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, 30 October 2014 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 31 July 2014 | TH-H | |
| 1.5 | Matters arising | TH-H | |
| 1.6 | Chairman's Report | TH-H | |
| 1.7 | Chief Executive's Report (oral) | APB | |
| 1.8 | Council of Governors Report including Membership Report | TH-H | |
| **2** | **QUALITY** | | |
| 2.1 | Patient Experience (video) | EM | |
| 2.2 | Safer Staffing | EM | |
| 2.3 | Ebola Update (oral) | EM | |
| **3** | **GOVERNANCE** | | |
| 3.1 | Care Quality Commission Report (oral) | APB/EM | |
| 3.2 | Approval of the Terms of Reference of the Audit Committee | JB | |
| **4** | **PERFORMANCE** | | |
| 4.1 | Finance Report – September 2014 | LB/RP | |
| 4.2 | Performance Report – September 2014 | RH | |
| 4.3 | Monitor In-Year Reporting & Monitoring Report Q2 | LB | |
| **5** | **STRATEGY** | | |
| 5.1 | West Middlesex Update (oral) | APB | |
| 5.2 | Research and Innovation Strategy 2014-19 | DB/APB | |
| **6** | **ITEMS FOR INFORMATION** | | |
| | **QUALITY** | | |
| 6.1 | Assurance Committee Report – June, July and September 2014 | KN | |
| 6.2 | Infection Control Annual Report 2013/14 | EM | |
| | **GOVERNANCE** | | |
| 6.3 | Board Assurance Framework and Risk Report Q2 | APB/EM | |
| 6.4 | Register of Seals Report Q2 | LH | |
| 6.5 | Proposed Board meeting dates for 2015 (to be tabled) | TH-H | |
| 6.6 | Fit and Proper Person Test and Duty of Candour | SY | |
| 6.7 | Audit Committee Minutes – 8 July 2014 | JB | |

| | | |
|---|---|---|
| **7** | **ANY OTHER BUSINESS** | |
| **8** | **QUESTIONS FROM THE PUBLIC** | |
| **9** | **DATE OF NEXT MEETING – 29 January 2015** | |
| | **CLOSE** | **5.30** |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Board of Directors Meeting, 30 October 2014 PUBLIC

| | |
|---|---|
| **Subject/Title** | Draft Minutes of the Public Meeting of the Board of Directors held on 31 July 2014/1.4/Oct/14 |
| **Purpose of paper** | To provide a record of any actions and decisions made at the meeting |
| **Decision/action required/ recommendation** | The meeting is asked to agree the minutes as a correct record of proceedings<br><br>The Chairman is asked to sign the agreed minutes |
| **Summary of the key risks/issues from the paper** | This paper outlines a record of the proceedings of the public meeting of the Board of Directors held on 31 July 2014. |
| **Link to corporate objectives** | NA |
| **Executive Sponsor** | Sir Tom Hughes-Hallett, Chairman |

**Board of Directors Meeting, 31 July 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 |
| | Dr Andrew Jones | AJ | |
| | Eliza Hermann | EH | |
| | Sir John Baker | JB | |
| | Jeremy Jensen | JJ | |
| | Jeremy Loyd | JL | |
| | Karin Norman | KN | |
| | Nilkunj Dodhia | ND | |
| **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 | Head of Communications & Marketing (minute-taker) |

## 1 GENERAL BUSINESS

### 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, Professor Richard Kitney and Liz Shanahan.

### 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 27 May 2014** **TH-H**

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

**1.5 Matters arising** **TH-H**

TH-H confirmed that all matters arising were complete.

Governor Tom Pollak asked for more clarity on what progress had been made in respect of ensuring sufficient numbers of cycle racks in the local vicinity to the hospital. TH-H referred TP to the note in the maters arising which contained a detailed report from the Director of Estates and Facilities.

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

TH-H said that, in addition to his written report, he continues to regularly visit peer organisations and had this month met with Imperial College Healthcare and Kings College Hospital senior management colleagues. In particular, the meeting with Kings College Hospital provided an opportunity to discuss their experience of unifying hospitals into a new organisation and the challenges that resulted.

**1.7 Chief Executive's Report** **APB**

APB highlighted the key points from his report:

- Healthwatch Annual General Meeting – APB thanked the organisation for the opportunity to talk through the organisation's long term vision for healthcare in North West London and stressed the importance of the work Healthwatch do to act as a critical friend to Chelsea and Westminster, ensuring that we are providing health provision that meets the needs of local communities
- Accountable Care Group (ACG) APB talked through progress as a national pilot, noting that the notion behind the concept of accountable care is to ensure that we work with partners to provide a holistic approach to healthcare, meeting the health and well-being needs of the communities we serve, which does not need to be constrained by the hospital setting. Our work with community trusts, GPs and mental health will provide an integrated care system that will truly meet population need.
- Neonatal Intensive Care Unit (NICU) incident – APB thanked the quick action of our NICU clinicians and Director of Infection Prevention and Control Dr Berge Azadian for identifying the infection risk which ensured that swift action could be taken to protect affected patients both at the Trust and nationally. The Chief Executive of Public Health England noted the significant contribution made by the team at Chelsea and Westminster.
- Star Awards and Open Day events – APB acknowledged the significant contribution made by the Council of Governors for the success of both events and noted the efforts made by the Communications Team to deliver high quality events highly regarded by other NHS organisations. The Star Awards – APB in particular recognised the quality of staff at the Trust who go the extra mile in delivering excellent care to patients.

**1.8 Council of Governors report including Membership Report and Quality Awards** **TH-H**

TH-H noted the hugely supportive Quality Awards which are funded, chosen and presented by Governors highlighting excellence at the Trust. The report illustrates a strong membership and at the last Council of Governors meeting it was agreed there would be a focus on engaging with our existing membership base.

## 2 QUALITY

### 2.1 Patient experience — EM

The Board received two patient stories from maternity, one positive and one negative. The Board agreed that getting feedback directly from patients is important in learning and improving the care we provide and while we cannot go into detail on either case both ZP and EM will use this feedback to review standards of care.

### 2.2 Assurance Committee Report April and May 2014 — KN
### 2.3 Assurance Committee Annual Report 2013/14 — KN

TH-H stated that both items were discussed in length at the closed session and so would be taken as read unless any members of the public wanted to ask questions. None were raised.

### 2.4 Complaints Annual Report 2013/14 — EM

EM outlined the importance of listening to complaints in an open manner in order to improve care and experience and noted the key points from the report:

- Themes – clinical care, attitude and communication
- Increase in the number of people referring to the Health Service Ombudsman (HSO) which we believe to be as a result of the NHS's transparency agenda. The Trust hasn't seen an increase in the number of cases upheld by the HSO

EH noted that the full report was very helpful and asked how the report is disseminated more widely in the organisation and to external partners e.g. Monitor. EM said that it is shared with the Care Quality Commission and disseminated internally through the divisional structure. In addition to this, complaints are discussed at every Executive Team meeting and on a quarterly basis they are reviewed by theme. Complaints are a fundamental topic in the Trust annual Quality Account, reviewed by key stakeholders.

ZP remarked that each complaint is reviewed by the Medical Director and Chief Nurse and Director of Quality.

JJ asked whether there is clarity on the timeliness of replies, number of outstanding enquiries and the ages of complainants. EM confirmed this is the case.

JB asked whether, as one of the themes is staff attitude, we identify individuals concerned and if the appraisal system recognises complaints.

ZP confirmed that all doctors have complaints against them logged on the online system and these are discussed both during the complaints service and through appraisal.

SY commented that the Trust response depends on the severity of the incident and

level of action is based on this through established HR processes.

TH-H concluded that a rise in complaints does not necessarily illustrate a failing hospital but could be a positive illustration of openness and the ability of patients to feel able to communicate with the Trust. He thanked the author for a detailed and comprehensive report.

**2.5 Risk Management Annual Report 2013/14** **EM**
**2.6 Risk Management Strategy and Policy 2013/14** **EM**

EM noted both items were taken as read.

She confirmed both reports illustrate that there is a risk management system in place and that the strategy illustrates the processes used to identify roles and escalate risks. She highlighted risks related to medicines management, falls and pressure ulcers, identified and actively managed by the appropriate senior clinical lead.

JB asked whether these items were linked to strategic risk management. APB responded by saying that strategic risk is identified in the Board Assurance Framework and these risks are intrinsically linked to the risk register, hence why both documents are presented together at the Board.

TH-H noted that the report illustrated this was ongoing work and asked whether there were any other significant risks not identified in reports. EM confirmed this was not the case.

KN commented that risk is also discussed at the Assurance Committee, a subcommittee of the Board.

ND thanks EM for the detailed items and asked whether the Trust has a sense of whether there is an open culture at the organisation. EM said that different evidence used can demonstrate different outcomes in respect of having an open culture e.g. Care Quality Commission's Intelligent Monitoring Report and to get a true sense it is important to triangulate data. EM confirmed that the Trust felt there was an open reporting culture.

ND queried whether the Trust provided feedback to staff on how risks identified have been acted upon. EM confirmed there was an appropriate system in place, detailed in the strategy, and SY noted that incident reporting is a key focus in the national and independent Staff Survey.

## 3 GOVERNANCE

**3.1 CQC Announced Inspection Update** **EM**

EM confirmed that the inspection had concluded with one announced inspection lasting two days and subsequent unannounced inspections of hospital services. EM thanked staff for the efforts they made to continue to deliver care at the same time as being inspected and appreciate the opportunity the process provided to both highlight excellent care and have an opportunity to learn.

Governor Martin Lewis praised staff for their commitment during the process and commented that the CQC – in this new process – also had an opportunity to learn from our feedback.

TH-H concluded that communications following the outcome of the inspection process would be vital in respect of maintaining staff pride and morale. He thanked JB for deputising as Chair during the inspection interview process.

**3.2 Monitor In-Year Reporting and Monitoring Report Q1** **LB**
**4.1 Finance Report – June 2014** **RP**

TH-H asked for items 3.2 and 4.1 to be taken together.

APB confirmed that the Trust has declared the total risk rating of Red for finance as a consequence for not achieving planned Cost Improvement Programmes (CIPs) and private patient income, though it important to note that the negative financial position has been partly offset by a better than expected clinical income. The Trust maintains a Continuity of Service Risk Rating (COSR) of 3. APB noted this was a disappointing position and the Trust has taken immediate action including:

- Meeting with Divisions to discuss CIP performance and what support is needed to achieve the annual programme
- Readjusting financial position to achieve a realistic surplus
- Reducing levels of vacancies and therefore the need for agency staff
- Ensuring teams work to their staffing establishment levels
- Improving efficiency and productivity
- Underpinned by regular communication with staff on the issue throughout the summer

The consequence of not achieving our financial position by Q3 will put the organisation at significant risk.

LB confirmed that the reinstatement of executive controls on spend should have a successful impact on the future financial position.

TH-H commented that the financial position was discussed at length in the closed session and that the Non-executive Directors gave their full support to the Executive Team in achieving the readjusted forecast.

JB asked APB to explain how we have got ourselves in this position. APB said that unlike other hospitals Chelsea and Westminster had not had to deal with such a financial position before and as such the cultural change that needs to be implanted will be crucial to our success.

KN noted that CIPs are agreed with the Chief Nurse and Director of Nursing and Medical Director to ensure patient care is not unduly affected.

LB outlined the contents of item 3.2 and the Board agreed delegation of approval to LB in order to submit our return within the stipulated deadline.

**Action: LB authorised to submit item 3.2 to Monitor within the stipulated deadline.** **LB**

**3.3 Board Assurance Framework and Risk Report Q1** **APB**

TH-H stated that this item would be taken as read unless any members of the public wanted to ask questions. None were raised.

**3.4 Register of Seals Report Q1*** **SY**

This item was starred and taken as read.

**3.5 A Framework of Quality Assurance for Responsible Officers and Revalidation: Annual Board Report 2014** **ZP**

TH-H asked for this item to be taken as read, but noted that the report required the Chairman and Chief Executive's signature for approval. TH-H expressed concern that the Trust was satisfied by appraisal levels of 82% and encouraged the Medical Director to drive performance next year to 100%. ZP confirmed that those doctors not willing to be appraised are then referred to the General Medical Council, sanctions including that they can be taken off the medical register for non-compliance. TH-H and APB approved the use of their signatures for this document.

**4 PERFORMANCE**

**4.2 Performance Report - June 2014** **RH**

RH highlighted key items from the report including:
Monitor compliance with clinical targets
A&E seeing a disproportionate increase in blue light attendances, unduly affecting performance
Improved performance in the reduction of caesarean section rates, though more needs to be done
Improved performance in both time to theatre for urgent surgery and choose and book slot accessibility

RH focused on referral to treatment times and noted NHS England's £250 million investment to reduce the backlog of patients waiting across the country. It is expected that all Trusts will be compliant with this by the end of Q3.

RH also noted that our cancer waiting times for the 62 day target was the best in London.

JB thanked RH for the comprehensive report but asked whether it was credible that falls and pressure ulcer performance are rated as green.

**Action: EM and ZP to bring a comprehensive update to the next Board.** **EM/ZP**

Governor Tom Pollak asked whether the A&E Department will be able to cope with expected increases in patient numbers because of the A&E closures at Hammersmith and Charing Cross.

APB commented that Charing Cross will still have an Urgent Care Centre and emergency surgery would be relocated to St May's. It is expected patients will choose to attend our A&E Department because of the high quality care we provide and 60 step down beds have been identified to aid discharge, which is vitally important to the smooth running of A&E services.

**5 STRATEGY**

**5.1 Strategy update** **APB**

This Item was covered in the Chief Executive's Report.

## 6 WORKFORCE

### 6.1 Annual Workforce Monitoring Report SY

SY confirmed that the Trust met targets in relation to staff engagement, sickness rates and time to recruit being above average for each indicator compared to other NHS Trusts.

All metrics improved except vacancies (due to it being a stretch target, not a national target).

The workforce as a whole has 100 more Whole Time Equivalents compared to the preceding year and 138 more clinical staff will join the Trust by October.

Risk remains in the area of high turnover.

SY asked for approval of the workforce metrics in the report. These were approved subject to a suggestion by KN who asked for an equality and diversity metric to be incorporated.

EH thanked SY for a comprehensive report and noted that turnover costs money so reducing this should be a priority.
APB confirmed that workforce will be an upcoming item for the Directors Strategy sessions.

## 7 ITEMS FOR INFORMATION

7.1 Audit Committee Minutes – 22 May 2014

Noted.

## 8 ANY OTHER BUSINESS

None.

## 9 QUESTIONS FROM THE PUBLIC

Governor Sandra Smith-Gordon noted that there remain some staff not attending mandatory training and asked whether internal communications and engagement filters effectively throughout the organisation.

APB commented that top-down communications is highly rated but that there is more work to be done to ensure visibility of the Board.

## 10 DATE OF NEXT MEETING – 30 October 2014

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Board of Directors Meeting, 30 October 2014 PUBLIC

| | |
|---|---|
| **Subject/Title** | Matters Arising – 31 July 2014/1.5/Oct/14 |
| **Purpose of paper** | To provide a record of actions raised and any subsequent outcomes from the July Board of Directors Meeting Public. |
| **Decision/action required/ recommendation** | The Board is asked to note the actions or outcomes reported by the respective leads. |
| **Summary of the key risks/issues from the paper** | This paper outlines matters arising from the public meeting of the Board of Directors held on 31 July 2014. |
| **Link to corporate objectives** | NA |
| **Executive Sponsor** | Sir Tom Hughes-Hallett, Chairman |

**Board of Directors Meeting, 31 July 2014 Public**

| Ref | Description | Lead | Subsequent Actions/Outcomes |
|---|---|---|---|
| **3.2/Jul/14** | **Monitor In-Year Reporting and Monitoring Report Q1** | | |
| | **Action: LB authorised to submit item 3.2 to Monitor within the stipulated deadline.** | **LB** | Completed |
| **4.2/Jul/14** | **Performance Report - June 2014** | | |
| | JB thanked RH for the comprehensive report but asked whether it was credible that falls and pressure ulcer performance are rated as green. | | |
| | **Action: EM and ZP to bring a comprehensive update to the next Board.** | **EM/ZP** | |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Board of Directors Meeting, 30 October 2014 PUBLIC

| | |
|---|---|
| **Subject/Title** | Chairman's Report/1.6/Oct/14 |
| **Purpose of paper** | This paper is intended to provide an update to the Board on key issues |
| **Decision/action required/ recommendation** | For information |
| **Summary of the key risks/issues from the paper** | This report updates the Board on a number of key developments and news items that have occurred since the last meeting. |
| **Link to corporate objectives** | All |
| **Executive Sponsor** | Sir Tom Hughes-Hallett, Chairman |

## Chairman's Report

### Council of Governors elections

I am delighted to announce that next month sees the Council of Governors elections being held. There are vacancies in the following constituencies:

- Patient constituency – 2 seats
- Public constituency – Kensington and Chelsea Area 2
- Staff constituency – 1 seat from each of the following:
    - Allied Health Professionals, Scientific and Technical
    - Management
    - Support, Administrative and Clerical.

Voting will take place from 6 November until 27 November with results published on the Trust website on 28 November. I encourage every member that falls within each of the above constituencies to exercise their right to vote as the Council of Governors will have a major role to play in many key strategic decisions that will take place over the next year.

### Quality Summit

I very much welcomed the opportunity to discuss the CQC's report and discuss actions to be taken forward as a result of their findings at the recently held Quality Summit. The active participation of stakeholders will be fundamental in improving some of our performance across the CQC's domains, as they relate to system wide issues (for example medical staffing levels) which the Trust like others cannot resolve alone, and look forward to agreeing our action plan with stakeholders by the end of November. The Board of Directors and the Council of Governors will be kept fully informed of our progress against the action plan, which we believe will be fully completed by the end of the financial year.

### Royal Borough of Kensington and Chelsea visit

I enjoyed meeting newly appointed the Worshipful the Mayor of the Royal Borough of Kensington and Chelsea, Councillor Maighread Condon-Simmonds, earlier this month. The Mayor has a tour of our hospital facilities, including A&E where she heard about our A&E redevelopment plans, and gave a very interesting perspective on care at the hospital thanks to her professional nursing background.

### Goodbye and Thank you to Karin Norman

I have valued Karin's contribution to this Board very much in the time we have worked together, and I know that she has been enormously committed to Chelsea and Westminster over the past years. I will be sorry to see Karin go, and we will make sure we mark the occasion appropriately in due course.

# Board of Directors Meeting, 30 October 2014 PUBLIC

| | |
|---|---|
| **Subject/Title** | Council of Governors Report including Membership Report/ 1.8.Oct/14 |
| **Purpose of paper** | Part A – provides highlights of the Council of Governors meeting held on 17 July 2014<br>Part B – updates the Board on membership numbers |
| **Decision/action required/ recommendation** | For information. |
| **Summary of the key risks/issues from the paper** | This paper highlights the pertinent issues discussed at the Council of Governors meeting held on 17 July 2014 and the updates the Board on membership numbers. |
| **Link to corporate objectives** | NA |
| **Executive Sponsor** | Sir Tom Hughes-Hallett, Chairman |

**Part A**

## Council of Governors Report

### 1.0 Chief Executive's Report

The Governors noted that the Board informally discussed the progress on the potential acquisition of the West Middlesex University Hospital (WMUH).

The Governors also noted that the Shaping a Healthier Future (SaHF) continues and due to closure of A&E departments at Central Middlesex Hospital and Hammersmith Hospital, Chelsea and Westminster has seen an increase in A&E attendances and an implementation business case will be submitted to NHS England and HM Treasury in autumn. The redevelopment of the Emergency Department is moving forward due to increasing number of patients to be seen in the A&E in the coming years.

Governors noted that a bid for winter pressure funding would be submitted to the Department of Health.

Governors noted that SytemOne EPR Core was going live by end September in the Emergency Department which would enable our consultants to view a patient's record such as allergies, current medications, recent consultations etc.

### 2.0 Care Quality Commission (CQC) Announced Inspection update

The Governors noted that the Trust had received a draft CQC report and the report will be checked for factual accuracy. The CQC will hold a quality summit where the results will be shared at a public meeting and governors will be informed of the date.

### 3.0 West Middlesex – update

An update on the West Middlesex was provided and governors visit to the site was noted. It was noted that the governors would wish the Board to consider moving forward to a full business case. A number of questions remain to be answered including cultural integration, whether Information Management and Technology (IMT) expenditure expressed in the transaction is sufficient and rescheduling the PFI debt. It was also noted that Governors wished to receive advice on health and well-being of population of both Chelsea and Westminster and the WMUH.

### 4.0 Re-appointment of Non-Executive Directors

Governors noted that two Non-executive Director appraisals were due to be carried out. Governors also noted that Karin Norman's and Professor Richard Kitney's terms of office were coming to an end on 31 October 2014. The possibility of Professor Kitney continuing to work with the Board in an advisory capacity would be discussed.

### 5.0 Any other business

Governors noted that the Public Governor Tom Pollak was going to present at the Annual Members' Meeting on behalf of the Council of Governors.

**Part B**

## Membership Report

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

During Q2 2014/15 156 members joined and 336 left the Trust membership. A data cleanse was performed during October to prepare for the November Governor Elections. This would affect leavers to cleanse names of members who have moved from eligible Borough areas or sadly have deceased.

Membership numbers are broken down (below) to reflect patient, public and staff membership representation for Q2 2014/15.

