Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting (PUBLIC SESSION)

Location: Hospital Boardroom, Lower Ground Floor, Lift Bank C
Date: Thursday, 25 June 2015 Time: 16.00 – 18.00

Agenda

		GENERAL BUSINESS		
16.00	1.	Welcome & Apologies for Absence	Verbal	Chairman
16.03	2.	Declarations of Interest	Verbal	Chairman
16.07	3.	Minutes of the Previous Meeting held on 26 May 2015, *including response to Minute 8d*	Report	Chairman
16.10	4.	Matters Arising & Board Action Log	Report	Chairman
16.15	5.	Chairman's Report	Verbal	Chairman
16.30	6.	Chief Executive's Report	Report	Chief Executive Officer
16.40	7.	Patient Story	Verbal	Director of Nursing
		STRATEGY		
17.10	8.	Quality Strategy	Report	Medical Director
		QUALITY & TRUST PERFORMANCE		
17.20	9.	Performance & Quality Report, *including Financial Performance Summary*	Report	Executive Directors
		GOVERNANCE		
17.30	10.	Corporate Governance Statement: Self-Certifications	Report	FT Secretary
		ITEMS FOR INFORMATION		
17.40	11.	Questions from Members of the Public	Verbal	Chairman/ Executive Directors
17.50	12.	Any Other Business	Verbal	
17.55	13.	Date of Next Meeting – 27 July 2015		

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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Minutes of the Board of Directors (Public Session)
Held at 16.00 on 26 May 2015 in the Boardroom, Chelsea & Westminster Hospital

Present:	Sir Thomas Hughes-Hallett	Trust Chairman	(Chair)
	Jeremy Loyd	Non-Executive Director	(JL)
	Jeremy Jensen	Non-Executive Director	(JJ)
	Liz Shanahan	Non-Executive Director	(LS)
	Elizabeth McManus	Chief Executive	(EM)
	Lorraine Bewes	Chief Financial Officer	(LB)
	Zoe Penn	Medical Director	(ZP)
	Dominic Conlin	Director of Strategy & Integration	(DC)
	Susan Young	Chief People Officer & Director of Corporate Affairs	(SY)
	Vanessa Sloane	Director of Nursing	(VS)
	Thomas Lafferty	Company Secretary	(TL)

1. a.	**Welcome and Apologies for Absence** The Chair welcomed all present to the meeting. It was noted that Sir John Baker (JB), Eliza Hermann (EH), Andrew Jones (AJ), Nilkunj Dodhia (ND), Non-Executive Directors and Karl Munslow-Ong (KMO), Chief Operating Officer, had all given their apologies for the meeting.	
2. a.	**Declarations of Interest** Nil.	
3. a.	**Minutes & Actions from Previous Meeting: 30 April 2015** The minutes from the previous meeting were agreed as a true and accurate record, subject to the following correction: - EM noted that minute 6c should have referred to a 'CQC-*style* Peer Review' rather than a 'CQC Peer Review'. It was noted that the outcomes of the Review were to be considered in greater detail later in the meeting;	**TL**
4. a.	**Matters Arising & Board Action Log** The Board Action Log was reviewed and noted. The Board noted that all actions had either been completed or were in the process of being addressed.	
5. a.	**Chairman's Report** The Chairman noted that the annual Star Awards event had occurred on 30 April 2015 and that this had provided an excellent opportunity for Board members to express their thanks to staff for their continued efforts and commitment to high-quality patient care. He welcomed the decision of the Executive Team to personally present the awards to staff as this reflected the Trust's organisational values and allowed for a greater degree of connectivity between the Board and frontline staff.	

b.	The Chairman noted that the Trust had hosted an Open Day on 9 May 2015 and that this had also been a hugely successful event; involving and engaging many Governors, members of staff and members of the public. However, he requested that, for future years, thought be given to the positioning/accessing of displays relating to the provision of care for disabled persons.	
c.	The Chairman advised that the shortlisted candidates for the permanent Chief Executive post would be interviewed on 9 June 2015. He confirmed that the Panel would only make an appointment if there was a unanimous view that one of the shortlisted candidates was the 'right individual', noting that EM had agreed to continue to operate as Interim Chief Executive in the event that the Panel were unable to make an appointment. He added that he had engaged with the Trust's Council of Governors on the appointment process and that the Lead Governor would be a member of the interview Panel.	
6.	**Chief Executive's Report**	
a.	In relation to Staff, EM noted that the Trust's Sexual Health Team had recently been nominated for a National Safety Award; this was a fantastic achievement and helped to raise staff morale within the organisation. She would be encouraging other Trust Departments to put themselves forward for national awards in recognition of the clinical innovation and world-class treatment which many specialities provided within CWFT.	
b.	EM confirmed that the Trust had reviewed its employment check processes in light of a recent adverse case at Stepping Hill Hospital which had received national media attention. The Trust's own procedures had recently been audited by KPMG and this had confirmed that the Trust complied with all national standards in this area. However, the Trust would ensure that the two key recommendations arising from the audit were duly implemented: These related to the archiving of HR documentation and the verification of qualifications.	
c.	In relation to Grip, EM confirmed that, in terms of operational performance, the Trust continued to comply with the majority of Monitor's Compliance Framework performance indicators, including the 4-hour A&E target and all three 18 weeks Referral-to-Treatment (RTT) KPIs.	
d.	In relation to Growth, EM advised that the Trust continued to make good progress with regard to the transaction pathway relating to the potential acquisition of WMUH. A Board-to-Board meeting with Monitor had been scheduled for 25 June 2015. Aside from the transaction aspects of the acquisition programme, the Trust continued to engage with its local membership (through Constituency Meetings), clinicians (through Clinical Summits) and other members of staff (through regular joint CEO briefings).	
7.	**Patient Experience Case Study**	
a.	The Board received a presentation from Trystan Hawkins (TH), Director of Arts at CW+ and Anna Matthams (AM), Visual Arts Officer at CW+. The presentation stressed the importance of design in enhancing the patient experience in a holistic way, focusing on aspects of care such as the aesthetics of care settings, lighting, sound and temperature; all of which had been shown to have a clear therapeutic impact upon patients. To this end, TH was developing a set of 'design standards' which would reflect best practice and could be incorporated into the design of any new estate project within CWFT.	
b.	The Board discussed the merits of supplementing NHS funded services with charitable expenditure to support the Trust's strategic objective of being the best Hospital in the country in terms of the overall patient experience provided.	

c.	EM agreed that the aesthetics of the care environment could be used to benefit patients but also noted the positive impact that this had upon staff wellbeing and morale; motivating staff to provide the best possible care.	
d.	The Chairman urged CW+ to ensure that the excellent work being undertaken by CW+ with regard to the design of healthcare services extended to the WMUH site post-acquisition. TH confirmed that plans were already in place in relation to this.	
8.	**Shaping a Healthier Future (SAHF) Update**	
a.	In presenting the report, LB noted that it had now been confirmed that the Ealing Hospital Maternity Unit would close on 1 July 2015. As a result, the Board had again been asked to confirm that the Trust was 'ready' to react to the operational consequences of this- this was expected to be in the region of 350 additional births per annum. DC confirmed that the WMUH Board had met earlier in the month and had confirmed WMUH's readiness to respond to the closure, noting that the additional births generated at WMUH as a result of the closure would be greater than that at CWFT (estimated at 1,000 additional births per annum).	
b.	ZP and VS confirmed that the Trust continued to have the capacity to take on the additional activity but noted the current risk that existed with regard to staffing within maternity. In relation to this, VS advised that the Trust had now recruited six midwives to start in June, with eight further midwives expected to be offered posts later in the week. Furthermore, seven midwives would move from Ealing Hospital to CWFT at the point of the closure of the unit.	
c.	The Chairman noted that he had asked EM and SY to consider what accommodation packages and other incentives might be offered to staff to strengthen the Trust's recruitment activities and in order to reduce staff turnover.	
d.	The Board **AGREED** that the Trust had achieved the level of operational readiness required to implement the changes to maternity and neonatal services brought about by the impact of SAHF from 1 July 2015[1].	
9.	**Performance & Quality Report**	
a.	Reporting on the Trust's quality metrics, ZP confirmed that the Trust continued to perform well with regard to limiting the number of hospital-acquired infections and in respect of mortality compared with the peer average. Areas of under-performance included the time taken to transfer patients requiring urgent surgery- this was largely due to the elderly nature of many of the relevant patients which posed mobilisation issues. In addition, the Trust was still reporting a risk in relation to the 12 hour Consultant assessment metric; however, performance was steadily improving.	
b.	VS advised that the Trust's Friends & Family Test (F&FT) response rate was at 40% which was the highest rate in North West London. Within the responses received, 89.1% were positive for the month of April 2015. She noted that A&E in particular was making good progress with regard to the use of F&FT feedback. The Board noted that the Trust's aggregated F&FT performance was still slightly behind its target and requested that F&FT performance be presented by clinical speciality within the next iteration of the Report.	**VS**
c.	SY advised that the Trust continued to make progress in terms of staff recruitment and noted that 26 HCAs had recently been recruited at the Trust Open Day. As had been	

[1] This minute is subject to a further Board note on the matter in light of a related media issue. Please see the appended note.

	mentioned earlier in the meeting, the Trust was reviewing the incentives that could be offered in order to recruit and retain high calibre staff- as part of this, a programme of refurbishment of clinical staff rooms had been commenced in support of employee welfare. The Trust was also pursuing overseas recruitment drives.	
d.	With regard to statutory/mandatory training performance, the People & OD Committee had recently reviewed a plan to rapidly improve Trust compliance in this area; exploring innovative training methods such as e-learning and 'train the trainer' initiatives. The Chairman noted that the Board had accepted the recommendation of the People & OD Committee that the Trust needed to aspire to the training compliance levels currently achieved by WMUH in relation to Fire, Local Induction and Information Governance.	
e.	Turning to financial performance, LB advised that the Trust had achieved its Month 1 financial position; achieving a £1.6m deficit against a planned £1.7m deficit. However, she acknowledged that the Month 1 plan allowed for a greater degree of deficit than in later months to account for the back-ended realisation of CIP delivery and it was vital that the Trust was able to meet the reduced deficit position in future months. She noted that the Finance & Investment Committee (FIC) had particularly scrutinised the Trust's delivery of projected private patient income and its collection of aged debt at a meeting held earlier in the day. The Chairman added that the Board had also requested that the Executive consider the Trust's overall expenditure on external consultants and emphasised the need to invest its resource in a high calibre permanent staff base.	
10.	**CQC Update: CQC Peer Review Outcomes**	
a.	In presenting the report, VS noted that, following the publication of the Trust's CQC Inspection Report in October 2014, the Trust had agreed to commission a CQC-style Peer Review led by a collection of key external stakeholders which would reassess the Trust's services using the CQC Inspection methodology. The Trust had also commissioned EY to undertake a desktop review of the extent to which the Trust had embedded the specific improvement actions arising out of the 2014 inspection. The report detailed the preliminary outcomes of both exercises.	
b.	VS noted that the EY review showed the Trust to have addressed the majority of shortfalls previously highlighted by the CQC. Furthermore, the Peer Review had found that the Trust's services overall merited an assessment of 'Good', compared to the overall 'Requires Improvement' rating given by the CQC in 2014. However, both reviews nevertheless highlighted areas requiring redress; these principally related to the standard of clinical documentation, a reported shortage of staffing in specified areas and some poor practices with regard to the management of medicines (e.g. drug trolleys being broken or left unlocked).	
c.	In terms of next steps, VS advised that she would be setting up a Task & Finish Group in order to review the Trust's approach to improving the standard of clinical documentation in the short-term. Longer-term, she noted that the installation of the Electronic Patient Record (EPR) system was essential in improving the Trust's performance in this area. All other recommendations highlighted by the two reviews would be incorporated into an action plan which would be cascaded within the Divisions and shared with staff.	
d.	JJ noted the improvements detailed within the report but asked whether the extent of the improvement was sufficient given the time and expenditure the Trust had invested in addressing the shortfalls previously identified by the CQC. VS agreed that there was further work to do but that the Trust was continuing to demonstrate that it was a learning organisation and that quality performance was on an upward trajectory.	
e.	The Chairman expressed concern that the Trust's maternity services appeared to have	

	deteriorated since the previous CQC inspection. ZP noted that the nature of the inspections made them inherently subjective and that a degree of variation from assessment-to-assessment was to be expected. She added that a recent Deanery visit had concluded that the concerns previously expressed by the CQC in relation to a culture of 'bullying' within the Trust's NICU had now been resolved and that the Trust had been notified that it was no longer on the GMC's 'special concerns' list with regard to the clinical management arrangements in NICU.	
f.	The Board collectively expressed concern that the one area in which the Trust continued to 'require improvement' was in relation to the 'safety' category. ZP agreed to provide the Board with further information on what aspects of care fell within the 'safety' definition.	**ZP**
g.	In summarising discussion, the Chairman thanked VS and the clinical teams for their work in arranging and supporting the two reviews. He noted the assurance provided to the Board by the EY work that the vast majority of concerns identified by the CQC in 2014 had been successfully addressed. The Executive Team now needed to consider the additional 'risks' identified by the reviews in detail and develop plans accordingly in order to mitigate these risks. VS noted that a repeat CQC-style Peer Review involving the WMUH site was currently scheduled for October 2015.	
11.	**Questions from Members of the Public**	
a.	Tom Pollak (TP), Public Governor, asked when the SAHF programme projected the closure of the Ealing Hospital A&E Department. DC confirmed that the current projected date was March 2018.	
b.	Martin Lewis (ML), Public Governor, welcomed the progress that was highlighted within the CQC-style review documentation and noted that many of the issues requiring improvement required longer-term solutions that would take several months to embed within the organisation.	
c.	Melvyn Jeremiah (MJ), Public Governor and TP both raised concerns with regard to the Trust's level of staffing turnover and emphasised the need to invest in staff development and incentives so that the Trust could address this. MJ noted that the Council of Governors' concern on this point had been referenced within the Trust Quality Accounts. SY noted that the People & OD Committee had recently reviewed a draft Recruitment & Retention Strategy document which looked to address these issues.	
12.	**Any Other Business**	
a.	Nil.	
13.	**Date of Next Meeting:** 25 June 2015	

The meeting was closed at 18.03.

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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors PUBLIC SESSION – 26 May 2015

Meeting	Minute Number	Agreed Action	Current Status	Lead
May 2015	3a.	TL to correct minutes in April 2015 Public meeting minutes, to ensure discussion referenced the 'CQC-*style* Peer Review'.	Complete	**TL**
	9b.	VS to produce breakdown of Friends & Family Test results by clinical area/Department.	This has been circulated to the Board.	**VS**
	10f.	ZP to provide the Board with a briefing on the components of the CQC's 'safety' domain used as part of formal CQC assessments.	Sent CQC standards under domain 12 'Safe Care and Treatment' and Key Lines of Enquiry appendix B of CQC Inspection Guidance to all board members.	**ZP**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 June 2015

PUBLIC

AGENDA ITEM NO.	6/Jun/15
REPORT NAME	Chief Executive's Report
AUTHOR	Elizabeth McManus, Chief Executive Officer
LEAD	Elizabeth McManus, Chief Executive Officer
PURPOSE	To provide an update to the Public Board on high-level Trust affairs.
SUMMARY OF REPORT	As described within the appended paper. Board members are invited to ask questions on the content of the report.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	NA
DECISION/ ACTION	This paper is submitted for the Board's information.

Chief Executive's Report
June 2015

1.0 Staff

1.1 Medical Engagement Scale/Healthcare Engagement Scale

The results of the recent Medical Engagement Scale (MES) survey show that medical staff at both Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) and West Middlesex University Hospital NHS Trust (WMUH) aim to adopt new ways of working in order to improve patient care. The survey, which examined the views of more than 250 medical staff, found that those working for the two hospitals are more engaged in strategic planning and decision-making than elsewhere in the health service across the country.

The Healthcare Engagement Scale (HES) survey, which is the first of its kind, closed for Nurses, Midwives and AHP staff on 16th June and we are anticipating the high level outcomes will be available next week.

In terms of next steps, Professor Peter Spurgeon, Warwick University, is presenting the outcomes of both the MES & HES at the Acquisition Project Board meeting on 9 July 2015. He will take a holistic view of the outcomes, share some of the differences and similarities and draw attention to those areas where we need to focus our attention.

This will be followed-up with a meeting of leads from each area to explore lessons learned from other organisations who have undertaken the MES/HES and the intention is to share the outcomes at 31 July 2015 Clinical Engagement Meeting and ask for interested parties to join a working group to take forward the outcomes and next steps.

1.2 Clinical summit on innovation and discovery

More than 100 people from both CWFT and WMUH attended a recent joint clinical summit which focused upon innovation and discovery. A range of staff; including nurses, doctors and managers attended the event hosted by the Medical Directors of the two Trusts.

The content of the summit included:

- An assessment of the obstacles to innovation and the advancement of patient care within the health service;
- An overview of how research and development opportunities can be maximised within the enlarged organisation;
- Speciality-specific presentations on bowel cancer and HIV treatment.

The next clinical summit is planned for 31 July 2015 and will have a focus upon our Transformation Programme.

1.3 Staffing

With the national shortage of nurses particularly acute in London, we have appointed a senior nurse to lead recruitment and retention within the Trust and have appointed two agencies to recruit overseas nurses to fill some of our 200 nursing vacancies.

These developments are however being impacted by recent national changes to the shortage occupation list (with the removal of NICU nurses from this list) and certificates of sponsorship for overseas nurses and AHP's being turned down. I have escalated our concerns to NHS England and also asked various Directors of Nursing groups to lobby the Department of Health and the Home Office on our behalf.

Jane Cummings, Chief Nursing Officer NHS England, is aware of this situation, which has also been raised as a concern by HR Directors across London.

This comes at a crucial time for us when we are looking to Croatia & Australia for nurses: nurses from both these countries will require certificates of sponsorship.

2.0 Grip

2.1 Performance

As detailed within the Performance & Quality Report, the Trust continues to deliver all Monitor Compliance indicators, with the exception of compliance with requirements for patients with learning disabilities (LD). However, as per the below, significant change in what will be monitored in future with regard to the RTT standard is due to be introduced within the coming months.

In terms of financial performance, there are positive signs that the Trust is gaining a tighter 'grip' on its business. As of Month 2, the Trust is reporting a deficit position of £0.5m which is £0.3m ahead of plan. The year to date position is a deficit of £2.1m, which is £0.4m ahead of plan. Within this, each of the Clinical Divisions reported favourable variances in month.

2.2 Changes in the Referral to Treatment Performance (RTT) Targets

Following a review undertaken by Sir Bruce Keogh, NHS England Medical Director, two of the current three key performance indicators relating to RTT times will be abolished. Sir Bruce's review found that the 18 week RTT standard was being measured in three conflicting ways with the admitted and non-admitted standards resulting in perverse incentives which penalised providers for treating patients who have waited more than 18 weeks.

The RTT 'incomplete standard', introduced in 2012, which incentivises hospitals to treat patients who have been waiting the longest, will be retained.

The Trust will however continue to report against all three RTT targets until directed to revise its reporting arrangements.

2.3 Lord Carter Review of Operational Productivity in NHS Providers

Lord Carter of Coles, Chair of the NHS Procurement and Efficiency Board, published his interim report into improving productivity within the NHS on 11 June 2015. In particular, the report highlights:

- **The Adjustment Treatment Index (ATI)**- This is a new measure of provider efficiency that will allow healthcare providers to compare their cost per unit of weighted output, at organisational level and at service level;

- **The Efficiency Opportunity**- The report identifies that the NHS could save £5bn per annum by 2019/20 through:

    i) Improved management of the workforce: annual leave, sickness, theatre productivity, reduction in non-productive tasks;

    ii) Improved efficiencies in the areas of procurement, estates management and pharmacy/medicines optimisation.

In terms of next steps, Lord Carter is expected to conclude his work during Autumn 2015. Thereafter, the first cut of hospital productivity data based upon the ATI system will be made available (during early 2016). The Trust will undertake work to understand the new ATI indicator and will continue to progress its own plans aimed at driving up operational productivity, maximising the efficiency opportunities afforded by the proposed WMUH acquisition.

3.0 Growth

3.1 Five Year Forward View

NHS England, Monitor, the TDA, Public Health England, CQC and Health Education England have published a joint overview of the progress made with the Five Year Forward View (FYFV) to date, and the steps that need to be taken if the ambition of FYFV is to be delivered. In terms of the latter, the 'Time to Deliver' document focuses upon three key areas:

- **Closing the Care & Quality Gap-** to narrow the gap between the best and the worst providers of healthcare whilst raising the quality bar higher for everyone;

- **Closing the Health Gap**- encouraging the living of 'healthier lives' across the country;

- **Closing the Funding & Efficiency Gap**- the Forward View set the ambition for the NHS to achieve an extra 2 - 3% average annual net efficiency gain over the next period.

The full report can be found here: http://www.england.nhs.uk/wp-content/uploads/2015/06/5yfv-time-to-deliver.pdf .

The Trust will continue to use the national strategic context provided by the FYFV in the formulation of its own local strategic plans.

3.2 Proposed Acquisition of West Middlesex University Hospital NHS Foundation Trust

The Trust remains on track to complete its acquisition of WMUH by 1 September 2015. The conclusion of Monitor's formal assessment of the transaction will be marked by a 'Board-to-Board session' which will be held on 25 June 2015, shortly before the Public Board meeting. Following this, the Trust expects to receive a 'Transaction Risk Rating' from the Regulator at some point prior to 15 July which will determine the next steps of the overall process.

