timely manner so as to prevent re-occurrence or escalation of incidents.
FINANCIAL ISSUES	NA
OTHER ISSUES	NA
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This report presents a summary of the feedback and trends identified by the complaints team during the year 2012/2013. It provides a summary of the number and type of complaints and concerns, information on performance in the response process, and organisational change initiated in response to feedback from complaints and concerns. The full Trust Complaints report for 1012-13 is available from Vida Djelic, FT Secretary at vida.djelic@chelwest.nhs.uk and

	gives greater details of all issues highlighted in this report. A total of 809 type 1 concerns were received with the top 3 most common concerns being appointments/delay or cancellation (out-patients), attitude of staff and written / oral information given to patients. 354 type 2 and 23 type 3 complaints were received from the 1st April 2012 to 31st March 2013. There was a 14% reduction in the number of formal complaints received between the year 2011/2012 and the year 2012/2013 The top 3 complaints by subject relate to aspects of clinical care or treatment, attitude or behavior of staff and written / oral information given to patients. The Chief Executive, the Chief Operating Officer and the Chief Nurse review all the final responses to ensure the quality of the investigation The Trust demonstrates a positive approach to organisational learning and development from complaints. This is integrated to our patient experience strategy and into local service changes.
DECISION/ ACTION	The Board is asked to receive and comment on the. Complaints and MPALS Annual Report summary 2012/2013.

Complaints Annual Report Summary 2012/2013

1.0 Introduction

1.1 This report presents a summary of the feedback and trends identified by the complaints and Patient Advice and Liaison Service during the year 2012/2013. It provides a summary of the number and type of complaints and concerns, information on performance in the response process, and organisational change initiated in response to feedback from complaints and concerns.

2.0 Background

2.1 The complaint handling regulations were introduced in April 2009 (The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 Statutory Instrument), together with guidance from the Department of health ('Listening, Responding, Improving" 2009).

2.2 The complaint arrangements require that the response to a complainant is proportional to its nature and accurately focuses on the issues raised. Response time-scales are no longer stipulated in the national regulations. The Trust has determined three types of complaint with associated target response times. Each case is graded using the Trust matrix which assesses consequence to the patient and or the organisation, and the likelihood of the incident recurring (see table 1).

Table 1: Grading of concerns and complaints

Grade	Description	Trust Target Response Time
Type 1	Low risk	10 working days
Type 2	Medium risk	25 working days
Type 3	High risk	50 working days

3.0 Annual Trends

Table 2 (below) shows a comparison of complaint and concerns by type over the past 3 years.

Table 2: Total Complaints 2009-2012

	10-11	11-12	12-13
Total	1343	1284	1186
Type 1	956	848	809
Type 2	379	419	354
Type 3	8	17	23

3.1. Type 1 Concerns

During 2012/13, the M-PALS service received a total of 809 Type 1 concerns. This compares to 848 in 2011/2012. The most common concerns raised with the M-PALS service are detailed in table 3 below.

Table 3: Top 3 Primary Subjects type 1 2012/2013

Subject	2011/12	2012/13
Appointments/delay or cancellation (out-patients)	279	201
Attitude of staff	72	85

Communication/Information to patients (written and oral)	106	115

3.2 Type 2 and 3 Complaints

A total of 354 type 2 and 23 type 3 complaints were received from the 1st April 2012 to 31st March 2013. There was a 14% reduction in the number of formal complaints received between the year 2011/2012 and the year 2012/2013. The top 3 issues are shown in table 3 below.

Table 3: Top 3 Primary Subjects type 2 and 3 2012/2013

Subject	Number of Complaints
Aspects of Clinical Care or Treatment	171 [45%]
Attitude or behaviour of staff	75 [20%]
Information/Information to patients (written and oral)	40[11%]

3.3 Type 2 Complaints

Directorates were asked to respond to these within 25 working days. Of these, 81% were responded to within this timeframe. A performance target of 90% in meeting response time is established for such complaints; Clinical Support service, Surgery, Central Outpatients and HIV/GUM achieved the target (Range 66%–96%). Performance in relation to these response times has been escalated to the appropriate Divisional Directors of Operations.

Of the 377 type two and three complaints; 23 were re-opened. This represents 6% of the complaints received this year, compared with 5% in 1011-2012. Of those complaints that were re-opened, 18 were resolved through further local resolution and meetings.

An Action Plan is sent to the Directorates and they are required to confirm that the complainant has been given the opportunity to discuss their concerns and the time scales for a response. 89% of all complainants were contacted to discuss their complaint; this is against the Trust target that 95% of all complainants should be contacted with 5 days of the complaint been acknowledged to discuss resolution.

3.3 Type 3 Complaints

23 complaints were graded as type 3 during the reporting period 2012-2013. All complaints identified clinical care as the primary subject. Response times for these were extended to 50 working days to allow for the type of investigation required. 30% of the type 3 complaints received a response within 50 working days. 16 complainants received a response after 50 days.

With regard to the increase in type 3 complaints; since the introduction of the new Complaint Handling Regulations, the Patient Affairs Team and the Risk teams are better at cross-referencing the complaints with clinical incident reporting. Some incidents are now automatically graded as Orange; therefore any complaints relating to these incidents are graded as Orange. Some complaints were initially graded as orange; they investigated and reviewed as clinical incidents but downgraded on the Risk Matrix once the investigation was complete.

4.0 Complaints by Subject

4.1 **Aspects of Clinical Care**: During the year 2012/2013 the Trust has received 171 complaints where the primary concern relates to clinical care or treatment. A further 10 complainants identified an issue regarding their clinical care but this was not the primary subject. Complaints in this category include any allegations about standards of clinical care or practice. It includes diagnosis, physical examination, disputes about the appropriateness of treatment, questioning of competence and clinical interventions. Further information is noted on pages 9-14 of the full Trust Complaints report.

4.2 **Staff Attitude/Behaviour**: During 2012/2013, the Trust received 75 complaints where the primary concern related to the attitude and behaviour of staff. A further 54 complainants identified concerns regarding the attitude of staff but not as the primary concern. Complaints in the category relating to staff attitude and/or behaviour including concerns raised about rudeness, lack of sympathy, apparent disinterest and not providing a standard of personal service expected by the complainant. Further information is noted on pages 15-17 of the full Trust Complaints report.

4.3 **Communication:** During 2012/2013 the Trust has received 40 complaints or concerns where the primary concern related to the communication and information given to patients; a further 24 complainants identified this as an area of concern. Communication remains a key theme that has been identified in our recent inpatient and outpatient surveys. Communication is a core strand of the strategy to improve the patient experience at the hospital. Further information is noted on pages 18-19 of the full Trust Complaints report.

5.0 Parliamentary and Health Service Ombudsman

5.1 This year the Trust was notified by the Parliamentary Health Service Ombudsman (PHSO) that they intended to consider nine complaints. In eight cases, the PHSO decided they would not accept the complaint for investigation and would take no further action. In one case the patient was referred back to the Trust for further local resolution, following further work from the division to resolve the issues, the Ombudsman advised they would take no further action. The Trust has taken reassurance that the complaints referred to the Ombudsman have not been accepted for investigation or upheld.

5.2 From April 2013, the Ombudsman's office has advised that they will begin investigating and sharing reports on more of the complaints. This is part of their new strategy 'More Impact for More People'. They will be investigating thousands rather than hundreds of complaints each year. The Ombudsman will continue to publish figures for the number of complaints they investigate about each organisation in our jurisdiction, but will be explicit that our change of process is a reason for the significant increase in the number of investigations they will undertake during 2013/14. Further information is noted on pages 19-20 of the full Trust Complaints report.

6.0 Patient Experience

6.1 The Patient Experience Strategy has been developed to improve the experience patients receive. The three themes are attitude of staff, communication and discharge. The themes were identified through analysis of national patient survey responses and analysis of complaints and concerns. The complaints and PALS

teams report on the numbers of complaints and concerns received relating to these themes and identify the main issues reported by our patients. Each division has developed action plans; the key achievements are reported to the Patient Experience Committee and Quality Committee.

7.0 Change of Practice

7.1 As a learning organisation, committed to continuous improvement, it is important that lessons learned from complaints are shared across the Trust and used to enhance the quality of services for the future. Further information is noted on pages 22 -25 of the full Trust Complaints report.

7.2 All recommendations made are recorded on the Risk Management Database and a quarterly report is sent to General Managers. A range of changes and improvements have been initiated across the Trust as a result of complaints received during the year 2012-2013.

Examples include;

- In response to a number of concerns raised about the ophthalmology department [logged as outpatient] a service improvement meeting has been set up to monitor progress against the plans for improvement; this was led by the General Manager for Surgery. A business case was approved to increase the numbers of nursing and medical staff in order to support the growing service. The number of administrative staff has also been increased and the staffs have now been fixed to the speciality in order to provide continuity.

- A service improvement plan of the admissions department has been undertaken. As part of the process a new telephone system will be introduced to ensure all patients who are trying to get through to the department are communicated with efficiently and expediently. It is intended to stop the use of answering machines within the department. Patients who raised a concern were invited to attend a meeting with members of the surgical management team to share ideas from a patient's point of view.

- A clinical protocol is developed for the management of patients attending with abdominal pain and raised inflammatory markers (blood tests indicating a source of infection). This will provide all medical and nursing staff with a consistent and structured approach to support the assessment and effective management of patients attending with these symptoms.

- A pain audit has been recently completed and as a result of this, the documentation used within the ED has been re-designed and re-printed to emphasise the importance of recording and re-evaluating a pain score.

- 40 breastfeeding peer supporters are being recruited and a new breastfeeding lead is about to be appointed.

- The visiting hours for partners have been extended on the postnatal ward; this will prove valuable for our patients and encourage family bonding during the early days following birth.

8.0 Summary

8.1 This report has provided a summary and analysis of complaints and concerns raised through the Complaints Service during the year 2012/13. The complaints and concerns we receive continue to inform the action plans relating to the Patient Experience. Robust systems and processes are in place to ensure compliance with the current national complaints handing regulations and related DH guidance. There is a clear focus on complaints and concerns by the Executive Team. The Chief Executive, the Chief Operating Officer and the Chief Nurse review all the final responses to ensure the quality of the investigation. They are each responsible for one of the divisions and work closely with the complaints team and Divisional Directors to identify trends and ensure that prompt action is taken in response to complaints.

8.2 The learning and changes identified are monitored and any outstanding actions escalated to the Chief Nurse. The Trust demonstrates a positive approach to organisational learning and development, through a range of changes and developments initiated as a result of patient and public feedback.

Carol Davis
Head of Patient Affairs

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.8/Jul/13
PAPER	Complaints Policy and Procedure
AUTHOR	Carol Davis – Patient Affairs Manager
LEAD	Tony Pritchard, Acting Chief Nurse
PURPOSE	To update the Board
LINK TO OBJECTIVES	Improving the patient experience
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	The complaints policy was updated in July 2013, to meet the requirements of the NHSLA Risk Management Standards. This was due for review in September 2013. However in February 2013, the Francis report was published. The report delivers 290 recommendations to be considered. Following the Francis report a review of hospital complaints was announced by the Prime Minister. The Clwyd and Hart review of NHS hospital complaint handling will involve patients, their carers and representatives, staff and managers and other organisations involved in handling patient complaints to hear how trusts currently deal with concerns that are raised. It will look at the common standards that should be applied to the handling of complaints. It is anticipated that both the complaints and PALS policy will require changes once the Clwyd and Hart review of NHS

	hospital complaint handling has been completed. It is anticipated that this review will be completed in November 2013. The Complaints policy will be reviewed to reflect the recommendations of this review and the statement from Norman Lamb, the Minister of State for Care and Support regarding complaints about the Liverpool Care Pathway, and revision to the policy will be presented to the Board in January 2014
DECISION/ ACTION	To approve extension of the expiry date of the complaints policy and procedure to January 2014 when a revised document will be presented.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.9/July/13
PAPER	Review of strategic objectives, Board Assurance Framework report and risk report Q1
AUTHOR	Fleur Hansen, General Manager to the Chief Executive Cathy Mooney, Director of Governance and Corporate Affairs
LEAD	Tony Bell, Chief Executive
PURPOSE	To inform the Board of the next steps for developing clear deliverables for our strategic objectives which will inform a revised Board Assurance Framework. To update the Board on risks arising from the previous year's BAF and Board papers.
LINK TO OBJECTIVES	Links to strategic objectives
RISK ISSUES	Included in paper
FINANCIAL ISSUES	Included in paper
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	The Board Assurance Framework for 2013/14 Q1 would normally be presented at the June Board. It has been suggested by a number of Board members that it would be helpful to map expected progress for our strategic objectives to inform the Board what to expect for the coming year and beyond. It is also important to ensure that whilst reflecting our Annual Plan, our objectives have clear deliverables with specific timeframes to provide clarity. This objective mapping exercise will then inform the Board Assurance Framework going forward with the intention that it

	will allow the Board to check progress identify risks to achievement, and identify where progress is not in the timeframe expected in a more specific way than in previous years. A detailed proposal will be developed with the executive directors to be presented to the September Directors' Strategy meeting for discussion. The Board is therefore asked to note that a Board Assurance Framework will not be presented at this meeting but the Risk Report is being presented to provide the Board with assurance that these risks are being managed. Strategic risks will continue to be identified and actively managed through the Board and the sub-committee processes and will be highlighted to the Board as necessary.
DECISION/ ACTION	For information and noting the risk update.

RISK REPORT QUARTER 1 June 2013 UPDATE

The risks below are those identified from Board reports and previous Board Assurance Frameworks that are rated orange or above.

Risks from board reports Q4 12/13 and Q1 13/14

Risks not on this report have been mitigated or superseded by subsequent reports e.g. performance reports

Updates from Q3 12/13 are in italics and bold

Date	Source	Risk(s) Identified (Description)	Controls/actions	Risk Register ID and grade
Apr 2013	Papers to Board 13/14 PUBLIC	**Monitor In-Year Financial and Governance Combined Return for 2012/13** The Trust is submitting a 'Green' Governance Risk Rating having achieved all its clinical targets. The Trust has triggered 2 financial risk indicators per the Monitor template, as follows: • Debtors > 90 days old are greater than 5% of total debtors. • Capital expenditure is <75% of the reforecast plan for the full year. However the reforecast plan included the purchase of adjacent accommodation which has now slipped into 2013/4, therefore the revised plan if this is excluded is £23.1m. Actual outturn is £18.6m against this revised plan therefore on this basis capital expenditure is 81% of the plan.	**This related to the 2012/13 outturn position and the Trust achieved its overall financial and governance targets therefore this risk has closed.** **(It will be replaced with the risk identified for the 2013/14 financial position.)**	
Apr 2013	Papers to Board 13/14 PRIVATE	**Trust Budget and Business Plan 2013/14** 1. Transfer of £19m of sexual health services to local authority commissioning brings a risk of reduced margin. 2. Potential risk of £.1.1m to the financial plan if	This risk is in relation to local authority commissioning of sexual health services. The risk is graded orange. Action plan: 1) TB has written to David Nicholson to escalate concerns and explore alternative models of commissioning.	Orange

		sexual health services are not funded at the 2013-14 non-mandatory tariff.	2) The Trust has billed local authorities for months 1 and 2, most of which has not yet been paid and is being actively pursued for resolution.	
Mar 2013	Papers to Board 12/13	**Trust Budget and Business Plan 2013/14** 1. Transfer of £19m of sexual health services to local authority commissioning brings a risk of reduced margin. 2. CIP delivery is high risk with £2.4m recurrent gap carried forward from 12/13 and only 66% of 13/14 target identified at time of report. 3. Cash risk with potential impact on ratings on all commissioning contracts for April and May due to delay in contract agreement. 4. Treatment of the Cheyne lease on buy back of Doughty House may deteriorate the risk rating if our treatment is not accepted.	1) Sexual health commissioning is covered in the above risk within the April Finance Board paper. 2) CIP delivery- this is red rated because at M3 risk adjusted delivery is £12.9m out of £18.7m total incl b/f therefore £5.8m remaining. 3) Cash risk- this risk is graded Orange. At the time of writing there is £2.7m of Q1 income billed to CCGs that has not been paid, partly awaiting contract closure. 4) This risk on accounting treatment of lease buy back is graded yellow; dependent on concluding transaction and completing treatment and agreeing it with auditors and potentially Monitor.	Orange
Feb 2013	Papers to Board 12/13	**Finance and Capital Plans for SAHF Reconfiguration** 1. The 'Do minimum' build, which forms the basis of the NPV evaluation for the capital requirement is not the preferred design solution though it is technically feasible. The Executive Directors have assurance from the NWL Programme sponsor that we will not be held to deliver this solution and there will be a fair risk share on any capital spend above the 'Do Minimum'. (cf Paragraph 13). 2. The outline timetable is too ambitious and the phasing of the Chelsea and Westminster build vis a vis the St Mary's build need to be more aligned. (cf Paragraph 14) 3. Alternative options for the local hospitals have been considered and are preferred in principle	This risk is subject to the SaHF business case being developed during 2013/14.	TBC

		but these involve builds up to 6 times the level of the Do Minimum Capital Investment and would require a cumulative additional efficiency of 5% by 17/18 to maintain the target 1% net surplus position. The affordability to the whole reconfiguration plan therefore depends on the outcome of the next phase of OBCs and FBCs to be worked up by individual trusts. (cf Paragraph 20 – 23)		

Orange and red risks from risk register relating to previous BAF and from papers to the Board

Date	Source	Risk(s) Identified (Description)	Controls/actions	Risk Register ID and grade
Apr 12	Papers to Board 12/13	**Inpatient Survey 2011** Reputational risk due to poor results on the inpatient survey. Also demonstrates potentially poor care. (Remains orange until next survey results)	The patient and staff experience committee is now established. A patient experience lead has been appointed. ~~for a six month contract~~ to take forward key objectives within the patient and staff experience action plan. Real time and quarterly patient surveys are now in place to allow closed monitoring and action planning to address areas of poor performance Trust values and linked behaviours have been developed and have been launched. Values have been sent to all staff and teams and departments **have identified** behaviours Values have been included in the quality planning process, incorporated into appraisals and wok in on-going to incorporate into other HR processes such as recruitment,	783 Orange
April 11-June 11	Papers to Board 11/12	SUI Report – **gynaecology death** Risk of not having timely consultant reviews. Audit showed performance could improve.	The incident review actions were: To introduce a system (amend the rotas) to ensure that patients admitted to gynaecology as an emergency are seen by a consultant at the earliest opportunity. Ideally this should be within 12 hours and should not be longer than 24 hours. Documentation of the first consultant review should be clearly indicated in the clinical records and be subject to 6-monthly audit, or until assurance is provided to the Divisional Board that this is in place. **Update on Consultant Attendance Emergency**	715 Orange

			The last formal audit was July 2012 where 91% of women admitted were seen within 24 hours and 62% were seen within 12hrs with continuing improvement from previous years (78% and 48% respectively for 2011. **There has not been a repeat formal audit since July 2012 but this is now due. There is directorate priority to meet new pan London commissioning standards for Consultant review of emergency admissions within 12 hours.** **Currently day time Emergency Consultant cover is provided by consultants from a rota where sessions are either providing care in an SPA or from other clinical sessions. However since July 2012 we have resourced 3 dedicated day time emergency gynaecology sessions from new appointment and locum consultant sessions. These sessions are highly regarded with improvement in teaching, quality of care and responsive proactive consultant input from a consultant with dedicated session for emergency gynaecology.** **Simultaneously the Directorate have put forward a business case for 168 hours consultant cover for labour ward which includes provision of two consultant posts which mirror each other but who will also provide resident on call. Their duties will include responsibility for weekday consultant emergency care from leading an emergency assessment/admissions, review of inpatient admissions and performing or supervising emergency gynaecology e operating in the daytime. Even in the event that the 168 hours consultant cover for labour is phased, the two emergency gynaecology consultant roles will be in the first wave of phased resident consultant expansion,** **Summary** **There has been a year on year improvement of consultant attendance of emergency gynaecology inpatients. There has been in year strengthening of the provision of the**	

			emergency gynaecology consultant cover during the day with additional dedicated daytime sessions which allow proper triaging, management of emergency admissions in hours. There are firm plans to provide robust dedicated care by the appointment of two emergency gynaecology consultants as part of the 168 hours Labour ward business case. A repeat audit is due.	
Mar 12	Papers to Board 11/12 Performance Report	**Never events**	Schedule for review of controls and assurances in place for all never events. Retained swab – actions been discussed at Quality Committee and Assurance Committee. Assurance Committee requested monthly update on Never Events **Confirmed remains orange**	787 Orange
12/13	BAF	**Develop and embed our values** Lack of engagement by staff means that there is no change to behaviour and therefore no impact on patient experience	Values have been sent to all staff and teams and departments **have identified** behaviours Values have been included in the quality planning process, incorporated into appraisals and work in on-going to incorporate into other HR processes Patient Experience Committee -define expected outcomes, measure and review. - establish a model of engagement - highlight good and bad practice **Patient experience summit – 130 staff and stakeholders attended – developed a series of always events based on values and good practice.**	801
12/13	BAF	**IT/telephony** - significant investment and substantial CIP Risk is timeliness and delivery Not all identified partners will join. Clarifying that partners requirements are aligned Concern re our IT resilience to be able to support Implementation Chief Technical Officer is key and need to identify Complexity re economics of scale Some potential issues Issues about partners' IT Directors	Long term programme director is now in place. Board level ownership from partners to be established. No Project plan in place yet and no reporting of the programme board in place. Progress Q3 12/13 - Need programme Director in place. Recruitment not successful. Confirmed only RMH and C&W. Can now progress programme. Scope in place for next stage. Due to be signed 15th Feb Action from Q3 BAF- Reinstate formal feedback to Mon Execs on SLR	802

			Update Q3 - No progress. Business case for changing the Finance structure to devolve business analysts to the Divisions and change the roles to be presented to the Exec team in Feb 13 **Update: The new structure is agreed: Director of Finance is in post and recruitment for the devolved business analysts is underway.** **For the IT shared service project the business case for the Fulham Road shared services IT project was approved at the June FIC.**	
12/13	BAF	**Drive efficiency through service line reviews** Lack of engagement from services for service line reviews and lack of follow through on implementation leading to no change	Facilitators identified - clinicians - strategy - Performance - Finance Been trained. Overseen by COO and Director of Finance to ensure progress. Formal reporting on progress to Divisional Board and Mon execs (management assurance) is not occurring(gap identified Q2 12/13) **Update: SLR Updates still outstanding**	803
10/11	BAF	**Staff failure to recognise deteriorating patient.**	Actions for this covers two areas, early warning systems supported by documentation and a communication tool SBAR. **NEWS is being rolled out.** MEWS – recent audit showed a greater than 75% compliance rate. SBAR – This has been introduced via the hospital at night programme. It has been decided that SBAR would be re-introduced and supported further as part of the NEWS role out. SBAR is currently taught on all resuscitation courses which include induction and updates.	594 Orange
11/12	BAF	**Staff not trained or competent which affects quality of care.**	Training provision; selection process; appraisals. Mandatory training reports to managers and Trust Executive and Assurance Committee meetings every quarter. Appraisal rates are now over 80% and feedback is that they are well structured. Mandatory training is still falling short of requirements.	663 Orange

			No change	
11/12	BAF	**Agency staff - not familiar with the area and level of competency unclear** - can, therefore, affect quality of care to patients.	Recruitment policies aiming to minimise agency staff. Bank office only books via LPP approved agencies. Induction training procedures to reduce risk. Vacancy and sickness management reduces likelihood of needing agency staff. Regular monitoring of agency use. We know from a recent audit that local induction is not occurring for agency staff and therefore they remain a risky group. A senior nurse has been appointed to support training and recruitment of bank and agency staff. **In July a working group will be established to focus on more effective use of agency staff and reducing numbers**	664 Orange
11/12	BAF	**Failure to retain CLAHRC collaborative.**	CLAHRC Board need to get programme grants in. Develop and maintain partnership working within the CLAHRC. Ensure CLAHRC projects align with BSC research. Actively working with CEO and others in area including AHSN. **Presentation in July – went well -awaiting outcome**	678 Orange

Risks downgraded since last report (Q3 2012-13)

Date	Source	Risk(s) Identified (Description)	Controls/actions	Risk Register ID and grade
Oct 12*	Paper on NWL Collaboration of CCGs Strategic Commissioning Intentions for 2013/14	Section 3 of the paper set out a number of risks to the financial plan as a result of the strategic intentions. The o impact : could be up to £5m above financial plan = 4 Likelihood: likely = 4 Overall in impact = 16 Red	Meeting arranged with the CCG to discuss further. We have responded to their intentions indicating our wish to work collaboratively and identifying that clarity is needed on PbR rules and noting that we have a legally binding contract with them. Weekly contract negotiation meetings with the commissioners are in place. We are ensuring optimal clinical engagement. This is discussed weekly at the Executive team meetings. **Risk mitigated by successful partnership approach**	Yellow
10/11	BAF	**Reconfiguration of emergency surgery** NWL Provider reconfiguration e.g. another site is emergency surgery hub.	Ensure clinical representative on reconfiguration meetings. Extend links with GPs. Influencing and lobbying especially GPs Seeking partnerships to strengthen our position. Agreed to be pilot for quality and safety analysis and safety audit (NWL). Good results from audit. **No active discussions on-going so considered grade reduced.**	609 Yellow
June 12	Papers to Board 12/13	**Electronic Document Management (EDM)** There are some risks with the operating relationship with Kainos and their sub contractor which has led to slower	. Contract now signed, PID and programme plan in place. ***EDM is now live.***	785 yellow

		progress to date than planned. The risk is that slippage in delivery affects the implementation of the IT strategy.		
12/13	BAF	Either loss of A and E and all consequent patient flows OR a significant increase in activity as a result of the closure of the A&E at CXH. Loss of activity of this scale would threaten our viability as an FT. Gain of activity would lead to an increase in some specialities and further pressure on physical capacity. (Risk from Monitor Business Plan) **Update:** Option A Identified as preferred option, but remains unclear whether outcome will be implemented. Uncertainty may affect our ability to develop service strategy	SAHF planning groups preparing the case for JCPCT on the basis of recommending option A Trust engagement in SAHF which will review proposals prior to JCPCT in February.	793
	BAF	The process for designation of 'facility' status for burns could allow other providers to bid. The risk is that they take market share and in due course would be more competition for subsequent designation as a unit/centre. The main risks are St. George's which is a trauma centre and BLT	Specialist Commissioners have awarded the Trust £2-3m Capital for adult burns development.	794
	BAF	There are risks that the paediatric review could compromise C&W's status as a tertiary centre	The contract for paeds surgery is now in the main contract.	795
12/13	Papers to Board 12/13 Performance Reports	**Failure to achieve the 9 CQUINs, worth approx £3.3m** **CQUIN: Update Q2** Whilst progress in Q1 and Q2 has been compliant, the most significant challenges commence from Q3 onwards. Of the 9 CQUINS agreed with NWL the greatest financial weighting is on GP real-time information, where the Trust is required to ensure that GPs receive notification in real time of patients attending the Trust, outpatient letters within 5 days and discharge summaries within 24 hours of discharge, amongst others. Plans are in hand with divisions to minimise the risk to the Trust.	Negotiation through the contract to ensure targets are realistic and achievable. Owners assigned Implementation plans developed Performance review process established. * Q1 & Q2 signed off by commissioners * GP real time live w/c 1/10 * Performance review process established to secure achievement in Q3 and Q4	788 Closed

			CQUINS achieved	
May 12	Papers to Board 12/13	**Sexual Health Strategy** Market share – competitors increasing marketing activity. Commissioning uncertainty – commissioning moves partly to local authorities and unaware of their intentions Commissioners seeking to reduce expenditure in this area	Involvement in strategic change programmes regionally. Commissioning process for 2013 clarified which reduces potential risk. Adjust service mix in response to updated commissioning arrangements. **Marketing plan and activity underway**	784
11/12	BAF	**Building new paediatric capacity and failing to get referrals - the risk is we are not profitable and there is no ROI.**	Influencing GPs to refer. Paediatrics Outpatients and In Patients is targeting waits to attract referrals and maximise use of capacity as part of access initiative. **Update: This is no longer an orange risk as we have sufficient referrals**	687
11/12	BAF	**Lose tender for paediatric surgery and medicine in NWL - risk is significant reduction in activity, linked to the above.**	***This risk has been reduced as paediatric surgery and medicine in NWL is now within the contract***	688
11/12	BAF	**Inability to improve patient experience in postnatal** further as actions taken so far demonstrated little impact.	Review of year 1 data. Meet with women to identify where initiatives are not improving experience. Decrease in complaints and change in nature of complaints. PET. **Update: *patient experience surveys now show that this is amongst the best results in the Trust.***	703
11/12	BAF	**Inability to improve patient experience in Paediatric outpatients** as booking in process is limited - not sufficient capacity at peak times at reception	Paeds access initiative approved at the Board **Update: there are still space issues in paediatric outpatients but we no longer have long waits.**	704

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.10/Jul/13
PAPER	Quality Awards*
AUTHOR	Melanie van Limborgh, Head of Quality and Assurance
LEAD	Catherine Mooney, Director of Governance and Corporate Affairs
PURPOSE	This paper provides a briefing on the winners from the recent Awards.
LINK TO OBJECTIVES	The Quality Awards link to the Care Quality Commission Quality and Safety requirements externally and the Corporate Governance Divisional objectives in the Trust.
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	The Council of Governors' Quality Awards are awarded for Patient Safety, Patient Experience, Clinical Effectiveness and the Trust Values. For Spring 2013 there were 5 winners and 1 commendation. Following introductions by the relevant governors these awards will be presented by the Chairman during the July 2013 Council of Governors Meeting. (Further details of any of these awards are available from the Head of Quality and Assurance - Melanie.vanlimborgh@chelwest.nhs.uk)
DECISION/ ACTION	For the Board of Directors to note for information

Council of Governors' Quality Sub Committee Quality Awards Report Spring 2013

1.0 Introduction

The aim of the Trust's Quality Award is to recognise and reward contributions to quality initiatives in the Trust from an individual or team who have made a contribution to quality for patients under four categories, (Patient Safety, Patient Experience and Clinical Effectiveness and the Trust Values). This award is open to Chelsea and Westminster Trust employees who all have the potential to directly or indirectly improve quality through improving the patient's experience. The award can be received for a project, an initiative, or a change in the work of staff that as a result provide benefit to quality of care.

As part of the award the winners have the opportunity to meet with key Directors and governors of the Council of Governors Quality Sub-Committee to discuss their initiatives and highlight their achievements. The winners also receive £250 to benefit the work of their department.

The Council of Governors Quality Awards are supported, directed and awarded by the governors from the Council of Governors Quality Sub-Committee. The Quality Awards are held twice yearly. Award applications are required to meet set criteria.

The Spring applications have seen sustained good numbers as on previous awards and there were 5 teams in the winning category and one commended application.

2.0 The Quality Award winners

2.1 Respiratory Physiotherapy - A review of service provision and implementation of simulation based on-call physiotherapy training.

The respiratory physiotherapy service is offered 24 hours a day, 7 days a week. The primary role of this service is to minimise and re-inflate areas of lung collapse, clear respiratory secretions and reduce the need for mechanical ventilation, hence escalation of care. The respiratory physiotherapy team (in collaboration with the centre for good clinical practice) led this work to enhance practice in the Trust.

Prior to this new initiative, the respiratory physiotherapy service had been provided by the specialist respiratory physiotherapy team split into a separate day and evening service. The evening was covered by on-call staff that was often non-specialist and worked in many different clinical areas across the hospital. Due to recent changes in the service provision across therapies, there was an increasing and unsustainable overlap between the end of a normal working day and the beginning of the evening on-call. The on call service was also not cost effective as the majority of call outs (50%) occurred between 4.30pm and 8pm in the evening.

In order to adapt to new hours of work across the therapies department; to reduce staffing costs; and ensure that patients are seen by specialist staff; the existing hours of service provision within the respiratory physiotherapy team was reviewed and amended. Additionally, the team also had to ensure clinical competence within the non-specialist workforce covering evening respiratory patients' on-call. This has previously been achieved through case study and lecture based annual training.

The project sought and established review and changes to the existing service provision with respiratory physiotherapy. A simulation training day aimed at

improving clinical reasoning/ non-technical skills in the non-specialist work force was implemented in the physiotherapy team to provide and improved and enhanced service for patients.

2.2 Implementation of a men's health physiotherapy service for the treatment of incontinence post radical prostatectomy.

Best practice demonstrates that pre and post radical prostatectomy pelvic floor exercise training with a physiotherapist reduces incontinence rates post radical prostatectomy.
As part of this quality improvement, the women's health physiotherapy team changed practice to treat not only women with incontinence but also to increase their skills and to provide more care in the service to include treatment to men with specialist needs.

The multidisciplinary team (MDT) and their patients were questioned via a survey monkey audit of the service and how treatment should be reviewed. Work went forward with a specialist course and development of protocols in practise. The initiative in the new service met several effectiveness and patient experience goals for both male and female patients that included:

- Providing further treatment to improve the quality of life of patients following surgery and using evidence based care.
- Additional education for staff for treating incontinence - this resulted in a reduction in patients reporting in incontinence
- Meeting patients before surgery, planning patient centred care, explaining possible symptoms and supporting patients to help improve any symptoms if experienced.
- Assessments were developed to be patient centred and developing goals the patients wanted to achieve with individualised programmes
- Facilitating patients with pre-surgery exercises to help them to focus on their post-surgery requirements.
- Post-surgery follow up, support and familiarity with known experienced health professionals.

As a result, clinical consultants reported the new direction of care was considered 'essential to treatment' and the evidence from the survey undertaken demonstrated evidence of positive patient reports following treatment.

2.3 Implementation of the Nutritional Assessment Tool and National Care Pathway to improve Adult Patient Nutritional Care in an Inpatient setting

The Nutrition and Dietetic Department Acute Team of Dieticians and EPR team established the Nutritional Assessment Score (NAS), related nutritional care pathway, and electronic ward kitchen screens. There was support from several staff disciplines, volunteers and capital funding.

Over 5 years, audits identified inefficiencies in the Nutritional Assessment of patients. Formerly there was a stand-alone, paper-based process that was not integrated to the Electronic Patient Records, and not consistently benchmarked to national criteria. This meant time consuming Nutritional Assessment requiring audit and also when a patient moved within a ward or between wards, that the nutritional records regarding patients'' requirements would have to be manually updated. This was costly in terms of hospital resources and often fell behind a patient's immediate nutritional

requirements for the next day. The system was noted as unreliable, and not every case of potential malnutrition was being identified.

The National Patient Safety Agency (NPSA) and Care Quality Commission (CQC) identified patients' nutrition as a priority requiring all hospitals to have a process in place to prevent malnutrition from happening or worsening in patients. Patients have to be nutritionally screened for malnutrition on admission and weekly thereafter, to identify vulnerable patients allowing for systems to be put in place to support the nutritional care of that patient.

The objectives were to:

- Develop a system of screening embedded within the electronic admission process of the patient and weekly thereafter (paediatrics, maternity & ITU excluded)
- Consistently achieve 90% patients nutritionally assessed within 24 hours of admission
- Introduce weekly nutritional re-screening and achieve a target of 90% of patients re-screened
- Improve communication between all relevant parties (e.g. dieticians, nursing staff, catering staff and volunteer staff) by implementing an electronic identification system to keep staff constantly up to date with information.
- Acquire funding to support the delivery of electronic ward kitchen screens
- Ensure structures are in place to support best nutritional practices (Nutrition Pathway)

The project addressed quality in 2 phases and achieved:

- A more effective nutritional screening system was introduced in 2010, undertaken by nurse at the time of patient admission. The system moved from a paper-based system and the data was entered directly into a new system.

- In Phase 2 there was the implementation of an electronic communication system, aiming to improve the communication between all disciplines of staff on the nutritional care of all patients, especially those highlighted at risk of malnutrition. Dieticians worked with the EPR team (Electronic Patient Records) to agree how the nutritional care requirements could be integrated and accessed for each patient at the point of treatment.

Capital bids secured in 2012 funded screens within 10 selected adult wards. Since April 2013 these screens have been live in each selected adult ward kitchen, displaying up to date, and real time information on each patient's nutritional requirements. This has reported by the dietetic team to have enhanced the patient's experience of hospital, improved the patient's recovery and contributed to reducing the cost of patient care. The live information updates the Nutritional Care Plan and is clearly outlined for all at-risk patients. The overall initiative has raised the profile of nutritional care and ensures all disciplines are committed to positive improvements. The 90% target for initial screening is being achieved and the performance for re-screening is showing improvement every month.

2.4 Improving Medication Reconciliation at Discharge – Closing the Loop (M@D)

M@D project team led this initiative. Transitions between interfaces of care, especially discharge from acute hospital care into the community, are widely recognised as high-risk settings for the development of medicines-related problems

(MRPs), and a leading cause of morbidity and mortality. 'Medication continuity errors' are reported as extremely frequent (involving up to 70% of patients) and have a major impact on rates of hospital readmission. Cost, to both patients and the NHS, is reported by the high by the DoH and the NPSA.

Local and national policies have raised the need for guidance for medication management at transfers of care (NICE/NPSA/CQUIN). Improving medication reconciliation (MR) throughout hospital stay is of strategic importance for both patient safety and financial measures.

The first project led by the team successfully improved MR on admission within the Acute Assessment Unit (AAU) at Chelsea and Westminster Hospital. After this the electronic prescribing (EPR) and electronic discharge summaries (DSUM) have become well established at the hospital. M@D has extended the improved process to discharge for all patients admitted acutely to AAU and subsequently discharged from any wards. The project was supported by the hospital and Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Northwest London.

This initiative increased patient safety, effectiveness and patient experience by:

- Reducing harm from MRPs due to incomplete/inaccurate information about medications at discharge
- Reducing the potential for re-admission due to preventable MRPs
- Ensuring clinical effectiveness of treatments by encouraging adherence through enhanced information provision
- Improving junior doctors' ability at completing changes to medications at discharge.
- Improving pharmacy staff contact with patient care through admission/discharge MR
- Expanding on tools available to nurses to counsel patients at discharge
- Improved documentation of changes to medications on the discharge summary

2.5 A model for responding to Domestic Abuse within a healthcare organisation - ensuring the safety of patients and protection of their information.

The Domestic Abuse team led on this work within the Trust and it has created a unique model of response to domestic abuse which could be adopted by other Trusts in the UK. The initiative included:

- Trust training in Domestic Abuse awareness and safe practice – on-going since 2010
- Enhanced training for high risk cases of domestic abuse and safety planning – for staff that have voluntarily become leads in their clinical areas and also Domestic Abuse Links (DALs.
- Training in routine enquiry for Domestic Abuse in Maternity services that has ensured a robust response by the team of midwives within a supported organisational framework, to protect the individual women; their unborn children and others who may be also be at risk of abuse.
- A confidential Social Information (CSI) Log that went live in April 2013 - the development of a tool on LASTWORD to safely document sensitive disclosures. This information can now be held in a separate area of the electronic patient record and is available to view by clinicians only, and automatically sets up a discreet shared patient alert. This has improved

appropriate sharing of information and maintaining patient confidentiality and respecting patient privacy. It is a tool that permits the recording of key multidisciplinary contacts for the patient within the Log – ensuring that all relevant information is recorded in one place. The tool also has the functionality to directly link staff into the Intranet folders on Domestic Abuse and Information Sharing guidance.

- Development of a Domestic Abuse referral pathway – to guide staff on best practice when a patient discloses domestic abuse. This will offer support to staff and a systematic approach with their patient management: Risk assessment/Clinical Care/ Safeguarding – it also includes how to document the disclosure, who to share information with, and how to protect the patient and others who may be at risk.
- Development of a Domestic Abuse folder on the Intranet – a key helpful resource available on the Intranet through the Safeguarding gateway, which contains useful required information.
- Development of a Safeguarding gateway icon on the Intranet homepage – a 'quick link' enabling all staff to access from a single point.
- Development of a Trust Domestic Abuse Policy – placing strategic managerial responsibility across the organisation to ensure that each clinical area has a nominated DAL and has the relevant resources available to support patients who disclose domestic abuse.

The team has received strong commissioning endorsement of their approach in this field and it is hoped by the team that when the Domestic Abuse Policy is given final approval in July 2013, it could become a model for other Trusts in Inner North West London to consider adopting. This could deliver a consistent approach within the sector for survivors of domestic abuse. The Trust's response to Domestic Abuse was due to be presented up as a model for others to consider at the British Association of Sexual Health and HIV's Sexual Violence training day in June 2013 at the Royal Society of Medicine.

3.0 The Commended Winner

The commended winner was the Acute Assessment Unit (AAU) Therapies Mapping and Service Improvement initiative. This was led by the inpatient therapy teams; Respiratory, Medical Rehabilitation and the Acute Assessment Team.

4.0 Summary

The Quality Awards led by the Council of Governors' Quality Sub-Committee are awarded for Patient Safety, Patient Experience, Clinical Effectiveness and the Trust Values. There were 5 winners and 1 commendation. Following introductions by the Quality Sub Committee Governors these awards were presented by the Chairman during the July 2013 Council of Governors Meeting.

Further details of any of these awards are available from the Head of Quality and Assurance (Melanie.vanlimborgh@chelwest.nhs.uk)

Melanie van Limborgh
Head of Quality and Assurance, July 2013

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.12/Jul/13
PAPER	Sustainable Development and Carbon Reduction
AUTHOR	David Butcher, Director of Estates and Facilities
LEAD	David Radbourne, Chief Operating Officer
PURPOSE	To update the Board of Directors on progress with Carbon Reduction and Sustainable Development
LINK TO OBJECTIVES	Ensure financial and environmental sustainability
RISK ISSUES	
FINANCIAL ISSUES	Continual investment to improve the built environment.
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	In April 2010 the Board of Directors approved the first Sustainable Management Development Plan which laid out a response to the NHS Carbon Reduction Strategy for England (2009) produced by the NHS Sustainable Development Unit. This document acts as an update to the approved plan, a review of progress to date, and suggested terms of reference for a 'Sustainable Development Committee'.
DECISION / ACTION	The Board of Directors is asked to note progress.

Sustainable Development and Carbon Reduction

1. Introduction

The Board of Directors may recall approving the first Sustainable Management Development Plan (SDMP) in April 2010 which provided a response to the NHS Carbon Reduction Strategy for England (2009); this paper provides further background information on 'sustainability', an update to the approved plan, and a review of progress achieved.

2. What is sustainability?

The UK Government defined sustainability in its sustainable development strategy 'Securing the Future' published in 2005. The Department of Health and the NHS Sustainable Development Unit adopted this definition, which states that the five guiding principles of sustainability are:

- Living within environmental limits
- Ensuring a strong, healthy and just society
- Achieving a sustainable economy
- Promoting good governance
- Using sound science responsibly

3. The NHS commitment

The NHS Carbon Reduction Strategy for England (2009) sets out a number of requirements for all NHS bodies in taking action to reduce their carbon emissions. These include:

- The production of a Board-approved Sustainable Development Management Plan containing a commitment to reduce the organisation's 2007 carbon footprint by 10% by 2015;
- Signing up to the Good Corporate Citizenship Assessment Model;
- Monitoring, reviewing and reporting on carbon reduction; and
- Actively raising carbon awareness at every level of the organisation.

The NHS Sustainable Development Unit (SDU) identifies the need to take action in each of the following ten areas (referred to as the Strategic Themes):

- Energy and Carbon Management
- Procurement and Food
- Travel and Transport
- Water
- Waste
- Designing the Built Environment
- Organisational and Workforce Development
- Partnerships and Networks
- Governance
- Finance

4. Trust Context

4.1 Position statement

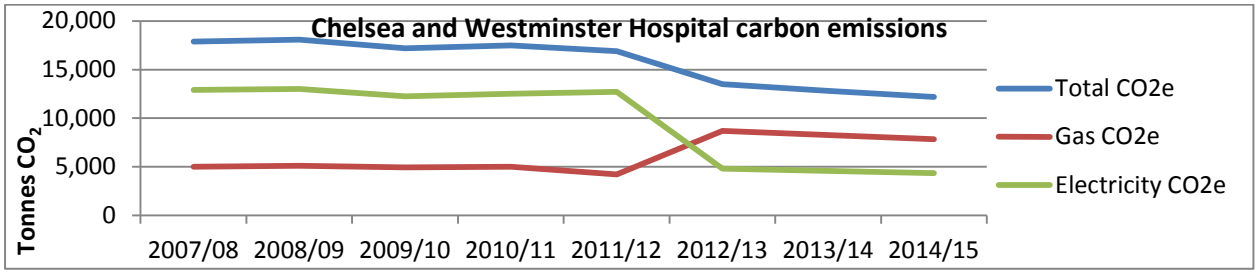
Chelsea and Westminster Hospital NHS Foundation Trust understands its duty to behave responsibly and ethically in all aspects of its business. Directors may recall The Trust agreed Financial & Environmental sustainability as one of its four corporate objectives for the year 2012, demonstrating its commitment to the core principles of sustainable development, the economy and the environment; this applies in the role of the Trust as a provider of health care services and as an employer.

4.2 Where are we?

4.2.1 Monitoring, reviewing and reporting on carbon reduction

The Trust regularly reviews and reports its carbon emissions through a number of mechanisms, CRC, EU ETS and ERIC, and, thereby monitors carbon reductions.

As a participant in both the EU-ETS and CRC schemes all emissions data is externally verified. Externally verified data is submitted to DEFRA who are the UK administrators for both schemes.
The verified carbon emissions data is presented in the graph below with projections, based on planned investments, to 2014/15. The dramatic change in 2012/13 is due to the commissioning of the CCHP plant.



4.2.2. Capital investments

The Trust has invested c£4 million in plant and equipment to reduce its carbon footprint:

- CCHP to use the waste heat from electricity generation to supplement heating and cooling;
- Energy efficient lighting in the new Dermatology and Paediatric wards;
- New, energy efficient heating calorifiers;
- Inverter drives to improve the efficiency of fans and pumps.

4.2.3 Waste management and recycling

The Trust has made significant changes in the way it manages waste, there is now an established waste group chaired by the General Manager of Facilities. During the past year the following actions have resulted in an increase in the percentage of waste being recycled:

- Investment to replace a large number of clinical, domestic and recycling bins;
- A trial has taken place for the shredding of confidential paper on site, enabling us to convert our confidential waste to recycling;
- Tool box talks and awareness sessions have taken place at ward level;
- Introduction of “Dusty”; our new Waste trolley mascot. “Dusty” has been out and about since October 2012 and a plan is in place for 2013 to help the Trust with waste awareness and segregation education for all staff.

4.3. Delivering our vision

In order to achieve our objective to deliver sustainable healthcare provision for the Trust, and to deliver the elements outlined in the position statement, it is proposed that we set up a Trust ‘Sustainable Development Committee’, to be launched in Autumn 2013. A copy of the Terms of Reference is available on request from David Radbourne, Chief Operating Officer.

4.3.1. Sustainable Development Committee

The Sustainable Development Committee will be the delivery mechanism for the Sustainable Development Management Plan. The Chief Operating Officer has been appointed as the

Board lead for sustainable development and the committee will report progress through the Facilities Committee which is a subcommittee of the Board.

This committee will be responsible for championing sustainable development with colleagues and partners to ensure the strategic vision is realised throughout the Trust. The Committee will also take responsibility for the on-going development and review of this policy, ensuring that corporate and local developments and requirements are taken into account as well as developing, implementing and reviewing the outcome of performance monitoring measures.

The Committee will use the strategic themes identified by the NHS Sustainable Development Unit as the basis of its work. However, it is recognised that each of these themes present different challenges and work is already underway in some areas. It is proposed therefore to concentrate efforts on the following five areas in the first year whilst at the same time preparing for other work streams in 2014 and beyond.

- Energy and water efficiency
- Waste minimisation and recycling
- Low carbon travel and transport
- New buildings and refurbishment
- Procurement

5. The 5 work streams

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Work stream:	Our commitment:	How we'll achieve it:	How we'll measure it:
Energy and Water *Reducing carbon dioxide and other greenhouse emissions*	-Monitor, measure and report on energy use to improve understanding of consumption and promote efficiency -Minimise resource use through efficient and innovative technology and upgrading of the Trust's estate -Ensure compliance with environmental legislation, such as the Carbon Reduction Commitment Energy Efficiency Scheme	-Install energy monitors on high consumption equipment -Install motion sensors for lighting across Trust -Invest in energy saving refurbishment projects -Water saving devices installed as standard in refurbishment and new builds	-Overall carbon emissions for the Trust -Sub-metering in key areas -Energy consumed per member of staff per year
Waste minimisation and recycling *Promoting appropriate use of materials and sorting of waste*	-Reduce the materials we use -Promote the re-use of materials -Promote proper waste disposal Empower staff to take action	-Improve awareness about responsible use of resources -Increase recycling facilities in staff and public areas -Recycle food waste Identify innovative ways to re-use waste materials	-Percentage of overall waste recycled -Regular auditing of all waste streams -Measure electrical waste sent for recycling
Low carbon, travel and transport *Encourage active and sustainable travel for patients and staff*	-Develop processes to promote sustainable transportation -Promote health and well-being through improved information about and opportunities to participate in active and sustainable travel	-Develop a sustainable transport plan -Improve the efficiency of vehicles use by the Trust -Commit to the London NHS Cycling Strategy	-Track the number of staff using active travel options, such as cycling -Staff and patient questionnaires -Measure Trust vehicle miles fuelled by alternative sources Reduce total miles driven

			by Trust vehicles and patient transportation
New Buildings and Refurbishment *Ensure our sustainability aims are reflected in new build and refurbishment*	-Integrate processes to ensure sustainability is prioritised when planning building work -Develop sustainable design standards for refurbishments and new buildings	-Project Managers to complete sustainability evaluation for all major projects -Investment in resource saving refurbishments	-Sustainability Impact Assessments
Procurement *Address sustainability in what we buy and in the supply chain*	-Consider whole life cycle costs of goods purchased, including origin, materials, efficiency, and end of life -Encourage suppliers to reduce transportation, packaging and improve the sustainability of their products	-Increase awareness of sustainability issues for Trust staff and key suppliers -Further consolidate freight delivery to reduce transport emissions in the supply chain -Increase services and food sourced from local suppliers -Co-operate with supply chain to encourage low carbon production of materials	-Sustainability Impact Assessments -Tracking the transportation supply chain -Measure the number of purchases delivered by consolidated freight transportation

6. Conclusion

The Board is asked to note progress in the Trusts carbon reduction programme and to consider the proposal to set up a Sustainable Development Committee.

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.13/Jul/13
PAPER	Annual Workforce Report 2012/13
AUTHOR	Priti Bhatt, Equality and Diversity Manager and Matt Guilfoyle, Workforce and ESR Manager
LEAD	Mark Gammage, Director of Human Resources
PURPOSE	This report provides an overview of the Trust's workforce for the financial year 2012/13, and an outline of equality and diversity work for the same period.
LINK TO OBJECTIVES	Improve the Patient Experience
RISK ISSUES	N/A
FINANCIAL ISSUES	N/A
OTHER ISSUES	N/A
LEGAL REVIEW REQUIRED?	N/A
EXECUTIVE SUMMARY	This report provides an overview of the Trust's workforce for the financial year 2012/13, and an outline of equality and diversity work for the same period. The report provides information to enable the Trust to meet its statutory obligations under existing equality legislation in terms of monitoring of the workforce and agreeing actions to address any issues of concern, and provides an overview of the key staffing issues that the Trust is facing. The Trust has achieved most of its HR targets for 2012/13 including managing sickness absence, vacancies and stability and new targets for 2013/14 have been set. The Trust has also met its legal obligations under the Equality Act 2010 through publishing equality information and developing objectives. Work will continue to implement the Equality Delivery System tool and develop patient focused objectives, which will be overseen by the Equality and Diversity Steering Group. As a result of this workforce analyses, the Trust can be satisfied

	that there are no significant areas of concern which are unique to this organisation, although there are a number of issues such as such as BME staff being disproportionately represented in disciplinary cases and fewer BME staff being represented at senior levels in the organisation, which require further understanding and investigation and/ or specific action to address with external partners.
DECISION/ ACTION	For information and approval.

WORKFORCE REPORT

1.0 Overview

1.1 The Trust made progress towards achieving its HR targets as well as embedding the values that underpin our patient experience offering in 2012/13. Further targets have been set for the coming year as we continue to strive to be an employer of choice, offering world class patient care. As a result of the workforce analyses, the Trust can be satisfied that there are no significant areas of concern which are unique to the organisation. BME staff still continue to be disproportionately affected by the employee relations procedures, a phenomenon seen across the NHS, and marginally fewer are promoted into more senior roles (although the overall numbers are small).

1.2 The Trust continues to employ a diverse workforce with just under 3200 staff. Approximately 75% of our staff are female and 35% are from Black Minority and Ethnic (BME) groups. 1.5% of staff have a declared disability.

2.0 Trust Values

2.1 The Trust aims to ensure the highest quality care for patients being treated at Chelsea and Westminster and the highest quality environment for all staff working here. Research tells us that there is a positive relationship between staff motivation and wellbeing and patient experience. We understand the importance of all staff understanding the role they have in ensuring the highest quality of care for patients. To enable this we have focused on the four Trust values—safe, kind, excellent and respectful— and in 2012/13 we defined the behaviours that underpin everything we do. This will continue to be a priority in 2013/14.

2.2 We have reviewed all aspects of staffing policy including recruitment, appraisal and training in light of these values and amended practice accordingly. All new staff now receive a copy of the values in the information pack for new starters and these values are included in all job adverts, interview questions, job descriptions and person specifications as well as the Staff Handbook, which is published annually. The appraisal form was redesigned to include evidence of behaviours based on these values and the October issue of Trust News carried a pull-out poster that teams used to develop their own priorities related to these values and behaviours. The values and behaviours have also been included in the Corporate Induction Programme, the Excellence in Care Programme for healthcare assistants and the development programme for staff nurses.

2.3 Local teams and departments have been developing their own priorities related to the Trust values and behaviours. These have been reported at the Patient and Staff Experience committee, Senior Operations group, and through the Trust daily noticeboard communications.

2.4 Our Friends and Family Test surveys now include a section of the Trust values so that patients can feedback about their care and this is reported to wards and departments on a monthly basis.

2.5 During 2013/4 the Trust will continue to look at how to ensure the Values are delivered on a daily basis, and the learning is extracted from the Francis report on how care is delivered.

3.0 HR Metrics

3.1

Metric	2012/3 Target	2012/3 Year end	2012/3 Average	2013/14 Target
Vacancy %	8.38%	7.64%	8.34%	8%
Sickness %	3.83%	3.31%	3.73%	3.6%
Turnover %	13.5%	14.60%	13.59%	13.5%
Agency (% of WTE)	3.15%	5.2%	4.40%	3.15%
Stability %	83%	N/A	85.1%	83%
Appraisals %	87%	N/A	82%	90%
Mandatory training %	80%	73%	N/A	85%
Staff Survey response rate	N/A	66%	N/A	N/A
Staff Survey: Staff Engagement	N/A	3.87	N/A	N/A
Staff Survey: 'Friends & Family'	N/A	80%	N/A	N/A

3.2 Significant progress was made towards ambitious targets that were set for HR at the beginning of 2012. These targets are based on previous performance and comparison of similar organisations in London such as Imperial College Healthcare, Royal Free and Kings College Hospitals (an explanation of how these measures are calculated can be seen in Appendix 13). Voluntary Turnover increased slightly on the previous year to 13.59% for the year, missing the target set for the year of 13.5%. This was primarily due to increased resignations in the final quarter of the year with the most common stated reason for resignation over the year (18%) being relocation, with a further 16% giving promotion as the reason for leaving. The Trust continues to review reasons for leaving and identify any themes that arise. Vacancies at an average 8.34% for the year, are 0.76% lower than the average rate for last year, and finished the year at 7.64% well within their 8.38% target, while vacancies being actively recruited to were at an average of 2.88% for the year (down from 2.89% in 2011/12). Sickness rates, at an average at 3.72% which is better than our target; non-reporting continues to be addressed but remains an issue in some areas, and in the next financial year will need to be further addressed. Stability remained within target at 85.1% for the year. 82% of staff agreed in the 2012 NHS Staff Survey that they had an appraisal within the last 12 months. Although this was the highest rate since the Survey began, the Trust did not meet its target of 87% of staff. 45% of staff agreed they had received a well-structured appraisal, which placed the trust in the top 20% of acute trusts nationally for this measure. Although Bank and Agency usage has increased during the second half of the year, the overall pay bill control for the organisation remained within budget. Targets for the new financial year have been set as a trajectory towards year-end targets in consultation with the Divisions.

4.0 Trust Workforce Profile

4.1 The Trust employs 3197 staff, (2927 Whole Time Equivalent) which is comparable to other medium sized acute NHS trusts such as the Homerton Hospital, although the Trust appears to employ a slightly lower proportion of Band 7 staff and more staff between Bands 2-5. This is mainly due to a number of restructures that have occurred in recent years at directorate level to ensure that nursing and administrative staff roles are increased to support the clinical care of patients. Appendix 1 shows the Trust Agenda for Change profile by band.

4.2 34.7% of staff identified as BME, with the majority in Bands 2-7, with White staff well represented from Bands 6 and above. When comparing the Trust's staff composition against the population of London, we employ a more diverse range of staff, although other central London Trusts employ more BME staff than us. The ethnic composition of our workforce has only marginally changed since last year. Appendix 2 highlights the Trust's ethnic profile by Band.

4.3 In common with most NHS organisations, approximately 75% of the Trust's workforce is female and 1.5% of staff declared that they had a disability. The Trust has a younger age profile compared to other Trusts, with 52% of employees occupying the 25-39 age brackets. Christianity appears to be the highest practising faith. However, it is worth noting that high non-disclosure rates of sexual orientation, religion and disability mean that it is generally difficult to draw conclusions from the data collected for these equality strands.

4.4 For other protected characteristics, including religion, sexual orientation and disability, too few people disclosed information to allow meaningful analysis. Also when looking at the range of ethnic groups employed by the Trust – over 17 in total – some groups have such a small representation that comparative group results are statistically insignificant. We have no record of employees having undergone or currently undergoing gender reassignment, therefore no analysis or conclusions can be made for this protected characteristic.

4.5 Further analysis of length of service, average salary and flexible working is noted in Appendix 12. Under the specific duties of the Equality Act, this is new information organisations are requested to report on.

5.0 Joiners and Leavers, Turnover and Vacancies

5.1 A total of 492 staff (excluding rotational training doctors and honorary staff) joined the Trust last year. The number of joiners peaked in September and October 2012; this was mainly due to newly qualified nursing and midwifery joiners. Reasons for leaving are broadly attributed to natural turnover e.g. 'voluntary resignation other', 'end of fixed term contract' or 'retirement' and there are no areas of concern to note. The total numbers of staff joining and leaving the Trust, as well as by protected characteristic can be found in Appendix 3a-g.

5.2 Voluntary turnover increased marginally on last year to an average of 13.59% as shown in Appendix 4, particularly in the last quarter of the year. The Trust has revisited its Exit Interview process for the coming year to help understand leaving reasons better and identify improvements to reduce turnover. It should be noted however that turnover remains lower than the 3 year average of 14.42%; this may be partly due to the uncertain economic climate.

5.3 Average vacancy rates were lower in 2012/13 than in the previous financial year, at 8.34%, compared to a 3 year average of 9.87%, however, the Clinical Support and Women's and Children, and HIV/GUM Divisions registered an increase on the previous year. Nursing and Midwifery vacancies increased

over the previous year, ending the year at 12.46%. The Trust also monitors "active" vacancies, which are posts that the organisation is actively trying to fill. The 2012/13 average rate decreased to 2.88% and provides a more realistic figure of the vacancy position, as shown in Appendix 5.

6.0 Sickness

6.1 Average sickness rates for the year reduced to 3.73%, which is within target for the year, and broadly comparable to the 3 year average of 3.71% Sickness absence for the first three quarters of the year tracked below the NHS average of 4.2%. The highest sickness levels were seen during the autumn and winter periods in 2012-13 which is to be expected due to the weather and the peak of cold and flu related illnesses. Analysis by grade suggests that staff in Bands 2-5 had a significantly higher absence rate than the Trust average. Further investigation will be undertaken to understand the reasons for absence, and ensure that this group of staff are appropriately supported by management and HR if it is required. Appendix 6 details monthly sickness rates for the Trust throughout 2012/13, as well as sickness by protected characteristic and grade.

6.2 Reporting of absence for Medical staff remains an issue and further work will be undertaken to address this long standing issue in 2013/14. A QIPP project looking at reducing sickness absence across the Trust in 2012/13 will continue in 2013/14 with input from senior managers and Nurses as well as Divisional HR representatives.

6.3 As part of the QIPP project, a number of sickness absence management initiatives were launched in 2012/13, including a requirement that managers complete a 'Return to Work' interview after each absence. The returns for these are gathered centrally, allowing HR to monitor the process more effectively. Further work will continue in 2013/4 to embed this project across the Trust.

7.0 Recruitment

7.1 Recruitment analysis by protected characteristic has not changed significantly in the last few years. The data seems to suggest that the type of role a candidate applies for is connected to their ethnicity or gender. This could be attributed to the importance placed on different career choices by men, women or different ethnic groups and other factors such as education and training which limits choices. It is worth noting that the 'success rate' of applicants by ethnicity has varied over the last few years, which suggests that applicants are fairly appointed against the person specification of each post and not due to their ethnic background. We still continue to employ a diverse workforce which is positive, but it is difficult to draw conclusions from this analysis without looking at recruitment activity across London to gauge whether the minor changes are statistically significant. Further detailed analysis is provided in Appendix 7 and section 3 of Appendix 12.

8.0 Employee Relations

8.1 All ER cases have been reviewed and indicate that action has been taken for valid reasons and the outcomes taken appear to be proportionate. However BME staff still continue to be disproportionately affected compared with White colleagues. This is not unique to this organisation as this trend has been evidenced across the NHS in a report commissioned by NHS Employers, titled 'The Involvement of Black and Minority Ethnic Staff in NHS Disciplinary Proceedings'. Following the publication of a similar report by the RCM earlier this year, a meeting was held with Maternity managers and union

representatives to understand the report's findings and develop solutions to address this trend. All formal closed disciplinary and grievances, including bullying and harassment cases, have been reported in Appendix 9.

8.2 The Trust continued to work with staff side representatives to manage the impact on patient care from the on-going dispute between some professional organisations and the Government on proposed changes to the NHS pension scheme.

8.2.1 With modest levels of membership at the Trust, the impact of the Unite industrial action of the 10th May 2012 on patient care, was minimal. Some services provided by external organisations were affected, but overall there was no major impact on service delivery.

8.2.2 The British Medical Association which represents the majority of Trust medical staff took industrial action on the 21st June 2012. On the day non urgent and emergency care was limited and some 250 patients had their appointments rescheduled in advance as a result of the action. 38 medical staff took action on this day, although all attended work on the day to ensure urgent care was not compromised.

8.2.3 The Trust will continue to engage with staff-side representatives to minimise the impact of industrial disputes on patient care while recognising the right of staff to participate in official industrial action.

9.0 Training

9.1 The Trust made progress on reaching the NHSLA target of 95% mandatory training delivered within the required period, ending the year at 73% compliance, against 58% for March 2012, and a reported London average of 65%. Trust staff completed almost 18,000 training episodes in 2012/3, which is broadly comparable with the previous year. 53% of all training activity was delivered via 'Learn Online' and other e-learning platforms. The attendance per person is marginally higher for White staff as opposed to BME staff. Younger staff, aged under 20-35 attended the most mandatory training than any other age group, and women generally benefitted from more training attendance than men. This is likely to be due to the increase in the number of newly appointed nurses and midwives to the Trust.

9.2 As has been the case for several years, White staff were more likely to attend professional development training than BME staff. The Trust will continue to do further work to understand the reasons for this, although it may relate to white staff being more to occupy more senior grades within the organisation where this kind of training is more regularly accessed, The breakdown of access to training including mandatory and non-mandatory courses is illustrated in Appendix 10.

9.3 The Trust ran a series of leadership development programmes accredited by the Institute of Leadership and Management and will launch a multi-professional leadership programme in September 2013, running through to May 2014. Its aim is to prepare people who want to take up clinical leadership posts in the future by equipping them with the necessary skills and knowledge but also to build networks of support among other clinical specialties and general managers.

10.0 Bank and Agency Staff/Usage

10.1 2012/13 has seen an increase in the usage of Agency staff, with an average of 4.4% of Trust WTE being supplied by Agencies, against 4.2% for the

previous year, and a 3-year average of 4.1%. Despite this increase the overall pay bill of £176.7 million was within the budgeted limit, with Agency spend as a proportion of this spend reduced from the previous year.

10.2 As part of the QIPP project focusing on the reduction of Sickness and Agency, the Trust continues to work on an Agency reduction strategy and the Staffbank has increased recruitment activity through 2012 to increase the numbers of active Bank staff available to the Trust. The highest usage of bank and agency staff remained with Nursing and Midwifery staff as shown Appendix 11.

11.0 Delivering a Safe Workforce

11.1 In order to ensure the safest possible patient care, the Trust maintains a regular process for the checking of employee professional registrations. Human Resources liaise with staff and managers to ensure these are updated in a timely manner. New staff are subject to a number of checks to confirm identity and suitability for the post they have been recruited to. Further information on the Professional Registration of staff and Recruitment checks are shown in Appendix 12.

11.2 The Trust undertakes regular skill mix and grading reviews ensuring staffing levels, particularly in clinical areas, remain safe and appropriate.

12.0 Equality and diversity

12.1 The Trust's Chief Operating Officer handed over responsibility for the Executive lead for Equality and Diversity to the Director of Human Resources. The group continues to lead the Trust's work on addressing equality and diversity issues in the workforce and also in terms of service provision to patients. During 2013-14 we will review how equality and diversity is delivered across the organisation, in light of the creation of Clinical Commissioning Groups and the Trust's patient and staff experience work.

13.0 Equality objectives progress

13.1 The Trust continued to make progress towards meeting actions in accordance with the Equality Act 2010 and against key objectives. Progress includes organising a seminar for staff to raise awareness of sexual orientation considerations of staff and patients; creating a dementia friendly environment on David Erskine Ward, and providing specialist training on learning disabilities to staff in clinical areas. A more detailed account of progress is shown in section 6 of Appendix 12

14.0 Next steps

14.1 Key objectives for the HR function have been agreed which include addressing issues raised in this report. Specifically actions emanating from this report include:

- Continuing to work towards meeting our key staffing metrics, thereby reducing our reliance on agency staff and managing our activity within staffing budgets.

- During the first quarter of 2013/4, we will introduce a Trust Values based assessment process for use in the recruitment of Healthcare Assistants.

- We will continue to identify strategies to improve compliance in Mandatory Training, including the release of a DVD to support the training of non-clinical staff.

- The Clinical Leadership programme will continue to support the delivery of service excellence in the Trust.

- Sharing the findings from this report, and the Staff Survey with the Senior Nursing and Midwifery Committee and the Divisional Boards to develop staff group specific actions to address the employee relations, bullying and harassment and promotion trends.

- Similarly, set up a series of focus groups with staff to understand this report's findings particularly around bullying and harassment, promotions and employee relations, with the aim of developing solutions to address these trends.

- Finalise and roll out the diversity resource booklet to increase staff knowledge of different equality issues across all protected characteristics.

- Continue to host speaking events through the Leadership Forum to raise awareness of different equality issues across all protected characteristics and challenge current thinking, as well as looking at innovative ways to promote and celebrate diversity with the support of Communications team.

- Developing a series of local staff surveys to measure staff engagement and provide further analysis of the areas of concern identified in the annual national Staff Survey. The results of these surveys will be analysed in conjunction with patient surveys and areas of improvement identified.

15.0 Conclusions

15.1 The Trust met its statutory obligations to monitor and report on equality and diversity issues and provides assurance that action is being taken and planned to address issues of note.

15.2 As a result of this workforce analyses, the Trust can be satisfied that there are no significant areas of concern which are unique to this organisation, although there are a number of issues which continue to be raised which require further understanding and investigation and/ or specific action to address with external partners.

15.3 Many of the HR metrics were achieved during 2012/13, and new targets have been agreed for 2013/14. HR will continue to work with the Divisions to ensure areas of concern are addressed and the targets set for 2013/14 are achieved or exceeded. More information on those targets can be seen in Appendix 13.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.14/Jul/13
PAPER	Update on the Emergency Department Redevelopment
AUTHOR	David Radbourne, Chief Operating Officer
LEAD	David Radbourne, Chief Operating Officer
PURPOSE	To update the Board on the proposed redevelopment of the A&E department
LINK TO OBJECTIVES	- Develop patient centred model - Provide the appropriate mix of emergency services - Safe and Effective Care - Exceptional Patient Experience
RISK ISSUES	- Elements of the funding plan are awaiting final resolution with the CCG
FINANCIAL ISSUES	Capital Investment
OTHER ISSUES	
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	There have already been discussions with the Board and the Council of Governors in relation to the proposed redevelopment of the Emergency Department. This redevelopment is in line with our wish to develop world class facilities, tackle current inadequacies in the space and environment and prepare for future growth in emergency activity including potential additional activity from the Shaping a Healthier Future reconfigurations. The Finance and Investment Committee have reviewed the

	case for change and the proposed development and have recommended proceeding to the next stage of detailed design.
DECISION/ ACTION	For information

BRIEF SUMMARY OF THE PROPOSED EMERGENCY DEPARTMENT REDEVELOPMENT

Case for Change

The key drivers for change which have been discussed with the Board of Directors are as follows:

- That the current department was built over 20 years ago, for 60,000 attendances, it now sees 112,000.
- That the overall environment did not meet with our expectations to provide a world class environment commensurate with being a major acute health care provider.
- That with current trends in activity, this would present additional burdens and challenges for what is a high performing department, operating within a constrained environment.
- That with the proposals for Shaping a Healthier future, the Trust may need to further expand capacity over the medium term.
- That the CCG has indicated it is supportive of the Trust redeveloping its A&E in the context of the above.

Financials

The total capital cost is estimated at £10.7m inclusive of relocation costs and additional equipment which would be required e.g. the addition of a dedicated CT scanner for the department in line with good practice.

Discussions are on-going with the local CCGs regarding their financial support for this scheme but the Board's Finance and Investment Committee has recommended that the capital development proceed to the next stage with recognition that further analysis will need to be done regarding the revenue implications.

Next Steps

The project will now proceed to the next stage which entails developing the detailed design. This stage will involve consultation regarding the layout and functionality of the space with staff as well as patients and other stakeholders. The Council of Governors have been briefed on the initial design and will nominate two of their number to participate in developing the detailed plans.

