Chelsea & Westminster Hospital NHS Foundation Trust
Board of Directors Meeting (PUBLIC SESSION)

Room A, West Middlesex

5 July 2018 10:00 - 5 July 2018 12:30

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting (PUBLIC SESSION)
Location: Room A, West Middlesex
Date: Thursday, 5 July 2018
Time: 10.00 – 12.30

Agenda

	1.0	**GENERAL BUSINESS**		
10.00	1.1	Welcome and apologies for absence Apologies received from Sir Tom Hughes-Hallett.	Verbal	Deputy Chairman
10.03	1.2	Declarations of Interest including Register of Interests	Report	Deputy Chairman
10.05	1.3	Minutes of the previous meeting held on 3 May 2018	Report	Deputy Chairman
10.07	1.4	Matters arising and Board action log	Report	Deputy Chairman
10.10	1.5	Chairman's Report	Report	Deputy Chairman
10.20	1.6	Chief Executive's Report	Report	Chief Executive Officer
	2.0	**QUALITY/PATIENT EXPERIENCE AND TRUST PERFORMANCE**		
10.30	2.1	Patient Experience Story	Verbal	Chief Nurse
10.50	2.2	Quality Improvement	Report	Chief Nurse
11.00	2.3	Serious Incidents Report	Report	Chief Nurse
11.10	2.4	Integrated Performance Report including: 2.4.1 Workforce performance report	Report Report	Chief Operating Officer Chief Financial Officer
11.20	2.5	'Reducing sugar sweetened drinks' declaration	Report	Deputy Chief Executive
	3.0	**PEOPLE**		
11.25	3.1	Gender Pay	Report	Chief Financial Officer
	4.0	**GOVERNANCE**		
11.35	4.1	People and Organisational Development Committee Terms of Reference – for approval	Report	Steve Gill
11.37	4.2	Annual report on use of the Company Seal 2017/18	Report	Company Secretary

11.42	4.3	Updated Standing Financial Instructions (SFIs) and Reservation of Powers to the Board and Delegation of Powers (SoD)	Report	Chief Financial Officer
	5.0	**ITEMS FOR INFORMATION**		
11.45	5.1	Questions from members of the public	Verbal	Deputy Chairman
11.55	5.2	Any other business	Verbal	Deputy Chairman
12.00	5.3	Date of next meeting – 6 September 2018		

Board of Directors Register of Interests – updated 24 May 2018

VOTING BOARD MEMBERS	INTEREST(S)
Sir Tom Hughes-Hallett Chairman	Directorships held in private companies, Public Limited Companies or Limited Liability Partnerships: HelpForce Community Ownership or part-ownership of private companies, businesses of consultancies: THH Consultancy advising the Deputy Chair of United Health Group Position of authority in a charity or voluntary body: Chair & Founder HelpForce; Chair – Advisory Council, Marshall Institute; Trustee of Westminster Abbey Foundation Connections with a voluntary or other organisation contracting for or commissioning NHS Services: Chair & Founder HelpForce Son and Daughter-in-law – NHS employees
Nilkunj Dodhia Non-executive Director	Directorships held in private companies, Public Limited Companies or Limited Liability Partnerships: Turning Points Ltd; Express Diagnostic Imaging Ltd; Express Healthcare; Bolo Ltd; Macusoft Ltd (Sponsored by Imperial College London comprising incubation and access to the Data Science Institute, machine learning labs and Imperial College Healthcare NHS Trust); Ownership or part-ownership of private companies, businesses of consultancies: Turning Points Ltd; Express Diagnostic Imaging Ltd; Macusoft Ltd (Sponsored by Imperial College London comprising incubation and access to the Data Science Institute, machine learning labs and Imperial College Healthcare NHS Trust); Position of Authority in a charity or voluntary body: Independent Examiner of St. John the Baptist Parish Church, Old Malden Spouse – Senior Nurse at University College London Hospitals NHS FT
Nick Gash Non-executive Director	Trustee of CW + Charity Associate Director Interel (Public Affairs Company) Lay Advisor to HEE London and South East for medical recruitment and trainee progress Lay member North West London Advisory Panel for National Clinical Excellence Awards Spouse - Member of Parliament for the Brentford and Isleworth Constituency

Stephen Gill Non-executive Director	Owner of private company: S&PG Consulting Positions of authority in a charity or voluntary body: Chair of Trustees; Age Concern Windsor Shareholder: HP Inc; HP Enterprise; DXC Services; Microfocus Plc
Eliza Hermann Non-executive Director	Positions of authority in a charity or voluntary body: Board Trustee: Campaign to Protect Rural England – Hertfordshire Branch (2013 – present) Committee Member, Friends of the Hertfordshire Way (2013 – present) Close personal friend – Chairman on Central & North West London NHS Foundation Trust
Jeremy Jensen Non-executive Director	Directorships held in private companies, Public Limited Companies or Limited Liability Partnerships: Stemcor Global Holding Limited; Frigoglass S.A.I.C Ownership or part-ownership of private companies, businesses or consultancies: JMJM Jensen Consulting Connections with a voluntary or other organisation contracting for or commissioning NHS services: Member of Marie Curie (Care and Support Through Terminal Illness)
Dr Andrew Jones Non-executive Director	Directorships held in the following: Ramsay Health Care (UK) Limited (6043039) Ramsay Health Care Holdings UK Limited (4162803) Ramsay Health Care UK Finance Limited (07740824) Ramsay Health Care UK Operations Limited (1532937) Ramsay Diagnostics UK Limited (4464225) Independent British Healthcare (Doncaster) Limited (3043168) Ramsay UK Properties Limited (6480419) Ramsay Global Sourcing Limited (11316940) Ramsay Health Care (UK) N0.1 Limited (11316318) Linear Healthcare UK Limited (9299681) Ramsay Health Care Leasing UK Limited (Guernsey) (39556) Ownership or part-ownership of private companies, businesses or consultancies: A&T Property Management Ltd Additional employment: Chief Executive Officer of Ramsay Health Care UK Other relevant interests: Board member NHS Partners Network

Liz Shanahan Non-executive Director	Owner of Santé Healthcare Consulting Limited Shareholder in: GlaxoSmithKline PLC, Celgene, Gilead, Exploristics, Official Community, Park & Bridge, Captive Health, some of whom have an interest in NHS contracts/work
Gary Sims Non-executive Director	Directorships held in private companies, Public Limited Companies or Limited Liability Partnerships: The Parole Board, Non-Executive Director – Independent body to decide if prisoners can be allowed parole Plexus Housing, Non-Executive Director – Regulated Housing Association Omega Housing, Non-Executive Director – Regulated Housing Association G AND C LTD, Director – Consulting Company Ownership or part-ownership of private companies, businesses or consultancies: Faxi LTD, Shareholder – Hi Tech start up Majority of controlling shareholdings: G AND C LTD, Director – Consulting Company Position of authority in a charity or voluntary body: Parentkind (formerly Parent Teachers Association) Trustee – Supporting parents of school pupils Discovery Schools Academy Trust, Trustee – Multi Academy Trust
Lesley Watts Chief Executive Officer	Trustee of CW + Charity Husband — consultant cardiology at Luton and Dunstable hospital Daughter – member of staff at Chelsea Westminster Hospital Son – Director of MTC building constructor
Sandra Easton Chief Financial Officer	Sphere (Systems Powering Healthcare) Director representing the Trust Treasurer — Dartford Gymnastics Club Chair — HfMA Sustainability
Robert Hodgkiss Chief Operating Officer	No interests to declare
Karl Munslow-Ong Deputy Chief Executive	Director of North West London Pathology (an arms-length organisation, owned by three partner Trusts)

	Director of Imperial College Health Partners Wife – GP Partner, Springfield Health Centre, Stamford Hill N16 6LD
Pippa Nightingale Chief Nurse	Trustee in Rennie Grove Hospice CQC specialist advisor Specialist advisor PSO
Zoë Penn Medical Director	Trustee of CW + Charity Daughter – employed by the Trust Member of the Independent Reconfiguration Panel, Department of Health (examines and makes recommendations to the Secretary of State for Health on proposed reconfiguration of NHS services in England, Wales and Northern Ireland)
Kevin Jarrold Chief information Officer	CWHFT representative on the SPHERE board Joint CIO role Imperial College Healthcare NHS Trust / Chelsea and Westminster Hospital NHS Foundation Trust
Martin Lupton Honorary NED, Imperial College London	Employee, Imperial College London
Dr Roger Chinn Deputy Medical Director	Private consultant radiology practice is conducted in partnership with spouse. Diagnostic Radiology service provided to CWFT and independent sector hospitals in London (HCA, The London Clinic, BUPA Cromwell)
Gillian Holmes Director of Communications	None.
Julie Myers Company Secretary	Trustee, Cambridge House Fellow, Royal Society of Arts Member, Chartered Institute of Trading Standards

Minutes of the Board of Directors (Public Session)
Held at 11.00 on 3 May 2018, Boardroom, Chelsea and Westminster

Present:	Sir Thomas Hughes-Hallett	Trust Chairman	(THH)
	Nilkunj Dodhia	Non-Executive Director	(ND)
	Sandra Easton	Chief Financial Officer	(SE)
	Nick Gash	Non-Executive Director	(NG)
	Stephen Gill	Non-Executive Director	(SG)
	Eliza Hermann	Non-Executive Director	(EH)
	Rob Hodgkiss	Chief Operating Officer	(RH)
	Karl Munslow-Ong	Deputy Chief Executive	(KMO)
	Pippa Nightingale	Chief Nurse	(PN)
	Zoe Penn (from item 1.6)	Medical Director	(ZP)
	Liz Shanahan	Non-Executive Director	(LS)
	Lesley Watts	Chief Executive	(LW)
In attendance:	Roger Chinn	Deputy Medical Director	(RC)
	Chris Chaney	CEO, CW+	(CC)
	Gillian Holmes	Director of Communications	(GH)
	Kevin Jarrold	Chief Information Officer	(KJ)
	Julie Myers	Company Secretary	(JM)
	Renuka Jeyarajah-Dent	NExT Director	(RJD)
	Charlotte Scuse, Matron (in part)	Matron A&E, WM	(CS)
	Dave Shackleton (in part)	Consultant A&E, WM	(DS)
	Jennifer Parr (in part)	General Manager HIV, Sexual Health and Dermatology Services	(JP)
	Michael Post (in part)	Partnership Development Manager	
	Dr Tara Suchak (in part)	Safeguarding Lead	(TS)
	Sophie Jones (in part)	Senior Health Adviser	(SJ)
	Dr Sara Day (in part)	Clinical Lead	(SD)
	Mark Titcomb (in part)	Divisional Director of Operations, EMIC and Hospital Director CW	(MT)
	Gary Davies (in part)	EIC Clinical Director, Consultant Respiratory and Acute Medicine Consultant	(GD)
	Ashkan Sadighi (in part)	Consultant AEC, WM	(AS)
	Vida Djelic	Board Governance Manager	(VD)

1.0	**GENERAL BUSINESS**
1.1	**Welcome and apologies for absence** The Chairman welcomed Board Members, and those in attendance, to the meeting, noting that all should be proud to be part of what is presently the highest performing, lowest cost Trust in London. Apologies for absence had been received from Jeremy Jensen, Andrew Jones and Gary Sims.

1.2	**Declarations of Interest** In his absence, the Company Secretary reported that Andrew Jones had declared a new interest: Directorship of Ramsey Health Care (UK) No. 1 Limited.
1.3	**Minutes of the previous meeting held on 1 March 2018** The minutes of the previous meeting were approved as a true and accurate record of the meeting subject to: - Page 5, item 2.2 – consideration of how to ensure learning from good practice is embedded across the Trust to be added to the action log. **Action: VD to add to the action log**.
1.4	**Matters arising and Board action log** Meeting 01.03.2018 Action 1.5 – the action had been incorrectly marked as complete. THH and LW would take forward an action to invite the CEO and Deputy CEO of the Royal College of Nursing (RCN) to the Trust. Action 2.1 - RC reported that the use of Standardised Process Control (SPC) charts had been discussed at Quality Committee and charts in this format would be available to that Committee at its next meeting. EH confirmed that the Committee was pressing to see these charts used. Action 2.2.1 – SE confirmed that data on career development by gender was available and that consideration was being given as to how best present this data in the workforce report. Action 2.2.1 – SE confirmed that the Trust had published its gender pay gap report and that the action plan associated with the findings of the report would be brought to the July Board meeting. Meeting 11.01.18 Action 1.6 – PN advised that the team were preparing a 'learning from' patient voices report and that this would be presented to Quality Committee at each meeting. As such, the Board would receive information through the Quality Committee minutes.
1.5	**Chairman's Report** The Chairman reported that further to a meeting with counter-parts at Guy's and St Thomas' Hospital NHS Foundation Trust, Peter Homa CBE (former CEO of Nottingham University Hospitals NHS Trust) had been appointed to chair a new board overseeing the collaboration between Royal Brompton and Harefield FT and Guy's. It remained the case that no agreement had been reached on the proposal to regarding location of Children's Congenital Heart Disease services. He conveyed congratulations to the Trust by Dominic Dodd, Chair of Royal Free London NHS Foundation Trust, on its strong position as regards cost and quality. The Chairman also reported that he had met the Chair of NHS Improvement (NHSI), its Director of

	Nursing and its lead on productivity in the context of his work with HelpForce on volunteering, and that they had also congratulated the Trust on its achievements.
1.6	**Chief Executive's Report** **Care Quality Commission (CQC) and NHSI use of resources**. The CEO reported the CQC's 'good' rating for both hospital sites within the Trust and the NHSI's 'outstanding' rating for the Trust's use of resources. She also reported that NHSI had written to the Trust this week to confirm that it had been moved into 'segment 1' of its Single Oversight Framework. This confirmed that the Trust was recognised as being one of the highest performing providers, allowing the Trust the maximum autonomy allowed, with light touch regulation. Only one other acute Trust in London is in this segment, Homerton University Hospital NHS FT. The CEO noted that this was a great tribute to all Trust staff, and paid particular tribute to the COO and his team, as a significant contributor to the result was the level of performance. The results were absolutely in line with the Trust's strategic priorities. **Quality priorities**. Quality priorities for 2018/19 had now been agreed and performance against these would be monitored closely. **Staff achievements**. The CEO noted that her report celebrated the latest awards and achievements of staff and strong reference to these would be made in the Annual Report **GDPR**. Board Members were reminded that new legislation comes into force on 25 May. A considerable amount of work was required to ensure compliance and, like most other NHS organisations, and many others in the public sector, the Trust would not be compliant on day one. Work was, however, well underway. **STP matters**. A significant amount of work was going on within the STP, particularly around: pathology, radiology, emergency care and bank and agency staffing. KMO was also coordinating work on use of estates, where there was recognition that all would need to use assets more smartly. **Paediatrics**. It remains this Trust's position that consideration should be given to more than one option and there now seemed to be a degree of agreement to this. **Implementation of Electronic Patient Record (EPR)**. The CEO reminded the Board that the EPR system was due to go live at West Middlesex Hospital this weekend. She noted that, thanks to the very hard work and leadership of the team, the Trust feels very well prepared. Responding to the report EH commended the CEO for its breadth and depth but requested whether future reports could use less 'jargon' and explain terms. This was acknowledged and agreed. The Chairman asked that headlines from the staff survey be shared with the Board later in the meeting and that it be added to a forthcoming Council of Governor's agenda. **Action: Staff survey to be added to the agenda for a Council of Governor's meeting**. **Communications strategy update.** LW asked the Board to note the excellent progress being made on the Trust's communications strategy thanks to the work of GH and her team. The work to date had really improved the Trust's profile and allowed the work of staff to be showcased as widely as

	possible. The Chairman asked for clarification that reference, in year two, to 'strengthening and promoting external relationships', was intended to capture communications with and growing the Membership. GH confirmed that it did and that discussions had just started with the Company Secretary as to how to approach that aspect. She advised that, for year one, the priority was to get a firm grip on the Trust's communications channels, asses how well they worked, so that there was a baseline to build from. It was agreed that Membership be explicitly mentioned in the strategy. **Action. Explicit reference to Membership to be included within the communications strategy**. LS commended the progress made on communications, which she regarded as superb, noting it had been commented on by senior communications professionals elsewhere in the NHS.
2.0	**QUALITY/PATIENT EXPERIENCE AND TRUST PERFORMANCE**
	The Board agreed to take items 2.1 and 2.7 together as they had close correlation. 2.1 **Staff Experience Story – Winter in A&E** 2.7 **Growth in non-elective demand** **Winter in A&E** The COO introduced Charlotte Scuse, A&E Matron, WM and Dave Shackleton, A&E Consultant, WM who presented their experience of working in A&E over the most recent and preceding winters. They noted that the recent winter was the worst on record for the NHS, but that the Trust had not just 'survived' but had been proud to achieve the national A&E target. This was due to tremendous team working between medical and nursing staff, managers and administrators and support staff. Added to the general winter pressure, the Trust had also been inspected by the CQC during one of the busiest times, in December. The team had been pleased to read the CQC report, and to see the commendation of the kindness of the nursing care. The team felt that A&E was now a well-oiled machine; there was a lot of work that went on behind the scenes to make sure the process works well and that patients flow smoothly through the system. They felt that there was strong back-up from across the whole organisation and both reported the noise and horror that goes with wards where patients are left unable to be placed. Now that winter was over, a quality improvement group had been set up, which was also working with the charity CW+ to consider the A&E environment. There was little time to consider innovation during the winter period itself. The team was also working with external stakeholders to consider how best to improve matters at the 'front door' which included considering innovative, new ways of working. Finally, the team noted that they were excited about the introduction of the EPR system, which they felt well-prepared for, and would deliver real benefits for patients. In discussion, the following points arose: - NG congratulated the team for providing a calm, orderly experience for patients and noted the impressive triage process. The team agreed, noting that their triage system was very in-depth and had really improved the flow of patients. It was front-loaded so that nurses could order tests and x-rays straight-away, meaning results were available for Drs. - ML asked for thoughts on the number of Drs who did not see a career in emergency medicine as sustainable because of the work pressures. DS said that it was important to tell

junior Drs that it does get better, and that they can make improvements for themselves. His observation was that this Trust was genuinely encouraging and responsive to ideas for improvements from anywhere within the team. GD reflected that there was an ongoing systemic issue regarding training, with placements being decided by Health Education England on a historic pattern that did not reflect the pattern of patients. He encouraged medical colleges to lead on challenging Health Education England in this regard. The CEO agreed and informed the Board she would be writing to HEE in that regard.

- The Chairman informed the Board and attendees that a pilot project had just been agreed with the London Ambulance Service to trial how volunteers might help with frequent attendees at A&E.

The Chairman extended huge thanks to the team for their work, and congratulated them on the excellent levels of performance.

Growth in non-elective demand

The COO noted that the Board had discussed this topic in November 2016 and July 2017, reflecting its status as one of the most significant risks facing the Trust. He introduced Mark Titcomb, Gary Davies and Ashkan Sadighi, who gave a presentation describing the nature of demand and the Trust's plans for developing its approach to ambulatory care as a way of mitigating the impact of the growth in demand.

In response to a question from THH, MT reflected that the reason the predicted demand for non-elective services at this Trust's was above that predicted for London as a whole was because of the services offered, the quality of care combined with some shifts in the healthcare landscape. In response to a question from SG, MT reflected that this was in part due to patient choice but not solely. Some reflected growth in ambulance number arrivals at WM. LW reminded the Board of the scheduled closure of A&E at Ealing. There had been a lot of communication on this and some patients may think it had already closed.

The impact of the growth in demand on the Trust's finances was discussed, including the positive impact should NHS ever move to paying the full tariff for the service. MT presented the Trust's performance relative to others, noting that it was such that other providers, and NHSI, were keen to learn from our experience.

GD and AS presented the proposed developments to the Trust's ambulatory care offering, illustrating the treatment areas where the offering could be introduced, and the impact it had on inpatient stay using the example of the Out Patient Antibiotic Pathway. Developing this service would be critical to meeting the expected demand for services, and to allow patients to return to their own beds rather than wait for scarce hospital beds. The Trust was already leading the way in providing these services and the staff were confident that more could be achieved. One risk was noted, however: as more patients are diverted to ambulatory care, there was a risk that the average length of stay may increase, as only patients with more complex needs would be admitted. In addition, it was also noted that there were constraints to developing the service, including space and staffing. As one example, only 20 patients can currently access the OPAT, whereas there are many more patients within the hospitals in different surgical specialities who could benefit.

The COO advised that a business case for the service was being developed. It benefitted from enthused, engaged clinicians who were committed to improving the patient experience, decreasing length of stay and helping with capacity. The CEO summarised that this was a strategic response to a major challenge.

	Action: The subject to be added to the agenda for the Board's strategy awayday in June. The following points were discussed: - understanding the impact on the urgent care centre of the changes in the emergency department - working together with a range of external stakeholders around the front door in order to create a very different system - testing how planned interventions might impact on the rate of growth in demand, acknowledging that there is only ever so much modelling that can be done - implications for funding or service delivery arising from changing patterns of healthcare. For instance, older patients ceasing to use GP services as they become increasingly frail. The Chairman thanked the team for their presentation which illustrated how the Trust was developing and embracing 21 Century medicine. He challenged colleagues to think about whether we could put a value on the expertise we were increasingly being asked to share with others.
2.2	**Care Quality Commission report** The Chairman noted that, because of timing, the Board had already had the opportunity to discuss the CQC report at a strategy session in April. It would be a substantive item on the forthcoming Council Of Governors' meeting. PN introduced the report noting that it was the first time the Trust had been inspected by the CQC since its merger, and was the first under the new inspection framework. She was delighted to report that both sites had been rated as 'good', noting that before integration, each site had been rated as 'requires improvement'. The Trust had also received an 'outstanding' rating for its use of resources from NHSI. Care had been rated as 'outstanding' on the Chelsea site. She was also pleased to note that the Trust had received no 'severe' or 'must do' recommendations. There were 57 recommendations for 'should do' actions. An action plan had been developed not just to address these actions, but also the themes of the report, to ensure that best practice observations were also recorded. The staff had shown amazing commitment and now wanted to know what they needed to do to get to 'outstanding'. As Chair of the Quality Committee, EH advised the Board that the report would stay on the Committee's agenda as it began to look at the overarching quality improvement journey. PN confirmed that the areas rated as good or outstanding on the last inspection had not been included and unannounced inspections were therefore anticipated this year. The outcome of any one of those inspections could affect the overall rating for the Trust.
2.3	**Serious Incidents Report** PN introduced this item, noting that the paper presented the picture of incidents over the full year. She noted that the number of serious incidents (SIs) were broadly similar to last year. The themes observed were: - maternity

	- falls with harm, which is to be a quality priority for 2018/19 - diagnostics PN reported that there had been six 'never events' over the year. Each had been investigated, and a deep dive was now taking place into all of the events, to see if any themes could be identified (such as time of day, groups of staff etc). She noted the impact that prompt intervention had on reducing serious incidents, citing the work carried out on identifying deteriorating patients: there had been some instances during the prior year and, after training and alerts had been introduced, there had been none at WM. EH confirmed that Quality Committee scrutinises all of these reports in great detail and commissions deep dives. Looking ahead, the Committee intended to explore triangulating these events with sources such as complaints and patient feedback. SG noted that it was pleasing to see a significant decrease in the number of outstanding SI action points. EH agreed but reiterated that she expected to see none. The CEO concluded discussion by assuring the Board that the themes identified were not out of kilter with those observed in other acute settings. The challenge was to ensure that the positive improvements delivered by training and development interventions were maintained in an environment where there was considerable staffing turnover.
2.4	**Integrated Performance Report including:** **2.4.1 Workforce performance report** **Operational performance**. RH introduced the integrated performance report reflecting that 2017/18 had been a fantastic year. In April 2017, the Trust had not been incompliance with any of the three core national standards but there had been significant improvement over the course of the year, resulting in the Trust, in March 2018: - achieving the RTT target - achieving the cancer targets - narrowly not meeting the A&E target, albeit achieving performance of 94% and ranking 7th out of 137 reporting Trusts. This reflected a huge contribution from all of our staff for the benefit of patients and the wider public. **Financial performance**. SE reported on the end of year financial position noting that, since the paper had been prepared, the Trust had received notification of its final funding allocation from the centre. As a consequence of the Trust's strong performance, it had received additional STF allocations which would result in an improved surplus position at year end of £38million. In total, the Trust had received £27.7m in STF funding. Whilst this appeared to show that the Trust was a fortunate position, she stressed that the Trust was still running with a significant underlying deficit, and was also in receipt of non-recurrent funding, related to the integration, that would come to an end next year. It was critical that on 2018/19, the Trust achieved financial sustainability. **Staff survey results**. SE reported on the results of the Trust in the national NHS staff survey. Overall engagement was at 3.93 which was the 11th best in the country and an improvement on the position in 2016/17, when the Trust's score was below average for the country. Overall, there had been no major deterioration on any question area. The team had prepared an

	action plan to respond to the survey results. SG noted that there had been a decline in the number of participants this year. This was acknowledged although the Trust remained in the top 20 for participation. In discussion, the Board noted: - that there did remain a number of areas where performance need to improve, notably voluntary turnover and mandatory training rates - that the three breaches relating to colorectal cancer at WM were not indicators of a systemic issue of concern. The Chairman thanked the team for the comprehensive report, urging all concerned to never be satisfied and ever-improving, and noted that he, along with the Deputy Chair and Company Secretary, would be considering the Board's role in relation to performance. **Action: THH, JJ and JM to discuss Board's role in performance**
2.5	**Mortality Surveillance Q4 Report** ZP introduced this report, advising the Board that every death is reviewed by each department. Each is allocated a grade and, where there is any sense that failings in care might have been a contributing factor, the case is taken to the surveillance group. To derive maximum benefit from the process, these reviews have to take place quickly. ZP noted that, when benchmarked , this Trust has a lower than average number of deaths, and is showing a downward trend (ie mortality rates are steadily improving against the average). The process allows the Trust to identify trends and themes so that action can be taken where necessary. One theme that has emerged recently is 'difficulty in transferring patient', either between our sites or with any other service externally. This is an area that the group is now interrogating. In her view, the process was working well, and provides useful information. In response to a question from SG, ZP advised that, as this was a new process, there was no information available on what a target speed of review should be. She expressed a view that this Trust was in the vanguard when it came to implementation, however, when compared to others nationally. She also noted that reviews were occasionally delayed because the death was connected to a major incident, a coroner investigation or inquest or some other medicolegal reason. In addition, because the numbers for review were so small in some specialities, reviews had been scheduled quarterly. This process had been challenged so that reviews now took place on an at least monthly basis. The Chairman thanked ZP for the report and suggested that this might be an area where the use of SPC charts would be appropriate. **Action: Executive to consider the use of SPC charts for mortality surveillance report**.
2.6	**Sexual Health E-Services** The Board welcomed Jennifer Parr, Michael Post, Dr Tara Suchak, Sophie Jones and Dr Sara Day, members of the sexual health e-services team, to the meeting. The team described the service they had developed to provide services to asymptomatic patients meeting agreed eligibility criteria, including being 16 years or older, and living in an eligible London borough. Registration was online, and testing kits could be collected from a range of clinics. Safeguarding was built into the service:

	there was understandable concern about vulnerable persons who might not receive the support they need if they only access a service online. The system was designed to prevent access by under 16's, and also investigated: age imbalance in any sexual partnership; concerns about coercion; the use of drugs or alcohol; and whether the person was known to children's services. In any of those circumstances, the young person was contacted directly and the account locked. Feedback so far had been excellent. The COO noted that this was a flagship service, and reminded the Board that the Trust was the country's largest provider of sexual health services. In an environment where Commissioners were looking to reduce funding for such services, it was important to innovate to provide services differently. JP concurred noting that it was inevitable that these services would have to move out of clinics to being online. It was confirmed that this is an additional service and not a replacement for GUM, although it was likely that the consequence would be an increase in complexity of cases being seen by GUM. The two services worked together. The Board noted the potential for this service to be rolled out nationally and reflected on whether the Trust should consider its ambitions in this area. The CEO concluded the discussion, noting that the questions around 'comfort' of using online services were complex and were not necessarily related to demographics. This would have to explored. There was however no doubt there was much to learn from the sexual health service. The team were thanked warmly for their presentation.
2.8	**NICU/ICU developments** CC, CEO of CW+, provided an overview of the plans to redevelop the IC/NICU facilities at Chelsea and Westminster Hospital. He explained that, as demand at A&E has grown, so there has been consequential pressure on these units. The development was costed at £25m and, to date, the charity had raised £10.8mof the £12.5m it had committed to raise. The development presented a real opportunity to innovate, and to build in environmental features such as noise control and air quality that would have a positive impact on the therapeutic environment. ZP added that the environmental factors were much more than 'nice to have': noise reduction, in particular, was critical to reducing incidents of delirium, and the improved layout would be beneficial for infection control. RH confirmed that the contract for the build had been awarded and work was expected to start in July. The expectation was that the units would be operational by 2021. The Chairman commended the teams at the Trust and CW+ for a great fundraising effort for an essential project.
3.0	**GOVERNANCE**
3.1	**Risk Register**

	KMO introduced the current risk register, noting that the two top risks had both been on the agenda of this meeting and that Committees were increasingly taking a risk-based approach to agenda planning. Responding to the paper, EH noted that, whilst it was helpful to see the top level risks on the register, it would also be important for the Board to be aware of those risks with low probability but very high impact. These risks had to be factored into contingency planning. She also queried how the 'black swan' risk list, developed by the Board, was factored into the register. In response, KMO advised that many of the 'black swan' risks were contained within the 231 risks below those seen by the Board. It would be important to establish what level of granularity the Board wanted in risk reporting. By way of example, EH cited the example of a highly contentious Court of Protection type matter, of the kind seen in the media in recent months. How could the Board be assured that risks of this kind were being identified and mitigated? The CEO responded that, in an acute hospital environment, these types of risks were faced all of the time. Such cases were not at all unusual. The Chairman noted that NG, as incoming Chair of Audit and Risk Committee, would be asked to discuss risk reporting with KMO. **Action: NG and KMO to discuss risk reporting and the relationship between the RAF and BAF**.
3.2	**Modern Slavery Act 2015 and Statement** The statement was approved. **Action: CEO to confirm which Executive Director was the lead for this area**.
3.3	**EPR go live** KJ reminded the Board that the EPR system was due to go live at West Middlesex on 4 May. He reported confidence in readiness and that this had been a real partnership project, which had been tracked carefully at executive and Board-level. There had been four Gateway reviews, all of which had been positive, and a fifth and final review was due tomorrow. The team felt it was in as good a place as it could be, although there were bound to be challenges. RH agreed and reported a real buzz and excitement about the project. The Chairman shared the team's excitement which he noted was palpable at West Middlesex. He requested that, as a final piece of process assurance, RH, as Senior Responsible Officer for the project, inform ND of the outcome of the final gateway review on 4 May. **Action: RH to contact ND on 4 May with details of the final Gateway review**. SG reported that he had discussed the project with KJ. He noted that this was not the first time this team had implemented this system and that the level of preparation he had observed was first class. RC added that the clinical safety case had been approved by the Medical Director, Chief Nurse and Chief Operating Officer. Additionally, informal feedback from Cerner had commended the Trust for

	preparing the best clinical safety case they had ever seen for a system implementation of this kind. Gary Hartnoll was to be commended for his work on this. In response to a question from THH, KJ advised that the Trust would know by Tuesday morning how well the go live had gone. The CEO added that, whilst this was a critical point, the Trust was prepared for the system not working as anticipated and had guarded its income by negotiating block contracts for the immediate post-implementation period. The true impact will not be known until the Chelsea site was also up and running. The Chairman and CEO noted the incredible amount of hard work that was being put into this project and thanked all concerned.
4.0	**ITEMS FOR INFORMATION**
4.1	**Questions from members of the public** **Governor Kush Kanodia** congratulated the Trust on good CQC report but asked for reassurance that the Trust was preparing for the 'financial cliff edge' that would emerge when the integration funding ceased and should STF expire, especially at a time when some key non-executives terms would be close to expiry. **Governor Anna-Hodson-Pressinger** reiterated this concern, which she reported was shared by a number of Governors. The CEO stressed that she was pleased to be asked 'what's next'? As regards the financial situation, she urged caution around the use of the term 'cliff edge'. The challenge was to get the Trust to a recurrent run-rate. Current financial planning anticipated the loss of transitional funding, this had long been known, and the Trust was planning to get to an underlying deficit position of just under £5m this year and to break-even next year. She stressed that STF was expected to remain and reminded attendees that the reason STF was introduced was in recognition of the 30% shortfall in funding for emergency care. STF would remain, or an alternative would have to be introduced. In response to the question on succession planning, the Chairman reported that work was well underway on a proposal for consideration by Council of Governor's Nomination and Remuneration Committee. **Governor Kush Kanodia** expressed his concern that the Trust had appeared to be encouraging inappropriate use of A&E in its presentation on non-elective demand. The CEO refuted this strongly: at no point would the Trust even encourage the inappropriate use of A&E. As regards the provision of GP-type services, the Chairman noted that there were examples nationally where Trusts owned GP practices. Any developments of this kind would be discussed carefully with Commissioners. **Governor Anna Hodson-Pressinger** stressed that Governors would always be willing to assist with fundraising efforts. This was welcomed by the Chairman.
4.3	**Any other business** The Chairman reported the intention to resign of non-executive director, Gary Sims. Gary had worked hard for the Trust and thanks were extended to him on behalf of the Board. This would also be discussed with the Governor's Nomination and Remuneration Committee.

4.4	**Date of next meeting** – 5 July 2018

Meeting closed at 13.40

Trust Board Public – 3 May 2018 Action Log

Meeting Date	Minute number	Subject matter	Action	Lead	Outcome/latest update on action status
03.05.18	1.3	Minutes of the previous meeting held on 1 March 2018	Action: VD to add to the action log – consideration of how to ensure learning from good practice is embedded across the Trust to be added to the action log.	VD	This has been considered by Pippa Nightingale and taken forward by the Quality Committee.
	1.6	Chief Executive's Report Staff Survey	Action: Staff survey to be added to the agenda for a Council of Governor's meeting.	VD	Complete. On agenda for July Council of Governors.
		Communications strategy	Action: Explicit reference to Membership to be included within the communications strategy.	GH	Noted.
	2.7	Growth in non-elective demand	Action: The subject to be added to the agenda for the Board's strategy awayday in June.	JM	Complete. Formed part of discussion at awayday.
	2.4	Integrated Performance Report including: Workforce performance report	Action: THH, JJ and JM to discuss Board's role in performance	THH/JJ/JM	Complete – agreed to ensure appropriate opportunity is provided to the Council of Governors to address operational performance with NEDs.
	2.5	Mortality Surveillance Q4 Report	Action: Executive to consider the use of SPC charts for mortality surveillance report.	Execs	The HSMR/SHMI data references our performance against a nationally set bench mark and so does not lend itself to an SPC format. We can however use this for our crude mortality rates and will add this format to future reports. The Board should be aware that there is considerable seasonal variation in mortality rates/data and this will be reflected in these charts.

Meeting Date	Minute number	Subject matter	Action	Lead	Outcome/latest update on action status
	3.1	Risk Register	Action: NG and KMO to discuss risk reporting and the relationship between the RAF and BAF.	KMO/NG	Complete.
	3.2	Modern Slavery Act 2015 and Statement	Action: CEO to confirm which Executive Director was the lead for this area.	LW	Pippa Nightingale, Chief Nurse
	3.3	EPR go live	Action: RH to contact ND on 4 May with details of the final Gateway review.	RH	Complete.
01.03.18	2.2	Integrated Performance Report	Action: SE and Company Secretary to review Committee meeting scheduling from 2019.	SE/JM	Draft schedule of 2019 meetings prepared for discussion.
	2.2.1	Workforce performance report	Action: Equality data for qualified nurses and midwives promotion, and access to training, to be reviewed by PODCom and a report brought to the Board in six months.	SE	Equality report to be on POD forward plan.
			Action: Staff career development tables to also include breakdown by gender.	SE	This is under review.
	3.3	EPR cut-over plan	Action: GH to consider how best to celebrate the implementation of Cerner EPR at West Middlesex	GH	Verbal update.
		Patient Voices	The Board agreed to receive a report on what patient voices are telling us instead of a patient experience story at a future Board meeting.	NA	Action ongoing. This is on the forward plan for September Board.
11.01.18	3.1	Delivery of the communications strategy	POD to review delivery of the communications strategy.	SG/GH	Action ongoing. To be put on the People and OD Committee forward plan.
		Membership	Membership growth to be added as a KPI to communications strategy.	GH	Action ongoing.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 5 July 2018

PUBLIC SESSION

AGENDA ITEM NO.	1.5/Jul/18
REPORT NAME	Chairman's Report
AUTHOR	Sir Thomas Hughes-Hallett, Chairman
LEAD	Sir Thomas Hughes-Hallett, Chairman
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.

Chairman's Report
July 2018

1.0 NHS 70th celebrations

It has been wonderful to see the NHS celebrated so widely over recent weeks as the 70th anniversary approaches. I hope the events at our hospitals today go well and enable all of our staff, patients and members of the public to pay tribute to the service and give thanks for the vital role it plays in our society.

2.0 Board's May 2018 Extraordinary meeting and June strategy awayday

The Board met in May to receive and approve the Annual Report and Accounts 2018, including the Quality Account. These were subsequently laid before Parliament on 19 June 2018 and will be presented to Governors and Members at the September Annual Members Meeting.

In June, the Board held an awayday to discuss its strategic approach for the short to longer term. We had an excellent discussion, underpinned by an over-riding commitment to making sure this Trust continues on a journey from good to outstanding, with our workforce right at the heart of all that we do.

3.0 Council of Governors Nominations and Remuneration Committee

On 20 June, I chaired a meeting of the Council of Governors Nominations and Remuneration Committee to discuss succession planning for the non-executive director (NED) members of the Board. The Committee will report to the Council of Governors on 26 July.

4.0 External engagements

Since the last Board meeting I have:

- Met Baroness Dido Harding, Chair of NHS Improvement as part of the NHSI Chair and CEO Advisory Panel. The meeting had an interesting discussion on the tenure of NEDs, where it became clear that many Foundation Trusts were now deviating from the best practice guidance issued by Monitor suggesting that NEDs should not serve longer than six years unless there were extenuating circumstances.
- Volunteering afternoon with Professor Sir Malcolm Grant CBE, Chairman of NHS England on the Chelsea Hospital site
- Meeting with all the London Chairs of NHS Trusts
- Meeting with the Chair of Barts Health NHS Trust meeting
- Visit to Liverpool NHS Trust including visiting end of life care unit
- Visit to Sandwell and West Birmingham NHS Trust
- Meeting with Imelda Redmond, CEO of Healthwatch England
- Visit to Northumbria Healthcare NHS Foundation Trust
- Meet Lord Drayson with Lesley Watts, Trust CEO.

5.0 Volunteering

I was pleased to see the Trust take part in Volunteer's Week in early June. Our work in this area is really having an impact and I was delighted to learn that Dr Neil Churchill, Director for Experience, Participation

and Equalities at NHS England chose to spend time volunteering at the Trust, to see how we are making good use of volunteers.

Sir Thomas Hughes-Hallett
Chairman

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 5 July 2018

PUBLIC SESSION

AGENDA ITEM NO.	1.6/Jul/18
REPORT NAME	Chief Executive's Report
AUTHOR	Karl Munslow Ong, Deputy Chief Executive Officer
LEAD	Lesley Watts, 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 2017

1.0 Anniversaries of major incidents

This year we have been commemorating the anniversaries of major incidents across the country, including London terror attacks and the Grenfell Tower tragedy. Our teams responded to four major incidents in a four-month period alone in 2017, and as each anniversary arises we have remembered all those affected, honoured the hard work of our staff, and reminded everyone about support available. These events shook the nation, but also saw our teams responding as we knew they would with huge compassion and professionalism, and showing great resilience and determination at a time of real tragedy. Most recently was the first anniversary of Grenfell (14 June), where our staff observed the national minute's silence at midday. A Grenfell memorial service was held in our chapel on 23 June which our chaplains arranged for the families we supported.

2.0 Performance

May was another very challenging month not just with the continued growth in non-elective demand but also due to the implementation of the new Cerner EPR at our West Middlesex Site. Despite these challenges both of our sites responded incredibly well and for the second consecutive month of this financial year, we delivered on the A&E waiting time standard (the best performing Trust in London) and the Referral to Treatment incomplete target was achieved on both sites. Also, as a Trust we were compliant with all reportable Cancer Indicators. Overall, this is a fantastic achievement; I'm not aware of another NHS Trust that has maintained their regulatory performance standards following a new EPR implementation and demonstrate the amazing efforts of all of our staff to ensure we provide our patients with the very best, timely care.

3.0 Celebrating 70 years of the NHS

Our Trust is proudly marking the 70th anniversary of the NHS on 5 July at our hospitals and satellite clinics. Both Chelsea and Westminster and West Middlesex University hospitals are holding mini open days and inviting staff, patients and supporters to raise a cup of tea and enjoy something sweet for the 'big7tea', along with the rest of the NHS family. There will be a range of stalls, school choir performances, NHS70-themed children's poetry, history photos, therapy dogs, a CW+ art tour and more. We will also look to the future and promote innovation, and will launch the construction of our Critical Care project at Chelsea. The day gives us a great opportunity to celebrate the achievements of the NHS, reflect on the vital role the service plays in everyone's lives and thank our staff for their tireless dedication to our patients each and every day. As such,

on the day, eight special NHS 70th CW+ Proud Awards will be given to staff to celebrate the milestone.

4.0 Staff Achievements and Awards

Celebrating our staff – special awards

In May, we recognised staff with 25 years or more of service through the reintroduction of our long service awards. These staff members attended afternoon tea events and received a badge, certificate and a special Trust notebook. Awards for 10, 15 and 20 years will be given out via the Divisions throughout the rest of the year.

Our latest CW+ PROUD award winners:

- **Emergency and Integrated Care:** Dr Cerys Morgan, Speciality Registrar, Ron Johnson Ward, Chelsea site
- **Women and Children's:** Marina Wingham, Matron, Queen Mary Maternity Unit, West Mid site
- **Planned Care:** Miriam Segawa, Sister, Chelsea site
- **Corporate:** Iheoma Asoluka, Receptionist (Chelsea site) and Lisa Macey, HR Service Centre Manager (Harbour Yard)

External recognition:

- **The Neonatal Data Analysis Team** has received a Royal College of Physicians Excellence in Patient Care award for innovation. Their forward-thinking specialist neonatal work has seen them set up a national research database – which is a powerful, unique resource that is improving healthcare for pre-term babies.

- **The AAU team** at Chelsea and Westminster Hospital, including FY1 Doctors Dr Maria Goryaeva and Dr Diana Newman, were recognised for their innovative Acute Medicine projects at the SAMsterDAM (Society for Acute Medicine and Dutch Acute Medicine) conference in Amsterdam in May. Research Prof Derek Bell OBE also presented 'Acute Care: The British Way' and Dr Hannah Skene presented 'Lessons Learnt from London's Major Incidents.'

- **Emily Berrisford**, an Orthopaedic Clinical Lead Physiotherapist at Chelsea and Westminster Hospital, has recently won an NHS70 Women Leaders Award for her contribution to the NHS. She was also recognised for her inspiration, courage, influence, resilience, drive and compassion.

5.0 Communications and Engagement

In May we celebrated Chelsea and Westminster's 25th birthday, and brought this to life across our internal and external communications channels. Engagement was positive and wide-spread, and centred around staff, supporters and patients celebrating our hospital in a special video.

We received prominent coverage in the Evening Standard – a full page 3 article on the hospital's birthday – highlighting the high-profile supporters who have commended us on our excellent care (including Claudia Winkleman, Holly Willoughby, Piers Morgan and more). The story also ran online, and included our branded birthday video, featuring staff, patients and supporters, along with our logos and 'PROUD to care' message. This received significant traction on social media, supported by Piers Morgan retweeting to his 6.5 million followers. The coverage followed two successful long service award events for staff, as well as a supporter reception by CW+, all of which earned congratulations from key stakeholders, including NW London commissioners.

Other press coverage

We received coverage on ITV's 'NHS Saved My Life' – when Amanda Holden shared her story of using our hospitals and thanked midwives who supported her at West Mid. This was a very high-profile and emotional piece on primetime national television. It has received subsequent online news coverage and was popular on social media as well, with many messages of support for Amanda, who was recounting the stillbirth of her son.

Internal communications / ongoing activity

We have implemented a new internal communications tool, Poppulo, which is helping us send staff emails in an engaging, targeted way, as well as track open rates and adjust our strategy accordingly. In our first month, we achieved our KPI for staff reading internal communications emails, with open rates of more than 50% (up from approximately only one fifth of staff reading all staff emails).

We are now sending a new-look daily noticeboard, issuing five monthly newsletters (CEO News, Nursing/Midwifery News and 3x Divisional News), and in June we launched our bumper NHS 70th anniversary edition of **Going Beyond**.

Our monthly all staff briefings at the start of June were well-attended, covering volunteering, ePay and West Mid's Older Adult Therapy Team 7-day Service Pilot. Podcasts are available on the intranet and are being promoted for those who were unable to attend. The latest all staff briefing is attached to my report.

Our increasing use of video has led to higher engagement across all digital channels such as:

- **International Day of the Midwife** – new staff/patient video produced to recognise maternity area
- **International Nurses Day** – new video produced to recognise nurses, photos and video with Pippa Nightingale shared
- **Chelsea site's 25th anniversary: #CWH25** – 'happy birthday' video produced, featuring staff, patients and volunteers, history photos shared
- **Cerner EPR go-live –** video with Rob Hodgkiss received high engagements on the day of the go-live, with ongoing positive content throughout the first week

Together, these generated significant engagements—we reached more than 350,000 social media users with 15,000 interactions in a 28-day period. This is much higher than an average month, made possible by a high-volume of video content and celebrity endorsement. This follows our CQC result social media activity in April, which reached nearly 100,000 social media users for this one story alone.

Our program of revamping key pages on the website is ongoing in line with demand and divisional priorities. We have also launched a special anniversaries page and a video library.

6.0 Williams Review

In the spring of this year I was asked by the Secretary of State to join Professor Sir Norman Williams as part of a panel set up to conduct a rapid policy review into the issues relating to gross negligence manslaughter in healthcare.

The review was asked to consider the following:

1. how we ensure healthcare professionals are adequately informed about:
    - where and how the line is drawn between gross negligence manslaughter (GNM) and negligence;
    - what processes are gone through before initiating a prosecution for GNM;
    - In addition, provide any further relevant information gained from engagement with stakeholders through this review about the processes used in cases of gross negligence manslaughter**;**

2. how we ensure the vital role of reflective learning, openness and transparency is protected where the healthcare professional believes that a mistake has been made to ensure that lessons are learned and mistakes not covered up;

3. lessons that need to be learned by the General Medical Council (GMC) and other healthcare professionals' regulators in relation to how they deal with professionals following a criminal process for gross negligence manslaughter.

The findings of the Williams review were shared with the Secretary of State and made public in June. The aim of the panel recommendation is to change the environment by establishing a just culture and providing reassurance to healthcare professionals, patients and their families that gross negligence manslaughter cases will be dealt with in a fair and compassionate manner. The implementation of the recommendations it is hoped will dispel fear within the healthcare professions and improve patient safety. By seeking to remove inconsistencies in the approach to gross negligence manslaughter, it is anticipated that fewer investigations will be pursued and only those rare individuals whose performance is so "truly exceptionally bad" that it requires a criminal sanction will be indicted. By so doing, the panel hopes that the public will be reassured that patients' families will be treated fairly, with respect and will receive honest explanations for their loved ones' deaths. In addition, the public will see effective action by the police, courts and regulators, where appropriate.

7.0 Visitor and migrant programme

I have recently been appointed as the Chair of the Senior Advisory Board which has been established to advise and challenge the Overseas Visitor and Migrant NHS Cost Recovery Programme Board. There is an increasing imperative to ensure the effective implementation of

the NHS Cost Recovery Charging Regulations. In particular, there is a strategic need to increase senior oversight of and engagement with Overseas Cost Recovery across the health system whilst ensuring urgent treatment is never delayed or denied and protections are in place for the most vulnerable patients. I will keep the Board updated on progress with this important work.

8.0 Strategic Partnerships Update

Sector and STP Leadership

Mark Easton has recently been appointed as the Accountable Officer (AO) for the 8 CCGs in North West London. Mark takes over from Clare Parker (previously AO for the 5 inner NWL CCGs) and Rob Larkman (previously AO for 3 outer NWL CCGs). As the Board is aware, I have over the past year increased my involvement in system leadership, firstly as the Provider Lead, and have very recently now taken over as the overall STP lead. I will be continuing to work closely with provider and commissioner colleagues and will be keeping the Board regularly updated on progress with our sector wide work.

Capital Plans

A significant amount of work has taken place over recent months with STP partners to update the sector's strategic estates plan ahead of a July submission to the national bodies. Large scale investment is clearly required to address backlog maintenance issues across the NW London healthcare estate. However, investment decisions need to be taken in the context of the wider strategy, value for money and affordability.

Much of the initial investment proposals likely to be taken forward in the July submission are based on the outer North West London Strategic Outline Case (SOC1) which was approved by the STP in late 2017. The sector has however been considering investment requirements across the whole STP including the significant requirements for Imperial College Healthcare Trust and primary, community and mental health colleagues. It is anticipated that the July submission (known as wave 4) will then be followed by further capital bid opportunities in the autumn (wave 5) where further elements of both the STP estates and digital capital investment requirements can be taken forward.

Royal Brompton and Harefield

In November 2017, NHS England Board agreed that Royal Brompton could work with Kings Health Partners on their proposal to enable Royal Brompton's compliance with the national standards for congenital heart disease, specifically colocation of the paediatric service for congenital heart disease with other specialised paediatric services. This proposal involves all services (adult and paediatric) transferring from the RBH site on Fulham Road to a new paediatric and cardiovascular centre on the St Thomas's site.

NHS England London has received legal advice on its role following the November 2017 decision which indicated that they would need to go to public consultation on this reconfiguration due to

its scale. As part of this consultation NHS England must be able to show it is acting independently, although acknowledging that the work and data provided by RBH/GSTT will form a key component of the consultation document.