Over the past month, the focus of the WMUH acquisition project has transitioned from preparing for a 'safe landing' on 'Day 1' to the Post-Transaction Implementation Plan (PTIP) which describes how the Trust will progress each of its planned service developments, quality improvement initiatives and cost improvement plans over the years ahead.

Elizabeth McManus
Chief Executive Officer
June 2015

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 June 2015

PUBLIC

AGENDA ITEM NO.	8/Jun/15
REPORT NAME	Quality Strategy and Plan
AUTHOR	Zoe Penn, Medical Director and Director of Quality
LEAD	Zoe Penn, Medical Director and Director of Quality
PURPOSE	For approval.
SUMMARY OF REPORT	The Quality Strategy and Plan 2015-2018 in consultation with the Trust's clinicians through the Safety and Effectiveness Committee and by way of two clinical summits at which the themes for the Plans were developed and agreed. It has been presented to, and approved by, the Trust's Quality Committee and the Board of Governors. The strategy sets our overarching ambitions in respect of the best experience of care, underpinned by the safety and effectiveness of care and good access to our services. It describes the architecture and organisation of our clinical governance structure. We will deliver our ambitions through 4 'special projects' which will focus on our key priorities: the best care for frail patients, improvements in the clinical care of planned admissions, the prompt recognition and treatment of septic patients and improved care and survival of the fetus and new born. Through these Plans will run the 'golden thread' of the best patient experience. The QSP has been developed with involvement of the clinicians at West Middlesex University Hospital and is expected to meet the needs of the proposed newly formed and larger organisation from September 2015.
KEY RISKS ASSOCIATED	None
FINANCIAL IMPLICATIONS	The delivery of these ambitious plans, whilst expected to deliver value in respect of 'the right care, right first time', will need adequate project management and information support and a way of permitting clinicians to focus on implementation of systematic good practise. These plans will be supported through the project management resource at the Trust.
QUALITY	See above

IMPLICATIONS	
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	To excel in providing high quality, efficient clinical services
DECISION/ ACTION	For information and approval.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Quality Strategy and Plan
2015 to 2018

DRAFT FOR REVIEW

Version: 0.20 Dated 30 April 2015

Confidential

Document information

Document information	
Document Title:	Quality Strategy and Plan
Date:	05 May 2015
Director responsible:	Zoe Penn, Medical Director and Director of Quality
Author:	Ross Graves (RG)

Document history			
Version	**Change made by**	**Date**	**Description of change**
0.1	RG	30.03.2015	Initial working draft taking expanded outline QSP from 2014 (based in PowerPoint) and converting this into a word document
0.12	RG	07.04.2015	Further updated draft reflecting feedback from initial review cycle with Exec and other key stakeholders
0.14	RG	19.04.2015	Incorporating feedback on performance scorecard sections. Shared for further validation with Performance Team
0.20	RG	05.05.2015	Incorporating further feedback from Medical Director and Quality Committee. Performance scorecard sections validated and updated to latest position by Performance team. Version to be shared with key internal and external stakeholders and with Governors' Quality Subcommittee

Drafting and review approach

Drafting notes (either questions outstanding or key points and remarks for the reader to be aware of) are indicated throughout with 'DN's and grey highlighted text.

Quality performance information included in Section 3 is latest available data and subject to final sign-off.

Contents

1 Introduction

1.1 Introduction to the Quality Strategy and Plan and 'Strategy on a Page'

The Quality Strategy and Plan (QSP) sets out a three-year journey for how we will work to continuously improve the quality of the services provided by Chelsea and Westminster Hospital NHS Foundation Trust (CWFT).

In developing the QSP we have taken account of the Trust's vision, considering this against a backdrop of the local and national context including the recommendations of the CQC review conducted during July 2014.

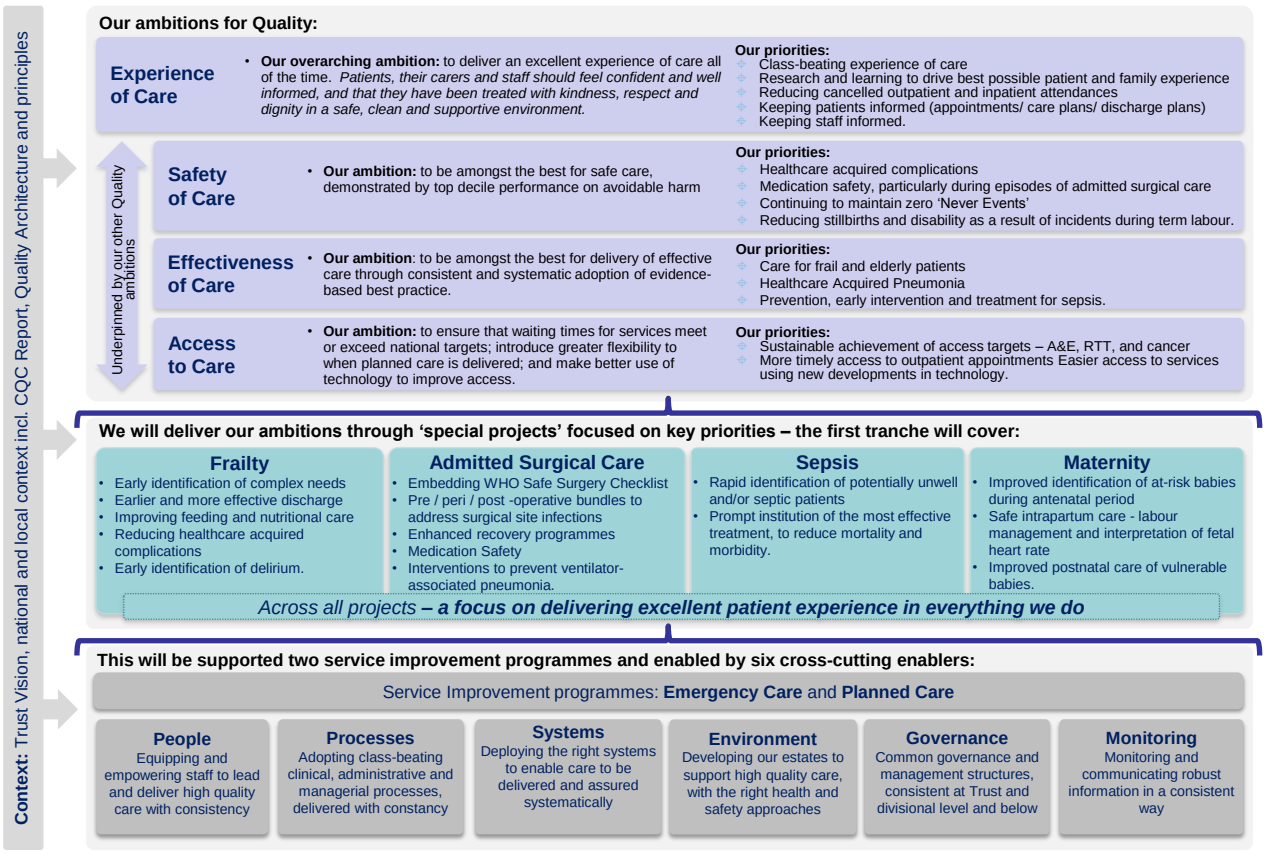
We have considered quality based on the four components of Experience, Safety, Effectiveness and Access (recognising that this represents an expanded definition of Quality that includes Access). For each component we have set ambitions and supporting priorities, taking into account our current performance. Delivering excellence in Experience of Care will be an overarching ambition for us over the next three years, supported by our ambitions across Safety, Effectiveness and Access.

We will deliver our ambitions for Quality through tranches of 'special projects' focusing on priority areas that have been identified through engagement to date on the development of the QSP. The initial tranche of projects will focus on Frailty, Admitted Surgical Care, Sepsis and Maternity.

Delivery will be supported by the Trust's two overarching service improvement programmes and enabled through six cross-cutting 'Enabler' workstreams. Work across these Enablers will be essential for delivering a rigorous and systematic approach to quality, clinically led, with multidisciplinary ownership from doctors, nurses and managers across the Trust.

A high level overview of the structure of the QSP and its headline content is set out in Figure 1 below.

Figure 1 Quality Strategy and Plan - 'Strategy on a Page'



1.2 Document structure

This document expands each of the elements set out in the 'Strategy on a Page' above, consisting of the following sections:

- **Section 2** sets out the **context** for the Strategy including how this links to the Trust's Vision and strategic objectives, how it is informed by local and national strategic context, and the principles and Quality Architecture which underpin the Strategy.
- **Section 3** sets out the Trust's **ambitions for improving quality**, consisting of our overarching ambition for delivering excellent Experience of Care, supported by our ambitions for Safety of Care, Effectiveness of Care, and Access to Care. For each component we consider our current position, our ambition, and our key priorities.
- **Section 4** describes how these ambitions will be delivered through **'special projects'** focusing on priority areas.
- **Section 5** describes how the Trust's agenda for quality is underpinned by **enabling and supporting workstreams** consisting of the Trust's two service improvement programmes and six cross-cutting enablers.
- Finally **Section 6** describes the **forward plan** for developing and implementing the Strategy, including how work will be extended post the planned acquisition of WMUH (subject to transaction).

2 Context

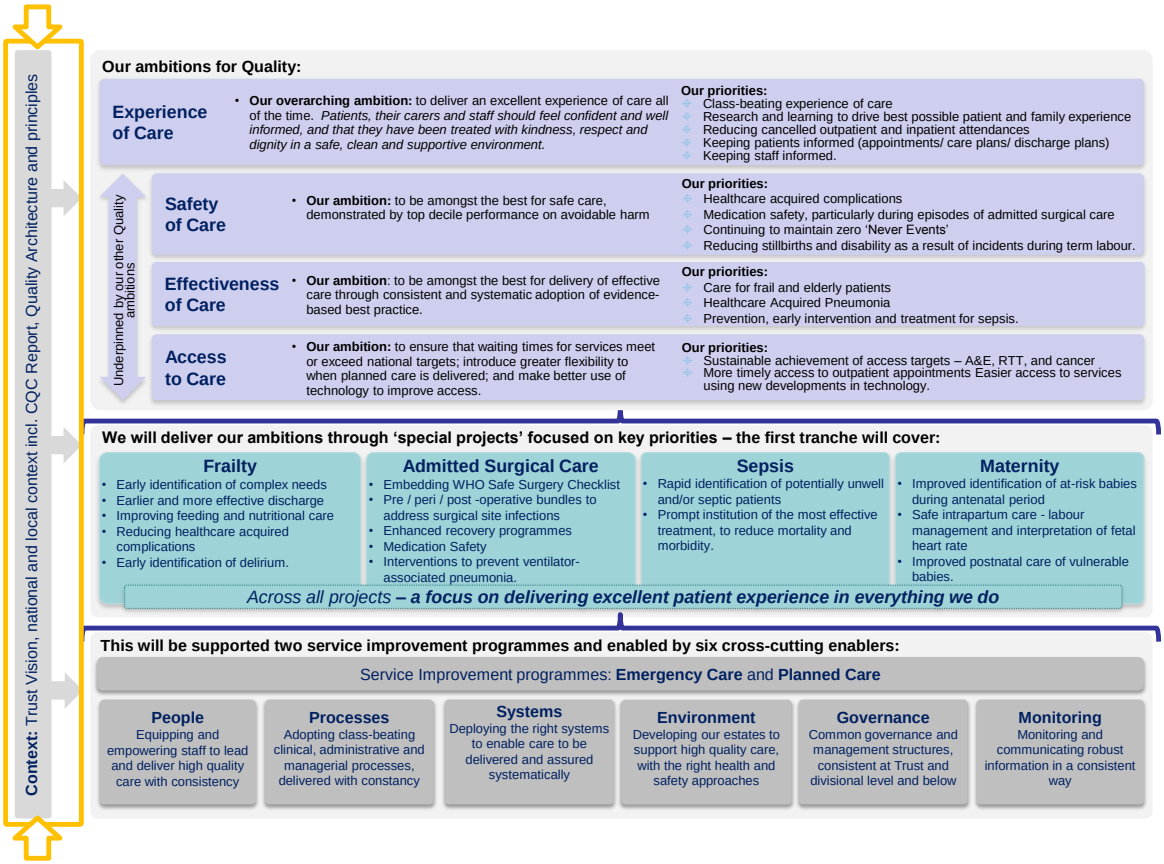
2.1 Introduction – Key context that informs the development of the Strategy

The Quality Strategy is informed by a number of key contextual elements:

- **The Trust's Vision –** the vision, values and strategic objectives that drive the strategic and corporate agenda across the Trust
- **National context –** the major strategic, statutory and regulatory drivers that inform the Strategy
- **Local context –** the backdrop of the services provided by the Trust, its strategic development agenda, and the specific clinical quality requirements that it must satisfy
- **Quality Architecture –** the framework through which quality is managed and improved across the Trust
- **Principles –** the principles that drive the delivery of quality in everything we do.

The figure below sets out these elements and how they relate to the rest of the Strategy. This section goes on to explore each element in more detail.

Figure 2 How Context informs the other components of the QSP



2.2 Trust Vision – Best possible experience and outcomes for our patients

Quality is at the heart of our Vision, which is to deliver **the best possible experience and outcomes for our patients**. In achieving this vision, we are guided by our values, which are to provide **safe**, **kind**, **respectful** and **excellent** care.

This QSP builds on this Vision to set out our quality ambitions that underpin the delivery of best possible experience and outcomes for our patients.

Our Vision is supported by our four Strategic Objectives:

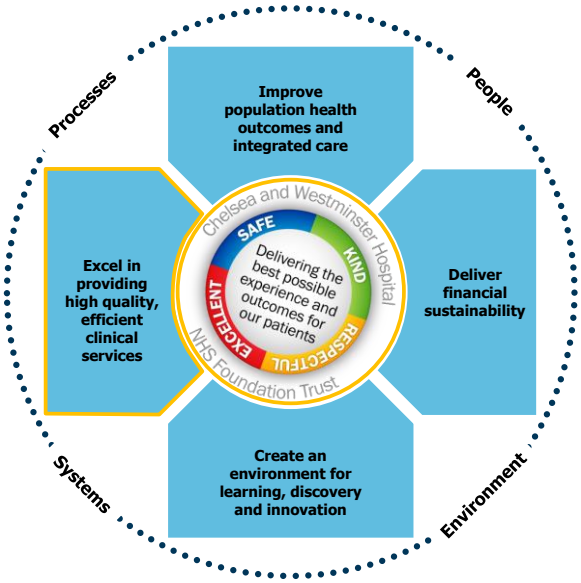
1. Excel in providing high quality, efficient clinical services
2. Improve population health outcomes and develop integrated care
3. Deliver financial sustainability
4. Create an environment for learning, discovery and innovation.

The QSP primarily supports the delivery of the first of these strategic objectives, 'Excel in providing high quality, efficient clinical service,' but the other objectives both support and are integral to this QSP and are essential to the delivery of the Trust's Vision.

Underpinning the Trust's Vision and Strategic Objectives are four Enablers, focused on ensuring we have the best People, Processes, Environment and Systems in place. These are a subset of the broader set of enablers we consider in Section 5 of the QSP.

Figure 3 below shows the Vision and Strategic Objectives for the Trust, highlighting the key components supported by the QSP.

Figure 3 Vision and Strategic Objectives for the Trust and how he QSP supports delivery of these



2.3 National context – Significant strategic drivers shaping the quality agenda

The NHS Outcomes Framework (2012) sets out the quality regime for the NHS according to five domains, consisting of:

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long-term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment; and protecting them from avoidable harm.

Over recent years a number of very significant drivers have further framed the context for quality across the NHS. These set clear strategic imperatives for how we continually work to maintain and improve the quality of the services we deliver. A brief synopsis of these drivers is set out below.

- **The Francis Report (2013)** into the systemic failings at the Mid Staffordshire NHS Foundation Trust set out a series of recommendations to ensure best possible care for patients in the NHS. Responses to the Francis Report by the Government and the National Quality Board will drive approaches to improving nursing, midwifery and care staffing. It also includes the rollout of a set of fundamental standards which come into force for all health and adult social care services from 01 April 2015.

- **The Keogh Report (2013)** into hospitals with higher mortality rates highlighted that all trusts must understand more about the care they provide to patients and develop a consistent approach to continuous improvement in quality.
- **The Berwick Review (2013)** into patient safety has significant implications for NHS providers, stating that, 'the single most important change in the NHS.... would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care top to bottom and end to end'.
- The **NHS Services, Seven Days a Week Forum (2014)** reported to NHS England on how NHS services can be improved to provide a more responsive and patient centred service across the seven day week, with an initial focus on urgent and emergency care. The review found significant variation in outcomes for patients admitted to hospital at the weekend, seen in mortality rates, patient experience, length of stay and re-admission rates.
- In September 2013 the **Care Quality Commission (CQC)** implemented a new regime for the inspection of hospitals which examines the quality and safety of the care provided based on whether they are safe, effective, caring, responsive to people's needs, and well-led. CWH was inspected under this regime in July 2014 (see Section 2.4 for further detail). The CQC inspection regime is being further augmented from 01 April 2015 to take account of new statutory and regulatory requirements on providers of health and social care in England (see below).
- **From April 2015** a number of **statutory and regulatory changes** will come into force which will affect providers of health and social care. For example providers will be required by legislation to follow new regulations called the 'fundamental standards', which are more focused and clearer about the care that people should always expect to receive. There are also new requirements for providers on being open about mistakes when they happen (called the 'duty of candour') and on making sure directors and their equivalents are 'fit and proper'.
- The NHS **Five Year Forward View (5YFV)** was published in October 2014 and sets out a vision for the future of the NHS. This vision will significantly transform the NHS. As well as a 'radical upgrade in prevention and public health', and patients having greater control of their own care, the 5YFV proposes a number of steps to break down the barriers to how care is provided. Providers will need to continue to provide high quality services, continuously improving, against this significantly changing landscape which includes the expansion of integrated care and the need for hospitals to operate seamlessly across the care continuum.

2.4 Local context – Consistent improvement of quality alongside an ambitious strategic agenda

CWFT is situated in the borough of Kensington and Chelsea. It treats more than 360,000 patients a year and employs over 3,000 staff. The Trust provides a breadth of services within its clinical portfolio:

- The main specialised services are offered in an environment of academic specialisation and comprise of paediatrics (including tertiary paediatric surgery), neonatal intensive care, maternity services, burns, bariatric services, plastic surgery and HIV.
- The Trust delivers local services comprising 24/7 adult and paediatric A&E services with co–located Urgent Care Centres (UCCs), a full maternity service and a range of medical and surgical specialties. In addition to local hospital services, the Trust also provides community–based clinics in musculoskeletal (MSK), gynaecology, dermatology and direct access sexual health services.
- The Trust also provides a range of inpatient and outpatient services to private patients.

Strategic development and growth

The strategic agenda of the Trust is being significantly shaped three major developments:

- The planned acquisition of West Middlesex University Hospital (WMUH) NHS Trust in 2015, and subsequent programme of integration between the two trusts

- The impact of Shaping a Healthier Future (SaHF), North West London's whole system programme for reconfiguring hospital based and out of hospital care, under which Chelsea and Westminster Hospital (CWH) and WMUH will be retained as 'major hospitals'
- The development of integrated care and growth of community-based 'accountable care' -type models of care. These are being driven locally through SaHF (including North West London's Integrated Care Pioneer Pilot), but are also being catalysed by emerging plans in relation to the 5YFV.

Clinical quality and CQC Review

In July 2014 the CQC carried out an inspection of the Trust. Whilst the CQC found that the Trust provides good and outstanding care in many areas, their overall rating for the Trust was 'needs improvement'.

In order to proactively address areas where action is required, speciality specific action plans were developed, with the Trust's Quality Committee responsible for monitoring progress and seeking assurance from divisional representatives that actions are being implemented and completed. All feasible actions were completed by the end of March 2015, with appropriate actions and programmes in place to address the actions requiring longer term development (such as the reconfiguration or the Trust's Emergency Department).

The CQC report made broader recommendations in relation to establishing a culture of consistency and rigour in how quality is approached across the Trust. **The Quality Strategy and supporting Quality Architecture described in this document are key to ensuring that both the specific actions and the broader recommendations identified by the CQC – in particular in relation to consistency of quality assurance process across the organisation – become part of ongoing systematic and rigorous ways of working within the Trust as it delivers its strategic and growth agenda.**

2.5 Quality Architecture – Framework supporting delivery of quality across the Trust

Delivery of the Quality Strategy is supported through the Trust's Quality Architecture, the overarching framework that combines corporate and clinical governance structures with key supporting processes and deliverables. Figure 3 overleaf summarises our high level Quality Architecture.

