Chelsea and Westminster Hospital NHS
NHS Foundation Trust

24 July 2014

Dear Colleagues,

Board of Directors Meeting (PUBLIC)
Thursday, 31 July 2014

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

Please also note that papers which have been 'starred' will not be discussed unless an advance request is made to the Chairman.

Light refreshments will be provided from 3.30pm in the Atrium area.

Yours sincerely,

Vida Djelic
Board Governance Manager

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting (PUBLIC)

Location: Hospital Boardroom, Lower Ground Floor, Lift Bank C
Chair: Sir Tom Hughes-Hallett
Date: Thursday, 31 July2014 Time: 4.00pm

Agenda

Ref	Item	Lead	Time
1	**GENERAL BUSINESS**		**4.00**
1.1	Welcome and Apologies for Absence	TH-H	
1.2	Chairman's Introduction	TH-H	
1.3	Declaration of Interests	TH-H	
1.4	Draft Minutes of the Meeting of the Board of Directors held on 27 May 2014	TH-H	
1.5	Matters arising	TH-H	
1.6	Chairman's Report	TH-H	
1.7	Chief Executive's Report	APB	
1.8	Council of Governors Report including Membership Report and Quality Awards	TH-H	
2	**QUALITY**		**4.10**
2.1	Patient Experience (oral)	EM	
2.2	Assurance Committee Report – April and May 2014	KN	
2.3	Assurance Committee Annual Report 2013/14	KN	
2.4	Complaints Annual Report 2013/14	EM	
2.5	Risk Management Annual Report 2013/14	EM	
2.6	Risk Management Strategy and Policy 2014/15	EM	
3	**GOVERNANCE**		**4.35**
3.1	CQC Announced Inspection Update	EM	
3.2	Monitor In-Year Reporting & Monitoring Report Q1	LB	
3.3	Board Assurance Framework and Risk Report Q1	APB/EM	
3.4	Register of Seals Report Q1*	LH	
3.5	A Framework of Quality Assurance for Responsible Officers and Revalidation: Annual Board Report 2014	ZP	
4	**PERFORMANCE**		**4.50**
4.1	Finance Report – June 2014	LB/RP	
4.2	Performance Report – June 2014	RH	
5	**STRATEGY**		**5.05**
5.1	Strategy Update (oral) - Accountable Care Group progress	APB	
6	**WORKFORCE**		**5.20**
6.1	Annual Workforce Monitoring Report	SY	
7	**ITEMS FOR INFORMATION**		

7.1	Audit Committee Minutes – 22 May 2014	JB
8	**ANY OTHER BUSINESS**	
9	**QUESTIONS FROM THE PUBLIC**	
10	**DATE OF NEXT MEETING – 30 October 2014**	
	CLOSE	**5.30**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 July 2014 (PUBLIC)

AGENDA ITEM NO.	1.4/Jul/14
PAPER	Draft Minutes of the Meeting of the Board of Directors held on 27 May 2014
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Sir Tom Hughes-Hallett, Chairman
PURPOSE	To provide a record of any actions and decisions discussed at the meeting
LINK TO OBJECTIVES	NA
RISK ISSUES	None in addition to those included in the minutes
FINANCIAL ISSUES	None in addition to those identified in the minutes
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This paper outlines a record of the proceedings of the public meeting of the Board of Directors on 27 May 2014
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, 27 May 2014 PUBLIC
Draft Minutes

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

Present

Non-Executive Directors	Sir Tom Hughes-Hallett	TH-H	Chairman
	Sir John Baker	JB	
	Jeremy Loyd	JL	
	Prof Richard Kitney	RK	
	Karin Norman	KN	
Executive Directors			
	Tony Bell	APB	Chief Executive
	Lorraine Bewes	LB	Chief Financial Officer
	Elizabeth McManus	EM	Chief Nurse and Director of Quality
	Zoe Penn	ZP	Medical Director
In attendance			
	Robert Hodgkiss	RH	Divisional Director of Operations, Division of Womens, Neonates, Childrens and Young People, HIV/GUM and Dermatology Services (deputising for David Radbourne)
	Rakesh Patel	RP	Director of Finance
	Susan Young	SY	Director of Human Resources and Organisational Development
	Layla Hawkins	LH	Interim Head of Corporate Affairs/Company Secretary
	Steven Picken	SP	Quality Governance Manager, Deloitte
	Vida Djelic	VD	Board Governance Manager

1.1 Welcome and Apologies for Absence **TH-H**

TH-H welcomed members of the public and governors to the meeting.

Apologies were received from David Radbourne.

1.2 Chairman's Introduction **TH-H**

None.

1.3 Declarations of Interests **TH-H**

There were no declarations of interests.

1.4 Draft Minutes of the Meeting of the Board of Directors held on 24 April 2014 **TH-H**

The minutes of the previous meeting were approved as a true and accurate record.

1.5 Matters arising **TH-H**

Governor Tom Pollak queried if there was an update on the availability of cycle racks at the hospital. EM responded that this has been addressed by the Health and Wellbeing Steering Group and the Front of House Development Group. **EM to provide an update on availability of cycle racks.** **EM**

1.6 Chairman's report **TH-H**

TH-H said, in addition to his written report, that references have been obtained for all newly appointed Non-executive Directors. It was noted that the formal offers of appointment have been made, inviting them to join the Board with effect from 1 July 2014. We are awaiting the candidates' formal acceptance of these offers.

TH-H noted that he will be attending the Chair of the Association of Teaching Hospitals meeting later in May.

1.7 Chief Executive's report **APB**

APB highlighted the key points from his report:

- CQC visit – APB noted that the CQC announced visit will begin on 8 July. The inspection team will spend two days at the trust inspecting every site that delivers acute services and could subsequently conduct an unannounced inspection. EM is the executive director lead.
- Open Day – APB highlighted that the event will be held on 14 June from 11-3pm at the main hospital site. The event is open to all visitors. APB thanked governors and volunteers involved in helping to organise the event.
- Star Awards – APB thanked Chelsea and Westminster Health Charity for generously funding a successful evening, the governors involved in the judging process and all staff that helped to make it successful and memorable event.

TH-H queried how long it will take to receive the results of the CQC announced inspection. APB responded that any concerns will be shared with the trust immediately and the formal report would be received by the trust a few weeks after the announced inspection.

QUALITY

2.1 Patient experience **EM**

The Board received a patient story which highlighted an issue in relation to a surgery appointment and a complimentary story highlighting great care and good attitude of staff, subsequently received by the same patient.

PERFORMANCE

3.1 Finance Report commentary – April 2014 **LB/RP**

LB noted that there is a deficit of £1.1m in April which is £1.5m behind plan. The main reason for the adverse position include:

- unachieved Cost Improvement Programme (CIPs)
- under-recovery of private patient income
- budget pressure with clinical supplies and drugs

There is continuous weekly executive team focus on CIP delivery with divisional and corporate teams to address the adverse impact.

TH-H queried whether a £25.4m CIP delivery is achievable. APB responded that deficit is usually expected at month 1 and this will be balanced out throughout the year.

LB noted that pay costs were higher than planned (this includes unachieved CIPs). However, non pay costs produced an adverse variance of £0.8m in month 1.

The Board noted that the Continuity of Services Risk rating at month 1 is a 3 (consists of a capital service rating of 1 and a liquidity rating of 4) which is in line with the financial plan.

The Board discussed capital expenditure for month 1 reflecting the continuing spend against capital schemes approved in the last financial year.

The Board approved the revised capital programme budget for 2014/15 of £30.1m to include carry forward of £1.5m for capital schemes.

LB to circulate a comparative cost paper presented at the recent Finance and Investment Committee to the Board. **LB**

LB to circulate the level of expenditure approval as per the Reservation of Powers and Scheme of Delegation to the Board. **LB**

3.2 Performance Report Commentary – April 2014 **RH**

RH highlighted the following from the performance report:

- Best performing A&E with a significant increase in the number of A&E attendances
- Good performance on patient safety and clinical effectiveness
- *C difficile* target of 8 cases for 14/15
- A reduction in the elective c. section rates (being below 30%) in part due to new birthing Unit
- Currently non-compliant with 18 weeks elective surgery; there is a recovery plan to treat as quickly as possible a backlog of patients waiting for surgery

and root cause analysis will be undertaken to understand, address and sustain compliance with referral to treatment time (RTT) performance

- Achieved 96% compliance on CQUINs against an expectation of 96%

The Board noted a new clinical effectiveness ward dashboard development which links data from five information systems and demonstrates performance of any ward at the Chelsea and Westminster in near real time.

RK queried the Monitor dashboard and the reason for having a target of 5 MRSA in 14/15 when the month 1 position was already 1 case. RH responded that the target of 5 presents the threshold and is red, even though the Trust is compliant due to a stretch target of 0.

JL queried a low uptake in fire training. RH responded that this was discussed by the Senior Operations Managers Group. TH-H suggested that the executive team provide the required level of staff training so that the Board can robustly monitor this. SY clarified that not all training is mandatory for all staff on annual basis.

JB queried ambulance handovers and redirects. Alison Kingston, Divisional Manager responded that there has been an increase in the number of red light attendances and the trust is working with the London Ambulance Service and commissioners to understand the reasons for this change and will work with them to improve how intelligent conveyancing spreads demand across the system and avoids large numbers of ambulances arriving in a short amount of time.

ITEMS FOR DECISION/APPROVAL

STRATEGY

4.1 Strategy Update (oral)

APB confirmed to the Board that the A&E department development should continue apace regardless of the timeline for the implementation of *Shaping a Healthier Future*.

APB noted that a potential West Middlesex acquisition continues to be a matter of discussion with the NHS Trust Development Authority (TDA) and the Board will be subsequently consulted as to whether to proceed to the Full Business Case stage.

APB also noted that the development of accountable/integrated care continues. An update on this will be provided at the next Board meeting.

GOVERNANCE

4.2 Corporate Governance Statement Sign-Off **LH**

JB noted that most of assurances for the annual reports and Monitor plan come via the Audit Committee.

The Board noted the response for each question and the assurances in place for the corporate governance statement.

The Board approved the corporate governance statement which forms part of the

Annual Plan submission to Monitor.

5 ITEMS FOR INFORMATION

None.

6 ANY OTHER BUSINESS

None.

7 QUESTIONS FROM THE PUBLIC

None as answered earlier in the meeting.

9 DATE OF NEXT MEETING – 31 July 2014

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 July 2014 (PUBLIC)

AGENDA ITEM NO.	1.5/Jul/14
PAPER	Matters Arising – 27 May 2014
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Sir Tom Hughes-Hallett, Chairman
PURPOSE	To provide a record of actions raised at the Board of Directors meeting and any 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 the meeting of the Board of Directors held on 27 May 2014 with any subsequent actions or outcomes.
DECISION/ ACTION	The Board is asked to note the actions or outcomes reported by the respective leads.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 27 May 2014 PUBLIC

Ref	Description	Lead	Subsequent Actions/Outcomes
1.5/May/14	**Matters arising**		
	EM to provide an update on availability of cycle racks for bikes.	**EM**	The Trust have the following Cycle Racks available: • 6 x Cycle Racks in Nightingale Place for Public and Staff use, Capacity for 12 Cycles • 72 x Cycle Racks for Public and Staff use in the Hospital Car Park, Capacity for 144 Cycles • 26 x Cycle Racks for Staff use in a Secure Cage, Capacity 52 Cycles • 48 Cycle 2 Tier Rack donated by Boris Johnson in the Secure Cage, Capacity 48 Cycles The area outside of the Starbucks Coffee shop belongs to the RBK&C has 12 x Cycle Racks, Capacity 24 Cycles. We do have capacity for more cyclists to use the Car Park and we encourage all of our staff to take that option. The Security Manager is going to Police the frontage and start to politely label the offenders, In order to keep the frontage clear of clutter. It is intended to hold further meetings with the RBK&C to see if we could re-design the racks outside Starbucks

			and get as many as 20 racks in place with a capacity of 40 Cycles.
3.1/May/14	**Finance Report Commentary – April 2014**		
	LB to circulate a comparative cost paper presented at the recent Finance and Investment Committee to the Board.	**LB**	Completed.
	LB to circulate the level of expenditure approval as per the Reservation of Powers and Scheme of Delegation to the Board.	**LB**	Completed.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 July 2014 (PUBLIC)

AGENDA ITEM NO.	1.6/Jul/14
PAPER	Chairman's Report
AUTHOR	Sir Tom Hughes-Hallett, Chairman
LEAD	Sir Tom Hughes-Hallett, Chairman
PURPOSE	This paper is intended to provide an update to the Board on key issues
LINK TO OBJECTIVES	All
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 since the last meeting.
DECISION/ ACTION	For information

Chairman's Report

1.0 Council of Governors sub committees

We have had discussions about reviewing the Council of Governors sub Committee structure to ensure that they provide the right mechanism for Governors to be able to use their expertise in driving improvements to patient care and experience.

An initial meeting has been held with Director of HR and OD Susan Young, Governor Martin Lewis, Board Governance Manager Vida Djelic, Head of Communications & Marketing Layla Hawkins and myself to review Governors areas of interest and whether the sub Committees are aligned to these interests and expertise. Our aim is to make sure that each Governor can use their limited time with the hospital most effectively to both support the organisation and feel fulfilled by this volunteering role.

In order to do this, I would like the Council of Governors to consider the following:

- Whether the list of Governors interests (attached) best reflect their personal priorities as a Governor
- Whether the existing meetings and committees can be streamlined to make sure we use Governors time as effectively as possible
- For Governors to put themselves forward for involvement in any of the sub committees and meet a Governor sessions

These are initial discussions but the first meeting looked at having the following sub Committees for the Council to consider:

- Patient experience sub committee
- Membership and public engagement sub committee
- Agenda sub committee
- Nominations committee for the appointment of Non-executive Directors.

We will review in more depth the Quality Sub-Committee.

It is suggested that all sub committees are chaired by a Governor.

In addition to sub committees, I would like to hold a range of task and finish groups for key trust priorities e.g. Front of House Group.

We are also considering Governor Melvyn Jeremiah's suggestion of Governors to be paired with Non-executive Directors.

Please note that this review is separate to the ongoing review of the trust executive and other committees, which is ongoing.

2.0 West Middlesex visits

I am delighted that the West Middlesex team have arranged a site visit to their hospital for Governors. These will take place on the following dates:
29th July 09.00 am – 12.00 noon

The event will be led by our West Middlesex Hospital colleagues and will include a tour of the site.

3.0 Thank you to departing Governors

I would like to thank Frances Taylor and Cyril Nemeth for their most insightful contributions as appointed governors – both are no longer local councillors, hence why they will not be able to represent the Royal Borough of Kensington and Chelsea and Westminster City Council.

Dominic Clarke and Maddy Than have left the organisation for new roles and we wish them the best in their respective trusts. They have been excellent ambassadors for staff as governors.

Caroline Fenwick, one of our newest Governors, has been offered a secondment opportunity at the trust which means she is no longer able to represent the Allied Health Professionals constituency. In her short time as a Governor she has been very engaged in the role, and has been actively involved in many committees.

The Council of Governors remains quorate and we are working with our local Councils to recruit new appointed representatives. Elections to non appointed Governor posts will commence in September.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 July 2014 (PUBLIC)

AGENDA ITEM NO.	1.7/Jul/14
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	All
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 since the last meeting.
DECISION/ ACTION	For information

Chief Executive's Report

1.0 Healthwatch Annual General Meeting (AGM)

We were delighted to have been asked by Healthwatch to present Chelsea and Westminster's vision for the triborough at their AGM this month. Many thanks to Dominic Conlin, Director of Strategy and Integration, for his input into the event. We look forward to working with our Healthwatch colleagues to ensure that our vision meets the needs of the populations they represent.

2.0 Accountable Care Group (ACG)

The ACG brings together a number of organisations to form a single entity which puts patients' needs at the heart of the design and delivery of healthcare services. These organisations include:

- Network 2 GPs: five practices within Hammersmith and Fulham CCG boundary
- Chelsea and Westminster Hospital NHS Foundation Trust
- Central London Community NHS Trust
- Central and North West London NHS Foundation Trust (with West London Mental Health NHS Trust via a service level agreement)

The partnership will be driven by the needs of the local population, using shared data (a common electronic patient record system) and strong clinical leadership to achieve clear objectives. These objectives include improved health outcomes, better patient experience and improved use of resources.

The ACG uses a range of innovative tools and techniques to ensure improved effectiveness and efficiency. Its 'early adopter' bid is based around care for the Network 2 registered GP population and seeks to test use of individual care plans, joint decision-making (with an initial focus on long term conditions and HIV patients).

3.0 NICU incident

On Friday 30 May the Trust identified an issue with a bacterial infection which has subsequently been found in four babies on our neonatal unit at Chelsea and Westminster Hospital. The NICU team worked extremely hard to provide care and support to the families involved and I would like to thank them, and those other staff that supported the service, for their efforts during what was a most traumatic time. We are not providing further updates on this issue in order to preserve the confidentiality of patients and their families.

I communicated directly with the Chief Executive of Public Health England, Duncan Selbie, who wrote to individuals including Consultant Neonatologist Dr Mark Thomas, Director of Infection Prevention and Control Dr Berge Azadian and Consultant Honorary Senior Lecturer in Neonatal Medicine Dr Sabita Uthya for their speed, professionalism and quick response as the incident unfolded. Communications Manager Katie Drummond-Dunn was also thanked for her communications support.

Gerald Heddell, the MHRA's Director of Inspection, Enforcement and Standards, said: "Based on the information we currently have, we believe this is an isolated incident and the appropriate immediate action has been taken at ITH Pharma's facility to avoid a reoccurrence. Therefore we are allowing this critical product to be supplied to patients while our investigation proceeds.

“Further inspections are being made as part of our ongoing investigation and it’s our priority to find out how this incident happened. We are regularly updating and working closely with the NHS, Public Health England, the Department of Health and other health organisations in our detailed investigation.”

5.0 Star Awards

The Star Awards ceremony took place on Thursday 15 May and a full list of the winners are available both in Trust News and on the website. I would like to congratulate all nominees and winners for their efforts in providing standards of care that we ourselves would rightly expect from Chelsea and Westminster Hospital. Thanks to Governors that participated in the judging process, the HR team for coordinating the nominations process and to the Communications Team for organising the event.

6.0 Open Day

The Open Day took place on Saturday 14 June with nearly 2,000 people in attendance. Feedback we have received about the event was overwhelmingly positive and I would like to thank both Governor Wendie McWatters for her help in arranging for Joanna Lumley to be our star guest and those other Governors who took the time to attend. Thanks to Governor Rochelle Gee and the Communications Team for organising the event.

7.0 Award winning staff

- Congratulations to all Quality Award winners.
- The trust has been shortlisted for two HSJ Value in Healthcare awards: Value and Improvement in Acute Service Redesign and Value and Improvement in the use of Diagnostics.
- CliniQ at 56 Dean Street has been shortlisted for a Nursing Times award in the Enhancing Patient Dignity category.
- Professor Barry Jubraj (on behalf of the STOPIT project team) is a finalist in the Preventing Avoidable Harm category for the Patient Safety + Care Awards 2014. The winner will be announced in July.
- Congratulations to Radio Chelsea and Westminster presenter Alex Baker, who was shortlisted for Male Presenter of the Year at the National Hospital Radio Awards 2014.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 July 2014 (PUBLIC)

AGENDA ITEM NO.	1.8/Jul/14
PAPER	Council of Governors Report including Membership Report and Quality Awards
AUTHOR	Vida Djelic, Board Governance Manager Sian Nelson, Membership Manager
LEAD	Sir Tom Hughes-Hallett, Chairman
PURPOSE	Part A – provides highlights of the Council of Governors meeting held on 15 May 2014 Part B – updates the Board on membership numbers and engagement activities Part C – provides an update of the Spring 2014 Quality Award winners
LINK TO OBJECTIVES	All
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This paper highlights the pertinent issues discussed at the Council of Governors meeting held on 15 May 2014.
DECISION/ ACTION	To note

Part A

Council of Governors Report

1.0 Chief Executive's Report

The Governors noted that that the redevelopment of the Emergency Department continues and that the Chelsea and Westminster Health Charity was raising funds in order to support artwork for the redevelopment project.

2.0 Financial Strategy (presentation)
Chelsea and Westminster Hospital 2014/15 Annual Plan – update

The Council of Governors received a presentation on the Financial Strategy and Monitor plan.

The highlights include:

- financial rating assessment by Monitor
- the trust's financial objectives and strategic plan
- the development of specialised services and as part of it considering the potential acquisition of West Middlesex University Hospital
- the opportunity to grow private patient income
- the challenges associated with implementing our Cost Improvement Programme (CIP) targets
- our ambitious investment plan

3.0 Quality Account overview and approval of the Governors Commentary

The governors represented on the Quality Sub-Committee who supported the production of the Quality Account 2013/14 were thanked for their contribution.

The Council of Governors approved the Governors' Commentary.

4.0 West Middlesex – update

An update on the West Middlesex was provided and governors noted that a tour for them of the site was in the process of being arranged.

5.0 Staff survey – results and action plan

Governors noted the survey results.

6.0 Open Day – 14 June 2014

Governor Wendie McWatters was thanked for arranging for Joanna Lumley to officially open the event.

The promotional material for the event was made available for governors to take away and display in their constituencies.

Part B

Membership Report Q1

1.0 Membership joiners and leavers April-June 2014 (Q1 2014/15).

During Q1 2014/15 31 members joined and 20 left the trust membership.

Membership numbers are broken down (below) to reflect patient, public and staff membership representation for Q1 2014/15.

Start Period	01/04/2014	01/05/2014	01/06/2014
End Period	30/04/2014	31/05/2014	30/06/2014

Totals	**Apr**	**May**	**Jun**
Period Start	**15,274**	**15,283**	**15,277**
Joiners	14	4	13
Leavers	5	10	5
Period End	**15,283**	**15,277**	**15,285**

Public	**Apr**	**May**	**Jun**
Period Start	**5,649**	**5,652**	**5,648**
Joiners	6	2	6
Leavers	3	6	5
Period End	**5,652**	**5,648**	**5,649**

Patient	**Apr**	**May**	**Jun**
Period Start	**6,230**	**6,236**	**6,234**
Joiners	8	2	7
Leavers	2	4	0
Period End	**6,236**	**6,234**	**6,241**

Staff	**Apr**	**May**	**Jun**
Period Start	**3,395**	**3,395**	**3,395**
Joiners	0	0	0
Leavers	0	0	0
Period End	**3,395**	**3,395**	**3,395**

Table 1.0 Joiners and Leavers, Q1 2014/15

2. Membership ethnicity

2.1 Figure 1 shows overall members ethnicity. At the end of Q1 2014/15, the highest proportion of representation is within the White category, whilst there is a high category of Unknown – this is due to members not disclosing their ethnicity. The lowest representation remains in the 'Mixed' group and 'Other' group, which means ethnicity, is not that of the criteria options. The representation is further presented in the public member's ethnicity table (figure 2) where comparisons are made to the local population that the Trust serves.

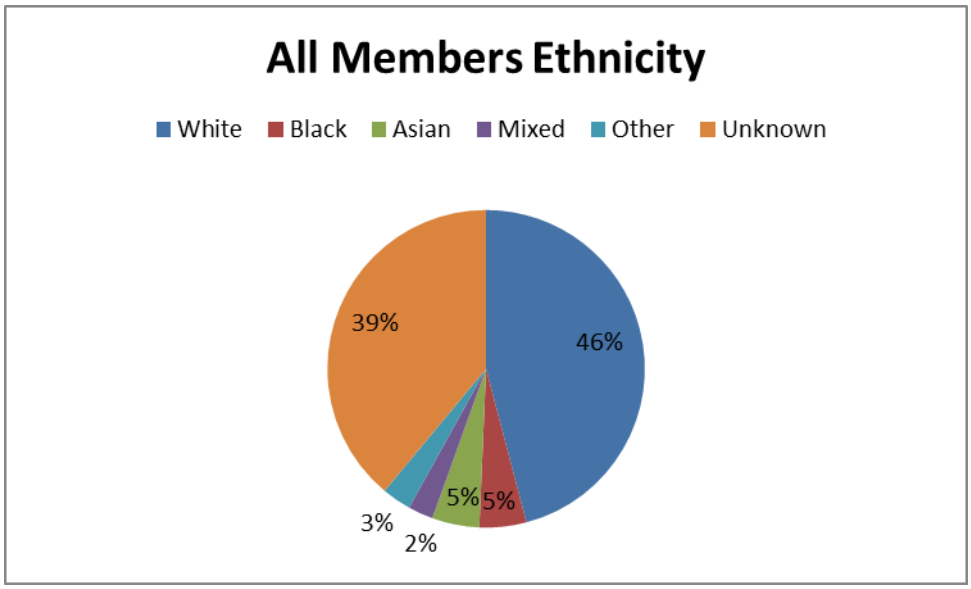
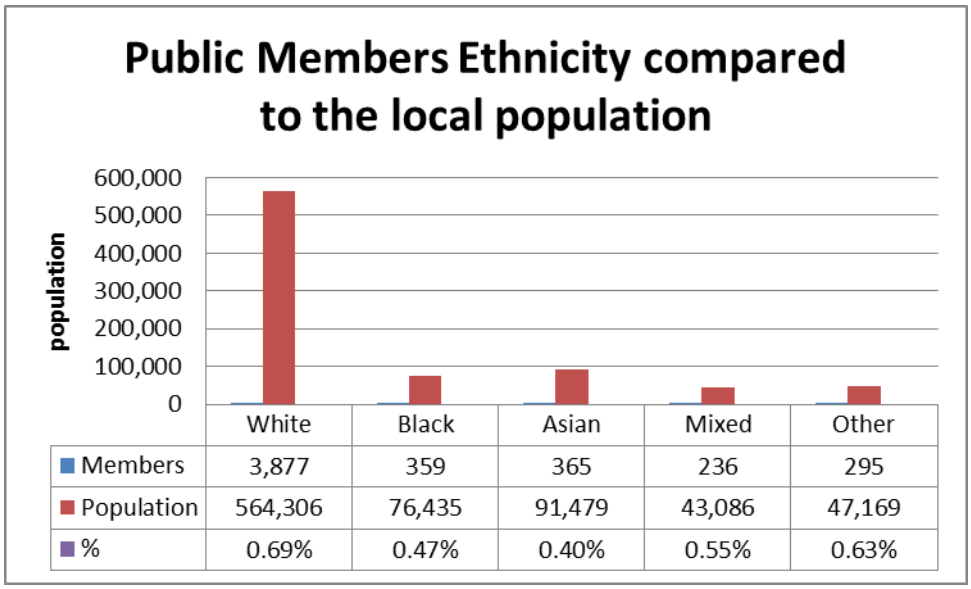


Figure 1.0 Overall Members Ethnicity Q1 2014/15

2.2 The figures are more balanced when we compare Trust membership to the populations that we typically serve including Hammersmith and Fulham, Kensington & Chelsea, Westminster and Wandsworth.

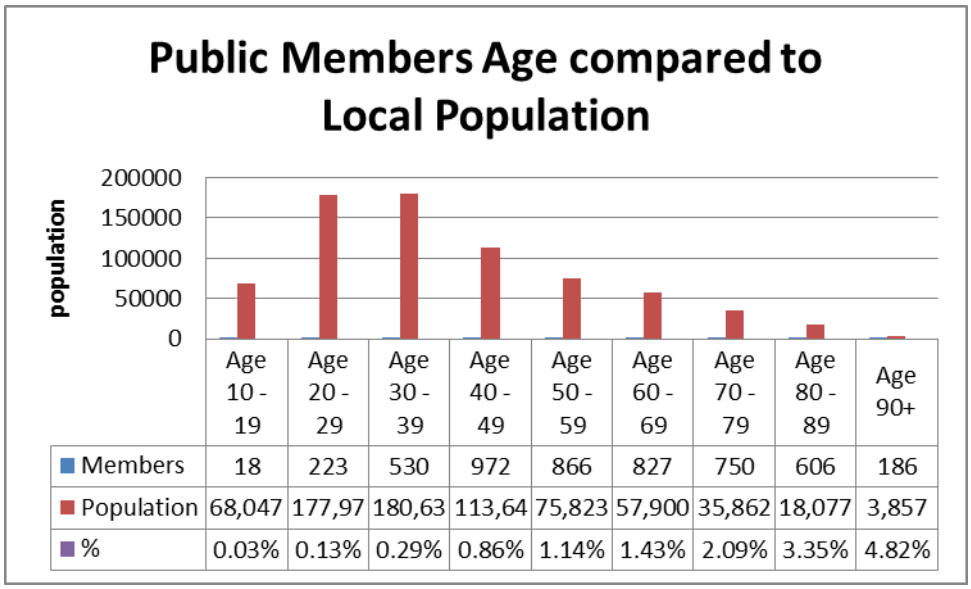


	White	Black	Asian	Mixed	Other
Members	3,877	359	365	236	295
Population	564,306	76,435	91,479	43,086	47,169
%	0.69%	0.47%	0.40%	0.55%	0.63%

Figure 2.0 Public Membership Comparisons to the Local Population Q1 2014 15

3.0 Public membership age

Figure 3 shows a profile of public membership by age. Public membership representation rises at age group 40-49 years whereas the lowest age group is those within the 16-19 age groups. However, when compared to the local population, the highest representation starts from the age group 70-79 onwards to 90+



	Age 10 - 19	Age 20 - 29	Age 30 - 39	Age 40 - 49	Age 50 - 59	Age 60 - 69	Age 70 - 79	Age 80 - 89	Age 90+
Members	18	223	530	972	866	827	750	606	186
Population	68,047	177,97	180,63	113,64	75,823	57,900	35,862	18,077	3,857
%	0.03%	0.13%	0.29%	0.86%	1.14%	1.43%	2.09%	3.35%	4.82%

Figure 3.0 Public Membership Age Q1 2014/15
In the youngest age group that Monitor accepts as valid membership is from 16years+ however, the local population figures start at 10 years therefore this is guidance only. There are 690 members with unknown age therefore the data has been omitted as cannot be compared to the local population data.