**Table 1.0 Joiners and Leavers, Q2 2014/15**

| **Start Period** | 01/07/2014 | 01/08/2014 | 01/09/2014 |
|---|---|---|---|
| **End Period** | 31/07/2014 | 31/08/2014 | 30/09/2014 |

| **Totals** | **Jul** | **Aug** | **Sep** |
|---|---|---|---|
| **Period Start** | **15,294** | **15,378** | **15,137** |
| Joiners | 84 | 36 | 36 |
| Leavers | 0 | 277 | 59 |
| **Period End** | **15,378** | **15,137** | **15,114** |

| **Public** | **Jul** | **Aug** | **Sep** |
|---|---|---|---|
| **Period Start** | **5,658** | **5,669** | **5,544** |
| Joiners | 11 | 0 | 8 |
| Leavers | 0 | 125 | 9 |
| **Period End** | **5,669** | **5,544** | **5,543** |

| **Patient** | **Jul** | **Aug** | **Sep** |
|---|---|---|---|
| **Period Start** | **6,241** | **6,313** | **6,198** |
| Joiners | 72 | 36 | 27 |
| Leavers | 0 | 151 | 48 |
| **Period End** | **6,313** | **6,198** | **6,177** |

| **Staff** | **Jul** | **Aug** | **Sep** |
|---|---|---|---|
| **Period Start** | **3,395** | **3,396** | **3,395** |
| Joiners | 1 | 0 | 1 |
| Leavers | 0 | 1 | 2 |
| **Period End** | **3,396** | **3,395** | **3,394** |

### 2. Membership ethnicity

2.1 Figure 1 shows overall members ethnicity. At the end of Q2 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.

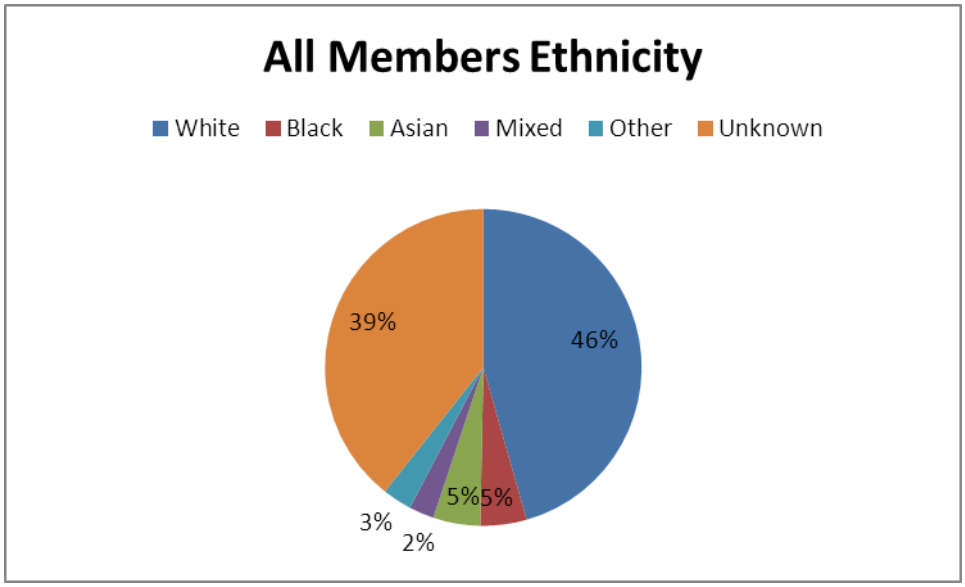
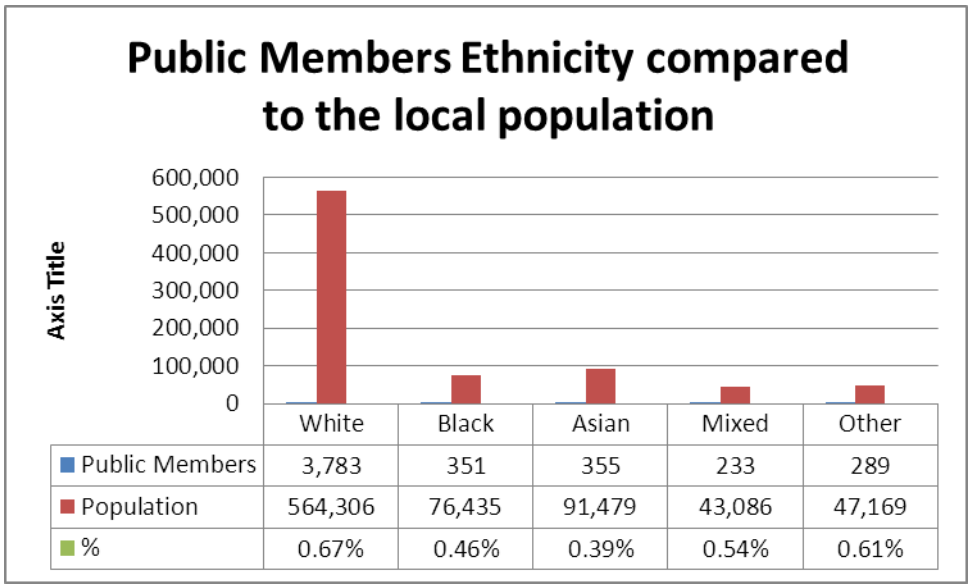



**Figure 1.0 Overall Members Ethnicity Q2 2014/15**

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




| | White | Black | Asian | Mixed | Other |
|---|---|---|---|---|---|
| Public Members | 3,783 | 351 | 355 | 233 | 289 |
| Population | 564,306 | 76,435 | 91,479 | 43,086 | 47,169 |
| % | 0.67% | 0.46% | 0.39% | 0.54% | 0.61% |

**Figure 2.0 Public Membership Comparisons to the Local Population Q2 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+

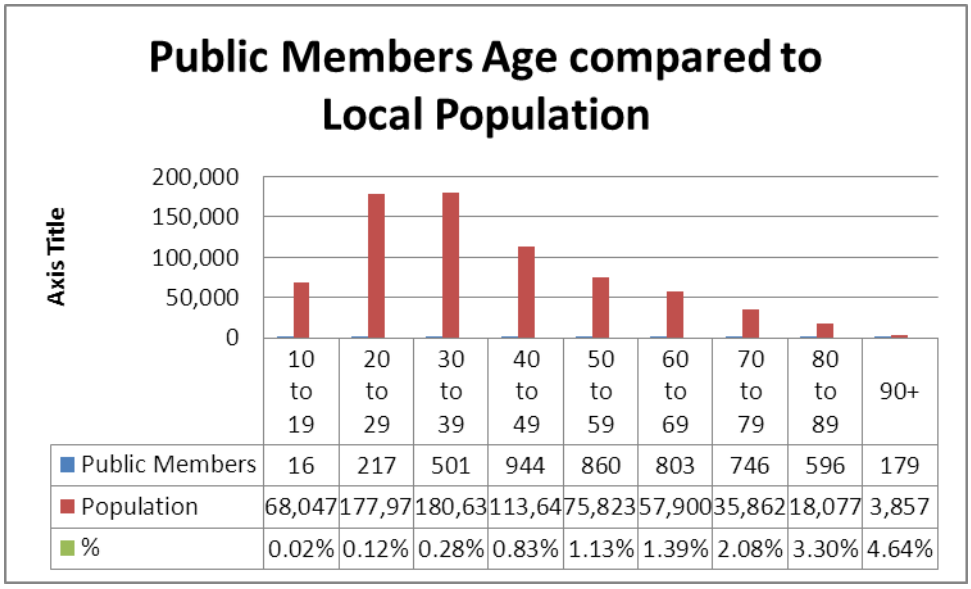



**Figure 3.0 Public Membership Age Q2 2014/15**
In the youngest age group that Monitor accepts as valid membership is from 16years+ however, the local population figures start at 10 years therefore this is guidance only.

3.1 The chart below shows 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.

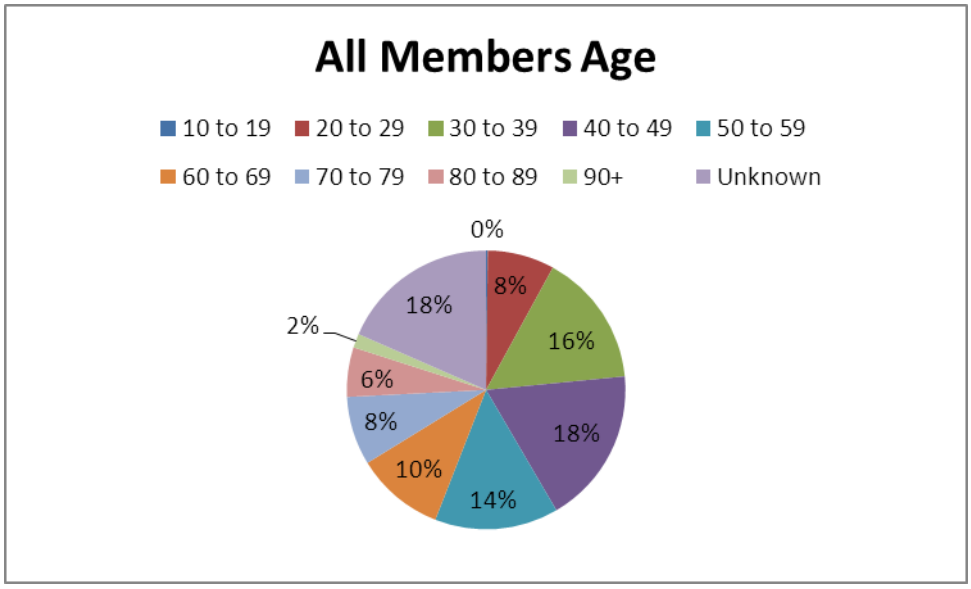



**Figure 3.1 Overall Membership Age Groups. Q2 2014 15**
***Age 10-19 indicates 16-19 years**

## 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 (Q2 2014 15) the main representation is in the ABC1 and DE classification.

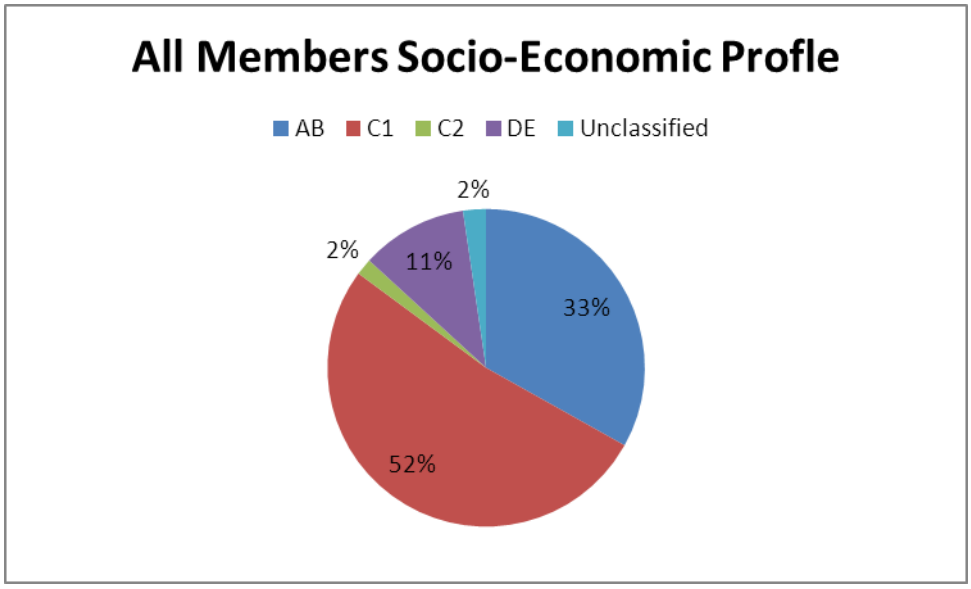



**Figure 4.0 Overall Membership - Socio-Economic Groups***

*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 Q2 2014/15 156 members joined and 336 left the Trust membership.

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. The most recent data cleanse was performed during October to prepare for the November Governor Elections. 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 Membership recruitment strategy. The membership figures will be reviewed at each Membership Sub-Committee meeting with a decision made whether to commission recruitment activities.

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. The Communications team concentrate on Membership engagement.

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** |

**Figure 6. Membership trends 2007-2014**

# Board of Directors Meeting, 30 October 2014 PUBLIC

| | |
|---|---|
| **Subject/Title** | Safer Staffing/2.2/Oct/14 |
| **Purpose of paper** | The National Quality Board State that Boards must take full and collective responsibility for nursing, midwifery and care staffing capacity and capability. Delivery of this will be monitored by the Care Quality Commission, our Commissioners and reported through to NHS England. |
| **Decision/action required/ recommendation** | The Board is asked to;<br>**1.** Agree to the realignment of budgets to existing staffing models with immediate effect<br>**2.** Support the case for 3 supervisory days for ward sisters<br>**3.** Acknowledge the immediate risks and support the remedial action<br>**4.** Agree and support the development of a business focussing on further supervisory time and priority areas, including nights |
| **Summary of the key risks/issues from the paper** | This staffing review has demonstrated that;<br>• Our 2014/15 budgets do not align to existing staffing models<br>• That the redistribution of existing budgets would align staffing models to budgets and provide for 3 days supervisory time<br>• That registered nurse staffing levels at night in several areas require further consideration<br>• That overall staffing levels for 3 wards present a risk |
| **Link to corporate objectives** | Quality |
| **Executive Sponsor** | Elizabeth McManus, Chief Nurse and Executive Director of Quality |

# Safer Staffing

## 1. Introduction

Our patients have the right to be cared for by appropriately qualified staff in a safe environment. This right is defined in the NHS Constitution and makes explicit the Board's corporate accountability for quality. Demonstrating sufficient staffing is one of the six essential standards that all health care providers must meet to comply with the Care Quality Commission regulation. The effect of too few nurses is clearly evidenced and researched and the guidance produced by the Chief Nursing Officer of England as part of the Governments response to the Francis Report clearly identifies the need for organisations to ensure they have the correct staffing levels.

This paper details the staffing review for the adult inpatient areas within Medicine and Surgery and additionally Ron Johnson and Annie Zunz.

## 2. Decision/action required

The Board is asked to;

1 Agree to the realignment of budgets to existing staffing models with immediate effect
2 Support the case for 3 supervisory days for ward sisters
3 Acknowledge the immediate risks and support the remedial action
4 Agree and support the development of a business case focussing on further supervisory time and priority areas, including nights

## 3. Background

The Board received an update on the progress made against the National Quality Board Report (NQB) requirements and Hard Truths Commitments in June 2014. At that time a commitment was made to submit a staffing review to Board in October 2014.

The NQB guidance defines a number of elements which should be included in a full staffing review, not all of these are covered in this report but the following elements have been included;

- A review of existing budgets
- Clarity over the allowance that has been made for planned and unplanned leave (headroom/uplift)
- Clarity over the supervisory allowance that has been built into establishments for the sister/charge nurse
- Comparison of establishments to Royal College of Nursing and specialist guidance where this exists
- Use of evidence based tools for measuring patient acuity and dependency and comparing existing establishments to the findings of these tools

By considering these elements organisations will be able to triangulate findings to professionally agree the right staffing levels for their wards.

## 4. Content

4.1 Existing Budgets

Following some early analysis undertaken in April 2014 it was clear that the budget for 2014/15 did not align to the staffing models being deployed. It was felt that budgets had been eroded over time and staffing models had changed to reflect service demands but without subsequent financial adjustment. A full budget review was commissioned with the aim of determining if the current budgeted establishment (the whole time equivalent and money accounted for in the budget) was sufficient to provide the existing staffing model (the number of staff deployed on a daily basis).

4.1.1 Clarity over the allowance that has been made for planned and unplanned leave (headroom/uplift)

Headroom is usually made up of the following elements; an allowance to cover annual leave, study leave and sickness. The national range for headroom is 20% to 26%. Maternity leave is generally either dealt with by an additional allowance or centrally funded. The Trust has historically built in 22% headroom, it was agreed that this percentage would remain for the purpose of the budget review. Whether 22% is sufficient would be subject to further analysis.

4.1.2 Clarity over the supervisory allowance that has been built into establishments for the sister/charge nurse

The importance of providing wads sisters with sufficient time to fulfil their duties was first highlighted in “Breaking Down Barriers, Driving up Standards” (RCN 2009) and “Making the business case for ward sisters/team leaders to be supervisory to practice” (RCN 2010) and has subsequently been endorsed by the Francis enquiry and the National Quality Board.

Many Trusts have adopted a model whereby ward sisters are wholly supervisory, where this is the case they have been able to demonstrate improved patient and staff satisfaction and improved outcome and quality measures for patients. University of Southampton Hospital were able to demonstrate a reduction in staff sickness from 5% to 1.8% following the introduction of supervisory sisters and reduced incidence of falls, pressure ulcers and complaints.

To date the Trust has provided 1 day per week, it is recognised that this is insufficient time to enable ward sisters to fulfil their role. It was agreed that the budget review would make provision for 3 days supervisory time, with a desire to move towards to full supervisory status in the next 12 months.

The cost of supervisory time equates to circa 145k across the 10 clinical areas where the budget review has focussed. The budget review demonstrates that staffing models and budget can be aligned and 3 days supervisory time provided for within the overall budget envelope. This will require budgets to be redistributed across wards and divisions. For some areas this may mean either a reduction in headcount or reduced budget. It also demonstrates that if budgets were rebased and a consistent budget methodology applied that full supervisory status could also be introduced with minimal additional investment.

4.2 Comparison of establishments to Royal College of Nursing and specialist guidance where this exists

The RCN recommend that the skill mix (the ratio of registered to unregistered staff) for general adult in patient areas should as a minimum be 65/35, although this may be higher in specialist areas and lower in slower stream/rehab type settings. Additionally research evidence shows a correlation between the likelihood of adverse events/patient harm occurring and the number of patients a registered nurse is responsible for. This research demonstrates that where a nurse is responsible for more than 8 patients, care is more than likely to be compromised, fundamental aspects of care will be missed and adverse events will happen.

The analysis of the wards' skill mix and registered nurse ratios can be found in Appendix 1, table 1. The biggest risk highlighted through this analysis is the skill mix ratio and overall registered nursing numbers at night in ward areas where some of our most vulnerable/sick patients are cared for (those wards highlighted in red). Whilst the research evidence for the registered nurse 1:8 ratio is based on day time care it must be acknowledged that our patients do not become less sick overnight and whilst the activity on the ward at night will be different (less ward rounds, less admissions and discharges) a ratio of 1 nurse to 14 patients will mean that fundamental aspects of care may be omitted or significantly delayed.

4.5 Use of evidence based tools for measuring patient acuity and dependency and comparing existing establishments to the findings of these tools

A 2 week acuity and dependency audit was undertaken during May 2014. The Trust has not routinely measured acuity and dependency previously and therefore there is no comparator data to determine if case mix is changing. The audit information is helpful nonetheless as it provides us with a baseline measure and the ability to benchmark. For the audit the wards used two evidence based tools; the Safer Nursing Care Tool (SNCT) and the Leeds Dependency tool.

The SNCT uses patient classification and staffing multipliers, briefly summarised below;

- Level 0 – stable, requiring hospital care, needs met by normal ward care (multiplier 0.99)
- Level 1a – Acutely unwell, greater potential to deteriorate (multiplier 1.39)
- Level 1b – stable but heavily dependent and requiring considerable support with most activities of daily living (multiplier 1.72)
- Level 2 – generally managed in specific designated beds, may be awaiting transfer to a more suitable facility, should be known to critical care outreach (multiplier 1.97)

To illustrate; if a ward had 28 patients who were all level 0 then the staffing requirement for the ward would be 28 x 0.99 = 27.72 wte plus provision for supervisory time (if supervisory time was 3 days) then the **total establishment** would be 28.32 wte, which would equate to a ratio of 1.

Table 2, appendix 1, shows the staff ratio for each ward based on current budget (prior to adjustment), existing staffing model and if the staffing levels were adjusted to meet case mix requirements. If the Board support the case for supervisory time and for the budgets to be aligned to existing staffing models there will be 3 areas whose

staffing levels remain a risk in the context of their case mix; David Erskine, David Evans and Lord Wigram (those wards highlighted in red on table 2 appendix 1).

## 5. Summary

This staffing review has demonstrated that;

- Our 2014/15 budgets do not align to existing staffing models
- That redistribution of existing budgets will not only deal with the budget/model anomalies and budget erosion that has occurred over time but will support 3 days supervisory time
- That registered nurse staffing levels at night in several areas require further consideration
- That overall staffing levels for 3 wards present a risk

In assuring the Board that appropriate action is being taken further analysis will be conducted immediately in relation to night time staffing for the several areas and the overall staffing levels for the 3 areas of concern. This analysis will include safety metrics, local intelligence monitoring and may include further acuity and dependency auditing. The subsequent findings will be used to build a business case for investment in these areas.

The Board is also asked to acknowledge that the National Quality Board obliges us to demonstrate how our agreed establishments compare against standard workforce metrics (vacancies, turnover, sickness) and quality and outcome measures. This review has demonstrated how our roster, workforce and finance systems do not align. Work must continue to address these issues. It is suggested that in the future structure the new Quality Committee is asked to consider staffing levels, workforce and quality/outcome information on a monthly basis thorough the dashboards that are being developed.

In addition, the intention is to develop an annual nursing staffing review cycle that is aligned to the business planning process, which will formalise the process for ensuring and agreeing that out staffing levels are safe, fit for purpose and meet our patient needs.

## Appendices

Appendix 1 - Skill mix, registered nurse ratios and audit findings

Author:
Lucy Connolly
Assistant Chief Nurse
October 2014

**Appendix 1**

| Ward | Skill Mix (avge based on budget) | Skill mix nights | RN to pt ratio - early | RN to pt ratio - late | RN to pt ratio - night |
|---|---|---|---|---|---|
| **Nell Gwynne** | 50/50 | 40/60 | 5 | 6 | 12 |
| **David Erskine** | 62/38 | 50/50 | 6 | 7 | 14 |
| **Edgar Horne** | 46/54 | 33/67 | 6 | 7 | 14 |
| **David Evans** | 66/34 | 50/50 | 6 | 6 | 14 |
| **SAL** | 66/34 | closed | variable | variable | closed |
| **Lord Wigram** | 62/38 | 50/50 | 6 | 7 | 14 |
| **Rainsford Mowlem** | 60/40 | 60/40 | 6 | 6 | 9 |
| **Chelsea Wing** | 65/35 | 66/34 | 5 | 5 | 7 |
| **Annie Zunz** | 75/25 | 66/34 | 4.5 | 4.5 | 8 |
| **Ron Johnson** | 60/40 | 50/50 | 5 | 5 | 9.5 |
| **AAU** | 80/20 | 90/10 | 4.4 | 4 | 5 |
| **AAU (trollies)** | 100/0 | closed | 5 | 5 | closed |
| **Burns** | 85/15 | 66/34 | 2.5 | 2.5 | 5 |

Table 1 (the skill mix and registered nurse status is based on the position if budgets are realigned to existing staffing models)

| Ward | Staff to bed ratio based on existing budget | Staff to bed ratio if budget aligned to existing model | Staff to bed ratio if adjusted for case mix (SNCT) | Staff to bed ratio if adjusted for case mix (Leeds) | Is our casemix comparable to benchmarks |
|---|---|---|---|---|---|
| **Nell Gwynne** | 1.7 | 1.5 | | | Audit results invalid |
| **David Erskine** | 1 | 1 | 1.45 | 1.37 | good correlation |
| **Edgar Horne** | 0.9 | 1.38 | 1.5 | 1.49 | Low than expected level 0 |
| **David Evans*** | 0.86 | 1 | 1.26 | 1.3 | Needs adjusmtent for w/e capacity |
| **Lord Wigram** | 0.96 | 1.02 | 1.4 | 1.4 | good correlaiton |
| **Rainsford Mowlem** | 1.1 | 1.24 | 1.23 | 1.23 | good correlation |
| **Chelsea Wing** | 1.6 | 1.6 | 1.4 | n/a | audit incomplete low occupancy |
| **Annie Zunz** | 0.96 | 1.15 | 1.13 | n/a | good correlation |
| **Ron Johnson** | 1.5 | 1.41 | 1.46 | 1.33 | good correlation |
| **AAU **** | 1.4 | 1.5 | 1.6 | 1.6 | lower than expected level 1a |
| **Burns** | subject to furhter analysis | | | | |
| * SAL staffing is additional to this | | | | | |
| ** Trolley staffing is additional to this | | | | | |

Table 2

# Board of Directors Meeting, 30 October 2014 PUBLIC

| | |
|---|---|
| **Subject/Title** | Approval of the Terms of Reference of the Audit Committee/ 3.2/Oct/14 |
| **Purpose of paper** | To maintain good governance by periodically reviewing the terms of reference. |
| **Decision/action required/ recommendation** | The Board is asked to approve the Terms of Reference |
| **Summary of the key risks/issues from the paper** | The Audit Committee terms of reference are reviewed on a bi annual basis and were last approved by the Board in October 2012.<br><br>The terms of reference were reviewed and approved by the Audit Committee 22 October 2014 and no amendments were made to the existing terms of reference.<br><br>The ToR's are in line with the guidance issued best practice by the Foundation Trust Network. |
| **Link to corporate objectives** | NA |
| **Executive Sponsor** | Sir John Baker, Non-executive Director |

# Audit Committee
# Terms of Reference

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

**Terms of Reference**

- Review the establishment and maintenance of effective systems of internal control, establishment of value for money and risk management including fraud and corruption.
- Assure the Board on completeness and compliance of required disclosure statements and policies
- Review the Trust's annual financial statements, Annual Governance Statement and Head of Internal Audit Opinion and assure the Board on compliance
- Assure the Board on judgements and adjustments relating to annual financial statements.
- Assure the Board on the appropriateness and effectiveness of the internal audit service, its fees, findings and co-ordination with external audit
- Assure the Board on the appropriateness, effectiveness and co-ordination of external auditors, their reviews and the Trust's management response and outcomes.
- Assure the Board on the appropriateness and effectiveness of the local counter fraud specialist service, their fees, findings and co-ordination with internal audit and management.
- Make recommendations to the Council of Governors on the appointment, re-appointment and remuneration and terms of engagement of the external auditors.
- Ensure that arrangements are in place for investigation of matters raised, in confidence, by staff relating to matters of financial reporting and control, clinical quality, patient safety or other matters.
- Undertake such other tasks as shall be delegated to it by the Board in order to provide the level of assurance the Board requires
- Report to the Council of Governors on significant matters where these matters are not notified to the Council of Governors via other means.

**Key Relationships:** Some shared membership and agenda items with the Assurance Committee

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

**In Attendance:** Chief Executive, Director of Finance, Director of Governance and Corporate Affairs, Head of Internal Audit , External Audit representatives and a Counter Fraud representative. Other Directors only when required. Deputies have to attend if the Chief Executive or Director of Finance cannot.