Critical success factors

In order for the Trust's Quality Architecture to function effectively the following factors need to be in place:

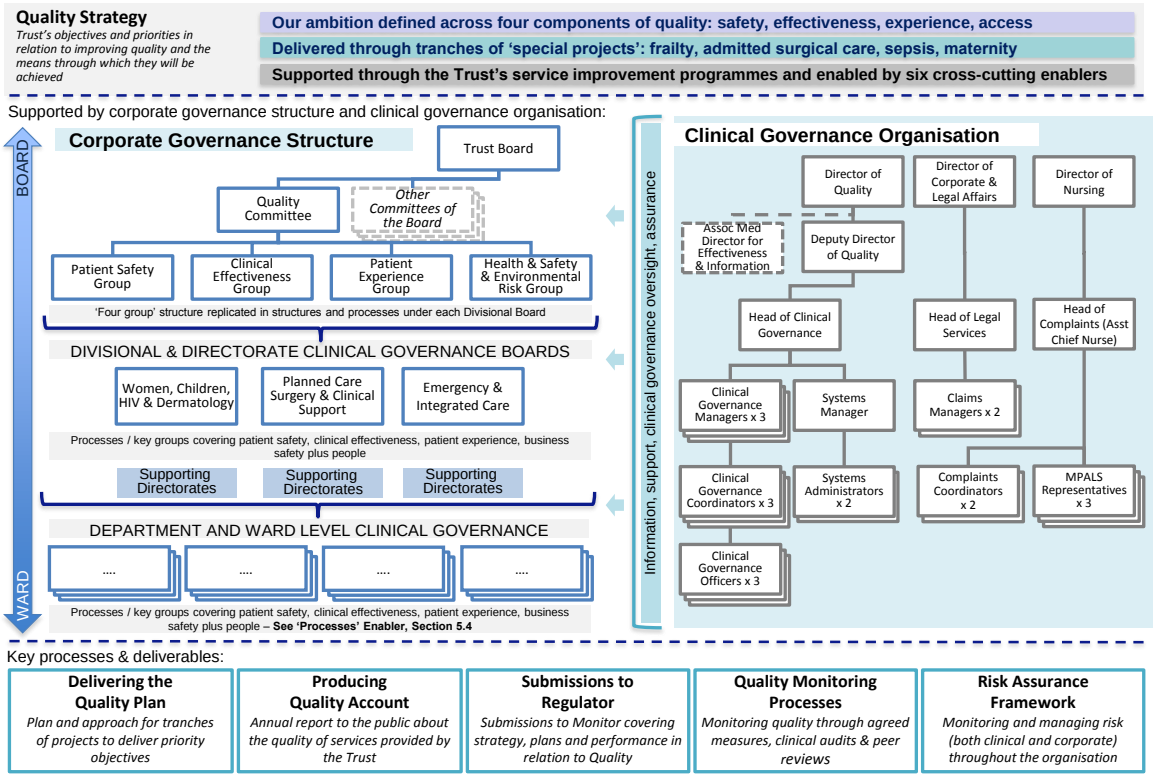
- Robust and consistent quality and clinical governance processes – these are described in more detail in Section 5.4
- Strong multi-disciplinary working between all staff at all levels of the organisation, supported by the Clinical Governance Team
- Clarity of purpose for all staff on their roles and responsibilities for improving quality and their specific responsibilities in relation to the priority changes being delivered.

Key elements of the our Quality Architecture

The **Quality Architecture** consists of the following elements:

- The **Quality Strategy** sets out the Trust's objectives in relation to improving quality and the means through which they will be achieved
- The **Corporate governance structure** is the corporate committee structure responsible for managing and assuring quality 'from Board to ward'
- The **Clinical Governance structure** is the structure of the Clinical Governance function within the Trust (reflecting a position post planned acquisition), which is responsible for providing information, support, clinical governance oversight and assurance over all aspects of quality across the Trust
- **Delivery of the Quality Plan** describes the process, approach and plan for delivering priority objectives identified in the Quality Strategy through tranches of 'special projects'
- **Producing the Quality Account** describes the process for producing the annual report to the public about the quality of services provided by the Trust. The document forms part of the Trust's Annual Report.

Figure 4 High-level Quality Architecture



Key elements of the our Quality Architecture *(Continued)*

- **Submissions to Regulator** consist of Monitor's regulatory reporting requirements in relation to Quality, such as the Quality Plans included as part of 2014/15 two-year Operational Plan submissions
- **Quality Monitoring processes** provide monitoring and assurance over the delivery of quality and quality improvement. This will be through a range of mechanisms including review of key measures and metrics (for example through quality and performance dashboards), delivering the clinical audit plan for the Trust, and carrying out regular peer reviews (such as the peer review planned for April focused on testing the outcomes of the CQC Action Plan)
- The **Risk Assurance Framework** is the process for monitoring and managing risk throughout the organisation.

2.6 Principles – Five principles that must apply to everything we do

We have set out overarching principles for our approach to quality improvement which must apply to everything we do. All care that we deliver will:

1. **Be patient-focused**
   - Our primary goal is to deliver and embed sustainable improvements in clinical outcomes and experience of care for patients and their families or carers.
   - The **"voice of the patient"** will be reflected in all aspects of our approach to ensure that what we do is meaningful to patients and their families or carers.
2. **Be best practice - all the time**
   - Provide evidence-based standards of care, first time and irrespective of the time of day or night, or location of care – so the **"voice of evidence"** will be a key driver for the clinical processes we deploy.
   - Increase the reliability of our care to reduce unacceptable variation.
   - Implement systems that allow all staff and our patients and families to get assurance that best practise standards are being met.
3. **Deliver Value**

- We believe that through improving quality, we can also improve efficiency, so we will also focus on interventions that allow us to do this – thus also helping to improve the value and financial sustainability of our services.

4. **Be underpinned by collective and personal accountability**
   - Create a working environment (systems, processes, training etc) that supports and empowers staff to deliver high quality care – so the **"voice of staff"** will also be an important contributor to our approach.
   - It should always be clear to our patients and staff who is responsible for what and the role each of our staff have in delivering high-quality care.
5. **Be continuously improving**
   - Improve everything we do, setting more ambitious goals where we have achieved existing ones, constantly challenging ourselves to do better and focusing most attention on those areas where the benefits are greatest.

3 Components of Quality

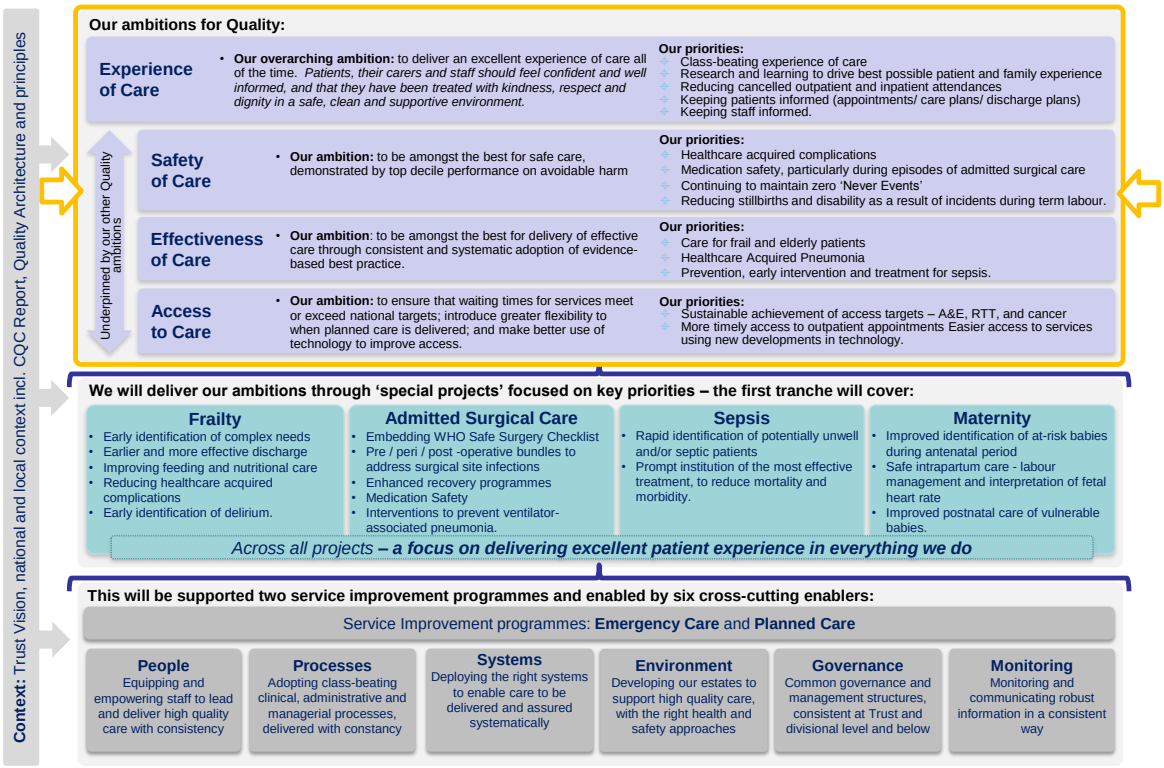
3.1 Introduction – How we define quality based on four components

We define Quality based **on four components** that we are aiming to improve continually:

- **Experience of Care –** ensuring patients, their carers and our staff have a positive experience of the services we deliver. In our Quality Strategy we focus on Experience of Care as our overarching focus, supported and enabled by the other three components below
- **Safety –** all treatment and care provided to patients being free from preventable harm
- **Effectiveness –** achieving the best clinical and patient related outcomes
- **Access –** the timeliness and ease with which patients can secure our services at the most appropriate place and time.

Quality is often defined based on the first three of these four components, omitting 'Access' in its own right (for example National Patient Safety Executive, 2015 and High Quality Care for All, 2008). We have chosen to include 'Access to Care' within our definition in order to place appropriate emphasis on timeliness and ease of access to services at the most appropriate place and time. This in turn drives safety, effectiveness and positive experience of services.

Figure 5 How the four components of Quality fit within the overall structure of the QSP



The following section sets out what each of these components means to us, our current position, our ambition for each, and our key priorities to address.

3.2 Ambition 1 – Deliver an excellent experience of care, all the time

We recognise that illness, diagnosis and treatment are stressful for patients and their families, but also that experience of care can be healing and positive for patients if delivered by caring and compassionate staff. Clearly, satisfaction with care will also be associated with the best possible patient outcomes as well.

A positive experience of care is integral to the Trust's Vision of delivering excellent outcomes and experience and the Trust has been recognised for its innovation and patient-centric approach to deliver excellent patient experience in a number of areas, such as its sexual health and HIV services (for example by the CQC during their 2014 review). Sexual health services have provided bespoke and responsive services to promote access and patient satisfaction to several hard to reach groups but we would like this level of innovation and excellent to be a constant across all services we provide.

A positive experience of care will be a key objective in both our overarching strategy but is also central to each of our Quality Plans and will be embedded as a key outcome and metric.

What Experience of Care means to us

A positive experience of care means ensuring that patients, families and careers as well as our staff have a positive experience of the services we deliver:

- **For patients, their families and carers –** this is about being treated with kindness and respect, with a recognition of people's individual needs and making sure they are informed and involved, and that we respond to their concerns.

- **For staff –** this to ensure that staff feel supported and valued but the Trust, thereby making it easier for them to deliver high quality and responsive care to patients and so to make sure that staff have a good experience of care as well.

Our ambition

Our ambition is to deliver **an excellent experience of care, all the time**:

Patients, their carers and families should feel that:

- They have been treated with kindness, respect and dignity in a safe, clean and supportive environment
- They are well informed regarding the treatment and care they receive, with the information to make choices and an environment in which they feel confident and in control of their care.

Our staff should feel that:

- They are part of an organisation in which every day we deliver on our vision to provide excellent patient outcomes and experience in everything we do
- They are well informed of changes and plans and why decisions have been made.

We recognise the need to continue to improve and excel against established experience measures such as the Patient Survey and Friends and Family Test. Strong performance against these measures is a given and a foundation which we will build on through a significant programme of research and learning into how we can provide excellent experience at all stages of the patient journey .

However we also recognise that to provide timely learning, feedback and quality improvement we need to collect richer and more frequent data at ward and departmental level to ensure responsive and rapid quality improvement and we will work on suitable measures that proved this rapid feedback loop to staff.

We will bring together public and patient voice, clinicians, and applied research to shape the services we deliver and the standards we set ourselves around providing excellent experience. We will consider each stage of the patient / customer journey, including:

- Keeping patients well informed in a timely fashion before their arrival at the hospital

- Planning care and treatment together with patients and their families and / or carers
- How patients experience the delivery of care and treatment whilst they are under our care
- Supporting patients on and after discharge.

All the 'special projects' we mobilise to deliver the priorities of the Quality Strategy will include objectives in relation to experience of care.

Where are we now – and how do we know?

The table below summarises our performance on key measures for patient experience during 2014/15.

Where we are doing well	Where we could do better
✓ Zero breaches of same sex accommodation, year to date ✓ FFT response rate is above target for both A&E and inpatients, for 2014/15 ✓ Intensive Care Customer Service Excellence Award ✓ Achievement of the Imaging Services Accreditation Scheme (ISAS) - one of only 12 in the country and the first non-specialist hospital in London ✓ Staff survey results – where the Trust remains in the top 20%	✘ To continue to improve the number of formal complaints that are responded to within 25 days – 61.43% against a target of 100% ✘ To continue to reduce the number of type 1 and 2 complaints received (in particular in relation to communication and attitude / behaviour) ✘ Friends and Family Test, where 89.7% would recommend the Trust on a response rate of 24.8% (versus target of 30%) ✘ Appraisal rate for non-medical and medical staff is 72% and 79% respectively against a target of 85% ✘ Mandatory training 78% compliant against a target of 95%

What are our priorities and how will we address these?

The table below sets out our key priorities for Experience of Care and how these will be delivered through the different elements of the Quality Strategy.

Priority	How we will address
⌖ Continue to improve on existing measures of patient experience – in particular the Friends and Family Test (FFT) which is a priority for the 2015-16 Quality Account	• Campaign to increase FFT inpatient update including communications and staff training • Re-establishment of the Patient Experience Committee as part of our Quality Architecture
⌖ Undertake multidisciplinary research and learning into how we can consistently provide the best possible patient and family experience	• Launch Research and Development initiative working with partners across the system
⌖ Develop a customer-centric set of standards for patient experience across the Trust's services. Consistently deliver class-beating experience as measured by these standards, as well as existing measures such as such as the Friends and Family Test (being taken forward as a quality measure for the 2015/16 Quality Account)	• Launch Research and Development initiative working with partners across the system • Workplan supporting delivery of 2-15/16 Quality Account priorities
⌖ Reduce the frequency of cancelled outpatient and inpatient attendances	• Planned Care Improvement Programme • Business as usual, underpinned by Quality Architecture and key enablers
⌖ Keep patients informed of changed/ cancelled appointments/ care plans/ discharge plans/ why decisions have been made	• Planned Care Improvement Programme and Emergency Care Programme • Business as usual, underpinned by Quality Architecture and key enablers
⌖ Keep staff informed of changes, plans and why decisions have been made.	• Business as usual, underpinned by Quality Architecture and key enablers

3.3 Ambition 2 – Be amongst the best for safe care

What Safety of Care means to us

Safety of Care means eradicating harm and ensuring that care delivered is as safe as possible, regardless of when or where patients seek our services.

Our ambition

Our ambition is to be amongst the best for safe care. We will demonstrate this through consistent achievement of top decile performance on avoidable harm.

We will achieve this ambition through a combination of working across our four 'special projects' and embedding a systematic and rigorous approach to Safety through the Trust's Quality Architecture.

Where are we now – and how do we know?

The table below summarises our performance on key measures of safety during 2014/15.

Where we are doing well	Where we could do better
✓ Incidence of newly acquired Category 3 and 4 pressure ulcers ✓ Safety Thermometer harm score showing constant improvement ✓ Hand hygiene compliance at 97.3% for 2014/15 against a target of 90% ✓ Delivering our targets for reducing incidence of Healthcare Acquired Infections (HCAIs) (C.Difficile, MSSA, E.Coli, MRSA) ✓ Consistent achievement of target for medication related safety incidents per 1000 admissions ✓ Zero Never Events for 2014/15	✘ Pressure ulcers – still an area we wish to see the numbers much reduced ✘ Further improvement on HCAIs • C.Difficile – bringing incidence per 100k bed days below target of 14.7 (2014/15 performance is 34.8) • MRSA – screening all elective patients (2014/15 performance is 93.4% against a target of 95%) ✘ In-patient falls per 1000 inpatient bed days 3.31 against a target required of no more than 3 ✘ Continue to improve compliance with national guidance in serious incident reporting

What are our priorities and how will we address these?

The table below sets out our key priorities for Safety of Care and how these will be delivered through the different elements of the Quality Strategy.

Priority	How we will address
⌖ Reducing harm through healthcare acquired complications (continuing to build on progress in relation to preventable VTE and C.Difficile and working to achieve targets for reduction in pressure ulcers, MRSA screening and falls)	• Special project on Frailty • Business as usual, underpinned by Quality Architecture and key enablers
⌖ Working to enhance medication safety, particularly during episodes of admitted surgical care	• Special project on Admitted Surgical Care
⌖ Continuing to maintain zero Never Events	• Special project on Admitted Surgical Care
⌖ Reducing stillbirths and disability as a result of incidents during term labour.	• Special project on Maternity

3.4 Ambition 3 – Be amongst the best for delivery of effective care through consistent adoption of evidence-based best practice

What Effectiveness of Care means to us

Effectiveness of Care means achieving the best clinical and patient related outcomes for our patients by deploying evidence-based care processes and procedures consistently throughout the organisation.

Our ambition

Our ambition is to be amongst the best for delivery of effective care, with consistent and systematic adoption of evidence-based best practice. We will continue to reduce mortality across our services, delivering maintained upper-decile performance across HSMR and SHMI measures.

We will achieve this through the adoption and continual embedding of evidence based pathways and care bundles that are proven to improve outcomes for our patients.

Where are we now – and how do we know?

The table below summarises our performance on key measures of effectiveness based during 2014/15.

Where we are doing well	Where we could do better
✓ Consistently met our target for numbers of patients with preventable VTE – 96.5% for 2014/15 against a target of 95% ✓ Compliance with care bundles for central line and urinary catheters within continuing care – 99.1% and 93.2% respectively against a target of 90% ✓ Lower than average mortality as measured by HSMR - 4th lowest in the country and SHMI - 4th lowest in the country[1] ✓ Maintaining NHS Litigation Authority Level 3 Accreditation ✓ 'Practical guidance for the management of palliative care on neonatal units' was launched in Feb'14 led by the Trust's neonatal unit and now forms part of national guidance on appropriate care for babies and families receiving end of life care	✗ Continue to focus on reducing VTE incidence ✗ Elective length of stay – long stayers continue to be above target ✗ Emergency readmissions within 30 days continues to be above target – 2.99% versus a target of 2.8% ✗ Improvement of nutritional screening: • Screening on admission 80.2% for 2014/15 against a target of 90% • Patients in hospital longer than a week who are nutritionally re-screened 66.8% against a target of 90% ✗ In-patient falls per 1000 Inpatient bed days 3.31 against a target required of no more than 3 ✗ Continue to improve compliance with national guidance in serious incident reporting

What are our priorities and how will we address these?

The table below sets out our key priorities for Effectiveness of Care and how these will be delivered through the different elements of the Quality Strategy.

Priority	How we will address
⌖ Improving care for frail and elderly patients, including: • Earlier and more effective discharge • Improving nutritional care including screening • Improving identification and care for those with delirium (linked with longer stay in hospital, hospital acquired complications, dementia and mortality)	• Special project on Frailty
⌖ Improving prevention and care for Healthcare Acquired Pneumonia (HAP)	• Special project on Frailty
⌖ Improving prevention, early intervention and treatment for sepsis, targeting a reduction in ITU admission, reduction in length of stay and reduction in infection rates, as well as reduced mortality.	• Special project on Sepsis

[1] SHMI taken from April Board Report. Updated figures to be published 29 April 2015

3.5 Ambition 4 – Continuing to improve access, ensuring waiting times meet or exceed targets, combined with easier access and use of technology

What Access to Care means to us

Access to care means the timeliness and ease with which patients can secure our services at the most appropriate place and time:

- *Timely Access* **–** the ability for patients to access urgent, emergency and elective care without undue delay
- *Easy Access* **–** the ability for patients to access our services in a mode appropriate to their circumstances, needs and wishes**.**

Our ambition

- For *Timely Access* our ambition is to ensure that waiting times for services **meet or exceed national targets** – including A&E waiting times, Referral to Treatment Times, and Cancer waiting times
- For *Easy Access our ambition* is to introduce **greater flexibility** to when planned outpatient or inpatient care is delivered, reflecting patient preferences – for example through delivering clinics at evenings and weekends. We will use **technology** to deliver more services – for example through virtual clinics, telephone consultations and postal testing services.

Where are we now – and how do we know?

The table below summarises our performance on key measures of access during 2014/15.

Where we are doing well	Where we could do better
✓ Year to date to February 2015 performance against cancer access targets other than 'Subsequent Surgery' ✓ Six-week waits for a diagnostic test ✓ Rapid access chest pain clinics ✓ RTT performance other than 'Admitted Patients'.	✘ Bringing A&E time to treatment below 60 minutes (2014/15 performance 1.08) ✘ Continue to improve cancer diagnosis to treatment waiting times – 'Subsequent Surgery', currently 92.3% against 94% target ✘ Improving Choose and Book slot issue % from 7.2% against a target of 2% ✘ Improving 18 week RTT times for admitted patients from 86% against target of 90%.

What are our priorities and how will we address these?

The table below sets out our key priorities for Access to Care and how these will be delivered through the different elements of the Quality Strategy.

Priority	How we will address
⌖ Consistent sustainable achievement of all our access targets – in particular: • A&E • RTT • Cancer	• Planned Care Improvement Programme • Emergency Care Programme • Business as usual, underpinned by Quality Architecture and key enablers
⌖ More timely access to outpatient appointments through more productive use of capacity	• Outpatients Improvement Programme – linked to Planned Care Improvement Programme and CIPs
⌖ Easier access to services using new developments in technology (for example patient module of the Trust's new clinical portal, due to be rolled out during 2015/16)	• 'Systems' enabler workstream, incorporating the Trust's IT Strategy and clinical systems blueprint.

