Chelsea & Westminster Hospital NHS Foundation Trust

Board of Directors

Board of Directors Meeting PUBLIC SESSION 27 July 2015

Hospital Boardroom

27 July 2015 16:00

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting (PUBLIC SESSION)

Location: Hospital Boardroom, Lower Ground Floor, Lift Bank C
Date: Monday, 27 July 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 25 June 2015	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
16.45	7.	Why Become a Nurse?	Pres.	Director of Nursing
		QUALITY & TRUST PERFORMANCE		
17.00	8.	Performance & Quality Report, *including Update on RTT Position*	Report	Executive Directors
17.10	9.	Monitor In-Year Reporting & Monitoring Report Q1	Report	Chief Finance Officer
		GOVERNANCE		
17.20	10.	Register of Seal Report Q1	Report	FT Secretary
17.25	11.	A Framework of Quality Assurance for Responsible Officers and Revalidation: Annual Board Report	Report	Medical Director
		ITEMS FOR INFORMATION		
17.35	12.	Questions from Members of the Public	Verbal	Chairman/ Executive Directors
17.45	13.	Any Other Business		
18.00	14.	Date of Next Meeting – 24 September 2015		

PAPER 3

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Minutes of the Board of Directors (Public Session)
Held at 16.00 on 25 June 2015 in the Boardroom, Chelsea & Westminster Hospital

Present:	Sir Thomas Hughes-Hallett	Trust Chairman	(Chair)
	Sir John Baker	Non-Executive Director	(JB)
	Jeremy Jensen	Non-Executive Director	(JJ)
	Jeremy Loyd	Non-Executive Director	(JL)
	Andrew Jones	Non-Executive Director	(AJ)
	Eliza Hermann	Non-Executive Director	(EH)
	Liz Shanahan	Non-Executive Director	(LS)
	Nilkunj Dodhia	Non-Executive Director	(ND)
	Elizabeth McManus	Chief Executive	(EM)
	Lorraine Bewes	Chief Financial Officer	(LB)
	Zoe Penn	Medical Director	(ZP)
	Karl Munslow-Ong	Chief Operating Officer	(KMO)
	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)
In Attendance:	Lesley Watts	Incoming Chief Executive	(LW)
	Vivien Bell	Head of Midwifery	(VB)
	Alex Mancini	Lead Nurse for Neonatal Palliative Care	(AM)

1.	**Welcome and Apologies for Absence**	
a.	The Chair welcomed all present to the meeting. He particularly welcomed LW who was attending her first Public Board meeting at CWFT as an observer.	
b.	It was noted that there had been no apologies given for the meeting.	
2.	**Declarations of Interest**	
a.	AJ declared a new interest in respect of Nuffield Health's purchase of Playgate Ltd. He noted that he would need to update his entry on the Board Register of Interests accordingly. It was noted that the interest did not appear to give rise to any conflicts.	
3.	**Minutes & Actions from Previous Meeting: 26 May 2015**	
a.	The minutes from the previous meeting were agreed as a true and accurate record, subject to an amendment being made to minute 9d which should have stated that the recommendation of the People & OD Committee to the Board was that the Trust *would attain* the compliance levels currently achieved by WMUH in relation to Fire, Local Induction an Information Governance training by the end of August 2015.	
b.	In relation to minute 8d, ZP confirmed that the Trust remained operationally ready to respond to the closure of the Ealing Hospital Maternity Unit at the end of the month. She noted that the Trust had received media coverage in May with regard to the temporary closure of its Maternity Unit for capacity reasons. However, this closure reflected an	

	extreme 'spike' in activity levels far in excess of the projected Ealing increase which equated to one additional delivery per day. ZP added that the CCG Boards and the SAHF Strategic Programme Board had also approved the Trust's operational readiness for the Ealing closure. VS added that both CWFT and WMUH had recently been able to successfully recruit midwives and neonatal nurses to further improve the two organisations' maternity capacity.	
4. a.	**Matters Arising & Board Action Log** The Board Action Log was reviewed and noted. The Board noted that all actions had been completed.	
5. a. b.	**Chairman's Report** The Chairman noted that the Trust was currently working through an intensely 'busy' period, where management staff were being stretched to sufficiently plan for the forthcoming WMUH acquisition whilst continuing to deliver against 'business as usual' priorities. Furthermore, there had been a number of recent guidelines, requests for information and new legislative provisions which the Trust had needed to respond to during this period. He particularly noted the recent letter received from the Secretary of State for Health which asked for assurances in relation to the Trust's processes for reviewing/approving levels of Executive/senior officer remuneration. The Chairman advised that, earlier in the day, the Board had met with Monitor in a 'Board-to-Board' session which formed the penultimate part of the Regulator's assessment of the WMUH Transaction. The next step was for the Trust to submit a suite of documents to Monitor which would include the report of the Independent Reporting Accountant. Following this, Monitor would issue the Trust with its Transaction Risk Rating; this was expected to be received by 15 July 2015.	
6. a. b. c.	**Chief Executive's Report** In relation to Staff, EM noted the positive levels of staff engagement highlighted by the recent Medical Engagement Scale and Healthcare Engagement Scale exercises. The recent Clinical Summit held jointly by CWFT and WMUH had further emphasised this high level of clinical engagement, particularly in the context of clinical innovation and the development of clinical service strategies. A further Clinical Summit would be held on 31 July 2015. In relation to 'growth', EM noted the review of the Five Year Forward View undertaken by the main national NHS agencies and the recent outcomes of the Lord Carter review which stressed the importance of NHS providers being able to improve clinical effectiveness and efficiency. She said that the Trust would need to respond to this national context through the development of its Clinical Services Strategy which would look far beyond the WMUH acquisition in terms of how the Trust would seek to deliver its services in the longer-term. ZP agreed, adding that innovation and the rollout of the new EPR system were essential in driving the clinical transformation that was required in order to deliver such a Strategy. The Chairman added that, as part of its Clinical Services Strategy, the Trust needed to continue to consider the role of charitable support and philanthropy in supplementing the healthcare services provided by the Trust.	
7.	**Patient Story**	

a.	The Board received a presentation from VB and AM on a baby who had been born with a life-limiting complex medical condition and who, as a result, had received palliative care from birth. The presentation detailed how the Trust had supported the child's family in being able to celebrate the child's short life. It was noted that, at times, this went beyond what ordinarily would have been expected of healthcare professionals in order to provide the family with the best possible experience in the circumstances.	
b.	The Chairman thanked VB and AM for the excellent presentation and said that the story highlighted the compassionate and caring nature of the Trust's workforce which remained the organisation's greatest asset.	
8.	**Quality Strategy**	
a.	In presenting the report, ZP noted that the Quality Strategy had previously been reviewed by the Quality Committee and was now being presented for the Board's approval. She noted that the key themes of the Quality Strategy had been reflected within the Trust's Quality Accounts and were underpinned by a number of Special Projects which were: Frailty, Admitted Surgical Care, Sepsis and Maternity. ZP confirmed that clinical colleagues at WMUH (and other external stakeholders) had been engaged in the development of the Strategy and the Special Projects referenced also aligned well with WMUH's own clinical priorities.	
b.	EM supported the Strategy but asked whether there were any risks to its deliverability in terms of implementation. ZP acknowledged that the targets within the Strategy were ambitious and that resource would be required in order to fully embed each of the plans that were envisaged. EH agreed, but noted that in some cases, the Trust was already making significant progress with regard to the delivery of the Strategy, particularly in the case of the management of Sepsis.	
c.	JJ asked how the Trust's delivery of its Quality Strategy would be benchmarked against the Trust's peers. ZP advised that the Trust's aim was to achieve upper decile performance in respect of each of the four special projects included within the Quality Strategy. The Trust would also continue to compare its performance with others with regard to the nationally-recognised quality indicators (e.g. mortality, infection control) through the Performance & Quality Report. It was agreed that a new KPI to reflect each of the Special Projects would be included within future iterations of the Performance & Quality Report.	**ZP**
d.	ZP advised that the delivery of the Quality Strategy would also bring about cost benefits through maximising clinical efficiencies, such as reducing length of stay. The Chairman welcomed this but stressed that the key driver behind the Strategy needed to be the provision of world-class healthcare in order to truly motivate staff. ZP agreed and noted that the Special Projects had specifically been designed in a way that all clinical staff would in some way be involved in the delivery of the Projects.	
e.	The Board **APPROVED** the Quality Strategy.	
9.	**Performance & Quality Report**	
a.	In relation to operational performance, KMO advised that the Trust continued to achieve each of the national Monitor compliance targets (RTT, 4-hour A&E target) with the exception of the learning disabilities target which the Trust was taking remedial action to address. He advised that his current operational priorities related to improving the administration of clinical services, particularly with regard to clinical documentation, and the improvement of the Trust's operational productivity.	

b.	In relation to workforce performance, SY advised that the Trust's mandatory training performance had improved in month and that the Trust's level of compliance was 1% above the average for the London Teaching Hospitals. This improvement had followed a review and refocusing of the entirety of the Trust's mandatory training offering.	
c.	However, with regard to Level 1 Safeguarding Training, VS advised that the local CCGs had agreed that the Trust's current approach of distributing leaflets to staff was inadequate and that the completion of an e-learning package was required. Whilst the Trust would seek to rollout the new training system over the months ahead, this would inevitably have an adverse impact upon the Trust's current compliance rate of 100% for Safeguarding training.	
d.	The Chairman asked that clarity be provided with regard to which training packages were mandatory for Non-Executive Directors.	**SY**
e.	SY advised that the Trust had recently won an award for Innovation in HR which reflected the Trust's role in the HR Streamlining Project. The Board congratulated SY on this achievement and discussed the opportunities available to the Board to be able to congratulate staff in recognition of their achievements	
f.	With regard to financial performance, LB advised that the Trust had delivered a £0.5m deficit position at Month 2 which was ahead of the planned deficit of £0.8m. As part of this position, she noted that income was above plan and that the Trust's cost run rate remained within projected levels. The Trust was also slightly ahead of its CIP Programme trajectory. The main areas of concern related to an underperformance with regard to Private Patient income and the level of aged debt.	
g.	With regard to quality performance, VS noted that the Trust was currently responding to 100% of its formal complaints within the prescribed time period. In respect of the Friends & Family Test, the Trust had just missed its 30% response rate target; however new innovative options were being considered as to how this could be improved, including the use of the patient entertainment system and through volunteer services. VS added that every ward sister with a response rate under 30% or a satisfaction rate under 90% was being supported to ensure that improvements were made.	
h.	ZP advised the Trust's level of incident reporting remained high when compared with the peer average: this indicated that there was a positive incident reporting culture within the Trust. She additionally noted that, of these incidents, the percentage where moderate-serious harm was caused as a result of the incident remained low. ZP confirmed that the Trust's mortality rates remained favourable compared with the national average.	
i.	In terms of quality risks, ZP advised that the Trust's number of hospital-acquired pressure ulcers remained a concern and this was reflected within the prioritisation of this area within the Quality Strategy, as discussed earlier in the meeting. In addition, the Trust continued to under-perform against the 12 hour Consultant assessment indicator; however this represented a reporting issue as opposed to reflecting a genuine clinical risk.	
j.	AJ noted that the Trust's number of Ecoli bloodstream infections appeared to radically alter from month-to-month and asked why this was the case. ZP agreed to report back upon this at the next Board meeting.	**ZP**
k.	ND asked KMO to explain the national changes that had been proposed in relation to the RTT indicators. KMO explained that Monitor was currently consulting on a proposal to reduce the three current indicators to one indicator: the 'incomplete pathway' indicator. The aim of the change was to reduce the possibility of reverse incentives and to ask providers to report against a single indicator which reflected the length of time patients were waiting to be treated in totality.	