In addition to developing the design we will also be looking in detail at revenue expenditure costs to ensure that we have taken every opportunity to integrate innovation and best practice in the operating model for the redevelopment department.

At the conclusion of the above pieces of work further detail will be brought back to the Board.

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.15/Jul/13
PAPER	Monitor In-Year Financial and Governance Combined Return for Q1 2013/14
AUTHOR	Carol McLaughlin, Financial Controller
LEAD	Rakesh Patel, Director of Finance
PURPOSE	Compliance with Monitor's Compliance Framework 2013-14
LINK TO OBJECTIVES	Ensure Financial and Environmental Sustainability Deliver 'Fit for the Future' programme
RISK ISSUES	The Trust is submitting a 'Green' Governance Risk Rating having met all of its clinical targets in Q1. The Trust has triggered 2 financial risk indicators per the Monitor template, as follows: • Debtors > 90 days old are greater than 5% of total debtors. • Creditors > 90 days old are greater than 5% of total creditors. These are explained in more detail in the commentary below.
FINANCIAL ISSUES	The Trust has achieved a year-to-date Financial Risk Rating of 3 for Q1 of 2013/14, which is in line with the planned 3 rating. However YTD EBITDA is £1.5m behind plan (5.6% YTD actual compared to plan of 7.4%) which is forecast to continue across the remaining quarters of the year. Therefore the Trust has initiated a recovery plan to return to planned outturn. The recovery plan is being worked up in detail under an overriding principle to ensure there is no detrimental impact on quality, with an aim to be operational by end August. The main reason for the Trust being behind plan is slippage in delivery of Cost Improvement Plans (CIPS). The Trust is £2.1m behind on its Q1 CIP plan and action is being taken to bring this back into line in future quarters, in order to achieve the annual planned surplus. Monitor's new Risk Assessment Framework has not yet come into effect,

	however the Trust is monitoring performance against the new COSR (Continuity of Services) rating alongside the FRR and the rating at Q1 was a 3 against a plan of 3.
OTHER ISSUES	
LEGAL REVIEW REQUIRED?	No.
EXECUTIVE SUMMARY	**<u>Governance Declaration</u>** The Board is asked to authorise a GREEN declaration with respect to its governance risk rating having met all of the targets for Quarter 1 2013/14. *(NB: there is an error in the Monitor Plan, stating that the MRSA target for the year is 0, when it in fact should read 6. Thus the Trust is within the target and has stated the MRSA objective as achieved - and the plan will be corrected with Monitor).* In the first quarter of 2013/14, there were no elections to fill vacant posts on the Council of Governors. There was however one stakeholder resignation within the Council of Governors. There was a change in the composition of the Board of Directors, with the appointment of an Acting Chief Nurse. (See Appendix 1 for a full breakdown of all these changes). **<u>Finance</u>** The Trust recorded a Financial Risk Rating of 3 YTD at Quarter 1 compared to a plan of 3. The EBITDA % is in line with the planned 3 at Q1 but the actual performance is 5.6% rather than the planned 7.4%. The EBITDA % of plan achieved is a 3 against a planned 5, and the Net Return after Financing and I&E Surplus Margin ratings are both 2 against a planned 3. Liquidity is in line with plan at a rating of 4. The COSR rating was also a 3 against a planned 3. The YTD financial performance for the Trust at Quarter 1 is summarised in the table below:

	Plan YTD	Act YTD	Var YTD
	£m	£m	£m
Operating Revenue	86.3	86.1	(0.2)
Employee Expenses	(44.7)	(45.3)	(0.6)
Other Operating Expenses	(37.6)	(38.2)	(0.6)
Non-Operating Income	0.0	0.0	0.0
Non-Operating Expenses	(2.8)	(2.8)	0.0
Surplus/(Deficit)	1.3	(0.1)	(1.4)
Net Surplus %	1.5%	-0.1%	-1.6%
Net Surplus rating	3	2	(1)
Total Operating Revenue for EBITDA	85.3	85.1	(0.2)
Total Operating Expenses for EBITDA	(79.0)	(80.3)	(1.3)
EBITDA	6.3	4.8	(1.5)
EBITDA Margin %	7.4%	5.6%	-1.8%
EBITDA Margin rating	3	3	0
Capex (Cash Spend)	(3.2)	(5.7)	(2.5)
Net Cash Inflow / (outflow)	(3.1)	(14.5)	(11.3)
Period end cash	38.5	27.2	(11.3)
CIP	3.5	1.5	(2.1)
Financial Risk Rating	3	3	0

NB: There are a number of items excluded from both revenue and expenses that are not included in the EBITDA calculation.

As at the end of Quarter 1 the Trust reported a deficit of £0.1m against a plan of £1.3m with an EBITDA of £4.8m (5.6%) against a plan of £6.3m (7.4%).

The first quarter performance of a £2.7m actual surplus (from operations) vs a £4.1m planned surplus (from operations) has been largely driven by under-achievement of Trust CIP plans (£2.1m - including revenue generation schemes), under-performance on Private Income (£0.5m); these are offset by over-performance in NHS Clinical Revenue. It should be noted that within this over-performance there is a high level of excluded drugs income, that is offset by excluded drugs expenditure, mainly in relation to HIV ARV drugs.

The achieved Q1 CIPs for C&W are in the table below, which shows a Q1 under-achievement of £2.1m. A detailed re-forecast of the Trust CIP plan is under-way to ensure that these are fully met in future quarters.

Monitor Return Category	Q1 Actual
Pay Expense savings CIP recurrent	0.490
Drugs expense savings CIP recurrent	0.065
Clinical Supplies expense savings CIP recurrent	0.174
Non-clinical Supplies expense savings CIP recurrent	0.358
Revenue Generation	0.390
	1.478

Statement of Comprehensive Income

NHS Clinical Revenue

NHS Clinical revenue was £0.3m ahead of plan in Quarter 1. Overall planned admitted patient care activity was £0.2m ahead of plan in the quarter, with a £0.5m over-performance in Day Case income offset by a £0.3m under-performance in Elective activity, due to the higher transfer of activity from inpatient to day case settings than planned. The main over-performing specialities were paediatric dentistry to address waiting list pressures and increased demand and a number of adult surgical specialties.

The Trust reported a £0.1m favourable variance against plan for non-elective activity in the quarter, which comprised of with lower levels of emergency activity than planned resulting in under-performance on activity, but an offsetting benefit due to improvements against locally agreed commissioner productivity and efficiency metrics aimed at reducing emergency admissions and length of stay.

Outpatient activity was £0.3m ahead of plan in the first 3 months, mainly due to higher activity for GUM services than planned (£0.2m) plus a benefit due to improved performance against local commissioner metrics to reduce the number of internally generated referrals. This is partly offset by under-performance in other specialties and the impact of tough new to follow up target ratios. A&E and UCC activity was broadly on plan in the quarter.

Other NHS income reported an adverse variance of £0.2m in Quarter 1, which was driven by low activity in direct access therapies and radiology and variances in adult, burns, paediatric and neonatal critical care. CQUIN income is assumed at planned levels in the first quarter while final CQUIN schemes and the quarter 1 achievement are agreed with commissioners. The Trust reported an over-performance against excluded drugs relating to HIV anti-retroviral drugs, which is offset by expenditure.

Non-Mandatory/Non protected revenue

Non-Mandatory/Non-Protected income under-performed by £0.2m mainly due to under-performance in planned RTA Income.

Income from non-NHS sources (formally Private Patient Income Cap)

From October 1st 2012 the revised definition for the private patient cap

	obliges foundation trusts to ensure that the income received from providing goods and services for the NHS (their principal purpose) is greater than income from other sources. At Quarter 1 the Trust generated £2.8m of private patient income and currently there is no risk to breaching the revised cap definition. This level of income represents under-performance against plan (£0.5m), across a number of Trust specialties, including Private Maternity where delivery numbers are down by 20%. **Other Operating Income** Research & Development Income and Education & Training income were marginally behind plan, with no material variances to review. It should also be noted that there was planned £1.0m donated/grant income for a Paediatric Robot. There were positive variances in other income categories (£0.4m) in respect of additional accommodation recharges, sponsorship income being above plan and back-dated salary-recharges. **Operating Expenditure** Operating Expenditure within EBITDA was £1.3m higher than plan during Quarter 1. The key variances are as follows: **Employee Benefits (£0.6m over-spent):** The majority of the over-spend is due to the Trust planning for a level of pay CIPs which has yet to be delivered (see below for further detail of forecast plans). In addition to slippage on CIPs, vacancies offset by bank and agency usage have marginally contributed to the adverse position. **Drugs Costs (£0.9m over-spent):** HIV ARV excluded drugs are the main driver for the overspend position, due to continued growth in HIV newly diagnosed patients. These costs are however fully offset by income. **Clinical Supplies (£0.2m overspend):** The underspend position is mainly the result of CIP slippage (see below). **Other Raw Materials & Consumables (£0.2m under-spent):** The main drivers of this under-spend are due to reduced costs for facilities management, where costs have been reduced through increased procurement involvement within contract negotiations. **Other Operating Expenditure (£0.2m under-spent):** This under-spend is due to the release of prior year provisions for bad debt, offset by additional use of consultancy services for a number of transformation and transaction projects being undertaken by the Trust. **CIP (£2.1m below target):** The Trust set a CIP target for 2013/14 of £16.9m and has achieved £1.5m in Q1. The table below shows the Q1 and year-end position.

CIP as Per Monitor Template	Q1		
	Plan	Actual	Variance
Pay Cost savings CIP	1.013	0.490	(0.522)
Drugs Cost savings CIP	0.058	0.065	0.007
Clinical Supplies CIP	0.412	0.174	(0.238)
Non-Clinical Supplies CIP	1.164	0.358	(0.806)
Income Generation	0.885	0.390	(0.495)
Sub Total as Per Monitor Template	**3.532**	**1.478**	**(2.055)**

Due to the CIP under-performance being the main driver of the Q1 adverse position against plan, a full trust-wide CIP recovery plan process has been put into action. The executive has asked each Division/Directorate to present back a plan to forecast a year end break-even position, to include full achievement of CIP plans. This review will include tighter controls on bank and agency expenditure, putting a stop to any planned un-essential investments, bringing forward back-office re-organisation and also assessing what centralised support is required to help facilitate recovery plans. The timescale is to have the operationalised recovery plans in full action for the end of August 2013.

Statement of Financial Position

Property, Plant and Equipment

Capital spend at Q1 is reported at £3.8m against the planned capex of £3.7m. This variance of 3% against plan is within tolerance of Monitor's capex financial indicator.

Capital spend in Q1 is shown below in the capex table by Monitor categories. The Trust has incurred capital spend of £0.8m against plan of £0.3m on maintenance expenditure. This is due to an early start on a number of small schemes to refurbish, and also to carry out flooring replacement in the various areas within the Trust. Design of the major schemes is underway. The expenditure incurred on other property plant and equipment category is behind the plan by 27%. This has not affected the quality of service provision.

Capital spend on both information technology and purchase of intangible assets is 11% ahead of plan. IT expenditure has been mainly on LastWord Development, Electronic Document Management (EDM), and PICIS Upgrade.

46% of YTD spend (£1.7m) has been incurred on Plant & Equipment primarily on the replacement of monitors across the Trust and the purchase of scopes in the Radiology and Fluoroscopy Departments. The equipment capex is behind plan by 14%. The planned equipment replacement

Property Plant and Equipment Capex at Q1

Monitor Scheme Categories	YTD Budget £'m	YTD Actual £'m	YTD Var £'m	Var %
Property - New land, buildings or dwellings	-	0.002	(0.002)	0%
Property - Maintenance expenditure	0.246	0.757	(0.511)	-208%
Property, plant and equipment - Other expenditure	0.741	0.538	0.203	27%
Plant and equipment - Information Technology	0.172	0.356	(0.184)	-107%
Purchase of Intangible Assets	0.571	0.473	0.098	17%
Plant and equipment - Other equipment	2.012	1.736	0.277	14%
Grand Total	3.742	3.862	(0.120)	-3%

Receivables and Other Current Assets

Receivables and other current assets (£26.2m excluding cash) are £4.4m above plan as at 30th June 2013. This is mainly due to NHS trade receivables being above plan for the first quarter, due to two main issues: i) delays in payment of invoices due to discussions around the transfer of activity between CCGs and NHS England and ii) set up issues relating to the transfer of GUM commissioning from PCTs to Local Authorities, resulting in higher levels of accrued income whilst invoicing and payment arrangements are set up. Both are short term issues and are expected to be resolved by Q2.

The Trust has triggered Monitor's financial risk indicator relating to debtors >90 days old being higher than 5% of total debtors, as it did in 2012/13 (the actual position being 11.1%). Of the balance >90 days old, £0.85m relates to Welsh Health Boards and is fully provided for and the remainder is mainly Overseas and other General Trading debt which is also between 80-100% provided for.

Trade and Other Payables – Current

The total of trade and other payables, accruals and other current liabilities is £30m at the end of Quarter 1, which is £3.1m below plan. This is mainly due to capital payables and accruals being slightly below plan.

The Trust has triggered Monitor's financial risk indicator relating to creditors >90 days old being higher than 5% of total creditors at the end of Quarter 1, the actual figure being 5.1% (approx. £800k in value). A significant part of this balance relates to one supplier where the issues delaying payment are expected to be resolved imminently, thus bringing the total > 90 days value below the 5% threshold.

Provisions

The provisions balance is £2.9m at the end of Quarter 1, which is £0.2m lower than plan. This is due to the earlier than planned release of prior year provisions for contractual disputes relating to clinical income, as a result of the contractual issues being resolved.

	Cash Flow The cash balance at the end of Quarter 1 is £27.2m, which is £11.3m below plan. The main reason for cash being below plan is the adverse position on NHS debtors explained above, together with the I&E deficit position (£1.4m adverse) and cash outflow on settlement of capital creditors (£2.5m adverse variance). The cash position is being monitored closely to ensure that the issues affecting collection of NHS debt are resolved as soon as possible. **<u>Finance Declaration</u>** The Trust has achieved a Financial Risk Rating of 3 YTD at the end of Quarter 1 of 2013/14 compared to a plan of 3. The Trust has triggered two financial risk indicators in Quarter 1 as described above.
DECISION/ ACTION	The Board is asked to; • Approve submission of the in-year financial reporting return Quarter 1 2013/14 to Monitor. • Approve the commentary for submission to Monitor. • Approve the declaration that the Trust will continue to maintain a financial risk rating of at least 3 over the next 12 months. • Approve the In Year Governance Statement (attached).

Appendix 1

In the first quarter of 2013/14:

I. ELECTIONS

There were no elections to fill posts on the Council of Governors.

II. BOARD OF DIRECTORS

There have been changes in the composition of the Board of Directors.

Following departure of Therese Davis, Chief Nurse and Director of Patient Experience and Flow (21.06.2013) Anthony Pritchard was appointed as Acting Chief Nurse (21.06.2013).

Role	Date of change	Full Name	Telephone	Email address	Job Title (if different to 'role')
Chief Nurse and Director of Patient Experience and Flow	21/06/2013	Anthony Pritchard	02033156721	Anthony.Pritchard@chelwest.nhs.uk	Acting Chief Nurse

III. COUNCIL OF GOVERNORS

a. Retirements and Resignations

i. Elected

A vacancy was created following the resignation of Julie Armstrong, Staff Constituency – Contracted resigned (19.06.2013)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.16/Jul/13
PAPER	Register of Seals Report Q1*
AUTHOR	Vida Djelic, Foundation Trust Secretary
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
PURPOSE	To keep the Board informed of the use of seal.
LINK TO OBJECTIVES	NA
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	There were no documents to which the seal was affixed during the period under review.
DECISION/ ACTION	The Board is asked to note the paper.

Register of Seals Report Q1

Section 12 of the Standing Orders provided below refers to the custody of the seal and the sealing of documents.

12.2 Sealing of Documents

12.2.1 Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief Executive, and not also from the originating department, and shall be attested by them.

12.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an employee nominated by him/her) and authorised and countersigned by the Chief Executive (or an employee nominated by him/her who shall not be within the originating directorate).

During the period 1 April 2013 through 30 June 2013, there were no documents to which the seal was affixed.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.17/Jul/13
PAPER	Assurance Committee Terms of Reference*
AUTHOR	Cathy Mooney, Director of Governance and Corporate Affairs
LEAD	Karin Norman, Non-executive Director
PURPOSE	For approval.
LINK TO OBJECTIVES	None specifically but up to date terms of reference are important for good governance.
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	The revised terms of reference which were agreed at the Assurance Committee meeting in June 2013. It was recognised that there may be further changes to the Assurance Committee in due course and the terms of reference may be reviewed in the next 6 months.
DECISION/ ACTION	The Board is asked to approve the Terms of Reference.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Assurance Committee
Terms of Reference

Aim:
On behalf of the Board, to seek assurance on systems, processes and outcomes relating to quality (patient safety, effectiveness and patient experience), staff satisfaction and safety and the environment, and assuring compliance with the Care Quality Commission Standards

Terms of reference

- To oversee the process for assuring compliance with the Care Quality Commission standards and monitor progress on areas which may be of concern.

- To assure the Trust Board that the risks covered by the remit of the Assurance Committee are appropriately identified, monitored and managed. These include clinical and operational risks and those associated with the contracted out services. (Risks associated with delivery of objectives, including financial risks are reported directly to the Board through the Board Assurance Framework).

- To assure the Board on the performance of support services (estates, facilities, transport and other under the remit of the Facilities Committee).including staff training and health and safety.

- To assure the Board that effective systems are in place in the Trust for Health and Safety, and emergency preparedness.

- To assure the Board on quality through:

    - monitoring progress on the Trust objectives for quality,
    - monitoring indicators for patient safety, clinical effectiveness and patient experience.

- To assure the Trust Board that the Trust systems of internal controls for clinical governance and quality are effective.

- To assure the Trust Board that the terms of reference, functions, roles and responsibilities of the relevant Trust executive committees are clearly defined and aligned.

- To receive and discuss relevant reports on behalf of the Board e.g. external recommendations.

- To hold the relevant Executive Committees to account to deliver accurate and relevant information.

- To undertake an annual review of effectiveness based on the terms of reference of the committee

To produce an annual report for the Board.

Key relationships
Audit Committee

Membership
Core:
Non-Executive Director (chair)
Non-Executive Director
Non-Executive Director
Chief Executive
Director of Finance

In attendance:
Director of Nursing and Quality (from appointment date, interim Director of Nursing until then)
Medical Director
Director of Governance and Corporate Affairs

Chief Operating Officer
Governor
Governor
Head of Clinical Governance
Head of Quality and Assurance

In attendance when required:
General Manager Estates and Facilities
Safety Officer
Director of Human Resources
Other members of staff as required
Chief Pharmacist

Quorum
Of the core members, three out of five should be present with at least one executive director and one non-executive director. Either the Medical Director or Nursing Director must be present. If either the Finance Director or the Chief Executive cannot attend, the Chief Operating Officer can deputise for the Chief Executive.

Frequency of meetings
Approx monthly (10 per year)

Attendance requirements
Two thirds of the meetings.

Circulation requirements for papers
At least three working days in advance of the meeting.

Reporting Committee
Board of Directors

Committees reporting to the Assurance Committee
Quality Committee
Risk Management Committee
Facilities Committee
Health and Safety Committee

Review date for the terms of reference
Yearly

Approved by
To be approved by the Board July 2013

Date of terms of reference
July 2013

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.18/Jul/13
PAPER	Finance and Investment Committee Terms of Reference*
AUTHOR	Lorraine Bewes, Chief Financial Officer
LEAD	Prof Sir Christopher Edwards, Chairman
PURPOSE	To ensure terms of reference are up to date and reflect the needs of the organisation.
LINK TO OBJECTIVES	Ensure Financial and Environmental Sustainability
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	None
EXECUTIVE SUMMARY	The terms of reference of the Finance and Investment Committee have been reviewed by the Committee in line with the requirement to review every two years (the TOR were last approved by the Board in July 2011). The following minor changes have been made to the terms of reference: i) **Membership** – the membership of the FIC has been amended to incorporate the recent changes to the Finance structure, so the attendees now include the Chief Financial Officer (CFO) plus Director of Finance and Commercial Director. The requirement for the Chair of the Audit Committee

	to attend is amended to require two NEDs to attend. ii) **Attendance requirements** – these have been amended from three meetings out of four to two thirds of meetings. iii) **Quorum** – The arrangements for the meeting being quorate have been updated to state that the Chief Operating Officer (rather than Deputy Chief Executive) can attend for the Chief Executive provided the Chief Financial Officer (previously Finance Director) can attend. The Finance Director (previously Deputy Finance Director) can attend for the Chief Financial Officer providing the Chief Executive can attend. It has been made mandatory for one NED to attend, and if the Chair cannot attend there is now a requirement for a second NED to be present.
DECISION/ ACTION	The Board is requested to approve the amendments to the Finance and Investment Committee Terms of Reference (full document attached).

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Finance and Investment Committee
Terms of Reference

The Finance and Investment Committee is constituted as a Standing Committee of the Trust Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings.

The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

Aim: The Finance and Investment Committee shall conduct objective review of financial and investment policy issues on behalf of the Board.

Scope of the committee:

Financial Policy, Management and Reporting

- To consider the Trust's medium-term financial strategy, in relation to both revenue and capital.
- To consider the Trust's annual financial targets and performance against them.
- To review the annual budget, before submission to the Trust Board of Directors.
- To consider the Trust's financial performance, in terms of the relationship between underlying activity, income and expenditure, and the respective budgets.
- To review proposals for major business cases and their respective funding sources prior to submission to the Board.
- Maintain an oversight of the robustness of the Trust's key income sources and contractual safeguards.

Investment Policy, Management and Reporting

- To approve and keep under review, on behalf of the Board of Directors, the Trust's investment strategy and policy (including the Trust's treasury policy)
- To maintain on oversight of the Trust's investments, ensuring compliance with the Trust's policy and Monitor's requirements.

Other

- To make arrangements as necessary to ensure that all Board of Directors members maintain an appropriate level of knowledge and understanding of key financial issues affecting the Trust.
- To examine any other matter referred to the Committee by the Board of Directors.

Reporting: The minutes of all meetings shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors. Oral reports will be made to the Board as appropriate as part of the monthly finance report.

Review: The Terms of Reference of the Committee shall be reviewed by the Board of Directors every two years.

Membership: The members are the Trust Board Chairman who is also the Chair of the Finance & Investment Committee, the Chief Executive, the CFO,,the Director of Finance and the Commercial Director and two NEDs.The Committee may invite other Trust staff to attend its meetings as appropriate.

Frequency of meetings: Meetings shall be held quarterly, with additional formal meetings as deemed necessary.

Attendance requirements: Two thirds of meetings

Quorum:
The Trust Board Chair and the Chief Executive or CFO. The COO may attend for the Chief Executive providing the CFO can attend. The Finance Director may attend for the CFO, providing the Chief Executive can attend. One NED must attend. If the Chair cannot attend there must be a second non-executive director present.

Approved by the Board of Directors September 2008
Reviewed by the Finance and Investment Committee March 2011
Approved by the Board July 2011
Reviewed by the Finance and Investment Committee June 2013

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.19/Jul/13
PAPER	Annual Members' Meeting proposal
AUTHOR	Layla Hawkins, Head of Communications and Marketing
LEAD	Tony Bell, Chief Executive
PURPOSE	
LINK TO OBJECTIVES	N/A
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This paper is intended to propose the format and themes of this year's Annual Members' Meeting on Thursday 19 September. The meeting is a statutory requirement and must include presentations by the Chairman, Chief Executive, Director of Finance and a Governor. The Council of Governors are in support of this proposal.
DECISION/ ACTION	To approve the format of the meeting and to ensure attendance at the event.

ANNUAL MEMBERS' MEETING PROPOSAL

1. Executive summary

The Annual Members' Meeting will be held at **5.30pm** on **Thursday 19 September** in the Restaurant on the Lower Ground Floor of the hospital.

All Board members are expected to attend.

The meeting is organised by the Head of Communications & Marketing on behalf of the Chairman and Chief Executive.

Our Foundation Trust constitution sets the following requirements for the meeting:

- The Board of Directors shall present to Foundation Trust members the annual report and accounts 2012/13; report of the external financial auditor (included in the annual report and accounts); forward planning information for 2012/13
- The Council of Governors shall present to Foundation Trust members a report on steps taken to ensure that the membership of the Trust is representative of those eligible for membership of the public, patient and staff constituencies; progress on the membership strategy; results of Council of Governors elections; announcement of Non-Executive Directors appointed in 2012/13

The Annual Members' Meeting is a positive event which enables the Board and the Council of Governors to set out the key achievements of the last financial year and plans for the current financial year.

The meeting aims to create a dialogue with Foundation Trust members and members of the public by providing them with an opportunity to ask questions of the Board of Directors and to provide their feedback on the Trust's performance and future plans.

2. Themes at the meeting

Patient experience and quality remain at the top of our agenda, and rightly so, following the Francis Inquiry and other cases of care falling below the standards we'd all expect as patients. The statutory presentations will discuss the quality of care and experience we currently provide and our plans for 2013/14.

Progress around *Shaping a Healthier Future* will be discussed. The event provides us with an opportunity to showcase our expansion plans for A&E and how this investment will help us continue to deliver an excellent standard of emergency care as the best performing department in the country. This will form part of the Chief Executive's presentation.

As an example of quality, the Dean Street Express facility will open in October 2013 and it is an opportunity to showcase this unique service and other innovations in sexual health that will improve the quality and provision of care and advice we provide to the diverse range of populations we serve.

The second clinical presentation will be a review of research endeavours involving the Trust over 2012/13. The focus of this presentation will be how our research portfolio translates into better care and experience for patients.

We would also like to recognise the spring winners of the quality awards as part of the meeting schedule.

It is the 20th anniversary of the opening of the main hospital building and we are hoping to show an edited version of the original video of the hospital opening and a new video we would like to commission, highlighting our achievements and innovation over the last 20 years.

3. Proposed format

Annual Members' Meeting opens with original video of hospital opening (5 minutes)

Statutory presentations (5-10 minutes maximum for each speaker):

1. Chairman
Content to be discussed nearer the time.

2. Chief Executive
Content to be discussed nearer the time.

3. Director of Finance
Presentation of accounts and brief overview of our financial position, in particular how we have used our Foundation Trust freedoms to invest our surplus in developments to improve patient care.

4. Council of Governors representative (confirmed as James Dennis at July Council of Governors meeting)
Membership report to include an explanation of the role of Governors and the role of members and Governors in supporting the Trust.

Question & Answer session (30 minutes maximum)

Questions from the public to be answered by the Trust Board of Directors – this session will be chaired by the Chairman.

Presentations by clinicians (10 minutes each)

Announcement of Quality Awards winners (5 minutes)

Annual Members' Meeting closes with 20th anniversary video (5 minutes)

Layla Hawkins
Head of Communications & Marketing
July 2013

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	4.1/Jul/13
PAPER	Audit Committee minutes – 23 May 2013
AUTHOR	Lorraine Bewes, Director of Finance
LEAD	Sir John Baker, Non-executive Director
PURPOSE	The purpose of this report is to share minutes with the Board.
LINK TO OBJECTIVES	Ensure financial and environmental sustainability
RISK ISSUES	None noted
FINANCIAL ISSUES	None noted
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This paper outlines a record of proceedings of the meeting of the Audit Committee held on 23 May 2013.
DECISION/ ACTION	For information.

Date…….. **Signed……..**

Audit Committee, 23rd May 2013
Minutes

Present:

Non-Executive Directors:	Sir John Baker (JB) Chairman Sir Geoff Mulcahy (GM), Non-Executive Director
In Attendance:	Tony Bell (TB), Chief Executive Lorraine Bewes (LB), Director of Finance Cathy Mooney (CM), Director of Governance and Corporate Affairs Carol McLaughlin (CMl), Acting Deputy Director of Finance Helena Moss (HM) Neil Hewitson (NH), KPMG Neil Thomas (NT), KPMG Simon Spires (SS), Parkhill Heather Bygrave (HB), Deloitte Ben Sheriff (BS), Deloitte

1. GENERAL BUSINESS

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1.1 Apologies for Absence

Prof. Dick Kitney (DK), Non-Executive Director,

1.2 Declarations of Interest

None

1.3 Minutes of the Previous Meetings held 31st January 2013

The minutes were agreed as a true and accurate record.

1.4 Schedule of Actions

- 2.1 Counter Fraud Progress Report

The Committee was informed that the Parkhill benchmark report on levels of fraud referrals would be presented at the next Committee meeting.

Action: SS to present benchmark report on fraud referrals at the next Committee meeting

- 2.2 2013/14 Counter Fraud Work Plan

LB confirmed that a fraud risk assessment would be carried out to inform the Counter Fraud plan and the revised plan would be presented at the July Audit Committee.

Action: SS to present 2013/14 Counter Fraud revised Work Plan at the next Committee meeting

2. EXTERNAL AUDIT

2.1 Quality Governance Framework

CM explained that this report outlines Monitor's Quality Governance Framework and gives examples of how the Trust meets the framework requirements.
She stated that the risk rating is included in this report and we still have two areas rated amber-green.
The Chair noted that this was a sensible and reasonable framework and sought confirmation from the external audit partner, HB, that she was content with the report and this was confirmed.
TB informed the Committee that meeting the Quality Governance Framework will be a standard requirement for all pipeline Foundation Trusts from now on.

This report was noted by the Committee.

2.2 Risk Appetite

CM highlighted that previously the Trust has not included a definition of risk appetite but that it was timely now to define it and describe it in the Annual Governance Statement (AGS) to fully meet the requirements of the AGS. She stated that financial risk is the only outstanding risk in this report. The Committee noted that finance risk should be split between performance and investment risk but that otherwise the report was agreed.

Action: CM to split finance risk between performance and investment risk.

2.3 Annual Governance Statement

CM presented this report which had also been circulated to the Board as part of the Annual Report.
She stated that comments from BS (external audit) had been included in the report.

It was noted that operational clinical risk and significant internal control issues had been included in this report for the first time.

JB asked if there were any issues in the report which the Audit Committee should be aware of. CM replied that there was only one issue related to mandatory training received by staff and this would be addressed in 2013/14.

The Committee approved the report.

2.4 Report to those charged with governance of the financial statements for the year ended 31st March 2013

HB presented Deloitte's Annual Audit Report for 2012-13.
She advised that the status of the audit was as expected at this stage of the timetable agreed in their plan.
She added that the following areas still needed to be completed to finalise the audit:

- Review of forecasts to 30 June 2014
- Testing of the Foundation Trust Consolidation schedules (FTCs) and review for consistency with the accounts

HB noted that value for money (VfM) is about appropriate governance arrangements being in place rather than VFM per se and HB confirmed that the Trust has demonstrated that the appropriate arrangements are in place.

HB highlighted that the annual report and accounts provide a clear and balanced account of the performance of the Trust. She stated that from their review of risk management and internal control systems no significant deficiencies in the financial reporting systems had been identified. JB noted that Deloitte had flagged up some helpful suggestions for improving the content of the annual report and CM

should ensure that these were updated in next year's report.

Action: CM to ensure the comments flagged by Deloitte on the content of the annual report should be incorporated in next year's report.

Deloitte declared that they have been appointed to support the Trust in its initial red flag due diligence phase for the West Middlesex transaction.
In response to a query raised by GM, BS from Deloitte advised that the fee was £116k.

BS highlighted that the key findings in the report were as follows:

- Provision levels had come down significantly compared with last year
- The agreement of balances was pretty clean
- Grant and donation income –testing was clean and to note treatment of capital grant for the Burns development.
- To note treatment of income for the Da Vinci robot as a contingent asset rather than inclusion in the balance sheet as the donation for this had been received after the year end and at the time of the balance sheet the Trust did not have a contractual commitment from the Charity to transfer the funds. It was noted that these funds had been received after the balance sheet date.
- No significant movement in the overall value of fixed assets had been identified, with land value rising and buildings reducing. It was noted that the Trust had not commissioned a valuation which was regarded as less prudent than last year but still within the acceptable range.
- Inventories – it was noted that a couple of control recommendations had been identified and a pricing error in the inventory valuation.
- Deferred income was not significant

BS advised that the Trust has achieved a very good position on its risk rating.

JB thanked Deloitte for their report and welcomed the very clear layout. He added that whilst there was adequate disclosure of the West Middlesex opportunity in the report there was no reference to the RBH opportunity. BS stated that there was a limit to what needed to be included in the report.

LB commented that the benchmarking of our income growth against other trusts and reducing agency costs was very helpful. She noted that whilst we had grown income over last year this was significantly less than other Trusts. She also reflected that the reduction in agency costs over the previous year had not really been brought out in the management accounts during the year. She thought this should be reflected in the management accounts going forward.

She asked if Deloitte had a view about what was driving the differential growth. BS replied that he would look at this.

Action: BS to review differential income growth to explain possible drivers and present his findings at the next Committee meeting.

The report was noted by the Committee.

2.5 Directors briefing on Annual Accounts

LB commended the Directors' briefing as a line by line explanation of the changes from last year which should help inform the Committee about the underlying financials. LB highlighted that this showed that the Trust had held pay costs successfully and achieved a significant reduction in agency spend.

In response to JB, LB advised that there were no other significant issues which the Committee should be aware of.

The report was noted by the Committee.

2.6 Review of Annual Accounts year ended 31st March 2013

LB highlighted that there were only minor changes in the format and presentation of the accounts this year compared with last year.
External Audit confirmed that there were no issues that they wished to raise on the accounts other than what had been covered in their earlier report.
The Committee confirmed they were content to recommend to the Board approval of the annual accounts for the year ended 31 March 2013.

2.7 Report on work performed on the Quality Accounts

HB advised that this was a draft report and it would be sent to the Governors and Monitor.

She advised that the outstanding issues were as follows:

- 62 day cancer wait – rated yellow (satisfactory, minor issues only), not completed as the March 2013 data had not yet been uploaded to the Open Exeter national system. Housekeeping errors had been noted but these had not impacted on the accuracy of report. However some errors had not been corrected and it was noted that the Trust had a higher level of errors than other Trusts that had been audited. There were no system errors but the data errors needed to be addressed.
- Incidents resulting in severe harm or death – this was rated red (significant improvement required) and at the time of publication was awaiting receipt of all management responses .The total figures were now available and the report would be updated and presented at the Governors' meeting for approval.

The Committee was advised that in the review of C-diff, sample testing identified no errors affecting reported performance against the target indicator.
TB asked if these issues were preventable and could be repeated or if they were due to carelessness.
JB concluded from the discussion that most errors were due to carelessness and not due to a deficiency in systems. HB noted that the errors were first drawn to the attention of management by the audit rather than flagged by Trust staff so performance validation needed to be reviewed.

HB informed the Committee that "Incidents resulting in severe harm or death" is a new indicator tested for the first time. She stated that a number of issues had been identified during the testing of this indicator and all of these issues had been escalated to management for confirmation or to provide additional information to resolve them. She added that once all queries had been resolved, recommendations for improvement would be made.
HB noted that the indicator was still rudimentary and subjective and advised that there were no external implications of the indicator being red rated at this stage as this was a private report to the Directors and Governors of the Trust.
JB asked how these findings related to our clinical audit processes. CM replied that this relates to quality of data and not to clinical audit.

The Committee was informed that we had 125 orange incidents last year.

The report was noted by the Committee.

2.8 Sector Development

HB informed the Committee that Deloitte had benchmarked performance for the year across their 33 foundation trust audit clients for the year ended 31st March 2013 including 22 acute and specialist trusts. She stated that our Trust met all governance indicator targets at 31st March 2013 and one of the highest EBITDA performances.

The report was noted by the Committee.

4. INTERNAL AUDIT

4.1 Internal Audit Progress Report and technical update

The report was noted by the Committee.

4.2 Recommendations tracker

NH highlighted that of the 32 recommendations included in this report, 22 were not yet due, 10 were overdue and of these 4 were medium priority and 6 low priority. He added that he was satisfied with the reasons for recommendations being deferred and that proposed actions were adequate to implement them and that the original risk rating did not need to be escalated.

The report was noted by the Committee.

4.3 Internal Audit 2013/14 plan

NH informed the Committee that the risk assessment for 2013-14 included in this report had been updated for feedback received from the Committee on what should be prioritised and noted that an audit of clinical audit processes had been included in the revised plan. He stated that indicative timetable had been also updated accordingly.

The internal audit plan for 2013/14 was approved by the Committee.

4.4 Audit of Reference Costs

LB noted that each year the Trust has to submit reference costs to the DH and now to Monitor and these costs ultimately feed into the calculation of the tariff. She stated that the report should be read in conjunction with KPMG's audit report on reference costs which confirms that the Trust has adequate systems and processes in place to carry out the reference cost submission for 2012/13. She added that in the previous years the only assurance on the adequacy of reference costs was through sign off by the Finance Director but this year external assurance was required. The Trust has taken KPMG's feedback on board and has plans to implement the recommendations that they have made.

The reference cost process and external assurance on the adequacy of their preparation were noted by the Committee.

5. GOVERNANCE & RISK MANAGEMENT

4.1 Standing Orders, Standing Financial Instructions, Reservation of Powers to the Board and Scheme of Delegation

CM confirmed that the Trust's constitution was updated in March and the changes were approved by the members at the Special Members' meeting. She stated that there are further changes to be made to the constitution and to these documents.

The Audit Committee was asked to approve an extension of 6 months to finalise all changes.

The Audit Committee agreed to an extension of 6 months to finalise all changes in SO, SFIs and SoD.

6. ITEMS FOR APPROVAL/INFORMATION

6.1. Summary of key points of Assurance Committee on 28th January, 25th February and 25th March

2013

6.2 Summary of key points of Finance and Investment Committee on 21st February, 21st March and 18th April 2013

6.4 Waivers of Tenders and Quotations

6.5 Forward Audit Committee Plan

All noted.

6.3 Losses and Special Payments including write offs

CMl informed the Committee that there was a total of £161,467 for losses and special payments for the period 1st March 2013 to 30th April 2013, of which £131,047 related to debts written off and £30,420 related to special payments. She stated that two special payments related to damages paid to staff.

The report was noted by the Committee.

The Committee decided that the Assurance Committee minutes and Finance and Investment Committee minutes should be taken off the Agenda as members would have seen these minutes via the Trust board paper circulation. JB noted that he would like to be on the FIC minute circulation.

Action: PC to take Assurance Committee minutes and Finance and Investment Committee Minutes off the Audit Committee Agenda

PC to add Sir John Baker to the circulation list of Finance and Investment Committee Minutes

3. COUNTER FRAUD PRO-ACTIVE WORK

3.1 Interim Counter Fraud Workplan April-June 2013

SS advised that this interim document detailed the proposed counter fraud work for the period 1st April 2013-30th June 2013. He stated that the remaining work plan would be drafted following completion of a full risk assessment which would be completed and presented at the July 2013 Committee meeting.

The Committee discussed the issues raised by the fraudulent submission of duplicate timesheets.
LB stated that payroll found out that some of the timesheets were claimed more than once and that this had highlighted a weakness in control as it was possible for the staff member to claim for the same shifts more than once if they were submitted in different weeks. In order to mitigate this the Trust has run a report on the top ten earners through bank and their timesheets will be checked regularly. Also an additional validation check has been instituted to validate for duplicate dates submitted in different weeks. This is manual at the moment but will be automated.

SS flagged that a systematic review was required and he had significant concern regarding the apparent lack of diligent time-sheet authorisation. The fraud referral had flagged there was a significant issue with nurse managers either not checking the timesheets properly and the possibility that there may have been collusion, though it was stressed this was only a possibility being investigated and not a confirmed finding.

TB stated that ward sisters were very busy people, often needing to deal with urgent clinical issues which would explain why they did not always pay enough attention to what they were signing. He suggested that we should be looking to add shift authorisation to timesheet review and that these should go to matrons for review.
SS agreed to look at this as a recommendation.

Action: SS to review the possibility of including shift and timesheet authorisation in a matron's responsibility to review.

JB asked how many timesheets were signed per week. SS replied that we process around 800 timesheets per week.

TB stated that the person who books staff from agency should sign their timesheets and that this should be set up as an administrative process and link back to who booked the session as too much was being pushed down to ward level. SS added that the MAPS system is not updated regularly by staff which is a big issue.

JB suggested that once the booking has been ordered there should be a central place which matches against what has been authorised and there should be a move to e-timesheets.

The interim plan was approved by the Committee.

7. DATE OF THE NEXT MEETING

10th July 2013 1-3pm Main Hospital Boardroom

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.3/Jul/12
PAPER	Assurance Committee Annual Report 2012/13 Supplementary paper
AUTHOR	Catherine Mooney, Director of Governance and Corporate Affairs
LEAD	Karin Norman, Non-executive Director
PURPOSE	The paper is to advise the Board of the areas under discussion by the Assurance Committee in the year 2012/13 including assurance that appropriate actions have been taken or are in progress.
LINK TO OBJECTIVES	Patient and Staff Safety
RISK ISSUES	None other than those identified in the paper
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This paper outlines the discussions and summaries from the Assurance Committee over the year 2012/13 i.e. up until March 13. This supports a shorter version in the main Board papers.
DECISION/ ACTION	The Board is asked to note the report and confirm that the Assurance Committee provides an effective assurance process.

Annual Report to the Board from the Assurance Committee
April 2012 to March 2013

1. Introduction

This report contains a summary of the key issues that have been discussed over the period April 2012 to March 2013 by the Assurance Committee. This report will be presented to the Board as part of seeking confirmation that the Assurance Committee fulfils its function of assuring the Board on matters within its remit.

The Board receives a copy of the minutes of the Assurance Committee and in addition a monthly summary report which indicates levels of assurance where this has been possible. This summary is based on the reports to the Board.

2. Background

The Assurance Committee is responsible for assuring on a wide range of issues including quality on behalf of the Board. It receives reports from the Quality Committee, Facilities Committee, Health and Safety Committee and Risk Management Committee.

3 Key issues

3.1 Health & Safety

In June 2012 the Committee received a presentation on Health and Safety focusing on actions required for Directors and Board Members and the organisational structures and processes in place. This was the first report of its kind to the Assurance Committee and it was suggested that the arrangement whereby the Assurance Committee assures on H&S on behalf of the Board is reviewed in a year to determine if the Board feels it is a robust system.

The Committee agreed that the Health and Safety Committee would have a direct reporting line to the Assurance Committee as the Risk Management Committee does and that there would be a monthly report on Health and Safety.

The challenges of ensuring staff are trained was discussed and the actions taken to improve uptake.

A report from the Health, Safety and Fire Committee for May and June 2012 was also presented and the Committee requested a more detailed analysis in future.

In July 2012 a more detailed report was provided covering the main issues discussed at the Health, Safety and Fire Committee held on 3 July 2012. It was reported that extensive work relating to COSHH was being carried out to ensure divisions and departments have identified representatives and relevant training is undertaken. 110 fire marshalls have been identified across the Trust and there is a programme of fire marshall training in place. The HSC were concerned about the level of compliance for mandatory health and safety training which is less than 50%.

In September 2012 Divisional engagement with Health & Safety was highlighted and that the Chief Nurse has written to each Executive and Divisional Director to remind them of their obligations and to request an update on the position with a number of areas and including action plans if necessary.

The H&S Objectives for 2012/2013 were noted and made available to the Committee.

A detailed analysis was provided in October 2012 and this identified gaps in control and assurance and the action plan to address those gaps based on learning from the St. Stephen's incident. Overall there was evidence of a lax approach to understanding and

addressing health and safety issues in some areas, with slow progress being made against the action plan. It was noted that a major cultural change was required. There are plans to reinforce the level of rigour within the divisions and there is evidence that some divisions are progressing and it is expected that the approach taken by the Women's and Children's Division will be emulated in other divisions.

In November 2012 improvements were noted. However, the Committee remained concerned about pace of change and in particular, continued low attendance at "mandatory" training in all areas and non-completion of some divisional risk assessments. They were concerned that every individual in the Trust should be aware that this is a top priority and that their personal actions are a vital part of delivering a safe culture and that this clear message was being delivered from the top. They noted the good work and progress in the Medicine and Surgical Division.

In January 2013 it was reported that there has been 56% overall compliance with health and safety training but continued progress needs to be made; the target is 95% by the end of March.

There are two key areas in which there have been no significant progress; mandatory training take-up and risk assessments for lone working. The capacity is there but attendance is low.

In January key issues reported included that the levels of incidents relating to violence and aggression are increasing. This is also being seen nationally and will continue to be addressed and reported through the Health and Safety Committee Report.

Other issues noted were the development of KPIs as it is intended that these will be part of the KPIs going to the executive team weekly. Progress on mandatory training is still slower than hoped and steady progress is being made around gaps relating to lone working.

However in March 2012 the Committee noted that despite some good progress in H&S in the last 12 months in terms of quality and ownership, the staff death in St Stephen's should have prompted a radical step change of H&S performance and awareness and reiterated the need for a culture change.

3.2 Never events - assurance

In June 2012 the Committee reviewed the actions that were being taken to avoid another never event relating to retained vaginal swabs. The importance of following protocols was emphasised and the need for sanctions if this does not occur. The Divisional Medical Director Women and Children's Services attended the meeting in July 2012 and confirmed that a number of controls have been introduced to prevent occurrences of missed swabs, such as double counting of swabs and continuing audit. Large 8" swabs with a plastic disc attached to a long tail are now used as these are more difficult to lose. Those with no double signatures are actively followed up and the London Deanery escalates them to the relevant educational supervisors. It is the responsibility of the surgeon or midwife to double count and it is their responsibility to find someone to do the second count. This is included in trainee induction. A report on the audit of swabs is due at the meeting in May 2013.

In July 2012 the Committee received assurance reports on two never events – Wrong site surgery and death following Post partum haemorrhages (PPH) following elective caesarean section.

In October 2012 there was a report on the outcome of the double counting audit which showed that there was 88% compliance with double signing. The Medical

Supervisor/Supervisor of Midwives is informed of those responsible for the 12% non-compliance. The importance of compliance is emphasised in induction.

In November 2012 the revised Never Events Policy Framework was noted. A schedule is in place for checking each category of never events for adequate controls and assurance. These will be discussed at the Quality Committee and then at the Assurance Committee.

A report on controls and assurance relating to patient ID wristbands being on all patients was presented in January 2013. It was felt to be too detailed for the Assurance Committee and a summary report was required in future, identifying management's assessment e.g. low, medium or high assurance.

In February 2013 a RAG rated Never Events Assurance paper was presented. In summary, the Trust was assured on 7 out of a total of 25 Never Event categories at that time.

In March 2013 it was reported that of the 25 never event categories, one, correct site surgery is rated red (due to a further event occurring) 11 are rated orange, 11 are green and 3 are still to be reviewed. The orange rating is either due to there being no assurance and/or where assurance reports indicate that the controls are not effective.

The assurance committee has asked to see timescales for all to be green.

3.3 Mandatory Training

The report in June 2012 noted that the rates of mandatory training have improved and the revised approach to training was described i.e. annual updates for all staff which means that the bulk of training can now be done in one day. Training rates increased to 63% in May 2012 against a target of 80%. Low compliance of medical staff with Health and Safety Training and Moving and Handling Training was reported. The idea of a directorate fine of £90 per delegate (the cost per person for running an event) for non attendance or non completion was noted. Ideally staff should not be permitted to do professional development training until they have completed mandatory training, but enforcing this will be difficult. Other concerns were that on-line induction needs to be readily accessible and to be easily tracked and monitored.

In September 2012 the Committee noted the introduction of Qlikview, which will allow access to managers to check staff training against requirements for that staff member.

The Committee heard about developments to the training process to reduce complexity, e.g. many aspects of training being covered by update days, the range of methods for training (taught sessions, update dates and e-learning, which is available from home) and the introduction of the escalation process. Training rates were noted to be 63% in August 2012.

The report in January 2013 stated that compliance with training has increased fairly steadily over the last 2 years but is now tailing off and is still significantly below target. Issues discussed included access by individuals directly to their records, pre-booking staff on courses rather than the managers having to do it, weekend training and how to increase the perception of the quality of mandatory training and the importance of it.

In March 2013 it was noted that the data presented may not be correct due to a breakdown in the Trust systems for recording data which may have resulted in an underperformance of approximately 4%. There was a full discussion of how to make rapid, substantial and sustainable change in mandatory training which has not reached acceptable levels despite efforts over the last 5 years. The Executive will seek a step-change in performance going forward.

The Assurance Committee remains concerned about the slow progress with mandatory training.

3.4 Facilities Report
In June 2012 the Committee noted that the overall performance of Norland during the last two quarters demonstrated improvement.

The Quarterly Balanced Scorecard for Estates Maintenance Services showed a number of red and yellow areas which are being addressed. Fire alarms maintenance is a priority and Norland are focusing on this. In September the report indicated that there was a good service from the contractors and that the services were being adequately monitored

3.5 Top concerns
In November 2012 the Committee members were asked to consider their top 5 concerns. These included mandatory training – attendance, assurance, Health & Safety – culture, ownership, assurance, Clinical Indicators including departmental level performance, Patient Experience – improved consistency in satisfaction, Values – embedding at all levels, staff appraisals – effective, meaningful and regular, performance management processes for staff – ensure effective part of behaviour change and overall culture shift and Learning from incidents. It was agreed that these items will remain a priority for the Committee until assurance is obtained and in addition, the Committee requested a brief report from the Chief Nurse and Medical Director on an ongoing basis.

In the next three months the top concerns from the Medical Director were noted to be handover, failure to recognise and escalate deteriorating patients, meeting the acute care standards and having 24 hour consultant presence (C&W is probably the most compliant with acute care staffing standards in London but this will continue to be a concern until we are fully compliant), delayed follow up of outpatient appointments e.g. patients needing to be seen in 4 weeks being seen in 3-4 months, and administrative processes around appointments which can lead to delayed results and never events.

The top concerns from the Director of Nursing were noted to be getting the Health & Safety culture right in the organisation, attitude of staff towards patients, pressure ulcers and a particular clinical area – Nell Gwynne - although this was noted to be improving.

The alert received from the CQC regarding infection in maternity relating to incidents of peuperal sepsis and the work that was being undertaken was also noted.

4. Annual Reports and updates in year
4.1 Infection Control Annual Report
A summary of the report was presented in July 2012.

4.1.1 Infection Control Q2 Report Jan
The key points were highlighted. This included the Trust's performance on orthopaedic surgical site surveillance where the latest result is 1.8% infection rate against an average of 0.7%. A root cause analysis has been done for each one and the numbers are small. The strong performance with MRSA.and *C difficile* was noted.

Targets for next year are increasingly challenging as C&W has one of the lowest rates in the UK. There is zero tolerance for MRSA and the target for *C difficile* will decrease.

4.2 Risk Management Annual Report
Highlights of the summary of the full report were discussed in July 2012:

Key achievements included attaining NHLSA risk management standards level 2 in December 2011, achievement of the falls related CQUIN, the introduction of new online training for nursing and medical staff in clinical record keeping and clinical audit, and revised online training module for risk and incident management.

The top 5 incident types have not changed significantly since last year; they are blood/blood related incidents, medication, care and documentation.

There were 183 open risks on the Trust wide risk register at the end of the year. Risks are reported at other committees e.g. IT related risks are reported to the IT Committee and information governance risks to the Information Governance Committee. The Risk Register is difficult to use and to extract information from; it will be replaced by a new Risk Register in April 2013.

4.2.1 Risk Report Q1 Trust November
As a result of a number of audits, some systems and processes have been changed and other changes are planned. The NHSLA assessment process was valuable in identifying gaps and evidence that action was taken.

4.2.2 Risk Report Q2 January
The number of incidents reported in Q2 (July – Sept 2011) were fairly static. There were issues with batching but this is being addressed. The focus needs to be on assurance that actions are taking place and that policy is being implemented in practice.

There were 4 incidents in one shift relating to patients with mental health issues. It was confirmed that there was an action plan in relation to the patient who absconded and committed suicide and this led to some significant changes e.g. the mental health assessment room in A and E, and the beginnings of the close working with Mental Health that we see now.

4.3 Maternity Risk Management Report
The annual maternity risk report was presented in July 2012 and key achievements highlighted.

There has been a significant reduction in the caesarean section rate (26%, which is the national average). Orange incidents are mostly related to deliveries and key areas are bladder injuries and third and fourth degree tears. The incidence of 3rd and 4th degree perineal tears in normal delivery ought to be 1-2% but is actually running at 3.5%. The cause of this is unknown although data is being collected. Patients are warned about complications at the consent stage.

One orange risk relates to CTG machines and the department aims to introduce an automated system. Obstetric incidents are associated with complicated delivery. Incidents of bladder injury during caesarean delivery have been investigated and recommendations implemented. Term babies being admitted to NICU resulted from a failure to follow relevant guidelines and escalate appropriately.
There has been an 11% increase in incident reporting around blood due to better reporting. 60% of blood transfusions come from maternity. The rate of labelling bottles was benchmarked and we are not worse than elsewhere in the country. A large number of incidents were due to the closure of the unit and staffing levels due to flu, etc.

Maternity has a good incident reporting system in place with staff at all grades completing forms and a high level of reporting which feeds into the risk register.

4.3.1 Maternity Risk Management Quarterly 1 Report

This report outlines incidents and risks in the maternity service for quarter 1. There was one never event during the quarter relating to a retained swab.

Incidents and risks were discussed and in particular a capacity problem with cardiac services to pregnant women. However, it was later clarified that the risk was financial and low for that particular service.

4.4 Medicines Management Annual Report 2011-2012
The highlights of this report were noted in September 2012 and changes to the policy were agreed.

Audits are being undertaken to provide evidence for NHSLA Level 3.

The work being done around quality initiatives, the urinary catheter CQUIN and VTE was highlighted.

4.5 Safeguarding Children Annual Report
This was presented in September 2012. The Committee noted the outcomes of external visits which were good and noted that these assess not just the Trust but also the performance of the local Boroughs and other hospitals and this can be variable. There is a commitment to working with the Boroughs to achieve excellence.

It was confirmed that the Lastword electronic alert flag for children with safeguarding issues is linked to all four Boroughs, however there is a gap if patients come through the Urgent Care Centre as the flag is not on Adastra. However, staff communicate around this to ensure that no child is missed.

The Committee discussed mandatory training compliance which remains a challenge. There is 100% compliance with Level 1, 63% compliance rate with level 2 which is online and 54% compliance with level 3. Letters from the Medical Director and Chief Nurse have been sent to staff requesting they undertake Level 2 and Level 3 training and this is being followed up. CQC and Ofsted did not highlight training levels as a risk. It was confirmed that 54% compliance is not all in one area within the Trust and the list of trained staff is checked to ensure there is no area at risk through untrained staff.

The Committee noted the report and the results of inspections which were good but remained concerned around uptake of training. It was noted that there are plans in place to increase this.

4.5.1 Safeguarding Children 6 monthly Report
The 6 monthly report was presented in February 2012. The CQC integrated inspection rated all aspects as ‘Good’. (The next bar is ‘Excellent’)

Reviewing the access policy and the process for following up children who do not attend appointments has not yet been completed. A letter is sent to the GP if children fail to attend appointments.

The main focus is on training. 71% have done Level 2 training and 62% have done Level 3 training. It was noted that intakes of new doctors & nurses cause training figures to deteriorate, so 100% may not be realistic. The focus is on getting evidence of Level 3 training carried out elsewhere which can then be added to staff records.

There was a discussion about cross referencing across three software systems LastWord, Adastra and Lilie and how this is achieved and the involvement of all four boroughs,

Hammersmith & Fulham, Westminster, Kensington & Chelsea and Wandsworth with these systems. This is done manually but the Committee was given assurance that this process is effective and fit for purpose.

The Assurance Committee was assured that robust systems are in place.

4.6 Safeguarding Adults Annual Report
The key points from the report were highlighted in July 2012. This included allegations against the Trust (similar numbers of allegations against the Trust were made in 2010/11 and 2011/12) and the use of a flagging system to denote people with learning difficulties. Only 34% of patients were flagged in Q4 but this is now much higher. Alerts raised by staff have demonstrated increased awareness in particular around adults with learning disabilities.

Future work will entail looking at safeguarding in transition i.e. 14 – 18 year olds, working with children and young people services and local authorities. The Joint Child and Adult Safeguarding Board will be reviewing this in August.

4.6.1 Safeguarding Adults Q1-Q3 Report
A key assurance is the number of adult safeguarding referrals about the Trust. There has been a rise in escalation of concerns about the Trust - 22% up from 18% for the same period last year.

External assurance on Adult Safeguarding is provided by pan London network/Tri Borough working. Safeguarding leaflets, training and update sessions are provided.

The processes in place meant the Trust was aware of the safeguarding issues on Nell Gwynne and raised them with the Borough. A rapid improvement process was initiated, an action plan agreed and the report shared with the Borough. The Trust has been commended for its openness.

There has been an increase in Type 2 incidents where concerns were raised about care in the Trust; 24 during the last three quarters. There was a query as to the reason for this, aside from issues in Nell Gwynne. A limited number of cases concerned allegations of sexual assault but Social Services and the police advised the Trust these were unsubstantiated.

The Assurance Committee was assured that there are no Safeguarding issues of concern.

4.7 Annual Workforce Report
In July 2012 highlights from the report were outlined. The report does not raise any areas of concern unique to this organisation but a source of some concern is the over representation of BME staff involved in employee relations (disciplinary procedures) and this is seen across the NHS and is therefore to be addressed nationally. It could be linked to origin of training rather than ethnicity as doctors involved are trained abroad. The GMC has the same profile; complaints are more often made regarding doctors who have been trained elsewhere. Training on understanding diversity is available for managers in the Trust. An internal and external mediation service is available as well as training relating to bullying and harassment etc. in order to try to resolve issues before they escalate.

The Assurance Committee noted the concerns relating to BME staff and employee relations but otherwise noted no major concerns regarding the workforce report.

4.8 Complaints and Concerns Annual Report Summary 2011 – 2012

A summary of the Complaints and Concerns Annual Report was noted. This was subsequently presented to the Board.

4.8.1 Complaints Report Q2
The Q2 report was received in January 2013. It was noted that the number of complaints was above national average and in particular complaints relating to attitude. Most complaints are from inpatients, and are not solely about nursing staff. Complaints about the appointments system were also noted.

4.9 Annual Claims Report 2011/12
The report was presented in November 2012. Although the number of claims has gone down, the number varies yearly. An example of an improvement in service as a result of claims is centralised monitoring for CTGs.

There were no concerns raised from the claims report.

5. Audits
5.1 Audit of Discussion between Clinician and Patient relating to consent
In April 2012 the Committee noted the results of an audit demonstrating that there was 100% compliance with the documentation of a general discussion between clinician and patient as part of the consent process. However the risks of anaesthesia were not documented on 50% of the anaesthetic forms. The results were noted to be generally good and that follow up and re-audit is planned.

5.2 National Care of the Dying Audit
In April 2012 the Committee noted the results of the national audit and the data for the Trust showed that this is an area that needs improvement. Recommendations include training in the Liverpool Care Pathway (LCP) as part of on-going nursing training, and considering mandatory training for senior healthcare staff in the LCP as well as communication skills. An End of Life Care Strategy Implementation Group has been set up, chaired by Dr Richard Morgan. End of life care was subsequently chosen as one of the Trust's four quality priorities.

5.3 Audit on signing for Controlled Drug (CD) requisitions
An audit in January 2012 showed compliance of 20% with correct documentation and the latest audit reported in April 2012 shows compliance of 26%. The process for ordering and receiving CDs was described. The step of signing the pink slip in the order book by the member of staff who receives the CDs into the clinical area was highlighted as a key part of the audit trail. Although no discrepancies have been linked to a failure to sign receipt to date, it was noted compliance and documentation in this area is an important part of Trust CD management processes. It was agreed that alternative processes to improve compliance will be explored by the Pharmacy Department.

5.4 Medicines storage audit
This audit presented in July 2012 looked at whether handling/storage of medicines in clinical areas in the Trust is safe and secure. This was checked by unannounced visits to a total of 23 clinical areas to check against standards in the medicines policy in March 2012.

The Assurance Committee was assured that there was 100% compliance with 8 of the 19 standards checked and over 90% compliance with a further 8 based on the independent audit. The areas where there was less than 90% compliance were discussed.

It was confirmed that there are existing stringent control measures in the Trust to prevent misappropriation of CDs; including signature checks by pharmacy staff on receipt of CD requisitions and identity checks on receipt of CD supply. However, a recommendation from

this audit will be to store CD books awaiting collection by pharmacy in the locked treatment room.

The Trust has a reasonable degree of assurance of the safe and secure handling/storage of medicines.

5.5 Medicines Policy Audit October 2012
Overall the results of the audit were positive and in particular where electronic prescribing was in place. There were two issues identified, pre-printed charts not containing details of administration on the Burns Unit and ITU and documentation of the destruction of controlled drugs. There are actions in place for both.

5.6 KPMG Audit on Patient Experience
In February 2013 the outcome of this was reported as 'requires improvement' but with minor recommendations relating to patient experience identified as low priority which will be taken forward by the Patient and Staff Experience Committee.

6. Care Quality Commission
6.1 CQC Quality Risk Profile Update
In April 2012 the Assurance Committee considered the CQC QRP for March 2012 on behalf of the Board as the Board needs to confirm it has considered the CQC QRP since it is part of the sign off for the Quality Account. These reports look at areas where the Trust is significantly worse than expected in a wide range of areas based on nationally available data.

It was noted that there is an action plan in place for all areas highlighted as red.

Further reviews of the QRP in July 2012 and September 2012 demonstrated that no overall standards are rated amber and there is nothing causing undue concern. The majority of red rated risks were already known, however there were some areas highlighted as red that we were unaware of and these are being investigated - these refer to analysis of data.

In January 2012 the QRP for Outcome 4 - Care and welfare of people who use services and Outcome 21 – Records – which relate to information indicators which were rated red, was discussed in more detail.

The overall risk estimate for the standards ranges from low yellow to high green so despite some red ratings on individual data there were no concerns overall. This will continue to be monitored and the unexplained data followed up.

6.2 CQC Standards Provider Compliance Assessments (PCAs) review of action plans
These were reviewed in November 2012. Any risks were rated amber; there are no red risks in the current PCAs.

Areas of discussion included the Trust not meeting the 5 day turnaround for clinical letters and it was noted that this is monitored as part of a CQUIN and is being tracked by the Executive Team on a weekly basis. Further information and clarification was requested on early warning systems for adults, neonates and maternity, and the communication tool SBAR (Situation, Background, Assessment, Recommendation).

6.3 Essential Standards of Quality and Safety – monitoring at ward level Oct
The process of transferring these standards into a practical toolkit was described and the approach to continuous assessment, feedback and action planning. This involves ward based assessments by senior teams and others, including governors, against key questions

developed from the standards. Summaries of the outcomes from the assessments against nutritional needs and co-operating with other providers were presented.

The Committee noted the report and the positive feedback from staff. The CQC inspections identified that staff had a good knowledge of the standards and the latest inspection identified no actions.

7. Other

7.1 Emergency preparedness and business continuity

In July 2012 the Committee received an update on the main achievements including having the highest Number of Staff Vaccinated in a London Trust March 2012, and being presented with a Council of Governors Quality Award July 2012.

The Trust plans are up to date including the Heatwave Plan 2012, COMAH (Control of Major Accidents and Hazards), CBRNE/HAZMAT Plan – (Chemical, Biological, Radiological, Nuclear, Explosives/Hazardous Materials), the Mass Prophylaxis Centre Plan (MPC) and the Business Continuity Policy and Corporate Business Continuity Plan

Several exercises have been undertaken including Exercise Exodus in 2011 (evacuation) and Exercise Sensu Carens, a live theatre evacuation exercise using dummies acting as recovery patients and anaesthetised patients, including bariatric patients, in the middle of surgery. An exercise to test communication was undertaken in May 2012. 55% of staff answered within 2 hours.

The report in March 2013 identified two gaps - the Trust does not have a current Pandemic Influenza Plan - the most recent was written in 2009, and an updated plan will be available by August 2013 - and that essential items of CBRNE/HAZMAT equipment stored in Core 8 fire lift go missing which could result in the inability to decontaminate. A risk assessment has been completed and an alternative secure storage area is being sought.

7.2 Learning Disabilities Report

This was presented in July 2012 and one of the areas discussed was the electronic flag system which has been developed for safeguarding vulnerable adults, including LD patients. An easy to read consent form is now available and volunteer escorts are available to accompany patients and carers during hospital visits. The Trust has installed Browse Aloud on its website which will enable those with learning difficulties to access information, and there is an LD section containing easy to read documents, information on local services and links to MENCAP. MPALS also have resources for people with LD.

Signage in the hospital will shortly be reviewed from the perspective of people with a learning disability. A training plan for staff, carers and LD teams that includes LD awareness, deprivation of liberty and mental capacity, is in place and is being developed for different areas. The Trust has strong links and joint projects with local groups with representation of people with LD.

An update was provided in March 2013 - there are no concerns in any areas and significant progress has been made. The Trust works closely with a Learning Disabilities group in the community.

The Committee was assured on the work undertaken for patients with learning disabilities and that we met the CQC standards.

7.3 Equality and Diversity update

The paper presented in April 2012 demonstrated that the Trust has met its legal responsibilities in accordance with the Equality Act 2010 and also provides an update on

how the Trust is progressing with implementing the NHS Equality Delivery System tool. There were no immediate concerns.

An update was presented in February 2013 and it was noted that there is more to do in relation to feedback from the staff survey on values. Bullying and harassment needs to be addressed. Focus groups have flagged that staff need to be trained better to improve interaction with patients with learning disabilities etc.

7.4 Inpatients Survey - Analysis of London hospitals and amalgamated action plans following the Inpatients and Outpatients Survey
In June 2012 the Committee considered a paper which provided Trust scores for each of 10 components of the 2011 National Inpatient Survey and compared them with the scores of 6 other London teaching hospitals. The categories for which C&W has low scores (A&E, Discharge, Nurses) validate what we believe to be problem areas.

The Committee also reviewed the action plan for the outpatient and inpatient surveys. The Patient Experience Committee has been revised and consists of a range of staff including senior divisional representatives, a non-executive Director (JL) and a governor, with MG and TD co-chairing.

The Committee noted concern about the inpatients survey results and the poor performance compared with other London hospitals and was assured that action will be taken through the Patient Experience Committee.

7.5 Summary Hospital Level Mortality Indicator (SHMI) /Hospital Standardised Mortality Rate (HSMR)
In June 2012 the Committee discussed the SHMI and HSMR and noted that C&W was the only hospital in the country to be low on all four hospital mortality indicators reported by Dr Foster and the Committee reviewed a comparison with our peer group and the performance over three years. This demonstrated the variability and the low numbers for some of the indicators e.g. deaths after surgery in patients with complications. It will be affected by coding, e.g. if the complications are not recorded the numbers of deaths associated with complications may be low.

7.6 National Reporting and Learning System (NRLS) report on incidents
In June 2012 the NRLS report was considered and an additional report comparing four reporting periods for London Acute Trusts was circulated. The Trust is in the middle quartile. It was noted that we had supplied information late and the processes have been changed to avoid this in future.

7.7 External Trustwide/Corporate External agency visits, inspections and accreditations update report
In June 2012 the Committee received a report on external visits but asked for more clarification on any risks. In October 2012 a report was presented which RAG rated progress on actions from the visits and it was agreed that further reports would include whether there were any causes for concern or recommendations highlighted as part of the visits.

7.8 Complaints Policy - Annual Review
This was approved in September 2012.

7.9 Complaints, Claims and Incidents – Aggregated Q3 and Q4
This paper in September 2012 reports on themes from looking at complaints, claims and incidents together and reports on actions taken and assurances in place. The areas identified as common themes include failure to follow up on results or required outpatient appointments, communication, education and training and handover.

8. Other regular reports

8.1 Report from the Trust Executive Quality Committee

The Committee considered these reports at every meeting. These included the Controlled Drugs Accountable Officer Occurrence Report and Controlled Drug Reports every quarter. Others areas noted included the Dementia Audit in April 2012 - this is a general report and does not include specific results for the Trust, a group has been set up to drive forward improvements; the National Early Warning Scoring and actions taken to introduce it; the Quality and Safety Programme (AES Standards) Report and a paper summarising activity and performance relating to breaches of the Emergency Department 4 hour access target for patients presenting with a mental health condition.

8.2 Monthly Reports on Local Quality Indicators

The Committee considered these reports at every meeting. Discussions were mainly around HSMR, SHMI and areas where performance was red and amber.

8.3 Quality priorities

Progress on quality priorities for each quarter was presented. The year end position is as described in the quality report.

9. Review of Assurance Committee Effectiveness

The effectiveness of the Assurance Committee measured against the terms of reference was considered in September 2012. Generally the Committee agreed that most aspects of the terms of reference were met but further work needed to be done in ensuring focus on the main priorities (Committee members were asked to identify these – see 7.5) and ensuring that the key issues are identified in a clear way with an assessment of assurance. It was also agreed to review the membership and functioning of the Committee.

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.6/Jul/13
PAPER	Risk Management Annual Report 2012/13 Supplementary paper
AUTHOR	Malin Zettergren, Risk Manager Vivia Richards, Head of Clinical Governance
LEAD	Cathy Mooney, Director of Governance and Corporate Affairs
PURPOSE	• To report risk management activity during the year 2012/13 • To report on the number and type of incidents and risks arising in 2012/13 and the actions taken to manage risks or address incidents • To highlight lessons learned during 2012/13 and changes to practice as a result of incidents being reported • To summarise the risks on the register and examples of mitigation
LINK TO OBJECTIVES	Links to the Trust objectives for safety.
RISK ISSUES	None
FINANCIAL ISSUES	NA
OTHER ISSUES	NA
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This is the full Risk Management Annual Report 2012/13 which supports the summary available to the Board and gives greater details of all issues highlighted in this report. The Trust is committed to the management of risk and this is clearly demonstrated by the commitment demonstrated

	through risk management activities within divisions and the progress that has been made during 2012/13, however there are still areas for improvement. This report outlines a summary of issues identified and trends arising from incidents reported and risks highlighted and reported on the Trust Risk Register. It provides summaries of the number and types of incidents and risks, information on lessons learned and changes to practice in response to these incidents and risks. Good incident reporting and risk management practices can only be achieved through effective communication at all levels within the organisation, which is the lynchpin to the effectiveness of all risk management systems.
DECISION/ ACTION	The Board is asked to note the Risk Management Annual Report 2012/13.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

RISK MANAGEMENT ANNUAL REPORT
2012/13

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Appendix 1: Frequently Asked Questions and Answers relating to Incident Investigations (pages 38-40)

1. INTRODUCTION

This report gives an overview of the work that has continued in the Trust in 2012/13, building on previous achievements, to ensure that the management of risk is firmly established in order to ensure quality, safety and continued improvement of services provided to patients. An in-depth analysis of maternity incidents is not provided, as they are covered in a separate annual report but the numbers are included in this report.