The decision confirmed that NHS England would work with RBH and other potential partners on the full range of options for delivering a solution that could offer full compliance with the congenital heart disease standards including the paediatric standards and ensuring the sustainability of other connected services. It required RBH to develop and deliver a credible solution for meeting colocation requirements, against a set of milestones to progress a Strategic Outline case by 30 June 2018, an Outline Business Case (OBC) by 30th November 2019 and full colocation by April 2022.

Consideration has been given to how to garner a wide spectrum of advice on the proposals and options as they develop. To this end NHS England London has established a Clinical Advisory Panel to be chaired by Professor Sir Mike Rawlins. The panel brings together the chairs of relevant national Clinical Reference Groups (as is required for NHS England commissioned service reconfigurations) and representatives of relevant Royal Colleges.

NHS England London Specialised Commissioning has been engaging other key stakeholders, including ourselves, in developing an understanding of viable alternative options. We are currently working with our North West London partners to evaluate a number of potential options and will provide a further update on progress with this at our next Board meeting.

North West London Pathology (NWLP)

Following my last update in May where I reported on the recent go live of the new Laboratory Information Management System (LIMS) on the Chelsea site, we have continued to experience a number of challenges in terms of ongoing service delivery. I have over the last 6 weeks met twice with the senior team from NWLP to discuss a number of clinical, operational and strategic issues and the team remain in very regular contact as we work through the process, system and communication issues that have emerged over recent months.

We have more recently received greater assurances that the NWLP team are getting on top of the issues although we have not yet agreed a roll out date for the West Middlesex site until we are satisfied that the problems that occurred following the Chelsea go live are fully resolved.

9.0 Cerner Electronic Patient Record Implementation Update

The Cerner systems continues to bed in well at the West Middlesex Hospital. The clinical and operational teams are working together to stabilise the system and check that we are utilising the correct work flows. We are using both the reports directly from Cerner but also a data quality dashboard which compares our current data with our previous baseline. In terms of activity, including the rate of booking appointments, we are back to pre go-live levels. Our current focus is on diagnostic booking and RTT outcomes.

The plan is to undertake the Gateway 6 review during the month of July. The purpose of this will be to assess progress towards stable business as usual operation and review the plans that are being developed for the roll out of clinical functionality at West Middlesex and the full implementation at the Chelsea site.

10.0 Finance

At the end of May, month 2, our year to date adjusted position is a deficit of £1.14m which is to £0.32m adverse to the internal plan. Pay costs are over plan by £2.6m offset, in part, by underspends in non-pay and revenue in excess of plan.

We had planned to achieve 10% of our savings target for 2018/19 of £25.1m by the end of month 2 but actually achieved 9%. We will be focusing on getting our CIP delivery back on plan and to ensure we achieve our yearend target.

Lesley Watts
Chief Executive Officer
July 2017

All staff briefing

June 2018

All managers should brief their team(s) on the key issues highlighted in this document within a week.

One month of Cerner EPR

Cerner EPR has now been live at WMUH for a month and we are delighted that it has gone so well. Following the success of such a significant change, it's vital that our new way of working becomes our 'business as usual' as quickly as possible. So while preparations for the next steps at WMUH and C&WH are already underway, our priority remains making sure that Cerner EPR at WMUH beds in properly and that everyone is confident using it. The Trust would like to thank all staff for their patience and hard work in making the go-live such a success.

Financial performance

For Month 1 (April) the Trust is reporting a £1.32m deficit which is £0.14m adverse against the NHSI plan. After adjusting for non-recurrent funding for STF and Transaction the Trust has an underlying deficit of £3.6m. The Trust is required to deliver CIPs of £25.1m in 2018/19 and has achieved 64% of the month 1 target, with most of the shortfall due to unidentified schemes.

Anniversaries in 2018

We are celebrating special anniversaries this year.

- On 5 July we will be celebrating the 70th anniversary of the NHS with events at each hospital.
- 13 September will be the 30th anniversary of the Kobler Centre

Thank you to those who joined us in celebrating the 25th anniversary of Chelsea and Westminster Hospital in May. As always, if you have any great historical photos or stories to share, we'd love to hear from you. Please email communications@chelwest.nhs.uk. Thank you to everyone who has sent us photos so far.

Care Quality Programme (CQP)

Our Care Quality Commission inspection process continues. This summer we are expecting inspection visits to both main sites for maternity, gynaecology, critical care, diagnostics and imaging; also to Sexual Health and HIV services at main sites and off-site locations from our main sites. These visits will be unannounced.

To support this work the CQP team are delivering updates and briefings for staff in the areas concerned. Further information is available on the intranet page, http://connect/departments-and-mini-sites/cqp/ or email cqp@chelwest.nhs.uk

Recent ward accreditation activity has been focussed on these services. This has helped to identify our areas of outstanding practice and areas that need improvement.

If you have not been part of the ward and department accreditation teams, reviewing our clinical services that support the quality improvement and CQC work, please get involved. The teams are accrediting some of the clinical areas on the next Perfect Day on 26 June, this month, focussing on the C&WH site. Contact: warddepartment.accredation@chelwest.nhs.uk

Mandatory and statutory training

We continue to make progress toward the Trust's compliance target of 90%, currently 88% for the whole Trust.

Staff are reminded of their responsibility in ensuring they are up-to-date with their mandatory training. Managers should ensure that their staff have this in hand. GDPR is now in force, so IG training is especially important for everyone. As we are now in the new cycle for PDR please can all managers ensure they check Qlikview before an individual's review to confirm compliance. Compliance figures as at 31st May are as follows:

Division	Compliance
Corporate	**92%**
Emergency and Integrated Care	**86%**
Planned Care	**88%**
Women, Neonatal, Children, Young People, HIV/Sexual Health	**89%**
Overall compliance	**88%**

Moving and Handling compliance has increased by 4% across the trust but remains low at 69% whilst all clinical staff at WMUH are brought in line with Trust policy. The moving and handling teams are running multiple additional sessions on the WMUH site and these can be booked by contacting learninganddevelopmentadmin@chelwest.nhs.uk

Staff can now complete eight of the core training eLearning modules at learning.chelwest.nhs.uk—which is available from both within and outside the Trust, across a variety of devices (including smartphones and tablets). Face to face learning is only required for BLS, patient Moving and Handling and Safeguarding Children / Adults level 3.

Latest CW+ PROUD award winners

Well done to our latest winners who have all demonstrated how they are living our PROUD values:

- Planned Care: **Bryan Sy**, Technician, Intensive Care Unit (WMUH)
- Emergency and Integrated Care: **Danilo Passero,** Junior Charge Nurse (C&WH)
- Women and Children: **Laura Parry and Emily Bridges,** Midwives, Birth Centre (C&WH)
- Corporate: **Alice Howard,** Lead Information Analyst, HY

Visit the intranet to nominate a team or individual.

July *All Staff Briefing*:

- Will take place the first week of July.

Board of Directors Meeting, 5 July 2018

PUBLIC SESSION

AGENDA ITEM NO.	2.2/Jul/18
REPORT NAME	Improvement Programme update
AUTHOR	Serena Stirling, Director of Improvement
LEAD	Pippa Nightingale, Chief Nurse Sandra Easton, Chief Finance Officer
PURPOSE	To report on the progress of the Improvement Programme
SUMMARY OF REPORT	The Trust is developing an improvement programme aligned with the 3 strategic objectives to support the continual delivery of affordable, high quality of care. This will focus on ensuring that: • Continuous improvement becomes everyone's job. • Development of an organisational culture which enables our workforce to focus on quality, innovation and productivity. • Staff are '**Enthused, Enabled and Empowered'** to improve their services • Development of a standardised Trust-wide approach to improvement which supports delivery of the Quality Strategy and Quality Priorities. • Update on ward accreditation process and progress. **Initial steps** • Co-location of Clinical Fellows, Care Quality Programme and Programme Management office teams to the Chelsea site. This is the first step to creating the 'Improvement Hub'. A space on the West Middlesex site has been identified for the same purpose. • Refocused monthly Improvement Board meetings to ensure quality and finance improvement efforts are given equitable consideration. **Next steps** • Define Improvement Framework • Define the 'toolkit' to support quality improvement • Define the educational offer for staff and continue building a faculty to support delivery to ensure learning is tailored to individual need • Develop an engagement plan to ensure staff, patients and members of the Trust are aware of the value of their contribution to quality improvement and feel that they can shape the delivery of high quality healthcare This paper also summarises the key issues arising from the 'Identified' Improvement Board 20th June 2018.
KEY RISKS ASSOCIATED	Failure to continue to deliver high quality patient care Failure to deliver 2018/19 improvement and efficiency targets

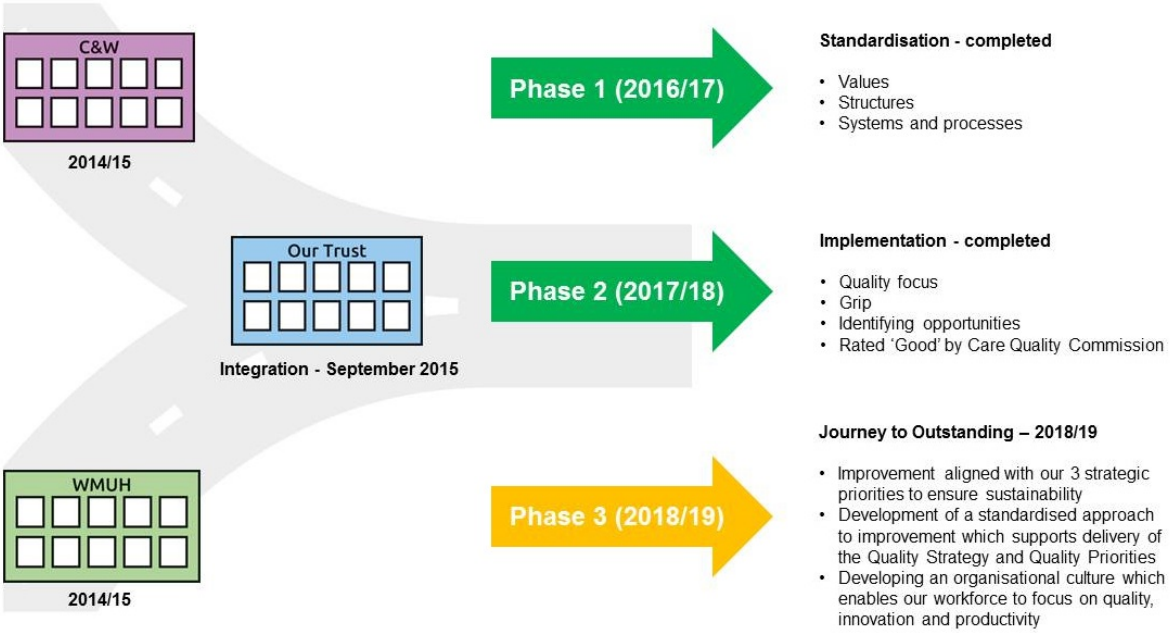
FINANCIAL IMPLICATIONS	These are regularly considered as part of the risk assessment and review process of Cost Improvement Schemes through the divisional structures and Improvement Board.
QUALITY IMPLICATIONS	These are considered as part of the embedded Quality Impact Assessment process of the Improvement Programme, which is led by the Chief Nurse and Medical Director.
EQUALITY & DIVERSITY IMPLICATIONS	Equality and Diversity implications have been considered as part of the embedded Quality Impact Assessment process of the Improvement Programme, which is led by the Chief Nurse and Medical Director.
LINK TO OBJECTIVES	State the main corporate objectives from the list below to which the paper relates. • Deliver high-quality patient-centred care • Deliver better care at lower cost
DECISION/ ACTION	The report is for information

Improvement Programme

Background

In 2014/15 the West Middlesex and Chelsea and Westminster organisations were inspected individually by the Care Quality Commission (CQC) and were both rated 'Requires Improvement'. In September 2015 both hospitals integrated, bringing together c6000 staff and created a bed base of c1000. 2017/18 saw the first comprehensive CQC inspection of Chelsea and Westminster NHSFT as one organisation. Both Chelsea and West Middlesex sites are now rated 'Good', and the Trust is currently rated 'Good' overall. The Trust is rated as 'Outstanding' for Use of Resources.

The Trust's improvement journey to get to this point since integration is outlined below:



Phase 3 – Journey to Outstanding and Beyond…….

The next aim is to achieve an overall Trust rating of 'Outstanding', whilst maintaining 'Outstanding' rating for Use of Resources. The delivery of this is within the external context of:

- Increasing quality expectations
- National financial pressures
- Increased demand on non-elective care
- National workforce challenges in attracting, training and retaining high quality people
- National & local policy changes (reconfiguration plans, integrated care, shared care etc.)

The Trust must also ensure delivery of the following internal strategic objectives, ensuring the PROUD values are a lived experience for all staff:

- Deliver high quality patient centred care
- Deliver better care at lower cost
- Be the employer of choice

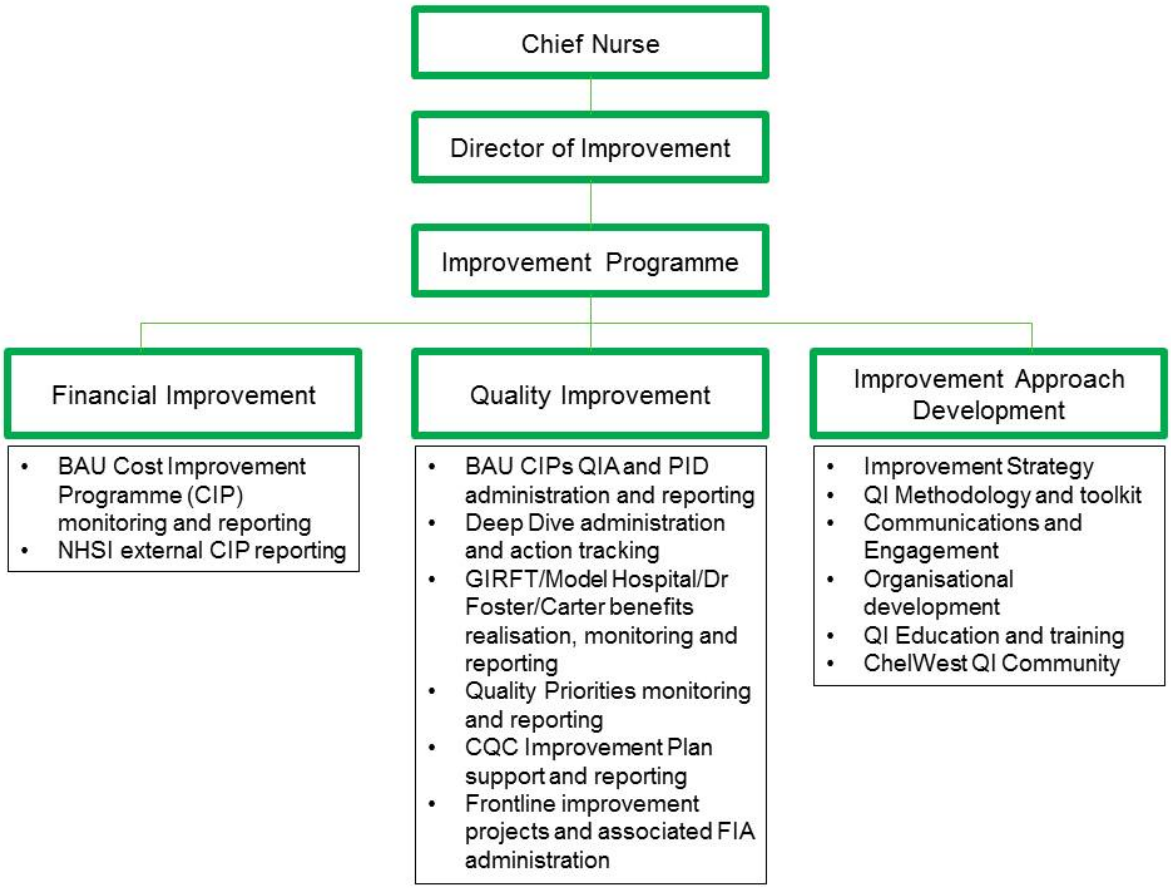
The Trust is developing an improvement programme aligned with the 3 strategic objectives to support the continual delivery of affordable, high quality of care. This will focus on ensuring that:

- Continuous improvement becomes everyone's job.
- Development of an organisational culture which enables our workforce to focus on quality, innovation and productivity.
- Staff are '**Enthused, Enabled and Empowered'** to improve their services
- Development of a standardised Trust-wide approach to improvement which supports delivery of the Quality Strategy and Quality Priorities.

This improvement programme builds upon the quality improvement activities within the organisation to date. This includes: the work of the Quality Improvement Team (led by Roger Chinn/Hugh Rogers/Josh Allison); Project Management Office; Finance Team; Learning and Organisational Development; Strategy Team and the Care Quality Programme Team to name but a few.

Leadership Structure

The leadership structure of the programme will take the following form:



Resources

The current programme workforce is as follows:

Financial improvement	• 1 x Band 8A (Senior Finance Manager)
Quality improvement	• 1 x Band 6 (PMO Support Manager) • 4 x Clinical Fellows (3 commencing 3rd September 2018, 1 currently in post)
'Improvement' Development **(Core Group)**	• Strategy Team • AMD for Innovation and Service Transformation • Assistant Director of Nursing Quality • Communications Team • Assistant Director of Learning & Organisational Development • CLAHRC • Deputy Director of Finance • SI&E Leads (Divisional representation)

Programme Governance

Improvement Team	• Weekly internal team meeting to monitor workstream progress, highlight risks and ensure reporting is on track. • Senior Finance Manager and Dep Director of Finance regular meetings to review reported data and highlight areas of risk/challenge. All financial data being produced by Improvement Team have first level sign off by Dep Director of Finance. • Fortnightly Improvement Team meeting with Divisional FBPs, SI&E leads and Procurement Team to review progress, challenges/risks and share learning. • Director of Improvement regular 1:1s with CFO and CNO
Improvement Development (core group)	• Fortnightly meeting to plan, produce and implement programme led by Director of Improvement (To be established)

Monitoring and Reporting Structure

Improvement Board (monthly cycle)	Week 1 – Unidentified Opportunities (GIRFT, Model Hospital, Dr Foster, Carter and frontline improvement projects, CQC Additional Actions) Week 3 – Identified Opportunities (CIPs incl QIA/PIDs, Quality Priorities, CQC Must Do actions)
Executive Management Board	Week 4 – progress report and highlight of key issues
Quality Committee	Week 1 – summary of previous month progress
Finance and Investment Committee	Week 4 - summary of previous month progress

Initial steps

- Co-location of Clinical Fellows, Care Quality Programme and Programme Management office teams to the Chelsea site. This is the first step to creating the 'Improvement Hub'. A space on the West Middlesex site has been identified for the same purpose.
- Refocused monthly Improvement Board meetings to ensure quality and finance improvement efforts are given equitable consideration.

Next steps

- Define Improvement Framework
- Define the 'toolkit' to support quality improvement
- Define the educational offer for staff and continue building a faculty to support delivery to ensure learning is tailored to individual need
- Develop an engagement plan to ensure staff, patients and members of the Trust are aware of the value of their contribution to quality improvement and feel that they can shape the delivery of high quality healthcare

Identified Improvement Board update 20th June 2018

Cost Improvement Programme (CIP)

Trust-level progress

The current CIP forecast is £21.6m, which is an improvement of £1.2m from the prior month. £3.5m of the programme remains unidentified.

The profile of cost improvement schemes in the programme is summarised below:

- Red £1.2m or 6%
- Amber £6.9m or 32%
- Green £13.4m or 62%

CIP Governance

Additional projects have been added in M02 that have launch date in Q1 and require PIDs and QIA. Divisional leads have been communicated with the list of projects outstanding on the 20th June 2018.

Total 2018/19 outstanding projects requiring PIDs and QIA are as follows:

Project Start Date with value (£000)

Division	Q1	Q2	Q3	Q4	Total
Corp	£123	£0	£83	£0	£206
EIC	£490	£687	£315	£0	£1,492
W&C	£297	£288	£400	£345	£1,330
PC	£940	£160	£75	£0	£1,175
Total	£1,850	£1,134	£873	£345	**£4,202**

Quality priorities

The five Trust Quality Priorities projects identified for 2018/19 will be reported in detail in future Identified Improvement Board meetings. The Improvement Team are developing relevant reporting template and ensuring the following steps will be taken to implement the process:

- Key Performance Indicators to be developed to monitor progress for all five quality priorities projects.
- All projects to be financially appraised alongside the SROs and clinical leads.
- Improvement Team have liaised with quality priority SRO leads to discuss KPIs and financial benefits
- Monthly update on progress will also be provided to the Quality Committee

CQC Improvement Tracker

- This tracker details the 'Should Do' (mandatory) actions arising from the 2017/18 CQC inspection, and also the additional actions identified in the report narrative (attached in appendices 1 and 2). In total, 147 actions have been identified, of which 57 are 'Should Do' actions. Going forward, the 57 'should do' actions will be discussed in the Improvement board for identified schemes and additional actions will be discussed in the Improvement board for unidentified opportunities. The Trust meets quarterly with the CQC to review progress, highlight any risks to delivery and give assurance that regulatory compliance is embedded ward to board.

Ward accreditation

The ward accreditation programme continues into the second year, the tools was reviewed and refined and now also meets the CQC core standards. All clinical areas are now part of the ward accreditation process which has increased the number of areas to be assessed from 42 areas originally assessed to 102 areas to be assessed in 18/19. This process allows us to have a full detailed view of all clinical areas with rigor and standardisation applied to the methodology used to assess the ratings.
Of the areas that have been assessed for a second year, 14 have improved, 9 have remained the same and 2 have deteriorated.

Unit	Div	Site	2016	2017	2018 Prev	2018 Current	Change
Discharge Lounge	Corp	C&W				White	
Acute Assessment Unit	EIC	C&W	Silver				
David Erskine Ward	EIC	C&W	Bronze				
David Evans Ward	EIC	C&W	Silver				
Diagnostics	EIC	C&W		Bronze		White	⇩
Edgar Horne Ward	EIC	C&W	Silver				
Emergency Department, Adults	EIC	C&W	Silver				
Emergency Department, Paediatrics	EIC	C&W	Silver				
Endoscopy	EIC	C&W		Bronze			
Medical Day Unit	EIC	C&W		Bronze		Silver	⇧
Nell Gwynne Ward	EIC	C&W	Bronze				
Rainsford Mowlem Ward	EIC	C&W	Bronze			Bronze	⇨
Therapies	EIC	C&W					
Burns Unit and Burns Theatres	PCD	C&W		Bronze			
Fracture/orthopaedic OPD	PCD	C&W	Silver				
Intensive Care Unit	PCD	C&W		Silver		Silver	⇨
Imaging	PCD	C&W		Bronze		Bronze	⇨
Lord Wigram ward	PCD	C&W	Bronze			Silver	⇧
Main Outpatients Department	PCD	C&W		Bronze			
Phlebotomy	PCD	C&W					
Plastics Outpatients	PCD	C&W		Silver			
Saint Mary Abbots Ward	PCD	C&W	Silver				
Theatres	PCD	C&W		Bronze			
Treatment Centre	PCD	C&W		Bronze			
Anne Stewart (PN)	W&C	C&W		Bronze		Bronze	⇨
Annie Zunz Ward	W&C	C&W	Silver			Silver	⇨
Antenatal clinic	W&C	C&W				Bronze	
Apollo Paediatric HDU	W&C	C&W	Bronze				
Assisted Conception Unit	W&C	C&W				Bronze	
Birth Centre	W&C	C&W				TBC	
Chelsea Wing	W&C	C&W		Bronze			
Cheyne Children's Centre	W&C	C&W					
Community Paediatrics	W&C	C&W					
Dermatology Day Care/OPD	W&C	C&W		Silver		Silver	⇨
Elizabeth Suite	W&C	C&W				Silver	

Unit	Div	Site	2016	2017	2018 Prev	2018 Current	Change
Gynaecology OPD	W&C	C&W				White	
John Hunter Clinic	W&C	C&W		Silver		White	⇩⇩
Josephine Barnes (AN)	W&C	C&W		Bronze	White	Bronze	⇧
Jupiter Ward	W&C	C&W	Silver				
Kensington Wing	W&C	C&W		Bronze		Silver	⇧
Kobler Day Care	W&C	C&W					
Kobler Outpatients	W&C	C&W				White	
Labour Ward & Simpson Unit	W&C	C&W		Bronze		Silver	⇧
Labour Ward Theatres	W&C	C&W		Silver			
Mars Children's Burns Unit	W&C	C&W					
Mercury Ward	W&C	C&W	Silver				
Neonatal Intensive Care Unit	W&C	C&W		Silver			
Neptune Ward	W&C	C&W	Gold				
Paediatric OPD	W&C	C&W					
Ron Johnson	W&C	C&W	Silver			Gold	⇧
Saturn Ward	W&C	C&W	Silver				
Westminster Wing	W&C	C&W					
10 Hammersmith Broadway	W&C	Outreach	Silver			Silver	
56 Dean Street	W&C	Outreach		Silver		Silver	
Dean Street Express	W&C	Outreach		Silver		Silver	
Harlow HIV OPD	W&C	Outreach					
Herefordshire HIV OPD - Watford	W&C	Outreach					
Hertfordshire HIV OPD - Stevenage	W&C	Outreach					
Sexual Health Hounslow - Feltham	W&C	Outreach					
Sexual Health Hounslow – Heart of Hounslow	W&C	Outreach					
Sexual Health Sutton – Green Wrythe Lane	W&C	Outreach					
Sexual Health Sutton - Jubilee	W&C	Outreach					
Sexual Health Sutton – St Helier	W&C	Outreach					
Acute Medicine Unit	EIC	WMUH	Bronze				
Cardiology/CCU	EIC	WMUH	Silver				
Crane Ward	EIC	WMUH	Bronze				
Diagnostics	EIC	WMUH			White	White	⇨
Emergency Department	EIC	WMUH		Silver			
Endoscopy	EIC	WMUH	Bronze				
Haematology Day Unit	EIC	WMUH					
Kew Ward	EIC	WMUH	Bronze			Silver	⇧
Lampton Ward	EIC	WMUH	Gold				
Marble Hill 1 Ward	EIC	WMUH		Bronze		Silver	⇧
Marble Hill 2 Ward	EIC	WMUH		Silver			
Osterley 1 Ward	EIC	WMUH	Bronze			Bronze	⇨
Osterley 2 Ward	EIC	WMUH	Silver				
Therapies	EIC	WMUH		Silver			

Unit	Div	Site	2016	2017	2018 Prev	2018 Current	Change
Cardiac Catheter Laboratory	PCD	WMUH					
Dermatology	PCD	WMUH					
ICU	PCD	WMUH		Silver		Silver	⇨
Imaging	PCD	WMUH		Bronze		Silver	⇧
Outpatients 1 - 5	PCD	WMUH		Bronze			
Outpatients 6 & 8	PCD	WMUH		Bronze			
Phlebotomy	PCD	WMUH				Bronze	
Richmond Ward/SDU	PCD	WMUH	Silver				
Surgical Assessment Unit	PCD	WMUH					
Syon 1 Ward	PCD	WMUH	Silver				
Syon 2 Ward	PCD	WMUH	Silver				
Theatres	PCD	WMUH					
Antenatal clinic	W&C	WMUH				Bronze	
Antenatal ward	W&C	WMUH				Silver	
Gynaecology OPD, Twick Hse	W&C	WMUH				White	
Labour Ward	W&C	WMUH				Silver	
Labour Ward Theatres	W&C	WMUH		Bronze		Silver	⇧
Maternity Triage	W&C	WMUH				Silver	
Natural Birth Centre	W&C	WMUH				Silver	
Postnatal Ward	W&C	WMUH				Bronze	
Paediatric Short Stay Unit	W&C	WMUH					
Sexual Health Hounslow – Twick Hse	W&C	WMUH		Bronze		Silver	⇧
Special Care Baby Unit	W&C	WMUH		Silver			
Starlight Ward	W&C	WMUH		Silver			
Sunshine Ward	W&C	WMUH		Silver			

Appendix 1 – CQC Action Tracker – for 'Should Do' actions (1/3)

Number	CQC Recommendation	CQC Domain	Should Do Action (Yes/No)	CQC Core Service	Site	Division	Corporate theme
1	The Trust should ensure fridge and room temperature checks are completed daily, and if temperatures exceed the maximum temperature, that this is reported to facilities and pharmacy in a timely way.	Safe	Yes	Urgent and Emergency Services	CW	EIC	Medicines Management
2	The Trust should ensure that ED consultant cover continues to increase to provide 16 hours per day consultant cover as per Royal College of Emergency Medicine guidelines.	Safe	Yes	Urgent and Emergency Services	CW and WM	EIC	Medical Staffing
3	The West Middlesex Emergency Department should ensure that all patient records are completed fully, including risk assessments for capacity and dementia.	Safe	Yes	Urgent and Emergency Services	WM	EIC	Clinical Documentation
4	The West Middlesex Hospital should review the arrangements for supervision of the Clinical Decision Unit.	Safe	Yes	Urgent and Emergency Services	WM	EIC	Local
5	The West Middlesex clinical staff should have access to a wider range of standardised pathways to ensure patients receive consistent, evidence-based treatment.	Effective	Yes	Urgent and Emergency Services	WM	EIC	Local
6	The Trust should make more use of national and local audits to monitor care and treatment and bring about improvement at West Middlesex Hospital. The performance of the department was worse than the national average in a number of Royal College of Emergency Medicine audits: the consultant sign off audit (2016/17), vital signs in children 2015/16 and procedural sedation in adults (2016/7). Audits to bring about improvement in patient treatment outcomes were not given sufficient priority.	Effective	Yes	Urgent and Emergency Services	WM	EIC	Clnical Audit
7	The Emergency Department at West Middlesex should provide more information to patients to help them lead healthier lives.	Effective	Yes	Urgent and Emergency Services	WM	EIC	Health Promotion
25	The Trust should have a clear policy on the opening and closing of escalation areas at Chelsea and Westminster Hospital.	Responsive	Yes	Medical care (including older people's care)	CW	EIC	Site Operations
26	The Trust should review medical cover at night in order to address continuing staff shortages at night at Chelsea and Westminster Hospital.	Safe	Yes	Medical care (including older people's care)	CW	EIC	Medical Staffing
27	The Trust should ensure that agency staff has access to electronic patient records.	Safe	Yes	Medical care (including older people's care)	CW	EIC	Temporary Staffing
28	The Trust should ensure that staff assess patients for the risk of malnutrition on admission.	Effective	Yes	Medical care (including older people's care)	CW and WM	EIC	Nutrition and Hydration
29	The Trust should ensure that staff reassess patients for the use of the red tray system at Chelsea and Westminster Hospital as per Trust policy.	Effective	Yes	Medical care (including older people's care)	CW	EIC	Nutrition and Hydration
30	The Trust should ensure that medicines are managed and stored safely in all medical areas	Safe	Yes	Medical care (including older people's care)	CW	EIC	Medicines Management
31	The West Middlesex Hospital should ensure senior staff comply with Trust policy on agency nurses, including positive ID verification and inductions.	Safe	Yes	Medical care (including older people's care)	WM	EIC	Temporary Staffing
32	The West Middlesex Hospital should ensure all staff adhere to the Control of Substances Hazardous to Health Regulations 2002 to ensure the safe storage of chemicals or hazardous substances in relation to national guidance.	Safe	Yes	Medical care (including older people's care)	WM	EIC	Health and Safety
33	The West Middlesex Hospital should improve oversight of storage areas used for chemicals and cleaning equipment.	Safe	Yes	Medical care (including older people's care)	WM	EIC	Health and Safety
62	The West Middlesex Hospital should improve the quality of the risk register and include all risks mentioned in the CQC report.	Well-Led	Yes	Surgery	WM	PC	Risk Management
63	The West Middlesex Hospital should improve the utilisation rate in theatres. Theatre utilisation was recorded as 73% for day patients. This was a 2% decrease from the last inspection which recorded as 75% utilisation in October 2014. Utilisation for elective surgery was recorded at 78% in both inspections.	Responsive	Yes	Surgery	WM	PC	Local
64	The West Middlesex Hospital should improve the response rate for complaints and adhere to Trust policy of responding to complaints within 25 days. The department had 76 complaints which took an average of 51 days to investigate and close.	Responsive	Yes	Surgery	WM	PC	Complaints
65	The West Middlesex Hospital should improve the response rate of the Friends and Family Test.	Caring	Yes	Surgery	WM	PC	Friends and Family Test
66	The West Middlesex Hospital should conduct starvation audits to access how many patients were starved for the recommended number of hours, and to assess whether or not practice complies with the Trust's protocol.	Effective	Yes	Surgery	WM	PC	Local
67	The hospitals should continue its implementation of one electronic patient record.	Well-Led	Yes	Surgery	CW and WM	PC	Electronic Patient Records
68	Chelsea and Westminster Hospital should ensure action is taken when fridge temperatures are outside the recommended temperatures.Staff took minimum, current and maximum temperature readings each day however, we did not find evidence of action taken by staff when temperatures were found to be outside of the recommended range.	Safe	Yes	Surgery	CW	PC	Medicines Management
69	Chelsea and Westminster Hospital should continue to review its policies and guidelines.	Safe	Yes	Surgery	CW	PC	Polices, Procedures, Guidelines
70	Chelsea and Westminster Hospital should work towards reducing RTT rates. The service had not achieved its referral to treatment (RTT) target for general surgery, oral surgery, trauma and orthopaedics and urology.	Responsive	Yes	Surgery	CW	PC	Performance
71	Chelsea and Westminster Hospital should work towards improving appraisal rates.	Well-Led	Yes	Surgery	CW	PC	Appraisal
98	The Trust should ensure staff in the service complete required mandatory training to improve compliance with the Trust's target for completion eg medical staff was slightly below trust targets.	Safe	Yes	Services for children and young people	CW	W,C,HIV/GUM, D&PP	Mandatory Training
99	The Trust should review training and processes for ensuring that nurse managers in all paediatric clinical areas understand their responsibilities for safely managing controlled drugs. For example ensuring that the key to the controlled drug cupboard remains with the nurse in charge, or authorised delegate, at all times.	Well-Led	Yes	Services for children and young people	CW	W,C,HIV/GUM, D&PP	Medicines Management
100	The Trust should take further steps to ensure that safe staffing levels are maintained for all shifts across children and young people services at Chelsea and Westminster Hospital eg example nurse staffing in the neonatal unit and on the paediatric burns unit.	Safe	Yes	Services for children and young people	CW	W,C,HIV/GUM, D&PP	Nurse Staffing

Appendix 1 – CQC Action Tracker – for 'Should Do' actions (2/3)

Number	CQC Recommendation	CQC Domain	Should Do Action (Yes/No	CQC Core Service	Site	Division	Corporate theme
100	The Trust should take further steps to ensure that safe staffing levels are maintained for all shifts across children and young people services at Chelsea and Westminster Hospital eg example nurse staffing in the neonatal unit and on the paediatric burns unit.	Safe	Yes	Services for children and young people	CW	W,C,HIV/GUM, D&PP	Nurse Staffing
101	The Trust should develop the Trust's intranet search function to ensure staff can find and access policies, guidelines and other information in a timely way. Some trust computer systems did not always work as effectively as they should, which impacted staff efficiency, for example the policy database and online learning platform.	Effective	Yes	Services for children and young people	CW	W,C,HIV/GUM, D&PP	Polices, Procedures, Guidelines
102	The Trust should take steps to improve nursing involvement and leadership in clinical research activities.	Well-Led	Yes	Services for children and young people	CW	W,C,HIV/GUM, D&PP	Research and Development
103	The Trust should review consent training and processes to ensure all clinicians understand their responsibilities for obtaining and recording consent in patient records eg paediatric surgery did not always follow best practice.	Effective	Yes	Services for children and young people	CW	W,C,HIV/GUM, D&PP	Consent
104	The Trust should take steps to improve the training, development and engagement of healthcare assistants and nursery nurses.	Effective	Yes	Services for children and young people	CW	W,C,HIV/GUM, D&PP	Clinical Education
105	The Trust should clarify the intended purpose and admission criteria for the paediatric high dependency unit. HDU admission criteria were not always followed, which resulted in some patients being admitted to the ward who did not require HDU level care, or those with unclear dependencies.	Responsive	Yes	Services for children and young people	CW	W,C,HIV/GUM, D&PP	Site Operations
106	The Trust should ensure plans for the relocation of the paediatric ambulatory care unit at Chelsea and Westminster Hospital to a more suitable space are enacted in a timely way. The present location of the paediatric ambulatory care unit on Saturn ward was suboptimal and could impact on the patient experience.	Responsive	Yes	Services for children and young people	CW	W,C,HIV/GUM, D&PP	Estates and Facilities
107	The Trust should review paediatric theatre usage to improve efficiency and utilisation rates at Chelsea and Westminster Hospital.	Responsive	Yes	Services for children and young people	CW	W,C,HIV/GUM, D&PP	Local
108	The Trust should take steps to reduce discharge delays, such as medication and patient transport delays.	Responsive	Yes	Services for children and young people	CW	W,C,HIV/GUM, D&PP	Discharge Planning
109	The Trust should take steps to reduce complaint response times to improve compliance with the trust's complaints policy.	Responsive	Yes	Services for children and young people	CW	W,C,HIV/GUM, D&PP	Complaints
110	The Trust should ensure all staff with leadership and management responsibilities have sufficient protected time, training and support to discharge their responsibilities eg band 6-7 nurses felt that the trust could support them with more development opportunities to be better leaders.	Well-Led	Yes	Services for children and young people	CW	W,C,HIV/GUM, D&PP	Learning and Development
111	The Trust should take steps to improve Wi-Fi network access in all areas of the children and young people services at Chelsea and Westminster Hospital to ensure staff can access the Trust network eg we found that the Children's Outpatients area was located in a Wi-Fi network 'dead spot' within the Hospital, which meant staff could not access the trust network on mobile devices.	Well-Led	Yes	Services for children and young people	CW	W,C,HIV/GUM, D&PP	IT
112	The Trust should ensure agency staff have access to electronic patient information.	Safe	Yes	Services for children and young people	WM	W,C,HIV/GUM, D&PP	Temporary Staffing
113	The Trust should address children and young people having timely access to speech and language therapy at West Middlesex.	Effective	Yes	Services for children and young people	WM	W,C,HIV/GUM, D&PP	Therapies
114	The Trust should ensure that data recording in the National Neonatal Audit Programme (NNAP) improves at West Middlesex.	Effective	Yes	Services for children and young people	WM	W,C,HIV/GUM, D&PP	Clinical Audit
115	The Trust should ensure the service meets all the NICE quality standards for Epilepsy at West Middlesex.	Effective	Yes	Services for children and young people	WM	W,C,HIV/GUM, D&PP	NICE Compliance
116	The Trust should ensure staff receive timely appraisals and meet the Trust's target rates for completion.	Well-Led	Yes	Services for children and young people	WM	W,C,HIV/GUM, D&PP	Appraisal
117	The Fracture Clinic at West Middlesex should have appropriate waiting and treatment areas for children.	Responsive	Yes	Services for children and young people	WM	W,C,HIV/GUM, D&PP	Local
118	The Trust should clarify the funding and level of high dependency care on the Special Care Baby Unit at West Middlesex.	Responsive	Yes	Services for children and young people	WM	W,C,HIV/GUM, D&PP	Local
119	The Trust should ensure all staff at West Middlesex feel engaged in service planning, research and service reconfiguration.	Well-Led	Yes	Services for children and young people	WM	W,C,HIV/GUM, D&PP	Staff Engagement
127	The Trust should ensure there is improved consistency in the completion of DNACPRs. A recent audit of DNACPR showed there were certain areas which fell below the 100% target for all standards. For example, results showed that 63% were reviewed by a consultant within 48 hours; 39% showed a discussion took place with next of kin where patient had capacity and 71% showed discussion took place with next of kin where patient lacked capacity.	Effective	Yes	End of life care	CW and WM	EIC	End of Life
128	The Trust should ensure that information technology is compatible with working practices. The current information technology system did not fully support all aspects of record keeping. It did not allow for certain data to be collected and could not support coordinated care plans between the Hospital and GP. The current information technology system did not support staff to do their work efficiently. There were different IT systems on which patient information was stored. This made it time consuming to access each part of a patient's record.	Well-Led	Yes	End of life care	CW and WM	EIC	End of Life
129	The Chelsea and Westminster should ensure that Compassionate Care Agreements are consistently completed. There was inconsistency in how compassionate care agreements were completed. This was evident in areas which included preferred place of death and recording the spiritual and emotional needs of the patient.	Safe	Yes	End of life care	CW and WM	EIC	End of Life
130	The Chelsea and Westminster Hospital should ensure that staff training for the London End of Life Care Register 'Coordinate My Care' continues in order to maximise usage.	Safe	Yes	End of life care	CW	EIC	End of Life
132	The West Middlesex Hospital should ensure that staff meet the Trust's target for staff completing mandatory training. The lowest completion rates were for the conflict resolution module 65%, patient handling 70% and basic life support 70% as at August 2017.	Safe	Yes	Outpatients	WM	PC	Mandatory Training

Appendix 1 – CQC Action Tracker – for 'Should Do' actions (3/3)

Number	CQC Recommendation	CQC Domain	Should Do Action (Yes/No)	CQC Core Service	Site	Division	Corporate theme
132	The West Middlesex Hospital should ensure that staff meet the Trust's target for staff completing mandatory training. The lowest completion rates were for the conflict resolution module 65%, patient handling 70% and basic life support 70% as at August 2017.	Safe	Yes	Outpatients	WM	PC	Mandatory Training
133	The West Middlesex Hospital should ensure that incidents are investigated and there is learning from incidents across the department. Senior managers could not be assured that OPD staff were learning from incidents across the trust. A review of OPD meeting minutes, staff meetings showed incidents were not discussed.	Safe	Yes	Outpatients	WM	PC	Incident Reporting
134	The West Middlesex should ensure staff meet the trust's target for appraisal rates. The trust reported 68% of nursing staff had received an appraisal during the 12 month period from August 2016 to July 2017.	Well-Led	Yes	Outpatients	WM	PC	Appraisal
135	The West Middlesex Hospital should ensure they are monitoring clinic waiting times for patients. This was one of the main concerns raised by patients that we spoke with during the inspection. Patients told us that their waits had varied from 15 minutes to an hour.	Responsive	Yes	Outpatients	WM	PC	Local
136	The Trust should ensure the OPD risk register is reflective of risks within the OPD department. The OPD had eight incidents waiting to be investigated which meant there was no learning from them. Two of the incidents related to medicines, one of the incidents had been reported in June 2017 and the other in September 2017. The backlog of incidents waiting investigation had not been identified on the risk register. There were two risks identified, a third risk seen on documentation related to paediatric patients being seen in the OPD due to lack of space within the paediatric OPD was no longer on the risk register.	Well-Led	Yes	Outpatients	WM	PC	Risk Management

Appendix 2 – CQC Action Tracker – for additional actions (1/4)

Number	CQC Recommendation	CQC Domain	Should Do Action (Yes/No)	CQC Core Service	Site	Division	Corporate theme
8	At the time of inspection there will still some delays in patients being triaged. Patients were not always triaged in line with the recommended 15 minute triage target.	Safe	No	Urgent and Emergency Services	CW	EIC	Performance
9	Staff had difficulty accessing AMHPs out of hours to conduct Mental Health Act assessments, creating delays and increased waiting times for patients with mental health concerns in the Emergency department.	Safe	No	Urgent and Emergency Services	CW	EIC	Mental Health
10	In the Urgent Care Centre FP10SS prescriptions were available but NHS Protect guidance was not being followed in regards to the security of these prescriptions.	Safe	No	Urgent and Emergency Services	CW	EIC	Medicines Management
11	Royal College of Emergency Medicine (RCEM) vital signs in children audit was in the lower quartile for three standards.	Effective	No	Urgent and Emergency Services	CW	EIC	Clinical Audit
12	Not all staff had received their annual appraisal.	Effective	No	Urgent and Emergency Services	CW	EIC	Appraisal
13	The percentage of patients who left before being seen was higher than the England average. The median length of total time spent in the department was also consistently higher than the England average.	Responsive	No	Urgent and Emergency Services	CW	EIC	Performance
14	There were sometimes delays for patients requiring specialist mental health beds. This was on the department's risk register as this was a national challenge.	Responsive	No	Urgent and Emergency Services	CW	EIC	Mental Health
15	The numbers of staff with up to date training in high-level child safeguarding needed to increase	Safe	No	Urgent and Emergency Services	WM	EIC	Safeguarding
16	There was a shortage of middle grade doctors within the department, although the trust had invested in one additional middle grade a shift, and 98% of shifts were filled by hospital staff rather than locums.	Safe	No	Urgent and Emergency Services	WM	EIC	Medical Staffing
17	Staff did not document episodes of restraint as incidents in line with trust policy.	Safe	No	Urgent and Emergency Services	WM	EIC	Mental Health
18	Some data was collected manually which made data analysis difficult and potentially unreliable.	Effective	No	Urgent and Emergency Services	WM	EIC	Local
19	On this inspection we saw staff asking patients about pain and that pain scoring tools were available, but not always completed.	Effective	No	Urgent and Emergency Services	WM	EIC	Clinical Documentation
20	There is difficulty maintaining privacy and dignity in the small resuscitation area when this was full. The situation had not changed as it was constrained by the space available until planned refurbishment took place	Caring	No	Urgent and Emergency Services	WM	EIC	Local
21	There was limited provision for patients living with dementia.	Caring	No	Urgent and Emergency Services	WM	EIC	Dementia
22	There was little information for patients in the waiting room or the inside department itself about what to expect in ED. The information board for majors patients was not visible to most patients in the department.	Responsive	No	Urgent and Emergency Services	WM	EIC	Patient Information
23	Friends and family test scores were lower than expected. The Hospital was not capitalising on the willingness of patients and families to provide feedback on the service	Responsive	No	Urgent and Emergency Services	WM	EIC	Friends and Family Test
24	Inherited paper-based systems from the previous trust limited the analysis of clinical data to understand performance and bring about improvement. However we were aware that plans for a new electronic system were well-advanced.	Well-Led	No	Urgent and Emergency Services	WM	EIC	Electronic Patient Records

Appendix 2 – CQC Action Tracker – for additional actions (2/4)

Number	CQC Recommendation	CQC Domain	Should Do Action (Yes/No)	CQC Core Service	Site	Division	Corporate theme
34	Due to staff shortages, ambulatory emergency care (AEC) staff were not always able to follow up patients requiring urgent investigation or ongoing support following discharge from AAU.	Safe	No	Medical care (including older people's care)	CW	EIC	Local
35	There was variable completion of mandatory training. For medical staff, the trust target of 90% was met in one out of eight training modules. For nursing staff the target was met in four out of nine modules.	Safe	No	Medical care (including older people's care)	CW	EIC	Mandatory Training
36	The results of national early warning scores (NEWS) audits were variable across medical wards with some wards achieving 0% compliance.	Safe	No	Medical care (including older people's care)	CW	EIC	Deteriorating Patient
37	There was poor overall compliance with annual staff appraisals with only 64% of staff having been appraised from August 2016 to July 2017.	Effective	No	Medical care (including older people's care)	CW	EIC	Appraisal
38	For the heart failure audit, Chelsea and Westminster Hospital's results were worse than the England average in terms of the percentage of inpatients and cardiologist input, and for seven of the nine standards relating to discharge.	Effective	No	Medical care (including older people's care)	CW	EIC	Clinical Audit
39	From July 2016 to June 2017, the average length of stay for both medical elective and medical non-elective patients at Chelsea and Westminster Hospital was higher than the England average.	Responsive	No	Medical care (including older people's care)	CW	EIC	Performance
40	From August 2016 to August 2017, the Hospital had 91 complaints which took an average of 49 days to investigate and close. This was not in line with their complaints policy, which states complaints should be closed within 25 working days. Eighteen complaints remained open at the time of the trust's submission.	Responsive	No	Medical care (including older people's care)	CW	EIC	Complaints
41	Between September 2016 and August 2017 three of eight medical specialties performed worse than the national average for referral to treatment within 18 weeks.	Responsive	No	Medical care (including older people's care)	CW	EIC	Performance
42	On some medical areas, staff said they did not feel they were part of the service, for example the diagnostic centre.	Well-Led	No	Medical care (including older people's care)	CW	EIC	Local
43	Although the working culture was generally positive, some individuals said they did not feel supported by colleagues or senior staff on the wards.	Well-Led	No	Medical care (including older people's care)	CW	EIC	Local
44	There was variable compliance with the early warning scores system, which staff used to identify, monitor and escalate patients whose conditions were deteriorating. We saw limited evidence of sustained improvement as a result of audits and overall compliance was 92%, which did not meet the trust standard of 95%.	Safe	No	Medical care (including older people's care)	WM	EIC	Deteriorating Patient
45	There was variable completion of mandatory training and no clinical staff group in this division met the trust target for all training. Nursing and medical staff did not meet the trust target for basic life support, with only 80% of eligible staff holding up to date training.	Safe	No	Medical care (including older people's care)	WM	EIC	Mandatory Training
46	There were significant inconsistencies and gaps in the completion of venous thromboembolism (VTE) risk assessments and prophylaxis provision and limited evidence that initiatives to improve this had been effective.	Safe	No	Medical care (including older people's care)	WM	EIC	Thrombosis
47	Senior staff used a patient acuity tool to establish the safe number of nurses needed for each shift. However staff in some areas told us this was often insufficient and they felt patient safety could be compromised as a result.	Safe	No	Medical care (including older people's care)	WM	EIC	Nurse Staffing
48	Although there were gaps in seven-day working in some teams, individual teams were piloting increased capacity in the acute medical unit and therapies teams.	Effective	No	Medical care (including older people's care)	WM	EIC	Seven Day Services
49	Dietician audits indicated there was a need for improved effectiveness in the use of the malnutrition universal scoring tool (MUST).	Effective	No	Medical care (including older people's care)	WM	EIC	Nutrition and Hydration
50	Nursing staff did not consistently use recording tools for nutrition and hydration.	Effective	No	Medical care (including older people's care)	WM	EIC	Nutrition and Hydration
51	Neurology services were limited and staff described delays in patients being seen by this team. However the trust told us after the inspection that a new consultant neurologist had been appointed.	Effective	No	Medical care (including older people's care)	WM	EIC	Local
52	The infection control team found inconsistent practice in relation to the treatment and prevention of Clostridium difficile in two cases in 2016/17.	Effective	No	Medical care (including older people's care)	WM	EIC	Infection Control
53	Overall performance in national inpatient audits was variable and the Hospital did not meet minimum standards by significant margins (over 10% difference) in the national audit of inpatient falls or the lung cancer audit. The Hospital performed worse than minimum standards in six out of nine measures. There was evidence of a deterioration of standards in some areas. For example, between 2015 and 2016 the proportion of patients seen by a cancer nurse specialist as part of the national lung cancer audit decreased by 10% to 73%. This was worse than the minimum standard of 90%. The Hospital achieved level C performance rating in the quarterly Sentinel Stroke National Audit programme.	Effective	No	Medical care (including older people's care)	WM	EIC	Clinical Audit
54	Seven out of eight staff groups did not meet the trust's standard of 90% annual appraisal completion. Amongst doctors and nurses, 62% had an up to date appraisal.	Effective	No	Medical care (including older people's care)	WM	EIC	Appraisal
55	Relatives provided variable feedback on the attentiveness of staff. Ward-based teams we spoke with described significant challenges in establishing positive communication with relatives and feedback from both groups was demonstrative of this.	Caring	No	Medical care (including older people's care)	WM	EIC	Local
56	Although medical services performed better than trust and national averages in response rates for the NHS Friends and Family Test (FFT), recommendation rates were highly variable with little consistency in meeting the 90% target. Between September 2016 and August 2017 medical wards had an average FFT recommendation rate of 82%. This was below the trust target of 90% and represented a wide range of individual ward scores, with seven individual wards or departments averaging below 90%. In addition none of the wards achieved a consistent track record of recommendation scores of 90% or above during this period.	Caring	No	Medical care (including older people's care)	WM	EIC	Friends and Family Test