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

**Attendance requirements**
The members are expected to attend two thirds of the meetings per year.

**Circulation requirements for papers**
At least three working days in advance of the meeting.

**Reporting Committee**
Board of Directors

**Committees reporting to the Audit Committee**
Information Governance Committee

**Forward Plan of Work:** This is agreed on a regular basis.

**Review date for the terms of reference**
Every two years.
Next due for review October 2016

**Approved by**
Trust Board

**Date of terms of reference**
Reviewed by the Audit Committee in September 2010
Approved by the Board in October 2010
Reviewed by the Audit Committee October 2012
Approved by the Board in October 2012
Reviewed by the Audit Committee October 2014

# Board of Directors Meeting, 30 October 2014 PUBLIC

| | |
|---|---|
| **Subject/Title** | Finance Report – September 2014/4.1/Oct/14 |
| **Purpose of paper** | To report the financial performance for the six months ending September 2014 |
| **Decision/action required/ recommendation** | The Trust Board is asked to note the financial position for September 2014. |
| **Summary of the key risks/issues from the paper** | **The Trust financial performance can be summarised as:**<br>- In September a deficit of £0.3m against a planned surplus of £1.0m – an adverse variance of £1.3m<br>- Year to date deficit of £0.8m against a planned surplus of £5.1m – an adverse variance of £5.9m<br>**The key drivers behind the September performance I&E**<br>- Unidentified CIP of £0.8m in month and £5.8m year to date<br>- Continued pressures in pay related to reliance on agency staffing, unplanned cost pressures in NICU, Midwifery and Hand surgery.<br>- Non-pay is overspent primarily due to high levels of elective activity to clear the RTT backlog.<br>- Income shortfalls in specialist commissioned emergency activity.<br>- **Cash and Capital**<br>- The cash position is £12.8m which is lower than plan due to continued high levels of debt and impact of I&E performance<br>- Capital spend in September was £2.6m and year to date was £6.8m. Year to date the capital is underspent by £3.4m.<br>**COSR**<br>- The Trust's COSR rating year to date at September is a 3 which is in line with plan.<br>**The Year End forecast**<br>- The year-end forecast remains a surplus of between £1.2m and £3.4m, with a £3.4m surplus generating a forecast COSR of 3. |
| **Link to corporate objectives** | Ensure Financial and Environmental Sustainability<br>Deliver 'Fit for the Future' programme |
| **Executive Sponsor** | Rakesh Patel, Director of Finance |

**Finance Report for the period ending September 2014 (Month 6)**

## 1. Introduction

1.1. This report provides the Board with a commentary on the financial performance for the six months ending September 2014.

## 2. Decision/Action required

2.1. The Trust Board is asked to note the financial position for September 2014.

## 3. Background

3.1. The Trust reported a deficit of £0.2m in September 2014, which was £1.3m behind plan. The year to date position is a deficit of £0.8m, which is an adverse variance of £5.9m against a planned surplus of £5.1m. The year to date EBITDA is 7% against a planned EBITDA of 10%.

3.2. Divisions were set control totals to achieve a revised year end forecast of £3.4m surplus. In order to achieve this, the Trust should have delivered a surplus of £0.8m in September, and therefore was £1.0m behind the revised trajectory.

3.3. The CIP achieved to date is 3.1% and the forecast is 3.7%, and is therefore almost meeting the minimum requirement of 4%. However the Trust has experienced unplanned cost pressures which are detailed in the paper.

3.4. Although the current year to date position is a deficit, the year-end forecast remains a surplus of between £1.2m and £3.4m. Further actions and controls agreed by the Executive Team are being implemented to ensure delivery of this.

## 4. Content

4.1. NHS and Local Authority Clinical Income

- The underlying NHS clinical income (after adjusting for excluded drugs and devices) is on plan in September and £2.0m ahead of plan year to date. The year to date over-performance continues to be driven by high GUM activity at Dean Street Express (£1.6m), elective activity associated with 18 week referral-to-treatment targets (RTT) (£0.7m) and high levels of A&E attendances (£0.7m), offset by an under-performance on non-elective specialised services (£0.6m), which are not under the block contract.
- The year to date elective inpatient activity is £0.7m ahead of plan, which is primarily as a result of increased surgical work associated with the planned clearance of long waiting patients on RTT pathways, particularly in Trauma and Orthopaedics. The high elective activity for RTT is partly offset due to a significant under-performance in August and September for Endoscopy (£0.3m for the year to date), due to a reduction in GP direct access referrals.
- Non Elective activity was £0.1m behind plan in September and £0.6m behind plan for the year to date. Overall non-elective activity is in line with 2013/14, despite an increase in attendances in ED, which is an indication that ambulatory care and other admissions avoidance schemes put in place are working. The Trust is continuing to under-perform on specialised activity attributed to NHS England, which is not subject to the block funding, particularly in Burns, HIV and Paediatric

Gastroenterology. The in-month under-performance is partly offset by higher numbers of obstetric deliveries than plan, with September having the highest number of deliveries for the year to date.

- Outpatient income was £0.3m ahead of plan in the month and £2.3m ahead of plan year to date. The single biggest contributor continues to be GUM (£1.6m year to date) following the opening of Dean Street Express in February 2014. Overall GUM activity has increased by 14% against 2013/14. Obstetrics antenatal pathways also continue to over-perform by £0.6m year to date due to an increase in bookings.

- NHS Clinical Contract Income relating to other points of delivery was £0.1m ahead of plan in the month and £1.0m ahead of plan for the year to date, after adjusting for excluded drugs and devices. The Trust has seen continued high levels of A&E and UCC activity in September, continuing a trend started in the latter part of last year which is contributing a favourable variance of £0.1m in month and £0.7m year to date.

4.2. **Other Income**

- In September, Private Patient income was below plan by £0.3m in September and is now behind plan year to date by £1.7m. This is mainly attributed to the Chelsea Wing, although income continues to be higher than the previous year's income, particularly in medical cases. There are a number of work-streams underway to improve the income for the remainder of the year, primarily targeting Assistant Conception and Private Maternity.

4.3. **Expenditure**

- There was an adverse variance for pay in September of £0.2m, and year to date adverse variance of £0.6m. There continue to be pressures within the pay expenditure across all staffing groups. The monthly pay expenditure continues to increase over the last three quarters and is higher than the prior year monthly average.

- The key drivers for the increase in pay are higher use of nursing agency as a result of vacancies, higher levels of sickness (e.g. maternity) and specific cost pressures in medical staffing, particularly NICU and hand surgery and more escalation beds open compared to the prior year and plan.

- Clinical supplies are overspent by £0.3m in June and £2.1m 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.

- Non-clinical supplies are underspent by £0.4m in June and £1.6m year to date relating to the release of contingency.

- Non-operating expenditure is over-spent by £0.2m for the year to date, reflecting higher depreciation costs.

- Un-identified CIPs continue to be the largest contributor to the adverse variance with the current month unidentified CIP at £0.8m and the year to date at £5.7m.

4.4. **Forecast and Further Actions**

- The year-end forecast is a surplus of between £1.2m and £3.4m. Further actions and controls agreed by the Executive Team, are being implemented to ensure delivery of this. These include:
- Divisional control totals have been set and weekly review meetings to assess progress against these will be instigated – These will assess prospective key drivers and put in place actions with accountable leads.
- Weekly escalation – There will be weekly review of the progress against plans by the Executive Team with specific focus on areas that are off trajectory.
- Controls on agency staff – Additional controls on agency staff are being put into place, with all medical locums authorised by the Medical Director or Chief Operating Officer (COO) in her absence, all nursing agency to be authorised by the Chief Nurse (or her nominated deputies) and all corporate agency to be authorised by the Chief Financial Officer (CFO) / Director of Finance (DOF). Any out of hours agency requests will be retrospectively reviewed to assess appropriateness. There will be continued focus on recruitment and sickness absence and the HR Director will work with Divisional Directors to reduce recruitment times.
- Ward nursing establishment and budgets - These will be reset and agreed by the Executive Team following detailed review by the Chief Nurse. This will ensure clarity over rotas and will enable the Chief Nurse to hold ward managers to greater scrutiny and accountability.
- Review of income shortfalls – Director of Finance to undertake a deep dive on specialties where there is a shortfall on income and agree key actions to address these.
- Scrutiny of non-pay spend – Additional scrutiny of all non-pay spend, particularly discretionary non-pay and weekly reviews of all orders placed by the COO/ DOF.
- Progress against these actions will be monitored by the Chief Executive and Executive Team

4.5. **Continuity of Services Risk Rating (COSR)**

- The Trust's COSR rating year to date at September is a 3 compared to a planned COSR rating of 3.

4.6. **Loans**

- There was no drawdown against the loans from the Independent Trust Financing Facility (ITFF) but further draw down is planned for later in the financial year. The first repayment of the loan in respect of Doughty House was made in September 2014.

4.7. **Capital**

- The Trust capital plan for 2014/15 is £30.1m. The year to date (YTD) capital expenditure year is £6.8m against the Trust capital plan of £10.2m, £3.4m behind plan.

  £4.1m of the YTD spend was on building projects, the majority of spend being for the Immunology Lab (£0.8m), Outpatients 3 (£0.5m), Paediatric Ward/Burns (£0.4m) and Ground Floor/A&E Extension (£0.3m). IT

Spend YTD was £2.1m with the major projects being IT Portal (£0.2m), Electronic Document Management - EDM (£0.2m), Lastword Development (£0.4m) & IT Strategy Implementation (£0.6m). The remaining £0.7m of YTD spend was on various items of medical and non-medical equipment, predominantly (EBUS) Bronchoscope and Ultrasound Processor (£0.13m) and Replacement of Ultrasound Machines (£0.26m).
The capital plan will be reviewed against the current financial position, with £5m of reduced spend as noted below.

- In September the Trust spent £2.5m against a plan of £1.9m, and therefore was overspent by £0.6m in month, mainly due to the re-phasing of capital expenditure. £0.9m (40%) of the monthly spend was on three projects, namely Immunology Lab (£0.25m), IT Strategy Implementation (£0.39m), and Replacement of Ultrasound Machines (£0.26m).

- The Trust capitalised £0.4m of capital spend in the second quarter, which related to various items of medical equipment purchased in this financial year.

- The Trust Executive has agreed to reduce capital expenditure by £5m, with £2.5m targeted from building projects. The full reduction of £5.0m has been profiled within the annual forecast.

4.8. **Cash Flow**

- The cash position at June is £12.8m. The current deficit is impacting on the cash balance. The top ten debtors outstanding are £10.5m relating to NHS organisations and Department of Health, FT debt amounting to £0.6m and Local Government debt amounting to £0.5m. The Trust will further increase efforts in collecting debt to improve the cash position, targeting the organisations with the highest debt and ensuring early escalation of disputes.

## 5. Summary

5.1. The Trust reported:

- In month deficit of £0.2m against a planned surplus of £1.0m – an adverse variance of £1.3m
- Year to date deficit of £0.8m against a planned surplus of £5.0m – an adverse variance of £5.9m
- The year to date continuity of service risk rating (COSR) as at September is 3, against a plan of 3.

5.2. The year-end forecast position is between £1.2m and £3.4m surplus against a plan of £7.0m. The forecast COSR, on delivery of a £3.4m surplus, is a rating of 3.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Board of Directors Meeting, 30 October 2014 PUBLIC

| | |
|---|---|
| **Subject/Title** | Performance Report – September 2014/4.2/Oct/14 |
| **Purpose of paper** | To report the Trust's performance for September 2014, highlight risk issues and identify key actions going forward |
| **Decision/action required/ recommendation** | The Trust Board is asked to note the performance for September 2014. |
| **Summary of the key risks/issues from the paper** | The Trust continues to meet all key performance indicators for Monitor, with the exception of planned non-achievement of RTT 18 weeks admitted and incomplete patient pathways in Q1 & Q2.<br><br>- RTT admitted and incomplete targets were not achieved in Q2, as part of the planned clearance of long waiting patients. Work continues to reduce the admitted waiting list backlog as part of the accelerated trajectory. The Trust was awarded national funding towards this backlog reduction. The Trust's current trajectory delivers the sustainable backlog position by the end of November, in line with the national requirement. A key risk remains regarding Paediatric Dentistry, with significant capacity issues and work is ongoing to resolve resourcing issues for the service.<br><br>- Patient Safety: The Trust maintained good performance, meeting the C Difficile and MRSA targets for the year to date.<br><br>- Clinical Effectiveness: Caesarean section rates have improved slightly in September, however remain above the target. There is also ongoing work on clinical effectiveness measures such as care bundle compliance and nutritional screening, which are being addressed through a number of focus working groups.<br><br>- Patient experience: Response rates have improved for the Friends and Family Test. Work continues to improve turnaround times and address themes identified through complaints.<br><br>- Access and Efficiency: A&E continued to be under pressure during Q2 following the trend seen in the first quarter. Although the Trust did not meet its internal stretch target of 98% of patients seen in less than 4 hours in September, the Trust remains compliant with the Monitor target, at 95.1% for September and 96.7% for the year to date. |
| **Link to corporate objectives** | Improve patient safety and clinical effectiveness<br>Improve the patient experience<br>Ensure Financial and Environmental Sustainability |
| **Executive Sponsor** | Rob Hodgkiss, Interim Chief Operating Officer |

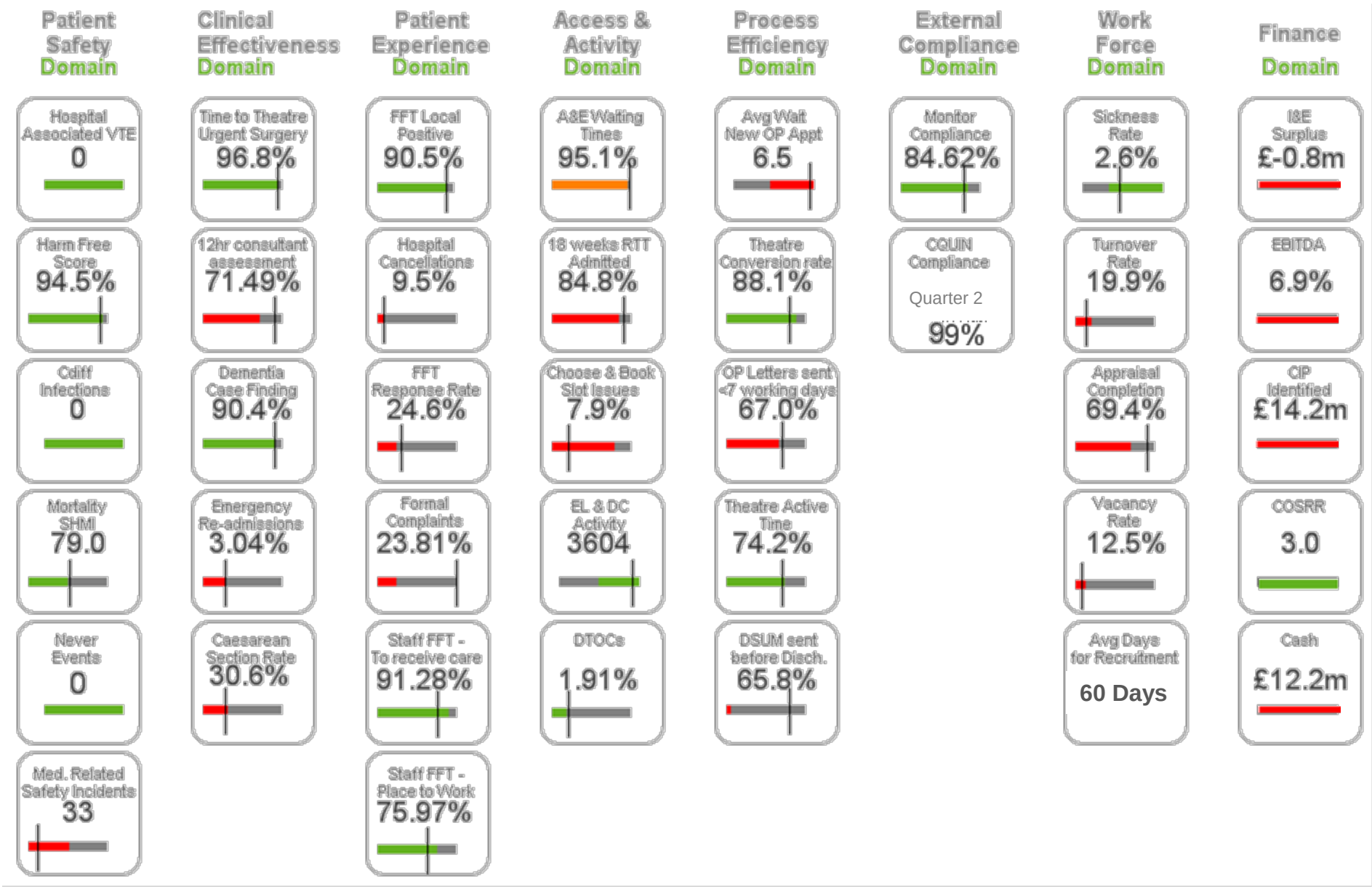
Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Corporate Performance Report

## Performance to 30th Sept 2014

# At a Glance Performance – September

Chelsea and Westminster Hospital NHS
NHS Foundation Trust



# Trust Headlines – 2014

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

## Monitor Compliance – Sept 2014

| Sub Domain | Trust Level Monthly Data @ 13/10/2014 XL | | | | YTD XL |
|---|---|---|---|---|---|
| | MonthYear | Jul 2014 | Aug 2014 | Sep 2014 | 01/04/2014 |
| Harm | Clostridium difficile infections (Target: < 0.67) | 2 | 0 | 0 | 4 |
| | 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%) | 100.0% | N/A | N/A | 100.0% |
| | Cancer diagnosis to treatment waiting times - Subsequent Medicine (Target: > 98%) | 100.0% | 100.0% | N/A | 100.0% |
| | Cancer urgent referral GP to treatment waiting times (62 Days) (Target: > 85%) | 89.5% | 92.0% | N/A | 90.5% |
| | Cancer urgent referral Consultant to treatment waiting times (62 Days) (Target: > 90%) | N/A | N/A | N/A | 100.0% |
| | Cancer urgent referral to first outpatient appointment waiting times (2WW) (Target: > 93%) | 94.5% | 92.6% | N/A | 94.6% |
| RTT | 18 week referral to treatment times Admitted Patients (Target: > 90%) | 84.3% | 80.7% | 84.6% | 82.9% |
| | 18 week referral to treatment times Non Admitted Patients (Target: > 95%) | 96.0% | 95.6% | 96.0% | 96.3% |
| | 18 week RTT incomplete pathways (Target: > 92%) | 92.0% | 91.0% | 91.6% | 92.0% |
| A&E | A&E waiting times (Target: > 98%) | 96.3% | 96.5% | 95.1% | 96.7% |
| 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

- With the exception of agreed non-compliance of 18 weeks RTT admitted and incomplete indicators, the Trust has achieved all of the Monitor indicators for quarter 2
- There has been an improvement in the rate of Dementia case finding in September
- Day case rates have increased in September following reducing delays in discharge processes by junior doctors
- There has been a continued improvement in the time to theatre for fractured neck of femur patients
- There has been a significant reduction in the rate of inpatient falls over the last quarter.

### Challenges

- RTT admitted and incomplete targets were not compliant in September as part of the planned clearance of long waiting 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.
- A&E waiting times and LAS handover times continue to be a challenge for the Trust in September, with very high level of attendances in the month. However, the Trust did achieve the Monitor target of 95% in the month and work continues throughout the hospital to improve flow and work with external partners to target frequently attending patients.
- Caesarean section rates have improved slightly in September, however remain above the target.

| Sub Domain | Trust Level Monthly Data @ 16/10/2014 | | | | YTD |
|---|---|---|---|---|---|
| | Month Year | Jul 2014 | Aug 2014 | Sep 2014 | 01/04/2014 |
| Harm | Incidence of newly acquired category 3 and 4 pressure ulcers (Target : <3.6) | 1 | 1 | 0 | 8 |
| | Safety Thermometer - Harm score (Target : >90%) | 93.5% | 94.6% | 94.5% | 94.1% |
| | Safety Thermometer - Prevalence of Pressure Ulcers (Rate) (Target : <3.45%) | 4.7% | 4.2% | 5.5% | 4.4% |
| HCAI | C Diff rate per 100k bed days pts aged >=2 (Target : <14.7) | 99.0 | 0.0 | 0.0 | 34.8 |
| | Clostridium difficile infections (Target : <0.67) | 2 | 0 | 0 | 4 |
| | Hand Hygiene Compliance (trajectory) (Target : >90%) | 97.2% | 98.1% | 97.5% | 97.3% |
| | Methicillin Sensitive Staphylococcus Aureus Target <4.0) | 2 | 1 | 0 | 6 |
| | E Coli bloodstream infections Target <12.0) | 7 | 9 | 3 | 37 |
| | MRSA Bacteraemia (Target >=0) | 0 | 0 | 0 | 0 |
| | Screening all elective in-patients for MRSA (Target : >95%) | 94.3% | 89.5% | 92.8% | 92.1% |
| | Screening Emergency patients for MRSA (Target : >95%) | 97.3% | 98.5% | 96.9% | 97.3% |
| Incidents | Incident reporting rate per 100 admissions (Target : >8.50) | 8.38 | 5.69 | 5.31 | 7.06 |
| | Inpatient falls per 1000 Inpatient bed-days (Target : <3.00) | 3.65 | 2.96 | 2.55 | 3.60 |
| | Never Events (Target >=0) | 0 | 0 | 0 | 0 |
| | Medication related safety incidents Target <90.7) | 64 | 56 | 33 | 276 |
| | Rate of patient safety incidents per 100 admissions (Target : <2.9) | 8.20 | 5.33 | 4.94 | 6.76 |
| | Rate of pt. safety incidents resulting in severe harm - death per 100 admissions (Target >=0.00) | 0.00 | 0.03 | 0.00 | 0.01 |
| Mortality | Mortality (HSMR) (2 months in arrears) (trajectory) (Target : <104) | N/A | N/A | N/A | 0.0 |
| | Mortality SHMI *TRUST ONLY* (Target : <82) | 79.0 | 79.0 | 79.0 | 80.3 |
| | Number of In-hospital Deaths (Adults) (Target >=0.6) | 30 | 25 | 32 | 163 |
| | Number of in-hospital deaths (Paeds) (Target >=0) | 0 | 0 | 0 | 0 |
| | Number of in-hospital deaths (Neonatal) (Target >=0.1) | 4 | 6 | 4 | 22 |

**Safety Thermometer - Pressure Ulcers:**
The Preventing Harm group continue to focus on hospital acquired pressure ulcers. The incidence of newly acquired grade 3 and 4 pressure ulcers remains low, which indicates that the grade 2 pressure ulcers are being identified and escalated earlier and also that the patients have been in for a long length of stay and therefore will be noted during each prevalence audit.

The main area of focus currently is device related pressure ulcers, with a number of pilots in place to trial different masks, pressure relieving aids and oxygen tubing. The Trust is also continue to work with other providers in North West London to collaboratively look at pressure ulcer prevention and management across the patient pathway.

**MRSA screening, elective inpatients:**
The planned care division have been undertaking a piece of work to review the screening process ensuring that it is more robust and enables screening of patients within 3 months of surgery. The surgical team have introduced screening packs which can be sent to patients with a stamped address envelope. Patients are also being called 2 weeks in advance to confirm that their screens have been updated.

**Incident Reporting Rate**
There has been a dip in September 2014, due to delayed reporting, which includes a late report of a significant number of incidents from the pathology laboratory.

In addition to this, an increasing number of staff are reporting anecdotal incidents however these are not translating to actual incident reporting. This may be an indicator of staffing pressures which have been discussed at the Risk Management Committee in August and September 2014. A risk assessment with associated action plan is being agreed with relevant leads, and the issue of reduced reporting highlighted to specific wards or departments where this is indicated.