3.1 The chart below shows the percentage (%) representation of all members' constituencies which again shows the highest representation in the age group 40-49 years and lowest in the 16-19 years.

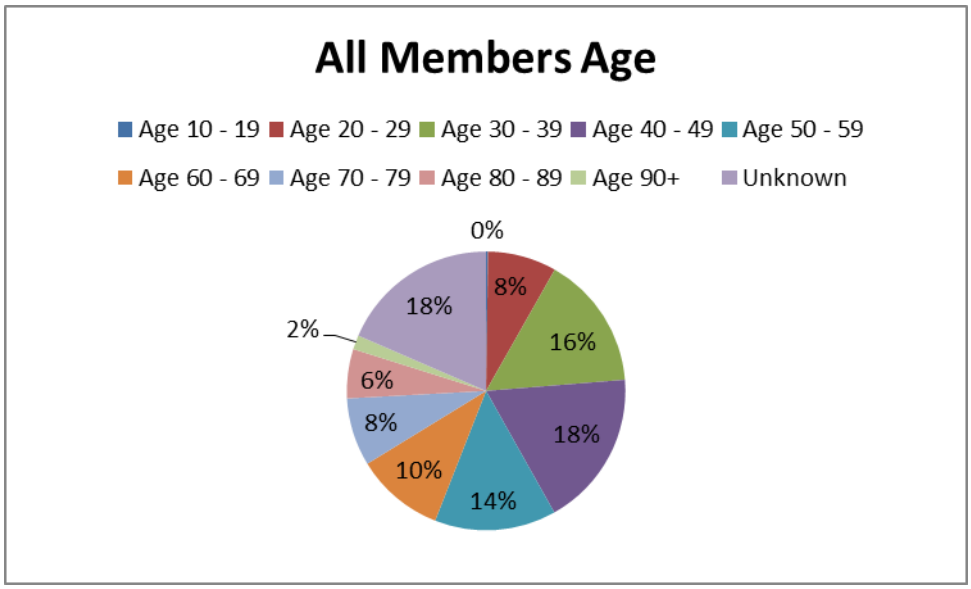


Figure 3.1 Overall Membership Age Groups. Q1 2014 15
***Age 10-19 indicates 16-19 years**

5.0 Public membership - socio-economic grouping

5.1 Figure 4.shows the socio-economic profile of all groups of membership. At end of June 2014 (Q1 2014 15) the main representation is in the ABC1 and E classification.

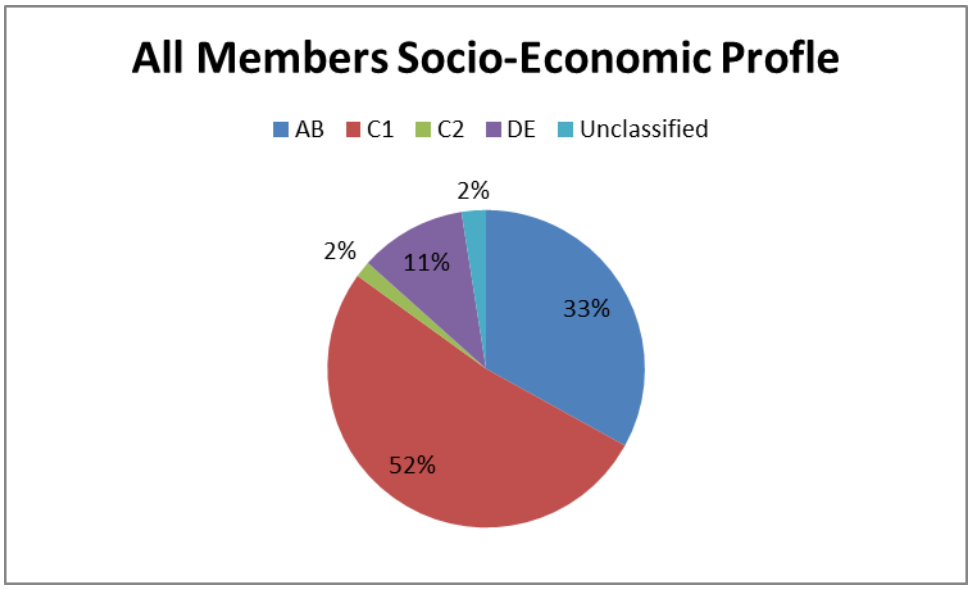


Figure 4.0 Overall Membership - Socio-Economic Groups*

*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 Q1 2014/15 31 members joined and 20 left the Trust membership.

However, recent recruitment activities took place in June at Open Day and these figures will reflect in the next report (Q2 2014/15).

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 Sub-Committee of the Council of Governors develops and reviews the recruitment strategy, which is currently being updated. Recruitment activity is focused on both maintaining our membership numbers whilst also enabling a diverse and representative membership.

6.2.1 A team of Governors continue to host 'Meet a Governor' sessions on a regular basis which recruits new members whilst engaging with constituents. They are held 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.

6.3. 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.

6.4. Figure 6 shows the trends in trust membership from 2007-2014.

Membership Trends	Public	Patient	Staff	Total
2007 (as of 01/04/2007)	6,933	5,785	653	**13,373**
2008 (as of 01/04/2008)	6,580	6,095	465	**13,156**
2009 (as of 01/04/2009)	6,372	6,136	487	**13,101**
2010 (as of 01/04/2010)	6,131	6,010	3,046	**15,433**
2011 (as of 01/04/2011)	5,738	5,591	3,173	**14,816**
2012 (as of 01/04/2012)	5,942	5,685	3,231	**15,289**
2013 (as of 01/04/2013)	5,850	5,994	3,424	**15,824**
2014 (as of 01/04/2014)	5,650	6,232	3,395	**15,875**

Part C

Council of Governors Quality Awards

The Spring Council of Governors Quality Awards winners were as follows:

- The revolutionary Sexual Health Screen Service - Dean Street Express
- Mars Paediatric Burns Dressing and Scar Management Team - Moving forwards for a family friendly service
- 'Practical Guidance for the Management of Palliative Care on Neonatal Units' a national document for all healthcare professionals caring for babies with palliative care needs and their families
- Turning around phototherapy
- Birth Centre
- CNS contribution to patient centred care and information delivery to people living with HIV and cancer (PLWHC)

Highly commended categories were:

- Improving patient choice and outcomes
- Looking after lone working staff in the community
- Radiology accreditation

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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 July 2014 (PUBLIC)

AGENDA ITEM NO.	2.2/Jul/14
PAPER	Assurance Committee Report – April and May 2014
AUTHOR	Melanie van Limborgh, Head of Quality and Assurance
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	Excel in providing high quality clinical services
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	A summary of the key issues discussed at the meeting in April and May 2014 is attached. The overview of the June meeting will be included in the next Board of Directors' report when minutes have been approved at the July Assurance Committee.
DECISION/ ACTION	For information.

ASSURANCE COMMITTEE REPORT FROM MEETINGS APRIL & MAY 2014

1.0 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 key issues that have been discussed at the April and May meetings.

2.0 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.

3.0 Items discussed at the Assurance Committee April 2014

3.1 Summary of discussions of Minutes and Matters Arising

- All reports should outline where the Trust differs from national guidelines (including NICE guidelines)
- Mandatory performance and appraisal to be linked into incremental progression as per Trust policies
- It was confirmed the system chosen for online risk reporting meets the Trusts requirements for functional specification
- Noted progress made with the Staff Survey Report outcomes, bullying and Equality and Diversity and further work to follow
- Further work to clarify the required number of fire marshalls are in place
- Further work underway to address key performance indicators
- The Board Assurance Framework is reported quarterly and will be reviewed for 2014/15.
- Amendments were agreed to Assurance Committee cover sheets and Terms of Reference to ensure adequate quorum. Lines of Accountability to be reviewed in the near future.
- Discussions highlighted control measures to address incident trends in Blood Transfusion and Pathology. Error rates in the trust were noted as lower than most in the country for blood transfusion, there was concern noted on handling specimens and results for general pathology. **Assurance was provided that progress in collaboration with the Pathology contractors (Imperial College) is overseen by the Pathology Joint Governance Committee reporting and into the Quality Committee.**

3.2 Health, Safety and Fire Committee Monthly Report

To assure the committee, actions for an investigation report were reported as complete. It has noted that further work may be required in preparation for an inquest. The reporting of RIDDOR, (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) to be submitted to the Head of Clinical Governance so that this can be included in the template for Annual and quarterly Risk Management Reports. **The committee was assured that required external reporting of RIDDOR incidents is in place and that the committee is informed of the most serious incidents as applicable.**

3.3 Never Events Assurances

There was discussion concerning sufficient controls in place to prevent Never Events. It was however noted the Trust is compliant with 6 of 6 best practice standards outlined by guidance and there is assurance from training and 'physical barriers' in place.

It was agreed an audit should show if staff are observing the controls. **To provide assurance, it was agreed to rank Never Events in order of risks and timescales for action.**

3.4 Quality and Management – Quality Indicators

It was agreed that the number of indicators reported at the Assurance Committee should be reduced to concentrate on key indicators and those removed to be considered at the Council of Governors' Quality Sub Committee. **For future assurance if there were any items removed that require action this should be undertaken and reported to the Assurance Committee as required to include trends over 3-6 months reported.**

3.5 Top concerns - Medical Director/Director of Nursing and Quality

No new items reported at the meeting. Confirmation that work is underway to develop robust systems for returning pathology results was reported. Noted that the issue of NED's attending divisional meetings is a matters arising item.

3.6 Report from the Trust Executive Quality Committee

From a 3 week pilot, the National Early Warning Score Audit (NEWS) Audit has reported some assurance that observations of patients are being undertaken and scoring is being applied. **It was noted that the system is currently not electronic. There was limited assurance if this is being applied correctly throughout the Trust.**

3.7 Suitability of Staffing

This highlighted the National Quality Board Report - *(How to ensure the right people, with the right skills, are in the right place at the right time – A guide to nursing, midwifery and care staffing capacity and capability).* The Trust is required to publish staffing data regarding nursing and midwifery and care by June 2014 and this will include a monthly Board update and agreed staff establishments, gaps and action plans. **The work already undertaken in the Trust was highlighted and the assurance that monitoring will be in place by auditing and inclusion of information on the performance dashboard.**

3.8 Stress Report

Reported there was low attendance at 'Stress Solutions' training and that staff may not 'self-refer' for support. It was noted that the BUPA contract due for renewal during June, but as feedback was confidential, it would be challenging to assess the service outcomes. **It was recognised there may be drivers that effect stress at work and it was agreed further work would take place to determine the issues involved/compile an action plan.**

3.9 AOB

The Trust Charity report conquering noise levels in the ICU in line with the World Health Organisation maximum decibel levels was highlighted. It was reported the findings from the international work demonstrate that where noise levels are reduced in these clinical areas, that medical errors are reduced. **It was confirmed the committee would receive the report.**

4. Items discussed at the Assurance Committee May 2014

4.1 Summary of discussions of Minutes and Matters Arising

- All reports should outline compliance with NICE, local and national guidelines
- Fire marshall training numbers to be included in Health and Safety Reports
- Agreed that Assurance Committee 'lines of accountability' to be outlined
- Never Events Assurance to be ranked in terms of likelihood and risk, timescales controls and assurances
- Trust Charity Report (Noise Levels) to be forwarded to the 'Good Night Group' for action. On-going capital development consider noise reduction methods
- External Visits reporting to be managed in Divisions.
- Health and Safety training rates have increased, but require further progression

4.2 Health and Safety and Fire Committee Monthly Report

No issues raised on report**. It was agreed enhancements to cover pages for the Assurance Committee should include compliance with statutory guidelines and an overall summary box to outline the reporting situation.**

4.3 Health and Safety Review

It was reported the review had commenced and would be reported to the Assurance Committee at a future meeting.

4.4 Quality and Management – IMT Strategy Review

The importance of high quality information for patients on their care and the development of a 'Patient Portal' for patients to access clinical information for this were highlighted. There is capital funding available to support IT developments and an IT Strategy Committee chaired by the CEO**. The Assurance Committee will be regularly updated on a new system (System One) that will facilitate the sharing of information with GPs and CQUIN management.**

The Trust needs to link with other IT systems to share information and integration and for single patient records for other partners to an access. A migration plan is underway for System One. There are plans in place to forward work for an acute patient electronic record. The relevant supplier will work with the Trust to achieve the higher adoption levels of HIMSS (Health Information Management Systems Society). The Trust is currently at level 4/5 and the aim would be to reach level 7. It was noted there are 4 IT options for moving forward with working with West Middlesex. **Updates to the Assurance Committee will continue quarterly.**

4.5 Monthly Report on Local Quality Indicators

To add assurance - a column to highlight status at the end of the financial year has been added to the Quality Indicators Dashboard.

4.6 Progress on Quality Priorities

<u>Priority 1 – (Safety) To have no hospital associated preventable venous thromboembolism (VTE)</u>

In 2013-14 most targets were achieved. Gaps in assurance included omitted and delayed medication doses due to LastWord access rights for agency nursing staff to electronically sign for medication. Assurance was provided that the issue is to be

resolved via the Information Governance Committee. Completion rates of the VTE online training module was also identified as a gap in control. A VTE link nurse is on every ward however consultants and registrars new to the Trust have not yet completed the VTE module to be completed within 6 weeks. **Assurance was provided that managers should be addressing this.**

Priority 2 (Patient Experience) Communication, discharge and delivering safe and compassionate care to all our patients & Priority 3 (Staff Experience)To be in the top 20% of acute Trusts nationally for staff engagement and staff appraisals as measured by the NHS staff survey to ensure our agreed Trust values inform everything that we do

The staff friends and family test will be implemented during 2014/15. The staff friends and family test will be uploaded from July 2014. This will provide a rich source of data and an opportunity to listen to staff and make changes. Discharge arrangements are being monitored as a priority for those medically fit to be discharged between 7 – 11am. There will be a focus on communication skills in the coming year with customer service standards training to improve communications. Complaints re processes, letters or how people have been spoken to will be addressed separately

Priority 4 (Clinical Effectiveness) Progress on end of life care

The End of Life Care Strategy supersedes the withdrawal of the Liverpool Care Pathway. There is a gap in assurance until the full implementation of the 'Coordinate my Care' strategy has been completed. Funding is expected by September to deliver a 6 day service for palliative care. All learning is discussed at weekly team meetings, complaints are addressed (including meeting families) and producing action plans. A family member has joined the End of Life Care Strategy Group. An individual Care Plan is developed for end of life care and there is an End of Life Care Steering Group. A 'Coordinate My Care' database used by patients to plan care can be used in the community by other agencies. A Community Education provider is to work with the Trust and other agencies, providing rotational training for those involved in end of life care.

4.7 Top Concerns - The upcoming Care Quality Commission Inspection was highlighted.

4.8 Facilities Committee

Assurance for completion of Estates actions was received. Any relevant risks are being flagged as part of the scorecard and there are no gaps in control. The Balanced Scorecard is for externally sourced contracts and the overall RAG rating is green. Savings were confirmed in reducing linen changes, energy reduction, transport use and waste. **The Facilities Committee is confident that there is a clear line for escalation of amber and red rated risks relating to contractors via numerous committees.**

5.0 Staff Survey results and action plan

To be presented in September with a separate session to update on the detail of the Staff Survey and the People Strategy. The key findings and priorities will be outlined.

Melanie van Limborgh
Head of Quality and Assurance
July 2014

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 July 2014 (PUBLIC)

AGENDA ITEM NO.	2.3/Jul/14
PAPER	Assurance Committee Annual Report 2013/14
AUTHOR	Melanie van Limborgh, Head of Quality and Assurance
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 2013/14, including assurance that appropriate actions have been taken or are in progress.
LINK TO OBJECTIVES	All
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 a brief of the discussions, activity and summaries from the Assurance Committee over the year 2013/14 up until March 2014.
DECISION/ ACTION	The Board is asked to note the report and recognise that current reviews of committee structures will further develop and build on our assurance processes.

Annual Report to the Board from the Assurance Committee
April 2013 to March 2014

1. Introduction

This report contains a summary of the work of the Assurance Committee over the period April 2013 to March 2014. This report is presented to the Board as part of demonstrating 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 provides an update indicates levels of assurance where applicable. This paper is based on the monthly reports to the Board and provides an overview of the year's activity of the key issues addressed by the committee.

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. Appendix 1 highlights the agenda items addressed by the committee throughout the year.

3. Membership during 2013/14

Non-Executive Directors
The meeting is chaired by Non-Executive director Karin Norman. Other Non-Executive Directors are Professor Richard Kitney and Jeremy Loyd.

Governors
Christine Blewett and Melyvn Jeremiah

Executive Directors
Tony Bell, Chief Executive Officer
Lorraine Bewes, Chief Financial Officer
David Radbourne, Chief Operating Officer
Zoe Penn, Medical Director
Elizabeth McManus, Chief Nurse and Director of Quality
Susan Young, Director of Human Resources and Organisational Development

Leads
Melanie van Limborgh, Head of Quality and Assurance
Vivia Richards, Head of Clinical Governance

4. Terms of Reference and Schedule

The committee met the requirements of the Terms of Reference during the year. To ensure meetings were able to function effectively and flexibly, the Terms of Reference regarding quorum membership was updated during the year. This included highlighting suitable deputies to attend in the absence of directors and clear clinical availability. At the time of writing, recommendations from a review of governance and committee structures is due to report. When the information from the review is available, the Terms of Reference of the Committee will able to be

updated together with any other committee amendments recommended and with committee approval as required.

A committee schedule was updated during the year and this can be published to all contributors of the committee when the review recommendations have been consulted.

The committee met as required on each month with the scheduled and planned exception of August and December 2013.

5. Forward planning and monitoring in 2014/15

As noted, the governance committee structure (to include that Assurance Committee) is subject to an external review at the time of writing. Work required following the recommendations of the review is tentatively planned to include an annual plan for 2014/15, lines of accountability, review of the committee agenda an amended schedule and Terms of Reference. The review of Committee effectiveness will be taken in part from the recommendations of the review.

The Assurance Committee actions will be monitored prior to and during meetings. Actions will continue to be listed and RAG rated in the matters arising section of the meeting until actions are completed. Reporting of agenda themes and progress will be reported to the Board via the monthly reports and the end of year Annual report.

6. Quarter Summaries key themes addressed by the Assurance Committee

Quarter 1 (April - June 2013)

Health and Safety Reporting - There was concern highlighted on the number of staff attending Health and Safety training and risk assessments being undertaken in divisions. It was noted that Key Performance Indicators were noted as in place for Health and Safety in future reporting structures.
It was requested that future reporting considers responsible Director's opinion and a focus on outcomes. The committee noted the staff survey highlighting an increase in work-related stress.
The Facilities Committee Report - highlighted audit compliance for contracted services and the Committee suggested some amendment to RAG (Red, Amber, Green) rating, future audit profile and patient transport services. Also discussed were the environmental and sustainability strategies.
Never Events - progress reported of a good standard, the work required detailed management and a request was made to understand outstanding concerns. A 'wrong site surgery' Never Event was highlighted. Training was determined as a current gap.
Infection Control Report Q3 - the committee heard the key issue of the Trust's hip and knee infection rate of 1% against national average of 0.7% and emerging drug resistant infections.
Early Warning Systems – the committee noted that the system was changing to that of a national system and it was agreed the reporting and audit in this area should be formalised.
Care Quality Commission (CQC) end of Year Report - highlighted processes in place to manage CQC compliance.
Top Concerns - included failure to recognise and treat deteriorating patients, attitude of staff and complaints handling, pressure ulcers, management of mental health patients, health and safety culture and failure to follow –up patients /results, early

warning score, infection control. It was requested Information Technology should become a subject of scheduled reporting to the committee.

Quarter 2 (July - September 2013)

Never Events - progress was noted as focus of working is in areas not RAG rated as green.
Local Quality Indicators highlighted some areas of concern, but the committee was assured there were measures in place to address the items.
Top concerns - noted as pressure ulcers and noise at night. It was noted the work plan continues to address the issues in the Keogh and the Francis Reports.
Induction and Statutory Mandatory training Annual Report - noted that overall compliance had increased to 69 from 61%, but that overall greater progress was needed to reach 85% compliance by end March 2014.
CQC Provider Assessments and Risk Profiles - were noted as satisfactory. Areas for further attention were noted as early warning systems and five day turnaround for clinic letters.
Health and Safety Fire Committee – themes regarding internal controls were highlighted and it was noted that further progress was still required to provide assurance to the committee.
Safeguarding adult and Children 6 monthly Reports – the alerting and sharing system was highlighted as a gap for reporting which was being taken forward for action and the system for monitoring DNA's (Did Not Attend) in children's appointments and follow- up. The committee was overall assured of the system in place but noted training and liaison in the community as a gap.
Emergency Preparedness - the Committee noted the challenges with a new NHS structure affecting preparedness for the Trust and requested further clarity for further assurance. Progress was noted as solid in this area.
Mortality Indicators - it was understood the Trust's Hospital Standardised Mortality Ratios (HSMR) could be affected by current coding procedures. As a result a paper was to be submitted to the Finance and Investment committee concerning coding.
Out of hours Report - although it was agreed no actual risk existed that the item should be monitored on the agenda
Confidential Enquiry Study Report - the trust agreed to participate in new studies but the demand resource was noted as relevant.
Equality and Diversity 6 monthly report - it was noted a work plan was in place and the committee agreed to continue to focus on this area to oversee assurance.

Quarter 3 (October – December 2013)

Maternity Clinical Review - highlighted the review instituted to review puerperal infection, progress for CNST (Clinical Negligence Scheme for Trusts) Level 3 assessment, consultants' working hours, elective caesarean section rate and NICE (National Institute for Health and Care Excellence) guidelines. The committee was assured that actions were in progress.
Risk Report Maternity - It was noted a new governance structure was in place for Maternity.
Health and Safety Monthly Report- the report highlighted recent thefts and it was agreed this would be monitored by the Audit Committee. It was noted that Health and Safety and Manual handling training rates had increased but risk assessment for all areas were still required. It was agreed a review would be undertaken by the Chief Nurse for Health and Safety. Assurance is not fully in place.
Facilities Report - noted good progress, but further information concerning risk was invited.

Medicines Committee Annual Report 2012/13 - an 18% reduction was noted for antibiotic use. The committee requested additional information on training for nurses in medicines.
Quality Indicators - red areas noted.
Top Concerns - it was agreed the current list existing would be reviewed by the new Chief Nurse and Medical Director.
Q2 Update on Quality Objectives - the progress on the 4 quality priorities were reported with further work needed on prophylaxis in venous thromboembolism (VTE) prevention and missed does and training of agency staff. Further information was requested regarding end of life care.
CQC Intelligent Monitoring - The Trust grading with the new CQC risk system was outlined and it was agreed that the Head of Quality and Assurance would work with the Information Team to fully understanding the information being presented. It was noted the Chief Executive and the Chief Nurse had met with the CQC regarding the grading presented and that the CQC had agreed to provide a response.
Out of hours Report - themes discussed included Clinical Site Management, the use of early warning systems and specialist roles to support out of hours. It was agreed that the Chief Nurse and the Medical Director would lead this work and a report would be presented to a meeting in the new financial year. The committee agreed that the data presented did not suggest a risk, but monitoring would be important.
Stress Report - this demonstrated that 1:4 staff has reported being unwell from stress. The committee noted the actions already in place to address stress issues and requested further assurance that measures were in place to support staff.

Quarter 4 (January - March 2014)

The Health and Fire Safety Committee - noted significant improvement in year for mandatory training, but that assurance should remain in place. Fire marshall and assault cases numbers to be reviewed. Compliance with the Health and Safety at Work Act was confirmed. Key Performance Indicators (KPIs) to be used on all health and safety reporting were agreed.
Never Events - a 'missed swab' never event was reported with assurance that a full investigation would be undertaken. The committee discussed the viability of an internal Never Events classification.
Top Concerns - added agency staffing rates and VTE (for missed doses of prophylaxis).
Risk Management Report - the committee asked for assurance that a new risk management reporting system would be meet the Trust's requirements. It was noted an external review would be taking place of reporting procedures.
Mandatory Training Report - noted on-going improvement of Training at 76%.
Local Quality Indicators - were noted to be reduced to allow scope to concentrate on the most important themes with responsibility with Executives and clinicians. The reduced indicators were agreed for future inclusion in the Quality Account after a review.
Quality Account Quality Priorities - these were agreed to remain the same as the previous year.
Facilities Committee Report - the committee highlighted requirements to continue to monitor contractor's health, fire and safety training and compliance.
Equality and Diversity 6 monthly Report - this provided focus on bullying and harassment, equality and discrimination. The committee noted the high degree of process and work being undertaken in this area and asked for ongoing assurance.
Quality committee Terms of Reference - to include updating following the NHS Litigation Authority (NHSLA) assessment were agreed.
Safeguarding Adults and Children Committees - the committee was assured by Safeguarding Level 2 training for adults and the Trust IT system. The manual

workaround for the Children's safeguarding system was noted and assurance was agreed in terms of safeguarding children processes.
Emergency Preparedness - the committee noted that assurance of the Trust processes could be demonstrated by a positive NHS England London audit.
Learning Disabilities - progress was noted as meeting CQC standards and on-going and with a focus to continue on staff training.
Report from the Trust Executive Quality Committee - failure or delay to follow up results (blood and imaging) and communicating the same to discharged patients was noted. The committee asked for assurance that process were in place for addressing follow up of results.
Risk Management Committee - it was noted that amber incidents closed in 45 days have reduced in Q3. Assurance was provided to the committee that the new reporting system would provide full functionality for future reporting. It was noted that the Pathology Joint Governance Committee monitors pathology incidents. The committee requested greater assurance in the adequacy of pathology clinical incidents.

7. Action required from the Board

The Board is asked to note the report and recognise that current reviews of committee structures will further develop and build on our assurance processes.

Melanie van Limborgh
Head of Quality and Assurance
July 2014

Appendix 1 - Agenda items addressed by the Assurance Committee during 2013/14

Never Events Assurance Reports
Monthly report on local quality indicators
Monthly Report from Trust Executive Quality Committee
Top Concerns Chief Nurse and Medical Director
Health & Safety Committee monthly report
Infection Control Report (Quarterly and Annual)
Complaints Report (at April meeting but no longer reports to Assurance Committee)
Audit Committee Minutes – for information
Progress on quality priorities 13/14 (safety, effectiveness and patient experience) (Quarterly)
Facilities Report (Quarterly)
Risk Management Annual Report – Trust-wide (Annually and 6monthly)
Maternity Risk Management Report
Safeguarding Adults 6 monthly report
Safeguarding Children 6 monthly report
Emergency Preparedness 6 monthly Report
Learning Disabilities 6 monthly report
Equality and Diversity 6 monthly report
Essential Standards of Quality and Safety (CQC) end of year report
Assurance Committee Annual Report
Mandatory Training Report July (Quarterly and Annually)
Medicines Annual Report
Claims Annual Report
Risk Management Committee Terms of Reference
Quality Committee Terms of Reference, Assurance Committee Terms of Reference, Facilities Committee Terms of Reference, Health, Safety and Fire Committee Terms of Reference
Update on early warning systems
Fall from Height Investigation – action plan update
Proposed changes to Assurance Committee
Review of Assurance Committee report front cover
IT Presentation
Mortality indicators
Confidential Enquiry Study report (one off – reported via monthly TEQC report)
Maternity Clinical Review
Stress Report
Action Plan – following CQC Mental Health Act Visit – 1st May
CQC Quality and Risk Profile
CQC Standards - Provider Compliance Assessments (PCAs) amber risk
Care Quality Commission Quality and Risk Profile
CQC update – Intelligent Monitoring
CQC presentation (detailed account of ratings)
Quality Account – Quality Priorities for 2014/2015

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 July 2014 (PUBLIC)

AGENDA ITEM NO.	2.4/Jul/14
PAPER	Complaints Annual Report Summary 2013/14
AUTHOR	Carol Davis; Head of Patient Affairs
LEAD	Elizabeth McManus Chief Nurse and Director of Quality
PURPOSE	• To report complaints activity during the year 2013/2014 • To report on the number and type of issues and complaints received • To present a summary of key trends in complaints raised • To report on performance in relation to the complaints response process • To summarise organisational change and development in response to feedback from complaints
LINK TO OBJECTIVES	Excel in providing high quality clinical services
RISK ISSUES	It is essential that issues raised from complaints 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 2013/2014. It provides a summary of the number and type of complaints, information on performance in the response process, and change initiated in response to feedback from complaints. The full Trust complaints report is available from Vida Djelic, Board Governance Manager at vida.djelic@chelwest.nhs.uk

	and gives greater details of the issues highlighted in this report. 344 type 2 and 12 type 3 complaints were received from the 1st April 2013 to 31st March 2014. 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 annual report summary 2013/2014.