l.	The Chairman noted that the Board would be receiving a presentation from KMO in July on the new Integrated Performance Report which would encompass WMUH performance. He asked that a similar presentation be provided at the time of the next Council of Governors meeting.	**KMO**
10. a. b. c.	**Corporate Governance Statement: Self-Certifications** In presenting the report, TL noted that the Board was being asked to approve two separate statements: a Corporate Governance Statement and a self-declaration as to compliance with Licence Condition G6. This was a component part of Monitor's annual planning process for Foundation Trusts. The paper provided a high-level narrative on the evidential basis which justified the Board being able to fully confirm both statements. As Chair of the Audit Committee, JB confirmed that he supported the assurances that had been provided within the report as to the Trust's ability to confirm the requested declarations. However, he asked whether data quality issues needed to be reported as part of the declarations. TL confirmed that this was not the case but noted that the Trust's risk in this area had otherwise been fully disclosed within the Trust's 2014/15 Annual Report and Quality Accounts. The Board **APPROVED** the submission of the statements to Monitor.	
11. a. b.	**Questions from Members of the Public** Angela Henderson, Patient Governor, noted the discussion which had been held earlier in the Board meeting with regard to congratulating staff and suggested that the Trust consider holding quarterly meetings for all staff in order to raise morale and express Board appreciation. The Chairman welcomed this suggestion and asked EM and LW to duly consider this. Martin Lewis, Public Governor, asked what the Trust was doing to improve its signage within the Hospital. VS advised that this would be the main item for discussion at the next PLACE Committee meeting and that both the Estates teams and CW+ were engaged in progressing the improvement of 'wayfinding' within the Trust.	EM
12. a.	**Any Other Business** The Chairman advised that there was a growing national recognition of the important role of charitable/volunteer organisations within healthcare. As a result, the Cabinet Office had approached the Marshall Institute for Philanthropy and Social Entrepreneurship for advice on a pilot it wished to run in West London. The Trust would duly need to consider whether it itself wished to engage in the project.	
13.	**Date of Next Meeting:** 27 July 2015	

The meeting was closed at 17.41.

Board of Directors PUBLIC SESSION – 25 June 2015

Meeting	Minute Number	Agreed Action	Current Status	Lead
June 2015	8.c	To include a new KPI to reflect each of the Special Projects within future iterations of the Performance & Quality Report.	Verbal update at meeting.	**ZP**
	9.d	SY to provide clarity with regard to which training packages were mandatory for Non-Executive Directors.	Verbal update at meeting.	**SY**
	9.j	ZP agreed to report back on Ecoli bloodstream infections which appear to radically alter from month-to-month at the next Board meeting.	Verbal update at meeting.	**ZP**
	9.l	KMO to provide a new Integrated Performance Report which encompasses WMUH performance to the next Council of Governors meeting.	This is scheduled for October.	**KMO**
	11.a	EM to consider holding quarterly meetings for all staff in order to raise morale and express Board appreciation.	For discussion with Lesley Watts.	**EM**

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 27 July 2015

PUBLIC

AGENDA ITEM NO.	6/Jul/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
July 2015

1.0 Staff

1.1 People First

Many people are taking well-earned summer holidays at the moment and I would like to wish everyone a happy and restful/restorative time. The whole of the organisation has been continuing to work hard on their different priorities – whether it be direct patient care, providing administrative support to teams or working hard on the forthcoming acquisition of West Middlesex University Hospital NHS Trust (WMUH).

Every fortnight I now get the pleasure of meeting all of our new recruits and last month I was able to welcome a number of new people to the organisation across a range of clinical specialties and corporate departments. I also had the opportunity to meet some of our people who have now been here for six months in order to have conversations with them about how well they are supported and what challenges they have faced to date. I think this is such an important part of our role as leaders, staying close to how it really feels for our staff.

1.2 Executive Team Developments

Over the last few weeks, I have been able to spend some time with our new Chief Executive, Lesley Watts and am already enjoying working with her and making plans for her arrival in September. Lesley has taken an opportunity whilst here to go and introduce herself in different areas. I know how much this has been appreciated.

I want to take this opportunity to wish our Chief People Officer and Director of Corporate Affairs, Susan Young, all the very best in her future. Susan is leaving the organisation at the end of July for personal reasons. We have made significant progress on our acquisition of West Middlesex under Susan's leadership and we are sorry to see her go. We wish her all the best as she moves on to work closer to home and spend more time with her family.

2.0 Grip

2.1 Performance

As detailed within the Performance & Quality Report, the Trust continues to achieve the majority of the national operational performance targets (e.g. A&E 4-hour wait, 18 weeks Referral-to-Treatment). It has been particularly pleasing to note the Trust's financial performance as of Month 3, with the Trust's I&E position ahead of plan. As part of this, the Trust is achieving its CIP trajectory which is important considering that this was a key area for improvement within 2015/16. The Trust's performance in relation to the nationally-recognised key quality indicators remains strong, particularly in respect of MRSA/CDiff levels and mortality.

Despite this positive outturn at Month 3, the Trust will nevertheless be declaring areas of non-compliance to Monitor as part of its Quarter 1 submission following the Board meeting. These relate to the Trust's inability to maintain a COSRR of '3' in year as a standalone organisation (as forecast) and with regard to the national targets in relation to patients with Learning Disabilities. The full explanation of the Trust's position in these areas will be covered under the specific agenda item.

3.0 Growth

3.1 Proposed Acquisition of West Middlesex University Hospital NHS Foundation Trust

We are now entering the final stage of the process relating to the acquisition of WMUH. Since the last Board meeting, there has continued to have been a significant amount of progress made both in respect of the

transactional/assurance aspects of the acquisition pathway and also with regard to public/staff engagement on the transaction.

Accordingly, the Trust remains on track to complete the acquisition on 1 September 2015. Prior to this, there are a number of key process steps:

- **27 July 2015**- At the Private Board meeting held today, the Board will be asked to self-certify against the Trust's projected Working Capital position in support of its application to acquire. The Board has previously self-certified in respect of the organisation's Quality Governance, Financial Reporting Procedures and Post-Transaction Implementation Plan assurance documentation.

- **7 August 2015**- The Trust expects to receive Monitor's 'Transaction Risk Rating' which signifies the level of risk which the Regulator attributes to the transaction in totality, giving consideration to the due diligence work undertaken by Monitor on the transaction over the preceding months. The outcome of Monitor's Transaction Risk Rating will inform the decisions of the Board and of the Council of Governors in relation to the acquisition later in the month.

- **11 August 2015**- An Extraordinary Private meeting of the Board will be held in order to consider the approval of the WMUH acquisition, informed by Monitor's Transaction Risk Rating. Following this, a Council of Governors meeting will be held later in the day to consider the same issue. In particular, in making its decision, the Council will be asked to consider whether the Board has:

  i) been thorough and comprehensive in reaching its proposal (that is, has undertaken proper due diligence);

  ii) obtained and considered the interests of trust members and the public as part of the decision-making process.

- **12 August 2015- 28 August 2015:** Following its 11 August Board/Council meetings (assuming that both agree to acquire), the Trust will formally submit an application to acquire to Monitor. This will concurrently trigger a parallel process that involves the NW London CCGs, the Trust Development Authority and NHS England each separately concluding their governance processes and formally agreeing the Transaction Agreement with a view to the dissolution of WMUH. The end of this 'external' part of the process is the Secretary of State's approval of the transaction which is expected to be received at the very end of August.

- **1 September 2015-** Day 1!

3.2 <u>External Engagement: WMUH Acquisition</u>

As part of the transition towards 1 September, the Trust continues to engage with a number of stakeholder organisations in order to promote and raise awareness of the planned clinical and organisational benefits associated with the WMUH transaction.

A range of clinical and managerial representatives from Chelsea and Westminster Hospital were invited to present at Hammersmith and Fulham Council's Health, Adult Social Care and Social Inclusion Policy and Accountability Committee on Tuesday 7 July. Following this, clinical and managerial representatives presented to the Hammersmith and Fulham Older People's Consultative Forum on Tuesday 14 July. Both presentations focused on the clinical service developments that Hammersmith and Fulham residents could experience as a result of the acquisition going ahead and led to some very healthy debate and discussion. Following these presentations, a written update on progress around the acquisition has been provided to all Local Authorities served by Chelsea and Westminster Hospital.

These presentations follow on from a briefing provided to Hammersmith and Fulham Council's Health, Adult Social Care and Social Inclusion Policy and Accountability Committee in June on both the acquisition and our progress against actions detailed in the Trust's 2014 CQC report.

Also taking place on 14 July was the WMUH Annual Public Meeting (APM) which provided an opportunity for members of the WMUH Board to present an overview of the organisation's 2014/15 Annual Report and Accounts, highlighting key successes and areas for development. As part of the occasion, I presented an item on the rationale underpinning the acquisition which was focused upon the clinical benefits which will be brought about through the two organisations' integration. The discussion that followed was interactive and free-flowing, highlighting the overall levels of interest and engagement from members of the public and from Trust staff.

These specific engagement opportunities are in addition to the Trust's arranged Membership Constituency Meetings, all of which have now taken place in each Local Authority covered by the Trust constitution. The purpose of these meetings has been to provide further opportunities for Trust staff and Governors to engage with the Trust's membership base. Further Constituency Meeting dates will be announced at the August Council of Governors meeting and will include new Constituency Meetings in the London Boroughs of Hounslow, Richmond and Ealing.

Indeed, the Trust continues to reach out to its new 'constituency areas' in a number of ways. On 10 July, members from the CWFT Executive Team engaged with the Hounslow and Richmond Healthwatch organisations with a view to raising awareness of Foundation Trust membership and in order to explain the FT model.

I will continue to keep the Board apprised of all key external engagement events as and when they occur.

3.3 Shaping a Healthier Future (SAHF): Closure of Ealing Hospital Maternity Unit

As of 1 July 2015, the Maternity Unit at Ealing Hospital closed. As a result, all women who had been booked into the unit have had their treatment transferred to an alternative Hospital. Whilst this includes the Trust and WMUH, there has been little evidence of a spike in maternity activity arising from this to date and the Trust remains confident that it has the operational resilience to cope with any additional demand in the longer-term.

The principles underpinning SAHF with regard to the consolidation of maternity care across six hospitals in north-west London is to provide more senior consultant cover in the maternity units, more midwives able to give 1 to 1 care for women, a move towards 24/7 consultant cover on the labour wards and greater investment in home birth teams.