**Inpatient falls:**
There has been a significant reduction in the number of inpatient falls over the last quarter.

# Safe Nursing and Midwifery Staffing

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

| 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 | 86.3% | 93.3% | 73.7% | 71.5% |
| Annie Zunz | 88.3% | 70.1% | 100.0% | 110.0% |
| Apollo | 84.3% | 63.3% | 87.2% | - |
| Jupiter | 118.8% | | 118.3% | |
| Mercury | 101.3% | 53.3% | 109.7% | 35.5% |
| Neptune | 92.8% | 73.3% | 106.7% | 66.7% |
| NICU | 103.2% | | 101.9% | |
| AAU | 100.5% | 122.5% | 128.5% | 160.0% |
| Nell Gwynne | 123.3% | 178.3% | 193.3% | 195.6% |
| David Erskine | 101.1% | 128.4% | 125.0% | 136.7% |
| Edgar Horne | 94.6% | 100.0% | 100.0% | 105.9% |
| Lord Wigram | 88.6% | 133.3% | 100.0% | 133.3% |
| Rainsford Mowlem | 114.7% | 141.2% | 121.2% | 166.7% |
| David Evans | 89.6% | 96.7% | 118.3% | 157.4% |
| Chelsea Wing | 88.1% | 100.0% | 100.0% | 100.0% |
| Burns Unit | 95.6% | 123.3% | 104.4% | 150.0% |
| Ron Johnson | 94.2% | 209.7% | 103.3% | 196.8% |
| ICU | 98.7% | 78.9% | 100.3% | |

**National Quality Board Report – Hard Truths expectations**
The September fill rate data is presented in the format as required by NHS England.

**Definition – Fill rate**
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.

In previous months Edgar Horne had been showing fill rates for care staff ranging from 150% to 300%, under new leadership the ward sister has changed the way her team work, and how they provide care to patients this has led to a significant reduction in the requirement for patient specials (one to one care). This is reflected in the fill rates for care staff for this month.

**Summary for September**
The paediatric fill rates – low fill rates on Apollo relate to reduced occupancy, the high fill rates for Jupiter relate to RMN shifts for a particularly vulnerable patient. The Mercury and Neptune low fill rates for care staff relate to ongoing vacancies in this area.
**RMN shifts** – there have been a significant number of mental health patients requiring registered mental health nurse (RMN) support; particularly AAU (78), Jupiter (21), David Erskine (33), and Rainsford Mowlem (20). There is a very robust review process in place 7 days a week to ensure that the patients with mental health needs receive the right level of support.
**Additional Capacity -** The 10 assessment beds on the Acute Admissions Unit were open overnight every night through out September. Both Nell Gwynne and Rainsford Mowlem had to open their additional beds for the majority of the month, this is reflected in the fill rates for these areas.
It is unusual for David Evans to have high fill rates, this relates to additional staff required in the provision of care to bariatric patients.
**Care staff fill rates** - The high fill rates for the remaining areas are in the main due to additional staff required to provide care to our most vulnerable patients, particularly on David Erskine and Ron Johnson Wards.

# Clinical Effectiveness

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

| Sub Domain | Trust Level Monthly Data @ 16/10/2014 XL | | | | YTD XL |
|---|---|---|---|---|---|
| | MonthYear | Jul 2014 | Aug 2014 | Sep 2014 | 01/04/2014 |
| Admitted Care | Elective LoS - Long Stayers (Target: < 51) | 58 | 49 | 63 | 342 |
| | Elective Length of Stay (Target: < 3.7) | 3.7 | 3.2 | 3.3 | 3.5 |
| | Emergency Care Pathway - Discharges (Target: N/A ) | 200.0 | 198.3 | 192.4 | 1163.4 |
| | Emergency Care Pathway - Length of Stay (Target: < 4.5) | 5.21 | 4.02 | 4.67 | 4.48 |
| | Emergency Re-Admissions within 30 days (adult and paed) (Target: < 2.8%) | 3.13% | 2.71% | 3.04% | 3.03% |
| | Non-Elective Long Stayers (Target: < 516) | 469 | 423 | 454 | 2588 |
| | Non-Elective Length of Stay (Target: < 3.9) | 4.4 | 3.6 | 4.0 | 3.9 |
| | VTE Assessment (Target: > 95%) | 96.6% | 95.8% | 96.0% | 96.5% |
| Best Practice | % Patients Nutritionally screened on admission *TRUST ONLY* (Target: > 90%) | 75.5% | 78.6% | 55.3% | 77.1% |
| | % Patients in longer than a week who are nutritionally re-screened *TRUST ONLY* (Target: > 90%) | 59.4% | 59.0% | 56.6% | 66.1% |
| | 12 Hour consultant assessment - AAU Admissions (Target: > 90%) | 65.6% | 74.0% | 74.8% | 68.4% |
| | 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%) | 83.3% | 95.7% | 91.7% | 87.8% |
| | Urinary catheters continuing care—compliance with Care bundles (Target: > 90%) | 100.0% | 100.0% | 100.0% | 98.4% |
| | Fractured Neck of Femur - Time to Theatre < 36 hrs for Medically Fit Patients (Target: = 100%) | 64.3% | 87.5% | 100.0% | 87.2% |
| | Safeguarding adults - Training Rates (Target: > ) | tba | tba | tba | tba |
| | Safeguarding children - Training rates (Target: > ) | tba | tba | tba | tba |
| | Stroke: Time spent on a stroke unit *TRUST ONLY* (Target: > 80%) | 100.0% | 100.0% | 100.0% | 100.0% |
| Best Practice | Dementia Screening Case Finding (Target: > 90%) | 95.3% | 86.6% | 90.4% | 93.1% |
| | Appropriate referral Dementia specialist diagnosis *TRUST ONLY* (Target: > 90%) | 100.0% | 100.0% | 100.0% | tba |
| | Dementia Screening Diagnostic Assessment (Target: > 90%) | 100.0% | 100.0% | 100.0% | 100.0% |
| Theatres | Procedures carried out as day cases (basket of 25 procedures) (Target: > 85%) | 78.3% | 76.1% | 80.3% | 78.9% |
| | Theatre Active Time - % Total of Staffed Time (Target: > 70%) | 71.6% | 74.4% | 74.2% | 73.3% |
| | Time to theatre for urgent surgery (NCEPOD recommendations) (Target: > 95%) | 96.2% | 93.6% | 96.8% | 94.0% |

**Elective length of Stay:** The elective LOS working group has agreed that patients will be given fentanyl instead of patient controlled analgesia in order to help patients mobilise more quickly. This will support a reduction in LOS and will be implemented from 30th October .

**Procedures carried out as day cases:** Daycase rates continued to improve in September and has continued to reach 94% in mid-October. To support further improvements, there has been agreement that no day case patient can be transferred from recovery to the ward without the discharge summaries and TTO's being written up. This is following an root cause analysis demonstrating that the key reasons for patients not being discharged is the delay in getting these completed by juniors on the wards. By changing the practice, the tasks are now being completed when the surgeon is in theatres.

**Nutritional Screening:** The Trust did not achieve the nutritional screening and re-screening targets in September. This is due to vacancies in the Dietetics team and the resultant drop in training and support available to ward staff. Recruitment is underway and performance is expected to improve above target levels once staff members have been appointed.

**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.

The AAU team continue to work to improve this standard and have made improvements month-by-month. Steps are in place to improve timeframes for surgical consultant assessment arrangements on the Acute Assessment Unit.

**Non-Elective Length of Stay:** This continues to be reviewed, with an initiative starting in October to review long stay (>6 days) patients daily commencing with Edgar Horne Ward, which this will then be rolled out across other wards. Also, a daily meeting has been put in place with Trust staff and partner organisations, to facilitate the earlier discharge of delayed transfer of patients and patients needing complex discharge packages of care. Finally, the Trust is working with partners to increase the ability to discharge patients requiring care packages at the weekends.
Healthcare at Home is also being used to care for patients in the short term if local community teams are unable to provide this care for a period of time.

# Clinical Effectiveness – Maternity

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

| | Indicator | Measure | Target | Apr | May | Jun | Jul | Aug | Sep | YTD Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Activity in Month | NHS Deliveries | Benchmarked to 5042 per annum | 416 | 417 | 405 | 422 | 412 | 433 | 462 | 2,551 |
| | Private Deliveries | Benchmarked to 840 per annum | 72 per month | 62 | 76 | 71 | 73 | 63 | 70 | 415 |
| | Trust Deliveries | Total Maternities (Mother) | | 479 | 481 | 493 | 485 | 496 | 532 | 2,966 |
| | Estimated Date of Delivery | Forecast deliveries from Booking EDD | | 543 | 575 | 570 | 578 | 578 | 611 | 3,455 |
| | | Attrition Rate: EDD / Actual deliveries (all) | | 11.8% | 16.3% | 13.5% | 16.1% | 14.2% | 12.9% | |
| | | Attrition Rate: EDD / Actual deliveries (NHS) | | 23.2% | 29.6% | 26.0% | 28.7% | 25.1% | 24.4% | |
| | Total NHS Births (infants) | | | 424 | 417 | 428 | 424 | 443 | 471 | 2,607 |
| | Births | Birth Centre (excludes transfers) | No. of patients | 83 | 67 | 79 | n/a | n/a | n/a | 229 |
| | | Rate of Trust total SVD (NHS) | % | 37.4% | 31.6% | 36.1% | n/a | n/a | n/a | |
| | | Home births - rate of NHS maternities | % NHS Dels | 1.2% | 1.2% | 1.2% | 0.7% | 0.5% | 0.9% | |
| | Norm. Vaginal Deliveries | SVD (Normal Vaginal Delivery) | No. of patients | 222 | 212 | 219 | 215 | 213 | 230 | 1,311 |
| | | Maintain normal SVD rate | 52% | 53.2% | 52.3% | 51.9% | 52.2% | 49.2% | 49.8% | |
| | C- Section | Total C/S rate overall | <27% | 29.3% | 32.3% | 28.4% | 28.9% | 31.6% | 30.1% | |
| | | Emergency C Sections | No. of patients | 59 | 66 | 66 | 64 | 85 | 77 | 417 |
| | | | <12% | 14.1% | 16.3% | 15.6% | 15.5% | 19.6% | 16.7% | |
| | | Elective C Sections | No. of patients | 63 | 65 | 54 | 55 | 52 | 62 | 351 |
| | | | <15% | 15.1% | 16.0% | 12.8% | 13.3% | 12.0% | 13.4% | |
| | Assisted Deliveries | Ventouse, Forceps Kiwi | No. of patients | 73 | 62 | 83 | 78 | 83 | 93 | 472 |
| | | | 10-15% (SD) | 17.5% | 15.3% | 19.7% | 18.9% | 19.2% | 20.1% | |
| | **Total CS Rate Based on Coded Spells** | | <27% | 29.0% | 32.5% | 29.2% | 29.2% | 31.9% | 30.6% | |
| KPI | Trust Level Indicators | NBBS - offered and discussed | 100% | 100% | 100% | 100% | 100% | 100% | 100% | |
| | | Maternity Unit Closures | LSA Db | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | 1:1 care | 100% | 93.5% | 93.2% | 96.5% | 93.6% | 93.4% | 93.0% | |
| | | Breastfeeding initiation rate | 90% | 89.9% | 91.9% | 93.4% | 88.8% | 86.8% | 89.8% | |
| | | Women smoking at time of delivery | <10% | 1.2% | 0.7% | 0.9% | 1.5% | 1.4% | 1.7% | |
| | | Midwife to birth ratio - Births per WTE | 1:30 | 1:33 | 1:32 | 1:31 | 1:33 | 1:32 | 1:38 | |
| | | DSUMs complete & sent in 24hrs | 80% | 71.6% | 50.0% | 50.5% | 50.0% | 59.8% | 69.5% | |

| | Indicator | Measure | Target | Apr | May | Jun | Jul | Aug | Sep | YTD Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Indicators | PP Heamorrage | Blood loss >2000mls | <10 | 11 | 3 | 5 | 11 | 7 | 8 | 45 |
| | | Blood loss >4000mls | No. of patients | 1 | 0 | 0 | 1 | 0 | 0 | |
| | Perineum | 3rd/4th degree tears | <5% (RCOG) | 7 | 10 | 9 | 6 | 8 | 8 | 48 |
| | | | | 2.4% | 3.6% | 3.0% | 2.0% | 2.7% | 2.5% | |
| | Stillbirths | Number of Stillbirths | | 3 | 2 | 4 | 1 | 4 | 3 | 17 |
| | Sepsis | GBS - NHS maternities | | 32 | 31 | 35 | 30 | 23 | 33 | 184 |
| | | Pyrexia in labour | ≥38°C | 8 | 16 | 12 | 4 | 13 | 16 | 69 |
| | Readmissions | Neonatal < 28 days of Birth (Feeding) | | 4 | 5 | 2 | 7 | 7 | 2 | 27 |
| | | Of which were born at C&W | | 2 | 5 | 4 | 7 | 6 | 2 | 26 |
| PbR | Pathways | Antenatal Bookings completed | 509 | 463 | 539 | 492 | 524 | 476 | 471 | 2,965 |
| | | Ref by 11w | | 351 | 377 | 383 | 406 | 356 | 341 | 2,214 |
| | | % Ref by 11w | | 76% | 70% | 78% | 77% | 75% | 72% | |
| | | **KPI:** % Ref by 11w and seen by 12+6w | 95% | 92.9% | 91.8% | 95.8% | 97.3% | 95.8% | 96.8% | |
| | | Breaches (11w ref and booked > 12+6w | | 25 | 31 | 16 | 11 | 15 | 11 | 109 |
| | | Postnatal discharges | 221 | 222 | 214 | 238 | n/a | n/a | n/a | |
| | Antenatal Casemix | Standard | 65.5% | 62.8% | 63.7% | 66.8% | 70.1% | 71.8% | 70.8% | |
| | | Intermediate | 27.3% | 25.5% | 26.0% | 23.1% | 24.8% | 22.7% | 24.4% | |
| | | Intensive | 7.1% | 11.7% | 10.3% | 10.0% | 5.1% | 5.5% | 4.8% | |
| | Postnatal Casemix | Standard | 64.2% | 74.8% | 68.9% | 69.0% | 71.5% | 69.2% | 72.1% | |
| | | Intermediate | 35.0% | 24.3% | 29.0% | 30.4% | 27.5% | 29.1% | 26.2% | |
| | | Intensive | 0.8% | 0.8% | 2.1% | 0.6% | 1.0% | 1.6% | 1.8% | |
| Risk | Maternal Morbidity | Maternal Death | Incident Form | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | ITU Admissions in Obstetrics | In 2 mths < 6 | 1 | 1 | 0 | 1 | 1 | 0 | 4 |
| | Serious Incidents | Serious Incidents (Orange Incidents) | 0 | 3 | 3 | 2 | 3 | 1 | 4 | 16 |
| | VTE | Assessments | 95% | 97.2% | 98.0% | 97.6% | 96.5% | 97.2% | 96.3% | |

**Maternity Board Headlines:**

- September had the highest number of deliveries over the last year with 462 in month. This activity is not related to transfers due to Shaping a Healthier Future and this is being monitored weekly to manage capacity.
- The high volume of deliveries has meant the midwife to birth ratio was stretched to 1:38. A retrospective look at complaints and incidents has confirmed that these have not increased during this period, however a staff stress risk assessment is underway following feedback from permanent staff. New starters have commenced in October and more are due in November.
- Discharge summary data appears low however this is not inclusive of women to have delivered; a mother and baby summary is given to all women on discharge and this is not reflected in the data here.
- The caesarean section rate remains relatively static at around 30% with processes in place to enforce rigour for elective bookings.

| Sub Domain | Trust Level Monthly Data @ 16/10/2014 XL | | | | YTD XL |
|---|---|---|---|---|---|
| | Month Year | Jul 2014 | Aug 2014 | Sep 2014 | 01/04/2014 |
| Complaints | Breach of Same Sex Accommodation *TRUST ONLY* (Target: = 0) | 0 | 0 | 0 | 0 |
| | Complaints (Type 1 and 2) - Communication (Target: ≤ 13) | 10 | 21 | 19 | 134 |
| | Complaints (Type 1 and 2) - Discharge (Target: ≤ 2) | 2 | 1 | 3 | 11 |
| | Complaints (Type 1 and 2) - Attitude / Behaviour (Target: ≤ 16) | 16 | 21 | 18 | 85 |
| | Complaints Re-opened (Target: ≤ 5%) | 13.64% | 0.00% | N/A | 6.47% |
| | Complaints upheld by the Ombudsman *TRUST ONLY* (Target: = 0) | 0 | 1 | 0 | 3 |
| | Formal complaints responded in 25 working days (Target: = 100%) | 68.18% | 70.37% | N/A | 66.19% |
| | Total Formal Complaints | 22 | 27 | 21 | 139 |
| Friends & Family | Friends & Family Test - A&E response rate (Target: ≥ 20%) | 24.6% | 24.2% | 20.8% | 20.5% |
| | Friends & Family Test - Inpatients response rate (Target: ≥ 30%) | 30.2% | 34.0% | 27.2% | 30.8% |
| | Friends & Family Test - Local +ve score (Trust) (Target: ≥ 90%) | 89.6% | 91.4% | 90.5% | 90.3% |
| | Friends & Family Test - Net promoter score (Target: ≥ 62) | 57.6 | 62.0 | 63.3 | 60.6 |
| | Friends & Family Test - Total response rate (Target: ≥ 30%) | 23.1% | 24.4% | 24.6% | 23.7% |

**Complaints – Communication:**
There was a slight decrease in the number of formal communication complaints logged from August to September (from 7 to 6). On analysis no patterns emerged in regards to type of communication failure.

**Complaints – Attitude/behaviour:**
There was also a decrease in the number of formal attitude/behaviour complaints logged from August to September (from 9 to 6) and the trend analysis carried out didn't raise any themes.

**Complaints – Discharge:**
There was 1 formal complaint in regards to discharging issues that related to discharge planning of elderly patients, and this is being reviewed.

**Friends and Family:**
Overall the Friends and Family response rates are achieving above the target and qualified for CQUIN payments. However, the inpatients response rate decreased in September, which was due to challenges of contacting patients from Edgar Horne, Lord Wigram and Nell Gwynne wards, which admit a more elderly population. Agent calls have now replaced text messaging in Nell Gwynne and Edgar Horne ward to assure a personalised service and this will also be followed in Lord Wigram.

# Access and Efficiency (1)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

| Sub Domain | Trust Level Monthly Data @ 16/10/2014 XL — MonthYear | Jul 2014 | Aug 2014 | Sep 2014 | YTD XL 01/04/2014 |
|---|---|---|---|---|---|
| A&E | A&E Time to Treatment (Target: ≤ 60) | 01:07 | 01:01 | 01:12 | 01:07 |
| | A&E waiting times (Target: ≥ 98%) | 96.3% | 96.5% | 95.1% | 96.7% |
| | A&E: Unplanned Re-attendances (Target: ≤ 5%) | 6.85% | 7.10% | 6.76% | 6.71% |
| | LAS Patient Handover Times - 30 mins (KPI2) *TRUST ONLY* (Target: ≤ 0) | 90 | 49 | 96 | 445 |
| | LAS arrival to handover more than 60mins (KPI 3) *TRUST ONLY* (Target: ≤ 0) | 2 | 0 | 5 | 9 |
| Cancer | Cancer Consultant Upgrade (Target: ≥ 85%) | N/A | N/A | 100.0% | 100.0% |
| | 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 Medicine (Target: ≥ 98%) | 100.0% | 100.0% | N/A | 100.0% |
| | Cancer diagnosis to treatment waiting times - Subsequent Surgery (Target: ≥ 94%) | 100.0% | N/A | N/A | 100.0% |
| | Cancer urgent referral Consultant to treatment waiting times (62 Days) (Target: ≥ 90%) | N/A | N/A | N/A | 100.0% |
| | Cancer urgent referral GP to treatment waiting times (62 Days) (Target: ≥ 85%) | 89.5% | 92.0% | N/A | 90.5% |
| | Cancer urgent referral to first outpatient appointment waiting times (2WW) (Target: ≥ 93%) | 94.51% | 92.57% | N/A | 94.62% |
| OP | Average Wait – Referral to First Attendance (Weeks) (Target: ≤ 6 weeks) | 5.6 | 5.6 | 6.5 | 5.7 |
| | Choose and Book slot issues *TRUST ONLY* (Target: ≤ 2.0%) | 7.0% | 10.0% | 7.9% | 5.7% |
| | Number of patients waiting longer than six weeks for a diagnostic test (Target: = 0) | 0 | 0 | 0 | 0 |
| | Rapid access chest pain clinic waiting times (Target: ≥ 98%) | 100.0% | 100.0% | 100.0% | 100.0% |
| RTT | 18 week referral to treatment times Admitted Patients (Target: ≥ 90%) | 84.4% | 80.9% | 84.8% | 83.0% |
| | 18 week referral to treatment times Non Admitted Patients (Target: ≥ 95%) | 96.0% | 95.6% | 96.0% | 96.3% |
| | 18 week RTT incomplete pathways (Target: ≥ 92%) | 92.0% | 91.0% | 91.6% | 92.0% |
| | RTT Incomplete 52 Wk Patients @ Month End (Target: = 0) | 1 | 0 | 0 | 1 |
| IP | Average Wait – Decision to admit to Admission (Weeks) (Target: ≤ 6 weeks) | 7.9 | 8.6 | 8.5 | 9.0 |

**A&E Time to treatment:**
This decrease in performance reflects the overall challenging A&E position for September which was also seen across the North West London sector. The reason for this was higher numbers of admissions in month and a lack of onward flow from the A&E Department. This has significantly improved in October however, and the Trust is the best performing Trust in NW London over this month to date. The closure of the two A&Es at Central Middlesex and Hammersmith Hospitals has put pressure on the sector, although this effect is less at Chelsea and Westminster than those in the north west of the sector. There are daily conference calls with all NWL partners to try to mitigate risks relating to these pressures.

**A&E Unplanned Re-attendance –** This continues to be a challenge and the trust has consistently been unable to achieve the 5% target. The department has ongoing projects in partnership with community services and GP to review the frequent attenders who make up a significant proportion of this number.

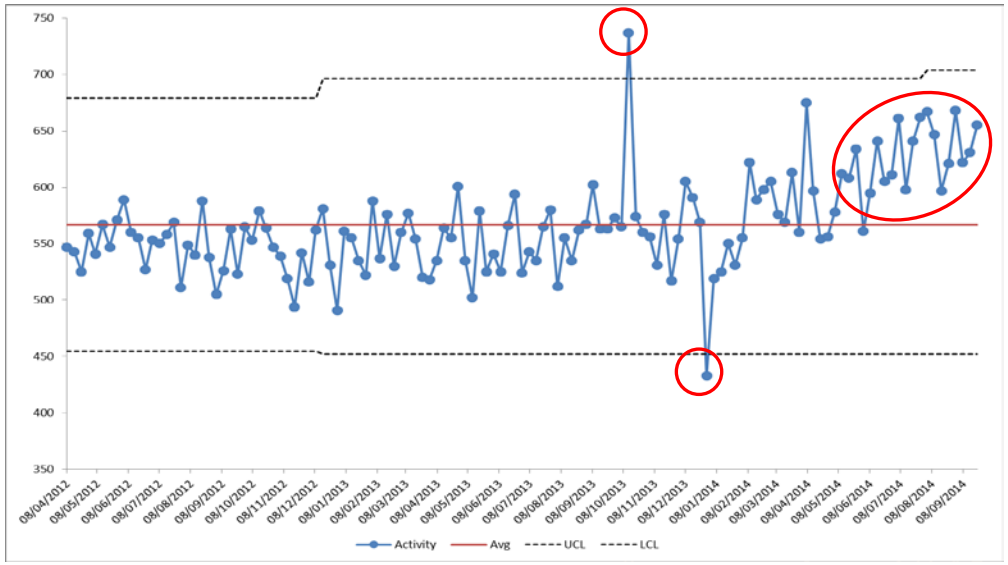
**LAS arrival to handover more than 30 mins:**
There were 96x 30 mins breaches and 5x 60 mins in September. The increase in LAS breaches reflects the increase in A&E activity for this period and was again, a theme across all NWL acute providers.

**Choose and Book slot issues:**
The Trust continues to experience challenges with choose and book slot issues, particularly in Community Dermatology and Ophthalmology. The Trust is recruiting to an additional post in Dermatology to improve the capacity in the community service and additional sessions in Ophthalmology, which have shown some improvements in September.