The Trust Board needs to be confident that systems, policies and people they have put in place are operating in a way that is effective, focussed on key risks and are driving the delivery of objectives. This summary report is intended to be part of that process and assist in providing assurance that key risks are being identified, measured and managed.

Throughout the report, where possible comparisons are made with previous years so that trends are highlighted and where possible to identify improvements made in the Trust.

1.1 Key achievements during 2012/13

These include:

- The Trust saw a 42% reduction in the number of falls causing moderate or severe injuries compared to the previous year.
- Improvement in the proportion of incidents on the Datix Risk Management system that were closed during this time period – in 2011/12 65% of incidents were closed within 45 days, compared to 2012/13 where 71% were closed within 45 days. Monthly specialty specific reports now include information on the number of incidents of any grade that were closed within 45 days to raise further awareness of the need to improve this target.
- Increased consultant engagement and involvement in incident reviews leading to a more multi-disciplinary approach.
- Establishment of expert standing incident review panels for falls and pressure ulcers in Medicine & Surgery where the vast majority of these incidents occur. These multi-disciplinary panels meet on a bi-monthly basis to review all falls resulting in fractures or other serious injuries and all hospital acquired grade 3 or 4 pressure ulcers respectively. Scheduled standing panels have also now been adopted within Maternity, and are now being established within other areas of the Women's, Neonatal, Paediatric and Young People, HIV/GUM and Dermatology Division. The benefit of these panels has been a consistent approach in how these incidents are reviewed, development of investigative expertise by the panel members, and continuity in terms of the follow-up and implementation of actions.
- Agreement of a Joint Operational Policy for Mental Health Service Provision with the Central and North West London NHS Foundation Trust. This follows a joint review into a red graded incident where it was recommended that a contractual agreement be reached and implemented defining the roles and responsibilities of the psychiatric liaison team and the admitting medical team at C&W.
- The House of Commons presented the Trust with the national Lifeblood VTE award 2012 for 'Best Obstetrics VTE Prevention Programme' recognising exemplary leadership, dedication and improving patient safety for innovative initiatives to help reduce VTE events in pregnant women. The Trust team was selected to present their collaborative work on a multidisciplinary approach to VTE prevention in hospital patients at the International Forum on Quality and Safety in Healthcare 2013.
- 47/47 root cause analyses were performed for hospital associated VTEs. Last year we set an objective to continue to ensure that we meet our target of 90% adult patients admitted with completed VTE risk assessments. Our weekly and monthly monitoring of completed VTE risk assessments showed that we achieved this target.
- One of the recurring themes arising from serious incidents over the past few years has related to emergency admissions and ensuring that there is appropriate senior leadership, explicit decisions made which must be clearly documented soon after the decision to admit. In view of these imperatives, we met our target of 75% of emergency general medical and surgical patients to be seen by a consultant within 12 hours of the decision to admit to hospital or within 14 hours of their arrival at the hospital.

1.2 Training

Throughout the year, we have continued to develop systems, roll out training, undertake both internal and external reviews and ensure that all members of staff are encouraged to take the opportunity to ensure that we learn from adverse events when they occur. In taking this ethos forward within the year we have:

Provided training in risk assessment and incident management via:

- Staff induction events such as the Corporate Induction where Risk Management forms part of the mandatory training agenda.
- Staff annual refresher updates.
- Department and individual specific training events, including use of the Clinical Governance Half Day meetings for mandatory training, infection control updates and CEWS, and later NEWS, related training sessions.
- Individual 1:1 training for nominated Lead Investigators at the outset of an incident investigation.
- 100% of the senior managers who joined to organisation in 2012/13 received Risk Awareness Training for Senior Managers provided by the Head of Clinical Governance.

1.3 Risk Management Strategy and Policy

The Risk Management Strategy and Policy supports the Trust vision and sets out the Trust's approach to the management of risk and implementation of ongoing processes, which systematically identify, measure and enable the management of risk. It also clearly defines the roles and responsibilities of key managers and committees and sets out the specific responsibilities of the directors and other individuals for the effective management of risk.

The Risk Management Strategy is reviewed on an annual basis with the next review due in Q1 2013/14.

1.4 Progress on Objectives from the Risk Management Strategy

1. To achieve level 3 NHSLA general risk management standards by Q3 2012/13.
   Progress: Level 3 NHSLA assessment abandoned in December 2012, scheduled to take place in October 2013.

2. To achieve level 3 CNST (maternity) in February 2013.
   Progress: Level 3 CNST assessment abandoned. A further assessment has been scheduled for July 2013.

3. To implement on line incident and risk reporting and a supporting risk management system (to include incidents, claims, risks, COSHH assessment and complaints/M-PALS) by March 2013.
   Progress: This was not in place within the timeframe set out in the strategy due to the demands of the NSHLA risk management standards assessment.

4. To increase the rate of patient safety incident reporting to 8 incidents per 100 admissions by March 2013 (currently 6.6 per 100 admissions based on NRLS data April to September 2011). This will place us in the top 25% of reporters amongst 27 acute teaching organisations.
   Progress: The Trust is not meeting this target but plan that this will be achieved once online reporting is implemented.

5. To continue the focus on mechanisms of assurance in relation to actions implemented from incidents, risks and external requirements, building on the work completed in 2011/12.
   Progress: This work is still underway although progress has been made, for example in relation to the extended Never Events lists with assurance reports having been completed by nominated leads and presented to the Trust Executive Quality Committee. Reviews of incidents, risks, claims and complaints are completed at both local and Trust level such as the Complaints, Claims and Incidents Group, Divisional Boards, Risk Management Committee and local Clinical Effectiveness and Governance meetings.

6. To implement additional actions from the CQC visit relating to outcome 16: in relation to incident reporting
    - A regular 'batching' section within the Trust-wide Risk Management Quarterly and annual reports will be introduced from Q1 onwards in order that this issue is routinely monitored via the Risk Management Committee, and issues or concerns formally escalated to the Trust Executive Quality Committee as required.
      Progress: Complete.
    - A communication will be sent to all ward and department leads by May 12 setting out expectations with respect to timely submission and effective managerial follow-up for reported incidents. This communication will also set out how these will be monitored. Inconsistent local/departmental approaches to reporting, taking action and providing feedback for less serious incidents will be referenced within the communication outlined above.
      Progress: Complete.
    - The process of local feedback and monitoring of less serious incidents will be reviewed by July 12
      Progress: Complete.
    - Quarterly risk news 'one-liner' reports will be extended by July 12, providing a brief summary for all staff. Staff will be sign-posted to these through the daily notice board, Trust news and other communication mechanisms.
      Progress: More of these have been done but their role in relation to the quality campaign theme of the week needs to be reviewed.
    - To review processes for risks to be identified and managed, including local risks as well as high level organisational, strategic and clinical risks – by October 2012.
      Progress: Many processes for identification and management of risks have been audited and the results will be used to update existing policies and re-audit will be built into the Risk Management Committee schedule.
    - To identify and then monitor appropriate timescales for investigating incidents, including panel meetings and completion of reports in order to meet national targets – by Sept 2012.
      Progress: Complete.

2. CLINICAL NEGLIGENCE SCHEME FOR TRUST RISK MANAGEMENT STANDARDS

The Clinical Negligence Scheme has made a significant contribution to putting risk management high on the organisation's agenda. It improves the safety of patient care, as well as engaging clinicians and managers in improving quality. The Trust is currently accredited at Level 2 for both Maternity services and Trust-wide general services.

The Levels are set out as follows:

- Level 1 - Policy (approved policies in place)
- Level 2 - Practice (demonstrated implementation of the approved policies)
- Level 3 - Monitoring (systems to monitor policy implementation and where deficiencies are identified, evidence that recommendations have been developed and changes implemented).

The CNST Standards consolidate best practice from a number of sources and translate this into practical guidelines which cover:

1. Governance
2. Learning From Experience
3. Competent & Capable Workforce
4. Safe Environment
5. Acute Providers

During 2012/13, staff continued to work toward embedding and sustaining many of the systems previously introduced, but unfortunately the attempt to achieve Level 3 in December 2012 had to be abandoned due to lack of evidence showing that the practice in place on the wards is in accordance with Trust policy. Another assessment has been booked in to take place in October 2013 and work is underway to prepare for this. The work will further embed risk management throughout the organisation and further enhance the Trust's reputation. This work involves monitoring documented processes in relation to the standards, and where monitoring has identified shortfalls, implementing changes to address them.

3. RISK REGISTER

3.1 Risks Contained On the Risk Register in 2012/13

At the end of March 2013, there were a total of **218 open** risks on the Trust wide register, representing a 14% increase on 2011/12. 70 out of the total 218 risks relate to corporate objectives identified in the development of the Assurance Framework over the years and through papers provided to the Board. Assurance Framework risks relating to the current years' objectives are reported directly to the Trust Board by the Director of Governance and Corporate Affairs.

Of the open risks on the register, **32** out of the remaining 148 non Assurance Framework risks were graded **orange**, and **1** was graded **red**.

Risks are categorised by 'risk type', indicating the type of consequence that an identified risk may have. The open risks on the register at the end of March 2013 were categorised by type as follows:

Chart 3.1: Open risks on the register by risk type and source

	Clinical	Financial	H&S	IT	Performance	Total
Assurance framework	15	21	5	0	29	**70**
Comprehensive risk review	2	0	1	0	0	**3**
Incident	3	1	5	1	2	**12**
Risk Assessment	57	4	59	7	6	**133**
Totals:	**77**	**26**	**70**	**8**	**37**	**218**

Risks are routinely categorised by the source of the risk, i.e. risk assessment, incident, assurance framework for example. Assurance Framework risks are those identified through the development of the Assurance Framework and relate to the Trusts corporate objectives.

In 2012/13 a total of **91** new risks were opened on the register (compared to 169 the previous year) with **11** being closed during the same time period. **23** of the new risks related to the Assurance Framework.

45 out of the **91** new risks were graded orange and **1** was graded red. This red risk related to the 'Shaping a Healthier Future' consultation, which may have led to the closure of our emergency department had we been unsuccessful.

Chart 3.2: New Risks 2012/13

Directorate	VLOW	LOW	MOD	HIGH	TOTAL
Anaesthetics and Imaging Directorate	0	4	3	0	7
Clinical Support Services	6	1	3	0	10
Non Clinical Support Services	0	0	2	0	2
HIV GUM Directorate	1	3	2	0	6
Whole Hospital	1	4	2	1	8
Medical Directorate	1	1	3	0	5
Surgical Directorate	0	1	2	0	3
Women and Children Directorate	0	11	10	0	21
Governance & Corporate Affairs	0	1	1	0	2
TOTAL	9	26	29	1	65*

*26 of the new risks in 2012/13 were not assigned to a specific directorate, the majority of these were Assurance Framework risks.

Chart 3.3: Closed Risks 2012/13

Directorate	VLOW	LOW	MOD	HIGH	TOTAL
Anaesthetics and Imaging Directorate	0	0	1	0	7
Clinical Support Services	0	0	0	0	0
Governance and Corporate Affairs	1	0	0	0	1
HIV GUM Directorate	1	1	0	0	2
Whole Hospital	1	7	2	0	10
Medical Directorate	1	2	0	0	3
Non Clinical Support Services	0	1	0	0	1
Nursing Directorate	0	0	0	0	0
Surgical Directorate	0	3	1	0	4
Women and Children Directorate	7	2	2	0	11
TOTAL	11	17	6	0	34

Chart 3.4: Risks remaining on the register for more than 1 year as at 31st March 2013

Directorate	VLOW	LOW	MOD	HIGH	TOTAL
Anaesthetics and Imaging Directorate	8	1	0	0	9
Clinical Support Services	8	4	0	0	12
Imperial College Healthcare Trust	0	1	0	0	1
HIV GUM Directorate	5	8	0	0	13
Whole Hospital	6	43	11	0	60
Medical Directorate	0	5	6	0	11
Non Clinical Support Services	0	3	4	0	7
Surgical Directorate	0	5	1	0	6
Women and Children Directorate	2	12	2	0	16
TOTAL	29	82	24	0	135

3.2 Actions Taken to Mitigate Risks on the Register

During 2012/13 a total of 66 risk assessments were downgraded. A number of action plans relating to risk assessments have been completed in 2012/13, including:

- **Trust wide falls risk assessment:** The Slips, Trips and Falls Group have been pro-active in reviewing current documentation, including the policy, updating the falls risk assessment and continuing to promote the yellow falls prevention aids (such as slippers and daily assessment charts). This year, a bespoke root cause analysis (RCA) tool for falls related incident investigations was developed. An improvement was seen in 2012/13 in not only the total number of falls but also the number of falls causing moderate or severe injury.

- **Adastra IT System in the Urgent Care Centre:** Due to changes to the agreement with the license holder of the Adastra IT system, access and non-compatibility with LastWord is no longer an issue and the risk was closed in 2012/13.

- **Medical Devices Procurement Process:** The Business Case forms were amended to incorporate: signature sign-off of proposals by Clinical Engineering and Clinical Skills Departments and a standard proforma/PQQ of device information required prior to approval in order to streamline the process and avoid the situation of devices being brought into the Trust without the knowledge or input of the Clinical Engineering Team.

- **NICU infection control and capacity:** Number of cots reduced by 4 special care cots in October 2012 - leading to more surrounding space between cots. Whilst the clinical risks are mitigated, this action impacted heavily on capacity with financial losses incurred. In addition Norlands are to take out a shower and toilet from the nursery called HDU3 to remove risk of standing water and provide additional storage.

- **Paediatric mental health provision:** The Mental Health Admission guideline was updated and ratified to support management of these patients. The Directorate Nurse also met and discussed the issue with a representative from CNWL.

- **Sexual Health Strategy (AF 12/13)**: The Trust has involvement in strategic change programmes regionally and the commissioning process for 2013 was clarified which led to the potential risk being considered reduced. The service mix has been updated in response to updated commissioning arrangements.

- **Wrong route administration of intralesional vinblastine**: Due to adequate safeguards, such as the Intrathecal Cytotoxic Chemotherapy Policy which exercises robust and tight controls on the safe prescribing, preparation, collection and administration of intrathecal chemotherapy and restricts involvement with intrathecal chemotherapy to trained and accredited staff members who are on a Trust Intrathecal Register, being in place the risk assessment was downgraded from orange to yellow.

4. INCIDENT REPORTING

When things go wrong, or are narrowly avoided, we need to find out why it happened so that we can take steps to avoid a recurrence and make Chelsea and Westminster an even safer environment for patients and staff.

But we can only do that if we know about the things that might cause problems. That's why staff are constantly encouraged to report all mistakes (incidents) promptly, however trivial they may seem. It's just as important to know about the things that nearly happened as those that did, therefore we encourage the reporting of 'near misses' as well as 'actual' incidents.

The evidence shows that teams, departments, and organisations that report more safety incidents are more willing to learn from their mistakes and to promote a culture where patient and staff safety is a high priority. A reporting culture indicates an open and healthy culture.

The number of patients treated at the hospital varies from day to day, so rather than simply measuring the number of incidents reported, we compare this figure with the proportion of patients treated to arrive at the incident reporting rate. This is a measure of the rates of patient safety incidents per 100 admissions at the hospital.

Experience in other industries shows that as an organisation's reporting culture becomes established, staff become more likely to report incidents. But we know that not all incidents are reported, particularly those regarded as trivial. So we constantly remind staff about the importance of flagging up anything that could or did go wrong, and encourage them to tell us about it. It is second nature for staff to report incidents (including those that led to no harm or were prevented) as they have confidence in the investigation process and understand the value of reporting and learning from incidents.

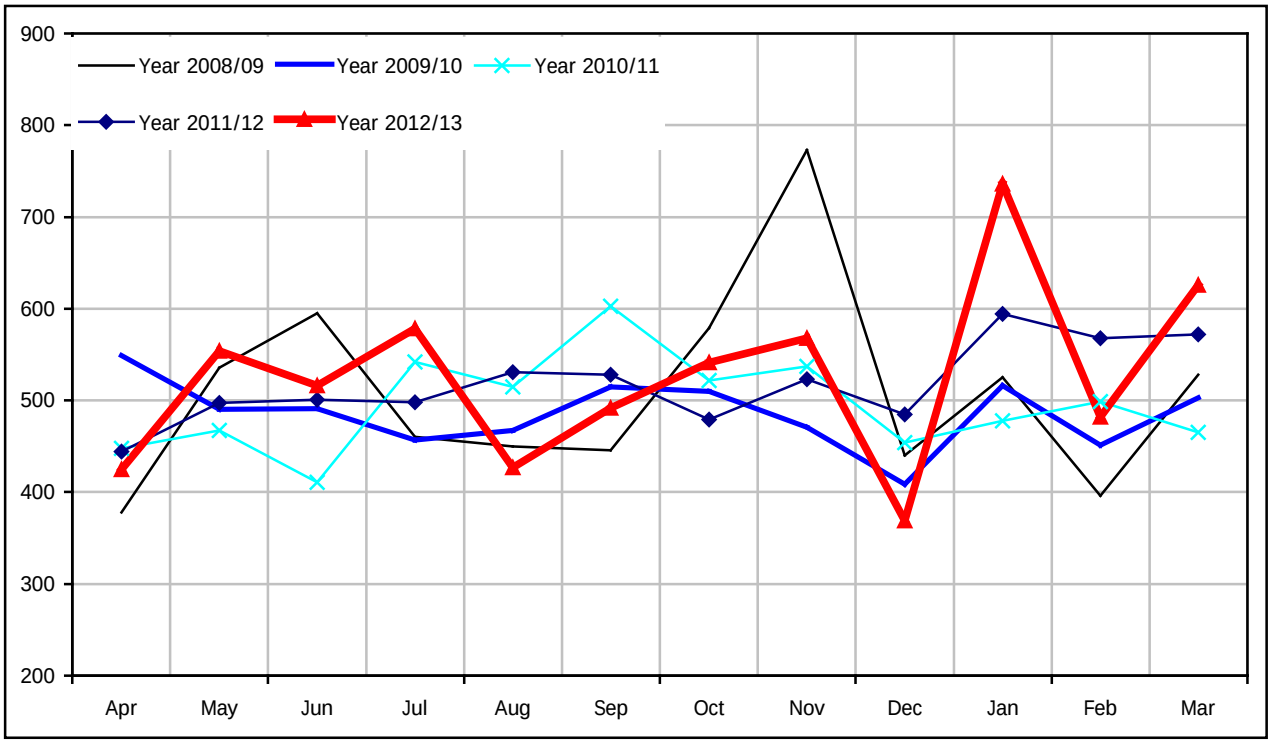
We make great efforts to ensure that information relating to incidents reported are accessible, making sure that staff see how their incident reports are being used to improve patients' safety, and that patients and staff involved in incidents are treated fairly.

Accidents, near misses and incidents must be formally reported through the Trust's Incident Reporting System. Incidents are reviewed and graded by the relevant Risk Lead or department manager, Service Director, Clinical Director or relevant Divisional Director. The Chief Executive is notified of any serious (orange or red) incident. Where indicated, for example when orange or red incidents occur, an investigation is held in order to determine the facts and details surrounding the incident and to identify actions to improve care.

4.1 Total Number of Incidents Reported 2012/13

A total of **6,314** incidents were reported during the 12-month period 1st April 2012 to 31st March 2013. This compares with a total of **6,220** incidents in the previous year (2011/12), representing a **1.5% increase**.

Chart 4.1: Reported incidents: Monthly breakdown incidents Apr 2008 - Mar 2013



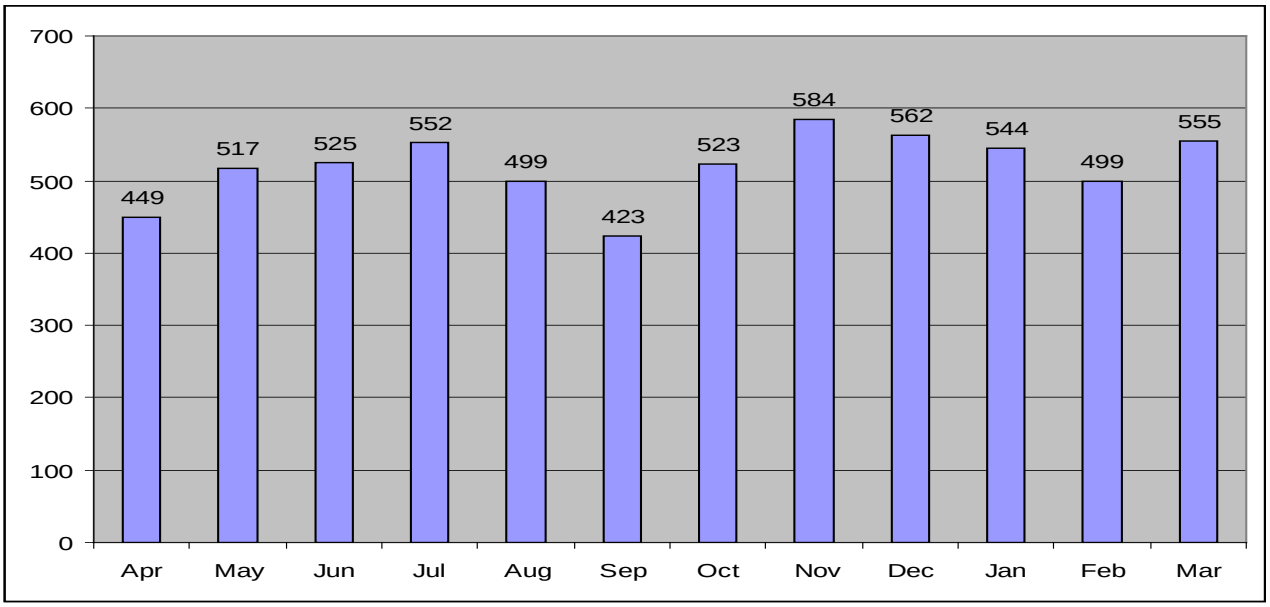
The above graph shows the total number of incidents received by the Risk Management Department by month and illustrates occasions where there has been a noticeable delay in incident forms being submitted, such as in November 2008/009 and January 2012/13. See section 4.3 on page 13 for more information relating to batching.

Chart 4.2: Reported Incidents: Number of incidents per month, Apr 2008 – Mar 2013

Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2008/09	378	535	595	460	450	446	579	773	439	525	396	528	6104
2009/10	549	490	491	457	467	515	510	471	409	516	451	503	5829
2010/11	448	467	411	542	515	603	522	537	454	478	499	465	5941
2011/12	444	497	501	498	531	528	479	523	485	594	568	572	6220
2012/13	460	521	531	560	505	426	530	597	569	555	504	556	6314

The graph and table above compare the total number of incidents reported each month during 2012/13 with the 4 previous financial years.

Chart 4.3: Incidents in 2012/13 by actual incident ate

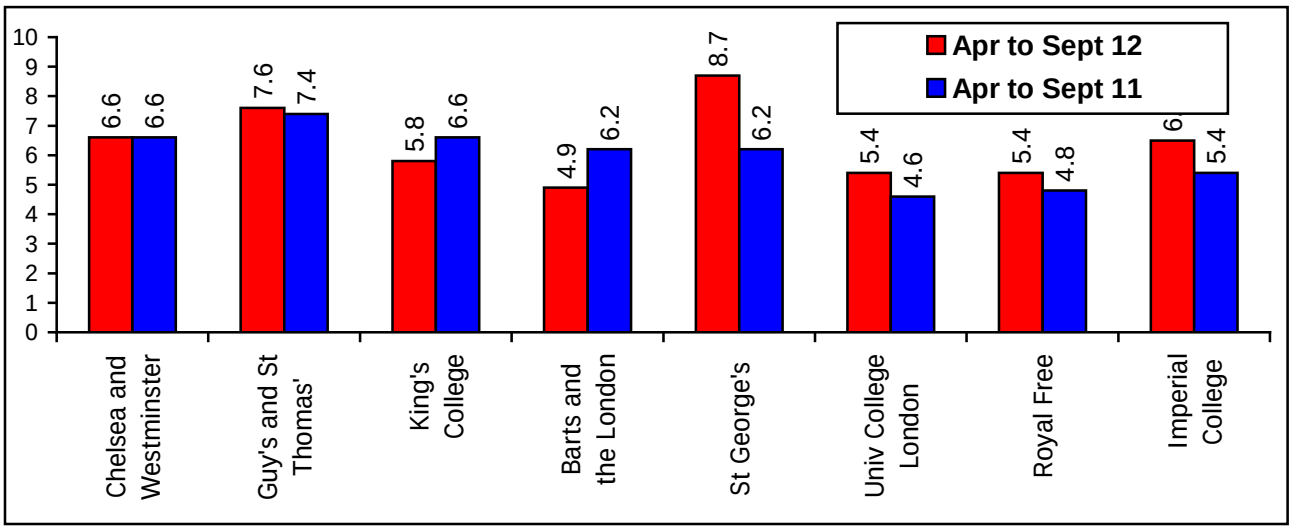


The above graph shows the number of incidents in 2012/13 by the month they actually occurred. This supports graph 4.1 in evidencing the delay in submitting forms as the number of incidents occurring has remained fairly stable throughout the year. The data in the annual report is displayed by opened date as this is the most accurate way to ensure all incidents are included in the report as batching may delay receipt of the forms.

4.2 Comparison with our Peers – Patient Safety Incidents

A high reporting rate indicates a strong reporting and learning culture. Experience from other industries shows that as an organisation's reporting culture matures, staff become more likely to report incidents. The graph below shows the reporting rate per 100 admissions, comparing the Chelsea and Westminster Hospital with other Acute Teaching Trusts in the London Strategic Health Authority, based on incidents occurring between April - September 2010, and also April - September 2011. The reporting rate per 100 admissions at the Chelsea and Westminster Hospital was 6.6 in 2011/12, compared with an average of 6.5 reporting rate at similar Trusts. The data used for this comparison was extrapolated from the NPSA website.

Chart 4.4: Reporting rate per 100 admissions: Comparing Acute Teaching Trusts in NHS London



It is most often the case that those organisations which report more have a stronger learning culture where patient safety is a high priority – so resulting in better and more established reporting amongst all staff. The

substantial increase in reporting seen at St George's is largely due to the recent introduction of an online reporting system.

Nationally – in 2012/13 - 67% of incidents were reported as no harm, and 1% as severe harm or death. However, not all organisations apply the national coding of degree of harm in a consistent way, which contributes to variations in the harm profile of each organisation. Therefore, deaths are often reported as incidents, even though it may relate to a natural course of events/the patient's illness or underlying condition.

Organisations are advised to record the actual harm to patients rather than potential degree of harm. **86%** of all incidents reported by the Trust were **no harm** incidents, well above the national average.

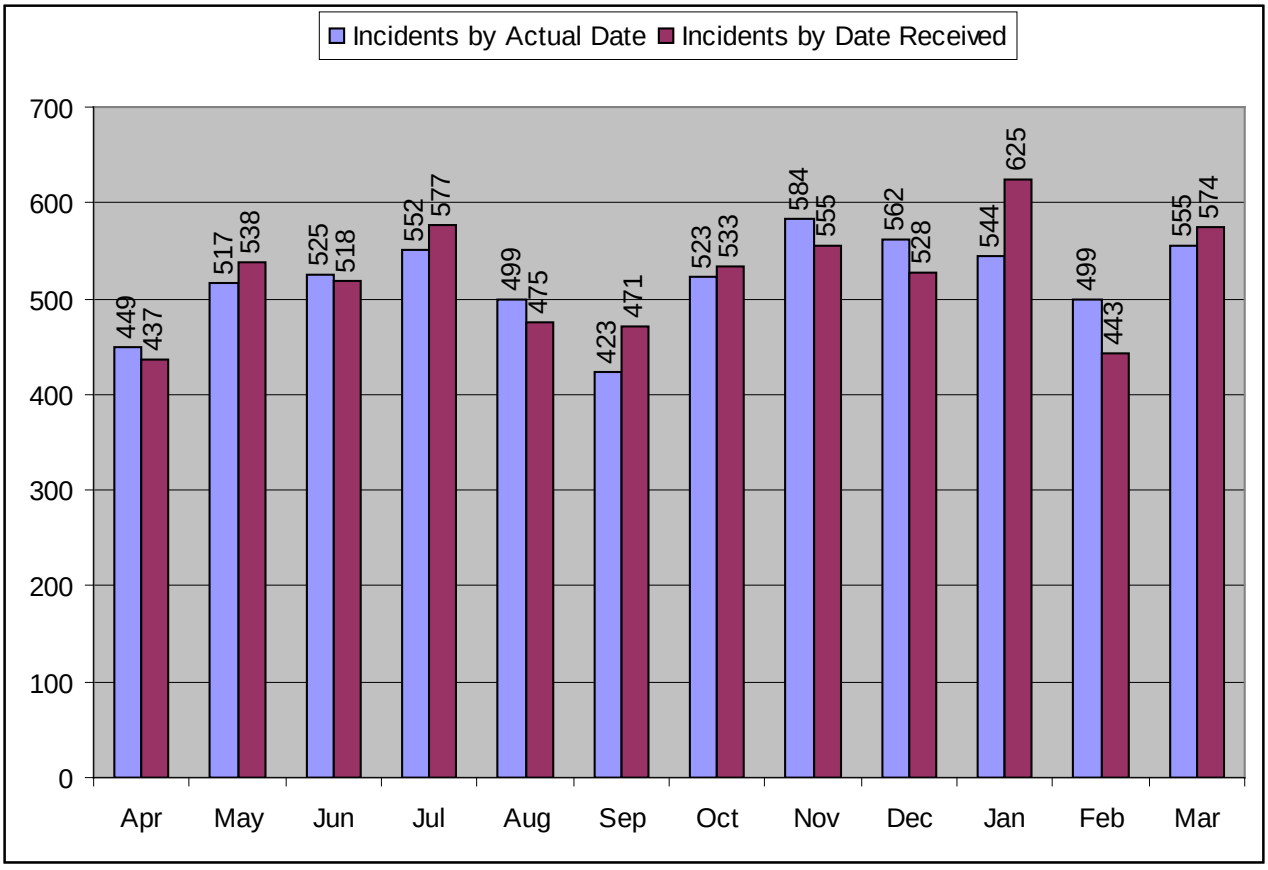
The source of the above comparative information is the National Patient Safety Agency (NPSA). On Friday 1 June 2012 the key functions and expertise for patient safety developed by the NPSA transferred to the NHS Commissioning Board Special Health Authority.

The information within the remainder of this incident reporting section will focus predominantly on the comparisons between 2011/12 and 2012/13.

4.3 Batching Incident Forms 2012/13

The graph below compares incidents according to the month entered onto the system and the month the incident occurred over the previous twelve months. The graph below shows a comparison between the date that the incident actually occurs and the date that incidents were received by the Risk Management Department during 2012/13.

Chart 4.5 Number of incidents by the date received compared to actual incident date



The above chart illustrates that during 2012/13 there was an improvement in batching, albeit small, and that departments are submitting their incident forms closer to the date that the incident took place. Actions taken to address the issue of batching, such as incident form amnesties in Medicine & Surgery, Maternity and Paediatrics have largely been effective.

In order to reliably compare month on month statistics, incidents are reported according to the date that they are reported and received by the Risk Management office, rather than the date that the incident occurs. This takes into account the frequent bottlenecks within reporting areas, and ensures that statistics reported to the range of committees, and also weekly, monthly and quarterly report data is not subject to frequent conflicting information as a result of late batches of submitted forms.

Delays in forwarding incident forms account for the discrepancies shown above. This issue has in the past been brought to the attention of the relevant departments such as Pharmacy, Maternity and Pathology, and is escalated to the relevant department managers or risk leads as required.

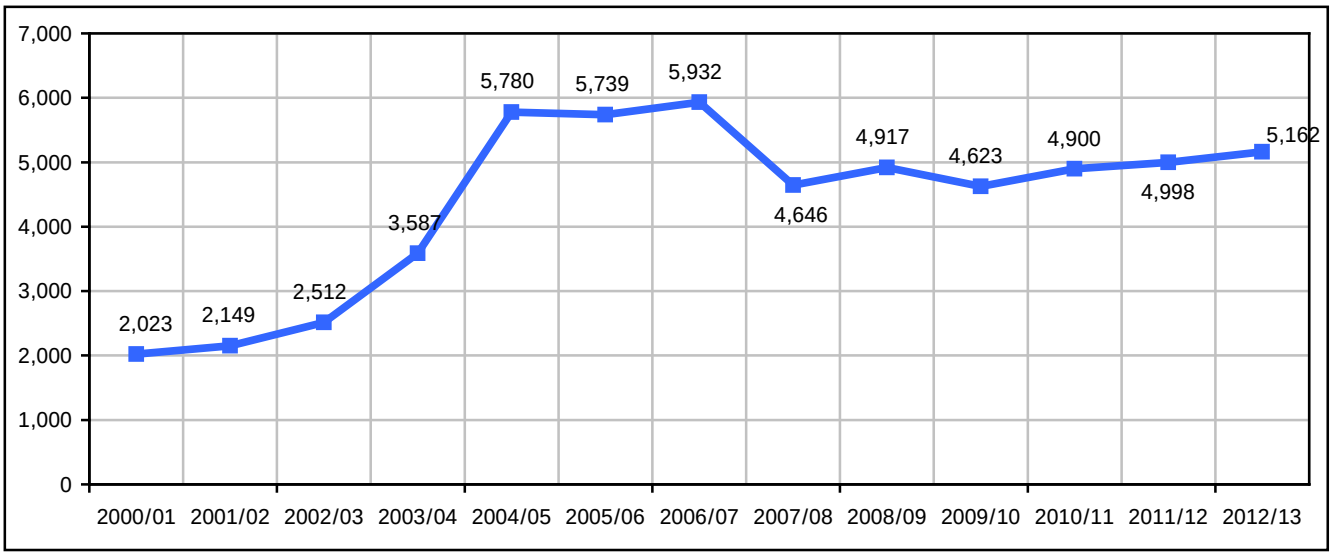
Prompt reporting of incidents is important for:

- Ensuring appropriate management to reduce identified risks
- Documenting the incident and the circumstances, in case of later complaint or claim
- Providing accurate monitoring, so that collective data analysis can inform measures to improve patient and staff safety, and reduce the risk of further exposures.

4.4 Incident Types Reported 2012/13

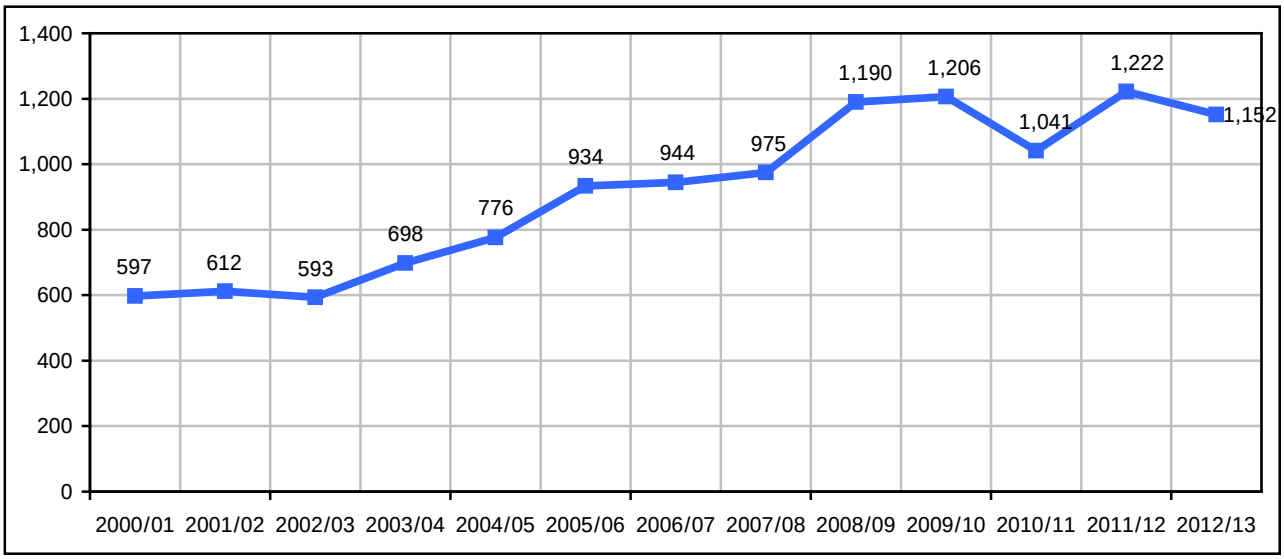
Of the 6,314 incidents reported in 2012/13, 5,162 related to patient safety incidents (clinical incidents), and 1,152 related to non-clinical (Health & Safety) incidents. The number of reported patient safety incidents is outlined in chart 5.6 and the number of reported non-patient/staff related incidents is outlined in chart 5.7.

Chart 4.6: Number of reported patient safety incidents reported over 13 years: Apr 2000 - Mar 2013



The variations in the graph above can be attributed to the reporting of blood incidents as 2003/04 only 211 such incidents were reported (6% of the total number) compared to 1078 the following year (19%). This upwards trend continued until 2007/08 when there was a sudden drop in blood related incidents with only 475 reported (10%).

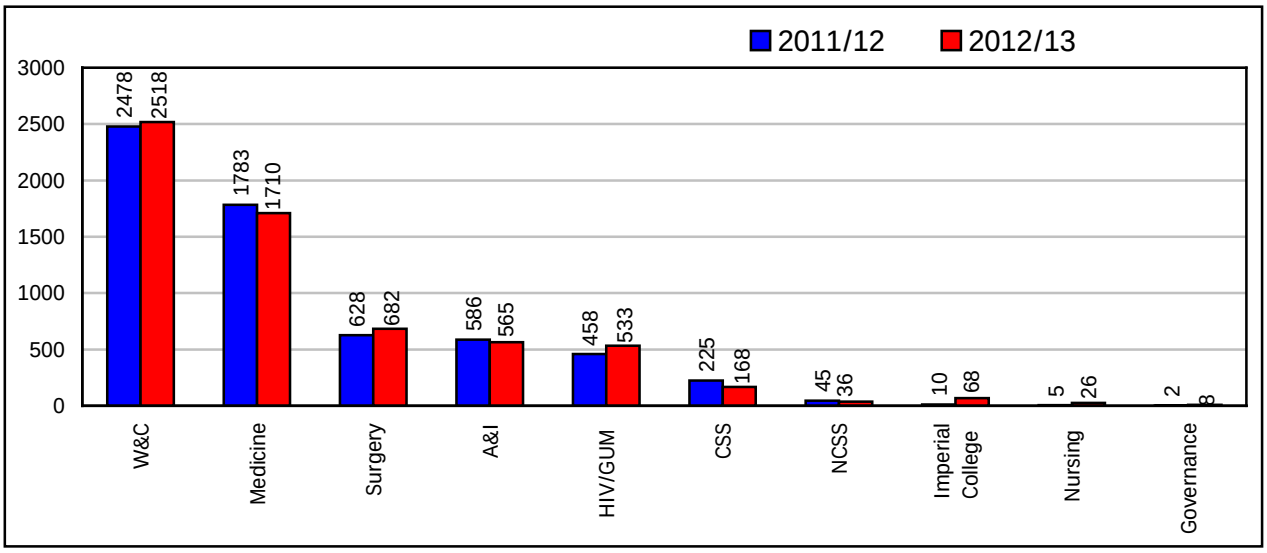
Chart 4.7 Number of reported staff-related non-clinical incidents reported over 13 years: Apr 2000 - Mar 2013



2012/13 saw a decrease of 6% in the number of reported non clinical incidents and a 3% increase in patient safety incidents. **This represents an increase of 1.5% in the total number of incidents reported (both clinical and non-clinical).**

The number of incidents received for each directorate is shown in Graph 4.8.

Chart 4.8: Incidents Reported by Directorate, 2011/12 vs. 2012/13 (Clinical and non-clinical)

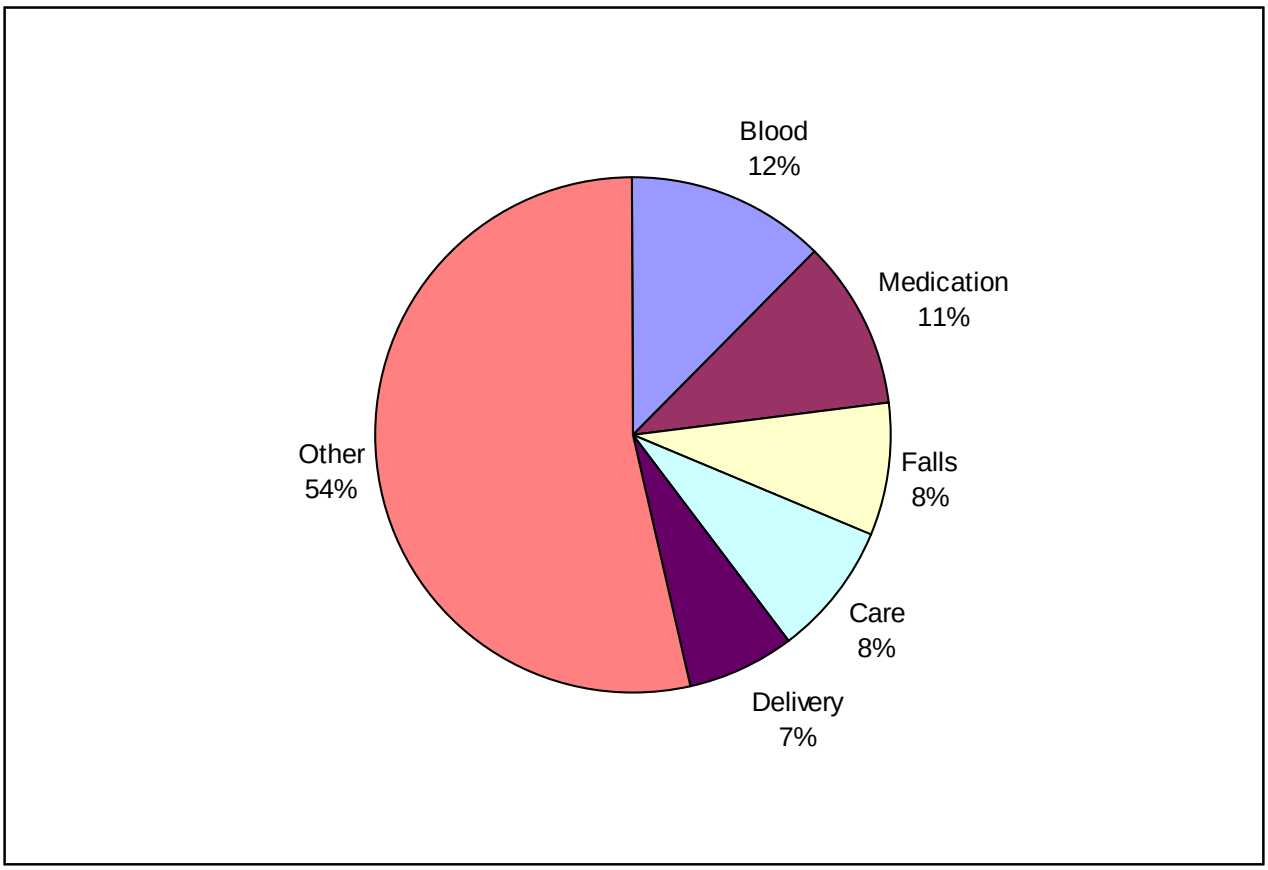


There are occasions where incidents reported by one division/directorate/department may require action by another; the risk managers employ judgement about which directorate reports and takes action on the incident. Actions taken by other divisions/directorates/departments are fed back to the reporting division or directorate.

4.5 Top 5 Incident Types Reported

The trends in incident types reported remain unchanged in 2012/13, and are similar to trends reported during the previous year, the only difference being delivery/birth related incident replacing documentation in 5th place. Documentation related incident saw a 1% decrease in reporting compared to 2011/12, down from 382 to 326 incidents. Birth/delivery incidents saw a 14% increase during the same period.
During 2012/13, the top five incident types were as follows:

Chart 4.9: Top 5 incident types reported, 2012/13



The top 5 are as follows as illustrated above:

1 **Blood/blood related incidents** – 782, a **decrease** of 12% from 888 in 2011/12

2 **Medication** – 766, an **increase** of 3% from 743 in the previous year

3 **Falls** – 533, a **decrease** of 0.5% from 562 in 2011/12

4 **Care** – 522, an **increase** of 0.5% from 493 in 2011/12

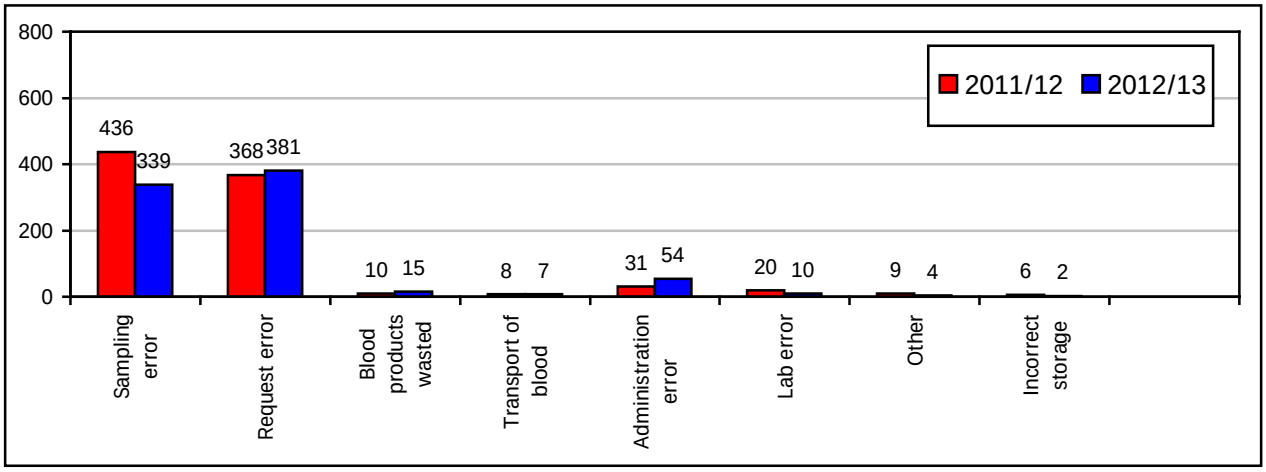
5 **Delivery** – 429, an **increase** of 14% from 377 in 2011/12 – mainly due to a 42% increase in PPH >1000mls (see page 24 for further details).

Included in the 'other' incidents are all other incident reporting categories not already featured in the top 5, such as 385 pressure ulcers (both community and hospital acquired), 354 documentation incidents, 253 treatment related events, 242 equipment incidents, 233 staff related incidents, 200 related to patient transfers and 153 incidents related to pathology matters.

1. Blood Incidents

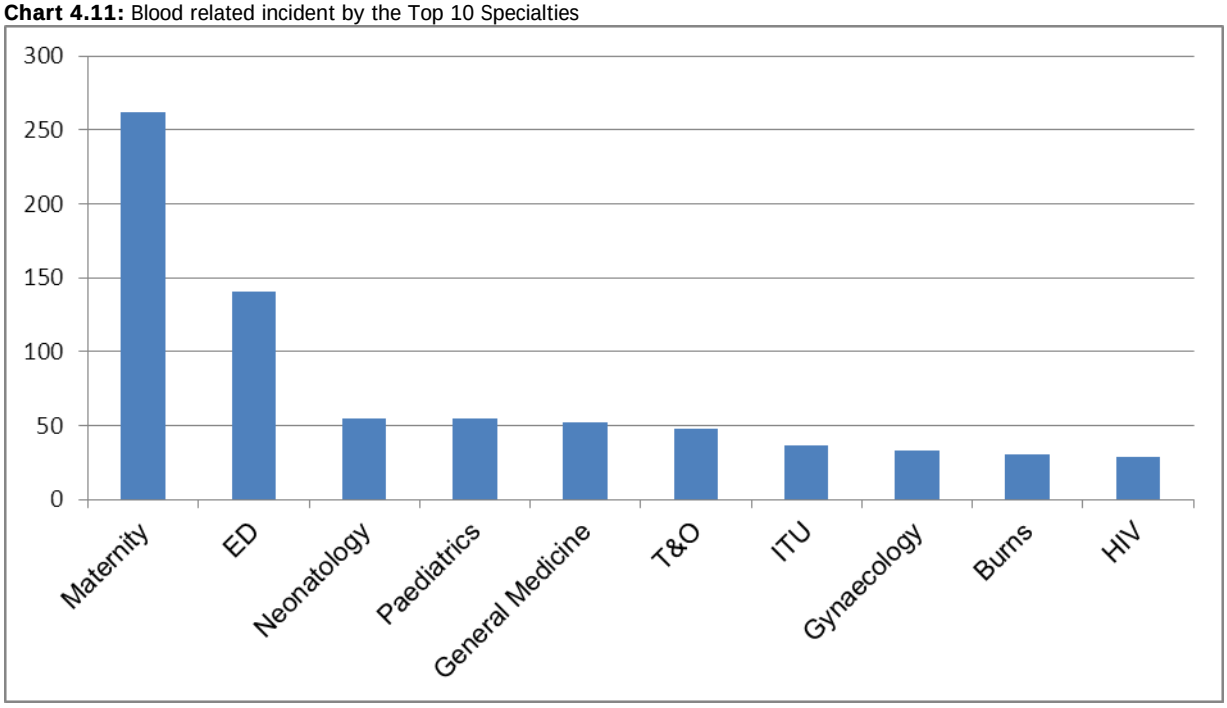
There were 782 blood related incidents reported during 2012/13, a decrease of 12% compared to the number reported in 2011/12 (n=888).

Chart 4.10: Blood related incident categories, 2012/13 compared with sub-categories in previous year



The graph above illustrates that most incidents relate to sampling errors, bottles and tubes being incorrectly labelled which means patients have to be re-bled.

Chart 4.11: Blood related incident by the Top 10 Specialties



33% of the blood related incidents were reported by Maternity and 18% by the Emergency Department. The majority of the Maternity incidents were reported by the Antenatal Clinic, relating to insufficient clinical details on the request form, and to address the issue the Clinic Manager attends the Hospital Blood Transfusion Committee meeting and feeds back to the staff in their area. In the ED the most commonly occurring incident in relation to bloods is also insufficient clinical detail on the request forms and feedback is provided to individual staff members involved in these errors. An ED Consultant also regularly attends the Hospital Blood Transfusion Committee.

The trigger for reporting blood related incidents was changed during 2007/08 in order to better target problem areas. Blood related incidents that lead to a patient being re-bled, blood being discarded, and sampling errors (i.e. incidents where the wrong patient details were recorded on the specimen tube), are

reported as individual incidents. Issues that are resolved by laboratory staff, such as minor labelling mismatches, are not reported as an individual incident.

Other incident types that are reported are predetermined by the National Blood Transfusion Committee. These incident types are commonly known as Serious Hazards of Transfusion (SHOT) or Serious Adverse Blood Reactions & Events (SABRE) categories. These incidents relate to tests required for safe blood or blood component transfusions, not routine blood tests (e.g. biochemistry).

2. Medication

There were 766 medication incidents reported during 2012/13, an increase of 3% compared to the number reported in 2011/12 (n=743).

Chart 4.12: Top 5 medication-related incident types during 2012/13, including % change since 2011/12

	N° OF INCIDENTS 2012/13	N° OF INCIDENTS 2011/12	% CHANGE
Medication /premedication not given	64	60	+7%
Controlled Drugs Discrepancy	54	44	+23%
Wrong dose given to patient	54	50	+8%
Medication other	53	73	-27%
Administration of medication delayed	46	46	+/-0%

All medication incidents are reviewed monthly by the Lead Directorate Pharmacists (LDPs) in order that they can provide timely support to ward staff and help to change systems and processes where this would reduce the risk of recurrence. The LDPs are responsible for following up relevant incidents within their directorate and liaise with their ward nurses and or doctors as appropriate. Every quarter a Pharmacist Summary of Medication Incidents is produced to ensure that there is a centralised analysis of trends and actions taken as a result of medications incidents are followed up until point of completion. The report is used to inform agenda items referred for addressing via the Senior Nurse and Midwifery Committee (SNMC). Medication Safety initiatives are a standing item on the SNMC agenda and discussed monthly. Any actions specific to clinicians are discussed directly with the appropriate lead clinician. The Pharmacist Summary of Medication Incidents report and subsequent discussions and/or actions taken as a result of medication incidents are reflected within the Trust Quarterly/Annual Risk Management Reports for shared learning Trustwide.

3. Falls

Falls were the third highest Trust-wide reported incident type during 2012/13. 533 falls were reported during this period, of which 489 were patient safety related (compared to 517 in 2011/12) and 44 were non-clinical (staff/members of public), compared to 45 the previous year.

Although the vast majority of falls incidents result in minor injuries or no harm even these can reduce patients' confidence, lead to delays in discharge and the loss of independent living. Nationally, it is estimated that over 500 people suffer hip fractures each year following a fall in hospital, with potentially devastating consequences for their long-term health.

The reasons why patients fall are complex and influenced by contributing factors such as physical illness, mental health, medication and age, as well as environmental factors.

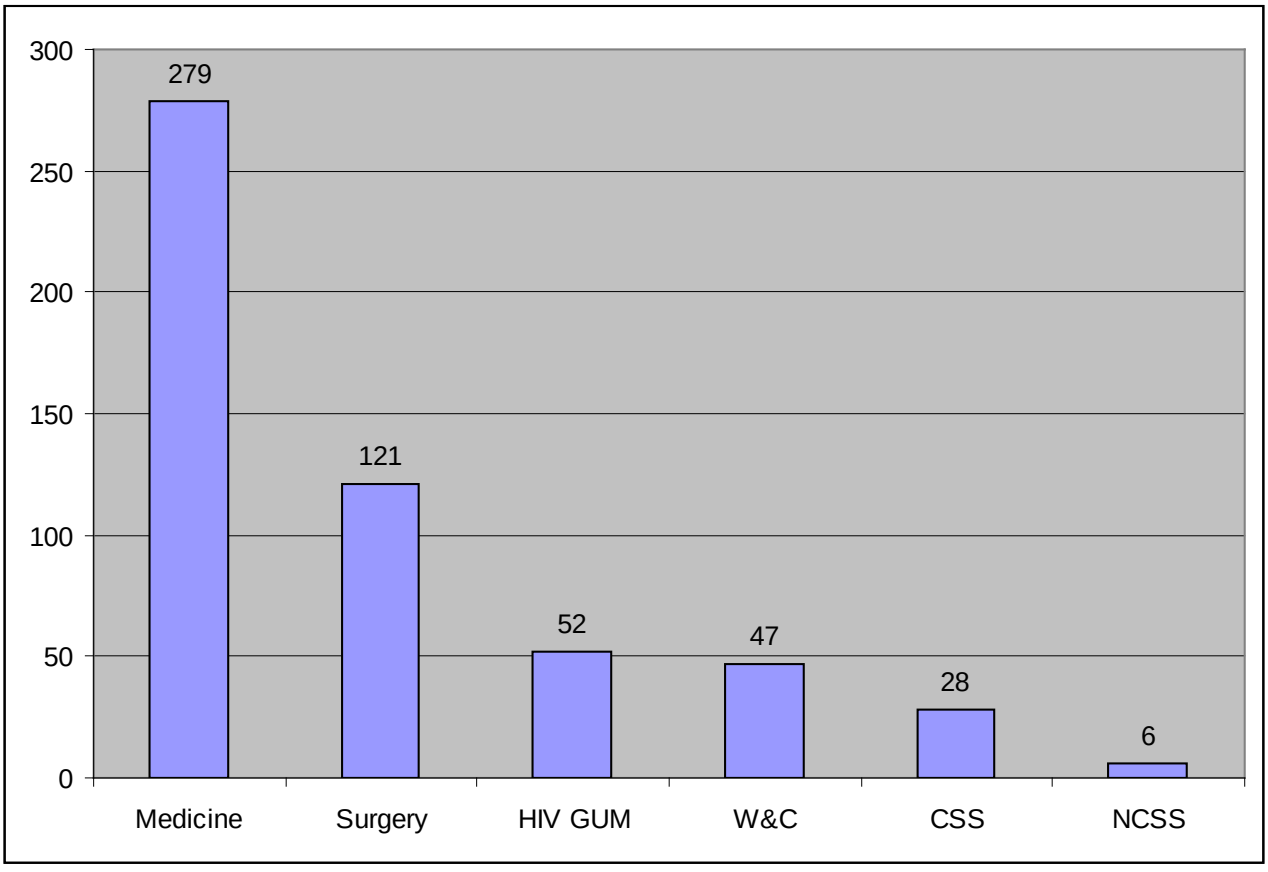
A fall can be the result of a single factor, such as tripping or fainting, affecting an otherwise fit and healthy person. However, most falls, particularly in older people, are the result of several interacting factors. The factors that appear to be most significant in hospital patients are:

- Walking unsteadily
- Being confused
- Being incontinent or needing to use the toilet frequently
- Having fallen before
- Taking sedatives

Preventing patients from falling is a particular challenge in hospital settings. Patients' safety has to be balanced against their right to make their own decisions about the risks they are prepared to take, their dignity and their privacy.

A ward where no patient ever falls is likely to be a ward where patients are unable to regain their independence and return home. Efforts to reduce falls and injuries involve a wide range of staff and, in particular, those working in nursing, medical, therapy, pharmacy, management and facilities services.

Chart 4.13: Falls, both clinical and non-clinical, by Directorate, 2012/13



Overall there was a 0.5% decrease in the number of falls reported in 2012/13 compared to 2011/12. In 2011/12 12 clinical falls were graded orange, 2% of the total number of falls reported. The same figure for 2012/13 was 7, 1% of the total number of falls reported. This represents a 42% reduction in the number of falls causing moderate or severe injuries. The Trust has also seen reduction in the overall proportion of falls causing injury. In 2011/12 73% of all falls resulted in no harm and in 2012/13 it was 75%.

Chart 4.14: Clinical falls by degree of harm, 2012/13

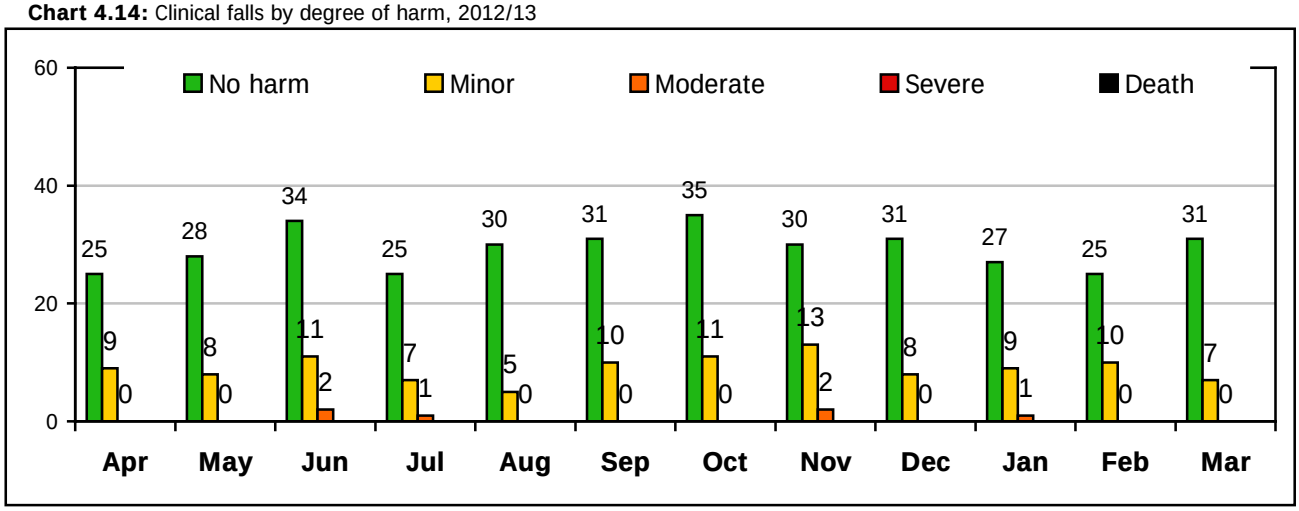


Chart 4.15: Trust Falls Rate per 1000 Bed-days Performance, 2012/13

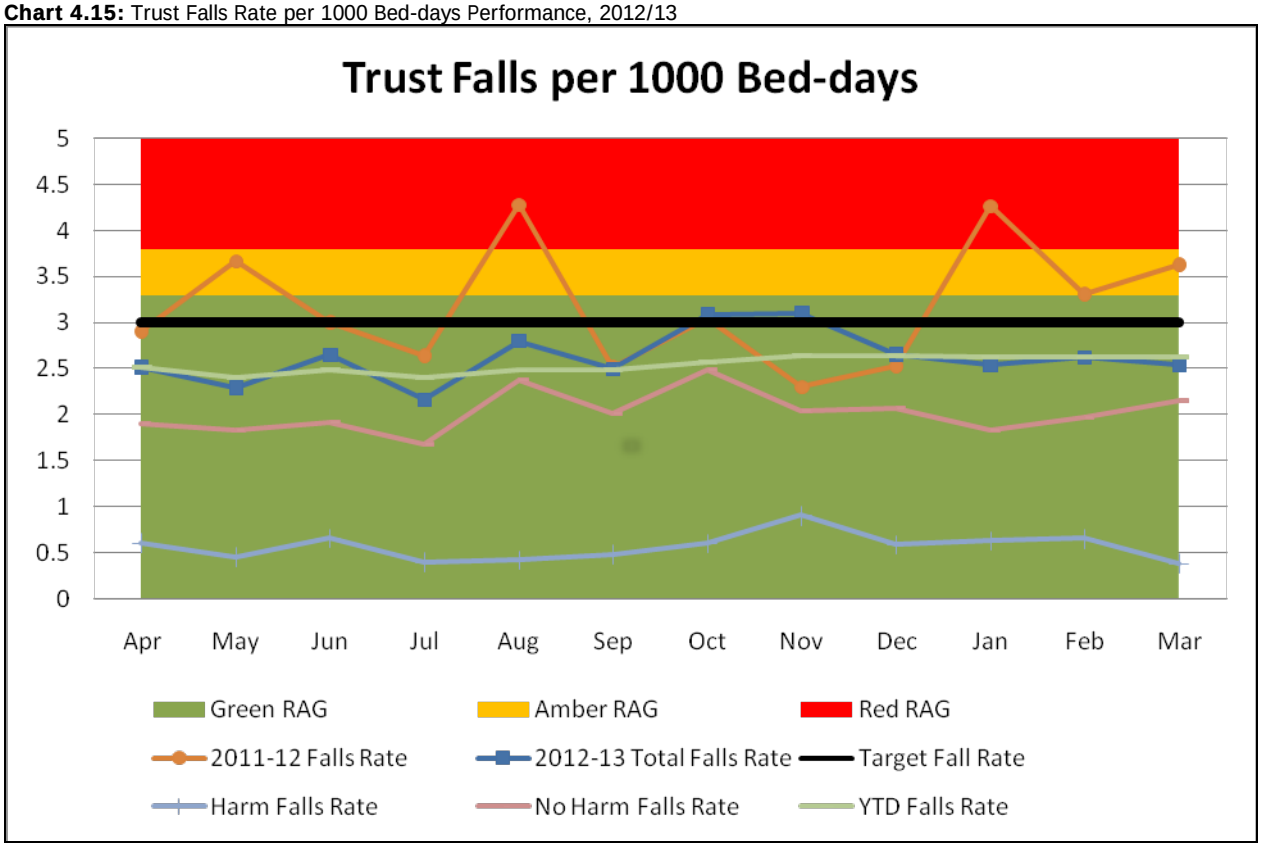
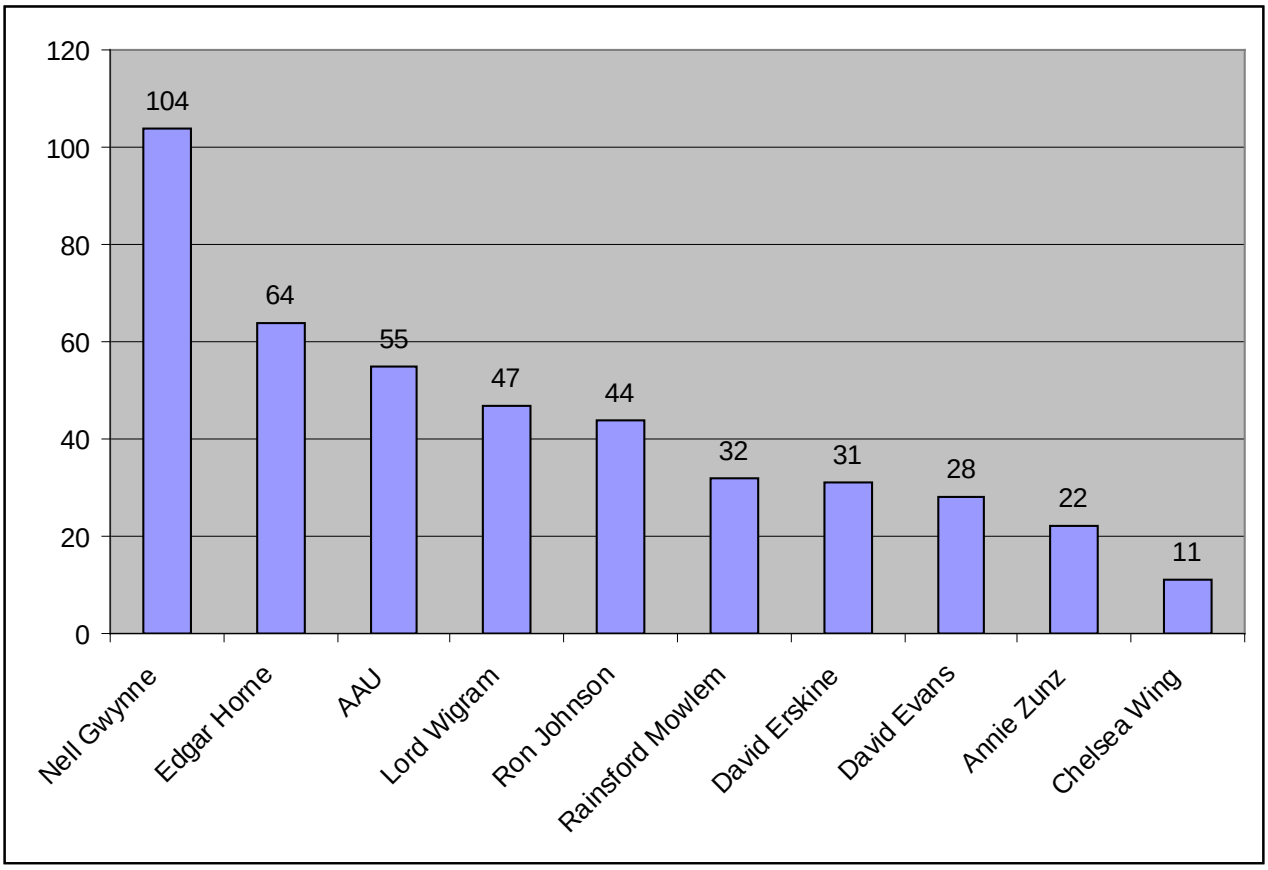


Chart 4.16: Clinical falls by the top 10 reporting wards, 2012/13



Nell Gwynne and Edgar Horne reported the highest number of clinical falls which can partly be attributed to the case mix of patients admitted to these 2 wards. These patients are often cognitively impaired as a result of a stroke or neurologically impaired. In 2012/13 a Nell Gwynne rapid improvement group was assembled to address issues on the ward, including pressure ulcers and falls. Falls prevention also remains high on the agenda of the bi-monthly Stroke Clinical Governance Meeting which is attended by nursing and therapy staff. The times of day when patients are more likely to fall have been monitored and as a result a member of the physiotherapy team will be carrying out an observational study on the ward with the results due to be discussed by the Preventing Harm Group in Q2 2013/14. David Erskine ward has benefited from the impact of the comfort ward rounds which were being implemented in all adult inpatient areas at the time this data was collated.

Ron Johnson ward (previously Thomas Macauley) reported a slight increase in the number of falls since the relocation and introduction of single rooms only which has made it more difficult for staff to directly observe patients. Single rooms have their advantages but there are also challenges attached. A number of different falls alarms have been trialled on Ron Johnson but staff are not always able to tend to a patient in time as the alarms are difficult to hear from behind a closed door and there are also a number of other alarms, such pump alarms, sounding at the same time and it may be difficult to distinguish one from another. This issue has been discussed by the STF Group, which the Ron Johnson Matron attends, and at the time of writing this report a number of possible solutions were being explored such as piloting a 'bleep style' alarm carried by staff.

A new environmental risk assessment was introduced during this financial year and completed for the majority of the inpatient wards. The key risks identified related to the flooring and the need for it to be re-laid/ repaired. There were some risk identified related to storage and clutter and the need for organised storage areas where items are kept off the floor and safely on shelves (not above head height). These issues have or will be addressed through the current refurbishment programme which is underway and will be completed in 2013/14.

In 2012/13 work began to focus on the particular risks of multiple fallers which have a significant impact on the number of falls occurring. Approximately 20% of all falls can be attributed to a patient falling more than once during their hospital admission. A structured authorisation process for one to one specials is now in

place with a form consisting of questions asked by a senior nurse (matron, divisional nurse or clinical site manager) being completed before a one to one special is booked. These questions include – has the patient had a falls risk assessment completed, do they have a falls alarm cushion and has an assessment been completed regarding whether a visible bay area would be appropriate. This has had an impact on both the falls rate but also the number of specials being booked. Further work to prevent multiple falls will be undertaken in 2013/14 with plans in place for the outcome and learning of case studies completed by the standing falls incident review panel being shared with ward staff.

The week commencing 17th June 2013 has been designated a dedicated falls awareness week with a range of ideas having been discussed by the Slips, Trips & Falls Group including interactive quizzes, use of leaflets etc. The arrangements will be finalised by STF Group in early 2013/14 and the aim is to increase awareness amongst staff members as well as patients, relatives and other visitors in order to further reduce the Trust's falls rate in 2013/14.