Elizabeth McManus
Chief Executive Officer
July 2015

Board of Directors Meeting, 27 July 2015

PUBLIC

AGENDA ITEM NO.	8/Jul/15
REPORT NAME	Performance and Quality Report – June 2015
AUTHOR	Virginia Massaro, Assistant Director of Finance
LEAD	Karl Munslow-Ong, Chief Operating Officer
PURPOSE	To report the Trust's performance for June 2015, highlight risk issues and identify key actions going forward.
SUMMARY OF REPORT	The Trust met all key performance indicators for Monitor in June 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. - Clinical Effectiveness: The caesarean section rate improved in June for the second month in a row, despite remaining above target. There is an on-going consultant led analysis of the data to understand variation. Nutritional initial and rescreening has continued to improve in June following in depth weekly monitoring. - Patient experience: As a Trust we are becoming more focussed on FFT and addressing patients' concerns. Each clinical area responds to the concerns raised and to highlight good practice through the 'What you said we did' Boards on the wards. - Access and Efficiency: The Trust has continued to achieve A&E waiting times and there has been a continued reduction in the number of ambulance handover breaches in June. There is an on-going programme of work underway to improve the overall Referral to Treatment process and reduce the average waits between referral and treatment. However, the Trust achieved all 3 RTT indicators in June. - 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 ASSOCIATED:	There is a risk to achievement of the challenging C. Diff target in 2015/16 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 June and £2.6m deficit for the year to date, which was £0.6m ahead of plan year to date. CIP delivery was also ahead of target in June.
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 June 2015.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Performance and Quality Report

Performance to 30th June 2015

At a Glance Performance – June

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Patient Safety Domain

- Hospital Associated VTE: 0
- Harm Free Score: 96.2%
- Cdiff Infections: 0
- Mortality SHMI: 81.1
- Never Events: 0
- Med. Related Safety Incidents: 9.6

Clinical Effectiveness Domain

- Time to Theatre Urgent Surgery: 92.1%
- 12hr consultant assessment: 72.61%
- Dementia Case Finding: 77.0%
- Emergency Re-admissions: 2.66%
- Caesarean Section Rate: 32.3%

Patient Experience Domain

- FFT Local Positive: n/a
- Hospital Cancellations: 9.4%
- FFT Response Rate: n/a
- Formal Complaints: 73.81%
- Staff FFT - To receive care: n/a
- Staff FFT - Place to Work: n/a

Access & Activity Domain

- A&E Waiting Times: 96.8%
- 18 weeks RTT Admitted: 90.0%
- Choose & Book Slot Issues: n/a
- EL & DC Activity: 3675
- DTOCs: 2.22%

Process Efficiency Domain

- Avg Wait New OP Appt: 6.7
- Theatre Conversion rate: 87.0%
- OP Letters sent <7 working days: 62.2%
- Theatre Active Time: 73.1%
- DSUM sent before Disch.: 69.9%

Work Force Domain

- Sickness Rate: 2.8%
- Turnover Rate: 19.5%
- Appraisal Completion: 79%
- Vacancy Rate: 13.3%
- Avg Days for Recruitment: 57.0

Finance Domain

- I&E Surplus: £-2.6m
- EBITDA: 3.9%
- CIP Achieved: £1.7m
- COSRR: 3.0
- Cash: £14.0m

Trust Headlines – 2015

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Monitor Compliance – June 2015

Sub Domain	Trust Level Monthly Data @ 06/07/2015 XL				YTD XL
	MonthYear	Apr 2015	May 2015	Jun 2015	YTD
Harm	Clostridium difficile infections (Target: < 0.67)	1	0	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	N/A
	Cancer diagnosis to treatment waiting times - Subsequent Surgery (Target: > 94%)	N/A	100.0%	N/A	N/A
	Cancer diagnosis to treatment waiting times - Subsequent Medicine (Target: > 98%)	100.0%	100.0%	N/A	N/A
	Cancer urgent referral GP to treatment waiting times (62 Days) (Target: > 85%)	89.7%	100.0%	N/A	N/A
	Cancer urgent referral Consultant to treatment waiting times (62 Days) (Target: > 90%)	100.0%	100.0%	N/A	N/A
	Cancer urgent referral to first outpatient appointment waiting times (2WW) (Target: > 93%)	93.4%	93.3%	N/A	N/A
RTT	18 week referral to treatment times Admitted Patients (Target: > 90%)	90.5%	90.9%	90.1%	90.5%
	18 week referral to treatment times Non Admitted Patients (Target: > 95%)	95.3%	95.5%	95.0%	95.2%
	18 week RTT incomplete pathways (Target: > 92%)	93.0%	92.1%	92.1%	92.4%
A&E	A&E waiting times (Target: > 98%)	95.7%	97.3%	96.8%	96.6%
LD	Self-certification against compliance with requirements regarding access to healthcare for pe...	Compliant	Compliant	Compliant	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. 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.

Performance Headlines

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

Improvements

- All Monitor indicators were achieved in June and Q1, with the exception of compliance with access to healthcare for people with learning difficulties.
- The caesarean section rate improved in June for the second month in a row, despite remaining above target. There is an on-going consultant led analysis of the data to understand variation.
- Nutritional initial and rescreening has continued to improve in June following in depth weekly monitoring.
- Ambulance handovers have improved for June, with a reduction in reported breaches for 30 mins handover times and no 60 mins breaches.
- All financial indicators were achieved in the month and quarter.

Challenges

- 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 is continuing to focus on reducing the backlog of outpatient letters over the last few months.
- Dementia Screening Case Finding underperformed for the second time since the target was set. Refresher training has been organised for the clinical areas where this screening takes place.
- There is an on-going programme of work underway to improve the overall Referral to Treatment (RTT) process and reduce the average waits between referral and treatment. However, the Trust achieved all 3 RTT indicators in June.

Sub Domain	Trust Level Monthly Data @ 17/07/2015 XL				YTD XL
	Month Year	Apr 2015	May 2015	Jun 2015	YTD
Harm	Incidence of newly acquired category 3 and 4 pressure ulcers (Target: < 3.6)	3	1	1	5
	Safety Thermometer - Harm score (Target: > 90%)	93.5%	94.2%	96.2%	94.6%
	Safety Thermometer - Prevalence of Pressure Ulcers (Rate) (Target: < 3.45%)	5.9%	5.8%	3.6%	5.1%
HCAI	C Diff rate per 100k bed days pts aged >=2 (Target: < 14.7)	8.8	0.0	0.0	2.9
	Clostridium difficile infections (Target: < 0.67)	1	0	0	1
	Hand Hygiene Compliance (trajectory) (Target: > 90%)	97.0%	97.4%	97.5%	97.3%
	Methicillin Sensitive Staphylococcus Aureus Target < 4.1)	2	0	0	2
	E.Coli bloodstream infections Target < 12.4)	0	1	3	4
	MRSA Bacteraemia (Target: = 0)	0	0	0	0
	Screening all elective in-patients for MRSA (Target: > 95%)	96.4%	98.8%	97.9%	97.7%
	Screening Emergency patients for MRSA (Target: > 95%)	97.7%	98.5%	97.6%	97.6%
Incidents	Incident reporting rate per 100 admissions (Target: > 8.50)	9.02	7.87	6.92	7.92
	Inpatient falls per 1000 Inpatient bed-days (Target: < 3.00)	3.39	3.48	2.99	3.29
	Never Events (Target: = 0)	0	0	0	0
	Medication related safety incidents per 1000 admissions Target < 6.8)	8.5	10.5	9.6	9.5
	Rate of patient safety incidents per 100 admissions (Target: < 2.9)	8.53	7.49	6.59	7.52
	Rate of pt. safety incidents resulting in severe harm - death per 100 admissions (Target: = 0.00)	0.00	0.02	0.02	0.01
Mortality	Mortality (HSMR) (2 months in arrears) (trajectory) (Target: < 104)	79.5	79.5	79.5	79.5
	Mortality SHMI *TRUST ONLY* (Target: < 82)	81.1	81.1	81.1	81.1
	Number of In-hospital Deaths (Adults)	34	31	26	91
	Number of in-hospital deaths (Paeds)	0	0	0	0
	Number of in-hospital deaths (Neonatal)	7	6	5	18

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 safety thermometer data on this report doesn't differentiate between hospital and community acquired, however there continues to be a firm downward trend from 5.8% to 3.6%. In June the Trust sustained only one newly acquired 3/4 Pressure Ulcer.

There continues to be a renewed focus on the Root Cause Analysis (RCA) process with the newly introduced RCA tool. This is to improve our understanding of why these ulcers are occurring.

Themes continue to be reviewed but the current focus is on:

- Robust handover of patient risk
- Clear and accurate documentation,
- Timely assessment and re-assessment
- Immediate escalation to senior colleagues where patient compliance is a concern.
- ICU are exploring a number of products to address medical device related ulcers as part of their Tissue viability strategy group.

Safe Nursing and Midwifery Staffing

	Day		Night	
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered nurses	Average fill rate - care staff
Maternity	76.9%	72.9%	70.0%	54.4%
Annie Zunz	98.2%	90.0%	100.0%	100.0%
Apollo	93.9%	40.0%	93.9%	-
Jupiter	108.9%	82.4%	141.7%	-
Mercury	112.7%	43.3%	116.7%	41.4%
Neptune	95.9%	90.0%	98.9%	100.0%
NICU	94.6%	-	93.7%	-
AAU	102.1%	100.0%	139.2%	116.7%
Nell Gwynn	94.6%	95.8%	100.0%	100.0%
David Erskine	97.3%	151.7%	98.9%	120.0%
Edgar Horne	95.0%	97.9%	96.7%	100.8%
Lord Wigram	89.3%	170.8%	96.7%	105.0%
St Nary Abbots	93.6%	101.7%	95.6%	101.7%
David Evans	96.6%	99.2%	123.5%	108.5%
Chelsea Wing	93.2%	98.3%	100.0%	100.0%
Burns Unit	89.3%	48.3%	98.9%	93.3%
Ron Johnson	95.2%	92.7%	84.9%	93.5%
ICU	100.0%	133.1%	99.7%	-

National Quality Board Report – Hard Truths expectations:

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

Definition – 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 June:

AAU fill rate relates to assessment trollies being open overnight for the majority of the month and to RMN usage. David Erskine Ward had highly dependent patients requiring one to one care. Lord Wigram Ward had in place an agreement to staff the day shift with additional health care assistants to offset their registered nursing vacancy factor (providing this was managed within the bottom line budget), it would appear that this needs further scrutiny and grip as the overfill rate appears to far outstrip the RN shortfall.