Complaints Annual Report Summary
2013/14

1.0 Introduction

1.1 This report presents a summary of the feedback and trends identified by the Complaints Service during the year 2013/2014. 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 complaints by type over the past 4 years.

Table 2: Total Complaints 2010-2013

	10-11	11-12	12-13	13-14
Total	387	436	377	356
Type 2	379	419	354	344
Type 3	8	17	23	12

3.1 Type 2 and 3 complaints

A total of 344 type 2 and 12 type 3 complaints were received from 1 April 2013 to 31 March 2014. The top 3 issues are shown in table 3 below.

Table 3: Top 3 Primary Subjects type 2 and 3 2013/2014

Subject	Number of Complaints
Aspects of clinical care or treatment	151 [42%]
Attitude or behaviour of staff	64 [18%]

Information/information to patients (written and oral)	59 [17%]

3.3 **Type 2 complaints**

Directorates were asked to respond to these within 25 working days. A performance target of 90% in meeting response time is established for such complaints, 82% were responded to within this timeframe. An action plan is sent to the directorates to confirm that the complainant has been given the opportunity to discuss their concerns and the time scales for a response. There has been a reduction in the number of complaints where we are able to evidence that the complainant was contacted to discuss their complaint and the type of resolution they were seeking. For the year 2013-2014 81% of complainants [type 2 and 3] were contacted to discuss their complaint and the type of resolution they were seeking, this compares with 89% last year and 86% the previous year.

3.4 **Type 3 complaints**

A total of 12 type 3 complaints were received during the year 2013-2014. 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. 3 complainants received a response after 50 days [range 44-116 working days].

4.0 Complaints by subject

4.1 **Aspects of clinical care**: During 2013-2014 the Trust received 151 complaints where the primary concern relates to clinical care or treatment. A further 14 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 10-14 of the full trust complaints report.

4.2 **Staff attitude/behaviour**: During the year 2013-2014, the trust received 64 complaints where the primary concern related to the attitude and behaviour of staff. A further 34 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 14-17 of the full trust complaints report.

4.3 **Communication:** During the year 2013-2014, the Trust received 59 complaints or concerns where the primary concern related to the communication and information given to patients; a further 42 complainants identified this as an area of concern. This is an increase in the total number of complaints received relating to communication. Having looked at details of the complaints raised, 45 relate to communication and information about processes and 56 relate to the communication a patient has had with a member of staff. We will continue to review the details of the complaints and concerns relating to communication to inform the development of our coaching, leadership and other training programmes. Further information is noted on pages17-18 of the full trust complaints report.

5.0 Parliamentary and Health Service Ombudsman (PHSO)

5.1 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. In total for the year 2013-2014, the trust was notified of ten complainants who referred their complaint to the PHSO for review. To date the trust has received four final reports and one draft report. One complaint was upheld, two were partially upheld and two were not upheld.

5.2 Where a complaint has been upheld or partially upheld the PHSO has asked the trust to provide assurance that lessons have been learnt and to develop an action plan. The trust has agreed to:

- develop a trust wide documentation audit using the nationally agreed tool
- to undertake an audit of nursing records/assessments within medicine and surgery to monitor the standard of record keeping and to identify and address any gaps
- to review the current library and use of electronic care plans to ensure they are fit for purpose and utilised effectively
- to review the comfort rounds to identify effectiveness and any areas for improvement
- to continue to undertake monthly nutritional audits and action plans for areas who do not meet the target
- to provide detail regarding how improvements to end of life care have been qualified, to provide detail on how they will be audited and to audit how care has improved

5.3 The trust will continue to provide monthly updates to the Ombudsman's office on the progress against our action plans. Further information is noted on pages 20-24 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 team reports on the numbers of complaints and concerns received relating to these themes and identify the main issues reported by our patients.

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 26-29 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 2013-2014. Examples include:

- During 2014 the Maternity Service will start to run one hour daily drop in sessions on breast feeding for new mothers; midwives will use the same teaching template to deliver consistent information and encourage feeding concerns to be raised and actioned as early as possible.

- There are plans to change the layout of the changing rooms and waiting areas in the Treatment Centre to ensure privacy and single sex waiting areas.

- In response to difficulties identified in contacting Surgical Admissions Department, refresher customer service training was undertaken with the team. All calls are now recorded; this allows division to carry out regular spot checks whilst phone calls are taking place allowing real-time monitoring of the service being provided.

- In response to concerns raised about the clinical management and communication of test results for patients who are sent to the Acute Assessment Unit for further investigation, “Hot Clinics” have been introduced to support patients to have tests done, return home and come back the following day to discuss the results.

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 2013/14. The complaints 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 Department of Health 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.

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.

8.3 The results of the complaint satisfaction survey show that whilst some people have had a good experience of the complaints process, this was not the case for everybody who made a complaint. People who complain want a proportionate response. In order to ensure that we are responding to complaint and concerns in the most appropriate way, the Trust has invited Niche Patient Safety to undertake an external review of the complaints and concerns processes; as part of this review they will look at what the Trust might need to do to improve the quality of its response to complaints and concerns.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 July 2014 (PUBLIC)

AGENDA ITEM NO.	2.5/Jul/14
PAPER	Risk Management Annual Report 2013/14
AUTHOR	Vivia Richards, Head of Clinical Governance
LEAD	Elizabeth McManus, Chief Nurse & Director of Quality Zoe Penn, Medical Director
PURPOSE	This report provides an overview of risk management activity which has continued in the Trust in 2013/14, in order to evidence that the management of risk is firmly established throughout the organisation.
LINK TO OBJECTIVES	All
RISK ISSUES	No specific risks, however the report provides an overview of the management of current Trust risks.
FINANCIAL ISSUES	No
OTHER ISSUES	No
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	A culture which embraces the identification of incidents and risks, and learning will support the provision of quality, safety and continued improvement of the clinical services provided to patients. An in-depth analysis of maternity safety is covered in a separate annual report but the reported incidents, and themes for maternity are included in this report. The Trust Board requires assurance that systems, processes, policies and people 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. A copy of the full report is enclosed in the supporting papers.
DECISION/ ACTION	To note.

Risk Management Annual Report 2013/14

1.0 Introduction

This report provides an overview of risk management activity which has continued in the Trust in 2013/14, in order to evidence that the management of risk is firmly established throughout the organisation. A culture which embraces the identification of incidents and risks, and learning will support the provision of quality, safety and continued improvement of the clinical services provided to patients. An in-depth analysis of maternity safety is covered in a separate annual report but the reported incidents, and themes for maternity are included in this report.

The Trust Board requires assurance that systems, processes, policies and people 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 and Messages during 2013/14

These include:

- The Trust successfully achieved NHSLA Level 3 in October of 2013. The NHS Litigation Authority (NHSLA) concluded their assessment process for the Trust's application to meet the standards for NHSLA Level 3 accreditation on 4th October 2013 and confirmed that the Trust achieved Level 3 accreditation having passed 48 out of 50 of the criteria. This is a tremendous achievement.

- A total of 7,063 incidents were reported during the 12-month period 1st April 2013 to 31st March 2014. This compares with a total of 6,314 incidents in the previous year (2012/13), representing a 12% increase.

- 81% of the total number of incidents reported during 2013/14 was closed within 45 working days. This is an improvement on 2012/13 when 71% of incidents were closed within this timescale. The best performing out of the three divisions in terms of meeting this target was CSS who closed 92% of their incidents within the required timescale, followed by Medicine & Surgery with 84%. Women, Children, Neonatal & Young Peoples' Services closed 75% of their incidents within 45 working days. Further work will be undertaken during 2014/15 with the aim of achieving 100% closure within the given timescales.

- With respect to the timely reporting and investigation of serious incidents, during 2013/14 we reviewed and revised our serious incident escalation, reporting and investigation processes. This has meant that incidents which require reporting on the Strategic Executive Information System (STEIS) are communicated and investigated in a more timely fashion.

- The standing panels are well established in all Divisions with the exception of CSS, where panel dates are arranged at an early stage following escalation of a serious incident. This has contributed to the timely review and closure of serious incidents.

- To strengthen the process for completion of the review of pressure ulcer Root Cause Analysis (RCA) a timetable for the panel to convene has been agreed. The completed reports are presented at the Preventing Harm Group, with executive sign

off prior to this if required in order to meet the timescales for provision of reports to the commissioners.

- Development of a training tool which brings together relevant sections of risk management policies and procedures for use in senior manager induction and lead investigator training.

- The Acute Mental Health Group has strengthened communication and working relationships between Central and North West London NHS Foundation Trust.

- There was a minor reduction in the number of falls leading to significant harm when compared to the previous financial year, however, overall, there was no reduction in the total number of falls reported. Detailed analysis of the timing and location of falls was undertaken and presented at the Preventing Harm Group in order to agree recommendations to further reduce the number of falls.

- A trust VTE project aimed at driving novel initiatives in preventing VTE's was awarded second place at the Thrombus Innovation Awards.

1.2 Training

Throughout the year, the Trust has 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 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.
- Department and individual specific training events, including use of the Clinical Governance Half Day meetings for feedback on learning and recommendations from incident investigation.
- 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.
- 'Ad hoc' training at the request of staff
- Staff annual updates.

100% of the senior managers who joined to organisation in 2013/14 received Risk Awareness Training for Senior Managers provided by the Head of Clinical Governance.

1.3 Risk Management Strategy and Policy

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 the Risk Management Strategy 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.

The Risk Management Strategy is reviewed on an annual basis with the next review due in Q1 2014/15.

1.4 Objectives from the Risk Management Strategy 2013/14

- 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
    - Progress: A never event assurance document should be prepared for all never events. The document is presented at the Quality Committee in accordance with a predefined schedule. Further work is required to ensure that all never event reports are considered, and where necessary, strengthened during 2014/15.

- To achieve level 3 NHSLA general risk management standards in October 2013
    - Progress: This was achieved 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
    - Progress: There has been a notable improvement in the timely investigation and closure of all incidents, including serious incidents. This objective will be taken forward in 2014/15 to incorporate the KPI of 45 working days for serious incidents.

- 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
    - Progress: Whilst the implementation of the system has not yet taken place, procurement is due to be finalised during Q1 2014/15. The anticipated timescales are six months from the date of procurements but will be implemented fully within the next financial year.

- 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
    - Progress: This objective will be considered for inclusion in the 2014/15 objectives.

- To ensure appropriate application of the Quality Governance Framework to risk structures and processes by March 2014
    - Progress: This objective will be considered for inclusion in the 2014/15 objectives.

2.0 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

The NHS Litigation Authority (NHSLA) concluded their assessment process for the Trust's application to meet the standards for NHSLA Level 3 accreditation on 4th October 2013 and confirmed that the Trust achieved Level 3 accreditation having passed 48 out of 50 of the criteria. This is an extremely positive outcome for the Trust.

During this two day assessment the NHSLA assessors have examined evidence of how the Trust complies with their risk management standards. This process included evidence of policies and procedures and also how these are put into practice by the assessors visiting wards and looking at records.

Further detail, including the risk register, mitigations, details of incident reporting and associated learnings are included in the main report in the supporting paper.

3.0 Action/Decision

The Board is asked to note the Risk Management Annual Report 2013/14.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 July 2014 (PUBLIC)

AGENDA ITEM NO.	2.6/Jul/14
PAPER	Risk Management Strategy and Policy 2014/15
AUTHOR	Vivia Richards, Head of Clinical Governance
LEAD	Elizabeth McManus, Chief Nurse and Director of Quality Zoe Penn, Medical Director
PURPOSE	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. Please note that the Strategy and Policy document is contained within the supporting papers.
LINK TO OBJECTIVES	Excel in providing high quality services
RISK ISSUES	No
FINANCIAL ISSUES	No
OTHER ISSUES	No
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	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. 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 14/15 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. The Risk Management Strategy and Policy 2014/15 was already approved by the Risk Management Committee on 17 July and the final strategy and policy is enclosed for endorsement by the Board in the supporting papers. Changes compared to last year strategy and policy include changes in responsibilities, and objectives for the coming year.
DECISION/ ACTION	For approval by the Board.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 July 2014 (PUBLIC)

AGENDA ITEM NO.	3.1/Jul/14
PAPER	Care Quality Commission (CQC) Announced Inspection Update
AUTHOR	Jon Hanlon, Communications Manager
LEAD	Elizabeth McManus, Chief Nurse and Director of Quality
PURPOSE	To update the Board on the recent CQC announced inspection.
LINK TO OBJECTIVES	Excel in providing high quality services Create an environment for learning, discovery and innovation
RISK ISSUES	None
FINANCIAL ISSUES	None
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This paper details the process undertaken by the CQC
DECISION/ ACTION	To note.

Care Quality Commission announced inspection update

1.0 Introduction

The Care Quality Commission (CQC) carried out a planned inspection of the trust from Tuesday 8 July - Friday 11 July.

This encompassed all sites and the nearly all clinical areas with 40 inspectors (the majority of whom having clinical backgrounds) in attendance. There were visits during the normal working day and also out-of-hours. CQC inspectors could follow-up with an unannounced visit up to two weeks after the planned inspection.

They assessed the quality of services across five 'domains': safe, effective, caring, responsive and well-led.

The CQC has updated its approach to inspections in response to perceived failings at other trusts and the Francis report. We are among the early group of organisations to undergo this new regime.

The inspection gave an opportunity to share good practice about what we do to provide high-quality care and to provide awareness and learning about the aspects of care we know need improvement.

2.0 Background

The CQC carried out an unannounced inspection in September 2013 and the trust passed all areas of care assessed in this inspection.

In March this year, the CQC gave the trust a 'band 6' rating in its Intelligent Monitoring report, the best risk banding possible.

The diagram below is reproduced from the CQC's briefing and shows how, as part of their updated approach, they define the five domains against which the assessment is carried out.

Safe	By safe, we mean that people are protected from abuse and avoidable harm.
Effective	By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.
Caring	By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.
Responsive	By responsive, we mean that services are organised so that they meet people's needs.
Well-led	By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

The information collected before and during the inspection will form the basis for an overall rating of either *outstanding, good, requires improvement* or *inadequate*.

The key components of the inspection were:

- Information requests prior to the site visit, asking us to provide strategies, policies, risk registers, minutes of meetings, staffing data, performance information, surveys.

- CQC Inspectorate team conducted:
  - Patient listening event
  - Focus group with governors

- Focus groups with staff, covering all key groups: consultants, junior doctors, nurses, healthcare assistants, midwives, allied health professionals, admin and support and managers

- One-to-one interviews with the executive team (including the chairman)

- Interviews with key staff in eight core services, including (for each service) the lead consultant, lead nurse and general manager

- Observation and discussion with staff in clinical areas - mainly wards and outpatient clinics.

  Feedback has been given to staff – an informal session was held on Friday 11 July to broadly outline key findings and next steps. Approximately 100 members of staff were in attendance from a range of professions and levels. Most staff felt that they had engaged well with the process and hoped that their views had been taken on board through the process.

  Email communication has gone to all staff that could not make this session. An update was provided to the Council of Governors at their July meeting.

  Both communication tools have encouraged staff to provide their feedback on how the process has gone so that the Care Quality Commission have the opportunity to use their experiences to better inform future inspections.

3.0 Summary: next steps

3.1 Reporting

The CQC Head of Hospital Inspection will draft one or more 'quality reports' (depending on the number of locations inspected) and a report for the trust overall. They will do this in conjunction with other members of the inspection team.

3.2 Quality control

Following this, the Head of Hospital Inspection will submit the report to a peer review group to check for quality and consistency. A national quality control and consistency panel, chaired by the CQC's Chief Inspector of Hospital or a Deputy Chief Inspector, then reviews the report.

Once approved by the national panel, the report will be sent to the trust to check for factual accuracy. It is also shared with the regulator Monitor and/or the NHS Trust Development Authority.

3.3 Action planning with local partners

The inspection findings form the basis of a discussion at a 'quality summit' which is a meeting with partners in the local health and social care system that are responsible for commissioning or providing scrutiny.

The purpose of the quality summit is to develop a plan of action and recommendations based on the inspection team's findings. The CQC sets the date, and sends invitations and guidance.

The quality summit is likely to consider:

- The findings of the inspection.
- Whether planned action by the trust to improve quality is adequate or whether additional steps need to be taken.
- Whether support should be made available to the trust from other stakeholders, such as commissioners.

The summit attendees could include:

- Inspection Chair
- The Head of Hospital Inspection or team leader for this inspection visit
- Clinical expert(s) from the inspection team
- Expert(s) by experience or patient and public representatives from the inspection team
- Trust representatives
- Monitor/NHS Trust Development Authority representatives
- Triborough Healthwatch
- NHS England Area Team representative
- Local Authority representatives
- Representatives from relevant Clinical Commissioning Groups
- Health Education England representative
- Others as appropriate (for example, a Health and Safety Executive representative).

The CQC Inspection Chair will chair the first part of the quality summit. The second part is chaired by a representative from Monitor, the NHS Trust Development Authority or the trust itself, depending on the findings of the inspection.

The trust is given an opportunity to respond to the findings of the report. The focus is then on the trust and partner organisations identifying and agreeing any action that needs to be taken in response to the inspection findings.

After the quality summit, the recommendations for action will be captured in a high level action plan.

3.4 Publication

The CQC will publish the inspection reports, ratings and data pack on its website soon after the quality summit.

4.0 Action/Decision

To note.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 July 2014 (PUBLIC)

AGENDA ITEM NO.	3.2/Jul/14
PAPER	Monitor In-Year Reporting & Monitoring Report Q1
AUTHOR	Carol McLaughlin, Assistant Director of Finance – Financial Management Virginia Massaro, Assistant Director of Finance – Contracts & Information
LEAD	Lorraine Bewes, Chief Financial Officer
PURPOSE	Submission of commentary to Monitor on the Quarter 1 2014/15 In year Financial Return
LINK TO OBJECTIVES	Deliver financial sustainability
RISK ISSUES	The risk is rated Red as per the risk matrix – see appendix 3. Risk of Trust not delivering financial plan. Risk Rating: Impact 4 – Major (Loss of between £1.0m & £4.9m). Likelihood 4 – Likely Total Rating: **Red**
FINANCIAL ISSUES	The Trust has achieved a year-to-date (YTD) Continuity of Service Rating (COSR) of 3 as at 30th June 2014, which is in line with plan. Within this, the liquidity element achieves a score of 4, and the capital servicing ratio a score of 1. The Trust reported a net deficit of £0.8m, compared with a plan of a surplus £0.05m. The EBITDA was £5.8m (6.44%), against a plan of £6.4m (7.13%).
OTHER ISSUES	The trust did not achieve the indicator: referral to treatment time 18 weeks admitted patients with a Q1 performance at 82.2%.
LEGAL REVIEW REQUIRED?	No.
EXECUTIVE SUMMARY	As below.
DECISION/ ACTION	The Board is asked to: 1) Delegate approval to the Chief Financial officer to approve, on behalf of the Board, submission of the Quarter 1 2014/15 in-year

financial reporting return to Monitor.

2) Approve the commentary for submission to Monitor.

3) Approve the In Year governance statement (attached at Appendix 1) which includes the following elements:

a) Approve the finance declaration that the Trust will continue to maintain a **Continuity of Service Rating** of at least 3 over the next 12 months.

b) Approve the governance declaration:

The Board with the **exception** of the below 'satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards':

The trust had identified a risk to delivery of the Referral to Treatment Time (RTT) standard for admitted patients in 2014/15 and has been in discussion with commissioners over the preferred option for resolution. After wide discussion of the RTT plan with local commissioners, there is support for the Trust to ensure prompt treatment for a backlog of patients who are currently waiting over 18 weeks vs full achievement of the RTT standard throughout 2014/15.

The trust did not achieve the target for RTT standard for admitted patients in Q1 and is not planning to achieve this until Q3 but met the RTT standards for non-admitted and incomplete patients in Q1 and planning to achieve in Q2. This is in line with the national initiative to reduce admitted patient waits and the Trust has received an award of £1.4m to support this.

This has been to ensure prompt treatment for a backlog of patients who are currently waiting over 18 weeks. This has arisen for three main reasons: sub specialty specialist skill constraints, some mismatch between capacity and demand in surgical services and data quality improvements.

The trust has engaged the national intensive support team in quarter 1 as part of the work programme to implement best in class waiting list management, which also offers a source of external assurance on future compliance for Monitor, commissioners and the trust. The support team will be doing further work with the trust in quarter 2 to undertake a review of demand and capacity across a number of specialties.

The trust has put a number of actions in place including arranging additional capacity, ensuring optimal theatre efficiency and exploring outsourced capacity from other providers where appropriate.

Monitor In-Year Reporting & Monitoring Report Q1

1.0 Introduction/Background

A financial reporting return and commentary are required to be submitted to Monitor on a quarterly basis.

2.0 Content

2.1 Governance Declaration: The Trust did not achieve the indicator: referral to treatment time 18 weeks admitted patients with a quarter 1 performance at 82.2%. The Trust is meeting all the remaining performance indicators at the end of quarter 1.

2.2 Continuity of Service Rating (COSR) for June***:*** The Trust recorded a Continuity of Service Rating (COSR) of 3 year to date at quarter 1 compared to a plan of 3.

2.2.1 The overall COSR is based on two ratios: Capital serving capacity ratio: is the degree to which the organisation's generated income covers its financial obligations. The capital service cover rating is a 1 (against a planned 2). Liquidity: is based on the days of operating costs held in cash or cash equivalent forms including wholly committed lines of credit available for drawdown. The liquidity rating is a 4 (against a planned 4).

2.2.2 The financial performance for the year ended 31^{S} June 2014 is summarised below:

Table 2: Finance performance summary

Key Statistics from Monitor Q1 Return	Plan YTD	Act YTD	Var YTD F/(A)
	£m	£m	£m
Operating Revenue	90.2	90.5	0.3
Employee Expenses	(46.7)	(46.3)	0.4
Other Operating Expenses	(37.1)	(38.4)	(1.3)
Non-Operating Income	0.0	0.0	(0.0)
Non-Operating Expenses	(6.4)	(6.7)	(0.3)
Surplus/(Deficit)	0.0	(0.8)	(0.9)
Net Surplus %	0.05%	-0.93%	-258.52%
Total Operating Revenue for EBITDA	90.2	90.5	15.9
Total Operating Expenses for EBITDA	(83.8)	(84.7)	(18.1)
EBITDA	6.4	5.8	(2.2)
EBITDA Margin %	7.13%	6.44%	-1.00%
Capital Expenditure	(3.7)	(3.3)	0.4
Net Cash Inflow / (outflow)	(2.0)	2.8	4.8
Period end cash	20.3	15.2	(5.1)
COSR	3	3	0

NB: There are a number of items excluded from both revenue and expenses that are not included in the EBITDA calculation.

2.2.3 The trust achieved a net deficit of £0.8m, compared with a plan of a surplus £0.05m. The EBITDA was £5.8m (6.4%), against a plan of £6.4m (7.1%).

2.2.4 The adverse variance against the planned surplus was £0.9m lower than originally planned £0.05m surplus the key drivers include:

- Private practice income adverse variance of £1.4m – the adverse variance relates mainly to the available theatre access and uptake by consultants.

- Clinical supplies adverse variance of £1.0m – The adverse position is across a number of clinical supplies categories, and relates to activity cost pressures associated with additional activity including RTT and combined with CIP slippage on some procurement led initiatives.

- Non-operating expenditure adverse variance of £0.4m related to depreciation, however non-operating expenditure is forecast to be on budget for the remainder of the year.

- The actual level of CIP achievement in quarter 1 of £2.4 m (against a plan of £2.9m) represented a £0.4m under-achievement on the plan for the quarter.

2.3 Statement of comprehensive income

NHS Clinical Revenue

2.3.1 NHS and Local Authority Clinical Contract Income was £1.2m ahead of plan for the first quarter. However, this includes under-performance in excluded drugs and devices of £1.1m, so the underlying position is £2.3m ahead of plan for the quarter. The over-performance has primarily been in elective, maternity and outpatient points of delivery, particularly in elective surgical specialties to address waiting list pressures and GUM outpatients.

2.3.2 Elective inpatient activity reported an over-performance of £0.4m for the period, continuing the trend above that was reported during the final quarter of 2013/14. This was primarily driven by adult surgical specialties, particularly orthopaedic and general surgery elective and day cases which were £0.3m ahead of plan, due to additional capacity put on to address waiting list pressures as part of an agreed accelerated backlog reduction of admitted patients. Dermatology phototherapy regular day attenders also continued the improvement seen in March following resolution of resourcing issues at the end of 2013/14 and were £0.1m ahead of plan for the quarter.

2.3.3 Non-elective inpatient income was £0.6m behind plan in for the period to the end of June, including adjustments made under the contract for block agreements for emergency admissions. The major factor however was reduced activity against the NHS England specialised services contract, contributing £0.7m of the total under-performance. This was primarily driven by under-performance in Paediatric Gastroenterology, General Medicine and Burns Care for the period.

2.3.4 Outpatient new and follow-up attendances were above plan, reporting a £1.2m favourable variance to the end of June. This derives from a combination of over-performing specialties, most notably GU Medicine (£0.7m), as a result of the continuation of activity levels at the Dean Street Express clinic which opened during Q4 2013/14. Obstetrics over-performance (£0.3m) derives from the implementation of the maternity pathway tariff. The other significant over-performing specialty is Radiology (£0.1m).

2.3.5 NHS Clinical Contract Income relating to other points of delivery and A&E was ahead of plan by £0.2m for the quarter; however this includes an under-performance on excluded drugs and devices of £1.1m, so the underlying activity and income was ahead of plan by £1.3m for the period. Within this, A&E and UCC activity was ahead of plan by £0.3m, due to continued high levels of attendances and ambulance transfers following the trend observed during March 2014.

Income from non-NHS sources (formerly Private Patient Income Cap)

2.3.6 The Trust earned almost £3.4m from providing services to private patients, meaning there was no breach of the limits on earning income from non-NHS sources (the broad requirement being that income received from providing goods and services for the NHS is greater than income earned from other sources).

2.3.7 The private patient income of £3.4m (against a plan of £4.7) relates primarily to the under-performance of income in the Chelsea Wing. This key driver behind the underperformance relates mainly to the available theatre access and uptake by consultants. This is forecast to improve based on service assumptions related to increased surgical activity and improved access to theatres.

Other Operating Income

2.3.8 Income earned from the Trust's Research and Development activities, along with income contributing to Education and Training costs are in line with the plan with a combined income of £6.8m (against a plan of £6.9m).

Operating Expenditure

2.3.9 Operating Expenditure within EBITDA was £0.9m higher than plan during Quarter 1. The key variances are listed below:

2.3.10 Employee Benefits (£0.4m under-spent): Pay shows a favourable variance against the plan mainly related to the CIP being phased towards the end of the financial year. The year to date pay CIP has under-achieved by £1.0m, this was offset against holding of vacancies to ensure that pay was not overspent. The quarter 1 pay budget of £46.7m was set higher than the 2013/14 quarter 4 run-rate of £45.4m due to additional investments agreed during business planning.

2.3.11 Drugs Costs (£0.5m under-spent): The favourable variance in drugs mainly relates to pass through drugs, which is offset against an adverse variance in drug income.

2.3.12 Clinical Supplies (£1.0m over-spent): The adverse position is across a number of clinical supplies categories, and relates to activity cost pressures associated with additional activity including RTT and combined with CIP slippage on some procurement led initiatives £0.3m.

2.3.13 Non Clinical Supplies (£0.4m over-spent): The overspend in non-clinical supplies relates to CIP slippage £0.1m and cost pressures included in areas such as energy and facilities.

2.3.14 Other Operating Expenditure (£0.5m over-spent): The remaining overspend mainly relates to consultancy in trust general services and ICT shared service project.