4 Making it Happen – Special Projects

4.1 Introduction – Special projects and how we will deliver them

We will deliver our quality ambition through **'special projects'** which will focus on delivery of key objectives and priorities identified by the Quality Strategy.

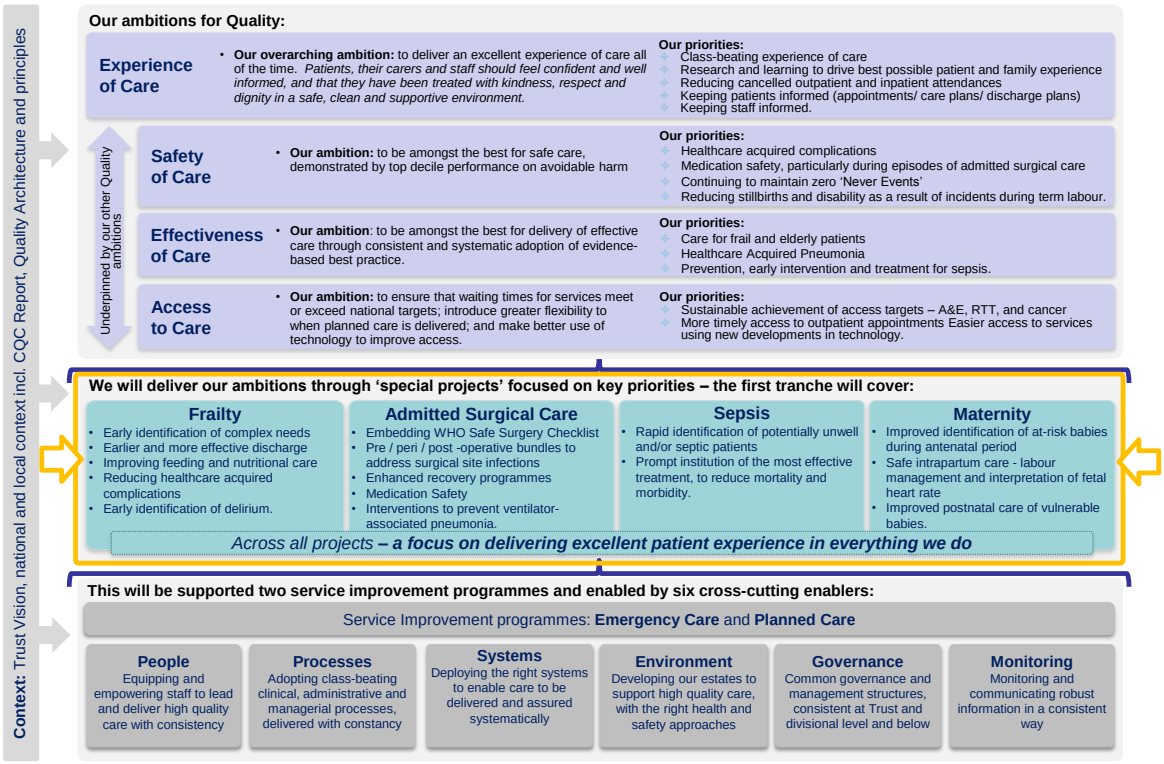
These projects will be delivered in tranches over the three years of the Strategy. A first tranche of projects for 2015/16 has been identified based on clinical input and stakeholder engagement over the development of the QSP to date.

This tranche will consist of four projects, focusing on:

- Frailty
- Admitted surgical care (working alongside the ongoing Planned Care Improvement Programme)
- Sepsis
- Maternity (linking to the national 'Each Baby Counts' initiative).

The figure below describes how 'special projects' fit alongside other components of the Strategy.

Figure 6 How 'special projects' fit within the overall structure of the QSP



This section sets out the overall project delivery approach that will apply to these projects and the high level project mandate for each. **All project mandates should be viewed as <u>first draft</u>, <u>subject to further shaping by project groups and stakeholders</u>.**

Project Delivery Approach

The key to realising the objectives and benefits of special projects will be ensuring that the changes to processes, systems and structures resulting from each project are implemented fully and consistently across the organisation with full understanding and buy-in from our people. Achieving this will require:

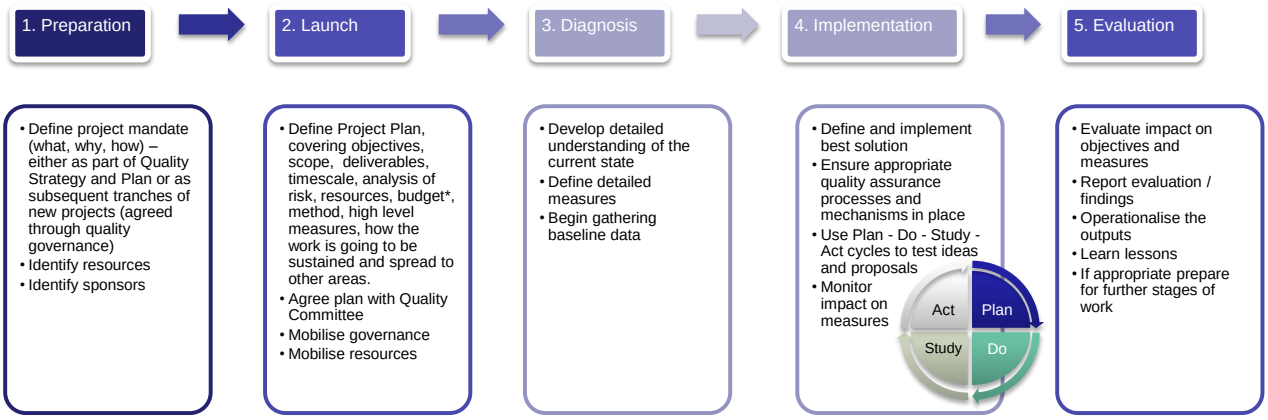
- A robust and consistent approach to project delivery

…supported by:

- Clinical leadership of the priorities
- Strong multi-disciplinary working between all staff at all levels of the organisation
- Clarity of purpose for staff on their roles and responsibilities for improving quality and their specific responsibilities in relation to the priority changes being delivered
- Oversight by the Quality Governance structure, supported by the Trust's Quality Architecture.

The approach for delivering the projects themselves will be based common project delivery approach, outlined in Figure 7 below.

Figure 7 Project Delivery Approach



As at early May 2015:

- Special projects on **Frailty** and **Admitted Surgical Care** are currently in the '**Preparation**' phase and are in the process of securing resources and sponsorship and developing and agreeing project plans
- The **Maternity** project is moving into the '**Launch**' phase, with identified resources and sponsorship in place and project plans being developed
- The **Sepsis** project is in the '**Implementation**' phase, with rollout of Thinkshield and associated training and process changes underway.

4.2 Project mandate for Frailty – Improving patient outcomes and experience for frail patients

INITIAL DRAFT SUBJECT TO FURTHER DEVELOPMENT BY PROJECT GROUP

Rationale – why focus on this priority?

The local population served by CWFT includes an increasing proportion of patients in the older age groups, particularly over 90 and over 80 years, meaning that caring for those with conditions such as frailty, dementia and multiple co-morbidities is a key priority.

Early identification and providing the right care for frail patients has been shown to improve patient outcomes and experience and to reduce length of stay in hospital. Areas where we know quality of care can be improved to deliver better patient outcomes and experience for frail patients include:

- Length of stay, where the Trust is seeking to improve non-elective length of stay and length of stay for elective and non-elective long-stayers
- Patient experience and outcomes at discharge
- Nutritional care, where performance is below target for nutritional screening on admission and re-screening after 1 week
- Healthcare acquired complications, where prevalence of pressure ulcers and incidence of falls per 1000 bed days continue to be a target area for improvement. Medicines management and reconciliation is also a key driver for reducing falls. Complications from drug interactions, side effects and direct effects can be implicated in anywhere from 9 to 20% of admissions to acute hospitals with falls being one of the commonest complications
- Delirium, linked with longer stay in hospital, hospital acquired complications, dementia and mortality.

Objectives and benefits – what does the project seek to achieve?

The project will implement a series of interventions focused on improving patient outcomes and experience through:

- Early identification of patients with frailty and/or complex needs in order that they can be cared for in the most appropriate setting, with the right support, as quickly as possible. This will draw on applied research by the NWL CLAHRC around finding key identifiers for frailty
- Earlier and more effective discharge through supportive discharge and use of discharge coordinators to remove ‘exit block’ where patients are unable to be discharged due to factors such as availability of nursing home accommodation, equipment or packages of care not being in place. Reducing unnecessary length of stay also has the potential to reduce incidence of healthcare acquired complications and healthcare acquired pneumonia (HAP), as well as improving patient experience
- Improving feeding and nutritional care which will in turn improve patient outcomes and experience
- Reducing healthcare acquired complications through clear, consistently delivered processes for safety, preventing harm, and medicines management and reconciliation
- Improving early identification of patients suffering from delirium through improved training and guidance for staff caring for those with delirium and dementia and exploring focused use of resources such as dedicated ward space and support from mental health nurses.

Approach – how will this be delivered?

A project group will be formed in early Q1 2015/16 to further develop the objectives and approach of the project based on this high-level mandate. This will include multi-disciplinary input from geriatricians, nursing, occupational therapy and applied research.

Some objectives of the project are likely to be implemented through a care bundle based approach (a bundle is a structured way of improving the processes of care and patient outcomes through a small, straightforward set of evidence-based practices that, when performed collectively and reliably, have been proven to improve patient outcomes). Other objectives are likely to be delivered through broader service improvement approaches.

Key measures – how will delivery be measured?

The delivery of the project objectives will be evaluated based on a series measures that will be agreed and trajectories set as part of the project 'Launch' phase. These measures will include:

- Consistent reduction in prevalence of stage 3 and stage 4 pressure ulcers **(priority measure for 2015/16 Quality Account)**
- Reduction in length of stay for elderly and frail patients
- Consistent improvement in nutritional screening and re-screening
- Reduction in number of falls
- Improved identification of patients suffering from delirium
- Patient experience (including experience of relatives and carers for those suffering from delirium).

4.3 Project mandate for Admitted Surgical Care – Consistently delivering safe and effective care for patients undergoing surgery

INITIAL DRAFT SUBJECT TO FURTHER DEVELOPMENT BY PROJECT GROUP

Rationale – why focus on this priority?

Planned care – and in particular admitted surgical care – offers a significant opportunity to improve the quality of care through consistent adoption of evidence-based best practice.

There has been good progress in improving care but there is still more that can be done to address such areas as:

- Maintaining never events at zero
- Reducing incidents of surgical site infections (accounts for up to 20% of all hospital acquired infection)
- Speeding recovery time and further reducing length of stay (elective length of stay currently 3.2 days year to date against a target of 3.7)
- Avoiding medication errors
- Reducing ITU admissions.

Objectives and benefits – what does the project seek to achieve?

The planned care priority comprises a series of intervention 'bundles' to help more reliably deliver the best possible care for patients undergoing particular treatments with inherent risks. It includes:

- Embedding of the WHO Safe Surgery Checklist
- Pre / peri / post -operative bundles to address surgical site infections
- Enhanced recovery programmes that improve patient outcomes and experience and reduce length of stay
- Medication Safety (analgesia, antibiotic and thromboprophylaxis)
- Interventions to prevent ventilator-associated pneumonia (VAP).

Approach – how will this be delivered?

A multidisciplinary project group will be formed in early Q1 2015/16 to further develop the objectives and approach of the project based on this high-level mandate.

The project will focus on the implementation of care bundles focusing on a number of aspects of admitted surgical care. A bundle is a structured way of improving the processes of care and patient outcomes through a small, straightforward set of evidence-based practices that, when performed collectively and reliably, have been proven to improve patient outcomes.

To help support and enable the rollout of the Safe Surgery Checklist the Trust is working with the Imperial College Simulation Centre to roll out a simulation package for theatre staff focusing on communication skills and leadership in the theatre environment. This approach is being piloted during Q1 2015/16 and will be rolled out over the year

Key measures – how will delivery be measured?

The delivery of the project objectives will be evaluated based on a series of measures that will be agreed and trajectories set as part of the project 'Launch' phase. These measures will include:

- Full compliance with WHO Safe Surgery Checklist, as measured through clinical audit **(priority measure for 2015/16 Quality Account)**
- Reduction in incidence of surgical site infections
- Effectiveness of enhanced recovery programmes, measured through patient outcomes and length of stay
- Ongoing reduction in medication errors
- Patient experience.

4.4 Project mandate for Sepsis – Reducing mortality and morbidity for patients suffering from sepsis

INITIAL DRAFT SUBJECT TO FURTHER DEVELOPMENT BY PROJECT GROUP

Rationale – why focus on this priority?

Sepsis is a significant driver of mortality and morbidity and it has been shown that early intervention and effective care will improve patient and clinical outcomes and reduce the chances of death. The Trust has an agreed pathway (care bundle) for patients with sepsis and the Emergency Department is taking part in a national research project on the treatment of sepsis.

This priority will build on existing work, targeting a reduction in ITU admission, reduction in length of stay and reduction in infection rates.

Objectives and benefits – what does the project seek to achieve?

The project will implement a process to rapidly identify potentially unwell and/or septic patients and institute prompt treatment, in order to reduce mortality and morbidity. This will utilise an electronic NEWS scoring and escalation system with prompts to identify potentially unwell and/or septic patients. For septic patients prompts and algorithms will be used to initiate investigation and treatment according to a recognised sepsis algorithm (such as Sepsis 6).

All stages in identification and treatment will be subject to audit of process and patient benefit will be recorded routinely as will deaths from sepsis, admissions to ITU with sepsis and length of stay in hospital.

Approach – how will this be delivered?

A project group has been mobilised during Q4 2014/15 to fully define and launch the project. The project is now being implemented. Work will consist of a number of overlapping phases:

- *Phase 1*: will implement the roll out of Thinkshield to the hospital
- *Phase 2*: will implement an investigation and treatment algorithm for Sepsis
- *Phase 3*: will consist of the production of Obstetric version of Think Vitals
- *Phase 4*: will consist of the production of Paediatric version of Think Vitals
- *Phase 5:* will increase the scope of individuals to perform sepsis bundle
- *Phase 6*: will introduce the AKI Bundle.

Key measures – how will delivery be measured?

The delivery of the project objectives will be evaluated based on a series of measures which includes:

- Consistent improvement in identification of deteriorating patients (NEWS, PEWS, MEWS), measured through clinical audit **(priority measure for 2015/16 Quality Account)**
- Delivering full compliance with delivery of antibiotics within 1 hour by Year 2
- Reducing mortality from sepsis
- Patient experience.

4.5 Project mandate for Maternity – Improving identification and care for 'at risk' babies

INITIAL DRAFT SUBJECT TO FURTHER DEVELOPMENT BY PROJECT GROUP

Rationale – why focus on this priority?

The Maternity Department at CWH delivered 5986 babies in 2014. Of those structurally normal babies at term, approximately 3% were admitted unexpectedly to the neonatal unit. The national rate of admission is quoted as 5%. This is one of the top three incidents reported within the department and although most babies are discharged home with an anticipated normal outcome, the period of separation creates anxiety for parents and involves additional bed days for the mother. For the small minority that have permanent brain injuries the impact for those families is immeasurable, and the financial costs of litigation are significant.

Objectives and benefits – what does the project seek to achieve?

Our ambition is to achieve a 20% reduction in unexpected term admissions to NICU. To achieve this the project has the following objectives:

- **Improve identification of at-risk babies in the antenatal period.** Identify at risk babies i.e. those who are growth restricted prior to the onset of labour who will have limited reserve for the additional stress of labour
- **Ensure safe intrapartum care.** Review practice and target teaching and education regarding labour management and interpretation of the fetal heart rate in labour (both intermittent auscultation and CTG interpretation)
- **Improve postnatal care of vulnerable babies.** Review practice on the postnatal ward in caring for babies that are vulnerable to hypoglycaemia and hypothermia. To ensure babies receive IV antibiotics within the recommended timescale.

Approach – how will this be delivered?

The outline approach for the project is as follows:

- **Quarter 1 –** Increasing the information from existing audits and gathering evidence about current systems in place to support staff and women
- **Quarters 2 and 3 –** Anticipated that the review and audit results will have clarified metrics that can be used in the following quarters. Rollout of GROW software to improve antenatal detection of growth restriction. New fetal heart rate monitoring teaching sessions will be implemented and an assessment tool will be introduced for key staff. Results of the postnatal audit will have identified areas for change that will be implemented within these quarters.
- **Quarter 4 –** Re-audit will be undertaken on key areas: postnatal admissions, compliance with new CTG classification and monitoring tool, identification of growth restricted babies.

Key measures – how will delivery be measured?

The delivery of the project objectives will be evaluated based on a series of measures that will be agreed and trajectories set as part of the project 'Launch' phase. These measures will include:

- Reduction in unexpected term admissions to NICU **(priority measure for 2015/16 Quality Account)**
- Reduction in third and fourth degree tears
- Experience of mothers, their families and birth partners.

5 Making it Happen – Supporting Programmes and Enablers

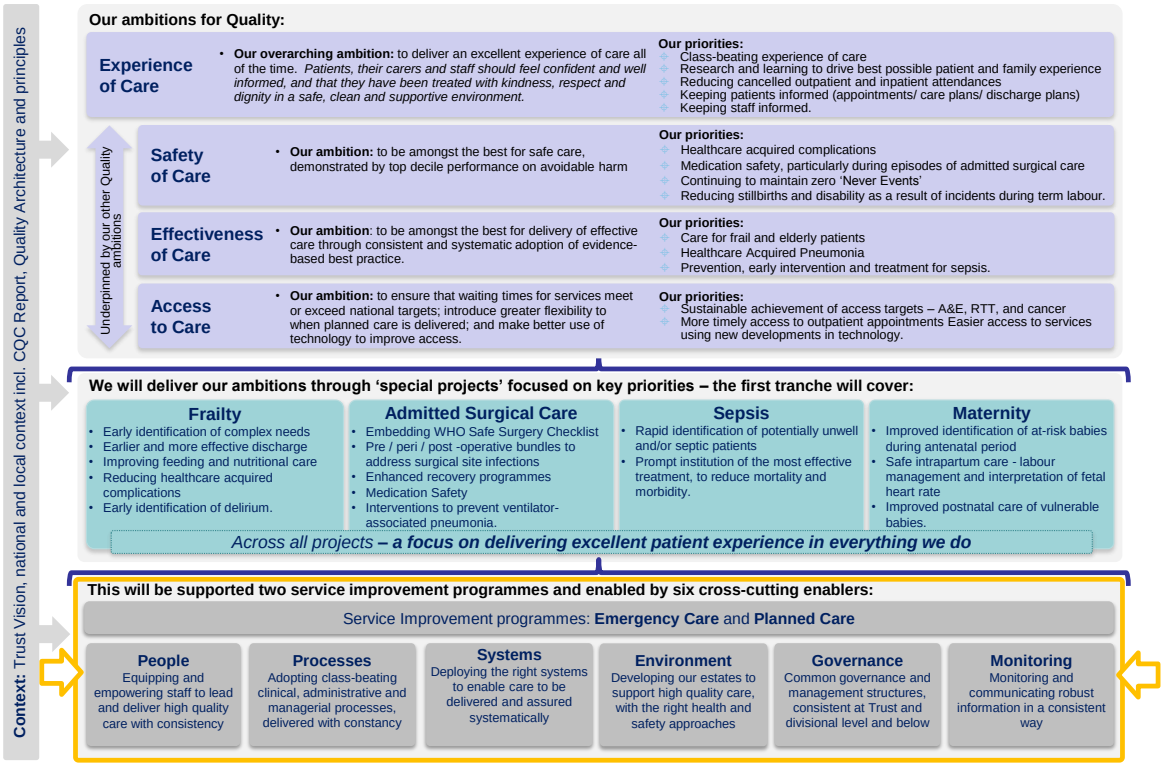
5.1 Introduction – How do supporting programmes and enablers ensure delivery of the QSP

Delivery of the QSP will be underpinned by supporting and enabling work across a number of areas.

- The Trust's two overarching service improvement programmes focused on **Emergency Care** and **Planned Care**
- Six **cross-cutting enabling workstreams** which together will transform the Trust's Quality Architecture:
  - **People –** How we will equip and empower staff to lead and deliver high quality care
  - **Processes –** How we will adopt class-beating clinical, administrative and managerial processes
  - **Systems –** How we will deploy the most appropriate technologies to deliver high quality care
  - **Environment –** How we will develop our estates and facilities to support high quality care
  - **Governance –** How our governance and management structures will drive quality improvement
  - **Monitoring –** How we will know how we are doing and communicate that information.

The figure below describes how supporting programmes and cross-cutting enablers fit alongside the other components of the Strategy. This section then goes on to summarise work across each of these areas.

Figure 8 How supporting and enabling workstreams fit within the overall structure of the QSP



5.2 Service improvement programmes – Leveraging the Emergency Care and Planned Care Improvement Programmes

Delivery of service improvement across the Trust is supported through two overarching multi-year programmes – the Emergency Care Programme and the Planned Care Improvement Programme.

The **Planned Care Improvement Programme** is focused on high-level objectives, to:

- Align and 'right size' the organisation's resources to enable the delivery of an integrated planned care pathway in a safe, kind, excellent and respectful manner
- Improve quality, specifically safety of care, effectiveness of care, patient experience and access
- Improve productivity in outpatients, pre-assessment, theatres and inpatient elective beds
- Optimise resource utilisation: providing GP access to specialist opinion; and through improvement in use of capacity for NHS activity, to increase the resource capacity (diagnostics, theatres, outpatient clinics and beds) available to deliver Private Patient services at the trust.