Although the percentages are low for maternity this is their average fill rate and midwifery staffing is covered elsewhere in the performance report

Clinical Effectiveness

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Sub Domain	Trust Level Monthly Data @ 17/07/2015 XL				YTD XL
	MonthYear	Apr 2015	May 2015	Jun 2015	YTD
Admitted Care	Elective LoS - Long Stayers (Target: < 48)	51	43	53	147
	Elective Length of Stay (Target: < 3.7)	3.4	2.7	3.4	3.2
	Emergency Care Pathway - Discharges (Target: N/A)	186.6	184.9	191.6	563.0
	Emergency Care Pathway - Length of Stay (Target: < 4.5)	5.03	5.29	5.00	5.11
	Emergency Re-Admissions within 30 days (adult and paed) (Target: < 2.8%)	3.01%	3.03%	2.66%	2.89%
	Non-Elective Long Stayers (Target: < 513)	392	423	430	1245
	Non-Elective Length of Stay (Target: < 3.9)	4.4	4.1	4.3	4.3
	VTE Assessment (Target: > 95%)	95.9%	95.2%	96.8%	96.0%
Best Practice	% Patients Nutritionally screened on admission *TRUST ONLY* (Target: > 90%)	77.7%	89.8%	89.8%	85.8%
	% Patients in longer than a week who are nutritionally re-screened *TRUST ONLY* (Target: > 90%)	67.6%	84.2%	93.3%	81.1%
	12 Hour consultant assessment - AAU Admissions (Target: > 90%)	79.05%	74.15%	72.61%	75.24%
	Central line continuing care—compliance with Care bundles (Target: > 90%)	94.3%	93.8%	96.3%	94.9%
	Peripheral line continuing care—compliance with Care bundles (Target: > 90%)	81.5%	77.8%	86.0%	81.6%
	Urinary catheters continuing care—compliance with Care bundles (Target: > 90%)	92.6%	95.0%	100.0%	95.3%
	Fractured Neck of Femur - Time to Theatre < 36 hrs for Medically Fit Patients (Target: = 100%)	92.3%	92.9%	tba	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%)	94.7%	83.4%	77.7%	85.4%
	Appropriate referral Dementia specialist diagnosis *TRUST ONLY* (Target: > 90%)	100.0%	N/A	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%)	79.8%	78.3%	85.1%	81.3%
	Theatre Active Time - % Total of Staffed Time (Target: > 70%)	72.3%	72.6%	73.2%	72.7%
	Time to theatre for urgent surgery (NCEPOD recommendations) (Target: > 95%)	94.8%	92.6%	92.2%	93.0%

Emergency Care Pathway LoS: June has seen a slight decrease in LoS, particularly in Medicine for this month. Increases have been seen in Planned Care and HIV/Sexual Health.

Non-Elective Length of Stay: Non-Elective Length of Stay is slightly higher than month 2 but is lower than Month 1. Excess bed day income has increased however, in line with the increased LOS.

Nutritional Screening: Initial screening has maintained a very slight underperformance against a target of 90% for June. Rescreening has improved from last month and is above the target of 90%. Wards continue to be monitored weekly and ward sisters are notified of performance.

12 hour consultant assessment: A slight decline in performance is reported from 74.15% to 72.61%. Key areas affecting this position are HIV/Sexual Health, but improvements have been made in Diagnostics and Surgery.

Dementia Screening Case Finding: This target has underperformed for the second time since the target was set. Refresher training has been organised for the clinical areas where this screening takes place, although the delivery of this training has been affected due to sickness of a key member of staff.

Clinical Effectiveness – Maternity

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

	Indicator	Measure	Target	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	YTD Total
Activity in Month	NHS Deliveries	Benchmarked to 5042 per annum	416	412	433	461	464	427	432	463	398	416	412	468	421	1,301
	Private Deliveries	Benchmarked to 840 per annum	72 per month	73	63	70	71	53	60	85	50	69	69	71	67	207
	Trust Deliveries	Total Maternities (Mother)		485	496	531	535	480	492	548	448	485	481	539	488	1,508
	Total NHS Births (infants)			424	443	468	474	445	442	478	406	431	421	479	432	1,332
	Births	Birth Centre (excludes transfers)	No. of patients	65	65	68	59	64	48	67	47	45	38	53	69	160
		BC maternities rate of Trust total SVD	%	30.2%	30.5%	29.6%	28.8%	28.2%	24.7%	28.5%	25.1%	22.0%	20.8%	25.6%	33.5%	26.6%
		Home births - rate of NHS maternities	% NHS Dels	0.7%	0.5%	0.9%	0.6%	0.2%	1.6%	0.6%	1.3%	0.5%	1.0%	0.2%	0.7%	0.6%
	Norm. Vaginal Deliveries	SVD (Normal Vaginal Delivery)	No. of patients	215	213	230	205	227	194	235	187	205	183	207	206	596
		Maintain normal SVD rate	52%	52.2%	49.2%	49.9%	44.2%	53.2%	44.9%	50.8%	47.0%	49.3%	44.4%	44.2%	48.9%	45.9%
	C- Section	Total C/S rate overall	<27%	28.9%	31.6%	29.9%	33.2%	27.9%	35.0%	31.5%	30.9%	30.5%	39.1%	38.7%	32.3%	36.7%
		Emergency C Sections	No. of patients	64	85	77	69	58	77	84	64	56	84	104	68	256
			<12%	15.5%	19.6%	16.7%	14.9%	13.6%	17.8%	18.1%	16.1%	13.5%	20.4%	22.2%	16.2%	19.6%
		Elective C Sections	No. of patients	55	52	61	85	61	74	62	59	71	77	77	68	222
			<15%	13.3%	12.0%	13.2%	18.3%	14.3%	17.1%	13.4%	14.8%	17.1%	18.7%	16.5%	16.2%	17.1%
	Assisted Deliveries	Ventouse, Forceps Kiwi	No. of patients	78	83	93	105	81	87	82	88	84	68	80	79	227
			10-15% (SD)	18.9%	19.2%	20.2%	22.6%	19.0%	20.1%	17.7%	22.1%	20.2%	16.5%	17.1%	18.8%	17.5%
	Total CS Rate Based on Coded Spells		<27%	28.4%	32.3%	29.9%	34.2%	26.9%	35.1%	32.3%	31.0%	29.4%	40.4%	39.7%	32.0%	37.4%
Clinical Indicators	PP Heamorrage	Blood loss >2000mls	<10	11	7	8	9	4	6	8	4	7	8	1	4	13
		Blood loss >4000mls	No. of patients	1	0	0	2	0	0	1	1	1	1	0	1	2
	Perineum	3rd/4th degree tears	<5% (RCOG)	6	8	8	19	13	13	14	10	10	4	11	11	26
				2.0%	2.7%	2.5%	6.1%	4.2%	4.6%	4.4%	3.6%	3.5%	1.6%	3.8%	3.9%	3.1%
	Stillbirths	Number of Stillbirths		1	2	2	2	1	0	3	2	3	3	4	2	9
	Sepsis	GBS - NHS maternities		30	23	33	27	26	36	32	27	17	26	43	37	106
		Pyrexia in labour	≥38°C	4	13	16	12	9	5	11	13	12	26	20	14	60
	Readmissions	Neonatal < 28 days of Birth (Feeding)		7	7	2	3	8	1	5	0	8	10	10	2	22
		Of which were born at C&W		7	6	2	3	6	1	3	0	6	10	10	2	22
PbR	Pathways	Antenatal Bookings completed	509	525	475	467	498	496	433	466	432	486	494	509	452	1,455
		Ref by 11w		403	352	333	350	358	304	324	317	356	328	365	339	1,032
		% Ref by 11w		77%	74%	71%	70%	72%	70%	70%	73%	73%	66%	72%	75%	71%
		KPI: % Ref by 11w and seen by 12+6w	95%	97.3%	95.7%	96.7%	95.1%	96.4%	95.4%	91.4%	90.2%	94.1%	90.9%	93.2%	96.2%	93.4%
		Breaches (11w ref and booked > 12+6w		11	15	11	17	13	14	28	31	21	30	25	13	68
		Postnatal discharges	221	228	249	223	235	254	242	236	255	204	236	n/a	n/a	236
Risk	Maternal Morbidity	Maternal Death	Incident Form	0	0	0	0	1	0	0	0	0	0	0	0	0
		ITU Admissions in Obstetrics	In 2 mths < 6	1	1	0	1	1	1	0	0	1	0	0	0	0
	HDU	Maternity HDU days		22	14	22	40	25	17	37	30	72	13	28	21	62

Trust deliveries: NHS deliveries remain above plan both in month and year to date. There were no unit closures and no ITU transfers from Obstetrics.

Caesarean section rate: the overall caesarean section rate has fallen for the second successive month. Both elective and emergency c-sections rates are the lowest in the quarter. 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. 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.

Midwifery Led Unit: Birth Centre deliveries increased again with June seeing the highest number of deliveries for the quarter, a 30% increase from May to 69. Normal birth rate: 85%, Transfer rate: 38%.

Bookings: 12+6 KPI compliance was achieved in June for the first time this quarter and remains above the 95% target through July to date. Capacity is continually reviewed and additional clinics are being flexibly delivered. New community hubs opened mid-June to service SaHF boundary growth into Chiswick and H&F areas, initially delivering postnatal care. Mid pathway transfers from Ealing and other NWL providers are now channelled through a central Maternity Booking Service (MBS) following the closure of Ealing Hospital Maternity Service.

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

Sub Domain	Trust Level Monthly Data @ 20/07/2015 XL				YTD XL
	MonthYear	Apr 2015	May 2015	Jun 2015	YTD
Complaints	Breach of Same Sex Accommodation *TRUST ONLY* (Target: = 0)	0	0	0	0
	Complaints (Type 1 and 2) - Communication (Target: < 13)	32	28	38	98
	Complaints (Type 1 and 2) - Discharge (Target: < 2)	3	2	0	5
	Complaints (Type 1 and 2) - Attitude / Behaviour (Target: < 16)	19	13	15	47
	Complaints Re-opened (Target: < 5%)	11.11%	0.00%	N/A	3.57%
	Complaints upheld by the Ombudsman *TRUST ONLY* (Target: = 0)	0	0	0	0
	Formal complaints responded in 25 working days (Target: = 100%)	81.48%	90.00%	N/A	73.81%
	Total Formal Complaints	27	20	37	84
Friends & Family	Friends & Family Test - A&E response rate (Target: > 20%)	35.2%	23.1%	N/A	27.7%
	Friends & Family Test - Inpatients response rate (Target: > 30%)	41.3%	41.3%	N/A	41.3%
	Friends & Family Test - Local +ve score (Trust) (Target: > 90%)	88.5%	89.6%	N/A	89.1%
	Friends & Family Test - Net promoter score (Target: > 62)	62.3	64.8	N/A	63.6
	Friends & Family Test - Total response rate (Target: > 30%)	38.0%	29.2%	N/A	33.0%

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.

Complaints:
The Trust aims to respond to all complaints received as timely as possible. To monitor this the Trust measures itself against a target.

90% of type two complaints received by the Trust should be responded to within 25 days. In May the trust performance was 90%.

23 of the complaints received were logged as type 1, 20 complaints received were logged as type 2. 2 complaints breached this target.

Friends and Family Test:
As a Trust we are becoming more focussed on FFT and addressing patients' concerns. Some of the lower scoring reflects the low response rate from some clinical areas including paediatrics who recently engaged with FFT.

Each clinical area responds to the concerns raised and to highlight good practice through the 'What you said we did' Boards on the wards. Some recurring trends emerging from FFT findings reflect similar trends from the Picker Inpatient Survey, Complaints and PALs highlighting positive feedback related to: staff attitude, clinical care/treatment, environment, waiting times, communication but also areas of concern including poor communication, lack of or conflicting information, poor staff attitude and behaviour.