2.3.15 Non-Operating Expenditure (£0.4m over-spent): This relates to depreciation however non-operating expenditure is expected to be on plan for the year.

2.3.16 CIP (£1.3m below target): There is an under-performance against the CIP plan of £1.3m YTD, this is mainly related to unidentified CIP.

Table 3: CIP Achievement

CIP as per Monitor Template	Plan YTD	Act	Var YTD
	£m	£m	£m
Operating Revenue	0.8	1.0	0.2
Pay Expense	1.9	0.9	(1.0)
Drug Expense	0.1	0.0	(0.0)
Clinical Supplies	0.5	0.2	(0.3)
Non Clinical Supplies	0.5	0.4	(0.1)
Subtotal	3.7	2.4	(1.3)

2.4 Statement of Financial Position

2.4.1 Property, Plant and Equipment

2.4.1.1 Capital spend in Q1 is reported at £3.3m against the Monitor plan of £3.7m (11.9% behind plan). This is within +/- 15% of reforecast threshold of Monitor.

2.4.1.2 Major schemes in progress at 31st March 2014 completed in Q1 2014/15 are Outpatients 3/ Phlebotomy and Children Outpatients. The major schemes in progress in this financial year are ED refurbishment and Pathology & Research Lab. There are some other buildings and IT schemes being worked on and the expenditure will be incurred in future quarters.

2.4.1.3 Capital spend in Q1 is profiled in the capex table (below) by Monitor categories. The variance in Property maintenance expenditure £0.4m 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. The other major schemes are at the design stage and thus the expenditure incurred on other property plant and equipment category is behind the plan by 19.6%.

2.4.1.4 Capital spend on information technology is 2% behind the plan whereas purchase of intangible assets is ahead of plan with an adverse variance of £0.1m. IT expenditure has been mainly on LastWord Development, Electronic Document Management (EDM), and It Portal.

2.4.1.5 Plant & Equipment capital expenditure is behind the plan by 68%. The equipment replacement programme is in place and the expenditure will be incurred in future quarter.

Table 4- Property Plant and Equipment including Intangibles Capital expenditure at Q1

Monitor Scheme Categories	Q1 Budget £'m	Q1 Actual £'m	Q1 Var £'m	Q1 Var %
Property - Maintenance expenditure	0.061	0.495	0.428	-706.6%
Property, plant and equipment - other expenditure	2.243	1.802	0.440	19.6%
Plant and equipment - Information technology	0.555	0.554	0.010	1.9%
Plant and equipment - Other equipment	0.815	0.258	0.557	68.3%
Purchase of intangible assets	0.063	0.199	0.136	-217.9%
Grand Total	3.736	3.308	0.444	11.9%

2.5 Receivables and Other Current Assets

2.5.1 Receivables and other current assets (£47.2m excluding cash and inventories) are £4.9.m above plan as at 31st July 2014. The key variance against plan is in NHS trade receivables, which are £7.8m higher than plan.

2.5.2 The factors causing this variance continue to be the issues arising from CCG's signing SLA contracts late and a late payment of an HEE invoice (paid in July). The majority of contracts have now been signed and the Trust will pursue the CCG's vigorously for any balances outstanding.

2.5.3 The delays in payments by Local Authorities experienced in 2013/14 have improved however this area of debt remains a concern for the Trust.

2.5.4 Improvements to the cash collection process are expected prospectively.

2.6 **Trade and Other Payables – Current**

2.6.1 The total of trade and other payables, accruals and other current liabilities is £45.1m at the end of quarter 1, which is £4.6m above plan. This is mainly due to trade payables being above plan in the quarter. This position is expected to move to plan as issues with debtors are resolved.

2.7 **Cash Flow**

2.7.1 The cash balance at the end of quarter 1 is £15.2m, which is £5.2m below plan. As Debt collection improves the cash position will fall back in line with the plan.

2.8 **Forecast**

2.8.1 The current mitigated forecast is for a £3.4m surplus for the Trust (which is a £3.6m adverse variance against a £7.0m planned surplus). This mitigated forecast would achieve a Continuity of Service Rating of 3.0.

2.9 **Finance Declaration**

2.9.1 The Trust has achieved a COSR of 3 YTD at the end of quarter 1 of 2014/15 compared to a plan of 3

3.0 **Summary**

3.1 The Trust has achieved a year-to-date (YTD) Continuity of Service Rating (COSR) of 3 as at 30th June 2014, which is in line with plan. Within this, the liquidity element achieves a score of 4, and the capital servicing ratio a score of 1.

3.2 The Trust achieved a net deficit of £0.8m, compared with a plan of a surplus £0.05m. The EBITDA was £5.8m (6.44%), against a plan of £6.4m (7.13%).

4.0 **Decision/Action required**

4.1.1 The Board is asked to:

Delegate approval to the Chief Financial officer to approve, on behalf of the Board, submission of the Quarter 1 2014/15 in-year financial reporting return to Monitor.

4.1.2 Approve the commentary for submission to Monitor.

4.1.3 Approve the In Year Governance Statement (attached at Appendix 1) which includes the following elements:

4.1.4 Approve the Finance declaration that the Trust will continue to maintain a **Continuity of Service Rating** of at least 3 over the next 12 months.

4.1.5 Approve the Governance Declaration:

The Board with the **exception** of the below 'satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards':

The Trust had identified a risk to delivery of the Referral to Treatment Time (RTT) standard for admitted patients in 2014/15 and has been in discussion with commissioners over the preferred option for resolution. After wide discussion of the RTT plan with local commissioners, there is support for the Trust to ensure prompt treatment for a backlog of patients who are currently waiting over 18 weeks vs full achievement of the RTT standard throughout 2014/15.

The Trust did not achieve the target for RTT standard for admitted patients in Q1 and is not planning to achieve this until Q3 but met the RTT standards for non-admitted and incomplete patients in Q1 and planning to achieve in Q2. This is in line with the national initiative to reduce admitted patient waits and the Trust has received an award of £1.4m to support this.

This has been to ensure prompt treatment for a backlog of patients who are currently waiting over 18 weeks. This has arisen for three main reasons: sub specialty specialist skill constraints, some mismatch between capacity and demand in surgical services and data quality improvements.

The Trust has engaged the national intensive support team in quarter 1 as part of the work programme to implement best in class waiting list management, which also offers a source of external assurance on future compliance for Monitor, commissioners and the Trust. The support team will be doing further work with the Trust in quarter 2 to undertake a review of demand and capacity across a number of specialties.

The Trust has put a number of actions in place including arranging additional capacity, ensuring optimal theatre efficiency and exploring outsourced capacity from other providers where appropriate.

Appendix 1 – In Year Governance Statement

Worksheet "Governance Statement"

Click to go to index

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)

	For finance, that:	Board Response
4	The board anticipates that the trust will continue to maintain a Continuity of Service 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 A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.	Not Confirmed

Otherwise:

The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework page 22, Diagram 6) which have not already been reported. — Confirmed

Consolidated subsidiaries:

Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds. — 0

Signed on behalf of the board of directors

Signature	Sign Here.	Signature	Sign Here.
Name		Name	
Capacity	[job title here]	Capacity	[job title here]
Date		Date	

0

Notes: *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: The Board with the exception of the below 'satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards':

The Trust had identified a risk to delivery of the Referral to Treatment Time (RTT) standard for admitted patients in 2014/15 and has been in discussion with commissioners over the preferred option for resolution. After wide discussion of the RTT plan with local commissioners, there is support for the Trust to ensure prompt treatment for a backlog of patients who are currently waiting over 18 weeks vs full achievement of the RTT standard throughout 2014/15.

The Trust did not achieve the target for RTT standard for admitted patients in Q1 and is not planning to achieve this until Q3 but met the RTT standards for non-admitted and incomplete patients in Q1 and planning to achieve in Q2. This is in line with the national initiative to reduce admitted patient waits and the Trust has received an award of £1.4m to support this.

This has been to ensure prompt treatment for a backlog of patients who are currently waiting over 18 weeks. This has arisen for three main reasons: sub specialty

B:

C:

Appendix 2

In the first quarter of 2014/15:

I. ELECTIONS

There were no elections to fill posts on the Council of Governors.
There have been changes to the Council of Governors stakeholder appointments.

II. BOARD OF DIRECTORS

There have been no changes in the composition of the Board of Director this quarter. The only change relates to Elizabeth McManus's job title which changed from the Executive Director of Nursing and Quality to the Chief Nurse and Director of Quality on 01.04.14.

Role	Date of change	Full Name	Telephone	Email address	Job Title (if different to 'role')
Executive Director	01/04/2014	Elizabeth McManus	02033156721	elizabeth.mcmanus@chelwest.nhs.uk	Chief Nurse and Director of Quality

During the quarter we were actively recruiting to replace Non-executive Directors whose appointments come to an end later this year. Appointments which were approved by the Council of Governors on 15 May 2014 are from 01.07.14 so will be detailed the quarter two.

III. COUNCIL OF GOVERNORS

a. Retirements and Resignations

i. Elected

A vacancy was created in the Staff – Management Constituency following the resignation of Dominic Clarke 30.05.14
A vacancy was created in the Staff – Support, Administrative and Clerical following the resignation of Maddy Than 21.05.14.

ii. Stakeholders

Frances Taylor retired from the Royal Borough of Kensington and Chelsea and therefore resigned from the Council of Governors on 21.05.14.
Cyril Nemeth retired from the Westminster City Council and therefore resigned from the Council of Governors on 21.05.14.

b. Appointments (stakeholder)

Cllr Catherine Faulks of the Royal Borough of Kensington and Chelsea appointed to the Council of Governors to fill the vacant seat 11.06.14.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 July 2014 (PUBLIC SESSION)

AGENDA ITEM NO.	3.3/Jul/14
PAPER	Board Assurance Framework (BAF) 2014/15, and Risk Report for Quarter 1 2014/15
AUTHOR	Ron Agble, Head of Programme Delivery Vivia Richards, Head of Clinical Governance
LEAD	Tony Bell, Chief Executive
PURPOSE	The purpose of the Board Assurance Framework is to support the Board in understanding the implementation of strategy in the context of risk management. The framework is part of the trust's internal control processes.
LINK TO OBJECTIVES	All
RISK ISSUES	As described in the attached.
FINANCIAL ISSUES	As described in the attached.
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	This paper outlines the key risks which could prevent the Trust achieving its Strategic Objectives and it describes the actions being taken to mitigate those risks. The BAF is developed by the Executives in discussion with the Head of Programme Delivery. The framework has been revised following the development of the new strategic objectives in 2014/15. The Risk Report for Q1 is also attached. The document is linked to the Risk Strategy and Policy. Definitions of risk ratings are in accordance with the Board Governance Arrangements Policy.

	Following the recent independent review of our Quality Governance Framework, the CQC visit, and other work to be undertaken in relation to Board assurance, a new policy for the BAF will be developed.
DECISION/ ACTION	The Board is asked to note the progress on the management of risks for the Strategic Objectives.

BOARD ASSURANCE FRAMEWORK 2014/15 – July 2014

Strategic Objective 1: Excel in providing high quality clinical services **Owner:** **Elizabeth McManus** **Zoe Penn**	**Principal Risks** *[what are the main risks to achieving the objective]*	**Risk Mitigation** *[what action are we taking to reduce the likelihood or impact of the risks identified]*	**Controls and Measures** *[What controls/systems are in place to assist securing the delivery of our objective?]*	**Risk Ratings** **Initial** (April 2014) **Current**
a) Deliver safe clinical services, evidenced by outcome data and audits.	• Inconsistent implementation of best practice clinical or operational processes across the organisation • Lack of accurate or comprehensive data with which to Monitor performance in all areas or aspects of quality.	• Ensure the review of all clinical incidents identifies if and how care could be improved to deliver a better outcome. • Implement the Safety Thermometer across the whole organisation. • Implement Safe Staffing across all staff groups.	• Risk Management Strategy • Risk Report to Board • Quality Committee review of policies, performance, incidents and risks. • Clinical Audits to monitor performance and processes.	**Initial = Orange** **Current = Orange**
b) Deliver effective clinical services, evidenced by outcome data and audits.	• Inconsistent implementation of best practice clinical or operational processes across the organisation.	• Standardising clinical and operational processes across the organisation. • Implementation of the processes and delivery of the outcomes required to achieve Best Practice Tariffs.	• Emergency & Elective Care Programme Boards to monitor performance in key aspects of care and coordinate improvements. • Quality Committee (as above) • Clinical Audits (as above).	**Initial = Yellow** **Current = Yellow**
c) Deliver excellent patient experience (including access), evidenced by patient experience data and performance against access targets set out in the NHS Constitution.	• Increasing levels of activity as seen over recent weeks continues	• Plans in place to create sustainable inpatient capacity through improved throughput.	• Emergency & Elective Care Programme Boards (as above). • Patients' Experience Committee. • Board reports track performance across key measures.	**Initial = Yellow** **Current = Yellow**

d) Improve quality and safety of health and care across North West London by delivering the Shaping a Healthier Future (SaHF) programme to localise settings of care, centralise settings of most serious acute care and provide seamlessly integrated care across all settings.	• Adverse implications in relation to the financial and operational risks identified in the current OBC for the Trust's SaHF Programme	• Trust is working with commissioners through the OBC Assurance Process to find a sustainable solution to capital financing and the operational risks identified.	• Various external programme boards hosted by NWL CCG. • CWFT SaHF Steering Group • Board and Committee updates	**Initial = Yellow** **Current = Yellow**
e) Secure the medium and longer-term future of key specialised services in our clinical service portfolio, in particular, the designation of our inpatient HIV Service for NWL.	• NHS England intention to rationalise specialised services in fewer centres. • Clinical sustainability of some services that are or may become sub-scale.	• Partnership working • Pursuit of strategic opportunities to increase our patient catchment area to enable growth and secure key service infrastructure • Ensuring the trust is fully engaged in the designation process and is a key stakeholder to inform future planning	• National and regional groups • Specialist commissioning groups	**Initial = Yellow** **Current = Yellow**

Strategic Objective 2: Improve population Health Outcomes and Integrated Care **Owner: David Radbourne**	**Principal Risks** *[what are the main risks to achieving the objective]*	**Risk Mitigation** *[what action are we taking to reduce the likelihood or impact of the risks identified]*	**Controls and Measures** *[What controls/systems are in place to assist securing the delivery of our objective?]*	**Risk Ratings** **Initial** (April 2014) **Current**
a) Work with local NHS partners and expert suppliers (legal, IT etc) to develop the care pathways, technical infrastructure and payment mechanisms to pilot ("early adopter") Accountable Care in the NWL area through the Whole Systems Programme.	• Lack of clarity regarding the role of the ACG and what each partner contributes to it. • Poor data quality on out of hospital activity and costings limit the extent to which efficiencies can be evidenced	• Common values and principles have been agreed and documented. • MoU (leading to formal partnership agreement) is under development. • NWL programme has commissioned pan-sector work to establish financial baselines.	• Accountable Care Group (ACG) Project Board in place. • NWL Whole Systems Project Board and Executive (CWFT membership) established.	**Initial = Green** **Current = Green**
b) Work with partners in the local health economy, particularly Clinical Commissioning Groups (CCGs) and Central London Community Healthcare (CLCH), on a jointly resourced programme to deliver improvements in the quality and efficiency of the Emergency Care Pathway.	• Challenging timeline to design and implement sustainable change • Ability to work at pace across organisational boundaries • Delivery of longer term CIP • Loss of income (CQUIN)	• Emergency Care Pathway Board in place • Discussions with commissioners on resourcing for winter pressures	• Project Initiation Document and formal programme management structure • Exec Senior Responsible Officer • Executive Team oversight	**Initial = Yellow** **Current = Yellow**

c) Work with partners in the local health economy, particularly CCGs, on a jointly resourced programme to deliver improvements in the quality and efficiency of the Planned Care Pathway.	• Challenge to deliver sustainable change and align to the trust's short term needs with long term strategic ambition • Loss of income (CQUIN) • Ability to work at pace across organisational boundaries • Delivery of longer term CIP	• In place to deliver sustainable change through quality improvement • Monthly Board meetings with GP & CCG representatives that takes a collaborative approach to undertaking change • Joint Outpatient Programme Project plan signed by GP reps, CCG representatives that is aligned to CQUIN's	• Project Initiation Document and formal programme management structure • Exec Senior Responsible Officer • Executive Team oversight	**Initial = Yellow** **Current = Yellow**
d) Work with Health and Well-being Boards and other partners in the local health economy to increase involvement in delivery of primary prevention services.	• H&WB still developing as decision-making and partnership body, which could adversely impact • Insufficient Trust capacity and expertise due to the vacancy in Public Health SpR role. • Insufficient funds to support key initiatives.	• Relationship Management • Exploring solutions with Deanery/PHE re secondment or other recruitment strategies for the PH SpR role. • Bid fund secured (e.g. Smoking Cessation)	• Health & Wellbeing Strategy • Trust Health and Wellbeing Board • Attendance at local Health and Wellbeing	**Initial = Green** **Current = Green**

Strategic Objective 3: Deliver Financial Sustainability **Owner:** **Lorraine Bewes** **Rakesh Patel**	**Principal Risks** *[what are the main risks to achieving the objective]*	**Risk Mitigation** *[what action are we taking to reduce the likelihood or impact of the risks identified]*	**Controls and Measures** *[What controls/systems are in place to assist securing the delivery of our objective?]*	**Risk Ratings** **Initial** (April 2014) **Current**
a) Ensure plans are in place to achieve financial sustainability of each our clinical services over the medium term.	• Currently, there are some services within our clinical portfolio that are financially challenging under current tariff and contractual arrangements.	• Improve efficiency to make services more financially viable. • Work with commissioners to secure appropriate funding and contractual arrangements.	• EBITDA monitored for each clinical service line.	**Initial = Yellow** **Current = Yellow**
b) Deliver greater efficiency across the organisation through clinical service and corporate transformation.	• CIPs currently not on track to deliver target in full. • The extent to which the transformation programme will deliver financial benefits in the short-term is not yet clear.	• Reduce capital investment programme to maintain cash position. • Executive-led mitigation plans. • Enhanced communication to engage staff in identifying CIPs and controlling costs.	• Financial reporting. • CIPs monitoring. • Run-rate monitoring. • Financial recovery meetings.	**Initial = Red** **Current = Red**
c) Diversify income [away] from NHS sources and in particular deliver the budgeted increases in Private Patient Service income and contribution.	• Private patient income target not delivered • Inpatient bed capacity constraints limit elective activity that can be undertaken.	• Ring-fenced theatre capacity now secured. • Enhanced managerial capacity put in place. • Refurbishment of Chelsea Wing planned to take place this year.	• Tracking private patient income through financial reporting. • Private Patients Operational and Strategic Groups oversee operational and strategic planning.	**Initial = Red** **Current = Red**
d) Invest in facilities, equipment and technologies in key areas of potential income and profitability growth.	• Some capital investments may not deliver sufficient financial return on investment. • Shortfall on CIP delivery	• Rigorous business case appraisal to reduce risk of inappropriate investments. • Periodical review of capital programme to adjust according to	• Regular reporting on capital expenditure. • Finance and Investment Committee • Capital Programme Board	**Current = Yellow**

	results in reduced ability to fund capital programme.	broader financial circumstances. • Benefits realisation reviews to help drive benefits after investments have been made.		**Current = Yellow**
e) Strategic investments in acquisitions, joint-ventures or other forms of partnership that can help the medium and longer-term financial sustainability of the Trust.	• Failure to secure business case capital and revenue requirements • Regulatory constraints impact on the decision-making process. .	• Working with TDA Transaction Board and Commissioners • Working with regulators early in the process to ensure work is done to address regulatory bodies' concerns. • Obtaining expert professional advice on the likelihood of regulatory barriers and how these can be addressed [where applicable]. • Undertaking financial due diligence to ensure negotiations with external parties are rigorously informed.	• NED led Acquisition Steering Committee in place. • Clear review and approval process in place at key stages of SOC, OBC and FBC.	**Initial = Green** **Current = Green**

Strategic Objective 4: Create an environment for Learning, Discovery and Innovation **Owner:** **Susan Young** **Tony Bell**	**Principal Risks** *[what are the main risks to achieving the objective]*	**Risk Mitigation** *[what action are we taking to reduce the likelihood or impact of the risks identified]*	**Controls and Measures** *[What controls/systems are in place to assist securing the delivery of our objective?]*	**Risk Ratings** **Initial** (April 2014) **Current**
a) To build an academic research capability and develop expertise in translational research for West London	• Loss of R&D income through NIHR • Constrained R&D facilities and estate • Failure to increase commercial research income	• Clear strategy for R&D including CHLARC NIHR funded facility • Strong research leadership, communications and relations with Imperial College and Academic Health Science Network (AHSN) • Effective industry liaison and marketing of research capability through contract research organisations	• R&D Strategy Board to monitor direction and progress • R&D Director and team in place • Board level engagement in managing key relationships	**Initial = Green** **Current = Green**
b) To develop competent, capable, professional and flexible people in a great teaching hospital	• Loss of training places as they become allocated to primary care • Failure to deliver the IT system requirements needed to modernise and streamline learning processes • Inability of operational areas to commit staff time to train due to operational pressures	• Building good relationships with HENWL, and using opportunities provided by the Accountable Care Group approach • IT project manager in place • Strategic workforce planning to enable full establishment	• Education Strategy Board and IM & T Strategy Board in place to monitor progress • Director of Multi-Professional education oversees position on training places • Assurance Committee reports • Executive Team and Board track turnover and staffing levels	**Initial = Green** **Current = Green**
c) To become a leading innovator in healthcare in North West London.	• Insufficient generation of innovative practises • Failure to capitalise on intellectual property	• Enterprising Health Partnership (EHP) to support innovative ideas • Collaboration with technology transfer hubs and assess to structured venture capital	• Project board monitoring • Annual review with the Chelsea and Westminster Health Charity re EHP	**Initial = Yellow**

		arrangements • Structured path for stimulating and supporting new ideas		**Current = Yellow**

Enablers – To ensure that our People, Processes, Systems and Environment facilitate delivery of the best possible experience and outcomes for our patients.	**Principal Risks** *[what are the main risks to achieving the objective]*	**Risk Mitigation** *[what action are we taking to reduce the likelihood or impact of the risks identified]*	**Controls and Measures** *[What controls/systems are in place to assist securing the delivery of our objective?]*	**Risk Ratings** **Initial** (April 2014) **Current**
a) People – Vision for our People: We aim to have high performing, kind and respectful people – providing safe and excellent care, with visible and engaging leaders at all levels who enthuse & inspire colleagues and enable the best possible experience for our patients. Owner: Susan Young	• High turnover leads to high agency spend and impacts on patient safety, experience and effectiveness • Staff leave to join other trusts • Adverse effect of CIP reductions on the motivation of the workforce • Reduction in staff engagement has adverse impact on ability to change	• Development of People Strategy • Bank and agency project group • Strategic workforce planning • Talent management and succession planning • Leadership development programme • Clinical summits • Focus on values • Project on healthcare support workers	• Board workforce reports • Turnover measured and monitored • Staff Friends and Family test • Annual NHS staff survey • Exit interview data	**Initial = Green** **Current = Green**
b) Processes – to adopt the safest, most effective and efficient clinical and managerial processes across the whole organisation. Owner: David Radbourne	• Organisational capability to identify and implement best practice consistently across the organisation.	• Re-structured Divisions to ensure alignment of services based on the patient pathway • Developing and implementing a service and quality improvement training programme for all staff groups to improve the organisation's capability and capacity to improve clinical and managerial processes. • Work with a partner organisation to deliver change	• Transformation Programme Boards • Project and Programme management reporting	**Initial = Green** **Current = Green**

c) Systems – adopting the IT systems and equipment to deliver services in a way that is commensurate with patients' expectations and modern ways-of-working. Owner: David Radbourne	• IT strategy and investment programme are unable to 'keep up' with the trust strategic objectives and deliver in a timely enough way. • Competing demands we are trying to achieve which all require bespoke IT solutions • Insufficient progress replacing our existing systems (e.g. for scheduling) adversely impacting on current performance and efficiency • Reduction in capital programme inevitably means a reduction in IT investment.	• Protecting essential IT investment in capital programme • Prioritisation of IT projects from the IT strategy at executive level and where appropriate Board committee level • IT investment factored into FBCs relating to potential joint venture work/acquisition	• IM and T Strategy Board monitoring progress • Executive review • Forthcoming Board session	**Initial = Orange** **Current = Orange**
d) Environment – investing in our facilities to ensure they are clean, modern and comfortable, whilst supporting staff to deliver care safely and respectfully. Owner: David Radbourne	• The Trust may not be able to invest in all capital programmes • Complexity of delivering an ambitious service strategy within a constrained footprint to time and schedule.	• Financial sustainability stream and a carefully prioritised capital programme. • Careful planning – and we already have working plans to help guide our activities in an outline estates plan.	• Capital Programme Board • Finance and Investment committee • Assurance Committee • PLACE assessment and group	**Initial = Green** **Current = Green**

RISK REPORT QUARTER 1 2014/15 - JULY 2014 UPDATE

The risks below are those that are rated orange or above, identified from previous reports to the Board. Risks not on this report have been mitigated or superseded by subsequent reports

Updates from Q4 13/14 are in italics and bold.

Date	Source & Lead	Risk(s) Identified (Description)	Controls/actions	Risk Register ID and grade
Feb 13	Papers to Board 12/13 **Lorraine Bewes and Rakesh Patel**	**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 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	This risk is subject to the SaHF business case which was developed during 2013/14. The business case clearly identifies the financial impact of implementing SAHF. The Trust has evaluated and quantified the financial risk and made it explicit on the business case. ***The Trust is engaged In the OBC assurance process with the Commissioners. This will include discussions and agreement to mitigate any financial risk to the Trust.*** ***The Trust Board will approve any financial package before agreement with the Commissioners.***	Orange 863

Date	Source & Lead	Risk(s) Identified (Description)	Controls/actions	Risk Register ID and grade
		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 in 12/13

Date	Source	Risk(s) Identified (Description)	Controls/actions	Risk Register ID and grade
April 11-June 11	Papers to Board 11/12 **Zoe Penn**	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, including amending 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. ***Regular annual audit shows year on year improvement of compliance with post admission (post-take) review by a consultant, but this improvement has now plateaued to 70% compliance, as demonstrated in an audit in July 2013.*** **<u>Update on Consultant Attendance of Emergency</u>** Currently the majority of day time Emergency	Orange 715

Date	Source	Risk(s) Identified (Description)	Controls/actions	Risk Register ID and grade
			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, three dedicated daytime emergency gynaecology sessions have been resourced from a new appointment and also 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 emergency assessment/admissions, review of inpatient admissions and performing or supervising emergency gynaecology operating in the daytime. 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 on emergency gynaecology inpatients. A repeat audit undertaken in July and August 2013 shows maintenance of a 70% adherence to post take ward rounds of emergency admissions. There has been in year strengthening of the provision of the emergency gynaecology consultant cover during the day with additional dedicated daytime sessions.	