Appendix 2 – CQC Action Tracker – for additional actions (3/4)

Number	CQC Recommendation	CQC Domain	Should Do Action (Yes/No)	CQC Core Service	Site	Division	Corporate theme
57	Patients in general medicine had a much higher than expected risk of readmission for elective admissions, with rates for respiratory medicine also higher.	Responsive	No	Medical care (including older people's care)	WM	EIC	Performance
58	From July 2016 to June 2017 the average length of stay for medical elective patients was 10.3 days, which was higher than the national average of 4.2 days. The average length of stay for all individual specialities at the Hospital was also higher.	Responsive	No	Medical care (including older people's care)	WM	EIC	Performance
59	Between August 2016 and August 2017 the Hospital took an average of 59 days to investigate and close complaints. This was not in line with the 25 day standard indicated by the complaints policy.	Responsive	No	Medical care (including older people's care)	WM	EIC	Complaints
60	Although the working culture was generally positive, some individuals said they had been pressured to work when unwell.	Well-Led	No	Medical care (including older people's care)	WM	EIC	Local
61	Information management processes did not always ensure patient confidentiality was maintained.	Well-Led	No	Medical care (including older people's care)	WM	EIC	Local
72	Access to mandatory training for nursing staff varied across wards and clinical areas with some staff having dedicated time to complete training whilst others having to undertake their training in their own time.	Safe	No	Surgery	CW	PC	Mandatory Training
73	There were a number of different ways in which staff were recording medical data at the time of our inspection. This had the potential to cause confusion, given the combination of written notes and online notes.	Safe	No	Surgery	CW	PC	Clinical Documentation
74	There remained some overlap in understanding of differences between mental capacity and mental health and this was mainly amongst junior nurses, though they were clearly aware of when and how to escalate to senior nurses.	Safe	No	Surgery	CW	PC	Mental Health
75	Storage space was limited in theatres for equipment and as a result, equipment was temporarily being stored in an old paediatric recovery room.	Safe	No	Surgery	CW	PC	Local
76	The service must review and act upon the PROM data to ensure outcomes are improved for patients	Effective	No	Surgery	CW	PC	Local
77	The service did not meet national standards for care and treatment in key areas, such as length of Hospital stay and perioperative assessments.	Responsive	No	Surgery	CW	PC	Local
78	From August 2016 to August 2017 there were 160 complaints about surgery. The trust took an average of 57 working days to investigate and close complaints. This was not in line with the trust's complaints policy, which states complaints should be completed within 25 working days. As of August 2017, there were 22 complaints still open and yet to be completed.	Responsive	No	Surgery	CW	PC	Complaints
79	A surgeon told us of a lack of image intensifying equipment for hand surgery, which was raised on the risk register. We saw no evidence of this having been added to the risk register.	Well-Led	No	Surgery	CW	PC	Risk Management
80	The trust training target was not met for any applicable modules for medical staff.	Safe	No	Surgery	WM	PC	Mandatory Training
81	Storage space was still limited in theatres. We saw equipment stored in the corridors due to a lack of storage space	Safe	No	Surgery	WM	PC	Local
82	The surgical wards contained outliers and senior nurses informed us that a mixture of specialities caused difficulties with inexperienced nurses.	Safe	No	Surgery	WM	PC	Local
83	Theatres did not operate on emergency cases on a Monday morning; this was preserved for paediatric surgeries	Safe	No	Surgery	WM	PC	Local
84	We saw that the Hospital had a low staff retention rate, therefore wards often relied on agency staff which sometimes added pressure to other nurses on that ward.	Safe	No	Surgery	WM	PC	Nurse Staffing
85	Some fridge temperatures that were out of range were not acted upon.	Safe	No	Surgery	WM	PC	Medicines Management
86	There was some inconsistency in staff following the world health organisation five steps to safer surgery. While we observed satisfactory practice in general surgery, during our inspection, we observed an ultrasound guided liver biopsy in the radiology unit. The WHO checklist was not completed correctly, although boxes were ticked. For example, the patient ID was not verified against the patient's wristband.	Safe	No	Surgery	WM	PC	Local
87	From June 2016 to May 2017, all patients had a slightly higher than expected risk of readmission for elective admissions when compared to the England average.	Effective	No	Surgery	WM	PC	Performance
88	For hip and knee replacements, performance was worse than the England averages.	Effective	No	Surgery	WM	PC	Local
89	Competencies for full time nurses on the surgical wards were newly introduced to the Hospital and it was not yet confirmed how often these competencies would be re-checked.	Effective	No	Surgery	WM	PC	Clinical Education
90	The Hospital had an overall appraisal completion rate of 64% from August 2016 to July 2017. This was lower than the average appraisal completion rate from the last inspection, which was reported at 78%	Effective	No	Surgery	WM	PC	Appraisal
91	We saw old do not attempt cardiopulmonary resuscitation (DNACPR) forms filed in some patient notes. New forms were required to be completed for each in-patient episode.	Effective	No	Surgery	WM	PC	End of Life
92	The fragility hip fracture best pratice tarrif criteria states patients should be assessed by a geriatrician in the preoperative period within 72 hours of admission. The Trust's hip fracture preoperative medical assessment rate was 50%, which failed to meet the national standard of 100% and fell in the bottom 25% of trusts. This was due to the fact that the trust was unable to recruit a consultant geriatrician to the post at West Middlesex despite several attempts. In October 2017 the Trust changed the clinical pathway so that all patients were admitted through the Acute Assessment Unit (AAU). The AAU was a consultant led unit 24 hours per day seven days per week which meant that a consultant pre-operative medical assessment was able to be achieved on admission. There was also a full time orthopaedic clinical nurse specialist on site to ensure the clinical pathway was followed.	Effective	No	Surgery	WM	PC	Local

Appendix 2 – CQC Action Tracker – for additional actions (4/4)

Number	CQC Recommendation	CQC Domain	Should Do Action (Yes/No)	CQC Core Service	Site	Division	Corporate theme
93	The day surgery unit was often opened at night for additional patients, when there was no space on the surgical wards. Staff told us that this was not ideal for patients as the ward was not suitable for overnight stay patients.	Responsive	No	Surgery	WM	PC	Site Operations
94	Referral-to-treatment time (RTT) performance remained below the England average for urology, trauma and orthopaedics, oral surgery and general surgery.	Responsive	No	Surgery	WM	PC	Performance
95	The trust had stopped using butterflies as a representative symbol for dementia and had started using butterflies for end of life patients but this information had not filtered down to all staff. Many staff we spoke with said that butterflies were an association with dementia.	Responsive	No	Surgery	WM	PC	End of Life
96	Improve the on-call urologist, pharmacy cover, physiotherapists and occupational therapists availability over the weekend.	Responsive	No	Surgery	WM	PC	Seven Day Services
97	Some of the administration staff we spoke with felt that if was difficult to build a rapport with the executive team.	Well-Led	No	Surgery	WM	PC	Local
120	All staff were not achieving the trust's 90% mandatory training target in December 2017. With the exception of managers and SCBU, children and young people's staff were not achieving the trust's 90% mandatory training target in December 2017.	Safe	No	Services for children and young people	WM	W,C,HIV/GUM, D&PP	Mandatory Training
121	There remained some challenges with nursing staffing vacancies, for example, nurse staffing in Starlight Ward.	Safe	No	Services for children and young people	WM	W,C,HIV/GUM, D&PP	Nurse Staffing
122	Senior staff told us some staff could become task focused if the service was very busy and had to be reminded about providing emotional support at these times.	Caring	No	Services for children and young people	WM	W,C,HIV/GUM, D&PP	Local
123	The fracture clinic did not have dedicated children's plastering area	Responsive	No	Services for children and young people	WM	W,C,HIV/GUM, D&PP	Local
124	Complaints were not always investigated in accordance with the trust's complaints policy.	Responsive	No	Services for children and young people	WM	W,C,HIV/GUM, D&PP	Complaints
125	Senior staff with leadership and management responsibilities did not always have sufficient protected time and support to discharge their responsibilities.	Well-Led	No	Services for children and young people	WM	W,C,HIV/GUM, D&PP	Local
126	Some medical staff told us decision making could be slow due to the clinical lead's workload.They were also the named doctor for safeguarding and the college tutor.	Well-Led	No	Services for children and young people	WM	W,C,HIV/GUM, D&PP	Local
131	Fast track discharges were occasionally delayed due to the timely provision of Hospital beds in the community to a patient's home.	Responsive	No	End of life care	CW	EIC	End of Life
137	Managers in the department felt that incidents were underreported by staff. Incidents were not reported promptly and we were not assured that learning was shared. Few meetings had minutes taken so we were unable to ascertain whether incidents were discussed and learning shared at meetings. The incident log showed that there was an average of 22 days between incidents occurring and being reported in the three months prior to inspection.	Safe	No	Outpatients	CW	PC	Incident Reporting
138	Failure to mitigate staffing shortages in ophthalmology had resulted in poor patient outcomes for patients undergoing injections for wet macular degeneration.	Safe	No	Outpatients	CW	PC	Medical Staffing
139	Mandatory training attendance remained below the trust target, and attendance was low at fire safety training.	Safe	No	Outpatients	CW	PC	Mandatory Training
140	There was some out of date single use equipment stored in the department. We were told by staff that these would not have been used and would be disposed of.	Safe	No	Outpatients	CW	PC	Local
141	There was limited auditing of the performance of the department. Clinical auditing was left to individual specialties so there was limited monitoring of the effectiveness of care and treatment in the department and this information was not consistently used to improve patient outcomes. Although there were plans to audit key performance indicators for the department, at the time of inspection these were not in place which meant that managers could not identify adverse patterns and use data to improve the department.	Effective	No	Outpatients	CW	PC	Clinical Audit
142	There was a low staff appraisal rate, only 38% of staff had received an appraisal between August 2016 and July 2017.	Effective	No	Outpatients	CW	PC	Appraisal
143	There was limited evidence that people's views and experiences were gathered and used to shape improvements to the department.	Caring	No	Outpatients	CW	PC	Patient Experience
144	The department was not compliant with all referral to treatment targets across the reporting period. Though there was improvement in recent months across all referral targets, data provided by the trust showed that the department did not meet the 18 weeks referral treatment target in each of the months between June and November 2017 at an average of 89.93% against the national target of 92%. Across the reporting period the trust did not meet the 93% standard for patients receiving an appointment within two weeks of an urgent referral or the 85% standard of 62 days to treatment, though there was improvement at the time of inspection.	Responsive	No	Outpatients	CW	PC	Performance
145	The service did not routinely monitor waiting times for patients in clinics and so were unable to identify patterns and areas of concern to improve the service.	Responsive	No	Outpatients	CW	PC	Local
146	There was not a consistent view among staff of the risks in the department or what was on the risk register.	Well-Led	No	Outpatients	CW	PC	Risk Management
147	The OPD pharmacy was open hours Monday to Friday from 9.10am until 5.30pm. There was no Saturday or evening opening when the OPD was open.	Responsive	No	Outpatients	WM	PC	Pharmacy

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 5 July 2018

PUBLIC SESSION

AGENDA ITEM NO.	2.3/Jul/18
REPORT NAME	Serious Incident Report
AUTHOR	Shân Jones – Director of Quality Improvement Stacey Humphries – Quality and Clinical Governance Assurance Manager
LEAD	Pippa Nightingale – Chief Nurse
PURPOSE	The purpose of this report is to provide the Trust Board with assurance that serious incidents are being reported and investigated in a timely manner and that lessons learned are shared.
SUMMARY OF REPORT	This report provides the organisation with an update of all Serious Incidents (SIs) including Never Events reported by Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) since 1st April 2018. Comparable data is included for both sites.
KEY RISKS ASSOCIATED	• Failure to implement actions will not mitigate risk of future incidents
FINANCIAL IMPLICATIONS	N/A
QUALITY IMPLICATIONS	• The quality of documentation is key to investigating incidents and ensuring quality care
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	• Delivering high quality patient centred care • Be the Employer of Choice • Delivering better care at lower cost
DECISION/ ACTION	The Trust Board is asked to note and comment on the report.

SERIOUS INCIDENTS REPORT
Quality Committee 3rd July 2018

1.0 Introduction

This report provides the organisation with an update of all Serious Incidents (SIs) including Never Events reported by Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) since 1st April 2018. For ease of reference, and because the information relates to the two acute hospital sites, the graphs have been split to be site specific. Reporting of serious incidents follows the guidance provided by the framework for SI and Never Events reporting that came into force from April 1st 2015. All incidents are reviewed daily by the Quality and Clinical Governance Team, across both acute and community sites, to ensure possible SIs are identified, discussed, escalated and reported as required. All complaints that have a patient safety concern are reviewed discussed, escalated and reported as required. In addition as part of the mortality review process any deaths that have a CESDI grade of 1 or above are considered and reviewed as potential serious incidents.

2.0 Never Events

'Never Events' are defined as '*serious largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers*'.

Since the 1st April 2018, there have been no Never Events reported.

3.0 SIs submitted to CWHHE and reported on STEIS

Table 1 outlines the SI investigations that have been completed and submitted to the CWHHE Collaborative (Commissioners) in May 2018. There were 6 reports submitted. A précis of the incidents can be found in Section 7.

Table 1

STEIS No.	Date of incident	Incident Type (STEIS Category)	External Deadline	Date report submitted	Site
2018/3018	20/01/2018	Maternity/Obstetric incident: baby only	01/05/2018	01/05/2018	CW
2018/3363	04/02/2018	Slips/trips/falls	03/05/2018	03/05/2018	WM
2018/4861	04/02/2018	Pressure ulcer	23/05/2018	23/05/2018	CW
2018/4436	13/02/2018	Treatment delay	17/05/2018	17/05/2018	CW
2018/4967	21/02/2018	Pressure ulcer	24/05/2018	08/05/2018	CW
2018/5183	23/02/2018	Surgical/invasive procedure incident	25/05/2018	25/05/2018	WM

Table 2 shows the number of incidents reported on StEIS (Strategic Executive Information System), across the Trust, in May 2018.

Table 2 – Incidents reported by category

Incident Type (STEIS Category)	WM	C&W	Total
Diagnostic incident including delay	1		1
Maternity/Obstetric incident: baby only		1	1
Medical equipment/ devices/disposables incident	1		1
Medication incident	1		1
Pressure ulcer		1	1
Grand Total	**3**	**2**	**5**

The number of SIs reported in May (5) is slightly higher than the previous month, April (3). During both months the Trust reported against the category; Medication incident.

Charts 1 and 2 show the number of incidents, by category reported on each site during this financial year 2018/19.

Chart 1 Incidents reported at WM by category YTD 2018/19 = 6

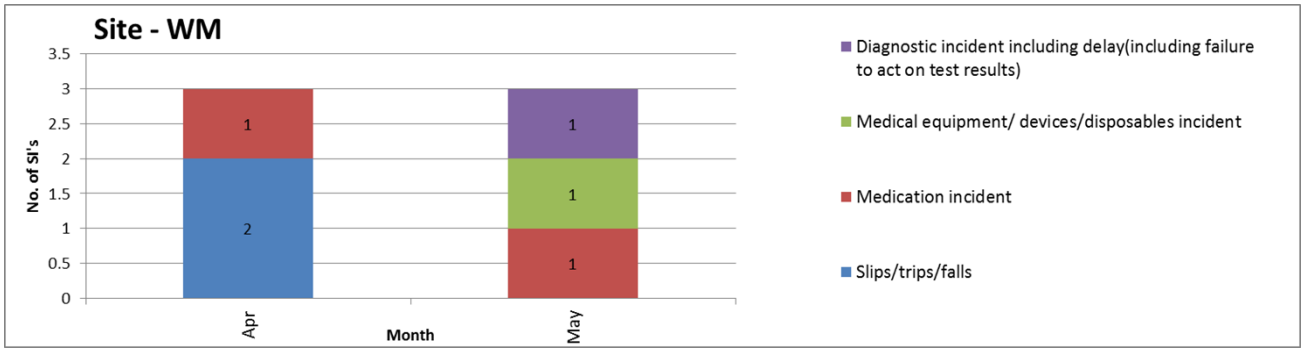
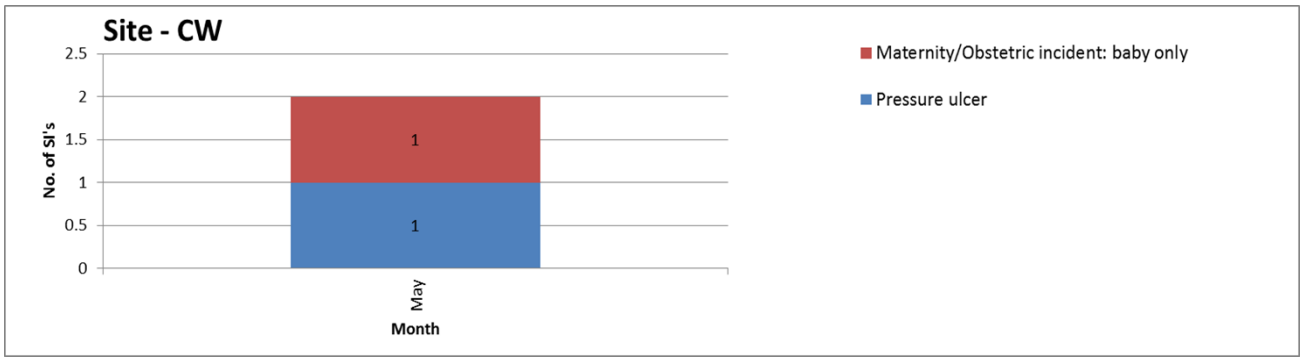


Chart 2 Incidents reported at C&W by category YTD 2018/19 = 2



Charts 3 and 4 show the comparative reporting, across the 2 sites, for 2016/17, 2017/18 and 2018/19.

Chart 3 Incidents reported 2016/17, 2017/18 & 2018/19 – WM

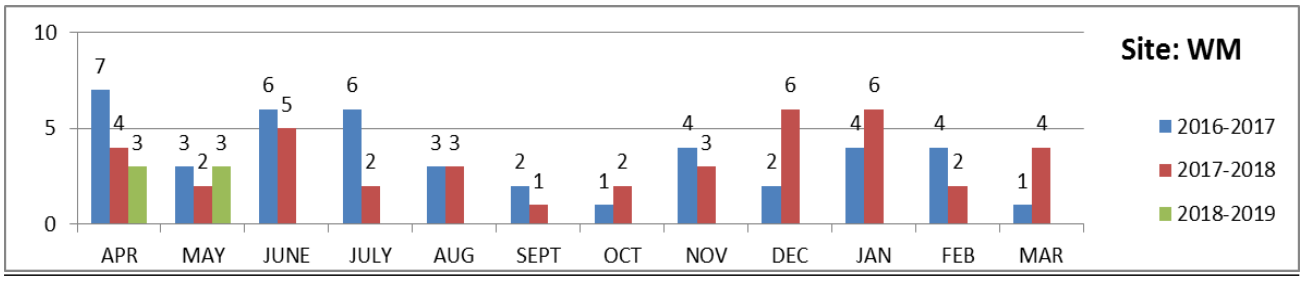
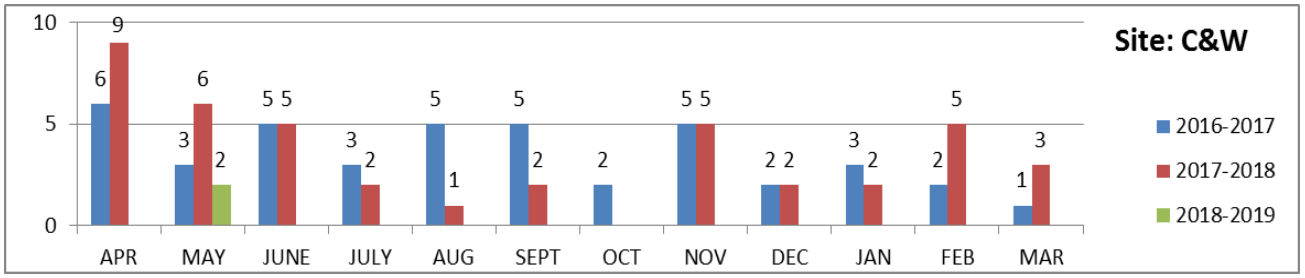


Chart 4 Incidents reported 2016/17, 2017/18 & 2018/19 – C&W

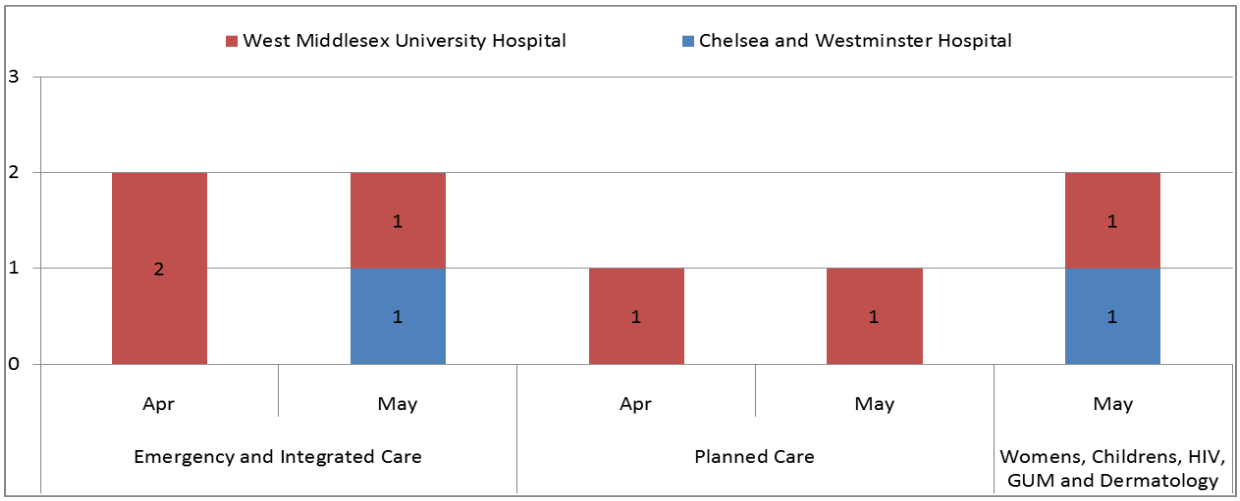


3.1 SIs by Clinical Division and Ward

Chart 5 displays the number of SIs reported by each division, split by site, since 1st April 2018. As the year progresses we will be able compare the number of incidents reported by each division.

Since April 1st 2018, the Emergency and Integrated Care Division has reported 4 SIs (C&W 1, WM 3). The Women's, Children's, HIV, GUM and Dermatology Division have reported 2 SIs (C&W 1, WM 1) and the Planed Care Division have reported 2 SIs (C&W 0, WM 2).

Chart 5 Incidents reported by Division and Site 2018/19



Charts 6 and 7 displays the total number of SI's reported by each ward/department. All themes are reviewed at divisional governance meetings.

Chart 6 - Incident category and location exact, WM 2018/19

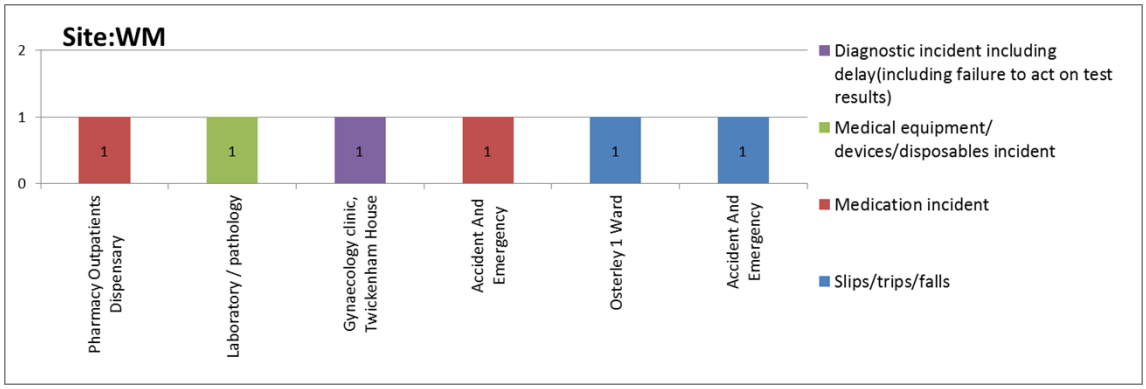
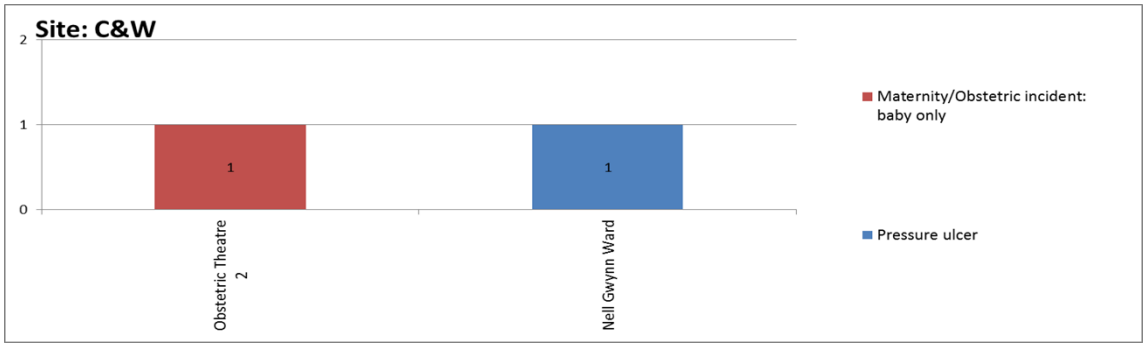


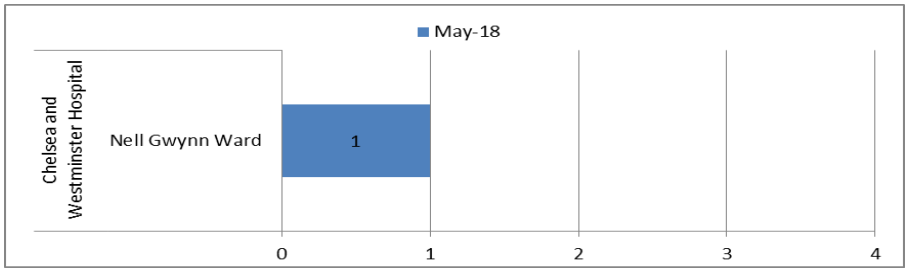
Chart 7 - Incident category and location exact, C&W 2018/19



3.2 Hospital Acquired Pressure Ulcers

Hospital Acquired Pressure Ulcers (HAPUs) remain high profile for both C&W and WM sites. The reduction in HAPU remains a priority for both sites and is being monitored by the Trust Wide Pressure Ulcer working group. The position for 2018/19 is 1 compared to 7 for 2017/18.

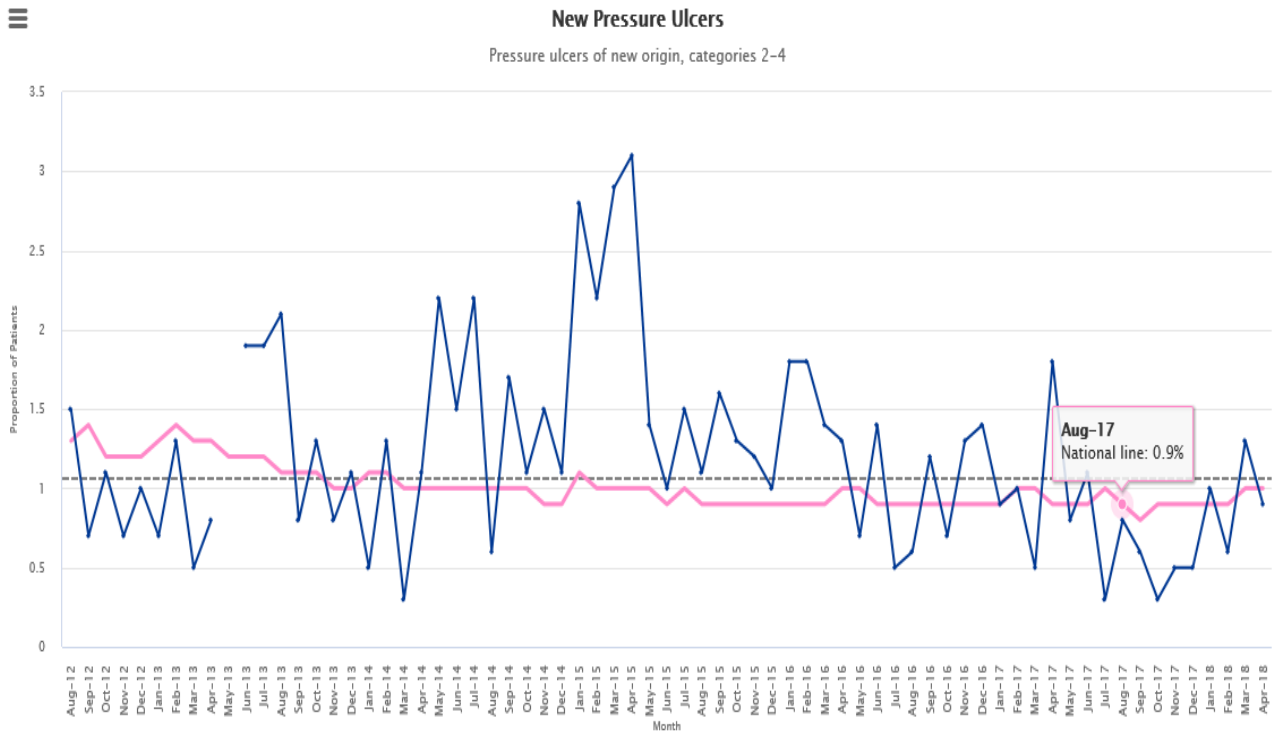
Chart 8 – Pressure Ulcers reported (Apr 2018–March 2019) YTD total = 1



3.2.1 Safety Thermometer Data

The national safety thermometer data provides a benchmark for hospital acquired grade 2, 3 and 4 pressure ulcers. The nationally reported data for Chelsea and Westminster Hospital NHS Foundation Trust is as a combined organisation and is showing a favourable position below the national average. National data is published up to April 2018.

Graph 1 – New Pressure ulcers of new origin, categories 2-4 (Comparison with national average)

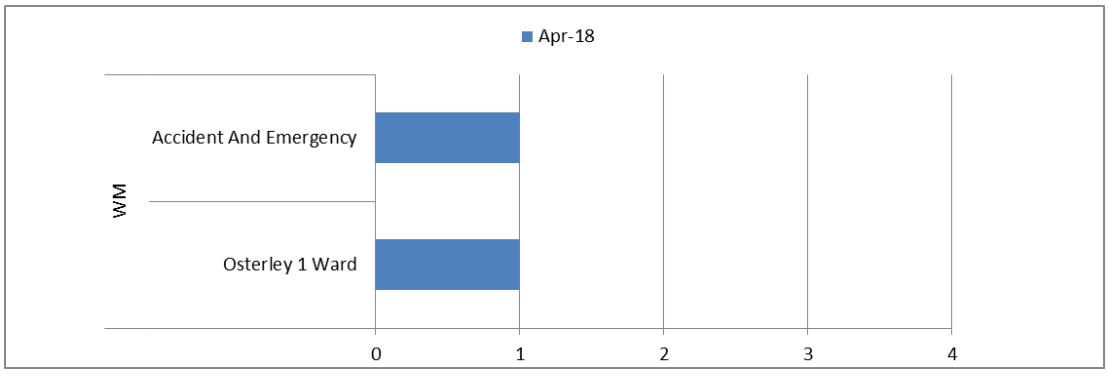


3.3 Patient Falls

Inpatient Falls continue to be a quality priority for 2018/19 and will therefore be a focus for both C&W and WM sites during 2018/19.

Since the 1st of April 2018, the Trust has reported 2 patient falls meeting the serious incident criteria. The 2018/19 position is 2 compared to 0 for the same period last year.

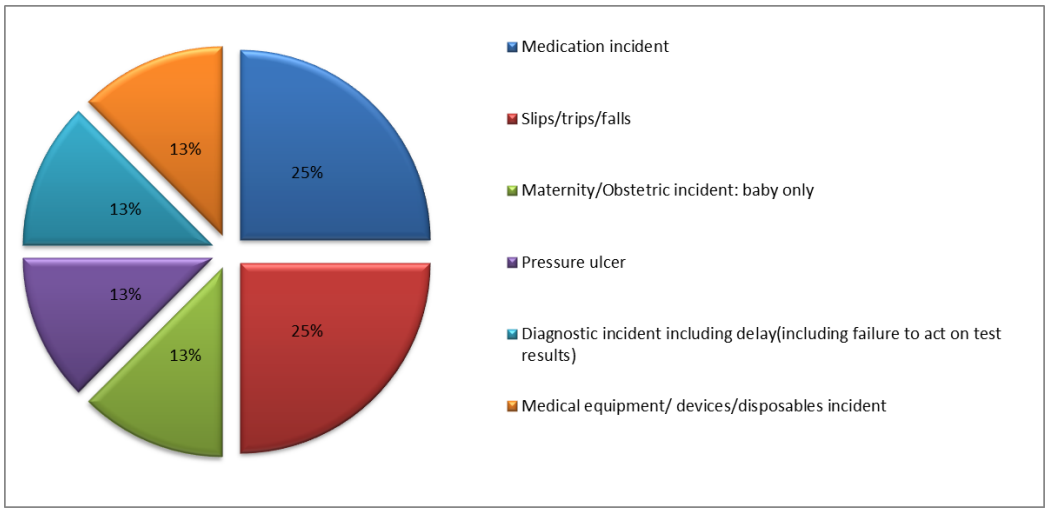
Chart 9 Patient Falls by Location (exact) (Apr 2018–March 2019) YTD total =2



3.4 Top 10 reported SI categories

This section provides an overview of the top 10 serious incident categories reported by the Trust. These categories are based on the externally reported category. To date we have reported against 6 of the SI categories.

Chart 10 – Top 10 reported serious incidents (April 2018 – March 2019)



3.5 SIs under investigation

Table 3 provides an overview of the SIs currently under investigation by site (13). There is one SI report that was due for submission in March. The investigation has been held up because of police investigation. CWHHE have been kept informed.

Table 3

STEIS No.	Date of incident	Clinical Division	Incident Type (STEIS Category)	Site	External Deadline
2017/30662	09/12/2017	EIC	Abuse/alleged abuse of adult patient by staff	WM	13/03/2018
2018/7169	13/03/2018	PC	Abuse/alleged abuse of adult patient by staff	WM	19/06/2018
2018/6980	18/03/2018	EIC	Slips/trips/falls	CW	15/06/2018
2018/7655	22/03/2018	W&C,HGD	Unauthorised absence	WM	26/06/2018
2018/8001	06/03/2018	W&C,HGD	Maternity/Obstetric incident: mother only	CW	26/06/2018
2018/10181	25/03/2018	EIC	Slips/trips/falls	WM	18/07/2018
2018/9766	12/04/2018	EIC	Slips/trips/falls	WM	13/07/2018
2018/10193	23/03/2018	PC	Medication incident	WM	18/07/2018
2018/10774	08/04/2018	W&C,HGD	Diagnostic incident including delay	WM	26/07/2018

STEIS No.	Date of incident	Clinical Division	Incident Type (STEIS Category)	Site	External Deadline
2018/12177	01/05/2018	PC	Medical equipment/ devices/disposables incident	WM	09/08/2018
2018/11572	10/05/2018	EIC	Pressure ulcer	CW	02/08/2018
2018/12499	18/05/2018	W&C,HGD	Maternity/Obstetric incident: baby only	CW	13/08/2018
2018/12918	22/05/2018	EIC	Medication incident	WM	17/08/2018

4.0 SI Action Plans

All action plans are recorded on DATIX on submission of the SI investigation reports to CWHHE. This increases visibility of the volume of actions due. The Quality and Clinical Governance team work with the Divisions to highlight the deadlines and in obtaining evidence for closure.

As is evident from table 4 there are a number of overdue actions across the Divisions, 25 actions overdue at the time of writing this report. This is an increase compared to last month when there were 11. Women's, Children's, HIV, GUM and Dermatology Division has 11 outstanding actions, the Planned Care Division has 6 outstanding, and the Emergency and Integrated Care Division has 8.

Table 4 - SI Actions

	Month due for completion									
	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Mar 2019	Total
EIC	0	2	0	0	6	4	4	1	0	**17**
PC	0	0	1	0	5	2	5	1	0	**14**
W&C,HGD	1	0	0	1	9	23	4	3	1	**42**
Total	**1**	**2**	**1**	**1**	**20**	**29**	**13**	**5**	**1**	**73**

Table 4.1 highlights the type of actions that are overdue. Divisions are encouraged to note realistic time scales for completing actions included within SI action plans. Divisions have been asked to focus on providing evidence to enable closure of the actions so an updated position can be provided to the Quality Committee.

Table 4.1 – Type of actions overdue

Action type	EIC	PC	W&C,HGD	Grand Total
Create/amend/review - Policy/Procedure/Protocol	5	2	4	11
Share learning	2	2	3	7
Audit	1		1	2
Personal reflection/Supervised practice			2	2
Duty of Candour - Patient/NOK notification		1		1
Other action type		1		1
Set up on-going training			1	1
Grand Total	**8**	**6**	**11**	**25**

5.0 Analysis of categories

Table 5 shows the total number of Serious Incidents for 2016/2017, 2017/18 and the current position for 2018/19. Tables 6, 7 and 8 provide a breakdown of incident categories the Trust has reported against.

Since April 2018 the number of reported serious incidents is 8 which is significantly less compared to the same reporting period last year and the year before (2016/17 = 19, 2017/2018 = 21).

Table 5 – Total Incidents reported

Year	Site	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2016-2017	**WM**	7	3	6	6	3	2	1	4	2	4	4	1	**43**
	CW	6	3	5	3	5	5	2	5	2	3	2	1	**42**
		13	**6**	**11**	**9**	**8**	**7**	**3**	**9**	**4**	**7**	**6**	**2**	**85**
2017-2018	**WM**	4	2	5	2	3	1	2	3	6	6	2	4	40
	CW	9	6	5	2	1	2	0	5	2	2	5	3	42
		13	**8**	**10**	**4**	**4**	**3**	**2**	**8**	**8**	**8**	**7**	**7**	**82**
2018-2019	**WM**	3	3											6
	CW	0	2											2
		3	**5**											**8**

Table 6 - Reported Categories 2016/17

Incident Category	A	M	J	J	A	S	O	N	D	J	F	M	YTD
Pressure ulcer	5	1	4	4	3	2					1		20
Slips/trips/falls	2	1	1	1	1			1	1	3	2		13
Sub-optimal care of the deteriorating patient	1		1	2	2		1	1		2	1		11
Diagnostic incident	1	1			1	4			1				8
Maternity/Obstetric incident: baby only	1		1			1		1			1	1	6
Maternity/Obstetric incident: mother only	2	1						2		1			6
Treatment delay		1			1				2	1			5
Surgical/invasive procedure incident			2	1				1					4
Abuse/alleged abuse of adult patient by staff		1	1					1					3
Apparent/actual/suspected self-inflicted harm				1				1				1	3
Medication incident	1						1						2
HCAI/Infection control incident			1										1
Confidential information leak/IG breach								1					1
Maternity/Obstetric incident: mother and baby							1						1
Grand Total	13	6	11	9	8	7	3	9	4	7	5	2	84

Table 7 – Reported Categories 2017/18

Incident Category	A	M	J	J	A	S	O	N	D	J	F	M	YTD
Pressure ulcer	6	1	2					2	1		2		14
Diagnostic incident	2		1	2	2	1		1	2	2		1	14
Maternity/Obstetric incident: baby only		2	1					2		3	2	1	11
Slips/trips/falls					1		2	1	1	1	1	1	8
Abuse/alleged abuse of adult patient by staff			1		1				2			2	6
Sub-optimal care of the deteriorating patient	2	1	1	2									6
Treatment delay	1	2	1					1			1		6
Surgical/invasive procedure incident	1	1				1				1	1		5
Maternity/Obstetric incident: mother only			1					1		1		1	4
Maternity/Obstetric incident: mother and baby						1			1				2
Environmental incident		1											1
Unauthorised absence												1	1
Blood product/ transfusion incident			1										1
Medication incident			1										1
Pending review									1				1
Disruptive/ aggressive/ violent behaviour	1												1
Grand Total	13	8	10	4	4	3	2	8	8	8	7	7	82

Table 8 – Reported Categories 2018/19

Incident Category	A	M	J	J	A	S	O	N	D	J	F	M	YTD
Pressure ulcer		1											1
Diagnostic incident		1											1
Maternity/Obstetric incident: baby only		1											1
Slips/trips/falls	2												2
Medication incident	1	1											2
Medical equipment/ devices/disposables incident		1											1
Grand Total	3	5											8

The quality and clinical governance team continues to scrutinise all reported incidents to ensure that SI reporting is not compromised.

6.0 Serious Incidents De-escalations

The figures within the report do not include the SIs that were reported but have since been de-escalated by the Commissioners. So far during 2018/2019 no incidents have been de-escalated by the commissioners.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 5 July 2018

PUBLIC SESSION

AGENDA ITEM NO.	2.4/Jul/18
REPORT NAME	Integrated Performance Report – May 2018
AUTHOR	Robert Hodgkiss, Chief Operating Officer
LEAD	Robert Hodgkiss, Chief Operating Officer
PURPOSE	To report the combined Trust's performance for May 2018 for both the Chelsea & Westminster and West Middlesex sites, highlighting risk issues and identifying key actions going forward.
SUMMARY OF REPORT	The Integrated Performance Report shows the Trust performance for May 2018. **Regulatory performance** – The A&E Waiting Time figure for May was 95.7%. National figures show that Chelsea and Westminster ranked 1st amongst London Trusts. Both sites were complaint with the standard. The RTT incomplete target was achieved in May for the Trust, with performance of 92.8%. This represents the seventh consecutive month the national standard was reached. Both sites were complaint with the standard. Of particular note is the delivery of compliance despite the implementation of a new EPR system on the WMUH site. There continues to be no reportable patients waiting over 52 weeks to be treated on either site and this is expected to continue. The WMUH site narrowly missed the delivery of the 62 Day standard in May. As a Trust, we are currently compliant at just over 85% but we have experienced a high number of breaches (9.5). Some of these breaches were unavoidable however 3 were avoidable and have been investigated. All other cancer indicators passed. There was one reported CDiff infection in May. **Access** The Diagnostic wait metric returned 98.49%. Issues in Urology at Chelsea and in Endoscopy, Urology and Cardiology at West Middlesex remain a focus.
KEY RISKS ASSOCIATED:	There are continued risks to the achievement of a number of compliance indicators, including A&E performance, RTT incomplete waiting times while cancer 31 and 62 day waits remains a high priority. The Trust will continue to focus on the Diagnostic Waiting time issues in the weeks to come.

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 Board is asked to note the performance for May 2018 and to note that whilst some indicators were not delivered in the month, the overall YTD compliance remained good.