The **Emergency Care Programme** is a multi-agency programme bringing together all key stakeholders in the emergency care pathway from the community, acute and first response sectors. Its top-level objectives are to:

- Reduce avoidable emergency admissions, both pre-arrival and in the A&E/ Short Stay phase
- Reduce length of stay in acute and increase in use of Out of Hospital support
- Deliver increased use of care planning and case management
- Reduce the acute bed footprint
- Deliver a seamless transition between acute and sub-acute phases

The Programme has a series of system-wide 'partnership' objectives, to:

- Design and implement a "boundary-less" patient pathway crossing the organisations, and then enable this with technology to support delivery of the quality and productivity improvements outlined above.
- Align with 'Whole Systems' working to further develop case management, earlier discharge and support specific cohorts of patients, for example frail elderly
- Expand involvement of Social Care, and focus on delayed transfers of care and moving patients into sub-acute settings, resulting in a more seamless flow of patient transfers.

5.3 People – Empowered and equipped to lead and deliver excellent quality care in a systematic way

The 'People' enabler focuses on equipping and empowering staff to lead and deliver high quality care with consistency across the organisation. Figure 9 below sets out the components of our People Strategy & Plan which underpins this enabler. Each includes aspirations and actions that support the delivery of Quality across the Trust, also taking into account the planned acquisition and integration of WMUH.

Figure 9 People Strategy and Plan – key components

For **Culture, Values and Engagement** we will embed our values so that these translate into great experience of care. During 2015/16 we will:

- Focus on areas for improvement identified by Staff Survey

- Deliver an OD programme for Integration including confirming the new organisation's values
- Deliver a programme of staff engagement to support integration.

For **Inspirational Leadership & Talent** we will ensure staff have the capability to lead delivery of high quality care through rollout of leadership programme to all staff groups. During 2015/16 we will:

- Roll out the Trust's talent management programme
- Mobilise a Leadership Development Programme across both sites (linked to the planned integration with WMUH).

For **Workforce Strategy and Planning** we will ensure we have the right staffing, skill-mix and capacity to deliver high quality care in all our areas, seven days a week. During 2015/16 we will:

- Focus on staff retention
- Develop a quarterly workforce information pack and supporting analysis
- Align CWH and WMUH workforce plans (subject to WMUH transaction)
- Explore joint staff bank arrangements to reduce reliance on agency.

For **HR & Learning Processes** we will ensure we facilitate the processes through which staff are informed about, conduct and report completion of mandatory training processes. During 2015/16 we will:

- Develop an HR and Learning intranet portal
- Continue review of statutory and mandatory training requirements adopting best practice from the HR London 'streamlining project.

For **Skills & Capability** we will ensure staff have the capability to design and implement service improvements. During 2015/16 we will:

- Improve the Trust's e-learning offer to staff
- Continue review of statutory and mandatory training requirements adopting best practice from the HR London 'streamlining project.

For **Performance, Reward & Recognition** we will ensure quality improvement activity is acknowledged and incentivised, we will be introducing a trust-wide recognition and reward mechanism for quality improvement. During 2015/16 we will:

- Re-launch the Trust's recognition scheme
- Renew focus on staff appraisals.

5.4 Processes – Consistently applied and class-beating

The 'Processes' Enabler focuses on adopting class-beating clinical, administrative and managerial processes, delivered with consistency across the Trust.

At all levels these processes will have multidisciplinary ownership from doctors, nurses and managers, supported by the Trust's Clinical Governance team. It is essential that there is clarity of purpose for all staff in relation to quality. This means each member of staff being clear on their role and responsibilities in relation to clear and consistent delivery of processes based on best practice and evidence, and achieving this 'first time, every time'.

Consistent clinical processes

The Trust's Quality Architecture is set out in Section 2.4. Supporting our Quality Architecture we will continue work to embed consistent clinical governance and quality processes which will be delivered consistently across ward, directorate and divisional levels. These will include the areas of Safety, Effectiveness, Experience and Access, as well as People. Some of the key processes are set out below (the list is subject to further development and not intended to be exhaustive).

- **People** including number of appraisals completed and outstanding, leavers, joiners and sickness absence rates, to inform ward and departmental operational management

- **Performance against key quality measures** including a number of areas which will be further defined as part of operationalising the Trust's Quality Architecture:
  - Patient Safety Thermometer: pressure ulcers, falls, urinary infections, venous thromboembolism, prophylaxis
  - Other safety measures, including MRSA, C.Difficile, hand hygiene, compliance with NEWS, PEWS, and MEWS, medication errors, nutritional screening and peripheral line care
  - Patient experience including Friends and Family Test, Patient Survey, complaints and other measures of patient experience
  - Surgical Safety including WHO Safe Surgery Checklist and surgical simulation training
- **Incident management** including number of incidents and root cause analysis (where a requirement for a RCA is triggered)
- **CQC domains** ongoing self-assessment and peer review against all standards at least twice per year
- **Clinical audit progress** including how many completed and their findings, and details of planned audits
- **Review of policies, procedures, guidelines and protocols** including number reviewed in the past month and number outstanding for review
- **Risk management** including reviewing new risks, progress at closing existing risks, outstanding actions and key learnings. This will form a key 'bottom-up' input into the Trust's Risk Assurance Framework (RAF) and local ownership of risk registers.

Transforming administrative and managerial processes

We are working through the Emergency Care Programme, the Planned Care Improvement Programme, and other supporting projects, to improve operational processes to deliver better quality outcomes for patients, and in particular better access to care and experience of care. Areas of focus for 2015/16 include:

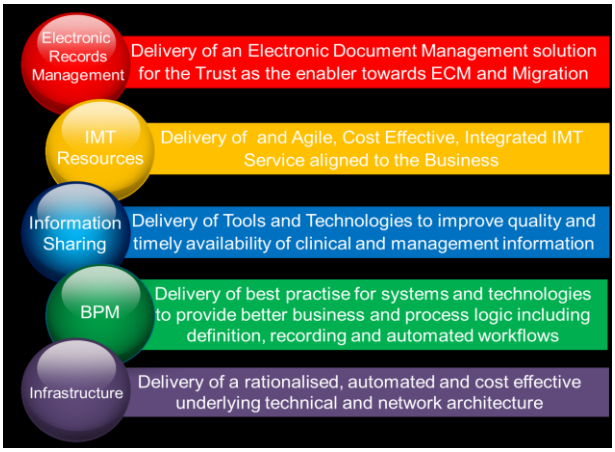
- **Improving patient ownership and empowerment over their care** through maintaining a robust and consistent access policy and ensuring correspondence with patients is clear and consistent and in ways that are responsive to their needs
- **Transforming processes for managing outpatients**, enabling more patients to be seen during clinic time, and reducing cancellations, DNAs and un-booked slots. This work builds on pilot projects in gynaecology and ophthalmology
- **Redesigning clinical administration processes** to improve the alignment of clinical administrative resources with the needs and demands of the patient pathways within the Trust. This will deliver consistent, standardised models and processes across the Trust and improve pathway management from end to end
- **Improving theatre utilisation and productivity**, increasing theatre active time and improving patient experience through being able to deliver more cases per list with reduced late starts and overruns (hence better access)
- **Systems training for all staff involved in the Referral to Treat (RTT) pathway**, to drive understanding and consistency of approach, helping to ensure that RTT targets are met or exceeded
- **Ensuring consistent and robust planning and monitoring processes** including proactively planning for demand and capacity across the Trust and consistent monitoring and reporting drawing on tools such as Qlikview and Service Line Reporting (SLR).

5.5 Systems – IT that enables a consistent and rigorous approach to quality

The 'Systems' enabler focuses on deploying the right systems to enable high quality care to be delivered systematically across the Trust, with appropriate levels of assurance. Our IT Strategy describes the objectives for technology deployment in the organisation and how these will be achieved. Figure 10 below outlines the key components of the Strategy. Each component includes objectives that support the

delivery of Quality across the Trust both across the current CWH footprint, and across the broader CWH and WMUH footprint (subject to the planned acquisition of WMUH during 2015). These aspirations are supported by specific actions and initiatives, summarised below for 2015/16

Figure 10 IT Strategy – key components



Electronic Records Management (ERM) We will transform ERM over a multi-year programme, to improve availability of information across care settings and support consistent ways of working, resulting in improved safety, effectiveness and integration of care. This is a very significant enabler of quality both for CWH and (subject to planned acquisition) for WMUH. Please see the Integrated Business Plan for the Acquisition for more detail of the benefits case. Specific deliverables for 2015/16 include:

- Upgrade of current PACS system to a new web-based portal Q2 2015/16.
- Roll out of an Electronic Document Management system (Evolve) by the end of H2 2015/16
- Replacement of the current Electronic Patient Record system (LastWord) through a three year programme with supplier selection complete by the end of Q3 2015/16
- Implementation of a Clinical Portal enabling common access to records across the Trust, to be rolled out by early Q4 2015/16.

IM&T Resources We will improve user support and functionality of IT service to improve staff satisfaction with IT and overall organisational effectiveness. This will include delivering IT Helpdesk services through the new SPHERE joint venture.

Information Sharing We will improve collation of quality performance information, to help drive quality improvement focus and activity. We will continue to leverage Qlikview as the solution to capture and report clinical and management information. We will pursue opportunities to enable the sharing of information across health and social care to support integrated working across the local health system, including the rollout of SystmOne, the clinical system of choice for the majority of local GPs.

Business Process Management (BPM) We will enhance patient resource management through patient scheduling and communication to improve timeliness and mode of access to care. A key element of this will be the implementation of the Clinical Portal which includes within it a Patient Portal.

Infrastructure We will improve overall IM&T system resilience and capacity to deliver better staff and patient use of technology. This includes completion of our desktop replacement programme, upgrading the Trust's network and wifi to enable more mobile working, and establishing a dedicated network link to WMUH.

5.6 Environment – Achieving the right environment to support high quality care

5.6.1 Estates

Our vision is to provide tailored Facilities Management, distinguished by safety and excellence. A proficient, responsive team, providing high quality services in an environmentally sustainable way.

The Estates function will provide services to the Trust in such a manner that healthcare is enhanced, safety is assured, conservation of physical and financial resources is maximised and improvement by change becomes a constant.

We want to provide an environment and facilities that directly enhance experience of care and also facilitate the delivery of high-quality care. Our Estates and Facilities Plan sets out a number of developments to our facilities that will do this over the next two to three years, including:

Developments:

- The Maternity Led Birthing Unit – Provision of a modern midwife led maternity unit for low risk births, design to promote the birth experience
- LED Lighting Project – replacement of all lighting in the Atria and majority of wards with modern LED fittings – improving quality and economy of lighting provided
- Private Maternity – Private Suite
- Purchase of Doughty House– to allow future expansion of clinical services on site
- Refurbishment of the Hydro Therapy Pool
- Antenatal Clinic move to the 1st Floor
- Annual Place Audit
- Refurbishment and re-location of Annie Zunz Ward
- Newly Opened Patient Transport & Discharge Lounge – supporting more effective discharge and improved patient experience
- David Evans Ward and the Surgical Admissions Lounge – general light touch upgrade to the ward environment
- Dean Street Express - 'drop-in' sexual health facility
- Paediatric Outpatients
- Refurbishment of David Erskine Ward
- Refurbishment of Edgar Horne Ward
- Refurbishment of St Mary Abbots Ward
- Decant of the Emergency Department

Current projects:

- The Emergency Department Extension
- Opening up of the Stairwells for Visitors
- Internal Move Management
- Retail Pharmacy (Boots)
- MediCinema
- Supporting WMUH Acquisition from an Estates and Facilities perspective
- Provision of accommodation for the IT Shared Service (SPHERE)

Future plans and projects:

- ITU Expansion
- Refurbishment of Floors on Neptune/Jupiter Ward
- Car Park Lift to stop on the LGF
- The Potential deployment of the Discharge Unit to Mulberry Ward K&CMHT
- Extraction / Air Quality Mercury Ward
- PALS Office and opening up Ground Floor corridor
- NICU Improvements
- Relocating WLCSH to 10 Hammersmith Broadway
- Upgrade to core lifts

Patient Led Assessments of the Care Environment (PLACE)

During March 2015 the Trust's Annual Place Assessment was undertaken. In the time leading up to the assessment, the Estates and Facilities team were proactive in examining standards of cleanliness and quality of the fabrics, and worked with ward leads and dieticians on hydration and nutritional needs.

We have introduced Place+, an initiative by Norland Managed Services, which purely looks at Fabric works in all areas. To launch Place+ a small working group was assembled from across Estates and Facilities, ISS, Norland and Patient Governors, to assess the hospital for quality of fabrics, cleanliness and clutter.

During 2014/15 the Trust was assessed on the new Dementia Friendly Ward Environment. This is will form a focus for all of refurbishments and new builds going forward. The results will be available in October but initial feedback from patient representatives has been positive.

Other developments contributing to quality and patient experience

- **Security** The ISS Security Team has successfully completed a three-month trial on Body Worn Cameras (BWCs) and the Trust is in the process of purchasing nine 'Reveal' cameras to enhance our security in the Emergency Department and across the Trust.
- **Cycling** The Borough are planning to install further cycle racks outside on the Hospital frontage for patients and members of the public.
- **Post** The Trust's move to Royal Mail has contributed to a significant drop in DNA rates and complaints from patients of not getting their mail in time for their appointment. The next step will be to examine options for mail being printed offsite, enveloped and posted on our behalf.
- **Patient Transport** The Patient Transport Team has introduced a Passport for Wheelchairs Scheme that determines the serviceability of the wheelchair and compatibility for travelling in an Ambulance. The wheelchair owner is then issued with a passport for the wheelchair and the wheelchair is tagged.

- **Getting Around the Hospital** There is an ongoing programme of building improvements to enhance patient experience in getting around the Hospital.

5.5.2 Health, Safety and Fire

We are committed to providing and maintaining a safe and healthy environment for all employees, contractors, patients, visitors and those who may be affected by work related activities. The Trust recognises that the only effective approach to the prevention of injury and loss is the systematic identification and control of risk through the Trust's risk assessment process, the adoption of best practice in health and safety management and the allocation of necessary resources.

The Trust manages health and safety using the process of risk management including the identification of hazards, assessment of risks and introduction of control measures. We adopt a systematic approach that includes following all standards published by the Health & Safety Executive, Department of Health, NHSLA, CQC and Improving Lives initiative. Further details are set out in the Trust's Health and Safety Policy.

What are the controls in place?

The Trust has a Health, Safety & Fire Committee (HSFC) that meets monthly to consult, review and monitor progress on safety arrangements. The committee has representation from all Divisions as well as other organisations that share Trust premises. Each Division provides an assurance report once a year and reports progress on action plans quarterly.

A programme of health and safety inspections is in place. This identifies both good practice and shortfalls. The key themes/findings are reported to the HSFC quarterly.

There is a range of health and safety policies and guidance prepared, setting minimum standards to safeguard all who visit or work in Trust premises. These documents are reviewed regularly to ensure they are practical, effective and up to date.

What are we doing to address gaps in assurance?

Attendance at mandatory training has improved, but below the Trust's targets. Particular concern is the level of fire training compliance (61% February 2015). Mandatory training attendance is reviewed on a monthly basis, with areas of concern highlighted to Divisional Managers.

Where we have assurance what does it tell us?

The most significant assurance is the external NHSLA assessment, where all health and safety related criteria were judged to meet level 3 (highest). The assessors noted, *'throughout the assessment, the attention to detail and diligence in developing and using effective risk management processes was demonstrated and staff were clearly engaged and committed in support of both patient and staff safety.'*

5.7 Governance – Clear, consistent and rigorous governance of quality

Steps be taken to ensure systematic governance of quality

Key actions that we are taking in relation to governance to support the delivery of the Quality Strategy are set out below.

- Introduce a common framework to Corporate and Divisional Boards to support effective quality management. This framework will enable teams to provide assurances to the Trust Board and accurately understand the quality of the care and services the Trust provides
- Apply best practice recommendations to develop an aligned and relevant set of metrics; making best use of technology and existing systems to eliminate duplication. Local metrics will include flexible parameters to enable specialties to identify "low-lying" problems or tackle underperformance
- Provide relevant and reliable management information to continually assess and mitigate quality risks
- Continually reinforce the Quality Strategy by ensuring that quality is embraced as a responsibility of every staff member and is visibly led by those reporting to Corporate and Divisional Boards
- Ensure there are clear roles and accountabilities in relation to governance and quality

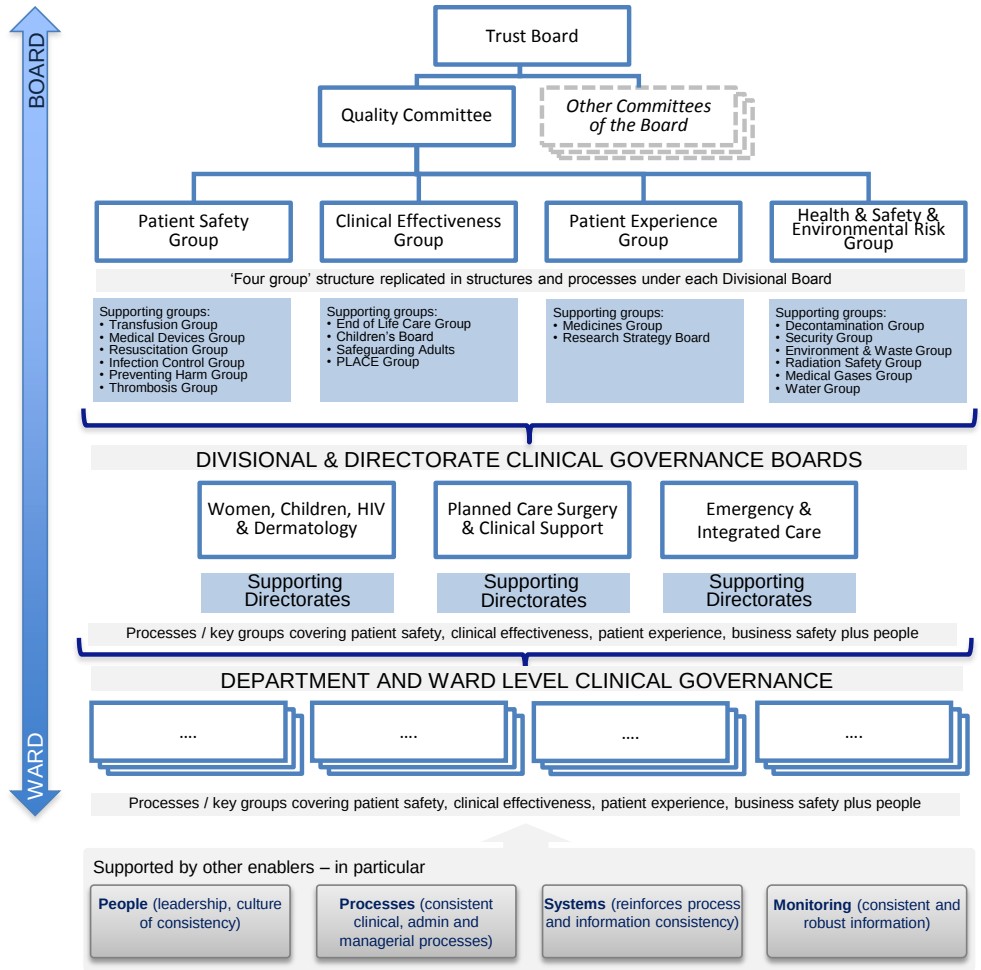
- Continue to improve awareness and information for staff, to ensure that there are clearly defined and well understood processes for escalating and resolving issues and managing quality performance
- Involve and engage patients, staff and other key stakeholders, using recent standards and indicators, in governance and quality improvement initiatives.

Governance structure for quality

The figure below sets out the Trust's 'top-level' governance structure in relation to quality and how this will be systematised through a common framework across each of the Corporate and Divisional Boards.

The figure also shows how other cross-cutting enablers – in particular People, Processes, Systems and Monitoring will support and reinforce these arrangements by ensuring a common and robust approach. Further detail on these enablers is included elsewhere, in Sections 5.3, 5.4. 5.5 and 5.8 respectively.

Figure 11 High level overview of governance structure for quality



5.8 Monitoring – The right information, monitored in a consistent way

In order to evaluate our performance and level of improvement, we must baseline our position and then track how we are performing against agreed outcomes and measures. We must do this in a consistent way across divisions, directorates and wards, using this information to adjust our plans or take action as needed. Currently, we collect a great deal of data, but we do not always utilise it as well as we can to help deliver quality improvement.

Building on what we already do well, we have set out some principles for how we will determine how we are doing and disseminate that information appropriately. Information must be:

- **Meaningful** – We must measure what is most meaningful to establishing quality

- **Timely** – Information must be collected and disseminated in as timely a fashion as possible, with forecast or predictive information about future performance provided wherever possible (in addition to historic)
- **Disseminated appropriately** – It should be clear who should receive information and what they are expected to do in response to it, including those who should be informed exceptionally [for outlying performance]
- **Easy to interpret** – Those responsible for collating or reporting information should use formats that are easy to absorb and provide summaries and annotations that make it easy to identify outlying performance
- **Proportionately collected** – the resources and mechanisms deployed to collect and aggregate information should be the minimum possible and should be [at least] commensurate with the value of the information.