Date	Source	Risk(s) Identified (Description)	Controls/actions	Risk Register ID and grade
			There are firm plans to provide further robust dedicated care by the appointment of two emergency gynaecology consultants as part of the 168 hours Labour ward business case in 2014/15. ***Further improvements will require further investment in resource to enable post-take consultant ward rounds by clinicians with no other commitments at 8am on post-take days.***	
Mar 12	Papers to Board 11/12 Performance Report **Zoe Penn & Elizabeth McManus**	**Never Events**	Schedule for review of controls and assurances in place to prevent any of the 25 Never Events. This continues to be monitored through the Quality Committee and Assurance Committee ***An updated report presented to both the June and July 2014 Assurance and Quality Committees. This reflected current status and arrangements in place or planned to ensure that any risks relating to the occurrence of specific incident categories are managed and prevented.*** ***The Never Events have been ranked in order of the likelihood of the incident category occurring at the Chelsea and Westminster.*** ***Monthly reports reflecting the status of Never Events are considered monthly at each Assurance Committee.***	Orange 787
12/13	BAF **Rakesh Patel**	**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	Service Line Reporting and more detailed EBITDA information and targets have now been issued to divisions and discussed at wider Executive as part of the financial planning round.	Orange 803

Date	Source	Risk(s) Identified (Description)	Controls/actions	Risk Register ID and grade
			The Trust is continuing to develop and roll out Service Line Reporting as part of the overall financial reviews of service lines and divisional performance.	
10/11	BAF **Zoe Penn & Elizabeth McManus**	**Staff failure to recognise and respond to the deteriorating patient.**	Actions for this cover two areas, early warning systems and the SBAR communication tool (Situation, Background, Assessment and Recommendation). • NEWS (National Early Warning Score) is in use throughout the organisation, SBAR training was an integral part of the roll-out and integrated into on-going resuscitation courses which include induction and updates. Audit considered at the Quality Committee in April 2014 highlighted deficiencies with respect to correct calculation of NEWS scores. • ***MEWS (Maternity Early Warning Score) - Audit presented to the Quality Committee in July 2014 highlighted areas of deficiency, which was accompanied by a report of actions to address these. The team have been asked to include a measure of the frequency of temperature measurement within their re-audit (links to sepsis).*** ***Rolling audits planned in 2014 using available technology, to measure scoring, escalation and response, including the use of SBAR. Until this is in place teams are required to improve compliance and provide monthly audits showing progress and improvements. Incident reporting is***	Orange 594

Date	Source	Risk(s) Identified (Description)	Controls/actions	Risk Register ID and grade
			encouraged to be able to address any identified risks.	
11/12	BAF **Susan Young**	**Agency staff - not familiar with the area and level of competency unclear** - **can, therefore, affect quality of care to patients.**	There has been a significant reduction in the reliance on bank and agency staff in Q4 & Q1. This has enabled better continuity of care for patients along with a significant reduction in costs. This has been achieved as a result of highly focussed divisional and corporate control in the use of agency staff. Other Policy changes have been made, for example to ensure that agency staff are not caring for patients at end of life. ***No change to risk grade/previous report***	Orange 664

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 July 2014 (PUBLIC)

AGENDA ITEM NO.	3.4/Jul/14
PAPER	Register of Seals Report Q1*
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Susan Young, Director of Human Resources and Organisational Development
PURPOSE	To keep the Board informed of the Register of Seals
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 Q4

Section 12 of the Standing Orders provided below refers to 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 2014 – 30 June 2014, there were no documents to which the seal was affixed.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 July 2014 (PUBLIC)

AGENDA ITEM NO.	3.5/Jul/14
PAPER	A Framework of Quality Assurance for Responsible Officers and Revalidation - Annual Board Report July 2014
AUTHOR	Tim Fairclough, Medical Appraisal and revalidation Officer, Jacqueline Durbridge, RO Delegate, Zoe Penn, Medical Director
LEAD	Zoe Penn, Medical Director
PURPOSE	The Framework of Quality Assurance (FQA) provides an overview of the elements defined in the Responsible Officer Regulations, along with a series of processes to support Responsible Officers and their Designated Bodies in providing the required assurance that they are discharging their respective statutory responsibilities
LINK TO OBJECTIVES	Excel in providing high quality clinical services
RISK ISSUES	Minor risk to not discharging statutory duties.
FINANCIAL ISSUES	Continued funding for appraisal/revalidation officer and Trust medical appraisal lead. Funding for training of appraisers.
OTHER ISSUES	No
LEGAL REVIEW REQUIRED?	Uncertain
EXECUTIVE SUMMARY	Chelsea and Westminster Hospital NHS Foundation Trust has 352 doctors with a prescribed connection. There have been 289 completed appraisals within the appraisal year (82%). The appraisal team follow up and investigate missing appraisals and the majority of doctors eventually complete

	an appraisal. We have made positive revalidation recommendations for 74 (21%) of our doctors in 2013/14 against a GMC mandated target of 20%.
DECISION/ ACTION	To accept report. (Please note it will be shared, along with the annual audit, with the higher level responsible officer). To support any resource requirements to deliver a higher standard of appraisal. To approve the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annual Board Report July 2014

1. Executive summary

Chelsea and Westminster Hospital NHS Foundation Trust has 352 doctors with a prescribed connection. There have been 289 completed appraisals within the appraisal year. The appraisal team follow up and investigate missing appraisals and the majority of doctors eventually complete an appraisal. We have made positive revalidation recommendations for 74 (21%) of our doctors in 2013/14.

2. Purpose of the paper

The Framework of Quality Assurance (FQA) provides an overview of the elements defined in the Responsible Officer Regulations, along with a series of processes to support Responsible Officers and their Designated Bodies in providing the required assurance that they are discharging their respective statutory responsibilities.

This report describes the implementation of revalidation and is a statement of compliance with the FQA to the board and higher level responsible officers.

3. Background

Medical staff appraisal is a process of facilitated self-review, supported by information gathered from the full scope of a doctor's work. At this organisation, medical staff appraisal has three main purposes:

- To enable doctors to discuss their practice and performance with their appraiser in order to demonstrate that they continue to meet the principles and values set out in Good Medical Practice and thus to inform the responsible officer's revalidation recommendation to the General Medical Council (GMC);
- To enable doctors to enhance the quality of their professional work by planning their professional development;
- To enable doctors to consider their own needs in planning their professional development.

Revalidation is the process through which licensed doctors demonstrate they remain up to date and fit to practise. It is based on clinical governance and appraisal processes. Effective medical appraisal and subsequent revalidation will satisfy the requirements of Good Medical Practice and support the doctor's professional development.

Appraisal is focused on a doctor's fitness to practise and professional development to enhance this. This means that there is a clear distinction between appraisal and job planning, which is focused on determining the quantity and scope of a doctor's work to meet service and organisational objectives – and should be a process that is carried out at a separate meeting.

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in

discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

4. Governance arrangements

The RO is accountable to the Board for ensuring the implementation and operation of appraisals for all medical staff with whom the organisation has a "prescribed connection"; it is also a contractual requirement for all medical staff to participate in annual appraisal. Therefore, the objective will be to maintain an appraisal rate of 100% for medical staff over a twelve month period.

The Medical Appraisal and revalidation officer will provide monthly reports showing the appraisal rates for medical staff at organisational, Divisional and Directorate level and also show which appraisals are overdue. These monthly reports are circulated to (and should also be a standing agenda item at the monthly Divisional Board meetings):

- Clinical Directors, Divisional Medical Directors and the RO;
- Director of HR, Deputy Director of HR and HR Business Partners

We currently maintain our database of doctors by checking the monthly Starters and Leavers report supplied by the Workforce team. We also receive emails from the GMC documenting those doctors whom we have a responsibility for.

a. Policy and guidance

The Trust Medical Appraisal Policy was published September 2012 and then revised and re-published in November 2013.

5. Medical appraisal

a. Appraisal and revalidation performance data

Please See Annual Report Appendix A

b. Appraisers

We have 66 trained appraisers as at end of 2013/14. During this period we held 2 new appraiser training sessions provided by external facilitators. All previously trained appraisers had top up training prior to the commencement of revalidation. We held 3 appraiser forums to provide education and an opportunity to discuss the implementation of revalidation during the year; approximately half of our appraisers attended at least one of these.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

c. Quality assurance

The organisation will be monitoring the quality of the appraisal process and its outputs through:

- Appraiser self-assessment using standardised forms (Audit to be completed in 2014/15)
- Appraisee feedback on their appraisal using periodic questionnaires(Audit to be completed 2014/15)
- Internal review of appraisal inputs and outputs (see below)

Appraisers have been provided with access to a self-assessment questionnaire, this can be completed as part of their own appraisal and included in their portfolio of Supporting Information for discussion during their appraisal: any developmental needs for Appraisers can then be identified during their appraisal and appropriate actions recorded in their PDP.

- Periodically, the Trust will invite a sample of appraisees to complete a standardised questionnaire reviewing the effectiveness of their appraisal and the appraisal process.

A sample of completed online appraisal forms (119) has been reviewed in 2013/14 by the Trust Medical Appraisal Lead. The sample comprised all doctors that have required a revalidation recommendation during this period. The aim of this review was to assess the content of the appraisal inputs and outputs and the extent to which they provided evidence of the quality of the appraisal. Also to ensure the presence of the minimum mandatory supporting evidence documents as stipulated by the GMC. On first review the majority of the 119 did not have sufficient supporting evidence. However this was subsequently added to ensure all those requiring revalidation recommendations meet the GMCs minimum requirements.

No doctor was given a positive recommendation until they had provided the mandatory supporting evidence including clinical governance information from all places of work, mandatory training report, MSF (patient and colleague) evidence of adequate CPD, a PDP and completed appraiser summary and outputs.

For the individual appraiser:

At present we have no formal process for quality assurance of appraisers. Informally on review of completed forms assessment of the quality of the appraisal summary has been undertaken by the Trust medical appraisal lead. This may or may not reflect the quality of the actual appraisal meeting. The Trust medical appraisal lead has observed 2 appraisals and provided feedback to the individual appraisers.

3 appraiser forums have been provided to inform and educate the appraisers of the new expectations of enhanced appraisal, approximately half of the appraisers have attended at least one. Attendance at a minimum of 2 per year will be mandated for 2014/15 along with completion of the self-assessment form for their own appraisal.

(See **Annual Report Template, Appendix B;** Quality assurance audit of appraisal inputs and outputs)

d. Access, security and confidentiality

Appraisal folders are provided by a web based system that is password protected. There is the capacity to lock documents for only the appraisee, appraiser, RO and delegate to see. The system meets the highest standards of IT security and document storage.

There are warnings not to upload documents with patient information and advice to anonymise. No audit of information governance has been undertaken.

e. Clinical governance

Corporate data is used for individual doctors to contribute to supporting information. The clinical governance team provide individuals a report for appraisal which includes any clinical incident and/or complaint recorded on the Trust database linked to them in any capacity, any registered audit activity and participation in guideline review or publication.
A similar report or statement is required from any other place of work of an individual as supporting evidence.

6. Revalidation recommendations

Number of recommendations between April – March – **91**

Recommendations completed on time **90***; not on time* – **1**

Positive recommendations - **67**

Deferrals requests - **24**

Non engagement notifications - **1**

Reasons for all missed or late recommendations – **RO Delegate on leave**

Please see **Annual Report Appendix C;** Audit of revalidation recommendations

7. Recruitment and engagement background checks

See **Annual Report Appendix E**

Audit of recruitment and engagement background

8. Responding to Concerns and Remediation

See **Annual Report Appendix D**

9. Trinity Hospice

We have recently agreed to be the responsible body for Trinity Hospice doctors. This currently consists of 2 doctors, both of whom will be undergoing appraisals in line with our Appraisal Policy. Currently they have no doctors undergoing investigation or partaking in remediation. They have provided assurance to the RO that they are able to fulfil the requirements for governance information and in due course the RO will make appropriate recommendations for revalidation.

10. Improvement plan and next steps

To reduce the delay in the collection of patient multisource feedback we are aiming to introduce an electronic service that is able to constantly collect responses.

To improve the quality of appraisals, we will be collecting feedback on individual appraisers to allow them to reflect on their appraisal skills and address any learning needs.

In line with GMC guidance, we will be re-allocating appraisees to new appraisers next year, which may require cross specialty appraisals to commence.

11. Recommendations

1. Board to accept report. Please note it will be shared, along with the annual audit, with the higher level responsible officer and to support any resource requirements to deliver a higher standard of appraisal.
2. Board to approve the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations

Annual Report Template Appendix A

Audit of all missed or incomplete appraisals audit

Doctor factors (total)	**54**
Maternity leave during the majority of the ‘appraisal due window’	3
Sickness absence during the majority of the ‘appraisal due window’	1
Prolonged leave during the majority of the ‘appraisal due window’	0
Suspension during the majority of the ‘appraisal due window’	1
New starter within 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	0
Postponed due to incomplete portfolio/insufficient supporting information	48
Appraisal outputs not signed off by doctor within 28 days	1
Lack of time of doctor	0
Lack of engagement of doctor	0
Other doctor factors	0
(describe)	
Appraiser factors	**1**
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	1
Lack of time of appraiser	0
Other appraiser factors (describe)	0
(describe)	
Organisational factors	**8**
Administration or management factors	0
Failure of electronic information systems	8
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

Annual Report Template Appendix B

Quality assurance audit of appraisal inputs and outputs

Total number of appraisals completed		290
.	Number of appraisal portfolios sampled - 119	Number of the sampled appraisal portfolios deemed to be acceptable against standards – 119*
Appraisal inputs	119	119
Scope of work: Has a full scope of practice been described?	119	119
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	119	119
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	119	119
Patient feedback exercise: Has a patient feedback exercise been completed?	Yes – if within their allocated MSF year	
Colleague feedback exercise: Has a colleague feedback exercise been completed?	119	119
Review of complaints: Have all complaints been included?	119	119
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	119	119
Is there sufficient supporting information from all the doctor's roles and places of work?	119	119
Appraisal Outputs		
Appraisal Summary	119	119
Appraiser Statements	119	119
PDP	119	119

*****As explained in the report, the sample reviewed was every doctor being revalidated in 2013/14 and therefore time and effort was spent informing the doctor of inadequate supporting information and providing assistance in completing the portfolio until each was deemed acceptable and therefore a revalidation recommendation could be made

Annual Report Template Appendix C

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2013 to 31 March 2014	
Recommendations completed on time (within the GMC recommendation window)	**90**
Late recommendations (completed, but after the GMC recommendation window closed)	**1**
Missed recommendations (not completed)	**0**
TOTAL	**90**
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	**0**
New starter/new prescribed connection established within 2 weeks of revalidation due date	**0**
New starter/new prescribed connection established more than 2 weeks from revalidation due date	**0**
Unaware the doctor had a prescribed connection	**0**
Unaware of the doctor's revalidation due date	**0**
Administrative error	**0**
Responsible officer error	**0**
Inadequate resources or support for the responsible officer role	**0**
Other	**1**
Describe other – RO Delegate on leave	
TOTAL [sum of (late) + (missed)]	**1**

Annual Report Template Appendix D

Audit of concerns about a doctor's practice

Concerns about a doctor's practice	High level	Medium level	Low level	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern				Number
Capability concerns (as the primary category) in the last 12 months		1	1	2
Conduct concerns (as the primary category) in the last 12 months	2	4	7	13
Health concerns (as the primary category) in the last 12 months				0
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2014 who have undergone formal remediation between 1 April 2013 and 31 March 2014 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*				3
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				0
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				2
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All DBs				1

Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All DBs	0
TOTALS	3
Other Actions/Interventions	
Local Actions:	0
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included	1
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	0
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	2
GMC Actions: Number of doctors who:	
Were referred to the GMC between 1 April and 31 March	1
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	2
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	1
Had their registration/licence suspended by the GMC between 1 April and 31 March	1
Were erased from the GMC register between 1 April and 31 March	1
National Clinical Assessment Service actions:	0
Number of doctors about whom NCAS has been contacted between 1 April and 31 March:	
For advice	9
For investigation	0
For assessment	1
Number of NCAS investigations performed	0
Number of NCAS assessments performed	0

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 July 2014 (PUBLIC)

AGENDA ITEM NO.	4.1/Jul/14
PAPER	Finance Report – June 2014
AUTHOR	Carol McLaughlin, Assistant Director of Finance – Financial Management Virginia Massaro, Assistant Director of Finance – Contracts & Information
LEAD	Rakesh Patel, Director of Finance
PURPOSE	To report the financial performance for June 2014
LINK TO OBJECTIVES	Deliver financial sustainability
RISK ISSUES	Risk of Trust not delivering financial plan. Risk Rating: Impact 4 – Major (between £1.0m loss & £4.9m loss) Likelihood 4 – Likely Total Rating: **Red**
FINANCIAL ISSUES	See below
OTHER ISSUES	N/A
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	The Trust delivered: • In month surplus of £0.04m in June against a planned £1.2m surplus. • Year to date a net deficit of £0.8m against a planned £2.4m surplus. The year to date EBITDA was 6.4% against a plan of 9.9%. The key drivers for the 1st quarter position is:

	1) Slower delivery of the Cost Improvement Programme (CIPs) than required. 2) An increase in expenditure on pay. 3) Under-delivery of private patients' income. However, the above items are partially offset by clinical income being higher than planned. The year to date Continuity of Service Risk Rating (CoSRR) for the first quarter remains at 3 which is in-line line with the plan. The year-forecast, based on the first quarter performance and projected financial performance over the next nine months, is £3.4m surplus. The forecast CoSR remains at 3. The Trust has put in place mitigation plans to deliver the financial plan. This includes, staff briefings, additional controls on expenditure, weekly Executive review of mitigations and greater scrutiny on private patients income. The cash position as at 30th June 2014 is £15.2m.
DECISION/ ACTION	The Trust Board is asked to note the financial position for June 2014.

Finance Report for the period ending June 2014 (Month 3)

1. Introduction

1.1. This report provides the Board with a commentary on the financial performance for the quarter ending June 2014.

2. Background

2.1. The Trust posted a deficit of £0.8m in the first quarter against a plan of £2.4m surplus.

2.2. CIP achievement continues to be a significant challenge with a year to date £3.3m adverse variance.

2.3. A mitigation plan, which is detailed section 3.4 below, has been put in place address the shortfall posted in the first quarter.

2.4. The forecast is for a surplus of £3.4m against a plan of £7.0m which is an adverse variance of £3.6m.

3. Detail

3.1. NHS and Local Authority clinical income

3.1.1. NHS and Local Authority Clinical contract income was £1.2m ahead of plan for the three months to the end of June. The over-performance has primarily been in elective, maternity and outpatient activity, particularly in elective surgical specialties to address waiting list pressures and GUM outpatients.

3.1.2. Elective inpatient activity reported an over-performance of £0.2m for the period, continuing the trend above observed during the final quarter of 2013/14. This was primarily driven by adult surgical specialties, particularly orthopaedic and general surgery elective and day cases due to additional capacity put on to address 18 week pressures. Dermatology phototherapy regular day attenders also continued the improvement seen in March and were £0.1m ahead of plan for the quarter.

3.1.3. Non-elective inpatient income was £0.6m behind plan in for the period to the end of June, including adjustments made under the block contract agreed with local Commissioners. Emergency admissions have increased and the Trust is engaging with Commissioners to rebase the block contract. The contract with NHS England for specialist services remains on a PbR basis. However, this contract is underperforming by £0.8m in areas such as paediatric gastroenterology, general medicine and burns care

3.1.4. Outpatient attendances were also above plan, reporting a £1.1m favourable variance to the end of June. There are two main over-performing specialities, GUM (£0.7m) following the opening of Dean Street Express at the end of 2013/14 and obstetrics (£0.3m). These specialties are not included in the local CCG block on outpatients agreed for 2014/15

3.1.5. NHS clinical contract income relating to other points of delivery was £0.6m ahead of plan for the quarter. Within this, A&E and UCC activity was ahead of plan by £0.3m, due to continued high levels of attendances and ambulance transfers following the trend observed during March 2014.

3.2. Other income

3.1.1 In Month 3, private patient income was below plan by £0.4m and is now behind plan year to date by £1.1m. This is mainly attributed to the Chelsea Wing, although income continues to be marginally up from previous year income, the key driver behind the under-performance relates to available theatre access and uptake by consultants. Additional theatre sessions have now been ring-fenced for private patient activity and the forecast assumes improved private patient income for the remainder of the year.

3.3. Expenditure

3.1.2 There was an adverse variance for pay in month 3 of £0.7m, and year to date adverse variance of £2.8m. This is primarily driven by unidentified CIPs of £0.8m in month and £3.3m year to date. There continues to be pressures within the pay expenditure across all staffing groups. Staff costs were £0.4m higher in June compared to the last three months of the previous financial year.

3.1.3 Clinical supplies are overspent by £0.4m in June and £0.7m year to date. This is across a number of clinical supplies categories and activity cost pressures associated with additional activity including RTT and CIP slippage on some procurement led initiatives.

3.1.4 Non-clinical supplies are underspent by £0.4m in June and £0.7m year to date relating to the release of contingency.

3.4. Forecast and Mitigation Plan

3.4.1. The current mitigated forecast is for a £3.4m surplus for the Trust (which is a £3.6m adverse variance against a £7.0m planned surplus).

3.4.2. The Trust has put in place a mitigation plan to address the deterioration in quarter one. They are:

- The Trust is engaging with local commissioners to increase the value of the contract based on increased emergency activity. This has been discussed with the commissioners at the Emergency Care Transformation Board. Further discussions are due to take place at the contract monitoring meeting.
- Additional ring-fenced theatre sessions for private patients have been identified and came on-stream in July. This is part of the new operational private patient plan which is being implemented.
- There are targeted staff briefings so that all staff are aware of the financial position and have the opportunity to contribute to the solutions.

- Areas of increased expenditure have been identified to assist divisional managers to focus on specific areas. Additional controls and approval routes have also been implemented. There will be greater oversight at the Financial Review meetings to ensure that these controls are implemented in full.
- Fortnightly Financial Reviews, chaired by the COO and DoF, have continued from last year. These meetings are used primarily for deep dives into the divisional action plans, CIPs and a forward look into activity and pay.
- The Divisions are conducting service line reviews, using the Trust's SLR and patient level information, to identify areas of efficiencies.
- The Trust has commissioned Dr Foster to undertake analysis of clinical and operational information in T&O and Paediatrics to identify areas of variability and opportunities for efficiencies. If these pilots prove successful, the approach will be rolled out to other specialities.
- The Trust has begun working with three other Trusts to identify opportunities for procurement savings. This builds on the current arrangement of CWFT and Marsden having a joint Procurement department.
- The Trust is working on two significant transformational programmes – Emergency Pathway and the Elective Care Pathway.
- A specification is also being finalised to engage a strategic partner to work with the Trust to embed transformational change.
- There will be weekly review by the Executive Directors on the progress of this plan.

3.5. Continuity of Services Risk Rating (COSR)

3.5.1. The Trust remains at a CosRR of 3 as planned.

3.6. Loans

3.6.1. There was no drawdown against the loans from the Independent Trust Financing Facility (ITFF) but is planned for later in the financial year.

3.7. Capital

3.7.1. The capital plan for 2014/15 is £30.1m. The year to date capital expenditure year is £0.4m behind the plan. The capital plan will be reviewed against the current financial position.

3.7.2. Building projects completed in this quarter include Outpatients 3, Phlebotomy and Children Outpatients. These projects were started last financial year.

3.7.3. Emergency Department Expansion: Tenders have been received and are being reviewed before being awarded to a contractor. The Emergency Department buildings are anticipated to start in August 2014.

3.8. Cash flow

3.8.1. The cash position at June is £15.2m. The current deficit is impacting on the cash balance. The Trust has strengthened its debt management by: having more senior input and review at an earlier stage, more frequent and earlier engagement with debtors and earlier escalation.

3.8.2. The Trust has reviewed and reduced the capital programme to improve liquidity and maintain a CoSRR of 3 at year end.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 July 2014 (PUBLIC)

AGENDA ITEM NO.	4.2/Jul/14
PAPER	Performance Report – June 2014
AUTHOR	Virginia Massaro, Assistant Director of Finance – Contracts & Information
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 2014.
OBJECTIVES	This paper reports progress on a number of key performance areas which support delivery of the Trust's overarching aims.
RISK ISSUES	None.
FINANCIAL ISSUES /OTHER ISSUES	None.
LEGAL REVIEW REQUIRED?	No
EXECUTIVE SUMMARY	The Trust continues to meet all key performance indicators for Monitor, with the exception of planned non-achievement of RTT 18 weeks admitted patient pathways and has shown overall good performance throughout the first quarter and June 2014. The Trust maintained good performance on patient safety, meeting the challenging CDiff and MRSA targets for the first quarter. The Maternity team have sustained a reduction in the caesarean section rate in June to below 30% with the Midwifery led unit continuing to successfully promoting natural birth. The Trust is also on track to achieve its Q1 CQUIN targets for the NWL contract. The A&E department continued to be under pressure during June following on from the trend seen over the last 4 months, with higher acuity of cases and some evidence of ambulance conveyances clustering together and potentially transfer of trauma work from the Charing Cross area. These issues are under further investigation and discussion with LAS and commissioners. Although the Trust did not meet its internal stretch target of 98% of patients seen in less than 4 hours in June, we remain fully compliant with the Monitor and contractual target of 95% (at

	96.9% for June). Areas for focus are primarily around the Planned Care Pathway where a planned reduction in RTT Admitted Pathways compliance is under way as part of the recovery plan to treat a backlog of patients awaiting surgery as quickly as possible in the first half of 2014/15. The Trust was awarded £1.4m of national funding to support the backlog recovery action plan and revised specialty level trajectory to achieve compliance by the end of September 2014. The Planned Care transformation work is also reviewing theatre efficiency and day case/length of stay, particularly focusing on enhanced recovery. There is also ongoing work required on reducing pressure ulcers and on a number of Best Practice clinical effectiveness measures such as care bundle compliance and nutritional screening, which are being addressed through a number of focus working groups. On patient experience, improved performance was seen in the response rates for the Friends and Family Test due to new ways of offering the survey in May and June and the first quarter CQUIN target was achieved. Work is continuing to improve complaint turnaround times and address issues and themes identified through complaints.
DECISION/ ACTION	The Trust Board is asked to note this report.