Access and Efficiency (1)

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Sub Domain	Trust Level Monthly Data @ 14/07/2015 XL — MonthYear	Apr 2015	May 2015	Jun 2015	YTD XL — YTD
A&E	A&E Time to Treatment (Target: < 60)	01:02	01:00	01:03	01:02
	A&E waiting times (Target: > 98%)	95.7%	97.3%	96.8%	96.6%
	A&E: Unplanned Re-attendances (Target: < 5%)	6.72%	6.84%	6.63%	6.73%
	LAS Patient Handover Times - 30 mins (KPI2) *TRUST ONLY* (Target: < 0)	50	32	21	103
	LAS arrival to handover more than 60mins (KPI 3) *TRUST ONLY* (Target: < 0)	1	0	0	1
OP	Average Wait – Referral to First Attendance (Weeks) (Target: < 6 weeks)	6.1	6.4	6.7	6.4
	Choose and Book slot issue % *TRUST ONLY* (Target: < 2.0%)	8.0%	15.2%	N/A	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%	89.1%	96.1%
RTT	18 week referral to treatment times Admitted Patients (Target: > 90%)	90.5%	90.9%	90.1%	90.5%
	18 week referral to treatment times Non Admitted Patients (Target: > 95%)	95.3%	95.5%	95.0%	95.2%
	18 week RTT incomplete pathways (Target: > 92%)	93.0%	92.1%	92.1%	92.4%
	RTT Incomplete 52 Wk Patients @ Month End (Target: = 0)	1	1	0	2
IP	Average Wait – Decision to admit to Admission (Weeks) (Target: < 6 weeks)	7.8	7.4	8.7	8.0

A&E Performance: The national Emergency Department waiting times standard of >95% has been maintained for June. Compared with this month the previous year, we have seen a slight increase in adult A&E (rather than UCC) attendances.

LAS: ambulance handovers has improved for June, with a reduction in reported breaches for 30 mins handover times and no 60 mins breaches.

Average Wait – Referral to First Attendance & Average Wait – Decision to admit to Admission: Performance is below target for both indicators. Ongoing programme of work being carried out to improve the overall Referral to Treatment process being led by the Divisional Director of Operations for Planned Care.

Choose and Book Slot Issues: An area of high demand is gastroenterology, for which additional locum resource has been arranged from July. HSCIC has advised that it will not make monthly data available until August 2015.

Referral to Treatment Indicators: All three referral to treatment indicators were achieved in June.

Sub Domain	Trust Level Monthly Data @ 06/07/2015 XL				YTD XL
	MonthYear	Apr 2015	May 2015	Jun 2015	YTD
Cancer	Cancer Consultant Upgrade (Target: ≥ 85%)	100.0%	100.0%	N/A	N/A
	Cancer diagnosis to treatment waiting times - 31 Days (Target: ≥ 96%)	100.0%	100.0%	N/A	N/A
	Cancer diagnosis to treatment waiting times - Subsequent Medicine (Target: ≥ 98%)	100.0%	100.0%	N/A	N/A
	Cancer diagnosis to treatment waiting times - Subsequent Surgery (Target: ≥ 94%)	N/A	100.0%	N/A	N/A
	Cancer urgent referral Consultant to treatment waiting times (62 Days) (Target: ≥ 90%)	100.0%	100.0%	N/A	N/A
	Cancer urgent referral GP to treatment waiting times (62 Days) (Target: ≥ 85%)	89.7%	100.0%	N/A	N/A
	Cancer urgent referral to first outpatient appointment waiting times (2WW) (Target: ≥ 93%)	93.42%	93.3%	N/A	N/A

Cancer Indicators:

All Cancer indicators were achieved in May. Cancer data is not yet available for June, though all indicators are expected to be achieved.

Access and Efficiency (2)

Sub Domain	Trust Level Monthly Data @ 17/07/2015 XL				YTD XL
	MonthYear	Apr 2015	May 2015	Jun 2015	YTD
Admitted	Delayed transfers - Patients affected *TRUST ONLY* (Target: < 2.00%)	3.74%	2.51%	2.22%	2.82%
	Delayed transfers of care days lost (Target: < 644)	451	436	228	1115
DQ	Coding Levels complete - 7 days from month end (Target: > 95%)	98.8%	98.7%	98.6%	98.7%
	Total NHS Number compliance (Target: > 98%)	96.9%	96.7%	96.9%	96.8%
GP Real Time	Discharge Summaries Sent < 24 hours (Target: > 70%)	81.1%	80.9%	82.8%	81.6%
	Discharge Summaries Sent In Real Time (Target: > 80%)	68.2%	69.4%	69.9%	69.2%
	GP notification of an A&E-UCC attendance < 24 hours (Target: > 70%)	99.93%	99.94%	99.98%	99.95%
	GP notification of an emergency admission within 24 hours of admission (Target: >)	99.83%	99.92%	100.00%	99.91%
	GP Notification of discharge planning within 48 hours for patients >75 (Target: > 70%)	66.37%	63.84%	65.37%	65.19%
Outpatients	OP Letters Sent < 7 Working Days (Target: > 70%)	61.2%	63.1%	62.1%	62.1%
	Average PICs per patient (Target: < 0.64)	0.59	0.59	0.62	0.60
	DNA Rate (Target: <11.1%)	11.1%	11.6%	11.5%	11.4%
	First to Follow-up ratio (Target: < 1.5)	1.64	1.49	1.49	1.54
	Hospital cancellations \ reschedules of outpatient appointments % of total attendances (Target: < 8.00%)	10.5%	10.7%	9.4%	10.2%
	Hospital cancellations made with less than 6 Weeks Notice (Target: < 3%)	5.6%	5.4%	4.9%	5.3%
	Patient cancellations \ reschedules of outpatient appointments % of total attendances (Target: < 8%)	8.9%	9.0%	8.8%	8.9%
Theatres	No urgent op cancelled twice (Target: = 0)	0	0	0	0
	On the day cancellations not rebooked within 28 days (Target: = 0)	N/A	N/A	N/A	N/A
	On the day cancelled operations (non clinical) % total elective admissions (Target: < 0.80%)	0.40%	0.41%	0.46%	0.42%
	Theatre booking conversion rate (Target: > 80%)	88.4%	88.1%	87.1%	87.9%

Delayed Transfers – Patients Affected: This performance has improved in June and the Trust is aiming for the challenging target of <2%. There is a weekly meeting of all partner organisations to address complex delays.

DNA Rate: The Trust has experienced a number of issues with regard to set-up of the text reminder service since the transition from the old provider of NHS mail to EE. This was resolved in mid June and therefore the DNA rate is expected to reduce back in line with the Trust target.

On the day Cancellations: Due to inconsistencies in the systems the 'on the day cancellations' indicator is under investigation.

Mandatory Training

Division	Total	Corporate Division	Emergency & Integrated Care Division	Planned Care Division	Womens, Childrens and Sexual Health Division
Mandatory Training Compliance %	78%	87%	78%	79%	77%
Fire	73%	83%	72%	74%	70%
Moving & Handling	74%	77%	72%	73%	75%
Equality & Diversity	85%	84%	91%	87%	81%
Information Governance	74%	85%	73%	78%	69%
Hand Hygiene	75%	77%	76%	75%	75%
Health & Safety	86%	86%	83%	86%	87%
Basic Life Support	71%	84%	70%	68%	74%
Safeguarding Adults Level 1	100%	100%	100%	100%	100%
Child Protection Level 1	100%	100%	100%	100%	100%
Safeguarding Children Level 2	81%	93%	83%	80%	81%
Safeguarding Children Level 3	77%	N/A	74%	86%	77%
Conflict Resolution	36%	N/A	37%	39%	32%

Red – 0-79%
Amber – 80-94%
Green – 95-100%

Mandatory training:

Mandatory training compliance against the 10 core topics identified in the UK Core Skills Training Framework currently stands at 78% which is 4% above the average for London teaching hospital trusts.

The inclusion of Conflict Resolution (previously unreported) has negatively impacted Trust compliance figures - for example, without Conflict Resolution, the overall Trust compliance is 81%.

However, the Trust is now in a position to consistently and more accurately monitor and compare performance with other Trusts.

Health & Safety training compliance stands at 86% (ratio of staff trained within the two year refresher period across all staff groups), equal to last month. A new approach to Fire Training is also being piloted to ensure increased compliance.

A detailed report on the progress with the fundamental review of statutory and mandatory training is being reviewed at the People and OD Committee on 22 July.

Average (Appraisal rate) across LATTIN Trusts = 74% (latest data available)

Average (Statutory mandatory training) across LATTIN Trusts = 75% (latest data available)

Workforce

Workforce Metric	Jun-15	Monthly Target	2014/15 Outturn10	2015/16 Annual Target11	Average 12 Month Rolling YTD12
Turnover Rate1	19.51% (1.35%)	(1.38%)	19.12%	16.50%	-
Vacancies - Budgeted2	13.34%	12%	10.94%	8%	11.42%
Vacancies - Active3	4.14%	-	4.45%	-	4.32%
Time to Recruit4	57 days	<55 days	54.5 days	<55 days	55 days
Sickness Rate5	2.84%	3%	2.85%	3%	2.93%
Agency % of WTE6	4.20%	3.15%	3.50%	3.15%	3.80%
Appraisals - Non M&D7	72%	76%	72%	85%	71%
Appraisals - M&D8	86%	83%	79%	85%	81%
Mandatory Training9	79%	79%	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 2.10% on the same period in the previous year, from 17.41% (July 13 - June 14) to 19.51% (July 14 - June 15). This is largely due to a significant spike in voluntary resignations in Q2 of 2014/15 meaning 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 June there were 45 voluntary resignations, which equates to 1.35% of the total workforce (14 lower than the same period last year). To achieve the target of 16.5% turnover for the financial year there would need to be an average of 41 voluntary leavers per month. Over the last three months the Trust has seen 145 voluntary leavers and 139 new starters (excluding jnr. docs). An update on Nursing workforce issues and Recruitment and Retention Plans will be taken to the July People and OD Committee, detailing 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 provided in June were 'Other/Not Known' and 'Relocation'.

Average across LATTIN Trusts = 15.2% (latest data available)
LATTIN = London Acute Training Trusts (Imperial College, King's College, Royal Free Marsden, UCLH, Chelsea & Westminster, and Guy's).

Bank & Agency Usage: Total temporary staffing WTE's for June 15 were 34.67 higher than the same period last year. The bulk of this is accounted for by an increase in agency WTE of 32.14. As a proportion to substantive WTE, the highest agency use was in Medicine and Intensive Care. Recruitment drives continue in these areas and others with increased establishments, to reduce the use of agency staff. Temporary staffing made up 12.9% of the overall workforce in June 15 compared to 12.1% in June 2014. Of this, agency WTE as a % of workforce increased from 3.3% to 4.2%. The need to reduce agency spend is recognised as a priority and Kingsgate are monitoring PIDS for CIP schemes 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 Trust vacancy rate for June 15 was 13.34%, an increase of 1.68% on last year and 1.34% above the monthly target. There have been increases in some nursing establishments, to meet staffing level requirements identified by the last CQC report. The medical establishment in A&E also increased in June. It is also important to recognise that not all vacancies are being actively recruited to, and a large proportion of them are held on the establishment to support the Cost Improvement Programme (CIP). Finance & Human Resources continue to reconcile their establishments on a monthly basis to ensure consistent reporting.
A truer measure of vacancies is the number of posts being actively recruited to, based on the WTE of posts advertised on NHS jobs. Bulk recruitment continues in nursing (Medical wards, A&E & ICU), along with multiple medical posts in A&E.
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 June 15 starters was 57 days which is marginally above the Trust target of <55days.
Average vacancies across LATTIN Trusts = 12.02% (latest data available)

Sickness Absence: The Trust's sickness absence rate in June 15 was 2.84% (Trust target = 3%).