We will apply these principles across all of the quality metrics and measures that we monitor and communicate to our stakeholders. In practice this consists of the following (overlapping) requirements:

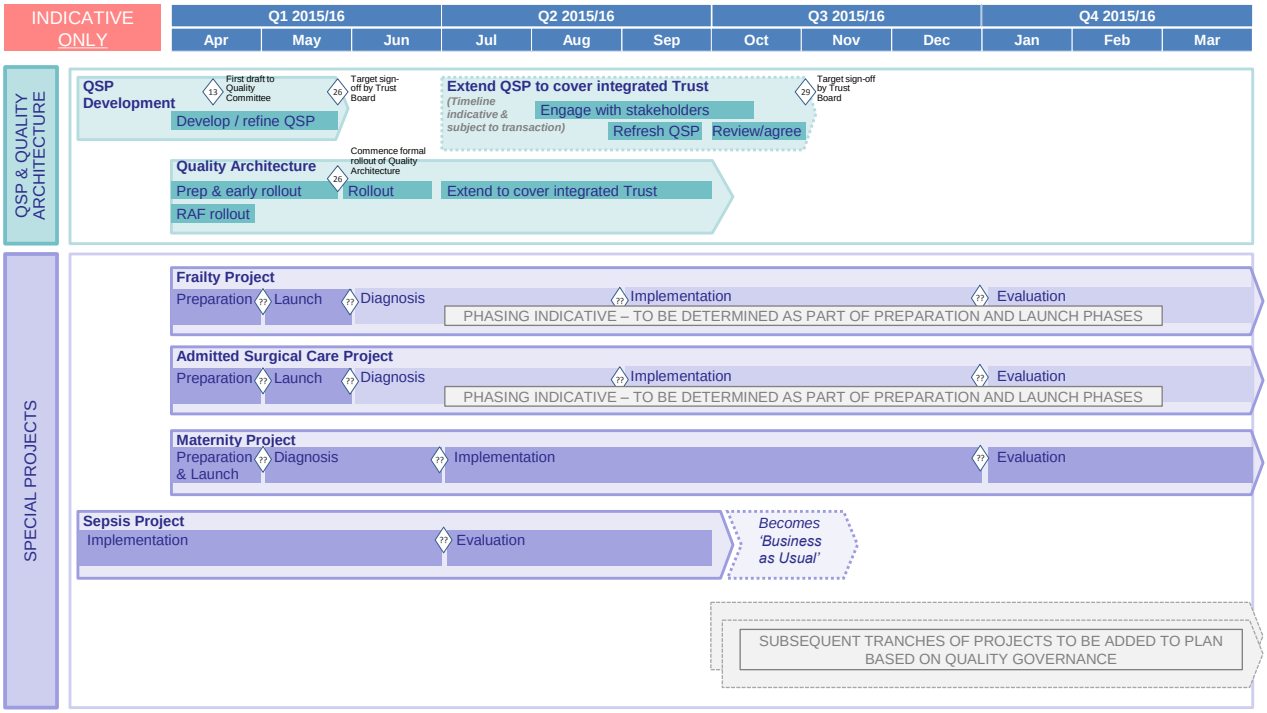
- **Our internal monitoring requirements**, driven by how we ensure that we are maintaining and continually improving the quality of everything that we do
- **The requirements of our commissioners**, consisting of the information that local CCG and NHS England need to monitor to ensure that we are meeting the quality requirements of the services they commission
- **The requirements of our regulators**, consisting of the information that Monitor and CQC need to ensure that we are meeting required standards as an NHS Foundation Trust
- **The requirements that support our accountability to our patients and public**, including our Governors and Membership.

6 Forward Plan and Next Steps

6.1 Plan for development and implementation of the QSP during 2015/16

The figure below sets out the high level plan for development and implementation of the Quality Strategy and Plan.

Figure** 12 **How the QSP will be developed and implemented during 2015/16



6.2 Steps to develop and implement the QSP

Please note this section will be refreshed appropriately to reflect actions completed at the point the document is signed off.

Our steps for development and implementation of the QSP fall into three areas:

1. Developing the QSP

- We have worked with content owners and internal stakeholders across the Trust to fully populate and further develop this draft.
- We are now engaging with our external stakeholders including commissioners, other local providers, and Healthwatch groups, to ensure that our approach fully aligns with broader work and expectations across the local health system.
- We took a first draft of the QSP to the Trust Quality Committee on 13 April for review and feedback.
- We are targeting sign off by the Trust Board at its meeting on 26 May.

2. Implementing the QSP

- Following sign-off for the QSP in May, we will work to align and implement the structures, systems and processes that comprise the Trust's Quality Architecture. Where feasible and sensible to prepare for this work in advance of formal sign-off we will do so.
- We will continue to implement the special project focusing on Sepsis and will rapidly mobilise the special projects focusing on Frailty, Planned Care and Maternity, ensuring that each has appropriate plans, governance and resources in place to be set up for success.

3. Handling the planned acquisition of WMUH in relation to development of the QSP

- The Trust is planned to acquire WMUH during 2015. Whilst this document currently reflects a 'standalone' CWH perspective, we have sought to engage staff from WMUH through its development. Where possible we will work with the WMUH Integration Programme to engage and align work across the two sites ahead of the planned acquisition.

  Post planned acquisition (subject to its approval) we will expand and extend the QSP to fully describe the Quality Strategy, Quality Architecture, supporting projects and other work across both CWH and WMUH sites.

6.3 Immediate next steps

Our immediate next steps for further development of the draft QSP are:

- Update of performance measures included against each component of Quality with final 'year end' figures as soon as these become available. This action is now complete in most cases.
- Circulate draft to stakeholders (including local CCGs and WMUH) for further feedback
- Further mobilisation of project groups to take forward work on 'special projects' (with corresponding further development of project mandates). Particular focus on Frailty and Admitted Surgical Care.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 June 2015

PUBLIC

AGENDA ITEM NO.	9/Jun/15
REPORT NAME	Performance and Quality Report – May 2015
AUTHOR	Virginia Massaro, Assistant Director of Finance
LEAD	Karl Munslow-Ong, Chief Operating Officer
PURPOSE	To report the Trust's performance for May 2015, highlight risk issues and identify key actions going forward.
SUMMARY OF REPORT	The Trust met all key performance indicators for Monitor in May with the exception of the compliance with requirements regarding access to healthcare for people with learning disabilities. - The Trust is currently not fully compliant will all 6 of the learning disabilities indicators, but working to achieve compliance in 2015/16, in line with our CQC Action Plan. - Patient Safety: The prevalence of pressure ulcers remains high, and the preventing harm group and is working closely with the Tissue Viability Nurse, the divisional nurses and the governance team to ensure that the right degree of focus and accountability is in place across all areas. - Clinical Effectiveness: Caesarean section rates continued to be high in May There is an on-going consultant led analysis of the data to understand variation. - Patient experience: The current FFT scoring set the Trust in the lower quartile of London Hospitals not recommended by patients, which is of concern for the Trust. There is a high vacancy factor in some clinical areas affecting overall performance. There is a drive by each Divisional Team to support these areas and to address as a matter of urgency the vacancy factor, as part of the action plan to improve patient experience. There has been an improvement in response rates to formal complaints. - Access and Efficiency: There has been a significant improvement in A&E waiting times and reduction in the number of ambulance handover breaches in May. The Trust continued to achieve the RTT waiting targets. - Workforce: Unplanned staff turnover rates remain high and a senior nurse has been employed full time to focus on recruitment and retention issues for nursing staff.
KEY RISKS	There is a risk to achievement of the challenging C. Diff target in 2015/16

ASSOCIATED:	of 7 cases or less, however the Trust is compliant for the year to date.
FINANCIAL IMPLICATIONS	The Trust reported a £0.5m deficit in May and £2.1m deficit for the year to date, which was £0.4m ahead of plan year to date. CIP delivery was also on target.
QUALITY IMPLICATIONS	As outlined above.
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	Improve patient safety and clinical effectiveness Improve the patient experience Ensure Financial and Environmental Sustainability
DECISION/ ACTION	The Trust Board is asked to note the performance for May 2015.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Performance and Quality Report

Performance to 31st May 2015

At a Glance Performance – May

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Patient Safety Domain

- Hospital Associated VTE: 0
- Harm Free Score: 94.3%
- Cdiff Infections: 0
- Mortality SHMI: 81.1
- Never Events: 0
- Med. Related Safety Incidents: 7.9

Clinical Effectiveness Domain

- Time to Theatre Urgent Surgery: 92.6%
- 12hr consultant assessment: 73.74%
- Dementia Case Finding: 85.0%
- Emergency Re-admissions: 3.02%
- Caesarean Section Rate: 39.0%

Patient Experience Domain

- FFT Local Positive: 89.6%
- Hospital Cancellations: 10.8%
- FFT Response Rate: 29.2%
- Formal Complaints: n/a
- Staff FFT - To receive care: -
- Staff FFT - Place to Work: -

Access & Activity Domain

- A&E Waiting Times: 97.3%
- 18 weeks RTT Admitted: 91.0%
- Choose & Book Slot Issues: 15.2%
- EL & DC Activity: 3487
- DTOCs: 2.51%

Process Efficiency Domain

- Avg Wait New OP Appt: 6.4
- Theatre Conversion rate: 87.9%
- OP Letters sent <7 working days: 63.1%
- Theatre Active Time: 72.8%
- DSUM sent before Disch.: 69.2%

Work Force Domain

- Sickness Rate: 2.95%
- Turnover Rate: 1.72%
- Appraisal Completion: 80.5%
- Vacancy Rate: 12.3%
- Avg Days for Recruitment: 57 days

Finance Domain

- I&E Surplus: £-2.1m
- EBITDA: 3.4%
- CIP Achieved: £0.5m
- COSRR: 2
- Cash: £13.7m

Trust Headlines – 2015

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Monitor Compliance – Apr 2015

Sub Domain	MonthYear	Mar 2015	Apr 2015	May 2015	YTD
Harm	Clostridium difficile infections (Target: < 0.67)	1	1	0	1
	MRSA Bacteraemia (Target: < 0)	0	0	0	0
Cancer	Cancer diagnosis to treatment waiting times - 31 Days (Target: > 96%)	100.0%	100.0%	N/A	100.0%
	Cancer diagnosis to treatment waiting times - Subsequent Surgery (Target: > 94%)	100.0%	N/A	N/A	N/A
	Cancer diagnosis to treatment waiting times - Subsequent Medicine (Target: > 98%)	N/A	100.0%	N/A	100.0%
	Cancer urgent referral GP to treatment waiting times (62 Days) (Target: > 85%)	84.6%	89.7%	N/A	94.0%
	Cancer urgent referral Consultant to treatment waiting times (62 Days) (Target: > 90%)	0.0%	100.0%	N/A	100.0%
	Cancer urgent referral to first outpatient appointment waiting times (2WW) (Target: > 93%)	96.1%	93.4%	N/A	93.4%
RTT	18 week referral to treatment times Admitted Patients (Target: > 90%)	92.8%	90.6%	91.0%	90.8%
	18 week referral to treatment times Non Admitted Patients (Target: > 95%)	95.8%	95.3%	95.5%	95.4%
	18 week RTT incomplete pathways (Target: > 92%)	92.7%	93.0%	92.09%	92.09%
A&E	A&E waiting times (Target: > 98%)	95.8%	95.7%	97.3%	96.5%
LD	Self-certification against compliance with requirements regarding access to healthcare for pe..	Non-Compliant	Non-Compliant	Non-Compliant	Non-Compliant

Self certification against compliance with requirements regarding access to healthcare for people with learning difficulties:

The Trust is currently not fully compliant will all 6 of the learning disabilities indicators, but working to achieve compliance in 2015/16. This is also part of our CQC Action Plan. The main actions to achieve compliance are:

- Launch of a new LD flag in May 2015. Until then, the CSI log is being used.
- Development of easy read information for patients
- LD training program for staff is in place. To be expanded to include obstetric staff and improve training at Clinical Trust Induction
- Improvement of protocols to regularly audit its practices for patients with learning disabilities and to demonstrate the findings, as currently our only audits are of the use of CSI log for LD. Plan to report bi-annually to the Quality committee/CQG.

*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

- All Monitor Compliance indicators were achieved in May, with the exception of compliance with requirements for patients with learning disabilities.
- Improvement in nutritional screening following training and weekly monitoring on wards.
- Significant improvement in A&E waiting times and reduction in the number of ambulance handover breaches, with no patients waiting over 60 minutes in May.
- There has been an improvement in response rates to formal complaints.
- The Trust has achieved it's financial plan in May and is ahead of target with CIP achievement.

Challenges

- Caesarean section rates continued to be high in May There is an ongoing consultant led analysis of the data to understand variation.
- Focus continues to reduce the turnaround times for outpatient letters and discharge summaries, which remain above target for the month and year to date. The Trust has been focussing on reducing the backlog of outpatient letters over the last few months.
- Choose and book slot issues remain high in May, with particular capacity issues in a number of specialties, which are being addressed.
- Unplanned staff turnover rates remain high and a senior nurse has been employed full time to focus on recruitment and retention issues for nursing staff.

Patient Safety

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Sub Domain	Trust Level Monthly Data @ 12/06/2015 XL — Month Year	Mar 2015	Apr 2015	May 2015	YTD XL — YTD
Harm	Incidence of newly acquired category 3 and 4 pressure ulcers (Target: < 3.6)	3	3	1	4
	Safety Thermometer - Harm score (Target: > 90%)	91.7%	93.5%	94.3%	93.9%
	Safety Thermometer - Prevalence of Pressure Ulcers (Rate) (Target: < 3.45%)	7.1%	6.0%	5.7%	5.9%
HCAI	C Diff rate per 100k bed days pts aged >=2 (Target: < 14.7)	8.6	8.8	0.0	4.3
	Clostridium difficile infections (Target: < 0.67)	1	1	0	1
	Hand Hygiene Compliance (trajectory) (Target: > 90%)	97.6%	97.0%	97.4%	97.2%
	Methicillin Sensitive Staphylococcus Aureus Target < 4.3)	0	2	0	2
	E.Coli bloodstream infections Target < 13.0)	0	10	0	10
	MRSA Bacteraemia (Target: = 0)	0	0	0	0
	Screening all elective in-patients for MRSA (Target: > 95%)	97.9%	96.4%	98.7%	97.5%
	Screening Emergency patients for MRSA (Target: > 95%)	97.3%	97.4%	98.3%	97.6%
Incidents	Incident reporting rate per 100 admissions (Target: > 8.50)	7.65	8.78	6.41	7.58
	Inpatient falls per 1000 Inpatient bed-days (Target: < 3.00)	3.17	3.24	2.71	2.97
	Never Events (Target: = 0)	1	0	0	0
	Medication related safety incidents per 1000 admissions Target < 6.8)	6.4	8.4	7.9	8.1
	Rate of patient safety incidents per 100 admissions (Target: < 2.9)	7.31	8.29	6.19	7.23
	Rate of pt. safety incidents resulting in severe harm - death per 100 admissions (Target: = 0.00)	0.00	0.00	0.00	0.00
Mortality	Mortality (HSMR) (2 months in arrears) (trajectory) (Target: < 104)	79.5	79.5	79.5	79.5
	Mortality SHMI *TRUST ONLY* (Target: < 82)	79.5	81.1	81.1	81.1
	Number of In-hospital Deaths (Adults)	35	34	31	65
	Number of in-hospital deaths (Paeds)	0	0	0	0
	Number of in-hospital deaths (Neonatal)	4	7	6	13

Note: The SHMI figure of 81.08 refers to Oct 2013 to Sept 2014 as the most up to date SHMI available. This is in the Lower than expected band meaning it is statistically significantly lower than expected and hence Green.

Prevalence of pressure ulcers:
The incidence of Grade 3 and Grade 4 pressure ulcers remains a high priority for the nursing cabinet. Claire Painter has taken over the chair of the preventing harm group and is working closely with the Tissue Viability Nurse, the divisional nurses and the governance team to ensure that the right degree of focus and accountability is in place across the Trust. This focus is divided into a number of key elements which have been highlighted from serious incidents Root Cause Analyses.

Safe Nursing and Midwifery Staffing

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Ward	Day RN	Day HCA	Night RN	Night HCA
Maternity	79.4%	59.5%	72.3%	54.5%
Annie Zunz	121.8%	133.3%	115.0%	130.0%
Apollo	100.6%	64.5%	100.0%	-
Jupiter	154.8%	17.9%	158.1%	-
Mercury	112.2%	45.2%	107.8%	60.0%
Neptune	99.2%	90.3%	112.9%	83.9%
NICU	98.5%	-	96.1%	-
AAU	98.3%	87.5%	115.7%	123.7%
Nell Gwynn	93.7%	98.8%	100.0%	100.0%
David Erskine	107.4%	178.8%	126.8%	104.6%
Edgar Horne	95.9%	98.4%	100.0%	98.4%
Lord Wigram	98.9%	100.0%	100.0%	100.0%
St Nary Abbots	98.9%	75.0%	100.0%	71.0%
David Evans	96.3%	79.8%	92.8%	93.6%
Chelsea Wing	92.2%	96.8%	100.0%	100.0%
Burns Unit	84.9%	60.7%	87.7%	100.0%
Ron Johnson	98.4%	98.4%	101.6%	100.0%
ICU	99.1%	-	100.0%	-

National Quality Board Report – Hard Truths expectations:

The May fill rate data (table 1) 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.

Trusts are also required to publish this information on their own web sites, a recent survey has revealed that very few Trusts receive enquiries on the back of their fill rate data. The concern from the outset is that data aggregated at this level provides little or no meaning to the public.

Summary for May:

The fill rate position above is a typical picture for each area with excess fill rates generally relating to either additional capacity, AMU and Annie Zunz and one to one care requirements in other areas.

The detailed analysis has not been possible this month due to tighter timescales for reporting and difficulty in collating the information.

The fill rates will be further analysed by the divisional nurses in due course

The team attempted to transition from manual data collection to automated through health roster this month but due to data validation issues this has not been possible. Work continues in this area.

Clinical Effectiveness

Sub Domain	Trust Level Monthly Data @ 12/06/2015 XL	Mar 2015	Apr 2015	May 2015	YTD XL
	MonthYear				YTD
Admitted Care	Elective LoS - Long Stayers (Target: < 40)	67	51	41	92
	Elective Length of Stay (Target: < 3.7)	3.3	3.4	2.7	3.1
	Emergency Care Pathway - Discharges (Target: N/A)	199.1	186.6	185.0	371.6
	Emergency Care Pathway - Length of Stay (Target: < 4.5)	4.61	5.03	5.13	5.08
	Emergency Re-Admissions within 30 days (adult and paed) (Target: < 2.8%)	3.30%	3.01%	3.02%	3.02%
	Non-Elective Long Stayers (Target: < 538)	402	393	410	803
	Non-Elective Length of Stay (Target: < 3.9)	3.9	4.4	4.0	4.2
	VTE Assessment (Target: > 95%)	96.2%	95.9%	95.0%	95.4%
Best Practice	% Patients Nutritionally screened on admission *TRUST ONLY* (Target: > 90%)	89.4%	77.7%	89.8%	83.7%
	% Patients in longer than a week who are nutritionally re-screened *TRUST ONLY* (Target: > 90%)	62.5%	67.6%	84.2%	75.7%
	12 Hour consultant assessment - AAU Admissions (Target: > 90%)	73.97%	79.05%	73.74%	76.35%
	Central line continuing care—compliance with Care bundles (Target: > 90%)	100.0%	94.3%	93.8%	94.1%
	Peripheral line continuing care—compliance with Care bundles (Target: > 90%)	82.0%	81.5%	77.8%	80.1%
	Urinary catheters continuing care—compliance with Care bundles (Target: > 90%)	100.0%	92.6%	95.0%	93.6%
	Fractured Neck of Femur - Time to Theatre < 36 hrs for Medically Fit Patients (Target: = 100%)	80.0%	92.3%	92.9%	92.6%
	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%)	94.2%	94.5%	85.0%	90.0%
	Appropriate referral Dementia specialist diagnosis *TRUST ONLY* (Target: > 90%)	100.0%	100.0%	N/A	N/A
	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%)	87.2%	79.8%	77.9%	79.0%
	Theatre Active Time - % Total of Staffed Time (Target: > 70%)	74.4%	72.3%	72.8%	72.5%
	Time to theatre for urgent surgery (NCEPOD recommendations) (Target: > 95%)	96.1%	94.7%	92.6%	93.5%

Emergency Care Pathway LoS: This target measures the average length of stay for all non-elective (emergency) admissions, excluding obstetric and babies. The performance improved on last month but to highlight again that the Trust continues to have 25 step down beds which look after patients who are medically fit but cannot yet be discharged for various, non medical reasons. These beds have been in place since Q3 and will continue for 15/16, and will affect the performance against this target.

Emergency Re-Admissions within 30 days: This target, which is applied to both adults and paediatrics, has remained unchanged since March. In order to establish more detail, both adult and paediatric areas are needing to audit these re-admissions to establish if there are any cause for concern.

Non-Elective Length of Stay: The Non-elective LOS is slightly higher than the target in May but has improved in month (4.4 to 4.0).

Nutritional Screening: Initial screening has increased from 78% and almost achieved the target of 90%. Rescreening has also improved from 68% to 85%, but remains under the target of 90%. Wards continue to be monitored weekly and ward sisters are notified of performance.

12 hour consultant assessment: Performance has fallen slightly in month. There is a cohort of patients who are short stay on the Acute Assessment Unit overnight (after 8pm) and the Emergency Observation Unit and are all are seen by a middle grade. Key areas identified have been flagged Trust-wide.

Dementia screening: This target has underperformed for the first time since the target was set. Refresher training will be organised for the clinical areas where this screening takes place.