TRUST PERFORMANCE & QUALITY REPORT

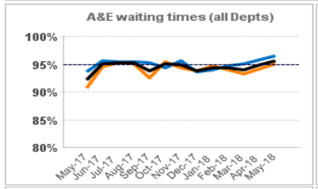
May 2018

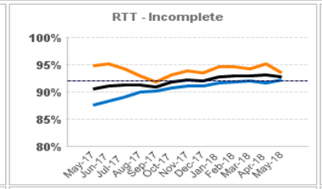
May 2018
Performance Dashboard

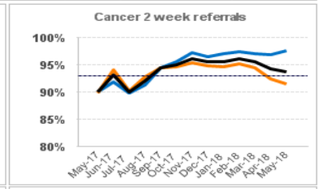
Chelsea and Westminster Hospital NHS
NHS Foundation Trust

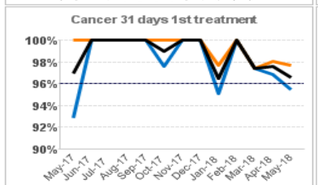
Regulatory Compliance

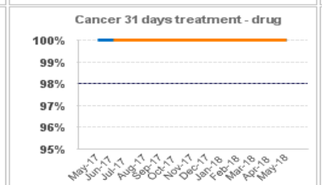
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined Trust data: last Quarter, YTD & 13m trend					
Indicator	Mar-18	Apr-18	May-18	Mar-18	Apr-18	May-18	Mar-18	Apr-18	May-18	Quarter	YTD	Trend
A&E waiting times - Types 1 & 3 Depts (Target: >95%)	95.0	95.9	96.5	93.3	94.2	95.0	94.0	95.0	95.7	95.3	95.3	
RTT - Incomplete (Target: >92%)	92.1	91.7	92.2	94.3	95.2	93.6	93.0	93.2	92.8	93.0	93.0	
Cancer 2 week urgent referrals (Target: >93%)	97.0	96.8	97.6	94.4	92.5	91.4	95.5	94.2	93.6	93.9	93.9	
Cancer 2 week Breast symptomatic (Target: >93%)	n/a	n/a	n/a	96.1	93.8	94.4	96.1	93.8	94.4	94.0	94.0	
Cancer 31 days first treatment (Target: >96%)	97.4	96.9	95.5	97.4	98.1	97.7	97.4	97.6	96.6	97.1	97.1	
Cancer 31 days treatment - Drug (Target: >98%)	100	n/a	100	100	100	100	100	100	100	100	100.0	
Cancer 31 days treatment - Surgery (Target: >94%)	100	n/a	100	100	100	100	100	100	100	100	100.0	
Cancer 62 days GP ref to treatment (Target: >85%)	90.6	90.6	87.0	82.8	93.9	83.6	86.3	92.9	85.0	88.4	88.4	
Clostridium difficile infections (Targets: CW: 7; WM: 9; Combined: 16)	1	1	1	0	0	0	1	1	1	2	2	
Average Emergency PreOp LoS	0.90	0.55	0.51	1.52	1.42	0.79	1.18	0.94	0.64	0.79	0.79	
Average Elective PreOp LoS	0.17	0.08	0.14	0.19	0.15	0.01	0.18	0.10	0.11	0.10	0.10	

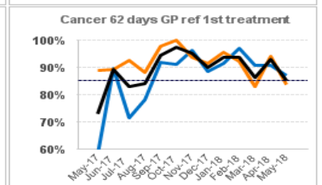






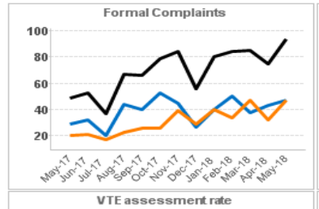


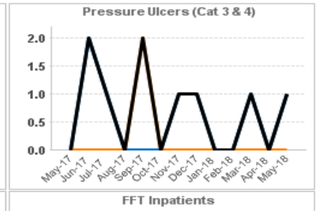


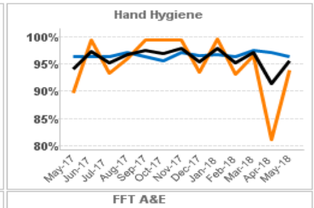


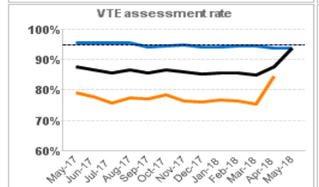
Quality

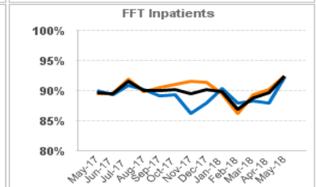
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined: latest Quarter, YTD & 13m trend					
Indicator	Mar-18	Apr-18	May-18	Mar-18	Apr-18	May-18	Mar-18	Apr-18	May-18	Quarter	YTD	Trend
Hand Hygiene (Target: >=90%)	97.5	97.1	96.4	96.7	81.1	93.9	97.2	91.5	95.6	93.5	93.5	
Pressure Ulcers (Cat 3 & 4)	1	0	1	0	0	0	1	0	1	1	1	
VTE assessment % (Target: >=95%)	94.7	93.9	94.0	75.4	84.7		84.9	87.8	94.0	89.3	89.3	
Formal complaints number received	38	43	47	47	32	47	85	75	94	169	169	
Formal complaints responded to <25days	20	32	31	21	21	31	41	53	62	115	115	
Serious Incidents	3	0	2	4	3	3	7	3	5	8	8	
Never Events (Target: 0)	1	0	0	0	0	0	1	0	0	0	0	
FFT - Inpatients recommend % (Target: >90%)	88.2	87.9	92.3	89.3	90.2	92.5	88.9	89.6	92.4	90.8	90.8	
FFT - A&E recommend % (Target: >90%)	89.4	89.0	90.2	82.3	83.2	82.5	88.3	88.0	88.9	88.5	88.5	
Falls causing serious harm	0	0	0	0	0	0	0	0	0	0	0	

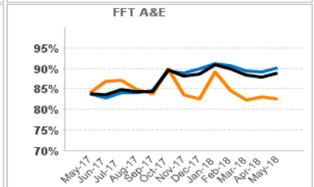






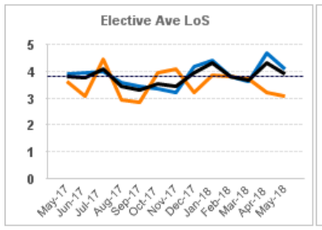


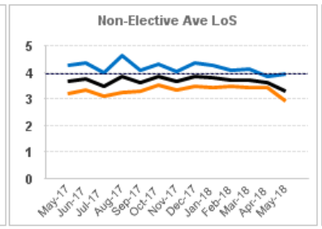


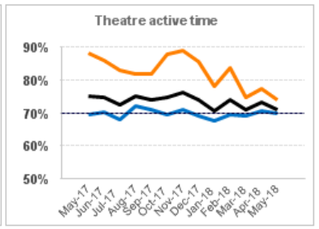


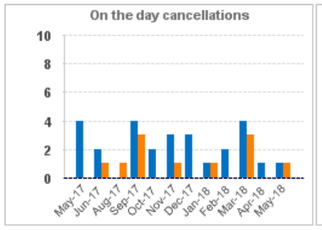
Efficiency

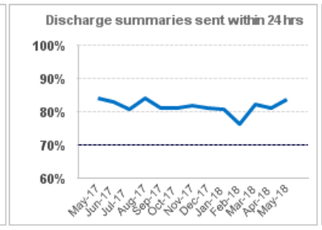
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined: latest Quarter, YTD & 13m trend					
Indicator	Mar-18	Apr-18	May-18	Mar-18	Apr-18	May-18	Mar-18	Apr-18	May-18	Quarter	YTD	Trend
Elective average LoS (Target: <3.8)	3.6	4.7	4.1	3.7	3.2	3.1	3.7	4.3	3.9	4.1	4.1	
Non-Elective average LoS (Target: <3.95)	4.1	3.8	3.9	3.4	3.4	2.9	3.7	3.6	3.3	3.5	3.5	
Theatre active time (Target: >70%)	69.2	70.6	69.7	74.8	77.3	73.8	70.8	73.0	70.9	72.0	72.0	
Discharge summaries sent within 24 hours (Target: >70%)	82.1	81.1	83.8	dev	dev	dev	82.1	81.1	83.8	82.5	82.5	
Outpatient DNA rates (Target: <11.1%)	10.8	10.5	10.5	10.6	11.5	14.1	10.7	10.9	11.7	11.3	11.3	
On the day cancelled operations not re-booked within 28 days (Target: 0)	4	1	1	3	0	1	7	1	2	3	3	

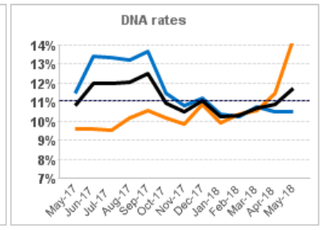






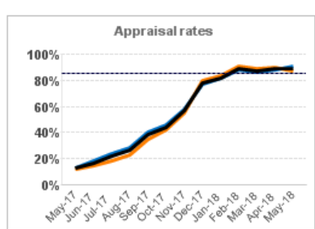


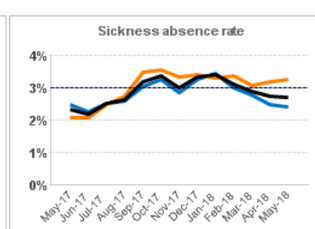


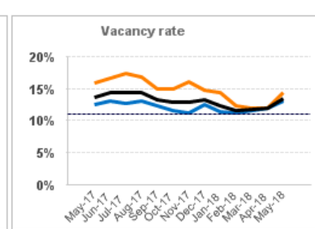


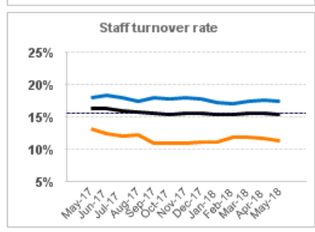
Workforce

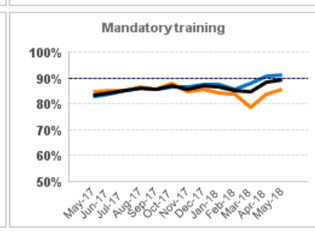
Hospital Site	CWFT	CWFT	CWFT	WMUH	WMUH	WMUH	Combined: latest Quarter, YTD & 13m trend					
Indicator	Mar-18	Apr-18	May-18	Mar-18	Apr-18	May-18	Mar-18	Apr-18	May-18	Quarter	YTD	Trend
Appraisal rates (Target: >85%)	86.4	88.5	90.6	88.7	89.8	87.2	87.2	88.9	89.4	89.2	89.2	
Sickness absence rate (Target: <3%)	2.78	2.50	2.42	3.08	3.17	3.25	2.89	2.73	2.70	2.72	2.72	
Vacancy rates (Target: CW<12%; WM<10%)	11.5	12.1	13.1	12.0	12.0	14.3	11.7	12.0	13.5	13.5	13.5	
Turnover rate (Target: CW<18%; WM<11.5%)	17.4	17.5	17.3	11.8	11.7	11.3	15.5	15.6	15.3	15.3	15.3	
Mandatory training (Target: >90%)	88.1	90.9	91.1	78.7	83.7	85.8	84.6	88.2	89.1	88.7	88.7	
Bank and Agency spend (£ks)	£2,963	£2,652	£2,311	£2,964	£2,397	£2,312	£5,926	£5,049	£4,623	£9,672	£9,671.9	
Nursing & Midwifery: Agency % spend of total pay (Target: tbc)	9.0	8.3	6.4	12.6	10.1	8.3	10.4	9.0	7.1	8.1	8.1	

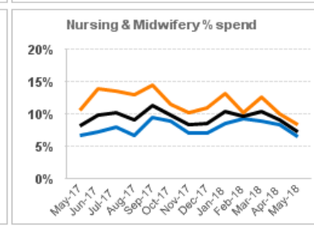












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NHSI Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Mar-18	Apr-18	May-18	2018-2019	Mar-18	Apr-18	May-18	2018-2019	Mar-18	Apr-18	May-18	2018-2019 Q1	2018-2019	Trend charts	
A&E	A&E waiting times - Types 1 & 3 Depts (Target: >95%)	95.0%	95.9%	96.5%	96.2%	93.3%	94.2%	95.0%	94.6%	94.0%	95.0%	95.7%	95.3%	95.3%		-
RTT	18 weeks RTT - Admitted (Target: >90%)	72.3%	74.4%	75.4%	74.9%	87.7%	86.4%	86.3%	86.4%	81.8%	82.2%	79.8%	81.3%	81.3%		!
	18 weeks RTT - Non-Admitted (Target: >95%)	95.0%	94.4%	94.9%	94.6%	91.7%	90.9%	90.5%	90.8%	93.6%	93.1%	93.6%	93.3%	93.3%		!
	18 weeks RTT - Incomplete (Target: >92%)	92.1%	91.7%	92.2%	91.9%	94.3%	95.2%	93.6%	94.4%	93.0%	93.2%	92.8%	93.0%	93.0%		-
Cancer (Please note that all Cancer indicators show interim, unvalidated positions for the latest month (May-18) in this report)	2 weeks from referral to first appointment all urgent referrals (Target: >93%)	97.0%	96.8%	97.6%	97.2%	94.4%	92.5%	91.4%	91.9%	95.5%	94.2%	93.6%	93.9%	93.9%		-
	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: >93%)	n/a	n/a	n/a	n/a	96.1%	93.8%	94.4%	94.0%	96.1%	93.8%	94.4%	94.0%	94.0%		-
	31 days diagnosis to first treatment (Target: >96%)	97.4%	96.9%	95.5%	96.1%	97.4%	98.1%	97.7%	97.9%	97.4%	97.6%	96.6%	97.1%	97.1%		-
	31 days subsequent cancer treatment - Drug (Target: >98%)	100%	n/a	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		-
	31 days subsequent cancer treatment - Surgery (Target: >94%)	100%	n/a	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		-
	31 days subsequent cancer treatment - Radiotherapy (Target: >94%)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		-
	62 days GP referral to first treatment (Target: >85%)	90.6%	90.6%	87.0%	88.4%	82.8%	93.9%	83.6%	88.5%	86.3%	92.9%	85.0%	88.4%	88.4%		-
	62 days NHS screening service referral to first treatment (Target: >90%)	n/a	n/a	n/a	n/a	100%	66.7%	100%	81.8%	100%	66.7%	100%	81.8%	81.8%		-
Patient Safety	Clostridium difficile infections (Year End Targets: CW: 7; WM: 9; Combined: 16)	1	1	1	2	0	0	0	0	1	1	1	2	2		!
Learning difficulties Access & Governance	Self-certification against compliance for access to healthcare for people with Learning Disability	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant	compliant		-
	Governance Rating	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		-

Please note the following three items	n/a	Can refer to those indicators not applicable (eg Radiotherapy) or indicators where there is no available data. Such months will not appear in the trend graphs.	
		RTT Admitted & Non-Admitted are no longer Monitor Compliance Indicators	! Either Site or Trust overall performance red in each of the past three months

Trust commentary

A&E Waiting Times

The Trust delivered a combined performance of 95.7% in May which was the best performance across London. This was more notable given the performance at West Middlesex, which saw it deliver the national target for the first time in seven months- this despite the implementation of a new PAS (Patient Administrative System).

18 weeks RTT – Incomplete

The Trust again reached the national target – 92.8% against a target of 92%. As with the A&E metric, this is an achievement given the complexities of transferring pathways between the old and new PAS systems at West Middlesex

Cancer - 2 Weeks from referral to first appointment all urgent referrals

Two-week waits have been compliant for April and May at a Trust level.

At a site level West Middlesex failed in April and May. However in June , the Trust is on course to achieve at both sites. Trend is an improvement in performance cross site

Cancer - 62 days GP referral to first treatment

The Trust was again compliant for April with a validated position of 92.9%. Unvalidated performance is very close for May, but forecast to be marginally compliant. The trust is seeing very high numbers of patients for treatment, higher than any time in the last year. This has offset our higher than normal breach numbers (9.5)

Breaches are a mixture of unavoidable (heart attack, complex diagnosis) and avoidable (diagnostic capacity, diagnostic reporting, transport and admin issues) 3-3.5 breaches were avoidable and 6-6.5 breaches unavoidable

(Details of breaches by tumour site can be found on page 12 of this report)

Safety Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Mar-18	Apr-18	May-18	2018-2019	Mar-18	Apr-18	May-18	2018-2019	Mar-18	Apr-18	May-18	2018-2019 Q1	2018-2019	Trend charts	
Hospital-acquired infections	MRSA Bacteraemia (Target: 0)	0	0	0	0	0	0	0	0	0	0	0	0	0		-
	Hand hygiene compliance (Target: >90%)	97.5%	97.1%	96.4%	96.7%	96.7%	81.1%	93.9%	87.5%	97.2%	91.5%	95.6%	93.5%	93.5%		-
Incidents	Number of serious incidents	3	0	2	2	4	3	3	6	7	3	5	8	8		-
	Incident reporting rate per 100 admissions (Target: >8.5)	7.9	7.0	7.3	7.2	10.2	10.1	8.7	9.4	9.0	8.4	8.0	8.2	8.2		!
	Rate of patient safety incidents resulting in severe harm or death per 100 admissions (Target: 0)	0.02	0.00	0.03	0.02	0.00	0.04	0.00	0.02	0.01	0.02	0.02	0.02	0.02		!
	Medication-related (NRLS reportable) safety incidents per 100,000 FCE bed days (Target: >=280)	483.06	535.09	487.66	511.15	254.99	233.83	158.59	194.74	374.57	385.92	319.84	352.08	352.08		!
	Medication-related (NRLS reportable) safety incidents % with harm (Target: <=12%)	7.0%	10.0%	15.4%	12.6%	20.6%	13.3%	9.1%	11.5%	11.4%	11.0%	13.8%	12.3%	12.3%		-
	Never Events (Target: 0)	1	0	0	0	0	0	0	0	1	0	0	0	0		-
Harm	Safety Thermometer - Harm Score (Target: >90%)	95.6%	97.1%	95.6%	96.6%	92.0%	96.5%	93.5%	94.9%	92.9%	96.8%	94.2%	95.6%	95.6%		-
	Incidence of newly acquired category 3 & 4 pressure ulcers (Target: <3.6)	1	0	1	1	0	0	0	0	1	0	1	1	1		-
	NEWS compliance %	98.4%	97.7%	98.0%	97.9%	98.0%	98.8%	98.7%	98.8%	98.2%	98.2%	98.3%	98.3%	98.3%		-
	Safeguarding adults - number of referrals	16	26	20	46	6	17	4	21	22	43	24	67	67		-
	Safeguarding children - number of referrals	15	28	22	50	64	63	89	152	79	91	111	202	202		-
Mortality	Summary Hospital Mortality Indicator (SHMI) (Target: <100)	81.7	81.7	81.7	81.7	81.7	81.7	81.7	81.7	81.7	81.7	81.7	81.7	81.7		-
	Number of hospital deaths - Adult	40	35	35	70	72	56	56	112	112	91	91	182	182		-
	Number of hospital deaths - Paediatric	2	1	0	1	0	0	0	0	2	1	0	1	1		-
	Number of hospital deaths - Neonatal	2	3	1	4	0	0	0	0	2	3	1	4	4		-
	Number of deaths in A&E - Adult	3	2	1	3	10	5	3	8	13	7	4	11	11		-
	Number of deaths in A&E - Paediatric	0	0	0	0	0	1	0	1	0	1	0	1	1		-
	Number of deaths in A&E - Neonatal	0	0	0	0	0	0	0	0	0	0	0	0	0		-

Please note the following	blank cell	An empty cell denotes those indicators currently under development	!	Either Site or Trust overall performance red in each of the past three months

Trust commentary

Number of serious incidents

5 Serious Incidents were reported during May 2018; this is higher than April (3 incidents reported). Of the 5 reported, 3 incidents occurred on the WMH site; one medication incident, one medical equipment/ devices/disposables incident and one diagnostic incident. 2 incidents occurred on the C&W site; one Maternity/Obstetric incident and one Hospital acquired Pressure ulcer.

Table 2 within the SI report prepared for the Board reflects the number of incidents, by category reported on each site during the month.

Incident reporting rate per 100 admissions

The calculated rate of reported patient safety incidents per 100 admissions during May 2018 was 7.7% against a target of 8.5%.

We continue to encourage reporting, with an increased focus on the reporting of no harm/near miss incidents.

Trust commentary continued

Rate of patient safety incidents resulting in severe harm or death

3 incidents resulting in Severe Harm were reported during May 2018 (2 X CWH; 1 X WMH).

Two of these incidents have been reported externally due to a delayed diagnosis of cancer and a neonate unexpectedly admitted to SCBU.

The third incident is being investigated as an internal SI and relates to a neonate who was escalated to the surgeons shortly after birth for exclusion of testicular torsion.

Medication-related safety incidents

68 patient safety medication incidents were reported at the CWH site, 22 patient safety medication incidents reported at WMH site.

Medication-related (reported) safety incidents per 100,000 FCE Bed Days

The Trust has achieved an overall reporting rate of NRLS reportable medication-related incidents of 316/100,000 FCE bed days in May 2018. This is higher than the Trust target of 280/100,000. There were 480 and 159 medication-related incidents per 100,000 FCE bed days at CW and WM sites respectively. The WM rate of 159 is on a downward trajectory and is significantly less than that for CW site (480) for May 2018.

In general, there has been a decrease in reporting of medication incidents this month compared to recent months; with reporting at WM site lower than the Trust target.

Medication-related (reported) safety incidents % with harm

The Trust had 14% medication-related safety incidents with harm in May 2018. This figure is higher than in previous months (11%) and is above the Carter dashboard National Benchmark (10.3%). The year to date figure is 12.4%.

There were 12 incidents with harm, 10 at CW site and 2 at WM site. At CW site, 6 were low harm and 4 were moderate harm. At WM site, 1 was low harm and 1 was moderate harm

- Themes CW site: Low harm – old rivastigmine patch not removed before new patch administered, incorrect dose of Zomorph administered, over-administration of paracetamol, omitted analgesia when clinically indicated, and incorrect administration of insulin.
- Themes CW site: Moderate harm – diabetic ketoacidosis as a result of no supply of insulin and delayed medication arrival on ward, patient not contacted for liver function monitoring for ulipristal (Esmya) following MHRA alert due to reports of serious liver injury associated with this medication, no review of high dose chlordiazepoxide during admission until discharge date, missed dose (36 hours after loading dose) of vancomycin for MRSA positive bacteraemia resulting in sub-therapeutic levels and patient deterioration.
- Themes WM site: Low harm – incorrect administration of teicoplanin due to brand and generic names.
- Themes WM site: Moderate harm – Co-amoxiclav prescribed and administered in Emergency Department with a documented penicillin allergy, requiring anaphylaxis management.

The Medication Safety Group continues to encourage incident reporting, monitor trends and aims to improve learning from medication related incidents.

NEWS compliance %

We continue to have high compliance in both completion & escalation of early warning scores. Trends are identified for each area. Any areas of concern are addressed through Divisional Directors of Nursing & plans put in place to rectify.

Safeguarding Adults - number of referrals

West Middlesex referral numbers continue to show variation on a declining number that reflects changes in IDVA work flows

Patient Experience Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Mar-18	Apr-18	May-18	2018-2019	Mar-18	Apr-18	May-18	2018-2019	Mar-18	Apr-18	May-18	2018-2019 Q1	2018-2019	Trend charts	
Friends and Family	FFT: Inpatient recommend % (Target: >90%)	88.2%	87.9%	92.3%	90.4%	89.3%	90.2%	92.5%	91.0%	88.9%	89.6%	92.4%	90.8%	90.8%		-
	FFT: Inpatient not recommend % (Target: <10%)	5.1%	6.0%	4.6%	5.2%	3.5%	3.5%	3.1%	3.3%	4.2%	4.2%	3.8%	4.0%	4.0%		-
	FFT: Inpatient response rate (Target: >30%)	31.6%	34.0%	44.4%	39.2%	28.1%	59.7%	45.6%	53.7%	29.4%	49.6%	45.0%	47.5%	47.5%		-
	FFT: A&E recommend % (Target: >90%)	89.4%	89.0%	90.2%	89.7%	82.3%	83.2%	82.5%	82.8%	88.3%	88.0%	88.9%	88.5%	88.5%		!
	FFT: A&E not recommend % (Target: <10%)	5.9%	7.2%	5.9%	6.5%	8.1%	7.1%	11.3%	9.2%	6.2%	7.2%	6.8%	6.9%	6.9%		-
	FFT: A&E response rate (Target: >30%)	18.1%	18.2%	20.3%	19.2%	12.9%	14.6%	15.7%	15.2%	17.0%	17.4%	19.4%	18.4%	18.4%		!
	FFT: Maternity recommend % (Target: >90%)	88.1%	92.7%	90.7%	91.5%	90.0%	93.9%	96.6%	95.3%	88.6%	93.1%	92.5%	92.7%	92.7%		-
	FFT: Maternity not recommend % (Target: <10%)	7.3%	4.2%	6.3%	5.4%	7.1%	3.0%	1.7%	2.3%	7.3%	3.8%	4.9%	4.4%	4.4%		-
	FFT: Maternity response rate (Target: >30%)	22.0%	17.9%	24.9%	21.4%	19.1%	26.8%	32.7%	29.7%	21.2%	20.2%	26.8%	23.5%	23.5%		!
Experience	Breach of same sex accommodation (Target: 0)	0	0	0	0	0	0	0	0	0	0	0	0	0		-
Complaints	Complaints formal: Number of complaints received	36	42	47	89	47	32	47	79	83	74	94	168	168		-
	Complaints formal: Number responded to < 25 days	20	32	34	66	21	21	33	54	41	53	67	120	120		-
	Complaints (informal) through PALS	130	115	114	229	116	93	107	200	246	208	221	429	429		-
	Complaints sent through to the Ombudsman	0	0	0	0	0	0	0	0	0	0	0	0	0		-
	Complaints upheld by the Ombudsman (Target: 0)	0	0	0	0	0	0	0	0	0	0	0	0	0		-

Please note the following	blank cell	An empty cell denotes those indicators currently under development	!	Either Site or Trust overall performance red in each of the past three months

Trust commentary

Friends and Family Test

Inpatients
Inpatient areas saw an increase to over 44% response rate in May and also saw the recommended cares return to above 90% for both sites. The Trust overall was compliant for this indicator in May.

Accident and Emergency
Chelsea site ED saw an increase in response rates to above 20% and also in the recommended score to above 90%. Whilst the response rate remains below the 30% Trust target it is significantly above the national average of 12.5%. The West Middlesex site continues to fall below the response rate and recommendation targets. Introduction of real time data collection and volunteers the ED are anticipated to help improve this.

Maternity
Both sites continue to achieve above the 90% recommendation score. There has been an increase in the response rate at both sites with the West Middlesex site achieving above the 30% target.

Same Sex Accommodation
In May, as per previous months, there were no breaches of the same sex accommodation metric

Complaints
Response to complaints within 25 days continues to improve with an increase in May to 60% compliance. In addition the number of overdue complaints has fallen, and the total number of open complaints has reduced. There continues to be a focus on improving the compliance with 25 day response times. No ombudsman referrals have been upheld in May.

Efficiency & Productivity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Mar-18	Apr-18	May-18	2018-2019	Mar-18	Apr-18	May-18	2018-2019	Mar-18	Apr-18	May-18	2018-2019 Q1	2018-2019	Trend charts	
Admitted Patient Care	Average length of stay - elective (Target: <3.7)	3.65	4.67	4.10	4.38	3.65	3.21	3.08	3.15	3.65	4.30	3.88	4.09	4.09		-
	Average length of stay - non-elective (Target: <3.9)	4.13	3.84	3.92	3.88	3.41	3.44	3.19	3.30	3.73	3.63	3.48	3.55	3.55		-
	Emergency care pathway - average LoS (Target: <4.5)	4.94	4.62	4.48	4.55	3.96	3.98	3.71	3.83	4.33	4.24	3.97	4.09	4.09		-
	Emergency care pathway - discharges	217	212	207	419	364	316	401	717	582	528	608	1136	1136		-
	Emergency re-admissions within 30 days of discharge (Target: <2.8%)	3.63%	3.89%	3.97%	3.93%	9.23%	7.97%	10.40%	9.26%	6.23%	5.72%	7.03%	6.40%	6.40%		!
	Non-elective long-stayers	506	432	403	835	430	390	312	702	936	822	715	1537	1537		-
Theatres	Daycase rate (basket of 25 procedures) (Target: >85%)	80.4%	81.1%	82.0%	81.5%	83.2%	88.9%	87.1%	88.1%	81.5%	84.5%	83.8%	84.1%	84.1%		!
	Operations canc on the day for non-clinical reasons: actuals	16	20	14	34	17	3	1	4	33	23	15	38	38		-
	Operations canc on the day for non-clinical reasons: % of total elective admissions (Target: <0.8%)	0.55%	0.70%	0.47%	0.59%	1.23%	0.20%	0.08%	0.15%	0.77%	0.53%	0.36%	0.44%	0.44%		-
	Operations cancelled the same day and not rebooked within 28 days (Target: 0)	4	1	1	2	3	0	1	1	7	1	2	3	3		!
	Theatre active time (C&W Target: >70%; WM Target: >78%)	69.2%	70.6%	69.7%	70.1%	74.8%	77.3%	73.8%	75.8%	70.8%	73.0%	70.9%	72.0%	72.0%		!
	Theatre booking conversion rates (Target: >80%)	85.5%	84.5%	85.6%	85.1%	68.5%	72.4%	79.8%	75.3%	78.2%	79.1%	83.6%	81.2%	81.2%		!
Outpatients	First to follow-up ratio (Target: <1.5)	1.49	1.57	1.47	1.51	1.29	1.26	1.34	1.29	1.34	1.34	1.38	1.36	1.36		-
	Average wait to first outpatient attendance (Target: <6 wks)	6.7	6.6	6.9	6.8	6.7	7.0	7.5	7.2	6.7	6.8	7.2	7.0	7.0		!
	DNA rate: first appointment	11.6%	10.6%	11.3%	10.9%	10.8%	12.0%	14.0%	12.9%	11.2%	11.2%	12.4%	11.8%	11.8%		-
	DNA rate: follow-up appointment	10.5%	10.5%	10.2%	10.4%	10.4%	11.1%	14.2%	12.6%	10.4%	10.7%	11.4%	11.0%	11.0%		-

Please note the following	blank cell	An empty cell denotes those indicators currently under development	!	Either Site or Trust overall performance red in each of the past three months

Trust commentary

Non-Elective and Emergency Care Average LoS

May ‘18 has seen a very minor shift at Chelsea Site (within tolerance) .

A recent detailed NEL LOS review by division is now compete with confirmation that the Trust benchmarks well (top quartile) when compared with peer group hospitals for NEL LOS. However, within Care of the Elderly, there remains a further opportunity to improve LOS further at both hospitals. Delivering this improvement remains a strong focus for the BEDS/LOS work stream, and this is being tracked via the system-wide AE Delivery Board.

Emergency readmissions within 30 days

This continues to a significant disparity between sites and the figure has jumped significantly at West Middlesex. Two actions are taking place to address this: 1) checking the monthly data feed (data quality) is correct following Cerner implementation at WM , and 2) undertaking a divisional deep dive into the readmissions trends across both hospitals to isolate the causes (repeating patients, transfers to AEC) and then work up schemes to mitigate the causes. This work links closely to the development of expanded ambulatory services at both sites which is planned for Autumn 2018.

On the day cancellations not re-booked within 28 days

The one patient whose operation was cancelled by the hospital on the day at the Chelsea Site, was not re-booked within 28 days. This is noted as being for reasons of patient choice

Theatre Active Time - % of staffed time

Lower than usual theatre active time due to 2 bank holidays in month (Consultant Surgical Leave on CW site)

Clinical Effectiveness Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Mar-18	Apr-18	May-18	2018-2019	Mar-18	Apr-18	May-18	2018-2019	Mar-18	Apr-18	May-18	2018-2019 Q1	2018-2019	Trend charts	
Best Practice	Dementia screening case finding (Target: >90%)	90.9%	92.5%	92.9%	92.7%	92.6%	84.0%		84.0%	91.8%	87.8%	92.9%	89.4%	89.4%		-
	#NoF Time to Theatre <36hrs for medically fit patients (Target: 100%)	87.5%	100.0%	87.5%	93.9%	81.5%	66.7%	84.0%	78.4%	84.3%	86.2%	85.4%	85.7%	85.7%		!
	Stroke care: time spent on dedicated Stroke Unit (Target: >80%)	100.0%	100.0%	100.0%	100.0%	100.0%	92.9%	90.0%	91.7%	100.0%	96.0%	95.7%	95.8%	95.8%		-
VTE	VTE: Hospital-acquired (Target: tbc)					0	0	0	0	0	0	0	0	0		-
	VTE risk assessment (Target: >95%)	94.7%	93.9%	94.0%	93.9%	75.4%	84.7%		84.7%	84.9%	87.8%	94.0%	89.3%	89.3%		!
TB Care	TB: Number of active cases identified and notified	1	0	7	7	9	3	3	6	10	3	10	13	13		-
	TB: % of treatments completed within 12 months (Target: >85%)															-

Please note the following	blank cell	An empty cell denotes those indicators currently under development	!	Either Site or Trust overall performance red in each of the past three months

Trust commentary

#NOF Time to Theatre <36h for medically fit patients

We have seen 41 patients with #NOF during May 2018. 6 patients were taken to theatre >36h of admission:

- 2 patients were medically unfit for surgery, one on each site.
- 1 patient at CW was delayed due to theatre capacity
- 3 patients at the West Middlesex site were delayed. 2 related to theatre capacity/ previous list overrunning and 1 due to not having an anaesthetic cover.

VTE Hospital-acquired

Chelsea site: Identification of positive VTE events from radiology reports in progress, with review of hospital records to establish hospital associated VTE events for root cause analysis investigation.

West Middlesex site: A multidisciplinary thrombosis pathway implemented in Ambulatory Emergency Care (AEC) in April 2018 to review all VTEs on a weekly basis; potential HATs are identified and reported on Datix by AEC staff.

VTE Risk assessments completed

Chelsea site: No significant improvement in performance. Performance has been disseminated to divisions to highlight amongst clinical teams, with support for areas not meeting ≥ 95% target. Weekly and monthly VTE performance reports continue to be circulated to all divisions.

West Middlesex site: Performance not reported for May 2018 – commentary not provided. Target unlikely to be achieved due to current IT infrastructure, and will improve with Cerner implementation (Clinical Documentation phase).

Access Dashboard

Domain	Indicator	Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months
		Mar-18	Apr-18	May-18	2018-2019	Mar-18	Apr-18	May-18	2018-2019	Mar-18	Apr-18	May-18	2018-2019 Q1	2018-2019	Trend charts
RTT waits	RTT Incompletes 52 week Patients at month end	0	0	0	0	0	0	0	0	0	0	0	0	0	-
	Diagnostic waiting times <6 weeks: % (Target: >99%)	98.95%	98.79%	98.23%	98.54%	97.60%	97.62%	98.67%	98.08%	98.17%	98.09%	98.49%	98.26%	98.26%	!
	Diagnostic waiting times >6 weeks: breach actuals	33	40	48	88	104	120	52	172	137	160	100	260	260	-
A&E and LAS	A&E unplanned re-attendances (Target: <5%)	8.4%	8.7%	8.7%	8.7%	8.3%	8.5%	7.8%	8.2%	8.4%	8.6%	8.4%	8.5%	8.5%	!
	A&E time to treatment - Median (Target: <60')	01:08	01:04	01:06	01:05	00:51	00:47	00:45	00:46	01:05	00:59	01:00	01:00	01:00	!
	London Ambulance Service - patient handover 30' breaches	29	8	9	17	53	40	63	103	82	48	72	120	120	-
	London Ambulance Service - patient handover 60' breaches	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Choose and Book (available to Mar-18 only for issues)	Choose and book: appointment availability (average of daily harvest of unused slots)	1567	1347	1483	1418	0	0	0	0	1567	1347	1483	1418	1418	-
	Choose and book: capacity issue rate (ASI)														-
	Choose and book: system issue rate														-

Please note the following	blank cell	An empty cell denotes those indicators currently under development	!	Either Site or Trust overall performance red in each of the past three months

Trust commentary

RTT Incompletes – 52 week waiters at month end

The Trust again reported no patient waiting 52 weeks at Month End for Elective treatment

Diagnostic waiting times

The underperformance is driven by a backlog in Endoscopy and Cardiology largely on the West Middlesex site. As part of the transition to Cerner we have moved from a paper based system to a fully electronic system, which gives full visibility of all our patients. Performance continues to improve back to compliance.

London Ambulance Service – patient handover

Whilst neither site breached the 60 minutes handover tolerance there were challenges at the West Middlesex site for the 30 minutes handover target. The Chelsea Site again saw minimal breaches of this metric

Maternity Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Mar-18	Apr-18	May-18	2018-2019	Mar-18	Apr-18	May-18	2018-2019	Mar-18	Apr-18	May-18	2018-2019 Q1	2018-2019	Trend charts	
Birth indicators	Total number of NHS births	458	479	455	934	383	371	377	748	841	850	832	1682	1682		-
	Total caesarean section rate (C&W Target: <27%; WM Target: <29%)	36.6%	39.1%	31.1%	35.2%	29.6%	27.8%	29.0%	28.4%	33.5%	34.1%	30.1%	32.1%	32.1%		!
	Midwife to birth ratio (Target: 1:30)	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:30		-
	Maternity 1:1 care in established labour (Target: >95%)	95.7%	97.2%	93.8%	95.5%	98.4%	97.8%	98.4%	98.1%	97.0%	97.5%	95.9%	96.7%	96.7%		-
Safety	Admissions of full-term babies to NICU	22	12	15	27	n/a	n/a	n/a	n/a	22	12	15	27	27		-

Please note the following	blank cell	An empty cell denotes those indicators currently under development	!	Either Site or Trust overall performance red in each of the past three months

Trust commentary

Total caesarean section rate

The c-section rate at the Chelsea site dropped considerably in May from April. This constituted the lowest monthly rate since October 2016 at the Chelsea site. As a result, the Trust as a whole was able to report a rate better than any month since February 2017.

Maternity 1:1 care in established labour

The underperformance at the Chelsea & Westminster site in May is a data recording issue where the field to capture data relating to 1:1 care in labour is non-mandatory.

The midwifery managers for the Chelsea site will be actively reviewing and monitoring compliance to ensure future data is appropriately captured in the future. The service is also discussing with Information Governance if it is possible to retrospectively update the data for May.

Workforce Dashboard

		Chelsea & Westminster Hospital Site				West Middlesex University Hospital Site				Combined Trust Performance					Trust data 13 months	
Domain	Indicator	Mar-18	Apr-18	May-18	2018-2019	Mar-18	Apr-18	May-18	2018-2019	Mar-18	Apr-18	May-18	2018-2019 Q1	2018-2019	Trend charts	
Staffing	Vacancy rate (Target: CW <12%; WM <10%)	11.5%	12.1%	13.1%	13.1%	12.0%	12.0%	14.3%	14.3%	11.7%	12.0%	13.5%	13.5%	13.5%		!
	Staff Turnover rate (Target: CW <18%; WM <11.5%)	17.4%	17.5%	17.3%	17.3%	11.8%	11.7%	11.3%	11.3%	15.5%	15.6%	15.3%	15.3%	15.3%		-
	Sickness absence (Target: <3%)	2.8%	2.5%	2.4%	2.5%	3.1%	3.2%	3.2%	3.2%	2.9%	2.7%	2.7%	2.7%	2.7%		-
	Bank and Agency spend (£ks)	£2,963	£2,652	£2,311	£4,963.3	£2,964	£2,397	£2,312	£4,708.5	£5,926	£5,049	£4,623	£9,672	£9,672		-
	Nursing & Midwifery Agency: % spend of total pay (Target: tbc)	9.0%	8.3%	6.4%	7.4%	12.6%	10.1%	8.3%	9.2%	10.4%	9.0%	7.1%	8.1%	8.1%		-
Appraisal rates	% of Performance & Development Reviews completed - medical staff (Target: >85%)	70.6%	83.2%	87.7%	85.5%	90.1%	84.1%	84.0%	84.0%	77.9%	83.6%	86.2%	84.9%	84.9%		-
	% of Performance & Development Reviews completed - non-medical staff (Target trajectory: >60%)	88.4%	89.2%	91.0%	91.0%	88.5%	90.9%	87.8%	87.8%	88.4%	89.8%	89.9%	89.9%	89.9%		-
Training	Mandatory training compliance (Target: >90%)	88.1%	90.9%	91.1%	91.0%	78.7%	83.7%	85.8%	84.7%	84.6%	88.2%	89.1%	88.7%	88.7%		!
	Health and Safety training (Target: >90%)	95.4%	96.2%	95.6%	95.9%	87.7%	92.5%	93.4%	92.9%	92.6%	94.8%	94.8%	94.8%	94.8%		-
	Safeguarding training - adults (Target: 90%)	91.5%	94.7%	93.9%	94.3%	87.6%	92.3%	92.9%	92.6%	90.1%	93.8%	93.5%	93.7%	93.7%		-
	Safeguarding training - children (Target: 90%)	90.1%	92.3%	92.9%	92.6%	85.5%	90.1%	91.8%	91.0%	88.4%	91.5%	92.5%	92.0%	92.0%		-

Please note the following	blank cell	An empty cell denotes those indicators currently under development	!	Either Site or Trust overall performance red in each of the past three months

Trust commentary

Staff in Post
In May we employed 5403 whole time equivalent (WTE) people on substantive contracts, 4 WTE more than last month.

Turnover
Our voluntary turnover rate was 15.3%, 0.3% less than last month. Voluntary turnover is 17.4% at Chelsea and 11.3% at West Middlesex.

Vacancies
Our general vacancy rate for May was 13.5%, which is 1.3% higher than April. The vacancy rate is 14.3% at West Middlesex and 13.1% at Chelsea.

The increase in vacancy reflects changes to the establishment as a result of the business planning process.

Sickness Absence
Sickness absence in the month of May was 2.7%, 0.3% lower than April.

Core training (statutory and mandatory training) compliance
The Trust reports core training compliance based on the 10 Core Skills Training Framework (CSTF) topics to provide a consistent comparison with other London trusts.

Our compliance rate stands at 90% against our target of 90%.

Performance and Development Reviews
The PDR rate increased by 0.11% in May and now stands at 89.8%.

The rolling annual appraisal rate for medical staff was 87.72%, 3.72% higher than last month.

62 day Cancer referrals by tumour site Dashboard

Target of 85%

		Chelsea & Westminster Hospital Site					West Middlesex University Hospital Site					Combined Trust Performance						Trust data 13 months	
Domain	Tumour site	Mar-18	Apr-18	May-18	2018-2019	YTD breaches	Mar-18	Apr-18	May-18	2018-2019	YTD breaches	Mar-18	Apr-18	May-18	2018-2019 Q1	2018-2019	YTD breaches	Trend charts	
62 day Cancer referrals by site of tumour	Brain	n/a	n/a	n/a	n/a		n/a	n/a	n/a	n/a	0	n/a	n/a	n/a	n/a	n/a	0		-
	Breast	n/a	n/a	n/a	n/a		90.9%	100%	100%	100%	0	90.9%	100%	100%	100%	100%	0		-
	Colorectal / Lower GI	n/a	80.0%	82.4%	81.8%	2	62.5%	66.7%	100%	80.0%	1	62.5%	72.7%	85.7%	81.3%	81.3%	3		-
	Gynaecological	75.0%	50.0%	75.0%	66.7%	1	50.0%	50.0%	50.0%	50.0%	1	66.7%	50.0%	66.7%	60.0%	60.0%	2		!
	Haematological	100%	n/a	n/a	n/a		100%	100%	77.8%	84.6%	1	100%	100%	77.8%	84.6%	84.6%	1		-
	Head and neck	n/a	100%	100%	100%	0	66.7%	50.0%	66.7%	62.5%	1.5	66.7%	75.0%	75.0%	75.0%	75.0%	1.5		!
	Lung	n/a	n/a	n/a	n/a		100%	100%	100%	100%	0	100%	100%	100%	100%	100%	0		-
	Sarcoma	n/a	n/a	n/a	n/a		0.0%	n/a	n/a	n/a		0.0%	n/a	n/a	n/a	n/a			-
	Skin	100%	100%	88.2%	90.5%	1	100%	100%	83.3%	92.3%	0.5	100%	100%	87.0%	91.2%	91.2%	1.5		-
	Upper gastrointestinal	33.3%	100%	n/a	100%	0	100%	100%	50.0%	71.4%	1	50.0%	100%	50.0%	77.8%	77.8%	1		-
	Urological	90.0%	94.1%	92.3%	93.3%	1	94.1%	100%	72.2%	83.3%	5	91.9%	97.6%	77.6%	86.7%	86.7%	6		-
	Urological (Testicular)	n/a	n/a	n/a	n/a		100%	n/a	n/a	n/a		100%	n/a	n/a	n/a	n/a			-
	Site not stated	100%	n/a	100%	100%	0	n/a	100%	100%	100%	0	100%	100%	100%	100%	100%	0		-

Please note the following	n/a	Refers to those indicators where there is no data to report. Such months will not appear in the trend graphs	! Either Site or Trust overall performance red in each of the past three months

Trust commentary

The unvalidated breaches in May by Tumour site are as follows:

Note that a pathway can be shared between organisations hence the fractions of a breach

Colorectal / Lower GI: C&W: 1.5 breaches of 8.5 patients treatments

Gynaecological: C&W: 1 breach of 2 patients treatments
WMUH: 0.5 of a breach of 1 patient treated

Haematological: WMUH: 1 breach of 4.5 patients treated

Head and Neck: WMUH: 1 breach of 3 patients treated

Skin: C&W: 1 breach of 8.5 patients treated
WMUH: 0.5 of a breach of 3 patients treated

Upper Gastrointestinal: WMUH: 0.5 of a breach of 1 patient treated

Urological: C&W: 0.5 of a breach of 6.5 patients treated
WMUH: 2.5 breaches of 9 patients treated

All other pathways on both sites were treated within the 62 day target

Nursing Metrics Dashboard

Safe Nursing and Midwifery Staffing

Chelsea and Westminster Hospital Site

Ward Name	Average fill rate				CHPPD			National bench mark
	Day		Night					
	Reg Nurses	Care staff	Reg Nurses	Care staff	Reg	HCA	Total	
Maternity	95.7%	84.8%	93.7%	83.8%	6.9	2.4	9.3	7 – 17.5
Annie Zunz	99.9%	84.6%	100.0%	100.0%	5.7	2.3	8.0	6.5 - 8
Apollo	103.4%	106.5%	102.6%	100.0%	14.5	2.9	17.4	
Jupiter	146.2%	95.5%	142.3%	-	9.4	2.5	11.9	8.5 – 13.5
Mercury	68.0%	87.1%	66.7%	90.3%	9.1	1.8	10.9	8.5 – 13.5
Neptune	100.0%	-	100.0%	0.0%	8.5	0.0	8.5	8.5 – 13.5
NICU	117.0%	-	117.0%	-	13.8	0.0	13.8	
AAU	106.9%	79.6%	100.0%	99.9%	9.4	2.1	11.6	7 - 9
Nell Gwynn	97.3%	81.2%	133.3%	100.0%	4.1	3.2	7.3	6 – 8
David Erskine	98.0%	99.1%	104.3%	104.2%	3.4	3.2	6.6	6 – 7.5
Edgar Horne	96.7%	104.6%	98.9%	108.1%	3.0	3.5	6.6	6 – 7.5
Lord Wigram	97.3%	97.4%	114.0%	105.4%	4.0	2.8	6.7	6.5 – 7.5
St Mary Abbots	96.3%	91.4%	97.6%	104.3%	4.0	2.6	6.6	6 – 7.5
David Evans	79.7%	90.4%	89.4%	102.0%	6.1	3.1	9.1	6 – 7.5
Chelsea Wing	88.1%	95.5%	99.9%	96.8%	13.7	8.3	21.9	
Burns Unit	96.9%	100.0%	97.9%	100.0%	9.9	3.1	12.9	
Ron Johnson	96.1%	116.1%	101.1%	112.9%	4.8	3.0	7.8	6 – 7.5
ICU	100.0%	100.0%	100.4%	-	37.9	1.0	38.9	17.5 - 25
Rainsford Mowlem	82.2%	85.0%	99.2%	100.0%	3.3	3.1	6.4	6 - 8

West Middlesex University Hospital Site

Ward Name	Average fill rate				CHPPD			National bench mark
	Day		Night					
	Reg Nurses	Care staff	Reg Nurses	Care staff	Reg	HCA	Total	
Maternity	74.6%	78.9%	95.0%	96.6%	8.2	1.5	9.7	7 – 17.5
Lampton	100.1%	157.3%	97.7%	100.4%	3.2	3.1	6.3	6 – 7.5
Richmond	99.0%	97.2%	79.2%	47.5%	6.2	2.9	9.1	6 – 7.5
Syon 1	98.8%	98.9%	97.6%	108.1%	4.2	2.4	6.6	6 – 7.5
Syon 2	97.0%	157.5%	100.9%	183.9%	3.7	3.7	7.4	6 – 7.5
Starlight	103.0%	0.0%	103.2%	0.0%	8.6	0.0	8.6	8.5 – 13.5
Kew	102.1%	88.0%	131.2%	127.4%	4.5	3.4	7.9	6 - 8
Crane	99.0%	99.3%	100.0%	104.8%	3.5	2.8	6.3	6 – 7.5
Osterley 1	114.4%	78.5%	115.2%	151.6%	3.8	3.6	7.4	6 – 7.5
Osterley 2	103.6%	123.4%	102.4%	200.0%	3.9	3.8	7.7	6 – 7.5
MAU	102.7%	94.2%	94.3%	95.2%	4.7	2.3	7.0	7 - 9
CCU	99.8%	96.8%	100.4%	-	5.8	0.7	6.5	6.5 - 10
Special Care Baby Unit	118.6%	-	118.3%	-	5.7	0.0	5.7	
Marble Hill 1	79.0%	87.7%	86.3%	93.5%	4.3	3.1	7.4	6 - 8
Marble Hill 2	100.8%	114.3%	106.8%	121.0%	3.8	3.7	7.6	5.5 - 7
ITU	81.3%	0.0%	76.1%	-	32.2	0.0	32.2	17.5 - 25

Summary for May 2018

Nell Gwynne showing high fill rates due to enhanced care being given to a patient with a tracheostomy.

Jupiter showing high fill rates due to number of RMNs being used. Mercury has had beds closed due to infection outbreak and ITU activity low at West Middx, so fill rates on both department were low – as temporary staffing reduced.

ITU activity on ITU at Chelsea also low, and therefore showing high CHPPD , though staff were redeployed into other areas.

CHPPD is showing an overly generous amount on Richmond due to bed census data being counted at midnight and therefore not accounting for day surgery activity. Additional HCAs booked to care for confused patients at risk of falls on Osterley 1 & 2 and for high number of patients on NIV. Increased fill rate for HCAs on Syon 2 as a result of high number of confused patients at risk of falls. On going work is occurring to further reduce usage of specials and improve substantive staffing levels.

CQUIN Dashboard

May 2018

National CQUINs

No.	Description of goal	Responsible Executive (role)	Forecast RAG Rating
A.1	Improvement of health and wellbeing of NHS staff	Director of HR & OD	
A.2	Healthy food for NHS staff, visitors and patients	Deputy Chief Executive	
A.3	Improving the uptake of flu vaccinations for front line staff within Providers	Director of HR & OD	
B.1	Sepsis (screening) - ED & Inpatient	Medical Director	
B.2	Sepsis (antibiotic administration and review) - ED & Inpatient	Medical Director	
B.3	Anti-microbial Resistance - review	Medical Director	
B.4	Anti-microbial Resistance - reduction in antibiotic consumption	Medical Director	
C.1	Improving services for people with mental health needs who present to A&E	Chief Operating Officer	
D.1	Offering Advice and guidance for GPs	Medical Director	
E.1	NHS e-Referrals	Chief Operating Officer	
F.1	Supporting safe & proactive discharge	Chief Operating Officer	

NHS England CQUINs

No.	Description of goal	Responsible Executive (role)	Forecast RAG Rating
N1.1	Enhanced Supportive Care	Chief Operating Officer	
N1.2	Nationally standardised Dose banding for Adult Intravenous Anticancer Thera	Chief Operating Officer	
N1.3	Optimising Palliative Chemotherapy Decision Making	Chief Operating Officer	
N1.4	Hospital Medicines Optimisation	Chief Operating Officer	
N1.5	Neonatal Community Outreach	Chief Operating Officer	
N1.6	Dental Schemes - recording of data, participation in referral management & p	Chief Operating Officer	

CQUIN Scheme Overview

The Trust agreed 12 CQUIN schemes (6 schemes with CCGs, 6 schemes with NHS England) for 2017/18. For 2018/19, CQUIN schemes will number 11 in total; CCG schemes will reduce to 5, but NHSE schemes are unchanged.

2017/18 Quarterly Performance
For NHSE schemes, Q1 and Q2 performance was confirmed as 100%, Q3 as 85%. For CCG schemes, performance was 92% for Q1 and 86% for Q2 for CCG schemes. Confirmation from the CCGs of Q3 achievement is imminent. Partial achievement was reported for the 'Sepsis screening and Antimicrobial resistance', 'Improving services for people with mental health needs who present to A&E', 'NHS e-Referrals' and 'Supporting proactive and safe discharge' schemes in Q2, which was in line with forecast achievement. Submission of Q4 reports to both Commissioners is complete and confirmation of the outcomes expected by the end of June.

National Schemes (CCG commissioning)
There is a continued risk to delivery of certain schemes, including 'Sepsis screening and Anti-microbial resistance', in line with the year to date delivery, and the Trust is forecasting partial achievement. The 'e-Referrals' scheme performance is also likely to be less than 100% owing to a particularly challenging Q4 indicator. However the associated financial risk is partly mitigated by a local payment agreement with NWL CCGs.

National Schemes (Specialised Services commissioning)
The schemes are expected to achieve 100%, with the exception of the 'Neonatal Community Outreach' scheme. The Commissioner and Neonatal Network continue to co-design the specification, but the uncertainty could adversely affect full year performance.

2018/19 CQUIN Schemes overview
2018/19 is the second year of delivery for the majority of the schemes. The 'Supporting safe & proactive discharge' scheme has been suspended for 2018/19, with the weighting given to the other schemes increasing as a result. Certain other scheme specifications have been updated following provider feedback. A new scheme is introduced for 18/19 only, replacing a previous scheme intended for 17/18 only. A similar local payment arrangement with NWL CCGs has been agreed for 18/19, which will mitigate the financial risk of under-performance. The Specialised Services schemes remain unchanged from 17/18.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Finance Dashboard

Month 2 2018-19 Integrated Position

Financial Position (£000's)

£'000	Combined Trust		
	Plan to Date	Actual to Date	Variance to Date
Income	107,609	106,886	(723)
Expenditure	(102,571)	(102,373)	197
Adjusted EBITDA	5,039	4,513	(526)
Adjusted EBITDA %	4.682%	4.222%	-0.46%
Interest/Other	(889)	(886)	3
Depreciation	(3,107)	(2,899)	208
PDC Dividends	(1,872)	(1,872)	0
Other	0	0	0
Trust Deficit	**(829)**	**(1,144)**	**(315)**

Comments

In May (Month 2) the Trust is reporting a £0.18m surplus which is £0.14m adverse against the internal plan. The YTD position is £1.14m deficit which is £0.32m adverse against the internal plan.