Staff in Post: In June 15 the Trust substantive staff in post position was 3043.83 WTE (whole time equivalents), an increase of 31.78 since June 14. There were 45 voluntary leavers and 53 joiners (excluding jnr. Docs) over the month. The largest annual increases were in the Women, Children & Sexual Health Division (41.36 WTE), and the Additional Clinical Services staff group (35.59 WTE). The largest decreases were in the Corporate Services Division (26.99 WTE), and the Admin and Clerical staff group (22.05 WTE). These reductions relate largely to the outsourcing of Finance transactional services in August and October 14. Reductions in Pharmacy (13.45 WTE) largely relate to the CNWL SLA ending in March 15, and staff that were on fixed term contracts leading up to the Pharmacy outsourcing coming to an end.

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	(379,954)	(94,550)	(95,415)	864
Expenditure	362,270	91,435	91,664	(229)
EBITDA	(17,685)	(3,115)	(3,751)	636
EBITDA %	4.7%	3.3%	3.9%	0.6%
Surplus/(Deficit) from Operations	17,685	3,115	3,751	636
Interest/Other Non OPEX	811	203	201	1
Depreciation	12,951	3,238	3,255	(17)
PDC Dividends	11,421	2,855	2,878	(23)
Surplus/(Deficit)	(7,498)	(3,181)	(2,584)	597

Comments

The month 3 position is a deficit of £0.5m, which brings the year to date position to a deficit of £2.6m (EBITDA of 3.9%). This is a £0.6m favourable variance against the year to date plan of £3.2m.

The Trust over-performed against the CIP target in month 3 and achieved a COSR rating of 2.

The Q1 Monitor Plan is a £3.9m deficit, so the Trust has a £1.3m favourable variance against the Q1 Monitor plan.

Risk Rating (year to date)

COSR Rating	Weighting	M3 Planned Rating	M3 Actual Rating
Capital Servicing Capacity	50%	1	1
Liquidity	50%	4	4
Total Rating		3	3

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

Month ended: June

Risk Rating	PID (£'000)	Month 3 Performance Plan	Month 3 Performance Actual	Month 3 Performance Var	YTD Performance Plan	YTD Performance Actual	YTD Performance Var
High	1 - Outpatient CIP	0	5	5	0	5	5
Medium	2 - LOS	23	23	0	45	41	(5)
High	3 - Theatre productivity	0	0	0	0	0	0
Low	4 - Diagnostic Services	3	4	1	9	7	(2)
Medium	5 - Clinical Admin	8	4	(4)	25	50	25
Medium	6 - Temporary Staffing	60	19	(41)	140	172	32
	6a - Pay controls	0	82	82	0	353	353
High	7 - Medical Staff Productivity	0	0	0	0	0	0
Low	8 - Management Structure	0	0	0	0	0	0
Medium	9 - Corporate Services and Back Office	0	0	0	0	0	0
Medium	10 - Estates	203	203	0	368	362	(6)
Medium	11 - Procurement	35	68	33	84	118	34
Low	12 - Pharmacy Led Savings	264	423	158	425	453	28
High	13 - Divisional Savings	59	69	9	113	117	4
Low	14 - FYE	14	14	0	42	42	0
	15 - Specialist Nurses	0	3	3	0	9	9
	Total	670	916	246	1,252	1,728	476

Comments

The CIP achievement in month 3 was £0.9m against the target of £0.7m. The over-performance was primarily in the pharmacy outsourcing CIP scheme which went live in June and pay controls due to underspends within budgets.

Key Financial Issues

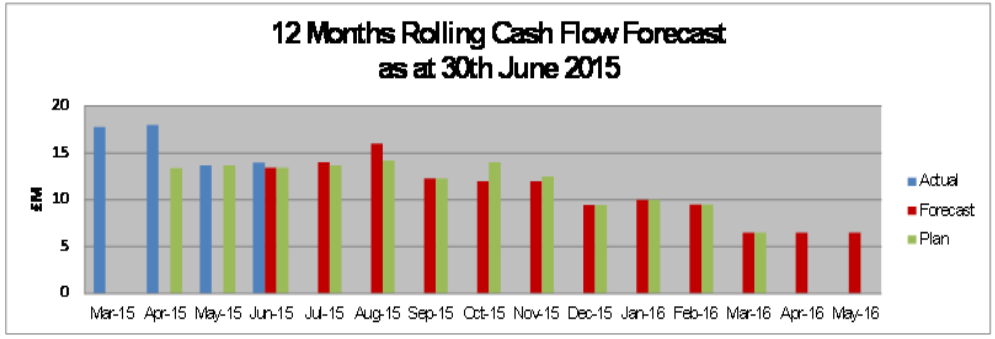
Performance against plan

The key drivers for the £0.6m over-performance against the plan

- Clinical income over-performance mainly related to over-performance in local authority income for GUM £0.96m
- Private Patient income shortfall of £0.9m offset against underspends in expenditure
- Other income over-performance of £0.9m mainly related to income offset against expenditure
- Pay underspend of £0.9m mainly related to nursing under-spends
- Non pay over-spend of £1.1m related to additional cost pressures and management consultancy charges

The key risks to delivery of the plan are
- CIP delivery
- Private Patient income
- Clinical income

Cash Flow



Comments

The cash position at M03 is £14.0m compared to a plan of £13.4m. The favourable variance was assisted by the drawing of £2.7m of loan finance during the month, relating to the ED capital development.
Concerns remain regarding the historically high levels of debt. Actions are in place to reduce the level of uncollected cash, including weekly meetings and escalation of old debt and a short advisory piece of work has been commissioned from PWC to report at the end of July.

Trust Performance Report – June 2015
RTT (Referral to Treatment) Performance – Briefing Note

Board of Directors (Public)
30th July 2015

1. Context

1.1. In recent months, there has been an unexplained growth in the backlog of patients waiting beyond 18 weeks for treatment and the limited assurance report provided by our auditors as a result of data quality issues that they found. This prompted the Chief Operating Officer to request an investigation into the cause of this backlog growth with a view to ascertaining whether this backlog growth was genuine and what impact this has on the stability of the organisation's RTT performance.

1.2. Between May and July, the performance, operational and information teams have worked together to investigate this issue. This investigation phase is nearing completion and there is now a clearer view that the root cause of the backlog is largely due to poor data quality which is compounded by operational processes that are not in line with good practice.

1.3. The data quality issues have largely resulted from user data-entry errors. Additionally, there are anomalies with the RTT coding in the organisation's computerised patient administration system and in the data warehouse which generates the Trust's performance reports.

2. Plan to address the data quality issues

2.1. The Trust has developed a plan to validate (cleanse) the data related to RTT waiting times. The Trust's Corporate Directors have agreed some fixed term additional funding to support this work which is expected to take 12 weeks to complete, commencing in August with completion in mid—November. This approach allows the substantive administrative teams to focus on "correct first time" data entry and business as usual pathway validation work.

2.2. It is recognised that this first phase of data validation work may uncover other data quality issues and it is anticipated that this would start to emerge within the first four weeks of the work programme. As required, secondary validation would be planned to commence towards the end of September 2015. A full plan would be developed as appropriate.

3. The risk to the organisation in relation to its RTT performance compliance

3.1. Current projections suggest that once data cleansing work commences, this will expose a material volume of previously unreported or incorrectly reported pathways, some of which may not have been managed within 18 weeks.

3.2. It must be noted however that if there were a large number of patients waiting extended lengths of time or not receiving the appropriate treatment, this would have materialised in the form of complaints and incidents which the Trust has not seen.

3.3. Based on the organisation's level of confidence of the known scale of the problem and a resourced plan to address data cleansing and backlog clearance, it is the intention that the Trust continue to report its RTT position, but with the known caveat of the work to improve our data quality.

Board of Directors Meeting, 27 July 2015

PUBLIC

AGENDA ITEM NO.	9/Jul/15
REPORT NAME	Monitor In-Year Reporting & Monitoring Report Q1
AUTHOR	Virginia Massaro, Assistant Director of Finance
LEAD	Lorraine Bewes, Chief Financial Officer
PURPOSE	Submission of commentary to Monitor on the Quarter 1 2015/16 in year financial return
SUMMARY OF REPORT	**Financial Performance** The Trust reported a £2.6m deficit in the first quarter of 2015/16 against a planned deficit of £3.9m, £1.3m ahead of plan. The EBITDA was £3.8m (3.9%) for the quarter. The overall COSR is based on two ratios capital serving capacity ratio and liquidity; was 3 compared against a plan of 3. CIP performance (including revenue generation) was ahead of plan by £0.6m, which mainly relates to holding of non-recurrent vacancies and CIP delivery for estates non-pay recognised earlier than the plan. **Targets and Indicators** The Trust achieved all indicators in quarter 1, with the exception of compliance with requirements regarding access to healthcare for people with learning difficulties.
KEY RISKS ASSOCIATED	- Financial declaration "Not Confirmed" that the Trust will continue to maintain a continuity of service rating of at least 3 over the next 12 months, due to planned COSRR of 2 in 2015/16 - Governance Declaration "Not confirmed" that the Trust has plans in place to achieve on-going compliance with all existing targets due to non-compliance with access to people with learning difficulties and risk to delivery of challenging C.Diff target.
FINANCIAL IMPLICATIONS	The Trust was £1.3m ahead of plan in Q1, with a COSRR of 3. The forecast is £7.5m deficit (which is in line with the Trust's annual plan).
QUALITY IMPLICATIONS	There is a risk to on-going compliance with all existing targets due to non-compliance with access to healthcare for people with learning difficulties.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	Ensure Financial and Environmental Sustainability Deliver 'Fit for the Future programme'

DECISION/ ACTION	The Trust Board is asked to: 1. Delegate approval to the Chief Financial Officer to approve, on behalf of the Board, submission of the Quarter 1 2015/16 in-year financial reporting return to Monitor. 2. Approve the commentary for the submission to Monitor 3. Approve the forecast at £7.5m deficit for the year 4. Approve the In Year Governance Statement (attached in Appendix 1) which includes the following elements: - Approve the financial declaration "Not Confirmed" that the Trust will continue to maintain a continuity of service rating of at least 3 over the next 12 months, due to planned COSRR of 2 in 2015/16 - Approve the Governance Declaration "Not confirmed" that the Trust has plans in place to achieve ongoing compliance with all existing targets due to non-compliance with access to people with learning difficulties.

Monitor In-Year Reporting & Monitoring Report Q1

1. Introduction/ Background

1.1. A financial reporting return and commentary are required to be submitted to Monitor on a quarterly basis. This report provides commentary to be submitted with the financial return for the quarter ending June 2015.

2. Decision/Action required

2.1. The Trust Board is asked to:

2.1.1. Delegate approval to the Chief Financial Officer to approve the submission of the Quarter 1 2015/16 in-year financial reporting return to Monitor, on behalf of the Board.