The STF group has been working within a threshold set in terms of the measurement of fall rate that to some extent controls for the level of ward activity. The Trust through leadership of the STF group succeeded in not breaching the threshold for fall rate. The threshold presents a comparatively low figure of 3 in comparison of the national level of 5.6 falls per 1000 occupied bed days.

The STF group has led the support of the provision of an honorary contract in partnership with the community health services of a falls liaison physiotherapist. The post supports a patient falls pathway across the hospital/community transition. This has involved case finding work within the fracture work and supporting referrals to the community falls services by medical staff in the hospital.

The group has worked to improve its monitoring of performance in terms of risk assessment and care planning that enables departmental representatives identify areas that require support to improve standards. The performance team provide ward level performance figures monthly.

The STF group is working to develop a falls prevention care plan within the trust wide paper based care plan project that will eventually replace the Seven Steps to Falls Prevention document.

The STF group has now been integrated within A Preventing Harm group that is designed to disseminate the effective improvement approaches developed within the fall group to also prevent tissue damage and hospital acquired pressure ulcers.

The Lead Therapist developed a simple guide for the safe provision of walking frames to be used by nurses out-of-hours prior to full physiotherapy assessment. This will support patients getting assistance to walking aides in a timely fashion.

4. Care Incidents

There were 522 care-related incidents reported between 1st April 2012 and 31st March 2013, compared to 493 during April 2011 – March 2012.

Chart 4.17: Top 5 Care-related incident types during 2012/13, including % change since previous year

INCIDENT SUB CATEGORY	N° OF INCIDENTS 2012/13	N° OF INCIDENTS 2011/12	% CHANGE
Failure to carry out adequate observations	176	137	+28%
Policy/procedure guidelines not followed	169	157	+8%
Management plan/clinical advice not followed	57	52	+10%
Extravasation injury	38	24	+58%
Absent/inadequate management plan	27	47	-43%

2012/13 saw a 28% increase in incidents reported relating to failure to carry out adequate observations. However, it is worth noting that 90 (51%) of these incidents related to safeguarding concerns raised over care provided in the community which are reported under this category, mainly by staff in the ED.

A 58% increase in extravasation injuries was noted compared to the previous year. The majority of these incidents occurred in paediatrics (47%) and neonatology (24%). 3 of these incidents were escalated as orange due to the degree of harm sustained by the patients (details of these incidents can be found in

appendix 1). 1 was reported by NICU, 1 by paediatrics and 1 by ITU. All 3 incidents have undergone root cause analysis and panel review. Further work is in progress in paediatrics and neonatology to agree a means of developing a grading matrix specific to extravasation injuries. A further 11 orange incident were labelled as care incidents with the majority relating to absent/inadequate management plan (3 incidents), failure to carry out adequate observations or policy/procedure guidelines not followed (2 incidents each).

Other care related incidents of note are detailed below:

- A staff member noticed that the wrong dressing had been used on an infant's abdominal wound and no Duoderm applied under stoma bag as advised. The site was cleaned and wound re-dressed with the correct dressing.
  Action taken: Appropriate staff members informed and spoke to the individuals involved regarding the importance of adhering to stoma care plans and dressing as advised.

- An immobile patient was left on his back for five hours despite having a grade three pressure ulcer.
  Action taken: Senior ward staff spoke to individuals and reminded them of the importance of turning patients and clearly documenting the reasons if unable to do so. The patient was being nursed on air mattress for pressure relief.

- Sensitive social information regarding a paediatric patient was not followed up from their notes when they were admitted to the ward.
  Action taken: All ward staff aware of the referrals that need to be made and new CAMHS guidelines are now in use.

- A patient attended for colposcopy. Results indicated an abnormality requiring treatment but the result was not followed up for six months which delayed treatment.
  Action taken: Fail-safe system in place reviewed and presented at the Gynaecology Clinical Effectiveness meeting.

- It was discovered that a patient given an anti-D injection had the incorrect date of birth on their name band, stickers and other clinical documentation.
  Action taken: Appropriate staff member informed, who contacted blood transfusion and informed them immediately. Staff advised to ask patient to verify their name and date of birth.

5. Delivery Incidents

There was an increase of 14% in the number of delivery related incidents reported during this financial year when compared to 2011/12.

Chart 4.18: Delivery Incidents by Sub-category, 2012/13

Delivery Incident Sub-Categories	2011/12	2012/13
PPH >1000 mls	113	160
Unanticipated admission to NICU	56	55
3rd/4th degree tear	54	45
Shoulder dystocia	48	41
Stillbirth/Neonatal Death	25	25
Born Before Arrival	9	24
Soft tissue damage to bladder	1	14
Undiagnosed breech	10	12
Meconium Aspiration	0	9
Apgar <4@5 minutes/ cord pH >7.15	8	8
	337	393

Within this category, the subcategory has remained constant throughout the year; the majority of incidents relating to postpartum haemorrhage. The number of incidents of postpartum haemorrhage greater than 2000mls is monitored through the maternity dashboard and is also subject to a Root Cause Analysis. Where there is evidence of significant harm or ITU admission the incidents are investigated as an orange incident. PPH >1000mls is not a particular cause for concern.

The increase in number of third/ fourth degree tears reported was addressed through an audit of practice for the last quarter of the year and this included a swab count audit, and also a review of all unanticipated admission to NICU was undertaken during the year. Specific themes emerging during the year include:

- For women who have 3rd/4th degree tear it was noted in the audit that women who are nulliparous, low risk, low BMI, white ethnic group and had a precipitous labour were more likely to sustain a 3rd/4th degree tear. This audit was presented at the Maternity Services meeting and an action plan is currently being devised by the Supervisor of Midwives
- Major Obstetric haemorrhage: All MOH that are over 2000mls are audited and reviewed using a NPSA MOH RCA. These are then sent to the risk manager for review. There was an audit conducted to analyse why the maternity department was an outlier for MOH, this included the review of women with MOH > 2000mls and women with MOH 1500-1999mls. This was presented at a local meeting in March 2013. There was an action plan which included the introduction of the 6 steps to reducing MOH and PPH called "Put the Plug in": The 6 steps are as follows:
    - Risk assess all women antenatally and in the Intrapartum
    - Ensure controlled delivery of the baby's head and the guarding of the perineum
    - Administer Syntocinon/ Syntometrin with delivery of the anterior shoulder
    - Immediate recognition of blood loss >500mls. Act early and escalate early
    - Perform early bimanual compression
    - Prompt suturing of the perineal trauma and removal of placenta. Anticipate large blood loss and move to theatre early.

- Unanticipated admission to NICU is continuously being review as part of the incident review process. Most common themes associated with unanticipated admission to NICU are the need to recognise early signs of sepsis and CTG interpretation, particularly subtle changes in the presence of infection.
- Never events – there was a recent audit to analyse the maternity expectation for the pre and post counting and double signing of swabs and instruments. The department does have a number of specific documentation tools which aid in the assurance that this is happening. The audit did find that countersigning is 98% compliant; this includes the auditing of both the perineal proforma and the nursing care plan in theatre.
- In the last quarter it was reported through the dashboard that the maternity department had an increase in reported stillbirths. An audit was conducted to analyse if these were unanticipated or whether care or service delivery issues contributed to the outcome. The audit used the NPSA intrauterine death proforma. It was found that out of 10 stillbirths 2 had service or care issues that might have contributed to outcome. These were then followed up through the SI process and have been subjected to a throughout root cause analysis. The other 7 (one set of notes was missing in the audit) were attributed to fetal abnormality, consanguinity and 4 were unexplained. The audit find that there was an overrepresentation of women from BME groups and further work needs to be done to establish if the maternity need to introduce services for women from BME communities.

Further information relating to Delivery Incidents can be found in the Annual Maternity Risk Management Report 2012/13.

Incidents categorised as 'Other' – 54%

Chart 4.19: 'Other' incidents by category

Pressure Ulcer	356
Documentation (poor/unclear/missing)	326
Treatment (eg treatment plan not defined or followed)	235
Equipment Related incident (predominantly no harm)	219
Staff Related Incident	218
Patient Transfer	189
Pathology	142
Verbal Abuse	138
Communication	135
Sharps	118
Capacity Related Incident	98
Behavioural Issues	97
Appointment / Administrative Booking related incident	92
Operation (preparation or related to clinical procedure)	88
Accidental Injury	85
Discharge Related Incident	78
Patient Absconded	74
Theatre Instrumentation related incident	71
Physical Assault	62
Confidentiality	48
Infection Control/Prevention	47
Environmental Factors	46
Bleep Response	36
Lost Property	33
Splash Injury/Incident	30
Transport	29
Dissatisfaction with Service	25
Food	25
Moving and Handling	25
Diagnosis Incident	24
IT incident	24
Security	22
Referral	20
Theft	19
Nutrition	17
Imaging of Diagnostic Related Incident	14
Admission Related Event	13
Consent Related Incident	12
Staff Injury	12
Other	8
Phlebotomy	6
Porter	5
Accidental Fire	4
Anaesthetic	4
Contact with Harmful Substances	3
Exposure to Harmful Substances	3
Self Harm	3
Unexpected death	2
Property Damage	2

4.6 Incidents Reported by Time of Day

Times of reported incidents are influenced by variations in patients' abilities and activities, including variations in alertness, or by staff workload, breaks and shift patterns, basic routines such as mealtimes, and clinical routines such as medication rounds and surgery schedules. The pattern of incidents by time of day remains consistent between weekends and weekdays, and across weekdays.

Incident rates begin to rise around 8am and peak in the period between 10am and 12noon. This is the period when patients are most likely to be active. Staffing levels are usually highest during this period, but workload is also high. Many nursing activities will involve caring for one patient behind closed curtains or doors, which makes observing other patients more difficult – this will impact on incidents such as falls.

The charts below are reasonably consistent, and compare the times that serious and less serious incidents occur across the organisation.

Chart 4.20: All Incidents by Time of Day (where recorded on the incident form, n=4004) – All grades

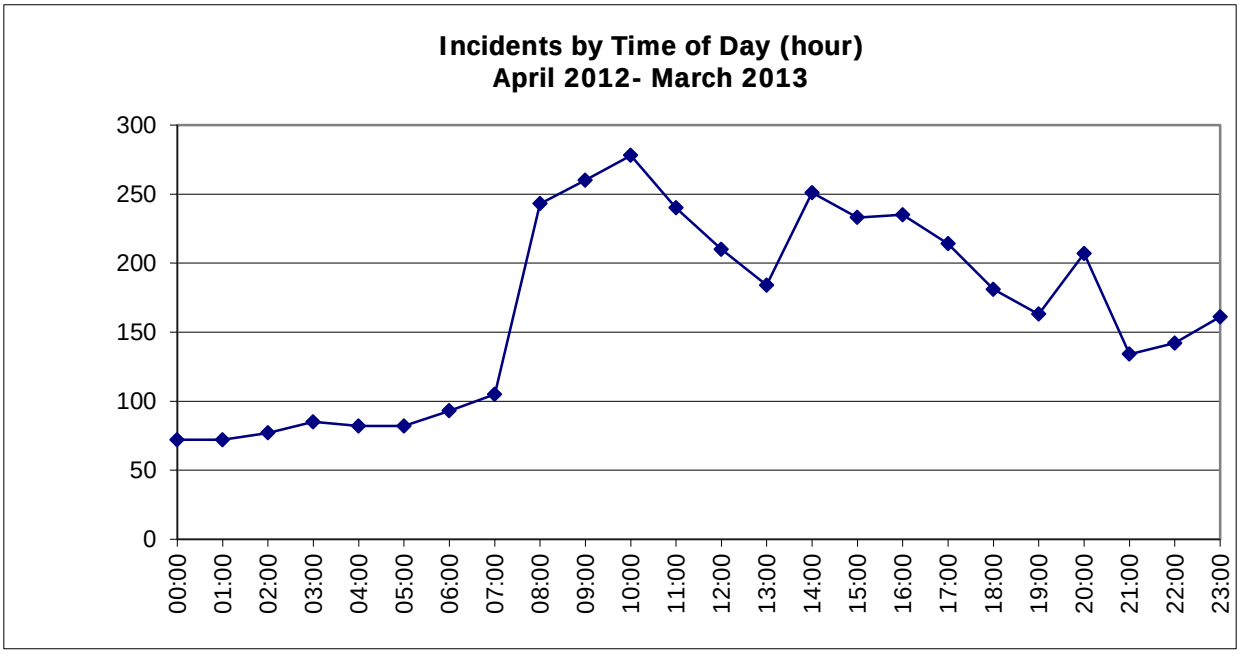
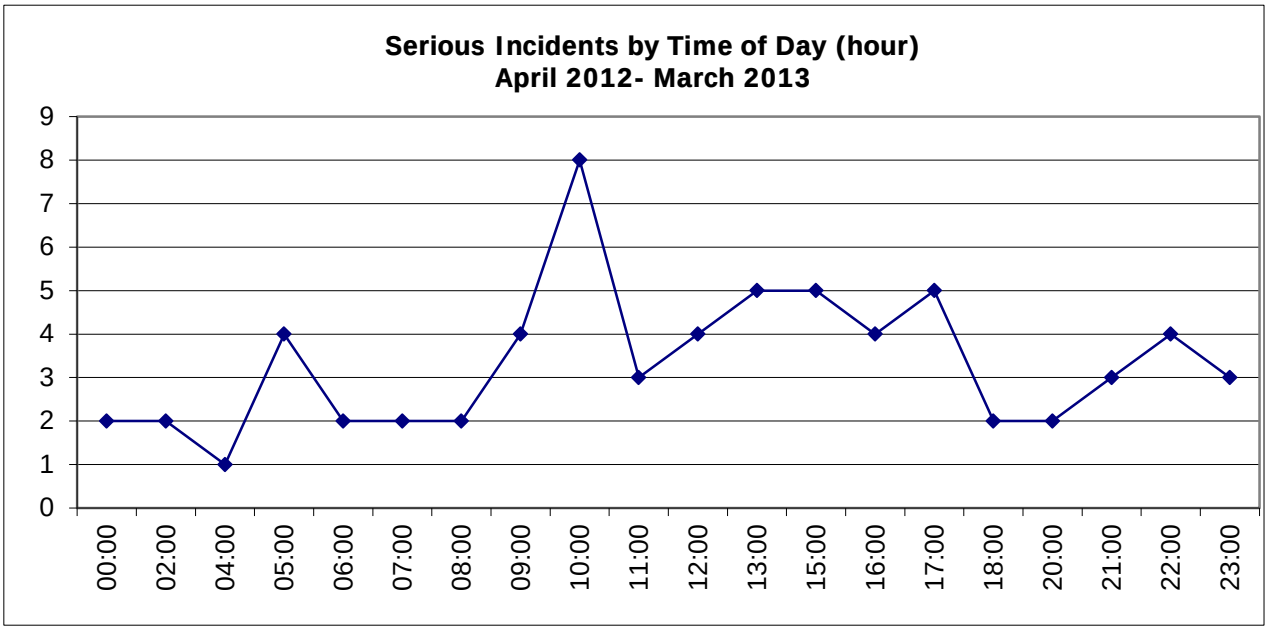


Chart 4.21: Serious Incidents by Time of Day (where recorded on the incident form, n=4004) – Orange/Reds



5. INCIDENTS AND LEARNING DURING 2012/13

5.1 Incidents Graded Orange or Red

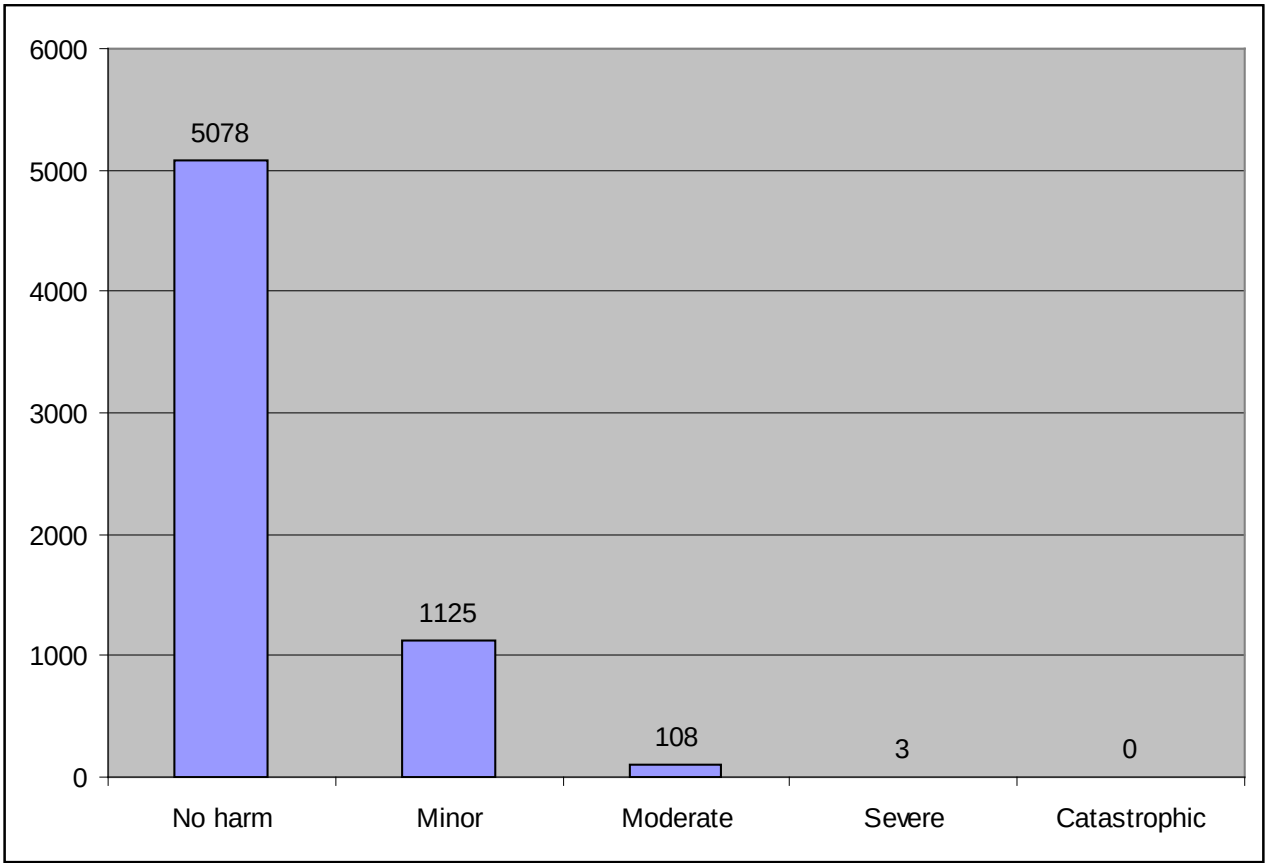
Chart 5.1: Number of Incidents Reported in 2012/13 – by Grade

	VLOW	LOW	MOD	HIGH	TOTAL
Patient Safety Incidents (Clinical)	2,571	2,460	131	0	5,162
Staff Related Incidents (Non-Clinical)	763	385	4	0	1,152
TOTAL	3,334	2,845	135	0	6,314

Chart 5.2: Number of Incidents Occurring in 2012/13 – by Grade

	VLOW	LOW	MOD	HIGH	TOTAL
Patient Safety Incidents (Clinical)	2,561	2,397	127	0	5,085
Staff Related Incidents (Non-Clinical)	759	384	4	0	1,147
TOTAL	3,320	2,781	131	0	6,232

Chart 5.3: Incidents reported in 2012/13 – by degree of harm



The three incidents leading to severe harm were as follows:

- Patient had left radial arterial line in place and hand noted to be pale. Line removed soon after and hand noted to be blue/black.
- Patient found collapsed following handover. Resuscitated and transferred – later stabilised. The patient later died of an undiagnosed condition.
- Patient transferred from external Trust with a clinical complication. Taken to theatre for procedure. Condition deteriorated during procedure leading to a collapse. CPR commenced but unsuccessful.

The Trust's risk assessment scoring matrix provides a tool for assessing the seriousness of an incident. The grade is categorised as red, orange, yellow, or green. This rating helps to identify the level at which the incident will be investigated and managed in the organisation. This scoring system can be applied to outcomes for patients, staff and relatives, and also for implications for the Trust.

The level of investigation to be undertaken will be determined by:

- The level of severity of harm to the patient/carer/relative or staff member, and/or
- Results of risk assessment; and/or
- The potential for learning (which could include investigating those incidents, complaints or claims which are high frequency, but are of low severity)

Red and orange incidents are subject to a review and root cause analysis, after which a summary of the investigation, outlining key learning points, is presented at the Risk Management Committee to support Trust-wide learning and dissemination of recommendations. Copies of Trust investigation reports are also occasionally requested by, and provided to, the Coroner.

Safeguarding Alerts (SGAs) raised against the Trust are graded orange and investigated as such. Generally, the trust internal investigation will inform the SGA conference. There were 5 such incidents reported in 2012/13. 3 of these incidents related to hospital acquired pressure ulcers, 1 to a fall in which a vulnerable adult sustained a fracture and 1 incident related to a patient who disclosed to a member of staff that they were suffering from pain after they had been dropped during transfer. In the last 2 cases the allegations were not substantiated.

5.1.1 Incidents Graded 'Red' (n=0) and 'Orange' (n=135) during 2012/13

135 orange incidents were reported during 2012/13, compared with 1 red and 95 orange in 2011/12, reflecting a 42% increase in orange incidents while 2011/12 saw a 33% increase in orange incidents. The contributing factors of serious incidents are being monitored in order that themes and trends can be addressed. For more information on contributory factors please see section 5.3 on page 33.

Incidents graded orange during 2012/13 occurred in the following directorates/services:

Chart 5.4: Red and orange incidents by directorate

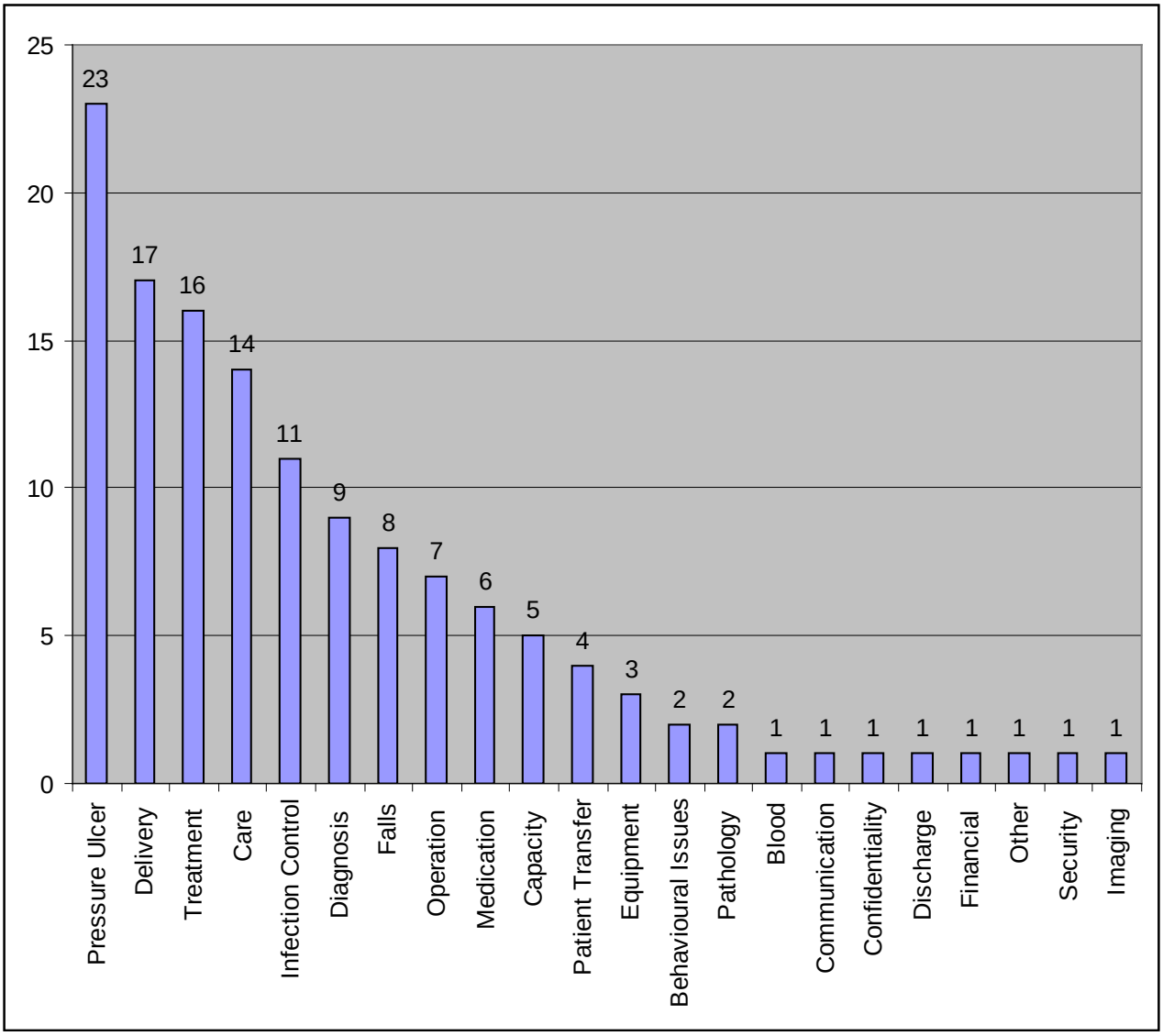
	2012/13	2011/12	2010/11	2009/10	2008/09
Anaesthetics & Imaging Directorate	6	3	6	9	6
HIV and GUM Directorate	8	9	3	2	2
Medical Directorate	53	37	23	21	12
Pathology	1	0	3	0	1
Pharmacy	0	2	1	0	0
Surgical Directorate	27	17	12	7	5
Women and Children's Directorate	40	27	22	30	11
Whole Hospital	0	0	4	7	10
Non-Clinical Support Services	1	0	0	0	0
Total	135	96	74	76	47

Incidents giving rise to risks are noted on the Trust Risk Register. A system of control is in place, whereby the risk management team reviews the grading and detail within the risk assessment documentation prior to their transfer to the Risk Register.

A précis of incidents and the recommendations are placed on the incident review register, which tracks progress towards completion. This register is updated as recommendations are achieved and actions reviewed every quarter to ensure progress and identify any significant delays. The Incident Review Register is also uploaded on the Intranet and is kept up to date by the Clinical Governance Support Team.

The incident categories for orange incidents can be found in the table below:

Chart 5.5: Orange incidents by category



- **7** orange incidents were also linked to a formal complaint with joint investigations undertaken.
- **4** out of the 135 incidents investigated as orange were **near misses** that resulted in no harm.
- A further **10** orange incidents were recorded as no harm incidents while **20** resulted in minor harm.
- 98 incidents resulted in moderate harm such as increased length of stay and/or admission to high dependency/ITU, grade 3 and 4 pressure ulcers, 4th degree tears during delivery, fractures sustained through a fall and major obstetric haemorrhages.
- **10** incidents were linked to, without being the primary cause of, a **patient death**:

1. Patient was admitted with sepsis, initial observation scored 3 on CEWS and this was not escalated to appropriate staff members. Apparent failure to recognise severity of condition and apparent failure to instigate timely management.
2. Concerns raised regarding patient not being diagnosed with the condition that caused their death. Patient seen by several professionals during the months leading up to death and also underwent several procedures. Investigation focussed on ensuring seamless and joined-up care for patients with several complex co-morbidities.
3. Sudden deterioration in the patient's condition and a subsequent cardiac arrest from which the patient could not be resuscitated.
4. Maternal death.
5. Unexpected deterioration following surgical procedure leading to a sudden and unexpected death.

6. Patient became unwell with rigors, Blood cultures taken which confirmed MRSA bacteraemia. Patient's condition deteriorated and he died.
7. Patient admitted with increase in shortness of breath, cough and brown sputum. Known MRSA and pseudomas infection during previous admission. Developed fever and tachycardia followed by a failure to recognise the rapid deterioration and escalate this to the appropriate teams and individuals prior to the patient suffering a cardiac arrest.
8. Undiagnosed clinical condition prior to surgical procedure.
9. Possible hospital acquired VTE.
10. Medication incident (community related).

Information relating to the 135 orange incidents reported during 2012/13 was considered by the various committees with overarching responsibility for risk, including the Trust Risk Management Committee and the Assurance Committee.

This level of detail is not available to the general public as it is considered that the synopsis of each incident at a case by case level may reveal the identity of people affected by these incidents. The Trust has therefore introduced measures to remove this level of detail from the annual report, to ensure that information about an individual whose identity is apparent or can reasonably be ascertained from the information or synopsis.

5.1.2 External Reporting on the Strategic Executive Information System- STEIS

From December 1st 2010 all trusts, including Foundation Trusts, are required to use the Strategic Health Authority's incident reporting system 'STEIS' within 2 working days of discovering the incident. Reporting on STEIS has further highlighted the need for prompt recognition and escalation of serious incidents. Audits were carried out in April and May 2013 in order to identify if any incidents had not yet been reported externally that should have. These reviews resulted in a further 6 incidents being uploaded on STEIS.

In 2012/13 the Trust reported 21 incidents on STEIS. This included 7 Never Events as retrospective reporting of 4 of these occurred in response to the extended reporting categories. The reporting categories include, but are not limited to, unexpected outcome of surgery, serious injury in a child, disruption to maternity services, transfusion errors, medication errors, breaches of the LAS handover time target and grade 3, 4 and unstageable hospital acquired pressure ulcers.

5.1.3 Hospital Associated VTE Events

In the Trust a root cause analysis (RCA) is performed on all confirmed cases of pulmonary embolism (PE) and deep vein thrombosis (DVT) associated by patients whilst in hospital (including those cases arising during a current hospital stay and those cases where there is a history of hospital admission within the last three months, but not including patients admitted to hospital with a confirmed VTE with no history of an admission to hospital within the last three months).
The Trust improved the process for identifying hospital associated VTE events in 2012/13. Radiology reports are screened to identify new VTE diagnoses. Electronic records on the prescribing system are reviewed to determine whether the VTE diagnosis is hospital associated or not. For hospital associated VTE events, clinicians perform root cause analysis to establish whether the VTE event was preventable or not, if appropriate preventative actions were taken, identify any changes to practice to prevent reoccurrence and feedback contributory factors for preventable VTEs.

The Trust's target for 2012/13 was to have a 25% reduction of hospital associated preventable VTEs i.e. to have no more than 13 hospital associated preventable VTEs and this was achieved.

In 2012/13:

- 166 new VTE diagnosis were identified
- 47 hospital associated VTE events (HATs) occurred
  - 27 HATs occurred in Medicine
  - 11 HATs occurred in Surgery
  - 3 HATs occurred in Imaging & Anaesthetics
  - 1 HAT occurred in HIV

    - 5 HATs occurred in Maternity and Gynaecology
- 47/47 root cause analyses were performed for hospital associated VTEs
- 13 VTEs were preventable and 34 VTEs were non-preventable

Identified contributory factors for preventable VTEs included:

- No VTE risk assessment completed on admission or within 24hours of admission
- Inaccurate completion of VTE risk assessments - thrombosis and bleeding risk factors not identified
- Thromboprophylaxis not prescribed when VTE risk factors present during admission
- Delayed prescribing of prophylactic/therapeutic enoxaparin, in particular on day of admission and post-procedure.
- In one case, warfarin therapy was not prescribed following positive DVT diagnosis (delayed prescribing by 2 days).
- Prescribed doses of thromboprophylaxis not administered during admission without a documented reason for omission.
- Warfarin stopped on a previous admission with no documented reason. Warfarin was to be reviewed during elective admission and restarted; however this did not occur as team forgot to review and initiate therapy.
- Patient in a full leg cast (plaster cast immobilisation) with other VTE risk factors present and was not prescribed enoxaparin on discharge as per Trust guidelines.
- In many cases the completed RCAs highlighted a lack of prescribing TED stockings. Many patients were wearing these but there was no evidence on LastWord that these had been prescribed as per policy.

In 2013/14, the Trust target is having no more than 10 preventable hospital acquired VTEs and work will continue with root cause analysis for hospital associated VTE events with a focus on addressing the contributory factors for preventable VTEs by:

- Continuing to provide monthly feedback on completed VTE risk assessments by ward and department, and following up on the areas which do not meet the 95% target.
- A multidisciplinary group will be put together to look at why preventive treatment was delayed or omitted, and looking in particular at those drugs that help prevent VTE.
- Continuing to educate medical staff about the importance of prompt prescribing of preventive treatment.
- Addressing the issues relating to prescribing TED stockings. Discussion have been held in the past regarding whether or not it would be appropriate for nursing staff to prescribe these and these discussions will continue in 2013/14 as well as exploring other options.

Patients at risk of VTE should be offered appropriate pharmacological and mechanical thromboprophylaxis, if indicated and no contraindications are present. The Trust set a target of 90% of adult patients should receive appropriate pharmacological and mechanical thromboprophylaxis. Monthly audits were performed on adult wards to establish whether patients received appropriate thromboprophylaxis. Results of the audits are fedback to the ward, medical and pharmacy staff and the Thrombosis & Thromboprophylaxis Committee.

In 2012/13, over 90% of patients received appropriate pharmacological thromboprophylaxis and 79% of patients received appropriate mechanical thromboprophylaxis e.g. anti-embolism stockings.
It was investigated why the Trust was not achieving the target of 90% for appropriate mechanical thromboprophylaxis and there was some confusion about whether anti-embolism stockings should be prescribed and which staff group is responsible for prescribing them. There were a number of multidisciplinary discussions to clarify and agree the staff group responsible for prescribing mechanical thromboprophylaxis. It was agreed that the responsibility of prescribing anti-embolism stockings should remain with the medical staff except in areas where nurses or midwives are specifically trained. Nursing and pharmacy staff will help encourage the medical staff to prescribe anti-embolism stockings for patients if no contraindications are present. To help ensure anti-embolism stockings are fitted appropriately and monitored daily to inspect skin condition, the Trust developed a monitoring form.

In addition, individual thromboprophylaxis plans were introduced for maternity patients considered to be at high risk.

5.1.4 Pressure Ulcers

Over the past year the Trust has continued to work toward a reduction in the incidence of hospital acquired pressure ulcers. However an increase has been seen in the reporting of ulceration, though not a significant increase in the more severe ulceration of grades 3 and 4.

The severity of pressure ulcers are categorised by grades. The Trust looked at how we categorise the severity of ulceration in 2012/13 and amended this to add a further category. We now use grades 1-4 and have added 'unstageable'. This category is attributed when staff are unable to see the true extent of the ulceration, i.e. where the skin is black or the wound is covered with dead tissue. The damage is then re-graded when the true extent is evident. This has been done as it has been found that many of the ulcers previously graded as stage 4 have subsequently been less severe; often grade 2 or 3. This change in categorisation is in line with that of other London hospital trusts and thus enables better comparative benchmarking.

The Trust has implemented a new electronic record for reporting pressure ulcers; however this is less reliable than the reporting of clinical incidents. Our targets continue to be based on clinical incident reporting data as this appears to be the most reliable data set.
The Trust has seen an increase in reported community acquired (ulcers present on admission) ulcers over the last year which evidences improved reporting of pressure ulcers.

Efforts to reduce pressure ulceration included the introduction of pressure ulcer care bundle documentation that will be rolled out across Medicine and Surgery. A pressure ulcer committee will also be launched in 2013/14 to help deliver and monitor pressure ulcer incidence in the Trust, community stakeholders will be invited to take part in this committee to work together in reducing pressure ulceration.

5.2 Never Events in 2012/13

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. An updated list of the never events list for 2012/13 was published on 18 January 2012. There are 25 national categories of "never events" on the expanded list. This includes the original eight events from previous years, some of which have been modified, and builds on the draft list published in October 2010.

In 2012/13 the Trust reported 3 incidents linked to never events, 1 related to maternity, 1 to orthopaedic surgery and 1 to Dermatology.

In all cases a thorough investigation was undertaken and measures put in place to prevent re-occurrence. The Trust is systematically working through all never event categories to ensure that effective preventative measures are in place and are working.

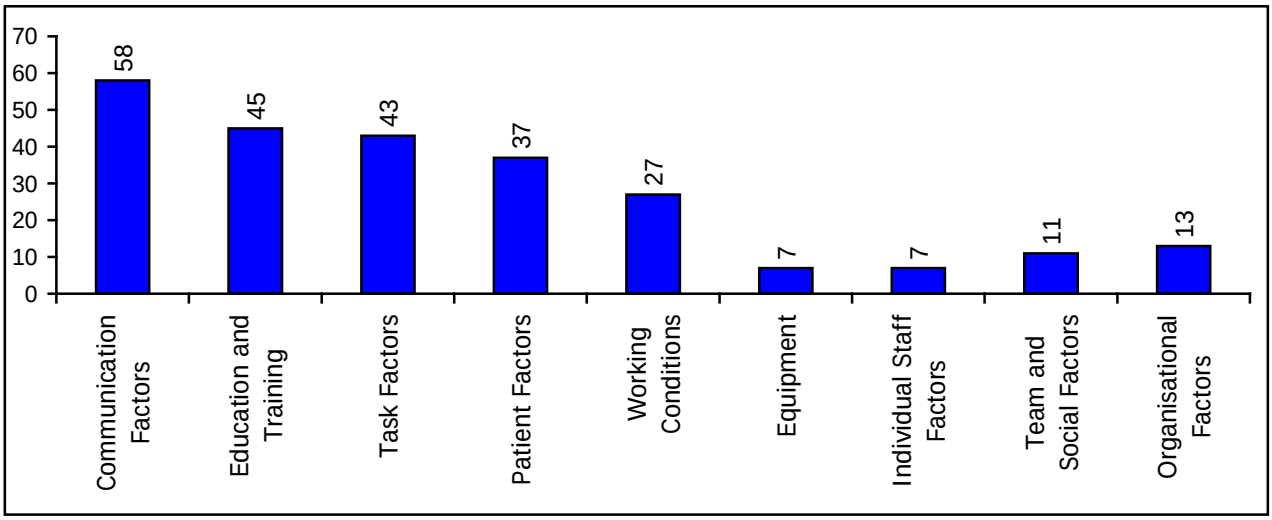
Full reports relating to Never Events have been provided to the Board.

5.3 Contributory Factors

Root cause analysis (RCA) involves identifying those issues which may have had an influence or may have directly caused an incident. During incident investigations, the use of RCA tools such as the fishbone technique with its contributory factors framework supports identification of relevant contributory factors. This exercise is useful in informing appropriate recommendations and ensures that further action can be taken where gaps have been highlighted for example in relation to training and education provided to staff.

An analysis of contributory factors relating to incidents reported in 2012/13 highlighted the contributory factors noted in the graph below:

Chart 5.6: Identified Contributory Factors for the 135 orange incidents in 2012/13



The most commonly occurring contributory factor identified during 2012/13 was communication, both written and oral. 58 out of the 135 orange incidents featured issues around communication, including inappropriate communication of diagnosis/treatment and failure of communication at handover or ward round. Written documentation in the medical notes is often poor and sometimes even affects the investigation into an incident as no evidence can be found to verify if a task was completed or not. Education and training issues also feature frequently, especially in relation to the incidents related to grade 4 hospital acquired pressure ulcers and falls. Task factors is a commonly recurring contributory factor in the maternity service but is also common in relation to incidents involving failures to escalate deteriorating patients where guidelines are not followed.

5.4 Lessons Learned During 2012/13 and Changes to Practice

Reporting incidents is essential, but even more important is how we respond to, and learn from them, and that includes looking for any emerging themes or trends, so that we can nip potentially more persistent or serious issues in the bud. Investigation of serious incidents can support identification of trends and provides an opportunity to discover what the service can learn from these events. A number of specific areas for further scrutiny were identified during investigation.

The outcomes from incident reviews are also presented at a variety of meetings, and in particular at the Risk Management Committee. This allows staff to share their experiences and learn from each other. Examples of actions taken and lessons learned in 2012/13:

- The patient locator on AAU has been re-launched by the Lead Consultant to ensure it is being used by junior medical staff to highlight any delays in clerking patients and initiate treatment.
- Psychiatric Liaison staff now have access to LastWord and there is a process in place for new starters getting access.
- Additional security measures were put in place with the introduction of infant tagging within the maternity service. There have been some issues with availability of the tags and additional supplies

have been purchased. Additional teaching on application and removal have been initiated and a risk assessment is in place to ensure controls are in place to manage the emerging risks.

- On AAU patients' pressure ulcer risk scores are now handed over with their CEWS score and is also documented on the handover sheet. Stickers of green, amber and red to notify staff of the level of risk are placed on the medical notes so that the whole MDT are aware of the risks and likelihood of that particular patient developing pressure ulcers.

- The Infection Control Team and Nell Gwynne ward staff developed a C.Diff algorithm for insertion in the bedside observations folder to help guide staff on when and when not to, take stool samples in patients with diarrhoea. Further education was also provided to ensure efficient use of the stool charts and screening tools.

- Visual aids are now used in all cancer related MDTs in order to ensure that the site of any malignancy can be determined and is clear to all those attending the meeting. The diagram is then inserted in the patient's notes for future reference. Scopeguides are also routinely used during all colonoscopy procedures to reduce the risk of malignancies being missed.

- In maternity a suturing proforma which requires two signatures was introduced as a response to a retained swab never event.

- A 'quick prompt guide' was developed by a consultant in the ED and circulated to all staff in the department to help, in particular junior members of the team out of hours when the ED is struggling with capacity. By including helpful hints and tips on actions to take, and when, the aim of the guide is to prevent handover and waiting time related target breaches. The ED Escalation Policy was also updated to include clearer roles and responsibilities to aid communication.

- In Dermatology a policy was developed to help staff manage patients who receive overexposure of phototherapy as a response to an incident where medical advice was not sought before the patient was discharged from the department. The phototherapy machine in questions has also been replaced as the timer was found to be faulty.

- Although not considered surgical procedures the WHO checklist was introduced for all pain management related procedures, such as nerve blocks, carried out in the Treatment Centre.

- Following receipt of a formal complaint it was highlighted that the patient's pain score had not been recorded in triage or at a later stage of their attendance therefore a pain audit was carried out in the ED. In response to the results the documentation used was re-designed with the aim of emphasising the importance of recording and re-evaluating a patient's pain score.

- The alcohol withdrawal policy has been reviewed by an expert group to simplify the content after an incident revealed that the policy had not been followed on this occasion as it was unclear. Accessing the policy was also highlighted as an issue therefore staff are working on ensuring that the policy is easily found on the Trust intranet. The current alcohol withdrawal education provided to junior doctors is being reviewed and a withdrawal algorithm is being developed.

- Following 3 incidents relating to NJ tubes becoming detached from the main tube specific training was completed in association with the company supplying the tubes. Further work is also ongoing to get the company to develop stickers which can be placed in the notes to identify batch numbers.

- LastWord has been updated to provide triggers for neonatal staff when requesting blood products to ensure the requirements are made clear to laboratory staff. The lab standard operating procedure has also been updated as a response to an incident which occurred in Q4 where an infant received non-irradiated blood contrary to their requirements.

- An MDT has been introduced in paediatrics where complex cases are discussed and further management agreed.

5.5 Reports from Committees

Trust Risk Management Committee

The Risk Management Committee is a cross divisional multidisciplinary committee which aims to achieve a safer service for patients through the review of incidents and risks, safety alerts and relevant external guidance to facilitate Trust wide learning and changes in practice.

The committee calendar includes Divisional and Specialty updates from nominated risk leads, presentation of investigation reports, new risks graded orange or red, progress on recommendations arising from incident investigation and review and ratification relevant clinical guidelines. The Committee also receives feedback from sub-committees including the Maternity Risk Management Committee, Medical Devices Committee and Blood Transfusion Committee, regular reviews of the incident review register, risk register and quarterly risk management and maternity risk management reports. The sharing of information and discussion at the meeting facilitates Trust wide learning.

Assurance:
Audit was undertaken on compliance to the processes outlined within several risk related policies during November 2012. The audits identified overall compliance. Where deficiencies were identified actions were introduced to strengthen controls. Progress on implementation of the agreed actions is monitored through the committee in accordance with the committee calendar.

Issues raised at the committee:
To support risk management processes a number of incident investigation related templates were updated and approved by the Committee in 2012/13. These include the template for escalating orange and red incidents, the incident investigation task list and the panel investigation report template. The purpose of this was to strengthen areas such as 'being open' and 'supporting staff' by inclusion of specific triggers on the check list and investigation report template.

A number of policies and procedures were reviewed and approved by the members, for example the Artificial Radiation Safety Policy, Tourniquet Policy, Blood Transfusion Policy and the Nasogastric Tube (Adults) Policy. These policies are particularly relevant as there have been incidents in the past where guidance has not been adhered to, which has impacted on patient care, or the policies relate to 'Never Events'. To provide assurance that controls detailed within the policies are effective, audits on compliance to the policies are presented to the committee. Where deficiencies are identified, the committee members consider actions which will support future compliance to the guidelines. A new innovation introduced during this year, was to invite clinical staff to participate in the update of relevant older guidelines and preparation of new guidelines to ensure they are achievable in the clinical environment.

For further information on Risk Management Committee issues, **contact Cathy Mooney, Chair of the Committee, Vivia Richards, Head of Clinical Governance, or one of the Clinical Risk Managers.**

Blood Transfusion Committee
The Hospital Transfusion Committee, and the Hospital Transfusion Team, seeks to ensure a high quality of blood transfusion practice in the Trust.

Controls:
The Trust adheres to the following regulations to maintain and improve the safety of transfusion:

- The Blood Safety and Quality Regulations (BSQR (2005) Statutory Instrument)
- The National Patient Safety Agency (NPSA) Safer Practice Notices
- The British Standards in Haematology (BCSH) Guidelines
- SHOT (Serious Hazards of Transfusion)

These initiatives focus on correct patient identification, documentation and communication.

Additional controls include:

Trust Transfusion Guidelines and Policies
Following a review of all of the Trust Clinical Transfusion Guidelines and Policies, the following policies and guidelines have been updated or replaced:

- Major haemorrhage protocol for adults-updated Aug 2012
- Guidelines for patients refusing blood.-replaced March 2013

The Trust Transfusion Policy is currently being rewritten to include guidance from:

- BCSH - British Committee for Standards in Haematology - Guidelines on Pre Transfusion Sampling
- SaBTO - The Advisory Committee on the Safety of Blood, Tissues and Organs - Recommendations on the provision of CMV negative blood components

Appointment of Transfusion Practitioner and Blood Bank Manager
David Mold was appointed to the post of Transfusion Practitioner and commenced work in June 2012.
Hugh Boothe was appointed to the post of Blood Bank Manager and commenced work in November 2012.

Assurance:
Blood Safety and Quality Regulations 2005
The Medicines and HealthCare products Agency undertook a "For Cause" inspection of the transfusion laboratory on Friday 21 September 2012. The triggers for this inspection included the new 24 hour shift system, problems with validating the new LIMS (Laboratory Information Management System), plans to change the auto-analysers, and apparent procedural controls to prevent Electronic Issue on samples where results have been entered manually. Chelsea and Westminster Hospital had never previously been subject to an MHRA inspection.

The inspector's report identified no Critical or Major non compliances but seven other non-compliances were identified. The Quality Manager at Imperial HealthCare identified which Trust needed to deal with the seven non compliances. The blood transfusion laboratory manager in conjunction with the Chelsea & Westminster Transfusion Team then produced an action plan in order to address these issues and which was submitted to the MHRA by the end of October 2012.

Training and Competency Assessment
The Transfusion Practitioner has reviewed and updated the transfusion training packages used for induction and mandatory update so that they are in line with current guidelines. Induction training is conducted face to face and mandatory update training is delivered using a workbook. The Transfusion Practitioner has requested at the Mandatory Training Committee that the mandatory update training be conducted as face to face for a period of a year and this was agreed. In the future it is hoped to move to the national e-learning packages, Learn Blood Transfusion, to fulfil the requirements for mandatory update for all staff.
The Transfusion Competency Assessment documents were also reviewed and have been replaced with new ones that are more in line with national guidelines. To facilitate the requirement under the NPSA Safer Practice 14, Right Blood, Right Patient, to competency assess all staff involved in the process of transfusion; Transfusion Link Nurses/Midwives have been recruited from every clinical area to undertake basic training and competency assessment for all staff requiring it.

Audits
The following audits were undertaken in the last year:

National Audits
National Comparative Audit of Blood Sample Collection & Labelling
National Comparative Audit on the Medical Use of Blood (Part 2)
The reports for all of the National Comparative Audits of Transfusion are available on the Trust Intranet.

Local Audits
Audit of Bedside Transfusion
Ongoing audit of Blood Wastage
Ongoing audit of transfusion sample rejection and rebled.

For further information relating to blood transfusion or blood related incidents, **contact Transfusion Leads: Francis Matthey, Consultant Haematologist or David Mold, Transfusion Practitioner.**

Medication Safety Initiatives

Medication Safety is a monthly standing agenda item at Pharmacy Board meetings and the SNMC (Senior Nursing and Midwifery Committee). Joint feedback is provided to the Risk Management Committee in accordance with the schedule. The purpose is to monitor trends related to high risk medications/medication practices, learn from medication incidents and implement medication safety initiatives as appropriate.

Controls and Assurance:
The Control and assurance for Medicines Management within the Trust lies within the Trust Medicines Policy which is audited yearly. Additional Trust assurance has been sought specifically against the nine medicine related Never Events which are discussed and RAG rated at the Trust Quality Committee. A gap in assurance has been identified into the Never Event relating to the proportion of staff having evidence of Medicines Management Training, which stood at 72% at the end of year 12/13. Strategies have been introduced to improve the percentage of staff with evidence of Medicines Management Training, and there has been some improvement in this area, which now stands at 81%.

During 2012/13 the pharmacy department considered areas where there is evidence that compliance to guidance had not been followed. These include:

The safe administration of IV medications
A trend in serious incidents related to the administration of IV medications and the identification of over infusion being the second most frequent type of medication incident, led to an audit being conducted which assessed adherence of administration practices against Trust policy standards in 11/12. The audit findings were presented back to the SNMC and the Trust Medicines Committee and re-audits with associated recommendations continued throughout 12/13. Actions include:

- The Trust 'IV addition sticker' was reviewed in consultation with the SNMC and a pilot of the new design undertaken in Obstetrics. The new design was approved after the pilot identified that adherence to standards improved. A trust-wide roll out of the stickers is in progress.
- In response to two moderate incidents related to the infusion rate of variable rate infusions, Trust policy was updated to include the requirements of a double check at the point of a syringe change and/or infusion rate change. The method in which to document this check was approved through the SNMC and disseminated to frontline staff.
- The SNMC continued to impress to ward managers the importance of assessing the competencies of all ward staff, including bank and agency staff prior to assigning medication administration duties. Only nurses that have evidence of competency (completion of learning package, a series of learning profiles and a series of supervised practice) have authority to administer IV medications and a MAPs implementation group has been initiated to ensure the Trust maintains a central database of authorised staff.
- The injectable standards were incorporated into the Nursing and Midwifery 'CQC walk arounds' in order to target specific clinical areas and engaging frontline staff. Using the pro-forma to spot check Injectable practices continued throughout 12/13

Reducing the risk of patients being prescribed medications that they are allergic to
A trend was identified of a number of near misses where a patient was prescribed medications for which they had a documented allergy to; fortunately none of these incidents led to serious harm. The SNMC led on dissemination of the trend analysis and encouraged frontline staff to continue to check allergy as part of the administration process, highlighting the potential risks. The annual identification audit considered appropriate use of allergy bands.

Reducing the appropriate storage of Medications
Audit identified that there were some clinical areas where safe storage of medication could be improved. Trust Policy for safe storage was reviewed by the SNMC and agreed standards disseminated amongst frontline staff e.g. requirement for Controlled Drug keys to be separate from other medication storage keys. All Clinical areas where the fridge was identified as being unlocked made arrangements either to fit on a suitable locking device to the fridge if required and all fridges were moved into locked treatment rooms if appropriate. Work is on-going in some areas to minimise risks in relation to this area. Where compliance is challenging, risk assessments have been undertaken.

Improving the appropriate management of patients with hypoglycaemia
The SNMC led on the implementation of recommendations from a pharmacy led audit:

- Ensuring that hypo boxes are in a prominent, accessible place on the ward
- Ensuring that all HCAs measuring blood glucose on the ward know when to refer to a nurse so that treatment can be administered and/or arrange hypo training for these staff members
- Highlighting to frontline staff the importance of documentation of hypo treatment (as per the Trust algorithm) in comm. notes/ BG chart

Improving appropriate and timely administration of Analgesia
One of the most significant trends identified was the number of patients reported as not receiving adequate analgesia in the post -operative period. There were 12 such incidents reported over the course of the year and in response:

- The Trust has relaxed the regulations surrounding the prescribing, administration and recording of Morphine Sulphate 10mg/5ml Oral Solution (Oramorph®). These changes are intended to reduce unnecessary delays in administration, ensuring patients receive prompt analgesia.
- A system has been set up to ensure that the Acute Pain Team are provided with a summary of Medication Incidents reports related to analgesia quarterly and these are discussed as a standing item at the Acute Pain Team Clinical Governance Meetings.

For further information relating to medication safety related initiatives, contact **Anna Bischler, Pharmacy Risk Management Lead.**

Decontamination Committee

Controls:
The Decontamination Committee oversees the development and implementation of the National Decontamination Programme, which states that every department for the decontamination of surgical instruments and flexible endoscope must meet requirements of the Medical Devices Directive, health Act and Care Quality Commission.

The Chelsea and Westminster Hospital Decontamination Service has developed and implemented a Quality Management System (QMS) ISO 9001 and ISO 13485 in order to ensure compliance with the standards and reduction of risk for the patients associated with the hospital acquired infection.

The QMS addresses the requirements of the Medical Devices Directive 93/42/EEC (including the amendments of 2007/47/EC) The system covers all the activities undertaken by both the Sterile Services Department (SSD) and Endoscope Decontamination Unit (EDU) relevant to the quality of the products and services provided by the department. The CJD policy was approved during the year.

Assurance:
The decontamination department has been accredited during the year. This is confirmation that there are established systems and procedures in place. Evidence is held within the department.

The Trust is compliant with the requirements of identifying patients with risk of CJD; patients safety-checking instruments after surgical procedures by theatres staff; loan medical devices to other organisations; single use medical devices and consequences of re-use; safe transportation of surgical instruments; traceability.

Issues raised by the Committee
Risk Assessment: Environmental mycobacterium in final rinse water for endoscope decontamination; high TVC level. Initial actions undertaken to mitigate the risk were unsuccessful. Further investigation identified contamination in the machine.

Additional controls introduced to manage the risk include:

- weekly water tests
- daily self-disinfection
- replacement of contaminated parts
- changes to maintenance contract

Missing Instruments: Between November 2012 and May 2013, a total of 18 incidents of missing instruments were reported. Additional controls introduce include monitoring of checklists to ensure they have been signed following procedure.

Committee objectives included improved patient safety initiatives and prevention of cross infection.

For further information relating to decontamination safety related initiatives, contact **Olga Sleigh, Head of Decontamination Services**

6. CONCLUSION

The Chelsea and Westminster Hospital NHS Foundation Trust is committed to the management of risk and this is clearly demonstrated by the progress that has been made during 2012/13, however there are still areas for improvement and these will be reflected in the risk management objectives for 2013/14.

To ensure that staff feel involved in the risk management process, can appreciate the benefits, and continue to report incidents, feedback mechanisms will continue to be developed during 2013/14.

All of the above requirements are to be addressed through the Trust's risk management systems. Good incident reporting and management practices can only be achieved through effective communication at all levels within the organisation, which is the lynchpin to the effectiveness of all risk management systems.

FREQUENTLY ASKED QUESTIONS ABOUT INCIDENT INVESTIGATION

APPENDIX 1

INCIDENT INVESTIGATION Q&A

Incident Investigation Q&A

1. How are incidents reviewed?

Red, Orange and many yellow incidents are subject to a detailed investigation. A key purpose of the investigation and subsequent report is to introduce safety measures and share learning from incidents, claims and complaints.

2. How is the quality and appropriateness of investigations checked?

The Director of Governance and Corporate Affairs, Head of Clinical Governance, and nominated membership of the investigation team (and other Directors, if necessary) reviews and approves a summary of the investigation and recommendations. The summary and recommendations are also presented at the Risk Management Committee and, where relevant, the Trust Executive Quality Committee, Information Governance Committee or the Health and Safety Committee.

3. How is learning shared?

Incidents which have been investigated, predominantly orange or red incidents, are presentation at the Risk Management or other relevant departmental and Trust-wide Committee. The causes of the incidents are discussed, along with contributory factors. Recommendations with trustwide implications are discussed and, where appropriate, directorates are allocated actions to mitigate the possible repeat of a similar incident in their departments - even if the incident happened elsewhere. Incident summary reports and action plans are published on the Intranet and frequently presented and discussed at clinical governance half day meetings.

4. How are the actions from incidents monitored?

A précis of the incident and the recommendations are placed on an incident review register, which tracks progress towards completion. The register is updated as recommendations are achieved. Actions are reviewed every quarter to ensure progress and identify any significant delays. The Incident Review Register is also uploaded on the Intranet and is available to view.

5. Why are some incidents still outstanding after some time?

There may be a variety of reasons. An incident is considered open until all the actions are complete and some actions outstanding may be relatively minor. Some delays have occurred as the named individual for an action has left the trust and the action has not been reassigned yet. Directorates are being encouraged to prioritise their actions so the most significant relating to the root cause(s) are actioned first. This is, however, an area that requires some attention.

7. **Are incidents linked to complaints and claims?**

Yes. Incidents, complaints, claims and PALS enquiries are all recorded on our Risk Management Reporting System and, where applicable, are linked.

8. What do we do to involve and support patients, relatives or carers affected by incidents?

The Trust has a policy describing what we do to ensure that we are open and honest with patients who are affected by incidents. Our investigations will always address and consider the extent to which those affected have been given an accurate, open, timely and clear explanation of what has happened, regardless of, but with sensitivity to, the distressing nature of the incident. We also provide information to those affected to explain what is going to happen regarding any investigation.

Patients, relatives or carers affected by serious incidents are advised of investigations and notified that findings will be shared with them as they wish, and advised of whom they can contact should they want information on the progress toward completing investigations, or implementation of recommendations.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 July 2013 (PUBLIC)

AGENDA ITEM NO.	3.7/Jul/13
PAPER	Complaints Annual Report 2012/2013
AUTHOR	Carol Davis; Head of Patient Affairs
LEAD	Tony Pritchard; Acting Chief Nurse
PURPOSE	• To report Complaints and Patient Advice and Liaison Service (PALS) activity during the year 2011/2012. • To report on the number and type of issues and complaints received. • To present a summary of key trends in complaints and concerns raised. • To report on performance in relation to the complaints response process. • To summarise organizational change and development in response to feedback from complaints and concerns.
LINK TO OBJECTIVES	Improving the patient experience
RISK ISSUES	It is essential that issues raised from complaints and concerns are dealt with in a sensitive and timely manner so as to prevent re-occurrence or escalation of incidents.
FINANCIAL ISSUES	NA
OTHER ISSUES	NA
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This report presents the feedback and trends identified by the complaints team during the year 2012/2013. It provides a details of the number and type of complaints and concerns, information on performance in the response process, and organisational change initiated in response to feedback from

	complaints and concerns. . A total of 809 type 1 concerns were received with the top 3 most common concerns being appointments/delay or cancellation (out-patients), attitude of staff and written / oral information given to patients. 354 type 2 and 23 type 3 complaints were received from the 1st April 2012 to 31st March 2013. There was a 14% reduction in the number of formal complaints received between the year 2011/2012 and the year 2012/2013 The top 3 complaints by subject relate to aspects of clinical care or treatment, attitude or behavior of staff and written / oral information given to patients. The Chief Executive, the Chief Operating Officer and the Chief Nurse review all the final responses to ensure the quality of the investigation The Trust demonstrates a positive approach to organisational learning and development from complaints. This is integrated to our patient experience strategy and into local service changes.
DECISION/ ACTION	The Board is asked to receive and comment on the. Complaints and MPALS Annual Report summary 2012/2013.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Annual Complaints Report

2012/2013

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1.0 Introduction

1.1. This report presents a summary of the feedback and trends identified by the Complaints Team during the year 2012/2013. The aim of this report is to provide an overview of trends identified through the complaints process. The report outlines how the Trust responded to the complaints and identifies the action the Trust has taken to improve services in response to concerns and complaints.

1.2. In February 2013, the Francis report was published. The Francis report is the result of an inquiry into the role of commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire NHS Foundation Trust. The Inquiry asked fundamental questions as to how the failings in care were not dealt with sooner and what more regulators can do to tackle cases of poor care and prevent future incidents from happening elsewhere. The Francis Report also highlighted serious failures with the complaints process and the performance of the Trust Board. The report said: 'It [the Board] did not listen sufficiently to its patients or its staff or ensure the correction of deficiencies brought to the Trust's attention …' Trust boards should be looking at what is happening on their wards and where there are problems they must act or be responsible for the failings. The report delivers 290 recommendations many of which focus on putting the patient at the centre of how the NHS delivers care. Following the Francis report a review of hospital complaints was announced by the Prime Minister. The Clwyd and Hart review of NHS hospital complaint handling will involve patients, their carers and representatives, staff and managers and other organisations involved in handling patient complaints to hear how trusts currently deal with concerns that are raised. It will also look at what common standards can be applied to the handling of complaints, how intelligence from concerns and complaints can be used to improve service delivery, the role of the trust board and senior managers in developing a culture that takes the concerns of individuals seriously and acts on them, the skills and behaviors that staff need to ensure people's concerns are at the heart of their work, and how concerns raised by staff are handled, including support for whistleblowers.

2.0 Background

2.1. The current complaint handling regulations were introduced in April 2009 (The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 Statutory Instrument), together with guidance from the Department of Health ('Listening, Responding, and improving 2009"). A direct relationship between the Ombudsman and health bodies is embedded within the complaints system's structure. The Ombudsman has stated that when the NHS listens to patients and takes action on what they say, it can make a direct and immediate difference to the care and treatment that patient's experience.

2.2. Through its complaints policy, the Trust ensures that people, and those acting on their behalf have their comments and complaints listened to and acted on effectively, and know that they will not be discriminated against for making a complaint.

2.3. The issues raised from complaints are dealt with in a sensitive and timely manner to prevent re-occurrence or escalation of incidents. Staff are trained and supported to do this by acknowledging the problem or concern being raised and where possible resolving the issue at an early stage. The complaints and concerns we receive inform the action plans relating to the Patient Experience.

2.4. The regulations no longer stipulate a specific time-scale for responding to complaints; the Trust has therefore determined three levels of response to complaints and concerns, together with set targets for response (see Table 1).

Table 1: Grading of Concerns and Complaints

Type	Description	Timescale for Response	Target for Response
Type 1	Low Risk**[MPALS]**	10 working days	> 90%
Type 2	Medium Risk	25 working days	> 90%
Type 3	High Risk	50 Working days	> 90%

3.0 Total Complaint Numbers: Monthly Trend

Table 2: Number of Complaints Performance, April 2010 –March 2011

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total number Type 2	23	24	41	22	33	29	32	37	24	36	35	43	**379**
Performance	87%	83%	83%	86%	82%	86%	90%	84%	88%	67%	74%	88%	**83%**
Total number Type 3	0	0	0	0	1	1	1	2	0	0	0	3	**8**

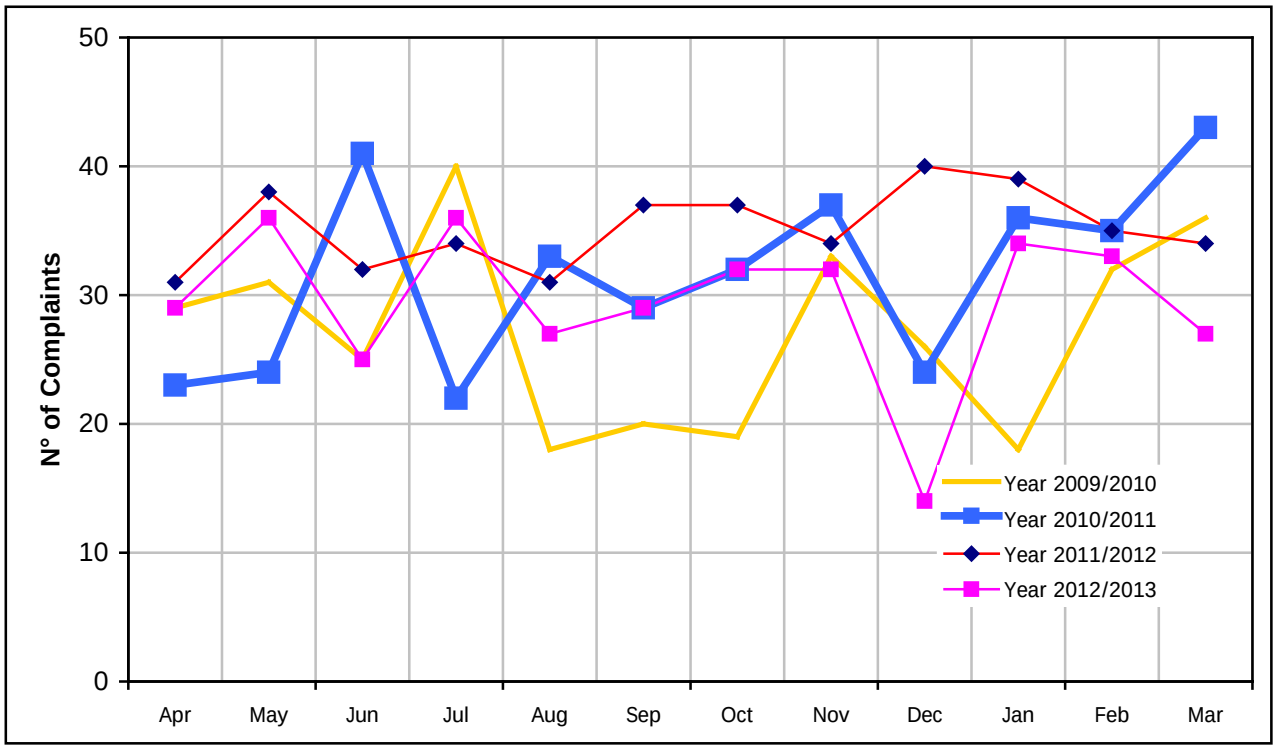
Table 3: Number of Complaints/ Performance, April 2011 –March 2012

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total number Type 2	29	37	32	34	31	37	37	34	40	39	35	34	**419**
Performance	76%	73%	75%	85%	84%	81%	95%	82%	70%	69%	97%	82%	**80%**
Total number Type 3	3	1	1	2	1	0	3	4	2	0	0	0	**17**

Table 4: Number of Complaints/ Performance, April 2012 –December 2013

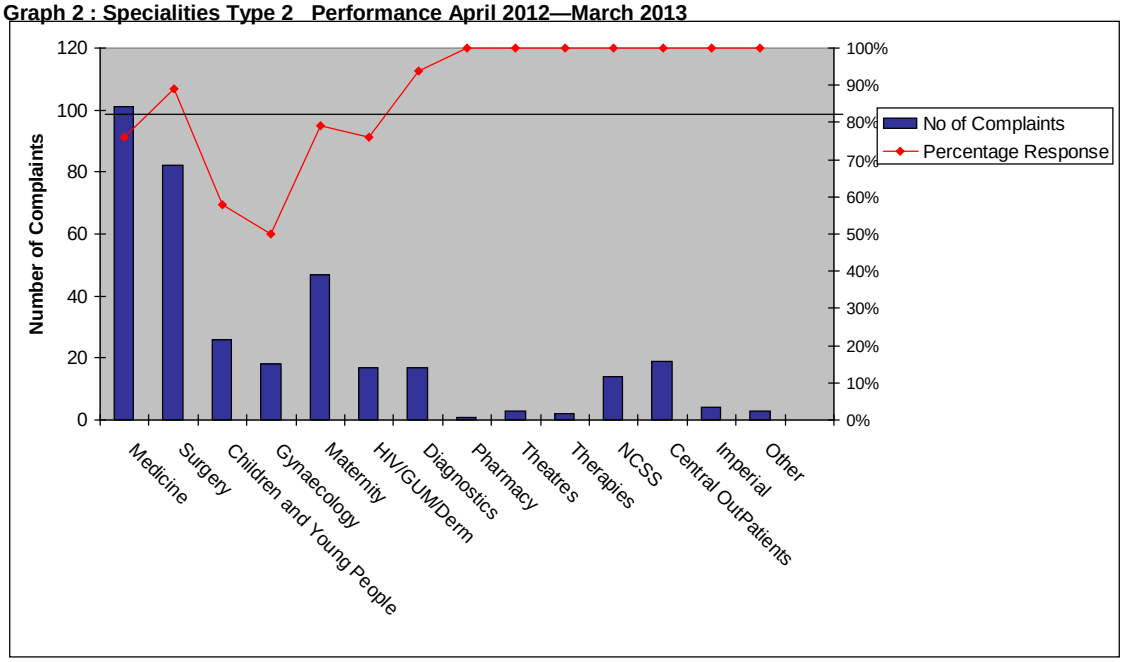
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total number Type 2	29	36	25	36	27	29	32	32	14	34	33	27	**354**
Performance	69%	83%	80%	75%	89%	86%	84%	88%	64%	80%	79%	78%	81%
Total number Type 3	2	1	0	2	1	2	0	2	2	1	7	3	**23**

Graph 1: Complaints between April 2009 –March 2013



The graph compares the number of complaints received each month during the current financial year with the three previous years. A total of 354 type 2 were received during the year 2012-2013. This compares with 419 type 2 received during the year 2011-2012. Of the Type 2 concerns (81%) were responded to and resolved by the Directorates within 25 days, this falls below the Trust target to respond to 90% of Type 2 complaints within 25 days.

Graph 2 : Specialities Type 2 Performance April 2012—March 2013



23 type 3 complaints were received during the year 2012-2013 compared with 17 type 3 complaints received during 2011-2012. The response times for the type 3 complaints was extended to 50 working days to allow for the type of investigation required. All complaints identified clinical care as the primary subject. 7 of the type 3 complaints received a response within 50 working days, 16 received a response after 50 days.