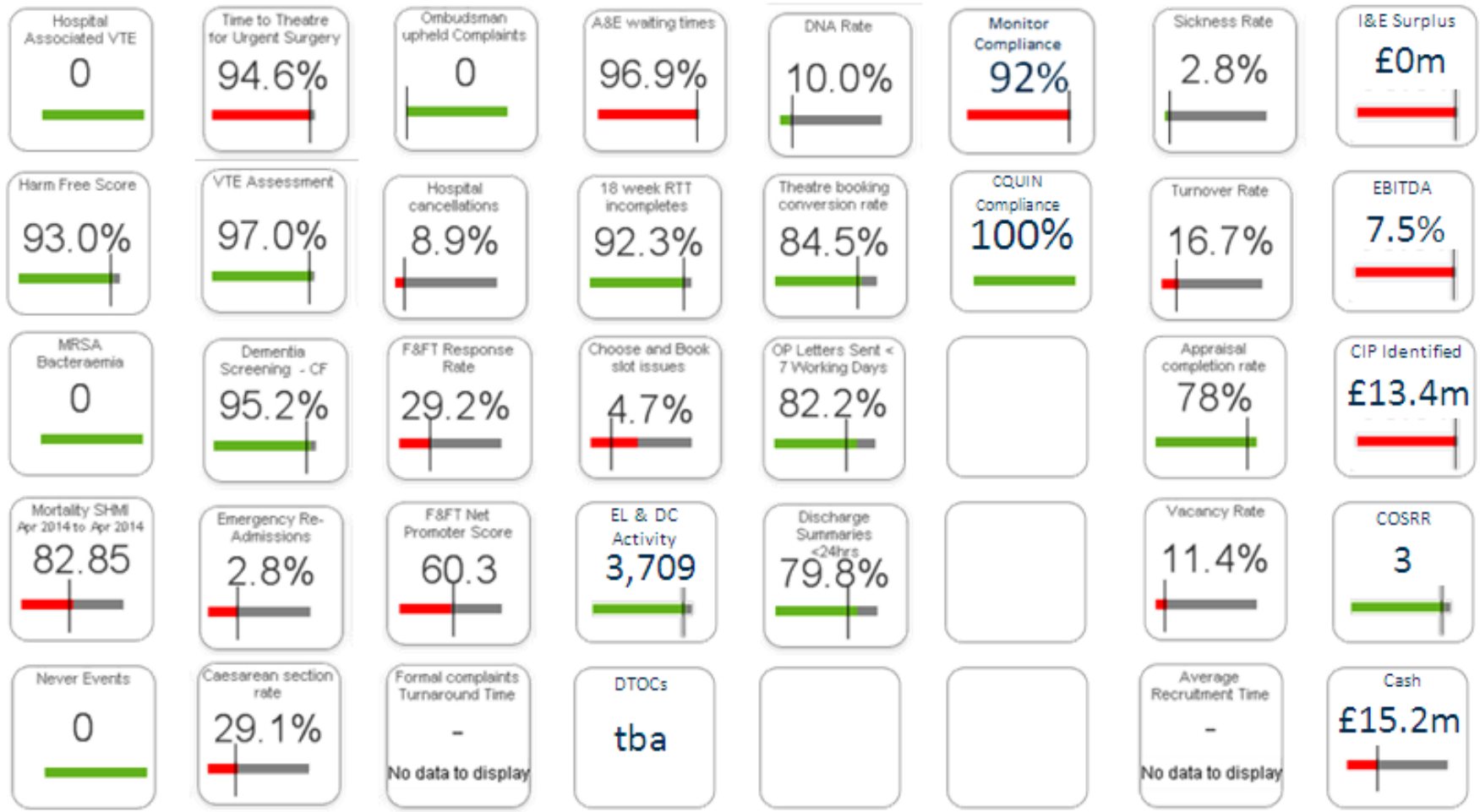
Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Corporate Performance Report

Performance to 30th June 2014

At a Glance Performance – June 2014

Chelsea and Westminster Hospital NHS
NHS Foundation Trust



Trust Headlines – 2014

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Monitor Compliance – June 2014

Sub Domain	Trust Level Monthly Data @ 17/07/2014 XL				YTD XL
	MonthYear	Jun 2014	May 2014	Apr 2014	01/04/2014
Harm	Clostridium difficile infections (Target: < 0.67)	0	0	2	2
	MRSA Bacteraemia (Target: < 0)	0	0	0	0
Cancer	Cancer diagnosis to treatment waiting times - 31 Days (Target: > 96%)	100.0%	100.0%	100.0%	100.0%
	Cancer diagnosis to treatment waiting times - Subsequent Surgery (Target: > 94%)	N/A	100.0%	100.0%	100.0%
	Cancer diagnosis to treatment waiting times - Subsequent Medicine (Target: > 98%)	N/A	100.0%	100.0%	100.0%
	Cancer urgent referral GP to treatment waiting times (62 Days) (Target: > 85%)	93.3%	82.6%	100.0%	93.2%
	Cancer urgent referral Consultant to treatment waiting times (62 Days) (Target: > 90%)	100.0%	N/A	N/A	100.0%
	Cancer urgent referral to first outpatient appointment waiting times (2WW) (Target: > 93%)	94.0%	94.7%	97.0%	95.2%
RTT	18 week referral to treatment times Admitted Patients (Target: > 90%)	79.3%	82.2%	86.4%	82.6%
	18 week referral to treatment times Non Admitted Patients (Target: > 95%)	96.4%	97.6%	96.3%	96.8%
	18 week RTT incomplete pathways (Target: > 92%)	92.3%	92.7%	92.1%	92.3%
A&E	A&E waiting times (Target: > 98%)	96.9%	97.8%	97.3%	97.3%
LD	Self-certification against compliance with requirements regarding access to healthcare for pe...	Compliant	Compliant	Compliant	Compliant

*The Monitor MRSA de minimus target is 6 cases, however we measure against a stretch target of 0

*The Monitor A&E target is 95% under 4hr wait, however we measure against an internal stretch target of 98%

Performance Headlines

Improvements

- Compliant with all Monitor indicators for the quarter, with the exception of planned non-compliance of 18 week RTT admitted patients. Work continues to reduce the admitted waiting list backlog as part of the accelerated trajectory. The Trust has been awarded national funding to assist with this backlog reduction.
- Continued achievement of MRSA and CDiff targets, with no cases in June
- On track for North West London CQUIN Q1 targets
- Improvement in DNA rates in June
- Maternity indicators have shown an improvement in June, particularly for caesarean section rates and waiting times following prospective management by the team.
- Reported best performance in London on Cancer 62 day waiting times in 2013/14

Challenges

- The Trust has continued to see challenges in achieving the 4 hour A&E waiting times due to significant increases in attendances in 2014/15, however remains above the Monitor target of 95%.
- Focus on reducing the number of newly acquired pressure ulcers continues, including rolling out and implementing the Pressure Ulcer Care Bundle.
- Work continues to improve day case and elective length of stay, with a particular focus on enhanced recovery.
- Continued choose and book slot issues, particularly in paediatric specialties currently being reviewed.
- Under achievement of reduction of inpatient falls, action is underway, particularly focussing on the highest fall categories

CQUIN Update – Q1

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

CQUIN Title	Summary	Lead (Exec)	Value	Apr	May	June	Q1 Performance
Friends and Family Test	Implementation of staff FFT; Roll out Patient FFT to new areas (OP and DC) Increase response rate in A&E to 20% and Inpatients to 30%	Sian Nelson (Libby McManus)	£75k NHSE £186k NWL	Achieved A&E 3.2% IP 21.9	Achieved A&E 22% IP 39.7%	Achieved A&E: 25.9% IP: 32.3%	Achieved
NHS Safety Thermometer	Data collection and a 25% reduction in Pressure Ulcer prevalence by year end (this equates to <3.45% PU per month in ALL (new and existing community acquired) Pus	Holly Ashforth (Libby McManus)	£75k NHSE £186k NWL	3.4%	4.8 %	4.2%	Implementation of the Pressure Ulcer Care Bundle – to rolled across the Trust
Dementia	Identification/Referral of 90% of patients at risk, clinical leadership and supporting carers	Sarah Bryan (Libby McManus)	£75k NHSE £372k NWL	Find: 97 % Assess: 100 % Refer: 100%	Find: 93% Assess: 100 % Refer: 100%	Find: 95% Assess: 100 % Refer: 100%	Achieved
Shared Patient Records and Real Time Information Systems	Implementation of EPR Core to access GP record Provision of Discharge Summaries to GPs in real time and electronically Implementation of NWL Diagnostic Cloud	Bill Gordon (David Radbourne)	£447k	N/A 63% N/A	N/A 66% N/A	N/A 64% N/A	Action Plan Completed Achieved Action Plan Completed
Improving the Emergency Care Pathway	Implementation of Day of Care Audits in A&E and wards and improvement in % of inappropriate admissions/stays. Notify to GP within 24hrs all non-elective admissions	Alison Kingston (David Radbourne)	£298k	N/A 99%	N/A 100%	N/A 99%	DOCA signed off at ECB Achieved
Improving the Planned Care Pathway	Complete roll-out of Co-ordinate My Care Improving the efficiency of planned care pathways to enable a reduction in outpatient activity	Karen Robertson (Libby McManus)	£670k NA	N/A	N/A	N/A	Report Q4 Action Plans to be completed
Planning and implementation of "seven day services" program	An action plan towards key seven day services standards Weekend consultant cover 12hrs on site for A&E; Weekend acute surgical and medical ward rounds daily; Weekend nurse led discharge Seven day access to diagnostic services	Alison Kingston (David Radbourne)	£670k	N/A	N/A	N/A	Action Plans to be completed
GP / Patient Access	GP Urgent Access Telephone number GP Routine Web Query form Single point of access for patient appointment / admission queries	Justine Currie / Mike Delahunty (Zoe Penn)	£894k	N/A	N/A	N/A	Actions complete

CQUINs schemes for quarter 1 are currently being finalised, with the draft Q1 performance figures shown in this table.

National Schemes:

Friends and family test has been implemented for staff at the end of quarter 1 and the response rates in A&E and inpatients have improved in May and June resulting in the quarterly targets to be fully achieved.

NHS Safety Thermometer – on track for the first quarter, but there is a year-end target on delivering a 25% reduction in pressure ulcer prevalence by year end, which is very challenging.

Dementia – Q1 targets fully achieved.

Local Schemes:

Local CQUIN schemes are on track for the first quarter, most of the indicators relate to action plans being signed off by commissioners. The local CQUIN schemes have been aligned to either the joint emergency care, planned care boards, or the joint IT specific group and action plans will be discussed and agreed through these groups.

The roll out of Co-ordinate My Care is a year end target and therefore there are no milestones in Q1.

Q1 CQUIN schemes will be formally signed off at the NWL Clinical Contract Group in August.

Patient Safety

Trust Level Monthly Data @ 17/07/2014 XL

Sub Domain	Month Year	Jun 2014	May 2014	Apr 2014	YTD 01/04/2014
Harm	Confirmed Incidents of Hospital Associated VTE (Target: = 0)	0	0	2	2
	Inpatient falls per 1000 Inpatient bed-days (Target: < 3.00)	4.03	3.98	4.36	4.12
	Incidence - Newly Acquired Pressure Ulcers Grade 2 (Target: <1)	7	9	6	22
	Incidence - Newly Acquired Pressure Ulcers Grade 3 and 4 (Target: <3)	3	1	2	6
	Safety Thermometer - Newly Acquired Pressure Ulcers (Target: < 4)	5	8	4	17
	Safety Thermometer - Harm score (Target: > 90%)	93.0%	94.3%	94.3%	93.9%
HCAI	Clostridium difficile infections (Target: < 0.67)	0	0	2	2
	MRSA Bacteraemia (Target: < 0)	0	0	0	0
	Hand Hygiene Compliance (trajectory) (Target: > 90%)	97.4%	96.9%	96.9%	97.0%
	Screening all elective in-patients for MRSA (Target: > 95%)	91.9%	88.3%	94.1%	91.7%
	Screening Emergency patients for MRSA (Target: > 95%)	97.0%	96.5%	97.2%	97.0%
Incidents	Rate of pt. safety incidents resulting in severe harm - death per 100 admissions (Target: >)	0	0	0	0
	Never Events (Target: = 0)	0	0	0	0
Pathways	Stroke: Time spent on a stroke unit (Target: > 80%)	100.0%	100.0%	100.0%	100.0%
	Proportion of people with higher risk TIA who are scanned and treated within 24 hours. (Target: > 75%)	66.7%	100.0%	100.0%	93.8%
	Fractured Neck of Femur - Time to Theatre < 36 hrs for Medically Fit Patients (Target: = 100%)	85.7%	93.3%	85.7%	88.4%
Mortality	Mortality (HSMR) (2 months in arrears) (trajectory) (Target: < 71)	N/A	N/A	N/A	N/A
	Mortality SHMI (Target: < 77)	82.8	82.8	82.8	82.85

Inpatient Falls:
Whilst we remain over our target of falls per 1000 bed days in June, there has been a reduction coupled with an increase of admitted patients. The PHG group continue to focus on patients found on the floor and patients who fall on multiple occasions. These two areas contribute towards the highest category for patients who fall.

Newly Acquired Pressure Ulcers Grade 2 and Safety Thermometer Newly acquired Pressure ulcers:
In June, we have seen a slight reduction although remain above target. The POP project implemented on AAU has now been started on Lord Wigram along with the Trust wide roll out and implementation of the Pressure Ulcer Care Bundle.

MRSA screening, elective inpatients:
In June, this has improved although we remain below target. The process for screening is currently being reviewed to ensure that it is robust and enables better follow up for patients who have a positive result.

Fractured neck of Femur – Time to Theatre: In June 2 patients out of a total of 14 medically fit patients were unable to be operated on within 36 hours due to lack of available operating time. One of these patients had been admitted on a Saturday and the other on a Thursday. In order to help reduce waiting times for fracture neck of femur and achieve this target we will start a process to write the time that patients should be operated on the board in theatre reception. With the increasing demand for emergency surgery we will also continually assess whether to increase emergency lists, including on weekends. We are currently considering implementing a second on-call team who could be called in as necessary.

Proportion of people with higher risk TIA:
The Trust does not have a TIA clinic over the weekend and as such, all high risk patients should be transferred to Charing Cross Hospital. The pathway for this is clear and available to all acute clinicians but on occasion, the pathway is not followed. The Stroke team will re-iterate the pathway to the medical teams to remind them of the need to refer to Charing Cross at weekends. The numbers of high risk TIA patients are very low and although the drop in percentage performance in June is high, there was one breaching patient.

Safe Nursing and Midwifery Staffing

Ward Name	Average fill rate registered nurses/midwives (%) day shift	Average fill rate care staff (%) day shift	Average fill rate registered nurses/midwives (%) night shift	Average fill rate care staff (%) night shift
Maternity	75.7%	78.8%	74.0%	70.8%
Annie Zunz	100.0%	100.0%	100.0%	100.0%
Apollo	87.4%	na	94.7%	na
Jupiter	127.2%	na	136.7%	na
Mercury	96.8%	100.0%	100.7%	123.5%
Neptune	98.3%	56.7%	110.0%	50.0%
NICU	103.8%	na	103.2%	na
AAU	115.1%	92.5%	131.9%	140.0%
Nell Gwynn	92.2%	124.2%	118.3%	168.9%
David Erskine	95.0%	183.3%	96.7%	196.7%
Edgar Horne	99.3%	139.2%	125.0%	154.2%
Lord Wigram	88.7%	126.7%	98.3%	161.7%
Rainsford Mowlem	95.7%	116.7%	102.2%	92.2%
David Evans	97.7%	94.5%	116.7%	100.0%
Chelsea Wing	85.9%	75.0%	100.0%	96.7%
Burns Unit	99.4%	226.9%	104.4%	240.0%
Ron Johnson	114.2%	113.3%	135.0%	116.7%
ICU	99.0%	0.0%	99.0%	na

Table 1

National Quality Board Report – Hard Truths expectations

The June fill rate data (table 1) is presented in the format as required by NHS England.

Definition

The fill rate percentage is measured by collating the planned staffing levels for each ward for each day and night shift and comparing these to the actual staff on duty on a day by day basis. The fill rate percentages presented are aggregate data for the month and it is this information that is published by NHS England via NHS Choices each month. The definitions for what should and should not be included/counted are provided by NHS England and are fairly complex. As this is a new initiative the definitions and guidance are subject to change on an ongoing basis.

Next steps

We are currently working on supplementary information which will provide a more meaningful context. This will include plan versus actual staffing, agency reliance and the professional view of staffing capacity and capability in the context of patient case mix and bed capacity.

Information in the future will also be reported alongside other metrics such as general workforce information (e.g. vacancies, sickness etc.) and considered in the context of the outcomes of the safety thermometer and other quality metrics.

Summary for June

Fill rate short fall- Although some areas did not achieve their planned staffing levels, none of the adult general in patient areas breached a nurse to patient ratio of more than 8 on the day shift, there were a handful (<10 shifts) where this was a potential but staff were redeployed from other areas to support. Where numbers fell below the plan, staffing levels were deemed to be professionally acceptable for the number of, and dependency of patients at that time.

There are significant pressures in the maternity staffing due to vacancy rate of 11.49%, sickness rate of 6.09%, a significant number of staff on maternity leave (15). To mitigate these risks the following actions have been taken; increased recruitment – 26 staff commencing in October/November, staff redeployed to prioritise labour : 1-1 care in labour maintained at 96% and midwifery ratio 1:31. The enhanced bank scheme is to be introduced to reduce the need for temporary (agency) staff.

Fill rate excess- A significant number of areas are reporting fill rates in excess of 100 % these are due in the main to additional activity (escalation areas being open), one to ones for patients at risk of falling and specialist RMN requirements for vulnerable mental health patients. A significant proportion of additional shifts are provided through agency staff, at premium cost and in excess of budgeted establishment. Further work is being undertaken to look at what appears to be significant reliance/ requirement for additional staff and to provide the Board with assurance that our current processes for managing this are robust .

Clinical Effectiveness

Sub Domain	Trust Level Monthly Data @ 17/07/2014 XL MonthYear	Jun 2014	May 2014	Apr 2014	YTD XL 01/04/2014
A&E	A&E Time to Treatment (Target: < 60)	68.0	66.0	68.0	67.0
	A&E waiting times (Target: > 98%)	96.9%	97.8%	97.3%	97.3%
	A&E: Unplanned Re-attendances (Target: < 5%)	6.09%	6.60%	6.92%	6.53%
	LAS arrival to handover more than 60mins (KPI 3) (Target: = 0)	0	0	2	2
Admitted Care	Day case rate Relative risk (Target: < 100)	108.7	109.0	103.9	106.8
	Elective length of stay relative risk (Target: < 100)	103.9	148.4	139.5	130.4
	Emergency Re-Admissions within 30 days (adult and paed) (Target: < 2.8%)	2.83%	3.33%	3.05%	3.07%
	Non-Elective length of stay relative risk (Target: < 100)	82.9	85.4	82.3	83.5
Best Practice	Time to theatre for urgent surgery (NCEPOD recommendations) (Target: > 95%)	94.6%	94.1%	89.4%	92.5%
	Central line continuing care—compliance with Care bundles (Target: > 90%)	100.0%	100.0%	100.0%	100.0%
	Peripheral line continuing care—compliance with Care bundles (Target: > 90%)	78.9%	95.2%	80.0%	85.0%
	Urinary catheters continuing care—compliance with Care bundles (Target: > 90%)	100.0%	100.0%	88.9%	96.4%
	% Patients Nutritionally screened on admission (Target: > 90%)	84.2%	85.7%	83.4%	84.4%
	% Patients in longer than a week who are nutritionally re-screened (Target: > 90%)	82.4%	78.5%	64.9%	74.5%
	Access to healthcare for people with a learning disability (Target: = 100%)	100%	100%	100%	100%
Best Practice CQUIN	VTE Assessment (Target: > 95%)	97.0%	96.9%	96.8%	96.9%
	Dementia Screening Case Finding (Target: > 90%)	95.2%	93.6%	97.1%	95.3%
	Appropriate referral Dementia specialist diagnosis (Target: > 90%)	100.0%	100.0%	100.0%	100.00%
	12 Hour consultant assessment - AAU Admissions (Target: > 90%)	59.1%	67.1%	70.6%	65.4%

12 hour consultant Assessment :

The 12 hour consultant assessment target is reported as non compliant, but manual audits have demonstrated that much of the issue lies with electronically capturing the time when patients are reviewed and that over 90% of patients are assessed within the timescale. There is therefore not concern regarding the quality of patient care and review. The Senior Divisional Management team will continue to promote electronic data capture further.

An additional two consultants will be placed in the Acute Assessment Unit from August with extended working hours which should also improve compliance.

A&E:
The A&E department has been underperforming against the majority of the clinical effectiveness targets for the 3rd month this year and as such, has not managed to achieve quarterly compliance against Trust targets. The reasons for this are an step increase in attendances, with two of the last four months having higher attendances than the peak number for any month of 2012/13 and 2013/14. The department is working to recover this position, by matching additional staff to work at peak times and to improve the speed of review and referral, but it is under significant pressure in terms of space and capacity.

The ED have been liaising with partners at the London Ambulance Service to try to ensure that C&W's ED does not receive patients who would have previously been referred to neighbouring units, before it is ready to do so (following its redevelopment). More information is included in the separate A&E recovery separate focus page.

Patients Nutritionally Screened:
Both targets were again missed in June, Ward sisters have been asked to encourage all patients to be screened. Both Ward sisters and charge nurses have also been reminded to review ward screening and given explicit instructions how to undertake the screening, in addition further training has been offered.

Peripheral line continuing care compliance:
An audit has been undertaken of the uncompliant peripheral lines and the main reasons for non compliances are nurses not labelling the administration sets and not recording the cannula insertion in the medical notes. An IV care bundle action group has been set up to review how to improve compliance and will meet for the first time at the end of July.

Clinical Effectiveness – Maternity

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

	Indicator		Target	Measure	Apr	May	Jun
Activity	NHS Deliveries	Benchmarked to 5042 per annum	420 per month	NHS	417	405	422
	Private Deliveries	Benchmarked to 840 per annum	72 per month	PMU	62	76	71
	Trust Deliveries	Total Maternities (Mother)	492	Trust	479	481	493
	Estimated Date of Delivery	Forecast deliveries from Booking EDD			554	585	571
		Attrition Rate: EDD / Actual deliveries (all)			13.5%	17.8%	13.7%
		Attrition Rate: EDD / Actual deliveries (NHS)			24.7%	30.8%	26.1%
	Total NHS Births (infants)			NHS	424	417	428
	Births	Birth Centre (excludes transfers)		No. of patients	62	76	79
		Rate of Trust total SVD (NHS)		%	37.4%	31.6%	36.1%
		Home births - rate of NHS maternities		% NHS Dels	1.2%	1.2%	1.2%
	Norm. Vaginal Deliveries	SVD (Normal Vaginal Delivery)			222	212	219
		Maintain normal SVD rate	52%	SVD Rate	53.2%	52.3%	51.9%
	C- Section	Total C/S rate overall	<29%		29.3%	32.1%	28.4%
		Emergency C Sections		No. of patients	59	65	66
			<15%	%	14.1%	16.0%	12.8%
		Elective C Sections		No. of patients	63	65	83
			<11%	%	15.1%	16.0%	19.7%
	Assisted Deliveries	Ventouse, Forceps Kiwi		No. of patients	73	62	83
			10-15% (SD)	%	17.5%	15.3%	19.6%
Risk	Maternal Morbidity	Maternal Death		Incident Form	0	0	0
		ITU Admissions in Obstetrics	In 2 mths < 6	Patients	1	1	0
	Serious Incidents	Serious Incidents (Orange Incidents)	0	Incidence	3	3	2
	VTE	Assessments	95%		97.0%	98.0%	97.6%

	Indicator		Target	Measure	Apr	May	Jun
Clinical Indicators	PP Heamorrage	Blood loss >2000mls	<10	PPH>2L	11	3	5
		Blood loss >4000mls		No. of patients	1	0	0
	Perineum	3rd/4th degree tears	<5% (RCOG)		7	10	9
					2.40%	2.40%	3.00%
	Stillbirths	Number of Stillbirths			3	2	4
	Readmissions	Neonatal < 28 days of Birth (Feeding)			4	5	2
		Of which were born at C&W			2	5	4
PbR	Pathways	GP referrals received			1004	972	958
		Antenatal Bookings completed	528		467	539	492
		Ref by 11w			357	380	383
		% Ref by 11w			76%	71%	78%
		KPI: % Ref by 11w and seen by 12+6w	95%		93.0%	91.8%	96.1%
		Breaches (11w ref and booked > 12+6w			25	31	15
		Postnatal discharges	221		222	214	238
	Antenatal Casemix	Standard	64.60%	Risk factors at Booking	62.8%		
		Intermediate	28.50%		25.5%		
		Intensive	6.90%		11.7%		
KPI	Trust Level Indicators	NBBS - offered and discussed	100%		100%	100%	100%
		Maternity Unit Closures		LSA Db	0	0	0
		1:1 care	100%		93.5%	93.2%	96.5%
		Breastfeeding initiation rate	90%		90.2%	91.9%	93.4%
		Women smoking at time of delivery	<10%		1.20%	0.70%	0.10%
		Midwife to birth ratio - Births per WTE	01:30		01:33	01:32	01:31
		DSUMs complete & sent in 24hrs	80%		71.6%	49.1%	50.5%

12+6:

96.1% in June, which is above the target. Improvement from April & May following prospective look at all bookings and escalation to matron for all cases where capacity not immediately available.

Activity:

NHS deliveries were 12 above plan in month. Private deliveries were on plan. Antenatal booking numbers continue to be above plan. 18% of all births are now delivered on the birthing unit.

Caesarean Section:

C-Section rate was 28.6% June, 9% decrease vs June 2012.
Birth unit C-Section rate for June was 7%
C-Section rate includes private patients and differs from rate on page 2 which is for NHS patients only.

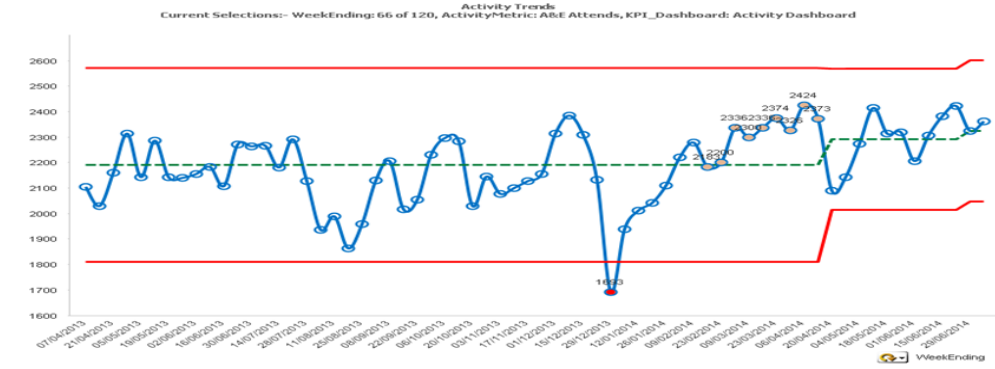
Clinical Effectiveness – Focus on A&E Recovery

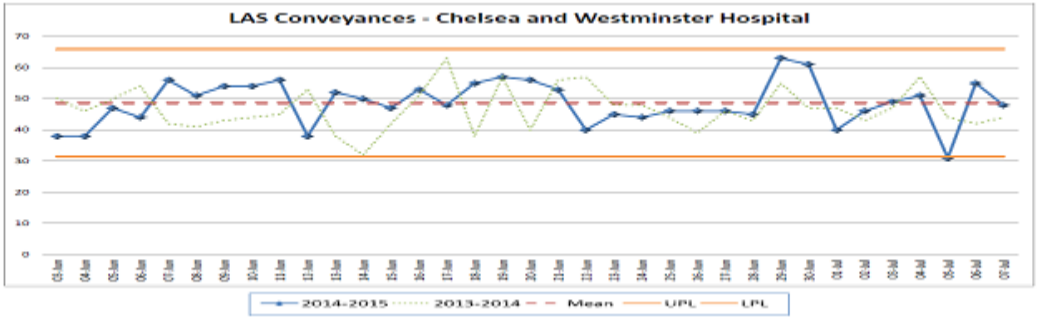
Chelsea and Westminster Hospital NHS
NHS Foundation Trust

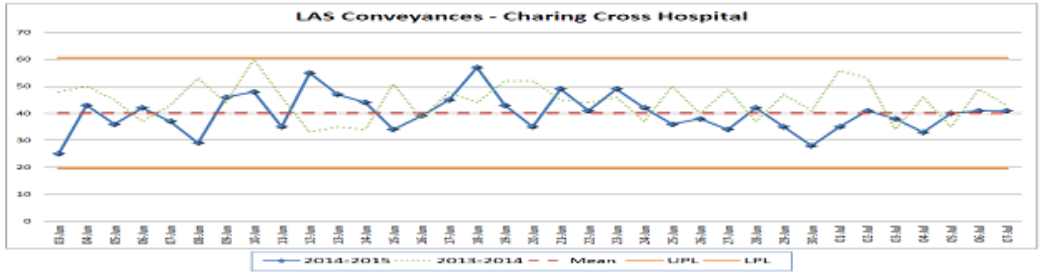
2014/15 Year to date ED Performance - < 4 hours wait percentage

Month Year	% < 4 hours	4 Hr Breaches	Attendances
Apr-14	97.34%	257	9660
May-14	97.79%	225	10175
Jun-14	96.86%	314	10145
Totals	97.34%	**796**	**29980**

SPC Chart – Overall ED attendances April 2013 – June 2014







Since February 2014, the Trust has seen a statistically significant increase in Emergency Department (ED) attendances and has such has been struggling to achieve 98% performance for the 4 hour waiting times standard. This position has worsened since February and for the month of June the Trust achieved 96.9% (against a national standard of 95%, but a Trust target of 98%). Some of the other indicators relating to ambulance handover times have also deteriorated and there have been 2 breaches of the 60 min ambulance handover times over the quarter. It should be noted however, that whilst very disappointing, no harm came to any of these patients and this is also a much smaller number of breaches than most of the other acute hospitals in NW London.

The Trust has seen a step increase in the number of attendances to the ED over the last four months (although still within control limits). If the Trust receives a higher than average number of ambulances and conversion to admissions, it can take several days to 'recover' as bed capacity is constrained. The Trust does communicate with partners at the London Ambulance Service, especially at times of pressure, but this is not always effective as it could be. Work is underway to see if the growth in attendances has been genuine or is in fact a shift of work from other EDs / UCCs or changes in flows from LAS. This will then be discussed with the commissioners to ensure that any early unplanned transfer of patients prior to the full implementation of SaHF is properly funded.

The Division of Emergency and Integrated Medical Care is undertaking year 2 of an Emergency Care Transformation project and is working so achieve a set of Key Performance Indicators including reducing admissions, increasing access to Ambulatory Care, improving the flow of patients through the hospital and accelerating the discharge of patients who are no longer in need of medical care. This has necessitated close working with external health and social care partners, and the team have worked jointly on bids for funding to improve access to community health and social care at weekends.

Furthermore, though the use of audits and data analysis, it has been possible to develop well structured, joint bids for additional neuro-rehabilitation and intermediate care beds outside of the acute hospital.

This work will continue to accelerate and improve the patient pathway, which in turn will provide more capacity for acute patients admitted as emergencies through A&E or the Acute Assessment Unit directly.

Clinical Effectiveness – Focus on Length of stay

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

YTD Position			
Directorate	Day case rate Relative risk (Target: < 100)	Elective length of stay relative risk (Target: < 100)	Non-Elective length of stay relative risk (Target: < 100)
Surgery	103.0	90.6	81.1
Medicine	N/A	331.7	67.4
Chelsea Children's Hospital	120.5	200.3	85.1
HIV, Sexual Health and Derm.	N/A	331.7	67.4
Diagnostics	N/A	732.6	233.2
Pre-Op Theatres and Anes.	N/A	0	167.1
Women's Services	103.8	121.6	100.8
Trust position	106.1	131.0	82.5

The Length of stay relative risk (RR) is calculated by comparing the Trust's performance to that of a Dr Foster forecast. The forecast is based on national Secondary User Service (SUS) data and is made on the Trust's case-mix. Trusts identified as high for this metric are those above the national upper quartile. Trusts identified as low for this metric are those below the national lower quartile.

The Relative Risk ratio is calculated by dividing the actual number of events above the 75th percentile by the expected number of events above the 75th percentile, the result is multiplied by 100. A trust having an RR of 100, means that the number of events is exactly as would be expected and represents the national average. An RR of 110 means there were 10 events above the national average; 90 events means that were 10 fewer than the average. *((number of "long stayers") / (Expected number of long stayers)) *100 = Relative risk.*

The Trust is reporting figures above the relative risk ratio for both day case and elective length of stay, particularly in some of the specialised areas such as paediatrics and HIV. Further work is underway to fully understand the drivers behind this performance.