2.1.2. Approve the commentary for the submission to Monitor

2.1.3. Approve the forecast of £7.5m deficit for the year (which is in line with the annual plan)

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

- Approve the financial declaration – "Not Confirmed" that the Trust will continue to maintain a continuity of service rating of at least 3 over the next 12 months, due to planned COSRR of 2 for 2015/16
- Approve the Governance Declaration – "Not Confirmed" that the Board, is 'satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards', due to non-compliance with the access to healthcare for people with learning difficulties:

3. Content

3.1. **Governance Declaration**

3.1.1. **Continuity of Service Rating (COSR):** The Trust recorded a Continuity of Service Rating (COSR) of 3 at quarter 1 compared to a plan of 3.

Finance declaration - "Not Confirmed" that the Board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months. The forecast and annual budget is £7.5m deficit which gives a COSR of 2.

3.1.2. **Compliance with targets:** The Trust achieved all targets and indicators in quarter 1; with the exception of compliance with requirements regarding access to healthcare for people with learning difficulties.

The Trust is not currently fully compliant with all six requirements regarding access to healthcare for people with learning disabilities, but is working to achieve compliance in 2015/16, in line with the Trusts CQC action plan.

Governance declaration - "Not confirmed" that the Board is 'satisfied that plans in place are sufficient to ensure: on-going compliance with all existing targets as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards'.

This is due to not achieving compliance with requirements regarding access to healthcare for people with learning difficulties, with an action plan in place to achieve compliance in 2015/16 and an identified risk with regard to clostridium difficile, due to the challenging target of 7 in 2015/16.

3.2. In the first quarter of 2015/16 there were no elections to fill posts on the Council of Governors, there were one resignation from the Council of Governors and there were no changes to the Council of Governors stakeholder appointments (Appendix 2).

3.3. **Capital Declaration -** Capital Spend for quarter 1 is £4.6m against Plan of £4.0m, a variance of £0.6m (15% of plan). The forecast out-turn capital expenditure for 2015/16 is £23.9m against the plan of £23.9m.

3.4. **Financial Position -** In quarter 1, the Trust reported a deficit of £2.6m (against a quarter 1 planned deficit of £3.9m). The EBITDA was £3.8m (3.9%). The forecast outturn is £7.5m deficit (as per the annual plan).

3.5. **Statement of Comprehensive Income**

NHS Clinical Revenue

3.5.1. The underlying NHS clinical income is ahead of plan in the first quarter of 2015-16.

3.5.2. Elective and day case activity is £0.3m ahead of plan in Q1. Elective spells are £0.2m ahead of plan mainly in general surgery and burns care. Day case spells are also ahead of plan in the quarter (£0.1m) particularly in endoscopy.

3.5.3. Non Elective activity is £0.3m ahead of plan in Q1. This is largely driven by an increase in non-emergency activity particularly in maternity and neonatal surgery following the discharge of one of the two long stay patients in June. Emergency activity is in line with plan reflecting a similar trend in A&E activity.

3.5.4. Outpatient income is £0.5m ahead of plan in Q1. This is largely driven by an increase in first and follow-up attendances in several Medicine specialties such as cardiology, clinical haematology and respiratory medicine.

3.5.5. NHS Clinical Income for other points of delivery is £0.6m below plan in the quarter. Critical care activity is £0.3m below plan mainly due to under-performance in burns critical care (£0.1m) and paediatric HDU (£0.3m) partly off-set by over-performance in adult critical care (£0.2m). Maternity pathway income is in line with plan.

3.5.6. Pass through drugs are £0.5m below plan for the quarter largely driven by under-performance in PbR excluded drugs, which is offset by an under-spend on non-pay expenditure. Pass through devices are in line with plan.

Non NHS Clinical Income/Other Operating Income

3.5.7. Private Patient income was £1.0m behind the Q1 plan, which was attributed to private HIV/GUM, maternity, paediatrics and the Chelsea wing. This adverse variance in income relates to activity shortfalls against the activity targets. These have been offset against under-spends in pay and non-pay.

3.5.8. Other non-NHS clinical income is ahead of the Q1 plan by £1.0m. This is driven by the continued over-performance of GUM activity commissioned by local authorities.

3.5.9. Other Operating revenue is ahead of the Q1 plan by £2.8m. This mainly relates to £1.8m of income related to integration funding for the West Middlesex acquisition, which is offset by expenditure, £0.7m over-performance against accommodation income and income and £0.4m for miscellaneous other operating income of which £0.2m relates to IT shared services set up costs.

Operating Expenditure

3.5.10. Pay - There was an adverse variance against the Q1 plan by £0.3m. The Trust is overspent on permanent staff by £0.2m in the quarter, the temporary staffing is over-spent by £0.1m. Quarter 1 overspends were related to medical pay due to additional cost pressures and additional medical spend on service developments. There was an increase requirement of special hours for mental health nurses and HCA's. It is noted that nursing was underspent against the plan.

3.5.11. Raw materials and consumables are overspent by £1.1m in the quarter, this is mainly related to activity related overspends in areas such as GUM, which is offset against clinical income, and other cost pressures in general supplies. Purchase of healthcare services is overspent by £0.3m due to additional cost pressures and includes £0.1m related to the setup costs for pathology hub.

3.5.12. Other non-pay is £0.3m overspent in the quarter. This is driven by expenditure related to transaction integration work streams of £1.9m (offset by income), additional consultancy costs supporting corporate strategy and development and CIP implementation costs. This was offset by under-spends in miscellaneous other operating expenses which mainly relate to planned cost pressures within reserves, which have not materialised in the first quarter.

CIP

3.5.13. CIP performance (including revenue generation) was ahead of plan by £0.6m, which mainly relates to holding of non-recurrent vacancies £0.4m and over-performance in non-pay CIP of £0.2m for delivery for estates non-pay recognised earlier than planned.

Forecast

3.5.14. The forecast outturn is £7.5m deficit which is in line with the annual plan.

3.6. **Statement of Financial Position**

3.6.1. **Property Plant and Equipment:** The capital expenditure in quarter 1 was £4.6m against the plan of £4.0m, which was £0.6m (15%) ahead of plan. Overspends in the year to date position are primarily driven by the phasing of the capital expenditure and is forecast to underspend in future months.

3.6.2. The majority of the year to date spend (£3.6m) related to Building Projects, representing 78% of total spend. The majority of building spend was on the following projects: ED Expansion project (£2.65m), Reconfiguration of MDU (£0.27m), Children Outpatient (COP) project (£0.18m), and Medi-Cinema (£0.4m).

3.6.3. The remaining £1.0m of YTD spend was against IT projects and a number of Medical Equipment schemes, highlighted by spend on the Diagnostic Cloud /ICE project (£0.28m), LastWord Development (£0.13m), and Diagnostic Scopes (£0.15m).

3.6.4. **Receivables and Other Current Assets:** At 30 June, total receivables were £58.5m (against the plan of £45.8m). A review of process has been commissioned from PwC to devise methods of reducing this exposure.

3.6.5. **Current Liabilities:** At 30 June, total current liabilities were £52.4m (against the plan of £45.6m).

3.6.6. **Cash Flow:** The cash balance at the end of the quarter was £14.0m, against plan of £13.4m, which represents a slightly favourable position against plan.

4. Summary

4.1. **Financial Performance**

4.1.1. In quarter 1, the Trust reported a deficit of £2.6m (against a Q1 planned deficit of £3.9m), a favourable variance of £1.3m. The EBITDA was £3.8m (3.9%).

4.1.2. The Trust has achieved a Continuity of Service Rating (COSR) of 3 as at 30th June 2015, which is in line with plan. The forecast COSR rating is 2.

4.2. **Targets and Indicators**

4.2.1. In quarter 1, the Trust achieved all targets and indicators, with the exception of compliance with requirements regarding access to healthcare for people with learning difficulties.

Appendix 1 – In Year Governance Statement

Click to go to index

In Year Governance Statement from the Board of Chelsea and Westminster NHS Foundation Trust

The board are required to respond "Confirmed" or "Not confiirmed" to the following statements (see notes below)	Board Response
For finance, that: The board anticipates that the trust will continue to maintain a Continuity of Service risk rating of at least 3 over the next 12 months.	Not Confirmed
For governance, that: The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.	Not Confirmed
Otherwise: The board confirms that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework, Diagram 6) which have not already been reported.	Confirmed
Consolidated subsidiaries: Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds.	0

Signed on behalf of the board of directors

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

Appendix 2

In the first quarter of 2015/16:

I. ELECTIONS

There were no elections to fill posts on the Council of Governors.
There was one resignation from the Council of Governors.
There were no changes to the Council of Governors stakeholder appointments.

II. BOARD OF DIRECTORS

There were no changes in the composition of the Board of Director this quarter.

During the quarter we were actively recruiting to appoint the substantive Chief Executive Officer. Appointment which was approved by the Board of Directors (via the Nominations and Remuneration Committee) 09.06.15 and the Council of Governors 16.07.15 will be detailed in the quarter two.

III. COUNCIL OF GOVERNORS

a. Retirements and Resignations

i. Elected

A vacancy was created in the Patient Constituency following the resignation of Chris Birch 11.05.15

ii. Stakeholders

There were no changes.

b. Appointments (stakeholder)

There were no changes.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 27 July 2015

PUBLIC

AGENDA ITEM NO.	10/Jul/15
REPORT NAME	Register of Seals Report Q1
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Thomas Lafferty, Foundation Trust Secretary
PURPOSE	To keep the Board informed of the Register of Seals.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	NA
LINK TO OBJECTIVES	NA
DECISION/ ACTION	For Information.

Register of Seals Report Q1

Section 12 of the Standing Orders provided below refers to the sealing of documents.

12.2 Sealing of documents

12.2.1 Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two senior managers duly authorised by the Chief
Executive, and not also from the originating department, and shall be attested by them.

12.2.2 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Director of Finance (or an employee nominated by him/her) and authorised and countersigned by the Chief Executive (or an employee nominated by him/her who shall not be within the originating directorate).