Income is below plan in month and YTD mainly due to critical care, elective and emergency admissions. A&E and outpatients are on plan and trend.

Pay is overspent by £0.9m in month 02 and by £2.57 YTD. The Trust continues to use bank and agency staff to cover vacancies. Temporary staffing is also used to cover, sickness, additional activity and Cerner training. The position includes unidentfied CIPs.

Non-pay, excluding pass through drugs, is £0.82m favourable in month and £2.76m favourable YTD.

Risk rating (year to date)

Use of Resource Rating (UORR)	M02 (Before Override)	M02 (After Override)
Use of Resource Rating	2	2

Comments

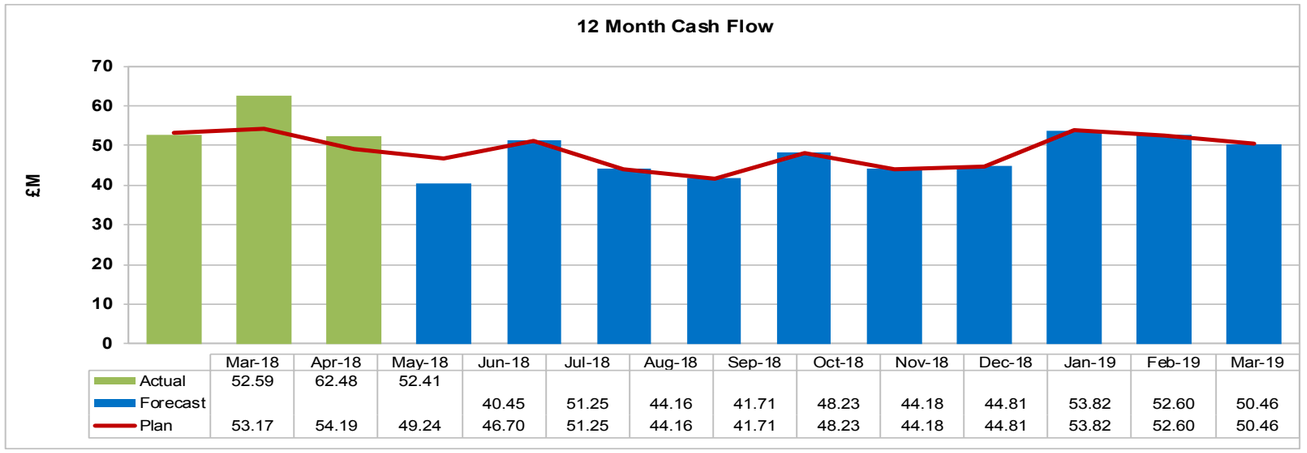
Under the Use of Resources Rating (UORR) the Trust is performing in line with plan for all areas of measurement except against its I&E margin distance from plan and also its agency rating, where YTD expenditure was £3.270m against a ceiling of £3.269m, an adverse variance of £0.001m.

As the Trust did not score a "4" in any of its risk ratings, the override does not apply and the Trust achieved a UORR rating of "2" in line with plan.

Cash Flow

Comments RAG rating

The cash balance at the end of May is £52.41m which is £3.17m more than plan of £49.24m. The main drivers of this increase are: increase in capital expenditure on a cash basis of £(1.73m) spent on items brought forward from the prior year programme; an increase in working capital and other movements compared to plan of £5.30m; and decrease in cash flows from operating activities £(0.40m). The planned end of year cash balance is £50.46m. The Trust has currently set the monthly cash forecast to equal plan from July onwards and is currently working on updating these forecasts. The Trust has a number of planned external funding requirements for capital projects which has planned to call upon from Q2 of the year. There is no expected borrowing requirement for revenue expenditure this year.



	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Actual	52.59	62.48	52.41										
Forecast				40.45	51.25	44.16	41.71	48.23	44.18	44.81	53.82	52.60	50.46
Plan	53.17	54.19	49.24	46.70	51.25	44.16	41.71	48.23	44.18	44.81	53.82	52.60	50.46

Cost Improvement Programme (CIPs)

Theme	In Month			Year to Date		
	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000
Targeted Specialities	956	500	(457)	1,910	925	(985)
Corporate savings	225	176	(49)	495	320	(175)
Residual % Based Savings	508	508	0	1,017	1,017	0
Trust Total	1,690	1,184	(506)	3,422	2,262	(1,160)

Comments RAG rating

The Trust has achieved YTD CIPs of £2.26m against a target of £3.42m with an adverse variance of £1.16m.

Key drivers for not maximising CIP achievement relate to underachieving clinical pay schemes from the original plan submitted.

The current unidentified efficiencies is £3.54m however through new schemes the trust will aim to achieve the CIP target of £25.1m.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

PUBLIC SESSION

Board of Directors Meeting, 5 July 2018

AGENDA ITEM NO.	2.4.1/Jul/18
REPORT NAME	Workforce Performance Report - Month 2
AUTHOR	Natasha Elvidge. Associate Director of HR; Resourcing
LEAD	Sandra Easton, Chief Financial Officer
PURPOSE	The workforce performance report highlights current KPIs and trends in workforce related metrics at the Trust.
SUMMARY OF REPORT	**Staff in Post** In May the trust employed 5403 whole time equivalent (WTE) people on substantive contracts, 3.8 WTE greater than last month. The trust's substantive workforce has grown by 4.1% (222.3 WTE) over the last twelve months. **Turnover** Our voluntary turnover rate was 15.3%, 0.41% lower than last month. Voluntary turnover is 17.4% at Chelsea and 11.3% at West Middlesex. **Vacancies** Our general vacancy rate for May was 13.5%, which is 1.5% higher than April. The vacancy rate is 14.3% at West Middlesex and 13.1% at Chelsea. **Sickness Absence** Sickness absence in the month of May was 2.7%, 0.03% lower than April. **Agency spend** In May agency spend was £1,575,411 which breached the total target agency spend by 0.3%. **Core training (statutory and mandatory training) compliance** The Trust reports core training compliance based on the 10 Core Skills Training Framework (CSTF) topics to provide a consistent comparison with other London trusts. Our compliance rate stands at 89% against our target of 90%. The recent introduction of the single compliance reporting platform (QlikView) has coincided with the trust achieving and increasing its highest level of compliance since the introduction of core training reporting.

	<u>Performance and Development Reviews</u> From April '17 a new PDR process was introduced, specifying date windows for PDR completion according to pay band. A target of 90% was set for all non-medical staff to have had a PDR by the end of December. The PDR rate increased by 0.1% in May and now stands at 89.9%. The rolling annual appraisal rate for medical staff was 86.6%, 2.43% higher than the previous month.
KEY RISKS ASSOCIATED	The need to reduce vacancy and turnover rates.
FINANCIAL IMPLICATIONS	Costs associated with high vacancy and turnover rates and high reliance on agency workers.
QUALITY IMPLICATIONS	Risks associated workforce shortage and instability.
EQUALITY & DIVERSITY IMPLICATIONS	We need to value all staff and create development opportunities for everyone who works for the trust, irrespective of protected characteristics.
LINK TO OBJECTIVES	• Excel in providing high quality, efficient clinical services • Improve population health outcomes and develop integrated care • Deliver financial sustainability • Create an environment for learning, discovery and innovation
DECISION/ ACTION	For noting

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Workforce Performance Report
to the Workforce Development Committee

Month 2 – May 2018

Workforce Performance Report Jun‘17 - May‘18

Performance Summary

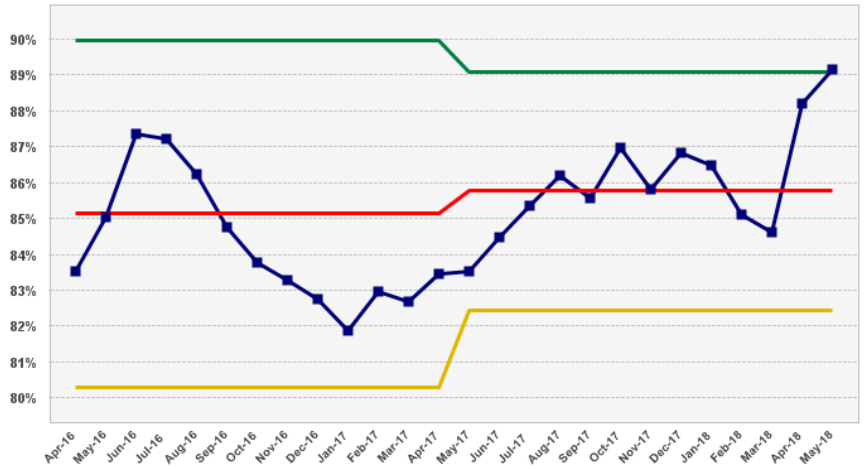
Summary of overall performance is set out below

Page	Areas of Review	Key Highlights	Previous Year	Previous Month	In Month	Target	Change
5	Vacancy	Vacancy rate has increased by 1.5%	13.7%	12.0%	13.5%	10.0%	↗
6	Turnover	Turnover has decreased by 0.1%	21.6%	19.6%	19.5%		↘
7	Voluntary Turnover	Voluntary turnover has decreased by 0.41%	16.4%	15.7%	15.3%	13.0%	↘
10	Sickness	Sickness has decreased by 0.03%	2.3%	2.7%	2.7%	3.3%	↔
15	Temporary Staffing Usage (FTE)	Temporary Staffing % usage has decreased by 0.9% this month		16.4%	15.4%		↘
17	Core Training	Core Training compliance has increased by 0.8%	83.5%	88.2%	89.0%	90.0%	↗
18	Staff PDR	The percentage of staff who have had a PDR has increased by 0.1%	4.3%	89.8%	89.9%	90.0%	↗

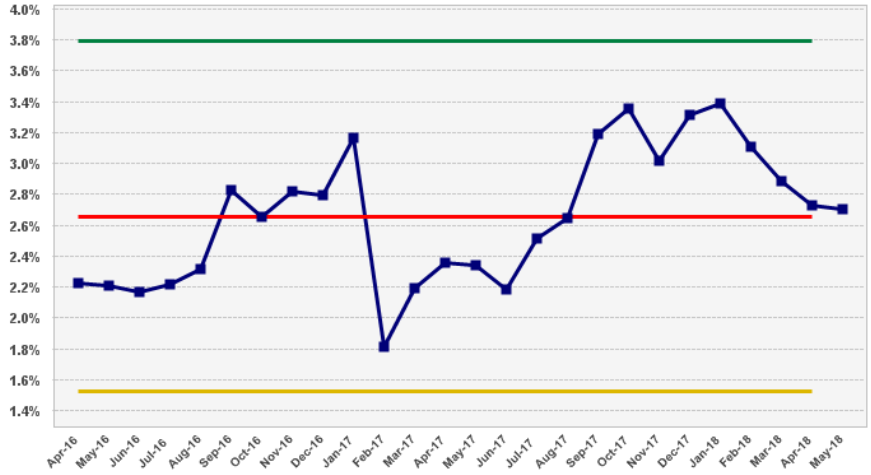
In addition to the information in this report, the trust monitors its workforce data by protected characteristics as defined by the Equality Act. To view the most recent annual workforce equality report please click this link http://connect/departments-and-mini-sites/equality-diversity/

Statistical Process Control – April 2016 to May 2018

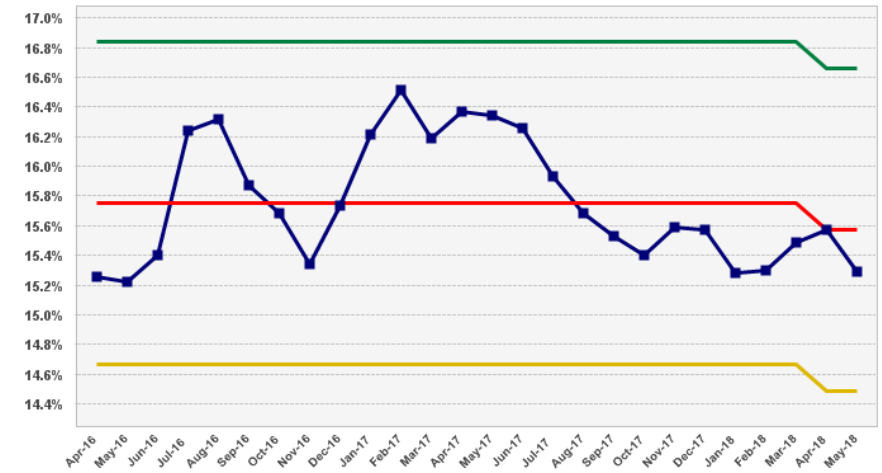
Mandatory Training compliance



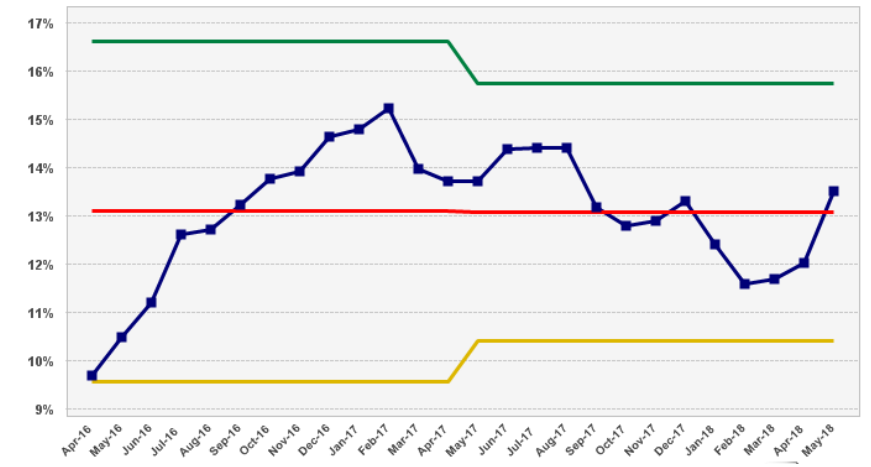
Sickness absence



Staff turnover rate

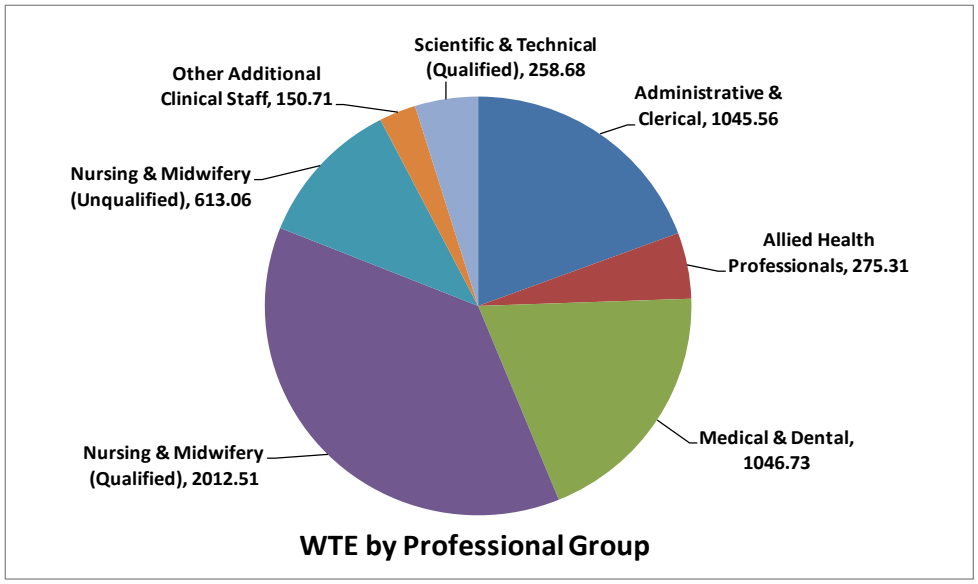


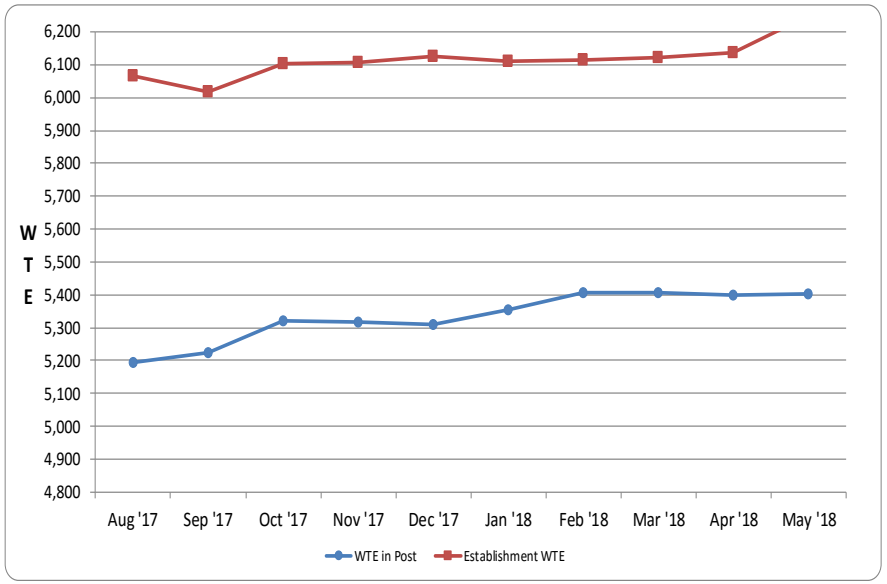
Vacancy rate

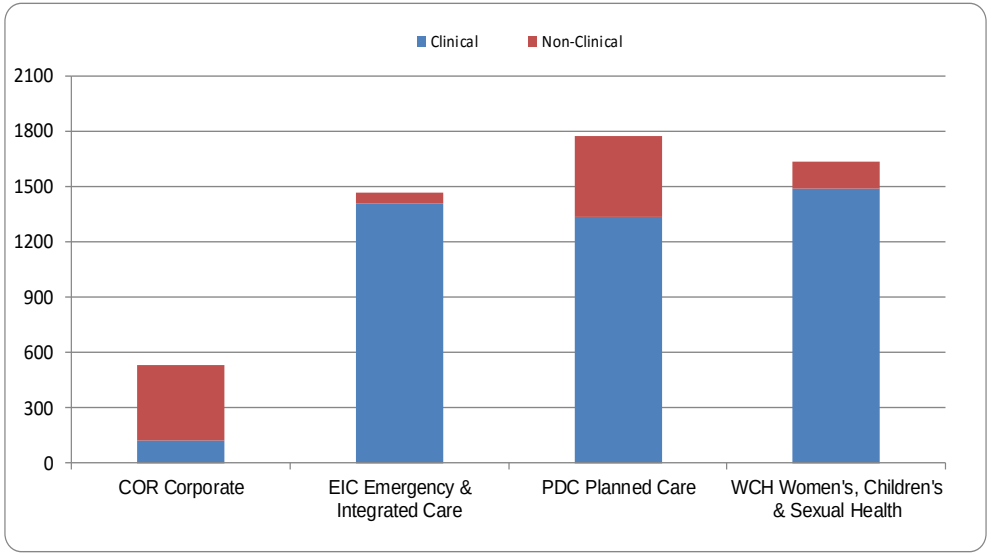


Current Staffing Profile

The data below displays the current staffing profile of the Trust







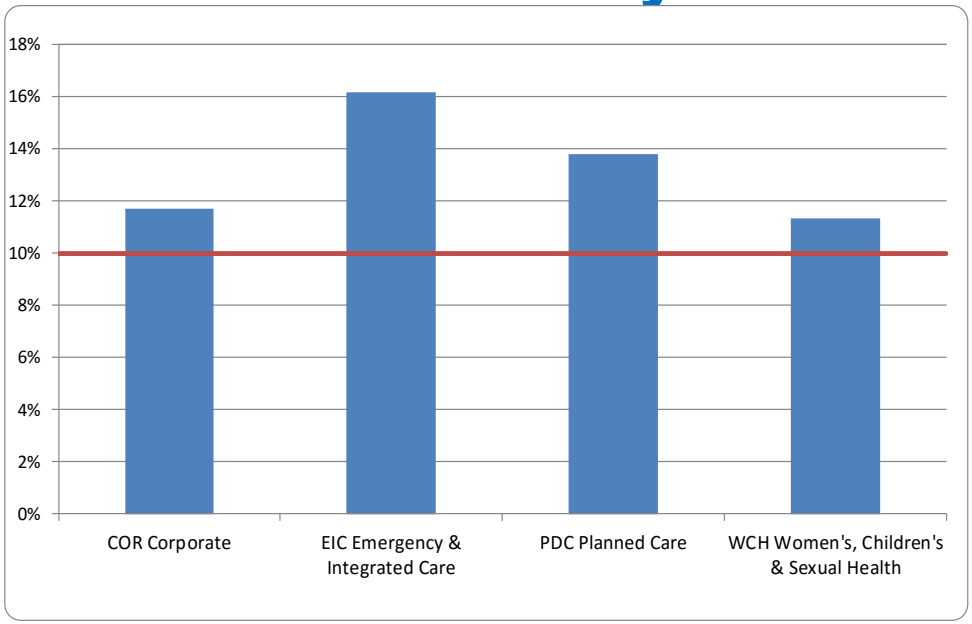
COMMENTARY

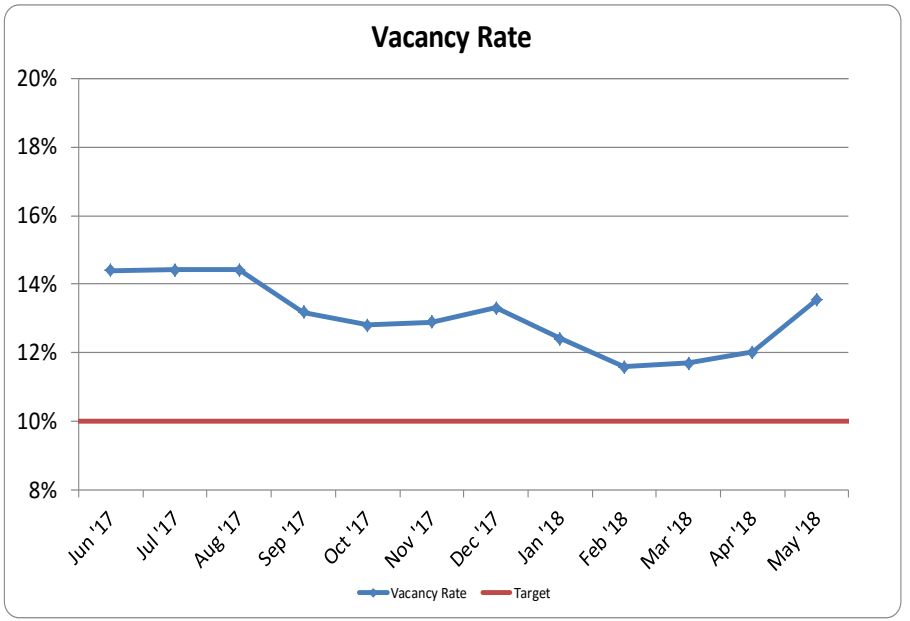
The Trust currently employs 5878 people working a whole time equivalent of 5403 which is 3.8 WTE greater than April. The largest increase in May was Unqualified Nursing (4.34 WTE), whilst Administrative & Clerical staff reduced by 3.86 WTE.

Over the last year, staff numbers have increased by 222.3 WTE with the highest increase being in the EIC Division (137.4 WTE). The professional group with the highest increase has been Qualified Nursing & Midwifery (94.4 WTE).

In May there were 1868 WTE staff assigned to the West Middlesex site and 3535 WTE to Chelsea.

Section 1: Vacancy Rates





Vacancies by Division	Feb '18	Mar '18	Apr '18	May '18	Trend
COR Corporate	9.9%	10.5%	11.0%	11.7%	↗
EIC Emergency & Integrated Care	14.0%	14.0%	13.5%	16.2%	↗
PDC Planned Care	10.6%	11.0%	11.8%	13.8%	↗
WCH Women's, Children's & Sexual Health	11.0%	10.8%	11.2%	11.3%	↗
Whole Trust	**11.6%**	**11.7%**	**12.0%**	**13.5%**	↗
West Mid Site	**12.3%**	**12.0%**	**12.0%**	**14.3%**	↗
Chelsea Site	**11.2%**	**11.5%**	**12.1%**	**13.1%**	↗

Vacancies by Professional Group	Feb '18	Mar '18	Apr '18	May '18	Trend
Administrative & Clerical	10.8%	11.5%	11.6%	13.7%	↗
Allied Health Professionals	10.0%	10.8%	13.1%	14.5%	↗
Medical & Dental	9.3%	10.1%	10.8%	13.0%	↗
Nursing & Midwifery (Qualified)	13.5%	12.8%	12.7%	13.4%	↗
Nursing & Midwifery (Unqualified)	13.5%	14.0%	14.5%	16.2%	↗
Other Additional Clinical Staff	8.3%	7.5%	5.0%	6.1%	↗
Scientific & Technical (Qualified)	7.5%	7.8%	9.8%	12.1%	↗
Total	**11.6%**	**11.7%**	**12.0%**	**13.5%**	↗

Service	Establishment WTE	Staff in Post WTE	Vacancy Rate %	Trend
WM Paediatric Starlight Unit	59.2	35.5	40.1%	↗
WM Radiology	60.7	37.9	37.5%	↗
WM Marble Hill 2	32.4	20.8	36.1%	↗
CW Mercury Ward	21.4	13.8	35.5%	↗
CW Nell Gwynne Ward	38.4	25.0	34.9%	↗

COMMENTARY

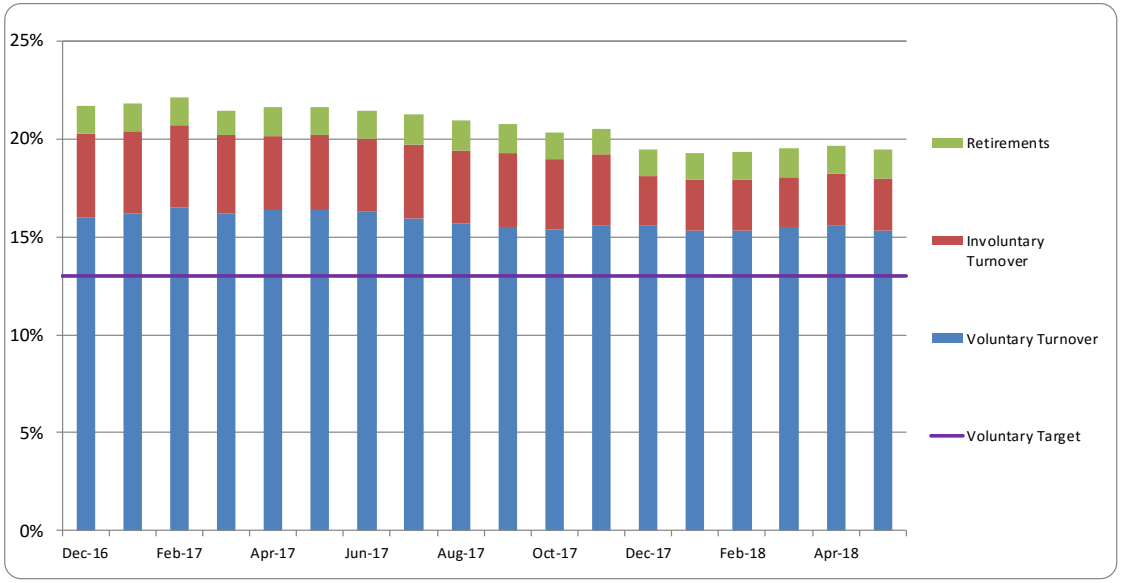
The vacancy rate has increased by 1.5% in May. The significant increase in the vacancy rate illustrates the effect of the business planning cycle.

The vacancy rate currently is highest in the Nursing & Midwifery (Unqualified) professional group at 16.2% and in the Emergency & Integrated Care Division at 16.2%.

The table above shows the services with more than 20 staff which currently have the highest vacancy rates at the Trust.

Section 2a: Gross Turnover

The chart below shows turnover trends. Tables by Division and Staff Group are below:



COMMENTARY

The total trust turnover rate has decreased slightly by 0.1% to 19.5% this month. In the last 12 months there have been 1014 leavers.

The Trust now has data from responses to exit surveys to enable more focused work on retention.

	Gross Turnover				
Division	**Feb '18**	**Mar '18**	**Apr '18**	**May '18**	**Trend**
COR Corporate	21.0%	23.3%	21.4%	21.4%	↔
EIC Emergency & Integrated Care	19.6%	20.0%	20.1%	20.2%	↗
PDC Planned Care	18.0%	17.8%	18.2%	18.1%	↘
WCH Women's, Children's & Sexual Health	20.0%	19.7%	20.2%	19.7%	↘
Whole Trust	**19.4%**	**19.5%**	**19.6%**	**19.5%**	↘

	Gross Turnover				
Professional Group	**Feb '18**	**Mar '18**	**Apr '18**	**May '18**	**Trend**
Administrative & Clerical	18.2%	19.9%	18.8%	19.4%	↗
Allied Health Professionals	21.6%	20.9%	20.8%	21.5%	↗
Medical & Dental	15.7%	14.6%	16.3%	16.1%	↘
Nursing & Midwifery (Qualified)	19.8%	19.3%	19.5%	19.2%	↘
Nursing & Midwifery (Unqualified)	21.1%	21.8%	23.0%	22.1%	↘
Other Additional Clinical Staff	25.7%	25.5%	23.2%	22.3%	↘
Scientific & Technical (Qualified)	18.2%	19.1%	19.6%	19.1%	↘
Whole Trust	**19.4%**	**19.5%**	**19.6%**	**19.5%**	↘

Leaver Category	Number of Leavers
Death in Service	2
Dismissal	19
Employee Transfer	10
End of Fixed Term Contract	107
Redundancy	4
Retirement	68
Voluntary Resignation	804
Total	**1014**

Section 2b: Voluntary Turnover

	Voluntary Turnover						Other Turnover May 2018	
Division	Feb '18	Mar '18	Apr '18	May '18	Trend	Leavers HC	In-voluntary	Retirement
COR Corporate	16.4%	18.0%	16.7%	16.5%	↘	88	3.6%	1.3%
EIC Emergency & Integrated Care	16.8%	17.2%	17.3%	17.2%	↘	223	2.1%	0.9%
PDC Planned Care	13.4%	13.3%	13.2%	13.3%	↗	229	3.1%	1.7%
WCH Women's, Children's & Sexual Health	15.7%	15.7%	16.3%	15.5%	↘	256	2.4%	1.8%
Whole Trust	**15.3%**	**15.5%**	**15.6%**	**15.3%**	↘	**796**	**2.7%**	**1.5%**
West Mid Site	**11.8%**	**11.8%**	**11.7%**	**11.3%**	↘	**200**		
Chelsea Site	**17.1%**	**17.4%**	**17.6%**	**17.4%**	↘	**596**		

	Voluntary Turnover						Other Turnover May 2018	
Professional Group	Feb '18	Mar '18	Apr '18	May '18	Trend	Leavers HC	In-voluntary	Retirement
Administrative & Clerical	14.3%	15.7%	14.9%	15.3%	↗	168	2.7%	1.5%
Allied Health Professionals	19.9%	18.9%	18.6%	19.0%	↗	59	1.6%	1.0%
Medical & Dental	5.9%	5.7%	6.2%	5.5%	↘	32	9.2%	1.4%
Nursing & Midwifery (Qualified)	17.5%	17.1%	17.4%	17.0%	↘	362	0.8%	1.5%
Nursing & Midwifery (Unqualified)	17.2%	18.0%	19.0%	18.5%	↘	118	2.0%	1.6%
Other Additional Clinical Staff	14.7%	14.6%	12.2%	11.5%	↘	19	6.6%	4.2%
Scientific & Technical (Qualified)	13.2%	14.1%	14.3%	13.4%	↘	38	4.6%	1.1%
Whole Trust	**15.3%**	**15.5%**	**15.6%**	**15.3%**	↘	**796**	**2.7%**	**1.5%**

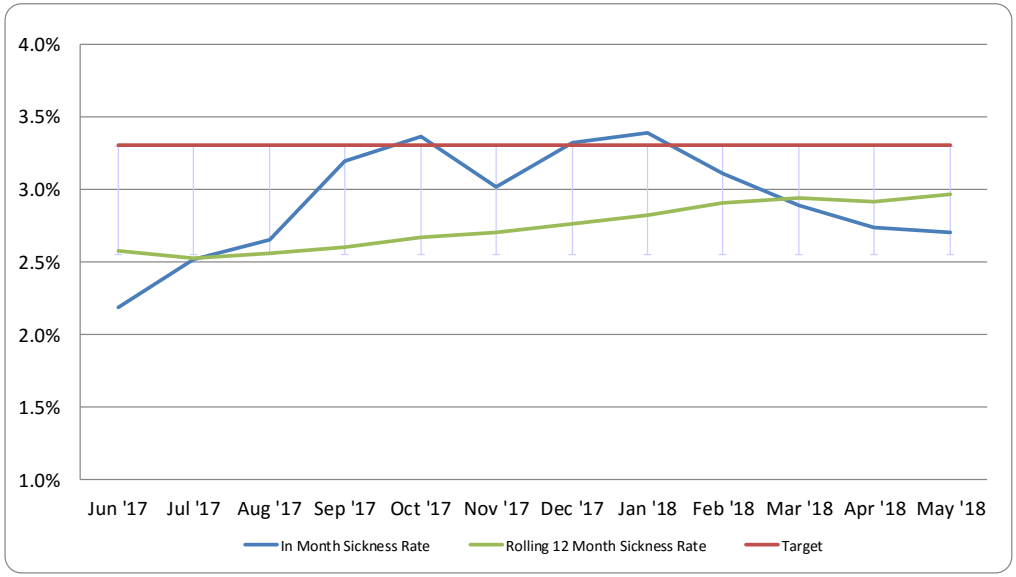
Service	Average Staff in Post HC	Leavers HC	Voluntary Turnover Rate
CW Ron Johnson	25	11	44.9%
CW Nell Gwynne Ward	36	13	36.6%
CW Mercury Ward	28	10	36.4%
CW Outpatients	21	7	34.2%
CW David Evans Ward	34	11	32.8%

COMMENTARY

Voluntary Turnover has decreased by 0.41% this month. Chelsea Site has a voluntary turnover rate consistently about 5 % higher than West Mid. The 5 services with more than 20 staff with the highest voluntary turnover rates are shown in the bottom table. Divisional HR Business Partners are working within divisions to tackle any issues within these areas. The Trust is also taking part in the NHSi Retention Support Program to help reduce turnover.

Section 3: Sickness

The chart below shows performance over the last 11 months, the tables by Division and Staff Group are below.



COMMENTARY

The monthly sickness absence rate is at 2.7% in May which is a decrease of 0.03% on the previous month.

The Planned Care Division had the highest sickness rate in May at 3.41%. The professional group with the highest sickness rate was Nursing and Midwifery (Unqualified) at 4.7%.

The table below lists the services with the highest sickness absence percentage during May 2018. Below that is a breakdown of the top 5 reasons for absence, both by the number of episodes and the number of days lost.

Sickness by Division	Feb '18	Mar '18	Apr '18	May '18	Trend
COR Corporate	2.58%	2.82%	1.92%	1.83%	↘
EIC Emergency & Integrated Care	2.81%	2.46%	2.36%	2.14%	↘
PDC Planned Care	3.15%	3.29%	3.35%	3.21%	↘
WCH Women's, Children's & Sexual Health	3.51%	2.84%	2.65%	2.89%	↗
Whole Trust In Month %	**3.11%**	**2.89%**	**2.73%**	**2.70%**	↘
Whole Trust Annual Rolling %	**2.90%**	**2.94%**	**2.91%**	**2.96%**	↗
Long Term Sickness Rate %	**1.60%**	**1.49%**	**1.36%**	**1.29%**	↘
Short Term Sickness Rate %	**1.51%**	**1.40%**	**1.37%**	**1.43%**	↗

Sickness by Professional Group (In Month)	Feb '18	Mar '18	Apr '18	May '18	Trend
Administrative & Clerical	3.42%	3.67%	3.54%	3.14%	↘
Allied Health Professionals	2.07%	1.83%	1.91%	1.53%	↘
Medical & Dental	0.73%	0.59%	0.40%	0.39%	↘
Nursing & Midwifery (Qualified)	3.66%	3.20%	2.87%	3.20%	↗
Nursing & Midwifery (Unqualified)	5.24%	4.81%	4.71%	4.65%	↘
Other Additional Clinical Staff	4.36%	1.53%	2.33%	2.61%	↗
Scientific & Technical (Qualified)	2.87%	4.07%	4.32%	2.97%	↘
Whole Trust In Month %	**3.11%**	**2.89%**	**2.73%**	**2.70%**	↘
Chelsea Site %	**2.98%**	**2.78%**	**2.50%**	**2.42%**	↘
West Mid Site %	**3.36%**	**3.08%**	**3.17%**	**3.25%**	↗

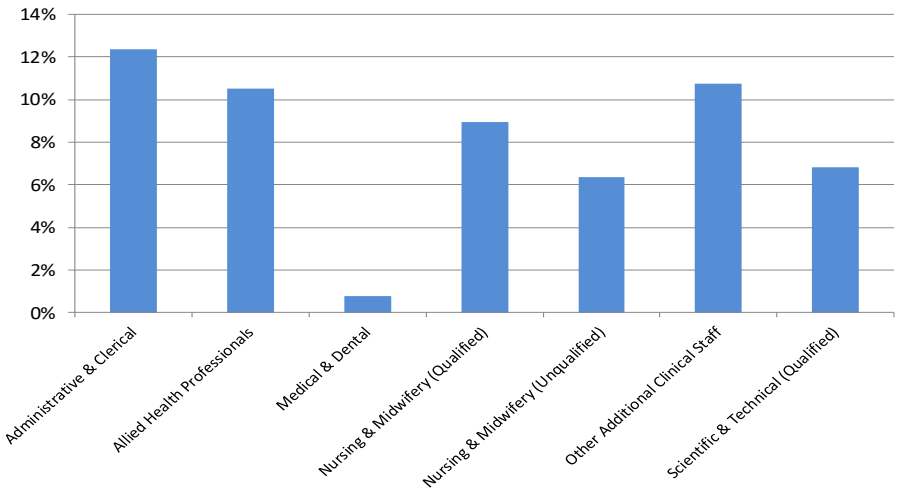
Service	Staff in Post WTE	Sickness WTE Days Lost	WTE Days Available	Sickness %
WM Syon 2 Pay	31.13	127.28	986.13	12.9%
WM Critical Care	51.71	165.76	1603.63	10.3%
CW Edgar Horne Ward	38.01	104.52	1193.41	8.8%
CW John Hunter Clinic	46.37	130.65	1682.37	7.8%
WM Paediatric Starlight Unit	35.48	78.28	1099.88	7.1%

Top 5 Sickness Reasons by Number of Episodes	% of all Episodes
S25 Gastrointestinal problems	19.30%
S13 Cold, Cough, Flu - Influenza	18.75%
S12 Other musculoskeletal problems	9.65%
S10 Anxiety/stress/depression/other psychiatric illnesses	8.33%
S16 Headache / migraine	8.22%

Top 5 Sickness Reasons by Number of WTE Days Lost	% of all WTE Days Lost
S10 Anxiety/stress/depression/other psychiatric illnesses	17.73%
S12 Other musculoskeletal problems	14.34%
S25 Gastrointestinal problems	10.56%
S28 Injury, fracture	8.68%
S13 Cold, Cough, Flu - Influenza	8.63%

Section 4: Staff Career Development

The chart below shows the percentage of current staff promoted in each staff group over the last 12 months.



COMMENTARY

In May, 24 staff were promoted, there were 72 new starters to the Trust (excluding Doctors in Training). In addition, 73 employees were acting up to a higher grade.

Over the last year 8.1% of current Trust staff have been promoted to a higher grade. The highest promotion rate can be seen in the Corporate Division.

Admin & Clerical currently have the highest promotion rate at 12.4% followed by the Other Additional Clinical Staff group at 10.5%.

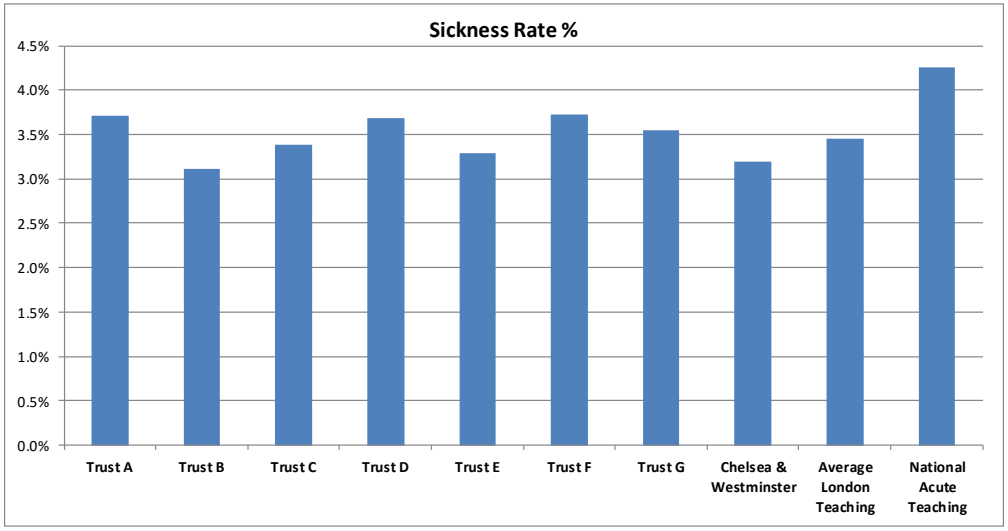
	Monthly No. of Promotions				
Division	Feb '18	Mar '18	Apr '18	May '18	Trend
COR Corporate	6	3	5	0	↘
EIC Emergency & Integrated Care	9	6	17	8	↘
PDC Planned Care	7	13	17	10	↘
WCH Women's, Children's & Sexual Health	10	14	28	6	↘
Whole Trust Promotions	**32**	**36**	**67**	**24**	↘
New Starters (Excludes Doctors in Training)	**92**	**89**	**98**	**72**	↘

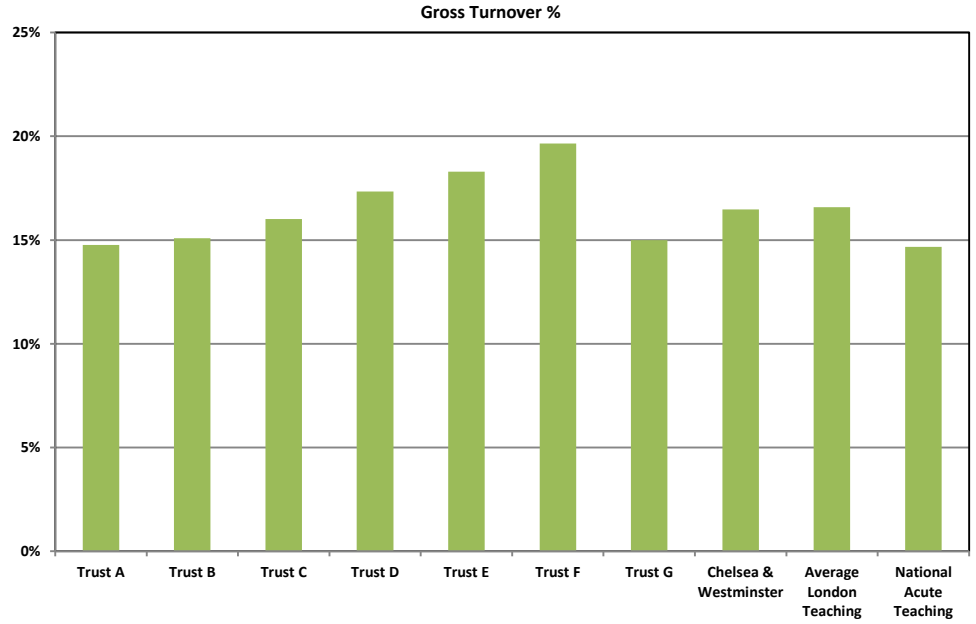
Division	Staff in Post + 1yrs Service	No. of Staff Promoted (12 Months)	% of Staff Promoted	Currently Acting Up	BME % Overall Division	BME % Promoted
COR Corporate	429	49	11.4%	8	43.4%	44.9%
EIC Emergency & Integrated Care	1042	83	8.0%	18	45.4%	45.8%
PDC Planned Care	1448	98	6.8%	24	48.0%	44.9%
WCH Women's, Children's & Sexual Health	1388	121	8.7%	23	34.5%	17.4%
Whole Trust	**4307**	**351**	**8.1%**	**73**	**42.6%**	**35.6%**
New Starters (Excludes Doctors in Training)		**989**				

	No. of Promotions				
Professional Group	Feb '18	Mar '18	Apr '18	May '18	Trend
Administrative & Clerical	10	10	19	4	↘
Allied Health Professionals	2	4	6	3	↘
Medical & Dental	0	2	0	6	↗
Nursing & Midwifery (Qualified)	19	16	27	6	↘
Nursing & Midwifery (Unqualified)	0	1	6	6	↔
Other Additional Clinical Staff	0	0	4	1	↘
Scientific & Technical (Qualified)	1	3	5	0	↘
Whole Trust	**32**	**36**	**67**	**24**	↘

Professional Group	Staff in Post + 1yrs Service	No. of Staff Promoted (12 Months)	% of Staff Promoted	Currently Acting Up	BME % of Prof Group	BME % Promoted
Administrative & Clerical	882	109	12.4%	27	44.0%	44.0%
Allied Health Professionals	228	24	10.5%	10	18.6%	20.8%
Medical & Dental	645	5	0.8%	0	37.0%	20.0%
Nursing & Midwifery (Qualified)	1710	153	8.9%	28	42.2%	26.8%
Nursing & Midwifery (Unqualified)	486	31	6.4%	0	60.0%	58.1%
Other Additional Clinical Staff	121	13	10.7%	1	49.1%	30.8%
Scientific & Technical (Qualified)	235	16	6.8%	7	46.2%	50.0%
Whole Trust	**4307**	**351**	**8.1%**	**73**	**42.6%**	**35.6%**

Section 5: Workforce Benchmarking





COMMENTARY

This benchmarking information comes from iView the Information Centre data warehouse tool.

Sickness data shown is from Feb '17 which is the most recent available on iView. Compared to other Acute teaching trusts in London, Chelwest had a rate just below the average at 3.1%. In the top graph, Trusts A-G are the anonymised figures for this group. The Trust's sickness rate was lower than the national rate for acute teaching hospitals in January.

The bottom graph shows the comparison of turnover rates for the same group of London teaching trusts (excluding junior medical staff). This is the total turnover rate including all types of leavers (voluntary resignations, retirements, end of fixed term contracts etc.). Chelwest currently has higher than average turnover (12 months to end March). Stability is lower than average. High turnover is more of an issue in London trusts than it is nationally which is reflected in the national average rate which is 1.6% lower than Chelwest.

**As with all benchmarking information, this should be used with caution. Trusts will use ESR differently depending on their own local processes and may not consistently apply the approaches. Figures come direct from the ESR data warehouse and are not subject to the usual Trust department exclusions and so on.

Reference Group	Gross Turnover Rate %	Stability Rate %	Sickness Rate %
Trust A	14.77%	84.74%	3.71%
Trust B	15.08%	84.53%	3.11%
Trust C	16.01%	83.58%	3.38%
Trust D	17.34%	82.61%	3.69%
Trust E	18.29%	82.00%	3.29%
Trust F	19.65%	80.44%	3.72%
Trust G	14.99%	84.75%	3.55%
Chelsea & Westminster	16.48%	82.97%	3.19%
Average London Teaching	16.58%	83.20%	3.46%
National Acute Teaching	14.67%	85.20%	4.26%

Section 6: Nursing Workforce Profile/KPIs

Nursing Establishment WTE

Division	Feb '18	Mar '18	Apr '18	May '18	Trend
COR Corporate	89.1	88.1	89.1	89.1	↔
EIC Emergency & Integrated Care	1024.3	1024.3	1022.5	1060.0	↗
PDC Planned Care	711.9	712.0	716.4	716.9	↗
WCH Women's, Children's & Sexual Health	1181.7	1182.4	1189.8	1189.8	↔
Total	**3007.0**	**3006.7**	**3017.8**	**3055.8**	↗

Nursing Staff in Post WTE

Division	Feb '18	Mar '18	Apr '18	May '18	Trend
COR Corporate	86.0	85.0	83.8	83.7	↘
EIC Emergency & Integrated Care	848.2	852.2	861.9	861.3	↘
PDC Planned Care	645.7	651.6	649.6	650.9	↗
WCH Women's, Children's & Sexual Health	1021.2	1024.2	1026.8	1029.6	↗
Total	**2601.0**	**2613.1**	**2622.1**	**2625.6**	↗

Nursing Vacancy Rate

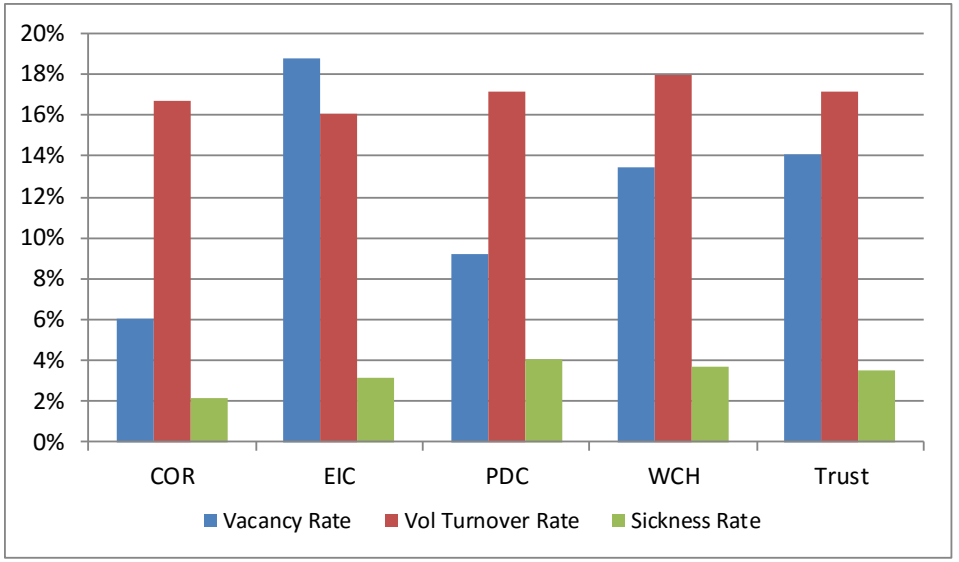
Division	Feb '18	Mar '18	Apr '18	May '18	Trend
COR Corporate	3.5%	3.5%	5.9%	6.0%	↗
EIC Emergency & Integrated Care	17.2%	16.8%	15.7%	18.7%	↗
PDC Planned Care	9.3%	8.5%	9.3%	9.2%	↘
WCH Women's, Children's & Sexual Health	13.6%	13.4%	13.7%	13.5%	↘
Total	**13.5%**	**13.1%**	**13.1%**	**14.1%**	↗

Nursing Sickness Rates

Division	Feb '18	Mar '18	Apr '18	May '18	Trend
COR Corporate	3.7%	4.2%	3.0%	2.2%	↘
EIC Emergency & Integrated Care	3.7%	3.3%	3.3%	3.1%	↘
PDC Planned Care	4.0%	4.0%	3.7%	4.1%	↗
WCH Women's, Children's & Sexual Health	4.4%	3.5%	3.1%	3.7%	↗
Total	**4.5%**	**4.0%**	**3.6%**	**3.5%**	↘

Nursing Voluntary Turnover

Division	Feb '18	Mar '18	Apr '18	May '18	Trend
COR Corporate	17.97%	16.79%	18.44%	16.70%	↘
EIC Emergency & Integrated Care	16.23%	16.71%	16.36%	16.06%	↘
PDC Planned Care	17.52%	16.75%	17.05%	17.16%	↗
WCH Women's, Children's & Sexual Health	18.36%	18.17%	19.06%	18.00%	↘
Total	**17.5%**	**17.3%**	**17.7%**	**17.1%**	↘
West Mid Site	**12.5%**	**12.5%**	**12.1%**	**11.2%**	↘
Chelsea Site	**20.3%**	**20.1%**	**21.0%**	**20.8%**	↘



COMMENTARY

This data shows a more in-depth view of our nursing workforce (both qualified and unqualified combined).