Table 5: Total Number Complaints by Directorate: April 2012-March 2013

Directorates	Type2	Type3
Clinical Support Services	23	
Medicine	101	7
Surgery	82	6
Children, Young People and Neonatal Services	26	6
Gynaecology	18	2
Maternity	47	1
HIV/GUM/Dermatology	17	1
NCSS	14	
Central Outpatients	19	
Imperial	4	
Other		
Total	354	23

4.0 Complaints by Area

The areas with the highest number of complaints during the year 2012-2013 are:

Table 6: 2012-2013 Areas with Highest Number of Complaints

Emergency Department[adult]	42	Complaints
AAU	21	Complaints
Labour Ward	20	Complaints

4.1 Emergency Department

Table 7: Emergency Department by Subject 2012-2013

	CLINICAL CARE	ATTITUDE	INFORMATION	DISCHARGE	OTHER
Medical Staff	21	10	3	3	1
Nursing Staff	5	8	1	1	5

NB: Where there is a discrepancy between the total numbers of complaints reported in an area and the total number where the complaints are analysed, this is because some complainants identify more than one area or issue which is reflected in the tables above.

4.1.1. Last year there were approximately 112,000 attendances in the Emergency Department. 42 complaints were received relating to the Adult Emergency Department. 26 concerns were raised relating to the clinical care received in the Emergency Department this compares with 23 received last year. These are analysed in section **5.1.2**

4.1.2. 18 concerns were raised relating to the attitude of staff compared with 4 last year whilst 4 complainants raised concerns regarding the discharge of elderly patients. A further 8 complaints were received relating to the Paediatric Area of the Emergency Department.

4.2 AAU

Table 8: AAU by Subject 2012-2013

	CLINICAL CARE	ATTITUDE	INFORMATION	OTHER
Medical Staff	9		2	3
Nursing Staff	6			1

NB. Where there is a discrepancy between the total numbers of complaints reported in an area and the total number where the complaints are analysed, this is because some complainants identify more than one area or issue which is reflected in the tables above.

4.2.1. 21 complaints were received relating to the Acute Assessment Unit; 25 issues were identified. Of note no complaints were received relating to staff attitude or behaviour. However, there was an increase in the number of formal complaints relating to the clinical care of patients on AAU.

4.2.2. Mind the Gap is an initiative on the Acute Assessment Unit (AAU) led by junior doctors and facilitated by NIHR CLAHRC for North West London. This will shorten the time it takes to see and treat patients admitted to the Unit and allow patients to get tests and critical medicines immediately after their arrival on the unit rather than after a full medical history has been taken.

4.2.3. Emergency General Medical patients admitted to the Acute Admissions Unit (AAU) are now reviewed by the on-call consultant on twice daily ward-rounds, in the morning and the evening; increasing the number of medical patients that are seen by a consultant within 12 hours of their admission. For Emergency General Surgical patients admitted to the AAU there are now twice daily ward rounds conducted by the on-call General Surgeon.

4.3 Labour Ward

Table 9: Labour Ward by Subject 2012-2013

	CLINICAL CARE	ATTITUDE	INFORMATION	OTHER
Medical Staff	9	3	1	1
Midwife Staff	11	5		1

NB. Where there is a discrepancy between the total numbers of complaints reported in an area and the total number where the complaints are analysed, this is because some complainants identify more than one area or issue which is reflected in the tables above.

The Labour Ward received 20 formal complaints, 31 issues were raised. 16 formal complaints were made about the clinical care on the Labour Ward compared to 14 last year. These are analysed in section **5.1.4.**

4.4 Outpatients

4.4.1. Between April 2012 and March 2013 the outpatient activity is recorded as 649,500. During this period 166 type 2 complaints were received relating to patients experience in the outpatient areas. The themes identified include information for patients in relation to cancelled or changed appointments, information about waiting times or delays in clinic, information regarding decisions about care and treatment. The outpatient areas with the highest number of complaints are:

Outpatients 3- 21 complaints received
Paediatric Outpatients- 10 complaints received
Surgical Admissions Office- 9 complaints received
The central outpatient team now sits in Clinical support Services. The Central outpatient team addresses issues relating to the infrastructure and organisation of clinics.

4.4.2. Further customer care training is planned for staff within outpatient areas. Key prompts for customer care have been developed for reception staff in these areas. Guidelines for staff on informing and updating patients of delays to waiting times have been developed for outpatient staff.

4.4.3. Volunteers have been working in Lower Ground Floor outpatients to provide a friendly welcome and to support to older patients if required.

4.4.4. A service improvement plan of the admissions department has been undertaken. This looked at the department's capacity, processes and resources. As part of the process a new telephone system was introduced to ensure all patients who are trying to get through to the department are communicated with efficiently and expediently. The aim is that the system will eliminate unanswered calls and that queries will be dealt with in a prompt and timely fashion by a knowledgeable staff member.

5. Complaints by Subject 2012/2013

The top three subjects remain the same as the previous year, clinical care, attitude and information. The published national data relating to complaints undertaken by the Health and Social care Information Centre for 2012-2013 is not yet available. This will be reported in quarter one.

Graph 3: Complaints by Primary Subject 2012/2013

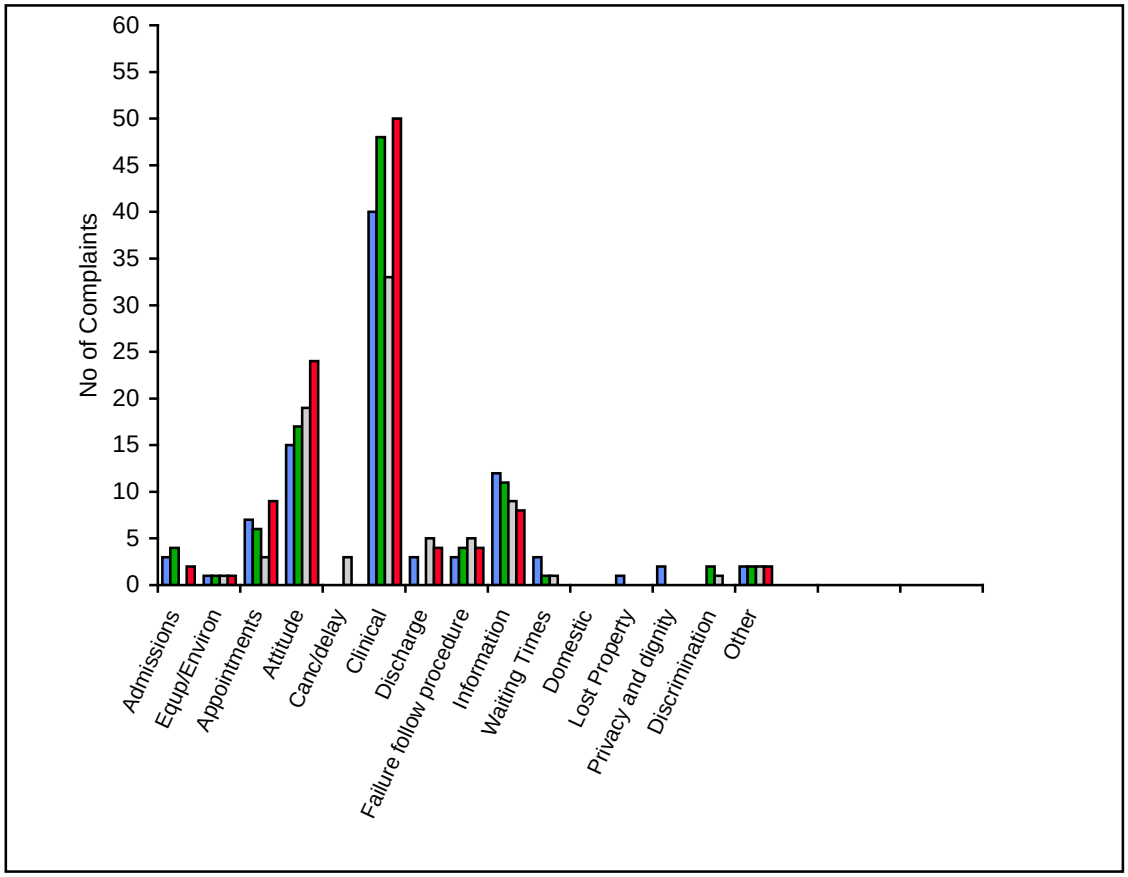


Table 10: Top 3 Primary Subjects 2012/2013

Subject	Number of Complaints
Aspects of Clinical Care	171 [45%]
Attitude or behaviour of staff	75 [20%]
Information	40 [11%]

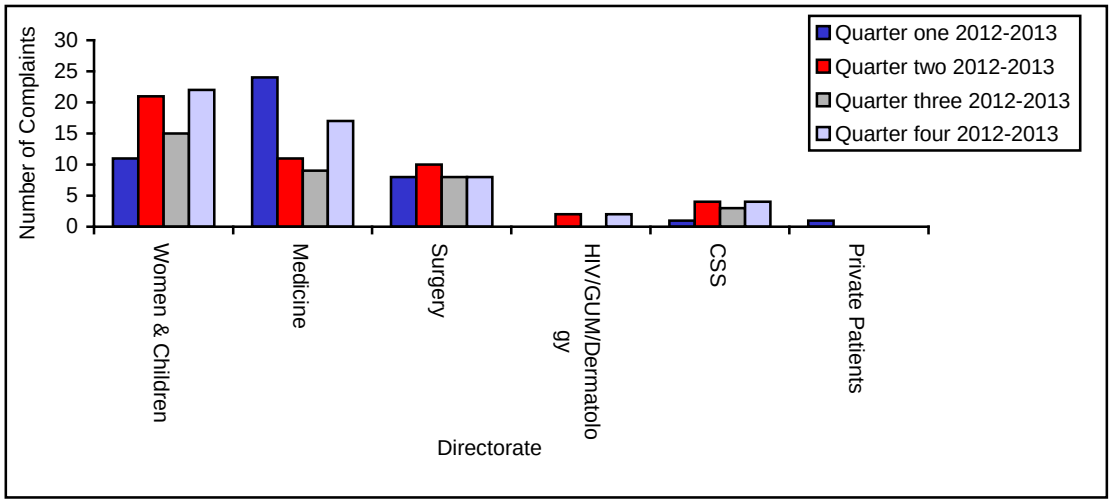
Table 11: Top 3 Primary Subjects 2011/2012

Subject	Number of Complaints
Aspects of Clinical Care or Treatment	206 [47%]
Attitude or behaviour of staff	90 [21%]
Information	40 [9.5%]

5.1 Aspects of Clinical Care or Treatment

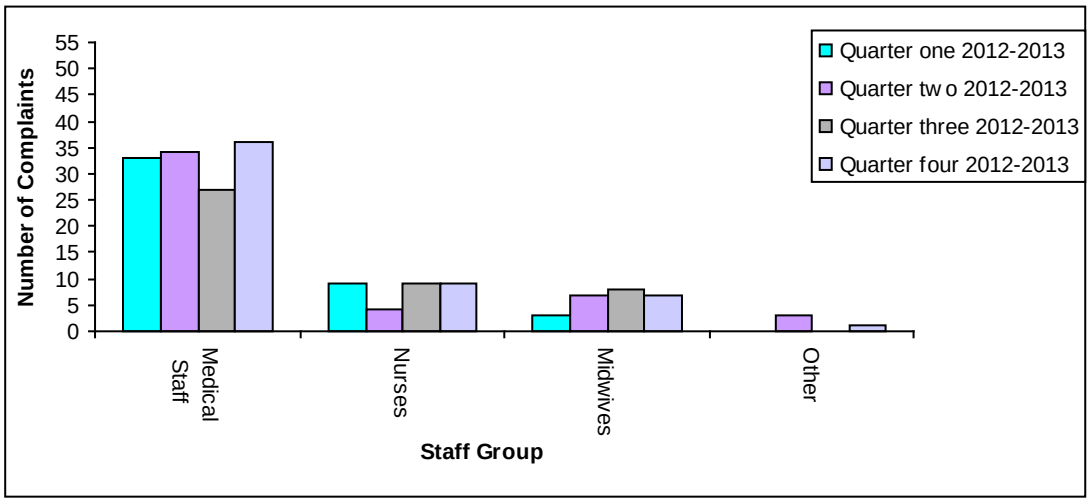
During 2012/2013 the Trust received 171 complaints where the primary concern relates to clinical care or treatment. 10 other complainants raised clinical care as a concern but not as the primary complaint.

Graph 4: Complaints about Clinical Care or Treatment by Directorate



NB: Where there is a discrepancy between the total numbers of complaints reported in an area and the total number where the complaints are analysed, this is because some complainants identify more than one member of staff where a concern is raised about clinical care.

Graph 5: Complaints about Clinical Care or Treatment by staff



NB: Where there is a discrepancy between the total number of complaints reported and the numbers where the complaints are analysed, this is because some complainants have identified more than one member of staff with regard to their Clinical Care.

5.1.1 Aspects of Clinical Care or Treatment –Medical Staff

Table 12: Aspects of Clinical Care Medical Staff by speciality

Speciality	Medical
Anaesthetics	***2***
Cardiology	***4***
Colorectal	***1***
Elderly care	***1***
Emergency Department	***19***
Endoscopy	***3***
Gastroenterology	***5***
General Medicine	***9***
General Surgery	***6***
GUM	***1***
Gynaecology	***12***
Hand Management	***1***
HIV	***3***
Maternity	***15 [23]***
Metabolic Medicine	***1***
Neonatology	***3***
Oncology	***1***

Ophthalmology	***3***
Paediatrics	***18***
Palliative Medicine	***1***
Plastic Surgery	***1***
Radiology	***1***
Rheumatology	***1***
Stroke Service	***2***
Trauma and Orthopaedics	***10***
Ultrasound	***1***
Urology	***5***

130 concerns were raised regarding the clinical treatment of patients by medical staff. The reasons for these complaints include poor communication regarding the rationale for treatment decisions and the quality of treatment given. All complaints regarding clinical treatment are raised with the clinician concerned and inform their annual appraisal. In response to concerns raised about clinical care full explanations and apologies are given in line with the "Being Open" principles.

5.1.2 Aspects of Clinical Care or Treatment – Emergency Department

19 concerns were raised about the clinical care received from medical staff in the Emergency Department, 11 of these being upheld by investigation. 4 complaints related to nursing of which one was upheld. Examples include

- A patient's condition was not initially diagnosed and they were discharged in extreme pain. An urgent outpatient appointment should have been given as opposed to a routine one
- A missed fracture which was discussed with the doctor concerned as a point of learning for future practice.
- A contradictory diagnosis provided by 2 doctors. A senior Consultant met with the junior doctor to address the complaint and highlight points of learning to inform future practice.
- Delayed diagnosis of a fracture. The doctor underestimated the completeness of the fracture and the true significance of the x ray appearances.
- An Inaccurate diagnosis due to inadequate history taking and examination
- A missed diagnosis which was later diagnosed elsewhere
- Treatment of a patient with was not treated with the urgency it merited. The induction course for new doctors includes guidance in accordance with NICE algorithm.
- A patient was discharged with inadequate treatment. The emergency and radiology departments plan to introduce a more robust process to avoid reoccurrence. A consultant

review book has been introduced and the time a consultant is present in the department has been increased to 10:30pm. An electronic system of alerting ED doctors when radiology reports are finalised is being considered.

- Failure to take patients concerns seriously or listen to them and failure to seek specialist advice. A senior Consultant resolved the complaint by speaking with the patient and has met with both teams to address concerns which will be used as learning for future practice.

- Nursing staff viewed as rude and inattentive, the person left in pain and was not given sufficient analgesia. "Comfort care rounds' have now been introduced to regularly check on patients wellbeing

5.1.3 Aspects of Clinical Care or Treatment – Paediatric Department

18 concerns were raised about aspects of the clinical care given to children by medical staff, a further two complaints were received relating to the clinical care of paediatric nursing staff. One consistent theme relating to a number of complaints received this year was a lack of communication with parents about the clinical management of their children. Six of the complaints relating to Paediatric clinical care were graded as type three.

- Parents of a child expressed concern with care management and lack of communication / information The process with regard to internal referrals now includes e-mail as well as via internal post

- Parent reported that child did not receive a review as agreed and child then underwent an emergency procedure at another hospital. Apologies were given for any anxiety or distress caused by the doctor's manner. Further attempt could have been made to commence intravenous fluids

- Parent raised concerns that child was dismissed on numerous occasions and a correct diagnosis was not made until they were taken elsewhere. It was identified that initial management was appropriate, but that on re-presenting they should have been seen by a senior clinician. Steps are being taken to ensure there is a greater presence of consultants within the department.

- Parent raised concern about long waits in clinic, that communication about delays was poor and the consultation was very short. The clinic template has been revised to help ensure that those patients with pre-booked follow-up appointments are seen as close as possible to their allocated clinic time.

- Parent complained about child’s care management and conflicting information by two different consultants. Apologies were given for the shortfall in communication the parent of the child received. .

5.1.4 Aspects of Clinical Care or Treatment –Maternity

13 concerns were raised where the primary concern was the clinical care given by medical staff in the Maternity unit. However in total 36 complainants raised concerns about aspects of the clinical care they received from our Maternity service. 23 complainants identified the clinical care they received from midwives as their primary concern. The Maternity services received a total of 49 formal complaints.
17 complaints were received relating to the clinical care during the birth. 13 complaints were received relating to post natal clinical care. One complaint relating to Maternity services was as graded as type three

With regard to the labour ward, 16 complainants raised concerns about their clinical care. In total 20 members of staff were identified; 11 midwives and 9 doctors. The complainants identified that individual care plans were not being followed and they did not receive full explanations for the rationale behind decisions made. Women described feeling that their labour was not managed pro-actively. Several of the complaints relating to clinical care were from women who felt that they had not been listened to when they had expressed the level of pain and had not received adequate pain relief.
With regard to post natal care, concerns related to blood levels not being checked after birth, despite being requested several times, concerns that a baby's condition was left undiagnosed for 6 days, despite being regularly assessed by several midwifery and medical practitioners during this time, and incorrect advice following the birth regarding breast-feeding. In general concerns were expressed regarding the lack of observations on mothers and babies and the failure to monitor changes. Concerns were raised regarding the behaviour of staff who showed no empathy or respect.

Last year we reported that breast feeding issues consistently figured in complaints regarding postnatal care and this mainly centred around lack of support. This year there has been a significant reduction in the number of complaints relating to this aspect of care; this can be attributed to the 40 breastfeeding peer supporters who were recruited alongside a new breastfeeding lead. The Trust/Maternity Service has received Stage 3 of Baby Friendly Accreditation which is a UNICEF Quality Award for the commitment to breast feeding. The infant feeding team (consisting of 2 specialist Midwives) are now working regular clinical shifts on the ward to monitor and support best practice.

The equality and diversity lead for the Trust has undertaken cultural awareness training within the department particularly around issues on assisting with hygiene needs. This will be mainstreamed within the mandatory training for all staff groups annually.

All midwives or doctors involved in a complaint were met either by their midwifery manager or their consultant/divisional medical director to talk through the care they had provided and to identify points of learning.

All complaints were fully investigated and meetings were offered with senior midwife or consultant. The Birth Afterthoughts Midwife continues to be valuable in effectively resolving concerns and reassuring new mothers. "Thank you for taking the time to talk to me, after that I have felt happier as you were very empathetic to my feelings. I have also felt more confident regarding my future care in the Chelsea and Westminster"

5.1.5. Aspects of Clinical Care or Treatment –Nursing Staff

Table 13: Aspects of Clinical Care Nursing Staff by area

Location	Nursing
AAU	***6***
ACU	***1***
Burns	***1***
David Erskine	***1***
Daniel Turner	***1***
Edgar Horne	***1***
ED	***4***
Endoscopy	***1***
Nell Gwynne	***7***
Rainsford Mowlem	***1***
Recovery	***2***

31 concerns were raised regarding the clinical care of nursing staff. In response to a number of concerns raised over a period of time relating to Nell Gwynne ward, a multi-professional Rapid Improvement Leadership Group was implemented; this was chaired by the Divisional Director of Operations and supported by the Deputy Chief Nurse. Alongside this, separate meetings have taken place with the Chief Nurse and the Tri-borough Safe Guarding Lead in order to discuss progress, demonstrate openness and transparency in the management of concerns and to provide assurance that the concerns raised are being addressed. An action plan has been developed. Our local LINK's undertook observational audits over a three day period on the ward. A report was written highlighting aspects of good practice and areas for improvement. Recommendations were suggested including improvements to the environment, patient information and communication. In January the first stroke patient forum was held and was attended by 7 former patients. A progress report was submitted to the Quality Committee in January 2013 and a further updated report was submitted in March 2013.

Within the Medical and Surgical Division, comfort rounds have been rolled out to all the inpatient areas.

The Trust aims to undertake dementia screening on all patients who are admitted as inpatients. The dementia steering group meets every month to coordinate strategy and drive changes. This year the Volunteer Services carried out a Kings Fund Environmental Audits on all adult wards; this helped to identify changes that we could make to improve the environment. Funding has now been agreed for a dementia case manager to improve how we identify and care for patients with dementia.

As part of the Patient Experience Campaign the Medicine and Surgery Division have developed a discharge campaign group. The group was brought together to explore the theme of discharge from the patient experience perspective. The Division is developing a seven/seven discharge support to enhance the links with carers, and ensure consistent use of the choice policy and best interest documentation. A Palliative and End of Life Care Discharge Liaison Nurse has now been employed and works as part of the discharge team.

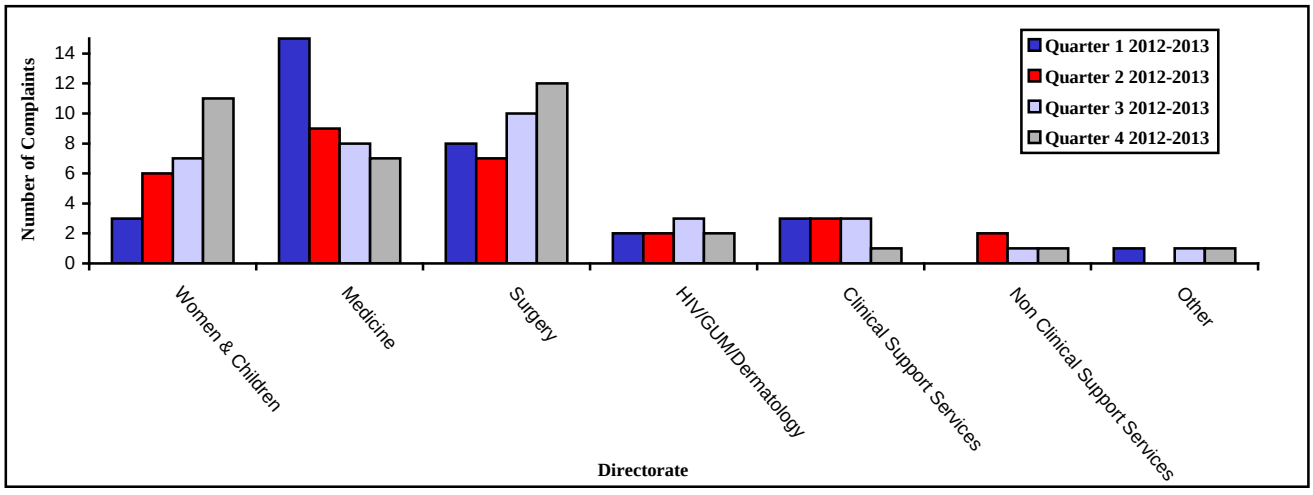
An important part of understanding how we provide care to patients and what needs to be improved is seeing what actually happens on the wards and in departments. Senior clinical rounds were introduced in March 2013. The visits provide a board to ward approach through linking senior nurses and managers with patients and families, whilst providing a visible presence for staff within clinical areas. The visits focus on our priorities around safety, effectiveness, and patient experience and emphasise the Trust values of respectful, kind, safe, and excellent. Anything arising from these visits is taken to the Senior Nursing and Midwifery Committee and the Patient and Staff Experience Committee and reported back to the quality and assurance committees and relevant divisional meetings.

The health and social care regulator, the Care Quality Commission (CQC), carried out an unannounced inspection of the Trust on the 26 July 2012. The visit aimed to find out whether Chelsea and Westminster was meeting its Essential Standards of Quality and Safety. Inspections of this kind are normal procedure for all NHS trusts. The inspection was part of a themed inspection programme to assess whether older people in hospitals are treated with dignity and respect, and whether they are getting enough to eat. The CQC inspectors visited three wards and departments in the hospital, and spoke to staff, visitors and patients about care provision. Patients told the inspectors that they felt well looked after and that staff were attentive and caring. Feedback about the hospital, the ward environment, choice of menu, facilities and surroundings was generally positive. The CQC found that the Trust met all the essential standards.

5.2 Attitude or Behaviour of Staff

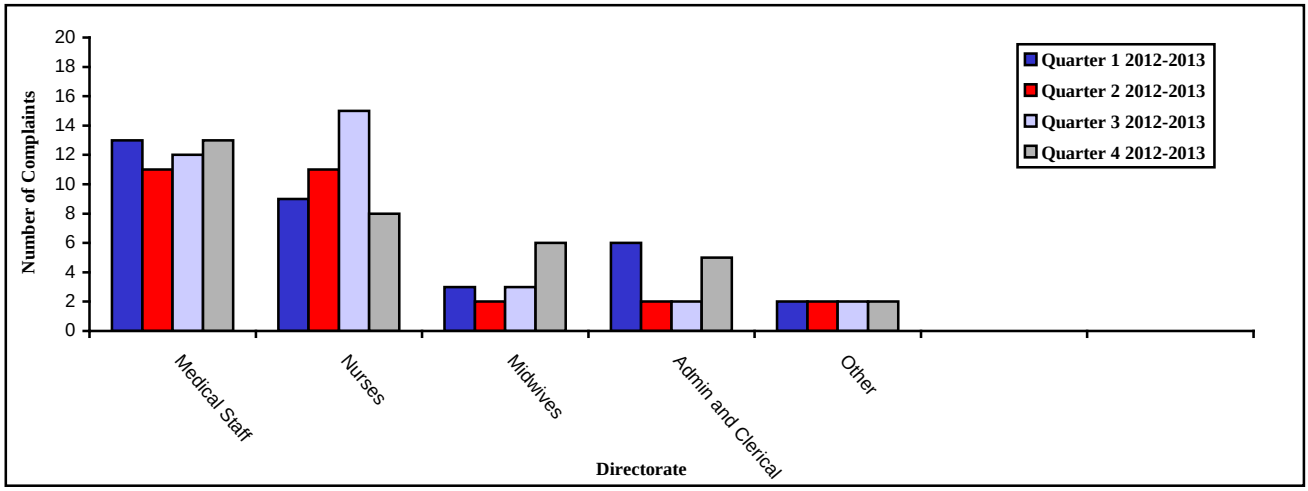
During 2012-2013 the Trust received 75 complaints or concerns where the primary concern related to the attitude and behaviour of staff. A further 54 complainants identified concerns regarding the attitude of staff but not as the primary concern.

Graph 6: All Complaints about Attitude and Behaviour by Directorate 2012/2013



NB: Where there is a discrepancy between the total number of complaints reported and the numbers where the complaints are analysed, this is because some complainants have identified more than one member of staff with regard to Attitude or Behaviour.

Graph 7: All Complaints about Attitude and Behaviour by Staff Group 2012/2013



NB: Where there is a discrepancy between the total number of complaints reported and the numbers where the complaints are analysed, this is because some complainants have identified more than one member of staff with regard to Attitude or Behaviour.

5.2.1 Attitude or Behaviour of Staff Medical

Table 14: Attitude or Behaviour of Medical Staff by speciality

Speciality	Medical
Anaesthetics	***1***
Dermatology	***2***
ED	***9***
Endoscopy	***1***
Gastroenterology	***6***
General Medicine	***2***
General Surgery	***1***
GUM	***1***
Gynaecology	***4***
HIV	***1***
Imaging	***1***
Maternity	***2***
Neonatology	***1***
Ophthalmology	***1***
Pain	***5***
Paediatrics	***2***
Plastics	***2***

Respiratory	***2***
Stroke Service	***1***
Ultrasound	***1***
Urology	***5***

49 concerns were raised regarding the attitude or behaviour of medical staff. The main themes that arose from the complaints were that staff were dismissive and unsympathetic or did not listen to the patient.

5 complainants raised a concern about the attitude of a member of the Urology team. This was managed by the Service Lead under the appropriate HR process with the support of the General Manager. The Divisional Director of Operations, the Divisional Medical Director and the Medical Director are aware of the issues raised and the actions taken.

5.2.2 Attitude or Behaviour of Staff Nursing

Table 15: Attitude or Behaviour of Staff Nursing by speciality

Area	Nursing
AAU	***1***
Annie Zunz	***1***
Burns Unit	***1***
Chelsea Wing	***1***
ED	***9***
Edgar Horne	***1***
Endoscopy	***1***
Daniel Turner	***2***
David Erskine	***2***
David Evans	***6***
Labour Ward	***1***
Lord Wigram	***1***
Mercury	***1***
Nell Gwynne	***4***
OP1	***1***
OP3	***1***
Pre assessment	***1***
Rainsford Mowlem	***6***
Ron Johnson	***1***

43 concerns were raised regarding the attitude or behaviour of nursing staff. Complaints in the category relating to staff attitude and/or behaviour include concerns raised about rudeness, lack of sympathy, apparent disinterest and not providing a standard of personal service expected by the complainant.

Six complaints were received relating to staff attitude and behaviour on Rainsford Mowlem Ward. The issues identified by patients or their relatives were that a member of staff did not treat patients with respect or dignity. One member of staff was described as unhelpful, rude and uncaring. Whilst a member of staff was seen as aggressive and shouted at an elderly patient. Two of the complaints received were investigated with the support of Human Resources Team in accordance with the Trust's Disciplinary process.

The Ward Sister and Divisional Matron have undertaken teaching on the staff away days with regard to communication. The staff were sent a letter to explain that the number of complaints relating to their area had increased; they were asked to reflect on how this can be changed and how the patient experience can be improved. A display board has been introduced to the staff room which highlights the themes raised through concerns and complaints.

Six complaints were received relating to staff attitude on David Evans ward. 4 complainants identified issues with regard to pain relief and felt that the nursing staff did not demonstrate any compassion or advocate on behalf of the patient. The ward sister is working with the acute pain team to provide teaching updates for the team with regard to pain management.

Visits are now been undertaken by Senior Nursing Staff, this helps to capture feedback from patients who do not tend to access the PALS or complaints service if there are concerns.

5.3 Communication

During 2012-2013 the Trust received 40 complaints or concerns where the primary concern related to the communication and information given to our patients, a further 24 complainants identified concerns relating to the information and communication they had received.

Communication remains a key theme that has been identified in our recent inpatient and outpatient surveys. Communication is a core strand of the strategy to improve the patient experience at the hospital.

A range of improvements and initiatives have been taken forward over the past year, a summary of our values and behaviours was produced as a centre page poster and distributed in Trust News in October. A detailed plan for embedding values and beliefs within the organisation has been developed. Changes introduced include more information to patients on ward routines, 'patient experience reminder' sheets for staff, more information displayed in waiting areas on likely waiting times.

The Trust lead for Patient Experience is now in post. A key objective is to support teams across the Trust in relating the Trust values to their own work and role so that the values are owned and embedded by individuals and teams. A number of people are working on a part time basis to act as patient experience links with the divisions. A patient and staff experience committee meets every 6 weeks with representation from different groups of staff and patients representatives.

As a result of the feedback large identification badges have been introduced. These badges are compulsory for all staff and identify in large print the name and position of the individual, thereby

allowing patients to more easily verify the medical professionals they are being treated by.

A 'patient passport' has been developed for those with a learning disability to enable communication and continuity of care.

"You Said-We did" notice boards are to be placed in all key clinical areas, these will provide a summary of the feedback relating to these areas and what has been done to address any area of concern. The aim is to display the three headline scores with information regarding what our patients are saying about the area, their care and improvements that patients have suggested. Information with three areas for improvement will also be displayed with actions of how these will be addressed and how this will improve care or the patient experience.

The complaints team will continue to monitor action plans with respect to complaints, where communication is a contributory factor. Feedback from complaints and also within the patient surveys will be used as a source of assurance that the controls and measures in place to improve communication are effective.

6.0. Complaints Graded as Moderate or High

6.1. Complaints are graded using the Trust matrix incorporating consequence to the patient and/or the organisation, and the likelihood of the incident recurring. Those complaints which are graded as Orange or Red i.e. Type 3 will require a longer time scale and this should be discussed and agreed with the complainant. If a complaint is received, the incident procedure should take preference in terms of an investigation. Those involved in the investigation should be provided with a copy of the complaint. The issues raised by the complainant will be taken into consideration when agreeing the Terms of Reference. The complaint should be acknowledged in the usual way but permission should be sought from the complainant to extend the time limit beyond 25 working days. It is important that a member of the Directorate is identified to liaise with the complainant and update them about the progress of the investigation and the timescales. With regard to the length of time taken to complete the reviews and provide a response, the risk management team have undertaken further training to increase the pool of staff able to perform this role.

6.2. Information relating to the 23 complaints graded as moderate to high reported during 2012/13 was considered by the various committees with overarching responsibility for risk, including the Trust Risk Management Committee, the Assurance Committee and the Patient & Staff Experience Committee

6.3. This level of detail is not available to the general public as it is considered that the synopsis of each incident at a case by case level may reveal the identity of people affected by these incidents. The Trust has therefore introduced measures to remove this level of detail from the annual report, to ensure that information about an individual whose identity is apparent or can reasonably be ascertained from the information or synopsis is protected.

7.0 Parliamentary Health Service Ombudsman

7.1. Around 10% of all complaints made about NHS services are brought to the Ombudsman. The Ombudsman is independent and is not part of government or the NHS. They are the final step in the NHS complaints process and their role is to investigate complaints that people have been treated unfairly or have received poor care. The Ombudsman considers the issues that each complaint raises, examine how the NHS trust responded, take clinical advice if needed, and then reach a decision. The initial decision is whether or not the PHSO will investigate the complaint. If they decide to investigate they write to the Trust with their findings and any recommendations.

7.2. Last year, the Ombudsman received 50% more complaints from people who felt that the NHS had not acknowledged mistakes in care. They also received more complaints from people who felt they had not received a clear or adequate explanation in response to their complaints, and more complaints about inadequate remedies, including apologies. The goal of the Ombudsman is to see an NHS that is much better at listening to patients and their families and responding to their concerns. Local and early resolution of complaints for individuals is important. "An effective complaints process should also drive learning from ward level to board level so that possible systemic problems can be picked up more quickly and lessons learned."

7.3. Last year 8 complainants referred their complaint to the Parliamentary and Health Service Ombudsman for an independent review. In seven cases, the PHSO decided they would not accept the complaint for investigation and would take no further action. In one case the patient was referred back to the Trust for further local resolution, once this had been completed, the Ombudsman advised they would take no further action. The Trust has taken reassurance that the complaints referred to the Ombudsman have not been accepted for investigation or upheld.

7.4. From April 2013, the Ombudsman's office has advised that they will begin investigating and sharing reports on more of the complaints. This is part of their new strategy 'More Impact for More People'. They will be investigating thousands rather than hundreds of complaints each year. The Ombudsman will continue to publish figures for the number of complaints they investigate about each organisation in their jurisdiction, but will be explicit that the change of process is a reason for the significant increase in the number of investigations they will undertake during 2013/14.

8.0. Redress

8.1. The Parliamentary and Health Service Ombudsman is clear within her Principles of Good Complaints Handling (February 2009) that "putting things right" should include, where appropriate, financial compensation for direct or indirect financial loss, loss of opportunity, inconvenience, distress or any combination of these. The level of compensation decided should take in to account:

- The nature of the complaint
- The impact on the complainant
- How long it took to resolve the complaint
- The trouble the complainant was put to in pursuing it

9.0 Reopened Complaints

9.1. Of the type 2 and type 3 complaints received between 1st April 2012 and 31st March 2013, 23 have been reopened to date, 6% of the complaints received.

9.2. Complainants who were unhappy with their responses felt that there were discrepancies between what was said in the response and their recollection of events. Some complainants felt that the investigation had been superficial and had not addressed the concerns raised. Others identified that they were unhappy with the tone of the response and that the Trust had failed to offer a sincere apology. A number of complainants wanted further information in order to help them understand the decisions made about their care. Of the complaints that were re-opened 18 were resolved through further responses or through local resolution and meetings.

10.0 Action Plans and resolution of complaints

10.1. In her report last year, the Ombudsman noted that NHS is still not dealing adequately with the most straightforward matters, minor disputes over unanswered telephones or mix-ups over appointments can end up with the Ombudsman because of knee-jerk responses by NHS staff and poor complaint handling. While these matters may seem insignificant alongside complex clinical judgments and treatment, they contribute to a patient's overall experience of NHS care. The Ombudsman expects that all Trusts should work to achieve the commitment in the NHS Constitution to acknowledge mistakes, apologise, and explain what went wrong and put things right, quickly and effectively.

10.2. An Action Plan is sent to the Directorates and they are required to confirm that the complainant has been given the opportunity to discuss their concerns and agreed the type of resolution and the time scales for a response. Although most complainants are being contacted within 5 days of the Trust's receipt of their complaint, the Action Plans are not completed and sent back to the Complaints Team.

10.3. Only 55% of the Action plans were returned to the Complaints team. Although the completion of action plans continues to be poor, discussions with complainants are fed-back to the complaint team by e-mail or at the weekly complaints meeting. 89% of all complainants [type 2 and 3] were contacted to discuss their complaint and the type of resolution they were seeking, this compares with 86% last year. In a number of cases this initial contact had resolved the issue for the complainant and they did not require any further action. The feedback received from patients and members of staff on this type of resolution has been very positive.

10.4. Details of action plans received are as follows:

Table 16: Action Plans and contact to discuss resolution

DIRECTORATE	NUMBER OF COMPLAINTS	EVIDENCE OF COMPLAINANT BEING CONTACTED	ACTION PLANS RECEIVED
Medicine	**108**	**94**	**36**
Surgery	**88**	**79**	**57**
CSS	**23**	**23**	**23**
HIV/GUM /Derm	**18**	**16**	**12**
Gynae	**20**	**17**	**16**
Maternity	**48**	**42**	**27**
Paediatrics	**32**	**29**	**17**
Patient Flow	**19**	**18**	**9**

NCSS	**14**	**13**	**3**
Imperial	**4**	**2**	**3**
Other	**3**	**3**	**3**

10.5. It is important that our response reflects the initial discussion as to how the complainant wants their concerns addressed. Senior members of staff from all specialties have met with patients or their carers to discuss the issues they raised and successfully resolve their concerns. The feedback received from patients and members of staff on this type of resolution has been very positive. Other complainants have asked to have a written response to their concerns.

10.6. The complaints team attends the weekly divisional meetings for both the Medicine and Surgery Division and Women's, neonatology, children's and young peoples. The Head Midwife meets with the complaints team each week. This is an opportunity to update the divisions on their current and reopened complaints, and to ensure that any recommendations are discussed. The complaints team update and send a log of current and reopened complaints to all the divisions once a week.

10.7. During the year we have received positive feedback from a number of complainants with regard to the way that their concerns have been resolved.

"I would like to thank you for the extremely thorough and professional investigation into the issues raised by myself and my family".

"Thank you for the earnestness with which you and your team have responded to my complaints".

"Thank you for your sympathetic and comprehensive reply to my letter and for reassuring me that my complaint had been taken seriously and points of learning would be taken forward with the nurses to inform their future practice".

"It is extremely reassuring in the modern NHS to have your complaints taken seriously. Thank you so much".

11.0 Change of Practice 2012-2013

It is important that the Trust is a "learning organisation" and ensures that complaints are used to learn lessons, and that this results in improved services. An important aspect of handling complaints is to listen to patients' views, observe what and where things are going wrong and change practice(s) to improve services. The Complaints action monitoring form is sent to the Directorates each quarter, this requires the Directorate to provide an update on actions arising from complaints. In some instances complaints have resulted in learning and reflection for individuals or in the implementation of teaching that reflects the issues raised in complaints. In a small number of cases the issues identified have been managed through the Trust's disciplinary process. The following changes have been identified as a result of concerns or complaints received during 2012-2013.

11.1. Surgery

In order to improve the communication between teams an electronic documentation record has been introduced for discharge which enables all multi-disciplinary staff to record the services organised and when they will start.

Extra operating lists have been arranged for Maxilla-facial consultant to clear waiting list. This involves various options including operating at the weekends and in the evening.

The Hand Team have now developed an outpatient procedure consent form which will be used in clinics to ensure there is a record of consent for steroid injection in the future.

Division is reviewing the times that patient are asked to attend for their operation. It is recognised that the admissions should be staggered on the day of surgery. This is a matter been taken forward under the Theatre Transformation Project.

Work has been undertaken in the Division with regard to missed doses of medication; the issue has been discussed at the monthly Sisters and Matrons. The nursing staff are able to print off a list of all missed doses of medication and are encouraged to do this once a day and highlight any issues during the handover process.

The Trust is in the process of implementing a major transformation programme of the appointments processes in order to improve the management and experience of patients.

The Trust is in the process of implementing a major transformation programme of the appointments processes in order to improve the management and experience of patients.

Following review, the clinical and administrative processes for paediatric patients requiring pinnaplasty have been streamlined to the Craniofacial Department.

Medical staff in Trauma and Orthopaedics have been reminded of the need to consider soft tissue injury in patients with on-going pain.

In response to a number of concerns raised about the ophthalmology department a service improvement meeting has been set up to monitor progress against the plans for improvement; this was led by the General Manager for Surgery. A business case was approved to increase the numbers of nursing and medical staff in order to support the growing service. The number of administrative staff has also been increased and the staffs have now been fixed to the speciality in order to provide continuity.

A service improvement plan of the admissions department has been undertaken. As part of the process a new telephone system will be introduced to ensure all patients who are trying to get through to the department are communicated with efficiently and expediently. It is intended to stop the use of answering machines within the department. Patients who raised a concern were invited to attend a meeting with members of the surgical management team to share ideas from a patient's point of view.

The Trust is currently undertaking a refurbishment of the day room on David Evans ward.

A revised uniform policy has recently been approved at the quality committee; this includes guidance for all clinical staff.

11.2. Medicine

A review of the AAU documentation for the transfer of patients has been undertaken to support the handover of expected patients and ensure that all staff are aware of patients being transferred.

A clinical protocol has been developed for the management of patients attending with abdominal pain and raised inflammatory markers (blood tests indicating a source of infection). This will provide all medical and nursing staff with a consistent and structured approach to support the assessment and effective management of patients attending with these symptoms.

A pain audit was completed and as a result of this, the documentation used within the ED has been re-designed and re-printed to emphasise the importance of recording and re-evaluating a pain score.

The Emergency Department have introduced a review book for junior doctors to record issues for consultants to review when there is no consultant in the department

The division is looking to develop an electronic system of alerting Emergency Department doctors when radiology reports are finalised.

The process for ordering tests for inpatients was reviewed and streamlined.

11.3. CSS

Following concerns raised by a mother who attended with her baby for a fluoroscopy but had to leave as the child became too distressed to have the procedure, the department has reviewed the clinic times. The first appointment now starts at a later start time, the length of the appointment time for each child has been increased and urgent inpatients will be scheduled at a time that will have the least impact on the waiting outpatients.

The Nuclear Medicine Department have reviewed their practice to ensure that all patients who are having a Myocardial Perfusion Scan understand the information leaflet they have been previously given before the procedure commences.

Following a meeting with a patient who raised a concern regarding the delay in receiving their chemotherapy the Pharmacy manager has agreed that chemotherapy will be made the night before to reduce the waiting time in clinic. If the blood results are available the day before chemotherapy and patient confirmed fit to proceed, the pharmacy team will pre-make the chemotherapy the evening before. This would allow a 24 hour window for administration. Patient has already received a dose under this new system and other patients have also received their doses under the new system.

The Therapy Team are looking at potential ways that the Trust could work with other NHS organisations to develop a shared cost effective mechanism for collecting unused walking aids and other equipment from patient's homes as well as from residential and nursing homes.

Pharmacy is reviewing the process for the receipt of discharge medicines; they will reiterate to all staff at departmental meetings the importance of entering discharge prescriptions onto the tracking system. The discharge medication tracking system is being improved to document all discharge prescriptions that have been sent to the wards with the porter. Nursing staff will then have to sign to say they have received discharge medicines from pharmacy.

11.4. HIV/GUM/Dermatology

The Division have undertaken a review of the dermatology service.

Mandatory customer care training was organised for the reception staff in the Kobler Clinic.

The division is preparing an assurance document that requires a detailed assessment of the phototherapy service. Further training has been provided for all staff on new phototherapy equipment. The division is installing software to support the treatment protocols.

Requests for copies of test results will now be considered on a case by case basis, and there will no longer be a charge for test results alone if these are requested to take to another provider of care. The patient had sexual health screens but declined bloods to be taken. In future, those that refuse these tests, due to their high risk care being undertaken at another hospital will now have this clearly documented as to why this test was declined.

11.5. Central Out Patients

A screening group has been established to look at how the Trust can improve the number of patients who are screened for MRSA as part of the admission process and where this is undertaken.

Changes have been made to the check in screen; there is a specific prompt now in place for patients who may not be able to read the screen to go to reception desk

11.6. Paediatrics

An improved internal referral process has been implemented: the referral is now dictated and emailed to the department as well as being put in the internal post in order to ensure the receiving consultant is aware of the request.

Steps are being taken to ensure there is a greater presence of consultants within the Paediatric Emergency Department at all times.

11.7. Gynaecology

ACU information leaflet is to be updated to explain in more detail the home ovulation kit.

11.8. Maternity

A new initiative (NEST - Nurturing Essential Support for Transition to motherhood) will soon be commencing whereby Doula's (labour supporters) will be provided to support women in early labour on the wards and on the birthing unit.

An urgent care unit has being developed which will improve speed of access and assessment for maternity and gynaecology patients.

40 breastfeeding peer supporters are being recruited and a new breastfeeding lead is about to be appointed.

The visiting hours for partners have been extended on the postnatal ward; this will prove valuable for our patients and encourage family bonding during the early days following birth.

12. Patient Advice and Liaison Service (PALS)

12.1. The Trust is committed to active engagement with our patients and local community to ensure that we achieve a culture where the patient is at the centre of all that we do, enabling patients, the local community, members of staff and partners to influence service development, ensuring that our services continue to develop and meet the needs of local people.

12.2. The Patient Advice and Liaison Service (PALS) offer information and help to patients and visitors about Trust services. The team provide

- Confidential advice and support to patients, families and their carers
- Information on NHS services and health related queries
- Confidential assistance to resolve concerns by working in partnership with other staff
- Recording of concerns, suggestions, queries and compliments
- Explanation about the complaints procedure and information relating to organisations such as the Independent Complaints Advocacy Service (ICAS)
- Patient information or patient leaflets in an alternative format or another language

12.3. PALS act independently when handling patient and family concerns, liaising with staff, managers and, where appropriate, relevant organisations, to negotiate immediate and prompt solutions. If necessary, the service can also refer patients and families to specific local or national-based support agencies.

12.4. During 2012/13, the PALS service received a total of 809 Type 1 concerns. This compares to 848 in 2011/2012. Table 17 below shows trends in total number of concerns raised for the past 3 years.

Table 17. Informal concerns 10 – 11 to 12-13

	10-11	11-12	12-13
Type 1 Concerns	956	848	809

12.5. The most common concerns raised with the PALS service are detailed in table 18 below, and this shows comparison to the previous year.

Table 18: Top 3 Primary Subjects type 1 2012/2013

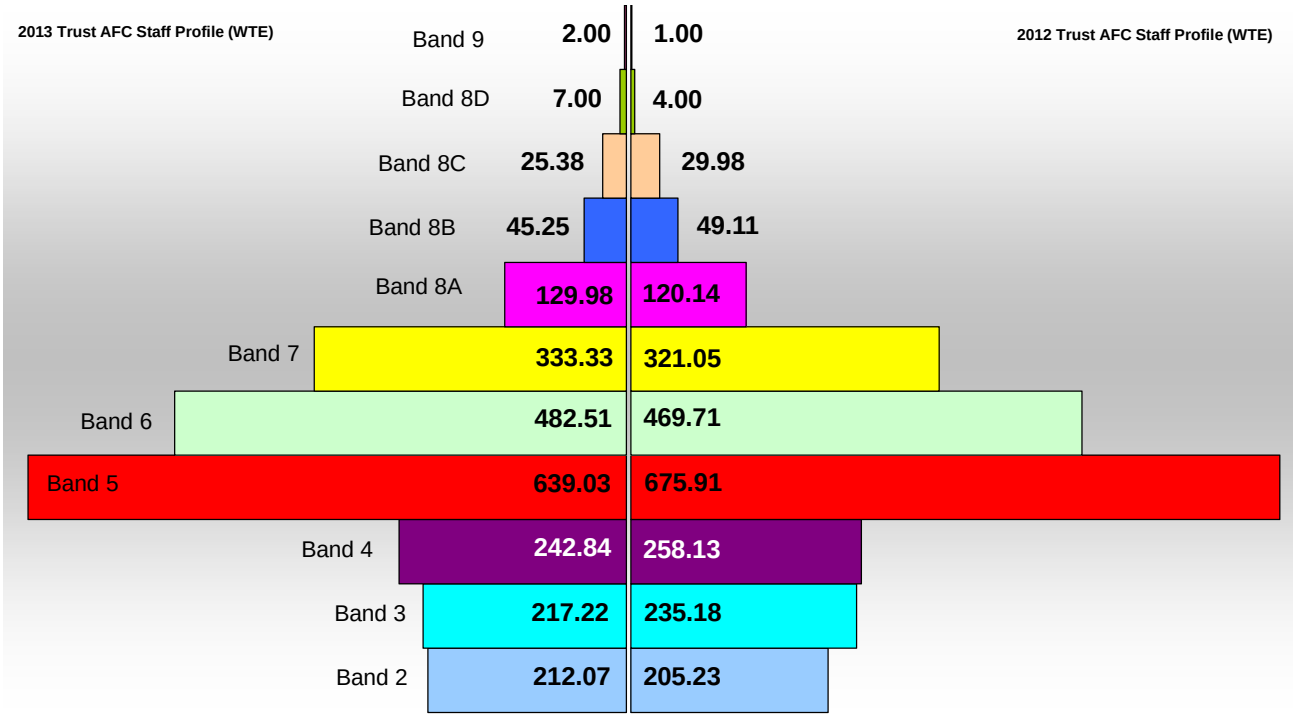
Subject	2011/12	2012/13
Appointments/delay or cancellation (out-patients)	279	201
Attitude of staff	72	85
Communication/Information to patients (written and oral)	106	115

13.0 Summary

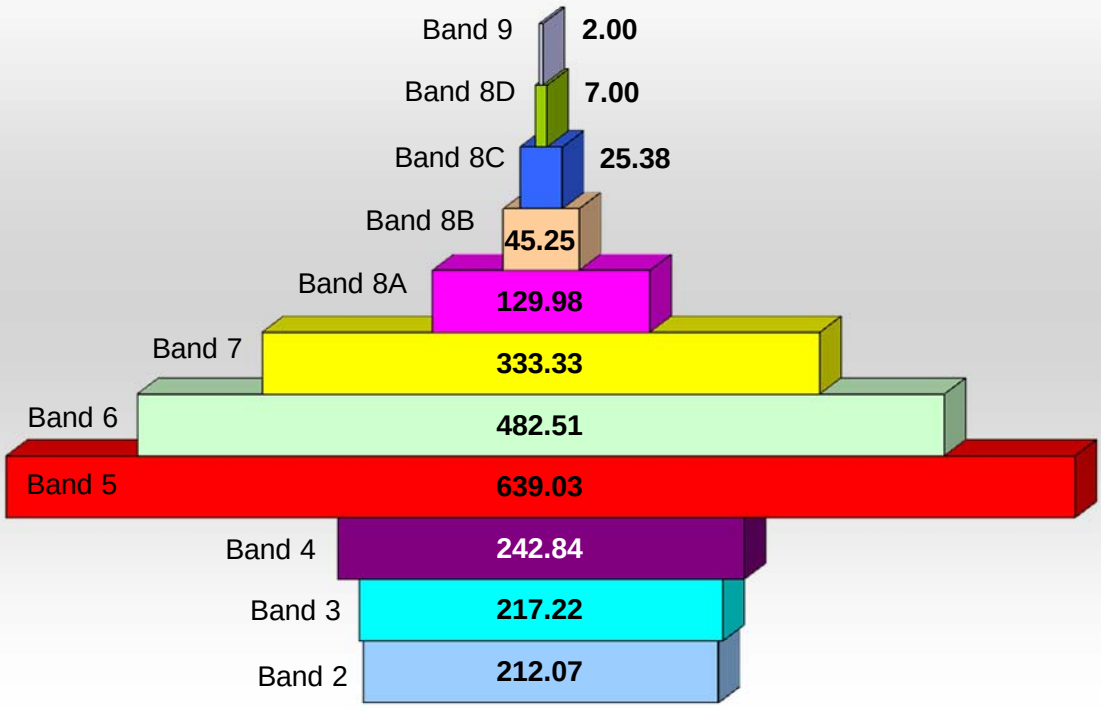
This report has provided a summary and analysis of complaints and concerns raised through the Complaints Service during the year 2012/13. The complaints and concerns we receive continue to inform the action plans relating to the Patient Experience. Robust systems and processes are in place to ensure compliance with the current national complaints handing regulations and related DH guidance. There is a clear focus on complaints and concerns by the Executive Team. It is expected that each complaint response should be initially reviewed by the Divisional Director. The Chief Executive, the Chief Operating Officer and the Chief Nurse then provide a final review to ensure the quality of the response and investigation. They are each responsible for one of the divisions and work closely with the complaints team and Divisional Directors to identify trends and ensure that prompt action is taken in response to complaints. All new complaints and any overdue complaints are reported weekly at the Trust Exec meeting. There is also a weekly meeting with the Chief Nurse, the Director of Governance and Corporate Affairs, the Head of Clinical Governance, the Head of Patient Affairs and the Divisional Directors; during this meeting the progress of the type three complaints and re-opened complaints are discussed.

The learning and changes identified are monitored and any outstanding actions escalated to the Chief Nurse. The Trust demonstrates a positive approach to organisational learning and development, through a range of changes and developments initiated as a result of patient and public feedback.

Appendix 1



2013 Trust AFC Staff (WTE)



Appendix 2

Trust Ethnic Profile 31-Mar-2013

Below Trust Profile
Above Trust Profile

	Ethnic Code																	
Grade	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**J**	**K**	**L**	**M**	**N**	**P**	**R**	**S**	**Z**	**Trust Profile**
Band 2	27.7%	3.0%	10.2%	0.0%	0.0%	1.3%	2.6%	5.5%	3.0%	1.3%	5.5%	11.9%	12.8%	0.9%	0.9%	6.0%	7.7%	**7.4%**
Band 3	28.4%	3.0%	13.1%	1.7%	0.0%	0.4%	2.1%	1.3%	0.4%	2.1%	8.5%	14.4%	11.9%	1.3%	0.8%	5.5%	5.1%	**7.4%**
Band 4	41.0%	1.1%	19.5%	1.1%	0.0%	0.8%	1.1%	3.4%	0.4%	1.9%	4.2%	11.9%	3.8%	3.4%	0.8%	2.7%	2.7%	**8.2%**
Band 5	42.6%	4.5%	11.0%	1.0%	0.4%	0.4%	0.6%	3.6%	0.4%	0.1%	8.0%	4.5%	12.9%	1.0%	0.6%	5.2%	3.0%	**21.1%**
Band 6	47.9%	4.1%	11.2%	0.6%	0.6%	0.4%	1.7%	3.9%	0.6%	0.2%	6.5%	3.2%	8.6%	1.5%	1.7%	5.4%	2.1%	**16.7%**
Band 7	54.9%	8.1%	10.3%	0.3%	0.8%	0.3%	0.3%	4.9%	0.5%	0.5%	4.3%	5.1%	3.8%	0.0%	1.6%	1.4%	3.0%	**11.6%**
Band 8A	69.2%	7.0%	11.9%	0.0%	0.7%	0.0%	0.7%	2.1%	0.7%	0.0%	0.7%	0.7%	0.7%	0.7%	2.1%	1.4%	1.4%	**4.5%**
Band 8B	66.7%	12.5%	4.2%	0.0%	2.1%	2.1%	0.0%	6.3%	0.0%	0.0%	0.0%	0.0%	2.1%	0.0%	0.0%	2.1%	2.1%	**1.5%**
Band 8C	77.8%	3.7%	7.4%	0.0%	0.0%	0.0%	0.0%	3.7%	0.0%	0.0%	0.0%	0.0%	3.7%	0.0%	0.0%	3.7%	0.0%	**0.8%**
Band 8D	71.4%	14.3%	0.0%	0.0%	0.0%	14.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.2%**
Band 9	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.1%**
Exec	80.0%	0.0%	20.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.3%**
Medical	47.8%	2.2%	14.4%	0.2%	0.2%	1.4%	2.0%	12.4%	2.2%	0.5%	4.2%	0.2%	2.8%	0.0%	2.2%	4.8%	2.8%	**20.2%**
Non-AFC	50.0%	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.1%**
Trust Profile	**45.8%**	**4.1%**	**12.4%**	**0.6%**	**0.4%**	**0.7%**	**1.3%**	**5.5%**	**1.0%**	**0.6%**	**5.5%**	**5.1%**	**7.4%**	**0.9%**	**1.3%**	**4.3%**	**3.1%**	

~ The 2011 census includes ethnic categories that are not reflected on the NHS HR system. The %'s for 'Gypsy or Irish Traveller' has been added to 'B - White Irish' and 'Arab has been added to 'C - Any other White background
* Employees we do not hold ethnic ID Data for have been excluded from this data

Ethnicity	**~2011 Census (London)**	***Trust Profile 2011**	**Variance**	***Trust Profile 2012**	**Variance**	***Trust Profile 2013**	**Total Variance 2011-13**
A - White British	44.9%	46.1%	0.92%	47.0%	0.26%	47.2%	1.18%
B - White Irish	2.3%	4.5%	-0.54%	4.0%	0.27%	4.2%	-0.27%
C - Any other White background	13.9%	12.5%	-0.04%	12.5%	0.25%	12.8%	0.21%
D - White & Black Caribbean	1.5%	0.9%	-0.18%	0.8%	-0.16%	0.6%	-0.33%
E - White & Black African	0.8%	0.5%	-0.09%	0.4%	0.00%	0.4%	-0.09%
F - White & Asian	1.2%	0.7%	0.06%	0.7%	0.00%	0.7%	0.07%
G - Any other mixed background	1.5%	1.2%	0.17%	1.4%	-0.03%	1.4%	0.14%
H - Indian	6.6%	5.2%	0.03%	5.3%	0.38%	5.7%	0.41%
J - Pakistani	2.7%	1.0%	-0.05%	1.0%	0.04%	1.0%	-0.02%
K - Bangladeshi	2.7%	0.5%	-0.03%	0.5%	0.13%	0.6%	0.10%
L - Any other Asian background	4.9%	5.7%	0.23%	6.0%	-0.27%	5.7%	-0.03%
M - Black Caribbean	4.2%	5.6%	-0.25%	5.4%	-0.17%	5.2%	-0.42%
N - Black African	7.0%	8.1%	-0.05%	8.1%	-0.45%	7.6%	-0.50%
P - Any other Black background	2.1%	0.9%	0.05%	1.0%	0.00%	1.0%	0.06%
R - Chinese	1.5%	1.9%	-0.19%	1.7%	-0.38%	1.4%	-0.57%
S - Any other ethnic group	2.1%	4.4%	-0.06%	4.3%	0.12%	4.5%	0.06%

Non-Medical

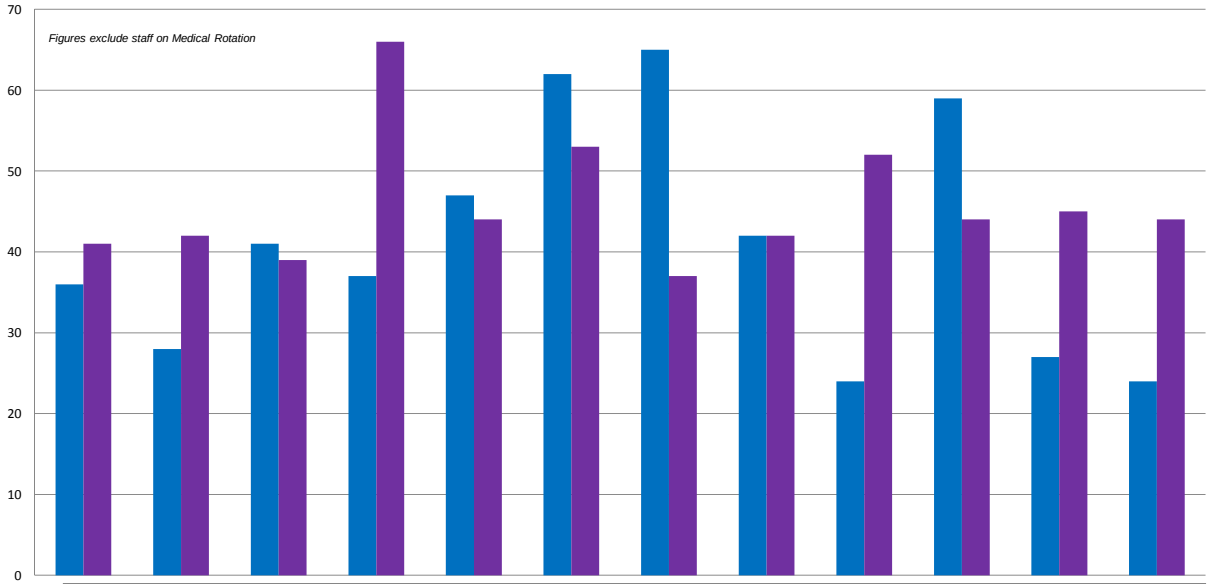
Ethnicity	**Band 2**	**Band 3**	**Band 4**	**Band 5**	**Band 6**	**Band 7**	**Band 8A**	**Band 8B**	**Band 8C**	**Band 8D**	**Band 9**	**Exec**	**Non-AFC**	**Non Med Trust Profile**
A - White British	5.6%	5.8%	9.3%	24.9%	22.2%	17.6%	8.6%	2.8%	1.8%	0.4%	0.2%	0.7%	0.2%	**45.2%**
B - White Irish	6.0%	6.0%	2.6%	25.6%	18.8%	25.6%	8.5%	5.1%	0.9%	0.9%	0.0%	0.0%	0.0%	**4.6%**
C - Any other White background	7.9%	10.3%	16.9%	24.5%	19.9%	12.6%	5.6%	0.7%	0.7%	0.0%	0.0%	0.7%	0.3%	**11.8%**
D - White & Black Caribbean	0.0%	22.2%	16.7%	38.9%	16.7%	5.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.7%**
E - White & Black African	0.0%	0.0%	0.0%	27.3%	27.3%	27.3%	9.1%	9.1%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.4%**
F - White & Asian	21.4%	7.1%	14.3%	21.4%	14.3%	7.1%	0.0%	7.1%	0.0%	7.1%	0.0%	0.0%	0.0%	**0.5%**
G - Any other mixed background	20.7%	17.2%	10.3%	13.8%	31.0%	3.4%	3.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.1%**
H - Indian	13.7%	3.2%	9.5%	25.3%	22.1%	18.9%	3.2%	3.2%	1.1%	0.0%	0.0%	0.0%	0.0%	**3.7%**
J - Pakistani	38.9%	5.6%	5.6%	16.7%	16.7%	11.1%	5.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.7%**
K - Bangladeshi	17.6%	29.4%	29.4%	5.9%	5.9%	11.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.7%**
L - Any other Asian background	8.7%	13.3%	7.3%	36.0%	23.3%	10.7%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**5.9%**
M - Black Caribbean	17.4%	21.1%	19.3%	18.6%	10.6%	11.8%	0.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%	**6.3%**
N - Black African	13.8%	12.8%	4.6%	39.9%	21.1%	6.4%	0.5%	0.5%	0.5%	0.0%	0.0%	0.0%	0.0%	**8.5%**
P - Any other Black background	6.7%	10.0%	30.0%	23.3%	26.7%	0.0%	3.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.2%**
R - Chinese	7.1%	7.1%	7.1%	14.3%	32.1%	21.4%	10.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.1%**
S - Any other ethnic group	13.1%	12.1%	6.5%	32.7%	27.1%	4.7%	1.9%	0.9%	0.9%	0.0%	0.0%	0.0%	0.0%	**4.2%**
Z - Undefined	22.0%	14.6%	8.5%	24.4%	13.4%	13.4%	2.4%	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	**3.2%**
Trust Profile	**9.2%**	**9.3%**	**10.2%**	**26.4%**	**21.0%**	**14.5%**	**5.6%**	**1.9%**	**1.1%**	**0.3%**	**0.1%**	**0.4%**	**0.2%**	

Medical

Ethnicity	**FY1**	**FY2**	**CT**	**ST**	**Assoc. Spec.**	**Clin. Asst.**	**Spec. Dr**	**Consultant**	**Med Trust Profile**
A - White British	4.2%	7.4%	5.8%	30.4%	1.9%	1.6%	3.2%	45.3%	**47.8%**
B - White Irish	21.4%	7.1%	0.0%	7.1%	0.0%	0.0%	0.0%	64.3%	**2.2%**
C - Any other White background	4.3%	3.2%	5.4%	41.9%	2.2%	0.0%	6.5%	36.6%	**14.4%**
D - White & Black Caribbean	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	**0.2%**
E - White & Black African	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	**0.2%**
F - White & Asian	0.0%	11.1%	22.2%	22.2%	0.0%	0.0%	0.0%	44.4%	**1.4%**
G - Any other mixed background	0.0%	7.7%	0.0%	53.8%	7.7%	0.0%	15.4%	15.4%	**2.0%**
H - Indian	10.0%	8.8%	6.3%	46.3%	0.0%	1.3%	3.8%	23.8%	**12.4%**
J - Pakistani	14.3%	7.1%	0.0%	21.4%	7.1%	0.0%	7.1%	42.9%	**2.2%**
K - Bangladeshi	66.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	33.3%	**0.5%**
L - Any other Asian background	14.8%	3.7%	7.4%	44.4%	0.0%	0.0%	11.1%	18.5%	**4.2%**
M - Black Caribbean	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	**0.2%**
N - Black African	5.6%	0.0%	11.1%	38.9%	5.6%	0.0%	0.0%	38.9%	**2.8%**
P - Any other Black background	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
R - Chinese	21.4%	14.3%	7.1%	35.7%	0.0%	0.0%	7.1%	14.3%	**2.2%**
S - Any other ethnic group	3.2%	12.9%	3.2%	51.6%	3.2%	0.0%	3.2%	22.6%	**4.8%**
Z - Undefined	5.6%	0.0%	5.6%	44.4%	11.1%	0.0%	11.1%	22.2%	**2.8%**
Trust Profile	**6.5%**	**6.8%**	**5.7%**	**36.2%**	**2.2%**	**0.9%**	**4.5%**	**37.2%**	

Appendix 3a

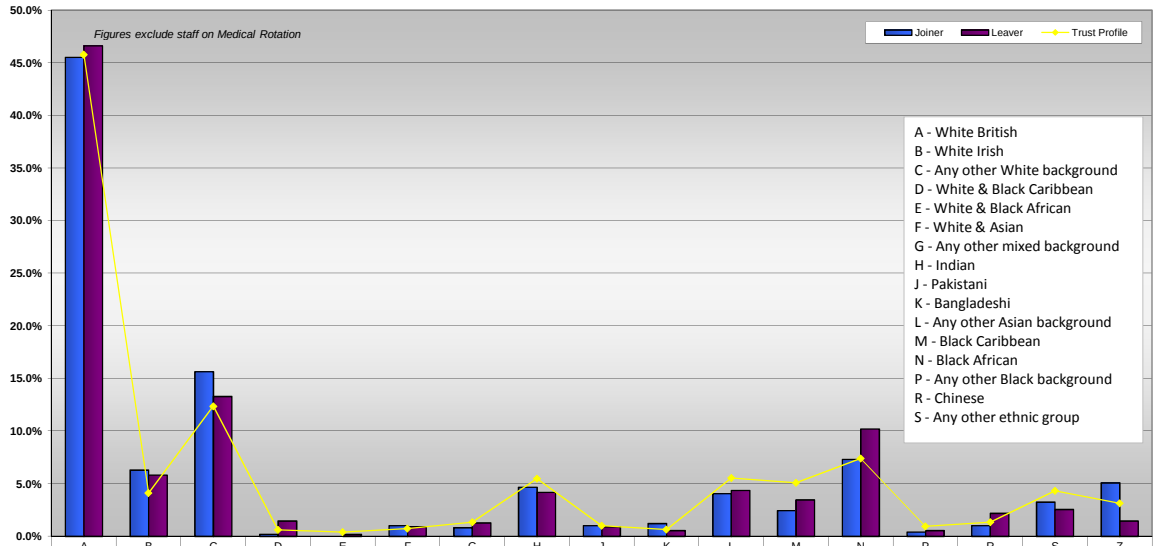
Trust Joiners & Leavers : April 2012 - March 2013



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Joiner	36	28	41	37	47	62	65	42	24	59	27	24
Leaver	41	42	39	66	44	53	37	42	52	44	45	44

Appendix 3b

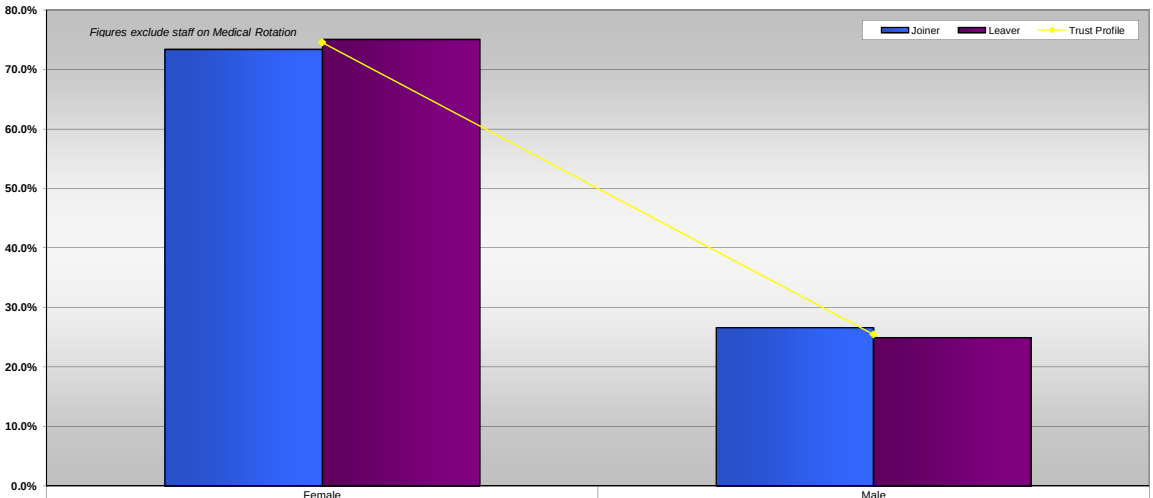
Joiners and Leavers by Ethnic Group : April 2012 - March 2013