Daycase rate relative risk:
Working groups have been set up develop reduced length of stay for laparoscopic cholecystectomies and day case suitable hernias. This month there has been achievement of the BADS day case rates for all day case procedures apart from lap choles, where the working group have established differences between post op recovery plans and transfers to the wards.

Elective length of stay relative risk:
A small working group has been established for an Enhanced Recovery Programme, meeting weekly to identify enhanced recovery pathways. Key focus on ensuring patient information is accurate and up to date for each aspect of the pathway.

Medihome are working with the group in order to help identify patients that are suitable for earlier discharge through attendance at hip & knee school, daily OT ward rounds and presence on the wards. The team have also arranged to visit Stanmore to see how they have embedded the Enhanced Recovery Practice.

Patient Experience

MonthYear	Jun 2014	May 2014	Apr 2014	01/04/2014
Complaints (Type 1 and 2) - Communication (Target: < 13)	23	23	21	67
Complaints (Type 1 and 2) - Discharge (Target: < 2)	0	3	0	3
Complaints (Type 1 and 2) - Attitude / Behaviour (Target: < 16)	13	11	14	38
Complaints Re-opened (Target: < 5%)	N/A	1.5%	0%	0%
Complaints upheld by the Ombudsman (Target: = 0)	0	2	0	2
Formal complaints responded in 25 working days (Target: > 100%)	N/A	65%	69%	69%
Total Formal Complaints (Target: NA)	0	23	26	26
Hospital cancellations <6 Weeks\ reschedules of outpatient appointments % of total attendances (Target: < 8%)	4.7%	4.7%	4.8%	4.7%
Friends & Family Test - Local +ve score (Trust) (Target: > 90%)	89.0%	91.0%	90.5%	90.3%
Friends & Family Test - Net promoter score (Target: > 62)	60.3	63.9	58.9	61.4
Friends & Family Test A&E - response rate (Target: > 15%)	25.9%	22.0%	3.2%	17.0%
Friends & Family Test Inpatients - response rate (Target: > 25%)	32.3%	39.7%	21.9%	31.3%
Breach of Same Sex Accommodation (Target: = 0)	0	0	0	0

Friends and Family Test:

The Trust has achieved the Q1 baseline CQUIN which is based on the response rate for FFT. The new methods of offering FFT survey by text/ land line messaging and agent calls has shown a great improvement throughout the majority of clinical areas. The decrease in Net Score is understood to be a normal decline - surveys conducted at home instead of the hospital environment create an unbiased environment where patients can be more honest and have had more time to reflect on their care.

The patients comments are available to all ward staff and areas with low scores will start to action plan in response to negative comments.

Complaints:

Type 1 complaints regarding communication remain high and are dispersed amongst all Divisions. Typically the issues mainly relate to cancellation of appointments that have not been communicated to the patient.

Complaints also relate to inability to contact clinical departments to discuss care or treatment concerns, for example departments not answering the phone.

Type 1 complaints regarding attitude and behaviour are also widespread amongst Divisions. Managers are informed of the issues relating to this subject and manage the issue accordingly.

Access and Efficiency (1)

Sub Domain	Trust Level Monthly Data @ 17/07/2014 XL				YTD XL
	MonthYear	Jun 2014	May 2014	Apr 2014	01/04/2014
RTT	18 week referral to treatment times Admitted Patients (Target: > 90%)	79.5%	82.3%	86.4%	82.6%
	18 week referral to treatment times Non Admitted Patients (Target: > 95%)	96.4%	97.6%	96.3%	96.8%
	18 week RTT incomplete pathways (Target: > 92%)	92.3%	92.7%	92.1%	92.3%
	RTT Incomplete 52 Wk Patients @ Month End (Target: = 0)	0	0	0	0
OP	Choose and Book slot issues (Target: < 2.0%)	4.7%	2.9%	2.7%	3.4%
Cancer	Cancer urgent referral Consultant to treatment waiting times (62 Days) (Target: > 90%)	100.0%	N/A	N/A	100.0%
	Cancer urgent referral GP to treatment waiting times (62 Days) (Target: > 85%)	93.3%	82.6%	100.0%	93.2%
	Cancer diagnosis to treatment waiting times - Subsequent Surgery (Target: > 94%)	N/A	100.0%	100.0%	100.0%
	Cancer diagnosis to treatment waiting times - Subsequent Medicine (Target: > 98%)	N/A	100.0%	100.0%	100.0%
	Cancer urgent referral to first outpatient appointment waiting times (2WW) (Target: > 93%)	94.0%	94.7%	97.0%	95.2%
	Cancer diagnosis to treatment waiting times - 31 Days (Target: > 96%)	100.0%	100.0%	100.0%	100.0%
Referrals	GP Referrals (Target: > NA)	7434	7498	7489	22421
OP/IP Wait Times	Outpatients - New Appointment Waiting Times (Target: > NA)	5.7	5.5	5.4	5.5
	Inpatient - New appointment waiting times (Target > NA)	8.9	8.9	11.8	9.8

Choose and Book slot issues:

The specialties with consistent choose and book slot issues in June were Ophthalmology, Paediatric Ophthalmology, Cardiology and Paediatric Cardiology.

The Paediatric Cardiology service is run in conjunction with the Brompton and work is underway to increase the number of clinics to address capacity issues.

An in-depth review will be undertaken into the other specialties with consistent slot issues, including mapping demand and capacity across sub-specialties.

18 week Admitted Patients:

The overall backlog of admitted patients had decreased with the introduction of additional operating lists and sessions. However, the cranio-facial department continues to face capacity challenges, along with other national units. The clinical teams have seen a steady increase in referrals, with patients electing to wait to have their surgery under specific Consultant specialists.

A recovery plan is in place to bring the backlog down – more information is included on the separate focus page.

Cancer:

C&W uploaded a compliant position on the 62 day target for May, however an additional shared breach was reported by the Royal Marsden which led to an uncompliant position being reported at the month end. This breach has been disputed with the Royal Marsden and with commissioners, and should be removed from the figures before quarter 1 performance is reported.

The Trust has been identified as having the best 62 day wait performance in London in 2013/14 at 92.1%.

Access and Efficiency (2)

Sub Domain	Trust Level Monthly Data @ 17/07/2014 XL	Jun 2014	May 2014	Apr 2014	YTD XL 01/04/2014
	MonthYear				
Admitted	Delayed transfers - Patients affected (Target: < 0)	N/A	0.0%	0.5%	0.4%
	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%)	84.5	87.3	88.9	86.9
	Theatre Active Time - % Total of Staffed Time (Target: > 70%)	71.0%	70.9%	72.6%	71.5%
DQ	Coding Levels complete - 7 days from month end (Target: > 95%)	This indicator is currently under review – internal reporting shows as compliant against this target			
GP Realtime	GP notification of an A&E-UCC attendance < 24 hours (Target: > 70%)	99.94%	99.55%	99.96%	99.86%
	GP notification of an emergency admission within 24 hours of admission...	99.83%	100.00%	99.92%	99.92%
	GP Notification of discharge planning within 48 hours for patients >75 (Targ ...	62.7%	76.6%	63.6%	67.6%
	OP Letters Sent < 7 Working Days (Target: > 70%)	82.2%	81.7%	81.6%	81.8%
	Discharge Summaries Sent < 24 hours (Target: > 70%)	79.8%	80.3%	79.0%	79.7%
OP	DNA Rate (Target: <11.1%)	10.0%	11.2%	10.9%	10.7%

Coding Levels Completion:

This indicator is under review as internal reports show that the Trust is compliant with this indicator in the quarter.

DNA Rates:

DNA rates have improved in June and have shown an improved trajectory over the last two years.

GP Notification of discharge planning

The Trust has improved the planned discharge date completion for all patients by getting staff to input it at Board Rounds on medical and surgical wards, but further work is underway to improve completion and accuracy of the planned discharge dates.

Access and Efficiency – Focus on RTT

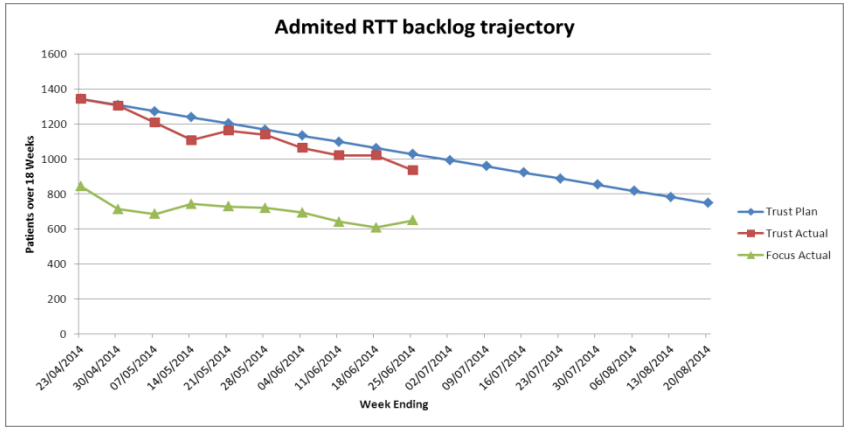
The April 2014 Board agreed, with Monitor and with CCG Commissioners support, that C&W will pursue an accelerated RTT backlog clearance programme in order to treat the long waiting patients identified in early 2014 in both Surgical Specialties and Paediatrics, as quickly as possible. This was planned to result in the Trust RTT performance against the Admitted standard being non-compliant during Q1 and Q2, but retain an overall Monitor governance rating of green.

This programme has now been set up and is in progress since the beginning of May with the following actions taken:

- A trajectory for accelerated clearance was been developed and agreed with Monitor and CCG Commissioners in April, particularly focussing on Trauma and Orthopaedics, Plastic Surgery, General Surgery and Paediatric Surgery.
- The trajectory has been reviewed and assured by the NHS Intensive Support Team (IST) who will also undertake a review of scheduling processes and non-admitted pathways in the summer/ early autumn to support the recovery plan.
- A programme of work is in place to arrange additional capacity, ensure optimal theatre efficiency and explore outsourced capacity from other providers where appropriate. Delivery against the action plan is monitored on a weekly basis through divisional meetings and reported to the weekly Access meeting.
- Overall the Trust is on trajectory for the reduction in admitted backlog, with General Surgery ahead of trajectory. Paediatric specialties and plastic surgery have plans in place to reduce the waiting list further in July and August, including putting on additional theatre lists, with challenges continuing in T&O, particularly due to long waits in outpatients. Outsourcing options are being reviewed for orthopaedic work at other providers where capacity is available and where appropriate and a review of outpatient capacity and pathways is underway.
- NHS England, Monitor and the Trust Development Authority announced a resilience programme in June to improve nationwide RTT performance, including reducing the backlog to 16 weeks, training and validation with some additional funding to support this. The Trust has received £1.4m of national funds, £0.5m higher than the Trust's notional allocation, to support the backlog recovery action plan and revised specialty level trajectory to achieve compliance by the end of September 2014.

June 2014 Admitted Referral to Treatment Performance

Treatment Function	ClockStops <= 18Weeks	ClockStops > 18Weeks	Total Clock Stops	% Perf (Target 90%)
Total	**1036**	**267**	**1303**	**79.51%**
Dermatology	11	5	16	68.75%
General Surgery	73	31	104	70.19%
Plastic Surgery	76	29	105	72.38%
Urology	60	16	76	78.95%
Trauma & Orthopaedics	86	19	105	81.90%
Gastroenterology	137	6	143	95.80%
Gynaecology	103	3	106	97.17%
Ophthalmology	62	1	63	98.41%
Neurology	1	0	1	100.00%
Thoracic Medicine	3	0	3	100.00%
Other	424	157	581	72.98%



Admitted Care RTT focus specialties w/c 25/6/2014

Focus Specialties	Backlog plan	Total Backlog actual*	Backlog (shortfall) / delivery
Plastic Surgery	94	131	-37
T&O	133	232	-99
General Surgery	127	67	60
Paediatric Specialties	183	220	-37
Total	**537**	**650**	**-113**

** includes dated & undated*

Health & Safety and Mandatory Training

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Division	Total	Clinical Support Services Division	Management Exec & Corporate Services Division	Medicine,Surgery & Private Patients Division	Womens, Childrens and Sexual Health Division
Fire	**61%**	65%	84%	53%	57%
Moving & Handling	**76%**	81%	71%	72%	76%
Safeguarding Adults Level 1	**100%**	100%	100%	100%	100%
Slips Trips and Falls	**72%**	78%	78%	70%	68%
Harrassment & Bullying	**86%**	92%	84%	85%	83%
Information Governance	**64%**	73%	72%	58%	58%
Hand Hygiene	**75%**	78%	77%	74%	74%
Health & Safety	**74%**	79%	78%	69%	72%
Child Protection Level 1	**100%**	100%	100%	100%	100%
Innoculation Incident	**84%**	84%	75%	88%	84%
Basic Life Support	**75%**	84%	89%	67%	74%
Health Record Keeping	**83%**	86%	96%	83%	81%
Medicines Management	**90%**	95%	100%	91%	88%
VTE	**89%**	91%	96%	85%	91%
Blood	**81%**	87%	96%	80%	80%
Safeguarding Children Level 2	**86%**	87%	84%	84%	87%
Safeguarding Children Level 3	**69%**	77%	100%	90%	66%
Corporate Induction	**84%**	84%	75%	88%	84%
Local Induction	**37%**	43%	38%	33%	36%
Mandatory Training Compliance %	**78%**	82%	84%	77%	77%

Health and Safety Indicators	Total	Clinical Support Services Division	Management Exec & Corporate Services Division	Medicine, Surgery & Private Patients Division	Womens, Childrens and Sexual Health Division
Fire Evacuation Drill	**21.30%**	16.70%	62.50%	0.00%	9.10%
Inspection Audit	**43.30%**	26.10%	0.00%	69.20%	47.80%
Lone Working Risk Assessment	**11.60%**	25.00%	3.70%	8.30%	7.10%
Security Risk Assessment	**33.00%**	25.90%	23.10%	84.60%	24.00%
Slip Trips and Falls RA	**2.00%**	3.60%	3.30%	0.00%	0.00%
Total	**16.30%**	**15.40%**	**14.00%**	**26.90%**	**13.90%**

NB: Health and Safety Data is updated on a quarterly basis. The data validity is to be checked against the records held by Divisions. The frequencies for inspections require ranking against level of risk with adjustment to be made to the data table.

Workforce

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

HR Metric		Monthly Target	Jun 14	~2013/14 Out-turn	2014/15 Annual Target	12 Month Rolling YTD
Turnover rate***		15.05%	16.72%	14.82%	13.50%	15.19%
Vacancies	Total	9.36%	11.38%	8.74%	8%	9.45%
	Active	3.25%	5.22%	3.02%	3.25%	3.54%
Time to Recruit	Authorisation to pre-employment checks completed	<55 days	50 days	-	<55 days	**53 days
Sickness rate		3.00%	2.81%	2.92%	3.00%	2.88%
Agency % of WTE		3.15%	3.4%	4.00%	3.15%	3.50%
Appraisals	Non-Med	78.64%	78%	85%	85%	84.22%
	Medical	78.64%	79.3%	70%	85%	72%
Mandatory training*		81.91%	78%	77%	95%	77.92%

Appraisals & Training

The non-medical appraisal rate decreased by 2% in June 2014 to 78% which is below both the monthly and yearly targets set. Reports of overdue and due appraisals are issued to managers monthly. Consultant appraisal rates currently stand at 79.3% which is above the monthly target, with on-going work to support medical appraisals being undertaken.

Mandatory training figures decreased by 1% in June 2014 to 78% which is 4% below target for the month. The ambitious target of reaching 95% compliance by the close of 2014/15 is highly aspirational and will require a review of our policy and processes in relation to mandatory training. Health & Safety training stands at 74% (compliance rate of staff trained within the two year refresher period across all staffgroups)

Average (Appraisal rate) across LATTIN Trusts = 73% (latest data available)
Average (Statutory mandatory training) across LATTIN Trusts = 78% (latest data available)

Vacancies

The total Trust vacancy rate for June 2014 was 11.38%, which is the highest it's been since December 2010 and represents an increase of 3.40% on last year. It is important to recognise that not all vacancies are being actively recruited to, and a large proportion of these vacancies are held on the establishment to support the Cost Improvement Programme (CIP). 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 2014. The active vacancy rate for June was 5.22% which is the second highest it has been since we started recording this performance indicator in April 2013 and is considerably above the monthly target of 3.25%. This large increase was caused by bulk HCA and nursing and midwifery recruitment in Women's and Children's throughout June. A new central establishment process came into effect at the end of January 2014 which has contributed to more posts being queried, held, or covered by alternative means.

The average time to recruit (between the authorisation date and the date that all pre-employment checks were completed) for June starters was 50 days (once international, Deanery and planned recruitment was excluded). This was 5 days quicker than the 55 day monthly target set for 2014/15 with the YTD position remaining within target.
Average across LATTIN Trusts = 11.62% (latest data available)

Turnover

Unplanned staff turnover (i.e. resignations) increased to 16.72% in June 2014 which is the highest it has been since we started monitoring this KPI. This is 1.67% above the monthly target of 15.05% set for June 2014. The highest percentage of leavers in June were Allied Health Professionals (particularly in Therapy Services) and Nursing and Midwifery staff across all areas with Paediatrics being the highest.

Human Resources have conducted further in-depth analysis on turnover, leaving reasons and the length of service of leavers. Areas of most concern have been identified and will be targeted through surveys and 1:1 interviews over the coming months. Human Resources working with senior Nurses recently carried out a series of listening events to understand the staff experience and identify ways in which we can improve retention, which will continue throughout 2014 to help inform the retention strand of the People & OD strategy currently in development. Analysis of 104 exit questionnaires received over 2013/14 financial year showed that 'Promotion/Career Development' was the most common reason for leaving, with 79% of employees rating their experience of working at the Trust as either Good or Excellent and 80% stating that given the right opportunity would return to the Trust.
Average across LATTIN Trusts = 12.3% (latest data available)
LATTIN = London Acute Training Trusts (Imperial College, King's College, Royal Free Marsden, UCLH, Chelsea & Westminster, and Guy's).

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
Income	(366,167)	(91,225)	(90,543)	(682)	72
Expenditure	332,328	82,237	84,710	(2,473)	(2,071)
EBITDA for FRR excl Donations/Grants for Assets	33,839	0	0	0	0
EBITDA % for FRR excl Donations/Grants for Assets	9.3%	9.0%	3.8%	-5.2%	-9.0%
Surplus/(Deficit) from Operations before Depreciation	**33,839**	**8,988**	**5,833**	**(3,155)**	**(1,999)**
Interest	1,429	357	213	144	92
Depreciation	13,948	3,375	3,658	(283)	(189)
Other Finance costs	0	0	0	0	0
PDC Dividends	11,400	2,850	2,800	50	33
Retained Surplus/(Deficit) excl impairments	**7,062**	**2,406**	**(838)**	**(3,244)**	**(2,063)**
Impairments	0	0	0	0	0
Retained Surplus/(Deficit) incl impairments	**7,062**	**2,406**	**(838)**	**(3,244)**	**(2,063)**

Comments

Risk Assessment
Impact 5 – Loss of over £5.0m. Likelihood 3 – possible. **Red**

The YTD position is a deficit of £0.8m (EBITDA of 3.8%) which is an adverse variance of £3.2m against plan. However COSR target of 3 has been achieved.

I&E variance (£3.2m) includes the following material items:
- Un-achieved CIPs (£3.0m);
- Under recovery on Private Income (£1.1m);
- Continued budgetary pressures within Clincial Supplies and Drugs (£0.4m)
- Inflationary reserves of £1.1m released into the position.

Risk Rating (year to date)

COSR Rating	Weighting	M3 Actual Score	M3 Actual Rating
Capital Servicing Capacity (times)	50%	1.21x	1
Liquidity (days)	50%	7	4
Total Rating (roundup)			3

Comments

The COSR rating for Month 3 of 2014-15 is a 3, comprising a capital servicing ratio of 1 and a liquidity rating of 4 rounding up to a 3 overall. The score of 1 on the capital servicing rating is due to the cummultative deficit.

Cost Improvement Programme (£000)

		Total		YTD		Forecast
Division	CIP Target	Identified CIPs	Unidentified CIPs	Unachieved Identified	Unachieved CIPs	CIP
Planned Care	-6,290	3,131	3,159	-230	-861	3,026
Emergency & Integrated Care	-3,916	1,421	2,495	67	-641	1,422
W&N, C&Y, HIV & SHP	-6,903	4,612	2,291	-76	-573	4,505
Corporate	-5,790	3,594	2,197	-31	-521	3,797
Procurement	-3,500	690	2,810		-733	690
Over-Programming	1,500		-1,500		296	
Total	**-24,900**	**13,448**	**11,452**	**-271**	**-3,033**	**13,440**

Comments

CIPs 14/15
The CIP target for 14/15 is £24.9m (£18.9m for 14/15 + £6.0m b/f from 13/14).
Schemes implemented YTD where a budget saving has been achieved is £2.4m or 10% of the annual target.
The forecast achievement is £13.4m leaving a gap of £11.5m.

Key Financial Issues

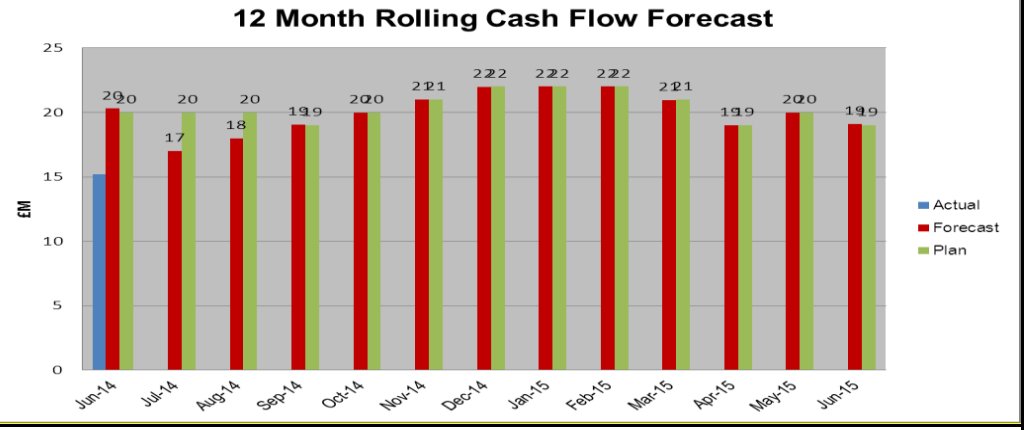
Key Issues

- CIP 14/15 under delivery of circa £11.5m.
- Private Patient Income is behind Plan with a forecast variance of £2.6m.
- A number of mitigations including review of investments and improvements in the run-rate for pay are required to improve the position.

Other issues
- GUM Public Health commissioning & payment
- Delivery of the Trust's activity plan, particularly for elective inpatients
- Achievement of commissioner metrics & KPIs to minimise penalties and fines
- Achievement of CQUIN targets for 2013/14

Future Developments
- Strategic developments e.g. West Midd, SaHF
- West Middx at the Outline Business Case stage
- Operationalising the capital plan
- ED capital redevelopment
- Business Planning for 2014/15
- Delivery of increased Private Patient income plans

Cash Flow



Comments

The cash position at June is £15.2m. The current deficit impacting on the cash balance. This impact is further exacerbated by movement in Debtors of £14m above plan (adverse) and Creditors £7.1m above plan (favourable). NHS/LA Debtors account for the majority of the adverse movement on Debtors. The Trust will increase its vigour in attempting to collect debt.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 July 2014 (PUBLIC)

AGENDA ITEM NO.	6.1/Jul/14
PAPER	Annual Workforce Monitoring Report
AUTHOR	Mary Sampson, Corporate HR Manager
LEAD	Susan Young, Director of HR and OD.
PURPOSE	A workforce report is produced on an annual basis to inform the Board about the workforce position over the previous year. The analysis within the report is used to inform the Trust's People Strategy and Plan for the following year, and to help determine key workforce metrics going forwards. Please note that the full workforce report is contained within the supporting papers.
LINK TO OBJECTIVES	The report informs the "People" enabler of the strategic objectives
RISK ISSUES	The main risk arising from the workforce report is in relation to high turnover and the consequences of that operationally and strategically
FINANCIAL ISSUES	High turnover can lead to high agency spend which has an adverse impact on our financial position
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	Under the Equality Act 2010 the Trust is required to publish workforce information in relation to equality. This report complies with that obligation.
EXECUTIVE SUMMARY	The 2013/14 Annual Workforce and Monitoring Report provides data, both quantitative and qualitative, about the Trust's workforce in terms of the workforce composition by Division, Pay and Bands/grades and professional group. The report highlights the workforce metrics achieved last year (staff engagement, sickness and time to recruit and those

	where more work has to be done to meet the internal stretch targets even though results were higher than the previous year (appraisal rates, mandatory training rates and the use of agency staff). Turnover represents a key risk going forwards and the report highlights more detail on where that is, why it occurs, and what actions are being taken to address it. New metrics are proposed for the Board to monitor for 2014/15.
DECISION/ ACTION	The Board is asked to: • note the content of the annual workforce report for 2013/14, and • agree the workforce metrics to be reported to the Board for 2014/15

Annual Workforce Monitoring Report 2013/2014

1 Introduction

This 2013/14 Chelsea and Westminster Annual Workforce and Monitoring Report provides data, both quantitative and qualitative, about the Trust's workforce in terms of the workforce composition by Division, Pay and Bands/grades and professional group.

The Trust has met its legal obligations under the Equality Act 2010 through publishing equality workforce information and identifying its equality objectives for 2013/14 in the Annual Report

2 Workforce metrics

Key workforce targets for turnover, vacancies, sickness rates, agency, appraisals and mandatory training were identified for 2013/14 and the report details the progress the Trust has made against these targets. Targets on staff engagement, sickness rates and time to recruit were achieved for 2013/14. Our sickness levels remain below the NHS average, and our staff engagement levels put us in the top 20% of acute trusts across the country, an achievement which has been sustained over the last 5 years.

Against all other metrics (except vacancies) the trust has improved against last year's performance, although not met the stretch targets which were set at the start of the year. So, appraisal rates have improved from 83% to 85%, and we are in the top 20% of acute trusts for staff having "well-structured" appraisals. Similarly, mandatory training rates have increased by 8% from 69% in 2012/13 to 77% in 2013/14, but fall short of our internally set target of 85%.

Our overall use of agency staff (as a percentage of our Whole Time Equivalent (WTE) staffing), has reduced from 4.4% last year to 4% in 2013/14. However, we need to reduce this further to enable costs savings to be made. Vacancies also remain high, although many posts are not being recruited to deliberately in order to support Cost Improvement Programmes (CIPs). So the vacancy measure, on its own, can be misleading if taken out of context.

3 Workforce Analysis

At the end of 2-13/14 the Trust employed a headcount of 3317 staff (3038.49 Whole Time Equivalents) which is an increase of 102 staff, or 3.47% compared with 2012/13.

The largest Division is Women, Childrens and Sexual Health with a headcount of 1226, whilst the largest staff group are those on pay Band 5 accounting for 21.25% of the workforce. Registered nurses and midwives at Band 5 level make up 44.90% of the nursing workforce with a headcount of 533.

Compared with 2012/13, we now employ 42.36 WTE more nursing and midwifery staff, (4.05% increase). We have 36.4 WTE more medical and dental staff (6.21% increase). Of these, we have increased our consultant body by 21.08 WTEs (10.05% increase). In January 2014 we hit our highest number of WTE staff since the trust was formed (3065 WTEs).

We have a very diverse workforce in terms of ethnicity with 40% of our staff from Black and Minority Ethnic groups, and 60% of our staff being White. 74.16% of the workforce is female and 25.84% which is similar to the national picture for the NHS.

Our turnover for the year closed at 14.7%. The groups with the highest levels of turnover are Band 2 Healthcare Assistants and Band 5 Nursing staff. Hence most our recruitment activity was targeted at these groups. Of our 565 new joiners in 2013/14, over 40% of those were Band 5 nurses, and almost 20% were healthcare assistants.

Staff reporting having an appraisal continues to show an increase, and was at 84% for the period 2013/14. It is anticipated that changes to the Trust Appraisal system introduced in April 2014 to link appraisal and incremental pay will help move reporting closer to the Annual target of 90% within the forthcoming year.

Bank and agency usage continues to be a challenge for the Trust with increases showing for both types in year, particularly over the months of November and December 2013. This led to the establishment of a Bank and Agency focus group which led to some reductions compared with the previous year, but this needs a continued focus

This years report shows that BME staff, still continue to be disproportionately represented in employee relations cases compared with White colleagues. This is an issue in NHS trusts nationwide. This will require further understanding and investigation and /or specific action to address.