The nursing workforce has increased by 3.4 WTE in May.

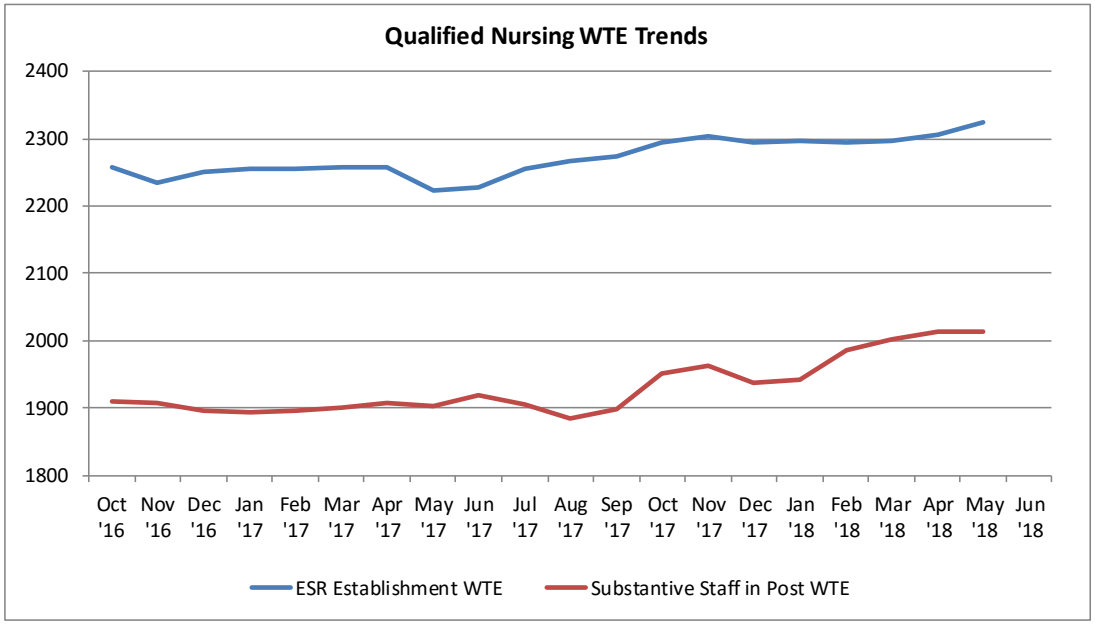
Voluntary Turnover is much higher at the Chelsea site compared to West Mid.

Section 7: Qualified Nursing & Midwifery Recruitment Pipeline

Measure	Jan '18	Feb '18	Mar '18	Apr '18	May '18	Jun '18	Jul '18	Aug '18	Sep '18	Oct '18	Nov '18	Dec '18	Jan '19	Feb '19	Mar '19
ESR Establishment WTE	2296.2	2295.6	2296.0	2306.1	2324.2										
Substantive Staff in Post WTE	1943.3	1985.3	2001.5	2013.4	2012.5										
Contractual Vacancies WTE	353.0	310.3	294.4	292.7	311.7										
Vacancy Rate %	15.37%	13.52%	12.82%	12.69%	13.41%										
Actual/Planned Leavers Per Month*	28	27	23	44	48	34	34	34	34	34	34	34	34	34	34
Actual/Planned New Starters**	34	53	42	50	29	46	40	40	40	40	40	40	40	40	40
Pipeline: Agreed Start Dates						32	21	7	8	31	1	0	0	0	0
Pipeline: WTE No Agreed Start Date						280 with no agreed start date									

* Based on Gross Turnover of 20%

** Number of WTE New Starters required per month to achieve a 10% Vacancy Rate by May 2018



COMMENTARY

This information tracks the current number of qualified nurses & midwives at the Trust and projects forward a pipeline based on starters already in the recruitment process.

May saw more leavers than starters which has resulted in an increase in the vacancy rate. There are 280 nurses in the pipeline without a start date, 73 of which are from overseas.

The planned leavers is based on the current qualified nursing turnover rate of 20% and planned starters takes into account the need to reduce the nursing and midwifery vacancy rate down to 10% by March 2019.

NB Starters & Leavers do not always add up to the change in staff in post due to existing staff changing their hours

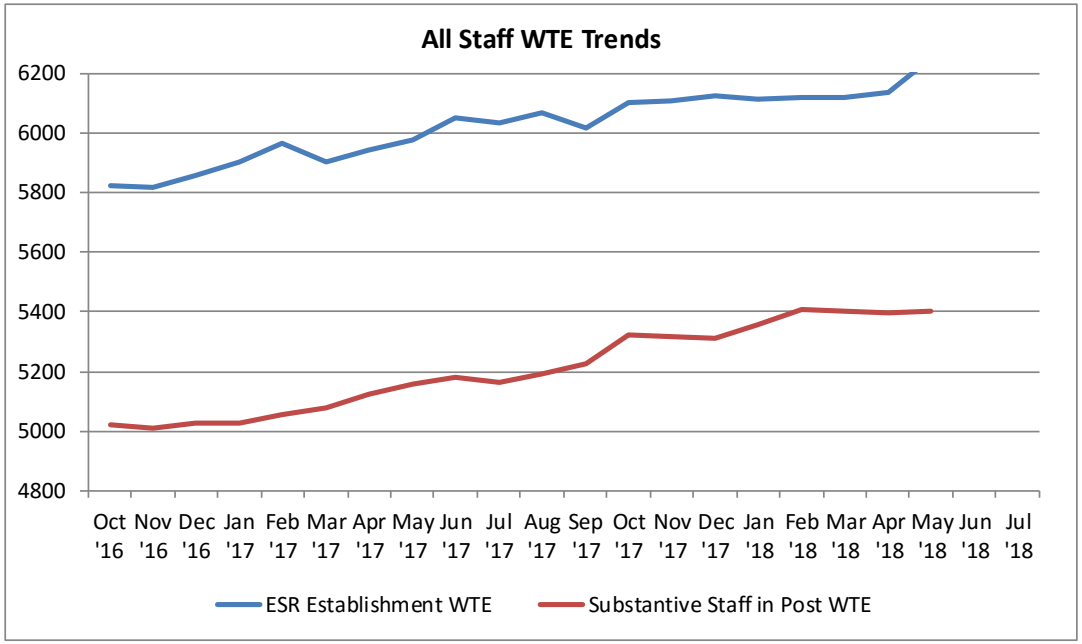
Section 8: All Staff Recruitment Pipeline

Measure	Jan '18	Feb '18	Mar '18	Apr '18	May '18	Jun '18	Jul '18	Aug '18	Sep '18	Oct '18	Nov '18	Dec '18	Jan '19	Feb '19	Mar '19
ESR Establishment WTE[1]	6112.7	6116.2	6120.7	6136.1	6247.6										
Substantive Staff in Post WTE	5354.6	5407.7	5404.9	5398.7	5402.6										
Contractual Vacancies WTE	758.1	708.5	715.7	737.4	845.1										
Vacancy Rate %	12.40%	11.58%	11.69%	12.02%	13.53%										
Actual/Planned Leavers Per Month[2]	71	103	96	131	75	90	90	90	90	90	90	90	90	90	90
Actual/Planned New Starters[3]	124	129	114	126	83	109	101	101	101	101	101	101	101	101	101
Pipeline: Agreed Start Dates						71	55	24	20	31	1	0	0	0	0
Pipeline: WTE No Agreed Start Date						503 with no agreed start date									

[1] Doctors in Training are included in the Establishment, Staff in Post and Actual Starters/Leavers figures

[2] Based on Gross Turnover of 20%

[3] Number of WTE New Starters required per month to achieve a 10% Vacancy Rate by May 2018



COMMENTARY

This information tracks the current number of staff at the Trust and projects forward a pipeline based on starters already in the recruitment process.

The planned leavers is based on the current qualified nursing turnover rate of 20% and planned starters takes into account the need to reduce the vacancy rate down to 10% by March 2019.

NB Starters & Leavers do not always add up to the change in staff in post due to existing staff changing their hours. Staff becoming substantive from Bank may also not be reflected

Section 9: Agency Spend

COR Corporate

Corporate	Feb '18	Mar '18	Apr '18	May '18	YTD
Actual Spend	£143,845	£204,960	£157,047	£224,261	£381,308
Target Spend	£210,631	£210,150	£0		
Variance	-£66,786	-£5,190	£157,047	£224,261	£224,261
Variance %	-31.7%	-2.5%	0.0%	0.0%	0.0%

EIC Emergency & Integrated Care

Emergency & Integrated Care	Feb '18	Mar '18	Apr '18	May '18	YTD
Actual Spend	£588,256	£770,487	£595,862	£651,242	£1,247,104
Target Spend	£509,252	£508,087	£0		
Variance	£79,004	£262,400	£595,862	£651,242	£651,242
Variance %	15.5%	51.6%	0.0%	0.0%	0.0%

PDC Planned Care

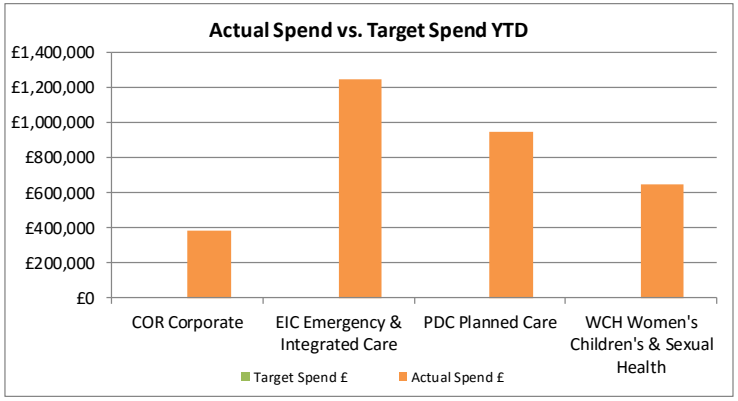
Planned Care	Feb '18	Mar '18	Apr '18	May '18	YTD
Actual Spend	£484,656	£637,825	£554,818	£395,358	£950,176
Target Spend	£342,547	£341,763	£0	£0	£0
Variance	£142,109	£296,062	£554,818	£395,358	£395,358
Variance %	41.5%	86.6%	0.0%	0.0%	0.0%

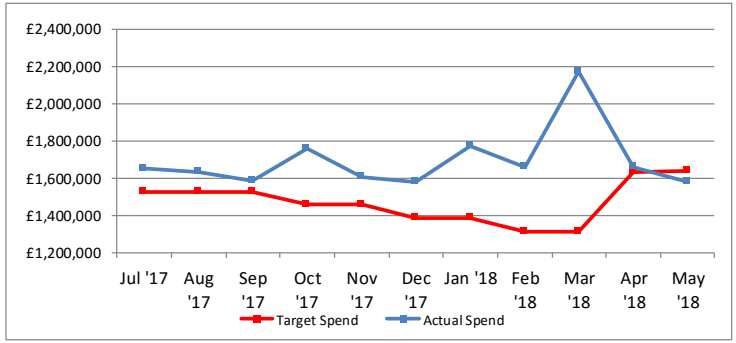
WCH Women's, Children's & Sexual Health

Women's, Children's & Sexual Health	Feb '18	Mar '18	Apr '18	May '18	YTD
Actual Spend	£444,066	£558,385	£347,708	£301,186	£648,894
Target Spend	£249,570	£248,999	£0		
Variance	£194,496	£309,386	£347,708	£301,186	£301,186
Variance %	77.9%	124.3%	0.0%	0.0%	0.0%

Clinical Divisions and Corporate Areas

Trust	Feb '18	Mar '18	Apr '18	May '18	YTD
Actual Spend	£1,660,823	£2,171,657	£1,655,435	£1,575,411	£3,230,846
Target Spend	£1,312,000	£1,308,999	£1,634,000	£1,635,000	£1,635,000
Variance	£348,823	£862,658	£21,435	-£59,589	-£59,589
Variance %	26.6%	65.9%	1.3%	-3.6%	97.6%





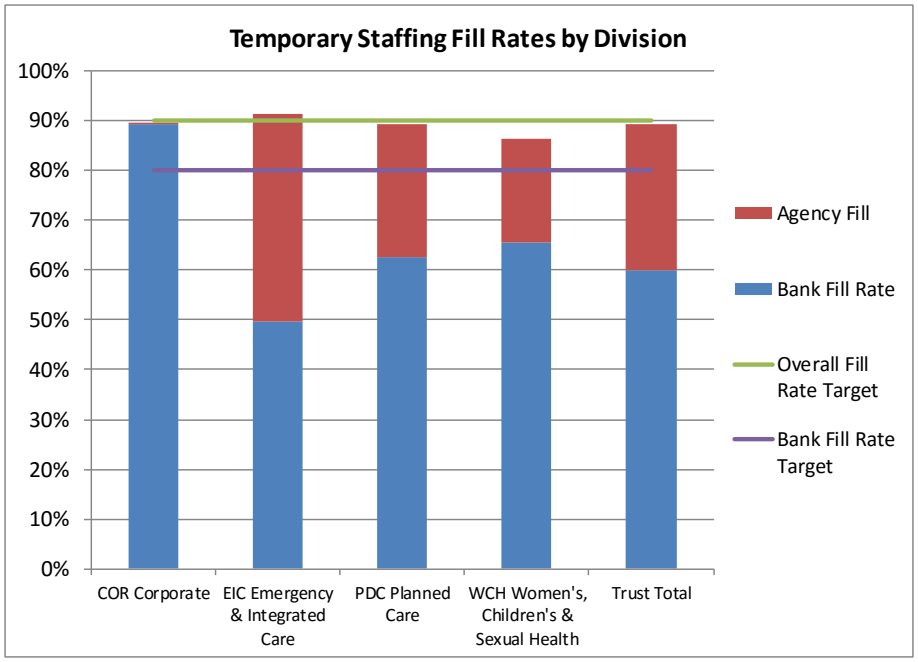
COMMENTARY

These figures show the Trust agency spend by Division. Spend ceilings by Division have not yet been set for 18/19.

In Month 2, the trust went over the total target spend by 0.3% which represents a 1% decrease in over target spending. The highest spend was in the Emergency and Integrated Care Division.

** please note that the agency cap plan figures are phased differently in the NHSI monthly returns. This summary shows performance against the equally phased plan.*

Section 10: Temporary Staff Fill Rates



COMMENTARY

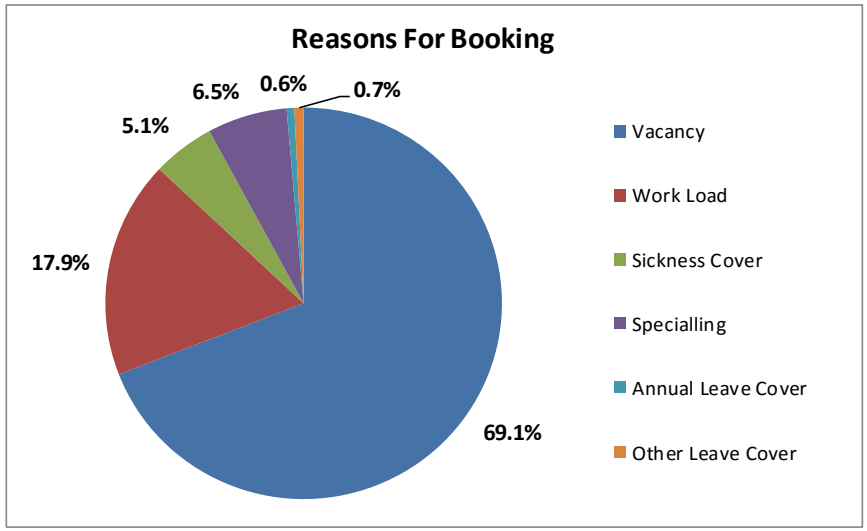
The “Overall Fill Rate” measures our success in meeting temporary staffing requests, by getting cover from either bank or agency staff. The remainder of requests which could not be covered by either group are recorded as being unfilled. The "Bank Fill Rate" describes requests that were filled by bank staff only, not agency.

The Overall Fill Rate was 89.3% this month which is a 2.95% increase since April. The Bank Fill Rate was reported at 59.9% which is 6.2% lower than the previous month. The EIC Emergency & Integrated Care is currently meeting the demand for temporary staff most effectively.

The Bank to Agency ratio for filled shifts was 67:33. The Trust target is 80:20.

The pie chart shows a breakdown of the reasons given for requesting bank shifts in April. This is very much dominated by covering existing vacancies, workload and other leave.

This data only shows activity requested through the Trust's bank office that has been recorded on HealthRoster and Locum Tap.



Overall Fill Rate % by Division	Feb '18	Mar '18	Apr '18	May '18	Trend
COR Corporate	79.9%	81.7%	85.1%	89.6%	↗
EIC Emergency & Integrated Care	85.0%	83.5%	86.3%	91.5%	↗
PDC Planned Care	87.4%	86.1%	87.3%	89.4%	↗
WCH Women's, Children's & Sexual Health	83.2%	83.1%	85.6%	86.3%	↗
Whole Trust	**85.0%**	**84.1%**	**86.4%**	**89.3%**	↗

Bank Fill Rate % by Division	Feb '18	Mar '18	Apr '18	May '18	Trend
COR Corporate	76.0%	76.2%	80.7%	89.3%	↗
EIC Emergency & Integrated Care	57.3%	56.2%	60.1%	49.7%	↘
PDC Planned Care	70.6%	69.0%	70.0%	62.6%	↘
WCH Women's, Children's & Sexual Health	61.8%	62.7%	67.1%	65.6%	↘
Whole Trust	**63.7%**	**62.9%**	**66.1%**	**59.9%**	↘

Section 11: Core Training

Core Training Topic	Apr '18	May '18	Trend
Basic Life Support	82.0	82.0	↔
Conflict Resolution	90.0	91.0	↗
Equality, Diversity and Human Rights	92.0	92.0	↔
Fire	89.0	90.0	↗
Health & Safety	95.0	95.0	↔
Inanimate Loads (M&H L1)	89.0	93.0	↗
Infection Control (Hand Hyg)	92.0	87.0	↘
Information Governance	85.0	90.0	↗
Patient Handling (M&H L2)	67.0	70.0	↗
Safeguarding Adults Level 1	94.0	94.0	↔
Safeguarding Children Level 1	91.0	93.0	↗
Safeguarding Children Level 2	77.0	80.0	↗
Safeguarding Children Level 3	85.0	83.0	↘

COMMENTARY

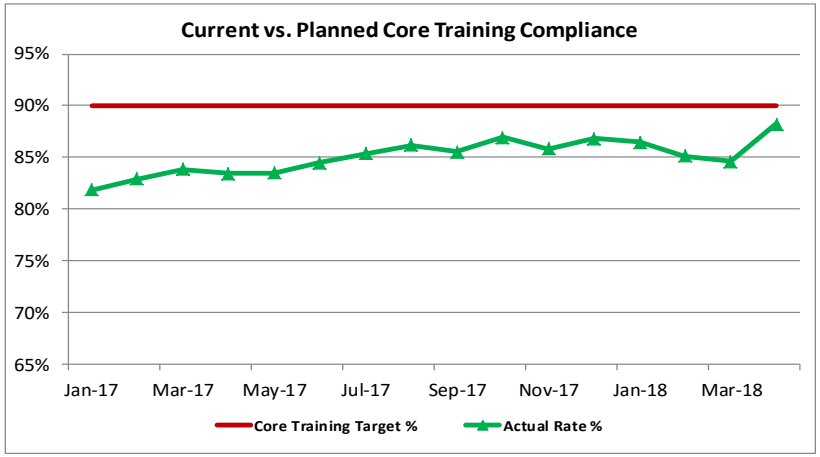
Compliance continues on an upward trend, now at 89%.

Moving & Handling (Patient-Handling) has started to recover its position following last month's drop which resulted from aligning the requirements at WMUH to CW and national (best practice) guidelines. The delivery of a significant number of sessions at WMUH have had an immediate impact, and it is anticipated that the number of staff trained at WMUH will average 40 per week over the next 3 months which will show a positive impact on the compliance figure.

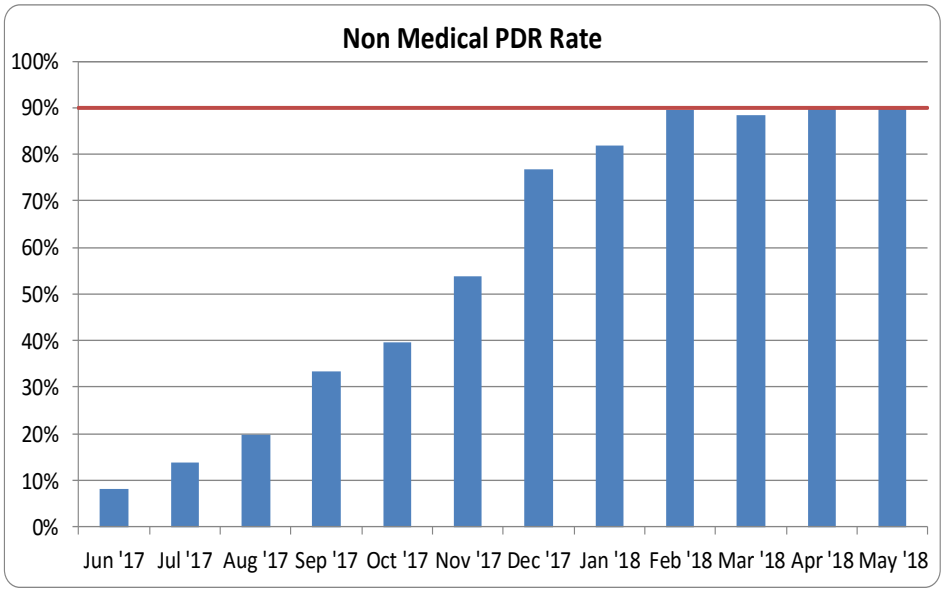
The largest improvement this month has been Information Governance (up 5%) due to the continued drive from senior management, the restriction of system access for new staff unless they complete IG training, the impact on both study leave requests and incremental steps through the PDR process.

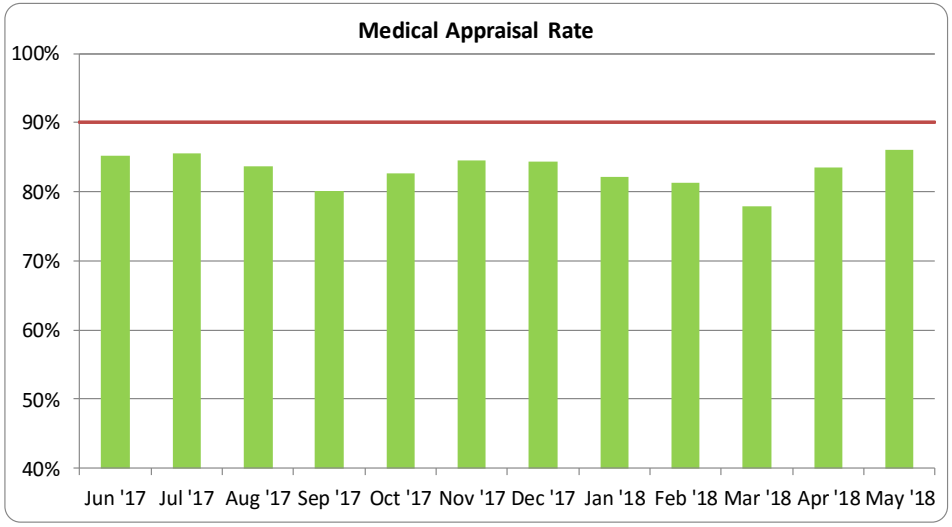
Two Divisions have now achieved the minimum 90% compliance requirement, with a third (Planned Care) expected to achieve this during the coming month.

Core Training Compliance % by Division	Feb '18	Mar '18	Apr '18	May '18	Trend
COR Corporate	86.0%	91.0%	94.0%	94.0%	↔
EIC Emergency & Integrated Care	85.0%	82.0%	85.0%	87.0%	↗
PDC Planned Care	84.0%	84.0%	88.0%	89.0%	↗
WCH Women's Children's & Sexual Health	84.0%	86.0%	90.0%	90.0%	↔
Whole Trust	**85.0%**	**85.0%**	**88.0%**	**89.0%**	↗



Section 12: Performance & Development Reviews





PDR Compliance

Non Medical PDRs by Division	Feb '18	Mar '18	Apr '18	May '18	Trend
COR Corporate	90.9%	90.3%	92.8%	94.0%	↗
EIC Emergency & Integrated Care	91.6%	89.0%	91.4%	88.3%	↘
PDC Planned Care	89.5%	88.9%	89.6%	90.1%	↗
WCH Women's, Children's & Sexual Health	87.8%	86.6%	87.6%	89.5%	↗
Whole Trust	**89.6%**	**88.4%**	**89.8%**	**89.9%**	↗

Medical Appraisals

Medical Appraisals by Division	Feb '18	Mar '18	Apr '18	May '18	Trend
COR Corporate	-	-	-	-	-
EIC Emergency & Integrated Care	84.1%	89.4%	86.9%	87.0%	↗
PDC Planned Care	77.3%	72.1%	82.0%	85.0%	↗
WCH Women's, Children's & Sexual Health	83.4%	76.7%	83.0%	87.0%	↗
Whole Trust	**81.3%**	**77.9%**	**83.6%**	**86.0%**	↗

Non-Medical Commentary

From May ’18 the PDR compliance rate include staff who have been working at the Trust 12 months or more. It increased by 0.11% in May and now stands at 89.88% which is just below the Trust target of 90%.

Medical Commentary

The appraisal rate for medical staff was 86.6%, 2.43% higher than last month.

Board of Directors Meeting, 5 July 2018

PUBLIC SESSION

AGENDA ITEM NO.	2.5/Jul/18
REPORT NAME	Reducing Sugar Sweetened Beverages
AUTHOR	Marie Courtney, Deputy Director of Estates and Facilities
LEAD	Karl Munslow-Ong, Deputy Chief Executive
PURPOSE	For information and Board approval
SUMMARY OF REPORT	This paper outlines the actions taken to achieve the targeted reduction in the sale of Sugar Sweetened Beverages and achieve the CQUIN indicator 1B – Healthy food for NHS Patients, Visitors and Staff.
KEY RISKS ASSOCIATED	Failure to adhere to CQUIN indicator 1B
FINANCIAL IMPLICATIONS	Loss of CQUIN funding from the local commissioner
QUALITY IMPLICATIONS	None
EQUALITY & DIVERSITY IMPLICATIONS	None
LINK TO OBJECTIVES	Improve population health outcomes and integrated care
DECISION/ ACTION	The Board to approve actions taken as part of our commitment to CQUIN indicator 1B.

Commitment to CQUIN Indicator 1B – Healthy food for NHS Patients, Visitors and Staff

Introduction

This paper has been written to inform the Trust Board of the action the Trust have taken to support NHS England's scheme to try and reduce the sale of Sugar Sweetened Beverages on NHS premises as part of nationwide public health initiative.

This approach is now also supported by the 18/19 CQUIN, which requires all hospitals to be signed up to the scheme and achieving the 10% target to be eligible for full CQUIN payments.

Summary

NHS England have had a positive response to this initiative from most of the Trusts across the country, including Chelsea and Westminster Hospitals FT. NHS England are now planning to provide a public statement on progress and next steps around this strategy.

The Trusts estates and facilities team have been working closely with the Trusts Soft FM provider, ISS, are firmly committed to delivering the outcomes of this CQUIN (indicator 1B) being a leading NHS partner in the delivery of healthier catering for patients, visitors and staff to ensure the Trust is seen as a supporter of this initiative are firmly committed to delivering the outcomes of this CQUIN (indicator 1B)

The Trust have recently signed an agreement to commit to reduce the volume sales of sugar-sweetened beverages on its premises. The commitment includes:

- A reduction in the total volume of monthly sugar sweetened beverage sales per outlet, aiming for a target of 10% or less volume of drinks sales.
- Providing a quarterly report on progress to NHS England which comprises total monthly beverage sales on a site by site/outlet by out basis.

ISS and other partners are firmly committed to delivering the outcomes of this CQUIN in the delivery of healthier catering for patients, visitors and staff.

Recommendation

Members of the Trust Board are requested to note the important public health commitments that the Trust are making and the corresponding actions to ensure the Trust also receive the full CQUIN payment as a result of ensuring the target reduction in the sale of Sugar Sweetened Beverages.

1.0 Gender Pay Gap

Gender pay reporting legislation requires employers with 250 or more employees from April 2017 to publish statutory calculations every year showing how large the pay gap is between their male and female employees. The results must be published on both the employer's website and the government website https://gender-pay-gap.service.gov.uk/Viewing/

1.1 Gender Pay Reporting is different to Equal Pay

Equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the difference in the average pay between all men and women in the workforce.

The NHS terms and conditions of service handbook contain the national agreements on pay and conditions of service for NHS staff other than very senior managers and medical staff.

Job evaluation enables non-medical jobs to be matched to national job profiles and allows Trusts to evaluate jobs locally to determine in which Agenda for Change (AfC) pay band a post should sit.

1.2 What are The Gender Pay Gap Indicators

An employer must publish six calculations showing their:

1. Average gender pay gap as a mean average
2. Average gender pay gap as a median average
3. Proportion of males and females when divided into four groups ordered from lowest to highest pay.
4. Average bonus gender pay gap as a mean average
5. Average bonus gender pay gap as a median average
6. Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment

What Is the Mean?
The mean is average of all staff

What Is the Median?
The median is ranking all staff in order (highest to lowest) and looking at the staff in the middle

1.3 Chelsea & Westminster Workforce

The snapshot date for the purposes for the gender pay gap report is 31st March 2017. As at 31st March 2017 the total relevant paid workforce was **5681** across all sites and staff groups.

The gender split of the workforce as at 31st March 2017

Table 1. Gender split of workforce

Gender	Numbers of staff	
Male	1378	24.26 % of the total workforce
Female	4303	75.74 % of the total workforce

The Average and Median Hourly Rates:-

Table 2. Average & Median Hourly rates

Gender	Avg. Hourly Rate	Median Hourly Rate
Male	25.07	21.29
Female	19.87	17.82
Difference	5.20	3.47
Pay Gap %	20.75%	16.30%

The above is for **all** staff groups (including medical staff and senior management) and also includes all bank only workers who were paid in the pay week of 31st March 2017. This shows that overall there is a 21% pay gap in average pay between male and female staff and a 16% pay gap in the median hourly rate.

This data can also be reviewed by staff group as per the table below:-

Table 3. Average Hourly rates by staff group

Row Labels	Admin and clerical	AHP's	Medical and Dental	Nursing and Midwifery Reg	Nursing and Midwifery (unqualified)	Other Additional Clinical Staff	Scientific and Technical	Grand Total
Male	19.22	21.67	37.71	20.78	12.25	13.67	18.93	25.07
Female	15.76	20.66	33.00	19.84	12.01	13.46	20.22	19.87
Pay Gap %	18.02%	4.63%	12.49%	4.53%	1.98%	1.58%	-6.83%	20.75%
Higher Figure	Male	Male	Male	Male	Male	Male	Female	Male

This shows that the pay gap difference where male employees receive a higher average hourly rate is within all staff groups aside from scientific and technical. The total pay gap % is larger than the individual staff groups % because of the significantly higher hourly rate within the medical and dental workforce.

The below table shows the proportion of males and females when divided into four groups ordered from lowest to highest pay:-

Table 4.Quartile pay by Gender

Quartile	Female	Male	Female %	Male %
Lower	1086	341	76.1	23.9
Lower Middle	1187	236	83.4	16.6
Upper Middle	1160	259	81.8	18.2
Upper	870	542	61.6	38.4

The below tables shows the average bonus Gender Pay gap:-

Table 5. Average & Median Bonus pay

Gender	Avg. Pay	Median Pay
Male	16,115.61	10,496.78
Female	10,967.37	7,160.60
Difference	5,148.24	3,336.18
Pay Gap %	31.95	31.78

For the purpose of this report the bonus payments referred to are those made to medical staff in the form of Clinical Excellence Awards or Discretionary Points

Table 6. Quartile bonus payments by gender

Quartile	Female	Male	Female %	Male %
Lower	22	28	44.00	56.00
Lower Middle	27	23	54.00	46.00
Upper Middle	21	29	42.00	58.00
Upper	11	30	26.83	73.17

The above shows the proportion of males and females receiving a bonus payment.

2.0 Gender Pay Gap Benchmarking & Analysis

As at 31st March 2018, 242 NHS organisations (including organisations such CCG's, NHS Professionals, NHS Property and Health Education England) had submitted their data.

2.1 Average gender pay gap as a mean average

Of the 242 NHS organisations who have reported, the Trust is shown at 111 with a mean average pay gap of 21% in favour of male employees.

In terms of other London Trusts there is a similar picture in terms of the mean average pay gap with Guy's & St Thomas' NHS Foundation Trust at 16.5%, The Royal Free London NHS Foundation at 17.7% and Imperial College Healthcare NHS Trust at 18.7%. The Trust with the largest average pay gap both in London and nationally is North East London NHS Foundation Trust who are currently reporting a 41% pay gap in favour of male employees.

Whilst most NHS orgsniations on this list have gaps that favour men, some have pay gaps that favour women including Poole Hospital NHS Foundation Trust where women's mean pay is show as 9.4 % higher and Liverpool Community Health NHS Trust where this is shown as 1.8% in favour of female employees.

2.2 Average gender pay gap as a median average

The Trusts median average pay gap is 16.3 in favour of male employees which places the Trust at 199.

Based on this the Trusts median pay gap is less positive than the majority of other London Trusts with Guy's & St Thomas' NHS Foundation Trust at 10.7% and both The Royal Free London NHS Foundation and Imperial College Healthcare NHS Trust at 13.3%.

2.3 Average bonus gender pay gap as a mean average

In terms of the mean average bonus pay gap the Trust has reported a 31.9% gap in favour of male employees placing us at 135 on the list.

There are four NHS organisations reporting a 100% mean average bonus pay gap in favour of males including Hounslow and Richmond Healthcare NHS Trust and West Midlands Ambulance Service NHS Foundation Trust.

In this calculation around 30 NHS organisations report mean average bonus pay gap in favour of female employees, including Guy's & St Thomas' NHS Foundation Trust (+1%) and North Middlesex University Hospital NHS Trust (+8.6%) A further 32 NHS organisations show no difference in the average bonus pay for male and female employees in bonus pay bet at all.

2.4 Average bonus gender pay gap as a median average

The Trust median bonus pay gap is 31.7% in favour of male employees meaning we are at 116 out of 242 in the list of NHS organisations.

The same four NHS organisations who have reported a 1005 mean average bonus also report the same for their median.

There are also around 70 NHS organisations reporting a median average bonus pay gap in favour of female employee or with no difference at all.

For this calculation in terms of London, whilst a number of London Trusts report a smaller median bonus pay gap, others such as Bart's Health NHS Trust (33.3%), Great Ormond Street Hospital NHS Foundation Trust (44.6%) and Imperial College Healthcare NHS Trust (40%) all show a higher median bonus pay gap with a figure of 40% in favour of male employees.

3.0 Gender Pay Gap Trust Analysis

The first point to note is that the reference point used for the gender pay gap report (31st March 2017) was also the first month in which the two payrolls of Chelsea & Westminster Hospital and West Middlesex Hospital, which had been separate up to that month, merged into one. Therefore this may have meant that there may have been some slight anomalies which the data.

The gender pay gap analysis also does not take into account age or length of service (either at the Trust or other NHS organisations) which is important when considering that the majority of staff are paid on incremental pay scales that means their salaries increase on an annual basis.

The data has been reviewed based on the individual staff groups based on the reported gender pay gap to develop an understanding of the drivers of the gap to help determine the most appropriate actions.

3.1 Administrative & Clerical

In this group an 18% pay gap in favour of male employees is shown, which is the highest gap of all of the staff groups even though there are more females that males employed in these roles.

The analysis for this group of staff shows that for the majority of pay bands, the pay gap on average is in favour of females. However this changes particularly in the higher pay bands (bands 8d and 9) where the pay gap is in favour of male employee despite the fact there are fewer males than females in post at this level.

On further analysis of this staff group the data is skewed by a number of secondment agreements the Trust has in place to employ staff on behalf of other organisations. With these posts excluded pay gap is significantly reduced although there remains a marginally gap in favour of male employees.

3.2 Medical staff

The pay gap across the Medical and Dental staff group is 12.49%. Based on the data, the Trust has more female than male medical staff overall in the Trust at the time of the report, including all junior level posts and non-training grades.

However at Consultant level there are more male Consultants than there are females. It is also interesting to note that when looking at length of service there are considerably more male Consultants, than female who have been employed in the Trust for 10 years or more meaning it is likely their basic salary would be higher.

The analysis across the medical workforce actually shows that in the junior medical grades the pay gap is in favour of females, however this reverses as careers progress and when including the more senior grades (shown here as ST3+ and Consultant level) the pay gap is overall in favour of males. Whilst this may be in part due to the issue of Consultant length of service it is less clear why this gap exists in the ST3+ level (where the average gap appears to be that male employees received around £0.72 more per hour).

3.3 AHP's

The pay gap for this staff group is 4.63% and from the analysis of this this shows the overall pay gap is marginally in favour of males across 6 of the 11 pay bands despite the fact the majority of the workforce is female.

The largest pay gap in favour of males appears at the Band 7 level, where there are also slightly more male employees than appear at any other AHP grade.

3.4 Nursing and Midwifery (Qualified)

The nursing and midwifery (qualified) staff group is the single biggest staff group in the Trust with female staff making up almost 90% of this. However overall the pay gap for this staff group is shown as 4.53% in favour of male employees.

From reviewing this at a pay band by pay band level, there is a marginal pay gap in favour of male employees at both Band 5 and Band 6 level. The data shows that of the male employees at this grade a high proportion of them are paid towards the top end of their pay band which may be linked to length of service or service from another Trust.

There is also a gap in favour of males at band 8a and 8c, although at bands 8b and 8d the gap is in favour of females.

3.5 Bonus pay gap

As has been highlighted earlier in this report the bonus payments referred to are those made to medical staff in the form of Clinical Excellence Awards (CEA) or Discretionary Points.

Clinical Excellence Awards recognise and reward NHS consultants who perform 'over and above' the standard expected of their role. There are 12 Levels of award with Levels 1-8 being awarded locally (employer based awards) and Levels 10-12 (Silver, Gold and Platinum) being awarded nationally. Level 9 Awards in England can be awarded locally as employer based awards or nationally as Bronze. Those who are eligible to apply are Consultants who are substantive and who have at least one year in service at the time to applications process opens. It is up to individual Consultants if they choose to apply and once a CEA is awarded the Consultant will continue to receive the payment associated with this level until they retire or claim their pension. Those in receipt of a CEA can also apply for the next level of award in any following year.

The data shows that of the 192 Consultants, who received a bonus in March 2017, 85 of these were female and 107 were male. At every level aside from CEA level 3, more males than females are in receipt of a CEA.

In 2017 58 Consultants applied for a CEA of which 27 were female (53% of applications) and 31 (47% of applications) were male. Of these 23 female Consultants were successful and 19 male Consultants were successful. This was similar to the 2016 cycle.

This demonstrates that there does not appear to be a current issue with female Consultants applying for and receiving CEA awards. However based on what we know about length of service the difference in bonus pay may stem from the fact generally male Consultants have a longer length of service in the Trust and therefore will have had more years in which to apply for these awards.

4.0 Gender Pay Gap Actions

Following the above analysis and benchmarking undertaken following the publication of the Gender Pay gap report a number of actions have been agreed with the People & Organisational Development Committee.

1. The gender pay gap report would be shared with and discussed at the next Partnership forum. This was discussed with Staffside representatives at the June Partnership Forum.

2. The women's group within the Trust will be re-launched and will look at issues which may be influencing the gender pay gap. The CFO is meeting with the group chair in July.

3. Review of the appointment process to ensure the integrity of the agenda for change pay progression. This will include gender monitoring of applications to deviate from Agenda for Change policy.

4. The constitution of the clinical excellence panel will be reviewed and if required rebalanced for the 2018/19 process.

5. The detailed analysis of the gender pay gap will be used to develop an informative report which will be shared with staff. This will then be used as the reporting format for future years gender pay gap reports.

5.0 Action required

The Board is asked to:

- Note the reported Gender pay gap
- Note the benchmarking and analysis that the HR team have undertaken to develop the Trusts understanding of our position.
- Note the actions agreed with P&OD committee to start to address the gender pay gap.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 5 July 2018

PUBLIC SESSION

AGENDA ITEM NO.	4.1/Jul/18
REPORT NAME	People and Organisational Development Committee Terms of Reference
AUTHOR	Julie Myers, Company Secretary
LEAD	Sandra Easton, Chie Financial Officer
PURPOSE	To maintain good governance.
SUMMARY OF REPORT	Revised Terms of Reference for the People and Organisational Development Committee are attached for approval.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	None.
LINK TO OBJECTIVES	All
DECISION/ ACTION	For approval.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

People and Organisational Development Committee
Terms of Reference

1. Constitution

The People and Organisational Development Committee (PODC) is established as a sub-committee of Chelsea ~~&~~ and Westminster Hospital NHS Foundation Trust (CWFT) Board of Directors.

The ~~People and Organisational Development Committee~~PODC is authorised by the Board of Directors to act within its terms of reference. In doing so, it may instruct professional advisors and request the attendance of individuals and authorities from outside its membership and the Trust with relevant experience and expertise if it considers this necessary for or expedient to the fulfilment of its functions.

The ~~People and Organisational Development Committee~~PODC will review these Terms of Reference at least annually (or more frequently, as may be required) as part of a self-assessment of its own effectiveness.

2. Authority

The ~~People & Organisational Development Committee~~PODC is directly accountable to the Board of Directors**.**

3. Aim

3.1 Strategic Aims

The vision for the Trust is to deliver excellent experience and outcomes for our patients and be the employer of choice. Supporting this are a number of strategies including quality and clinical services. The People and Organisational Development Strategy is as follows;

"We aim to have a workforce that puts patients first, ~~are~~ is responsive and supportive to our patients and each other, ~~are~~ is open, welcoming and honest, ~~are~~ is unfailingly kind, respectful and compassionate, treating our patients with dignity. We are also determined to develop the skills of our people. This will ensure we achieve our objectives of providing the best quality care and become an employer of choice."

3.2 Specific Aims

To provide the Trust Board of Directors with assurance on matters related to its staff, and the development thereof to the highest standards and that there are appropriate processes in place to identify any risks and issues and manage them accordingly. It is also there to ensure opportunities are not missed and are capitalised upon for the benefit of patients, our people ~~&~~ and the organisation.

In particular, the Committee will consider the following work areas:

- People and Organisational Development Strategy and planning (including recruitment and retention)

- Leadership development and talent management
- Education, sSkills and capability (clinical and non-clinical, statutory and mandatory)
- Performance, reward and recognition
- Culture, values and engagement
- Health and well-being

4. Objectives

4.1 To ensure the Trust's People & and Organisational Development Strategystrategies and& plans link into the Trust's overall objectives & and reflect the culture & and values of the organisation we aspire to be.

4.2 To have oversight of the Trust's People and Organisational Development Sstrategy and plan.

4.3 To consider matters referred to the People and Organisational Development CommitteePODC by its sub-groups and by other Trust Committees; in particular, matters raised by the Improvement Board Efficiency Board relating to the management of people through the Cost Improvement Programme (CIP) and transformation agendas.

4.4 To ensure the trusts Employee Value Proposition is fit for purpose

4.3.1 In relation to: **PEOPLE STRATEGY AND PLANNING**

- To ensure that the Trust has a robust People Strategy and that it, and the associated plans, are aligned and focussed on meeting the needs of the Trust's strategic priorities including the Clinical Strategy.

- To ensure that the organisation has a grip on critical workforce issues such as people in posts, time to fill, retention & and essential training.

- To set and monitor the Key Performance Indicators (KPIs) relating to staff.

- To ensure that appropriate recruitment and retention strategies are in place.

4.3.2 In relation to: **LEADERSHIP DEVELOPMENT AND TALENT MANAGEMENT**

- To oversee the identification, nurturing and development of leaders within the organisation; to establish and monitor the strategy for leadership development in the Ttrust.

- To ensure that the Ttrust is developing an appropriate process to manage its succession planning and talent management.

4.3.3 In relation to: **EDUCATION, SKILLS AND CAPABILITY**

- Have oversight of the education agenda in the context of the future strategy.

- Have oversight of the annual training needs analysis including rationalisation of requirements to fit the funding allocation.

- Have an overview of the process to identify skills and competency development required for staff to meet the changing needs of the organisation providing appropriate training as required within national and local budgets.

- To keep under review the Trust's general skill mix/balance and workforce capacity/capability, identifying key strengths as well as 'skills gaps', taking action to address such gaps, as appropriate.

- To receive the annual educational cost collection report and note its contents.

- To receive reports on apprenticeships and progress to meeting national standards.

- To receive reports on educational quality performance and national trainees surveys and associated action plans.

- Set the objectives for the Education Strategy Board and receive regular progress reports.

4.3.4 In relation to: **PERFORMANCE, REWARD AND RECOGNITION**

- To ensure that performance, reward and recognition policies support the Trust's overarching people (recruitment, development ~~&~~ and retention) strategy.

- To receive and review reports to give assurance that key workforce policies are being appropriately applied and to make recommendations to change policy as appropriate.

- To review and scrutinise the effectiveness of risk mitigation plans, based upon the people risks detailed within the Risk Assurance Framework.

- To ensure the Trust acts with speed where inappropriate behaviour or performance is identified.

4.3.5 In relation to: **CULTURE, VALUES AND ENGAGEMENT**

- To ensure strategies are in place that engage the Trust's people in understanding the vision for the organisations future.

- To oversee the embedding of the Trust's organisational values within all aspects of the Trust's people strategies, policies and procedures, ensuring a 'golden thread' and ensure ~~during the acquisition & integration process~~ they are embedded ~~in the new~~across the organisation.

- To ensure the review of the annual NHS staff survey results and monitor the associated action plans.

- To receive and review reports to provide assurance that appropriate and effective policies and practices are in place to meet the Trust's obligations to encourage, support and protect its staff in raising concerns about the safe and proper running of the Trust.

- To receive reports to provide assurance that the Trust is meeting its legal duty to promote workforce equality and combat unlawful discrimination.

- To receive reports on progress towards the Trust's commitment to support the health and wellbeing of its staff. To ensure the review of the staff Friends and Family Test and monitor associated action plans.

4.3.6 **Other**

- To scrutinise and provide assurance to the Board of Directors on the Trust's compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; and The Care Quality Commission (Registration) Regulations 2009 (as amended) in so far as they relate to the aims and objectives of the Committee

- To scrutinise and provide assurance on the self-certification to NHS Improvement of: Continuity of services condition 7 - Availability of Resources; and the Corporate Governance Statement in so far as they relate to the aims and objectives of the Committee

5. Method of working

5.1 The ~~People and Organisational Development Committee~~PODC will have a standard agenda, but on occasion, the meetings will address a strategic issue so will not conform to the standard agenda. At every meeting, the following item headings will be on the agenda:

1. Apologies for absence
2. Declarations of Interest
3. Minutes of the previous meeting
4. Business to be transacted by the Committee
5. Key Performance Indicators/Performance report
6. Review of organisational P&OD priorities
7. Any Other Business
8. Date of next meeting

5.2 All minutes of the ~~People and Organisational Development Committee~~PODC will be presented in a standard format. All meetings will receive an action log (detailing progress against actions agreed at the previous meeting) for the purposes of review and follow-up.