	A	B	C	D	E	F	G	H	J	K	L	M	N	P	R	S	Z
Joiner	45.53%	6.30%	15.65%	0.20%	0.00%	1.02%	0.81%	4.67%	1.02%	1.22%	4.07%	2.44%	7.32%	0.41%	1.02%	3.25%	5.08%
Leaver	46.63%	5.83%	13.30%	1.46%	0.18%	0.91%	1.28%	4.19%	0.91%	0.55%	4.37%	3.46%	10.20%	0.55%	2.19%	2.55%	1.46%
Trust Profile	45.76%	4.10%	12.36%	0.59%	0.38%	0.72%	1.31%	5.47%	1.00%	0.63%	5.54%	5.07%	7.38%	0.94%	1.31%	4.32%	3.13%

Appendix 3c

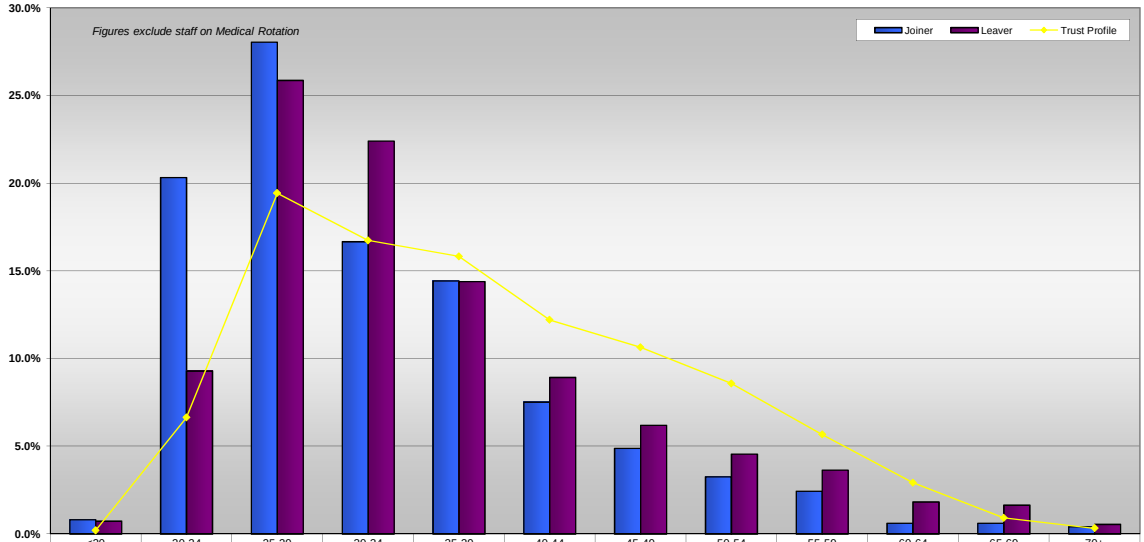
Joiners and Leavers by Gender : April 2012 - March 2013



	Female	Male
Joiner	73.37%	26.63%
Leaver	75.05%	24.95%
Trust Profile	74.54%	25.46%

Appendix 3d

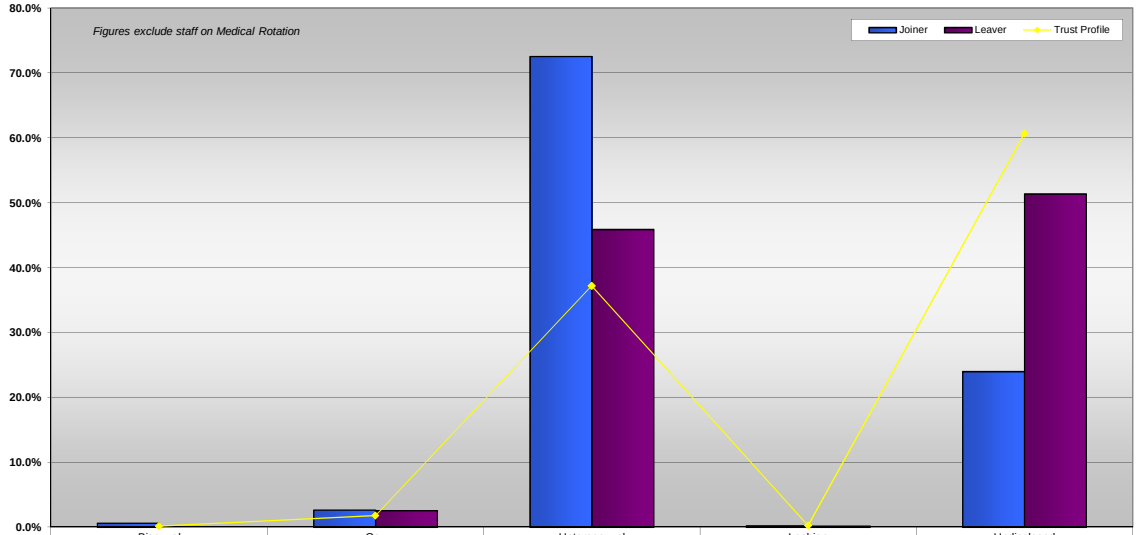
Joiners and Leavers by Age Range : April 2012 - March 2013



	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Joiner	0.81%	20.33%	28.05%	16.67%	14.43%	7.52%	4.88%	3.25%	2.44%	0.61%	0.61%	0.41%
Leaver	0.73%	9.29%	25.87%	22.40%	14.39%	8.93%	6.19%	4.55%	3.64%	1.82%	1.64%	0.55%
Trust Profile	0.19%	6.63%	19.42%	16.73%	15.83%	12.20%	10.63%	8.57%	5.66%	2.91%	0.91%	0.31%

Appendix 3e

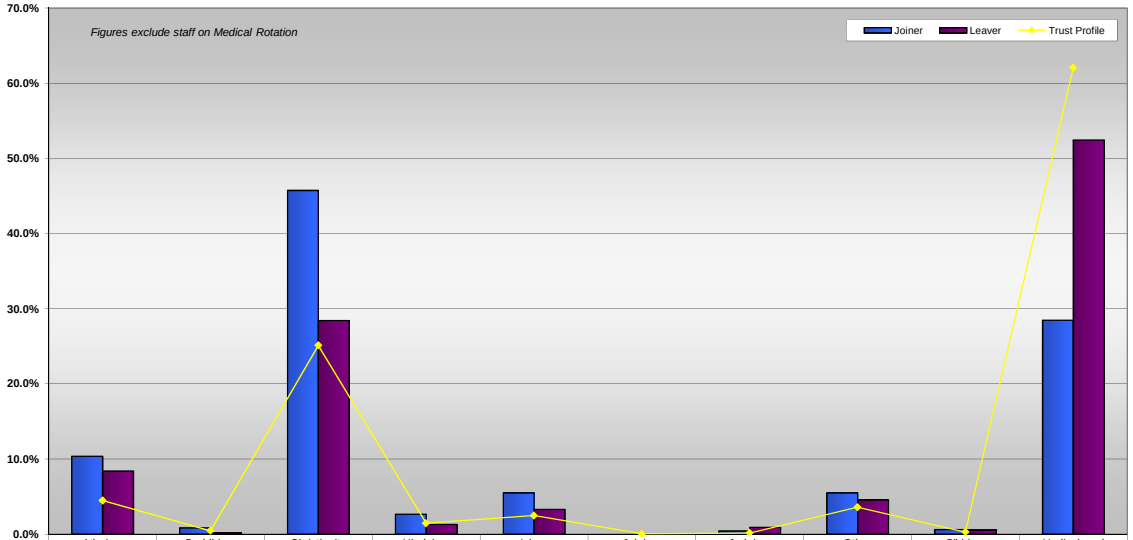
Joiners and Leavers by Sexual Orientation: April 2012 - March 2013



	Bisexual	Gay	Heterosexual	Lesbian	Undisclosed
Joiner	0.61%	2.64%	72.56%	0.20%	23.98%
Leaver	0.00%	2.55%	45.90%	0.18%	51.37%
Trust Profile	0.16%	1.75%	37.19%	0.25%	60.65%

Appendix 3f

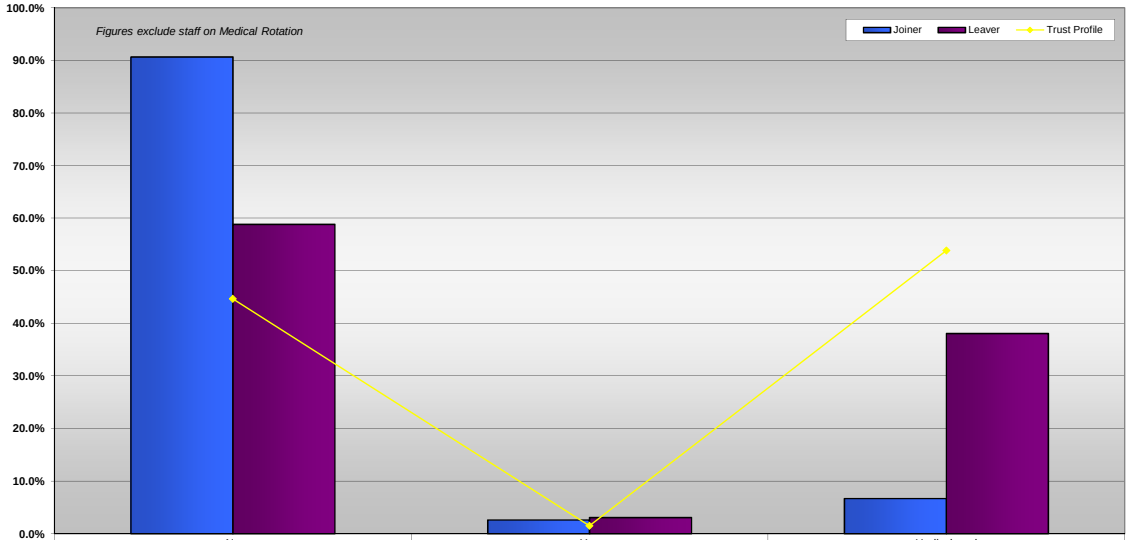
Joiners and Leavers by Religious Belief : April 2012 - March 2013



	Atheism	Buddhism	Christianity	Hinduism	Islam	Jainism	Judaism	Other	Sikhism	Undisclosed
Joiner	10.37%	0.81%	45.73%	2.64%	5.49%	0.00%	0.41%	5.49%	0.61%	28.46%
Leaver	8.38%	0.18%	28.42%	1.28%	3.28%	0.00%	0.91%	4.55%	0.55%	52.46%
Trust Profile	4.47%	0.44%	25.12%	1.44%	2.47%	0.03%	0.16%	3.57%	0.28%	62.03%

Appendix 3g

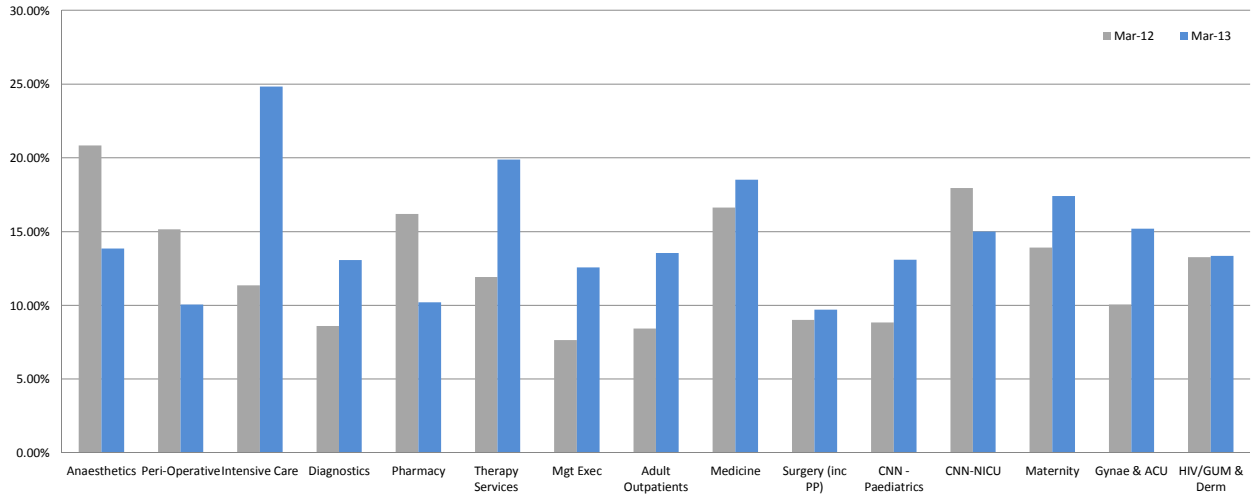
Joiners and Leavers by Disability : April 2012 - March 2013



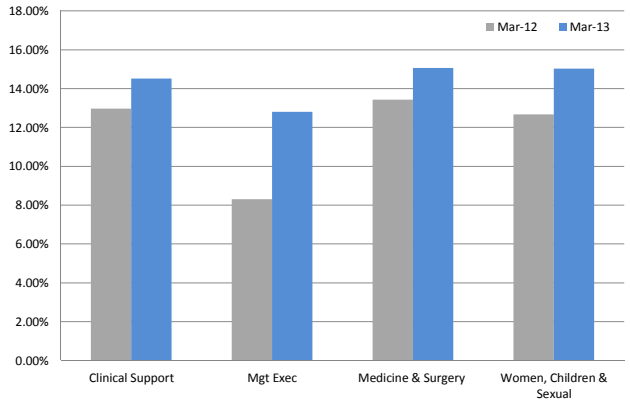
	No	Yes	Undisclosed
Joiner	90.65%	2.64%	6.71%
Leaver	58.83%	3.10%	38.07%
Trust Profile	44.67%	1.50%	53.83%

Appendix 4

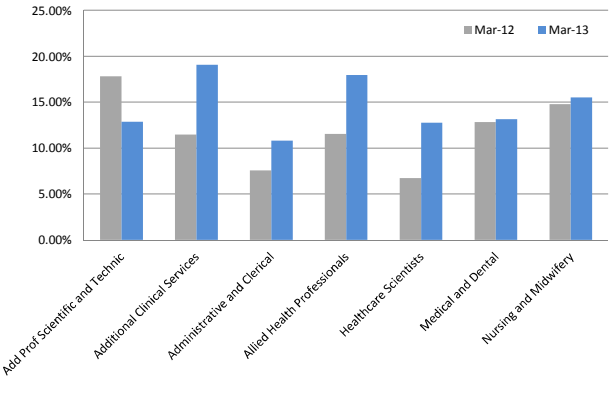
Unplanned Staff Turnover (Rolling year %) by Directorate



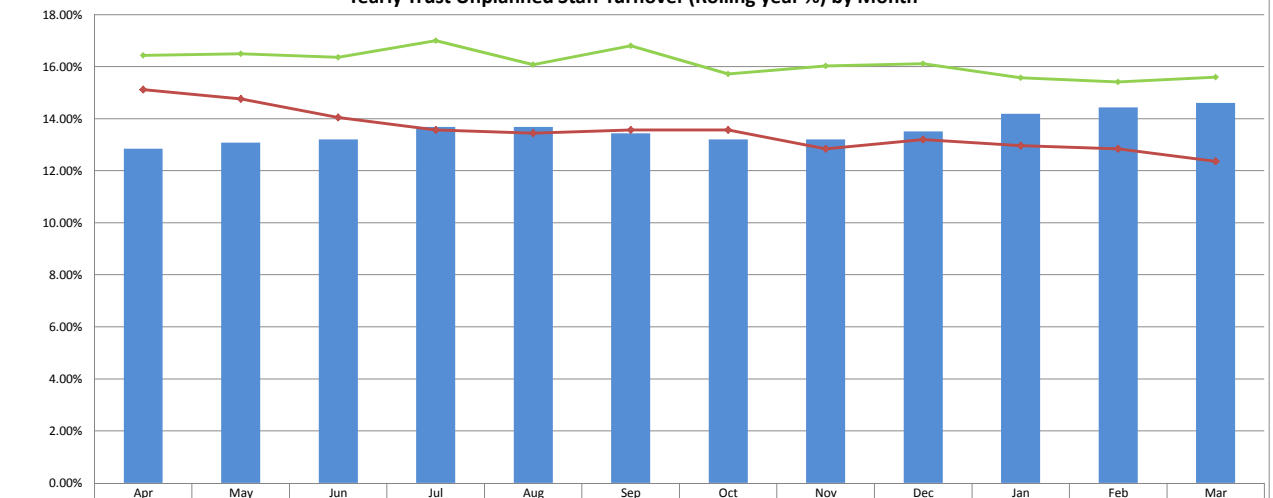
Unplanned Staff Turnover (Rolling year %) by Division



Unplanned Staff Turnover (Rolling year %) by Staffgroup



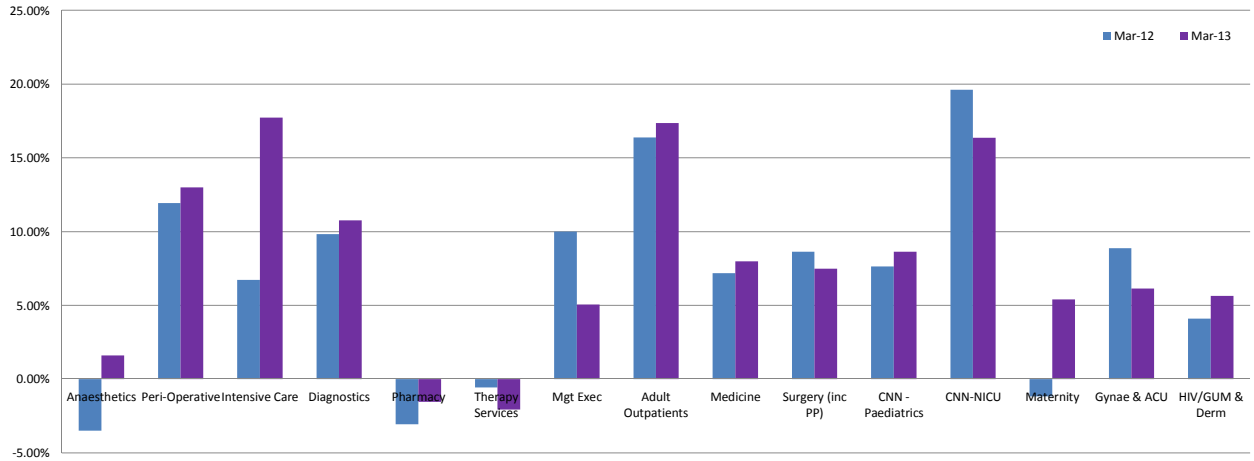
Yearly Trust Unplanned Staff Turnover (Rolling year %) by Month



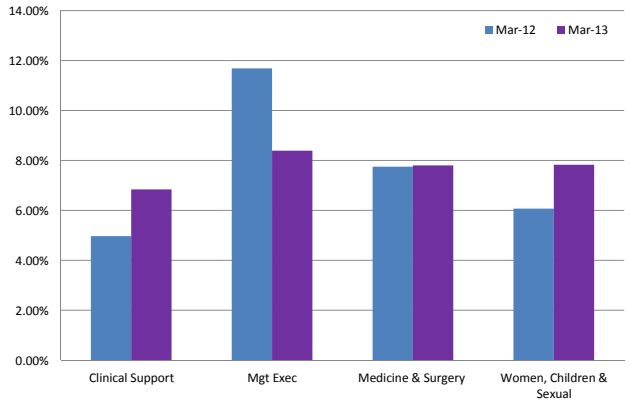
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	12.84%	13.08%	13.20%	13.68%	13.68%	13.44%	13.20%	13.20%	13.51%	14.19%	14.43%	14.60%
2010/11	16.43%	16.49%	16.35%	17.00%	16.08%	16.80%	15.72%	16.02%	16.12%	15.57%	15.41%	15.59%
2011/12	15.12%	14.76%	14.04%	13.56%	13.44%	13.56%	13.56%	12.84%	13.20%	12.96%	12.84%	12.36%

Appendix 5

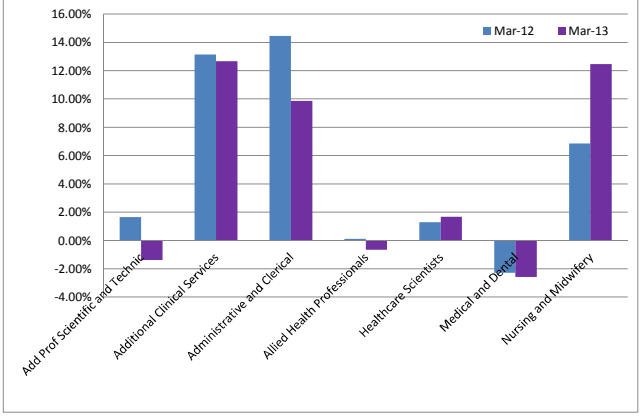
Vacancy Rate by Directorate



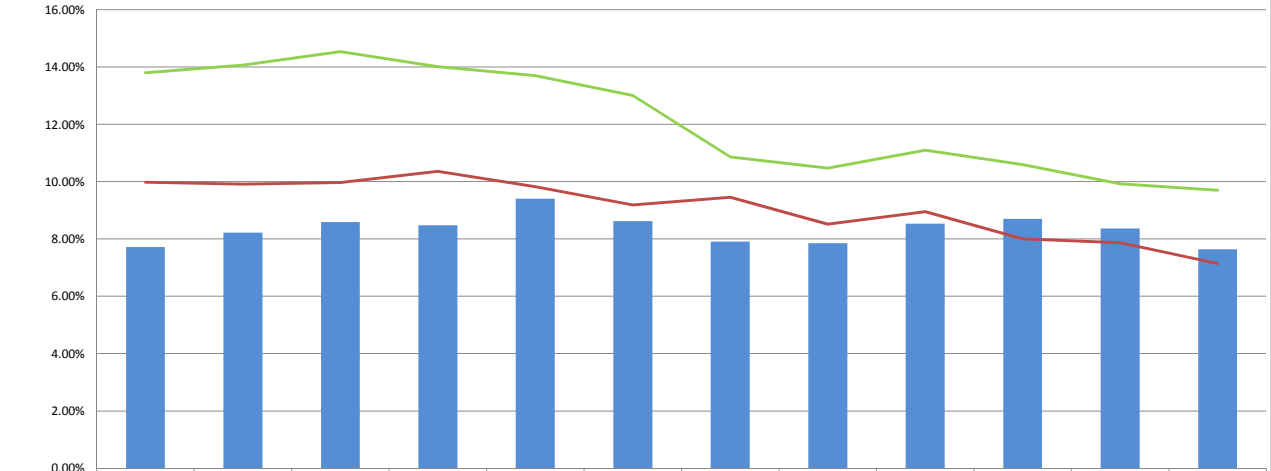
Vacancy Rate by Division



Vacancy Rate by Staffgroup

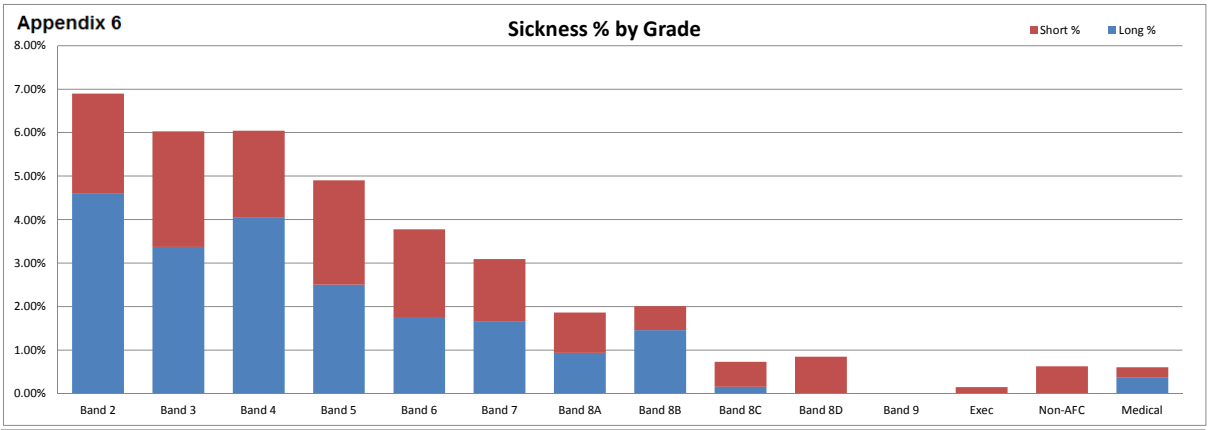


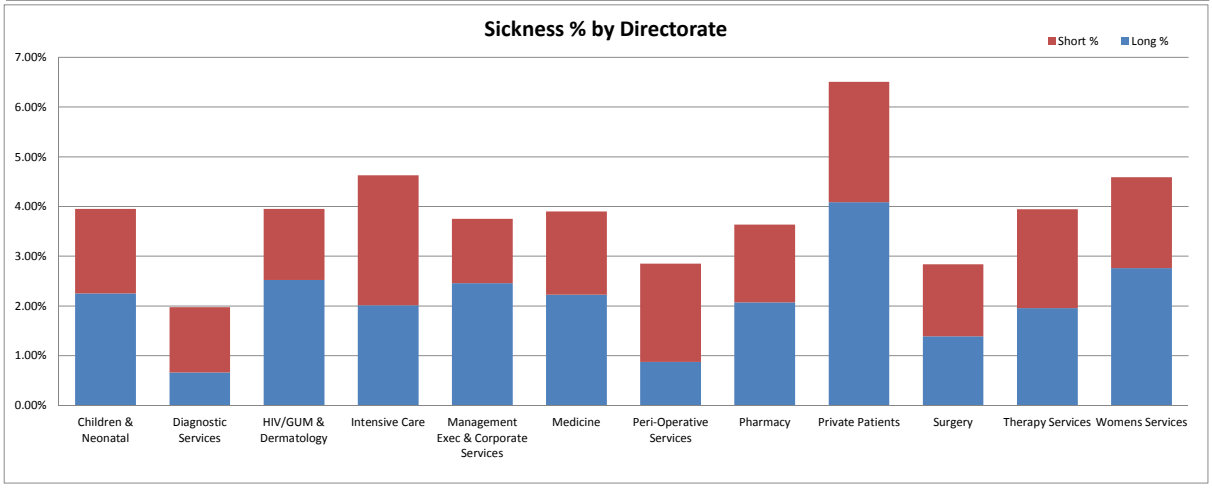
Trust Yearly Vacancy Rate by Month

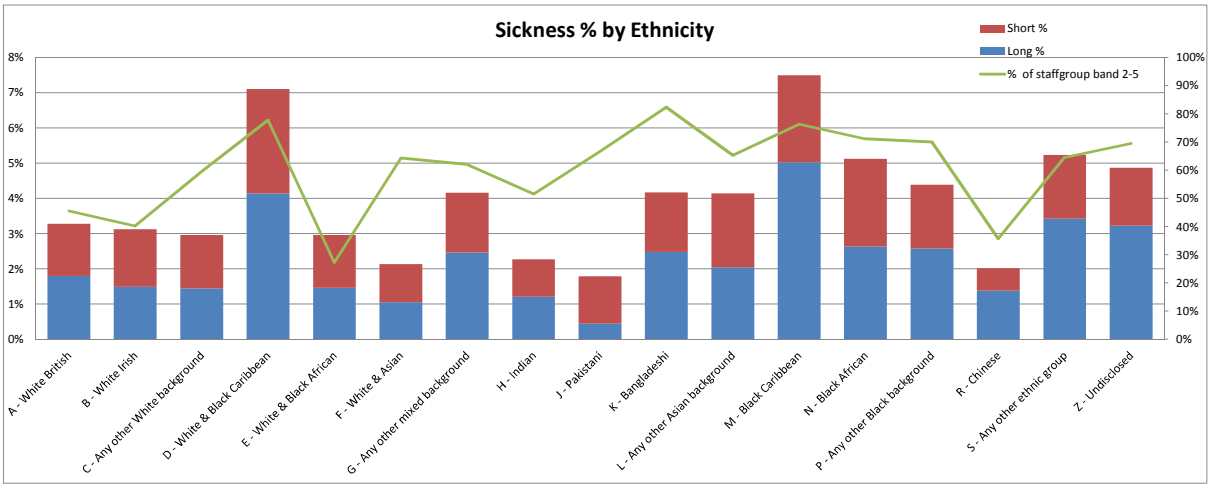


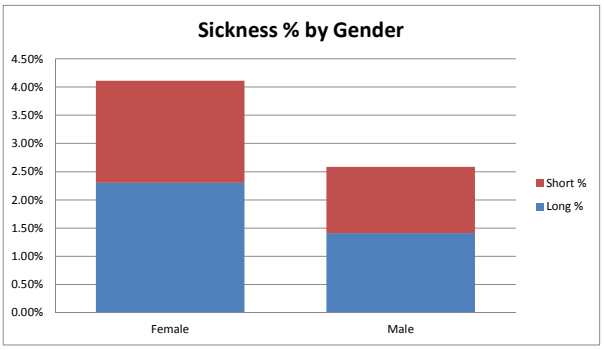
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	7.72%	8.22%	8.59%	8.48%	9.40%	8.62%	7.91%	7.85%	8.53%	8.70%	8.37%	7.64%
2010/11	13.80%	14.07%	14.53%	14.01%	13.70%	13.00%	10.86%	10.47%	11.09%	10.59%	9.92%	9.70%
2011/12	9.98%	9.91%	9.97%	10.36%	9.82%	9.19%	9.45%	8.52%	8.95%	8.00%	7.87%	7.14%

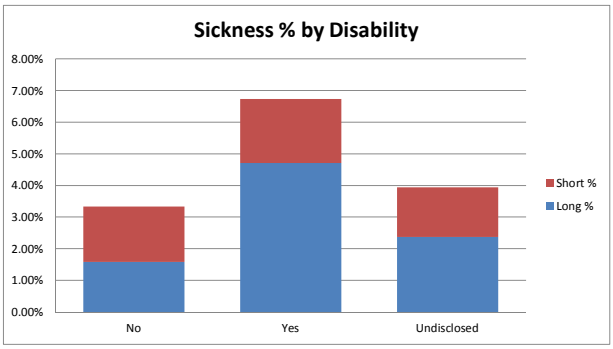
Appendix 6

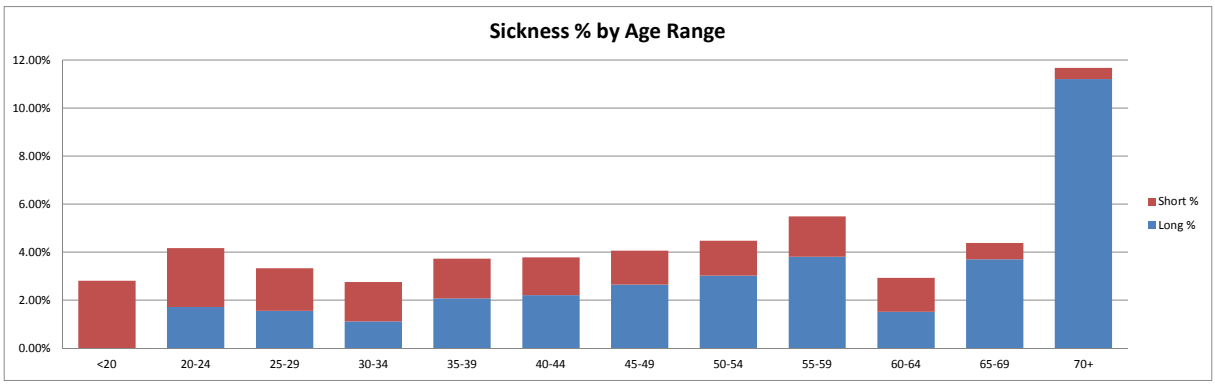

Sickness % by Grade
Short %
Long %
8.00%
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Band 2
Band 3
Band 4
Band 5
Band 6
Band 7
Band 8A
Band 8B
Band 8C
Band 8D
Band 9
Exec
Non-AFC
Medical

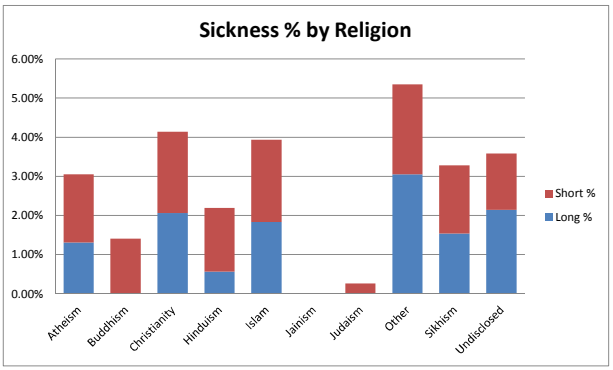

Sickness % by Directorate
Short %
Long %
7.00%
6.00%
5.00%
4.00%
3.00%
2.00%
1.00%
0.00%
Children & Neonatal
Diagnostic Services
HIV/GUM & Dermatology
Intensive Care
Management Exec & Corporate Services
Medicine
Peri-Operative Services
Pharmacy
Private Patients
Surgery
Therapy Services
Womens Services

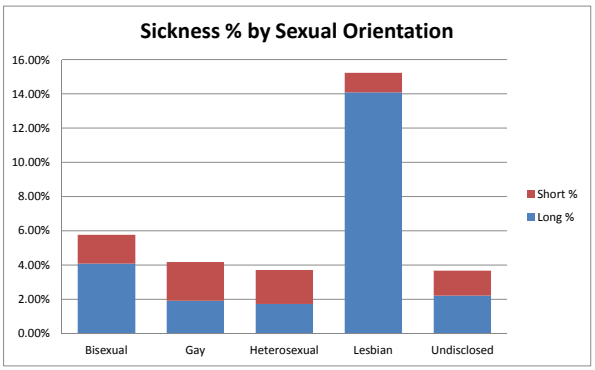

Sickness % by Ethnicity
Short %
Long %
% of staffgroup band 2-5
8%
7%
6%
5%
4%
3%
2%
1%
0%
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
A - White British
B - White Irish
C - Any other White background
D - White & Black Caribbean
E - White & Black African
F - White & Asian
G - Any other mixed background
H - Indian
J - Pakistani
K - Bangladeshi
L - Any other Asian background
M - Black Caribbean
N - Black African
P - Any other Black background
R - Chinese
S - Any other ethnic group
Z - Undisclosed

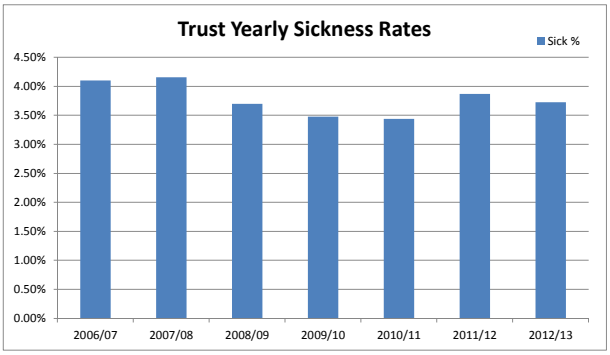


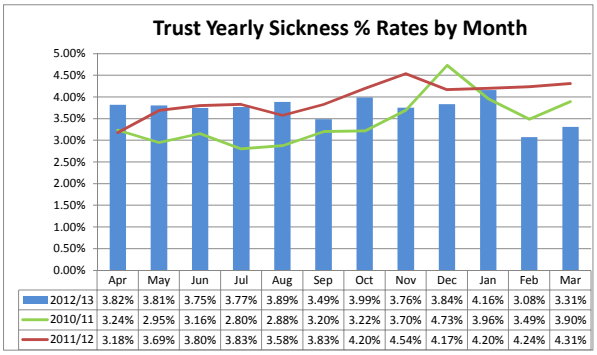








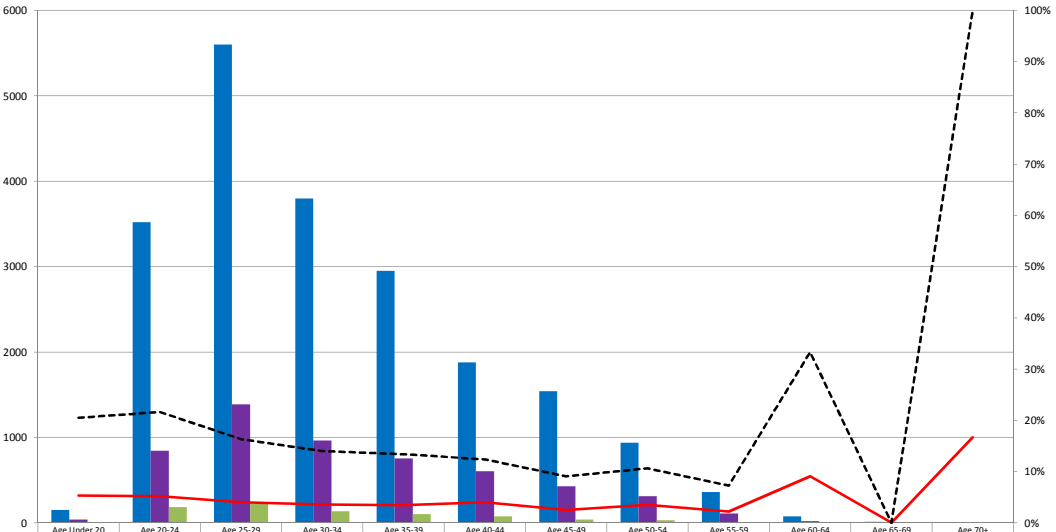




	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	3.82%	3.81%	3.75%	3.77%	3.89%	3.49%	3.99%	3.76%	3.84%	4.16%	3.08%	3.31%
2010/11	3.24%	2.95%	3.16%	2.80%	2.88%	3.20%	3.22%	3.70%	4.73%	3.96%	3.49%	3.90%
2011/12	3.18%	3.69%	3.80%	3.83%	3.58%	3.83%	4.20%	4.54%	4.17%	4.20%	4.24%	4.31%

Appendix 7a

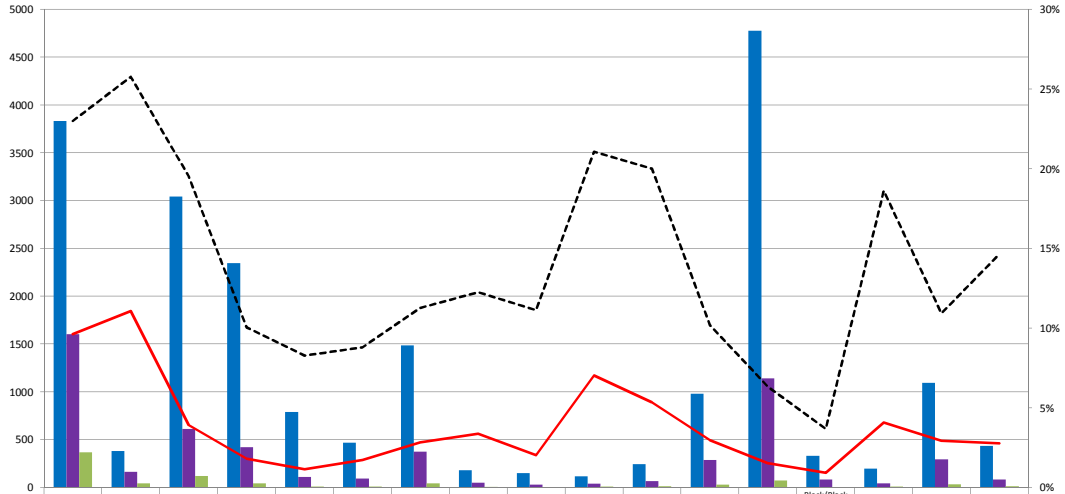
Recruitment by Age Range



	Age Under 20	Age 20-24	Age 25-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70+
Applicant	150	3519	5599	3797	2949	1877	1543	937	361	77	14	6
Shortlisted	39	845	1386	965	756	606	429	311	110	21	1	1
Appointed	8	183	226	135	101	75	39	33	8	7	0	1
% of Applicants Appointed	5.33%	5.20%	4.04%	3.56%	3.42%	4.00%	2.53%	3.52%	2.22%	9.09%	0.00%	16.67%
% of Shortlisted Appointed	20.51%	21.66%	16.31%	13.99%	13.36%	12.38%	9.09%	10.61%	7.27%	33.33%	0.00%	100.00%

Appendix 7b

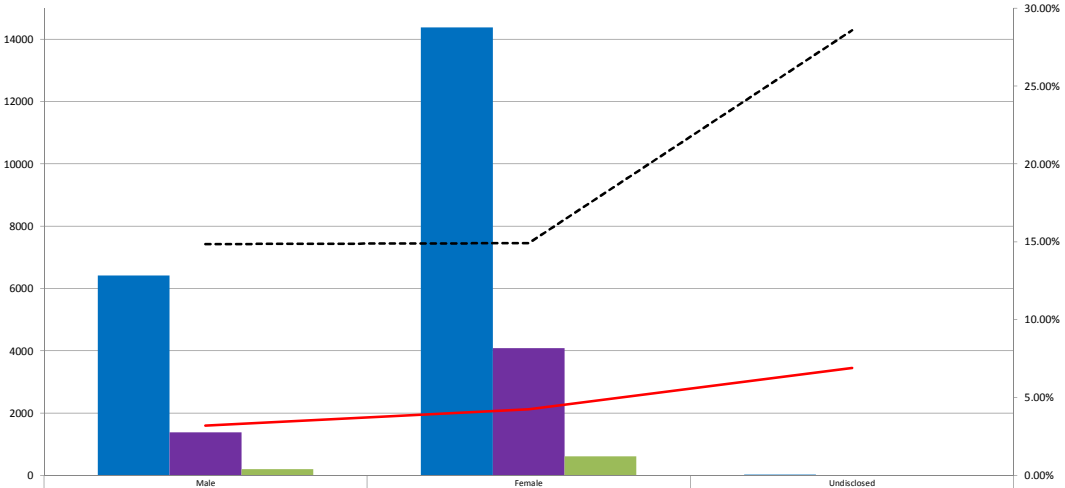
Recruitment by Ethnicity



	White - British	White - Irish	White - Other	Asian/Asian British - Indian	Asian/Asian British - Pakistani	Asian/Asian British - Bangladeshi	Asian/Asian British - Other	Mixed - White & Black Caribbean	Mixed - White & Black African	Mixed - White & Asian	Mixed - Other	Black/Black British - Caribbean	Black/Black British - African	Black/Black British - Any Other Black Background	Chinese	Other - Any Other Ethnic Group	Ethnicity Undisclosed
Applicant	3830	380	3043	2344	787	467	1485	178	149	114	244	979	4774	331	197	1092	435
Shortlisted	1601	163	610	419	109	91	373	49	27	38	65	285	1140	82	43	293	82
Appointed	368	42	119	42	9	8	42	6	3	8	13	29	72	3	8	32	12
% of Applicants Appointed	9.61%	11.05%	3.91%	1.79%	1.14%	1.71%	2.83%	3.37%	2.01%	7.02%	5.33%	2.96%	1.51%	0.91%	4.06%	2.93%	2.76%
% of Shortlisted Appointed	22.99%	25.77%	19.51%	10.02%	8.26%	8.79%	11.26%	12.24%	11.11%	21.05%	20.00%	10.18%	6.32%	3.66%	18.60%	10.92%	14.63%

Appendix 7c

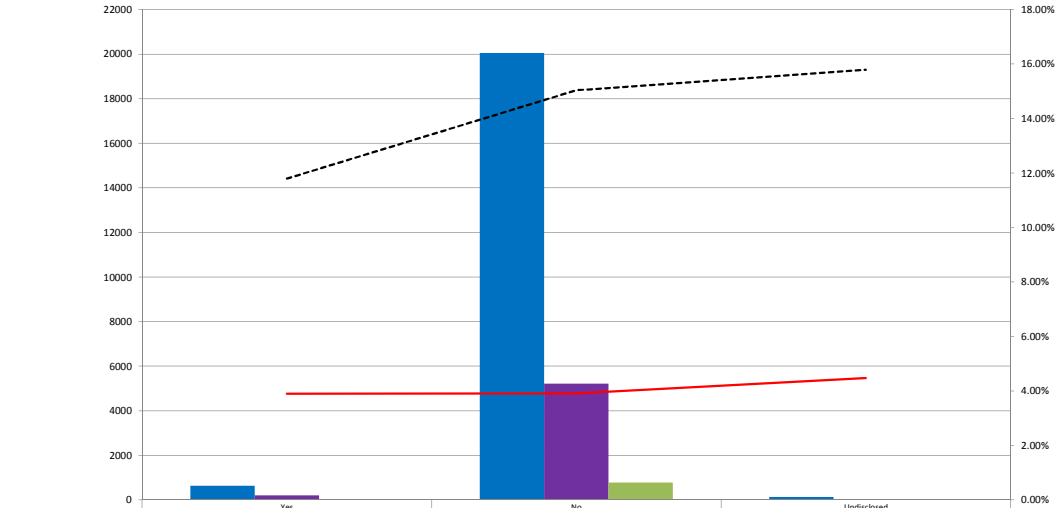
Recruitment by Gender



	Male	Female	Undisclosed
Applicant	6421	14379	29
Shortlisted	1380	4083	7
Appointed	205	609	2
% of Applicants Appointed	3.19%	4.24%	6.90%
% of Shortlisted Appointed	14.86%	14.92%	28.57%

Appendix 7d

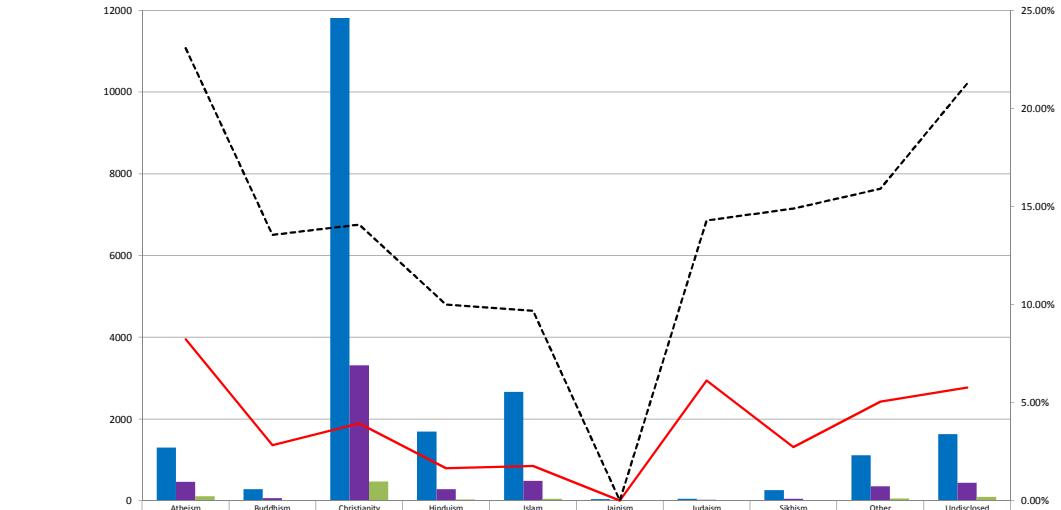
Recruitment by Disability



	Yes	No	Undisclosed
Applicant	642	20053	134
Shortlisted	212	5220	38
Appointed	25	785	6
% of Applicants Appointed	3.89%	3.91%	4.48%
% of Shortlisted Appointed	11.79%	15.04%	15.79%

Appendix 7e

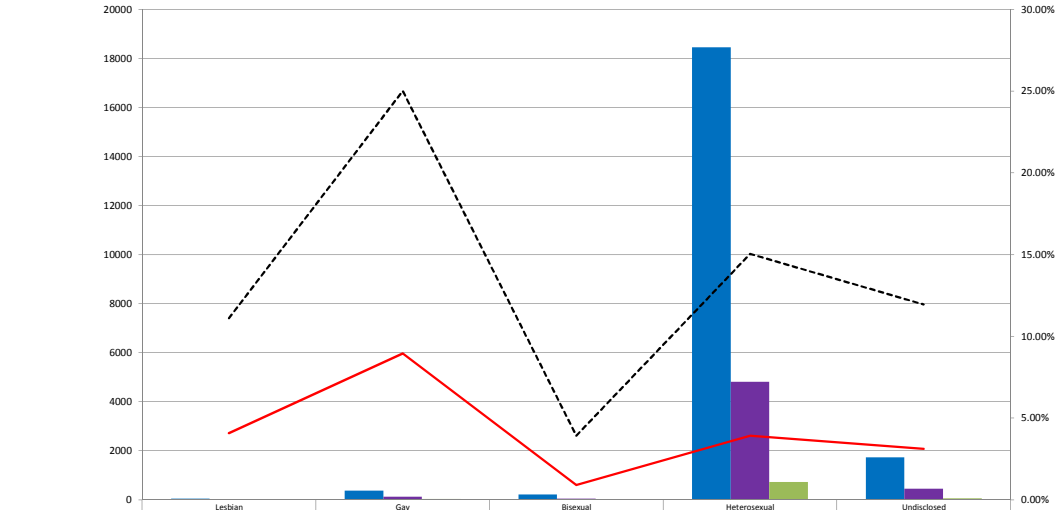
Recruitment by Religion



	Atheism	Buddhism	Christianity	Hinduism	Islam	Jainism	Judaism	Sikhism	Other	Undisclosed
Applicant	1300	283	11815	1690	2660	35	49	256	1110	1631
Shortlisted	464	59	3313	280	485	7	21	47	352	442
Appointed	107	8	466	28	47	0	3	7	56	94
% of Applicants Appointed	8.23%	2.83%	3.94%	1.66%	1.77%	0.00%	6.12%	2.73%	5.05%	5.76%
% of Shortlisted Appointed	23.06%	13.56%	14.07%	10.00%	9.69%	0.00%	14.29%	14.89%	15.91%	21.27%

Appendix 7f

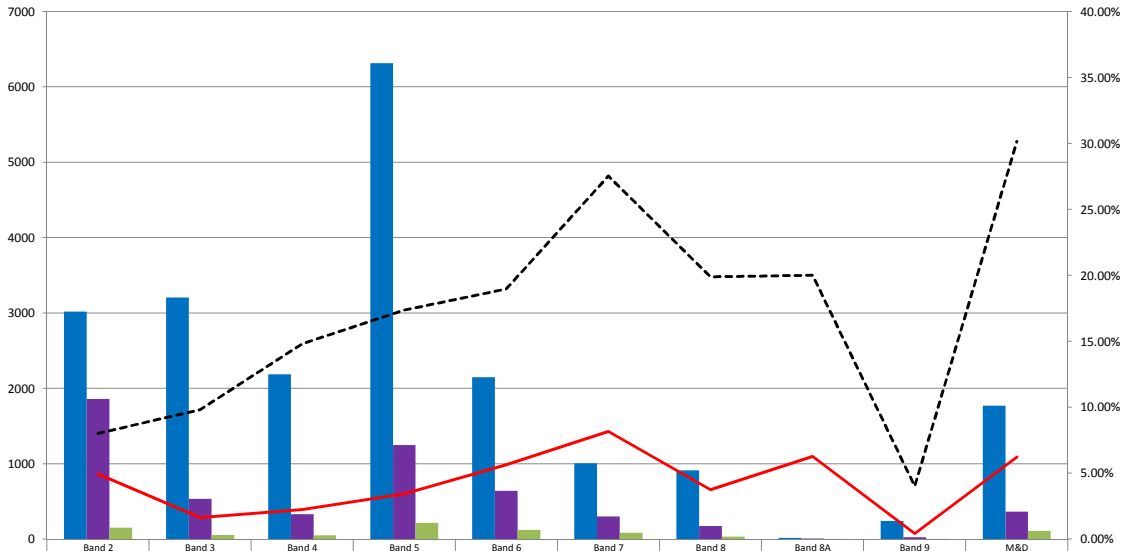
Recruitment by Sexual Orientation



	Lesbian	Gay	Bisexual	Heterosexual	Undisclosed
Applicant	49	369	222	18455	1734
Shortlisted	18	132	51	4817	452
Appointed	2	33	2	725	54
% of Applicants Appointed	4.08%	8.94%	0.90%	3.93%	3.11%
% of Shortlisted Appointed	11.11%	25.00%	3.92%	15.05%	11.95%

Appendix 7g

Recruitment by Grade



	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8	Band 8A	Band 9	M&D
Applicant	3018	3204	2185	6313	2148	1006	911	16	242	1768
Shortlisted	1860	531	331	1245	638	298	171	5	25	365
Appointed	149	52	49	216	121	82	34	1	1	110
% of Applicants Appointed	4.94%	1.62%	2.24%	3.42%	5.63%	8.15%	3.73%	6.25%	0.41%	6.22%
% of Shortlisted Appointed	8.01%	9.79%	14.80%	17.35%	18.97%	27.52%	19.88%	20.00%	4.00%	30.14%

Appendix 8

Promotions

Ethnic Code

Band Promoted to	A	B	C	D	E	F	G	H	J	K	L	M	N	P	R	S	Z	Promotions
Band 3	25.0%	12.5%	12.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	12.5%	12.5%	0.0%	0.0%	12.5%	12.5%	4.0%
Band 4	35.7%	0.0%	21.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	21.4%	0.0%	14.3%	0.0%	7.1%	0.0%	7.0%
Band 5	27.8%	0.0%	22.2%	0.0%	5.6%	0.0%	5.6%	5.6%	5.6%	0.0%	5.6%	0.0%	16.7%	5.6%	0.0%	0.0%	0.0%	9.0%
Band 6	58.2%	5.1%	7.6%	2.5%	0.0%	0.0%	2.5%	2.5%	0.0%	0.0%	5.1%	1.3%	6.3%	0.0%	1.3%	6.3%	1.3%	39.7%
Band 7	63.6%	9.1%	9.1%	0.0%	0.0%	0.0%	0.0%	4.5%	4.5%	0.0%	4.5%	2.3%	2.3%	0.0%	0.0%	0.0%	0.0%	22.1%
Band 8A	68.2%	4.5%	4.5%	0.0%	0.0%	0.0%	4.5%	9.1%	4.5%	0.0%	0.0%	0.0%	0.0%	0.0%	4.5%	0.0%	0.0%	11.1%
Band 8B	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.5%
Band 8C	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%
Band 8D	50.0%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%
Band 9	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medical	22.2%	0.0%	22.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	11.1%	0.0%	0.0%	0.0%	0.0%	11.1%	33.3%	4.5%
Total Promotions	**53.3%**	**5.0%**	**10.6%**	**1.0%**	**0.5%**	**0.5%**	**2.0%**	**3.5%**	**2.0%**	**0.0%**	**4.0%**	**3.0%**	**5.5%**	**1.5%**	**1.0%**	**4.0%**	**2.5%**	
Trust Profile	**45.8%**	**4.1%**	**12.4%**	**0.6%**	**0.4%**	**0.7%**	**1.3%**	**5.5%**	**1.0%**	**0.6%**	**5.5%**	**5.1%**	**7.4%**	**0.9%**	**1.3%**	**4.3%**	**3.1%**	

% of Ethnic Code Promoted

	A	B	C	D	E	F	G	H	J	K	L	M	N	P	R	S	Z	Total % Promoted
% Promoted	7.2%	7.6%	5.3%	10.5%	8.3%	4.3%	9.5%	4.0%	12.5%	0.0%	4.5%	3.7%	4.7%	10.0%	4.8%	5.8%	5.0%	6.2%

Age Range

Grade	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+	Promotions
Band 3	0.0%	0.0%	25.0%	0.0%	0.0%	25.0%	12.5%	25.0%	12.5%	0.0%	0.0%	0.0%	4.0%
Band 4	0.0%	28.6%	21.4%	14.3%	0.0%	0.0%	14.3%	14.3%	7.1%	0.0%	0.0%	0.0%	7.0%
Band 5	0.0%	11.1%	44.4%	11.1%	11.1%	5.6%	5.6%	5.6%	5.6%	0.0%	0.0%	0.0%	9.0%
Band 6	0.0%	10.1%	46.8%	13.9%	16.5%	6.3%	1.3%	3.8%	1.3%	0.0%	0.0%	0.0%	39.7%
Band 7	0.0%	4.5%	27.3%	34.1%	15.9%	9.1%	4.5%	2.3%	2.3%	0.0%	0.0%	0.0%	22.1%
Band 8A	0.0%	0.0%	18.2%	36.4%	31.8%	4.5%	9.1%	0.0%	0.0%	0.0%	0.0%	0.0%	11.1%
Band 8B	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%
Band 8C	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%
Band 8D	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.0%
Band 9	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medical	0.0%	0.0%	22.2%	11.1%	44.4%	0.0%	11.1%	11.1%	0.0%	0.0%	0.0%	0.0%	4.5%
Total Promotions	**0.0%**	**8.0%**	**34.7%**	**19.6%**	**17.1%**	**6.5%**	**6.5%**	**5.0%**	**2.5%**	**0.0%**	**0.0%**	**0.0%**	
Trust Profile	**0.2%**	**6.6%**	**19.4%**	**16.7%**	**15.8%**	**12.2%**	**10.6%**	**8.6%**	**5.7%**	**2.9%**	**0.9%**	**0.3%**	

Ethnic Code
A - White British
B - White Irish
C - Any other White background
D - White & Black Caribbean
E - White & Black African
F - White & Asian
G - Any other mixed background
H - Indian
J - Pakistani
K - Bangladeshi
L - Any other Asian background
M - Black Caribbean
N - Black African
P - Any other Black background
R - Chinese
S - Any other ethnic group
Z - Undefined

Gender

Grade	Female	Male	Promotions
Band 3	62.5%	37.5%	4.0%
Band 4	35.7%	64.3%	7.0%
Band 5	72.2%	27.8%	9.0%
Band 6	89.9%	10.1%	39.7%
Band 7	72.7%	27.3%	22.1%
Band 8A	81.8%	18.2%	11.1%
Band 8B	0.0%	100.0%	0.5%
Band 8C	50.0%	50.0%	1.0%
Band 8D	100.0%	0.0%	1.0%
Band 9	0.0%	0.0%	0.0%
Medical	55.6%	44.4%	4.5%
Total Promotions	**76.4%**	**23.6%**	
Trust Profile	**76.9%**	**23.1%**	

Sexual Orientation

Grade	Bisexual	Gay	Heterosexual	Lesbian	Undisclosed	Promotions
Band 3	0.0%	0.0%	25.0%	0.0%	75.0%	4.0%
Band 4	7.1%	7.1%	35.7%	0.0%	50.0%	7.0%
Band 5	0.0%	11.1%	72.2%	0.0%	16.7%	9.0%
Band 6	0.0%	2.5%	69.6%	1.3%	26.6%	39.7%
Band 7	0.0%	6.8%	63.6%	2.3%	27.3%	22.1%
Band 8A	0.0%	9.1%	45.5%	0.0%	45.5%	11.1%
Band 8B	0.0%	0.0%	0.0%	0.0%	100.0%	0.5%
Band 8C	0.0%	0.0%	50.0%	0.0%	50.0%	1.0%
Band 8D	0.0%	0.0%	0.0%	0.0%	100.0%	1.0%
Band 9	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medical	0.0%	11.1%	33.3%	0.0%	55.6%	4.5%
Total Promotions	**0.5%**	**5.5%**	**58.8%**	**1.0%**	**34.2%**	
Trust Profile	**0.2%**	**1.8%**	**37.2%**	**0.3%**	**60.7%**	

Religious Belief

Grade	Atheism	Buddhism	Christianity	Hinduism	Islam	Jainism	Judaism	Other	Sikhism	Undisclosed	Promotions
Band 3	0.0%	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%	12.5%	0.0%	75.0%	4.0%
Band 4	0.0%	0.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	7.0%
Band 5	11.1%	0.0%	55.6%	0.0%	5.6%	0.0%	0.0%	5.6%	0.0%	22.2%	9.0%
Band 6	6.3%	0.0%	54.4%	1.3%	1.3%	0.0%	1.3%	10.1%	1.3%	24.1%	39.7%
Band 7	4.5%	0.0%	47.7%	0.0%	4.5%	0.0%	0.0%	6.8%	0.0%	36.4%	22.1%
Band 8A	0.0%	0.0%	36.4%	4.5%	0.0%	0.0%	0.0%	4.5%	0.0%	54.5%	11.1%
Band 8B	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.5%
Band 8C	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	1.0%
Band 8D	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	1.0%
Band 9	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medical	0.0%	0.0%	11.1%	0.0%	22.2%	0.0%	0.0%	0.0%	0.0%	66.7%	4.5%
Total Promotions	**5.0%**	**0.0%**	**45.2%**	**1.0%**	**3.5%**	**0.0%**	**0.5%**	**7.0%**	**0.5%**	**37.2%**	
Trust Profile	**4.5%**	**0.4%**	**25.1%**	**1.4%**	**2.5%**	**0.0%**	**0.2%**	**3.6%**	**0.3%**	**62.0%**	

Disabled

Grade	No	Yes	Undisclosed	Promotions
Band 3	25.0%	0.0%	75.0%	4.0%
Band 4	50.0%	0.0%	50.0%	7.0%
Band 5	44.4%	5.6%	50.0%	9.0%
Band 6	68.4%	2.5%	29.1%	39.7%
Band 7	38.6%	2.3%	59.1%	22.1%
Band 8A	13.6%	4.5%	81.8%	11.1%
Band 8B	100.0%	0.0%	0.0%	0.5%
Band 8C	50.0%	0.0%	50.0%	1.0%
Band 8D	50.0%	0.0%	50.0%	1.0%
Band 9	0.0%	0.0%	0.0%	0.0%
Medical	44.4%	11.1%	44.4%	4.5%
Total Promotions	**49.2%**	**3.0%**	**47.7%**	
Trust Profile	**44.7%**	**1.5%**	**53.8%**	

Appendix 9

Employee Relations

Below Trust Profile Above Trust Profile

Staffgroup	B&H	Disciplinary	Grievance	% of Total Cases	Trust Profile
Add Prof Scientific and Technic	0.00%	4.55%	0.00%	**3.70%**	5.47%
Additional Clinical Services	25.00%	11.36%	0.00%	**12.96%**	10.67%
Administrative and Clerical	25.00%	38.64%	50.00%	**37.04%**	19.83%
Medical and Dental	12.50%	2.27%	0.00%	**3.70%**	20.21%
Nursing and Midwifery Registered	37.50%	43.18%	50.00%	**42.59%**	35.69%
% of Total Cases	**14.81%**	**81.48%**	**3.70%**		

Grade	B&H	Disciplinary	Grievance	% of Total Cases	Trust Profile
Band 2	37.50%	22.73%	0.00%	**24.07%**	7.35%
Band 3	0.00%	11.36%	0.00%	**9.26%**	7.38%
Band 4	0.00%	11.36%	0.00%	**9.26%**	8.16%
Band 5	12.50%	29.55%	100.00%	**29.63%**	21.05%
Band 6	25.00%	13.64%	0.00%	**14.81%**	16.73%
Band 7	12.50%	6.82%	0.00%	**7.41%**	11.57%
Band 8C	0.00%	2.27%	0.00%	1.85%	0.84%
Consultant	0.00%	2.27%	0.00%	1.85%	7.51%
FY1	12.50%	0.00%	0.00%	**1.85%**	1.31%
% of Total Cases	**14.81%**	**81.48%**	**3.70%**		

Age Range	B&H	Disciplinary	Grievance	% of Total Cases	Trust Profile
20-24	0.00%	9.09%	0.00%	**7.41%**	6.63%
25-29	12.50%	18.18%	0.00%	**16.67%**	19.42%
30-34	25.00%	6.82%	0.00%	**9.26%**	16.73%
35-39	0.00%	11.36%	100.00%	**12.96%**	15.83%
40-44	25.00%	18.18%	0.00%	**18.52%**	12.20%
45-49	37.50%	13.64%	0.00%	**16.67%**	10.63%
50-54	0.00%	11.36%	0.00%	**9.26%**	8.57%
55-59	0.00%	6.82%	0.00%	**5.56%**	5.66%
60-64	0.00%	4.55%	0.00%	**3.70%**	2.91%
% of Total Cases	**14.81%**	**81.48%**	**3.70%**		

Ethnicity	B&H	Disciplinary	Grievance	% of Total Cases	Trust Profile
A - White British	12.50%	20.45%	0.00%	**18.52%**	45.76%
B - White Irish	0.00%	4.55%	0.00%	**3.70%**	4.10%
C - Any other White background	12.50%	11.36%	0.00%	**11.11%**	12.36%
D - White & Black Caribbean	0.00%	2.27%	0.00%	**1.85%**	0.59%
G - Any other mixed background	0.00%	6.82%	0.00%	**5.56%**	1.31%
H - Indian	25.00%	0.00%	0.00%	**3.70%**	5.47%
L - Any other Asian background	0.00%	2.27%	0.00%	**1.85%**	5.54%
M - Black Caribbean	0.00%	20.45%	100.00%	**20.37%**	5.07%
N - Black African	37.50%	15.91%	0.00%	**18.52%**	7.38%
S - Any other ethnic group	0.00%	9.09%	0.00%	**7.41%**	4.32%
Z - Undisclosed	12.50%	6.82%	0.00%	**7.41%**	3.13%
% of Total Cases	**14.81%**	**81.48%**	**3.70%**		

Gender	B&H	Disciplinary	Grievance	% of Total Cases	Trust Profile
Female	75.00%	63.64%	100.00%	**66.67%**	74.54%
Male	25.00%	36.36%	0.00%	**33.33%**	25.46%
% of Total Cases	**14.81%**	**81.48%**	**3.70%**		

Disability	B&H	Disciplinary	Grievance	% of Total Cases	Trust Profile
No	62.50%	31.82%	50.00%	**37.04%**	44.67%
Undisclosed	37.50%	68.18%	50.00%	**62.96%**	53.83%
% of Total Cases	**14.81%**	**81.48%**	**3.70%**		

Religion	B&H	Disciplinary	Grievance	% of Total Cases	Trust Profile
Atheism	0.00%	6.82%	0.00%	**5.56%**	0.10%
Christianity	12.50%	11.36%	50.00%	**12.96%**	25.12%
Other	12.50%	6.82%	50.00%	**9.26%**	3.57%
Undisclosed	75.00%	75.00%	0.00%	**72.22%**	62.03%
% of Total Cases	**14.81%**	**81.48%**	**3.70%**		

Sexual Orientation	B&H	Disciplinary	Grievance	% of Total Cases	Trust Profile
Gay	0.00%	2.27%	0.00%	**1.85%**	1.75%
Heterosexual	37.50%	25.00%	100.00%	**29.63%**	37.19%
Undisclosed	62.50%	72.73%	0.00%	**68.52%**	60.65%
% of Total Cases	**14.81%**	**81.48%**	**3.70%**		

Disciplinaries

Ethnicity	Investigation	First Warning	Final Warning	Dismissed
A - White British	55.56%	11.11%	11.11%	22.22%
B - White Irish	0.00%	50.00%	0.00%	50.00%
C - Any other White background	20.00%	20.00%	20.00%	40.00%
D - White & Black Caribbean	0.00%	0.00%	0.00%	100.00%
G - Any other mixed background	100.00%	0.00%	0.00%	0.00%
L - Any other Asian background	0.00%	0.00%	100.00%	0.00%
M - Black Caribbean	55.56%	11.11%	33.33%	0.00%
N - Black African	28.57%	14.29%	14.29%	42.86%
S - Any other ethnic group	25.00%	25.00%	25.00%	25.00%
Z - Undisclosed	33.33%	33.33%	33.33%	0.00%
% of Disciplinaries	**40.91%**	**15.91%**	**20.45%**	**22.73%**

Ethnicity	Investigation	First Warning	Final Warning	Dismissed	% of Total Cases	Trust Profile
A - White British	27.78%	14.29%	11.11%	20.00%	**20.45%**	**45.76%**
B - White Irish	0.00%	14.29%	0.00%	10.00%	**4.55%**	**4.10%**
C - Any other White background	5.56%	14.29%	11.11%	20.00%	**11.36%**	**12.36%**
D - White & Black Caribbean	0.00%	0.00%	0.00%	10.00%	**2.27%**	**0.59%**
G - Any other mixed background	16.67%	0.00%	0.00%	0.00%	**6.82%**	**1.31%**
L - Any other Asian background	0.00%	0.00%	11.11%	0.00%	**2.27%**	**5.54%**
M - Black Caribbean	27.78%	14.29%	33.33%	0.00%	**20.45%**	**5.07%**
N - Black African	11.11%	14.29%	11.11%	30.00%	**15.91%**	**7.38%**
S - Any other ethnic group	5.56%	14.29%	11.11%	10.00%	**9.09%**	**4.32%**
Z - Undisclosed	5.56%	14.29%	11.11%	0.00%	**6.82%**	**3.13%**

	Disciplinary %		
Ethnic ID	2012/13	2011/12	2010/11
A - White British	20.45%	25.00%	28.57%
B - White Irish	4.55%	0.00%	7.94%
C - Any other White background	11.36%	0.00%	7.94%
D - White & Black Caribbean	2.27%	7.14%	1.59%
E - White & Black African	0.00%	0.00%	0.00%
F - White & Asian	0.00%	0.00%	0.00%
G - Any other mixed background	6.82%	0.00%	4.76%
H - Indian	0.00%	0.00%	3.17%
J - Pakistani	0.00%	0.00%	0.00%
K - Bangladeshi	0.00%	0.00%	0.00%
L - Any other Asian background	2.27%	10.71%	6.35%
M - Black Caribbean	20.45%	21.43%	19.05%
N - Black African	15.91%	17.86%	9.52%
P - Any other Black background	0.00%	3.57%	1.59%
R - Chinese	0.00%	0.00%	0.00%
S - Any other ethnic group	9.09%	3.57%	6.35%
Z - Undisclosed	6.82%	10.71%	3.17%

	Trust Profile		
Ethnic ID	2012/13	2011/12	2010/11
A - White British	45.76%	45.86%	44.73%
B - White Irish	4.10%	3.86%	4.37%
C - Any other White background	12.36%	12.21%	12.18%
D - White & Black Caribbean	0.59%	0.75%	0.92%
E - White & Black African	0.38%	0.38%	0.46%
F - White & Asian	0.72%	0.72%	0.66%
G - Any other mixed background	1.31%	1.35%	1.18%
H - Indian	5.47%	5.15%	5.09%
J - Pakistani	1.00%	0.97%	1.02%
K - Bangladeshi	0.63%	0.50%	0.53%
L - Any other Asian background	5.54%	5.84%	5.58%
M - Black Caribbean	5.07%	5.27%	5.48%
N - Black African	7.38%	7.88%	7.88%
P - Any other Black background	0.94%	0.94%	0.89%
R - Chinese	1.31%	1.69%	1.87%
S - Any other ethnic group	4.32%	4.24%	4.27%
Z - Undisclosed	3.13%	2.39%	2.89%

Appendix 10

Below Trust Average Training Episodes Above Trust Average Training Episodes

No. of Delegates

	Ethnic Origin	A White - British	B White - Irish	C White - Other	D Mixed - White & Black Caribbean	E Mixed - White & Black African	F Mixed - White & Asian	G Mixed - Other	H Asian/Asian British - Indian	J Asian/Asian British - Pakistani	K Asian/Asian British - Bangladeshi	L Asian/Asian British - Other	M Black/Black British - Caribbean	N Black/Black British - African	P Black/Black British - Any Other Black Background	R Chinese	S Other - Any Other Ethnic Group	Z Ethnicity Undisclosed	Total
	% of Trust staff	46%	4%	12%	1%	0.4%	1%	1%	5%	1%	1%	6%	5%	7%	1%	1%	4%	3%	100%
	Number of Trust Staff	1,463	131	395	19	12	23	42	175	32	20	177	162	236	30	42	138	100	3,197
Mandatory	Number of training episodes	7487	494	2218	73	78	156	254	1072	203	124	700	692	1041	111	292	606	726	16327
	Attendance per employee	5.12	3.77	5.62	3.84	6.50	6.78	6.05	6.13	6.34	6.20	3.95	4.27	4.41	3.70	6.95	4.39	7.26	5.11
Non Mandatory	Number of attendees	733	34	239	4	10	21	54	169	20	14	72	40	100	6	40	51	60	1667
	Attendance per employee	0.50	0.26	0.61	0.21	0.83	0.91	1.29	0.97	0.63	0.70	0.41	0.25	0.42	0.20	0.95	0.37	0.60	0.52

No. of Delegates

	Ethnic Origin Category	White	BME Staff	Z Not Stated	Total
	% of staff	62%	35%	3%	100%
	Number of Trust Staff	1,989	1108	100	3197
Mandatory	Number of training episodes	10199	5402	726	16327
	Attendance per employee	5.13	4.88	7.26	5.11
Non Mandatory	Number of training episodes	1006	601	60	1667
	Attendance per employee	0.51	0.54	0.60	0.52

No. of Delegates

	Gender	Female	Male	Total
	% of staff	74%	25%	100%
	Number of Trust Staff	2378	814	3197
Mandatory	Number of training episodes	12203	4124	16327
	Attendance per employee	5.13	5.07	5.11
Non Mandatory	Number of training episodes	1201	466	1667
	Attendance per employee	0.51	0.57	0.52

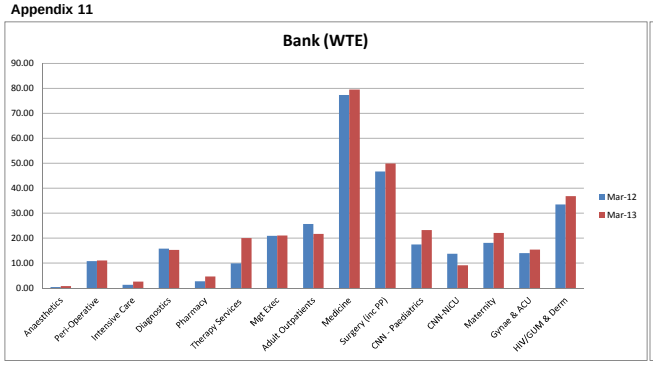
No. of Delegates

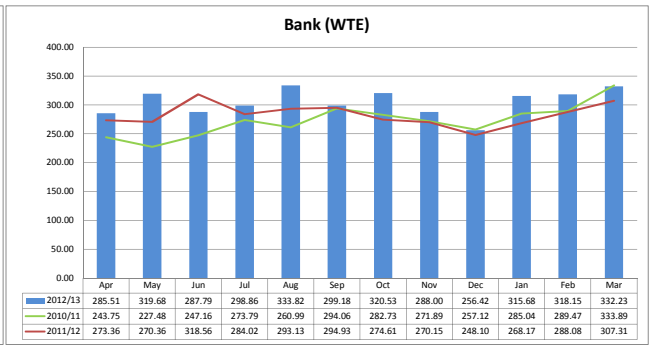
	Age Band	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+	Total
	% of staff	0.2%	7.0%	20.4%	17.6%	16.6%	12.8%	11%	9.0%	5.9%	3.1%	1.0%	0.3%	100%
	Number of Trust Staff	6	212	621	535	506	390	340	274	181	93	29	10	3197
Mandatory	Number of training episodes	28	1112	3411	3261	2432	1553	1212	1083	687	291	109	3	16327
	Attendance per employee	4.67	5.25	5.49	6.10	4.81	3.98	3.56	3.95	3.80	3.13	3.76	0.30	5.11
Non Mandatory	Number of training episodes	5	61	514	531	261	157	118	66	44	24	5	1	1667
	Attendance per employee	0.83	0.29	0.83	0.99	0.52	0.40	0.35	0.24	0.24	0.26	0.17	0.10	0.52

No. of Delegates

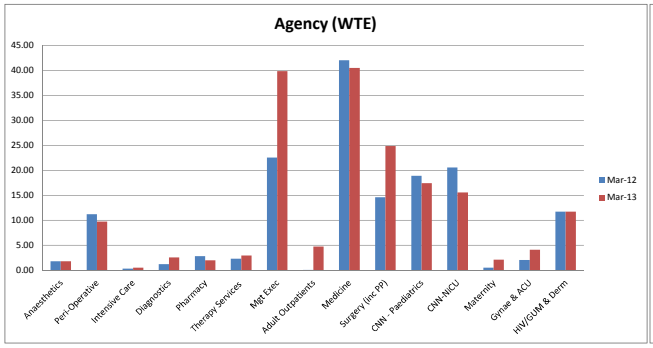
	Staff Group	Add Prof Scientific	Additional Clinical Services	Admin & Clerical	Allied Health Professional	Healthcare Scientist	Medical & Dental	Nursing & Midwifery Reg	Total
	% of staff	5.6%	11.1%	20.9%	7.1%	1.5%	21.3%	38%	100%
	Number of Trust Staff	169	339	636	215	47	650	1172	3197
Mandatory	Number of training episodes	597	1448	1726	805	185	4724	6842	16327
	Attendance per employee	3.53	4.27	2.71	3.74	3.94	7.27	5.84	5.11
Non Mandatory	Number of training episodes	92	105	171	27	5	976	294	1667
	Attendance per employee	0.54	0.31	0.27	0.13	0.11	1.50	0.25	0.52

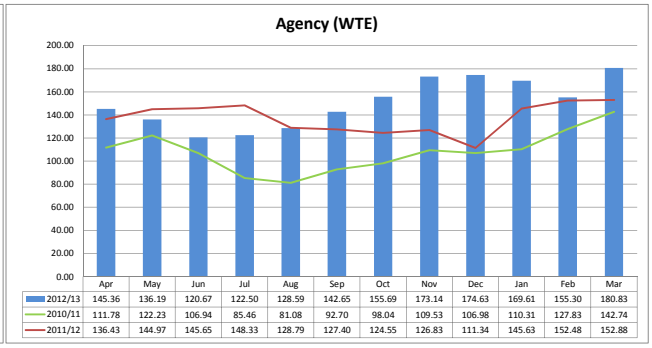
Appendix 11





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	285.51	319.68	287.79	298.86	333.82	299.18	320.53	288.00	256.42	315.68	318.15	332.23
2010/11	243.75	227.48	247.16	273.79	260.99	294.06	282.73	271.89	257.12	285.04	289.47	333.89
2011/12	273.36	270.36	318.56	284.02	293.13	294.93	274.61	270.15	248.10	268.17	288.08	307.31





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	145.36	136.19	120.67	122.50	128.59	142.65	155.69	173.14	174.63	169.61	155.30	180.83
2010/11	111.78	122.23	106.94	85.46	81.08	92.70	98.04	109.53	106.98	110.31	127.83	142.74
2011/12	136.43	144.97	145.65	148.33	128.79	127.40	124.55	126.83	111.34	145.63	152.48	152.88

Appendix 12 – Narrative supplementary paper

1. Context

1.1 Under the Equality Act 2010 the Trust is required to annually publish, as a minimum, any progress made in meeting equality objectives and analysis of equality information.