During the period 1 April 2015 – 30 June 2015, the seal was affixed to the following documents:

Seal Number	Description of the Document	Date of sealing	Affixed by	Attested
155	Chelsea Harbour Lease Unit G2, Harbour Yard, Chelsea Harbour, London SW10 0XD (5 copies)	17.04.15	Elizabeth McManus, Chief Executive Officer	Lorraine Bewes Chief Financial Officer
156	Reversionary Lease between Essex County Council and the Trust – Reversionary Underlease relating to part lower ground, part ground, first, second, third and fourth floor premises at 56 Dean Street, London W1 (1 Copy)	13.05.15	Elizabeth McManus, Chief Executive Officer	Lorraine Bewes Chief Financial Officer
157	Deed of Variation on Grant of Supplemental Lease between Essex County Council and Chelsea and Westminster Hospital NHS Foundation Trust dated 11 September 2008 relating to part lower ground, part ground, first, second, third and fourth floor premises at 56 Dean St, London W1 (1 copy)	13.05.15	Elizabeth McManus, Chief Executive Officer	Lorraine Bewes Chief Financial Officer
158	Underlease relating to part third floor premises at 56 Dean Street, London W1, between the Trust and Boots UK Limited (1 copy)	13.05.15	Elizabeth McManus, Chief Executive Officer	Lorraine Bewes Chief Financial Officer
159	Essex County Council to Chelsea and Westminster Hospital NHS Foundation Trust and Boots UK Limited – Licence to Underlet relating to part third floor, 56 Dean Street, London W1 (3 copies)	13.05.15	Elizabeth McManus, Chief Executive Officer	Lorraine Bewes Chief Financial Officer

160	Chelsea and Westminster Hospital NHS Foundation Trust and Boots UK Limited – Licence to carry out alterations to premises known as Part Third Floor, 56 Dean Street, London W1 (1 copy)	13.05.15	Elizabeth McManus, Chief Executive Officer	Lorraine Bewes Chief Financial Officer
161	Stamp Duty Land Tax Authorisation Form – Transaction Return in relation to the Trust's reversionary lease and authorisation form. (1 copy)	13.05.15	Elizabeth McManus, Chief Executive Officer	Lorraine Bewes Chief Financial Officer

Board of Directors Meeting, 27 July 2015

PUBLIC

AGENDA ITEM NO.	11/Jul/15
PAPER	A Framework of Quality Assurance for Responsible Officers and Revalidation - Annual Board Report July 2015
AUTHOR	Tim Fairclough, Medical Appraisal and revalidation Officer, Jacqueline Durbridge, RO Delegate, Zoe Penn, Medical Director
LEAD	Zoe Penn, Medical Director
PURPOSE	The Framework of Quality Assurance (FQA) provides an overview of the elements defined in the Responsible Officer Regulations, along with a series of processes to support Responsible Officers and their Designated Bodies in providing the required assurance that they are discharging their respective statutory responsibilities
LINK TO OBJECTIVES	To improve patient safety and clinical effectiveness
RISK ISSUES	Minor risk to not discharging statutory duties.
FINANCIAL ISSUES	None.
OTHER ISSUES	Nil
LEGAL REVIEW REQUIRED?	no
EXECUTIVE SUMMARY	Chelsea and Westminster Hospital NHS Foundation Trust have 314 doctors with a prescribed connection. There have been 256 completed appraisals within the appraisal year. We have made positive revalidation recommendations for 204 (65%) of our doctors in 2014/15.
DECISION/ ACTION	Board to accept report. Please note it will be shared, along with the annual audit, with the higher level responsible officer. Board to approve the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations.

DH Department of Health

NHS England

THE NHS CONSTITUTION
the NHS belongs to us all

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annual Board Report July 2015

1. Executive summary

Chelsea and Westminster Hospital NHS Foundation Trust have 314 doctors with a prescribed connection. There have been 256 completed appraisals within the appraisal year. The appraisal team follow up and investigate missing appraisals and the majority of doctors eventually complete an appraisal. We have made positive revalidation recommendations for 204 (65%) of our doctors in 2014/15.

2. Purpose of the Paper

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

This report describes the progress against last year's improvement plans and sets out the future direction in light of the recent audit and recommendations. This is a statement of compliance with the FQA to the Board and higher level responsible officers.

3. Background

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

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

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

Appraisal is focused on a doctor's fitness to practise and professional development to enhance this. This means that there is a clear distinction between appraisal and Job Planning, which is focused on determining the quantity and scope of a doctor's work to meet service and organisational objectives – and should be a process that is carried out at a separate meeting.
Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their

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

doctors;

- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

4. Governance Arrangements

The RO is accountable to the Board for ensuring the implementation and operation of appraisals for all medical staff with whom the organisation has a "prescribed connection"; it is also a contractual requirement for all medical staff to participate in annual appraisal. Therefore, the objective will be to maintain an appraisal rate of 100% for medical staff over a twelve month period. The 2014-15 rate was 86%.

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

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

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

a. Policy and Guidance

The Trust Medical Appraisal policy was published September 2012 and then revised and re-published in November 2013. The policy is in the process of being reviewed in line with new NHS England guidance, the integration with West Middlesex and the outcome of the external audit.

5. Medical Appraisal

a. Update on Action Plan from 14/15 Board Report

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

We haven't introduced an electronic system due to the complexness of doing so. However Zircadian has consistently reduced the upload time to 10 working days or less. Feedback from the users has been favourable. The ideal would be to move to a continual collection of patient feedback, reportable at an individual level.

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

Since April we have been able to collect feedback on appraisers via the system. An overview of this has been presented at the latest Appraiser Forum. See details below.

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

This was achieved from the beginning of April. All appraises have been reallocated and cross-specialty appraisals have commenced.

b. Appraisal and Revalidation Performance Data

Please See Annual Report Appendix A

c. Appraisers

We have 74 trained appraisers as at end of 2014/15. During this period we held 2 new appraiser training sessions provided by external facilitators. We held 2appraiser forums to provide education and an opportunity to discuss the implementation of revalidation during the year; approximately half of our appraisers attended at least one of these. The focus of these has now shifted to quality improvement of appraisals. Attendance at a minimum of 2 per year will is mandated for 2015/16.

Since April 2015 we have started collecting electronic feedback from appraises about their appraiser once they have completed their appraisal. This includes feedback on their listening, support and overall effectiveness. Throughout the year the Appraisal Lead intends to have 1:1 meetings with each individual appraiser and present their feedback.

d. Quality Assurance

In May 2015 an external audit of the Appraisal and Revalidation process at Chelsea and Westminster was commissioned to ensure GMC compliance and provide a baseline of the current appraisal system and practice in preparation for integration planning with West Middlesex in 2015/2016.

The findings of the audit established that a robust system and associated guidance has been implemented at Chelsea and Westminster. However, there is a need for improvement in terms of doctors' application of consistent practice. The quality of the appraisal summary on which the legally appointed Responsible Officer bases recommendations for the GMC is good but variable. In addition, appraisees need more support to improve the quality of supporting information, reflection and personal development planning in order to demonstrate their ongoing fitness to practice.

A sample of completed online appraisal forms (204) has been reviewed in 2014/15 by the Trust Medical Appraisal Lead. The sample comprised all doctors that have required a revalidation recommendation during this period. The aim of this review was to assess the content of the appraisal inputs and outputs and the extent to which they provided evidence of the quality of the appraisal. Also to ensure the presence of the minimum mandatory supporting evidence documents as stipulated by the GMC. On first review the majority of the 204 did not have sufficient supporting evidence. However this was subsequently added to ensure all those requiring revalidation recommendations meet the GMCs minimum requirements.

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

(See **Appendix B;** Quality assurance audit of appraisal inputs and outputs)

e. Access, security and confidentiality

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

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

f. **Clinical Governance**

Corporate data is used for individual doctors to contribute to supporting information. The clinical governance team provide individuals a report for appraisal which includes any clinical incident and/or complaint recorded on the Trust database linked to them in any capacity, any registered audit activity and participation in guideline review or publication. In 14/15 the process has been streamlined by a monthly correspondence between the Workforce and Clinical Governance departments which has improved the accuracy of the reports.

A similar report or statement is required from any other place of work of an individual as supporting evidence.

6. Revalidation Recommendations

Number of recommendations between April 14 – March 15– ***206***

*Recommendations completed on time -****204***

Positive recommendations - ***138***

Deferrals requests - ***64***

Non engagement notifications - ***0***

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

See **Annual Report Appendix C;** Audit of revalidation recommendations

7. Responding to Concerns and Remediation

See **Annual Report Appendix D**

8. Trinity Hospice

We have are still the responsible body for Trinity Hospice doctors. There are currently 3 doctors, whom undergo appraisals in line with our appraisal policy. Currently they have no doctors undergoing investigation or partaking in remediation. In 14/15 we successfully revalidated one of their doctors.

9. Improvement Plan and Next Steps

To do a gap analysis of the audit and recommendations, including securing a budget for the revalidation team and its functions.

To develop a 3-5 year strategy for the improvement and standardisation of the quality of appraisals across the trust.

Work with the integration team for West Middlesex to ensure a smooth transition of RO responsibilities and revalidation process and perform an external audit to help aid this.

Review and update appraisal policy, including the MSF questionnaires across both sites.

10. Recommendations

1. Board to accept report. Please note it will be shared, along with the annual audit, with the higher level responsible officer and to support any resource requirements to deliver a higher standard of appraisal.
2. Board to approve the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations
3. Board to approve a budget to allow the team to meet the audit recommendations.
4. Board to approve an audit of West Middlesex's appraisal process.

Audit of all missed or incomplete appraisals audit

Doctor factors (total)	**73**
Maternity leave during the majority of the 'appraisal due window'	4
Sickness absence during the majority of the 'appraisal due window'	4
Prolonged leave during the majority of the 'appraisal due window'	1
Suspension during the majority of the 'appraisal due window'	0
New starter within 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	0
Postponed due to incomplete portfolio/insufficient supporting information	62
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	0
Lack of engagement of doctor	2
Other doctor factors	0
(describe)	
Appraiser factors	**0**
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors (describe)	0
(describe)	
Organisational factors	**0**
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

Quality assurance audit of appraisal inputs and outputs

Total number of appraisals completed	
	35
Appraisal inputs	Number audited
Scope of work: Has a full scope of practice been described?	35
Continuing Professional Development (CPD): Is CPD compliant with GMC requirements?	35
Quality improvement activity: Is quality improvement activity compliant with GMC requirements?	35
Patient feedback exercise: Has a patient feedback exercise been completed?	35
Colleague feedback exercise: Has a colleague feedback exercise been completed?	35
Review of complaints: Have all complaints been included?	35
Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included?	35
Is there sufficient supporting information from all the doctor's roles and places of work?	35
Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)? Explanatory note: For example • Has a patient and colleague feedback exercise been completed by year 3? • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? • Have all types of supporting information been included?	35
Appraisal Outputs	
Appraisal Summary	35
Appraiser Statements	35
PDP	35

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2014 to 31 March 2015	
Recommendations completed on time (within the GMC recommendation window)	**204**
Late recommendations (completed, but after the GMC recommendation window closed)	**1**
Missed recommendations (not completed)	**0**
TOTAL	**204**
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	**0**
New starter/new prescribed connection established within 2 weeks of revalidation due date	**0**
New starter/new prescribed connection established more than 2 weeks from revalidation due date	**0**
Unaware the doctor had a prescribed connection	**0**
Unaware of the doctor's revalidation due date	**0**
Administrative error	**0**
Responsible officer error	**0**
Inadequate resources or support for the responsible officer role	**0**
Other	**3**
Describe other – RO Delegate on leave	
TOTAL [sum of (late) + (missed)]	**1**

Audit of concerns about a doctor's practice

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

March should be included	
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months	
Number of doctors who have had local restrictions placed on their practice in the last 12 months?	1
GMC Actions: Number of doctors who:	
Were referred to the GMC between 1 April and 31 March	
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March	
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March	
Had their registration/licence suspended by the GMC between 1 April and 31 March	
Were erased from the GMC register between 1 April and 31 March	
National Clinical Assessment Service actions:	4
Number of doctors about whom NCAS has been contacted between 1 April and 31 March:	
For advice	2
For investigation	1
For assessment	1
Number of NCAS investigations performed	1
Number of NCAS assessments performed	1