6. Membership

6.1 The membership of the ~~People and Organisational Committee~~PODC shall consist of:

- 1 Non-Executive Director who will Chair the meeting
- 2 Additional Non-Executive Directors
- Chief Executive or suitable deputy
- ~~Director of HR or suitable deputy~~Executive Director responsible for HR or suitable deputy
- Medical Director or suitable deputy
- Chief Nurse or suitable deputy
- Chief Operating Officer or suitable deputy
- ~~Associate Director of HR – Resourcing and People Planning~~
- ~~Assistant Director of Learning & Organisational Development~~
- ~~One Hospital~~ Director of Nursing (WM~~one from either site~~)
- Company Secretary or suitable deputy

- Director of Communications

6.2 The CEO, ~~Director of HR~~Executive Director with responsibility for HR, Medical Director and Chief Operating Officer must send a deputy in their absence.

7. Quorum

7.1 The ~~People and Organisational Development~~ Committee will be deemed quorate to the extent that the following members are present:

- Two Non-Executive Directors (one of whom may be the Chair of the Committee)
- Two Executive Directors or suitable deputies
- Either the ~~Director of HR~~Executive Director with responsibility for HR ~~or Deputy Director of HR~~Chief Nurse

8. Frequency of meetings

8.1 Meetings shall be held ~~six~~ ten times per year.

8.2 Urgent items may be handled by email or via conference call.

8.3 Members are expected to attend a minimum of 75% of all meetings within one year.

9. Secretariat

9.1 Minutes and agenda to be circulated by the ~~Trust Secretary or deputy~~Board Governance Manager.

10. Reporting Lines

10.1 The ~~People and Organisational Development Committee~~PODC will report to the Board of Directors after each meeting. The minutes of all meetings of the ~~People and Organisational Development Committee~~PODC shall be formally recorded and submitted as a draft to the next Board.

10.2 Matters of material significance in respect of people issues will be escalated to the following meeting of the Board of Directors. However, any items that require urgent attention will be escalated to the Chief Executive and Chairman at the earliest opportunity and formally recorded in the ~~People and Organisational Development Committee~~PODC minutes.

10.3 The following groups shall report to the People and Organisational Development Committee:

- Education Strategy Board
- Workforce Development Committee
- Health and Well-being Committee ~~(from autumn 2017)~~
- Partnership forum (for the purposes of policy approval only)

Other groups may be invited to report into or attend the meeting on an ad hoc basis.

10.4 The above groups will report as per the ~~People and Organisational Development Committee~~PODC ~~Workplan~~forward plan, and also at times when requested by the ~~People and Organisational Development~~ Committee. The reports provided by the groups should be in written format unless agreed by the C~~c~~hair.

10.5 The above groups Terms of Reference and the Committee's effectiveness will be reviewed by the ~~People and Organisational Development~~ Committee annually. Any recommended changes to the Terms of Reference, will require Board of Directors approval.

10.6 The ~~People and Organisational Development~~ Committee has key relationships with other committees and groups via its membership.

- Members will facilitate information gathering and sharing with other key committees such as the Quality Committee and the Trust Executive Team.
- In addition, there will also be links to Health Education England and the "HR for London" network in relation to London-wide streamlining initiatives.

11. Openness

11.1 The agenda, papers and minutes of the ~~People and Organisational Development Committee~~PODC are considered to be confidential.

Reviewed by: People & OD Committee
Date: 22 July 2015
Approved by: Board of Directors
Date: 27 July 2015
Review date: 21 July 2016
Reviewed by: People & OD Committee
Date: 17 November 2016
Amended following People & OD Committee – 17 November 2016
Reviewed by: People & OD Committee
Date: 26 July 2017
Approved by: Board of Directors
Date: August 2017
Reviewed by: People and OD Committee
Date: 23 May 2018

Board of Directors Meeting, 5 July 2018

PUBLIC SESSION

AGENDA ITEM NO.	4.2/Jul/18
REPORT NAME	Annual report on use of the Company Seal 2017/18
AUTHOR	Vida Djelic, Board Governance Manager
LEAD	Julie Myers, Company Secretary
PURPOSE	The Trust's Constitution requires that a report is presented to the Board at least biannually on the use of the Company Seal.
KEY RISKS ASSOCIATED	None.
FINANCIAL IMPLICATIONS	None.
QUALITY IMPLICATIONS	None.
EQUALITY & DIVERSITY IMPLICATIONS	NA
LINK TO OBJECTIVES	NA
DECISION/ ACTION	For information.

Report on use of the Company Seal 2017/18

1. The Constitution, at Annex 7 (Standing Orders), Section 11 refers to the sealing of documents. This section states:

Custody of Seal and Sealing of Documents

11.1. **Custody of Seal** – the common seal of the Trust shall be kept by the Company Secretary in a secure place.

11.2. **Sealing of documents** - where it is necessary that a document shall be sealed, the seal of the Trust shall be affixed in the presence of two Executive Directors or one Executive Director and either the Chairman or Company Secretary, duly authorised by a resolution of the Board of Directors (or of a Committee thereof where the Board of Directors has delegated its powers) and shall be attested by them.

11.3. **Register of sealing** - an entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealing shall be made to the Board of Directors at least bi-annually. The report shall detail the seal number, the description of the document and date of sealing.

11.4. The seal should be used to execute deeds (e.g. conveyances of land) or where otherwise required by law.

2. During the period 1 April 2017 – 31 March 2018, the seal was affixed to the following documents:

Seal Number	Description of the document	Date of sealing	Affixed and attested by
180	Chelsea and Westminster Hospital NHS Foundation Trust and Imperial College of Science Technology and Medicine - Lease of parts of the lower ground, second, third and fourth floors, forming part of Chelsea and Westminster Hospital, 369 Fulham Road, London SW10 (5 copies)	07.06.17	Lesley Watts Chief Executive Officer Karl Munslow-Ong Deputy Chief Executive

181	1) Chelsea and Westminster Hospital NHS Foundation Trust 2) Bywest Limited 3) West Middlesex Hospital Project Limited Supplemental agreement to project agreement in respect of VE308 – energy efficiency variation at West Middlesex University Hospital (1 copy)	29.06.17	Karl Munslow-Ong Deputy Chief Executive Sandra Easton Chief Financial Officer
182	Lease between Chelsea and Westminster Hospital NHS Foundation Trust and CW+ MediCinema (1 copy)	01.08.17	Lesley Watts Chief Executive Officer Sandra Easton Chief Financial Officer
183	Chelsea and Westminster Hospital NHS Foundation Trust and JCA Engineering Ltd Appointment of services construction relating to ICU/NICU expansion at Chelsea and Westminster Hospital NHS Foundation Trust (2 copies)	01.08.17	Lesley Watts Chief Executive Officer Sandra Easton Chief Financial Officer
184	Lease relating to Unit 1, occupied by WH Smith Ltd Parties – Bywest, Chelsea and Westminster Hospital NHS Foundation Trust and WH Smith (2 copies)	03.10.17	Karl Munslow-Ong Deputy Chief Executive Sandra Easton Chief Financial Officer
185	Supplemental Agreement for the development of the West Middlesex site, and provision of services dated 30/01/2001. The agreement provides for the building of a modular maternity facility (2 copies)	03.10.17	Karl Munslow-Ong Deputy Chief Executive Sandra Easton Chief Financial Officer

186	Lease Car Parking spaces 1, 7, 8, 9 and 10 Verney House, Fulham Road, London SW10 between Martin's Properties (Chelsea) Limited and Chelsea and Westminster Hospital NHS Foundation Trust (2 copies)	17.01.18	Lesley Watts Chief Executive Officer Karl Munslow-Ong Deputy Chief Executive
187	Letting of Units 111, G1, G2, G3 and 101-112 Harbour Yard, Chelsea Harbour Yard, London, SW10 ('the let premises') (5 copies)	02.03.18	Pippa Nightingale Chief Nurse Karl Munslow-Ong Deputy Chief Executive
188	Chelsea and Westminster Hospital NHS Foundation Trust and International AIDS Vaccine Initiative Lease of Rooms on Second Floor at Chelsea and Westminster Hospital, 369 Fulham Road, London SW10 9NH (2 copies)	29.03.18	Karl Munslow-Ong Deputy Chief Executive Sandra Easton Chief Financial Officer

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Board of Directors Meeting, 5 July 2018

PUBLIC SESSION

AGENDA ITEM NO.	4.3/Jul/18
REPORT NAME	Standing Financial Instructions (SFIs) and Reservation of Powers and Scheme of Delegation (SoD)
AUTHOR	Susan Heimbach, Deputy Director of Finance, Financial Operations
LEAD	Sandra Easton, Chief Financial Officer
PURPOSE	To maintain good housekeeping.
SUMMARY OF REPORT	Amendments to the Trust's Standing Financial Instructions (SFIs) and Reservation of Powers to the Board and Delegation of Powers (SoD) were reviewed and approved by Audit and Risk Committee at its March 2018 meeting. Amendments to both documents were required to reflect: • Changes to legislation, guidance and regulatory framework • Changes to job titles and committee names to reflect Trust structure • Current Trust policies • Cross referencing between documents Board Members may wish to note the following changes to the SFIs in particular: • Section 2.2 Fraud, Bribery and Corruption – Updated to reflect current applicable Trust policy • Section 4 Annual Accounts and Reports – Updated to reflect the current regulatory framework and Trust structure and responsibilities • Section 9.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services – Updated to reflect current process and the "No PO, No Pay" procurement policy • Section 10.2 Investments – Updated to reflect current applicable Trust policy Board members should also note that in the SoD Section 5.2, the limit for lowest level of expenditure approval has been increased from £7,500 to £10,000. A copy of the revised versions of both documents, following approval by Audit and Risk Committee, is attached.
KEY RISKS ASSOCIATED	• Lack of corporate governance • Risk to financial sustainability

FINANCIAL IMPLICATIONS	None
QUALITY IMPLICATIONS	None
EQUALITY & DIVERSITY IMPLICATIONS	N/A
LINK TO OBJECTIVES	• Corporate governance • Deliver financial sustainability
DECISION/ ACTION	For approval.

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

START DATE:	March 2018	**EXPIRY DATE**	March 2019
COMMITTEE APPROVAL:	**NAME OF COMMITTEE:** Trust Board	**NAME OF CHAIR OF APPROVING COMMITTEE**	
	DATE APPROVED:		
	Endorsed By: Audit and Risk Committee **DATE:** 28 March 2018		
DISTRIBUTION	Trust-wide		
RELATED DOCUMENTS/ OTHER INFORMATION:	• Scheme of Delegation • Standing Orders – Annex 9 to Constitution of Chelsea & Westminster Hospital NHS Foundation Trust July 2015 • Trust Purchasing Guide • Counter Fraud and Corruption Policy and Response Plan • Conflicts of Interest, Anti-Bribery and Corruption Policy • Treasury Management Policy • Raising a Concern Policy • Governance Framework • Capital Governance Framework Policy • Information Governance Policy • Information Security Policy • Data Protection and Confidentiality Policy • Freedom of Information Policy • Losses and Special Payments Guidance Notes and Procedures • Purchase Order Compliance Policy • Patient Property Policy and Procedure • Other Trust-wide Policies and Procedures		
AUTHOR:	Chief Financial Officer Sandra.Easton@chelwest.nhs.uk		
STAKEHOLDERS INVOLVED:	Chairs of key Trust committees Human Resources (in particular Equality and Diversity Manager) All Trust staff		

IS AN EQUALITY ANALYIS REQUIRED?	NO
IF AN EQUALITY ANALYIS IS REQUIRED, HAS IT BEEN SENT TO THE EQUALITY AND DIVERSITY MANAGER?	NO

DOCUMENT REVIEW HISTORY:

Date	Version	Responsibility	Comments
January 2018	13	Chief Financial Officer	Revised front sheet in line with Policy on Non-Clinical Policies Updates to: • Current legislation and guidance • Changes to regulatory framework • Job titles and committee names to reflect current structure Changes to reflect current Trust policies Other minor updates

STANDING FINANCIAL INSTRUCTIONS

MARCH 2018
Version 13

CONTENTS

1.0 INTRODUCTION

1.1 GENERAL

1.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the requirements of the Secretary of State which state that Foundation Trusts shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

1.1.2 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Financial officer.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs, the advice of the Chief Financial officer MUST BE SOUGHT BEFORE ACTING. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SO's.

1.1.5 **FAILURE TO COMPLY WITH SFIs AND SOs IS A DISCIPLINARY MATTER WHICH COULD RESULT IN DISMISSAL.**

1.1.6 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit and Risk Committee for referring action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Financial Officer as soon as possible.

1.2 TERMINOLOGY

1.2.1 Any expression to which a meaning is given in the National Health Service Act 2006, Health and Social Care Act 2012 and other Acts relating to the National Health Service, or in the Financial Directions made under the Acts, or in the Authorisation or Constitution shall have the same meaning in these instructions; and in addition:

- "Authorisation" means the authorisation of the Trust by Monitor, the Independent Regulator of NHS Foundation Trusts (now part of NHS Improvement)
- "Board" means the Board of Directors of the Trust
- "Budget" means a resource, expressed in financial, activity or manpower terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
- "Budget Holder" means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation or capital project; and
- "Chief Executive" means the Chief Officer of the Trust;

- "Constitution" means the constitution of the Trust as approved from time to time by Monitor, the Independent Regulator of NHS Foundations Trusts;

- "Chief Financial Officer" means the Chief Financial Officer of the Trust;

- "Executive Director" means a director who is an officer of the Trust appointed in accordance with the Standing Orders of the Trust. For the purposes of this document, 'Director' shall not include an employee whose job title incorporates the word Director but who has not been appointed in this manner;

- "Legal Adviser" means the properly qualified person appointed by the Trust to provide legal advice;

- "Trust" means Chelsea and Westminster Hospital NHS Foundation Trust;

1.2.2 Wherever the title Chief Executive, Chief Financial Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.3 RESPONSIBILITIES AND DELEGATION

1.3.1 The Trust Board

The Board exercises financial supervision and control by:

(a) Formulating the financial strategy;

(b) Requiring the submission and approval of budgets within approved overall income;

(c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) Defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document.

1.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Reservation of Powers to the Board' document.

1.3.3 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

1.3.4 The Chief Executive and Chief Financial Officer

The Chief Executive and Chief Financial Officer will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

Within the Standing Financial Instructions it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors of the Trust and, as Accounting Officer, for ensuring that the Board of Directors meets its obligation to perform its functions within the available resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

It is the duty of the Chief Executive to ensure that all directors and employees and all new appointees are notified of and understand their responsibilities within these instructions.

1.3.5 **The Chief Financial Officer**

The Chief Financial Officer is responsible for:

(a) Implementing the Trust financial policies and for coordinating any corrective action necessary to further these policies;

(b) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) Ensuring that sufficient records are maintained to show and explain the Trust's transactions in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

And, without prejudice to any other functions of directors and employees of the Trust, the duties of the Chief Financial officer include:

(d) The provision of financial advice to the Trust and its directors and employees;

(e) The design, implementation and supervision of systems of internal financial control;

(f) The preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

(g) Managing cash resources within the committed facility agreed by the Board and Monitor;

(h) Ensuring a robust system of budgetary control is in place to meet the Trust's financial objectives;

(i) Developing the Trust's financial strategy.

1.3.6 **Board Members and Employees**

All members of the Board and employees severally and collectively, are responsible for:

(a) The security of property of the Trust;

(b) Avoiding loss;

(c) Exercising economy, efficiency and effectiveness in the use of resources; and

(d) Conforming with the requirements of Standing Orders, Standing Financial Instructions, financial procedures and the Scheme of Delegation.

1.3.7 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income, shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.8 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Chief Financial officer.

2.0 AUDIT

2.1 AUDIT AND RISK COMMITTEE

2.1.1 In accordance with the Constitution, the Board shall formally establish an Audit and Risk Committee, with clearly defined terms of reference which will provide an independent and objective view of internal control by;

(a) Overseeing Internal and External Audit and Counter Fraud services;

(b) Reviewing financial and non-financial systems and processes;

(c) Monitoring compliance with Standing Orders and Standing Financial Instructions;

(d) Reviewing schedules of losses and compensations and making recommendations to the Board.

2.1.2 Where the Audit and Risk Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chair of the Audit and Risk Committee should raise the matter at a full meeting of the Board. Exceptionally the matter may need to be referred to NHS Improvement, the Independent Regulator of Foundation Trusts, in consultation with the Chief Executive in the first instance.

2.1.3 It is the responsibility of the Audit and Risk Committee, supported by the Chief Financial officer, to ensure that an adequate internal audit service is provided and the Audit and Risk Committee is involved in the selection process when an internal audit service provider is changed.

2.2 Fraud, Bribery and Corruption

2.2.1 In line with best practice, the Trust Chief Executive and Chief Financial officer shall monitor and ensure compliance with National Standard Commissioning Contract Directions on fraud, bribery and corruption detection and prevention.

2.2.2 It is the responsibility of the Audit and Risk Committee to appoint a Counter Fraud Service provider, supported by the Chief Financial officer, and to ensure an adequate counter fraud service is provided to the Trust.

2.2.3 The Trust shall nominate a suitable professionally accredited person to carry out the duties of the Counter Fraud Specialist (CFS) as specified by NHS Counter Fraud Authority (NHSCFA) implementing the NHSCFA published good practice and guidance.

2.2.4 The Chief Financial officer must prepare a ‘Counter Fraud Policy and Response Plan’ that sets out action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

2.2.5 The CFS shall liaise with the Chief Financial officer and NHSCFA in accordance with the NHS Counter Fraud and Corruption Manual and working in line with the current “Standards for Providers – Fraud, Bribery and Corruption” and the NHSCFA organisational strategy “Leading the Fight against NHS Fraud 2017”.

2.2.6 If it is considered that evidence exists and that a prosecution is desirable, the CFS will consult with the CFO to obtain the necessary authority and agree the appropriate route for pursuing any action.

2.2.7 In accordance with the Whistleblowing Policy, the Trust shall have a whisle-blowing mechanism to report any suspected or actual fraud, bribery or corruption matters and

internally publicise this, together with the national fraud and corruption line provided by the NHSCFA

2.2.8 The CFS shall report to the Chief Financial officer and shall work with staff in NHSCFA in accordance with NHSCFA guidance.

2.2.9 The CFS will ensure that measures to mitigate identified risks are included in an organisational work plan which ensures that an appropriate level of resource is available to the level of any risks identified. Work will be monitored by the Chief Financial Officer and outcomes fed back to the Audit and Risk Committee.

2.2.10 The CFS will provide a written report, at least annually, on counter fraud work within the Foundation Trust.

2.2.11 The Trust will report annually on how it has met the standards set by NHSCFA in relation to anti-fraud, bribery and corruption work and the Chief Financial Officer will sign off the annual self-review and authorise its submission to the NHSCFA

2.2.12 **Security Management**

In line with their responsibilities, the Chief Executive and Chief Financial officer shall monitor and ensure compliance with NHS Standard Service Condition 24 to put in place and maintain appropriate security management arrangements having regard to NHSCFA standards

2.2.13 The Trust shall nominate a suitable person to carry out the duties of Local Security Management Specialist (LSMS) as specified in the NHSCFA standards

2.2.14 The Trust shall prepare a 'Security Policy' that sets out measures to protect staff, visitors, premises and assets.

The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Director responsible for security management and the appointed LSMS.

2.3 CHIEF FINANCIAL OFFICER

2.3.1 The Chief Financial officer is responsible for:

(a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

(b) Ensuring that the internal audit function is adequate and meets the mandatory audit standards.

(c) Deciding at what stage to involve the police, and the LCMS, in cases of misappropriation and other irregularities;

(d) Ensuring than an annual internal audit report is prepared for the consideration of the Audit and Risk Committee and the Board. The report must cover:

i. A clear statement on the effectiveness of internal control,
ii. Major internal financial control weaknesses discovered,
iii. Progress on the implementation of internal audit recommendations,
iv. Progress against plan over the previous year,
v. Strategic audit plan covering the coming three years,
vi. A detailed plan for the coming year.

2.3.2 The Chief Financial officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) Access at all reasonable times to any land, premises or employee of the Trust;

(c) The production of any cash, stores or other property of the Trust under an employee's control; and

(d) Explanations concerning any matter under investigation.

2.4 ROLE OF INTERNAL AUDIT

2.4.1 Internal Audit will review, appraise and report on:

(a) The extent of compliance with and the financial effect of relevant established policies, plans and procedures;

(b) The adequacy and application of financial and other related management controls;

(c) The suitability of financial and other related management data including internal and external reporting and accountability processes;

(d) The efficient and effective use of resources;

(e) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

i. Fraud and other offences;
ii. Waste, extravagance, inefficient administration;
iii. Poor value for money or other causes;
iv. Any form of risk, especially business and financial risk but not exclusively so.

Internal Audit shall also independently assess the process in place to ensure that the assurance frameworks are in accordance with current guidance from the Care Quality Commission and NHS Improvement.

2.4.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately, and the matter referred to the LCFS and/or LSMS, as appropriate.

2.4.3 The Head of Internal Audit will normally attend Audit and Risk Committee meetings and has a right of access to all Audit and Risk Committee members, the Chair and Chief Executive of the Trust.

2.4.4 The Head of Internal Audit shall be accountable to the Audit and Risk Committee and shall be managed by the Chief Financial officer. The reporting system for internal audit shall be agreed between the Chief Financial Officer, the Audit and Risk Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Internal Audit Standards for the NHS. The reporting system shall be reviewed at least every 3 years.

2.4.5 The Head of Internal Audit shall liaise with the Chief Financial Officer, who shall refer audit reports to the appropriate officers designated by the Chief Executive, and report findings to the Audit and Risk Committee. Progress reports will be presented to the Audit and Risk Committee at each meeting. Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation of the objectivity of the audit, the Head of Internal Audit shall seek the advice of the Chair of the Audit and Risk Committee.

2.5 EXTERNAL AUDIT

2.5.1 The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare quality accounts for each financial year. In addition to the legislative requirements, guidance on the form and content of annual quality reports for NHS foundation trusts is contained in the *NHS Foundation Trust Annual Reporting Manual*. NHS foundation trusts are required to seek external assurance over their annual quality report. The audit work undertaken by auditors of NHS foundation trusts in relation to quality reports must be carried out in accordance with the detailed guidance issued by NHS Improvement for that financial year. The external auditor is appointed by the Council of Governors from an approved list recommended by the Board of Directors and paid for by the Trust. The Audit and Risk Committee must ensure a cost-efficient service. If there appears to be a problem, this should be raised with the external auditor and referred on to the Council of Governors. If the issue cannot be resolved by the Council of Governors, it should be reported to NHS Improvement.

2.5.2 The Trust must ensure that the external auditor appointed by the Council of Governors meets the criteria included by the National Audit Office in its 'Code of Audit Practice', at the date of appointment and on an on-going basis throughout the term of their appointment.

External audit responsibilities (in compliance with the requirements of the National Audit Office) are to:

(a) Be satisfied that the accounts comply with the directions provided;

(b) Be satisfied that the accounts comply with the requirements of all other provisions contained in, or having effect under, any enactment which is applicable to the accounts;

(c) Be satisfied that proper practices have been observed in compiling the accounts;

(d) Be satisfied that proper arrangements have been made for securing economy, efficiency and effectiveness in the use of resources;

(e) Express an opinion on the accounts;

(f) Certify the completion of the audit;

(g) To consider the issue of a report in the public interest;

(h) To report to the regulator if the auditor has reason to believe that the audited body (or a director or officer of the audited body) is about to make, or has made, a decision which involves or would involve unlawful expenditure; or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

(i) Comply with the Code of Audit Practice prepared by the Comptroller and Auditor General and approved by Parliament

(j) Have regard to guidance to auditors issued by the Comptroller and Auditor General

2.5.3 External auditors will ensure that there is a minimum of duplication of effort between themselves, Internal Audit and the work of relevant regulators e.g. NHS Improvement, Care Quality Commission.

2.5.4 External audit will be responsible for ensuring that audits are completed and reports made available to the Audit and Risk Committee.

2.5.5 The Trust will provide the external auditor with every facility and all information which may reasonably be required for the purposes of their functions.

3.0 BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

3.1 **HEALTH AUTHORITIES** Not applicable.

3.2 PREPARATION AND APPROVAL OF BUSINESS PLANS AND BUDGETS

3.2.1 The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

(a) A statement of the significant assumptions on which the plan is based;

(b) Details of major changes in workload, delivery of services or resources required to achieve the plan;

(c) The Financial Plan for the year;

(d) Such other contents as may be determined by NHS Improvement.

The annual plan must be submitted to NHS Improvement in accordance with agreed requirements and timescales.

3.2.2 Prior to the start of the financial year, the Chief Financial officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) Be in accordance with the aims and objectives set out in the annual business plan;
(b) Accord with workload and manpower plans;

(c) Be produced following discussion with appropriate budget holders;

(d) Be prepared within the limits of available funds;

(e) Identify potential risks;

(f) Be based on reasonable and realistic assumptions; and

(g) Enable the Trust to comply with the regulatory framework for foundation trusts.

3.2.3 The Chief Financial Officer shall monitor financial performance against the budget and business plan, periodically review them, and report to the Board.

3.2.4 All budget holders must provide information as required by the Chief Financial Officer to enable budgets to be complied.

3.2.5 The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.3 BUDGETARY DELEGATION

3.3.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) The amount of the budget;

(b) The purpose(s) of each budget heading;

(c) Individual and group responsibilities;

(d) Authority to exercise virement;

(e) Achievement of planned levels of service; and

(f) The provision of regular reports.

3.3.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

3.3.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.3.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.4 BUDEGETARY CONTROL AND REPORTING

3.4.1 The Chief Financial officer will devise and maintain systems of budgetary control. These will include:

(a) Monthly financial reports to the Board in a form approved by the Board containing:

i. Income and expenditure to date showing trends and forecast year-end position;

ii. Movements in working capital;

iii. Capital project spend and projected outturn against plan;

iv. Explanations of any material variances from plan;

v. Details of any corrective action where necessary and the Chief Executive's and/or Chief Financial Officer's view of whether such actions are sufficient to correct the situation;

(b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder covering the areas for which they are responsible;

(c) Investigation and reporting of variances from financial, workload and manpower budgets;

(d) Monitoring of management action to correct variances; and

(e) Arrangements for the authorisation of budget transfers.

3.4.2 Each budget holder is responsible for ensuring that:

(a) Any likely overspend or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

(b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

(c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for in the budgeted establishment as approved by the Board.

3.4.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and planned financial targets.

3.4.4 The Chief Financial Officer will include a written introduction to the Trust's Standing Financial Instructions, Standing orders and Scheme of Delegation in the induction pack for all Trust induction attendees.

3.5 CAPITAL EXPENDITURE

3.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. The particular applications relating to capital are contained in Section 11.

3.6 MONITORING RETURNS

3.6.1 The Chief Executive is responsible for ensuring the appropriate monitoring forms are submitted to the requisite monitoring organisation e.g. NHS Improvement, Independent Regulator of NHS Foundation Trusts.

4.0 ANNUAL ACCOUNTS AND REPORTS

4.1 The Chief Financial Officer, on behalf of the Trust, will:

(a) Prepare annual financial accounts and corresponding financial returns in such form as NHS Improvement and HM Treasury prescribe ;

(b) Ensure these annual accounts and financial returns comply with current guidelines and directions given by NHS Improvement as to their technical accounting content and information / data shown therein before submission to NHS Improvement

4.2 The Company Secretary will be responsible for the preparation of the Annual Report in accordance with Department of Health and NHS Improvement guidance

4.3 The Trust's Annual Report, Annual Accounts and financial returns to NHS Improvement must be audited by the external auditor appointed by the Council of Governors in accordance with appropriate auditing standards.

4.4 The Annual Report and Accounts, including the auditor's report must be approved by the Board of Directors or by the Audit and Risk Committee when specifically delegated the power to do so under the authority of the Board of Directors

4.5 The Annual Report and Accounts, including the auditor's report, is submitted to NHS Improvement by the Chief Financial Officer and put forward to be laid before Parliament in accordance with prescribed timetables.

4.6 The Annual Report and Accounts, including the auditor's report, must be published and presented to a general meeting of the Council of Governors by 30th September each year and made available to the public for inspection at the Trust's headquarters AND MADE AVAILABLE ON THE Trust's website.

4.7 The Director of Nursing shall prepare the Annual Quality Report in the format prescribed by NHS Improvement / Care Quality Commission and in accordance with the DH Group Accounting Manual. The Quality Report presents a balanced picture of the Trust's performance over the financial year and up to the agreed submission date.

4.8 The Chief Executive and Chairman shall sign off the "Statement of Directors' Responsibilities in Respect of the Quality Report" under the Health Act 2009 and the NHS (Quality Accounts) Regulations 2010.

5. BANK AND GOVERNMENT BANKING SERVICE (GBS) ACCOUNTS

5.1 GENERAL

5.1.1 The Chief Financial Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/directions issued from time to time by NHS Improvement.

5.1.2 The Board shall approve the banking arrangements.

5.2 BANK AND GBS ACCOUNTS

5.2.1 The Chief Financial Officer is responsible for:

(a) All bank accounts and GBS accounts (refer to Treasury Management Policy for further details)

(b) Ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(c) Reporting to the Board all arrangement made with the Trust's bankers for accounts to be overdrawn;

(d) Monitoring compliance with NHS Improvement or DH guidance on the level of cleared funds; and

(e) Ensuring covenants attached to bank borrowings are adhered to.

5.3 BANKING PROCEDURES

5.3.1 The Chief Financial Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) The conditions under which each bank and GBS account is to be operated;

(b) The limit to be applied to any overdraft; and

(c) Those members of staff with mandated authority to carry out transactions, by signing transfer authorities or cheques or other orders in accordance with the authorisation framework of each account.

5.3.2 The Chief Financial Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 TENDERING AND REVIEW

5.4.1 The Chief Financial Officer will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

5.4.2 Competitive tenders should be sought every 3 to 5 years. The results of the tendering exercise should be reported to the Board.

6.0 INCOME, FEES AND CHARGES AND SECURITY OF CASE, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 INCOME SYSTEMS

6.1.1 The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and collection and coding of all monies due.

6.1.2 The Chief Financial Officer is also responsible for the prompt banking of all monies received.

6.2 FEES AND CHARGES

6.2.1 The Trust shall follow the Department of Health's guidance on Payment by Results when entering into contracts for patient services where applicable.

6.2.3 The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's 'Commercial Sponsorship – Ethnical Standards in the NHS' shall be followed.

6.2.3 All employees must inform the Chief Financial Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.2.4 Contracts must conform to the strategy and business plans of the Trust and shall be approved according to the limits specified within the "Reservation of Powers and Scheme of Delegation".

6.3 DEBT RECOVERY

6.3.1 The Chief Financial Officer is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures (see Section 13).

6.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.4 SECURITY OF CASH, CHEQUES AND OTHER NEGITIABLE INSTRUMENTS

6.4.1 The Chief Financial Officer is responsible for:

(a) Approving the form of all receipts books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) Ordering and securely controlling any such stationery;

(c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

(d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7.0 CONTRACTING FOR PROVISION OF SERVICES

7.1 The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Business Plan, and for establishing the arrangements for providing extra-contractual services. In carrying out these functions, the Chief Executive should take into account the advice of the Chief Financial Officer regarding:

(a) Costing and Pricing of services;

(b) Payment terms and conditions; and

(c) Amendments to contracts and extra-contractual arrangements

7.2 Contracts should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. Contract prices shall comply with National Regulations, Standard NHS Contract and NHS Improvement requirements.

7.3 The Chief Financial Officer shall produce regular reports detailing actual and forecast contract income linked to contract activity with a detailed assessment of the impact of the variable elements of income.

7.4 Any pricing of contracts at marginal costs must be undertaken by the Chief Financial Officer and reported to the Board.

7.5 When contracting for clinical services the Trust must ensure the Private Patient Cap is not breached in any one financial year.

7.6 Contracts shall be deemed to cover all Service Level Agreements.

8.0 TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND EMPLOYERS

8.1 REMUNERATION

8.1.1 In accordance with the Constitution, the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

8.1.2 The Committee will:

(a) Decide the remuneration and allowances and other terms and conditions of office of Executive Directors and the Secretary;

(b) Approve recommendations for the remuneration and allowances and other terms and conditions of office of other senior managers under their remit;

(c) Decide such rates at which the travelling and other expenses incurred by all Directors may be reimbursed.

8.1.3 The Committee shall report in writing to the Board on any decisions made and the basis for such decisions with respect to:

(a) Remuneration, allowances, pensions and gratuities of Executive Directors, the Secretary and other senior managers under its remit; and

(b) Rates at which the travelling and other costs and expenses incurred by all Directors may be reimbursed.

8.1.4 Appointments to senior management or Director posts above the salary of the Prime Minister (currently circa £142,500) must be referred to NHS Improvement and onward ratification by the Secretary of State

8.2 FUNDED ESTABLISHMENT

8.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

8.2.2. The funded establishment of any department may not be varied without the approval of the Chief Executive or Chief Financial Officer as nominated officer.

8.2.3 Funded establishments should be reconciled on a regular basis to ensure that the data held by Human Resources matches the establishment funded in the budgets maintained by the Finance Department.

8.3 STAFF APPOINTMENTS

8.3.1 No director of employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration;

(a) Unless authorised to do so by the Chief Executive; and

(b) Within the limit of their approved budget and funded establishment.

8.3 2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

8.4 PROCESSING OF PAYROLL

8.4.1 The Chief Financial Officer shall be responsible for the final determination of pay, including the verification that the rate of pay and relevant conditions of service are in accordance with current arrangements

8.4.2 The Chief Financial Officer is responsible for the agreement to and management of the payroll contact with external providers

8.4.3 The Chief Financial Officer is responsible for:

(a) Specifying timetables for submission of properly authorised time records and other nominations;

(b) The final determination of pay;

(c) Making payment on agreed dates; and

(d) Agreeing methods of payment

8.4.4 The Chief Financial Officer will issue instructions regarding;

(a) Verification and documentation of data;

(b) The timetable for receipt and preparation of payroll data and the payment of employees;

(c) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) Security and confidentiality of payroll information;

(e) Checks to be applied to completed payroll before and after payment;

(f) Authority to release payroll data under the provisions of the Data Protection Act;

(g) Methods of payment available to various categories of employee;

(h) Procedures for payment by cheque, bank credit, or cash to employees;

(i) Procedures for the recall of cheques and bank credits;

(j) Pay advances and their recovery;

(k) Maintenance of regular and independent reconciliation of pay control accounts;

(l) Separation of duties for preparing records and handling cash; and

(m) A system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

8.4.5 Appropriately nominated managers have delegated responsibility for:

(a) Submitting time records and other notifications in accordance with agreed timetables;

(b) Completing time records and other notifications in accordance with the instructions of and in the form prescribed by the Chief Financial Officer; and

(c) Submitting termination forms in prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Chief Financial Officer must be informed immediately.

8.4.6 Managers and employees are jointly responsible and accountable for ensuring claims for pay and expenses are timely, correct and any under or over payments are highlighted as soon as discovered.

8.4.7 Regardless of the arrangements for providing the payroll service, the Chief Financial Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.5 CONTRACTS OF EMPLOYMENT

8.5.1 The Board shall delegate responsibility to a manager for:

(a) Ensuring that all employees are issues with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

(b) Dealing with variations to, or termination of, contracts of employment.

9.0 NON-PAY EXPENDITURE

9.1 DELEGATION OF AUTHORITY

9.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

9.1.2 The Chief Executive will set out:

(a) The list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) The maximum level of each requisition and the system for authorisation above that level.

9.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services. These have been summarised in the Trust Purchasing Guide and the Trust Procurement Strategy.

9.2 CHOICE, REQUISITIONING, ORDERING, RECEIPT AND PAYMENT FOR GOODS AND SERVICES

9.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Procurement Department shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Procurement (and/or the Chief Financial Officer) shall be consulted. The Procurement Department is both obliged and authorised to divert a requisition to an alternative supplier or equivalent product in pursuit of best value or to ensure contractual obligation compliance.

9.2.2 The Chief Financial Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contact terms, or otherwise, in accordance with national guidance.

9.2.3 The Chief Financial Officer will:

(a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and regularly reviewed;

(b) Prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds where not already provided in the Reservation of Powers and Scheme of Delegation;

(c) Be responsible for the prompt payment of all properly authorised accounts and claims;

(d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i. A list of directors/employees authorised to authorise invoices and that the expenditure has been authorised by the officer responsible for the contract or budget which is to be charged .

ii. Certification that:

- Goods have been duly received, examined and are in accordance with specification and the prices are correct. Certification may be either through a goods received note or by personal certification by authorised officers;

- Work done or services rendered have been satisfactorily carried out in accordance with the order, and where applicable, the materials used are of the requisite standard and the charges are correct;

- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
-
- Where an officer certifying accounts relies upon other officers to do preliminary checking, he/she shall wherever possible ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms and that such checks are evidenced;

- The account is arithmetically correct;

- The account is in order for payment.

iii. A timetable and system for submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

iv. Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

9.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. Cash-flow must be discounted to NPV using National Loans Fund NFL rate plus 2%);

(b) The appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Chief Financial Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and must immediately inform the appropriate Director or Chief Executive if problems are encountered.

9.2.5 The Trust operates a “No PO, No Pay” policy (See Purchase Order Compliance Policy). With the exception of items specifically detailed as “exceptions” within the policy, all purchases will be made on a Purchase Order in the Trust’s e-ordering system, or using the Trust’s Purchasing Card, in which case these orders must comply with the Trust’s Purchasing Card policy. Refer to the Procurement department for further guidance. Official Purchase Orders must:

(a) Be consecutively numbered;

(b) Be in a form approved by the Chief Financial Officer

(c) State the Trust's terms and conditions of trade, and

(d) Only be issued to, and used by, those duly authorised by the Chief Executive.

9.2.6 Managers ordering goods or services listed as "exceptions" in the Purchase Order Compliance Policy must ensure, in line with the policy that the supplier includes sufficient information on the invoice to ensure that the cost can be allocated to the correct budget. The information required is:

- Approver's name
- Department
- Cost centre and account code

9.2.7 Managers must ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer and that:

(a) All contracts (other than for a simple purchase permitted within the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Financial Officer in advance of any commitment being made;

(b) Contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement and comply with the White Paper on Standards, Quality and International Competitiveness (CMND 8621);

(c) Where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the NHS Executive;

(d) No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than;

i. Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

ii. Conventional hospitality, such as lunches in the course of working visits;

(e) No requisition/order is placed for any item or items for which there is no budget provision unless previous written authorisation has been received from the Chief Financial Officer on behalf of the Chief Executive;

(f) All goods, services, or works are ordered on an official order (created following an electronic requisition via the Procurement Department) except works and services executed in accordance with a contract and purchases from petty cash;

(g) Verbal orders must only be issued very exceptionally – only by a member of the Procurement Department and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(h) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds contained within the Reservation of Powers and Scheme of Delegation;

(i) Goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) Changes to the list of directors/employees authorised to certify invoices are notified to the Chief Financial Officer;

9.2.8 **Petty Cash**

(a) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Financial Officer; and

(b) All reimbursements must be supported by receipt(s) and certified by an authorised signatory.

(c) Petty cash records are maintained in a form as determined by the Chief Financial Officer.

9.2.9 **Building and Engineering Construction Work**

The Chief Financial Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

10.0 EXTERNAL BORROWING AND INVESTMENTS

10.1 EXTERNAL BORROWING

10.1.1 The Chief Financial Officer will advise the Board concerning the Trust's ability to pay interest on, and repay, both Public Dividend Capital and any proposed new borrowing, with the limits set by NHS Improvement. The Chief Financial Officer is also responsible for reporting periodically to the Board concerning the originating debt and all loans and overdrafts.

10.1.2 Any application for a loan or overdraft will only be made by the Chief Financial Officer or by an employee so delegated by him/her.

10.1.3 The Chief Financial Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

10.1.4 All short term borrowings should be kept to a minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Chief Financial Officer.

10.1.5 All long term borrowing must be consistent with the plans outlined in the current Business Plan approved by the Board

10.2 INVESTMENTS

10.2.1 The Trust may invest money for the purposes of its strategic objectives and operational functions

10.2.2 The Audit and Risk Committee shall set the investment policy (setting out acceptable risks and unacceptable risks) and shall oversee all investment transactions by the Trust. The Treasury Management Policy shall set out the guidelines and shall be approved by the Audit and Risk Committee.

10.2.3 Investments may be made in forming and / or acquiring an interest in bodies corporate where authorised by the Board.

10.2.4 Temporary cash surpluses must be held only in investments permitted by NHS Improvement and meeting the criteria in the Treasury Management Policy.

10.2.5 The Chief Financial Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held through the Audit and Risk Committee.

10.2.6 The Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained and will ensure compliance with the Treasury Management Policy at all times.

11.0 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

11.1 CAPITAL INVESTMENT

11.1.1 The Chief Executive:

(a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) Shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

11.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) That a business case is produced (in line with the Trust's Capital Governance Framework and guidance contained within NHS Improvement's 'Capital Regime, Investment and Property Business Case Approval Guidance for NHS Trusts and Foundation Trusts' setting out:

i. An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

ii. Appropriate project management and control arrangements; and

(b) That the Chief Financial Officer has certified professionally to the costs and revenue consequences detailed in the business case.

(c) That the business case where the proposed capital expenditure is not within the Trust's capital plan and >£200k or is within the Trust's capital plan and >£1m is presented to the Finance and Investment Committee.

11.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of CONCODE[1]

The Chief Financial Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

The Chief Financial Officer shall assess on an annual basis the requirement for the operation of the Construction Industry Tax Deduction Scheme (CIS) in accordance with Inland Revenue guidance.

11.1.4 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

[1] Guidance on contracting procedures for construction projects

(a) Specific authority to commit expenditure;

(b) Authority to proceed to tender;

(c) Approval to accept a successful tender.

11.1.5 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with NHS Improvement's 'Capital Regime, Investment and Property Business Case Approval Guidance for NHS Trusts and Foundation Trusts' and the Trust's Standing Orders.

11.1.6 The Chief Financial Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.
These procedures will:

(a) Be designed to ensure that each project stays within estimated/budgeted costs at each milestone;

(b) Be issued to project managers and other employees/persons involved in capital projects;

(c) Incorporate simple checklists designed to ensure that important requirements are complied with on each project.

11.2 PRIVATE FINANCE (INCLUDING LEASING)

11.2.1 The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its Allocations, the following procedures should apply:

(a) The Chief Financial Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) The proposal must be specifically agreed by the Board.

(c) Any Finance or Operating lease must be agreed and signed off by the Chief Financial Officer.

11.3 ASSET REGISTERS

11.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register.

11.3.2 Each Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Accounting Manual as issued by the Department of Health.

11.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) Properly authorised and approved agreements, architects' certificates, suppliers' invoices and other documentary evidence in respect of purchases from third parties;

(b) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(c) Lease agreements in respect of assets held under a finance lease and capitalised.

11.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

11.3.5 The Chief Financial Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

11.3.6 The value of each asset shall be depreciated using methods and rates as specified in the Annual Financial Reporting Manual issued by NHS Improvement.

11.4 ASSETS USED FOR COMMISSIONER REQUESTED SERVICES

11.4.1 A register of assets used for the provision of commissioner requested services is required to be maintained in accordance with requirements issued by NHS Improvement.

11.4.2 The Trust, as Licensee, shall not dispose of or relinquish control over any relevant assets except with the consent in writing of NHS Improvement and in accordance with the provisions of the Licence.

11.4.3 An Annual Plan will be produced which will include proposed changes in the treatment of such assets and proposed disposals and acquisitions

11.5 SECURITY OF ASSETS

11.5.1 The overall control of fixed assets is the responsibility of the Chief Executive.

11.5.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments and also including donated assets) must be approved by the Chief Financial Officer. This procedure shall make provision for:

(a) Recording managerial responsibility for each asset;

(b) Identification of additions and disposals;

(c) Identification of all repairs and maintenance expenses;

(d) Physical security of assets;

(e) Periodic verification of the existence of, condition of, and title to, assets recorded;

(f) Identification and reporting of all costs associated with the retention of an asset; and

(g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

11.5.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Financial Officer.

11.5.4 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS Foundation Trust property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

11.5.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

11.5.6 Where practical, assets should be marked as Trust property.

12.0 STORES AND RECEIPT OF GOODS

12.1 All goods for delivery to the Trust should be routed via the Goods Receipt Point unless formally agreed in advance by the Purchasing & Supplies Department. In this way goods may be properly accounted for via the electronic purchasing and receipt system and thus invoices may be matched and paid appropriately.

12.2 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) Kept to a minimum;

(b) Subjected to an annual stock take as a minimum;

(c) Valued at the lower of cost and net realisable value.

12.3 Subject to the responsibility of the Chief Financial Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated to department employees and store managers/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer. The control of pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer and the control of fuel oil and coal of a designated Estates Manager.

12.4 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

12.5 The Chief Financial Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues and returns to stores, and losses.

12.6 Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items in store at least once a year.

12.7 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer.

12.8 The designated manager/Pharmaceutical Officer shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice (see section 13 Disposals and Condemnations, Losses and Special Payments.) Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

12.9 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Chief Financial Officer who shall satisfy himself that the goods have been received before accepting the recharge.

13.0 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

13.1 DISPOSALS AND CONDEMNATIONS

13.1.1 The Chief Financial Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

13.1.2 When it is decided to dispose of an Trust asset, the head of department or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate.

13.1.3 All unserviceable articles shall be:

(a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer;

(b) Recorded by the Condemning Officer in a form approved by the Chief Financial Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Financial Officer.

13.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer who will take the appropriate action.

13.2 LOSSES AND SPECIAL PAYMENTS

13.2.1 The Chief Financial Officer must prepare procedural instructions on the recording and accounting for condemnations, losses and special payments in accordance with the DH Group Accounting Manual (See Trust "Losses and Special Payments Guidance"). The Chief Financial Officer must also prepare with the Trust's Counter Fraud Specialist a Counter Fraud and Corruption Policy that sets out the action to be taken by persons detecting a suspected fraud and by those persons responsible for investigating it. The Counter Fraud and Corruption Policy should ensure that contact details for the Counter Fraud Specialist are clearly set out within the policy. The policy should also set out clear guidance to staff and managers reporting a suspected fraud.

13.2.2 Any officer or employee discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Financial Officer, or inform an officer charged with responsibility for responding to concerns involving loss confidentiality. This officer will then immediately inform the Chief Financial Officer and/or Chief Executive. Where a criminal offence is suspected, the appropriate Executive Director must immediately inform the police, and the LSMS if theft or arson is involved. In cases of fraud and corruption or of anomalies that may indicate fraud or corruption, the Chief Financial Officer must inform the relevant CFS in accordance with Secretary of State Directions.

13.2.3 The Chief Financial Officer must notify the Counter Fraud Specialist, NHSCFA, and both the Internal and External Auditor of all frauds.

13.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer must immediately notify;

(a) The Board,

(b) The External Auditor

(c) The Head of Internal Audit, and

(d) The Local Security Management Specialist

13.2.5 The Board shall approve the writing-off of losses. Authorising officers must undertake fuller reviews of systems to reduce the risk of similar losses occurring in the future and seek advice where they believe a particular case raises issues of principle.

13.2.6 The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

13.2.7 For any loss, the Chief Financial Officer should consider whether any insurance claim can be made.

13.2.8 The Chief Financial Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded and shall report these periodically to the Audit and Risk Committee.

13.2.9 No special payments exceeding delegated limits advised by HM Treasury shall be made without the prior approval of the Board.

14.0 COMPUTERISED FINANCIAL SYSTEMS

14.1 The Chief Financial Officer, supported by the Chief Information Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust shall:

(a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1984;

(b) Ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness and timeliness of the data, as well as the efficient and effective operation of the system;

(c) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

14.2 The Chief Financial Officer shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

14.3 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trusts in the Region wish to sponsor jointly) all responsible directors and employees will send to the Chief Financial Officer:

(a) Details of the outline design of the system;

(b) In the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

14.4 The Chief Financial Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contact should also ensure rights of access for audit purposes.

14.5 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

14.6 Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall satisfy him/herself that:

(a) Systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
(b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Chief Financial Officer staff have access to such data;

(d) Have adequate controls in place; and

(e) Such computer audit reviews as are considered necessary are being carried out.

14.7 No software package should be procured for or used on Trust equipment (PCs, laptops, tablets) without the knowledge of the ICT team. All quotes to purchase software should therefore be managed through the ICT helpdesk

FREEDOM OF INFORMATION

14.8 The Responsible Director shall publish and maintain a 'Freedom of Information (FOI) Publication Scheme', or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

14.9 It is the responsibility of the Responsible Manager to notify the Trust Responsible Director of any new documents to be included in a Publication Scheme already registered with the Information Commissioners Office (ICO).

15.0 PATIENTS PROPERTY

15.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

15.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- Notices and information booklets;

- Hospital admission documentation and property records;

- The oral advice of administration and nursing staff responsible for admissions;

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

15.3 The Chief Financial Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

15.4 Where Department of Health instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Chief Financial Officer.

15.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

15.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

15.7 Where patients' property or income is received for specific purposes and held for safekeeping, the property or income shall only be used for that purpose unless any variation is approved by the donor or patient in writing.

15.8 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Health and Department of Social Security guidance.

15.9 Where a deceased patient is intestate and there is no lawful next-of-kin, details of any monies or valuables should be notified to the Treasury Solicitor.

15.10 Any Funeral expenses necessarily borne by the Trust in respect of a deceased patient shall be reimbursed from any of the patient's monies held by the Trust.

16.0 RETENTION OF RECORDS AND INFORMATION

16.1 The Chief Executive shall be responsible for maintaining archives for all records, information and data required to be retained in accordance with the Information Governance Alliance's 'Records Management Code of Practice for Health and Social Care 2016' published for the Department of Health in July 2016

16.2 The records held in archives shall be capable of retrieval by authorised persons. Destruction of archived records will only be undertaken by authorised personnel and a full audit trail will be maintained.

16.3 Records and information held in accordance with 'Records Management Code of Practice for Health and Social Care 2016' shall only be destroyed before the recommended period has elapsed at the express instigation of the Chief Executive. Proper details shall be maintained of records and information so destroyed.