1.2 An annual report highlighting the outcome of this statutory monitoring duty and recommended actions is prepared by the Director of HR in April of each year as part of an annual 'Workforce Report'. The report also includes analyses of additional staffing metrics over the previous year.

2.0 Flexible Working

2.0.1 From the analysis of staff working flexibly (704 or 22% of staff reported working flexibly), it appears that part-time working is the most popular flexible working arrangement. Nursing and Midwifery and Allied Health Professional staff have the most flexible working arrangements in place. It is worth noting that staff survey results indicate a higher proportion of staff have flexible working arrangements in place. No further conclusions can be drawn from this although we will continue to encourage more staff to declare their working arrangements so that we can accurately report on this in future.

2.1 Length of Service

2.1.1 The average length of service for staff is 6.31 years (excluding junior doctors). Analysis by protected characteristic shows that women hold the longest length of service, however there is no significant statistical difference when compared to men to cause concern. Employees aged 60-64 average over 12 years' service and white staff have marginally longer length of service than BME staff. Staff that have not disclosed their disability, religion or sexual orientation status tend to have greater length of service. No other conclusions can be made from this data; this is to be expected as data gathering for these characteristics only began in recent years.

2.2 Pay

2.2.1 The median Trust salary is £27,901 which equates to the top of a Band 5 grade. The mean average salary for the country is lower at £26,500 (confirmed by the Office of National Statistics for year ending April 2012). A breakdown of the median basic salary of employees highlights that White staff earn the highest average salary over BME staff. Although there are fewer men in the Trust they earn the highest average salary compared to women. Staff aged between 40-54 continue to maintain the highest average salary; in contrast staff aged below 20 earn the lowest. It is worth noting that junior doctors were included in this analysis.

2.3 Joiners, Leavers, Turnover and Staff In-Post

2.3.1 **Joiner and Leavers:** The graphs shown in Appendix 3a indicate the numbers of staff joining and leaving the Trust by month, with the number of joiners and leavers by ethnic group against the total number of staff in post shown in Appendix 3b. Graph 3b indicates that more White Irish, White Other, Indian, Bangladeshi and White & Asian (Mixed) and Black African people joined the Trust. Across most of the ethnic categories more staff left than joined the Trust. There are no specific concerns/reasons for these turnover trends other than natural turnover

2.3.2 As shown in Appendix 3d more staff aged between 20-29 joined the Trust that any other age group. In contrast, marginally more women and staff aged 40 and over left which can be mainly attributed to natural turnover. Further

analysis of leaver and joiners by sexual orientation, religion and disability can not be gleaned due to the significant proportion of staff having not disclosed their protected characteristics.

3.0 Recruitment and Retention

3.0.1 This section of the report looks at comparing number of applicants who applied against those short-listed and appointed to jobs in the Trust by age, ethnicity, gender, disability, religious belief and sexual orientation.

3.0.2 The Trust workforce continues to be predominately from the local and central London population.

3.0.3 The central London population comprises those living in the boroughs of Camden, Islington, Kensington and Chelsea, Lambeth, Southwark, Wandsworth and Westminster, with the majority of applicants coming from the local and/or central London catchments area.

3.1 Age

3.1.1 The highest number of applications came from applicants aged 25-29 and this group also had a high "success rate" and is evidenced in the number of joiners during 2012/13, as shown in Appendix 7a. No further statistically significant analysis can be drawn.

3.2 Ethnicity

3.2.1 For the last seven years, we consistently receive more applications from Black/Black British African background than any other ethnic group. 23% of applicants were from this ethnic group, showing a slight decrease on last year. The second largest group of applicants are from a White British background, at 18.4% which also shows a marginal decrease as shown in Appendix 7b. This is may be due to applicants wanting job security in the current uncertain economic climate.

3.2.2 The "success" rate for applicants that were shortlisted and appointed was highest for White Irish applicants at 11.05% (i.e. 380 applied for posts and 42 were successful) whereas Asian Pakistani applicants have the lowest success rate at 1.14% (787 applied and 9 appointed.)

3.3 Gender

3.3.1 Recruitment analysis by gender has not changed in the last 5 years. The largest group of candidates are female; a total of 14,379 applications out of a total of 20,829 as seen in Appendix 7c. The NHS has traditionally employed a greater proportion of females in nursing and midwifery roles and this is the largest group of employed staff. This also translates into the largest group short-listed and appointed to posts in the Trust. This is reflective across the wider NHS and not specific to the workforce here at Chelsea and Westminster Hospital NHS Foundation Trust.

3.4 Disability

3.4.1 Applicants that chose not to disclose their disability status had the highest success rate at 4.48%a shown in Appendix 7d, although the number of applicants in this pool was smaller compared to applicants with no disability. The analysis reinforces our commitment to our status as a Two Ticks employer.

3.5 Religious Belief

3.5.1 Appendix 7e shows applicants by declared religious belief. Consistent with the last five years reports, the largest group of applicants came from

candidates identifying as Christian, followed by Muslim and then Hindu. 1631 applicants did not disclose their religious belief, which is fewer than last year. A possible explanation for this is likely to be that applicants are becoming more accepting of declaring their religion. Applicants who declared themselves as following Atheism were the most successful this year, whereas Jain applicants were the least successful. No further analysis can be drawn from this data.

3.6 Promotions

3.6.1 Breakdown of the promotions data by ethnicity and band in Appendix 8 shows that over half the promotions were gained by White staff at Band 2-8A and 8C-D. BME staff were promoted into Bands 3-4 with some exceptions in Bands 6-7 and Medical posts. 69% of the promotions were gained by White staff and 28% of the promotions were gained by BME staff which is the same as last year. It is recognised that fewer BME staff hold senior posts across the Trust and more work be will done to encourage BME staff to apply for internal promotions where applicable.

3.6.2 76% of the total promotions were gained by women, although 44.4% of the medical promotions were gained by men which is less than last year (60%). Staff aged between 25-34 gained the most promotions and staff who did not wish to disclose their religion gained the most number of promotions. There was insufficient data for promotions by sexual orientation to draw any meaningful conclusions.

3.7 Employee Relations

3.7.1 All formal closed disciplinary and grievances cases have been reported in Appendix 9.

3.8 Harassment and Bullying

3.8.1 A total of 8 formal cases were raised, all of which were resolved through investigation or referred for mediation; 6 of the cases involved women and 2 involved men. No further conclusions can be drawn from this other than women raised more bullying and harassment concerns compared to men in 2012-13.

3.9 Grievance

3.9.1 2 grievance cases were raised in 2012/13 by 2 BME female staff. No further conclusions can be drawn.

3.10 Disciplinary

3.10.1 A total of 28 disciplinary cases were managed in 2012/13 for women and 17 cases were for male staff. A higher percentage of these cases were brought against ‘Black Caribbean’ and ‘Black African’ staff (both made up 36.4% of all cases). Comparing this data against the ethnic composition of the workforce suggests that ‘Black Caribbean’ and ‘Black African’ staff were more disproportionately represented in disciplinary cases than White British staff, although the same number of cases were reported against both groups.

3.11 Overall observations/statement of findings

3.11.1 Appendix 9 shows that when comparing the Trust ethnic profile against the ethnicity of all employees involved in employee relations procedures, BME staff, particularly staff from Black African and Black Caribbean ethnic groups still continue to be disproportionately affected compared with White colleagues. When comparing this to the staff group profile of the Trust, staff in junior bands or Administrative & Clerical and Nursing and Midwifery staff were disproportionately involved in ER cases. Further analysis of disciplinary cases

showed that a greater number of BME were invited to investigations and issued with final warnings compared to White staff. However, of the total number of staff dismissed from the Trust 50% were White staff and 50% were BME staff.

3.11.3 Analysis by gender and age suggests that men and staff under 20-24 are disproportionately represented in disciplinary cases; in contrast women and staff aged 30-49 are disproportionately represented in grievance and harassment and bullying cases. Due to high numbers of staff that have not their disability, religion or sexual orientation it is not possible to drawn valid conclusions from these datasets.

3.11.2 As last year, all ER cases have been reviewed and indicate that the action has been taken for valid reasons and the outcomes taken appear to be proportionate. HR will continue to work with managers to ensure that staff are managed fairly and equitably, the data provided in this report will be shared with managers so that they are aware of these issues. HR periodically undertakes local briefing sessions to remind managers of key processes within employee relations policies. In summary, further analysis and on-going involvement with BME staff is needed to fully understand why BME staff continue to be disproportionately represented in employee relations cases.

4.0 Training

4.0.1 Appendix 10 shows staff from White Irish, Black African, Black Caribbean and other Black ethnic categories have a lower attendance for mandatory and non mandatory training and further analysis will be undertaken to understand the reasons for this.

4.0.2 Attendance for mandatory training for Medical & Dental and Nursing & Midwifery staff was above average and probably reflects staff attendance at the new update days.

4.0.3 86% of staff who accessed Professional Development training came from a white background.

4.1 Appraisals

4.1.1 The Trust appraisal completion rate as measured by the NHS Staff Survey in 2012/13 was 82% against a target of 87%

4.1.2 Analysis of data by protected characteristic indicates that appraisal completion rates were higher for men, younger staff in the 20-34 age brackets and staff in senior bands. In contrast, staff from Nursing & Midwifery (78%) and Additional Clinical Services (77%) staff groups and staff from Black ethnic groups (ranging from 72-77%) had slightly lower appraisal completion rates. This could be explained by the fact that there are proportionately more BME staff in lower bands or clinical roles compared to White staff. Further investigation is needed to understand the reasons for the lower appraisal rate in order for recommendations to be made.

4.1.3 The Trust has invested in a new IT system for the capturing of medical staff appraisals to support the introduction of medical Revalidation. Appraisals for medical staff matched the overall Trust rate in 2012/13 according to the NHS Staff Survey.

4.1.4 Due to changes to Agenda for Change terms and conditions introduced in 2013, as well as the embedding of Consultant Appraisals, the Trust has set an ambitious target of 90% having had an appraisal in the last 12 months, as measured by the NHS Staff Survey.

5.0 Bank and Agency Staff Usage

5.0.1 2012/13 has seen an increase in the usage of Agency staff, particularly in the last quarter; see Appendix 11. An average of 4.4% of Trust WTE was supplied through Agencies or Contracted staff. This is an increase on previous year, however overall spend on this type of staff was lower than the previous year and the Trust remained within its overall pay budget for the year. Agency staff as well as being more generally more expensive than other staff, do not provide the Trust the same level of confidence that the workforce is delivering the excellent patient care we expect our staff to deliver. The Trust will continue to monitor the use of Agency staff and as part of the on-going QIPP project has set a target for 2013/14 that will see a reduction in Agency use to no more than 3.15%

5.0.2 This highest usage of bank and agency staff remains with Nursing and Midwifery staff and in general the Bank and Agency usage is lower than the Trusts vacancy rate.

5.0.3 The Trust retains ethnicity and gender information for Bank staff. Analysis of the composition of Bank members of staff against the Trust indicates that slightly more men and BME staff hold bank positions. Disability, sexual orientation and religion can also be recorded but the majority of Bank staff prefer not to disclose these details.

5.0.4 The age profile of bank staff is younger than the Trust age profile. There continues to be a higher proportion of people under the age of 34 (last year people aged under 25 made up the highest proportion) working through the bank than substantively employed. The probable reason for people under the age of 34 choosing to work through the Bank is to gain experience of working in different departments/wards given the current economic climate, or working flexibly in addition to studying.

6.0 Delivering a Safe Workforce

6.0.1 Nearly 2300 of the Trust staff are registered with a professional body. The Trust monitors these registrations on a regular basis and engages with staff and managers to ensure that up to date registration is maintained in line with the Trust Procedure for Checking Professional Registration.

6.0.2 Staff and their line managers receive notification of any expired registration and HR take appropriate action as outlined in the Procedure for Checking Professional Registrations. In 2012/3, 13 staff were paid as non-qualified staff and required to work non-clinically whilst issues with their expired registrations were resolved.

6.0.3 During 2012, the Trust reviewed its communication methods with staff regarding their registration to ensure that all staff and their managers receive adequate notification of expiring registrations.

6.0.4 Following a review of the monitoring and compliance section of the Procedure for checking professional registrations, the HR department has reviewed the distribution of the quarterly monitoring report for registrations, and from Quarter 1 2013/14, these reports will be tabled at Divisional Boards, to provide the Divisions with assurance that their staffs registration is monitored and where appropriate, action has been taken to resolve any lapses.

6.0.5 As well as professional Registration checks, the Trust carries out a number of pre-employment checks on staff commencing with the Trust, in line with the six NHS Employment Check Standards for new starters. The audits highlighted no significant issues, although a number of issues were addressed, with some additional safeguards introduced in the checking process.

6.0.6 The Trust Staffbank Office verifies the professional registration of non-medical staff employed via an agency on a quarterly basis. During 2012/13 the

agency verification reports did not highlight any issues with professional registration. The Trust can therefore assure that the agencies used have commensurate registrations compliance procedures in place.

6.0.7 Where locum medical staff are booked through an agency, the agency must provide evidence of the doctors registration and license to practice. This evidence is then provided to the requesting Consultant/General Manager for review and approval.

6.0.8 A series of audits were undertaken by the Recruitment team in 2012/13 to review these pre-employment processes and a number of recommendations have been implemented as a result. The Trust continues to monitor and improve all of the processes involved in ensuring a safe workforce.

7.0 Equality and diversity

7.1 Implementation of Equality Delivery System

7.1.1. In 2011-12, the Trust Board agreed to support the implementation of the Equality Delivery System (EDS, is an NHS tool to help organisations performance managing equality across the Trust) to replace the Single Equality Scheme.

7.1.2 The EDS was partly implemented in 2011-12 and further work was needed to engage relevant interest groups and other external stakeholders such as LINks to ensure that the EDS was implemented effectively. A successful engagement event was held in July 2012 where feedback was collected on areas of improvement e.g. communication, way finding and the appointments process which are all areas the Trust is currently working on.

7.1.3 A follow up workshop was organised in November 2012 to grade the Trust's achievements against the EDS framework. Unfortunately this workshop was not was well attended by external stakeholders. It was agreed that more work needed to be done on strengthening collaborative working relationships with external community groups before the EDS could be successfully implemented.

7.2 Equality Objectives progress

7.2.1 A new set of equality objectives replaced the Single Equality Scheme in April 2012, following the passage into law of the Equality Act 2010. This section provides a brief account of progress made in year against each objective.

7.3 Objective 1: Improve equality data collection and usage across all protected characteristics

7.3.1 A national review of the patient IT systems was scheduled to take place but progress has been delayed due to reorganisation of primary care organisations and strategic health authorities. In 2013-14 will undertake a local review of the IT systems to identify the gaps and decide how they can be plugged.

7.3.2 Development of a disability category on the current Trust audit process for complaints now enables complaints involving LD issues to be reported on.

7.4 Objective 2: Continue to develop and promote an organisational culture that supports the principles of equality

7.4.1 Equality Analysis

7.4.1.1 Under the Equality Act 2010, the term equality impact assessments is now called equality analysis. The expectation to 'equality check' our policies,

functions or a process still remains. It has been noted that not as much progress has been made in 2012/13 compared to previous years.

7.4.2 In 2012/13, the assessment documentation was simplified to make it easier for managers to complete the assessments and implement changes. The new template will be rolled out to managers in 2013-14 and managers will also be asked to confirm which policies they intend to assess. Completion rates will be performance managed by the Equality and Diversity Steering Group

7.5 Workforce and Training

7.5.2 The Trust continues to monitor equality and diversity training attendance. The internal measure was for all departments to send 25% of their staff on mandatory equality and diversity training. Attendance rates are monitored by the Equality and Diversity Steering Group and it has been noted that attendance has been lower than last year but increased towards the end of the year. Feedback from staff that have attended this training has been positive; therefore we will continue to promote the importance of completing this mandatory course across the Trust. Last year 372 (14.8% of non-medical staff) attended the Making a Difference course, and 80% of new joiners attended Corporate Induction. Overall 80% of the Trust workforce have had some form of Equality & Diversity training within the required four year period.

7.6 Staff Survey

7.6.1 The NHS Staff Survey conducted in 2012 achieved a 66% response rate, one of the highest acute trust responses in the country, and the highest of any London acute trust. The results identified several areas of strength, such as the highest percentage nationally, of staff reporting good communication between staff and management, for the second year running. The Trust remained in the Top 20% of acute trusts for Overall staff engagement, staff feeling their roles makes a difference to patients and % of staff satisfied with the quality of patient care they are able to deliver. Areas of concern included % of staff experiencing discrimination or bullying and harassment. These will be investigated further during 2013/14.

7.6.2 The demographic profile of the recent staff survey respondents continues to show that we employ a higher percentage of staff with a declared disability than that noted on the ESR database. This is encouraging and shows that the Staff Survey has become a particularly useful tool in engaging with all our staff, regardless of gender, ethnicity or disability.

7.6.3 Results from the Staff Survey showed an increase in the number of staff who had experienced harassment and bullying or discrimination from colleagues or patients than staff, this increase was reflected across the NHS in 2012, however the Trust will continue to work with departments that scored highly on having experienced harassment and bullying in the workplace.

7.6.4 The percentage of staff believing that the Trust provides equal opportunities for career progression and promotion is higher for men and lower for BME staff. Staff satisfaction levels seem to be lower for staff with disabilities and more work will need to be done to understand these issues.

7.7 Addressing Bullying and Harassment

7.7.1 The Harassment Advisory Service continues to provide a confidential support service to staff and this is also highlighted to new staff at induction. In 2013-14, the service will be promoted more widely across the organisation to remind staff of this vital resource.

7.7.2 In 2012-3 ‘Respectful’ focus groups were held with staff from Maternity at which staff were asked to define what ‘respectful’ behaviour meant to them to develop ward philosophy that provides an excellent patient experience.

7.7.3 This year's Staff Survey results showed a significant increase in the number of staff stating they had experienced bullying and harassment or discrimination in some departments. The Trust takes the issue of bullying and harassment very seriously and a Trust-wide action plan has been developed to address this issue.

7.7.4 3 mediation referrals were made and resolution was reached for all cases. 9 referrals to the harassment advisory service were made and all queries were resolved satisfactorily. The Employee Assistance Programme received 5 referrals from employees. No other trends or analysis can be drawn from this data.

7.8 OBJECTIVE 3: Effectively communicate with, engage, and involve all of our stakeholders in equality

7.8.1 The newly reformed Stroke Forum held a meeting in January 2013. Valuable insight was gained into how the service could be improved in relation to the referral process from the GP and the transfer process between hospitals. The patients also identified where the service demonstrated examples of good practice and areas for improvement in relation to the Trust values. The feedback has been developed into an action plan and progress will be reviewed at the next meeting.

7.8.2 David Erskine Ward has been refurbished to become a 'Dementia Friendly' environment and there is a similar planned refurbishment of Edgar Horne Ward.

7.8.3 A patient engagement guidance pack is also being developed to support managers to set up new patient groups, or provide a range of methods for engaging with patients.

7.9 OBJECTIVE 4: Strengthen equality and diversity communications and resources across the Trust

7.9.1 Staff from across the Trust attended an equality seminar in September 2012. The purpose of this was to raise awareness of issues relating to sexual orientation in the workplace. In 2013-14, we will continue to organise equality seminars to raise awareness of other equality issues like disability and corporate social responsibility.

7.9.2 The Trust has a staff training plan that includes learning disability awareness, deprivation of liberty and mental capacity for all staff on induction and clinical updates. Focused training has now taken place in a number of patient critical areas such as A and E and Out Patients. Further training will be delivered to other areas in due course.

7.9.3 We have started to develop a diversity handbook which will be rolled out in 2013-14. The handbook will provide staff with a quick reference guide on how best to support staff or patients with diverse needs.

Appendix 13 – HR Key Performance Indicators.

1. Summary

1.1 Human Resources reports on a monthly basis to both Divisional and Trust performance Boards, performance against a range of HR KPIs with areas of concern flagged up. During 2012/3, the measures were extended to include appraisals, mandatory training and time to recruit, to ensure that the Trust and Divisional boards was kept informed of areas of concern for these measures. During 2013-14, HR will work with Finance and Performance, continuing to ensure that the delivery of patient care in line with the Trust values is maintained and improved. A brief summary of each measures performance and how the measure is calculated is listed below.

2.0 Vacancies

Measure (Average rate)	Performance
2012/13 Performance	8.34%
2012/13 Target	8.38%
3 Year Performance	9.87%
2013/14 Target	8.00%
How measured?	Monthly KPIs

2.1 The total vacancy rate is calculated as the proportion of budgeted posts that remain unfilled. Finance and HR reconcile their establishments on a monthly basis to ensure that the measure is as accurate as possible. Posts that have been frozen or are being filled by long term Bank employees are excluded from the calculation.

2.2 Additionally HR reports on a monthly basis an active vacancy rate. This is the proportion of the establishment that is being advertised during the period. This recognises the need to provide some workforce flexibility to meet service requirements, as well as recognition of delays that can arise in commencement of the recruitment process. In 2012/3, the average active rate was 2.88% which is broadly comparable to the previous year.

2.3 The average total vacancy rate for the year was 8.34% against a target of 8.38% and ended the year at 7.64%. The average rate for the year was significantly lower than the historical 3 year average of 9.87%, this reflects improvements to the recruitment process as well as establishment management.

2.4 Areas with a high concentration of vacant posts are highlighted at a Trust and Divisional level, with the recruitment team and HR Business Partners providing support to managers to resolve issues.

2.5 The 2013/4 vacancy target has been set at 8% (average monthly rate).

3.0 Turnover

Measure (Average rate)	Performance
2012/13 Performance	13.59%
2012/13 Target	13.50%
3 Year Performance	14.42%
2013/14 Target	13.50%
How measured?	Monthly KPIs

3.1 Voluntary turnover is calculated as the percentage of staff resigning from the Trust during a period (rolling year) as a percentage of the average headcount during the period. The stability rate is calculated as the percentage of employees with more than one years' service.

3.2 While some turnover is beneficial to the organisation, creating opportunities for staff advancement, for instance, the Trust recognises that the impact of too high a turnover rate can also have negative consequences such as the impact on recruitment of staff, increased use of temporary staffing and damaging staff morale.

3.3 The average turnover rate for 2012/13 was 13.59%, which was slightly above the target set at the beginning of the year of 13.5%, due to an increase in the numbers of resignations received in the final quarter of the year. Although above target, the turnover rate remains low by historical standards for the Trust.

3.4. Allied Health Professionals and Healthcare Assistants saw the biggest increase in turnover in 2012/3 compared to the previous year. The HR department plans to fully revisit it's exit interview process and explore reasons for leaving more fully in 2013/4.

3.5 The turnover target has been set at 13.5% for 2013/14.

4.0 Sickness

Measure (Average rate)	Performance
2012/13 Performance	3.73%
2012/13 Target	3.83%
3 Year Performance	3.71%
2013/14 Target	3.60%
How measured?	Monthly KPIs

4.1 The sickness rate is a calculation of working days lost as a proportion of total working days available. This is shown as either long term (15 working days absent or more), or short term absences.

4.2 Additionally HR monitors individual absences and provides support to managers in ensuring the policy for managing sickness absence is applied.

4.3 The average monthly sickness rate was 3.73%, which was lower than the target set for the year of 3.83%. This reduction was primarily due to a larger than anticipated reduction of long term absence through the year. Although the absence rate remains slightly higher than the historical average, it should be noted that data collection methods have improved significantly in that period, allowing more confidence in the validity of the data. Further work will be undertaken during 2013/4 to address pockets of under-reporting.

4.4 Analysis of sickness trends over the year show that absence rates for each band between 2 and 8 are higher than the next band directly above, with

band 2 absence almost double the Trust average. As part of the continuing QIPP project on absence, more investigation of the causes for this will be undertaken in 2013/4.

4.5 The absence target for 2013/4 has been set at 3.6% (2% long term, and 1.6% short term absence)

5.0 Agency usage

Measure (Average % of monthly workforce)	Performance
2012/13 Performance	4.40%
2012/13 Target	3.15%
3 Year Performance	4.20%
2013/14 Target	3.15%
How measured?	Monthly KPIs

5.1 Agency usage is a calculation of those staff employed via an agency as a percentage of the total workforce (including Staffbank and substantively employed staff).

5.2 The use of temporary staff to meet short term service needs and ensure staffing is adequate and safe for service delivery will mean that some agency usage is to be expected. We recognise however that increased costs and reliance on external agencies where the Trust is less able to guarantee the quality of the staff supplied means that agency usage should be limited in favour of the Trust's internal Staffbank.

5.3 Agency usage increased to an average of 4.4% in 2012/3. This was due to increased usage in the latter half of the year.

5.4 It should be noted however that despite this increase, the percentage of paybill used for agency staff was lower than the previous year at 6.57% (6.66% in 2011).

5.5 The QIPP project to reduce sickness absence and agency usage in the Trust will continue in 2013/14. The Trust spent £300,000 less on agency nursing staff than it did in 2011/12.

5.6 A joint Finance/HR target for Agency will be developed for 2013/4 to ensure that the Trust remains focussed on reduction of spend as well as usage of agency staff.

6.0 Appraisals

Measure (Staff Survey)	Performance
2012/13 Performance	82%
2012/13 Target	87%
3 Year Performance	79%
2013/14 Target	90%
How measured?	Annual Staff Survey/Monthly KPIs

6.1 The Appraisal rate is measured by the staff agreeing in the annual staff survey that they have had an appraisal within the last 12 months.

6.2 Additionally HR monitor and report to the Trust on a monthly basis progress of appraisal completions, highlighting any overdue ones.

6.3 The Trust achieved its highest ever appraisal rate of 82% in the 2012 Staff

Survey, however it did not meet its target of 87% and being in the top 20% of acute trusts nationally for this measure. The Trust remained in the top 20% of trusts for % of staff agreeing the appraisal was well structured (objectives had been set, the review helped them in doing their job better, and left them feeling valued)

6.4. The target for appraisal completions for 2013/4 has been set at 90%, as measured by the Staff Survey. An additional target of at least 50% of staff reporting the appraisal had been well structured has been set.

7.0 Staff Survey

Measure	2012	National average
Response rate	66%	50%
Overall Staff Engagement (on a scale of 1-5, 5 being higher)	3.87	3.81
Staff Recommendation: Treatment	80%	60%
Staff Recommendation: Working here	76%	73%

7.1 The 10th Annual NHS Staff Survey was completed, with a response rate of 66%, which places the Trust in the top 20% of acute trusts.

7.2 The Trust was in the top 20% of acute trusts for 14 of the 28 Key Findings (KF), including achieving the highest score nationally for % of staff reporting good communication between staff and senior management for the second year running.

7.3 The staff remained in the top 20% of acute trusts nationally for overall staff engagement, which measures staff willingness to recommend the trust, suggest improvements at work, and motivation.

7.4 Areas of concern, where the Trust scored lower than the national average, or registered significant deterioration on the previous year have been addressed in the Trust staff survey action plan. Action plans have been prepared to address areas of local concern.

7.5 The Trust in 2013/4 has rolled out new local ‘pulse’ surveys to deliver more immediate feedback and explore in greater depth, issues raised by the national survey.

Appendix 13 – HR Key Performance Indicators.

1. Summary

1.1 Human Resources reports on a monthly basis to both Divisional and Trust performance Boards, performance against a range of HR KPIs with areas of concern flagged up. During 2012/3, the measures were extended to include appraisals, mandatory training and time to recruit, to ensure that the Trust and Divisional boards was kept informed of areas of concern for these measures. During 2013-14, HR will work with Finance and Performance, continuing to ensure that the delivery of patient care in line with the Trust values is maintained and improved. A brief summary of each measures performance and how the measure is calculated is listed below.

2.0 Vacancies

Measure (Average rate)	Performance
2012/13 Performance	8.34%
2012/13 Target	8.38%
3 Year Performance	9.87%
2013/14 Target	8.00%
How measured?	Monthly KPIs

2.1 The total vacancy rate is calculated as the proportion of budgeted posts that remain unfilled. Finance and HR reconcile their establishments on a monthly basis to ensure that the measure is as accurate as possible. Posts that have been frozen or are being filled by long term Bank employees are excluded from the calculation.

2.2 Additionally HR reports on a monthly basis an active vacancy rate. This is the proportion of the establishment that is being advertised during the period. This recognises the need to provide some workforce flexibility to meet service requirements, as well as recognition of delays that can arise in commencement of the recruitment process. In 2012/3, the average active rate was 2.88% which is broadly comparable to the previous year.

2.3 The average total vacancy rate for the year was 8.34% against a target of 8.38% and ended the year at 7.64%. The average rate for the year was significantly lower than the historical 3 year average of 9.87%, this reflects improvements to the recruitment process as well as establishment management.

2.4 Areas with a high concentration of vacant posts are highlighted at a Trust and Divisional level, with the recruitment team and HR Business Partners providing support to managers to resolve issues.

2.5 The 2013/4 vacancy target has been set at 8% (average monthly rate).

3.0 Turnover

Measure (Average rate)	Performance
2012/13 Performance	13.59%
2012/13 Target	13.50%
3 Year Performance	14.42%
2013/14 Target	13.50%
How measured?	Monthly KPIs

3.1 Voluntary turnover is calculated as the percentage of staff resigning from the Trust during a period (rolling year) as a percentage of the average headcount during the period. The stability rate is calculated as the percentage of employees with more than one years' service.

3.2 While some turnover is beneficial to the organisation, creating opportunities for staff advancement, for instance, the Trust recognises that the impact of too high a turnover rate can also have negative consequences such as the impact on recruitment of staff, increased use of temporary staffing and damaging staff morale.

3.3 The average turnover rate for 2012/13 was 13.59%, which was slightly above the target set at the beginning of the year of 13.5%, due to an increase in the numbers of resignations received in the final quarter of the year. Although above target, the turnover rate remains low by historical standards for the Trust.

3.4. Allied Health Professionals and Healthcare Assistants saw the biggest increase in turnover in 2012/3 compared to the previous year. The HR department plans to fully revisit it's exit interview process and explore reasons for leaving more fully in 2013/4.

3.5 The turnover target has been set at 13.5% for 2013/14.

4.0 Sickness

Measure (Average rate)	Performance
2012/13 Performance	3.73%
2012/13 Target	3.83%
3 Year Performance	3.71%
2013/14 Target	3.60%
How measured?	Monthly KPIs

4.1 The sickness rate is a calculation of working days lost as a proportion of total working days available. This is shown as either long term (15 working days absent or more), or short term absences.

4.2 Additionally HR monitors individual absences and provides support to managers in ensuring the policy for managing sickness absence is applied.

4.3 The average monthly sickness rate was 3.73%, which was lower than the target set for the year of 3.83%. This reduction was primarily due to a larger than anticipated reduction of long term absence through the year. Although the absence rate remains slightly higher than the historical average, it should be noted that data collection methods have improved significantly in that period, allowing more confidence in the validity of the data. Further work will be undertaken during 2013/4 to address pockets of under-reporting.

4.4 Analysis of sickness trends over the year show that absence rates for each band between 2 and 8 are higher than the next band directly above, with

band 2 absence almost double the Trust average. As part of the continuing QIPP project on absence, more investigation of the causes for this will be undertaken in 2013/4.

4.5 The absence target for 2013/4 has been set at 3.6% (2% long term, and 1.6% short term absence)

5.0 Agency usage

Measure (Average % of monthly workforce)	Performance
2012/13 Performance	4.40%
2012/13 Target	3.15%
3 Year Performance	4.20%
2013/14 Target	3.15%
How measured?	Monthly KPIs

5.1 Agency usage is a calculation of those staff employed via an agency as a percentage of the total workforce (including Staffbank and substantively employed staff).

5.2 The use of temporary staff to meet short term service needs and ensure staffing is adequate and safe for service delivery will mean that some agency usage is to be expected. We recognise however that increased costs and reliance on external agencies where the Trust is less able to guarantee the quality of the staff supplied means that agency usage should be limited in favour of the Trust's internal Staffbank.

5.3 Agency usage increased to an average of 4.4% in 2012/3. This was due to increased usage in the latter half of the year.

5.4 It should be noted however that despite this increase, the percentage of paybill used for agency staff was lower than the previous year at 6.57% (6.66% in 2011).

5.5 The QIPP project to reduce sickness absence and agency usage in the Trust will continue in 2013/14. The Trust spent £300,000 less on agency nursing staff than it did in 2011/12.

5.6 A joint Finance/HR target for Agency will be developed for 2013/4 to ensure that the Trust remains focussed on reduction of spend as well as usage of agency staff.

6.0 Appraisals

Measure (Staff Survey)	Performance
2012/13 Performance	82%
2012/13 Target	87%
3 Year Performance	79%
2013/14 Target	90%
How measured?	Annual Staff Survey/Monthly KPIs

6.1 The Appraisal rate is measured by the staff agreeing in the annual staff survey that they have had an appraisal within the last 12 months.

6.2 Additionally HR monitor and report to the Trust on a monthly basis progress of appraisal completions, highlighting any overdue ones.

6.3 The Trust achieved its highest ever appraisal rate of 82% in the 2012 Staff

Survey, however it did not meet its target of 87% and being in the top 20% of acute trusts nationally for this measure. The Trust remained in the top 20% of trusts for % of staff agreeing the appraisal was well structured (objectives had been set, the review helped them in doing their job better, and left them feeling valued)

6.4. The target for appraisal completions for 2013/4 has been set at 90%, as measured by the Staff Survey. An additional target of at least 50% of staff reporting the appraisal had been well structured has been set.

7.0 Staff Survey

Measure	2012	National average
Response rate	66%	50%
Overall Staff Engagement (on a scale of 1-5, 5 being higher)	3.87	3.81
Staff Recommendation: Treatment	80%	60%
Staff Recommendation: Working here	76%	73%

7.1 The 10th Annual NHS Staff Survey was completed, with a response rate of 66%, which places the Trust in the top 20% of acute trusts.

7.2 The Trust was in the top 20% of acute trusts for 14 of the 28 Key Findings (KF), including achieving the highest score nationally for % of staff reporting good communication between staff and senior management for the second year running.

7.3 The staff remained in the top 20% of acute trusts nationally for overall staff engagement, which measures staff willingness to recommend the trust, suggest improvements at work, and motivation.

7.4 Areas of concern, where the Trust scored lower than the national average, or registered significant deterioration on the previous year have been addressed in the Trust staff survey action plan. Action plans have been prepared to address areas of local concern.

7.5 The Trust in 2013/4 has rolled out new local ‘pulse’ surveys to deliver more immediate feedback and explore in greater depth, issues raised by the national survey.

Chelsea and Westminster Hospital NHS

NHS Foundation Trust

In Year Financial Reporting return

Chelsea and Westminster NHS FT

Report of Actual performance against Plan to 30 Jun 2013
Plan data sourced from your latest submitted plan

Customised for Acute FT with MARS ID 'CHELSEA'.

IYR template version 14.3.2.6

This template completed by (and Monitor queries to be directed to):

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Job Title: Director of Finance

Telephone number: 02033158119

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Date: 18 July 2013

Approved on behalf of the Board of Directors by:

Name: Lorraine Bewes

Job Title: Chief Finance Officer

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guidance: Click for guidance (requires internet access)

Monitor

Worksheet "Index"

Click to go to index

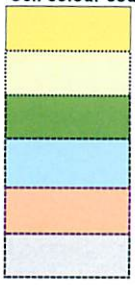
Index to workbook

This index page also allows you to set a selection of sheets to print in one go.

Type	Name	Goto	Print
Worksheet	Cover	Click to go to	No
Worksheet	Index		No
Worksheet	Guidance	Click to go to	No
Worksheet	SoCI	Click to go to	No
Worksheet	SoCF	Click to go to	No
Worksheet	SoFP	Click to go to	No
Worksheet	Checks	Click to go to	No
Worksheet	Variances	Click to go to	No
Worksheet	Summary	Click to go to	No
Worksheet	Risk Rating	Click to go to	No
Worksheet	Elections	Click to go to	No
Worksheet	Targets and Indicators	Click to go to	No
Worksheet	Finance Risk Indicators	Click to go to	No
Worksheet	Governance Statement	Click to go to	No

Monitor In-Year Reporting (IYR) Template General Guidance

Cell colour coding



These cells are unlocked and Trusts should either be entering the required description or a numeric value. These are past values. Generally an input (or zero) is required.

These cells are unlocked and depending on your circumstances an input may or may not be required. If required Trusts should either be entering the required description or a numeric value.

These cells are unlocked and Trusts should either be entering the required description or a numeric value. The values relate to the 2012-13 financial year (i.e are past not future values)

These cells are locked and are populated with values taken from your Annual Plan (or LTFM plan at the time of authorisation) or any later reforecast plan.

If you can see these cells they are unlocked and you can input a numeric value for a prior period.

These Cells have values calculated from other values on the same worksheet. These cells are locked and Trusts are unable to input into them.

Signage Rules

Income	Income should entered as positive values.
Expenditure	Expenditure should be entered as negative values.
Assets	Assets should be entered as positive values.
Liabilities	Liabilities should be entered as negative values.
Equity	Equity should be entered as positive values.

Materiality Checks in this workbook will allow disagreements of £0.01m before an explanation is required

Suggested approach

1) enter your financial results for the 2013-14 financial year to date in the yellow cells on the **SoCI, SoFP** and **SoCF** worksheets
2) enter your analysis and description of variances from your plan on the **Variances** worksheet

for quarterly returns only

3) enter your risks on the **Finance Risk Indicators** worksheet
4) enter your results on the **Target and Indicators** worksheet
5) complete the various Board declarations

for all returns

6) review the worksheet **Checks**
7) put your logo and your contact details on the cover
8) put a board member's signature on the cover
9) login to MARS and put the return in the outbox

Worksheet "SoCI"

Click to go to index

Quarterly planned and actual statement of comprehensive income for CHELSEA

This layout is identical to your Annual Plan

					Audited for Year ending 31-Mar-13	Plan for Quarter ending 30-Jun-13	Actual for Quarter ending 30-Jun-13	Plan for Quarter ending 30-Sep-13	Plan fo Quarte ending 31-Dec-
Operating			units	sense					
NHS Clinical Revenue									
NHS Ambulance activity revenue									
A&E - Cost & Volume/PbR revenue			£m	(+ve)	-				
PTS - Cost & Volume/PbR revenue, PCTs			£m	(+ve)	-				
PTS - Cost & Volume/PbR revenue, non PCTs			£m	(+ve)	-				
Other - Cost & Volume/PbR revenue			£m	(+ve)	-				
A&E - Block Contract revenue			£m	(+ve)	-				
PTS - Block Contract revenue, PCTs			£m	(+ve)	-				
PTS - Block Contract revenue, non PCTs			£m	(+ve)	-				
Other - Block Contract revenue			£m	(+ve)	-				
Other clinical revenue from mandatory services			£m	(+ve)	-				
NHS Ambulance activity Income, Total			£m		0.000	0.000	0.000	0.000	0.000
NHS Community activity revenue									
Cost & Volume/PbR revenue, inpatient activity			£m	(+ve)	-				
Cost & Volume/PbR revenue, outpatient activity			£m	(+ve)	-				
Cost & Volume/PbR revenue, community based activity			£m	(+ve)	0.543	0.210	0.155	0.210	0.210
Block Contract revenue, inpatient activity			£m	(+ve)	-				
Block Contract revenue, outpatient activity			£m	(+ve)	-				
Block Contract revenue, community based activity			£m	(+ve)	3.096	0.525	0.525	0.525	0.525
Block Contract revenue, other activity			£m	(+ve)	-				
NHS Community activity revenue, Total			£m	(+ve)	3.639	0.735	0.680	0.735	0.735
NHS Mental Health activity Income									
High Cost Low Volume Activity - Cost & Volume Contract revenue			£m	(+ve)	-				
Short term episodic treatment - Cost & Volume Contract revenue			£m	(+ve)	-				
Other - Cost & Volume Contract revenue			£m	(+ve)	-				
Block contract #1			£m	(+ve)	-				
Block contract #2			£m	(+ve)	-				
Block contract #3			£m	(+ve)	-				
Block contract #4			£m	(+ve)	-				
Clinical Partnerships providing mandatory services (including S31 agreements)			£m	(+ve)	-				
Clinical income for the Secondary Commissioning of mandatory services			£m	(+ve)	-				
Other clinical income from mandatory services			£m	(+ve)	-				
NHS Mental Health activity Income, Total			£m		0.000	0.000	0.000	0.000	0.000
NHS Acute Activity Income									
Elective inpatients									
Tariff revenue			£m	(+ve)	16.545	4.320	3.654	4.462	4.880
Non-Tariff revenue			£m	(+ve)	2.635	0.715	1.057	0.714	0.731
Elective activity revenue, Total			£m		19.180	5.035	4.711	5.175	5.611
Elective day case patients (Same day)									
Tariff revenue			£m	(+ve)	21.521	6.172	6.062	6.251	6.477
Non-Tariff revenue			£m	(+ve)	1.343	0.265	0.849	0.277	0.307
Elective Day Case activity revenue, Total			£m		22.864	6.437	6.911	6.528	6.784
Non-Elective patients									
Tariff revenue			£m	(+ve)	60.568	14.228	11.905	14.285	14.591
Non-Tariff revenue			£m	(+ve)	6.919	0.473	2.933	0.497	0.504
Non-Elective activity revenue, Total			£m		67.488	14.701	14.838	14.783	15.096
Outpatients									
Tariff revenue			£m	(+ve)	57.979	11.992	11.805	12.383	12.344
Non-Tariff revenue			£m	(+ve)	10.244	6.260	6.772	6.351	6.194
Outpatients activity revenue, Total			£m		68.223	18.252	18.577	18.734	18.538
A&E									
Tariff revenue			£m	(+ve)	6.395	1.599	1.494	1.474	1.683
Non-Tariff revenue			£m	(+ve)	5.238	1.268	1.323	1.220	1.282
A&E activity revenue, Total			£m		11.634	2.868	2.817	2.694	2.965
Other NHS activity									
Tariff revenue			£m	(+ve)	-	0.462	0.257	0.473	0.455
Non-Tariff revenue			£m	(+ve)	98.344	24.111	24.078	24.188	24.178
Other NHS activity revenue, Total			£m		98.344	24.573	24.335	24.661	24.633
Total NHS Tariff income			£m		163.009	38.773	35.177	39.328	40.429
Total NHS Non-Tariff income			£m		124.724	33.093	37.012	33.248	33.197
NHS Acute Activity Income, Total			£m		287.732	71.865	72.189	72.576	73.626
Sub-total NHS Clinical Revenue			£m		291.371	72.600	72.869	73.311	74.361
Contract penalties or adjustments not included above			£m	(-/+ve)	-				
NHS Clinical Revenue, Total			£m		291.371	72.600	72.869	73.311	74.361
Non Mandatory/Non protected revenue									
Private patient revenue			£m	(+ve)	11.921	3.304	2.759	3.326	3.380
Other Non Mandatory/Non protected clinical revenue			£m	(+ve)	1.619	0.600	0.375	0.601	0.603
Non Mandatory/Non protected revenue, Total			£m		13.540	3.905	3.134	3.928	3.983
Other Operating Revenue									
Research and development revenue			£m	(+ve)	5.405	1.157	1.156	1.120	1.083
Education and training revenue			£m	(+ve)	25.348	6.006	5.965	6.006	6.006
Revised	PFI or other non-recurrent revenue support		£m	(+ve)	-				
NEW	PFI or other recurrent revenue support		£m	(+ve)	-				
Donations received in cash & to fund Operating Expenses			£m	(+ve)	0.057		0.009		
Grants received in cash & to fund Operating Expenses			£m	(+ve)	-				
Donations & Grants received of PPE & intangible assets (see comment)			£m	(+ve)	-				
Donations & Grants received **of cash to buy** PPE & intangible assets (see comment)			£m	(+ve)	1.929	1.000	1.000		
Donations & Grants received of PPE & intangible assets (see comment)					1.929	1.000	1.000	0.000	0.000
Parking revenue			£m	(+ve)	0.900	0.212	0.249	0.212	0.212
Catering revenue			£m	(+ve)	0.013	0.004	0.004	0.004	0.004
Accommodation revenue			£m	(+ve)	1.916	0.446	0.532	0.446	0.446

Worksheet "SoCI"

Click to go to index

Quarterly planned and actual statement of comprehensive income for CHELSEA

This layout is identical to your Annual Plan

Operating	units	sense	Audited for Year ending 31-Mar-13	Plan for Quarter ending 30-Jun-13	Actual for Quarter ending 30-Jun-13	Plan for Quarter ending 30-Sep-13	Plan fo Quarte ending 31-Dec-
Operating Expenses							
Raw Materials and Consumables Used							
Drugs	£m	(-ve)	(55.433)	(14.410)	(15.293)	(14.580)	(14.751
Clinical supplies	£m	(-ve)	(37.239)	(8.983)	(9.226)	(8.948)	(9.001
Decrease (increase) in inventories of finished goods & WIP	£m	(-ve)	-				
Vehicle Fuel costs (ambulance trusts)	£m	(-ve)	-				
Non-clinical supplies	£m	(-ve)	(40.276)	(10.390)	(10.187)	(10.450)	(10.857
Raw Materials and Consumables Used, Total	£m		(132.947)	(33.783)	(34.706)	(33.979)	(34.609
Ambulance trust vehicle operating expenses							
Vehicle insurance costs	£m	(-ve)	-				
Vehicle leasing costs	£m	(-ve)	-				
Vehicle maintenance/Other Costs	£m	(-ve)	-				
Ambulance trusts vehicle operating expenses, Total	£m		0.000	0.000	0.000	0.000	0.000
Cost of Secondary Commissioning of mandatory services	£m	(-ve)	-				
Employee Expenses [was "Pay"]							
Employee expenses, permanent staff	£m	(-ve)	(151.699)	(41.065)	(38.836)	(41.070)	(41.290
Employee expenses, agency & contract staff	£m	(-ve)	(25.187)	(3.647)	(6.478)	(3.617)	(3.675
Employee Expenses, Total	£m	(-ve)	(176.885)	(44.712)	(45.314)	(44.687)	(44.965
Research & Development expense	£m	(-ve)	(0.005)	(0.088)	(0.172)	(0.084)	(0.079
Education and training expense	£m	(-ve)	(0.685)	(0.271)	(0.121)	(0.271)	(0.271
Consultancy expense	£m	(-ve)	(1.901)		(0.419)		
Misc. other Operating expenses	£m	(-ve)	-				
(Increase)/decrease in Provisions, Current and Non-Current, net	£m	(+/-ve)	1.120		0.326		
(Increase)/decrease in Impairment of receivables, Current and Non-Current, net	£m	(+/-ve)	0.979	(0.175)	0.065	(0.175)	(0.175
PFI operating expenses							
PFI unitary payment	£m	(-ve)	-				
IFRIC12 revenue/(expense) adjustment	£m	(+/-ve)	-				
Other PFI expenses	£m	(-ve)	-				
PFI operating expenses, total	£m	(-ve)	0.000	0.000	0.000	0.000	0.000
Operating Expenses within EBITDA, Total	£m		(310.325)	(79.029)	(80.341)	(79.197)	(80.095
Depreciation and Amortisation							
Depreciation and Amortisation - purchased/constructed assets	£m	(-ve)	(11.303)	(3.183)	(3.017)	(3.195)	(3.117
Depreciation and Amortisation - donated/granted assets	£m	(-ve)	(0.144)	(0.059)	(0.061)	(0.059)	(0.059
Depreciation and Amortisation - owned assets			(11.447)	(3.242)	(3.078)	(3.254)	(3.176
Depreciation and Amortisation - assets held under finance leases	£m	(-ve)	(0.243)		(0.060)		
Depreciation and Amortisation - PFI assets	£m	(-ve)	-				
Depreciation and Amortisation, Total	£m		(11.690)	(3.242)	(3.138)	(3.254)	(3.176
Impairment (Losses) / Reversals net - purchased/constructed assets	£m	(-/+ve)	-				
Impairment (Losses) / Reversals net - donated/granted assets	£m	(-/+ve)	-				
Impairment (Losses) / Reversals net (on non-PFI assets)			0.000	0.000	0.000	0.000	0.000
Impairment (Losses) / Reversals net - PFI assets	£m	(-/+ve)	-				
Restructuring Costs	£m	(-ve)	-				
Operating Expenses excluded from EBITDA, Total	£m	(-ve)	(11.690)	(3.242)	(3.138)	(3.254)	(3.176
Operating Expenses IFRS, Total			(322.015)	(82.271)	(83.479)	(82.451)	(83.275
Surplus (Deficit) from Operations			23.903	4.068	2.667	3.751	3.995

Quarterly planned and actual statement of comprehensive income for CHELSEA

This layout is identical to your Annual Plan

		units	sense	Audited for Year ending 31-Mar-13	Plan for Quarter ending 30-Jun-13	Actual for Quarter ending 30-Jun-13	Plan for Quarter ending 30-Sep-13	Pl Q e 31-
Operating								
Non Operating								
Non-Operating income								
Finance Income [for non-financial activities]								
Gain (Loss) on Financial Instruments Designated as Cash Flow Hedges		£m	(+ve)	-				
Gain (Loss) on Derecognition of Available-for-Sale Financial Assets		£m	(+ve)	-				
Gain (Loss) on Derecognition of Non-Current Assets Not Held for Sale, Total		£m	(+ve)	-				
Gain (Loss) on Investments & Inv.Property (Not charitable funds)		£m	(+ve)	-				
Interest Income		£m	(+ve)	0.156	0.025	0.027	0.025	0.
Dividend Income		£m	(+ve)	-				
Share of profit (loss) from equity accounted Associates, Joint Ventures								
Share of Private Patient Income from equity accounted Associates, Joint Ventures		£m	(+ve)	-				
Share of non Private Patient Income from equity accounted Associates, Joint Ventures		£m	(+ve)	-				
Share of expenses from equity accounted Associates, Joint Ventures		£m	(-ve)	-				
Share of profit (loss) from equity accounted Associates, Joint Ventures, Total		£m		0.000	0.000	0.000	0.000	0.
Finance Income [for non-financial activities], Total		£m		0.156	0.025	0.027	0.025	0.
Other Non-Operating income		£m						
Gain/(loss) on asset disposals		£m	(+/-ve)	(0.120)				
Gain/(loss) on transfers by absorption		£m	(+/-ve)	-				
Historic	Income of NHS Charitable Funds (if consolidated)	£m	(+ve)	-				
Historic	Gain (Loss) of NHS Charitable funds' investments (if consol.)	£m	(+ve)	-				
Other Non-Operating income		£m	(+ve)	-				
Other Non-Operating income, Total		£m		(0.120)	0.000	0.000	0.000	0.
Non-Operating income, Total		£m		0.036	0.025	0.027	0.025	0.
Non-Operating expenses								
Finance Costs [for non-financial activities]								
Interest Expense								
Interest Expense on Overdrafts and Working Capital Facilities		£m	(-ve)	-				
Interest Expense on Bridging loans		£m	(-ve)	-				
Interest Expense on Non-commercial borrowings		£m	(-ve)	(0.831)	(0.205)	(0.205)	(0.196)	(0.
Interest Expense on Commercial borrowings		£m	(-ve)	-				
Interest Expense on Finance leases (non-PFI)		£m	(-ve)	(0.100)	(0.032)	(0.032)	(0.031)	(0.
Interest Expense on PFI leases & liabilities		£m	(-ve)	-				
Interest Expense, Total		£m		(0.931)	(0.237)	(0.237)	(0.227)	(0.
Other Finance Costs		£m	(-ve)	(0.019)				
PDC dividend expense		£m	(-ve)	(9.947)	(2.559)	(2.559)	(2.560)	(2.
Finance Costs [for non-financial activities], Total		£m		(10.896)	(2.796)	(2.796)	(2.787)	(2.
Other Non-Operating expenses								
Non-Operating PFI costs (eg contingent rent)		£m	(-ve)	-				
Historic	Expenditure of NHS Charitable Funds (if consolidated)	£m	(-ve)	-				
Other Non-Operating expenses (developments)		£m	(-ve)	-				
Misc Other Non-Operating expenses		£m	(-ve)	-				
Other Non-Operating expenses, Total		£m		0.000	0.000	0.000	0.000	0.
Non-Operating expenses, Total		£m		(10.896)	(2.796)	(2.796)	(2.787)	(2.
Surplus (Deficit) before Tax		£m		13.043	1.297	(0.102)	0.989	1.
Income Tax (expense)/ refund		£m	(-/+ve)	-				
Surplus (Deficit) After Tax		£m		13.043	1.297	(0.102)	0.989	1.
Profit/(loss) from discontinued Operations, Net of Tax		£m	(+/-ve)	-				
Surplus (Deficit) After Tax from Continuing Operations		£m		13.043	1.297	(0.102)	0.989	1.
Elements of Comprehensive Income								
Share of comprehensive income from associates and joint ventures		£m	(+/-ve)	-				
Revaluation gains/(losses) of donated/granted assets straight to reval reserve		£m	(+/-ve)	-				
Revaluation gains/(losses) of purchased/constructed assets straight to reval reserve		£m	(+/-ve)	-				
Revaluation gains/(losses) straight to revaluation reserve				0.000	0.000	0.000	0.000	0.
(Impairments)/reversals of purchased/constructed assets straight to reval reserve		£m	(+/-ve)	-				
(Impairments)/reversals of donated/granted assets straight to reval reserve		£m	(+/-ve)	-				
Impairments/(reversals) straight to revaluation reserve				0.000	0.000	0.000	0.000	0.
Fair Value gains/(losses) straight to reserves		£m	(+/-ve)	-				
Additions/(reduction) in "Other reserves"		£m	(+/-ve)	-				
NEW	Gain/loss on relevant transfers (1st April)	£m	(+/-ve)	-				
Other recognised gains/(losses) straight to reserves		£m	(+/-ve)	-				
Actuarial gains/(losses) on defined benefit pension schemes		£m	(+/-ve)	-				
Elements of Comprehensive Income, Total				0.000	0.000	0.000	0.000	0.
Total Comprehensive Surplus/(Deficit)				13.043	1.297	(0.102)	0.989	1.
Memorandum lines								
Total Revenue		£m		345.954	86.364	86.173	86.226	87.
Total Expenses		£m		(332.911)	(85.067)	(86.275)	(85.238)	(86.
Total Operating Revenue for EBITDA		£m		343.989	85.339	85.146	86.201	87.
Total Operating Expenses for EBITDA		£m		(310.325)	(79.029)	(80.341)	(79.197)	(80.
EBITDA (for FRR calculation: Plan values from APR)		£m		33.664	6.310	4.805	7.005	7.
Operating Surplus (Deficit)		£m		23.903	4.068	2.667	3.751	3.
Surplus (Deficit) After Tax (for FRR calculation)		£m		13.043	1.297	(0.102)	0.989	1.
Return After Financing (for FRR calculation)		£m		11.234	0.297	(1.102)	0.989	1.
OTHER INFORMATION								
Revenue Generation Programmes								
Revenue Generation, net		£m	(+/-ve)	5.227	0.885	0.390	0.960	1.
Cost Improvement Programmes								
Pay Expense savings CIP recurrent		£m	(+/-ve)	5.393	1.013	0.490	1.097	1.
Pay Expense savings CIP non-recurrent		£m	(+/-ve)	-				
Pay Expense savings CIP, TOTAL		£m	(+/-ve)	5.393	1.013	0.490	1.097	1.