Clinical Effectiveness – Maternity

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

	Indicator	Measure	Target	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD Total
Activity in Month	NHS Deliveries	Benchmarked to 5042 per annum	416	422	412	433	462	464	427	432	463	398	416	412	468	5,146
	Private Deliveries	Benchmarked to 840 per annum	72 per month	71	73	63	70	71	53	60	85	50	69	69	71	810
	Trust Deliveries	Total Maternities (Mother)		493	485	496	532	535	480	492	548	448	485	481	539	6,495
	Total NHS Births (infants)			428	424	443	471	474	445	442	478	406	431	421	479	5,759
	Births	Birth Centre (excludes transfers)	No. of patients	79	65	65	65	59	64	48	66	47	45	38	53	761
		BC maternities rate of Trust total SVD	%	36.1%	30.2%	30.5%	28.3%	28.8%	28.2%	24.7%	28.1%	25.1%	22.0%	20.8%	25.5%	
		Home births - rate of NHS maternities	% NHS Dels	1.2%	0.7%	0.5%	0.9%	0.6%	0.2%	1.6%	0.6%	1.3%	0.5%	1.0%	0.2%	
	Norm. Vaginal Deliveries	SVD (Normal Vaginal Delivery)	No. of patients	219	215	213	230	205	227	194	235	187	205	183	208	2,733
		Maintain normal SVD rate	52%	51.9%	52.2%	49.2%	49.8%	44.2%	53.2%	44.9%	50.8%	47.0%	49.3%	44.4%	44.4%	
	C- Section	Total C/S rate overall	<27%	28.4%	28.9%	31.6%	30.1%	33.2%	27.9%	35.0%	31.5%	30.4%	30.5%	39.1%	39%	
		Emergency C Sections	No. of patients	66	64	85	77	69	58	77	84	64	56	84	103	953
			<12%	15.6%	15.5%	19.6%	16.7%	14.9%	13.6%	17.8%	18.1%	16.1%	13.5%	20.4%	22.0%	
		Elective C Sections	No. of patients	54	55	52	62	85	61	74	62	59	71	77	77	854
			<15%	12.8%	13.3%	12.0%	13.4%	18.3%	14.3%	17.1%	13.4%	14.8%	17.1%	18.7%	16.5%	
	Assisted Deliveries	Ventouse, Forceps Kiwi	No. of patients	83	78	83	93	105	81	87	82	88	84	68	80	1,074
			10-15% (SD)	19.7%	18.9%	19.2%	20.1%	22.6%	19.0%	20.1%	17.7%	22.1%	20.2%	16.5%	17.1%	
	Total CS Rate Based on Coded Spells		<27%	29.2%	29.2%	31.9%	31.2%	32.7%	27.9%	34.2%	31.5%	30.7%	30.5%	39.1%	39%	
Clinical Indicators	PP Heamorrage	Blood loss >2000mls	<10	5	11	7	8	9	4	6	8	4	7	8	2	80
		Blood loss >4000mls	No. of patients	0	1	0	0	2	0	0	1	1	1	1	1	
	Perineum	3rd/4th degree tears		9	6	8	8	18	12	13	14	10	10	4	11	133
			<5% (RCOG)	3.0%	2.0%	2.7%	2.5%	5.8%	3.9%	4.6%	4.4%	3.6%	3.5%	1.6%	3.8%	
	Stillbirths	Number of Stillbirths		4	1	4	3	3	2	1	3	2	3	4	4	36
	Sepsis	GBS - NHS maternities		35	30	23	33	27	26	36	32	27	17	26	43	386
		Pyrexia in labour	≥38°C	12	4	13	16	12	9	5	11	13	12	26	20	169
	Readmissions	Neonatal < 28 days of Birth (Feeding)		2	7	7	2	3	8	1	5	n/a	8	10	10	68
		Of which were born at C&W		4	7	6	2	3	6	1	3	n/a	6	10	10	63
PbR	Pathways	Antenatal Bookings completed	509	492	524	476	471	498	495	430	465	431	486	494	537	5,801
		Ref by 11w		383	406	356	341	354	361	306	327	321	356	329	376	4,593
		% Ref by 11w		78%	77%	75%	72%	71%	73%	71%	70%	75%	73%	67%	70%	
		KPI: % Ref by 11w and seen by 12+6w	95%	95.8%	97.3%	95.8%	96.8%	95.2%	96.4%	95.4%	91.1%	90.3%	94.1%	90.9%	91.8%	
		Breaches (11w ref and booked > 12+6w		16	11	15	11	17	13	14	29	31	21	30	31	270
		Postnatal discharges	221	238	228	249	223	235	254	242	236	255	204	236	n/a	2,814
Risk	Maternal Morbidity	Maternal Death	Incident Form	0	0	0	0	0	1	0	0	0	0	0	0	1
		ITU Admissions in Obstetrics	In 2 mths < 6	0	1	1	0	1	1	1	0		1	0	0	7
	Serious Incidents	Serious Incidents (Orange Incidents)	0	2	3	1	4	3	3	4	3	3	4	1	7	14
	VTE	Assessments	95%	97.6%	96.5%	97.2%	96.3%	98.6%	97.2%	96.3%	97.2%	94.7%	96.1%	95.1%	95.3%	
KPI	Trust Level Indicators	NBBS - offered and discussed	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
		Maternity Unit Closures	LSA Db	0	0	0	1	0	0	0	0	0	0	0	1	1
		1:1 care	100%	96.5%	93.6%	93.4%	93.0%	97.9%	98.4%	94.4%	96.5%	95.6%	96.0%	96.7%	93.1%	
		Breastfeeding initiation rate	90%	93.4%	89.8%	88.5%	89.8%	88.8%	89.7%	90.3%	88.8%	87.4%	88.1%	86.2%	87.4%	
		Women smoking at time of delivery	<10%	0.9%	1.5%	1.4%	1.7%	0.9%	2.1%	1.6%	1.3%	2.3%	1.4%	0.7%	2.6%	
		Midwife to birth ratio - Births per WTE	1:30	1:31	1:33	1:32	1:36	1:37	1:30	1:34	1:36	1:28	1:30	1:31	1:38	
		DSUMs complete & sent in 24hrs	80%	50.5%	50.0%	59.8%	69.5%	54.4%	67.0%	61.2%	67.4%	54.3%	64.3%	40.9%	22.1%	

Trust deliveries: There were an exceptionally high number of NHS deliveries in May (468, >8% above plan). There was a single reportable unit closure due to a combination of sustained high activity with acute complexity over several days. The divert to maintain clinical safety, was taken after all other options had been exhausted and was for the minimum time possible. 3 women were diverted to other units, all have been contacted directly by the Head of Midwifery.

Caesarean section rate: the overall caesarean section rate for May saw a slight reduction from April's peak but remains high. There is an ongoing consultant led analysis of the data to understand variation. We have also commissioned improvement to local reporting to facilitate detailed and timely statistical analysis to support these audits. Through the Maternity board meeting and our WMUH clinical meetings we have asked senior clinicians from WMUH to carry out an review of the pathways of care from booking through to delivery providing an external overview and analysis.

Midwifery Led Unit: May saw Birth Centre deliveries increase by 39% from April to 58. The unit has had over 1,000 births since opening: Normal birth rate: 85%, Transfer rate: 38%

Bookings: antenatal clinic saw the highest number of bookings appointments since July 2014. 12+6 KPI compliance continues to be below the 95% target – an ongoing audit of women breeching this target is underway. Capacity is continually reviewed and additional clinics have been flexibly delivered. New community hubs open mid-June to service SaHF boundary growth into Chiswick and H&F areas, initially delivering postnatal care.

Breastfeeding initiation rate: there is a rolling audit, in line with UNICEF Baby Friendly standards. In addition ongoing work is looking to improve data quality.

Patient Experience

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Sub Domain	Trust Level Monthly Data @ 12/06/2015 XL				YTD XL
	MonthYear	Mar 2015	Apr 2015	May 2015	YTD
Complaints	Breach of Same Sex Accommodation *TRUST ONLY* (Target: = 0)	0	0	0	0
	Complaints (Type 1 and 2) - Communication (Target: < 13)	23	27	28	55
	Complaints (Type 1 and 2) - Discharge (Target: < 2)	3	3	2	5
	Complaints (Type 1 and 2) - Attitude / Behaviour (Target: < 16)	15	18	13	31
	Complaints Re-opened (Target: < 5%)	2.70%	4.17%	N/A	2.17%
	Complaints upheld by the Ombudsman *TRUST ONLY* (Target: = 0)	0	0	0	0
	Formal complaints responded in 25 working days (Target: = 100%)	81.08%	87.50%	N/A	65.22%
	Total Formal Complaints	37	24	22	46
Friends & Family	Friends & Family Test - A&E response rate (Target: > 20%)	27.6%	35.2%	23.1%	27.7%
	Friends & Family Test - Inpatients response rate (Target: > 30%)	40.2%	41.3%	41.3%	41.3%
	Friends & Family Test - Local +ve score (Trust) (Target: > 90%)	89.4%	88.5%	89.6%	89.1%
	Friends & Family Test - Net promoter score (Target: > 62)	60.0	62.3	64.8	63.6
	Friends & Family Test - Total response rate (Target: > 30%)	31.3%	38.0%	29.2%	33.0%

Complaints:

This month, the performance against the Trust target that 90% of type two complaints should receive a response within 25 working days is 88%, which is an improvement on previous months.

All areas achieved 100% apart from Women's services which achieved 40%. Five complaints were received by the Directorate; the performance and total numbers for each area is as follows:

- Gynaecology 2 complaints 50%
- Private Maternity 1 complaint 0%
- Private ACU 1 complaint 100%
- ACU 1 complaint 0%

Note: Formal complaints responded to within 25 days and Complaints reopened are reported a month in arrears due to their nature, commentary relates to previous month .

Friends and Family Test:

The current FFT scoring set the Trust in the lower quartile of London Hospitals not recommended by patients, which is of concern for the Trust. Some of the lower scoring reflects the low response rate from some clinical areas including; day cases, some wards and paediatrics who recently engaged with FFT. Each clinical area is expected to respond to the concerns raised and to highlight good practice but this is not happening on a consistent basis. Some recurring trends emerging from FFT findings reflect similar trends from the Picker Inpatient Survey, Complaints and PALs highlighting poor communication, lack of or conflicting information, waiting times, poor staff attitude and behaviour.

The reports show that some clinical areas have a very low response rate and some of these clinical areas have the highest percentage of respondents saying they would not recommend the hospital. Some of these clinical areas have already been highlighted as of concern from some of our monthly reporting including staffing and our safety thermometer. There is a high vacancy factor in these clinical areas affecting overall performance. There is a drive by each Divisional Team to support these areas and to address as a matter of urgency the vacancy factor. The Trust has appointed a Recruitment and Retention Lead Nurse and has recently appointed 35 nurses. These clinical areas have also been targeted and offered support by the patient experience team through the Sisters/Charge Nurses, Matrons and Divisional Leads.

The manger leading on FFT went on maternity leave in quarter three last year leaving a gap in service. This partially lead to a loss of focus in ensuring that the response rate to FFT was improved and actions taken by the Divisions to address patients' positive comments and concerns were undertaken and reviewed. The Trust now has an acting Lead for FFT - PALS Manager, who is supported by the Patient Experience lead and Assistant Chief Nurse.

There is an action plan in place and all Divisions and Senior Nurses have been contacted and told to take a lead on addressing the concerns in their areas of practice focussing on the themes coming through.

Access and Efficiency (1)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Sub Domain	Trust Level Monthly Data @ 12/06/2015 XL				YTD XL
	MonthYear	Mar 2015	Apr 2015	May 2015	YTD
A&E	A&E Time to Treatment (Target: < 60)	01:09	01:02	01:00	01:01
	A&E waiting times (Target: > 98%)	95.8%	95.7%	97.3%	96.5%
	A&E: Unplanned Re-attendances (Target: < 5%)	6.81%	6.73%	6.84%	6.79%
	LAS Patient Handover Times - 30 mins (KPI2) *TRUST ONLY* (Target: < 0)	56	50	32	82
	LAS arrival to handover more than 60mins (KPI 3) *TRUST ONLY* (Target: < 0)	5	1	0	1
OP	Average Wait – Referral to First Attendance (Weeks) (Target: < 6 weeks)	6.1	6.1	6.4	6.2
	Choose and Book slot issue % *TRUST ONLY* (Target: < 2.0%)	14.1%	8.0%	15.2%	11.4%
	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%)	92.8%	90.6%	91.0%	90.8%
	18 week referral to treatment times Non Admitted Patients (Target: > 95%)	95.8%	95.3%	95.5%	95.4%
	18 week RTT incomplete pathways (Target: > 92%)	92.7%	93.0%	92.09%	92.09%
	RTT Incomplete 52 Wk Patients @ Month End (Target: = 0)	2	1	1	2
IP	Average Wait – Decision to admit to Admission (Weeks) (Target: < 6 weeks)	8.6	7.8	7.4	7.6

A&E Performance: The national ED waiting times standard of >95% has been maintained for April and May and there has been a significant improvement in May, with 97.3% achieved.

LAS: The Trust is reporting 32 LAS delays for 30 minutes and no 60 minute delays this month.

Average Wait – Referral to First Attendance & Average Wait – Decision to admit to Admission:

Both targets are marginally behind the required performance. Significant work is being carried out to improve the overall Referral To Treatment (RTT) process. The Trust's Access Group Meeting is to be reconfigured to support the implementation of good waiting list management governance and redirect operational focus to provide grip and assurance around sustainable RTT delivery.

Choose and Book Slot Issues: The Trust's Access Group is looking at ways to address the Choose & Book (C&B) target for <2%, including availability of clinics to C&B, and general capacity (e.g. Gastro and C&W Dermatology). Available slot issues in Community Dermatology (approx. 20% of May's total) will not impact on the target for June, as these services have transferred to Imperial.

RTT Incomplete 52 week breach: The 52 week breach in April related to a Gynaecology patient. The breach was identified in April following communication from the patient's GP that a date for surgery had not been made.

The patient breached their 52 week date in January 2015. The patient has been contacted and booked for attendance in the Gynaecology outpatient clinic for review. Theatre capacity had been identified in April and May, however the patient had indicated a preference for treatment in June.

Cancer Waiting Times – Deep dive

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Sub Domain	Trust Level Monthly Data @ 12/06/2015 XL				YTD XL
	MonthYear	Mar 2015	Apr 2015	May 2015	YTD
Cancer	Cancer Consultant Upgrade (Target: ≥ 85%)	0.0%	100.0%	N/A	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%)	N/A	100.0%	N/A	100.0%
	Cancer diagnosis to treatment waiting times - Subsequent Surgery (Target: ≥ 94%)	100.0%	N/A	N/A	N/A
	Cancer urgent referral Consultant to treatment waiting times (62 Days) (Target: ≥ 90%)	0.0%	100.0%	N/A	100.0%
	Cancer urgent referral GP to treatment waiting times (62 Days) (Target: ≥ 85%)	84.6%	89.7%	100.0%	94.0%
	Cancer urgent referral to first outpatient appointment waiting times (2WW) (Target: ≥ 93%)	96.11%	93.42%	93.31%	93.36%

Cancer Performance: The Trust met all cancer targets in April (nb: these targets are reported one month in arrears.)
There is capacity pressure in the area of two week waits and so work is underway to feedback to GPs about the appropriateness of referrals using the two week wait pathway).

Access and Efficiency (2)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Sub Domain	Trust Level Monthly Data @ 12/06/2015 XL				YTD XL
	MonthYear	Mar 2015	Apr 2015	May 2015	YTD
Admitted	Delayed transfers - Patients affected *TRUST ONLY* (Target: < 2.00%)	3.97%	3.74%	2.51%	3.11%
	Delayed transfers of care days lost (Target: < 644)	461	451	436	887
DQ	Coding Levels complete - 7 days from month end (Target: > 95%)	96.3%	98.9%	98.7%	98.8%
	Total NHS Number compliance (Target: > 98%)	96.8%	96.8%	96.6%	96.7%
GP Real Time	Discharge Summaries Sent < 24 hours (Target: > 70%)	82.6%	81.1%	80.8%	81.0%
	Discharge Summaries Sent In Real Time (Target: > 80%)	70.3%	68.3%	69.2%	68.8%
	GP notification of an A&E-UCC attendance < 24 hours (Target: > 70%)	97.22%	99.93%	99.95%	99.94%
	GP notification of an emergency admission within 24 hours of admission (Target: >)	98.34%	99.82%	99.92%	99.87%
	GP Notification of discharge planning within 48 hours for patients >75 (Target: > 70%)	63.90%	66.22%	63.84%	65.03%
Outpatients	OP Letters Sent < 7 Working Days (Target: > 70%)	64.8%	61.2%	63.1%	62.1%
	Average PICs per patient (Target: < 0.64)	0.58	0.59	0.59	0.59
	DNA Rate (Target: <11.1%)	12.7%	11.2%	11.7%	11.4%
	First to Follow-up ratio (Target: < 1.5)	1.54	1.64	1.48	1.56
	Hospital cancellations \ reschedules of outpatient appointments % of total attendances (Target: < 8.00%)	10.9%	10.6%	10.8%	10.7%
	Hospital cancellations made with less than 6 Weeks Notice (Target: < 3%)	5.8%	5.7%	5.5%	5.6%
	Patient cancellations \ reschedules of outpatient appointments % of total attendances (Target: < 8%)	8.9%	9.0%	9.2%	9.1%
Theatres	No urgent op cancelled twice (Target: = 0)	0	0	0	0
	On the day cancellations not rebooked within 28 days (Target: = 0)	5	0	0	4
	On the day cancelled operations (non clinical) % total elective admissions (Target: < 0.80%)	0.40%	0.40%	0.41%	0.40%
	Theatre booking conversion rate (Target: > 80%)	88.5%	88.5%	87.9%	88.2%

Delayed Transfers – Patients Affected: There has been significant improvement in month, with a reduction in patients waiting for continuing care assessments and complex placements.

Discharge Summaries sent in real time: The Discharge Summaries sent in 'real time' target has been complicated by some process issues regarding the actual dispatching of the discharge summaries from the Trust PAS system. This is being addressed

GP Notification of Discharge planning within 48 Hours for patient >75: This target is consistently underperforming so work is underway to investigate how to provide faster communication to GPs via use of the GP portal.

OP Letters Sent < 7 Working Days: The Medicine directorate has put in place escalation arrangements to ensure that the teams meet the 5 day letter turnaround. This can be challenging for part-time staff, but mitigations are in place to expedite arrangements where possible.

Mandatory Training

Division	Total	Corporate Division	Emergency & Integrated Care Division	Planned Care Division	Womens, Childrens and Sexual Health Division
Fire	69%	80%	67%	71%	65%
Moving & Handling	74%	77%	72%	74%	75%
Safeguarding Adults Level 1	100%	100%	100%	100%	100%
Equality & Diversity	85%	83%	90%	87%	82%
Information Governance	72%	84%	69%	77%	66%
Hand Hygiene	75%	76%	76%	74%	74%
Health & Safety	86%	85%	84%	86%	87%
Child Protection Level 1	100%	100%	100%	100%	100%
Basic Life Support	71%	85%	70%	68%	73%
Safeguarding Children Level 2	81%	93%	81%	80%	80%
Safeguarding Children Level 3	73%	N/A	80%	68%	72%
Conflict Resolution	31%	N/A	29%	36%	29%
Mandatory Training Compliance %	76%	86%	77%	77%	75%

Mandatory training compliance currently stands at 76% which is 1% above the average for London teaching hospital trusts.
As agreed at the People and OD Committee, mandatory training compliance is now being reported against the 10 core topics identified in the UK Core Skills Training Framework which enables comparisons with other trusts.

A fundamental review of statutory and mandatory training has been carried out and workstreams initiated to improve on:

- IT systems and reporting
- Clarification of learning requirements
- Improving communications
- Cultural change and accountability

Compliance rates continue to improve with increases this month in Fire, Moving and Handling, Information Governance, Hand Hygiene and Basic Life Support. The largest improvement this month (a 7% increase) is in Conflict Resolution. Local induction is also improving significantly and returns are now coming back from the divisions at a rate of 15-20 per day which will enable us to have a fuller picture of this for the next Board report.
Progress across the topics which were of particular concerns at the February Board is as follows:

- Fire: Up 8% (from 61%)
- Information Governance: Up 17% (from 55%)
- Local Induction: Up 12% (from 34%) with further data still to be uploaded

Substantial work this month has been done with the senior nursing and other divisional teams to clarify the training requirements for staff to ensure that requirements for training match role specific requirements rather than generic requirements which will increase the relevance of the training, improve compliance, and reduce time away from front-line activities. The impact of this on compliance rates should be clearer next month once the reporting systems have been updated.