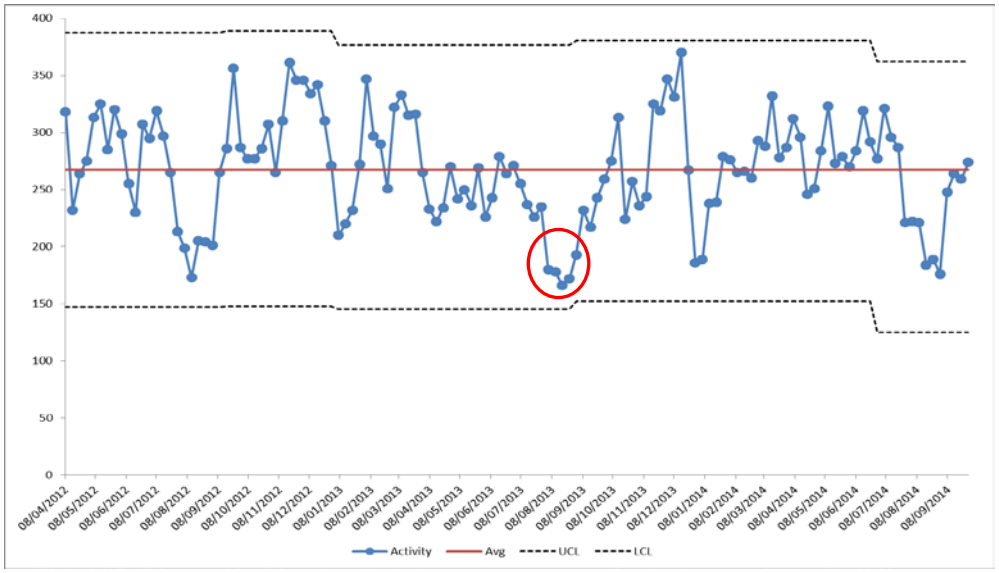
# Access and Efficiency – A&E Performance



## Adult Majors

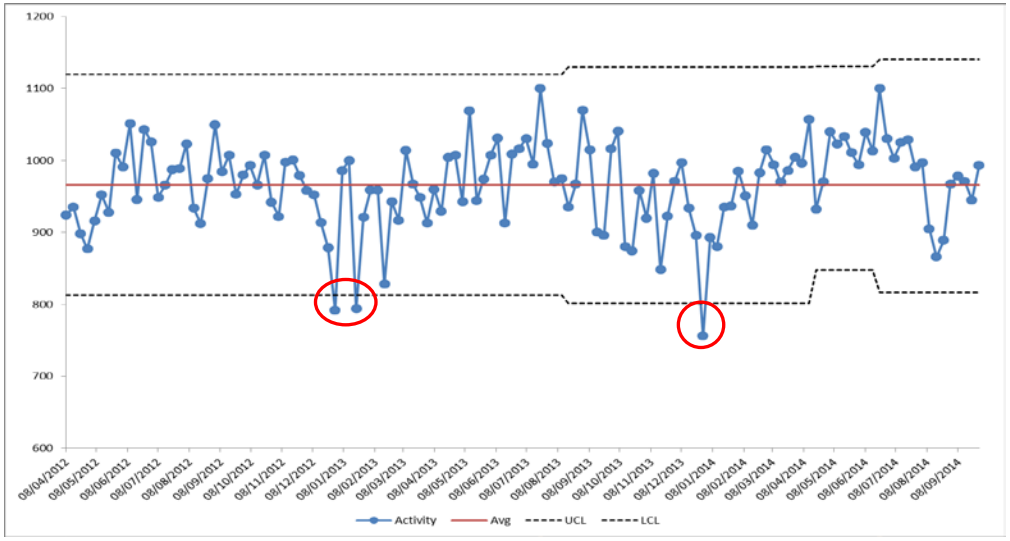



## Paed Majors

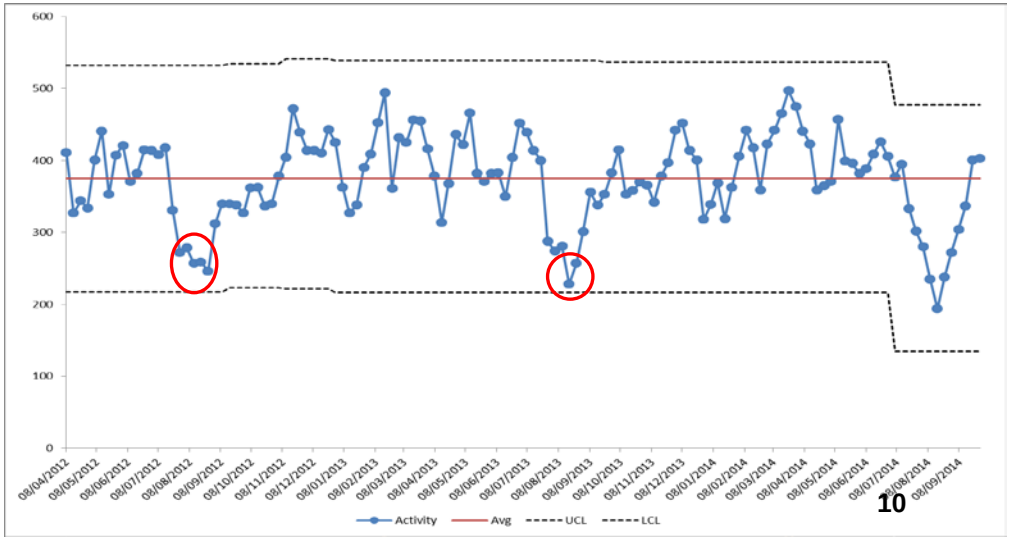



Statistical Process Control analysis of A&E activity confirms a recent increase in adult major activity that is outside the normal realms of control, which is driving the pressures in the Emergency Department.

## Adult UCC

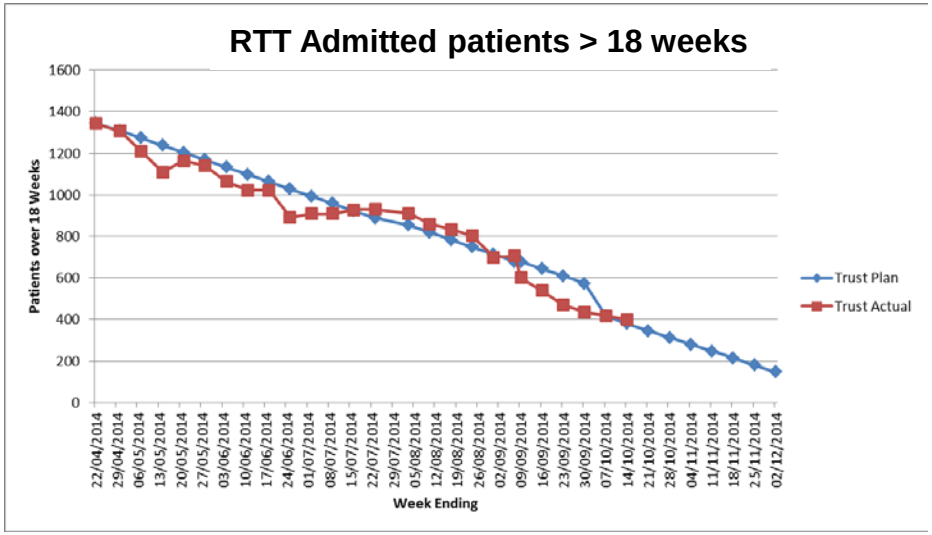



## Paed UCC



# Access and Efficiency Deep Dive - RTT






## RTT Incomplete pathways by Specialty - Sept

| Specialty | % Perf (Target 92%) |
|---|---|
| **Total** | **91.64%** |
| Cardiology | **90.18%** |
| Dermatology | 97.92% |
| Gastroenterology | 93.28% |
| General Medicine | 99.10% |
| General Surgery | **91.13%** |
| Geriatric Medicine | 95.83% |
| Gynaecology | 97.52% |
| Neurology | 95.12% |
| Ophthalmology | **88.29%** |
| Other | **91.62%** |
| Plastic Surgery | **83.22%** |
| Respiratory Medicine | **90.95%** |
| Rheumatology | 96.15% |
| Thoracic Medicine | 100.00% |
| Trauma & Orthopaedics | **83.76%** |
| Urology | **91.10%** |

## RTT Admitted patients - Sept

| Treatment Function | % Perf (Target 90%) |
|---|---|
| **Total** | **84.81%** |
| Cardiology | 100.00% |
| Dermatology | 91.67% |
| Gastroenterology | 96.55% |
| General Surgery | **78.89%** |
| Gynaecology | 95.03% |
| Ophthalmology | **87.10%** |
| Plastic Surgery | **64.86%** |
| Trauma & Orthopaedics | **73.89%** |
| Urology | **87.64%** |
| Other | **87.86%** |
| Thoracic Medicine | 100.00% |

In April 2014 the Board agreed, with Monitor and with CCG Commissioners support, that C&W would undertake an accelerated RTT admitted backlog clearance programme in order to treat long waiting patients as quickly as possible. This was planned to result in the Trust RTT performance against the Admitted and Incomplete standards being non-compliant during Q1 and Q2.

In terms of the national context, RTT performance has been under the spotlight since February 2014, when the admitted standard was not achieved for the first time in 3 years, and has remained below 90% nationally, while Trusts work to reduce long waiting lists. The Trust has received £1.4m from NHS England to undertake additional admitted and non-admitted work throughout Q2 and Q3, including funding for an additional 500 inpatient cases, profiled from July to October.

A significant amount of work has been completed over the period to reduce the number of long waiting patients and move to a sustainable position. The following issues still exist that require operational attention:

- Trust admitted backlog remains above sustainable position (395 compared to 147 patients)
- The rate of additions to the backlog remains over the 10% sustainable rate
- The Trust has extended waits related to pathway milestones, particularly related to the wait for a first outpatient appointment in some surgical specialities
- Data quality issues and the difficulties associated with LastWord
- Significant concerns around the sustainability of the Paediatric Dentistry service

External support from NHS IMAS has been sought to assure that we are doing the right things in terms of our approach to RTT compliance and ultimately patient care. A task group has been established to address and monitor the issues identified for resolution.

**Admitted Position**

The number of long waiting patients has significantly reduced from c1,400 in April to c400 at the end of September by putting on additional capacity and improving utilisation of theatre sessions. However we still have not reached the sustainable position, which equates to less than 147 patients on the admitted waiting list over 18 weeks. The Trust's current trajectory delivers the sustainable backlog position by the end of November, in line with the national requirement.

One particular problematic speciality area for the Trust is the Paediatric Dental service, with a significant proportion of the clinical workforce having resigned from post which has impacted on the Trust capacity to deliver the service. In cooperation with the Commissioners, we have implemented a restricted referral criteria for the service in an attempt to reduce the referral rate, and are attempting to recruit additional clinical capacity both in the interim and long term, however to date this has been unsuccessful. Various options are currently being explored.

**Incomplete Standard**

A significant piece of work has been undertaken to validate a large cohort of the incomplete waiting list. Validation of these pathways has now been built into normal operational processes and is being picked up as part of the daily task of the outpatient's team.

# Access and Efficiency (2)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

| Sub Domain | Trust Level Monthly Data @ 16/10/2014 XL — Month\Year | Jul 2014 | Aug 2014 | Sep 2014 | YTD XL 01/04/2014 |
|---|---|---|---|---|---|
| Admitted | Delayed transfers - Patients affected *TRUST ONLY* (Target: < 2.00%) | 1.14% | 1.19% | 1.91% | 1.51% |
| | Delayed transfers of care days lost (Target: < 644) | 308 | 291 | 190 | 1620 |
| DQ | Coding Levels complete - 7 days from month end (Target: > 95%) | 99.0% | 99.0% | 95.7% | 98.5% |
| | Total NHS Number compliance (Target: > 98%) | 96.5% | 96.4% | 96.7% | 96.7% |
| GP Real Time | Discharge Summaries Sent < 24 hours (Target: > 70%) | 81.7% | 80.2% | 81.5% | 80.3% |
| | Discharge Summaries Sent Before Discharge (Target: > 80%) | 66.0% | 64.0% | 65.8% | 64.5% |
| | GP notification of an A&E-UCC attendance < 24 hours (Target: > 70%) | 100.00% | 99.76% | 100.00% | 99.64% |
| | GP notification of an emergency admission within 24 hours of admission (Target: > ) | 100.00% | 99.82% | 99.83% | 99.87% |
| | GP Notification of discharge planning within 48 hours for patients >75 (Target: > 70%) | 69.51% | 63.11% | 72.60% | 68.00% |
| Outpatients | OP Letters Sent < 7 Working Days (Target: > 70%) | 80.6% | 79.2% | 67.0% | 78.7% |
| | Average PICs per patient (Target: < 0.64) | 0.63 | 0.64 | 0.63 | 0.64 |
| | DNA Rate (Target: <11.1%) | 12.0% | 11.5% | 10.8% | 11.1% |
| | First to Follow-up ratio (Target: < 1.5) | 1.72 | 1.72 | 1.72 | 1.72 |
| | Hospital cancellations \ reschedules of outpatient appointments % of total attendances (Target: < 8.00%) | 9.6% | 9.8% | 9.5% | 9.3% |
| | Hospital cancellations made with less than 6 Weeks Notice (Target: < 3%) | 5.0% | 4.8% | 5.2% | 4.9% |
| | Patient cancellations \ reschedules of outpatient appointments % of total attendances (Target: < 8%) | 9.2% | 9.6% | 9.4% | 9.3% |
| Theatres | 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 |
| | On the day cancelled operations (non clinical) % total elective admissions (Target: < 0.80%) | 0.17% | 0.20% | 0.47% | 0.29% |
| | Theatre booking conversion rate (Target: > 80%) | 87.8% | 89.3% | 88.1% | 87.6% |

**NHS Number Compliance**
The Trust continues to be below the 98% target, mainly due to gaps in staffing in the appointments office. Additional staff are being sought to support the patient registration service whilst there are resourcing issues and staff are working at weekends and evenings to improve the current position

**Discharge Summaries sent before discharge**
Work is underway in some specific areas of the Medicine to improve the performance for this target to achieve the year end CQUIN target.

**OP Letters Sent < 7 Working Days:**
Staffing issues have resulted in a delay in turning letters round for clinical services. This is being addressed through pooling of the Trust's admin resource and through additional staff members being brought in to support the services. It is anticipated that this will be resolved by the end of October.

# Health & Safety and Mandatory Training

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

| Division | Total | Corporate Division | Emergency & Integrated Care Division | Planned Care Division | Womens, Childrens and Sexual Health Division |
|---|---|---|---|---|---|
| Fire | 60% | 74% | 51% | 60% | 61% |
| Moving & Handling | 74% | 77% | 72% | 73% | 76% |
| Safeguarding Adults Level 1 | 100% | 100% | 100% | 100% | 100% |
| Slips Trips and Falls | 84% | 88% | 78% | 86% | 86% |
| Harrassment & Bullying | 85% | 78% | 90% | 89% | 82% |
| Information Governance | 65% | 72% | 64% | 69% | 60% |
| Hand Hygiene | 74% | 82% | 69% | 74% | 75% |
| Health & Safety | 85% | 89% | 79% | 87% | 87% |
| Child Protection Level 1 | 100% | 100% | 100% | 100% | 100% |
| Innoculation Incident | 82% | 65% | 88% | 83% | 82% |
| Basic Life Support | 72% | 83% | 71% | 72% | 73% |
| Health Record Keeping | 85% | 90% | 85% | 86% | 85% |
| Medicines Management | 89% | 92% | 91% | 90% | 87% |
| VTE | 88% | 87% | 86% | 86% | 92% |
| Blood | 80% | 85% | 80% | 81% | 80% |
| Safeguarding Children Level 2 | 86% | 84% | 85% | 86% | 87% |
| Safeguarding Children Level 3 | 70% | 100% | 91% | 73% | 67% |
| Corporate Induction | 82% | 65% | 88% | 83% | 82% |
| Local Induction | 38% | 23% | 41% | 43% | 38% |
| Mandatory Training Compliance % | 79% | 81% | 79% | 80% | 79% |

| Health and Safety Indicators | Total | Planned Care Division | Management Exec & Corporate Services Division | Emergency and Integrated Medical Care 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 | Sept 14 | ~2013/14 Out-turn | 2014/15 Annual Target | 12 Month Rolling YTD |
|---|---|---|---|---|---|---|
| Turnover rate | | 14.54% | 19.92% | 14.76% | 13.50% | 15.39% |
| Vacancies | Total | 8.82% | 12.52% | 9.74% | 8% | 9.67% |
| | Active | 3.25% | 2.60% | 3.02% | 3.25% | 3.61% |
| Time to Recruit | Authorisation to pre-employment checks completed | <55 days | 60 days | - | <55 days | 52.25 days |
| Sickness rate | | 3.00% | 2.61% | 2.92% | 3.00% | 2.87% |
| Agency % of WTE | | 3.15% | 4.10% | 3.82% | 3.15% | 3.40% |
| Appraisals | Non-Med | 80.18% | 69% | 85% | 85% | 83.47% |
| | Medical | 81.18% | 75.40% | 70% | 85% | 73.2% |
| Mandatory training | | 86.28% | 79% | 77% | 95% | 78.17% |

**Appraisals & Training:** The non-medical appraisal rate in September is 75%, which is below both the monthly and yearly targets set. Reports of overdue and due appraisals continue to be issued to managers monthly. Medical appraisal rates currently stand at 75%, which is a decrease from last month and now below the monthly target. There continues to be on-going work to support medical appraisals.

Mandatory training figures in September improved slightly to 79%, which is 7% 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.

*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 Sept 2014 was 12.52%, which is an increase of 0.5% on last month and is 3.7% above the monthly target set for Sept. 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 Sept 2014. The active vacancy rate for Sept was 2.60% which is 0.61% below the monthly target of 3.25%. This increase was identified within Maternity, A&E and Paediatrics services throughout Sept. A new central establishment process came into effect at the end of Jan 2014 which has contributed to more posts being queried, held, or covered by alternative means to achieve CIPs. This level of scrutiny will continue for the rest of the year. The average time to recruit for Sept starters was 60 days (once international, Deanery and planned recruitment was excluded). This was over the 6 days set target of 55 days for 2014/15 with the YTD position also remaining over the target.

*Average vacancies across LATTIN Trusts = 11.62% (latest data available)*

**Turnover Rate:** Unplanned staff turnover (i.e. resignations) increased to 19.92% in Sept 2014 which is the highest it has been since we started monitoring this KPI. This is 5.38% above the monthly target of 14.54% set for Sept 2014. Nursing and Midwifery, Support staff and Admin and Clerical make up over half of the Trust's total establishment and accounted for 24.93% of voluntary resignations. In response to the increase in leavers, further in-depth analysis on turnover has been undertaken, reviewing leaving reasons and the length of service of leavers. Areas of most concern have been identified and are developing action plans to help understand and improve retention, a key strand of the People & OD strategy.

An action plan on HCA recruitment and retention and specific HCA working group co-ordinate work jointly by Nursing and HR colleagues. 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. Further work is currently underway to look at the exit Interviews process and targeting those employees that no longer work for 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 Overview as at 30 September 2014 (Month 6)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

### Financial Performance

**Financial Position (£000's)**

| | Full Year Plan | Plan to Date | Actual to Date | Mth 6 YTD Var | Mth 3 YTD Var |
|---|---|---|---|---|---|
| Income | (367,770) | (182,922) | (182,249) | (674) | (682) |
| Expenditure | 333,931 | 164,665 | 169,609 | (4,943) | (2,473) |
| EBITDA for FRR excl Donations/Grants for Assets | (33,839) | (18,257) | (12,640) | (5,617) | (3,155) |
| EBITDA % for FRR excl Donations/Grants for Assets | 9.2% | 10.0% | 6.9% | -3.0% | -5.2% |
| **Surplus/(Deficit) from Operations before Deprec** | **33,839** | **18,257** | **12,640** | **(5,617)** | **(3,155)** |
| Interest | 1,429 | 714 | 410 | 304 | 144 |
| Depreciation | 13,948 | 6,811 | 7,338 | (527) | (283) |
| PDC Dividends | 11,400 | 5,700 | 5,738 | (38) | 50 |
| **Retained Surplus/(Deficit) excl impairments** | **7,062** | **5,031** | **(847)** | **(5,879)** | **(3,244)** |
| Impairments | 0 | 0 | 0 | 0 | 0 |
| **Retained Surplus/(Deficit) incl impairments** | **7,062** | **5,031** | **(847)** | **(5,879)** | **(3,244)** |

**Comments**

**Risk Assessment**

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

The YTD position is a deficit of £0.84m (EBITDA of 6.9%) which is an adverse variance of £5.9m against plan.
However a COSR of 3 has been achieved for the year to date.

The year end forecast remains a surplus of between £1.2m and £3.4m.
Further actions and controls agreed by the Executive Team are being implemented to ensure delivery of the £3.4m surplus.

### Risk Rating (year to date)

| COSR Rating | Weighting | M6 Actual Score | M6 Actual Rating | M6 Planned Score | M6 Planned Rating |
|---|---|---|---|---|---|
| Capital Servicing Capacity (times) | 50% | 1.38x | 2 | 1.33x | 2 |
| Liquidity (days) | 50% | 11 | 4 | 4 | 4 |
| **Total Rating (roundup)** | | | **3** | | **3** |

**Comments**

The COSR rating for Month 6 of 2014-15 is a 3, comprising a capital servicing ratio of 2 and a liquidity rating of 4 rounding to an overall 3, against a planned COSR of 3.

### Cost Improvement Programme

| Division | YTD Identified | YTD Actual | YTD Variance | 14/15 CIP Target | Forecast Delivery | Forecast Variance |
|---|---|---|---|---|---|---|
| Total Planned Care | 1,437 | 1,284 | -153 | 6,289 | 2,692 | -3,597 |
| Total Emergency Care | 629 | 602 | -27 | 4,035 | 1,329 | -2,706 |
| Total W&N, C&Y, HIV & SH | 2,104 | 1,749 | -355 | 6,903 | 4,281 | -2,622 |
| Total Facilities | 1,407 | 1,407 | 0 | 3,059 | 2,794 | -266 |
| Total ICT | 132 | 132 | 0 | 634 | 284 | -350 |
| Total Chief Nurse | 157 | 157 | 0 | 1,214 | 315 | -899 |
| Total HR & Education and Training | 69 | 48 | -21 | 232 | 161 | -70 |
| Total Procurement/Commercial | 341 | 341 | 0 | 3,500 | 961 | -2,539 |
| Total Finance | 115 | 114 | -1 | 597 | 490 | -107 |
| Total Central Budgets | 0 | 0 | 0 | -1,595 | 0 | 1,595 |
| 2014/2015 CIP Total | 6,389 | 5,832 | -557 | 24,868 | 13,307 | -11,560 |

**Comments**

The CIP target is £24.9m (£18.9m in 14/15 + £6.0m brought forward from 13/14).
Schemes implemented year to date where a budget saving has been achieved is £5.8m, or 23% of the annual target.
The forecast achievement is £13.3m leaving a gap of £11.6m.
Overall the Trust is forecasting delivery of 3.7%, and is therefore almost meeting the minimum requirement of 4%., despite unexpected cost pressures resulting in a shortfall against the total target.

### Key Financial Issues

**Key drivers behind the £5.9m overspend**

- Un-achieved CIPs year to date of £5.7m
- Continued reliance on temporary bank/ agency usage due to high levels of vacancy, sickness and activity pressures and slippage in CIPs £0.6m year to date
- Non Clinical Supplies is overspent £2.2m year to date mainly related to increased activity due to clearance of RTT backlog
- Contingency released into the position is £2.5m and release of unutilised provisions of £0.4m
- Non Operating expenditure is £0.3m overspent year to date, due to higher depreciation costs than plan.

**Key Issues**

- Forecast unachieved CIP of £11.6m
- A number of mitigations including review of investments and improvements in the run-rate for pay are required to improve the position.
- The Trust is planning a £5m reduction in capital expenditure this financial year to maintain the liquidity position following the deterioration in I&E Surplus.