	Audited for Year ending 31-Mar-13	Plan for Quarter ending 30-Jun-13	Actual for Quarter ending 30-Jun-13	Plan for Quarter ending 30-Sep-13	Plan for Quarter ending 31-Dec-13	Plan for Quarter ending 31-Mar-14
Surplus/(deficit) after tax	**13.043**	**1.297**	**(0.102)**	**0.989**	**1.241**	**5.482**
Non-cash flows in operating surplus/(deficit)						
Tax expense	-		0.000			
Finance income/charges	0.775	0.212	0.210	0.202	0.194	0.221
Share of profit/(loss) from equity accounted investments net of cash	-					
Donations & Grants received of PPE & intangible assets (not cash)	-					
Other operating non-cash movements	(0.578)	0.175	(0.065)	0.175	0.175	0.175
Depreciation and amortisation, total	11.690	3.242	3.138	3.254	3.176	3.235
Impairment losses/(reversals)	-		0.000			
Unrealised (gains)/losses on foreign currency exchange	-					
Gain/(loss) on disposal of property plant and equipment	(0.120)					
Gain/(loss) on disposal of intangible assets	-					
Share of profit/(loss) from investments	-					
PDC dividend expense	9.947	2.559	2.559	2.560	2.560	2.560
Other increases/(decreases) to reconcile to profit/(loss) from operati	0.207	0.547	0.205	(0.263)	0.202	(0.297)
Non-cash flows in operating surplus/(deficit), Total	**21.921**	**6.735**	**6.047**	**5.928**	**6.307**	**5.894**
Operating Cash flows before movements in working capital	**34.964**	**8.032**	**5.945**	**6.917**	**7.548**	**11.376**
Increase/(Decrease) in working capital						
(Increase)/decrease in inventories	(0.133)	0.461	0.614	0.058	(0.811)	0.440
(Increase)/decrease in tax receivable	-					
(Increase)/decrease in NHS Trade Receivables	(0.097)	(6.541)	(12.650)	0.594	(1.519)	6.763
(Increase)/decrease in Non NHS Trade Receivables	0.267	0.704	1.077	0.060	0.067	(0.831)
(Increase)/decrease in other related party receivables	(0.656)	0.765	0.495			
(Increase)/decrease in other receivables	0.024	0.115	0.207	(0.720)	(0.340)	0.848
(Increase)/decrease in accrued income	(0.413)	0.211	(0.252)	(0.022)	(0.023)	(0.023)
(Increase)/decrease in other **financial assets**	-					
(Increase)/decrease in prepayments	0.006	(3.079)	(0.793)	(0.753)	0.058	3.773
(Increase)/decrease in **Other assets** (non chartable assets)	-					
Historic (Increase)/decrease in Other assets (chantable assets only)	-					
Increase/(decrease) in **Deferred Income** (excl. Govt Grants.)	(3.458)	2.568	0.076	0.970	(0.030)	(3.030)
Increase/(decrease) in **Deferred Income** (Govt. Grants)	(1.478)		0.000			(0.172)
Increase/(decrease) in Current provisions	(3.621)	(0.199)	(0.411)	(0.200)		
Increase/(decrease) in post-employment benefit obligations	-					
Increase/(decrease) in tax payable	-					
Increase/(decrease) in Trade Creditors	(0.164)	0.672	0.512	(0.001)	0.061	0.324
Increase/(decrease) in Other Creditors	0.118	(1.707)	(1.266)	0.038	(0.122)	0.038
Increase/(decrease) in accruals	(0.008)	0.532	(0.410)	0.023	0.023	0.023
Increase/(decrease) in other **Financial liabilities**	0.036	(0.233)	(0.209)	(0.018)	0.005	0.005
Increase/(decrease) in **Other liabilities** (non charitable assets)	1.138		0.561			
Historic Increase/(decrease) in Other liabilities (charitable assets)	-					
Increase/(Decrease) in working capital, Total	**(8.439)**	**(5.732)**	**(12.449)**	**0.028**	**(2.631)**	**8.158**
Increase/(decrease) in Non-current provisions	-	(0.011)		(0.011)	(0.011)	(0.011)
Net cash inflow/(outflow) from operating activities	**26.525**	**2.289**	**(6.504)**	**6.933**	**4.906**	**19.523**
Net cash inflow/(outflow() from investing activities						
Property - new land, buildings or dwellings	-		(0.002)	(0.025)	(14.000)	(3.575)
Property - maintenance expenditure	(2.669)	(0.246)	(0.757)	(0.241)	(0.235)	(0.475)
Plant and equipment - Information Technology	(2.822)	(0.172)	(0.356)	(0.572)	(0.893)	(3.927)
Plant and equipment - Other	(3.254)	(2.012)	(1.736)	(1.228)	(1.117)	(2.116)
Property, plant and equipment - other expenditure	(9.013)	(0.741)	(0.538)	(1.880)	(3.342)	(9.710)
Proceeds on disposal of property, plant and equipment	-					
Purchase of investment property	-					
Proceeds on disposal of investment property	-					
Purchase of intangible assets	(0.875)	(0.571)	(0.473)	(0.290)	(0.291)	(2.222)
Proceeds on disposal of intangible assets	-					
Expenditure on capitalised development	-					
Increase/(decrease) in Capital Creditors	1.873	0.572	(1.845)	0.400	0.300	0.387
Payments for other capitalised costs	-					
Purchase of subsidiaries net of cash acquired	-					
Net bank balance acquired with subsidiaries	-					
Proceeds from disposal of subsidiaries net of cash disposed	-					
Net bank balance disposed with subsidiaries	-					
Purchase of associates net of cash acquired	-					
Net bank balance acquired with associates	-					
Proceeds from disposal of associates net of cash disposed	-					
Net bank balance disposed with associates	-					
Purchase of joint ventures net of cash acquired	-					
Net bank balance acquired with associates	-					
Proceeds from disposal of joint ventures net of cash disposed	-					

Net cash inflow/(outflow) from financing activities						
Public Dividend Capital received	-					0.274
Public Dividend Capital repaid	-					
PDC Dividends paid	(9.592)			(5.021)		(5.120)
Interest (paid) on bridging loans	-					
Interest (paid) on commercial loans	-					
Interest (paid) on non-commercial loans	(0.794)	(0.415)	(0.415)		(0.387)	
Interest (paid) on bank overdrafts	-					
Interest element of finance lease rental payments - *other*	(0.086)	(0.016)	(0.020)			
Interest element of finance lease rental payments - *On-balance she*	-					
Capital element of finance lease rental payments - *other*	(0.214)	(0.018)	(0.016)	(0.137)	(0.018)	(0.048)
Capital element of finance lease rental payments - *On-balance she*	-					
Interest received on cash and cash equivalents	0.156	0.025	0.026	0.025	0.025	0.025
Movement in Other grants/Capital received	-					
Donations received in cash	-					
Drawdown of bridging loans	-					
Repayment of bridging loans	-					
Drawdown of non-commercial loans	3.200				14.600	9.000
Repayment of non-commercial loans	(1.813)	(1.813)	(1.813)		(1.813)	
Drawdown of commercial loans	-					
Repayment of commercial loans	-					
(Increase)/decrease in non-current receivables	-					
Increase/(decrease) in non-current payables	-					
Other cash flows from financing activities	-					
Net cash inflow/(outflow) from financing activities, Total	**(9.143)**	**(2.236)**	**(2.238)**	**(5.133)**	**12.408**	**4.131**
Net increase/(decrease) in cash	**0.622**	**(3.116)**	**(14.449)**	**(2.036)**	**(2.265)**	**2.016**
Opening cash	**40.996**	**41.618**	**41.618**	**38.502**	**36.465**	**34.200**
Effect of exchange rates	-					
Closing cash	**41.618**	**38.502**	**27.169**	**36.465**	**34.200**	**36.216**
	41.618	38.502	27.167	36.465	34.200	36.216
	0.000	0.000	0.002	0.000	0.000	0.000
	TRUE	*TRUE*	*TRUE*	*TRUE*	*TRUE*	*TRUE*
Opening Cash and Cash equivalents	40.996	41.618	41.618	38.502	36.465	34.200
Net increase/(decrease) in cash & cash equivalents	0.622	(3.116)	(14.449)	(2.036)	(2.265)	2.016
Closing Cash and Cash equivalents	**41.618**	**38.502**	**27.169**	**36.465**	**34.200**	**36.216**
	41.618	38.502	27.167	36.465	34.200	36.216
	0.000	0.000	0.002	0.000	0.000	0.000
	TRUE	*TRUE*	*TRUE*	*TRUE*	*TRUE*	*TRUE*
MEMORANDUM lines						
Debt Capital repayments		(1.830)	(1.829)	(0.137)	(1.830)	(0.048)
Drawdown / (Repayment) of overdraft		0.000	0.000	0.000	0.000	0.000
Drawdown / (Repayment) of working capital facility		0.000	0.000	0.000	0.000	0.000
Sale / (Purchase) of current asset investments		0.000	0.000	0.000	0.000	0.000
Change in Current Receivables		(4.957)	(10.871)	(0.066)	(1.792)	6.780
Change in Current Payables		(1.035)	(0.754)	0.036	(0.061)	0.362
Capital expenditure (cash basis)		(3.170)	(5.707)	(3.837)	(19.579)	(21.638)
Capital expenditure with donated / granted funds (cash basis)			(1.000)			
Asset sale proceeds		0.000	0.000	0.000	0.000	0.000
Net interest		(0.406)	(0.409)	0.025	(0.362)	0.025
Movement in loans		(1.813)	(1.813)	0.000	12.788	9.000
Capital expenditure (accruals basis)		(3.742)	(3.862)	(4.237)	(19.879)	(22.025)
Capital expenditure with donated / granted funds (accruals basis)			(1.000)			

Worksheet "SoFP"

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Quarterly planned and actual statement of financial position for CHELSEA

This layout is identical to your Annual Plan

	units	sense	Audited at 31-Mar-13	Plan at 30-Jun-13	Actual at 30-Jun-13	Plan at 30-Sep-13	Plan at 31-Dec-13	Plan 31-Ma
Assets								
Assets, Non-Current								
Intangible Assets, Net, Donated or granted	£m	(+ve)	-		0.029			
Intangible Assets, Net, Purchased or created	£m	(+ve)	6.245	6.245	6.185	6.245	6.245	6.24
Intangible Assets, Net, Total	£m	(+ve)	6.245	6.245	6.214	6.245	6.245	6.24
Property, Plant and Equipment, Net, Donated or granted	£m	(+ve)	6.610	6.610	7.654	6.610	6.610	6.61
Property, Plant and Equipment, Net, Purchased or constructed	£m	(+ve)	333.551	334.019	333.264	334.971	351.648	370.5
Property, Plant and Equipment, Net, Total	£m	(+ve)	340.161	340.629	340.918	341.581	358.258	377.1
On balance sheet PFI assets, Non-Current								
PFI: Property, Plant and Equipment, Net	£m	(+ve)	-					
PFI Other Assets	£m	(+ve)	-					
On balance sheet PFI assets, Non-Current, Total	£m		0.000	0.000	0.000	0.000	0.000	0.00
Investment Property	£m	(+ve)	-					
Investments, Non-Current								
Investments in Subsidiaries, at Cost	£m	(+ve)	-					
Investments in Associates, at Cost	£m	(+ve)	-					
Investments in Joint Ventures, at Cost	£m	(+ve)	-					
Other Investments, at Cost	£m	(+ve)	-					
Investments, Non-Current, Total	£m		0.000	0.000	0.000	0.000	0.000	0.00
Deferred Tax Assets	£m	(+ve)	-					
Trade and Other Receivables, Non-Current								
NHS Trade Receivables, Non-Current, Gross	£m	(+ve)	-					
Non NHS Trade Receivables, Non-Current, Gross	£m	(+ve)	-					
Other related party receivables	£m	(+ve)	-					
Other Receivables, Non-Current	£m	(+ve)	-					
Impairment of Receivables for Bad & doubtful debts, Non-Current	£m	(-ve)	-					
Trade and Other Receivables, Net, Non-Current, Total			0.000	0.000	0.000	0.000	0.000	0.00
Prepayments, Non-Current								
Prepayments, Non-current, PFI related (eg lifecycle assets)	£m	(+ve)	-					
Prepayments, Non-current, non-PFI related	£m	(+ve)	-					
Prepayments, Non-Current	£m	(+ve)	0.000	0.000	0.000	0.000	0.000	0.00
Other Financial Assets, Non-Current								
Derivatives and embedded derivatives	£m	(+ve)	-					
Other Financial Assets, Non-Current	£m	(+ve)	-					
Other Financial Assets, Non-Current, Total			0.000	0.000	0.000	0.000	0.000	0.00
Off balance sheet PFI assets, Non-Current								
PFI Residual interest	£m	(+ve)	-					
PFI Deferred Assets	£m	(+ve)	-					
Off balance sheet PFI assets, Non-Current, Total			0.000	0.000	0.000	0.000	0.000	0.00
Other Assets, Non-Current								
Histo Non-Current Assets held by charitable funds	£m	(+ve)	-					
Other Assets, Non-Current	£m	(+ve)	-					
Other Assets, Non-Current, Total			0.000	0.000	0.000	0.000	0.000	0.00
Assets, Non-Current, Total			346.406	346.874	347.132	347.826	364.503	383.3
Assets, Current								
Inventories	£m	(+ve)	6.473	6.012	5.859	5.954	6.765	6.32
Current Tax Receivables	£m	(+ve)	-					
Trade and Other Receivables, Current								
NHS Trade Receivables, Current, Gross	£m	(+ve)	7.528	14.069	20.178	13.475	14.994	8.23
Non NHS Trade Receivables, Current, Gross	£m	(+ve)	3.685	2.981	2.608	2.921	2.854	3.68
Other related party receivables, Gross	£m	(+ve)	1.265	0.500	0.770	0.500	0.500	0.50
Other Receivables, Current, Gross	£m	(+ve)	2.803	2.688	2.596	3.408	3.748	2.90
Impairment of Receivables, Current (for bad & doubtful debts)	£m	(-ve)	(3.919)	(4.094)	(3.854)	(4.269)	(4.444)	(4.61
Trade and Other Receivables, Net, Current, Total			11.363	16.144	22.298	16.036	17.652	10.6
Other Financial Assets, Current								
Accrued Income	£m	(+ve)	1.248	1.037	1.500	1.059	1.082	1.10
Derivatives and embedded derivatives assets, current	£m	(+ve)	-					
Available for Sale financial assets	£m	(+ve)	-					
PDC dividend overpayment receivable	£m	(+ve)	0.099	0.099	0.099			
Deposits and Investments (illiquid or non-'safe harbour')	£m	(+ve)	-					
Other Financial Assets, Current	£m	(+ve)	-					
Other Financial Assets, Current, Total			1.347	1.136	1.599	1.059	1.082	1.10
Prepayments, Current								
Prepayments, Current, PFI related not lifecycle assets	£m	(+ve)	-					
Prepayments, Current, PFI related for Lifecycle assets (only)	£m	(+ve)	-					
Prepayments, Current, non-PFI related	£m	(+ve)	1.489	4.568	2.282	5.321	5.263	1.49
Prepayments, Current, Total	£m		1.489	4.568	2.282	5.321	5.263	1.49
Cash and Cash Equivalents								
Cash with Government Banking Service	£m	(+ve)	41.610	38.502	27.167	36.465	34.200	36.2
Cash with commercial banks and in hand	£m	(+ve)	0.008					
Deposits and Investments (liquid and 'safe harbour')	£m	(+ve)	-					
Cash and Cash Equivalents, Total	£m		41.618	38.502	27.167	36.465	34.200	36.2
Other Assets, Current								
Histo Current Assets held by charitable funds	£m	(+ve)	-					
Non-Current Assets held for sale	£m	(+ve)	-					
Other Assets, Current	£m	(+ve)	-					
Other Assets, Current, Total			0.000	0.000	0.000	0.000	0.000	0.00
Assets, Current, Total	£m		62.290	66.362	59.205	64.835	64.963	55.8

Worksheet "SoFP"

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Quarterly planned and actual statement of financial position for CHELSEA

This layout is identical to your Annual Plan

	units	sense	Audited at 31-Mar-13	Plan at 30-Jun-13	Actual at 30-Jun-13	Plan at 30-Sep-13	Plan at 31-Dec-13	Plan 31-Ma
Liabilities								
Liabilities, Current								
Interest-Bearing Borrowings, Current								
Bank Overdraft	£m	(-ve)	-					
Drawdown in Committed Facility	£m	(-ve)	-					
Bridging loans, Current	£m	(-ve)	-					
Loans, non-commercial, Current (DH, FTFF, NLF, etc)	£m	(-ve)	(3.625)	(3.625)	(3.625)	(3.625)	(4.876)	(5.27
Loans, commercial, Current	£m	(-ve)	-					
Interest-Bearing Borrowings, Current, Total	£m		(3.625)	(3.625)	(3.625)	(3.625)	(4.876)	(5.27
Non-Interest-Bearing Borrowings, Current	£m	(-ve)	-					
Deferred Income, Current	£m	(-ve)	(2.100)	(4.668)	(2.176)	(5.638)	(5.608)	(2.57
Deferred Grant Income, Current	£m	(-ve)	(0.102)	(0.102)	(0.102)	(0.102)	(0.102)	
Provisions, Current	£m	(-ve)	(2.620)	(2.421)	(2.209)	(2.221)	(2.221)	(2.22
Post-Employment Benefit Obligation, Current	£m	(-ve)	-					
Current Tax Payables	£m	(-ve)	-					
Trade and Other Payables, Current								
Trade Payables, Current	£m	(-ve)	(11.282)	(11.954)	(11.794)	(11.952)	(12.013)	(12.3
Other Payables, Current	£m	(-ve)	(3.881)	(2.174)	(2.615)	(2.159)	(2.038)	(2.07
Capital Payables, Current	£m	(-ve)	(3.171)	(3.743)	(1.326)	(4.143)	(4.443)	(4.83
Trade and Other Payables, Current, Total	£m		(18.334)	(17.870)	(15.735)	(18.254)	(18.494)	(19.2
Other Financial Liabilities, Current								
Accruals, Current	£m	(-ve)	(11.917)	(12.447)	(11.507)	(12.470)	(12.492)	(12.5
Payments on Account	£m	(-ve)	-					
Finance Leases, Current	£m	(-ve)	(0.202)	(0.195)	(0.210)	(0.196)	(0.203)	(0.20
PFI leases, Current	£m	(-ve)	-					
PDC dividend payable, Current	£m	(-ve)	-	(2.559)	(2.559)		(2.560)	
Derivatives and embedded derivatives liabilities, current	£m	(-ve)	-					
Interest payable on bridging loans, current	£m	(-ve)	-					
Interest payable on non-commercial interest bearing borrowings, cı	£m	(-ve)	(0.237)	(0.038)	(0.028)	(0.020)	(0.025)	(0.03
Interest payable on commercial interest bearing borrowings, currer	£m	(-ve)	-					
Other Accrued Financial Liabilities, Current	£m	(-ve)	-					
Other Financial Liabilities, Current	£m	(-ve)	-					
Other Financial Liabilities, Current, Total	£m		(12.356)	(15.239)	(14.304)	(12.686)	(15.280)	(12.7
Other Liabilities, Current								
Donation income deferred to future periods	£m	(-ve)	-					
Liabilities in disposal groups classified as held for sale	£m	(-ve)	-					
Histo Liabilities held by Charitable Funds, Current	£m	(-ve)	-					
Other Accrued Liabilities, Current	£m	(-ve)	-					
Other Liabilities, Current	£m	(-ve)	(4.205)	(4.365)	(4.766)	(4.368)	(4.371)	(4.37
Other Liabilities, Current, Total	£m		(4.205)	(4.365)	(4.766)	(4.368)	(4.371)	(4.37
Liabilities, Current, Total	£m		(43.341)	(48.291)	(42.917)	(46.894)	(50.953)	(46.4
NET CURRENT ASSETS (LIABILITIES)	£m		18.949	18.071	16.288	17.941	14.010	9.38
Liabilities, Non-Current								
Interest-Bearing Borrowings, Non-Current								
Loans, Non-Current, non-commercial (DH, FTFF, NLF, etc)	£m	(-ve)	(23.563)	(21.750)	(21.750)	(21.750)	(33.286)	(41.8
Loans, Non-Current, commercial	£m	(-ve)	-					
Interest-Bearing Borrowings, Non-Current, Total	£m		(23.563)	(21.750)	(21.750)	(21.750)	(33.286)	(41.8
Non-Interest-Bearing Borrowings, Non-Current	£m	(-ve)	-					
Deferred Income, Non-Current	£m	(-ve)	-					
Deferred Grant Income, Non-Current	£m	(-ve)	(0.070)	(0.070)	(0.070)	(0.070)	(0.070)	
Provisions, Non-Current	£m	(-ve)	(0.710)	(0.699)	(0.710)	(0.688)	(0.677)	(0.66
Post-Employment Benefit Obligation, Non-Current	£m	(-ve)	-					
Deferred Tax liabilities	£m	(-ve)	-					
Trade and Other Payables, Non-Current								
Trade Creditors, Non-Current	£m	(-ve)	-					
Other Creditors, Non-Current	£m	(-ve)	-					
Trade and Other Payables, Non-Current, Total	£m		0.000	0.000	0.000	0.000	0.000	0.00
Other Financial Liabilities, Non-Current								
Finance Leases, Non-current	£m	(-ve)	(1.895)	(2.012)	(1.876)	(1.856)	(1.837)	(1.81
PFI leases, Non-Current	£m	(-ve)	-					
Derivatives and embedded derivatives liabilities, non-current	£m	(-ve)	-					
Other Financial Liabilities, Non-Current	£m	(-ve)	-					
Other Financial Liabilities, Non-Current, Total	£m		(1.895)	(2.012)	(1.876)	(1.856)	(1.837)	(1.81
Other Liabilities, Non-Current								
Donated Assets deferred Income, Non-Current	£m	(-ve)	-					
Histo Liabilities held by Charitable Funds, Non-Current	£m	(-ve)	-					
Other Liabilities, Non-Current	£m	(-ve)	-					
Other Liabilities, Non-Current, Total	£m		0.000	0.000	0.000	0.000	0.000	0.00
Liabilities, Non-Current, Total	£m		(26.238)	(24.531)	(24.406)	(24.364)	(35.870)	(44.3
TOTAL ASSETS EMPLOYED	£m		339.117	340.414	339.014	341.403	342.643	348.3
Taxpayers' and Others' Equity								
Non Controlling interest *(was Minority Interest)*	£m	(+ve)	-					
Taxpayers Equity								

Worksheet "Checks"

Click to go to index

High level checks of financial information entered by Chelsea and Westminster

Note if your return fails checks 1,2 or 3 it will be rejected

			Checks Quarter ending 30-Jun-13	
1 Statement of Financial position balances	*from SoFP*		*OK*	
2 Cash in SoCF agrees to cash in SoFP	*From CF*		*OK*	
3 Cash and Cash Equivalents agree between SoFP and SoCF	*From CF*		*OK*	
4 Retained Surplus/(Deficit) check				
Opening I&E reserve balance	*from SoFP*	£m	87.381	
Movement in Retained Surplus in period				
I&E Movement in period	*from SoCI*	£m	-0.102	
Share of comprehensive income from associates and joint ve	*from SoCI*	£m	0.000	
Calculated closing I&E reserve balance		£m	87.279	
Closing I&E reserve balance	*from SoFP*	£m	87.279	*explanation (if required)*
		Check	*OK*	
5 Revaluation Reserve Check				
Opening Revaluation reserve balance	*from SoFP*	£m	89.187	
Movement in period	*from SoCI*	£m	0.000	
Calculated closing Revaluation reserve balance		£m	89.187	
Closing Revaluation reserve balance	*from SoFP*	£m	89.187	*explanation (if required)*
		Check	*OK*	
6 Available for Sale Reserve Check				
Opening Available for sale reserve balance	*from SoFP*	£m	0.000	
Movement in period	*from SoCI*	£m	0.000	
Calculated Closing Available for sale reserve balance		£m	0.000	
Closing Available for sale reserve balance	*from SoFP*	£m	0.000	*explanation (if required)*
		Check	*OK*	
7 Merger Reserve Check				
Opening Merger reserve balance	*from SoFP*	£m	0.000	
Movement in period	*from SoCI*	£m	0.000	
Calculated Closing Merger reserve balance		£m	0.000	
Closing Merger reserve balance	*from SoFP*	£m	0.000	*explanation (if required)*
		Check	*OK*	
8 Pensions Reserve Check				
Opening Pensions reserve balance	*from SoFP*	£m	0.000	
Movement in period	*from SoCI*	£m	0.000	
Calculated Closing Pensions reserve balance		£m	0.000	
Closing Pensions reserve balance	*from SoFP*	£m	0.000	*explanation (if required)*
		Check	*OK*	
9 Other Reserves Check				
Opening Other Reserves balance	*from SoFP*	£m	0.000	
Movement in period	*from SoCI*	£m	0.000	
Calculated Closing Other Reserves balance		£m	0.000	
Closing Other Reserves balance	*from SoFP*	£m	0.000	*explanation (if required)*
		Check	*OK*	
10 PDC balance check				
Opening PDC balance	*from SoFP*	£m	162.549	
Movement in PDC in period				
PDC drawn down	*from CF*	£m	0.000	
PDC repaid	*from CF*	£m	0.000	
Calculated closing PDC balance		£m	162.549	
Closing PDC reserve balance	*from SoFP*	£m	162.549	*explanation (if required)*
		Check	*OK*	
11 Interest Bearing Borrowings check				
Interest-Bearing Borrowings	*from SoFP*	£m	27.188	
Movement in Borrowings in period				
Borrowed	*from CF*	£m	0.000	
Repaid	*from CF*	£m	-1.813	
Calculated closing Interest-Bearing Borrowings			25.375	
Closing Interest-Bearing Borrowings	*from SoFP*	£m	25.375	*explanation (if required)*
		Check	*OK*	
12 Deposits and Investments check				
Deposits and investments	*from SoFP*	£m	0.000	
Movement in period in deposits and investments				
Purchased	*from CF*	£m	0.000	
Disposed	*from CF*	£m	0.000	
Calculated closing deposits and investments			0.000	
Closing Deposits and investments	*from SoFP*	£m	0.000	*explanation (if required)*
		Check	*OK*	
13 Non-Current receivables check				
Non-current receivables	*from SoFP*	£m	0.000	
Movement in period in non-current receivables	*from CF*	£m	0.000	
Calculated closing non-current receivables			0.000	
Closing non-current receivables	*from SoFP*	£m	0.000	*explanation (if required)*
		Check	*OK*	
14 Non-Current payables check				
Non-current payables	*from SoFP*	£m	0.000	
Movement in period in non-current payables	*from CF*	£m	0.000	
Calculated closing non-current payables			0.000	
Closing non-current payables from SP	*from SoFP*	£m	0.000	*explanation (if required)*
		Check	*OK*	
15 Asset Movements check				
Opening PPE & intangibles balance	*from SoFP*	£m	346.406	
Movement in PPE & intangibles in period				
Purchases	*from CF*	£m	3.862	
Disposal proceeds	*from CF*	£m	0.000	
less profit/(loss) on disposal	*From SoCI*	£m	0.000	
Donations of PPE & intangible assets received	*From SoCI*	£m	0.000	*explanation (if value input)*
Adjustments *(if you enter a value you MUST explain in column AQ)*	*input*	£m	-	
Revaluations	*From SoCI*	£m	0.000	
Depreciation	*From SoCI*	£m	-3.138	
Impairments	*from SoCI*	£m	0.000	
Calculated closing PPE & intangibles balance		£m	347.130	
Closing PPE & intangibles balance	*from SoFP*	£m	347.132	*explanation (if required)*
		Check	*OK*	
16 Working capital Movements check				
(Increase)/decrease in inventories	*from CF*	£m	0.614	
values in CF and movement in SP must agree	*from SoFP*	£m	0.614	*explanation (if required)*
		Check	*OK*	
17 Working capital Movements check				
(Increase)/decrease in tax receivable	*from CF*	£m	0.000	
values in CF and movement in SP must agree	*from SoFP*	£m	0.000	*explanation (if required)*
		Check	*OK*	
18 Working capital Movements check				
(Increase)/decrease in NHS Trade Receivables	*from CF*	£m	-12.650	
values in CF and movement in SP must agree	*from SoFP*	£m	-12.650	*explanation (if required)*
		Check	*OK*	
19 Working capital Movements check				
(Increase)/decrease in Non NHS Trade Receivables	*from CF*	£m	1.077	
values in CF and movement in SP must agree	*from SoFP*	£m	1.077	*explanation (if required)*
		Check	*OK*	
20 Working capital Movements check				
(Increase)/decrease in other related party receivables	*from CF*	£m	0.495	
values in CF and movement in SP must agree	*from SoFP*	£m	0.495	*explanation (if required)*
		Check	*OK*	
21 Working capital Movements check				
(Increase)/decrease in other receivables	*from CF*	£m	0.207	
values in CF and movement in SP must agree	*from SoFP*	£m	0.207	*explanation (if required)*
		Check	*OK*	
22 Working capital Movements check				
(Increase)/decrease in Accrued income & **Other fin. assets**	*from CF*	£m	-0.252	
values in CF and movement in SP must agree	*from SoFP*	£m	-0.252	*explanation (if required)*
		Check	*OK*	
23 Working capital Movements check				
(Increase)/decrease in **Prepayments**	*from CF*	£m	-0.793	
values in CF and movement in SP must agree	*from SoFP*	£m	-0.793	*explanation (if required)*
		Check	*OK*	
24 Working capital Movements check				
(Increase)/decrease in Other assets	*from CF*	£m	0.000	
values in CF and movement in SP must agree	*from SoFP*	£m	0.000	explanation (if required)

Worksheet "Variances"

Click to go to index

High level explanations of variances against plan for Chelsea and Westminster

Please input SHORT descriptions of MATERIAL variances

	Variances in Quarter ending 30-Jun-13
OPERATING INCOME	
Ambulance Cost & Volume / PbR Revenue	
Original Planned value	-
In Period Variances (brief explanation)	
Other (include all Variances under £0.1M on this line)	
Explained value	0.000
Actual value (check)	0.000
Of Which:	
Subtotal of above variances due to Price	
Subtotal of above variances due to Volume	
Validation	TRUE
Ambulance Block and Other Revenue	
Original Planned value	-
In Period Variances (brief explanation)	
Other (include all Variances under £0.1M on this line)	
Explained value	0.000
Actual value (check)	0.000
Validation	TRUE
Community Cost & Volume / PbR Revenue	
Original Planned value	0.210
In Period Variances (brief explanation)	
Under-performance on community dermatology & gynaecology contracts	Adv (0.055)
Other (include all Variances under £0.1M on this line)	
Explained value	0.155
Actual value (check)	0.155
Of Which:	

Subtotal of above variances due to Price		
Subtotal of above variances due to Volume	Adv	(0.055)
Validation		TRUE

Community Block and Other Revenue

Original Planned value	0.525
In Period Variances (brief explanation)	
Other (include all Variances under £0.1M on this line)	
Explained value	0.525
Actual value (check)	0.525
Validation	TRUE

Mental Health Cost & Volume / PBR Revenue

Original Planned value	-
In Period Variances (brief explanation)	
Other (include all Variances under £0.1M on this line)	
Explained value	0.000
Actual value (check)	0.000
Of Which:	
Subtotal of above variances due to Price	
Subtotal of above variances due to Volume	
Validation	TRUE

Mental Health Block Contract

Original Planned value	-
In Period Variances (brief explanation)	
Other (include all Variances under £0.1M on this line)	
Explained value	0.000
Actual value (check)	0.000
Validation	TRUE

Mental Health Other Clinical Revenue

Original Planned value	-
In Period Variances (brief explanation)	

Other (include all Variances under £0.1M on this line)	
Explained value	0.000
Actual value (check)	0.000
Of Which:	
Subtotal of above variances due to Price	
Subtotal of above variances due to Volume	
Validation	*TRUE*

Acute Elective Inpatient Revenue

Original Planned value		5.035
In Period Variances (brief explanation)		
Trauma & Orthopaedics - decrease in elective spells	Adv	(0.129)
Decrease in regular day admissions particularly HIV and dermatology	Adv	(0.136)
Other (include all Variances under £0.1M on this line)	Adv	(0.059)
Explained value		4.711
Actual value (check)		4.711
Of Which:		
Subtotal of above variances due to Price		
Subtotal of above variances due to Volume	Adv	(0.324)
Validation		*TRUE*

Acute Elective Day-Case Revenue

Original Planned value		6.437
In Period Variances (brief explanation)		
Paediatric dentistry - increase in day case activity	Fav	0.149
Endoscopy - increase in day case activity	Fav	0.100
Increase in day case activity in a number of surgical specialties	Fav	0.245
Other (include all Variances under £0.1M on this line)	Adv	(0.020)
Explained value		6.911
Actual value (check)		6.911
Of Which:		
Subtotal of above variances due to Price		
Subtotal of above variances due to Volume	Fav	0.474
Validation		*TRUE*

Non-Elective patients

Original Planned value		14.701
In Period Variances (brief explanation)		
Over-performance on emergency care pathway excess bed days metric	Fav	0.117
Over-performance on emergency care pathway reduction in admissions metric	Fav	0.524
Paediatric orthopaedics - decrease in non-elective activity	Adv	(0.124)
HIV - decrease in non-elective activity	Adv	(0.263)
Plastic and hand surgery - under-performance in emergency activity	Adv	(0.116)

Other (include all Variances under £0.1M on this line)	Adv	(0.001)
Explained value		14.838
Actual value (check)		14.838
Of Which:		
Subtotal of above variances due to Price	Fav	0.641
Subtotal of above variances due to Volume	Adv	(0.504)
Validation		*TRUE*

Acute Outpatient Revenue

Original Planned value		18.252
In Period Variances (brief explanation)		
GU medicine - increase in outpatient attendances	Fav	0.177
Paediatric ophthalmology - decrease in outpatient attendances	Adv	(0.130)
Over-performance on non-GP referrals metric	Fav	0.112
Over-performance on other outpatient metrics	Fav	0.300
Under-performance in rheumatology, partly relating to new to follow up ratios	Adv	(0.084)
Other (include all Variances under £0.1M on this line)	Adv	(0.050)
Explained value		18.577
Actual value (check)		18.577
Of Which:		
Subtotal of above variances due to Price	Fav	0.412
Subtotal of above variances due to Volume	Adv	(0.087)
Validation		*TRUE*

Acute A&E Revenue

Original Planned value		2.868
In Period Variances (brief explanation)		
A&E - decrease in attendances	Adv	(0.071)
Urgent Care Centre - increase in attendances	Fav	0.028
Other (include all Variances under £0.1M on this line)	Adv	(0.008)
Explained value		2.817
Actual value (check)		2.817
Of Which:		
Subtotal of above variances due to Price		
Subtotal of above variances due to Volume	Adv	(0.043)
Validation		*TRUE*

Acute Other PBR Revenue

Original Planned value		24.573
In Period Variances (brief explanation)		
Special Care Baby Unit - increase in cot days	Fav	0.129
Paediatrics HDU - increase in bed days	Fav	0.113
Adult critical care - decrease in bed days	Adv	(0.112)
Burns critical care - decrease in bed days	Adv	(0.136)
Under-performance on direct access activity for therapies & radiology	Adv	(0.137)

Other (include all Variances under £0.1M on this line)	Adv	(0.095)
Explained value		24.335
Actual value (check)		24.335
Of Which:		
Subtotal of above variances due to Price		
Subtotal of above variances due to Volume	Adv	(0.238)
Validation		*TRUE*

Acute Other Block / Non-PBR Revenue

Original Planned value		-
In Period Variances (brief explanation)		
Other (include all Variances under £0.1M on this line)		
Explained value		0.000
Actual value (check)		0.000
Of Which:		
Subtotal of above variances due to Price		
Subtotal of above variances due to Volume		
Validation		*TRUE*

Non Mandatory/Non protected revenue

Original Planned value		3.905
In Period Variances (brief explanation)		
Assisted Conception Unit	Adv	(0.096)
NHS Personal Injury Scheme	Adv	(0.061)
Overseas Patients	Adv	(0.057)
Private Maternity deliveries behind plan	Adv	(0.091)
Private Patients (all other specialties)	Adv	(0.154)
Amenity Beds under-utilisation	Adv	(0.089)
CIP slippage (on revised CIP schemes)	Adv	(0.243)
Other (include all Variances under £0.1M on this line)	Fav	0.020
Explained value		3.134
Actual value (check)		3.134
Of Which:		
Subtotal of above variances due to Price		
Subtotal of above variances due to Volume	Adv	(0.771)
Validation		*TRUE*

Research & Development Income

Original Planned value		1.157
In Period Variances (brief explanation)		
Other	Adv	(0.001)
Explained value		1.156

Actual value (check)		1.156
		TRUE

Education & Training Income

Original Planned value		6.006
In Period Variances (brief explanation)		
Other	Adv	(0.041)
Explained value		5.965
Actual value (check)		5.965
		TRUE

PFI Specific Income

Original Planned value		-
In Period Variances (brief explanation)		
Other		
Explained value		0.000
Actual value (check)		0.000
		TRUE

Other Operating Income

Original Planned value		2.671
In Period Variances (brief explanation)		
Facilities recharges for accomodation	Fav	0.086
Sponsorship Income	Fav	0.103
General Misc income (including salary recharges)	Fav	0.102
Other (include all Variances under £0.1M on this line)	Fav	0.060
Explained value		3.022
Actual value (check)		3.022
Of Which:		
Subtotal of above variances due to Price		
Subtotal of above variances due to Volume	Fav	0.351
Validation		TRUE

Operating Expenses

Employee benefits expenses

Original Planned value		(44.712)
In Period Variances (brief explanation)		
Vacancies, net of temporary staff	Adv	(0.112)
CIP slippage (on revised CIP schemes)	Adv	(0.490)
Other (include all Variances under £0.1M on this line)		
Explained value		**(45.314)**
Actual value (check)		**(45.314)**
Of Which:		
Subtotal of above variances due to PAY RATES (PERM. STAFF)		
Subtotal of above variances due to VACANCIES (PERM. STAFF)	Fav	5.357
Subtotal of above variances due to OVERTIME & BANK	Adv	(2.539)
Subtotal of above variances due to CONTRACT & AGENCY	Adv	(2.939)
Subtotal of above variances due to OTHER	Adv	(0.481)
Validation		*TRUE*

Drug Costs

Original Planned value		(14.410)
In Period Variances (brief explanation)		
HIV ARV Excluded drugs (recovered by income)	Adv	(0.881)
Other (include all Variances under £0.1M on this line)	Adv	(0.002)
Explained value		**(15.293)**
Actual value (check)		**(15.293)**
Of Which:		
Subtotal of above variances due to Price		
Subtotal of above variances due to Volume	Adv	(0.883)
Validation		*TRUE*

Clinical Supply Costs

Original Planned value		(8.983)
In Period Variances (brief explanation)		
CIP slippage (on revised CIP schemes)	Adv	(0.250)
Other (include all Variances under £0.1M on this line)	Fav	0.007

Explained value		(9.226)
Actual value (check)		(9.226)
Of Which:		
Subtotal of above variances due to Price		
Subtotal of above variances due to Volume	Adv	(0.243)
Validation		TRUE

Other Raw Materials and Consumable Costs

Original Planned value		(10.390)
In Period Variances (brief explanation)		
Rent & Rates	Fav	0.037
Estates Maintenance	Fav	0.118
Other (include all Variances under £0.1M on this line)	Fav	0.048
Explained value		(10.187)
Actual value (check)		(10.187)
Of Which:		
Subtotal of above variances due to Price		
Subtotal of above variances due to Volume	Fav	0.203
Validation		TRUE

Ambulance Trust Vehicle Operating Expenses

Original Planned value		-
In Period Variances (brief explanation)		
Other (include all Variances under £0.1M on this line)		
Explained value		0.000
Actual value (check)		0.000
Of Which:		
Subtotal of above variances due to Price		
Subtotal of above variances due to Volume		
Validation		TRUE

PFI Operating Costs

Original Planned value		-
In Period Variances (brief explanation)		
Other (include all Variances under £0.1M on this line)		
Explained value		0.000
Actual value (check)		0.000
Of Which:		
Subtotal of above variances due to Price		
Subtotal of above variances due to Volume		

Validation	TRUE

Other Operating Expenses within EBITDA

Original Planned value		(0.534)
In Period Variances (brief explanation)		
Release of provisions in relation to 12/13	Fav	0.551
Additional Consultancy usage (including transactions work)	Adv	(0.419)
Other (include all Variances under £0.1M on this line)	Fav	0.071
Explained value		(0.331)
Actual value (check)		(0.321)
Of Which:		
Subtotal of above variances due to Price	Fav	0.566
Subtotal of above variances due to Volume	Adv	(0.353)
Validation		TRUE

Other Operating Expenses outside EBITDA

Original Planned value		(3.242)
In Period Variances (brief explanation)		
Depreciation & Amortisation on owned assets is lower than planned in Q1	Fav	0.104
Other (include all Variances under £0.1M on this line)		
Explained value		(3.138)
Actual value (check)		(3.138)
Of Which:		
Subtotal of above variances due to Price		
Subtotal of above variances due to Volume	Fav	0.104
Validation		TRUE

Non Operating Items

Non Operating Income

Original Planned value		0.025
In Period Variances (brief explanation)		
Interest Income	Fav	0.002
Other		
Explained value		0.027
Actual value (check)		0.027
		TRUE

Non Operating Expenditure

Original Planned value		(2.796)
In Period Variances (brief explanation)		
Other		
Explained value		(2.796)
Actual value (check)		(2.796)
		TRUE

Income Statement Variances

	Quarter ending 30-Jun-13
Operating Income	
Ambulance Cost & Volume / PbR Revenue	0.000
Ambulance Block and Other Revenue	0.000
Community Cost & Volume / PbR Revenue	(0.055)
Community Block and Other Revenue	0.000
Mental Health Cost & Volume / PBR Revenue	0.000
Mental Health Block Contract	0.000
Mental Health Other Clinical Revenue	0.000
Acute Elective Inpatient Revenue	(0.324)
Acute Elective Day-Case Revenue	0.474
Acute Non-Elective Day-Case Revenue	0.137
Acute Outpatient Revenue	0.325
Acute A&E Revenue	(0.051)
Acute Other PBR Revenue	(0.238)
Acute Other Block / Non-PBR Revenue	0.000
Non Mandatory/Non protected revenue	(0.771)
Research & Development Income	(0.001)
Education & Training Income	(0.041)
PFI Specific Income	0.000
Other Operating Income	0.351
	(0.194)
Operating Expenses	
Employee benefits expenses	(0.602)
Drug Costs	(0.883)
Clinical Supply Costs	(0.243)
Other Raw Materials and Consumable Costs	0.203
Ambulance Trust Vehicle Operating Expenses	0.000
PFI Operating Costs	0.000
Other Operating Expenses within EBITDA	0.203
Other Operating Expenses outside EBITDA	0.104
	(1.218)
Non operating items	
Non Operating Income	0.002
Non Operating Expenditure	0.000
	0.002

Number of IS variances checks failed 0

Non cash flows in operating surplus/(deficit)

Original Planned value		6.735
In Period Variances (brief explanation)		
Depreciation & Amortisation lower than planned in Q1	Adv	(0.104)
Bad debt provision movement was a decrease rather than an increase	Adv	(0.240)
Other movements in non cash flows in operating surplus	Adv	(0.342)
Other	Adv	(0.002)
Explained value		**6.047**
Actual value (check)		**6.047**
		TRUE

Working Capital Movements

Original Planned value		(5.732)
In Period Variances (brief explanation)		
Increase in NHS debtors above plan at Q1	Adv	(6.109)
Deferred income release higher than plan at Q1	Adv	(2.492)
Prepayments lower than plan at Q1	Fav	2.286
Provision released earlier than planned at Q1	Adv	(0.212)
Other	Adv	(0.190)
Explained value		**(12.449)**
Actual value (check)		**(12.449)**
		TRUE

Non Current Provision Movements

Original Planned value		(0.011)
In Period Variances (brief explanation)		
No release of non current provisions in Q1	Fav	0.011
Other		
Explained value		**0.000**
Actual value (check)		**0.000**
		TRUE

Investing Cash flow Variances

Original Planned value		(3.170)
In Period Variances (brief explanation)		
Capital creditors decreased rather than increased in Q1	Adv	(2.417)
Capex slightly ahead of plan at Q1	Adv	(0.122)
Other		
Explained value		**(5.709)**
Actual value (check)		**(5.707)**
		TRUE

Financing Cash flow Variances

Original Planned value		(2.236)
In Period Variances (brief explanation)		

Other	
Explained value	**(2.236)**
Actual value (check)	**(2.238)**
	TRUE

Cash Flow Statement Variances

	Quarter ending 30-Jun-13
Surplus / (deficit) variance	1.410
Non cash flows in operating surplus/(deficit) variance	(0.688)
Working capital movements variance	(6.717)
Non Current Provision Movements	0.011
Operating Cash flows after movements in working capital	**(8.804)**
Investing Cash flow Variance	**(2.539)**
Financing Cash flow Variance	**0.000**
Variance in increase (decrease) in cash	**(11.343)**

Number of CF variances checks failed 0

CIP Variances

Original Planned value		2.648
In Period Variances (brief explanation)		
Slippage on achievement of CIP schemes (revenue); forecast Q2 improvement	Adv	(1.560)
Other		
Explained value		1.088
Actual value (check)		1.088
		TRUE

Number of CIP variances checks FALSE 0

Additional information for DH budgeting for Chelsea and Westminster

Notes: *The DH has asked for, and Monitor has agreed to collect and provide, the information in the tables on this worksheet each quarter. The information does not form part of the formal regulatory framework or Monitor's approach to the potential use of its statutory powers of intervention.*

1 Movement in Provisions for liabilities and charges

			Plan for Quarter ending 30-Jun-13	Actual for Quarter ending 30-Jun-13	Plan for Quarter ending 30-Sep-13	Plan for Quarter ending 31-Dec-13	Plan fo Quarter en 31-Mar-
Opening Balance	£m	(-ve)	(3.330)	(3.330)	(3.120)	(2.909)	(2.898
Change in the discount rate	£m	(+ve/-ve)	-		-	-	-
Arising during the year	£m	(-ve)	-		-	-	-
Utilised during the year	£m	(+ve)	0.210	0.127	0.211	0.011	0.011
Reclassified to liabilities held in disposal groups in year	£m	(+ve)	-		-	-	-
Reversed unused	£m	(+ve)	-	0.284	-	-	-
Unwinding of discount	£m	(-ve)	-		-	-	-
Calculated closing Balance	£m		(3.120)	(2.919)	(2.909)	(2.898)	(2.887
Closing balance from SoFP	£m	(-ve)	(3.120)	(2.919)	(2.909)	(2.898)	(2.887
Difference			0.000	0.000	0.000	0.000	0.000
Check			*TRUE*	*TRUE*	*TRUE*	*TRUE*	*TRUE*

2 Revenue costs of IFRS: Arrangements brought on SoFP under IFRIC12 (e.g PFI)

Depreciation charge	£m	(-ve)	-		-	-	-
Interest expense	£m	(-ve)	-		-	-	-
Impairment charge - AME on PFI assets only	£m	(-ve)	-		-	-	-
Impairment charge - DEL on PFI assets only	£m	(-ve)	-		-	-	-
Other expenditure	£m	(-ve)	-		-	-	-
Revenue receivable from subleasing	£m	(-ve)	-		-	-	-
Impact on PDC dividend payable	£m	(-ve)	-		-	-	-
Total IFRS expenditure (IFRIC12)	£m	(-ve)	0.000	0.000	0.000	0.000	0.000
Revenue costs of the same schemes if they had been accounted for under UK GAAP / ESA95 (net of any sublease income)	£m	(-ve)	-		-	-	-
Net IFRS change (IFRIC12)	£m	(+/-ve)	0.000	0.000	0.000	0.000	0.000

Capital costs of IFRS: Arrangements brought on SoFP under IFRIC12 (e.g PFI)

Capital consequences of IFRS: PFI and other items under IFRIC12	£m	(+ve)	-		-	-	-
Capital expenditure on UK GAAP basis	£m	(+ve)	-		-	-	-

3 Impairment of assets

Activity Information for Chelsea and Westminster

Notes: *Monitor will in future be devoting more attention to the activity levels reported by foundation trusts. The information does not form part of the formal regulatory framework or Monitor's approach to the potential use of its statutory powers of intervention.*

Trusts on monthly monitoring should note that this information is required only on a quartely basis so data is for a 3 month period.

The following section should only be completed by Acute and Specialist FT's.

Acute & Specialist Activity Metrics

		Plan for Quarter ending 30-Jun-13	Actual for Quarter ending 30-Jun-13	Plan for Quarter ending 30-Sep-13	Plan for Quarter ending 31-Dec-13	Qu
Elective inpatients	Spells	4,621	3,072	4,666	4,894	
Elective day case patients (Same day)	Cases	6,186	6,808	6,279	6,532	
Non-Elective	Spells	8,094	7,868	8,160	8,328	
Outpatients - first attendance	Attendances	56,481	57,008	57,809	57,010	
Outpatients - follow up	Attendances	54,234	62,335	55,510	54,742	
Outpatients - procedures	Procedures	9,722	8,160	9,951	9,813	
A&E	Attendances	28,484	28,222	26,962	29,243	
Other NHS activity	Various	221,814	217,966	222,673	222,374	
Other		-		-	-	

		Reported Quarter to 30-Jun-13	Reported YTD to 30-Jun-13
Underlying performance			
EBITDA YTD	*from SoCI*	4.805	4.805
Operating Revenue for EBITDA YTD	*from SoCI*	85.146	85.146
EBITDA Margin metric		5.6%	5.6%
EBITDA Margin rating		3	3
Achievement of plan			
Actual EBITDA from SoCI		4.805	4.805
Planned EBITDA from SoCI (APR Plan)		6.310	6.310
EBITDA % of plan achived metric		76.1%	76.1%
EBITDA % of plan achived rating		3	3
Financial Efficiency			
Net return after financing costs, YTD	*from SoCI*	(1.102)	(1.102)
Opening Financing	*from SoFP*	368.402	368.402
Closing Financing	*from SoFP*	366.476	366.476
Net return after Financing metric		-1.2%	-1.2%
Net return after financing rating		2	2
Surplus / (deficit) YTD	*from SoCI*	(0.102)	(0.102)
Gain / (loss) on asset disposals	*from SoCI*	-	-
Gain / (loss) on transfers by absorption	*from SoCI*	-	-
I & R (Impairments & restructuring) expenses Y	*from SoCI*	-	-
Total IFRS Operating Revenue YTD	*from SoCI*	86.146	86.146
IS Surplus margin metric		-0.1%	-0.1%
IS Surplus margin rating		2	2
Financial Efficiency rating		2	2
Liquidity			
Cash for liquidity purposes	*from SoFP*	30.429	30.429
Operating expenditure within EBITDA YTD	*from SoCI*	80.341	80.341
WCF in terms of Operating Expenditure YTD		22.4	22.4
Liquidity days metric (WCF limited to 30 days)		34.1	34.1
Liquidity rating		4	4
Weighted Average Rating		2.85	2.85
Overriding rules			
3 Return submitted on time		YES	
3 Return submitted complete and correct		YES	
2 PDC dividend not paid in full	NO		
3 Year 2 OR Year 3 deficit planned excluding I &	NO		
2 Year 2 AND Year 3 deficit planned excluding I &	NO		
3 One financial criteria scored at '2'		3	3
2 One financial criteria scored at '1'		TRUE	
2 Two financial criteria scored at '2'		FALSE	
1 Two financial criteria scored at '1'		FALSE	
2 Unplanned breach of PBC ratios		FALSE	
4 Less than 1 year as an Foundation Trust		FALSE	
Limit due to overriding rules		3	3
Financial Risk Rating		3	3

key to scoring

Underlying performance				25%
5	4	3	2	1
11%	9%	5%	1%	<1%

Achievement of plan				10%
5	4	3	2	1
100%	85%	70%	50%	<50%

Net Return after financing				20%
5	4	3	2	1
3%	2%	-0.5%	-5%	< -5%

IS surplus margin				20%
5	4	3	2	1
3%	2%	1%	-2%	< -2%

Liquidity metric				25%
5	4	3	2	1
60	25	15	10	<10

	F	G	H	I	J	K	L
12	**Financial Summary**	**Previous YE**		**Current Quarter**			YT
13	**£m**	**Actual**		**Plan**	**Actual**	**Variance**	
14	**Operating Revenue for EBITDA**	344.0		85.3	85.1	(0.2)	
15	Employee Expenses	(176.9)		(44.7)	(45.3)	(0.6)	
16	Drugs	(55.4)		(14.4)	(15.3)	(0.9)	
17	PFI operating expenses	0.0		0.0	0.0	0.0	
18	Other costs	(78.0)		(19.9)	(19.7)	0.2	
19	*Clinical supplies*	(37.2)		(9.0)	(9.2)	(0.2)	
20	*Decrease (increase) in inventories of finished goods & WIP*	0.0		0.0	0.0	0.0	
21	*Vehicle Fuel costs (ambulance trusts)*	0.0		0.0	0.0	0.0	
22	*Non-clinical supplies*	(40.3)		(10.4)	(10.2)	0.2	
23	*Cost of Secondary Commissioning of mandatory services*	0.0		0.0	0.0	0.0	
24	*Research & Development expense*	(0.0)		(0.1)	(0.2)	(0.1)	
25	*Education and training expense*	(0.7)		(0.3)	(0.1)	0.2	
26	*Misc. other Operating expenses*	0.0		0.0	0.0	0.0	
27	**EBITDA**	33.7		6.3	4.8	(1.5)	
28	Donations of PPE & intangible assets	1.9		1.0	1.0	0.0	
29	Depreciation and amortisation	(11.7)		(3.2)	(3.1)	0.1	
30	Impairment Losses (Reversals) net (on non-PFI assets)	0.0		0.0	0.0	0.0	
31	Impairment Losses (Reversals) net on PFI assets	0.0		0.0	0.0	0.0	
32	Restructuring Costs	0.0		0.0	0.0	0.0	
33	**Operating Surplus**	23.9		4.1	2.7	(1.4)	
34	Net interest	(0.8)		(0.2)	(0.2)	0.0	
35	*Interest Income*	0.2		0.0	0.0	0.0	
36	*Interest Expense on Overdrafts and Working Capital Facilities*	0.0		0.0	0.0	0.0	
37	*Interest Expense on Bridging loans*	0.0		0.0	0.0	0.0	
38	*Interest Expense on Non-commercial borrowings*	(0.8)		(0.2)	(0.2)	0.0	
39	*Interest Expense on Commercial borrowings*	0.0		0.0	0.0	0.0	
40	*Interest Expense on Finance leases (non-PFI)*	*(0.1)*		*(0.0)*	*(0.0)*	0.0	
41	*Interest Expense on PFI leases & liabilities*	*0.0*		*0.0*	*0.0*	0.0	
42	Other Non-Operating items	**(10.1)**		**(2.6)**	**(2.6)**	0.0	
43	*Gain (Loss) on Financial Instruments Designated as Cash Flow Hedges*	*0.0*		*0.0*	*0.0*	0.0	
44	*Gain (Loss) on Derecognition of Available-for-Sale Financial Assets*	*0.0*		*0.0*	*0.0*	0.0	
45	*Gain (Loss) on Derecognition of Non-Current Assets Not Held for Sale, Total*	*0.0*		*0.0*	*0.0*	0.0	
46	*Gain (Loss) from investments*	*0.0*		*0.0*	*0.0*	0.0	
47	*Dividend Income*	*0.0*		*0.0*	*0.0*	0.0	
48	*Share of profit (loss) from equity accounted Associates, Joint Ventures, Total*	*0.0*		*0.0*	*0.0*	0.0	
49	*Other Non-Operating income, Total*	*(0.1)*		*0.0*	*0.0*	0.0	
50	*Other Finance Costs*	*(0.0)*		*0.0*	*0.0*	0.0	
51	*PDC dividend expense*	*(9.9)*		*(2.6)*	*(2.6)*	0.0	
52	*PFI Contingent Rent*	*0.0*		*0.0*	*0.0*	0.0	
53	*Other Non-Operating expenses (incl. Misc)*	*0.0*		*0.0*	*0.0*	0.0	
54	*Income Tax (expense)/ income*	*0.0*		*0.0*	*0.0*	0.0	
55	**Net Surplus / (Deficit)**	**13.0**		**1.3**	**(0.1)**	**(1.4)**	
56							
57	*EBITDA % Income*	9.8%		7.4%	5.6%	-1.8%	
58	*CIP% of Op.Exp. less PFI Exp.*	3.7%		3.2%	1.3%	-1.9%	
59	*Pay CIPs as % Pay Costs*	-3.1%		-2.3%	-1.1%	1.2%	
60							
61	**Net Surplus / (Deficit)**	13.0		1.3	(0.1)	(1.4)	
62	Change in working capital	(8.4)		(5.7)	(12.4)	(6.7)	
63	*(Increase)/decrease in inventories*	*(0.1)*		*0.5*	*0.6*	0.2	
64	*(Increase)/decrease in tax receivable*	*0.0*		*0.0*	*0.0*	0.0	
65	*(Increase)/decrease in NHS Trade Receivables*	*(0.1)*		*(6.5)*	*(12.7)*	(6.1)	
66	*(Increase)/decrease in Non NHS Trade Receivables*	*0.3*		*0.7*	*1.1*	0.4	
67	*(Increase)/decrease in other related party receivables*	*(0.7)*		*0.8*	*0.5*	(0.3)	
68	*(Increase)/decrease in other receivables*	*0.0*		*0.1*	*0.2*	0.1	
69	*(Increase)/decrease in accrued income*	*(0.4)*		*0.2*	*(0.3)*	(0.5)	
70	*(Increase)/decrease in other financial assets*	*0.0*		*0.0*	*0.0*	0.0	
71	*(Increase)/decrease in prepayments*	*0.0*		*(3.1)*	*(0.8)*	2.3	
72	*(Increase)/decrease in Other assets*	*0.0*		*0.0*	*0.0*	0.0	
73	*Increase/(decrease) in Deferred Income (excl. Donated Assets)*	*(3.5)*		*2.6*	*0.1*	(2.5)	
74	*Increase/(decrease) in Deferred Income (Donated Assets)*	*(1.5)*		*0.0*	*0.0*	0.0	
75	*Increase/(decrease) in Current provisions*	*(3.6)*		*(0.2)*	*(0.4)*	(0.2)	
76	*Increase/(decrease) in post-employment benefit obligations*	*0.0*		*0.0*	*0.0*	0.0	
77	*Increase/(decrease) in tax payable*	*0.0*		*0.0*	*0.0*	0.0	
78	*Increase/(decrease) in Trade Creditors*	*(0.2)*		*0.7*	*0.5*	(0.2)	
79	*Increase/(decrease) in Other Creditors*	*0.1*		*(1.7)*	*(1.3)*	0.4	
80	*Increase/(decrease) in accruals*	*(0.0)*		*0.5*	*(0.4)*	(0.9)	
81	*Increase/(decrease) in other Financial liabilities*	*0.0*		*(0.2)*	*(0.2)*	0.0	
82	*Increase/(decrease) in Other liabilities*	*1.1*		*0.0*	*0.6*	0.6	
83	*Increase/(decrease) in Non Current provisions*	*0.0*		*(0.0)*	*0.0*	0.0	
84	Non cash I&E items	21.9		6.7	6.0	(0.7)	
85	*Tax expense*	*0.0*		*0.0*	*0.0*	0.0	
86	*Finance income/charges*	*0.8*		*0.2*	*0.2*	(0.0)	
87	*Share of profit/(loss) from equity accounted investments net of cash distributions rec*	*0.0*		*0.0*	*0.0*	0.0	
88	*Donations & Grants received of PPE & intangible assets*	*0.0*		*0.0*	*0.0*	0.0	
89	*Other operating non-cash movements*	*(0.6)*		*0.2*	*(0.1)*	(0.2)	
90	*Depreciation and amortisation, total*	*11.7*		*3.2*	*3.1*	(0.1)	
91	*Impairment losses/(reversals)*	*0.0*		*0.0*	*0.0*	0.0	
92	*Unrealised (gains)/losses on foreign currency exchange*	*0.0*		*0.0*	*0.0*	0.0	
93	*Gain/(loss) on disposal of property plant and equipment*	*(0.1)*		*0.0*	*0.0*	0.0	
94	*Gain/(loss) on disposal of intangible assets*	*0.0*		*0.0*	*0.0*	0.0	
95	*Share of profit/(loss) loss from investments*	*0.0*		*0.0*	*0.0*	0.0	
96	*PDC dividend expense*	*9.9*		*2.6*	*2.6*	0.0	
97	*Other increases/(decreases) to reconcile to profit/(loss) from operations*	*0.2*		*0.5*	*0.2*	(0.3)	
98	**Cashflow from operations**	**26.5**		**2.3**	**(6.5)**	(8.8)	
99	Cashflow from investing activities	(16.8)		(3.2)	(5.7)	(2.5)	
100	*Property, plant and equipment - maintenance expenditure*	*(2.7)*		*(0.2)*	*(0.8)*	(0.5)	
101	*Property, plant and equipment - non-maintenance expenditure*	*0.0*		*0.0*	*(0.0)*	(0.0)	
102	*Plant and equipment - Information Technology*	*(2.8)*		*(0.2)*	*(0.4)*	(0.2)	
103	*Plant and equipment - Other*	*(3.3)*		*(2.0)*	*(1.7)*	0.3	
104	*Property, plant and equipment - other expenditure*	*(9.0)*		*(0.7)*	*(0.5)*	0.2	
105	*Proceeds on disposal of property, plant and equipment*	*0.0*		*0.0*	*0.0*	0.0	
106	*Purchase of investment property*	*0.0*		*0.0*	*0.0*	0.0	
107	*Proceeds on disposal of investment property*	*0.0*		*0.0*	*0.0*	0.0	
108	*Purchase of intangible assets*	*(0.9)*		*(0.6)*	*(0.5)*	0.1	
109	*Proceeds on disposal of intangible assets*	*0.0*		*0.0*	*0.0*	0.0	
110	*Expenditure on capitalised development*	*0.0*		*0.0*	*0.0*	0.0	
111	*Increase/(decrease) in Capital Creditors*	*1.9*		*0.6*	*(1.8)*	(2.4)	

	F	G	H	I	J	K	L
151	*(Increase)/decrease in non-current receivables*	*0.0*		*0.0*	*0.0*	0.0	
152	*Increase/(decrease) in non-current payables*	*0.0*		*0.0*	*0.0*	0.0	
153	*Other cash flows from financing activities*	*0.0*		*0.0*	*0.0*	0.0	
154	**Net increase/(decrease) in cash**	**0.6**		**(3.1)**	**(14.4)**	**(11.3)**	
155							
156	**Cash at period end**	**41.6**		**38.5**	**27.2**	**(11.3)**	
157	**Cash and Cash equivalents at period end**	41.6		38.5	27.2	(11.3)	
158							
159	**Detailed Financial Summary**	**Previous YE**		**Current Quarter**			**YT**
160	**£m**	**Actual**		**Plan**	**Actual**	**Variance**	
161	Community						
162	Co Cost & volume contract revenue	0.5		0.2	0.2	(0.1)	
163	Co Block contract revenue	3.1		0.5	0.5	(0.0)	
164	Ambulance						
165	Am Cost & volume contract revenue	0.0		0.0	0.0	0.0	
166	Am Block contract revenue	0.0		0.0	0.0	0.0	
167	Am Other clinical MS revenue	0.0		0.0	0.0	0.0	
168	Mental Health						
169	Mh Cost & volume contract revenue	0.0		0.0	0.0	0.0	
170	Mh Block contract revenue	0.0		0.0	0.0	0.0	
171	Mh Clinical partnership (s31) revenue	0.0		0.0	0.0	0.0	
172	Mh Secondary commissioning revenue	0.0		0.0	0.0	0.0	
173	Mh Other clinical MS revenue	0.0		0.0	0.0	0.0	
174	Acute						
175	Ac Elective revenue	42.0		11.5	11.6	0.2	
176	Ac Non-Elective revenue	67.5		14.7	14.8	0.1	
177	Ac Outpatient revenue	68.2		18.3	18.6	0.3	
178	Ac A&E revenue	11.6		2.9	2.8	(0.1)	
179	Ac other revenue	98.3		24.6	24.3	(0.2)	
180	Private patient revenue	11.9		3.3	2.8	(0.5)	
181	Grants and donations in cash	0.1		0.0	0.0	0.0	
182	Other operating revenues	40.6		9.4	9.5	0.1	
183	**Total operating revenue for EBITDA**	344.0		85.3	85.1	(0.2)	
184	Grants and donations of PPE and intangible assets	1.9		1.0	1.0	0.0	
185	**Total operating revenue**	**345.9**		**86.3**	**86.1**	**(0.2)**	
186							
187	Employee Expenses	(176.9)		(44.7)	(45.3)	(0.6)	
188	Drugs expense	(55.4)		(14.4)	(15.3)	(0.9)	
189	Supplies (clinical & non-clinical)	(77.5)		(19.4)	(19.4)	(0.0)	
190	*Clinical supplies*	*(37.2)*		*(9.0)*	*(9.2)*	*(0.2)*	
191	*Non-clinical supplies*	*(40.3)*		*(10.4)*	*(10.2)*	*0.2*	
192	PFI expenses	0.0		0.0	0.0	0.0	
193	Other expenses	(0.5)		(0.5)	(0.3)	0.2	
194	*Decrease (increase) in inventories of finished goods & WIP*	*0.0*		*0.0*	*0.0*	*0.0*	
195	*Vehicle Fuel costs (ambulance trusts)*	*0.0*		*0.0*	*0.0*	*0.0*	
196	*Cost of Secondary Commissioning of mandatory services*	*0.0*		*0.0*	*0.0*	*0.0*	
197	*Research & Development expense*	*(0.0)*		*(0.1)*	*(0.2)*	*(0.1)*	
198	*Education and training expense*	*(0.7)*		*(0.3)*	*(0.1)*	*0.2*	
199	*Misc. other Operating expenses*	*0.0*		*0.0*	*0.0*	*0.0*	
200	**Total operating expenses within EBITDA**	**(310.3)**		**(79.0)**	**(80.3)**	**(1.3)**	
201							
202	**EBITDA**	**33.7**		**6.3**	**4.8**	**(1.5)**	
203	Depreciation and amortisation	(11.7)		(3.2)	(3.1)	0.1	
207	Impairments & Restructuring	*0.0*		*0.0*	*0.0*	*0.0*	
208	**Total operating expenses**	**(322.0)**		**(82.3)**	**(83.5)**	**(1.2)**	
209	**Operating Surplus (Deficit)**	**23.9**		**4.1**	**2.7**	**(1.4)**	
210	Profit (loss) on asset disposal	(0.1)		0.0	0.0	0.0	
211	Net interest	(0.8)		(0.2)	(0.2)	0.0	
212	Taxation	0.0		0.0	0.0	0.0	
213	PDC dividend	(9.9)		(2.6)	(2.6)	0.0	
214	Other non-operating items	1.9		1.0	1.0	(0.0)	
215	**Net Surplus / (Deficit)**	**13.0**		**1.3**	**(0.1)**	**(1.4)**	
216							
217	EBITDA % of Op. revenue	9.8%		7.4%	5.6%	-1.8%	
218							
219	**EBITDA**	**33.7**		**6.3**	**4.8**	**(1.5)**	
220	Change in Current Receivables	(0.5)		(5.0)	(10.9)	(5.9)	
226	Change in Current Payables	(0.0)		(1.0)	(0.8)	0.3	
230	Other changes in WC	(7.9)		0.3	(0.8)	(1.1)	
231	Change in Non Current Provisions	0.0		(0.0)	0.0	0.0	
232	Other non-cash items	1.3		1.7	1.1	(0.6)	
233	**Cashflow from operating activities**	26.5		2.3	(6.5)	(8.8)	
234	Capital expenditure (accurals basis)	0.0		(3.7)	(3.9)	(0.1)	
235	Asset sale proceeds	0.0		0.0	0.0	0.0	
236	other Investing cash flows	(16.8)		0.6	(1.8)	(2.4)	
237	**Cashflow before financing**	9.8		(0.9)	(12.2)	(11.3)	
238	Net interest	(0.9)		(0.4)	(0.4)	(0.0)	
245	PDC dividends (paid)	(9.6)		0.0	0.0	0.0	
246	Movement in loans	1.4		(1.8)	(1.8)	(0.0)	
247	PDC received/(repaid)	0.0		0.0	0.0	0.0	
248	Donations received in cash	0.0		0.0	0.0	0.0	
249	other financing cashflows	(0.1)		0.0	0.0	0.0	
250	**Net cash inflow (outflow)**	**0.6**		**(3.1)**	**(14.4)**	**(11.3)**	
251							
252	**Cash at period end**	**41.6**		**38.5**	**27.2**	**(11.3)**	
253	**Cash and Cash equivalents at period end**	**41.6**		**38.5**	**27.2**	**(11.3)**	
254	**Non Safe Harbour Investments at period end**	**0.0**		**0.0**	**0.0**	**0.0**	

Worksheet "Elections"

Click to go to index

List of Governors' elections for Chelsea and Westminster

The Compliance Framework requireds a quarterly report of elections held and resuls as below:

Elections Held in the quarter ending 30 Jun 2013

	Constituency Type	Full Name of Constituency	No. of candidates	No. of Votes cast	Turnout	No. of Eligible voters	Date of election
example	*Public*	*North west ourtown*	*4*	*1,345*	*16.3%*	*8,230*	*01/05/2010*
		There were no elections held in Q1.					

Worksheet "Targets and Indicators"

Declaration of risks against healthcare targets and indicators for 2013-14 by Chelsea and Westminster

These targets and indicators are set out in the **Compliance Framework**

Definitions can be found in Appendix B of the Compliance Framework 13/14

NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

Key: must complete / may need to complete

Target or Indicator (per Compliance Framework 13/14)	Threshold or target YTD	Scoring	Risk declared at Annual Plan	Score	Quarter 1 Actual Performance	Achieved /Not Met	Any comments or explanations	Score
Referral to treatment time, 18 weeks in aggregate, admitted patients	2	1.0	No		90.6%	Achieved		
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	0	1.0	No		97.4%	Achieved		
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	>92%	1.0	No	0	93.6%	Achieved		0
A&E Clinical Quality- Total Time in A&E under 4 hours	>95%	1.0	No	0	98.6%	Achieved	*Provisional figures until open exeter extract is downloaded*	0
Cancer 62 Day Waits for first treatment (from urgent GP referral)	>85%	1.0	No		87.7%	Achieved	*Provisional figures until open exeter extract is downloaded*	
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	>90%	1.0	No	0	100.0%	Achieved	*Provisional figures until open exeter extract is downloaded*	0
Cancer 31 day wait for second or subsequent treatment - surgery	>94%	1.0	No			Achieved	*No treatments*	
Cancer 31 day wait for second or subsequent treatment - drug treatments	>98%	1.0	No			Achieved	*No treatments*	
Cancer 31 day wait for second or subsequent treatment - radiotherapy	>94%	1.0	No	0	0.0%	Not relevant		0
Cancer 31 day wait from diagnosis to first treatment	>96%	0.5	No	0	97.4%	Achieved	*Provisional figures until open exeter extract is downloaded*	0
Cancer 2 week (all cancers)	>93%	0.5	No		95.5%	Achieved	*Provisional figures until open exeter extract is downloaded*	
Cancer 2 week (breast symptoms)	>93%	0.5	No	0	0.0%	Not relevant		0
Care Programme Approach (CPA) follow up within 7 days of discharge	>95%	1.0	No		0.0%	Not relevant		
Care Programme Approach (CPA) formal review within 12 months	>95%	1.0	No	0	0.0%	Not relevant		0
Admissions had access to crisis resolution / home treatment teams	>95%	1.0	No	0	0.0%	Not relevant		0
Meeting commitment to serve new psychosis cases by early intervention teams	>95%	0.5	No	0	0.0%	Not relevant		0
Ambulance Category A 8 Minute Response Time - Red 1 Calls	>75%	0.5	No		0.0%	Not relevant		
Ambulance Category A 8 Minute Response Time - Red 2 Calls	>75%	0.5	No	0	0.0%	Not relevant		0
Ambulance Category A 19 Minute Transportation Time	>95%	1.0	No	0	0.0%	Not relevant		0
Clostridium Difficile -meeting the C.Diff objective	as agreed	1.0	Yes	1	0.0	Achieved		0
MRSA - meeting the MRSA objective	as agreed	1.0	No	0	2.0	Achieved	*The plan should have been 6 and not 0. Please see commentary and the target needs to be*	0
Minimising MH delayed transfers of care	<=7.5%	1.0	No	0	0.0%	Not relevant		0
Data completeness, MH: identifiers	>97%	0.5	No	0	0.0%	Not relevant		0
Data completeness, MH: outcomes	>50%	0.5	No	0	0.0%	Not relevant		0
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	0.5	No	0	100.0%	Achieved		0
Community care - referral to treatment information completeness	>50%	1.0	No		0.0%	Not relevant		
Community care - referral information completeness	>50%	1.0	No		0.0%	Not relevant		
Community care - activity information completeness	>50%	1.0	No	0	0.0%	Not relevant		0
Risk of, or actual, failure to deliver Commissioner Requested Services	N/A	4.0	No	0		No		0
CQC compliance action outstanding (as at 30 Jun 2013)	N/A	special	No			No		
CQC enforcement action within last 12 months (as at 30 Jun 2013)	N/A	special	No			No		
CQC enforcement action (including notices) currently in effect (as at 30 Jun 2013)	N/A	4.0	No			No		
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at 30 Jun 2013)	N/A	special	No			No		
Major CQC concerns or impacts regarding the safety of healthcare provision (as at 30 Jun 2013)	N/A	2.0	No	0		No		0
Trust unable to declare ongoing compliance with minimum standards of CQC registration	N/A	special	No			No		

Results left to complete	0	0
Total Score	1	0
Overide Rating (if any)		Enter the reason for any non-scoring related rating override here
Indicative Governance risk rating	AMBER-GREEN	GREEN

Finance Risk Indicators for Chelsea and Westminster

Please respond "True" or "False" in the yellow cells below to statements 3 to 7 inclusive

	Finance Risk Indicators	Response
1	Unplanned decrease in (quarterly) EBITDA margin in two consecutive quarters	FALSE
2	Trust is unable to certify that Board anticipates that the Quarterly FRR will be at least 3 over the next 12 months (from Governance Statement)	FALSE
3	Working capital facility (WCF) was used at any point in the quarter ending 30 Jun 2013	FALSE
4	Debtors > 90 days past due account for more than 5% of total debtor balances	TRUE
5	Creditors > 90 days past due account for more than 5% of total creditor balances	TRUE
6	Two or more changes in Finance Director in a twelve month period	FALSE
7	Interim Finance Director in place over more than one quarter end	FALSE
8	Quarter end cash balance <10 days of *(annualised)* operating expenses	FALSE
9	Capital expenditure < 85% of Latest Plan for the year to date	FALSE
10	Capital expenditure > 115% of Latest plan for the year to date	FALSE
	Note: Once your financial results are entered in SoCI, SoFP and SoCF the "?" cells will be calculated	0

Notes: *As set out in Monitor's Compliance Framework 2013-14, Monitor will separately consider this limited set of indicators to highlight the potential for any future material financial risk. Where Monitor believes that one or more of these indicators are present at an NHS foundation trust, Monitor will consider whether an earlier meeting with the trust to discuss them is appropriate. Following this meeting, Monitor may request the preparation of plans, or the provision of other assurances as to an NHS foundation trust's capacity to mitigate any potential risk. The use of these indicators will not form part of the formal regulatory framework or Monitor's approach to the potential use of its statutory powers of intervention.*

In Year Governance Statement from the Board of Chelsea and Westminster

The board are required to respond "Confirmed" or "Not confiirmed" to the following statements (see notes below)

		Board Response
For finance, that:		
4	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.	Confirmed
For governance, that:		
11	The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in **Appendix B** of the Compliance Framework; and a commitment to comply with all known targets going forwards.	Confirmed
Otherwise		
	The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per Compliance Framework page 17 Diagram 8 and page 63) which have not already been reported.	

Signed on behalf of the board of directors

Signature	Sign Here.	Signature	Sign Here.
Name	Sir Christopher Edwards	**Name**	Tony Bell
Capacity	Chairman	**Capacity**	Chief Executive
Date	25th July 2013	**Date**	25th July 2013

Notes: *The contents of this statement are specified in Monitor's Compliance Framework for 2013-14* 1

Monitor will accept either 1) electronic signatures pasted into this worksheet or 2) hand written signatures on a paper printout of this declaration posted to Monitor to arrive by the submission deadline.

In the event than an NHS foundation trust is unable to confirm these statements it should NOT select 'Confirmed' in the relevant box. It must provide a response (using the section below) explaining the reasons for the absence of a full certification and the action it proposes to take to address it.

This may include include any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance.

Monitor may adjust the relevant risk rating if there are significant issues arising and this may increase the frequency and intensity of monitoring for the NHS foundation trust.

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

A

B

C