Workforce

Workforce Metric	May-15	Monthly Target	2014/15 Outturn 10	2015/16 Annual Target11	Average 12 Month Rolling YTD12
Turnover Rate1	19.87% (1.72%)	(1.38%)	19.12%	16.50%	-
Vacancies - Budgeted2	12.26%	12%	10.94%	8%	11.26%
Vacancies - Active3	3.95%	-	4.45%	-	4.41%
Time to Recruit4	57 days	<55 days	54.5 days	<55 days	55 days
Sickness Rate5	2.95%	3%	2.85%	3%	2.92%
Agency % of WTE6	4.50%	3.15%	3.50%	3.15%	3.70%
Appraisals - Non M&D7	75%	76%	72%	85%	71%
Appraisals - M&D8	86%	83%	79%	85%	80%
Mandatory Training9	79%	77%	78%	95%	78%

1. Turnover Voluntary resignations over the most recent 12 months / average headcount over the most recent 12 months. The figure quoted in brackets relates to the number of voluntary resignations in month / headcount in month (excluding junior doctors)
2. Vacancies – Budgeted (Budget WTE - Inpost WTE) / Budget WTE
3. Vacancies – Active The WTE of posts actively recruited to on NHS Jobs in month / Budget WTE
4. Time to Recruit For new starters in month, the average amount of days between authorisation and pre-employment checks completed
5. Sickness Rate WTE days lost to sickness absence / Total WTE available days
6. Agency % of WTE's Agency WTE / (Substantive WTE + Bank WTE + Agency WTE)
7. Appraisals – Non M&D % of non M&D staff with an appraisal that is not overdue
8. Appraisals – M&D % of consultant and SAS grade Drs with an appraisal that is not overdue
9. Mandatory Training % of staff that have completed relevant mandatory training topics within the refresher period
10. 2014/15 Outturn The mean of the 12 months indicators of 2014/15
11. 2015/16 Annual Target Targets as agreed at the People and OD Committee to be achieved by the close of 2015/16 financial year
12. Average 12 Month Rolling YTD Average of the most recent 12 months data e.g. Jan-Dec
Red – below/worse than both monthly target and 2014/15 outturn
Amber – below/worse than either monthly target or 2014/15 outturn
Green – above/better than monthly target and 2014/15 outturn

Turnover: Unplanned staff turnover over the last 12 months increased by 3.37% on the same period in the previous year, from 16.50% (June 13 - May 14) to 19.87% (June 14 - May 15). This is largely due to a significant spike in voluntary resignations in Q2 of 2014/15 which means that the Trust's cumulative turnover rate will remain high until early Q3 of 2015/16 even if normal levels of leavers ensue in Q1 & Q2 of 2015/16. A more 'real-time' indicator of turnover is that of voluntary resignations within the most recent month as a % of total headcount for the month (excluding junior doctors.) In the month of May there were 52 voluntary resignations which equates to 1.72% of the total workforce (17 higher than the same period last year). Over the last three months the Trust has seen 145 voluntary leavers and 181 new starters (excluding jnr. docs). An update on Retention Plans was taken to the May People and OD Committee, detailing further analysis on turnover and key initiatives and proposals for improvement. A senior nurse has been employed full time to work on recruitment and retention issues for nursing. The main leaving reasons stated for staff include 'Other/Not Known', 'Promotion' and 'Relocation'.

Bank & Agency Usage: The temporary staffing WTE's for May 15 were 70.89 WTE higher than the same period last year, with Bank showing an increase of 18.09 WTE and Agency showing an increase of 52.79 WTE. As a proportion to substantive WTE, the highest agency use was in Medicine and Intensive Care. The largest actual increases in agency WTE's were in Medicine (21.33 WTE), Maternity (10.59 WTE) and Intensive Care (8.95 WTE). Recruitment drives in these areas in recent months have taken place to fill gaps in their establishment, and lessen their reliance on agency staffing. Increased temporary staffing usage was caused in part by the nursing establishments increasing and temporary staff being used to fill the additional posts while the Trust recruits substantively to them.

Temporary staffing made up 13.9% of the overall workforce in May 15 compared to 12.1% in 2014. Of this, agency WTE as a % of workforce increased from 3.1% in May 14 to 4.5% in May 15. The need to reduce agency spend is recognised as a priority and the Trust have a specific CIP scheme relating to temporary staffing to tackle this issue. The Nursing Temporary Staffing Challenge Board was set up in March 15 to scrutinise requests for nursing and Admin agency staff, and a further Medical Temporary Staffing Challenge Board was set up in April to scrutinise medical requests.

Vacancies: The overall Trust vacancy rate for May 15 was 12.26%, an increase of 1.12% on last year and 0.26% above the monthly target set for May 15. 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 May 15. Bulk recruitment has taken place in Nursing (Medical Wards & ICU), along with multiple medical and administrative posts in A&E and Surgery.
26 Healthcare assistants were offered posts as a result of a recruitment day held at the Trust's Open Day.
The average time to recruit (between the authorisation date and the date that all pre-employment checks were completed) for May 15 starters was 57 days which is marginally above the Trust target of <55days.

Staff in Post: In May 15 the Trust substantive staff in post position was 3045.12 WTE (whole time equivalents), a small decrease of 1.15 WTE (0.04%) since May 14. There were 52 voluntary leavers and 52 joiners (excluding jnr. Docs) over the month.

Finance Balanced Scorecard

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Financial Performance

Financial Position (£000's)

	Full Year Plan	Plan to Date	Actual to Date	Variance to Date
Income	(377,021)	(62,045)	(62,497)	452
Expenditure	359,336	60,360	60,378	(18)
EBITDA	(17,685)	(1,685)	(2,119)	434
EBITDA %	4.7%	2.7%	3.4%	0.7%
Surplus/(Deficit) from Operations	**17,685**	**1,685**	**2,119**	**434**
Interest/Other Non OPEX	811	135	132	3
Depreciation	12,951	2,158	2,170	(11)
PDC Dividends	11,421	1,903	1,919	(15)
Surplus/(Deficit)	**(7,498)**	**(2,512)**	**(2,102)**	**410**

Comments

The month 2 position is a deficit of £0.5m, which brings the year to date position to a deficit of £2.1m (EBITDA of 3.4%). This is a £0.4m faourable variance against the year to date plan of £2.5m.

The Trust achieved the CIP target in month 2 and achieved a COSR rating of 2.

Risk Rating (year to date)

COSR Rating	Weighting	M2 Planned Rating	M2 Actual Rating
Capital Servicing Capactity	50%	1	1
Liquidity	50%	3	3
Total Rating		**2**	**2**

Comments

The Trust recorded a Continuity of Service Rating (COSR) of 2 in April compared to a plan of 2. The capital service cover rating is a 1 (against a planned 2) and the liquidity rating is a 3 (against a planned 3).

Cost Improvement Programme

Risk Rating	PID (£'000)	Identified (£'000) Year 1	Year 2	Add. Year 2	Total	Month 2 Performance Plan	Actual	Var
High	1 - Outpatient CIP	1,000	1,500	1,500	4,000	0	0	0
Medium	2 - LOS	250	250	0	500	23	18	(5)
High	3 - Theatre productivity	600	600	600	1,800	0	0	0
Low	4 - Diagnostic Services	50	50	0	100	3	1	(2)
Medium	5 - Clinical Admin	100	350	0	450	8	18	9
Medium	6 - Temporary Staffing	820	480	1,200	2,500	50	53	3
	6a - Pay controls	0	0			0	271	271
High	7 - Medical Staff Productivity	0	0	0	0	0	0	0
Low	8 - Management Structure	100	300	0	400	0	0	0
Medium	9 - Corporate Services and Back Office	364	536	0	900	0	0	0
Medium	10 - Estates	1,000	1,596	0	2,596	83	77	(6)
Medium	11 - Procurement	1,557	2,040	0	3,596	28	24	(4)
Low	12 - Pharmacy Led Savings	3,662	130	0	3,792	148	18	(130)
High	13 - Divisional Savings	419	353	200	972	26	23	(3)
Low	14 - FYE	168	0	0	168	14	14	0
	15 - Specialist Nurses	35	0	0	35	6	6	(0)
	Total	10,124	8,185	3,500	21,809	389	522	133

Comments

The CIP achievement in month 2 was £0.5m against the target of £0.4m. The over-performance was primarily in pay costs relating to the clinical admin and temporary staffing CIP schemes which have offset the slippage in the pharmacy outsourcing CIP scheme, which was delayed due to issues with signing the lease, however went live in June 2015.

Key Financial Issues

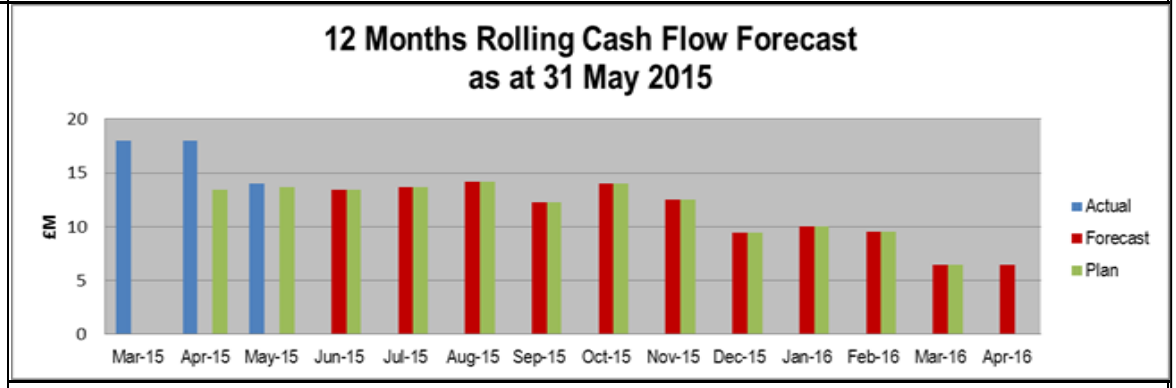
Performance against plan

The Trust delivered a deficit of £2.1m for the year to 31st May 2015, compared to a plan of £2.5m. The key drivers are:

- Clinical income has increased by £0.8m against last month, and is £0.3m favourable against the May plan
- Private patient income has improved by £0.3m against last month, due to higher volume of hip/ knee replacements but adverse against plan by £0.3m.
- Pay has increased by £0.1m against last month's run-rate mainly as a result of increased RMN usage. However pay costs remain underspent by £0.4m in month 2.
- Non pay has increased by £0.3m primarily related to increased clinical supplies expenditure and slippage on the pharmacy outsourcing CIP scheme.

The key risks to delivery of the plan are:
- achievement of the CIP target
- delivery of the increased private patient income plan
- control of pay and non-pay expenditure

Cash Flow



Comments

The cash position at 31st May 2015 was £13.7m. This is a deterioration from April, but is in line with the planned cash position of £13.7m. The cash forecast for March 2016 is £6.5m.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 25 June 2015

PUBLIC

AGENDA ITEM NO.	10/Jun/15
REPORT NAME	Monitor Self-Certifications
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Thomas Lafferty, FT Secretary
PURPOSE	To present to the Board of Directors Monitor self-certification declarations.
SUMMARY OF REPORT	As part of the Annual Planning process NHS Foundation Trusts are required to make declarations to Monitor around the systems in place for compliance with provider licence conditions and on its Corporate Governance Statement. The declarations are required to be submitted to Monitor which require the Board's consideration and certification. The attached Appendix 1 presents the evidence generated to support the Trusts self-declaration against the Corporate Governance Statement. The attached Appendix 2 presents the evidence generated to support the Trust's self-declaration against the statement against the general condition 6 of the NHS Provider Licence.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	All
DECISION/ ACTION	For review and approval of self-certification to Monitor by 30 June 2015.

Appendix 1

Corporate Governance Statement from the Board of Chelsea and Westminster for Monitor Annual Plan 2015

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

Corporate Governance Statement

1. The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

   Confirmed

   Assurance: The Trust's Annual Governance Statement outlines the main arrangements in place to ensure the Trust applies the principles, systems and standards of good governance.

   The Trust's new Constitution, outlining the Trust's underpinning corporate governance framework, has recently been signed off by the Trust's constitutional legal advisors.

   The Trust also complies in full with the Monitor Code of Governance.

   In 2014/15, the Trust's Board composition and Committee structure have both been significantly refreshed to further strengthen these arrangements.

   No corporate governance risks have been identified as a result of the Trust's internal or external audit programmes in year.

   Risk: There are no known risks to compliance with this area.

2. The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time.

   Confirmed

   Assurance: Compliance with the Monitor Code of Governance compliance is considered as part of Annual Report sign–off process and, as above, the Trust has assessed itself as fully complying with the Code.

   The Trust ensures all other guidance issued by Monitor is received, noted and where necessary acted upon by the appropriate Executive Director within the Trust. In particular, the Trust adheres to Monitor's Risk Assessment Framework and, within the last 12 months, has been obliged to conform to Monitor's Transaction guidance.

   Risk: There are no known risks to compliance with this area.

3. The Board is satisfied that the Trust implements:

   (a) Effective board and committee structures;
   (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
   (c) Clear reporting lines and accountabilities throughout its organisation.

   Confirmed

   Assurance: The Board revised its committee structure in January 2015 under new Terms of Reference which has strengthened the level of scrutiny and decision making on important matters of the Board business.

   As part of routine business, Board Committee Terms of Reference are reviewed annually to ensure the effective performance of the Board.

In March 2015, the Board signed-off an updated corporate meetings' organogram which reflects the incorporation of meetings currently held by West Middlesex University Hospital NHS Trust. This organogram provides for clear reporting line/accountabilities throughout the organisation.

In terms of personnel, the Trust will in June 2015 fully sign-off its 'Tiered' personal structure for Day 1 post-acquisition which will, again, clearly outline accountabilities throughout the organisation.

Risk: There are no known risks to compliance with this area.

4. The Board is satisfied that the Trust effectively implements systems and/or processes:

(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;
(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
(h) To ensure compliance with all applicable legal requirements.

Confirmed

Assurance: The Board has established a Finance & Investment Committee (FIC) that is specifically charged with ensuring that the Trust operates in an economic and efficient manner through the holding to account of Executive Directors and Divisional Leads for delivery against agreed I&E positions and CIP targets.

The Board itself reviews financial and operational performance at each meeting through the Performance & Quality Report, with a more detailed financial view being provided by the Finance Reports which the Board reviews as a standing item on its Private agenda.

As referenced below with regard to the Board's oversight of quality, the Board and the Board Quality Committee regularly review the Trust's compliance against the CQC standards. To complement this regular item, a CQC-Style Independent Peer Review was undertaken in April 2015 which showed the Trust, overall, to have improved its level of CQC compliance since the July 2014 CQC inspection.

The Board Audit Committee oversees the output of all audits undertaken by the Trust internal and external auditors, reporting any risks identified to the Board accordingly.

Risk itself is considered, reviewed and managed through the Risk Assurance Framework (RAF), a new risk process introduced in March 2015 which significantly improves the robustness and comprehensiveness of the Trust's systems of risk management.

Risk: The Trust recognises the deterioration of the Trust's financial position in 2014/15 increases the risk to its longer-term viability. This risk has been exacerbated by changes in the national tariff which adversely affects the Trust due to its portfolio of services. The economies of scale brought about through the WMUH acquisition will mitigate this risk; with the LTFM projecting the post-acquisition Trust to be achieving a COSRR of '3' by the end of 2016/17.

5. The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;
(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
(f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

Confirmed

Assurance: The Board has identified clear roles with accountability for leadership of quality issues. The board scrutinises quality at each Board meeting through:

- Performance & Quality Report (which provides comprehensive and up-to-date information on the quality of care);
- Serious Incidents Report;
- Patient Experience Narrative (where patients or carers are invited to present);
- CQC Compliance Updates.

Moreover, there is a dedicated Committee of the Board, the Quality Committee, focused upon gaining assurance in terms of patient safety, patient experience, clinical effectiveness and health and safety. The Quality Committee also takes into account the views of Public/Patient Governors who act as representatives of the patients of the Trust.

The Council of Governors itself has a dedicated Quality Sub-Committee which helps to ensure that the views of all stakeholders are considered when developing positive quality initiatives, such as the Quality Strategy. Linked to the Strategy is the Quality Accounts, a document which the Trust directly engages with local Health Overview & Scrutiny Committees, Local Healthwatch Organisations and the Council of Governors with regard to.

The Trust actively participates with the local CCGs on these matters through the clinical quality group. We encourage and use direct patient feedback through multiple formal and informal mechanisms. Formal mechanisms include regular use of friends and family data, complaints themes and positive feedback. Informally we encourage and act upon any feedback to any member of staff, governor or volunteer. In addition there are direct routes in which and staff can raise risks and concerns other than by formal committee route or structures. The Trust also uses its CQUIN portfolio to demonstrate accountability and how quality issues are raised to the Board and to the Commissioners.

The Board uses Quality Impact Assessments (QIAs) when exercising decision-making relating to CIPs or service strategies to ensure that any development or financial initiative will not have an adverse impact upon quality issues.

Risk: The Trust recognises that the CQC identified care shortfalls in its 2014 inspection and that this identified risks to the quality of care provided by the Trust. In response, a robust and comprehensive CQC Action Plan is in place. An external review undertaken in May 2015 concluded that the Trust had addressed each shortfall originally highlighted by the CQC; although the standard of clinical documentation and aspects of the emergency care physical environment still need to improve. There are detailed plans in place to address both (e.g. EPR, A&E refurbishment).

In addition, the Board realised a risk in 2014/15 relating to the reporting of the RTT 18 weeks calculation. A plan of how the Trust would look to improve the accuracy of reporting of performance data was considered by the Board at its March 2015 meeting.

For governance, that:

6. The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

Confirmed
Assurance: A Board skills gap assessment was undertaken in 2014/15 which highlighted the key areas to address in terms of the expertise of Board personnel. These 'gaps' were covered by the appointments made during the year, particularly in terms of the appointment of several Non-Executive Directors and the Chief Operating Officer.

Recognising the need to increase management bandwidth and the size and scale of the Executive Team in light of the WMUH acquisition, the Trust has developed a new Tier 1 structure that again draws on key areas of skills gaps; e.g. high-level IT proficiency will be addressed through the appointment of a Chief Information Officer.

The Trust's Divisional structure provides strong clinical and management leadership and provides the Executive Team with the service delivery.

Risk: However, the Trust acknowledges that there remains a risk relating to management bandwidth and capacity due to a number of vacancies that currently exist. Aspects of this will be resolved by the integration with WMUH. In addition, the Trust continues to recruit to senior posts.

The Trust has also developed a new Recruitment & Retention Strategy and an L&D Plan that looks to support staff in furthering their careers.

Other certifications

5 Certification on AHSCs and governance

For NHS foundation trusts:

- that are part of a major Joint Venture or Academic Health Science Centre (AHSC); or
- whose Boards are considering entering into either a major Joint Venture or an AHSC.

The Board is satisfied it has or continues to:

- ensure that the partnership will not inhibit the trust from remaining at all times compliant with the conditions of its licence;
- have appropriate governance structures in place to maintain the decision making autonomy of the trust;
- conduct an appropriate level of due diligence relating to the partners when required;
- consider implications of the partnership on the trust's financial risk rating having taken full account of any contingent liabilities arising and reasonable downside sensitivities;
- consider implications of the partnership on the trust's governance processes;
- conduct appropriate inquiry about the nature of services provided by the partnership, especially clinical, research and education services, and consider reputational risk;
- comply with any consultation requirements;
- have in place the organisational and management capacity to deliver the benefits of the partnership;

- involve senior clinicians at appropriate levels in the decision-making process and receive assurance from them that there are no material concerns in relation to the partnership, including consideration of any re-configuration of clinical, research or education services;
- address any relevant legal and regulatory issues (including any relevant to staff, intellectual property and compliance of the partners with their own regulatory and legal framework);
- ensure appropriate commercial risks are reviewed;
- maintain the register of interests and no residual material conflicts identified; and
- engage the governors of the trust in the development of plans and give them an opportunity to express a view on these plans.

  Confirmed

  Assurance:
    - Business cases for any JV and partnerships approved by Finance and Investment Committee and Trust Board.
    - The Trust Chief Executive is a member of the AHSC Board

  Risk: There are no known risks to compliance with this area.

6. Training of Governors

The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Confirmed

Assurance: Induction to new governors provided; budget allocated for governors to attend GovernWell training courses to ensure governors are equipped with the skills and knowledge required to undertake their role.

Risk: There are no known risks to compliance with this area.

Appendix 2

1 & 2 General condition 6 - Systems for compliance with license conditions

1. Following a review for the purpose of paragraph 2(b) of licence condition G6[1], the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed

Assurance: The Board has established a Finance & Investment Committee (FIC) that is specifically charged with ensuring that the Trust operates in an economic and efficient manner through the holding to account of Executive Directors and Divisional Leads for delivery against agreed I&E positions and CIP targets.

The Board itself reviews financial and operational performance at each meeting through the Performance & Quality Report, with a more detailed financial view being provided by the Finance Reports which the Board reviews as a standing item on its Private agenda.

As referenced below with regard to the Board's oversight of quality, the Board and the Board Quality Committee regularly review the Trust's compliance against the CQC standards. To complement this regular item, a CQC-Style Independent Peer Review was undertaken in April 2015 which showed the Trust, overall, to have improved its level of CQC compliance since the July 2014 CQC inspection.

The Board Audit Committee oversees the output of all audits undertaken by the Trust internal and external auditors, reporting any risks identified to the Board accordingly.

Risk itself is considered, reviewed and managed through the Risk Assurance Framework (RAF), a new risk process introduced in March 2015 which significantly improves the robustness and comprehensiveness of the Trust's systems of risk management.

Risk: The Trust recognises the deterioration of the Trust's financial position in 2014/15 increases the risk to its longer-term viability. This risk has been exacerbated by changes in the national tariff which adversely affects the Trust due to its portfolio of services. The economies of scale brought about through the WMUH acquisition will mitigate this risk; with the LTFM projecting the post-acquisition Trust to be achieving a COSRR of '3' by the end of 2016/17.

AND

2. The board declares that the Licensee continues to meet the criteria for holding a licence.

[1] Licence condition G6:
1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:
(a) the Conditions of this Licence,
(b) any requirements imposed on it under the NHS Acts, and
(c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.
2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:
(a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
(b) regular review of whether those processes and systems have been implemented and of their effectiveness.