4 Actions Developed

Over the last few months a People Strategy has been developed and tested with a number of small groups across the trust. This will be brought to a Directors Strategy meeting in due course. Some of the detailed actions under the strategy, and existing action plans are detailed in the attached workforce report.

In summary, the vision we have developed for our people is to have high-performing, kind and respectful staff providing safe and excellent care, supported by visible and engaging leaders at all levels who enthuse and inspire colleagues. The strategy itself, which outlines our ambitions and priorities for the next few years has 6 main themes:

1. Culture, Values and Engagement;
2. Inspirational Leadership and Talent;
3. Workforce Strategy and Planning;
4. HR and Learning processes;
5. Skills and Capability;
6. Performance, Reward and Recognition.

Some of the key actions identified for 2014/15 which will assist in addressing the issues identified in the workforce report are:

- Development of Leadership programmes at all levels
- New development programme, based on role-play, to develop appropriate values, behaviours, and customer service
- Piloting an approach to Talent Management to help address some of the retention issues at senior levels

- New Trust Appraisal system under which incremental pay progression is a reward rather than an entitlement
- Implementation of the Staff Friends and Family Test, which will give us more rapid feedback than the annual NHS staff survey
- Health and Wellbeing strategy for staff, with a focus on physical and mental wellbeing
- Bank and Agency working group to focus on the reduction of agency staffing and spend, and to encourage the use of bank staff where appropriate
- A more robust, and strategic approach to workforce planning which focuses on having the right establishment levels
- Promotion and alignment of our recognition schemes with our trust values and strategies
- Take part in the national work on "unconscious bias".

In addition, we will continue to identify strategies to improve compliance in Mandatory Training, and review Corporate Induction, to ensure comprehensive coverage and it is fit for purpose. These aspects of the strategy are reported to the Assurance Committee

5 Ongoing Risks and Issues

The risks highlighted in the Board Assurance Framework are as follows:

- High turnover leads to high agency spend and unsafe staffing levels
- Staff leave to join neighbouring trusts
- CIP reductions in staffing and/or pay de-motivate the workforce
- Poor clinical engagement hinders change

Recruitment initiatives and incentives to address specific areas of high turnover and agency usage are bringing improvements in the short term but sustainability is something we will need to focus on. The London NHS jobs market is becoming increasingly competitive and some of the local reconfigurations will bring both challenges and opportunities for us. There is a balance to be maintained between ensuring that people are paid at the appropriate rate for the job, and our ability to retain staff with living costs rising substantially, especially in the local area.

Our People Strategy, and associated action plans, such as the talent management pilot, and our leadership development programmes will be important differentiators for us in the local market.

6 Workforce Metrics

In order that we can monitor and measure our People Strategy and our workforce improvements, we need to develop an appropriate set of measures for the Board to be able to gain assurance in these areas. Our workforce information is continuously improving and we are proposing a new set of workforce metrics for the Board to consider:

Headcount and Whole Time Equivalents at Trust level, and by Division/Directorate, Pay Band and Professional Group
Turnover, at trust level, and by Division/Directorate, Pay Band and Professional Group
Sickness absence, at trust level, by Division/Directorate, Pay Band and Professional Group
Agency usage (WTE, percentage of workforce and spend, at trust level, by Division/Directorate, Pay Band and Professional Group)
Bank usage (WTE, percentage of workforce and spend, at trust level, and by Division/Directorate, Pay Band and Professional Group)
Staff Friends and Family Test

Staff Survey Results: Staff engagement, questions on appraisal and those where we score least well compared with others (annual basis)
Mandatory Training compliance rates
Vacancy rates (with clarity on whether vacancies being held or actively recruited to)
Reasons for leaving (at trust level, by Division/Directorate, Pay Band and Professional Group)

Decision Required: The Board is asked to discuss/agree the above metrics for future Board reporting purposes.

7 Conclusion

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. 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.

The Trust performance for a number of HR metrics shows continued improvement with regard to sickness at 3.44% (below target of 3.5%), appraisals at 84%, mandatory training 77%, Time to Recruit at 69 days. However, challenges are still faced in the area of turnover which is above the target at 14.70%. Staff engagement levels remain high, despite the challenging environment, and the development of the People Strategy should help to address some of the remaining issues.

Issues will continue to be monitored via a revised set of metrics which the Board is asked to agree.

Susan Young

Director of HR and OD

23 July 2014

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 31 July 2014 (PUBLIC)

AGENDA ITEM NO.	7.1/Jul/14
PAPER	Audit Committee Minutes – 22 May 2014
AUTHOR	Helena Moss, Head of Technical Accounts
LEAD	Sir John Baker, Non-executive Director
PURPOSE	To inform the Board of matters discussed at the Audit Committee on 22 May 2014
LINK TO OBJECTIVES	Deliver financial sustainability
RISK ISSUES	None
FINANCIAL ISSUES	None noted
OTHER ISSUES	None
LEGAL REVIEW REQUIRED?	None
EXECUTIVE SUMMARY	This paper outlines a record of the proceedings of the Audit Committee on 22 May 2014
DECISION/ ACTION	For information

Date…….. **Signed……..**

Audit Committee, 22nd May 2014
Minutes

Present:

Non-Executive Directors:	Sir John Baker (JB) Chairman Professor Richard Kitney (RK) Non Executive Director
In Attendance:	Tony Bell (TB), CEO Lorraine Bewes (LB), CFO Rakesh Patel (RP), Director of Finance Carol McLaughlin (CMcL), Assistant Director of Finance Helena Moss (HM), Head of Financial Services Libby McManus (LM), Director of Nursing & Quality Melanie van Limborgh (MvL), Head of Quality & Assurance Layla Hawkins (LH), Interim Head of Corporate Affairs Simon Spires (SS), Parkhill Heather Bygrave (HB), Deloitte Ben Sheriff (BS), Deloitte Neil Thomas (NT), KPMG

1. GENERAL BUSINESS

1.1 Apologies for Absence

There were no apologies for absence.

1.2 Declarations of Interest

None

1.3 Minutes of the Previous Meeting held 29th January 2014

The minutes were agreed as a true and accurate record.

1.4 Schedule of Actions

- 2.3 Counter Fraud Progress Report 1st April 2013 – 3rd July 2013 – The action carried forward was for an update to be given to the Audit Committee on progress with assuring controls over timesheet authorisation. SS updated the meeting that the Trust has now begun the move to e-timesheets and although there have been some teething problems with these, SS is working with the Staff Bank to improve the

process. The plan is that paper time sheets will be phased out over a period of time.

- 6.1 Update required on actions being taken in PP to reduce the risk relating to insurance companies withdrawing authorisation after treatment has commenced – RP reported that he had discussed progress on this with Amanda Grantham (General Manager for Private Patients) and that there was an action plan in place to address this, consisting of the following: 1) Education of the PP team to ensure that they always obtain authorisation up front, 2) Contract negotiations with insurance companies to ensure that new contracts include items that were previously excluded – this is being led by Amanda and Aiden O'Neill (Commercial Director); 3) the bedding down of electronic invoicing on Compucare.

- 3.2 Reporting to the Board (findings from KPMG report) – RP reported that the Finance Team was in the process of putting together its business plan, and that as part of this the content of the Board Report was being updated. The findings outlined in the KPMG report about reporting against self determined indicators of short to medium term performance would be incorporated into the design of the updated report. Realistically it will take 2-3 months to produce the first draft of this report and RP would discuss this with the Executive Team.

- 4.1 Sector Developments report from Deloitte re requirements of the updated Code of Governance – to be picked up later in the meeting.

4.4 Deloitte Findings and Recommendations from the 2013-14 NHS Quality Report Review

In view of the fact that LM and MvL were in attendance for the Quality Report, JB suggested that this item be taken next on the agenda. BS explained that as our external auditors Deloitte are required to test two mandated indicators and one local indicator. The report presented to the Audit Committee was a draft of the report that will go to the Trust's Council of Governors.

Mandated Indicators

BS explained that in terms of their testing, they had not found any errors with 28 day readmissions but had found the process of getting records pulled out slow. In terms of the 62 day cancer target, the issue is that there are complicated rules about when to start and stop the clock and the interpretation of these is a challenge. Deloitte noted a lot of differences in their testing but none that would affect whether there was a breach or not. The number of differences found was higher than in 2012/13 but not out of line with the national average.

LM asked whether the differences were down to several people not applying the guidance correctly or one individual repeatedly making errors. BS replied that this was not clear but that he could go back to the detail if required.

BS reported that Deloitte had found one instance of a breach that had not been recorded as such by the Trust, but this was due to the Marsden not passing on correct information in respect of a particular patient. This breach

would not change the Trust's overall score when rounded to the nearest whole number. BS noted that Deloitte would be able to issue a clean opinion but that there was room for improvement.

LM asked whether BS was sure there was no need for further testing to check there were no more patients where discrepancies had been identified – BS replied that they had not carried out further testing as no further errors were identified. JB asked whether this error mattered – LM replied that it might if it brought out something that we need to learn to do better for patients. She suggested that it might be good to understand what proportion of our patients go between us and the Marsden / Brompton and look at these patients more closely.

Local Indicator – Complaints

BS noted that the underlying complaints data for the Trust was adequate, although there could be inconsistencies in reporting depending on who had taken the complaint. However, there had been an error in compiling data into the figures into the report for the prior year comparative.

He pointed out that next year the Quality Account regulations are changing but it is not yet known what the change will be. When the changes are published, BS suggested that the Trust will need to review the process for getting each of the reported metrics into the report.

JB thanked BS for his presentation and noted the Deloitte report.

4.5 Quality Accounts

LM explained that the Quality Accounts set out the quality priorities for 2014-15 and explain what the Trust did in 2013-14. The committee was being asked to approve the Quality Accounts on the basis that they had been through due process, and MvL noted that they had worked very closely with the commissioners. BS agreed that the Quality Accounts had the correct content and noted that it was good that the Trust had obtained replies from the commissioners as not all Trusts had been able to get these.

LM noted that she felt that the Quality Accounts were hard to read, and that it would be worth trying to turn them into something more easily digestible for the general public. JB felt that it did not appear to be good value for money to spend a lot of time making the Quality Accounts digestible, although he did think it would be worth doing a summarised version for communications. BS noted that if we believe it is only the commissioners who will read the report then we could change the focus to reflect this.

JB noted that it was important to ensure that Never Events are made clear in the Annual Report and it was agreed that this is appropriately highlighted in the Annual Governance Statement.
BS reported that there were a couple of items still be to be checked relating to the Quality Accounts but that this would not change the substance of the report. LM thanked MvL for all her hard work on the Quality Accounts.

JB stated that the Quality Accounts would be approved, and LM and MvL left the meeting at this point.

(Bill Gordon (BG) and Caroline Law (CL) joined the meeting for the next item).

5.1 Information Governance

JB queried whether the committee should be concerned that the Trust's score had dropped on some of the indicators. CL replied that there were no risks arising for either patients or the financial position of the Trust. CL went on to say that she felt that the reported position on the indicators would be accepted by an external assessor – JB asked whether CL felt that the Trust's scores should rise again in future years and CL replied that they should.

LB queried whether there was benchmarking information available to indicate that everyone is finding it harder to score well on information governance – CL replied that she had attended an external event recently and it was certainly the case that other Trusts were finding this hard. JB asked whether it was proving challenging to respond to FOI requests and CL replied that it was, since she had to go through each request in detail and departments often had a lot of other priorities which meant that some requests breached. However CL would always keep in communication with the requestor to let them know the progress of their request.

BS queried point 6 in the report relating to Information Governance Incidents and queried whether there were any reportable incidents – CL confirmed that there were not.

JB queried whether there was a pattern emerging in Freedom of Information (FOI) requests – CL replied that the general public were getting more interested in these types of request and that it depended on what the main subject was in the media at the time, for example FGM. DK queried why Corporate Information Assurance was at 77% - CL replied that this was probably because there are some requirements that the Trust has yet to look into and some requirements that have not yet been sent out.

JB asked CL whether she had any concerns on Information Governance that the committee should be made aware of – CL replied that she had not.

The report was noted. BG and CL left the meeting at this point.

1.5 Internal Audit Recommendations Tracker

RP presented the update on the Trust's progress with meeting internal audit recommendations. He stated that in relation to the M&M coding review, this action was now complete as the coders were attending M&M meetings. The actions on data quality and ACU storage would all be complete by the July meeting. RP noted that he felt that the clinical coding recommendations would always be partially implemented and that this action would not be brought back to the next meeting because this would always be a rolling programme of work. The Treasury Policy action would be achieved by the policy going to the June Finance and Investment Committee.

JB asked KPMG whether they were happy with the progress being made on internal audit recommendations and NT replied that they were.

The report was noted.

2.1 Counter Fraud Annual Report

SS presented this report and pointed out that the format had changed compared to the previous year as mandated by NHS Protect. JB asked whether the total programme of counter fraud work had taken 60 days as per the work plan, and SS replied that it had taken longer than this if the time spent on investigations was taken into account. JB enquired whether anything had been missed out of the original planned work as a result of this, and SS replied that he had managed to fit all of the planned work in within the available days.

SS noted that in relation to case 5751 on page 12 of the report a good outcome had been achieved as the subject had received an 18 month sentence suspended for 2 years. They had also had to pay back all costs, which meant that the Trust would receive approx. £45k back which was a significant win.
In relation to case 6044, the subject was due to be arrested that week and SS hoped that there would be a similar outcome in this case.

SS reported to the committee that he had carried out a proactive review of staff bank timesheets and fraud and no evidence of fraud had been found. Articles about fraud had been attached to payslips and SS was also planning to do a write up of case 5751 to give out a strong message to the Trust. DK queried the point on page 8 about the proposed use by HR of "trusted terminal scanners" for scanning the ID documents of new starters and asked why these were more secure. SS replied that these were necessary because of the high quality of fraudulent ID documents that were now possible, meaning that it would not be fair to expect HR to spot such fraud simply by observation.

2.2 Counter Fraud Work Plan

SS told the committee that he had conducted a full risk assessment during 2013/14 and that this had highlighted 3 areas of potential weakness to be investigated relating to Procurement. He would now meet RP to decide which ones should be tackled first. JB asked whether RP would recommend these as an area of high priority to be reviewed and RP responded that he would, and that he was going to meet with Hilary Gillies (Director of Procurement) to discuss. JB asked whether this could be an area for collusion and SS replied that procurement has long been an area of weakness in the NHS.

RP noted that he would discuss with SS whether there was scope to reduce the number of days in the counter fraud work plan and would bring this back to the next meeting.

Action: RP to discuss scope for reduction of days in 2014-15 counter fraud work plan with SS and bring back to July audit committee.

The report was noted.

3.1 Internal Audit Data Quality Review

NT presented this report and explained that this year the scope of the review had been the local indicators, whereas last year they had looked at national indicators. Two high risk recommendations had been raised – 1) lack of clarity around indicators and 2) the calculations themselves – there had been two cases tested where the calculations were found to be incorrect. KPMG had recommended a review of the data used to report the indicators during the year.
There were 3 medium priority indicators raised, the first one relating to access to medial records. KPMG had experienced delays in obtaining medical records for sample testing and JB asked that his concern about this be recorded. JB requested that RP take this away as an action to investigate.

Action: RP to investigate reasons for the reported delays in medical records being pulled out for testing and report back to the July audit committee.

JB also expressed concern about the point noted on page 8 of the report about KPMG being asked by management to drop the testing of the fourth indicator due to difficulties in diarising time with the KPI lead and accessing medical records. DK agreed that this was not acceptable. LB asked whether the problem was that staff couldn't physically locate records but knew where they had been tracked out to, and NT confirmed that this was the case. JB queried whether KPMG had increased their sample because of this and NT replied that they had, from 25 to 50 to 75 records. LB asked whether KPMG had a sense of how large the issue was around OP letters turnaround time – NT replied that they did not, because it was not possible to extrapolate the error rate.

JB thanked NT for sharing the report. NT noted that the Trust had performed well on mandated indicators but that their findings showed where the Trust's ambition for improvement rubbed up against difficulties with systems.

The report was noted.

3.2 Business Continuity

JB asked if this report could be taken as read and this was agreed. The report was noted.

3.3 Clinical Audit Planning and Reporting

NT stated that the overall rating for this review was "Requires Improvement", and that there were 5 key recommendations. The key recommendations to note were the three medium priority recommendations.

JB queried the recommendation on page 7 about governance roles and responsibilities and asked if the audit committee was planning to assume responsibility for ensuring governance structures were fit for purpose. LB responded that she would take this back to Execs to be discussed but felt that this should be done and was consistent with discussions that had taken place the previous year. JB noted the point about the Trust not having an annual risk based clinical audit plan that is signed off at the start of the year determining the key areas of focus for audits for the coming year and requested that this plan be brought back to a future audit committee.

Action: RP and LB to ensure that the Clinical Audit Work Plan is brought to a future audit committee.

3.4 Incident Reporting

JB apologised for not having had time to read this report due to it being sent out late – NT apologised for this. The report was rated as "Requires Improvement" and NT noted that the Trust's policies were in line with requirements but the main area for development was around how learning and action points are communicated to the Trust. Recommendation one was highlighted as being key, in that KPMG had found that Serious Incident investigations assigned actions to individuals but that these individuals had not always had these actions clearly communicated to them. JB agreed that this was very important and asked how people could be expected to take the lead on actions if they did not know they had been assigned this responsibility. JB enquired whether LM knew about these findings and NT replied that she did and had agreed to feed back on them.

The report was noted.

3.5 Internal Audit Annual Report and Head of Internal Audit Opinion

NT presented this report and pointed out that the key point to note was on page 2 where substantial assurance had been given over the Trust's internal controls. JB asked whether NT felt that KPMG were treating the Trust even handedly compared to other Trusts and NT replied that he did. NT pointed out that on page 3 of the report, which summarised the ratings given to each internal audit review during the year, there were more red ratings than he would have expected, however they were still assured that the core systems are working well.

LB explained to the committee that the key area of value to the Trust from KPMG is when we direct their reviews to the areas we feel need scrutiny, and added that she would be concerned if all reviews were given a green rating.

The report was noted.

3.6 Internal Audit Plan for 2014-15

NT presented this report and stated that the key item to note was the plan for 2014-15 which was laid out on page 8. He also drew the committee's attention to page 11 where the report highlighted a change in the assurance level ratings system. NT explained that rather than reports being given a red, amber or green rating they would now be given one of four ratings – significant assurance, significant assurance with minor improvement opportunities, partial assurance with improvements required or no assurance. KPMG would also be converting the Trust's 2013-14 ratings into the new scoring system for comparison.

JB stated that he felt there should be a much greater level of visibility on the procurement front from "the centre" – the Trust should adopt KPIs relating to procurement and these should be reported to the Board and included in the 2014-15 Annual Report. He also noted that it might be helpful if KPMG reviewed procurement in the latter half of the year when any actions required had been completed. LB suggested that this could be included within the

planned Stock Management review and NT replied that this could be done in conjunction with the Marsden.

JB asked if something could also be added to the plan about teaching income streams and LB said that we would need more time to think about this. JB queried whether HB felt there were any areas that should be looked at – HB replied that there were none in particular with the exception of the obvious area of data quality.
RP stated that the Trust is in the process of outsourcing its accounting system and asked whether this should be covered by an internal audit review – it was agreed that this would be picked up under the normal review of Financial Management and Financial Reporting arrangements. LB asked that these reviews should also cover the process for management of NHS debt and cash collection.

LB agreed that the changes suggested would be reflected in the 2014-15 internal audit plan and that this would then be signed off by the Execs.

Action: LB and RP to ensure that the points about procurement, outsourcing the accountancy system and the review of NHS debt collection and cash management are reflected in the KPMG 2013-14 internal audit plan and that this is signed off by Execs.

JB agreed this course of action and the report was noted.

4.1 Deloitte Final Report on the 2013-14 Audit

HB presented this report and drew the committee's attention to the first section entitled "The Big Picture". The key point noted was the significant increase in the Trust's debt compared to the previous year. HB noted that the level of judgement involved was significantly higher, and that the levels of debt were also relatively higher than those at other Trusts. LB queried whether our debt levels would be more normal if the Local Authority debt was stripped out – BS replied that we would still be above average but not at the top of the list. Other Trusts had been able to collect more cash at the year end in comparison to Chelsea and Westminster.

DK asked whether there was a specific problem with local authorities and RP replied that he didn't think local authorities had properly understood the nature of the sexual health service but that lessons had been learned from this. HB pointed out the impact of the Trust's reduced cash balance at year-end on the PDC payable and JB stated that he felt it was unacceptable that the Treasury in effect had received a "prize" for not paying our outstanding debt.

BS stated that Deloitte had flagged up this issue with Monitor and that the hit to Chelsea and Westminster had been approx. £0.5m whereas for other Trusts it had been on average £0.25m. BS pointed out that Deloitte had carried out a lot of work on the Trust's debt, including email correspondence with local authorities.
HB noted that the Trust's provision levels were low but that Deloitte had concluded that they were reasonable based on all the data reviewed. HB felt that the Trust had been less prudent than in 2013-14 and compared to other

Trusts who were making higher provisions, but there was no reason for us to book a higher level of provision because there was no evidence of any dispute.

The second key risk area was the valuation of land and buildings and the acquisition of Doughty House – JB noted that he thought the land value would be higher in Chelsea and HB agreed that the valuation was subject to a high level of subjectivity but that it was within a reasonable range.
HB noted that there was nothing to raise in relation to Deloitte's Value for Money conclusions.

In terms of the Annual Report, HB noted that these had been evolving across the sector and that there were new requirements and a lot of change to take on board. However HB anticipated that Deloitte would be issuing an unmodified audit opinion and assured the committee that all major outstanding audit areas were fully cleared or in the process of being cleared. The only remaining items were Deloitte's review of the FTCs and the NAO work together with the review of events since 31 March 2014 and the rep letter. HB stated that Deloitte would re-issue their report to state this.

JB queried the tick mark on the chart on page 4 relating to capital expenditure reporting and asked why it was so far to the right on the chart – BS explained that the Trust capitalised new expenditure into buildings but did not dispose of expenditure relating to the existing asset and that this involved a significant judgement. CMcL pointed out that this was superseded by the valuation. HB agreed that the tick mark would be moved one place over to the left in the next version of the report.

BS presented the section on NHS debtors and stated that there was no issue with debtors not paying anything at all, but that in general quarter 3 and 4 over performance was still outstanding and the value was slightly higher than for quarters 1 and 2. There were no disputes in the Agreement of Balances exercise and only a few queries on old invoices but these were being dealt with.

In terms of local authority debt, BS noted that there was clearly a big compliance issue with providing activity information to local authorities, and RP responded that the nature of the activity was confidential and therefore this made it difficult to provide the level of information about patients that was being requested. JB noted that this sounded like an issue of process rather than that there were any particular disputes and BS agreed that this was the case. CMcL pointed out that £18m of the £26m NHS debt total was not yet due for payment, and that last year PCTs had been keen to settle debt prior to the year end so our 2013-14 debt level had been unusually low whereas this year it was unusually high.

LB stated that she felt there was an education here in terms of the Trust's debt collection and cash management processes. RP pointed out that the situation would improve in 2014-15 due to the fact that 11 local authorities had formed an alliance, and that contract discussions so far had been constructive therefore he was hopeful that the cash collection situation would improve.

JB stated that he was happy with the property valuation and DK agreed.

Moving on to the Annual Report, BS stated that Deloitte had received a revised draft and that there were a number of items still to be worked through. In terms of the Audit Committee Report, BS had suggested some wording for this to meet the new requirements, and noted that the Annual Report as a document was now very long and could be daunting to the reader.

JB stated that he did not feel it was a good use of time for the Audit Committee to discuss the Trust's business model, since there was no choice of business model available – we are mandated to provide healthcare. However JB noted that he was concerned that the Audit Committee must assure the Board that what they are being presented with is "fair, balanced and understandable" – RP responded that he would receive this assurance prior to the Board meeting and that this was still work in progress.

JB noted the contents of the Remuneration Report and requested that a note should be included about the pensions figures reported for the Medical Director – it was agreed that this should be done. CMcL agreed that the note would be updated with some prior year figures.

LB stated that she had discussed with TB the disclosure of a contingent liability in the rep letter and he had agreed that this should be added. The Trust has a small number of possible litigations which would not be covered through our insurance but these are not material. We are at the start of a process that could take a number of years to conclude.
JB asked whether the rep letter as presented to the committee was in a standard format – HB replied that it was, but that it had been tailored specifically to the Trust in points 30 and 31.

4.2 And 4.3 Directors' Briefing and Annual Accounts 2013-14

LB presented the overall view on the Trust's financial position and noted that our non-elective income went down but this was deliberate because we had moved to a block approach for paying for services that were not appropriate to be provided in a hospital setting. There had been a small increase in PP income and we had been anticipating a significant drop in R&D income but this had remained largely flat. The committee should be aware that the income in year from charitable contributions had skewed the surplus reported, and that the actual surplus was £3.2m when charitable contributions were stripped out.

LB also drew the committee's attention to the change in commissioners shown on page 3 of the accounts. DK queried page 2 of the Directors' briefing which showed a £781k reduction in R&D income and queried whether this was because there had been a reduction in external R&D activity. LB replied that this was not clear and that this was also related to the fact that the previous year's figure included prior year income. She assured the committee that this was not a sign that we had reduced our research activity.

LB also pointed out that there had been an 8% increase in overall operating expenses and JB agreed that this was a significant problem. JB asked Deloitte how this compared to other Trusts – HB responded that other Trusts had experienced similar increases in costs compared to income. LB pointed out that we would expect to see higher costs because the Trust has been going through a transaction during 2013-14. JB noted that the big ticket items were where there is more variability in cost, for example staff costs, drugs,

transport and premises. JB also noted that the Directors' Briefing was a very useful analysis in directing the Board to areas requiring their focus. LB agreed and noted that the Trust should be looking at these trends all the way through the year.

JB noted the report and thanked CMcL on behalf of the committee for all her hard work.

JB moved on to ask whether there were any changes to the Annual Accounts as presented to the committee, and CMcL replied that there were some minor changes to the Cash Flow Statement and handed out new copies. It was agreed that negative figures should be reported in brackets and in black. CMcL informed the committee that there were four figures to be changed on the face of the cash flow statement and that these related to a £1.354m reduction in the NHS debtors figure due to an invoice raised by the Trust on behalf of Imperial College Health Partners being correctly removed from this figure, and also a correction required to move £899k of Assets Under Construction from PPE to Intangibles.

CMcL also noted that some minor changes were required to Note 5.6 relating to Senior Managers Remuneration and JB agreed that a footnote was needed to explain the Medical Director's figures. LB also pointed out that note 26.1 relating to contingent liabilities would need to change due to the litigation already mentioned.

JB stated that subject to these changes the Audit Committee would recommend the Accounts for adoption by the Trust Board.

5.2 Audit Committee Annual Report to the Trust Board

JB noted that there were two gaps in this report as it stood – one relating to the requirement for the Audit Committee to evaluate the external auditors and the other relating to the requirement for the Audit Committee to assure the Board that the Annual Report presented a fair, balanced and understandable view. RP agreed to take this away and assured the committee that these gaps would be addressed before the report went to the Trust Board the following week.

JB stated that the report was approved, subject to the above items.

JB noted that he and DK had not seen the draft Annual Report and therefore could not give an opinion on it at this point or provide assurance to the Board that is presented a fair, balanced and understandable view. TB replied that the draft report would be sent out the following day to allow the Board to have sight of it before the meeting the following Tuesday. JB noted that he felt that we should not hide the challenges that the Trust had faced and would continue to face.

5.3 Annual Governance Statement

LH introduced the Annual Governance Statement and noted that she felt that page 9 of the report helped to address JB's point about risks. LH went on to ask for the committee's views on the Care Quality Commission section and queried whether anything should be added in relation to the CQC Intelligent Monitoring tool. The committee felt that this was not necessary.

BS picked up a point relating to page 8 about the Trust's compliance with Monitor's Code of Governance and asked where this had been formally considered – LH replied that this was considered and minuted at the April Trust Board.

The report was noted and agreed.

6.1 Single Tender Waivers

JB queried the single tender waiver relating to the purchase of a simulation system and asked whether the Trust risked replacing something that was going to fail again. This was noted and taken away for consideration.

The report was noted.

6.2 Losses and Special Payments

RP presented the report and noted that there were no items of particular note reported. JB asked BS whether the Trust was out of line with other Trusts in terms of the level of losses and special payments and BS replied that the figures reported this year were better than the prior year.

The report was noted.

6.3 Audit Committee Forward Plan

RP agreed to add the Clinical Audit Work Programme to the forward plan.

In conclusion, JB thanked the Trust team for all their work during the year and TB responded by thanking JB for doing such a diligent job in chairing the Audit Committee.

Any other Business

None noted.

7. DATE OF THE NEXT MEETING

8th July 2014 1-3pm Main Hospital Boardroom