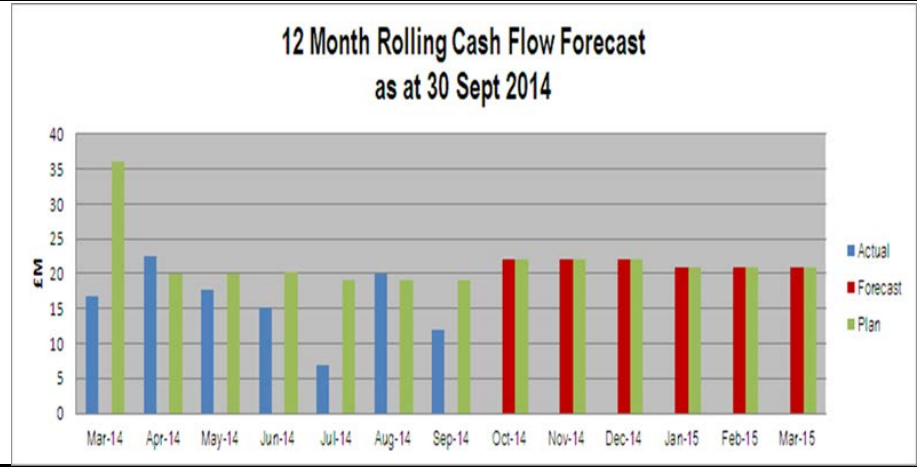
**Future Developments**

- Strategic developments e.g. West Midd, SaHF
- West Middx at the Full Business Case stage
- ED capital redevelopment
- Delivery of increased Private Patient income plans

**Further Actions**

- Divisional control totals and weekly review meetings
- Controls on agency staff and improved recruitment to vacant posts
- Review of income shortfalls
- Additional scrutiny of non-pay spend

### Cash Flow




**Comments**

The cash position at end September is £12.2m compared to a plan of £19.0m. The Top 10 debtors outstanding is made up of NHS organisations & Department of Health amounting to £10.5m, FT debt amounting to £0.6m and Local Government debt amounting to £0.5m.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Board of Directors Meeting, 30 October 2014 PUBLIC

| | |
|---|---|
| **Subject/Title** | Monitor In-Year Reporting & Monitoring Report Q2/4.3/Oct/14 |
| **Purpose of paper** | Submission of commentary to Monitor on the Quarter 2 2014/15 in year financial return |
| **Decision/action required/ recommendation** | The Trust Board is asked to:<br>1. Delegate approval to the Chief Financial Officer to approve, on behalf of the Board, submission of the Quarter 2 2014/15 in-year financial reporting return to Monitor.<br>2. Approve the commentary for the submission to Monitor<br>3. Approve the In Year Governance Statement (attached in Appendix 1) which includes the following elements:<br>- Approve the financial declaration that the Trust will continue to maintain a continuity of service rating of at least 3 over the next 12 months<br>- Approve the Governance Declaration, with the exception of the RTT admitted and incomplete indicators<br>4. Approve the capital expenditure declaration and reforecast |
| **Summary of the key risks/issues from the paper** | **Financial Performance**<br>The Trust achieved a net deficit of £0.8m for the year to date compared against a planned surplus of £2.2m. The EBITDA was £12.6m (6.9%) against a plan of £15.0m (8.2%).<br><br>The overall COSR is based on two ratios capital serving capacity ratio and liquidity; was 3 compared against a plan of 3.<br><br>**Targets and Indicators**<br>The Trust did not achieve the following indicators in the second quarter of the 2014:<br>Referral to treatment time 18 weeks admitted patients 83.3% (target 90%)<br>Referral to treatment, 18 weeks in aggregate incomplete pathways 91.0% (target 92%)<br><br>This is the same report as for the public Board. |
| **Link to corporate objectives** | Ensure Financial and Environmental Sustainability<br>Deliver 'Fit for the Future programme' |
| **Executive Sponsor** | Lorraine Bewes, Chief Financial Officer |

## Monitor In-Year Reporting & Monitoring Report Q2

### 1. Introduction/ Background

1.1. A financial reporting return and commentary are required to be submitted to Monitor on a quarterly basis. This report provides commentary to be submitted with the financial return for the quarter ending September 2014.

### 2. Decision/Action required

2.1. The Trust Board is asked to:

2.1.1. Delegate approval to the Chief Financial Officer to approve the submission of the Quarter 2 2014/15 in-year financial reporting return to Monitor, on behalf of the Board.

2.1.2. Approve the commentary for the submission to Monitor

2.1.3. Approve the In Year Governance Statement (attached in Appendix 1) which includes the following elements:

- Approve the financial declaration that the Trust will continue to maintain a continuity of service rating of at least 3 over the next 12 months
- Approve the Governance Declaration that the Board, **with the exception of RTT admitted and incomplete indicators**, is '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':

2.1.4. Approve the Capital Expenditure declaration statement and reforecast

### 3. Content

3.1. **Governance Declaration**

3.1.1. **Continuity of Service Rating (COSR):** The Trust recorded a Continuity of Service Rating (COSR) of 3 year to date at quarter 2 compared to a plan of 3. The capital service cover rating is a 2 (against a planned 2) and the liquidity rating is a 4 (against a planned 4).

3.1.2. **Compliance with targets:** The Trust did not achieve the referral to treatment time 18 weeks admitted and incomplete patients in the second quarter, with performance of 83.3% (target 90%) for admitted patients and 91.0% (target 92%) for incomplete pathways. The Trust is meeting all the remaining performance indicators at the end of quarter 2.

3.1.3. The Board with the **exception** of the below is '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':

3.1.4. 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.

3.1.5. The Trust did not achieve the target for RTT standard for admitted patients and incomplete pathways in Q2, and has a trajectory to reduce the number of long waiting patients to a sustainable level and achieve compliance in Q3, subject to resolution of resourcing issues, particularly in paediatric dentistry. 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. The Trust met the RTT standards for non-admitted in Q2 and is planning to continue to achieve this in Q3.

3.1.6. 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.

3.2. In the second quarter of 2014/15 there were no elections to the Council of Governors (Appendix 2).

3.3. **Capital Declaration**

3.3.1. Capital spend for year to date is reported at £6.8m against the plan of £9m (24.2% behind plan). This has triggered a capital reforecast to Monitor. The main reason for the capital expenditure to be behind the plan is due to the delay in expenditure on the Emergency Department refurbishment (ED) project. Also the Trust has agreed to reduce the capital plan by £2.5m in this financial year to meet the liquidity position. This requires the rephasing of the capital programme for 2014/15 which will be reflected in the capital reforecast to be submitted in the return.

3.3.2. 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. The Property maintenance expenditure is ahead of the plan by 40% 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.

3.3.3. Capital spend on information technology is 29% behind the plan whereas purchase of intangible assets is ahead of plan with an adverse variance of £0.5m. IT expenditure has been mainly on LastWord Development, Electronic Document Management (EDM), and It Portal and IT shared services.

3.3.4. Plant & Equipment capital expenditure (other equipment) is behind the plan by 66%. The equipment replacement programme is in place and the expenditure will be incurred in future quarter.

3.4. **Summary of Financial Position**

3.4.1. The Trust reported a break even position in Q2 and a net deficit of £0.8m for the year to date, against a planned surplus of £2.2m. The EBITDA was £12.6m (6.9%) against a plan of £15.0m (8.2%).

3.5. **Statement of Comprehensive Income**

***NHS Clinical Revenue***

3.5.1. The underlying NHS clinical income (after adjusting for excluded drugs and devices) is £0.6m ahead of plan in Q2 and £3.0m ahead of plan for the year to date. The year to date over-performance continues to be driven primarily by

elective, A&E and outpatient points of delivery, particularly in elective surgical specialties to address waiting list pressures and GUM outpatients.

3.5.2. Elective and day case activity was slightly behind plan in Q2, but remains £0.4m ahead of plan for the year to date, primarily as a result of increased surgical work associated with the planned clearance of long waiting patients on referral-to-treatment (RTT) pathways, particularly in Trauma and Orthopaedics. Non Elective activity was £0.7m behind plan for the year to date. The Trust is continuing to under-perform on specialised activity, which is not subject to the block funding, partly offset by higher numbers of obstetric deliveries than plan.

3.5.3. Outpatient income was £0.7m ahead of plan for the year to date. This is primarily due to high GUM activity at the new Dean Street clinic. Obstetrics antenatal pathways also continue to over-perform by £0.6m year to date due to an increase in ante-natal bookings.

3.5.4. NHS Clinical Income for other points of delivery was £2.6m behind the plan in the quarter and £0.6m behind the plan for the year to date. Excluded drugs were £3.2m behind plan for the year to date, which is offset by an under spend on non-pay expenditure. The Trust has seen continued high levels of A&E and UCC activity in Q2, which is contributing a favourable variance of £0.5m in the quarter and £0.8m year to date.

***Other Operating Income***

3.5.5. Private Patient income was below plan by £1.2m for the quarter and £2.6m year to date. There is an improvement in income in the second quarter of £0.2m compared against Q1, mainly attributed to the Chelsea Wing as a result of increased medical cases and surgical activity.

3.5.6. Non protected clinical income is ahead of plan by £1.2m in the quarter and £1.3m year to date. This is primarily related to over-performance in local authority GUM income.

3.5.7. Other Operating revenue is ahead of plan by £0.9m in the quarter and £1.2m year to date due to income related to West Middlesex acquisition which is offset against costs within non-pay.

***Operating Expenditure***

3.5.8. Pay - There was an adverse variance for pay in the second quarter of £0.9m, and £0.5m year to date. This is primarily driven by unidentified CIP which has been offset against holding of vacancies across all staffing groups. The pay CIP has been phased towards the end of the financial year. Contracted pay has decreased in the second quarter by £0.5m and temporary pay spend has increased in the second quarter by £1.7m due to higher use of nursing agency as a result of vacancies, higher levels of sickness and increased capacity compared to previous year and specific cost pressures in medical staffing in NICU and hand surgery.

3.5.9. Drugs – There is a favourable variance of £1.5m in the quarter and £2.0m year to date as of September, which is primarily driven by an under spend on HIV pass through drugs, which is offset by income.

3.5.10. Clinical supplies are overspent by £1.5m in the quarter and £2.4m year to date. £1.0m of the adverse variance relates to other clinical costs, pathology and other tests – this mainly relates to increase in costs associated with Dean Street

Express which is offset against over-performance in GUM outpatient tariff income. £0.2m of the adverse variance relates to prosthetics associated with the increase in additional RTT backlog clearance which is offset against increase in elective clinical income.

3.5.11. Non-clinical supplies are overspent by £0.1m in the quarter and overspent by £0.5m year to date. An increase in bad debt provisions in the second quarter of £0.2m has been offset against underspends in other areas.

3.5.12. There is an under-performance against the CIP plan of £4.2m for the year to date; this is related to unidentified CIP (£3.6m) and slippage on identified schemes (£0.6m).

3.6. **Statement of Financial Position**

3.6.1. **Property Plant and Equipment:** The capital plan for 2014/15 is £28.6m. The year to date capital expenditure year is £6.8m against the Trust plan of £9.0m, £2.2m behind the plan. This is 76% of the latest capital year to date spend, and therefore triggered the requirement of a capital reforecast.

3.6.2. **Receivables and Other Current Assets:** As at September 2014 was £44.8m (against a plan of £32m). The top ten debtors outstanding of £10.5m relate principally to NHS organisations and Department of Health.

3.6.3. **Trade and Other Payables - Current:** The total trade and other payables, accruals and other current liabilities was £33.0m against a plan of £36.9m.

3.6.4. **Cash Flow:** The cash balance at the end of quarter 2 is £12.8m against a plan of £19m, driven by the movement of working capital and I&E shortfalls.

3.7. **Forecast**

3.7.1. 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.

## 4. Summary

4.1. **Financial Performance**

4.1.1. The Trust reported a net deficit of £0.8m for the year to date, against a planned surplus of £2.2m. The EBITDA was £12.6m (6.9%) against a plan of £15.0m (8.2%).

4.1.2. The Trust has achieved a year-to-date (YTD) Continuity of Service Rating (COSR) of 3 as at 30th September 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 2.

4.2. **Targets and Indicators**

The Trust did not achieve the referral to treatment time 18 weeks admitted and incomplete patients in the second quarter, with performance of 83.3% (target 90%) for admitted patients and 91.0% (target 92%) for incomplete pathways. The Trust is meeting all the remaining performance indicators at the end of quarter 2.

# 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)*

| | | Board Response |
|---|---|---|
| | **For finance, that:** | |
| 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 |
| NEW | **Consolidated subsidiaries:** Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds. | |

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 | |

1

**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 is '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 and incomplete pathways in Q2, and has a trajectory to reduce the number of long waiting patients to a sustainable level and achieve compliance in Q3, subject to resolution of resourcing issues, particularly in paediatric dentistry. 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. The Trust met the RTT standards for non-admitted in Q2 and are planning to continue to achieve this in Q3.

**Appendix 2**

In the second quarter of 2014/15:

**I. ELECTIONS**

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

**II. BOARD OF DIRECTORS**

Following departure of David Radbourne 28.09.14 Robert Hodgkiss was appointed as Interim Chief Operating Officer 29.09.14.

One Non-executive Director, Jeremy Jensen has been appointed on 01.07.14 to fill in a vacant seat on the Board.

Four Board members have been appointed to the Board, namely Eliza Hermann, Dr Andrew Jones, Nilkunj Dodhia and Liz Shanahan (01.07.14) who will fill in the vacancies which are coming up in due course.

| Role | Date of change | Full Name | Job Title (if different to 'role') |
|---|---|---|---|
| Non-Executive Director | 01.07.14 | Jeremy Jensen | |
| Board member | 01.07.14 | Eliza Hermann | |
| Board member | 01.07.14 | Dr Andrew Jones | |
| Board member | 01.07.14 | Nilkunj Dodhia | |
| Board member | 01.07.14 | Liz Shanahan | |
| Chief Operating Officer | 29.09.14 | Robert Hodgkiss | Interim Chief Operating Officer |

**III. COUNCIL OF GOVERNORS**

**a. Retirements and Resignations**

**i. Elected**

A vacancy was created in the Staff Constituency – Allied Health Professionals, Scientific and Technical following the resignation of Caroline Fenwick 01.07.14

A vacancy was created in the Patient Constituency following the resignation of Andrew Lomas 01.09.14

**ii. Stakeholders**

There were no changes.

**b. Appointments (stakeholder)**

There were no changes.

# Appendix 3 – Capital Expenditure Declaration

## Worksheet "Capex Declaration"

Click to go to index

## Capital Expenditure Declaration for Chelsea and Westminster

*Where year-to-date capital expenditure is less than 85% or greater than 115% of levels in the latest annual plan (or any later capital expenditure reforecast) an NHS foundation trust must submit a capital expenditure reforecast for the remainder of the year. This is set out at the bottom of page 22 of the Risk Assessment Framework issued by Monitor April 2014.*

*If you have triggered one of these criteria (see worksheet "Capex Reforecast Trigger") then you must complete the worksheet "Capex Reforecast" and sign one and only one of the declarations below. If you have not triggered one of these criteria then please do not input into this worksheet and the worksheet "Capex Reforecast" at all.*

### Declaration 1

The Board anticipates that the trust's capital expenditure for the remainder of the financial year will not materially differ from the attached reforecast plan.

**Signed:**

**On behalf of the Board of Directors**

**Acting in Capacity as:** [job title here]

### Declaration 2

The Board cannot make Declaration 1 and has provided relevant details on documents accompanying this return.

**Signed:**

**On behalf of the Board of Directors**

**Acting in Capacity as:** [job title here]

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Board of Directors Meeting, 30 October 2014 PUBLIC

| | |
|---|---|
| **Subject/Title** | Research and Innovation Strategy 2014-2019/5.2/Oct/14 |
| **Purpose of paper** | For Information. Approved by the Research, Development and Innovation Board on the 2nd Oct 2014 |
| **Decision/action required/ recommendation** | None. The Research Strategy for information only. It has already been approved by the Research, Development and Innovation Board. |
| **Summary of the key issues from the paper** | • To embed a research and innovation culture capable of driving high quality research, service innovation and improvement.<br>• To build research capacity and capability to deliver research excellence and readiness within an evolving research and innovation landscape.<br>• To deliver world class research and innovation aligned to clinical and academic priorities with capacity to transform the quality of treatments and services.<br>• To develop and strengthen collaborative partnerships with industry.<br>• To continue to build strong synergistic partnerships across North West London to respond to national and local priorities and opportunities |
| **Link to corporate objectives** | Excellent Teaching and Research |
| **Executive Sponsor** | Prof Derek Bell, Director of Research and Development<br>Tony Bell, Chief Executive |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

**Delivering World Class Research and Innovation for Patients**
**Research and Innovation Strategy**
**2014-2019**

**1) Introduction:** The NHS has a statutory duty to deliver research with a renewed focus upon research and innovation, service improvements and economic growth. To achieve this, the government has embarked upon an ambitious national strategy; '***Innovation for health and wealth***'[1] and the ***Strategy for UK Life Sciences***[2] to transform healthcare delivery and improve patient outcomes. The ***'Cooksey Review'*** (2006) highlighted the UK's global reputation for high quality basic research but emphasised the poor uptake and adoption of research evidence into routine practice. The NHS and Universities were challenged to focus upon the entire research pathway from discovery to delivery and the need to develop productive partnerships between the NHS, academia and industry. More recently, ***'Innovation, Health and Wealth'*** (2011), and the ***Strategy for UK Life Sciences*** emphasised the need to transform the UK health innovation and life sciences landscape to promote economic growth, and accelerate patient access to new therapies and innovation within the NHS.

**2) Decision/Action Required:** None It is for Trust Board information. The strategy has been approved by the Research, Development and Innovation Board.

**3) Background:** The previous Trust research strategy (2010) reflected an ambition to deliver high quality patient-focused research and achieve the objectives of ***'Best Research for Best Health'*** (2006). Consequently, the Trust has achieved a higher research profile with increased patient and investigator engagement and improved and streamlined governance processes. The Trust research portfolio has strengthened and NIHR CRN targets have been exceeded (Appendix 1). As part of this expansion, the Trust hosts two large National Institute of Health Research (NIHR) funded programs, the NIHR NW London Collaboration for Leadership in Health Research and Care (CLAHRC) and the NIHR Applied Research Program (Medicines for Neonates) both leading changes in patient care, clinical service delivery, and research practice.

Our vision for the next five years is to be a leading center for applied and translational research and innovation where patients will have access to world class research and staff will embrace research and innovation to improve patient care and experience. Building on the previous Trust strategy the aim is to be responsive to new opportunities in the evolving research and innovation landscape through engaging in strong partnerships with the Local CRN for NW London, Imperial College, the Academic Health Science Network (AHSN) Imperial College Health Partners, the Royal Brompton & Harefield, and the Royal Marsden NHS Foundation trusts as well as industry and charities.

**4) Content:** The strategy builds on our existing strengths and the important research partnerships across North West London, while recognising the changing national research landscape. Our vision, aims and objectives reflect a current analysis of the local and national strategy, our clinical and research strengths, and the views and opinions of senior investigators, managers, staff, patients and the public. Over the next five years we will prioritise the following key strategic aims.

[1] Innovation, Health and Wealth: Accelerating adoption and diffusion in the NHS (2011), Department of Health
[2] Strategy for UK Life Sciences (2011), Department for Business Innovation and Skills

The strategy builds on our existing strengths and the important research partnerships across North West London, while recognising the changing national research landscape. Our vision, aims and objectives reflect a current analysis of the local and national strategy, our clinical and research strengths, and the views and opinions of senior investigators, managers, staff, patients and the public. Over the next five years we will prioritise the following key strategic aims.

**To embed a research and innovation culture capable of driving high quality research, service innovation and improvement**

A strong research and innovation culture provides a supportive environment within which to develop and retain a skilled workforce with capacity to undertake high quality research and translate the benefits into improved patient outcomes. The Trust aims to embed research and innovation at all levels of the organisation and to create multi-professional leadership roles to promote staff engagement. Senior investigators will be supported and nurtured to maximise research outputs based on clinical and research expertise. This aim will be achieved in partnership with patients and public and by creating greater awareness of the research opportunities provided by the Trust and other partners including National Institute of Health Research (NIHR), Clinical Research Network (CRN) and the NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) based at Chelsea and Westminster Hospital.

**To build research capacity and capability to deliver research excellence and readiness within an evolving research and innovation landscape**

A skilled and knowledgeable research workforce is necessary to increase both the number of clinical trials undertaken and patients recruited to clinical trials (local and national research objectives). To support staff high quality in-house research training will be provided combined with professional development opportunities including higher degrees and research fellowships in partnership with Imperial College and health care charities. Our team of multi-professional Research Associates will work to increase engagement of all staff including nurses, midwives and allied health professionals. The aim is continue investment in the Research Associates and support the growing virtual trial unit infrastructure.

A research portal will be developed that is fully integrated with the Trust Information Management & Technology (IM&T) strategy. The research portal will support and manage all research data and expand opportunities for patients to directly contribute to research. The proposed research portal design will place the Trust in a unique position to improve patient and staff access to research, to better design and deliver trials, and facilitate all research partnerships. A sub-component of the portal will be a patient registry, **Consent for Consent**, to provide the 'front end' and promote patient engagement, improve clinical trial development and patient recruitment. The portal would be a major component of a clinical trials unit. Continued investment in the NHS-funded research staff infrastructure to maintain high standards of trial delivery is critical to maximising financial growth, and improved performance against NIHR objectives.

**To deliver world class research and innovation aligned to clinical and academic priorities with capacity to transform the quality of treatments and services**

The Trust will build on existing research strengths, which includes the local research partnerships between the basic and clinical sciences for the delivery of world class applied and translational research. Key research priorities include Acute Medicine, Child and Maternal Health, HIV and Immunology, and translating the outcomes from the nationally successful NIHR CLAHRC for North West (NW) London and Neonatal Research programmes into improved patient outcomes. The Trust with Imperial College was awarded a further £10M from January 2014 for the NIHR CLAHRC programme and the research programme is aligned with Trust and regional objectives.

World class innovation inspired by the Trust's strong legacy for service innovation, quality improvement and safety will be achieved through partnership across NW London including Imperial College London, Royal Brompton & Harefield and Royal Marsden Hospitals and Imperial College Health Partners. Knowledge and technology partnerships such as those with Imperial Innovations will help staff to manage intellectual property (IP), and ensure innovation is translated into service improvements. Service innovations will be aligned to the CQUIN framework, clinical and financial targets as well as key clinical and service priorities, for example the planned growth in paediatric services.

**To develop and strengthen collaborative partnerships with industry**

The Trust will foster improved industry engagement with the aim to become recognised as a growing centre for high quality clinical research. This will build on a shared industry post with the Royal Brompton & Harefield NHS Foundation Trust with support from the NIHR CRN for NW London and support investigators design and deliver high quality clinical research. Improved industry engagement will yield benefits for patients, staff and the wider organisation. Increased industry trials within the Trust improve patient outcomes and over time provide additional research income. The NIHR CLAHRC has a growing number of industry research partners working with the Trust and it is envisaged this will further increase over the next five years.

**To continue to build strong synergistic partnerships across North West London to respond to national and local priorities and opportunities**

The Trust will maintain high quality research and clinical services, and increase the speed at which new healthcare solutions are adopted into practice, placing the Trust at the forefront of innovative clinical practice. Partnerships with local NHS providers and community, the NIHR family network, Imperial College, industry, and local charities such as Chelsea and Westminster Health Charity (C&W Health Charity), St Stephen's Aids Trust (SSAT), and Westminster Medical School Research Trust will be strengthened. Exploratory discussions in line with Shaping a Healthier Future are taking place with West Middlesex University Hospital Trust. As such we will develop a strategic dialogue with all partners, streamline cross-organisational collaboration, and develop synergistic partnerships with common goals.