17.0 GOVERNANCE, RISK MANAGEMENT AND INSURANCE

17.1 The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board.

17.2 The programme of risk management shall include:

(a) A process for identifying and quantifying risks and potential liabilities;

(b) Engendering among all levels of staff a positive attitude towards the control of risk;

(c) Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) Contingency plans to offset the impact of adverse events;

(e) Audit arrangements including; internal audit, clinical audit, health and safety review;

(f) Arrangements to review the risk management programme.

The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of Internal Financial Control within the Annual Report and Annual Accounts as required by NHS Improvement guidance.

17.3 The Chief Financial Officer shall ensure that insurance arrangements exist in accordance with the risk management programme.

18.0 DATE OF NEXT REVIEW

These Standing Financial Instructions are to be updated and reviewed on an annual basis.

19.0 REVISIONS

VERSION	APPROVAL	AUTHOR	DATE
1	Prior 2003	Finance Director	
2	Audit Committee	Lorraine Bewes – Director of Finance	29/05/03
3	Audit Committee	Lorraine Bewes – Director of Finance	17/11/05
4	Audit Committee	Lorraine Bewes – Director of Finance	18/09/07
5	Audit Committee	Lorraine Bewes – Director of Finance	18/03/09
6	Trust Board	Lorraine Bewes – Director of Finance	28/05/09
7	Audit Committee Trust Board	Lorraine Bewes – Director of Finance	20/05/10 24/06/10
8	Audit Committee Trust Board	Lorraine Bewes – Director of Finance	24/03/11 21/04/11
9	Audit Committee	Lorraine Bewes – Director of Finance	18/10/12
10	Audit Committee	Rakesh Patel – Director of Finance	22/10/14
11	Audit Committee	Sandra Easton – Acting Chief Executive Officer	23/03/16
12	Audit Committee Trust Board	Sandra Easton – Chief Financial Officer	23/10/16 05/01/17
13	Audit and Risk Committee Trust Board	Sandra Easton – Chief Financial Officer	28/03/18 TBC

RESERVATION OF POWERS AND SCHEME OF DELEGATION

START DATE:	March 2018	**EXPIRY DATE**	March 2019
COMMITTEE APPROVAL:	**NAME OF COMMITTEE:** Trust Board	**NAME OF CHAIR OF APPROVING COMMITTEE**	
	DATE APPROVED:		
	Endorsed By: Audit and Risk Committee **DATE:** 28 March 2018		
DISTRIBUTION	Trust-wide		
RELATED DOCUMENTS/ OTHER INFORMATION:	• Standing Financial Instructions • Standing Orders – Annex 9 to Constitution of Chelsea & Westminster Hospital NHS Foundation Trust July 2015 • Trust Purchasing Guide • Counter Fraud and Corruption Policy and Response Plan • Conflicts of Interest, Anti-Bribery and Corruption Policy • Treasury Management Policy • Raising a Concern Policy • Governance Framework • Capital Governance Framework Policy • Information Governance Policy • Information Security Policy • Data Protection and Confidentiality Policy • Freedom of Information Policy • Losses and Special Payments Guidance Notes and Procedures • Purchase Order Compliance Policy • Patient Property Policy and Procedure • Other Trust-wide Policies and Procedures		
AUTHOR:	Chief Financial Officer Sandra.Easton@chelwest.nhs.uk		
STAKEHOLDERS INVOLVED:	Chairs of key Trust committees Human Resources (in particular Equality and Diversity Manager) All Trust staff		
IS AN EQUALITY ANALYIS REQUIRED?		NO	

IF AN EQUALITY ANALYIS IS REQUIRED, HAS IT BEEN SENT TO THE EQUALITY AND DIVERSITY MANAGER?			NO
DOCUMENT REVIEW HISTORY:			
Date	**Version**	**Responsibility**	**Comments**
March 2018	14	Chief Financial Officer	Revised front sheet in line with Policy on Non-Clinical Policies. Updates to: • References to legislation • Job titles and committee names to reflect current structure • Regulatory body from Monitor to NHS Improvement Increase to limit for lowest level of expenditure approval from £7,500 to £10,000 Updates to cross referencing to SOs and SFIs Other minor updates

RESERVATION OF POWERS

TO THE BOARD

AND DELEGATION OF POWERS

March 2018
Version 14

CONTENTS

1. INTRODUCTION

1.1 Within the Terms of Authorisation issued by Monitor, the Independent Regulator, NHS Foundation Trusts (now part of NHS Improvement) are required to demonstrate appropriate attention to providing comprehensive governance arrangements in accordance with the Health and Social Care (Community Health and Standards) Act 2003 as updated by the Health and Social Care Act 2012.

1.2 Standing Orders (SOs) regulate the proceedings and business of the Trust and are part of its corporate governance arrangements. In addition, as part of accepted Codes of Conduct and Accountability arrangements, boards are expected to adopt schedules of reservation of powers and delegation of powers. These schedules are incorporated with the *Reservation of Powers to the Board and Delegation of Powers.*

1.3 The purpose of this document is to provide the means for those powers to be reserved by the Board, while at the same time delegating to the appropriate levels the detailed application of Trust policies and procedures. However the Board remains accountable for all of its functions, even those delegated to the Chairman, individual directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.4 Role of the Chief Executive

All powers of the Trust which have not been retained as reserved by the Board or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying functions he/she shall perform personally and which functions shall be delegated to other directors and officers.

a) The Chief Executive is the designated Accounting Officer under the NHS Act 2006 and is responsible for ensuring the discharge of his/her obligations under the NHS Foundation Trust Accounting Officer Memorandum of April 2008 as updated August 2015.
b) As Accounting Officer, he/she is responsible for ensuring that the public funds for which he/she is personally responsible are properly safeguarded and are used in line with the Trust's constitutional functions and responsibilities, including the duty to exercise functions effectively, efficiently and economically.
c) The Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designated to ensure that financial transactions are carried out in accordance with the law and government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They provide a framework of procedures and rules for employees to follow.

1.5 Caution over the Use of Delegated Powers

Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a matter which in their judgement was likely to be a cause for public concern.

1.6 Directors' Ability to Delegate their own Delegated Powers

The Scheme of Delegation shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

1.7 Absence of Directors or Officers to whom Powers have been delegated

In the absence of a director or officer to whom powers have been delegated, those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent, powers delegated to him/her may be exercised by the Nominated Deputy.

2 RESERVATION OF POWERS TO THE BOARD

2. A.1 The NHS Foundation Trust Accounting Officer Memorandum of April 2008 as updated August 2015, which has been adopted by the Trust, requires the Board to determine matters on which decisions are reserved unto itself.

2. B General Enabling Provision

2. B.1 The Board may determine any matter it wishes in full session within its statutory powers.

2. C Regulation and Control

2. C.1 Approval of Standing Orders (SOs), a Schedule of Matters Reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business.

2. C.2 Approval of a Scheme of Delegation of Powers from the Board to officers.

2. C.3 Requiring and receiving the declaration of directors' interests which may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration.

2. C.4 Requiring and receiving the declaration of interests from officers which may conflict with those of the Trust.

2. C.5 Disciplining directors who are in breach of statutory requirements or SOs.

2. C.6 Approval of the disciplinary policy for officers of the Trust.

2. C.7 Approval of the policy for dealing with complaints.

2. C.8 To receive reports from committees including those which the Trust is required by NHS Improvement or other regulation to establish and to take appropriate action thereon.

2. C.9 To confirm the recommendations of the Trust's committees where the committees do not have executive powers. To establish the terms of reference and reporting arrangements of all sub-committees.

2. C.10 Ratification of any urgent decisions taken by the Chairman and Chief Executive in accordance with SO 4.2.

2. C.11 Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

2. D Appointments

2. D.1 The appointment and dismissal of committees which report to the Board.

2. D.2 The appointment, appraisal, disciplining and dismissal of executive directors (subject to SO 2.2)

2. D.3 The appointment of members of any committee of the Trust or the appointment of representatives on outside bodies.

2. D.4 The appointment and removal of the Company Secretary subject to the approval of the Council of Governors

2. E Policy Determination

2. E.1 The approval of personnel policies providing for the appointment, removal and remuneration of staff, including arrangements relating to standards of business conduct (specifically disclosure of interests, hospitality, gifts and expenses)

2. F Strategy and Business Plans and Budgets

2. F.1 Definition of the strategic aims and objectives of the Trust

2. F.2 Approval annually of plans in respect of:-

- Health investment and purchasing intentions
- The application of available financial resources

2. F.3 Overall approval of programmes of investment to guide the letting of contracts for the supply of clinical services.

2. F.4 Approval and monitoring of the Trust's strategy and policy for the management of risk.

2. G Direct Operational Decisions

Note – throughout the remainder of this document any references to financial value shall be taken to exclude VAT.

2. G.1 Acquisition, disposal or change of use of land and/or buildings.

2. G.2 The introduction of discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £500,000.

2. G.3 Approval of individual contracts of a capital or revenue nature amounting to, or likely to amount to over £500,000 for the period of the contract.

2. G.4 Approval of individual compensation payments over £50,000.

2. G.5 To agree action on litigation against or on behalf of the Trust.

2. H Financial and Performance Reporting Arrangements

2. H.1 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees, associate directors and officers of the Trust as set out in management policy statements. All monitoring returns required by NHS Improvement shall be reported, at least in summary, to the Board.

2. H.2 Approval of the opening or closing of any bank or investment account.

2. H.3 Receipt and approval of a schedule of NHS contracts signed in accordance with arrangements approved by the Chief Executive.

2. H.4 Annual Report including the annual accounts, prior to submission to the Council of Governors.

2. H.5 Approval of any loan agreement on behalf of the Trust.

2. I Audit Arrangements

2. I.1 To approve audit arrangements and to receive reports of the Audit and Risk Committee meetings and take appropriate action.

2. I.2 The receipt of the annual management letter received from the external auditor and agreement of actions on the recommendations where appropriate of the Audit and Risk Committee.

2. I.3 The receipt of the annual report from the Audit and Risk Committee.

3. DELEGATION OF POWERS

3. A Delegation to Committees

3. A.1 The Board may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be determined by the Board from time to time taking into account where necessary the requirements of NHS Improvement (including the need to appoint an Audit and Risk Committee and a Remuneration Committee). The Board shall determine the reporting requirements in respect of these committees. In accordance with SO 5.4 committees may not delegate executive powers to sub-committees unless expressly authorised by the Board.

3. B Scheme of Delegation to Officers

3. B.1 Standing Orders and model Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive (CE), the Chief Financial Officer (CFO), and other directors. These responsibilities are summarised below.

Certain matters needing to be covered in the scheme of delegation are not covered by SFIs or SOs or they do not specify the responsible offers. These are:

Area of Responsibility	Overall Responsibility
Information Governance including: • Senior Information Risk Officer for the Information Governance Toolkit • Data Protection Act Requirements	Chief Operating Officer
Health and Safety Arrangements	Chief Nurse and Director of Quality Improvement
Caldicott Guardian	Medical Director
Corporate Governance	Chief Financial Officer and Deputy Chief Executive Officer
Clinical Governance	Medical Director
Accountable Officer for Controlled Drugs	Medical Director

This scheme of delegation covers only matters delegated by the Board to directors and certain other specific matters referred to in the SFIs. Each director is responsible for the delegation within his/her directorate. He/she should produce a scheme of delegation for matters within his/her directorate. In particular the scheme of delegation should include the means by which the directorate budget and procedures for approval of expenditure are delegated.

4 SCHEME OF DELEGATION IMPLIED BY STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

SCHEME OF DELEGATION IMPLIED BY STANDING ORDERS

SO REF	DELEGATED TO	DUTIES DELEGATED
1.4 of Constitution	CHAIR	Final authority in interpretation of Standing Orders.
3.4	CHAIR / COMPANY SECRETARY	Calling meetings.
3.11	CHAIR	Chair all board meetings and associated responsibilities.
6.8	COMPANY SECRETARY	Register(s) of interests.
SFI 5.4.1	CHIEF FINANCIAL OFFICER (CFO)	Best value for money is demonstrated for all services provided under contract or in-house.
SFI 11.2.1	CFO	Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector.
9.7.2	CHIEF EXECUTIVE (CE)	Nominate an officer to oversee and manage each contract on behalf of the Trust.
10.3	CE	Nominate officers to enter into contracts of employment, authorise the regrading of staff, and enter into contracts for the employment of agency staff or consultancy services.
9.9.2	CE	Nominate officers with power to negotiate for the provision of healthcare services with commissioners of healthcare.
10.1 (a)	CE	Determining a matter in which a fair price can only be obtained by negotiation or sale by auction.
11.1	COMPANY SECRETARY	Keep the common seal of the Trust in a safe place and maintain a register of sealing.

SCHEME OF DELEGATION IMPLIED BY STANDING ORDERS

SO REF	DELEGATED TO	DUTIES DELEGATED
12.2.2	CE/CFO	Approve and sign all building, engineering, property or capital documents.
12.1	CE	Approve and sign all documents which will be necessary in legal proceedings involving the Trust.
12.2	CE	Sign on behalf of the Trust any agreement or document not requested to be executed as a deed.
13.1	CE	Existing Directors and employees and all new appointees are notified of and understand their responsibilities within Standing Orders and SFIs.
Annex A 2.3	CE	Designate an officer responsible for receipt and custody of tenders before opening.
Annex A 3.1	TWO SENIOR OFFICERS DESIGNATED BY THE CE	Open tenders.
Annex A 4.2	CE/CFO	Decide whether any late tenders should be considered.
Annex A 5.3	CFO	Keep lists of approved contracts, framework agreements, contracts let from framework agreements, mini-competitions, leases and maintenance agreements let with third parties.

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
1.3.4	CE	To ensure all employees and directors, present and future, are notified of and understand Standing Financial Instructions.
1.3.5	CFO	Responsible for implementing the Trust's financial policies and coordinating corrective action, maintaining an effective system of internal financial control and ensuring sufficient records are maintained.
1.3.6	ALL DIRECTORS AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy, efficiency and effectiveness in using resources and conforming to Standing Orders, Financial Instructions and financial procedures and the Scheme of Delegation.
1.3.8	CFO	Form and adequacy of financial records of all departments.
2.1.1	AUDIT AND RISK COMMITTEE	Provide independent and objective view on internal control and probity
2.2	CE AND CFO	Chief Executive and Chief Financial Officer must monitor and ensure compliance with National Standard Commissioning Contract Directions on fraud, bribery and corruption detection and prevention including the appointment of the Counter Fraud Specialist and the Local Security Management Specialist.
2.3 and 2.4	CFO/INTERNAL AUDIT	Review, appraise and report in accordance with mandatory audit standards as applicable to the NHS and best practice.
2.5.1	AUDIT AND RISK COMMITTEE	Ensure cost-effective external audit service.
3.2.2	CFO	Submit budgets.
3.2.3	CFO	Monitor financial performance against budget, periodically review and report to Board
3.3.1	CE	Delegate budgets to budget holders .
3.4.1	CFO	Devise and maintain systems of budgetary control.

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
4	CFO	Annual accounts and reports.
5	CFO	Banking arrangements.
6	CFO	Income systems.
7.1	CE	Negotiating contracts for provision of patient services.
7.3	CFO	Regular reports of actual and forecast contract income.
8.1.1	BOARD	Remuneration Committee.
8.2.2	CE/CFO	Reporting variation to funded establishment of any department. Staff appointments including agency staff
8.1.3	REMUNERATION COMMITTEE	Report in writing to the Board on any decisions made and the basis for such decisions about remuneration and terms of service of Executive Directors, the Company Secretary and senior employees.
8.4	CFO	Payroll.
9.1.1	CE	Determine and set out level of delegation of non-pay expenditure to budget managers.
9.2.2	CFO	Prompt payment of accounts.
9.2.5	CFO	Authorise who may use and be issued with official orders.
9.2.9	CFO	Ensure that arrangements for financial control and audit are compatible with NHS requirements re building and engineering contracts.
10	CFO	Advise Board on borrowing and investment needs and prepare procedural instructions.

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
11.1.1	CE	Capital Investment.
11.1.2	CFO	Certifying costs and revenue consequences.
11.3	CFO	Maintenance of asset registers and monitoring of capital schemes.
11.3.6	CFO	Calculate capital charges in accordance with NHS requirements.
11.5.1	CE	Overall responsibility for fixed assets.
11.5.4	ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to CFO and reporting losses in accordance with Trust procedure.
12	CFO	Responsible for systems of control over ordering goods and services and receipt of goods.
12.9	CE	Identify persons authorised to requisition and accept goods and services on behalf the Trust supplied via the NHS Supply Chain central warehouses.
13.2	CFO	The Chief Financial Officer must prepare procedures for recording and accounting for losses and special payments. Where a criminal offence is suspected the CFO must inform the police and the Head of Security if theft or arson is involved. In cases of fraud and corruption the CFO must inform the CFS in line with Secretary of State directions.
14	CFO	Responsible for accuracy and security of computerised financial data.
15	CE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
16	CE	Retention of document procedures.

SCHEME OF DELEGATION IMPLIED BY STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	DUTIES DELEGATED
17.1	CE	Risk management programme
17.3	CFO	Insurance arrangements.

5. DETAILED SCHEME OF DELEGATION

5.1. BUDGETARY CONTROL

5.1.1 Schedule of Budgetary Responsibility

Each Divisional Medical Director and Divisional Director is responsible for maintaining a Schedule of Budgetary Responsibility to be approved by the Chief Financial Officer. The Schedule indicates who within each Directorate fulfils the roles identified throughout the Scheme of Delegation. The Divisional Director is also responsible for ensuring that the Finance Department is kept informed of any amendments to the Schedule within their delegated limits.

The Procurement Department will maintain a record of any ordering limits for users of the electronic ordering system that are set lower than the overall budgetary responsibility limits.

The Schedule and any subsequent amendments must be approved by the Chief Financial Officer.

5.1.2 Business Case Approval

A business case is required for all service and capital developments and must be completed using the Trust's business case template. The template is published by the Finance Department and is located on the intranet. The business case approval process is applicable for business cases requiring capital investment, revenue funding, a combination of capital and revenue funding or business cases that are self-funding/income generating.

All business cases will initially proceed through a Division specific process resulting in sign-off by the Divisional Director.

New risks identified in business cases must be logged onto the Trust risk register.

Business cases requiring capital investment must receive approval from the relevant Executive Director (refer to table below) before following the same approval process as revenue business cases. Depending on the specifics of the business case, this approval by the relevant Executive Director may be sufficient to secure the capital funding. If not the next stage, i.e. approval by the Chief Executive, Capital Programme Board and Trust Board, will be followed as appropriate.

A business case register will be maintained by the Chief Financial Officer.

A full description of the process to secure capital investment is detailed in the table below:

Capital Investment Approval Process				
Capital Asset Category	**Business Case Value (including VAT)**	**Within Trust Plan**	**Approval Process**	**Report to**
Medical Equipment	< /=£200K	Yes	Approved by the relevant Divisional Board and then approved by Medical Director (chair of the Equipment Sub Group) within delegated budget and reported to the Capital Programme Board for information	Capital Programme Board
IM&T equipment or systems business cases	< /=£200K	Yes	Approved by the relevant Divisional Board and then approved by Chief Operating Officer	Capital Programme Board
Capital Works to maintain Condition B and other building capital works (Estates)	< /=£200K	Yes	Approved by the relevant Divisional Board and then approved by Chief Operating Officer	Capital Programme Board
Non-Medical Equipment	< /=£200K	Yes	Approved by the relevant Divisional Board and then approved by Chief Operating Officer	Capital Programme Board
All capital types	< /=£200K	No	Approved by the relevant Divisional Board and then approved by Chief Operating Officer and Chief Financial Officer	Capital Programme Board
All capital types	£200K - £1m	Yes	Approved by the Executive Board, then Capital Programme Board for approval	Capital Programme Board
All capital types	£200K - £1m	No	Approved by Executive Board and Capital Programme Board then FIC / Trust Board for approval. Any urgent capital business cases in this category (i.e. greater than £200k and with no capital budget) must be approved by the Chief Executive and Chief Financial Officer and Chairman's action.	FIC / Trust Board
All capital types	>£1m	No	Approved by Executive Board and specific approval from the Finance Investment Committee for recommendation to the Trust Board	FIC / Trust Board
All capital types	>£1m	Yes	Approved by Executive Board and then approval by Finance Investment Committee	FIC / Trust Board
Variations to all capital types	£200k - £1m	N/A	Approved by Executive Board and then approval by Capital Programme Board for them to decide the subsequent authorisation process for the variation prior to additional commitment being made with the supplier.	Capital Programme Board
Variations to all capital types	>1m	No	Approved by Executive Board and then approval by the Finance Investment Committee for recommendation to the Trust Board	FIC / Trust Board

The approval process for Revenue only or Revenue and Capital business cases is outlined in the table below:

Revenue Only or Revenue and Capital Business Cases Approval Process				
Capital Asset Category	**Business Case Value (including VAT)**	**Within Trust Plan**	**Approval Process**	**Report to**
Revenue only	< /=£50k	N/A	Approved by Divisional Director up to an annual limit of £200k.	N/A
Revenue & Capital Investment	>£50K plus capital investment		Approved by the relevant Divisional Board and then up to an annual limit of £200,000 and then follow the capital process as described in the table above. If the aggregate is exceeded then the Executive Board must approve the Business Case.	Capital Programme Board
Revenue & Capital Investment	<£200k	Yes	Approved by the relevant Divisional Board and then approved by relevant Chair of Subgroup, Chief Operating Officer, Chief Financial Officer.	Capital Programme Board
Revenue & Capital Investment	£200k – £1m	Yes	Approved by Executive Board and then for Capital – Approved by relevant Chair of Capital Subgroup, Chief Executive, Capital Programme Board. Revenue – Divisional Director, Chief Operating Officer/Chief Financial Officer and then Chief Executive.	Capital Programme Board
Revenue & Capital Investment	£200k - £1m	No	Approved by Executive Board and then for Capital – Approved by relevant Chair of Capital Subgroup, Chief Executive, Capital Programme Board and then Trust Board for approval. Revenue – Divisional Director, Chief Operating Officer/Chief Financial Officer and then Chief Executive.	FIC / Trust Board
Revenue & Capital Investment	>£1m	Yes	Approved by Executive Board and then approved by Finance Investment Committee.	FIC / Trust Board
Revenue & Capital Investment	>£1m	No	Approved by Executive Board and to the Finance Investment Committee for recommendation to the Trust Board.	FIC / Trust Board

Business case applicants are required to demonstrate that they have involved their Finance and Business Manager and the Procurement Department at the start of the activity for support and advice on costing and procurement strategy.

Business case applicants are not permitted to talk directly with suppliers about costs and must instead obtain guide costs and quotations from the Procurement Department, IT Directorate or Estates Department as appropriate, for inclusion in business cases. At all points of the business case or procurement process, business case applicants must not discuss commercial issues such as prices with suppliers unless a representative from the Procurement Department is present.

In order to provide indicative costs to inform business cases, the Estates Department and IT Department must comply with the Trust's legal obligations and ask the required number of suppliers as outlined in the SO, to provide a quote against an independently drafted specification. Any third parties commissioned to undertake any part of the business planning or procurement process must comply with the Trust's Scheme of Delegation and Standing Financial Instructions.

5.1.3 Management of Budgets

The budgets agreed annually by the Board are to be treated independently and should not be aggregated for the purposes of monitoring.

With the exception of the Chairman, Chief Executive and Chief Financial Officer, no other officer of the Trust is empowered to incur expenditure beyond their budgeted limits.

Budget Holders must confirm either in writing or via online confirmation that they have read the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation before they are approved as authorised signatories within the appropriate delegated limits. This confirmation must be renewed annually to take into account the annual revision to these documents.

5.1.4 Governance of Capital Projects

For individual capital schemes of at least £200k or capital projects that cross divisional structures, a Project Board should be set up and meet at least monthly throughout the life of the project. The terms of reference and required membership of Capital Project Boards are defined in detail in the Capital Governance Framework which is available on the Trust intranet.

If there is a need to change the specification of a project once it has commenced and if this has an adverse impact on the budget then the decision to change the specification must be taken at the Project Board. The additional budget must be sought and approved before the change can proceed. If there is no Project Board then the additional budget must be sought and approved before the change in specification can proceed.

For all completed capital schemes over £25k the budget holder should report on whether the planned benefits have materialised, using the pro-forma for Benefits Realisation Reporting – please refer to the Capital Governance Framework (on the intranet) for further guidance.

5.2 REVENUE EXPENDITURE

5.2.1 Requisitions for Goods, Works & Services

Authorisation limits for the requisitioning of goods & services; (All departments excluding Pharmacy):

Up to £10,000	Budget Holder / Manager
Up to £50,000	General Manager
Up to £100,000	Non-Board Director, Divisional Medical Director
Up to £200,000	Executive Director, Chief Financial Officer
Up to £500,000	Chief Executive or Chief Financial Officer
Over £500,000	Trust Board

Authorisation limits for the requisitioning of Pharmaceutical Drugs; - Pharmacy Department)

Up to £10,000	Pharmacy Purchasing Co-ordinator Pharmacy Payments Administrator Pharmacy Invoicing Manager Pharmacy Buying Office and Stores Manager Homecare Administrator (for Healthcare at Home only)
Up to £50,000	Pharmacy Purchasing and Distribution Manager
Up to £300,000	Associate Chief Pharmacist Head of Pharmacy / Chief Pharmacist / Chief Financial Officer
Up to £500,000	Chief Executive or Chief Financial Officer
Over £500,000	Trust Board

5.2.2 Confirmation of Goods Received

All Orders	Appropriate staff member as nominated by Budget Manager and receipt and delivery staff on their behalf

5.2.3 Contracts for Goods & Services

The following are the authorisation levels for entering into contracts for goods and services:

Contract Value up to £10,000	Budget Holder
Contract Value up to £50,000	General Manager
Contract Value up to £100,000	Non-Board Director, Clinical Director
Contract Value up to £200,000	Executive Director, Chief Financial Officer
Contract Value up to £500,000	Chief Executive or Chief Financial Officer
Contract Value over £500,000	Trust Board

Budget holders are reminded that only Procurement Department members of staff have the delegated authority to enter into contract negotiations with suppliers however agreement of the contract remains subject to a budget holder's approval in line with the limits above. Contracts can only be signed by Procurement.

5.2.4 Variations to Revenue Contracts

Note – for all construction projects authorisation is the responsibility of the relevant Project Board or Executive Director.

Contract Value up to £100,000	Non-Board Director, Clinical Director
Contract Value up to £200,000	Executive Director, Chief Financial Officer
Contract Value up to £500,000	Chief Executive or Chief Financial Officer
Contract Value over £500,000	Trust Board

5.2.5 Call-off Orders against Existing Revenue Contracts

The following are the authorisation levels for signing call-off orders against existing contracts:

Up to £10,000	Budget Holder
Up to £50,000	General Manager
Up to £100,000	Non-Board Director, Clinical Director
Up to £200,000	Executive Director, Chief Financial Officer
Up to £200,000	Chief Executive or Chief Financial Officer
Over £500,000	Trust Board

5.2.6 Invoices against Existing Revenue Service Contracts (All departments excluding Pharmacy)

The following are the authorisation levels for signing off invoices against existing service contracts:

Up to £10,000	Budget Holder / Manager
Up to £50,000	General Manager
Up to £100,000	Non-Board Director, Clinical Director
Up to £200,000	Executive Director, Chief Financial Officer
Over £200,000	Chief Executive or Chief Financial Officer

5.2.7 Invoices against Existing Service Contracts – Pharmacy

The following are the authorisation levels for signing off invoices against existing service contracts specific to the Pharmacy Department:

Up to ££10,000	Pharmacy Invoicing Manager Pharmacy Buying Office Manager Pharmacy Payments Administrator Pharmacy Operational Dispensary Manager Lead Clinical Dispensary Pharmacist Chief Technician Technical Services
Up to £50,000	Pharmacy Purchasing and Distribution Manager Lead Directorate Pharmacist Medicine Lead Directorate Pharmacist W&C Lead Directorate Pharmacist HIV/GUM
Up to £300,000	Associate Chief Pharmacist / Head of Pharmacy / Chief Pharmacist Non-Board Director, Chief Financial Officer
Over £300,000	Chief Executive or Chief Financial Officer

5.2.8 Non-Budgeted Non-Pay Expenditure

Non-pay expenditure, for which no specific budget has been set up and which is not subject to funding under delegated powers of virement (as specified in the budget manual), may only be authorised by the Chief Executive or the Chief Financial Officer.

The Chief Financial Officer is responsible for maintaining a register of occasions when the power above is used.

5.3 QUOTATION, TENDERING AND CONTRACT PROCEDURES – REVENUE EXPENDITURE

The following procedures relate to all revenue expenditure and should be followed in conjunction with the authorisation limits stated in Section 2. All tendering activity is to be processed through the Trust's e-tendering system. Paper tenders will not be accepted, and will be deemed to be non-compliant.

5.3.1 Expenditure under £10,000

There are no formal quotation or tendering procedures relating to expenditure below £10,000. There is, however, a duty upon those responsible for the expenditure to achieve the best value for money – this means the optimisation of both cost and quality.

5.3.2 Expenditure between £10,000 and £50,000

There is a requirement to request a minimum of three written quotations, of which a minimum of two must be returned. Proposed purchases must first be verified by authorised staff from the Procurement Department prior to the order being placed.

5.3.3. Acceptance of Quotation

The best value for money quotation should be accepted, that is the bid, which in the opinion of the independent evaluators, represents the most economically advantageous outcome and which under this condition is therefore deemed to be the offer that represents the best combination of quality and price. This may not, therefore, be the lowest priced quotation. Acceptance is subject to validation by the Procurement Department.

5.3.4 Waiving of Quotations

The requirement to obtain quotations may only be waived with the prior approval of the Chief Executive or the Chief Financial Officer on a normal Single Tender Waiver document, and clear reasons for such being provided. All such instances must be recorded and reported to the Audit Committee in line with 5.6.3.7.

5.4 Expenditure over £50,000

5.4.1 The Formal Tendering Process

The formal tendering process is facilitated by the Procurement Department. It is applied to all revenue expenditure over £50,000 and must be adhered to unless the expenditure fits the criteria under which formal tendering may be waived in line with the procedures in 5.6.3.7.

Standing Order 9.3.4 states "The Board shall ensure that invitations to tender are sent to a sufficient number of firms / individuals to provide fair and adequate competition as appropriate and in no case less than three firms / individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.
At least six tenders must be requested, of which at least three must be returned.

If the proposed expenditure for the whole term of contract is likely to exceed the prevailing OJEU threshold, the Procurement Department must be consulted.

Expenditure under the tender must not be disaggregated to avoid the requirement for tenders and/or quotes.

The process from the opening of tenders onwards to both capital and revenue expenditure and is detailed in section 5.6.3.2.

5.5 CAPITAL PROJECTS / EXPENDITURE AND PRIVATE FINANCE SCHEMES

5.5.1 Management

All capital expenditure must be within the agreed capital programme approved by the Board. A business case submission must be completed for every capital project. All business cases greater than £1m will be reported to the Finance and Investment Committee. The financial monitoring and reporting of all capital scheme expenditure is the responsibility of the Chief Financial Officer. Capital expenditure should be reported monthly to the Capital Programme Board, to the relevant Capital Project Board and to the Finance and Investment Committee as appropriate. Please refer to the Capital Governance Framework for guidance (see Trust intranet.)

5.5.2 Leases

The table below sets out the authorisation levels for leases:

Type of Lease	Authorisation Level
Granting of all new equipment leases (with prior approval in line with non-pay limits set out in section 5.2)	Chief Executive or Chief Financial Officer
Granting of all new land and buildings leases (with prior approval in line with non-pay limits set out in section 5.2)	Trust Board
Termination of leases with an annual rental of less than £50,000	Chief Executive or Chief Financial Officer
Termination of leases with an rental greater than £50,000	Chief Executive or Chief Financial Officer reporting to the Trust Board

5.6 QUOTATION, TENDERING & CONTRACT PROCEDURES – CAPITAL

5.6.1 Expenditure under £10,000

There are no formal quotation or tendering procedures relating to expenditure below £10,000. There is, however, a duty to achieve the best value for money, therefore the capital must be procured through the Procurement Department and a quotation must be obtained and approved before the order is placed. The nominated Capital Project Manager can authorise expenditure up to £10,000.

5.6.2 Expenditure between £10,000 and £50,000

The nominated Capital Project budget holder is responsible for the authorisation of all expenditure up to £50,000. There is a requirement to request a minimum of three written

quotations, of which a minimum of two must be returned. All formal communication to initiate the procurement process should be undertaken by the Procurement Department.

5.6.2.1 Acceptance of Quotation

Best Value for Money quote:

If quote does not vary from pre-quote estimate by >5% and there is sufficient funding	Nominated Capital Project budget holder (see above)
If quote does vary from pre-quote estimate by >5%	Chief Executive, Chief Financial Officer, Chief Operating Officer or Medical Director as appropriate (depending on who approved the original capital bid)
A quote other than the best value for money	Chief Executive or Chief Financial Officer

5.6.2.2 Waiving of Quotations

The requirement to obtain quotations may only be waived by the Chief Executive or the Chief Financial Officer, as stated in section 5.3.4 above.

5.6.3 Expenditure over £50,000

5.6.3.1 Formal Tendering Process

The formal tendering process applies to all expenditure over £50,000 and must be adhered to, unless the expenditure fits the criteria under which formal tendering may be waived. In addition, the OJEU process must be complied with; refer to the Procurement department for the prevailing OJEU thresholds and the application of such to the whole life of the contract.

In line with the provisions of SO 9 (Tendering and contract procedure), it is a requirement to ensure that invitations to tender are sent to a sufficient number of firms or individuals to provide fair and adequate competition. In no case should fewer than three firms or individuals be requested to provide tenders.

A minimum of four tenders should be requested and three should be returned.

All tendering activity must be conducted through the electronic tendering system; paper submissions will not be accepted and may be deemed non- compliant.

THE FOLLOWING SECTION IS APPLICABLE TO BOTH CAPITAL AND REVENUE TENDERS:

5.6.3.2 Opening Tenders

Tenders will not be accepted in paper format

Where tenders are received via the Trust's online Tender Management system: These need only be verified by representatives from the Legal Department and Procurement, as the system has built in security and is fully compliant with all relevant legal obligations.

5.6.3.3 Insufficient Tenders

If insufficient tenders are returned, the decision whether to re-tender or continue rests with the Chief Executive or Chief Financial Officer reporting to the Board

5.6.3.4 Receipt of Late Tenders

In the event that a tender is received by the Trust beyond the official deadline, only the Chief Executive or Chief Financial Officer is authorised to decide if the tender can still be included for consideration. Valid reasons for inclusion would include evidenced delivery to the Trust before the deadline where the Trust's internal postal system caused the delay in receipt.

5.6.3.5 Acceptance of Tender

Tenders should be evaluated in accordance with the guidance contained in the Purchasing Handbook (see the Trust intranet).

The best value tender should be accepted. In the case of variations from the pre-tender estimates the following rules apply:

- If the tender does not vary from the pre-tender estimate by more than 5% and there is sufficient funding, the Project Director or Senior Responsible Officer are authorised to accept it.
- If the tender does vary from the pre-tender estimate by more than 5%, it may only be accepted with the agreement or the Chief Executive or Chief Financial Officer.

Where a tender **other than the best value** is accepted, the following should apply:

Tender value under £500,000	Chief Executive to approve and report reasons to Board
Tender value over £500,000	This power is reserved to the Trust Board. The Chief Executive should make a recommendation as appropriate

5.6.3.6. Reporting Of Tenders

Reporting of all tenders including companies invited to tender, dates and values of tenders received.

Over £50,000	Chief Financial Officer

5.6.3.7 Waiving of Formal Tendering Process

Formal tendering procedures for expenditure over £50,000 may be waived under SO 9.3.2 under the circumstances set out below. The Standing Orders specifically prohibit the use of these waivers for the purpose of avoiding competition or for administrative convenience. Single Tender Waivers must be sought and approved PRIOR to any procurement taking place.

Supply under special arrangements negotiated by the Department of Health which must therefore be complied with.	Chief Financial Officer or Chief Executive and reported to the Board
Timescales preclude competitive tendering. (Cannot apply to OJEU – explicit in Public Sector Regulations)	Chief Financial Officer or Chief Executive and reported to the Board
Specialist expertise is required and is available from only one source. (Refer to Procurement Department to validate the issue of a VEAT notice if applicable)	Chief Financial Officer or Chief Executive and reported to the Board

Task is essential to complete project AND arses as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate.	Chief Financial Officer or Chief Executive and reported to the Board
There is clear benefit from continuity with an earlier project.	Chief Financial Officer or Chief Executive and reported to the Board

5.6.3.8 Recording of Tender and Quotation Waiving

The Chief Financial Officer is responsible for maintaining a record of the occasions when the requirement for tenders and quotations has been waived.

5.7 SIGNING OF CONTRACTS FOR INCOME

The following are the authorisation levels for the approval of contracts for income:

Contract Value up to £10,000	Budget Holder/Manager
Contract Value up to £50,000	General Manager
Contract Value up to £100,000	Non-Board Director
Contract Value up to £200,000	Executive Director, Chief Financial Officer
Contract Value up to £500,000	Chief Executive and Chief Financial Officer
Contract Value over £500,000	Trust Board and delegated to CFO/CFO

In addition to the budget holder's signature on a contract, all contracts with a value of up to £100,000 must be countersigned by the following people:

- Head of Procurement – in order to review all of the legal aspects of the contract
- Chief Financial Officer/Deputy Director of Finance/Head of Financial Operations/Head of Financial Management – in order to review the financial aspects of the contract and ensure that the budget exists for the related expenditure.
- Director of IT for ICT related contracts

Healthcare Contracts

All healthcare contracts and contracts for private or new business ventures regardless of value must be approved by the Chief Executive or the Chief Financial Officer.

Grants

All grant applications should be reviewed and signed off by the relevant Business Analyst/Finance and Business Manager in the first instance. All applications for grants exceeding £50,000 should also be counter signed by the Chief Financial Officer and the above rules on the signing of contracts would apply.

5.8 FINANCIAL CONTROL

5.8.1 Bank Accounts

Maintenance and operation of bank accounts:

- Chief Financial Officer

Approval of cheque signatories:

- Chief Executive and Chief Financial Officer

Signing cheques or approval of direct electronic payments up to £50,000:

- Two approved signatories

Signing cheques or approval of direct electronic payments over £50,000:

Two approved signatories including at least one signatory from the following:

- Chief Financial Officer
- Deputy Director of Finance
- Finance Business Partner

Electronic authoriser of direct electronic services payments approved as above by two approved signatories:

- Head of Financial Operations
- Head of Financial Management
- Deputy Head of Financial Operations

The only exception to the limits for approval of direct electronic payments over £50,000 is in the case of the transmission of funds to the National Loans Fund for short term deposits. In this case only, the transmission of funds can be approved by any two approved signatories.

5.8.2 BACS payments transmission

BACS payments transmission of approved invoices is prepared by Accounts Payable and approved in line with schedule 5.8.1 above.

BACS payments transmission of salaries is prepared and authorised by the outsourced payroll provider.

5.8.3 Fees and Charges

The responsibility for setting fees and charges lies with the Chief Financial Officer; however in some cases the value may be set externally, e.g. by the Department of Health or legislation.

Price of NHS Service Agreements.	Chief Financial Officer
Charges for all NHS Service Agreements.	Chief Financial Officer
Price of Non-NHS activities: Income generation including Private Patients, Overseas Visitors and all other services.	Chief Financial Officer
Invoicing as appropriate for all NHS, non-NHS, income generation and any other chargeable activity.	Chief Financial Officer

5.8.4 Losses, Write-Offs and Compensation

5.8.4.1 Authorisation of debt write-off or partial write-off: Individual debts for Private Patients, Private Maternity Patients or Private ACU Patients

Up to £1,000 (where necessary as part of the complaints process)	General Manager or Non-Board Director
Up to £5,000	Head of Financial Operations
Up to £20,000	Deputy Director of Finance
Up to £50,000	Chief Financial Officer
Up to £100,000	Chief Executive
£100,000 and above	Decision reserved to the Board

5.8.4.2 Authorisation of debt write-off: All other individual debts

Up to £5,000	Head of Financial Operations
Up to £20,000	Deputy Director of Finance
Up to £50,000	Chief Financial Officer
Up to £100,000	Chief Executive
£100,000 and above	Decision to be reserved for the Board

5.8.4.3 Package of debts

Up to £5,000	Head of Financial Operations
Up to £20,000	Deputy Director of Finance
Up to £100,000	Chief Financial Officer
Up to £250,000	Chief Executive
£250,000 and above	Decision reserved to the Board

5.8.4.4 Authorisation of losses and special payments, including ex-gratia payments

Less than £1,000	General Manager
Less than £5,000	Non Board Director
Less than £25,000	Chief Financial Officer
Less than £50,000	Chief Executive
£50,000 and above	Decision reserved to the Board

All severance payments must be authorised by HM Treasury and notified to the Audit Committee.

NHS Improvement has published a template to be used for all special severance cases to be submitted to HM Treasury for approval which is located on the www.gov.uk website.

All bad debt write-off, losses and special payments are notified to the Audit Committee.

5.8.4.5 Investigation of suspected fraud	Chief Financial Officer, reported to the CFS, Head of Internal Audit, External Audit and Audit and Risk Committee.

5.8.5 Petty Cash

The overall responsibility for Petty Cash Floats held within a Department lies with the General Manager.

Approval for Petty Cash Float	General Manager and Head of Financial Operations
Expenditure up to a maximum £100 claim / transaction	Budget Manager

Costs incurred by staff in the ordinary course of business, e.g. travel costs, must be reclaimed through an expenses application form and paid to the employee in the salary to ensure the tax implications are correctly accounted for.

5.8.6 Purchasing Cards

The Chief Financial Officer has overall responsibility for Trust purchasing cards including security, authorised use and purchasing limits.

Responsibility for the security and use of an individual Trust purchasing card is the named holder of the card. Each card must only be used for the purpose for which it is authorised, for example, travel and subsistence costs. Each cardholder must comply with the administrative requirements of the Trust's Purchasing Cards guidance.

Approval for issue of new cards	Chief Financial Officer
Approval of overall and individual limits	Chief Financial Officer

5.8.7 Patients Monies and Valuables

The General Manager / Clinical Director is responsible for the control and safe-handling of patient monies and valuables up to the point of receipt by the Cashiers Officer after which the Chief Financial Officer is responsible for their safe-keeping and recording.

Withdrawal of patient monies (maximum £100 per day).	Ward Manager
Reimbursement of closing balance of patient monies and valuables.	Ward Manager

These transactions must also be authorised by the Patient.

In the event of a patient's death where no next of kin is known, the claimant must provide evidence that he/she is the executor of the patient's estate. If there is no such evidence available then if the claimant can show the original death certificate then the monies and valuables will be returned to the claimant.

5.8.8 Internal and External Audit Recommendations

Implementation of recommendations	Officers identified in the audit report and monitored by the Chief Financial Officer
Follow up of recommendations to ensure effective implementation	Audit and Risk Committee

5.8.9 Trust Financial Procedures

Maintenance and update of Trust financial procedures	Chief Financial Officer

5.8.10 Investment of Funds

Approval of organisations in which investments may be made and types of permitted investments.	Chief Financial Officer and approved by Trust Board
Authorisation of individuals	Chief Financial Officer

5.8.11 Borrowing

The authority to sign loan draw-downs against approved loans is delegated to the Chief Financial Officer or the Chief Executive.

5.8.12 Charitable Donations

The following criteria must be considered when making charitable donations from the Trust funded budgets:

- Whether the donation is an appropriate use of NHS funds
- Whether the donation directly supports the department's objectives

Any donation for an amount greater than £5,000 must be countersigned by an Executive Director and donations may only be made to arm's length charities, i.e. charities that are not controlled by the budget holder making the donation.

5.9 HUMAN RESOURCES

5.9.1 Engagement of Staff on the Establishment

Authority to fill funded post on the Establishment with permanent staff	Refer to Establishment Management Panel Guidance

5.9.2 Engagement of Staff not on the Establishment

This is bound by the rules governing revenue expenditure including the need for quotation and tender, and the Trust's policy on the use of contract staff as owned by Human Resources (HR).

5.9.3 Additional Staff to the agreed Establishment

With specifically allocated finance	General Manager/Chief Financial Officer/Deputy Chief Executive Officer

Without specifically allocated finance	Chief Executive or Chief Financial Officer

5.9.4 Fixed Term Contracts

Authorisation or renewal of fixed term contracts	Trust Establishment Panel

5.9.5 Pay Increases/Decreases

The granting of additional increments to staff within budgets	General Manager and HR Business Partner
All requests for upgrading/re-grading	Trust Establishment Panel dealt with in accordance with Trust procedure
Authority to complete standing data affecting pay, new starters, variations and leavers	Budget Holder and HR representative forms
Authority to complete and authorise timesheets	Budget Manager (subject to limits to be set by the General Manager)
Authority to authorise overtime	Budget Manager (subject to limits to be set by the General Manager)
Authority to authorise travel and subsistence expenses	Budget Manager (subject to limits to be set by the General Manager)
Approval of performance related pay	Chief Executive / Remuneration Committee

5.9.6 Annual Leave

Approval of annual leave	Line / General Manager
Approval of carry forward of annual leave to a maximum of 5 days	Line / General Manager
Time off in lieu	Line / General Manager

5.9.7 Bereavement Leave

Up to 6 days on full pay	*Line / General Manager

*With guidance from Human Resources

5.9.8 Special Leave

Dependents leave	*Line / General Manager

*With guidance from Human Resources

5.9.9 Maternity, Paternity and Adoption Leave

Maternity leave – Paid and unpaid	*General Manager
Adoption leave – Paid and unpaid	*General Manager
Paternity leave – Paid and unpaid	*General Manager

*With guidance from Human Resources and outsourced payroll provider

5.9.10 Sick leave

Extension of sick leave on half pay up to three months	General Manager and Chief Financial Officer and Deputy Chief Executive Officer/Deputy Director of Human Resources
Return to work part-time on full pay to assist recovery	General Manager with Occupational Health and/or HR advice
Extension of sick leave on full pay	General Manager and Chief Financial Officer and Deputy Chief Executive Officer or Chief Executive

5.9.11 Study leave

Study leave	General Manager

5.9.12 Redundancy

Redundancy	General Manager and HR Business Partner

5.9.13 Ill Health Retirement

Decision to pursue retirement on the grounds of ill health	Line Manager with Occupational Health and HR Support

5.9.14 Dismissal

Dismissal	Dismissing Officers

5.9.15 Removal Expenses

Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview):

Up to £3,000	Human Resources / General Manager
Over £3,000	General Manager / Chief Executive

5.9.16 Reporting of Incidents to the Police

Where a criminal offence is suspected:

• Of a violent nature	Executive Director/Chief Financial Officer / on call Manager

• Other	Executive Director on call
• Where a fraud is involved	Chief Financial Officer

5.9.17 Receiving Hospitality

Applies to both individual and collective hospitality:	
• Receipt of items in excess of £75 per item received	Declaration required in Trust's hospitality register
Maintenance of hospitality register	Chief Financial Officer

5.10 ESTATE MANAGEMENT

5.10.1 Rental Agreements and Licences

Preparation and signature of all tenancy agreements / licenses for all staff subject to Trust policy on accommodation for staff	Chief Financial Officer and Deputy Chief Executive Officer or nominated deputy
Extension to existing leases for staff	Chief Financial Officer and Deputy Chief Executive Officer or nominated deputy
Letting of premises to outside organisations	Chief Financial Officer and Chief Executive
Approval of rent based on professional assessment	Chief Financial Officer

5.10.2 Condemning and Disposal

Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively:	
• With estimated replacement cost under £5,000	General Manager
• With estimated replacement cost over £5,000	Chief Financial Officer
Disposal of x-ray films:	
• Estimated sale proceeds under £5,000	General Manager
• Estimated sale proceeds over £5,000	Chief Financial Officer
Disposal of mechanical & engineering plant:	
• Estimated sale proceeds under £5,000	Deputy Chief Executive Officer
• Estimated sale proceeds over £5,000	Deputy Chief Executive Officer / Chief Financial Officer

5.11 CORPORATE AFFAIRS

Insurance policies and risk management	Chief Executive
The keeping of a Declaration of Interest Register	Chief Executive

Attestation of sealing in accordance with Standing Orders Section 12	Chairman / Chief Executive
The keeping of a Register of Sealing	Company Secretary
The keeping of the Hospitality Register	Company Secretary
Retention of records	Chief Executive

5.12 DISTRIBUTION LIST

Chairman
Chief Executive
Executive Directors
Non-Executive
Directors Non-Board
Directors General Managers
Director of Procurement
Finance Department
Human Resources Department
Budget Holders *(See Budget Holder List held by Finance)*

6 .0 REVISIONS

Version	Approval	Author	Date
1	Prior 2003	Finance Director	
	Audit Committee	Lorraine Bewes – Director of Finance and Information	29/05/2003
3	Audit Committee	Lorraine Bewes – Director of Finance and Information	17/11/2005
4	Trust Board	Lorraine Bewes – Director of Finance and Information	28/11/2007
5	Audit Committee	Lorraine Bewes – Director of Finance and Information	18/03/2009
6	Audit Committee	Lorraine Bewes – Director of Finance and Information	28/05/2009
7	Audit Committee Trust Board	Cathy Mooney - Director of Governance and Corporate Affairs and Lorraine Bewes - Chief Financial Officer and Information	20/05/2010 24/06/2010
8	Audit Committee Trust Board	Lorraine Bewes – Executive Director of Finance	24/03/2011 21/04/2011
9	Audit Committee	Lorraine Bewes – Executive Director of Finance	18/10/2012
10	Audit Committee	Rakesh Patel – Director of Finance	22/10/2014
11	Audit Committee	Lorraine Bewes – Chief Financial Officer	23/07/2015
12	Audit Committee	Sandra Easton – Chief Financial Officer	23/03/2016
13	Audit Committee	Sandra Easton – Chief Financial Officer	25/10/2016
14	Audit and Risk Committee	Sandra Easton – Chief Financial Officer	28/03/2018