**5) Summery:**

**Strategic Vision:**

To be a leading centre for applied and translational world class research and innovation

**Year 1 (2014)**

- Align Divisional-led strategic plans to vision for world class research and innovation and Trust corporate strategy
- Ensure appraisal system to support the professional development of senior investigators
- Support increased patient and public engagement in Trust-wide research activity
- Develop implementation plans developed for each research priority
- Align Trust-wide research and innovation with service improvement activities.
- Implement marketing and communication plan to increase commercial trial portfolio
- Achieve annual targets for patient recruitment and performance, initiation and delivery (PID)

**Year 2 (2015)**

- Establish professional development pathways established for nurses, midwives and AHP
- Multi-professional research programme with submission/award of funded grant proposals
- Active Research Portal and Patient Registry
- Expanded Virtual Clinical Trials Unit with on-site expertise for research trial delivery
- Clear Joint strategy between Chelsea and Westminster and key stakeholders
- Formalise internal clinical science partnership centred on key themes including immunology /inflammation and tissue engineering)
- Achieve annual targets for patient recruitment and performance, initiation and delivery (PID)

**Year 3-5 (2016 – 2019)**

- Deliver a large virtual Clinical Trials Unit to support a Clinical Trials Facility development
- Ensure large multi-disciplinary collaborative programme grant proposals in pipeline
- Established centre for excellence in translational research
- Highly effective partnerships with industry and recognised Prime Site Status
- Achieve annual targets for patient recruitment and performance, initiation and delivery (PID)

**Appendix 1: C&W Research Performance as at 06 February 2014**

# Research Performance in Set-up, Initiation and Delivery, 06.02.2014

## Set-up


**Set-up Service Survey Results (April 2013–Jan 2014):**

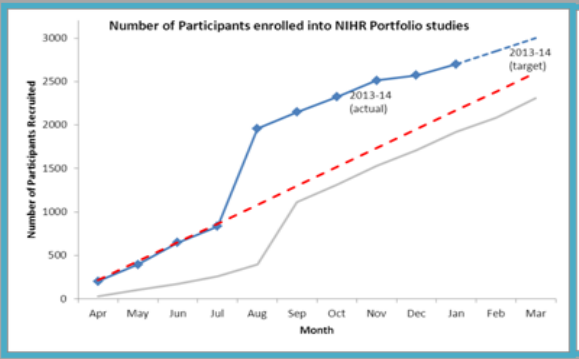
- 94% of Investigators kept well informed of progress and knew the anticipated R&D approval date
- 94% of Investigators felt fully/often supported throughout process
- 94% of Investigators rated their experience with us a 'very good' (i.e. rated us 5 out of 5

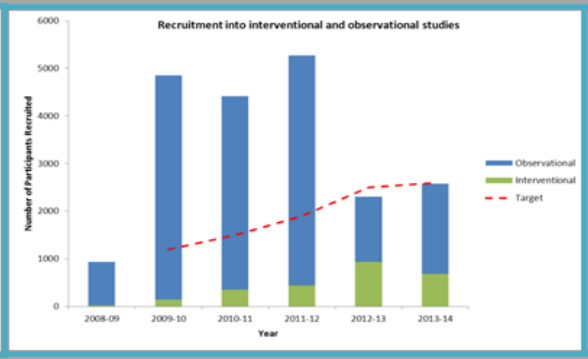
## Initiation

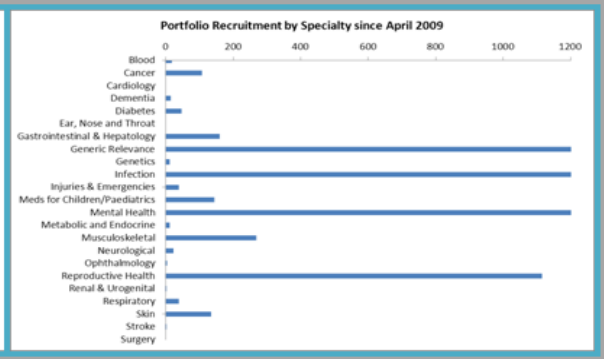
| Proportion of NIHR Portfolio studies achieving first participant recruited within 30 calendar days of NHS Permission | | |
|---|---|---|
| Year | % | Target |
| 2009-10 | 11.1% | 80% |
| 2010-11 | 20.8% | |
| 2011-12 | 4.8% | |
| 2012-13 | 6.7% | |
| 2013-14 | 21.0% | |

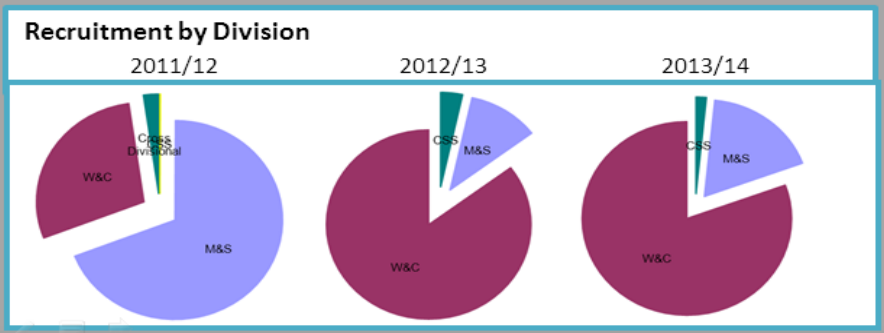
Identified as priority for 2014/2015 (raising awareness of metrics, robust feasibility, weekly reviews)

## Delivery





Recruitment to time and target has been Identified as a priority for 2014/2015 (RA support for commercial studies, PI/study team training, guidance on intranet, weekly reviews)

# Board of Directors Meeting, 30 October 2014 PUBLIC

| | |
|---|---|
| **Subject/Title** | Assurance Committee Report – June, July and September 2014/6.1/Oct/14 |
| **Purpose of paper** | 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. |
| **Decision/action required/ recommendation** | For information |
| **Summary of the key risks/issues from the paper** | Assurance was provided on all areas of business discussed by the Committee. Further work is ongoing to provide additional assurance in relation to:-<br>• Health & Safety Training (para 3.1)<br>• Inpatient Survey results (para 5.1)<br>Both of these will be picked up by the new Quality Committee.<br>The effectiveness of the Assurance Committee will be picked up by the Review of Board Committees. |
| **Link to corporate objectives** | Excel in providing high quality and effective clinical services. |
| **Non- Executive Sponsor** | Karin Norman, Non-Executive Director |

**ASSURANCE COMMITTEE REPORT TO THE BOARD, JUNE AND JULY AND SEPTEMBER 2014**

## 1. Introduction

The Assurance Committee is responsible for assuring on a wide range of issues on behalf of the Board, including quality. This report is a summary to inform the Board on the issues that have been discussed at the June, July and September meetings.

## 2. Background

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

**Items discussed at the Assurance Committee in June 2014**

### 3.0 Safeguarding and Safety

### 3.1 Health, Safety and Fire Committee Monthly Report – June 2014

The Health and Safety Review being undertaken by the Chief Nurse and Health and Safety Advisor to be reported at the July Meeting. Noted that assurance was provided by the Chief Nurse regarding Maternity Reception staffing levels as acceptable during September 2014. To close down any remaining risk gaps, it was clarified that areas of high risk such as COSHH and Lone working risk assessments were reported as undertaken in all areas. Assurance of risk reporting was identified as provided by mandatory Divisional reporting.

### 3.2 Never Events Assurance Report

The RAG status report was presented. The Committee requested for the most probable Never Events risks to be clarified in order for future reporting together with any Trust trends and actions taken. Death or severe harm due to mis-placement of naso or oro-gastric tubes in adults was noted as a particular concern. It was, however, noted on-going work is under consideration by the Quality Committee for this. The list was reviewed and placed in order considered appropriate by the committee. Further Never Event risks highlighted were discussed with relevant mitigation actions reported as in progress.

### 3.3 Retained foreign object post-procedure Assurance Reports

In theatres, interactive multidisciplinary team responsibilities led by the operating surgeon was highlighted as important to effective and safe practice. The current procedure for swab, needle and instrument counting required updating and this together with staff training and checking and reviewing practice has been undertaken. A table of recommendations and assurance was highlighted to include continued auditing of practice and a medical lead on the surgical team to enforce practice. 'Partial' compliance to throat pack retention was noted as changed to 'complete'. The 'How to Guide' for the five steps to safer surgery requires further embedding. Overall, the assurance provided a RAG of yellow with an agreement that once Human Factors training has been completed, that this will be re-graded as green. The Maternity report highlighted actions taken following an incident of retained swab in January 2014. It was reported that controls are in place for staff to understand their responsibilities for checking and double signing for swabs used. 2 days of mandatory training for Maternity staff including the use of simulation is in place.

**4.0 Quality and Management**

**4.1 Monthly Report on Local Quality Indicators**

The Committee agreed for the current Quality Indicators to be reviewed for order and relevance, with prior publication to the Quality Committee. It was noted the Early Warning Audits undertaken monthly are important to be included.

**4.2 Top Concerns from Medical Director and Director of Nursing and Quality**

The themes highlighted were: pressure ulcers and maladministration of drugs. The reporting upcoming CQC inspection was highlighted as a challenge to engage all staff. The CQC end of year report (item 5.4) was noted. The committee highlighted the importance of continued visibility of managers and directors for all staff.

**4.3 Report from the Trust Executive Quality Committee**

The Committee noted the work being undertaken for Medical Records risk assessments and that most issues are connected to the EDM project and some connected to the Planned Care and Clinical Support Division. There were some areas noted to include issues to overcome for staff using the system and contact details for 'out of range results' especially out of hours. Assurance was provided and highlighted that on-going work is being undertaken in this area. A report to outline the new system from the Head of Governance and confirmation from the Medical Director to assure the results notification procedure meets requirements to follow to provide assurance where appropriate. ZP confirmed that she is assured with regard to the new procedures.

**5.0 Suitability of Staffing**

**5.1 Inpatient survey results and Action Plan (2013)**
It was noted that response survey was reported as average for London Trusts. One area the Trust did not report scoring as well as some other Trusts was 'Planned Admission: date changed by hospital' and it was noted this would be further addressed in the Divisions. There were issues relating to asking patients' views on the quality of their care and gaining 'real-time' feedback. The perception of patient trust in nurses was once again the younger age range of nurses at CW. It was noted that the lower scoring questions were of similar themes from the previous year. For further assurance the committee requested a report to outline 8 trends/themes of key areas and to understand on questions where other Trusts score well and if there are themes identified that may inform Chelsea and Westminster's practice. This should to be considered at the Quality or the Patient/Staff Experience Committee.

**Items discussed at the Assurance Committee in July 2014**

**6.0 Safeguarding and Safety**
**6.1 Health, Safety and Fire (HS&F) Committee Monthly Report**

Agreed that progress was positive and for a systematic mode of reporting to identify continuing trends was important. First the need for a safety culture with transparency and then personal responsibility for all staff. The work of clear identification of monitoring actions was highlighted. It was noted that the overall risk grading was yellow and the Executive Lead had assurance of this. The quarterly reporting of the action plan for moving and handling demonstrates improvement in risk assessments and care plan completion rates.

**6.2 Health, Safety and Fire Review**

Noted significant progress over previous 3 years, however a perception that further staff engagement required. There were discussions on the need for further training or alignment with an external quality system. Assurance was provided that a review of safety management arrangements would be undertaken.

**7.0 Quality and Management**

**7.1 Report from the Facilities Committee**

Reported that processes in place to ensure transport arrangements are not abused have shown significant improvement. Electrical failure (noted as a risk to any organisation) is reported as mitigated by regular monthly Estates testing. Rating on the Norland contractor's scorecard noted as providing an assessment of risk of 'good'

**7.2 Risk Management Annual Report**

The aggregated annual report is presented to the Quality Committee and the actions being undertaken to the Board and detail is provided on the Datix system. It was noted that trends reported on Datix is important. Keys areas of note included discussions clarifying medication errors and the automatic system to clarify the data that was taken as an action. Further information to be provided.

A query concerning breech deliveries in Maternity to be examined further and a look into the times more frequently occur in clinical areas. Progress was noted on timeliness and accuracy of STEIS reporting. Confirmation that the Trust can mitigate any deviation of non-compliance to NICE guidance was outlined. It was confirmed that the External auditors and the consultant reviews and CQC reports would be aggregated to form overarching Divisional action plans.

Staffing issues were discussed in terms of balancing CIPs in relation to variances of staff establishments and quality. It was noted that 80 new nursing staff commence work in the Trust during September to move to filling the nursing establishment vacancies which will relieve pressures on permanent staff previously working regularly with agency staff.

**7.3 Maternity Annual Risk Report**

The key themes highlighted were the 12 open risks on the register. The Chief Nurse and Director of Quality outlined the control measures in place to monitor and mitigate Maternity risks.

It was agreed a repeat review of the Kensington Wing could be undertaken within 6 months in terms of Risk and Governance culture to ascertain the effectiveness of recent action plans. There was general discussion regarding how simplified models of risk reporting could assist staff.

**7.4 Infection Control Annual Report**

The action to diminish a virulent strain of MRSA from a patient admitted from another NHS Burns Unit/the action taken in the Trust, was highlighted. Reported that the C Difficile had met the yearly target and the next target has been lowered as a result. It was noted that the Trust has a policy to manage Ebola and risk assessments have been undertaken in key areas. The importance of the correct antibiotic stewardship was highlighted and the rapid

response to the infection detected by the Trust in the Neonatal unit from an outside supply of intravenous nutrition. The work in-year to improve Surgical Site Infection was noted.

The importance of reporting accurate data and in particular for external use and for coding was discussed. The Committee is assured on the policies and processes around Infection Control and noted the continuing good work of this team.

**7.5 Monthly Report on Local Quality Indicators**

It was confirmed the development of updated Quality Indicators is being led by the Medical Director and the Chief Nurse and Director of Quality.

**7.6 Assurance Committee Annual Report**

A summary report was presented of the work of the committee over the year as requested. It was noted that the 'committee effectiveness' on this occasion would be included in the governance review. It was agreed that the committee should consider an annual work plan to guide its future work with a 3-year area of focus. To follow the governance review, future annual reports should feature committee effectiveness and progress against work plan in favour of an account of the meetings.

**7.7 Top Concerns from the Medical Director and Chief Nurse and Director of Quality**

On-going work for recruitment and retention of nurses, HCAs and midwives was noted. It was highlighted that the Trust is actively working to reduce vacancy rates. The Chief Nurse and Director of Quality highlighted a continuing area of focus concerning the care of the deteriorating patient and how a software system in the AAU and other areas could assist the collation of information. The importance and need for sufficient staff to move forward the Electronic document management project for the strategic direction of the Trust were raised.

A main area of attention was the CQC inspection undertaken in July. An overview of the inspection and noted the report is anticipated in September. Following the report a Quality Summit is required when the report will be presented by the CQC and the Trust will be required to respond. It was noted that the CQC Intelligent Monitoring Report risk grading will be available from the CQC following the publishing of their CQC inspection report.

**7.8 Report from the Trust Executive Quality Committee**

Key items presented to the Quality Committee were highlighted. The volume of circulated material that the committee members are required to review was outlined. The work to consider the work of the committee and its reporting as part of the governance review was highlighted.

**8.0 Audit Committee Minutes of 22nd May 2014**

No comments received

It was agreed that the development of the Assurance Committee would be in line with the recommendations of the governance review.

**Items discussed at the Assurance Committee in September**

A detailed presentation on the 2013 Staff Survey results was presented by the Chief People Officer and Director of Corporate Affairs. Members of the Council of Governors were also invited to attend this meeting which looked at both the results and action plans. The Trust's People Strategy was also presented and discussed for further assurance that issues identified were being picked up and actioned.

Melanie van Limborgh
Head of Quality and Assurance
9 October 2014

# Board of Directors Meeting, 30 October 2014 PUBLIC

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|---|---|
| **Subject/Title** | Infection Control Annual Report 2013/14/6.2/Oct/14 |
| **Purpose of paper** | • To provide a background to the role and objectives of the Infection Prevention and Control Team<br>• To present a summary of key activities during the year<br>• To summarise Saving Lives and auditing activities<br>• To report on mandatory surveillance and progress against targets<br>• To summarise the Infection Prevention and Control Team's Annual Programme<br>• To provide assurance to the Board in relation to compliance with the Hygiene Code<br><br>To highlight the Trust position in relation to other comparative London Trusts |
| **Decision/action required/ recommendation** | For information |
| **Summary of the key risks/issues from the paper** | An annual report to the Board on infection prevention and control is a statutory duty. The Infection Prevention and Control Team (IPCT) implement the annual programme and policies; makes clinical decisions on the prevention and control of infection and advises other staff.<br><br>The IPCT ensures that there are processes to manage risks associated with IPC through the statutory requirements of the Health Act 2008, the associated CQC criteria and NHSLA Risk Management Standards.<br><br>This paper outlines the statutory assurance measures related to infection prevention and control, summarises performance against these and provides links to more detailed information within the Infection Prevention and Control Annual Report. |
| **Link to corporate objectives** | Trust Objective: Improve patient safety and clinical effectiveness |
| **Executive Sponsor** | Elizabeth McManus, Chief Nurse and Director of Quality |

## Introduction

**1.1** This paper outlines key aspects of the annual report summarising the measures taken to protect patients and staff against infections, and provides assurance to the Board in relation to the Trust's compliance with the statutory requirements of the Health Act 2008 and CQC Quality Standards:

- Mandatory surveillance reporting and progress against targets
- Serious Incidents
- Saving Lives Care Bundles
- Antibiotic prescribing
- Education and training

## 2.0 Compliance with Statutory Requirements

The Trust has a statutory responsibility to report the following healthcare acquired infections. In addition to these, surveillance of gram negative organisms is also undertaken.

2.1. ***Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia***: The DH MRSA Target for 2013-14 was zero hospital acquired cases. The Trust had five cases which were hospital acquired. Three of these were in our Burns Unit which partly reflects an increase in the number of patients with big burns (more than 35% skin loss) being admitted. (Section 7.1). Robust incident reviews outlined in Appendix 6 summarise each case and the lessons learned.

2.2. ***Clostridium difficile (C.difficile):*** The *C.difficile* Target for 2013-14 was 13 hospital-acquired (HCAI) cases. The Trust had 9 toxin positive cases of Clostridium difficile (section 7.2). As a result of incident reviews, new processes for the taking and requesting of samples have been implemented.

2.3. ***Orthopaedic Surgical Site Infections (OSSI):*** In 2013-14 the Trust collected data on 2 categories including all patients undergoing total hip replacement repairs and neck of femur repairs (section 7.3). Our infection rate (at the time of writing this report) for the last reported four quarters was 1.5% against the national average of 0.7%. To address this ~~led~~ a wound assessment form has been introduced in which nurses record daily wound observations until the patient is discharged. A flagging system has also been introduced on the Electronic Patient Record (Last Word) to capture patient's readmissions. Regular meetings were also set up with the Orthopaedic specialist nurse to closely monitor all patients at risk of developing infections. Since these changes were introduced we have seen no further infections.

2.4. ***Glycopeptide Resistant Enterococci (GRE):*** GRE bacteraemias are subject to mandatory surveillance but no target. There was only 0 GRE bacteraemia in 2013/14. (Section 8.4)

2.5. **Meticillin Sensitive Staphylococcus aureus (MSSA):** Mandatory surveillance of MSSA bacteraemias began in January 2011. The Trust had 10 HCAI and 18 CAI MSSA bacteraemias in 2013-14. The target set by PHE was of no more than 15 HCAI cases in 2013-14.

2.6. Since June 2011 the Department of Health has introduced mandatory surveillance of ***E.Coli bacteraemias*** but no target. The Trust had 73 blood culture positive cases in 2013-14. 16 of these were likely to have been HCAI. (Section 7.6)

3. **Serious Incidents (SI's):** Appendix 6 outlines the MRSA incident reviews and lessons learned. Two of the 5 MRSA bacteraemia cases were contaminations (i.e. the patients did not have a blood stream infection rather; the blood specimen became contaminated in the process of taking it). Lessons learned include ensuring that blood cultures must only be taken by staff that have completed their induction training, improvement needed in aseptic techniques and in equipment availability.

4. **Antibiotic and Proton Pump Inhibitor (PPI) Prescribing:** Through regular monthly audit and feedback on PPI prescribing, the Trust has seen large improvements in appropriate PPI prescribing, rising from 29% in 2011/12 to 74% in 2012/13. This coincides with a fall in the number of patients prescribed a PPI, with those prescribed a PPI falling from 30% in 2011/12 to 25% for this financial year (section 4.9.10).

5. **Saving Lives Care Bundles:**
The Saving Lives Care Bundles are audit tools used by the Trust for intravenous lines and urinary catheters. They were designed by the DH (DH, 2007) to drive up standards of care and have played a significant role in reducing our MRSA blood stream infection rates. Ward staff enter the data on to Synbiotix and the results are disseminated via the IPCC to the divisions. Compliance was 84.5% compared to 79% for adult peripheral lines and 82.3% for paediatrics, 92.1% for adult central lines (compared to 94% in 12/13) and 92% for urinary catheters (Section 5.1). Aspects of the care bundles where both Adult and Paediatrics need to improve include the documentation of PVC insertion within the medical notes and the labelling of the lines with either date of insertion or the coloured day-of-the-week sticker which indicates when the line should be removed.

6. **Education and Training:**
Infection Prevention and Control is included in the Trust Mandatory face-to-face Induction and Updates. Hand Hygiene/Infection Control compliance for 2013/14 was 75%. The overall Trust compliance for all mandatory training was 79% this is against the Trust target of 85% compliance (section 4.2). Follow-up of non-compliers is a rigorous process and Improvements in performance are overseen by the Mandatory Training Committee.

## 7. Summary

7.1 The Trust has continued to make significant improvements over the year in the way in which patients and staff are protected from acquiring infections whilst in hospital, in controlling infections when they do occur and learning from incidents when they have occurred. Particular achievements have been the reduction in *Clostridium difficile* cases, continuous Surgical Site Infection surveillance and a robust flu vaccination and awareness campaign.

7.2. The achievements outlined in this report not only demonstrate the Trust's continued compliance with its statutory obligations, but importantly, a significant improvement to the experience of patients within the Trust.

## 8. Decision

To note the contents of the annual report.

**Dr Berge Azadian, Director of Infection Prevention and Control**
**Rosalind Wallis, Consultant Nurse, Infection Prevention and Control**
**May 2014**

# Board of Directors Meeting, 30 October 2014 PUBLIC

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|---|---|
| **Subject/Title** | Board Assurance Framework and Risk Report for Q2/ 6.3/Oct/14 |
| **Purpose of paper** | This paper is to support the Board in understanding the implementation of strategy in the context of risk management.<br><br>The framework and the risk register is part of the trust's internal control processes. |
| **Decision/action required/ recommendation** | No decisions, options, actions or recommendations required of the Board. |
| **Summary of the key risks/issues from the paper** | 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.<br><br>The BAF is developed by the Executives in discussion with key staff. The framework has been revised following the development of the new strategic objectives in 2014/15.<br><br>The key risks identified relate to financial sustainability. Other risks where the position has deteriorated since July relate to the enablers, for example the People enabler which is now yellow due to the increase in turnover.<br><br>The Risk Report for Q2 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.<br><br>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. |
| **Link to corporate objectives** | All. |
| **Executive Sponsor** | Tony Bell, Chief Executive |

# BOARD ASSURANCE FRAMEWORK 2014/15 – October 2014

| **Strategic Objective 1: Excel in providing high quality clinical services**<br><br>**Owner:**<br>**Elizabeth McManus**<br>**Zoe Penn** | **Principal Risks**<br>*[what are the main risks to achieving the objective]* | **Risk Mitigation**<br>*[what action are we taking to reduce the likelihood or impact of the risks identified]* | **Controls and Measures**<br>*[What controls/systems are in place to assist securing the delivery of our objective?]* | **Risk Ratings**<br>**Initial** (April 2014)<br>**Current** |
|---|---|---|---|---|
| a) Deliver safe clinical services, evidenced by outcome data and audits. | • Inconsistent implementation of best practice clinical or operational processes across the organisation<br>• 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.<br>• Implement the Safety Thermometer across the whole organisation.<br>• Implement Safe Staffing across all staff groups. | • Risk Management Strategy<br>• Risk Report to Board<br>• Quality Committee review of policies, performance, incidents and risks.<br>• Clinical Audits to monitor performance and processes. | **Initial = Orange**<br>**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.<br>• 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.<br>• Quality Committee (as above)<br>• Clinical Audits (as above). | **Initial = Yellow**<br>**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).<br>• Patients' Experience Committee.<br>• Board reports track performance across key measures. | **Initial = Yellow**<br>**Current = Yellow** |

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| 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.<br>• CWFT SaHF Steering Group<br>• Board and Committee updates | **Initial = Yellow**<br>**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.<br>• Clinical sustainability of some services that are or may become sub-scale. | • Partnership working<br>• Pursuit of strategic opportunities to increase our patient catchment area to enable growth and secure key service infrastructure<br>• Ensuring the trust is fully engaged in the designation process and is a key stakeholder to inform future planning | • National and regional groups<br>• Specialist commissioning groups | **Initial = Yellow**<br>**Current = Yellow** |

| **Strategic Objective 2: Improve population Health Outcomes and Integrated Care**<br><br>**Owner:**<br>**Dominic Conlin**<br>**Rob Hodgkiss** | **Principal Risks**<br>*[what are the main risks to achieving the objective]* | **Risk Mitigation**<br>*[what action are we taking to reduce the likelihood or impact of the risks identified]* | **Controls and Measures**<br>*[What controls/systems are in place to assist securing the delivery of our objective?]* | **Risk Ratings**<br>**Initial** (April 2014)<br>**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.<br>• Poor data quality on out of hospital activity and costings limit the extent to which efficiencies can be evidenced<br>• Complex commissioning (and wider external) environment leading to 'stop/start' initiatives | • Common values and principles have been agreed and documented.<br>• MoU (leading to formal partnership agreement) is under development inc project plan to develop product.<br>• NWL programme has commissioned pan-sector work to establish financial baselines<br>• Director of Strategy & Integration and Associate Medical Director provide additional capacity to support delivery and management of internal and external relationships | • Accountable Care Group (ACG) Project Board in place.<br>• NWL Whole Systems Project Board and Executive (CWFT membership) established.<br>• CWFT (and partners) established as an Early Adopter | **Initial = Green**<br>**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<br>• Ability to work at pace across organisational boundaries<br>• Delivery of longer term CIP<br>• Loss of income (CQUIN) | • Emergency Care Pathway Board in place<br>• Discussions with commissioners on resourcing for winter pressures | • Project Initiation Document and formal programme management structure<br>• Exec Senior Responsible Officer<br>• Executive Team oversight | **Initial = Yellow**<br>**Current = Yellow** |

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| 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<br>• Loss of income (CQUIN)<br>• Ability to work at pace across organisational boundaries<br>• Delivery of longer term CIP | • In place to deliver sustainable change through quality improvement<br>• Monthly Board meetings with GP & CCG representatives that takes a collaborative approach to undertaking change<br>• 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<br>• Exec Senior Responsible Officer<br>• Executive Team oversight | **Initial = Yellow**<br>**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<br>• Insufficient Trust capacity and expertise due to the vacancy in Public Health SpR role.<br>• Insufficient funds to support key initiatives. | • Relationship Management<br>• Exploring solutions with Deanery/PHE re secondment or other recruitment strategies for the PH SpR role.<br>• Bid fund secured (e.g. Smoking Cessation) | • Health & Wellbeing Strategy<br>• Trust Health and Wellbeing Board<br>• Attendance at local Health and Wellbeing | **Initial = Green**<br>**Current = Green** |

| **Strategic Objective 3: Deliver Financial Sustainability**<br><br>**Owner:**<br>**Lorraine Bewes**<br>**Rakesh Patel** | **Principal Risks**<br>*[what are the main risks to achieving the objective]* | **Risk Mitigation**<br>*[what action are we taking to reduce the likelihood or impact of the risks identified]* | **Controls and Measures**<br>*[What controls/systems are in place to assist securing the delivery of our objective?]* | **Risk Ratings**<br>**Initial** (April 2014)<br>**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.<br>• Work with commissioners to secure appropriate funding and contractual arrangements.<br>• Undertake deep dive service reviews for identified clinical services to identify areas of opportunity | • EBITDA monitored for each clinical service line.<br>• Outcome of service line reviews to be reported to Executive Team | **Initial = Yellow**<br>**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.<br>• 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.<br>• Executive-led mitigation plans.<br>• Enhanced communication to engage staff in identifying CIPs and controlling costs.<br>• Redirect PMO on in year CIP support<br>• External consultancy engaged to quantify 2 year CIP programme | • Financial reporting.<br>• CIPs monitoring.<br>• Run-rate monitoring.<br>• Financial recovery meetings.<br>• Divisional Business Managers to report to DF/CFO/CEO on financial recovery actions<br>• Reset Unidentified CIPs centrally to focus Divisions on delivering agreed control totals<br>• Reset nursing budgets within current resource and CN to hold divisional nurse leads to account on reset budget. | **Initial = Red**<br>**Current = Red** |
| c) Diversify income [away] from NHS sources and in particular deliver the budgeted | • Private patient income target not delivered<br>• Inpatient bed capacity | • Ring-fenced theatre capacity now secured.<br>• Enhanced managerial capacity | • Tracking private patient income through financial reporting. | **Initial = Red** |

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| increases in Private Patient Service income and contribution. | constraints limit elective activity that can be undertaken.<br>• The risk associated with obstetric indemnity insurance costs rising which could impact on private maternity growth<br>• The variability in the commitment by surgeons to utilise the theatre capacity for PP<br>• Momentum for new non-NHS income increases will reduce as a result of Commercial Director leaving at end December | put in place.<br>• Refurbishment of Chelsea Wing planned to take place this year.<br>• Trust working with Consultants to find solution regarding indemnity costs<br>• External Consultants being invited to have private practicing privileges on Kensington Wing.<br>• Booking of list overruns to NHS theatre sessions for additional private cases<br>• Move GM for PP to full time corporate with appointment of 2 service managers for PP units<br>• Recruit Commercial Director<br>• New NED, Andy Jones, to provide oversight of PP development plans | • Private Patients Operational and Strategic Groups oversee operational and strategic planning. | **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.<br>• Shortfall on CIP delivery results in reduced ability to fund capital programme. | • Rigorous business case appraisal to reduce risk of inappropriate investments.<br>• Periodical review of capital programme to adjust according to broader financial circumstances.<br>• Benefits realisation reviews to help drive benefits after investments have been made. | • Regular reporting on capital expenditure.<br>• Finance and Investment Committee<br>• Capital Programme Board | **Current = Yellow**<br>**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 WMUH business case capital and revenue requirements<br>• Regulatory constraints impact on the decision-making process. | • Working with TDA Transaction Board and Commissioners<br>• Working with regulators early in the process to ensure work is done to address regulatory bodies' concerns.<br>• Obtaining expert professional advice on the likelihood of regulatory barriers and how these | • NED led Acquisition Steering Committee in place.<br>• Clear review and approval process in place at key stages of SOC, OBC and FBC.<br>• Engagement with TDA and CCGs at Director level | **Initial = Green**<br>**Current = Orange** |

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| | • Risk of bandwidth constraints to delivering strategic developments due to deteriorating financial position requiring additional Board assurance to proceed with strategic developments.<br><br>• Failure to secure SaHF business case capital and revenue requirements<br>. | can be addressed [where applicable].<br>• Undertaking financial due diligence to ensure negotiations with external parties are rigorously informed.<br>• Secure integration budget and additional income to support in year pressures to ensure adequate resource to deliver business as usual<br>• Ensure gateway review of integration road map<br>• Sign Heads of Terms<br>• Clear CQC action plan and assurance that resource in place to deliver<br><br>• Work with commissioners to secure required capital and revenue funding for SaHF<br><br>• Agree HoT with NHS to confirm gain share agreement for pharmacy outsourcing to fund NICU capital development | | |

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

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| | | arrangements<br>• 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.<br><br>Owner:<br>Susan Young | • High turnover leads to high agency spend and impacts on patient safety, experience and effectiveness<br>• Staff leave to join other trusts<br>• Adverse effect of CIP reductions on the motivation of the workforce<br>• Reduction in staff engagement has adverse impact on ability to change | • Development of People Strategy<br>• Bank and agency project group<br>• Strategic workforce planning<br>• Talent management and succession planning<br>• Leadership development programme<br>• Clinical summits<br>• Focus on values<br>• Project on healthcare support workers<br>• High volumes of recruitment to nursing and healthcare assistant posts (starting Sept-Nov 2014) | • Board workforce reports<br>• Turnover measured and monitored<br>• Staff Friends and Family test<br>• Annual NHS staff survey<br>• Exit interview data | **Initial = Green**<br>**Current = Yellow** |
| b) Processes – to adopt the safest, most effective and efficient clinical and managerial processes across the whole organisation.<br><br>Owner:<br>Robert Hodgkiss | • 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<br>• 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.<br>• Work with a partner organisation to deliver change | • Transformation Programme Boards<br>• Project and Programme management reporting<br>• Exec Monitoring | **Initial = Green**<br>**Current = Yellow** |

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|---|---|---|---|---|
| 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.<br><br>Owner:<br>Robert Hodgkiss | • IT strategy and investment programme are unable to 'keep up' with the trust strategic objectives and deliver in a timely enough way.<br>• Competing demands we are trying to achieve which all require bespoke IT solutions<br>• Insufficient progress replacing our existing systems (e.g. for scheduling) adversely impacting on current performance and efficiency<br>• Reduction in capital programme inevitably means a reduction in IT investment. | • Protecting essential IT investment in capital programme<br>• Prioritisation of IT projects from the IT strategy at executive level and where appropriate Board committee level<br>• IT investment factored into FBCs relating to potential joint venture work/acquisition | • IM and T Strategy Board monitoring progress<br>• Executive review<br>• Forthcoming Board session | **Initial = Orange**<br><br>**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.<br><br>Owner:<br>Robert Hodgkiss | • The Trust may not be able to invest in all capital programmes<br>• Complexity of delivering an ambitious service strategy within a constrained footprint to time and schedule. | • Financial sustainability stream and a carefully prioritised capital programme.<br>• Careful planning – and we already have working plans to help guide our activities in an outline estates plan. | • Capital Programme Board<br>• Finance and Investment committee<br>• Assurance Committee<br>• PLACE assessment and group | **Initial = Green**<br><br>**Current = Yellow** |

## RISK REPORT QUARTER 2 2014/15 - OCTOBER 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 Q1 14/15 are in italics and bold***. Four corporate risks identified through papers to the Board in July 2014 have not yet been added to the risk register, as the detail to fully describe the risk, along with controls and actions, are required from leads.

| Date | Source & Lead | Risk(s) Identified (Description) | Controls/actions | Risk Register ID and grade |
|---|---|---|---|---|
| Feb 13 | Papers to Board 12/13<br><br>**Lorraine Bewes and Rakesh Patel** | **Finance and Capital Plans for SAHF Reconfiguration**<br>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).<br><br>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)<br><br>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 | This risk is subject to the SaHF business case being 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.<br><br>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.<br><br>***The Board will receive an update on the outcome of the Commissioner assurance process and funding negotiations at the October 2014 meeting and a recommendation for the funding required in order to maintain financial viability.***<br><br>The Trust Board will approve any financial package before agreement with the Commission. | Orange<br><br>863 |

| Date | Source & Lead | Risk(s) Identified (Description) | Controls/actions | Risk Register ID and grade |
|---|---|---|---|---|
| | | the next phase of OBCs and FBCs to be worked up by individual trusts. (cf Paragraph 20 – 23) | | |

**Orange and red risks from risk register relating to previous BAF and from papers to the Board 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<br><br>**Zoe Penn** | SUI Report – **gynaecology death**<br>Risk of not having timely consultant reviews. Audit showed performance could improve. | The incident review actions were:<br><br>• 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.<br><br>• 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.<br><br>**Summary**<br>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 | Orange<br><br>715 |

| Date | Source | Risk(s) Identified (Description) | Controls/actions | Risk Register ID and grade |
|---|---|---|---|---|
| | | | sessions.<br><br>***A re-audit was recently undertaken in gynaecology - the results are currently being assimilated and will be included in the next Board report. The grade of this risk will be adjusted according to the results of the audit.***<br><br>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.*<br><br>***With respect the Trust-wide 12-hour consultant assessment target, the AAU team continue to work to imp0rove 12 hour consultant assessment and have made improvements month-by-month. However, it has been identified that patients from the Emergency Observation Unit can affect the 12 hour assessment reporting criteria. Steps are in place to improve timeframes for surgical consultant assessment arrangements on AAU.*** | |
| Mar 12 | Papers to Board 11/12 Performance Report<br><br>**Zoe Penn & Elizabeth McManus** | **Never Events** | Schedule for review of controls and assurances in place to prevent any of the 25 Never Events.<br><br>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 | Orange<br><br>787 |

| Date | Source | Risk(s) Identified (Description) | Controls/actions | Risk Register ID and grade |
|---|---|---|---|---|
| | | | managed and prevented.<br><br>***The Never Events have been ranked in order of the likelihood of the incident category occurring at the Chelsea and Westminster.***<br><br>***The Never Event Category ranked with the greatest risk relates to placement of NG Tubes. An audit of paediatric and NICU practice was presented to the September Risk Management Committee, and the corresponding assurance report considered at the Quality Committee confirms that controls are in place and effective in Paediatrics and NICU.***<br><br>***Audit results and an assurance report remains outstanding for adults, hence the risk grade of orange,***<br><br>***Significant changes to practice are embedded in order to prevent the retention of foreign objects post-procedure, and also wrong site surgery. Audits have been completed with reassuring results, and the assurance report considered at the Quality Committee confirming that activities are being sustained to ensure that controls are effective.*** | |
| 12/13 | BAF<br><br>**Rakesh Patel** | **Drive efficiency through service line reviews**<br>Lack of engagement from services for service line reviews and lack of follow through on implementation leading to no change | SRL 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.<br><br>The Trust is continuing to develop and roll out SRL as part of the overall financial reviews of service lines | Orange<br><br>803 |

| Date | Source | Risk(s) Identified (Description) | Controls/actions | Risk Register ID and grade |
|---|---|---|---|---|
| | | | and divisional performance.<br><br>***No change to risk grade/previous report*** | |
| 10/11 | BAF<br><br>**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).<br><br>• **NEWS (National Early Learning Score) is in use throughout the organisation. The results of the audit was presented at the Quality Committee in August 2014, and shows an overall improvement in performing required NEWS observations, accuracy, documentation, calculation and escalation.**<br><br>• 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).<br><br>***Rolling audits using available technology, to measure scoring, escalation and response, including the use of SBAR remain outstanding. Until this is in place teams are required to improve compliance and provide monthly audits showing progress and improvements. Incident reporting is encouraged to be able to address any identified risks.*** | Orange<br><br>594 |

| Date | Source | Risk(s) Identified (Description) | Controls/actions | Risk Register ID and grade |
|---|---|---|---|---|
| 11/12 | BAF<br><br>**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.<br><br>***No change to risk grade/previous report*** | Orange<br><br>664 |

# Board of Directors Meeting, 30 October 2014 PUBLIC

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|---|---|
| **Subject/Title** | Register of Seals Report Q2/6.4/Oct/14 |
| **Purpose of paper** | To keep the Board informed of the Register of Seals. |
| **Decision/action required/ recommendation** | The Board is asked to note the report. |
| **Summary of the key risks/issues from the paper** | There was one document to which the seal was affixed during the period under review. |
| **Link to corporate objectives** | NA |
| **Executive Sponsor** | Susan Young, Chief People Officer and Director of Corporate Affairs |

## Register of Seals Report Q2

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 July 2014 – 30 September 2014, the seal was affixed to the following document:

| Seal Number | Description of the Document | Date of sealing | Affixed by | Attested |
|---|---|---|---|---|
| 154 | Lease of the 1st floor, St Stephen's Centre, 369 Fulham Road, London SW10 9NH between Chelsea and Westminster Hospital and St Stephen's AIDS Trust (2 copies) | 01.08.14 | Tony Bell, Chief Executive | Lorraine Bewes Chief Financial Officer |

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

# Board of Directors Meeting, 30 October 2014 PUBLIC

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|---|---|
| **Subject/Title** | Fit and Proper person requirement for directors and the duty of candour/6.6/Oct/14 |
| **Purpose of paper** | This paper informs the Board of new regulatory (CQC) requirements which are expected to be approved by Parliament shortly, and which are likely to apply with effect from November 2014. |
| **Decision/action required/ recommendation** | For information. |
| **Summary of the key risks/issues from the paper** | New regulations setting out fundamental standards of care will come into force for all care providers on 1 April 2015. Two of the new requirements – the fit and proper person requirements for directors and the duty of candour – will come into force for "NHS bodies" sooner.<br><br>As the legislation is still progressing through Parliament, and final guidance has not yet been issued, trusts are not yet entirely clear on what must be done to satisfy the requirements. We have assumed that a self-declaration will be satisfactory and have developed the self-declaration form, however, we will wait until the final guidance has been published. |
| **Link to corporate objectives** | All |
| **Executive Sponsor** | Susan Young, Chief People Officer and Director of Corporate Affairs |

# Board of Directors Meeting, 30 October 2014 PUBLIC

| | |
|---|---|
| **Subject/Title** | Audit Committee minutes – 8 July 2014/6.7/Oct/14 |
| **Purpose of paper** | To inform the Board of matters discussed at the Audit Committee on 8 July 2014 |
| **Decision/action required/ recommendation** | For information |
| **Summary of the key risks/issues from the paper** | This paper outlines a record of the proceedings of the Audit Committee on 8 July 2014. |
| **Link to corporate objectives** | Deliver financial sustainability |
| **Executive Sponsor** | Sir John Baker, Non-executive Director |

**Date……..** **Signed……..**

**Audit Committee, 8th July 2014**
**Minutes**

**Present:**
Sir John Baker (JB), Chairman
Jeremy Jensen (JJ), Non-Executive Director (via conference call)

**In Attendance:**
David Radbourne (DR) Chief Operating Officer (via conference call)
Rakesh Patel (RP), Director of Finance
Carol McLaughlin (CMcL), Assistant Director of Finance
Layla Hawkins (LH), Interim Head of Corporate Affairs
Simon Spires (SS), Parkhill
Ben Sheriff (BS), Deloittes
James Carroll (JC), KPMG
Deborah Basham, (minutes)

## 1. GENERAL BUSINESS

### 1.1 Apologies for Absence

Professor Richard Kitney (RK) Non-Executive Director
Tony Bell (TB), Chief Executive
Heather Bygrave (HB), Deloittes
Neil Thomas (NT), KPMG

### 1.2 Declarations of Interest

None

### 1.3 Minutes of the Previous Meeting held 22nd May 2014

BS asked the following paragraph to be amended:

Rather than '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.' The point in the second sentence is probably more accurately put as 'The number of differences found was higher than in 2012/13 and more than noted at other trusts. BS noted that the National Audit Office study on waiting times (covering general waiting times rather than 62 day cancer waiting times specifically) indicated a broadly similar overall error rate among their sample.'

BS suggested the following amendments (noted in italics):

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.*

**1.4 Schedule of Actions**

- 2.3 Counter Fraud Work Plan – SS confirmed he and RP had discussed the scope for reduction of days in 2014-15 counter fraud work plan. This item is on the agenda and was discussed in detail under item 2.2.

- 3.3 Clinical Audit Planning and Reporting – RP apologised that an update on the Clinical Audit Work Plan was not yet available and this action was deferred to the next meeting

- 3.6 Internal Audit Plan for 2014-15 - RP to ensure that the points about procurement, outsourcing the accountancy system and the review of debt collection and cash management are reflected in the KPMG 2013-14 internal audit.

**1.5 Internal Audit Recommendations Tracker**

RP stated that Clinical Coding validation recommendation should be removed from this report as there was a rolling programme of validations undertaken by the clinical coding team and clinicians. JB enquired if the Trust was losing money as a result of coding. RP confirmed that validations had been undertaken in the larger specialities already so it limited the potential loss.

In respect of the recommendation on the Estates Strategy, JB asked if the work that has been done has been formalised into the strategy document. DR said that the estates plan had been developed following work on SAHF and Doughty House, however the work has not been done to consolidate into one document.

The remaining progress reports on the KPMG Internal Audit Recommendations were noted. It was confirmed there was no slippage relating to high priority recommendations.

**2.1 Counter Fraud Progress Report**

JJ asked if the Trust has a whistleblowing system in place and JB confirmed the Trust has a well- publicised whistleblowing system in place.

**2.2 Counter Fraud Work Plan**

This was an update of the draft brought to the Audit Committee in May.

SS reported that he had benchmarked the number of days in the CWFT plan against similar sized Trusts and the Trust was found to be comparatively low. RP and SS had reviewed the work plan and the number of days has been reduced from 60 to 55 with the caveat that there are 5 days in reserve in case they are required.

**3.1 Internal Audit Progress Report**

JC presented the report, stating 4 reviews have been done for the Audit Committee, scopes have been agreed and fieldwork has started on the provider licence.

JC summarised the work performed since the May Audit Committee meeting. RP confirmed that management was content to sign up to the audit programme listed in the table.

JB said there is an expectation that NHS Foundation Trusts carry out an external review of their governance every three years.

**Action:** JB asked RP to look into this to establish whether this is above and beyond what is already undertaken.

**4. External Audit**

There were no reports to be presented.

**5.1 Audit Committee self-assessment checklist 2014**

RP tabled an update received from BS relating to the External Audit section of the checklist (from 55 onwards) but nothing had been red flagged.

JB flagged up the discrepancies in responses:

No 18 - KPMG claimed to be unaware whether the Committee meetings were scheduled prior to important decisions being made – JB confirmed they are scheduled prior to Board meetings and suggested KPMG's response is due to absence of knowledge.

No 21 - JB said that although KPMG had confirmed the Committee formally assessed whether there is a need for the support of a 'Company Secretary' role or its equivalent, JB asked RP to pursue who, as Compliance Director, attends the meetings. CM pointed out that Cathy Mooney, former Director of Quality and Governance, attended in this capacity prior to her departure from the Trust.

**Action:** RP to confirm who acts as Compliance Director at the Audit Committee.

No 36 - RP explained that KPMG's response that they were unaware that the key principles of the terms of reference are set out in the Standing Financial Instructions is due to KPMG not being provided with the information.

No 48 - JC confirmed that the opportunity for periodic private discussions with the Committee and the Head of Internal Audit is available if required.

No 51- JB confirmed that it is the case that the Committee agreed a range of internal audit performance measures to be reported on a routine basis and that his response should be amended to 'Yes'.

No 63 - JB confirmed that the review of the nature and value of non-audit work carried out by the external auditors is carried out by him personally as Chair of the Audit Committee, rather than formally by the Committee as a whole, and he asked if this is sufficient. CM suggested it might be commercially sensitive to bring it to the Audit Committee.
No 67 - Are counter fraud plans derived from clear processes based on risk assessment? RP reported that Counter fraud had undertaken a risk assessment which was presented to the Committee and the plan was based on this assessment.

JB confirmed all the responses were noted.

**5.2 Anti-Bribery Policy Review**

RP explained that the tracked changes were not removed in order to make it easier to distinguish amendments.

The amendments were agreed.

**5.3 Gifts, Hospitality and Sponsorship Policy review**

LH presented the paper, confirming that other than changes to job titles, the only change related to 7.1.2 Monetary Gifts which had been suggested by Alison Heeralall, Deputy Director of HR regarding registering receipt of gifts.

**Action:** The text to be changed to read: *If staff accept any amount of money or cheque in the form of a gift exceeding £75 it must be deposited at the Cashiers' Office/Finance Department and declared by using the Gifts, Hospitality and Sponsorship Form (Appendix A).*

**Action:** To make it clear in the flow chart (p.3) that if the value of the monetary gift is less than £75, no action is required; if a monetary gift of more than £75 value is accepted it must be deposited at the Cashiers' Office/Finance Department and declared.

SS provides Counter Fraud awareness training and he confirmed that there is a section on the Trust website about 'Do's and Don'ts' and said that a leaflet containing examples of fraud is distributed at induction which could also be made available on the intranet.

The changes to the policy were agreed subject to further revisions being made as suggested by AH and JB with the flow chart being adjusted to reflect these amendments.

**6.1 Losses and Special Payments**

RP noted there were none to report.

**6.2 Details of single tender waivers**
It was noted that good progress has been made on waivers which has seen a significant reduction with only one waiver which RP has signed off.

**6.3 Audit Committee Forward Plan**

This was noted.

**7. Any other Business**

None noted.

**8. DATE OF THE NEXT MEETING**

**22nd October 2014, 1 - 3pm, Main Hospital Boardroom**